

2010

Current Care and Emerging Technologies: Lung Cancer in the Natural State

Friday, June 11



The inaugural *Current Care and Emerging Technologies: Lung Cancer in the Natural State* conference was provided in partnership by the Arkansas Cancer Coalition, Arkansas Department of Health Stamp Out Smoking (SOS) program, and the University of Arkansas for Medical Sciences. It was held on June 11, 2010 at the University of Arkansas for Medical Sciences in the I. Dodd Wilson Building. The purpose of the conference was to provide an updated review of the multidisciplinary approach of diagnosing, staging, and treating patients with lung cancer. The entire symposium was supported by state funds and targeted an audience of lung cancer advocates and lung cancer medical professionals.

The following conference report summarizes key themes appreciated throughout the day and identifies gaps where additional resources and discussion may be necessary.

WELCOME

Arkansas' battle with lung cancer is faced both by medical professionals and advocates. The welcoming remarks by State Representative Fred Allen and Dr. Peter Emmanuel, Director of the Winthrop Rockefeller Cancer Institute, painted a clear picture of how both players are needed in order to tackle the undeniably destructive disease of lung cancer.

As Dr. Emmanuel reminded listeners, Arkansas consistently ranks among the top five states in lung cancer mortality. In 2010 it is projected that over 2,100 Arkansans will lose their lives to lung cancer - more than will die from breast, colon and prostate cancer combined. Dr. Emmanuel offered that it is necessary to build a floor for multi-disciplinary service so providers can easily practice together, not in silos.

The importance of the day was not lost on State Representative Fred Allen, as he has been personally impacted by cancer. As he described his battle with prostate cancer, the sadness and fear he depicted was lessened through the support and prayer of friends and colleagues in his life. Importantly, he also noted his father's struggle with lung cancer in the 1970s; specifically, how far technology has come in order to supply a more hopeful and curative prognosis and treatment than four decades prior.

Representative Allen noted that lung cancer is the lead cause of cancer death in Arkansas; if we could stop tobacco use we could wipe it out. His continued goal for lung cancer advocacy in Arkansas is to create legislation to support it similar to the Arkansas Cervical Cancer Taskforce. In doing so, he recently introduced a new bill that inhibits adults from smoking in a car with minors. He is confident that this alone will assist in giving our children a healthier future.

Both Dr. Emmanuel's discussion of a multi-pronged approach to impacting lung cancer in the medical community and Representative Allen's personal testimony and hand in shaping

meaningful state legislation, indicate that both advocates and medical professionals are essential in attacking lung cancer in Arkansas.

JOINT SESSION: Advocates and Medical Professionals

A joint session was provided to lay a foundation for both providers and advocates. Two presentations by well respected lung cancer treatment and advocacy specialists were provided.

>> Dr. Carolyn Dressler, Director of the State SOS program presented an overview of cancer incidence and mortality rates as well as a recap of the historical events surrounding tobacco that got us to where we are today. Her talk, titled, *Epidemiology of Lung CA: This Really Matters!* highlighted that 71% of all lung cancer is attributable to cigarette smoking.

In 1964 the United States Surgeon General produced the first authoritative report on the health effects of tobacco use. As we have come to discover, lung cancer continues to be the most common cancer diagnosis since 1985. Currently, 1.35 million people are diagnosed with lung cancer each year; 71% of people diagnosed are male. Additionally, incidence rates also climb as one ages.

She shared the Lopez Descriptive Model with the audience. It is a model that indicates rates of tobacco use increase by year and shows a coordinated death rate increase following the same pattern years later. The trend worldwide shows higher male smoking rates; however, as male smoking rates decrease, the death rates decrease. The Lopez Curve predicts the same for females.

Death rates in the US peaked for men in 1985 and are now trending down. Women in the US realized a slower uptake of smoking habits and have yet to show a turn down in rates. Globally there is a 51% increase in lung cancer incidence rates; 76% in women and 44% in men. Fifty-percent of 'new' lung cancer cases are in developing worlds.

In Arkansas, rates are also starting to trend down. Applying the Lopez Model, in the coming years as Arkansas' smoking rate decreases, the death rate should also decrease – great news for any tobacco control advocate!

>> Dr. Mazen Safar provided a very candid discussion of the past and current research surrounding tobacco-related cancers. The impact of current therapies can be very frustrating. He noted studies that take intense time and resources to discover even minute success, and once completed, are published decades later. From these studies and from experience, we know that when scientific opportunities do surface, much of the medical community uses great

Currently, 1.35 million people are diagnosed with lung cancer each year; 71% of people diagnosed are male.

caution in comprehending, expanding, interpreting and applying the results to real life cases – rendering them almost useless. Additionally, the cost of providing therapies cannot always guarantee more survival time or increased quality of life; therefore, it is imperative that physicians educate themselves continuously and understand what research is beneficial in practical application even years after it has been published.

Cancer treatment versus prevention and cessation of tobacco use was another important area to which Dr. Safar spoke. He challenged physicians to become more comfortable with tobacco cessation therapies and to learn to have honest and serious discussions with their patients about quitting. Ideally, he would like to see providers always counsel the patient and family members and to look to the cessation literature for guidance and evidence. In doing so, some of the cost incurred through downstream cancer treatment could be avoided.

Finally, it will be important for cancer treatment providers to be inclusive of their colleagues and other medical clinicians when creating treatment plans for their patients. So often boundaries are erected among medical professionals, which eliminates the multi-pronged approach needed in treating and caring for cancer patients.

PHYSICIAN AND ADVOCATE BREAKOUT SESSIONS

During the day both physicians and advocates spent dedicated time expanding their knowledge. Separate breakout sessions were provided focusing on the clinical components of lung cancer (physicians) and the environmental and public health components of lung cancer (advocates). Following is a brief outline of the topics and content discussed in the sessions.

Physician Breakouts

Objectives:

- Describe the benefits from prevention, cessation for risk reduction and cessation after diagnosis.
- Identify the current staging system for lung cancer with emphasis on recent changes and its impact on care.
- List the options available for treating lung cancer patients with regards to emerging technologies.
- Explain the role of current standards and their comparison to novel therapeutic regimens.
- Describe the severity of the problem of lung cancer in the state of Arkansas and the importance of raising the survival rate.

>> Dr. Imran Ahmad kicked off the session with a discussion of adjuvant therapy (chemotherapy after surgery). Specifically he discussed what improvements are needed for overall survival after complete resection of Non Small Cell Lung Cancer (NSCLC).

Dr. Ahmad discussed several randomized trials that were completed in the past two decades. Some show benefit in median and overall survival, while others show minimal differences. Ultimately, the science is moving forward in defining further which patients would get the most benefit from adjuvant therapies; however, more data is needed to define adjuvant versus neo-adjuvant decisions in the treatment of NSCLC.

>> Dr. Konstantinos Arnaoutakis continued with a discussion of the differing stages of NSCLC; specifically Stage III disease. The survival difference between Stage III and IV is minimal. Patients with Stage III heterogeneous disease are difficult candidates for clinical trials because not all patients behave in the same way. Factors such as weight loss, performance status and biology play a significant role in treatment success; therefore, patients should be offered a multi-pronged approach.

Individualizing the approach to Stage III disease is necessary. Research trials show that the standard of care should include multi-modal therapy with an experienced multidisciplinary group of practitioners. For example, one study that combined three therapies – surgery, chemotherapy, and radiation (trimodality therapy) – concluded that the survival benefit is better.

>> In closing the morning session for physicians, Dr. Thaddues Bartter discussed thoughts on why research trials should not be stage-based, but rather, biology-based. He discussed the many benefits of staging, such as staging offering a common language across providers and patients and staging offering ease when designing and recruiting for clinical research studies.

The old staging system saw a lot of problems. From it, and studies of survival, refinements have been made. One of the main purposes of the new classification system is to identify when to resect a patient. In answering that question the new system now shows separate survival curves for each stage (like combed hair); thereby making a more decisive decision on whether a patient is operable.

>> Dr. Bartter continued with a brief discussion of the history and advances in pathological staging. He highlighted a new staging tool, endobronchial ultrasound (EBUS). Intuitively it is a much superior tool that is more likely to find nodules as it provides real-time imaging of the surface of the airways, blood vessels, lungs, and lymph nodes. It is also less invasive than mediastinoscopy and in skilled hands can be just as accurate - if not more. The EBUS is a valuable tool that is experiencing explosive growth and favorable outcomes in current studies.

Additional break-out session topics included:

VATS Lobectomy

Stereotactic Radiation

RFA

Impact of Histologic Subtypes on Systemic Therapy (Stage IV Disease)

VATS and other Surgeries

Tailored Therapy

Non-chemotherapy Agents for NSLC

ASCO 2010 News

Advocate Breakouts

Objectives:

- Describe the benefits from prevention, cessation for risk reduction and cessation after diagnosis.
- Recognize that the majority of lung cancer cases are a direct result of the tobacco industry's marketing, and profiting from, a specific highly addictive product, the cigarette.
- Recognize that the challenges of prevention are in great part a political challenge to a tobacco permissive norm; taxes, tobacco free environments, marketing reform.
- Translate an understandable perspective for the types of lung cancer and the contemporary techniques for screening, detection, and treatment.
- Offer opportunities for action to prevent lung cancer before it strikes.
- Describe the severity of the problem of lung cancer in the state of Arkansas and the importance of raising the survival rate.

>> Leading off the second breakout series for advocates was Dr. Thaddeus Bartter. He engaged the audience in some of the misconceptions and dishonesty surrounding screening for lung cancer. Ultimately his challenge to the advocates - and to the broader cancer treatment world - was to find something less expensive, more specific, and not anatomy-based on which to diagnose. Collateral damage has been recognized when using CT scans for diagnosing. As an example, a small consolidation of nodules is part of a normal lung – especially of a smoker – however, a CT scan cannot tell you if it is cancer. A patient who receives results indicating possible cancer and therefore undergoes a biopsy, experiences fear, anxiety, injury, and expense just to name a few. Determining a biological marker that would correlate with a malignancy would be a perfect substitute.

>> Cal Wasson delivered a thought-provoking discussion of the many facets of tobacco control and sale. Nicotine is a trillion dollar addiction market. Recently, morally suspect and powerful business sectors have made inroads into harm reduction and nicotine replacement therapy (NRT).

While the US nicotine market is still growing even in a recession, tobacco companies continue to work toward making 'harm reduction' spit tobacco perceived as a health product. The pharmaceutical industry is also seizing an opportunity and pushing NRT. They may seek future regulations such as consumer subsidies, mandated insurance coverage and reduced restrictions on sales to minors.

High economic and social costs associated with tobacco use are driving the anti-smoking legislation worldwide. Just this month 'light' and 'low tar' is banned from tobacco marketing materials. In the future we may see an alteration of nicotine – maybe even a non-addictive cigarette.

This phenomenon is conceptually difficult to grasp for advocates. Why does something (a non-addictive cigarette) need to be introduced in order to 'quit' cigarette use? Is this quitting or just switching delivery methods? Has harm really been reduced? Has the advocates' role been diminished? Do advocates start pushing skoal or a separate addiction?

There are so many questions to consider, but the true answer is, as Mr. Wasson described, "TO QUIT IS TO QUIT."

>>Dr. Matthew Steliga outlined different surgical options for cancer node removal in order to increase the knowledge of the advocate audience. Importantly, he conveyed that there are minimally invasive surgical options for cancer node removal and different levels of cancer benefit from different treatments (i.e. surgery alone, surgery with or without chemotherapy and radiation). Not all resections are the same and not all patients warrant the same approach. There are multiple options available depending on oncologic criteria and physiologic criteria; therefore, a multidisciplinary "team" approach is necessary for optimal care.

>> Rounding out the advocate presentations was a very special presentation from a nine year cancer survivor, Joanne Blos, *Never Give Up Hope!* She was diagnosed with Stage IV adrenal lung cancer in May 2001 and given six months to live. After surgery she

You have to be your own advocate. You have to know about your cancer, the drugs, how they interact and you have to be in the conversation with your doctor. Be involved.

had immediate chemotherapy, however stopped the therapy to enter a clinical trial to focus on her quality of life.

Throughout her journey she had a wonderful support system and knew she needed to give back to the cause by passing along her help to others suffering with cancer. She has since become a patient advocate and specifically encourages clinical trials and the many free services available to cancer patients.

She noted several strategies to assist in the cancer care and treatment process. The first, have a good relationship with your doctor. They should be invested in you and they should work hard to see your success. Your doctor should also listen well to you, offer choices, give you actual information, and let you know that there is hope.

You have to be your own advocate. You have to know about your cancer, the drugs, how they interact and you have to be in the conversation with your doctor. Be involved.

Additional break-out session topics included:

History of Lung Cancer
Smoking and Guilt
Definitions

CLOSING SESSION

The final portion of the conference brought providers and advocates back together to culminate the messages of the day.

>> Dr. Carolyn Dressler revisited the group and provided more fuel for the tobacco cessation fire. She shared perspectives on why cigarette use continues to exist and how advocates and providers can tackle the problem head-on. Several points were made, including:

- Most individuals begin smoking at age 12 or 13,
- Individuals with higher incomes and more education are less likely to use tobacco,
- Most myocardial infarctions are diagnosed at around 65 years of age,
- 3-5% of US physicians smoke,
- If adults quit, kids no longer have role models to observe behavior,
- Light cigarettes are characterized by perforations (ventilation) seen on the cigarette; however, the concept does not work as the perforations are covered up by the mouth when inhaling,
- SNUS: little packets of smokeless tobacco that get a person to their next cigarette (implemented because of many states' clean indoor air acts),
- Concomitant Use: smokeless tobacco use with cigarette use, and
- Moreover, smoking prevalence over time has been driven by the tobacco industry.

The majority of smokers want to quit, and many have tried more than once. Because nicotine addiction is a chronic disease, providers and advocates just need to catch people when they are most ready. Providers can play a major role in cessation by providing a supportive environment, pharmacotherapy resources and behavioral modification programs to their patients.

The US recommendation is for pharmacotherapy with behavioral support spanning at least 100 minutes.

To begin the process, physicians can use **The 5 A's**: Ask, Advise, Assess, Assist, Arrange when working with their patients.

Ask: at every visit ask if they smoke and document the response as a vital sign

Advise: personalize the message to the patient and strongly urge all tobacco users to quit

Assess: the patients willingness to quit

Assist: the patient in quitting, help them design a quit plan, counsel

Arrange: for follow-up contact with the patient

Arkansas has an ideal resource for physicians: 1-800-QUIT-NOW. Physicians can call this number to access the FAX referral program and assist in enrolling their patients.

>> Assistant Professor of Surgery at the University of Arkansas, Matthew A. Steliga, MD, provided perspective on second opinions, noting that a second opinion or a differing perspective is valuable when assessing cancer diagnoses. Specifically, second opinions are of value for something that may be 'unresectable' or for someone who may be deemed 'inoperable'.

>> Sarah Beth Harrington, MD shared an introduction to palliative care in caring for lung cancer patients.

Palliative Care: relieving or soothing the symptoms of a disease or disorder with the goal of preventing and easing suffering.

Palliative care can be initiated at any point of an illness and can be provided alongside curative care - independent of medical care payer or health care professional. Palliative care should increase over the duration of a patient's disease with modifications in

The 5 A's

Ask: at every visit ask if they smoke and document the response as a vital sign

Advise: personalize the message to the patient and strongly urge all tobacco users to quit

Assess: the patients willingness to quit

Assist: aid the patient in quitting, help them design a quit plan, counsel

Arrange: or refer the patient for follow-up

Physician Resource

**AR Stamp Out Smoking
1-800-QUIT-NOW**

The Fax Referral Program links tobacco users to the Arkansas Tobacco Quitline by working through their health care providers. REFER patients to 1-800-QUIT-NOW by using the Fax Referral Form.

treatment if their condition worsens. Hospice is a next step option for many, followed by bereavement support for the surviving family and support system.

Palliative care can treat symptoms of advanced disease, making the process more comfortable for the patient. Symptoms such as: pain, fatigue, nausea, constipation, diarrhea, dyspnea, cough, anorexia, delirium, depression and many others can be addressed.

For more information, contact: www.getpalliativecare.com www.palliativedoctors.org

>> Closing out the day was a panel discussion of case studies to put some of the knowledge gained into practice. Many of the solutions highlighted a team approach to diagnosing and preparing a treatment plan, benefits or drawbacks of neo-adjuvant versus an adjuvant approach, and assessing complications from past medical histories or lifestyle.

OVER-ARCHING THEMES

Several themes were identified throughout the day by providers and advocates. The list below is a summary of key themes:

- A team approach is absolutely necessary in order to deliver optimal care /a multi-modality approach to care should be used,
- Palliative care can be offered as an option,
- Always involve the patient – individualize the care plan,
- There is a changing tide in tobacco legislation and lobbying – shift toward harm reduction therapies (i.e. nicotine replacement therapy),
- Technology is advancing – consider the endobronchial ultrasound,
- The current tobacco-related cancer research is not particularly convincing,
- Trends in tobacco prevention and mortality rates are important – note the mortality trend lines that decline years after a smoking prevalence decrease,
- Challenges for medical oncology still exist – new intelligent ideas are desired, and
- Survival impacts are questionable. In many studies there is no advantage or disadvantage of survival.

There also stood out two gaps identified from the current discussion:

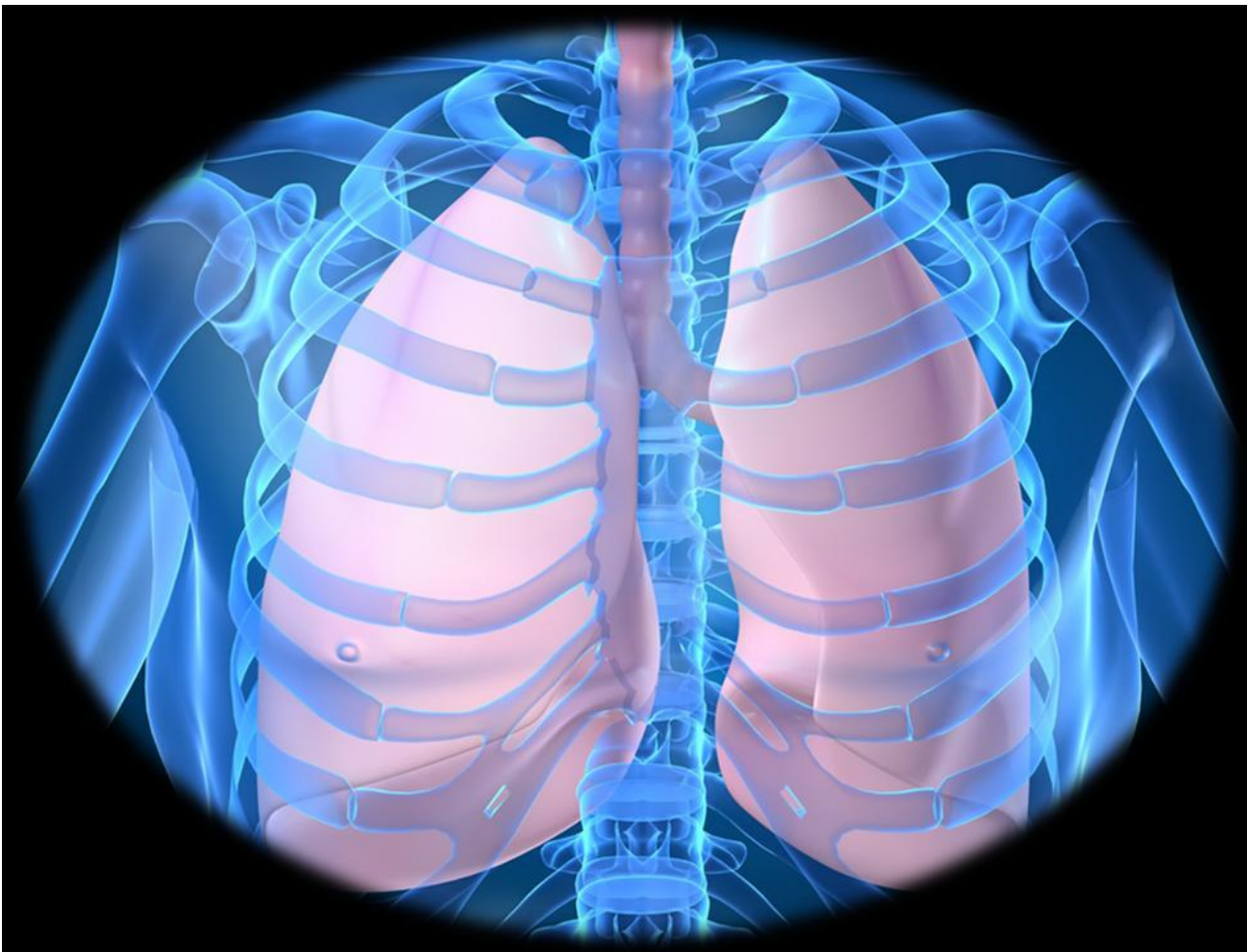
- There is a need to determine how to best measure second-hand smoke, and
- We need to understand research limitations and work to streamline the research publishing, interpreting and application process.

CONFERENCE EVALUATIONS

The advocate group seemed very pleased with the conference as all 15 evaluations that were returned 'strongly agreed' or 'agreed' that it met the stated objectives. All participants also rated all speakers above average or excellent with the exception of one. From these results it is clear that the conference planning committee knew their target audience and provided substantial resources for them from which to learn throughout the day.

The physician group also seemed very pleased with how the conference met the specified objectives, as 44 of 50 evaluation respondents 'agreed' or 'strongly agreed.' The remaining six respondents varied their responses between 'neutral' to 'strongly disagreed.' The majority of respondents rated speaker presentations 'above average' or 'excellent.'

Full evaluation results can be seen in Appendix A.



Special thanks to Dr. Matthew Steliga for initiating the dialogue that led to the inaugural Lung Cancer in the Natural State conference; and to the conference sponsors, Arkansas Cancer Coalition, Arkansas Department of Health Stamp Out Smoking (SOS) program, and the University of Arkansas for Medical Sciences.

Arkansas Cancer Coalition Workgroup

Chair: Thaddeus Bartter
Co-Chair: JR "Pinky" Few
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APPENDIX A

Advocate Evaluation Results

The topics presented at the symposium were relevant to my work.

Strongly Agree:	7
Agree:	6
Disagree:	0
Strongly Disagree:	0
No Answer:	2

The networking opportunities were valuable to me professionally.

Strongly Agree:	7
Agree:	6
Disagree:	0
Strongly Disagree:	0
No Answer:	2

Describe the benefits from prevention, cessation for risk reduction and cessation after diagnosis.

Strongly Agree:	8
Agree:	4
Disagree:	0
Strongly Disagree:	0
No Answer:	2

Recognize that the majority of lung cancer cases are a direct result of the tobacco industry's marketing and profiting from a specific highly addictive product, the cigarette.

Strongly Agree:	10
Agree:	4
Disagree:	0
Strongly Disagree:	0
No Answer:	0

Recognize that the challenges of prevention are in great part a political challenge to a tobacco permissive norm; taxes, tobacco free environments and marketing reform.

Strongly Agree:	8
Agree:	6
Disagree:	0

Strongly Disagree:	0
No Answer:	0

Offer opportunities for action to prevent lung cancer before it strikes.

Strongly Agree:	6
Agree:	8
Disagree:	0
Strongly Disagree:	0
No Answer:	0

Describe the severity of the problem of lung cancer in the state of Arkansas and the importance of raising the survival rate.

Strongly Agree:	7
Agree:	6
Disagree:	1
Strongly Disagree:	0
No Answer:	0

Thaddeus Bartter, MD: Knowledge of Subject Matter		Organized Presentation		Useful Information		Speaker/ Participant Interaction		Audio/ Visual Aids		
	Excellent:	11	Excellent:	11	Excellent:	10	Excellent:	10	Excellent:	12
	Above Average:	2	Above Average:	2	Above Average:	3	Above Average:	2	Above Average:	1
	Average:		Average:		Average:		Average:	1	Average:	
	Below Average:		Below Average:		Below Average:		Below Average:		Below Average:	
	Poor:		Poor:		Poor:		Poor:		Poor:	
	No Answer:	2	No Answer:	2	No Answer:	2	No Answer:	2	No Answer:	2
Joanne Blos: Knowledge of Subject Matter		Organized Presentation		Useful Information		Speaker/ Participant Interaction		Audio/ Visual Aids		
	Excellent:	10	Excellent:	9	Excellent:	9	Excellent:	9	Excellent:	10
	Above Average:		Above Average:	1	Above Average:	1	Above Average:	1	Above Average:	
	Average:		Average:		Average:		Average:		Average:	
	Below Average:		Below Average:		Below Average:		Below Average:		Below Average:	
	Poor:		Poor:		Poor:		Poor:		Poor:	
	No Answer:	5	No Answer:	5	No Answer:	5	No Answer:	5	No Answer:	5
Carolyn Dresler MD, MPA: Knowledge of Subject Matter		Organized Presentation		Useful Information		Speaker/ Participant Interaction		Audio/ Visual Aids		
	Excellent:	11	Excellent:	11	Excellent:	10	Excellent:	10	Excellent:	12
	Above Average:	1	Above Average:	1	Above Average:	2	Above Average:	2	Above Average:	
	Average:		Average:		Average:		Average:		Average:	
	Below Average:		Below Average:		Below Average:		Below Average:		Below Average:	
	Poor:		Poor:		Poor:		Poor:		Poor:	
	No Answer:	3	No Answer:	3	No Answer:	3	No Answer:	3	No Answer:	3
JR "Pinky" Few: Knowledge of Subject Matter		Organized Presentation		Useful Information		Speaker/ Participant Interaction		Audio/ Visual Aids		
	Excellent:	6	Excellent:	6	Excellent:	6	Excellent:	6	Excellent:	6
	Above Average:	1	Above Average:	1	Above Average:	1	Above Average:	1	Above Average:	1
	Average:		Average:		Average:		Average:		Average:	
	Below Average:		Below Average:		Below Average:		Below Average:		Below Average:	
	Poor:		Poor:		Poor:		Poor:		Poor:	
	No Answer:	8	No Answer:	8	No Answer:	8	No Answer:	8	No Answer:	8
Matthew Steliga, MD: Knowledge of Subject Matter		Organized Presentation		Useful Information		Speaker/ Participant Interaction		Audio/ Visual Aids		
	Excellent:	11	Excellent:	11	Excellent:	11	Excellent:	10	Excellent:	12
	Above Average:	1	Above Average:	1	Above Average:	1	Above Average:	1	Above Average:	
	Average:		Average:		Average:		Average:		Average:	
	Below Average:		Below Average:		Below Average:		Below Average:		Below Average:	
	Poor:		Poor:		Poor:		Poor:		Poor:	
	No Answer:	3	No Answer:	3	No Answer:	3	No Answer:	1	No Answer:	3
Cal Wasson: Knowledge of Subject Matter		Organized Presentation		Useful Information		Speaker/ Participant Interaction		Audio/ Visual Aids		
	Excellent:	8	Excellent:	7	Excellent:	7	Excellent:	7	Excellent:	8
	Above Average:	2	Above Average:	2	Above Average:	1	Above Average:	1	Above Average:	1
	Average:	1	Average:	1	Average:	1	Average:		Average:	1
	Below Average:		Below Average:		Below Average:	1	Below Average:		Below Average:	
	Poor:		Poor:		Poor:		Poor:	1	Poor:	
	No Answer:	5	No Answer:	5	No Answer:	5	No Answer:	5	No Answer:	5

Physician Evaluation Results

Describe the benefits of prevention, cessation for risk reduction and cessation after diagnosis:

Strongly Agree:	24
Agree:	20
Neutral:	1
Disagree:	0
Strongly Disagree:	2
No Answer:	2

Identify current staging system for lung cancer w/ emphasis on recent changes on impact on care:

Strongly Agree:	22
Agree:	22
Neutral:	2
Disagree:	0
Strongly Disagree:	2
No Answer:	1

List options available for treating lung cancer patients w/ regards to emerging technologies:

Strongly Agree:	22
Agree:	22
Neutral:	1
Disagree:	0
Strongly Disagree:	2
No Answer:	1

Explain role of current standards & their comparison to novel therapeutic regimes:

Strongly Agree:	20
Agree:	24
Neutral:	2
Disagree:	0
Strongly Disagree:	2
No Answer:	1

Describe severity of the problem of lung cancer in AR & importance of raising the survival rate:

Strongly Agree:	26
Agree:	18

Neutral:	1
Disagree:	2
Strongly Disagree:	2
No Answer:	1

Please rate the projected impact of this activity on whether it increased your: *****(SEE COMMENTS BELOW)***

knowledge		competence		performance		patient outcomes	
Yes:	44	Yes:	34	Yes:	38	Yes:	35
No:		No:	2	No:	1	No:	2
No Change:	4	No Change:	10	No Change:	9	No Change:	9
No Answer:	1	No Answer:	3	No Answer:	2	No Answer:	3

Do you feel the activity was scientifically sound and free of commercial bias or influence:

Yes:	49
No:	0
No Answer:	0

Please identify how you will change your practice as a result of attending this activity:

This activity validated my current practice; no changes will be made:	20
Change the management and/or treatment of my patients:	16
Create/ revise protocols, policies, and/ or procedures:	9
Other, please specify:	10
No Answer:	4

Please indicate any barriers you perceive in implementing these changes:

Cost:	20
Lack of opportunity (patients):	8
Lack of administrative support:	4
Lack of experience:	8
Lack of consensus or professional guidelines:	7
Lack of resources (equipment):	9
Lack of time to assess/ counsel patients:	9
Reimbursement/ insurance issues:	8
Patient compliance issues:	10

No barriers:	9
Other, please specify:	4
No Answer:	6

Other, describe:	9
No Answer:	3

Will you attempt to address these barriers in order to implement changes in your competence, performance, and/ or patients' outcomes?

N/A:	20
Yes:	21
No:	4
No Answer:	4

The content of this activity matched my current (or potential) scope of practice

Yes:	38
No:	6
No Answer:	5

How might the format of this activity be improved for the content presented (select all that apply)?

Format was appropriate; no changes needed:	25
Include more case-based presentations:	12
Increase interactivity with attendees:	4
Add breakouts for subtopics:	3
Add a hands-on instructional component:	3
Schedule more time for Q and A:	8

Overall, were the presentations balanced, objective, and scientifically rigorous?

Yes:	49
No:	0
No Answer:	0

COMMENTS:

2.

KNOWLEDGE
Better data
Impressive case presentations, treatment, and future outcomes.
Lots of good information.
Patient and family education.
More current information.
Lots of good/ new information.
New staging system EBUS.
I only see metastatic lung cancer patients. I needed update on stage I information.
Learned new information.
Good information.
Treatment and care.
Patients on chemo who stop smoking increase life by 5 months. Impact of smoking = chemotherapy.
I have added to my knowledge base.
Good balance for doctors and nurses, and other advocacy professionals.

More knowledgeable.
EBUS and EUS were totally new to me- new staging system.
Increased knowledge.

COMPETENCE
Spur more in-depth study of genetics and EGFR TKI's.
Increased my knowledge base.
Appropriate to the patients.
Hopefully it will improve.
Increased ability to apply data.
Will be able to take this new info to the clinic.
Primarily through awareness.
Patients and family education.
Can better counsel patients.
Lots of good new information.

PERFORMANCE
More focus on patient's smoking cessation.
More confident with my knowledge.

We care for daily. Increased.
Better educate the patients and family.
Increased ability to apply data.
I will be able to understand and interpret information better.
Better knowledge.
Will definitely increase emphasis on smoking.
Used the added knowledge for more accurate recommendations for treatment.
Patient and family education.
Can better counsel patients.
Lots of good new information.

4. Please identify how you will change your practice as a result of attending this activity. If other, please specify:
Education of others.
Patient education.
Will encourage cessation more strongly.
Continue with such disciplinary approach.
Continue discouraging smoking in my area of contacts, it has worked before.

More group discussion of cases
As an RN I hope to promote the most up to date diagnoses & treatment of our lung cancer patients
I am new to the oncology setting, so this will help me better understand what is going on.
Patient education and advocacy.
5. Please indicate any barriers you perceive in implementing these changes. If other, please specify:
Time.
Patient population/ limitations.
Retired.
6. Will you attempt to address these barriers in order to implement changes in your competence, performance, and /or patients' outcomes? If yes, How? If no, Why not?
YES Being positive and giving examples. Advocacy and education. Will give smoking cessation more priority. Discuss with administration. Talk to social worker about cost. Via patient education & focus on prevention. Always working to improve efficiency & approach. Increase my knowledge.

<p>Increase patient load. Communication to staff. Continue to get more education & network with others.</p>
<p>No</p> <p>Clinic manager to do.</p>
<p>7. How might the format of this activity be improved for the content presented (select all that apply)? If other, describe:</p>
<p>Talks should be more than 15 minutes.</p>
<p>Have questions after each speaker when better remembered.</p>
<p>Provide handouts of speaker's slides.</p>
<p>Handouts, overview of pathophysiology, & standard of care chemo regimens for NSCLS.</p>
<p>Handouts.</p>
<p>Advertisement about the conference should come out earlier to allow more people to participate.</p>
<p>Need additional breakout sessions for nurses that work with these patients to attend.</p>
<p>Identify speakers in program to be able to evaluate better.</p>
<p>8. The content of this activity matched my current (or potential)</p>

<p>scope of practice. If yes, How? If no, Please explain.</p>
<p>YES</p> <p>What I see in our daily practice comparable standard of care. I work in Radiation Oncology. Will help in educating public. Work for thoracic surgeon. Minimally invasive surgeries. Interdisciplinary approach is the best way to attack this. I'm expanding my practice for oncology. As an oncology nurse in an outpatient setting, this was very pertinent to me. I'm a thoracic surgeon.</p>
<p>NO</p> <p>Do not care for lung patients. To a degree it did. Too much focus o doctor's work and not enough on nurse's work. Not in practice. I am not a physician.</p>
<p>10. Describe any presentations that were exceptional:</p>
<p>All material very timely & appropriate to our practice. Would like to see another conference next year (include genetics/ DNA topics)</p>
<p>I appreciated the physician panel discussions.</p>
<p>Dr. Steliga did an excellent job. Easy to understand and very good speaker and teacher. Very good conference and very knowledgeable speakers!!!</p>
<p>Carolyn Dresler & Sarah Harrington.</p>
<p>The presentation on the staging of the disease and treatment by Dr.</p>

Matthew Steliga.
EBUS- I am in the private community setting here in Little Rock, but think UAMS is such an asset for our state.
Dr. Safar (excellent), Dr. Bartter, Dr. Steliga, Dr. Dresler, Dr. Penagaricano.
Carolyn Dresler, MD, the simplicity of the presentation and humorous delivery.
Dr. Bartter, Dr. Safar, Dr. Dresler, very understandable speech.
Dr. Dresler and Dr. Bartter. Very good to see palliative/ hospice care in the program.
Dr. Bartter and Dr. Dresler.
Palliative Care.
Dr. Steliga and Dr. Bartter were very easy to understand, and logically applied their information.
I really enjoyed Dr. Dresler, but they were all good.
Dr. Bartter, excellent explanations. Dr. Steliga, excellent slides.
Carolyn Dresler, MD, delivery was the same tone throughout her presentation and I was able to understand her better.
Dr. Bartter and Dr. Steliga.
All.
Wolf Herberlein, MD, Thaddeus Bartter, MD, and Carolyn Dresler, MD MPA for delivery.

Dr. Bartter for presentation and answering questions honestly. Dr. Dresler was very good at bringing home prevention.
Dr. Bartter's presentation is beyond excellent. I love the controversial cases for panel discussion. Definitely need to keep that format.
Dr. Safar.
VATS Lobectomy.
Dr. Bartter.
Stereotactic Radiotherapy and RFA. Second opinions and VATS.
Staging of lung cancer and new modalities for staging. Palliative Care.
The end case presentations and discussions were excellent. This is a good format and I think for community practitioners it could be very helpful.
All speakers were prepared, knowledgeable and eloquent.
Have to say that all were good-with good information. Dr. Safar's presentation on "what has been done wrong" was great food for thought.
Dr. Mazin Safar and Dr. Bartter were the best. Everybody was good.
Dr. Bartter- very good speaker.
11. Describe any presentations that did not meet your needs or expectations:
Dr. Dresler did not provide enough Arkansas specific data regarding

smoking and lung cancer.
Because of difficulty understanding some speakers, it would be helpful to have printed handouts.
Dr. Safar's morning presentation was not appropriate for their audience.
Need handouts from each speaker. Helps for review when at home and is more proper for note taking.
Further explanation was needed on some therapies, specific trials, and the acronyms used.
Would have liked to be able to participate in advocates sessions on economic, political, and social aspects.
12. Please describe any clinical situations that you find difficult to manage or resolve that you would like to see addressed in future educational activities:
Helping patients receive hospice at late stage. Looking at helping patient's goal to have best quality of life as long as possible. Need handouts on staging.
Small cell lung cancer.
Small cell and mesothelioma.
I am a primary care physician and my challenge is to get patients to quit tobacco use!
Pre-op work up.
Information on integrative disciplines such as adjuvant therapies- hypnosis, meditation, massage, acupuncture, chiropractic, etc.

Multidisciplinary approaches to difficult situations would be helpful. Esophageal carcinoma complications of lung carcinomas- treatments.
Spiritual issues.
Techniques used to help patients stop smoking; When should you not consider chemo? Is the extra month of "life" worth the cost?
Outreach through churches, schools/ school nurse programs, streets, homeless sites. For smokers, and ones exposed to smoking and exposed to other lung complications. Schools need preventive measuring. Provide scholarships to students organizing student coalitions.
Would include more role of interventional pulmonary in diagnosing and managing complications.
Miscellaneous Comments:
Temperature in lecture room is too cold.
Please add future lectures on Asbestosis of lungs.
Need signs posted to turn off cell phones.
For attendees asking questions, the moderator needs to repeat the question first and then get an answer, or a microphone is needed for the attendee to ask the question- the audience can't hear the question.
Need water added to the beverages at breakfast.
Great location!!! Keep it for next year.

Mazin Safar, MD: Knowledge of Subject Matter		Organized Presentation		Useful Information		Speaker/ Participant Interaction		Audio/ Visual Aids	
Excellent:	39	Excellent:	37	Excellent:	35	Excellent:	31	Excellent:	34
Above Average:	6	Above Average:	6	Above Average:	5	Above Average:	5	Above Average:	6
Average:	1	Average:	3	Average:	4	Average:	6	Average:	2
Below Average:		Below Average:		Below Average:	1	Below Average:		Below Average:	1
Poor:		Poor:		Poor:		Poor:	1	Poor:	1
No Answer:	3	No Answer:	3	No Answer:	3	No Answer:	5	No Answer:	3

Imran Ahmad, MD: Knowledge of Subject Matter		Organized Presentation		Useful Information		Speaker/ Participant Interaction		Audio/ Visual Aids	
Excellent:	36	Excellent:	28	Excellent:	24	Excellent:	25	Excellent:	27
Above Average:	7	Above Average:	12	Above Average:	11	Above Average:	3	Above Average:	10
Average:	3	Average:	4	Average:	8	Average:	11	Average:	6
Below Average:		Below Average:		Below Average:	2	Below Average:	1	Below Average:	2
Poor:		Poor:		Poor:		Poor:	1	Poor:	
No Answer:	3	No Answer:	3	No Answer:	3	No Answer:	4	No Answer:	3

Kostas Arnaoutakis, MD: Knowledge of Subject Matter		Organized Presentation		Useful Information		Speaker/ Participant Interaction		Audio/ Visual Aids	
Excellent:	40	Excellent:	33	Excellent:	29	Excellent:	29	Excellent:	32
Above Average:	7	Above Average:	12	Above Average:	12	Above Average:	5	Above Average:	8
Average:	1	Average:	2	Average:	4	Average:	11	Average:	6
Below Average:		Below Average:		Below Average:	1	Below Average:		Below Average:	1
Poor:		Poor:		Poor:		Poor:		Poor:	
No Answer:	2	No Answer:	2	No Answer:	2	No Answer:	4	No Answer:	2

Sarah Harrington, MD: Knowledge of Subject Matter		Organized Presentation		Useful Information		Speaker/ Participant Interaction		Audio/ Visual Aids	
Excellent:	45	Excellent:	34	Excellent:	32	Excellent:	29	Excellent:	29
Above Average:	2	Above Average:	2	Above Average:	3	Above Average:	4	Above Average:	5
Average:	3	Average:	3	Average:	4	Average:	3	Average:	3
Below Average:		Below Average:		Below Average:		Below Average:	1	Below Average:	1
Poor:		Poor:		Poor:		Poor:		Poor:	
No Answer:	10	No Answer:	10	No Answer:	10	No Answer:	12	No Answer:	11

Wolf Herberlein, MD: Knowledge of Subject Matter		Organized Presentation		Useful Information		Speaker/ Participant Interaction		Audio/ Visual Aids	
Excellent:	40	Excellent:	35	Excellent:	31	Excellent:	25	Excellent:	34
Above Average:	3	Above Average:	7	Above Average:	9	Above Average:	12	Above Average:	7
Average:	1	Average:		Average:	3	Average:	5	Average:	2
Below Average:		Below Average:	1	Below Average:		Below Average:		Below Average:	
Poor:		Poor:		Poor:		Poor:		Poor:	
No Answer:	5	No Answer:	6	No Answer:	6	No Answer:	10	No Answer:	6

Jose Penagaricano, MD: Knowledge of Subject Matter		Organized Presentation		Useful Information		Speaker/ Participant Interaction		Audio/ Visual Aids	
Excellent:	34	Excellent:	28	Excellent:	23	Excellent:	23	Excellent:	25
Above Average:	7	Above Average:	9	Above Average:	13	Above Average:	7	Above Average:	12
Average:	4	Average:	6	Average:	6	Average:	8	Average:	5
Below Average:		Below Average:		Below Average:	2	Below Average:	2	Below Average:	1
Poor:		Poor:		Poor:		Poor:		Poor:	
No Answer:	5	No Answer:	6	No Answer:	6	No Answer:	9	No Answer:	6

Carolyn Dresler MD, MPA: Knowledge of Subject Matter		Organized Presentation		Useful Information		Speaker/ Participant Interaction		Audio/ Visual Aids	
Excellent:	39	Excellent:	37	Excellent:	35	Excellent:	31	Excellent:	33
Above Average:	3	Above Average:	4	Above Average:	5	Above Average:	9	Above Average:	5
Average:	2	Average:	3	Average:	4	Average:	2	Average:	6
Below Average:		Below Average:		Below Average:		Below Average:		Below Average:	