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For immediate release:

In this month's edition

1. Christopher J. Farrell, M.D., Joins Department of Neurological Surgery at Jefferson
2. Fox Chase Researchers Find that Recurring Cancers Among Women with a History of Breast Cancer Differ Significantly from the Original Tumors
3. Temple University Hospital Bone Marrow Transplant Program Offers Varied Program of Clinical Trials and Research

Editors note: Research, new techniques and improved facilities by Philadelphia International Medicine hospitals and physicians may lead to new ways to treat some of our most challenging diseases. Below are just some examples from our hospitals.

Christopher J. Farrell, MD, Joins Department of Neurological Surgery at Jefferson

[Christopher J. Farrell, MD.](#), recently joined the [Department of Neurological Surgery](#) at Thomas Jefferson University Hospital and was named assistant professor of neurological surgery at Jefferson Medical College of Thomas Jefferson University. Dr. Farrell specializes in brain tumor surgery and research.

Prior to his appointment at Jefferson, Dr. Farrell served as assistant professor of Neurosurgery at Massachusetts General Hospital, teaching hospital of Harvard Medical School. Dr. Farrell completed a fellowship in cranial base neurosurgery from Semmes-Murphey Neurologic and Spine Institute in Memphis, TN. He also completed a fellowship in brain tumor research at Massachusetts General Hospital.

Dr. Farrell performed his residency in neurosurgery at Massachusetts General Hospital and his internship in general surgery at Emory University. He earned his medical degree from Temple University School of Medicine in 2002 and his bachelor's degree in cellular and molecular biology from Haverford College in 1997. Board-eligible in neurological surgery, Dr. Farrell's research on brain tumors has been published extensively in journals such as the *Journal of Neurosurgery* and the *Journal of Neuro-Oncology*.

Dr. Farrell has won numerous awards for academic excellence and brain tumor research, including the American Brain Tumor Association Research Award, which came with grant support. Dr. Farrell is a member of multiple medical societies, including the American Association of Neurological Surgeons, the Congress of Neurological Surgeons and the North American Skull Base Society.

Fox Chase Researchers Find that Recurring Cancers Among Women with a History of Breast Cancer Differ Significantly from the Original Tumors

When women with a history of breast cancer learn they have breast cancer again, one of the first questions they and their doctors ask is: Has my cancer come back, or is this a new case? Now, new data from Fox Chase Cancer Center suggest that both new and recurring cancers will differ significantly from the original tumors, regardless of how many months or years women spent cancer-free, and doctors should tailor treatment to the specific qualities of the second tumor, regardless of whether it's old or new.

Anita Patt, MD, surgical oncology fellow at Fox Chase and lead author on the study, will be presenting the findings at the 2011 Annual Meeting of the American Society of Clinical Oncology on Monday, June 6.

“There tends to be a stigma and a lot of anxiety about the word ‘recurrence,’” says [Richard J. Bleicher, MD, FACS](#), attending surgeon at Fox Chase and senior author on the study. “Sometimes women will worry more if they believe their original cancer is back, meaning they didn't ‘beat it’ the first time around. These findings suggest they should not get hung up on that idea, because any subsequent diagnosis – whether it's a recurrence or a new tumor – will look significantly different from their first cancer.”

In women with a history of breast cancer, doctors often approach new tumors differently depending on whether they believe it's a recurrence of the first tumor, or a totally new one, Bleicher explains. But there are no official ways to distinguish between the two types, so doctors typically rely on a few criteria, then form their own opinion based on an “overall gestalt,” he says.

One of the criteria doctors have used to distinguish between new and recurring cancers is the amount of time women spent cancer-free, reasoning that the longer the time between the two tumors, the more likely the second one is to be an entirely new case.

To investigate if this and other criteria indeed distinguish new and recurring tumors, Bleicher, Patt, and their colleagues looked at data collected from 4,420 women with a history of breast cancer. Two-hundred and thirty five women were eventually diagnosed with another tumor in the same breast, suggesting it could be a recurrence.

However, when the researchers compared the first and second tumors, they saw that 89% differed in at least one key characteristic that could potentially affect treatment or prognosis, regardless of whether

the second tumors were new cases or a recurrence of the original cancer. Sixty percent of the second tumors differed from the first by at least 2 or more criteria, including whether or not it would respond to hormones, how it was diagnosed, and whether at least 25 percent of the tumor was confined to the ducts, and therefore less able to spread throughout the body.

Half of the women experienced a second tumor within 60.5 months of their first. And, importantly, the amount of time they spent cancer-free appeared to have no bearing on whether the two tumors differed in any key characteristics.

The findings suggest that patients and doctors shouldn't spend much time determining if the second tumor is a recurrence of the first, or a totally new entity, says Bleicher, and should instead tailor treatment to the specific qualities of the second tumor, regardless of whether it's old or new.

“When a patient comes back with a relapse, whether it's a new tumor or a recurrence, it really,” he says. “We treat them both as potentially curable.”

Temple University Hospital Bone Marrow Transplant Program Offers Varied Program of Clinical Trials and Research

The Temple University Hospital Bone Marrow Transplant Program offers state-of-the-art clinical trials, including one-of-a-kind studies conducted only at Temple. We currently are participating in the following trials:

For Patients Without Matched Donors

Title: A Phase II Study of Nonmyeloablative Conditioning and Transplantation of Partially HLA-Mismatched Bone Marrow for Patients with Hematologic Malignancies

The objective of this study is to determine the safety of using half matched or "haplo" identical bone marrow cells as allogeneic grafting cells in patients with certain hematologic malignancies. These include patients with acute lymphoblastic leukemia/lymphoma, acute myeloid leukemia, Burkitt's lymphoma, relapsed lymphoma but not myelodysplastic syndrome (MDS).

Reviewed and approved by the Temple University Institutional Review Board and assigned Protocol #12-021. FIRB Protocol #08-903.

For Non-Hodgkin's Lymphoma

Title: A Phase II Study of the antibody CT-011 after autologous transplant for patients with Large Cell Non Hodgkins Lymphoma

The objectives of this study are to determine the safety and efficacy of CT-011 (1.5 mg/kg, three courses of treatment separated by 42 days) in patients over 18 years of age with Diffuse Large Cell Lymphoma who have not progressed by 30 days following autologous peripheral blood stem cell transplantation (50-65 days post transplant) compared to their pre-transplantation status, as determined by

CT scan. Progression is defined as the appearance of new lesions on CT scan and/or an increase of nodal size by > 50%.

Reviewed and approved by the Temple University Institutional Review Board and assigned Protocol #11664. WIRB Protocol #20080617.

Title: BMT CTN 0701: A Phase II Trial of Non-Myeloablative Allogeneic Transplant for Patients with Relapsed Follicular Non-Hodgkin's Lymphoma Beyond First Complete Response

The objectives of this study are to determine the safety and efficacy of a non-myeloablative allogeneic conditioning regimen, FCR, for treating patients with relapsed follicular lymphoma that has not transformed (large cell or grade III disease). Eligible patients are < 75 years old and have histologically confirmed recurrent follicular lymphoma, grade I or II (WHO classification grade 1, 2 or 3a). Patients must have chemosensitive disease by achieving lymph node axial diameter < 3cm or >50% reduction in nodal diameter after recent salvage therapy.

Reviewed and approved by the Temple University Institutional Review Board and assigned Protocol #12454. FIRB Protocol #09-905.

For Chronic Myeloid Leukemia

Title: A Phase II Open-Label Study of the Subcutaneous Administration of Homoharringtonine (Omacetaxine) (CGX-635) in the Treatment of Patients with Chronic Myeloid Leukemia (CML) with the T315I BCR-ABL Gene Mutation

To evaluate the safety and efficacy of subcutaneous administration of Omacetaxine (OMA) in achieving a clinical response in CML patients in chronic, accelerated or blast phase who have the T315I BCR-ABL gene mutation. OMA is given BID x 14 days during induction followed by BID x 7 days during maintenance with each cycle equaling 28 days.

Reviewed and approved by the Temple University Institutional Review Board and assigned Protocol #11337. WIRB Protocol #20071870.

For Acute Myeloid Leukemia and MDS

Title: E 1905: A Randomized Phase II Study of Azacitidine with or without the Histone Deacetylase Inhibitor MS-275 for the treatment of Myelodysplastic Syndrome, Chronic Myelomonocytic Leukemia (dysplastic type), and Acute Myeloid Leukemia with Multilineage Dysplasia

This trial compares the effect of the Azacitidine with or without the experimental agent MS-275 in patients with dysplastic AML, dysplastic CMML or myelodysplastic syndrome (MDS). MDS with any IPSS score and < 20 % blasts in the peripheral blood or marrow. Patient with low IPSS score must have a platelet count < 50,000 or an absolute neutrophil count < 500 within a week of registration OR CMML,

dysplastic type OR AML with multilineage dysplasia. No therapy induced leukemia. Age > 16, ECOG 0-2, no prior treatment with Azacitidine or MS-275

Reviewed and approved by the Temple University Institutional Review Board and assigned Protocol # 12136. FIRB Protocol #06-211.

Title: BMT CTN 0502: A Phase II study of Allogeneic Transplant for Older Patients with AML in First Morphologic Complete Remission Using a Non-Myeloablative Preparative Regimen

This trial evaluates the place of mini allogeneic transplant using a conditioning regimen of fludarabine, busulfan and ATG in patients, ages 60-75, with AML (excluding FAB M3) who have achieved a first morphologic complete remission. Patients with preceding MDS or treatment-related AML are eligible. CR must have been achieved after no more than two cycles of induction chemotherapy. Patients may have received as many as but no more than two cycles of consolidation therapy prior to transplant. No more than 6 months can elapse from documentation of morphologic CR to transplant. Patients with acute leukemia following blast transformation of prior CML or other myeloproliferative disease are excluded

Reviewed and approved by the Temple University Institutional Review Board and assigned Protocol # 11426. FIRB Protocol #08-901.

For Acute Graft Versus Host Disease (GVHD)

Title: BDP-GVHD: A Trial of the agent BDP in the treatment of early acute GI GVHD

This trial evaluates the use of a non-absorbed steroid preparation, BDP, for the treatment of acute GVHD of the GI tract. Patients must have biopsy proven GVHD with less than a liter of diarrhea each day, bilirubin < 3 and no more than 50% GVHD skin rash.

Reviewed and approved by the Temple University Institutional Review Board and assigned Protocol # 12469. WIRB Protocol #20091282.

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