IT ALL COMES DOWN TO YOU.

Owensboro Health’s mission is to heal the sick and to improve the health of the communities we serve. The Mitchell Memorial Cancer Center is recognized by the Commission on Cancer (CoC), a program of the American College of Surgeons (ACoS), for its commitment to providing comprehensive, multidisciplinary and outstanding patient-centered care.

Our team includes cancer physician specialists, registered nurses, radiation therapists, allied health professionals, dietitians, social workers, and patient navigators. Their goal is to improve survival and quality of life for cancer patients through standard-setting, prevention, research, education, and monitoring of care. Whether it’s your fight or the struggle of someone close to you, we are committed to work together as a team so we can provide excellent cancer treatment, recovery and healing.
WHAT TO KNOW ABOUT MELANOMA

WHAT IS MELANOMA?
Melanoma is a type of skin cancer that originates in the melanocytes, a type of skin cell. Melanocytes release melanin when exposed to ultraviolet radiation, which causes skin to turn brown and tan as a defense against UV damage.

While less common than basal cell and squamous cell cancers, melanoma stands apart from other skin cancers. Basal cell cancer almost never metastasizes. Squamous cell cancer rarely metastasizes and tends to only do so in a region around the primary tumor.

In contrast, melanoma often spreads beyond its primary site, spreading to other sites in the body. Typically, this first happens through the lymph system to nearby lymph nodes. Melanoma can also spread through the bloodstream to other parts of the body, including (but not limited to) the lungs, liver, bones and brain.

The ease with which melanoma spreads means that it is essential to detect this cancer quickly. As with other cancers, early detection of a melanoma increases the likelihood of this cancer being cured. This is because it is more likely to be found in its earlier stages and less likely to have spread elsewhere in the body. Unlike other cancers, early detection of melanoma does not require multiple tests or procedures.

Early detection and treatment also reduce the chances that a melanoma will recur or that a patient will die from the disease. Self-exams and awareness are key to early detection. Therefore, it is important to have any new or changing skin lesions evaluated by a medical provider.

BY THE NUMBERS
Skin cancer is the most common type of cancer diagnosed in the United States, with 3.5 million cancers diagnosed in 2 million people annually, according to the National Cancer Institute. Melanoma is the deadliest of the skin cancers, despite the fact that it only makes up 5 percent of the diagnosed cases.

More alarmingly, melanoma incidence has generally increased for the past 40 years. In 2016, the NCI estimates that 76,380 new cases of melanoma will be diagnosed and 10,130 people will die as a result of the disease.
### WHAT TO KNOW ABOUT MELANOMA

#### MELANOMA SURVIVAL RATES AT FIVE AND 10 YEARS, BY STAGE OF DISEASE:

<table>
<thead>
<tr>
<th>STAGE</th>
<th>FIVE-YEAR SURVIVAL RATE</th>
<th>10-YEAR SURVIVAL RATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage IA</td>
<td>97%</td>
<td>95%</td>
</tr>
<tr>
<td>Stage IB</td>
<td>92%</td>
<td>86%</td>
</tr>
<tr>
<td>Stage IIA</td>
<td>81%</td>
<td>67%</td>
</tr>
<tr>
<td>Stage IIB</td>
<td>70%</td>
<td>57%</td>
</tr>
<tr>
<td>Stage IIC</td>
<td>53%</td>
<td>40%</td>
</tr>
<tr>
<td>Stage IIIA</td>
<td>78%</td>
<td>68%</td>
</tr>
<tr>
<td>Stage IIIB</td>
<td>59%</td>
<td>43%</td>
</tr>
<tr>
<td>Stage IIIC</td>
<td>40%</td>
<td>24%</td>
</tr>
<tr>
<td>Stage IV</td>
<td>15-20%</td>
<td>10-15%</td>
</tr>
</tbody>
</table>

Source: American Cancer Society

#### IN OWENSBORO HEALTH’S SERVICE AREA, HERE ARE THE OCCURRENCE AND DEATH RATES FOR MELANOMA FROM 2009-2013, ACCORDING TO DATA FROM THE NATIONAL CANCER INSTITUTE:

<table>
<thead>
<tr>
<th>LOCATION</th>
<th>OCCURRENCE RATE (PER 100,000)</th>
<th>DEATH RATE (PER 100,000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>20.3</td>
<td>2.7</td>
</tr>
<tr>
<td>Kentucky</td>
<td>24.4</td>
<td>3.2</td>
</tr>
<tr>
<td>Daviess County</td>
<td>27.2</td>
<td>3.6</td>
</tr>
<tr>
<td>Breckinridge County</td>
<td>26.7</td>
<td>**</td>
</tr>
<tr>
<td>Butler County</td>
<td>*</td>
<td>**</td>
</tr>
<tr>
<td>Grayson County</td>
<td>25.4</td>
<td>**</td>
</tr>
<tr>
<td>Hancock County</td>
<td>*</td>
<td>**</td>
</tr>
<tr>
<td>Henderson County</td>
<td>19.6</td>
<td>**</td>
</tr>
<tr>
<td>Hopkins County</td>
<td>24.2</td>
<td>**</td>
</tr>
<tr>
<td>McLean County</td>
<td>*</td>
<td>**</td>
</tr>
<tr>
<td>Muhlenberg County</td>
<td>24.2</td>
<td>**</td>
</tr>
<tr>
<td>Ohio County</td>
<td>23.2</td>
<td>**</td>
</tr>
<tr>
<td>Union County</td>
<td>*</td>
<td>**</td>
</tr>
<tr>
<td>Webster County</td>
<td>*</td>
<td>**</td>
</tr>
<tr>
<td>Indiana</td>
<td>17.8</td>
<td>3.1</td>
</tr>
<tr>
<td>Perry County, IN</td>
<td>13.7</td>
<td>**</td>
</tr>
<tr>
<td>Spencer County, IN</td>
<td>21.5</td>
<td>**</td>
</tr>
</tbody>
</table>

* Data was suppressed to protect confidentiality and stability of rate estimates.
** Data are too sparse to provide stable estimates of annual rates needed to calculate trend.
WHO MAY BE AT RISK?

RISK FACTORS FOR MELANOMA:
- Long-term exposure to ultraviolet radiation (especially the sun and tanning beds)
- Skin complexion:
  - Skin that is fair, does not tan or only tans slightly, or that burns/freckles readily
  - Individuals with blue or green eyes
  - Individuals with fair (red or blond) hair
  - Presence or history of moles or other skin anomalies
- People with weakened or compromised immune systems
- Family history
- History of radiation therapy or exposure
- Certain conditions such as actinic keratosis or exposure to arsenic

Melanoma is most common in elderly men. However, younger people are also at significant risk. It is the second most common cancer diagnosed between the ages of 15-29, and most common in those aged 25-29. In men, it is most commonly found on the head, neck and trunk of the body. In women, it is most common on the extremities, particularly the legs.

While fair skin is a risk factor for melanoma, those with darker skin tones are still at risk. Melanoma can also form in unexpected areas, such as under fingernails and toenails, in the eye, and on the palms of hands and soles of feet.

According to the National Cancer Institute -
http://www.cancer.gov/types/skin
THE ABC’S OF MELANOMA

MELANOMA, OR LESIONS THAT ARE PRECURSORS TO MELANOMA, OFTEN MANIFEST IN CERTAIN WAYS.

These can be remembered as the ABCs of melanoma, and a spot or mole that has one or more of these signs should be examined by a doctor:

• **A is Asymmetry:** Draw an imaginary line down the middle of a mole, birthmark or other suspicious spot. Does one half match the other, like a mirror image? If it does not, it is asymmetric.

• **B is for Border:** Is the edge of the mole or spot even and cleanly defined? An irregular or indistinct edge is a common feature of melanoma.

• **C is for Color:** Melanoma can be found in spots or moles that have uneven coloration. While melanoma is often darker colored, it can also take place in lesions, spots or moles that are pink, red, blue or white.

• **D is for Diameter:** Size of a spot or mole can be a tell-tale sign of melanoma. Watch for spots or moles larger than one-quarter inch (a pencil is about one-quarter inch thick).

• **E is for Evolving:** Watch for new moles or spots, or for changes in existing ones. Changes in size, shape or color should be checked immediately.

Though the ABCs are useful, they are not an all-inclusive list of signs and symptoms. Changes to your skin and the appearance of new spots, especially ones that look different from other existing spots or moles, should be examined by a physician.

OTHER WARNING SIGNS INCLUDE:

• Sores or wounds that won’t heal
• Spread of pigment beyond the border of a spot or mole
• Redness or new swelling beyond the border of a spot or mole
• Changes in sensation in the skin or moles/spots on the skin, including itching, soreness or pain
• Changes in the surface of a mole, including becoming scaly, oozing, bleeding or new bumps/lumps on the mole

Diagnosing and Treating Melanoma

The Success of Modern Cancer Care is largely owing to a key component: teamwork.

In the course of treating melanoma, a wide variety of providers and clinicians will impact a patient’s care, both directly and indirectly. Physicians – including primary care doctors and specialists – are joined by allied health professionals (nurse practitioners and physician assistants), nurses, therapists, dietitians, social workers, technicians and many more. Working together increases the chance of a good outcome for the patient because each area of expertise has something of merit to offer the patient.

Once a week, providers and clinicians will hold “tumor board” meetings. At these discussions, our providers and experts will pool their resources and their knowledge.

Ever Vigilant
Dr. Carl Watkins
Owensboro Health Outpatient Radiology
Diagnostic imaging can be an important tool in the fight against melanoma, especially in cases where there is a risk for this cancer to spread to other parts of the body. In particular, we use three different types of scanning technology: Computerized Tomography, Magnetic Resonance Imaging and Positron Emission Tomography.

Before we had these technologies, autopsies of patients commonly found that melanoma had spread farther throughout the body than we could detect. Now, these imaging techniques give us more information that can be used to help patients, at a time when we can still offer care that can help patients with treating or managing their cancer.

Computerized Tomography (CT)
CT scans use X-rays to scan in “layers” through the body. A computer then analyzes the scans and assembles these layers into detailed, digital picture slices of the body. This type of scan is especially useful for showing and analyzing internal structures throughout the body.
DIAGNOSING AND TREATING MELANOMA

MAGNETIC RESONANCE IMAGING (MRI)
MRI scanning uses an extremely powerful magnet and radiofrequency waves to scan through the body in a similar manner as CT scans. MRI is useful for analyzing internal structure, but its properties can show the inside of the body in ways that are very different than CT, making it useful for scanning in places where CT is less effective at showing fine details, especially in diagnosing metastasis of a melanoma to an area like the brain.

POSITRON EMISSION TOMOGRAPHY (PET)
PET scanning is very different than CT and MRI scans. Where those methods show the structure inside the body, PET scanning can show the way that cells function. This is extremely valuable because cancer cells have a significantly accelerated metabolism, which can be seen on PET scan. This functional scanning can lead to earlier diagnosis of the spread of a melanoma that would not be visible on a structural scan like an MRI or CT. PET scanning is most useful when combined with CT imaging in what is called a “fusion study,” allowing doctors to compare and contrast structure and function when looking for cancer.

HOW WE USE DIAGNOSTIC IMAGING
Diagnostic imaging is most useful after a patient has been diagnosed with melanoma. Stage of cancer is determined by the size and spread of cancer, and different types of treatments are recommended depending on the stage of the cancer. Having detailed imaging capabilities gives providers the information they need to prepare the best treatment plans and options for the patient.

Using the above three techniques, either independently or in combination, can make an enormous difference in detecting the spread of cancer. Diagnostic imaging is also important in surveillance for cancer after a patient has been treated, showing if cancer is responding during a course of treatment, or if cancer has returned in a patient who was previously treated.
Treatment options for melanoma, especially at early stages, often start with surgery. Excising a melanoma before it has the chance to grow and spread increases the chance of a good outcome for patients. If caught early enough, surgery can stand alone as the treatment method.

Surgical techniques for melanoma, like many other cancers, make use of “margins,” where surgeons like myself remove some of the healthy tissue surrounding the primary tumor. The goal of this approach is to be as certain as possible that all malignant cells of the tumor are being excised. We work to balance our surgical approach, removing as little healthy tissue as we can while still removing all of the tumor. If the tumor can be completely removed in its earlier stages, this increases the chances that the cancer will not return and/or spread to other areas of the body.

In the mid-stages of melanoma, we not only examine tissue immediately surrounding the primary tumor, but also the lymph nodes. These small organs are a key component of the body’s immune system. Similar to breast cancer, melanoma typically spreads to lymph nodes before moving elsewhere in the body. The first lymph node to be affected by cancer is called the “sentinel” lymph node. Determining whether or not melanoma has spread to the lymph nodes is important because if cancer has spread to the lymph nodes, there is an increased likelihood that cancer has spread elsewhere.

One of the most noteworthy trends in surgery surrounds the use of “radical” procedures. In previous years, it was common for surgeons to remove a melanoma and also perform a radical removal of some or all of the nearby lymph nodes as a precaution. Today, radical surgery is less common and I predict that trend will continue. Cutting less whenever possible benefits the patient, both in their recovery process immediately following surgery, and also by preventing later complications.
Dr. Kevin Ridenhour
One Health Hematology & Oncology

Melanoma is a serious problem, but the news is not all bad. Medical science’s approach to melanoma has advanced tremendously in recent years, and some of our greatest gains are taking place in the field of hematology and oncology. New medications and treatment regimens are doing more to improve patients’ life expectancy and overall quality of life, even in the later stages of melanoma. Because melanoma can spread to virtually any part of the body, it is important that we have ways to attack it anywhere in the body. We do this by studying how melanoma cells function and exploiting the cellular weaknesses we find.

Chemotherapy

A tried-and-true approach to treating melanoma is the use of chemotherapy. Melanoma spreads because the malignant cells grow and reproduce without limit, spreading throughout the body. Chemotherapy drugs function by disrupting the life cycle of melanoma, preventing its growth and spread. These drugs are commonly used in combination with other drugs and therapies.

Many patients have concerns about the side effects associated with chemotherapy, including hair loss, weight loss, fatigue, nausea, vomiting and immune system suppression. However, we’ve made great strides in creating drugs with fewer side effects. We also have many options in the realm of supportive treatments, which help diminish the impact of various side effects.

Targeted Therapy

Like normal cells, cancer cells need specific chemicals or proteins to survive. Sometimes, what they need can be used against them. This is where targeted therapy becomes extremely useful. An example of this is a genetic mutation that causes cancer cells to grow by using a certain protein. If they can’t get that protein, then the cancer cells will starve to death, while healthy cells remain unharmed.

Once scientists figured that out, they went looking for a way to test for the genetic mutation, and they found it. By running a genetic test on cancer cells from a primary tumor, we can identify genetic weaknesses in the cancer itself. While melanoma is a single type of cancer, they aren’t all the same. We’ve discovered multiple genetic weaknesses that commonly appear in this cancer, allowing us to develop new medications that help treat these cancers. These medications can be very effective in patients who have advanced cancer that has spread to other places in the body. Before, these patients would be facing very difficult odds. Today, their chances can be greatly improved, thanks to these scientific and medical advances.
IMMUNOTHERAPY
Your body has a defensive network, the immune system, which is meant to stop outside intruders, like bacteria, viruses and parasites. The immune system also keeps the cells of your body in line. When cells start to malfunction, the immune system sends specialized protective cells to step in and destroy the cells that are misbehaving.

Scientists have discovered that certain cancers get around this by sabotaging the immune system or by cleverly hiding from it. Immunotherapy corrects this, allowing the immune system to resume its normal functions and destroy the malfunctioning cells that have become cancer. Similar to targeted therapy, we can use genetic testing to determine how these cancers work and then use certain drugs that help the immune system fight back.
DR. S. RYAN FAUGHT
ONE HEALTH RADIATION ONCOLOGY

When a patient is being treated for melanoma, radiation oncologists like myself can offer therapies and care that can enhance other treatments or improve the patient’s quality of life. This is especially true in the most advanced stages of the disease, when cancer has spread throughout the body.

Radiation can be useful in conjunction with surgery if there is a concern that tumor cells may remain. In this scenario, radiation can be used at the site in question. The goal is the precise delivery of radiation, destroying tumor cells. This can be done using different technologies and techniques, helping to minimize radiation exposure to healthy tissue.

When cancer has metastasized, radiation can be used to help treat those secondary cancers and the symptoms they cause. Common examples of this approach include secondary cancer in the brain or bones of a patient. Radiation can help ease symptoms, such as pain, in these cases.

Lastly, regional radiation therapy can be used along with immunotherapy in new and novel ways to treat metastatic melanoma. Regional delivery of radiation, such as to a bone metastasis, can work along with immunotherapy to systemically attack melanoma throughout the body. This example of systemic response to regional radiation therapy is yet another example of how it is possible to exploit the body’s immune system to treat melanoma.

DR. JIM TIDWELL
ONE HEALTH PLASTIC AND RECONSTRUCTIVE SURGERY

For patients undergoing treatment for melanoma, winning the fight against cancer is the primary goal. After the fight is won, however, visible effects can remain. That’s where plastic and reconstructive surgery comes into play. My role is typically in the reconstruction after the melanoma has been removed. I work to close the affected area and conceal it as well as is possible. Keeping these patients as whole as possible is important.

To that end, I work closely with general surgeons and other specialists. The goal is to give the patient the best possible outcome, and I very much see us as part of the team. The patient’s judgment or perception of how well their surgery was done can largely be based on what they can see, which is the work I’ve done.

Reducing the visible impacts of melanoma is important to both providers and patients. I try to emphasize to my patients that plastic and reconstructive surgery after melanoma removal is not vanity and that it’s not wrong in any way for them to think about that aspect. It’s a part of the cancer treatment.

At all points, one of the most important things with melanoma is prevention. It’s one of the cancers that is increasing throughout the world. Be familiar with the ABCs of melanoma and protect your skin.
A FIGHTING CHANCE: HOLLY DYER, STURGIS, KY

GETTING A MOLE EXAMINED SAVED HOLLY DYER’S LIFE.

“I noticed the mole on my left thigh before I became pregnant with my son and kept meaning to get it checked out,” Dyer said. “After I had him, when he was about two days old, I had my family doctor remove the mole.”

Days later, Dyer’s physician called back and told her the mole was a melanoma.

“When you first hear, you think it’s a death sentence. I knew it was a serious skin cancer,” Dyer said. “I said, ‘I’m going to fight it to the end.”

Shortly after, Dyer had the mole removed and a sentinel node biopsy was performed. The sentinel node also was positive for melanoma, so another 17 lymph nodes were excised. The news was good this time, with all showing negative.

Dr. Ridenhour then offered Dyer a chance to participate in a research study for an immunotherapy drug, and Dyer readily accepted. The drug had seen great success in treating patients with Stage IV melanoma, and the trial was trying to determine if it could prevent melanoma from returning.

“The reason I signed myself up for it was that I have a daughter, a son and a stepdaughter. I’d rather take the chance and try than later in life have it come back,” Dyer said.

Originally diagnosed in 2013, Dyer remains cancer-free. She still receives surveillance imaging to check for any return of her melanoma, but said she finds the follow-up scans reassuring.

“I feel pretty good. I like the fact that I do get scans and see Dr. Ridenhour every three months. It does make me feel better,” Dyer said.

Today, Dyer said she’s vigilant about protecting her skin, as well as her children’s.

“I do try to be more conscious about the sun. I don’t like to be in the sun too much,” Dyer said. “My children are pale, so I’m cautious with their skin.”

Dyer also said she enjoys the questions she gets about it, because it’s an opportunity to share her story with others and hopefully spread awareness.

“When I got this, a lot of people in my small town hadn’t thought a lot about it. It wasn’t talked about a lot. I like that people ask me and are curious,” Dyer said. “I tell women if they don’t want to look old, get out of the tanning bed and put sunscreen on. I always feel like I’m a teacher, in a way. My girlfriends say I’m always preaching.”
MISSION CRITICAL ASSISTANCE

OWENSBORO HEALTH FOUNDATION

Supporting the critical mission of the Mitchell Memorial Cancer Center is Owensboro Health Foundation. This philanthropic arm of Owensboro Health provides vital funding to several programs and services available at the Mitchell Memorial Cancer Center. Thanks to the generosity and kindness of Owensboro Health Foundation and its donors, those battling cancer at the Mitchell Memorial Cancer Center don’t face their fight alone.

PROGRAMS SUPPORTED BY OWENSBORO HEALTH FOUNDATION IN FISCAL YEAR 2016:

- LifeSpring: This program provides a combination of coping and sharing, health and wellness education, and creative and complementary therapies for cancer survivors and anyone in our service area affected by a cancer diagnosis.

- Mitchell Memorial Cancer Center Medication Fund: This fund provides financial assistance to cancer patients who cannot afford the medicines needed for controlling or relieving symptoms.

- Mitchell Memorial Cancer Center Transportation Fund: This program includes two separate funds. These provide mileage reimbursement to needy and retired cancer patients who must travel to the cancer center multiple times per week for treatment.

- Owensboro Health Oncology Conference: This is an annual educational event for medical professionals that provides information and updates on trends in staging, diagnosis and treatments of predominant cancers in our area.

- Breast Cancer Assistance Fund: This program provides financial assistance to breast cancer patients who cannot afford specialty bras and/or medicines needed for controlling or relieving symptoms.

Pat Serey, executive director of the Owensboro Health Foundation, said he is proud to see the foundation support the worthy programs provided at the Mitchell Memorial Cancer Center.

“Owensboro Health Foundation is proud to support Owensboro Health Mitchell Memorial Cancer Center in treating cancer patients and assisting cancer survivors,” Serey said. “Mitchell Memorial Cancer Center is a key resource in the battle against cancer and does outstanding work to care for all those affected by the disease, including patients, survivors and their loved ones. We’re glad to lend our support to those who are facing the greatest battle of their lives, and those who will help them in that fight.”
Owensboro Health's Mitchell Memorial Cancer Center regularly participates in research studies for new medications. These studies are an extremely important part of advancing our understanding of cancer and how to fight it. Sometimes what we learn from our patients during these studies can help advance our understanding of cancer, allowing us to develop or improve drugs that fight it. That knowledge may one day hold the key to saving the lives of others facing the same battle.

HOW PATIENTS CAN HELP THEMSELVES AND OTHERS

Contact information

2016 OWENSBORO HEALTH CANCER COMMITTEE

Brian Ward, MD – Pathology, Cancer Committee Chairman
Alan Mullins, MD – General Surgery, Cancer Liaison Physician
Jewraj Maheshwari, MD – Medical Oncology/Hematology, Cancer Conference Coordinator
J. Randall Thomas, MD – Medical Oncology/Hematology, Quality Improvement Coordinator
Doug Adams, MD – Cardiothoracic Surgery, Community Outreach Coordinator
S. Ryan Faught, MD – Radiation Oncology, Clinical Research Coordinator
Dattatraya S. Prajapati, MD – Medical Oncology/Hematology
Kevin Ridenhour, MD – Medical Oncology/Hematology
Thomas Logan, MD – Otolaryngology
Carl Watkins, MD – Radiology
Robert Lewe, MD – Urology
Ryan Abel, MD – Radiation Oncology
R. Wathen Medley, MD – Sr. Vice President of Medical Affairs
Melanie Farrell, MD – Internal Medicine, Palliative Care
Lisa Jones, DSc, MHA, FACHE – Owensboro Health VP of Clinical Services
Bonnie Roberts, MSN, BSN, RN, OCN, CTR – Director of Cancer Services
Vanessa Sorrels, CTR – Supervisor, Cancer Registry Quality Coordinator
Colleen Bachmeier, LSW/CCM – Social Worker, Psychosocial Services Coordinator
Karen Bishop, RT (R) (M) – Radiation Oncology Director
Claire Boomershine, PharmD, BCOP – Clinical Pharmacy Specialist, Hematology/Oncology
Kim Prater, BSN, RN, OCN – Oncology Oncology Supervisor
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Judy Snobell, BSN, RN, OCN, CCPR – Clinical Trials Coordinator
Carla Terrell, BA, BSN, RN, OCN – Oncology Patient Educator
Amy Davis, BSN, RN, OCN – Oncology Patient Educator
Holly Hollis, BSN, RT, (R) (T) (CT) – Manager Radiation Oncology
Holly Gardner, RD, LD – Nutrition Services
Colleen Brey, BSN, RN, OCN – Patient Navigator
Debbie Zimmerman, BSN, RN, OCN – Patient Navigator
Mary Kammrath, BSN, RN – Patient Navigator
Sarah Campbell, CTR – Cancer Registrar
Brian Hamby – Director of Marketing
Bonnie Brown, BCC – Director of Pastoral Services
Ellen Schroeder – American Cancer Society
Cindy Mattingly, BSN, RN, OCN – Clinical Program Specialist, Inpatient Oncology
Patricia Hamilton, Lab, MT-ASCP
Robin Osborne, Clinical Trials Coordinator

ACCREDITATION

The American College of Surgeons Commission on Cancer

Owensboro Health’s Mitchell Memorial Cancer Center is dedicated to providing care that meets nationally accepted standards to residents of Kentucky and Indiana. To demonstrate that commitment, the center has earned accreditation by multiple governing healthcare bodies, reflecting that we deliver treatment in keeping with the highest recognized standards of care.

THE FOLLOWING ACCREDITATIONS HAVE BEEN EARNED BY OWENSBORO HEALTH’S MITCHELL MEMORIAL CANCER CENTER:

2016

The American College of Surgeons Commission on Cancer

2015

The American College of Radiology Certificate of Accreditation in Radiation Oncology Services

2010

The National Accreditation Program for Breast Centers

Owensboro Health’s Mitchell Memorial Cancer Center is accredited as a “Comprehensive Cancer Center,” the highest endorsement awarded to any community hospital from the Commission on Cancer of the American College of Surgeons.

The Radiation Oncology Accreditation Program provides third-party, impartial peer review and evaluation of patient care. Staff, equipment, treatment planning and records, patient safety and quality control activities are assessed.