



COLUMBIA UNIVERSITY

*College of Physicians
and Surgeons*

┌ New York-Presbyterian Hospital
└ Columbia University Medical Center

The Pancreas Center

Herbert Irving Comprehensive Cancer Center
161 Fort Washington Avenue, 8th Floor
New York, NY 10032
Tel: 212.305.9467 • Fax: 212.305.5992

The Pancreas Center



A diagnosis of pancreatic cancer can be incredibly stressful for patients and families. Here at the Pancreas Center of the Herbert Irving Comprehensive Cancer Center, we strive to decrease the burden of the disease by providing highly coordinated, compassionate, and dedicated patient care. Pancreas Center patients have access to an experienced team of clinicians, oncologists, surgeons, radiologists, genetic counselors, psychiatrists, and nutritionists. As referring doctors, you are the frontline of this team. Together, we can provide the best possible experience for our patients.

John A. Chabot, MD, FACS
 Director, Pancreas Center
 Chief, Division of GI/Endocrine Surgery



COLUMBIA UNIVERSITY
 College of Physicians
 and Surgeons

┌ NewYork-Presbyterian Hospital
 └ Columbia University Medical Center

TABLE OF CONTENTS

Pancreas Center Mission Statement and Goals2

Referring a Patient.....2

Gastroenterology and GI Endoscopy4

Medical Oncology; Open Oncology Clinical Trials7

Surgery10

Genetics, Early Detection & Prevention of Pancreatic Cancer.....13

Psychiatry, Counseling, and Support Group Services.....14

Recent Additional Publications15

Conferences16

Pancreas Center Faculty and Staff17

MISSION STATEMENT

The mission of the Pancreas Center at NewYork-Presbyterian Hospital/Columbia University Medical Center is to be a center of excellence dedicated to decreasing the burden of pancreatic cancer and making it a controllable illness by providing outstanding medical care, undertaking breakthrough research, pioneering prevention and early detection techniques, educating patients and clinicians, and training physicians to become experts in the treatment of pancreatic cancer.

GOALS

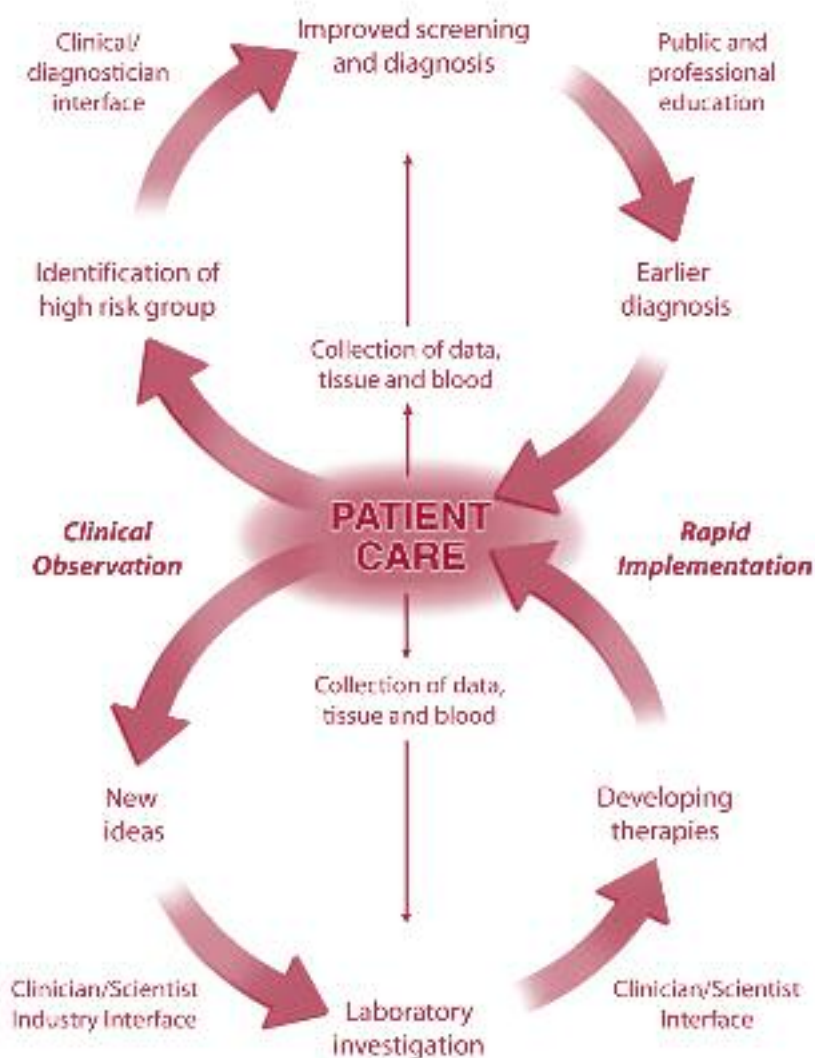
- Significantly increase the cure rate of individuals with pancreatic cancer
- Maintain best possible quality of life for individuals with pancreatic cancer
- Be the regional center with the most expertise in treating pancreatic cancer
- Provide genetic testing and counseling for at-risk individuals
- Understand the etiology and biology of the disease via clinical, translational, and basic research
- Be a magnet site for industry and the medical community to test new concepts in pancreatic cancer care
- Eliminate the fatalism that is commonly expressed about pancreatic cancer

REFERRING A PATIENT

- The patient or referring physician contacts the Pancreas Center clinical coordinator.
- At coordinator's request, the patient will send in copies of films, blood work, imaging studies, and physician notes for review by a nurse practitioner and physician.
- After the review, the Pancreas Center coordinator will contact the patient to set up an appointment with an appropriate hospital department or specialist. The coordinator may also request that the patient undergo further imaging studies before making any appointments.
- The patient is seen by one or more Pancreas Center physicians.
- The patient's case is presented and reviewed at a multi-disciplinary weekly meeting, where the plan of care for the patient is determined by the entire clinical team.
- The patient will be prepared for surgery, begin chemotherapy, or be under active surveillance as decided by the entire Pancreas Center team.
- The patient's progress will be discussed in weekly meetings as needed.
- The Pancreas Center team will update the referring physician on the patient's progress.

Clinical Coordinator: Bonnie Badenchini 212.305.9467

INTEGRATED CYCLE OF PATIENT CARE AND RESEARCH

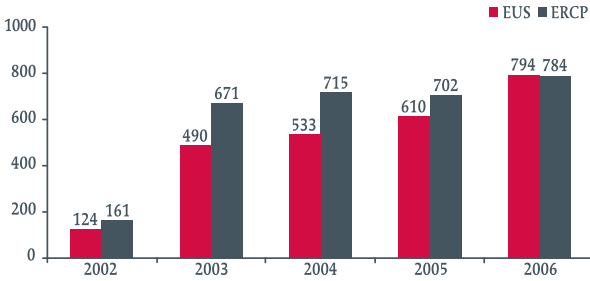


GASTROENTEROLOGY AND GI ENDOSCOPY

The Pancreas Center receives referrals from a number of primary care physicians and gastroenterologists. The endoscopic reports we receive become the first

diagnostic tool used for the patient work up. For those patients who do not have access to the most advanced endoscopy options, we refer patients to our Pancreas Center endoscopists. Last year the GI endoscopy physicians performed over 1,500 EUS and ERCP procedures.

Interventional Endoscopy (EUS) and Endoscopic Retrograde Cholangiopancreatography (ERCP)



Endoscopic Ultrasound (EUS)

The endoscopists in the Pancreas Center are able to perform endoscopic ultrasound, with fine needle aspiration or injection (FNA/I) as needed, for a variety of diagnostic and therapeutic indications. The most common indications for EUS are for pancreatic cysts and suspected pancreatic cystic and solid tumors. For patients with pancreatic cysts, imaging with EUS is complemented by analysis of cyst fluid for cytology, tumor markers, and genetic mutational analysis. Inflammatory diseases of the pancreas, including acute and chronic pancreatitis, are evaluated by EUS. In some cases secretin stimulation of pancreatic secretions is used during the examinations to better visualize ductal anatomy and to evaluate pancreatic function.

Therapeutic indications for EUS include drainage of pancreatic and peripancreatic fluid collections, injection of the celiac plexus for pain control, and most recently for EUS\ERCP rendezvous procedures (ERVP). ERVP harnesses the power of EUS to provide access to bile and pancreatic ducts under fluoroscopy to facilitate therapeutic ERCP procedures. In these procedures the ducts of interest are first accessed via a direct transduodenal or transgastic route when standard ERCP access techniques fail due to difficult or surgically altered anatomy.

ERCP

High quality ERCP is available to many patients through their own gastroenterologists. If you feel your patient would benefit from our consultation, and outside films of these procedures are available, patients and referring physicians are encouraged to forward the films with the patient for review. Additionally, the Pancreas Center offers a full range of advanced diagnostic and therapeutic ERCP procedures that may not be available locally.

Choledochoscopy and Pancreatoscopy

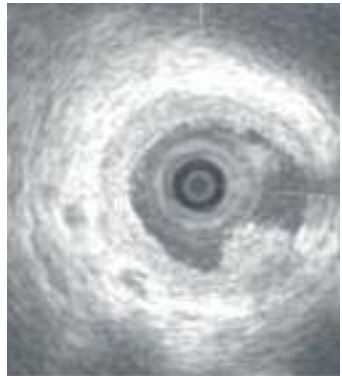
Pancreas Center endoscopists frequently employ the latest technology for evaluation of the bile and pancreatic ducts with direct visualization using the SpyGlass™ Direct Visualization System for single-operator duodenoscope assisted cholangiopancreatoscopy (SODAC). This procedure allows visually directed diagnostic and therapeutic interventions. It is especially useful in difficult-to-access ducts of patients with indeterminate biliary and pancreatic strictures, premalignant lesions such as IPMN, and difficult to manage stones.



SpyGlass image of focal pancreatic duct lesion in patient with IPMN

Intraductal Ultrasound (IDUS)

Though many endoscopists perform EUS (endoscopic ultrasound) on patients regularly, IDUS is used by endoscopic gastroenterologists at the Pancreas Center to better visualize tumors and cysts within the pancreas gland itself. IDUS uses mini probes less than 2 mm in size which can be passed through standard endoscopes directly into pancreatic ducts for more accurate, higher resolution images.



20 MHz IDUS image of a mural-based nodular projection

Altered Anatomy ERCP: Double Balloon and Minimal Access Surgery Techniques

For patients with difficult post-surgical anatomy (long afferent limbs after Whipple, Billroth II, Roux Y hepaticojejunostomy, and gastric bypass operations) who are not candidates for endoscopic rendezvous procedures, ERCP can now often be accomplished with standard ERCP accessories using a double-balloon endoscopy system. When this is not possible, Pancreas Center endoscopists and surgeons team together to use minimal access surgery techniques to provide ERCP access.

Recent GI Publications

Stevens PD, Chen YK, Pleskow D, Haluszka O, Peterson B. Biliary Stone Extraction (BSE) Guided By Direct Visualization Using the New SpyGlass™ Direct Visualization System. *Gastrointestinal Endoscopy*. 65(5):AB96-AB96.

Stavropoulos S, Larghi A, Verna E, Battezzati P, Stevens P. Intraductal ultrasound for the evaluation of patients with biliary strictures and no abdominal mass on computed tomography. *Endoscopy*. 2005 Aug;37(8):715-21.

Stavropoulos S, Larghi A, Verna E, Stevens P, Therapeutic endoscopic retrograde cholangiopancreatography without fluoroscopy in four critically ill patients using wire-guided intraductal ultrasound. *Endoscopy*. 2005 April;37(4):389-92.

Larghi A, Verna EC, Stavropoulos SN, Rotterdam H, Lightdale CJ, Stevens PD. EUS-guided trucut needle biopsies in patients with solid pancreatic masses: a prospective study. *Gastrointest Endosc*. 2004;59(2):185-90.

Stevens PD. EUS of the pancreas. In: Gress FG, Bhattacharya I, Eds. *Endoscopic Ultrasonography*. Blackwell Science; 2001.

Contact Numbers:

| | |
|-----------------------|--------------|
| Vashuda Dhar, MD | 212.305.1909 |
| Charles Lightdale, MD | 212.305.4382 |
| Peter D. Stevens, MD | 212.305.1909 |
| Leslie Schmidt, NP | 212.305.3955 |

MEDICAL ONCOLOGY

The Pancreas Center medical oncology team administers chemotherapy treatment pre-operatively, post-operatively, and for primary treatment. Our team also strives to develop and deliver cutting edge treatment options that can lengthen patient survival when faced with this disease. If you believe your patients will benefit from enrolling in one of our open clinical trials, please contact one of our physicians or our clinical coordinator.

For patients who are being treated outside of clinical trials, we collaborate with the primary referring oncologist to develop the most effective treatment plan for our patients.

Innovative Chemotherapy Research

GTX (Gemzar, Taxotere, Xeloda) chemotherapy for pancreatic cancer was developed in laboratories at Columbia University's College of Physicians and Surgeons over a two-year period. This drug combination has low toxicity to patients and decreases resistance to chemotherapy.

GTX has the highest response rate in the U.S. and Europe in Phase II trials. Phase III trials are planned.

GTX Increases Response Rates and Survival

| | | GEMZAR | GTX |
|---------------------|--------------------|--------|------|
| METASTATIC PATIENTS | RESPONSE RATES (%) | 10 | 50 |
| | SURVIVAL (MO) | 4.5 | 11.2 |
| INOPERABLE PATIENTS | RESPONSE RATES (%) | 8 | 67 |
| | SURVIVAL (MO) | 7 | 24 |

Clinical Trials in Oncology

Phase II study for inoperable non-metastatic pancreatic cancer (stage IVa) with neoadjuvant GTX and radiation therapy with Gemzar

For patients with locally unresectable pancreatic cancer, but no metastasis to other organs

OPEN - contact Dr. Robert Fine or Kyung Chu

Phase II study of GTX for adjuvant pancreatic cancer

Open to all patients who have had prior chemo/radiation therapy and or surgery to control pancreatic cancer

OPEN - contact Caitlin Kilts

Clinical Trials in Oncology (continued)

Phase II study of capecitabine and temozolomide for progressive, differentiated, metastatic neuroendocrine cancers

Open to patients with metastatic neuroendocrine tumors

OPEN - contact Dr. Robert Fine or Kyung Chu

Phase II randomized study to assess the efficacy and safety of AZD6244 vs. capecitabine (Xeloda) in patients with advanced or metastatic pancreatic cancer, who have failed first line gemcitabine therapy (Gemzar).

Open to patients with advanced or metastatic cancer for whom gemcitabine (Gemzar) does not work

OPEN - contact Dr. Robert Fine or Kyung Chu

Phase II study of alternating Taxotere Gemzar Xeloda (T-GX) for metastatic pancreatic cancer (stage IVb)

Open to patients with metastatic pancreatic cancer

OPEN - contact Dr. Robert Fine or Kyung Chu

Phase I dose finding study with CellCept in metastatic pancreatic cancer

Open to all patients with metastatic pancreatic cancer

OPEN - contact Dr. Robert Fine or Kyung Chu

Phase II GTX +/- sirolimus in metastatic pancreatic cancer

Open to all patients with metastatic pancreatic cancer

OPEN - contact Dr. William Sherman or Kyung Chu

Phase II study with GTX for adjuvant therapy in pancreatic cancer

Open to all patients who have undergone resection or attempted resection for pancreatic cancer

OPEN - contact Dr. Robert Fine or Kyung Chu

Laboratory Research Efforts

p53 Peptide Therapy is a synthetic peptide designed to attack the pathogenic mutagen responsible for 70% of pancreatic cancers and over 50% of all human cancers including breast, lung, colon, and prostate cancer. Synthetic p53 peptides work by forcing a shape change in mutant p53 so that it becomes functional.

Ras and p53 Gene Therapy is a gene therapy that destroys only those cells that exhibit both mutant ras and mutant p53 thereby diminishing the threat of cancer, but protecting the body from unnecessary harm.

AAA can kill pancreatic cancer cells by alternative cell death pathways (aponecrosis). The AAA combination is unique because there are no classic "chemotherapy drugs," and thus it is less toxic to the patient. Clinical trials with the Pancreas Center are pending so that this new treatment regimen can be tested.

Recent Publications

Fine RL, Fogelman DR, Schreiber SM, Desai M, Sherman W, Strauss J, Guba S, Andrade R, Chabot J. The gemcitabine, docetaxel, and capecitabine (GTX) regimen for metastatic pancreatic cancer: a retrospective analysis. *Cancer Chemother Pharmacol.* 2008 Jan;61(1):167-75. Epub 2007, Apr 18.

Contact Numbers:

| | |
|---------------------|--------------|
| Robert Fine, MD | 212.305.1168 |
| William Sherman, MD | 212.305.3856 |
| Kyung Chu, NP | 212.305.1921 |
| Caitlin Kilts | 212.305.2666 |

SURGERY

The Pancreas Center offers multiple and innovative surgical options for resection of pancreatic neoplasms. Our procedural experience leads to high success rates for our patients.

2005-2006

Academic Year Statistics

| | |
|---------------------|-----|
| New Patient Visits | 195 |
| Follow Up Visits | 701 |
| Pancreas Resections | 132 |
| Whipple | 66 |
| Distal | 28 |
| Total | 7 |
| Central | 8 |
| Other | 23 |

2006-2007

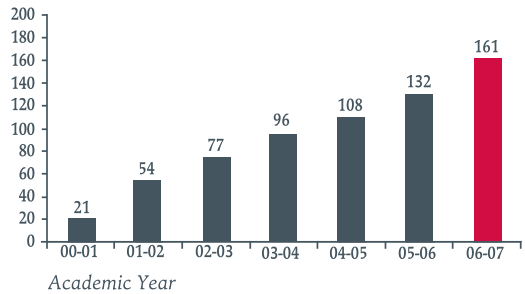
Academic Year Statistics

| | |
|---------------------|-----|
| New Patient Visits | 178 |
| Follow Up Visits | 803 |
| Pancreas Resections | 161 |
| Whipple | 80 |
| Distal | 44 |
| Total | 9 |
| Central | 8 |
| Other | 20 |

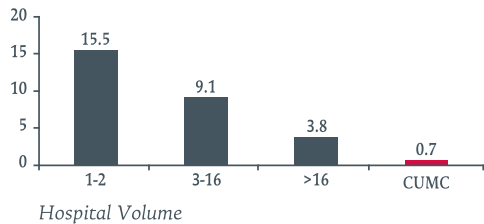
The specialists at the Pancreas Center are constantly innovating and improving surgical procedures for pancreatic cancer. They are able to customize pancreas surgery and preserve more healthy tissue, while still safely removing tumors.

The Pancreas Center team is also focused on identifying and treating precancerous lesions like IPMN. Due to the increasing number of patients seen each year, the team is adept at recognizing these precancerous conditions and delivering the most appropriate treatment for each individual patient.

Pancreas Operations Performed at the Pancreas Center



Pancreas Resection Mortality* (1994-1999)



*By number of procedures per year except CUMC which is cumulative to the present
Source: New England Journal of Medicine April 11, 2002, p1136

SURGICAL INNOVATIONS AND ADVANCES

Surgery is the standard treatment for pancreatic cancer. Unfortunately 1/3 of patients are inoperable due to vascular invasion. Here at the Pancreas Center, neoadjuvant chemotherapy has become a valued tool in treating inoperable patients, thereby increasing the surgical option for 35% of these patients.

Neoadjuvant Chemotherapy

Patients with advanced pancreatic cancer deemed to be surgically unresectable, are often able to undergo a regimen of neoadjuvant chemotherapy and radiation therapy that reduces their disease to operable levels.

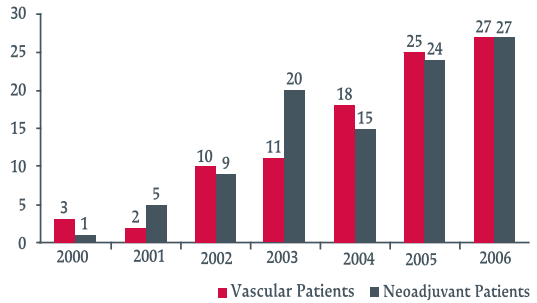
Vascular Resection

Patients with tumors encroaching on and encasing vessels are operated on at our institution with a high success rate.

Laparoscopic Distal Pancreatectomy

Patients can safely undergo distal pancreatectomies laparoscopically. At our institution, the majority of these laparoscopic pancreatectomies are for neuroendocrine tumors and cysts. Our laparoscopic distal pancreas patients tend to experience shorter hospital stays, less blood loss, and lower leak and complication rates.

Neoadjuvant and Vascular Resection Patients Rendered Eligible for Surgery



Laparoscopic Pancreatectomy is a Safe and Effective Option

| | MEDIAN LENGTH OF STAY | LEAK RATE | COMPLICATION RATE |
|---------------------|-----------------------|-----------|-------------------|
| LAPAROSCOPIC (N=37) | 5 >5 DAYS=44.1% | 5.4% | 15.2% |
| OPEN (N=1000) | 7 >7 DAYS=66.3% | 8.1% | 28.1% |
| P-VALUE | .01 | NS | NS |

Central Pancreatectomy

Central pancreatectomies are performed at our institution. These operations can eradicate a neoplasm in the body or neck of the pancreas without removing the healthy pancreatic tail; enabling the patient to have a highly functional pancreatic head and tail with exocrine and endocrine functions intact.

Recent Surgery Publications

Allendorf JD, Lauerman M, Bill A, Digiorgi M, Goetz N, Vakiani E, Remotti H, Schrope B, Sherman W, Hall M, Fine RL, Chabot JA. Neoadjuvant Chemotherapy and Radiation for Patients with Locally Unresectable Pancreatic Adenocarcinoma: Feasibility, Efficacy, and Survival. *J Gastrointest Surg.* 2007 Sep 5 [Epub ahead of print]

Fisher JC, Kuenzler K A, Bodenstern L, Chabot J A. Central Pancreatectomy with Pancreaticogastrostomy in Children. *J Pediatric Surg.* 2007 Apr; 42 (4), 740-6.

Allendorf JD, Schrope BA, Lauerman MH, Inabnet WB, Chabot JA. Postoperative glycemic control after central pancreatectomy for mid-gland lesions. *World J Surg.* 2007 Jan;31(1):164-8; discussion 169-70.

Recent Presentations

Pancreatectomy with vascular resection and reconstruction: A single institution 12 year experience. Presented by John Allendorf, MD, April 18, 2007. Presented to the New York Surgical Society at the New York Academy of Medicine, New York, NY.

Neoadjuvant Chemotherapy and Radiation for Patients with Locally Unresectable Pancreatic Adenocarcinoma: Safety, Feasibility, and Survival. Presented by John Allendorf, MD, at SAGES/AHPBA Conference, April 18-22, 2007, Las Vegas, NV.

A Single-Institution Review of Laparoscopic and Open Distal Pancreatectomies. Presented by Beth Schrope, MD, PhD, at SAGES/AHPBA Conference, April 18-22, 2007, Las Vegas, NV.

Contact Numbers:

| | | | |
|---------------------|--------------|-----------------------|--------------|
| John Allendorf, MD | 212.305.6514 | James Lee, MD | 212.305.0333 |
| John Chabot, MD | 212.305.9468 | Beth Schrope, MD, PhD | 212.305.9441 |
| Andrew Gumbs, MD | 212.305.8363 | Nicole Goetz, MS, NP | 212.305.9467 |
| William Inabnet, MD | 212.305.0444 | | |

GENETICS, EARLY DETECTION, & PREVENTION OF PANCREATIC CANCER

Risk analysis can help those with a family history of pancreatic cancer to determine their own chance of getting the disease. We take into consideration all factors known to contribute to an individual's risk of pancreatic cancer, a process known as risk stratification. We analyze personal and family medical history, provide genetic counseling and testing, and recommend imaging of the pancreas with sensitive techniques in order to detect pre-cancerous abnormalities or small cancers that are surgically curable.

Inherited genetic mutations play a role in up to 25% of cases, and there is a 2 to 125-fold increase in the risk of pancreatic cancer in individuals with a family history of the disease. It is known that at least five distinct cancer syndromes account for a number of inherited pancreatic cancers: Familial atypical multiple mole melanoma syndrome (FAMMM); Peutz-Jeghers syndrome (PJS); early-onset familial breast cancer syndrome due to BRCA1 or BRCA2 mutations; hereditary non-polyposis colorectal cancer syndrome (HNPCC); and hereditary pancreatitis.

The backbone of the Muzzi Mirza Pancreatic Cancer Prevention Program is a pancreatic cancer registry (Columbia Pancreatic Cancer Prevention Program, C2P3) that combines tissue and blood samples with epidemiologic, clinical, and family history data for people afflicted with pancreatic cancer and for those individuals who are at high risk for developing the disease. The program aims to prevent pancreatic cancer, understand the molecular genetics of pancreatic cancer, and establish an infrastructure that will allow future clinical, basic, and translational research.

Clinical Trials

Columbia Pancreatic Cancer Prevention Program Registry and Tissue Bank for High-Risk Individuals (C2P3)

OPEN - Contact Dr. Harold Frucht or Joanna Martinez-Gomez

MRCP with Secretin-Stimulation for the Evaluation of Pancreatic Endocrine and Exocrine Function Following Surgical Resection for Pancreatic Adenocarcinoma

OPEN - Contact Dr. Harold Frucht or Joanna Martinez-Gomez

Secretin-Stimulated MRCP as an Early Screening Modality for Pancreatic Ductal Abnormalities in Patients at High Risk for Pancreatic Adenocarcinoma

OPEN - Contact Dr. Harold Frucht or Joanna Martinez-Gomez

Molecular Genetics (BRCA1, BRCA2) and Epidemiology of Pancreatic Cancer in Ashkenazi Jewish Patients

OPEN - Contact Dr. Harold Frucht or Joanna Martinez-Gomez

Research Initiatives

- Germline Mutation of the Rb Tumor Suppressor Gene Causing Pancreatic Cancer
- Germline Mutation of the p16 Tumor Suppressor Gene (FAMMM Syndrome Variant) Causing Pancreatic Cancer, Head & Neck Squamous Cell Cancer, and Melanoma
- Incidence of Pancreatic Adenocarcinoma in Young Individuals with a History of Genetic Syndromic Cancers Using the SEER Database
- PanIN Lesions as a Risk Factor for Local Pancreatic Cancer Recurrence

Pancreas Cancer Prevention Program Contact Numbers:

| | | | |
|-----------------------|--------------|-------------------------|--------------|
| Wendy Chung, MD | 212.305.6731 | Colina Chapman | 212.305.1021 |
| Harold Frucht, MD | 212.305.1021 | Mary Kay Dabney, MS | 212.305.3701 |
| Caroline Hwang, MD | 212.305.1021 | Nicole Goetz, MS FNP BC | 212.305.9467 |
| Aimee L. Lucas, MD | 212.305.1021 | Joanna Martinez-Gomez | 212.305.9337 |
| Elizabeth C. Verna MD | 212.305.1021 | | |

PSYCHIATRY, COUNSELING, AND SUPPORT GROUP SERVICES

The Pancreas Center has established a regular referral service for patients who would like to have a Columbia University psychiatrist address the common issues of adjustment and depression that many patients experience. Additionally, support groups for patients and families are available through the Herbert Irving Comprehensive Cancer Center.

Cross-Departmental Studies

Quality of Life as Affected by a Multidisciplinary Care Model

PIs: Nicole Goetz, NP, John A. Chabot, MD

OPEN - Contact Nicole Goetz, NP

Temporal Relationship of Pancreatic Cancer and Depression

PIs: Alex Dranovsky, MD, Jon Levenson, MD

OPEN - Contact Jon Levenson, MD

Pilot study to assess the responses to adversity among newly diagnosed patients and patients who survived > 5yrs

PIs: Judith Jacobson, Victor Grann, MD

OPEN - Contact Judith Jacobson

Contact Numbers:

| | | | |
|------------------|--------------|------------------|--------------|
| Victor Grann, MD | 212.305.9529 | Nicole Goetz, NP | 212.305.9467 |
| Jon Levenson, MD | 212.305.9985 | Judith Jacobson | 212.305.2502 |

RECENT ADDITIONAL PUBLICATIONS

2006-2007 Academic Year

Fine RL, Fogelman DR, Schreibman SM, Desai M, Sherman W, Strauss J, Guba S, Andrade R, Chabot J. The gemcitabine, docetaxel, and capecitabine (GTX) regimen for metastatic pancreatic cancer: a retrospective analysis. *Cancer Chemother Pharmacol*. 2008 Jan;61(1):167-75. Epub 2007, Apr 18.

Suciu-Foca N, Feirt N, Zhang QY, Vlad G, Liu Z, Lin H, Chang CC, Ho EK, Colovai AI, Kaufman H, D'Agati VD, Thaker HM, Remotti H, Galluzzo S, Cinti P, Rabitti C, Allendorf J, Chabot J, Caricato M, Coppola R, Berloco P, Cortesini R. Soluble Ig-Like Transcript 3 Inhibits Tumor Allograft Rejection in Humanized SCID Mice and T Cell Responses in Cancer Patients. *J Immunol*. 2007 Jun 1;178(11):7432-41.

Yun SS, Remotti H, Vazquez ME, Crapanzano JP, Saqi A. Endoscopic ultrasound-guided biopsies of pancreatic masses: comparison between fine needle aspirations and needle core biopsies. *Diagn Cytopathol*. 2007 May;35(5):276-82.

Schönleben F, Qiu W, Bruckman KC, Ciau NT, Li X, Lauerman MH, Frucht H, Chabot JA, Allendorf JD, Remotti HE, Su GH. BRAF and KRAS gene mutations in intraductal papillary mucinous neoplasm/carcinoma (IPMN/IPMC) of the pancreas. *Cancer Lett*. 2007 May 8;249(2):242-8. Epub 2006 Nov 9.

Lebedeva IV, Washington I, Sarkar D, Clark JA, Fine RL, Dent P, Curiel DT, Turro NJ, Fisher PB. Strategy for reversing resistance to a single anticancer agent in human prostate and pancreatic carcinomas. *Proc Natl Acad Sci U S A*. 2007 Feb 27;104(9):3484-9. Epub 2007 Feb 21.

2005-2006 Academic Year

Schönleben F, Qiu W, Ciau NT, Ho DJ, Li X, Allendorf JD, Remotti HE, Su GH. PIK3CA mutations in intraductal papillary mucinous neoplasm/carcinoma of the pancreas. *Clin Cancer Res*. 2006 June 15;12 (12): 3851-5.

Stavropoulos S, Larghi A, Verna E, Battezzati P, Stevens P. Intraductal ultrasound for the evaluation of patients with biliary strictures and no abdominal mass on computed tomography. *Endoscopy*. 2005 Aug;37(8):715-21.

Sahin F, Qiu W, Wilentz RE, Iacobuzio-Donahue CA, Grosmark A, Su GH. RPL38, FOSL1, and UPP1 are predominately expressed in the pancreatic ductal epithelium. *Pancreas*. 2005; 30:158-67.

CONFERENCES

Pancreas Center Weekly Conference

The Pancreas Center holds weekly CME accredited meetings for physicians in all disciplines to discuss patients with diseases of the pancreas. If you have referred a patient, they will most likely be discussed at the weekly meeting before any plans are made for their care. Cases are presented by attending physicians and housestaff. Physicians in radiology, oncology, surgery, and gastroenterology are always present to collaborate in designing a clinical plan.

If you would like to attend our conference to discuss your patient or learn about pancreatic cancer, please contact our clinical coordinator at 212.305.9467.

Past Conferences

2006-2007 Academic Year

Pancreas Cancer Awareness Day, Saturday, November 10, 2007, hosted by the Pancreas Center, the Faculty Club, P&S building, NewYork-Presbyterian Hospital/Columbia University Medical Center

PanCAN New York City Symposium, Saturday, June 23, 2007

Early Detection, Prevention and Treatment of Pancreatic Cancer, Sunday, November 19, 2006, hosted by the Pancreas Center, Club 101, New York City

Pancreas Cancer Awareness Day; Saturday, November 4, 2006, Hosted by the Pancreas Center, Milstein Hospital Building, NewYork-Presbyterian Hospital/Columbia University Medical Center

2005-2006 Academic Year

Medical, Surgical, and Endoscopic Management of Pancreatic Masses, an Evening of Clinical Discussion, hosted by the Pancreas Center.

October 25, 2005, Northwest Restaurant, New York, New York

May 24, 2005, Morton's Steak House, Hackensack, New Jersey

February 1, 2005, F & J Pines Restaurant, Bronx, New York

Pancreas Cancer Awareness Day; Saturday, November 19, 2005, hosted by the Pancreas Center, Milstein Hospital Building, NewYork-Presbyterian Hospital/Columbia University Medical Center

PANCREAS CENTER FACULTY AND STAFF

Surgery

| | |
|--|--------------|
| John D. Allendorf, MD | 212.305.6514 |
| John A. Chabot, MD—Director | 212.305.9468 |
| Shamly Dhiman, MD—Endocrine Fellow | 212.305.0444 |
| Andrew Gumbs, MD | 212.305.8363 |
| William B. Inabnet, MD | 212.305.0444 |
| James A. Lee, MD | 212.305.0333 |
| Beth Schrope, MD, PhD | 212.305.9441 |
| Nicole Goetz, NP | 212.305.9467 |

Medical Oncology

| | |
|---------------------------|--------------|
| Robert Fine, MD | 212.305.1168 |
| William Sherman, MD | 212.305.3856 |
| Kyung Chu, NP | 212.305.1921 |

Gastroenterology and GI Endoscopy

| | |
|---|--------------|
| Vashuda Dhar, MD | 212.305.1909 |
| Charles J. Lightdale, MD | 212.305.4382 |
| Shashin Shah, MD—Biliary Endoscopy Fellow | 212.305.1909 |
| Peter D. Stevens, MD | 212.305.1909 |
| Leslie Schmidt, NP | 212.305.3955 |

Studies in Family Genetics/GI Cancers

| | |
|-------------------------|--------------|
| Harold Frucht, MD | 212.305.8156 |
|-------------------------|--------------|

Diagnostic Radiology

| | |
|---------------------------------|--------------|
| Inna Postolov, MD | 212.305.2986 |
| Martin R. Prince, MD, PhD | 212.305.2986 |

Psychological Oncology

| | |
|------------------------|--------------|
| Jon Levenson, MD | 212.305.9985 |
|------------------------|--------------|

Pathology

| | |
|-------------------------|--------------|
| Helen Remotti, MD | 212.305.6719 |
|-------------------------|--------------|

Basic Science Research

| | |
|----------------------|--------------|
| Gloria Su, PhD | 212.851.4624 |
|----------------------|--------------|

Staff

| | |
|--|--------------|
| Bonnie Badenchini—Clinical Coordinator | 212.305.9467 |
| Francine Castillo—Administrative Director | 212.342.3677 |
| Jeanette Hall—Medical Secretary | 212.305.9468 |
| Diana Hernandez—Administrative Coordinator | 212.305.9468 |

