SOUTH JERSEY
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ADVANCED CARE AND DIAGNOSTIC NEWS FOR PHYSICIANS AND HEALTH CARE PROFESSIONALS

Cooper is First South Jersey Hospital to Earn Advanced Certification as a Comprehensive Stroke Center

On June 1, 2017, Cooper University Health Care joined the elite ranks of U.S. hospitals to earn The Joint Commission's Gold Seal of Approval and the American Heart Association/American Stroke Association's Heart-Check mark for Advanced Certification for Comprehensive Stroke Centers.

Cooper is one of only 124 hospitals in the nation, and the only hospital in South Jersey to achieve this voluntary certification to date, affirming that Cooper offers the highest level of stroke care available.

"As a Comprehensive Stroke Center, we have personnel available 24/7 with the specialized expertise to care for any type of stroke, even the most complex," explains Ryna K. Then, MD, a board-certified vascular neurologist who is the medical director of Cooper's stroke program. This includes large ischemic strokes, intracerebral hemorrhage, and subarachnoid hemorrhage.

"This means we have board-certified neurologists with stroke expertise and nurses with stroke training in the hospital around the clock," she continues. "We have neurosurgeons who are here within 30 minutes in case invasive surgery is required, and we have stroke-certified interventionists who can perform endovascular techniques—such as clipping or coiling aneurysms or retrieving blood clots from the brain—available 24/7.

"In addition, we have the capability

(continued on page 2)

Hayan Dayoub, MD, and Hamza Shaikh, MD, neurointerventional surgeons, and William Stanten, RT, (R) CV.

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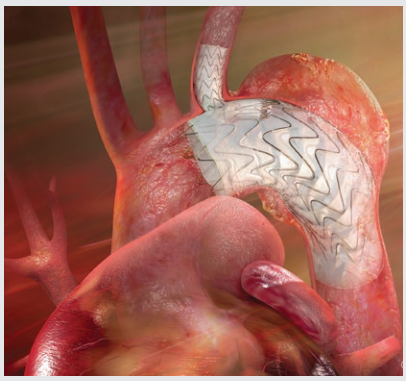

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Cooper University Health Care

Cooper is First South Jersey Hospital to Earn Advanced Certification as a Comprehensive Stroke Center (continued)

for neuro-imaging at all times, and we have an ICU with capabilities for neuro cases and intensivists certified in neuro-intensive care," she adds. The advanced imaging techniques Cooper offers include MRI and MR angiography, CT angiography, digital subtraction angiography, and transcranial Doppler ultrasound.

Each state has its own certifications or designations for stroke care, Dr. Then notes. And there are currently more than 900 Joint Commission-certified Primary Stroke Centers in the nation that have an established formal program to treat stroke patients effectively and consistently, with the goal of improving care and outcomes.

"But to be certified as a Comprehensive Stroke Center is the most prestigious—and reassuring—designation because it's based on stringent AHA/ASA standards of care," she says, "and it recognizes the significant differences in resources, staff, and training that are necessary for treating complex stroke cases.

"In the first couple of hours of onset, a stroke may look self-limiting," she points out. "But it may continue to progress to where a patient needs a hemicraniectomy—and this can't be known until the patient is admitted, and the situation unfolds. That's why it's vital to have qualified, certified, and advanced stroke care available at all times."

To earn certification as a Comprehensive Stroke Center, hospitals must first demonstrate compliance with stroke-related standards as a Primary Stroke Center, then meet additional requirements, including those related to advanced imaging capabilities, the availability of specialized treatments, and providing staff with the unique education and competencies to care for complex stroke patients. To document its compliance with these additional requirements, Cooper underwent a rigorous two-day onsite evaluation by The Joint Commission this past April.

"They visited our floors, ICU, Emergency Department…they talked to doctors, nurses, even housekeeping, to make sure we comply with guidelines if there's someone who may be having a stroke and follow the protocol to activate the stroke alert in the hospital," Dr. Then relates.

Ryna K. Then, MD
Medical Director
Cooper Stroke Program

"We have been providing this level of advanced stroke care here at Cooper for years," she adds. "Now, with this certification, it's 'official.'"

Dr. Then also points out that in addition to the extensive resources available to diagnose and treat acute stroke, Cooper has a team of physiatrists and physical, occupational, and speech-language therapists with specialized neurological rehabilitation expertise.

"To our way of thinking, this is part of being a Comprehensive Stroke Center, too, because it helps contribute to the best possible outcomes," she adds.

When Cooper's certification was announced, Mark R. Chassin, MD, FACP, MPP, MPH, President and Chief Executive Officer of The Joint Commission, commented, "By achieving this advanced certification, Cooper has thoroughly demonstrated the greatest level of commitment to the care of its patients with a complex stroke condition. Certification is a voluntary process, and The Joint Commission commends Cooper University Health Care for successfully undertaking this challenge to elevate the standard of its care for the community it serves."

Nancy Brown, Chief Executive Officer of the American Heart Association/American Stroke Association, also commended Cooper's achievement: "The American Heart Association/American Stroke Association congratulates Cooper on achieving Comprehensive Stroke Center certification," she said. "Meeting the standards for Comprehensive Stroke Center certification represents a commitment to deliver high-quality care to all patients affected by stroke."

Established in 2012, Advanced Certification for Comprehensive Stroke Centers is awarded for a two-year period to Joint Commission-accredited acute care hospitals. ■

American Heart Association®
American Stroke Association®
CERTIFICATION
Meets standards for
Comprehensive Stroke Center

The Cooper Neurological Institute Stroke Program Team (l to r): Hayan Dayoub, MD; Tapan R. Kavi, MD; Ryna K. Then, MD; Jessica Bryson, PA-C; Bethann Mercanti, PA-C; Thomas R. Mirsen, MD; Hamza A. Shaikh, MD.

For questions about the Cooper Neurological Institute or to refer a patient, email Stroke@cooperhealth.edu.

Cooper Joins Pivotal Study of First Device For Endovascular Treatment of Aortic Arch Lesions

Cooper is one of only a handful of hospitals in the tri-state region—and fewer than 40 nationwide—participating in a pivotal study of the GORE® TAG® Thoracic Branch Endoprosthesis (TBE), the first device designed specifically for the endovascular treatment of aortic arch lesions.

It offers a minimally invasive treatment for patients with these more complicated aortic aneurysms.

"Technology came out about 20 years ago that enabled us to endovascularly repair aortic aneurysms below the kidney arteries," says vascular surgeon Joseph V. Lombardi, MD, FACS, head of the Division of Vascular and Endovascular Surgery and director of the Cooper Aortic Center.

"But the technology has developed slowly for treating thoracic aneurysms and aortic arch disease," he continues. "While we can treat many thoracic and thoracoabdominal aneurysms with an endovascular stent graft, there are limitations when the aortic arch is involved. As a result, these patients have required open surgical procedures."

Not any more—if this new clinical study lives up to its promise. The objective of the study is to determine the safety and efficacy of the TBE in treating lesions of the aortic arch and descending thoracic aorta, which includes dissection, trauma or aneurysm.

This pivotal study follows both an early feasibility study conducted in Zones 0-1 with the branch device in the brachiocephalic or left common carotid arteries, and a feasibility study in Zone 2 with the branch device in the left subclavian artery. The new pivotal study will include up to 40 sites across the U.S. that are expected to recruit up to 435 patients, treating all etiologies requiring proximal graft placement in Zones 0-2.

"Through this trial, we can treat these arch aneurysms, or thoracic aneurysms with arch involvement, endovascularly, through the groin," Dr. Lombardi explains. "We don't have to put the patient on cardiopulmonary bypass or crack the chest, and potentially reduce associated complications resulting in these existing methods of access."

Bottom line, as a commercially available device—which it already is in Europe—the TBE could offer an important less-invasive treatment option for the population of U.S. patients with aortic arch disease, a condition that traditionally has posed significant challenges for both open surgical and endovascular management.

The limited options currently available for treating patients with aortic arch disease is one of the reasons that the TBE is the first GORE device to receive the new FDA Expedited Access Pathway (EAP) designation, and among the first medical devices to receive this designation in the U.S. This pathway is limited to certain medical devices that demonstrate the potential to address unmet medical needs for life-threatening diseases and offer a meaningful patient benefit compared to existing options.

"There's a commitment on the part of the Cooper Aortic Center to introduce new technology to the South Jersey community that enables us to treat more complicated aneurysms," Dr. Lombardi says. "This trial represents a major milestone in our ability to do just that.

"The company that makes this device (W.L. Gore & Associates, Inc.) is meticulous about the hospitals they select to participate in this trial," he adds, noting that selection is based on surgical expertise, volume, and national stature. "So being chosen for this trial speaks loudly about the quality of Cooper's aortic program." ■

"There's a commitment on the part of the Cooper Aortic Center to introduce new technology to the South Jersey community that enables us to treat more complicated aneurysms. This trial represents a major milestone in our ability to do just that."

If you have questions about this study or a patient's eligibility for enrollment, call Dr. Lombardi at 856.968.7067 or email Lombardi-joseph@cooperhealth.edu.

Cooper Commits to "80% by 2018" Initiative To Reduce Colorectal Cancer in Adults 50+

More than 1,300 organizations across the nation have committed to substantially reducing colorectal cancer as a major public health problem for those aged 50 and older. MD Anderson Cancer Center at Cooper is among them, working toward the shared goal of having 80 percent of adults aged 50 and older being regularly screened for colorectal cancer by 2018.

This "80% by 2018" initiative is led by the National Colorectal Cancer Roundtable (NCCRT), which was started by the American Cancer Society and the Centers for Disease Control and Prevention (CDC) in 1997. The NCCRT launched the awareness campaign in 2014.

"We're aiming to increase from about a 35 percent screening rate to 80 percent," says Steven R. Peikin, MD, FACG, AGAF, Head of the Division of Gastroenterology and Hepatology. "It's an ambitious goal, but one that will save a significant number of lives. Colorectal cancer is the number two cause of cancer deaths in the United States, with around 135,000 people diagnosed every year, and about 57,000 dying from advanced disease."

"We're aiming to increase from about a 35 percent screening rate to 80 percent. It's an ambitious goal, but one that will save a significant number of lives."

In New Jersey, more than 4,000 people will be diagnosed with colorectal cancer this year, and over 1,420 will die from the disease.

"But when we screen with colonoscopy and find precancerous polyps, there's a 100 percent chance of preventing cancer having developed in that polyp," he continues. "And there's a 90 percent chance of a cure when we find early cancer. Screening does save lives."

In fact, research suggests that if the United States can achieve an 80 percent screening rate by 2018, 277,000 cases and 203,000 colorectal cancer deaths would be prevented by 2030.

Unfortunately, today, about one in three adults between 50 and 75 years of age—about 23 million Americans—are not getting tested as recommended.

"We know that men, in particular, are less likely to get screened," notes Cooper colorectal surgeon Michael E. Kwiatt, MD. "So are Hispanics and those with lower education and income. So these populations are certainly targets for this initiative, but so are all adults between age 50 and 75."

Steven R. Peikin, MD
Head, Division of Gastroenterology and Hepatology

Michael E. Kwiatt, MD
Attending Physician
Colorectal Surgery

South Jersey community leaders came together on March 6, 2017 to announce their commitment to implement changes within their individual organizations to increase colorectal cancer screening in Camden and the surrounding area, officially kicking off the "80% by 2018" initiative in this region.

Since then, MD Anderson Cooper has been partnering with local businesses to encourage employees to undergo screening, and physicians and nurses have been participating in community events to raise awareness.

"With a team of a dozen gastroenterologists here at Cooper, we have significant capacity to handle a high volume of screening colonoscopies," Dr. Peikin notes. "In addition, we offer other screening options including CT colonography (virtual colonoscopy), barium enema, FIT (fecal immunochemical testing) to detect occult blood in the stool, sigmoidoscopy, and DNA testing."

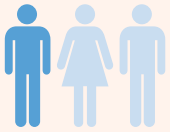
Drs. Peikin and Kwiatt agree that primary care physicians play a crucial role in encouraging patients to get screened.

"They're the ones on the frontlines who know if their patients need screening and can make the referral," Dr. Peikin says.

"We're confident this initiative will have a huge impact on colorectal cancer," he adds, "and that this type of cancer will no longer be the number two cause of cancer death in the United States." ■

Colorectal Cancer Screening Saves Lives

90% **About 90% of people live 5 or more years when their colorectal cancer is found early through testing.**

1 in 3  **About 1 in 3 adults (23 million) between 50 and 75 years old is not getting tested as recommended.**

1 in 10 **10% of adults who got tested for colorectal cancer used an effective at-home stool test.**

National Center for Chronic Disease Prevention and Health Promotion

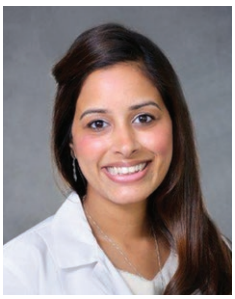
ASGE Quality
ENDOSCOPY UNIT RECOGNITION PROGRAM

The Cooper Digestive Health Institute (DHI) of Mount Laurel has been recognized by the American Society for Gastroenterology Endoscopy (ASGE) with an Endoscopic Unit Recognition Program (EURP) Certificate of Excellence Award.

For more information about "80% by 2018," please email Jordan Goldberger at Goldberger-Jordan@CooperHealth.edu or call 1.855.MDA.COOPER (1.855.632.2667).

Cooper Among Top Hospitals in the Northeast Offering SIRSpheres Y90 Radioembolization for Primary and Metastatic Liver Cancer

In terms of volume, Cooper is among the top six hospitals in the Northeast performing SIRSpheres Y90 radioembolization, a minimally invasive procedure that combines embolization and radiation therapy to treat both primary and metastatic hepatocellular cancer. Importantly, this means a growing number of patients have had—and continue to have—access to a treatment that's been shown to extend survival and improve quality of life.



Sabina Amin, MD,
Attending Physician
Interventional Radiologist

With radioembolization, tiny glass or resin beads filled with the radioactive isotope yttrium-90 (Y90) are placed inside the blood vessels that feed a tumor. This allows the beads to be delivered directly by the blood supplying the cancer cells and delivers a high dose of radiation to the tumor while sparing nearby normal tissue.

"While this procedure is not considered curative, it has been shown to allow the liver to survive about eight months longer than with conventional chemotherapy and can often allow patients to become surgical candidates when they weren't before" says board-certified interventional radiologist Sabina Amin, MD, who works with oncologists at the MD Anderson Cancer Center at Cooper to provide this state-of-the-art treatment.

"We've had some great successes; we now have patients who we have halted progression of their disease in the liver," she adds.

The Y90 radioembolization procedure is indicated for treating inoperative liver tumors in patients with liver-dominant or liver-only tumors.

"Patients can have metastasis in other parts of the body as long as there are liver-dominant tumors," Dr. Amin explains. She notes that Cooper has seen good results in treating cholangiocarcinoma, breast, renal, neuroendocrine, pancreatic, colorectal, and ovarian cancers that have metastasized to the liver, as well as primary hepatocellular carcinoma. Y90 radioembolization has been shown to be effective in treating metastatic uveal melanoma, too.

"It also allows for patients to undergo chemotherapy concurrently," she continues, "so we're not putting all our eggs in one basket. Instead, we can double down on the cancer in the liver."

Dr. Amin notes that radioembolization enables physicians to radiate the tumor at a higher dose than can be delivered externally. "The radioactive isotope Y90 only penetrates 2.5 mm, sparing skin, bone and, often, normal liver tissue," she says. "And we can retreat if new tumors appear, without the systemic effects of chemo."

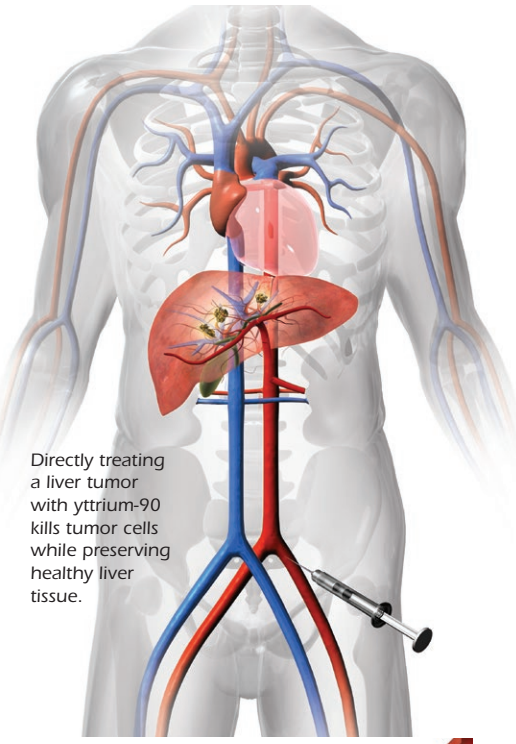
She also points out that while there are other options for treating liver cancer—including systemic chemotherapy, external beam radiation, stereotactic radiosurgery (CyberKnife®), or surgery, including transplantation—these are not always appropriate for every patient.

"Y90 radioembolization allows for progression-free survival within the liver, giving patients statistically significant improvement in survival and allowing them to maintain their quality of life and potentially stay on chemotherapy or qualify for surgical resection," she adds.

This treatment is a collaboration between Cooper's Interventional Radiology Department and the team at the MD Anderson Cancer Center at Cooper. Cooper was the first hospital in South Jersey to offer SIRSpheres Y90 radioembolization nearly two years ago and today ranks among the top U.S. hospitals to offer it in terms of volume—a testament to the expertise that resides here. The other high-volume centers include Massachusetts General Hospital, NYU Langone Medical Center, New York-Presbyterian, NYP/Columbia University Medical Center, and Thomas Jefferson University Hospital.

"We would be happy to evaluate patients in our clinic to determine if they are a candidate for Y90 radioembolization," Dr. Amin says. "Referring physicians don't have to be part of the Cooper system, nor do patients have to be seen by an MD Anderson Cancer Center oncologist to obtain this treatment."

"We are here to work in collaboration with community physicians and to make this life-extending treatment accessible to as many patients as possible," she adds. ■



Directly treating a liver tumor with yttrium-90 kills tumor cells while preserving healthy liver tissue.

Minimally invasive SIR-Spheres® Y90 resin microspheres are designed to treat liver tumors with beta radiation.

For questions about Y90 radioembolization or to refer a patient, Dr. Amin can be reached at: amin-sabina@cooperhealth.edu or by phone at 856.342.3094.

Cooper's Hand and Nerve Surgery Center: Advanced Expertise for Complex Hand Injuries

With a team of four hand surgeons, Cooper's Hand and Nerve Surgery Center—a collaboration between the Division of Plastic Surgery and the Cooper Bone & Joint Institute—offers a level of specialized upper extremity surgical expertise that's rare in the South Jersey region.

"Through this integrated program, we have plastic and orthopaedic surgeons working together to reconstruct upper extremity deformities, whether they're traumatic or congenital," says board-certified orthopaedic surgeon David A. Fuller, MD, Director, Hand and Upper Extremity Surgery. "I was the only certified hand surgeon for some time, but we've added three more surgeons—including people with specialty expertise in congenital and pediatric disorders—expanding our capacity to meet the growing need in our community."

David A. Fuller, MD
Director, Hand and Upper Extremity Surgery

"Through Cooper's Trauma program, we see a lot of hand injuries, and we want to help take care of these difficult problems that are often underserved in this region."

"We are willing and able to tackle the complex cases," says Nicole J. Jarrett, MD, a plastic and reconstructive surgeon who is fellowship-trained in hand surgery. "Through Cooper's Trauma program, we see a lot of hand injuries, and we want to help take care of these difficult problems that are often underserved in this region."

These difficult problems include comminuted or compound fractures, brachial plexus injuries, and conditions that require tendon repair, replantation of fingers and hands, nerve transfer, repair or release, revascularized bone grafting, and skin grafts and flaps.


Nicole J. Jarrett, MD
Attending Plastic and Reconstructive Surgeon

She cites a recent case in which a patient's wrist bone hadn't healed despite two previous surgeries performed elsewhere. "We took a piece of bone from the patient's leg, along with the blood supply, and reconnected it in the wrist under the surgical microscope," Dr. Jarrett relates. "We did this as a team—orthopaedics and plastic surgery—so it was tremendously efficient. And the outcome was successful.

"With our expanded team, we're not only better able to serve patients for this type of challenging condition, but also for everything else," she adds, referring to more routine procedures such as joint replacement and carpal tunnel release.

Cooper's Hand and Nerve Surgery Center has also added a certified hand therapist to its team.

"Therapy and rehabilitation are important to patient outcomes, whether with or without surgery," Dr. Fuller says. "We're committed to providing the full spectrum of services our community needs, delivered in a way that's tailored to the individual patient."

It's this level of commitment that Drs. Fuller and Jarrett believe distinguishes Cooper's Hand and Nerve Surgery Center.

"We not only want to increase the community's access to care but also maintain the quality of care for an urban population, and do it in a socially and culturally responsible manner," Dr. Fuller says. "I think the volume we can now handle and our willingness to provide this level of care really do set us apart.

"A lot of the care we provide starts with Cooper's Trauma unit, but we're available to take referrals from the entire tri-state area," he adds.

"Historically, there simply weren't enough hand surgeons, so we didn't have the staffing to see patients in a timely manner," Dr. Jarrett says. "Now, patients with acute injuries can be seen in an efficient manner and get an operation if and when they need it. Patient access is much improved.

"There's really no case that we'll refuse," she adds. "If someone needs our help, we're able and willing to help. Patients—both adults and children—don't have to go across the river for expert hand surgery." ■

For questions about the Cooper Hand Center or to refer a patient, contact the Cooper Hand Program Navigator at 856.968.7262.

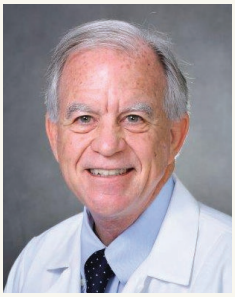
Cooper Aims to Separate Hype from Hope Via Its Groundbreaking Stem Cell Research

Cooper is stepping into the forefront of clinical translational medicine with a multi-disciplinary, evidence-based, bench-to-bedside approach to stem cell research.

"There's a lot of hype that stem cells are the miracle cure that will do everything," says Spencer A. Brown, PhD, Cooper's director of surgical research. "But too many of these claims aren't based on strict scientific inquiry. We aim to separate the hype from the hope in this field with step-by-step studies that break new ground to prove the safety and efficacy of stem cells in treating a range of diseases."

Patient enrollment is now underway for the first such study at Cooper, an FDA-approved IDE (investigation device exemption) trial to test the safety and efficacy of autologous adipose-derived stromal vascular fraction (SVF) cells in treating osteoarthritis (OA) of the knee. The study will collect and disassociate adipose tissue and inject the SVF into the knee of the same patient. The study is controlled, randomized, and double-blinded with two SVF treatments (high- and low-dose) and a placebo control. This study is multi-disciplinary with Lawrence S. Miller, MD (PI) from Orthopaedics and Steven C. Bonawitz, MD and Martha S. Matthews, MD from Plastic Surgery.

"We are one of only three sites in the nation participating in this trial, which is the first of its kind in human subjects," Dr. Brown notes. "We're hopeful this pivotal study will answer questions about how many cells are needed and whether there is an age, gender or severity of disease in which this treatment won't work. If successful, the treatment can be marketed commercially and expanded to OA of other joints."



Spencer A. Brown, PhD
Director, Surgical Research

> "We aim to separate the hype from the hope in this field with step-by-step studies that break new ground to prove the safety and efficacy of stem cells in treating a range of diseases."

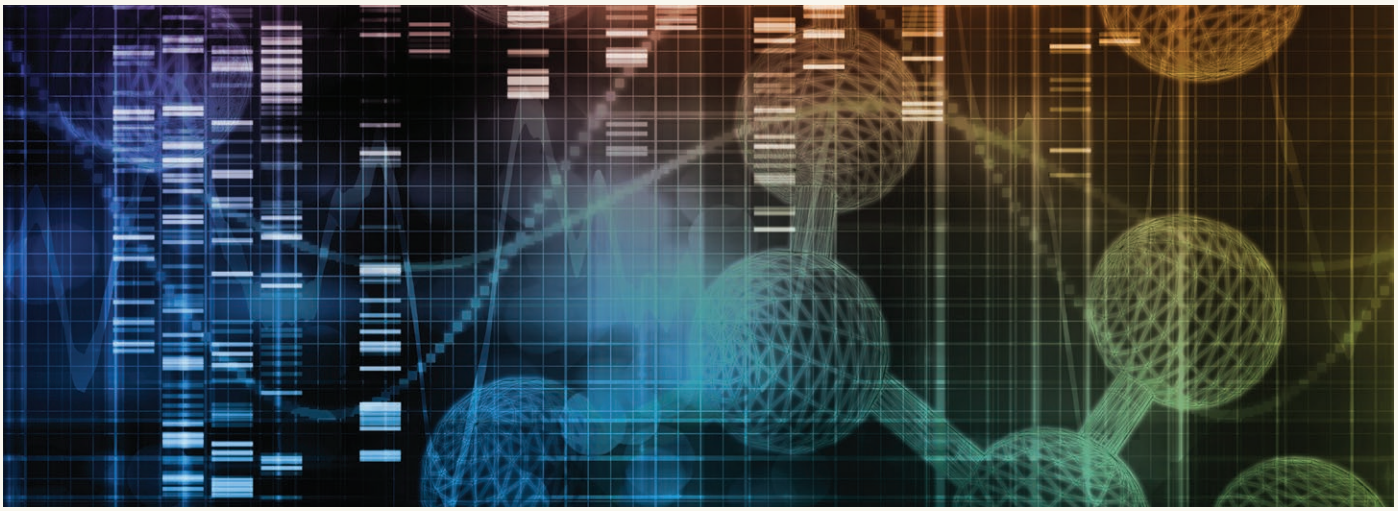
Cooper is also looking to expand into or develop other trials that will study the application of stem cells in treating such conditions as septic shock in the Trauma bay and erectile dysfunction.

"We are already involved in a large animal phase looking at diabetic wound healing involving stem cells," he says. "The promise in wound healing is very good because stem cell treatment increases the vasculature of wounds."

In addition, Cooper is the recipient of a three-year, $2.2 million award to study a newly identified mesenchymal stem cell (MSC) and its role in cancer, wound healing, and vision issues. MSCs are stromal cells that can differentiate into a variety of cell types, including osteoblasts (bone cells), chondrocytes (cartilage cells), myocytes (muscle cells), and adipocytes (fat cells that give rise to marrow adipose tissue).

"These funds were given by a grateful patient whose life was saved by Richard D. Lackman, MD (chief of orthopaedic oncology at the MD Anderson Cancer Center at Cooper), a leader in sarcoma research and treatment," Dr. Brown says. "Our efforts are building on the scientific work of Mindy George-Weinstein, PhD, Chief Research and Science Officer at Philadelphia College of Osteopathic Medicine. The Cooper Surgery Department Laboratory now includes five PhDs, a research manager, and a full-time research writer.

"We are very excited about the possibilities of stem cell research and the clinical benefits it promises," he continues. "Our hope is to become a center of excellence in this area by following FDA-approved pathways to prove these treatments work, training others in their application, working with companies to bring medications to market, and offering groundbreaking therapeutic options to patients." ■



If you have a patient who may be a candidate for enrollment in the pivotal study testing autologous adipose-derived SVF cells in treating knee osteoarthritis, please contact Dr. Brown at Brown-Spencer@cooperhealth.edu.

SOUTH JERSEY
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Clinical Trials

More than 450 clinical trials, including national trials, are currently underway at Cooper University Health Care, addressing a wide range of the latest pharmacologic, surgical, and device-related therapeutic options. Cooper's robust research program offers clinicians and their patients access to some of the most novel therapies and innovative trials in the region.

The following list represents some of the clinical trials currently enrolling patients at Cooper.

Study Area	Principal Investigator (PI)	Contact Info	Study Type	Study Description	Main Inclusion Criteria
Cardiology Arrhythmia/Implantable Defibrillator	Andrea M. Russo, MD	Claire F. Beeper 856.253.2361 Julie F. 856.669.8847	ICD Programming Study	The primary purpose of this study is to evaluate a subcutaneous ICD at specifically programmed settings.	1. Patient ≥21 years of age. 2. New patients undergoing a subcutaneous ICD System (S-ICD) for primary prevention. 3. Patients without spontaneous sustained VT or VF.
Cardiology Arrhythmia	Andrea M. Russo, MD	Claire F. Beeper 856.253.2361 Julie F. 856.669.8847	Treatment Study	Apixaban for the reduction of thrombo-embolism in patients with device-detected sub-clinical atrial fibrillation.	1. Device-detected episode of SCAF >6 mins but <24 hours. 2. Must have at least one Stroke Risk Factor.
Cardiology Arrhythmia/Implantable Defibrillator	Andrea M. Russo, MD	Claire F. Beeper 856.253.2361 Julie F. 856.669.8847	ICD Education Study	The purpose of this study is to provide patients with information about an implantable cardioverter defibrillator device (ICD) that prevents sudden cardiac death (SCD), to learn more about what kind of information is helpful to patients in making treatment decisions with their doctors.	1. Patient >21 years of age. 2. Eligible for an implantable cardioverter defibrillator (ICD) for the primary prevention of sudden cardiac death. 3. Non-hospitalized patients with ejection fraction ≤35 percent.
Gynecologic Oncology Ovarian, fallopian tube, or primary peritoneal cancer	David P. Warshal, MD	Jackie T. 856.735.6396	Treatment Study	This study compares standard platinum-based chemotherapy to Olaparib as single-agent or in combination with Cediranib in women with recurrent platinum-sensitive ovarian, fallopian tube, or primary peritoneal cancer.	1. Female Patient >18 years of age. 2. Must have had a complete response to prior line of platinum therapy. 3. Patients who have no measurable disease following initial cytoreductive surgery and no evidence of disease progression for at least 6 months following their last platinum-based therapy or their date of surgery (whichever is later) are also eligible.
Hematology/Oncology Prostate	Ashish Patel, MD	Jackie T. 856.735.6396	Prospective Toxicity Evaluation & Quality of Life	This is a prospective evaluation of men undergoing stereotactic body radiation therapy (SBRT) for prostate cancer.	1. Males 18 years of age and older with low to intermediate risk prostate adenocarcinoma (T1-T2b, pretreatment PSA <10, Gleason sum 7 or less). 2. Patient must be a candidate for external beam radiation therapy (prior hormone therapy is allowed).
Hematology/Oncology Brain/Glioblastoma	Nati Lerman, MD	Jackie T. 856.735.6396	Treatment Study	This study evaluates concurrent chemoradiation and adjuvant temozolomide in patients with newly diagnosed glioblastoma (GBM).	1. Patient >18 years of age. 2. Histologically confirmed de novo Grade IV glioma (GBM, gliosarcoma or other subvariants) confirmed by central pathology tissue screening.
Infectious Diseases HIV	Rosalie Pepe, MD	Dana O. 856.968.7008	Treatment Study	This study is testing the effects of statin-preventive therapy on vascular events in HIV patients not meeting 2013 ACC/AHA guideline thresholds for recommended statin initiation.	1. Patient ≥40 and ≤75 years of age. 2. CD4+ cell count >100 cells/mm3. 3. Fasting LDL cholesterol <190 mg/dL.
Infectious Diseases HIV	Katherine Doktor, MD	Dana O. 856.968.7008	Treatment Study	This study is to evaluate safety, tolerability, and efficacy of an injectable drug therapy on LDL-C in subjects with HIV and hyperlipidemia and/or mixed dyslipidemia.	1. Patient ≥18 years of age. 2. Subject on stable lipid-lowering therapy for ≥4 weeks prior to randomization. 3. Fasting triglycerides ≤600 mg/dL.
Neurology TIA or Minor Stroke	Thomas R. Mirsen, MD	Patricia N. 856.968.7269	Drug Study	This study evaluates the safety and efficacy of a drug therapy for prevention of reoccurring ischemic event.	1. Patient >18 years of age. 2. High risk TIA: or minor ischemic stroke.
Neurology Huntington's Disease	Amy Colcher, MD	Justin F. 856.682.2501	Drug Study	This study evaluates the safety and efficacy of drug therapy for Huntington's Disease.	1. Patient >18 years of age. 2. Huntington's Disease Stage I or II. 3. Ambulatory patients.
Neurology Parkinson's Disease	Andrew McGarry, MD	Amanda L. 856.968.7615	Drug Study	This study evaluates the efficacy of drug therapy for reduction of fatigue levels in patients with Parkinson's Disease.	1. Patient >18 years of age. 2. Diagnosis of Parkinson's Disease. 3. Significant levels of daytime fatigue.

Study Area	Principal Investigator (PI)	Contact Info	Study Type	Study Description	Main Inclusion Criteria
Neurosurgery Acute Spinal Cord Injury	Steven S. Yocom, DO	Justin F. 856.682.2501	Device Study	This study evaluates the safety and efficacy of a surgical device implanted in those with spinal cord injury.	1. Patient ≥16 and ≤70 years of age. 2. AIS A classification of traumatic spinal cord injury at spinal cord level T2 to T12/L1. 3. Non-penetrating SCI that is approximately 4 mm in diameter or greater.
Neurosurgery Acute Spinal Cord Injury	Steven S. Yocom, DO	Justin F. 856.682.2501	Drug Study	This study evaluates the safety and efficacy of drug therapy injections in adults with spinal cord injury.	1. Patient ≥ 14 and ≤75 years of age. 2. Acute traumatic cervical SCI, motor level of C4, C5, or C6 on each side. 3. AIS grade A or AIS grade B.
Orthopaedics Osteoarthritis	Lawrence S. Miller, MD	Justin F. 856.682.2501	Treatment Study	This study is to compare the safety and efficacy of using SVF cells derived from autologous adipose tissue to treat osteoarthritis of the knee.	1. Patient ≥40 and ≤75 years of age. 2. Must have grades II or III knee OA from KL-grade scale. 3. Having already tried two or more conservative therapies for relief: oral pain medications, physical therapy, corticosteroid injection of the knee, viscosupplementation injection of the knee.
Orthopaedics Bone Fractures	Douglas S. Tase, MD	Justin F. 856.682.2501	Registry	The American Orthopaedic Association's Own the Bone program is a national post-fracture, systems-based, multidisciplinary fragility fracture prevention initiative.	1. Patient with an osteoporotic fracture.
Trauma Surgery Necrotizing Infections	Ju-Lin Wang, MD	Janika S.R. 856.361.1324	Drug Study	This study evaluates treatment and outcomes for patients with surgery for necrotizing soft tissue infections.	1. Patient >18 years of age. 2. Clinical diagnosis of necrotizing soft tissue infections AND requires surgery for treatment.
Vascular Surgery AAA	Jose L. Trani, MD	Jonelle O. 856.342.2150	Device Study	This study evaluates the safety and efficacy of a polymer and endovascular graft combination in the treatment of abdominal aortic aneurysms (AAA).	1. Patient >18 years of age. 2. Must have an aneurysm/ulcer of the abdominal aorta.
Vascular Surgery AAA	Joseph V. Lombardi, MD	Jonelle O. 856.342.2150	Device Study	This study evaluates a thoracic branch device in the treatment of aneurysms of the aortic arch and descending thoracic aorta.	1. Patient >18 years of age. 2. Must have an aneurysm/ulcer of the thoracic aorta.

For more information about clinical trials at Cooper, please contact:

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