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

Cooper and Inspira Join Forces to Serve More Cardiac Patients in South Jersey

CARDIA PARTNERS
Cooper inspira

A recent agreement between Cooper University Health Care and Inspira Health Network, called Cardiac Partners at Cooper and Inspira, provides patients with access to coordinated and comprehensive cardiac services across the continuum of care.

The integration of the two health systems' cardiac service lines creates what is now the largest program in South Jersey, expanding access and convenience for referring physicians and their patients throughout the region. Cardiac Partners includes more than 65 cardiac specialists and offers a comprehensive range of services [see page 2 sidebar for listing].

"There is tremendous synergy in what each of us does," says Phillip A. Koren, MD, FACC, FSCAI, Medical Director of the Cooper Heart Institute. "Here at Cooper, one of our strengths is tertiary and advanced-level care for patients with heart and vascular disease. Inspira is a three-hospital health system and provides state-of-the-art cardiovascular care at the community hospital level.

"Working in partnership, we complement each other's offerings and offer seamless cardiac care through a single point of access to residents throughout South Jersey," he continues. "And patients can receive the care they need in the most

(continued on page 2)

John A. Andriulli, DO, FACC and Sandy Durflinger, RN, Cooper Cardiac Electrophysiology Lab

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Introducing Cardiac Partners: Cooper and Inspira Join Forces to Serve More Cardiac Patients in South Jersey (continued)

appropriate, convenient setting."

For example, Dr. Koren notes, Inspira has a cardiac rehabilitation program—something that Cooper has not developed—while Cooper offers advanced cardiac surgery capabilities, including transcatheter aortic valve replacement (TAVR), mitral valve repair and replacement, and placement of the Watchman left atrial appendage closure (LAAC) device. In addition, as an academic medical center, Cooper is involved in clinical trials investigating leading-edge cardiac surgery techniques and new devices.

"Equally important, Cooper and Inspira physicians will have access to both health care systems, making referrals easier than ever," he adds. "And patients can stay here in New Jersey, close to home, for the most advanced, high-quality cardiac care."

As the health care landscape continues to shift, this innovative business model not only increases patient access, but also enables the two health care systems to expand service offerings, operate more efficiently, reduce duplication of services, and continue to improve quality.

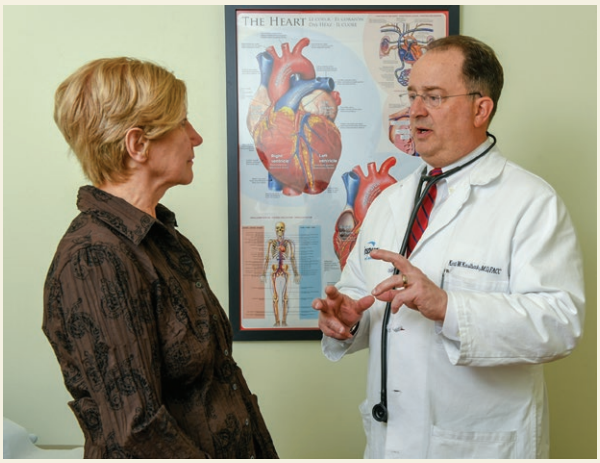
"Together, we're developing additional services, including a program for the management of advanced heart failure," Dr. Koren says. "By sharing resources and expertise, we'll be able to care for patients at Inspira's community hospitals as well as at Cooper.

"We're also focusing on quality improvement in both systems," he continues. "We're adopting best practices to help reduce clinical variation as well as readmissions and boost the overall health of our shared patient population."

Care coordination is another important benefit offered by Cardiac Partners.

"One of our overarching objectives is to make the care process seamless for patients who need cardiac care," Dr. Koren stresses, acknowledging that the health care system can sometimes feel overwhelming and fragmented. "Whatever services a patient needs—from basic screening and diagnostic testing in the outpatient setting, to the full range of treatments, including advanced cardiac surgery and rehabilitation—we aim to make it as simple and efficient as possible."

This starts with a patient's first call to Cardiac Partners. Should someone have questions or need assistance in choosing a provider, Cardiac Partners has a dedicated phone number with an option to speak to a nurse navigator who can provide answers and help connect patients to the right care. ■



Kurt W. Kaulback, MD, FACC, Clinical Director, Inspira Cardiovascular Services

Cardiac Partners: A Full Spectrum of Cardiac Care

Our combined services—all conveniently located here in South Jersey—span the full range of cardiac care, including:

- State-of-the-art diagnostic capabilities
- Comprehensive medical management of cardiac disorders
- Non-surgical/catheter-based interventional procedures, such as emergent and elective angioplasty, stent placement, and TAVR
- Arrhythmia management including ablation, open-heart Maze procedures, pacemaker and implantable cardioverter defibrillator (ICD) placement, and LAAC device placement
- Advanced cardiac surgery options for valve repair and replacement, thoracic and aortic procedures, minimally invasive and robotic-assisted cardiac procedures
- Cardiac rehabilitation

Phillip A. Koren, MD, FACC, FSCAI
Medical Director, Cooper Heart Institute

For questions about Cardiac Partners at Cooper and Inspira, contact Dr. Koren at Koren-Phillip@CooperHealth.edu. To schedule an appointment with a Cardiac Partners physician, patients may call 833-SJ-HEART (833-754-3278).

Treating Mitral Valve Disease with Advanced Surgical Techniques at Cooper

Since cardiothoracic surgeon Michael Rosenbloom, MD, FACS, FACC, FACCP, joined Cooper in 2007, he and his team have performed more than 1,100 minimally invasive valve operations. Their level of specialization and expertise consistently results in excellent patient outcomes. The Cooper Cardiothoracic Surgery team also includes Frank W. Bowen III, MD, FACS and Richard Highbloom, MD, FACS. Recently, they were joined by Joseph A. Kuchler, MD and Pasquale A. Luciano, DO.

Over the last 20 years, mitral valve surgery has continued to evolve, and Cooper has remained at the forefront of advancements in surgical treatment options. "In the Delaware Valley, we are a regional leader in mitral valve surgery," says Dr. Rosenbloom, who is Head of Cooper's Division of Cardiothoracic Surgery and Co-Director of the Cooper Heart Institute. "Notably, there aren't a lot of places in the country where mitral valve repair is regularly done, let alone focused on. We are one of those places."

When treating patients with mitral valve disease, the goal is to fix their valve with a durable repair, as studies have shown that repairing a native valve is always more effective than replacing it with an artificial valve. However, there is recent evidence that suggests that in certain situations, valve replacement is preferable. Ultimately, the most appropriate treatment really comes down to evaluating the condition of the individual patient as to the likelihood of a good long-term result.

Rheumatic heart disease, once the leading cause of mitral stenosis and often regurgitation, is no longer as prevalent, thanks to antibiotics. Today, degenerative conditions, often with a hereditary component, are a frequent culprit. "Mitral valve regurgitation represents a spectrum of conditions related to connective tissue deficiency," Dr. Rosenbloom says. "Rupture of chordae tendineae with leaflet prolapse can be fairly straightforward, but a more billowing valve that's very abnormal is more challenging to repair."

Michael Rosenbloom, MD, FACS, FACC, FACCP
Head, Division of Cardiothoracic Surgery
Co-Director, Cooper Heart Institute
Director, Cooper Aortic Center

Leaking mitral valves can also result from cardiomyopathy, heart failure, and coronary artery disease. "While treatment doesn't change the course of heart failure, symptoms generally improve, and sometimes there's improved muscle function when valve competency is restored," says Dr. Rosenbloom. "For patients with coronary artery disease who have had an MI that misaligns their mitral valve, recent data suggest that replacement is as good or is better than repair."

> "In the Delaware Valley, we are a regional leader in mitral valve surgery. Notably, there aren't a lot of places in the country where mitral valve repair is regularly done, let alone focused on. We are one of those places."

When replacement is the suggested approach, there are two options: tissue valves or mechanical valves. "In younger patients, we typically recommend a mechanical valve because they are more permanent," Dr. Rosenbloom says. "The downside of using a mechanical heart valve is that it requires taking warfarin for life. The FDA has not investigated or approved other anticoagulation strategies for this application."

Tissue valves are not permanent, potentially lasting 10-15 years on average. Their advantage is that they do not require the patient to be on lifelong warfarin therapy. So for many patients, particularly older patients, this may be a more desirable option. In addition, when a tissue valve degenerates, it no longer mandates a reoperation since a replacement valve can now be delivered via catheter into an existing tissue valve. While this option formerly was applied in high-risk patients only, technology has now advanced to the point where we can expect to see this approach become commonplace within the next decade.

The bottom line is, when significant mitral valve disease is identified, current evidence suggests that it should be addressed.

"An important study recently published in *JAMA* showed that when patients are operated on soon after identifying a mitral valve issue, their survival short, medium, and long term is improved as compared to people operated upon later in the course of their disease. The risks/benefits favor early intervention, even if the patient is asymptomatic," says Dr. Rosenbloom. "We urge physicians not to wait to refer a patient for evaluation. Even if the patient isn't quite ready for mitral valve surgery, it is often comforting to meet the surgeon and better understand their condition and treatment options." ■

Michael Rosenbloom, MD, FACS, FACC, FACCP

To schedule an initial office appointment with a Cooper cardiothoracic surgeon, patients may call 856.342.2141.

MD Anderson Cancer Center at Cooper Lung Nodule Program: A Smart Adjunct to Lung Cancer Screening

When the National Cancer Institute's landmark National Lung Screening Trial (NLST) found that screening with low-dose CT reduced lung cancer mortality in high-risk individuals by 20 percent compared to chest x-rays, it changed the landscape of lung cancer screening, with hospitals across the nation launching programs to help current and former smokers improve their chances of surviving this deadliest form of cancer through early detection.

David D. Shersher, MD
Thoracic Surgeon

Polina Khrizman, MD
Hematologist/Medical Oncologist

As a result of these screening programs, however—along with incidental findings on chest X-ray or CT scans obtained for other purposes—an estimated one million pulmonary nodules are being detected in the U.S. each year. The challenge now is to distinguish between benign and malignant nodules, expediting diagnosis for malignant nodules while minimizing testing of those that are benign.

"It's simply not feasible or appropriate to take everyone with a lung nodule to the OR and do invasive tests," says thoracic surgeon David D. Shersher, MD. "You need a strategy to identify who needs more of a workup, who needs to be followed, and who doesn't."

At MD Anderson Cancer Center at Cooper, that strategy entailed creation of a dedicated multi-disciplinary Lung Nodule Program, spearheaded by Dr. Shersher and medical oncologist Polina Khrizman, MD. In addition to their respective specialties, the disciplines that comprise the program include pulmonologists, interventional pulmonologists, radiologists, an imaging navigator, a nurse navigator, and other pulmonary and cancer experts.

So how do you distinguish between a benign and malignant nodule without invasive testing?

"There is a certain appearance to nodules that are concerning, which our lung-specialist radiologists recognize," explains Dr. Khrizman. "It has to do with size and shape—if it's well-circumscribed, ragged or invasive—and its growth pattern over time."

"We also look at the patient's age, smoking history, and environmental exposure to things like asbestos," she continues. "All these components help us identify those nodules that are more or less likely to be concerning. Patient A may have a lung nodule that looks suspicious, and we may recommend biopsy right away. Patient B's nodule, by its size and shape, isn't as concerning, so we may recommend a CT in six months and follow-up in clinic.

"It's very individualized, based on different risk stratification and what we see on imaging," she adds.

"Surgery is indicated when concern is very high from a clinical standpoint and there's tremendous risk, such as when a nodule is growing in size and PET shows it's active," Dr. Shersher says, noting that MD Anderson at Cooper offers a range of non-invasive testing, including biopsy performed through the airway by the interventional pulmonary team.

A unique aspect of MD Anderson at Cooper's Lung Nodule Program is its emphasis on smoking cessation.

"We've built in a robust, evidence-based smoking cessation program that's been shown to work over the long term," Dr. Shersher says. "We know it takes up to nine attempts to quit smoking, and we have strategies that help people succeed."

Drs. Shersher and Khrizman urge community physicians to get their at-risk patients screened for lung cancer—those between the ages of 55 and 74 who have a 30 pack/year smoking history and currently smoke or have quit within the past 15 years.

"For decades we struggled to find a test to identify lung cancer early," Dr. Khrizman says. "Now we do, and it's improving survivorship."

"Our program is designed to guide and manage patients through this complex condition while keeping referring physicians informed throughout the care process," Dr. Shersher adds. ■

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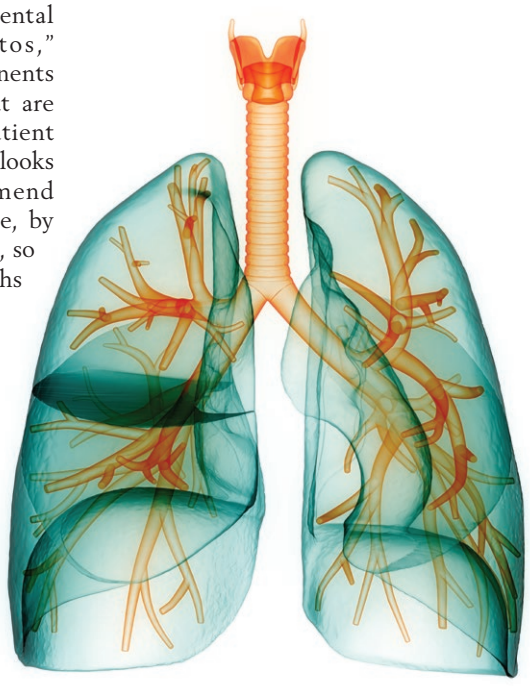

For a direct physician-to-physician consultation about a patient, call Dr. Shersher at 609.947.3658 or Dr. Khrizman at 215.422.2484. For all new patient appointments, our schedulers can be reached at 1.855.MDA.COOPER.

Deep Brain Stimulation: An Important Option for the Right Patients

For medically refractory patients with Parkinson's disease, essential tremor or dystonia, deep brain stimulation (DBS) offers a safe, effective way to improve their symptoms and reduce—sometimes completely eliminating—the need for certain medications. Notably, Cooper is the only medical center in South Jersey to offer DBS.

DBS is a neurosurgical procedure in which a neurostimulator delivers small electric shocks via implanted electrodes to specific parts of the brain. The electrical impulses render these parts of the brain inactive without surgically destroying them, thereby reducing tremor and blocking involuntary movements in patients with certain movement disorders and other conditions.

"In patients with Parkinson's who undergo DBS, we're seeing total or near-complete resolution of tremor, and improvement in rigidity and dyskinesia," says James C. Barrese, MD, a neurosurgeon with the Cooper Neurological Institute who specializes in DBS. "For those with essential tremor, we're seeing complete resolution or, at the very least, a drastic reduction in symptoms.

"While I tell most patients they can expect to reduce their movement-disorder medications by at least 75 percent, lately we've been getting patients completely off them," he continues. "Reducing medication dependence is one of the biggest reasons patients seek DBS, so this is a significant upside of this procedure," he adds.

"What's more, unlike medications—for which patients can develop a tolerance—DBS continues to work for a lifetime," Dr. Barrese notes. "We may have to titrate up the voltage over time, but symptom relief is maintained."

While Dr. Barrese performs the procedure to implant the electrodes and neurostimulator, Cooper neurologist Andrew McGarry, MD, performs the programming to determine the optimal stimulation parameters after implantation and over time.

WHO IS A CANDIDATE FOR DBS?

"Patients with Parkinson's disease who are having severe motor fluctuations and dyskinesia, and have become tolerant to medication, are ideal candidates," Dr. Barrese explains.

James Barrese, MD, performs Deep Brain Stimulation surgery on a patient with Parkinson's Disease.

Anyone with advanced dementia or Alzheimer's disease probably would not do well with DBS, he notes. "And if someone with Parkinson's disease is not responsive to dopamine, that patient is unlikely to respond to DBS," he says.

ARE THERE OTHER INDICATIONS FOR DBS?

"Essential tremor is the second-most common condition for which I perform DBS, and dystonia is the third," he continues. "In addition, the FDA recently approved DBS for treating obsessive-compulsive disorder (OCD), and it's showing promising results," he adds. DBS is also used in multiple sclerosis patients to help control arm tremor.

The applications for DBS are likely to continue to expand, with research underway to investigate its efficacy in treating major depression, stroke recovery, addiction, and dementia.

DBS has been performed since the 1980s; an estimated 40,000 people have successfully undergone treatment, and the technology continues to evolve.

"The biggest change is that we have replaced the stereotactic head frame with an image-guided frameless approach," Dr. Barrese explains, referring to how a patient's head is immobilized during the DBS procedure. "It vastly improves the patient experience because it's more comfortable and less constricting."

Despite decades of successful outcomes with DBS, some community physicians still hesitate to refer patients with movement disorders for this procedure—depriving them of the opportunity to improve their symptoms and reduce or eliminate medications.

"This treatment has been proven to be very safe, and it works extremely well," Dr. Barrese says. "If you have questions about whether a certain patient is a candidate for DBS, please send them for an evaluation," he urges. "We're not here to take your patient, but to help them with this specific problem." ■

Andrew McGarry, MD, programs a DBS neurostimulator for a patient with Parkinson's Disease.

For more information about DBS surgery for Parkinson's disease, or to refer a patient, please call Dr. James Barrese at 941.685.7724.

Orthopaedic Oncology: Growing Treatment Options for Adults and Children

Orthopaedic oncology is a relatively rare subspecialty—but not at Cooper. Three fellowship-trained orthopaedic oncologists are part of the Cooper Bone and Joint Institute and MD Anderson Cancer Center at Cooper, a testament to the exceptional depth of clinical expertise available here for adults and children with benign and malignant bone and soft tissue tumors.

The orthopaedic oncology surgical team. From left, Christina Gutowski, MD, Richard Lackman, MD, and Tae Won Kim, MD, Division Head, Orthopaedic Oncology Center.

"We're the only orthopaedic oncology group in South Jersey, and we see the largest volume of orthopaedic oncology patients in the entire Delaware Valley," says Tae Won Kim, MD, who co-directs Cooper's Orthopaedic Oncology Center with the nationally renowned Richard D. Lackman, MD, FACS. More recently, attending orthopaedic oncologist Christina J. Gutowski, MD, MPH, joined the practice.

Recent advances in their field are notable.

"One of the major new diagnostic tools we're using is genetic profiling—testing tumors for mutations to see if a targeted therapy is appropriate," Dr. Kim says. "And we're using more PET scans in staging and evaluating how tumors respond to chemotherapy."

"Musculoskeletal imaging is enabling us to visualize tumors in a much more precise way, so we can more clearly elucidate what structures are involved and determine whether limb salvage is possible," Dr. Gutowski adds, noting that with today's techniques and technology, limb salvage is "more often than not an option over amputation for these tumors."

When it comes to treating orthopaedic cancers, the options continue to expand and improve.

"We're working with radiation oncologist Gregory J. Kubicek, MD, using CyberKnife® radiosurgery for treating soft-tissue sarcomas," Dr. Kim says. "This allows us to deliver similar dose radiation in roughly one-third the time, so rather than five to six weeks of radiation therapy, patients can complete the treatment in two weeks."

"We also have newer systemic and targeted treatments for both primary and metastatic disease," Dr. Gutowski says. Plus, through its partnership with MD Anderson and participation in the Sarcoma Alliance for Research through Collaboration (SARC), Cooper is bringing national clinical trials to South Jersey to test novel chemotherapeutic agents.

On the surgical front, Cooper's orthopaedic oncologists are using enhanced nutrition and post-op protocols to improve recovery after major sarcoma surgery, enrolling all surgical patients in specialized "prehab" and rehab programs. And they are investigating the role of bone transportation in reconstruction—transporting local bone to make up the defect caused by a tumor.

In addition, advanced implants and prostheses are improving postsurgical outcomes for both adults and children.

"New implants were recently FDA-approved for complex shoulder reconstruction after massive tumor resection," says Dr. Gutowski, "and they're proving more functional and durable for the long term.

"We also now have noninvasive 'growing prostheses' that allow for a child's implant to grow like their limb normally would, so there's no limb-length discrepancy after we remove a portion of a femur, for example," she continues. "It's really amazing."

The foundation of the orthopaedic oncology group's effectiveness is its collaborative, multi-disciplinary approach to care—one that places the patient at the center.

"We have an interdisciplinary tumor board conference that meets weekly to discuss individual patients," Dr. Kim says. "It includes our team of orthopaedic oncologists as well as radiation oncologists, medical oncologists, musculoskeletal radiologists, and pathologists who are specially trained in these rare types of orthopaedic cancers.

"We treat all patients like our own family," he continues. "We'd never make a recommendation to a patient that we wouldn't make to a loved one.

"And we're committed to working closely with referring physicians, keeping them in the loop about their patients," he adds. "Our practice exists because we follow this model." ■

Tae Won Kim, MD, and Christina Gutowski, MD, perform a surgery together.

For more information on Cooper's orthopaedic oncology program, or to refer a patient, please call 856.361.1754.

Cooper Center for Dermatologic Surgery: The Latest Options for Scar Revision

Naomi Lawrence, MD, Dermatologic Surgeon and head of the division of Procedural Dermatology, (right) is shown with Ashley B. Decker, MD, Dermatologic Surgeon. Cooper Center for Dermatologic Surgery offers a range of services including Mohs, dermabrasion, liposuction, and fillers, in addition to the scar treatments mentioned in this article.

Trauma. Surgery. Acne. Burns. Regardless of the cause of a scar, today there are more options than ever to improve its appearance. And they're all available at the Cooper Center for Dermatologic Surgery.

"Once skin is structurally scarred, it's permanently altered," says dermatologic surgeon Naomi Lawrence, MD, head of the Division of Dermatology, Section of Procedural Dermatology at Cooper. "But we can improve the texture and appearance of a scar, helping it blend better into the surrounding skin so it's harder to find."

"There are two main types of scars we treat," explains dermatologic surgeon Ashley B. Decker, MD. "A hypertrophic scar is raised and bumpy, while an atrophic scar is depressed, like a pockmark. With either type, treatment involves re-wounding the skin in order to get collagen to form down in a more organized fashion."

Treatments fall into two categories as well: invasive and non-invasive.

"Invasive scar revision involves cutting out a scar in such a way that it leaves a better scar," says Dr. Lawrence. "For example, we can perform serial excisions to change a depressed atrophic scar into a fine-line linear scar. And Z-plasty is a surgical technique that can elongate a contracted scar or rotate a scar's tension line, improving its functional and cosmetic appearance."

Lasers play an important role in nonsurgical scar revision.

"We find the best lasers to be the fractionated lasers, particularly the fractionated CO2 laser," Dr. Lawrence notes. "It re-wounds the scar in such a way that it stimulates deep collagen, which re-heals so that the scar line is less obvious.

"We use this laser not only to treat typical scars, but also burns and severe traumatic scars," she continues. "It helps soften and improve the quality and texture of the skin, making the scar less apparent."

"The pulsed-dye laser is another type of laser that can cause changes in the distribution of fibroblasts, helping a scar to form flatter," says Dr. Decker. "It also can help to minimize redness when that's an issue."

Drs. Lawrence and Decker note that people with darker skin have a higher risk of hypo- or hyperpigmentation from laser treatment because the laser energy can damage melanocytes.

"But it doesn't mean they can't undergo treatment," Dr. Lawrence says.

"We often prescribe hydroquinone to help minimize post-procedure hyperpigmentation," Dr. Decker adds.

Other nonsurgical options include microdermabrasion and steroid-solution injections that may help scars form flatter. Micro-needling, or collagen induction therapy, is another option in which a device with fine needles creates tiny punctures in the skin, triggering new collagen and elastin production which, in turn, can improve texture, firmness, and the appearance of scars.

"The better micro-needling devices are those restricted to medical practices since they go deeper and produce a better result than at the spa," Dr. Lawrence says.

A nonsurgical treatment specifically for depressed acne scars is subcision, in which a special hypodermic needle is inserted through the skin to free the scarred skin from underlying subcutaneous fat, relieving the depression and improving the skin's appearance.

"There really is a lot available for treating scarring," Dr. Lawrence stresses. "Even if a patient had a scar evaluated in the past, there are newer techniques all the time, and it could be worth a second look."

"Patients don't have to feel discouraged," Dr. Decker adds. "There are options to minimize scarring and help patients get their confidence back. The sooner we see the patient, the better opportunity we can provide for positive long-term results." ■

Before and after images of treatment of scars using the fractionated laser.

To refer a patient for scar removal to Drs. Lawrence and Decker, or for questions concerning procedural dermatology, call 856.596.3040.

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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.

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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
Anesthesiology Carotid Surgery	Rhea Temmermand, CRNA	Bill T. 856.968.7331 Brian M. 856.968.7333	Treatment Study	Evaluation of time to hemodynamic stability and time to post-op cognitive function after carotid endarterectomy.	1. Age >18 years. 2. No dementia or head trauma history. 3. No history of long emergence from anesthesia.
Anesthesiology Hip Fracture	Kelly A. Bolkus, DO	Bill T. 856.968.7331 Brian M. 856.968.7333	Comparative Study	Evaluation of two types of anesthesia to promote independence after hip fracture.	1. Age >50 years. 2. Must have a hip fracture requiring surgical treatment. 3. Must have had the ability to walk without assistance before fracture.
Anesthesiology Left Ventricle Function	Robert A. Hirsh, MD	Bill T. 856.968.7331 Brian M. 856.968.7333	Device Study	Evaluation of new method to assess inotropic and lusitropic function of the left ventricle.	1. Age >18 <80 years. 2. Referrred for nonurgent transthoracic echo (TTE) or dobutamine stress echo (DSE).
Cardiology Arrhythmia	Andrea M. Russo, MD	Claire F. Beeper: 856.253.2361 Julie F. 856.669.8847	Treatment Study	Medication study for the reduction of thrombo-embolism in patients with device-detected subclinical 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	Device Education Study	Patient education study about an implantable cardioverter defibrillator device (ICD) for prevention of Sudden Cardiac Death (SCD) and what kind of information is helpful to patients in making treatment decisions with their doctors.	1. Age >21 years. 2. Eligible for an implantable cardioverter defibrillator (ICD) for the primary prevention of sudden cardiac death. 3. Non-hospitalized patients with ejection fraction ≤35%.
Cardiology Heart Failure	Andrea M. Russo, MD	Claire F. Beeper: 856.253.2361 Julie F. 856.669.8847	Device Study	Evaluation of experimental medical device for improving heart strength using electrical signals applied to the heart.	1. Heart failure with a QRS <130ms. 2. EF ≥25% and ≤45%. 3. NYHA Class III or IV.
Gynecologic Oncology Ovarian, fallopian tube, or primary peritoneal cancer	David P. Warshal, MD	Maria D. 856.735.6233	Treatment Study	Evaluation of efficacy of atezolizumab on a specific type of cancer (ovarian, fallopian tube, or primary peritoneal).	1. Age ≥18 years. 2. Receive a histologic diagnosis of epithelial ovarian cancer, peritoneal primary carcinoma, or fallopian tube cancer. 3. Adequate hematologic and end-organ function.
Hematology/Oncology Breast	Robert A. Somer, MD	Robin T. 856.735.6234	Treatment Study	Comparison of usual (neoadjuvant) chemotherapy plus atezolizumab is more effective than chemotherapy and placebo before surgery for breast cancer.	1. The diagnosis of invasive adenocarcinoma of the breast must have been made by core needle biopsy. 2. Local testing on the diagnostic core must have determined the tumor to be ER-negative, PgR-negative, and HER2-negative by current ASCO/CAP guidelines.
Hematology/Oncology Lung	David D. Shersher, MD	Jackie T. 856.735.6396	Early Detection and Prevention	Creation of a research bank for use in future research related to cancer and/or biomarkers.	1. Male or Female age ≥50 years. 2. Must have a current or previous cumulative cigarette smoking history of ≥20 pack years.
Hematology/Oncology Kidney	Christian Squillante, MD	Maria S. 856.735.6323	Treatment Study	Comparison of the efficacy and safety of drug combination vs. drug alone in first-line treatment of advanced renal cell carcinoma.	1. Histological or cytological confirmation of RCC with a clear-cell component (original tissue diagnosis of RCC is acceptable). 2. Documented evidence of advanced RCC. 3. At least 1 measurable target lesion according to RECIST 1.1.
Hematology/Oncology NSCLC/brain metastases	Nati Lerman, MD	Maria S. 856.735.6323	Device Study	Evaluating the safety and effectiveness of a study device with stereotactic radiosurgery in subjects with brain metastases as a result of non-small cell lung cancer (NSCLC).	1. Age >18 years. 2. Life expectancy of >3 months. 3. New diagnosis of brain metastases from a histologically or cytologically confirmed primary or metastatic NSCLC tumor within 5 years of registration on the study.
Infectious Diseases HIV	Rosalie Pepe, MD	Dana O. 856.968.7008	Treatment Study	Effectiveness of statin-preventive therapy on vascular events in HIV patients not meeting 2013 ACC/AHA guideline thresholds for recommended statin initiation.	1. CD4+ cell count >100 cells/mm3. 2. Men and women age ≥40 and ≤75 years. 3. Fasting LDL cholesterol <190 mg/dL.

Study Area	Principal Investigator (PI)	Contact Info	Study Type	Study Description	Main Inclusion Criteria
Infectious Diseases HIV	Katherine Doktor, MD	Dana O. 856.968.7008	Treatment Study	Evaluating safety, tolerability, and efficacy of an injectable drug therapy on LDL-C in subjects with HIV and hyperlipidemia and/or mixed dyslipidemia.	1. Male or female ≥18 years. 2. Stable on lipid-lowering therapy for ≥4 weeks prior to randomization. 3. Fasting triglycerides ≤600 mg/dL.
Infectious Diseases HIV	Pola de la Torre, MD	Dana O. 856.968.7008	Treatment Study	Evaluating the efficacy, safety, and tolerability of switching to a two-drug regimen in HIV-1 infected adults who are virologically suppressed.	1. Male or female ≥18 years. 2. Documented evidence of at least two plasma HIV-1 RNA measurements <50 c/mL in the 12 months prior to screening. 3. Must be on uninterrupted antiretroviral therapy (ART) for at least 6 months prior to screening.
Neurology Huntington's Disease	Amy Colcher, MD	Justin F. 856.968.7563	Observational Study	Evaluation of clinical and biological information in Huntington's disease.	1. Males or females age >18 years. 2. Carriers or non-carriers of HD gene expansion mutation.
Ob/Gyn	Lioudmila Lipetskaia, MD	Elena S. 856.968.7547	Educational Study	Comparison of patients' understanding of stress and urge urinary incontinence based on viewing a video of the topic or not in an ambulatory office setting.	1. New patient with chief complaint of urinary incontinence. 2. Established patient with a new complaint of urinary incontinence. 3. Age >18 years. 4. Primary English or Spanish-speaking patient.
Ob/Gyn	Jocelyn A. Mitchell-Williams, MD, PhD	Elena S. 856.968.7547	Camden Prenatal Collaborative Program Study	To improve patient adherence to prenatal doctor appointments and health knowledge more than the standard health coaching program.	1. Pregnant women being seen in the Jaffe Family Women's Care Center. 2. English speaking only. 3. 18 years of age or older/childbearing years. 4. Gestational diabetes and/or gestational hypertension. 5. Participating in the Health Coach Program.
Surgical / Radiation Oncology Breast	Catherine E. Loveland-Jones, MD	Robin T. 856.735.6234	Observational /Treatment Study	Observation on the frequency of recurrence of breast cancer in patients in complete remission after chemotherapy and radiation treatment but without surgery.	1. Pathologically confirmed unicentric invasive breast cancer defined as radiologic clinical stage T1 or T2 (≤5 cm), N0 or N1. 2. Patient desires breast conserving therapy. 3. Age >40 years.
Vascular Surgery AAA	Joseph V. Lombardi, 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. Age >18 years. 2. Must have an aneurysm/ulcer of the abdominal aorta.
Vascular Surgery Thoracic Aneurysm	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. Age >18 years. 2. Must have an aneurysm/ulcer of the thoracic aorta.

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

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