

2006

Cancer Committee

Annual Report



The Washington Hospital

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Based on 2006 data

Released August 2007

Chairman's Report

In 2006, The Washington Hospital Cancer Center continued the pursuit of excellence in cancer care through improvements in patient care, technology and patient safety. The Cancer Center provided programs in education and screening as well as fulfilling all the requirements of a Community Hospital Comprehensive Cancer Center as certified by the American College of Surgeons.

Advancements in cancer patient care occurred in multiple hospital departments and programs. An inpatient palliative care service was established and a Certified Registered Nurse Practitioner was added to the Palliative Care program. Patient safety was improved with the addition of the bedside pharmacy bar code system. Diagnostic advances included the addition of equipment for MRI guided breast biopsy and an additional MRI unit. Radiation therapy completed a joint venture with UPMC Cancer Centers which included new treatment planning computers and an updated computer network and software.

The Goals and objectives of the cancer program for 2006 included:

- Expand and enhance breast cancer services.
- Provide enhanced MRI and CT scanning services for pre-treatment work-up and staging.
- Expand and enhance palliative services to include inpatient unit and outpatient clinic.
- Develop and implement an exercise program for patients with a cancer diagnosis.

This 2006 annual report will focus on colon cancer. This is a frequent diagnosis at The Washington Hospital Cancer Center with about 68 cases diagnosed annually. Recent advances in

treatment of this disease will be reviewed and a comparison will be made between our registry statistics and the available national data.

Wayne J. Pfrimmer, M.D.

Chairman, Cancer Committee

Colon Cancer

Colorectal cancer is a common malignancy in the United States with about 149,000 new cases annually. Of these about 107,000 are colon cancer and the remainder are rectal cancer. In 2006, more than 55,000 Americans will die of large bowel cancer.

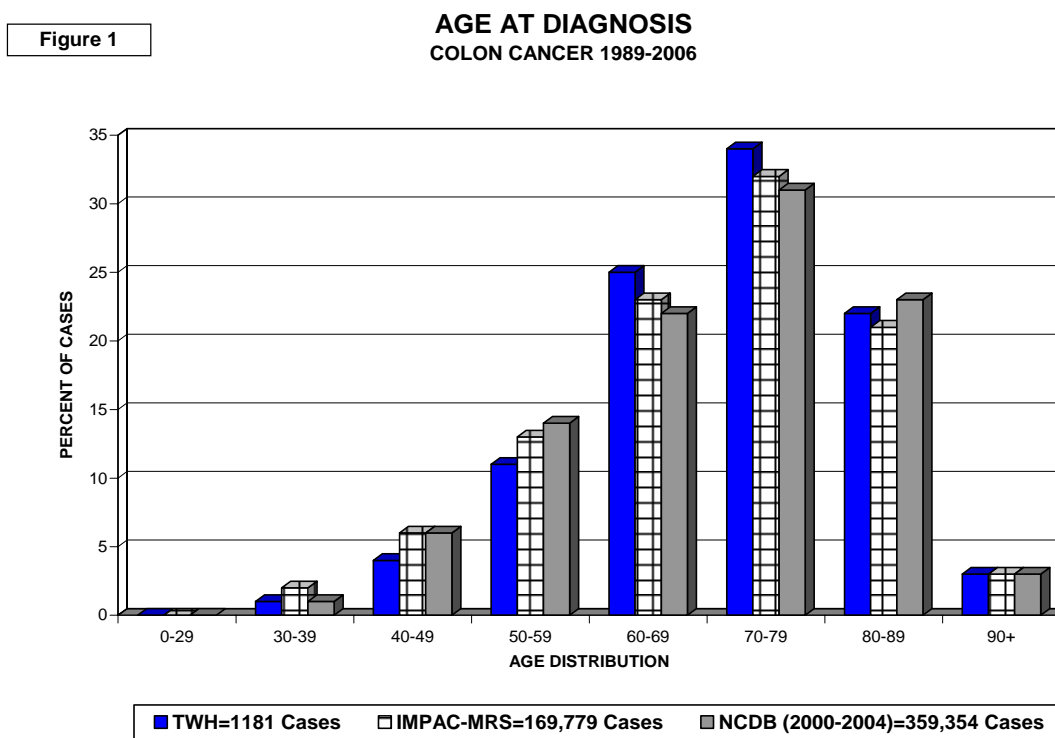
The prognosis at diagnosis of colon cancer is closely correlated with the presenting stage. Screening with occult blood testing, flexible sigmoidoscopy and colonoscopy can lead to diagnosis at an earlier stage with a corresponding reduction in mortality. However compliance with screening guidelines remains poor and over half the patients are diagnosed after the onset of symptoms. Analyzed by stage, 46% of patients present with stage III or IV disease. The 5 year survival for subsets of stage III disease range from 44% to 83% and for stage IV disease it is 8%.

Surgical resection remains the primary treatment for newly diagnosed colon cancer. Post operative adjuvant therapy has been successful in reducing recurrences and increasing survival. Modern adjuvant therapy for this disease has evolved through years of large clinical trials involving research centers and cooperative groups from North America and Europe.

Initial success with adjuvant therapy utilized the modulation of 5 Fluorouracil (5FU) by Leucovorin. Protocols adding newer agents such as irinotecan and oxaliplatin improved upon the results of the initial 5FU programs and became the new standard for stage III disease. These same programs evolved as palliative therapy for metastatic disease as well with significant response rates and improvement in survival.

The addition of targeted agents has been the most recent development in the therapy of locally advanced and metastatic colon cancer. These monoclonal antibodies attack growth factors such as vascular endothelial growth factor (VEGF) and epidermal growth factor (EGF). These agents are very promising although additional toxicities remain problematic. The National Surgical Adjuvant Breast and Bowel Project (NSABP) has recently completed protocol C-08 which compared standard chemotherapy with or without one year of Bevacizumab for the adjuvant therapy of stage II and III colon cancer. Results of protocols like this will forge the future of care for this lethal disease.

The following graphs will review the treatment of colon cancer at The Washington Hospital Cancer Center and compare this data to national data.



In Figure 1, the age at diagnosis of colon cancer at The Washington Hospital is compared to 2 sets of national data, IMPAC and the National Cancer Data Base (NCDB). Colon cancer is predominately a disease of the sixth through eighth decade of life in all three data sets.

Figure 2 depicts stage at diagnosis of colon cancer. There is a slight trend for earlier stage diagnosis at The Washington Hospital compared to the national data. This may reflect more aggressive screening programs by our medical community.

Figure 2

AJCC STAGE AT DIAGNOSIS
COLON CANCER 1989-2006

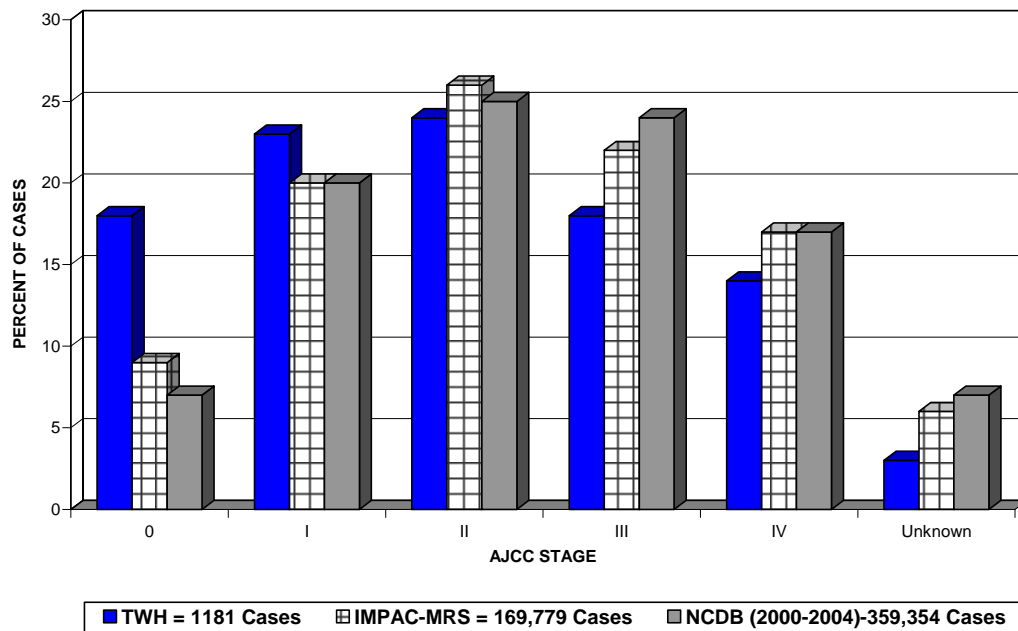
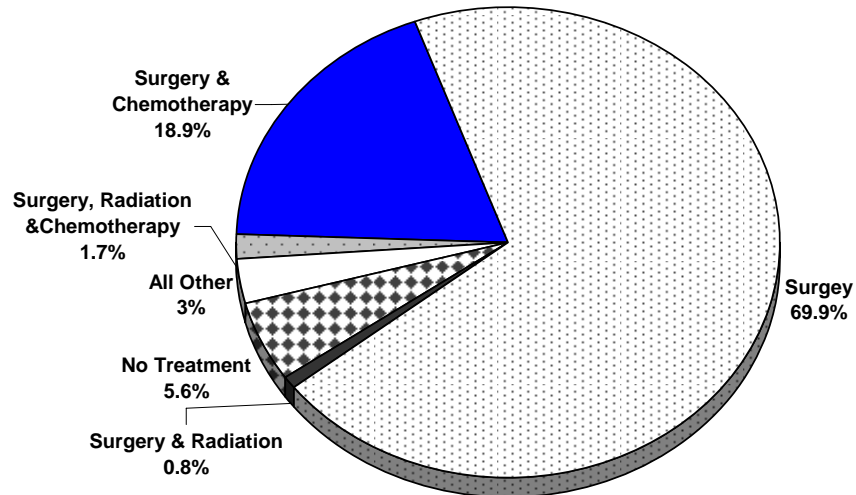


Figure 3

INITIAL THERAPY
COLON CANCER 1989-2006
 The Washington Hospital = 1,181



Initial therapy of colon cancer at The Washington Hospital (Figure 3) and NCDB national data (Figure 4) confirms the predominance of surgery and surgery plus chemotherapy in appropriate cases.

Figure 4

INITIAL THERAPY
COLON CANCER 2000
 NCDB = 66,848 Cases

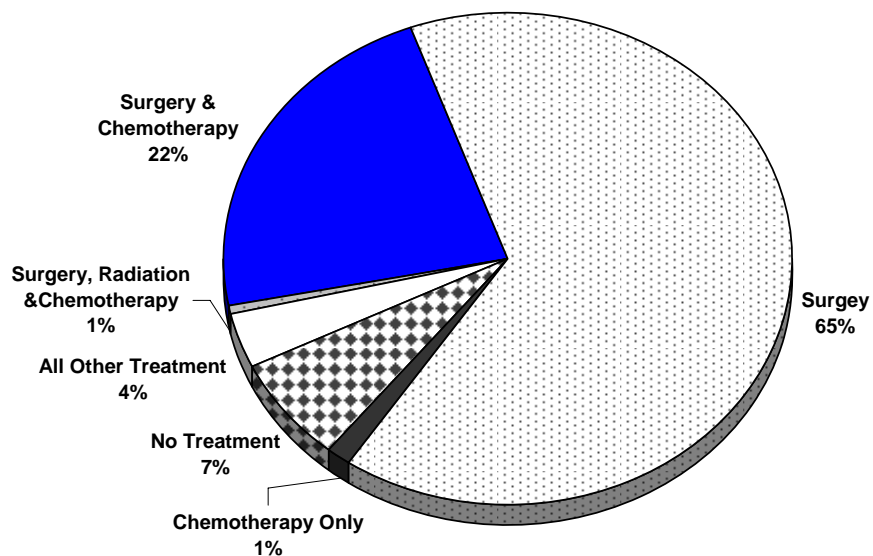
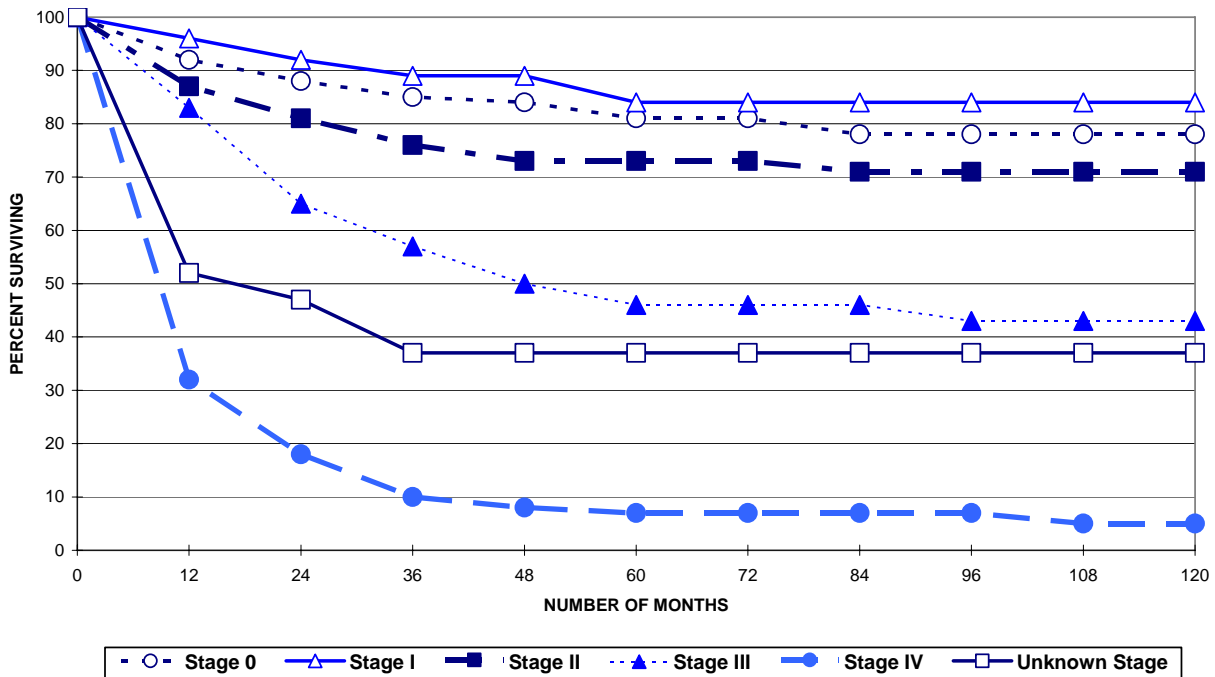


Figure 5

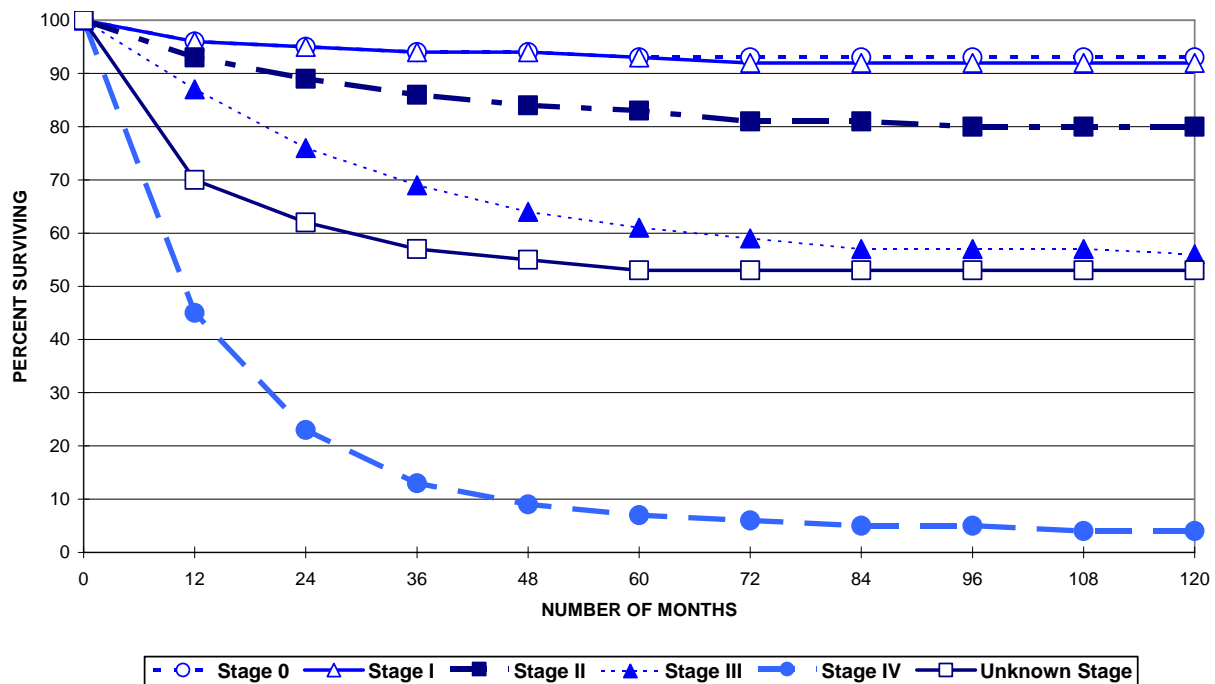
10 YEAR SURVIVAL BY AJCC STAGE
COLON CANCER
THE Washington Hospital 1989-2001 - 847 Cases



10 year survival by stage is shown in Figure 5 (TWH) and Figure 6 (IMPAC). The prognosis for stage I and II disease is relatively good, while stage III and IV patients do poorly.

Figure 6

10 YEAR SURVIVAL BY AJCC STAGE
COLON CANCER
IMPAC National Data 1989-2001 = 107,148 Cases



The slightly decreased survival in stage I-III patients at The Washington Hospital compared to the national data may reflect our significantly older population with associated comorbidities.

Cancer Registry

The Cancer Registry at The Washington Hospital is an information system designed to collect, manage and analyze data on patients with a diagnosis of malignant or neoplastic disease. The intent of the registry is to encourage lifetime medical follow-up of cancer patients and to provide a database for epidemiological, clinical, research and cancer program management. The Registry staff identifies eligible cases, collects demographics, tumor characteristics, therapies received, diagnostic procedures, response to treatment, and length of survival of cancer patients.

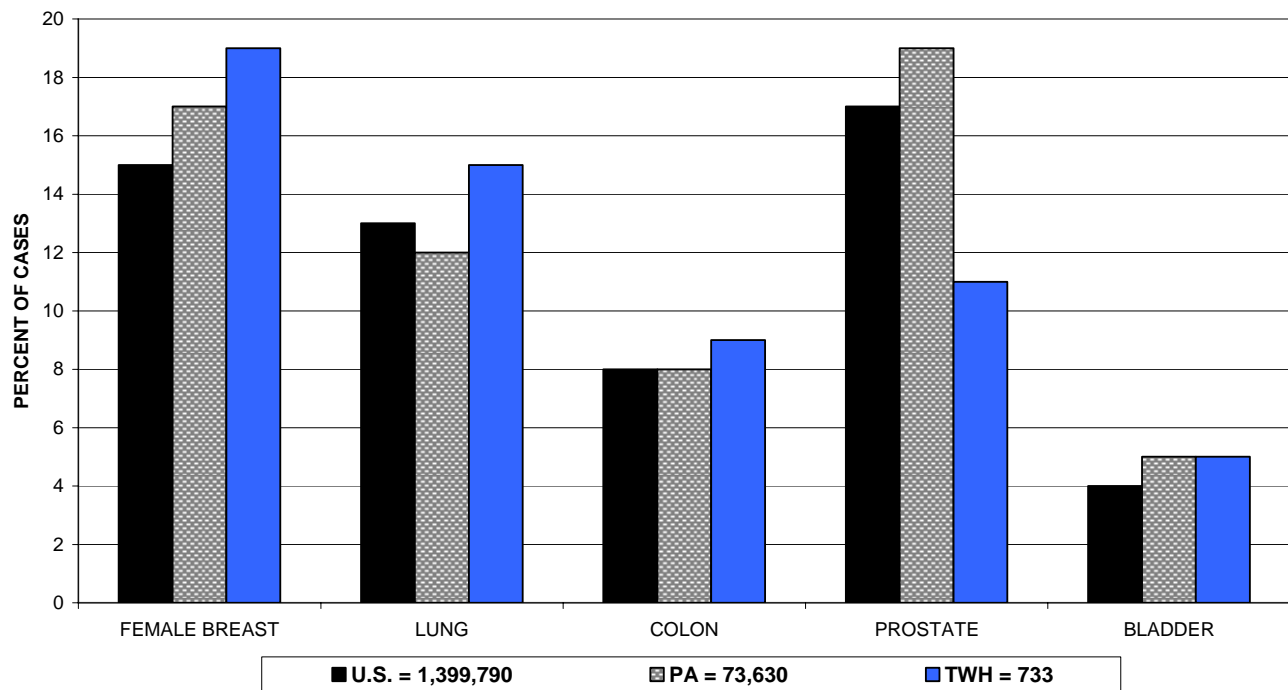
Accountable to the Cancer Committee, the Pennsylvania Cancer Registry-Department of Health, the American College of Surgeons Commission on Cancer (ACoS CoC), and the National Cancer Data Base (NCDB), the registry is responsible for complying with the reporting regulations of Act 224-The Pennsylvania Cancer Control, Prevention and Research Act, the Facility Oncology Registry Data Standards, and the ACoS CoC Accreditation Standards. The Registry consists of two staff members, one full-time Certified Tumor Registrar (CTR) and Registered Health Information Technician (RHIT) and one part-time Registry Assistant, pursuing her CTR. The registrars also coordinate activities for weekly Tumor Board Conferences, quarterly Cancer Committee meetings, the publication of the annual report and quality studies, and completion of the ACoS CoC Survey Application Record. Both registrars are members of the Pennsylvania Association of Cancer Registrars, the National Cancer Registrars Association, and regularly attend education programs offered by these organizations.

For 2006, there were 733 new cancer cases diagnosed and/or given their first course of therapy at The Washington Hospital. Since January 1989, the Cancer Registry has compiled 13,327 patients (as of August 2, 2007). Of these, 4,844 patients are being followed annually for a follow-up rate of 97%, well above the required ACoS CoC standard of 80%.

The Cancer Registry remains committed to providing quality, timely data to health care professionals. We can retrieve information on any collected data element and can obtain data from IMPAC Medical Registry Services Cancer Information Reference File and the NCDB of the ACoS-CoC, making comparative analysis possible. We continue to emphasize data quality during routine peer review and physician review processes, resulting in consistently high accuracy rates.

Figure 7

**MAJOR PRIMARY SITES - 2006
UNITED STATES, PENNSYLVANIA & THE WASHINGTON HOSPITAL COMPARISON**



US/PA estimated stats based on incidence rates from the NCI SEER program published in:
American Cancer Society, *Cancer Facts & Figures 2006*. Atlanta: American Cancer Society; 2006

The major primary cancer sites for 2006 at The Washington Hospital were female breast, lung, colorectal, prostate and bladder. When compared to state and national data above in Figure 7, The Washington Hospital has a higher percentage of breast, lung and colon cancer with a lower incidence of prostate cancer. The following page demonstrated our analytical caseload by site for 2006.

Billie L. White, RHIT, CTR

Cancer Registrar

2006 Analytical Cases

PRIMARY SITE	TOTAL	%	SEX		AJCC STAGE					N/A	*B/B	
			M	F	0	I	II	III	IV			UNK
Base Of Tongue	2	0.3	1	1	0	0	0	2	0	0	0	0
Gum	2	0.3	0	2	0	0	0	1	1	0	0	0
Floor Of Mouth	1	0.1	0	1	0	1	0	0	0	0	0	0
Other Parts Of Mouth	1	0.1	0	1	0	1	0	0	0	0	0	0
Parotid Gland	1	0.1	0	1	0	1	0	0	0	0	0	0
Tonsil	3	0.4	3	0	0	0	0	0	3	0	0	0
Oropharynx	2	0.3	2	0	0	0	1	0	1	0	0	0
Nasopharynx	4	0.5	4	0	0	0	1	1	2	0	0	0
Hypopharynx	2	0.3	2	0	0	1	1	0	0	0	0	0
Esophagus	18	2.5	15	3	0	5	0	6	4	3	0	0
Stomach	6	0.8	4	2	0	0	0	2	2	1	1	0
Colon	68	9.3	42	26	12	12	20	11	12	1	0	0
Rectosigmoid Junction	4	0.5	3	1	1	1	0	1	1	0	0	0
Rectum	23	3.1	15	8	3	4	3	5	5	2	1	0
Anus And Anal Canal	3	0.4	0	3	0	2	1	0	0	0	0	0
Liver-Intraheptic Bile Dcts	4	0.5	4	0	0	2	1	0	1	0	0	0
Gallbladder	3	0.4	1	2	0	1	1	0	1	0	0	0
Other & Unspec Pts Of Bili Ducts	2	0.3	2	0	0	0	1	0	0	1	0	0
Pancreas	19	2.6	7	12	0	0	9	1	9	0	0	0
Nasal Cavity/Middle Ear	1	0.1	0	1	0	0	0	0	0	0	1	0
Accessory Sinuses	1	0.1	1	0	0	1	0	0	0	0	0	0
Larynx	8	1.1	6	2	0	1	2	3	2	0	0	0
Bronchus And Lung	113	15.4	68	45	0	23	6	39	44	1	0	0
Heart, Mediastinum & Pleura	2	0.3	1	1	0	0	1	0	1	0	0	0
Hematopoietic/Reticuloendothelium	16	2.2	9	7	0	0	0	0	1	0	15	0
Skin	4	0.5	1	3	0	0	2	0	2	0	0	0
Retroperitoneum & Perianal	1	0.1	0	1	0	0	0	0	0	0	1	0
Conn, Subq And Other Soft Tissue	3	0.4	3	0	0	3	0	0	0	0	0	0
Breast	141	19.2	2	139	23	62	29	13	13	0	1	0
Vulva	2	0.3	0	2	1	0	0	1	0	0	0	0
Cervix Uteri	4	0.5	0	4	0	0	3	1	0	0	0	0
Corpus Uteri	30	4.1	0	30	0	24	0	4	0	1	1	0
Ovary	13	1.8	0	13	0	2	4	4	3	0	0	0
Penis	1	0.1	1	0	0	1	0	0	0	0	0	0
Prostate Gland	81	11.1	81	0	0	0	65	7	8	1	0	0
Testis	5	0.7	5	0	0	3	1	1	0	0	0	0
Kidney	26	3.5	14	12	0	15	4	1	6	0	0	0
Bladder	40	5.5	30	10	20	12	5	0	2	1	0	0
Other Urinary Orgs	1	0.1	0	1	0	0	0	0	0	0	1	0
Eye And Adnexa	1	0.1	0	1	0	0	0	0	1	0	0	0
Meninges	12	1.6	6	6	0	0	0	0	0	0	0	12
Brain*	15	2	9	6	0	2	0	0	0	0	13	0
Thyroid Gland	16	2.2	4	12	0	11	1	3	1	0	0	0
Adrenal Gland	1	0.1	0	1	0	0	0	0	0	0	1	0
Other Endocrine Glds/Rel Sys	2	0.3	0	2	0	0	0	0	0	0	0	2
Other Ill-Defined Sites	1	0.1	1	0	0	0	0	0	0	0	1	0
Lymph Nodes	19	2.6	12	7	0	5	6	4	4	0	0	0
Unknown Primary Site	5	0.7	3	2	0	0	0	0	0	0	5	0
Total	733	100	362	371	60	196	168	111	130	12	42	14

*Beginning with 2004 cases, benign & borderline brain & central nervous system tumor are reportable conditions.

Glossary

AJCC Stage	Staging classification published by the American Joint Committee on Cancer. Required by the American College of Surgeons. T – Tumor Extent N – Nodal Status M – Metastasis
Analytical Cases	Cases initially diagnosed and/or receiving all or part of the first course of treatment at The Washington Hospital
Annual Report	A yearly report describing the activities of the Cancer Committee and the Cancer Program.
B/B	Benign Brain/Central Nervous System Tumors – These cases are now reportable to the Pennsylvania Cancer Registry and the American College of Surgeons.
Follow-Up	A system to determine the status of a patient's disease on an annual basis and to encourage continued medical care.
Initial Therapy	The treatment restricted to any and all procedures administered during the first clinical diagnosis of cancer, usually within the first four months after diagnosis.
IMPAC	IMPAC Medical Registry Services – a comprehensive, computerized nationwide cancer data management system.
Screening	Testing of asymptomatic individuals for the purpose of early detection of a cancer when it is most curable.

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