

2005

Cancer Committee

Annual Report



The Washington Hospital

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Based on 2005 data

Released November 2006

Chairman's Report

2005 yielded significant advancements in technology, procedures and palliative care at the Washington Hospital Cancer Center. This center continued to meet and exceed the requirements for a Community Hospital Comprehensive Cancer Center as established by the American College of Surgeons Commission on Cancer while delivering personal, compassionate care to each cancer patient.

Many departments and disciplines contributed to improvements in the program during 2005. The palliative care program was fully established and was welcomed by patients, families, staff physicians and nurses. The oncology exercise program and Lymphedema program were established as adjuncts to the care of the cancer patients. Breast MRI was instituted to assist in the primary management of early breast cancer. The Pharmacy began a triple check system for chemotherapy to eliminate any possibility of error in their treatments. Radiation therapy developed an MRI/CT fusion technique to aid in planning for complex radiation cases.

Palliative care and the Hospice program remained a focus point for the cancer program. Both inpatient and outpatient Hospice services continued to be highly praised by patients and families. In addition, palliative care and symptom management became a topic for discussion at the weekly Tumor Board Conferences.

The goals and objectives of the Cancer Program for 2005 included:

- Expand and enhance breast cancer services.
- Improve physician attendance at Tumor Board Conferences.
- Enhance and expand The Washington Hospital Website to promote cancer program services.
- Promote availability and utilization of palliative care services.
- Enhance and expand cancer support groups; coordinate with community agencies.

This annual report will focus on Ovarian Cancer and Palliative Care.

Ovarian cancer although responsive to treatments, remains difficult to cure primarily because of difficulty in early diagnosis. This report will review Ovarian Cancer at The Washington Hospital since 1989 and compare our experience with national data. Dr. Minter will discuss palliative care which fortunately has become a recognized integral part of the care of our cancer patients.

Wayne J. Pfrimmer, M.D.

Chairman, Cancer Committee

Ovarian Cancer

Ovarian cancer is a relatively uncommon gynecologic cancer in the United States but remains the leading cause of death in this group of malignancies. This is the result of the difficulty in early diagnosis of this disease with the majority of patients presenting in advanced stage. Thus far, screening methods even in very high risk populations have not been proven of benefit in early detection.

Early stage disease (Stage I & II) with surgical resection and often with the use of adjuvant chemotherapy, is highly curable with 5 year disease free survivals ranging between 80 to 95%. Patients presenting in the more advanced stage require detailed debulking surgery by an experienced gynecologic surgeon to maximize potential benefit from chemotherapy. However, even with the use of combination chemotherapy, the long term disease free survival of these patients remains in the 10-30% range. Extensive clinical research continues in an attempt to improve upon these results. Recent results utilizing a combination of intravenous and intraperitoneal chemotherapy have yielded improved 5 year survivals although at the expense of increased toxicity.

Hopefully in the future with improvement in screening techniques and the addition of new agents specifically designed to attack molecular targets, the curability of this disease will improve substantially.

The following graphs will review ovarian cancer at The Washington Hospital Cancer Center with comparison to national data.

Figure 1 below demonstrated the age at diagnosis of ovarian cancer at The Washington

Hospital compared to national data. The disease occurs predominately in the age 50 and greater population.

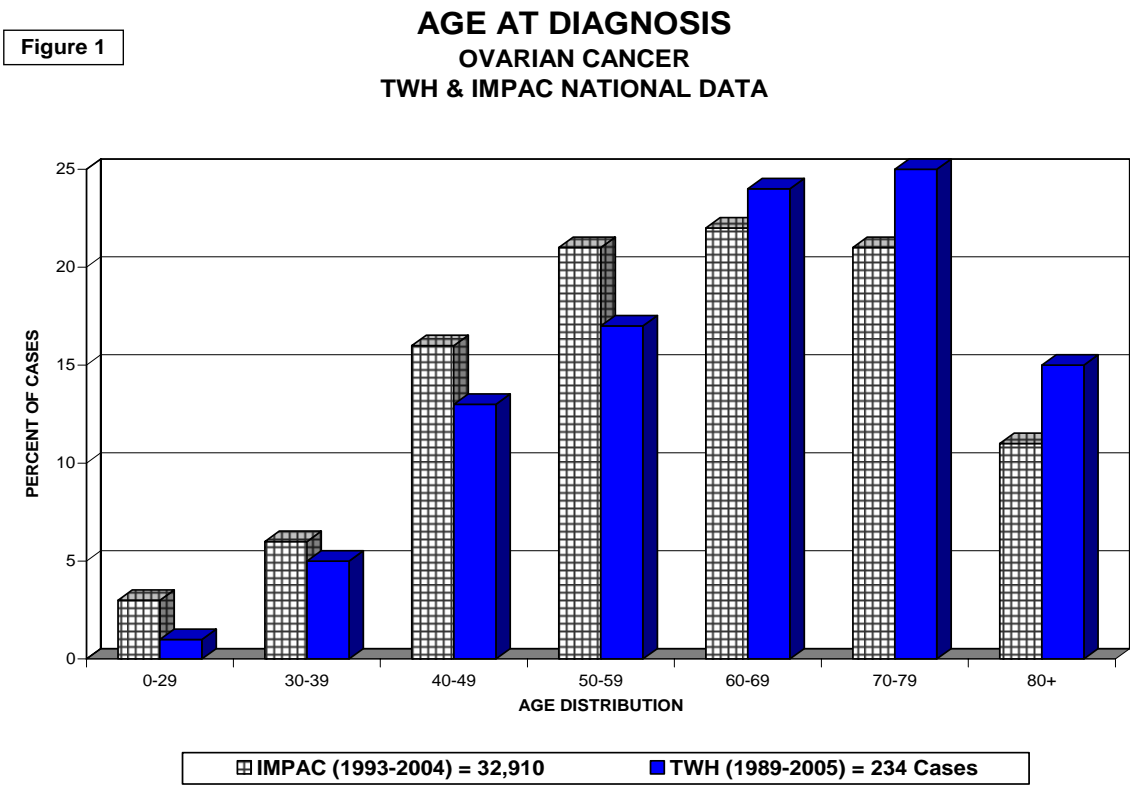


Figure 2 shows the stage at diagnosis with similar results at The Washington Hospital and nationally. Of note is the bulk of patients presenting in stage III and IV.

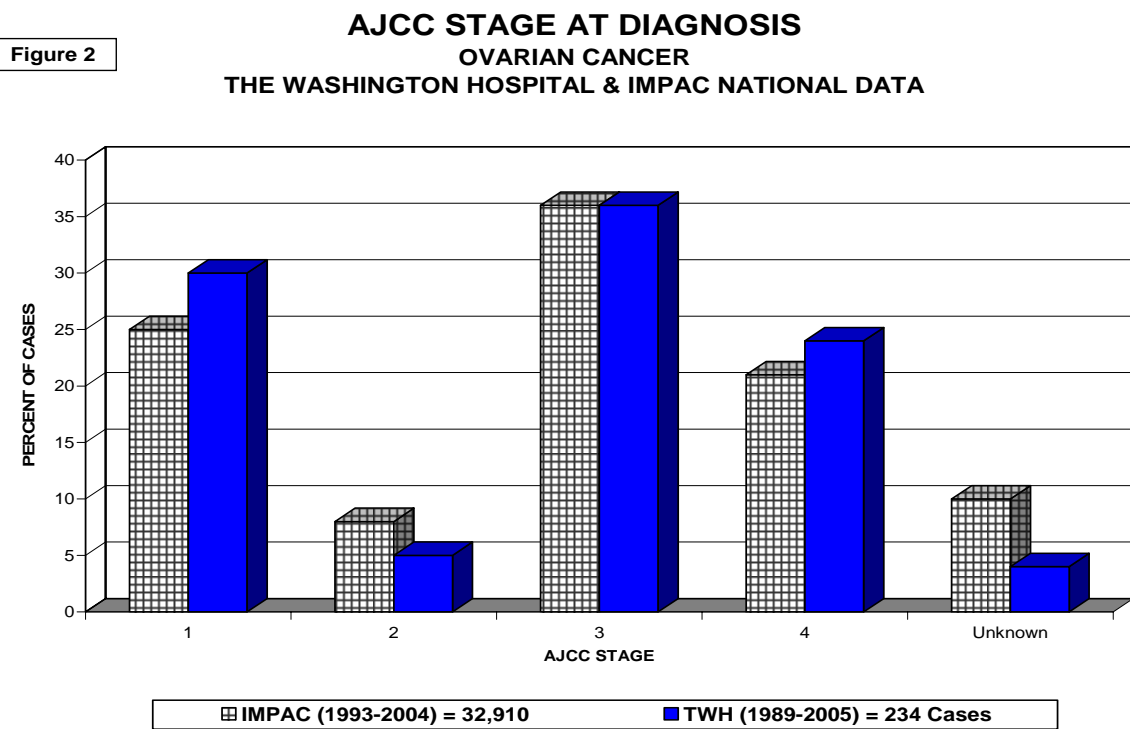
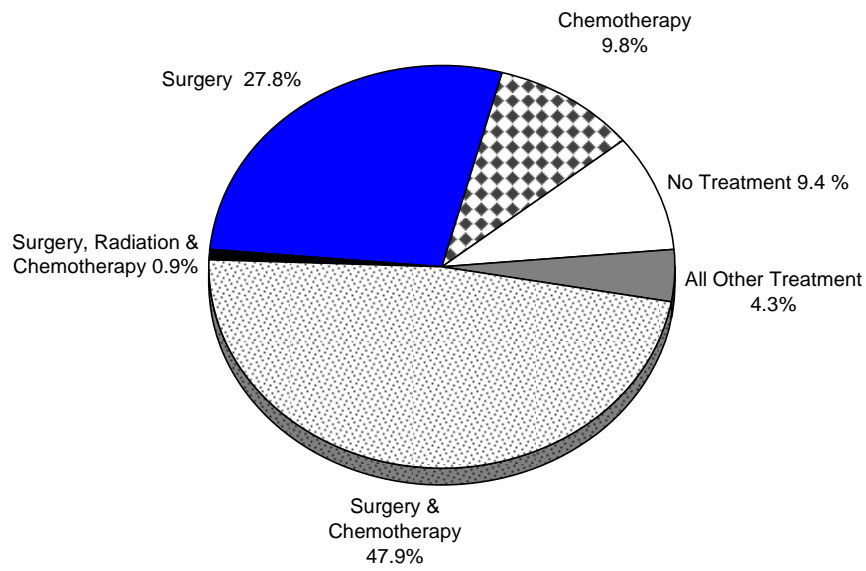


Figure 3

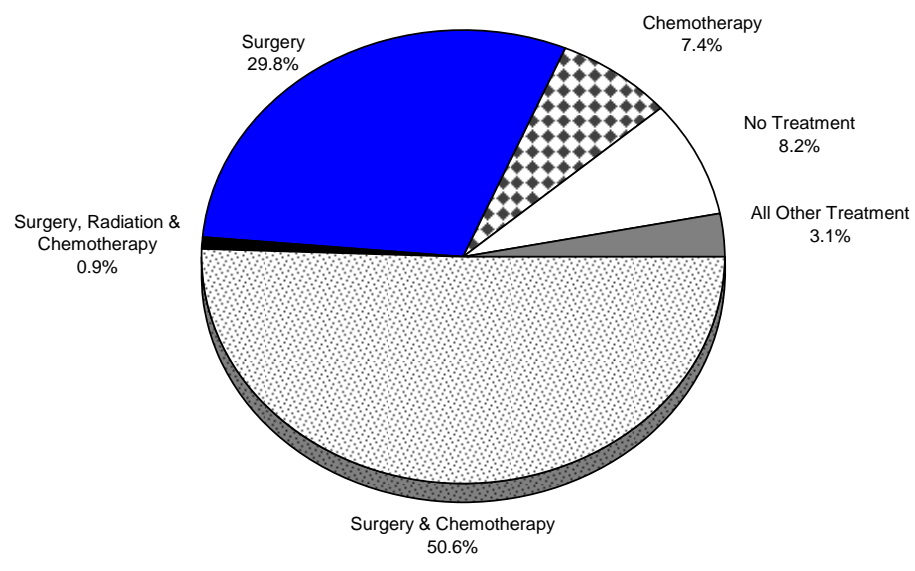
**INITIAL THERAPY
OVARIAN CANCER 1989-2005
TWH = 234 CASES**



In Figure 3 above and Figure 4 below, initial therapy at The Washington Hospital is compared to the national data. Both charts reveal the predominate therapy of surgery followed by chemotherapy as discussed in the text.

Figure 4

**INITIAL THERAPY
OVARIAN CANCER 1993-2004
IMPAC = 32,910 CASES**



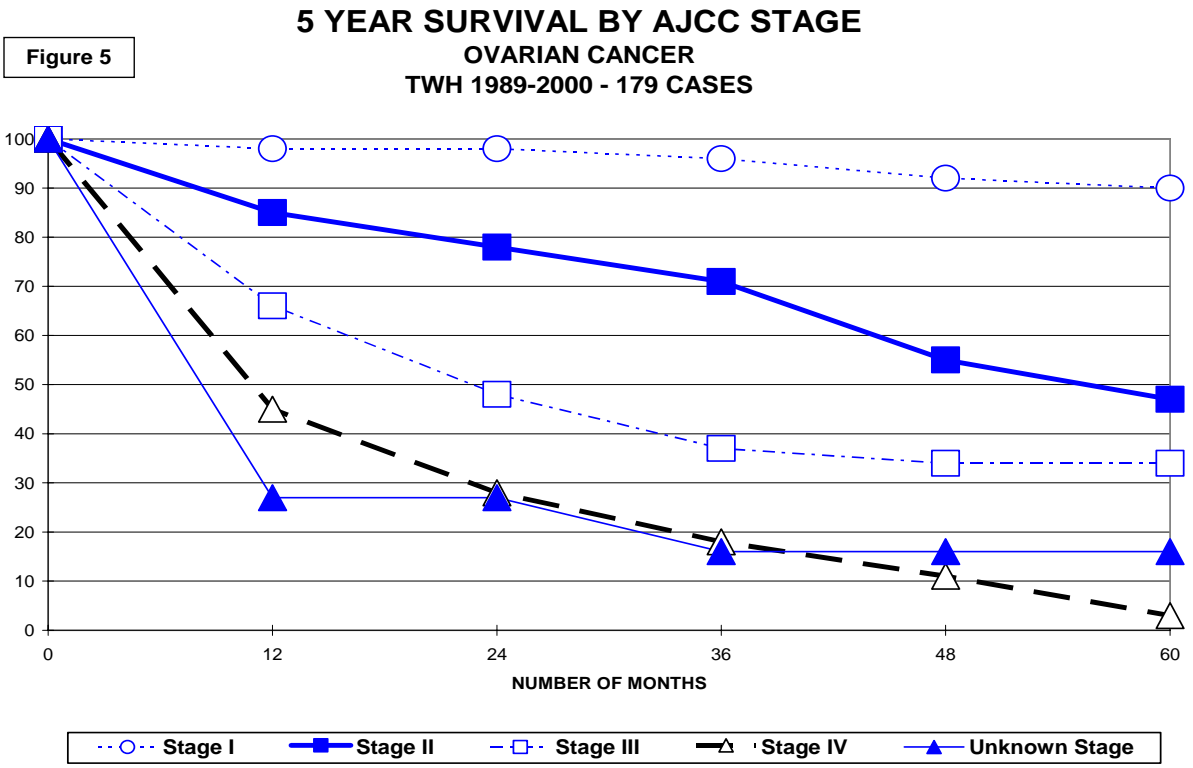
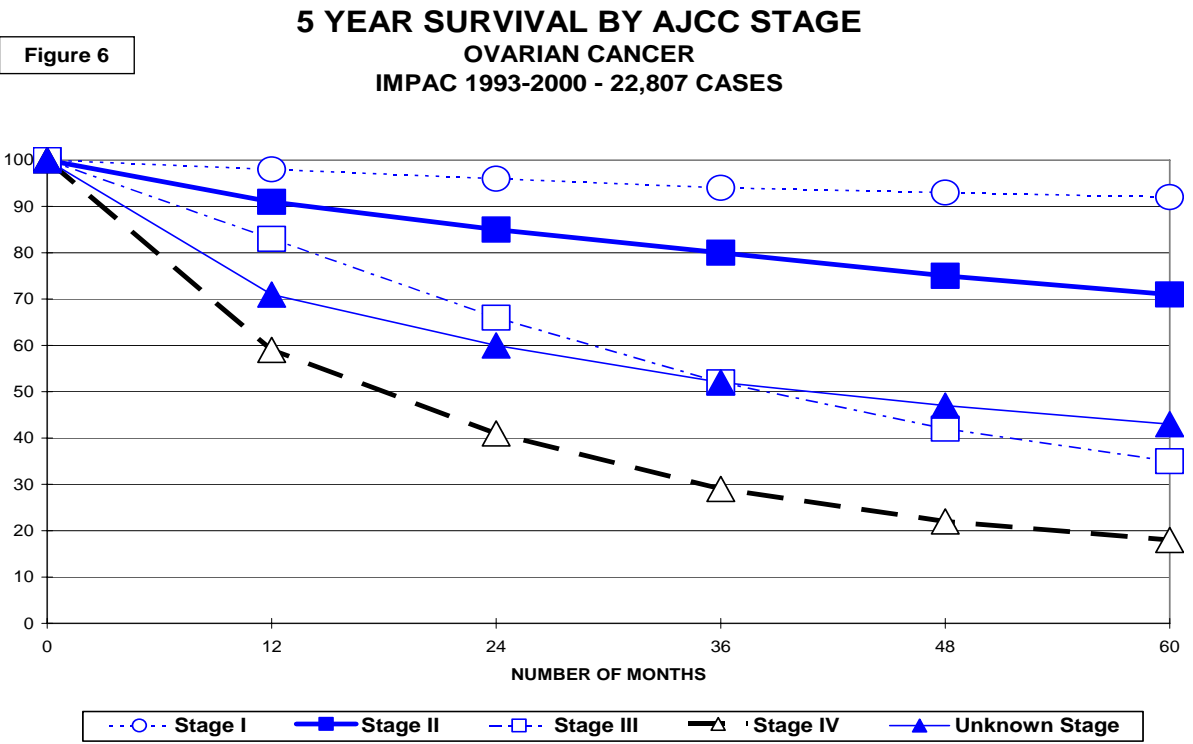


Figure 5 and 6 show the overall 5 year survival for ovarian cancer at The Washington Hospital compared the national data. Stage I and III survivals are similar for both graphs. The survival for Stage II patients at The Washington Hospital may not be accurate based on the very low number of patients in this group.



Palliative Care and Ovarian Cancer

*"To cure sometimes,
To relief often,
To comfort always."*

15th C French saying

Palliative medicine focuses on relieving suffering and improving quality of life regardless of the ability to cure. Nowhere in that statement do you see an indication that this type of care is only provided if cure is no longer possible. In fact, palliative concepts fit into any system of care including those with curative intentions. For this reason, the practice of palliative care has become an important part of treatment of cancer of any type or stage. As part of the full service cancer center, The Washington Hospital has developed a palliative medicine service to work closely with the surgical, medical and radiation oncologists.

Ovarian cancer is the number one gynecologic killer and the seventh most common cancer in women. Unlike cervical and breast cancer there remains no easy, accurate method to screen for this disease in the early stages. The symptoms are vague including fullness in the pelvis, abdominal bloating and changes in bowel and bladder patterns. Ten percent of women with ovarian cancer have a family history of the ovarian cancer which means that the other 90% have no 'genetic warning signs'. The inability to detect this cancer early unfortunately means the disease is frequently found in an advanced stage. Recent advances in surgical and chemotherapeutic treatments have realized a median survival rates 50-66 months. However, with a relapse rate of up to 80% the goals of treatment are often focused on palliation and symptom control.

The aggressive chemotherapeutic regimens can have side effects including nausea, vomiting, hair loss, fatigue, memory loss, anxiety and changes in sexual functioning all of which can adversely affect a patient's quality of life. Newer techniques such as intraperitoneal chemotherapy (giving chemotherapy directly into the abdomen) have improved median survivals up to an additional 16 months, however the side effects are often more severe. New palliative protocols are constantly being developed to help relieve these symptoms before they start.

Distressful symptoms are more common and severe with a relapse. For example, blockage of the bowel either by tumor or as a consequence of surgery occurs more frequently with ovarian cancer than any other type of cancer. Symptoms include abdominal pain, uncomfortable distension and vomiting. Surgery to relieve the blockage is always considered the first line of treatment. Unfortunately some patients in this situation may not be strong enough to undergo this form of treatment. An aggressive palliative approach with medications can help lessen the distension thereby improving pain control and vomiting if surgery is not an option.

Another frequently encountered problem associated with ovarian cancer is accumulation of fluid in the abdomen termed ascites. This fluid can accumulate to the point of being very uncomfortable with symptoms of distension, pain and breathing difficulties. Removing the extra fluid often alleviates these symptoms. The Interventional Radiology Department of the Washington Hospital performs that task by inserting a catheter through the abdominal wall into the abdomen to remove the ascitic fluid. This, unfortunately, may not be a permanent solution as the fluid may return in days to weeks. If the ascites continues to re-accumulate a more permanent catheter can be inserted permitting home drainage.

These and other active palliative care protocols are utilized by the entire cancer treatment team to keep patients with ovarian cancer comfortable while the oncologist attempts to stop the disease. Until research uncovers better methods of detection and cure, palliative care techniques can “*relieve often and comfort always*”.

Jeffrey F. Minter, M.D.

Medical Director, Hospice

& Palliative Care

Cancer Registry

As an integral part of our American College of Surgeons Commission on Cancer (ACoS CoC) accredited Community Hospital Comprehensive Cancer Program, the Cancer Registry identifies eligible cases, collects demographics, cancer identifications, treatments and follow-up data on each cancer patient that has been diagnosed at The Washington Hospital since 1989. Data is utilized by physicians, the Cancer Committee, hospital administration, and other healthcare professionals. The Cancer Registry also coordinates activities for weekly Tumor Board Conferences and quarterly Cancer Committee meetings. The Cancer Registry is staffed by a full time Certified Tumor Registrar who is also a Registered Health Information Technician and a part time Cancer Registry Assistant. It is equipped with IMPAC Medical Registry Services computerized system with extensive reporting capabilities.

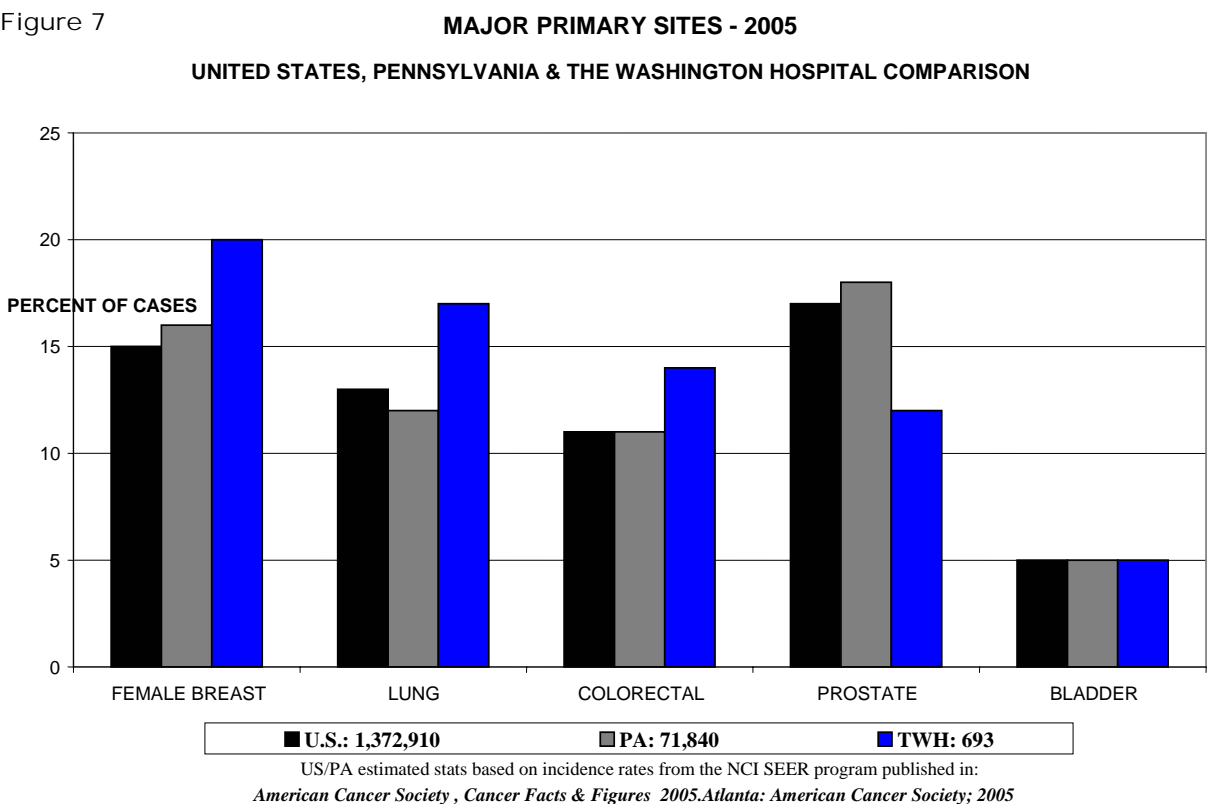
Since 1989, the Cancer Registry has compiled 12,634 total cases. For 2005 there were 693 new cancer cases diagnosed or given their first course of therapy at The Washington Hospital. Cancer patients are followed by the Registry annually throughout their lifetime for continued outcome analysis. We are currently following 4,706 patients for a follow-up rate of 97%, well above the required ACoS CoC standard of 80%.

Accountable to The Washington Hospital Cancer Committee, the Pennsylvania Cancer Registry and the American College of Surgeons Commission on Cancer and National Cancer Data Base, the Registry is responsible for complying with the reporting regulations of Act 224-

The Pennsylvania Cancer Control Prevention and Research Act, Facility Oncology Registry Data Standards, and the ACoS CoC Accreditation Standards. Data is used to compare tumor characteristics, treatment received, response to treatment and length of survival of cancer patients. The ultimate goal is to improve overall survival and decrease morbidity.

The major primary cancer sites for 2005 at The Washington Hospital were breast, lung, colorectal, prostate and bladder. Compared to state and national data below in Figure 7, The Washington Hospital has a higher percentage of breast, lung, and colorectal cancer with a lower incidence of prostate cancer.

Figure 7



Billie L. White, RHIT, CTR
Cancer Registrar

2005 Analytical Cases

PRIMARY SITE	TOTAL	%	SEX		AJCC STAGE								
			M	F	0	I	II	III	IV	UNK	N/A	B/B	
Lip	1	0.1	1	0	0	1	0	0	0	0	0	0	0
Base of tongue	1	0.1	1	0	0	0	0	0	1	0	0	0	0
Other & unspec parts of tongue	2	0.3	2	0	0	1	0	0	1	0	0	0	0
Gum	1	0.1	0	1	0	0	0	0	1	0	0	0	0
Floor of mouth	1	0.1	1	0	0	0	0	0	1	0	0	0	0
Other parts of mouth	1	0.1	1	0	0	0	0	0	1	0	0	0	0
Parotid gland	4	0.6	2	2	0	3	0	1	0	0	0	0	0
Other parts major salivary gland	2	0.3	1	1	0	1	1	0	0	0	0	0	0
Tonsil	4	0.6	4	0	0	0	0	1	3	0	0	0	0
Pyriform sinus	1	0.1	1	0	0	0	0	0	1	0	0	0	0
Esophagus	4	0.6	3	1	0	0	0	2	2	0	0	0	0
Stomach	8	1.2	5	3	0	2	1	0	2	1	2	0	0
Small intestine	2	0.3	2	0	0	0	2	0	0	0	0	0	0
Colon	72	10.4	37	35	13	22	11	14	11	1	0	0	0
Rectosigmoid Junction	5	0.7	1	4	1	4	0	0	0	0	0	0	0
Rectum	20	2.9	9	11	2	4	5	4	5	0	0	0	0
Anus and anal canal	2	0.3	1	1	0	0	1	1	0	0	0	0	0
Liver-intrahepatic bile ducts	6	0.9	4	2	0	2	0	2	2	0	0	0	0
Other/unspec pts of bili ducts	3	0.4	0	3	0	0	1	0	0	2	0	0	0
Pancreas	15	2.2	7	8	0	0	5	3	7	0	0	0	0
Oth & ill-defined digest	1	0.1	1	0	0	0	0	0	0	0	1	0	0
Accessory sinuses	1	0.1	0	1	0	0	0	0	1	0	0	0	0
Larynx	6	0.9	4	2	0	0	2	1	3	0	0	0	0
Bronchus and Lung	118	17	59	59	0	26	5	34	52	1	0	0	0
Heart, mediastinum & pleura	2	0.3	2	0	0	1	1	0	0	0	0	0	0
Hematopoietic/reticuloendothel	16	2.3	9	7	0	0	0	0	0	0	16	0	0
Skin	3	0.4	1	2	0	2	0	1	0	0	0	0	0
Peripheral nerves	1	0.1	0	1	0	1	0	0	0	0	0	0	0
Conn, subq & other soft tissue	3	0.4	2	1	0	0	1	1	1	0	0	0	0
Breast	142	20.5	1	141	23	63	33	13	9	1	0	0	0
Vulva	3	0.4	0	3	1	0	0	2	0	0	0	0	0
Cervix uteri	5	0.7	0	5	0	1	1	2	1	0	0	0	0
Corpus uteri	18	2.6	0	18	0	13	1	1	1	0	2	0	0
Ovary	11	1.6	0	11	0	3	0	4	4	0	0	0	0
Penis	1	0.1	1	0	0	0	0	1	0	0	0	0	0
Prostate gland	82	11.8	82	0	0	0	68	4	9	1	0	0	0
Testis	6	0.9	6	0	0	4	2	0	0	0	0	0	0
Other male genital organs	1	0.1	1	0	0	1	0	0	0	0	0	0	0
Kidney	24	3.5	16	8	0	14	2	2	6	0	0	0	0
Bladder	32	4.6	23	9	13	12	2	2	3	0	0	0	0
Eye and adnexa	1	0.1	1	0	0	1	0	0	0	0	0	0	0
Meninges	4	0.6	1	3	0	0	0	0	0	0	0	4	0
Brain	8	1.2	5	3	0	0	0	0	0	0	8	0	0
Other central nervous system	1	0.1	1	0	0	0	0	0	0	0	0	1	0
Thyroid gland	13	1.9	1	12	0	6	3	2	2	0	0	0	0
Other endocrine glands/rel sys	3	0.4	1	2	0	0	0	0	0	0	0	3	0
Lymph nodes	15	2.2	6	9	0	1	3	5	6	0	0	0	0
Unknown primary site	17	2.5	12	5	0	0	0	0	0	0	17	0	0
Total	693	100%	319	374	53	189	151	103	136	7	46	8	0

Glossary

AJCC Stage	<p>Staging classification published by the American Joint Committee on Cancer. Required by the American College of Surgeons.</p> <p style="margin-left: 40px;">T – Tumor Extent N – Nodal Status M – Metastasis</p>
Analytical Cases	<p>Cases initially diagnosed and/or receiving all or part of the first course of treatment at The Washington Hospital</p>
Annual Report	<p>A yearly report describing the activities of the Cancer Committee and the Cancer Program.</p>
B/B	<p>Benign Brain/Central Nervous System Tumors – These cases are now reportable to the Pennsylvania Cancer Registry and the American College of Surgeons.</p>
Follow-Up	<p>A system to determine the status of a patient’s disease on an annual basis and to encourage continued medical care.</p>
Initial Therapy	<p>The treatment restricted to any and all procedures administered during the first clinical diagnosis of cancer, usually within the first four months after diagnosis.</p>
IMPAC	<p>IMPAC Medical Registry Services – a comprehensive, computerized nationwide cancer data management system.</p>
Screening	<p>Testing of asymptomatic individuals for the purpose of early detection of a cancer when it is most curable.</p>

Cancer Committee 2005

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