

Table of Contents

TABLE OF CONTENTS	1
CHAIRMAN'S REPORT	2
NON-SMALL CELL LUNG CANCER	3
CANCER REGISTRY	9
GLOSSARY	12
CANCER COMMITTEE 2003	13

CHAIRMAN'S REPORT

The Washington Hospital Cancer Center continued to provide excellent state-of-the-art therapy to cancer patients in this area in 2003. The program maintained strict requirements as a Community Hospital Comprehensive Cancer Center as established by the American College of Surgeons Commission on Cancer. This designation required active programs in education, screening, supportive care, as well as up-to-date therapeutic modalities and participation in clinical trials. The Tumor Registry remained a key component of the program serving as a resource for data collection and analysis, as well as a tool to measure comparative outcomes across the country.

Many hospital departments contributed significantly to the cancer program during this year. The Radiation Therapy Department expanded the intensity modulated radiation therapy (IMRT) to include breast cancer in addition to prostate and head and neck cancers. Staging of cancer was enhanced by the outstanding efforts of the Radiology and Nuclear Medicine Departments in interpretation and clinical correlation of CAT scans and PET scans. Interventional Radiology provided the latest techniques in diagnostic and therapeutic procedures.

The Laboratory Department continued efforts to identify malignancies with special stains as well as the implement of the CAP anatomic protocols. The Hospice Program received praise from families, patients and referring physicians for the personal supportive care delivered in the inpatient and home settings.

The goals and objectives of the Cancer Program for 2003 included:

- Expand public education programs for screening and early detection of specific malignancies for high-risk populations.
- Compare hospital data with national and/or regional data to ensure appropriateness of pre-treatment work-up and staging.
- Enhance and expand cancer support services and programs.
- Serve as a resource to the community. Ensure availability of cancer related consultative service to all patients.
- Promote availability and utilization of cancer rehabilitation services.

This annual report will focus on non-small cell lung cancer. This is a very common malignancy across the country in men and women, ranking second in number of new cases behind prostate cancer in men and breast cancer in women. In this report we will review progress in diagnosis and treatment of this disease, and in particular the experience at our center with non-small cell lung cancer since 1989.

Wayne J. Pfrimmer, M.D.
Chairman, Cancer Committee

NON-SMALL CELL LUNG CANCER

Non-small cell lung cancer is a very common malignancy in the United States with over 170,000 cases reported in 2003. This malignancy is the leading cause of cancer-related mortality for men and women in the United States as well as Japan and Western Europe. Reduction of cigarette smoking in the U.S. has led to a reduction of lung cancer death rates in men, and death rates in women have begun to plateau as well. Smokers account for 85% of lung cancers in the United States. Smoking cessation is the most effective approach to control lung cancer mortality. Environmental second-hand smoke has become a significant issue as well as interaction of smoking with other environmental carcinogens.

Studies to evaluate screening for lung cancer in high-risk populations have generally failed to demonstrate a decrease in mortality. A large U.S. prospective trial is underway which randomizes between CAT scan screening and chest x-ray screening in smokers over age 50, and this may shed some further light on this issue. Progress has been made in the preoperative staging of lung cancer utilizing CAT scans and PET scans. This has decreased the number of futile thoracotomies by identifying patients with advanced disease and also has limited the need for mediastinoscopy in selected patients before attempt at surgical resection.

Advancements have been made in the post-operative adjuvant therapy of non-small cell lung cancer as well. In lung cancer, even early stage disease which has been resected, has a substantial relapse rate and mortality at five years. Several recent large studies have shown for the first time a survival advantage for adjuvant chemotherapy in resected non-small cell lung cancer. Ongoing studies will better define the best chemotherapy in this setting and also possibly identify subsets which benefit most or perhaps not at all from these treatments. Chemotherapy has been established as superior to supportive care in patients with advanced non-small cell lung cancer. Multiple two-agent combinations of chemotherapy have been successful in this setting, although efforts to increase the number of agents or intensity of treatment have not resulted in improved survival.

New agents with novel mechanisms of action have remained the subject of intense investigation. One of these agents, gefitinib (Iressa), is now available for palliative therapy of advanced non-small cell lung cancer. This drug targets the epidermal growth factor receptor, which is frequently expressed in a variety of malignancies including non-small cell lung cancer. Studies thus far have demonstrated a significant palliative benefit to this drug. The hope is that agents like this and other new agents with novel mechanisms may be proven useful in combination with standard treatment modalities in improving the outlook for patients with all stages of non-small cell lung cancer.

In the following graphs, we will review the cases of non-small cell lung cancer at our center and compare them to national databases.

**AGE AT DIAGNOSIS
1989-2003 ANALYTICAL NSCLC
TWH VS IMPAC NATIONAL DATA**

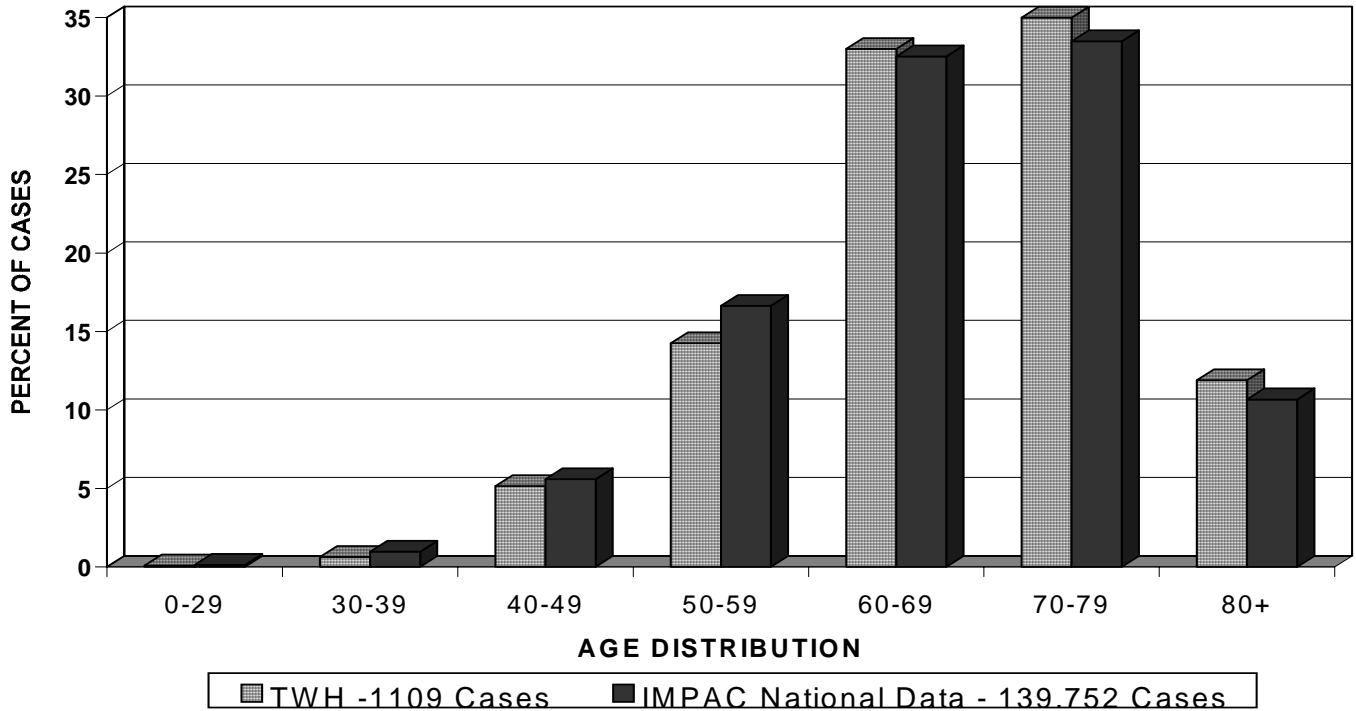


Figure 1

Figure 1 demonstrated the age at diagnosis of our cases compared to national data. The peak incidence of this malignancy is in the 60-79 year-old age range in both sets of data.

**AJCC STAGE AT DIAGNOSIS
1989-2003 ANALYTICAL NSCLC
TWH VS IMPAC National Data**

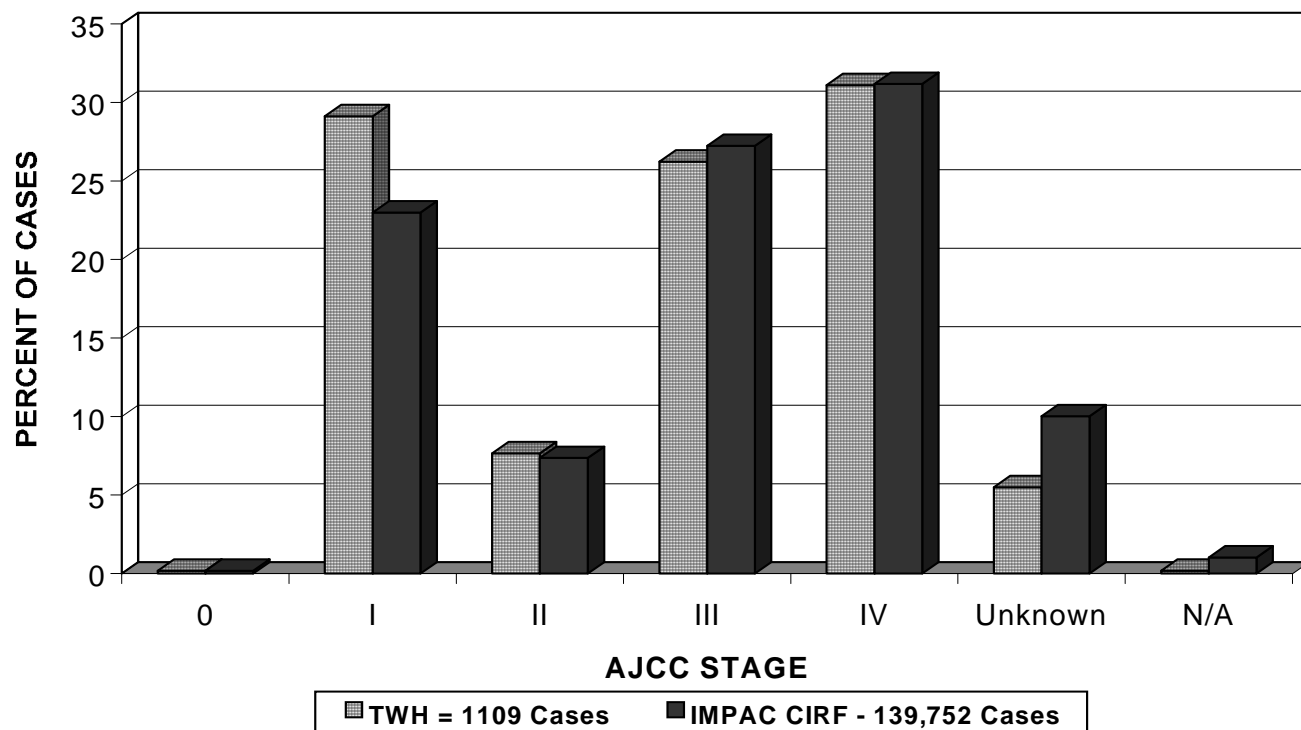


Figure 2

In Figure 2 the stage at diagnosis is compared. Although there are a significant number of cases diagnosed in Stage I, the majority of cases are advanced Stage III and IV in both our data and national data.

HISTOLOGY OF NON-SMALL CELL CARCINOMA LUNG CANCER
Benchmark Report
The Washington Hospital and The National Cancer Data Base - 2001 Cases

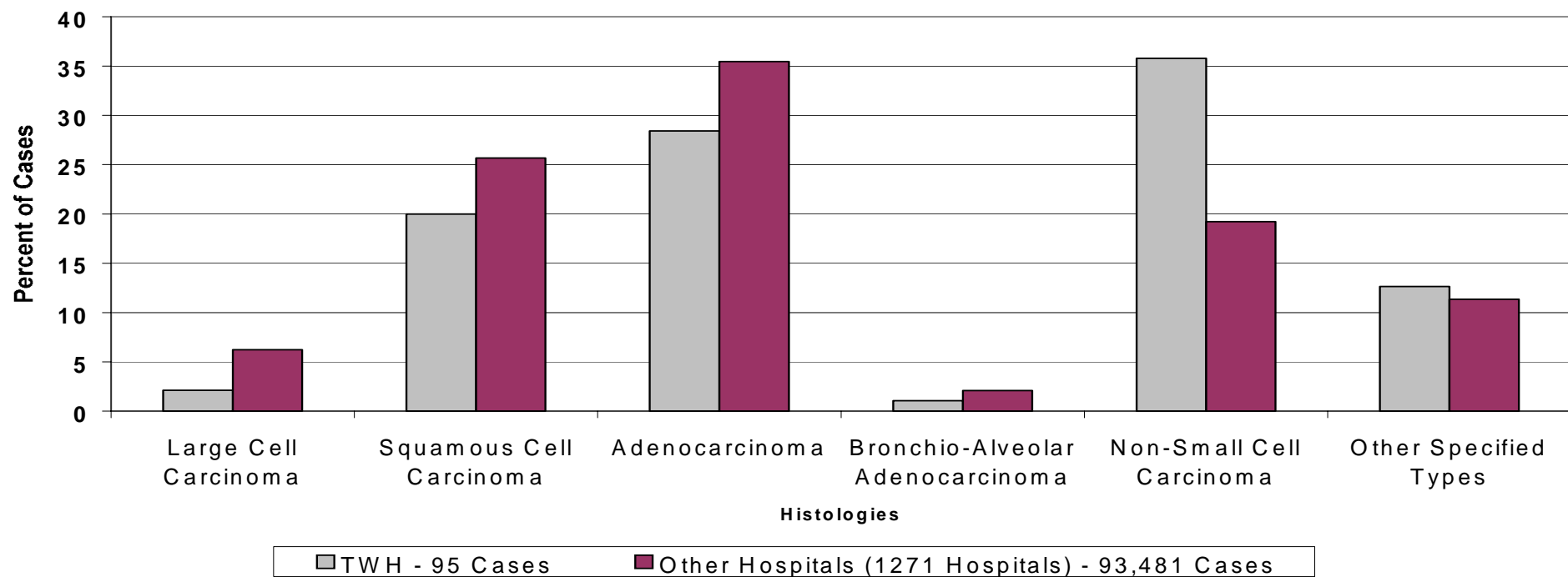


Figure 3

In Figure 3 the various histological types of non-small cell lung cancer are depicted. Adenocarcinoma is the most common specific type in our data and the National Cancer Data Base.

INITIAL THERAPY
1989-2003 ANALYTICAL NSCLC
TWH - 1,109 Cases

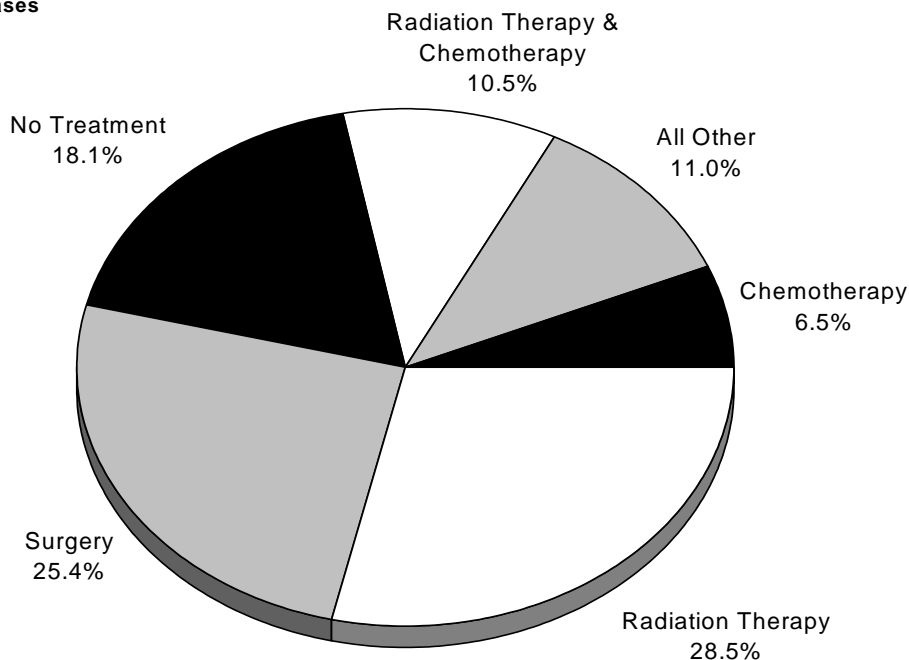


Figure 4

Initial therapy for NSCLC varies considerably depending upon stage at diagnosis. Figure 4 shows the initial therapy for our cases from 1989-2003. A large number of patients received surgery and radiation therapy. Combined modality therapy including chemotherapy was utilized in selected patients. The national data in Figure 5 reveals a similar distribution of therapeutic modalities.

INITIAL THERAPY
1989-2003 ANALYTICAL NSCLC
IMPAC National Data - 139,752 Cases

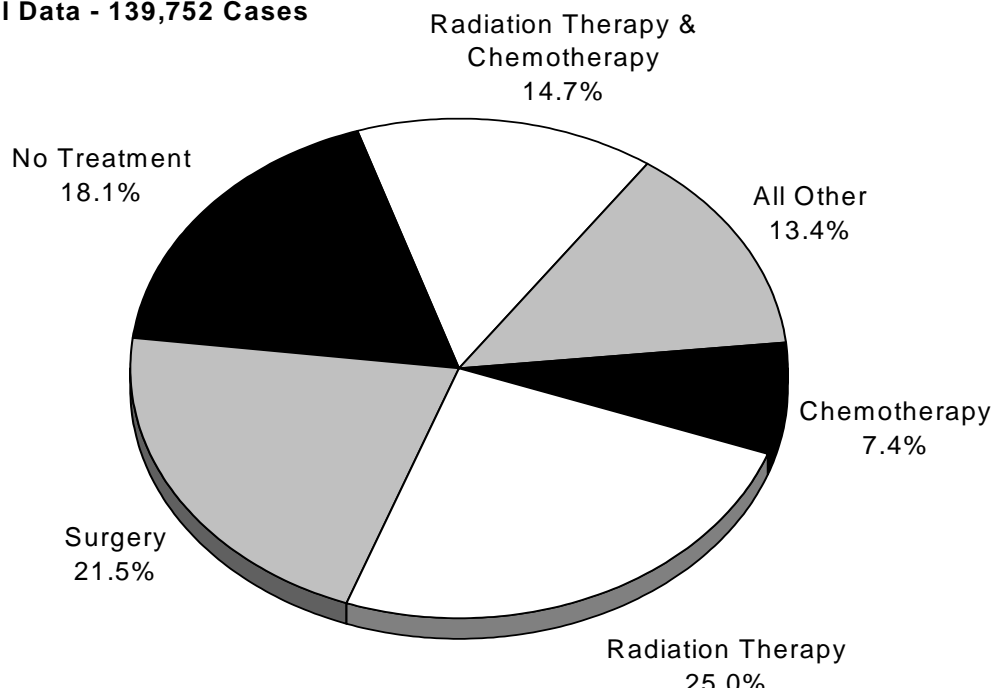


Figure 5

Figure 6 and 7 compare survival of non-small cell lung cancer patients at The Washington Hospital with the national data. The survival curves are quite similar in both graphs.

5-YEAR SURVIVAL BY AJCC STAGE
The Washington Hospital - 699 Analytical Cases
1989-1998 Non-Small Cell Lung Cancer

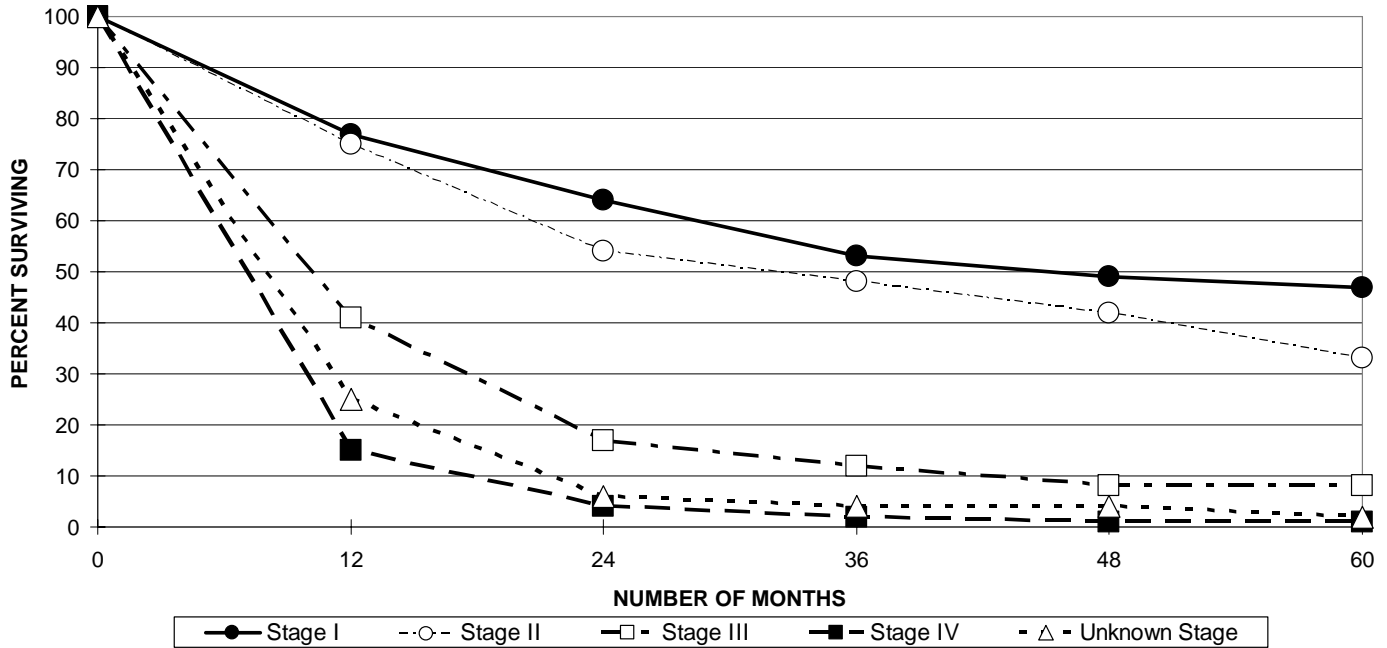
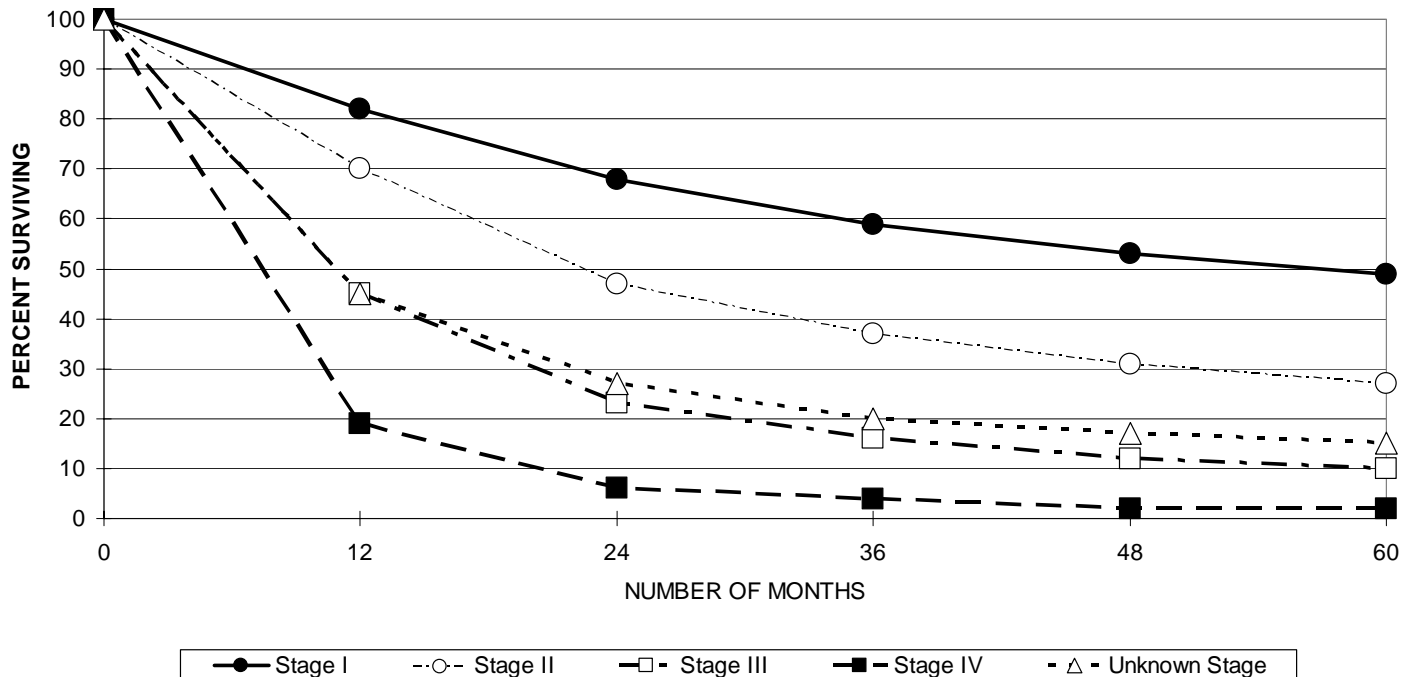


Figure 6 ↑ Figure 7 ↓

5 YEAR SURVIVAL BY AJCC STAGE
IMPAC National Data - 94,720 Analytical Cases
1989-1998 Non-Small Cell Lung Cancer



Cancer Registry

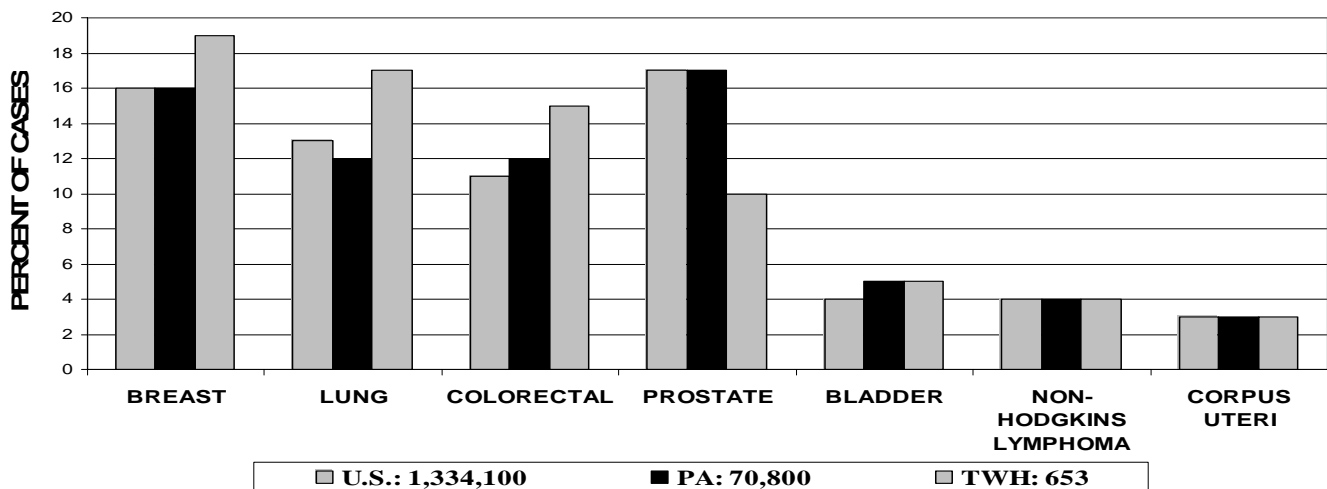
Since 1989, the Cancer Registry has collected demographics, cancer identifications, treatment, and follow-up data on each cancer patient that has been diagnosed and treated at The Washington Hospital. The registry is supported by a fully computerized system, which monitors all of the cancer cases. This data is utilized by physicians, the Cancer Committee, hospital administration, and other healthcare professionals.

653 new cancer cases were diagnosed or given their first course of therapy at The Washington Hospital in 2003. These cases are followed annually by the registry during the lifetime of the patients for outcome analysis studies. Currently, there are 11,132 patients in the registry. Of these, 4,238 are being tracked annually with a follow-up rate of 96%.

The Cancer Registry submits data to the Pennsylvania Cancer Registry and the National Cancer Data Base.

The Cancer Registrar coordinates activities for weekly Tumor Board Conferences and quarterly Cancer Committee meeting. The Registrar is a Certified Tumor Registrar and a Registered Health Information Technician. A registry analyst assists the Registrar with abstracting and yearly follow-up activities. The Registrar and Registry Analyst are active in the Pennsylvania Association of Cancer Registrars and regularly attend educational programs offered by local organizations.

**MAJOR PRIMARY SITES - 2003
UNITED STATES, PENNSYLVANIA, THE WASHINGTON HOSPITAL
COMPARISON**



US/PA estimated stats based on incidence rates from the NCI SEER program - *Cancer Facts & Figures - 2003*

Figure 8

As shown in Figure 8, breast, lung, prostate, colorectal, and bladder cancers were the five most frequently diagnosed cancers at The Washington Hospital during 2003. The Washington Hospital data is similar to state and national findings. Data from the registry is utilized to evaluate these and other sites for improvements in patient care.

Billie L. White, RHIT, CTR

Cancer Registrar

2003 Analytical Cases

Primary Site	Total	Perc	Sex		AJCC						
			M	F	0	1	2	3	4	UNK	N/A
Base Of Tongue	4	0.6	4	0	0	0	0	2	2	0	0
Oth & Unspec Parts Of To	3	0.5	3	0	0	0	0	1	2	0	0
Floor Of Mouth	2	0.3	1	1	0	0	1	0	1	0	0
Palate	2	0.3	2	0	1	1	0	0	0	0	0
Oth Parts Of Mouth	2	0.3	2	0	0	0	0	0	2	0	0
Parotid Gland	1	0.2	0	1	0	0	0	1	0	0	0
Tonsil	3	0.5	2	1	0	0	0	1	2	0	0
Oropharynx	2	0.3	2	0	0	0	0	1	1	0	0
Nasopharynx	1	0.2	1	0	0	0	0	1	0	0	0
Esophagus	6	0.9	5	1	0	2	0	1	3	0	0
Stomach	4	0.6	3	1	0	1	1	0	1	1	0
Colon	66	10.1	27	39	15	19	14	10	8	0	0
Rectosigmoid Jct	7	1.1	3	4	1	1	1	1	3	0	0
Rectum	25	3.8	17	8	2	8	4	5	6	0	0
Anus And Anal Canal	4	0.6	0	4	0	0	3	0	0	1	0
Liver-Intrahep Bile Dcts	2	0.3	1	1	0	0	1	1	0	0	0
Gallbladder	3	0.5	1	2	0	1	2	0	0	0	0
Oth & Unspec Pts Of Bili	5	0.8	1	4	0	1	0	0	3	1	0
Pancreas	13	2	6	7	0	1	4	0	8	0	0
Larynx	9	1.4	8	1	1	6	0	1	1	0	0
Bronchus And Lung	115	17.7	68	47	0	31	9	32	41	1	1
Heart, Mediastinum And P	1	0.2	0	1	0	1	0	0	0	0	0
Hematopoietic/Reticuloen	20	3.1	8	12	0	0	0	0	0	0	20
Skin	16	2.5	9	7	2	7	2	2	2	0	1
Conn, Subq And Oth Soft	5	0.8	1	4	0	2	0	1	1	0	1
Breast	125	19.2	3	22	25	53	31	7	9	0	0
Vulva	2	0.3	0	2	0	1	0	0	1	0	0
Cervix Uteri	4	0.6	0	4	0	1	2	1	0	0	0
Corpus Uteri	19	2.9	0	19	1	14	1	1	1	1	0
Ovary	11	1.7	0	11	0	4	0	6	1	0	0
Prostate Gland	63	9.7	63	0	2	0	51	3	7	0	0
Testis	9	1.4	9	0	0	7	1	1	0	0	0
Kidney	19	2.9	13	6	0	5	5	4	5	0	0
Renal Pelvis	1	0.2	1	0	0	0	0	1	0	0	0
Ureter	1	0.2	1	0	0	1	0	0	0	0	0
Bladder	30	4.6	22	8	6	17	4	1	1	1	0
Brain	7	1.1	4	3	0	0	0	0	0	0	7
Thyroid Gland	1	0.2	0	1	0	1	0	0	0	0	0
Adrenal Gland	1	0.2	0	1	0	0	0	0	0	0	1
Lymph Nodes	24	3.7	14	10	0	3	7	11	3	0	0
Unknown Primary Site	16	2.5	9	7	0	0	0	0	0	0	15
Total	653	100	313	340	56	188	144	96	116	6	47

Glossary

AJCC Stage	Staging classification published by the American Joint Committee on Cancer Required by the American College of Surgeons T – Tumor N – Node 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 publication describing the activities of the Cancer Committee and the Cancer Program
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.

Cancer Committee 2003

Wayne J. Pfrimmer, M.D.	CHAIRMAN, MEDICAL ONCOLOGY
Louis C. D'Oro, M.D.	GENERAL SURGERY
Natasha Eshbaugh, M.D.	RADIOLOGY
Jeffrey S. Hilger, M.D.	RADIOLOGY
John A. Hyland, M.D.	RADIATION ONCOLOGY
Robert G. Kelley, M.D.	RESIDENT, FAMILY PRACTICE
William W. Kottner, M.D.	INTERNAL MEDICINE/GERIATRICS
Dean F. Lomago, M.D.	THORACIC SURGERY
Jeffrey F. Minteer, M.D.	FAMILY PRACTICE
James D. Pareso, M.D.	GENERAL SURGERY, ACoS LIAISON
Richard S. Pataki, M.D.	PATHOLOGY
Michael J. Platto, M.D.	PHYSICAL MEDICINE/REHABILITATION
Rebecca L. Plute, M.D.	FAMILY PRACTICE
W. Paul Slomiany, M.D.	FAMILY PRACTICE
Timothy P. Weyrich, M.D.	UROLOGY
Michael H. Zinsser, M.D.	OBSTETRICS/GYNECOLOGY
Colleen C. Allison	VICE PRESIDENT, SUPPORT SERVICES/RISK MANAGEMENT
Jennifer Bitkowski, RHIA	MANAGER, MEDICAL RECORDS
Judy Campsey, MN Ed, RN, C	DIRECTOR, EDUCATION DEPARTMENT
Karen Clark, RTR	MANAGER, RADIOLOGY
Regina Davin, RN, BSN, MSN	ASSOCIATE NURSE EXECUTIVE
Joseph Edwards, RN	CASE MANAGEMENT
Pam Famularo, RN, BSN, OCN	CLINICAL ONCOLOGY COORDINATOR
Nancy Fausak, RN, MHSA	NURSE MANAGER, MEDICAL/SURGICAL UNITS 6E, 5S
Anne S. Hast, RN, MSN	VICE PRESIDENT, PATIENT CARE SERVICES
Michelle Jox, MSW	CASE MANAGEMENT
Tamara Keen, RHIA	DIRECTOR, MEDICAL RECORDS
Joy McClenathan, RN, BSN, OCN	ASSISTANT NURSE MANAGER, 6E
Mary Ann Loar, RN, BSN, OCN	MANAGER, AMBULATORY CARE
Matt McCracken, RTT	DIRECTOR, RADIATION THERAPY
Barbara Retucci, RD	CLINICAL DIETITIAN, NUTRITIONAL SERVICES
Katy Shultz, LSW	EXECUTIVE DIRECTOR, HOSPICE
Donna Smith, RT(R)(M)	MANAGER, WOMENS HEALTH CENTER
Gary Weinstein	EXECUTIVE VICE PRESIDENT
Billie L. White, RHIT, CTR	CANCER REGISTRAR