Table of Contents

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer Committee</td>
<td>2</td>
</tr>
<tr>
<td>Chairman’s Report</td>
<td>3</td>
</tr>
<tr>
<td>Quality Improvement Measures</td>
<td>6</td>
</tr>
<tr>
<td>Cancer Registry</td>
<td>8</td>
</tr>
<tr>
<td>Cancer Sites</td>
<td>9</td>
</tr>
<tr>
<td>Oral and Pharyngeal Cancer: The Role of HPV</td>
<td>10</td>
</tr>
</tbody>
</table>
2015 Cancer Committee

James Watkins, MD, Medical Oncology, Chairman, Cancer Conference Coordinator
Alka Wells, MD, Radiology
James Pennington, MD, Cancer Liaison Physician, ENT
Paul Chomiak, MD, Thoracic Surgeon
Charles Mayfield, MD or Nicholas Hilliard, MD, Pathology
Gerald Lowrey, MD, Radiation Oncology
Terri Smith, RN, MS, VP, Cancer Services
Megan Moralita, RN, Patient Care Manager, Inpatient Oncology Unit
Lois Gaston, RN, Nursing Manager, Outpatient Oncology Unit
Lavonda Harrison, RN, Manager, Ann L. Baroco Center for Breast Health (Mammography), Community Outreach Coordinator
Jocelyn Longo, RN, Breast Cancer Nurse Navigator
Angela Nicholson, RN, Lung Cancer Nurse Navigator
Denise Ingram, RN, Quality Management
Hayley Craft, RN or Jennifer Dulin, MD, Palliative Care
Jeanie Sherman, MSN, Social Work, Psychosocial Services Coordinator
Maegan Rose, PharmD, Pharmacy
Betsy Brou, RN, Cancer Research, Clinical Trials Coordinator
Linda Wall, RN, MD Anderson Cancer Center Liaison, Quality Improvement Coordinator
Edith Baker, RD or Mary Elizabeth Halliday RD, Dietary
Wendy Williams, RHIT, CTR, Cancer Registry, Cancer Registry Coordinator
Julie Manley, RHIT, CTR, Cancer Registry
Laura Kindergan, RHIT, CTR, Cancer Registry
Jill Pait, American Cancer Society
Abbi DuBose, Patient Family Advisor
2015 Chairman’s Report

I am pleased to present the 2015 Annual Report summarizing the accomplishments of the Cancer Program at Sacred Heart Hospital.

This has been a very productive year of improvements in patient care and expansion of services. In 2015 our Cancer Registry abstracted 1,928 cases. This is 332 more cases than in 2014. Of these, 1,458 were analytic and 470 were non analytic.

We continue our affiliation with MD Anderson and continue to work to improve quality of care and adherence to evidence based clinical guidelines. This is done through physician peer review, concordance studies, Peer to Peer consultations, joint tumor boards and collaboration with MD Anderson in the care of patients needing care that cannot be provided locally.

Our ability to bring the latest treatments to our patients has also expanded through our clinical research program. During this past year we have placed 110 patients on clinical trials. This represents 8% of our new cancer cases.

This year we also started our Cancer Survivorship Program. The goal of this program is to assist people with cancer to live fully after cancer treatment. People ending treatment meet with our Survivorship Navigator to discuss healthy living and appropriate follow-up for their cancer.
The hallmark of our care at Sacred Heart is our physicians working together in development of the plan of care for patients. At Cancer Conference/Tumor Board in 2015 a total of 736 cases were presented. We hold a general tumor board, breast tumor board, hepatobiliary/GI tumor board, GYN tumor board, brain tumor board, pediatric oncology tumor board and an MD Anderson tumor board. We have also seen an increase in the multidisciplinary participation in our Cancer Conferences resulting in better care for patients.

Having clinical data to improve care to our patients is very important. To this end we have continued participation in the “Rapid Quality Reporting System” of the American College of Surgeons. This allows us to track our performance on the national quality indicators on a monthly basis, assisting our Cancer Committee to focus on improvements.

Our Cancer Program goals for 2015 were as follows:

- **Clinical Goal:** Develop an advanced care planning program
- **Programmatic Goal:** Expansion and consolidation of the Sacred Heart Cancer Centers to our Airport Blvd location

Our Quality Improvements for the year included:

- ENT physician authored an educational article for medical staff on the role of HPV in Oral and Pharyngeal Cancer. This was in result of a quality study that we completed on this topic in 2014.
- Developed Gamma Knife Treatment Guidelines.

We also completed two Quality Studies:

- The Cancer Committee studied Ports placed for chemotherapy. We studied this to have a better understanding of the factors that affect the long term placement of ports for patients who are receiving chemotherapy. What are the factors that play into ports being removed before the end of treatment?
- We reviewed our data on Clostridium difficile and developed a plan to decrease infection rates.

We have participated in many community events over this past year to promote healthy behaviors and to celebrate survivors. Some of these events include:

- Camp Bluebird - a cancer camp for adults
- Look Good Feel Better
- Relay for Life - Survivor Dinner
• Cattle Barons Ball
• Community Health Fairs
• Lung Cancer Screening
• Provided free mammograms for uninsured or underinsured patients in the Ann Baroco Center

The Nemours Children’s Specialty Care at Sacred Heart Hospital cares for children with cancer. During this past year a total of 48 new pediatric cancer cases were accrued into the Cancer Registry. Weekly there is a multidisciplinary Pediatric Tumor Conference where cases are presented for discussion regarding further treatment and evaluation.

This has been a year of growth and development for the Cancer Program at Sacred Heart Hospital. We do all of this for the patients we serve. They do deserve the very best cancer care!

James Watkins, MD
Chair, Cancer Committee
Medical Director, Sacred Heart Cancer Center
Quality Improvement Measures

Cancer Committee ensures that patients with cancer are treated according to nationally accepted quality improvement measures. Our performance rates below reveal the number of breast, colon and rectal patients treated according to recognized standards of care.

Data reported from 2014 and 2015 utilizing the Rapid Quality Reporting System (RQRS).

**Breast**
Radiation therapy is administered within one year of diagnosis for women under age 70 receiving breast conserving surgery.

- **Performance rate:** 96.3%  
- **Compared to Florida:** 83.4%  
- **Goal:** 90%

Radiation therapy is considered or administered following mastectomy within 1 year (365 days) of diagnosis of breast cancer for women with \( \geq 4 \) positive regional lymph nodes.

- **Performance rate:** 100%  
- **Compared to Florida:** 73.1%  
- **Goal:** 90%
Combination chemotherapy is considered or administered within four months (120 days) of diagnosis for women under 70 with AJCC T1cN0M0, Stage II or III, and ER/PR negative.

**Performance rate:** 100%

**Compared to Florida:** 87.8%

**Goal:** 90%

Tamoxifen or third generation aromatase inhibitor is considered or administered within one year of diagnosis for women with T1cN0M0 or stage II or III, ER and/or PR positive breast cancer.

**Performance rate:** 97.1%

**Compared to Florida:** 85.2%

**Goal:** 90%

**Colon**

Adjuvant chemotherapy is considered or administered within 4 months of diagnosis for patients under the age of 80 with AJCC Stage III (lymph node positive) colon cancer.

**Performance rate:** 100%

**Compared to Florida:** 77.3%

**Goal:** 90%

At least 12 regional lymph nodes are removed and pathologically examined for resected colon cancer.

**Performance rate:** 97.3%

**Compared to Florida:** 91.3%

**Goal:** 85%
Cancer Registry
By Wendy Williams, RHIT, CTR; Julie Manley RHIT, CTR; Laura Kindergan, RHIT, CTR

The Cancer Registry is a vital component of the Comprehensive Community Cancer Program at Sacred Heart Hospital. The registry’s reference date is January 1, 2000. The registry receives and maintains data on patients diagnosed and/or receiving treatment for cancer at our facility. This data is used to monitor cancer incidence and cancer care management. It also serves as a source for tracking outcomes and survival statistics of patients through annual follow-up on all analytic cases.

In 2015, the Cancer Registry accessioned 1,928 new cases into the database with 1,458 (76%) representing analytic cases and 470 (24%) representing non analytic cases. The top five sites represented breast (15.35%), lung (12.76%), colorectal (6.48%), prostate (6.12%) and bladder (4.56%).

As required by state law, cases are submitted to the Florida Cancer Data System (FCDS). All analytic cases are reported annually to the National Cancer Data Base (NCDB) as required by the American College of Surgeons, Commission on Cancer as an approved cancer program.

The Cancer Registry currently conducts annual follow-up on over 9,500 patients and has a current follow-up rate of 85% for all analytic patients and a 92% follow-up rate for analytic patients diagnosed within the last five years.
# 2015 Cancer Sites Diagnosed at Sacred Heart Hospital Pensacola

<table>
<thead>
<tr>
<th>Cancer Site</th>
<th>Cases</th>
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<tbody>
<tr>
<td>Breast</td>
<td>296</td>
</tr>
<tr>
<td>Digestive System</td>
<td>293</td>
</tr>
<tr>
<td>Respiratory System</td>
<td>274</td>
</tr>
<tr>
<td>Female Genital</td>
<td>210</td>
</tr>
<tr>
<td>Blood &amp; Bone Marrow</td>
<td>210</td>
</tr>
<tr>
<td>Urinary System</td>
<td>166</td>
</tr>
<tr>
<td>Male Genital</td>
<td>128</td>
</tr>
<tr>
<td>Lymphatic System</td>
<td>102</td>
</tr>
<tr>
<td>Brain &amp; CNS</td>
<td>61</td>
</tr>
<tr>
<td>Skin</td>
<td>55</td>
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<tr>
<td>Oral Cavity</td>
<td>53</td>
</tr>
<tr>
<td>Endocrine</td>
<td>41</td>
</tr>
<tr>
<td>Unknown Primary</td>
<td>18</td>
</tr>
<tr>
<td>Other/Ill-Defined</td>
<td>8</td>
</tr>
<tr>
<td>Bone</td>
<td>8</td>
</tr>
<tr>
<td>Connect/Soft Tissue</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1928</strong></td>
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</tbody>
</table>
Oral and Pharyngeal Cancer: The Role of HPV
By James Pennington, MD, Otolaryngology

Finding an oral or pharyngeal cancer at an early stage may save your patient’s life.

The oral cavity and pharyngeal screening exam is relatively painless and only takes a few minutes and is incorporated into routine physicals.

Historically OPC has been associated with abuse of tobacco and alcohol, which act synergistically to multiply their affect. However, the demographics are changing with the fastest growing group of patients being younger nonsmokers with HPV exposure. Patients with HPV positive oropharyngeal cancer have a lower risk of dying and less risk of recurrence. U.S. Data shows 7 percent of population has oral HPV exposure and 1 percent with exposure to HPV16 strain linked to oral cancer. HPV now causes most oropharyngeal cancers in the U.S. with 63 percent of oropharyngeal cancer being associated with HPV.

The signs and symptoms are subtle but progressive. Patients may experience persistent earache with normal ear examination, foreign body sensation in the pharynx with dysphagia or odynophagia. Changes in voice and articulation that last over two weeks need evaluation. The development of a painless lump in the neck is the most common presentation at 47 percent of cases. Be aware of subtle warning signs, such as

- Voice and articulation changes that last longer than two weeks.
- Progressive earache with normal examination.
- Dysphagia and odynophagia.
- Persistent oral cavity ulceration
- Painless neck mass.
Oral and pharyngeal cancers (OPC) make up about 2.5 percent of all new cancer cases in the U.S. according to the SEER database. Approximately 1.1 percent of men and women will be diagnosed with oral and pharyngeal cancer during their lifetime. Men are approximately 2.5 times more likely to contract the disease. This means five-year survival is approximately 63 percent, which has only increased 11 percent since 1975.

The physical examination is both a tactile and visual experience. Ear canal and tympanic membranes are evaluated for effusion that can signal swelling and infiltration of the eustachian tube. Premalignant and malignant lesions may appear as a thickened white or erythematos plaque known as leukoplakia or erythroplakia. As these lesions grow they become a non-healing ulceration.

Oral cavity lesions are found on the hard palate, ventral tongue, dorsal tongue, floor of mouth, alveolar ridge and buccal mucosa. The biological and clinical course of oral cavity lesions is different than pharyngeal lesions, with the oral cavity lesions having higher recurrence. The pharynx begins with the anterior tonsillar pillar and includes tonsils, base of tongue and posterior pharyngeal wall. These areas are best examined by palpation as well as direct visualization.

Frequently, lesions cannot be visualized, but can be palpated. Infiltrating lesions stand out as a dense firmness surrounded by soft normal tissue. Evaluation of the neck involves palpation of the lateral, anterior and base of neck with bimanual palpation of the submandibular region. Normal size lymph nodes are up to 1 cm in diameter and anything beyond that requires consideration for excisional biopsy.

The opportunity for successful treatment comes at identifying the lesion when confined to the primary site, where treatment can be as simple as an excision with minimal morbidity. The overall five-year survival is 83 percent when treated at the primary level versus 60 percent when spread to regional nodes. The treatment course is more extensive for regional disease frequently involving XRT surgery and, possibly, chemotherapy. SEER database reveals 31 percent of cases present with localized diseases versus 47 percent with regional nodes at presentation.

In summary, the evaluation of the oropharynx is readily accessible with minimal morbidity and can make a significant difference during routine physical exam. The savings to the patient in healthcare dollars spent and morbidity to find lesions at an early stage is well worth the effort to evaluate as part of routine physical exam.