Cancer Report 2002

Sacred Heart Hospital

James H. Baroco Cancer Center

Contents

Chairman's Report

2002

Joanne Bujnoski, DO

As chairman of the Cancer Committee at Sacred Heart Hospital, I am pleased to present the Annual Report summarizing the Cancer Program activities during the 2002 calendar year. Our Cancer Committee includes physicians, oncology nurses, pharmacists, allied oncology care professionals, representatives from hospital administration, social services, palliative care, and pastoral care.

In December 2002, The American College of Surgeons (ACoS) conducted an onsite survey of our Cancer Program. This was an extensive review of the program's ability to meet the challenges of caring for cancer patients and their families. Numerous aspects of care including public and professional education, cancer screening, diagnosis, treatment, rehabilitation, palliative care and emotional and spiritual support were evaluated. Sacred Heart Hospital is pleased to say the Cancer Program was found to have no deficiencies, and received a three-year accreditation as a Community Hospital Comprehensive Cancer Program.

Dr. Michael Caluda was appointed our Physician Liaison to the American College of Surgeons (ACoS) for the term 2002-2005. He will provide leadership and direction to establish, maintain, and support the hospital's cancer program consistent with the criteria set by the Approvals Program of the ACoS Commission on Cancer.

Dr. Richard Cardosi, GYN/Oncologist, and Dr. Thomas Fitzgerald, Hematologist/Medical Oncologist, joined our medical staff. We look forward to their participation in tumor boards and committee activities in the coming years.

Through the direction of the Cancer Committee, there was implementation of a hospital policy mandating clinical staging by the managing physicians in accordance with ACoS. We participated in a national AJCC sponsored video conference on "The Changing Strategies of TNM Staging" that was available to all physicians to encourage a better understanding of the new staging process.

At the outset of the year, the committee was able to facilitate improvements in our Cancer Library, enlarge our unit, and further develop our research program. To that end, we acquired a computer and printer to make our library services more "user friendly" for the patients and families. St. Catherine's Oncology unit expanded its capacity by 10 beds. We have enrolled an increased number of patients on national protocols, which resulted in a "commendation" by our ACoS surveyor.

As we all know, cancer represents an enormous burden for patients, their families, and communities. I would like to thank the members of the cancer committee for their support in efforts to provide the best quality care to our patients at Sacred Heart Hospital.

2002 Didactic Cancer Conferences

- The Doctor-Patient Relationship in Need of Repair--An End-of-Life Seminar
- Non-Myeloablative Transplants
- Lung Cancer Overview - Stage IV Non-Small Cell Lung Cancer
- Radiofrequency Ablation of Liver Tumors
- Molecular Basis of Cancer and Targeted Therapy
- Endoscopic Ultrasound: A New Technique in Evaluation and Treatment of Cancer
- Well-Differentiated Thyroid Cancer
- Current Modalities in the Treatment of Brain Tumors
- First Line Treatment of Ambulatory Patients with Unresectable NSCLC
- Barrett's Esophagus Management of Pre-malignant and Malignant Disease of the Esophagus
- Changing Strategies of TNM Staging: Introduction to the AJCC 6th Edition
- End-of-Life/Palliative Care

Endometrial Cancer

Richard Cardosi, MD
Gynecologic Oncologist

SACRED HEART HOSPITAL, 2002 CANCER REPORT~

Endometrial Cancer (EC) is the most common malignancy of the female genital tract in the United States, and the Surveillance Epidemiology and End Results program (SEER) estimates over 40,000 new EC cases in 2003. Approximately 2,500 women are estimated to be diagnosed with carcinoma of the endometrium in the state of Florida during 2003. Fortunately, survival rates for women with EC are relatively good.

High survival rates are likely related to the typical early stage diagnosis of EC since over 90% of these patients present with abnormal vaginal bleeding, most commonly postmenopausal bleeding. Intermenstrual bleeding or heavy prolonged bleeding in the perimenopausal woman may also be a sign of EC. Unfortunately, some of this latter group of women have the diagnosis delayed because the bleeding is ascribed to a hormonal imbalance, without further evaluation.

Most ECs are sporadic and not familial or genetic. The exception to this is in families with mutations in the mismatch repair genes resulting in hereditary nonpolyposis colorectal cancer (HNPCC), also known as Lynch Syndrome II. More commonly, EC is related to risk factors associated with an increased exposure to unopposed estrogen–hormone replacement therapy, obesity, estrogen secreting tumors, and anovulatory menstrual cycles. On the other hand, oral contraceptive use tends to be protective against EC. There is no reliable screening test for EC.

Staging for EC was clinical until the late 1980's when surgical staging became the standard of care (Table 1). Staging has helped to accurately define spread and individualization of treatment, particularly with respect to adjuvant radiotherapy.

Even in the absence of complete surgical staging, surgery should be performed when feasible since it offers improved cure rates compared to radiation alone. Surgery is also usually successful in palliating the patient's symptoms as it removes the bleeding organ.

With this in mind, treatment/staging for EC is peritoneal cytology, total abdominal hysterectomy, bilateral salpingo-oophorectomy, and pelvic and periaortic lymph node sampling (performed either routinely or on the basis of uterine prognostic factors determined intraoperatively). Some authorities recommend lymph node dissection based on uterine prognostic factors, that correlate with

Table 1:
International Federation of Gynecology and Obstetrics (FIGO) staging for carcinoma of the endometrium

Stage	IA	Tumor limited to the endometrium
	IB	Invasion of less than 50% of myometrium
	IC	Invasion of more than 50% of myometrium
	IIA	Cervical gland involvement
	IIB	Cervical stroma involvement
	IIIA	Tumor invades uterine serosa and/or adnexa and/or positive peritoneal cytology
	IIIB	Vaginal involvement
	IIIC	Retroperitoneal lymph node metastases
	IVA	Invasion of bladder or rectal mucosa
	IVB	Upper abdominal and/or inguinal lymph node and/or distant metastases

lymph node metastases, when they wish to avoid the potential morbidity of node dissection. Other authorities recommend routine lymph node evaluation in all patients, citing the therapeutic benefit of lymphadenectomy, or the potential for incorrect intraoperative frozen section results. Lymphadenectomy can be accomplished without significant morbidity in the majority of patients. Results of lymphadenectomy may modify the use of adjuvant therapy, as will be discussed below.

Following surgery, patients can often be categorized into low, intermediate, and high-risk groups for recurrent disease.

Low Risk: Patients with grade 1 or 2 tumors confined to the uterine fundus with only superficial myometrial invasion, no evidence of extrauterine spread, and no lymph vascular space involvement. These patients receive no benefit from adjuvant therapy.

Intermediate Risk: Grade 1 or 2 tumors confined to the uterine fundus with <50% myometrial invasion, no evidence of extrauterine spread, and no lymph vascular space invasion. If lymph nodes have been sampled and are negative, most would consider these patients at low risk for recurrence. Even in the absence of information on lymph node status, adjuvant therapy is at best described as controversial. Some experts recommend postoperative pelvic teletherapy while some utilize only intravaginal brachytherapy, yet others recommend no additional treatment. Radiation appears to decrease the chance for local recurrence, but a survival advantage has never been proven and is unlikely to be given the high salvage rate of local recurrence.

High Risk: Grade 3 tumors with deep (>50%) myometrial invasion, adnexal metastases, lymph node metastases, lymph vascular space involvement, or cervical tumor involvement. These patients do appear to benefit from postoperative pelvic radiotherapy.

Most recently, data have been presented at scientific meetings and/or published in peer-reviewed journals suggesting that patients with EC should be offered consultation with a gynecologic oncologist. When these subspecialty surgeons are involved in the patient's care, the use and/or need for postoperative adjuvant radiotherapy is decreased.

Our experience: Sacred Heart Hospital provided care for 42 women with uterine carcinoma in 2002. The median age was 61 years but 3 patients were less than 40 years old. 5 patients had sarcomas and 37 had endometrial carcinoma. Our gynecologic oncologists were involved in the care of 33 of these 37 women.

Stage of diagnosis relative to our EC experience is illustrated in Table 2.

Table 2:
FIGO stage at diagnosis for EC at Sacred Heart Hospital in 2002

Stage	Number
IA	8
IB	12
IC	3
IIA	4
IIB	3
IIIA	1
IIIB	1
IIIC	0
IVA	1
IVB	4

Treatment included surgical exploration for all but one patient. Hysterectomy with removal of the adnexa was performed in 36 (97.3%) women, and lymph nodes were sampled in 22 (61.1 %) of the women. Reasons for not evaluating lymph nodes in 14 patients were as follows: favorable uterine prognostic findings at frozen section in 9 patients, occult EC identified pathologically that was not

Endometrial Cancer

known preoperatively in 2 patients, extensive metastases obviating the need for lymph node evaluation in 2 patients, and morbid obesity or co-morbid conditions led to lower risk transvaginal surgery in 1 patient. The single patient that did not undergo surgery had clinical stage 3 disease, and was too ill to withstand surgery; this patient succumbed to her disease within 2 weeks of her diagnosis.

Adjuvant radiotherapy was administered to 6 women. Five of these 6 patients were treated because of locally or regionally advanced disease. The additional patient to receive radiation was the woman who underwent vaginal hysterectomy, based on unfavorable prognostic factors identified within the uterus. Three of these same patients also received cytotoxic chemotherapy. One additional patient received chemotherapy for a concomitantly diagnosed ovarian cancer.

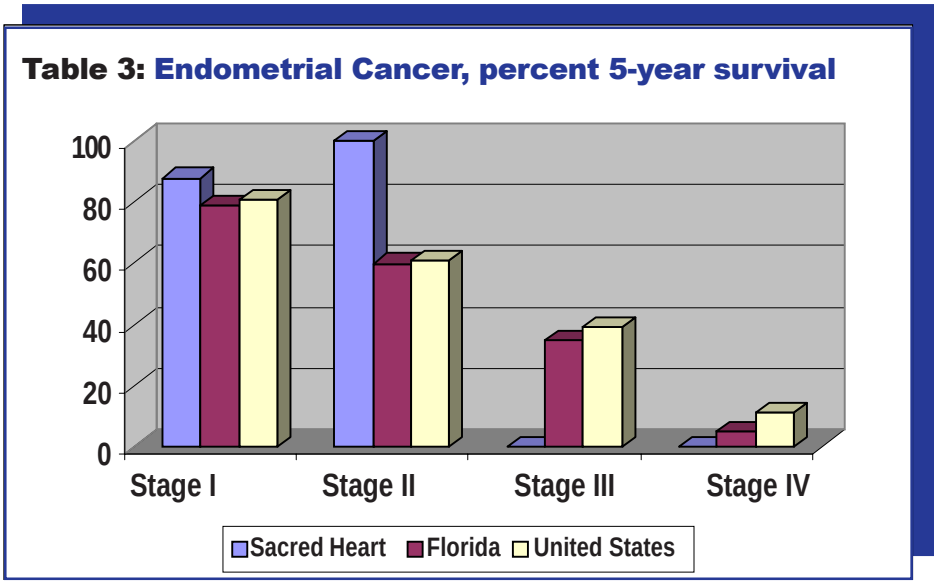
Our limited use of adjuvant treatment is exciting to report at a time when other communities are administering postoperative radiation therapy to a majority of patients, because of incomplete surgical staging. We are proud to say that the adjuvant radiation and chemotherapy administered to our patients was for histologically documented advanced disease and not based on just prognostic factors in nearly all cases here. In this latter patient (who underwent vaginal hysterectomy alone), the risk/benefit ratio for extensive surgery/lymph node sampling versus adjuvant pelvic radiotherapy favored radiation.

The outcomes of these women are excellent, but some patients unfortunately recur and die as a result of disease. Despite the very selective use of adjuvant radiation in our patients, there have been no local recurrences to date. Two patients developed distant recurrent disease at 2 and 3 months following initial therapy, and both originally had stage 4 disease and had received aggressive adjuvant therapy with both radiation and chemotherapy. Both patients succumbed to their disease 1 and 2 months after recurrence was detected. One patient never received any treatment and died within 2 weeks of diagnosis. One additional patient died for reasons unrelated to her cancer 2 months postoperatively. Our 5-year survival statistics compared to the rest of Florida and all of America are shown in Table 3.

In conclusion, we are proud to report that Sacred Heart Hospital provides care for EC that meets or exceeds the accepted standard. There was limited use of adjuvant therapy, due to more complete staging. Our outcome statistics are similar to those across the state and the rest of the nation for Stage I and II disease. We cannot make a meaningful comparison with regards to patients with more advanced disease given our limited exposure to such women. Despite aggressive surgical therapy followed by radiation and/or chemotherapy in patients with advanced disease, long-term survival is poor. Such investigations are currently evaluating the role of novel molecular agents, cytotoxic chemotherapy, immunotherapy, and combinations of radiation and chemotherapy. Some of these protocols are available to women with EC cared for at Sacred Heart.

Patients with advanced disease are excellent candidates for investigational protocols, and we are pleased to be able to offer such options to our patients in collaboration with the Gynecologic Oncology Group, an international cooperative study group.

Table 3: Endometrial Cancer, percent 5-year survival

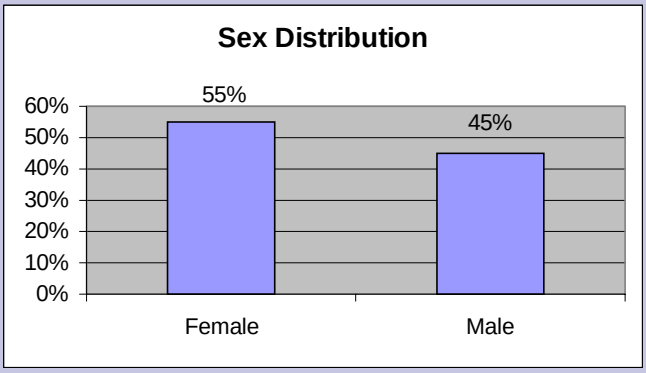


Cancer Statistics and Data

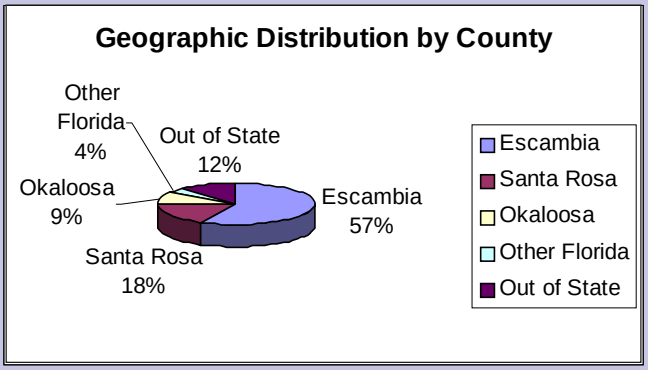
2002

The Statistics

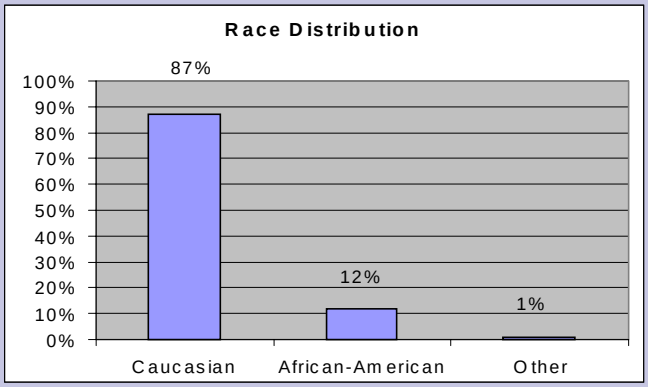
Sex Distribution



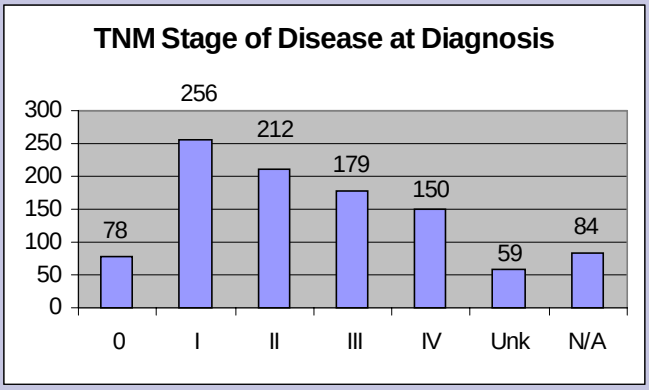
Geographic Distribution By County



Race Distribution



TNM Stage of Disease at Diagnosis



Includes analytic cases only.

Ten Most Frequent Sites

Ten Most Frequent Sites	SHH	National
Breast	17%	16%
Lung	16%	13%
Prostate	10%	15%
Colorectal	7%	12%
Uterus	4%	3%
Bladder	4%	4%
Non-Hodgkin's Lymphoma	4%	4%
Ovary	4%	2%
Kidney & Renal Pelvis	3%	2%
Pancreas	3%	2%

**Includes analytic cases only*

Cancer Registry

Wendy Williams, RHIT, CTR
Julie Manley, RHIT, CTR

The Cancer Registry is a cornerstone component of the Cancer Program at Sacred Heart Hospital. The Registry receives and maintains data on patients diagnosed 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 of tracking outcome and survival statistics of patients through annual follow-up on all analytic cases.

In 2002, the Cancer Registry accessioned 1271 new cases into the database, bringing the total number of cases to over 15,000. This reflects data collected since the reference date of January 1, 1979. As required by state law, cases are submitted to the Florida Cancer Data System (FCDS).

The Cancer Registry currently conducts annual follow-up on over 4900 patients, and has a current follow-up rate of 93 percent for all patients.

A total of 170 cases were presented at the weekly multidisciplinary Tumor Board meetings during the past year. All cases presented were prospective which included current patient management issues. The average physician attendance at Tumor Board was 13.

Continuing education is a necessity for the rapidly changing requirements in the collection and utilization of cancer data. Wendy Williams, RHIT, CTR attended the Florida Cancer Registrars Association and Florida Cancer Data System combined annual conference "Keeping up with Change" in Sarasota, Florida, in July/August 2002.

2002 Community Outreach Programs

"Life and Death on Your Own Terms"
with featured speaker Dr. Lofty Basta - Jan. 29
Camp Bluebird - April/December
Skin Cancer Seminar - April 17
Relay for Life - May 10-11
Prostate Cancer Screening - June 11
I Can Cope - June/July
Drive for the Cure - October 8
Tell-a-Friend Tuesday - October
Through with Chew - An educational forum for middle school age children presented by registered nurses. Included question and answer sessions and role play. Four presentations.

BLAB TV Presentations:

Palliative Care	Children's Oncology
Prostate Cancer	Breast Cancer Talk

Cancer Support Group open to all cancer patients. Meets 3rd Thursday of every month.

Breast Cancer Support Group open to all women with diagnosis of breast cancer. Meets 3rd Wednesday of every month.

Statistical Summary of Registry Data

A total of 1,271 cases were diagnosed and/or treated at Sacred Heart Hospital in 2002. Analytical cases (1,018) accounted for 80% of the total population; non-analytical cases (253) for 20%. Nationally, 1,284,900 new cancer cases were projected to be diagnosed in 2002, with 92,200 from Florida.

The data shows distribution by race: 87% White, 12% Black, and 1% Other. A total of 55% were female and 45% male. Geographically, 57% of analytic cases were from Escambia County, 18% from Santa Rosa County, 9% from Okaloosa County, 4% from other Florida counties and 12% of the cases reported were out of state. Stage distribution for analytic cases was 8% stage 0, 25% stage I, 21% stage II, 18% stage III, 15% stage IV, 13% were unknown stage or not applicable. Cancer incidence by site demonstrated that the ten most frequent sites are breast 17%, lung 16%, prostate 10%, colorectal 7%, corpus uteri 4%, bladder 4%, non-Hodgkin's lymphoma 4%, ovary 4%, kidney/renal pelvis 3%, and pancreas 3%.

Primary Site Tabulation for 2002 Cases

Primary Site	Total	Class		Sex	
		A	N/A	M	F
All Sites	1271	1018	253	575	696
ORAL CAVITY	**33**	**26**	**7**	**19**	**14**
LIP	0	0	0	0	0
TONGUE	6	3	3	4	2
OROPHARYNX	0	0	0	0	0
HYPOPHARYNX	1	1	0	1	0
OTHER	26	22	4	14	12
DIGESTIVE SYSTEM	**174**	**153**	**21**	**90**	**84**
ESOPHAGUS	11	11	0	7	4
STOMACH	18	17	1	11	7
COLON	60	47	13	30	30
RECTUM	25	21	4	12	13
ANUS/ANAL CANAL	5	5	0	0	5
LIVER	10	8	2	8	2
PANCREAS	33	33	0	18	15
OTHER	12	11	1	4	8
RESPIRATORY SYSTEM	**193**	**171**	**22**	**111**	**82**
NASAL/SINUS	0	0	0	0	0
LARYNX	10	9	1	9	1
LUNG/BRONCHUS	181	161	20	101	80
OTHER	2	1	1	1	1
BLOOD/BONE MARROW	**62**	**32**	**30**	**41**	**21**
LEUKEMIA	42	26	16	25	17
MULTIPLE MYELOMA	20	6	14	16	4
OTHER	0	0	0	0	0
BONE	**3**	**1**	**2**	**2**	**1**
CONNECT/SOFT TISSUE	**0**	**0**	**0**	**0**	**0**
SKIN	**53**	**32**	**21**	**35**	**18**
MELANOMA	51	31	20	35	16
OTHER	2	1	1	0	2
BREAST	**217**	**170**	**47**	**1**	**216**
FEMALE GENITAL	**153**	**138**	**15**	**0**	**153**
CERVIX UTERI	36	31	5	0	36
CORPUS UTERI	45	42	3	0	45
OVARY	40	36	4	0	40
VULVA	18	17	1	0	18
OTHER	14	12	2	0	14
MALE GENITAL	**146**	**110**	**36**	**146**	**0**
PROSTATE	137	103	34	137	0
TESTIS	5	5	0	5	0
OTHER	4	2	2	4	0
URINARY SYSTEM	**103**	**84**	**19**	**68**	**35**
BLADDER	53	40	13	38	15
KIDNEY/RENAL	40	35	5	23	17
OTHER	10	9	1	7	3
BRAIN & CNS	**19**	**15**	**4**	**11**	**8**
BRAIN	18	14	4	11	7
OTHER	1	1	0	0	1
ENDOCRINE	**29**	**23**	**6**	**7**	**22**
THYROID	25	19	6	5	20
OTHER	4	4	0	2	2
LYMPHATIC SYSTEM	**62**	**43**	**19**	**30**	**32**
HODGKIN'S DISEASE	8	5	3	6	2
NON-HODGKIN'S	54	38	16	24	30
UNKNOWN PRIMARY	**21**	**18**	**3**	**14**	**7**
OTHER/ILL-DEFINED	**3**	**2**	**1**	**0**	**3**

Multidisciplinary Services

Treatment of Children with Cancer

Nemours Children's Clinic, an affiliate of Sacred Heart Children's Hospital, has been a Children's Oncology Group (COG) institution through the Community Clinical Oncology Program since 1983. Each year, Nemours Children's Clinic places newly diagnosed patients and relapsed cancer patients on available COG studies. Each month there is a multidisciplinary tumor conference/tumor board where patients are presented for discussion/advice regarding further treatment/evaluation. Pediatric oncology, surgery, orthopaedics, radiology, pathology and radiation oncology are the disciplines regularly represented. Furthermore, the patients' physicians as well as nurses, social workers, and pediatric residents are encouraged to attend.

St. Catherine Oncology Unit

Our multidisciplinary team approach addresses every facet of the patient's needs, from the time of hospital admission to the time of discharge and into the home setting. The provision of all private rooms in our 31-bed oncology unit offers a family-centered approach to our mission of service to those who are poor in mind, body or spirit. In close liaison with the physician, the registered nurse coordinates numerous ancillary services in an effort to ensure complete, individualized care.

Cancer Research

Patients in Northwest Florida and South Alabama are given the opportunities to remain in Pensacola and participate in some of the latest NCI sponsored Cooperative Group or pharmaceutical sponsored trials. Northwest Florida's only GYN Oncologists, in partnership with Moffitt Cancer Center in Tampa, are able to offer eligible women entry into Gynecologic Oncology Group (GOG) treatment trials. Our medical oncologists, in partnership with Tulane University Cancer Center in New Orleans, offer eligible patients opportunities to participate in other "treatment/medical research" trials covering a variety of different cancers and offer eligible community members participation in cancer "prevention" trials. In 2002, the total number accrued to clinical trials exceeded the American College of Surgeons (ACoS) commendable standard of 6%--Outstanding!

Palliative Care Program

Palliative care is the comprehensive management of patients' physical, psychological, social, spiritual and existential needs. It can be part of the treatment plan for any person and their family at any stage of disease. Palliative care affirms life and regards the dying process as a natural process that is a profoundly personal experience for the individual and family. The focus of palliative care is the relief of suffering, control of symptoms, quality of life as determined by the patient, and maintenance of functional capacity. Palliative care guides patients and families as they journey through the changing goals of care and assists the patient who wishes to address issues of life completion and closure. For more information about palliative care call Erin Bowers, RN, Palliative Care Manager at (850) 416- 7705 or Randal Hamilton, RN (850) 416-2693.

Multidisciplinary Services

Pastoral Care

The Pastoral Care department provides spiritual care for all patients, families, and hospital staff. A chaplain regularly visits the patients on our St. Catherine's oncology unit, as well as the outpatient Center for Cancer Care. The priest chaplain is always available to patients and families. Besides being available to patients during their hospital stay or visit, we extend our support even after discharge to their homes or nursing homes.

Social Services

Social workers facilitate communication between health care team members and patients and their families. Social workers are professionals trained to provide counseling and support as well as assistance in identifying resources that are helpful when coping with a serious illness. Assistance includes information about government entitlement programs, home health care, durable medical equipment, hospice, transportation, vocational rehabilitation, short term and long term disability and alternative living arrangements. Individual, family and group counseling is available at no charge.

Nutrition Services

Nutrition support is essential for the patient to withstand the stress of cancer and its treatment. All cancer patients are screened for nutritional risks and may be referred to a registered dietician or registered diet technician. During one-on-one counseling the patient is able to discuss their current diet, nutritional problems and a personalized care plan is developed. When needed, tube feeding and intravenous nutrition therapies are available.

Performance Improvement

The Cancer Service Line incorporates a multidisciplinary team approach to performance improvement. By identifying short and long-term improvement opportunities and applying outcome criteria, we are able to ensure that performance improvement is ongoing and pertinent. Because oncology patients have been identified as having multiple risk factors for developing deep vein thrombosis (DVT) and pulmonary embolism (PE), a DVT/PE prophylaxis protocol was implemented in 2002. Advance directive identification and documentation was also a performance improvement initiative for the year.

Miracle Camp

In November 2002, Sacred Heart Health System opened Miracle Camp with the mission to provide a premier camp and retreat center for chronically and/or terminally ill children and adults. Miracle Camp has a special commitment to those with cancer, and regardless of financial barriers or physical concerns the ultimate goal is to meet the physical, spiritual, and emotional needs of every client.

Miracle Camp is set in a pristine, wooded, 40-acre nature preserve. A large pond provides fishing and canoeing, while a beautiful labyrinth and a charming outdoor chapel serve as quiet havens for introspection, reflection, and inspiration.

As evidence of the amazing opportunities that Miracle Camp offers, Camp Bluebird, a biannual adult cancer camp, now hosts all of its camps here. At Miracle Camp we are proud to say, "Everybody deserves a moment in the sun."

Directory

Sacred Heart Hospital	**416-7000**
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Patient Care Mgr., Lavonda Harrison, RN	
Center for Cancer Care	**416-6700**
Radiation Therapy	416-6700
Marsha Dorman, RN	416-6539
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Fax	416-7770
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Wendy Williams, RHIT, CTR	416-6639
Cancer Registry, Coordinator	
Cancer Research	
Susan Skirten, RN, Oncology Coordinator	416-6316
Joan Smith, RN	416-4611
St. Catherine Oncology Unit	**416-7290**
Patient Care Mgr., Brenda Shea, RN	416-6305
Palliative Care	**416-7705**
Erin Bowers, RN, Coordinator	
Randal Hamilton, RN	
Cancer Support Group	**416-7703**
Susan Kearney, LCSW	
Social Services	**416-7703**
Susan Kearney, LCSW	
I Can Cope	**416-6316**
Susan Skirten, RN	
Sacred Heart Home Care	**470-9288**
Pastoral Care	**416-7928**
Sister Bernadette LaFlamme	
Nutritional Support	**416-7579**
Kathy Faoro, RN, Clinical Coordinator	
Edith Baker, RD	
Outpatient IV Therapy	**416-6704**
Smoking Cessation	**416-7764**
Lisa Masterson, RRT	
Miracle Camp	**944-1677**

Our Core Values

We Are Called To:

SERVICE OF THE POOR
Generosity of spirit, especially for persons most in need

REVERENCE
Respect and compassion for the dignity and diversity of life

INTEGRITY
Inspiring trust through personal leadership

WISDOM
Integrating excellence and stewardship

CREATIVITY
Courageous innovation

DEDICATION
Affirming the hope and joy of our ministry

Sacred Heart Hospital

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