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# CANCER COMMITTEE REPORT

## 2007

The Sarah Cannon Cancer Center provides diagnosis, treatment and follow-up care for cancer patients throughout Tennessee and surrounding states. During 2007, a total of 4153 cases were accessioned into the databases of The Sarah Cannon Cancer Center facilities. Of this number, 3828 were new diagnoses, and are termed “Analytic” cases. The remaining 318 are non-analytic, and were previously diagnosed and had the first course of treatment elsewhere and came to The Sarah Cannon Cancer Center for the first time in 2007 for treatment of progression or recurrence of disease.

When reviewing the analytic cases that came to The Sarah Cannon Cancer Center for a new diagnosis of cancer in 2007, the most frequently occurring cancers parallel the national data. Prostate cancer was the type seen most often, followed by non-small cell lung cancer and breast cancer. Rounding out the “Top Five”, are colon and small cell lung cancer.

| 2003 | | | 2004 | | | 2005 | | | 2006 | | | 2007 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| TOTAL | 2932 | 100% | TOTAL | 3578 | 100% | TOTAL | 3792 | 100% | TOTAL | 3860 | 100% | TOTAL | 3828 | 100% |
| NSCLC | 524 | 18% | NSCLC | 616 | 17% | Breast | 671 | 18% | NSCLC | 655 | 17% | Prostate | 618 | 16% |
| Breast | 437 | 15% | Prostate | 515 | 14% | NSCLC | 654 | 17% | Breast | 584 | 15% | NSCLC | 588 | 15% |
| Prostate | 417 | 14% | Breast | 506 | 14% | Prostate | 482 | 13% | Prostate | 534 | 14% | Breast | 560 | 15% |
| Colon | 237 | 8% | Colon | 281 | 8% | Colon | 269 | 7% | Colon | 264 | 7% | Colon | 253 | 7% |
| NHL | 119 | 4% | SCLC | 148 | 4% | SCLC | 147 | 4% | SCLC | 163 | 4% | SCLC | 136 | 4% |

NSCLC = Non-Small Cell Lung Cancer
SCLC = Small Cell Lung Cancer
NHL = Non-Hodgkin Lymphoma

Sarah Cannon Cancer Center

## PRIMARY SITE TABLE

2007 Accessions

| SITE | TOTAL | CLASS | | SEX | | STAGE | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Group | Cases | Ana | NonAn | M | F | 0 | I | II | III | IV | N/A | Unk |
| **ALL SITES** | **4148** | **3827** | **317** | **2162** | **1983** | **236** | **839** | **936** | **498** | **550** | **446** | **322** |
| TONGUE | 27 | 26 | 1 | 20 | 7 | 2 | 6 | 4 | 4 | 5 | 0 | 5 |
| MOUTH, OTHER, & NOS | 17 | 14 | 3 | 12 | 5 | 0 | 6 | 3 | 1 | 2 | 0 | 2 |
| TONSIL | 18 | 18 | 0 | 11 | 7 | 0 | 0 | 3 | 4 | 6 | 0 | 5 |
| PHARYNX | 10 | 10 | 0 | 7 | 3 | 0 | 1 | 4 | 0 | 3 | 1 | 1 |
| ESOPHAGUS | 31 | 29 | 2 | 27 | 4 | 1 | 8 | 2 | 6 | 8 | 0 | 4 |
| STOMACH | 41 | 39 | 2 | 23 | 18 | 0 | 11 | 6 | 3 | 10 | 4 | 5 |
| SMALL INTESTINE | 14 | 13 | 1 | 7 | 7 | 0 | 0 | 0 | 2 | 1 | 9 | 1 |
| COLON | 278 | 253 | 25 | 127 | 151 | 22 | 65 | 55 | 53 | 43 | 1 | 13 |
| RECTUM & RECTOSIGMOID | 127 | 120 | 7 | 72 | 55 | 6 | 26 | 27 | 24 | 20 | 7 | 10 |
| ANUS, ANAL CANAL, ANORECTUM | 23 | 22 | 1 | 4 | 19 | 1 | 4 | 6 | 3 | 2 | 0 | 6 |
| LIVER | 41 | 38 | 2 | 33 | 7 | 0 | 11 | 3 | 4 | 1 | 1 | 18 |
| GALLBLADDER | 9 | 8 | 1 | 3 | 6 | 2 | 1 | 2 | 0 | 2 | 0 | 1 |
| BILE DUCTS | 10 | 10 | 0 | 5 | 5 | 0 | 3 | 3 | 1 | 2 | 0 | 1 |
| PANCREAS | 89 | 88 | 0 | 46 | 42 | 1 | 6 | 18 | 11 | 36 | 3 | 13 |
| OTHER DIGESTIVE | 9 | 9 | 0 | 4 | 5 | 0 | 1 | 0 | 1 | 0 | 6 | 1 |
| LARNYX | 35 | 34 | 1 | 27 | 8 | 1 | 19 | 3 | 5 | 3 | 0 | 3 |
| LUNG/BRONCHUS-SMALL CELL | 145 | 136 | 9 | 66 | 79 | 3 | 16 | 5 | 37 | 69 | 0 | 6 |
| LUNG/BRONCHUS-NON SM CELL | 631 | 588 | 43 | 354 | 277 | 11 | 133 | 38 | 156 | 200 | 5 | 45 |
| PLEURA | 6 | 6 | 0 | 3 | 3 | 0 | 1 | 0 | 0 | 4 | 0 | 1 |
| LEUKEMIA | 79 | 64 | 15 | 43 | 36 | 0 | 0 | 0 | 0 | 0 | 64 | 0 |
| MYELOMA | 46 | 41 | 5 | 21 | 25 | 0 | 0 | 0 | 0 | 0 | 41 | 0 |
| OTHER HEMATOPOIETIC | 53 | 48 | 5 | 21 | 32 | 0 | 0 | 0 | 0 | 0 | 48 | 0 |
| SOFT TISSUE | 19 | 17 | 2 | 7 | 12 | 0 | 3 | 4 | 0 | 2 | 2 | 6 |
| MELANOMA OF SKIN | 116 | 107 | 9 | 63 | 53 | 14 | 30 | 5 | 6 | 5 | 0 | 47 |
| OTHER SKIN CA | 12 | 12 | 0 | 6 | 6 | 0 | 3 | 3 | 1 | 0 | 5 | 0 |
| BREAST | 604 | 560 | 44 | 11 | 593 | 87 | 216 | 147 | 65 | 17 | 1 | 27 |
| CERVIX UTERI | 21 | 18 | 3 | 0 | 21 | 0 | 7 | 2 | 3 | 1 | 0 | 5 |
| CORPUS UTERI | 54 | 51 | 3 | 0 | 54 | 0 | 26 | 3 | 6 | 1 | 3 | 12 |
| OVARY | 44 | 40 | 4 | 0 | 44 | 0 | 6 | 4 | 6 | 18 | 0 | 6 |
| VULVA | 26 | 24 | 2 | 0 | 26 | 17 | 2 | 3 | 2 | 0 | 0 | 0 |
| OTHER FEMALE GENITAL | 6 | 6 | 0 | 0 | 6 | 3 | 2 | 0 | 0 | 1 | 0 | 0 |
| PROSTATE | 667 | 618 | 49 | 667 | 0 | 0 | 1 | 510 | 48 | 26 | 0 | 33 |
| TESTIS | 21 | 19 | 2 | 21 | 0 | 0 | 11 | 2 | 2 | 0 | 1 | 3 |
| BLADDER | 150 | 127 | 23 | 116 | 34 | 60 | 28 | 16 | 6 | 9 | 0 | 8 |
| KIDNEY AND RENAL PELVIS | 139 | 130 | 8 | 91 | 47 | 3 | 83 | 9 | 9 | 17 | 1 | 8 |
| URETER | 7 | 6 | 1 | 3 | 4 | 2 | 2 | 1 | 0 | 0 | 0 | 1 |
| EYE | 10 | 9 | 1 | 5 | 5 | 0 | 4 | 2 | 1 | 0 | 2 | 0 |
| BRAIN | 75 | 72 | 3 | 39 | 36 | 0 | 0 | 0 | 0 | 0 | 72 | 0 |
| OTHER NERVOUS SYSTEM | 70 | 68 | 1 | 18 | 51 | 0 | 0 | 0 | 0 | 0 | 68 | 0 |
| THYROID | 84 | 81 | 3 | 24 | 60 | 0 | 51 | 10 | 2 | 5 | 0 | 13 |
| OTHER ENDOCRINE | 16 | 16 | 0 | 7 | 9 | 0 | 0 | 0 | 0 | 0 | 16 | 0 |
| HODGKIN DISEASE | 21 | 20 | 1 | 12 | 9 | 0 | 5 | 9 | 2 | 3 | 0 | 1 |
| NON-HODGKIN LYMPHOMA | 152 | 122 | 30 | 90 | 62 | 0 | 38 | 24 | 24 | 26 | 0 | 10 |
| Other Sites * | 6 | 6 | 0 | 4 | 2 | 0 | 3 | 0 | 0 | 2 | 0 | 1 |
| UNKNOWN OR ILL-DEFINED | 90 | 85 | 5 | 42 | 48 | 0 | 0 | 0 | 0 | 0 | 85 | 0 |

*Other sites include sites with fewer than five cases each: sinus, penis, and other urinary sites.

# CHAIR REPORT

The year of 2007 was another time of growth and productivity of the Oncology program at Centennial Medical Center and the rest of the TriStar Hospital System. A record number of patients underwent evaluations and treatment, many with very successful outcomes. At Centennial Medical Center, we welcomed improvements and expansion to more specialized areas of the oncology program. Concurrently, many aspects of the program were evaluated and upgraded to maintain our level of excellence.

Construction was completed on our specialized Oncology Unit and Bone Marrow Transplant Unit, both of which opened in May as planned. Many patients have since enjoyed the opportunity for their care to take place in an environment with physical premises and personnel designed specifically for their needs. So far it has been an overwhelming success. Complimenting this was the development of an Oncology Navigator Program, designed to facilitate the connection between the outpatient and inpatient aspects of our patients' care and their educational and social needs. We were pleased to welcome Sharon Moore, RN in October as our Patient Navigator. Thus far, it has been very well received.

For our nursing units, standardized order forms for almost all aspects of oncology inpatient care were created and implemented. We created a specific Central Venous Line Catheter Committee. Their efforts, along with our Quality Assurance Committee, have resulted in a marked decrease in complications of the use of these devices. The unit welcomed the addition of some new oncology nurses, and several of the existing nurses received further certifications in oncologic care. The new Blood and Marrow Transplant Service also welcomed the addition of Dan Couriel, M.D. to assist in further development of this program. The service proudly and successfully completed its first autologous stem cell transplant in the first part of the year, and has performed more since then.

Various cancer conferences were well attended and provided educational and timely information for participants. Over 90% of the cases presented were prospective. Our Registry Personnel and Committee reviewed our data on the incidence of treatment of prostate cancer at Centennial Medical Center and then compared it to the National Data Base. The cancer committee focused on expanding our relationships with the American Cancer Society and the Leukemia Lymphoma Society. These relationships, as well as those of the Minnie Pearl Cancer Foundation and other oncology support institutions, continue to assist in the care of our patients. As in years past, the individuals involved in the Oncology program at Centennial Medical Center remained busy throughout the year, providing a continuum of care and maintaining the level of excellence.

Sincerely,

Anthony A. Meluch, M.D.
Oncology Committee Chair

Centennial Medical Center
TriStar Health System

# Centennial CANCER REGISTRY REPORT 2007

During 2007, a total of 1567 cases were accessioned into the Cancer Data Center's database. Of this number, 1460, or 93%, were newly diagnosed cases. In addition, 107 cases were first seen here in 2007 for treatment for recurrence or progression of their disease.

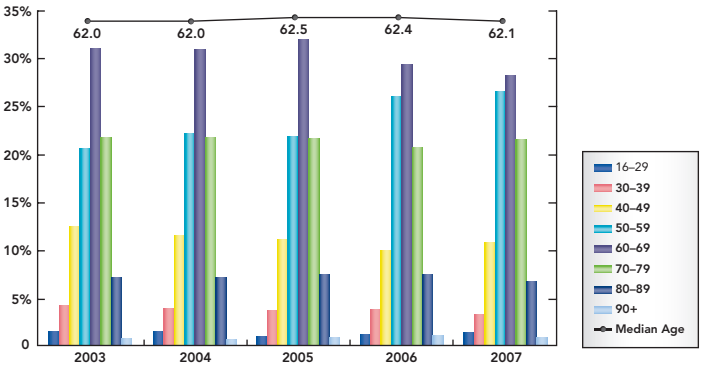
Reviewing the data from 2003–2007, the sites that are the most frequently occurring in our database have remained remarkably the same. Over this period, prostate cancer has been the site with the most cases, accounting for 23%–28% of the total analytic cases annually. Breast and non-small cell lung cancer are second and third each year, although the relative position changes. Colon cancer is the fourth most frequently diagnosed malignancy here. The fifth tumor site varies from year to year, possibly as a reflection of the practice patterns of our medical staff.

| 2003 | | | 2004 | | | 2005 | | | 2006 | | | 2007 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| TOTAL | 1086 | 100% | TOTAL | 1410 | 100% | TOTAL | 1418 | 100% | TOTAL | 1461 | 100% | TOTAL | 1460 | 100% |
| Prostate | 263 | 24% | Prostate | 375 | 27% | Prostate | 324 | 23% | Prostate | 355 | 24% | Prostate | 407 | 28% |
| NSCLC | 169 | 16% | NSCLC | 206 | 15% | Breast | 267 | 19% | NSCLC | 242 | 17% | Breast | 219 | 15% |
| Breast | 152 | 14% | Breast | 173 | 12% | NSCLC | 215 | 15% | Breast | 195 | 13% | NSCLC | 191 | 13% |
| Colon | 64 | 6% | Colon | 91 | 6% | Colon | 76 | 5% | Colon | 80 | 5% | Colon | 65 | 4% |
| NHL | 40 | 4% | SCLC | 47 | 3% | Kidney | 50 | 4% | Kidney | 68 | 5% | Kidney | 54 | 4% |

NSCLC = Non-Small Cell Lung Cancer
NHL = Non-Hodgkin Lymphoma
Kidney includes Renal Pelvis Cancers

## DISTRIBUTION BY AGE AT DIAGNOSIS

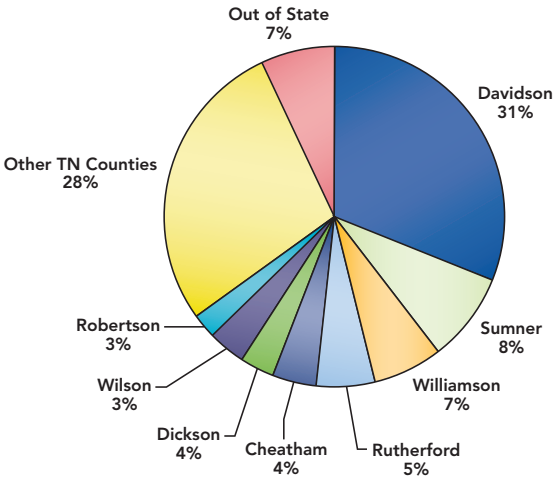
According to the American Cancer Society, "The risk of being diagnosed with cancer increases as individuals age. About 77% of all cancers are diagnosed in persons 55 and older." Our data confirms that most of our patients are older. However, because we are a referral center, about 74% of our patients are 55 or older.




**Distribution by Age at Diagnosis**
**CMC Analytic Cases, 2003–2007**

## DISTRIBUTION BY COUNTY OF RESIDENCE AT DIAGNOSIS – 2007

Almost one-third of our new accessions are among individuals who live in Davidson County at the time of diagnosis. An additional third of the patients live in the eight-county area surrounding Davidson County: Sumner, Williamson, Rutherford, Cheatham, Dickson, Wilson, Montgomery, and Robertson Counties. Seven percent of our new accessions are from states other than Tennessee.



# Centennial
# HEMATOLOGIC MALIGNANCIES SITE REPORT 2007

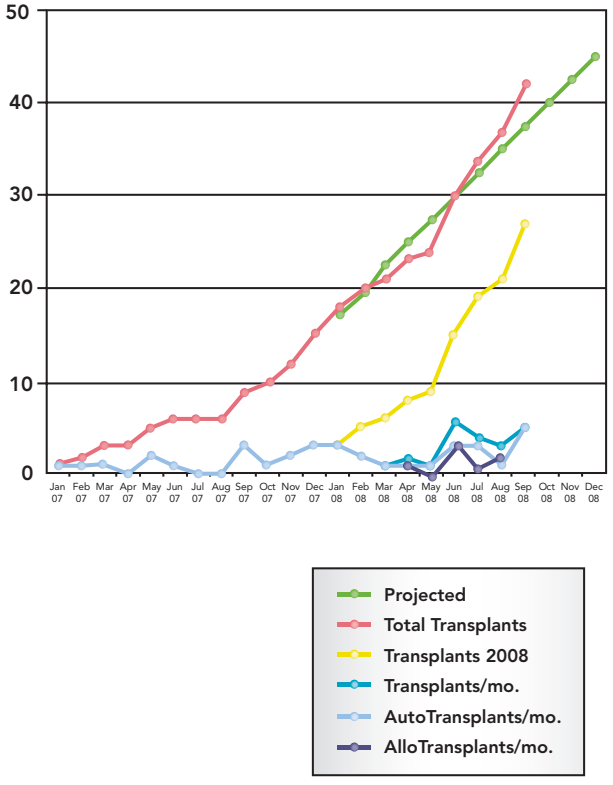
Hematologic malignancies consist of a diverse group of cancers that originate in hematopoietic or lymphoid tissues. These malignancies include acute and chronic leukemias, Hodgkin and Non-Hodgkin lymphoma, multiple myeloma and other very rare cancers. Hematologic malignancies account for nearly 10% of cancers diagnosed in the U. S. each year and 53,000 (9.4%) deaths from cancer in the United States.

The hematologic malignancies have for decades served as the testing ground for developing new cancer therapies. For instance, successes with combination chemotherapy were first seen in hematologic malignancies such as diffuse large-cell lymphoma, acute myelogenous leukemia and Hodgkin disease. Numerous other innovations in cancer therapy were first made in hematologic malignancies such as immunotherapy, blood and marrow transplantation, and differentiation therapy.

The Sarah Cannon Cancer Center at Centennial Medical Center has developed a comprehensive hematologic malignancies program that includes the Sarah Cannon Blood and Marrow Transplant Program, the Leukemia and Hematologic Malignancies Service and a diverse portfolio of clinical trials through its affiliation with the Sarah Cannon Research Institute.

## The Sarah Cannon Blood and Marrow Transplant Program

The Sarah Cannon Blood and Marrow Transplant Program was first formed in December 2006. The BMT program includes a comprehensive group of transplant professionals that guide patients through the transplant process, including three BMT physicians, oncology pharmacists, nurse practitioners, transplant coordinators, program psychologists, social workers, dietitians, case managers and financial coordinators. The program's first transplant was performed in January 2007. Fifteen autologous transplants were completed in 2007 with 100% engraftment and zero mortality. The SCBMTP anticipates more than doubling its volume in 2008. Approximately 40 transplants are projected to be completed in that year. The SCBMTP also began allogeneic transplants in 2007.




SCBMTP has state-of-the-art facilities including new inpatient and outpatient units that were opened in 2007. The outpatient clinic includes a stem cell collection center, private rooms and a 13-chair chemotherapy infusion suite. The inpatient unit

consists of a 25-bed facility for BMT and heme malignancy patients that is HEPA filtered. Adjacent to the inpatient unit is a suite for transfusions of patients and separately a hematopoietic stem cell processing laboratory.

### Hematologic Malignancies Service

There is substantial growth in the hematologic malignancies program. There has been a more than doubling of the level of patients diagnosed elsewhere and referred to Centennial for further management (24 versus 57) between 2005 and 2007. These are predominately patients with acute leukemia. This in-migration of patients is the result of an effort that began in 2006 to centralize acute leukemia care within the TriStar Division. This change was designed to enhance patient care. These changes include sub-specialized physicians, specialized nursing, pathology review by hemato-pathologists, dedicated inpatient/outpatient units, and improved transfusion support and infection prevention measures.

### Clinical Research

Clinical Research is an important part of our hematologic malignancies program. The best care for patients is often through a clinical trial. Through it's affiliation with the Sarah Cannon Research Institute, the patients of the Sarah Cannon Cancer Center have access to a range of clinical trials from early Phase I clinical trials to randomized Phase III studies.

Ian W. Flinn, M.D., Ph.D.
Hematology and Medical Oncology

# CHAIR REPORT

I am so excited to present this 2007 Greenview Regional Hospital Annual Report! The highlight of our year came in October, when we were surveyed by the American College of Surgeons. We have spent the last several years preparing to achieve this goal. The survey went very well. Many of our physicians and allied health personnel were involved in both the planning and the survey itself. We received our report in January, 2008. We were granted a three-year approval with six commendations! We are so proud of this achievement. This is truly a measure of the excellent multidisciplinary quality care that we give our oncology patients.

During 2007, we continued to improve on several aspects of our oncology program. Our Library of Hope was expanded. There is a volunteer now available to assist patients and their families. There is a computer for accessing internet information with a printer. We implemented a policy for ensuring that neutropenic patients are placed in isolation, improving their quality of care.

We continued our monthly Cancer Conferences with presentation of a variety of oncology cases. Images from pathology and radiology are presented. Several aspects of patient treatment and care are discussed. We continue to assess our quality by monitoring pain assessment and intervention, referrals to Reach to Recovery, and review of our prostate cancer data.

Community involvement remains very important to us. We provide education and screenings to many industry partners as well as to our h2u members.

We look forward to a busy 2008, with renewed energy as an approved program.

Cathy Heltsley, M.D.
Oncology Committee Chair

Greenview Regional Hospital
TriStar Health System

# Greenview CANCER REGISTRY REPORT 2007

During 2007, a total of 209 new cases were accessioned into the cancer database at Greenview Regional Hospital. Of these cases, 208 were newly diagnosed cases seen here for diagnosis and/or first course of treatment. These cases are designated as "analytic" cases. Only a single prostate case was "non-analytic," seen here for the first time for progression or recurrence of a previously diagnosed cancer.

When reviewing the most frequently seen types of cases, we see that breast, prostate, colon, and non-small cell lung cancers are among the "top five" sites. This is true, not only here at Greenview, but also nationally. The fifth site here is either melanoma or bladder cancer, reflecting our medical staff composition and practice patterns. Relative position of these sites varies from year to year.

| 2003 | | | 2004 | | | 2005 | | | 2006 | | | 2007 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| TOTAL | 245 | 100% | TOTAL | 278 | 100% | TOTAL | 259 | 100% | TOTAL | 243 | 100% | TOTAL | 209 | 100% |
| NSCLC | 38 | 16% | Breast | 41 | 15% | Breast | 53 | 20% | Breast | 44 | 18% | Breast | 30 | 14% |
| Breast | 34 | 14% | NSCLC | 33 | 12% | NSCLC | 31 | 12% | NSCLC | 37 | 15% | Prostate | 30 | 14% |
| Prostate | 27 | 11% | Colon | 29 | 10% | Colon | 25 | 10% | Prostate | 23 | 9% | Colon | 29 | 14% |
| Mela | 21 | 9% | Prostate | 26 | 9% | Prostate | 24 | 9% | Colon | 20 | 8% | NSCLC | 24 | 11% |
| Colon | 19 | 8% | Mela | 26 | 9% | Mela | 19 | 7% | Bladder | 18 | 7% | Mela | 14 | 7% |

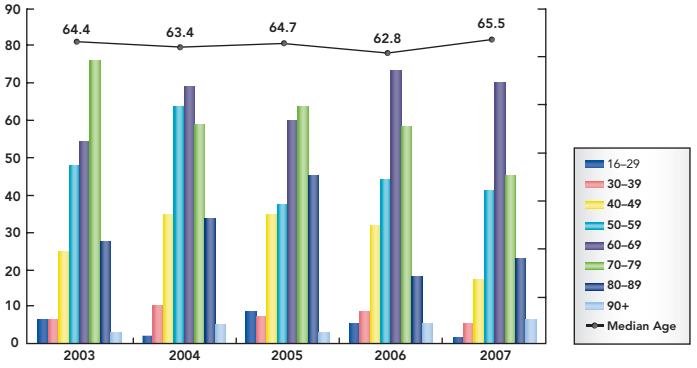
NSCLC = Non-Small Cell Lung Cancer
Mela = Melanoma of the skin only

## ONCOLOGY COMMITTEE MEMBERSHIP

Catherine Heltsley, MD Chair
Leslie Baas
Jamie Bergin, MD
Rocky Billups, RN, MSN
Donna Boden, MD
Kevin Burner, MD
Kathy Crawford, CTR
Brian Fischer, RN
Sue Gulley, RD
Jennifer Hamilton, RHIA
Altricia Harrell, RN
Mylinda King, OTR/L
Anne Leonard, RN
Kris Lowe, RN
Laura Massey, LSW
Harold Nicks, Pharm.D
Kevin Perry, MD
Sue Silcox, RN
Steven Smith, MD
Bonnie Spears, RN
Kelly Wiseman

## DISTRIBUTION BY AGE AT DIAGNOSIS

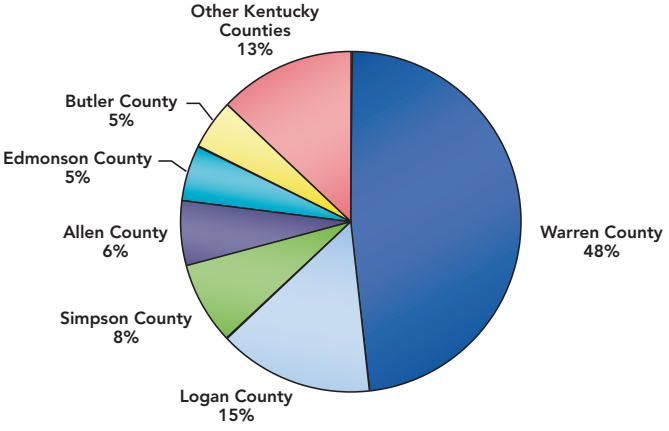
According to the American Cancer Society, “The risk of being diagnosed with cancer increases as individuals age. About 77% of all cancers are diagnosed in persons 55 and older.” This is reflected in our data, with 74–78% of our diagnoses being in persons older than 55, except for 2007, when 81% of our new diagnoses are in individuals 55 and older.




**Distribution by Age at Diagnosis**
**Greenview Accessions, 2003–2007**

## DISTRIBUTION BY COUNTY OF RESIDENCE AT DIAGNOSIS – 2007

About half of our newly diagnosed cancer cases come to us from Warren County. This has been true over the last five-year period, with the actual percentage varying from 40%–51%. The counties located around Warren County account for about 35% of the new cases, with about 15% coming from other counties in Kentucky. Over the past five years, we have had a total of four cases from outside Kentucky.

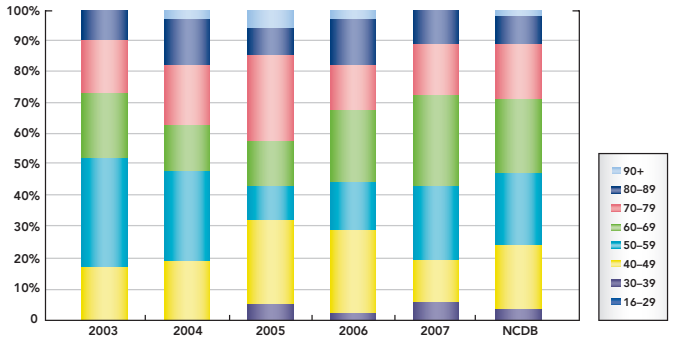


# Greenview
# BREAST CANCER REPORT

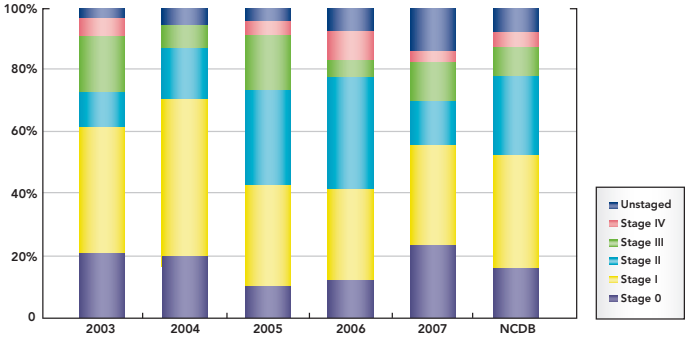
## 2007

Breast cancer continues to be one of the most important health concerns for women. An estimated 182,460 cases of invasive breast cancer are expected to occur among women in the United States during 2008. Breast cancer continues to be the most frequently diagnosed cancer in women. It is expected that there will be over 40,000 breast cancer deaths in 2008. Breast cancer continues to rank second only to lung cancer as a cause of cancer death in women. The positive news is that the death rates from breast cancer have decreased since 1990, with particularly large decreases in women younger than 50. This decrease is attributed to both earlier detection and improved treatment regiments.

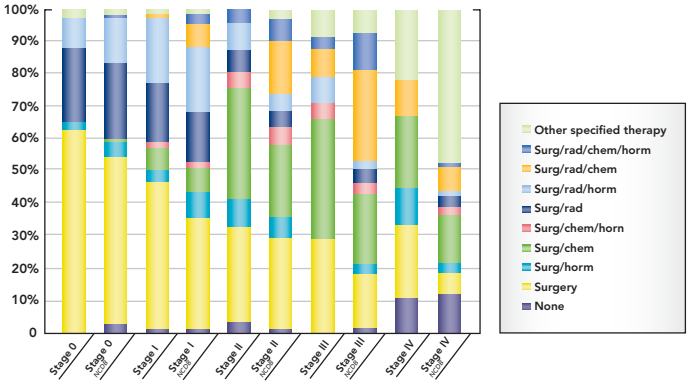
Review of the breast cancer cases at Greenview Regional Hospital demonstrate that the highest number of breast cancer diagnoses were made in women between the ages of 60 and 69. The NCDB data, which is actually from 2005, indicates that on a national basis the highest cases are from 50 to 59 (see graph). Stage of cancer diagnosis is a very important predictor of survival. The graph displayed demonstrates the distribution by stage of diagnosis of Greenview Regional Hospital compared with the NCDB. Stage 0 and Stage 1 cancers were the most common types treated at Greenview in 2007.




**Distribution by Age at Diagnosis**
**Greenview Analytic Breast Cancers compared to NCDB**

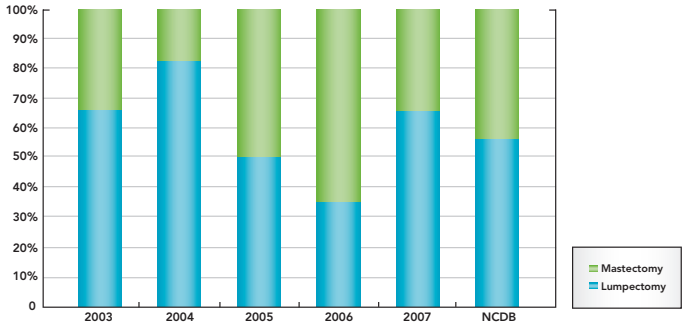



**Distribution by Stage at Diagnosis**
**Greenview Analytic Breast Cancers compared to NCDB**




**First Course of Treatment by Stage at Diagnosis**
**Greenview Analytic Breast Cancers compared to NCDB**

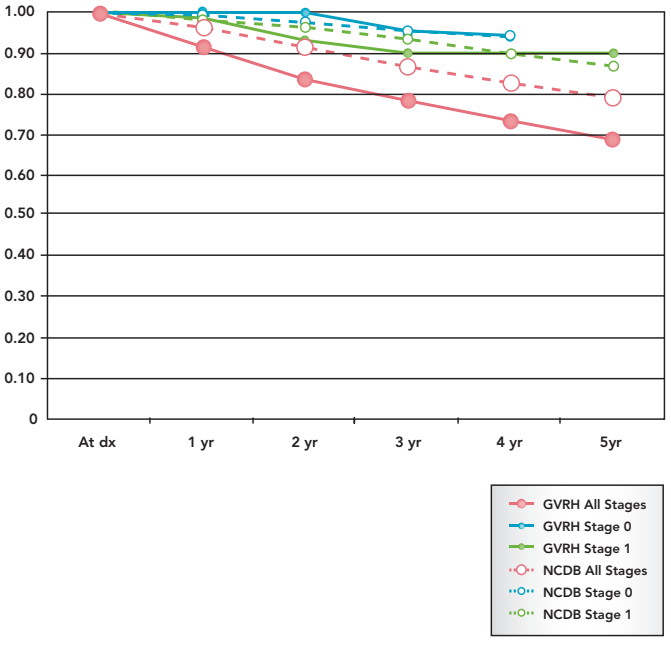
Surgical treatment for breast cancer generally includes breast conservation therapy or mastectomy. Breast conservation therapy includes lumpectomy (which is removal of the tumor with clear margins), as well as radiation therapy. Many studies have proven that long-term survival rates after breast conservation surgery are similar to survival rates with mastectomy. In 2007, breast conservation therapy (lumpectomy plus radiation therapy) actually exceeded the data from the NCDB (see graph).




**Lumpectomy/Mastectomy for Stage 1 & 2 Breast Cancer Treatment**
**Greenview Analytic Breast Cancers compared to NCDB**

The survival data from Greenview Regional Hospital demonstrates a greater than 90% five-year survival in Stage 0 and Stage 1 cases. This is actually higher than the NCDB data, and it emphasizes the importance of early detection and screening (see graph).

**Five-Year Observed Survival**
**Greenview Analytic Breast Cancers compared to NCDB**




Early detection remains the most important factor in the successful treatment of breast cancer. It is important that we continue to encourage women to have yearly physical examinations as well as mammography at the appropriate age. It is also important to increase awareness of genetic factors so that women who are at higher risk can be watched more closely and can be considered for genetic testing, if needed. We continue to look forward to more advances in both screening for breast cancer as well as treatments for this disease, in hopes that there will be a cure for all women.

Mark D. Jessen, M.D., F.A.C.S.

NCDB data from the National Cancer Data Base reflects the 2005 cases submitted by the 122 ACoS approved facilities in the American Cancer Society's Mid-South Division.

# Hendersonville CANCER REGISTRY REPORT 2007

During 2007, a total of 197 cases were accessioned into the Cancer Registry at Hendersonville Medical Center. Of these cases, 189 or 96% were newly diagnosed and presented to Hendersonville for diagnosis, first course of treatment or both. The remaining eight cases had been diagnosed and treated earlier and came to Hendersonville for treatment for recurrence or progression of disease.

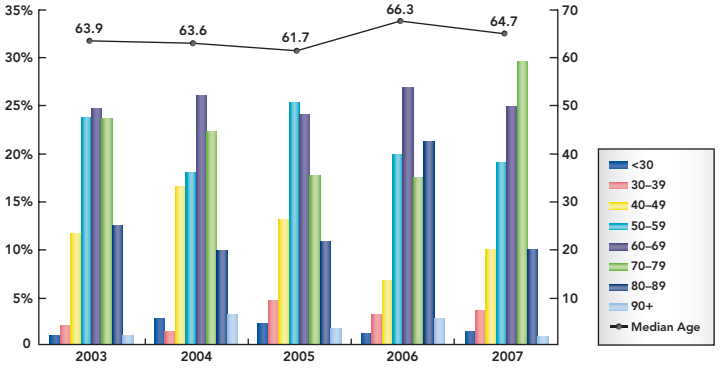
Nationally, the top cancer sites are breast, lung, colon, and prostate. In reviewing the data from Hendersonville, we see that for each of the last five years, our top three sites mirror national data. However, prostate is not one of the top five sites here, most likely due to the practice patterns for urology in this geographical area. Our fourth and fifth sites have varied from year to year.

| 2003 | | | 2004 | | | 2005 | | | 2006 | | | 2007 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| TOTAL | 97 | 100% | TOTAL | 151 | 100% | TOTAL | 190 | 100% | TOTAL | 155 | 100% | TOTAL | 189 | 100% |
| Breast | 22 | 23% | Breast | 23 | 15% | Breast | 39 | 21% | Breast | 22 | 14% | Colon | 30 | 16% |
| NSCLC | 15 | 15% | Colon | 20 | 13% | NSCLC | 24 | 13% | NSCLC | 20 | 13% | Breast | 29 | 15% |
| Colon | 12 | 12% | NSCLC | 16 | 11% | Colon | 20 | 11% | Colon | 15 | 10% | NSCLC | 21 | 11% |
| NHL | 7 | 7% | Bladder | 8 | 5% | Thyroid | 11 | 6% | Thyroid | 13 | 8% | Thyroid | 15 | 8% |
| Tie* | 5 | 5% | Tie** | 7 | 5% | Kidney | 10 | 5% | NHL | 10 | 6% | Kidney | 10 | 5% |

Tie* = Bladder and Kidney with five cases each
Tie** = Melanoma of the skin and Thyroid with seven cases each
NSCLC = Non-Small Cell Lung Cancer
NHL = Non-Hodgkin Lymphoma
Kidney includes Renal Pelvis

## DISTRIBUTION BY AGE AT DIAGNOSIS

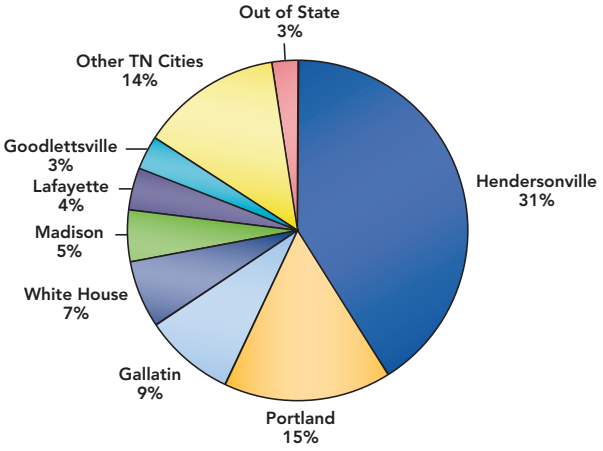
According to the American Cancer Society, “The risk of being diagnosed with cancer increases as individuals age. About 77% of all cancers are diagnosed in persons 55 and older.” Our data confirms that most of our patients are older. Our median age has increased for the past two years, and for each of these years, 77% of our patients are 55 years old or older.




**Distribution by Age at Diagnosis**
**Hendersonville Analytic Cases, 2003–2007**

## DISTRIBUTION BY CITY OF RESIDENCE AT DIAGNOSIS – 2007

As is expected, Hendersonville is home to the largest number of our patients; in 2007, 81 of our cases reported that they lived in Hendersonville. We also continue to see many patients from the surrounding areas, as well as several from Kentucky.



# ONCOLOGY COMMITTEE ACTIVITY

During 2007, the Oncology Committee at Horizon continued to be very active. Participation by the committee was excellent. In January, Natchez Medical Park opened, and we were able to offer Radiation Oncology to our patients.

Cancer conferences were scheduled monthly, as a multidisciplinary venue for discussion of treatment options. These conferences were well attended, and were valued for the opportunity to review diagnostic and treatment information for each case presented. We were also excited that we were able to move our conferences to Natchez Medical Park, and to have the PACS system available for our conferences.

The Cancer Registry, with our registrar, Joan McBee, CTR, met all national standards, and continued to help us stay on track as we anticipate our ACoS Survey next year.

We were involved in the hospital-wide quality initiatives for documentation of blood administration and improvement of patient satisfaction with pain management. In addition we reviewed our experience with colon cancer, comparing our data to that of the National Cancer Data Base.

We continued to be active in our community, with health fairs and many articles in the local papers. We also had much participation in the Relay for Life here in Dickson County.

We look forward to 2008, when we will apply for our Oncology Program to be surveyed by American College of Surgeons.

Horizon Medical Center

TRISTAR HEALTH SYSTEM

Horizon Medical Center had their initial survey by the American College of Surgeons Commission on Cancer on August 14, 2008. As a result, the cancer program received accreditation as a Community Hospital Cancer Program, with all nine commendations for the Outstanding Achievement Award.

## ONCOLOGY COMMITTEE MEMBERSHIP

Stuart Spigel, MD Chair
Stanley Anderson, MD
Rocky Billups, RN, MS
Gina Bullington, RN, MSN
Prakash Chougule, MD
Kathy Crawford, CTR
Terri Dysinger, RN
Ellie Geuss, RT(T), BS
Shanta Hinson, RN MSHSA
Tori Howk
Venk Mani, MD
John Marshall, RRT, PhD
Joan McBee, CTR
Patrick Nicks
Katie Petersen
Mary Piper, RN
Katharine Ray
Kim Sutton, RT(R)(M), BA
Betty Weaver
Eldred Wiser, MD

# Horizon CANCER REGISTRY REPORT 2007

During 2007, a total of 221 cases were accessioned into the Cancer Registry Database at Horizon Medical Center, almost double the 129 from 2006. Of these cases, 203, or 92%, were seen for diagnosis, first course of treatment, or both. These cases are known as “analytic” cases, and are those included when data is analyzed. The other eighteen cases are “non-analytic” cases which came to Horizon for treatment for a recurrence or for persistence of a malignancy which was diagnosed and treated somewhere else.

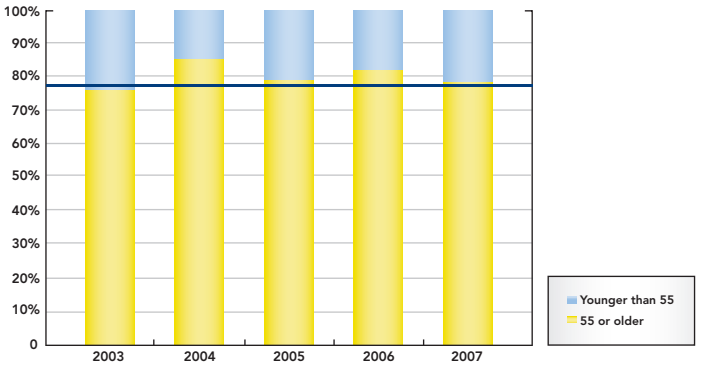
When reviewing the data for the past five years, it is important to remember that the older data was collected to meet the reporting requirements of the Tennessee Cancer Registry, and may not be as inclusive as the data for the past three years. During this five year period, the most frequently occurring cancers were non-small cell lung cancer, colon, and breast cancers, with some variation in relative position. The fourth and fifth sites are different each year, probably reflecting practice patterns in our community.

| 2003 | | | 2004 | | | 2005 | | | 2006 | | | 2007 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| TOTAL | 123 | 100% | TOTAL | 131 | 100% | TOTAL | 148 | 100% | TOTAL | 126 | 100% | TOTAL | 203 | 100% |
| Breast | 24 | 20% | Breast | 25 | 19% | Breast | 29 | 20% | NSCLC | 25 | 20% | Breast | 41 | 20% |
| NSCLC | 17 | 14% | NSCLC | 24 | 18% | NSCLC | 27 | 18% | Colon | 22 | 17% | NSCLC | 32 | 16% |
| Colon | 15 | 12% | Colon | 13 | 10% | Colon | 21 | 14% | Breast | 19 | 15% | Colon | 18 | 9% |
| NHL | 9 | 7% | Prostate | 13 | 10% | Rectum | 7 | 5% | Rectum | 7 | 6% | SCLC | 14 | 7% |
| Rectum | 8 | 7% | SCLC | 8 | 6% | SCLC | 6 | 4% | Mela | 6 | 5% | NHL | 10 | 5% |

NSCLC = Non-Small Cell Lung Cancer
SCLC = Small Cell Lung Cancer
NHL = Non-Hodgkin Lymphoma
Rectum includes Rectosigmoid
Mela = Melanoma of the skin only

## DISTRIBUTION BY AGE AT DIAGNOSIS

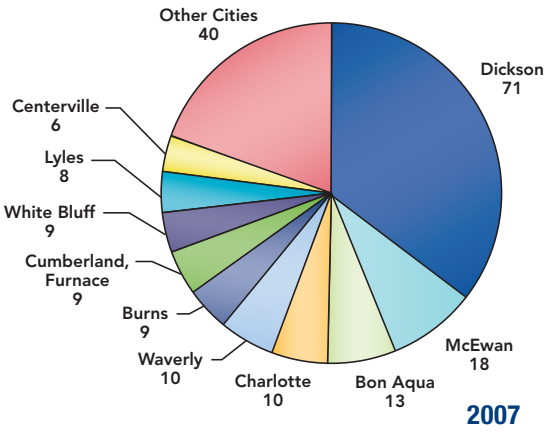
According to the American Cancer Society, "The risk of being diagnosed with cancer increases as individuals age. About 77% of all cancers are diagnosed in persons 55 and older." Our data confirms this increased incidence among older persons. Our population seems to be older than some others, since for this five-year period, about 80% of our patients are 55 or older.



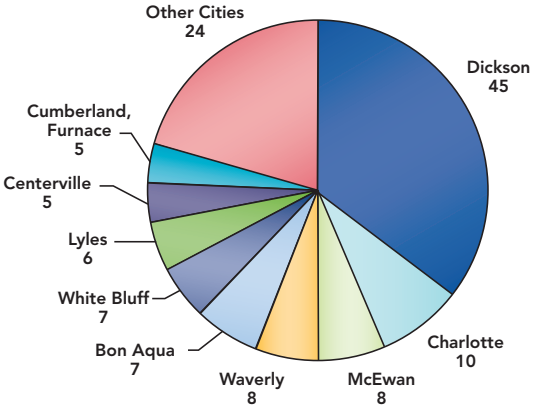

**Distribution by Age at Diagnosis**
**Horizon Analytic Cases, 2003–2007**

## DISTRIBUTION BY RESIDENCE AT DIAGNOSIS – 2006 & 2007

In reviewing the geographic distribution of our analytic cases, it is no surprise to see that for 2006 (bottom pie chart) and 2007 (top pie chart) a third of our patients are from Dickson. The two graphs look remarkably the same, except that the numbers of cases and the relative position of the smaller communities have varied from year to year. 45% come from various small communities nearby, with the remaining 19–20% from other locations.




**2007**




**2006**

# Horizon
# BREAST CANCER REPORT 2007

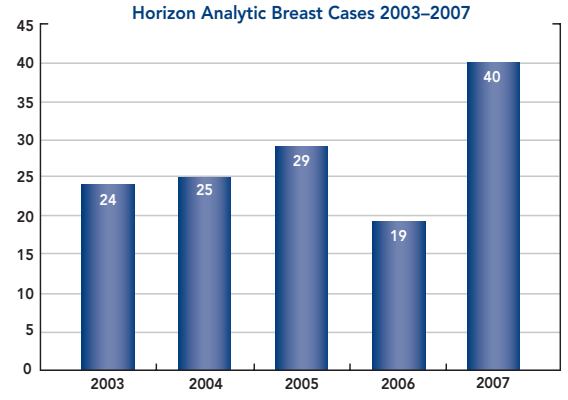
Breast cancer is the most frequently diagnosed cancer in women, excluding cancers of the skin. In 2008 an estimated 182,460 new cases of invasive breast cancer are expected to occur in women and an estimated 40,480 women are expected to die from breast cancer.

During 2007, a total of 40 cases of breast cancer were accessioned into the Cancer Registry Database at Horizon Medical Center. These cases include breast cancers that were diagnosed and/or received some of their first course of treatment at Horizon Medical Center and excludes those that were diagnosed and treated at other facilities and then presented to Horizon for progression or recurrence.

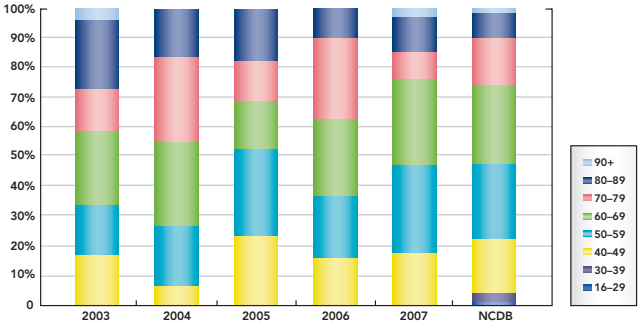
Historical data for each year from 2003 to 2007 indicates the number of breast cancer cases that were diagnosed and/or treated during the past five years at Horizon. Data from 2003 was collected to meet the reporting requirements of the Tennessee Cancer Registry and may not be as inclusive as later data particularly for stage at diagnosis and treatment given. Several more cases of breast cancer were dealt with at Horizon in 2007 than in prior years.

At Horizon Medical Center, similar to the NCDB experience, breast cancer is unusual before age 40, first occurs with frequency in the 40's age group, peaks in the 50's and 60's age groups, and tapers off in the 70's and 80's age groups.

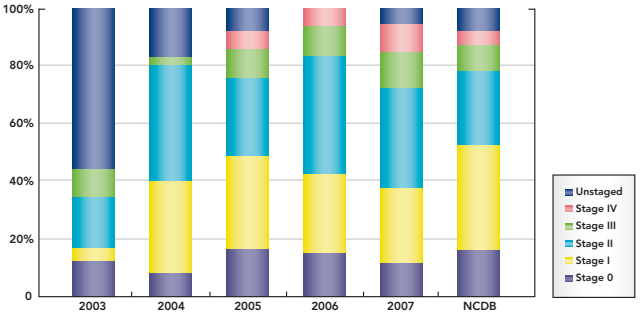
Most breast cancers at Horizon, as in the NCDB experience, are Stage II or less.



Horizon Analytic Breast Cases 2003–2007



Distribution by Age at Diagnosis
Horizon Analytic Breast Cancers compared to NCDB



Distribution by Stage at Diagnosis
Horizon Analytic Breast Cancers compared to NCDB

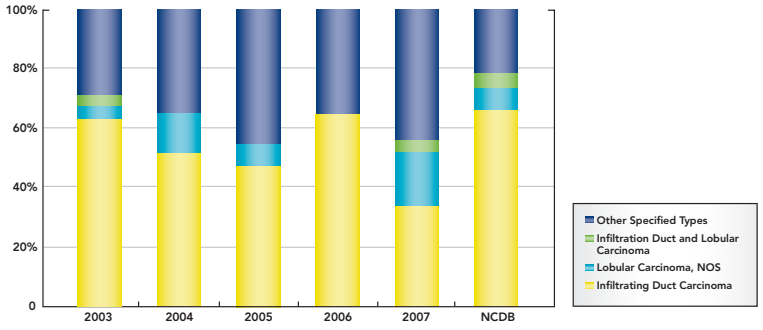
The most common histology of breast cancer at Horizon, as in the NCDB experience, is infiltrating ductal carcinoma.

Treatment for breast cancer includes various combinations of surgery, radiation, chemotherapy, and hormone therapy. Utilization of each of the various combinations of therapy varies according to the stage of the cancer at Horizon, as it does in the NCDB experience.

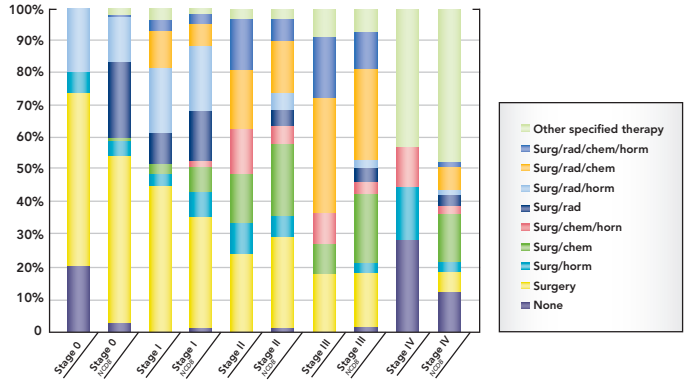
Options for primary surgical management of Stage I & II breast cancer consist of lumpectomy and mastectomy. Both are utilized with frequency at Horizon as well as the NCDB; however, mastectomy was used more frequently than lumpectomy at Horizon and lumpectomy was used more frequently than mastectomy in the data from NCDB.

Observed survival data from Horizon parallels data from NCDB.

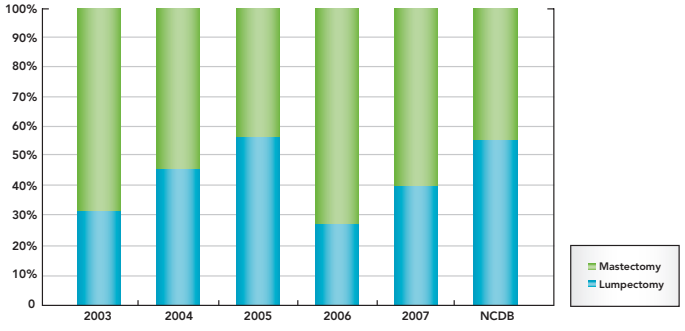
Eldred Wiser, M.D.
Cancer Liaison Physician



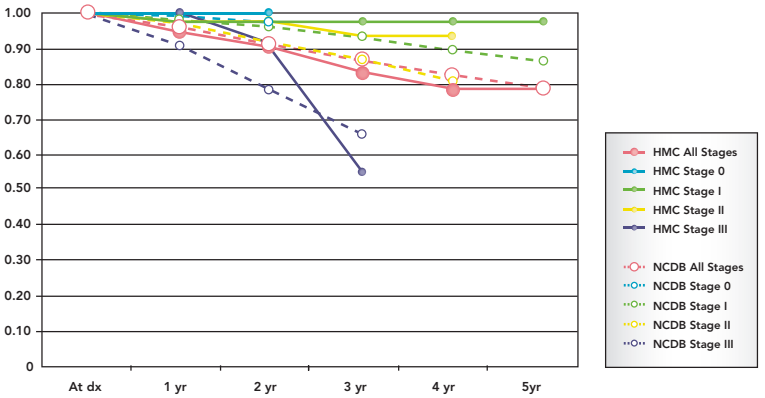

**Distribution by Histology**
**Horizon Analytic Breast Cancers compared to NCDB**




**First Course of Treatment by Stage at Diagnosis**
**Horizon Analytic Breast Cancers compared to NCDB**




**Lumpectomy/Mastectomy for Stage 1 & 2 Breast Cancer Treatment**
**Horizon Analytic Breast Cancers compared to NCDB**




**Five-Year Observed Survival**
**Horizon Analytic Breast Cancers compared to NCDB**

NCDB data from the National Cancer Data Base reflects the 2005 cases submitted by the 122 ACoS approved facilities in the American Cancer Society's Mid-South Division.

# CHAIR REPORT

The calendar year 2007 has been exceedingly rewarding and fruitful for the cancer program here at Parkridge Medical Center. I am pleased to report that the cancer program received accreditation by the American College of Surgeons Commission on Cancer with eight of nine commendations. This places us at the forefront in the community with regard to the College of Surgeons accreditation program as there is no other program in the community with as many commendations. All of the members of the Parkridge cancer program put in a great deal of work to accomplish this task, demonstrating their strong commitment to excellent cancer care at The Sarah Cannon Cancer Center at Parkridge Medical Center.

Cancer patients continue to benefit from the presence of The Sarah Cannon Cancer Center Resource Room located in the lobby of the cancer center. In addition, the ongoing role of oncology nurse navigator has been extremely rewarding for patients and staff alike as significant issues such as financial, social and transportation problems are dealt with so that the patient's care can continue without delay or compromise.

The cancer committee has met regularly to oversee the overall cancer program and to receive the data generated by the Tumor Registry. Meetings have been well attended, and the input of physician and non-physician members was instrumental in helping us achieve accreditation by the American College of Surgeons Commission on Cancer.

The weekly general Tumor Board continues to meet with increasing attendance and broad participation from the medical staff including members of pathology, radiology, medical oncology, radiation oncology, general and surgical oncology, internal medicine, gastroenterology and pulmonary medicine. Additionally, there is a biweekly GYN Tumor Board conference with participation by pathology, radiology, GYN oncology and radiation oncology. Both of these conferences provide useful up-to-date information relating to patient care and clinical research available here at Parkridge Medical Center.

The cancer program is pleased to report ongoing involvement of various members of the cancer program and community outreach programs including bereavement classes, "I Can Cope" classes, support of the Leukemia and Lymphoma Society with "Light the Night" and participation in the Ultimate Drive for Breast Cancer with BMW and, of course, placing a successful team in the American Cancer Society "Relay for Life." Additional programs included participation in the Susan G. Komen "Race For the Cure", a minority health fair and "Look Good Feel Better" as well as a health screening booth at the AIM Center.

Presentations to staff and community through *Health Matters* magazine and televised "Health Breaks" regarding cancer care included six topics. Additional educational topics offered included radio frequency ablation, new indication for Herceptin/Tarceva, utilization of Quadramet with prostate cancer and reduction of pain, radiation therapy, managing malabsorption-related diarrhea, microsatellite instability testing for colon cancer and a lecture on sepsis.

Quality improvements for the year 2007 included a review of dietary consults performed during initial patient evaluation, implementation of a bereavement program, improved utilization of patient resource center by continuing update of content and appearance, improved routine flow of charts between HIM and Tumor Registry for staging form verification, addition of PICC services, implementation of Alaris pumps and improved outpatient chemotherapy employee satisfaction from 72% in 2006 to 97% in 2007; there was a significant overall decrease in turnover rates in this unit.

## CHAIR REPORT CONT.

Future goals include active maintenance of our Commission on Cancer Accreditation and continuing to search for ways to improve the quality of cancer care here at The Sarah Cannon Cancer Center at Parkridge Medical Center.

Stephen L. Golder, M.D.
Cancer Committee Chairman

Parkridge Medical Center
TriStar Health System

### ONCOLOGY COMMITTEE MEMBERSHIP

Stephen Golder, MD Chair
Frank Bradford
Chip Chipman, MD
Todd Cockerham, MD
Wendy Cooley
Stephen DePasquale, MD
Martin Finnegan, MD
Jitendra Gandhi, MD
Harold Head, MD
Shirley Hicks, RN
John House, MD
Michael Howard
Kathryn King, RHIA, CTR
Dean Lenz, MD
Ryan McNamara, MD
Michael Prostko, MD
Chuck Reece
Laura Robinson, RN, BSN, OCN
Donna Sharp
Michael Stipanov, MD
Lynn Swearingen, MD
Ashley Tanis
Jerri Underwood, CNE
Alvaro Valle, MD
Frank Walton
Jamie Welch, MS, RD, LDN, CNM
Laura Witherspoon, MD

# Parkridge
# CANCER REGISTRY REPORT 2007

A total of 570 cancer cases were added to the Parkridge Medical Center's Cancer Registry database for 2007. Of this number, 499 were cases that were newly diagnosed, and were seen here for diagnosis and/or part of the first course of treatment. These cases are called "analytic". In addition, there were 71 cases that were "non-analytic", or cases that were seen here for treatment due to recurrence and/or progression of the patient's cancer.

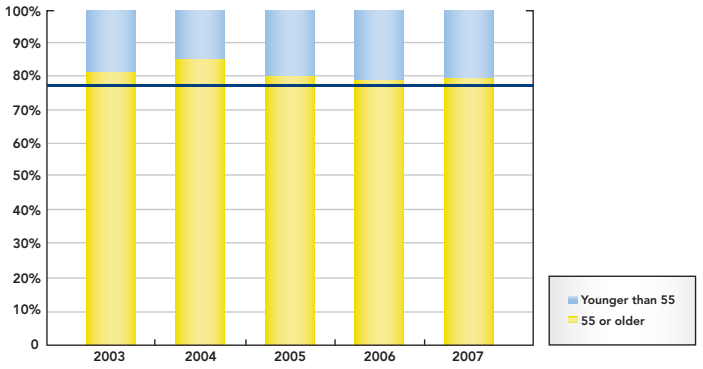
In reviewing the cancer types for the past five-year period, non-small cell lung cancer has been the most frequently diagnosed cancer each year. Prostate and breast malignancies rank second and third each year. The fourth and fifth sites vary from year to year, probably reflecting the practice patterns of physicians in our community.

| 2003 | | | 2004 | | | 2005 | | | 2006 | | | 2007 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| TOTAL | 458 | 100% | TOTAL | 492 | 100% | TOTAL | 500 | 100% | TOTAL | 508 | 100% | TOTAL | 499 | 100% |
| NSCLC | 119 | 26% | NSCLC | 151 | 31% | NSCLC | 124 | 25% | NSCLC | 99 | 19% | NSCLC | 121 | 24% |
| Breast | 47 | 10% | Breast | 41 | 8% | Prostate | 54 | 11% | Prostate | 72 | 14% | Prostate | 77 | 15% |
| Prostate | 46 | 10% | Prostate | 39 | 8% | Breast | 39 | 8% | Breast | 52 | 10% | Breast | 30 | 6% |
| Colon | 43 | 9% | SCLC | 37 | 8% | Colon | 39 | 8% | SCLC | 38 | 7% | Colon | 29 | 6% |
| NHL | 20 | 4% | Tie* | 29 | 6% | Uterus | 30 | 6% | Uterus | 30 | 6% | Uterus | 27 | 5% |

NSCLC = Non-Small Cell Lung Cancer
SCLC = Small Cell Lung Cancer
NHL = Non-Hodgkin Lymphoma
*Tie = Colon and Uterus each with 29 cases in 2004

## DISTRIBUTION BY AGE AT DIAGNOSIS

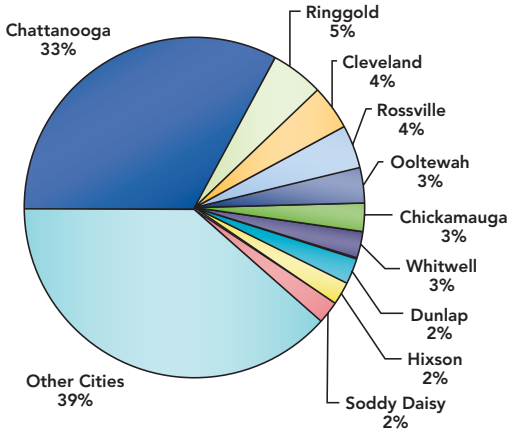
According to the American Cancer Society, “The risk of being diagnosed with cancer increases as individuals age. About 77% of all cancers are diagnosed in persons 55 and older.” This is certainly true here at Parkridge since 79%–85% of our new diagnoses are in patients 55 or older.




**Parkridge 55 and Older at Diagnosis**
**Horizon Analytic Cases, 2003–2007**

## DISTRIBUTION BY CITY OF RESIDENCE AT DIAGNOSIS – 2007

For the analytic cases seen here at Parkridge Medical Center in 2007, one third, or 151 cases, have addresses in Chattanooga. Cities with nine or fewer cases in 2007 are aggregated into the “Other Cities” category.



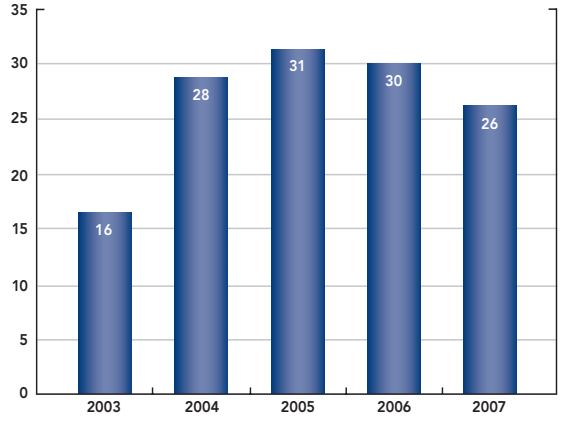
# Parkridge
# UTERINE CANCER SITE REPORT 2007

Adenocarcinoma of the endometrium is the most commonly diagnosed malignancy of the female genital tract in the United States. Approximately 40,000 cases of uterine cancer are diagnosed annually, and 75% of these malignancies are due to adenocarcinoma of the endometrium with uterine invasion. Interestingly the incidence of endometrial cancer has been declining by about 0.8% per year since 1998 after a period of increase during the previous 10-year time interval. American Cancer Society statistics indicate nationwide that approximately 7500 deaths occur due to this malignancy. The death rate has been relatively stable. According to American Cancer Society statistics, uterine corpus malignancies are the fourth most common type of newly diagnosed female cancer, representing approximately 6% of all female malignancies. Correspondingly, breast cancer represents the #1 cancer diagnosis in females at 26%.

The vast majority of patients present with symptoms of abnormal uterine bleeding or spotting. Other symptoms include pain or bleeding following intercourse and generalized pelvic pain. Diagnostic workup generally includes a complete history and physical examination with chest x-ray and CBC. The diagnosis can usually be made by an office endometrial biopsy. Risk factors for endometrial cancer include estrogen exposure, particularly from estrogen replacement therapy (without use of progestin), and obesity. Treatment for uterine malignancies generally involves primary surgery with consideration of radiation therapy, hormonal therapy and/or chemotherapy, depending upon the stage of disease and the patient's overall clinical situation.

American Cancer Society screening recommendations include education for women entering menopause regarding the risks of symptoms of endometrial cancer and the need to report unexpected vaginal bleeding or spotting. Annual screening for endometrial cancer with biopsy beginning at age 35 should be offered to women with or at risk for hereditary non-polyposis colon cancer (HNPCC).

The following analysis includes patients diagnosed and treated for endometrial cancer at Parkridge Medical Center between 2003 and 2007 inclusively. In general, our data compares very favorably when compared with data from the National Cancer Database (NCDB). A more thorough evaluation follows with respect to the numbers of cases diagnosed per year, age at diagnosis, stage, histology, treatment course and overall survival. The number of analytic cases beginning in the year 2003 was the low point for the study with 16 patients accessioned. Following this, between 2004 and 2007 the case number ranged from 26 to a high of 31.

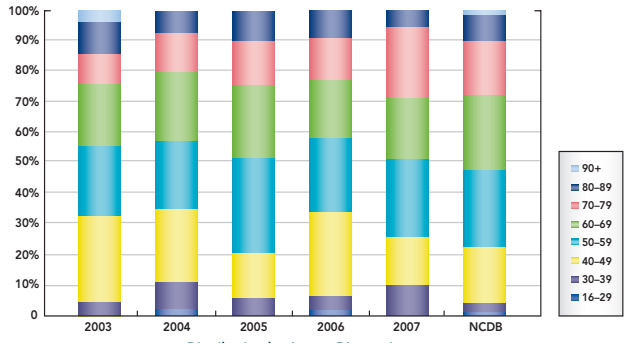



**Parkridge Analytic Uterine Cases 2003–2007**

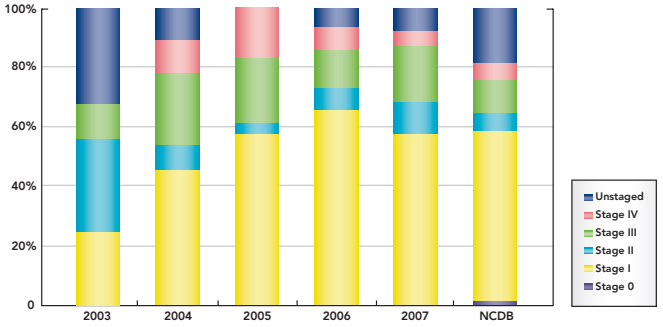
When comparing age at diagnosis in 2007 registry data, we find that the numbers for each year seen at Parkridge Medical Center is comparable to the NCDB data, with the bulk of cases being diagnosed between ages 50 and 80.

With regard to distribution by stage at diagnosis, there was an interesting increase in the percentage of Stage I cancers diagnosed between 2003 and 2006 with a rise from approximately 25% to approximately 68%. During the final year of the study, the percentage of Stage I patients was roughly equivalent to the NCDB data at approximately 60%. It would appear that the relatively low number diagnosed with Stage IV disease in 2003 may reflect the relatively low patient numbers treated here at Parkridge Medical Center that year.

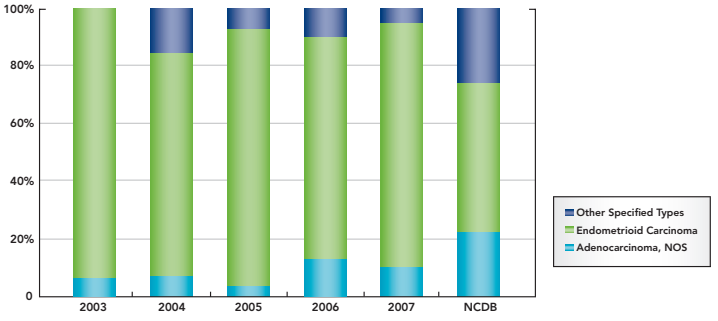
With regard to the histologic distribution of the uterine cancer cases seen in PMC, there is again favorable comparison with the NCDB data bank, although there is, in each year, a lower representation of specified types of malignancy other than endometrioid carcinoma in the Parkridge data. In each year of our study, the vast majority of patients have been endometrioid adenocarcinoma, in keeping with national statistics.




**Distribution by Age at Diagnosis**
**Parkridge Analytic Uterine Cancers compared to NCDB**

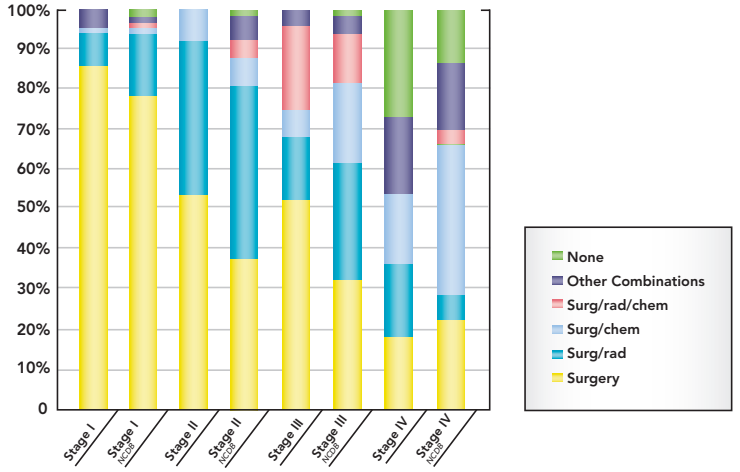



**Distribution by Stage at Diagnosis**
**Parkridge Analytic Uterine Cancers compared to NCDB**



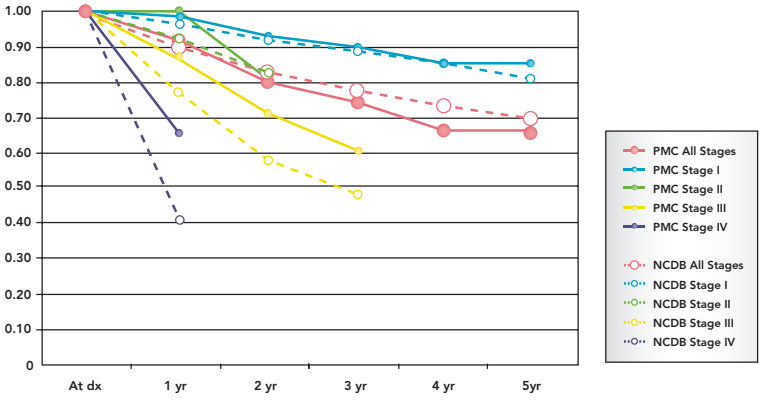

**Distribution by Histology**
**Parkridge Analytic Uterine Cancers compared to NCDB**

With regard to the first course of treatment by stage at diagnosis, this again compares favorably with the NCDB data, particularly for Stage I and Stage II disease. Stage III disease treated at Parkridge tended to have approximately 20 percentage points greater use of surgery than the NCDB data and correspondingly less use of surgery and chemotherapy as well as the combination of surgery and radiation therapy. However, more patients with Stage III at Parkridge were treated with a combination of surgery and radiation therapy and chemotherapy than in the NCDB data. Review of Stage IV uterine cancer management indicates approximately twice as many patients not offered aggressive therapy as reflected in the NCDB statistics with a corresponding drop in the rate of use of surgery and chemotherapy. There was an increased use of a combination of surgery and radiation therapy as opposed to the national data.




**First Course of Treatment by Stage at Diagnosis**
**Parkridge Analytic Uterine Cancers compared to NCDB**

Analysis of five-year observed survival data with comparison between Parkridge Medical Center data and NCDB data indicates excellent correlation in survival for patients with Stage I and Stage II disease. Parkridge Medical Center data actually exceeds the national average in one, two and three-year survival for Stage III patients and also exceeds the one-year survival comparing to the NCDB data for Stage IV patients.




**Five-Year Observed Survival**
**Parkridge Analytic Uterine Cancers compared to NCDB**

In conclusion, the cancer registry data from The Sarah Cannon Cancer Center at Parkridge Medical Center is very consistent with the NCDB data and actually shows improved survival statistics for patients with Stage III and Stage IV disease treated here compared to the National Cancer Database. The data reflects appropriate use of treatment modalities and treatment combinations including surgery, radiation therapy and chemotherapy and correlates well with practice trends documented by the National Cancer Data Base.

NCDB data from the National Cancer Data Base reflects the 2005 cases submitted by the 114 ACoS approved facilities in the American Cancer Society's Mid-South Division.

Stephen L. Golder, M.D.
Stephen E. DePasquale, M.D.
Donald H. Chamberlain, M.D.

# ONCOLOGY COMMITTEE ACTIVITY

The year 2007 was another active year in oncology here at Skyline Medical Center. We remain involved in all areas of the care of our oncology patients as well as educating the community.

Our Cancer Conferences were well attended by a variety of physicians representing multiple specialties, as well as many allied health personnel. Many cases were presented, and treatment options were discussed.

Our Cancer Registry continues to do an excellent job, identifying cases and abstracting the data required by the state as well as by the Commission on Cancer. All benchmarks were met, and timeliness and reporting measures were exceeded.

During the year, the committee was involved in two quality monitoring projects: improving the documentation of reassessment of pain following intervention and screening high-risk patients for MRSA. In addition, there were several improvements in patient care: a new CT scanner was installed; new IV pumps allow additional medication safety measures; a new probe for use in Sentinel Lymph Node biopsies is now available; and a new protocol for head and neck radiation therapy patients was instigated, requiring swallowing evaluation and exercises prior to beginning treatment.

There were several events offered to the community, including the Annual Cancer Symposium, where risk assessment material was distributed, and physicians presented oncology updates.

We look forward to an active 2008, with continued enthusiasm.

Skyline Medical Center
TriStar Health System

## ONCOLOGY COMMITTEE MEMBERSHIP

William Liggett, MD Chair
My Nguyen, M.D. Vice-Chair
Janet Barcroft, RD
Kirk Barnes, MD
Kenneth Bartholomew, MD
Rocky Billups RN, MS
Kathy Crawford, CTR
Carol Draper, RHIT
Michael Ellis, MD
Karen Giorgio
Thomas Hanes, MD
Johnny Harrison
Steven Hawkins, RN
Barbara Haynes
Bassam Helou, MD
Donna Herrington, CTR
Amy Johnson, PhD
Carol Knap, RN
Julie Mathias
Joy McCloud, CTR
Janice McKenzie
Tara Millette, RN
Greg Neal, MD
Cathy Pearce, RN
Rick Phillips
Katharine Ray
Shelley Sircy, RN
Alison Summers
Rebecca Taylor
Melissa Waddey
Harry Yates

# Skyline CANCER REGISTRY REPORT 2007

During 2007, a total of 599 cases were entered into the Skyline Medical Center Cancer Registry data base. Of these cases, 541, or 90%, were cases that were newly diagnosed here or had at least some of the first course of treatment here. The other 58 cases were seen here for recurrence or progression of a cancer that was diagnosed and treated elsewhere.

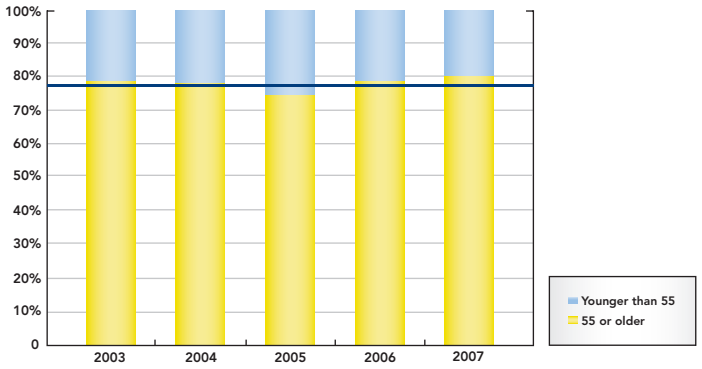
In reviewing our most frequently occurring cancers, we see that for the past five years, non-small cell lung cancer and breast cancer are seen most often here. Prostate, colon, small-cell lung cancer, and melanoma make up the annual list of the "top five" sites.

| 2003 | | | 2004 | | | 2005 | | | 2006 | | | 2007 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **TOTAL** | **453** | **100%** | **TOTAL** | **520** | **100%** | **TOTAL** | **598** | **100%** | **TOTAL** | **678** | **100%** | **TOTAL** | **599** | **100%** |
| NSCLC | 104 | 23% | NSCLC | 95 | 18% | NSCLC | 103 | 17% | NSCLC | 117 | 17% | NSCLC | 103 | 17% |
| Breast | 78 | 17% | Breast | 76 | 15% | Breast | 103 | 17% | Breast | 111 | 16% | Breast | 84 | 14% |
| Colon | 48 | 11% | Colon | 40 | 8% | Colon | 42 | 7% | Colon | 41 | 6% | Prostate | 48 | 8% |
| Prostate | 35 | 8% | SCLC | 31 | 6% | Prostate | 36 | 6% | SCLC | 40 | 6% | Colon | 41 | 7% |
| SCLC | 25 | 6% | Mela | 20 | 6% | Mela | 31 | 5% | Prostate | 37 | 5% | SCLC | 32 | 5% |

NSCLC = Non-Small Cell Lung Cancer
NHL = Non-Hodgkin Lymphoma
Kidney includes Renal Pelvis Cancers
Mela = Melanoma of the skin only

## DISTRIBUTION BY AGE AT DIAGNOSIS

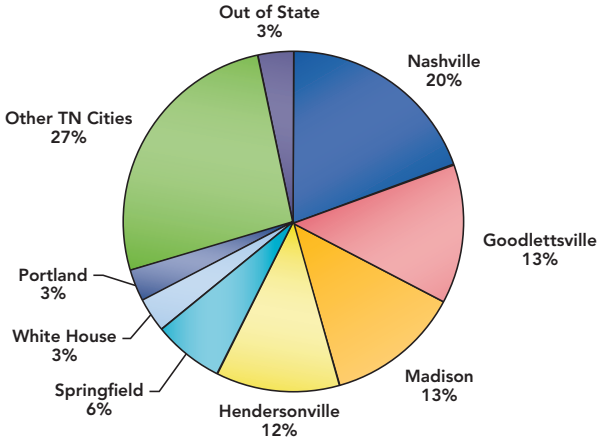
According to the American Cancer Society, "The risk of being diagnosed with cancer increases as individuals age. About 77% of all cancers are diagnosed in persons 55 and older." Our data confirms that most of our patients are older. Except for 2005, 78%–80% of our patients are 55 or older at diagnosis.




**Patients 55 and Older at Diagnosis**
**Skyline Analytic Cases, 2003–2007**

## DISTRIBUTION BY RESIDENCE AT DIAGNOSIS – 2007

In reviewing where our newly-diagnosed patients lived at the time of their diagnosis, 20% reported that they lived in Nashville. Half of the cases came from smaller municipalities close to our facility. A quarter of all of the cases came from locations in Tennessee, but with fifteen or fewer cases per town. Three percent, or sixteen cases, came from out of state, primarily from Kentucky.



# Skyline BREAST CANCER REPORT 2007

Skyline Medical Center has continued to maintain a collaborative association with the American College of Surgeons, the Commission on Cancer, and the National Cancer Data Base. The Skyline Cancer Committee routinely reviews our local data to identify areas of improvement and accomplishments. Along with the American Cancer Society, we strive to impact and improve cancer care for our local community. With the efforts of our staff and physicians, we have maintained our status as an accredited cancer center.

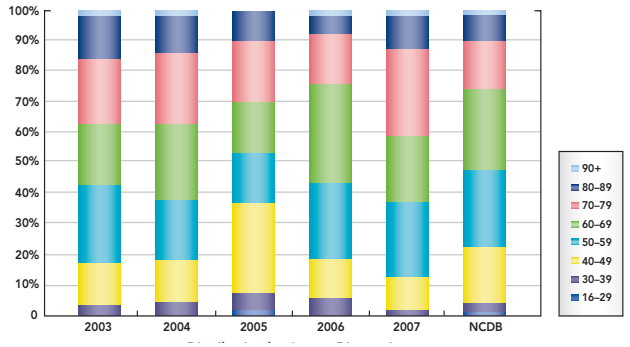
The Cancer Committee has chosen Breast Cancer as our site specific area of review for 2007. This site specific report provides an in-depth evaluation of our local medical community and compares those results to regional and national levels. These trends allow us to highlight areas in which we excel and assess protocols we can influence positively in a qualitative manner.

Traditionally, the month of October is Breast Cancer Awareness month. Skyline acknowledges this by presenting a pink rose to every mammogram patient during the month. Nationally, many awareness activities are promoted by celebrities and politicians alike whose lives have been touched by this disease. In 2008, 182,000 new cases of breast cancer will be diagnosed and almost 4,000 cases will be in Tennessee. Breast cancer remains the most common cancer found in females and the second most common cause of cancer deaths. Males are not immune to the disease as almost 1% of breast cancer occurs in men. Additionally, 67,000 cases of insitu or noninvasive cancers are expected to occur in 2008. These statistics emphasize our focus to encourage screening for early detection and treatment of women at risk for breast cancer.

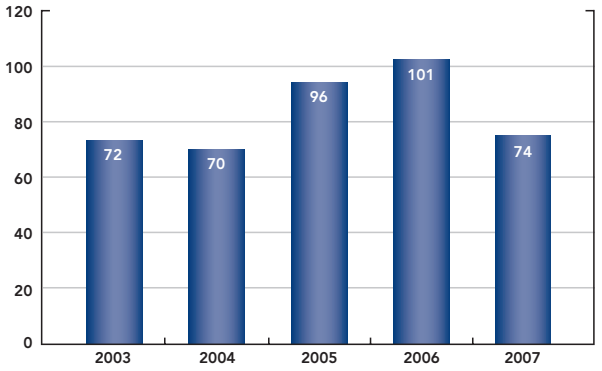
The earliest sign of breast cancer is often an abnormality detected on a mammogram. Many are found even before they can be palpated. Skyline has been a leader in promoting digital mammography. This method has not only improved patient satisfaction by decreasing exam times and callbacks, it has also improved the image quality and clarity and allowed better examinations in dense breast tissue. Computer aided detection has also been employed and is estimated to improve detection rates by over 25%. Other symptoms of cancer include palpable lumps, skin changes or spontaneous nipple discharge. Another modality recently implemented includes the use of MRI to help diagnose difficult patients. Risk factors, in addition to being female, include age and family history. Skyline has evaluated the use of DNA sampling to detect inherited genetic mutations in BRCA1 and BRCA2 genes to counsel patients on treatment protocols. Additional histories of breast disease, reproductive statistics, and lifestyle factors also influence the risk of being affected.

As with most cancers, onset after age 50 shows statistical significance. Approximately 75% of the cases seen at Skyline occurred between the ages of 50-79, compared to 67% nationally. However, the number of cases reviewed in 2007 was significantly less than the number seen in the previous two years. These numbers have likely been affected by the establishment of dedicated breast centers at competitive community medical centers that effectively market the community through local media outlets.

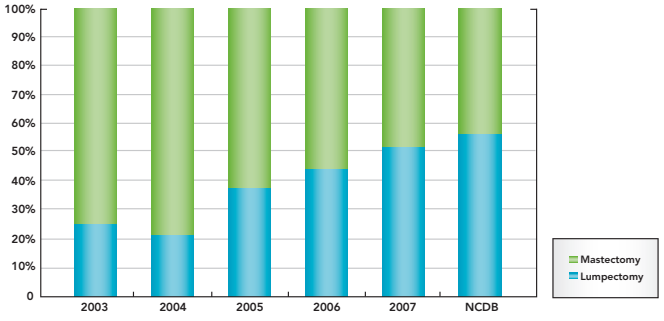
Surgery remains the most effective initial treatment modality following diagnosis. Depending on the size, location, lymph node status and patients concerns, options include mastectomy or lumpectomy followed by radiation therapy. Early stage cancers are most often candidates for cosmetic conservative management. The chart to the left compares Skyline's mastectomy rates to the National Data Base statistics. They are not significantly different at 48 and 43% respectively.




**Distribution by Age at Diagnosis**
**Skyline Analytic Breast Cancers compared to NCDB**



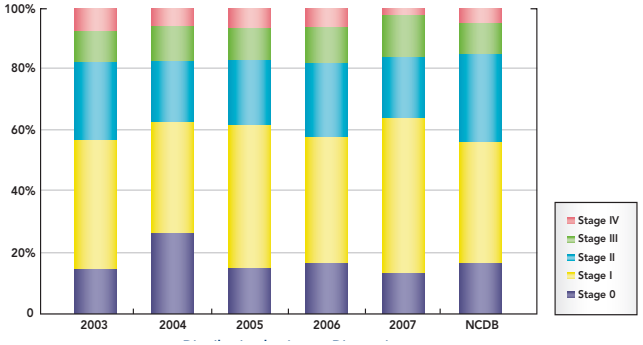

**Skyline Analytic Breast Cases 2003–2007**



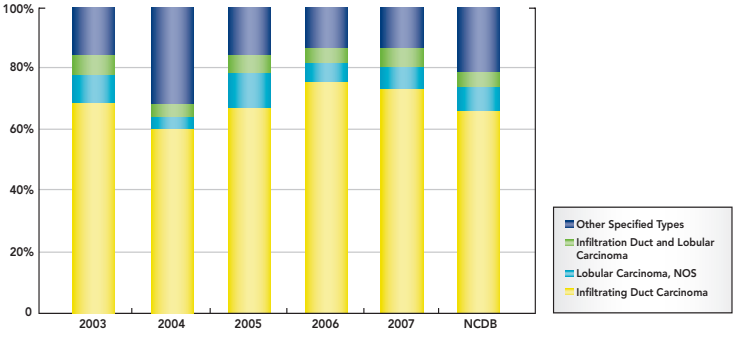

**Lumpectomy/Mastectomy for Stage 1 & 2 Breast Cancer Treatment**
**Skyline Analytic Breast Cancers compared to NCDB**

Staging of breast tumors is related to the size of the cancer and the involvement of the lymph nodes or distant metastatic disease. Early detection of lesions increases the likelihood of early stage disease and longer 5 year survival rates. Skyline had a significant number of cases diagnosed in Stage I compared to national data. Our assumption is that we are promoting better screening and pursuing mammographic abnormalities aggressively for earlier diagnosis. The distribution of histology has remained fairly steady over the last three years and parallels the national norms. Infiltrating Ductal Carcinoma remains the most common type of breast cancer accounting for 70-75% of microscopic findings.

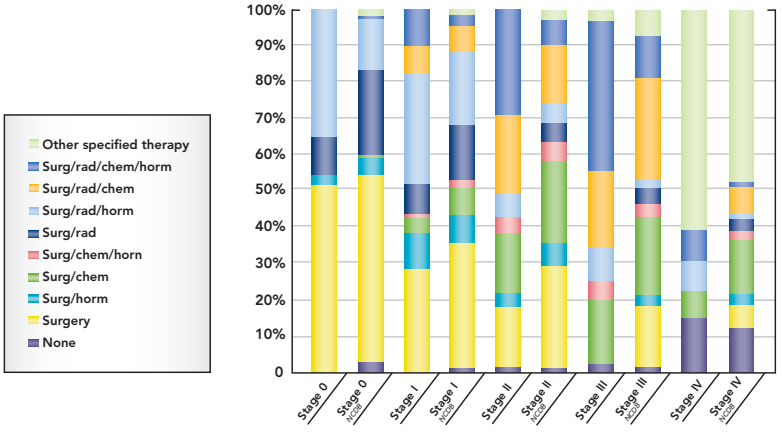
Following surgery, treatment and survival depends on the stage at diagnosis. Postoperative treatment involves radiation therapy for lumpectomies. Hormonal therapy and chemotherapy are also options depending on receptor status and lymph node involvement.




**Distribution by Stage at Diagnosis**
**Skyline Analytic Breast Cancers compared to NCDB**




**Distribution by Histology**
**Skyline Analytic Breast Cancers compared to NCDB**

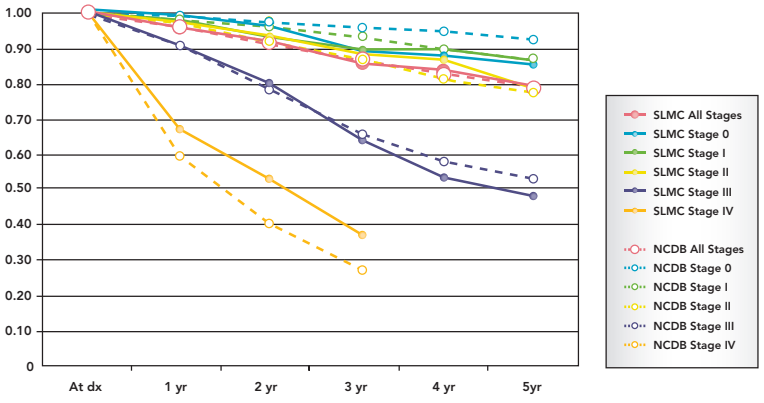



**First Course of Treatment by Stage at Diagnosis**
**Skyline Analytic Breast Cancers compared to NCDB**

Skyline oncologists continue to enroll patients with aggressive disease in clinical trials using targeted therapy in HER2/neu positive patients using Herceptin with encouraging results. A review of our data illustrates how the role of surgery combined with radiation and hormonal therapy correlates with early stage disease and chemotherapy is more prominent in advanced cases stage for stage.

Obviously, survival is the overall measure of success in treatment. Five year survival rates for localized cancer have improved to 98% from earlier studies.

For patients with positive lymph nodes, survival drops to 84% at five years and progresses to 25% for patients with metastatic disease. This graph demonstrates Skyline's survival rates compared to National Data Base figures with no statistical differences. Our survival rates indicate the standard of care that exists within our treatment modalities and speaks highly of our surgical and medical specialists. Surveillance in these populations is also enhanced by follow up PET scans at regular intervals which allow us to address recurrent disease early and aggressively.




**Five-Year Observed Survival**
**Skyline Analytic Breast Cases compared to NCDB**

NCDB data from the National Cancer Data Base reflects the 2005 cases submitted by the 122 ACoS approved facilities in the American Cancer Society's Mid-South Division.

There is a national effort by the National Quality Forum to monitor and report on the quality of cancer patient care at each facility. This report is based on the cancer registry data that is submitted to the National Cancer Data Base (NCDB) and is actually a measure of the completeness of data. It remains imperative that we support the efforts of our cancer registry staff to collect this data, including physician follow-up office reports. Currently, three breast cancer measures are being compared. The measures include: lumpectomy followed by XRT, estrogen and progesterone receptor positive tumors and hormone therapy, and chemotherapy for tumors larger than one centimeter with positive lymph nodes and negative hormone receptors.

## Patients receiving breast conserving surgery who are under age 70 should receive radiation therapy. [BCS/RT]

| | NCDB DATA DIAGNOSIS YEAR | | | NOT ON NCDB YET | | |
|---|---|---|---|---|---|---|
| | 2003 | 2004 | 2005 | 2006 | 2007 | TOTAL |
| Estimated Performance Rate | 89% | 100% | 93% | 88% | 83% | 90% |
| Cases Eligible | 18 | 19 | 27 | 26 | 23 | 113 |
| Cases without RT documented | 2 | 0 | 2 | 3 | 4 | 11 |
| Concordant Cases | 16 | 19 | 25 | 23 | 19 | 102 |

## Patients with Stage I (tumor size > 1cm and N0) or Stage II/III (any tumor size and N+), with ER/PR- tumors and who are under age 70 should receive or be considered for combination chemotherapy. [MAC]

| | NCDB DATA DIAGNOSIS YEAR | | | NOT ON NCDB YET | | |
|---|---|---|---|---|---|---|
| | 2003 | 2004 | 2005 | 2006 | 2007 | TOTAL |
| Estimated Performance Rate | 100% | 100% | 100% | 90% | 100% | 97% |
| Cases Eligible | 7 | 8 | 5 | 10 | 6 | 36 |
| Cases without chemo documented | 0 | 0 | 0 | 1 | 0 | 1 |
| Concordant Cases | 7 | 8 | 5 | 9 | 6 | 35 |

## Patients with Stage I (tumor size > 1cm and N0) or Stage II/III (any tumor size and N+), with ER+ or PR+ tumors should receive or be considered for hormone therapy (Tamoxifen or third generation Aromatase Inhibitor). [HT]

| | NCDB DATA DIAGNOSIS YEAR | | | NOT ON NCDB YET | | |
|---|---|---|---|---|---|---|
| | 2003 | 2004 | 2005 | 2006 | 2007 | TOTAL |
| Estimated Performance Rate | 100% | 93% | 88% | 63% | 61% | 82% |
| Cases Eligible | 26 | 28 | 32 | 27 | 23 | 136 |
| Cases without hormone tx documented | 0 | 2 | 4 | 10 | 9 | 25 |
| Concordant Cases | 26 | 26 | 28 | 17 | 14 | 111 |

In conclusion, breast cancer diagnosis and treatment has evolved into a collaborative multidisciplinary approach. Future direction will continue to concentrate on genetic modalities and minimizing the extent of invasive treatments without compromising survival or local controls. Skyline's support staff and medical staff will continue to strive for leadership in this valuable effort.

Gregory E. Neal, M.D.
Cancer Liason Physician

# CHAIR REPORT

Two thousand and seven proved to be another productive year for the Southern Hills Medical Center Cancer Committee. We continue to have a lively, informative, and well attended tumor conference monthly. Our committee also continues to play an active roll in monitoring and managing all aspects of cancer care that occur on our campus.

The Southern Hills Cancer Committee had two key areas of focus this year: a breast health initiative and an inpatient pain control initiative.

In regards to our breast heath initiative, the Cancer Committee was instrumental in bringing breast MRI capabilities to our campus. In 2007, the Southern Hills Medical Center became the first TriStar hospital to offer breast MRI. This cutting-edge technology will greatly improve our ability to screen for and diagnose breast cancer. Our committee is actively involved in educating the Nashville community about this exciting and useful technology. Championed by one of our leading general surgeons, James T. Ettien, M.D., we also announced the addition of mammotome biopsy to our campus. This will greatly streamline minimally invasive breast cancer diagnosis.

Pain control, both for postoperative patients and patients with chronic cancer pain, is chronically under-treated based upon national data. The Cancer Committee and the entire Southern Hills Medical Center chose to implement a campus-wide initiative to address this problem. We now have a systematic method to access, quantitate and reassess pain using validated pain scales.

Our Cancer Committee chose to perform a detailed analysis of our cancer registry data for kidney cancer. We compared our data to both local and national registry data.

As committee chair, I want to thank our committee members for their outstanding contributions to this worthwhile endeavor. We look forward to another productive year in 2008, when we will participate in our re-survey by the ACoS.

Jeff Patton, M.D.
Oncology Committee Chair

Southern Hills Medical Center
TriStar Health System

## ONCOLOGY COMMITTEE MEMBERSHIP

Jeffrey Patton, MD Chair
Karen Baker
Rocky Billups, RN, MS
Jennifer Brown, CTR
Travis Capers
Brad Cohen, MD
Kathy Crawford, CTR
James Ettien, MD
Veronica Gammons, RN, CCM
Andrea Jackson, PT
Adrian Lamballe, MD
Cay Lavender, RN
Brenda Logan, RN
Eugene Nelson, MD
Kim Smith, LPN
Chris Staigl, RN
Elisa Stephens, RN
Rebecca Taylor

# Southern Hills CANCER REGISTRY REPORT 2007

During 2007, a total of 149 cases were added to the Cancer Registry database at Southern Hills Medical Center. Of this number 148 were analytic cases; these cases were newly-diagnosed and were seen here either for diagnosis or for first course of treatment. There was one non-analytic case seen here for the first time in 2007 for progression or recurrence of a malignancy that was diagnosed and treated elsewhere.

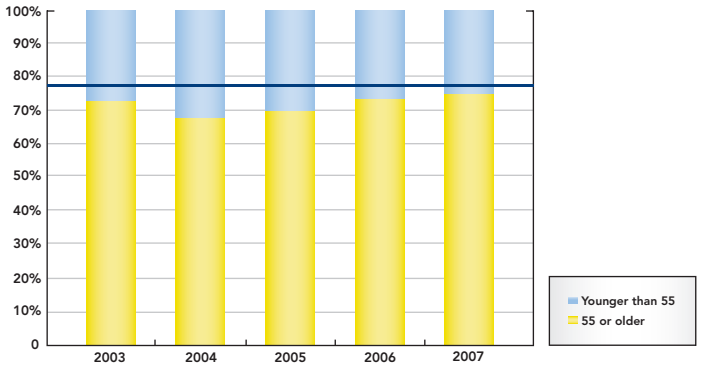
The total number of analytic cases accessioned has decreased during the past year. Non-small cell lung cancer, breast and colon cancer have been the three most-frequently seen cancer diagnoses here, although there has been some variation in the relative order. The fourth and fifth most-frequently seen malignancies have varied from year to year, and this variation is probably the result of the composition of our medical staff and referral patterns.

| 2003 | | | 2004 | | | 2005 | | | 2006 | | | 2007 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| TOTAL | 151 | 100% | TOTAL | 182 | 100% | TOTAL | 179 | 100% | TOTAL | 182 | 100% | TOTAL | 148 | 100% |
| NSCLC | 27 | 18% | Breast | 39 | 21% | NSCLC | 37 | 21% | NSCLC | 33 | 18% | NSCLC | 24 | 16% |
| Breast | 20 | 13% | NSCLC | 31 | 17% | Breast | 29 | 16% | Breast | 26 | 14% | Breast | 18 | 12% |
| Colon | 15 | 10% | Colon | 18 | 10% | Colon | 16 | 9% | Colon | 22 | 12% | Colon | 11 | 7% |
| Rectum | 8 | 5% | Rectum | 16 | 9% | NHL | 9 | 5% | Prostate | 10 | 5% | NHL | 9 | 6% |
| NHL | 8 | 5% | Bladder | 10 | 5% | Kidney | 8 | 4% | Kidney | 9 | 5% | Kidney | 8 | 5% |

NSCLC = Non-Small Cell Lung Cancer
NHL = Non-Hodgkin Lymphoma
Rectum includes rectosigmoid
Kidney includes Renal Pelvis Cancers

## DISTRIBUTION BY AGE AT DIAGNOSIS

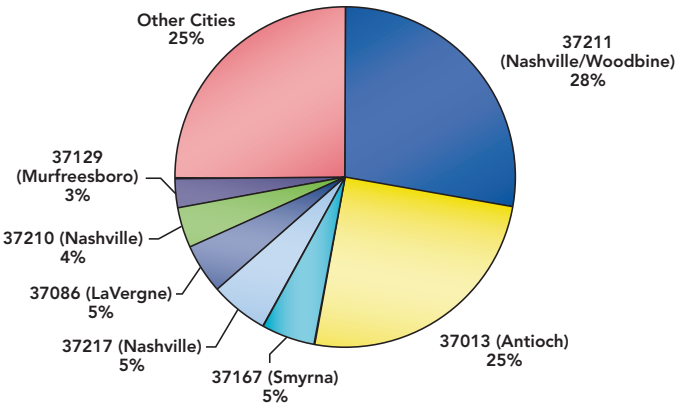
According to the American Cancer Society, "The risk of being diagnosed with cancer increases as individuals age. About 77% of all cancers are diagnosed in persons 55 and older." In reviewing our data, we find that while the percentage of our newly diagnosed cases that are age 55 or older is increasing, for 2007, only 74% of our patients are 55 or older, reflecting the composition of our community.




**Patients 55 and Older at Diagnosis**
**Southern Hills Analytic Cases, 2003–2007**

## DISTRIBUTION BY RESIDENCE AT DIAGNOSIS – 2007

It is not unexpected to see that a little more than one quarter of our 2007 accessions came from zip code 37211, since this is the address for our facility. An additional quarter came from Antioch. There are five other Middle Tennessee zip codes that each account for three to five percent of the new accessions, and the remaining quarter are from other zip codes in Tennessee.



# Southern Hills BREAST CANCER REPORT 2007

Although malignancy of the female breast remains a major cause of mortality and morbidity in women, the overall incidence has decreased 3.5% per year for the period 2001 –2004. Nationally, 182,460 new cases of breast cancer are anticipated in 2008. In Tennessee, we anticipate 3,720 new cases for the same period. In addition to incidence, the mortality of breast cancer is also decreasing. There has been a steady decline in mortality since 1990. This is more pronounced in younger women, with a 3.3% decline per year in women under age 50 compared to a 2.0% decline per year in women older than 50.

This report will cover the years 2003 to 2007 inclusive, and includes those breast cancer cases diagnosed and/or receiving their first course of treatment at Southern Hills Medical Center. Those cases diagnosed elsewhere and subsequently receiving care at SHMC for either progressive or recurrent disease have been excluded. Southern Hills data is compared to data derived from the National Cancer Data Base (NCDB), for the reporting hospitals from the American Cancer Society's MidSouth Division. NCDB data is from 2005, with the exception of survival data, which is from 1998–1999.

| YEAR | # CASES |
|---|---|
| 2003 | 20 |
| 2004 | 39 |
| 2005 | 28 |
| 2006 | 26 |
| 2006 | 18 |

**Table 1: Number of SHMC cases per year**

| | 2003 | 2004 | 2005 | 2006 | 2007 | NCDB |
|---|---|---|---|---|---|---|
| Younger than 50 | 20% | 26% | 21% | 15% | 17% | 22% |
| 50 and Older | 80% | 74% | 79% | 85% | 83% | 78% |

**Table 2: Age at Diagnosis: SHMC compared to NCDB**

The TNM/Derived Mixed Stage at Diagnosis is demonstrated in Table 3. This shows a tendency to early stage diagnosis, although a tendency to later stage diagnosis is noted in 2004.

| | 2003 | 2004 | 2005 | 2006 | 2007 | NCDB |
|---|---|---|---|---|---|---|
| Stage 0 | 50% | 15% | 19% | 17% | 25% | 18% |
| Stage I | 10% | 23% | 48% | 38% | 25% | 39% |
| Stage II | 30% | 51% | 26% | 29% | 25% | 28% |
| Stage III | 10% | 10% | 4% | 17% | 25% | 11% |
| Stage IV | 0% | 0% | 4% | 0% | 0% | 4% |

**Table 3: TNM/Derived Mixed Stage at Diagnosis**

| | SHMC | NCDB | SHMC | NCDB | SHMC | NCDB | SHMC | NCDB |
|---|---|---|---|---|---|---|---|---|
| | STAGE 0 | | STAGE I | | STAGE II | | STAGE III | |
| None | 14% | 3% | 8% | 1% | 5% | 1% | 0% | 2% |
| Surgery | 55% | 51% | 35% | 34% | 20% | 28% | 13% | 17% |
| Surg/horm | 7% | 5% | 16% | 8% | 7% | 6% | 13% | 3% |
| Surg/chem | 0% | 1% | 5% | 7% | 11% | 23% | 7% | 21% |
| Surg/chem/horm | 0% | 0% | 8% | 2% | 18% | 6% | 7% | 3% |
| Surg/rad | 21% | 23% | 3% | 16% | 2% | 5% | 0% | 4% |
| Surg/rad/horm | 3% | 14% | 19% | 19% | 5% | 5% | 7% | 3% |
| Surg/rad/chem | 0% | 0% | 3% | 8% | 16% | 17% | 20% | 28% |
| Surg/rad/chem/horm | 0% | 0% | 3% | 3% | 14% | 7% | 33% | 12% |
| Other specified therapy | 0% | 2% | 0% | 1% | 2% | 3% | 0% | 7% |

**Table 4: First Course of Treatment by Stage**

First course of treatment by stage is noted in Table 4. There is generally good concordance between SHMC treatment and NCDB therapy, although SHMC has a higher percentage of patients who receive no therapy, regardless of stage, than the NCDB data. The reason for this is unclear, but it may be postulated that it reflects a cultural bias. For Stage III tumors, SHMC utilized combination therapy (including hormonal therapy) at almost three times the NCDB incidence. In terms of initial surgery for Stage I and II tumors, the incidence of breast-sparing surgery increases over the observation period (Figure 1). A breast sparing rate of 85% in 2006 reflects favorably with NCDB data.

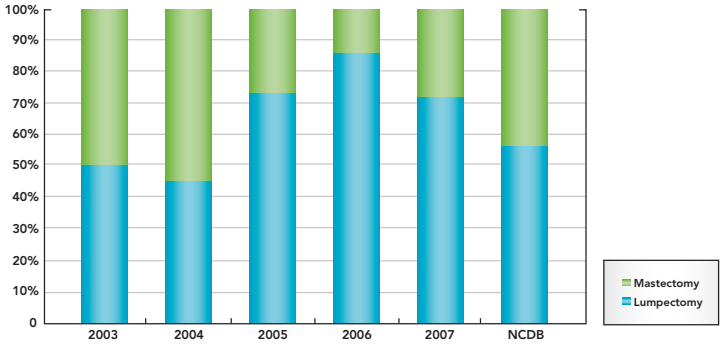
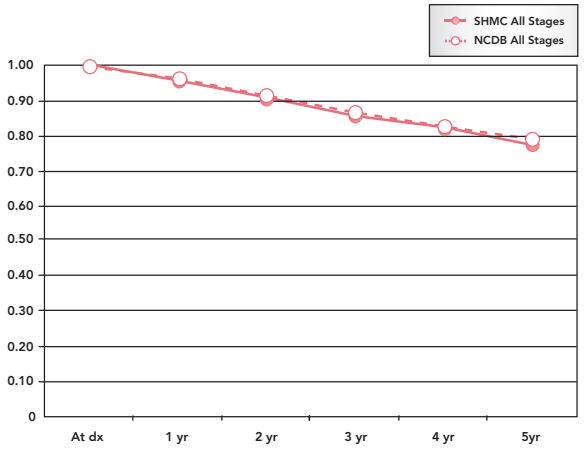



**Figure1:**
**Lumpectomy/Mastectomy for Stage 1 & 2 Breast Cancer Treatment**
**Southern Hills Analytic Breast Cancers compared to NCDB**

Survival statistics by stage are shown in Figure 2. There is strong concordance between the survival curves for SHMC and the NCDB. The decreased survival for Stage III is readily apparent. Stage IV statistics are not included in as much as only nine Stage IV cancers have been diagnosed at Southern Hills during the reporting period. The "All Stages" curve demonstrates excellent concordance with NCDB. The curve discrepancies in early stage tumors may be explained by the refusal of treatment already noted in Table 3.




**All Stages Survival**
**Southern Hills Analytic Breast Cases**
**compared to NCDB**

While the small data set unpowers any conclusions, it is helpful to compare Southern Hills data with the

NCDB data. Future studies will hopefully employ larger data sets.

Additionally, quality criteria have been adopted by the Commission on Cancer in collaboration with ASCO, NCCN and the National Quality Forum. These performance measures include:

- Patients undergoing breast-conserving surgery and are under the age of 70 should receive radiation therapy within one year of diagnosis.
- Patient with Stage T1cN0M0 or Stage II or Stage III ER/PR negative tumors and are under age 70 should receive or be considered for combination chemotherapy within four months of diagnosis.
- Patients with Stage T1cN0M0 or Stage II or Stage III ER/PR positive tumors should receive or be considered for hormonal therapy within one year of diagnosis.

James T. Ettien, M.D., FACS

NCDB data from the National Cancer Data Base reflects the 2005 cases submitted by the 122 ACoS approved facilities in the American Cancer Society's Mid-South Division.

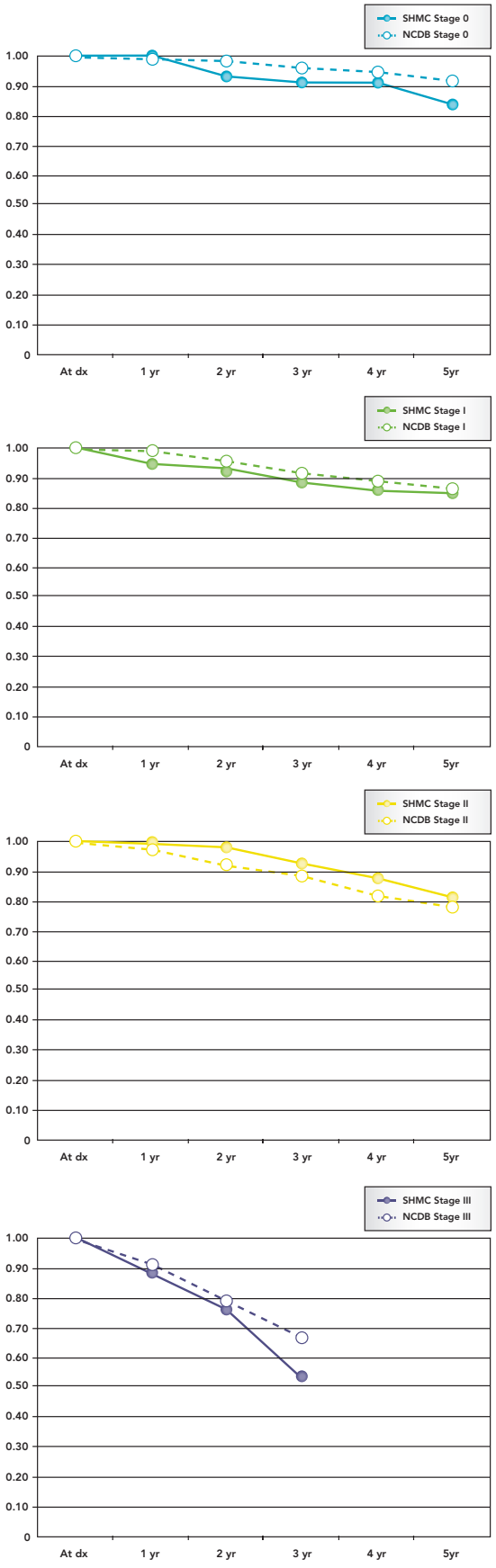



**Figure2:**
**Survival Graphs by Stage**
**Southern HIlls Analytic Breast Cases compared to NCDB**

# CHAIR REPORT

The year 2007 was a busy year for the Cancer Committee at StoneCrest Medical Center. The most pressing issue was to become prepared for the 2008 survey by the American College of Surgeons in order to become an accredited cancer program. The committee set forth several goals to achieve the desired result.

One of the first goals established was to develop a nutritional assessment and intervention program for all at-risk radiation therapy patients. A process was set into place and worked well to meet the needs of our patients. One program that showed considerable success was Vitalstim which allows patients with functional feeding difficulties to re-train themselves to swallow in order to attain adequate nutritional and caloric needs.

Other specific goals included an analysis of 2006 prostate cancer data which was achieved with a summary report. The committee wanted to provide cancer education to the community and did so by distributing brochures for cancer prevention, smoking cessation, and maintaining healthy weight at health fairs at Heritage Farms, General Mills, and for Rutherford County employees.

Following up on goals established in 2006, the Cancer Conference continues to be well attended and popular, presenting a multi-disciplinary approach to cancer care for difficult cases. Attention was given to meeting the national benchmarks for abstracting delay and case review for data quality. Lisa Flippin, the Cancer Registrar, continues to achieve incredible success meeting and exceeding set goals.

One of the study goals established was to assess pain management – documentation with Demerol PCA or IV. A new tool was developed from this study. Patient's pain can be measured objectively, instead of subjectively. The committee was reassured with the information that Demerol was not used to control cancer pain, except when other drugs were not available.

Several quality improvement initiatives were under taken including the development of a nutritional assessment tool in radiation medicine, Look Good/Feel Better on StoneCrest Campus, a skin care handout developed for radiation medicine patients, hand hygiene program throughout campus, and a new tool developed for pain assessment.

2008 brings many challenges and reason for optimism about cancer care at StoneCrest. In 2008, StoneCrest will be reviewed by the American College of Surgeons. While the committee feels prepared, we look forward to the ACoS recommendations as to how to provide the best possible quality care for our cancer patients.

Sean W. Silvernagel, M.D.

StoneCrest Medical Center
TRISTAR HEALTH SYSTEM

StoneCrest Medical Center had their initial survey by the American College of Surgeons Commission on Cancer on July 9, 2008. As a result, the cancer program received accreditation as a Community Hospital Cancer Program, with all nine commendations for the Outstanding Achievement Award.

# StoneCrest
# CANCER REGISTRY REPORT 2007

During 2007, a total of 204 cases were accessioned into the Cancer Database at StoneCrest Medical Center. Of the 204 cases, 88% or 179 cases, were seen here for diagnosis or first course of treatment or both. These cases are known as “analytic.” The remaining 25 cases were seen for the first time for recurrence or progression of a previously-diagnosed cancer and are “non-analytic”.

Nationally, the most frequently-occurring cases are cancers of the lung, prostate, breast, and colon. In reviewing our data for the past four years, we find that this pattern is also seen at our facility. The relative positions of these sites have varied from year to year, as well as the fifth most frequently occurring malignancy.

| 2004 | | | 2005 | | | 2006 | | | 2007 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| TOTAL | 90 | 100% | TOTAL | 171 | 100% | TOTAL | 184 | 100% | TOTAL | 179 | 100% |
| Colon | 13 | 14% | NSCLC | 30 | 18% | Breast | 39 | 21% | Breast | 41 | 23% |
| NSCLC | 12 | 13% | Breast | 29 | 17% | NSCLC | 25 | 14% | NSCLC | 21 | 12% |
| Breast | 10 | 11% | Colon | 16 | 9% | Prostate | 13 | 7% | Prostate | 19 | 11% |
| Prostate | 7 | 8% | Prostate | 12 | 7% | Colon | 10 | 5% | Bladder | 15 | 8% |
| Thyroid | 6 | 7% | SCLC | 9 | 5% | Kidney | 9 | 5% | Colon | 8 | 4% |

NSCLC = Non-Small Cell Lung Cancer
SCLC = Small Cell Lung Cancer
Kidney includes Renal Pelvis Cancers

## ONCOLOGY COMMITTEE MEMBERSHIP

Sean Silvernagel, MD Chair
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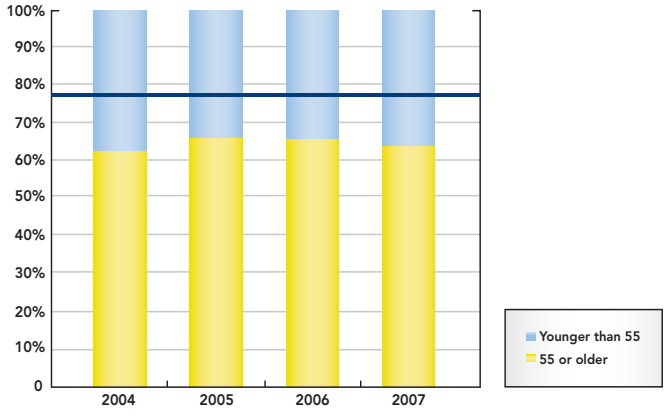
Jean Seals, RN
Melissa Sohrabi, BSN
Scott Weiskittel, MS, PT

## DISTRIBUTION BY AGE AT DIAGNOSIS

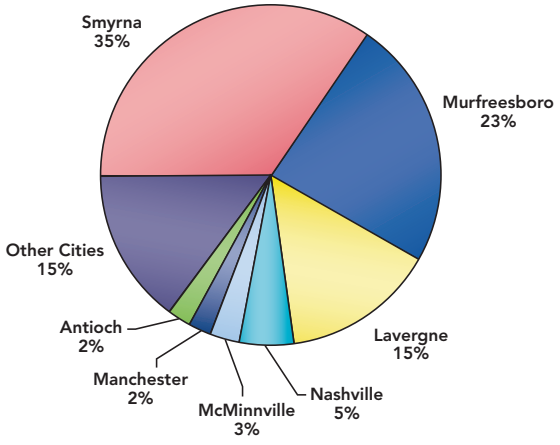
According to the American Cancer Society, “The risk of being diagnosed with cancer increases as individuals age. About 77% of all cancers are diagnosed in persons 55 and older.” This is not seen in our patient population, where only 62–66% of our cases occur in individuals older than 55.




**Patients 55 and Older at Diagnosis**
**Skyline Analytic Cases, 2004–2007**

## DISTRIBUTION BY CITY OF RESIDENCE AT DIAGNOSIS – 2007

A third of our newly-diagnosed patients live in Smyrna. This has remained fairly consistent over the past four years, with Smyrna residents accounting for 31%–38% of our analytic cases. Murfreesboro and LaVergne together account for 38% of our analytic cases this past year. We had only one case from out of state.

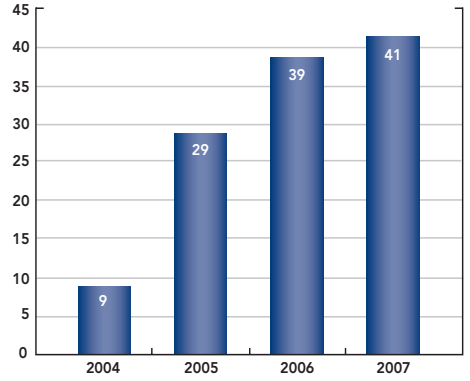


# StoneCrest BREAST CANCER REPORT 2007

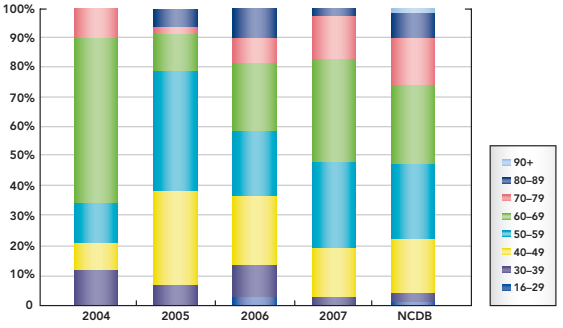
An estimated 186,460 new cases of invasive breast cancer are expected to occur among women in the US during 2008. After continuously increasing in frequency over the last two decades, breast cancer rates have decreased by 3.5% per year from 2001-2004. The number of patients diagnosed and/or receiving some of their first course of treatment at StoneCrest remained steady in 2007 with 41 new cases compared to 39 in 2006.

Increasing age is the most significant risk factor in female breast cancer. 78% of breast cancer patients at StoneCrest were between the ages of 50 and 79. This is similar to the rate of 68% seen in the National Cancer Data Base (NCDB).

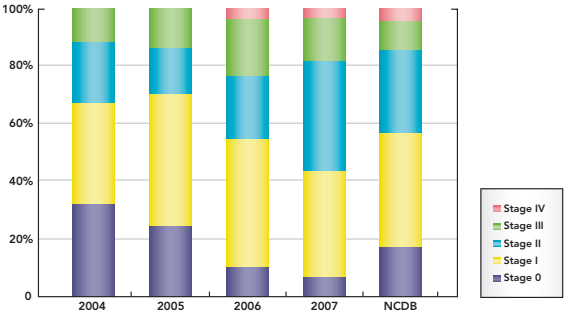
The recent declines in breast cancer mortality have been attributed to a combination of early detection and improvements in treatment. Seventy-three percent of breast cancer patients at StoneCrest presented at an early stage (0-II) which is similar to the 77% rate of early presentation seen in the NCDB.




**StoneCrest Analytic Breast Cases 2004–2007**




**Distribution by Age at Diagnosis**
**StoneCrest Analytic Breast Cancers compared to NCDB**



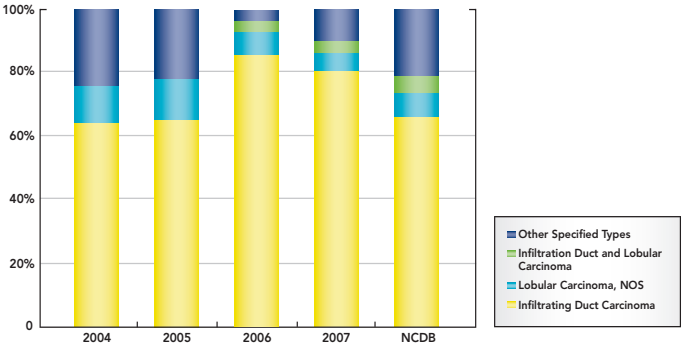

**Distribution by Stage at Diagnosis**
**StoneCrest Analytic Breast Cancers compared to NCDB**

The most common invasive histology seen in breast cancer is infiltrating ductal carcinoma. This was true in the StoneCrest experience with 33 of 41 patients presenting with invasive ductal carcinoma.

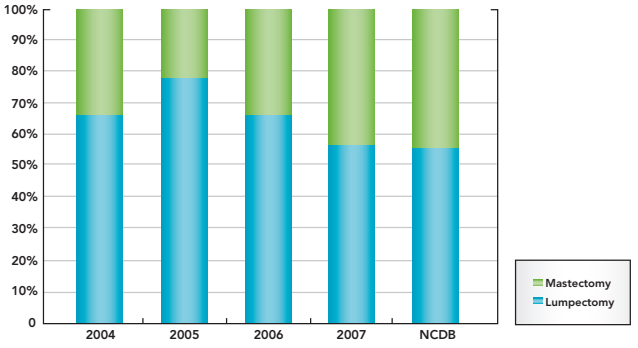
Breast conserving surgery with the addition of radiation has been shown in several prospective randomized clinical trials to yield equivalent long term survival rates when compared to mastectomy for patients with early stage breast cancer. Of the surgical cases at StoneCrest, 8 patients underwent lumpectomy while 6 patients had a mastectomy. Although the case volume was small, the 57% lumpectomy rate compared favorably with the 56% lumpectomy rate seen in the NCDB.

Survival data at StoneCrest is limited by the young age of the facility. Early stage breast cancer patients had a 95-100% three year survival rate as expected from the NCDB. Stage III patients also had a similar 1-3 year survival as compared to the NCDB.

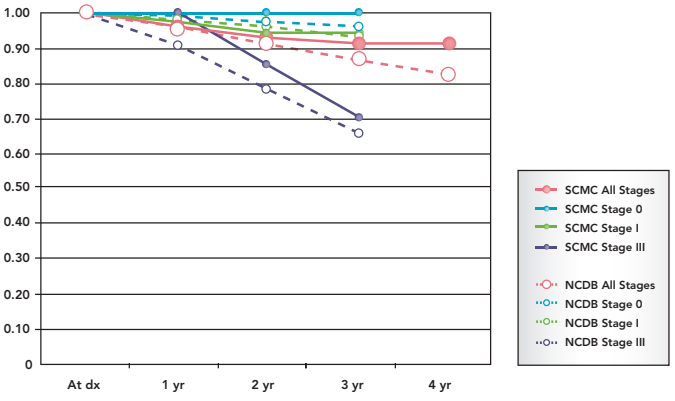
Mark Akins, M.D.




**Distribution by Histology**
**StoneCrest Analytic Breast Cancers compared to NCDB**




**Lumpectomy/Mastectomy for Stage 1 & 2 Breast Cancer Treatment**
**StoneCrest Analytic Breast Cancers compared to NCDB**




**Five-Year Observed Survival**
**StoneCrest Analytic Breast Cases compared to NCDB**

NCDB data from the National Cancer Data Base reflects the 2005 cases submitted by the 122 ACoS approved facilities in the American Cancer Society's Mid-South Division.

# CHAIR REPORT

The year 2007 was an outstanding year for the Summit Medical Center Oncology Program. Of special note was the ACOS Survey in November 2007 that resulted in Summit Medical Center being the first TriStar facility to receive the Outstanding Achievement Award!

The Cancer Committee continues to meet regularly, and all 2007 goals were met. Please note that one of the committee's clinical goals was to have Digital mammography available in 2007 and this goal was met.

The Summit Tumor Conference continues to meet twice a month, and attendance has been excellent and includes a wide range of specialties.

Jessica Davis continues to handle the Cancer Registry expertly and all requirements were met without difficulty.

Brad Cohen, M.D. continues to direct the Summit Medical Center Radiation Oncology Department. This department has seen significant increase in patient volume directly related to both patient and referring physician satisfaction.

The Summit Medical Center Oncology Program is now well known and respected in the Middle Tennessee area and beyond, and we look forward to 2008 and future successes.

Mitchell A. Toomey, M.D.
Oncology Committee Chair

Summit Medical Center℠
TriStar Health System®

## ONCOLOGY COMMITTEE MEMBERSHIP

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Katharine Ray
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Lori Thomas
Greg Thon
Thomas Westermeier, MD
Robin Williams, MD
Misty Woodward, RN
Lora Wren

# Summit
# CANCER REGISTRY REPORT 2007

During 2007, an additional 426 cases were accessioned into the Cancer Registry at Summit Medical Center. Of these cases, 399 (94%) were newly diagnosed and were seen here for diagnosis and/or first course of treatment. These newly diagnosed cases are "analytic." The remaining 27 cases, known as "non-analytic," came to Summit for additional treatment of a previously-diagnosed malignancy that either progressed or recurred.

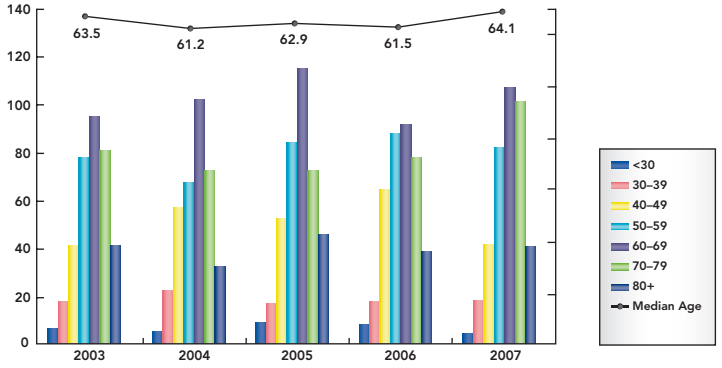
When reviewing the cancers diagnosed and/or treated here, breast cancer has remained the most frequently seen, accounting for 18-23% of all of the cases for each of the past five years. During this same period, non-small cell lung cancer (NSCLC), prostate and colon cancer have occupied positions two through four. Thyroid has held the fifth position each year.

| 2003 | | | 2004 | | | 2005 | | | 2006 | | | 2007 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **TOTAL** | **365** | **100%** | **TOTAL** | **380** | **100%** | **TOTAL** | **402** | **100%** | **TOTAL** | **391** | **100%** | **TOTAL** | **399** | **100%** |
| Breast | 66 | 18% | Breast | 84 | 22% | Breast | 92 | 23% | Breast | 89 | 23% | Breast | 78 | 20% |
| Prostate | 42 | 12% | NSCLC | 31 | 14% | NSCLC | 74 | 18% | NSCLC | 67 | 17% | NSCLC | 56 | 14% |
| NSCLC | 40 | 11% | Colon | 31 | 8% | Prostate | 27 | 7% | Prostate | 26 | 7% | Prostate | 31 | 8% |
| Colon | 24 | 7% | Prostate | 24 | 6% | Colon | 25 | 6% | Colon | 26 | 7% | Colon | 24 | 6% |
| Thyroid | 23 | 6% | Tie** | 22 | 6% | Thyroid | 19 | 5% | Thyroid | 19 | 5% | NHL | 22 | 6% |

Tie* = Thyroid and Rectum with five cases each
NSCLC = Non-Small Cell Lung Cancer
NHL = Non-Hodgkin Lymphoma

## DISTRIBUTION BY AGE AT DIAGNOSIS

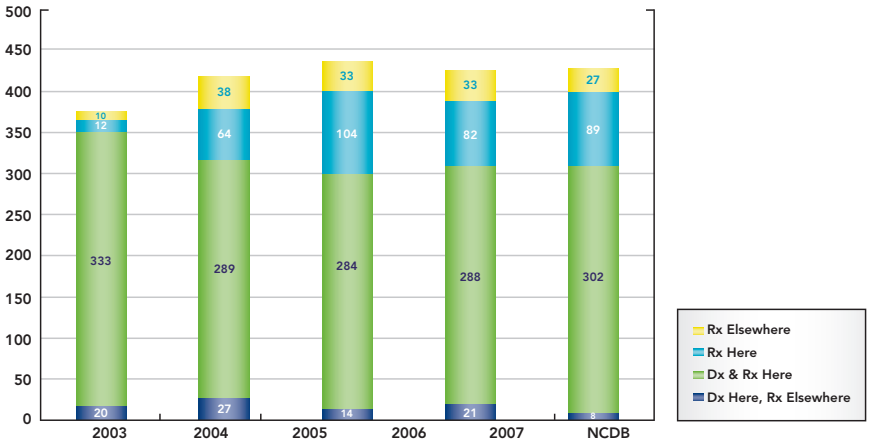
As in previous years, our data confirms that cancer is a disease of aging. The average age for our patient population is 61–64 years of age. This is also reflective of the population of the geographical area we serve.




**Distribution by Age at Diagnosis**
**Summit Analytic Cases, 2003–2007**

## REFERRAL PATTERNS – THE EFFECTS OF HAVING RADIATION THERAPY

The Radiation Therapy department here at Summit Medical Center opened in 2004. Our registry data reflects an increase in the number of patients referred here, both for first course of treatment and for treatment of recurrence or progression.




**Total Accessions**
**Summit Medical Center, 2003–2007**

## e-QuIP REVIEW

There is a national effort by the National Quality Forum to monitor and report the quality of cancer patient care at each facility. This report is based on the cancer registry data that is submitted to the National Cancer Data Base (NCDB), and is actually a measure of the completeness of data. The electronic Quality Improvement Packet (e-QuIP) is a tool that was developed by the Commission on Cancer to help assess data completeness for breast cancer patients recorded in the Cancer Registry.

At present there are three breast cancer measures: Lumpectomy followed by radiation therapy; chemotherapy for tumors greater than 1 cm, node positive and ER/PR negative; and hormone therapy for tumors greater than one cm and ER/PR positive. The estimated performance rates shown on the attached e-QuIP charts provide an indication of the proportion of patients treated according to recognized standards of care.

It appears that there is room for improvement with each of the measures at Summit. However, it should be taken into consideration that some of the data must be collected from physician offices and thus the numbers are probably lower than expected, especially for hormone therapy for ER/PR positive tumors. It is my personal observation over the past 10 years that probably more than ninety percent of our patients are treated within the guidelines.

It is important that we support the efforts of our cancer registry staff to collect this data, especially from the physician offices.

Robin Williams, M.D., FACS
Cancer Liaison Physician

### Patients receiving breast conserving surgery who are under age 70 should receive radiation therapy. [BCS/RT]

| | DIAGNOSIS YEAR | | | NOT ON e-QuIP | |
|---|---|---|---|---|---|
| | 2003 | 2004 | 2005 | 2006 | 2007 |
| Estimated Performance Rate | 100% | 74% | 93% | 85% | 95% |
| Cases Eligible | 28 | 34 | 27 | 3 | 19 |
| Cases without RT documented | 0 | 9 | 2 | 7 | 1 |
| Concordant Cases | 28 | 25 | 25 | 17 | 18 |

### Patients with Stage I (tumor size > 1cm and N0) or Stage II/III (any tumor size and N+), with ER/PR – tumors and who are under age 70 should receive or be considered for combination chemotherapy. [MAC]

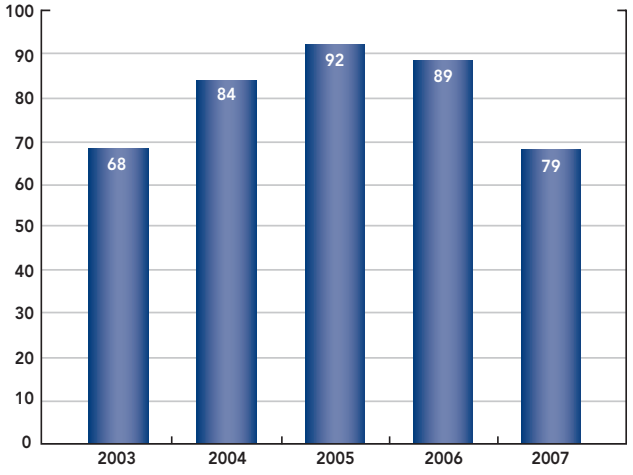
| | DIAGNOSIS YEAR | | | NOT ON e-QuIP | |
|---|---|---|---|---|---|
| | 2003 | 2004 | 2005 | 2006 | 2007 |
| Estimated Performance Rate | 88% | 89% | 75% | 81% | 56% |
| Cases Eligible | 8 | 9 | 8 | 11 | 9 |
| Cases without chemo documented | 1 | 1 | 2 | 2 | 4 |
| Concordant Cases | 7 | 8 | 6 | 9 | 5 |

### Patients with Stage I (tumor size > 1cm and N0) or Stage II/III (any tumor size and N+), with ER+ or PR+ tumors should receive or be considered for hormone therapy (Tamoxifen or third generation Aromatase Inhibitor). [HT]

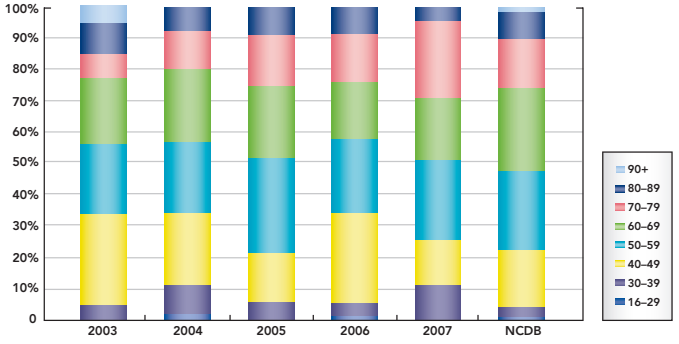
| | DIAGNOSIS YEAR | | | NOT ON e-QuIP | |
|---|---|---|---|---|---|
| | 2003 | 2004 | 2005 | 2006 | 2007 |
| Estimated Performance Rate | 89% | 83% | 82% | 79% | 75% |
| Cases Eligible | 27 | 40 | 28 | 39 | 24 |
| Cases without hormone tx documented | 3 | 7 | 5 | 7 | 6 |
| Concordant Cases | 24 | 33 | 23 | 31 | 18 |

Breast cancer remains the leading cause of cancer in women. It is estimated that 182,460 new cases of invasive breast carcinoma will be diagnosed in women in the U. S. in 2008. An estimated 1,990 new cases of invasive breast carcinoma will be diagnosed in men in the U.S. in 2008. In Tennessee, there will be an estimated 3,720 new cases of female breast cancers in 2008 and an estimated 920 deaths. For the first time in two decades, there was actually a 3.5% decrease in the incidence of female breast cancer each year between 2001–2004. The reasons for this may be multifactorial, in part attributable to a decreased usage of hormone replacement therapy as well as a slight decrease in mammography utilization. Simultaneously there has been a decrease in death rates from breast cancer. There has been a 3.3% decrease each year since 1990. This progress is a reflection of improved early detection and better treatment options.

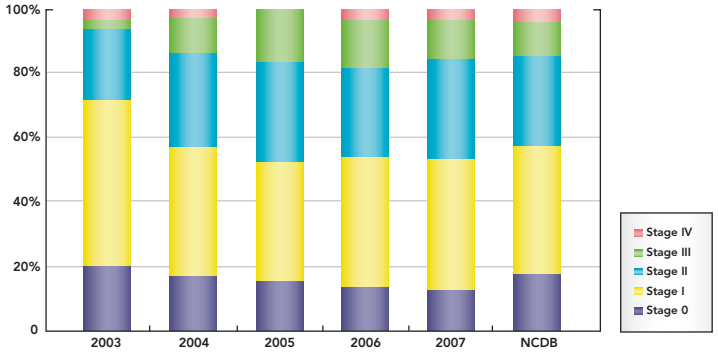
The number of new cases of breast cancer at Summit significantly increased between 2004-2006. However, there was a slight decrease of new cases in 2007. Most of our patients are diagnosed between the ages of 40 to 69. Greater than 80% of our cases are diagnosed at Stages 0, I and II. The distribution of breast cancers by age and stage at diagnosis is comparable to the distribution reported by the National Cancer Data Base. Seventy to eighty percent of all breast cancers are infiltrating ductal. The distribution by histology at Summit seems to be most comparable to the NCDB in 2007. Between 2004 and 2006, Summit had more cases of lobular carcinoma and mixed carcinomas compared to the NCDB. In 2003, there were approximately 10% more cases of in situ cancers compared to the NCDB.




**Summit Analytic Breast Cases 2004–2007**




**Distribution by Age at Diagnosis**
**Summit Analytic Breast Cancers compared to NCDB**



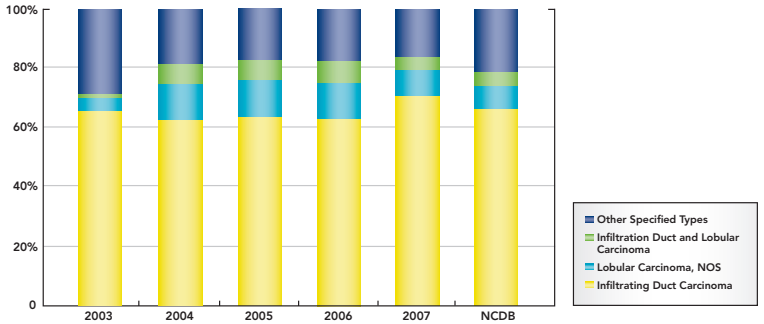

**Distribution by Stage at Diagnosis**
**Summit Analytic Breast Cancers compared to NCDB**

Treatment for breast cancer requires a multidisciplinary approach. The mainstay for treatment for early stage disease remains surgery followed by chemotherapy and/or radiation therapy and adjuvant hormonal therapy. The first course of treatment by stage at Summit is comparable to that found in the NCDB. The rate of lumpectomy for Stage I and II disease at Summit has been steadily declining over the past four years, unlike what is reported in the NCDB. The difference may, in part, be patient driven. It is not unusual for patients to request a mastectomy even for early stage disease.

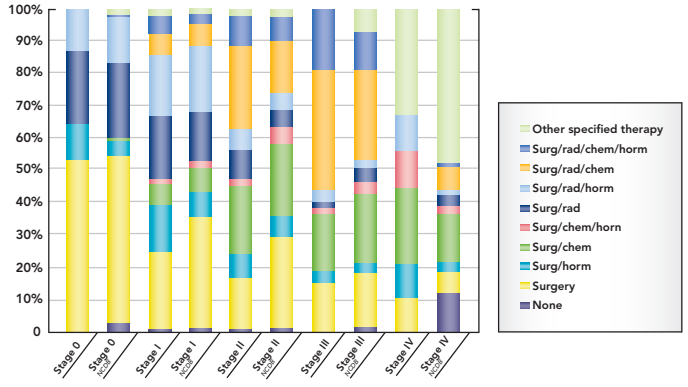
Since the majority of breast cancers are now detected at an early stage, the five year survival has improved significantly from 80% greater than 30 years ago to 98% today. The five year survival for our patients is comparable to the findings in the NCDB.

Robin Williams, M.D., FACS
Cancer Liaison Physician

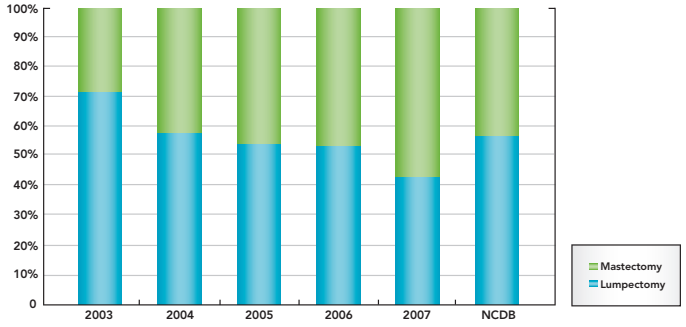
NCDB data from the National Cancer Data Base reflects the 2005 cases submitted by the 122 ACoS approved facilities in the American Cancer Society's Mid-South Division.



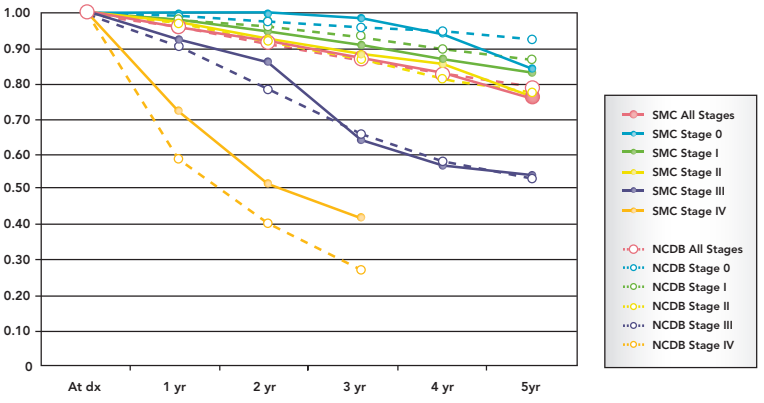

**Distribution by Histology**
**Summit Analytic Breast Cancers compared to NCDB**




**First Course of Treatment by Stage at Diagnosis**
**Summit Analytic Breast Cancers compared to NCDB**




**Lumpectomy/Mastectomy for Stage 1 & 2 Breast Cancer Treatment**
**Summit Analytic Breast Cancers compared to NCDB**




**Five-Year Observed Survival**
**Summit Analytic Breast Cancers compared to NCDB**


KY
TN
GREENVIEW
SKYLINE
HENDERSONVILLE*
The Sarah Cannon Cancer Center Network
SUMMIT
CENTENNIAL
HORIZON
SOUTHERN HILLS
STONECREST
NATCHEZ
PARKRIDGE
PARKRIDGE EAST*
* SCCC Affiliated Medical Facility
CoC Accredited Facility
Radiation Therapy Services