2012 Cancer Report

FirstHealth
OF THE CAROLINAS

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2012 Cancer Report

The Cancer Committee of FirstHealth Moore Regional Hospital, chaired by Dr. Ellen Willard, is pleased to present this statistical overview of the Moore Regional Hospital Cancer Program in 2011 and a major site report on prostate cancer.

The MRH Cancer Program is accredited with commendation by the American College of Surgeons Commission on Cancer (ACoS CoC) as a Community Hospital Comprehensive Cancer Program. This voluntary accreditation program encourages facilities to demonstrate availability of all major modalities of cancer treatment and meet rigorous requirements for multidisciplinary medical and hospital staff interaction, patient support services, community outreach activities, quality improvement and outcomes analyses.

Each cancer program must undergo a rigorous evaluation and review of its performance and compliance with the CoC standards. To maintain accreditation, facilities with accredited cancer programs must undergo an on-site review every three years.

The most recent on-site review of the MRH cancer program occurred in May 2011. We are pleased to report that the program received a full accreditation with Commendation. As a result of the 2011 survey, the MRH cancer program was awarded the Outstanding Achievement Award (OAA). Only 106 programs in the United States received the OAA as a result of surveys performed in 2011. This number represents approximately 22 percent of programs surveyed during this period.

Moore Regional is one of only 13 facilities to have received the CoC Outstanding Achievement Award for three consecutive surveys (2005, 2008 and 2011.)

Our accreditation ensures that each individual with cancer being treated at MRH will receive quality care close to home, including

- Comprehensive care offering a range of state-of-the-art services and equipment
- A multidisciplinary team approach to coordinate the best cancer treatment options available
- Access to cancer-related information, education and support
- Ongoing monitoring and improvement of care
- Information about clinical trials and new treatment options

Thank you for taking the time to review this report. If you would like additional information about FirstHealth of the Carolinas or any of the information presented in this overview, please feel free to contact us by calling (800) 213-3284.

State and National Comparison

2011 Most Prevalent Cancer Cases by Number of Cases and Percentage

	MRH		NC*		US*	
Primary Site	**Cases**	**Precent**	**Cases**	**Precent**	**Cases**	**Percent**
BREAST	200	17.9	7,390	15.1	230,480	14.4
LUNG	227	20.4	7,300	14.9	221,130	13.8
PROSTATE	183	16.4	7,580	15.5	240,890	15.1
COLORECTAL	94	8.4	4,200	8.6	141,210	8.8
BLADDER	35	3.1	1,900	3.9	69,250	4.3
NH LYMPHOMA	39	3.5	1,930	3.9	66,360	4.2
CORPUS UTERI	19	1.7	1,280	2.6	46,470	2.9
MELANOMA	7	.6	2,300	4.7	70,230	4.4
LEUKEMIA	9	.8	1,230	2.5	44,600	2.8
CERVIX	6	.5	380	.8	12,710	.8
ALL OTHERS	296	26.5	13,380	27.4	453,340	28.4
Total Cases	**1,115**	**100**	**48,870**	**100**	**1,596,670**	**100**

Throughout this report, percentages may not always total 100% due to rounding.
This report excludes basal and squamous cell skin cancers and in situ lesions of all sites except bladder.
State and national numbers are estimates of cancer incidence in the entire state and nation, regardless of where the patient is treated.
The FHMRH numbers, however, are actual cases that were diagnosed and treated at MRH, regardless of where the patient lives.
This, along with the age of the local population, may explain deviations from the state and national averages.

**American Cancer Society, 2011 Cancer Statistics, Estimated new cases.*

FHMRH CANCER REGISTRY

County of Residence at time of treatment at MRH

All 2011 Cases

Current County	**Cases**	**Percent**
MOORE	622	45
RICHMOND	208	15
LEE	134	10
SCOTLAND	76	5.5
MONTGOMERY	74	5
ROBESON	74	5
HOKE	73	5
CUMBERLAND	35	3
CHATHAM	26	2
HARNETT	14	1
OTHER NC	14	1
MARLBORO (SC)	13	1
RANDOLPH (NC)	7	.5
ANSON (NC)	6	.4
OTHER SC	5	.4
OUT OF STATE	2	.1
Total Cases	**1383**	**100**

FHMRH CANCER REGISTRY

Age by Gender Distribution

New Diagnoses 2011

Age Range	**Male**	**Female**
20 - 29	2	5
30 - 39	6	15
40 - 49	25	47
50 - 59	97	104
60 - 69	211	178
70 - 79	158	152
80 - 89	77	73
90 - 99	9	12
100 - 109	0	2
Totals	**585**	**588**

FHMRH CANCER REGISTRY

Distribution by Type of Case

All 2011 Cases

Class of Case	**Cases**	**Percent**
DX AND TX AT MRH	884	64
DX ELSEWHERE AND TX AT MRH	210	15
DX AT MRH AND TX ELSEWHERE*	79	6
INITIAL DX/TX ELSEWHERE, TX AT MRH FOR RECURRENCE OR PERSISTENCE	141	10
PATHOLOGY ONLY	69	5
Total Cases	**1383**	**100**

**Cases diagnosed at MRH and treated elsewhere are usually cases that require treatments offered at teaching hospitals, such as bone marrow transplant, induction chemotherapy for leukemias and management of most pediatric cancers.*
FHMRH CANCER REGISTRY

Distribution by Race

All 2011 Cases

Race	Cases	Percent
CAUCASIAN	1062	77
AFRICAN AMERICAN	264	19
NATIVE AMERICAN	49	3.5
ASIAN	6	.4
NOT STATED	2	.1
Total Cases	**1383**	**100.00**

FHMRH CANCER REGISTRY

Cancer Registry Data Overview 2012

In 2011, the Cancer Registry at FirstHealth Moore Regional Hospital recorded 1,383 cancer cases, representing a slight increase from the 1,364 cases documented in 2010. In order of incidence, lung, breast, prostate and colorectal cancer were the most frequent new diagnoses. This is similar to state and national averages with the exception of lung cancer, which accounted for 20.4 percent of newly diagnosed cases at Moore Regional but only 14.9 percent in North Carolina and 13.8 percent nationally. This has been a consistent finding over the past decade and is likely due to a disproportionate volume of referrals to local sub-specialists for diagnosis and treatment of thoracic tumors. The diagnosis of breast cancer was also slightly higher than state or national averages, likely due to the higher average age of the community.

A diagnosis of cancer was clearly related to age, with people aged 60 years and older accounting for 74 percent of cases. The racial distribution of the patient population is similar to that of the local area with approximately 77 percent of cases occurring among Caucasians, 19 percent among African-Americans, and 3.5 percent among Native Americans. Hispanic patients are included in the Caucasian category since this term is considered an ethnic rather than a racial designation.

Early diagnosis and treatment are vital factors in improving the long-term survival of nearly all cancers. As has been the case in previous years, the majority of cases in 2011 were diagnosed in Stages 0, I and II. One hundred nineteen of the 232 cases of breast cancer, 11 of the 19 cases of uterine body cancer and 26 of 35 cases of bladder cancer were diagnosed in very early stages (non-invasive Stage 0 or Stage I).

Of the 227 lung cancer cases diagnosed, 78 were detected in Stage I or Stage II, stages where surgical removal is possible. Among patients with a diagnosis of prostate cancer, 139 of the 183 cases were detected in Stage II, indicating no evidence of disease spread outside of the gland. Early detection can be attributed to patient education and awareness of warning signs, self-examinations and regular medical screening including physicals, mammograms, PSA testing, fecal occult blood testing, colonoscopies and gynecological exams/PAP smears.

In keeping with the referral patterns of past years, 45 percent of the patients who were diagnosed and/or treated at Moore Regional's Community Hospital Comprehensive Cancer Center reside in Moore County. An additional 15 percent of patients are residents of Richmond County. Between 5 and 10 percent of patients travel to Moore Regional from each of the following counties: Lee, Montgomery, Scotland, Robeson and Hoke. The remaining patients reside in more distant areas.

While 89 percent of patients were treated at Moore Regional, 6 percent were diagnosed here but treated elsewhere. This figure reflects the philosophy that certain types of cancers require services and technologies available only at a university-based teaching hospital. Examples of these services and technologies are high-dose chemotherapy with bone marrow support for blood-borne malignancies, immunotherapy for melanoma and management of most pediatric cancer cases. The remaining 5 percent of reported cases were either pathology reports from outside offices or were diagnosed and treated in a staff physician's office. Those patients did not enter Moore Regional for diagnosis or treatment.

Collecting, managing and analyzing data related to cancer diagnosis and treatment is a vital part of the cancer program at Moore Regional Hospital. The follow-up rate of 95 percent for treated patients far exceeds the American College of Surgeons (ACoS) program standard. Requested data is forwarded to both the N.C. Central Cancer Registry, as required by state law, and to the American College of Surgeons National Cancer Data Base, as required for an accredited Community Hospital Comprehensive Cancer Program.

In accordance with HIPAA guidelines, strict patient confidentiality measures are followed.

Nationally certified cancer registrars perform these extensive procedures in addition to organizing and assisting with weekly cancer conferences. Fourteen requests for specific analyses related to the Moore Regional cancer program data were fulfilled. In 2011, 392 cases were presented for review at 100 multidisciplinary conferences for discussion by a group of physicians representing all specialties involved in the diagnosis and treatment of cancer. Ninety-seven percent of the cases were presented prospectively, indicating that multidisciplinary input can affect future treatment decisions.

Jeffrey C. Acker, M.D.
Medical Director
Community Hospital Comprehensive Cancer Center
FirstHealth Moore Regional Hospital

2012 Cancer Report Summary for Clinical Trials at Moore Regional Hospital

Clinical trials are research studies to find better ways to prevent or treat disease. Each study is carefully designed to answer specific scientific questions. These studies are the final stages of a long and careful cancer research process to determine the value of promising approaches to cancer prevention, diagnosis and treatment.

In the case of cancer, these studies often compare the most accepted cancer treatment (standard of care) with a new treatment that is hoped to be better based on laboratory and small scale clinical research results. These studies help determine if new drugs, treatments, devices or approaches are safe and effective. Studies such as these are required for FDA approval for the drugs or treatments for future cancer patients. Studies are sponsored by the National Cancer Institute through its numerous research arms and the pharmaceutical industry. FirstHealth Moore Regional Hospital has participated in clinical trials since 1997. As of the writing of this document, the Clinical Trials office at Moore Regional has 27 studies open for cancer patients. These studies were selected to offer patients additional treatment options with a focus on types of cancer most frequently seen at Moore Regional. Patients in clinical studies must be referred by their physicians and are required to meet eligibility criteria to qualify for participation in a study. Most, but not all, studies target newly diagnosed patients.

All studies are reviewed by the FirstHealth Institutional Review Board (IRB). Volunteers including non-clinical members of our local community, physicians and nurses comprise the IRB, which examines the goals of each study, weighs the risks versus the benefits and judges the value of the study before the study can enroll patients at Moore Regional. The board also reviews each study every time there is a change in the study protocol and annually for a continuing review.

For a listing of current studies, please visit www.firsthealth.org/clinicaltrials.

During 2011, the MRH Clinical Trials office enrolled 47 new patients in clinical studies and seeks to match or exceed that total for 2012. The clinical trial environment is changing at the federal level to include the mergers of cooperative groups and changes in 1) the process for opening new studies and 2) the numbers of patients to be enrolled per study. The changes will create additional challenges in terms of enrolling patients at Moore Regional, but we hope the changes will lead to better research treatment opportunities from National Cancer Institute-sponsored organizations. This level of patient enrollment on clinical studies supports the Accreditation with Commendation of the FirstHealth Moore Regional Hospital Community Cancer Program by ACoS (American College of Surgeons).

2012 Major Site Report: Prostate Cancer

In 2012, about 241,740 new cases of prostate cancer will be diagnosed. About 28,170 men will die of prostate cancer.

Prostate cancer occurs primarily in older men. Nearly two-thirds are diagnosed over the age of 65. Prostate cancer is a serious disease, but most men diagnosed with the disease do not die from it. It is, however, the second leading cause of death in American men behind lung cancer.

The prostate cancer screening tool called a PSA (Prostate Specific Antigen) is a blood serum test. Normal PSA values range from 0-4 nl. The current recommendation for PSA screening, according to the American Cancer Society, is that men make an informed decision about whether to be screened. Men need to learn about what is known and unknown about the risks and benefits of testing and treatment.

Starting at age 50, men should talk to their physician about the benefits and risks of prostate screening so they can decide if testing is the right choice for them. Men who are African- American or who have a father or brother who have had prostate cancer before the age of 65 should have this conversation starting at age 45. If man decides to be screened, he should have a PSA with or without a rectal exam.

Aging can lead to benign prostate hypertrophy and cause the PSA to rise. If the PSA rises, a prostate biopsy can be used to determine if the increase is related to cancer. Once a cancer diagnosis is made, the PSA becomes a marker of that cancer and can be used to monitor response to treatment. PSA values that range from 0 to 10 in setting of a known cancer are considered low-risk disease. PSAs from 10 to 20 can indicate intermediate risk disease. PSA values greater than 20 may indicate high-risk disease with a likelihood of greater metastatic potential.

Survival rates and treatment options vary based on the stage of disease at diagnosis. Local disease is defined by the lack of spread of cancer outside the prostate gland. This is equivalent to Stage I or Stage II disease, and most cancers are found at this stage. Regional disease is defined as cancer that has spread to nearby areas including the lymph nodes or has invaded local structures around the prostate gland. Distant disease is defined as cancer that has spread to distant lymph nodes, bones or other organs. This is considered Stage IV cancer.

Within the local stage category, there are additional stratifications of risk based on Gleason score and PSA. Gleason score is an indication of the histologic aggressiveness of the tumor. The two most common areas of cancer within the prostate specimen are given a score from 1 to 5. A score of 1 represents tissue that appears most similar to normal prostate tissue while a score of 5 indicates that the histologic tissue looks aggressive or very different from normal prostate morphology. These numbers are added to give a Gleason score from 2 to 10.

Overall, prostate cancers with Gleason scores from 2 to 6 are considered to have low-grade disease. A Gleason score of 7 indicates moderate grade, and 8 to 10 is considered high-grade disease. The Gleason score in combination with PSA helps to stratify a patient into risk groups that can determine treatment options and define patient outcomes.

Stage, Gleason score and PSA help to determine the options related to prostate cancer treatment. These options can include surgery, radiation treatment, hormone therapy, a combination of these three modalities or observation.

In 2011, 183 patients were diagnosed with prostate cancer at Moore Regional Hospital. Some 94.5 percent of these cases were staged with local regional disease while 76 percent of these patients had stage II disease that could be treated with locally aggressive therapies. Sixty-one percent of the men diagnosed with prostate cancer at Moore Regional were Caucasian, 32 percent were African-American and 7 percent were Native American.

For patients with low- or intermediate-risk disease, treatment options can include surgery, radiation treatment either with external beam and/or HDR brachytherapy, hormone therapy or observation.

At Moore Regional Hospital, we have the benefit of having the latest in treatment options. From a surgical perspective, we offer radical prostatectomy with the possibility of using the da Vinci robot-assisted procedure. This approach to prostatectomy provides access to the internal anatomy through five small incisions. The surgeon is empowered to perform a very precise, nerve-sparing operation with the da Vinci Surgical System. For the patient, da Vinci prostatectomy may result in more complete eradication of cancer, retention of bladder control and potency.

From a radiation perspective, multiple options are available for prostate cancer treatment. Three-dimensional conformal and Intensity Modulated Radiation Therapy are available as external beam options for treatment with the additional assistance of image-guided techniques. High Dose Rate brachytherapy treatment is available for selected patients – either as monotherapy or in combination with external beam treatments for additional local regional treatment.

Hormone ablative medications can be used as single modality treatment or in combination with surgical or radiation treatments. The goal of these medications is to provide androgen blockage to eliminate the effects of testosterone and hinder the cancer's growth. An additional option for treatment is observation, which can include monitoring PSA serially and intervening if there is a rise in its value or clinical changes on examination.

For patients with metastatic disease, the use of anti-androgen hormone therapy, palliative radiation therapy for symptomatic areas of metastasis and chemotherapy can be used. All of these options are available at Moore Regional Hospital for the management of these advanced stage patients.

At Moore Regional Hospital in 2011, 50 percent of patients underwent surgical resection as their definitive procedure. Twenty-two percent of prostate patients received external beam radiation treatments alone as definitive management. Twenty-one percent of patients received hormones as part of their definitive treatment either in combination with surgery, radiation treatment or with both; and 4 percent of patients chose to do no treatments and proceed with observation alone. Hormone therapy alone was used in 1 percent of those patients.

We recently reviewed our experience with HDR prostate brachytherapy as monotherapy from the inception of our HDR program in 2004. From 2004 to 2009, 50 low-risk patients were treated with HDR prostate brachytherapy as the sole modality for treatment. Of this total, 37 patients had serial PSAs after the procedure of at least three years. A review of the data indicated that 95 percent of patients were biochemically without disease at last follow-up.

- All 37 patients had Gleason scores of 6
- Average pretreatment PSA was 6 (.95-16.2)
- Average age was 65 (44-83)
- Average nadir PSA was 0.16 (0-.79)

Ultimately, patients with prostate cancer do fairly well with most patients dying from comorbid illnesses rather than prostate cancer. The table below compares patient survival rates over a five-year period comparing Moore Regional Hospital data with the National Cancer Data Base

Observed Survival Analysis

Begin	MRH	National Cancer Data Base
YEAR 1	97.6	97.5
YEAR 2	95.2	95.1
YEAR 3	92.8	92.6
YEAR 4	90.4	90.2
YEAR 5	89.5	87.6

As you can see, similar survival rates are seen with our institution when compared with the National Cancer Data Base. Early diagnosis of prostate cancer leads to more available treatment options for the patient. As mentioned earlier, the decision to proceed with prostate cancer screening must include a discussion with the patient's physician. The decision regarding treatment should also include a discussion with the urologist as well as a radiation oncologist to provide all options available. At Moore Regional Hospital, we have the benefit of qualified physicians and staff to offer the latest in prostate cancer care.

Sushma Patel, M.D.
Radiation Oncology
FirstHealth Moore Regional Hospital

Site and Stage Distribution

New 2011 Cases

Primary Site	Total	M	F	Stage 0	Stage I	Stage II	Stage III	Stage IV	Unknown	N/A
ALL SITES	1173	584	588	57	285	297	223	203	17	90
ORAL CAVITY	17	10	7	0	4	2	4	7	0	0
ESOPHAGUS	7	3	4	0	0	1	3	3	0	0
STOMACH	17	11	6	0	2	4	1	7	1	2
COLON	80	38	42	7	13	18	23	17	1	1
RECTUM	21	12	9	0	7	3	8	2	1	0
ANUS/ANAL CANAL	4	0	4	0	1	2	1	0	0	0
LIVER	21	12	9	0	6	1	5	6	3	0
PANCREAS	37	18	19	0	3	11	4	19	0	0
OTHER DIGESTIVE	13	5	8	0	1	2	1	3	0	6
NASAL/SINUS	2	2	0	0	0	0	0	2	0	0
LARYNX	18	15	3	2	3	4	4	5	0	0
LUNG/BRONCHUS	227	122	105	0	60	18	68	78	3	0
OTHER RESPIRATORY	3	3	0	0	1	0	1	1	0	0
LEUKEMIA	10	7	3	0	0	0	0	0	0	10
MULTIPLE MYELONA	18	15	3	0	0	0	0	0	0	18
BONE	2	2	0	0	0	0	0	0	2	0
CONNECT/SOFT TISSUE	3	3	0	0	3	0	0	0	0	0
MELANOMA	12	9	3	5	3	1	0	2	1	0
OTHER SKIN	1	1	0	0	0	0	0	0	1	0
BREAST	231	6	225	31	88	75	28	7	2	0
CERVIX UTERI	6	0	6	0	1	0	4	1	0	0
CORPUS UTERI	19	0	19	0	11	3	3	0	0	2
OVARY	8	0	8	0	2	2	2	1	1	0
VULVA	2	0	2	0	0	0	2	0	0	0
OTHER FEMALE GENITAL	3	0	3	0	1	0	1	1	0	0
PROSTATE	183	183	0	0	0	139	34	10	0	0
TESTIS	5	5	0	0	4	1	0	0	0	0
BLADDER	35	27	8	11	15	4	3	2	0	0
KIDNEY/RENAL	43	23	20	1	28	0	7	6	1	0
BRAIN (BENIGN) & MENINGES	12	4	8	0	0	0	0	0	0	12
BRAIN (MALIGNANT)	15	8	7	0	0	0	0	0	0	15
THYROID	30	11	19	0	16	3	8	3	0	0
OTHER ENDOCRINE	5	4	1	0	0	0	0	0	0	5
HODGKIN'S DISEASE	4	2	2	0	0	0	1	3	0	0
NON-HODGKIN'S	39	18	21	0	12	3	7	17	0	0
UNKNOWN PRIMARY	11	6	5	0	0	0	0	0	0	11
OTHER/ILL-DEFINED	7	2	5	0	0	0	0	0	0	7

FHMRH CANCER REGISTRY

Moore Regional Hospital Foundation – Cancer CARE Fund Benefactors

In today's complex economy, not-for-profit health care organizations such as FirstHealth face an increasing challenge to provide high-quality care to patients in the most cost-effective manner. The future of reimbursement through insurance and governmental programs for these vital health services is uncertain, and while Americans are blessed with a multitude of health care options, these choices often come at an unexpected price.

The Cancer CARE Fund benefits patients in the primary FirstHealth service area of Moore, Montgomery, Richmond and Hoke counties, providing for such needs as transportation, medications, prostheses, wigs and other patients needs that arise during the course of treatment.

Thank you to the following individuals and organizations who generously supported the Cancer CARE Fund during Fiscal Year 2011-12 (October 1, 2011, to September 30, 2012). Our communities have consistently demonstrated their resolve to provide the financial support necessary to ensure the delivery of superior health care. In fact, one of the abiding strengths of our health system is its long-standing and successful partnership with the communities it serves.

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