2011 Cancer Report

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2011 Cancer Report

The Cancer Committee of FirstHealth Moore Regional Hospital, chaired by Dr. Ellen Willard, is pleased to present this statistical overview of the MRH Cancer Program in 2010 and a major site report on breast 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 2008 survey, the MRH cancer program was awarded the Outstanding Achievement Award. Only 95 programs in the United States received the OAA as a result of surveys performed in 2008. This number represents approximately 19 percent of the 478 programs surveyed during this period. The recipients of the 2011 OAA will be announced in 2012.

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 Comparisons

2010 Most Prevalent Cancer Cases by Number of Cases and Percentage

	MRH		NC*		US**	
BREAST	188	16.4	6,500	14.4	209,060	13.7
LUNG	262	22.9	7,520	16.7	222,520	14.5
PROSTATE	172	15	6,910	15.3	217,730	14.2
COLORECTAL	91	8	4,220	9.4	142,570	9.3
BLADDER	48	4.2	1,890	4.2	70,530	4.6
NH LYMPHOMA	40	3.5	1,800	4.0	65,540	4.3
CORPUS UTERI	16	1.4	1,190	2.6	43,470	2.8
MELANOMA	15	1.3	2,130	4.7	68,130	4.5
LEUKEMIA	6	.5	1,150	2.5	43,050	2.8
CERVIX	1	.1	360	.8	12,200	.8
ALL OTHERS	304	26.6	11,450	25.4	434,760	28.4
Total Cases	**1,143**	**100**	**45,120**	**100**	**1,529,560**	**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, 2010 Cancer Statistics, Estimated new cases.*

FHMRH CANCER REGISTRY

County of Residence at Time of Treatment

2010 New and Recurrent Cancer Cases

Current County	Cases	Percent
MOORE	647	47.40
RICHMOND	193	14.10
LEE	96	7.00
ROBESON	88	6.50
HOKE	81	6.00
MONTGOMERY	75	5.50
SCOTLAND	68	5.00
CUMBERLAND	39	3.00
CHATHAM	16	1.00
HARNETT	12	.88
ANSON	10	.73
MARLBORO (SC)	9	.66
RANDOLPH	8	.59
CHESTERFIELD (SC)	6	.45
OTHER NC	6	.45
OUT OF STATE	5	.37
STANLY	3	.22
ALAMANCE	2	.15
Total Cases	**1364**	**100.00**

FHMRH CANCER REGISTRY

Most Frequently Diagnosed/Treated Cancers

at Moore Regional Hospital

	Breast	Lung	Prostate	Colon/Rectum
2005	195	217	149	132
2006	197	248	160	111
2007	213	229	171	99
2008	201	206	168	85
2009	210	228	164	114
2010	218	262	172	97

FHMRH CANCER REGISTRY
Does not include cancers diagnosed and treated elsewhere and treated at MRH for recurrence.

Age By Gender

All 2010 Cases

Age	Male	Female
10 - 19	3	0
20 - 29	2	7
30 - 39	6	24
40 - 49	29	66
50 - 59	114	117
60 - 69	235	190
70 - 79	197	161
80 - 89	97	87
90 - 99	10	11
Totals	**693**	**663**

FHMRH CANCER REGISTRY

Distribution by Class

2010 All Cases

Class of Case	Cases	Percent
DX AT MRH/TX ELSEWHERE*	42	3
DX/TX AT MRH	1000	74
DX ELSEWHERE/TX MRH	151	11
INITIAL DX /TX ELSEWHERE. SUBSEQUENT TX AT MRH	56	4
PATHOLOGY ONLY	96	7
DX/TX ONLY AT STAFF PHYSICIAN OFFICE	19	1
Total Cases	**1364**	**100.00**

**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 2010 Cancer Cases

Race	Cases	Percent
CAUCASIAN	1021	74.19
AFRICAN AMERICAN	299	21.92
NATIVE AMERICAN	42	3.08
NOT STATED	7	.51
ASIAN	2	.15
JAPANESE	1	.07
VIETNAMESE	1	.07
Total Cases	**1364**	**100.00**

FHMRH CANCER REGISTRY

Cancer Registry Data Overview 2011

In 2010, the FirstHealth Moore Regional Hospital Cancer Registry recorded 1,364 cancer cases, representing a slight increase from the 1,328 cases documented in 2009. In order of incidence, lung, breast, prostate and colorectal cancer were the most commonly diagnosed. This is similar to state and national averages with the exception of lung cancer, which accounted for 22.9 percent of newly diagnosed cases at MRH, but only 16.7 percent in North Carolina and 14.5 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 lesions.

A diagnosis of cancer was clearly related to age, with people aged 60 years and older accounting for 73 percent of cases. The racial distribution of the patient population is similar to that of the local area with approximately 75 percent of cases occurring among Caucasians, 22 percent among African-Americans and 3 percent among American Indians. 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, most of the cases in 2010 were diagnosed in Stages 0, I and II. Some 179 of the 218 cases of breast cancer, 11 of the 16 cases of uterine body cancer and 34 of 48 cases of bladder cancer were diagnosed in very early stages (non-invasive Stage 0 or Stage I.)

Of the 262 lung cancer cases diagnosed, 80 were detected in Stage I or Stage II, stages where surgical removal is possible. Among patients with a diagnosis of prostate cancer, 133 of the 172 cases were detected in Stage II, indicating no evidence of disease spread outside of the gland.

Early cancer 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, 47 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 14 percent of patients are residents of Richmond County. Between 5 and 7 percent of patients travel to MRH 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 MRH, 3 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 and management of most pediatric cancer cases. The remaining 8 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 MRH for diagnosis or treatment.

Collecting, managing and analyzing data related to cancer diagnosis and treatment is a vital part of the cancer program at MRH. 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.

Three nationally certified cancer registrars perform these extensive procedures in addition to organizing and assisting with weekly cancer conferences. Thirty-five requests for specific analyses related to the MRH cancer program data were fulfilled. In 2010, 494 cases were presented for review at 98 multidisciplinary conferences for discussion by a group of physicians representing all specialties involved in the diagnosis and treatment of cancer. Ninety-five percent of the cases were presented prospectively, indicating that multidisciplinary input could affect future treatment decisions.

Jeffrey C. Acker, M.D.
Medical Director
FHMRH Community Hospital Comprehensive Cancer Center

2011 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, clinical trials 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. The studies help determine if new drugs, treatments, devices or approaches are safe and effective.

Studies such as these are required for FDA approval of the drugs or treatments for future cancer patients. They 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, Moore Regional's Clinical Trials office has 30 studies open for cancer patients. The studies were selected to offer patients additional treatment options with a focus on the cancer types most frequently seen at MRH. Patients in clinical studies must be referred by their physicians and are required to meet eligibility criteria to qualify for participation.

Most, but not all, studies target newly diagnosed patients.

All studies are reviewed by the FirstHealth Institutional Review Board (IRB), which is comprised of volunteers including non-clinical members of the local community, physicians and nurses. The IRB examines the goals of each study, weighs the risks versus the benefits and judges the value of the study before patients are enrolled. 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.

The MRH Clinical Trials office enrolled 65 new patients into clinical studies during 2010, and seeks to match or exceed that total for 2011. This level of patient enrollment on clinical studies supports the Accreditation with Commendation of FirstHealth Moore Regional Hospital Community Cancer Center by ACoS (American College of Surgeons).

2011 Major Site Report: Breast Cancer

In 2011, an estimated 230,480 new cases of invasive breast cancer were diagnosed in women in the United States along with 57,650 new cases of noninvasive (in situ) breast cancer. About 2,140 new cases of invasive breast cancer were diagnosed in men in 2011.

About one in eight women will develop invasive breast cancer over the course of their lifetime. A man's lifetime risk is about one in 1,000. About 39,520 women in the United States died from breast cancer in 2011.

Besides skin cancer, breast cancer is the most commonly diagnosed cancer among American women, accounting for just under 30 percent of cancers in women. For women in the U.S., breast cancer trails only lung cancer for cancer-specific mortality.

Most breast cancers are diagnosed at an early stage. This is likely due to the accepted role of annual mammographic surveillance and tremendous self-awareness regarding the potential danger of a palpable breast mass. A total of 212 breast cancers were diagnosed within the FHMRH system in 2010. Fifty-four percent of those cases were diagnosed at an early stage (14 percent in situ, 40 percent stage I). This is in keeping with the National Cancer Data Base (NCDB) figure of 58 percent. Stage of presentation of breast cancer diagnosis at FHMRH mirrors the NCDB across all stages (Table 1). Breast cancer incidence rates continue to demonstrate a downward trend. Female breast cancer incidence rates decreased by about 2 percent per year from 1999 to 2005. This trend was observed only in women aged 50 or older and was thought secondary to the decreased use of post- menopausal hormonal replacement therapy that occurred after the publication of the W omen's
Health Initiative in 2002.

Although a significant number of breast cancers are hereditary in nature (due to an inherited mutation in BRCA1 and BRCA2 or other genes such as CHEK2, PTEN, ATN, or p53), most breast cancers are nonfamilial in nature. Other risk factors associated with an increased risk of breast cancer include dense breast tissue, aging, prior chest irradiation, diethylstilbestrol exposure, nulliparity, recent oral contraceptive use, hormonal replacement therapy, alcohol use and obesity.

Surgery remains the mainstay of treatment for breast cancer except in those patients who present with metastatic disease. However, the optimal therapy for the majority of breast cancer patients includes multiple modalities. Hormonal therapy, radiation therapy and chemotherapy play important roles in addition to surgery. A review of the FHMRH Cancer Registry data demonstrates that 84 percent of breast cancer patients received some sort of combination therapy (Table 2). This environment of cooperation across medical specialties is fostered at FHMRH through weekly tumor boards and clinical case conferences in which representatives of the departments of surgery, radiation oncology, medical oncology, pathology, diagnostic radiology, nursing, cancer registry and clinical trials all attend. Stage of disease, hormone receptor status and patient preference continue to be key drivers regarding the selection of appropriate treatment.

Significant trends noticed in the past four years since this institution's last major site report on breast cancer include the following:

- An increased use of breast MRI imaging with the goal of detecting cancers at an earlier stage. This allows greater surgical options for a patient, hopefully improving the chance for long-term cure.
- Increased awareness and testing for the BRCA1 and 2 mutations. Armed with this information, patients may select an alternative surgical therapy and consider a prophylactic bilateral mastectomy and/or oophorectomy or opt for closer surveillance.
- Increased adoption of the Oncotype DX® diagnostic tool. This has contributed to the decreased use of adjuvant systemic therapy in the estrogen receptor-positive, lymph node-negative adjuvant breast cancer setting.

Use of these prognostic and predictive tools results in the avoidance of chemotherapy for women who are unlikely to benefit (and thus eliminate chemotherapy-associated toxicities), reserving chemotherapy for a more selective population of early-stage breast cancer that is likely to demonstrate some degree of benefit from the use of adjuvant chemotherapy. Other trends noticed since the last report include an increased utilization of the docetaxel/cyclophosphamide chemotherapy regimen and a decreased reliance on anthracycline-based therapies in the adjuvant setting.

Newly approved FDA agents such as ixabepilone, eribulin mesylate and lapatinib have all been successfully incorporated into the treatment plan for many of our metastatic breast cancer patients. There has not been significant uptake of the use of the FDA-approved preventive agent of tamoxifen or raloxifene within the FHMRH system.

Overall, significant progress has been made in the treatment of breast cancer, both nationally and at FHMRH. Death rates from breast cancer have been declining since 1990. Ninety percent of women diagnosed with invasive breast cancer will be alive five years after their diagnosis.

There are an estimated 2.63 million survivors of breast cancer within the United States as per the 2011 SEER database.

Some of these improvements are believed to be secondary to increased awareness, active screening programs, earlier stage of breast cancer diagnoses, the development of new breast cancer-specific therapies and the overall improvement of health care in general over the past number of years. Although tremendous strides have been made, much work lies ahead.

Charles S. Kuzma, M.D.
Medical Oncology/Hematology
PMC/FH Outpatient Cancer Center

Table 1
Stage at Diagnosis
2010 Breast Cancer

Stage	NBR-Cases	Percent
0	29	13.68
I	85	40.09
II	60	28.30
III	30	14.15
IV	6	2.83
UNK	2	.94
Total Cases	**212**	**100.00**

FHMRH CANCER REGISTRY

Table 2
Treatment Combinations
2010 Breast Cancer

Rx Type	NBR-Cases	Percent
SURG/RAD/HOR	53	25.00
SURG/HOR	36	16.98
SURG	33	15.57
SURG/CHEM/RAD/HOR	22	10.38
SURG/CHEM/RAD	20	9.43
SURG/RAD	19	8.96
SURG/CHEM	16	7.55
SURG/CHEM/HOR	6	2.83
OTHER COMBINATIONS	5	2.36
NONE	2	.94
Total Cases	**212**	**100.00**

FHMRH CANCER REGISTRY

Table 3
Observed Survival Analysis
2003-2005 Breast Cancer

Begin	MRH	North Carolina	American Cancer Society Southern Division	NCDB All Programs
YEAR 1	97.9	97.2	97.3	97.1
YEAR 2	95.6	93.9	93.9	93.9
YEAR 3	91.4	90.6	90.5	90.5
YEAR 4	88.2	87.7	87.4	87.4
YEAR 5	85.6	84.5	84.3	84.3
Total Cases	**390**	**20539**	**130073**	**130711**

FHMRH CANCER REGISTRY
ACOS NATIONAL CANCER DATA BASE

Site and Stage Distribution

Primary Site Tabulation for New 2010 Cases

Sites	Total	M	F	Stage 0	Stage I	Stage II	Stage III	Stage IV	Unknown	N/A
ALL SITES	1194	607	587	65	287	289	205	207	37	104
ORAL CAVITY	26	21	5	0	1	3	8	12	1	1
ESOPHAGUS	9	6	3	0	1	2	0	2	4	0
STOMACH	17	8	9	0	2	2	1	8	1	3
COLON	75	35	40	8	12	21	18	13	3	0
RECTUM	19	10	9	0	5	2	9	3	0	0
ANUS/ANAL CANAL	2	1	1	0	0	1	1	0	0	0
LIVER	9	6	3	0	1	0	3	4	1	0
PANCREAS	24	12	12	0	3	10	3	7	1	0
OTHER DIGESTIVE	21	9	12	0	2	2	1	9	1	6
NASAL/SINUS	2	1	1	0	1	0	0	1	0	0
LARYNX	17	14	3	1	3	5	4	4	0	0
LUNG/BRONCHUS	262	154	108	0	65	15	75	98	6	3
OTHER RESPIRATORY	4	3	1	0	2	0	0	1	0	1
LEUKEMIA	6	1	5	0	0	0	0	0	0	6
MULTIPLE MYELONA	20	15	5	0	0	0	0	0	0	20
OTHER	5	3	2	0	0	0	0	0	0	5
CONNECT/SOFT TISSUE	6	3	3	0	1	0	0	1	4	0
MELANOMA	18	14	4	3	6	5	1	2	1	0
OTHER SKIN	1	1	0	0	0	0	0	0	0	1
BREAST	218	4	214	30	88	61	30	6	3	0
CERVIX UTERI	1	0	1	0	0	0	0	1	0	0
CORPUS UTERI	16	0	16	0	11	1	3	0	1	0
OVARY	12	0	12	0	3	2	1	4	1	1
VULVA	2	0	2	2	0	0	0	0	0	0
PROSTATE	172	172	0	0	0	133	33	6	0	0
TESTIS	3	3	0	0	0	0	0	0	3	0
BLADDER	48	39	9	20	14	11	0	3	0	0
KIDNEY/RENAL	37	20	17	0	22	1	4	6	4	0
OTHER URINARY SYSTEM	4	4	0	1	2	0	0	1	0	0
BRAIN (BENIGN)	6	5	1	0	0	0	0	0	0	6
BRAIN (MALIGNANT)	14	7	7	0	0	0	0	0	0	14
OTHER CNS	17	5	12	0	0	0	0	0	0	17
THYROID	40	9	31	0	29	3	7	0	1	0
OTHER ENDOCRINE	6	2	4	0	0	0	0	0	0	6
HODGKIN'S DISEASE	1	1	0	0	1	0	0	0	0	0
NON-HODGKIN'S	40	15	25	0	12	9	3	15	1	0
UNKNOWN PRIMARY	11	4	7	0	0	0	0	0	0	11
OTHER/ILL-DEFINED	3	0	3	0	0	0	0	0	0	3

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 2010-11 (October 1, 2010, to September 30, 2011). 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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