# 2013 Cancer Report

FirstHealth
OF THE CAROLINAS

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# 2013 Cancer Report

The Cancer Committee of FHMRH, chaired by Dr. Ellen Willard, is pleased to present this statistical overview of the MRH Cancer Program in 2012 and a major site report on non-small cell lung 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. 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. In addition, FHMRH 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.

## FirstHealth Moore Regional Hospital New Cancer Cases Diagnosed 2012

| | FHMRH | | NC* | | US* | |
|---|---|---|---|---|---|---|
| **Primary Site** | **Cases** | **Percent** | **Cases** | **Percent** | **Cases** | **Percent** |
| BREAST | 223 | 19.4 | 7,090 | 13.7 | 226,870 | 13.8 |
| LUNG | 274 | 23.8 | 7,950 | 15.3 | 226,160 | 13.8 |
| PROSTATE | 132 | 11.5 | 8,010 | 15.4 | 241,740 | 14.8 |
| COLORECTAL | 75 | 6.5 | 4,140 | 8.0 | 143,460 | 8.8 |
| BLADDER | 43 | 3.7 | 2,100 | 4.0 | 73,510 | 4.5 |
| NH LYMPHOMA | 41 | 3.6 | 2,050 | 4.0 | 70,130 | 4.3 |
| CORPUS UTERI | 13 | 1.1 | 1,390 | 2.7 | 47,130 | 2.9 |
| MELANOMA | 17 | 1.5 | 2,360 | 4.6 | 76,250 | 4.7 |
| LEUKEMIA | 8 | .7 | 1,410 | 2.7 | 47,150 | 2.9 |
| CERVIX | 6 | .5 | 390 | .8 | 12,170 | .7 |
| ALL OTHERS | 319 | 27.7 | 14,970 | 28.9 | 474,340 | 28.9 |
| **Total Cases** | **1,115** | **100** | **51,860** | **100** | **1,638,910** | **100** |

**American Cancer Society, 2012 Cancer Statistics, Estimated new cases.*

*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.*

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## County of Residence at time of treatment at MRH – All 2012 Cases

| **Current County** | **Cases** | **Percent** |
|---|---|---|
| MOORE | 641 | 46 |
| RICHMOND | 197 | 14 |
| LEE | 121 | 9 |
| MONTGOMERY | 82 | 6 |
| SCOTLAND | 75 | 5 |
| HOKE | 71 | 5 |
| ROBESON | 61 | 4 |
| CUMBERLAND | 43 | 3 |
| CHATHAM | 36 | 3 |
| MARLBORO (SC) | 20 | 1 |
| HARNETT | 17 | 1 |
| OTHER NC | 9 | 1 |
| RANDOLPH (NC) | 9 | 1 |
| OTHER SC | 5 | .4 |
| OTHER OUT OF STATE | 6 | .4 |
| ANSON (NC) | 5 | .3 |
| **Total Cases** | **1398** | **100** |

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## Age by Gender Distribution – New Diagnoses 2012

| **Age Range** | **Male** | **Female** |
|---|---|---|
| 20 - 29 | 5 | 8 |
| 30 - 39 | 7 | 11 |
| 40 - 49 | 34 | 57 |
| 50 - 59 | 95 | 102 |
| 60 - 69 | 180 | 158 |
| 70 - 79 | 166 | 147 |
| 80 - 89 | 74 | 87 |
| 90 - 99 | 7 | 13 |
| **Totals** | **568** | **583** |

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## Distribution by Type of Case – All 2012 Cases

| **Class of Case** | **Cases** | **Percent** |
|---|---|---|
| DX AND TX AT MRH | 879 | 63 |
| DX ELSEWHERE AND TX AT MRH | 203 | 15 |
| DX AT MRH AND TX ELSEWHERE | 69 | 5 |
| INITIAL DX/TX ELSEWHERE, TX AT MRH FOR RECURRENCE OR PERSISTENCE | 170 | 12 |
| PATHOLOGY ONLY | 77 | 5 |
| **Total Cases** | **1398** | **100** |

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*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.*

## Distribution by Race – All 2012 Cases

| Race | Cases | Percent |
|---|---|---|
| CAUCASIAN | 1071 | 77 |
| AFRICAN AMERICAN | 285 | 20 |
| NATIVE AMERICAN | 35 | 3 |
| ASIAN | 6 | .4 |
| NOT STATED | 1 | .1 |
| **Total Cases** | **1398** | **100.00** |

*FHMRH CANCER REGISTRY*

# Cancer Registry Data Overview 2013

In 2012, the FHMRH Cancer Registry recorded 1398 cancer cases, representing a slight increase from the 1,383 cases documented in 2011. 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 23.8 percent of newly diagnosed cases at MRH, but only 15.3 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 72 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, 20 percent among African-Americans, and 3 percent among Native Americans. Hispanic patients are included in the Caucasian or African-American 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 2012 were diagnosed in Stages 0, I and II. Some 138 of the 223 cases of breast cancer, six of the 13 cases of uterine cancer and 31 of 43 cases of bladder cancer were diagnosed in very early stages (non-invasive Stage 0 or Stage I.)

Of the 274 lung cancer cases diagnosed, 83 were detected in Stage I or Stage II, stages where surgical removal is possible. Among patients with a diagnosis of prostate cancer, 103 of the 132 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, 46 percent of the patients who were diagnosed and/or treated at the FHMRH Community Hospital Comprehensive Cancer Center reside in Moore County. An additional 14 percent of patients are residents of Richmond County. Between 5 and 10 percent of patients travel to MRH from each of the following counties: Lee, Montgomery, Scotland and Hoke. The remaining patients reside in more distant areas.

While 90 percent of patients were treated at FHMRH, 5 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 FHMRH for diagnosis or treatment.

Collecting, managing and analyzing data related to cancer diagnosis and treatment is a vital part of the cancer program at FHMRH. 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. Sixteen requests for specific analyses related to the FHMRH cancer program data were fulfilled. In 2012, 410 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. Some 97 percent of the cases were presented prospectively, indicating that multidisciplinary input can affect future treatment decisions.

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

# 2013 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 of 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. Moore Regional Hospital has participated in clinical trials since 1997. As of the writing of this document, the Clinical Trials office at MRH has 23 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 MRH. 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 an Institutional Review Board (IRB). This board 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 MRH. 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 2013, the MRH Clinical Trials office enrolled 55 new patients in clinical studies and seeks to match or exceed that total in 2014. This level of patient enrollment on clinical studies supports the Accreditation with Commendation of the FirstHealth Moore Regional Hospital Community Hospital Comprehensive Cancer Program by ACoS (American College of Surgeons).

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 number of new trials to be opened. The changes will create challenges in terms of the number of patients enrolling at MRH, but the hope is that the changes will lead to better research treatment opportunities from NCI-sponsored organizations.

In addition, new changes coming into effect on Jan. 1, 2014, due to the Affordable Care Act have resulted in pre-authorization requirements by some private insurance companies before patients can be enrolled in clinical trials.

# 2013 Major Site Report: Non-Small Cell Lung Cancer – FHMRH Resection Experience 2011-2012

Lung cancer represents the most common cause of cancer mortality in the United States as well as worldwide. In 2012, approximately 160,300 Americans died from lung cancer, representing 28 percent of all cancer deaths and more than the combined total for colon, breast and prostate cancers, the next three most common types. It was estimated that 226,100 new cases of lung cancer would be diagnosed in 2012 – 14 percent of all cancer diagnoses that year.

The disease is prevalent in both men and women although diagnosed at a higher rate in men. However, this rate has slightly fallen for men during the past 30 years while more than doubling for women.

There are two broad classifications for lung cancer: non-small cell lung cancer (NSCLC) and small cell lung cancer. These classes represent 80 percent and 20 percent of lung cancers respectively.

The overall five-year survival rate is 16.3 percent with the importance of early diagnosis illustrated by a five-year survival rate of 52.6 percent for disease localized to the lungs and only 3.5 percent for Stage IV disease spread to other organs. Lung cancer can be largely attributed to environmental exposures, particularly smoking, which is estimated to be responsible for 90 percent of all lung cancers. Additional causes include environmental carcinogens such as radon and asbestos.

Men who smoke are 23 times more likely to develop lung cancer compared to those who never smoked with women 13 times more likely.

The clinical assessment of all newly diagnosed lung cancers involves the use of both noninvasive and invasive techniques to properly determine the extent or stage of the disease. Clinical assessment includes history and physical, imaging studies and laboratory testing. Pathologic staging incorporates the clinical stage with histologic evaluation of tissue specimens removed. Treatment modalities include surgical resection, chemotherapy and radiation therapy. Appropriate strategies could include a single modality or a combination of modalities depending on the stage of the cancer.

A full array of both diagnostic and treatment modalities is available at FirstHealth Moore Regional Hospital (FHMRH). Diagnostic modalities include CT-guided lung biopsy, bronchoscopic biopsy including use of endobronchial ultrasound (EBUS) and navigation bronchoscopy, esophagoscopy with esophageal ultrasound (EUS), thoracoscopic and mediastinoscopic biopsy, and surgical resection with video-assisted technique as well as traditional thoracotomy. A comprehensive array of chemotherapy and radiation treatment options is offered by the medical oncology and radiation oncology teams respectively.

In addition to establishing a clinical stage for each newly diagnosed lung cancer, patients are generally reviewed prospective of treatment at a multidisciplinary lung conference held weekly at FHMRH. This approach allows a team of surgeons, pulmonologists, radiologists, pathologists and oncologists to determine an optimal treatment strategy for each individual patient. History, physical exam and appropriate diagnostic cardiopulmonary testing coupled with the clinical stage are all utilized to determine resectability. This manner of review and the active participation in these discussions by the thoracic surgeons at FHMRH complies with the NCCN guidelines for principles of surgical resection for NSCLC in terms of pre-operative evaluation.

During 2011-2012, a total of 78 patients underwent surgical resection for NSCLC. Among those resected, 22 patients underwent a sublobar resection of either segmentectomy or wedge resection. Sublobar resection is appropriate according to NCCN guidelines for patients with poor pulmonary reserve or other major co-morbidity. A detailed review of these cases confirmed that the decisions to limit these patients to sublobar resections were all consistent with the guidelines. NCCN guidelines also stipulate that there should be appropriate sampling of both N1 and N2 lymph node stations at the time of surgery unless technically not feasible. Of the 22 sublobar resections, 10 cases (45 percent) had both N1 and N2 lymph nodes sampled. More importantly, an evaluation of the 12 cases in which no lymph node sampling was performed demonstrated that two cases were via thoracotomy and 10 with thoracoscopy. In each of the thoracotomy cases, the surgical decision not to proceed with nodal dissection was based on the presence of significant anatomic contraindications. There is evidence that failure to examine mediastinal lymph nodes is associated with poorer survival [1]. Other studies have documented that thoracoscopic techniques are associated with fewer lymph nodes sampled [2]. However, among these 10 cases, only one patient has presented with evidence of recurrent disease – manifested as Stage IV malignant pleural effusion 16 months following initial resection. Nonetheless, future efforts to add appropriate lymph node sampling concomitant with a thoracoscopic surgical approach in those patients in whom the effort does not add surgical risk represents an opportunity for process improvement.

The remainder of patients in the surgical cohort included 56 patients who underwent complete lobar resection for NSCLC. The NCCN guidelines stipulate that appropriate N1 and N2 lymph nodes with a minimum of three separate N2 stations sampled or complete lymph node dissection should be a routine component of these cases. An analysis of these cases indicates that 50 cases (89 percent) had complete nodal dissections performed, including at least one N2 station. Thirty-three patients (59 percent) had three separate N2 stations sampled.

NCCN guidelines regarding postoperative referrals for adjuvant therapy were also reviewed. Patients with pathologic stage II or greater should be referred for medical oncology evaluation. Among the surgical patients, there were 17 in this category of which 15 (88 percent) were evaluated by medical oncology and two (12 percent) who were deemed not appropriate or chose not to pursue a referral. Patients with resected stage IIIA disease should be referred for radiation oncology evaluation. This cohort totaled six patients, all of whom were evaluated by radiation oncologists.

This analysis indicates that the surgical approach to NSCLC at FHMRH conforms well to evidence-based practice as outlined in the NCCN guidelines. The multidisciplinary team approach in the pre- and postoperative assessment of these patients is extremely valuable in that regard. The three thoracic surgeons, all of whom have a significant amount of their practice devoted to thoracic oncology, conform to surgical principles for NSCLC resection.

*[1] Osarogiagbon RU, Allen JW, et al. Pathologic Lymph Node Staging Practice and Stage-Predicted Survival After Resection of Lung Cancer. Ann Thor Surg 2011;91:1486-93.*

*[2] Denlinger CE, Fernandez F, et al. Lymph Node Evaluation in Video-Assisted Thoracoscopic Lobectomy Versus Lobectomy by Thoracotomy. Ann Thor Surg 2010; 89:1730-1736.*

Thomas Arthur Edgerton, M.D., FACS
Cardiothoracic Surgery
FirstHealth Cardiovascular and Thoracic Center
Reid Heart Center
FirstHealth Moore Regional Hospital

# Site and Stage Distribution - New 2012 Cases

| Primary Site | Total | M | F | Stage 0 | Stage I | Stage II | Stage III | Stage IV | Unknown | N/A |
|---|---|---|---|---|---|---|---|---|---|---|
| ALL SITES | 1151 | 568 | 583 | 78 | 278 | 253 | 202 | 215 | 23 | 102 |
| ORAL CAVITY | 28 | 18 | 10 | 2 | 6 | 3 | 6 | 11 | 0 | 0 |
| ESOPHAGUS | 14 | 10 | 4 | 0 | 1 | 3 | 7 | 2 | 1 | 0 |
| STOMACH | 13 | 3 | 10 | 0 | 2 | 0 | 2 | 9 | 0 | 0 |
| COLON | 55 | 34 | 21 | 2 | 8 | 15 | 19 | 11 | 0 | 0 |
| RECTUM | 20 | 10 | 10 | 1 | 5 | 5 | 5 | 3 | 1 | 0 |
| ANUS/ANAL CANAL | 2 | 0 | 2 | 0 | 0 | 0 | 2 | 0 | 0 | 0 |
| LIVER | 13 | 10 | 3 | 0 | 0 | 0 | 3 | 6 | 4 | 0 |
| PANCREAS | 36 | 18 | 18 | 0 | 4 | 13 | 5 | 14 | 0 | 0 |
| OTHER DIGESTIVE | 14 | 6 | 8 | 0 | 2 | 3 | 2 | 3 | 0 | 4 |
| NASAL/SINUS | 1 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 |
| LARYNX | 13 | 8 | 5 | 1 | 4 | 4 | 2 | 2 | 0 | 0 |
| LUNG/BRONCHUS | 274 | 162 | 112 | 1 | 66 | 17 | 72 | 110 | 7 | 1 |
| OTHER RESPIRATORY | 6 | 4 | 2 | 0 | 1 | 1 | 0 | 2 | 1 | 1 |
| LEUKEMIA | 8 | 4 | 4 | 0 | 0 | 0 | 0 | 0 | 0 | 8 |
| MULTIPLE MYELOMA | 14 | 8 | 6 | 0 | 0 | 0 | 0 | 0 | 0 | 14 |
| OTHER HEMATOLOGIC | 7 | 4 | 3 | 0 | 0 | 0 | 0 | 0 | 0 | 7 |
| CONNECT/SOFT TISSUE | 4 | 3 | 1 | 0 | 3 | 1 | 0 | 0 | 0 | 0 |
| MELANOMA | 17 | 9 | 8 | 7 | 8 | 1 | 0 | 0 | 0 | 1 |
| BREAST | 223 | 3 | 220 | 46 | 92 | 53 | 22 | 8 | 2 | 0 |
| CERVIX UTERI | 6 | 0 | 6 | 0 | 1 | 3 | 1 | 1 | 0 | 0 |
| CORPUS UTERI | 13 | 0 | 13 | 1 | 5 | 1 | 4 | 1 | 1 | 0 |
| OVARY | 5 | 0 | 5 | 0 | 1 | 0 | 3 | 0 | 0 | 1 |
| VULVA | 2 | 0 | 2 | 0 | 0 | 1 | 1 | 0 | 0 | 0 |
| OTHER FEMALE GENITAL | 4 | 0 | 4 | 0 | 1 | 1 | 1 | 0 | 1 | 0 |
| PROSTATE | 132 | 132 | 0 | 0 | 0 | 103 | 18 | 10 | 1 | 0 |
| TESTIS | 2 | 2 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 0 |
| OTHER MALE GENITAL | 2 | 2 | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 0 |
| BLADDER | 43 | 33 | 10 | 17 | 14 | 7 | 1 | 2 | 1 | 1 |
| KIDNEY/RENAL | 29 | 16 | 13 | 0 | 14 | 2 | 6 | 6 | 1 | 0 |
| BRAIN (BENIGN) | 2 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 2 |
| BRAIN (MALIGNANT) | 19 | 9 | 10 | 0 | 0 | 0 | 0 | 0 | 0 | 19 |
| OTHER BRAIN & CNS | 22 | 7 | 15 | 0 | 0 | 0 | 0 | 0 | 0 | 22 |
| THYROID | 36 | 10 | 26 | 0 | 23 | 5 | 5 | 3 | 0 | 0 |
| OTHER ENDOCRINE | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| HODGKIN'S DISEASE | 9 | 6 | 3 | 0 | 3 | 3 | 3 | 0 | 0 | 0 |
| NON-HODGKIN'S | 41 | 22 | 19 | 0 | 11 | 7 | 11 | 11 | 1 | 0 |
| UNKNOWN PRIMARY | 20 | 13 | 7 | 0 | 0 | 0 | 0 | 0 | 0 | 20 |
| OTHER/ILL-DEFINED | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 |

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# 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 2012-13 (October 1, 2012, to September 30, 2013). 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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