

The DCH

CANCER TREATMENT CENTER

Annual Report

In this issue:

Lung Cancer

New Cancer Center Director

The Cancer Center



The region's cancer center

2008
Annual
Report

For 2007 Data



Chairman *from the*

This was a busy year for The DCH Cancer Treatment Center (CTC) with 1045 analytic cases accessioned. The Cancer Treatment Center continues to be the major treatment center for the West Alabama area, providing world-class cancer care in a community setting. That setting will soon change dramatically as there was significant progress this year in construction of the new Cancer Center which is scheduled to open in March of 2009.



women for treatment of breast cancer in radiation oncology. The increase in patient volumes on medical oncology necessitated the expansion of the existing infusion room to meet the growing needs. This was an interim adjustment until such time as the new Cancer Center is in use.

The CTC continued preparations for accreditation by the American College of Surgeons (ACoS). Great strides were made toward that goal with the Tumor Registry keeping all data current and submitted in a timely manner to the state. Progress was made toward a second criterion for ACoS accreditation with the initiation of a clinical trials program with patient accrual by midyear.

Goals and objectives established by the Cancer Committee for 2008 include preparation for a site visit from ACoS, clinical research enrollment to meet or exceed 4% of analytic cases for the previous year, and beginning implementation of the EMR.

The DCH Cancer Treatment Center is a community cancer center. It is our goal to care for the people of West Alabama by providing the most current therapies for our patients while always remembering we are taking care of our neighbors.

George W. Nunn, MD

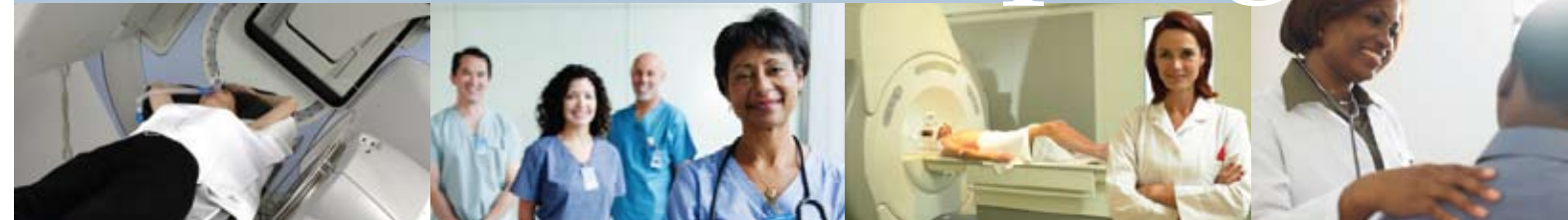
A new director for the Cancer Center was selected, and she began work in September of 2007. The medical staff includes three board certified hematologist/oncologists and two radiation oncologists. In addition to caring for patients at the Regional Medical Center, these physicians travel to three outlying clinics in Bibb, Fayette, and Pickens counties each week.

The Center conducted six free breast screenings in 2007 for women who were uninsured or underinsured. The DCH Cancer Treatment Center continues its commitment to community outreach through support groups for cancer survivors, and those going through treatment. This critical component of holistic patient care was augmented this year with the approval of a position for a community outreach coordinator. Patients are also facilitated through their treatment by a full time social worker and a financial counselor. Continued support from the community is evidenced by the monetary donations and participation in fundraising events such as "Relay for Life," "Barbeque and Blue Jeans," and "Nite on the Green."

During 2007 final selections were made for the radiation equipment that will be utilized in the new Cancer Center, the electronic medical record (EMR) for the Cancer Center was selected, and Axxent brachytherapy was chosen as another option for



Capital Campaign



Our vision is to elevate the DCH Cancer Treatment Center into the ranks of the top cancer centers in the nation.

West Alabama deserves to have the best possible services in the best possible facility, right here in our own community.

Currently, the DCH Cancer Treatment Center is operating beyond the capacity for which it was designed, and with projected increases in patient volumes, the current space will not be adequate.

Expansion will ease these space problems and will more than double its capacity. However, the planned expansion is as much about vision as about floor space – a vision of an even higher standard of holistic and compassionate care

backed by a world-class medical staff. The community has embraced a first-ever capital campaign at DCH Health System.

After considerable planning and volunteer recruitment, the

campaign was launched in June 2006 to support the new Cancer Center at DCH. Before the end of the year, more than \$5,645,000 had been raised. DCH employees raised more than \$1,842,000, and the volunteer auxiliaries at DCH Regional

Medical Center and Northport Medical Center raised another \$1,030,000. Members of the hospital's governing board and foundation board have raised more than \$1,700,000. The campaign among physicians is still underway, and so far has raised just over \$250,000. Well over 100 volunteers have been recruited to assist in reaching out to community leaders and prominent businesses and families. We

remain confident that we will surpass the \$10,000,000 that was initially tested during the campaign's feasibility study.

...a vision of an even higher standard of holistic and compassionate care backed by a world-class medical staff.

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2008 cancer Committee

George Nunn, MD
Surgeon/Chairman of Cancer Committee

John Dubay, MD
Medical Oncologist

Melanie Graham, MD
Radiation Oncologist

Charles Gross, MD
General Surgeon

Al Mathews, MD
Pathologist

Curtis Tucker, MD
Radiation Oncologist

James Bankston, MD
Diagnostic Radiologist

Joe Wallace, MD
Surgeon/Physician Liaison

Cindy Perkins, RN, Ph.D.
Clinical Research Coordinator

Amanda Henson
*Administrative Director of DCH
Cancer Treatment Center*

Kay Cook
Certified Tumor Registrar

Berni Dellapenna
Social Worker

Beth Donaldson
Dietitian

Cathy Goins
Senior Radiation Therapist

Becky Greggs
PI/QM

Donna Marrero
VP/Outpatient/Ancillary Services

Tom Rogers
Pharmacist

Bob Shaw
Chaplain

Sherry Skelton
Nurse Manager

Lisa Taylor
Recording Secretary

new Director



The DCH Cancer Treatment Center hired a new Administrative Director in 2007. Amanda Henson, originally from Louisville, Ky, started at the DCH Cancer Treatment Center in September. Ms. Henson received her master's degrees in both Healthcare Administration and Business Administration from the University of Alabama at Birmingham. She spent the last three years in Jacksonville, Fla, working for Shands at the University of Florida (UF) Healthcare System. Her first year was spent completing a residency in health-care administration by working with the President of Shands Jacksonville Hospital. Following that, she spent two years

managing a growing cancer program at UF and Shands Jacksonville. Ms. Henson has enthusiastically brought expertise and experience in cancer center operations with her to DCH Regional Medical Center. We are excited to have her here, and we look forward to her leadership as the DCH Cancer Treatment Center continues to expand and move into a new center in early 2009.

advanced Caring

At the DCH Cancer Treatment Center, our patients find a comprehensive facility with highly skilled staff and advanced treatment methods. But more than that, they also find a supportive, comfortable environment and personal attention. We call this approach "advanced caring."

Located in the Phelps Outpatient Center at DCH Regional Medical Center, the DCH Cancer Treatment Center provides a full range of cancer treatment services in one convenient location. Radiotherapy, chemotherapy, an outpatient lab, and a pharmacy are all under one roof. Along with the modern facilities and state-of-the-art equipment, our patients

find a team of skilled professionals including Physicians, Nurses, Therapists, Nutritional Counselors, a Financial Counselor, a Social Service Representative, and a Chaplain.

In addition to services provided at our Tuscaloosa facility, we, in partnership with local county hospitals, offer medical oncology clinics one day each week in surrounding counties to allow patients to receive treatment close to home.

Since 1986, we have combined advanced treatment with a strong focus on our patients. It is a reassuring approach for the individuals we serve and the physicians who refer them; it is an approach that makes it possible to provide the caring, effective treatment our patients deserve.

clinical Trials

In January of 2007 the DCH Cancer Treatment Center launched a clinical research program designed to oversee patients participating in clinical trials in cancer care. Clinical trials are part of a long process in which drugs and devices are developed and studied to determine their safety, dosages, and efficacy. They are a mechanism for developing better ways to detect, treat, and prevent cancer. Clinical trials may offer a patient a last hope in an otherwise exhausted list of treatment, or the newest weapon in the arsenal to fight cancer, and thus be the first line therapy in their treatment.

Cindy Perkins, RN, Ph.D., is the Clinical Research Coordinator for the clinical trials program. A Holt High School graduate, Dr. Perkins worked as a registered nurse at DCH Regional Medical Center and as an instructor at the University of Alabama. Dr. Perkins received her bachelor's of science in nursing from the UA Capstone College of Nursing, and a master's of science in nursing and a post master's certificate as a family nurse practitioner from the University of Alabama at Birmingham. She earned a doctorate in clinical health sciences from the University of Mississippi Medical Center in Jackson.

Dr. John Dubay is the principal investigator for medical oncology studies. Dr. Dubay came to DCH from the University of Alabama at Birmingham, where he conducted research for several years. Dr. Melanie Graham and Dr. Curtis Tucker share principal investigator roles for radiation oncology studies. All of the physicians at the DCH Cancer Treatment Center take an active role in clinical trials.



Cindy Perkins, RN, Ph.D.
Clinical Research Coordinator

They are instrumental in trial selection and patient accrual. It is critical to find the right trial for the right patient, and then to make sure the protocol is followed strictly for the patient's optimum outcome.

The DCH Cancer Treatment Center participated in clinical trials on a limited basis several years ago, and with the new Cancer Center now under construction, it was decided that the time was right for a full-scale program.

We offer so much in terms of cancer care right here in Tuscaloosa that it seemed only right that patients have the option of clinical trials as part of their treatment. Offering patients this option means access to drugs and treatments that would not otherwise be possible due to transportation and other economic barriers. We want to keep our patients at home for their care whenever possible. We believe they need to be with their families and other support systems during this very vulnerable time in their lives.

Under the new program, DCH Cancer Treatment Center patients can choose to participate in clinical trials, giving them access to experimental drugs or treatments long before they are available on the open market. Patients participating in clinical trials may take new drugs as part of carefully designed studies sponsored by pharmaceutical companies or government-funded agencies. The studies are closely monitored by the U.S. Food and Drug Administration.

Clinical trials come in many forms. Typically one thinks of a clinical trial as involving experimental drug or treatment, and that is often the case. However, there are also trials that strictly involve data collection to better understand diagnosis and treatment of a particular disease process. There are trials that are aimed at early detection of disease, and also trials that focus on the best way to treat side effects of cancer care, such as nausea, vomiting, or anemia.

Clinical trials are designed in phases. A Phase 1 trial looks at safety and dosage of the drug in a human host. Phase 2 is concerned with efficacy and side effects of the drugs being tested. Phase 3 is comparing the experimental drug or treatment to the standard of care treatment, which is the best we have to offer at any particular point in time. Finally, Phase 4 studies examine long-term safety and effectiveness

continued

of treatment, and other uses of the drugs or treatments.

Initially, the focus of the clinical trials program was to network with potential study sponsors and let them know that our program existed and to look for trials that would benefit our patient population. Next, we selected trials and applied for entry into the studies. Patient accrual began about midyear, and by the end of 2007 – 11 patients

were on a study initiated by DCH, or they were put on a protocol at another institution and were receiving their treatment at DCH. That in itself is a benefit to a patient - not to have to consistently travel out of town at great expense to be part of a study at another facility. DCH works in cooperation with other facilities to administer patient treatment locally for protocols initiated elsewhere.

These trials give cancer patients options and knowledge on their health-care alternatives. We want to be able to provide citizens of West Alabama with the most advanced treatment options available.

The DCH Cancer Treatment Center already offers state-of-the-art cancer care. The addition of a full-scale clinical trials program will only augment the already outstanding care available.

state and regional events. During 2007, we were fortunate to have two of our staff pass the NCRA's Certified Tumor Registrar (CTR) exam. These Registrars went above and beyond to accomplish this in such a short time. Another way that the Registry stays informed is to host onsite North American Association of Central Cancer Registries (NAACCR) educational Webinars. We started hosting these in 2006-2007, and we have signed up for the 2008-2009 series.

During 2007, the Tumor Registry abstracted 1,074 cases with 1,045 of those being analytic (class of case 0, 1, and 2) as seen in (Table 1). The top five sites for analytic cases included Breast

tumor. Registry activity & statistics

Kay Cook, CTR

As we look to the future of the cancer program at DCH Regional Medical Center and advances in treatment for our patients, education for Tumor Registry is in the forefront of our planning. We work hard to ensure that all information entered into the Cancer Registry database software meets all standards set by the American College of Surgeons (ACoS), National

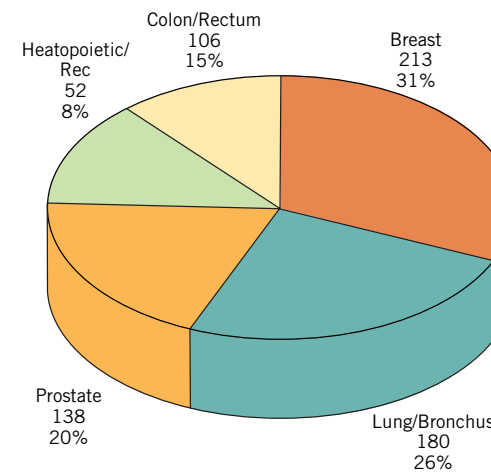
Cancer Data Base (NCDB), American Joint Committee on Cancer (AJCC), and Facility Oncology Registry Data Standards (FORDS). To accomplish this, the Registry regularly attends state, regional, and/or national meetings. For the past two years, the supervisor of the Registry has attended the National Cancer Registrars Association (NCRA) meetings, while the other staff attended

Table 1 2007 Frequency Report By Site and 1st Contact Year ICD-0-3 Format

Code	Topography Name	2007 Accession Year	%	Code	Topography Name	2006 Accession Year	%
C01	Base of Tongue	2	0.2	C44	Skin	19	1.8
C02	Other & Unspec Parts of Tongue	4	0.4	C48	Peripheral and Peri	2	0.2
C03	Gum	1	0.1	C49	Conn, Subq and Other Soft	6	0.6
C04	Floor of Mouth	1	0.1	C50	Breast	213	20.4
C05	Palate	1	0.1	C51	Vulva	1	0.1
C06	Other part of Mouth	1	0.1	C53	Cervix Uteri	9	0.9
C07	Parotid Gland	5	0.5	C54	Corpus Uteri	8	0.8
C09	Tonsil	1	0.1	C55	Uterus, NOS	1	0.1
C10	Oropharynx	1	0.1	C56	Ovary	4	0.4
C11	Nasopharynx	2	0.2	C60	Penis	1	0.1
C12	Pyiform Sinus	2	0.2	C61	Prostate Gland	138	13.2
C15	Esophagus	17	1.6	C62	Testis	4	0.4
C16	Stomach	16	1.5	C64	Kidney	32	3.1
C17	Small Intestine	5	0.5	C65	Renal Pelvis	2	0.2
C18	Colon	85	5.1	C66	Ureter	1	0.1
C19	Rectosigmoid Jct	5	0.5	C67	Bladder	47	4.5
C20	Rectum	16	1.5	C69	Eye and Adnexa	2	0.2
C21	Anus and Anal Canal	7	0.7	C70	Meninges	7	0.7
C22	Liver-Intrahepatic Bile Ducts	5	0.5	C71	Brain	18	1.7
C23	Gallbladder	2	0.2	C72	Other Central Nervous System	2	0.2
C24	Other & Unspec Parts of Bili	2	0.2	C73	Thyroid Gland	14	1.3
C25	Pancreas	21	2.0	C74	Adrenal Gland	1	0.1
C26	Other Ull-defined Digest	2	0.2	C75	Other Endocrine Glands/Rel S	1	0.1
C32	Larynx	16	1.5	C77	Lymph Nodes	33	3.2
C34	Bronchus and Lung	180	17.2	C80	Unknown Priamry Site	23	2.2
C38	Heart, Mediastinum and Pleura	3	0.3			1045	97.3
C41	Bones, Jnts, Art Cart Other	1	0.1				
C42	Hematopoietic/ Reticuloen	52	5.0				

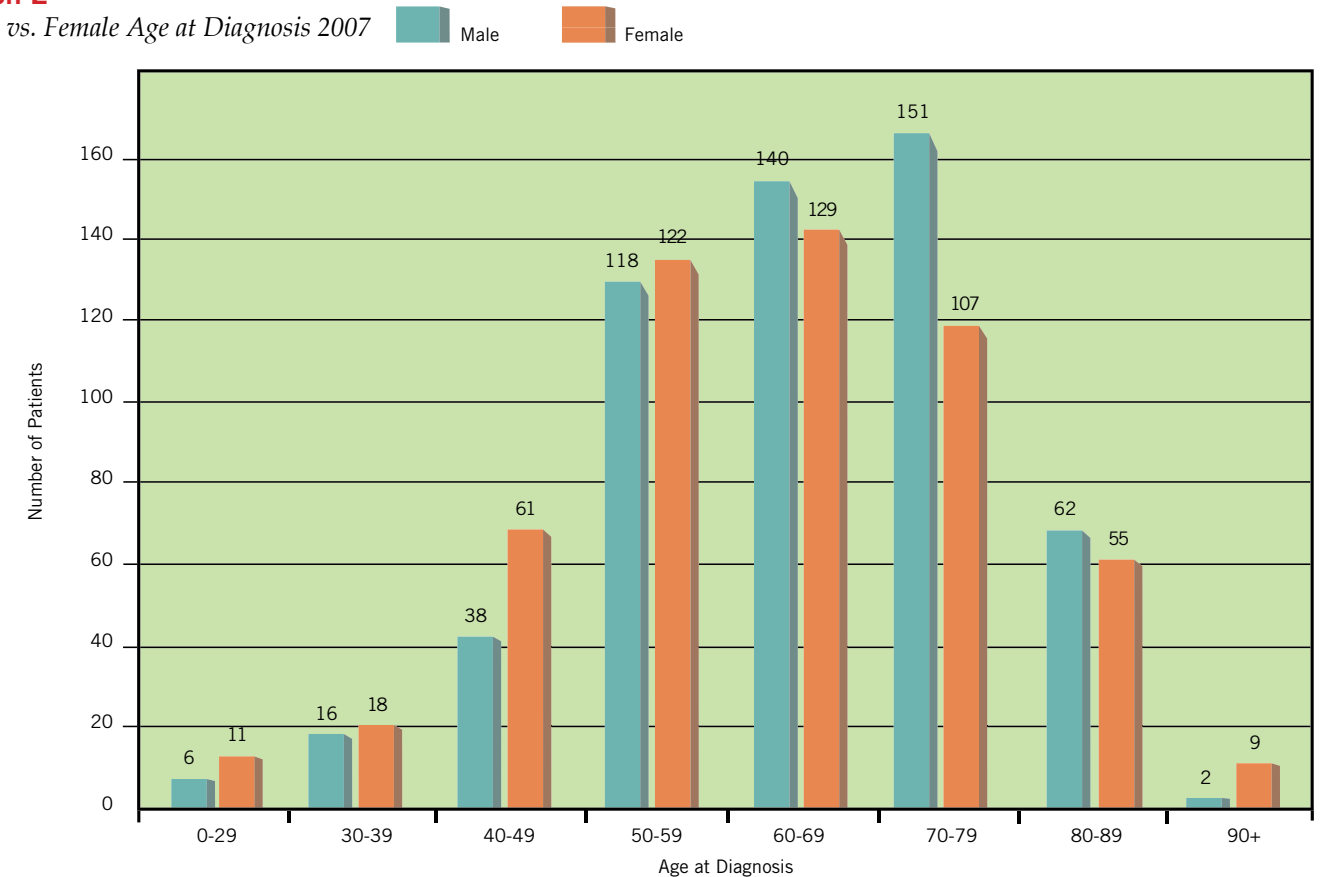
Rounded off to 100%

Graph 1
Frequency Report of Top 5 Sites



213, Bronchus/Lung 180, Prostate 138, Colon/Rectum 106, and Hematopoietic/Recticuloendothelial 52 (Graph 1). The average age at diagnosis is 60-69, with 140 males and 129 females as seen in (Graph 2). Race is predominantly white (693), with black (350), Chinese (1) and other (1) as seen in (Graph 3). AJCC Stage 1 disease at diagnosis for females is higher than males, while AJCC Stage 2 disease at diagnosis for males is higher than females, and AJCC Stage 4 diseases

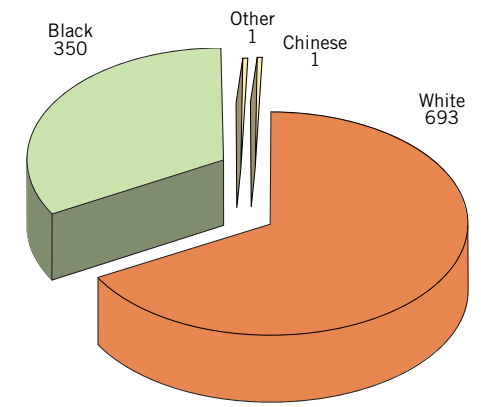
Graph 2
Male vs. Female Age at Diagnosis 2007



at diagnosis for males are higher than females (Graph 4). Tuscaloosa County remains predominately the largest volume of cases by county, with Hale, Pickens, Fayette, and Bibb counties following in that order (Graph 5).

On a quarterly basis, the Registry pulls 10% of cases abstracted for the previous three months that are reviewed by Cancer Committee physicians for quality of abstracting and Clinical Anatomical Pathology (CAP) reports. The findings are reported to the Cancer Committee, and all errors are corrected in the Registry database. The Registry follows patients on an annual basis from the date of last contact; currently the follow-up rate is 99 percent. Staging by the managing physician is mandatory for 90 percent of eligible cases. For 2007, there were 876 analytic cases eligible for staging by the managing physician. Of those, only 21 cases were not staged by the managing physician. Our completion rate was 96%, which exceeds the mandatory standard of 90%.

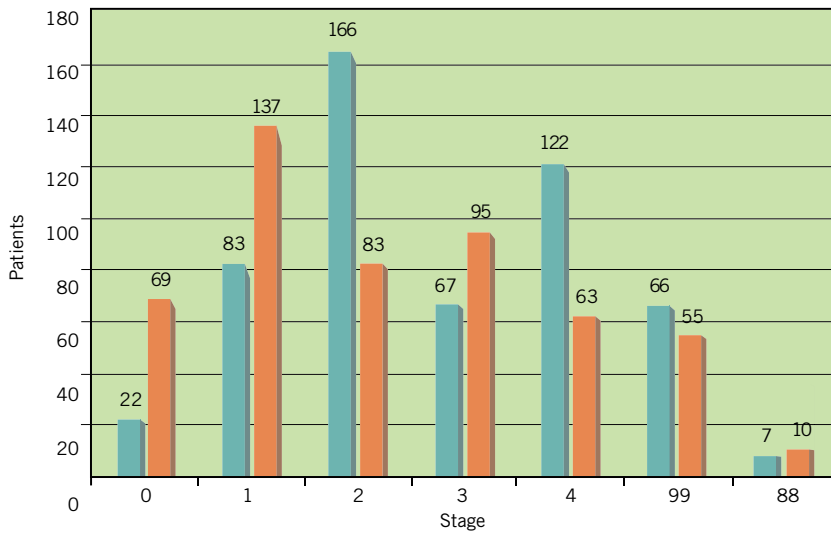
Graph 3 Race



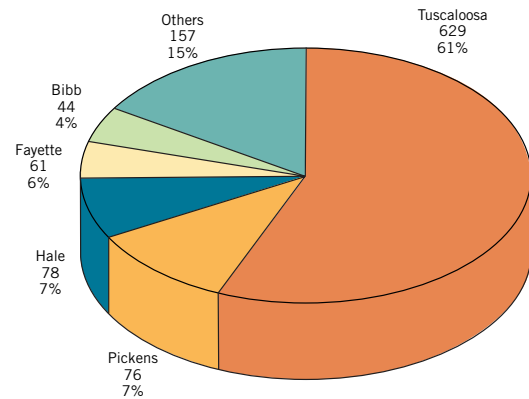
The Registry staff attends weekly facility-wide Cancer Conference/Tumor Boards, and the staff records site, histology, stage, and treatment recommendations made by a multidisciplinary team approach. In 2007, 157 (15 percent) cases were presented, with the standard being 10 percent. Of these, 156 (99.4 percent) were prospective and 1 (0.6 percent) was retrospective, with the standard being 75 percent prospective. The Registry attends quarterly Cancer Committee meetings and reports to the Committee the activity of the Registry from the previous quarter.

Graph 4
Stage Male vs. Female

Male Female



Graph 5
Distribution by County



Lung Cancer presentation

J. Curtis Tucker, MD

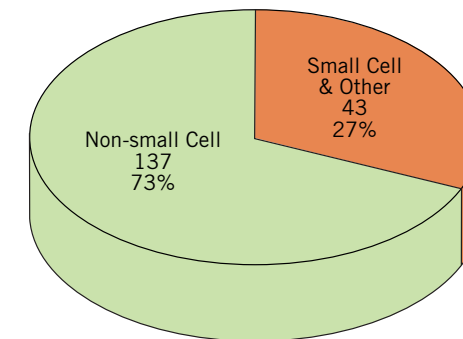
Lung cancer continues to be the leading cause of cancer death in the United States and is the leading cause of cancer death among both males and females. More people die from lung cancer than colon, breast, and prostate cancer combined. In 2007, there were more than 200,000 people

diagnosed with lung cancer, and over a 160,000 deaths secondary to lung cancer. It is the most common cancer diagnosis in the state of Alabama.

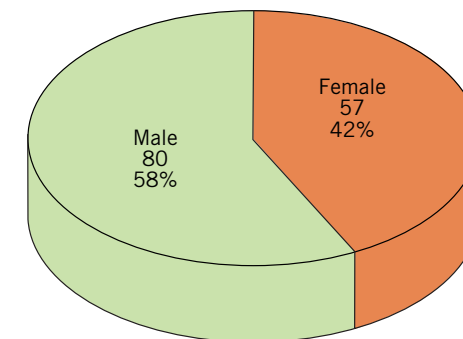
for the vast majority of lung cancers in both men and women, and the relationship appears to be dose dependent both to the length of time of smoking as well as the number of cigarettes per day. The standard treatment for small lung cancer is chemotherapy with or without radiotherapy. For non-small cell lung carcinoma surgery, chemotherapy and radiation are all used at times alone or in conjunction. We will review the lung cancer cases at DCH in the year 2007.

During 2007, there were 180 lung cancers diagnosed and/or treated at DCH Regional Medical Center. One hundred and thirty-seven of these were non-small cell lung carcinomas, and 43 were small cell carcinoma or other more unusual types (Graph 1). Our study will focus on the 137 non-small cell lung cancer cases. We had 80 males and 57 females (Graph 2). The distribution by race can be seen in Graph 3, age at diagnosis by gender in Graph 4 and stage of disease at diagnosis by gender in Graph 5. The predominant stage at diagnosis was Stage IV, with 61 cases. We saw 36 cases at Stage III with 36 cases, 11 cases at Stage II, and 28 cases at Stage I. There was one Stage 0 with an in-situ carcinoma.

Graph 1
2007 Lung Cancer Small Cell vs. Non-small Cell

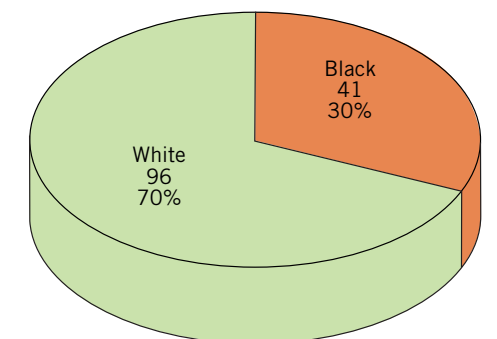


Graph 2
2007 NSC Lung Cancer: Male vs Female



There are two major subdivisions of lung cancer: small cell lung cancer, which account for 15-20 percent of the lung cancers, and non-small cell lung cancers, which account for the rest. Non-small cell lung cancers further subdivide into three major categories: adenocarcinoma, squamous cell carcinoma, and large cell carcinoma, the most common subtype of this being adenocarcinoma. At the time of diagnosis, roughly 30% of non-small cell cancer patients and 60% of small cell lung cancer patients will have metastatic disease. Tobacco use with cigarettes accounts

Graph 3
2007 NSC Lung Cancer by race



e-quip & cp3r Quality Indicator review of 2007 data

The Cancer Committee introduced three quality indicators in 2007 based on review of 2006 cases. The colon cancer study findings were reported in the 2006 annual report. The study continued with review of three quality indicators of 2007 cases, with findings reported to the Cancer Committee in July 2008. These quality indicators are all found through the national quality forum and endorsed by them through the American College of Surgeons and National Cancer Database.

The first study for breast cancer will include the use of tamoxifen or aromatase inhibitor administered within one year for women with hormone receptive positive breast cancer. Eighty-four cases were reviewed, with all patients receiving treatment at this facility or an outside facility. This would be 100 percent of the cases reviewed.

We are also following two quality indicators for colorectal cancer. The first indicator is that adjuvant chemotherapy is administered within 120 days for patients less than 80 years old and lymph node positive colon cancer. Eighteen cases were reviewed, with all patients receiving treatment at this facility or an outside facility. This would be 100 percent of the cases reviewed.

The final quality indicator that we are following is that radiation therapy is administered within six months of diagnosis for patients with a T-4 or Stage III rectal cancer receiving surgical resection. Three cases were reviewed, with two cases receiving either pre-operative chemotherapy. One patient died after chemo/radiation prior to surgery. This would be 100 percent of cases reviewed were either recommended or given.

These quality indicators will help us to follow and assess current treatment being given or recommended by DCH. DCH is currently not able to compare with national data, but we used the quality study to ensure that our patients are receiving therapy based on national guidelines.





Glossary

Accessioned

Cases entered into the DCH RMC data base

ACoS

American College of Surgeons

ACS

American Cancer Society

AJCC

American Joint Committee on Cancer

Analytic

Cases diagnosed and/or receiving first course of treatment at DCH RMC

Alabama Statewide Cancer Registry

Agency within the Alabama Department of Public Health where all reportable cases at DCH RMC are required to be sent.

DCH RMC

DCH Regional Medical Center

Initial Therapy

Cancer directed treatment, which was planned during original workup and staging.

Neo-adjuvant Therapy

Treatment in conjunction with other treatment methods, such as chemotherapy following surgery

Non-Small Cell Lung Cancer

Histologic distinction of lung cancer (80% of tumors)

Reference Date

Starting date after which all eligible cases must be included in the Registry. Established as of Jan. 1, 2006, for DCH RMC

Small Cell Lung Cancer

Histologic distinction of lung cancer (20% of tumors)

References

Alabama Cancer Facts and Figures 2006

ACS (American Cancer Society)

ASCR (Alabama Statewide Cancer Registry)

FORDS (Facility Oncology Registry Data Standards)

AJCC 6th Edition (American Joint Committee on Cancer)

NCI (National Cancer Institute)

NCDB (National Cancer Data Base)

The first course of treatment according to stage is as follows: **Stage IV** patients:

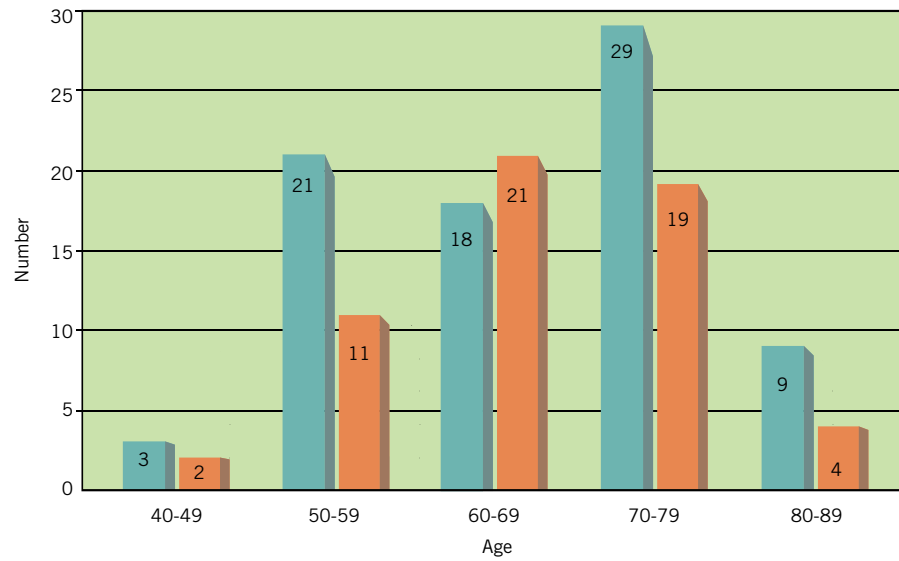
Seven received no treatments. Five received chemotherapy alone. Twenty received radiation alone. Eighteen received a combination of chemotherapy and radiation. One received surgery and radiation. One received surgery, radiation, and chemotherapy. **Stage III** patients:

Four patients received no treatment. Five patients received radiation alone. Thirteen patients received chemotherapy and radiation. Two patients received surgery alone. One received surgery and radiation. Seven received surgery, chemotherapy, and radiation. **Stage II** patients: We had one receiving radiation alone. Three received radiation and chemotherapy. One patient received surgery alone and five patients received chemotherapy, radiation, and surgery. **Stage I** patients: Two patients received no treatment. Four patients received radiation alone. Eighteen patients received surgery alone. One received surgery and chemotherapy. One received surgery and radiation, and one received surgery, radiation, and chemotherapy. The

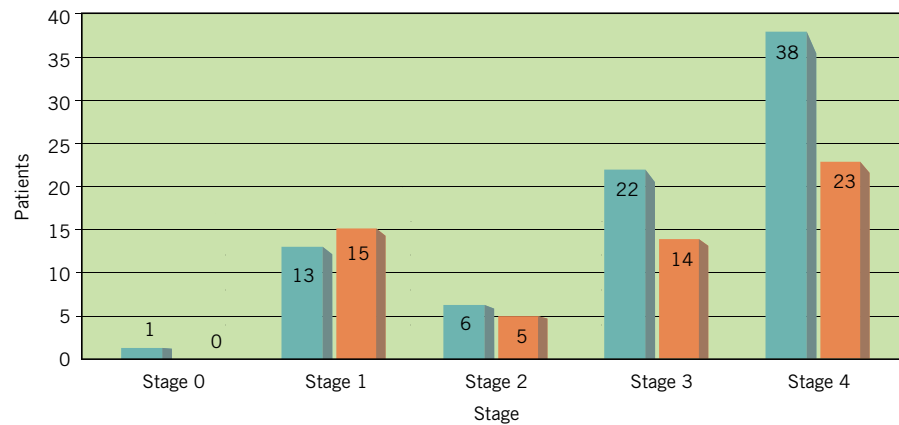
Stage 0 patient received no treatment. Fifty-five percent of the non-small cell lung cancer patients are still alive at the completion of this study. Currently we cannot compare state, regional, and national comparisons for disease-free intervals.

The comparison of the first treatment for non-small cell lung carcinoma for DCH Regional Medical Center, Alabama, Mid-South, and National is presented in **Graph 6** and shows fairly comparable numbers, since no adjustment is made for stage or performance status.

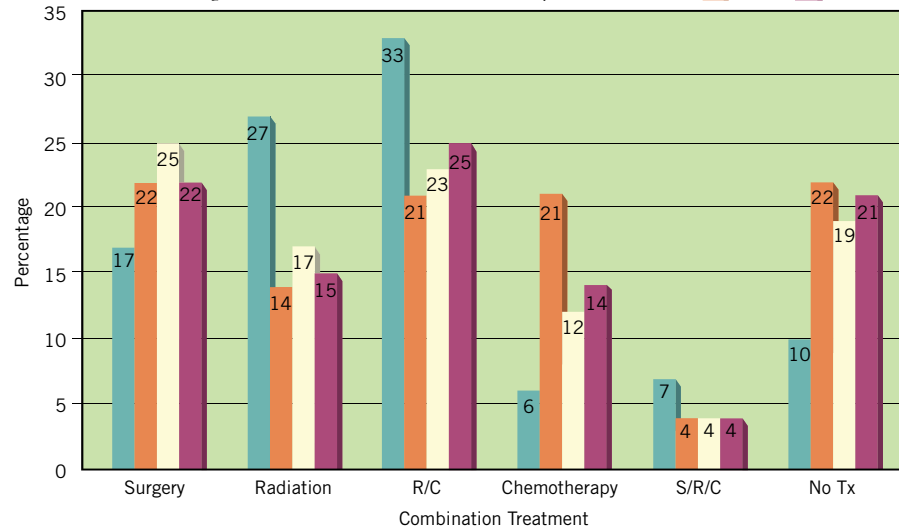
Graph 4
2007 Non-small Cell Lung Cancer Age at Diagnosis: Male vs Female



Graph 5
2007 NSC Lung Cancer by Stage: Male vs Female



Graph 6
2007 NSC Lung Cancer Combination Treatment Comparison



Credits

The DCH Cancer Treatment Center would like to express our gratitude to the following for their efforts in producing this Annual Report:

George W. Nunn, MD

Curtis Tucker, MD

DCH Cancer Committee

Amanda Henson, Director

Kay Cook, CTR

Becky Thomas, RHIA, CTR

NeShelle Prince,
Medical Record Assoc., CTR

Cindy Perkins, RN Ph.D.

Brad Fisher

TotalCom Advertising

What Cancer Cannot Do

*Cancer is so limited -
It cannot cripple love,
It cannot shatter hope,
It cannot corrode faith,
It cannot destroy peace,
It cannot kill friendship,
It cannot suppress memories,
It cannot silence courage,
It cannot invade the soul,
It cannot steal eternal life,
It cannot conquer the spirit.*