

DCH CANCER CENTER  
*The Region's Cancer Center*

2009 Annual Report  
*for 2008 data*

Hope



DCH Cancer Center



## Table of Contents

- 1 Chairman's Letter —Dr. George W. Nunn
- 2 Capital Campaign — Angela Fulmer
- 3 Outreach Coordinator — Ashley Stripling
- 4 Electronic Medical Record — Amanda Henson, Director
- 5 Tumor Registry Activity and Statistics — Kay Cook
- 7 APBI New Treatment Option — Dr. J. Curtis Tucker
- 8 Colon Study — Dr. David L. Hinton
- 9 Glossary
- 9 Credits
- 9 References

## 2008 Cancer Committee

George W. Nunn, MD  
*Surgeon/Chairman of Cancer Committee*

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*Medical Oncologist*

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Christopher G. Jordan, DO  
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*Clinical Research Coordinator*

Amanda Henson  
*Administrative Director of DCH Cancer Treatment Center*

Kay Cook  
*Certified Tumor Registrar*

Berni Dellapenna  
*Social Worker*

Ashley Stripling  
*Outreach Coordinator*

Beth Donaldson  
*Dietitian*

Cathy Goins  
*Senior Radiation Therapist*

Becky Greggs  
*PI/QM*

Donna Marrero  
*VP Outpatient Ancillary Services*

Tom Rogers  
*Pharmacist*

Bob Shaw  
*Chaplain*

Sandy Barger  
*Nurse Manager*

Sherry Skelton  
*Nurse Manager*

Lisa Taylor  
*Recording Secretary*



# From the Chairman



George W. Nunn

The DCH Cancer Center experienced a busy year in 2008, with 1,010 analytic cases accessioned. The Cancer Center continues to be the major treatment center for West Alabama by offering world class cancer care in a community setting. That setting will soon change dramatically as the completion of the new center draws near.

The medical staff of the Cancer Center includes three board-certified hematologist/oncologists and two radiation oncologists, with recruitment efforts continuing for a fourth medical oncologist. In addition to caring for patients at DCH Regional Medical Center, these physicians travel to clinics in Bibb, Fayette, and Pickens counties each week.

The Cancer Center conducted six free breast screenings in 2008 for women who were uninsured or underinsured. The Cancer Center continues its commitment to community outreach through support groups for cancer survivors and those undergoing treatment. Additional support programs are in the planning stages and will be implemented when the new center is ready. This critical component of holistic patient care was augmented this year with the addition of a community outreach coordinator in January 2008. 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*, *BBQ & Blue Jeans*, and *Nite on the Green*.

In May of 2008, the first breast cancer patient was treated with Axxent brachytherapy in lieu of external beam radiation. In addition, the Electronic Medical Record (EMR) was implemented in radiation oncology. The increase in patient volumes

on medical oncology necessitated the addition of one registered nurse position and two per diem positions, and a new nurse manager took the helm.

The Cancer Center continued preparation for an accreditation survey 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 significant patient accrual to clinical trials. The survey was scheduled for February of 2009.

Goals and objectives established by the Cancer Committee for 2009 include preparation for a site visit from ACoS, and clinical research enrollment to meet or exceed 4% of analytic cases for the previous year. We will begin implementation of the EMR on medical oncology, and surgeons will begin to use da Vinci Robotic Surgery System to perform minimally invasive prostatectomy. The main goal for 2009 is to occupy the new Cancer Center, continue with the state-of-the-art treatments already available, and initiate new support programs for our patients.

DCH Cancer 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. It has been my honor to serve as Chairman of the Cancer Committee and I look forward to the continued growth of our cancer center.

A handwritten signature in black ink, appearing to read "George W. Nunn".

George W. Nunn, MD

*The Cancer Center continues to be the major treatment center for the West Alabama area with world class cancer care in a community setting.*

# Capital Campaign

For 85 years, the DCH Health System has brought the highest level of care to West Alabama. Now, thanks to generous community support through the Help and Hope Capital Campaign, the new DCH Cancer Center will become a reality in 2009. It will truly transform the way cancer is treated, as well as the environment in which our patients and their loved ones experience that treatment.

The remarkable progress of the Capital Campaign has been possible due to the generosity of businesses, employees, physicians, DCH Health System Board members, volunteers, DCH Foundation Board members, individuals, families, and foundations. Thus far, pledges and gifts totaling almost \$9.3 million have been received from more than 2,000 contributors. The construction and equipment costs are expected to reach \$36 million.

To show appreciation for the generosity of major donors, the DCH Foundation is implementing a donor recognition program to be placed in the new Cancer Center. As the operating climate becomes increasingly challenging for health care providers, philanthropic giving and the continued involvement of caring individuals in the community are vital to help complete the fundraising for a project of this size and importance.

*Angela Fulmer*  
Director of Development  
DCH Foundation, Inc.





# Outreach Coordinator

**T**he DCH Cancer Center hired its first Outreach Coordinator in January 2008 to help create and manage the community outreach activities and support programs for patients of the Cancer Center.



Ashley Stripling

Ashley Stripling, a 2007 Business Administration/Marketing graduate from the University of Alabama, was the perfect fit for this position. Through a close family experience with cancer,

Mrs. Stripling formed a unique connection and awareness of the disease, thus creating her strong passion to help those going through their own journeys.

Mrs. Stripling began reorganizing and rejuvenating support programs currently in place in the Cancer Center, and looked for ways to expand the scope of offerings to include additional programs for patients, as well as their families and caregivers. Some of the programs in place upon her arrival included Cancer Wellness, Look Good...Feel Better, IMPACT (Breast Cancer Support Group), STRETCH (an exercise program developed in conjunction with UA recreation center), as well as a bimonthly breast screening events for underinsured or uninsured women in West Alabama.

Throughout 2008, Mrs. Stripling planned and organized monthly support meetings by scheduling a variety of speakers from the community. The reorganization of the existing programs resulted in a significant increase in patient participation. In addition, Mrs.

*The new Cancer Center opens in the spring of 2009, and along with the state of the art technology and superior clinical care comes a commitment to provide more services to meet the patient's mind, body, and spirit.*

Stripling collaborated with the University of Alabama to begin a music therapy program for our patients while they were undergoing treatment. She also brought back the Man to Man prostate cancer support group in August 2008 with excellent attendance.

The new Cancer Center opens in the spring of 2009, and along with the state of the art technology and superior clinical care comes a commitment to provide more services to meet the needs of each patient's mind, body, and spirit. Mrs. Stripling is working on the development of new programs for the opening in 2009. Some of those programs include monthly nutritional/dietary seminars, HEART: Healing with the Arts, and a Living with Breast Cancer series. In addition, she plans to expand

the free cancer screening services to include prostate screenings in September 2009.

Mrs. Stripling is the contact person for all ongoing support/educational programs, and she provides informational activities for participants in the community based on their requests. In addition, she acts as the DCH liaison with the American Cancer Society for joint community projects such as Reach to Recovery for breast cancer patients and Relay for Life for cancer survivors. Mrs. Stripling is truly an asset to the patients, families, and caregivers of West Alabama going through this tremendously difficult disease. DCH Cancer Center is fortunate to have someone like Mrs. Stripling dedicated to providing this important piece of cancer care.



# Electronic Medical Record

**T**he movement towards an Electronic Medical Record (EMR) has grown over the past several years. According to the National Center for Healthcare Statistics, a quarter of all office-

based physicians reported using a full or partial EMR. Unfortunately, less than 10% of these physicians actually have a "complete EMR system" with the four basic functions necessary for a complete

EMR: Computerized orders for prescriptions, computerized orders for tests, reporting of test results, and physician notes.

EMRs have tremendous cost saving and revenue producing abilities. A study at a large multispecialty clinic in Utah analyzed expenditures a year prior and a year following the implementation of an EMR. There were five notable areas of expense positively affected by EMR implementation:

- Expenses for transcription of physician dictation.
- Expenses for pulling, filing and maintaining charts.
- Expenses for developing charts for new patients.
- Expenses for paper and personnel costs.
- Expenses related to storing medical records.

It's estimated that \$10 million to \$12 million is spent nationally on transcription and management of medical records. In addition to cost savings, EMR implementation usually results in increased

revenue through more accurate coding.

The findings from the Utah study concluded that this large multispecialty group recovered \$952,000 through utilization of the EMR in the first year. Over the course of five years, this practice estimated receiving a cost reduction saving, cost avoidance saving, and increased revenue (due to coding improvements) totaling \$8 million.

So what keeps more medical institutions from moving to an EMR? There are issues about how an EMR will interface with current practice software. There are initial and ongoing expenses for implementing and maintaining the EMR, as well as concerns about the quality of the program and its safety relating to patient confidentiality. All of these factors play a role in the DCH Cancer Center's EMR implementation.

*The movement toward an Electronic Medical Record has grown over the past several years.*

Coinciding with the new DCH Cancer Center construction project, we began to implement an EMR conversion and hoped to have it completed prior to the move into the new building. A working EMR could potentially lead to timelier chart preparation and filing, improved documentation by providers, reduced expenses related to medical record management, and better communication across the patient's entire continuum of care. But, like many other health care institutions going through the same process, the DCH Cancer Center has also experienced its setbacks.

Initial interface development between DCH Regional Medical Center's IT system and the Cancer Center EMR took more time than anticipated. Separate project teams were responsible for rolling out the EMR to medical and radiation oncology. Both project teams from the software development company were unfamiliar with the capabilities of each other's software components, which made questions regarding information crossover challenging. In addition, the initial set-up for radiation oncology and medical oncology began separately. This also presented obstacles for staff working in both areas. In hindsight, implementing both medical and radiation oncology at the same time would have been more effective.

From the provider and staff standpoint, there was strong



Amanda Henson



buy-in toward moving electronic. But as the process of documentation and troubleshooting became increasingly cumbersome, the EMR became a challenge for the end users. Fortunately, through working out numerous interface questions and concerns for a little over a year and a half, the staff and physicians learned how to navigate and begin making changes on their own. In retrospect, more preparation and education should have been anticipated over a longer roll-out phase.

We continue to work on implementing the EMR in medical oncology. With growing patient volumes and physician clinics at a maximum, we decided to slow down the EMR implementation. We are working to ensure we have consistent protocols and processes during a busy time in medical oncology. With patient safety, proper documentation, and development and training associated with medication/ chemotherapy ordering as our priorities, we will continue to work behind the scenes to ensure all bugs are worked out prior to roll-out.

The goal for 2009-2010 is to complete EMR implementation within the entire Cancer Center. We anticipate being one of the very few fully integrated electronic cancer centers in the nation. Similar to the multispecialty clinic in Utah, we hope to have measurable cost savings, safer patient care, more thorough physician documentation, and improved access to patient data, which will provide our patients with a stronger continuum of care.

**Amanda Henson**  
Director  
DCH Cancer Center

**T**he year 2008 was a very busy time for the cancer program at DCH Regional Medical Center and the Tumor Registry, as we made preparation for our on-site visit of the American College of Surgeons (ACoS). During this time the Registry also went through a database conversion to OncoLog, a product that allows for the collection, interpretation, and maintenance of information on all reportable patients diagnosed and/or who receive their first course of treatment at DCH Regional Medical Center. Demographic, clinical, diagnostic, and treatment information are collected on each patient. GenEdits Plus, a quality data edit check, is run on a monthly basis prior to submission to the ASCR to ensure that the highest quality of data is submitted at all times. Currently, the registrars are abstracting within five months of diagnosis or date of first contact, whichever is the shortest, with an accuracy rate of 100%.

The registry works hard to ensure that all information entered into the Cancer Registry database 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). It was evident we achieved this when we submitted our 2007 data to NCDB error free on first submission.

Two of our Cancer Center registrars attended the Alabama Cancer Registry Associations' (ACRA) yearly educational meeting in Birmingham, Ala., while the supervisor/manager attended the National Cancer Registrars Association meeting in Minneapolis, Minn.

The registry staff strives to be abreast of the changes in our field by regularly attending monthly educational webinars held by the North American Association of Central Cancer Registries (NAACCR). We have hosted these seminars since 2006 and will continue through 2010. In 2008 we hosted webinars on the urinary bladder, coding pitfalls, hematopoietic, pharynx, staging tumors, brain and CNS, advanced abstracting and coding, prostate, breast, and changing data into information.

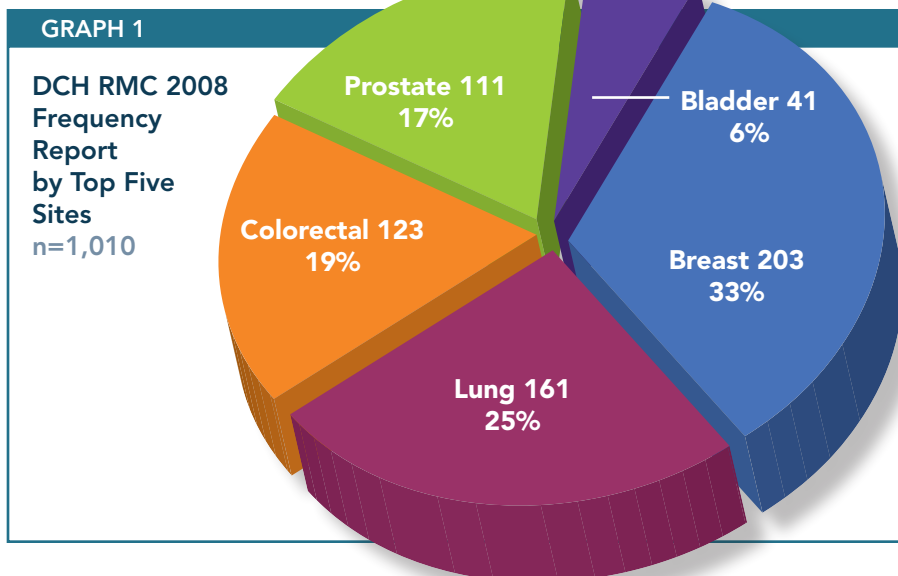




TABLE 1

ICD-O SITE CODE TOPOGRAPHY NAME	2008 ACCESSION YEAR	ICD-O SITE CODE TOPOGRAPHY NAME	2008 ACCESSION YEAR	ICD-O SITE CODE TOPOGRAPHY NAME	2008 ACCESSION YEAR
C01 - Tongue, base of NOS	4	C24 - Extrahepatic bile duct	1	C53 - Cervix uteri	3
C03 - Gum, lower	1	C25 - Pancreas, head	21	C54 - Corpus Uteri	7
C04 - Floor of mouth, NOS	1	C26 - Gastrointestinal tract, NOS	1	C56 - Ovary	3
C05 - Palate, soft, NOS	1	C30 - Nasal cavity	1	C60 - Prepuce	1
C06 - Mouth, NOS	1	C31 - Maxillary, sinus	2	C61 - Prostate gland	111
C07 - Parotid gland	3	C32 - Glottis	9	C62 - Testis, NOS	4
C09 - Tonsil, NOS	4	C34 - Bronchus-Lung	168	C64 - Kidney, NOS	36
C10 - Oropharynx, NOS	2	C38 - Pleura, NOS	2	C65 - Renal pelvis	4
C12 - Pyriform sinus	1	C41 - Vertebrae column	3	C66 - Ureter	1
C13 - Hypopharynx	2	C42 - Blood Bone Marrow Spleen	57	C67 - Bladder	41
C15 - Esophagus, upper third	8	C44 - Skin	22	C69 - Conjunctiva	1
C16 - Stomach	19	C47 - Nerves, periph, autonomic		C70 - Cerebral meninges	8
C17 - Small Intestine	10	NS of trunk, NOS	1	C71 - Brain	12
C18 - Colon	95	C48 - Retroperitoneum	2	C73 - Thyroid gland	23
C19 - Rectosigmoid junction	5	C49 - Connective, subq, other soft tiss;		C74 - Adrenal gland, cortex	1
C20 - Rectum, NOS	23	head, face,	6	C75 - Pituitary gland	1
C21 - Anus, NOS	5	C50 - Breast	214	C76 - Head, face, or neck, NOS	1
C22 - Liver	3	C51 - Vulva	2	C77 - Lymph nodes	26
C23 - Gallbladder	1	C52 - Vagina, NOS	5	C80 - Unknown primary site	20
				<b>Grand Total</b>	<b>1010</b>

During 2008, the Tumor Registry abstracted 1,052 cases with 1,010 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 203 cases, Bronchus/Lung 161, Colon/Rectum 123, Prostate 111, and Urinary Bladder 41 (Graph 1, page 5). The average age at diagnosis is 60-69, with 147 males and 114 females (Graph 2). Race is predominantly white (673), with black (331), Other Asian (1), Korean (1), Chinese (1), Asian Indian (1), and Other (1).

AJCC Stage 0 disease at diagnosis for females is higher than males; Stage I disease in females is higher than males, while stage II in males is higher than females. This can be attributed to breast cancer for females and prostate cancer for males. Stage III disease in males and females is fairly close with 63 males and 74 females.

Stage IV disease is higher in males than females with 114 males and 75 females (Graph 3).

Tuscaloosa County

remains predominately the largest volume of cases by county, with Hale, Pickens, Bibb, and Fayette counties following in that order (Graph 4).

Quarterly the Registry pulls 10% of cases abstracted for the previous three months so that they can be reviewed by Cancer Committee physicians for quality of abstracting and Clinical Anatomical Pathology (CAP) guidelines. 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 96%.

Staging by the managing physician is mandatory for 90% of eligible cases. For 2008 there were 875 analytic cases eligible for staging by the managing physician. Of those, only 68 were not staged by the managing physician. Our completion rate for reporting was 99.96%, which exceeds the mandatory standard of 90%.

The Registry staff attends weekly facility-wide Cancer Conference/Tumor Boards, and records the disease site for presented cases, as well as the histology, stage, and treatment recommendations based on NCCN guidelines when possible. Treatment recommendations

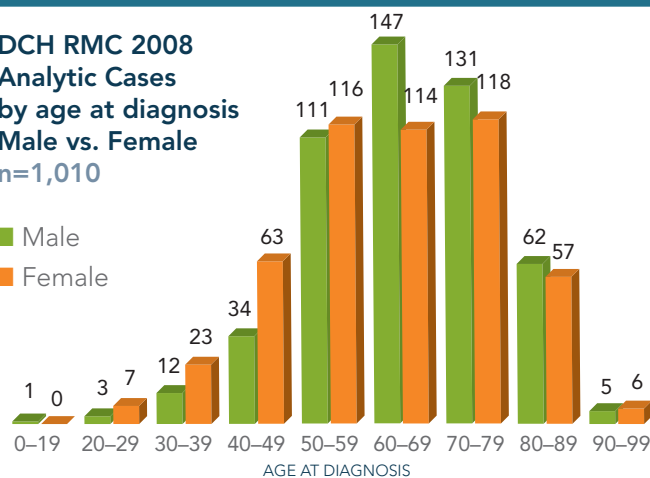
are discussed using a multidisciplinary team approach. In 2008, 195 (19%) were presented, with the standard being 10%. Of these, 100% were prospective with the standard being 75% prospective. The Registry attends quarterly Cancer Committee meetings and reports to the committee the activity of the Registry from the previous quarter.

Kay Cook  
Certified Tumor Registrar

GRAPH 2

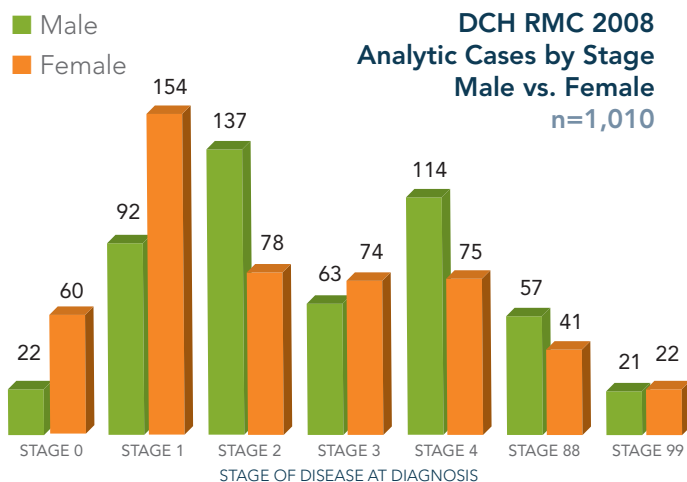
**DCH RMC 2008  
Analytic Cases  
by age at diagnosis  
Male vs. Female  
n=1,010**

■ Male  
■ Female

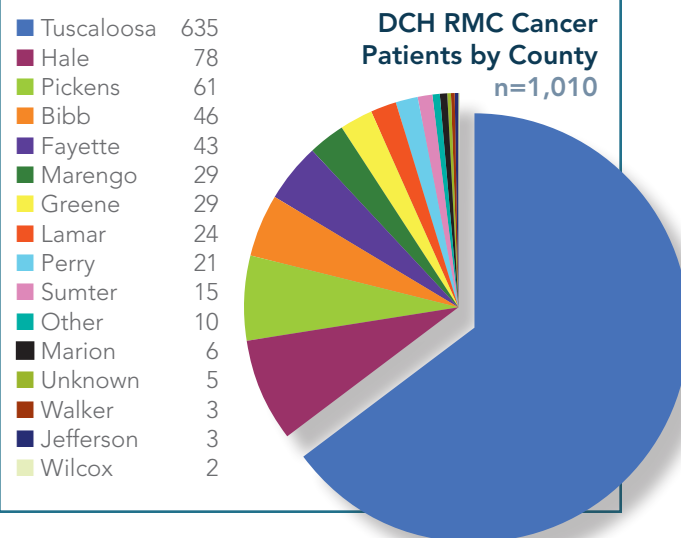




GRAPH 3



GRAPH 4



### *Accelerated Partial Breast Irradiation*

# New Treatment Option

**A**ugust of 2008 marked a milestone for Radiation Oncology at the DCH Cancer Center when our first patient was treated with Axxent Electronic Brachytherapy by Xoft, Inc. DCH was one of only nine sites nationwide to offer Accelerated Partial Breast Irradiation (APBI), a form of radiation to treat breast cancer.

To qualify for this procedure, a patient must meet several criteria, including a diagnosis of early stage breast cancer and no positive lymph nodes. Xoft APBI involves the insertion of a balloon catheter into the lumpectomy surgical site, usually within two to four weeks after surgery. The purpose of radiation in this type of breast cancer is to decrease the chance of recurrence. APBI treats the tumor bed from the inside out as opposed to external beam, which treats from the outside in.

For those who qualify, Xoft APBI treatment offers many advantages. The treatment time is much shorter, and a smaller area is treated, so there is less radiation exposure

to normal tissue. Patients also experience fewer side effects. The patient receives two treatments, each lasting about 20 minutes, each day for five days. Upon completion of the tenth treatment, the catheter is removed in the clinic, and the patient has completed radiation in seven to ten days, as opposed to whole breast radiation, which requires daily treatment for six to seven weeks. The logistics of completing 35 treatments is often enough to prevent some women from accepting radiation treatment, particularly if they live a significant distance from a cancer center. In addition to the shortened treatment time, the Xoft APBI offers less radiation exposure in general for both the patient and the staff. The electronic source is actually a miniature X-ray tube that delivers an appropriate dose of radiation to the site. Therapists are actually able to stay in the room with the patient during her treatment.

DCH Cancer Center is also participating with Xoft in a clinical research study examining long-term

effects of this type of treatment on a patient's skin. In 2008, DCH was one of only four centers in the United States participating in this study. We enrolled seven patients, and two additional patients were treated with the Axxent procedure who were not enrolled as study participants. DCH remains one of the top accruing sites for this study nationwide.

With the addition of Axxent Electronic Brachytherapy at DCH, we offer state-of-the-art technology to our patients, allowing more women to undergo breast conservation instead of mastectomy. Cancer diagnosis and treatment are constantly evolving, and DCH strives to provide our patients with excellence in cancer care. With efficacy comparable to external beam radiation, shorter treatment time, and significantly fewer side effects, Axxent Electronic Brachytherapy is one more way that DCH fights cancer in our community.

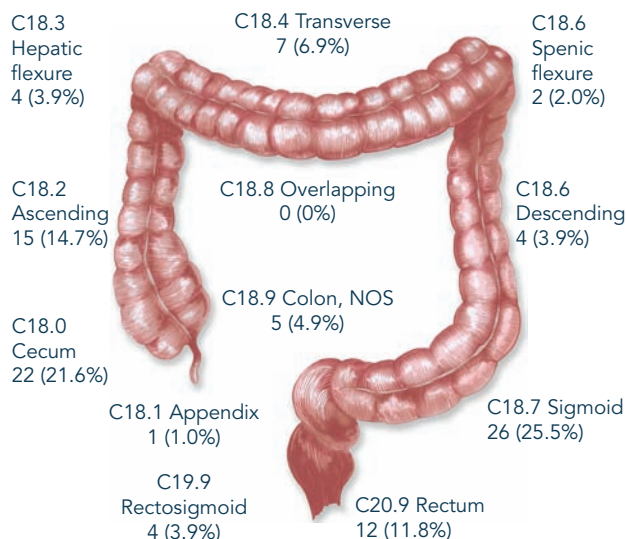
*J. Curtis Tucker, MD*  
Radiation Oncologist

# Colorectal Cancer Presentation

Cancers of the colon and rectum are common in the United States. About 150,000 new cases are diagnosed each year, and there are roughly 50,000 deaths per year from colorectal cancer. As is evident from these numbers, the majority of patients diagnosed with the disease do not die as a result of it. If found in the earlier stages, colorectal cancer is very curable. Most cases of these cancers are adenocarcinoma, a tumor type that can originate from many sites in the body (Graph 1).

TABLE 1 Study Group: 2008 Colon Stage 0-4; 102 Cases

## OCCURENCE OF CANCER BY SITE: COLON/RECTUM

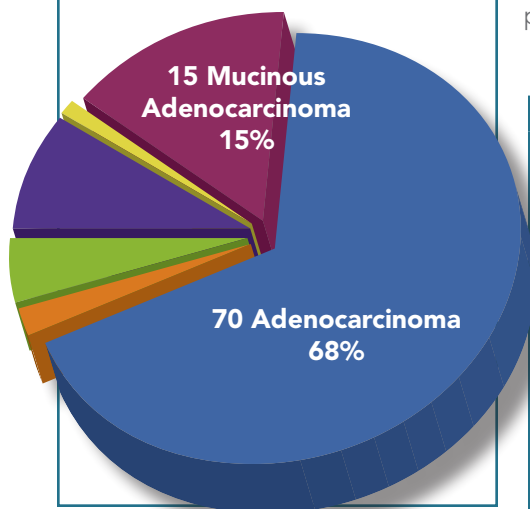


the colon and rectum when possible. After surgical resection, chemotherapy is frequently used as "adjuvant treatment" to reduce the risk for recurrence. Radiation therapy is used as well in certain circumstances, most commonly with rectal cancers. For many rectal cancers, "neoadjuvant" treatment with radiation therapy and chemotherapy is used before surgery in order to improve the chances for complete surgical resection. This preoperative treatment can also reduce the chances of requiring a permanent colostomy.

GRAPH 1

## DCH RMC 2008 Color/Rectal Cases by Histology n=102

- 1 Adenocarcinoma in-situ in tubulovillous adenoma 1%
- 9 Adenocarcinoma in tubulovillous adenoma 9%
- 5 Adenocarcinoma in villous adenoma 5%
- 2 Adenocarcinoma in adenomatous polyp 2%



Unfortunately, most patients are diagnosed only after they develop clinical symptoms. Abdominal pain is the most common presenting symptom, followed closely by a change in bowel habits. Gastrointestinal bleeding is also a common problem. Some patients are found to be anemic, particularly from iron deficiency. Screening for colorectal cancer is particularly important, because the outcome is influenced greatly by the stage at diagnosis.

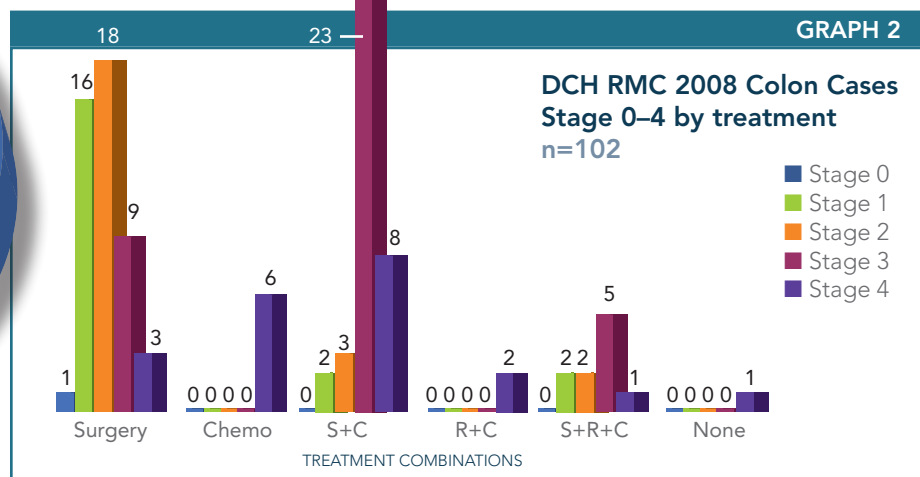
Surgical resection is the best primary treatment for cancers of

In 2008, there were 123 analytic cases of cancers of the colon and rectum diagnosed at DCH Regional Medical Center. For this study, cases that were unstageable due to histology or lack of staging information were eliminated. One hundred and two cases were stages 0 to 4. They were about equally divided between women and men. Women represented 54.9% of cases, and men represented 45.1% of cases.

Adenocarcinoma accounted for 84% of the cases. About 16% of the cases arose in the rectum or rectosigmoid regions and about 84% arose in the colon (Table 1). The

GRAPH 2

## DCH RMC 2008 Colon Cases Stage 0-4 by treatment n=102



# Glossary

percentage of rectal cancers is lower than nationally, where about 27% of colorectal cancers arise in the rectum (Graph 1).

Of the staged cases diagnosed at DCH RMC, one case was stage 0, 20 were stage I, 23 were stage II, and 37 were stage III (Graph 1). Of the 20 stage I colorectal cancer cases, all received treatment with surgery. Two were also treated with chemotherapy. Two patients received radiation therapy along with chemotherapy and surgery. Of the 23 patients with stage II disease, all required surgery. Three also received chemotherapy, and two received chemotherapy plus radiation. Of the 37 stage III disease, all were treated surgically. Twenty three of these patients also received chemotherapy with surgery. Five received chemotherapy as well as radiation. Of the 20 patients with stage IV disease at diagnosis, three were treated with surgery alone, and six received chemotherapy alone. Eight were treated with surgery and chemotherapy. Two received radiation plus chemotherapy. One was treated with all three treatment modalities (Graph 2). One patient declined treatment.

In April 2007, the Commission on Cancer, the American Society of Clinical Oncology, and the NCCN all agreed on a colon cancer measure for assessing the quality of care provided to colon cancer patients. The indicator consisted of the administration, or at least consideration of, adjuvant chemotherapy for patients under age 80 with stage III colon cancer. In 2008, 23 patients met these criteria, and all were offered or received such post-operative adjuvant chemotherapy.

**David L. Hinton, MD**  
Medical Oncologist/Hematologist



**David L. Hinton, MD**

## **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 work-up and staging.

## **Neo-adjuvant Therapy**

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

## **Reference Date**

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

# References

Alabama Cancer Facts and Figures 2007

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)

# 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*

*David Hinton, MD*

*DCH Cancer Committee*

*Amanda Henson, Director*

*Ashley Stripling*

*Kay Cook, CTR*

*Becky Thomas, RHIA, CTR*

*NeShelle Prince, Medical Record Ass., CTR*

*Cindy Perkins, RN, PhD*

*Brad Fisher*

*TotalCom Advertising*





# Hope

## 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.*

