2003 Annual Report

Including 2002 Cancer Registry Statistical Review

American College of Surgeons

Cancer Committee

Saint Francis/Mount Sinai Regional Cancer Center

Saint Francis Hospital and Medical Center
114 Woodland Street
Hartford, Connecticut 06105
860-714-4000
www.saintfranciscare.com

CANCER COMMITTEE – 2002/2003 MEMBERSHIP

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Robert Babkowski, M.D.	Pathology
George Barrows, M.D.	Pathology
Mark Belsky, MD	Family Practice
Steven Brown, M.D.	Colorectal Surgery/Cancer Liaison
Bruce Chozick, M.D.	Neurosurgery
Patricia Daigneault	Cancer Registry
Faye Davis, M.M., C.C.S.	Medical Records
Lynn Davis, M.D.	Medical Oncology
Judy Feret, R.N., M.S.	Medical Oncology
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Susan Gonsalves, R.H.I.T., C.T.R.	Cancer Registry
Sandra Gulla, RHIA, C.T.R.	Cancer Registry
Bruce Kaplan, M.D.	Radiation Oncology
Ann Long, RN,C, MS	Director, Continuum of Care Division
Allan Mayer, D.O.	Gynecologic Oncology
Reverend Marcus McKinney	Pastoral Care
Thomas Miller, M.D.	Rehabilitation Medicine
Joan Moore, A.P.R.N.	Clinical Nurse Specialist
Carolyn Reid, R.N., M.S.	Home Care Services
Zia Rahman, M.D.	Medical Oncology
Steve Rosen	Administration
Frank Setter, M.D.	Anesthesiology
Carolyn Tyler, M.A., R.D.	Health Promotion
Sandra Watcke, R.N.	Nurse Manager, Inpatient
George Wislo, M.D.	Radiology
Bonnie Zebrowski, R.N.	Nurse Manager, Outpatient

The Cancer Committee meets a minimum of four times a year, as required by the Commission on Cancer. The meetings are held on Friday mornings at 7:30 a.m. in Conference Room B, 3rd floor, in the Patient Care Tower.

Message From The Cancer Committee Chairman

Over the course of the last year, the Cancer Program at Saint Francis Hospital and Medical Center has experienced considerable strengthening, further consolidation, and significant overall growth. This year saw the successful completion of our ambitious faculty recruitment efforts for the Cancer Center, where we now have an internationally recognized cadre of outstanding clinicians and researchers to lead medical oncology and to be the liaison physicians to the new multidisciplinary organ system specific cancer programs. Together with the faculty came the addition of other key personnel, such as Inpatient Nurse Manager, Cancer Clinical Services Program Coordinator, Clinical Research Nurse, Research Assistant, an additional Medical Social Worker, an additional Physician's Assistant and a Patient Financial Counselor, to name just a few.

This absolute prerequisite, the filling of the personnel needs, set the stage for the strategic plan of the Cancer Center that was presented and endorsed at the annual Saint Francis Board Retreat on October 20, 2002. This Strategic Plan, the blueprint for the cancer efforts of the next five years, spells out the mission of our Cancer Program, defines the goals, describes the new programmatic areas to be developed and tries to set a reasonable timetable for accomplishing the goals.

In the center of the restructuring of oncology is the multidisciplinary cancer programs which reach across all the specialties and disciplines associated with cancer care. The special programs for gastro-intestinal malignancies, lung cancer, breast cancer, gynecologic malignancies, and leukemia-lymphoma are ready to be launched, with the gastrointestinal program taking a lead role in this complex endeavor.

The groundwork for establishing new treatment programs, such as high dose chemotherapy, immunotherapy or stem cell transplantation, has also been laid during this year, tasks that included financial negotiations with the payers, building of specialized support teams, streamlining various billing functions, generating the necessary regulatory documentation and CON applications, and, especially, providing the infrastructure and the space for these new initiatives.

A tangible sign of the success of these efforts is the renovation of the inpatient oncology unit, which was completed in January 2003, and now provides a modern, functional, safe, comfortable and aesthetically very pleasing environment for our cancer patients compatible with the holistic treatment philosophy of our program and our institution.

The architectural plans for the renovation and expansion of the Cancer Center have been completed, the CON application has been submitted, new support offices have been created in the renovated 8-1A space, and several structural upgrades were made in Radiation Oncology.

The CON for a major new initiative in Radiation Oncology, the IMRT or Intensity Modulated Radiation Therapy, has been approved, and the new equipment will soon be operative. Also included in this initiative is an upgrade to our existing stereotactic radiotherapy program and treatment planning systems.

Research efforts have resumed on a much larger scale. The Clinical Research office has been restructured, new staff, both clinical and clerical, has been added, a medical director has been named, an office manager appointed and a new procedural organization developed. This enables us to support not only national group study protocols, but to conduct pharmaceutical company sponsored and our own investigator initiated study protocols.

During this year we have intensified our outreach program efforts. To be more visible in the community we will be offering an additional consultation clinic in conjunction with Radiation Oncology at our Access Center in Enfield, the Enfield Cancer Treatment and Consultation Center, starting October 8, 2003. To support these outreach efforts, we have, in conjunction with the Wellness Center, developed a series of Community Education sessions, established a speakers bureau and gave numerous talks to the public, including a Breast Cancer Education Workshop which was well attended and

received. We have completely rewritten the Web Site of the Cancer Center, and given several grand round presentations both at Saint Francis and at other local hospitals.

The central effort of the professional education has been the Annual Saint Francis Hematology-Oncology Symposium. The Thirteenth Annual Symposium, a two day symposium, where an expert international faculty presented the newest concepts in Oncology, was well attended (91 attendees, 74 of whom practicing physicians) and well received. This successful program, directed to the generalist and not the oncologist, will be continued. The topic of the Fourteenth Symposium will be "Old Concepts in Oncology Revisited".

A major goal for the next year will be to increase efforts in Prevention of Cancer, and efforts to improve the holistic support of the patient. We were involved this year in the Connecticut Breast and Cervical Early Detection Program, but have to widen these efforts to include other cancer patient populations. We are already providing our community with numerous support groups, including groups for Breast Cancer, Prostate Cancer, Leukemia, and General Support and are in the processes of resuming the Bereavement Support Group. Institution wide we need to further increase the communication between and integration of various support systems, such as Hospice Care, Palliative Care, Spiritual Guidance, and Alternative Medicine. With the ever increasing complexity of care and the costs associated with cancer care, we will add a much strengthened financial counseling and support program. Task forces to develop and better coordinate these systems have already been set up.

We all can be proud of what we have achieved so far, but there is still a lot of work ahead. None of these goals could have been accomplished, and none of the planned programs will be successful were it not for the efforts and the support of the members of the Cancer Committee, who serve tirelessly on the committee and its subcommittees, who participate actively in the process of building a better Cancer Program, and who believe in the mission of our Center. For this support I am most grateful.

Peter J. Tutschka, M.D., PhD.

Cancer Committee Chairman

TUMOR REGISTRY DATA

ANALYTICAL SITES		2002
CNS	Brain/CNS	25
ORAL	Pharynx	15
	Mouth	13
	Tongue	3
	Lip	0
RESPIRATORY	Lung	199
	Larynx	11
	Other Respiratory	4
DIGESTIVE	Colon	116
	Rectum	51
	Pancreas	29
	Stomach	29
	Esophagus	20
	Liver/Biliary	23
	Other Digestive	3
	Small Intestine	4
GENITO-URINARY	Prostate	209
	Bladder	65
	Corpus Uteri	65
	Kidney/Other	50
	Other female	32
	Ovary	27
	Cervix Uteri	15
	Testis	9
	Other male	0
OTHER SITES	Breast	247
	Skin/Melanoma	36
	Thyroid	14
	Endocrine	0
	Connective Tissue	9
	Eye	0
	Bone	1
HEMATOLOGIC	Non-Hodgkin Lymphoma	48
	Leukemia	52
	Myeloma	26
	Hodgkin Lymphoma	15
MISC	All Other	67
	Totals	1532

TUMOR REGISTRY

The Cancer Registry at Saint Francis Hospital and Medical Center is an important program component for the evaluation of cancer care. The registry contributes to patient treatment planning, staging, and continuity of care through data management, documenting the diagnosis, treatment and follow-up of cancer patients into the registry software. The Registry provides data for research, education and benchmarking studies.

The Cancer Registry is managed and staffed by a Manager, a Coordinator and two Technicians. Through teamwork, cancer cases are abstracted and follow-up data is entered utilizing letters to physicians, extended care facilities, hospitals and patients. The Registry has consistently exceeded the 90 percent follow-up rate. Other sources used to follow our patients are daily review of obituaries, Medicare and motor vehicle listings and death certificates.

Based on our reference date of January 1, 1998, a total of 9,047 cases have been accessioned. In 2002 the Cancer Registry accessioned 1,596 cancer cases, 1,536 are analytical cases (96%). Analytic cases are those patients who are diagnosed and receive their first course of treatment at SFHMC. The five major sites of this institution are Breast, Prostate, Colon/Rectum, Lung, and Bladder. These major sites account for 58% of all analytical cases accessioned in 2002.

At each quarterly meeting of the Cancer Committee, the Registry presents reports and generates special reports as requested. The registry provided data for a comprehensive proposal for the Cancer Center composed of ten years of data on ten cancer sites. The information was incorporated into a presentation delivered by the Chairman of the Cancer Committee. Our staff met regularly during the year with the Chairman of the Cancer Committee to review our activities, gain his input and direction, and integrate the registry activities with the Cancer Clinical Program

One of our priorities this year was to evaluate Tumor Registry software and upgrade our current system. Criteria for selection of the new vendor was based on numerous criteria including ACOS approval, ability to generate meaningful reports including survival data to be utilized to improve the quality of our care, ability to migrate our present data into the new application and ease of use. IMPATH was our vendor of choice, and during the year we began the installation of the new software and training our staff on the application. We look forward to utilizing this new application and support the ongoing activities of our cancer program.

Registry activities for the past year include:

- Providing cancer data and statistics as requested by staff physicians and hospital personnel
- Attending quarterly Cancer Committee meetings and combined Medical/Surgical and GYN Cancer Conferences
- Attending education meetings of the Tumor Registrar's Association of Connecticut
- Cancer Committee Member participation in random review of 10 percent of our total annual analytical cases per ACOS requirements
- Submitted data to the annual call for data to the National Cancer Data Base
- Use of AJCC TNM staging system, General Summary Staging and SEER extent of disease staging system
- Quality management study on physician staging
- Request made to change reference date from 1/1/84 to 1/1/98
- Change of software vendor upgrading the system for maximum registry performance

TUMOR BOARD

The Tumor Board is a multidisciplinary meeting with emphasis on prospective management and therapeutic strategy of complex cases. The meeting takes place every Tuesday at noon in the Chawla Auditorium. An average of five cases is

presented for discussion by the group. Hospital based physicians as well as private attendings participate in the development of a recommended treatment strategy for the patient's management. The Gynecologic Tumor Board meets every Thursday in the Obstetrics Gynecologic Conference Room.

MESSAGE FROM THE CANCER LIAISON PHYSICIAN

It has truly been a pleasure and an honor to serve as the Cancer Liaison physician for another year. I have tried to keep our community updated with the activities and ever changing standards of the American College of Surgeons Commission on Cancer. In this role, I bring to attention the new studies available with which our patients can participate. I try to provide all pertinent updates as well as bring to focus the importance of the "awareness months" to ensure our patients have the necessary access to health care they need and deserve. Working closely with the tumor registry and department of pathology, I have made attempts to improve our staging form completion and accuracy. I look forward to the coming year where we can continue to modify our standards and procedures to continue to provide state of the art care and function as a true center of excellence in cancer management.

Steven Brown, MD, Cancer Liaison

LUNG CANCER SITE STUDY

Lung cancer remains a major public health problem in the United States. The American Cancer Society estimates that 171,900 new cases will be diagnosed in 2003 and that 157,200 people will die from the disease during this time.

In 2003, approximately 2,000 new cases will be diagnosed in Connecticut with 1,500 deaths from the disease. SEER data indicate that lung cancer survival at five years is a dismal 15% with African American and Hispanic American populations faring even worse. This is particularly concerning in light of the fact that the number of lung cancer deaths had been declining after the mid-1990s but that since the year 2000 the number of deaths from lung cancer has increased again, mostly in older men, and by more than a thousand cases annually in Connecticut alone.

It is important to note the relationship between tobacco smoking and the development of lung cancer. As outlined in the following report, only 5% (Figure 1) of afflicted patients were identified as having never-smoked. In recent years, lung cancer has clearly surpassed breast cancer as the leading cause of cancer death in women, most likely due to the increase in tobacco smoking in women.

Between January 1, 1999 and December 31, 2002, 807 cases of lung cancer were diagnosed at the Saint Francis Hospital and Medical Center. Consistent with the national trend, the most common histopathology was that of adenocarcinoma, which accounted for 40% of the cases. As expected from the national trend data, a relative decline of squamous cell type lung cancer to only 21% was observed. Small cell carcinoma accounted for 12% of cases. Twenty-four percent of patients were designated as “other” (Figure 2).

Consistent with the trend nation-wide, women are ‘catching up’ and now account for 45% of all cases of lung cancer at the Saint Francis Hospital and Medical Center (Figure 3.) The majority of lung cancer cases at our institution are still seen in men.

Figure 4 demonstrates, as in previous years, the distribution by site with higher percentage of lung cancer found initially in the upper lobes of 29%.

Figures 5 and 6 reflect stage at the time of diagnosis for Non Small Cell Lung Cancer and Small Cell Lung Cancer, though routine clinical practice rarely applies the TNM classification in the staging of Small Cell Lung Cancer.

Broncho-alveolar carcinoma is becoming a more common pathologic type of Non Small Cell Lung Cancer in the United States with distinct clinico-pathological and demographic characteristics. The occurrence rate of Broncho-alveolar carcinoma at Saint Francis Hospital and Medical Center may be hidden under the category 'others' and will require further investigation.

Review of our clinical data (Figure 7) with regards to initial treatment indicates increased utilization of combined modality treatments for lung cancer, such as surgery followed by radiation or combined/concurrent treatment of radiation and chemotherapy, which is especially true for Stage III Non Small Cell Lung Cancer. Tumor Registry data may not capture all secondary and tertiary treatments and treatment patterns in the clinic and private office setting and therefore a definitive analysis of secondary and tertiary treatments cannot be done.

Survival data for Non Small Cell Lung Cancer (NSCLC) and Small Cell Lung Cancer (SCLC) are depicted in Figures 8 and 9, respectively. These data show no difference to the national figures.

Of the 807 case of lung cancer diagnosed and treated that the Saint Francis Hospital and Medical Center, 680 patients or 89% were white and only 127 patients or 16% were black or belonging to other ethnic minorities. The ethnic distribution of patients seen at the Saint Francis Hospital and Medical Center does not reflect the demographic characteristics of Harford, CT which in the year 2000 showed 30% of people being white and 70% ethnic minorities, 40% of them being Black or African Americans. The skewed distribution of minority patients presenting to an inner city hospital when

compared to the demographic characteristics of its community, coupled with the fact that minority patients commonly present with far advanced disease, may indicate a problem with access to timely primary care resulting in delayed oncological intervention.

The access to care concerns many oncology providers and associations. The American Cancer Society, among others, is acutely aware of this issue. A recent article in CA-A Cancer Journal for Clinicians reviewed Cancer Statistics for African Americans and concluded the following: *"Most cancers detectable by screening are diagnosed at a later stage and survival rates are lower with each stage of disease in African Americans than in whites. The extent to which these disparities reflect unequal access to health care versus other factors is an active area of research." (CA Cancer J Clin 2002:53:326-341.)*

In summary, a comprehensive review of our tumor registry data regarding incidence, initial staging, initial therapy and survival outcome of patients diagnosed with lung cancer indicates the following:

- The observed changes in incidence of lung cancer, extent at initial staging and distribution of histo-pathologic subtypes reflect the changes seen in the national data.
- There is an increase in lung cancer in women, likely reflecting the smoking patterns of this population.
- The use of combined modality therapy encompassing surgery, radiation therapy and chemotherapy has increased over the past four years.
- The number of cases of adenocarcinoma particularly with the diagnosis of broncho-alveolar subtype continues to increase.
- The survival data for the patient population at the Saint Francis Hospital and Medical Center are similar to the national average.
- The special needs of ethnic minorities afflicted with lung cancer and their access to timely and comprehensive care will have to be addressed.

Figuire 1. Tobacco History

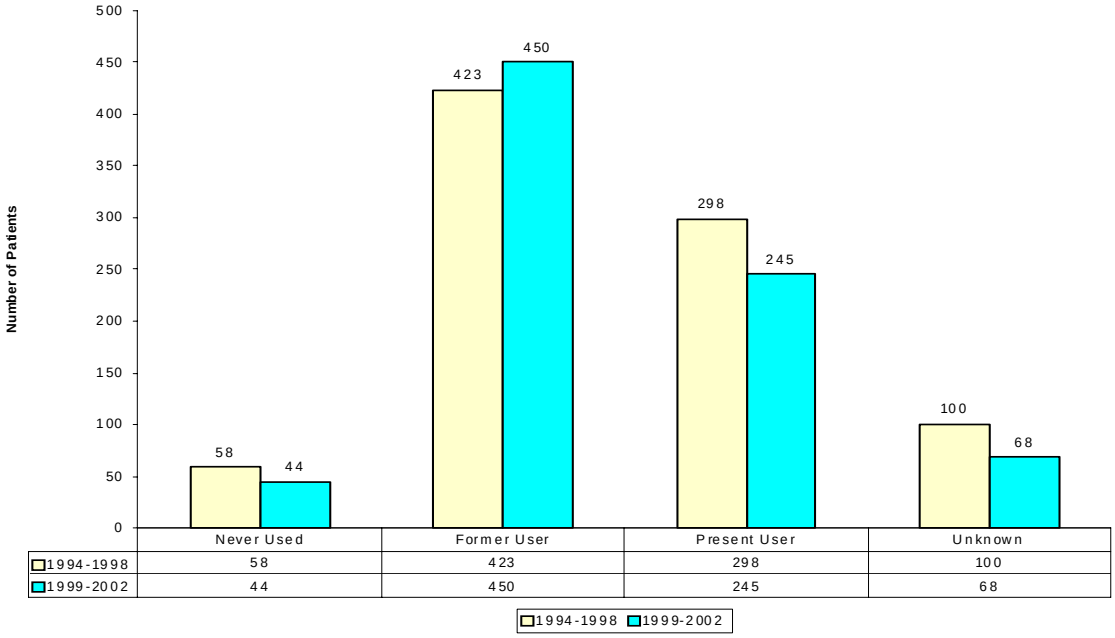


Figure 2. Histology

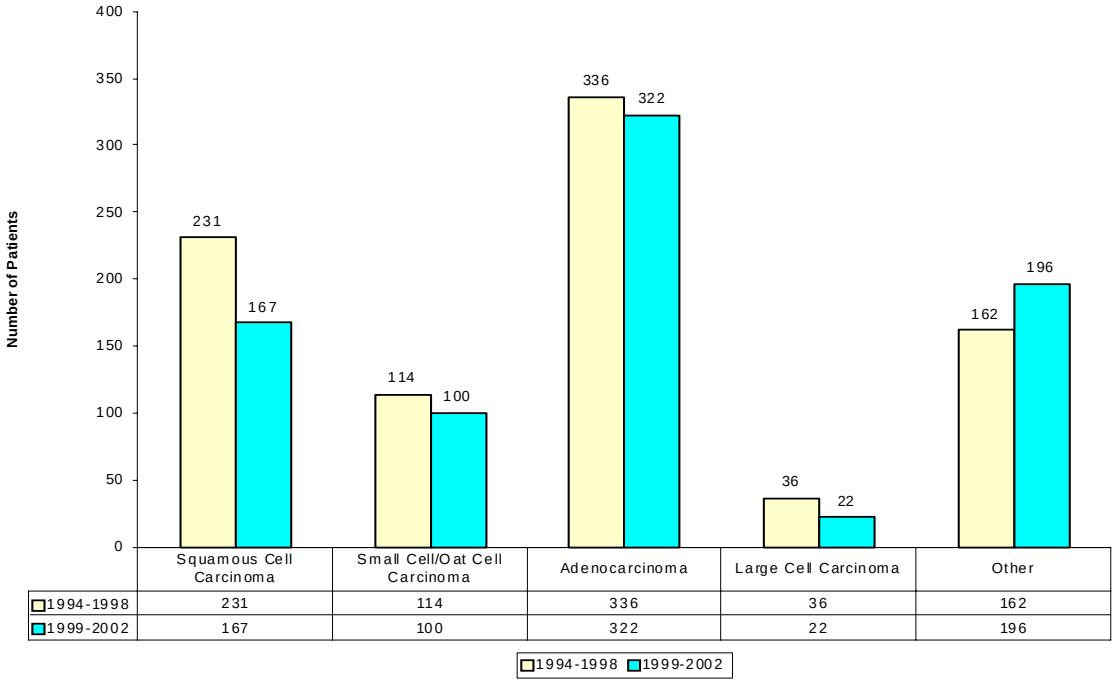
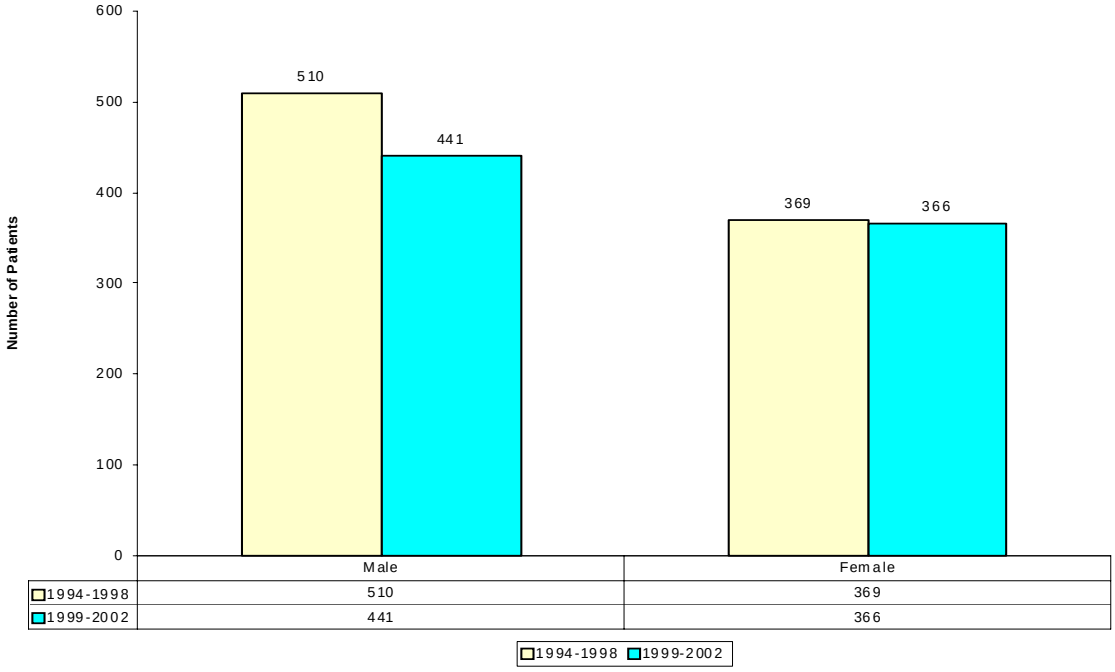
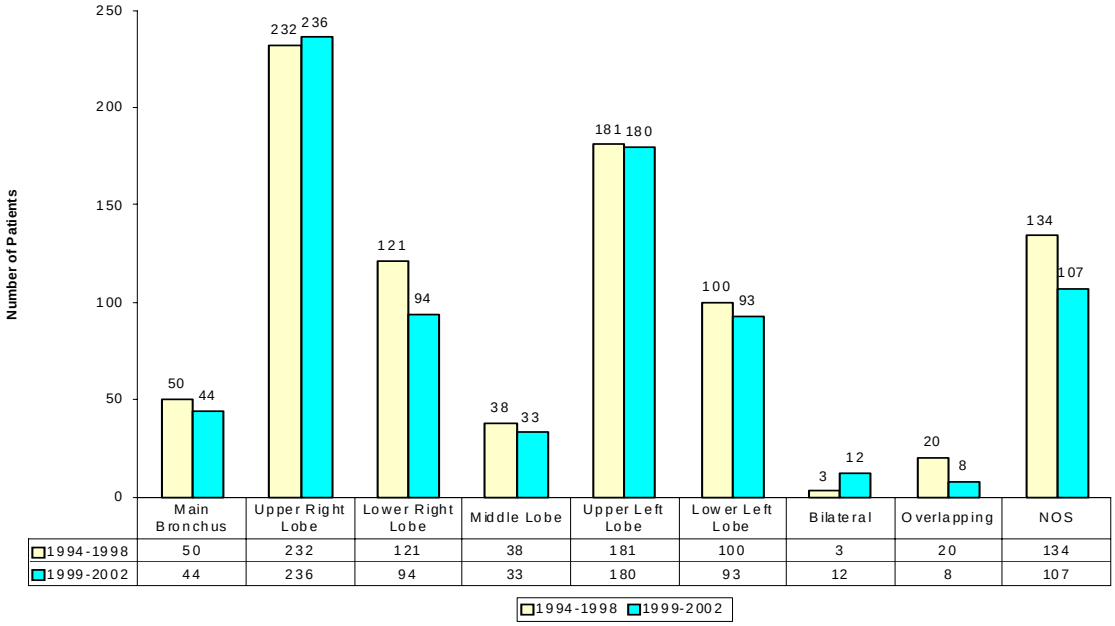


Figure 3, Distribution by Sex



	Male	Female
1994-1998	510	369
1999-2002	441	366

Figure 4. Anatomical Site



	Main Bronchus	Upper Right Lobe	Lower Right Lobe	Middle Lobe	Upper Left Lobe	Lower Left Lobe	Bilateral	Overlapping	NOS
1994-1998	50	232	121	38	181	100	3	20	134
1999-2002	44	236	94	33	180	93	12	8	107

Figure 5. Stage - NSCLC

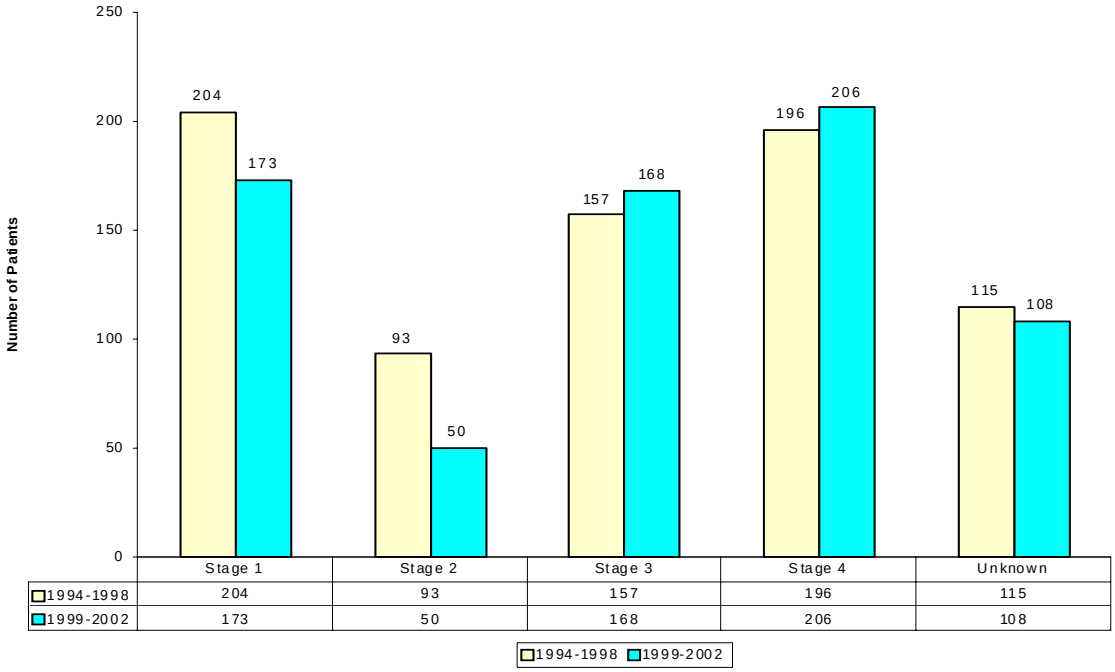


Figure 6. Stage - SCLC

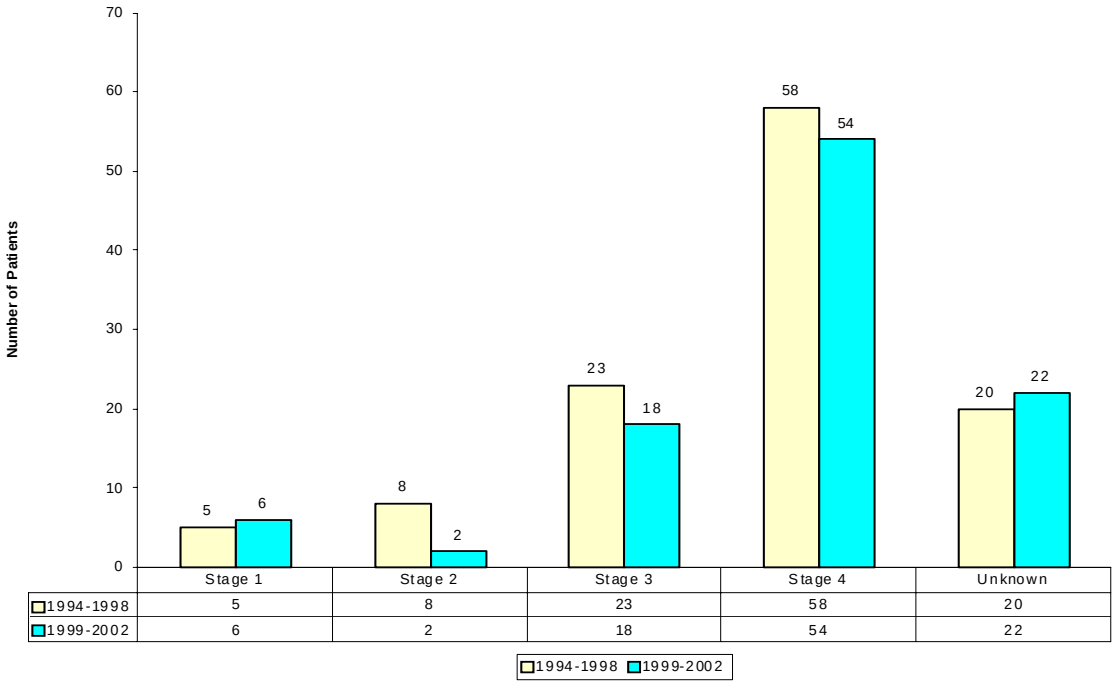
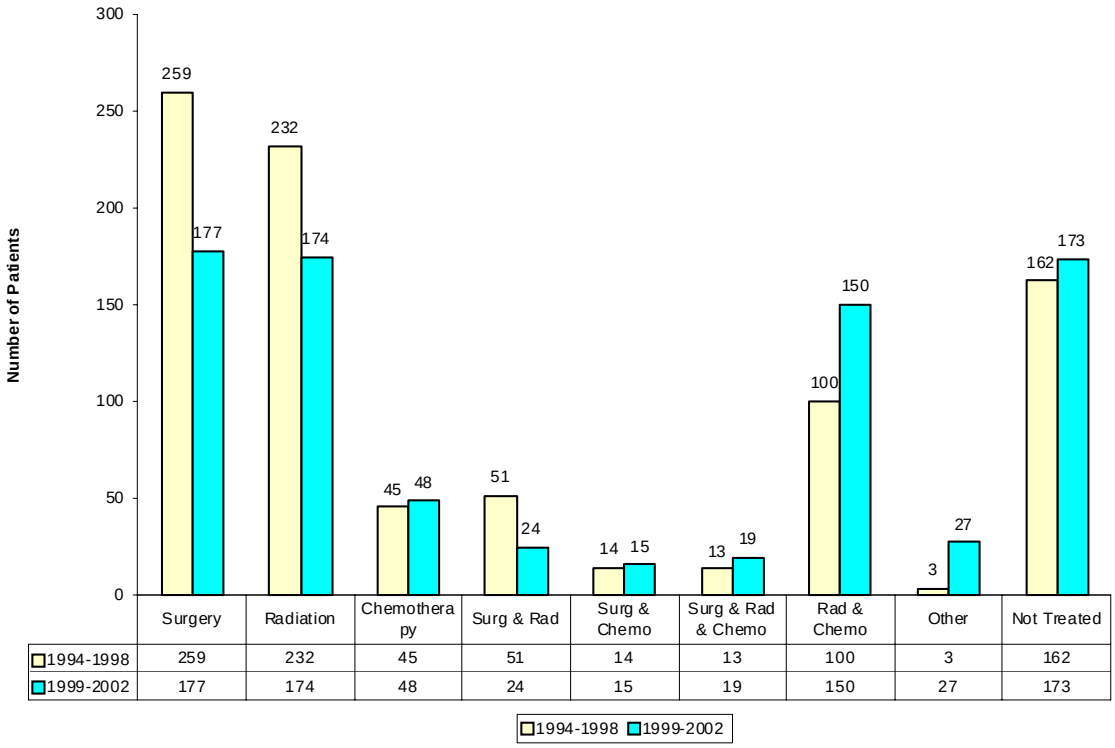
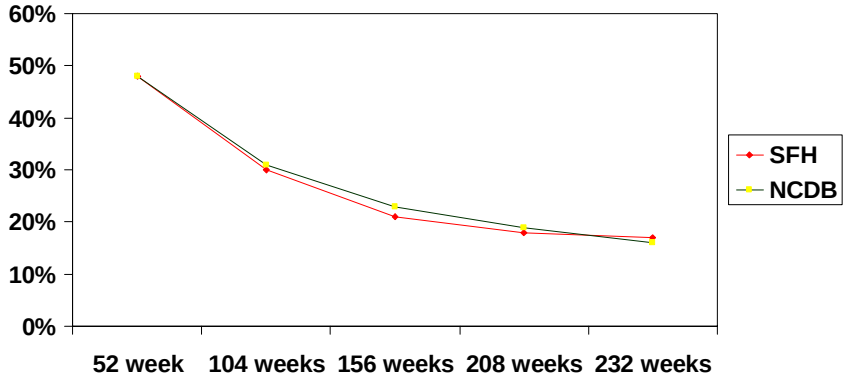


Figure 7. Treatment



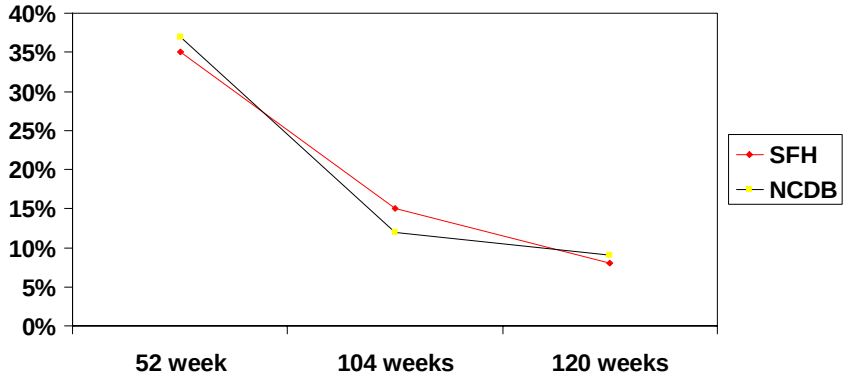
	Surgery	Radiation	Chemotherapy	Surg & Rad	Surg & Chemo	Surg & Rad & Chemo	Rad & Chemo	Other	Not Treated
1994-1998	259	232	45	51	14	13	100	3	162
1999-2002	177	174	48	24	15	19	150	27	173

Figure 8
NSCLC Survival



SFH = St. Francis Hospital NCDB = National Cancer Database
Last SFH patient expired at 232 weeks

Figure 9
SCLC Survival



SFH = St. Francis Hospital NCDB = National Cancer Database
Last SFH patient expired at 150 weeks