

Cancer Program Annual Report 2005



1328 Twenty-Second Street
Santa Monica, CA 90404-2091

The 2005 Oncology Annual Report is dedicated to the memory of
Ramona Crear, CTR.
Ramona was dedicated to Saint John's Health Center,
the Cancer Program and the Cancer Registry.
Her presence and spirit are truly missed.

2005 Cancer Committee Members

Robert Wollman, M.D., Radiation Oncology, Chairman

Warren Allen, M.D, Pathology

Richard Andersen, Pharm.D., Pharmacy

Robert Andrews, M.D., Otolaryngology

Geri Barelli-James, RN, MN, Quality Assurance

Stanley Brosman, M.D., Urology

David Butler, M.D., Otolaryngology

Mary Jo Byrne, MSW, Social Work

Rebecca Crane-Okada, PhD, RN, AOCN, CNS, Clinical Nurse Researcher

Ramona Crear, CTR, Cancer Registry

Maggie DiNome, M.D., Surgical Oncology

Shirley Edwards, MSN, AOCN, RN, CNS, Patient Care Services

Rebecca Fleming, RD, Nutrition Services

Nora Hansen, M.D, General Surgery

Kathryn A. Henick, M.D., Hematology/Oncology

Heidi Hoffman, M.D., Diagnostic Radiology

Maribelle Kim, RHIA, Health Information Management

Ellen Knell, Ph.D., Genetic Counseling

Jan Inouye Malek, RN, MN, AOCNS, Radiation Oncology

Gerald Markovitz, M.D., Pulmonary Medicine

Silvana Martino, D.O., Hematology/Oncology

Sister Marlene Panko, SSND, Chaplain Services

Vicki Schiller, M.D., Diagnostic Radiology

Stephanie Strauss, CTR, Cancer Registry

Bret Taback, M.D., Surgical Oncology

May Lin Tao, M.D., Radiation Oncology

Phillip Williams, RN, Nursing Oncology

Marc Wishingrad, M.D., Gastroenterology

Letter from the Chairman

As Chairman of the Saint John's Health Center Cancer Committee, I am pleased to present our 2005 Oncology Annual Report. The Cancer Program at Saint John's Health Center continues to grow and 2005 was a busy year.

Some of the activities of the Cancer Program included:

- Prostate education program in September for National Prostate Awareness Month.
- Implementing new Mammosite Brachytherapy radiation therapy services for breast cancer patients.
- Participated in Daffodil Day for the American Cancer Society.
- Adopted the National Coordinating Council on Medication Error Reporting and Prevention Guidelines to prevent chemotherapy related medication errors.
- Provide on site genetic counseling, testing, and referrals by Ellen Knell, Ph.D.

The following Annual Goals for 2005 were adopted:

- Plan and assemble Palliative Care Team to start services in 2006.
- "Radiation Oncology: A Guide for Physicians and Their Patients" pamphlet was distributed.
- A study of the use and documentation of the Surgical Specimen Slips was conducted which produced enhanced communication between the Pathologists and Radiologist performing needle localization biopsies.
- A Comfort Care Study was conducted on the Oncology Inpatient Unit increasing the comfort care provided to all inpatients.
- "Digital Mammogram" mammography unit is now available at the Wilshire Mammography Center.
- Multiple community outreach programs including multiple Women's Health Programs offered in English and Spanish, Men's Health Programs, Colorectal Health Education Program, and Anti-Smoking Program for Teens.

Colon Cancer is the focus of this year's Annual Report. Dr. DiNome, our Cancer Liaison Physician, look at the survival of our colon cancer patients as well as those treated by a laparoscopic surgical approach.

Our Cancer Program would not be the success it is without the support and enthusiasm of its members. I would like to thank all of the physicians, nurses, administrative staff who have graciously offered their time and talent to making our Cancer Program a success.

Sincerely,

Robert Wollman, M.D.
Department of Radiation Oncology
Chairman, Cancer Committee

Cancer Liaison Physician Report

As a Comprehensive Community Cancer Center, Saint John's Health Center provides patients with the most advanced treatment in surgical, radiation and medical oncologic care. In 2005, over 1650 cancer patients were treated at Saint John's Health Center reflecting the outstanding reputation of Saint John's Health Center as a cancer treatment facility.

In addition to providing state of the art care, Saint John's Health Center also focuses on the importance of community education and awareness in the early detection and prevention of cancer. Several community forums and lectures were sponsored by the hospital throughout the year highlighting common cancer types and providing patients with the information necessary to be active participants in their care. Through our ongoing partnership with the American Cancer Society, we continue to be engaged in a collaborative effort to reduce cancer-associated morbidity, mortality and suffering.

Maggie DiNome, M.D., F.A.C.S., F.S.S.O.
General Surgery/Surgical Oncology
Cancer Liaison Physician

Community Education

The Community Education Program offered a variety of programs, classes, health fairs and screenings for our community. In 2005, the following Community Education Forums were held:

**Cancer
Program
Components**

- ◆ Colorectal Health—Commemorating National Colorectal Cancer Awareness Month
Maggie DiNome, M.D., Surgical Oncology
Ira Smalberg, M.D, Diagnostic Radiology
Marc Wishingrad, M.D., Gastroenterology
- ◆ Colorectal Health Update, Saint John's Health Center Community Education Forum
Maggie DiNome, M.D., Surgical Oncology
- ◆ Prostate Cancer—Commemorating National Prostate Cancer Awareness Month
Leslie M. Kaplan, M.D, Urology
Robert J. Smith, M.D, Internal Medicine
Robert C. Wollman, M.D., Radiation Oncology
- ◆ After the Women's Health Initiative—Results from the Women's Health Initiative Study regarding Menopause, Breast Cancer and Heart Disease
Amy E. Rosenman, M.D, Urogynecology
Sandra Fallon, M.D, Cardiology
Tracy Childs, M.D., General Surgery
- ◆ Colon Cancer Awareness and Prevention, Santa Monica "Coffee Talk," Channel LA 36 and City TV 16
Maggie DiNome, M.D., Surgical Oncology

Cancer Registry

The Cancer Registry maintains a computerized database of over 18,000 cancer cases diagnosed and/or treated at Saint John's Health Center since 1990. In 2005, 1873 cases were added to the database, of which 1653 were diagnosed and/or received their first course of treatment at Saint John's. The Cancer Registry reports all cases to the Los Angeles County Cancer Surveillance Program, as part of the California Cancer Registry.

The data maintained by the Cancer Registry is available for use by the medical staff, hospital administration, other health care professionals for special studies, end-results reporting, medical education, patient care evaluations, and research. The Cancer Registry responded to over 100 requests for information from physicians, administrators, hospital staff, and outside sources. The data is used for treatment planning and evaluation, outcome measures, clinical research and cancer program strategic planning.

The Cancer Registry performs lifetime follow-up on all analytic cancer patients, which serves to continue to monitor for diagnostic and treatment results. In 2005, the Cancer Registry was following over 12,000 cancer cases.

For information regarding the Cancer Registry or for data request, please contact the Cancer Registry at (310) 829-8859.

Cancer Conferences

Cancer Conferences at Saint John's Health Center are multidisciplinary, include Breast Conference, Pre-Op Surgical Conference and General Tumor Board, and are attended by physicians from all specialties. Physicians representing the fields of General Surgery, Surgical Oncology, Hematology/Oncology, Radiation Oncology, Diagnostic Radiology, Pathology, Internal Medicine, Family Practice, Pulmonary, and Plastic Surgery all attended Cancer Conferences in 2005. Cancer Conferences focus on pretreatment evaluation, staging, treatment strategies, referrals to research protocols and rehabilitation.

In 2005, there were a total of 116 meetings with 350 cases present. Of the total cases presented, 345 were prospective cases, representing 20.9% of our analytic caseload. The primary sites presented reflect our caseload as well, with the most number of cases presented being breast and melanoma. The other primary sites presented include: kidney, thyroid, larynx, gallbladder, lung, tongue, soft tissue sarcoma, liver, bone, stomach, bladder, prostate, uterus, bone marrow, colon, head and neck, lymphoma, ovary and esophagus.

Institutional Review Board

The Joint Institutional Review Board (IRB) between Saint John's Health Center and the John Wayne Cancer Institute is charged with protecting the rights and welfare of human research subjects and assessing the risks and benefits of proposed research. Among its most important activities is to ensure compliance with state and federal guidelines governing research involving patients.

The IRB is currently assisting with nearly 100 active research protocols involving Saint John's investigators. For questions about the IRB or research submission requirements

**Cancer
Program
Components**

John Wayne Cancer Institute

The John Wayne Cancer Institute (JWCI) support research and development and education in basic and clinical science for the prevention, detection, diagnosis, and treatment of cancer. In the past ten years JWCI has received support from over 70 grants and contracts. Two of these grants are program projects that continue to be funded by the National Institute of Health. During this period physicians, research scientists, and fellows published over 225 papers and abstracts that were presented at a number of national and international meetings.

JWCI breast cancer surgeons are principal investigators in two important multicenter trials sponsored by the American College of Surgeons Oncology Group. One trial is examining the clinical importance of minute tumor deposits (micrometastasis) in the lymph nodes and bone marrow of patients with early breast cancer. Another trial is enrolling patients who have tumor-positive sentinel nodes. This study will determine whether axillary node removal contributes to the cure of breast cancer. Additionally, JWCI is the headquarters of the Multicenter Selective Lymphadenectomy Trial (MSLT), a program project funded by the National Institutes of Health, investigating the use of sentinel node mapping melanoma.

The U.S. Department of Defense is joining forces with JWCI to protect American males from a deadly enemy: prostate cancer. The DOD recently awarded the Institute a grant

Joyce Eisenberg Keefer Breast Center

The Joyce Eisenberg Keefer Breast Center (JEKBC) was founded under the auspices of the John Wayne Cancer Institute (JWCI) in 1993 by its current director, Armando E. Giuliano, M.D. The Center, located within Saint John's Health Center (SJHC), provides multidisciplinary care to patients with breast problems. Cutting-edge research is performed under the umbrella of JWCI, which supports and maintains the laboratories and administrative structure of the breast program. Thus, the JEKBC functions in a unique environment that blends a rigorous academic program with the beauty and efficiency of an extraordinary community hospital, Saint John's Health Center (SJHC), listed as one of the top 50 hospitals in the United States by AARP *Modern Maturity* in May/June 2002. Our state-of-the-art breast center was recognized by *Self* magazine in 1999 as one of the ten best breast centers in the United States. This recognition is based on outstanding patient care and new and innovative clinical, translational, and basic science research that is carried out in a warm, inviting, and non-threatening setting.

The Center has two surgical oncologists, three dedicated breast imaging specialists, two endocrinologists (dedicated to the management of hormone deficiency syndrome in breast cancer), an oncology nutritionist, two full time oncology nurses, one Ph.D. oncology nurse researcher on site, the Banchik Family Breast Cancer Library, and a Positive Appearance Center (to address body image issues). The Library offers a comfortable setting in which to review the latest information about breast cancer its treatment. Both popular and professional books, literature, and videotapes are available for patients and their families to use at the Center or to check out and take with them for further review. Internet access is also available for patient and family use. The JEKBC offers treatment for benign breast disease as well as a comprehensive approach to the detection and management of cancer in its earliest forms. The program provides patients with breast cancer screening, breast health education, supportive care, and prevention strategies. Additionally the Center provides interdisciplinary care for patients with complex problems in breast cancer. Patients are evaluated for multimodality treatment (surgery, radiation therapy, chemotherapy, and/or hormonal therapy) by an interdisciplinary team of physicians and nurses. The programs approaches the patient as a whole person and includes dedicated breast imaging, breast pathology, breast radiation oncology, surgical oncology,

medical oncology, nutritional counseling, psychosocial support, plastic and reconstructive surgery, community service and outreach, and research. We collaborate closely in programs and in referral of patients to the American Cancer Society, Wellness Community, and WeSpark.

The JEKBC offers its patients a level of medical expertise and an increasing repertoire of innovative diagnostic and therapeutic procedures not available at most community hospitals and often not offered at other tertiary cancer centers. For instance, the JEKBC is one of the very few centers that also treat patients with breast disease-related endocrine disorders such as osteoporosis and hormone deficiency syndrome in cancer patients. There were nearly 7000 patient visits in 2005. More than 18,000 diagnostic breast imaging studies were performed in 2005. About 400 new breast cancer cases are treated annually in the JEKBC.

In 1999 the John Wayne Cancer Institute expanded its spectrum of academic training programs to include a separate JEKBC Breast Fellowship for surgeons interested in advanced training in the field of breast disease. Commencing in 2002, the Society of Surgical Oncology (SSO) has recognized the need for a discrete breast fellowship, and the JWCI/JEKBC is a participating program. The JWCI/JEKBC Interdisciplinary Breast Fellowship Program trains one fellow funded by the Susan G. Komen Breast Cancer Foundation. This fellowship is one of only seven fellowships funded by the Komen Foundation-nationally.

The unique clinical resources of the JEKBC and the basic science resources of the JWCI have a proven track record in obtaining NIH and philanthropic support and have made major contributions to the treatment and understanding of breast cancer. The sentinel node biopsy, which has altered breast cancer management throughout the world, was developed at this institution from a philanthropic grant. Commencing in 1991, this grant, awarded by the Ben B. and Joyce Eisenberg Foundation, enabled us to perform the research that has resulted in a new way to treat breast cancer. This minimally invasive operation has had a major impact on the treatment of node-negative women, especially

Positive Appearance Center

The Positive Appearance Center, a non-profit facility, was the first of its kind on the Westside to address the cosmetic side effects and comfort needs related to cancer treatment. The Center has a warm boutique-like setting which provides a nurturing environment where cancer patients may receive individualized and specialized care. The Center offers an array of products and services to meet the needs of men and women undergoing cancer treatment.

The Center carries breast prostheses, mastectomy bras, camisoles, and bathing suits, as well as wigs and other alternatives including hats, caps, turbans and scarves. The Positive Appearance Center also carries support garments for lymphedema and a certified fitter on staff for both compression garments and mastectomy prosthesis and bras. There is no charge for fittings or consultations.

In addition, the Center also carries skin care products, sun blocks and sun protective hats, especially important for melanoma patients.

The Positive Appearance Center also hosts the Look Good, Feel Better program sponsored by the American Cancer Society on a quarterly basis. In 2005, the Look Good, Feel Better program met in January, May, August and November.

The Positive Appearance Center is open for walk-in visits Monday through Friday from 10 am to 4pm. Appointments are encouraged, though not required for fittings of prostheses and wigs. Home visits are available when needed.

The Positive Appearance Center is located in the Joyce Eisenberg Keefer Breast Center of

**Cancer
Program
Components**

Inpatient and Outpatient Services

Patients requiring inpatient care are treated at Saint John's 47 bed oncology unit, on the first floor of the North Pavilion. Nursing staff receive special training and certification in oncology. An oncology, clinical nurse specialist works closely with nursing administration in quality assurance monitoring, education and training activities. The oncology unit fully utilizes the team approach to patient care management with discharge rounds, patient care conferences, bioethics consultations and multi-professional training seminars which include clinical social workers, pastoral care, rehabilitation services, nursing staff, pharmacist and physicians. Case Managers provide discharge planning, emotional support and utilization review.

Saint John's Health Center offers a full range of outpatient services including referral services at the John Wayne Ambulatory Cancer Center on 3 West and the Joyce Eisenberg-Keefer Breast Center on 4 West.

Numerous support groups for patients and families focus on cancer information, nutrition, stress management and coping strategies. A library and audio-visual resource center are open all patients and family members as well as the public. Genetic screening is also available for patients and their families. The Positive Appearance Center is a unique, one-stop service, adjacent to the Joyce Eisenberg-Keefer Breast Center that helps patients deal with the cosmetic side effects and comfort needs related to their disease and cancer treatment.

Pharmacy

In 1999 Saint John's added a full-time Pain Management Pharmacist position to the staff. Teresa Fan, Pharm.D., makes daily rounds on all patients receiving patient controlled analgesia (PCA) and assesses level of pain, sedation, patient knowledge, and side effects or complications.

All members of the healthcare team can initiate a Pain Pharmacist referral without a chart order. The Pain Pharmacist will review the patient's current pain and symptom management plan, provide consultation, recommend changes, and/or initiate changes to the current regimen by contacting the physician.

Teresa is available if patients have questions or concerns about their pain control, to assist in initiating PCA's or to convert equal-analgesic dosage forms. She may be reached at

***Clinical
and
Diagnostic
Services***

Social Services

Total patient care extends beyond that provided by physicians and nurses. A diagnosis of cancer brings with it profound psychological trauma. Clinical social workers assist patients and family members to navigate their way through disease process from initial diagnosis and throughout treatment. They provide crisis intervention, brief insight oriented psychotherapy, guided meditation for stress reduction, conflict resolution, assistance with health care directives, discussion of end of life issues, maintenance of resource library and support for staff members. They refer to agencies within the community such as American Cancer Society, Wellness Community, Our House and We Spark in an effort to support both the patients and their families. In addition, clinical social workers facilitate programs to increase cancer awareness and promote preventive interventions both medical and non medical.

Spiritual Care

Serious illness often prompts one to reflect on human experience and the meaning of life. No matter what religious heritage they claim, an interfaith chaplain can help patients and their families deal with emotional and spiritual issues related to disease, suffering, and the human condition. A degreed and certified chaplain with background in spirituality, psychology of the human person, and CPE (Clinical Pastoral Education) is available to help patients draw on their own spiritual resources. At Saint John's, the chaplain sees oncology patients on the inpatient unit and in the Breast and Cancer Centers. Patients may also choose to receive visits from our faith-specific chaplains, including a visiting rabbi and visiting Protestant clergy, or they may request our assistance in contacting a representative from their own faith community. The interfaith chaplain participates in rounds and is an integral part of the interdisciplinary care team.

Nutritional Services

The Registered Dietitian (RD) plays an integral role in the nutritional assessment and management of the cancer patient. Through Saint John's nutritional therapy program and Biochemotherapy Protocol, the clinical dietician identifies the nutrition needs of the patient; establishes a feeding plan; and provides education and applicable materials for nutritional management.

Pathology

The Department of Pathology is involved in many aspects of the cancer management care of patients. The department is composed of eight pathologists, including sub-specialists with board certification in hematopathology and cytopathology. The Department of Pathology reviewed over 22,000 surgical specimens in 2005, providing primary tissue diagnosis and confirmation of diagnosis for cancer patients, including cases sent for second opinion from outside facilities. Other services include intraoperative consultation with frozen section diagnosis, performance of bone marrow biopsies, and fine needle aspiration biopsies of both palpable and deep-seated tumors, with extremely rapid turnaround times. The laboratory routinely provides a complete panel of breast cancer prognostic markers and continues to develop a library of antibodies available to pathologists to aid in cancer diagnosis. Pathology reports include diagnosis, relevant prognostic information and staging designation. This information is integral in determining the optimal care plan for our patients.

Diagnostic Radiology

The Department of Imaging performs a full range of routine diagnostic procedures including CT, MRI and ultrasound. Interventional specialists perform therapeutic procedures such as chemoembolization and radiofrequency ablation of the liver under CT guidance. A specialized staff in the Breast Center perform stereotactic core biopsies and pre-operative localization of breast lesions.

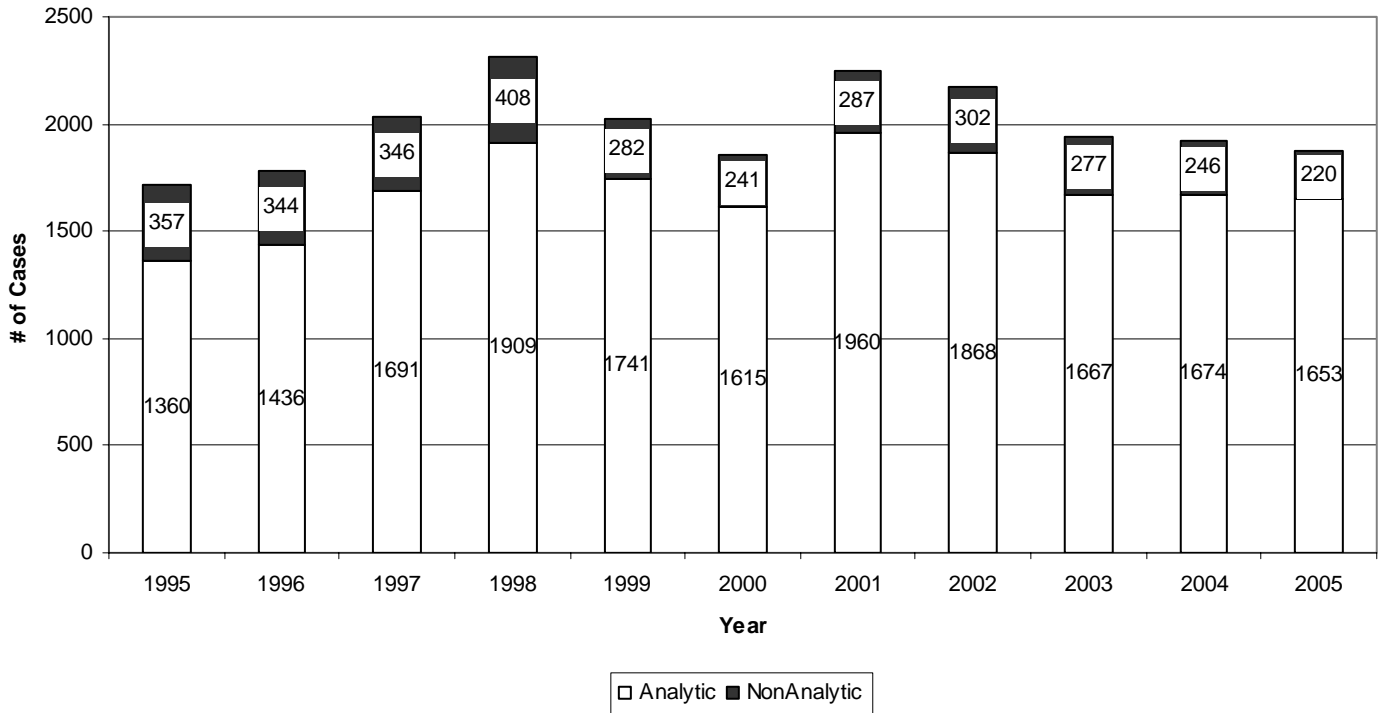
***Clinical
and
Diagnostic
Services***

2005 Primary Site Table

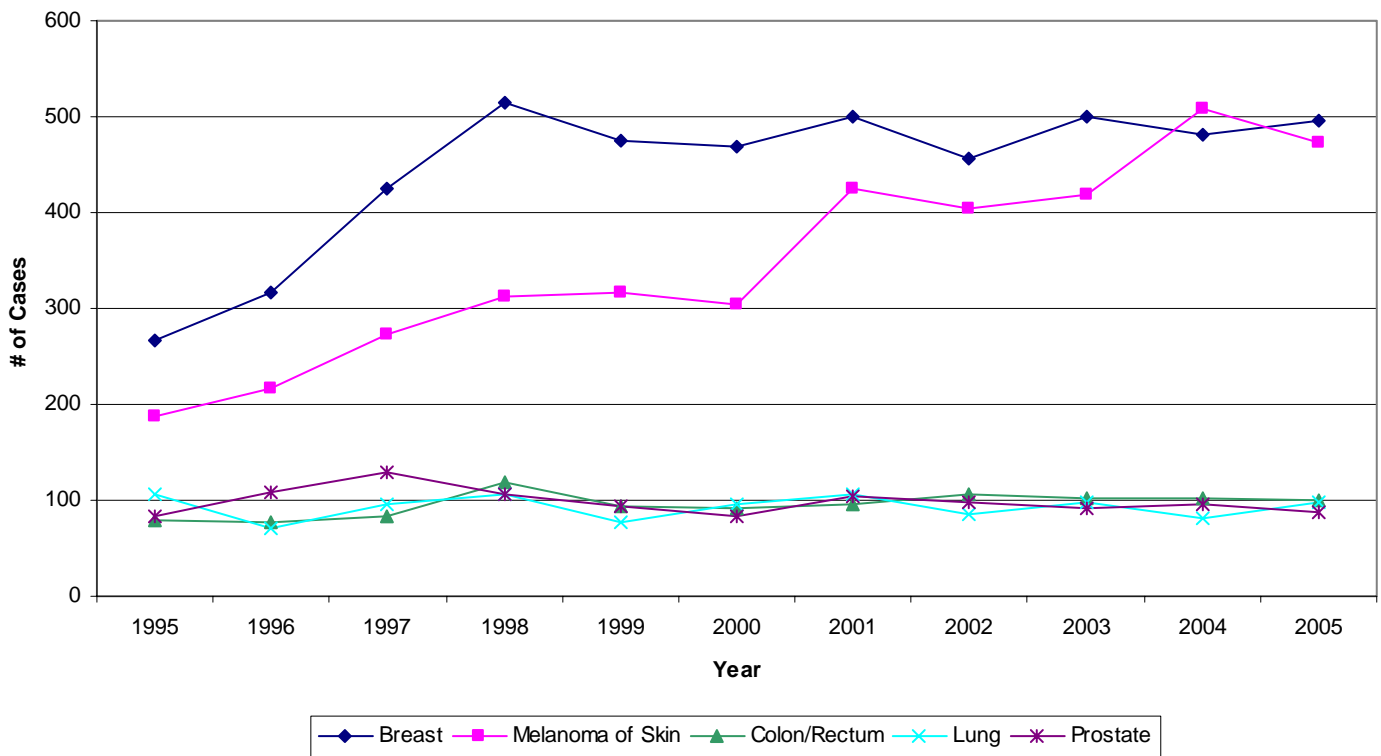
| Site Group | Total Cases | Class | | Sex | | Stage | | | | | | N/A | Unk |
|--------------------------|-------------|----------|-------|-----|------|---------|---------|----------|-----------|----------|----|-----|-----|
| | | Analytic | NonAn | M | F | Stage 0 | Stage I | Stage II | Stage III | Stage IV | | | |
| ALL SITES | 1873 | 1653 | 220 | 736 | 1137 | 225 | 615 | 328 | 198 | 130 | 92 | 65 | |
| TONGUE | 10 | 8 | 2 | 5 | 5 | 0 | 2 | 1 | 2 | 3 | 0 | 0 | |
| SALIVARY GLANDS, MAJOR | 2 | 2 | 0 | 2 | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 0 | |
| MOUTH, OTHER & NOS | 1 | 1 | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | |
| TONSIL | 4 | 4 | 0 | 3 | 1 | 0 | 0 | 0 | 2 | 2 | 0 | 0 | |
| NASOPHARYNX | 1 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | |
| HYPOPHARYNX | 1 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | |
| PHARYNX & ILL-DEFINED | 1 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | |
| ESOPHAGUS | 5 | 4 | 1 | 3 | 2 | 0 | 0 | 1 | 0 | 0 | 0 | 3 | |
| STOMACH | 18 | 17 | 1 | 8 | 10 | 0 | 2 | 3 | 5 | 2 | 2 | 3 | |
| SMALL INTESTINE | 9 | 4 | 5 | 6 | 3 | 0 | 0 | 0 | 0 | 2 | 2 | 0 | |
| COLON | 80 | 64 | 16 | 35 | 45 | 7 | 16 | 13 | 13 | 13 | 1 | 1 | |
| RECTUM & RECTOSIGMOID | 39 | 37 | 2 | 23 | 16 | 1 | 11 | 13 | 8 | 2 | 0 | 2 | |
| ANUS, ANAL CANAL | 4 | 3 | 1 | 2 | 2 | 0 | 1 | 0 | 1 | 0 | 1 | 0 | |
| LIVER | 4 | 3 | 1 | 2 | 2 | 0 | 0 | 1 | 2 | 0 | 0 | 0 | |
| GALLBLADDER | 1 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | |
| BILE DUCTS | 3 | 2 | 1 | 1 | 2 | 0 | 0 | 1 | 0 | 1 | 0 | 0 | |
| PANCREAS | 30 | 23 | 7 | 18 | 12 | 0 | 1 | 10 | 3 | 9 | 0 | 0 | |
| RETROPERITONEUM | 2 | 2 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | |
| PERITONEUM, OMENTUM | 3 | 3 | 0 | 0 | 3 | 0 | 0 | 0 | 0 | 0 | 3 | 0 | |
| NASAL CAVITY, SINUS, EAR | 5 | 5 | 0 | 3 | 2 | 0 | 0 | 0 | 0 | 1 | 3 | 1 | |
| LARYNX | 9 | 7 | 2 | 7 | 2 | 0 | 5 | 1 | 1 | 0 | 0 | 0 | |
| LUNG-SMALL CELL CA | 10 | 10 | 0 | 5 | 5 | 0 | 0 | 0 | 1 | 7 | 1 | 1 | |
| LUNG-NONSMALL CELL CA | 96 | 87 | 9 | 33 | 63 | 0 | 23 | 8 | 24 | 23 | 2 | 7 | |
| PLEURA | 1 | 1 | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | |
| LEUKEMIA | 15 | 11 | 4 | 5 | 10 | 0 | 0 | 0 | 0 | 0 | 11 | 0 | |
| MYELOMA | 5 | 4 | 1 | 2 | 3 | 0 | 0 | 0 | 0 | 0 | 4 | 0 | |
| OTHER HEMATOPOIETIC | 19 | 17 | 2 | 13 | 6 | 0 | 0 | 0 | 0 | 0 | 17 | 0 | |
| BONE | 3 | 0 | 3 | 2 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| SOFT TISSUE | 19 | 13 | 6 | 14 | 5 | 0 | 3 | 3 | 2 | 2 | 1 | 2 | |
| MELANOMA OF SKIN | 528 | 473 | 55 | 317 | 211 | 118 | 239 | 52 | 44 | 8 | 3 | 9 | |
| KAPOSIS SARCOMA | 1 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | |
| OTHER SKIN CA | 8 | 6 | 2 | 8 | 0 | 0 | 0 | 0 | 0 | 0 | 5 | 1 | |
| BREAST | 533 | 495 | 38 | 4 | 529 | 84 | 194 | 142 | 53 | 8 | 0 | 14 | |
| CERVIX UTERI | 3 | 3 | 0 | 0 | 3 | 0 | 1 | 0 | 2 | 0 | 0 | 0 | |
| CORPUS UTERI | 33 | 31 | 2 | 0 | 33 | 0 | 20 | 4 | 3 | 0 | 3 | 1 | |
| OVARY | 38 | 33 | 5 | 0 | 38 | 0 | 9 | 3 | 2 | 4 | 9 | 6 | |
| VAGINA | 2 | 1 | 1 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | |
| VULVA | 4 | 4 | 0 | 0 | 4 | 0 | 2 | 1 | 0 | 0 | 0 | 1 | |
| OTHER FEMALE GENITAL | 3 | 3 | 0 | 0 | 3 | 0 | 0 | 0 | 1 | 0 | 2 | 0 | |
| PROSTATE | 110 | 88 | 22 | 110 | 0 | 0 | 7 | 58 | 10 | 9 | 0 | 4 | |
| TESTIS | 12 | 11 | 1 | 12 | 0 | 0 | 8 | 1 | 2 | 0 | 0 | 0 | |
| PENIS | 1 | 1 | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | |
| BLADDER | 35 | 31 | 4 | 22 | 13 | 13 | 11 | 3 | 2 | 1 | 0 | 1 | |
| KIDNEY AND RENAL PELVIS | 12 | 9 | 3 | 8 | 4 | 2 | 5 | 1 | 1 | 0 | 0 | 0 | |
| URETER | 4 | 2 | 2 | 3 | 1 | 0 | 0 | 1 | 0 | 1 | 0 | 0 | |
| OTHER URINARY | 2 | 1 | 1 | 0 | 2 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | |
| EYE | 3 | 0 | 3 | 2 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| BRAIN | 4 | 4 | 0 | 2 | 2 | 0 | 0 | 0 | 0 | 0 | 4 | 0 | |
| OTHER NERVOUS SYSTEM | 3 | 3 | 0 | 2 | 1 | 0 | 0 | 0 | 0 | 0 | 3 | 0 | |
| THYROID | 53 | 51 | 2 | 9 | 44 | 0 | 34 | 0 | 10 | 3 | 0 | 4 | |
| HODGKIN'S DISEASE | 5 | 5 | 0 | 2 | 3 | 0 | 2 | 2 | 0 | 1 | 0 | 0 | |
| NON-HODGKIN'S LYMPHOMA | 63 | 49 | 14 | 30 | 33 | 0 | 15 | 4 | 3 | 24 | 0 | 3 | |
| UNKNOWN OR ILL-DEFINED | 13 | 12 | 1 | 6 | 7 | 0 | 0 | 0 | 0 | 0 | 12 | 0 | |

Analytic Case Distribution

Caseload Trend 1995-2005

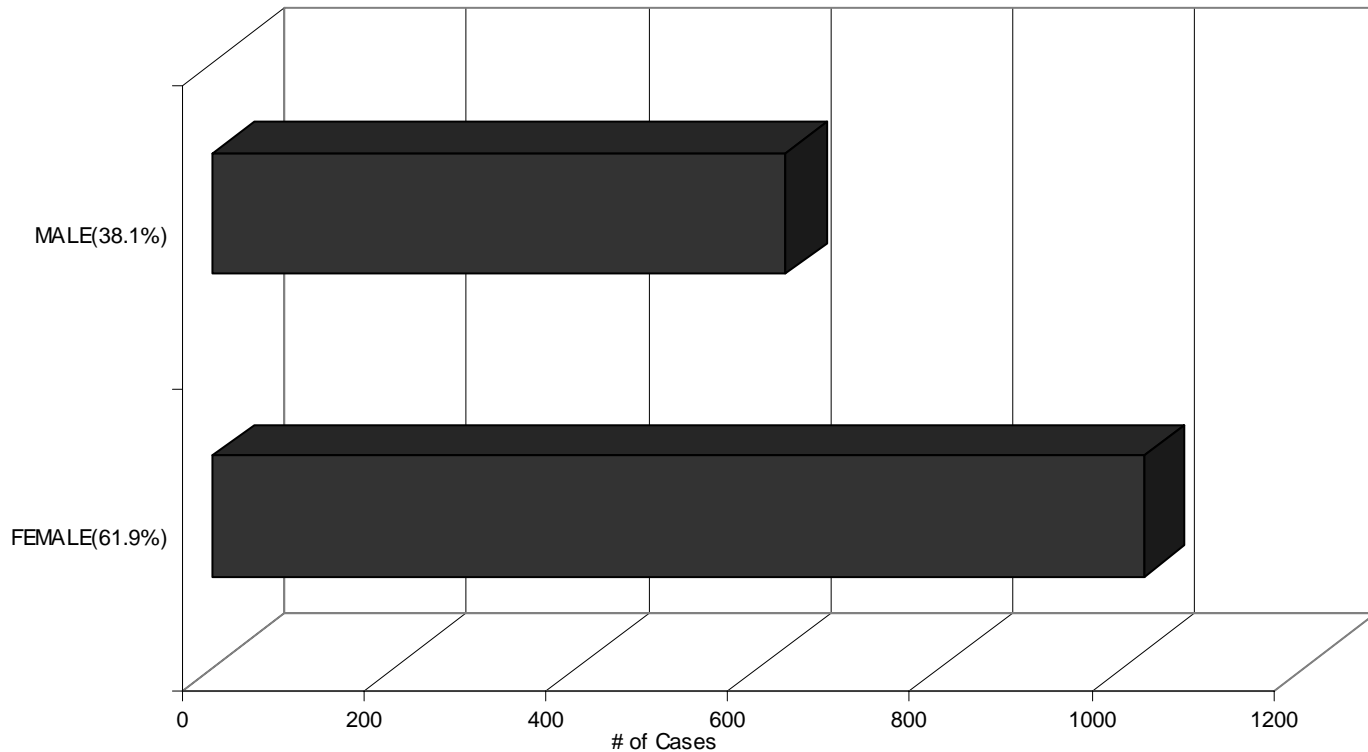


Comparison of Selected Sites at Saint John's Health Center 1995-2005

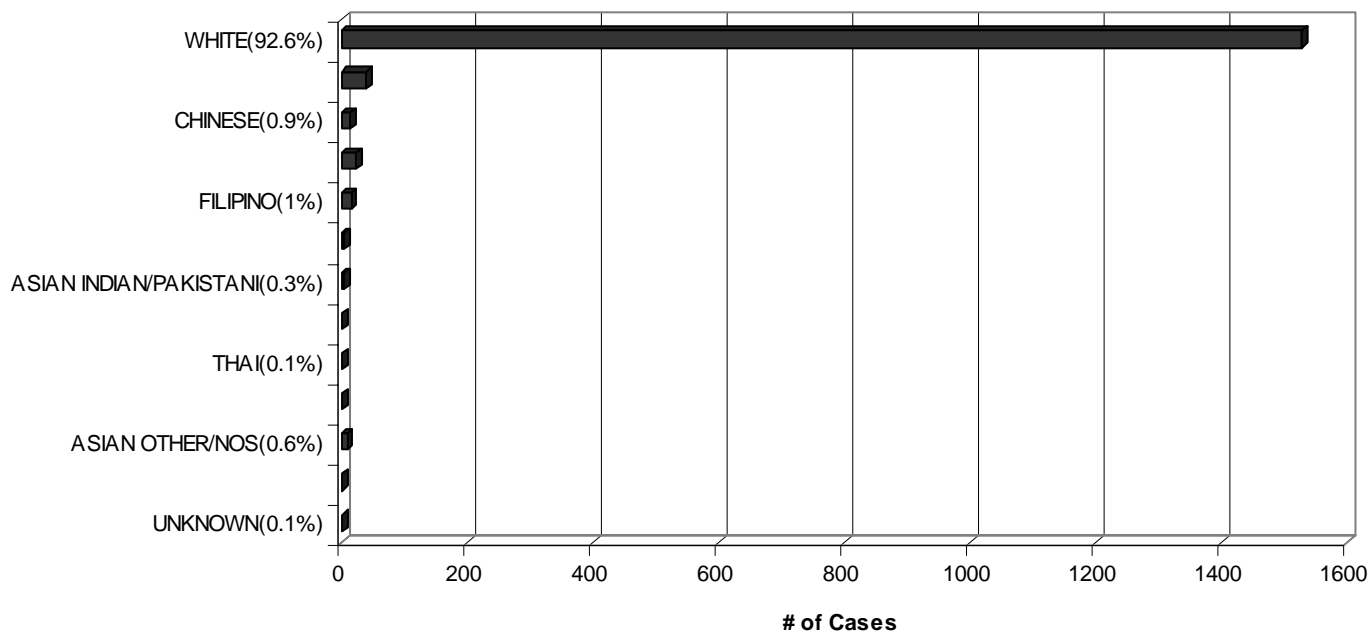


Analytic Case Distribution

Sex

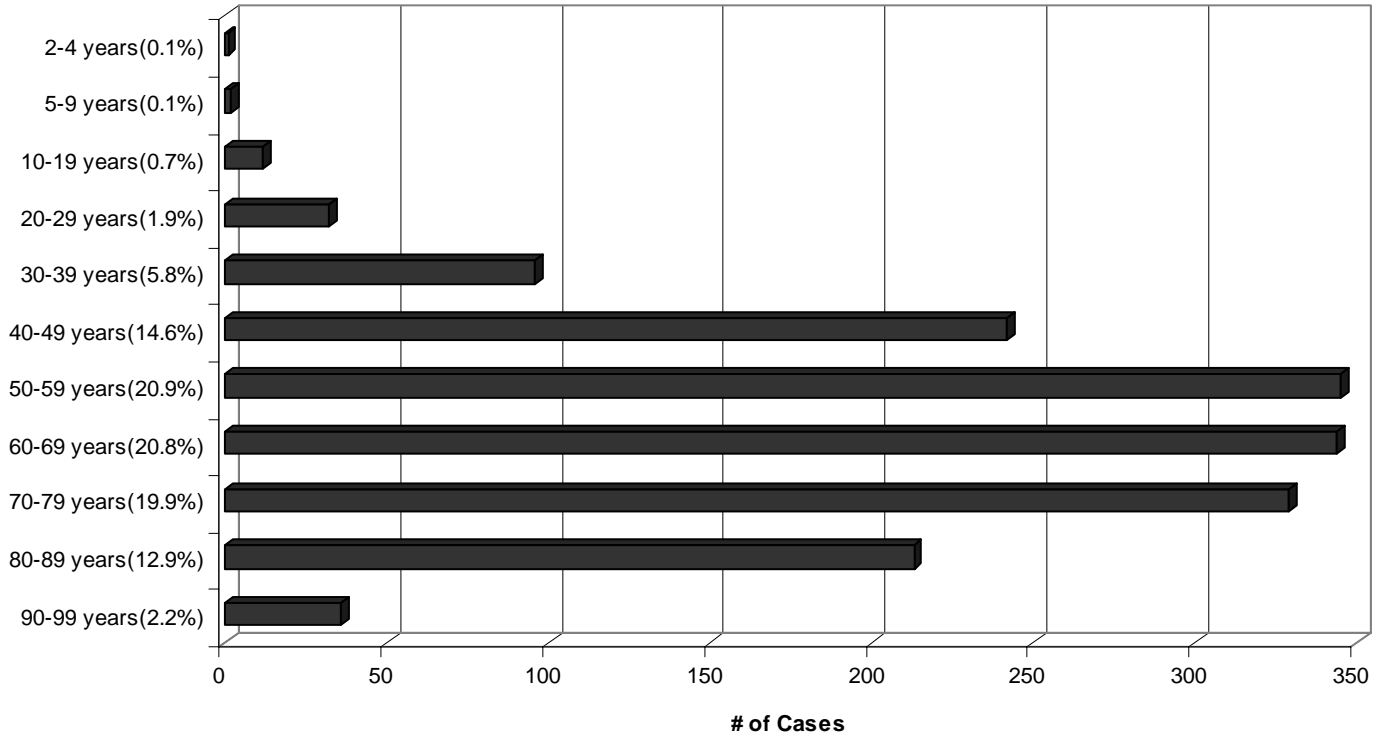


Race-Ethnicity

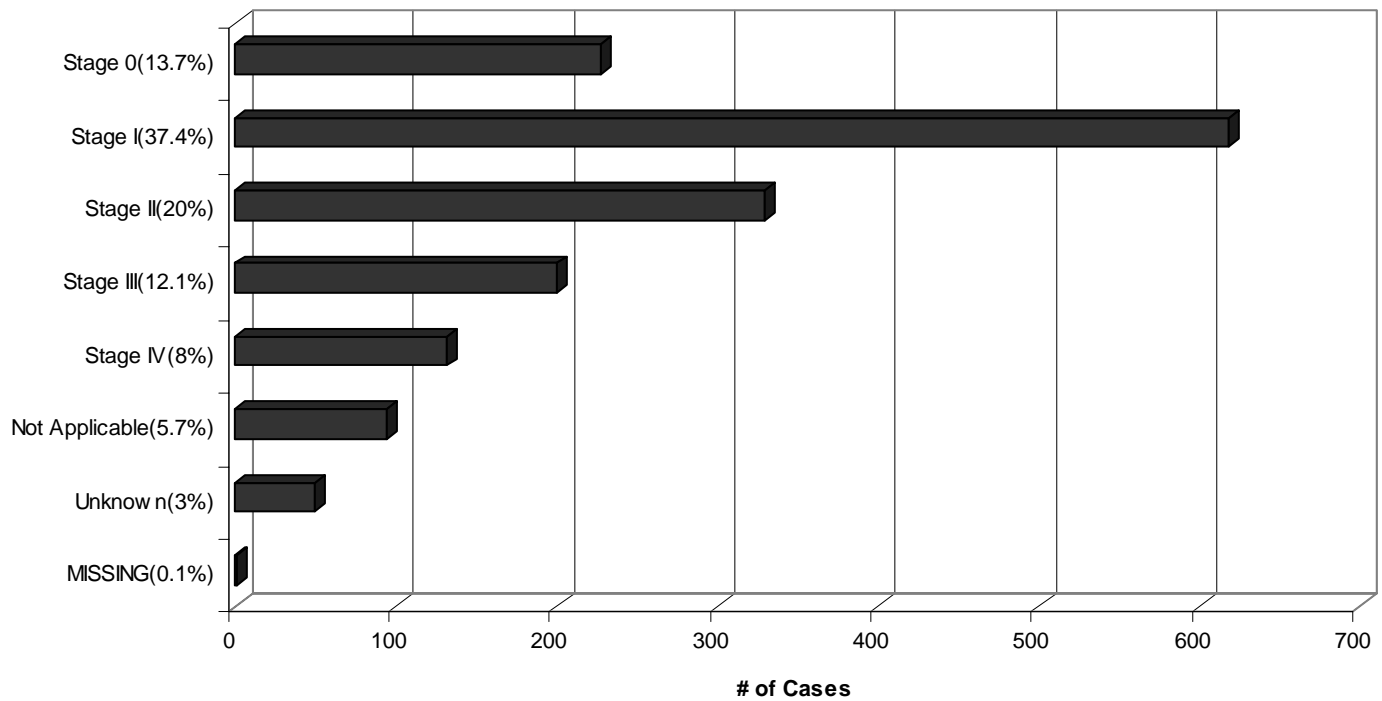


Analytic Case Distribution

Age at Diagnosis



TNM/CS Mixed Stage



Colorectal Cancer at Saint John's Health Center

Colorectal cancer is the third most common cancer diagnosed in both men and women in America, and the second leading cause of cancer death. Fortunately, we have seen an improvement in overall survival among all races of patients with colorectal cancer in the last few years. However, still over 50,000 Americans are estimated to die from this disease each year.

The impact of colorectal cancer screening on prevention and survival can not be over-emphasized. Yet, colorectal cancer screening remains underused, despite the availability of effective screening tests. The most recently published data by the Center for Disease Control and Prevention reported that only 40% of adults eligible for screening underwent screening. In fact, in California alone, up to 55% of adults over age 50 reported not having had any colorectal cancer screening (no fecal occult blood testing in the last year or endoscopy in the last five years). It is clear that survival from colorectal cancer is dependent on stage at diagnosis, with up to 90% 5-year survival rates reported for localized disease. However, on average, only 39% of colorectal cancers are diagnosed at this stage.

Along with the American Cancer Society, Saint John's Hospital has recognized the importance of education and screening in the prevention and treatment of colorectal cancer. In the last several years, as one of the nation's leading community hospitals, Saint John's Hospital has coordinated several community-based lectures, manned education booths at community Health Fairs, and developed an increasing collaboration with the American Cancer Society in an effort to enhance community awareness of this preventable and treatable cancer.

AMERICAN CANCER SOCIETY SCREENING GUIDELINES

Screening for the average risk individual should begin at age 50 and include one of the following:

- 1) Colonoscopy every 10 years,
- 2) Fecal Occult Blood Test (FOBT) every year using a home kit with three serial samples (not a single guaiac test via digital rectal examination),
- 3) Flexible Sigmoidoscopy every five years,
- 4) FOBT every year plus Flexible Sigmoidoscopy every five years (more accurate and therefore preferred than either test alone),
- 5) Double-contrast Barium Enema every five years

A diagnostic colonoscopy should be performed if any of the screening tests is positive. Screening colonoscopy has been considered the Gold Standard. However, because colonoscopy is an invasive procedure and carries inherent risks, other methods of screening are available and should be utilized to improve patient compliance with screening recommendations. Double-contrast Barium Enema has fallen out of favor for practical reasons. It is a fairly invasive test and has an overall low sensitivity rate. Although it is still listed as a recommended screening test by the American Cancer Society, most physicians do not rely on this test for routine screening.

Patients at high-risk for colorectal cancer should be screened earlier and/or more frequently than the average-risk individual. Screening for high risk patients is with colonoscopy alone. The other tests mentioned are not appropriate for high risk individuals. Patients at high risk include those with:

- a personal history of colorectal cancer or adenomatous polyps
- a personal history of chronic inflammatory bowel disease
- a strong family history of colorectal cancer or polyps (cancer or polyps in a first-degree relative [parent, sibling, or child] younger than 60, or in 2 first-degree relatives of any age) *
- a known family history of hereditary colorectal cancer syndromes (familial adenomatous polyposis or hereditary non polyposis colon cancer)

* *Colorectal cancer in relatives more distant than first-degree does not increase risk substantially above the average risk group*

The table below suggests screening guidelines for those with an **increased or high risk** of colorectal cancer, based on specific risk factors.

Colorectal Cancer at Saint John's Health Center

American Cancer Society Guidelines on Screening and Surveillance for the Early Detection of Colorectal Adenomas and Cancer -- Women and Men at Increased Risk or at High Risk

| Risk Category | Age to Begin | Recommen- | Comments |
|--|---|---|--|
| INCREASED RISK | | | |
| People with a single, small (< 1 cm) adenoma | 3-6 years after the initial polypectomy | Colonoscopy | If the exam is normal, the patient can thereafter be screened as per average risk guidelines. |
| People with a large (>1 cm) adenoma, multiple adenomas, or adenomas with high-grade dysplasia or vil- | Within 3 years after the initial polypectomy | Colonoscopy | If normal, repeat examination in 5 years; If normal then, the patient can thereafter be screened as per average risk guidelines. |
| Personal history of curative-intent resection of colorectal cancer | Within 1 year after cancer resection | Colonoscopy | If normal, repeat examination in 3 years; If normal then, repeat examination every 5 years. |
| Either colorectal cancer or adenomatous polyps in any first-degree relative before age 60, or in two or more first-degree relatives at any age (if not a hereditary syn- | Age 40, or 10 years before the youngest case in the immediate family, whichever is earlier | Colonoscopy | Every 5-10 years. |
| HIGH RISK | | | |
| Family history of familial adenomatous polyposis (FAP) | Puberty | Early surveillance with endoscopy, and counseling to consider ge- | If the genetic test is positive, colectomy is indicated. |
| Family history of hereditary non-polyposis colon cancer (HNPCC) | Age 21 | Colonoscopy and counseling to consider genetic testing | If the genetic test is positive or if the patient has not had genetic testing, every 1-2 years until age 40, then annually. |
| Inflammatory bowel disease Chronic ulcerative colitis Crohn's disease | Cancer risk begins to be significant 8 years after the onset of pancolitis, or 12-15 years after the onset of left- | Colonoscopy with biopsies for dysplasia | Every 1-2 years. |

Colorectal Cancer at Saint John's Health Center

VIRTUAL COLONOSCOPY

The role for virtual colonoscopy or CT Colonography in the routine screening of patients for colorectal cancer has not been established. It appears that the sensitivity for lesions ≥ 1 cm approximates that of traditional colonoscopy. However, the sensitivity decreases with the size of the lesion. In addition, a pre-procedural bowel preparation is still required, and the ability to perform a biopsy is lacking with the virtual colonoscopy. Until more experience and data is available, virtual colonoscopy has not been approved as a recommended screening test for the average risk individual.

Saint John's Health Center does offer virtual colonoscopy for selected patients. It has become invaluable in patients who are unable to complete a full colonoscopy either because of an obstructing lesion or a tortuous colon which precludes passage of the colonoscope. It has largely replaced the more cumbersome barium enema examination for this indication. In addition, because it is a CT scan, the liver and other organs within the abdomen can be assessed simultaneously for preoperative staging.

SAINT JOHN'S EXPERIENCE 2005

In addition to the emphasis on prevention, physicians at Saint John's Health Center continue to provide quality care to patients diagnosed with colorectal cancer through a multidisciplinary team approach. Between 2001 and 2005, 366 patients were evaluated and treated at Saint John's Hospital for colorectal cancer. Up to 76% of patients were treated with surgery alone. 16.6% received some form of adjuvant therapy, either chemotherapy or radiation, with only 1.4% receiving chemotherapy or chemoradiation alone (Figure 1). The primary diagnosis was adenocarcinoma, with only a small percentage of patients presenting with more rare histologic subtypes (including lymphoma or neuroendocrine tumor). Almost 90% of the patients in our population were Caucasian (Figure 2). More than half of patients presented with localized disease (Stages 0, I, II). 23.1% of patients presented with regional disease (Stage III), but still a significant percentage of patients (18.9%) were diagnosed with metastatic disease upon presentation (Figure 3). 92.6% of patients were over the age of 50, with the majority being between the ages of 70 and 89, emphasizing the importance of continued screening beyond age 50 in patients who have a reasonable life expectancy and are in otherwise good health (Figure 4). Figure 5 shows 5-year survival data at Saint John's Hospital, and once again highlights the improved survival rate seen with early stage disease.

ADVANCES IN SURGICAL THERAPY FOR COLORECTAL CANCER

Laparoscopic Colon Surgery for Curative Colon Cancer

As a hospital that embraces state of the art advances, Saint John's Health Center has led the community in recent years in offering our patients laparoscopic colon surgery for curative colon cancer. Several recently concluded randomized control trials have documented the efficacy and safety of laparoscopic colon surgery for colon cancer.

Following the first laparoscopic colon surgery for cancer in 1991, several disturbing reports were published documenting a phenomenon termed "trocar site recurrences", where patients were developing recurrent cancer at the sites where the instruments were inserted for laparoscopic surgery. Incidences reached as high as 21%. In 1994, a moratorium was placed on laparoscopic colon surgery for curative colon cancer by the American Society of Colon and Rectal Surgeons because of the unacceptably high rates of trocar site recurrences and unclear survival data of this approach. This led to the development of three large clinical trials performed in the US and Canada, Spain and the United Kingdom. The question posed was whether laparoscopic surgery was a safe and effective surgery for the treatment of curable colon cancer. Could the same cancer operation be performed laparoscopically with the same cancer goals without adversely affecting survival?

In May 2004, results from the COST trial, a seven-year, prospective, randomized, multi-institutional clinical trial, were published in the New England Journal of Medicine from 48 institutions in the US and Canada suggesting that appropriately performed laparoscopic surgery can be safely applied to colon cancer patients when performed by experienced surgeons. The data from the Lacy Trial from Spain and the United Kingdom Trial both published recently in Lancet confirm the findings of the COST trial. The recurrence rates (1%) and overall survival rates (85-86%) were similar for both laparoscopic and open surgery. Oncologic parameters, including margin status and number of lymph nodes retrieved, were also comparable. Also, and not of insignificance, patients appeared to recover more rapidly from laparo-

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scopic surgery with less pain, less narcotic requirement, more rapid return of bowel function, and shorter hospital stays.

To date, Saint John's surgeons have performed almost 100 laparoscopic colon surgeries for cancer with curative intent. While only 27% of colon surgeries were performed laparoscopically in 2004, **half** of all colon surgeries were performed laparoscopically in 2005, well above the national average which remains less than 15%. All surgical resection margins were clear, and the average number of lymph nodes retrieved was 14, which is above the recommended number of 13 for adequate staging. Bowel function (either passage of flatus or bowel movement) returned on average on the third post-operative day, and the average length of hospital stay was 5 days.

Surgery for Metastatic Colorectal Cancer

Surgery continues to be the mainstay of therapy for primary colon cancer, for treatment and staging as well as palliation. Surgery has also gained a place in the treatment of metastatic disease, with evidence of extended survival in patients with resectable hepatic metastases and no evidence of extrahepatic disease. Radiofrequency ablation (RFA) for technically unresectable liver lesions is also a viable treatment option, but does not replace surgical resection for lesions amenable to resection. RFA can be performed either percutaneously under CT-guidance, laparoscopically, or in conjunction with hepatic resection during laparotomy. With a multidisciplinary team approach to metastatic colon cancer, including surgery, RFA, and chemotherapy, physicians at Saint John's Hospital have seen survival rates reach as high as 40% for Stage IV disease. And, widespread metastatic disease, although still not considered curable, is now considered a potentially treatable disease, a heretical concept in the past.

ADVANCES IN ADJUVANT THERAPY

In 1988, the NSABP C-01 study was the first study to report a survival advantage for adjuvant chemotherapy in patients with Stage III colon cancer. Up until recently, a combination of 5-FU and Leucovorin has been the only adjuvant treatment regimen available for patients with regional disease. In recent years, however, we have witnessed the introduction of five new drugs that have significantly impacted our ability to treat patients with colon cancer.

In the adjuvant setting, the addition of **Oxaliplatin** to 5-FU/LV has been shown to significantly improve disease-free, 5 year-survival over infusional or bolus 5-FU/LV alone. Therefore, combination chemotherapy with the FOLFOX regimen has been recommended for all Stage III colon cancer patients. Data are still maturing regarding improvement in overall survival. The use of Oxaliplatin does result in added toxicity, however, most notably peripheral neuropathy.

In contrast, three randomized controlled trials evaluating **Irinotecan** in combination with 5-FU/LV in the adjuvant setting have failed to demonstrate any significant improvement in disease-free survival. Therefore, the FOLFIRI regimen has not been recommended for routine use in the adjuvant setting, but continues to have a role in the treatment of metastatic disease.

Infusional 5-FU/LV appears to have a lower toxicity profile than bolus 5-FU/LV with similar efficacy. However, continuous infusional therapy can be quite cumbersome for patients, requiring placement of an indwelling port and compromise in a patient's independence. Capecitabine (**Xeloda**), an oral form of 5-FU, appears to have similar effect in advanced colorectal cancer as bolus 5-FU/LV, and less toxicity, and is therefore a more palatable option for patients. A large Phase III randomized study (XELOX-A) is underway, evaluating the use of Xeloda with Oxaliplatin versus bolus 5-FU/LV in stage III colon cancer. Early safety data suggests that neutropenia occurs at a lower frequency with XELOX, which has encouraged some oncologists to use this regimen in lieu of infusional 5-FU in patients who are unable to tolerate indwelling ports.

The anti-angiogenesis agent, **Avastin** (Bevacizumab), targets the vascular epithelial growth factor (VEGF), and capitalizes on the concept that tumor cells need to recruit new blood vessels in order to grow beyond a certain size. The addition of Avastin to FOLFOX has demonstrated increased survival over chemotherapy alone, and has made this combination the first line therapy for Stage IV disease.

Erbix (Cetuximab), which targets the Epidermal Growth Factor Receptor (which is expressed on 75% of tumors), has also shown efficacy in the metastatic setting. Large scale Phase III trials are currently underway investigating these two agents in the adjuvant setting.

Colorectal Cancer at Saint John's Health Center

Adjuvant therapy for Stage II colon cancer continues to be an area of controversy. The current American Society of Clinical Oncology guidelines do not routinely recommend adjuvant treatment for Stage II colon cancer patients. However, certain risk factors may place a patient at higher risk and warrant the recommendation for adjuvant therapy. These factors include a poorly differentiated histology, T4 lesions, perforation at presentation, or less than adequate lymph node sampling (i.e. < 13 lymph nodes).

Our medical oncologists at Saint John's Health Center continue to bring the most advanced and up to date care to our patients in this community fighting colorectal cancer.

CONCLUSION

Colorectal cancer is a disease that affects both men and women equally. Unlike breast and prostate cancer, screening for colorectal cancer is far below acceptable levels. Only 40% of patients over age 50 are being screened, yet colon cancer is one of the truly preventable cancers. Premalignant polyps can be removed during routine colonoscopy which effectively prevents the development of colon cancer in that polyp. The burden is upon us, as healthcare providers, to educate our patients regarding the benefit of routine colon cancer screening. The misconception of most patients is that without symptoms, a cancer can not be present. The reality is that the most common symptom of colon cancer is ***no symptom at all.***

For those patients diagnosed with colorectal cancer, the good news is that we have seen tremendous strides made in the treatment of this disease in the past few years. Patients now have the option for a minimally invasive surgery to remove their cancer, which results in less post-operative pain, shorter hospital stays, earlier return to activities of daily living, and a smaller visible reminder of their surgical experience. Following surgery, with the addition of Oxaliplatin to the traditional 5-FU/LV regimen, patients with Stage III disease have improved disease-free survival. Patients with Stage IV disease no longer face a hopeless situation, but are able to see prolonged survival rates with a multidisciplinary approach including the newer monoclonal antibody therapies in addition to chemotherapy, and surgery or ablation therapy for metastatic disease.

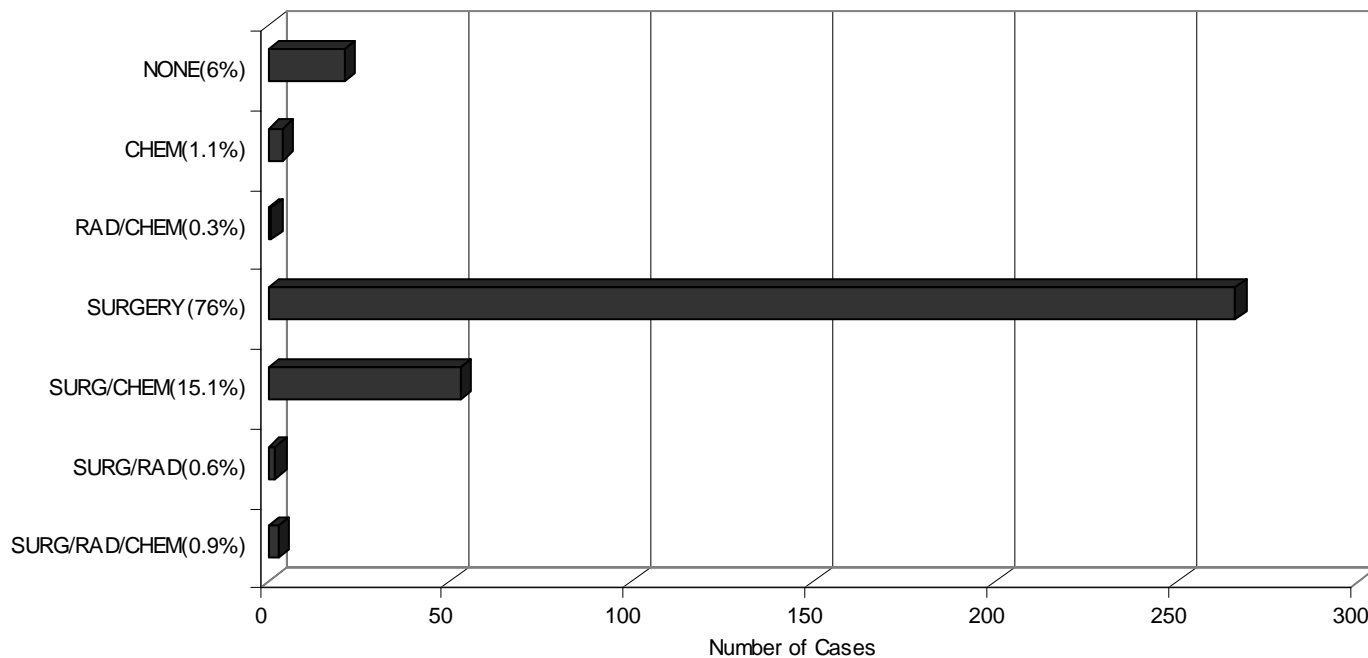
During this year, in 2007, when more Americans are anticipated to die from colon cancer than the total number of Americans who died in the ten years of fighting in the Vietnam War, our physicians at Saint John's Health Center are committed to the continued education, prevention, and treatment of this disease.

Respectfully submitted,

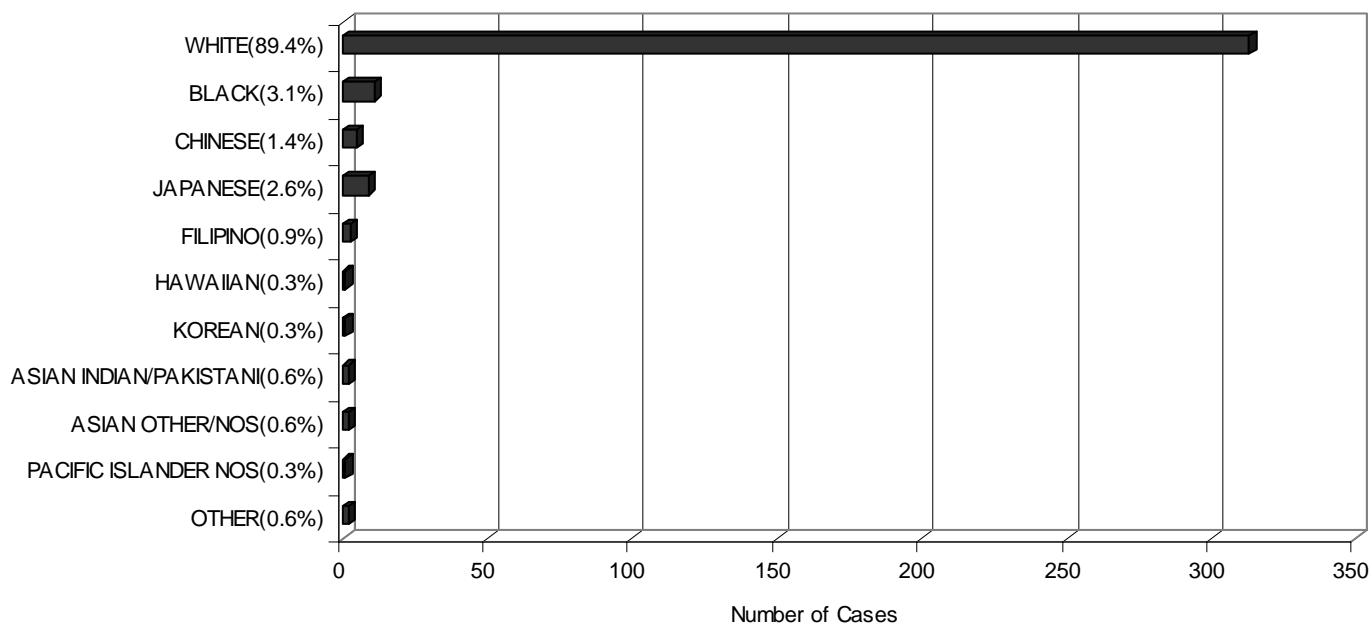
Maggie DiNome, M.D., F.A.C.S., F.S.S.O.
General Surgery/Surgical Oncology
Cancer Liaison Physician

Colorectal Cancer at Saint John's Health Center

1st Course Treatment Summary

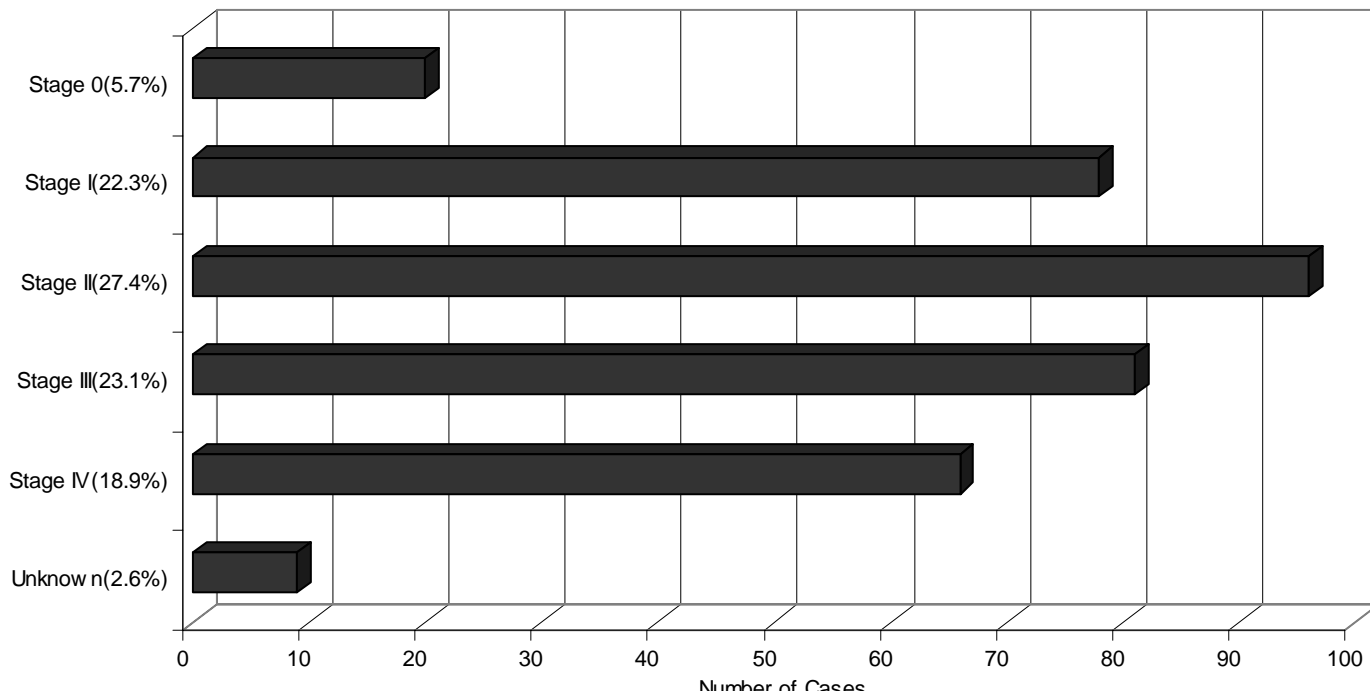


Race-Ethnicity

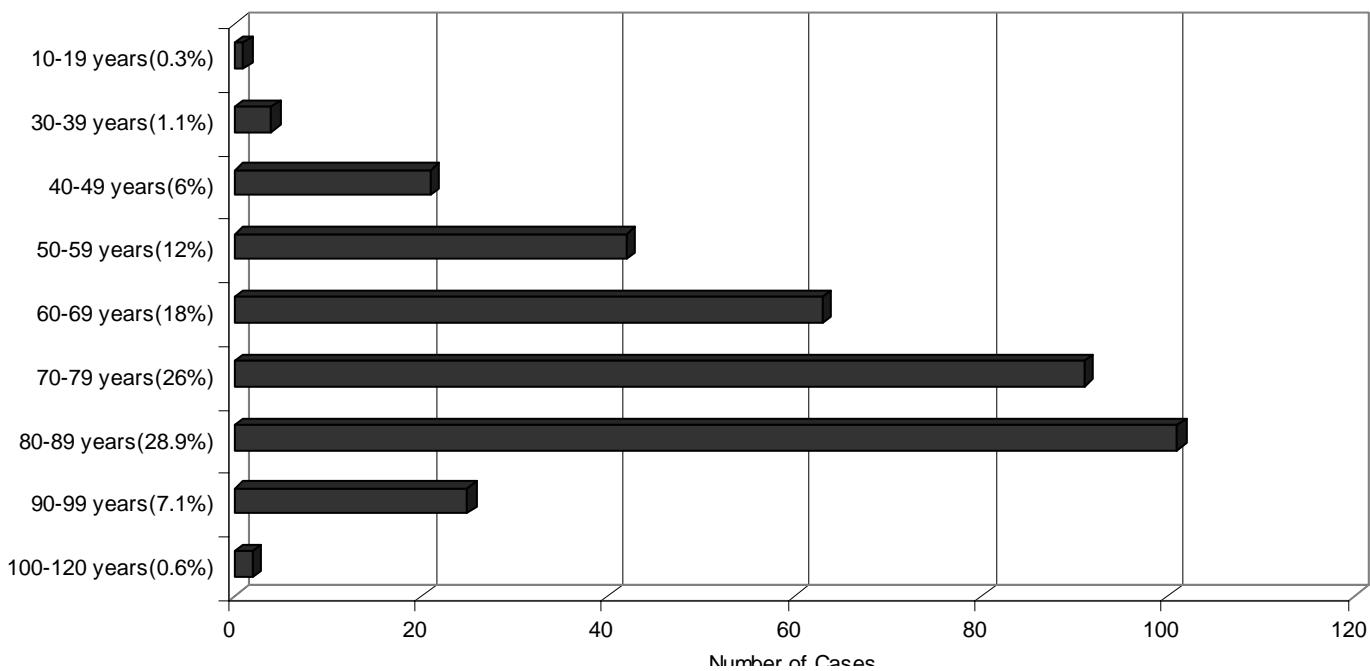


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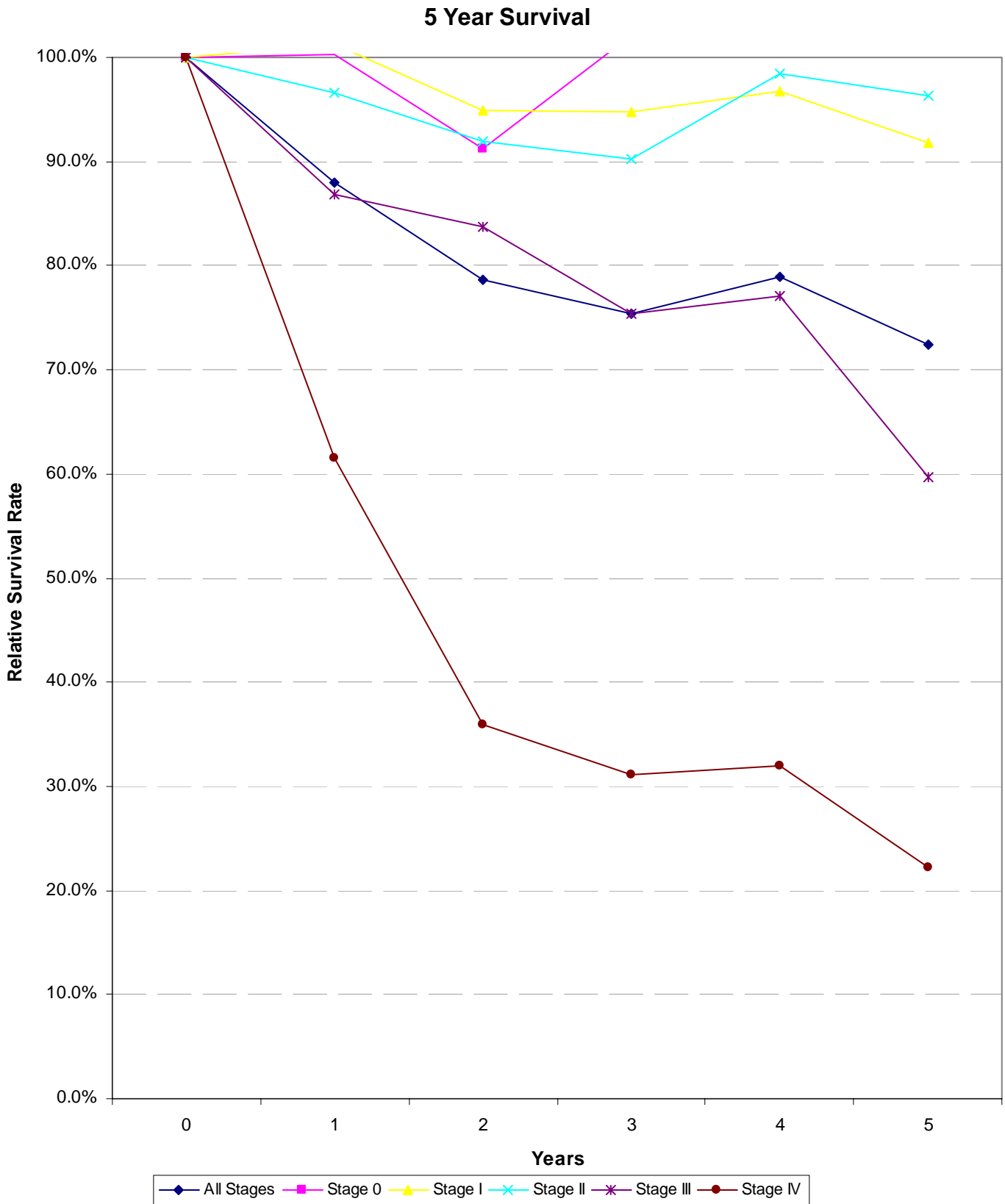
TNM/CS Mixed Stage



Age at Diagnosis



Colorectal Cancer at Saint John's Health Center



Definition of Terms:

Analytic Cases: Patients initially diagnosed and/or received first course of treatment at Saint John's Health Center. Statistical analyses in this report are based on analytic cases only.

Non-Analytic: A case first diagnosed and treated at another facility, including cases first diagnosed at autopsy.

First Course of Treatment: The initial tumor-directed treatment or series of treatments.

NOS: Not otherwise specified

Stage of Disease: The stage of disease is determined at the time of diagnosis, based on the AJCC TNM Staging Manual, 6th edition.

Survival Analysis: Proportion of patients surviving an interval of time from the time of diagnosis, expressed in percentage. The actuarial method provides a means for use of all follow-up data accumulated until the close of the study and any additional information on the survival pattern of the group being studied. The relative survival rate is used when the actual cause of death is unavailable, and indirect adjustment for normal mortality is performed.

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