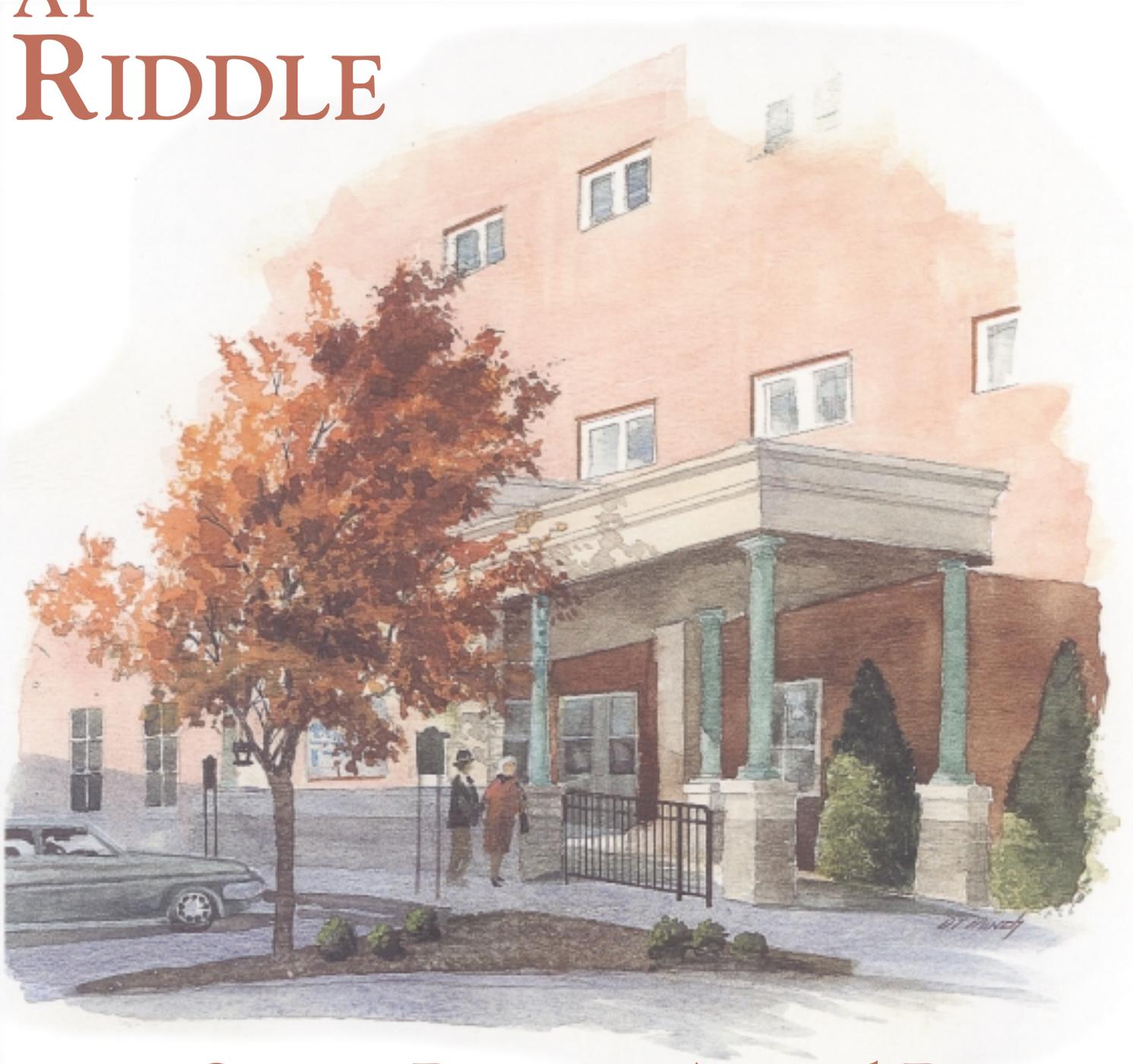


CANCER CENTER AT RIDDLE



2004 Cancer Program Annual Report

(Based on 2003 Data)



The Commission on Cancer awards this
Certificate of Approval
to the Community Hospital Cancer Program of
Riddle Memorial Hospital
Media, PA
Program approved through 2007

Alfred M. Cohen, MD, FACS
 Chair, Commission on Cancer

William P. Reed, Jr., MD, FACS
 Chair, Committee on Approvals

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The American College of Surgeons does not warrant or make any guarantees or assurances related to outcomes of treatment provided by institutions which have cancer programs approved by the Commission on Cancer.

Cover: Cancer Center at Riddle by artist Dennis Minch of Kennett Square, husband of one of our cancer survivors.



CANCER CENTER AT RIDDLE — Getting to Know Us

The Cancer Center at Riddle, established in 1999, consists of interactive components that serve our community members who have been diagnosed with cancer or have a family member, loved one or friend with cancer. It includes Jefferson Radiation Oncology at Riddle, Hematology/Oncology Associates, the Family Resource Center, Clinical Trials Department and the Cancer Registry. Riddle's Cancer Program is part of the Jefferson Cancer Network and has been accredited by the American College of Surgeons (ACoS) since 1993. This year's ACoS survey deemed Riddle's Cancer Program outstanding, and awarded commendation in six of the seven eligible areas.

Jefferson Radiation Oncology Center at Riddle, under the direction of Merrill Solan, MD, offers comprehensive, state-of-the-art radiation therapy services, similar to those offered at its parent facility at Thomas Jefferson University. The Center contains a treatment planning simulator that enables 3-Dimensional conformal treatment planning, and a dual energy linear accelerator capable of high and low energy photon treatment as well as a wide array of electron treatment energies. The accelerator was recently equipped with a multileaf collimator to allow intensity modulated radiation therapy (IMRT)—the latest in radiation treatment technology. Through Thomas Jefferson's Bodine Radiation Oncology Center, Riddle patients can take advantage of intraoperative radiation therapy, high and low dose rate brachytherapy, and radiosurgery.

Hematology/Oncology Associates offers the latest chemotherapy and hormonal cancer treatments, as well as management of hematological diseases. Four board certified physicians, Melvin Lapes, MD, Andrew Solan, MD, Lee Bogart, MD, and Christina Clay, MD, staff this private practice. Dr. Andrew Solan also serves as Riddle's Medical Director of Oncology Services and the Chairman of our Cancer Committee.

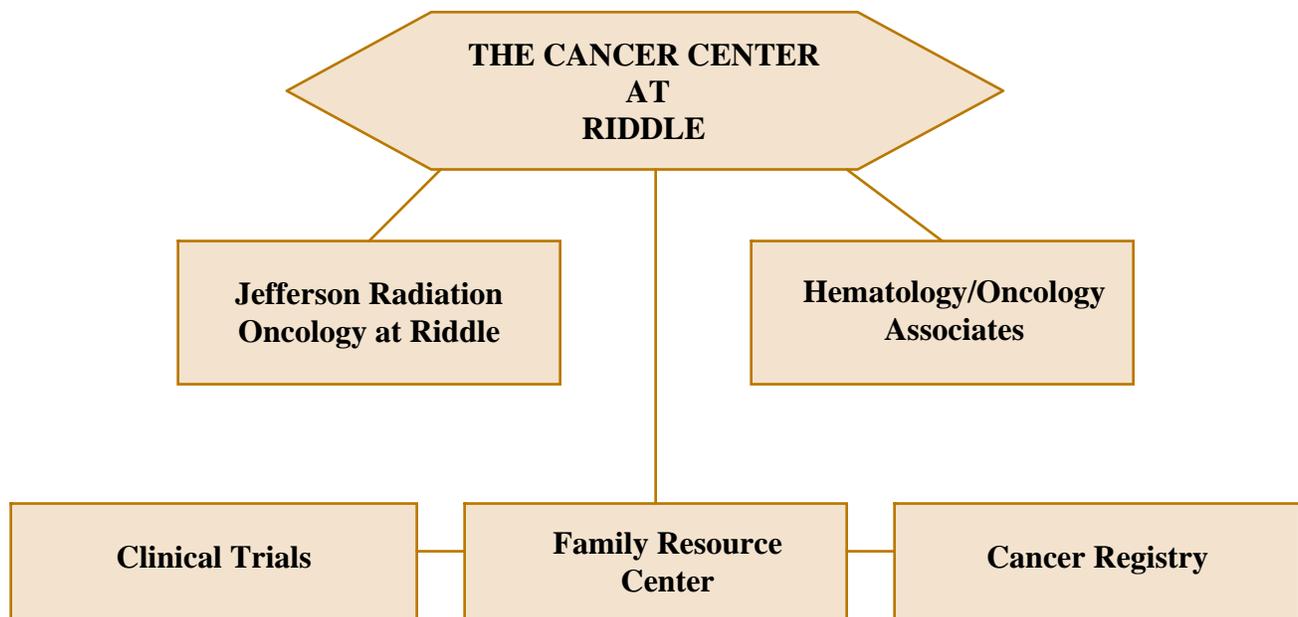
Family Resource Center, located in the Cancer Center waiting room, contains an extensive library of free, cancer-related material providing up-to-date information on the diagnosis and treatment of cancer. It offers books, pamphlets, movies and government printed booklets. In addition to the multitude of printed material available, there is a user-friendly computer with access to cancer-related sites on the Internet. The computer system is updated monthly, so that the information it contains is always relevant. The Family Resource Center is open to all members of the Riddle community as well as hospital personnel.

Clinical Trials – Riddle Memorial Hospital's membership in the Jefferson Cancer Network enables patients within our community access to nationally approved clinical trials for cancer prevention and treatment. Under the direction of Lorie Matson, RN, BSN, Riddle currently offers its cancer patient's participation in 33 different trials, including National Cancer Institute (NCI) approved prevention and treatment trials. In 1999, we joined with 500 other institutions nationally to participate in the STAR trial, a breast cancer prevention study looking at Tamoxifen vs. Raloxifene. During 2001, we began enrolling participants in the SELECT trial, a prostate cancer prevention trial looking at selenium and vitamin E. Although both of these trials have reached their participant recruitment goals, the studies are far from over. We appreciate the dedication of the men and women who will continue in the studies for several more years, in order for us to get the true answers about the risks and benefits of these medications or supplements in the fight against cancer.

Cancer Registry, under the direction of Judy Ford, RN, BSN, CTR, is a required component of every ACoS certified cancer program. The Registry collects demographic, diagnostic, treatment and survival data on every cancer patient who comes through the hospital. Mandated by the State of Pennsylvania, this data is sent to the Central Registry for inclusion in national statistics. Riddle's Cancer Registry data, along with data from registries in every other state, enables physicians who treat cancer patients to evaluate the success of specific tumor treatments, survival rates and outcome analysis. It also serves as a valuable resource for researchers

interested in the causes, diagnosis and treatment of cancer. Our Registry database currently contains over 7,000 patients. The Registrar also conducts annual follow-up on our cancer patients, allowing us to generate survival statistics and help ensure that all receive ongoing care.

Riddle's Cancer Program provides many free services to our community, including cancer prevention screenings, cancer support groups, lectures, cancer survivor celebrations and smoking prevention/cessation courses. Our cancer prevention screenings include colorectal cancer held in March, skin cancer in May, June, July and August, prostate cancer in September, and breast cancer for un-insured or under-insured women in October. We offer support groups specific to breast and prostate diagnoses as well as a general cancer support group. We have also initiated a Buddy Program that matches newly diagnosed cancer patients with patients who have successfully completed treatment for the purpose of providing additional information and emotional support. Riddle's newly-formed Patient Advocacy and Advisory Committee offers members of the Riddle cancer patient community the ability to advise the Cancer Committee on the best approaches to cancer management from the patient's perspective, and also allows our cancer survivors and family members to serve their community through a valuable volunteer effort. Questions regarding any of the cancer programs or groups should be directed to Lorie Matson, RN, BSN, Cancer Program Coordinator, at 610-627-4480. For information on the many smoking prevention and cessation lectures and courses, contact Riddle's Community Health Education Department at 610-891-3560.



COLORECTAL CANCER — An Overview

Colorectal cancer (CRC) remains an important issue in the American cancer experience with a national incidence of 146,940 new cases predicted for 2004*, and is responsible for approximately 56,000 deaths annually. Clearly, colorectal cancer presents a challenge to American healthcare. While significant developments have allowed a better understanding of the etiology of this spectrum of disease, further efforts at prevention, early detection and treatment continue, and will hopefully result in meaningful advances against this third most common cancer. Again this year, Riddle has the opportunity to evaluate our experience in the management of CRC, comparing our clinical material from 2003 with our results from 1998. Additionally, we can examine our survival data from our 1998 cohort, and compare to statewide and national data.

In 2003, 89 patients with CRC were diagnosed and treated at Riddle, nearly 40% more than the 64 patients from the 1998 group. This most likely represents an increase in hospital patient volume overall, rather than a true increase in the CRC incidence locally. Demographic patterns remain essentially unchanged. The site distribution is also similar, except for an unexplained increase in the number of lesions in the transverse colon. Proximal cancers still account for about one third of the total, and rectal lesions comprise about one eighth (graphs 1A & 1B). Stage at diagnosis has not changed materially, looking at both “early” (Stage 0, 1) and “late” (Stage 4) cases. However, there has been improvement in our efforts at staging, demonstrated by the greatly decreased number of cases staged as “Unknown” (graphs 2A & 2B).

Diagnostic evaluation patterns show that a complete colonic survey is still accomplished in nearly all patients. Notable, however, is the increasing use of colonoscopy, rather than barium enema, for completing the survey. Both CEA levels and liver function tests have been completed more often than 5 years ago, but these studies are still done (or documented) less than the established benchmarks. Efforts to improve documentation of pre-admission testing continue.

Surgical intervention remains the mainstay of treatment. Adjuvant chemotherapy for colon cancer and adjuvant radiation therapy plus chemotherapy for rectal cancers are utilized when indicated (chemotherapy for node-positive colon cancer, chemoradiation therapy for node-positive or transmural disease in rectal cancer.) In our elderly population, there continues to be instances where the risks of adjuvant therapy may outweigh the potential benefits. Also, some patients refuse adjuvant therapy. Of interest will be the evolving notion of adjuvant chemotherapy for high-risk node-negative colon cancers.

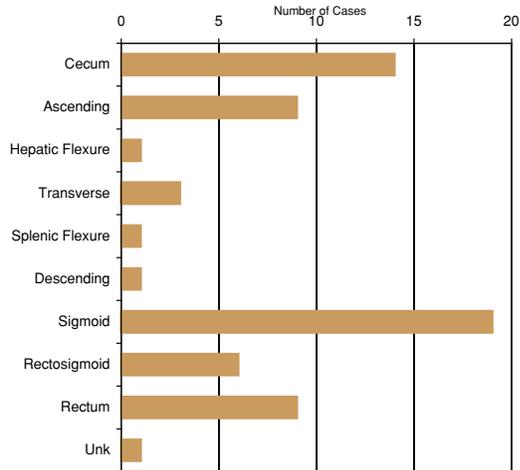
Recent data from the National Comprehensive Cancer Network (NCCN) have focused attention on lymph node retrieval in cases of surgically treated colorectal cancer. Statistical analysis suggests that a minimum of 14 nodes should be examined in a resection specimen to determine the lymph node stage with confidence. Review of our 2003 data shows that only 45% of our resection specimens held 14 or more lymph nodes. While this figure compares favorably with some university centers and local community hospitals, it is clearly an area where further effort is needed. To address this, the Divisions of Surgery and Clinical Pathology have agreed to work toward a goal of harvesting, and examining, as many regional lymph nodes as possible, ensuring that surgical resections are performed with oncologic principles in mind.

Examining survival data, our 1998 combined colon and rectal cases (all stages) follow a survival curve almost identical to the National Cancer Data Base, suggesting that our results are in keeping with national norms (graph 3). Stage for stage, comparing our data with 1995 and 1996 statewide data shows similar survival patterns for stage 4 disease, but better than expected survival for stages 0 and 3, yet worse than expected results among our stage 2 cases. The reasons for this are not clear, and these disparities may simply reflect small sample size. Ongoing analysis will hopefully elucidate any significant trends.

Kenneth J. Boyd, MD, Colorectal Surgery

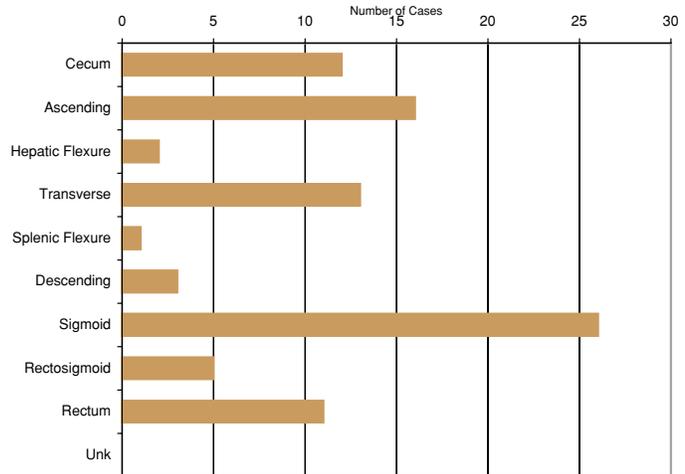
1A

**Distribution by Subsite
RMH Colorectal Cancer, 1998**



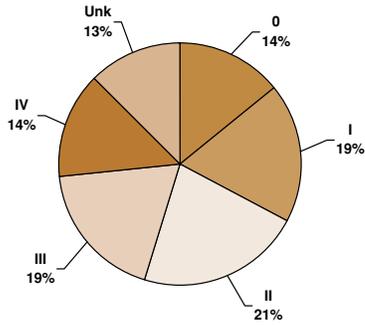
1B

**Distribution by Subsite
RMH Colorectal Cancer, 2003**



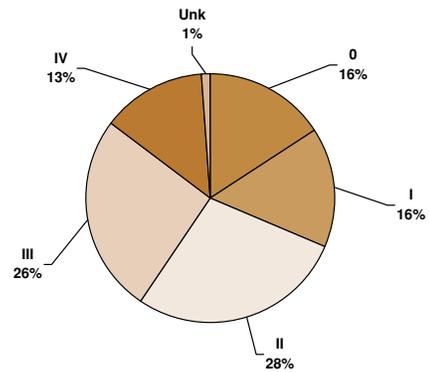
2A

**AJCC Stage at Diagnosis
RMH Colorectal Cancer, 1998**



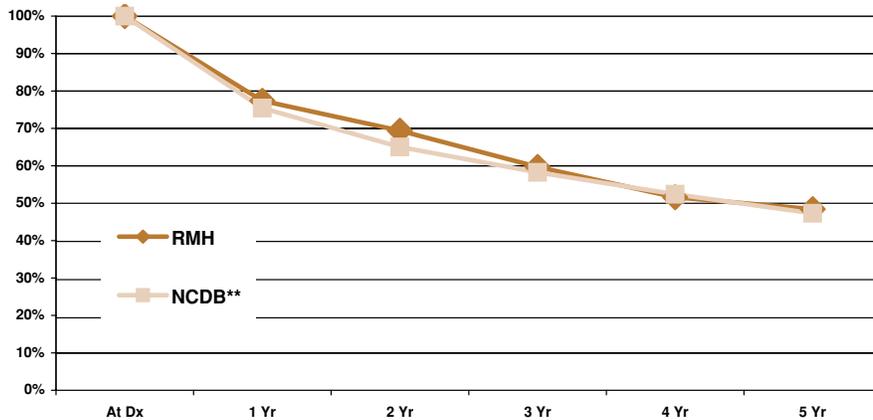
2B

**AJCC Stage at Diagnosis
RMH Colorectal Cancer, 2003**



3

**Colorectal, Combined Observed Survival
RMH 1998 (n=62) vs. NCDB** 1995 & 1996 (n=2064)**



*ACS Cancer Facts & Figures 2004

**National Cancer Data Base

SCREENING GUIDELINES FOR EARLY DETECTION OF CANCER IN ASYMPTOMATIC PEOPLE

CANCER SITE	RECOMMENDATIONS
Breast	<p>*Yearly mammograms are recommended starting at age 40. The age at which screening should be stopped should be individualized by considering the potential risks and benefits of screening in the context of overall health status and longevity.</p> <p>*Clinical breast exam should be part of a periodic health exam, about every three years for women in their 20s and 30s, and every year for women 40 and older.</p> <p>*Women should know how their breasts normally feel and report any breast change promptly to their health care providers. Breast self-exam is an option for women starting in their 20s.</p> <p>*Women at increased risk (e.g., family history, genetic tendency, past breast cancer) should talk with their doctors about the benefits and limitations of starting mammography screening earlier, having additional tests (i.e., breast ultrasound and MRI), or having more frequent exams.</p>
Colon and Rectum	<p>Beginning at age 50, men and women should follow <i>one</i> of the exam schedules below:</p> <ul style="list-style-type: none"> * A fecal occult blood test (FOBT) every year or fecal immunochemical test (FIT) every year * A flexible sigmoidoscopy (FSIG) every 5 years * Annual FOBT or FIT and flexible sigmoidoscopy every 5 years** * A double-contrast barium enema every 5 years * A colonoscopy every 10 years <p>** Combined testing is preferred over either annual FOBT or FIT, or FSIG every 5 years, alone. People who are at moderate or high risk for colorectal cancer should talk with a doctor about a different testing schedule.</p>
Prostate	<p>The PSA test and the digital rectal examination should be offered annually, beginning at age 50, to men who have a life expectancy of at least 10 years. Men at high risk (African American men and men with a strong family history of one or more first-degree relatives diagnosed with prostate cancer at an early age) should begin testing at age 45. For both men at average risk and high risk, information should be provided about what is known and what is uncertain about the benefits and limitations of early detection and treatment of prostate cancer so that they can make an informed decision about testing.</p>
Uterus	<p>Cervix: Screening should begin approximately three years after a woman begins having vaginal intercourse, but no later than 21 years of age. Screening should be done every year with regular Pap tests or every two years using liquid-based tests. At or after age 30, women who have had three normal test results in a row may get screened every two to three years. Alternatively, cervical cancer screening with HPV DNA testing and conventional or liquid-based cytology could be performed every three years. However, doctors may suggest a woman get screened more often if she has certain risk factors, such as HIV infection or a weak immune system. Women 70 years and older who have had three or more consecutive normal Pap tests in the last 10 years may choose to stop cervical cancer screening. Screening after total hysterectomy (with removal of the cervix) is not necessary unless the surgery was done as a treatment for cervical cancer.</p> <p>Endometrium: The American Cancer Society recommends that at the time of menopause all women should be informed about the risks and symptoms of endometrial cancer, and strongly encouraged to report any unexpected bleeding or spotting to their physicians. Annual screening for endometrial cancer with endometrial biopsy beginning at age 35 should be offered to women with or at risk for hereditary nonpolyposis colon cancer (HNPCC).</p>
Cancer-related check-up	<p>For individuals undergoing periodic health examinations, a cancer-related checkup should include health counseling, and depending on a person's age and gender, might include examinations for cancers of the thyroid, oral cavity, skin, lymph nodes, testes, and ovaries, as well as for some nonmalignant diseases.</p>

American Cancer Society, *Cancer Facts and Figures Pennsylvania, 2004*

Member of the Jefferson Cancer Network



Jefferson
Cancer
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