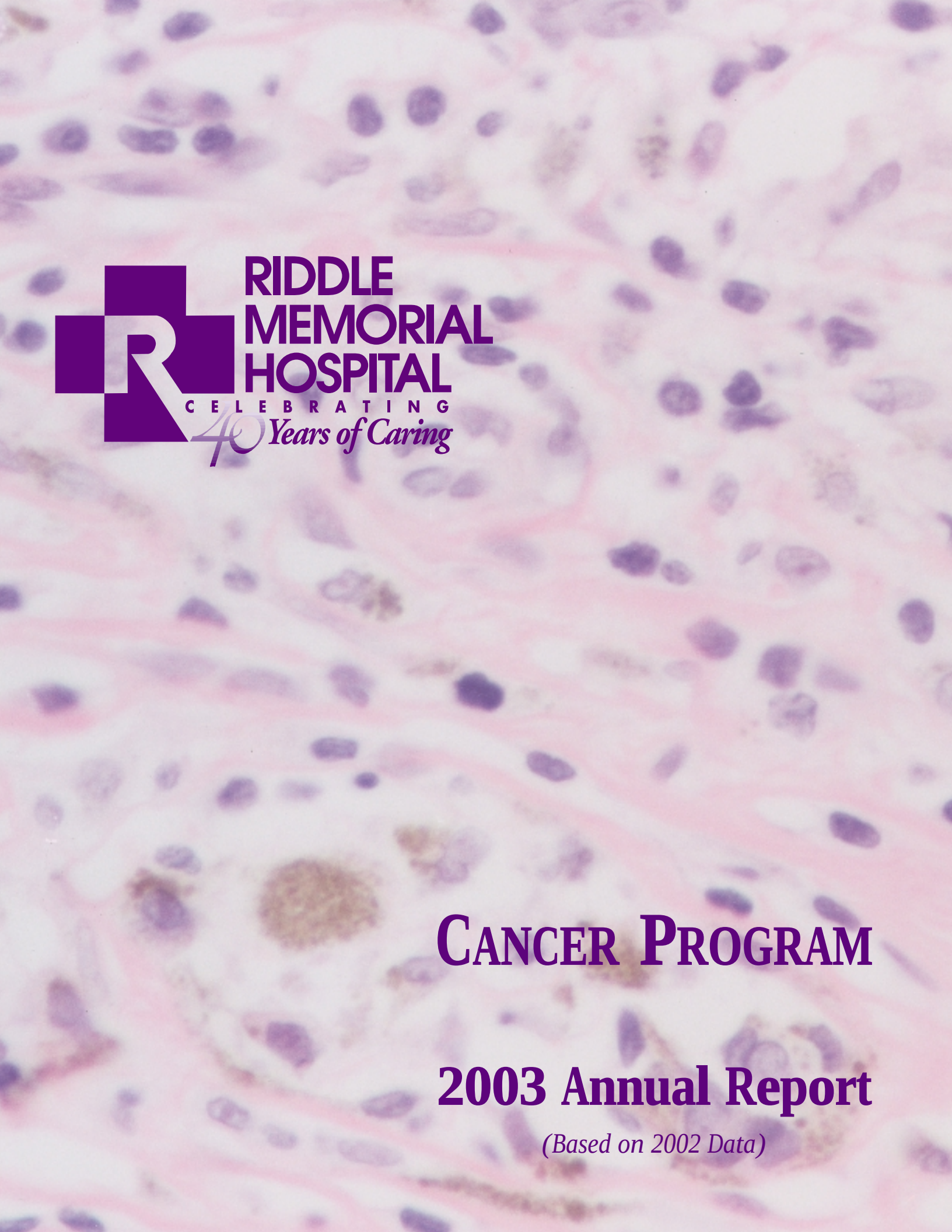


RIDDLE MEMORIAL HOSPITAL

CELEBRATING 40 Years of Caring

Cancer Program

2003 Annual Report

(Based on 2002 Data)

This 2003 Cancer Program Annual Report is dedicated to Christine Trabulsi, RN, MSN, AOCN, who was instrumental in the implementation of Riddle Memorial Hospital's Cancer Program. Our American College of Surgeon's approval was achieved through the insight and tenacity that Chris applied to every job she undertook. While officially retired, she continues to lend her support. Chris' hard work and exacting standards remain the backbone of our Cancer Program.

CANCER COMMITTEE MEMBERS, 2003

Physicians:

Andrew J. Solan, M.D., *Medical Oncology*
Chairman
Kenneth Boyd, M.D., *Colorectal Surgery*
Cancer Liaison Physician
William Ayers, M.D., *General Surgery*
Lee Bogart, M.D., *Medical Oncology*
Norman Braslow, M.D., *Pulmonary Medicine*
James Colombo, M.D., *Plastic Surgery*
Jacques DeCaestecker, M.D., *Urology*
Robert Haggerty, M.D., *Gynecology*
Timothy Hayes, M.D., *General Surgery*
William Merenich, M.D., *Radiology*
Daniel Soffer, M.D., *Internal Medicine*
Merrill Solan, M.D., *Radiation Oncology*
Susan Yaron, M.D., *Pathology*

Hospital Personnel:

Christina Blohm, R.N., *Oncology*
Caroline Corzine, MSW, *Social Services*
Victoria Cosgrove, R.N., *Nursing Education*
Elaine Dunn, R.N., *Nursing QA*
Judy Ford, R.N., CTR, *Cancer Registry*
Jackie Forney, MBA, *Public Relations*
Doreen Makos, R.N., *Utilization/Case Management/Social Service*
Debbie Mantegna, R.N., *Community Health*
Lorie Matson, R.N., *Cancer Program Coordinator*
Roxanne McNelis, R.N., *Home Care*
Jacqueline Moore, RHIT, *Medical Records*
Betsy Ramaika, R.N., *Quality/Risk Management*
Marilyn Sarno, R.D., *Clinical Nutrition*
Heather Scheckner, R.Ph., *Pharmacy*
Peggy Sinnott, R.N., V.P., *Nursing*
Rev. Paul Vail, *Chaplain*

CANCER PROGRAM

Twelve years ago, a committed medical staff joined forces with a supportive administration to form a cancer program to improve the quality of care for cancer patients at Riddle Memorial Hospital. Riddle's Cancer Program, first accredited by the American College of Surgeons' Commission on Cancer in 1994, now approaches a decade of growth, improvement in programs, and further developments in the interest of maximizing care for patients with malignant diseases.

In 2002, Riddle continued to provide care to an ever growing number of patients with cancer. In total, 682 cases were identified, the majority of which (80%) were diagnosed and/or treated at Riddle. As expected, the most prevalent primary sites reflect the population at large, with nearly 60% of cases comprising lesions of the breast, colorectum, prostate and lung. The Cancer Registry remains robust, with active follow-up on nearly 95% of patients. A recent audit revealed a commendable 99.4% accuracy rate of data collection.

The 9th Annual Anthony J. and Ruth H. Moretti Cancer Conference was held in May. Presented by Drs. Ernest and Francis Rosato, from the Department of Surgery at Thomas Jefferson University Hospital, "The Total Management of Liver Tumors" addressed one of oncology's most challenging clinical problems, yet one of the most promising areas for significant improvement as surgical and non-surgical adjuvant therapies evolve. In addition to this annual event, Cancer Conferences are held every three weeks to discuss current cases. This multidisciplinary conference, open to all staff, allows for the open exchange of ideas and treatment options, as well as serving an important educational function.

The cancer program continues to be involved with the health of the community by providing free cancer screening events, educational programs stressing preventative measures, and support groups for cancer victims and their families. Of particular note is the institution of a "Buddy Program" by which newly-diagnosed patients can be paired with a previously-treated patient in an effort to promote disease-specific, one-on-one social and psychological support.

The Third Annual Cancer Survivor's Day Celebration was held on May 28th. Cancer Committee member Dr. Lee Bogart spoke to cancer survivors and their families, followed by a motivational speaker, Mr. Steve McClatchy. The program was both well attended and well received.

Two current Patient Care Evaluation projects are outlined in this Annual Report. Malignant melanoma, rapidly becoming a more common disease, is discussed by Dr. Merrill Solan, Director of Jefferson Radiation Oncology at Riddle. Also examined is an initiative to provide cancer patients with a comprehensive resource tool allowing patients and their families full advantage of numerous community services and programs.

Celebrating its 40th year of caring, Riddle will no doubt continue to grow. The Cancer Program will also continue to expand and improve programs and services for our patients with all types of malignant diseases.

Kenneth J. Boyd, MD

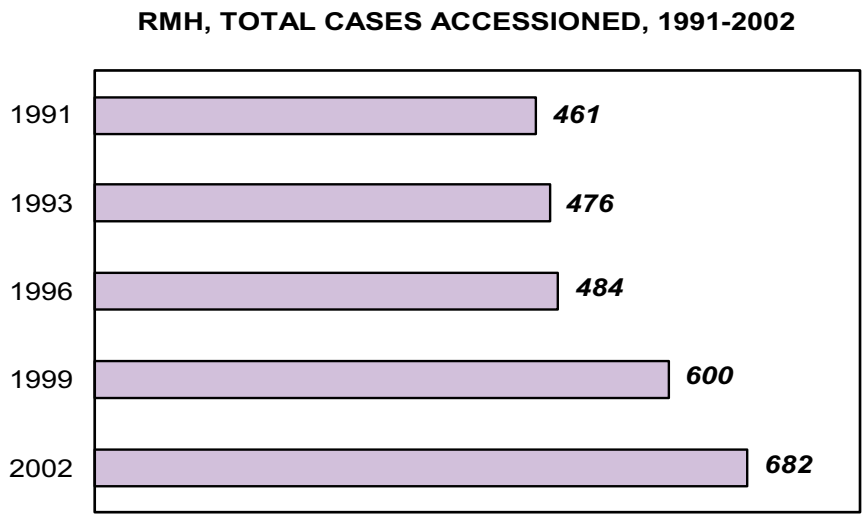
Kenneth J. Boyd, M.D.
Cancer Liaison Physician

CANCER REGISTRY

During 2002, the Cancer Registry of Riddle Memorial Hospital accessioned 682 cancer cases, an approximately 5% increase over last year. Of the 682 cases, 548 were analytic (diagnosed and/or treated at RMH). Initiated in 1991, our database now contains information on 6,415 patients. The data accumulated is electronically stored, allowing ease of retrieval for any analysis of demographic, diagnostic or treatment related information. The purpose of the registry is to provide accurate and complete cancer information while maintaining strict confidentiality of each patient.

While steadily increasing in number, as seen by the graph below, the Registry continues to follow all of the analytic patients. Lifetime follow-up directly benefits patients by reminding attending physicians and patients that routine medical examinations are encouraged. Follow-up also provides valid measurement of outcomes. More than 2,800 patients are currently under active follow-up by the Registry, with an average follow-up rate of 94 percent (93.5%).

The quality of the data in the Registry is of prime concern to the hospital, the Registrar, the Cancer Committee and the Commission on Cancer (CoC). During 2002, ten percent of the analytical abstracts entered into the Registry database were reviewed for quality and accuracy by physician members of the Cancer Committee, resulting in a 99.4% accuracy rate of all data fields monitored.



The Registry assists in a number of research efforts. During 2002, the Registry provided statistical and/or comparative data to the Pennsylvania Cancer Registry (PCR), National Cancer Data Base and Impath Information Services. It also provided statistical data to requesting RMH physicians and administration.

Riddle's Cancer Registry is currently staffed by one Certified Cancer Registrar. Besides maintaining the registry database, the Registrar also assists the Cancer Program Coordinator with all the cancer screenings, organizes the Cancer Conferences/Committee Meetings, develops the Cancer Program Annual Report and is an active source for cancer treatment information to both cancer patients and hospital staff. Maintaining a high level of expertise in the Registry is as important to Riddle's administration as it is to the Cancer Committee. They provide for and encourage the Registrar to attend yearly educational programs presented by the PCR and/or the National Cancer Registrar's Association.

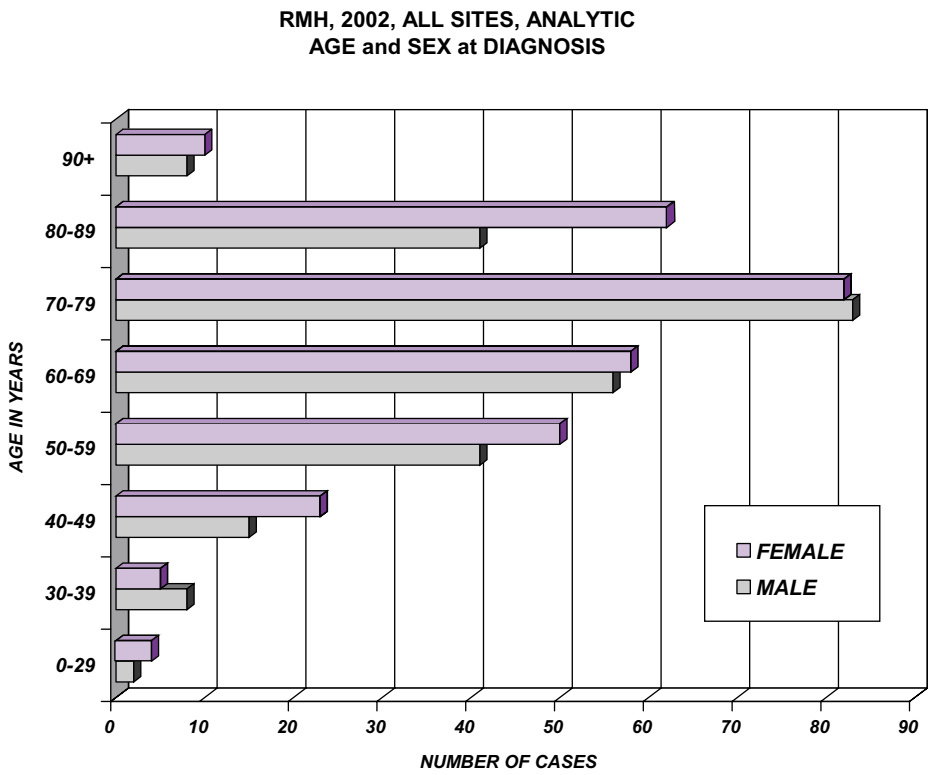
With the cooperation of all departments in Riddle Memorial Hospital, our Cancer Program has maintained a high level of care as evidenced by our accreditation from the CoC. We continue to look for new areas where we can expand and enhance our services. The Cancer Registry is an integral part of our Cancer Program and will continue to offer guidance through information management.

PRIMARY SITE	MALE	FEMALE	ANALYTIC*	NON-ANALYTIC**	TOTAL	PERCENT OF TOTAL: TOP 5 ANALYTIC SITES
Breast	**3**	**105**	**95**	**13**	**108**	**15.8%**
Colorectal	**47**	**59**	**97**	**9**	**106**	**15.5%**
Prostate	**103**	**n/a**	**63**	**40**	**103**	**15.1%**
Lung	**40**	**43**	**71**	**12**	**83**	**12.2%**
Melanoma	**21**	**20**	**39**	**2**	**41**	**6.0%**
Bladder	33	12	33	12	45	
Hematopoietic	17	20	24	13	37	
Pancreas	4	13	13	4	17	
Uterus	n/a	17	16	1	17	
Kidney	10	6	14	2	16	
Lymph Nodes	7	7	9	5	14	`
Stomach	7	4	9	2	11	
Skin	6	2	4	4	8	
Larynx	5	2	6	1	7	
Ovary	n/a	7	4	3	7	
Brain, CNS	2	4	4	2	6	
Unknown Primary	2	4	5	1	6	
Small Intestine	4	1	4	1	5	
Thyroid	2	3	5	0	5	
Anus	2	2	4	0	4	
Esophagus	4	0	2	2	4	
Liver, Intrahepatic Bile Ducts	3	0	3	0	3	
Biliary Tract	1	1	2	0	2	
Bones, Joints	1	1	2	0	2	
Connective/Soft tissue	2	0	2	0	2	
Gallbladder	0	2	2	0	2	
Other Female Genital	n/a	2	2	0	2	
Testis	2	n/a	2	0	2	
Tongue	0	2	1	1	2	
Tonsil	2	0	2	0	2	
Vulva	n/a	2	1	1	2	
Adrenal Gland	0	1	1	0	1	
Cervix	n/a	1	1	0	1	
Heart, Mediastinum, Pleura	0	1	1	0	1	
Hypopharynx	0	1	1	0	1	
Lip	0	1	1	0	1	
Mouth	0	1	0	1	1	
Nasal Cavity	0	1	1	0	1	
Nasopharynx	0	1	0	1	1	
Oropharynx	0	1	0	1	1	
Renal Pelvis	1	0	1	0	1	
Ureter	1	0	1	0	1	
TOTALS	**332**	**350**	**548**	**134**	**682**	

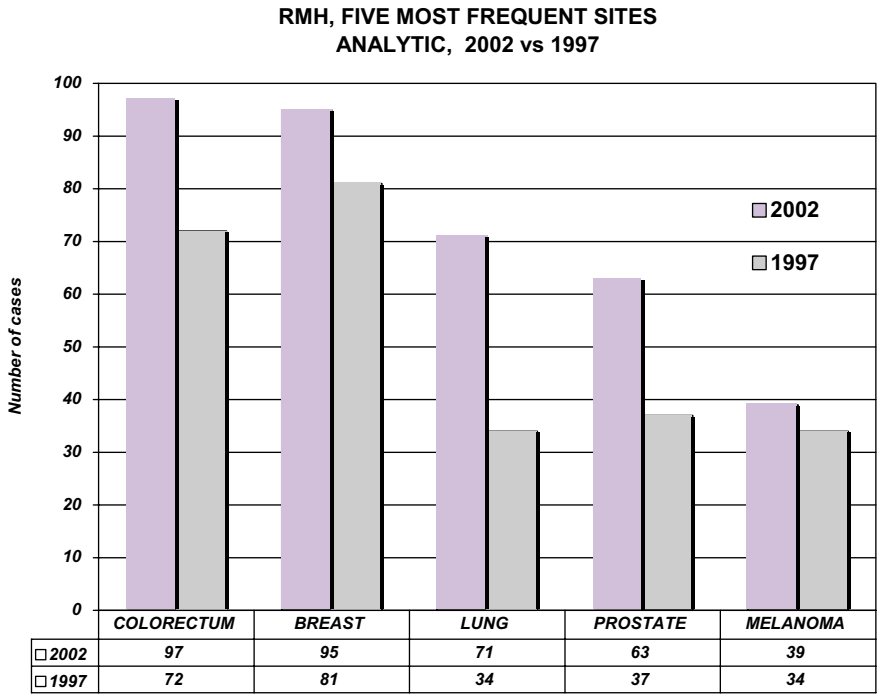
TABLE 1 RMH, PRIMARY CANCER SITES, 2002

The incidence rate of cancer cases seen at RMH has shown an overall increase of about 5% during the past year. The top five sites continue to be breast, colorectal, prostate, lung and melanoma. Women are now showing a higher incidence of both colorectal and lung cancers than men in our predominately elder population.

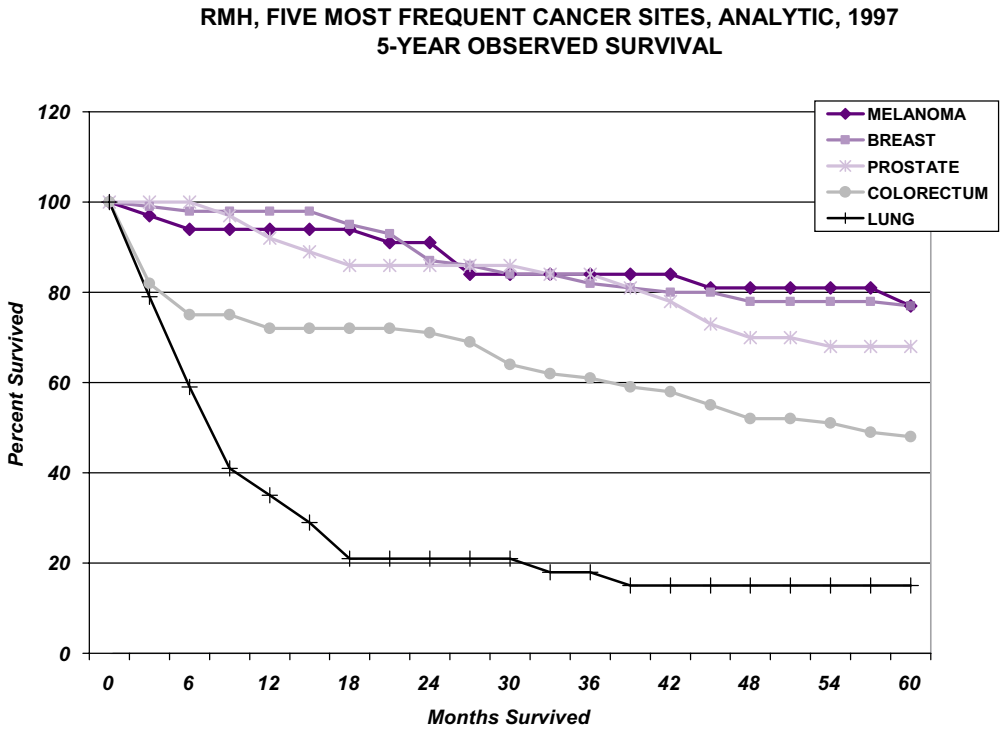
**Analytic: diagnosed and/or initially treated at RMH. **Non-analytic: seen for subsequent treatment or recurrence.*



GRAPH 2 RMH, AGE/SEX at DIAGNOSIS, 2002
Unlike Pennsylvania* as a whole, Riddle's predominately elder population shows a higher cancer incidence rate for females than males.
** Pennsylvania Department of Health, Cancer Facts and Figures, 2003*



GRAPH 3 RMH, FIVE MOST FREQUENT SITES, ANALYTIC, 2002 vs 1997
When comparing the top five, analytic RMH sites from 1997 to 2002, a significant increase in incidence is shown for both lung and prostate cancers.



GRAPH 4 SURVIVAL RATES FOR 1997 FIVE MOST FREQUENT ANALYTIC SITES

Observed survival rate shows a true reflection of the total mortality in our patient group by accounting for all deaths regardless of cause. The five-year survival curves shown here are strongly correlated to the stage of disease at diagnosis and are consistent with national* data for our age group of patients.

**Impath Information Services, CIRF, 2002*

CANCER CONFERENCE

Riddle Memorial Hospital's Cancer Conference, under the guidance of the Cancer Committee, is a multidisciplinary case review conducted to ensure access to consultative services by all disciplines, including Medical Oncology, Medicine, Pathology, Radiation Oncology, Radiology and Surgery. The conference is open to all physicians and health care professionals. Through our alliance with Thomas Jefferson University, Office of Continuing Medical Education, attendance provides one hour of Category I continuing education credits towards the AMA Physician's Recognition Award.

During 2002, twenty-four Cancer Conferences / Breast Panels were conducted. Sixty-one cases were discussed with an average of ten physicians and ten health care professionals in attendance. The cases presented during 2002 included:

breast	**14**	**tongue**	**2**	**plasmacytoma**	**1**
anus	**2**	**sarcoma**	**1**	**melanoma**	**3**
thyroid	**1**	**lymphoma**	**4**	**liver**	**1**
colorectal	**10**	**leukemia**	**2**	**ampulla**	**1**
stomach	**2**	**ovary**	**1**	**bladder**	**2**
kidney	**1**	**lung**	**4**	**larynx**	**1**
prostate	**5**	**testicle**	**2**	**uterus**	**1**

CLINICAL TRIALS

Riddle Memorial Hospital's membership in the Jefferson Cancer Network enables patients within our community to benefit from enrollment in nationally approved clinical trials for cancer prevention and treatment. Some of the treatment studies have involved the concurrent administration of chemotherapy and radiotherapy by our medical oncologists and the Jefferson Radiation Oncology Center within our facility. Additionally, scientific investigators at Thomas Jefferson University Hospital, via the Jefferson Oncology Group (JOG), have provided our patients with treatment options from their own research studies that are peer reviewed by nationally recognized scientists.

In 1999, we joined with 500 other institutions nationally to participate in one of the largest breast cancer prevention studies ever, the Study of Tamoxifen and Raloxifene (STAR). This trial will include 22,000 post-menopausal women at increased risk of breast cancer to determine whether the osteoporosis prevention drug raloxifene (Evista®) is as effective in reducing the chance of developing breast cancer as tamoxifen (Nolvadex®). The Clinical Trials Office at RMH currently has 11 STAR participants and continues to enroll eligible post-menopausal women who are at high risk for breast cancer. STAR is conducted by the National Surgical Adjuvant Breast and Bowel Project (NSABP) and is supported by the National Cancer Institute (NCI).

During 2001, RMH began enrolling participants in the largest ever prostate prevention study known as SELECT. SELECT stands for Selenium and Vitamin E Cancer Prevention Trial whose purpose is to determine if these two dietary supplements can protect against prostate cancer, the most common form of cancer, after skin cancer, in men. The study is funded by the National Cancer Institute and coordinated by a network of researchers known as the Southwest Oncology Group (SWOG). SELECT will include a total of 32,400 healthy men age 55 or older. RMH Clinical Trials Office presently has 14 participants enrolled in SELECT and continues to actively enroll eligible men. For more information on clinical trials, please call 610-627-4480.

COMMUNITY EDUCATION / SCREENING ACTIVITIES

Riddle Hospital once again conducted free cancer screenings and/or educational seminars for four of the most common cancers seen at Riddle. A total of 407 community members were screened for colorectal, prostate, skin and breast cancers. Since there are no effective methods to screen for lung cancer, our Community Health Team directed their efforts towards smoking cessation. This past year has been an exciting year with regard to these efforts.

In accordance with the Tobacco Settlement Act 77, Pennsylvania joined 45 other states in the Master Settlement Agreement. The Delaware County of Behavioral Health is a Primary Contractor for Pennsylvania. In May 2002, Riddle Memorial Hospital was selected to provide youth and adult smoking cessation services as part of the countywide tobacco control initiative. A formalized Tobacco Dependency Treatment program was started in July 2002 with the hiring of a full time tobacco dependency treatment specialist. In September 2002, we added a part time tobacco dependency treatment specialist to our staff.

In the fall of 2002, youth smoking cessation programs were conducted at six of the local high schools. Riddle Memorial Hospital also provided adult smoking cessation programs on campus, at the local mall and at County Government Centers.

In addition, Riddle Hospital is working to enhance the services it provides to both patients and staff. We have developed a new smoking cessation resource kit along with a smoking cessation curriculum which will be provided free of charge to participants. For more information about smoking cessation and upcoming classes, contact us at 610-891-3635 or smokefree@riddlehospital.org.

MELANOMA

Melanomas are malignant skin tumors that develop from melanocytes located in the basal layer of the epidermis. They may arise on any area of the skin as well as in the eye, central nervous system, and respiratory, gastrointestinal, and genitourinary tracts. While most melanomas arise *de novo*, as many as 30-50% arise from pre-existing dysplastic and congenital nevi. The incidence of melanoma has been increasing at the alarming rate of 6% per year since the 1950's. It is now the fifth most common malignancy in the United States, with an estimated 54,200 new cases and 7,600 deaths expected during 2003. At Riddle, 39 new cases of melanoma were diagnosed in 2002 compared to 34 in 1997 and 22 in 1991.

Sun exposure is the most important risk factor for the development of melanoma. Highest incidence is seen in lower latitudes (especially at the equator), in patients with a history of early childhood sunburn, and in white-skinned races. Lesions are most commonly located on the face in whites and on the lower extremities, soles, and subungual skin in blacks.

There are four types of malignant melanoma, each characterized by an initial radial growth phase of variable duration and relatively low metastatic potential. This is followed by a more rapid vertical growth phase, with the metastatic risk increasing in relation to the depth of penetration. Lentigo maligna (LMM) comprises 4-15% of melanomas and develops most often on sun-exposed skin of the head, neck and hands. This type is most common in women, has a median age of incidence of 70-years, and initially has a relatively slow radial growth. Superficial spreading melanoma (SSM) comprises about 70% of melanomas in whites. Most develop from a precursor nevus on the back or lower extremities. Nodular melanoma (NM) constitutes 12-30% of melanomas and is the most malignant form with very high metastatic potential. With a 2:1 male to female ratio, the median age of occurrence is 50 years. This lesion evolves rapidly over several months to a year and usually develops on trunk or head and neck sites *de novo*. Acral lentiginous melanoma (ALM) represents 2-8% of melanoma lesions overall but 35-90% of melanomas in blacks, Asians, and Hispanics. ALM develops on the palms and soles and subungual regions, most often in the sixth decade, and metastases are common.

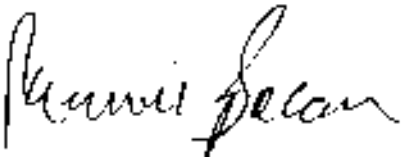
Surgery is the mainstay of treatment for the primary melanoma lesion and often for the lymph nodes and/or metastatic sites. Examination of sentinel lymph node(s) has gained acceptance in initial management. Various systemic agents have been used in the treatment of melanoma, including Interferon-Alfa and melanoma cell or antigen vaccines. Radiation therapy may be used as an adjuvant to surgery for the primary lesion, especially for head and neck sites where surgical margins may be close. It is also used for palliative treatment of metastatic disease.

Physician and patient education initiatives to increase awareness and the implementation of skin cancer screening programs such as ours at Riddle, have resulted in earlier detection and improved survival for patients with melanoma. The "**A,B,C,D**" rules for arousing suspicion of possible melanoma include **A**symmetry, **B**order irregularity or indistinctness, **C**olor variegation, and **D**iameter >6-mm. Important history includes change in color, shape, elevation, surface texture and appearance of the surrounding skin of a pre-existing nevus, bleeding, or the appearance of a new pigmented lesion, especially in persons over 40 years of age. In 2002, all 39 new cases of melanoma seen at Riddle were Stage 0 (15/30; *in-situ*) or I (24/39; ≤0.75-mm thick) compared to 1997 when 7 of 34 patients had more advanced disease.

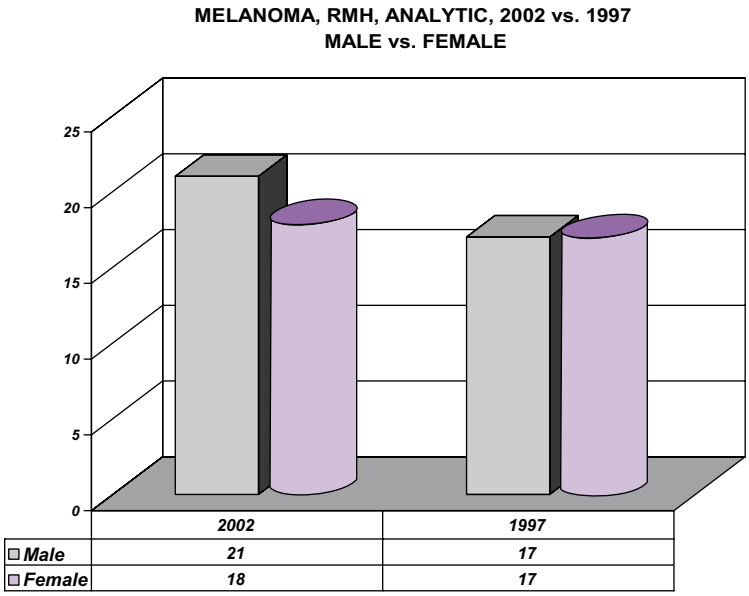
(Continued on page 9)

MELANOMA *(continued)*

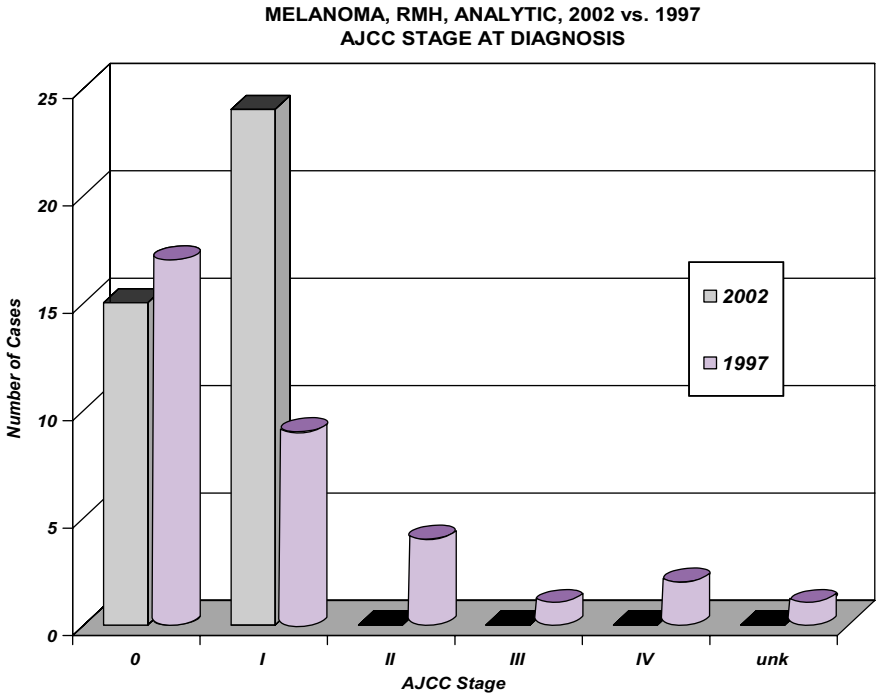
All suspicious skin lesions should undergo biopsy as over 90% of early stage melanoma lesions can be cured. Overall survival for very thin (<0.76-mm) melanomas is about 96%, falling to <10% for very thick lesions (>4-mm) or in patients with regional lymph node and/or distant metastatic disease. An estimated 3-5% of malignant melanoma patients will develop a second primary melanoma within 3 years of initial presentation, and this number increases to 33% 5-year risk in patients with numerous atypical moles from melanoma-prone families. While most melanomas that recur do so within the first 3 years after treatment, late failures are seen and lifetime surveillance is necessary.



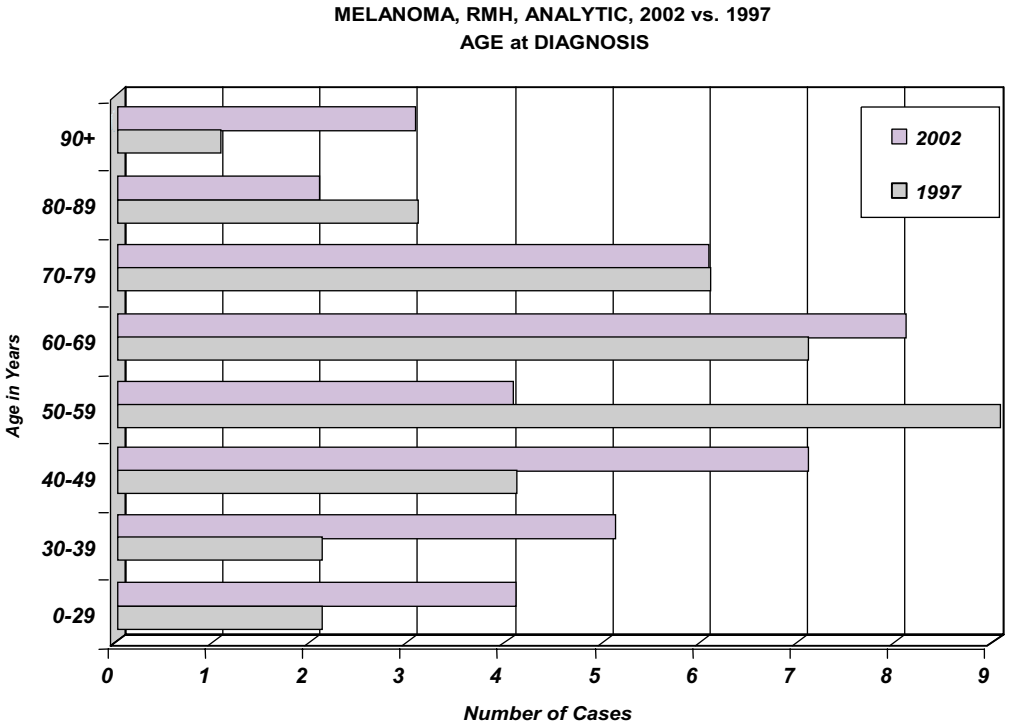
Merrill J. Solan, M.D., Director
Jefferson Radiation Oncology at Riddle



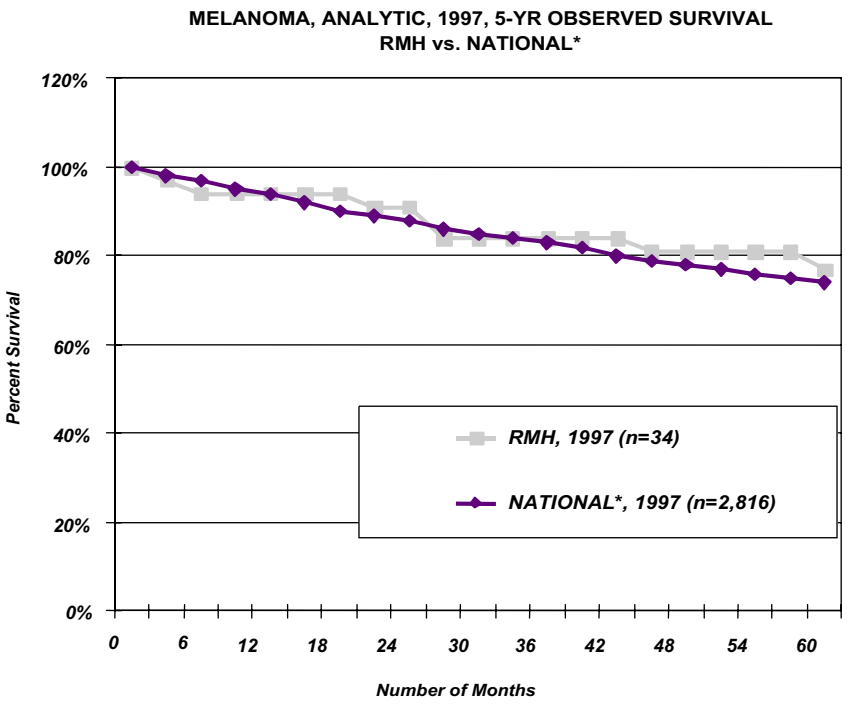
GRAPH 5 MELANOMA, RMH, ANALYTIC, MALE vs FEMALE, 2002 vs 1997
The number of new melanoma cases and the male to female ratio have both shown an increase since 1997 for Riddle's population.



GRAPH 6 RMH, MELANOMA, ANALYTIC, 2002 vs. 1997, AJCC STAGE AT DIAGNOSIS
All of the newly diagnosed melanoma cases during 2002 were discovered while still AJCC stage 0 or I (insitu or minimally invasive). This constitutes a significant improvement since 1997.



GRAPH 7 RMH, MELANOMA, ANALYTIC, AGE at DIAGNOSIS, 2002 vs 1997
Although melanoma is diagnosed most often among the middle age groups, our statistics show a substantial incidence rate increase in those under 40 years of age.



GRAPH 8 RMH vs NATIONAL*, MELANOMA, ANALYTIC, 5-YR OBSERVED SURVIVAL
Riddle Memorial Hospital's five-year survival rate for melanoma compares favorably with national statistics.
**Impath Information Services, CIRF, 2003*

SKIN CANCER PREVENTION

Sun avoidance is the best defense against skin cancer. Avoidance recommendations*:

- Seek shade between 10am and 3pm when the ultraviolet rays are most intense, especially when your shadow is shorter than you are tall.
- Wear light-colored, tightly woven protective clothing and wide-brimmed hats (3"brim).
- Apply sunscreens with a Sun Protection Factor (SPF) of at least 15. With a SPF 15 sunscreen applied properly, a fair-skinned person who sunburns in 20 minutes can tolerate 15 times 20 minutes (300 minutes) without burning. However, the use of sunscreens should not be an excuse to spend extra time in the sun because other sunrays still penetrate the sunscreen (UVA or infrared), which can age the skin and damage the skin's immune system.

It is very important to begin using sun protection in early childhood. It is estimated that 80% of lifetime sun damage occurs before age 18.

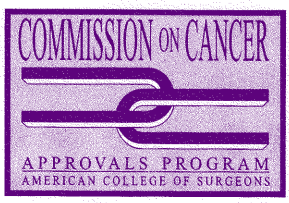
Early detection is the surest way to a cure for skin cancer.

**American Academy of Dermatology, 2003*

2003 AMERICAN CANCER SOCIETY (ACS) GUIDELINES FOR EARLY DETECTION OF CANCER IN ASYMPTOMATIC PEOPLE

CANCER SITE	RECOMMENDATIONS
General Cancer-Related Checkup	It is important to have periodic general health examinations that include a specific cancer-related checkup. These checkups should include health counseling and, depending on a person's age, might include examinations for cancers of the thyroid, oral cavity, skin, lymph nodes, testes, and ovaries, as well as for some nonmalignant diseases. (The Pennsylvania Department of Health highly recommends a complete clinical skin examination every year.)
Breast	Women aged 40 and older should have an annual mammogram and annual clinical breast examination (CBE) performed by a health care professional. The CBE should be conducted before the scheduled mammogram. Woman aged 20-39 should have a clinical breast examination by a health care professional every 3 years. Women known to be at increased risk may benefit from earlier screening and/or ultrasound or MRI. All adult women should be informed of the benefits and limitations of breast self exams.
Colon and Rectum	Beginning at age 50, men and women should follow *one* of the exam schedules below: 1. Fecal occult blood test (FOBT) every year or 2. Flexible sigmoidoscopy (FSIG) every 5 years or 3. Annual FOBT and flexible sigmoidoscopy every 5 years* 4. Double-contrast barium enema every 5 years 5. Colonoscopy every 10 years * Combined testing is preferred over either FOBT or FSIG every 5 years. People who are at moderate or high risk for colorectal cancer should talk with a doctor about a different testing schedule.
Prostate	The ACS recommends that both the prostate-specific antigen (PSA) blood test and the digital rectal exam be offered annually, beginning at age 50, to men who have a life expectancy of at least 10 years. Men at high risk (blacks and men who have a first-degree relative who was diagnosed with prostate cancer at an early age) should begin testing at age 45. Patients should be given information about the benefits and limitations of early detection and treatment so they can make an informed decision. (The Pennsylvania Department of Health is neither for nor against prostate cancer screening but encourages men to discuss the issue with their physician.)
Uterus	**Cervix:** All women who are or have been sexually active for approximately three years or who are 21 and older should have an annual regular Pap test or a liguid-based test every two years. At or after age 30, those who have three normal tests in a row can be screened every 2-3 years but doctors may screen more often if certain risk factors exist. Women aged 70+ with three or more normal Pap tests in a row in last 10 years may choose to stop screening. Screening is not necessary after total hysterectomy unless surgery was for cervical cancer treatment. **Endometrium:** All women should report any unexpected bleeding or spotting to their physician. Beginning at age 35, women with or at risk for hereditary non-polyposis colon cancer should have an annual endometrial biopsy.

Pennsylvania Department of Health - Cancer Facts and Figures Pennsylvania, 2003



The Commission on Cancer awards this

Certificate of Approval

to the Community Hospital Cancer Program of
Riddle Memorial Hospital
Media, PA
Program approved through 2004

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

David K. King, MD
Chair, Committee on Approvals

AMERICAN ACADEMY OF HOSPICE AND PALLIATIVE MEDICINE • AMERICAN ACADEMY OF PEDIATRICS • AMERICAN ASSOCIATION FOR CANCER EDUCATION, INC. • AMERICAN CANCER SOCIETY, INC.
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