

Main Line Health

Riddle Memorial Hospital

# 2007 CANCER PROGRAM ANNUAL REPORT

(Based on 2006 Data)

# ACS SCREENING GUIDELINES

For the Early Detection of Cancer in Asymptomatic People

| SITE                          | RECOMMENDATION  |
|-------------------------------|---|
| <b>Breast</b>                 | <ul style="list-style-type: none"><li>• 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.</li><li>• Clinical breast exam should be part of a periodic health exam about every 3 years for women in their 20s and 30s, and every year for women 40 and older.</li><li>• 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.</li><li>• 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.</li></ul>   |
| <b>Colon &amp; rectum</b>     | <p>Beginning at age 50, men and women should begin screening with 1 of the examination schedules below:</p> <ul style="list-style-type: none"><li>• A fecal occult blood test (FOBT) or fecal immunochemical test (FIT) every year</li><li>• A flexible sigmoidoscopy (FSIG) every 5 years</li><li>• Annual FOBT or FIT and flexible sigmoidoscopy every 5 years*</li><li>• A double-contrast barium enema every 5 years</li><li>• A colonoscopy every 10 years</li></ul> <p><i>*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.</i></p>  |
| <b>Prostate</b>               | <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 1 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>  |
| <b>Uterus</b>                 | <p><b>Cervix:</b> Screening should begin approximately 3 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 2 years using liquid-based tests. At or after age 30, women who have had 3 normal test results in a row may get screened every 2 to 3 years. Alternatively, cervical cancer screening with HPV DNA testing and conventional or liquid-based cytology could be performed every 3 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 aged 70 years and older who have had 3 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><b>Endometrium:</b> 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> |
| <b>Cancer-related checkup</b> | <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 guidelines for early cancer detection are assessed annually in order to identify whether there is new scientific evidence sufficient to warrant a reevaluation of current recommendations. If evidence is sufficiently compelling to consider a change or clarification in a current guideline or the development of a new guideline, a formal procedure is initiated. Guidelines are formally evaluated every 5 years regardless of whether new evidence suggests a change in the existing recommendations. There are 9 steps in this procedure, and these "guidelines for guideline development" were formally established to provide a specific methodology for science and expert judgment to form the underpinnings of specific statements and recommendations from the Society. These procedures constitute a deliberate process to ensure that all Society recommendations have the same methodological and evidence-based process at their core. This process also employs a system for rating strength and consistency of evidence that is similar to that employed by the Agency for Health Care Research and Quality (AHCQR) and the US Preventive Services Task Force (USPSTF).*

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## INTEGRATIVE ONCOLOGY—A GROWING DISCIPLINE IN CANCER MANAGEMENT

The field of Integrative Oncology developed over the last 10 years in response to patients and physicians who wanted to explore management and treatment options beyond those offered in conventional oncology practice. Areas of interest included the role of diet, vitamin and herbal supplements, massage and acupuncture therapies, and ways in which the mind can influence bodily functions such as the immune system. With growing scientific investigation of these areas, new discoveries could be integrated with mainstream oncology practice to enhance patient treatment, tolerance, and outcome.

There is a growing body of scientific knowledge now available to support the implementation of Integrative Oncology into modern cancer therapies. Various natural substances have biologic effects that may be helpful in patients with malignancies. Vitamin D helps cells form normally, and in high doses has been shown to kill cancer cells. Medicinal mushrooms such as Maitake and Coriolus, and herbs such as Mistletoe, can have beneficial effects on the immune system. Fish Oils can lower inflammation and may reduce the aggressive nature of certain types of cancer cells. Therapeutic massage and acupuncture can improve a patient's sense of well-being and facilitate recovery from surgery. However, our knowledge in these areas is still quite limited, and few large scale clinical studies exist that have looked at issues such as long-term survival. So decisions to make significant changes in diet, add vitamin and herbal supplements and participate in meditation are based on promising, hopeful, but still inconclusive and incomplete knowledge.

In addition, these integrative modalities have the potential for side-effects and interference with conventional treatment. Theoretically, antioxidants such as Vitamins C and E may interfere with the ability of chemotherapy and radiation to effectively kill cancer cells. It is therefore essential that decisions about integrative treatments are made carefully and responsibly and include input from your other treating physicians. In addition, a physician specially trained in Integrative Oncology can be extremely helpful in guiding cancer patients towards treatment options most appropriate for his/her individual situation and away from potentially harmful practices.

Integrative Oncology treatments may be helpful at every stage of cancer management. Some therapeutic goals include: **1. Support of body, mind and spirit during active cancer treatment to optimize treatment response.** These methods may improve nutrition, enhance effectiveness and tolerance of standard treatments, support immune function, reduce side effects, restore inner calm and sense of control, and mobilize mind, heart and spirit toward healing. **2. Acceleration of recovery after chemotherapy or radiation** by restoring antioxidants and other key nutrients, supporting detoxification and immune function, restoring bowel ecology, accelerating healing and reducing pain, and enhancing spiritual growth. **3. Support before and after surgery** to boost nutrition and promote healing, accelerate wound repair and reduce pain and anxiety. **4. For patients with metastatic disease or malignancies particularly resistant to chemotherapy and/or radiation therapy**, a potential increase in benefits and reduction of side effects of mainstream treatments **5. Prevention of cancer in the future** through nutritional guidance, use of supplements, support of immune function, and lifestyle counseling.

Consultation with a physician trained in Integrative Oncology is the first step in ensuring that the most appropriate treatment options are tailored to the patient's specific needs and that these treatments are coordinated with the oncologists and surgeons providing care. In this way, our cancer patients are empowered to play a more active role in their care, supported through difficult treatments, and encouraged to strive for a brighter future.

Ira S. Cantor, MD  
*Integrative Oncology Medicine*

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## LARGE CELL LYMPHOMA

Non-Hodgkin lymphoma (NHL) is a term that refers to many very different types of cancers of lymph cells (lymphocytes). Normal lymphocytes fight organisms in the body including bacteria, viruses and foreign cells. They are predominately found in lymph nodes (bean-shaped organs located throughout the body), blood, spleen and also in many other organs. NHL most often begins in the lymph nodes, bone marrow or spleen but can also involve the stomach, intestine, skin, thyroid gland, brain or any other part of the body. NHL is the fifth most common cancer among both men and women.

NHL can be divided into 2 major types: 1. indolent (slow growing) or 2. aggressive lymphomas. Aggressive lymphomas generally grow quickly and require treatment. Large B-cell lymphoma is the most common form of lymphoma (approximately 30% of all types) and is considered an aggressive form of NHL. This type of lymphoma involves organs outside the lymph nodes in approximately 40% of cases at the time of diagnosis.

Large cell lymphoma may occur in all age groups but is most common in the elderly. Graphs 1 & 2 show the age distribution of RMH patients diagnosed with large cell lymphoma during 2000-2001 and 2005-2006.

Symptoms of NHL may include swelling or lumps in the lymph nodes in the abdomen, groin, neck or axilla; fever that cannot be explained; weight loss and sweating. After a diagnosis of lymphoma, diagnostic tests are used to determine stage. These tests can include CT scans, bone marrow biopsies and more recently PET/CT scans.

The stage of lymphoma describes the extent of spread of the tumor using Roman numerals I through IV. Stages I & II non-Hodgkin lymphoma are early stages and generally localized. Stages III & IV non-Hodgkin lymphoma are more extensive and may involve lymph nodes throughout the body or major body organs. The disease stage helps determine the best treatment.

Graphs 3 & 4 show the stage at presentation of Riddle patients diagnosed during 2000-2001 & 2005-2006. The large number of early stage patients in 00-01 is unusual. The distribution seen in 05-06 is more typical with a larger number of late stage patients.

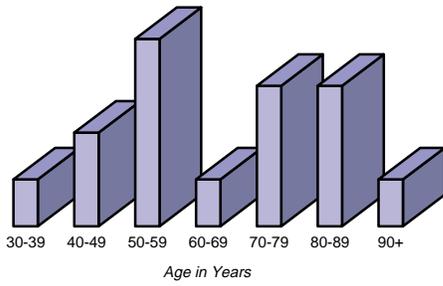
Large cell lymphomas are often curable. Treatment involves chemotherapy, sometimes combined with radiation therapy. Early stage patients (stage I and most stage II) are frequently cured with treatment. Late stage patients (stage III & IV) are cured approximately 40% of the time. Recently the addition of monoclonal antibody treatment (Rituxan) to chemotherapy has significantly increased the cure rate.

Graph 5 shows the survival of Riddle's large cell lymphoma patients from 2000-2001 compared to national statistics. The large number of early stage patients treated at Riddle during this time period probably explains the better results.

Andrew J. Solan, MD  
*Chief, Division of Hematology/Oncology*  
*Chairman, Cancer Committee*

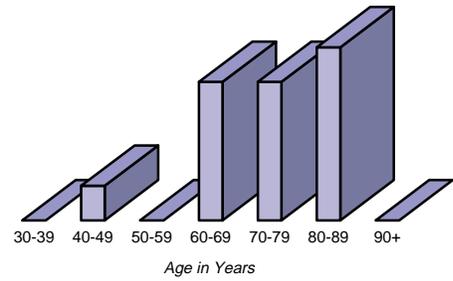
Graph 1

LARGE CELL LYMPHOMA, RMH 2000-2001 (n=15)  
AGE at PRESENTATION



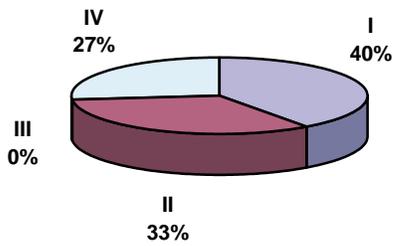
Graph 2

LARGE CELL LYMPHOMA, RMH 2005-2006 (n=14)  
AGE at PRESENTATION



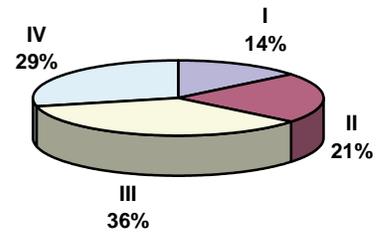
Graph 3

LARGE CELL LYMPHOMA, RMH 2000-2001 (n=15)  
AJCC STAGE at PRESENTATION



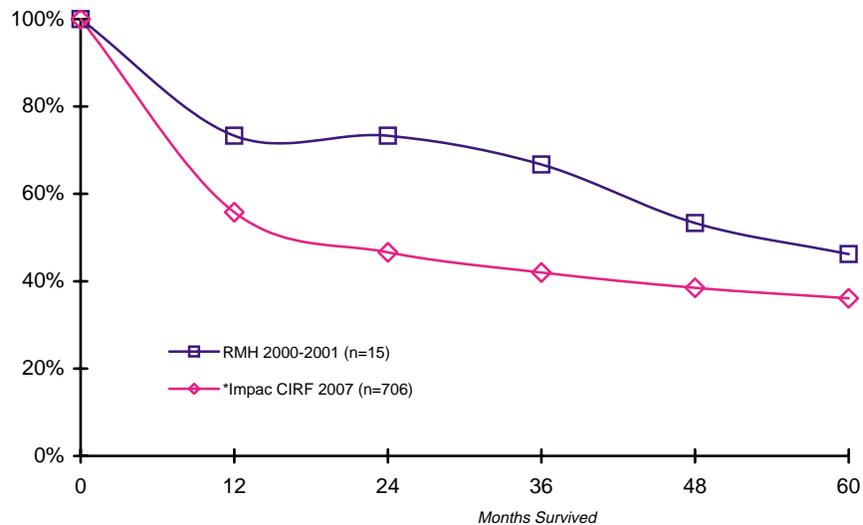
Graph 4

LARGE CELL LYMPHOMA, RMH 2005-2006 (n=14)  
AJCC STAGE at PRESENTATION



Graph 5

LARGE CELL LYMPHOMA 5-YR OBSERVED SURVIVAL  
RMH vs. NATIONAL\* 2000-2001



## CANCER REGISTRY

The Cancer Registry at Riddle Memorial Hospital, under the guidance of the Commission on Cancer's (CoC) American College of Surgeons (ACoS) and the State of Pennsylvania, is a unique computerized system designed to collect, store and analyze data on all our patients diagnosed with cancer. The Registry, originally established in 1991, currently contains more than 9,000 patients. During 2006 alone, 669 cases were added. Of these 669 cancer diagnoses, 561 were initially diagnosed and/or treated at Riddle (analytic) and 108 were initially diagnosed and treated elsewhere but with subsequent treatment given here (non-analytic). The six most frequent cancers seen at Riddle during 2006 were breast, colon/rectum, melanoma, lung, bladder and prostate. See Table 1 for a summation of all the sites added to the database in the past year.

The purpose of the Cancer Registry is to provide accurate and complete cancer information while maintaining strict confidentiality. The data collected includes patient demographics, medical history, diagnostic findings, diagnosis, cancer treatment, disease staging, disease recurrence and lifetime follow-up. The information collected is forwarded to the Pennsylvania Cancer Registry and the National Cancer Data Base, allowing comparative analysis with other hospitals of similar size and organization throughout the country. Besides making our data available to the national and state agencies, the Registry also provided cancer information to physicians for use in cancer conferences, to administration for Cancer Center usage studies and to physicians for individual cancer related studies.

One of the important functions of the Cancer Registry is the annual follow-up of our analytic cancer patients. Lifetime follow-up directly benefits patients by reminding physicians and patients that routine medical examinations are encouraged. This process may potentially bring lost patients back under medical supervision. With the continued support and cooperation of the medical staff, the Registry maintains a successful follow-up rate that exceeds the standards set by the ACoS.

Riddle's Cancer Program has been accredited by the ACoS since 1993 and most recently received three-year accreditation with commendation in every eligible standard. Our Cancer Committee is dedicated to maintaining the highest quality of patient care and continually utilizes data provided by the Registrar as a means of monitoring outcomes.

Table 1

| <i>SITE</i>  | <i>ANALYTIC</i> | <i>NON-ANALYTIC</i> | <i>TOTAL</i> |
|--|-----------------|---------------------|--------------|
| <i>Breast</i>                                      | 108             | 9                   | 117          |
| <i>Colorectum</i>                                  | 73              | 5                   | 78           |
| <i>Melanoma</i>                                    | 72              | 5                   | 77           |
| <i>Lung</i>  | 65              | 14                  | 79           |
| <i>Bladder</i>                                     | 46              | 15                  | 61           |
| <i>Prostate</i>                                    | 45              | 19                  | 64           |
| <i>Female Reproductive</i>                         | 25              | 13                  | 38           |
| <i>Urinary Tract (excl bladder)</i>                | 18              | 3                   | 21           |
| <i>Lymphoma</i>                                    | 16              | 2                   | 18           |
| <i>Unknown Primary</i>                             | 16              | 3                   | 19           |
| <i>Digestive (excl colorectum &amp; pancreas)</i>  | 14              | 7                   | 21           |
| <i>Hematopoetic</i>                                | 13              | 3                   | 16           |
| <i>Pancreas</i>                                    | 11              | 3                   | 14           |
| <i>Central Nervous System (incl benign tumors)</i> | 11              | 1                   | 12           |
| <i>Thyroid</i>                                     | 8               | 0                   | 8            |
| <i>Respiratory (excl lung)</i>                     | 7               | 2                   | 9            |
| <i>Lip, Oral Cavity, Pharynx</i>                   | 7               | 4                   | 11           |
| <i>Skin (excl melanoma) &amp; Soft Tissue</i>      | 6               | 0                   | 6            |
|  | 561             | 108                 | 669          |



THE COMMISSION ON CANCER AWARDS THIS  
*Certificate of Approval*  
WITH COMMENDATION

*to the Community Hospital Cancer Program of  
Riddle Memorial Hospital  
Media, PA  
Program approved through 2010*

A handwritten signature in dark blue ink, appearing to read 'Frederick L. Greene'.

FREDERICK L. GREENE, MD, FACS  
CHAIR, COMMISSION ON CANCER  
AMERICAN COLLEGE OF SURGEONS

A handwritten signature in dark blue ink, appearing to read 'Diana Dickson-Witmer'.

DIANA DICKSON-WITMER, MD, FACS  
CHAIR, COMMITTEE ON APPROVALS  
AMERICAN COLLEGE OF SURGEONS

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.

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Anthony J. and Ruth H. Moretti

Main Line Health

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**Cover Photo:** Large cell lymphoma provided by N. Susan Yaron, M.D., Director and Chairperson,  
Division of Pathology, Riddle Memorial Hospital