2008

Cancer Program Annual Report

(Based on 2007 RMH Data)



Main Line Health Riddle Memorial Hospital

The Commission on Cancer has awarded Riddle Memorial Hospital's Cancer Program with the 2007 Outstanding Achievement Award in recognition of our excellence in providing quality care to cancer patients. Our Cancer Program is one of only sixty-six programs nation-wide to have received this honor. While we are very proud of this achievement, our commitment is to continually strive for and maintain the best possible care for our cancer patients.



Established in 2004, the CoC Outstanding Achievement Award (OAA) is designed to recognize cancer programs that strive for excellence in providing quality care to cancer patients. A facility receives a Commendation level of compliance with seven standards that represent the full scope of the cancer program (cancer committee leadership, cancer data management, clinical services, research, community outreach and quality improvement). In addition the facility receives a compliance rating for the remaining 29 standards. Sixty-six programs received the OAA as a result of surveys performed in 2007. This number represents approximately fifteen percent of the 453 programs surveyed during this period. A majority of recipients are community-based facilities: teaching hospitals, NCI-designated Comprehensive Cancer Centers and Network Cancer Programs also received the award.

The CoC's core functions include setting standards for quality, multidisciplinary cancer patient care; surveying facilities to evaluate compliance with the 36 CoC standards; collecting standardized, high quality data from approved facilities; and using the data to develop effective educational interventions to improve cancer care outcomes at the national, state and local level. There are currently more than 1,400 CoC-approved cancer programs in the US and Puerto Rico, representing close to 25 percent of all hospitals. These CoC-approved facilities diagnose and/or treat 80 percent of newly diagnosed cancer patients each year.

The Approvals Program, a component of the CoC, sets quality-of-care standards for cancer programs and reviews the programs to ensure that they conform to those standards. Approval by the CoC is given only to those facilities that have voluntarily committed to providing the highest level of quality cancer care and that undergo a rigorous evaluation process and review of their performance. To maintain approval, facilities with CoC-approved cancer programs must undergo an on-site review every three years.

Receiving care at a CoC-approved cancer program ensures that a patient will have access to:

- Comprehensive care, including a range of state-of-the-art services and equipment
- A multi-specialty, team approach to coordinate the best treatment options
- Information about ongoing clinical trials and new treatment options
- Access to cancer-related information, education and support
- A cancer registry that collects data on type and stage of cancers and treatment results and offers lifelong patient follow-up
- Ongoing monitoring and improvement of care
- Quality care close to home

Cancer patient data is reported by each CoC-approved cancer program to the CoC's National Cancer Data Base (NCDB), a joint program with the American Cancer Society (ACS). The NCDB currently contains patient demographics, tumor characteristics, and treatment and outcomes information for more than 16 million cancer patients diagnosed and treated at hospital cancer programs in the US between 1985 and 2003. This data accounts for approximately two-thirds of newly diagnosed cancer cases in the US each year, and is used regularly to monitor the quality of patient care delivered in CoC-approved cancer programs.

Through an exclusive partnership with the ACS, the CoC provides the public with information on the resources, services and cancer treatment experience for each CoC-approved cancer program. This information is shared with the public on the ACS website at <u>www.cancer.org</u> and through the ACS National Cancer Information Center at 1-800/ACS-2345.

CANCER PROGRAM

2008 has been an exciting year for Riddle Memorial Hospital's Cancer Program.

First and foremost, Riddle has joined the Main Line Health System, creating many new opportunities for growth and expanded services for our staff as well as our community members. While we continue to offer close-to-home care to our patients, our pool of resources has now expanded to include our sister hospitals, Lankenau, Bryn Mawr and Paoli.

Secondly, and just as exiting, our Cancer Program was a recipient of the Commission on Cancer's Outstanding Achievement Award during the past year. Everyone involved in the Cancer Program worked diligently to help our Cancer Center provide the best possible care for our cancer patients and we are very proud of our accomplishment. See the previous page for details of what requirements we met in achieving this award.

Education, cancer prevention and support are important components of the care we offer to our community. During 2008, our program conducted educational seminars on liver and colon cancers and offered numerous free skin, prostate and breast cancer prevention screenings. We also provided regular support to our cancer patients through breast, prostate and general cancer support groups. Since Riddle became a totally smoke-free campus in the spring, we have conducted many smoking prevention & cessation programs both within the hospital and in the community.

Our oncology data specialists provided cancer related data to the National Cancer Data Base (NCDB) on 485 new cancer cases during 2007 (see Table 1), a 16% decrease from 2006, felt to be related more to changing medical practices (diagnosed and treated in outpatient settings rather than in hospitals) than to an actual decrease in cancer incidence. Our oncology data registry currently contains over 10,000 cases and maintains a 94% follow-up rate, contributing important diagnostic, treatment and outcome information to our scientific community.

While we are very pleased with our accomplishments this past year, we will continue to strive for even greater excellence in the years to come. Our goal remains to be the best place to receive care and to be the best place to give care.

SITE	ANALYTIC (dx & tx at RMH)	NON-ANALYTIC (subsequent tx at RMH)	TOTAL
Breast	91	5	96
Colon/rectum	79	4	83
Lung	64	9	73
Bladder	42	7	49
Prostate	19	17	36
Melanoma	32	2	34
Lymphoma	24	3	27
Digestive (excl colon/rectum & pancreas)	23	3	26
Miscellaneous	19	6	25
Female Reproductive	17	1	18
Urinary Tract (excl bladder)	16	2	18
Hematopoetic	12	4	16
Lip, Oral Cavity, Pharynx	11	2	13
Thyroid	10	0	10
Central Nervous System (incl benign tumors)	8	1	9
Pancreas	7	1	8
Respiratory (excl lung)	8	0	8
Skin (excl melanoma) & Soft Tissue	3	2	5
	485	69	554

Table 1

LUNG CANCER



Lung cancer is the leading cause of cancer deaths in the United States. There are 215,000 new cases diagnosed each year and over 160,000 deaths each year. Since 1985, more women die annually from lung cancer than from breast cancer. As seen from the following graphs, the incidence of lung cancer at Riddle Hospital is similar to the national average and outcome results are favorably comparable.

What is lung cancer?

Lung cancer is primarily a malignancy arising from the lining cells of the respiratory system – the trachea, bronchus, bronchioles and alveoli. There are several types of lung cancer, but primarily it is divided into two main types. The first is small cell or oat cell cancer; the second is non-small cell cancer. These are considered primary lung cancers. Cancer can also spread to the lungs from other organs such as breast or colon. These are called metastatic cancers. The pleura (lining of the chest and lungs) can be involved with metastatic cancer or with primary cancer, which is called mesothelioma.

Lung cancer symptoms

Most often there are no symptoms and the cancer is found when the patient is being evaluated for some other problem or on a routine chest x-ray. Cough and blood-tinged sputum can occur while chest pain and increasing shortness of breath are considered late events. The majority of patients are found to have advanced disease at diagnosis.

Diagnosis and staging

Cancer staging is the process of determining the extent of disease, utilizing universally accepted staging systems. Multiple tools are used in diagnosing and staging lung cancer such as chest x-ray, CT scan, PET scan, bronchoscopy and needle biopsy. Surgical diagnostic and staging procedures include mediastinoscopy, thoracoscopy and thoracotomy. These diagnostic and staging modalities provide the tools used by the managing physicians to predict the prognosis and plan the treatment of cancers.

Treatment

Depending on the stage of the cancer at the time of diagnosis, surgery, chemotherapy, radiation therapy or a combination of these therapies is used to treat lung cancer. The results of these therapies can be accurately predicted depending on the stage of the disease. However, for individual cases, they are only used to give the patient guidance in choosing their treatment since there can be different responses for different patients.

The Riddle approach

Here at Riddle Memorial Hospital, we use a collaborative multi-disciplinary approach to the treatment of cancer. This involves the patient's primary physician, medical oncologist, radiation oncologist, thoracic surgeon, radiologist and pathologist. Complicated cases are presented at the cancer conference where treatment plans are formulated. Patient and family input are of primary importance in the formulation of this treatment plan.

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Daniel J. Woody, M.D., Chief Thoracic Surgery



The incidence of lung cancer continues to rise in RMH patients. National statistics concur.



The majority of newly diagnosed lung cancers are already advanced in stage of disease at diagnosis.



Survival outcomes for RMH lung cancer patients after resection compare favorably to national statistics. The downward deviation at 5 years for our patient outcome is due to our much smaller incidence, as compared to national figures, rather than an actual decrease in survival years.

AMERICAN CANCER SOCIETY SCREENING GUIDELINES For the Early Detection of Cancer in Asymptomatic People

SITE	RECOMMENDATION
Breast	 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. 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. 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. Screening MRI is recommended for women with an approximately 20%-25% or greater lifetime risk of breast cancer, including women with a strong family history of breast or ovarian cancer and women who were treated for Hodgkin disease.
Colon & rectum	 Beginning at age 50, men and women at average risk should begin screening with one of the examination schedules below. Tests that detect adenomatous polyps and cancer: * A flexible sigmoidoscopy every 5 years * A colonoscopy every 10 years * A double-contrast barium enema every 5 years * Computed Tomographic (CT) colonography every 5 years Tests that primarily detect cancer: * A guaiac-based fecal occult blood test (gFOBT) or fecal immunochemical test (FIT), with high test sensitivity for cancer every year * Stool DNA test (interval uncertain) Individuals with a personal or family history of colorectal cancer or adenomas, inflammatory bowel disease, or high-risk genetic syndromes should continue to follow the most recent recommendations for individuals at increased or high risk.
Prostate	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.
Uterus	Cervix: 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. 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).
Cancer- related checkup	For individuals undergoing periodic health examinations, a cancer-related checkup should include health counseling about tobacco, sun exposure, diet and nutrition, sexual practices, environmental and occupational exposures 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 some nonmalignant diseases.

Faul + Haden Withwer, with DIANA DICKSON-WITMER, MD, FACS THE COMMISSION ON CANCER AWARDS THIS Certificate of Approval CHAIR, COMMITTEE ON APPROVALS to the Community Hospital Cancer Program of AMERICAN COLLEGE OF SURGEONS Program approved through 2010 Ríddle Memorial Hospital WITH COMMENDATION Commission on Cancer Media, PA FREDERICK L. GREENE, MD, FACS AMERICAN COLLEGE OF SURGEONS CHAIR, COMMISSION ON CANCER Junie R. Juna

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.

Funding for the publication of the RMH 2008 Cancer Program Annual Report was made possible through the generosity of the estate of Anthony J. and Ruth H. Moretti



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