Oncology
Annual Report
2009

Cancer Committee Chairman Report 2009

The cancer committee of Gwinnett Medical Center (GMC) saw further growth and expansion of cancer care services offered to our community, supporting continued efforts to ensure the latest in diagnostic, therapeutic and supportive services across the multidisciplinary spectrum are available close to home.

In addition to its top rating as a Community Hospital Comprehensive Cancer Program by the American College of Surgeons Commission on Cancer, our cancer program was one of the pilot survey sites for the National Accreditation Program for Breast Centers. The weekly breast cancer conference was initiated, providing a forum for all newly diagnosed cases to be discussed and thus optimizing multidisciplinary treatment planning. The Care-a-Van offered digital mammography across the region, and MRI mammography became readily available.

Rehab services (lymphedema) and palliative care were new additions to the cancer committee and community outreach was enhanced by the American Cancer Society Patient Resource Navigator program. These joined the oncology data center, physicians, nurses and allied health practitioners in supporting the numerous offerings of our cancer program, including weekly tumor conference, didactic educational sessions, breast care management, genetic testing and counseling, clinical trials through the Atlanta Regional Community Clinical Oncology program and state-of-the-art medical, radiotherapeutic and surgical care.

Great excitement surrounds the rapid innovations in cancer care, and I am grateful for the support of the GMC administration and the enthusiastic and dedicated work of the medical, nursing and allied health staff in providing excellence in the care of our patients fighting cancer.

Alexander Saker, MD
Chairman, Cancer Committee

Our mission is to offer our community compassionate cancer care through a network of integrated services and programs promoting the delivery of health and wellness in partnership with our patients and physicians.

Our vision is to be a premier comprehensive community cancer program that makes a difference in the lives of those who experience cancer.

The Oncology Data Center

The Oncology Data Center (ODC) is an information system designed for the collection, management and analysis of data on persons with the diagnosis of malignant (or neoplastic disease) and benign brain tumors. The information maintained in the registry includes demographic information, medical history, diagnostic findings, cancer information (including primary site, histology cell type and extent of disease and/or stage), cancer therapy (including surgery, radiation therapy, chemotherapy, hormone and/or immunotherapy) and follow-up (annual information concerning treatment, recurrence and patient status).

In 2007, the ODC processed 1320 analytic cases (patients diagnosed since the reference date of 1989 and/or all of the first course of treatment or patients diagnosed elsewhere and all or part of first course of therapy at hospital), and 242 non–analytic cases (patients diagnosed elsewhere and received all of first course of treatment elsewhere and seen at GMC now with active disease).

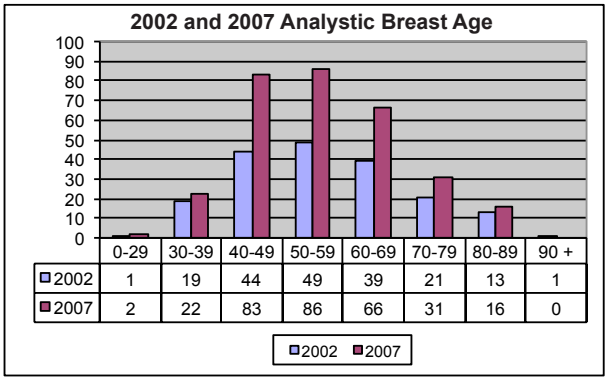
The top five cancers at GMC were breast 23.2%, lung 12.2%, prostate 9.9%, colon 8.5% and thyroid 5.0%. The majority of cases at GMC were diagnosed and/or treated in the local or AJCC Stage I group. Of the 1320, 558 were males and 762 were female. The majority of patients are from Gwinnett County 72.7%, Walton County 5.8%, Barrow County 5.0%, Dekalb County 3.3%, Jackson County 2.7% and all others 10.6%.

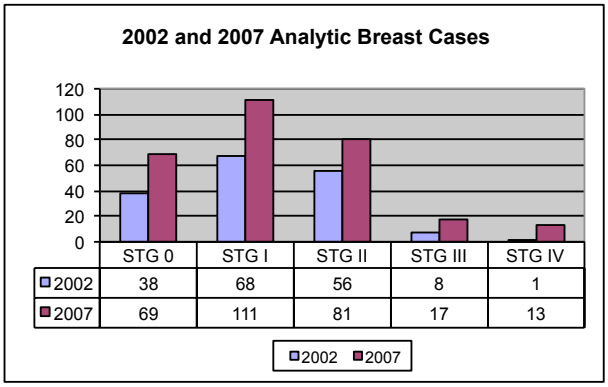
The ODC collects the required data items mandated by the American College of Surgeons, Georgia Comprehensive Cancer Registry and SEER (Surveillance Epidemiology and End Results), while maintaining strict patient confidentiality. The ODC reports monthly to the Georgia Center for Cancer Statistics and reports yearly to the National Cancer Database.

Breast Cancer

Breast cancer is the most commonly diagnosed cancer in women in the US. This year alone, more than 180,000 women will be diagnosed. During a woman's lifetime, there is a 1 in 7 chance of developing breast cancer. While most cases of breast cancer have no identifiable cause, researchers are learning more about ways breast cancer can be detected early, and more importantly, prevented.

The latest tool in the effort for early detection is a Breast MRI. The MRI is able to find certain breast cancers that might not be seen by conventional mammography. Certain women, especially younger women, women with prior breast surgery and those with dense tissue, may benefit most. Progress has also been made in breast cancer prevention. The STAR trial, which was available to patients at GMC proved that Evista was as beneficial as Tamoxifen for breast cancer prevention, with fewer side effects. Also exciting, was the release of the data showing that Zoledronate, when combined with hormonal therapy, prevented recurrences in women with a history of breast cancer.

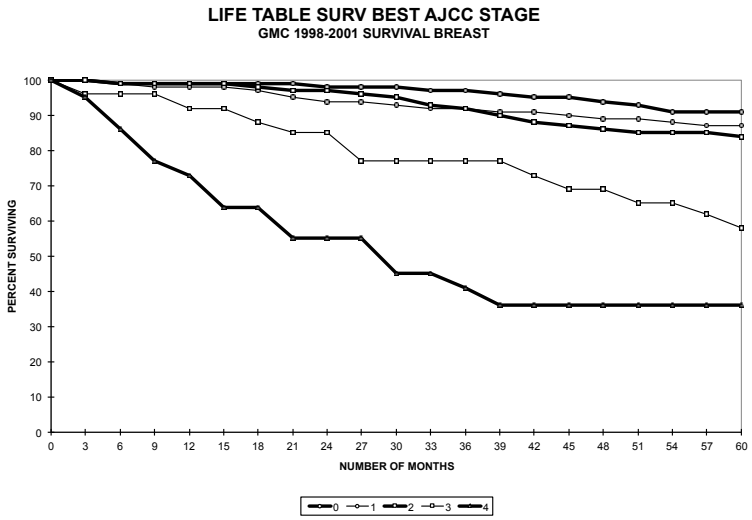




Women with breast cancer being treated at GMC have access to the best clinical trials in the nation. The 06-900 US Oncology trial is investigating whether the drug Adriamycin (doxorubicin) can be replaced by less toxic alternatives. Another exciting trial, Roche B020289, has been exclusively designed for so-called triple-negative breast cancer, a type of breast cancer that does not respond to hormonal therapy or Her2-based therapy. In this trial, Avastin (bevacizumab) is added to traditional chemotherapy. Avastin blocks the growth of new blood vessels, thus starving any new tumors from the nutrients needed for development.

Christopher Hagenstad, MD

BESTSTG	ENTER	0.0 yr	1.0 yr	2.0 yr	3.0 yr	4.0 yr	5.0 yr	95% Confidence Interval
0	94706	100.0	99.4	98.6	97.6	96.4	95.1	94.9 - 95.2
I	217850	100.0	98.9	97.3	95.4	93.2	90.9	90.8 - 91
II	174673	100.0	97.9	94.0	89.8	85.9	82.2	82 - 82.4
III	36140	100.0	92.3	80.3	70.4	62.6	56.4	55.9 - 57
IV	19512	100.0	62.0	44.1	31.9	24.1	18.6	18 - 19.2

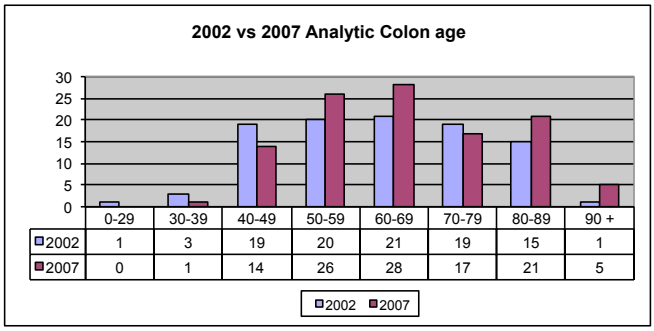


The total number of analytic breast cases for 2007 was 306, up from 187 in 2002.

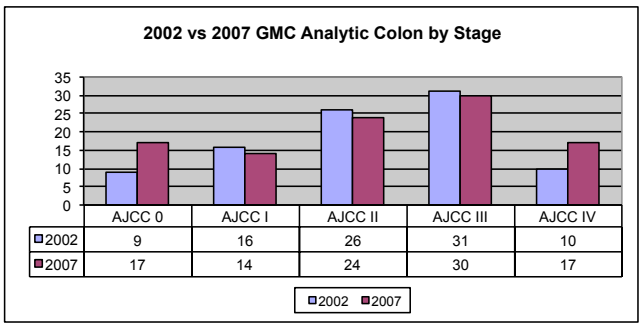
Of the 306 cases, 69 were Stage 0 (24%), 111 were Stage I (38%), 81 were stage II (27%), 17 were Stage III (6%) and 13 were Stage IV (5%). Comparing this to 2002 breast cases the following are the statistics 38 for Stage 0 (22%), 68 for Stage I (40%), 56 for Stage II (32.5%), 8 for Stage III (5%) and 1 for Stage IV (.5%). When comparing age for breast cases for 2002 and 2007, in both years the age group with highest diagnosed patients is in the 50-59 age groups, with 40-49 coming in second. The initial therapy for the 2007 breast cases broke down as follows: 18.63% had surgery, 18.30% had hormone, surgery and radiation therapy, 16.01% had surgery and radiation therapy, 15.03% had surgery, radiation therapy and chemotherapy, 9.80% had surgery and chemotherapy, and 22.22 had other treatment. The comparison of NCDB survival data is compared to GMC survival data with expected results.

Colon Cancer

The American Cancer Society estimates there will be approximately 108,000 cases of colon cancer and 40,700 cases of rectal cancer in 2008. There is 3,760 cases of colorectal cancer predicted in 2008 for the state of Georgia, making this the third most common malignancy in both men and women. Fortunately the incidence rates for this disease have been decreasing for the past two decades (from 66.3 cases per 100,000 populations in 1985 to 48.2 in 2004). This decline is thought to be due in large part to early diagnosis through screening.



Most cases of colon cancer begin as small benign growths called polyps. Polyps usually do not cause symptoms and can typically be detected and treated often before cancer develops. The American Cancer Society recommends individuals without risk factors begin screening at age 50. If there is a family history of colon cancer or a personal history of polyps or chronic bowel disease, screening should begin at an earlier age. Screening often includes testing the stool for occult blood and colonoscopy or sigmoidoscopy. Some other risk factors include advanced age (905 of cases diagnosed in people over 50), obesity, physical inactivity and certain hereditary conditions.

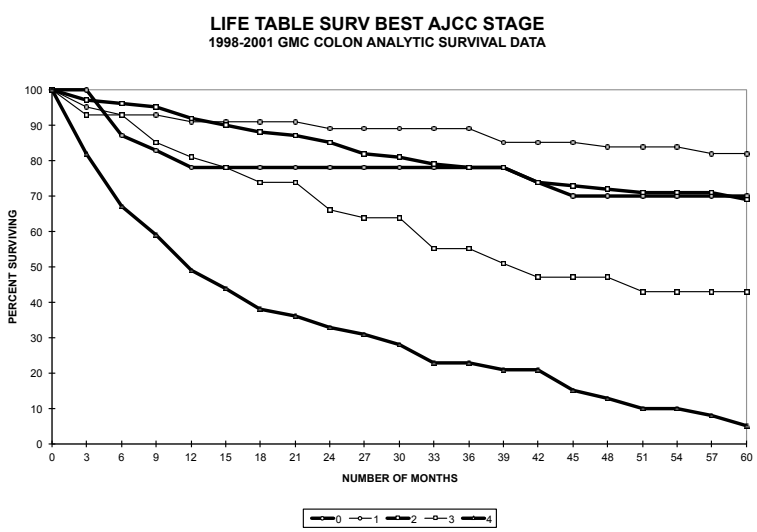


Surgery is the mainstay of treatment for colon cancer and is often curative. Chemotherapy alone or in combination with radiation (for certain rectal cancers) is frequently given along with surgery if the cancer has penetrated the bowel wall or spread to lymph nodes. New targeted forms of therapy have recently been approved for the treatment of metastatic colorectal cancers. Significant progress has been made in recent years in both length of survival and quality of life in patients with incurable colon cancer. When detected at an early localized stage, the 5 year survival is 90%.

The physicians and staff of GMC are committed to providing the best possible cancer care to patients and their families. It is gratifying to know that we can provide the latest breakthroughs in the diagnosis and treatment of colorectal cancer for our community while still maintaining a caring, personal approach.

John N. Gargus, MD
Radiation Oncology

BESTSTG	ENTER	0.0 yr	1.0 yr	2.0 yr	3.0 yr	4.0 yr	5.0 yr	95% Confidence Interval
0	15192	100.0	93.6	89.8	86.2	82.5	78.4	77.7 - 79.1
I	43611	100.0	92.2	88.0	83.7	79.3	74.8	74.4 - 75.2
II	57201	100.0	88.6	81.8	75.4	69.4	64.0	63.5 - 64.4
III	50376	100.0	83.7	71.4	61.8	55.2	49.9	49.4 - 50.3
IV	40781	100.0	42.7	22.0	12.8	8.8	6.6	6.3 - 6.8



The total number of analytic colon cases for 2007 was 112, up from 99 in 2002. In 2007 there were 52 males and 60 females, in 2002 there were 52 males and 47 females.

Of the 112 colon cases in 2007, 17 were AJCC Stage 0, compared to 9 in 2002. There were 14 AJCC Stage I in 2007 and 16 in 2002. There were 24 AJCC Stage II in 2007, and 26 in 2002. There were 30 AJCC Stage III in 2007, and 31 in 2002. This is the highest stage group in both years. There were 17 AJCC Stage IV in 2007, and 10 in 2002. The highest age group for 2007 and 2002 was the 60-69 year olds, with the 50-59 coming in second. The third for 2007 was the 70-79 and for 2002 the 40-49 and 70-79 had equal number of patients. The initial therapy for 2002 patients was as follows: Surgery 64.6%, surgery and chemotherapy 26.3%, no treatment 6.1%, surgery, radiation therapy and chemotherapy 2.0%, and chemotherapy 1.0%. The initial therapy for 2007 analytic colon patients is as follows: surgery 61.6%, surgery and chemotherapy 29.5%, no treatment 7.1%, and chemotherapy 1.8%. The comparison of NCDB survival data to GMC survival data has the expected similar results.

2008 Cancer Committee Members

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Miles Mason, MD	Surgery	Cancer Physician Liaison/ Community Outreach Coordinator
Aldemar Montero, MD	Hematology/Oncology	Quality Coordinator
Mark Quinn, MD	Radiation Oncology	
Cynthia Robinson, MD	Radiology	Quality Control of Data Coordinator
Paul Rubin, MD	Urology	
Alexander Saker, MD	Hematology/Oncology	Chairman
Stephen Salmieri, DO	GYN Oncology	Vice - Chair
Philip Shrake, MD	Radiation Oncology	Cancer Conference Coordinator
Robert Siegel, MD	Pathology	
James York, MD	Radiology	

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