Oncology
Annual Report

2010

Cancer Committee Chairman Report 2010

The cancer care program at Gwinnett Medical Center experienced further growth and expansion of services to the Gwinnett area and surrounding communities.

A dedicated full time oncology research nurse joined the cancer care team, thus providing local access to cutting-edge and innovative treatments and clinical trials through participation in the Atlanta CCOP..

The lymphedema services initiated an oncology rehabilitation program that helps patients cope with and relieve the side effects that often accompany cancer treatment. The Outpatient Treatment Center opened 10 new rooms available for infusions and other outpatient treatments, increasing access and comfort for our patients.

The cancer program initiated a number of support and educational programs for the community. These included Look Good, Feel Good classes for women, distribution of free screening colon kits and began hosting a women's cancer support group. Fresh Start Smoking Cessation classes were held to help and encourage those striving to lower their risk of cancer. Educational displays were featured in the hospital cafeteria to share preventative care information with staff and visitors. Furthermore the cancer committee had a Patient Resource Navigator from the American Cancer Society present at its meetings, and the hospital continued to be a prominent sponsor of Gwinnett Relay for Life.

Among the quality initiatives undertaken were participation and completion of the NCBC quality initiative and RQRS data collection and dissemination. The multidisciplinary cancer program at GMC was honored by accreditation from the NAPBC.

Our healthcare professionals, staff and volunteers work tirelessly to meet the needs of the growing greater Gwinnett community, providing compassionate and state-of-the art diagnostic, therapeutic and supportive care services close to home.

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, home and/or immunotherapy) and follow-up (annual information concerning treatment, recurrence and patient status).

In 2009, the ODC processed 1,293 analytic cases (patients diagnosed since the reference date and/or all of the first course of treatment for diagnosed elsewhere and all or part of the first course of therapy at GMC) and 248 non-analyitc cases (diagnosed elsewhere and received all of the first course of treatment elsewhere and seen at hospital now with active disease). The top three womens cancers in 2009 were breast, lung and thyroid gland. The top three mens cancers in 2009 were lung, prostate and bladder. All four of the associates in the ODC are Certified Tumor Registrars.

The Oncology Data Center 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 common cancer among women, excluding cancer of the skin, accounting for nearly one of every three cancers diagnosed in American women. During a women's lifetime, there is a 1 in 8 chance of developing breast cancer. Knowing if one is at risk of developing breast cancer is an essential part of one's breast health. Discovering if risk factors are present is key to preventing or indentifying breast cancer early. For this reason, in November 2010, the Gwinnett Breast Center's breast imaging program included a mammogram with something more, a breast cancer risk assessment utilizing the National Cancer Institute's (NCI) breast cancer risk assessment tool (BCRAT). The NCI BRAT is used to determine a five-year and lifetime risk of developing breast cancer based on one's age and the questionnaire that is completed at the time of one's mammogram.

The risk assessment provides the patient and her physician with information to plan an individualized breast healthcare plan. Recommendations are based on one's lifetime risk percent. Women at high risk (greater that 20 percent lifetime risk) should get an MRI and a mammogram every year. Women at moderately increased risk (15 - 20 percent lifetime risk) should talk with their doctors about the benefits and limitations of adding MRI screening to their yearly mammogram. Yearly MRI screening is not recommended for women whose lifetime risk of breast cancer is less that 15 percent. Women at high risk include those who have a known BRCA1 or BRCA2 gene mutation, have a first-degree relative (parent, brother, sister or child) with a BRCA1 or BRCA2 gene mutation and have not had genetic testing themselves, have a life time risk of breast cancer of 20 - 25 percent or greater, according to risk assessment tools that are based mainly on family history, have had radiation therapy to the chest when they were between the ages of 10 and 30 years, or have Li-Fraumeni syndrome, Cowden syndrome or Bannayan-Riley-Ruvalcaba syndrome or have one of these syndromes in first-degree relatives.

If MRI is used, it should be in addition to, not instead of, a screening mammogram. This is because although an MRI is a more sensitive test, it may still miss some cancers that a mammogram would detect. It is recommended that women who get a screening MRI do so at a facility that can perform an MRI-guided biopsy if needed. American Cancer Society and the Gwinnett Breast Center advocate the use of mammograms, MRI (in women at high risk), clinical breast exams and finding and reporting breast changes early offers women the best chance to reduce their risk of dying from breast cancer.

Kimberly Hutcherson, MD

2005 and 2009 GMC Breast Data

There were 236 analytic breast cases in 2005, and 295 analytic breast cases in 2009. This is an increase of 20 percent in a five year period. The ages for 2005 range from 30-39 to 90+. The ages for 2009 range from 0-29 to 80-89. See Graph 1.

Graph 1

Age	2005	2009
0-29	0	1
30-39	15	18
40-49	57	68
50-59	76	74
60-69	49	75
70-79	25	49
80-89	12	10
90+	2	0

Graph 2

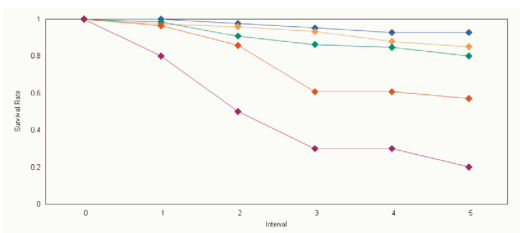
Stage	2005	2009
0	59	69
1	90	119
2a	43	48
2b	10	20
3a	3	11
3b	5	3
3c	4	4
4	7	13

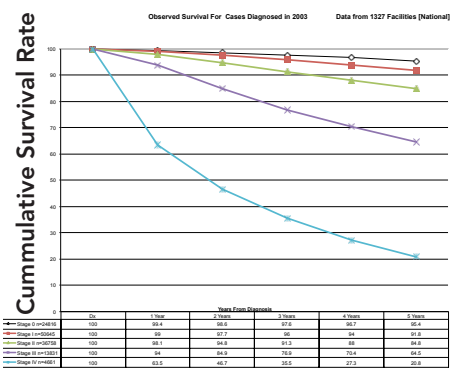
Graph 3

Initial Treatment	2005	2009
C		3
D		30
DC		6
DCH		1
DRC		2
DS	42	56
DSC	23	29
DSCH		9
DSH	9	22
DSR	21	9
DSRC	11	12
DSRCH		14
DSRH	18	36
P		1
S	31	24
SC	15	8
SCH		2
SH		5
SR	16	8
SRC		5
SRCH		7
SRH	14	15

The biggest age range for 2005 is 50-59. While the biggest age range in 2009 is 60-69. In Graph 2 we see the range of stage at initial diagnosis for the 2005 and 2009 analytic cases. In both years, AJCC Stage 1 was the most diagnosed stage at diagnosis.This means we are diagnosing our breast cancers at lower stages which is a better outcome from their diagnosis. Graph 3 shows the first course of treatment for the breast cancer – (C-chemo, D-biopsy, H-hormone, R-radiation therapy, S-surgery and P-palliative care). The most common treatment plan in 2009 was biopsy and surgery. The most common initial treatment in 2005 was also biopsy and surgery. GMC and NCDB have similar outcomes.

5 Year Survival for Breast Cancer





Bladder Cancer

In the United States in 2010, there was approximately 69,000 new cases of bladder cancer and 15,000 deaths. Bladder cancer is typically diagnosed in older individuals, with most common age at diagnosis of 69 years in men and 71 in women. There are racial and ethnic variations in bladder cancer incidence. In the United States, white males have the highest risk with almost twice the incidence seen in African-American and Hispanic men. Smoking is the most important factor contributing to the overall incidence of urothelial cancer in western countries. Chemical exposures at the workplace and an increased risk of urothelial cancer are thought to account for approximately 10 to 20 percent of bladder cancers.

At Gwinnett Medical Center there are about 50 patients diagnosed with bladder cancer each year. Most patients are in the earlier stages of cancer. Gwinnett Medical Center offers a multidisciplinary, well trained team of urologists, oncologists and radiation oncologists, in addition to state-of-the-art facilities and cutting edge technology for early diagnosis and treatment of bladder cancer with outcomes comparable to national average.

Aldemar Montero, MD

2005-2009 Analytic Bladder Cancer

In 2005, there were 31 men with bladder cancer and 12 women with bladder cancer making 43 total. In 2009, there were 39 men with bladder cancer and 14 women with bladder cancer. This is a 20 percent increase over 5 years.

Graph A shows the breakdown in age for 2005 and 2009 analytic bladder cancer. As you can see in both years the highest number of patients diagnosed is in the 60-69 age range. Graph B shows 2005 and 2009 by AJCC Stage, as you can see both years Stage 0 was the highest diagnosed stage with Stage 1 coming in second.

In Graph C you see Initial Treatment by year – (D – biopsy, C-chemo, R-radiation therapy, I-immunotherapy). As you can see, the majority of patients received surgery as their initial treatment. GMC and NCDB have similar outcomes.

Graph A

Age	2005	2009
0-29	0	1
30-39	0	0
40-49	1	2
50-59	4	4
60-69	6	10
70-79	3	5
80-89	3	3
90+	0	0

Graph B

Stage	2005	2009
0	17	25
1	12	13
2	10	0
3	0	3
4	4	0

Graph C

Initial Treatment	2005	2009
SRC	1	0
D	1	4
DC	1	0
DS	0	4
DSC	0	2
DSI	0	2
S	34	35
SC	4	5
SCI	1	1
SI	1	2
DSRC	1	0
None	1	0

5 Year Survival for Bladder Cancer