2008

Oncology

Annual Report

From the Cancer Committee Chair

The Cancer Committee of Gwinnett Medical Center 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 (ARCCOP), 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

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 cancer (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 1,320 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 male and 762 were female. The majority of patients were from Gwinnett County (72.7%), while other patients traveled from Walton County (5.8%), Barrow County (5.0%), Dekalb County (3.3%), Jackson County (2.7%) and other counties (10.6%).

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

Breast Cancer Update

Breast cancer is the most commonly diagnosed cancer for women in the United States—this year, alone, more than 180,000 women will be diagnosed. During a woman's lifetime, there is a one in seven chance of developing this form of cancer. While most cases of breast cancer have no identifiable cause, researchers are learning more and more every day about early detection methods and tactics for prevention.

Breast MRI is the latest tool in the ongoing effort for earlier detection. Breast MRI is able to find certain breast cancers that may go undetected by conventional mammography. Women who benefit from this tool more than others may include those who are young, have had a prior breast surgery or have dense breast tissue.

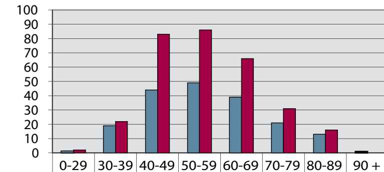
Progress has also been made in breast cancer prevention. The study of Tamoxifen and Raloxifene (STAR) trials, which was made available to Gwinnett Medical Center patients, proved that Evista was as beneficial as Tamoxifen for breast cancer prevention with fewer side effects. Data showing that Zoledronate prevented recurrences in women with a history of breast cancer (when combined with hormonal therapy) was also released in 2008.

Women being treated for breast cancer at GMC have access to the best clinical trials from across the nation. One such trial is US Oncology's 06900 trial, which is investigating whether Adriamycin (doxorubicin) can be replaced by less toxic alternatives. Another is the Roche B020289 trial, which has been exclusively designed for triple-negative breast cancer, a form of the cancer that does not respond to hormonal 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, Hematology/Oncology

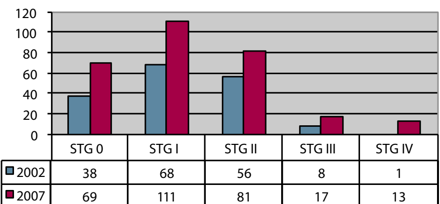
GMC Breast Cancer Statistics

Breast Cancer / Age at Diagnosis



	0-29	30-39	40-49	50-59	60-69	70-79	80-89	90 +
2002	1	19	44	49	39	21	13	1
2007	2	22	83	86	66	31	16	0

2002 and 2007 Analytic Breast Cases



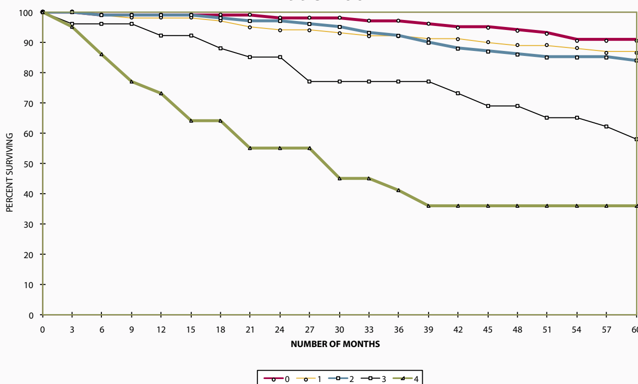
	STG 0	STG I	STG II	STG III	STG IV
2002	38	68	56	8	1
2007	69	111	81	17	13

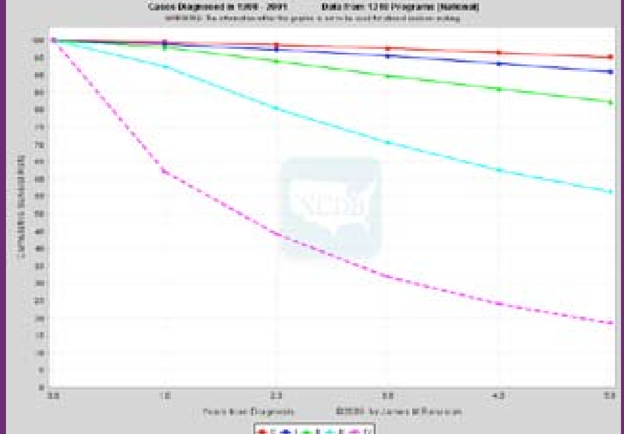
In 2007, Gwinnett Medical Center saw 306 analytic breast cases, 187 more than in 2002. Of those 306 cases, 69 were Stage 0 (24%), 111 were Stage I (38%), 81 were Stage II (27%), 17 were Stage III (6%) and 13 were Stage IV cases (5%).

The breakdown for the 171 cases in 2002 was 38 Stage 0 (22%), 68 Stage I (40%), 56 Stage II (32.5%), 8 Stage III (5%), and 1 Stage IV (.5%). In both 2002 and 2007, the most diagnosed age group was 50-59, with 40-49 coming second. The initial therapy for cases in 2007 was 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.

GMC's survival data compared favorably with that of the National Cancer database.

GMC Breast Cancer Survival - AJCC Stage
1998-2001





Colon Cancer Update

The American Cancer Society estimates there were approximately 108,000 cases of colon cancer and 40,700 cases of rectal cancer in 2008. More than 3,700 cases of colorectal cancer were predicted for the state of Georgia in 2008, making this the third most common malignancy in both men and women across the state. Fortunately, the incidence rate for this disease has been decreasing for the past two decades (from 66.3 cases per 100-thousand population 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 ACS 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, as well as colonoscopy or sigmoidoscopy. Other risk factors include advanced age, 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 five-year survival is 90%.

The physicians and staff of Gwinnett Medical Center 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

GMC Colon Cancer Statistics

2002 vs 2007 GMC Analytic Colon by Stage

	AJCC 0	AJCC I	AJCC II	AJCC III	AJCC IV
2002	9	16	26	31	10
2007	17	14	24	30	17

2002 vs 2007 Analytic Colon age

	0-29	30-39	40-49	50-59	60-69	70-79	80-89	90 +
2002	1	3	19	20	21	19	15	1
2007	0	1	14	26	28	17	21	5

In 2007, Gwinnett Medical Center saw 112 analytic colon cases, 13 more than in 2002. Of those cases, 17 were AJCC Stage 0, compared to only 9 in 2002. There were 14 Stage I cases in 2007, compared to 16 in 2002. There were 24 Stage II cases, compared to 26 in 2002. There were 30 Stage III cases, compared to 31 in 2002, making it the highest stage group in both years. And there were 17 Stage IV cases, compared to just 10 in 2002.

In 2007 there were 52 males and 60 females, in 2002 there were 52 males and 47 females. The highest age group for 2007 and 2002 was 60-69.

The initial therapy for 2002 patients was as follows: 64.6% had surgery; 26.3% had surgery and chemotherapy; 6.1% had no treatment; 2.0% had surgery, radiation therapy and chemotherapy; and had 1.0 % chemotherapy. The initial therapy for 2007 analytic colon patients is as follows: 61.6% had surgery; 29.5% had surgery and chemotherapy; 7.1% had no treatment; and 1.8% had chemotherapy.

GMC's survival data compared favorably with that of the National Cancer Data Base.

GMC Colon Cancer Survival - AJCC Statistics
1998-2001

PERCENT SURVIVING
NUMBER OF MONTHS
0 1 2 3 4

Observed Survival For Colon

GMC Cancer Committee had the following goals:

- Outpatient and inpatient oncology services will work collaboratively to assure the same standard of care for cancer patients.
- There will be 7 Outreach programs in 2008 including Breast (Care-A-Van), Breast (Breast Health Services), Genetics (Breast and Ovary), Colon screening kits, Smoking Cessation, ACS information at Employee benefits fair, and Prostate Screening.
- Recruit a Patients Resource Navigator for all cancer sites through collaboration with the American Cancer Society.
- Continue to improve data collected with the CoC data studies which include Breast and Colon.

Comparison of GMC with the state of Georgia and national numbers of new (estimated) numbers for 2007

2007	GMC	Georgia (est)	National (est)
All sites	1322	35,440	1,444,920**
Breast (F)	305	4,520	178,480**
Colon/Rectum	169	3,690	153,760**
Prostate	132	5,850	218,890**
Lung Bronchus	161	55,780	213,380**
Thyroid	66	n/a	33,550††

** Source: American Cancer Society Cancer Facts & Figures
†† Source: American Cancer Society Facts & Figures

2008 Cancer Committee Members

Physician Members	Speciality	Position
John Gargus, MD	Radiation Oncology	
James Hamrick, MD	Hematology/Oncology	
Kimberly Hutcherson, MD	Radiology	
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 Salmieir, DO	GYN Oncology	Vice- Chair
Philip Shrake, MD	Radiation Oncology	Cancer Conference Coordinator
Robert Siegel, MD	Pathology	
James York, MD	Radiology	

Associate Members	Title/Department
Beth Ladd, RN, BSN, MS	Clinical Research Nurse
Chuck Christie, M. DIV., BCC	Chaplain
Cindie Lou Roger, MSN, RN, BC, ANP, BC, AOCN	Pain Management Clinical Nurse Specialist
Cindy Snyder, RN, MSN, FNP-C	Manager, Oncology Services/Cancer Risk Counselor
Deborah Cotterell	Social Worker, Coordinated Care
Debra Fortier, RHIA, CTR	Coordinator, Oncology Data Center
Debra Nichols, APRN, BC	Clinical Nurse, SummitRidge
Donna Hyatt, RN, BSN, CHPN	Palliative Care Coordinator
Jamila Brown, BS ED, CHES, CTR	Health Education Specialist
Jessie Davis	Marketing
Kim Albertson, RN	Assistant Unit Manager, 8th floor
Laura Shafer, RNC, BSN, CWOCN	Director, Wound Treatment Center and Inpatient Wound Care/WOCN's
Laura Tucker, RN	VP, Speciality Service Line
Mary George, Pharm. D., BCNP	Clinical Pharmacist
Rita Michael, R.N., B.S., CPHQ	Performance Improvement Coordinator
Ron Corder	VP of Clinical Services
Samantha Cannon, MSOT/L-CLT	Lymphedema Therapy
Stella Chambers	Supervisor, Imaging
Tracie Johnson	Clinical Nutrition Manager
Vickie Mewborn-Waits, RN	Clinical Manager, Nursing Administration

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published 12/2008

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