The mission of Abington Memorial Hospital’s Rosenfeld Cancer Center is to promote a coordinated, multidisciplinary cancer program that provides high-quality, accessible, compassionate and cost-effective care to our community.
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The data contained in this report is for the time period January 1, 2008 to December 31, 2008.
Program Achievements in 2008

1 The Rosenfeld Cancer Center continued operations in 2008 with full service in medical oncology, gynecologic oncology, radiation oncology and surgical oncology.

2 Two patient care evaluations were performed in 2008. These included a longitudinal care study of gastric cancer cases in 2001 entered into the tumor registry, results of which were reported in The Rosenfeld Cancer Center 2008 Annual Report. In addition, a quality-of-care study of breast cancer was reported utilizing the Commission on Cancer’s electronic quality improvement packet (e-QuIP) quality indicators for 2006 data. Results of this study were published in OnCare Report, the Cancer Center’s newsletter. In addition, two patient care enhancement projects were performed in 2008. All of these evaluations and projects were first approved by Abington Memorial Hospital’s Cancer Committee and then reviewed by the committee after completion.

3 Physician and nursing education programs continued in 2008. These included a monthly oncology journal club, an invited oncology professor program with updates on new developments in cancer care and presentations at the annual update for primary care physicians as well as monthly department meetings. The quarterly OnCare Report continued to be published and distributed to all members of the medical staff.

4 Community cancer screening programs continued with planning and execution by the Abington Memorial Hospital Cancer Education Committee. These included twice-a-year breast cancer, skin cancer and prostate cancer screenings, as well as community education programs associated with the screenings.

5 Weekly tumor conferences continued in 2008 with disease-specific conferences in breast cancer, lymphoma and leukemia, GI malignancies, GU malignancies, pulmonary malignancies, endocrine malignancies, neurological, gynecological and general conferences for all other malignancies.

6 A cancer risk assessment program continued in 2008 for breast, ovarian and colon cancers with steadily increasing participation by members of the community at no cost.

7 In 2008, five patients were entered on trials through the Radiation Therapy Oncology Group (RTOG), five on Eastern Cooperative Oncology Group (ECOG), two on The North Central Cancer Treatment Group (NCCTG), one on genetic risk and four other oncology protocols. In addition, 50 patients were entered on Gynecology Oncology Group or Gynecologic Oncology Institute in-house protocols. A total of 67 patients were entered on cancer clinical research protocols in the past year.
Abington Memorial Hospital Cancer Committee

John Redmond, III, M.D.
Director, The Rosenfeld Cancer Center
Chief, Division of Medical Oncology
Fellow, American College of Physicians

Willard G. Andrews, III, M.D.
Associate director, Cancer Care Services for Clinical Research
Principal investigator, ECOG
Staff member, Medical Oncology Division

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Cancer registrar

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Cancer data manager

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Betty Cummings, R.N., M.S.N.
Breast cancer navigator

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Linda Griska, M.D.
Director of breast health

Maurice Gross, M.D.
Staff member, Family Medicine Department
Medical director, Hospice Program

Parviz Hanjani, M.D.
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Principal investigator, GOG

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Cancer information and referral specialist
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Staff member, Urology Division

Jere F. Seelaus, M.D.
Staff member, Radiology Department

Barbara Wadsworth, R.N., M.S.N., M.B.A.
Senior vice president, Patient Services
Chief nursing officer
**Medical Oncology and Hematology**

Fifteen board-certified physicians provide the full range of medical oncology direct care and consultative cancer services. Facilities are available for both inpatient chemotherapy (in a 27-bed Oncology Unit) and outpatient chemotherapy.

Willard Andrews, M.D., is the principal investigator for ECOG research studies.

**Cancer Research**

The Rosenfeld Cancer Center participates in clinical trials in the areas of prevention and treatment through the Eastern Cooperative Oncology Group (ECOG), Gynecology Oncology Group (GOG) under direction of Gynecologic Oncology Institute, Alpha Oncology, Radiation Therapy Oncology Group (RTOG) and American College of Surgeons Oncology Group (ACOSOG). The Rosenfeld Cancer Center also belongs to the Cancer Trials Support Unit (CTSU), a coordinating body for various research groups, giving AMH even more access to clinical trials.

**Surgical Oncology**

Surgery is a mainstay in the treatment of cancer. Abington Memorial Hospital offers a full range of options in general surgery, neurosurgery, oral/maxillofacial surgery, orthopaedics, otolaryngology, plastic and reconstructive surgery, thoracic surgery, urology and full colorectal service.

**Gynecologic Oncology**

The management of gynecologic cancer patients and the teaching of residents and medical students is provided by the Gynecologic Oncology Institute of Abington Memorial Hospital. The institute is under the direction of Parviz Hanjani, M.D., board-certified gynecologic oncologist. In addition to the director are two staff physicians, Mark S. Shahin, M.D., and Mitchell Edelson, M.D., both board-certified gynecologic oncologists.

The Gynecologic Oncology Institute is actively involved in extensive clinical research and is a full member of the GOG cooperative research organization funded by the National Cancer Institute (NCI). The institute is a major contributor of clinical research to the GOG with an outstanding record and is highly respected. Susan Nolte, C.R.N.P., Ph.D., is director of clinical research at the institute, and three full-time registered nurses are involved in clinical research, in-house and GOG protocols and all aspects of patient care.

**Radiation Oncology**

The Division of Radiation Oncology offers state-of-the-science care using the most contemporary technology staffed by three board-certified radiation oncologists.

**Prostate Brachytherapy**

Prostate brachytherapy, a program of ultrasound-guided percutaneous implantation of radioactive iodine or palladium, is being used extensively for eligible patients with early-stage prostate cancer.

**Pain Management Services**

The Department of Anesthesiology provides both inpatient and outpatient pain management services for complex oncologic needs.

**Breast Imaging Services**

The Mary T. Sachs Breast Center is located at the Abington Health Center—Schilling Campus in Willow Grove. Breast ultrasound and mammograms are available, as well as pre-operative needle localization. Stereotactic breast biopsies and ultrasound-guided biopsies are performed on the same campus to provide consolidated breast diagnostic procedures.

Magnetic resonance imaging (MRI) of the breast and MRI-guided biopsies are available at the hospital’s main campus.
Nuclear Medicine
Basic nuclear medicine diagnostic examinations involved in the detection and follow-up of cancer patients are performed. These studies include bone scans, PET scans, thyroid scans, thyroid whole-body imaging, liver scans, and gallium, sestamibi and thallium tumor imaging studies.

Thyroid Cancer
The Division of Endocrinology and the Nuclear Medicine section of the Radiology Department provide diagnostic and therapeutic care for patients with nodular disease of the thyroid and thyroid cancer.

Interventional Radiology
The Department of Radiology continues to offer the most current diagnostic, therapeutic and palliative technologies for the care of cancer patients through its section of Interventional Radiology. Interventional Radiology provides vascular access, diagnostic biopsies, thrombolytic therapy and drainage or stenting of pathways such as blood vessels or bile ducts compromised by tumors.

Cancer Rehabilitation
The comprehensive cancer rehabilitation program is designed to provide all Abington Memorial Hospital inpatients and outpatients with comprehensive, interdisciplinary care for impairments related to the direct and indirect effects of cancer and its treatment. In addition, the prevention and treatment of post-surgical lymphedema is carried out in a specialized program.

Inpatient Oncology Unit
Abington Memorial Hospital provides a multidisciplinary approach to the treatment of patients in its 27-bed inpatient Oncology Unit. The team consists of medical and gynecological oncologists, chemotherapy-certified oncology nurses, oncology social workers, an oncology case manager, an oncology clinical dietitian and chaplains.

Hospice Program
The Hospice Program of Abington Memorial Hospital provides skilled and supportive hospice care services to patients and their families. Care is primarily based in the patient’s home, enabling the patient to remain at home with care directed toward comfort measures. Inpatient level of care for symptom management is provided at Abington Memorial Hospital in a dedicated 4-bed unit and inpatient, residential and respite hospice care is provided at Abington Hospice at Warminster Abington Health Center—Warminster Campus with 19 beds. Safe Harbor, a free bereavement care program, is available for children, adolescents and their families to help deal with the loss of a parent or loved one.

Cancer Registry
The Cancer Registry at Abington Memorial Hospital is an information system designed for the collection, management and analysis of data on patients with the diagnosis of a malignant or neoplastic disease. All information obtained is forwarded to the Pennsylvania Cancer Registry and the National Cancer Data Base. A total of 2,093 abstracts were submitted for 2008.
Tumor Boards
A variety of sites and cases are discussed, and representatives from the Medical Oncology, Pathology and Radiation Oncology divisions, as well as General Surgery, Internal Medicine and Family Medicine departments attend these conferences.

Cancer Evaluation Services
The Rosenfeld Cancer Center’s Evaluation Services provide a team approach to prospective treatment planning at the initial time of diagnosis of a malignancy and at any point along the continuum of care.

Abington Memorial Hospital offers evaluation services free to patients and to members of the community who are not patients of Abington Memorial Hospital, yet are interested in the team’s opinion for the following malignancies:
—breast,
—gastrointestinal/colorectal,
—hepatobiliary,
—gynecologic oncology,
—lymphoma/leukemia,
—pulmonary,
—solid tumor,
—neurological,
—thyroid and
—urological.

Breast, Ovarian and Colon Cancer Risk Assessment and Genetic Testing
Abington Memorial Hospital’s Rosenfeld Cancer Center offers the Breast, Ovarian and Colon Cancer Risk assessment program for patients and members of the community who may be at risk for developing breast, ovarian and colon cancer. Patients and families participating in the program may be eligible for high-risk surveillance studies and genetic testing.

Cancer Information Helpline and Referral Service
In 1995, Abington Memorial Hospital instituted a Cancer Information Helpline and Referral Service, 800-405-HELP. This free, confidential service is staffed by an oncology clinical nurse specialist.

Cancer Education and Screening Activities
The Abington Memorial Hospital Cancer Education Committee, a subcommittee of the Cancer Committee, organizes and supervises a vast range of programs in the areas of staff, patient and community cancer education, screening and early detection. The members of this multidisciplinary institution-wide committee volunteer their time and expertise to offer the community these valuable free services.

The cancer sites chosen reflect both the most frequently occurring cancers in the community, and those for which there are low-cost, effective screening techniques.
—Breast cancer education and screening programs
—Prostate cancer screening programs
—Skin cancer screening
—Professional education
Cancer Support Services

A number of support groups and services are available to patients and their families to assist them in coping with the psychosocial impact of living with cancer. There is a great need and demand for these services throughout the continuum of diagnosis, treatment, disease management, recovery and terminal care. These services include:

— cancer support group,
— breast cancer support group,
— oncology social work,
— oncology dietitian,
— Look Good, Feel Better: a skin and cosmetic makeover session for cancer patients co-sponsored by the American Cancer Society,
— pastoral care services,
— grief recovery support groups,
— Reach to Recovery and
— Man to Man.

This annual report was approved on September 17, 2009 by the Cancer Committee of Abington Memorial Hospital.
<table>
<thead>
<tr>
<th>ICD-0 SITE</th>
<th>ANALYTIC*</th>
<th>NON-ANALYTIC**</th>
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### ICD-0 SITE

<table>
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<th>ICD-0 Site</th>
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<th>Non-Analytic**</th>
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<td>C64 Kidney</td>
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<td>C66 Ureter</td>
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<td>C68 Other Urinary Organs</td>
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<td>C71 Brain</td>
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<td>C72 Other Central Nervous System</td>
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<td>C77 Lymph Nodes</td>
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<td>C80 Unknown Primary Site</td>
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<tr>
<td><strong>Total</strong></td>
<td>1833</td>
<td>260</td>
<td>203</td>
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</table>

* Analytic cases include all cancer patients diagnosed at Abington Memorial Hospital who received their first course of treatment here or elsewhere, and all patients diagnosed elsewhere who received all or part of their first course of treatment here.

** Non-analytic cases include cancer patients who were diagnosed elsewhere, and received all of their first course of treatment elsewhere.

### AMH Tumor Registry

Number of new cases

![AMH Tumor Registry Chart](chart.png)
Breast Cancer Analysis—2008 Data

New breast cancer cases increased between 2007 and 2008 (from 306 to 332) at The Rosenfeld Cancer Center at Abington Memorial Hospital (AMH). The stage distribution of breast cancer is also very consistent from 2004 to 2008. In 2008, 24% of patients had stage 0 disease (intraductal carcinoma) as compared to 18.9% in the National Cancer Data Base (NCDB) and 22.9% at AMH in 2007. Fully 57% of patients had stage I or II disease which compares with 62% in the NCDB series and 60% in 2007. The incidence of stage III, IV disease was 7.5% and 5.1% respectively and very similar to the NCDB series (9.1% and 3.2%).

In 2008, 63% of patients at AMH had lumpectomy with radiation or lumpectomy alone followed by additional therapy. Only 8.7% of patients underwent a modified radical mastectomy and 15% had a simple mastectomy. In the NCDB data from 2006 only, 36.3% of patients had lumpectomy with radiation and 16.5% of patients had modified radical mastectomy. Thus the rate of breast preservation at The Rosenfeld Cancer Center is well above the national average. The large number of new breast cancer cases at AMH in 2008 (over 300 new cases a year) reflects the comprehensive breast cancer program which includes fast-track diagnosis program at the Mary T. Sachs Breast Center, multidisciplinary management at the weekly Breast Cancer Evaluation Service conferences, a patient-oriented nurse coordinator and state-of-the-art National Comprehensive Cancer Network (NCCN) treatment protocols.
Colon Cancer Experience

Historical experience
Number of new cases

AJCC stage grouping
Percentage of cases

Primary treatment
Percentage of all cases
Colon Cancer Analysis—2008

New cases of colon cancer remained stable at The Rosenfeld Cancer Center at Abington Memorial Hospital (AMH) over the past year with 130 cases in 2008, compared to 132 in 2007. The distribution of stage of colon cancer at AMH was compared to that reported by the 2006 NCDB database. At AMH, 5.4% of patients and 6.8% in the NCDB presented with stage 0 (in situ) disease. Further 19.2% of patients at AMH and 19.5% in the NCDB presented with stage I, and 30.8% of AMH patients and 24.2% NCDC patients with stage II. In addition, 26.2% of AMH patients presented with stage III disease and 22.4% in the NCDB. Patients with stage III disease are candidates for adjuvant chemotherapy which significantly improves the five-year, disease-free survival rate. In 2008, 13.8% of patients in the AMH and 16.8% in the NCDB series had stage IV disease with the majority of patients having liver metastases alone or liver and other metastases.

In 2008, 85% of patient at AMH and 84% of patients in the NCDB had colectomy with or without chemotherapy. The stage distribution and treatment results have been stable for years.
Lung Cancer Analysis—2008 data

New cases of non-small cell lung cancer (NSCLC) increased in 2008 (192 in 2008 compared to 172 in 2007). Cases of small cell lung cancer (SCLC) declined to 18 in 2008, compared to 25 the previous year.

The distribution of cases of NSCLC by stage has changed only slightly over the past five years and is very similar to that reported from the NCDB. In 2008, 19.8% of cases at The Rosenfeld Cancer Center at Abington Memorial Hospital (AMH) had stage I-II disease with a high chance (over 50%) of cure with surgical resection. This compares to 29.7% of cases reported in the NCDB with stage I or II disease in 2006. At AMH, 10.4% of patients presented with stage IIIA and 22.4% with stage IIIB in 2008, as compared to 23.2% in NCDB series with both stage IIIA and IIIB. Recent reports encourage the use of combined chemotherapy and radiation for these patients with a doubling of the two-year freedom from progression and survival intervals. Unfortunately, the number of patients presenting with stage IV disease increased to 42.2% in 2008 compared to 31.8% of cases in 2007. The NCDB data showed 34% presenting with stage IV disease. The advanced stage presentations—75% of patients with stage III or IV disease in 2008 at AMH—are reflected in the low five-year, disease-free survival rate overall for lung cancer (between 10% to 20%).
Prostate Cancer Analysis—2008 data

New prostate cancer cases were similar between 2007 and 2008 (229 and 220 respectively). This followed an increase from 2006 (177 cases) and in part was felt to reflect new technologies at The Rosenfeld Cancer Center at Abington Memorial Hospital (AMH) such as the daVinci® robotic surgery unit. The distribution by AJCC stage of AMH patients in 2008 showed no patients with in situ prostate cancer, 0% with stage I disease, 92% with stage II and only 2.3% with stage III and 5.9% with stage IV at presentation. This distribution is in contrast with that reported in the NCDB in which 76.3% of patients presented with stage II, 7.6% stage III, 4.7% stage IV and 10.2% with unknown stage. All patients at AMH had a known stage.

With respect to treatment at AMH in 2008, 40.4% had biopsy and radiation therapy (NCDB 22.3%) and 34.5% a radical prostatectomy (40% NCDB). The increase in radical prostatectomy reflected in part the availability of robotic surgery. The majority of patients with prostate cancer are now presenting with localized disease, often detected with PSA screening by primary physicians. These patients are being offered an array of local treatment options, which include implants, IMRT radiation and robotic prostatectomy, when appropriate.
Rectal Cancer PCE

Race distribution
Percentage of cases

AMH 2002
N=37

NCDB 2002
N=22,063

* Hispanic ethnicity is merged into White per SEER criteria.

Gender distribution
Percentage of cases

AMH 2002
N=37

NCDB 2002
N=22,063

Age distribution
Percentage of cases

AMH 2002
N=37

NCDB 2002
N=22,063
Analysis: Rectal Cancer 2002 Data Quality of Care Study

The goal of this patient care evaluation was to review the diagnosis and management of cases of rectal cancer entered into the Abington Memorial Hospital Cancer Registry in 2002 and to compare them to those in the National Cancer Data Base (NCDB) for 2002 and to clinical practice guidelines in oncology provided by the National Comprehensive Cancer Network (NCCN). A total of 37 patients with rectal cancer were identified at Abington Memorial Hospital and compared to 22,063 patients in the NCDB in 2002.

The age distribution of patients was somewhat different between the two series with 84% of AMH patients and 68% of NCDB patients presenting from 60 to 80 years of age. Only 16% of patients were less than 60 years old in the AMH study and 32% in the NCDB. The male/female comparison was almost identical with 59.5% male at AMH and 58.2% in the NCDB. The racial distribution was also very similar with 86.5% Caucasian, 5.4% African American and 8.1% other at AMH and 86.4%, 8.4% and 5.2% at the NCDB.

Seven of 37 patients presented with a malignant polyp. All patients underwent colonoscopy and pathology review per NCCN guidelines. Six patients had T1N0M0 disease and were observed without additional therapy. One patient had N1 disease but died prior to chemotherapy. Thus NCCN guidelines were followed for all patients.

The stage at presentation was also quite similar between the two studies with 13.1% of AMH patients having Tis N0 M0 and 8% in the NCDB. A large group of patients in both series had stage I-II disease (40% AMH and 45% in the NCDB). Overall, 27% of AMH patients and 20% of NCDB patients had stage III disease with positive regional lymph nodes. These patients are all candidates for combined modality therapy with radiation and concurrent chemotherapy which has been shown to significantly
improve disease-free survival. Finally, 10.8% of AMH patients and 12% of NCDB patients had metastases at the time of diagnosis and were candidates for only palliative therapy. Only 8.1% of AMH patients and 14.6% of NCDB patients had unknown stage. Staging workup generally followed NCCN guidelines for all 30 patients with other than polyps. All patients underwent biopsy, pathology review and colonoscopy. Eighteen patients had CT scans, 12 patients had CEA ordered.

AMH patients with T3N0M0 disease or greater stage were generally treated with combined modality therapy: surgery, radiation and chemotherapy (43.2% as compared to 25% in the NCDB). This reflects the increasing use of combined modality therapy for patients with stage II and III rectal cancer and patients treated with neoadjuvant radiation before surgical resection. Surgery alone was performed in 27% of AMH and 36.2% of NCDB patients. Treatment was reviewed with respect to NCCN guidelines. Patients with T1-2N0M0 disease were observed. Patients with T3N0 or N-positive disease were treated with chemotherapy/radiation when able, and with patient agreement. Patients with metastatic disease were treated with combination chemotherapy and radiation if able, or hospice depending on level of function and activity. Thus NCCN guidelines were followed.

Survival data was compared between AMH and NCDB patients. The small number of patients in each stage limits interpretation of the AMH survival data. However, it was very similar to the NCDB data stage for stage. In particular, five-year actuarial survival was 66.7% for stage I patients at AMH versus 74.6% at the NCDB; stage II 44% at AMH versus 60% at the NCDB; stage III 60% at AMH versus 52% at the NCDB. There were no five-year, disease-free survivors with stage IV disease at AMH versus 6.8% at the NCDB in 2002.

In summary, the demographic distribution, staging workup, staging distribution, surgical and adjuvant treatment of patients presenting with rectal cancer was compared between AMH and patients reported from the NCDB for 2002. Workup and treatment was compared to NCCN guidelines. No discrepancies were identified for improvement.