THE MISSION OF ABINGTON HOSPITAL’S ROSENFIELD 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 annual report was approved in November 2015 by the Cancer Committee of Abington Hospital.
1 In 2014, The Rosenfeld Cancer Center provided full service in medical oncology, gynecologic oncology, radiation oncology and surgical oncology.

2 Two patient care evaluations were performed. This included a longitudinal care study of ovarian and peritoneum cancers, using 2007 data entered into the tumor registry, results of which were reported in the 2014 Annual Report. A quality of care study of lung cancer was reported utilizing the NCCN treatment guidelines for the 2012 data. In addition, two patient care enhancement projects were performed in 2014. A program enhancement resulting from these studies included increased access to a dietitian and an improved chemotherapy flow sheet in e-Clinical, the hospital’s patient medical records system. All of these evaluations and projects were first approved by our Cancer Committee and then reviewed by the committee after completion.

3 Physician and nursing education programs continued in 2014. 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. In May 2014, a Grand Rounds was presented about the topic of colorectal cancer and staging.

4 Community cancer screening programs continued with planning and execution by the Abington Hospital Cancer Education Committee. These included breast, skin and prostate cancer screenings. Community education programs were based on the population and included, but were not limited to, high school students and residents of retirement communities.

5 Weekly cancer conferences continued in 2014 with disease-specific conferences in breast cancer, lymphoma and leukemia, gastrointestinal malignancies, genitourinary malignancies, gynecologic oncologic, head and neck, pulmonary malignancies, endocrine malignancies, neurological, thyroid and general conferences for all other malignancies.

6 A cancer risk assessment program continued in 2014 for breast, ovarian, endometrial and colon cancers with steadily increasing participation by members of the community at no cost.

7 In 2014, 47 patients were entered on NRG Oncology trials, seven industry sponsored and 163 on in-house medical protocols. In addition, four patients were entered on GOG or Gyn Oncology in-house protocols. A total of 221 patients were entered on cancer clinical research protocols in the past year.
John Redmond, III, MD*
Director, The Rosenfeld Cancer Center
Chief, Division of Medical Oncology
Fellow, American College of Physicians

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

Herbert Auerbach, DO
Chair, Pathology Department

Bernadette Cabry, RN, BSN, OCN
Clinical leader, The Rosenfeld Cancer Center

Andrea Cantagallo, certified tumor registrar
Cancer registrar

Ruth Clewell, certified tumor registrar
Cancer data manager

Betty Cummings, RN, MSN, OCN
Breast cancer navigator

Richard Eisenstaedt, MD
Chair, Department of Medicine

Linda Griska, MD*
Director, Breast Health

Maurice Gross, MD
Medical director, Hospice and Palliative Care Programs

Scott H. Herbert, MD
Chief, Radiation Oncology Division

WanLing Hung
American Cancer Society

Meredith Kohn, RN, MS, CS
Nurse genetic counselor

Miriam Lerner
Administrative manager, The Rosenfeld Cancer Center

Steven Levin, MD
Chief, Division of Rehabilitation Medicine

Meg McGoldrick
President, Abington – Jefferson Health

Sandy Meder, MBA
Interim Oncology Service Line Administrative Director

Linda Millevi
Director, Media Relations

Susan Nolte, PhD
Director, Center for Clinical Research

Michael Nussbaum, MD
Staff member, Surgical Oncology

Lynn O’Brien, RN, MSN*
Hospice/Palliative Care Coordinator

Mary Oleksiak, MSW
Oncology Social Service

Darshan Parekh, PharmD, BCPS
Director, Pharmacy

Christopher M. Pezzi, MD
Director, Surgical Oncology
Associate program director, Surgery
Medical director, Oncology Service Line
Cancer liaison physician, American College of Surgeons

Kelly Pressler, RN, MSN, OCN
Lung, GI & Head & Neck Cancer Navigator
Chair, Community Outreach and Education Committee

Valerie Ristvey, RPh
Lead pharmacist, Oncology

Michael Schumacher, RN, MSN, OCN
GU Nurse navigator

Michael Seidman, MD
Staff member, Medical Oncology Division

Mark Shahin, MD
Chief, Clinical Gynecologic Oncology
Acting Director, The Rosenfeld Cancer Center

Mark L. Sundermeyer, MD
Interim Chief, Medical Oncology Division

James Trainer, RN
Nurse manager, 2WW

*Retired 2015
Diagnostics
Diagnostic testing for all types of cancer is available throughout Abington – Jefferson Health. Abington is equipped with advanced diagnostic and treatment technologies. If a biopsy is indicated, Abington’s Pathology Department offers special expertise in analyzing test results with subspecialists in breast, gynecologic, gastrointestinal, lung, urologic, endocrine and hematologic (leukemia) cancers.

Breast Imaging Services
The Mary T. Sachs Breast Center is located at the Abington Health Center – Willow Grove. Breast ultrasound and mammograms are available, as well as preoperative needle localization. Stereotactic breast biopsies and ultrasound-guided biopsies are performed on the same campus to provide consolidated breast diagnostic procedures. Magnetic resonance imaging of the breast is also available at this location.

Evaluation Services
A multidisciplinary team, including surgeons, a pathologist, a radiologist, medical oncologists, a radiation oncologist and other appropriate specialists, reviews all diagnostic studies and discusses each patient’s treatment recommendations. Patients benefit from the collaborative thinking that comes from this meeting of subspecialists.

Evaluation services are available for patients with breast, gastrointestinal/colorectal/solid tumors, head and neck, gynecologic oncology, hepatobiliary, leukemia/lymphoma, neurological, pulmonary (lung), thyroid and urologic cancers.

Surgery
Our staff of board-certified surgeons is proficient in minimally-invasive laparoscopic surgery, laser surgery and traditional open surgery for cancer treatment. Their expertise includes a full range of procedures, from the most frequent types of cancer surgeries to surgical treatments for more rare forms of the disease. Certain cancer surgeries may be conducted using a robotic surgical system. Our advanced operating suites are outfitted with the most technologically up-to-date equipment.

Medical Oncology
Board-certified medical oncologists manage the full range of Medical Oncology services, including chemotherapy, targeted therapy and hormone therapy.

Gynecologic Oncology
The management of gynecologic cancer patients and the teaching of residents and medical students are provided by the Hanjani Institute for Gynecologic Oncology at Abington Hospital. The Institute is under the direction of Mark Shahin, MD, board-certified gynecologic oncologist. In addition to the director are three other physicians, Parviz Hanjani, MD, Mitchell Edelson, MD and Elizabeth R. Burton, MD, all board-certified gynecologic oncologists.

The Institute is actively involved in extensive clinical research and is a full member of NRG Oncology, a national cooperative research organization funded by the National Cancer Institute (NCI). The Institute is a major contributor of clinical research to NRG Oncology with an outstanding record.

Susan Nolte, CRNP, PhD, director, Center for Clinical Research, promotes research throughout the organization and oversees all of the research activities in the Institute. Three full-time registered nurses are involved in clinical research, in-house and NRG Oncology protocols and all aspects of patient care. Parviz Hanjani, MD is the principal investigator for NRG Oncology.

Radiation Therapy
The Radiation Therapy Program received the highest honor for patient safety and quality with the accreditation in oncology from the American College of Radiology and the American Society for Radiation Oncology.

With our advanced technology, the Radiation Oncology Department is able to offer patients the following:
- Accelerated Partial Breast Irradiation
- Calypso GPS for the Body
- Intensity Modulated Radiotherapy (IMRT)
- Image-Guided Radiotherapy (IGRT)
- Stereotactic Body Radiotherapy
- Stereotactic Radiosurgery

Interventional Radiology
Interventional radiologists can evaluate and remove cancer, or lessen its effects, without traditional open surgery. Interventional radiology aids diagnosis by enabling samples to be taken for analysis while avoiding damage to nearby blood vessels or organs. Similarly, treatment delivered by Interventional Radiology attacks cancer in targeted locations without affecting healthy areas.
At The Rosenfeld Cancer Center, several interventional radiology procedures are used in cancer treatment. Some are used against the cancer itself. A few treat symptoms caused by the disease or facilitate care.

- Radiofrequency ablation
- Cryoablation
- Microwave ablation
- Chemoembolization
- Kyphoplasty or vertebroplasty
- Biliary draining and stenting

**Clinical Trials**
The Rosenfeld Cancer Center participates in clinical trials in the areas of prevention and treatment primarily through NRG Oncology, a national cooperative group under the auspices of the National Cancer Institute. Parviz Hanjani, MD is the principal investigator and Willard Andrews, MD and Wayne Pinover, DO are co-principal investigators. In addition, several industry-sponsored trials are conducted annually. The Center for Clinical Research, under the direction of Susan Nolte, PhD, provides regulatory and research oversight for all oncology clinical trials.

If patients of The Rosenfeld Cancer Center have other healthcare needs that do not fall within the realm of cancer treatment, there are a variety of specialists who can be consulted for their expertise. The Abington Hospital medical staff is comprised of 1,100 physicians, all of them board certified in their area of expertise.

**In an Emergency**
Cancer patients can be confident knowing that if they need emergency care during their treatment, Abington Hospital’s Emergency Trauma Center (ETC) is available 24 hours a day, seven days a week. Emergency room physicians will have access to the patients’ medical records so that there is a continuity of care.

**Cancer Rehabilitation**
The comprehensive cancer rehabilitation program is designed to provide all Abington 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 postsurgical lymphedema is carried out in a specialized program.

**Inpatient Oncology Unit**
Abington Hospital provides a multi-disciplinary approach to the treatment of patients in its 27 private 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.

**Palliative Care Services**
Palliative Care Services are available to patients with advanced medical illness, especially chronic and progressive life-limiting conditions. This specialized team of physicians, nurses, social workers, a pharmacist and a chaplain focuses on meeting patients’ and families’ medical, emotional and spiritual needs while working with the entire healthcare team. The team provides expert pain and symptom management and focuses on open communication in difficult situations, as well as recognition of individual choices throughout serious illness. Palliative care services are available to patients of Abington Hospital and Abington – Lansdale Hospital, as well as to patients and their families in long term care settings. Palliative Care is also provided to patients at home by specially trained nurses in pain and symptom management and social workers for support and community resources.

**Hospice Program**
Abington’s Hospice provides skilled and supportive end-of-life care to patients and their families. Care is primarily based in the person’s home, enabling him or her to remain close to family and friends with care directed toward comfort measures. If necessary, inpatient care for symptom management is provided at Abington Hospital or Abington – Lansdale Hospital. Inpatient residential hospice care and respite care is provided in our 18-bed unit, Abington Hospice at Warminster. “Safe Harbor,” a specialized bereavement program, is available for children, adolescents and their families.

**Cancer Registry**
The Cancer Registry at Abington Hospital is an information system designed for the collection, management and analysis of data on persons 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 1,894 abstracts were submitted for 2014.

**Support**
Excellent patient care focuses on each person, not just the disease. Our cancer support services help patients and families cope with the physical, psychological, social and spiritual issues that may
accompany cancer diagnosis, treatment and recovery. In addition to support groups and other services, patient navigators are available. These navigators provide support and information to patients who are newly diagnosed or in active treatment. They answer questions, schedule appointments, help coordinate care and offer support throughout the treatment process. To connect with a navigator, call 1-800-405-HELP.

Cancer Risk Assessment Program
The 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, endometrial or colon cancer. Patients and families participating in the program may be eligible for high-risk surveillance and recommendations for studies and genetic testing.

Cancer Education and Screening Activities
The Abington 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 local 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

Abington Hospital Tumor Registry

Number of New Cases

<table>
<thead>
<tr>
<th>Year</th>
<th>Analytic and non-analytic cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>1,778</td>
</tr>
<tr>
<td>2007</td>
<td>1,946</td>
</tr>
<tr>
<td>2008</td>
<td>2,093</td>
</tr>
<tr>
<td>2009</td>
<td>2,091</td>
</tr>
<tr>
<td>2010</td>
<td>1,958</td>
</tr>
<tr>
<td>2011</td>
<td>2,042</td>
</tr>
<tr>
<td>2012</td>
<td>1,910</td>
</tr>
<tr>
<td>2013</td>
<td>1,963</td>
</tr>
<tr>
<td>2014</td>
<td>1,894</td>
</tr>
<tr>
<td>Primary Site</td>
<td>Analytic*</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>Lip</td>
<td>1</td>
</tr>
<tr>
<td>Base of Tongue</td>
<td>2</td>
</tr>
<tr>
<td>Other Unspecified Parts of Tongue</td>
<td>2</td>
</tr>
<tr>
<td>Gum</td>
<td>1</td>
</tr>
<tr>
<td>Palate</td>
<td>1</td>
</tr>
<tr>
<td>Other Major Salivary Glands</td>
<td>1</td>
</tr>
<tr>
<td>Parotid Gland</td>
<td>2</td>
</tr>
<tr>
<td>Tonsil</td>
<td>7</td>
</tr>
<tr>
<td>Nasopharynx</td>
<td>1</td>
</tr>
<tr>
<td>Esophagus</td>
<td>9</td>
</tr>
<tr>
<td>Stomach</td>
<td>26</td>
</tr>
<tr>
<td>Small Intestine</td>
<td>11</td>
</tr>
<tr>
<td>Colon</td>
<td>98</td>
</tr>
<tr>
<td>Rectosigmoid Junction</td>
<td>14</td>
</tr>
<tr>
<td>Rectum</td>
<td>19</td>
</tr>
<tr>
<td>Anus &amp; Anal Canal</td>
<td>3</td>
</tr>
<tr>
<td>Liver &amp; Intrahepatic Bile Duct</td>
<td>17</td>
</tr>
<tr>
<td>Gallbladder</td>
<td>2</td>
</tr>
<tr>
<td>Other Parts of Biliary Tract</td>
<td>13</td>
</tr>
<tr>
<td>Pancreas</td>
<td>37</td>
</tr>
<tr>
<td>Other Digestive Organs</td>
<td>7</td>
</tr>
<tr>
<td>Nasal Cavity &amp; Middle Ear</td>
<td>3</td>
</tr>
<tr>
<td>Larynx</td>
<td>4</td>
</tr>
<tr>
<td>Bronchus &amp; Lung</td>
<td>193</td>
</tr>
<tr>
<td>Heart, Mediastinum &amp; Pleura</td>
<td>7</td>
</tr>
<tr>
<td>Bones &amp; Cartilage of Limbs</td>
<td>4</td>
</tr>
<tr>
<td>Bones &amp; Cartilage of Other</td>
<td>2</td>
</tr>
<tr>
<td>Hematopoietic &amp; Reticuloendo System</td>
<td>77</td>
</tr>
<tr>
<td>Skin</td>
<td>70</td>
</tr>
<tr>
<td>Primary Site</td>
<td>Analytic*</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>Retroperitoneum &amp; Peritoneum</td>
<td>9</td>
</tr>
<tr>
<td>Connective and Other Soft Tissue</td>
<td>15</td>
</tr>
<tr>
<td>Breast</td>
<td>353</td>
</tr>
<tr>
<td>Vulva</td>
<td>13</td>
</tr>
<tr>
<td>Vagina</td>
<td>6</td>
</tr>
<tr>
<td>Cervix Uteri</td>
<td>18</td>
</tr>
<tr>
<td>Corpus Uteri</td>
<td>142</td>
</tr>
<tr>
<td>Uterus, NOS</td>
<td>4</td>
</tr>
<tr>
<td>Ovary</td>
<td>44</td>
</tr>
<tr>
<td>Other Female Genital Organs</td>
<td>9</td>
</tr>
<tr>
<td>Penis</td>
<td>1</td>
</tr>
<tr>
<td>Prostate</td>
<td>127</td>
</tr>
<tr>
<td>Testis</td>
<td>7</td>
</tr>
<tr>
<td>Kidney</td>
<td>37</td>
</tr>
<tr>
<td>Renal Pelvis</td>
<td>3</td>
</tr>
<tr>
<td>Ureter</td>
<td>6</td>
</tr>
<tr>
<td>Bladder</td>
<td>95</td>
</tr>
<tr>
<td>Eye &amp; Adnexa</td>
<td>1</td>
</tr>
<tr>
<td>Meninges</td>
<td>26</td>
</tr>
<tr>
<td>Brain</td>
<td>29</td>
</tr>
<tr>
<td>Spinal Cord &amp; Other CNS</td>
<td>6</td>
</tr>
<tr>
<td>Thyroid Gland</td>
<td>50</td>
</tr>
<tr>
<td>Adrenal Gland</td>
<td>2</td>
</tr>
<tr>
<td>Other Endocrine Glands</td>
<td>10</td>
</tr>
<tr>
<td>Other Sites</td>
<td>1</td>
</tr>
<tr>
<td>Lymph Nodes</td>
<td>52</td>
</tr>
<tr>
<td>Unknown Primary Site</td>
<td>16</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>1,715</td>
</tr>
</tbody>
</table>

* Analytic cases include all cancer patients diagnosed at Abington 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.
In 1998, a Presidential Commission recommended the creation of a national forum in which health care’s many stakeholders could, together, find ways to improve the quality and safety of America’s health care. This recommendation led to the creation of National Quality Forum (NQF), a private, not-for-profit, public benefit corporation established in 1999 to standardize healthcare quality measurement and reporting.

Established as a public-private partnership, the NQF has broad participation from all parts of the healthcare system, including national, state, regional and

**How We Compare to the National Cancer Data Base**

In 1998, a Presidential Commission recommended the creation of a national forum in which health care’s many stakeholders could, together, find ways to improve the quality and safety of America’s health care. This recommendation led to the creation of National Quality Forum (NQF), a private, not-for-profit, public benefit corporation established in 1999 to standardize healthcare quality measurement and reporting.

Established as a public-private partnership, the NQF has broad participation from all parts of the healthcare system, including national, state, regional and

**CPSR and AH’s Performance for Breast Cancer**

**BREAST CONSERVING SURGERY AND RADIATION THERAPY**

Percentage of All Cases

Breast Conserving Surgery and Radiation Therapy

Radiation therapy is administrated within one year (365 days) of diagnosis for women under the age of 70 receiving breast conserving surgery for breast cancer. **Abington Hospital’s compliance with this standard is favorable at 96.9%, compared to all CoC-approved programs’ norm of 92.4%.**

**CHEMOTHERAPY IN HORMONE RECEPTOR NEGATIVE BREAST CANCER PATIENTS**

Percentage of All Cases

Chemotherapy in Hormone Receptor Negative Breast Cancer Patients

Combination chemotherapy is considered or administered within four months (120 days) of diagnosis for women under the age of 70 with AJCC T1c N0M0, or Stage II or III hormone receptor negative cancer. **Abington Hospital’s compliance with this standard is excellent at 100%, compared to all CoC-approved programs’ norm of 92.1%.**

**TAMOXIFEN OR THIRD GENERATION AROMATASE INHIBITOR IN HORMONE RECEPTOR POSITIVE BREAST CANCER PATIENTS**

Percentage of All Cases

Tamoxifen or Third Generation Aromatase Inhibitor in Hormone Receptor Positive Breast Cancer Patients

Tamoxifen or third generation aromatase inhibitor is considered or administered within one year (365 days) of diagnosis for women with AJCC T1c N0M0, or Stage II or III hormone receptor positive cancer. **Abington Hospital’s compliance with this standard is favorable at 98%, compared to all CoC-approved programs’ norm of 91.5%.**
local groups representing consumers, public and private purchasers, employers, healthcare professionals, provider organizations, health plans and others involved in healthcare research or quality improvement. Together, the organizational members of the NQF work to promote a common approach to measuring healthcare quality and fostering system-wide capacity for quality improvement.

The Commission on Cancer (CoC), through the Cancer Program Practice Reports (CP3R), promotes twelve quality indicators utilizing the data submitted to the National Cancer Data Base. The data are from 2012.

**CPSR and AH’s Performance for Breast Cancer**

<table>
<thead>
<tr>
<th>BREAST CONSERVING SURGERY RATE</th>
<th>Percentage of All Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AH</strong></td>
<td>70%</td>
</tr>
<tr>
<td><strong>PA</strong></td>
<td>69%</td>
</tr>
<tr>
<td><strong>All CoC</strong></td>
<td>63%</td>
</tr>
</tbody>
</table>

**Radiation Therapy and Mastectomy**

Radiation therapy is considered or administered following any mastectomy within one year of diagnosis of breast cancer for women with four or more positive regional lymph nodes. Abington Hospital’s compliance with this standard is excellent at 100%.

<table>
<thead>
<tr>
<th><strong>AH</strong></th>
<th><strong>PA</strong></th>
<th><strong>All CoC</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>95.3%</td>
<td>89.2%</td>
</tr>
</tbody>
</table>

**Image or Palpation-guided Needle Biopsy Performed in Breast Cancer Diagnosis**

Image or palpation-guided needle biopsy is performed to establish diagnosis of breast cancer. Abington Hospital’s compliance with this standard is above the state’s average at 96%.

<table>
<thead>
<tr>
<th><strong>AH</strong></th>
<th><strong>PA</strong></th>
<th><strong>All CoC</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>96%</td>
<td>92.4%</td>
<td>89.9%</td>
</tr>
</tbody>
</table>
Adjuvant Chemotherapy for Node Positive Patients

Adjuvant chemotherapy is considered or administered within four months (120 days) of diagnosis for patients under the age of 80 with AJCC Stage III (lymph node positive) colon cancer. Abington Hospital’s compliance is very favorable at 93.3%, compared to all CoC-approved programs’ norm of 89.8%.

Regional Lymph Nodes in Surgically Resected Patients

At least 12 regional lymph nodes are removed and pathologically examined for resected colon cancer. The compliance rate for Abington Hospital’s is slightly better at 89.2%, compared to all CoC-approved programs’ norm of 88.2%.

Radiation Therapy in Rectal Carcinomas

Radiation therapy is considered or administered within six months of diagnosis for patients under age 80 with clinical or pathologic AJCC T4N0M0 or Stage III receiving surgical resection for rectal cancer. Abington Hospital’s compliance with this standard needs improvement at 50%, compared to all CoC-approved programs’ norm of 85%.
Surgery is not First Course of Treatment for Non-Small Cell Lung Cancer That Has Not Spread to Distant Organs or Areas

This quality measure examines whether surgery was used within the first course of treatment for Non-Small Cell Lung Cancer that has not spread to other organs. Abington Hospital is in compliance at 100% compared to CoC average of 90.9%.

Chemotherapy in Lymph Node Positive Non-Small Cell Lung Cancer

Chemotherapy administered within four months to day preoperatively or day of surgery to six months postoperatively, or it is considered for surgically resected cases with pathologic, lymph node positive Non-Small Cell Lung Cancer. Abington Hospital’s compliance is 100% compared to the CoC average of 90.7%.

Lymph Nodes in Surgically Resected Gastric Cancer

At least 15 regional lymph nodes are removed and pathologically examined for resected gastric cancer. Abington Hospital’s compliance with this standard is 100%, far exceeding the state and CoC compliance rates.
BREAST CANCER EXPERIENCE

HISTORICAL EXPERIENCE

Number of New Cases

![Bar chart showing the number of new cases from 2008 to 2014.]

STAGE AT PRESENTATION

Percentage of All Cases

![Bar chart showing the stage at presentation for cases from 2010 to 2014 and NCDB 2012 data.]

SURGICAL TREATMENT

Percentage of All Cases

![Bar chart showing the surgical treatment percentages for cases from 2010 to 2014 and NCDB 2012 data.]

AH 2014 N=353
NCDB 2012 N=218,273
The volume of new breast cancer cases has remained steady at Abington Hospital (AH) from 2010 to 2014 (325, 354, 340, 357, 353). The stage distribution at AH has been very consistent over the past five years. In 2014, 21% of patients had Stage 0 (in-situ), 47% had Stage I, 21% had Stage II, 7% had Stage III and 3% had Stage IV breast cancer at presentation. This compares to 21%, 42%, 24%, 8% and 4% respectively in the 2012 National Cancer Data Base (NCDB) experience. At AH in 2014, 89% of patients had Stage 0-II disease compared to 87% in the NCDB experience for 2012. At AH, the stage distribution has remained unchanged over the past five years.

In 2014, 65% of patients at AH, compared to 53% in the NCDB, underwent lumpectomy usually with radiation. A total of 5% of patients underwent a modified radical mastectomy and (23%) underwent a total mastectomy. Thus, the majority of patients at AH continue to have breast preservation with the initial diagnosis of breast cancer. This in turn encourages women to have regular mammographic screening with the prospect of early diagnosis and breast preservation if cancer is discovered. The Commission on Cancer (CoC) Program Practice Profile Reports (CP3R), 2012 data, currently has six quality indicators for breast cancer (see pages 8 and 9). Breast conserving surgery and radiation was administered in 96.9% of appropriate cases; chemotherapy was administered or considered in hormone receptor negative breast cancer cases in 100% of cases; Tamoxifen or third generation aromatase inhibitor was considered in 98% of cases. In all areas, these results surpassed averages from all CoC institutions.

The large number of new breast cancer cases at AH reflects the components of the program which include re-certification by the National Accreditation Program for Breast Centers in 2012, an extensive “fast track” diagnostic program through the Mary T. Sachs Breast Center, a weekly, multidisciplinary Breast Cancer Evaluation Service, a breast cancer nurse navigator and breast cancer specialists in the areas of radiology, pathology, surgery, medical oncology and radiation oncology. Patients presented at the weekly Breast Cancer Evaluation Service conference are staged and reviewed for treatment based on national treatment guidelines. Further cutting edge breast cancer research protocols are discussed and reviewed for appropriate patients. National quality indicators such as the CP3R above, consistently show outstanding outcomes. Most recently, cancer survivorship plans are provided to all patients completing potentially curable initial therapy (surgery, radiation and chemotherapy).
**Colon Cancer Experience**

**Historical Experience**

**Number of New Cases**

<table>
<thead>
<tr>
<th>Year</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>129</td>
</tr>
<tr>
<td>2009</td>
<td>120</td>
</tr>
<tr>
<td>2010</td>
<td>120</td>
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<tr>
<td>2011</td>
<td>98</td>
</tr>
<tr>
<td>2012</td>
<td>107</td>
</tr>
<tr>
<td>2013</td>
<td>104</td>
</tr>
<tr>
<td>2014</td>
<td>98</td>
</tr>
</tbody>
</table>

**Stage at Presentation**

**Percentage of All Cases**

- AH 2010
- AH 2011
- AH 2012
- AH 2013
- AH 2014
- NCDB 2012

**Primary Treatment**

**Percentage of All Cases**

- AH 2010
- AH 2011
- AH 2012
- AH 2013
- AH 2014
- NCDB 2012

AH 2014 N=98

(NCDB 2012 N=70,371)
New colon cancer cases at Abington Hospital (AH) were 98 in 2014 and have slowly declined since 2008 (129, 120, 120, 98, 107, 104, 98). Stage distribution was also little changed over the past five years with 51% of patients presenting with Stage 0, I or II disease with a greater than 80% chance of cure with surgical resection alone. 25% of patients presented with Stage III disease and might benefit from adjuvant chemotherapy. Finally, 16% of cases had Stage IV disease at presentation and were candidates for increasingly effective palliative therapy. These results are almost identical to cases reported from the NCDB database for 2012 (51%, 25%, 19%).

The majority of patients (75%) underwent colectomy with or without other therapy which is very similar to that reported by the NCDB (81%). Further 25% of patients underwent surgery and chemotherapy.

The Commission on Cancer (CoC) Program Practice Profile Reports (CP3R) provides quality indicators for the care of patients with colon cancer (see page 10).

In 2014, 93.3% of patients at AH received or were offered adjuvant chemotherapy for Stage III disease as compared to 89.7% of patients in all CoC programs (CP3R 2012 data). Adequate regional lymph nodes were obtained in surgically resected patients in 89.2% of cases at AH as compared to 88.2% in all CoC programs. Finally, chemo/radiation therapy was offered to 50% of patients with Stage III rectal cancer as compared to 85% of patients in all CoC programs. Three patients were non-concordant due to the following findings:
1. Carcinoma was an incidental finding in a rectal polyp during colectomy for Crohn’s disease
2. One patient was clinical T2 not clinical T3, and
3. Radiation was administered after 180 days following diagnosis.

The GI cancer program is being led by a working group and will prepare an application to become a Rectal Cancer Center of Excellence once the designation is available.
LUNG CANCER EXPERIENCE

HISTORICAL EXPERIENCE

Number of New Cases

NSCLC STAGE AT PRESENTATION

Percentage of All Cases

PRIMARY TREATMENT

Percentage of All Cases
New cases of Non-small cell lung cancer (NSCLC) were stable with 170 cases in 2014 and were in line with new case acquisition over the past five years. Cases of small cell lung cancer (SCLC) were stable with 16 cases. 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 2014, 34% of cases at Abington Hospital (AH) had Stage I-II disease with a high chance (over 50%) of cure with surgical resection. This compares to 36% of cases reported in the NCDB with Stage I or II disease in 2012. At AH, 20% of cases presented with Stage III disease (20% NCDB). Patients with Stage III disease may benefit from combined chemotherapy and radiation with a doubling of the two year freedom from progression and survival intervals. Unfortunately, 46% of patients at AH and 40% in the NCDB presented with Stage IV disease. The advanced stage presentations, 66% of patients with Stage III or IV disease in 2014 at AH, are reflected in the low five-year disease free survival rate overall for lung cancer (between 10-20%).

Initiatives underway at AH to address this dismal outlook include a smoking cessation program, a new low dose CT scanning program for high risk patients and a pulmonary nodule evaluation program. A pulmonary cancer working group has been formed and is actively evaluating all aspects of prevention and care for lung cancer patients.
**PROSTATE CANCER EXPERIENCE**

**HISTORICAL EXPERIENCE**

**Number of New Cases**

<table>
<thead>
<tr>
<th>Year</th>
<th>Cases</th>
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<tbody>
<tr>
<td>2010</td>
<td>222</td>
</tr>
<tr>
<td>2011</td>
<td>185</td>
</tr>
<tr>
<td>2012</td>
<td>132</td>
</tr>
<tr>
<td>2013</td>
<td>142</td>
</tr>
<tr>
<td>2014</td>
<td>127</td>
</tr>
</tbody>
</table>

**STAGE AT PRESENTATION**

**Percentage of All Cases**

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</thead>
<tbody>
<tr>
<td>I</td>
<td>Biopsy Only</td>
<td>Radiation</td>
<td>Prostatectomy</td>
<td>Radiation and Hormonal</td>
<td>Hormonal Therapy</td>
<td>Other</td>
</tr>
</tbody>
</table>

| AH 2014 N=127 | NCDB 2012 N=106,947 |

**PRIMARY TREATMENT**

**Percentage of All Cases**

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</tr>
</thead>
<tbody>
<tr>
<td>Biopsy Only No 1st Course Tx</td>
<td>Radiation</td>
<td>Prostatectomy</td>
<td>Radiation and Hormonal</td>
<td>Hormonal Therapy</td>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

| AH 2014 N=127 | NCDB 2012 N=106,947 |
New prostate cancer cases have continued to decrease since 2010. There was a decrease from 222 cases in 2010 to 127 cases in 2014. The distribution by AJCC stage in 2014 showed no patients with in-situ prostate cancer, 24% with Stage I disease, 53% with Stage II, 9% with Stage III and 13% with Stage IV at presentation. This distribution is in contrast with that reported by the NCDB in which 22% of patients presented with Stage I, 56% with Stage II, 11% with Stage III, 8% Stage IV and 3% with unknown Stage.

With respect to treatment at Abington Hospital (AH) in 2014, 17% had biopsy and radiation therapy (NCDB 16%) and 46% underwent radical prostatectomy (48% NCDB). The increase in radical prostatectomy is reflected in part by the increased use of robotic surgery. The majority of patients with prostate cancer are now presenting with localized disease, often detected with PSA screening by their primary physician. They are being offered an array of local treatment options, which include implants, IMRT radiation and robotic prostatectomy for selected patients.

A multi-specialty clinic is run each week at AH to evaluate patients with elevated PSA. In addition, a multidisciplinary Urologic Cancer Evaluation Services meets each month and reviews all cases of patients with urologic malignancies.
Abington Hospital (AH) had 177 new prostate cancer cases in 2014, compared to 220 new cases in 2008 (140,587 nationally).

The distribution by AJCC stage in 2008 showed no patients with in situ prostate cancer, 0% with Stage I disease, 92.4% with Stage II, 2.7% with Stage III, 4% with Stage IV and 0.9% unknown at presentation. This distribution is in contrast with that reported by the NCDB, in which 1% of patients presented with Stage I, 79.7% Stage II, 8.3% Stage III, 5.1% Stage IV and 5.9% with unknown Stage.

69.7% of patients diagnosed at AH with prostate cancer were between the ages of 60 and 79, which is slightly higher than the national average of 65.8% for the same age range.

Race distribution of men diagnosed with prostate cancer at AH and nationally was relatively similar as well. 84.8% Caucasian patients at AH, 76.7% nationally; 12% African American compared to 14.3% nationally; 0.9% Hispanic patients at AH compared to 4.4% nationally. Other races ranked at 2.2% at AH and 4.7% nationally.

Treatment at AH in 2008: 40.6% had biopsy and radiation therapy (NCDB 20.2%) and 36.6% a radical prostatectomy (47.7% NCDB). The increase in the treatment with radical prostatectomy over the last few years is a reflection of the increased use of robotic surgery. The majority of patients with prostate cancer are now presenting with localized disease, often detected with PSA screening by primary care physicians and being offered an array of local treatment options, which include radioactive implants, radiation and robotic assisted radical prostatectomy for selected patients.

As a Stage I or II prostate cancer patient, men have three treatment options per NCCN guidelines: surgery, XRT or no treatment (active surveillance). When we add the men at AH during 2008 who had surgery, XRT or no treatment; the total number equals 220. We can therefore infer that AH physicians are following NCCN guidelines as 220 Stage II, III, IV prostate cancer patients have chosen to proceed with surgery, XRT, active surveillance or hormonal therapy.

In summary, the prostate cancer cases at AH remain quite active.
THE MISSION OF ABINGTON 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 annual report was approved in November 2015 by the Cancer Committee of Abington Hospital.