

# Cancer Program

2009 ANNUAL REPORT

## CANCER COMMITTEE MEMBERSHIP

### PHYSICIANS

*Hazem El-Khatib, MD*  
Cardio-thoracic Surgeon  
Committee Chairperson

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Medical Oncologist  
Cancer Liaison Physician

*Hung-Chi Ho, MD*  
Radiation Oncologist

*Thomas Franco, MD*  
Interventional Radiologist

*David Melniczek, MD*  
General Surgeon

*Robert Patterson, MD*  
Pathologist

*George Davliakos, MD*  
Cardio-thoracic Surgeon

*Tom McGill, MD*  
Performance Improvement

*Robert Mc Nerney, MD*  
Hospitalist

*Mark Musmanno, MD*  
Urologist

*John Reefer, MD*  
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*Patricia Arnett, DO*  
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### ANCILLARY

*Vicky Ban, RHIA, CTR*  
Tumor Registrar

*Theresa Cirelli*  
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*Marie Yingling, RN*  
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*Stephanie Roskovski*  
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VP Operations

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VNA Hospice

*Erin Vero*  
American Cancer Society

*Peggy Wright*  
Women's Imaging Center

*Beverly Hesidenz*  
Education

*Mary Lutz, RN BSN*  
Oncology Protocol Nurse

# Message from the Cancer Committee Chairperson

In 2009 Butler Memorial Hospital's Cancer Program continued to add new programs and services to enhance cancer care. Educational, treatment planning and Tumor Board meetings continued to be held weekly with a total of 130 cases presented. An emphasis on AJCC staging and National Comprehensive Cancer Network Treatment Guidelines continues to be our goal.

This year Butler Health System was awarded two Community Partnership Awards from the American Cancer Society. One award was for the support and success of the "I Can Cope" program and the other for the marketing of Daffodil Days. Our Strategic Planning and Growth representative conducted an extensive market analysis and identified and prioritized tactics to enhance our cancer services. He utilized Cancer Registry data along with state/regional data to show that BHS commands a 34% market share in Butler County. This underscores a great opportunity for program expansion and services enhancement to strengthen our program. The opportunities were prioritized and included a Protocol Nurse, a General Surgeon with breast expertise (to develop a recognized brand), a web internet presence and functionality, a multi-disciplinary Cancer Care Clinic, the development or contracting of a Genetic Counseling services and the investigation of

palliative care options. Several new improvements were made as a result of this analysis. A marketing campaign, including newspapers, in-house publications, billboards, mailings and health system website was done. Also, a Protocol Nurse and two General Surgeons were hired.

This year, Butler Memorial Hospital opened its new patient tower, technologically advanced and built for comfort with state-of-the-art operating rooms, two full floors of Medical Surgical Units and an advanced Intensive Care Unit plus more. These advances will in turn allow us to take the next step-up in the accreditation process in 2011, when we undergo our next survey. The goal is to achieve a Comprehensive Cancer Center accreditation. This will allow us the opportunity to enroll patients into national cancer treatment protocols. We will be working with the Toledo Oncology Group to facilitate this process.



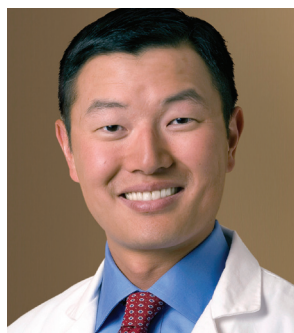
I appreciate all the help from the committee members, administration and the tumor registrar without whom these achievements would not have been possible.

Hazem El-Khatib, MD  
Cancer Committee Chairman

## Site Specific Study - Colon Cancer

by Dr. Meng-G Martin Lee

Colon cancer is one of the most common malignancies. According to American Cancer Society (ACS), colorectal cancer is the third leading cause of cancer related deaths in the United States. It is estimated that 49,470 men and 53,430 women will be diagnosed with colon cancer in 2010. Of those diagnosed, about 51,370 men and women succumb to the disease each year.



cancer is slightly more common in male than female according to ACS statistics. At our institution, the incidence of colon cancer is slightly higher in female.

Colorectal cancer incident rate has been decreasing for most of the past two decades. Risks of colon cancer increase with age. More than 90% of the cases are diagnosed in individuals age 50 or older. All of the patients in our registry with newly diagnosed colon cancer in 2009 are older than 50. The peak incidence of colon cancer at our institution is 70-79 and 80-90 age group. Both groups had 13 patients with distribution of 32.5%.

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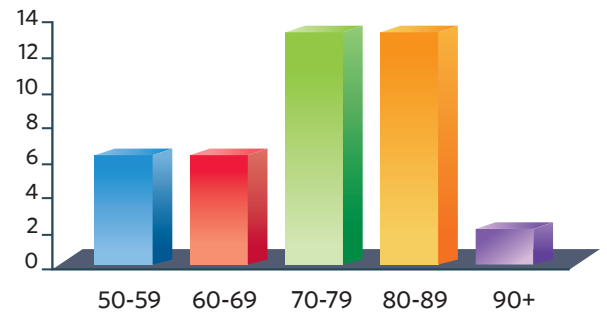
At our institution, the majority of colon cancer is stage I at diagnosis. We had 8 patients with Stage 0 (20%), 13 patients with Stage I (32.5%), 3 patients with Stage II (7.5%), 12 patients with Stage III (30%), 2 patients with Stage IV (5%) and 2 patients that were not staged (5%). Please see graph below for the distribution compared to National Cancer Data Base (NCDB) data.

Surgical resection is the primary treatment modality for colon cancer, and its outcome is closely related to the extent of disease at diagnosis. In our institution, 28 patients underwent surgery alone for their disease and 8 patients had surgery with chemotherapy post operatively. 2 patients with advanced disease and 2 patients who were not staged did not receive surgery or chemotherapy, presumably due to their medical condition at the diagnosis. 7 patients in Stage III received surgical resection and chemotherapy; one patient who had diffuse large B cell lymphoma who is Stage I E received both surgical resection and chemotherapy.

The data also reveals earlier detection of colon cancer at BMH. This is facilitated by offering state-of-the-art molecular testing to assist our surgeons and oncologists in delivering excellent care for colon cancer. Tests such as KRAS help guide in selecting the most effective chemotherapy agents when appropriate. More recently, Microsatellite Instability testing and Mismatch Repair Protein testing of tumors can reveal possible familial (hereditary) colo-rectal cancers found in conditions such as Lynch Syndrome or Muir-Torre Syndrome. The latter syndrome is often associated with benign or malignant sebaceous tumors, which can also be tested to reveal if the syndrome is present. These findings have prognostic significance not only for the patient but may also predict if family members may be at risk.

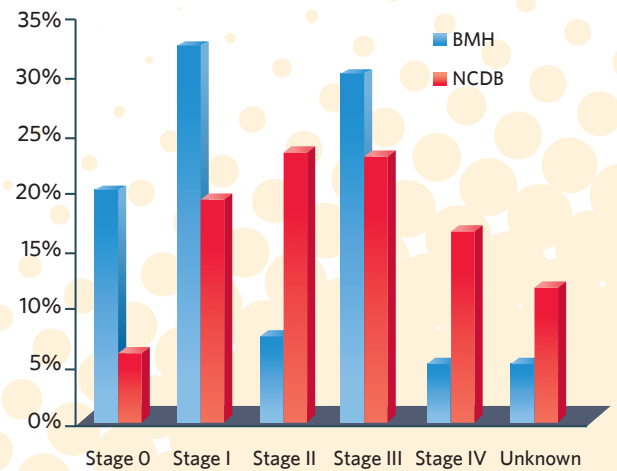
In summary, we found that our data are comparable to national data. We do not have any long term survival data at this time due to the fact that our cancer registry has been established only recently. We are working to increase screening, education, prevention and data collection to better serve our community.

### Age at Diagnosis



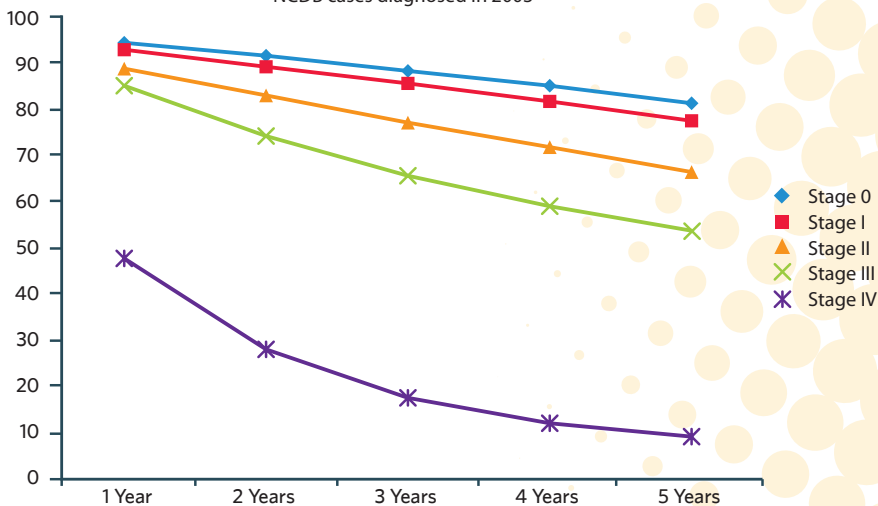
### AJCC Stage at Diagnosis

NCDB data from 2008



### National Observed Survival

NCDB cases diagnosed in 2003



## Female Top 5 Cancers for 2009

Breast	116
Lung	41
Colorectal	28
Lymphoma	15
Corpus Uteri	13

## Male Top 4 Cancers for 2009

Prostate	80
Lung	60
Bladder	28
Colorectal	27

## Cancer Registry Data

CNS	Brain/CNS	7
ORAL	All Sites	10
RESPIRATORY	Lung	101
	Larynx	3
DIGESTIVE	Colon	39
	Rectum	16
	Pancreas	17
	Esophagus	7
	Stomach	5
	Other Biliary	4
	Liver	2
	Retroperitoneum	1
	Small Intestine	1
	Gallbladder	1
GENITO-URINARY	Prostate	80
	Bladder	33
	Kidney/Other Urinary	19
	Corpus Uteri	13
	Testis	2
	Ovary	4
	Other Female Genital	3
OTHER SITES	Breast	116
	Thyroid	14
	Skin/Melanoma	11
	Mesothelioma	1
HEMATOLOGIC	Lymphoma	31
	Leukemia	9
	Myeloma	4
MISCELLANEOUS	All Other	12
TOTAL		566



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