

# 2004 CANCER OCCURRENCE

# CANCER REGISTRY REPORT

# Lymphoma: The Basics

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# Lymphoma Date: EMMC with National Cancer Database

## Accessioned (New to EMMC) Cancer Cases: 2004 Analytic/Non-Analytic Comparison

	2000	2001	2002	2003	2004
Total Analytic Cases	1283	1397	1338	1444	1525
Cancer diagnosed and/or treated at EMMC	693	693	667	766	858
Cancer diagnosed elsewhere and received all or part of first course of treatment at EMMC	590	704	671	678	667
Total Non-Analytic Cases	102	121	142	135	130
Cancer diagnosed and received all or part of first course of treatment other than EMMC					
Total Accessioned Cases	1385	1518	1480	1579	1655

## Primary Site Frequency Distribution: 2004 Accessioned Cases

Primary Site	Total	Analytic	% Analytic	# Non-Analytic	% Non-Analytic	Male	Female	Stage 0	Stage 1	Stage 2	Stage 3	Stage 4	Not Staged
Oral	17	14	1	3	2	16	1	0	1	3	6	1	3
Esophagus	19	18	1	1	1	14	5	0	2	2	4	6	4
Stomach	26	25	2	1	1	19	7	0	5	4	4	10	2
Colon	96	89	6	7	5	51	45	0	21	14	31	14	9
Rectum	46	45	3	1	1	29	17	1	10	7	14	9	4
Liver/Biliary	33	32	2	1	1	22	11	1	2	7	6	15	1
Pancreas	33	32	2	1	1	12	4	0	9	1	1	4	0
Larynx	16	15	1	1	12	4	0	4	0	9	1	1	4
Lung	325	309	20	16	12	189	136	1	72	15	96	97	28
Connective	10	8	1	2	2	2	8	0	2	1	3	1	1
Melanoma	56	42	3	3	2	18	27	11	17	4	5	2	3
Breast	296	287	19	9	7	3	293	56	106	74	29	10	12
Cervix Uteri	12	11	1	1	1	0	12	0	5	1	1	3	1
Corpus Uteri/Uterus	38	34	2	4	3	0	38	0	22	5	2	2	3
Ovary	17	15	1	2	2	0	17	0	0	1	2	8	4
Prostate	168	140	9	28	22	168	0	0	0	80	14	10	36
Testis	9	9	1	0	0	9	0	0	5	2	2	0	0
Bladder	36	29	2	8	6	28	8	5	8	4	2	5	5
Kidney/Ureter	43	39	3	4	3	25	18	1	2	6	8	4	8
Brain/CNS	47	46	3	1	1	24	23	0	0	0	0	0	46
Thyroid	21	18	1	3	2	7	14	0	15	0	1	1	1
Leukemia	40	36	2	4	3	25	15	0	0	0	0	0	36
Lymphoma	10	89	6	11	8	51	38	0	16	12	15	35	11
Other	161	152	10	19	15	87	126	3	11	7	13	29	89
<b>Total</b>	<b>1655</b>	<b>1525</b>	<b>100</b>	<b>130</b>	<b>100</b>	<b>813</b>	<b>872</b>	<b>79</b>	<b>348</b>	<b>258</b>	<b>261</b>	<b>268</b>	<b>311</b>



Margaret Chavaree, CTR

EMMC's Cancer Program was awarded a full three-year approval with Commendation by the Commission on Cancer in February 2005.

The Cancer Registry, an integral part of the cancer program at EMMC is staffed with three cancer registrars and a cancer registry assistant. Registrars are data management experts who report cancer statistics and work closely with physicians, administrators, researchers, and health care planners to provide support for cancer program development, ensure compliance of reporting standards, and serve as a valuable resource for cancer information with the ultimate goal of preventing and controlling cancer. They are involved in managing and analyzing clinical cancer information for the purpose of education, research, and outcome measurement. The primary role of the Cancer Registry is the collection and management of cancer data, both demographic and clinical, beginning at diagnosis and continuing throughout the cancer patient's lifetime. Cancer registrars develop a case abstract for each person diagnosed and/or receiving his or her first course of treatment at EMMC. The collected data is an invaluable tool in the fight against cancer.

Physicians utilize AJCC Staging to stratify patients and to determine optimal treatment decisions. At EMMC initial physician compliance with staging form completion requirements has been consistently above 90% (with registry follow up - nearly 100%) has provided us with a great base for this initiative.

On the last page you will find tables reflecting cancer case accessions, frequency, stage at presentation and prevalence for 2004 at EMMC.

Each patient diagnosed or who received his / her first course of treatment at EMMC is provided with an annual lifetime follow-up service monitoring diagnostic and treatment results. This process serves as an automatic reminder to physicians and patients to schedule regular exams. Successful follow-up provides accurate data for calculating survival rates. Successful follow-up provides accurate data for calculating survival rates. EMMC's lifetime follow-up is maintained at 98% for cases since 1998 (ACOS-COC standard is 90%).

Per regulatory compliance, data are collected, maintained, and reported to the Maine State Cancer Registry and the National Cancer Data Base (NCDB). Doing so assists public health professionals to better understand and address the cancer burden. CCOM's Clinical Research Department, administrators and clinicians use the data in grant preparation, strategic planning, and comparison of clinical outcomes. The Registry responded to 30 requests for information in 2004 with a time expenditure of 200 hours.

Cancer Conferences are held weekly. 212 cases were presented at these multidisciplinary discussions - 14% of our analytic case accessions. (ACOS-COC standard is 10%).

## 2004 EMMC Most Prevalent Analytic Cases Compared to American Cancer Society (ACS) 2004 New Case Estimates

Site	EMMC Analytic Cases	% of Analytic Cases	ACS National Estimates	% of Cases
Lung	325	21.3	173,770	12.7
Breast	296	19.4	215,990	15.8
Prostate	168	11.0	230,100	16.8
Colon/Rectum	134	8.9	146,940	10.7
Lymphoma	89	5.8	54,370	4.0
Brain/CNS	46	3.0	18,300	1.4
Melanoma	42	2.8	55,100	4.0
Kidney/Ureter	39	2.5	38,160	2.8
Leukemia	36	2.3	19,020	1.4
Pancreas	32	2.1	31,860	2.3
Bladder	29	1.9	60,240	4.4
<b>Top Case Totals</b>	<b>1236</b>	<b>81%</b>	<b>1,043,850</b>	<b>76%</b>
<b>Total Cases</b>	<b>1525</b>		<b>1,368,030</b>	



Ann Marie Blenc, MD

Lymphomas represent about 4% of new cancers diagnosed in the United States each year. That percentage was slightly higher at EMMC in 2004, with lymphoma accounting for 5.3% of all cancers. Lymphomas can be divided into non-Hodgkin Lymphoma (NHL) and Hodgkin Lymphoma (HL).

Nationally, approximately 80% of the lymphomas are NHL; the remainder are HL. EMMC showed a very similar distribution, with 10 cases of HL and 79 cases of NHL, in 2004. NHL's are a diverse group of diseases that can be indolent or aggressive. The incidence of NHL has doubled over the past two decades. It is now the fifth most common cancer diagnosed in the United States, and the fifth leading cause of cancer death. NHL is more common in men as compared to women nationally. This is similar to our experience at EMMC.

Patients with NHL often present with enlarged lymph nodes (66%) or general complaints (40%), such as fever, weight loss, or night sweats. Less frequent complaints (<10%) include fatigue, malaise, and itching. One is at greater risk for lymphoma if there is a prior history of malignancy, treatment with radiation, or chemotherapy, organ transplantation, certain infections, autoimmune conditions, and gastrointestinal diseases, such as Celiac disease, helicobacter pylori, and Crohn's disease. A complete history and physical is the starting point for this diagnosis. There is however, no currently recommended screening program. Diagnosis requires a lymph node or other tissue biopsy, as accurate microscopic evaluation is critical for appropriate treatment decisions.

How advanced a lymphoma is at presentation is determined using the Ann Arbor Staging System accepted by AJCC as the staging standard, which focuses on the number of tumor sites, location, and the presence or absence of general symptoms. Stage I refers to a single lymph node region. Stage II refers to two or more involved lymph node regions on the same side of the diaphragm. Stage III refers to lymph node involvement on both sides of the diaphragm. Stage IV refers to the presence of generalized involvement of one or more non-lymph node organs. In addition, the presence or absence of generalized symptoms is also important. Unlike many other tumors, however, the microscopic appearance is actually the most important factor in prognosis. EMMC uses the microscopic classification developed by the World Health Organization.

In 2004, at EMMC 79 people were diagnosed or treated for NHL. Of those, 54% were men, and 46% were women. There was a broad range of age at diagnosis, however, the majority (94%) of patients were at or above the age of 40, 67% at or above age of 60. Lymphoma is categorized by its microscopic appearance. Diffuse large B-cell lymphoma accounted for the largest number of cases (30%). Follicular lymphoma accounted for 16% and another 28% were diagnosed as malignant lymphoma, not otherwise specified. The remaining cases were as follows: small lymphocytic lymphoma (7), marginal zone lymphoma (5), mantle cell lymphoma (2), lymphoblastic lymphoma (2), anaplastic large cell lymphoma (1), Burkitt lymphoma (1), mature T-cell lymphoma (1), and primary cutaneous T-cell lymphoma (1). Regardless of its appearance under the microscope, 29% were diagnosed as Stage I, 10% as Stage II, 18% as stage III and 42% as stage IV. One case was not staged. The majority of patients received either systemic therapy alone (51%) or no treatment (28%) which included close observation (21%).

For HL, there were 2 females and 8 males diagnosed in 2004, with a wider age distribution. 10% of patients were diagnosed as stage I, 20% as stage II, 30% as stage III, and 40% as stage IV. The largest group received chemotherapy only.

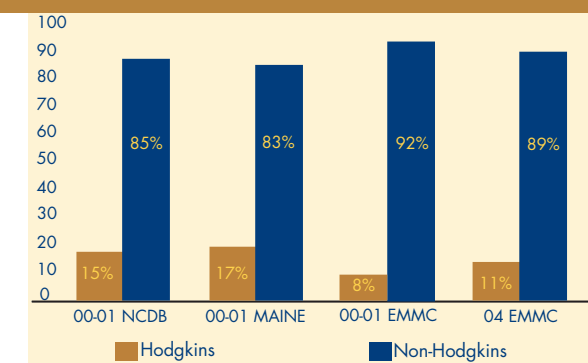
National estimates of five-year survival data for NHL, during the years 1993-1995, range from 30-53%, based on stage at time of diagnosis. EMMC cases for the same period range from 29-78%, with superior five-year survival for stage I patients and similar data for stage II-IV patients. National estimates of five-year survival data for HL, during the years 1993-1995, range from 54-78% based on stage at time of diagnosis. EMMC cases for the same period range from 100-25%, with superior survival for stage 1 patients.

Current treatment for NHL depends on the microscopic appearance and stage at the time of diagnosis. Indolent or low grade lymphomas such as small lymphocytic lymphoma, or follicular lymphoma, for example may or may not need treatment at the time of diagnosis, and are usually not considered curable. The main goal in these patients is to relieve symptoms and prolong survival. Therapy can include observation, radiation therapy, chemotherapy, or a combination approach. Radiation therapy is often used alone in patients with stage I or II disease, as the tumor is quite localized. Patients with more advanced disease, i.e. stage III or IV, are more often treated with chemotherapy alone, or combined radiation and chemotherapy. The more aggressive NHL, such as diffuse large B-cell lymphoma, can cause death in several months if not treated. These require aggressive combination chemotherapy, although localized disease, stage I or II, may also benefit from radiation therapy with less cycles of chemotherapy. Hodgkin Lymphoma, is most frequently treated with combined chemotherapy, but also may require radiation therapy, in certain instances.

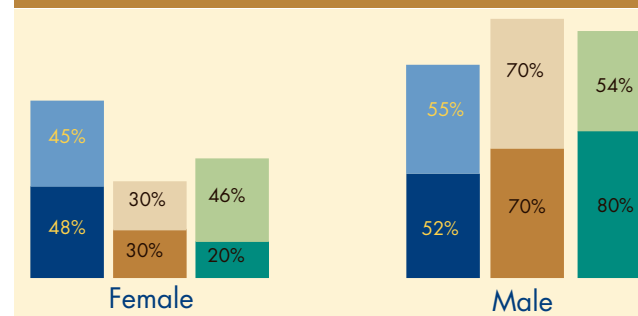
One of the important advances in lymphoma therapy has been the development of drugs that target specific proteins on the lymphoma cells, so-called "monoclonal antibodies". Rituxan, one of these new drugs, is used in both indolent and aggressive B-cell NHL. Side effects are mild, with a high response rate, and a slower progression of disease. Recent trials have shown longer event free survival and trend toward longer overall survival, with chemotherapy treatment including Rituxan. Other "target specific" drugs (called monoclonal antibodies) are under development. In addition, radioimmunotherapy, in which a monoclonal antibody is attached to a molecule that releases radiation, can increase the effectiveness of the monoclonal antibody, by killing neighboring cells. Two drugs are currently commercially available, Zevalin and Bexxar, that are useful in patients who have relapsed or no longer are responding to Rituxan.

Another important advance in the treatment of lymphoma, is the increased understanding of the genetics involved in lymphoma. This can help divide patients into risk groups, suggesting whom needs therapy right away, and who should wait, and estimates overall survival. Traditional evaluation of lymphoma cells for genetic changes provides important prognostic information. In addition, gene expression profiling using a new technology called "microarray technology", has provided exciting information on diffuse large cell lymphoma, and may be of more clinical importance as time goes on, as hundreds of genes can be evaluated at one time. Analyzing cells for characteristic markers using a technique called Flow Cytometry can help predict survival and outcome, for patients with certain lymphomas. Continued development of diagnostic and molecular tests will aid in the diagnosis, treatment and survival of patients with lymphoma. In addition, the development of new drugs should continue to improve patient outcome. We are fortunate in our community that EMMC offers the latest in diagnostic technology and treatment for our patients with lymphoma.

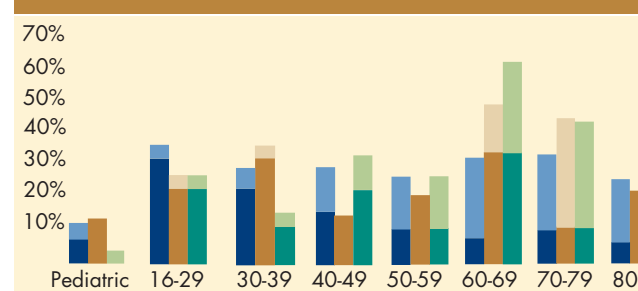
## Lymphoma: Hodgkins and non-Hodgkins Case Distribution at Diagnosis



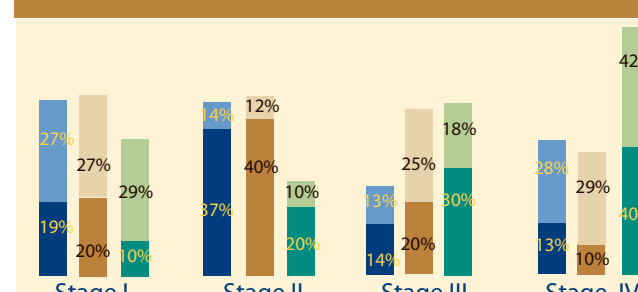
## Diagnosis by Gender



## Diagnosis by Age



## Diagnosis by Stage

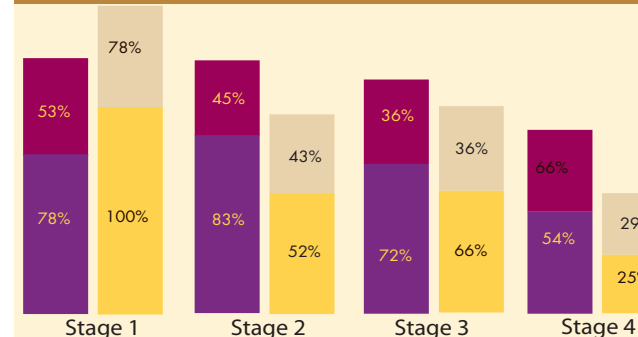


## First Course of Treatment



## Lymphoma: 5 Year Survival Rate by Stage

Cases diagnosed in 1993, 1994, and 1995



### KEY TO GRAPHS

- 00-01 NCDB Hodgkin's
- 00-01 EMMC Hodgkin's
- 04 EMMC Hodgkin's
- 00-01 NCDB non-Hodgkin's
- 00-01 EMMC non-Hodgkin's
- 04 EMMC non-Hodgkin's

### Number of cases for the first five graphs:

- 10,705 NCDB Hodgkin's
- 61 Maine Hodgkin's
- 10 EMMC Hodgkin's
- 10 EMMC Hodgkin's 2004
- 62,832 NCDB non-Hodgkin's
- 302 Maine non-Hodgkin's
- 112 EMMC non-Hodgkin's
- 79 EMMC non-Hodgkin's 2004

### Number of cases for this graph

- 11,635 Hodgkin's NCDB
- 20 Hodgkin's EMMC
- 61,278 non-Hodgkin's NCDB
- 77 Hodgkin's EMMC
- Hodgkin's NCDB
- Hodgkin's EMMC
- non Hodgkin's NCDB
- non Hodgkin's EMMC



## BREAST & OSTEOPOROSIS CENTER UPDATE



Elaine Chambers, RN, MS

The Breast and Osteoporosis Center continues to serve women from our two locations: the Breast and Osteoporosis Center on EMMC campus and the Screening Mammography site at the Union Street Healthcare Mall. Both offer FDA-certified and ACR accredited, quality mammography service.

Our digital mammography unit at the Union Street Healthcare Mall Screening Center provides easy access to an efficient high quality exam. This year we are replacing our mammography units in the Breast and Osteoporosis Center with new digital units. All of our exams include a CAD review, which will identify areas to look at again after our skilled Radiologists have read an exam. This provides our patients with a second review of their exam, and the added security of knowing that they have not only received the best possible mammogram, but the best possible interpretation of that exam as well! The Breast Diagnostic Clinic is in its third year. Under the expert direction of our BOC Medical Director, Dr. William Horner, women have an option for “a fast track” though the process of question to diagnosis.

The Prosthetics and Apparel Shop’s selection of bras, prosthesis, scarves, hats, hair pieces and swimwear is rivaled by none other in Maine. This service is provided by appointment, allowing women individual attention in for to the side effects.

Caring Connections, a cooperative program between EMMC and the Bangor/Brewer Y, is in its ninth year of offering community education on breast and cervical cancers, and osteoporosis, as well as assisting low-income women who qualify access to care for breast and cervical health issues. This program includes EncorePlus, a longstanding and important exercise and support group for breast cancer survivors. Under Caring Connections, EncorePlus is now available in 5 counties throughout northeastern Maine. The fifth annual **Beach to Beach** fundraiser was a huge success this summer, raising approximately \$14,000 for Caring Connections. A special thank you to the many swimmers, kayakers, sponsors and countless volunteers whose support made this beautiful summer day at Jenkins Beach so successful.

Our partnership with WLBY /Channel 2’s Buddy 2 Buddy program continues to offer women an educational and supportive approach to breast health and screening by enlisting a “buddy” to help women remember to do breast self exams, as well as practice age appropriate screenings. Women’s Week has included many healthy opportunities to celebrate and educate women in our community. The Breast and Osteoporosis Center along with Caring Connections continue to be involved in this celebratory week with a free Health Fair, as well as many seminars in women’s health during that week.

It is always a privilege to care for so many amazing women and we look forward to continuing to serve our patients.

## CANCER CASE CONFERENCE

Cancer Case Conference is held every Wednesday, 7:30-8:30 am in EMMC’s Governance Room. The forum is designed primarily for concurrent case review from a multidisciplinary perspective. Cases can be presented in person or via ITV. Discussions focus on diagnostic, staging, and management concerns. Both imaging studies and pathology are actively reviewed. Surgeons, medical oncologists, radiologists, and pathologists are joined by primary care providers and allied health professionals. In 2004, 216 cases were presented at these discussions--14% of our case accessions. (The ACOS-COC standard is 10%.) If you are interested in participating in person or via ITV, or would like to make a referral, please contact us at 973-7483.

## EXECUTIVE DIRECTOR’S REPORT



Greg Fecteau, RN, MHA

In February 2005, the American College of Surgeon’s Commission on Cancer (ACOS-COC) conducted a comprehensive review of all aspects of our program. The surveyor was very impressed with the quality care provided across EMMC. The program earned the highest level of recognition from ACOS-COC, accreditation with commendation, as a community cancer center through 2008. The surveyor made particular note of the caliber of our Cancer Registry. From accuracy to timely submissions to the degree of involvement in quality efforts, he recognized them as one of the best he has seen. The efforts of each person, physicians and staff alike, are to be applauded. Our patients, your patients, can be assured that they receive the best possible care at CancerCare of Maine.

The cancer program at Eastern Maine Medical Center is blessed with the incredible generosity of our community. Our Run for Hope, sponsored by the Lafayette Family/Best Western White House Inn has raised more than \$90,000 in \_\_\_ years for CCOM’s Clinical Research Program. In honor of their tireless dedication, Dan and Carla Lafayette are the recipients of the 2005 CCOM Community Support Award. Please join me in extending our heartfelt thanks, along with those of the community.

Those we care for appreciate your efforts, as indicated d by our overall patient satisfaction scores of 95% or greater, as measured by AVATAR. To all, donors, physicians, staff and volunteers contributing daily to our success, thank you.

## CANCER COMMITTEE 2005

C. Eric Hartz, MD* Medical Oncology Cancer Committee Chair	Greg Fecteau, RN, MHA* Executive Director CancerCare of Maine
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Anne Marie Blenc, MD Pathology	Dianne Bubar Director, Quality Improvement
Kathryn Bourgoin, MD Family Practice Center	Nadine Bullion, LCSW** Support Service Management, CCOM
Allan Currie, MD Chief, Internal Medicine	Andrea Byther, MS, LD Nutrition Services
Jeffrey Graham, MD Urology	Elaine Chambers, RN, MS* Department Head, Breast & Osteoporosis Center
William Horner, MD* Surgery, Medical Director Breast & Osteoporosis Center (BOC)	Margaret Chavaree, CTR* Supervisor, Cancer Registry
Peter Huang, MD* Surgery, Cancer Liason	Helen Genco* President/CEO Bangor Area Visiting Nurses/ Hospice of Eastern Maine
Thomas Openshaw, MD Medical Oncology, Medical Director, CCOM	Carol Guptill, RTT* Manager, Radiation Oncology
Philip Peverada, MD* Thoracic Surgery	Ambie Hayes-Crosby, RN* Manager, Clinical Research, CCOM
Karl-Heinz Spittler, MD Anesthesiology	Wendie Lagasse, MSB, CHES* Director, Community Wellness Service
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September 1, 2005  
Statistical Information Referenced:  
January 1, 2004-December 31, 2004

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Bringing Hope to Life



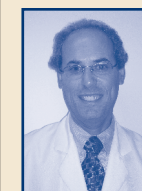
# CancerCare of Maine

## Report on Cancer 2005

Bringing Hope to Life



## CANCER COMMITTEE CHAIR REPORT



C. Eric Hartz, MD

Congratulations to our physicians and staff for their outstanding efforts. In 2005 we received an approval with commendation on each of the eight comprehensive review criteria as a Community Hospital Comprehensive Cancer Center from the American College of Surgeons (ACOS) – Commission on Cancer (COC).

### SERVICE

In 2004, 1243 patients underwent cancer related surgery at EMMC, with 675 having their definitive surgery at EMMC (an 11% increase over 2003). Each day more than 250 patients are seen at CancerCare of Maine. 1174 patients and families began care in medical oncology and 757 in radiation oncology. At the close of FY 2005, overall growth for both areas is 29% and 1% respectively. Pediatric care remains steady with 15 newly diagnosed cases in 2004. Admissions to the medical oncologists, primarily to Grant 6 Oncology, increased by 30%. Along the continuum of care, EMMC’s Palliative Care Consultation team served 210 patients (up nearly 78% from last year) and Hospice of Eastern Maine cared for 99 cancer patients and their families (an increase of 106%).

### RESEARCH

CCOM’s Clinical Research Department brings nationally recognized clinical and pharmaceutical trials to the region, helping patients get the very best of care close to home. In 2004, 64 patients were enrolled. Our Clinical Research staff review each new patient for potential clinical trial participation. Together with our physicians their efforts resulted in a commendation for research patient protocol participation during our 2005 ACOS-COC survey. Our clinical research staff was recognized by NSABP (National Surgical Adjuvant Breast and Bowel Project) as one of 21 institutions for the highest quality data management and for developing tools to assist caregivers with enrolling patients on study. In recognition of their superior performance, our staff has been invited by Cancer and Leukemia Group B to assist them in monitoring of other CALGB participants.

### NEW TECHNOLOGY

We’re aiming to make Digital Mammography II our gold standard. A fund raising effort is underway to obtain a third unit to maximize use of best technology for assessment of all patients. Dr. Paul Szal, Radiation Oncology, reports that use of IMRT continues to grow; an additional linear accelerator was fitted with MLC (Multi-Leaf Collimator) technology to expand the opportunity to utilize this technology. IMRT allows for very precise delivery of dose to an area of disease, such as the prostate, while minimizing dose to nearby organs, such as rectum and bladder. It does this by varying the amount of radiation entering the patient within each radiation field—intensity modulation. We are looking forward to the arrival of HDR (High Dose Rate) Brachytherapy for the treatment of breast cancer.

### QUALITY

We are proud to report that overall satisfaction has been above 95% for the Breast & Osteoporosis Center, pediatric, medical and radiation oncology services throughout 2005. Our commitment to excellence includes peer review, comparison to national standards, and program enhancements to assure our patients receive the best care possible. Each year for the four major cancer sites, we review our 5-year survival statistics with the National Cancer Data Base (NCDB). Statistically for colon and lung cancer our 5-year survival rates are the same. Survival for breast cancer is higher (overall when compared to Maine and the national data and for stage II compared to Maine), while prostate cancer is lower (for stage II and overall when compared to the national data, but the same as the rest of Maine).

### EDUCATION

Our “visiting professor program” under the direction of Merrill Garrett, MD, and in conjunction with Partners Institute (Boston, MA) featured experts in the areas of lymphoma, gynecologic, head and neck cancers, thoracic surgery, and breast oncology. This program, our weekly cancer case conferences, expanded format for breast cancer conferences, surgical and medical grand rounds form the nucleus of our continuing education efforts for physicians, nurses and allied health professionals. We held our inaugural Spring Cancer Care Symposium, Lung Cancer, Prevention, Detection & Management: A Multi-Disciplinary Perspective. I’d like to thank Dr. Philip Peverada for his leadership and commitment to this well received project. Plan on joining us for Breast Cancer – on April 27.

### COMMUNITY

EMMC is a key force behind Move & Improve, an effort that promotes physical activity, stress reduction and healthy eating and lifestyle habits. In 32 community-based work site screenings, employees were educated about their risk for lung, breast and colon cancer. Through Caring Connections, a jointly sponsored program between the Bangor/Brewer Y and EMMC, 270 low income, medically underinsured women were screened for breast and cervical cancer. With the American Cancer Society, EMMC featured Dr. Norman Sykes in a symposium on skin cancer in July. Dr. Peter Millard received a grant from the American Cancer Society to support provider based colon cancer screening education and patient outreach. A pamphlet for use in primary-care settings was developed with the grant funds.