

# 2005 CANCER OCCURRENCE

Accessioned (New to EMMC) Cancer Cases: 2005 Analytic/Non-Analytic Comparison				
	2002	2003	2004	2005
Total Analytic Cases	1348	1456	1552	1608
Cancer diagnosed and/or treated at EMMC	706	775	879	833
Cancer disgnosed elsewhere and received all or part of first course of treatment at EMMC	642	681	672	775
Total Non-Analytic Cases	149	138	140	198
Cancer diagnosed and received all or part of first course of treatment not at EMMC				
Total Accessioned Cases	1497	1594	1692	1806

Primary Site Frequency Distribution: 2005 Accessioned Cases													
Primary Site	Total	Analytic	% Analytic	# Non-Analytic	% Non-Analytic	Male	Female	Stago 0	Stage 1	Stage 2	Stage 3	Srtege 4	Not Staged
Oral	17	14	1	3	2	14	3	1	3	5	2	3	3
Esophagus	33	33	2	0	0	26	7	0	1	11	6	13	2
Stomach	20	16	1	4	2	10	10	1	6	0	4	5	4
Colon	118	105	7	13	7	58	60	0	20	36	20	22	20
Rectum	40	36	2	4	2	28	12	0	7	7	12	5	9
Liver/Biliary	23	22	1	1	1	13	10	0	4	3	5	6	5
Pancreas	27	26	2	1	1	16	11	0	1	6	4	13	3
Larynx	15	13	1	2	1	9	6	2	4	2	2	3	2
Lung	325	310	19	15	8	173	152	1	65	19	93	111	36
Connective	15	9	1	6	3	5	10	0	2	1	2	1	9
Melanoma	65	55	3	10	5	41	24	16	22	6	11	3	7
Breast	322	285	18	37	19	4	318	47	120	78	28	9	40
Cervix/Uteri	13	11	1	2	1	0	13	2	4	0	2	2	3
Corpus Uteri	38	31	2	7	4	0	38	1	15	3	6	1	12
Ovary	23	17	1	6	3	0	23	0	3	5	6	3	6
Prostate	190	160	10	30	15	190	0	0	0	122	15	13	40
Testis	17	17	1	0	0	17	0	0	12	3	1	0	1
Bladder	44	34	2	10	5	32	12	11	5	5	6	4	13
Kidney/Ureter	39	31	2	8	4	24	15	0	12	2	8	6	11
Brain/CNS	45	40	2	5	3	33	12	0	2	0	0	0	43
Thyroid	20	17	1	3	2	4	16	0	13	2	0	2	3
Leukemia	73	64	4	9	5	42	31	0	0	0	0	0	73
Lymphoma	102	98	6	4	2	45	57	0	19	13	19	45	6
Other	182	164	10	18	9	110	72	2	5	11	14	10	140
Total	1806	1608	100	198	100	894	912	84	345	340	266	280	491

# CANCER REGISTRY REPORT



Margaret Chavaree, BA, CTR

The Cancer Registry, an integral part of the cancer program at EMMC, is now staffed with four cancer registrars who report EMMC cancer statistics and work closely with physicians and staff to provide support for cancer program development. The Registry plays a key role in managing and analyzing clinical cancer information for the purpose of education, research, and outcome measurement. In 2005 over 165 hours were spent addressing such 34 requests.

With the ultimate goal of preventing and controlling cancer the Registry ensures compliance with Maine State Cancer Registry and the National Cancer Database reporting standards. Doing so assists public health professionals to better understand and address the cancer burden.

The Cancer Registry's primary role 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. This collected data is an invaluable tool in the fight against cancer.

Each patient diagnosed or who received his / her first course of treatment at EMMC is provided with an annual lifetime follow-up - 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. EMMC's lifetime follow-up is maintained at 98% for cases since 1998 (ACOS-COC standard is 90%).

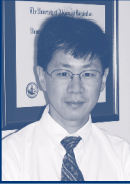
Physicians utilize American Joint Committee on Cancer (AJCC) staging to stratify patients and to determine optimal treatment. At EMMC initial physician compliance with staging form completion requirements has been consistently above 90% (with registry follow up - nearly 100%).

Tables presented here reflect cancer case accessions, frequency, stage of disease at presentation and prevalence for 2005 at EMMC.

At our Cancer Conferences in 2005 across all major sites 211 cases (including 35 cases from Breast Biopsy Correlation review) were presented - 13% of analytic case accessions. (ACOS-COC standard is 10%.) New, this year, we began a bi-monthly special focus on breast cancer. Doing so has broadened surgeon participation from across the region. Our Visiting Professor Program under the direction of Merrill Garrett, MD, and in conjunction with Partners Institute (Boston, MA) featured oncology experts in the areas of breast, gynecologic, head and neck, leukemia, lung, and lymphoma cancers. The forum as part of our quality care initiative provides best diagnostic and care review with participation open to medical and allied health professionals, both on and off site.

2005 EMMC Most Prevalent <u>Analytic</u> Cases Compared to American Cancer Society (ACS) 2005 New Case <u>Estimates</u>				
Site	EMMC Analytic Cases	% of Analytic Cases	ACS National Estimates	% of Cases
Lung	310	19	172,570	13
Breast	285	18	212,930	16
Prostate	160	10	232,090	17
Colon	105	7	104,950	8
Lymphoma	98	6	63,740	5
Brain/CNS	40	2	18,500	1
Rectum	36	2	40,340	3
Melanoma	55	3	59,580	4
Kidney/Ureter	31	2	38,670	3
Leukemia	64	4	34,810	3
Top Case Totals	1184	74%	978,180	71%
Total Cases	1608		1,377,718	

# MELANOMA: THE BASICS



Peter Huang, MD, FACS

It is estimated that over one million skin cancers are diagnosed in the United States annually. Squamous cell carcinomas and basal cell carcinomas account for the vast majority. They generally are non-aggressive malignancies that do not tend to spread to other sites. Complete surgical removal is generally curative.

Melanoma is a cancer that begins in skin cells called melanocytes. These cells make melanin, which gives skin its color. Melanin also protects the deeper layers of the skin from the sun's harmful ultraviolet (UV) rays. While melanoma accounts for only about 4% of new skin cancers, they are responsible for the majority of deaths from cutaneous malignancies.

During the 5-year period from 2001-2005, there were 201 melanomas diagnosed at EMMC. While the incidence of melanoma is relatively low, it is increasing steadily over time. In fact, among the 10 leading types of cancer in the United States, melanoma is the only cancer that is significantly increasing in incidence. On average, rates are rising 3.3% per year for men and 2.1% per year for women. In 2001 there were 51,400 new diagnoses of melanoma -- by 2006 it is estimated that there will be 62,190 new cases of melanoma diagnosed and 7,910 individuals will die of this disease.

Melanoma is slightly more common in men than women (55% vs. 45%) and increases in incidence with age, though melanoma can be found in young adults and even children. Regionally, melanoma is diagnosed more frequently in the age group between 30 to 49, when compared to national (p<0.0001) and state data (p=0.026). Evidence of this trend provides a potential target for surveillance education.

Individuals with fair skin, red or blond hair, and large numbers of moles (nevi) - particularly if these moles harbor atypical or dysplastic features - are at an increased risk for developing melanoma. A prior history of melanoma increases the risk for the development of additional new melanomas. Immunosuppressed individuals are also at increased risk. Approximately 10% of melanoma patients will have a close relative with melanoma. Much of this association can be attributed to similar environmental exposure or physical characteristics, though a small number are related to inherited genetic mutations of DNA repair or tumor suppression genes. For individuals with a strong family history, testing for genetic pre-disposition is available through EMMC.

The most significant environmental factor (and the only risk factor that can be influenced by individual choice) is exposure to UV radiation, which causes direct damage to cellular DNA. Extreme exposure resulting in sunburn and exposure during childhood is particularly implicated in subsequent melanoma risk. This risk is conferred regardless of whether the source of UV radiation is from the sun, or from artificial lamps or tanning booths. Regionally, education to minimize sun exposure aimed at parents of newborns and summer camp staff has been initiated in collaboration with Maine's Cancer Consortium and the American Cancer Society.

The early diagnosis of melanoma is extremely important, and self-examination is an important component of early detection. The ABCDE Rule is helpful in remembering the characteristics of melanoma - (A) Asymmetry in shape, (B) Border is irregular, (C) Color is multiple or variable, (D) Diameter is greater than 5mm and (E) Evolution in appearance over time. One should also be alert for lesions that are ulcerated or bleed. For suspicious lesions, the diagnostic method of choice is a full-thickness excisional biopsy of the skin. If excisional biopsy is not possible due to lesion size or location, an incisional or punch biopsy of the most suspicious portion of the lesion is sometimes necessary.

Common subtypes of melanoma have been described. Superficial spreading melanomas are the most common and have a more outward (radial) growth pattern. Nodular melanomas tend to have a more vertical growth pattern. Acral lentiginous melanoma is seen on the palms and soles and under the nails and is the most common form of melanoma in Asian- and African-Americans. Lentigo maligna are lesions that do not tend to be invasive, though can grow to large size.

Diagnosis of melanoma at an early stage is an important determinant of successful treatment. Independent of tumor subtype, the most important feature of melanoma and one of the important staging criteria in the American Joint Committee on Cancer (AJCC) system is the tumor, or Breslow, thickness. The presence of ulceration is also extremely important.

- Stage 0: non-invasive or in situ lesions that have an excellent prognosis.
- Stage I: Breslow thickness up to 1.0mm, or between 1.01-2.0mm without ulceration.
- Stage II: between 1.01-2.0mm with ulceration or tumors greater than 2.0mm without lymph node spread.
- Stage III: patients with spread to lymph nodes.
- Stage IV: metastases to distant sites.

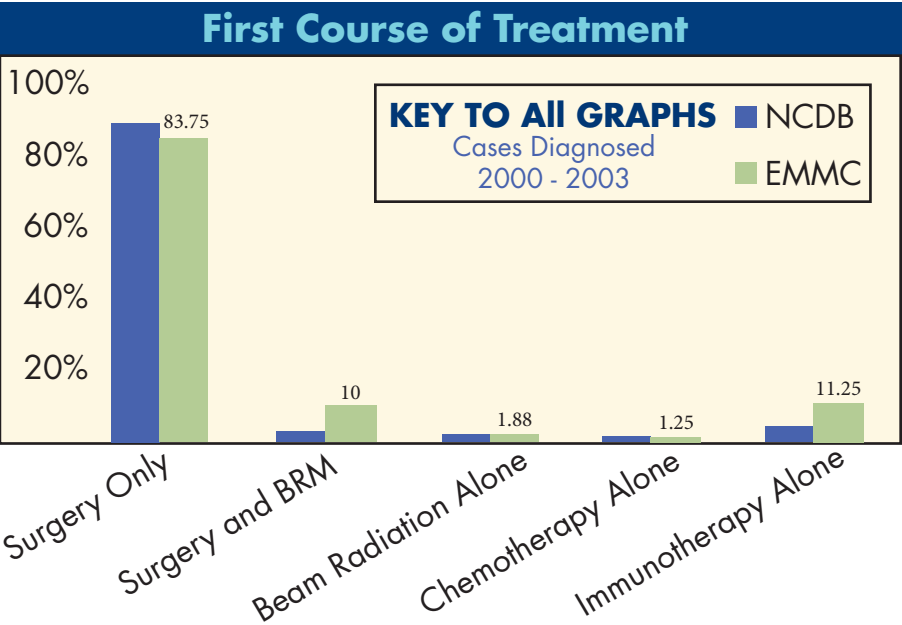
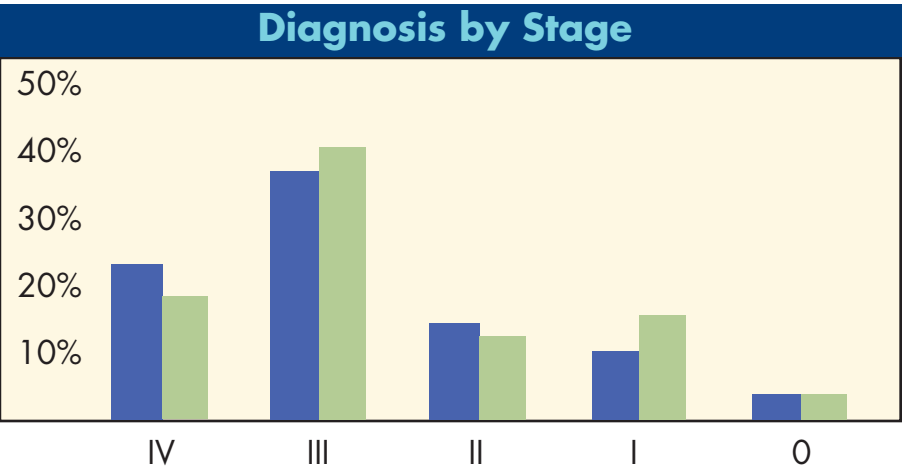
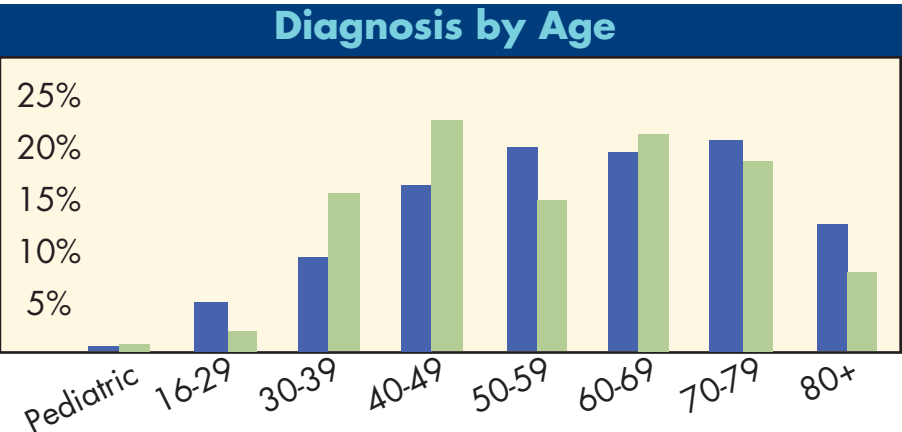
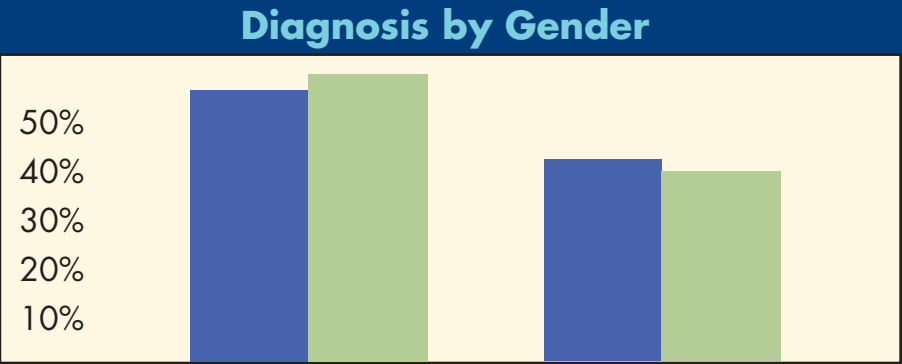
At EMMC, the stage of melanoma at diagnosis closely approximates national averages with a distribution for Stage 0 - 24.2% (vs. 21.9% nationally), Stage I - 40.6% (vs. 42.1%), Stage II - 16.5% (vs. 19.2%), and Stage IV - 3.3% (vs. 4.4%). For Stage III - 15.4% (vs. 12.4%), the rate of diagnosis at EMMC is statistically higher than national rates, reinforcing the need to advocate for routine skin surveillance.

The most effective treatment for melanoma is a wide and complete surgical excision. For localized melanomas, wide excision alone can result in cure rates of 60% to nearly 100% depending on tumor thickness and presence of ulceration. Melanomas that spread most commonly do so to lymph nodes, and the presence of nodal metastases is best determined with a technique called sentinel lymph node biopsy. In this technique, a combination of radioactive tracer and blue dye are injected at the site of the primary melanoma. Lymph nodes that receive dye are removed and analyzed for possible tumor spread. At EMMC, sentinel node biopsy was performed for 44.1% of patients with Stage I melanoma. Nodal examination was considered for 92% of patients with Stage II or III disease. Of those medically appropriate, 83% had lymph node evaluation completed - 54% had examination limited to sentinel nodes. Those without lymph node spread generally require no further treatment. If lymph node metastasis is found, more extensive lymph node surgery and treatment in addition to surgery is often recommended.

There are a number of options for treatment of node-positive patients and those with advanced metastatic disease. For our patients with Stage III or IV melanoma, 94% were referred to our Medical Oncologists for this consultation. Immunotherapy with Interferon-alpha2b is used in some patients with Stage III disease to stimulate a person's immune system against melanoma and has been shown in a large controlled study to increase survival in patients with node-positive melanoma. However, the side effects of interferon therapy have limited its use. Another method to stimulate the body's own immune system against melanoma is by the use of vaccines. These vaccines are made of tumor antigens, sometimes derived from a patient's own tumor cells, and are an active area of investigation. Traditional chemotherapy has not been found to significantly affect prognosis in previous melanoma studies. However, biochemotherapy - treating with immunotherapy together with combination chemotherapy - has shown some promise and is another treatment under investigation in a number of clinical trials. Regionally, significantly more (p<0.0001) of our patients receive combined modality treatment (surgery and behavior response modifiers / immunotherapy) when compared to national use rates (2000 to 2003).

The investigation into adjuvant therapy after surgical resection, and for patients with advanced metastatic disease is an area of great interest and potentially great clinical benefit for patients otherwise facing a poor prognosis. We are fortunate to be able to enlist our patients in these important clinical trials here at EMMC or in close collaboration with our colleagues at participating centers. Due to our commitment to state of the art treatment for this often-challenging disease, a 5-year survival rate of 82.1% (for those diagnosed in 1998) has been achieved for patients diagnosed with melanoma at EMMC, matching the national rate

# MELANOMA DATA: EMMC WITH NATIONAL CANCER DATABASE





# BREAST & OSTEOPOROSIS CENTER UPDATE



Elaine Chambers, RN, MS

The Breast and Osteoporosis Center serves women in two locations, the Breast and Osteoporosis Center on the EMMC campus (providing both screening and diagnostic services) and the Screening Mammography site at the Union Street Healthcare Mall. Both sites offer FDA certified and ACR accredited quality mammography service.

Early detection is still our best tool in the battle against breast cancer – digital mammography is a key part of the early detection process. All of our units have been replaced with digital mammography - allowing us to offer clearer sharper images, more efficient exams, and digital storage. The Radiologist has more image viewing options thus reducing patient callbacks, decreasing anxiety and increasing satisfaction.

All of our mammograms include a CAD review, a sort of spell check for Radiologists. Once our local skilled Radiologists have read an exam, it identifies areas to look at again to be sure everything has been scrutinized. This second review provides our patients with the knowledge that not only have they received the best possible mammogram but the best possible interpretation of that exam also! We continue to provide our diagnostic mammography patients with same day results.

The Breast Diagnostic Clinic is in its fourth year under the expert direction of our BOC Medical Director, Dr. William Horner. It provides women with an option focused on fast tracking from question or concern to diagnosis. Our patient satisfaction scores, often 97% and above, echo the importance and value of this service.

Responding to community provider requests, in April the BOC and CCOM sponsored a regional conference, *Applying Best Practices in Breast Cancer Diagnosis and Treatment*, attended by 110 providers. The conference featured speaker Blake Cady, MD, FACS. We introduced “Best Practices in Breast Care”, a guide to diagnostics. All attendees received a copy.

The Prosthetics and Apparel Shop's selection of bras, prosthesis, scarves, hats, hairpieces and swimwear continues to rival none other in the state. Private individual attention is a hallmark of this by appointment service. As of January 2007, appointment booking will be available through EMMC's Scheduling Center 7am to 7pm. Every other month we continue to host the ACS *Look Good, Feel Better* program providing women in treatment a positive and upbeat preparation to the side effect of hair loss; offering tips on skin care and make up.

*Caring Connections* is a cooperative program between EMMC and the Bangor/Brewer Y, in its tenth year of providing community education on breast and cervical cancer, osteoporosis as well as assisting low-income women who qualify to access breast and cervical health care. The program includes *Encore Plus*, a longstanding and important support group for breast cancer survivors. The sixth annual *Beach to Beach* fundraiser held this past August raised over \$15,000. I'd like to extend a special thank you to the many swimmers, kayakers, sponsors and countless volunteers whose support made this beautiful sunny summer day at Jenkins Beach, such a success.

Our partnership with WLBZ /Channel 2's *Buddy to Buddy* program, continues to offer women an educational and supportive approach to breast health and screening by enlisting a “buddy” to help remember to do breast self exam as well as practice age appropriate screenings. *Women's Week* included many healthy opportunities to celebrate and educate women in our community.

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

## CANCER CASE CONFERENCE

Cancer Case Conference is held every Wednesday, 7:30 – 8:30 at EMMC. The forum is designed for concurrent case review. Cases can be presented in person or via ITV or phone. Discussions focus on diagnostic, staging and management concerns. Imaging studies and pathology are actively reviewed. Surgeons, medical and radiation oncologists, radiologists, and pathologists are joined by primary care providers and allied health professionals. On the first and third Wednesdays of the month we added a section from 7:00 to 7:30 to focus on breast cancer cases. 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 follow up to our 2005 successful comprehensive review by the American College of Surgeon's Commission on Cancer (ACOS-COC) Eastern Maine Medical Center's Cancer Program was honored with an Outstanding Achievement Award in February of 2006. The award recognizes the commitment to excellence in all aspects of clinical care. You can be assured that your patients, our patients, receive the best possible care a Comprehensive Community Hospital Cancer Center can provide. To all, donors, physicians, staff & volunteers contributing daily to our success, I thank you.

Our annual report focuses on melanoma, one of the most frequently diagnosed cancers at EMMC - impacting both adults and children. We are proud of the care we deliver and our success in helping those diagnosed manage this disease. I would like to extend a special thanks to Dr. Huang, a surgical oncologist with Northeast Surgery, for his commendable efforts in pulling together this report.

While our patient satisfaction scores continue to be at the 95th percentile, increasingly we are challenged to deliver the kind of care you and your patients have come to expect. Our continued growth, the changes in duration of therapy, the arrival of new technologies have strained our capacity. In 2005, not satisfied with patient waits, a crowded space, and an inability to accommodate preferences for scheduling and activity during long treatments, EMMC submitted a proposal (Certificate of Need - CON) to build a new state of the art comprehensive cancer center. In June 2006, the State of Maine granted approval agreeing that we were outgrowing our current facility and needed to plan for the future.

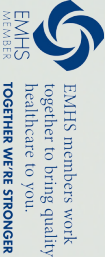
As this report goes to press, we are engaged in designing our new facility, which will be located in Brewer with improved patient access and parking. It will house medical and radiation oncology, hematology along with PET CT, digital imaging, basic laboratory and supportive services. We will share the site with The Maine Institute for Human Genetics and Health. Opportunities for collaborative research hold much promise for the region. We anticipate breaking ground in July 2007 with completion in early 2009.

At our 2006 celebration of Cancer Survivors, as the recipient of the 2006 CCOM *Community Support Award* we recognized a truly special individual - Mart Lapin. The award is given in recognition of exemplary support and leadership in furthering research, education, technology and care development at EMMC's CancerCare of Maine. Mr. Lapin is the driving force of the *Oncology Support Foundation* - a new group dedicated to easing the burden of those facing cancer, their families, through practical assistance, advocacy and innovative programs. Please join me in extending to Mr. Lapin our heartfelt thanks, along with those of the community.

## CANCER COMMITTEE 2006

Paul Szal, MD* Radiation Oncology Cancer Committee Chair	Allan Currie, MD Chief, Internal Medicine	Philip Peverada, MD* Thoracic Surgery
Greg Fecteau, RN, MHA* Executive Director, CancerCare of Maine	Andrea Byther, MS, LD Nutrition Services	Ambie Hayes-Crosby, RN* Manager, Clinical Research, CancerCare of Maine
Judith Allen, MD* Pediatric Oncology	Jeffrey Graham, MD Urology	Karl-Heinz Spittler, MD Anesthesiology
Nancy Aylward, RN Case Management	William Horner, MD Surgery, Medical Director, Breast & Osteoporosis Center	Paul Templeton, MD Radiology
Ann Marie Blenc, MD Pathology	Elaine Chambers, RN, MS* Department Head, Breast & Osteoporosis Center	Dianne Bubar Director, Quality Improvement
Helen Genco, RN* Chief Operating Officer Eastern Maine HomeCare	Margaret Chavaree, BA, CTR* Supervisor, Cancer Registry	Allen L'Italien, RN* Program and Business Manager, CancerCare of Maine
Katherine Bourgoin, MD Family Practice	Wendie Lagasse, MSB, CHES* Director, Community Wellness Service	Rich Maietta, RPh Pharmacy, CancerCare of Maine
Nadine Bullion, LCSW** Support Service Manager, CancerCare of Maine	Carol Guptill, RTT* Manager, Radiation Oncology	David Warner, MD Radiology
Peter Huang, MD* Surgery, ACOS-COC Cancer Liaison	Thomas Openshaw, MD* Medical Oncology, Medical Director, CancerCare of Maine	Nadine Tasker, RN* Coordinator, Palliative Care Program
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Cancer Registry  
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Pediatric Oncology  
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# CancerCare of Maine Report on Cancer 2006

*Bringing Hope to Life*



# CANCER COMMITTEE CHAIR REPORT



Paul Szal, MD

The American College of Surgeon's Commission on Cancer's special recognition of Eastern Maine Medical Center's cancer care is a tribute to the dedication and excellence of our physicians and staff alike. It is testimony to the fact that we provide your patients with the very best care possible. Equally important, with satisfaction survey scores topping 95%, your patients tell us that they're pleased with our care. We thank you for your referrals and your part in delivering high quality care throughout the region.

**SERVICE**

In 2005, 1191 cancer related surgical procedures were performed for 895 patients @ EMMC, of these 59% were definitive. Daily over 275 patients/families are seen at CancerCare of Maine (CCOM). 1394 patients and families began care in medical oncology and 745 in radiation oncology. At the end of FY 2006, growth was 5% & 1% respectively. Pediatric Care remains steady with care initiated for 14 in 2005. Grant 6 Oncology admissions increased by 30%. Along the continuum of care, EMMC's Palliative Care Consultation team served 377 (up nearly 79% from last year) while Hospice of Eastern Maine cared for 49 (on par with last year) cancer patients & their families.

**RESEARCH**

In 2005, 84 patients were enrolled – 5.0 % of our analytic case accessions, exceeding the ACOS-COC standard of 2%. CCOM's Clinical Research Department brings nationally recognized clinical and pharmaceutical trials to the region, helping patients access very best of care and investigational agents while staying close to home. For example we participated in national trials that demonstrated the efficacy of Avastin in the metastatic colorectal setting and for myelodysplastic syndrome. Now are both FDA approved.

The NSABP – National Surgical Adjuvant Breast & Bowel Project prevention trial – STAR (Study of Tamoxifen & Raloxifen) was “un-blinded” in Spring 2006. We had enrolled 50 participants. Results demonstrated the efficacy of Raloxifen in breast cancer prevention. We expect to participate in the next generation national breast cancer prevention trial beginning in spring of 2007. It will target postmenopausal high risk women. Most likely, it will compare an aromatase inhibitor with a serum estrogen receptor modulator. Once the trial is open we will look to enlist your support in enrolling eligible women.

**NEW TECHNOLOGY**

In Radiation Oncology, each treatment machines is now capable of fine tuning dose delivery. Installation of the MLC – multi-leaf collimator was completed on the third machine providing maximal flexibility for best treatment scheduling. IMRT (Intensity Modulated Radiation Therapy) for prostate cancer is now fully implemented. As our standard of practice we added Sonarray, an ultrasound imaging technique, to more precisely localize the prostate assuring best possible targeted treatment delivery. To fast-track our capacity to treat additional types of cancer with IMRT, we engaged D3-Radiation Planning, Inc associated with the University of Pittsburgh. Their expertise provided us with benchmarked protocols and specialized training for both physician and physics staff alike. As a result, we were able to offer IMRT for the treatment of head and neck cancers much sooner than anticipated. We have also initiated use of HDR – high dose rate brachytherapy – for the treatment of gynecologic cancers – eliminating the need for a 3 day inpatient stay in isolation. In the future this modality will be used in the treatment of other cancers as well.

**QUALITY**

Our commitment to excellence includes peer review, comparison to national standards, program enhancements to assure our patients receive the best care possible. Each year we review the four major cancer sites, comparing stage at diagnosis and survival with most currently available data from the National Cancer Data Base (NCDB). For cases diagnosed in 2003 when comparing EMMC with NCDB data, stage at diagnosis for

- breast cancer was the same for all but stage II, with EMMC having more diagnosed at this stage than NCDB
- colon cancer was the same for all but stage IV, with EMMC having more diagnosed at this stage than NCDB
- lung cancer was the same for all but stage III, with EMMC having more diagnosed at this stage than NCDB
- prostate cancer was the same for all stages.

For cases diagnosed in 1998, survival was the same across all 4 major sites by stage as NCDB. As part of Maine's Cancer Consortium, we are actively working to promote earlier detection of colon cancer through – SCREEN ME – a public education forum.

In this report you will find our focus on melanoma. I want to personally thank Dr. Peter Huang for his careful review and excellent report. I encourage you to take a moment to read it.

**EDUCATION**

Patients/families continue to benefit from participation in support groups, increasingly active over the past year, and programs held in conjunction with the American Cancer Society – I Can Cope & Look Good, Feel Better.

We hosted two multi-disciplinary conferences this year: *Applying Best Practices in Breast Cancer Diagnosis & Management* – under the guidance of Dr. William Horner and *Advanced Lung Cancer: When to Treat & When to Palliate* – under the guidance of Dr. Philip Peverada. or 2007, we look forward to a focused spring forum on breast cancer and in the fall a look at our progress with the development of our Thoracic Oncology Clinic for fast tracking lung cancer diagnosis.

**COMMUNITY**

Through its Community Wellness Program, EMMC screened over 1,563 community employees. Basic cancer risk items are reviewed, including indicators of potential genetic risk. Stop Smoking initiatives are individually based. Our genetic counseling referrals are steadily increasing. Again this year EMMC was a key force behind *Move & Improve*, a community wide effort engaging over 9,568 people to promote physical activity, stress reduction and healthy eating and lifestyle habits (including smoking cessation) with over 50% completing the program.