TOGETHER We're Stronger

CancerCare of Maine

Report on Cancer 2008

Bringing Hope to Life

Eastern Maine Medical Center℠
Inspiring confidence in care

EMHS MEMBER

EXECUTIVE DIRECTOR'S REPORT

Allen L'Italien, RN

In February 2008, the American College of Surgeon's Commission on Cancer conducted a detailed review of each segment of the cancer program at EMMC. Once again the program was rated at the highest level of recognition, accreditation with commendation as a community hospital comprehensive cancer center through 2011. Their extensive review validates for our community that the patients in our region receive an extremely high level of cancer care.

The past year has seen many enhancements for cancer patients. Deserving of special recognition are Dr. Ian Dickey as the state's only orthopedic oncology surgeon, Dr. Peter Huang as a general oncology surgeon and Dr. Susan O'Connor as a surgeon and serving as the new medical director for the Breast and Osteoporosis Center. Each enhances the quality of surgical care for those with difficult cancers. We are thankful to them as well as all the surgical and medical staff caring for our region.

The Franklin Carl Cloukey Family was recognized for their ongoing support of those faced with cancer and CancerCare of Maine in the Lincoln region. Carleen Cloukey was on hand to accept CancerCare of Maine's *Community Support Award* on behalf of the family at our 2008 Cancer Survivor Day Celebration. August saw the family hosting their annual golf tournament honoring their dad and supporting the care at CancerCare. Our continued thanks go out to the Cloukeys, along with Danny and Carla Lafayette in recognition of their continued generous support of the *Run for Hope*, an annual event supporting research at both CancerCare of Maine and the Maine Institute for Human Genetics & Health.

Champion the Cure… our capital campaign to raise money for our new cancer center in Brewer has many champions! Barely into retirement, Dr. Bill Horner and his wife, Cookie took on lead roles in the campaign; Fran Loring, RN, came back as a volunteer to lead the employee campaign. We hope many of you had the opportunity to join Eastern Maine Medical Center's Auxiliary at their fabulous Fall Kitchen Tour or their wicked good Winter Beach Ball. If not, we'll look forward to seeing you next year. Each event, held annually, is part of the Auxiliary's commitment to raise $250,000 towards the new cancer center.

Everyone is busy with daily activities as well as preparing for the new cancer center. A tentative opening is set for the facility located in Brewer - November 2009. Enhanced technology for those needing radiation as well as bright comfortable space is eagerly anticipated. I want to extend a special thank you to all those who are helping make this project a reality as well as to the generous supporters that do amazing things for our patients and program.

CANCER LEADERSHIP COMMITTEE 2008

Medical Staff

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Committee Chair

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Pediatric Oncology
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CANCER COMMITTEE CHAIR REPORT

Paul Szal, MD

The American College of Surgeons – Commission on Cancer conducted its accreditation visit in 2008. Our excellence in care was recognized by a full three year accreditation and commendation as a Community Hospital Comprehensive Cancer Program. Congratulations to all physicians and staff contributing to this outstanding level of care at Eastern Maine Medical Center. Also, please join me in welcoming Sarah Fryberger, MD to the pediatric oncology staff.

SERVICE
In **2007**, 87% of those diagnosed underwent some form of surgery. At EMMC both the number of procedures (1502) and the number of patients (1130) completing surgery was up by 14% & 15% from last year. For those having biopsies elsewhere 30% received their definitive surgery at EMMC (up 5% over last year) with 62% of all receiving definitive surgeries at EMMC. During **2008**, 1458 patients and families began care in medical oncology (MO); 804 in radiation oncology (RO) and 20 in pediatric oncology. Volume growth continues in each area. Grant 6 Oncology admissions were slightly less than in 2007. Along the continuum of care, EMMC's Palliative Care Consultation team completed 838 consultations (up nearly 16% from last year) while Hospice of Eastern Maine cared for 70 (up 30% from last year) cancer patients & their families. Palliative Care has re-instituted a physician component to their service with coverage available 7 days a week. To meet growing community needs, hospice added a bereavement coordinator. Held each year, the first Sunday of June, our Survivor Celebration hosted over 600.

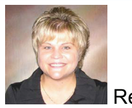
RESEARCH
In 2007, 68 patients were enrolled – 3.7 % of our analytic case accessions which exceeds the ACOS-COC standard of 2%. In 2008 Dr. Thomas Openshaw assumed the role of principal investigator for CCOM's Clinical Research program. With greater emphasis on early patient identification both at diagnosis and time of recurrence, physician engagement and patient education, accruals for 2008 (81 so far) will have exceeded the 2007 rate by nearly 20%. In spring 2009, we will host a talk by Lidia Schapira, MD, Massachusetts General Hospital, focusing on effective strategies to engage patients in clinical trials. Through enhanced collaboration with other institutions across the state, the program is looking to strengthen patient access to clinical trials statewide.

NEW TECHNOLOGY –
The Breast and Osteoporosis Center became one of only two facilities in the state to be ACR accredited for the use of ultrasound guided biopsy. PET CT services will be available beginning January 2009. The new imaging center located on Union Street is due to open in fall of 2009. Focused on planning for the new center equipment needs, Radiation Oncology is pleased to report that we will be bringing stereotactic radio therapy to the region. The GE Advantage Sim-MD Workstation, an advanced simulation tool enabling physicians to delineate tumor volumes and organs at risk with greater accuracy, will be utilized with the new multi-slice gated-image scanner at Brewer offering 4D display of tumors accounting for respiratory motion. The workstations will also provide enhanced tumor imaging with the new PET/CT scanner at Brewer. Together these enhancements will permit more precise delivery of therapy with anticipated improved outcomes and diminished effect on surrounding tissues.

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 current data from the National Cancer Data Base (NCDB). For cases diagnosed in 2006 when comparing EMMC with NCDB data for stage at diagnosis for breast, colon, lung and prostate cancer rates were for the most part the same statistically. Favorable exceptions included greater number of cases: for breast cancer in stage 0; lung cancer greater stage I. For cases diagnosed in 1998 to 2001, the 5-year survival rate was statistically higher than national rates for colon cancer diagnosed at stage I and III, for prostate cancer at stage IV. Other survival rates for breast, colon, lung and prostate cancer by stage were statistically the same as national rates. When compared to the rest of Maine, breast and lung cancer survival rates were higher for stage I; prostate cancer for stage IV.

In this report you will find our focus on colon cancer. I want to personally thank Dr. Peter Huang for his excellent report. I encourage you to take a moment to review his work.

CANCER REGISTRY REPORT



Renee Stefanik, RHIT, CTR

The Cancer Registry is an integral part of the cancer program at EMMC. During our most recent American College of Surgeon's Commission on Cancer (ACOS-COC) accreditation review, the registry staff was commended for their hard work, excellent organization and documentation. Cancer registrars develop a case abstract (summary) for each person diagnosed and/or receiving his or her first course of treatment at EMMC. They complete annual lifetime follow-up – monitoring diagnostic and treatment results. Successful follow-up provides accurate data for calculating survival rates. EMMC's lifetime follow-up is maintained at 96% for cases since 1998 (ACOS-COC standard is 80%); 97% for cases diagnosed within the past 5 years (ACOS-COC standard is 90%).

Physicians utilize AJCC Staging to stratify patients and to determine optimal treatment decisions. According to ACOS-COC standards, our registrars take this one step further to establish a collaborative stage. EMMC physician compliance with staging completion requirements has been consistently above the 90% standard at 99.98%.

On the page to the left are tables reflecting our cancer case accessions, frequency, stage of disease at presentation and prevalence for 2007 at EMMC.

Per regulatory compliance, data are collected, maintained, and reported to the Maine State Cancer Registry and the National Cancer Data Base (NCDB). Submissions were both on time and completed with a high degree of accuracy. Increasingly the Registry is being called on to share aggregate data – in 2007, the registry responded to 117 requests, double the 2006 number. The Registry will play a key role in the Maine Institute for Human Genetics and Health's developing tissue repository – holding the link between cellular observations and clinical outcomes.

Case Conferences held weekly provide physicians with the opportunity to prospectively discuss diagnostics and treatment options for their patients. All major cancer sites are reviewed. In 2007 over 37% more cases (315) were reviewed than in 2006 cases (198) (including 53 cases from Breast Correlation review and 70 from the Thoracic Oncology Clinic). Cases presented at these multidisciplinary discussions represent 17% of our analytic case accessions with 99% presented prospectively. (ACOS-COC standard is ten percent.) Our visiting professor program under the direction of Merrill Garrett, MD, and in conjunction with Partners Institute (Boston, MA) featured oncology experts in cancer treatment.

CANCER COMMITTEE CHAIR REPORT - continued

EDUCATION
We hosted two multi-disciplinary conferences this year and grand rounds: *Tailoring the Treatment of Non-Small Lung Cancer – From the Surgeon to the Oncologis*t and The Fourth Annual Oncology Update – *When is Heartburn More than Heartburn – A Focus on Esophageal Cancer* both under the guidance of Dr. Philip Peverada. Dr. Richard Long, along with survivors, presented an update on prostate cancer as part of Medical Grand Rounds.

The "Resource Corner" opened in February as a joint venture with the American Cancer Society, year –to-date providing information to over 600 patients and families. Medical oncology nursing inaugurated patient education classes providing those new to treatment the best opportunity to gain important information and skills to manage treatment related issues. For those unable to attend class, we expect to "go live" in 2009 with DVD format information for chair-side use.

COMMUNITY
As one of the major employers in the region, EMMC and EMHS have made major commitments to employee wellness – encouraging use of a self-assessment and access to health coaching to achieve personal wellness goals. The *Community Wellness Program* screened over 440 community employees. Again this year as a key force behind *Move & Improve*, a community wide effort, over 7254 people were engaged in promotion of increased physical activity, stress reduction and healthy eating and lifestyle habits (including smoking cessation) with 55% completing the program.

2007 CANCER OCCURRENCE

Accessioned (New to EMMC) Cancer Cases: 2007 Analytic /Non-Analytic Comparison

	2004	2005	2006	2007
Total Analytic Cases	**1568**	**1647**	**1719**	**1834**
Cancer diagnosed and/or treated @ EMMC	891	863	943	939
Cancer diagnosed elsewhere with first treatment @ EMMC	677	784	776	895
Total Non-Analytic Cases	**151**	**232**	**205**	**180**
Cancer diagnosed & treated elsewhere, follow up @ EMMC				
Total Accessioned Cases	**1719**	**1879**	**1924**	**2014**

Primary Site - Frequency Distribution: 2007 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	27	27	1%	0	0%	18	9	1	7	5	4	9	2
Esophagus	35	34	2%	1	1%	27	8	1	6	11	5	11	0
Stomach	32	31	2%	1	1%	24	8	0	10	2	4	13	2
Colon	114	104	6%	10	6%	63	51	1	19	28	26	20	10
Rectum	30	27	1%	3	2%	16	14	7	7	6	7	0	0
Recto-Sigmoid	18	15	1%	3	2%	9	9	0	0	3	9	3	3
Liver/Biliary	19	18	1%	1	1%	13	6	0	5	3	0	1	1
Pancreas	42	40	2%	2	1%	19	23	0	6	9	9	14	2
Larynx	18	17	1%	1	1%	12	6	0	8	2	4	3	0
Lung	384	371	20%	13	7%	215	169	0	97	27	90	139	17
Connective	18	17	1%	1	1%	9	9	0	4	1	3	3	6
Melanoma	50	42	2%	8	4%	31	19	9	19	7	2	2	2
Breast	314	316	17%	25	14%	1	340	67	129	85	24	8	3
Cervix/Uteri	14	13	1%	1	1%	0	14	4	3	1	1	4	0
Corpus Uteri	32	30	2%	2	1%	0	32	0	18	3	5	1	3
Ovary	19	14	1%	5	3%	0	19	0	1	1	6	6	0
Prostate	258	228	12%	30	17%	258	0	0	1	170	30	14	13
Testis	14	12	1%	2	1%	14	0	0	7	3	2	0	0
Bladder	67	55	3%	12	7%	46	21	26	10	5	2	8	4
Kidney/Ureter	59	50	3%	9	5%	33	26	0	28	4	7	8	2
Brain/CNS	34	30	2%	4	2%	19	15	0	4	0	0	0	30
Thyroid	19	19	1%	0	0%	6	13	0	10	2	5	1	1
Leukemia	59	59	3%	0	0%	87	47	0	0	0	0	0	0
Lymphoma	80	66	4%	14	8%	37	43	0	10	14	13	29	0
Other	265	199	11%	32	18%	86	70	0	13	17	11	32	190
Total	2014	1834	100%	180	100%	1043	971	114	422	409	269	329	291

2007 Most Prevalent Analytic Cases at Eastern Maine Medical Center (EMMC) Compared to American Cancer Society (ACS) Estimates

Site	EMMC Analytic Cases	% of Analytic Cases	ACS National Estimates	% of Cases
Lung	384	21%	213,380	14.8%
Breast	314	17%	180,510	12.5%
Prostate	258	14%	218,890	15.1%
Colon & Rectum	162	9%	153,760	10.6%
Lymphoma	80	4%	71,380	4.9%
Leukemia	59	3%	44,240	3.1%
Bladder	67	4%	67,160	4.6%
Melanoma	50	3%	59,940	4.1%
Uterus	32	2%	39,080	2.7%
Pancreas	42	2%	37,170	2.6%
Top Ten	750	79.0%	691,620	75.0%
Total Cases	1834		1,444,920	

FOCUS: COLON CANCER

Peter P. Huang, MD, FACS

Cancer of the colon and rectum is the third most common cancer diagnosed in men and women; the second most common cause of cancer deaths in the United States. The American Cancer Society estimates that there will be 148,000 cases of colorectal cancer this year. Colorectal cancer will cause nearly 50,000 deaths.

In most individuals, colorectal cancers develop slowly over a period of several years, many from non-cancerous growths of the bowel lining called polyps. Some polyps can enlarge and eventually can change into cancer. As these cancers continue to grow, they can invade the wall of the colon or rectum, where they can invade lymph vessels which drain into nearby lymph nodes, or blood vessels which may result in the spread to other parts of the body, such as the liver.

Fortunately, the death rate from colorectal cancers has decreased steadily for more than 20 years. This is due in part to fewer cases occurring during this time period. Removal of polyps before they develop into cancer can prevent this disease in many individuals. Increased availability of colonoscopy has played a role. Cases are being found earlier when they are easier to cure and there have been improvements in treatment.

The ACS recommends that individuals undergo screening for colorectal cancer at age 50, even in the absence of symptoms. Appropriate screening programs can include a radiographic examination of the colon called an Air-Contrast Barium Enema. Screening may also involve instruments that examine the inside lining of the colon and rectum during procedures called flexible sigmoidoscopy, or a more complete examination called colonoscopy. If small polyps are identified, they can be removed -- essentially preventing the potential for future growth and transformation into cancer. If larger polyps or tumors are found, they are generally biopsied to determine whether there is already cancer that has developed within the growth. These examinations are generally repeated every 5 to 10 years.

There are some individuals at increased risk for developing colorectal cancers. These include individuals with a prior history of colon polyps, or colon cancer, a strong family history of colorectal cancer, certain inflammatory diseases of the bowel such as Crohn's disease or ulcerative colitis, and with a known family history of hereditary colorectal cancer syndromes such as familial adenomatous polyposis (FAP) or hereditary non-polyposis colon cancer (HNPCC). Genetic counseling and testing is available through CancerCare of Maine for those suspected of an inherited pre-disposition. For individuals at increased risk for developing colorectal cancer, screening generally begins at an earlier age and tests are performed more frequently.

The goal of screening is to prevent colorectal cancer from developing, or to diagnose the disease when it is in an earlier, and more treatable, stage. The stage of the cancer describes the extent of the cancer. Stage I colorectal cancers have only limited involvement of the bowel wall. Stage II cancers have grown more extensively through the bowel wall but are still confined to the colon or rectum. Stage III cancers have spread to nearby lymph nodes. Stage IV cancers have spread to distant organs, such as the liver, lung, or distant lymph nodes.

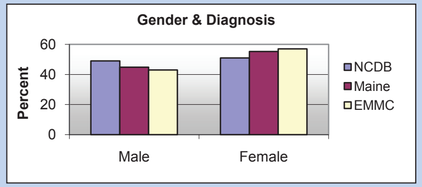
In a review performed in 2007 at EMMC, the stage of colon cancer at diagnosis was found to be similar to national benchmarks from the National Cancer Data Base (NCDB), with a distribution for Stage I - 22% (vs. 19%, NCDB), Stage II - 30% (vs. 24%), and Stage III - 23% (vs. 22%). For Stage IV - 24% (vs. 17%), while the rate of diagnosis at EMMC appears statistically higher than national rates it is not. For those diagnosed between 1998 -2001, the 5-year survival rates by stage are higher for Stage I - 84% (vs. 75%, NCDB) and Stage III – 53% (vs. 50%) with no statistical difference for those diagnosed at Stage II - 70% (vs. 64%) or Stage IV – 5.7% (vs. 6.5%).

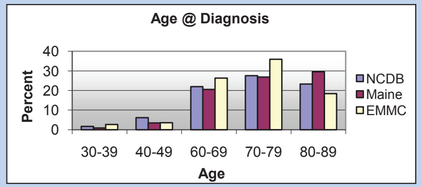
An important part of staging and treatment for colorectal cancer is adequate surgical resection of the tumor and surrounding lymph nodes. It has been estimated that at least 12 lymph nodes need to be removed for pathologic examination in order to accurately stage patients and to identify patients who may benefit from additional treatment with chemotherapy and radiation therapy. For all cases diagnosed in 2004 that underwent surgical resection at EMMC, 81.2% of patients had at least 12 lymph nodes removed. Collaborative work and education with our surgeons resulted in an increase to 89.8% of patients achieving adequate lymph node removal in our most recent review earlier this year exceeding national norms.

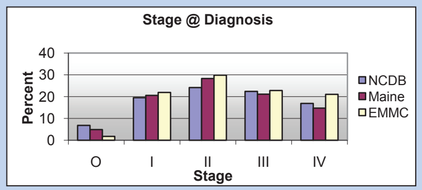
Administration of chemotherapy for Stage III colon cancer patients has been shown to improve survival rates and is accepted as the standard of care for these patients. However, national studies have found that many of these patients are not referred for consideration for chemotherapy, possibly resulting in lower cure rates. At EMMC, all Stage III colon cancer patients were reviewed from 1998 to 2004. In this group, 89.6% were considered for or received adjuvant chemotherapy. For patients not referred for chemotherapy, all patients either elected not to undergo this treatment or had prohibitive medical conditions that precluded consideration for therapy. Similarly, standard of care for patients with IIB or III rectal cancers includes the administration of radiation therapy. Cases treated at EMMC from 2003 to 2005 were reviewed. Referral for consideration of radiation therapy was 100% in these patients.

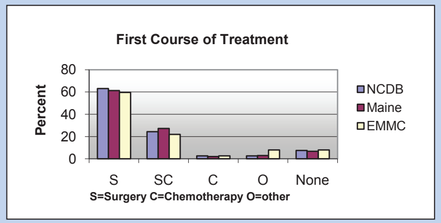
The data reflects high quality care – benchmarked with national standards, you and your patients can be assured they are receiving the best possible care.

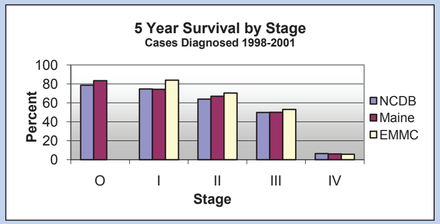
COLON CANCER DATA
EMMC, MAINE AND NATIONAL COMPARISONS











NCDB – National Cancer Data Base

Maine – all hospitals in Maine reporting to the National Cancer Data Base

EMMC – all cases accessioned at Eastern Maine Medical Center

S = surgery
C = chemotherapy
O = other
N = no first course of treatment

Tables 1 – 4
Cases reviewed were for those diagnosed in 2006

Table 5
Cases reviewed were those diagnosed between 1998 -2001

(Most currently available comparisons)

National Colon Cancer Screening Guidelines
American Cancer Society

"Colorectal cancer screening saves lives; if you are 50 or older, ***choose a test and get screened."***

Average Risk Adults – begin screening at age 50
High Risk Adults – review when to begin with your provider

Recommendations:

Annual Stool Testing
- with high sensitivity Guiaic based testing (gFOBT) OR
- immunochemical-based FOBT (FIT) OR
- stool DNA (sDNA)

Every Five Years
- Flexible sigmoidoscopy with annual gFOBT or FIT OR
- CT Colongraphy OR
- Double Contrast Barium Enema (DCBE)

Every Ten Years
- Colonscopy

BREAST AND OSTEOPOROSIS CENTER

Elaine Chambers, RN, MS

One of few nationally, the Breast and Osteoporosis Center was recognized by the American College of Radiology (ACR) as a *Breast Imaging Center of Excellence*. We continue to serve the community from our two locations: The Breast and Osteoporosis Center on the EMMC campus and the Screening Mammography site at the Eastern Maine Health Care Mall on Union Street. Both offer FDA certified and ACR accredited high quality digital mammography with all of our mammograms receiving a CAD review. A hallmark of our quality service continues to be same day results for our diagnostic mammography patients at our EMMC site.

Dr. Susan O'Connor joined us as Medical Director this year. Under her skilled direction The Breast Diagnostic Clinic completed its 6th year serving women across our region.

Early detection is the best tool in the battle against breast cancer. High quality mammography coupled with our commitment to community education is essential. Caring Connections, a cooperative program between EMMC and The Bangor Y, provides community education on breast and cervical cancer and osteoporosis. The program also assists low-income women, who qualify, access care for breast and cervical health issues. This past year 674 women attended education programs; thousands received brochures and educational information. Through our partnership with WLBZ/Channel 2's Buddy to Buddy program, women receive education and encouragement to participate in a supportive approach to breast health and screening, by enlisting a "buddy" to help remember to do breast self exam, schedule clinical exams and seek age appropriate mammography.

Caring Connections offers support groups to women across 5 of Maine's 16 counties. Six times a year breast cancer survivors throughout our region receive a newsletter. For many, the annual retreat is the highlight of their year, providing survivors with a chance to nourish themselves and each other, learn new skills and strengthen bonds of enduring support.

The Prosthetics and Apparel Shop in the Breast and Osteoporosis Center has one of the most complete and diverse selection of bra's, prosthesis, scarves, hats, hairpieces and swimwear in the state. To ensure that women receive individual attention from our Certified Fitter, this service is available by appointment only. Every other month we host the ACS Look Good Feel Better program. It is our pleasure to provide women going through cancer treatment a positive upbeat approach to hair loss, tips on skin care and make up.

In 2008, our BOC Nurse Educators teamed with CCOM Research staff on a grant project funded through Maine's Affiliate of Komen for the Cure offering breast cancer patients completing treatment the opportunity to work with a survivor coach. The new concept is designed to support women as they transition from intense treatment to being a survivor.

Join us for our ***Beach to Beach*** Fund Raiser for Caring Connections
– held each year the first Sunday in August –
call us at ***941-2808*** for more information!

CANCER CONFERENCE

Held weekly at Eastern Maine Medical Center – State Street Campus – in the Governance Room on Wednesdays from 730 to 830 a.m. Participation is open to physicians and allied health professionals. If you have a case you would like to refer or are interested in participating via interactive television connections – NNETS, contact the Cancer Registry at 973-7483.

2008 – Annual Report – December 12, 2008
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January 1 to December 31, 2007, except where otherwise specified
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