



RETREAT
HOSPITAL

The exclusive hospital for everyone.

CANCER PROGRAM

2004 ANNUAL REPORT





FROM THE DESK OF THE CANCER COMMITTEE CHAIRMAN

The diligent efforts of physicians and staff at Retreat Hospital reflect their commitment to quality care of cancer patients, as evidenced in the 2003 annual report. The Cancer Committee provides a mechanism for multidisciplinary leadership, guidance and evaluation of all cancer related activities including quality improvement, community outreach and data collection. Data compiled on cancer patients treated at Retreat includes their staging work-up, initial treatment and follow-up survival information. This data becomes part of the state and national cancer registries for use in determining resources, as well as a basis for future cancer research. Retreat Hospital Cancer Committee is pleased to present this Cancer Program annual report to provide details of the 2003 data.

ACTIVITY HIGHLIGHTS FOR 2003 INCLUDE THE FOLLOWING –

- Growth in the number and participation of physicians in the monthly Level I CME credit Cancer Conference
- Development and utilization of a chemotherapy information packet
- "What's With My Gut?," a community forum on gastrointestinal disorders, including cancer, with tremendous response
- Continued training of all nursing staff administering chemotherapy
- Participation in "Relay for Life," raising money for the American Cancer Society
- Site specific education in the community on prevention and early detection
- A pumpkin-carving contest benefiting the Susan G. Komen Foundation and providing breast cancer information

We acknowledge the dedication of the physicians, nurses, technical and support staff that allows Retreat Hospital to continue to provide our community with quality cancer care.

Ghulam D. Qureshi, MD

2003 CANCER COMMITTEE

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ACoS Program Liaison . General Surgery

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Clinical Coordinator

William Boldin, M. Div.
Chaplain

2004



A LOOK AT LUNG CANCER

By John R. Warkentin, MD and Carlene C. Bennett, RN, CTR

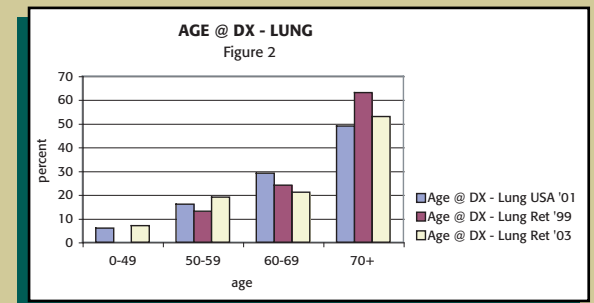
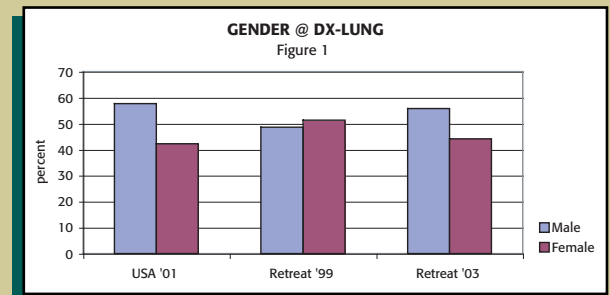
Approximately thirteen percent of new cancer diagnoses in the United States in 2004 will be of the lung and bronchus. The incidence rate in men declined between 1984 and 2000 from 102.1 per 100,000 to 79.8, while the 1990's increase in women reached a plateau in 1998 at 52.8 per 100,000. Retreat's configuration varies between 1999 and 2003 with fewer females than males in 2003, which is congruent with national data. *Figure 1.*

While declining by 10 percent between 1999 and 2003, the percentage of Retreat's patients who are diagnosed at age seventy or greater remains somewhat higher than the national average, which can be explained by Retreat's high Medicare population. *Figure 2.* The ethnicity of Retreat's patients varies markedly from national data due to shifting physician patterns and the closing of two similar size inner city hospitals. *Figure 3.*

Twenty-one percent of lung cases seen at Retreat in 1999 proved to be small cell carcinomas, with continued declines in 2001 and 2003, reflecting similar declining national trends in this subtype of lung cancer. Whether the subtype of cancer is small cell or non-small cell, as well as the stage at diagnosis, the individual's age and comorbidities will contribute to determining the treatment options for the patient. Generally speaking, small cell cancers are likely to have spread by the time the tumor is diagnosed, therefore

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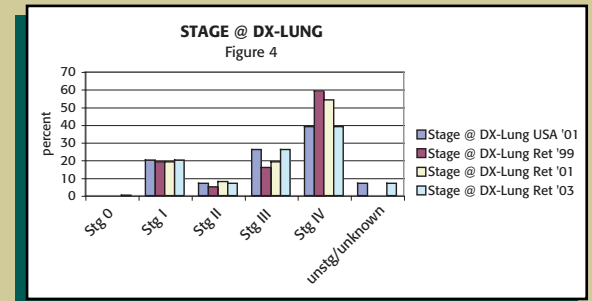
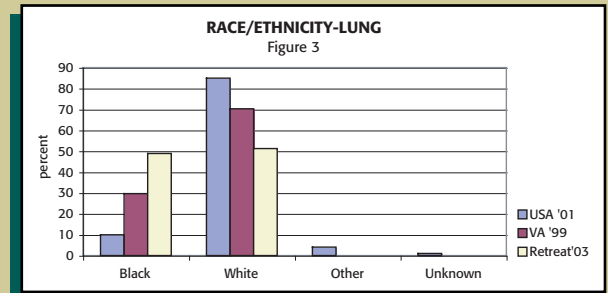
A Look at Lung Cancer continued

these tumors are most often treated with chemotherapy alone or in combination with radiation therapy, while non-small cell cancer may be amenable to surgery.

The stage at diagnosis is roughly comparable to national figures with Retreat having somewhat higher numbers of patients diagnosed at stage IV than nationally. *Figure 4*. Retreat sees a relatively small number of lung cancer patients, which means that only a few cases can have significant statistical impact. Unfortunately only a small percent of lung cancers are diagnosed at an early stage, thus impacting survival. Consequently, with ten percent more Retreat patients diagnosed at Stage III or IV than nationally and a higher percent of Retreat's patients seventy years of age or older the five-year survival rate is low.

Although the American Cancer Society does not recommend testing for early lung cancer detection in asymptomatic individuals, physicians and patients may elect to perform some screening tests in high risk patients. At this time early detection has not demonstrated improved survival, however the National Lung Screening Trial funded by the National Cancer Institute will determine if screening with either spiral CT or standard chest x-ray in asymptomatic individuals will reduce lung cancer deaths.

Twenty-one percent of lung cases seen at Retreat in 1999 proved to be small cell carcinomas, with continued declines in 2001 and 2003, reflecting similar declining national trends in this subtype of lung cancer.



A LOOK AT FEMALE BREAST CANCER

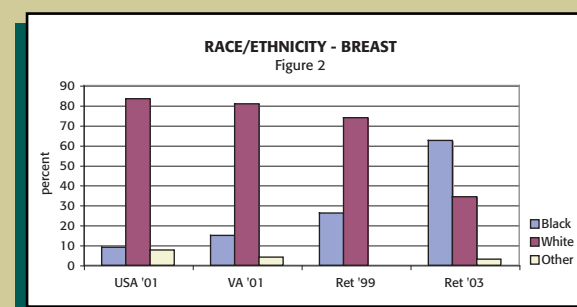
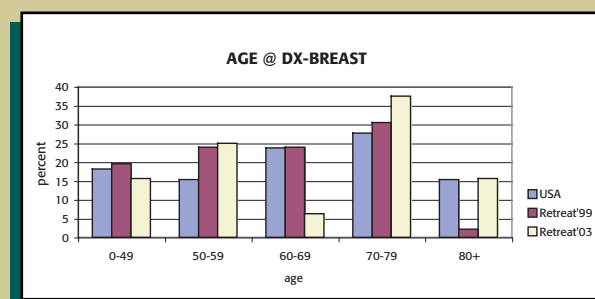
By Richard M. Clary, MD, JoAnne D. Walker, MD and
Carlene C. Bennett, RN, CTR

Breast cancer is the most common cancer among women in the United States, excluding skin cancer. An estimated 211,300 new invasive breast cancers and 55,700 non-invasive breast cancers were expected to be diagnosed in the United States in 2003 with about 6,000 of those cases in Virginia. Approximately 94 percent of these cases occur in women 40 years of age and older, with white women having a higher incidence in this age group. Black women have a slightly higher incidence before age 40 and have a greater likelihood of dying from the disease than white women. The incidence of breast cancer has risen annually since 1980 and is thought to be related to women delaying childbirth, having fewer children, greater use of mammographic screening and increased education regarding early detection.

During the past twenty-five years the incidence and diagnosis of non-invasive breast tumors has increased five times faster than invasive tumors, thought to be a result of increased use of mammography by which the presence of non-invasive tumors is almost always detected.

From 1999 to 2003 Retreat's experience reveals a twenty percent increase in women seventy years of age and older being diagnosed with breast cancer, while the United States and Virginia experience remained relatively stable from 1999 to 2001. *Figure 1.* As seen in *Figure 2*, Retreat had an increased number of black women diagnosed with breast cancer between 1999 and 2003, resulting from the closing of two inner city private hospitals and shifting physician practices. These data represent a significant variance of race/ethnicity from national and state data, both of which remain unchanged between 1999 and 2001.

It is estimated that less than fifty percent of women in the United States receive breast conservation therapy (lumpectomy and breast irradiation). Over the last ten years there has been considerable interest in accelerated partial breast irradiation as a means to allow more women to consider breast preservation rather than mastectomy. Conventional breast radiotherapy requires daily radiation treatment at a radiation facility for six to seven weeks. The main obstacle to women who are otherwise candidates for breast conserving therapy is the inconvenience of six to seven weeks of external beam radiotherapy. Patients living long distances from a radiation



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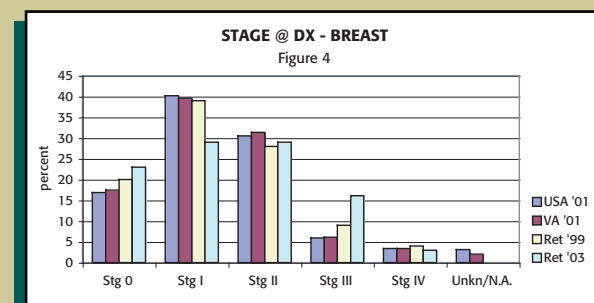
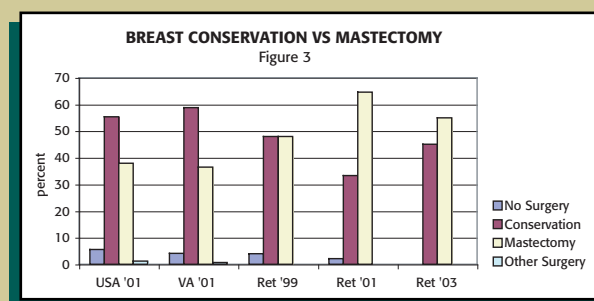
A Look at Female Breast Cancer continued

oncology center, depending upon a relative or friend for transportation, or who are working women, frail or elderly may prefer to preserve the breast but ultimately select mastectomy. Accelerated partial breast irradiation decreases the treatment length from five to six weeks to five days. Rather than treat the whole breast only the breast tissue surrounding the lumpectomy cavity is treated. This allows a more rapid treatment. Women are treated twice a day for five days. Data accumulated over the last decade suggests this is a reasonable alternative to the six to seven weeks of conventional radiation therapy in carefully selected patients. In the next several months the first randomized trial of partial breast radiation therapy is expected to open. This should define further which patients are good candidates for this more convenient form of radiation therapy.

National and Virginia data indicate fifty-five to fifty-nine percent of women now elect breast-conserving surgery followed by radiation therapy, rather than mastectomy. *Figure 3* demonstrates that an equal number of women at Retreat elected breast-conserving surgery as opposed to mastectomy in 1999, while a greater number had a mastectomy in 2003. The increased age and disease stage of patients being diagnosed with breast cancer at Retreat during this interval presumably contributed to this increase in number, as well as the fact that four of the women diagnosed in 2003 resided in rural areas, while one was a rest home resident.

Retreat had a ten percent decrease in women with Stage I disease in 2003 compared to 1999. There was a seven percent increase in the number of Stage III cases in 2003 compared to 1999, perhaps due to later diagnosis, while national and state data remain stable between 1999 and 2001. *Figure 4*. Stage at diagnosis is closely tied to prognosis and survival rates, therefore continuing efforts to educate women regarding risk factors and early detection remain one of our greatest tools in reducing mortality from breast cancer.

During the past twenty-five years the incidence and diagnosis of non-invasive breast tumors has increased five times faster than invasive tumors.



CANCER REGISTRY FOCUS

By Carlene C. Bennett, RN, CTR

Retreat's Cancer Registry contains demographic, diagnostic and treatment information on 4193 cases since 1991, with 3710 of these patients being diagnosed or receiving their first course of treatment at this facility. The remaining patients were diagnosed with or received treatment for recurrent disease at Retreat. Reporting of cases to the Virginia Cancer Registry is mandated by state law, while the American College of Surgeon's Commission on Cancer views reporting to the National Cancer Database as one of the requirements for approval. Since its initial survey Retreat Hospital has retained its approval by the American College of Surgeons Commission on Cancer, meeting the standards for a Community Hospital Cancer Program. The Cancer Registry, one component of an approved program, follows specific guidelines in collecting data as outlined by the Commission on Cancer, thus lending consistency to data collected by some 1400+ approved facilities.

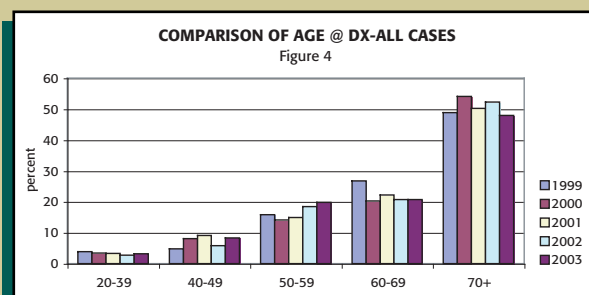
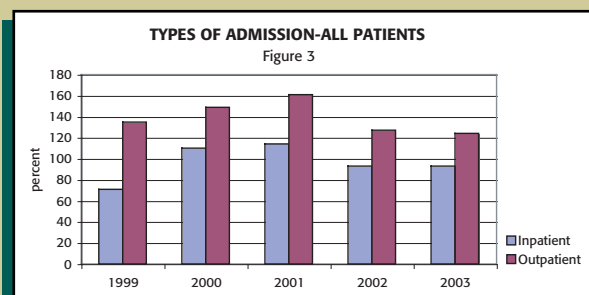
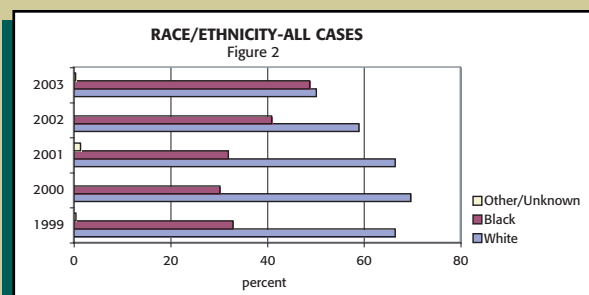
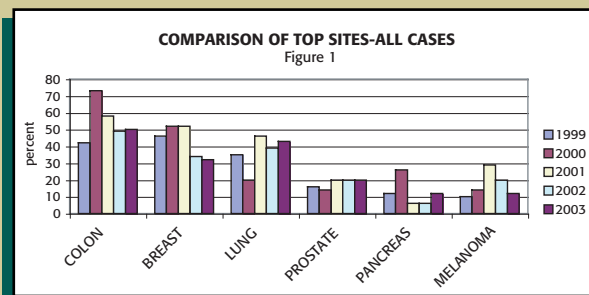
In addition to the above information being documented, annual follow-up is performed for the lifetime of the patient. Such monitoring reinforces the importance of annual follow-up and provides further statistical data, which can assist in the reduction of morbidity and mortality for cancer patients.

Over time the top three cancer sites at Retreat have followed national numbers with fluctuation in the fourth and fifth top sites varying somewhat from national data. *Figure 1*. This is due to shifts in physician practice patterns which will continue in a community of eleven hospitals, with two of them having closed in the past five years. These facts, and the global changes in healthcare in the United States contributed to the variance in number of cases beginning in 1995. This seems to have stabilized in 2003. Race/ethnicity of patients at Retreat has shifted from 1999 to 2003 following physician patterns of practice. *Figure 2*.

More than fifty percent of Retreat's cancer patients are being diagnosed as outpatients. In accordance with prevailing community practice, better than ninety percent of those requiring chemotherapy are being treated in physician offices. *Figure 3*.

Approximately fifty percent of Retreat's patients are seventy-plus years old reflecting Retreat's higher than average Medicare population. During 2002 and 2003 Retreat saw an increase in the number of cancer patients in the fifty to fifty-nine age ranges with stability in the remaining age groups. *Figure 4*.

Data maintained by the Cancer Registry remains a valued tool in cancer treatment.



2003 PRIMARY SITE TABLE Best Stage (ICD-0-3)

Primary Site	Cases	Analytic	Non-Analytic	Male	Female	Stage 0*	Stage I*	Stage II*	Stage III*	Stage IV*	Unkn/Unstg/ Stg 88
Oral Cav											
& Pharynx Digestive	1	1	0	1	0	0	0	0	0	1	0
Esophagus	1	1	0	1	0	0	1	0	0	0	0
Stomach	3	3	0	2	1	0	1	0	0	2	0
Colon	38	35	3	20	18	4	10	13	4	4	0
Rectum/Rectosig	16	15	1	12	4	1	9	2	2	1	0
Anus/Anal Canal	1	1	0	0	1	0	0	1	0	0	0
Liver	2	2	0	1	1	0	0	1	1	0	0
Pancreas	13	12	1	5	8	0	2	2	2	6	0
Other Digestive	0	0	0	0	0	0	0	0	0	0	0
Periton/Omen/Mes	0	0	0	0	0	0	0	0	0	0	0
Respiratory											
Lung/Bronch	47	43	4	25	22	0	8	2	11	22	0
Soft Tissue	7	5	2	2	5	0	5	0	0	0	0
Skin											
Melanoma	12	12	0	3	9	7	4	1	0	0	0
Other Non-epith Sk	0	0	0	0	0	0	0	0	0	0	0
Breast	40	32	8	1	39	7	9	9	5	1	1
Fe Genital											
Cervix Uteri	0	0	0	0	0	0	0	0	0	0	0
Corpus Uteri	3	3	0	0	3	0	2	0	0	0	1
Ovary	1	1	0	0	1	0	0	0	1	0	0
Vulva	3	3	0	0	3	3	0	0	0	0	0
M Genital											
Prostate	24	20	4	24	0	0	0	17	2	1	0
Testis	2	2	0	2	0	0	1	0	0	0	1
Penis	1	1	0	1	0	0	0	0	1	0	0
Urinary Sys											
Bladder	5	3	2	2	3	1	0	1	0	1	0
Kidney	5	5	0	4	1	0	1	2	0	2	0
Brain/CNS											
Brain	1	1	0	0	1	0	0	0	0	0	1
Other CNS	2	2	0	0	2	0	0	0	0	0	2
Endocrine											
Thyroid	2	2	0	1	1	0	1	0	0	1	0
Lymphoma											
Hodgkins	2	2	0	0	2	0	0	0	2	0	0
Non-Hodgkins											
Nodal	2	2	0	0	2	0	0	1	0	1	0
Extranodal	2	2	0	2	0	0	1	0	0	1	0
Myeloma	3	3	0	0	3	0	0	0	0	0	3
Leukemias											
Lymphocytic	2	2	0	1	1	0	0	0	0	0	2
Unspecif	1	1	0	0	1	0	0	0	0	0	1
TOTAL	242	217	25	110	132	23	55	52	31	44	12

* Only analytic cases are listed.



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