



RETREAT
HOSPITAL

The exclusive hospital for everyone.

CANCER PROGRAM

2005 ANNUAL REPORT



FROM THE DESK OF THE CANCER COMMITTEE CHAIRMAN...

The vision of Retreat Hospital is "To improve the health of the communities we serve by providing innovative, comprehensive and compassionate healthcare services at the best value." Retreat Hospital's Community Hospital Cancer Program embraces this vision as it follows the goal of the American College of Surgeons to decrease the morbidity and mortality of cancer, through meeting the standards for approval set forth by this organization.

This annual report reflects the 2004 activities of our Community Hospital Cancer Program, with some activity highlights as the following:

- Receipt of full three year approval, seven commendations and no deficiencies at American College of Surgeons survey September 2004
- Pink Tea, a breast cancer educational event open to the community
- Multiple site specific community presentations on cancer prevention and early detection
- Development of a post-colonoscopy brochure emphasizing the importance of follow-up
- Continued education and approval, through a national organization for staff administering chemotherapy
- On-site lymphedema program managed by nationally trained lymphedema therapists
- Involvement in Relay for Life, an American Cancer Society event

We are grateful for the dedication of our multidisciplinary team, as they continue to provide quality cancer care to the members of our communities.

Ghulam D. Qureshi, MD

2005

2003 CANCER COMMITTEE

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ACoS Program Liaison - *General Surgery*

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Cancer Program Coordinator

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American Cancer Society Dir Cancer Control

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Director Rehabilitation Services

Judith Poole, MSW
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Diane Ragan, RN, OCN
Clinical Coordinator



*40,340 individuals
will be diagnosed with
rectal cancer in the
United State in 2005*

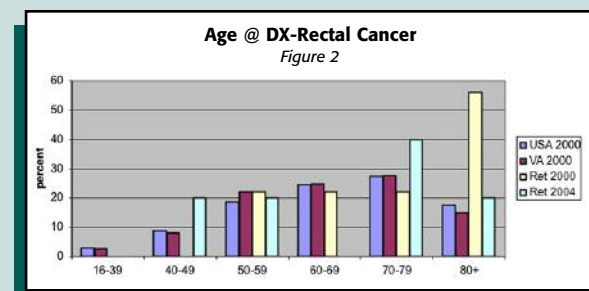
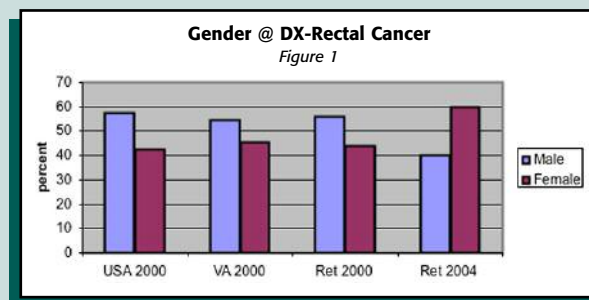
A LOOK AT RECTAL CANCER

By Cary L. Gentry, MD, JoAnne D. Walker, MD and
Carlene C. Bennett, RN, CTR

Overview:

According to American Cancer Society 40,340 individuals will be diagnosed with rectal cancer in the United State in 2005, with there being sixteen percent more males than females. In 2000 Retreat saw twenty percent more males than females while the national difference was fifteen percent, and the state variance was nine percent. (Figure 1) Virginia is expected to see 996 rectal cases in 2005 consequently Retreat Hospital would not be expected to see a great number of rectal cancers. Colorectal cancer is predominately a disease of people fifty or older. Interestingly, at Retreat Hospital the average age for rectal cancer at diagnosis was in the mid-sixties with little fluctuation between 2000 and 2004. However in 2000 Retreat had a greater percentage of patients in the seventy and above range than the nation and Virginia, which may be due to Retreat's relatively high Medicare population. (Figure 2)

Since prognosis deteriorates as the stage increases one might expect Retreat's survival rate to be somewhat lower than nationally and in the state. This proved not to be the case, for Retreat's five year survival rates stage for stage for cases diagnosed in 1995-1996 proved to be greater than national and state survival rates. (Figure 3) In 2000 Retreat saw thirty-six percent more stage III cases, than were seen in the nation or in the state with no stage IV cases. Conversely Retreat saw fewer stage I and II cases than the state and nation. (Figure 4)



Continued

2005

The primary treatment of rectal cancer remains surgical excision however it may also involve radiation and chemotherapy either pre-operatively or post-operatively. Management of rectal cancer is influenced by the size of the tumor, the exact location in the rectum, the degree of circumferential involvement and the stage of the disease at diagnosis.

Surgery:

Colorectal cancer is the second leading cause of cancer deaths in the United States. Unfortunately, most of these deaths are preventable. The advent of routine colonoscopy has improved the detection and prevention of colon and rectal polyps, and has led to a "flattening" of the mortality curve associated with colon and rectal cancer. In addition, techniques in surgical treatment of colorectal cancer have improved.

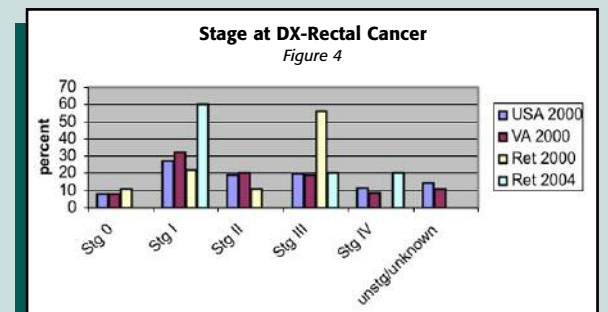
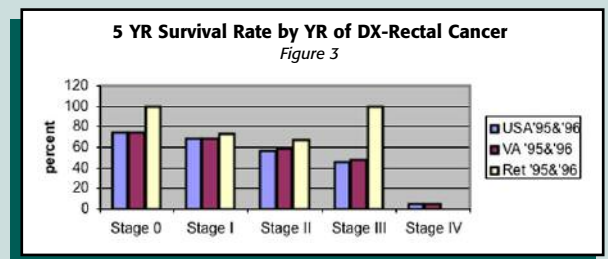
Laparoscopic or minimally invasive surgery for colon cancer has recently been evaluated through national and international clinical trials. The advantages of less pain, earlier return of bowel function and quicker recovery from colon surgery via the laparoscopic approach does not appear to have detrimental effect on oncologic outcomes. This is encouraging and should have positive clinical and economic impact on the surgical treatment of colon cancer.

Rectal cancer behaves somewhat differently than colon cancer due to its anatomic location and lymphatic drainage. The discovery of tumor deposits in the mesorectum distal to the tumor has led to an emphasis on removal of the entire mesorectal tissue or total mesorectal excision (TME). This technique was popularized by Heald, and led to local recurrence rates for rectal cancer less than seven percent. The TME technique emphasizes specific anatomic planes of dissection and focuses on excellent wide lymphadenectomy surgery to obtain clear lateral and distal margins of resection. The TME approach can be performed laparoscopically, and provides oncologic outcomes similar to the traditional technique.

Radiation Therapy:

Radiation therapy continues to play a major role in the treatment of locally advanced rectal cancer. Radiation added to surgery dramatically reduces the risk of local recurrence by fifty percent. Unlike colon cancers, locally recurrent rectal cancer causes significant morbidity. When chemotherapy and radiation is added to surgery, survival is also increased. New studies continue to validate the earliest randomized trials that showed increased survival when both radiation and chemotherapy were added to surgery.

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The current controversy concerns the timing of these adjuvant treatments relative to the surgery. The earliest randomized trials evaluated post-operative chemoradiation versus surgery alone. Subsequent single institution trials suggested preoperative chemoradiation was superior to postoperative chemoradiation. There is a recently published randomized German trial comparing preoperative and postoperative chemoradiation and it appears that we now have definitive proof that preoperative therapy carries several advantages over postoperative therapy. Both acute and late toxicities are decreased, local control is significantly improved, and the rate of sphincter preservation is higher, all with no observed increase in surgical complications.

What is the future direction to go about improving outcomes in locally advanced rectal cancer? With local failure rates falling as low as six percent at five years in the German neoadjuvant trial, future improvement in cure rates is likely to come with improved chemotherapy to decrease distant failure.

Chemotherapy:

Depending on the stage of disease and surgical method employed chemotherapy may be included in the treatment regime. In fact, chemotherapy is often utilized to enhance the effectiveness of radiation therapy, and may also be utilized neoadjuvantly or as adjuvant therapy. The National Comprehensive Cancer Network offers detailed Treatment Guidelines for Rectal Cancer which we have briefly discussed above. Naturally each patient's situation is evaluated individually and the expertise and clinical judgment of the physician may account for variation from these guidelines since they are just that, simply guidelines.

Since colorectal cancers generally develop slowly screening tests are vital to early detection, which is the key to successful outcomes. Screening for rectal cancer includes fecal occult blood test, digital rectal exam and flexible sigmoidoscopy and/or colonoscopy, which should begin at age fifty, or sooner if there is a family history, predisposing factors or symptoms. Virginians are fortunate that screening law assures insurance coverage for the full range of tests. The importance of screening for colon and rectal cancer coupled with advanced techniques in its treatment, have led to an improvement in the quality care for this disease. However, colon and rectal cancer continues to be a serious health concern that clinicians and patients must be educated about.

N.B. Carcinoid tumors of the rectum have been excluded from Retreat's data in this study.

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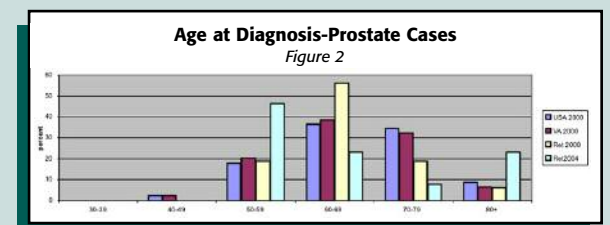
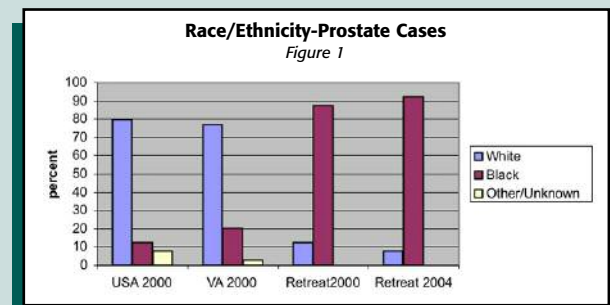
A LOOK AT PROSTATE CANCER

By Elwood B. Boone, MD and Carlene C. Bennett, RN, CTR

Prostate cancer will have the greatest number of all cancer cases diagnosed nationally in 2005 with an estimated 232,090 cases. Of those an estimated 5740 cases will be diagnosed in Virginia, just 270 fewer cases than female breast cancer. Incidence among African Americans is approximately sixty-two percent greater than whites. The American Cancer Society reports that nationally twenty-four percent of African Americans and twenty-two percent of Hispanics/Latinos live below the poverty level. Consequently these ethnic minority populations are more likely to be poorly insured or uninsured than the estimated eleven percent of whites uninsured, which may be one factor contributing to higher incidence in African Americans.

Reflecting physician practices and Retreat's population eighty-seven percent of Retreat's 2000 prostate cancer patients and ninety-two percent of 2004 prostate cancer patients were African American with the remainder being white. (Figure 1) Ethnicity, family history and age are known risk factors with more than seventy percent of all cases occurring in men older than sixty-five. Retreat age at diagnosis in 2000 is comparable to

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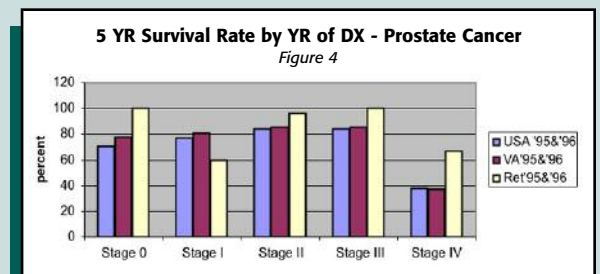
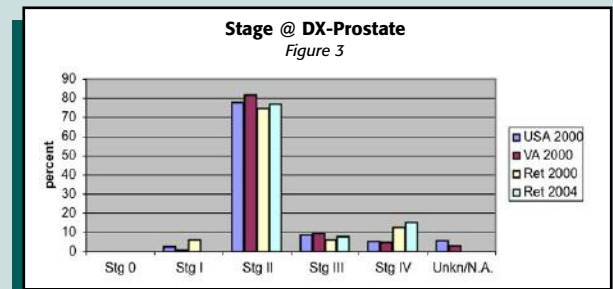
A Look at Prostate Cancer continued

national and state rates. Interestingly Retreat saw twenty-seven percent more men between the ages of fifty and fifty-nine in 2004 than in 2000. (Figure 2) Perhaps this may be attributed to increased awareness and widespread PSA screening.

In 2000 Retreat had a slightly greater percentage of patients diagnosed with stage I and stage IV disease than the state and nation, conversely Retreat had a lower percentage of stage II and III disease with 2004 percentages closely aligned to 2000. (Figure 3) Retreat's 1995-1996 survival rates stage for stage were greater than national & state rates, except for a lower percentage of stage I disease. (Figure 4) Not only does stage at diagnosis influence survival it also influences treatment decisions. Prevailing community practice is for patients to be biopsied in the physician's office followed by discussion of treatment options once results and perhaps other testing have been obtained. Age, general health, stage of disease, goals for treatment and treatment side effects will play a role in considering treatment options. One must bear in mind that Retreat's data is skewed since the majority of patients hospitalized have chosen prostatectomy as their first course of treatment. However, other options for curative therapy include radiation (external beam and/or brachytherapy) with or without hormonal therapy and cryotherapy. Palliative therapy for advanced disease includes hormonal manipulation or watchful waiting.

Continued efforts for early detection and screening with PSA and digital rectal exam remain the strongest tools in our arsenal to secure favorable outcomes through our management of this disease. With greater emphasis to the general public and physicians as to the factors that relate to the causes, onset and early detection of prostate cancer, we may better impact the natural history of this disease. Recent data suggests greater attention must be paid to those life style changes that affect prostate cancer such as diet, obesity, physical activity, smoking and being heart healthy.

Age, general health, stage of disease, goals for treatment and treatment side effects will play a role in considering treatment options.





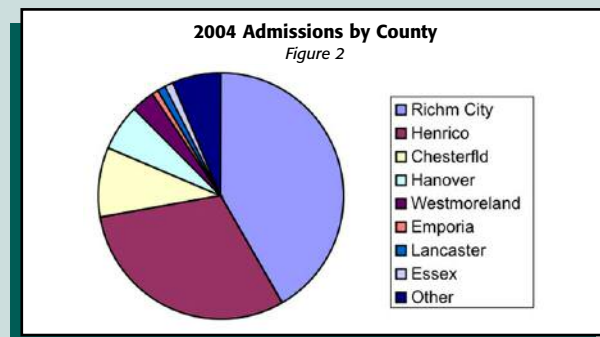
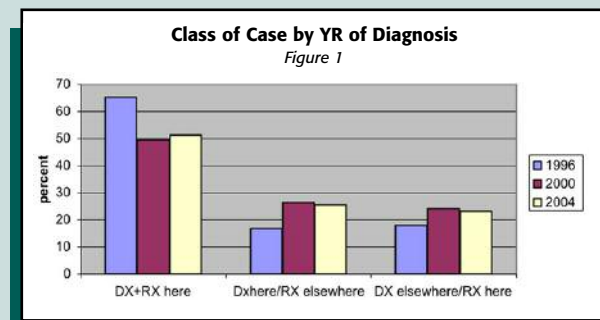
CANCER REGISTRY FOCUS

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

As required by the American College of Surgeons Commission on Cancer, the Cancer Registry operations remain an integral element of the Retreat's CoC approved Community Hospital Cancer Program. The database contains demographic, diagnostic and treatment information on 4,417 tumors for 4,253 patients since 1991. Over time the class of case has fluctuated primarily based on the primary site and specific treatment for any given site. In 2004 fifty-one percent of patients were diagnosed here and received first course of treatment here, while twenty-three percent were diagnosed elsewhere and received first course of treatment at Retreat. Figure 1 Those diagnosed elsewhere, receiving first course of treatment at Retreat were primarily breast, prostate and melanoma cases. Of the remaining twenty-six percent diagnosed here with first course of treatment elsewhere forty-nine percent were lung primaries, treated with radiation therapy and/or chemotherapy. As is the prevailing practice in our communities chemotherapy is generally administered in the oncologist's office, and radiation is given in free-standing or hospital based radiation facilities.

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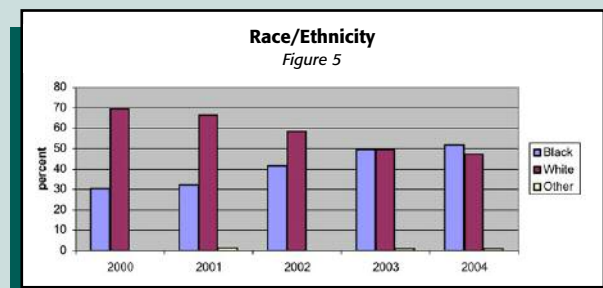
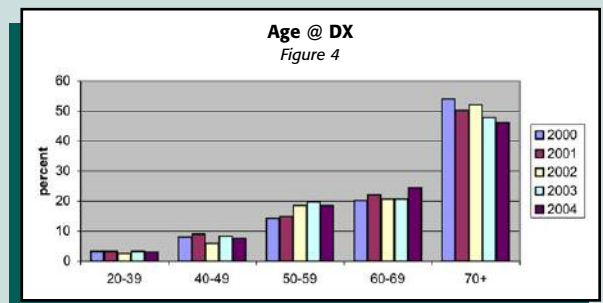
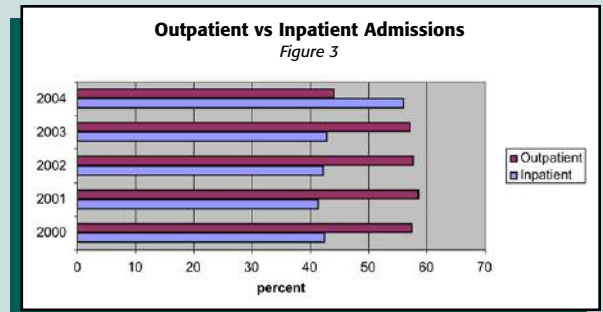


Cancer Registry Focus continued

Over time the top three sites of cancer at Retreat have followed national numbers with fluctuation in the fourth and fifth top sites varying somewhat from national data. As expected the majority of patients came from the City of Richmond and Henrico County, followed by Chesterfield County and Hanover County. Figure 2

For the first time in several years a greater number of patients were inpatients, rather than outpatients at Retreat Hospital in 2004. Figure 3 Our elderly population with their multiple co-morbid conditions requiring in-patient hospitalization at diagnosis may contribute to this trend. Figure 4 Race/ethnicity at Retreat continues to shift following physician practices and the composition of the City of Richmond population, as well as location of the various hospitals. Figure 5

To assure continued medical surveillance and to provide statistical data each case is followed annually. Data from our registry is reported to the Virginia Cancer Registry and the National Cancer Data Base. There are more than 1400 Commission on Cancer Approved hospitals in the United State and Puerto Rico, representing close to twenty-five percent of all hospitals. Eighty percent of newly diagnosed cancer patients each year are diagnosed and or treated at these Commission on Cancer approved hospitals. The data submitted to the National Cancer Data Base, contains demographic, tumor characteristics, treatment and outcome information for over sixteen million cancer patients treated at hospital cancer programs in the United States between 1985 and 2003. These data account for approximately two-thirds of newly diagnosed cancer cases in the U.S. each year. NCDB data is used regularly to monitor the quality of patient care delivered in CoC Approved Cancer Programs and is invaluable to improving cancer care outcomes. Thus our care of cancer patients in this community and data relative to them contributes to the effort to decrease the morbidity and mortality from cancer in the United States.



2004 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
Esophagus	3	3	0	2	1	0	1	0	0	2	0
Stomach	4	4	0	4	0	1	2	0	0	1	0
Colon	32	30	2	15	17	3	9	7	6	3	2
Rectum/Rectosig	12	12	0	5	7	0	3	3	1	1	4
Pancreas	7	6	1	4	3	0	1	1	0	4	0
Other Biliary	1	1	0	1	0	0	0	1	0	0	0
RESPIRATORY											
Lung/Bronch	37	34	3	18	19	2	3	2	12	14	1
Soft Tissue	1	1	0	0	1	0	0	0	1	0	0
SKIN											
Melanoma	6	6	0	4	2	0	1	2	1	2	0
Other Non-epith Sk	3	3	0	3	0	0	1	0	0	0	2
Breast	50	45	5	0	50	5	17	14	5	2	2
FEMALE GENITAL											
Cervix Uteri	1	0	1	0	1	0	0	0	0	0	1
Corpus Uteri	6	6	0	0	6	1	3	0	1	0	1
Ovary	5	5	0	0	5	0	2	0	0	3	0
MALE GENITAL											
Prostate	18	13	5	18	0	0	0	10	1	2	0
Testis	1	1	0	1	0	0	0	1	0	0	0
Penis	1	1	0	1	0	0	1	0	0	0	0
URINARY SYSTEM											
Bladder	6	5	1	5	1	1	0	3	1	1	0
Kidney	6	4	2	3	3	0	3	0	0	1	0
Ureter	1	1	0	0	1	1	0	0	0	0	0
ENDOCRINE											
Thyroid	3	2	1	2	1	0	1	0	1	0	0
LYMPHOMA											
Hodgkins	3	3	0	0	3	0	2	1	0	0	0
Non-Hodgkins	6	6	0	4	2	0	0	2	1	1	2
Myeloma	3	3	0	0	3	0	0	0	0	0	3
LEUKEMIAS											
Lymphocytic	1	0	1	0	1	0	0	0	0	0	1
Ill-defin/Unspecif	4	4	0	4	0	0	0	0	0	0	4
TOTAL	221	199	22	94	127	14	50	47	31	36	21



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