



# 2015 Cancer Program Annual Report

Based on 2014 Data

Presented to the Oncology Committee  
2015

Community Hospital Comprehensive  
Cancer Program



Surveyed October 2013  
Approved with Commendation

 **Parkridge  
Medical Center**

**PARKRIDGE HEALTH SYSTEM**

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2014**

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## Community Outreach Report 2014

### Parkridge Medical Center

During 2014, the community outreach for Hamilton County and the surrounding counties focused on providing information on early detection of colon cancer with proper screening and helping to support organizations that improve the quality of life for survivors.

#### Primary Prevention

In the **State of Tennessee Cancer Plan 2013-2017**, the primary prevention goal is to “raise awareness of actions that can be taken by individuals, communities, government, or other groups to prevent the occurrence of cancer through healthy lifestyle choices.” In line with this cancer prevention goal, we promoted the Great American Smokeout on November 20, 2014 and had smoking cessation materials available to patients and family members. Also, Parkridge Medical Center continues the dietary program in the cafeteria to encourage healthy choices. This initiative, called the Mindful Program, offers a variety of lower-sodium, lower-calorie entrée and dessert options. This program is also connected to the MyFitnessPal, which is a calorie counting weight loss app for smart phones.

#### Early Detection

In the **State of Tennessee Cancer Plan 2013-2017**, the early detection goal is to “increase detection of cancer at acceptable rates when disease is not causing a symptom and when treatment is more likely to be successful. Increase awareness regarding family history and risk factors for cancer.” In line with the early detection goal, Parkridge Medical Center participated in many different events related to the early detection of cancer.

January 2014- We implemented a CT lung screening program at Parkridge Medical Center and Parkridge East Hospital. Patients with a smoking history and in a certain age group may qualify for a screening with a physician’s order. There is a small fee (\$50) for the screening. Currently, 63 patients have been screened this year with three having positive readings. One of those three had a diagnosed lung cancer.

Spring 2014- During the month of March, fecal occult blood tests (FOBT) were available to individuals at risk during the month of March for colon cancer screening. Two individuals took advantage of the screening through Medline. Flyers were available throughout the hospital, handed out at two health fairs, and also handed out at the Chattanooga Rump Run to promote the screening.

March 15, 2014-We participated in the “Chattanooga Rump Run” to raise awareness about colon cancer. Parkridge had a couple teams participate and two employees participated on the planning committee for the event. Parkridge also had a table at the event with information on high fiber diets, FOBT take home test information, and the importance of colon cancer screening. Approximately 45 participants visited the table for education. The event raised \$25,000 for the Greater Chattanooga Colon Cancer

Coalition, which will be used for colon cancer awareness, education, and screening. There were over 450 participants overall.

June 25, 2014- The Sarah Cannon Cancer Center had a booth at the Parkridge West Open House. This event was for the community. Education was provided to people visiting the booth on breast education, mammograms, and demonstrations were given on how to do breast self-exams on a breast model. Screening mammograms were also offered to women free of charge. Twelve women took advantage of the screening with no abnormal findings.

July 12, 2014- The Oncology Navigator and the Greater Chattanooga Colon Cancer Foundation were at the Chattanooga Lookouts game handing out t-shirts and education to fans as they came in for the game. Education provided referenced screening colonoscopies and individuals at risk. A PSA was done before the game that educated the crowd that individuals over the age of 50 needed to have a screening colonoscopy, as well as other information. Colon cancer survivors were honored on the field before the game, as well.

All year- Monthly mammography cards were mailed to patients to remind them to get their annual screening mammogram. Over 2200 cards were mailed to patients at Parkridge Medical Center and Parkridge East Hospital.

#### Survivorship

In the **State of Tennessee Cancer Plan 2013-2017**, the survivorship goal is to “improve Tennessee cancer survivors’ quality of life through education and advocacy initiatives that address the physical, emotional, and practical challenges of cancer survivorship.” In line with this goal, Parkridge Medical Center has collaborated with non-profit organizations to provide continuum of care and access to additional resources and support for our cancer patients.

April 25, 2014- We hosted the fifth annual Wine & Pearls to benefit PearlPoint Cancer Support, formerly The Minnie Pearl Cancer Foundation. The event raised over to \$46,000 to assist local cancer patients. We had 250 guests in attendance. PearlPoint Cancer Support complements cancer care and compassionately helps people to navigate the journey through a cancer diagnosis. Services offered through this foundation are clinical trial advice, nutrition consultations, social work consultations, and comprehensive and education materials. All of these services are offered free of charge regardless of treatment facility.

June 2, 2014- We participated in National Cancer Survivors Day by inviting over 1300 of our survivors to come celebrate in the lobby of the cancer center with refreshments and visit with other survivors, nurses, and physicians. The American Cancer Society was present to share information and resources. We played inspirational survivor videos and encouraged survivors to leave words of wisdom on a note card for current patients. We had over 15 survivors attend.

June 21, 2014- We participated in the American Cancer Society Relay for Life at Finley Stadium. We had 12 employees and family members participate and our team raised \$280. The American Cancer Society provides transportation assistance, lodging assistance, support groups, resources, education, and hats and wigs for our local patients.

**Cancer Registry Report  
Parkridge Medical Center  
2014 Data**

During the 2014 calendar year, a total of 510 cases of cancer were accessioned into the Cancer Registry at Parkridge Medical Center. These were cases of cancer which were seen for the first time here in 2014. Of this number 425 (83%) were cases that were newly-diagnosed and/or received part of the first course of treatment here. The remaining 85 cases were seen for recurrence or progression of a previously diagnosed cancer which had been treated elsewhere and came here for the first time in 2014.

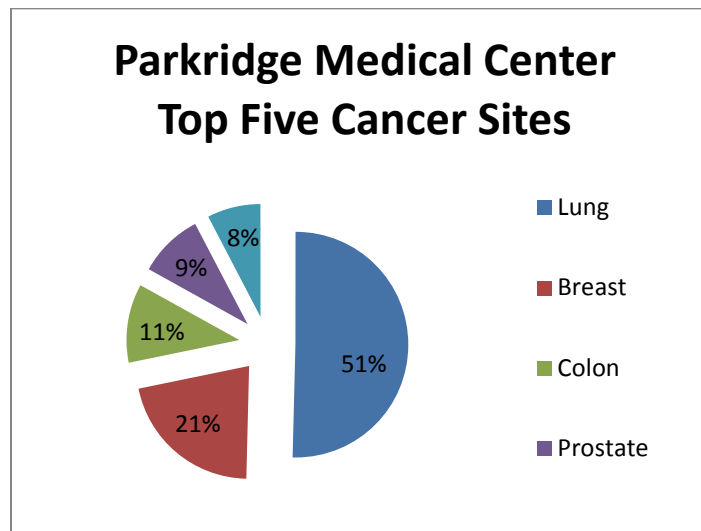
Reviewing the site distribution over the last five years shows that lung cancer has consistently been the number one site with breast cancer, colon cancer, prostate cancer and lymphoma completing the top five sites seen at Parkridge Medical Center. The top five sites for the nation and Tennessee are very similar to Parkridge Medical Center. With the exception of melanoma which was estimated to be the fifth most prevalent cancer in Tennessee and Prostate was the number one site for the nation as reported in American Cancer Society, Cancer Facts & Figures 2014.

**Analytic Cases by Site**

	<b>Parkridge Medical Center</b>	<b>Tennessee*</b>	<b>National*</b>
<b>Total</b>	<b>510</b>	<b>36,570</b>	<b>1,665,540</b>
<b>Lung</b>	<b>125</b>	<b>5 980</b>	<b>224,210</b>
<b>Breast</b>	<b>53</b>	<b>4,840</b>	<b>235,030</b>
<b>Colon (excluding rectum)</b>	<b>28</b>	<b>3,030</b>	<b>96,830</b>
<b>Prostate</b>	<b>23</b>	<b>4,670</b>	<b>233,000</b>
<b>Non-Hodkin Lymphoma</b>	<b>19</b>	<b>1,470</b>	<b>70,800</b>

\*American Cancer Society, Cancer Facts 2014 estimated new cases

This pie chart shows that a large percentage of our top five sites for 2014 cases were lung cancer. This is in line with the projected lung cancer cases for Tennessee. However prostate cancer is the number one cancer site for the United States as estimated by the American Cancer Society.



**Cancer Registry Report  
Parkridge Medical Center  
2014**

**Distribution by Stage at Diagnosis**

The stage at diagnosis is used to determine extent of disease, treatment plans and determine the quality of life once the patient has received treatment. The lower the stage at diagnosis the better the outcome from treatment, thus improved quality of life and survival.

<b>Site</b>	<b>Stage 0</b>	<b>Stage I</b>	<b>Stage II</b>	<b>Stage III</b>	<b>Stage IV</b>
<b>Lung</b>	<b>1</b>	<b>29</b>	<b>8</b>	<b>38</b>	<b>46</b>
<b>Breast*</b>	<b>9</b>	<b>22</b>	<b>13</b>	<b>6</b>	<b>3</b>
<b>Colon</b>	<b>0</b>	<b>5</b>	<b>9</b>	<b>4</b>	<b>9</b>
<b>Prostate</b>	<b>0</b>	<b>4</b>	<b>12</b>	<b>3</b>	<b>3</b>
<b>Non-Hodgkin Lymphoma</b>	<b>0</b>	<b>7</b>	<b>2</b>	<b>0</b>	<b>10</b>

\*Number reflect breast in women

Lung cancer is the number one cancer nationally and for Parkridge Medical Center. According to the American Cancer Society Cancer Facts and Figures (2014) smoking is the most important risk factor for lung cancer. Smoking is also considered one of the most preventable risk factor. The types of ways tobacco is used, the quantity and the length of time vary the level of risk for developing cancer. Additionally, the exposure to other toxic substances, such as asbestosis, metals and second hand smoke increases the risk of developing lung cancer.

**Parkridge Medical Center  
2014 Cases**

Primary Site	Total	Sex		Class of Case		Status		Stage at Diagnosis						
		M	F	Anal	NA	Alive	Exp	St 0	St I	St II	St III	St IV	88	Unk
Lip	1	1	0	1	0	1	0	0	0	0	0	0	0	1
Tongue	6	5	1	6	0	5	1	0	1	1	0	4	0	0
Other Head & Neck	8	8	0	8	0	8	0	0	0	2	1	5	0	0
Esophagus	2	1	1	2	0	2	0	0	0	0	1	1	0	0
Stomach	4	3	1	4	0	4	0	1	2	0	0	1	0	0
Small Intestine	3	3	0	2	1	2	1	0	0	0	1	1	0	0
<b>Colon Excluding Rectum</b>	<b>31</b>	<b>17</b>	<b>14</b>	<b>28</b>	<b>3</b>	<b>28</b>	<b>3</b>	<b>0</b>	<b>5</b>	<b>9</b>	<b>4</b>	<b>9</b>	<b>0</b>	<b>1</b>
Rectum & Rectosigmoid	12	7	5	9	3	11	1	2	2	3	0	2	0	0
Anus, Anal Canal & Anorectum	6	3	3	4	2	6	0	0	1	0	1	0	0	2
Liver & Intrahepatic Bile Duct	4	3	1	3	1	2	2	0	2	0	0	1	0	0
Gallbladder & Other Biliary	4	2	2	4	0	1	3	0	0	0	0	1	0	2
Pancreas	17	7	10	16	1	8	9	0	1	2	0	13	0	0
Peritoneum, Omentum & Mesentery	1	0	1	1	0	1	0	0	0	0	1	0	0	0
Larynx	7	6	1	7	0	7	0	0	4	0	1	2	0	0
<b>Lung &amp; Bronchus</b>	<b>145</b>	<b>78</b>	<b>67</b>	<b>125</b>	<b>20</b>	<b>94</b>	<b>51</b>	<b>1</b>	<b>29</b>	<b>8</b>	<b>38</b>	<b>46</b>	<b>0</b>	<b>3</b>
Trachea, Thorax & Other Resp	2	1	1	2	0	1	1	0	0	0	0	0	1	0
Melanoma -- Skin	6	5	1	4	2	4	2	2	2	0	0	0	0	0
Other Non-Epithelial Skin	3	2	1	3	0	3	0	0	1	0	1	0	1	0
<b>Breast</b>	<b>59</b>	<b>2</b>	<b>57</b>	<b>53</b>	<b>6</b>	<b>56</b>	<b>3</b>	<b>9</b>	<b>22</b>	<b>13</b>	<b>6</b>	<b>3</b>	<b>0</b>	<b>0</b>
Cervix Uteri	7	0	7	3	4	4	3	0	0	0	1	2	0	0
Corpus & Uterus, NOS	11	0	11	8	3	9	2	0	5	0	2	1	0	0
Ovary	10	0	10	9	1	9	1	0	1	1	4	2	0	1
Other Female Organs	3	0	3	1	2	3	0	0	1	0	0	0	0	0
<b>Prostate</b>	<b>35</b>	<b>35</b>	<b>0</b>	<b>23</b>	<b>12</b>	<b>33</b>	<b>2</b>	<b>0</b>	<b>4</b>	<b>12</b>	<b>3</b>	<b>3</b>	<b>0</b>	<b>1</b>
Penis	2	2	0	2	0	2	0	0	0	1	1	0	0	0
<b>Urinary Bladder</b>	<b>23</b>	<b>19</b>	<b>4</b>	<b>13</b>	<b>10</b>	<b>18</b>	<b>5</b>	<b>4</b>	<b>3</b>	<b>1</b>	<b>3</b>	<b>2</b>	<b>0</b>	<b>0</b>
Kidney & Renal Pelvis & Ureter	13	9	4	11	2	12	1	0	9	0	1	0	0	1
Brain	4	3	1	3	1	4	0	0	0	0	0	0	3	0
Cranial Nerves Other Nervous System	2	0	2	2	0	2	0	0	0	0	0	0	2	0
Thyroid	4	1	3	4	0	4	0	0	2	0	2	0	0	0
Hodgkin Lymphoma	1	0	1	1	0	1	0	0	0	0	0	1	0	0
<b>Non-Hodgkin Lymphoma</b>	<b>23</b>	<b>12</b>	<b>11</b>	<b>19</b>	<b>4</b>	<b>19</b>	<b>4</b>	<b>0</b>	<b>7</b>	<b>2</b>	<b>0</b>	<b>10</b>	<b>0</b>	<b>0</b>
NHL - Nodal	19	11	8	15	4	15	4	0	4	2	0	9	0	0
NHL - Extranodal	4	1	3	4	0	4	0	0	3	0	0	1	0	0
Myeloma	15	7	8	13	2	13	2	0	0	0	0	0	13	0
Lymphocytic Leukemia	7	3	4	6	1	7	0	0	0	0	0	0	6	0
Myeloid & Monocytic Leukemia	5	2	3	5	0	2	3	0	0	0	0	0	5	0
Unknown Primary	10	5	5	9	1	4	4	0	0	0	0	0	9	0
Miscellaneous	14	10	4	11	3	12	4	0	1	0	0	0	10	0
<b>Total</b>	<b>510</b>	<b>262</b>	<b>248</b>	<b>425</b>	<b>85</b>	<b>402</b>	<b>108</b>	<b>19</b>	<b>105</b>	<b>56</b>	<b>72</b>	<b>111</b>	<b>50</b>	<b>12</b>

# **PREOPERATIVE LIVER FUNCTION TESTS IN BREAST CANCER PATIENTS**

## **Parkridge Medical Center Cancer Committee**

**November 3, 2014**

### **INTRODUCTION**

A common question which arises during the evaluation of a newly diagnosed breast cancer patient is whether to order comprehensive imaging studies such as whole body bone scans or CT scans. The National Comprehensive Cancer Network guidelines (NCCN) version 3.2014 state that patients with clinical stage I, IIA, and IIB disease should have a history and physical exam, along with CBC, liver function tests, and an alkaline phosphatase test. They recommend imaging only for those patients with either (a) suspicious symptoms, (b) exam findings, or (c) abnormal labs. Recent work performed by members of this committee suggested that preoperative evaluations of breast cancer patients here did not include liver function tests or an alkaline phosphatase test. The purpose of this study was to review patient data more closely, to (a) gauge compliance with NCCN guidelines, and to (b) attempt to find reasons for any omitted testing.

### **METHODS**

Breast cancer patient data from the 1/2012 – 2/2013 cancer registry were reviewed, with missing data obtained from the hCare system and TN Oncology electronic medical records. Surgical clinic chart data were not available for review. Data were analyzed using Microsoft EXCEL.

### **RESULTS**

A total of 54 patients were treated for breast cancer during the 1/2012 – 2/2012. Of these, 25 patients had preoperative liver function tests drawn and 29 patients (54%) did not. However, 17 patients had either their initial biopsy or their definitive resection at another hospital, leaving 37 patients who had all of their surgical treatment at Parkridge Medical Center. Of these, 25 patients had liver function testing, and 12 patients (32%) did not. These data are summarized in Table 1.

### **CONCLUSIONS**

Although the sample size is small, the data suggest the following:

1. Even when patients whose surgeries or biopsies were performed elsewhere were excluded, nearly one-third of breast cancer patients did not have liver function tests drawn prior to their definitive surgery.



2. The data, when grouped by surgeon, show a variation in practice which could be improved through education or by establishing a different protocol for preoperative testing.

Weaknesses of this review include the following:

- (a) Clinic charts were not reviewed, and so it is possible that liver function tests for a given patient were obtained prior to preoperative testing (or simply outside of the Parkridge Medical Center),
- (b) These data were from 2012, and so practice patterns could have changed more recently.

#### Suggested Action

The Cancer Committee develops a letter outlining the NCCN Guidelines in regards to breast cancer pretesting that would be sent to physicians treating breast cancer patient.

# Post-mastectomy Radiation Therapy at Parkridge Medical Center

## Standard 4.6

November 3, 2014

Laura E. Witherspoon, MD, FACS

Cancer Liaison Physician

Purpose: The purpose of this study is to assess compliance with National Cancer Center Network (NCCN) guidelines with regard to post-mastectomy radiation therapy at Parkridge Medical Center (PMC). The study group included all analytic breast cancer cases in the PMC Tumor Registry during 2013. NCCN guidelines recommend post-mastectomy radiation therapy for breast cancer patients with four or more positive axillary nodes. Guidelines also recommend consideration of radiation therapy for tumors greater than five centimeters with negative nodes and for breast cancer with one to three positive axillary nodes. This study will determine whether patients appropriate for post-mastectomy radiation therapy were referred for radiation therapy consultation and whether they received this therapy. Analysis of this data will enhance treatment of patients presenting to PMC for breast cancer treatment.

Methods: All breast cancer cases entered into the PMC Tumor Registry for 2103 were identified. Data from both the Tumor Registry and the hospital medical record were pulled for direct review. There were a total of 56 breast cancer cases for 2103, 22 of which were mastectomies and 23 of which were lumpectomies. Eleven patients did not undergo surgery at PMC. Two of the mastectomies occurred in the same patient for a total of 21 patients analyzed.

Case detail was retrieved from the Cancer Registry and recorded on a spread sheet. This included tumor site within the breast, histology, whether or not the patient received radiation therapy (XRT), and the name of the radiation oncologist who assessed the patient. Also retrieved was the First Course Abstract Report from the PMC Cancer Registry for each patient as well as pathology reports and copies of various follow-up office notes. These documents contained adequate staging information and other detail sufficient to determine whether an individual patient met criteria for post-mastectomy XRT. Each case was individually reviewed and further notes made in the comments section on the spread sheet as to whether the patient's treatment was concordant with NCCN guidelines.

Results: A total of 21 patients underwent 22 mastectomies for cancer at PMC in 2013. Of these, 12 had no indication for post-mastectomy XRT. One patient (case #12) underwent mastectomy for a secondary cancer in a breast previously treated with lumpectomy and XRT. Her stage was T1Nx; no lymph node evaluation was done due to prior axillary dissection. The remaining patients had early stage (T1-2N0) disease without indication for XRT (case #'s 4,5,6,7,8,9,11,13,14,15,and 20).

The remaining ten cancers in nine patients all had indications for post-mastectomy XRT. All received appropriate radiation oncology consultation and treatment. One patient (case #'s 1 and 2) presented with bilateral T3N0 breast cancer with the right side having more adverse features than the left side. She received postoperative chemotherapy and then XRT to the right chest wall and lymphatics. She developed bone metastatic disease before completion

of XRT and has since died secondary to disease. XRT was considered but not given to the left side.

Another patient (case #3) with T3N1 disease had multiple complex hematologic and cardiac co-morbidities. She had a prolonged surgical recovery and was not felt able to tolerate chemotherapy. XRT was initiated, but she was unable to complete the last two weeks of therapy due to treatment effects. She has since died from other causes but was free of breast cancer.

Two patients with T3N0 disease (case #'s 10 and 16) were treated with systemic therapy as well as post-mastectomy XRT. One patient with T2N3 disease (case #19) was treated with systemic therapy followed by post-mastectomy XRT.

Another patient with T2N3 disease (case #21) was treated with mastectomy followed by systemic chemotherapy. She had multiple treatment related complications and was then diagnosed with bone metastatic disease. For this reason, plans for post-mastectomy XRT were abandoned. She is currently alive with stable disease.

A patient with T4N2M1 disease (case #17) was treated initially with systemic chemotherapy for an ulcerated cancer with axillary and mediastinal nodes and bone metastatic disease. She had a good response to therapy and underwent palliative mastectomy and axillary dissection. She received post-mastectomy XRT. She is alive with stable bone disease and no evidence of local disease.

A patient (case #18) had undergone intra-operative XRT with the Xofter system at the time of lumpectomy. Her pathologic stage was T1cN1miM0 with a microscopic metastasis in one of two sentinel nodes. She subsequently underwent bilateral mastectomies with node dissection on the cancer side. No further cancer was found in the breast and all eleven additional nodes removed were negative. She was evaluated but not felt require post-mastectomy XRT due to very limited nodal disease.

Another patient thought to have limited stage disease (case #22) underwent lumpectomy and intra-operative XRT with the Xofter system. She was found to have positive lumpectomy margins on final pathology. Axillary nodes were negative. She then underwent mastectomy with findings of significant residual disease in the breast totaling greater than 5 centimeters in size. She has undergone post-mastectomy XRT.

Summary: All 22 breast cancer patients in the PMC Tumor Registry for 2013 who underwent mastectomy were reviewed to determine compliance with NCCN guidelines for post-mastectomy radiation therapy. Ten cancers in nine patients had NCCN guideline indications for post-mastectomy XRT, and all nine received appropriate evaluation and radiation therapy. Compliance with NCCN guidelines was 100%; therefore this group of patients seems to undergo appropriate multidisciplinary management of their disease.

Recommendations: There are no current areas of concern with regard to appropriate post-mastectomy radiation therapy in this group of patients.

Action: Continued discussion of multidisciplinary care for breast cancer patients at Parkridge Medical Center Cancer Conference.

Monitoring: No ongoing recommended.



## No One Wins This Game

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...in the U.S., the most preventable cause of death and disease is tobacco use?<sup>1</sup>

...in our community, lung cancer is the most prevalent cancer diagnosed?<sup>2</sup>

...if you quit now, within one year your risk of coronary heart disease is reduced by half?<sup>3</sup>

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**PARKRIDGE** cares.  
HEALTH SYSTEM

<sup>1</sup>HealthyPeople.gov <sup>2</sup>Britton, 2014 <sup>3</sup>American Cancer Society



# The Sarah Cannon Cancer Center

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