2014 Cancer Annual Report

Using data from 2013

Franciscan
ST. ELIZABETH HEALTH

Franciscan St. Elizabeth Health Cancer Registry

The Cancer Registry is accredited by the American College of Surgeons Commission on Cancer and is staffed by a certified cancer registrar. The Cancer Registry maintains cancer data and follow-up on patients diagnosed and/or treated at Franciscan St. Elizabeth Health. This data is reported to both the Indiana State Department of Health Cancer Registry and the American College of Surgeons National Cancer Data Base.

In 2013, there were 477 analytic cases accessioned. These cases were used in the statistical analysis of the 2014 Franciscan St. Elizabeth Health Cancer Annual Report data.

Franciscan St. Elizabeth Health Cancer Registry currently maintains follow-up on approximately 6,452 patients. Lifetime follow-up is collected on all analytic cases to compare treatment outcomes and survival rates. The Cancer Registry consistently maintains a lost-to-follow-up rate of 10 percent or less as mandated by the American College of Surgeons Commission on Cancer.

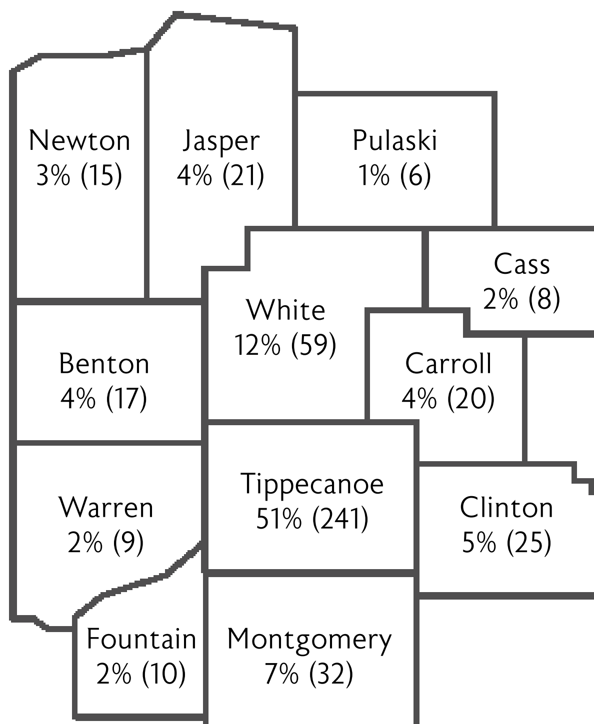
Studies completed in 2013:

- 2012-2013 HER2/Neu /Oncotype DX Comparison Study (Dr. Mario Contreras)
- 2011-2012 NSCLC Treated in Concordance with NCCN Guidelines Study (Dr. Kazumi Chino)
- 2003-2006 NSCLC 5 Year Survival Comparison with NCDB Data Study (Dr. Kazumi Chino)

–Charla J. Dark, CTR, Manager, Cancer Registry

County Stats

2013 COUNTY OF RESIDENCE AT DIAGNOSIS



Other Indiana counties and out of state: 3% (14)

Leading Sites of Cancer Incidence

Male	FSEH	National Estimate*	FSEH Actual
Lung	44	14%	23%
Colorectal	24	9%	13%
Prostate	22	28%	12%
Bladder	14	6%	7%

Female	FSEH	National Estimate*	FSEH Actual
Breast	137	29%	48%
Lung	40	14%	14%
Colorectal	27	9%	9%
Endometrium	21	6%	7%

These tables compare the top primary sites at FSEH with the national statistics of new cancers. The percentages are based on the actual number of cases reported by site and sex both nationally and at FSEH. The number of new cancer cases at FSEH for 2013 totaled 477 (190 men, 287 women). **American Cancer Society Facts & Figures 2013*

Deaths by Site and Sex

Male	FSEH	National Estimate*	FSEH Actual
Lung	30	28%	37%
Colorectal	10	9%	12%
Prostate	5	10%	6%

Female	FSEH	National Estimate*	FSEH Actual
Lung	24	26%	41%
Breast	7	14%	12%
Colorectal	5	9%	9%

Cancer related deaths reported by Franciscan St. Elizabeth Health. Cancer Registry in 2013 totaled 140, (82 men, 58 women). These figures were derived through the Cancer Registry's efforts to do lifetime follow-up on all cancer patients in our database.

**American Cancer Society Facts & Figures 2013*

New Cancer Cases – 477 cases diagnosed in 2013

	FSEH Actual Cases 2013	FSEH 2013	Estimated New Cases in US for 2013*
Oral Cavity/Pharynx	11	2%	2%
Stomach	5	1%	1%
Colorectal	51	11%	9%
Pancreas	10	2%	3%
Larynx	6	1%	1%
Lung	84	18%	14%
Blood/Bone Marrow	14	3%	4%
Melanoma	12	3%	5%
Breast	138	29%	14%
Cervix	5	1%	1%
Endometrium	21	4%	3%
Ovary	5	1%	1%
Prostate	22	5%	14%
Kidney	15	3%	4%
Bladder	19	4%	4%
Brain	5	1%	1%
Thyroid	8	2%	4%
Lymphoma	18	4%	5%
Unknown Primary	9	2%	2%
** Sites with less than 5 cases	19	4%	N/A
* American Cancer Society Facts & Figures 2013			
** Due to HIPAA privacy regulations, primary sites with less than 5 cases cannot be individually identified.			

2011 – 2012 Non-Small Cell Lung Cancer Treatment in Concordance with NCCN Guidelines

As treatments for cancer evolve, the National Comprehensive Cancer Network (NCCN) guidelines are updated to reflect changes in practice. Here we review the 2011 and 2012 non-small cell lung cancer (NSCLC) cases treated at Franciscan St. Elizabeth Health and surrounding community.

For Stage IA NSCLC, the NCCN guidelines recommend surgical resection of the tumor and lymph node sampling or dissection if the patient is a surgical candidate. If the patient is medically inoperable, the guidelines recommend definitive radiation therapy, including stereotactic ablative radiotherapy (SABR). In the 2011 – 2012 time period, 13 patients were identified at Franciscan St. Elizabeth Health with Stage IA NSCLC. All were treated with either surgery or radiation therapy, per NCCN guidelines.

Stage IB carries similar recommendations, with surgical resection and lymph node sampling being preferred for operable patients, and definitive radiotherapy recommended for those who are not surgical candidates. Additionally, chemotherapy may be considered for those patients with adverse risk factors (poorly differentiated tumors, vascular invasion, wedge resection, tumors > 4 cm in size, visceral pleural invasion, and incomplete lymph node sampling). Out of five (5) patients with Stage IB NSCLC at Franciscan St. Elizabeth Health, one (1) was treated surgically, two (2) with radiation alone, one (1)with radiation and chemotherapy, and one (1) with surgery followed by radiation and chemotherapy. The NCCN recommends adjuvant radiation with or without chemotherapy for positive margins after surgery.

For Stage IIA, the NCCN recommend treatment after a thorough evaluation of the mediastinal lymph nodes and for metastatic disease. Surgical resection of the tumor and lymph nodes is recommended for operable patients. If medically inoperable, patients should have definitive radiotherapy (including SABR) if N0 and definitive chemoradiation if N1. Four (4) patients were identified with Stage IIA disease at Franciscan St. Elizabeth Health. Two (2) were treated with radiation alone, one (1) with chemotherapy alone, and one (1) with combined chemotherapy and radiation. Treating Stage IIA with chemotherapy alone is not recommended per the NCCN, but it may be that the patient opted against radiation or was started with chemotherapy with the intention of starting radiation adjuvantly but did poorly and didn't make it to radiotherapy. For Stage IIB, the NCCN guidelines are the same. Five (5) patients from Franciscan St. Elizabeth Health had stage IIB disease. One (1) was treated with radiation alone, two (2) with surgery followed by chemotherapy, and two (2) with chemotherapy and radiation.

The NCCN recommends a combination of surgery if operable, followed by chemotherapy and radiation for the majority of Stage IIIA and IIIB patients, or chemoradiation if medicaly inoperable. A patient may have surgery followed by chemotherapy alone if N0 or N1 with a good resection with negative margins. Positive margins or N2 disease are indications for radiation as well as chemotherapy adjuvantly. Eighteen (18) patients were identified with Stage IIIA disease at Franciscan St. Elizabeth Health, and 10 patients with Stage IIIB disease. Of those combined 28 patients with Stage III disease, one died before starting treatment and four refused curative treatment (three opted for hospice). Two (2) patients were treated with surgery alone, three (3) patients with radiation alone. The NCCN guidelines would recommend more treatment than this, but it's possible that more treatment was planned but not able to be tolerated by the patients. One (1) patient was treated with surgery, chemotherapy and radiation, and the remaining 17 patients received chemoradiation for their Stage III disease.

Unfortunately, the majority of patients diagnosed with NSCLC in our community are diagnosed with Stage IV disease. Screening low dose CT scans have only recently been shown to be of benefit in diagnosing lung cancers sooner, and screening still largely hasn't been implemented in the community. Fifty-five (55) of the 110 cases of NSCLC at Franciscan St. Elizabeth Health were Stage IV. There is still a range of treatment options available to patients with Stage IV disease. The NCCN guidelines recommend evaluation of the pleural or pericardial fluid in patients with M1a disease with pericardial or pleural effusions. If positive, they recommend local therapy as needed with pleurodesis or pericardial window, and then treatment as indicated with the remainder of their disease. If the patient has distant metastasis in a single site, such as the brain or adrenal gland, then the NCCN recommends aggressive treatment of the metastatic site with either surgery or targeted radiation, and then treating the disease in the lung definitively per it's stage followed by chemotherapy. For wide-spread metastatic disease, the guidelines recommend systemic therapy, with palliative radiation or other therapy as indicated.

Of the 55 patients with Stage IV disease, 11 patients did not receive treatment. Two (2) died before starting treatment, two (2) refused treatment altogether, and the rest opted for hospice. Eight (8) patients received chemotherapy alone, 16 received radiation alone, and 20 received a combination of chemotherapy and radiation. While the NCCN guidelines do recommend systemic therapy for patients with Stage IV in general, many may not be able to tolerate it or refuse it.

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