Cancer Program
Annual Report 2017

Reflecting 2016 Data & Activities

Ocala Health

Ocala Health

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LETTER FROM THE CANCER COMMITTEE CHAIRMAN

I am privileged to present the annual report for 2017 for Ocala Regional Medical Center and West Marion Community Hospital Cancer Programs. This reflects data and activities from 2016 for our accredited cancer program, the only American College of Surgeons accredited program in Marion County. Certified data is prepared, compiled, and submitted to the State of Florida and National Data Base by our Certified Cancer Registrar. These cases analyze diagnoses, management, and follow-up of the cancer patients in our community.

Our cancer program includes an expanding nurse navigation program. There are many benefits of nurse navigation with education for patients and their families, coordination of multi-discipline cancer care delivery. The availability and eligibility for clinical trials are also communicated. This personalized touch to cancer care, visiting patients while in the hospital and also following up on their status and management has proved to serve as an ongoing source of support for patients and their families. This decreased barriers to care by assessing needs and also linking patients with support groups and community resources. Involvement with the Sarah Cannon Integrated Cancer Care Services has markedly improved this service provided to the community.

A new lung cancer screening program has been implemented using low dose CT imaging for a defined at-risk population of patients. Early detection of lung cancer reduces mortality among the high risk group including current and former smokers. The low dose computed tomography (LDCT) screening helps find disease earlier before symptoms begin, allowing detection and treatment to obtain optimal results.

To assist in the diagnosis of early and other lung cancers, the SPIN thoracic navigation system has been added for pulmonologists to use in diagnosing early lung cancer. This is an electromagnetic navigation system which navigates the airways of the lungs similar to the GPS in your car navigating our roadways. The data from CT scans of the chest are used with a computer build a 3D map. The physician uses special instruments with tiny sensors to track the location while navigating to a lung nodule for diagnostic biopsy. This allows nodules previously inaccessible with other navigation bronchoscopy tools to be accessed and biopsied.

Other technology used by the surgical services include the robotic surgical system. The "da Vinci" robotic surgical system has been in use for several years with the Mako robotic-arm assisted surgery recently added for orthopedic procedures.

We will continue to provide excellent care and management of oncologic cases in the community in the upcoming year. We are preparing for accreditation by the American College of Surgeons Commission on Cancer for the calendar year 2018. Our team of professionals guiding the direction of our cancer program through the committee includes key services not provided in other locations; the nurse navigator, a dedicated 18 bed oncology unit, outpatient infusion center, multi-disciplinary tumor board with weekly meetings, certified oncology nurses, resource room for patients and families, cancer registry, clinical dietician, and oncology pharmacists are all provided for the benefit of the community.

I continue to be honored and privileged to serve as the Chairman of the Cancer Committee and am proud of the continued growth of our program and the strategic lead we are taking in providing cancer care for Marion County.

Sincerely,

GUY STEVE BUCY, MD
Chairman, Cancer Committee
Ocala Regional Medical Center

Ocala Health

2016 CANCER COMMITTEE MEMBERSHIP

Dr. Steve Bucy (Chairman) - Radiation Oncologist

Dr. David Elliott – Hospice/Palliative Care Representative

Dr. Lawrence McChesney/Dr. Reginald Griffin - General Surgeons

Dr. Samuel Myrick - Physician Liaison and Medical Oncologist

Dr. Vipul Patel – Medical Oncologist

Dr. Jeff Gray/Dr. Fisher - Pathologists

Dr. John Cain/Dr. Bohsali – Radiologists

NON-PHYSICIAN MEMBERS

Linda Dolhay - Oncology Nursing Director

Jolene Hetsler - Nurse Navigator

Joan Whaley - Case Manager

Jamie Tondreault/Kevin Taylor - Clinical Dieticians

Deb Stockton - Quality Director

Melissa Small - Clinical Pharmacist

Melissa White/Janice Pagano – Certified Tumor Registrars

Jeff Nasman, DPT - Rehab Services

Jennifer McKathan - American Cancer Society

Hayley Creasey - Oncology Service Line Director

Mary Bowen, ARNP- Palliative Care Representative

2016 COORDINATORS

Community Outreach Coordinator - Hayley Creasey

Cancer Registry Quality Coordinator – Dr. Vipul Patel

Cancer Conference Coordinator - Dr. Jeff Gray/Dr. Fisher

Quality Improvement Coordinator – Deb Stockton

Clinical Research Coordinator – Trevor Pogue

Psychosocial Services Coordinator – Dr. Sarah Osian/Ashlee Legall

CANCER CONFERENCES

Cancer conferences are held every Tuesday at Ocala Regional Medical Center. Dr. Jeffrey Gray, Anatomic/Clinical Pathologist, is the coordinator for these conferences. A multidisciplinary group of physicians attend these conferences to discuss cancer cases. Representatives from medical oncology, radiation oncology, radiology, pathology, surgery, and multiple subspecialties convene to offer their insight into the treatment of specific cancer cases. There were 33 Cancer conferences in 2016. There were 741 analytic cases for 2016. 113 cases were presented at cancer conference which is 15.2% of the total analytic case load. Of these cases, all 113 were prospective.

2016 CME EVENTS

Educational activities ensure that members of the cancer care team have current knowledge of cancer prevention, early detection, diagnosis, stage of disease, treatment guidelines and prognosis factors, treatment, clinical trials and follow-up care. The committee is encouraged to use the AJCC developed material and to obtain continuing medical education or other appropriate credits for cancer conferences and other clinically focused educational activities.

- 3/1/16 – The Evolving Treatment Landscape for Metastatic Pancreatic Cancer: Clinical Advances for You and Your Patients – Andrea Wang-Gilliam, MD, PhD
- 3/15/16 – Hepatic Malignancy Role of Transplantation – Mark W. Johnson, MD
- 4/5/16 – Data-driven Choice of Novel Targeted Agents and Chemotherapy Combinations for Individualized Management of Metastatic Colorectal Cancer – Jeffrey Meyerhardt, MD
- 5/17/16 - Surgical approach to pancreatic cancer and cystic neoplasms of the pancreas – Jessica Cioffi, MD
- 6/28/16 - Defining Personalized Treatment Approaches in NSCLC: The Significance of EGFR Mutations – Maureen F. Zakowski, MD
- 7/19/16 - Surgical Management of Liver Metastases – Jessica Cioffi, MD
- 8/2/16 – B-Cell Malignancies: New Therapeutic Strategies for the Practicing Clinician - Danielle Brander, MD
- 8/23/16 – Best Practices and Promising Agents in Pancreatic Cancer – Bassel F. El-Rayes, MD
- 9/20/16 – Clinical Debates and Consensus Recommendations on the Use of Antiangiogenic Agents in Lung Cancer: A Focus on the Elderly Patient – Mark A. Socinski, MD
- 10/18/16 – Radioembolization: Angiosomal Ablation – Beau Toskich, MD

2016 SITE PRESENTATION FOR TUMOR BOARDS

Lung	17	Appendix	1	Ovary	3	Small Bowel	1
Breast	16	Uterus	3	Pancreas	2	Adrenal Gland	2
Unknown	1	Sarcoma	1	Head and Neck	3	Spine	1
Colon	8	Rectum	2	Cecum	1	Thyroid	2
Prostate	1	Cervix	1	Testis	1		
Stomach	4	Esophagus	1	Bladder	5		
Brain	4	Parotid	1	Gallbladder	1		
Lymphoma	11	Kidney	6	Liver	6		
Skin	4	Leukemia	2	Myeloma	1	**TOTAL**	**113**

Ocala Health

CANCER REGISTRY ACTIVITY REPORT

The Cancer Registry at Ocala Regional Medical Center/West Marion Community Hospital (ORMC/WMCH) is responsible for the collection of data on cancer patients diagnosed and/or treated at ORMC/WMCH. This data includes cancer occurrence, treatment, and extent of disease and outcomes. All of this data is entered into a computerized registry database. This confidential information is transmitted to the Florida Cancer Data System (FCDS), National Cancer Database (NCDB), American Cancer Society, and the American College of Surgeons, Commission on Cancer (CoC). A Certified Tumor Registrar (CTR) is responsible for the accurate abstraction and transmission of this data. The cumulative data in this Cancer Registry is used to develop cancer control programs, research protocols, epidemiological analyses, and educational forums.

All cancer cases accessioned into the registry are either analytic or non-analytic. Analytic cases are those initially diagnosed and/or treated at ORMC or WMCH, or those initially diagnosed elsewhere who received all or part of their first course of treatment at ORMC and/or WMCH. Follow-up is maintained on all analytic cases. Non-analytic cases are those diagnosed and given first course of treatment elsewhere, but are seen at ORMC and/or WMCH for subsequent or recurrent treatment. The Cancer Registry at ORMC/WMCH was established in 1981. The CoC approved our cancer program in 1983.

ANALYTIC VS. NON-ANALYTIC CASES

YEAR	ANALYTIC CASES	NON-ANALYTIC CASES	TOTAL CASES
2004	799	444	1243
2005	844	603	1447
2006	646	587	1233
2007	584	425	1009
2008	613	560	1173
2009	631	576	1207
2010	614	697	1311
2011	625	700	1325
2012	611	526	1137
2013	573	553	1126
2014	596	517	1113
2015	595	462	1057
2016	741	526	1267
TOTAL PATIENTS IN REGISTRY SINCE 1983 = 35,524			

PRIMARY SITE TABULATION FOR ALL 2016 CASES

Primary Site	Total (%)	Sex		Class of Case		Status		Stage Distribution - Analytic Cases Only							
		M	F	Analy	NA	Alive	Exp	Stg 0	Stg I	Stg II	Stg III	Stg IV	88	Unk	Blank/Inv
ORAL CAVITY & PHARYNX	31 (2.4%)	23	8	9	22	23	8	0	1	1	0	5	0	2	0
Tongue	4 (0.3%)	3	1	2	2	4	0	0	0	0	0	2	0	0	0
Salivary Glands	2 (0.2%)	1	1	2	0	2	0	0	0	1	0	0	0	1	0
Floor of Mouth	1 (0.1%)	0	1	1	0	1	0	0	1	0	0	0	0	0	0
Gum & Other Mouth	1 (0.1%)	0	1	0	1	1	0	0	0	0	0	0	0	0	0
Nasopharynx	2 (0.2%)	2	0	0	2	2	0	0	0	0	0	0	0	0	0
Tonsil	6 (0.5%)	4	2	2	4	5	1	0	0	0	0	1	0	1	0
Oropharynx	8 (0.6%)	7	1	1	7	3	5	0	0	0	0	1	0	0	0
Hypopharynx	1 (0.1%)	1	0	1	0	1	0	0	0	0	0	1	0	0	0
Other Oral Cavity & Pharynx	6 (0.5%)	5	1	0	6	4	2	0	0	0	0	0	0	0	0
DIGESTIVE SYSTEM	267 (21.1%)	154	113	171	96	201	66	1	20	34	26	50	9	31	0
Esophagus	21 (1.7%)	18	3	9	12	20	1	0	0	1	0	3	0	5	0
Stomach	25 (2.0%)	18	7	15	10	14	11	0	0	3	5	4	0	3	0
Small Intestine	3 (0.2%)	2	1	2	1	3	0	0	1	0	0	0	1	0	0
Colon Excluding Rectum	106 (8.4%)	53	53	75	31	85	21	1	13	21	14	18	0	8	0
Cecum	14	8	6	9	5	10	4	1	0	1	2	5	0	0	0
Appendix	3	2	1	2	1	3	0	0	0	1	0	1	0	0	0
Ascending Colon	20	8	12	18	2	16	4	0	3	7	3	3	0	2	0
Hepatic Flexure	2	1	1	1	1	2	0	0	0	0	0	0	0	1	0
Transverse Colon	20	11	9	19	1	18	2	0	4	7	4	2	0	2	0
Splenic Flexure	2	1	1	1	1	2	0	0	0	0	1	0	0	0	0
Descending Colon	6	4	2	6	0	5	1	0	3	2	1	0	0	0	0
Sigmoid Colon	19	6	13	12	7	17	2	0	3	3	2	3	0	1	0
Large Intestine, NOS	20	12	8	7	13	12	8	0	0	0	1	4	0	2	0
Rectum & Rectosigmoid	34 (2.7%)	20	14	22	12	29	5	0	3	2	3	7	0	7	0
Rectosigmoid Junction	8	5	3	6	2	5	3	0	0	1	1	3	0	1	0
Rectum	26	15	11	16	10	24	2	0	3	1	2	4	0	6	0
Anus, Anal Canal & Anorectum	5 (0.4%)	2	3	4	1	5	0	0	0	0	1	0	0	3	0
Liver & Intrahepatic Bile Duct	19 (1.5%)	16	3	8	11	13	6	0	0	1	0	3	4	0	0
Liver	16	13	3	8	8	12	4	0	0	1	0	3	4	0	0
Intrahepatic Bile Duct	3	3	0	0	3	1	2	0	0	0	0	0	0	0	0
Gallbladder	4 (0.3%)	0	4	1	3	1	3	0	0	0	0	1	0	0	0
Other Biliary	3 (0.2%)	1	2	2	1	2	1	0	0	0	0	0	0	2	0
Pancreas	44 (3.5%)	23	21	30	14	28	16	0	3	6	3	14	1	3	0
Peritoneum, Omentum & Meser	1 (0.1%)	0	1	1	0	0	1	0	0	0	0	0	1	0	0
Other Digestive Organs	2 (0.2%)	1	1	2	0	1	1	0	0	0	0	0	2	0	0
RESPIRATORY SYSTEM	253 (20.0%)	147	106	152	101	192	61	2	30	10	27	70	1	12	0
Nose, Nasal Cavity & Middle Ea	2 (0.2%)	2	0	0	2	0	2	0	0	0	0	0	0	0	0
Larynx	14 (1.1%)	12	2	7	7	13	1	0	0	1	3	3	0	0	0
Lung & Bronchus	237 (18.7%)	133	104	145	92	179	58	2	30	9	24	67	1	12	0
BONES & JOINTS	1 (0.1%)	1	0	1	0	1	0	0	0	0	0	1	0	0	0
Bones & Joints	1 (0.1%)	1	0	1	0	1	0	0	0	0	0	1	0	0	0
SOFT TISSUE	6 (0.5%)	5	1	3	3	5	1	0	1	0	0	2	0	0	0
Soft Tissue (including Heart)	6 (0.5%)	5	1	3	3	5	1	0	1	0	0	2	0	0	0
SKIN EXCLUDING BASAL & SC	24 (1.9%)	19	5	11	13	19	5	4	1	1	1	4	0	0	0
Melanoma -- Skin	22 (1.7%)	18	4	11	11	17	5	4	1	1	1	4	0	0	0
Other Non-Epithelial Skin	2 (0.2%)	1	1	0	2	2	0	0	0	0	0	0	0	0	0
BREAST	89 (7.0%)	3	86	37	52	84	5	2	12	13	1	7	0	2	0
Breast	89 (7.0%)	3	86	37	52	84	5	2	12	13	1	7	0	2	0
FEMALE GENITAL SYSTEM	70 (5.5%)	0	70	41	29	58	12	0	13	4	5	11	1	7	0
Cervix Uteri	6 (0.5%)	0	6	2	4	5	1	0	0	0	0	2	0	0	0
Corpus & Uterus, NOS	34 (2.7%)	0	34	24	10	27	7	0	12	4	1	3	1	3	0
Corpus Uteri	32	0	32	24	8	25	7	0	12	4	1	3	1	3	0
Uterus, NOS	2	0	2	0	2	2	0	0	0	0	0	0	0	0	0
Ovary	26 (2.1%)	0	26	12	14	24	2	0	0	0	4	4	0	4	0
Vagina	2 (0.2%)	0	2	1	1	0	2	0	0	0	0	1	0	0	0
Vulva	1 (0.1%)	0	1	1	0	1	0	0	1	0	0	0	0	0	0
Other Female Genital Organs	1 (0.1%)	0	1	1	0	1	0	0	0	0	0	1	0	0	0
MALE GENITAL SYSTEM	65 (5.1%)	65	0	23	42	55	10	0	6	10	3	2	0	2	0
Prostate	63 (5.0%)	63	0	23	40	54	9	0	6	10	3	2	0	2	0
Penis	1 (0.1%)	1	0	0	1	0	1	0	0	0	0	0	0	0	0
Other Male Genital Organs	1 (0.1%)	1	0	0	1	1	0	0	0	0	0	0	0	0	0
URINARY SYSTEM	111 (8.8%)	78	33	81	30	92	19	22	17	12	3	21	1	5	0
Urinary Bladder	66 (5.2%)	49	17	48	18	54	12	20	9	8	0	7	1	3	0
Kidney & Renal Pelvis	42 (3.3%)	27	15	33	9	35	7	2	8	4	3	14	0	2	0
Ureter	2 (0.2%)	1	1	0	2	2	0	0	0	0	0	0	0	0	0
Other Urinary Organs	1 (0.1%)	1	0	0	1	1	0	0	0	0	0	0	0	0	0

PRIMARY SITE TABULATION FOR ALL 2016 CASES

BRAIN & OTHER NERVOUS SY	58 (4.6%)	23	35	52	6	47	11	0	0	0	0	0	52	0	0
Brain	16 (1.3%)	7	9	16	0	10	6	0	0	0	0	0	16	0	0
Cranial Nerves Other Nervous S	42 (3.3%)	16	26	36	6	37	5	0	0	0	0	0	36	0	0
ENDOCRINE SYSTEM	18 (1.4%)	9	9	10	8	15	3	0	1	0	0	1	7	1	0
Thyroid	5 (0.4%)	1	4	3	2	3	2	0	1	0	0	1	0	1	0
Other Endocrine including Thym	13 (1.0%)	8	5	7	6	12	1	0	0	0	0	0	7	0	0
LYMPHOMA	62 (4.9%)	31	31	38	24	58	4	0	11	1	14	9	0	3	0
Hodgkin Lymphoma	8 (0.6%)	5	3	7	1	8	0	0	2	0	2	3	0	0	0
Non-Hodgkin Lymphoma	54 (4.3%)	26	28	31	23	50	4	0	9	1	12	6	0	3	0
NHL - Nodal	43	20	23	24	19	39	4	0	6	0	12	5	0	1	0
NHL - Extranodal	11	6	5	7	4	11	0	0	3	1	0	1	0	2	0
MYELOMA	28 (2.2%)	15	13	8	20	24	4	0	0	0	0	0	8	0	0
Myeloma	28 (2.2%)	15	13	8	20	24	4	0	0	0	0	0	8	0	0
LEUKEMIA	56 (4.4%)	35	21	18	38	38	18	0	0	0	0	0	18	0	0
Lymphocytic Leukemia	25 (2.0%)	16	9	6	19	22	3	0	0	0	0	0	6	0	0
Chronic Lymphocytic Leukemi	24	15	9	6	18	21	3	0	0	0	0	0	6	0	0
Other Lymphocytic Leukemia	1	1	0	0	1	1	0	0	0	0	0	0	0	0	0
Myeloid & Monocytic Leukemia	30 (2.4%)	18	12	12	18	16	14	0	0	0	0	0	12	0	0
Acute Myeloid Leukemia	18	12	6	10	8	7	11	0	0	0	0	0	10	0	0
Chronic Myeloid Leukemia	11	5	6	2	9	8	3	0	0	0	0	0	2	0	0
Other Myeloid/Monocytic Leuk	1	1	0	0	1	1	0	0	0	0	0	0	0	0	0
Other Leukemia	1 (0.1%)	1	0	0	1	0	1	0	0	0	0	0	0	0	0
MESOTHELIOMA	6 (0.5%)	4	2	2	4	5	1	0	0	0	0	1	0	1	0
Mesothelioma	6 (0.5%)	4	2	2	4	5	1	0	0	0	0	1	0	1	0
MISCELLANEOUS	123 (9.7%)	60	63	84	39	105	18	0	0	0	0	0	84	0	0
Miscellaneous	123 (9.7%)	60	63	84	39	105	18	0	0	0	0	0	84	0	0
Total	1,268	672	596	741	527	1,022	246	31	113	86	80	184	181	66	0

Exclusions: Not Male and Not Female 0

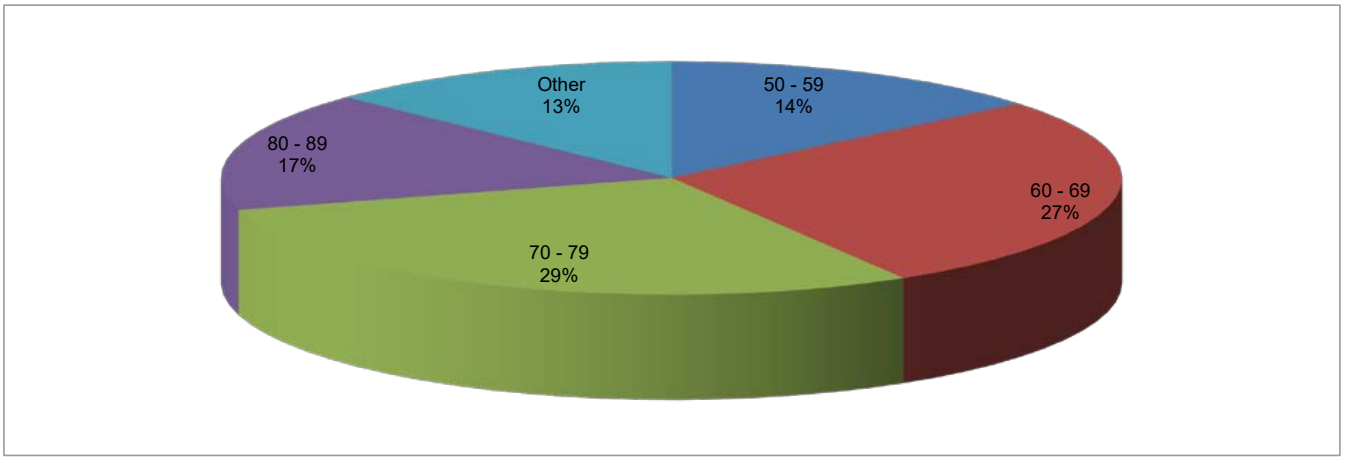
159 Cases that do not have an AJCC Staging Scheme

AGE AT DIAGNOSIS

Age at Diagnosis (in years)	**Count (N)**	**Percent (%)**
50 - 59	171	13.99%
60 - 69	335	27.41%
70 - 79	356	29.13%
80 - 89	203	16.61%
Other	157	12.85%
Total	1,222	100.00%

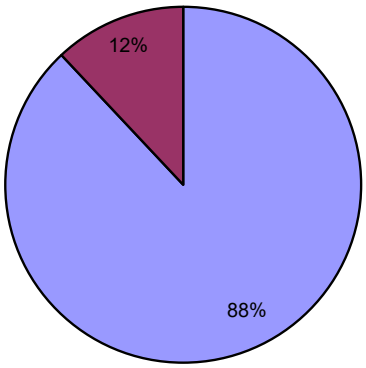
Range: 15 to 96

Mean: 68

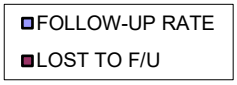


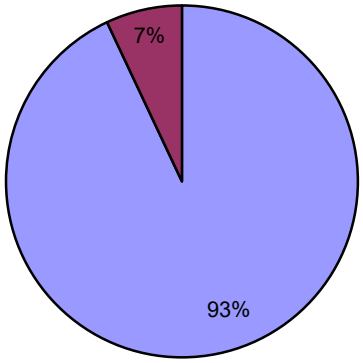
FOLLOW UP OF PATIENTS

In maintaining a Commission on Cancer approved program, yearly follow-up must be maintained on all analytic patients. Follow-up consists of additional treatment, long-term medications, remission information and vital status. Standard 5.3 follow-up on all analytic patients must be maintained at 80%.
Standard 5.4 follow-up on all analytic patients diagnosed in the last five years must be maintained at 90%.



STD. 5.3 FOLLOW-UP RATE SINCE 2004 REFERENCE DATE



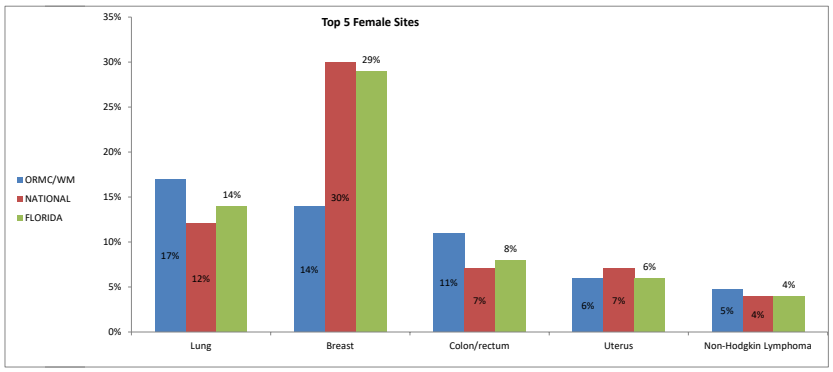


STD. 5.4 FOLLOW-UP RATE FOR PATIENTS DIAGNOSED IN THE LAST FIVE YEARS

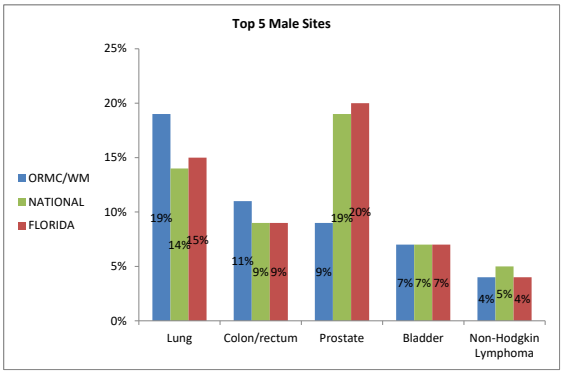
The ORMC/WMCH Cancer Program annual follow up rate on all analytic cancer patients is 88% from reference date and 93% for the last five years.

OCALA HEALTH TOP 5 CANCER SITES BY GENDER COMPARED TO ESTIMATED 2017 STATE AND NATIONAL CASES

FEMALE



MALE



National Estimated Numbers are from the ACS Facts and Figures 2017. Florida numbers obtained from Florida Cancer Data System Number of New Cancers by Sex and Race 2014.

COLORECTAL CANCERS

2016 REVIEW OF ANALYTIC CASES BY STAGE AND TREATMENT

Purpose:

1) To determine the work-up, management, and survival rates of patients with colorectal cancer by stage.

2) To compare by TNM staging, the percentage of colorectal cancers, treated with radiation and chemotherapy.

   The TNM Staging system assesses tumors in three ways: extent of the primary tumor (T), absence or presence of lymph node involvement (N), and absence or presence of distant metastases (M). Once the TNM are determined, a stage of I, II, III, or IV is assigned, with stage I being early stage and stage IV being advanced stage.

Study Data:

There were 94 analytic colorectal cancer patients from the Tumor Registry data files. These cases were diagnosed and/or had part or all of their first course of treatment at Ocala Regional Medical Center or West Marion Community Hospital during the year 2016.

Data statistics:

Colorectal cancer is the third most common cancer both in men and in women. Due to changing patterns in risk factors and the uptake of screening, colorectal cancer incidence rates have been declining for several decades. Incidence rates during 2004-2013 declined by about 3% per year among adults age 50 and older, but increased by about 2% per year among those younger than age 50, largely driven by an increase in rectal cancer. These excerpts were taken from the American Cancer Society - Cancer Facts and Figures, 2017, pg. 13.

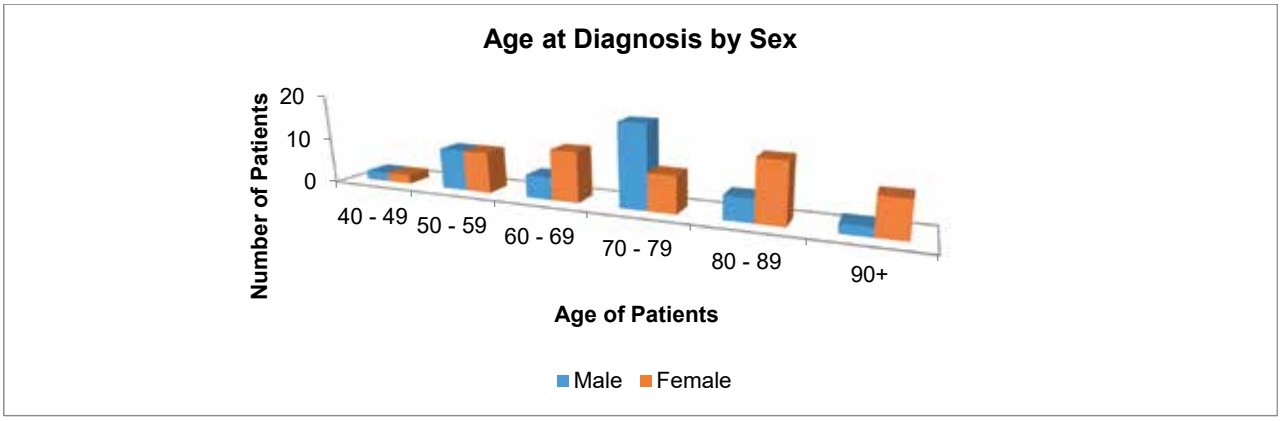
Demographics:

Table 1

The greatest number of colorectal cancers was diagnosed in the 70's age group, of which males outnumbered females 67% to 33% respectively.

Table 1

Gender and Race		
	Female	Male
Black	5	5
White	44	36
Hispanic	2	0
Total	51	41



- Two patients had two colon primaries and one patient presented to both ORMC and WM for treatment. Their age, race, and sex data was only counted once for the above tables.

Signs and Symptoms:

Table 2

Table 2 reflects the most common presenting symptoms of colorectal cancer. 47% reported symptoms of anemia followed by 39% reporting bloating/pain/cramping in the lower abdomen, and 20% reporting rectal bleeding. Patients also reported weight loss, weakness/fatigue, change in bowel habits, constipation and/or chronic diarrhea. 10% presented upon being screened, followed by 9% presenting with a bowel obstruction.

(Note: some patients may have reported more than one presenting symptom)

Table 2

Presenting symptoms reported by patients	
Anemia	43
Bloating/Pain/Cramping	36
Rectal Bleeding	18
Change in Bowel Habits	8
Constipation	5
Bowel Obstruction	8
Chronic Diarrhea	5
Weight Loss	14
Weakness/Fatigue	11
Decreased Appetite	3
Screening	9
GI Bleed	6
Incidental Finding	3
*Some patients may have reported more than one symptom	

Diagnostic Workup:

Table 3A

Radiology exams performed included CT Abdomen/Pelvis done on 73% of patients, PET scan on 13% of the patients, Abdominal Ultrasound and Endoscopic Ultrasound on 2%, and MRI Abdomen on 1%.

Table 3A

Imaging Studies		
CT Abdomen/Pelvis	67	73%
PET	12	13%
Abdominal US	2	2%
EUS	2	2%
MRI Abdomen	1	1%
CT Chest	14	15%
*Some patients may have had more than one of the above imaging studies		

Table 3B

84 of the 92 patients had a colonoscopy.

Table 3B

Endoscopy		
Colonoscopy	84	91%
None	8	9%

Table 3C

Laboratory testing was performed on 72 of the patients. Complete blood counts accounted for 78% of the testing, carcinoembryonic antigen (CEA) testing 51%, and fecal occult blood testing (FOBT) 10%.

Table 3C

Labs		
CEA	47	51%
CBC	72	78%
FOBT	9	10%
*Some patients may have had more than one of the above laboratory tests		

Table 3D

KRAS testing was performed on 5 patients. Mismatch repair testing was performed on two patients and Oncotype was performed on two patients.

Table 3D

Genetic Testing		
KRAS	5	5%
MMR	2	2%
ONCOTYPE DX	2	2%
*Some patients may have had more than one of the above tests		

Treatment by Stage:

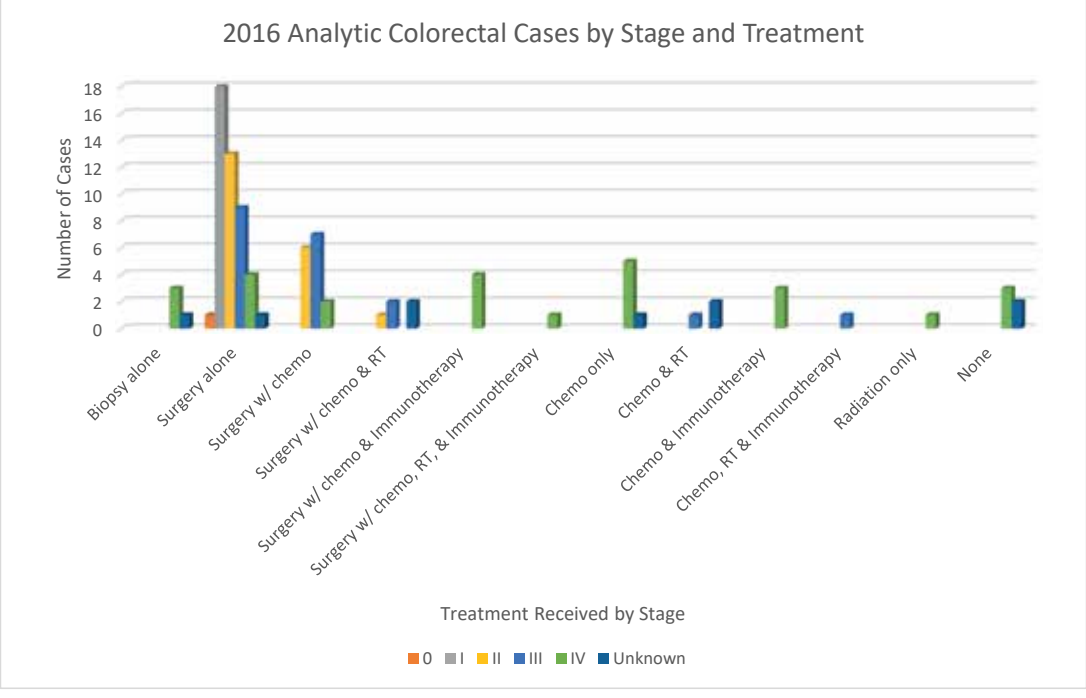
Table 4

The breakdown of treatment by stage demonstrates that the largest number of patients (26) were diagnosed with stage IV cancer, followed by 20 patients with stage II, 20 patients with stage III, 18 patients with stage I, and one patient with stage 0. Nine patients were not staged. Four patients had diagnostic biopsies only. 46 patients had surgery alone, while 15 patients had surgery with chemotherapy, 5 patients had surgery with chemotherapy and radiation therapy, 2 patients had surgery with chemotherapy, radiation therapy, and immunotherapy, 4 patients had surgery with chemotherapy and immunotherapy, 6 patients had chemotherapy alone, 3 patients had chemotherapy and radiation therapy, 3 patients had chemotherapy and immunotherapy, and one patient had radiation alone. 5 patients had no treatment.

Table 4

Cases by Stage and Treatment							
		Stage Groups					
Treatment	Total	0	I	II	III	IV	Unknown
Biopsy alone	4					3	1
Surgery alone	46	1	18	13	9	4	1
Surgery w/ chemo	15			6	7	2	
Surgery w/ chemo & RT	5			1	2		2
Surgery w/ chemo & Immunotherapy	4					4	
Surgery w/ chemo, RT, & Immunotherapy	1					1	
Chemo only	6					5	1
Chemo & RT	3				1		2
Chemo & Immunotherapy	3					3	
Chemo, Radiation, & Immunotherapy	1				1		
Radiation only	1					1	
None	5					3	2
Total	94	1	18	20	20	26	9

(see corresponding graph below)



Survival Data:

Table 5

Survival data reflects that 20 patients have expired, ten of which were in their 70's, three in their 80's, three in their 60's, and one in the 50's age group. Eight expired within one month of the date of diagnosis, three expired between one and two months after the date of diagnosis, six expired within two to four months of the date of diagnosis, one expired within seven months of the date of diagnosis, and two expired one year after the date of diagnosis. Ten of the 20 patients who expired had surgery, one of which also had chemotherapy after surgery and one who refused further treatment after surgery. Of the other ten patients who expired, surgery was not recommended for eight of them due to age, stage, or patient condition, and the remaining two patients refused all treatment.

Table 5

Age at Diagnosis	Time elapsed	Stage
56	10 weeks	4B
61	1 month	4B
67	2 weeks	4B
69	3 weeks	4B
71	3 months	4B
73	2 weeks	4B
74	14 weeks	3C
74	1 month	4B
74	13 months	3A
74	1 month	4B
75	7 months	4A
76*	15 weeks	3B
78	18 days	2B
79	3 weeks	2A
82	14 weeks	4B
83	3 weeks	3B
84	4 months	4B
91	1 year	Unknown
93	3 weeks	Unknown
93	11 days	Unknown

***Patient also had a simultaneous stage I colorectal primary.**

Of the 46 patients who had surgery alone, 13 were stage III or IV. Two of the 13 stage III and IV patients had poor performance status or comorbidities that contraindicated further treatment. Three expired before further treatment could be administered, three had further treatment planned but never presented for treatment, and five refused further treatment after surgery. Of the 32 patients that were Stage 0, I, or II and had surgery alone, three did not receive further treatment due to age, toxicity concerns, and comorbidities, two refused further treatment, two expired before any further treatment could be administered, and two patients never presented to the medical oncologist's office for consult. Further treatment was not recommended due to early stage for the remaining 23 patients.

Three yp staged patients received neoadjuvant chemotherapy and radiation therapy prior to definitive surgery.

Three patients had PET scans because of previous malignancies which were being monitored when their current colorectal cancers were diagnosed.

Only five of the patients studied had KRAS mutation testing performed.

Survival since surgery

Of the 71 patients who had surgery plus or minus additional treatment, the longest surviving patient is a 58 year old who had surgery at 14 months since surgery.

SITE REPORT REVIEW FOR 2016 ANNUAL CANCER PROGRAM ANNUAL REPORT

I have reviewed 2016 Review of Analytic Colorectal Cases by Stage and Treatment at ORMC and WMCH. Most of the cases were diagnosed in the 70's age group, which is slightly higher than the national average.

However I have noticed the patients younger than 50 is the fastest growing demographic. Presenting symptoms were close to the national average.

The treatments seemed appropriate and in accord with NCCN guidelines. Patients were staged appropriately. In general patients were treated appropriately. The only thing which was underperformed was KRAS and MMR testing which was 5% and 2% respectably. Otherwise, it all looks pretty much as expected.

Vipul Patel, MD, Medical Oncology

GUIDE TO ORDERING YOUR PATIENT'S LOW DOSE LUNG CANCER SCREENING

Deciding

Pre-scan shared decision making and counseling discussion in which you discuss need for lung cancer screening using low-dose CT scan. This can be part of an annual wellness visit or other E&M visit.

The following two new G codes should be used:

- G0296 — Counseling visit to discuss need for LDCT using low-dose CT scan (service is for eligibility determination and shared decision making)
- G0297— LDCT for lung cancer screening

*Note: Medicare will deny G0296 and G0297 for claims that do not contain ICD-10 Z87.891 or ICD-10 Z72.0, personal history of tobacco use/personal history of nicotine dependence or Tobacco use, respectively

Who Qualifies

- 55-77 years old (non-Medicare providers: age 55-80)
- 30 pack year history of smoking
- Currently smoke or quit within the past 15 years
- Shared Decision Making session with the ordering doctor to go over the risk and benefits of the lung screening protocol
- Asymptomatic

When Ordering:

- Please fill out the order form completely and fax to 352-291-6302
- Authorization for medical necessity might be needed from the insurer
- Diagnosis must include ICD10 Z87.891or ICD-10 Z72.0, accompanied by Low Dose CT Scan written order
- Call our scheduling office at 352-291-6341 and request that the patient be scanned in the CT department, located in West Marion Community Hospital

DETECTING LUNG CANCER EARLIER IS CHANGING PATIENT LIVES. ARE YOU A CANDIDATE FOR SCREENING?

Lung Cancer Screening

Ocala Health now offers low-dose computed tomography (LDCT) screenings for patients who meet specific criteria. Lung screening exams are tests performed to find the disease before symptoms begin with a goal of detecting disease at its earliest and most treatable stage.

If you:

- Are 55 to 77 years of age
- Have at least a 30-pack year history
- Currently smoke or have quit smoking within the last 15 years
- Are asymptomatic (patient should not experience coughing blood or wheezing, and must not have been diagnosed with severe pulmonary disease)

Ask your doctor about a low dose lung cancer screening. Medicare and most insurances cover the lung cancer screening.

For more information, please call 352-291-6341 or visit ocalahealthsystem.com

DETECTING LUNG CANCER EARLIER

Ocala Health offers Low-Dose Computed Tomography (LDCT) screenings for patients who meet specific criteria to enhance early detection of lung cancer and to reduce mortality among smokers. Lung screening examinations are tests performed to find disease before symptoms begin, with a goal of detecting disease at its earliest and most treatable stage. Using LDCT scans to screen smokers for lung cancer reduces the risk of death by 20 percent versus those screened by a chest X-ray, according to a National Cancer Institute study. For high risk individuals, the benefits of early detection far exceed the risks of low-dose radiation.

Screening Criteria

High risk individuals must meet the following criteria:

- Be asymptomatic (You should not experience coughing blood or wheezing, and must not be diagnosed with severe pulmonary disease)
- 55-77 years old
- Have at least a 30-pack year smoking history
- Currently smoke or have quit within the past fifteen years

Physician Order and Discussion

To participate in the screening, you must make an appointment with your primary care physician to have a Shared Decision Making session. Your physician will explain the risks and benefits of the study.

What To Expect During the Procedure

During the LDCT procedure, you will lie flat on the exam table. Pillows may be used for comfort to help you maintain the correct position and to help you remain still during the exam. You will be asked to hold your arms over your head. Next, the table will move through the scanner to the correct starting position for the scans. While you hold your breath for five to 10 seconds, the table will move through the machine as the

LDCT scan is done.

Questions

Will My Insurance Cover the Procedure?

LDCT screenings are covered under most insurance plans, and typically do not require a co-pay. Check with your insurance provider to be sure.

What Happens If My Results Are Positive?

If an abnormality is found on your LDCT scan, a letter will be sent to you and your physician with the report attached. Your doctor may recommend a followup CT scan. In the unlikely case that the abnormality does grow or may present a worry, your doctor may recommend further testing using a PET scan or a biopsy (taking out a small piece of the abnormality). Remember, lung cancer screening is not a single test: It is a process that must be done correctly under the direction of your doctor(s).

Call Today

For more information or questions regarding the LDCT screening, call 352-291-6341.

Ocala Health

INFORMATION ON CANCER

Ocala Regional Medical Center
(352) 401-1000
www.ocalahealthsystem.com

West Marion Community Hospital
(352) 291-3000
www.ocalahealthsystem.com

American Cancer Society (ACS)
(800) 227-2345
www.cancer.org

American College of Surgeons (ACoS)
(800) 621-4111
www.facs.org

American Institute for Cancer Research (AICR)
(800) 843-8114
www.aicr.org

Association of Community Cancer Centers (ACCC)
(301) 984-9496
www.accc-cancer.org

Center for Disease Control and Prevention (CDC)
www.cdc.gov

Cancer Programs (ACoS)
(321) 202-5085
www.facs.org/cancer

Florida Cancer Data System (FCDS)
(305) 243-4600
www.fcds.med.miami.edu

Florida Department of Health (FDH)
www.doh.state.fl.us

National Cancer Institute (NCI)
(800) 4CANCER
www.cancer.gov

National Comprehensive Center Network (NCCN)
(888) 909-6226
www.nccn.org

REFERENCES

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Ocala Regional Medical Center/
West Marion Community Hospital

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Reference:

Cancer Registry Database at ORMC

American Cancer Society, Cancer Facts and Figures 2017 Atlanta, GA

American Joint Committee on Cancer, Manual of Staging of Cancer, 7th Edition

World Health Organization, ICD-03, 3rd Edition

National Comprehensive Cancer Network

American Society of Clinical Oncology

National Cancer Institute

SEERS Data

Report Compiled By:

Dr. Samuel Myrick

Report Edited By:

2017 Cancer Committee

Updated January 2018

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Cancer Program
Annual Report 2017

Reflecting 2016 Data & Activities

Ocala Health