2012 Cancer Program

ANNUAL REPORT AND OUTCOME STUDY ON BREAST CANCER

The Jewish Hospital

MERCYHEALTH

Cancer Program Summary

The Jewish Hospital offers the highest quality of cancer care as evidenced by the approval of our cancer program by the Commission on Cancer, American College of Surgeons and Foundation for the Accreditation of Cellular Therapy for our Bone and Marrow Transplant Center. Under the leadership of the Surgical Oncology Specialty Quality Committee, our Cancer Program has also received commendations for excellence in key areas of patient care. Achieving and exceeding compliance with the required standards of care set by the American College of Surgeons, Commission on Cancer, assures our patients that they will receive the best of care from diagnosis, throughout the treatment period and continuing to end of life care.

In addition to a wide range of diagnostic and treatment services, our hospital offers many programs that provide assistance to both our patients and their families as they cope with a diagnosis of cancer. Our support services include nutritional support, spiritual support, rehabilitation, palliative care, educational programs for our patients and the community, information on access to clinical trials and cancer support groups and programs, many of which are provided through our collaboration with the American Cancer Society.

To meet the growing and changing needs of the patients and the communities we serve, our Surgical Oncology Specialty Quality Committee continually strives for Cancer Program excellence by annually reviewing our services, performing patient care studies, and by setting annual goals to improve and enhance our services.

The Blood and Marrow Transplant Program's affiliation with the National Marrow Donor Program (NMDP) and the Center for International Blood and Marrow Transplant Research (CIBMTR) allows patients access to national and international research protocols and increases their opportunity for participation in cutting edge oncology clinical trials.

The Jewish Hospital implemented many patient care improvements, sponsored a large number of patient, communities and staff educational offerings and improved many of our services last year. 2011 Cancer Program Achievements include:

- Implemented electronic medical record (EPIC) house wide.
- Amended the radioactive material license to include radioactive seed localizations for breast.
- Implemented a clinical trial through radiation oncology involving radioactive seeds for breast cancer patients.
- Began active process for the NAPBC Breast Accreditation.
- Re-Accredited by the Foundation for the Accreditation of Cellular Therapy for the Bone Marrow Stem Cell Transplant Program.
- Purchased and implemented tomosynthesis technology for the mammography department
- Co-management agreement with Oncology Hematology Care for Cancer Care.

The Jewish Hospital Surgical Oncology Specialty Quality Committee

The Surgical Oncology Specialty Quality Committee is a multi-disciplinary team comprised of hospital employees, staff physicians and members from the American Cancer Society. The committee meets quarterly to monitor the hospital's cancer program's performance and to review the available services and programs.

Our mission is to provide a patient-focused, integrated and comprehensive cancer program. We will serve in a compassionate and efficient manner, providing state-of-the-art technology and research, through caring for people one individual at a time.

2011 Cancer Committee Members

Physician Members:	**Discipline:**
Elizabeth Weaver, MD	Chair, Radiology
James Essell, MD	Medical Oncology
Kevin Monroe, MD	Pathology
Scott Hobler, MD	General Surgeon
Peter Fried, MD	Radiation Oncology
Allied Health Members:	**Department:**
Teresa Schleimer, MSN, CNP	Cancer Program Administrator
Robert Flores, MHA, BSN, RN, OCN, NE-BC	Cancer Program Administrator
Elena Stein, MAHL, BCC	Pastoral Care
Kathy Smith, RN, MSN	Patient Services
Jenny Martin, RN, MBA	Quality Management
Carolyn Green, RT, (R) (M)	ARDS Radiology
Chris Warders, RD, LD	Nutrition
Robin Hite, R.T. (R) (T)	Radiation Oncology
Cathy Beumer,	Pain Management
Michael DeVoe, Pharm.D	Pharmacy
Laura Metzler	American Cancer Society
Lyn Sontag, Psy.d, ABPP R.T. (R) (T)	Clinical Psychologist
Annette Shepherd,	Community Member
Jenny Martin, RN, MSN	Performance Improvement
Beverly Weinstein, RTRM	Mammography
Vicki Estridge, BSN, RN, OCN	Clinical Manager, BMTU
Pam VanSant, BS, MBA	Administration
Linda Miller, RN, MSN	Patient Services
Nancy Wolpert, RN, MSN	Blood and Marrow Transplant Center
Robert Flores, MHA, BSN, RN, OCN, NE-BC	Blood and Marrow Transplant Center
Debra Steinbuch, MA, CCC-SLP	Rehabilitation Services
Susan Colding, RN, OCN	Research Nurse
Mary Hill, MSW, LISW	Social Services
Yvonne Duhart, RHIT	Cancer Registry
Angela Price, RHIA	Medical Records
Cancer Program Coordinators:	
Kevin Monroe, MD	Quality of Registry Data
Yvonne Duhart, RHIT	Cancer Conference
Elizabeth Weaver, MD	Community Outreach, Cancer Liaison Physician
Jenny Martin, RN, MBA	Quality Improvement

Cancer Conferences

Cancer Conferences provide a multidisciplinary format for the development of a plan of care for the cancer patient. The conferences are integral to improving care and providing education to physicians and hospital staff. Consultative services and education are optimal when physicians representing all oncology related disciplines participate in the discussion. Patient identities are kept confidential

The Cancer Conferences are prospective, patient-oriented and multidisciplinary by design. Medical Oncology, Radiation Oncology, Diagnostic Radiology, Pathology, and General Surgery specialties are present to discuss diagnostic evaluations and possible treatment options for the types of cancers presented at the conferences. Physicians from all specialties, including Medical and Surgical residents are invited to attend.

Treatment options that are based on national guidelines and AJCC staging are the foundations of the discussions. National Comprehensive Cancer Network (NCCN) Practice Guidelines in Oncology, information on open clinical trials, NCDB and cancer registry data are provided for the cancer sites presented.

The Jewish Hospital Cancer Conferences

Surgical Cancer Conferences are held at The Jewish Hospital on the fourth Wednesday of each month at 7:30 a.m. in the Conference Room D. Breast Cancer Conferences are conducted 1st and 3rd Wednesdays of each month at 8:00 a.m. in Conference Room D. The Thoracic Cancer Conference is held on the 2nd and 4th Friday of each month at 7:00 a.m. in room 303 at the Annex (bank) building. All of these programs are approved by the Ohio State Medical Association for one Category 1 CME credit hour. The Medical Cancer Conference is held on the second Tuesday of each month at noon in the Conference Room A& B. The Bone Marrow Transplant Multidisciplinary Team Meeting is held each Wednesday in Conference Room A & B at 8:30 a.m.

Cancer Registry

The Cancer Registry is a vital component of the Cancer Program, providing data for programmatic and administrative planning, research, and for monitoring patient outcomes. Data are collected according to the current standards of the Commission on Cancer to create a detailed cancer–focused record for all reportable tumors diagnosed and/or treated at our hospital. Each record entered into the database contains information on the diagnosis, extent of disease, treatment received, recurrence of disease and lifetime follow-up for each patient. Aggregate data is analyzed and published without patient identifiers to protect the confidentiality of each patient entered into the cancer database according to Ohio state laws and HIPAA regulations.

A Cancer Registrar performs the collection, interpretation, analysis and reporting of cancer data. The National Cancer Registrars Association defines Cancer Registrars as "data management experts who collect and report cancer statistics for various healthcare agencies." Registrars work closely with physicians, administrators, researchers, and health care planners to provide support for cancer program development, ensure compliance with reporting standards, and serve as a valuable resource for cancer information with the ultimate goal of preventing and controlling cancer. The Cancer Registrar is involved in managing and analyzing clinical cancer information for the purpose of education, research, and outcome measurement.

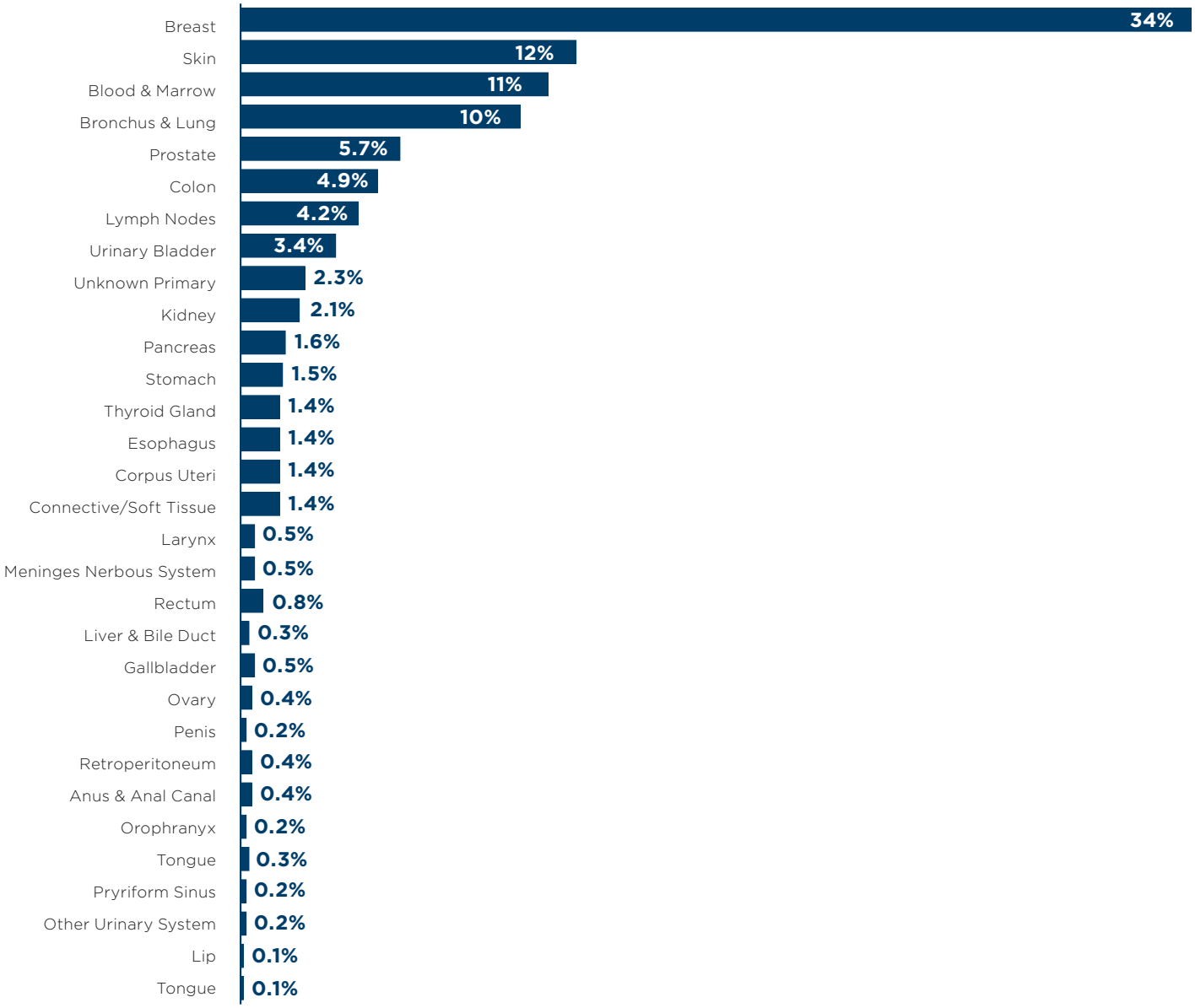
All approved Cancer Programs are required by the Commission on Cancer to submit registry data that is error free to the National Cancer Data Base (NCDB) annually. As a result of the data submission to the NCDB programs are able to benchmark their performances and outcomes to that of regional, state and national patterns. Major differences between the facility data and the national data are reviewed in an effort to identify the areas of improvement.

In addition, cancer data is submitted to the Ohio Cancer Incidence Surveillance System (OCISS). All reported data is used to support research, track trends, initiate epidemiologic studies, generate journal articles and provide data for allocation of services. The data is analyzed to identify opportunities for community cancer awareness and screening where higher stages (III – IV) of cancers are seen. This data also provides a means of identifying possible cancer clusters within the state.

2011 Cancer Data Summary and Comparisons

The total number of cases in The Jewish Hospital Cancer Registry database since the 2003 reference date is 9,679 cases, 8,272 of which are available for analytic studies. During 2011, a total of 1,016 cases were accessioned into the registry database; 915 analytic (newly diagnosed) cases and 101 non-analytic (recurrent cancer) cases. The statistics contained in this report represent only analytic cancer cases.

THE JEWISH HOSPITAL — MERCY HEALTH
PERCENTAGE OF NEWLY DIAGNOSED CASES IN 2012



Top Cancer Sites in 2011

The top sites in 2011 were Breast (34 percent), Skin (12 percent), Blood and Marrow (11 percent), and Lung (10 percent).

TOP CANCER SITES FOR 2011

Primary Site	US	OH	TJH
Breast	15%	14%	34%
Lung	14%	15%	10%
NHL	4%	4%	11%
Colorectal	9%	9%	5%
Melanoma	4%	4%	12%
Prostate	15%	15%	6%

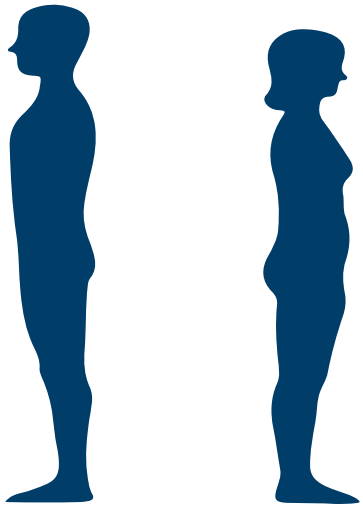
Estimated figures for US/Ohio

Compared with the estimated 2011 state and national data, our incidences of breast cancers are higher than the state and national averages. Potential explanations for the higher incidence include the availability at Jewish Hospital of ultrasound guided needle biopsies and stereotactic biopsies for breast cancer. Additional diagnostic studies provided by the hospital are digital and mobile mammography and breast MRI. Jewish Hospital provides sentinel lymph node biopsy for melanoma. Of special note is the FACT accreditation held by the Blood and Marrow Transplant Center.

Distribution of cases by gender reveals that breast cancer is the top site for females (50%) while melanoma of the skin was the top site in males (15%). The table demonstrates the percentage of cases seen at Jewish Hospital compared to the national average incidence for each cancer site.

2011 TOP CANCER SITES BY SEX
UNITED STATES VS THE JEWISH HOSPITAL — MERCY HEALTH (TJH)

Male		Female	
Prostate		Breast	
U.S. 28%	TJH 12%	U.S. 28%	TJH 50%
Lung & Bronchus		Lung & Bronchus	
U.S. 15%	TJH 13%	U.S. 14%	TJH 10%
Colon & Rectum		Colon & Rectum	
U.S. 9%	TJH 5%	U.S. 10%	TJH 5%
Urinary Bladder		Uterine Corpus	
U.S. 7%	TJH 7%	U.S. 6%	TJH 1%
Melanoma of the Skin		Thyroid	
U.S. 5%	TJH 15%	U.S. 5%	TJH 1%
Kidney & Renal Pelvis		Non-Hodgkin Lymphoma	
U.S. 4%	TJH 4%	U.S. 4%	TJH 4%
Oral Cavity & Pharynx		Melanoma of the Skin	
U.S. 3%	TJH 1%	U.S. 4%	TJH 7%
Leukemia		Kidney & Renal Pelvis	
U.S. 3%	TJH 9%	U.S. 3%	TJH 3%
Pancreas		Ovary	
U.S. 3%	TJH 5%	U.S. 3%	TJH 1%
		Pancreas	
		U.S. 3%	TJH 2%



American Cancer Society Inc., Surveillance and Health Policy Research, Facts and Figures, 2011
U.S. figures are estimated for 2010. Hospital figures are actual

Breast Cancer Outcome Study

Incidence and Mortality in the United States

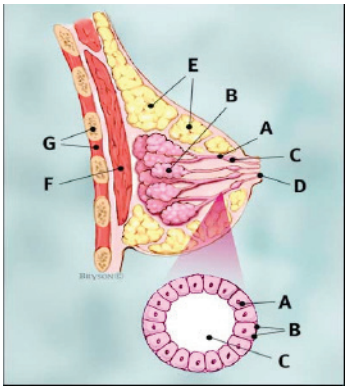
Incidence: The American Cancer Society (ACS) estimates 230,480 new cases of invasive breast cancer are expected to occur in women in the US during 2011, about 2,140 new cases are expected in men. Excluding cancers of the skin, breast cancer is the most frequently diagnosed cancer in women. The incidence rate for female breast cancer began to decline in 2000. The dramatic decrease of almost 7% from 2002 – 2003 has been attributed to reductions in the use of menopausal hormone therapy (HMT).

Mortality: An estimated 39,970 breast cancer deaths are expected in 2011. Breast cancer ranks second cause of cancer death in women (after lung cancer). Death rates for breast cancer have steadily decreased in women since 1990, with larger decreases in women younger than 50 (a decrease of 3.2% per year) than in those 50 and older (2.0% per year). The decrease in breast cancer death rates represents progress in earlier detection, improved treatment, and more recently, decreased incidence.

National, Ohio and Hospital Incidence Comparisons — Nationally, it is estimated that breast cancer will account for about 30% of the cancers diagnosed in 2011. In the state of Ohio, it is estimated that nearly 14% of the cancers will be breast cancer. At The Jewish Hospital, 34% of our diagnosed cases were breast cancer. Our breast cancer cases were about the same as the national average and about two and half times as the state average.

Anatomy and Physiology of the Breast: Breasts are composed of the following structures: mammary glands, connective tissue, blood vessels, nerves, and lymph vessels. Mammary glands contain the milk-producing cells. These glands are hormone dependent, and enlarge monthly with the menstrual cycle and during pregnancy.

Connective tissue of the breast includes fatty tissue and suspensory ligaments, which support the breast and give it shape. Sometimes a breast mass will pull on these ligaments, causing pitting of the skin of the breast — a sign that may indicate breast cancer. The breast has arteries and veins that allow circulation through the tissues, as well as nerves that provide information about touch and pain. The breast also contains lymph vessels, which drain into lymph nodes. About 75% of the breast lymph goes to the axillary nodes, which are located in the axilla (armpit area), and the rest goes to the parasternal nodes, which are located near the middle of the chest. Because breast cancer has a tendency to spread to local lymph nodes, examination of the lymph nodes in the armpit are a crucial component of the breast exam.



Breast profile:
A ducts
B lobules
C dilated section of duct to hold milk
D nipple
E fat
F pectoralis major muscle
G chest wall/rib cage

Breast Histologies: Most Breast cancers are Infiltrating Duct Carcinoma. At Jewish Hospital the incidence of Infiltrating Duct Carninoma is greater than other specified types.

BREAST CANCER HISTOLOGY DIAGNOSED 2003 – 2010

Breast Cancer Histology	U.S. %	TJH %
Infiltrating Duct Carcinoma	33%	83%
Infiltrating Duct & Lobular CA	11%	5%
Infiltrating Duct Mixed with Other Carcinoma	10%	0%
Other Specified Types	9%	3%
Lobular Carcinoma	8%	9%

National Cancer Data Base Statistics

Risk Factors for Americans: Increasing in age and being female are the most important risk factors for breast cancer. Several modifiable factors are associated with increased risk of breast cancer. Among these are obesity, use of combined estrogen and progestin hormone therapy, physical inactivity, and consumption of one or more alcoholic beverages per day. Medical findings that predict higher risk include high breast tissue density, high bone mineral density, and biopsy-confirmed hyperplasia. High dose radiation to the chest, typically related to cancer treatment, also increases risk. Reproductive factors that increase risk include a long menstrual history, recent use of oral contraceptives, never having children, and having one's first child after age 30.

Risk is also increased by a personal or family history of breast cancer and inherited genetic mutations in the breast cancer susceptibility genes BRCA1 and BRCA2. Although these mutations account for approximately 5 – 10% of all breast cancer cases, they are very rare in the general population (less than 1%). Some population groups, such as the Ashkenazi Jewish descent, have an increased prevalence of BRCA1 and BRCA2 mutation carriers. Women with a strong family history of breast and/or ovarian cancer should be offered counseling to determine if genetic testing is appropriate. Studies suggest that prophylactic removal of the ovaries and/or breasts in BRCA1 and BRCA2 mutation carriers decreases the risk of breast cancer considerably, although not all women who choose this surgery would have developed breast cancer.

Modifiable factors that are associated with the lower risk of breast cancer include breastfeeding, moderate and vigorous physical activity, and maintaining healthy body weight. Two medications, tamoxifen and raloxifene, have been approved to reduce breast cancer risk in women at high risk.

Research is ongoing to identify additional risk factors for breast cancer. The International Agency for Research on Cancer has concluded that there is limited evidence that tobacco smoking causes breast cancer. There is also some evidence that shift work, particularly at night, is associated with an increased risk of breast cancer.

Early Detection: Mammography can often detect breast cancer at an early stage, when treatment is more effective and a cure is more likely. Numerous studies have shown that early detection saves lives and increases treatment options. Steady declines in breast cancer mortality among women since 1990 have been attributed to a combination of early detection and improvements in treatment. Mammography is very accurate screening tool, both for women at average and increased risk; however, like most medical tests, it is not perfect. On average, mammography will detect about 80 – 90% of breast cancers in women without symptoms. All suspicious abnormalities should be biopsied for a definite diagnosis. Annual screening using MRI in addition to mammography is recommended for women at high lifetime risk of breast cancer starting at age 30. Concerted efforts should be made to improve access to health care and to encourage all women 40 and older to receive regular mammograms.

Signs and Symptoms: The earliest sign of breast cancer is often an abnormality detected on a mammogram, before it can be felt by the woman or a health care professional. Larger tumors may become evident as a painless mass. Less common symptoms include persistent changes to the breast, such as thickening, swelling, distortion, tenderness, skin irritation, redness, scaliness, or nipple abnormalities, such as ulceration, retraction, or spontaneous discharge. Typically, breast pain results from benign conditions and is not an early sign of breast cancer.

Age: Findings: age distribution compares favorably to what was seen nationally. The Jewish Hospital did diagnose more cancers in the age group of 40 – 49 and diagnosed less cancer in the 70 – 79 age group compared to national average.

2003 – 2010 BREAST — AGE AT DIAGNOSIS

Age Group	U.S. #	U.S. %	TJH #	TJH %
Under age 20	139	0.6%	0	0%
20 – 29	367	1.5%	10	4%
30 – 39	758	3.1%	15	6%
40 – 49	2,109	8.6%	33	13%
50 – 59	4,078	16.6%	49	19%
60 – 69	5,506	22.4%	60	23%
70 – 79	6,493	26.4%	53	20%
80 – 89	4,576	18.6%	36	14%
90+	591	2.4%	6	2%
Total	**24,617**	**100%**	**262**	**100%**

National statistics from NCDB

Stage

Findings: The distribution of the incidence of each stage of breast cancer closely mirrors that of the national average as seen in the table below.

2003 – 2010 BREAST — STAGE AT DIAGNOSIS

Stage Group	U.S. #	U.S. %	Hospital #	Hospital %
0	409,340	22%	901	19%
1	811,276	38%	1,637	40%
2	557,690	26%	1,187	29%
3	177,774	8%	306	7%
4	75,234	4%	68	2%
N/A	2,063	0%	2	0%
UNK	98,665	5%	4	0%
Total	**2,132,042**	**103%**	**4105**	**97%**

NCDB stats

Treatment of Breast Cancer

Surgery: Taking into account tumor size, extent of spread, and other characteristics, as well as patient preference, treatment usually involves lumpectomy or mastectomy. For women whose cancer has not spread to the skin, chest wall, or distant organs, numerous studies have shown that long term survival rates after lumpectomy plus radiation therapy are similar to survival rates after mastectomy. For women undergoing mastectomy, significant advances in reconstruction techniques provide several options for breast reconstruction, including the timing of the procedure (i.e., during mastectomy or in the time period following the procedure). Removal of some of the underarm lymph nodes during surgery is usually recommended to determine whether the tumor has spread beyond the breast. In women with early stage disease, sentinel lymph node biopsy is as effective as and less damaging than full axillary node dissection. For women with smaller tumors whose cancer has spread to only one of two nearby lymph nodes, the use of SLNB, in addition to treatment with whole-breast radiation and chemotherapy or hormone therapy, results in the same outcomes and fewer complications as axillary node dissection.

Treatment may also involve radiation therapy, chemotherapy (before or after surgery), hormone therapy (tamoxifen, aromatase inhibitor), or targeted therapy. Postmenopausal women with breast cancer that tests positive for hormone receptors benefit from treatment with an aromatase inhibitor, either after, or instead of, tamoxifen. For women whose cancer tests positive for HER2/neu, approved targeted therapies include Herceptin and, for advanced disease, Tykerb. After granting accelerated approval of Avastin for the treatment of metastatic breast cancer in 2008, the US Food and Drug Administration began the process of removing approval of the drug in early 2011 because subsequent studies have shown minimal benefit combined with some potentially dangerous side effects.

It is recommended that all patients with ductal carcinoma in situ (DCIS) be treated to avoid the potential development of invasive cancer. Treatment options for DCIS include lumpectomy with radiation therapy or mastectomy; either of these options may be followed by treatment with tamoxifen if the tumor is hormone receptor-positive. Removal of axillary lymph nodes is not generally needed.

Survival

The 5 year survival rate for female breast cancer patients has improved from 63% in the early 1960s to 90% today. The survival rate for women diagnosed with localized breast cancer is 98%. If the cancer has spread to nearby lymph nodes or distant lymph nodes, the 5-year survival is 84% or 23% respectively. Relative survival continues to decline after 5 years; for all stages combined, rates at 10 and 15 years after diagnosis are 82% and 75%, respectively. Caution should always be used when interpreting long term survival rates since they represent patients who were diagnosed and treated up to 22 years ago. Improvements in diagnosis and treatment may result in better outlook for more recently diagnosed patients.

Breast Cancer Survival by Stage

DIAGNOSED 2003

	Year				
Stage	**1**	**2**	**3**	**4**	**5**
1	100.0%	90.0%	90.0%	90.0%	70.0%
2	88.8%	83.3%	77.7%	66.6%	66.6%
3	66.6%	50.0%	50.0%	50.0%	50.0%
4	83.3%	66.0%	66.6%	58.3%	50.0%
Overall	**86.9%**	**76.0%**	**71.7%**	**65.2%**	**58.6%**

Comparison of The Jewish Hospital to National Survival

The most recent data on relative survival for breast cancer indicates that five year survival for breast cancer is 58.6% compared to national average of 58.1%.

Other Treatment Types

Palliative Treatment: Providing optimal palliative care for the patient with advanced breast cancer is a complex and challenging process. The best palliative care will likely come from a multidisciplinary team that individualizes the treatment plan in accordance with the patient's wishes, allowing symptoms to be maximally treated, lifespan to be optimized and hospital stay to be minimized.

Clinical Trials

Clinical trials for cancer treatment offer additional treatment options, including new drugs, new surgery or radiation therapy techniques, or even complementary or alternative medicines. Some trials study drugs that are approved for one type of cancer to determine the efficacy on a different type of cancer or to determine if effectiveness can enhanced by administering in a different way or in combination with other treatments. Clinical trials provide access to treatment that is not otherwise available, and might be safer or more effective than current treatment options. When clinical trials show that a new treatment is better than the current treatment, the new treatment may become a standard treatment. All clinical trials are reviewed and approved by scientific panels to make sure they are ethical, safe, and at least as good as, and possibly better than, the standard and currently available treatments.

According to the American Cancer Society, the number one reason people give for not taking part in a clinical trial is that they didn't know the studies were an option for them. Before starting treatment, patients may want to think about taking part in a clinical trial. Ideally, the patient, family, and health care team should be involved in the decision on choosing the most appropriate cancer treatment.

Treatment Comparison to National Cancer Database

BREAST-DIAGNOSED 2006 – 2010 TREATMENT BY STAGE COMPARISON: NATIONAL CANCER DATA BASE VS MERCY HOSPITAL — THE JEWISH HOSPITAL

Treatment Type	NCDB	TJH	NCDB	TJH	NCDB	TJH	NCDB	TJH	NCDB	TJH	NCDB	TJH
	Stage 1		Stage 2		Stage 3		Stage 4		Stage N/A		Stage Unknown	
Surgery Only	15%	13%	8%	0%	7%	1%	5%	0%	12%	0%	10%	0%
Surgery and Chemotherapy	6%	2%	8%	12%	10%	4%	7%	3%	7%	0%	7%	0%
Radiation and Chemotherapy	8%	7%	7%	14%	2%	0%	3%	2%	1%	0%	3%	0%
Chemotherapy Only	17%	22%	26%	14%	32%	27%	33%	23%	19%	0%	25%	0%
Surgery, Chemotherapy and Hormone	2%	9%	3%	10%	6%	5%	4%	8%	1%	0%	2%	0%
Chemotherapy and Hormone	4%	0%	11%	14%	13%	34%	13%	27%	4%	0%	5%	50%
Other Specified Therapy	29%	40%	23%	33%	14%	23%	16%	35%	8%	0%	16%	0%
No 1st Course Rx	20%	7%	14%	2%	16%	5%	19%	1%	47%	0%	33%	50%
% of Cases for Stage Group	18%	17%	15%	16%	20%	30%	30%	36%	1%	0%	17%	1%

Source: ©2011 National Cancer Data Base (NCDB) / Commission on Cancer (CoC)

Findings:

Percentage of cases for each stage is comparative between nationally and our organization.

Stage 1: We treated more stage 1 patients with surgery, chemotherapy, and hormones (9%) compared to the national average (2%).

Stage 2: More of our patients received radiation and chemotherapy (14%) in comparative to the national average (7%).

Stage 3: We treated more stage 3 patients with chemotherapy and hormones (34%) compared with the national average (13%). We also had significantly more patients treated with "Other specified therapy" (23% compared to 14% nationally).

Stage 4: We have more patients who received chemotherapy and hormones (27% compared to 13% nationally).

For both stage 3 and stage 4, we have more patients who received adjuvant chemotherapy. For stage 3, this may be related to our efforts to obtain information on treatment done elsewhere. Our performance in the Commission on Cancer, American College of Surgeons CP3R colon study indicates we have an average 2006 – 2007 concordance of 100% for adjuvant chemotherapy. Other Community Hospital Cancer Programs have an average of 86% and the state of Ohio has an average of 92% concordance for these years.

Summary of Findings:

- Breast cancer is the highest cancer diagnosed at The Jewish Hospital. Breast cancer incidence has decreased over the last two decades because of the increase in screening that allow for early detection.
- Most of the breast cancers presented with stage 2 disease.
- Our treatment of breast cancer follows the national standards.
- Our overall survival is slightly higher than the national survival statistics.

Recommendations:

- Promote breast cancer awareness through patient education and community outreach activities.
- Provide and monitor stage-based treatment in accordance with national guidelines.

Community Outreach

The Jewish Hospital and Cancer Program, led by our Surgical Oncology Specialty Quality Committee, are committed to making a difference in our community. We do this through several means, including increasing breast cancer awareness through participation in local Health Fairs, conducting Breast Cancer Awareness Month activities, increasing awareness of clinical trials and participation in or referral to American Cancer Society programs.

American Cancer Society Programs and Screening Guidelines

For information on American Cancer Society Programs and Screening Guidelines:

- Visit http://www.cancer.org or call 1-800-ACS-2345 (1-800-227-2345)

Informational websites

For information on breast and other cancers, call or visit:

- National Cancer Institute at 1-800-4-CANCER or www.cancer.gov
- People Living With Cancer: The official patient information website of the American Society of Clinical Oncology at www.cancer.net/portal/site/patient
- National Comprehensive Cancer Network at www.nccn.org/patients
- American Cancer Society - 1-800-ACS-2345 or www.cancer.org
- National Library of Medicine at www.nlm.nih.gov/medlineplus/healthtopics.html
- US TOO! International, Inc at www.ustoo.org)

Clinical Trial Information

For information on access to clinical trials in your area:

- Call the American Cancer Society, Clinical Trials Matching Service (a free, confidential program) at 1-800-303-5691 or visit www.cancer.org
- Visit the National Cancer Institute (NCI) website at: www.cancer.gov/clinicaltrials/search
- Visit the Coalition of Cancer Cooperative Groups at: www.cancertrialshelp.org

References/Sources:

American College of Surgeons

American Cancer Society

National Cancer Institute

Electronic Registry System

The Jewish Hospital

MERCYHEALTH

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