

**Parma  
Community  
General Hospital**  
Cancer Center

An affiliate of



Cancer Center Annual Report 2010

UTILIZING 2009 DATA

## PARMA COMMUNITY GENERAL HOSPITAL CANCER COMMITTEE 2010

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Cynthia Zahn, CTR TUMOR REGISTRY

## CHAIRMAN'S REPORT

SUZAN CHENG, MD  
CHAIRMAN, CANCER COMMITTEE

In 2009, the Cancer Center received accreditation for a full three years with commendation from the Commission on Cancer. Among our Areas of Excellence are: Patient Outcome Analysis; Accuracy in Completion of AJCC Staging; Utilization of Established Patient Treatment Guidelines; Cancer Related Quality Improvements; and Adherence to College of American Pathology Practice Guidelines. Another achievement was continued compliance with clinical trials enrollment by the minimum 2 % of analytic cases in clinical trials. Cancer Registry quality review benchmarks for chart abstract reviews within 6 months as well as five-year follow-up rates were met. Timely submission of registry data to the National Cancer Data Bank and State agencies continue.

As a Commission on Cancer Accredited Cancer Center, preparation was made for the 2010 New Standards Changes for the Commission on Cancer, which includes implementation of the 7th edition of the AJCC TNM Staging System, and the Facility Oncology Registry Data Standards (FORDS) revision. Our registrars actively trained and educated the Parma Medical Staff on their role in the revised Collaborative Stage Data Collection System (CSv2), which increases the volume and complexity of site-specific data being collected and submitted, in addition to the TNM Stage.

The Oncology Program Assistant, Patricia Jurecko, continues to prepare for the Certified Tumor Registrar (CTR) examination in 2011, and is the Cancer Program Activity Coordinator for the Cancer Conferences and Cancer Committee. In 2009, the registry operations were maintained through the oversight of a contracted CTR from Precyse Solutions.

The Cancer Committee is comprised of representatives from the medical staff, inpatient and outpatient nursing, social work, nutrition, education, quality, and hospice at its every other month meetings. Reports are given on cancer screenings, community outreach, quality, and clinical participation in cancer conferences, with concrete action plans developed to keep The Center meeting the highest standards of the Commission on Cancer. Incoming patients to the Center are tracked for complete, comprehensive, and timely initial evaluation and adherence to accepted guidelines for cancer care.

Breast, Lung and Tumor cancer conferences are attended by all the disciplines involved in diagnosis and treatment of new cancer cases, including radiology, pathology, general surgery, thoracic surgery, gastroenterology, pulmonary medicine, internal medicine/family practice, radiation oncology, medical oncology, nursing, social work, and patient education, as well as the cancer registry staff.

Parma Hospital completed screenings out in the community for skin/melanoma, colon, and prostate cancers.

SITE	NUMBER SCREENED	NORMAL	ABNORMAL	UNKNOWN
SKIN/MELANOMA	65	44	9	12
COLORECTAL	33	33	0	0

The Breast Cancer Support Group continues to bring a wide variety of health topics for discussion among patients at all stages of treatment, using guest speakers to enhance the knowledge base that promotes health-maintaining behaviors for all who participate. Among the topics covered this year were: Introduction to Yoga, The Benefits of Vitamin D, Sharing Healthy Snacks, Genetic Counseling, Stretching and Strengthening Exercises, Guided Imagery, and Your Emotions.

Seasons of Life Hospice has identified increasing staff needs for the current average daily census of 60 patients. The average length of stay of 57.5 days is near the national average but still very well below the 6 months prognosis qualifying patients for the Hospice Medicare Benefit. Our Hospice continues to reach out to all the nursing homes in the near communities supplementing the end-of-life care needs of the disabled and elderly, while providing service to all of Cuyahoga County. The 10-bed Hospice Residential Facility continues to offer respite and dedicated palliative care to terminally ill patients and their families.

## RADIATION ONCOLOGY

SUZAN CHENG, MD

DIRECTOR, RADIATION ONCOLOGY

The year 2009 saw a drop in total consults from 242 to 210, a 12.3 % decrease. Of these 210 cases, 17 cases were cancers of the lung, 59 cancers of the breast and 6 were cancers of the prostate. Seven rectal cases and 2 esophageal cases were also treated. A total of 12,682 fields were treated with 174 patient's actually starting treatment. Seventeen (17) of these cases used intensity-modulated radiation therapy (IMRT), which shapes the prescribed radiation dose to the targeted tissues as outlined on CT Scans.

Our operating and treatment planning computer systems continue to be updated, with Mosaic 8.0 allowing us to input all clinical documents and images into the electronic record. This then provides documentation for patient care, communication within the department, and billing. The attending physician can verify proper treatment localizations from not just conventional portal images and films but the newest image-guided modality, cone beam CT. This form of visualization is used daily when IMRT to the prostate or other sites is given, allowing the patient to be placed within millimeters of the ideal location on the machine prior to each treatment. This has allowed precise daily placement of treatment in the brain, head and neck, abdominal, prostate and even extremity sites. The benefit of this has been decreased toxicity to the surrounding normal tissues and therefore a smoother and less symptomatic treatment course for each patient.

As always, radiation oncology strives to contribute positively to the overall care and treatment of each patient at the Cancer Center. Our nurses work both in medical oncology and radiation oncology, giving them the ability to answer questions, and guide our patients in a uniquely sensitive way through the many potential issues that result from receiving both chemotherapy and radiation therapy. When asked about ease of access to treatment and their overall medical care, 90% of our patients report high satisfaction scores on their post treatment surveys each quarter. We continue to promote the achievement of quality measures throughout the hospital that assure accreditation as a Comprehensive Cancer Center.

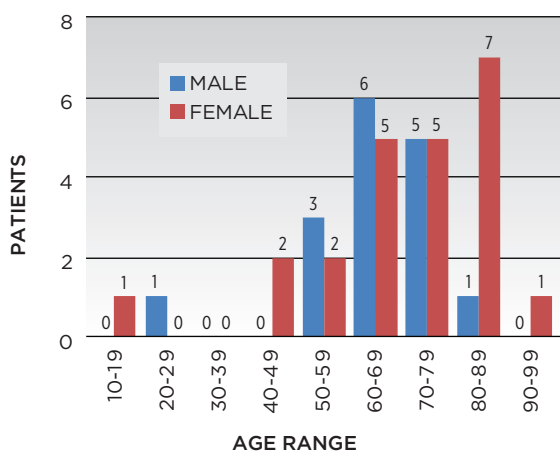
## NON-HODGKIN LYMPHOMA (NHL)

NADIA KAISI, MD  
DEPARTMENT OF PATHOLOGY

Based on rates from 2005-2007, 2.10% of men and women born today will be diagnosed with NHL at some time during their life. It is estimated that 65,540 men and women (35,380 men and 30,160 women) will be diagnosed with NHL and 20,210 men and women will die of NHL every year. (Statistics are based on NCI's SEER Cancer Statistics Review)

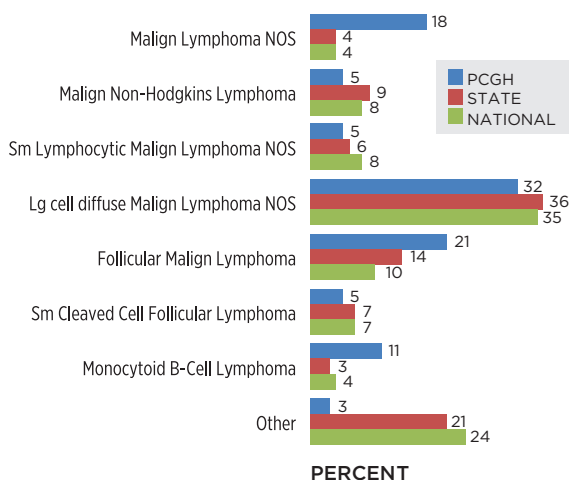
The age at diagnosis of NHL patient's at Parma Community General Hospital (PCGH) is older than that for Ohio and National (peak incidence at 80-89 years of age at PCGH compared to 70-79 years for Ohio and nationwide). 87% of patients were older than 60 years.

GRAPH 1. **AGE BY GENDER - LYMPHOMA PCGH 2009**



There are many different histologic types of non-Hodgkin lymphoma. They can be either B-cell or T-cell lymphomas. B-cell NHL include Burkitt lymphoma, chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL), diffuse large B-cell lymphoma, follicular lymphoma, immunoblastic large cell lymphoma, precursor B-lymphoblastic lymphoma, and mantle cell lymphoma. T-cell NHL includes mycosis fungoides, anaplastic large cell lymphoma, and precursor T-lymphoblastic lymphoma. Lymphomas that occur after bone marrow or stem cell transplantation are usually B-cell non-Hodgkin lymphomas. At PCGH, the most common histologic subtype was diffuse large cell lymphoma (32%) followed by follicular lymphoma (21%), a finding that parallels the Ohio and national trend.

GRAPH 2. **NHL-NODAL HISTOLOGY COMPREHENSIVE 2006**



Statistics taken from NCDB benchmarks 2008

Treatment of NHL depends on the stage and type of disease.

**Stage I:** Involvement of a single lymphatic site (i.e., nodal region, Waldeyer's ring, thymus, or spleen) (I); or localized involvement of a single extralymphatic organ or site in the absence of any lymph node involvement (IE) (rare in Hodgkin lymphoma).

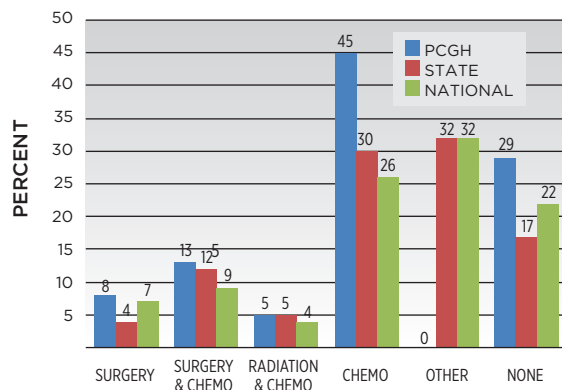
**Stage II:** Involvement of two or more lymph node regions on the same side of the diaphragm (II); or localized involvement of a single extralymphatic organ or site in association with regional lymph node involvement with or without involvement of other lymph node regions on the same side of the diaphragm (IIE). The number of regions involved may be indicated by a subscript, as in, for example, II<sup>2</sup>.

**Stage III:** Involvement of lymph node regions on both side of the diaphragm (III), which also maybe accompanied by extra lymphatic extension in association with adjacent lymph node involvement (IIIE) or by involvement of the spleen (IIIS) or both (IIIE,S). Splenic involvement is designated by the letter S.

**Stage IV:** Diffuse disseminated involvement of one or more extralymphatic organs, with or without associated lymph node involvement; or isolated extralymphatic organ involvement in the absence of adjacent regional lymph node involvement, but in conjunction with disease in distant site(s). Stage IV includes any involvement of the liver or bone marrow, lungs (other than by direct extension from another site), or cerebrospinal fluid.

Forty-five percent (45%) of PCGH patients received chemotherapy alone compared to 30% in Ohio and 26% nationally. Comparative use of surgery and radiation at PCGH/Ohio/National was 13%, 12%, and 9%, respectively, and radiation with chemotherapy was 5%, 5%, and 4% respectively.

**GRAPH 3. NHL-NODAL FIRST COURSE OF TREATMENT COMPREHENSIVE 2007**



Statistics taken from NCDB benchmarks 2008

Radiation techniques for NHL differ somewhat from those used in the treatment of Hodgkin lymphoma. The dose of radiation therapy usually varies from 25 Gy to 50 Gy and is dependent on factors that include the histologic type of lymphoma, the patient's stage and overall condition, the goal of treatment (curative or palliative), the proximity of sensitive surrounding organs, and whether the patient is being treated with radiation therapy alone or in combination with chemotherapy. Given the patterns of disease presentation and relapse, treatment may need to include unusual sites such as Waldeyer ring, epitrochlear, or mesenteric nodes. The associated morbidity of the treatment must be considered carefully. The majority of patients who receive radiation are usually treated on only one side of the diaphragm. Localized presentations of extranodal NHL may be treated with involved-field techniques with significant (>50%) success.

In asymptomatic patients with indolent forms of advanced NHL, treatment may be deferred until the patient becomes symptomatic as the disease progresses. When treatment is deferred, the clinical course of patients with indolent NHL varies; frequent and careful observation is required so that effective treatment can be initiated when the clinical course of the disease accelerates. Some patients have a pro-

longed indolent course, but others have disease that rapidly evolves into more aggressive types of NHL that require immediate treatment.

Prognostically, NHL can be divided into two groups: the indolent lymphomas and the aggressive lymphomas. Indolent NHL types have a relatively good prognosis with a median survival as long as 10 years, but they usually are not curable in advanced clinical stages. Early stage (stage I and stage II) indolent NHL can be effectively treated with radiation therapy alone. Most of the indolent types are nodular (or follicular) in morphology. The aggressive type of NHL has a shorter natural history, but a significant number of these patients can be cured with intensive combination chemotherapy regimens. The vast majority of relapses occur in the first 2 years after therapy. The risk of late relapse is higher in patients with a divergent histology of both indolent and aggressive disease.

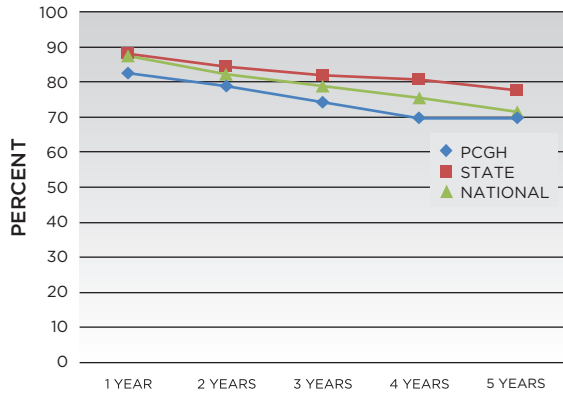
While indolent NHL is responsive to radiation therapy and chemotherapy, a continuous rate of relapse is usually seen in advanced stages. Patients, however, can often be retreated with considerable success as long as the disease histology remains low grade. Patients who present with or convert to aggressive forms of NHL may have sustained complete remissions with combination chemotherapy regimens or aggressive consolidation with marrow or stem cell support.

Another treatment option for B-cell NHL expressing CD20 receptor is Rituximab. Rituximab is a man-made antibody that was developed using cloning and recombinant DNA technology from human and murine (mice or rat) genes and was approved by the FDA in 1997. It is believed to attach to the CD20 receptor and cause the tumor cells to disintegrate. It may also prevent the production of more tumor cells.

The five year survival for Stage I - NHL patients at PCGH of 69.5% is slightly below the Ohio and National statistics at 77.7% and 71.6%, respectively. Similarly, the five-year survival percentages for PCGH/Ohio/National are for Stage II, 57.7%, 59.9%, and 64.4%, respectively; for Stage III 39.8% 56.8%, and 57.7% respectively; Stage IV 37.3%, 45.3%, and 47.3%, respectively.

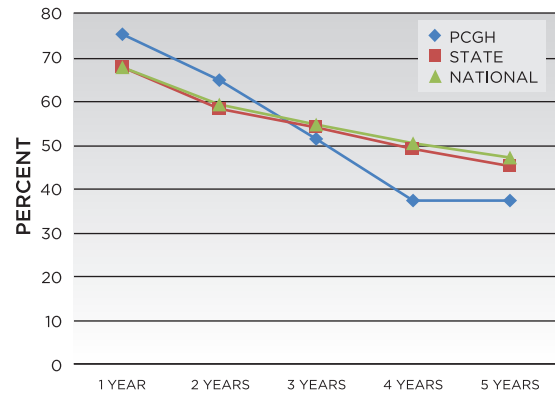
This poorer prognosis may reflect the advanced age at diagnosis and less aggressive treatment (chemotherapy, bone marrow transplant) over the course of disease.

GRAPH 4. NHL STAGE 1 SURVIVAL 2004-2008



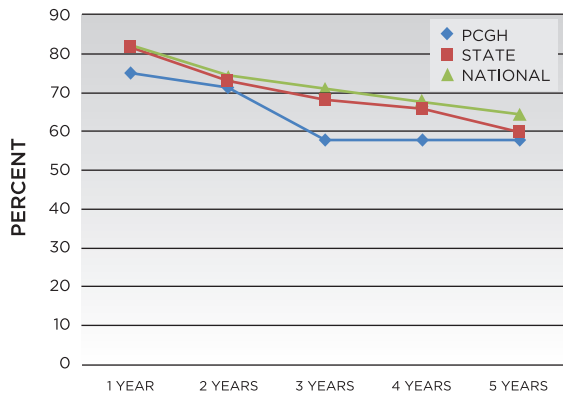
Statistics taken from NCDB benchmarks 2008

GRAPH 7. NHL STAGE 4 SURVIVAL 2004-2008



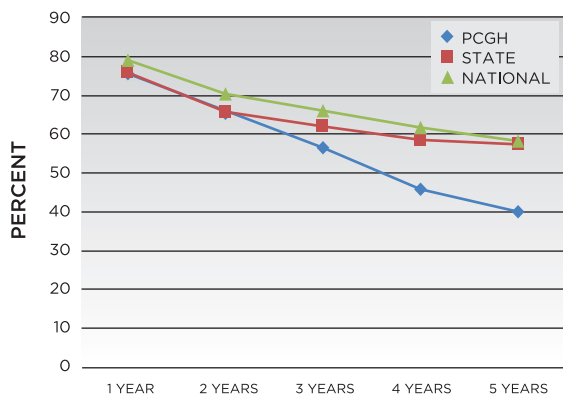
Statistics taken from NCDB benchmarks 2008

GRAPH 5. NHL STAGE 2 SURVIVAL 2004-2008



Statistics taken from NCDB benchmarks 2008

GRAPH 6. NHL STAGE 3 SURVIVAL 2004-2008



Statistics taken from NCDB benchmarks 2008

## CANCER REGISTRY

CYNTHIA ZAHN, CTR

The Cancer Registry at Parma Community General Hospital is under the management and direction of Oncology Administration and the Cancer Committee. With a reference date of January 1, 1981, the registry has a total of 17,998 cases in its database.

In 2009, 685 new cases were added. Of this total, 620 (91%) were analytic cases with initial diagnosis and/or first course of treatment at Parma Community General Hospital. Another 65 (9%) were non-analytic cases of recurrent or persistent disease. These were initially diagnosed and treated elsewhere or prior to our reference date.

The Cancer Registry database contains demographic and clinical information from diagnosis through treatment as well as annual lifetime follow-up data. The follow-up process, in addition to providing critical information about disease status and treatment outcomes, also performs a valuable service for physicians and patients by reminding them that regular reassessment of the disease is vital for early detection of recurrences or subsequent primaries. The Parma

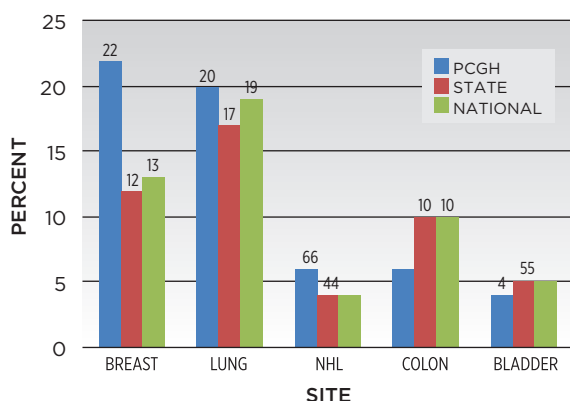
Community General Hospital Cancer Registry is actively following 4589 patients. Our current overall follow-up rate is 95.64% with a five-year follow up rate of 92.59%.

## SITE

Breast cancer (22%) was the leading cancer diagnosed at Parma Community General Hospital in 2009. This was followed by lung (20%), non-Hodgkin lymphoma (6%), colon (6%) and bladder cancer (4%). The top five sites make up 58%

of the total analytic cases that were diagnosed in 2009. Table 1 shows the percentages for analytic cases of the top five sites diagnosed at Para Community General Hospital in 2009 with totals for male and female. Graph 8 shows a comparison of analytic cases for our top five sites with state and national estimates for 2009. Ohio and national data were taken from The American Cancer Society's Facts and Figures 2009.

GRAPH 8. **TOP 5 SITES - 2009**



#### AGE/GENDER

In 2009, 62% of Parma's cancer patients were women and 38% were men. Cancer diagnosis occurred most frequently in men and women in the 70-79 age groups. Graph 9 illustrates the age at diagnosis by gender.

Through the Cancer Registry, recorded information for each malignancy is maintained and is inclusive but not limited to patient demographics, primary site, histology, stage of disease, treatment, recurrence, and follow-up data. This data provides physicians and administration with statistics for research, education, and planning. Confidentiality of patient identification and related medical data are strictly maintained.

GRAPH 9. **AGE BY GENDER - 2009**

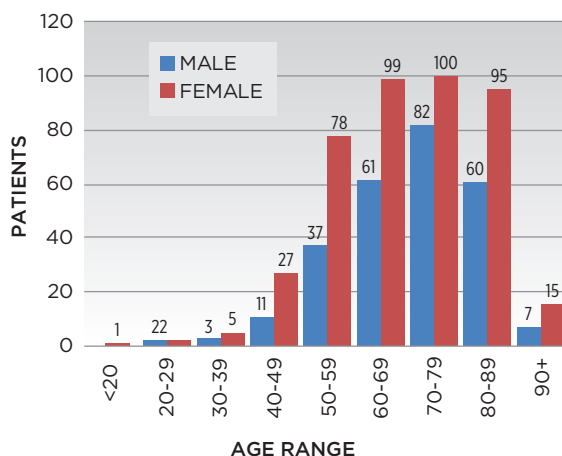


TABLE 1. **SITE DISTRIBUTION**

Analytic Cases Accessioned - PCGH 2009

SITE NAME	CASES	M	F
Breast	136	-	136
Lung/Bronchus	126	63	63
Non-Hodgkin Lymphoma (NHL)	40	16	24
Colon	38	13	25
Bladder	27	19	8
Corpus Uteri	24	-	24
Pancreas	23	10	13
Rectum	19	12	7
Unknown	18	8	10
Leukemia	17	9	8
Prostate	17	17	-
Thyroid	17	4	13
Kidney/Renal	16	9	7
Melanoma	14	8	6
Ovary	12	-	12
Stomach	8	4	4
Multiple Myeloma	7	3	4
Other digestive system	6	1	5
Esophagus	6	6	-
Larynx	6	4	2
Liver	5	3	2
Hodgkin Disease	4	1	3
Vulva	4	-	4
Connect/Soft Tissue	4	3	1
Brain (malignant)	3	2	1
Other Blood/ Bone Marrow	3	2	1
Other Skin	3	1	2
Anus/Anal Canal	2	1	1
Bone	2	2	-
Other/III-defined	2	-	2
Other oral cavity	2	-	2
Other Respiratory	2	1	1
Tongue	2	2	-
Brain (benign)	1	-	1
Cervix Uteri	1	-	1
Nasal/Sinus	1	-	1
Oropharynx	1	-	1
Other Brain/CNS	1	-	1
Testis	1	1	-

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