

2014 Annual Report

Containing 2013 Cancer Registry Statistics



St. Anthony's Hospital



Cancer Committee – Cancer Liaison’s Report

Robert Miller, MD

Cancer Liaison Physician, St. Anthony’s Cancer Committee



St. Anthony’s Hospital Cancer Committee is proud to present the 2014 Annual Report, reflecting the collected cancer data from 2013. The Cancer Committee monitors and guides the cancer program to ensure our patients have access to state-of-the-art care in screening, diagnosis and the management of cancer consistent with standards of care using national standards,

e.g. the National Comprehensive Cancer Network (NCCN) Guidelines, and also comparing the clinical experience at St. Anthony’s with state and national data, e.g. the NCDB database.

The cancer program was successfully surveyed by the American College of Surgeons, Commission on Cancer, and re-accredited for the next three years as a comprehensive cancer program with four well deserved commendations. St. Anthony’s will be surveyed again in 2017. Other goals and accomplishments for the year included implementing the Carefusion Texium Chemo Safety Closed System, expanding the electronic medical record access to include physician offices for data retrieval, and implementing planning on survivorship and psychosocial screening.

On reviewing the data, there has been growth in the number of analytic cancer cases diagnosed and cared for within St. Anthony’s Hospital (SAH). There is a disproportionate number of breast cancers in the database, reflecting the success and impact of the Susan Sheppard McGillicuddy Breast Center as well as the radiation center at St. Anthony’s, since St. Anthony’s has the only inpatient radiation center in southern Pinellas County. Otherwise the stage and distribution of cancer is similar to expected national data.

With recent improvements in endoscopic ultrasonography, diagnostic imaging and surgical technique, a team of doctors have developed a comprehensive approach to the diagnosis and treatment of pancreatic and biliary cancers. We reviewed our previous experience with pancreatic cancer and the results of this study are included in this report. Most patients still present with very advanced disease and the long-term survival rates are quite poor, but we are starting to see a shift in early diagnosis and hope to see this reflected in improving outcomes for our patients as this program continues to develop and newer therapeutic options become available.

The Cancer Committee will continue its commitment to patient monitoring and quality improvement activities and will strive to expand the care available to cancer patients in our community.



Quality Assessment And Improvements

Timothy McMahon

Director, Cancer Care Program for St. Anthony's Hospital

BayCare as an organization consistently seeks opportunities for improving clinical outcomes and the patient experience through a focus on process improvement. This approach is embraced throughout the St. Anthony's Hospital cancer program. In 2014, the physicians and other members of the St. Anthony's Hospital Cancer Committee (SAHCC) identified several process improvement opportunities focused on the service, outcome and cost needs of our customers. Additionally in 2014, BayCare continued to identify the patient-centered experience and providing one standard of care as key initiatives that will guide the SAHCC in the future.

In 2014, the SAHCC focused on patient safety with support of the hospital pharmacy's implementation of the CareFusion Texium Chemotherapy Safety Closed System. This system allows the pharmacy team to compound chemotherapy medications in a fully primed ("closed") tubing system that is compatible with the Alaris infusion pumps used in the hospital environment. The closed system dramatically reduces the risk of chemotherapy exposure for team members and patients. This system was fully implemented on September 18, 2014.

Another clinical improvement implemented in 2014 was the BayCare Medical Group physicians' migration to the Cerner Physician Office Record as their office-based EMR. These changes offered several significant advantages for oncology patients managed by those physicians, as the

inpatient hospital EMR and the physician office record became fully integrated so the patient's entire clinical "picture" was available for the physician during each encounter. Pertinent laboratory, radiology and pathology results were readily available, reducing clinical care delays that existed in the past. The rollout of the Cerner Physician Office Record was completed in mid-August 2014.

To meet some of the new Commission on Cancer Standards, the SAHCC also began considering the process for assessing patient's emotional distress and providing survivorship documentation for cancer patients receiving definitive treatment within one of the hospital's facilities. The SAHCC received information from the other BayCare cancer programs regarding their approach for meeting these standards. The decision was to pilot an emotional distress thermometer, modeled after the NCCN emotional distress tool. Additionally, the cancer program administrative team finalized a brochure that provided community services information to support the cancer patient's needs. The SAHCC also authorized the use of the Journey Forward cancer survivorship tool.

The SAHCC monitors indicators and improvements during Cancer Committee meetings. All St. Anthony's Hospital improvement activities are ultimately reported to the system president as well as the Board of Trustees through the Quality Leadership Task Force.

2013 Statistical Summary

Incidence: In 2013, there were 1,087 new cancer cases and 290 cases with recurrent or metastatic cancer (non-analytic). Figure 1 depicts the annual new accessions (patients) in St. Anthony's from 2005 through 2013.

Class of Case: Only analytic cases are reported to the Commission on Cancer. Class 00, although not followed for survival data, are reportable to the CoC as analytic cases and consist of patients diagnosed at St. Anthony's Hospital; the registry has documentation of where they have gone for further treatment. In 2013, we had 266 or 24 percent of class 00 cases. Class 10-14 are cases that have been diagnosed and/or treated at St. Anthony's Hospital or the decision of no further cancer treatment was made at our facility. For 2013, there were 565 or 52 percent of cases in the class 10-14 category. Class 20-22 are cases that have been diagnosed elsewhere and come to SAH for treatment, or St. Anthony's was involved in the diagnosing process and/or the decision was made for treatment with palliative comfort-measures only. In the 20-22 class of cases for 2013, there were 256 or 24 percent of the total cases (see figure 2).

Top Five Primary Cancer Sites 2013

The top five most frequent occurring cancers during 2013:

- St. Anthony's Hospital: Breast 288 (27%), lung 174 (16%), prostate 43 (4%), colorectal 76 (7%), and lymphatics 45 (4%)
- The American Cancer Society gives the following percentages: Breast 14%, lung 14%, prostate 14%, colorectal 9% and lymphatics 4% (see figure 4).

St Anthony's Hospital provides cancer diagnosing and treatment services through the Susan Sheppard McGillicuddy Breast Center and radiation therapy through the SAH Cancer Center, and because of this we report a greater volume of breast and lung cancers.

Comparison of Selected Cancer Sites 2013

See figure 3 for the comparison percentages.

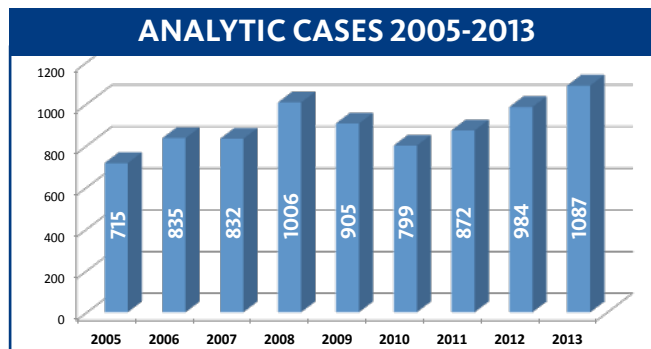


Figure 1

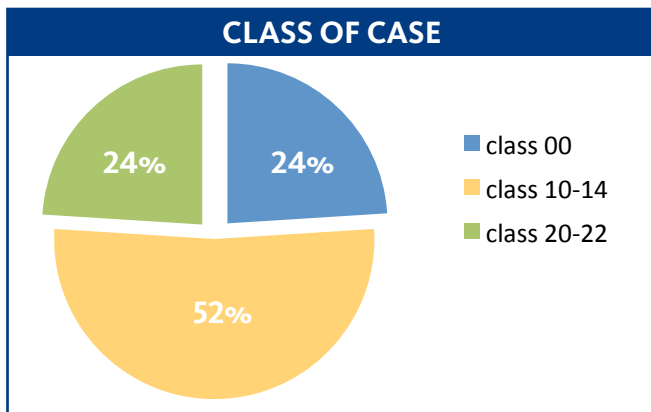


Figure 2

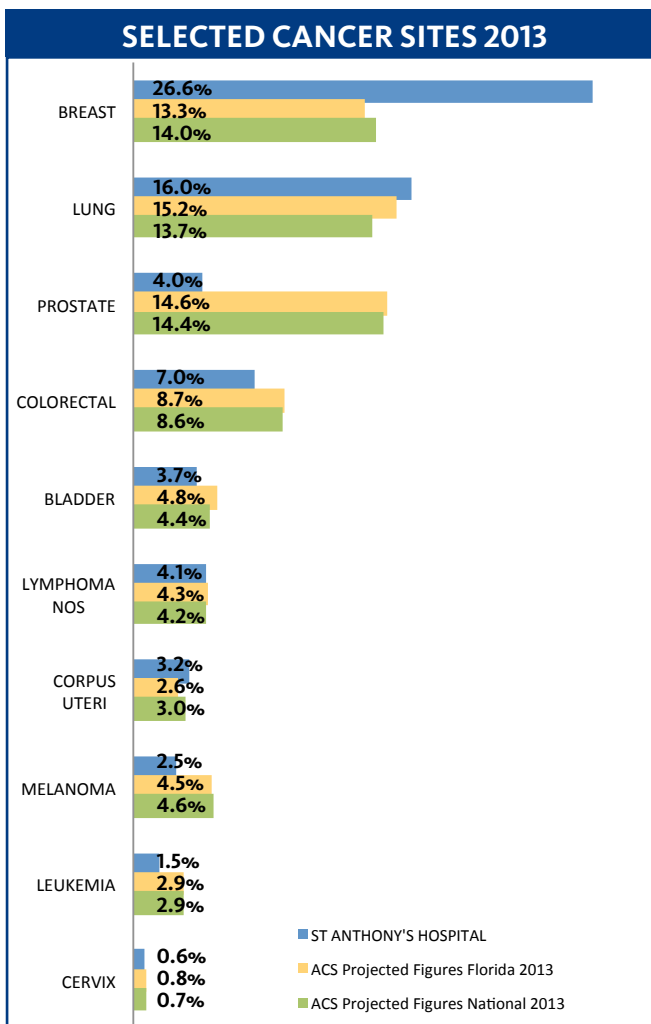


Figure 3

St. Anthony's Hospital - All Sites 2013 Analytic Cases

| Primary Site | Total Analytic Cases | Male - Analytic | Female - Analytic |
|---------------------------------------|----------------------|-----------------|-------------------|
| All sites | 1,087 | 424 | 662 |
| Head and neck | 31 | 24 | 7 |
| Tongue base and other | 10 | 6 | 4 |
| Floor and other mouth | 2 | 2 | 0 |
| Parotid gland | 1 | 1 | 0 |
| Tonsil | 10 | 8 | 2 |
| Oropharynx | 2 | 2 | 0 |
| Oral cavity/other | 4 | 4 | 0 |
| Pyriiform sinus | 2 | 1 | 1 |
| Digestive system | 199 | 105 | 94 |
| Esophagus | 8 | 7 | 1 |
| Stomach | 8 | 7 | 1 |
| Colon | 76 | 35 | 41 |
| Small intestine | 4 | 0 | 4 |
| Rectum | 17 | 6 | 11 |
| Anus/anal canal | 10 | 5 | 5 |
| Liver and bile ducts | 19 | 14 | 5 |
| Pancreas | 36 | 18 | 18 |
| Gallbladder/other biliary | 15 | 7 | 8 |
| Other digestive organs | 6 | 6 | 0 |
| Respiratory system | 201 | 102 | 99 |
| Nasal cavity/acc sinus/mid ear | 12 | 7 | 5 |
| Larynx | 13 | 10 | 3 |
| Lung/bronchus | 174 | 83 | 91 |
| Heart/mediastinum/pleura | 2 | 2 | 0 |
| Blood and bone marrow and bone | 31 | 17 | 14 |
| Connect/soft tissue | 9 | 1 | 8 |
| Melanoma and other skin | 27 | 16 | 11 |
| Breast | 288 | 2 | 286 |
| Female genital | 59 | 0 | 59 |
| Cervix uteri | 7 | 0 | 7 |
| Corpus utero | 35 | 0 | 35 |
| Ovary | 14 | 0 | 14 |
| Vulva and other | 3 | 0 | 3 |
| Male genital | 46 | 46 | 0 |
| Prostate | 43 | 43 | 0 |
| Testes | 3 | 3 | 0 |
| Urinary system | 73 | 52 | 21 |
| Bladder | 40 | 30 | 10 |
| Kidney/renal pelvis | 31 | 20 | 11 |
| Ureter | 2 | 2 | 0 |
| Brain and CNS | 24 | 8 | 16 |
| Brain (benign) | 12 | 4 | 8 |
| Brain (malignant) | 12 | 4 | 8 |
| Endocrine | 33 | 14 | 19 |
| Thyroid | 21 | 6 | 15 |
| Adrenal | 2 | 1 | 1 |
| Other | 10 | 7 | 3 |
| Lymphatics | 45 | 26 | 19 |
| Non-Hodgkin lymphoma | 3 | 3 | 0 |
| Lymphoma nos | 42 | 23 | 19 |
| Unknown primary/ill-defined | 21 | 11 | 9 |



Demographics: Data from American Cancer Society Facts and Figures for 2013 estimated that there will be over 1,660,290 new cancer cases reported in the U.S., with 118,320 new cases from Florida alone. At SAH, the data on distribution of cancer by gender was 424 for males or 39 percent, and for females 662 or 61 percent. When compared to the American Cancer Society percentages, St. Anthony's has a greater percentage of female than male, but this is expected given the fact that a greater percentage (27 percent) of our cases are breast cases, with the Susan McGillicuddy Breast Center attracting a larger female population (see figure 4).

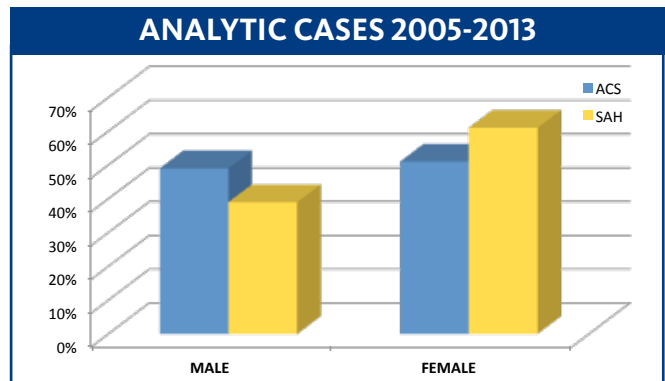


Figure 4

Age at diagnosis: According to the American Cancer Society Facts and Figures for 2013, the median age for developing cancer is age 67, and the probability by gender of developing cancer of any site is one in every two males and one in every three females. At St. Anthony's Hospital, the predominant age at diagnosis for both male and female also fell into the 60-69 age group, with 168 females (15 percent) and 127 males (12 percent) of the 2013 caseload (see figure 5).

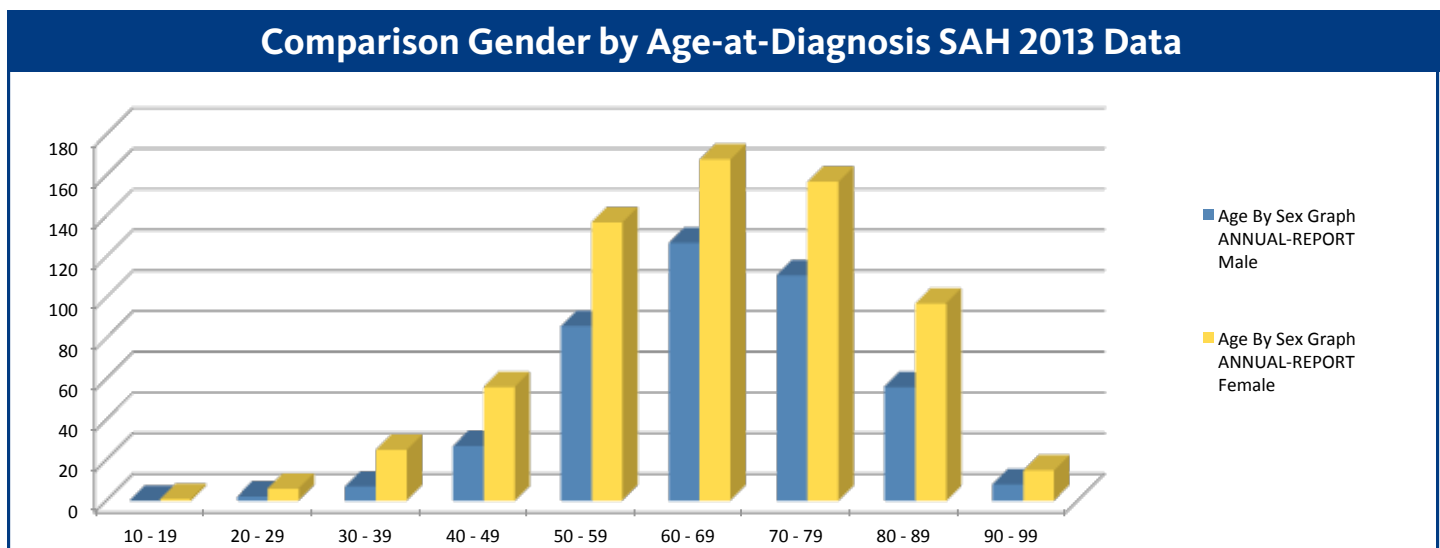


Figure 5



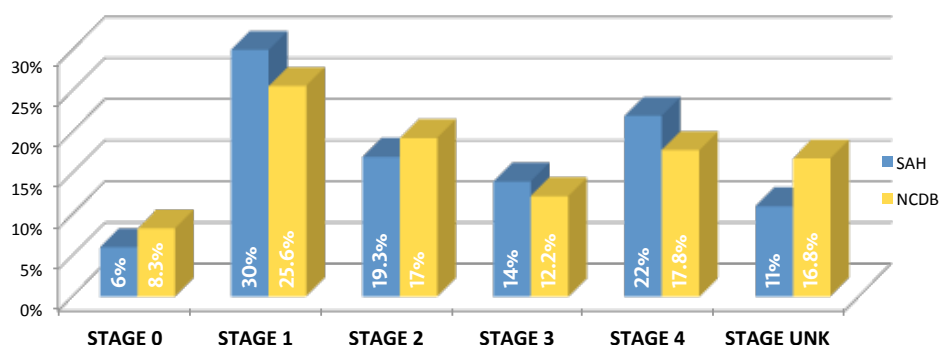
Stage at diagnosis: Some sites have no staging schemas and therefore cannot be AJCC staged (i.e. brain, leukemia, etc.), and since the Center for Disease Control has deemed it mandatory that the registry submit all reportable cases including benign and malignant brain masses, etc., there will always be a percentage of our cases that have no staging whatsoever. In 2013, a total of 119 (11 percent) of our cases fell into this category.

On further review of St. Anthony’s 2013 data, we see a higher total of stage 4 cancers, with 234 (22 percent) somewhat due to the provision of radiation therapy in the treatment of lung cancers, which is one of those sites of cancer that predominantly present in an advanced stage. Data within the registry for the other stage of cancer recorded 64 (7 percent) stage 0 cases, 337 (30 percent) stage 1 cases, 185 (17 percent) stage 2 cases and 148 (14 percent) stage 3 cases.

When comparing the 2013 stage-at-diagnosis with the 2011 and 2012 data, there is not a great deal of difference in the percentages. The majority of earlier stage cancers can be attributed in part to catching our breast cancer cases at an early stage, thanks to our ability to screen for early detection in the Susan S. McGillicuddy Breast Center.

| | Stage 0 | Stage 1 | Stage 2 | Stage 3 | Stage 4 | UNK/NA |
|------|---------|---------|---------|---------|---------|--------|
| 2011 | 7% | 30% | 18% | 14% | 21% | 10% |
| 2012 | 7% | 29% | 18% | 15% | 20% | 11% |
| 2013 | 6% | 30% | 17% | 14% | 22% | 11% |

Comparison with NCDB data shows that SAH compares favorably with the National Cancer Database, with the detection of early stage as mentioned above with the breast center and the predominance of advanced stage treated through our radiation center.



Respectfully submitted,
St. Anthony’s Hospital Cancer Registry



Pancreatic Cancer Within St. Anthony's Hospital – 2009–2013

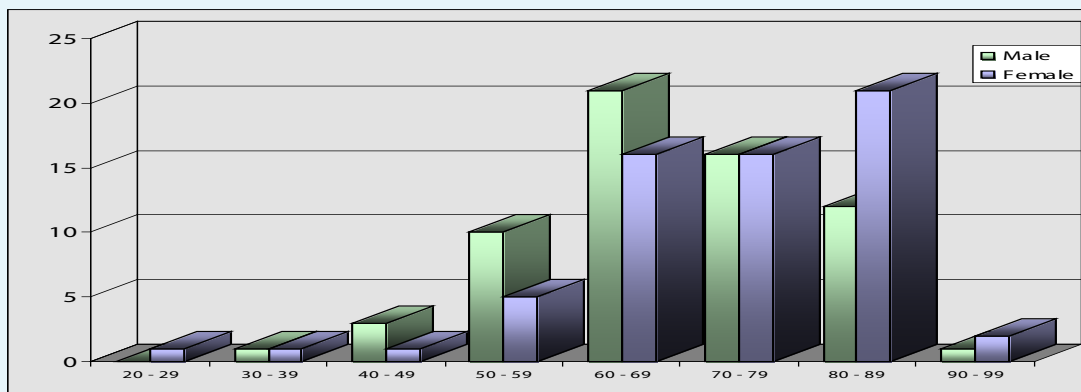
Purpose: In an effort to give the St. Anthony's pancreatic cancer patients the best available care and to comply with the American College of Surgeons Commission on Cancer (CoC) Standard 4.7, measuring quality of care and outcomes for these pancreatic cancer patients and plan for any improvement in the quality of care as needed.

Method: Data was gathered from the SAH Tumor Registry database on all analytic pancreatic cancers diagnosed and/or treated within St. Anthony's Hospital during 2009 through 2013. No cases of recurrent pancreatic cancers (nonanalytic) were included in this study. During 2009 through 2013, there were 127 analytic cases. For survival data comparison, the registry used data from 2006 through 2010.

Findings: Analytic cases are those diagnosed at St. Anthony's Hospital and go on to have treatment within our facility, or those who were diagnosed elsewhere and come to St. Anthony's Hospital for surgical intervention. Each of the 127 analytic cases was reviewed with the following findings:

- **Gender:** According to the American Cancer Society looking at a study (latest published) with data from 2005-2009, pancreatic cancer was more common in men than women by 30 percent. However this was not borne out by the SAH database with data from 2009-2013, where pancreatic cancer does not appear to be gender specific, being evenly split with 64 males and 63 females.

- **Age:** The American Cancer Society states that pancreatic cancer incidents increase and survival rates decline with advancing age, especially after age 50 at diagnosis. This is borne out in the St. Anthony's data, with the incident rate beginning to rise after age 50, with our greatest increase 105 (82 percent) at age 60 and above, and 19 (15 percent) between ages 40 and 59 at diagnosis. A small percentage of two cases (1.5 percent) fell into the 30-39 age group and one rare case (0.7 percent) was age 25 at the time of diagnosis.



■ **Symptomatology:** Patients with pancreatic cancer have pain at some time during the course of their disease but not always on initial presentation. If the tumor is located at the head of the pancreas, obstructive jaundice with or without pain, may result. Tumors in the body or tail usually do not cause any symptoms until they have increased in size or reached a more advanced stage. Since insulin is produced in the pancreas, there can also be an associated increase in diabetic symptoms due to the disruption of insulin production. The American Cancer Society notes that approximately 25 percent of patients have diabetes at the time of diagnosis.

On review of the 127 cases at SAH, 52 percent had increasing abdominal pain as the most predominant symptomatology by itself or in association with jaundice, rapid weight loss, discolored stools, dermatitis, nausea, vomiting and back pain. Jaundice was the second most predominant symptomatology either in combination with other symptoms or alone, at 19 percent. There was a set of patients (24 percent) without symptomatology whose pancreatic cancer was found incidentally during surveillance of another cancer or comorbid condition.

■ **Diagnostic workup and treatment plan:** The following imaging methods are used to determine the presence of any anatomical abnormalities and/or to retrieve a biopsy of tissue or cytologic fluid to confirm the presence of malignant cells. This helps the managing physician determine a clinically staged treatment plan.

- Computed tomography (CT)
- Transcutaneous ultrasonography (TUS)
- Endoscopic ultrasonography (EUS)
- Magnetic resonance imaging (MRI)
- Endoscopic retrograde cholangiopancreatography (ERCP)
- Positron emission tomography (PET)
- Esophagogastroduodenoscopy (EGD)

All patients (100 percent) had at least one of the imaging procedures mentioned above at the time of diagnosis, and although not included in the table, several patients had more than one imaging study during their staging and treatment planning. For some patients, a stent was placed as a palliative measure to alleviate pain for the patient at the time of ERCP.

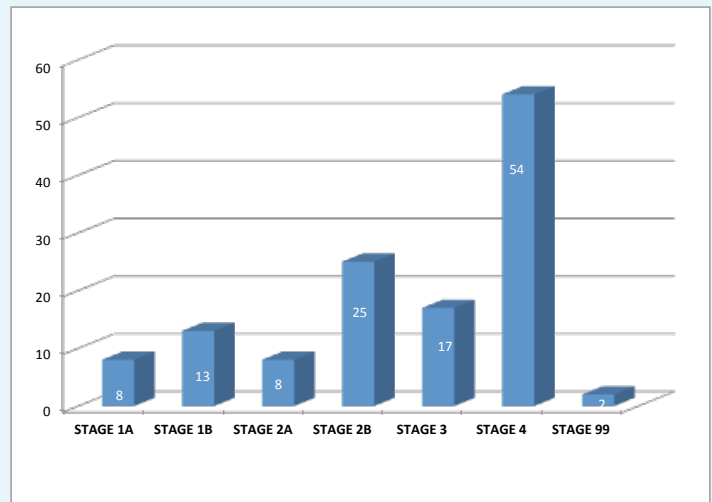
■ **Histology/Morphology:** Most exocrine pancreatic tumors (85 percent) are adenocarcinomas, usually of ductal origin. Papillary and cystic neoplasms carry a very favorable prognosis and are usually cured by surgery. Other rare histologic types include acinar cell, papillary and cystic neoplasm, and cystadenocarcinoma. It is also important to distinguish exocrine tumors from neuroendocrine tumors of the pancreas, also known as islet cell carcinomas. These tumors often produce secretory products with associated clinical syndromes. Carcinoid tumors usually have symptoms of flushing and diarrhea.

Review of pathology of the 127 St. Anthony’s Hospital cases revealed the most common morphology types fell into the following:

- Adenocarcinoma with 86 or 68 percent
- Carcinoma NOS and malignant neoplasm NOS 23 or 18 percent
- Neuroendocrine carcinoma 8 or 6.2 percent
- There were 10 cases or 8 percent with a variety of different morphologic cell types

| | | | |
|-----------------------------------|----|------------|-------------|
| Adenocarcinoma | | 86 | 68% |
| Carcinoma NOS/malignant neoplasm | | 23 | 18% |
| Neuroendocrine carcinoma | | 8 | 6% |
| Other | | 10 | 8% |
| • Acinar cell carcinoma | 1 | | |
| • Adenosquamous cell carcinoma | 1 | | |
| • Duct carcinoma | 2 | | |
| • Mucinous adenocarcinoma | 2 | | |
| • Pleomorphic carcinoma | 1 | | |
| • Small cell carcinoma NOS | 1 | | |
| • Solid pseudopapillary carcinoma | 1 | | |
| • Non-small cell carcinoma NOS | 1 | | |
| Totals | 10 | 127 | 100% |

■ **Stage:** Because of the vague symptomatology at the beginning of the cancerous process with pancreatic cancer, patients are more likely to present when the disease has reached an advanced stage (stage 4), thus drastically reducing the survival rate from this particular cancer. Pancreatic cancer has the highest mortality rate compared to all other cancers and results in roughly 7 percent of all cancer deaths. As can be seen in the graph to the right, of the 127 patients under review, there were 54 (43 percent) who presented with stage 4 disease, with 25 (20 percent) in the stage 2b category, and 17 patients (13 percent) presented as stage 3 at diagnosis. Stage 1b had 13 patients (10 percent) and stage 1a had eight patients (6 percent), with stage 2a also having eight patients (6 percent).



■ **Chemotherapy and/or radiation:** According to the National Comprehensive Cancer Network (NCCN) Treatment Guidelines, surgery is still the best treatment if the cancer is resectable. However, the majority of patients may not be candidates for surgery and may then be candidates for chemotherapy and/or radiation therapy, either in combination or alone. Within the unresectable tumors were 10 patients who had stent placement for palliative pain control, six of whom went on to have chemotherapy alone.

| Type of Treatment | | | Surg % down | Chemo % down | XRT % down |
|--|------------|-------------|-------------------|--------------------|------------------|
| Refusal of any treatment | 9 | 7% | 0 | 0 | 0 |
| Expired prior to any treatment | 17 | 13% | 0 | 0 | 0 |
| Unresectable tumor with chemotherapy alone | 42 | 33% | 0 | 42 | 0 |
| Unresectable tumor with chemo and radiation | 12 | 9% | 0 | 12 | 12 |
| Unresectable tumor with palliative care only | 25 | 20% | 0 | 0 | 0 |
| Surgery alone | 6 | 5% | 6 | 0 | 0 |
| Surgery with chemotherapy alone | 5 | 4% | 5 | 5 | 0 |
| Surgery with chemotherapy and radiation | 8 | 6% | 8 | 8 | 8 |
| Had surgery - refused chemo - had radiation | 1 | 1% | 1 | 0 | 1 |
| Had surgery with chemo - refused radiation | 1 | 1% | 1 | 1 | 0 |
| Refused surgery - had chemotherapy alone | 1 | 1% | 0 | 1 | 0 |
| Totals | | | 21 | 69 | 21 |
| | 127 | 100% | 17% | 54% | 17% |

■ **Surgery:** Surgery offers the only realistic chance of survival for most pancreatic cancers, but does not always lead to a cure. Curative surgery is carried out mainly to treat cancers in the head of the pancreas. Because these cancers are near the bile duct, they often cause jaundice, which allows them to be found early enough to be removed. Surgery for other parts of the pancreas are mentioned below, but this is only done when it's possible to remove all of the cancer.

| Year | Total Cases | Total Surgeries at SAH | Total Surgeries Outside BayCare |
|------|-------------|------------------------|---------------------------------|
| 2009 | 27 | 2 | 0 |
| 2010 | 14 | 1 | 0 |
| 2011 | 23 | 1 | 2 |
| 2012 | 27 | 5 | 2 |
| 2013 | 36 | 4 | 4 |

| | | |
|---------------------------------------|----|------------|
| Surgery at an outside facility | | 8 |
| Surgery within St. Anthony's Hospital | | 13 |
| Unresectable tumors with biopsy only | 85 | |
| • Patients had stent placed w/bx | 10 | |
| • Patient had cholecystectomy w/bx | 1 | |
| • Patient had splenectomy w/bx | 1 | |
| • Patient refused all treatment | 9 | 106 |
| Total cases reviewed | | 127 |

On review of the surgical patients, 13 patients completed their surgical treatment with St. Anthony's Hospital and eight went to an outside facility for surgery. Those patients having surgery underwent one of the following with either a laparoscopic or open approach:

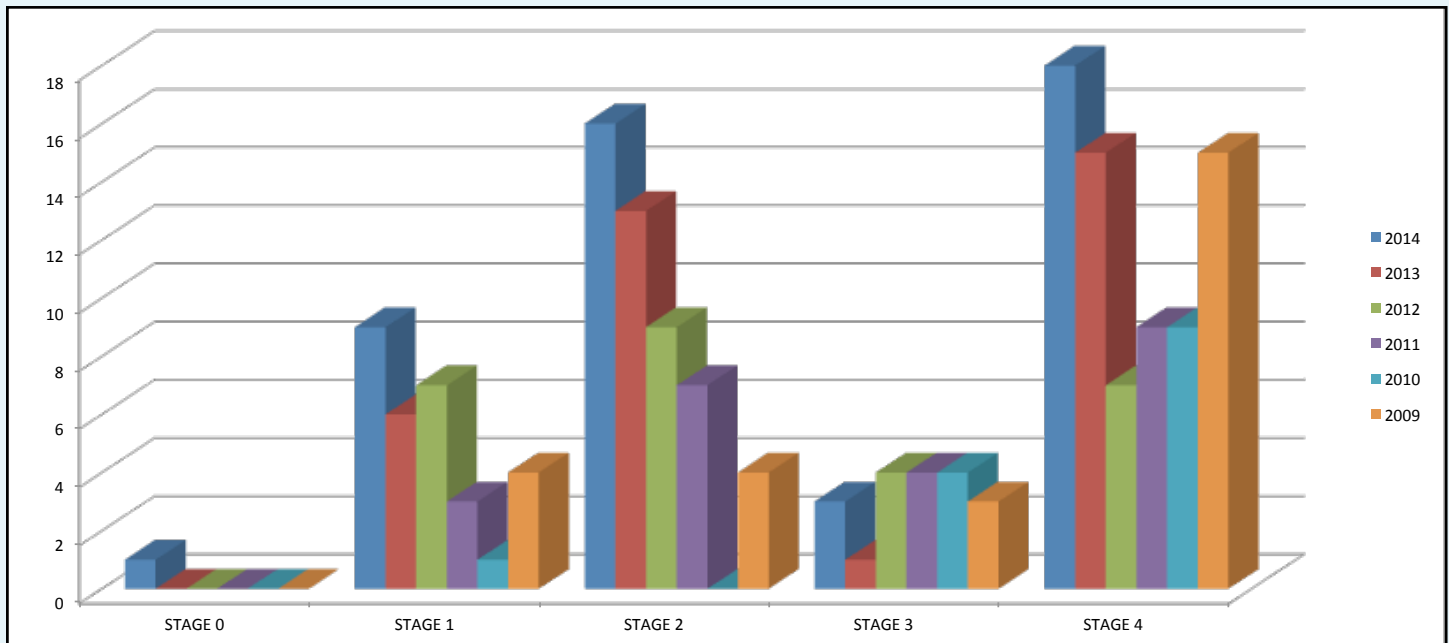
- Pancreaticoduodenectomy (Whipple procedure)
- Distal or partial pancreatectomy
- Total pancreatectomy

The following table shows findings of the 13 patients who completed surgery at St. Anthony's Hospital and any adjuvant treatment they underwent.

| | Stage at DX | Date of Surgery | Approach to Surgery | Endoscopic Ultrasound | ERCP or EGD | Type of Surgery | Chemo | Radiation |
|----|----------------|-----------------|---------------------|-----------------------|-------------|-----------------|---------|-----------|
| 1 | T2N0/Stage 2A | 7/28/2009 | Open | No | | Total | No | No |
| 2 | T3N1/Stage 3 | 11/3/2010 | Open | No | ERCP | Total | Yes | Refused |
| 3 | T2N0/Stage 2A | 5/1/2013 | Lap | EUS | | Total | No | No |
| 4 | T3N1M1/Stage 4 | 2/29/2012 | Lap | EUS | | Total | Yes | Yes |
| 5 | T1NX/Stage 1A | 1/18/2013 | Open | EUS | | Partial | No | No |
| 6 | T3NO/Stage 3 | 4/17/2013 | Open | EUS | | Partial | No | No |
| 7 | T3N1/Stage 3 | 7/6/2010 | Open | No | | Partial | No | No |
| 8 | T1N1/Stage 2B | 3/19/2009 | Open | No | ERCP | Whipple | Refused | Refused |
| 9 | T3N1/Stage 3 | 9/26/2012 | Open | EUS | | Whipple | Yes | Yes |
| 10 | T3N0/Stage 3 | 11/21/2012 | Open | No | ERCP | Whipple | Yes | No |
| 11 | T3N1/Stage 3 | 12/20/2012 | Open | EUS | | Whipple | No | No |
| 12 | T3N1/Stage 3 | 12/28/2012 | Open | EUS | EGD | Whipple | Yes | No |
| 13 | T3N1/Stage 3 | 7/3/2013 | Open | EUS | Neurolysis | Whipple | Yes | No |

■ **Endoscopic ultrasound:** Advancements in medical technology with endoscopic ultrasound have made it possible to now detect cancers of the pancreas at an earlier stage than in previous years, although there remains a predominantly high degree of pancreatic cancers diagnosed at an advanced stage. In recent years, BayCare has provided endoscopic ultrasound with a highly trained and dedicated endoscopic ultrasound surgeon, enabling an improved rate of early stage pancreatic cancer diagnoses with the hope of improving survival rates.

Looking at the graph below, a significant shift in early detection of pancreatic cancer from 2009 through 2013 can be seen. Data from 2014 was included in this table to show that the trend continues with an increase in stage 0 through stage 2 cancers of the pancreas being detected. However, as can also be seen, there is still that large number of late stage pancreatic cancers being diagnosed.



■ **Survival:** While pancreatic cancer survival rates have been improving from decade to decade, the disease is still considered largely incurable. According to the American Cancer Society, for all stages of pancreatic cancer combined, the one-year relative survival rate is **20 percent** and the five-year rate is **6 percent**. These low survival rates are attributable to the fact that fewer than 20 percent of patients' tumors are confined to the pancreas at the time of diagnosis; in most cases the malignancy has already progressed to the point where surgical removal is impossible. In those cases where resection can be performed, the average survival rate is 18 to 20 months. The overall five-year survival rate is approximately 10 percent, although this can rise as high as 20 to 25 percent if the tumor is removed completely and when cancer has not spread to lymph nodes.

Since survival is calculated after five years (60 months) survival from date of diagnosis, the table below shows the relative survival rate for all pancreatic cancers diagnosed and/or treated at SAH from 2006 through 2010 as a comparison with the survival rates given by the American Cancer Society. There are a total of five patients still living. One patient was a stage 2B who underwent a Whipple procedure and one patient was stage 1A and had a partial pancreatectomy. The other three living patients were deemed unresectable and therefore automatically considered stage 4 and went on to have chemotherapy only.

| Months | Totals Alive | SAH% | ACS% |
|-----------|--------------|------|------|
| 1 Month | 87 | 100% | 100% |
| 12 Months | 26 | 29% | 20% |
| 60 Months | 5 | 5% | 6% |



St. Anthony's Hospital Cancer Committee – 2014

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Conclusion

Surgery, when appropriate, continues to be the recommended treatment for pancreatic cancer patients at St. Anthony's Hospital. There is a recent trend toward an earlier stage at time of diagnosis of pancreatic cancer. This trend is most likely related to the recent addition of endoscopic ultrasound, enhanced imaging and a dedicated team of physicians available to these patients. The expectation is that this trend will continue allowing an earlier diagnosis of pancreatic cancer at our facility. This trend should translate into improved rates of complete resection and survival for pancreatic cancer patients.

Kevin Huguet, MD
Surgeon, St. Anthony's Cancer Committee

Mission: St. Anthony's Hospital will improve the health of all we serve through community-owned health care services that set the standard for high-quality, compassionate care.

Vision: St. Anthony's Hospital will advance superior health care by providing an exceptional patient-centered experience with a focus on spiritual well-being.

Values: The values of the St. Anthony's Hospital are trust, respect, and dignity and reflect our responsibility to achieve health care excellence for our communities.

