

2002 Annual Cancer Report

(based on 2001 data)



Latrobe Area Hospital Cancer Committee

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CANCER LIAISON PHYSICIAN OF THE COMMISSION ON
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Brenda Lee Steele, R.N., O.C.N.
RADIATION ONCOLOGY

Heather Walback, R.D.
FOOD AND NUTRITION SERVICES

Daryll Lee Wells, M.S., R.N., C.H.P.N.
HOSPICE SERVICES

ON THE COVER:

The Bruno Ferrari Family Cancer Center at Latrobe Area Hospital


Chairmen's Report

The Latrobe Area Hospital Cancer Program, based in the Bruno Ferrari Family Cancer Center, continued in 2001 to deliver state-of-the-art surgical, radiation and medical oncology treatments to the community. The primary focus in 2001 was clinical trials which are the foundations on which major breakthroughs are laid. A massive recruitment program was established through a Quality Council initiative headed by the radiation and medical oncologists. The rewards were noted only after a few short months as enrollment in clinical trials increased dramatically. Truly the only way to improve outcomes in cancer care is through medical research. Our clinical trials program was our number one priority in 2001. Our enrollment of patients into protocols was much higher than the local and national average. In clinical trials, patients receive state-of-the-art cancer care while we advance our knowledge of oncologic treatments. Our affiliation with the University of Pittsburgh, as well as national organizations such as NSABP and ECOG, allow us to offer very sophisticated studies that would otherwise be unavailable. This often includes medications that are still considered experimental and not yet approved by the FDA, but may hold out hope for a person with advanced cancer. This is a true blessing in that these often severely ill patients do not have to travel to major cities for experimental approaches.

Our Pain Management and Hospice programs continued to grow during 2001. A very valuable addition was made to the team of practitioners when Ray Paronish, CRNP moved to Latrobe Area Hospital from the University of Pittsburgh. His experience in palliative care is immeasurable and he has helped countless numbers of patients with advanced cancer regain control of their lives through good pain control. Hospice care is also a very important asset to the cancer program at Latrobe Area Hospital, and will remain so in the future through the dedication of many individuals such as the volunteers and the Home Health nurses who stay with a dying patient through the night.

In 2002, Latrobe Area Hospital plans to initiate and strengthen a multidisciplinary lung cancer program. Through cooperative and interdisciplinary care, patients with lung cancer can receive coordinated quality care. Ground-breaking for a new cancer center in a joint venture with UPMC will occur in 2002 with the goal of completion of the facility by summer 2003. The staff at Latrobe Area Hospital are preparing for an onsite visit by a representative of the American College of Surgeons Commission on Cancer to evaluate the cancer program in the near future.

In summary, the Latrobe Area Hospital cancer program continues to offer state-of-the-art cancer care at a community hospital level, where patients are very comfortable with their local surroundings and know the individuals who are caring for them.



John F. Robinson, M.D.
Cancer Committee Co-Chairman



Sanjeev Bahri, M.D. F.A.C.R.
Cancer Committee Co-Chairman

Head and Neck Cancer - Site Specific Discussion

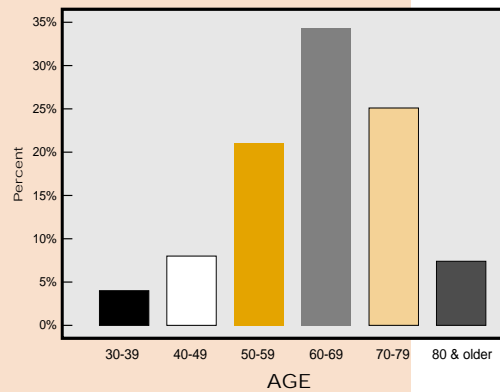
Head and neck cancer continues to be a significant cause of concern among all oncologists because of the morbidity and mortality associated with the diagnosis. The majority of cases in the United States can be associated with tobacco and alcohol use, and therefore, it is thought to be a preventable disease. Through education, the children of our community can hopefully avoid this unfortunate disease. Efforts are currently under way nationally to educate children on the dangers associated with tobacco use, which is the number one culprit or risk factor.

Epidemiology

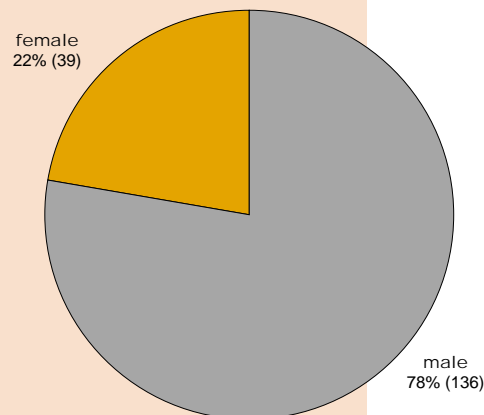
In the United States there are approximately 37,000 new cases of head and neck cancer.¹ This translates to 2 percent to 3 percent of all cancers and is responsible for 1 percent to 2 percent of all cancer deaths. Between 1987 and 2001 Latrobe Area Hospital recorded 175 cases of head and neck cancer. The average age of patients diagnosed with this illness nationally is between 50 and 70. The majority of patients in this hospital were between the ages of 60 and 69. This is usually a disease of men with 80 percent of cases nationally affecting the male population, and 78 percent of men locally.² Only 22 percent of the cases at Latrobe Area Hospital involved women between the years 1987 to 2001.

At Latrobe Area Hospital, the disease site was found to be the larynx in 47 percent of the 175 cases with a mix of other areas also seen, including the oral cavity (5 percent), base of tongue (5 percent), as well as the pyriform sinus (5 percent). The nasal cavity and middle ear were also involved in 7 percent of our cases. These numbers compare to the national numbers.

Age at Diagnosis
LAH Head and Neck Cancer 1987 - 2001

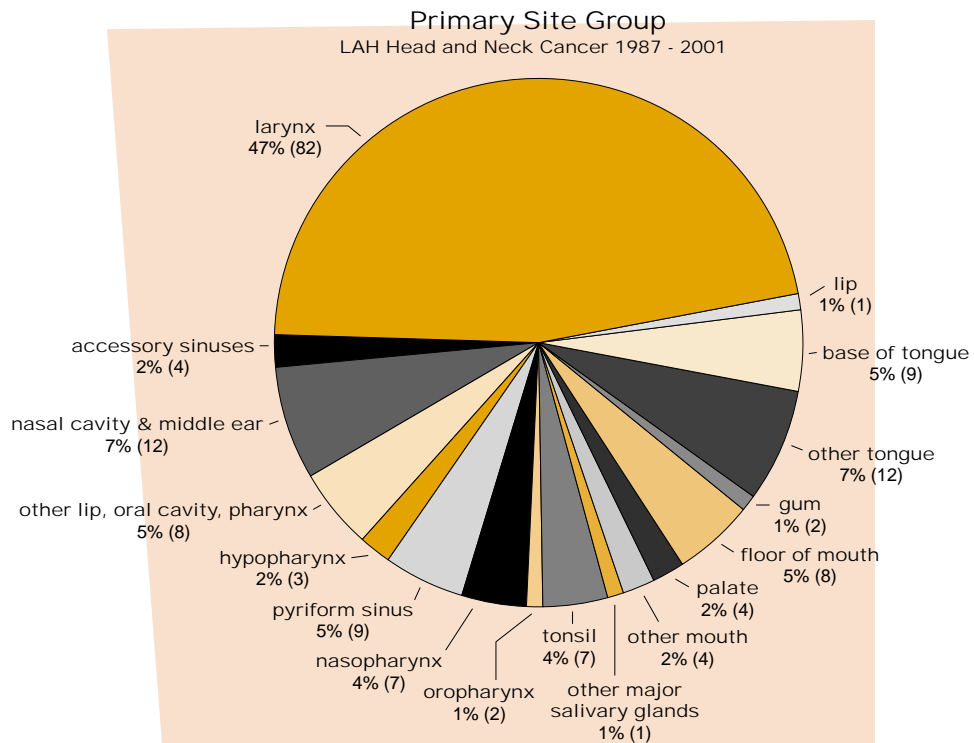


Sex
LAH Head and Neck Cancer 1987 - 2001



¹Pazdur R, Coia LR, & Hoskins WJ. (2002). Cancer Management: A Multidisciplinary Approach. 6th ed. (pp. 37-78). Melville, NY: PRR, Inc.

²Hoffman HT, Karnell LH, Funk GF, Robinson RA, & Menck HR. (1998). The National Cancer Data Base Report on Cancer of the Head and Neck. *Archives of Otolaryngology—Head and Neck Surgery*, 124, 951-962



Screening and Diagnosis

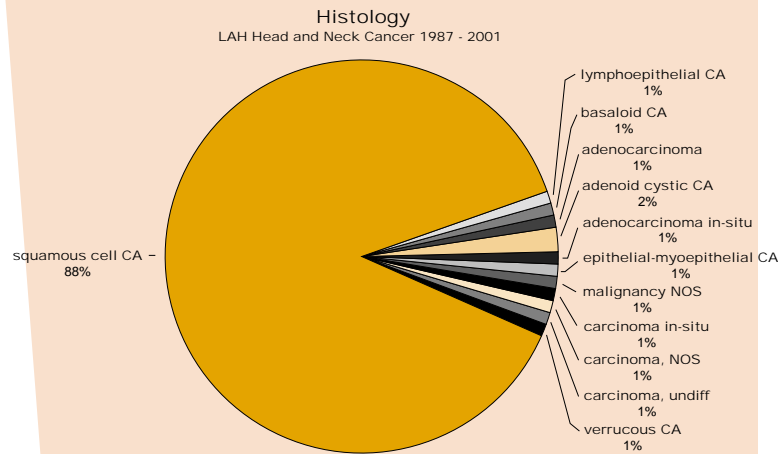
The cure rate for head and neck cancer is very high. Screening does have a great appeal in that early detection allows for surgical removal. Physicians should always examine the oropharynx in all patients, especially smokers, looking for any suspicious lesions. Any patient with voice changes or other symptoms should be evaluated immediately.

The diagnosis of head and neck cancer is usually made by the surgeon. A thorough history and physical examination including the skin, cranial nerves, eyes, ears, nose, oral cavity, neck as well as a possible laryngoscope and endoscopic exam may be needed. Plain X-rays including a PA and lateral of the chest to exclude lung metastases should be done. CT scans of the neck are especially helpful in planning treatment. PET scans are also becoming helpful in diagnosing distant metastases and the further staging of patients.

A biopsy is the most important aspect of diagnosis and can be done by several methods, including a punch biopsy, fine needle aspiration, core biopsy or open biopsy. An open biopsy is usually done by a surgeon who is then ready to carry out an excisional procedure.

Pathology

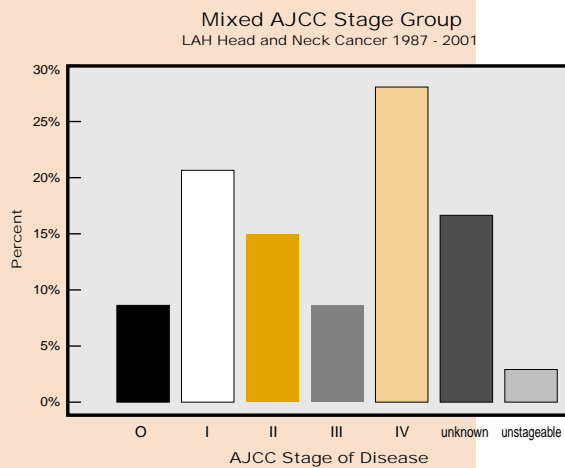
More than 90 percent of cases of head and neck cancer nationally are squamous cell carcinoma.¹ At Latrobe Area Hospital, 88 percent of our cases between years 1987- 2001 also were squamous cell cancers. There was a mix of other cell types found. Histologic grade is an important prognostic indicator and the higher the grade the more aggressive the cancer behaves.



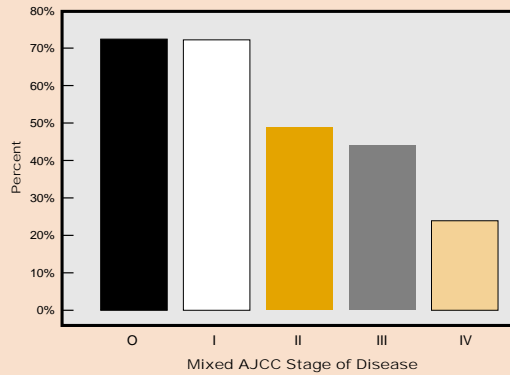
Staging and Prognosis

The TNM staging system of the AJCC is used in head and neck cancer to maintain uniform staging. Prognosis is, of course, linked closely to staging. Survival for patients with early stage disease is excellent. Unfortunately, as stage increases survival decreases. The finding of node metastases is associated with poor outcomes and unfortunately the majority of patients will have lymph nodes involved at the time of diagnosis.

Even with aggressive treatments to the primary sites, patients with head and neck cancer are at risk for metastases or the development of new lesions known as field cancerization. Close surveillance is, therefore, recommended even in patients who are already considered cancer free. Most likely sites of relapse are local regional. Survival is very poor in patients with metastatic disease despite major advances in chemotherapy drugs over the past several decades, with average survival only five months when a major organ is involved.



5-Year Survival
LAH Head and Neck Cancer 1987 - 2001



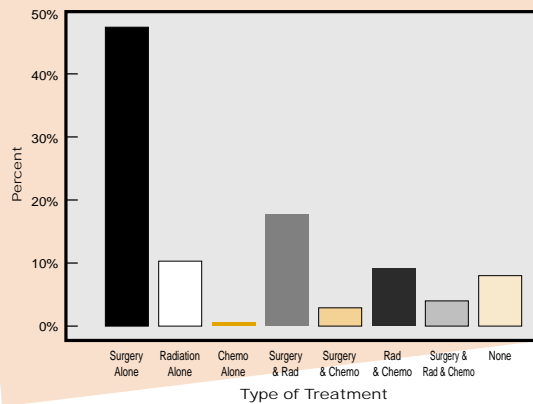
Treatment Options

The treatment of head and neck cancer is often surgical. Fifty percent of the patients with head and neck cancer between 1987 through 2001 underwent surgery alone. Surgery plus radiation accounted for approximately another 20 percent. This is comparable to the national numbers.² The recent advent of radio-sensitizing chemotherapy such as the Taxanes are very attractive when combined with radiation therapy to treat patients with cancers of the larynx or those who have unresectable lesions. Seventy percent response rates are recorded with this type of therapy and surgery can be avoided or often used as salvage maneuver. A multidisciplinary approach to head and neck cancer is needed to help more patients with this unfortunate diagnosis. The goal of Latrobe Area Hospital is to, indeed, form a multidisciplinary clinic where all patients can be evaluated by a team of surgeons, radiation and medical oncologists, dietary services and speech pathologists. This will certainly increase the number of patients who are treated on clinical trials and also allow us to deliver state-of-the-art therapy to patients who have been diagnosed with this unfortunate disease.

John F. Robinson MD

John F. Robinson, M.D.
Cancer Committee Co-Chairman

Treatment
LAH Head and Neck Cancer 1987 - 2001



Cancer Registry Report

The Cancer Registry at Latrobe Area Hospital is an information system designed to collect, manage and analyze data on patients with a diagnosis of malignant or neoplastic disease. The intent of the registry is to encourage lifetime medical follow-up of cancer patients and to provide a database for epidemiological, clinical, research and cancer program management. Information is abstracted from the medical record. Data collected includes demographic and historical data, tumor characteristics, therapies received, diagnostic procedures, response to treatment, duration of disease, and length and quality of survival.

The Latrobe Area Hospital registry was first accredited by the American College of Surgeons (ACOS) in January 1974 and has maintained accreditation since that time. The registry is part of the Clinical Information Department and is located on B-level of the hospital. Registry staff utilize the suggested ICD-0 Third Edition Manual and the SEER Summary Staging Manual 2000. Confidentiality of patient data is strictly maintained. In 2001, the registry staff responded to 19 physician and 14 non-physician requests for aggregate or trend data.

One full-time and one part-time Latrobe Area Hospital employee staff the registry. The Clinical Information Department Assistant Manager provides administrative support. In addition to collecting data for the Cancer database, staff also completes the Pennsylvania state mandatory data collection abstract. This provides epidemiological data for analysis by the Pennsylvania Department of Health. When the hospital elects to participate in ACOS studies, registry staff often collect additional data and assist in the analysis of the data. Cancer registry staff also provide the clerical support for the Cancer Conferences and the Cancer Committee, coordinate the publication of the annual report, and assist with internal registry auditing processes. Registry staff provide a quarterly quality report to the Cancer Committee on compliance with staging requirements and examination requirements for colorectal cancer.

The registry staff is preparing for the American College of Surgeon's Commission on Cancer survey to be held in the fall of 2002. The registry staff will complete the application and coordinate the document preparation. Additionally in the fall of 2002, the registry staff will be receiving new computer software. The new software, Précis, is expected to add additional functionality to the registry.

2001 Cancer Registry Statistics

There were 7,214 Analytical* Cases in the registry as of December 31, 2001. The following were excluded from the count: benign cases, borderline cases, carcinoma in-situ of the cervix cases, and in-situ and localized basal and squamous cell carcinoma of the skin cases.

There were 591 new or accessioned cases in 2001. This reflects an increase compared to 2000, but it is comparable to prior year volumes.

The follow-up rate for living and deceased patients was 95 percent. This is above the Commission on Cancer's required rate of 90 percent.

On the average, 275 follow-up letters are sent every month.

An analysis by Zip Code showed the most frequently occurring home addresses of the patients were Latrobe (24 percent), Greensburg (14 percent), Ligonier (9 percent), Blairsville (7 percent), and Derry (6 percent).

*Analytical cases are defined on page 17.

Outpatient Medical Oncology

In the Outpatient Medical Oncology Unit at Latrobe Area Hospital, patient care is provided by a dedicated, qualified and experienced staff. Members of this caring team include two UPMC hematologists/oncologists, a certified registered nurse practitioner specializing in oncology, a number of oncology certified registered nurses, and an experienced nurse aide and clerical support staff. For our patients' convenience, registration and phlebotomy services are handled in the Cancer Center. The unit's facilities were designed to meet the needs of the oncology patient and include six physician exam rooms along with 12 chairs and three carts in the infusion area.

One of our more recent goals was to increase public awareness of and patient enrollment in clinical trials. To this end, a newsletter was developed, distributed to physicians and made available to the public. That endeavor, along with a more diligent screening of patients, has resulted in an increase in the number of patients on study.

A recent addition to the Center is the establishment of an Oncology Resource Center, which provides our patients and their families with user-friendly internet access. Web sites offering a wealth of information on cancer and cancer treatments are easily accessed and a copy of the information can be printed if desired.

The Outpatient Medical Oncology Unit continues to deal with the challenges of coding and reimbursement issues. One of the major areas we address daily is obtaining reimbursement for chemotherapy drugs. Working with Pharmacy, Social Work Services, and various pharmaceutical firms, we have been able to obtain needed drugs for patients who are under-insured, uninsured, or not covered for specific drugs.

The Cancer Center also hosts skin and prostate cancer screenings annually; for the year 2001 we saw 260 patients in the prostate screening and 50 patients at the skin cancer screening.

Frances Suprano, R.N., B.S.N.
Nurse Manager

Inpatient Oncology Services

Inpatient services on 5 East are dedicated primarily to the care of the oncology patient. Our approach to treating cancer continues to be a multidisciplinary team effort that includes, but is not limited to, the services and support of Food & Nutrition, Home Health/Hospice, Pharmacy and Social Work Services.

The unit operates within the Patient Centered Care Concept to provide care and treatment to our patients. Delivering that care are Registered Nurse Partners, Technical Partners, Support Partners and Administrative Partners. The Patient Centered Care concept allows us to treat and care for the patient at all levels, from simple housekeeping/comfort level tasks to performing phlebotomies, transporting patients to and from the unit, etc.

In addition to the 15 patient beds, our unit houses a family room complete with recliner, TV and mini library containing helpful resources.

Frances Suprano, R.N., B.S.N.
Nurse Manager

Radiation Oncology

The Radiation Oncology Department functions primarily as an outpatient service of the Cancer Center of Latrobe Area Hospital in collaboration with the University of Pittsburgh Medical Center and the University of Pittsburgh Cancer Institute.

The department experienced dramatic growth and change in 2001. Medical Director and Radiation Oncologist Dr. Sanjeev Bahri along with our Nursing and ancillary staff performed consultations on 401 patients in 2001. New radiation treatment courses were initiated on 248 patients while an additional 55 courses were initiated on patients who had received radiation previously at our cancer center. In addition, 567 follow-up visits were conducted on patients who had previously received radiation therapy.

Our team of Radiation Therapists and Radiologic Technologists initiated and delivered external radiation treatments to 259 patients and the total number of external beam radiation therapy treatments was 7,501. Simulations were performed 569 times. Fabrication of treatment devices associated with these simulations totaled 1,499. Our Medical Dosimetrist completed 1,337 calculations and 349 computerized treatment plans.

Our medical physics team treated 88 patients with high dose rate (HDR) brachytherapy accounting for 118 HDR treatments. Our prostate HDR brachytherapy program continues to be the only one of its kind in the area. We are also planning to add a permanent seed implant program in the future.

The future of radiation oncology also will include a strategic move in 2003 to the new Arnold Palmer Pavilion, member of University of Pittsburgh Cancer Centers to be located at Mountain View Medical Park, where Latrobe Area Hospital already provides primary health care and occupational medicine services. The pavilion will be supported by a premier diagnostic testing and imaging center.

Ernie McClelland, BS, RT (R) (T)
Radiation Oncology

Cancer Conferences

The cancer conferences at Latrobe Area Hospital offer a multidisciplinary patient-oriented forum with the goal being to exchange information among participating physicians to guide ongoing patient therapy. This is done in order to improve the care of cancer patients, to identify treatment options, make recommendations for patient care, and to educate treating physicians. Often, at these informal and interactive conferences, nearly every specialty is represented. This allows the individual specialists to share their expertise, based on their own experience, as well as, knowledge of current literature. The primary care physicians are invited to attend and can take advantage of the opportunity to discuss a case prospectively with their colleagues. At the conference, computerized audio-visual equipment is used which allows all participants to view high quality radiological images and laboratory slides. The images and slides are presented and findings are discussed by a Radiologist and/or Pathologist. In addition to the treating physicians and specialists, family practice residents, medical students and allied health care professionals also attend the conferences. This further facilitates consistent and comprehensive care of cancer patients. To enhance physician and staff education, five speakers made presentations at cancer conferences in 2001. Topics included advances in Bladder, Breast, Prostate, and Liver Cancer as well as "Confessions of a Former Cancer Researcher." In 2001, 209 cases were presented at the Cancer Conferences. This represents 35% of the total number of new cancer patients in 2001.

Cancer conferences are held every Thursday at noon in the Alex G. McKenna Community Education Center. Physicians wishing to present or suggest cases or topics for discussion may contact either J. Conrad Bures, M.D, Ronald Berardi, M.D, or Maged Shenouda, M.D. at 724-537-1952 or the Cancer Registry at 724-537-1286.

Karen A. Hansen, RHIA
Assistant Manager, Clinical Information Department

Pharmacy

The Pharmacy Department consists of a staff of 11 pharmacists and 14 technicians. This group of people helps to ensure the right medication gets to the right person at the right time and at the right dose. These "rights" are part of the mission statement for the Department of Pharmacy. One of the Pharmacy's main roles in the care of cancer patients is to prepare the chemotherapy drugs that the nursing staff administers.

The chemotherapy drugs that patients receive are often quite toxic and, therefore, the doses must be mixed very accurately. The Pharmacy staff is highly trained in the proper methods to prepare these drugs, taking into consideration the appropriate dose, stability data, compatibility data, infusion rates, anecdotes and expected side effects.

The anticancer drugs must be compounded in a sterile environment that also protects the safety of the person mixing the drugs. Some of these procedures require extensive technical knowledge that has evolved into standard protocols.

Cancer patients' drug regimens not only consist of chemotherapy drugs but drugs which help to prevent certain side effects such as the nausea often experienced with cancer treatments. The pharmacist is involved in this area of drug use as well.

Given the hospital's affiliation with the Pittsburgh Cancer Institute (PCI), our pharmacists are called upon to handle and review new investigational drugs. This area of work requires quite a bit of time and communication with PCI to help ensure our patients are receiving the correct drug and dose. Often, very little is known about these new agents, since these drugs are not commercially available.

The role of the pharmacist is expanding at Latrobe Area Hospital as is evidenced by our increasing involvement with the total care of cancer patients. Recently, a pharmacist has been participating in morning rounds with the nurse, nurse practitioner and the oncologist. During "rounds" the pharmacist reviews the patient's drug records looking for opportunities to streamline or improve therapy. For example, every patient's renal function is assessed and, if indicated, some drug dosages are reduced, allergy issues are reviewed, and opportunities to change medicines from the IV route to the oral route are discussed. The Pharmacist plays an important and active role in providing optimum patient care.

Dean Matanin, Pharm. D.
Pharmaceutical Services Manager

Radiology

Diagnosing and treating cancer with its numerous potential complications is a task with a tremendously broad scope. The Department of Radiology at Latrobe Area Hospital provides a large number of diagnostic and therapeutic tools to improve the lives of cancer patients.

PET scanning has been added this year to complement CT, MRI, Ultrasound and x-ray in the noninvasive diagnosis of cancer and treatment follow-up. Invasive diagnostic procedures including percutaneous CT and ultrasound guided biopsies and aspirations, along with stereotactic breast biopsy have been mainstays in cancer diagnosis for years. Sentinel node imaging in breast cancer and melanoma are available in the Nuclear Medicine section.

Image-guide therapeutic procedures available include percutaneous biliary and renal drainage and IVC filter placement. The department has a very successful vertebroplasty program, a procedure that can provide significant relief of bone pain caused by cancer. The section of Interventional Radiology under the direction of Michael Miller, MD, has recently added endovascular biopsy, venous thrombolysis with stenting and the full spectrum of short and long-term vascular access. This includes the insertion and maintenance of PICC lines, portacatheters and Hickman catheters. Chemo embolization as a stand-alone therapy or as a presurgical adjunct, is also available.

In addition to formal and informal consultation with cancer patients and their physicians, our radiologists also participate in the weekly cancer conference and breast and lung clinics.

Kevin J. Kelly, MD,
Chief, Department of Radiology

Rehabilitation Services

Rehabilitation Services at Latrobe Area Hospital (Physical Therapy, Occupational Therapy and Speech Therapy) provide specialized care to meet the functional needs of the oncology patient to promote a better quality of life.

On the patient's first visit, the therapist performs an evaluation. Based on the evaluation findings and the patient's goals, we design an individualized treatment program.

PT/OT treatment can reduce pain, restore movement, increase strength, improve transfers and gait and improve/modify activities of daily living. Speech therapy can improve swallowing and speech. All disciplines strongly emphasize patient and family education (for example, energy conservation techniques, proper posture and body mechanics with functional activities, home exercise programs) to facilitate continuity of care after discharge.

Rehabilitation Services treats patients of all ages, from newborns to geriatrics.

Special services provided by the Rehab team that may benefit the oncology patient include: Mobilization/manual therapy; wound care; ergonomics; vestibular rehab; women's health (incontinence, pelvic pain); lymphedema clinic; swallowing therapy and voice training.

Kim Koroly, P.T.
Physical Therapy

Social Work Services

When people are diagnosed with cancer and become oncology patients they encounter an extremely stressful chain of events. Physically and psychologically they begin their personal journey of reacting to their life-threatening illness and their only perceived chance of survival-treatment.

The usual result is a person and family in crisis. The impact of this experience will vary according to other hardships that they have to endure. Their interpretation of how the situation will affect them individually, and as a family, will determine how stressful the experience will be. Even the most well-adjusted family can become disorganized and proceed as though on a roller coaster as they struggle to reach a state of equilibrium. Oncology Social Work Services at Latrobe Area Hospital is designed to help patients and their families cope with the many stressors they face and feel more in control.

Medical Social Work Services are available to all oncology patients and their families in a continuum extending from outpatient services through hospitalization to post-hospital case management. One social worker is specifically assigned to oncology patients. This worker services outpatient Medical Oncology and Radiation Oncology as well as inpatients on the oncology unit. This social worker provides counseling, discharge planning and case management through the continuum of care.

Social work with an oncology patient begins with assessment, proceeds with education, emotional support, coordination of financial resources and community services to increase coping mechanisms and foster positive outcomes. Including family members is crucial to preventing deterioration of the patient's support network as the family system experiences ups and downs throughout illness. Latrobe Area Hospital Oncology Social Work Services places emphasis on individual needs, goals and preferences in relation to personal, spiritual, alternative beliefs and end-of-life decisions.

Dave O'Brien, L.S.W., C.C.M.
Manager, Social Work Services

Food and Nutrition Services

Latrobe Area Hospital's Food and Nutrition Services Department provides Medical Nutrition Therapy in the outpatient setting to oncology patients to improve quality of life. This is accomplished through nutrition counseling on balanced diets, supplementation of diets or alternative forms of nutrition support.

Dietitians provide nutrition intervention with oncology patients who are admitted to Latrobe Area Hospital. Patients identified at nutritional risk are seen by a dietitian who plans and implements appropriate nutrition intervention. Examples of nutrition intervention include: obtaining food preferences, initiating diet education, providing nutrition supplements or recommending alternative nutrition support.

A dietitian representative attends Cancer Committee meetings regularly, as well as education programs dealing with pertinent cancer information as they are available. Additional services provided by Food and Nutrition Services include patient, family and staff education in the hospital and in Medical Oncology and Radiation Oncology outpatient areas.

Heather L. Walbeck, R.D.
Food and Nutrition Services

Home Health Services

During 2001, the Home Health Services Department provided home health care to more than 150 patients with 45 different cancer diagnoses. These patients received skilled nursing, home health aide, medical social services and rehabilitative services provided in the comfort of their own home. If appropriate, the patient was referred to the Palliative Care or Hospice programs also offered through this department. Care is provided to patients of any age and for virtually any type of cancer or cancer-related diagnosis. In support of our commitment to cancer education and screening, members of this department participated in the annual prostate cancer screening program held at the Bruno Ferrari Family Cancer Center in November.

Darlene M. Kubas
Home Health Services Department Manager

Home Health Services Hospice

Hospice has been providing services to terminally ill patients and their families since Medicare certification in 1996. During 2001, a total of 101 patients were referred to Hospice by staff and nonstaff physicians. Although the majority of the referrals had cancer-related diagnoses, there was an increase in referrals with noncancer diagnoses. Coinciding with the disturbing national trend, our average length of stay dropped to 42.5 days with many patients receiving end-of-life care for seven days or less.

With emphasis on the physical, psychosocial, emotional and spiritual needs of the patient family, the interdisciplinary team under the medical direction of Matthew Sulecki, MD and John Robinson, MD provided 24-hour/7 day per week nursing availability, pain and symptom management and family support. Three additional Hospice nurses successfully passed the Hospice and Palliative Care Certification Exam, which makes 88 percent of the Hospice nursing staff certified.

Through a grant from the Staunton Farm Foundation, with matching funds from the Latrobe Area Hospital Charitable Foundation, a comprehensive bereavement program to service Hospice, family members of Latrobe Area Hospital patients and the community at large was developed. Expanded Hospice bereavement services were implemented including the development of the Community Guide to Bereavement Support Services.

The Hospice staff also provided palliative care to 180 patients who were not yet hospice appropriate. The Palliative Care Program provides services to patients electing curative care and to those not at the end of life.

Daryll Lee Wells, M.S., R.N., C.H.P.N.
Hospice Patient Care Manager

2001 Primary Site Table - AJCC Mixed Stage Latrobe Area Hospital

Primary Site	Cases	Class of Case		Sex		Mixed AJCC Stage at Dx					
		A	N/A	M	F	0	I	II	III	IV	UNK
Lip, Oral Cavity, Pharynx	12	10	2	7	5	0	1	3	1	6	1
Lip	1	0	1	0	1	0	0	0	0	1	0
Tongue	5	5	0	4	1	0	0	2	1	2	0
Floor of Mouth	1	0	1	1	0	0	0	0	0	1	0
Palate	1	1	0	1	0	0	1	0	0	0	0
Tonsil	1	1	0	0	1	0	0	0	0	1	0
Pyriform/Hypopharynx	1	1	0	0	1	0	0	0	0	1	0
Other Oral/Pharynx	2	2	0	1	1	0	0	1	0	0	1
Digestive Organs	135	126	9	66	69	6	20	27	24	37	21
Esophagus	3	2	1	3	0	0	0	0	0	2	1
Stomach	13	13	0	9	4	0	2	1	3	4	3
Small Intestine	2	2	0	0	2	0	0	1	0	0	1
Colon	64	61	3	30	34	4	9	22	12	9	8
Rectum and Rectosigmoid	27	25	2	11	16	1	8	2	7	4	5
Anus/Anal Canal	1	1	0	1	0	1	0	0	0	0	0
Liver	2	1	1	1	1	0	0	0	0	2	0
Gallbladder	3	3	0	2	1	0	0	0	0	3	0
Other Biliary	5	5	0	2	3	0	0	0	0	2	3
Pancreas	15	13	2	7	8	0	1	1	2	11	0
Respiratory & Intrathoracic System	84	76	8	52	32	1	10	7	19	37	10
Nasal Cavity/Middle Ear	1	1	0	0	1	0	0	0	0	0	1
Larynx	5	5	0	4	1	1	0	3	0	1	0
Trachea	1	1	0	1	0	0	0	0	0	0	1
Lung & Bronchus	77	69	8	47	30	0	10	4	19	36	8

Primary Site	Cases	Class of Case		Sex		Mixed AJCC Stage at Dx					
		A	N/A	M	F	0	I	II	III	IV	UNK
Bones, Joints + Articular Cartilage	2	1	1	0	2	0	0	0	1	0	1
Bone and Joints	2	1	1	0	2	0	0	0	1	0	1
Hematopoietic Reticuloendothelial	34	31	3	24	10	0	0	0	0	0	34
Multiple Myeloma	11	11	0	4	7	0	0	0	0	0	11
Lymphoid Leukemias	8	7	1	6	2	0	0	0	0	0	8
Other	7	5	2	7	0	0	0	0	0	0	7
Myelodysplastic Syndrome	8	8	0	7	1	0	0	0	0	0	8
Skin	20	17	3	16	4	0	5	4	3	3	5
Melanoma	16	13	3	13	3	0	4	3	3	3	3
Skin (Basal and Squamous Cell)	1	1	0	1	0	0	0	1	0	0	0
Skin (Other)	3	3	0	2	1	0	1	0	0	0	2
Soft Tissue	2	2	0	2	0	0	0	1	0	0	1
Soft Tissue	2	2	0	2	0	0	0	1	0	0	1
Breast	92	79	13	2	90	21	30	22	5	4	10
Breast	92	79	13	2	90	21	30	22	5	4	10
Female Genital Organs	47	40	7	0	47	8	20	4	3	6	6
Vulva	2	1	1	0	2	1	0	0	0	0	1
Cervix Uteri	9	7	2	0	9	7	0	1	1	0	0
Corpus Uteri	27	27	0	0	27	0	19	3	2	2	1
Ovary	8	5	3	0	8	0	1	0	0	4	3
Other Female Genital NOS	1	0	1	0	1	0	0	0	0	0	1
Male Genital Organs	66	58	8	66	0	0	1	46	6	9	4
Prostate	65	57	8	65	0	0	0	46	6	9	4
Other Male Genital	1	1	0	1	0	0	1	0	0	0	0

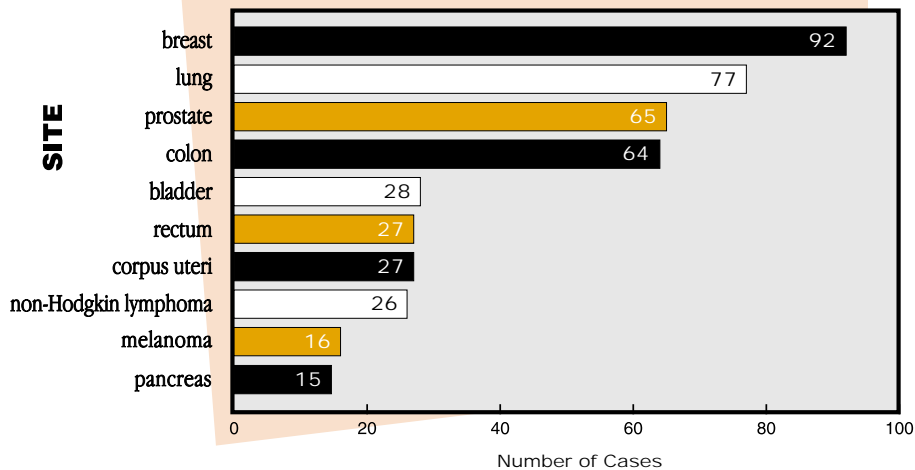
Analytic cases equal class of case 0, 1, 2, and 6. Non-analytic cases equal class of case 3, 4, 5, and 8.

- 0- First diagnosed at the reporting institution since the reference date and all of the first course of therapy elsewhere.
- 1- First diagnosed and all or part of the first course of therapy at the reporting institution.
- 2- First diagnosed elsewhere and treatment plan developed and documented and/or the first course of therapy given at the reporting institution after the reference date.
- 3- First diagnosed and all of the first course of therapy elsewhere.
- 4- First diagnosed and first course of therapy at the reporting institution before the reference date of the registry.
- 5- First diagnosed at autopsy.
- 6- Diagnosed and all of the first course of treatment only in a staff physician's office.
- 8- Diagnosis established only by death certificate.

Primary Site	Cases	Class of Case		Sex		Mixed AJCC Stage at Dx					
		A	N/A	M	F	0	I	II	III	IV	UNK
Urinary Tract	40	35	5	27	13	12	10	3	4	7	4
Kidney	9	8	1	4	5	0	3	1	2	3	0
Renal Pelvis & Ureter	3	3	0	2	1	0	1	0	1	1	0
Bladder	28	24	4	21	7	12	6	2	1	3	4
Eye, Brain & Other CNS	7	6	1	2	5	0	0	0	0	0	7
*Brain	7	6	1	2	5	0	0	0	0	0	7
Thyroid & Other Endocrine Glands	7	7	0	3	4	0	3	0	2	0	2
Thyroid	6	6	0	2	4	0	3	0	2	0	1
*Other Endocrine	1	1	0	1	0	0	0	0	0	0	1
Hodgkin's / Non-Hodgkin's	30	26	4	17	13	0	8	9	4	6	3
Hodgkin's Lymphoma Nodal	4	3	1	3	1	0	1	2	0	1	0
Non-Hodgkin's Lymphoma Nodal	19	18	1	10	9	0	4	6	4	4	1
Non-Hodgkin's Lymphoma Extranodal	7	5	2	4	3	0	3	1	0	1	2
Other / Unknown	13	13	0	5	8	0	0	0	0	0	13
Other	2	2	0	1	1	0	0	0	0	0	2
Unknown Primary	11	11	0	4	7	0	0	0	0	0	11
Totals	591	527	64	289	302	48	108	126	72	115	122

*includes one (1) benign brain tumor and one (1) benign other endocrine tumor.

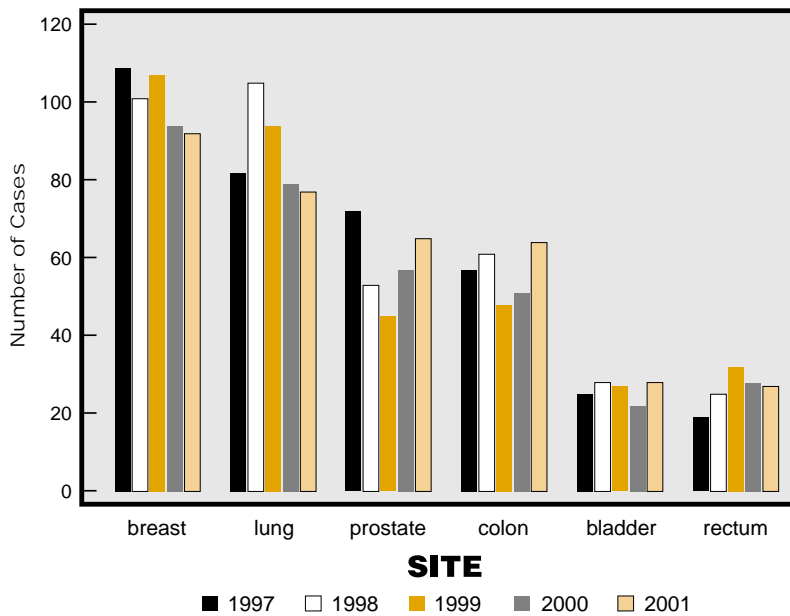
LAH - 2001 Most Common Primary Sites



Latrobe Area Hospital Top Most Common Primary Sites

At Latrobe Area Hospital, Breast, Lung, Prostate, and Colon cancers have remained the top most frequently occurring primary sites. The number of Breast and Lung cancers has remained fairly stable over the last two years but does show a decline compared to the prior three years. In contrast, the number of Prostate and Colon primary cancers has increased by 14 percent and 25 percent respectively in 2001 compared to 2000. There appears to be no decline in occurrence over a five-year span for these two sites. The occurrence of bladder and rectum cancers has also remained stable at Latrobe Area Hospital. In 2001, Corpus Uteri, non-Hodgkin Lymphoma, Melanomas and Pancreas cancers complete the list of the ten most frequently occurring primary sites.

Most Common Primary Sites





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