





Comprehensive Cancer Care For Our Community

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# **2004** Annual Report of the Cancer Program

2003 Statistical Review of Bay Medical Center's Cancer Registry Data

Bay Medical Center 615 North Bonita Avenue Panama City, Florida 32401

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#### Chairman's Report



Two-thousand and three marks the ninth year that Bay Medical Center has had an active cancer registry, recording important data on cancer patients, in Bay County and other surrounding counties. The tumor registry reference date is January 1995. In 2003, there were 669 new cancer cases entered into the registry. This was a slight increase from the year 2002. The cancer registry has accessioned over 3,514 cancer cases.

The past two years have also been a proliferation of new advances in cancer. To begin with technical achievements in surgery mark the advent of newer approaches in the management of patients with cancer (i.e. being sentinel lymph node biopsies in breast cancer patients).

Radiation therapy planning, as well as newer techniques such as the stereotactic approach to a localized area, is continuing to improve radiation therapy. There has also been a burgeoning of new chemotherapy and biotherapies to advance the treatment of cancer. The Cancer Registry must maintain an active role in tracking these patients and record the multi-disciplinary management.

Physicians who specialize in the Oncology field and have a practice in this community can help to sustain a great cancer registry. However, without strong community physician support, it would be difficult. We must continue to strive to keep cancer registry data accurate. I strongly suggest that family, urology, internal medicine and surgical sub-specialties play a crucial role in the entry of cancer patients into the data stream. The members of Bay Medical Center's Cancer Committee believe it is important to make decisive actions to avoid inaccuracies within the registry. The Cancer Committee is a multi-disciplinary committee consisting of surgeons, radiation oncologists, medical/hematology oncologists, pathologists and radiologists, as well as other non-physician members. The cancer committee meets at least four times a year to ensure that all Cancer Program Standards required by the American College of Surgeons are completed yearly.

Cancer Conferences are held bi-monthly at Bay Medical Center and cases are presented to the medical community by those who are directly involved with oncology care. This allows for many individuals in the medical field to see how patients are diagnosed, counseled, treated and supported. Cancer from a wide variety of sites is presented. Combined chemotherapy and radiation therapy has become the standard of care with many different cancer types. There were over 65 cancer patients presented in 2003 with the majority of these representing lung cancer, breast cancer and colorectal cancers.

Attendance at the conference grants physicians, as well as other credentialed medical personnel, Continuing Medical Education (CME) Units. They receive one (1) hour for each cancer conference they attend. All of the specialists involved in cancer care, as well as many ancillary staff, contribute to what has become an excellent teaching conference.

From a perspective of medical oncologists, we often have many therapies to choose from, some with divergent outcomes and others with similar survival outcomes. However, it is the collegiality that is the cornerstone of teaching. Surgeons, as well as radiologists, discuss the

best approach to diagnosis and interventional studies. Radiation oncologists provide treatment planning and now more than ever, work in close affinity to medical oncologists due to the increase in combined cancer treatments.

Quality Improvement/Enhancement Studies are conducted on a yearly basis. Due to increased concern with physician liability, the Cancer Committee decided that a study regarding yearly health screenings needed to be performed. Cancer Committee physicians were also concerned about Breast Cancer therapies and how they may or may not differ when Sentinel Lymph Node biopsies are performed.

Bay Medical Center promotes and supports programs such as the Relay for Life and Cancer Education and Awareness Seminars. The American Cancer Society provides support and educational groups such as I Can Cope, Reach to Recovery, Bosom Buddies, etc. Bay Medical Center refers patients to these support groups when they have been diagnosed with cancer. We also encourage the development of more support groups in disorders such as ovarian, pancreatic and colorectal carcinoma. There is also a host of other support groups available in our community and we encourage these groups to be as proactive as possible.

When one looks at the Cancer Registry spherical graph, it reveals again, that just like the rest of the nation, we are plagued by lung, breast and colorectal cancers. These malignancies are often smoking related, and because of this, smoking cessation programs are readily available. Breast cancer and colon cancer both may have genetic, as well as dietary, risks. The graph mirrors, as I noted in the United States graphs, the histological descriptions of the registered malignancies which is provided for your review. The gender and age difference noted show the ranking of lung, breast, colon and prostate cancer. These have remained in relative balance since 2002. With our better understanding of the immune system, we have noted that as the immune system ages the malignancies dramatically increase in the 50-59 year old age group. Thereafter, they continue to increase thereafter until the age of 90. Males still have a higher rate of malignancy at the present time.

Two Patient Care Evaluation/Site Studies were performed during 2003, breast and colon. Local, regional and national statistics were evaluated in regards to breast cancer. Further review of the breast cancer study is found in this report. I hope that these updates will provide you with useful data to take back to your practices.

Thank you,

John & Janpro

John J. Nanfro, M.D., F.A.C.P. Chairman, Cancer Committee

# **Bay Medical Center Cancer Registry Statistics**





# Bay Medical Center Cancer Registry Statistics





					Duinoan	Cito To	hla				A 100	Sta	205		
Primary Site Oral Cavity	<u>Total</u>	<u>Percent</u>	M	E	<u>Analytic</u>	Non-An	Alive	<u>Expired</u>	<u>o</u>	1	<u>2</u>	<u>3</u>	<u>4</u>	<u>99</u>	<u>88</u>
Tonque	6	0.9	4	2	5	1	6	0	0	1	1	1	2	0	0
Salivary Glands	3	0.0	3	0	3	0	3	0	0	0	ò	1	2	0	0
Gum & Other Mouth	3	0.4	3	0	3	0	3	0	0	1	2	0	0	0	0
Nasonbaryny	1	0.4	1	0	0	1	0	1	0	0	0	0	0	0	0
Tonsil	6	0.1	4	2	5	1	2	4	0	1	1	0	2	1	0
Orophan/ny	1	0.5	4	1	1	ò	1	4	0		1	0	0	0	õ
Hypophanyny	1	0.1	0	1	1	0	1	0	0	0	0	0	1	0	0
Other Oral Cavity	3	0.1	0	1	0	1	0	1	0	0	0	0	0	0	0
Digeotivo	5001	0.1	U		0	1.C	U		U	U	0	U	U	U	U
<u>Digestive</u>	14	0.4	0	5	10		0	F	0	2		2	4	2	0
Esophagus	14	2.1	9	5	13		9	5	0	3	4	2	1	3	0
Stomach	0	0.0	3	4	0	ģ	4	3	0	2	0				
	2	0.3	1	1	2	0	2	10	0	0	0	10	0	0	2
Colon	61	9.1	35	26	54	1	49	12	0	14	21	13	5	1	0
Rectosigmoid Junction	3	0.4	2	1	3	0	3	0	0	0	1	1	0	0	1
Rectum	21	3.1	13	8	17	4	16	5	0	3	2	1	5	5	1
Anus and Anal Canal	4	0.6	2	2	4	0	1	3	0	2	1	1	0	0	0
Gallbladder	2	0.3	0	2	2	0	1	1	0	0	1	0	1	0	0
Pancreas	15	2.2	9	6	14	1	6	9	0	1	4	0	7	2	0
Respiratory Tract															
Nose, Nasal Cavity	2	0.3	2	0	2	0	2	0	0	2	0	0	0	0	0
Larynx	13	1.9	11	2	11	2	10	3	1	5	1	2	2	0	0
Lung & Bronchus	154	22.9	93	60	140	13	72	81	0	30	5	44	52	8	1
Soft Tissue Soft Tissue - Incl Heart	3	0.4	3	0	3	0	3	0	0	0	0	1	0	0	1
<u>Skin</u> Malanama	22	2.2	11	11	17	5	20	2	5	٥	2	0	1	0	0
Other Skip	1	0.1	4	0	1	0	20	2	0	9	4	0	0	0	0
Samela Sites		0.1		0		U	3.6	U	U	U		U	U	U	0
Female Sites	101	10.0	•	400	100	00	445	10	45	45	24				•
Breast	131	19.6	3	128	108	23	115	16	15	45	31	11	5	1	0
Cervix Uteri	5	0.7	0	5	4	1	5	0	1	1	1	0	1	0	0
Corpus Uteri	1	1	0	1	/	0	4	3	0	2	1	1	0	1	2
Ovary	10	1.5	0	10	7	3	8	2	0	2	0	2	3	0	0
Vagina	2	0.3	0	2	1	1	1	1	0	0	0	0	1	0	0
Vulva	1	0.1	0	1	1	0	1	0	1	0	0	0	0	0	0
Male Sites															
Prostate	48	7.2	48	0	41	7	44	4	0	0	36	4	1	0	0
Testis	2	0.3	2	0	2	0	2	0	0	0	1	0	0	0	1
Penis	1	0.1	1	0	0	1	1	0	0	0	0	0	0	0	0
Urinary System															
Bladder	27	4	16	11	20	7	20	7	13	4	1	1	1	0	0
Kidney & Renal Pelvis	25	3.7	12	13	20	5	20	5	1	10	3	3	1	2	0
Ureter	2	0.3	1	1	2	0	2	0	0	2	0	0	0	0	0
C. N. System															
Brain	3	0.4	1	2	2	1	3	0	0	0	0	0	0	0	2
Cranial Nerves	3	0.4	2	1	2	1	3	0	0	0	0	0	0	0	2
Endocrine System	•	10	51 <b>2</b> 5	-	•		•	•	•	-	•			•	•
I hyroid	9	1.3	4	5	8	1	9	0	0	5	2	0	1	0	0
Lymphoma	0			2		120	•	•	•	•	0	~	•	12	•
Hodgkin's-Nodal	2	0.3	1	1	1	1	2	0	0	0	0	0	0	1	0
Non-Hodgkin's Nodal	13	1.9	8	5	9	4	9	4	0	0	2	4	3	0	0
Non-Hodgkin's Ex-nodal	4	0.6	4	0	3	1	2	2	0	1	0	0	1	0	1
<u>Bone Marrow</u>															
Myeloma	3	0.4	1	2	1	2	2	1	0	0	0	0	0	0	1
Leukemia															
Acute Lymphocytic	1	0.1	0	1	1	0	1	0	0	0	0	0	0	0	1
Chronic Lymphocytic	3	0.4	3	0	1	2	3	0	0	0	0	0	0	0	1
Mesothelioma															
Pleura	2	0.3	2	0	2	0	1	1	0	0	1	1	0	0	0
Miscellaneous															
Unknown, III-Defined	18	2.7	9	9	14	4	7	11	0	0	0	0	0	2	12
Total	667	100%	328	339	564	103	480	187	37	146	127	95	100	28	30

# 2003 Cancer Registry Report

Bay Medical Center's Cancer Program was established on January 1, 1995. The Cancer Registry data is maintained by using the IMPAC Cancer Registry Software Program designed for collecting, following, managing and analyzing cancer data. The Cancer Registry Coordinator analyzes data based on the patient's medical record and enters it into the computerized registry software. All reportable cancers are abstracted within six (6) months of the diagnosis date and/or the first date of contact with the patient. Accession numbers are assigned to patients based on the year in which they are diagnosed or the year of the first date of contact with the patient.

In 2003, there were 669 new cancer cases accessioned into the cancer registry. This gives the registry a total of 3,514 cases entered since the reference date.

In this report, the Primary Site Table is an anatomical breakdown of all the cancers reported by Bay Medical Center in 2003 detailing the site, sex, class of case, survival status and AJCC Stage.

Class of Case is determined by place of diagnosis and/or treatment.

Class of Case 0 – Diagnosed at reporting facility and all of first course of therapy elsewhere

- **Class of Case 1** Diagnosed at reporting facility and all/or part of first course of therapy at reporting facility
- **Class of Case 2** Diagnosed at elsewhere and all/or part of first course of therapy at reporting facility
- Class of Case 3 Diagnosed and all of first course of therapy elsewhere
- Class of Case 4 Diagnosed at reporting facility prior to the reference date
- **Class of Case 5** Diagnosed at autopsy
- Class of Case 6 Diagnosed and first course of therapy at physician's office
- Class of Case 7 Pathology report only, patient never entered reporting facility for diagnosis and/or treatment
- **Class of Case 8** Diagnosed by death certificate only
- Class of Case 9 Unknown

The Frequency of Cancer Graph represents the most common cancers diagnosed and or treated here at Bay Medical Center. Lung cancer (154) was the most common, followed by Breast (131), Colon/Rectum(85), Prostate (48), Bladder (27), Kidney/Renal Pelvis (25), Melanoma (22) and Lymphoma (19).

The Histology Frequency graph gives detail to the specific number of patients diagnosed with Adenocarcinoma (145), Ductal Carcinoma (83), Large Cell Carcinoma (58), Squamous Cell Carcinoma (53), Carcinoma, NOS (25), Melanoma (22), Small Cell Carcinoma (20), Renal Cell Carcinoma (15) and Papillary Transitional Cell Carcinoma (12).

The Age at Diagnosis graph specifies the age groups for males and females according to their age at diagnosis.

The Analytic AJCC Stage by Sex graph specifies the number of both males and females for each AJCC Stage Group. This graph includes only the analytical cases which are required to be staged by the managing/treating physician.

Bay Medical Center provides Bay County with yearly cancer education seminars and/or screenings. This, along with early diagnosis and treatment increase the long-term survival for Cancer patients.

In October of 2003, a Breast Cancer Screening was held here at Bay Medical Center. Free mammograms were offered to those who attended the screening and had a manual breast exam performed.

It is very important for cancer patients to maintain regular follow-up visits with their physician(s) who administer cancer related therapy. Early detection of a cancer recurrence is necessary in order to try to control the spread of disease.

# **2003 Cancer Program Activities**

April 2003 – Relay for Life – Held at Bay County Fair Grounds (Panama City) and J.R. Arnold High School (Panama City Beach) October 2003 – Breast Cancer Screening – Held at Bay Medical Center

October 2003 - Prostate Cancer Screening - Held at Gulf Coast Medical Center

# **2003 Support Programs and Services**

Support groups are available to cancer patients and their families. These groups are usually sponsored by the American Cancer Society. The following is a list of a few of the support groups available in this area.

- I Can Cope Cancer patients and their loved ones learn to cope with the cancer by increasing their knowledge of the disease, learning how to deal with cancer with a positive attitude and the skills needed in a supportive environment
- Reach to Recovery Trained volunteers who support and comfort patients before, during and after breast cancer treatments
- Look Good...Feel Better This is a free service offered to women, which teaches beauty techniques to help enhance appearance and self-image during treatments.
- Man to Man This program assists men and their families in coping with prostate cancer. It provides support, educational information and awareness of prostate cancer as a major health concern for all men.
- Tender Loving Care "tlc" A magazine that combines helpful articles and information with products for women coping with cancer treatments. Products such as wigs, mastectomy forms and products and a large selection of hats and head coverings are available.
- Solution Buddies A long-term support group for women with breast cancer
- Road to Recovery A free transportation service provided to patients needing rides to their doctor's appointments and treatment sessions.
- Still Coping An ongoing support group for patients and their families dealing with any type of cancer.
- Panhandle Lost Cord Club A support group for laryngectomy patients and their families.

# 2003 Cancer Committee

Steven Kinsey, M.D. General Surgery Chairman

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Gregory Morrow, M.D. Obstectrics/Gynecology

Nicole Eisenbrown, M.D. Urology

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Chris Olsen, M.D. Pathology

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Rhonda Daniel, M.S.W. Resource Management

Karen Myers Cancer Registry Assistant

Cindy Shipman Nutrition Services

### 2003 Cancer Conference Presentations

Bay Medical Center and Gulf Coast Medical Center have monthly Shared Cancer Conferences. Bay Medical Center's Cancer Conference is held on the second Tuesday of each month. A variety of cases are presented by the Managing/Treating Physicians. Physicians representing Surgery, Pathology, Radiology, Medical Oncology, and Radiation Oncology attend the monthly conferences and discuss cases and treatments in detail. The various sites discussed at conferences during 2003 are listed below.

Bladder	Blood	Bone
Bone Marrow	Brain	Breast
Colon	Ear	Esophagus
Gallbladder	Gastric	Kidney
Larynx	Liver	Lung
Lymph Node	Nasal	Pancreas
Prostate	Rectum	Skin
Small Bowel	Stomach	Testicle
Thigh	Thyroid	Tongue
Tonsil	Unknown Primary	Uterus
Vocal Cord	-	

# Glossary

AJCC TNM Stage – A staging system developed by the American Joint Committee on Cancer. The tumor (T) stage is determined by the size and/or depth of invasion of the tumor, lymph node (N) involvement, and distant metastasis (M), which is the spreading of the cancer to distant sites. For applicable sites the T, N, and M determine whether the stage is I, II, II or IV. Higher staged cancers usually have a poor prognosis.

Analytic Cases – Cancer cases diagnosed and/or treated for all or part of their first course of therapy at BMC, or cases meeting other standards, which require patient follow-up (Class of Case 0, 1 and 2).

Approved Cancer Program – A cancer program that has been successfully passed a survey required by the American College of Surgeons.

Class of Case – Divides the data into analytic and non-analytic categories (determining factor for whether or not patients are followed after being diagnosed)

First Course of Therapy – The initial cancer directed treatment of series of treatments administered within four months after diagnosis.

Histology – The specific cell type given to a tumor or a specimen from a biopsy and/or surgical resection.

Non-Analytical Case – Cancer cases diagnosed and all of first course of therapy administered elsewhere, or a case not meeting other standards that require patient follow-up (3, 4, 5, 8 and 9).

Neoplasm – An abnormal growth of malignant cells that often spreads if not treated in the early stages and then at times it still spreads after receiving cancer therapy.

**Reference Date –** The date in which a cancer program begins collecting cases. The date is always January 1<sup>st</sup> of the given year.

#### **2004 Patient Care Evaluation Study**

#### **Breast Cancer**

Breast Cancer is presently the most common malignancy occurring in women in the United States. However, 80 to 90% of breast problems are caused by benign diseases. There were over 200,000 estimated new cases of Breast Cancer in 2004 and about 88% of those will be tumors that are invasive beyond the micro-environmental structures of the breast. Breast Cancer is the second leading cause of mortality in women, amounting to almost 48,000 deaths annually. As you can see from the graphs provided, the risk for developing breast cancer clearly increases with age. The age groups from 50 to 89 had the highest incidence levels (**Graph 4**). This corresponds statistically to nationwide levels. The incidence of Breast Cancer is gradually increasing which may be an effect of better diagnostic tools. Early detection is the key to successful outcome, and therefore, breast cancer education is extremely important. Education, includes awareness of the problem, regular self-examination, history and physical by the family physician and the appropriate referral for mammograms and ultrasounds, and if necessary, surgical evaluation.

Minimally invasive surgeries like lumpectomy, quadrantectomy and sentinel lymph node dissection result in preservation of the breast, producing good cosmetic results without compromising the principles of cancer surgery. About ten years ago when Breast Cancers presented in advanced stages, radical mastectomies and extended radical mastectomies were the rule. We have come a long way. Today, the results of a lumpectomy with radiation, allowing preservation of the breast, are similar to radical procedures.

Certain risk factors should be recognized for more aggressive evaluation:

- 1. Increasing age
- 2. African-American race
- 3. Age at menarche, less than 11 years
- 4. Age of menopause, age 55 or above
- 5. Multiparity
- 6. Age at first pregnancy, 30 years or above
- 7. Breast feeding
- 8. Genetic mutation like BRCA-1, BRCA-2, P-53 etc.
- 9. Family history of Breast Cancer with multi-relatives (early onset of the onset with bilateral disease)
- 10. Family history of other cancers like Ovarian Cancer, multiple relatives affected by cancer with early onset, etc.
- 11. Previous Breast Cancer
- 12. Previous breast problems with breast operations, biopsies
- 13. Previous exposure to radiation
- 14. Pathological findings of atypia, LCIS, proliferative, fibrocystic disease

Even though a strong family history of cancer is a high risk, the majority of Breast Cancers have no family history of Breast Cancer (**Graph** 7).

Fortunately, in Bay County we have an excellent, well coordinated cancer program. We have the availability of exceedingly, well trained family physicians, good radiology service,

experienced general surgeons having keen interest in treating breast disease and excellent medical and radiation oncologists. We are seeing more and more cancers in the early stages requiring minimally invasive surgeries with radiation and preservation of the breast. However, this could be further improved by further educating the community.

Last year, Bay Medical Center reported 108 patients with breast cancers and 60% of them had Stage 0 and Stage I disease, 30% had Stage III and the rest Stage IV. We had eight percent mortality from the disease (**Graph 6**).

Currently, breast-conserving surgery followed by radiation therapy is the standard of care for Stage I and II Breast Carcinoma. The NSABP B-06 trial, which involved more than 1000 patients, showed that irradiation of the ipsilateral breast reduced local recurrence rates from 36% to 12%. Usually 4500 cGy is given to the breast and then a boost with electrons (1620 cGy) is given. The total dose to the lumpectomy site is about 6120 cGy. The patients with negative axillary nodes do not get the axilla or ipsilateral supraclavicular areas irradiated. Over the last five years here at Bay Medical Center Department of Radiation Oncology, there has been over a 98% rate of local tumor control in the ipsilateral breast. Also, those patients who are postmastectomy, pre-menopausal and have positive axillary nodes benefit from chest wall and local nodal irradiation. This is supported by the British Columbia trial which showed the local recurrence was reduced by 33% and a 29% reduction in mortality. Most patients get their chemotherapy before radiation therapy in order to lessen the toxicity. The above schedule is usually tolerated quite well.

Recently, there has been an interest in shortening the time of irradiation to Stage I and Stage II patients with use of Brachytherapy (MammoSite Radiation Therapy System) devices using iridium and irradiating the lumpectomy site only. Data is being collected and long term follow-up is needed before replacement of the current standard of treatment will be changed.

We have specific studies that are run here in our community which aid us in deciding upon the appropriate form(s) of therapy for patients with Breast Cancer. These include the estrogen/progesterone receptor status, the Her-2 Neu antigen expression, the Ki-67 status and the DNA index. We also take into account the size and age of the patient, whether or not there are positive lymph nodes in the axilla or superclavicular region and whether there are distant metastasis. Hormonal improvements include the addition of the aromatase inhibitors such as Arimidex, Femara and Aromasin. There has also been the introduction of the use of Faslodex, which acts similar to the agent Tamoxifen, as an intramuscular injection once a month. Tamoxifen use is now used predominantly in the pre-menopausal, estrogen/progesterone positive patients and the aromatase inhibitors are used in the post-menopausal female. There are recent reports of ovarian suppression in pre-menopausal women. There is recent data that suggests that after five years of Tamoxifen the patients benefit from continued use of Femara in terms of survival projected to the ten to fifteen year mark. Recent data includes using ovarian suppression in pre-menopausal females with Zoladex or Lupron plus an Aromatase Inhibitor may be more effective than Tamoxifen. The extended analysis of this data is still pending. There are standard regimens used in treating Breast Cancer; the most common being Adriamycin Cytoxan (AC), Cytoxan Methotrexate 5-FU (CMF), as well as others. The newer regimens such as Taxol, Carboplatin and Herceptin have significant activity, but not without increased toxicity. Females treated with Zoladex or Lupron and Aromatase inhibitor may be more effective than Tamoxifen. Other regimens with increased toxicity, but increased benefits in the more advanced cases of

Breast Cancer, are Gemsar Taxol (GT) and Navelbine Taxotere (NT). There is also new data to indicate that "Dose Dense Therapy", or giving therapy every two weeks along with growth factors, may lead to higher initial responses. For medical oncologists, the key endpoint is always whether this is an overall survival advantage. Studies which will determine these elements take many years to complete. As many patients as possible should be placed on clinical trials, including those patients of Bay County. As far as the age of diagnosis that corresponds to the 50-79 year old group as noted (**Graph 4**), Ductal Carcinoma is the most common (**Graph 3**) and surgery is performed in the majority of patients as well as chemotherapy and radiotherapy being frequently administered (**Graph 5**). Most patients present as Stage I disease and one can look at the genetics and determine that more patients do not have a family history than actually do have a family history (**Graph 7**). These are relative and overall there is still a fairly high number of patients having family association.

Tobacco use is associated, as noted by the graphs, with an increased sense of breast cancer (**Graph 8**). In the realm of Breast Cancer, survivals have definitely improved from 1950 to 2003. Survival has increased nearly 20-25% with the advent of newer surgical techniques, chemotherapy and radiotherapy (**Graph 1 and Graph 10**).

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### **2003 Breast Cancer Study**

### **Statistical Graphs**









#### **2003 Breast Cancer Study**

### **Statistical Graphs**









### **2003 Breast Cancer Study**

### **Statistical Graphs**







