It is my privilege to submit Cape Canaveral Hospital (CCH) Cancer Committee Chairman’s Report for 2010. Our Cancer Program Committee members, along with this hospital’s Medical Staff, and affiliate service organizations provided many comprehensive and diverse initiatives in 2010, which are covered in this report.

Funding was approved for a new three-year pilot Health First program to sponsor a congregational nurse at two Brevard County, Florida churches—Holy Trinity Church in Melbourne and Grace United Methodist Church on Merritt Island. The two “parish nurses” participating in the pilot program provided screening and health information to members of the two congregations. Depending on how well the program continues to be received, it may be expanded to other Brevard congregations. Also, The New Voice Club, a support group for post-laryngectomy patients, continues quarterly with meetings in South Brevard. The Wound Ostomy Department provided patients with advanced, low-air-loss surface beds, which helps with pressure distribution and improved pain relief for cancer patients.

Many cancer-related educational opportunities were also presented to Medical Staff members as well as hospital staff. On March 29, 2010, Dr. Surbhi Jain, from the Department of Neuro-Oncology at Moffitt Cancer Center in Tampa, Florida, presented Grand Rounds on “Brain Mapping for Surgical Management of Primary and Metastatic Brain Tumors.” On October 18, 2010, Dr. Firas Muwalla, Board-certified Medical Oncologist from Space Coast Cancer Center, presented a “TNM and AJCC Staging Update.” Health First’s Center for Learning offered 12 programs with Nursing Continuing Education Credits. In September 2010, the Florida Space Coast Chapter of Oncology Nursing Society (ONS) sponsored “The Oncology Potpourri” day-long educational opportunity for Oncology nurses. Ms. Denise Gangraw, RN-BC, MSN, OCN, who is among the first in the United States to be certified as a Nursing trainer in the new ONS teaches “Treatment Basics: Antineoplastic Therapy in the Non-Oncology Setting,” a four-hour course for nurses. It should be noted that 17 Chemotherapy-certified nurses and three ONS-certified nurses care for patients on the CCH Oncology Unit. There are two additional Chemotherapy-certified nurses who work on other floors at CCH. Dr. Al Pecoraro, a Board-certified General Surgeon, was reappointed as our Cancer Liaison physician by the American College of Surgeons (ACoS) Commission on Cancer (COC). He attended the clinical congress in Washington DC from October 3 to 4, 2010, and presented the proposed COC Standards to our Cancer Committee.

Ms. CarolAnn Muir, Cancer Registrar, received the Jean Byers Award for Excellence in Cancer Registration from the State of Florida. The Health First Diagnostic Center at Sykes Creek was awarded American College of Radiology (ACR) certification in CT and MRI scanning. The Women’s Diagnostic Center and Health First Diagnostic Center at Merritt Island both received a three-year ACR Accreditation for Mammography.

Enhancements in community service included additional nutritional education for the management of percutaneous endoscopic gastrostomy (PEG) feeding tube placement for patients. The Men’s Health Summit (free Prostate Cancer Screening event targeting men at higher risk and less preventive care access) was offered June 12, 2010, at Brevard Community College in Cocoa. A total of 111 men were screened. Dr. Todd Panarese, Board-certified Radiation Oncologist at Cancer Care Centers, and CCH Cancer Registry staff participated in the screening event. At the annual Skin Cancer Screening
event on May 15, 2010, 50 patients were screened by Dr. Cynthia Halcin, a Board-certified Dermatologist, who volunteers for this event on an annual basis. The Social Services and Case Management Departments’ staff identified cancer patients and provided them with information about healthcare resources, including an opportunity to be referred to the American Cancer Society (ACS). The CCH Resource Center continues to offer Oncology binders for patients as well as computer access for patient and family members to use in addition to packets of information discussing various cancer diagnoses, treatments, and psychosocial topics. Hospice of Health First again sponsored and offered Camp Bright Star, a one-day workshop for children who have lost loved ones to cancer and other diseases.

In 2010 there were a variety of fundraising activities. The Oncology Unit received $11,000 from CCH Auxiliary’s annual Lights of Love fundraiser, which was used to purchase three outpatient chemotherapy chairs equipped with heat and massage that can be used by cancer patients. The American Cancer Society (ACS) Making Strides Against Breast Cancer Walk on October 23, 2010, was attended by 7,000 participants and raised $375,000. The ACS offers scholarships to students who are cancer survivors, provides information on clinical trials, and assists with community cancer screening programs. Additionally, the 2010 Cattle Barons Ball raised more than $100,000 for the ACS.

Our Cancer Committee also completed and presented several Quality studies in 2010.

- One study on breast MRI criteria reviewed and summarized criteria from all insurance companies for approval for breast MRIs. The information from the breast MRI insurance criteria is now available to physicians and patients.
- A second study evaluated the impact of the current economic recession on cancer screening by comparing the stage and distribution of screening-related cancers with previous years. In addition, many insurance companies started no longer requiring a co-pay for some screening studies beginning January 1, 2011. Our Cancer Committee will assess if this change increases compliance and participation with screening guidelines. Our current results identified a steady decline in screening mammograms and screening colonoscopies from 2005 through 2009. The cause may be multifactorial, but it is believed that economic aspects are most likely involved.
- A third study evaluated cancer patients treated at CCH compared to cancer patients at other hospitals in Brevard County, Florida, and throughout the United States to determine if cancer patient distribution by diagnosis is similar, or if there were significant variations in the types of cancer diagnosed and treated at CCH. We found that 14% of Brevard County cancer cases were treated at CCH.
- On the inpatient Oncology Unit a study to properly identify skin breakdown issues in cancer patients admitted to 2 North, 4 East-West, and 7 North Units was completed. Additionally, monitoring and identifying fall prevention status among Oncology patients on the same floors was performed by Oncology nurses. The continuing goal is to decrease skin breakdown (decubitus events) and falls while patients are hospitalized. These studies showed that in 2010 there was increasing compliance in each quarter with respect to skin care and that falls prevention was slightly below goal in the 1st Quarter of 2010, but achieved goal in the remaining three quarters.
- Finally, the Pharmacy Department completed a study monitoring erythropoietin-stimulating agents (ESAs) in the hospital.

The new AJCC Staging Manual, 7th edition, was made available to all CCH Medical Staff members on January 1, 2010. This manual will assist physicians with staging cancer by utilizing complete and current AJCC criteria. Additionally, the new manual assists surgeons in clinically staging Breast Cancer patients prior to surgery.

The members of our Cancer Committee are dedicated to serving our community. We believe it is an honor to be given the opportunity to help direct and advance the medical care of cancer patients as well as provide support and continuing Oncology education for caregivers.

Respectfully submitted,

Richard M. Levine, MS, MD
Chairman, Cape Canaveral Hospital Cancer Committee and Cape Canaveral Hospital Program Advisor
Cape Canaveral Hospital was a Commission on Cancer (CoC)-approved program in 2010. Serving as our Cancer Program’s Cancer Liaison Physician (CLP) and Community Outreach Coordinator and with the help of our Cancer Committee, I have continued striving to keep and sustain a very close relationship with the American Cancer Society (ACS). Being a member of our local ACS Unit Board I hope to continue that strong relationship. My continued support for all fundraising efforts, including the annual Cattle Barons Ball, will remain a priority in my community endeavors.

The areas of focus of our Cape Canaveral Hospital Cancer Committee, of which I am a member, in 2010 included the continued implementation of the Commission on Cancer’s (COC) new Standards, especially as they relate to collaborative staging, as well as participating in continued review of our cancer cases, and participation and submission of our data to the National Cancer Data Base (NCDB) and individual case review by our Tumor Board.

The decision was made not to re-certify with the COC in 2011. Even though this prevents Cape Canaveral Hospital from continuing as an American College of Surgeons COC-certified site, we will continue offering the high quality of cancer care and processes as they relate to comprehensive cancer care and evaluate and improve these to best serve our patients.

Respectfully submitted,

Alphonse Pecoraro, MD
Cancer Liaison Physician and Community Outreach Coordinator
CCH Cancer Program
Our Tumor Board at Cape Canaveral Hospital convenes every month to discuss six pre-selected patients with malignant tumors. Tumors selected must fulfill the mandatory quota set by The American Joint Committee On Cancer (AJCC) for the top five malignant tumor sites in the practice setting for this hospital. Tumors from these sites, together with tumors from other sites, are often rare or of interest due to clinical and radiologic presentation or unusual pathology.

Cases to be presented are requested by clinicians or chosen by Dr. Charles. All physicians on the Tumor Board Committee attend the conferences together with any other physician involved in the care of the patient to be presented. Any others involved in medical care are most welcome to attend. A case is thus discussed from the onset of clinical problems through diagnostic testing up to diagnosis and treatment or post-treatment analysis. If the patient has undergone surgery then the surgical procedure is discussed. Likewise, if chemotherapy or radiotherapy has been initiated, this too is discussed. Finally, a consensus approach to further treatment options and follow-up care are addressed. Therefore, most cases are prospective in nature.

The National Comprehensive Cancer Network Guidelines are accessed in an online format for treatment option discussions. Tumor staging is based on *The AJCC Staging Manual (7th edition)*. Utilizing advanced technology, such as the PACs radiology system digital scans of gross specimens and microscopic slides, adds a further dimension to the conference. Discussions are diverse and informative with all present improving their range of medical knowledge.

A summary of all cases discussed is also presented to the Cape Canaveral Hospital Cancer Committee on a quarterly basis by Dr. Charles in accordance with American College of Surgeons’ Commission on Cancer Standard 2.8.

Special acknowledgment is given to CarolAnn Muir, our Cancer Tumor Registrar, as well as Diane Sullivan, our Cancer Registry Data Assistant, for all of their difficult and conscientious work in organizing Tumor Board meetings; preparing synopses of patient histories; as well as researching, correcting, and systematizing the vast amount of available data for each tumor case.

Respectfully submitted,

Jonathan Charles, MD
Tumor Board Coordinator
Cape Canaveral Hospital Cancer Program
Two thousand and ten was a challenging year for Cape Canaveral Hospital as well as for our patients. Economic realities sometimes change the way we do things, including how and where patients seek out health care, recommendations for treatment, and decisions on how those recommendations are implemented. The Cancer Program Committee asked several questions to try to improve access to health care at Cape Canaveral Hospital, while ensuring compliance with standard practice guidelines, by conducting the following studies:

- The first study sought to compare top insurance companies’ guidelines for breast MRIs. All the insurers studied follow the base American Cancer Society (ACS) guidelines, with varying indications specific to each insurer. Consistent indications make it easier for the ordering physician to comply with each insurance company’s guidelines and thus improve reimbursements without delays. It also ensures that the indications remain current with evolving diagnostic improvements as well as standards of care.
- We also evaluated the impact of the recession on cancer screening by examining the stage distribution at presentation compared to previous years, as well as the number of screening tests performed, specifically mammograms and colonoscopies. We found that colonoscopy screenings peaked in 2009 for patients 50 to 59 years old, while mammograms peaked in 2008 for women 40 to 60 years of age. There was a decline in screenings for both groups since then. Certainly, this peak and decline may not be exclusively the cause and effect of the recession. It was difficult to separate stage at presentation, especially for colonoscopies, since the data includes both screening and diagnostic studies.
- Since Cape Canaveral Hospital shares the patient population with at least two other hospitals in Central and North Brevard County, we compared the percentages of various cancers seen at Cape Canaveral Hospital with the expected rates in the population and estimated our market share. We found that our hospital could do better to increase this market share, and that perhaps our data was underserved due to coding issues or patterns of care.
- Inpatients were evaluated for skin breakdown and falls on several Nursing units. The safety goals for falls and skin care were met and improved through the year—a tribute to our excellent Nursing staff and proactive administrative supervision and support.
- Finally, we examined the proper utilization of erythropoietin-stimulating agents (ESAs), since improper use may increase tumor progression and decrease overall survival in some patients. We noticed a decrease in the number of patients receiving these agents, with increased monitoring of hemoglobin and iron levels and improved adherence to indications.

These studies reflect our commitment to excellent, safe, and quality patient care.

Respectfully submitted,

Todd Panarese, MD
Cape Canaveral Hospital Program
Quality Improvement Coordinator
ABOUT CAPE CANAVERAL HOSPITAL’S CANCER REGISTRY

Cape Canaveral Hospital’s (CCH) Cancer Registry is a component of the CCH Cancer Program, which is overseen by the Cancer Committee. The Registry is required by Florida Statute to collect data on every cancer patient who is treated at our hospital. Treatment data is forwarded to the Florida Cancer Data System (FCDS) and the National Cancer Data Base (NCDB), which is a joint collaboration between the American College of Surgeons (ACoS) and the American Cancer Society (ACS). The data is analyzed and used to support research, create protocols for treatment, and track trends of incidence and survival. It is also used in the allocation of resources. Our Registry data is used within the facility to evaluate treatment and help identify areas for improvement in patient care. Registry data is subject to quality analysis review by a physician who ensures that accurate and complete data is entered for each patient.

SUMMARY OF CANCER REGISTRY DATA FOR 2010

From the time that Cape Canaveral Hospital (CCH) Cancer Registry began collecting data in 1994 through December 2010, a total of 9433 cases have been accessioned—4587 men and 4846 women. In 2010, 587 cases were added—294 men and 293 women. (See Graph 1 “Age and Sex of Patients at Diagnosis of Disease at CCH in 2010”.) There were 465 analytic cases (those patients diagnosed and/or treated at CCH) and 122 non-analytic cases (those who were diagnosed and treated somewhere else, but who had active disease when they came to CCH).

The Primary Site table (see Table 1 on the next page) shows the five cancer sites most frequently diagnosed at CCH in 2010 by sex, case classification, and AJCC staging of analytic cases.

Our Cancer Registry uses an electronic database to collect and analyze information on patient diagnosis, treatment, and follow-up. Each patient must have a complete record within six months of the date of first contact. This includes diagnostic information, details of surgical procedures, and systemic and/or radiation treatments. In 2010 patients were staged using the American Joint Committee on Cancer’s AJCC Staging Manual, 7th edition. Staging by the patient’s managing physician allows comparison of effectiveness of treatment modalities and provides research data for the development of treatment protocols. In 2010 our Registry received the Jean Byers Memorial Award for Excellence in Cancer Registration. This award is given for timely and accurate submission of Cancer patient data. A rate of 90% for annual follow-up of all analytic patients is required by the CoC. The CCH Cancer Registry currently maintains a rate of 95%.
**TABLE 1: 2010 TOP FIVE PRIMARY CANCER SITES AT CAPE CANAVERAL HOSPITAL**

The Primary Site Table below reveals anatomical sites for the five cancers that were most frequently either diagnosed and/or treated at Cape Canaveral Hospital (analytic) or diagnosed and treated elsewhere (non-analytic) but seen here for subsequent treatment for recurrence of the original.

<table>
<thead>
<tr>
<th>PRIMARY SITE</th>
<th>TOTAL</th>
<th>SEX</th>
<th>ANALYTIC</th>
<th>NON-ANALYTIC</th>
<th>AJCC STAGE (ANALYTIC CASES ONLY)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>M</td>
<td>F</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Breast</td>
<td>101</td>
<td>1</td>
<td>100</td>
<td>92</td>
<td>9</td>
</tr>
<tr>
<td>Lung &amp; Bronchus</td>
<td>80</td>
<td>42</td>
<td>38</td>
<td>67</td>
<td>13</td>
</tr>
<tr>
<td>Colon Rectum</td>
<td>53</td>
<td>29</td>
<td>24</td>
<td>43</td>
<td>10</td>
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<tr>
<td>Prostate</td>
<td>47</td>
<td>47</td>
<td>0</td>
<td>34</td>
<td>13</td>
</tr>
<tr>
<td>Urinary Bladder</td>
<td>42</td>
<td>34</td>
<td>8</td>
<td>29</td>
<td>13</td>
</tr>
</tbody>
</table>

CCH varies from the state and the nation in the age of patients at first diagnosis. (See Graph 2: “Comparison of Incidence of Cases Diagnosed at CCH, in Florida, and Nationally.”) The 30 to 39 and 50 to 69 age groups have lower rates of diagnosis but the rate of patients age 70 and older is higher at CCH than the national and state in the same age group. In Florida and nationally, the age of patients at diagnosis of cancer climbs steadily and peaks in the 60 to 69 age bracket. At CCH, however, the most frequent age at diagnosis is in the 70 to 79 age group. Comparatively CCH has a lower rate of diagnosis than the state or nation prior to age 70. This may be reflective of the patient demographic is in the CCH service area, which is apparently older than in other locales.

**GRAPH 2: COMPARISON BY AGE OF PATIENTS DIAGNOSED AT CCH, IN FLORIDA, AND NATIONALLY**

Data for these graphs and tables has been obtained from the CCH Cancer Registry database and the Commission on Cancer NCDB database.
Introduction:
Prostate Cancer is the second most common cancer in men worldwide, with an estimated 900,000 cases and 258,000 deaths annually. In the United States alone, it is estimated that there will be 240,890 new cases, approximately 29% of all cancers diagnosed. Prostate Cancer is the most common cancer diagnosis among men in the United States and the second most common cause of cancer death (33,720) here, representing 11% of U.S. deaths in 2010. Rates of Prostate Cancer differ over 50-fold among various international populations. The current lifetime risk for Prostate Cancer for men living in the United States is estimated to be approximately 1:6.

Since the introduction of widespread screening using serum PSA, Prostate Cancer is often diagnosed while asymptomatic. However, screening with serum PSA is controversial since many of the Prostate Cancers discovered in this manner may never be clinically significant.

Prostate Cancer has one of the strongest relationships with age of any human malignancy. Clinically diagnosed Prostate Cancer rarely occurs before the age of 40, but the incidence rises rapidly thereafter. Additional risk factors for developing Prostate Cancer include ethnicity. Prostate Cancer is more common in black men than in white or Hispanic men. Family history and genetic factors can also influence risk of developing Prostate Cancer in that the risk is increased approximately two-fold in men with one or more affected first-degree relatives (brother or father). The presence of BRCA1 or BRCA2 gene mutations increases the risk of developing Prostate Cancer, with a 1.8-fold increase with BRCA1 mutation and a 4.7-fold increase in carriers of the BRCA2 mutation.

Diet may also have an association with developing Prostate Cancer. High intake of animal fat, particularly a large amount of alpha-linolenic acid and low amounts of linolenic acid, a combination common in red meat and some dairy products, appears to increase risk. A diet low in vegetables may also be another risk factor for developing Prostate Cancer. Tomato-based products are rich in lycopene, which has potent antioxidant properties. Some studies have suggested that lycopene-containing foods may lower the risk of Prostate Cancer while other studies have failed to show a relationship. The Prostate, Lung, Colorectal, and Ovarian (PLCO) Cancer Screening Trial did not identify an association between fruit and/or vegetable consumption and the risk of Prostate Cancer among 29,361 men in the screening arm. High intake of cruciferous vegetables, particularly broccoli and cauliflower, was associated with a significantly lower risk of advanced prostatic tumors (Stage III or VI) at presentation.

A 2001 meta-analysis based on 235 studies and including more than 117,000 cases failed to identify a consistent relationship between alcohol intake and Prostate Cancer. Increasing consumption of coffee appears to be associated with a decreased risk of lethal Prostate Cancer. A prospective analysis of almost 48,000 men from the Health Professionals Follow-up Study identified a decreasing risk of death due to Prostate Cancer for those drinking six or more cups of coffee per day. The regular use of multivitamins does not appear to affect the risk of early or localized Prostate Cancer, although in two reports there has been an observed increased risk of advanced or fatal Prostate Cancer in men using relatively large amounts of multivitamins. The dietary supplement folic acid was associated with an increased incidence of Prostate Cancer in a secondary analysis from the Aspirin/Folate Polyp Prevention Study. The large prospective SELECT Trial evaluating chemo-preventative aspects of selenium and Vitamin E supplementation did not demonstrate a benefit in decreasing Prostate Cancer incidence. Studies directly analyzing Vitamin E levels and the risk of Prostate Cancer have not fully supported a relationship with Prostate Cancer incidence. Serum concentrations of androgens and insulin-like Growth Factor1 have also been studied as possible risk factors for
Prostate Cancer. Serum concentrations of testosterone, dihydrotestosterone (DHT), and other active androgen derivatives were not associated with an increased risk of Prostate Cancer. In addition, no association was seen with serum levels of estrogens (estradiol, free estradiol). Testosterone supplementation as a treatment for hypogonadism does not appear to be associated with increased risk of Prostate Cancer, although monitoring for prostate abnormalities is recommended.

Observational studies provide conflicting data as to the association of obesity with Prostate Cancer, and it is not clear that there is a reduced incidence of Prostate Cancer among individuals who participate in regular physical exercise. Several studies have not established a relationship between Prostate Cancer and prostatitis, although there does appear to be an association with an increased risk of Prostate Cancer and exposure to Agent Orange, a herbicide defoliant, and chlordecone, an insecticide.

At Cape Canaveral Hospital a total of 47 patients were diagnosed with Prostate Cancer in 2010, 34 analytic and 13 non-analytic patients. Prostate was the second-most common analytic cancer, representing 16% percent of male patients diagnosed and treated at this facility in 2010. Ethnicity showed 28 Caucasian patients, 3 Afro-American patients, 2 Hispanic patients, and 1 “Other” race.

Graph 1 illustrates the age at time of diagnosis and Graph 2 the stage at diagnosis. These findings are consistent with state and national data.

The treatment of Prostate Cancer is influenced by the clinical stage of disease, tumor grade (Gleason Score), serum PSA, and any patient symptomatology and comorbidities, at time of diagnosis. For disease localized to the prostate or with locally advanced disease, active surveillance, surgery with radical prostatectomy (robotic or laparoscopic), or radiation therapy (external beam with or without brachytherapy — radiation seed implant) are options. Combining external beam radiation therapy with androgen deprivation therapy (ADT) has been shown to significantly improve disease-free survival, time to progression, and overall survival compared to radiation therapy alone in men with locally advanced and high-risk Prostate Cancer. Other approaches such as cryosurgery, high-intensity focused ultrasound, and proton beam radiation therapy have been used in initial management of patients with localized Prostate Cancer. Patients usually have more than one option in selecting a treatment modality, and it is recommended that they be evaluated in a multidisciplinary approach.

Patients who are not candidates for localized therapy but present with metastatic disease (Stage IV) are primarily treated initially with androgen deprivation therapy. The majority of patients are treated with gonadotropin-releasing hormone agonist (GNRH) such as leuprolide, goserelin, buserelin, or triptorelin. Bilateral orchiectomy (surgical castration) is a relatively simple, cost-effective procedure that in many countries remains the standard of care for initial hormone therapy in metastatic Prostate Cancer. Antiandrogen therapy binds to androgen receptors and competitively inhibits their interaction with testosterone and dihydrotestosterone. Unlike medical castration, antiandrogen therapy does not decrease luteinizing hormone levels and androgen production. Testosterone levels are normal or increased. Men can be treated with antiandrogen monotherapy, or in
combination with GNRH agonist. Although the testes produce 90% to 95% of total circulating testosterone, androgens produced by the adrenal gland can also stimulate tumor growth. Thus anti-androgens have been combined with medical or surgical castration to achieve a complete androgen blockade. Meta-analysis suggests that there is a survival advantage with complete androgen blockade, although toxicity and costs are higher. The nonsteroidal anti-androgens include flutamide, bicalutamide, and nilutamide. For patients with metastatic Prostate Cancer, clinical trials demonstrate that intermittent androgen deprivation provides the same survival as continuous androgen deprivation but with less acute and chronic side effects associated with treatment.

Advanced metastatic Prostate Cancer treatment is palliative, and the cancer will progress in the future.

**GRAPH 3: TREATMENT MODALITIES UTILIZED IN TREATMENT OF ANALYTIC PATIENTS DIAGNOSED AT CCH IN 2010**

The annual age-adjusted cancer incidence rate for Prostate Cancer has been relatively stable since 1995, at 170 cases per 100,000 population. The annual age-adjusted cancer death rate for Prostate Cancer has continuously decreased since 1994, with an estimated 23 deaths per 100,000 males in the United States.

There were a total of **52 patients diagnosed at CCH with Prostate Cancer in 2003**. Of this number **40 (76.9%)** survived for 5 years after diagnosis. The Florida and national data was supplied by NCDB Survival Reports. CCH information was obtained from CCH database. CCH numbers are very low and are not statistically significant. 2003 numbers are the latest available from NCDB. All stages were obtained using the **AJCC Staging Manual, 6th edition**. Comparison of 5-year survival of patients diagnosed in 2003 with Prostate Carcinoma at CCH, in Florida, and nationally is shown in **Graph 4**.

Palliative treatment options include localized radiation therapy for bone pain, and/or chemotherapy. Bisphosphonates (zoledronic acid – Zometa) and denosumab (Xgeva), have been shown to decrease the incidence of skeletal-related events (fractures, spinal cord compression, or the need for radiation therapy), in men with known bone metastasis from Prostate Cancer. Improved understanding and enhancement of the immune system in Prostate Cancer patients has led to the approval of a therapeutic vaccine (Sipuleucel-T-Provenge) for patients who have minimally symptomatic, castrate-resistant Prostate Cancer. There was a significant prolongation in overall survival compared to placebo. The initial treatment for patients diagnosed with analytic Prostate Cancer at CCH in 2010 is shown in **Graph 3**.
In summary, Prostate Cancer is the most common cancer diagnosed in men and the second-most common cause of cancer death in the United States. Prostate Cancer Screening, although controversial, has helped diagnose cancer at an earlier, more curable stage. Patients have options at time of diagnosis; and a multidisciplinary approach is preferred. At Cape Canaveral Hospital, any patient diagnosed with Prostate Cancer can request that his case be presented at the Cancer Program’s monthly Tumor Board. For patients who at time of diagnosis or later develop metastatic Prostate Cancer there have been medical advances in palliative treatment and improved prolonged survival. Future innovation and research, especially with the application of genomics and personalized medicine, give the hope of decreasing the incidence as well as morbidity and mortality associated with Prostate Cancer.

Respectfully submitted,

Richard M. Levine, MS, MD
2010 CANCER COMMITTEE MEMBERS

CANCER PROGRAM LEADERSHIP

CHAIRMAN & QA COORDINATOR

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Medical Oncology

PHYSICIAN LIAISON—OUTREACH COORDINATOR

Alphonse Pecoraro, MD
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CANCER CONFERENCE TUMOR BOARD COORDINATOR

Jonathan Charles, MD
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Quality & Outcomes

CANCER PROGRAM COORDINATOR

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VP Nursing Administration

CANCER REGISTRY STAFF

CarolAnn Muir, CTR
Diane Sullivan
American College of Surgeons (ACoS): The ACoS Commission on Cancer (CoC) is referenced throughout this report and in some tables, charts, and graphs. The ACoS CoC performs surveys and approves cancer programs nationally based on specific standards and criteria.

AJCC TNM stage: A staging system developed by the American Joint Committee on Cancer (AJCC). The size and/or depth of invasion of a tumor determines the tumor (T) stage. The (N) is determined by lymph node involvement. Distant metastasis (M) is the spreading of the cancer to distant sites. For applicable sites, the T, N, and M determine the stage—I, II, III, IV or “Unknown Stage (UNK).” Higher-staged cancers usually have a poorer prognosis.

Analytic cases: Cancer cases diagnosed and/or treated for all or part of the first course of therapy at Cape Canaveral Hospital.

Florida Cancer Data System (FCDS): FCDS is an incidence registry for the state of Florida and is a central cancer registry administered by the Florida Department of Health operated and maintained by the Sylvester Comprehensive Cancer Center at the University of Miami School of Medicine.

Non-analytic cases: Cancer cases diagnosed and treated elsewhere for the first course of therapy.

National Cancer Data Base (NCDB): Division of the ACoS Commission on Cancer that provides data used for benchmarking and survival reports.

Reference date: The year in which a cancer registry began collecting and maintaining cancer cases. The date is usually January 1st of a given year.
Requests for data as described below* are welcomed and should be directed to:

Cape Canaveral Hospital Cancer Registry
CarolAnn Muir, CTR
PO Box 320069
Cocoa Beach, FL 32932-9989
Tel: 321-799-7125
Fax: 321-799-7106

*The Cape Canaveral Hospital Cancer Registry has general information on cancer diagnosis, treatment, and clinical trials for the community. Clinicians may request information on our hospital's cancer trends and statistics by contacting the Cancer Registrar at 321-799-7125.