

Rising to the need
for a healthier community.

ARTHUR TEMPLE SR.,
REGIONAL CANCER CENTER

ANNUAL REPORT
2006





Chairman's Report

2006 marked the completion of a multi-year renovation of the Arthur Temple, Sr. Regional Cancer Center. More than \$7 million in grants and donations was received to replace two linear accelerators and add CT simulation, PET/CT scanning, and Anatom-e information systems to our cancer treatment repertoire. In addition, a complete facelift of the Cancer Center was done. Major funding for technology purchases was provided through comprehensive grants from the T.L.L. Temple Foundation and additional support from the Temple-Inland Foundation. Along with this technology came a complete facelift with furnishings for patient waiting and educational areas graciously funded by Harold and Louise Maxwell. Additional charitable gifts were received from Siemens Medical Solutions, Zeleskey Law Firm and Community Title, and Dr. and Mrs. Sidney C. Roberts.

The culmination of our effort was the continued recognition of the Arthur Temple, Sr. Regional Cancer Center by the American College of Surgeons Commission on Cancer as an accredited cancer program with commendations. Only 25% of hospitals have an approved cancer program, and less than half of these receive commendations.

From start to finish, the Arthur Temple, Sr. Regional Cancer Center is state of the art. We have diagnostic capabilities that are unsurpassed in PET/CT scanning. Later this year, digital mammography will be introduced in all of our system facilities. We have treatment design ability with CT simulation, Anatom-e Information Systems and IMRT planning that is second to none. We have Siemens Oncor linear-accelerator-based computer-driven treatment delivery techniques that are only now being considered in other community settings. Add to this the personal care that can only be given when patients are close to home, and you can see why the Arthur Temple, Sr. Regional Cancer Center continues to lead the way as a modern, state-of-the-art facility providing personalized care for East Texans... right here in East Texas!

A handwritten signature in black ink, appearing to read "Sid Roberts".

Chairman, Cancer Committee
Memorial Health System of East Texas



*“As one of the top 25% of all cancer centers
in the country, we make the fight
against cancer easier.”*

Tumor Board Conferences

Tumor Board conferences are educational conferences held for the benefit of the Medical Staff, Allied Health Professionals and others. In 2005, a total of 85 different, interesting, controversial or unusual cases of cancer were presented in a forum designed to give clinicians a way to share opinions and discuss treatment options that may improve individual patient care. In addition, category I Continuing Medical Education (CME) credit is offered for each meeting a physician attends.

Cases discussed in 2005 included the usual lung, breast, prostate and colorectal cancers, head and neck tumors, lymphomas, esophageal cancer, brain tumors, and a number of other less common sites or types of cancer such as leukemia, melanoma, vulva, anal canal, cervix, bladder and multiple myeloma.

The ability to present cases in a multi-disciplinary forum, where treatment options can be discussed in a prospective fashion, is one of the criteria that set an accredited cancer program apart. Almost all of our presentations were prospectively addressed, although an occasional patient was presented in follow-up so that our members could learn the outcome of our discussions.

Statistics

Total Number of Cases in the Registry	9320
Non-Analytical Cases	1500
Total Number Expired Cases	4172
Total Number of Cases Lost to Follow-Up	405
Total Number of Cases Known to be Alive	2174
Percent of Cases with Successful Follow-Up	94%

Tumor Registry Report

The Tumor Registry is a critical component of the Cancer Program at Memorial Health System of East Texas, supporting efforts in the area of patient care, education and research. Identification and monitoring of all cases meeting the eligibility criteria established by the hospital's Cancer Committee is a labor-intensive task which plays a vital part in the accreditation of the hospital's cancer program by the American College of Surgeons.

The Tumor Registry has been in existence at Memorial Health System of East Texas since 1990. The Registry, under the direction of the Cancer Committee, maintains a complete database of all cancer cases diagnosed and/or treated at Memorial. In 2005, there were 530 newly diagnosed and /or treated cancer cases at Memorial.

In order to encourage continued medical surveillance and to provide valid end-result statistics, every patient in the Registry is followed on an annual basis. The Registry, with the aid of its computerized database, is able to provide valid information regarding the current medical status of the patient to the physicians following the case.

The Registry also provides the physicians and hospital with survival information about patients treated in our Cancer Center. Patient confidentiality is strictly enforced under HIPPA guidelines. Currently we are able to maintain a high rate of successful follow-up.

The Registry's efforts in these areas yield useful demographic, diagnostic, therapeutic and follow-up data. This data is used to support efforts in reviewing patient care and treatment procedures. Registry data is also very useful in helping to create more effective patient education programs or research protocols.

Primary Site Table 2005

SITE	TOTAL	PERCENT
LUNG	133	(25.1%)
BREAST	94	(17.7%)
PROSTATE	54	(10.2%)
COLORECTAL	48	(9.1%)
NON-HODGKIN'S LYMPHOMA	16	(3.0%)
BRAIN	14	(2.6%)
UNKNOWN OR ILL-DEFINED	14	(2.6%)
MELANOMA OF SKIN	13	(2.5%)
KIDNEY	13	(2.5%)
MYELOMA	11	(2.1%)
LARYNX	9	(1.7%)
PANCREAS	8	(1.5%)
BLADDER	8	(1.5%)
STOMACH	8	(1.5%)
LEUKEMIA	8	(1.5%)
OTHER HEMATOPOIETIC	7	(1.3%)
OVARY	6	(1.1%)
ENDOCRINE (OTHER)	6	(1.1%)
LIVER	6	(1.1%)
ESOPHAGUS	4	(0.8%)
SOFT TISSUE	4	(0.8%)
GUM	4	(0.8%)
NASOPHARYNX	4	(0.8%)
UTERINE	4	(0.8%)
URETER	4	(0.8%)
TONGUE	3	(0.6%)
CERVIX IN SITU	3	(0.6%)
CERVIX	2	(0.4%)
OTHER NERVOUS SYSTEM	2	(0.4%)
ANAL	2	(0.4%)
THYROID	2	(0.4%)
HODGKIN'S DISEASE	2	(0.4%)
MOUTH	2	(0.4%)
OTHER SKIN	2	(0.4%)
VULVA	2	(0.4%)
LIP	1	(0.2%)
FLOOR OF MOUTH	1	(0.2%)
TONSIL	1	(0.2%)
HYPOPHARYNX	1	(0.2%)
PHARYNX	1	(0.2%)
OTHER DIGESTIVE	1	(0.2%)
NASAL CAVITY, SINUS, EAR	1	(0.2%)
PLEURA	1	(0.2%)

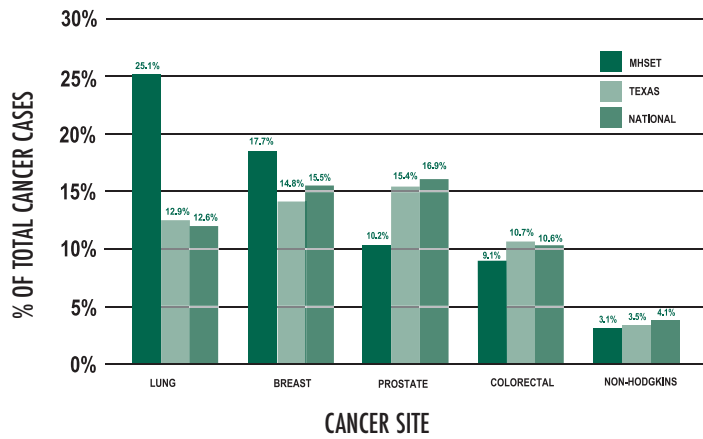
TOTAL 530

In 2005, 530 new analytic cases of cancer were entered into the Tumor Registry at Memorial Health System of East Texas. The most common sites were lung (25.1%), breast (17.7%), prostate (10.2%), colorectal (9.1%) and non-Hodgkin's lymphoma (3.0%).

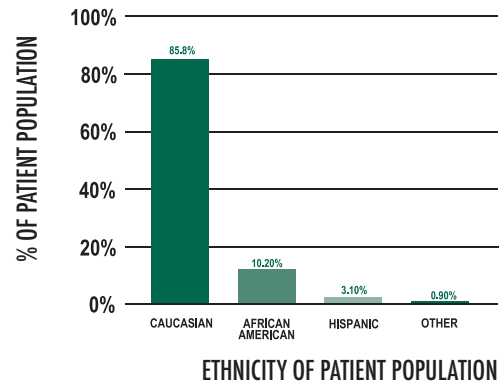
*“Among the many, rich opportunities
here in the heart of East Texas is the
additional positive influence of our
people and our cutting edge
technology.”*



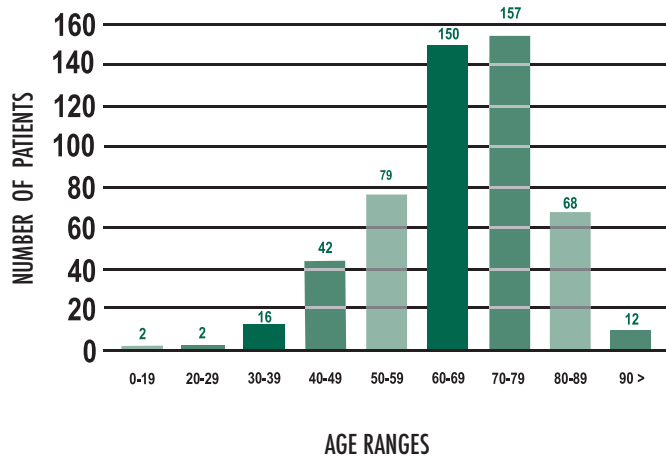
MHSET, Texas & National Top Five Site Comparison 2005



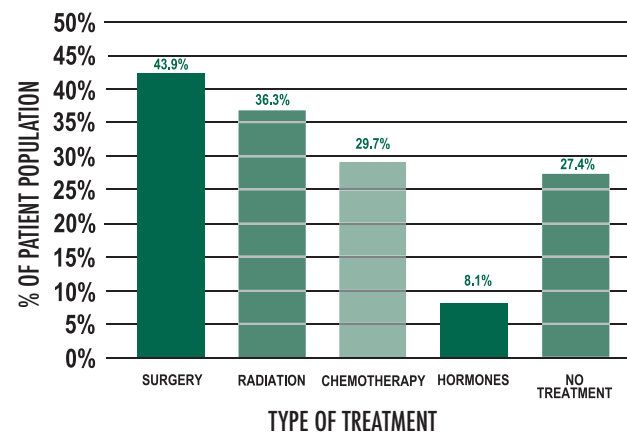
MHSET Ethnicity Of Cancer Patient Population 2005



MHSET Cancer Patient Age At Diagnosis 2005



MHSET First Course of Treatment 2005



Major Site Comparison

Memorial Health System of East Texas consistently has a higher percentage of lung cancer cases than state or national statistics would suggest. We also see a lower number of prostate cancer cases than we would predict. One factor that may influence the prostate cancer numbers is the fact that many prostate cancers are diagnosed in physician offices and may not be treated at this facility. Therefore, our statistics may not reflect the true incidence of prostate cancer in our area. On the other hand, the higher rate of lung cancer locally is a consistent finding over many years. We attribute this to higher rates of cigarette smoking throughout the Deep South in general and East Texas in particular.

Minority groups remain under-represented in our Registry statistics. Given our aggressive push to ensure access to care for all patients that we see, we presume this skewed statistic represents an under-diagnosis of cancer in minority populations, likely due to an overall difficulty in accessing the healthcare system.

The majority of patients diagnosed with cancer are in their sixth and seventh decade of life, although we certainly see a broad range of ages.

Surgery was a part of the first course of treatment in nearly half of cases. Radiation therapy was the next most common type of treatment offered in over one third of cases. Nearly three out of ten patients received chemotherapy as part of their first course of treatment. This number has risen in recent years as newer and better chemotherapy drugs have become available. Over 25% of patients may receive no treatment. This likely reflects the advanced state of their disease at presentation, poor health status at diagnosis, or a refusal to take treatment. This number may be declining and will be monitored.

Laryngeal Cancer Study 1990-2004

For each Annual Report, the Cancer Committee focuses its attention on a particular site where cancer develops. Previous reports have dealt with sites such as lung, breast, prostate and colon/rectum, to name a few. For this report, we turn our attention to the larynx – one of the sites of cancer in the head and neck region. The larynx is an organ located in the front of the neck. A common name for the larynx is the voice box. The larynx plays a role in breathing, swallowing, and talking. When a person gets cancer of the larynx they often experience symptoms that may include hoarseness, sore throat, earache, chronic cough, difficulty with breathing or swallowing, and weight loss.

Laryngeal cancer occurs most often in people who smoke and their risk increases even more if they drink alcohol. Men are four times more likely than women to be diagnosed with this cancer. African Americans have a higher risk when compared to whites. Laryngeal cancer is more common in older adults with the median age at the time of diagnosis being around 55.

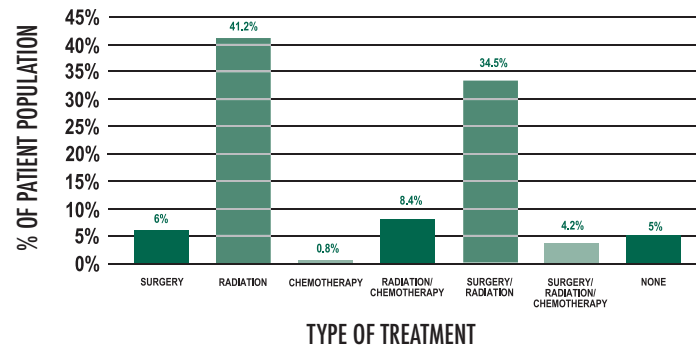
Less common occupational hazards associated with laryngeal cancer are exposure to sulfuric acid mist, nickel and asbestos. There has been some suggestion that certain viruses, diets low in Vitamin A, and history of gastro-esophageal reflux disease (GERD) may increase a person's risk of laryngeal cancer. However, tobacco and alcohol use remain the primary risk factors in this disease. And, because tobacco and alcohol expose a variety of tissues throughout the head and neck and lungs, one out of four people with a personal history of a head and neck cancer will develop another primary head and neck cancer or even a lung cancer.

In the United States, it is estimated by The American Cancer Society that 9,510 men and women will be diagnosed with laryngeal cancer and 3,740 will die from their disease by the end of 2006. As of January 2003, there are 97,313 men and women alive who had a history of cancer of the larynx in the United States. This number represents those who are alive with active disease or with no evidence of disease. The overall five-year relative survival rate is 64.1%. White men have the highest survival rate at 67.3 % and black women have the lowest survival rate at 44.4%.

In Texas, laryngeal cancer statistics are similar when compared with the nationwide statistics. In 2005, there were 714 new cases of laryngeal cancer and 282 deaths. African American men had the highest occurrence rate and were twice as likely to die from their laryngeal cancer when compared to non-Hispanic whites. The overall five-year survival rate is 65% and survival rates are much higher when the disease was detected early. Similar to the national relative survival rates, African American women had a higher mortality rate when compared to non-Hispanic white women.

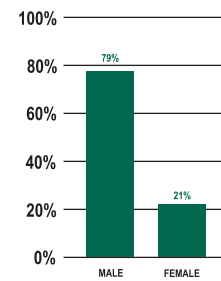
At Memorial Health System of East Texas, there have been 118 cases of laryngeal cancer diagnosed and or treated at our facility from 1990-2004. The following graphs will outline the data collected by the Tumor Registry at Memorial Health System of East Texas and compare these data with the average known national and state statistics.

First Course of Treatment 1990-2004



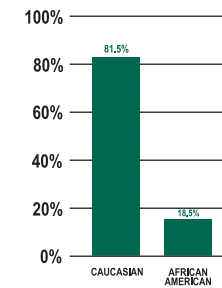
44.7% of all patients had some surgical procedure performed as part of their laryngeal cancer treatment. Because resection of laryngeal cancer would often require removal of the voice box, the vast majority of throat cancer patients are treated with radiation therapy – often along with chemotherapy – in order to preserve the ability to speak. Radiation therapy was utilized in 79.9% of all cases treated. Chemotherapy played a role in 13.4% of all cases. The role of chemotherapy is increasing in recent years.

Gender 1990-2004

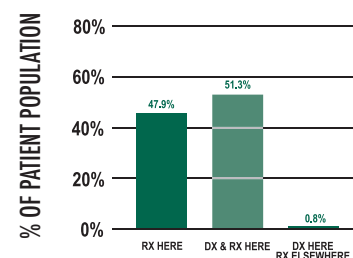


Comparable to national statistics, the majority of laryngeal cancer patients are male. The majority of patients seen at Memorial Health System of East Texas are white, with a significant minority of African American patients comparable to national and state statistics.

Ethnicity 1990-2004

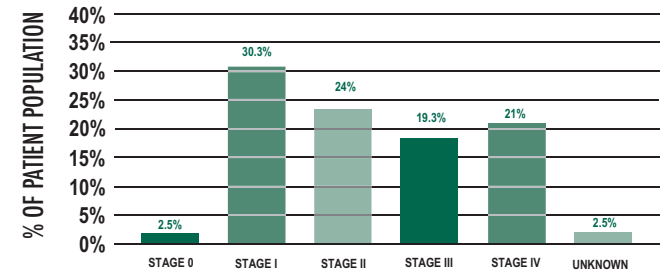


Class Of Case 1990-2004



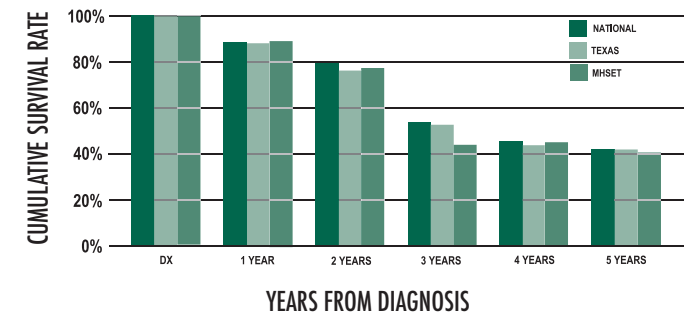
The majority of patients in the data base are both diagnosed and treated at Memorial Health System of East Texas. Less than 1% seeks treatment away from this facility.

Stage At Diagnosis 1990-2004



According to the National Cancer Institute's Surveillance Epidemiology and End Results (SEER) report for the years 1996-2002 for the United States, the percentage of laryngeal cancer still confined to the primary site at the time of diagnosis was 45%. The percentage of patients diagnosed after the cancer has spread to regional lymph nodes or directly beyond the primary site was 47%. The remaining 7% were either known to have metastatic disease or stage was unknown. In comparison, our patient population at Memorial Health System of East Texas presents with metastatic stage IV disease almost 20% of the time.

Comparison Of Five Year Relative Survival Rates



When compared with state and national statistics, five year relative survival rates at Memorial Health System of East Texas are comparable to what is seen elsewhere (data on 86 patients treated from 1990-1999 to provide comparable data set to state and national statistics). Considering the relatively more advanced patient population that we see, along with the typical delay in getting access to care that can affect outcomes, we are quite proud of this result. This reflects a strong, multidisciplinary approach to treatment of laryngeal and other head and neck cancers that includes not only physician care but also radiation therapists, oncology nurses, and dietary and social work support.

Case Presentation

Jack (not his real name) is a 53 year old Caucasian male from a surrounding county in our region. He has a long standing history of tobacco and alcohol abuse, typical of many head and neck cancer patients. He was seen initially by an outside physician in June for what the patient thought was “sinus trouble”. He was found to have a lump in his neck. A CT scan was suspicious for cancer.

The patient did not follow-up in July because he found a job in San Antonio and was feeling somewhat better after taking a course of antibiotics.

Delay #1 – Delay in Diagnosis **Possible Reasons – lack of money; fear** **Time Lost – one month**

In October, he went back to his physician again with recurrent pain in the left neck and left ear. The lump was biopsied and cancer was diagnosed. Due to lack of insurance, referrals were made to both the University of Texas MD Anderson Cancer Center in Houston and the University of Texas Medical Branch (UTMB) Galveston for further workup and treatment. Unfortunately, delays on the order of weeks (minimum) to months (often) are common with these facilities, as financial considerations trump quick access to care. Transportation issues – difficulty getting to and from these distant facilities – are often a compounding factor.

By late November, this particular patient had yet to receive an appointment at either facility. He presented to the Emergency Department at Memorial Health System of East Texas with increased pain and not knowing where to seek help.

Delay #2 – Delay in Workup **Possible Reasons – lack of insurance; no knowledge of local cancer treatment; bureaucratic barriers at state-supported institutions; transportation issues** **Time Lost – four months**

He was seen by local ENT as well as medical and radiation oncology physicians. After staging workup was completed locally, our Tumor Board group felt that this patient would benefit from consideration of major surgery first, and that this would best be done in either Houston or Galveston. We recommended his return to East Texas for continued postoperative care and possibly chemotherapy and radiation therapy, which are available locally.

By early December, our Cancer Center staff was communicating regularly by phone with UTMB Galveston. Bureaucratic and financial issues continued to delay his getting an appointment until late December, despite the willingness of the medical staff at the hospital to see the patient sooner. Of course, getting an appointment is not the same as having surgery; he was scheduled for surgery at the end of January. As you can see, even with aggressive and constant social work intervention, the time from presentation here to surgery in Galveston was still 2 months, and that was in a situation where contact had already been made in Galveston.

Delay #3 – Delay in Starting Treatment **Possible Reasons – continued bureaucratic hurdles; lack of insurance; delays in scheduling surgery** **Time Lost – Two months**

TOTAL TIME LOST - SEVEN MONTHS

Summary

Unfortunately, this case scenario of a head and neck cancer patient is quite common. In this specific case, *seven months* elapsed from initial presentation to actual surgery. Seven months in a cancer patient can make the difference between life and death. And, as pointed out above, there is no single reason for this delay. Multiple factors come into play, and none have easy or quick solutions.

Areas of potential improvement include:

- Promoting preventive measures regarding tobacco and alcohol use
- Educating the public on signs and symptoms of cancer and the need for early diagnosis
- Increasing public awareness of cancer treatment facilities in the East Texas area
- Improving coordination of care for those patients who require referral to outside institutions
- Breaking down of financial barriers to care at all health care institutions, especially those with the State of Texas mandate to care for the indigent.

Cancer Committee

Sidney C. Roberts, M.D.
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Munir Ahmad, M.D.

Waldo Gonzalez, M.D., ACoS Liaison

J. B. Alexander, M.D.

David Todd, M.D.

Mariela Vasquez, M.D.

Thomas McLaurin, M.D.

Mel Cole, M.D.

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Hospital Ex-Officio Members

Bryant Krenek

President and Chief Executive Officer

Richard Ahrens

Chief Operating Officer

Sue McCarty, RN, CNO

Chief Nursing Officer

Jennie Ferguson, MBA, CPCS

Director of Medical Staff Services

Cindi Reynolds

Core Measures Coordinator/Tumor Registry

Jewel Williams, RT(R)(T)

Cancer Center

Doris Duffield, RN

Nurse Manager, Oncology

Cindy Long, RN

Share Van/Cancer Screening Programs

Holly Randall, LMSW

Social Worker

Kelli Bass, LMSW

American Cancer Society Representative

Mario Estrella, RN

Vice President of Patient Services



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