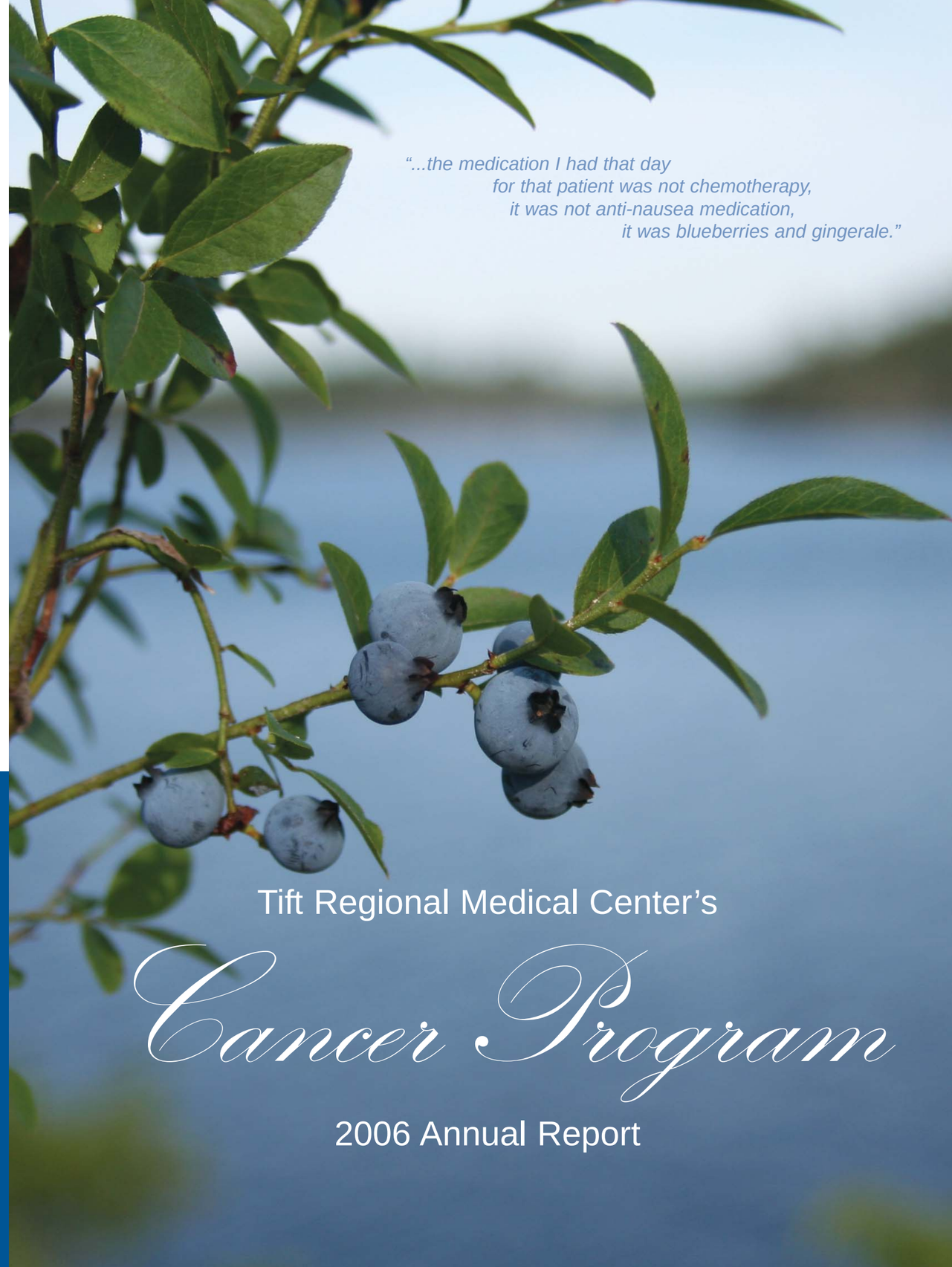
TIFT REGIONAL
MEDICAL CENTER
ONCOLOGY CENTER

References
National Cancer Institute
American Cancer Society
National Cancer Data Base (NCDB)
American College of Surgeons (ACoS)

www.tiftregional.com

1623 Madison Avenue ▪ Tifton, Georgia 31794 (229)386-1300 ▪ 800-648-1935



"...the medication I had that day
for that patient was not chemotherapy,
it was not anti-nausea medication,
it was blueberries and gingerale."

Tift Regional Medical Center's

Cancer Program

2006 Annual Report

Message

from our Chairman

Once again, it's time for the yearly report from the Cancer Committee. It seems to come up more quickly each year. As has been the custom in years past, the Cancer Committee continues to meet regularly and provides supervision and direction for the Cancer Program at Tift Regional Medical Center. The active members of the Cancer Committee remain committed to improving the program in all aspects including, but not limited to education, early detection, screening, prevention, treatment, supportive care, palliation and rehabilitation.

The Oncology Center is in its eighth year of operation and is continuing to expand and improve. The dedicated individuals associated with the Oncology Center continue to provide state-of-the-art services along with the highest quality of care in a warm and friendly environment. The inclusion of on-site social services, an on-site lab, and an on-site pharmacy adds to both the convenience and the high standard of care provided to the patients at Tift Regional's Oncology Center.

In addition, patients continue to benefit from resources made available through the generosity of the TRMC Foundation which has provided a cancer research library for patients, their family members, and the general public that includes access to the Internet, books, videos, pamphlets, and journals to assist them in acquiring information related to oncology topics.

A strong cancer care team at Tift Regional Medical Center continues to provide high quality, compassionate care to all patients while emphasizing a multidisciplinary team approach to treatment, education, support, and life long follow up that meets or exceeds nationally established standards. Recent statistics gathered and published by the tumor registry have verified our overall success and have established our position among the top community cancer centers in the nation.

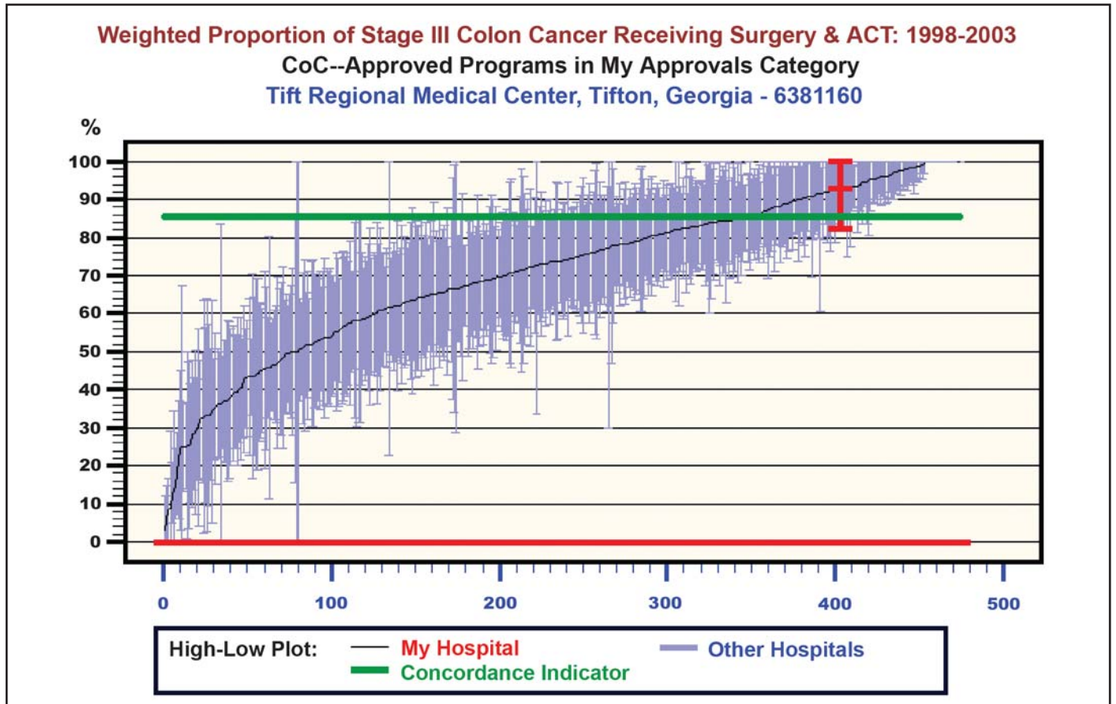
As we continue to grow and improve our Oncology Center, I would like to thank all the special individuals employed there whose commitment and hard work contributes greatly to the success of this endeavor. I would also like to thank the active members of the Cancer Committee, the interested and involved local and regional physicians and nurses, community citizens and all the ancillary departments for their dedication and hard work on behalf of the Oncology Center. In addition, I would like to thank the members of the Tift Regional Medical Center Administration and the Hospital Board for their continued support for the Cancer Program.

With pride for this year and anticipation for the future, the Cancer Committee is pleased to present the 2006 Annual Report summarizing Tift Regional Medical Center's experience with cancer for the year. In addition to providing a review of general statistical data on new cancer cases for the year 2005, the report highlights Cancer Program activities for the year 2005-2006.

James Milner, M.D.
Cancer Committee Chairman

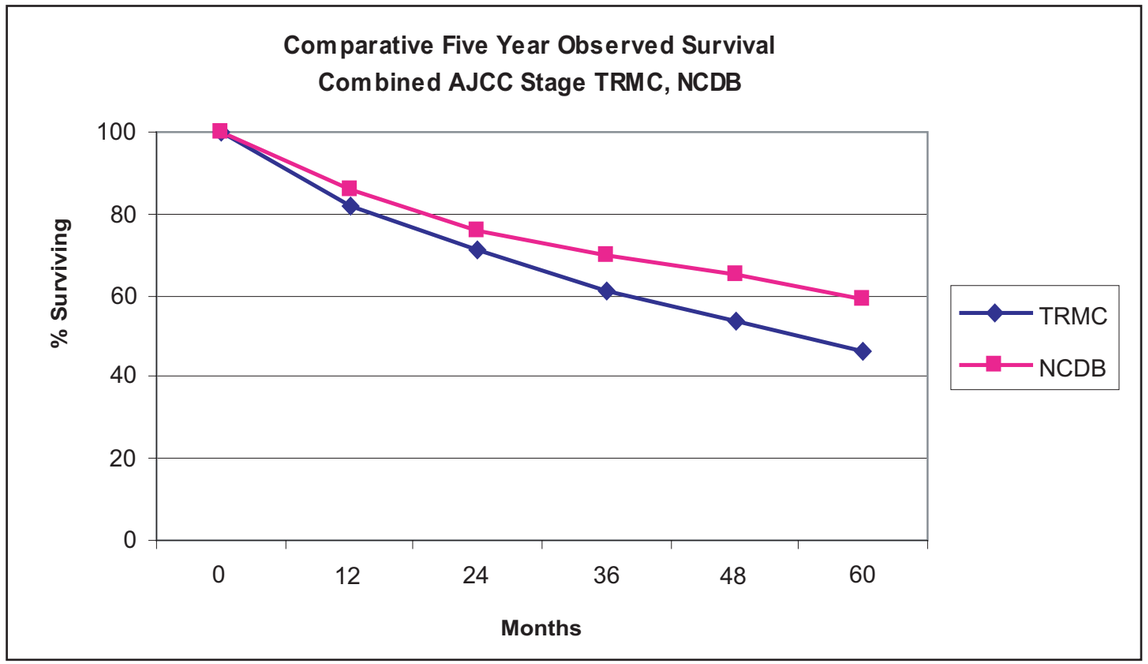
Cancer Program Practice Profile Reports: Stage III Colon Cancer, 1998-2003

Tift Regional Medical Center participated in an American College of Surgeons Commission on Cancer quality improvement study for stage III colon cancer patients. This Cancer Program Practice Profile Report (CP3R) allows our facility to evaluate specific interventions that affect patterns of care by local providers for patients with stage III colon cancer. Using the National Cancer Data Base (NCDB), a web-based CP3R was created, which would allow hospitals such as Tift Regional to compare their care for the aforementioned patients to that of other providers. These comparisons are based on widely recognized standards of care for stage III colon cancers, which includes adjuvant chemotherapy (ACT) following the surgical resection of primary colon tumors that are determined to have positive regional lymph node involvement. The term adjuvant refers to additional treatment, usually following surgery where all detectable disease has been removed but there remains a statistical risk for a recurrence due to occult or undetectable disease.



This graph exhibits the Tift Regional Medical Center Cancer Program's concordance with standards of care for stage III colon cancers, as compared to all other facilities in the Community Cancer Program approvals category.

Survival



Graph H shows five-year observed survival rates for bladder cancer cases from Tift Regional Medical Center for 2000-2005. These rates are given by Best AJCC Stage and are compared to those of the National Cancer Data Base (NCDB).

*TRMC data includes all analytical cases accessioned from 2000-2005 and represents 121 cases with an overall five year survival rate of 46%.

**NCDB data includes cases diagnosed in Community Cancer Centers across the nation and represents 5,913 selected cases diagnosed in 1998 with an overall survival rate of 59%.

Note: 84% of the cases at Tift Regional were greater than 60 years of age at the time of diagnosis. This places them at high risk for other comorbid conditions which may effect survival.

Committee Leaders

James MacDonald, M.D.

Cancer Liaison Physician

Dr. James MacDonald, pathologist, has served for the past three years as cancer liaison physician. Prior to serving as liaison, Dr. MacDonald served as chairman of the Cancer Committee. Cancer Liaison Physicians are volunteers who are responsible for providing the leadership and direction to establish, maintain, and support their facility's cancer program consistent with the criteria set by the Approvals Program of the Commission on Cancer; who facilitate submission of cancer program data to the National Cancer Data Base and use the comparative data provided back to the facility; and who work with the local American Cancer Society to develop and support cancer control programs for the community. Dr. MacDonald has contributed significantly to the success of the Cancer Program at Tift Regional.

Ray Moreno, M.D.

Vice President of Medical Affairs

This past year, Dr. Moreno worked at the local, regional and national level as an advocate for cancer services. At the local level, Dr. Moreno continued his active involvement as a member of the TRMC Cancer Committee. The TRMC Cancer Committee is dedicated to enhance the delivery of comprehensive cancer care services for all members of our local community. At the regional level, Dr Moreno was elected to the Board of Directors of the Southwest Georgia Cancer Coalition. This organization serves our community on the regional level by focusing on a strategy of developing a continuum of care for cancer patients ranging from education, prevention, early detection, treatment and research. At the national level, Dr. Moreno represents the second congressional district as a Celebration Ambassador for the American Cancer Society Cancer Action Network. In September, Dr. Moreno traveled to Washington DC in order to attend "Celebration on the Hill," a grassroots event designed to celebrate cancer survivorship and empower survivors and others to advocate for laws that will help people fight cancer.

Clarke Currie, MHA

Director, Oncology Services

This year has challenged us and expanded the boundaries of our oncology services; the logical result has been growth. In April, TRMC Oncology Center assumed responsibility for oncology patients at the Affinity Health Group. The 5000 square foot allocation in that facility has afforded us the opportunity to treat patients there without disrupting other services. The clinical and non-clinical staff have risen to the challenge, adapted to change and are looking forward.

We have experienced marked growth in the volume of patients treated in the TRMC Oncology Center, as well. Future facility expansion to meet the growing local and surrounding community needs seems certain. Built on a solid foundation of skilled and compassionate clinical staff, we are positioning ourselves for a promising future.

Our patients' satisfaction still serves as the litmus test to how we are doing from the community perspective. Outpatient satisfaction survey results have consistently shown high marks in customer satisfaction and our commitment is to continue that trend.

The Cancer Program 2006 Annual Report highlights what we are all about. As you review the information, please be reminded of the numerous people and countless hours involved in building an oncology program that is both beneficial to those we serve and which furthers our vision - "to provide competent and compassionate care in an environment that makes it unnecessary and undesirable for our patients to go anywhere else."

Committee Members

James Milner, M.D.
Chairman, Cancer Committee
Medical Oncology

James MacDonald, M.D.
Physician Liaison
Pathology

Wesley Walker, M.D.
Radiation Oncology

Wayne Stewart, M.D.
Radiology

William Kaiser, M.D.
Surgery

Ray Moreno, M.D.
Vice President/ Medical Affairs

Diane Patrick, BSN
Vice Pres., Patient Care Services

Clarke Currie, MHA
Director, Oncology Services

Faye Cooper, R.N., OCN
Radiation Oncology

Tina Mann, R.N.
Oncology Nurse Manager

Kathy Alberson, RHIA
Medical Records Director

Marilyn Richardson, RHIT, CTR
Tumor Registrar

Brenda Berry, R.N.
Medical Oncology Nurse

Stephanie Ellis, R.Ph.
Oncology Pharmacist

Stacey Heard
Transitions Coordinator

Mindy McStott, R.N.
Case Management

Christie Moore, R.N.
Hospice Director

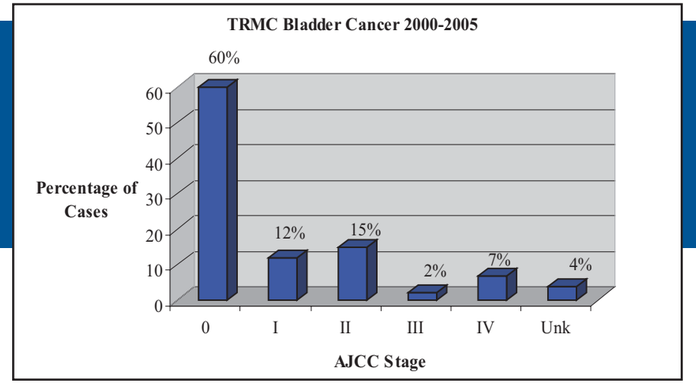
Aneisa Young, LMSW
Social Work Services

Angie King, BSN, CPHQ, ABQAURD
Quality Management Director

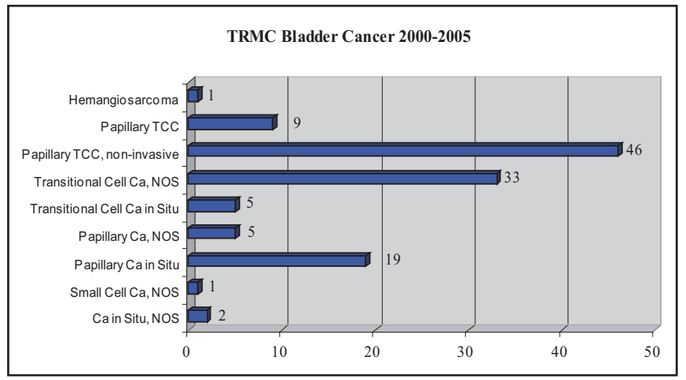
Nancy Hilton, R.N.
Director Med/Surg

Joy Davis
Marketing

Nancy Carrier, R.N.
Education



Graph E shows the distribution of bladder cancer by AJCC stage at diagnosis.

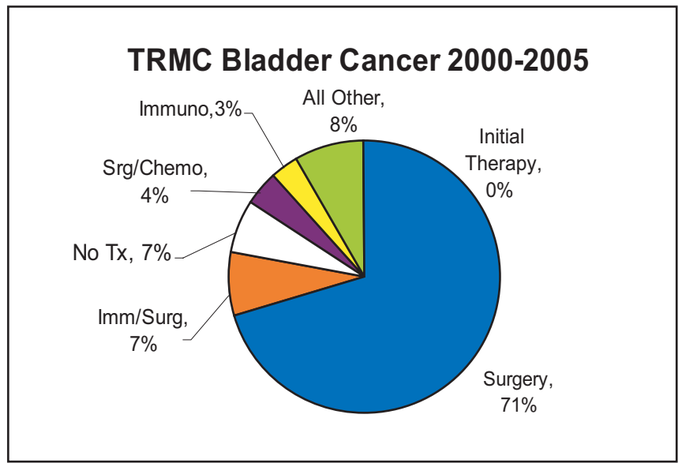


Graph F shows the distribution of bladder cancer by histology.

Treatment

There are a variety of treatment options available for patients with bladder cancer. Treatment will greatly depend upon the stage of the disease, but could include any of the following:

- Surgery: Transurethral resection, cystectomy, partial cystectomy, and radical cystectomy
- Intravesical immunotherapy
- Radiation therapy
- Systemic chemotherapy or immunotherapy
- Clinical trials

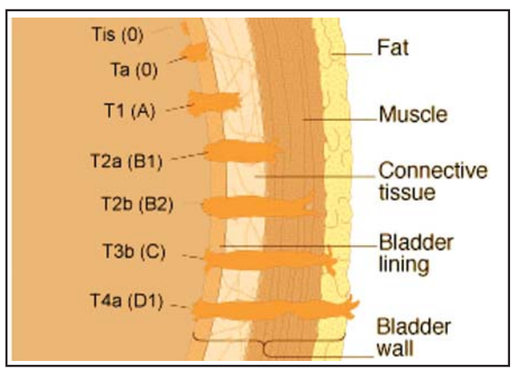


Graph G shows the distribution of bladder cancer by initial therapy.

Staging

If a biopsy of the bladder proves that there is cancer present, the next step is to determine the extent of the cancer and whether or not it has spread. Staging will help to determine the treatment and prognosis of the disease. The following table shows the AJCC stage groups, along with their corresponding survival rates, for bladder cancer.

Stage	Features	Survival Rate
Stage 0a	The cancer is a noninvasive papillary carcinoma. The cancer has grown toward the hollow center of the bladder.	95%
Stage 0is	The cancer is flat, noninvasive carcinoma. Also known as flat carcinoma in situ. The cancer is growing in the lining layer of the bladder only.	95%
Stage I	The cancer has grown into the layer of connective or supporting tissue under the lining layer of the bladder.	85%
Stage II	The cancer has spread to the thick muscle layer of the bladder wall but, it has not completely passed through the muscle layer.	55%
Stage III	The cancer has grown completely through the bladder into the layer of fatty tissue that surrounds the bladder. It may have spread to the prostate, uterus, or vagina.	38%
Stage IV	The cancer has spread through the bladder wall to the pelvic or abdominal wall and/or has spread to lymph nodes and/or to distant sites such as bones, liver, or lungs.	16%



The AJCC staging system is a refinement of the Jewett Staging system. Pathologist H.J. Jewett proposed this classification system in 1946. It was later revised by Marshall in 1956, which is why it is also known as Jewett-Marshall Staging. This is a histologic staging based on depth of the tumor invasion through the bladder wall. Jewett's staging does not consider grade of tumor, local recurrence rate or multicentricity of tumors.

Blueberries & Gingerale

A couple of years ago I was asked to start TRMC's first satellite pharmacy in the Oncology Center. I was hesitant. My concern was that working with such sick patients would be depressing. I can tell you now, having been here two years, this job is far from depressing. I have met some of the most wonderful people I have ever known. They are my patients.

While each patient has been special, there is one in particular that I adopted in my life, his name was Camilo. In fact, everyone in Oncology had a special attachment to this man. He had the most appreciative spirit of anyone I have ever known. His cancer was already advanced when he came to the Oncology Center, and it continued to grow faster than the chemotherapy could retain.

As his cancer grew, his basic needs grew as well. With no family here in the United States, we became his family. We found a bed for him when we learned he had nothing to sleep on. When he had no food, we took turns buying his lunch until our social worker, Blakely was able to link him with agencies that could help. Our van driver, Mr. Leo even helped him buy groceries when he did have some money.

Eventually, Camilo decided he could no longer take care of himself and would move into a nursing home. The day of his move, he asked Leo to bring him to the clinic because he wasn't feeling well.

I went into his room that morning to speak to him, as I usually did, and asked him if there was anything he needed or wanted. He whispered, in broken English, that he would like some gingerale. We had other sodas, but no gingerale. Something told me those weren't good enough that day.

I relied on Mr. Leo's kindness and asked if he would mind getting our friend some gingerale. As Mr. Leo always does, he smiled and was quickly on his way to pick up some gingerale. When Leo returned with the gingerale, our weary friend began to sip and smiled at us as if to say "thank you."

I was about to return to my office when I asked him if there was anything else he might want or need. Again in broken English, he asked for some blueberries.

My initial thought was, "You know, I really have to start mixing that chemo. I mean, I don't have time to be running all over town looking for gingerale and blueberries, and why didn't he just ask for those when he asked for the gingerale?"

But as I started walking out, I was emotionally overwhelmed by the scene playing out in front of me. I watched as two of the nurses began to give him a bath, knowing that he had been too weak and tired the few days before to do it himself. Then I looked beside his bed and saw the clean pajamas that our P.A., Dale, had bought to replace the worn our clothes he usually wore.

My heart swelled and I decided to ask Mr. Leo if he would go back to the store and get that patient some blueberries. Once again, Leo proved loyal to the needs of others.

When Mr. Leo arrived with the blueberries, our patient immediately, but slowly began to eat. We watched him as he would motion for a sip of gingerale and then motion for his cup of blueberries. He did not want to be alone those next few moments, and it soon became clear as to why. He died before lunch that day, right there in the clinic, surrounded by his family, and we knew that was the way he intended.

As I left Camilo's room that day, my heart was saddened. I went into my office and on my calendar I saw the thought for the day. It read, "When the arms of death are stretched toward you, who will you reach to for comfort?" It continued, "Will you look at the college diploma in the walnut frame on the wall? Will you ask someone to take you out to the garage to sit in your car? Will you look to people and relationships?"

It was then that I realized the medication I had provided that day for that patient was not chemotherapy; it was not anti-nausea medication; it was blueberries and gingerale.

Stephanie Ellis

Report from the Cancer Registry

The Tumor Registry at Tift Regional Medical Center is completing its 6th year of data collection. The Registry is a data base system designed to collect, manage and analyze data on patients with cancer. Tift Regional's registry has been operating since January 1, 2000 and currently has over 2800 patients. Annual follow-up of analytic patients is one of the functions of the cancer registry. Follow-up also provides valid measurement of outcomes. More than 1500 cases are currently under active follow-up with an average successful follow up rate of 92 percent.

The registry is maintained by a Certified Tumor Registrar who is a member of the National Cancer Registrars Association (NCRA) and the Georgia Tumor Registrars Association (GATRA). Knowing the importance of continuing education, registrars participate in workshops and conferences sponsored by NCRA, GATRA, GCCS (Georgia Center for Cancer Statistics) and Emory University's School of Public Health. The registry functions under the leadership of the Director of Health Information Management. High quality cancer registry data is essential to accurately assess treatment outcomes and patient survival. The cancer committee ensures the quality of the cancer registry data.

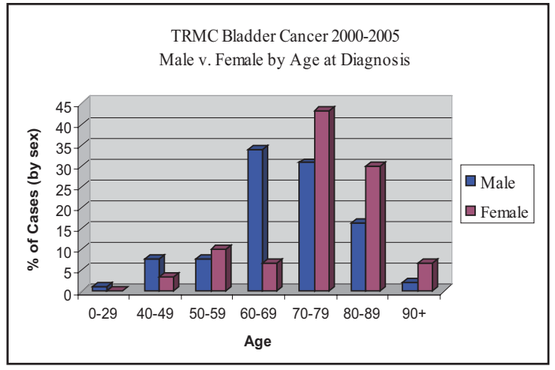
The Tumor Registry utilizes the required data set, data definitions and codes set forth by the American College of Surgeons Commission on Cancer.

The cancer registry assists research efforts by responding to all requests for data that will monitor, improve, and evaluate patient care and trends for physicians, administrators and other health-care professionals. Use of this data contributes to the effectiveness of the overall care being administered to patients. Continued and frequent use of the database is encouraged. The registry data is used at tumor conferences and community education programs. Data is also reported to the Georgia State Cancer Registry monthly, and to the National Cancer Database, annually. All individual patient information remains strictly confidential and is subject to Tift Regional Medical Center's policies regarding disclosure.

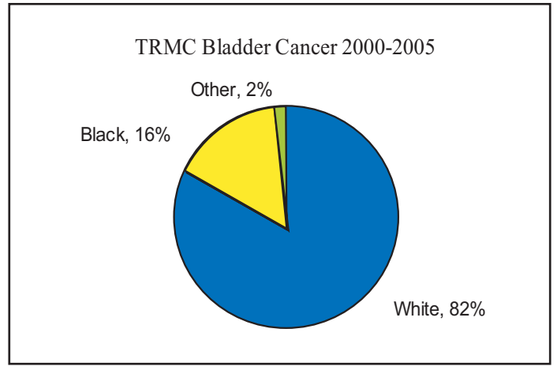
Tumor Boards provide physicians an opportunity to present patients in a multidisciplinary forum for the purpose of discussing treatment options. Tumor Boards promote the American Joint Committee on Cancer (AJCC) staging and provide continuing education credits to physicians, and other support personnel. The Cancer Registry is responsible for coordination of all Tumor Boards.

Sixteen (16) Tumor Board meetings were held during the year 2005 with forty-two (42) cases presented, which represents ten percent of the annual analytic caseload. Of the cases presented 100% were prospective.

During 2005, 459 new cases were entered into the database; 417 were analytic and 42 were non-analytic. Data for cancer diagnosed at Tift Regional Medical Center in calendar year 2005 is presented. A physician member of the cancer committee reviewed more than 10% of the 2005 cases for accuracy and completeness.



Graph C shows the distribution of bladder cancer, male versus female, by age at diagnosis. 84% of the patients were greater than age 60 at the time of diagnosis. 75% were male and 25% were female.



Graph D shows the racial breakdown of bladder cancer cases.

Diagnosing Bladder Cancer

If your doctor has any reason to suspect that you may have bladder cancer, one or more of the following methods may be used to find out if you really have the disease.

Medical History & Physical Exam - This is necessary to check for any risk factors or symptoms that may be present. This will also provide the doctor with other information about signs of bladder cancer and even other health problems that may be present. The rectum and vagina may be examined to determine the size of the bladder tumor, if present, and to determine how far it has spread.

Cystoscopy - This procedure is done using a cystoscope, or small tube with a lens and light. This tube is placed in the bladder through the urethra and it allows the doctor to examine the inside of the bladder. Local anesthesia is usually used. If suspicious areas are seen, a biopsy can be taken during this exam.

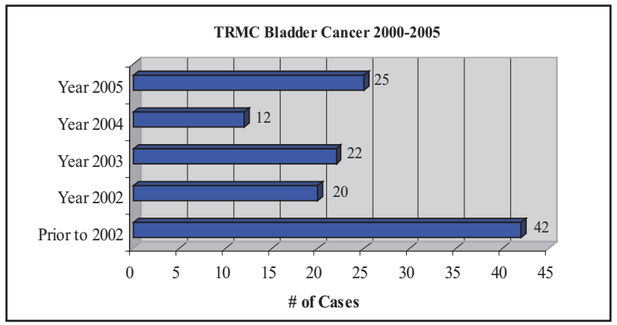
Laboratory Tests - Direct examination of the urine can be done using urine cytology or a urine culture. Bladder tumor marker studies such as NMP22 can also be done to detect evidence of bladder cancer in the urine.

Imaging Tests - Medical imaging such as intravenous pyelogram (IVP), retrograde pyelography, chest x-ray, computed tomography (CT), Magnetic resonance imaging (MRI), ultrasound, and bone scans. The usefulness of Positron emission tomography (PET) is still being investigated.

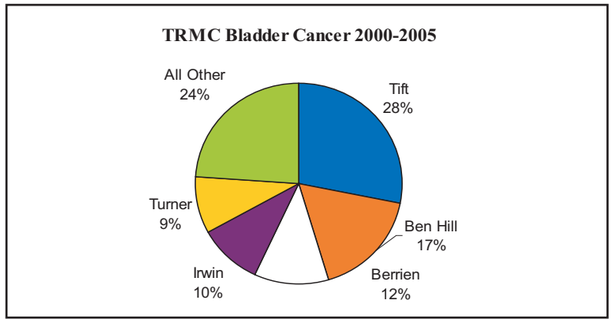
Case Study

Bladder Cancer

The American Cancer Society estimates that in 2006 there will be about 61,420 new cases of bladder cancer diagnosed in the United States, which will include about 44,690 men and 16,730 women. During the year 2006, there will also be an estimated 13,060 deaths from bladder cancer in the United States. The majority of people diagnosed with bladder cancer are white men over the age of 55. As you will find in the Risk Factor section of this report, this can be explained by the fact that men are four times more likely to have bladder cancer than women, whites are twice as likely to have bladder cancer as blacks, and nearly 90% of people diagnosed with bladder cancer are 55 or older. Bladder cancer is the fourth most frequent cancer diagnosed in men. It is the ninth most frequent cancer diagnosed in women.



Graph A shows that 121 bladder cancer cases were diagnosed and/or treated at Tift Regional Medical Center from 2000-2005. These cases account for 5% of the total analytical cases at this facility.



Graph B shows the distribution of bladder cancer cases by county of residence at the time of diagnosis.

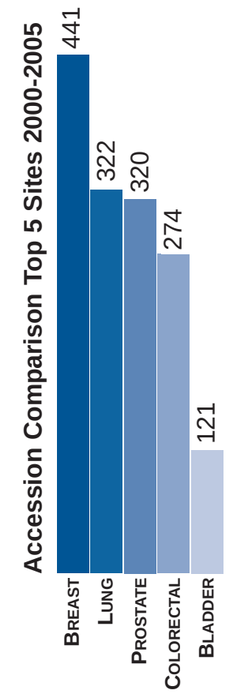
Risk Factors

Many people who are known to have one or more risk factors may never be diagnosed with bladder cancer, yet some who are diagnosed with this cancer have no known risk factors. It is very important to be aware of the risk factors associated with bladder cancer, so that a person with known risks can be carefully monitored for evidence of disease.

- Smoking
- Occupational exposure to industrial chemicals
- Race - being white
- Increasing age
- Gender - being male
- Chronic bladder inflammation
- Personal history of bladder cancer
- Bladder birth defects
- Genetics
- Previous chemotherapy and radiation therapy
- Drinking water that is contaminated with arsenic
- Permanent hair dye

Primary Site	Total	sex M	F
Oral Cavity	14	6	8
Lip	1	1	0
Tongue	3	2	1
Hypopharynx	1	0	1
Tonsil	1	0	1
Palate	2	1	1
Floor of Mouth	2	1	1
Other Parts of Mouth	3	1	2
Other Parts of Maj. Salivary Gland	1	0	1
Digestive System	65	35	30
Esophagus	2	2	0
Stomach	7	4	3
Small Intestine	1	0	1
Colon	33	18	15
Rectosigmoid Junction	2	2	0
Rectum	12	7	5
Anus/Anal Canal	2	0	2
Liver	2	2	0
Gallbladder	3	0	3
Pancreas	1	0	1
Respiratory System	48	29	19
Nasal/Sinus	1	1	0
Larynx	2	2	0
Lung/Bronchus	45	26	19
Blood and Bone Marrow	23	11	12
Bones, Joints, Cartilage	1	0	1
Hematopoietic/Reticuloendothelial	22	11	11
Connect/Soft Tissue	11	5	6
Skin	11	5	6
Breast	74	1	73
Female Genital	29	0	29
Cervix Uteri	6	0	6
Corpus Uteri	10	0	10
Uterus, NOS	1	0	1
Ovary	10	0	10
Vulva	2	0	2
Male Genital	75	75	0
Penis	1	1	0
Prostate	72	72	0
Testes	2	2	0
Urinary System	39	27	12
Bladder	25	20	5
Kidney/Renal	14	7	7
Brain and CNS	7	3	4
Meninges	1	0	1
Brain	5	3	2
Other	1	0	1
Endocrine System	5	0	5
Thyroid	5	0	5
Lymphatic System	11	6	5
Lymph Nodes	11	6	5
Unknown Primary	16	9	7
Total Cases	**417**	**207**	**210**

Table 1 shows the incidence of cancer in 2005 by primary site. 207 cases (49.6%) were male and 210 (50.49%) were female. Prostate cancer compromised 35% of the male cancer, followed by lung (13%) and colorectal cancer (13%) and bladder (10%). For females, the primary sites of cancers were breast (35%), colorectal (10%), lung (9%), and uterus (5%).



In the

Community

Hospice

When the treatment goal changes from a cure to comfort, hospice care is appropriate. Hospice of Tift Area seeks to maintain and improve the quality of life and to support the family, both during and after the illness.

The hospice team is composed of physicians, nurses, social workers, a chaplain, certified nursing assistants, a bereavement counselor and volunteers who work together to address the physical, emotional, social and spiritual needs that arise as families care for their loved ones near the end of life.

In 2005, approximately 41.7 percent of the patients cared for by the Hospice of Tift Area had a cancer diagnosis.

This year, Hospice celebrates 20 years of service in the Tift area.

Social Work Services

Social Work Services provide a number of services to patients and families throughout the continuum of treatment. Such services include support and counseling, education, advocacy, case management, and coordination of healthcare among the patient's healthcare team. The Oncology Social Worker assesses the needs of the patient and the family on multiple levels including medical, physical, social, emotional, financial and spiritual. We provide services to the community at large by facilitating a monthly cancer support group where individuals who have been affected by cancer, either directly or indirectly, can come to receive education and support. Not only does the Oncology Social Worker link patients and families to various resources, but also participates in events meant to increase funding available to our community such as The Nanci Bowen Charity Event, Relay for Life, and The Tree of Life Ceremony.

Outreach

Tift Regional reaches out to the communities we serve in an effort to improve the health of our families, our neighbors, and our friends. Focus is placed on public awareness and early detection of cancer. Public education takes on many forms such as cancer screenings, education classes, and participation in community health fairs and health awareness events.

Tift Regional employees enjoy participating in the American Cancer Society's signature event, Relay For Life. In 2006, the TRMC Relay For Life team raised more than $75,000 helping the Tift County Relay become the number one Relay in the Nation for a population our size. Tift Regional also received a special Lifetime Achievement Award from the American Cancer Society in recognition of its outstanding, continued support of all the American Cancer Society endeavors including Relay For Life, which started 15 years ago.

The annual Tree of Life ceremony, recently commemorating its 22nd year of giving, was held in the new Outpatient Registration Lobby of the hospital. The ceremony is designed to remember those who have passed on and honor those who are fighting the battle against cancer. This fund-raiser helps provide for the special needs of patients of Hospice of Tift Area, Transitions, and the Oncology Center of Tift Regional Medical Center.

Another fundraising event benefiting patients of Hospice of Tift Area, Transitions, and the Oncology Center of Tift Regional Medical Center is The Nanci Bowen Charity Event, held in the Spring of 2006. In 2006, 26 teams of local golfers teed up for the 8th Annual Nanci Bowen Charity Event. The tournament was a success, raising more than $43,000. The 2007 event is scheduled for May 14 at Spring Hill Country Club.

Other community programs include Reach to Recovery, Look Good/Feel Better, Road to Recovery and the TRMC Cancer Support Group.

In addition to the numerous community education and fundraising activities that Tift Regional is involved in, TRMC also provides a number of free screenings for various types of cancer. These screenings are held throughout the year and are held in Tift County and the surrounding counties through our HealthPlus clinics. In 2006, more than 135 men were screening for prostate cancer, more than 200 women were screened for breast cancer, more than 175 people were screened for skin cancer and more than 500 at-home colon cancer screening kits were distributed. Tift Regional is always looking for ways to increase awareness and promote early detection.