

# CANCER PROGRAM

ANNUAL REPORT 2007

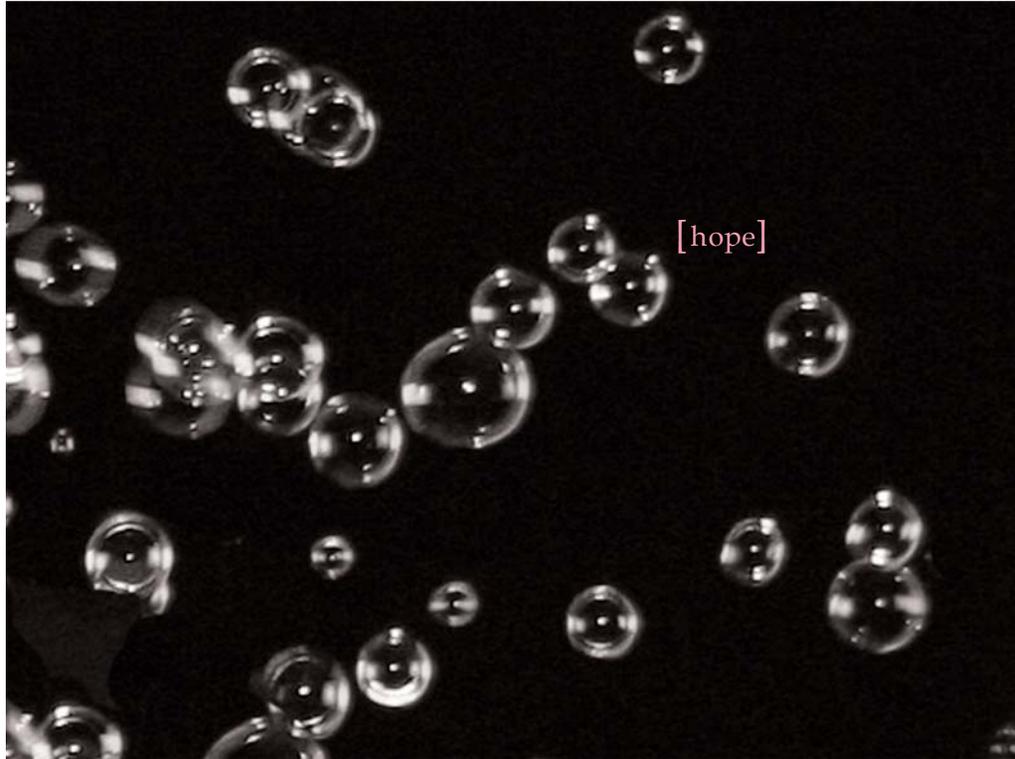
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#### SUMMARY

Looking over our breast cancer care and outcomes shows the care and services at Tift Regional to be comparable to other CoC approved programs. The treatment is within the current recommended guidelines. These guidelines change frequently and we contribute to the studies supporting these changes. Tift Regional looks forward to making a positive difference in breast cancer in our community.

#### REFERENCES

- American Cancer Society ([www.cancer.org](http://www.cancer.org))
- National Cancer Institute ([www.cancer.gov](http://www.cancer.gov))
- National Cancer Data Base (NCDB)
- American College of Surgeons (ACoS) ([www.facs.org](http://www.facs.org))
- [www.breastcancer.org](http://www.breastcancer.org)

## LEADERSHIP BIOS

### **James MacDonald, M.D.**      **Cancer Liaison Physician**

Dr. James MacDonald, pathologist, has served for the past four years as cancer liaison physician. 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. They facilitate submission of cancer program data to the National Cancer Data Base and use the comparative data provided back to the facility; and work with the local American Cancer Society to develop and support cancer control programs for the community. Dr. MacDonald provides pathology presentations at Cancer Conferences. He has contributed significantly to the success of the Cancer Program. Prior to serving as liaison, Dr. MacDonald served as chairman of the Cancer Committee.

### **Wesley Walker, M.D.**      **Radiation Oncologist**

Dr. Walker has been an active member of the Cancer Committee since 1999. He provides leadership and support to the cancer program by contributing to the annual goals and objectives. He currently monitors and reports to the cancer committee concerning Cancer Conference activity.

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

Dr. Moreno serves as an active member of the TRMC Cancer Committee, Southwest Georgia Cancer Coalition and the American Cancer Society Cancer Action Network. These organizations are dedicated to enhancing the delivery of comprehensive cancer care for all members of our local, regional and national community. He has been an advocate for cancer services for years.

### **Clarke Currie, MHA**      **Director, Oncology Services**

In December 2006, the oncology program received a Three-Year Approval with Commendation from the American College of Surgeons Commission on Cancer (CoC). In an era of accolades and recognition, what does this really mean?

A facility receives a Three-Year Approval with Commendation following the on-site evaluation by a physician surveyor. During the evaluation the facility must demonstrate a Commendation level of compliance with one or more standards that represent the full scope of the cancer program (cancer committee leadership, cancer data management, clinical services, research, community outreach, and quality improvement). In addition, a facility must receive a compliance rating for all other standards.

As a community hospital cancer program (CHCP) approved by the CoC, we are included in the 25 percent of all hospitals in the US and Puerto Rico that collectively diagnose and treat 80 percent of newly diagnosed cancer patients each year. This becomes more revealing when considering the numbers. The American Cancer Society estimates that more than 1.4 million cases of cancer will be diagnosed in 2007. Further, our participation in the National Cancer Data Base (NCDB) - a nationwide oncology outcomes database for more than 1400 hospitals in 50 states - enables us to compare our performance nationally.

The Cancer Program 2007 Annual Report again highlights what we are all about. Achieving a goal and attaining national recognition is always nice, but only through the daily focused work by many can such rewards become reality. Dedicated hands-on professionals coupled with community outreach programs have provided an effective quality mix. Although the medical environment continues to change, our vision remains constant - to provide competent and compassionate care in an environment that makes it unnecessary and undesirable for our patients to go anywhere else.

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## CANCER COMMITTEE MEMBERS

James Milner, MD  
Chairman, Cancer Committee  
Medical Oncology

Wesley Walker, MD  
Radiation Oncology

Kenneth Wurtz, MD  
Medical Oncology

Diane Patrick, RN, BSN  
Vice President - Patient Care Services

Christie Moore, RN  
Hospice Director

Mindy McStott, RN  
Quality Management

Kathy Alberson, RHIA  
HIM Director

Clarke Currie, MHA  
Director, Oncology Services

Marilyn Richardson, CTR  
Tumor Registrar

James MacDonald, MD  
Physician Liaison  
Pathology

Greg Anderson, MD  
Urology

Joel Johnson, MD  
Surgery

Stacey Heard  
Transitions Coordinator

Aneisa Young, LMSW, ACSW  
Oncology Social Worker

Kathy Lanier, RD  
Clinical Dietitian

Tressie Mathis, RN  
Pain Management

Nancy Hilton, RN  
Assistant VP - Patient Care Svs.

Stephanie Ellis, R.Ph.  
Pharmacy

Ray Moreno, MD  
Vice President  
Medical Affairs

Randall Lanier, MD  
Internal Medicine/Pulmonology

Wayne Stewart, MD  
Radiology

Faye Cooper, RN, OCN  
Oncology Nurse Manager

Karen Kimsey  
Education

Joy Davis  
Outreach and Development

## e - Q u I P

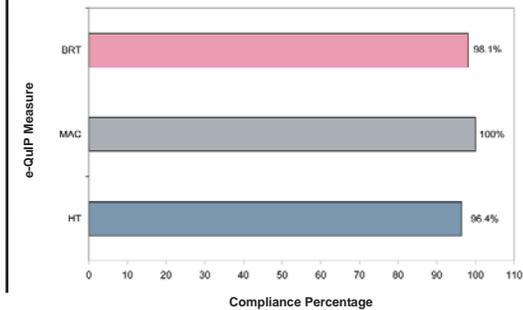
Commission on Cancer approved programs report cancers diagnosed at their facility to both State and National Agencies. e-QuIPs (Electronic Quality Improvement Packets) are released by the Commission on Cancer using the reported data to measure performance for each facility. Tift Regional participates in these ongoing E-QuIP studies. These treatment measures have been endorsed by the National Quality Forum (NQF). The most recent release of data measures for breast cancer treatment of cases diagnosed in 2003 & 2004 for the following measures include:

**BRT:** Patients receiving breast conserving surgery who are under age 70 should receive or be considered for radiation therapy.

**MAC:** Patients with Stage I (tumor size >1cm and N0) or Stage II/III (any tumor size and N+), with ER/PR- tumors should receive or be considered for combination chemotherapy.

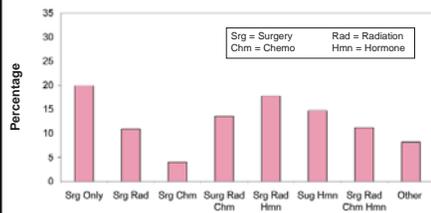
**HT:** Patients with Stage I (tumor size >1 and N0) or Stage II/III (any tumor size and N+) with ER+ or PR+ tumors should receive or be considered for hormonal therapy (Tamoxifen or third generation Aromatase Inhibitor)

Tift Regional Medical Center Breast Cancer e-QuIP Study Performance Rates  
2003-2004 Cases



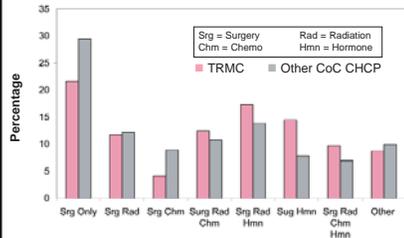
**Graph K:** shows TRMC performance rates for the e-QuIP breast cancer measures.

**TRMC Breast Cancer 2000-2006  
First Course Treatment**



**Graph H:** shows the first course therapy given to breast cancer patients at Tift Regional from 2000-2006.

**TRMC Breast Cancer 2000-2005 Compared to CoC Community Hospital Cancer Programs First Course Treatment**

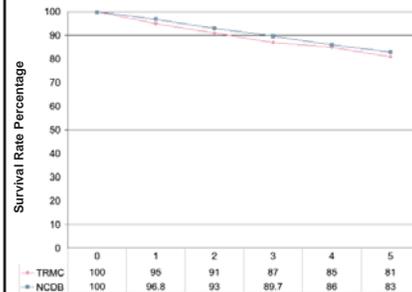


**Graph I:** NCDB Benchmark data from 2000-2005 compares the first course treatment combinations given at Tift Regional to other CHCP. Fewer patients are given surgery alone and a higher percentage of patients receive combination therapy at Tift Regional.

## S U R V I V A L

Long-term follow-up is essential to evaluate outcomes of cancer care. Patient follow-up obtained by the Tumor Registry enables Tift Regional to compare outcomes with national statistics. The breast cancer death rate in the United States continues to drop more than two percent per year, a trend that began in 1990 and is credited to progress in early detection and treatment.

**TRMC Five Year Observed Breast Cancer Survival Compared to NCDB Five Year Observed Breast Cancer Survival**



**Graph J:** The five year observed survival rate for breast cancer patients diagnosed compares favorably with NCDB benchmarks. 474,330 patients are included in the NCDB survival analysis compared to 502 patients in the Tift Regional survival analysis.

## CANCER CHAIRMAN REPORT

On behalf of the Cancer Committee, I am pleased to share with you the 2007 Annual Report summarizing Tift Regional Medical Center's experience with cancer for the year. This report provides a review of general statistical data on new cancer cases for the year 2006 and highlights Cancer Program activity for the year 2006-2007.

As in the 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 education, early detection, screening, prevention, treatment, supportive care, palliation, and rehabilitation.

The Oncology Center is in its ninth year of operation and is continuing to thrive and improve. The dedicated individuals associated with the Oncology Center, along with others in the community and surrounding areas, are committed to caring for cancer patients. They continue to provide state-of-the-art services with the highest quality and standard of care in a warm and friendly environment. This commitment has translated into recognition from independent groups that help define the national standard in these areas. For example, the American College of Surgeons has inspected and approved our center for accreditation with commendation.

As attested to and verified by multiple review organizations, the strong cancer care team at Tift Regional continues to provide quality and compassionate care to all patients while emphasizing a multidisciplinary team approach to treatment, education, social support, and life-long follow up that meets or exceeds nationally established standards. Statistics gathered and published by the tumor registry continue to verify our overall success and illustrate why we remain among the top community cancer centers in the nation.

As we continue to improve our Oncology Center, I would like to thank all of 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 members of 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. Without the efforts of all of these individuals, we would not enjoy the success that we have achieved as evidenced in the accomplishments that this report documents.

Once again, with pride and anticipation for the future, the Cancer Committee is pleased to present this report summarizing our experience with cancer this year.



**JAMES MILNER, MD**  
Cancer Committee  
Chairman

## TUMOR REGISTRY

The Tumor Registry has completed its 7th year of reporting cancer data. Cancer reporting began in the 1930's and was developed nationwide under the Federal Cancer Registry Amendment Act of 1992. Patient information remains confidential and is subject to Tift Regional Medical Center's disclosure policies.

The Registry is a data base of patients diagnosed and treated at Tift Regional. These patients are followed throughout their life. There are 3200 patients in the registry and follow-up is actively done on more than 1600 cases. Contact is maintained on an average of 94% of these patients. In 2006, 495 new cases were added to the data base, 413 of these cases were analytical and more than 10% of those were reviewed by a physician member of the cancer committee for accuracy.

Additions to the data base are reported monthly to the Georgia Comprehensive Cancer Registry (GCCR) through the Georgia Center for Cancer Statistics (GCCS) at the Rollins School of Public Health at Emory University. Annual reporting is done to the National Cancer Data Base, a joint program of the Commission on Cancer (CoC) and the American Cancer Society. Participation with the CoC is optional. We are proud of our recent 3 year approval with commendation.

The Registry is maintained by 2 fulltime Certified Tumor Registrars, both members of the National Cancer Registrars Association (NCRA) and the Georgia Tumor Registrars Association (GATRA). Active participation in workshops and conferences offered by NCRA, GATRA, GCCS and the CoC promote accurate reporting of cancer data. Health care professionals are encouraged to request this data locally to eval-

uate patient care and trends. The data is also used to attract donations and grants for use at the local level for research and care of our residents.

Under the guidelines established by the CoC, the Tumor Registry coordinates the Cancer Conference twice each month. Cancer Conference is designed to promote discussion of patient treatment plans in an interdisciplinary setting. Physicians may submit cases for discussion with pathologists, radiologists, surgeons and oncologists. Continuing education credits are available for physicians and other clinical personnel participating in the Conference. In 2006 eighteen Cancer Conferences were held with 52 cases presented. This represented over 10% of the Registry caseload.

In the future, the Tumor Registry looks forward to participation in a move to more rapidly report cancer data to provide health care professionals and researchers current information about cancer in the United States. We plan to assist with a CDC sponsored study evaluating patterns of care for prostate and breast cancer. For more information on cancer in Georgia, see the South Atlantic Division Cancer Facts and Figures 2007, distributed by the American Cancer Society with data supplied by Tumor Registries statewide.

## TREATMENT

In recent years, there's been an explosion of life-saving treatment advances against breast cancer, bringing new hope and excitement. Instead of only one or two options, today there's an overwhelming menu of treatment choices that fight the complex mix of cells in each individual cancer. Treatment options may include surgery, radiation, chemotherapy and hormonal (anti-estrogen) therapy.

**Surgery** - Most patients with breast cancer have surgery to remove the cancer from the breast. The lymph nodes closest to the cancer (the sentinel nodes) are analyzed to determine if there are cancer cells. This sentinel node is used to predict the spread to other lymph nodes. Further lymph nodes may be removed based on the biopsy. Depending on several factors, the patient may have breast-conserving surgery, simple or modified radical mastectomy. Reconstructive surgery may be offered. Even if the doctor removes all the cancer at the time of surgery, some patients may be given radiation therapy, chemotherapy, or hormonal therapy after surgery to kill any cancer cells that may remain.

**Medical Oncology** - Medical oncology utilizes an outpatient procedure known as chemotherapy, which is the use of

drugs to destroy cancerous cells and prevent further growth. Chemotherapy medications are given orally, by injection, or by infusion and can be used in combination with surgery and/or radiation.

**Radiation** - Using simulation and computerized treatment planning, the Oncology Center utilizes photon and electron radiation beam therapy to cure or control malignant growths. Intensity Modulated Radiation Therapy (IMRT) is also available to provide high dose radiation to the tumor site while assuring fewer side effects.

Hormonal therapy works against hormone-receptor-positive breast cancer. It is completely different from hormone replacement therapy (HRT), which some women take during or following menopause. HRT is not a breast cancer treatment, and for women with a breast cancer diagnosis, HRT is considered unsafe.

Aromatase inhibitors are now considered the standard of care for postmenopausal women with hormone-receptor-positive breast cancer. Tamoxifen remains the hormonal treatment of choice for pre-menopausal women.



MELISSA BAXTER  
[2 year ovarian cancer survivor]

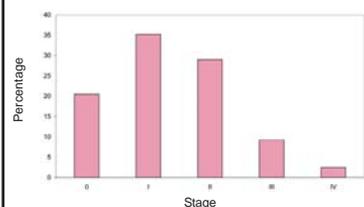
therefore make too much HER2 protein. If the test shows amplification of genes, the test is considered HER2 positive. If the test shows a normal number of genes, the test is considered HER2 negative.

**Oncotype DX** testing looks at many different genes in a breast cancer. Genes control the behavior and activities of all cells, including cancer cells. When cells are behaving abnormally, a high level of certain genes is usually present. By measuring the levels of specific genes, the Oncotype DX test calculates a recurrence score. The higher the recurrence score, the more likely the recurrence. In combination with other factors, such as age, cancer size, levels of hormone receptor protein, and cancer grade, this recurrence score can help predict the risk of cancer coming back in women with node-negative, estrogen-receptor-positive breast cancer. A woman whose risk of recurrence is high needs to seriously consider having chemotherapy, in addition to hormonal therapy after surgery with or without radiation.

## STAGING

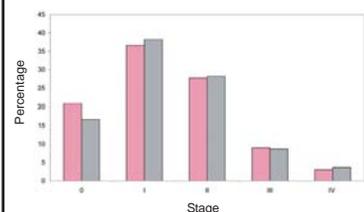
The prognosis (chance to recovery) and treatment options depend on the stage of the cancer (whether it is in the breast only or has spread to lymph nodes or other places in the body).

**TRMC Breast Cancer 2000-2006 Stage at Diagnosis**



**Graph F:** The majority of the cases at Tift Regional are diagnosed at stage I and II.

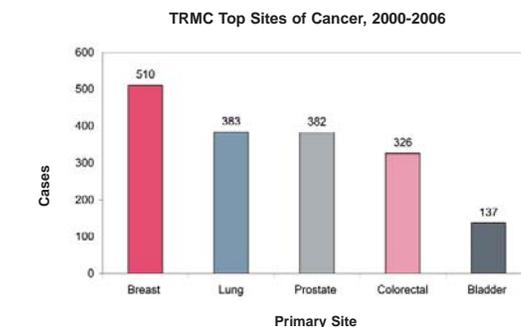
**TRMC Breast Cancer 2000-2005 Compared to Community Hospital Cancer Programs**



**Graph G:** NCDB Benchmark data from 2000-2005 shows a higher percentage of TRMC breast cancer patients diagnosed at stage 0 and less at stage IV compared to other CHCP.

## SITE

	Male	Female	Combined
Other & Unspecified			
Parts of the Tongue	1	0	1
Palate	1	0	1
Parotid Gland	1	0	1
Oropharynx	2	0	2
Nasopharynx	1	1	2
Pyrimiform Sinus	2	0	2
Esophagus	2	0	2
Stomach	2	3	5
Small Intestine	3	2	5
Colon	20	20	40
Rectosigmoid Junction	2	0	2
Rectum	8	2	10
Anus & Anal Canal	0	4	4
Liver-Intrahepatic Bile duct	0	7	7
Other, Unspecified			
Parts Biliary Tract	0	1	1
Pancreas	2	3	5
Accessory Sinuses	0	1	1
Larynx	9	0	9
Bronchus & Lung	32	26	58
Heart, Mediastinum & Pleura	1	0	1
Bones, Joints, Articular			
Cartilage of Limbs	1	0	1
Hematopoietic/			
Reticuloendothelial Systems	7	11	18
Skin	3	3	6
Connective, Subcutaneous			
& Other Soft Tissues	2	0	2
Breast	1	69	70
Vulva	0	1	1
Vagina	0	1	1
Cervix Uteri	0	6	6
Corpus Uteri	0	13	13



	Male	Female	Combined
Uterus, NOS	0	1	1
Ovary	0	2	2
Prostate Gland	61	0	61
Testis	1	0	1
Kidney	9	8	17
Renal Pelvis	1	0	1
Ureter	1	1	2
Bladder	15	2	17
Brain	3	6	9
Thyroid Gland	0	3	3
Lymph Nodes	4	6	10
Unknown Primary Site	5	7	12
<b>Total</b>	<b>203</b>	<b>210</b>	<b>413</b>

**Table 1** shows the incidence of cancer in 2006 by primary site. Of the total 413 analytical cases in 2006, 203 cases (49%) were male and 210 cases (51%) were female. The top sites for 2006 cases were breast, prostate, lung, colorectal, bladder and kidney. Prostate cancer comprised (30%) of the male cancer, followed by lung (15%), colorectal (15%) and bladder (7%). For females, the primary sites of cancers were breast (33%), lung (13%) colorectal (10%), uterus (7%) and hematopoietic (5%).

## ONCOLOGY SOCIAL WORKER

The Oncology Social Worker provides services to patients, families, and significant others facing the impact of a potential or actual diagnosis of cancer. These services are available to patients and families throughout all phases of cancer.

Specific services offered at our Oncology Center include:

- Patient/Family Assessment
- Case Management / Program Development / Multidisciplinary Team Coordination
- Supportive Counseling (Individual and family; provided by licensed professionals)
- Financial Counseling to include pharmacy assistance
- Grief/Bereavement Counseling
- Self Image Supplies
- Educational library for use by patients and family
- Look Good Feel Better: (Bi-monthly)
- Referral to Reach to Recovery and Road to Recovery
- Monthly Cancer Support Group (Open to the public)
- Transportation Program
- Fertility Counseling
- Spiritual Counseling by on-call clergy

## H O S P I C E

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 support the family, both during and after the illness.

The hospice team is composed of physicians, nurses, social workers, chaplains, certified nursing assistants, bereavement counselors 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 2006, approximately 36.5% of the patients cared for by the Hospice of Tift Area had a cancer diagnosis.

Hospice has served the community for over 20 years.

## C O M M U N I T Y O U T R E A C H

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 screening, education classes, community lectures, and participation in community health fairs and health awareness events.

Relay for Life: Tift Regional employees enjoy participating in the American Cancer Society's signature event, Relay For Life. TRMC is very involved in the planning of this event and always provides a very enthusiastic team - most recently raising more than \$80,000.

Education: For patients living with cancer and their families, education is an important aspect of care. The Tift Regional Medical

identifies breast cancer early in its development. This is often a year or two before it is large enough to be felt by a healthcare provider. Mammography detects about 2-3 times as many early breast cancers as a physical exam. Over 10,000 digital mammograms are performed annually at the Women's Imaging Center.

**Ultrasound** - A breast ultrasound may be used to evaluate possible breast abnormalities that are detected during screening, diagnostic mammogram or a clinical breast exam. It may also be used to distinguish between solid growths and fluid-filled cysts.

**MRI** (magnetic resonance imaging) - MRI of the breast is not a replacement for mammography or ultrasound imaging but rather a supplemental tool for detecting and staging breast cancer. In presenting guidelines for MRI breast examinations at the 12th annual National Comprehensive Cancer Network (NCCN) on Clinical Practice Guidelines and Quality Cancer Care, it was recommended breast MRI be performed with a dedicated breast coil. A dedicated breast coil works with the MRI unit to create the images. This technology is available at Tift Regional. During 2006 110 breast MRI's were performed. The procedure is performed with breast image radiologists familiar with the optimal timing sequences and other technical details for image interpretation. Breast MRI is per-

formed and interpreted by an expert breast imaging team working in concert with the multidisciplinary treatment team.

In 2007, Tift Regional installed the region's first High Field 1.5T open bore magnetic resonance imaging (MRI) system for larger patients and those with claustrophobia. Another unique component of the open bore MRI is a breast MRI feature with computer aided detection (CAD). This enables radiologists to improve identification of tumors that may be missed by mammography or ultrasound. The American Cancer Society now recommends that women with a 20 to 25% or greater lifetime risk of disease undergo an annual MRI in addition to mammography.

**Biopsy** - In many cases it is not possible to tell from the imaging studies alone whether a growth is benign or cancerous. To make this determination it is necessary to obtain a tissue sample for microscopic examination. Core biopsy, a less invasive alternative to open surgical biopsy, uses a hollow needle passed through the skin into the suspicious lesion with the help of special breast x-rays. This sample of breast tissue is evaluated to determine whether the lesion is malignant or benign. A special computerized mammography machine uses intersecting coordinates to pinpoint the area of tissue change. This method is called stereotactic biopsy or x-ray-guided biopsy. During 2006, 129 digital stereotac-

tic biopsies and 57 core biopsies were performed at this facility.

**Tumor Markers** - Tumor marker testing can help predict how a tumor may behave and help guide the choice of the best treatment options for that particular cancer. Results can help guide timing, extent and selection of cancer treatment. For breast cancer, the tests examine tumors to reveal the presence or absence of markers on the surface of the cell or in its nucleus, such as hormone receptors for estrogen (ER) and progesterone (PR) or human epidermal growth factor receptor-2 (HER2) protein over expression or gene amplification. These tests have both prognostic and therapeutic implication.

**IHC** or immunohistochemistry is an antigen-based diagnostic technique. In breast cancer it is used to identify whether cancer cells have over-expression of HER2 antigens. IHC measures HER2 antigen over expression on different levels -0, 1+, 2+ and 3+. If the test is 2+, the NCCN recommends that a FISH test be conducted to confirm HER2 positive or negative status. If the tumor is 3+, it is HER2 positive. IHC techniques are also used to identify ER and PR status.

**FISH** or fluorescence in-situ hybridization is a gene-based diagnostic technique used to identify women whose breast cancer cells carry amplified HER2 genes and



JUDY HART

[1.5 year breast cancer survivor]

## D I A G N O S I S

Today, more breast cancer cases are found early. This makes them more treatable and less life-threatening. The interdisciplinary health care team is committed to early detection of breast cancer.

The Outreach and Development Department coordinates education to the community. In honor of Breast Cancer Awareness Month in October, the TRMC Oncology Center and HealthPlus provide free clinical breast exam screenings throughout the region. During these events women are provided information concerning risk factors, breast self-examinations, mammograms, treatment options and general women's health.

**BSE** - Women should know how their breasts normally look and feel. Beginning in their 20's, they should learn the benefits of breast self-exam (BSE) and should perform monthly exams. Women should report any breast changes promptly to their healthcare provider.

**CBE** - Women between the ages of 20 and 30 should have a clinical breast exam as part of a regular health exam by a healthcare provider every three years. After age 40, women should have a clinical breast exam annually.

**Mammography** - Women age 40 and older should have a screening mammogram every year and should continue to do so for as long as they are in good health. Having regular mammograms is the first step toward preventing and surviving breast cancer.

The Women's Imaging Center at Tift Regional provides digital mammography services that are accredited by the American College of Radiology. Digital mammography pro-



[Tree of Life]



[The Nanci Bowen Charity Event always proves to be a fun day of good friends and good golf.]



[The Tift Regional employees are committed to the American Cancer Society's Relay For Life - it is evident in their efforts every year.]

Center Foundation has provided an educational area inside the Oncology Center equipped with internet access, brochures, and videos - all in a quiet place where people can relax while learning. Public education takes on many forms such as cancer screenings, education classes and participation in community health fairs and health awareness events. TRMC also hosts a variety of community lectures that focus on the prevention and early detection of cancer.

**Tree of Life:** The Tree of Life ceremony, commemorating its 21st year of giving, was held at the hospital in December of 2006. The event is held annually and is open to the public. The ceremony is designed to remember those who have passed on and honor those who are fighting the battle with cancer. This fund-raiser helps pro-

vide for the special needs of patients of Hospice of Tiftarea, Transitions, and the Oncology Center of Tift Regional Medical Center.

**Nanci Bowen Charity Event:** Every fall Tift Regional organizes the Nanci Bowen Charity Event, benefiting patients of Hospice of Tiftarea, Transitions, and the Oncology Center of Tift Regional Medical Center. This year 28 teams of local golfers teed up for the 8th Annual Nanci Bowen Charity Event. The tournament was a huge success, raising more than \$45,000.

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

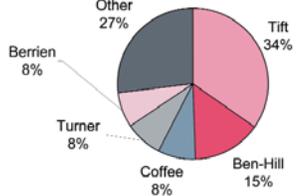
# CASE STUDY BREAST CANCER

According to the American Cancer Society, about 178,480 women in the United States will be found to have invasive breast cancer in 2007. About 40,460 women will die from the disease this year. Breast cancer is the most common reportable cancer among women in the United States. Currently, there are about two and a half million breast cancer survivors in the United States. The chance of a woman having invasive breast cancer some time during her life is about 1 in 8.

Five hundred and two (502) women were diagnosed or treated at Tift Regional Medical Center with breast cancer from 2000-2006. There were also 6 male breast cancer cases and 2 additional cases of sarcoma of the breast during this period, which are not included in this analysis.

Graph A

**TRMC Breast Cancer 2000-2006  
County of Residence at Diagnosis**



**Graph A:** shows the county of residence of the 502 women diagnosed or treated with breast cancer at Tift Regional.

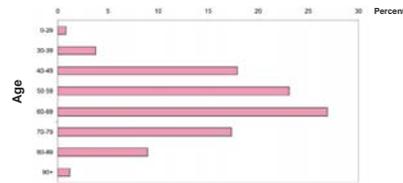
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## AGE

The chance of getting breast cancer increases as a woman gets older. About 2 out of 3 women with invasive breast cancer are age 55 or older when the cancer is diagnosed.

Graph B

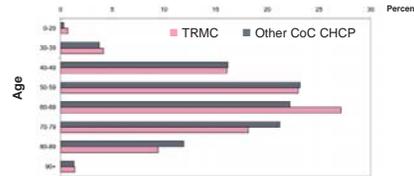
**TRMC Breast Cancer 2000-2006  
Age at Diagnosis**



**Graph B:** TRMC breast cancer cases increased with age from 2000-2006.

Graph C

**TRMC Breast Cancer 2000-2006 Age at Dx  
Compared to Community Hospital Cancer Programs**



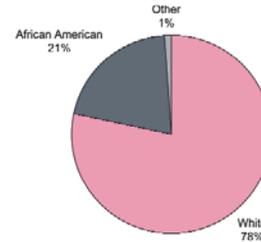
**Graph C:** NCDB Benchmark data shows as the population ages, the number of breast cancer cases increased at Tift Regional and other CHCP's during 2000-2005.

## RACE

White women are slightly more likely to be diagnosed with breast cancer than African-American, Asian, Hispanic or American Indian women. However, African-American women are more likely to die of this cancer. It seems to be that African-American women have faster growing tumors.

Graph D

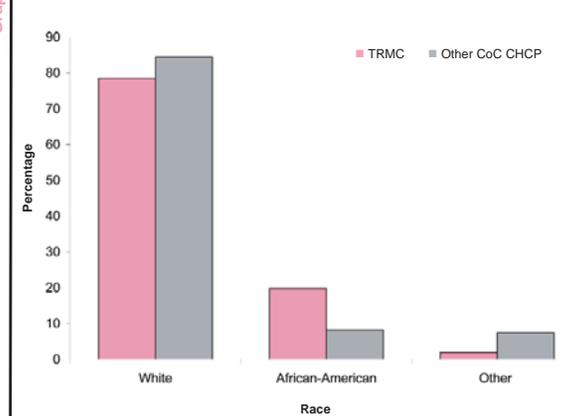
**TRMC Breast Cancer  
2000-2006 Race**



**Graph D:** The race of the TRMC breast cancer patients from 2000-2006 was 78% white, 21% African-American and 1% Other.

Graph E

**TRMC Breast Cancer 2000-2005  
Compared to Community Hospitals Cancer Programs**



**Graph E:** NCDB Benchmark comparison shows more white women are diagnosed with breast cancer than African-American Women, both at Tift Regional and at other CHCP.

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