Well, it's that time again for the yearly report from the Cancer Committee. As has been the custom in years past, the Cancer Committee continues to meet regularly and provides supervision and direction for a very active and progressive 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 seventh year of operation and is growing rapidly. The dedicated individuals associated with the Oncology Center continue to provide state-of-the-art services and technology along with the highest quality of care in a warm and friendly environment made possible by the successful renovation and expansion of the Oncology Center a year and a half ago that allowed for the integration of both Medical and Radiation Oncology in one convenient location. The inclusion of on-site social work services, an on-site lab, and an on-site pharmacy contributes tremendously to both the convenience and the high standard of care provided to the patients served by the 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 lifelong follow up that meets or exceeds nationally established standards.

Personnel changes in the past year have aided in further strengthening the Oncology Center by allowing open positions to be filled with only the most exceptional individuals of the finest capability and character firmly committed to the goals and mission of the Oncology Center. This has enabled us to better and more effectively serve the ever-growing and demanding cancer needs of our patients and our community. A new director of services has been selected, a new Hospice director has been chosen, a new nurse manager has been appointed, new staff positions have been filled and new services have been added to accommodate our growth and expansion.

As we continue to grow and improve our Oncology Center, I would like to thank all the special individuals employed there who are involved in the success of this endeavor. In this sense, I would also like to thank the active members of the Cancer Committee, the interested and involved local and regional physicians and nurses, and all ancillary departments for their dedication and hard work. 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.

At this time, the Cancer Committee is pleased to present the 2005 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 2004, the report highlights Cancer Program activities for the year 2004-2005.
Cancer Committee Members

Cancer Liaison Physician
Dr. James MacDonald, pathologist, has served for the past two 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 uses the comparative data provided back to the facility; and who works 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 Medical Center.

Ray Moreno, M.D.
Vice President/ Medical Affairs
Dr. Raymond Moreno is the newest member of our Tift Regional Cancer Committee. He assumes the position held by long time member and friend, Dr. Sammie Dixon. Dr. Moreno will continue to work closely with the Cancer Committee to enhance the delivery of comprehensive cancer care services to all members of our community.

Clarke Currie, MHA
Director, Oncology Services
At Tift Regional Medical Center Oncology Center, our vision is simple - "to provide competent and compassionate care in an environment that makes it unnecessary and undesirable for our patients to go anywhere else." Getting there takes focused work.

Our highly specialized team of dedicated providers is rising to the challenge. Allocating the necessary resources of time and money to maintain and build on our professional competencies is a commitment.

Compassion goes beyond any classroom; it resides in the heart of the caregiver. Our focus is the patient - that is clear. This tenet is fundamental to real success. Our exceptional patient satisfaction survey results provide the litmus test that we truly are committed to what we do.

Our investments in the latest medication and radiation treatment modalities and equipment means we can provide necessary services for our patients close to home. By providing both medical and radiation oncology services under one roof, the value to many of our patients is enhanced.

Becoming a center known for excellence requires the work of many. We are headed in the right direction. The relationship between provider and patient is unmistakable; the results of hard work are measurable. So why go anywhere else?
Cancer Committee Members

Faye Cooper, RN, OCN
Radiation Oncology
Tina Mann, RN
Oncology Nurse Manager
Nancy Hilton, RN
Assistant VP Nursing
Christie Moore, RN
Hospice Director
Blakely Harper, LMSW
Social Work Services
Angie King, BSN, CPHQ, ABQAURD
Quality Management Director
Joan Erstling, RN
Education
Maghan Campbell
Marketing Coordinator

Kathy Alberson, RHIA
Medical Records Director
Marilyn Richardson, RHIT, CTR
Tumor Registrar
Vance Bryant, PT
Physical Therapy
Stephanie Ellis
Pharmacy
Stacey Heard
Transitions Coordinator
Mindy McStott, RN
Case Management
The Tumor Registry at Tift Regional Medical Center is completing its 5th 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 2400 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 1,300 cases are currently under active follow-up with an average successful follow up rate of 95 percent.

The registry is maintained by a Certified Tumor Registrar and an additional registrar who are members of the National Cancer Registrars Association (NCRA) and the Georgia Tumor Registrars Association (GATRA). Knowing the importance of continuing education, they 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 healthcare 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 are held twice monthly and 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 2004 with forty-one (41) cases presented, which represents ten percent of the annual caseload. Of the cases presented ninety-eight percent were prospective and two percent were retrospective.

During 2004, 434 new cases were entered into the database; 377 were analytic and 57 were non-analytic. Data for cancer diagnosed at Tift Regional Medical Center in calendar year 2004 is presented. A physician member of the cancer committee reviewed more than 10% of the 2004 cases for accuracy and completeness.
Graph 1 illustrates the total number of analytical cases entered into the tumor registry database by accession year.

Graph 2 reflects the distribution of cases by county at diagnosis. Of the 373 new cases seen at Tift Regional Medical Center in 2004, 37% were from Tift County, and 63% were from neighboring counties in South Georgia.

<table>
<thead>
<tr>
<th>Female</th>
<th>2004 Cases: Distribution by County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast</td>
<td>5,430</td>
</tr>
<tr>
<td>Lung &amp; Bronchus</td>
<td>2,250</td>
</tr>
<tr>
<td>Colon &amp; Rectum</td>
<td>1,940</td>
</tr>
<tr>
<td>Uterine Corpus</td>
<td>790</td>
</tr>
<tr>
<td>Ovary</td>
<td>610</td>
</tr>
<tr>
<td>Non-Hodgkin’s Lymphoma</td>
<td>600</td>
</tr>
<tr>
<td>Melanoma</td>
<td>560</td>
</tr>
<tr>
<td>Uterine Cervix</td>
<td>430</td>
</tr>
<tr>
<td>Pancreas</td>
<td>400</td>
</tr>
<tr>
<td>Thyroid</td>
<td>360</td>
</tr>
<tr>
<td>Other</td>
<td>3,710</td>
</tr>
<tr>
<td>All Sites</td>
<td>17,080</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Male</th>
<th>2004 Cases: Distribution by County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prostate</td>
<td>5,710</td>
</tr>
<tr>
<td>Lung &amp; Bronchus</td>
<td>3,720</td>
</tr>
<tr>
<td>Colon &amp; Rectum</td>
<td>2,080</td>
</tr>
<tr>
<td>Bladder (including in situ)</td>
<td>1,050</td>
</tr>
<tr>
<td>Non-Hodgkin’s Lymphoma</td>
<td>600</td>
</tr>
<tr>
<td>Melanoma</td>
<td>760</td>
</tr>
<tr>
<td>Oral Cavity</td>
<td>620</td>
</tr>
<tr>
<td>Kidney &amp; Renal Pelvis</td>
<td>570</td>
</tr>
<tr>
<td>Pancreas</td>
<td>420</td>
</tr>
<tr>
<td>Leukemia</td>
<td>460</td>
</tr>
<tr>
<td>Other</td>
<td>460</td>
</tr>
<tr>
<td>All Sites</td>
<td>19,470</td>
</tr>
</tbody>
</table>

Table 1 shows the Georgia Center for Cancer Statistics' estimated number of cancer cases by sex for the year 2004.

Graph 3 and 4 demonstrate the percentage of cases of the five major sites of cancer in women and in men seen at Tift Regional Medical Center during 2004 compared to the State estimated percentage of cases for the same five sites.
During the last five years, the top five cancer sites have not shown a great deal of variability.

**Accession Comparison Top 5 Sites 2000-2004**

<table>
<thead>
<tr>
<th>Year</th>
<th>Breast</th>
<th>Lung</th>
<th>Prostate</th>
<th>Colorectal</th>
<th>Bladder</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>75</td>
<td>78</td>
<td>55</td>
<td>40</td>
<td>21</td>
</tr>
<tr>
<td>2001</td>
<td>75</td>
<td>68</td>
<td>47</td>
<td>51</td>
<td>21</td>
</tr>
<tr>
<td>2002</td>
<td>89</td>
<td>47</td>
<td>50</td>
<td>41</td>
<td>20</td>
</tr>
<tr>
<td>2003</td>
<td>77</td>
<td>47</td>
<td>38</td>
<td>52</td>
<td>22</td>
</tr>
<tr>
<td>2004</td>
<td>71</td>
<td>41</td>
<td>58</td>
<td>43</td>
<td>12</td>
</tr>
<tr>
<td>Total</td>
<td>367</td>
<td>277</td>
<td>246</td>
<td>227</td>
<td>55</td>
</tr>
</tbody>
</table>

**Graph 5** shows that breast cancer has occupied the number one position for the past five years followed by lung cancer with the third most prevalent site being prostate cancer and the fourth being colorectal cancer. During 2002 and 2004 prostate cancer exceeded lung cancer, in 2001 and in 2003 prostate cancer was slightly exceeded by colorectal cancer, and in 2000 lung cancer was slightly more prevalent than breast cancer. Bladder cancer has consistently remained in fifth position.

**Table 2** shows the incidence of cancer in 2004 by primary site. 178 cases (47%) diagnosed in 2004 were male and 199 cases (53%) were female. Prostate cancer comprised (33%) of the male cancer, followed by lung (14%), colon (11%) and hematopoietic (6%). For females, the primary sites of cancers were breast (36%), colon (9%), lung (8%) and uterus (5%).
Community 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 screening, education classes, and participation in community health fairs and health awareness events.

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

**Tree of Life** - The annual Tree of Life ceremony, recently commemorating its 20th year of giving, was held on the front lawn of the hospital. The event is held yearly and is open to the general 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 provide 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 we organize the Nanci Bowen Charity Event benefitting 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 6th Annual Nanci Bowen Charity Event. The tournament was a huge success raising more than $41,000.

**Relay For Life** - Tift Regional employees also 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 $50,000.

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

**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 2004, approximately 45.6 percent of the patients cared for by the Hospice of Tift Area had a cancer diagnosis.

**Social Work Services**

Social Work Services are actively involved in the care of cancer patients at Tift Regional Medical Center. The oncology social worker serves as an advocate for patients and caregivers and offers planning for post hospitalization, counseling and emotional support services, and assistance with financial concerns. Information is provided by the social worker about community resources and support groups, cancer wellness programs and programs sponsored by the American Cancer Society. The social worker facilitates our monthly cancer support group and actively participates on the Board of Directors of the local American Cancer Society. The Nanci Bowen Charity Event and The Tree of Life Ceremony provide funds for the special needs of patients of Hospice of Tiftarea and the Oncology Center of Tift Regional Medical Center.
Community Activity Calendar

February 22  Eighth Street Middle School Health Fair - Information provided on mouth cancer
March 29    Hospice Open House
March 31    Women’s Imaging Center Grand Opening
April 2     Arts in Black Festival - gave out 50 ColoCare Kits
April 22-23 Relay For Life - Tift County - TRMC team raised over $50,000
April 22-23 Cook County Relay For Life
May 13-14   Berrien County Relay For Life
May 21      Breast Cancer Screening - Tift Community Health Center
May 31      Senior Seminar - Cancer educational materials provided
June 11     Skin Cancer Screening at Sylvester HealthPlus (64 participants)
July 16     Mejor Salud: Mejor Vida - Hispanic Health Fair
            - information on breast, prostate, colon and lung cancer
August 5    Relay for Life - Turner County - sponsored survivor tent
August 9    Caring for You, Caring for Me - Seminar for caregivers
August 18   Bosom Buddies Support Group
August 20   Skin Cancer Screening at Adel HealthPlus (63 participants)
August 27   Women’s Event - Cancer information provided
September 1 Prostate Cancer Screening at Nashville HealthPlus (29 participants)
September 15 Prostate Cancer Screening at Adel HealthPlus (38 participants)
September 19 Nanci Bowen golf tournament
September 19 Prostate Cancer Screening at Sylvester HealthPlus (42 participants)
September 26 Prostate Cancer Screening at Ashburn HealthPlus (23 participants)
October 1   Prostate Cancer Screening at TRMC Oncology Center (95 participants)
October 3   Breast Cancer Screening at Adel HealthPlus (32 participants)
October 4   Breast Cancer Screening at Sylvester HealthPlus (51 participants)
October 17  Breast Cancer Screening at Nashville HealthPlus (30 participants)
October 21  Community Wide Health Fair at Leroy Rogers Center (50 ColoCare kits)
October 25  Lung Health Day - Lung health information (50 participants)
October 26  Breast Cancer Awareness Lecture - Judy Weaver, FNP (80 participants)
October 29  Breast Cancer Screening at TRMC Oncology Center (47 participants)
November 1  Colquitt EMC health fair (550 ColoCare kits)
November 17 Hospice Lecture, speaker: Dr. Martha Giddings
December 7  Hospice Lecture, speaker: Kristen Walker
December 8  Tree of Life

[Image of people at a health fair]

[Image of a health fair with information on mouth cancer]
Prostate cancer is the most commonly found cancer among American men, with the exception of skin cancer. The American Cancer Society estimates that there will be 232,090 newly diagnosed cases of prostate cancer in the United States in the year 2005. Prostate cancer is second only to lung in the number of cancer deaths each year among American men and about 30,350 men will die from this disease in 2005.

**Risk Factors**

One out of every six men will get prostate cancer during his lifetime. Although the exact cause of prostate cancer is unknown, there are certain risk factors linked to the disease. They are as follows:

- **Age** - The chance of getting prostate cancer increases as you age. Nearly 2 of 3 prostate cancers are found in men over the age of 65.

- **Race** - Although we do not yet understand why, prostate cancer is more common in African American men than in white men. African American men are also twice as likely to die from this disease. Asian men are less likely than white men to be diagnosed with prostate cancer.

- **Nationality** - This cancer is most commonly found in North America and northwestern Europe. It is less commonly found in Asia, Africa, Central America and South America.

- **Family History** - Men who have had a father or brother with prostate cancer are more likely to get it themselves. This is especially true if their relative was diagnosed at a young age.

- **Diet** - Men with a diet high in red meat or high-fat dairy products appear to have a greater risk of getting prostate cancer. Often these men eat fewer fruits and vegetables. Doctors are not sure which of these causes the risk elevation, so they currently advise men to eat 5 or more servings of vegetables and fruits each day and to eat less red meat and high-fat dairy products.
Warning Signs

Possible signs of prostate cancer include:

- Weak or interrupted flow of urine
- Frequent urination (especially at night)
- Trouble urinating
- Pain or burning during urination
- Blood in the urine or semen
- Pain in the back, hips, or pelvis that does not go away
- Painful ejaculation

Early prostate cancer usually has no symptoms. With more advanced disease a person may experience symptoms similar to those listed above. Most often, these symptoms are nonspecific and are similar to those caused by benign conditions. Anyone with these symptoms should see a doctor so that any problem can be diagnosed and treated as early as possible. Because early cancer does not cause pain it is important not to wait to feel pain before seeing a doctor.
Prostate cancer can be found and treated early through certain screening tests. 65% of the prostate cancer cases at TRMC from 2000-2004 were diagnosed because of an elevated PSA. Studies suggest that these tests have led to a drop in the number of prostate cancer deaths.

### AMERICAN CANCER SOCIETY
Prostate Screening Guidelines

1. The prostate-specific antigen (PSA) test and the digital rectal examination (DRE) should be offered annually, beginning at age 50, to men who have a life expectancy of at least 10 years.
2. Men at high risk (African-American men and men who have a strong family history of one or more first-degree relatives diagnosed with prostate cancer at an early age) should begin testing at age 45.
3. For men at average risk and high risk, information should be provided about what is known and what is uncertain about the benefits and limitations of prostate cancer screening tests so that they can make an informed decision about testing.

### Diagnosis

If a person has any signs or symptoms of prostate cancer, the doctor must determine whether they are due to cancer or some other cause. The doctor may ask about personal and family medical history and may do a physical exam and request one or more tests for screening. Often, the patient will have experienced some symptoms or have an elevated PSA. Only 14% of the prostate cancers at TRMC for the years 2000-2004 were found incidentally.

If tests show an abnormal area, a biopsy to check for cancer cells may be necessary.

At the time of diagnosis the cancer is graded with what is known as a Gleason score. This is a grading system used by a pathologist to determine how likely the tumor is to spread. This score is assigned at the time the pathology report is read. A low Gleason score means the cancer cells are similar to normal prostate cells and are less likely to spread; a high Gleason score means the cancer cells are very different from normal prostate cells and are more likely to spread. Gleason scores range from 2-10.

### Table 1
Table 1 shows the American Cancer Society's screening guidelines for prostate cancer.

### Graph G
Graph G shows the breakdown of patients at Tift Regional by Gleason score.
If the biopsy finds cancer cells, it may be necessary to do more tests to determine whether the cancer has spread, and if so, how far. The process of determining the spread of cancer is known as staging. Staging is very important in determining both the appropriate treatment and prognosis of the disease.

### Staging

<table>
<thead>
<tr>
<th>Stage</th>
<th>Features</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>The tumor is still within the prostate. No spread to regional lymph nodes or distant organs. Gleason score less than 5. Less than 5% of biopsy specimen contains cancer.</td>
</tr>
</tbody>
</table>
| II    | The tumor is still within the prostate. No spread to regional lymph nodes or distant organs, but has one of the following conditions:  
1) Gleason score of 5 or higher or more than 5% of the biopsy specimen contains cancer.  
2) Was found because of an elevated PSA.  
3) Can be felt by DRE or seen on transrectal ultrasound. |
| III   | The tumor has spread outside the prostate and may have spread to the seminal vesicles, but it has not spread to lymph nodes or distant organs. |
| IV    | One or more of the following apply:  
1) The cancer has spread to tissues outside the prostate such as the rectum and pelvis.  
2) The cancer has spread to lymph nodes.  
3) The cancer has spread to other, more distant places in the body. |

Table 2 shows the AJCC stage groups for prostate cancer.

A complete physical exam is important for prostate cancer staging. The doctor needs to examine other parts of the body to determine whether or not the cancer has spread. Not all men diagnosed with prostate cancer will require additional testing, but for those who do, the following tests may be recommended:

**Bone Scan**
This test is done to show whether or not the cancer has spread from the prostate gland to the bones. During this test radioactive material is injected into the body. The radioactive substance is attracted to diseased bone cells and shows up on the bone scan.

**CT Scan**
This is a special type of x-ray that takes pictures of the body from many angles. This test can help determine if the prostate cancer has spread to lymph nodes in the pelvis.

**MRI**
This test is similar to the CT scan except radio waves and strong magnets are used to create pictures of the body rather than x-rays. This test helps the doctor see if the cancer has spread to the bladder or seminal vesicles.

**Lymph Node Biopsy**
This test may be done to determine if the cancer has spread into nearby lymph nodes.
Methods of Treatment

Treatment for prostate cancer is based on a number of factors including age, overall health, the stage and grade of the cancer, and the chance of cure. In general, surgery, radiation, and hormone therapy are the most common types of treatment for prostate cancer. Chemotherapy may be given in some cases. Although not an active form of treatment, watchful waiting may also be an option for some men.

- Clinical Observation: Also known as "watchful waiting." Since prostate cancer spreads slowly, some men may never need treatment for their cancer. This may also be an option if the cancer is not causing any symptoms, will probably grow slowly, and is contained in one place.

- Surgery: The most common surgical treatments for prostate cancer are radical prostatectomy and transurethral resection of the prostate. A radical prostatectomy is done as an attempt to cure the cancer. The entire prostate gland and some tissue around it are removed. A transurethral resection of the prostate is done to relieve symptoms in men who can't have other types of surgery. This surgery is not done to cure the disease.

- Radiation Therapy: Treatment with high energy rays to kill or shrink cancer cells. This treatment can come from outside the body, which is called external radiation, or can come from radioactive materials placed inside the body, called brachytherapy or internal radiation.

- Hormone Therapy: The goal of this therapy is to decrease the levels of male hormones. This is also called androgen deprivation. This therapy will not cure the cancer but may slow its growth. A surgical procedure to remove the testicles, called an orchectomy, is another form of hormonal treatment.

- Chemotherapy: This treatment uses drugs to destroy cancer cells. The drugs are often injected directly into a vein but some can be swallowed in a pill. These drugs spread throughout the entire body to destroy cancer cells. This is not used as a treatment for early prostate cancer.

Graph H shows the distribution of prostate cancer patients at Tift Regional by AJCC stage at diagnosis.

Graph I shows the distribution of prostate cancer patients at Tift Regional by AJCC stage at diagnosis and race.
Prognosis

The prognosis (chance of recovery) depends on the following:

- The stage of the cancer (whether it affects part of the prostate, involves the whole prostate, or has spread to other places in the body)
- The patient's age and health
- Whether the cancer has just been diagnosed or has recurred (come back)

Prognosis also depends on the Gleason score and PSA level.

Survival

The National Cancer Data Base five year observed survival rate for the Community Care Center hospitals for prostate cancer is 73%. For Tift Regional the five year survival rate is 74%. The 2004 CIRF data shows a 75% survival rate. CIRF (Cancer Information Reference File) represents over 10% of the total national cancer cases accessioned annually and is used by the Impac Medical Registry Services software clients to benchmark their facility's data against regional and national data to help improve outcomes and, ultimately, patient care.

Summary

If the disease is caught in an early stage, patients have a very good chance of surviving prostate cancer. Prostate cancer, as with other cancers, does not cause symptoms until it has reached an advanced stage. This is why screening exams are so important.
Glossary of Terms

Accessioned: Entered into the Tumor Registry database.

Analytic Cases: Patients initially diagnosed at Tift Regional Medical Center and/or who received all or part of their first course of therapy here.

American College of Surgeons (ACoS): Institute that was established in 1932 in response to a request from the American College Society Inc., to improve the care of cancer patients at the hospital level.

Non-Analytic Cases: Patients diagnosed and/or treated at another facility for their first course of therapy, but who are receiving treatment at Tift Regional Medical Center for recurrence or progression of their cancer.

First Course of Therapy: All therapy directed at treatment of cancer, which was planned as initial course of treatment, usually initiated within four months of diagnosis.

AJCC Classification of Disease: Refers to the classification of most cancer sites as set forth by the American Joint Committee on Cancer in the Manual for Staging of Cancer. The higher the stage number, the greater the degree of cancer invasion.

References
American Cancer Society
Web MD
National Cancer Data Base (NCDB)
Cancer Research and Prevention Foundation
Center for Disease Control
National Cancer Institute

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