



Banner Health

Denali Center

Fairbanks Memorial Hospital

*Community-Owned*

# Cancer Program 2006 Annual Report

Report for 2005 Cancer Data



# Fairbanks Memorial Hospital Cancer Program Report 2006

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# Letter from the Chairman

Dear Colleagues:

In 2005, the cancer program at Fairbanks Memorial Hospital has continued to mature. The cancer committee is a hospital-wide committee with not only physician participation, but members from Administration, Social Services, Pharmacy and Outreach. It is hoped that over the next few years that it will continue to serve as an important resource to the community.

Ongoing studies continue to occur and, hopefully, the data from 2005 will be useful in counseling patients in your offices.

It is hoped that the progress that is being made in breast cancer will continue into the future.

Sincerely

A handwritten signature in black ink, appearing to read "J. Michael Carroll". The signature is fluid and cursive, with the first name "J. Michael" and last name "Carroll" clearly distinguishable.

J. Michael Carroll, MD  
Cancer Committee

# Cancer Committee

The Cancer Committee has been chaired by Dr. J. Michael Carroll for 29 years and is the policymaking body of the FMH Cancer Program meeting once a quarter. Dr. Andrew Evanger is serving his third year as the Cancer Program Liaison. The Cancer Committee provides leadership to plan, initiate, stimulate, and assess all cancer related activities at Fairbanks Memorial Hospital. The Committee is made up of a multidisciplinary team comprised of physicians from several disciplines and allied health professionals from many different departments in the hospital who serve cancer patients.

## *Cancer Committee Members:*

J Michael Carroll, MD, Medical  
Oncologist

Mary MacFarlane, MD, Pediatrician

Karl Baurick, MD, OB/GYN

Kendrick Blais, DO Family Practice

Thomas Hammond, MD,  
Otolaryngology

Richard Hattan, MD, Radiologist

Andrew Evanger, MD, Pathologist

Steven Sutley, MD, Oral/Maxillofacial  
Surgeon

Essam Shihadeh, MD, Radiation  
Oncologist

Rob Gould, Administration

Jim Button, Pharmacy

Sandy Larson, PIEO

Kathy Moss, Oncology Data

Laurie Puska, CTC Nurse

Sheron Smoyer, Social Worker

Liz Woodyard, PIEO

Pamela Warren PhD, CTR, CRP

The Cancer Conference is a multi-disciplinary educational service for the medical staff and allied professionals caring for cancer patients. Fairbanks Memorial Hospital has three different cancer conferences meeting four times a month; General Cancer Conference, Urology Cancer Conference, and the Stereotactic Breast Cancer Conference.

## Number of Cases Presented at The Cancer Conferences by Site

	# Presented	Total Diagnosed		# Presented	Total Diagnosed
Breast	77	57	Bone	1	2
Prostate	35	49	Cervical	1	6
Bladder	10	11	Colorectal	1	35
Leukemia, Lymphoma, MDS & Hodgkins Disease	8	8	Esophageal	1	4
Head & Neck	5	5	Melanoma	1	10
Kidney & Ureter	5	4	Mesothelioma	1	1
Lung	5	39	Ovarian	1	2
Liver	4	4	Vaginal	1	0

Total number of analytical cases for 2005=281

Total number of cases presented at Cancer Conference in 2005 = 157

# Fairbanks Cancer Program

Radiation Oncology has a new and exciting tool for cancer treatment. In August 2005, IMRT was added. IMRT (Intensity Modulated Radiation Therapy) is a technique used to kill tumor cells while sparing normal tissue more effectively than ever before. It utilizes powerful computer software and a sophisticated hardware upgrade to 'bend' isodose curves around critical structures. Because of this, there is a potential to escalate the total dose to the tumor volume by as much as 10% in some cases. This technique should yield better outcomes with fewer side effects. IMRT is currently being used at FCTC in select cases of Head and Neck, Pelvis, Breast and Primary Brain Cancer.

# Cancer Data Report

## Sites by Gender for 2005

	Male	Female	Total		Male	Female	Total
Base of Tongue	1	0	1	Nasopharynx	1	0	1
Bladder	9	2	11	Other Endocrine Glands	1	1	2
Bones & Cartilage	0	2	2	Ovary	0	2	2
Brain	4	5	9	Pancreas	0	2	2
Breast	0	57	57	Parotid Gland	1	0	1
Bronchus & Lung	21	18	39	Prostate Gland	49	0	49
Cervix Uteri	0	6	6	Rectosigmoid Junction	2	1	3
Colon	14	13	27	Rectum	3	2	5
Connective & Other Soft Tissue	1	0	1	Renal Pelvis	1	0	1
Corpus Uteri	0	2	2	Retroperitoneum & Peritoneum	1	0	1
Esophagus	4	0	4	Skin	3	7	10
Floor of Mouth	1	0	1	Small Intestine	0	1	1
Hematopoietic, Reticuloendo System	6	2	8	Stomach	5	2	7
Kidney	3	0	3	Testis	1	0	1
Larynx	0	1	1	Thyroid Gland	1	1	2
Liver & Intrahepatic Bile Duct	4	0	4	Unknown Primary	3	4	7
Lymph Nodes	5	3	8	Ureter	1	0	1
Nasal Cavity & Middle Ear	1	0	1				

Total	
Male	148
Female	133
<b>Total Number of Diagnoses</b>	<b>281</b>

# Cancer Data Report

Number of 2005 Cancer Cases by Age and Gender (N=282)



Number of 2005 Cancer Cases by Race (N=278)

Caucasian	80%	222
Native American	14%	40
African American	3%	7
Asian	2%	6
Unknown	1%	3

Comparisons for the Top Four Cancer Sites for Local and National

	2001		2002		2003		2004		2005	
	Local	National*	Local	National*	Local	National*	Local	National*	Local	National*
Breast**	56	203,500	47	211,300	59	215,990	51	217,440	57	212,920
Colorectal	34	148,300	53	147,500	46	146,940	34	146,940	32	148,610
Prostate	44	189,000	67	220,900	41	230,110	69	230,110	49	234,460
Lung/ Bronchus	25	169,400	35	171,900	36	173,770	36	173,770	39	174,470

National estimates only

\*\* Female cases only

# Cancer Data Report

The Fairbanks Cancer Program is required to maintain a 90% follow-up rate in order to maintain their American College of Surgeons Accreditation. Fairbanks consistently maintains a 97% or better follow-up rate.

Total Cases in the Fairbanks Registry since the reference date 1/1/87 =5,003

Total Analytical Cases	4,315
Total Deceased Cases	2,039
Total Cases Followed	2,276
Total Cases Lost to Follow-up	96
Follow-up Rate	97.78%

# Featured Study: Hodgkin Disease

The American Cancer Society estimates that in 2007 about 8,190 new cases of Hodgkin disease will be diagnosed in the United States. Of these new cases, 3,720 will occur in females and 4,470 in males. These numbers have not changed much over the past few years

Hodgkin disease can occur in both children and adults. It is most common in early adulthood (age 15 to 40, especially in a person's 20s), where it is mostly of the nodular sclerosis subtype, and in late adulthood (after age 55), where the mixed cellularity subtype is more common. Hodgkin disease is rare before 5 years of age. About 10% to 15% of cases are diagnosed in children and teenagers.

An estimated 1,070 people (300 females, 770 males) will die of Hodgkin disease in the United States during 2007. Because of advances in treatment, survival rates have improved considerably since the early 1970s. By 2004, there were over 138,000 people who had been diagnosed with this disease at some time and were still alive.

The 1-year relative survival rate for all patients after treatment is about 94%; the 5-year and 10-year rates are about 85% and 82%, respectively. At 15 years, the relative survival rate is about 74%, while at 20 years it is about 63%.

The survival rate (for example) refers to the percentage of patients who live *at least* that long after their cancer is diagnosed. (for example, the 5-year survival rate includes all people who live at least 5 years after being diagnosed.) Survival rates are used to produce a standard way of discussing prognosis. Of course, many people live much longer than these cutoffs. *Relative* survival rates are calculated in ways that exclude the impact of diseases other than cancer on survival; that is, people with Hodgkin disease who die of other causes are not counted.

Certain factors such as the stage of the disease and a patient's age affect these rates. For about the first 15 years after treatment, the main cause of death in these patients is recurrent Hodgkin disease (Hodgkin disease that comes back). By 15 to 20 years after treatment, death due to other causes is more common.

Of course, current 5-year survival rates are based on people with Hodgkin disease who were diagnosed and initially treated more than 5 years ago. Advances in treatment have produced a more favorable outlook for recently diagnosed patients.

What are the risk factors for Hodgkin disease?

A risk factor is anything that affects your chance of getting a disease such as cancer. Different cancers have different risk factors. For example, exposing skin to strong sunlight is a risk factor for skin cancer. Smoking is a risk factor for cancers of the lung, mouth, larynx, bladder, kidney, pancreas, and several other organs.

But risk factors don't tell us everything. Having a risk factor, or even several, does **not** mean that you will get the disease.

# Featured Study: Hodgkin Disease

Scientists have found a few risk factors that may make a person more likely to develop Hodgkin disease, although it's not always clear why these factors increase risk.

There is an increased risk of Hodgkin disease in people who have had infectious mononucleosis appears to be a few times higher than in people who have not had the disease,

although the overall risk is still very small.

The Epstein-Barr virus is found within the DNA of Reed-Sternberg cells in about half of all patients with Hodgkin disease. But the other half of patients with Hodgkin disease have no evidence of Epstein-Barr virus in their cancer cells.

## Overall Survival Rates (1987-2004) N=37

0<1 Year	92%
1<2 Years	84%
2<3 Years	84%
3<4 Years	81%
5+ Years	75%

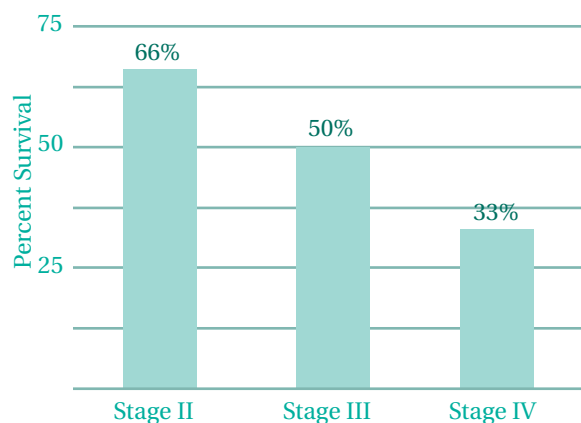
## By Race (N=37)

Caucasian	92%
African American	8%

## By Gender (N=37)

Male	62%
Female	38%

## Adjusted 5-Year Survival Rate (1987-2004) N=11



*Because there was only one case diagnosed with Stage I, it was eliminated from this data presentation.*

# Glossary of Terms

**Analytic:** Cases which are first diagnosed and/or receive all or part of their first course of treatment at Fairbanks Memorial Hospital

**Best Stage:** The most accurate stage known, either clinical or pathological.

**First Course Treatment:** Initial treatment or series of treatments usually initiated within the first four months after diagnosis.

**Non-Analytic:** Cases which are diagnosed elsewhere, but new to FMH, or first diagnosed and treated in the physician's office, or at autopsy.

**Stage of Disease:** Extent of disease determined by the time of first course of treatment. Defined by the American Joint Committee on Cancer (AJCC) based on the primary tumor, regional nodal involvement, and distant metastasis in the current AJCC Cancer Staging Manual.





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