



Huntington Cancer Center



2015 Annual Report

2015 Cancer Committee members



Applebaum, Steven, MD
Vice Chair, Hematology Oncology

Brady, Ann, RN
Palliative Care
Symptom Management

Carrillo, Sharon, CTR
Manager, Cancer Data Center

Chua, Mays, RN
Head & Neck/Prostate Navigator

Cohen, Robbin, MD
Thoracic Surgery

Conti, Christine, RN
Lung Navigator

Cushing, Nancy, RN
Breast Navigator

deKoomen, Saskia, RN
Colorectal Navigator

DeLeon, Edna, RN
Quality Management

Hedley, Christopher, MD
Diagnostic Radiology

Ivie, Tina, RN
Breast Navigator

Kaufman, Howard, MD
Committee Chair; General Surgery
Colorectal Surgery

Kim, Chrissy
American Cancer Society

Kline, Suzie, PhD
Integrative Oncology

Kurihara, Leah, RD
Registered Dietitian

Martel, Cynthia, MD
Hematology Oncology

Mayeda, Janet
Manager, Rehabilitation

Murakami, Susan, MD
Pathology

Nakao, Susie
Clinical Research

Perez, Martin, PhD
Psychosocial Services

Perry, Barbara, LCSW
Social Services

Rudie, Sheryl
Cancer Program Administrator

Satterthwaite, Roger, MD
Surgery, Urology

Spurgeon, Daniel, MD
Palliative Care

Tango, Gloria, RN
Manager, Oncology

Williamson, Ruth, MD
Director Radiation Therapy
Radiation Oncology

Yessaian, Annie, MD
Gynecology Oncology Surgery

Yu, David
Pharmacist

Zagha, Lois
Community Outreach

Huntington Hospital Cancer Center – 2015 year in review

Howard Kaufman, MD

Medical Director, Huntington Hospital Cancer Center



For decades, Huntington Hospital Cancer Center has delivered personalized, compassionate care to patients from across the San Gabriel Valley and beyond. Far surpassing the traditional community hospital in its quality and scope, our cancer center is accredited — with commendation — by the American College of Surgeons Commission on Cancer (CoC).

I am delighted to report that earlier this year we were once again awarded the Outstanding Achievement Award by the CoC. This award was established in 2004 and is only presented to 10 – 15% of eligible cancer centers per year. During a rigorous survey that occurs every 3 years, cancer centers that achieve compliance on 26 standards and commendation on all 7 commendation-eligible standards are considered for the award.

According to the American College of Surgeons:

The purpose of the award is to raise the bar on quality cancer care, with the ultimate goal of increasing awareness about high-quality, patient-centered care. In addition, the award is intended to:

- Recognize those cancer programs that achieve excellence meeting the CoC Standards
- Motivate other cancer programs to work toward improving their level of quality cancer care
- Facilitate dialogue between award recipients and healthcare professionals at other cancer facilities for the purpose of sharing best practices
- Encourage honorees to serve as quality-care resources to other cancer programs



This year marked the second time in the last 3 survey cycles (over 9 years) that Huntington Hospital Cancer Center received the Outstanding Achievement Award, which demonstrates the intense and continued dedication of the medical and hospital staff as well as the administration towards improving the lives of individuals in our community who are in need of comprehensive cancer treatment.

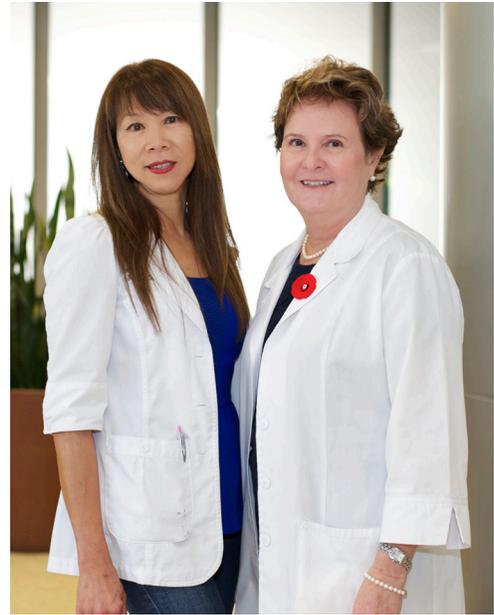
Excellence in cancer care.

Huntington Hospital Cancer Center provides comprehensive screening, diagnosis and treatment for the most prevalent cancers affecting our community — all types of cancer, including breast, lung, prostate, head and neck, colorectal and gynecological tumors. The center's high-quality outpatient services are located in the beautiful Huntington Pavilion.

Huntington Hospital Cancer Center's care team includes an array of specially trained professionals including physicians, cancer nurse specialists, social workers and dietitians with specialized oncology certification, radiation oncology professionals, nurse specialists, and a licensed cosmetologist. Nurse navigation services help coordinate the potentially complex array of services needed by patients and their families and provide vital education and other support. Our navigation process also continues beyond the acute treatment phase of cancer to now include longer-term survivorship care plans. *(Two of our nurse navigators are pictured right.)* Palliative care professionals offer a weekly clinic. As a result, even patients with the most serious conditions can remain as comfortable as possible throughout the course of their care.

Individual patient cases are reviewed during regular multidisciplinary tumor boards, further promoting multidisciplinary collaboration and best practices. A Cancer Committee, comprised of members of Huntington Hospital's medical, administrative, nursing and key support staff, meets quarterly to review the entire program. The committee identifies strategies to satisfy all 34 standards established by the American College of Surgeons Commission on Cancer. Annual goals for the program are set and reviewed, and quality indicators are discussed to identify opportunities for improvement.

As part of ongoing quality review, the committee utilizes quality measures developed by the National Quality Forum. These measures are accepted by the Commission on Cancer, which in turn publishes data regarding hospital performance. Statistics for 2014 were made available in 2015 and showed Huntington Hospital Cancer Center significantly outperforming other California hospitals (consolidated data) with regard to several important quality measures.



Integrative Oncology Program.

This program for East-West medicine was launched in 2013, and demand has continued to rise for complementary therapies as part of cancer care. Complementary medicine is used to describe therapeutic techniques that are not part of conventional medicine (also called “standard” or “western” medicine). Complementary therapies are used as a “complement” or addition to conventional medicine. When complementary medicine is integrated with conventional medical treatment for cancer patients, it is also called “Integrative Oncology.”



The goal of Integrative Oncology is to balance the whole person — physically, mentally, and emotionally — while conventional medicine does its work. Several studies in cancer patients suggest that complementary medicine can improve mood and quality of life and relieve symptoms. This stress relief might help the immune system function better and allow patients to better cope with treatment-related side effects.

The Integrative Oncology Program at Huntington Hospital Cancer Center has continued to grow in 2015. This program currently offers acupuncture (*pictured above*), massage therapy, hypnotherapy, guided imagery and mindfulness, training in post traumatic growth, music therapy, spirituality and prayer, support groups, exercise, and yoga.

The Cancer Data Registry Center — supporting continuous quality improvement.

Huntington Hospital’s Cancer Data Registry Center collects, maintains and effectively reports tumor data — allowing us to identify community and nationwide trends. Our cancer physicians and cancer nurse specialists also utilize this data to identify opportunities for further quality enhancements in caring for cancer patients at Huntington Hospital. Our Cancer Data Registry Center regularly participates in studies mandated by the American College of Surgeons Commission on Cancer.

Providing support for patients and their loved ones.

Patient support is an essential component of our work. We host support groups for breast, lung, prostate and colon cancer patients, as well as those receiving radiation therapy. Patients who are interested can also be matched with a cancer survivor for mentorship, emotional support and guidance. The cancer center also provides a variety of monthly workshops, including Return to Wellness workshops — specially designed for cancer patients — in exercise and yoga. A grief support group is available for those who have lost a loved one to cancer.

Reaching out to our community.

We place a great emphasis on community outreach and education. In fact, our outreach activities – consisting of lectures, screening events, and support groups – touched more than 1,100 people in 2015. Through these efforts, we seek to ensure that local and regional residents are aware of cancer risk factors and symptoms, understand how to reduce their risk for cancer, and know how they can access high-quality cancer-related services.

Annual screening events (often held in collaboration with the American Cancer Society)

provide screenings for colorectal, prostate and lung cancer. Informative lectures from cancer physician specialists from Huntington Hospital, and other invited national experts, provide information that emphasizes preventive lifestyle choices and early detection. These lectures are offered regularly throughout the year.

In 2015, Huntington Hospital Cancer Center continued to build on our valuable partnership with the Herald Cancer Association (*pictured above*). This community organization addresses the healthcare needs of Chinese communities in the greater Los Angeles area. Our partnership helps enhance access to cancer care among members of these communities in Huntington Hospital's service area.

Continued outreach to and communication with referring physicians helped us maintain physician satisfaction. In our lung and colorectal programs, for example, 100 percent post treatment follow-up was again achieved. By ensuring that information regarding diagnosis, treatment and outcomes is swiftly communicated to patients' primary care physicians, Huntington Hospital Cancer Center promotes continuity of patient care and further strengthened physician relations community-wide.

Research — expanding knowledge, enhancing care.

We offer patients significant opportunities to participate in clinical trials in areas as diverse as prevention of cancer to treatment of advanced disease.

The cancer center receives early information regarding new clinical trials in both the United States and Canada. After careful review, our physician investigators select the most promising of these to be offered through our San Gabriel Valley Clinical Oncology Research Program. Adult cancer patients in our service region who meet eligibility requirements and are interested in taking part in a clinical trial can enjoy significant benefits — and help to advance research in ways that may also impact thousands of other cancer patients in the future.

Our medical staff also worked with surgical residents — from both the hospital's Graduate Medical Education program and our affiliated academic centers — on a variety of research initiatives in 2015. This work contributes to improved delivery of cancer care at Huntington Hospital and beyond.

Specifically, over the course of the year, Huntington Hospital general surgery residents presented three papers involving cancer care, some of which have already been approved for publication in peer-reviewed journals. Overall, 107 Huntington Hospital patients were included in cancer-related research and studies.



Advanced technology implemented in 2015.

Stereotactic Radiation Therapy:

This latest, highly effective radiation treatment can be used to treat patients with various cancers and is also referred to as stereotactic radiation surgery, when it is used to treat brain cancer. Stereotactic radiation therapy (*pictured right*) involves delivering beams of high-dose radiation to target tumors and lesions with exact precision. This state-of-the-art equipment utilizes what is known as 4D technology to visualize the lesions. By combining information regarding space and time, clinicians can adjust for patient movement (as a patient breathes in and out, for example), thus helping to minimize damage to surrounding healthy tissue. Benefits can be achieved in fewer treatments than with standard radiotherapy, and patients may experience fewer side effects. There is no need to interrupt chemotherapy or other concurrent care.



daVinci Xi Robotic System: Intuitive Surgical launched its latest advance in robotic surgery systems, and Huntington Hospital quickly acquired this state-of-the-art surgical robot to complement our two existing da Vinci Si systems. The Xi system (*pictured right*) is an optimal platform for four-quadrant abdominal and chest surgery. It incorporates a completely new design for anatomical access and crystal-clear 3DHD vision while maintaining all of the safety-related advances that have been added onto Si systems. The robotic system is now integrated to the operating room table, so that patients may be repositioned without needing to undock and re-dock the robotic arms or add additional operating ports.



Update on 2015 cancer center goals.

Huntington Hospital Cancer Center is proud to have accomplished all goals established for 2015, as follows:

Clinical Goal: Open a Transfusion Clinic.

Blood transfusions are often required by patients undergoing cancer treatment. Blood loss and anemia are frequent clinical conditions associated with cancer. Tumors often bleed slowly into the gastrointestinal or genitourinary tracts and cause low red blood cell counts. In addition, cancer treatment can suppress bone marrow function and lead to reduced production of red blood cells. Blood transfusions are designed to replace these ongoing losses or inadequate production of red blood cells. In the past, patients would need to be admitted to the hospital to receive a transfusion. Therefore, we opened an outpatient transfusion clinic to meet the needs of our community and reduce the reliance on more costly inpatient services. Each visit to the transfusion center saves our patients between eight and twelve hours.

Programmatic Endeavors Goal: Partner with American Cancer Society and National Colorectal Round Table in their national initiative of reaching 80% screening by 2018 for colorectal cancer of adults age 50 and older.

Colorectal cancer remains the second leading cause of cancer death in the United States. Screening for colorectal cancer detects cancers at an earlier and more curable stage and allows for identification and removal of precancerous polyps. While screening programs have reduced the incidence of colorectal cancer in the US, many adults do not undergo screening. Our programmatic goal not only committed us to working towards a screening rate of 80% by 2018, but we also sought to establish our baseline screening rate in order to generate an achievable plan to reach that goal. Through collaboration with our community physicians, we determined that our baseline screening rate through 2014 was 65%.

Huntington Hospital Cancer Center continues to rely on charitable contributions from the community it serves. We are deeply grateful for the \$248,670 million in donations designated to the center in 2015. These gifts supported essential services and programs, including — for example — the work of our nurse navigators. We are also grateful for philanthropic support to the hospital, which has helped us acquire new state of the art equipment that can be used for all patients, including those with cancer. Gifts designated by the donor to a specific aspect of the cancer center's work are used strictly for that purpose.

Superior prostate cancer surgical care



Roger Satterthwaite, MD
Huntington Hospital Cancer Center



Huntington Hospital Cancer Center continues to serve patients and their families from both the local community and referrals from the greater San Gabriel Valley and beyond with a strong urologic oncology surgical presence and a diverse group of radiation and medical oncologists.

The vast majority of surgery for prostate cancer is now performed using one of our three daVinci robots, including two daVinci Si's and one daVinci Xi. Surgeons from City of Hope and USC along with private practice urologists performed 147 radical prostatectomies in 2015. A total of 1,223 robotic prostatectomies have been performed here from 2007-2015. The arrival of the first daVinci robot at Huntington Hospital in 2005 was shortly followed by the arrival of the first fellowship trained robotic surgeons, in turn leading to an increase of radical prostatectomies from 25 in 2004 to over 100 each year since 2007.

Radiation for prostate cancer patients in the form of brachytherapy, external beam therapy and Cyberknife exists in at least three locations in the Pasadena area including the City of Hope South Pasadena site, the Helen and Jim Gamble Radiation Oncology Center at the Huntington Pavilion and the Pasadena Cyberknife Center. Medical oncologists from City of Hope, UCLA, USC and private practices also have clinics in the Pasadena area. Our patients therefore benefit from the expertise of prominent oncology programs without having to seek those services outside of the local community. If a patient requires admission to Huntington Hospital during treatment, they will be able to see their established internists, cardiologists and other medical specialists. Our patients also have exposure to clinical trials in certain circumstances.

Increased ability to cure prostate cancer.

The treatment and clinical face of prostate cancer changed dramatically with the advent of prostate-specific antigen (PSA) testing in the late 1980's. Prior to the arrival of PSA testing, about 25% of men were potentially curable at the time of diagnosis. This dismal number skyrocketed to over 90% of men diagnosed with prostate cancer having clinically localized disease in the 1990's. Improvement in ultrasound technology – the imaging modality used to direct prostate biopsies – combined with refinement in both surgical and radiation techniques, led to a wave of men being treated for prostate cancer with the intent to cure.

Approximately 300,000 American men are diagnosed with prostate cancer annually, and an American man has a 15% chance of being diagnosed with prostate cancer. The risk of dying of prostate cancer currently is 3%. Risk factors for prostate cancer include age, family history of prostate cancer and ethnicity. African-American men suffer more aggressive prostate cancer at higher rates and at lower PSAs, and with twice the death rate as Asian or Caucasian men in the United States.

Prostate cancer in some men may be indolent. Based on autopsy studies, we may estimate that the true incidence of prostate cancer is roughly equal to a man's age. Most (but not all) cancers in men with low PSA's are not clinically significant. PSA can also be a marker for benign prostatic hypertrophy (enlargement of the prostate). Thus, PSA testing can lead to the identification of prostate cancers which do not need to be treated. The sensitivity and specificity of the PSA test for prostate cancer can be manipulated by changing the criteria for biopsy. Adjuncts to the PSA test include the patient's age, the change in PSA over time (PSA velocity), various subtypes of the PSA test (proPSA, free PSA ratio), imaging (multiparametric magnetic resonance imaging), biopsy history, prostate size (PSA density) and other tests that look at DNA. Unfortunately, none of these tests answer the question 'do I have prostate cancer', but rather simply change the probability of having cancer on biopsy. The biopsy itself is not 100% sensitive either, with approximately 10% of patients with an initial negative 12 core biopsy going on to have a subsequent positive biopsy at some point in their life.

The PSA testing controversy.

The use of PSA testing has become controversial. In 2011, the United States Preventive Service Task Force (USPSTF), an agency vetted by the US government, recommended abandoning PSA testing as screening for prostate cancer. The Task Force based its recommendations on the only two papers that filled the Task Force's criteria for prospective randomized trials and on outcomes from treatment that many in the urology community feel were outdated. Although there have been a number of rebukes of the USPSTF findings as well as the papers on which those findings were based, the number of men screened with PSA testing has dropped. Whether or not the decrease in PSA testing will lead to an increase once again in the death rate from prostate cancer remains to be seen and likely will not be known until the 2020's.

The American Urological Association, the European Urological Association and the National Comprehensive Cancer Network have released their own guidelines, which emphasized screening in men with long life expectancies and diminishing screening in men with shorter life expectancies. Nevertheless, the decision to proceed with PSA testing and by association with prostate cancer screening remains highly individualized. The uniform recommendation for shared decision making between patient and physician with regard to prostate cancer screening may not acknowledge the realities of the pace and demand of documentation of current medical practice in the United States for a large portion of the population.

Watchful waiting.

Treatment for men with prostate cancer may now also include active surveillance. The urology department at Johns Hopkins University, driven by H. Ballantine Carter, MD, has one of the longest and most thorough track records. The considerations for active surveillance include patient life expectancy, the PSA, change in PSA over time and the amount and level of aggressiveness of the prostate cancer. Repeat biopsy in about one third of men will identify a higher amount or higher level of aggressiveness that may preclude men from safely staying on active surveillance. About 50% of men on active surveillance will go off the program (receive treatment) within five years of initiation for a variety of reasons.

What lies ahead.

As the various programs for prostate cancer here evolve, physicians in Pasadena who care for men with prostate cancer, and those at risk, will continue working to develop and use advanced technology and statistical analysis that will enhance our ability to serve our patients. In the upcoming year, we will be partnering with imaging centers to provide MRI guided fusion biopsies for appropriate patients. Clinical trials regarding cytoreductive prostatectomy, immunotherapy, chemotherapy and PET scanning for prostate cancer are ongoing at the various clinical sites. All of this occurs within the context of the vast changes in American medicine, as we push to deliver effective, ethical and efficient medical care.

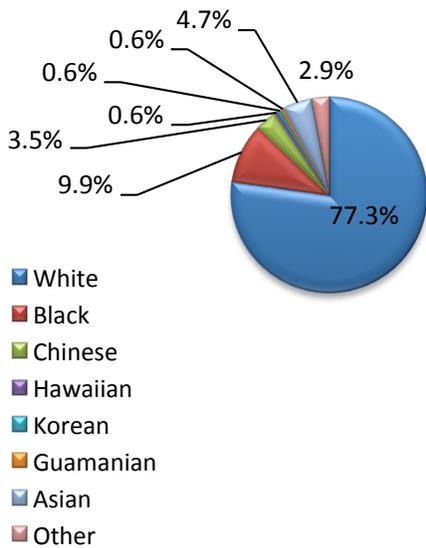


Prostate cancer

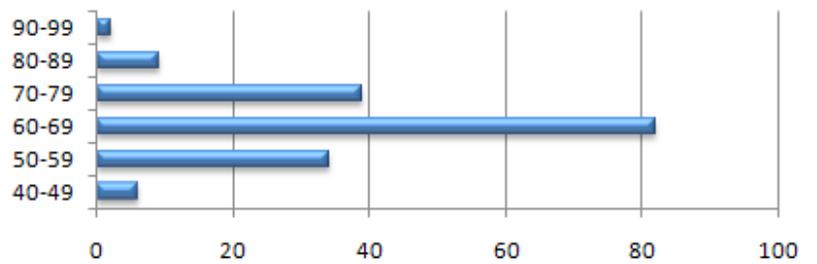


2015 Prostate cancer statistics

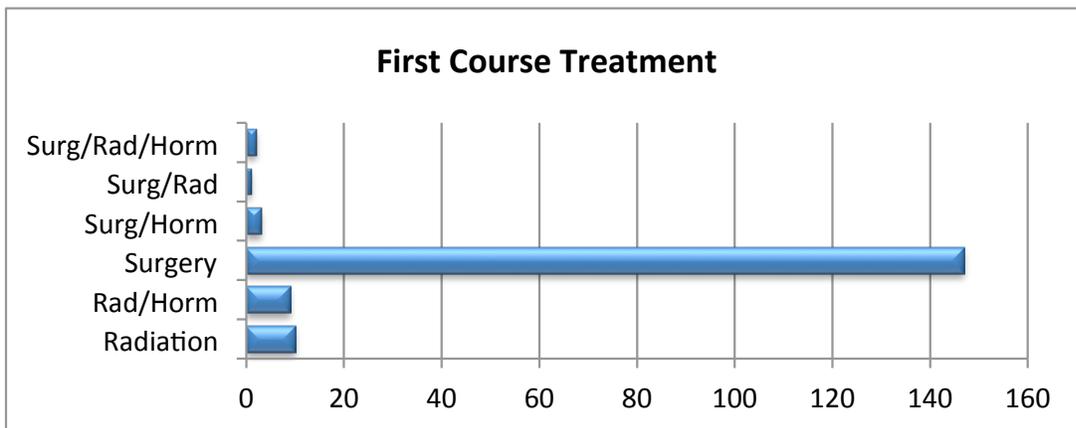
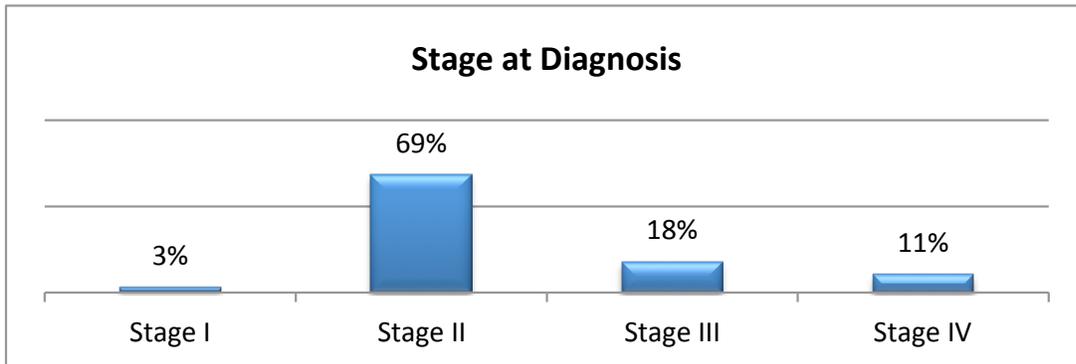
Race-Ethnicity



Age distribution



2015 Prostate cancer statistics



2015 Cancer Data Center report

The Cancer Data Center operates under the direction and guidance of the Cancer Committee. The Cancer Data Center first received accreditation by the American College of Surgeons in 1973 and has maintained accreditation since. The reference date for the organization is 2007. More than 55,846 cases have been added to the electronic database.

Cancer registrars collect and analyze all reportable and supplemental data; document Cancer Committee attendance, provide cancer registry data at meetings, document cancer conference information, supply reports of database information to the medical staff and administrative staff. The Cancer Data Center reports all cases to the Cancer Surveillance Los Angeles County (CSP) reporting facility. The registry follows patients annually to determine their health and/or any changes.

In 2015, a total of 2,017 cases were added to the database of which 1,781 (88%) are analytic (cases diagnosed and/or received first course of treatment at Huntington Hospital).

The Cancer Data Center is staffed by five Certified Tumor Registrars, one follow-up, one case finder, and one employee responsible for gathering all treatment rendered to the patient.

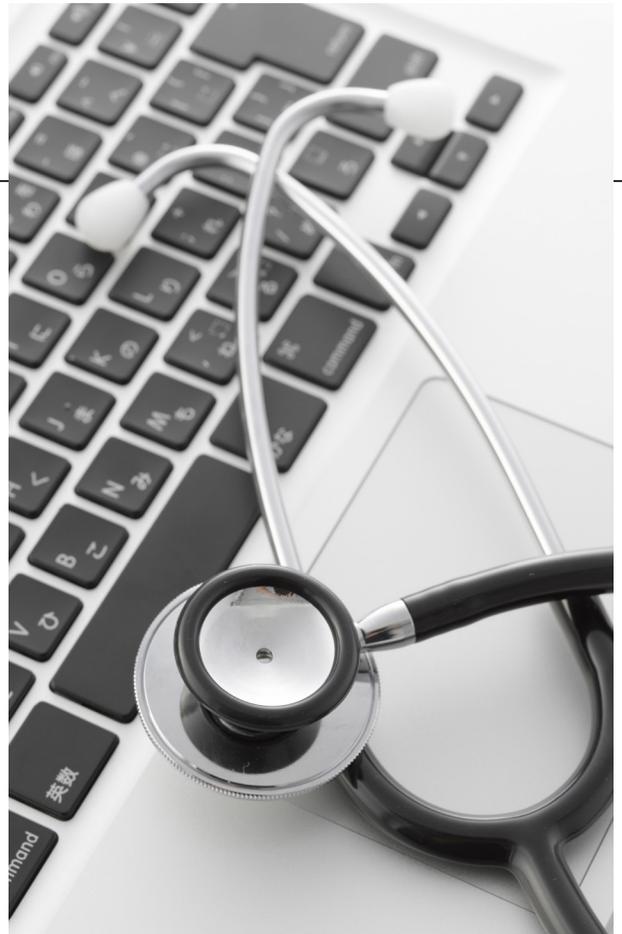
The Commission on Cancer accountability and quality improvement measures are monitored and evaluated for our facilities' performance rate to ensure quality care is provided to our patients.

In order to evaluate the effectiveness of cancer care provided by Huntington Hospital, and in keeping with the requirement of the American College of Surgeons standards, the Cancer Data Center performs annual patient follow-up. The follow-up rate of all analytic patients from 2007 is 92 percent, and the follow-up rate for analytic patients diagnosed within the last five years is 93 percent, which meets the Commission on Cancer requirements.

Multidisciplinary cancer conferences are held on a weekly and bimonthly basis. Cancer conferences provide consultative services. National accepted treatment guidelines, staging, prognostic indicators and clinical trial options are discussed at these conferences. Conferences include multidisciplinary, breast, GU, and thoracic. There were 514 cases presented to various conferences in 2015. One-hundred percent were prospective presentations.

The cancer program provides supportive services, which include:

- Nurse Navigation
- Personal Appearance
- Social Services
- Nutritional Guidance
- Rehabilitation
- Spiritual
- Palliative Care



Clinical education – *quality studies*

***Further enhancing
cancer care for
our community.***



Clinical education, *Standard 1.10*

Prostate Cancer

Presenter: R. Satterthwaite, MD

HIV Negative Plasmablastic Lymphoma

Presenter: Hologic and Huntington-Hill

Breast Cancer Screening

Presenters: Jon Foran, MD and
Lakshmi Tegulapalle, MD

Diseases of the Anal Cancer

Presenter: Gabriel Akopian, MD

Novel Pet Imaging Agents in Preclinical Models of Cancer and Diabetes

Presenter: John Shively, MD

Launching the T-Cell Differentiation Program

Presenter: Ellen Rothenberg, PhD

Mechanisms of Drug Resistance in Breast Cancer

Presenter: Susan Kane, PhD

Quality studies, *Standard 4.7*

In 2015, the following studies were completed and evaluated by cancer committee:

- “Breast Conservation Therapy for Triple Negative Breast Cancer.”
- “Reconstructing the Breast, to Transfuse or not to Transfuse?”

Standard 4.6

Monitoring Compliance with Evidence Based Treatment Guidelines:

A study of 2015 rectal cases was reviewed by Cynthia Martel, MD for compliance with NCCN guidelines.

Quality improvement activities Standard 4.8

Surgical site infection reduction for colorectal and breast cancer (study performed in 2012)

- NSQIP best practices implemented; Chlorhexiden prep, normothermia, glucose control, antibiotic prophylaxis, and antibiotic redosing.

Purchase, install unit and implementation of Tomosynthesis Machine

- 3D mammography

Goals 2015:

Clinical goal: Develop and Implement a Transfusion Clinic

- To increase capacity and improve physician satisfaction. To increase out-patient transfusion rate by 25%.

Programmatic goal: Increase Colorectal Screening to 80% of Adults Age 50+

- Partner with the American Cancer Society and National Colorectal Roundtable initiative to get 80% of adults age 50+ regularly screened for colon cancer by 2018.

Prevention and screening:

- Reduce Your Cancer Risks Through Self-Care
- Colorectal Cancer Awareness, Screening and Treatment
- Lymphedema Prevention and Management
- Improved Screening for Lung Cancer
- Mindfulness: Integrative Health Coaching for Self-Care
- Breast Health Panel Discussion
- Lung Cancer Screening



Standard 4.4 & 4.5

Accountability and quality improvement measures



Breast cancer

- **nBX**—Image or palpation-guided needle biopsy (core or FNA) is performed to establish diagnosis of breast cancer
- **MASTRT**—Radiation therapy is recommended or administered following any mastectomy within 1 year (365 days) of diagnosis of breast cancer for women with >4 positive regional lymph nodes
- **BCSRT**—Radiation is administered with 1 year (365 days) of diagnosis for women under the age of 70 receiving breast conservation surgery for breast cancer
- **MAC**—Combination chemotherapy is recommended or administered within 4 months (120 days) of diagnosis for women under 70 with AJCC T1N0, or stage IB-III hormone receptor negative breast cancer
- **HT**—Tamoxifen or third generation aromatase inhibitor is considered or administered within 1 year (365 days) of diagnosis for women with AJCC T1c or stage IB-III hormone receptor positive breast cancer

Measure	Breast Cancer	2011	2012	2013	2014
	Expected Performance Rate	Calculated Performance Rate	Calculated Performance Rate	Calculated Performance Rate	Calculated Performance Rate
NEEDLE BX	80%	96.8%	92.90%	98.70%	94.90%
MASTRT	90%	100%	100%	100%	100%
BCSRT	90%	97.50%	95.80%	97%	97%
MAC	N/A	96.70%	100%	95.50%	93.80%
HT	90%	98%	96.40%	97.10%	98.40%

Colon cancer

Measure	Expected Performance Rate	2011	2012	2013	2014
		Calculated Performance Rate	Calculated Performance Rate	Calculated Performance Rate	Calculated Performance Rate
At least 12 regional lymph nodes are removed and pathologically examined for resected colon cancer	85%	95.20%	85.50%	88.90%	91.20%
Adjuvant chemotherapy is recommended or administered within 4 months (120 days) of diagnosis for patients under the age of 80 with AJCC stage III lymph node positive colon cancer	N/A	100%	95.20%	100%	100%

Gastric cancer

Measure	Expected Performance Rate	2011	2012	2013	2014
		Calculated Performance Rate	Calculated Performance Rate	Calculated Performance Rate	Calculated Performance Rate
At least 15 regional lymph nodes are removed and pathologically examined for resected gastric cancer	80%	100%	92.30%	85.70%	100%

Lung cancer

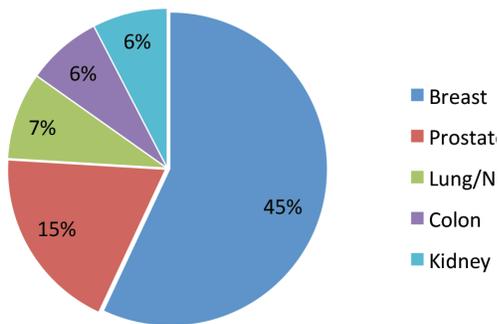
Measure	Expected Performance Rate	Calculated Performance Rate	Calculated Performance Rate	Calculated Performance Rate	Calculated Performance Rate
Systemic chemotherapy is administered within 4 months to day preoperatively or day of surgery to 6 months postoperatively, or it is recommended for surgically resected cases with pathologic lymph node positive pN1 and pN2 NSCLC	85%	100%	100%	100%	100%
Surgery is not the first course of treatment for cN2, M0 lung cases	85%	100%	100%	100%	100%

Rectum cancer

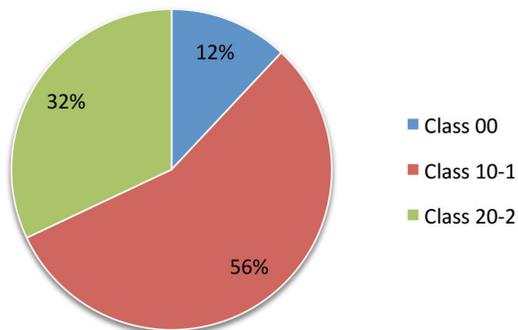
Measure	Expected Performance Rate	2011	2012	2013	2014
		Calculated Performance Rate	Calculated Performance Rate	Calculated Performance Rate	Calculated Performance Rate
Preoperative chemo and radiation are administered for clinical AJCC T3N0, T4N0, or Stage III; or postoperative chemo and radiation are administered within 180 days of diagnosis for clinical AJCC T1-2N0 with pathological AJCC T3N0, T4N0, or Stage III or treatment is recommended for patients under the age of 80 receiving resection for rectal cancer	85%	100%	100%	100%	91.70%

Major cancer sites

Five major cancer sites

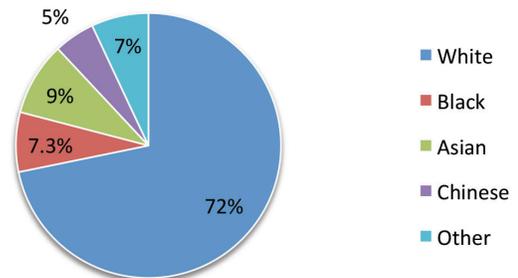


Analytic class of case distribution



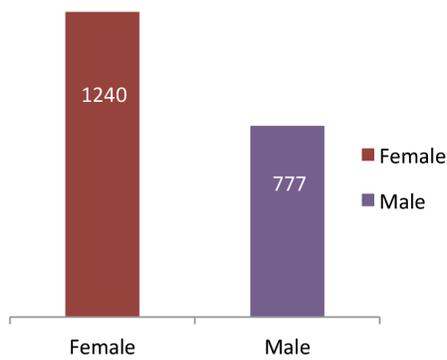
Class 10-14-Diagnosed here, all or part of first course

Race distribution

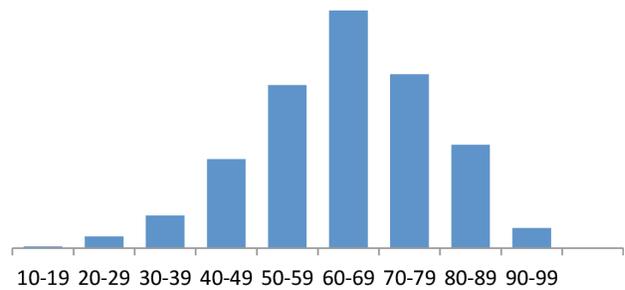


Major cancer sites

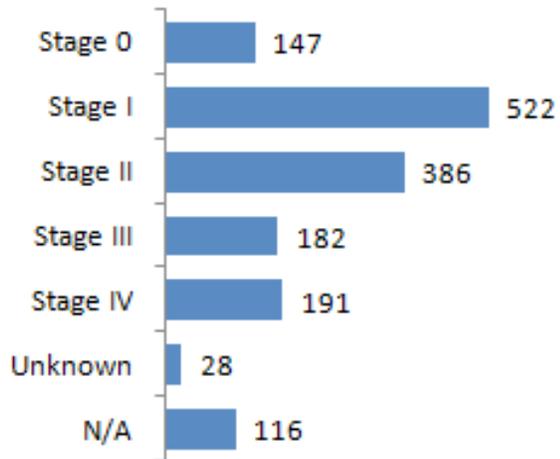
Sex distribution



Age at diagnosis



AJCC stage group at diagnosis



2015 Primary site table

Site Group	Total Cases	Class of Case		Sex		Stage 0	Stage I	Stage II	Stage III	Stage IV	NR
		Analytic	Non Analytic	M	F						
ALL SITES	2017	1781	236	777	1240	191	582	436	193	206	40
LIP	1	1	0	1	0	0	0	0	0	0	1
TONGUE	5	4	1	3	2	0	3	0	1	0	0
SALIVARY GLANDS, MAJOR	6	5	1	4	2	0	2	1	0	1	1
GUM	3	3	0	0	3	1	0	1	0	1	0
FLOOR OF MOUTH	2	2	0	1	1	1	0	0	0	0	1
MOUTH, OTHER & NOS	2	2	0	2	0	0	0	1	1	0	0
TONSIL	4	2	2	3	1	0	0	0	1	1	0
OROPHARYNX	2	2	0	2	0	0	0	0	0	1	1
NASOPHARYNX	3	3	0	3	0	0	0	1	2	0	0
PHARYNX & ILL-DEFINED	1	0	1	1	0	0	0	0	0	0	0
ESOPHAGUS	7	2	5	6	1	0	0	0	0	2	0
STOMACH	40	36	4	22	18	2	8	7	1	10	8
SMALL INTESTINE	13	12	1	7	6	1	3	1	4	3	0
COLON	98	87	11	47	51	14	20	22	17	9	5
RECTUM & RECTOSIGMOID	45	42	3	26	19	8	9	6	14	4	1
ANUS,ANAL CANAL,ANORECTUM	5	4	1	2	3	1	0	1	2	0	0
LIVER	41	31	10	31	10	0	12	1	7	2	7
GALLBLADDER	5	4	1	2	3	0	1	0	0	3	0
BILE DUCTS	20	17	3	13	7	2	1	6	2	4	2
PANCREAS	53	44	9	22	31	0	7	17	3	17	0
RETROPERITONEUM	2	2	0	2	0	0	1	0	1	0	0
PERITONEUM,OMENTUM,MESENT	1	1	0	0	1	0	0	0	1	0	0
OTHER DIGESTIVE	2	2	0	0	2	0	0	0	0	0	0
NASAL CAVITY,SINUS,EAR	1	0	1	1	0	0	0	0	0	0	0
LARYNX	3	2	1	1	2	1	0	0	0	1	0
LUNG/BRONCHUS-SMALL CELL	13	11	2	8	5	0	0	0	4	7	0
LUNG/BRONCHUS-NON SM CELL	105	84	21	52	53	2	20	6	13	42	1
PLEURA	2	2	0	2	0	0	1	0	1	0	0
LEUKEMIA	30	27	3	12	18	0	1	0	1	3	0
MYELOMA	14	10	4	7	7	0	0	0	0	0	0
OTHER HEMATOPOIETIC	9	5	4	6	3	0	0	0	0	0	0
BONE	1	0	1	1	0	0	0	0	0	0	0
SOFT TISSUE	12	9	3	5	7	0	4	1	1	1	2
MELANOMA OF SKIN	30	30	0	16	14	1	16	8	4	1	0
KAPOSIS SARCOMA	1	1	0	1	0	0	0	0	0	0	0
OTHER SKIN CA	8	8	0	2	6	1	3	3	0	0	0
BREAST	672	643	29	4	668	130	275	182	42	12	1
CERVIX UTERI	12	10	2	0	12	1	7	1	0	1	0
CORPUS UTERI	55	52	3	0	55	0	32	3	8	7	2
UTERUS NOS	3	1	2	0	3	0	1	0	0	0	0
OVARY	26	16	10	0	26	0	4	2	2	8	0
VAGINA	1	1	0	0	1	1	0	0	0	0	0
VULVA	4	3	1	0	4	0	3	0	0	0	0
OTHER FEMALE GENITAL	5	5	0	0	5	1	0	0	0	1	0
PROSTATE	223	175	48	223	0	0	4	119	31	19	2
TESTIS	14	13	1	14	0	1	10	2	0	0	0
PENIS	4	3	1	4	0	0	1	1	1	0	0
BLADDER	66	56	10	55	11	19	22	10	2	3	0
KIDNEY AND RENAL PELVIS	94	89	5	61	33	2	57	9	8	9	4
URETER	5	4	1	2	3	1	0	0	2	1	0
OTHER URINARY	5	4	1	5	0	0	0	0	0	0	0
EYE	2	1	1	2	0	0	0	0	0	0	0
BRAIN	21	19	2	13	8	0	0	0	0	0	0
OTHER NERVOUS SYSTEM	22	21	1	7	15	0	0	0	0	0	0
THYROID	70	61	9	19	51	0	37	5	7	10	1
OTHER ENDOCRINE	16	13	3	6	10	0	0	1	0	0	0
HODGKIN'S DISEASE	10	9	1	6	4	0	1	4	3	1	0
NON-HODGKIN'S LYMPHOMA	65	56	9	28	37	0	16	14	6	18	0
UNKNOWN OR ILL-DEFINED	32	29	3	14	18	0	0	0	0	3	0

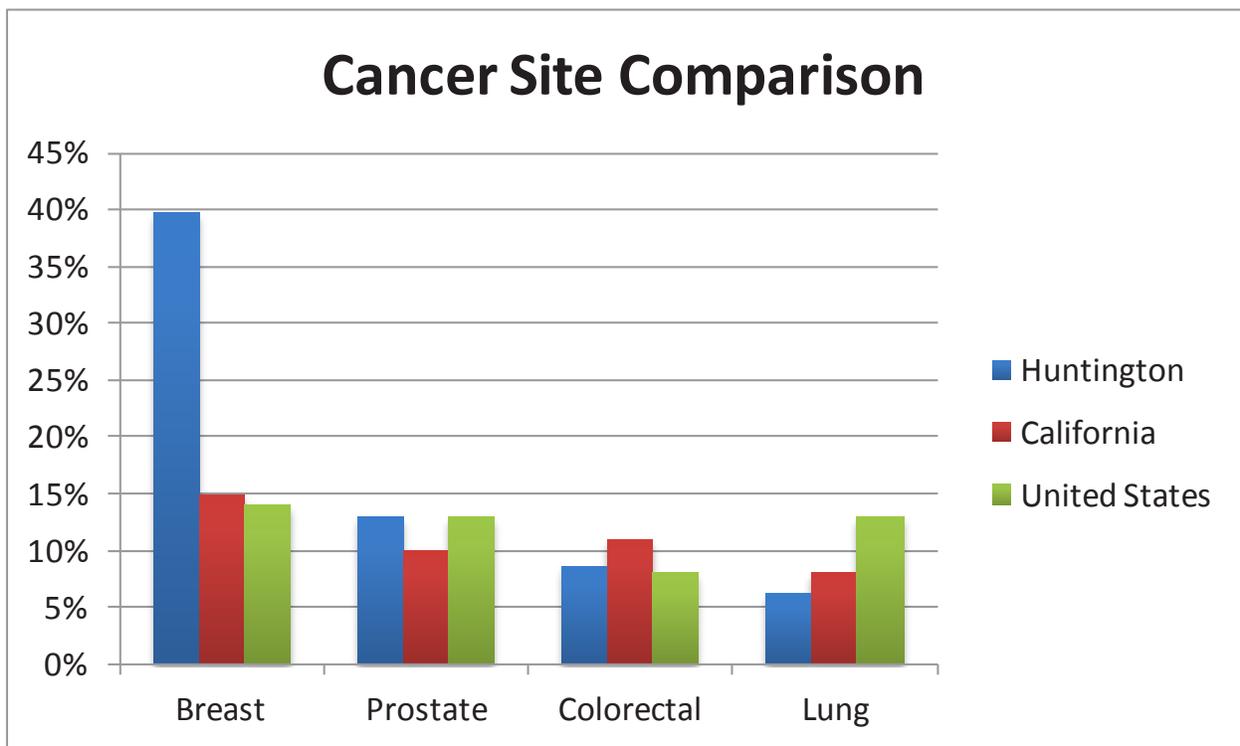
NR = unstageable, not recorded

2015 Cancer comparison

2015 Top Major Sites

It is estimated approximately 1,685,210 new cancer cases will be diagnosed in the United States in 2016. This estimated number excludes basal cell and squamous cell skin cancers and in situ carcinomas, except urinary bladder. Breast 249,260, prostate 180,890, colorectal 142,570 and lung 224,390 will account for 47 percent of all cancer sites diagnosed in the United States.

The graph below illustrates cancer site comparison of Huntington Hospital cases diagnosed in 2015, the estimated number for the state of California and for the United States, from the Cancer Facts & Figures, 2015.



Glossary of terms

Accession Number:

A unique number assigned to each patient entered into Huntington Hospital Cancer Data Center's Database. The first two digits specify the year of the diagnosis. The last four numbers are the numeric order in which the case was entered into the database.

AJCC Stage:

A staging system developed by the American Joint Committee on Cancer and the International Union Against Cancer. It takes into account the tumor size (T) and/or depth of invasion, lymph node involvement (N) and distant metastases (M). A combination of T, N and M elements gives an overall classification of stage 0, I, II, III, IV or unknown stage.

Analytic Case:

A case that is first diagnosed and/or receives all or part of the first course of treatment at Huntington Hospital.

First Course Treatment:

Initial tumor directed treatment or multi-modalities of treatments initiated within the first four months from the date of diagnosis.

Non-Analytic Case:

Patients diagnosed and treated elsewhere.

Not Recorded:

Cases that the extent of disease could not be determined or no staging system exists for that particular primary cancer site.

Stage at Diagnosis:

The extent of cancer within the body at the time of first diagnosis.

Survival Rate:

A statistical analysis that summarizes the probable frequency of specific outcomes for a group of patients at a particular point of time.



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