

INTRODUCTION

The year 2003 marks the continuation of the Falck Cancer Center into further efforts against the war on cancer by its various members. We, however, continue to arise to meet these challenges.

We continue to show excellence with our peers by, once again, achieving accreditation by the American College of Surgeons for three years. We also note a continued activity with community organizations and patients with various screening clinics, and National Cancer Survivors day. We, all members of the Falck Cancer Center, look forward to applying different and more innovative techniques to continue our battle against this deadly disease.

On a personal note, 2003 will also mark my last full year as Medical Director of the Cancer Center. Much has been accomplished but much remains and I am sure that the new Medical Director, Dr. William Muuse, will be up to the challenge. We look forward to supporting him in the future as well.

R. Thomas Abderhalden, MD
Medical Oncologist
Medical Director, Falck Cancer Center

EXECUTIVE DIRECTOR'S STATEMENT

In 2003 the Falck Cancer Center fully implemented IMRT (Intensity Modulated Radiation Therapy) for the treatment of prostate cancer and some brain tumors. IMRT is able to precisely target the tumor site while sparing normal nearby healthy tissue.

We continue to work with other community agencies to provide community screenings for breast, cervical, prostate, skin and colorectal cancers. Recognizing the burden that a family member's cancer can create, we have partnered with Southern Tier Hospice and Palliative Care to continue professionally facilitated support groups for caregivers of cancer patients.

We will continue to be committed to providing state of the art technologies and treatment modalities in a caring, supportive environment. We continue significant progress each year.

Karen Lower, RN, MS
Executive Director
Falck Cancer Center

GOALS FOR THE 2004 CANCER PROGRAM

- Continued implementation of Cancer Center Programs to include multidisciplinary support services (Social Work, Dietary, Pastoral Care, Etc...).
- Continue to improve quality of patient care through various multidisciplinary cancer case conferences.
- Cooperate with local community and national agencies to maintain public awareness regarding early detection and prevention of cancer.
- Continued implementation of early cancer detection screening programs for the community.
- Continued cooperation among Administration and Medical Staff to ensure consolidated services will provide patients with the best quality of care.
- Review data collected by the Cancer Registry to assure accuracy and completeness of data submitted to studies established by the American College of Surgeons (AcoS).
- Continued emphasis and expansion of Quality Improvement activities.

2003 REPORT OF THE CANCER COMMITTEE

The Cancer Committee is composed of individuals specializing in all aspects of care for patients with malignant disease. The Committee includes both hospital professionals as well as hospital administrators. The functions of the Committee include guidance of the Cancer Registry, organization of multidisciplinary educational conferences, review of patient care evaluation studies and various Quality Improvement activities. During the five meetings held in 2003, these responsibilities were carried out.

MEMBERSHIP OF THE 2003 CANCER COMMITTEE

2003 Chairman

R. Thomas Abderhalden, MD Medical Oncology

2003 Members

Edwin Acosta, MD	Radiology
Alan Angell, MD, FACS	Urology
Laura Balmer, RN, MS, ANP	Radiation Oncology
Rose Byland, MD	Radiation Oncology
JoAnne Casey	Quality Management Services
Amy Chrabaszcz, CSW	Medical Social Work
Dawn Heil, MD	Plastic Surgery
Patricia Knapp, BA, CTR	Tumor Registry
Joseph Krueger, MD	Radiation Oncology
Karen Lower, RN, MSCNA	Administration
Tammy Nisco, RN	Oncology Nursing
Patricia Schooler	Tumor Registry
Clay Stablein, MS	Physics
Darlene Stever	Radiation Oncology
Boyd Wilson, MD	Pathology

**GEOGRAPHIC DISTRIBUTION OF CANCER CASES
ACCESSIONED 1999 – 2003**

NEW YORK						
COUNTY	1999	2000	2001	2002	2003	TOTAL
Allegany	1	1	0	1	2	5
Broome	0	1	0	2	1	5
Cattaraugus	0	0	1	0	0	1
Cayuga	0	0	0	0	1	1
Chemung	370	361	401	388	422	1942
Cortland	1	0	0	1	0	2
Oneida	0	0	1	0	0	1
Onondaga	0	0	0	1	0	1
Ontario	0	0	1	0	0	1
Schuyler	48	38	48	49	45	228
Seneca	0	1	4	0	6	11
Steuben	54	73	60	87	93	367
St. Lawrence	1	0	0	0	0	1
Tioga	6	6	6	2	4	24
Tompkins	4	5	3	12	43	67
Yates	9	11	8	7	9	44
OUTSIDE NEW YORK						
Florida	0	2	6	0	1	9
Missouri	1	0	0	0	0	1
New Jersey	0	0	0	0	1	1
Pennsylvania	47	48	50	48	52	245
(Bradford)	(20)	(22)	(14)	(22)	(23)	(101)
(Centre)	(2)	(0)	(0)	(0)	(0)	(2)
(Erie)	(0)	(0)	(0)	(1)	(0)	(1)
(Lycoming)	(0)	(0)	(1)	(0)	(0)	(1)
(Potter)	(2)	(1)	(0)	(1)	(1)	(5)
(Tioga)	(23)	(25)	(35)	(24)	(28)	(135)
Virginia	1	0	1	0	0	2
Wyoming	0	0	1	0	0	1
TOTALS	543	547	591	598	681	2960

EDUCATIONAL CONFERENCES

Educational programs related to cancer include Gynecological Oncology Conferences, Cancer Case Discussions and Tumor Board conferences which provide the Medical Staff with a multidisciplinary approach to cancer treatment.

Members who attend the Cancer Case Discussions review and discuss the best possible treatment modalities for individual patients who have been diagnosed with cancer or have developed a recurrence from a previous cancer. During 2003, a total of 9 meetings resulted in the discussion of 19 patients.

Brent DuBeshter, MD is a Clinical Associate Professor of Oncology in Obstetrics and Gynecology and is an affiliate of Strong Memorial Hospital. He discusses treatment options with physicians as well as providing educational information at the Gynecological Oncology Conferences. A total of 31 patients benefited from the 6 conferences held in 2003.

The 23rd Annual Betts Komer Cancer Seminar was held on April 30, 2003. The seminar offered area physicians the opportunity to discuss case histories with John Finn, MD, FAAHPM. He is the Chief Medical Director of the Maggie Allesee Center for Quality of Life for Hospice of Michigan. His lecture "Hospice Approach to Palliative Medicine: My Approach For The Next Twenty Years" was well received.

DISEASE SITES DISCUSSED AT CANCER CONFERENCES

Cancer Case Discussions 9 Meetings		Gynecological Oncology Conference 6 Meetings	
Site	# of Cases	Site	# of Cases
Lung	5	Endometrium	11
Breast	2	Ovary	7
Hodgkins	2	Cervix	4
(NH) Lymphoma	2	Pelvic Mass	3
Bladder	1	Abdom Mass	1
Bone	1	Breast	1
Brain	1	Endocervix	1
Cervix	1	PMB	1
Endometrium	1	Unknown	1
Ovary	1	Uterus	1
Pelvic Mass	1	TOTAL	31
Prostate	1		
TOTAL	19		

RADIATION ONCOLOGY

The Arnot Ogden Medical Center Department of Radiation Oncology is now in its 12th year in the Falck Cancer Center. Two dual-energy Linear Accelerators, a Simulator with fluoroscopy, and a High Dose Rate Remote Afterloader are available to patients depending on their specific medical needs. With a broad spectrum of radiation therapy treatment equipment available, the technological sophistication of the Falck Cancer Center is equivalent or superior to many Radiation Oncology departments in large metropolitan areas. In 1998, we successfully added 3 Dimensional Conformal Treatment Planning and Prostate Seed Implantation to further expand services. These programs are fully implemented and growing. In 1999, we purchased a new dual-energy Linear Accelerator, which has higher energy photon and electron beam capability, allowing more ease in treating deep-seated tumors. In 2002, we began offering Intensity Modulated Radiation Therapy, allowing more exquisite targeting of tumors with better sparing of normal tissues.

The physicians and staff take great pride in the Falck Cancer Center and its sophisticated equipment. Most importantly, they remember that excellent patient care means more than cutting edge technology. It means caring and compassionate care.

Joseph B. Krueger, MD
Director, Radiation Oncology

2003 Radiation Oncology Staff:

Joseph Krueger, MD	Radiation Oncologist, Medical Director
Rose Byland, MD	Radiation Oncologist
Laura Balmer, RN,MS,ANP	Nurse Practitioner
Clay Stablein, MS	Medical Physicist
Charles Edwards, RT(T), CMD	Dosimetrist
Wendy Jurusik, RT(T)	Dosimetrist
Charles Onderko, RT(T)	Dosimetrist
Greg Denman, RT(T)	Radiation Oncology Supervisor
Michael Sheehe, RT(T)	Therapist
Peter Oggeri, RT(T)	Therapist
Karyn Ripley, RT(T)	Therapist
Mary McNelis, RN, OCN	Oncology Nurse
Phebe Cole, RN	Oncology Nurse
Darlene Stever	Secretary II
Tim Sweeney	Clinical Aide
Marilyn Berkey	Clinical Aide
Anna McCartney	Courtesy Transport Supervisor/Driver
Donna Knapp	Courtesy Transport Driver

Equipment:

- High and Low energy (6, 15 and 18MV) with 6-21 MeV electron beam linear accelerators
- Simulator with fluoroscopy
- High Dose Rate Remote Afterloader
- IMRT (Intensity Modulated Radiation Therapy)
- Vaginal cuff applicators

- ADAC 3D treatment planning computer
- Prostate seed implant stabilizer and needles

TOTAL RADIATION ONCOLOGY TREATMENTS

YEAR	INPATIENT	OUTPATIENT	TOTAL
1984	649	5042	5691
1985	638	5483	6121
1986	371	5910	6281
1987	591	6340	6931
1988	589	4210	4799
1989	481	5682	6613
1990	344	6653	6997
1991	473	7395	7868
1992	406	8488	8894
1993	339	12052	12391
1994	620	11027	11647
1995	249	10694	10943
1996	425	10803	11228
1997	617	9911	10528
1998	466	10504	10970
1999	484	9565	10049
2000	424	9075	9499
2001	555	8925	9480
2002	559	10097	10656
2003	531	10086	10617

MEDICAL ONCOLOGY SERVICES

The Oncology Program is dedicated to providing patient care and education to patients and their families. These objectives involve commitment to the universal concept of cancer management – to practice the most current methods of prevention, detection, diagnosis and treatment of disease. The program includes a very broad spectrum of inpatient and outpatient medical oncology services. Both services work closely through consultation of nursing staffs as well as through the Cancer Care Team to address the needs of oncology patients.

OUTPATIENT MEDICAL ONCOLOGY

The Arnot Ogden Outpatient Medical Oncology Program is located in the Falck Cancer Center. The program is available to all Arnot Ogden physicians who wish to have their patients treated on an outpatient basis. Services include patient/family education and counseling, enterostomal and rehabilitation therapy consultations, referrals to the Cancer Care Team, as well as access to programs of the American Cancer Society and other community agencies.

2003 Staff:

Tammy Nisco, RN

INPATIENT ONCOLOGY

Inpatient Oncology is a vital component of the oncology service line. The nurse case manager for 2B actively participates in the Falck Cancer Center Cancer Care Team.

Registered nurses on 2B have many years of experience in dealing with the multiple concerns and issues of cancer patients and their families. They collaborate with other disciplines and community services to provide comprehensive continuity of care. Palliative and hospice care as well as respite care are offered in cooperation with Southern Tier Hospice and Palliative Care as well as Guthrie Hospice.

Karen Lower, RN, MS

Executive Director

REHABILITATIVE SERVICES

The Rehabilitative Services Department provides physical, occupational and speech therapy for Arnot Ogden Medical Center cancer patients. Department staff work closely with other members of the Cancer Care Team to meet the unique needs of the cancer patient, their family and care givers. The goal of the service is to improve function, mobility and quality of life through the use of therapeutic interventions and patient education. Rehab therapists play a critical role in insuring that cancer patients have timely access to a wide range of rehabilitative and pain management services.

Richard N. Hoffman, FACHE
Executive Director

PASTORAL CARE

A diagnosis of cancer affects a person physically, emotionally and spiritually. The Pastoral Care Department of Arnot Ogden Medical Center is part of the oncology team with a primary focus on caring for the spiritual needs of cancer patients and their families. Spiritual need is expressed in many different ways, often without the use of religious terminology. The role of the Chaplain is to listen discerningly to the needs of patients and families and to meet them at their point of need. The Chaplain is an integral part of the Cancer Care Team and works closely with the nurses on the oncology unit, with other hospital support services and with area clergy in order to facilitate the comprehensive and holistic care of all cancer patients.

Rev. Jeffrey Palmer
Director, Pastoral Care

PHARMACY SERVICES

The Pharmacy Department was responsible for the preparation of 641 doses of chemotherapy in 2003. All Chemotherapy doses are prepared in the sterile environment of a vertical laminar air flow containment hood. This affords the greatest protection for the final product as well as the preparing pharmacist.

Our pharmacists work closely with the medical and nursing staffs to assure the integrity and appropriate use of the many complex and potent chemotherapy treatment protocols. Enhancement of patient understanding of the disease and its treatment is accomplished through this team approach to cancer care.

James Keetch, RPh
Director, Pharmacy

VOLUNTEERS

Specially trained volunteers continue to assist cancer patients at Arnot Ogden Medical Center in a variety of ways, including direct patient/family support, follow up calls to patients, and clerical assistance to Falck Cancer Center staff. A Falck Cancer Center volunteer attends the weekly Cancer Care Team meetings to help insure volunteers are connected with people in need of support. Our goal is to provide as much extra, one-to-one, personal attention as possible. Patients may want to share private feelings or fears...or just have some caring companionship. Volunteers help maintain our "Resource Room" (or patient library) and they also make outreach calls to each new patient at the FCC to offer them peer support, a referral to the American Cancer Society and acquaint them with special services available at the FCC; support groups and programs, dietary or social work counseling, transportation needs, etc.

The Auxiliary's annual "Orchids and Candlelight" event, and other Auxiliary fundraisers have funded a number of cancer services at Arnot Ogden in recent years, including transport vans for Falck Cancer Center patients, a 3D Conformal Radiation Therapy Treatment Planning System, and assistance for Twin Tier Lifeline for Children with Cancer.

The Auxiliary is committed to supporting Arnot Ogden's advanced cancer care services in the years ahead by enhancing therapy capabilities, patient comfort and educational resources.

Susan F. Reynolds
Director of Development

CANCER CARE TEAM

The purpose of the Cancer Care Team is to provide coordinated, multidisciplinary support and assistance to patients, their families and care givers so that they may maintain the highest quality of life possible. The Cancer Care Team also assists practitioners and other health care providers in caring for their patients. The Cancer Care Team coordinates the delivery of individualized cancer support services from program admission through discharge and follow up. Services include: patient education, medical social work, nutrition, pastoral care, rehabilitation services, hospice, community agency referral and peer support.

The team accepts referrals from patients, family members or care givers, physicians, nursing and allied health care providers, as well as community agencies. Upon referral, the patient is assessed for appropriate Cancer Care Team intervention. Patients with ongoing needs are assigned to a case manager who assumes responsibility for appropriate intervention, discharge planning and follow up. Physician and other provider involvement is encouraged dependent on patient need.

The Cancer Care Team works closely with the Inpatient Oncology Staff (Nursing, Nutritional Services, Medical Social Work, Pastoral Care, etc.) to assure continuity of care for patients undergoing the transition from the Inpatient to Outpatient setting and back.

2003 Members of Cancer Care Team:

Amy Chrabaszcz, CSW	Team Leader
Donzaleigh Priestley, MS, RD	Dietitian
Tammy Nisco, RN	Medical Oncology Nurse
Jeffrey W. Palmer	Chaplain
Karin Kurcoba	Hospice
Phebe Cole, RN	Radiation Oncology
Mary McNelis, RN, OCN	Radiation Oncology
Doris Ford, RN	Cancer Care Team Volunteer
Joan Peterson, RN	2B Case Manager
Deborah Dininny, BSN, RNC	Breast Health Specialist
Lucille Panosian	Outreach Cancer Care Team Volunteer
Barbara Furniss, RN	Resource Room Volunteer
Irene Bouchard, BSW	Social Work Assistant

NUTRITIONAL SERVICES

Proper nutrition is an important aspect of the total care and treatment of the oncology patient. Response to cancer therapy can often be enhanced by the delivery of appropriate nutritional care.

Nutritional screens are completed on each patient admitted. A complete nutritional assessment is performed on all patients found to be at high nutritional risk, or whenever ordered for a patient by his/her physician. Specialized nutrition support is utilized, when indicated, to nutritionally replete those patients found to be at increased risk. Nutritional support methods include the use of special diets, oral nutritional supplements, tube feedings and parenteral nutrition.

During their hospital stay, all patients are monitored by the clinical nutrition staff. A dietitian, diet technician or a nutritional services volunteer visits each oncology patient on a daily basis to assist in menu selection. Prior to discharge the dietitian or diet technician will provide the patient and/or his family with instruction on any necessary dietary restrictions or modifications which he/she should practice at home.

Following discharge, the clinical dietitian or diet technician remains available for consultation with the oncology patient and works closely with the Cancer Care Team dietitian to assure continuity of care.

John Jacobs, MA, RD
Chief Dietitian
Department of Nutritional Services

Donzaleigh Priestley, MS, RD
Cancer Care Team Dietitian
Falck Cancer Center

AMERICAN CANCER SOCIETY PROGRAMS & SERVICES FOR THE CHEMUNG AND SCHUYLER AREA

The American Cancer Society is the nationwide community-based voluntary health organization dedicated to eliminating cancer as a major health problem by preventing cancer, saving lives, and diminishing suffering from cancer, through research, education, advocacy, and service. The Society is headquartered in Atlanta, Georgia, with state Divisions and more than 3,400 local Units. The Society is the largest source of private, nonprofit cancer research funds in the United States. The Society's prevention programs focus on tobacco control, sun protection, diet and nutrition, comprehensive school health education, early detection, and treatment. A variety of service and rehabilitation programs are available to patients and their families. Through its advocacy program, the Society educates policy makers about cancer and how it affects the individuals and families they represent.

The American Cancer Society is active in your community and we can help! The Chemung and Schuyler American Cancer Society offers educational programs for the community, support groups and services for patients and their families, the National Cancer Information Center, and an information superhighway on the ACS website.

Cancer Information: The American Cancer Society remains the most trusted source of cancer information. Get answers to your questions about cancer research, risk factors, screening and diagnostic tests, and learn about prevention and detection programs in your community. Call the American Cancer Society 24 hours a day, seven days a week at 1-800-ACS-2345. On the Internet, www.cancer.org provides an unparalleled information resource available on your desktop.

Transportation: Road to Recovery provides transportation to life saving medical appointments. In many areas, American Cancer Volunteers drive cancer patients to treatments. In other cases, we can identify transportation resources in the community or help families in need with some of the costs of transportation.

Look Good...Feel Better: Look Good...Feel Better is an education and support program that helps women with cancer manage the appearance-related side effects of treatment. Professional cosmetologists volunteer their expertise during individual or group sessions. Complementary kits containing name-brand cosmetics are distributed during the group programs.

I Can Cope: I Can Cope is an educational program that teaches cancer patients and their families to become informed, active partners in treatment. Oncologists, nurses and nutritionists make local presentations on topics such as complimentary therapies, coping with side effects, and managing insurance and finances.

Man to Man: Man to Man is a confidential education and information program that enables prostate cancer survivors to get the information they need to resume active, productive lives. Group programs and individual volunteers offer support, as well as provide non-medical information on treatment options and side effects.

Reach to Recovery: For over 30 years, Reach to Recovery has linked newly diagnosed breast cancer patients with survivors. Visits may take place at the time of diagnosis or at any time throughout a woman's cancer experience, at home or in the hospital. Reach to Recovery volunteers offer information, answer questions, and provide support while serving as role models for life after cancer.

Cancer Survivor Network: Sometimes only a fellow cancer survivor can understand your experience. Call 1-877-333-HOPE (4673) to access hundreds of taped stories of cancer survivors and caregivers in circumstances similar to your own. Participate in a chat room of cancer survivors at www.cancer.org or follow instructions to create your own home page. Meet with an American Cancer Society volunteer who is a long-term cancer survivor – either in person or over the phone – through the Eastern Division's local survivor network.

Nutrition: Cancer treatment may cause nausea or affect appetite and sense of taste. Getting proper nutrition during this time may not be easy, but it is essential. The American Cancer Society provides up to date educational resources related to healthy eating before, during and after treatment.

Pain Control: Pain can result from cancer or its treatment, interrupting meaningful work and relationships, causing depression and fatigue. The American Cancer Society seeks to make pain control a reality throughout diagnosis, treatment and beyond by educating survivors and health professionals about recent advances, and advocating for insurance coverage for all.

Hope Lodge: Hope Lodge provides adult cancer patients and families who live outside of commuting distance to treatment with comfortable, safe housing. Located in Buffalo and Rochester, New York, Hope Lodge offers free private rooms as well as laundry and kitchen facilities and shuttle service to medical appointments.

Camp Adventure: Boating, swimming, sports and crafts – Camp Adventure helps children with cancer to simply be kids. This weeklong sleep-away camp on Long Island is open to patients and siblings ages 16 to 18, and staffed entirely by American Cancer Society Volunteers. The camp is supported by donations so that children can attend at no cost.

Living Well...Cancer Free: Get into the business of cancer control. Corporations can partner with the American Cancer Society to reach employees with information about prevention, early detection and treatment as well as volunteerism and fund-raising opportunities. New worksite wellness programs make it easy to talk about skin cancer prevention, smoke-free lifestyles, proper nutrition and physical activity, as well as breast, colorectal and prostate health.

Meeting Well: Too many of us live sedentary lives, spending our days in meetings and behind computer monitors. Meeting Well is a tool designed to help employers and community groups

follow American Cancer Society guidelines for diet, nutrition and exercise by incorporating activity and healthy menu choices into meetings and events.

Active For Life: Fitness can be fun! The American Cancer Society's flexible 10-week employee wellness program motivates people to be more active on a regular basis. A combination of individual and group strategies help participants set goals, win points and earn rewards for behavior change. The team approach boosts morale, self-esteem and success.

Comprehensive School Health Education: Children who learn to live healthy live longer. A coordinated approach to health education in grades K through 12 teaches children how to make sound health decisions. Quality school health programs not only prevent cancer and heart disease – they reduce violence, drug use, teen pregnancy and more. The American Cancer Society advocates for school health councils – local partnerships of parents and educators who support healthy learning environments.

Generation Fit: Healthy choices are best established in youth. Generation Fit teaches adolescents about good nutrition and active lifestyles – equipping them to be peer leaders who make these choices both popular and possible. Working in teams, young people build personal and social skills by addressing topics such as community hunger, school lunches and fitness options.

Patient Navigation: No two cancer patients are alike. Nor are their needs for information, support, and services exactly the same. That's why the American Cancer Society offers a wide range of programs and resources to help you learn about new treatments, arrange for home care, locate medical supplies, or find ways to feel positive and hopeful. We'll answer your questions and guide you to the assistance, care and advice you or your family needs. Patient Navigation is the foundation of what we do. We know we can help relieve some of the emotional, economic and physical problems caused by cancer. And we want to. Please call.

AMERICAN CANCER SOCIETY
(800)ACS-2345
www.cancer.org

If you are interested in local programs or volunteering in your community, please call your local American Cancer Society office at 734-1553. We look forward to hearing from you!

Julie McInerney
Community Executive
American Cancer Society
Chemung and Schuyler Area

SOUTHERN TIER HOSPICE

Southern Tier Hospice is a not-for-profit, community-based program providing comprehensive hospice services to residents of Chemung, Steuben and Schuyler Counties. Patients served by hospice must be certified by a physician to have a terminal illness with a prognosis of six months or less if their disease runs its normal course. Patients must have a plan for routine caregiving sufficient to meet their needs on a daily basis wherever the patient resides...private residence, adult home, foster home, contracted nursing home, etc. Hospice treats the patient and family as a unit, providing services to meet the physical, emotional, spiritual and social needs which arise out of the crisis of terminal illness.

Two interdisciplinary teams, one serving Chemung, Schuyler and Eastern Steuben Counties and the other serving Central and Western Steuben Counties, provide individualized care and support to patients and their families, primarily in the home. The teams include the services of physicians, home care nurses, social workers, spiritual care and bereavement counselors, and trained volunteers; each hospice team works in cooperation with the patient's personal physician. In addition to these core services, hospice has a full range of more than twenty services that can be offered if they are needed.

Southern Tier Hospice exists to affirm life by providing care and support for people in the end stage of any incurable disease, so that they may live as fully and comfortably as possible. Hospice is a program of palliative care, concentrating on pain management and control of other distressing symptoms related to the terminal disease. While insurance plans differ in their coverage of hospice services, Southern Tier Hospice will handle negotiations for reimbursement with all insurance plans. Reimbursements from Medicaid, Medicare and contracted private insurers are accepted as payment in full for all necessary hospice services. There is a sliding fee schedule in place to assure that all patients are served regardless of ability to pay. Anyone can refer a patient to Southern Tier Hospice. If you think that you or someone you know is in need of hospice services, ask your physician about referral to Hospice, or call Southern Tier Hospice at 607-962-3100. If this is long distance for you, please call 1-800-734-1570.

Mary Ann Starbuck
Executive Director
Southern Tier Hospice

TUMOR REGISTRY

The Tumor Registry provides a system to monitor all cancer patients diagnosed and/or treated at Arnot Ogden Medical Center. It provides critical information for cancer planning, administrative planning and allocation of hospital resources.

The Tumor Registry is responsible for the collection, management and analysis of data on cancer patients, and for reporting these cases to the New York State Department of Health. We work closely with physicians, hospital administrators, and health care practitioners to maintain ongoing records of the cancer patient's history, diagnosis, treatment and outcome. This information is used for education, lifetime patient follow up and research.

The Tumor Registry operates under the supervision of the Medical Center Cancer Committee and is regulated by the American College of Surgeons Commission on Cancer. The Registry is also responsible for compliance with the requirements of the Joint Commission on the Accreditation of Healthcare Organizations and the New York State Department of Health.

The Registry maintains a complete database of all cancer patients who have been diagnosed and/or treated for cancer at Arnot Ogden Medical Center. This database now includes over 9600 cancer cases diagnosed on or after January 1, 1988. To assure successful and complete cancer treatment as well as to provide meaningful end-result statistics, the Registry maintains life-long follow up on all registered cancer patients. Currently, over 3400 cases are being actively followed to achieve this objective.

The Tumor Registry keeps data for special studies, audits and research conducted by members of the Medical Staff. During 2003, the Registry provided statistics to physicians for individual studies, and conducted patient care evaluation studies as required by the American College of Surgeons Commission on Cancer.

2003 Staff:

Patricia Knapp, BA, CTR, Cancer Data Coordinator

Patricia Schooler, Follow Up Secretary

CANCER INCIDENCE 2003

The American Cancer Society Estimated Cancer Incidence by Site and Sex vs. Arnot Ogden Medical Center Actual Incidence by Site and Sex

American Cancer Society Estimated Cancer Incidence Male		Arnot Ogden Medical Center Actual Incidence Male	
Prostate	220,900 (33%)	Prostate	80 (29%)
Lung & Bronchus	91,800 (14%)	Lung & Bronchus	44 (16%)
Colon & Rectum	72,800 (11%)	Urinary Bladder	24 (9%)
Urinary Bladder	42,200 (6%)	Colon & Rectum	20 (7%)
Melanoma	29,900 (4%)	Leukemia	11 (4%)
Lymphoma (NH)	28,300 (4%)	Kidney	10 (4%)
Kidney	19,500 (3%)	Oral Cavity	9 (3%)
Oral Cavity	18,200 (3%)	Brain	8 (3%)
Leukemia	17,900 (3%)	Lymphoma (NH)	7 (2%)
Pancreas	14,900 (2%)	Melanoma	7 (2%)
		Stomach	7 (2%)
Other	118,900 (17%)	Other	50 (19%)
All Sites	675,300 (100%)	All Sites	277 (100%)

American Cancer Society Estimated Cancer Incidence Female			Arnot Ogden Medical Center Actual Incidence Female		
Breast	211,300	(32%)	Breast	124	(45%)
Lung & Bronchus	80,100	(12%)	Lung & Bronchus	31	(11%)
Colon & Rectum	74,700	(11%)	Colon & Rectum	19	(7%)
Uterine Corpus	40,100	(6%)	Uterine Corpus	15	(5%)
Ovary	25,400	(4%)	Leukemia	8	(3%)
Lymphoma (NH)	25,100	(4%)	Lymphoma (NH)	8	(3%)
Melanoma	24,300	(3%)	Ovary	8	(3%)
Thyroid	16,300	(2%)	Pancreas	7	(3%)
Pancreas	15,800	(2%)	Brain	6	(2%)
Urinary Bladder	15,200	(2%)	Cervix	6	(2%)
Other	130,500	(22%)	Other	43	(16%)
All Sites	658,800	(100%)	All Sites	275	(100%)

TOTAL CASES ACCESSIONED 1992– 2003

Year	# of Cases		Year	# of Cases
1992	660		1998	630
1993	706		1999	543
1994	684		2000	547
1995	637		2001	579
1996	630		2002	598
1997	583		2003	658

2003 CANCER CASES

Primary Site	Cases	Class of Case		Sex	
		A	N	M	F
Oral Cavity & Pharynx	16	11	5	12	4
Tongue	5	1	4	3	2
Salivary Glands	3	3	0	2	1
Floor of Mouth	1	0	1	1	0
Tonsil	6	6	0	5	1
Oropharynx	1	1	0	1	0
Digestive System	88	70	18	51	37
Esophagus	6	6	0	6	0
Stomach	9	8	1	8	1
Small Intestine	1	1	0	1	0
Colon Excluding Rectum	31	26	5	19	12
Cecum	4	4	0	2	2
Ascending Colon	7	6	1	5	2
Transverse Colon	5	5	0	3	2
Descending Colon	3	3	0	1	2
Sigmoid Colon	9	7	2	5	4
Large Intestine	3	1	2	3	0
Rectum & Rectosigmoid Junction	15	13	2	8	7
Rectosigmoid Junction	1	1	0	0	1
Rectum	14	12	2	8	6
Anus & Anal Canal	1	1	0	0	1
Liver	6	4	2	2	4
Gallbladder	1	0	1	1	0
Other Biliary	1	1	0	0	1
Pancreas	16	10	6	6	10
Retroperitoneum	1	0	1	0	1
Respiratory System	93	82	11	56	37
Nose & Nasal Cavity	1	1	0	1	0
Larynx	6	6	0	6	0
Lung & Bronchus	86	75	11	49	37
Skin excluding Basal & Squamous	20	16	4	15	5
Melanoma	11	8	3	9	2
Other Skin	9	8	1	6	3
Breast	131	124	7	0	131
Female Genital System	40	32	8	0	40
Cervix Uteri	6	6	0	0	6
Corpus Uteri	18	15	3	0	18
Ovary	10	8	2	0	10
Vagina	2	2	0	0	2
Vulva	4	1	3	0	4
Male Genital System	103	87	16	103	0
Prostate	96	80	16	96	0
Testis	6	6	0	6	0
Penis	1	1	0	1	0
Urinary System	54	43	11	44	10
Urinary Bladder	35	30	5	28	7
Kidney & Renal Pelvis	18	12	6	15	3
Ureter	1	1	0	1	0

Brain & Other Nervous System	15	14	1	9	6
Brain	13	12	1	7	6
Cranial Nerves/Other Nerv System	2	2	0	2	0
Endocrine System					
Thyroid	3	3	0	1	2
Lymphoma	25	21	4	14	10
Hodgkin Lymphoma	5	5	0	4	1
Non-Hodgkin Lymphoma	20	16	4	10	9
Myeloma	8	5	3	6	2
Leukemia	24	19	5	15	9
Lymphocytic Leukemia	12	9	3	10	2
Myeloid & Monocytic Leukemia	12	10	2	5	7
Miscellaneous	38	26	12	16	22
Totals	658	553	105	342	315

CANCER RATE AMONG ANALYTIC CASES, 2003

SITE	# OF CASES	%
Breast	124	22.4%
Prostate	80	14.5%
Bronchus & Lung	76	13.7%
Colon & Rectum	39	7%
Leukemia & Blood Disorders	35	6.3%
Bladder	30	5.4%
Skin	16	2.9%
Brain	15	2.7%
Corpus Uteri	15	2.7%
Lymphoma	15	2.7%
Unknown Primary	15	2.7%
Kidney	12	2.2%
Pancreas	10	1.8%
Stomach	9	1.6%
Ovary	8	1.4%
Cervix	6	1.1%
Esophagus	6	1.1%
Larynx	6	1.1%
Testis	6	1.1%
Tonsil	6	1.1%
Liver	4	0.7%
Parotid Gland	3	0.5%
Thyroid Gland	3	0.5%
Vagina	2	0.4%
Anus & Anal Canal	1	0.2%
Biliary Tract, Other	1	0.2%
Mouth, Other	1	0.2%
Nasal Cavity	1	0.2%
Nasopharynx	1	0.2%
Oropharynx	1	0.2%
Other	1	0.2%
Penis	1	0.2%
Small Intestine	1	0.2%
Tongue	1	0.2%
Ureter	1	0.2%
Vulva	1	0.2%
Total	553	100%

ALL SITES – 2003

553 Analytic Cases	0	I	II	III	IV	NS	Total
Biopsy/Staging Only	5	3	13	1	11	33	66
Surgery	16	12	17	3	0	12	60
Radiation	1	23	36	14	20	9	103
Chemotherapy	2	1	0	0	15	18	36
Hormone	0	0	1	0	1	2	4
Surgery & Radiation	6	14	5	5	4	8	42
Surgery & Chemotherapy	7	3	5	4	2	1	22
Surgery & Hormone	0	0	0	0	1	0	1
Radiation & Chemotherapy	0	2	4	12	12	5	35
Radiation & Hormone	0	0	16	4	1	0	21
Surg & Rad & Chemo	0	9	15	7	4	7	42
Surg & Rad & Hormone	17	30	4	0	1	0	52
Surg & Chemo & Hormone	0	1	0	0	0	0	1
Surg/Rad/Chemo & Horm	0	10	11	4	0	0	25
None	1	6	3	0	6	27	43
Totals	55	114	130	54	78	122	553

Sex		Age at Diagnosis			Stage		Treatment	
Male	50%	Age	#	%	0	10%	Surg	11%
Female	50%	0 – 9	1	0.2%	I	21%	Rad	19%
		10 – 19	1	0.2%	II	23%	Chemo	6%
		20 – 29	9	1.6%	III	10%	Horm	1%
		30 – 39	22	4.0%	IV	14%	Combo	44%
		40 – 49	47	8.5%	NS	22%	None	19%
		50 – 59	99	18%	Total	100%	Total	100%
		60 – 69	124	22.4%				
		70 – 79	154	27.8%				
		80 – 89	88	15.9%				
		90 & Up	8	1.4%				
		Total	553	100%				

The number of analytic cases increased from 502 in 2002 to 553 in 2003. This demonstrates the

community's desire to receive cancer treatment locally from a state-of-the-art facility. The above statistics also are revealing for the number of patients treated with combined therapy. Many years ago patients often received surgery as their only treatment. Now combinations of surgery, radiation and chemotherapy are commonly used, resulting in higher cure rates. It is now commonplace for patients with breast, lung, head and neck, gynecologic, and rectal cancers to receive combination therapy. Combined modality therapy is facilitated by the design of the Falck Cancer Center, which allows patients to receive chemotherapy and radiation therapy at its single location. Since the Falck Cancer Center is physically attached to the Arnot Ogden In-Patient cancer floor, surgical patients can be easily integrated into the comprehensive cancer treatment regimens.

The physicians and staff at Arnot Ogden Medical Center and the Falck Cancer Center take great pride in delivering state-of-the-art cancer treatments in a comfortable, convenient, and compassionate setting.

Joseph Krueger, MD
Radiation Oncology

LUNG CANCER - 2003

76 Analytic Cases	0	I	II	III	IV	Unk	Total
Surgery	0	0	0	0	0	0	0
Radiation	0	4	1	6	13	1	25
Chemotherapy	0	0	0	0	11	0	11
Surgery & Radiation	0	0	0	0	0	0	0
Surgery & Chemotherapy	0	0	0	0	0	0	0
Radiation & Chemotherapy	0	2	0	13	6	0	21
Surgery & Radiation & Chemo	0	1	1	0	1	0	3
None	0	2	0	0	10	4	16
Totals	0	9	2	19	41	5	76

Sex		Age at Diagnosis			Stage		Treatment	
Male	58%	Age	#	%	0	0	Surg	0
Female	42%	10-19	0	0	I	12%	Rad	33%
		20-29	0	0	II	3%	Chemo	14%
		30-39	1	1%	III	25%	Combo	32%
		40-49	7	9%	IV	54%	None	21%
		50-59	5	7%	Unk	6%	Total	100%
		60-69	25	33%	Total	100%		
		70-79	25	33%				
		80-89	13	17%				
		90 & Up	0	0				
		Total	76	100%				

Once again, lung cancer continues to be one of the most frequently diagnosed and treated cancers at the Falck Cancer Center. In the year 2003, seventy-six patients were treated with various modalities. Overall, there are no major differences from 2002 to 2003 with the exception of other medications coming to the forefront for use to combat this disease. We continue to strive to eliminate it as much as possible with cessation of smoking clinics as well as offering other treatments that are innovative and potentially useful for treatments. Hopefully, these efforts will show fruition in the near future.

R. Thomas Abderhalden, MD
 Medical Oncology
 Medical Director, Falck Cancer Center

BREAST CANCER - 2003

124 Analytic Cases	0	I	II	III	IV	UNK	Total
Surgery	1	2	2	0	1	0	6
Chemotherapy	0	0	0	0	2	0	2
Hormone	0	0	0	0	1	0	1
Surgery & Radiation	6	6	2	0	0	0	14
Surgery & Chemotherapy	0	1	1	0	0	0	2
Surgery & Radiation & Chemo	0	6	6	3	0	0	15
Surgery & Radiation & Hormone	17	31	3	0	0	0	51
Surgery & Chemo & Hormone	0	1	0	0	0	0	1
Surgery/Radiation/Chemo/Hormone	0	10	11	4	0	0	25
Chemo & Hormone	0	0	0	0	1	0	1
Radiation & Hormone	0	0	0	1	0	0	1
None	2	0	1	0	2	0	5
Totals	26	57	26	8	7	0	124

Age at Diagnosis			Stage		Treatment	
Age	#	%	0	21%	Surgery	5%
20-29	0	0	I	46%	Chemotherapy	2%
30-39	2	2%	II	21%	Hormone	1%
40-49	19	15%	III	6.5%	Combination	88%
50-59	43	35%	IV	5.5%	None	4%
60-69	27	22%	Unk	0	Total	100%
70-79	18	14%	Total	100%		
80-89	14	11%				
90& Up	1	1%				
Total	124	100%				

Breast cancer continues to invoke multidisciplinary interaction. As noted by the above statistics, all disciplines have to coordinate their efforts to affect the best outcome for the patient. In order to assist in this endeavor, the Arnot Ogden Medical Center Breast Program of Care, which was started in 2001, has coordinated radiology, surgery, pathology, chemotherapy and radiation therapy in regards to breast care. The committee has provided flow sheets to assist clinicians following breast lesions, helped organize sentinel lymph node injection procedures, and intervened with procedures to attend to abnormal mammograms in a timely manner, providing coordinated interdisciplinary care. Members of the committee are dedicated to streamlining the ongoing care for patients with this complex disease.

Rose Y. Byland, MD
Radiation Oncology

COLON/RECTUM CANCER - 2003

Analytic Cases	0	I	II	III	IV	Unk	Total
Surgery	3	5	7	2	0	1	18
Chemotherapy	0	0	0	0	2	0	2
Surgery & Chemotherapy	0	0	1	3	1	0	5
Radiation & Chemotherapy	0	0	0	0	1	0	1
Surgery & Radiation & Chemo	0	0	3	1	0	0	4
None	1	4	0	0	2	2	9
Totals	4	9	11	6	6	3	39

Age at Diagnosis			Stage		Treatment	
20-29	0	0	0	10%	Surgery	46%
30-39	1	3%	I	23%	Chemo	5%
40-49	5	13%	II	29%	Combo	26%
50-59	4	10%	III	15%	None	23%
60-69	6	15%	IV	15%	Total	100%
70-79	13	33%	Unk	8%		
80-89	9	23%				
90 & Up	1	3%	Total	100%		
Total	39	100%				

Sex	
Male	51%
Female	49%

In the year 2003, there were a total of 39 cases of colorectal cancer diagnosed at Arnot Ogden Medical Center. As in the past, the majority of these cases were treated primarily with surgery. Compared to 2002, there was a significant increase in patients presenting with early stage disease with 23% of all patients presenting with Stage I colon cancer and 29% presenting with Stage II. As in the past, there were significant numbers of patients who required adjuvant systemic chemotherapy for Stage III disease. Greater than 25% of all patients were in the age group of 80 or greater.

William T. Muuse, MD
 Medical Oncology

PROSTATE CANCER - 2003

80 Analytic Cases	0	I	II	III	IV	Total
Surgery	0	1	13	1	1	16
Radiation	0	1	21	1	0	23
Hormone	0	0	1	0	0	1
Surgery & Radiation	0	0	0	2	0	2
Surgery & Hormone	0	0	0	0	1	1
Radiation & Hormone	0	0	16	3	1	20
Surg/Rad/Hormone	0	0	1	0	1	2
None	0	0	15	0	0	15
Totals	0	2	67	7	4	80

Age at Diagnosis			Stage		Treatment	
40-49	1	1%	0	0	Surgery	20%
50-59	10	12%	I	2%	Radiation	29%
60-69	23	29%	II	84%	Hormone	1%
70-79	32	40%	III	9%	Combo	31%
80-89	14	18%	IV	5%	None	19%
90 & Up	0	0	Total	100%	Total	100%
Total	80	100%				

There was an 11% increase in newly diagnosed prostate cancers in 2003. This represents the second year in a row of increase in cases. There was a shift from the 60-69 year old age group to both older and younger age groups. There was also a shift in treatment from radiation to surgery, while there was little to no change in hormone, combination therapies and watchful waiting. It will be interesting to see if these trends continue in 2004.

Alan H. Angell, MD, FACS
 Urology
 American College of Surgeons Cancer Liaison Physician

SURVIVAL STUDY – ABOUT PANCREAS CANCER

The following information was taken from “Cancer Facts and Figures – 2003” distributed by the American Cancer Society.

New Cases: An estimated 30,700 new cases in the United States in 2003. Over the past 15 to 25 years, rates of pancreatic cancer have declined slowly in men and women.

Deaths: An estimated 30,000 deaths in 2003. The death rate from pancreatic cancer has continued to decline since the early 1970’s in men, while it continued to increase in women. However, both the decrease in men and increase in women have slowed in recent years.

Signs and Symptoms: Cancer of the pancreas generally develops without early symptoms. If a cancer develops in an area of the pancreas near the common bile duct, its blockage may lead to jaundice. Sometimes this symptom allows the tumor to be diagnosed at an early stage.

Risk Factors: Cigarette and cigar smoking increase the risk of pancreatic cancer; incidence rates are more than twice as high for smokers as for nonsmokers. Risk also appears to increase with obesity, physical inactivity, chronic pancreatitis, diabetes, and cirrhosis. Pancreatic cancer rates are higher in countries whose populations eat a diet high in fat. Rates are slightly higher in males than in females.

Early Detection: At present, only biopsy yields a certain diagnosis. Because of the “silent” early course of the disease, the need for biopsy may become obvious only with advanced disease. Researchers are focusing on ways to diagnose pancreatic cancer before symptoms occur.

Treatment: Surgery, radiation therapy, and chemotherapy are treatment options that can extend survival and/or relieve symptoms in many patients, but seldom produce a cure. Clinical trials with several new agents may offer improved survival and should be considered an option.

Survival: For all stages combined, the 1-year relative survival rate is 21%, and the 5-year rate is about 4%. Even for those people diagnosed with local stage disease, the 5-year relative survival rate is only 17%.

**Comparison Statistics
Survival Study 2003 – Pancreatic Cancer**

1994 – 1998 Cases	0	I	II	III	IV	Total	Stage	
Radiation	0	1	1	0	3	5	0	0%
Chemotherapy	0	0	0	0	2	2	I	8%
Radiation & Chemo	0	1	9	0	2	12	II	28%
Surgery/Rad/Chemo	0	0	1	1	0	2	III	3%
None	0	1	0	0	17	18	IV	61%
Total	0	3	11	1	24	39		
							Rad	13%
							Chemo	5%
							Combo	36%
							None	46%
							Total	100%

2003 Cases	0	I	II	III	IV	Unk	Total	Stage	
Chemotherapy	0	0	0	0	1	0	1	0	0%
Surgery & Chemo	0	0	1	0	0	0	1	I	0%
Surgery/Rad/Chemo	0	0	1	1	0	0	2	II	20%
None	0	0	0	1	5	0	6	III	20%
Total	0	0	2	2	6	0	10	IV	60%
								Unk	0%
									100%
								Treatment	
								Chemo	10%
								Combo	30%
								None	60%
								Total	100%

Age Distribution				Analytic Cases 1994 – 2003	
1994 – 1998		2003		1994	6
50–59	26%	50–59	20%	1995	11
60–69	26%	60–69	10%	1996	7

70-79	30%		70-79	40%			1997	6
80-89	13%		80-89	20%			1998	9
90-99	5%		90-99	10%			1999	8
							2000	3
							2001	10
							2002	12
Totals	100%		Totals	100%			2003	10

Survival Statistics 1994 – 1998 Pancreatic Cancer Cases

	0	I	II	III	IV	Total
< 1Mo	0	3	11	1	24	39
1 Mo	0	3	11	1	24	39
2 Mo	0	3	11	1	19	34
3 Mo	0	3	9	1	16	29
6 Mo	0	2	6	1	9	18
1 Year	0	2	4	1	4	11
2 Years	0	0	2	0	0	2
3 Years	0	0	0	0	0	0
4 Years	0	0	0	0	0	0
5 Years	0	0	0	0	0	0

Surv Rate '94-'98			0	I	II	III	IV
< 1 Mo	100%	< 1 Mo	0	100%	100%	100%	100%
1 Mo	100%	1 Mo	0	100%	100%	100%	100%
2 Mo	87%	2 Mo	0	100%	100%	100%	79%
3 Mo	74%	3 Mo	0	100%	82%	100%	67%
6 Mo	46%	6 Mo	0	67%	55%	100%	38%
1 Year	28%	1 Year	0	67%	36%	100%	17%
2 Years	5%	2 Years	0	0	18%	0	0
3 Years	0	3 Years	0	0	0	0	0
4 Years	0	4 Years	0	0	0	0	0
5 Years	0	5 Years	0	0	0	0	0

SURVIVAL STUDY SUMMARY

The Falck Cancer Center survival study of 2003 focuses on pancreatic carcinoma. We compared our findings with those of the American Cancer Society cases from the years 1994 – 1998. Thirty-nine patients were diagnosed and treated. The majority of these were in Stage IV, having 61% of patients in this category. About half of all patients were treated with various treatment modalities showing an actual one year survival rate of approximately 28%, this comparing favorably to national statistics of 21%. Looking at 2003 cases only, ten patients were diagnosed and treated, only 40% receiving treatment. Early data for survival shows an 18% two-year survival rate, comparing more favorably than the previous two-year survival rate in our institution of 5%.

Although the general statistics show generally poor prognosis and very unfavorable survival rates, the use of new drugs, especially Gemcytabine and others, may improve this. We look forward to improvement as we continue to battle this generally very fatal disease.

R. Thomas Abderhalden, MD
Medical Oncology
Medical Director, Falck Cancer Center

GLOSSARY OF TERMS

CLASS OF CASE:

Analytic: Cases which are first diagnosed and/or receive all or part of their first course of treatment at Arnot Ogden Medical Center.

Nonanalytic: Cases diagnosed and all of the first course of therapy is received elsewhere, diagnosed and treated at Arnot Ogden Medical Center prior to reference date, or diagnosed at autopsy.

AJCC STAGING:

T (Tumor) Evaluates the primary tumor and reflects tumor size and/or extension.

N (Nodes) Classifies the regional lymph nodes and describes the absence or presence and the extent of node metastases.

M (Metastasis) Records the presence or absence of distant metastases.

Stage Defines the anatomic extent of disease based on the previously coded T, N, and M elements.

TREATMENT:

Non Cancer-Directed Surgery: Surgical procedures performed to diagnose/stage disease (exploratory) or for relief of symptoms (palliative).

Cancer-Directed Surgery: Surgical procedures performed to modify, control, remove, or destroy proliferating cancer tissue.

Radiation: External Beam Radiation, High Dose Rate Brachytherapy, Radioactive Isotope Therapy, or a combination.

Chemotherapy: Consists of a group of anticancer drugs that inhibit the reproduction of cancer cells by interfering with the DNA synthesis and mitosis.

Hormone Therapy: Hormones can be used to alter the growth of cancer. Some tissues, such as prostate or breast, depend upon hormones to develop. When a malignancy arises in these tissues, it is usually hormone responsive. Other primary and histologic types may be hormone responsive, such as melanoma and hypernephroma. Hormonal therapy may effect a long-term control of the cancer growth. It is not usually used to "cure" the cancer.

Immunotherapy: Consists of biological or chemical agents that alter the immune system or change the host's response to the tumor cells.

Other: Includes therapies not defined in the above categories that are designed to modify or control the cancer cells.

REFERENCES

CANCER FACTS AND FIGURES, 2003, American Cancer Society.

GUIDELINES FOR PREPARING A HOSPITAL CANCER PROGRAM ANNUAL REPORT, 1982, American Cancer Society, California Division, Inc.

MANUAL FOR STAGING OF CANCER, FIFTH EDITION, American Joint Committee on Cancer, 1997.

CANCER REGISTRY OPERATIONS MANUAL, 1998, American College of Surgeons, Commission on Cancer.

STANDARDS OF THE COMMISSION ON CANCER, Volumes 1 and 2, Commission on Cancer, 1996.

STANDARDS OF THE COMMISSION ON CANCER, Volume 3, Commission on Cancer, 1999.

2001 CANCER PROGRAM ANNUAL REPORT, Arnot Ogden Medical Center.

Information for the 2003 Cancer Program Annual Report was compiled by Patricia Knapp, CTR, Certified Tumor Registrar.

For a complete copy of the 2003 Cancer Program Annual Report, please call 737-8118 or toll-free 1-800-262-3252.