Coffeyville Regional Medical Center

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2015 ANNUAL CANCER REPORT

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Coffeyville Regional Medical Center
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EXECUTIVE SUMMARY

Mark Woodring, DrPH, FACHE

Chief Executive Officer

Unfortunately today, too many conversations begin in our homes, or on our phones, or in our offices, with family members, loved ones, and other dear friends and co-workers with the words, "I have cancer." We will remember where we were, what we were doing, and the many moments thereafter hearing them. We gut-wrenchingly understand how the conversation with cancer begins. Our skilled medical staff and care team at CRMC want you to know we can help you with the next conversation starter, "We can beat it."

Our medical community is highly engaged with the war on cancer. I am incredibly impressed by the comprehensive cancer program that has been established here over the past four decades. Our program is proud to provide all modalities of cancer treatment including cancer surgery, medical oncology, radiation oncology, and cancer registry. Our program has been approved by the prestigious American College of Surgeons, and is one of only 11 accredited cancer centers in the state of Kansas.

Our Cancer Center was renamed The Tatman Cancer Center and moved to a new area in 2007, through the generous donation of Richard and Darlene Tatman and many others. In 2011, CRMC Radiation Therapy moved to the new $9.5 million Jerry Marquette Radiation Oncology Center, which includes a new Linear Accelerator, Large Bore CT Scanner and superficial therapy machine in addition to our diagnostic digital mammography, PET/CT and MR scanners. In the words of FDR nearly eighty years ago, "our vision for the future contains more than promises, and for all these we have only begun to fight." Our dedicated physicians and staff are committed to the care and treatment of cancer, and we believe in the promise of future research and new cures for cancer that are already upon us.

We look forward to strengthening our partnerships with other leaders in the field to help eradicate cancer. Our 2013 Community Health Needs Assessment (CHNA) identified "Cancer" as a critical issue impacting the overall health of Coffeyville and our patient population throughout southeast Kansas and Northeast Oklahoma. As we conclude 2015 and look ahead to the 2016 CHNA, despite the many advances we have made fighting this disease, we anticipate the community will again strongly recommend our engagement in the war on cancer must continue. While our region has access to a comprehensive range of cancer services unrivalled by other rural health systems, we will not rest until the war is won. We look ahead to forging new alliances to bring National Cancer Institute-accredited resources and clinical trials to Coffeyville Regional Medical Center next year.

We believe a day will come when we all win the war on cancer. In the meantime, as the only accredited cancer center in Southeast Kansas, we will continue to provide these services for as many years as our communities need us to. For those patients and families fighting cancer today, we are with you. If there is anything we can do to help make your battle just a little bit easier, please let me know.

Sincerely,

Mark Woodring, DrPH, FACHE

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EXECUTIVE SUMMARY

Jerry Marquette Radiation Oncolgy Center

Nathan Uy, MD

Radiation Oncologist

ASTRO consensus guidelines: Prostate and Breast cancer

In recent years, numerous guidelines have been published to help oncologist guide the treatment of cancer patients with evidence based practices that can be uniformly applied at any treatment facility. In the modern era of oncology, to the extent that it is possible, oncologic care is becoming further standardized so that patients can be assured that they will receive recommendations for care that are consistent between cancer centers. In the last 5 years the American Society for Radiation Oncology (ASTRO) has published 8 evidence-based clinical practice guidelines for a variety of cancers, including prostate cancer, the most common in men, and breast cancer, the most common cancer in women.

Perhaps the most significant guidelines set forth by ASTRO relates breast cancer treatment. First, in a paper from 2011, ASTRO published guidelines regarding fractionation schedules for treatment of breast cancer after lumpectomy. Based on the results of studies completed prior to 2011, which evaluated treatment plans of the radiation shorter than the traditional 6-7 week regimens, the office concluded that a subgroup of patients could clearly be treated with shorter courses of radiation without any decrement. Specifically, a course of treatment delivered over 16 fractions, taking just over 3 weeks, was associated with equivalent survival and without worsened side effects. Patients who are candidates for this treatment include women over the age of 50 with tumors less than 3 cm in size, without involvement of lymph nodes. This regimen was felt to be most appropriate for women who did not receive chemotherapy, and in whom the breast size was below a certain limit. This regimen has become increasingly popular as it reduces the number of treatments the patient must go through. New evidence indicates that this regimen is associated with fewer side effects than the longer course of the radiation despite the fact that the daily radiation dose is somewhat higher. In a separate paper, ASTRO discussed the impact of surgical margins on breast cancer radiotherapy in women who have undergone lumpectomies. The guideline brought clarity to an issue of much debate in recent years by stating that a negative inked surgical margin is sufficient for patient undergoing radiation, and that increasing margin distance is not necessary. The guidelines reaffirm the high recurrence rate associated with a positive surgical margin even in patients who receive radiation.

In May 2013 guideline, ASTRO addressed the role of radiation following prostatectomy in men with prostate cancer. The guidelines recommend that patients who undergo prostatectomy should be counseled beforehand that certain pathology findings are associated with a higher risk of recurrence and potential need for radiation therapy. These include positive surgical margins, seminal vesicle invasion, and extraprostatic extension.

Postoperative radiation therapy for men with these factors is associated with lower recurrence rates, but it is not clear if this leads to increased survival. Patients with these factors should be offered radiation therapy, particularly if the PSA remains detectable after prostatectomy. Patients whose PSA actually rises after surgery, particularly when it doubles in value in under 10 months, should be informed that they have a higher likelihood of harboring metastatic disease. Many of these patients should undergo pertinent radiologic imaging tests to rule out the presence of metastatic disease. In men who did not undergo radiation therapy immediately after prostatectomy, routine PSA screening should continue, and recurrence can be defined as a level greater than 0.2. These patients should then be offered radiation therapy. In this setting, radiation is most effective when started at the earliest sign of prostate cancer recurrence.

References:

Adjuvant and Salvage Radiation Therapy After Prostatectomy: American Society for Radiation Oncology/American Urological Association Guidelines, Int J Radiation Oncol Biol Phys, Vol. 86, No. 5, pp. 822-828, 2013

Society of Surgical Oncology/American Society for Radiation Oncology Consensus Guideline on Margins for Breast-Conserving Surgery With Whole-Breast Irradiation in Stages I and II Invasive Breast Cancer, Int J Radiation Oncol Biol Phys, Vol. 88, No. 3, pp. 553-564, 2014

Fractionation for Whole Breast Irradiation: An American Society for Radiation Oncology (ASTRO) Evidence-Based Guideline, Int J Radiation Oncol Biol Phys, Vol. 81, No. 1, pp. 59-68, 2011

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EXECUTIVE SUMMARY

The Tatman Cancer Center

Akinola Ogundipe, MD

Medical Oncologist/Hematologist

Cancer Screenings

The concept of screening for cancer has been widely publicized for several years. The purpose of screening is to identify a cancer early when the person has the best chance of a cure. A good screening test would have high sensitivity and specificity. Sensitivity measures the number of positive tests that are truly positive and specificity measures the number of negative tests that are truly negative. If a screening test for cancer is reported to be negative, the patient is relieved. However, if the patient really has cancer and it is not detected, this may be detrimental to the patient. Similarly, if the test is reported to be positive and the patient really does not have cancer, it may also be detrimental because of the increased distress to the patient, necessity for additional testing, and the possibility of unnecessary treatment.

Mammography is one example of a cancer screening that screens for breast cancer. The mammography has been found to have a sensitivity of 84.4 percent and a specificity of 90.8 percent. Everyone agrees that the mammogram is a good screening test. However, there is controversy about when someone should begin screening and how often the screening should occur. The average lifetime risk of breast cancer for a woman is 12% according to the National Cancer Institute.

In 2002, the U.S. Preventive Services Task Force recommended mammograms every 1-2 years starting age 40. However, the new recommendations are different. The task force recommends against routine screening in the 40-49 age group. The reason is that the net benefit of this screening is small and that harms are greater. The potential harms of screening are false positive results of the mammogram which lead to additional imaging and possible biopsies. These additional tests result in anxiety, distress and psychosocial effects. Screening is intended to decrease the risk of mortality, therefore finding cancer that would never have caused death is a potential harm. The patient is "over-diagnosed", screening detects a cancer that would not have been clinically detected or caused death. The patient could also potentially be over treated. The task force does recognize that some patients in this age range would benefit from screening, such as BRCA1 or BRCA2 positive men or women, those with history of chest radiation or other high risk indicators.

The U.S. Preventive Services Task Force recommends mammograms every 2 years for women aged 50-74 years of age. The task force found the most compelling evidence of reduction in mortality in this group of women, with the greatest benefit among women 60-69 years of age. Screening in this group of women provides a moderate to substantial net benefit. The task force felt after reviewing several trials, that the benefit of screening is maintained by biennial screening and also decreases the harms of mammography.

Akinola Ogundipe, MD- *Continued* **Cancer Screenings**

There is not a recommendation for routine screening for women age 75 and older as the task force did not find sufficient evidence to assess the additional benefits and harms of screening mammography. The task force has recommended further studies to determine the risks and benefits of screening after age 74 as well as studies of "over-diagnosis" of breast cancer.

In the Friday, August 7, 2015 ASCO Post Evening News, "The 17-year follow-up in the UK Age trial, reported in The Lancet Oncology by Moss et al, indicated a reduction in breast cancer mortality during the first 10 years after diagnosis but not thereafter among women invited for annual mammography screening from age 40 to 49 years compared with invitation to screening at age 50 and every 3 years thereafter." More research is needed to continue to determine the best screening schedules.

Another popular screening test is the Prostate Specific Antigen blood test that is done in men to detect Prostate Cancer. It is common practice in the United States to obtain annual PSAs starting at the age of 50. However, the most recent recommendation of the U.S. Preventive Services Task Force is to recommend against prostate-specific antigen (PSA) - based screening for prostate cancer. The primary goal of screening is decrease in mortality, increase length of life. The task force reviewed the most current studies regarding prostate screening and found that the benefit of screening was very small as most prostate cancers are slow growing and found in older men that would not alter their length of life. The other part of the decision deals with the harms of screening. As more people are screened, the number of number of false-positives increase (elevated PSA without prostate cancer). An elevated PSA leads to further testing such as a biopsy which may cause pain, bleeding and transient urinary problems. If the patient is then diagnosed with prostate cancer, studies have shown that up to 90 percent of those patients received treatment. The side effects of treatment may include urinary incontinence, erectile dysfunction and/or bowel problems.

The clinical guideline published in the July issue of Annuals of Internal Medicine does discuss the common practice of PSA screening and that patients will ask their providers about testing. The guideline states the provider should discuss the possible harms and benefits of testing and respect the patient's preference. The American Cancer Society has developed a booklet, "Testing for Prostate Cancer" to inform patients of benefits and risks of screening. The guideline discusses other considerations to determine testing such as race, BRCA1 or BRCA2 positive men and those with family history of prostate cancer. "UpToDate" recommends if screening is done, that it should be PSAs every 2-4 years. The guidelines also recommend no further testing when life expectancy is 10 years or less.

The task force has recommended further studies to identify methods to differentiate slow growing cancers from aggressive disease. Research is also needed to determine if a higher PSA should be used to determine need for biopsy, if the optimal frequency of testing, as well as strategies to decrease over-diagnosis and overtreatment. It is likely that these guidelines will continue to evolve as new testing methods become available or more affordable and as further studies are done to determine the cost effectiveness of various screening strategies.

References

1. U.S. Preventive Services Task Force, *Screening for Breast Cancer: U. S. Preventive Services Task Force Recommendation Statement.* Annals of Internal Medicine. 2009: 151(10): 716-726.
2.Elmore, Joann G., *Screening for Breast Cancer: Effectiveness and Harms.* UpToDate.
3.Moyer, Virginia A., *Screening for Prostate Cancer: U. S. Preventive Services Task Force Recommendation Statement.* Annals of Internal Medicine. 2012: 157(2): 120-134.
4.Hoffman, Richard M., *Screening for Prostate Cancer*. UpToDate.

COFFEYVILLE REGIONAL MEDICAL CENTER
CANCER COMMITTEE

What is the Cancer Committee?

The Cancer Committee is an active, multidisciplinary standing committee of the medical staff of Coffeyville Regional Medical Center. The Cancer Committee is responsible for planning, initiating, and evaluating cancer care at Coffeyville Regional Medical Center. It acts as the oversight mechanism for the cancer program activities. This committee has the responsibility to ensure full compliance with all the standards established by the American College of Surgeons Commission on Cancer for accreditation of the cancer program.

The Cancer Committee consists of a multidisciplinary group of physicians as well as non-physician representatives from administration, cancer registry, quality improvement, medical oncology nursing, radiation oncology, pharmacy, education, and nutrition services.

The major focus of the Cancer Committee is quality patient care. Also, we have continued to address new support areas, including pain management and nutrition for the cancer patient. The Cancer Committee has strongly supported Coffeyville Regional Medical Center's active participation in numerous community activities that promote public education, screenings and disease prevention as well as celebration of survivorship.

Cancer Committee Goals for 2015

1. Look into impact of automating chemotherapy orders for Breast and Colon Cancer.

2. Develop a protocol for patients receiving a feeding tube for education and teaching them the use of the tube.

COFFEYVILLE REGIONAL MEDICAL CENTER

2015 CANCER COMMITTEE MEMBERS

Physicians

- Akinola Ogundipe MD, Medical Oncologist
- Nathan Uy MD, Radiation Oncologist
- Chitra Kohli MD, Pathologist
- Donald White MD, Radiologist
- James Lin MD, Surgeon
- Shravan Gangula MD, Family Practice
- Bernard Howerter MD, Urologist
- Swati Choudhary MD, Internal Medicine
- Stephen Miller DO, OB/GYN

Other Staff

- Lori Rexwinkle, Chief Nursing Officer
- Vicky Portwood, Director Oncology
- Sharon Davolt, RN, Oncology
- Jennifer Carnahan, CMD
- Stephen Haley, Pharmacy
- Sarah Hoy, QI/RM
- Robin Doty, Relay for Life
- Ashley Tatman, Community Relations
- Teresa Barker, Director of Surgery
- Maranda Holmes, OT
- LuShawn Vaughn, RN, Care Manager
- Darla Dennis, CTR
- Abby Oliphant, RN, Care Manager

CANCER PROGRAM
Distinctions & Services

ACS Certification and Distinctions

23rd year accreditation by the American College of Surgeons (ACS)

- Only ACS-certified cancer center in Montgomery County
- Outcomes analysis and annual reporting
- Tumor staging documentation
- Patient care guidelines
- Prevention and early detection efforts
- Cancer Registration and staff education
- Ongoing program improvement efforts

Other Services Available

- Occupational Therapy referral
- Physical Therapy referral
- Speech Therapy referral
- Nutritional Services referral
- Home Health referral

CRMC Oncology Personnel

Medical Dosimetrist:
Jennifer Carnahan, A.S., R.T. (R)(T), CMD

Pharmacist:
Stephen Haley, R.Ph.

Pathologist:
Chitra Kohli, M.D.

Medical Oncologist/Hematologist:
Akinola Ogundipe, M.D.

Oncology Nurses:
Sharon Davolt, RN, OCN
Vicky Portwood, RN, MSN, OCN

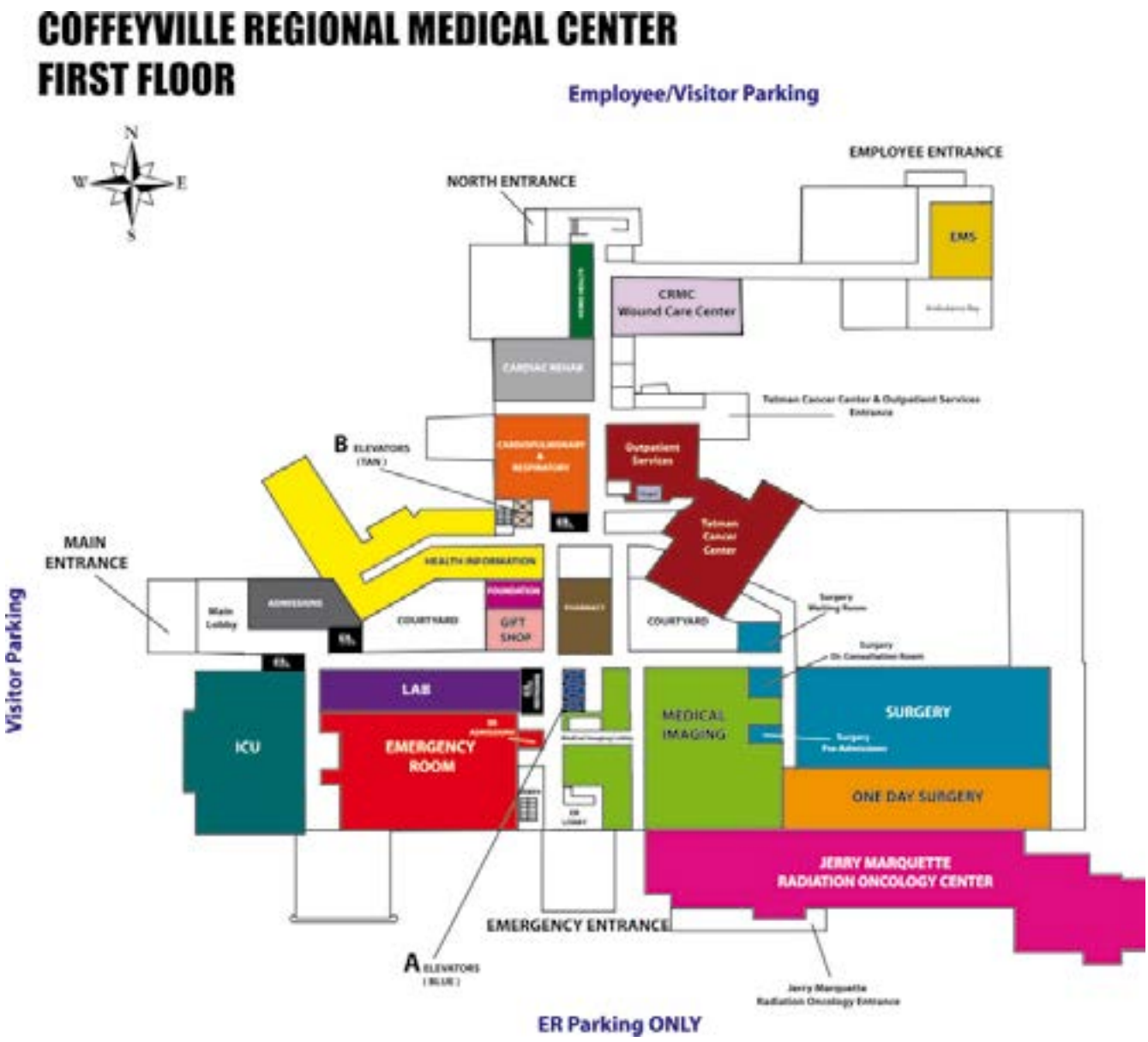
Medical Physicist:
Shawn Heldebrant, MS DABMP

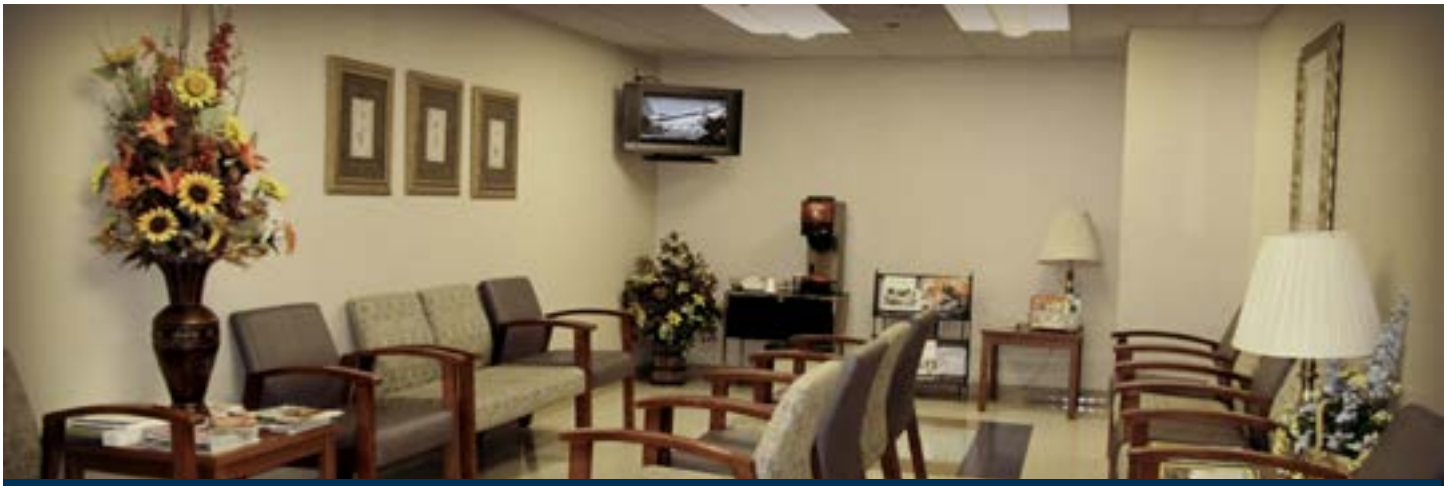
Radiologists:
Barbara Krueger, M.D.
Donald White, M.D.

Radiation Oncologists:
Terry Powell, M.D.
Nathan Uy, M.D.

Radiation Therapists:
Jennifer Carnahan, A.S., R.T.(R)(T), CMD
Alice McGuire. LRT

Hospital Map





Tatman Cancer Center
Medical Oncology

The Outpatient Services Department provides comprehensive care for patients in multiple clinics. In addition to the clinic offering diagnostic treatment and consultative services, the program provides special outpatient procedures including: IV chemotherapy, hormonal therapy, immunotherapy and blood component transfusion. The department offers an integrated source of self-help and rehabilitation for the cancer patients and their families.

The Medical Oncology Department has 6 exam rooms and an infusion center. The chemotherapy infusion area has 2 private rooms, and one of them includes an available hospital bed. There is also a group treatment room with five chairs available.

The Medical Oncology services are an intricate part of the Outpatient Services Department. This program is under the direction of Akinola Ogundipe, MD, Oncology/Hematology. Medical Oncology patients are seen in the department by Dr. Ogundipe. He comes to Coffeyville Regional Medical Center from Ponca City, Oklahoma. The Oncology aspect of the department has been in operation for approximately 28 years. The nursing staff includes two Oncology Certified RN's and a nurse who has been trained in chemotherapy administration and handling of the chemo agents.

The Medical Hematologist/Oncologist saw 115 new patients in 2015. Total Medical Hematologist/Oncologist visits for 2015 was 1,472. The oncology nurses performed 4,035 procedures in 2015, such as chemotherapy infusions and injections, blood transfusions, IM or Sub-Q injections, and other IV medications.

Tatman Cancer Center
Medical Onoclogy Summary

Department Hours

- **Medical Oncology Hours: Monday through Thursday 8:00 a.m. to 4:30 p.m.**

- Emergency Services on weekends and holidays, refer to CRMC Emergency Room

Board Certified, Medical Oncology Personnel

- **Medical Oncologist:** Specializes in diagnosing and treating cancer using chemotherapy, hormonal therapy, and biological therapy. They also consult with patients, establish and execute chemotherapy treatment plans.

- **Medical Oncology Nurses:** Administer chemotherapy, blood transfusions and injections under the direction of the medical oncologist. The RN also flushes intravenous access devices and administers other medications as needed. They provide education to the patient and their family and provide assistance and support through their journey.

- **Medical Oncology Assistant:** Prepares patient charts for clinic, obtains records from other providers as needed, transcribes the oncologist orders and flows laboratory results in the record. Checks patients into the clinic or treatment area. They are certified nursing assistants or medical assistants and assist the nurse in weighing patients, obtaining vital signs, and keeping the patient comfortable while here. The assistant also schedules appointments and tests as ordered by the medical oncologist.

Medical Oncology Services

- Chemotherapy treatments with a wide range of specialized infusions, such as Rituxan and Erbitux.

- Manage oral Chemotherapy treatments

- Antibiotic and iron infusions

- Blood product infusions

- Central line port access management

Jerry Marquette Radiation Oncology Center
Radiation Oncology

When patients are referred to Radiation Oncology, an appointment is made for them to consult with Dr. Uy. This initial consultation typically lasts 30-45 minutes. Patients are encouraged to bring family and to ask any questions that will help them understand their situation. Dr. Uy will explain, in detail, their diagnosis and the treatment he feels will be most beneficial for each patient. This one-on-one approach helps to put patients and family members at ease during a difficult time in their lives. After consultation, Dr. Uy and his staff will then take the patient for simulation. Simulation involves the patient lying on our CT scanner table in the treatment position for about 10 minutes. The patient is then marked or tattooed for future treatment in the same position. The patient is then scheduled to start radiation therapy in the near future. While undergoing radiation therapy, the patient will be seen weekly by Dr. Uy for a status check. Once all of the patient's treatments are completed, the patient will return to see Dr. Uy in about 6 weeks. At this time, Dr. Uy will discuss the outcome of the radiation therapy and if any future treatment is needed.

The goal of the radiation oncologist and staff is to surround their cancer patients in an environment of compassion and safety, giving them all the information they need to lead as normal life as possible during their treatments. Excellence in treatment planning and high competency in machine skills are the standard.

In 2015, the Radiation Oncology team treated 156 new patients. They provided 21 inpatient procedures and 7,131 outpatient procedures for a total of 7,152 procedures.

Jerry Marquette Radiation Oncolgy Center
Radiation Oncology Summary

Department Hours

- **Radiation Oncology Hours:**
  Monday through Thursday
  7:00 a.m. to 4:30pm
  Friday: 7:00am to 12:00pm

Emergency Services on weekends and holidays, refer to CRMC Emergency Room.

Radiation Oncology Services

- Varian Clinic IX Linear Accelerator
- Toshiba Aquillion Large-Bore CT Scanner
- Eclipse Treatment Planning System

Board Certified, Radiation Oncology Personnel

- **Radiation Oncologist:** Consults with patients, establishes and executes radiation treatment plan and evaluates treatment and follow ups.
- **Medical Dosimetrist:** Capable of performing dose calculations and assisting in calibration and verification of dose distribution within the patient. Also, aids in treatment plans and assist the physicist with quality control testing.
- **Medical Physicist:** Calibrates radiation oncology equipment and specifications of therapy equipment; performs acceptance testing and QA; measures, analyzes and tabulates beam data; reviews patients charts; and provides radiation safety.
- **Radiation Therapist:** Administers radiation therapy to patients under the instruction of oncologists. They work intimately with cancer patients, preparing them for therapy and subsequently monitoring their physical and psychological progress.

Coffeyville Regional Medical Center
Pathology & Histology

Pathology is the study of diseases. By the use of molecular, immunohistochemistry and morphological techniques, pathology explains the whys of the signs and symptoms manifested by patients while providing a rationale basis for clinical care and therapy. Pathology is divided into anatomic and clinical pathology. At CRMC anatomic pathologists trained from highly rated health systems perform intraoperative diagnosis to high class diagnosis of cancer patients with staging and addressing the minutest details for best standards of further clinical management. In addition to this, autopsies and analysis of tissues taken from patients during surgery or from outpatients and referral centers are also performed at CRMC. Clinical pathologists contribute to the diagnosis of disease by interpreting chemical tests and cells in blood, and body fluids such as sputum and urine. Both of these services are provided by CRMC.

Histology technicians prepare tissue samples that are used by pathologists to determine if a patient has a disease, dysfunction, or malignancy. Histology personnel prepare samples by using equipment to thinly slice tissue samples. They then mount these sections on microscope slides and use chemicals to stain them so important structures are visible. These slides are then given to the pathologist to be viewed and diagnosed. Most of the malignant cases diagnosed in our hospital are presented at our Cancer Conference held twice a month. Photos of the slides prepared by the pathologist are shown on a computerized overhead projector to all those attending the Cancer Conference. Discussion is held regarding the diagnosis of the tissue and the best treatment to be administered to the patient.

Procedures performed in 2015:

Pathology: 1,441

Laboratory: 100,343

Coffeyville Regional Medical Center
Medical Imaging

The Medical Imaging Department of Coffeyville Regional Medical Center offers state of the art equipment with our focus on high quality patient care. The modalities we have are: Digital Radiography, 64 Slice Computed Tomography (CT) Scanner, 16 Slice Large Bore Computed Tomography, Digital Mammography, Ultrasound, Nuclear Medicine, DEXA Scanner, Magnetic Resonance Imaging (MRI), and PET/CT. The Medical Imaging Department is a very important part of the "picture" that works very closely with the cancer program by assisting in the detection and identification of cancer in its earliest stages.

The Medical Imaging Department utilizes a Picture Archiving and Communications System (PACS). There are many advantages to having a PACS system, such as having immediate access to the images in the hospital as well as in the physician's office. Patients no longer "check out film"; instead, they are given their studies on a disc.

We continue to offer discount coupons in the months of April and October for screening mammograms.

Radiologists who are specialized in reading all studies performed at Coffeyville Regional Medical Center are Donald White, M.D. and Barbara Krueger, M.D. In association with these highly trained Radiologists, we have Registered Technologists in all of our modalities who offer high quality, compassionate care to our patients. The x-ray and ultrasound departments continue to maintain affiliations with colleges to act as a training platform for students.

In March of 2013, CRMC completed the installation of our MRI construction project. We now have a Toshiba Titan Large Bore MRI Scanner to offer to our patients. The Large Bore magnet produces the highest quality image in the market. The new MRI has the largest opening and friendlier than the normal open magnets for the claustrophobic patient and can accommodate larger patients.

Procedures performed in 2015:

Radiology : 14,187

CT: 3,636

PET/CT: 131

MRI : 1,514

Nuclear Medicine: 455

Ultrasound: 3,808

Coffeyville Regional Medical Center
Surgery

Our surgical department is very proud to be part of the cancer treatment at Coffeyville Regional Medical Center. You will be amazed at the surgical care given that is not expected at a community hospital. We are a Joint Commission accredited facility. Our Department Has It All! Your surgeon at CRMC is a Board-certified surgeon; with experienced professional Anesthesia staff that will meet your surgical needs.

Our Pre-admission Clinic Nurse will contact you in person or we have an on-line registration option (www.crmcinc.org). Our experienced nursing staff is prepared to help you and your family with every step of the surgical process. We are honoured for you to chosen CRMC for you surgical needs and want to give you and your family the quality of care that you deserve.

Surgical Specialties Offered

General Surgery; Gynecology; Ear, Nose and Throat; Gastroenterology; Hand Surgery; Neurosurgery; Ophthalmology (Eyes); Orthopedic; Pacemaker Implantation; Pain Management; Podiatry and Urology.

We Focus On You and Your Needs

At CRMC, we realize that having surgery and anesthesia causes some degree of anxiety and fear of the unknown. That is why we do as much as we can to give peace of mind to our patients and their family members. We want our patients to feel secure, knowing that expert hands are providing their services. You may be facing surgery now. Or perhaps you need to know that there is a nearby hospital with the ability to do what is needed when it is needed. From the moment you walk through our doors to the moment you are discharged, you will recognize our commitment to create a healthcare environment that is centered on you. We are here to offer you superior service.

Procedures performed in 2015:

Inpatients : 739

Outpatients: 2,113

TOTAL: 2,852

Coffeyville Regional Medical Center
Annual Cancer Registry

Coffeyville Regional Medical Center has registered cancer patients with the Kansas State Cancer Registry since 1965. The CRMC Cancer Registry was started in 1990 and received the Commission on Cancer Approval in 1992. CRMC has maintained the approval status since that date. The follow-up on living patients from 2009 to 2014 is current with 91.05% of patients followed, meeting the 90% follow-up required by the Commission on Cancer. Of all patients since 1994 there has been 87.23% follow-up which meets the requirement of 80%.

The Cancer Committee oversees the cancer registry and is responsible for approval and critiquing of abstracting and Patient Care Evaluations. The Cancer Committee is composed of a multi-disciplinary team of physicians and medical professionals from CRMC staff. The Committee meets quarterly in the months of February, May, August and November. The committee is also responsible for reviewing ten percent of all analytic cases entered into the database. The cancer committee is responsible for all Cancer Program activities such as the cancer symposium, cancer awareness activities and the bimonthly cancer conferences.

The Cancer Conference is open to physicians and medical professionals. Representation must include a Medical Oncologist, Radiation Oncologist, Diagnostic Radiologist, Pathologist, and a Surgeon. Other specialties that attend the conference include OB/GYN, Internist, Family Practice, General Practice, and Urologist. The conference meets bi-monthly on the second and fourth Wednesday of the month with the exception of February, May, August, and November when the Cancer Committee meets on the second Wednesday.

Total Cases in 2015:

Total cases presented: 64

Total Prospective: 62

Percentage of Prospective Cases: 96.9%

Type of Cases presented:		# entered in registry for 2015
Prostate	14	12
Lung	7	19
Breast	9	22
Colorectal	9	14
Other	25	61
Total	64	128

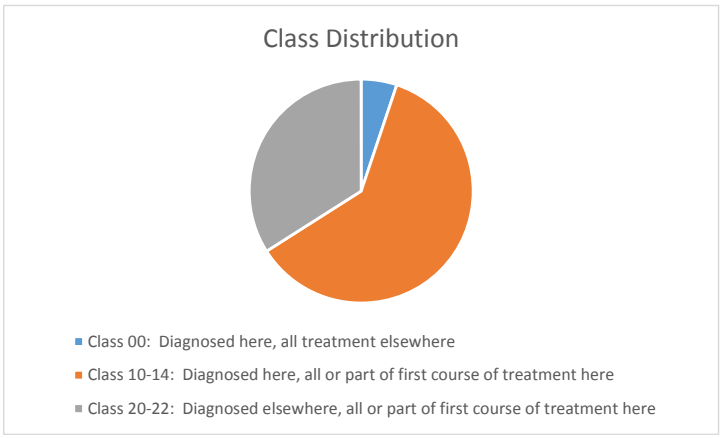
C3PR - Cancer Program Practice Profile Report

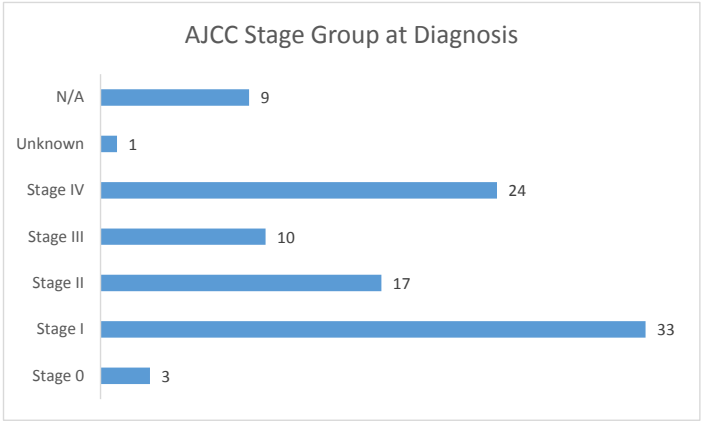
Measure	Measure Type	Goal	2011	2012	2013
Breast					
Breast Conservation Surgery rate for women with AJCC clinical stage 0, I, or II breast cancer. (BCS)	Surveillance	N/A	22.2	0	37.5
Image or palpation-guided needle biopsy (core or FNA) is performed to establish diagnosis prior to surgical treatment of breast cancer.	Quality Improvement	80%	20	16.7	42.9
Tamoxifen or third generation aromotase inhibitor is considered or administered within 1 year of diagnosis for women with AJCC T1c or Stage IB-III hormone receptor positive breast cancer.	Accountability	90%	77.80	100	100
Radiation therapy is considered or administered following any mastectomy with 1 year (365 days) of diagnosis of breast cancer for women with ≥ 4 positive regional lymph nodes.	Accountability	90%	100	100	100
Radiation is administered within 1 year of diagnosis for women under the age of 70 receiving breast conservation surgery for breast cancer.	Accountability	90%	81.80	100	100
Combination chemotherapy is considered or administered within 4 months of diagnosis for women under 70 with AJCC T1cN0, or stage IB-III hormone receptor negative breast cancer.	Accountability	90%	100	50	100
Colon					
Adjuvant chemotherapy is considered or administered within 4 months (120 days) or diagnosis for patients under the age of 80 with AJCC stage III (lymph node positive) colon cancer.	Accountability		No Cases	100	100
At least 12 regional lymph nodes are removed and pathologically examined for resected colon cancer.	Quality Improvement	85%	100	0	100
Rectum					
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 pathologic AJCC T3n0, T4N0, or Stage III; or treatment is considered; for patients under the age of 80 receiving resection for rectal cancer.	Quality Improvement	85%	No cases	No cases	100

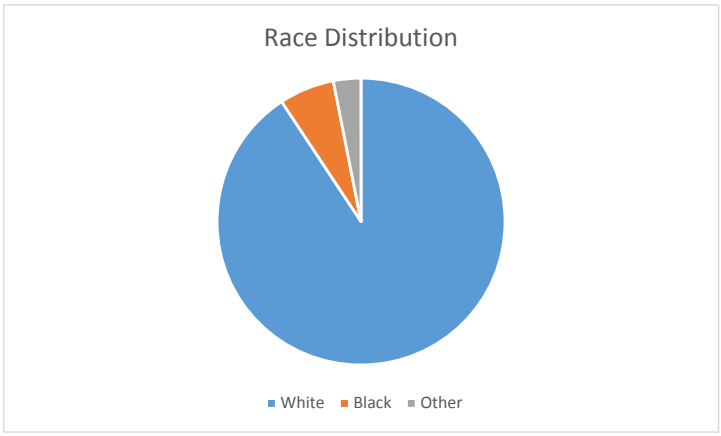
Coffeyville Regional Medical Center
Primary Site Table 2015

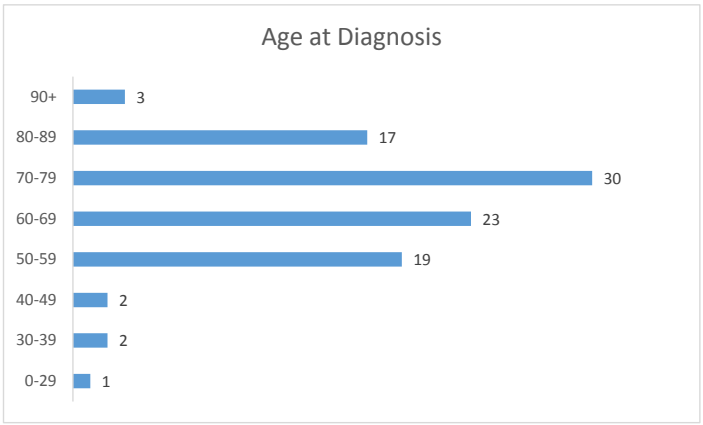
PRIMARY SITE	Analytical	Non-analytical	All Cases
All Cases 2015	97	11	108
Oral Cavity & Pharynx	2	0	2
• Tongue	1	0	1
• Salivary Glands	1	0	1
Digestive System	20	1	21
• Stomach	1	0	1
• Colon	7	1	8
• Rectum	4	0	4
• Esophagus	2	1	3
• Anus, Anal Canal, & Anorectum	1	0	1
• Liver & Intrahepatic Bile Duct	2	0	2
• Pancreas	1	0	1
Respiratory System	16	2	18
• Lung & Bronchus	13	1	14
• Larynx	2	1	3
Skin	1	1	2
• Melanoma	1	0	1
• Basal/Squamous cell carcinoma	0	1	1
Breast	20	1	21
Female Genital System	12	1	13
• Cervix Uteri	4	1	5
• Corpus & Uterus, NOS	6	0	6
• Ovary	1	0	1
• Vulva	1	0	1
Prostate	13	3	16
Urinary System	4	0	4
• Urinary Bladder	1	0	1
• Kidney & Renal Pelvis	3	0	3
Brain/CNS	1	0	1
Endocrine System	2	0	2
Lymphoma	1	1	2
• Non-Hodgkin Lymphoma	1	1	2
Multiple Myeloma	1	0	1
Leukemia	3	1	4
• Lymphocytic Leukemia	1	0	1
• Myeloid & Monocytic Leukemia	2	0	2
All Sites	**97**	**11**	**108**

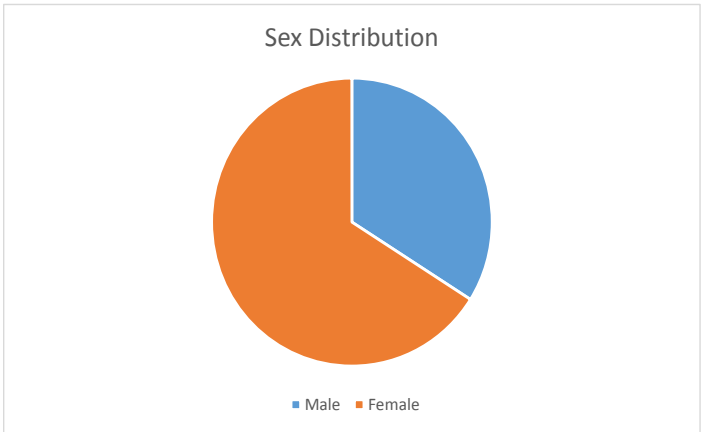
Statisical Graphs
Analytical Cases

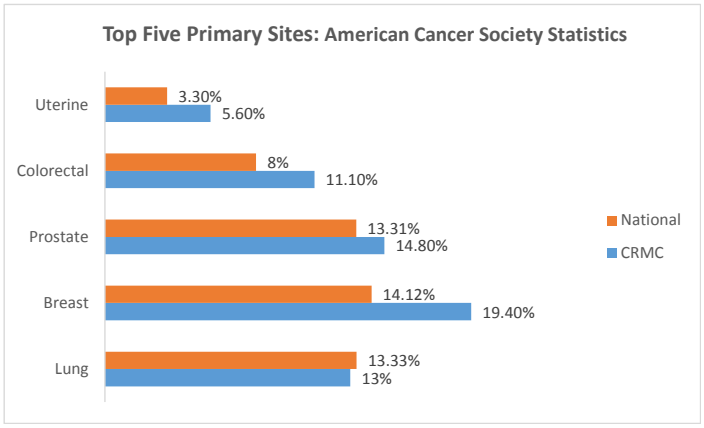












Glossary of Terms
For Primary Site Table

ACCESSIONED: Entered into the Cancer Registry by the year in which first seen at Coffeyville Regional Medical Center.

ANALYTIC CASE: Case first diagnosed and/or received all or part of their first course of treatment at Coffeyville Regional Medical Center. Class of case includes Class 0, 1, and 2.

NON-ANALYTIC CASE: Case diagnosed and received all of the first course of treatment elsewhere prior to receiving treatment at Coffeyville Regional Medical Center (class 3), or was diagnosed prior to the registry reference date of January 1, 1994 (class 4).

AJCC STAGING: a staging system that was developed by the American Joint Commission Committee on Cancer and the international Union Against Cancer, which takes into account the tumor size and/or depth of invasion (T); involvement of lymph nodes (N); and when the tumor has invaded organs or tissue distant from the original/primary site it is known as metastatic disease (M). The TNM of a tumor determines the stage of disease.

PRIMARY SITE: Location of original tumor as determined at initial diagnosis.

STAGE OF DISEASE: Extent of disease.

STAGE 0/IN SITU: Neoplasm, which fulfills the microscopic criteria for malignancy that is confined to the site of origin with no invasion beyond the tumor (encapsulated)

STAGE I/LOCALIZED: Neoplasm, which appears entirely confined to the organ of origin.

STAGE II: Neoplasm that has extended beyond the organ of origin into surrounding organs or tissue by direct extension to regional lymph nodes by metastasis.

STAGE III: Combination of Stage I and II and appears to have not spread any further.

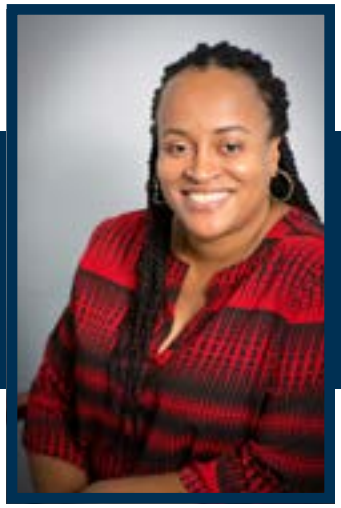
STAGE IV: Neoplasm has spread beyond immediately adjacent organs or tissue by direct extension, has developed a secondary or metastatic tumor, metastasized to distant lymph node or organ, or has been determined to be systemic in origin.

UNKNOWN STAGE: Stage is determined to be unknown when the site of origin cannot be identified from the patient's medical record and/or examination.

NCDB: National Cancer Data Base.

Coffeyville Regional Medical Center
www.crmcinc.org

Cervical Cancer
SUMMARY



Dara Gibson, MD
Obstetrics & Gynecology

It was estimated that 12,900 women would be diagnosed with Cervical Cancer in the United States in 2015. 90 of these cancers would be found in the state of Kansas, according to the American Cancer Society's 2015 Cancer Facts and Figures. The rates have decreased over the past several decades due to prevention and early detection with the Pap test.
Many women do not experience signs or symptoms of cervical cancer. The most common symptom is abnormal vaginal bleeding. The modifiable risks factors for cervical cancer include smoking and multiple sex partners. Exposure to HPV or human papillomavirus increases one's risk of cervical cancer.

Fortunately there are currently vaccines available to prevent HPV, which are recommended to girls between 9 and 26 years of age. Having regular pap tests are effective in early diagnosis and/or prevention. The current recommendation for screening for average risk women includes Pap test every 3 years from 21-29 years of age, and then HPV test and Pap test every 5 years from 30-65.

In 2013, Coffeyville Regional Medical Center performed a Community Needs Assessment and found that the community's women reported obtaining a pap/cervical test in the last two years was 12% below average, impacting 53% of the population. Annual visits to an obstetrical/gynecologic physician was 14% below average. Also the needs assessment identified 18% above average tobacco usage in the community.

In order to obtain a sample size of 30 patients, cervical cancer cases were from 1992 to 2011. Eighty-seven percent (87%) of the group were white females with a wide range of ages from one patient less than 30 years old up to 3 patients 90 + years of age. The majority of the cases were diagnosed at Stage II, however five cases were diagnosed at Stage IV. The cases for the 1st 10 years from 1999-2001 showed 53% staged I and II with the 2nd 10 years from 2002-2011 showed 61% staged I and II. Most patients received treatment for the cancer with varying combinations of treatment as well as radiation only or surgery only. Standard of care treatment for Cervical Cancer includes various combinations of surgery, radiation and chemotherapy based on the staging of the cancer.

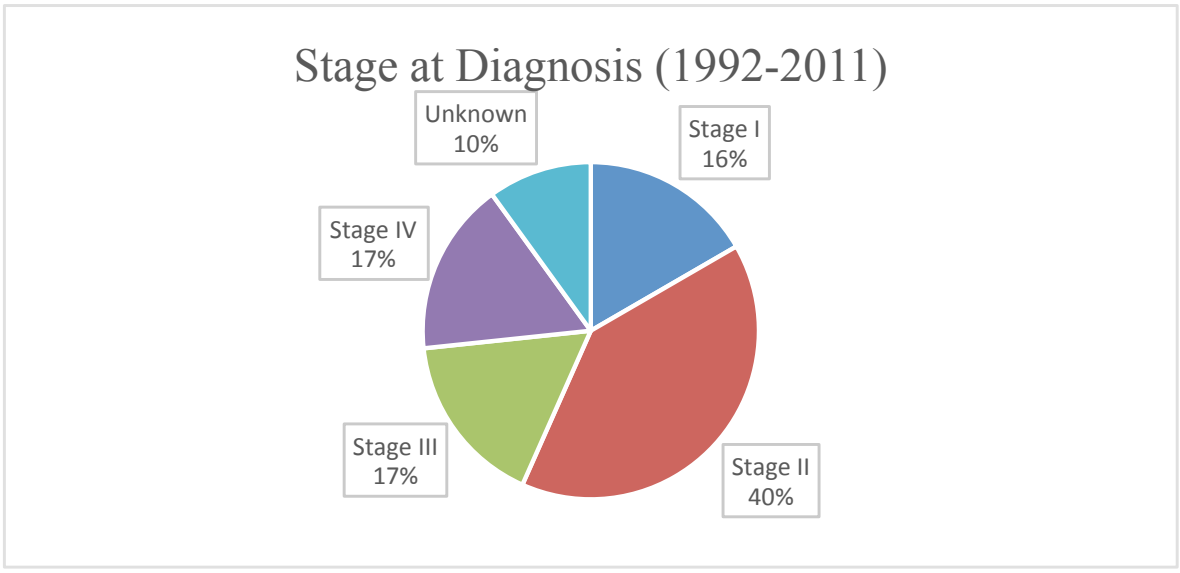
According to the American Cancer Society's 2015 Cancer Facts and Figures, the 5 year survival rate for all stages of cervical cancer (2004-2010) was 68%, however it is only 16% when diagnosed with distant disease. The good news is that five year survival increased to 91% when diagnosed with local disease only. The 5 year relative survival rate has not changed much for several years; 1975-77 = 69%, 1987-1989 = 70% and 2004-2010 = 70%.

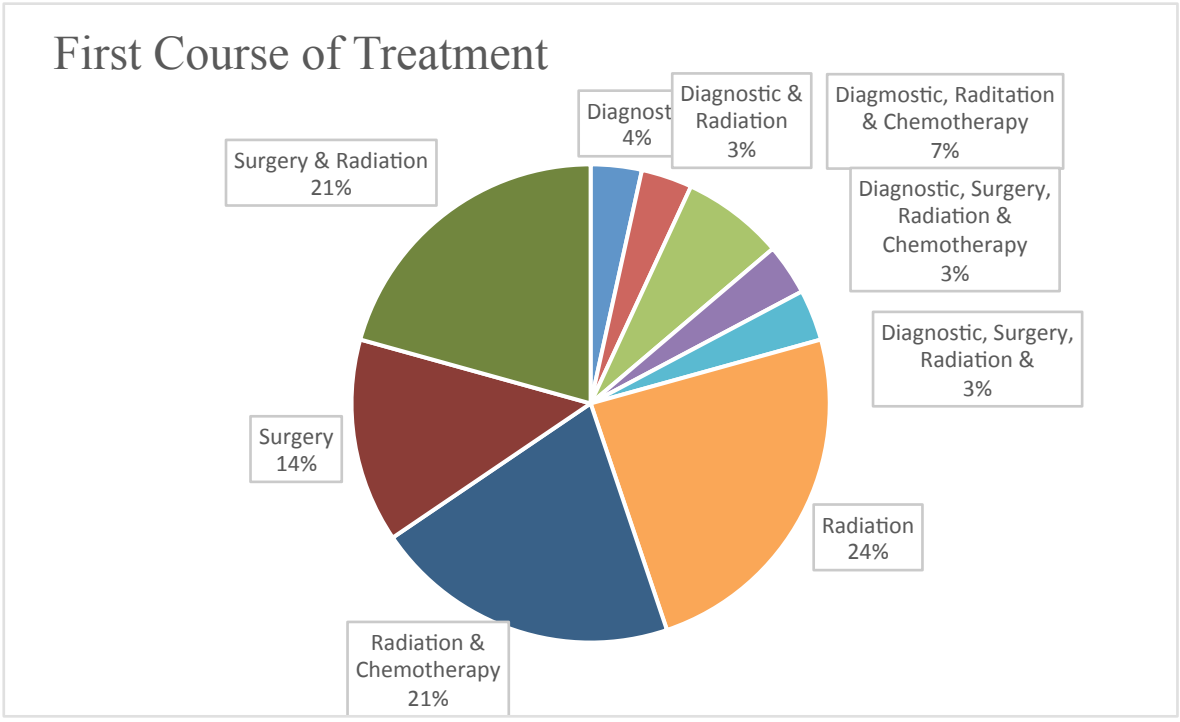
Cervical Cancer
SUMMARY

The five year survival for all cervical cases from 1992 to 2011 was 29%. However, this is a very small sample so it is questionable how useful this data really is. Forty-seven percent of the sample was 60 years or older and 17% were 80 years or older.

After reviewing the data, the primary areas that are important for our community to increase cervical cancer survival are regular visits for women to an obstetrical/gynecologic physician, regular pap smears and exams, and decrease usage of tobacco.

PATIENT CARE
EVALUATION STUDY : Cervical Cancer





PATIENT CARE
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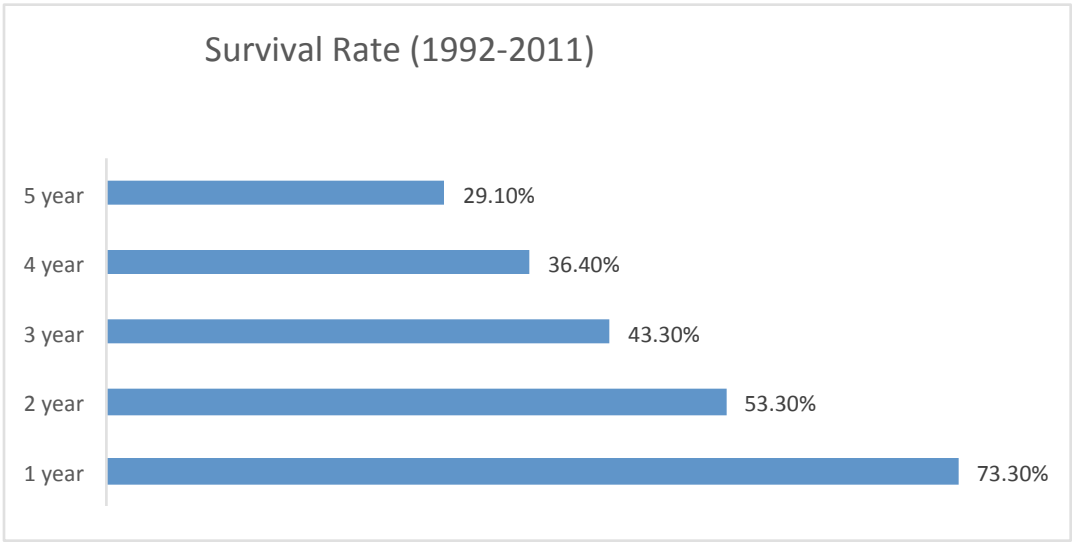

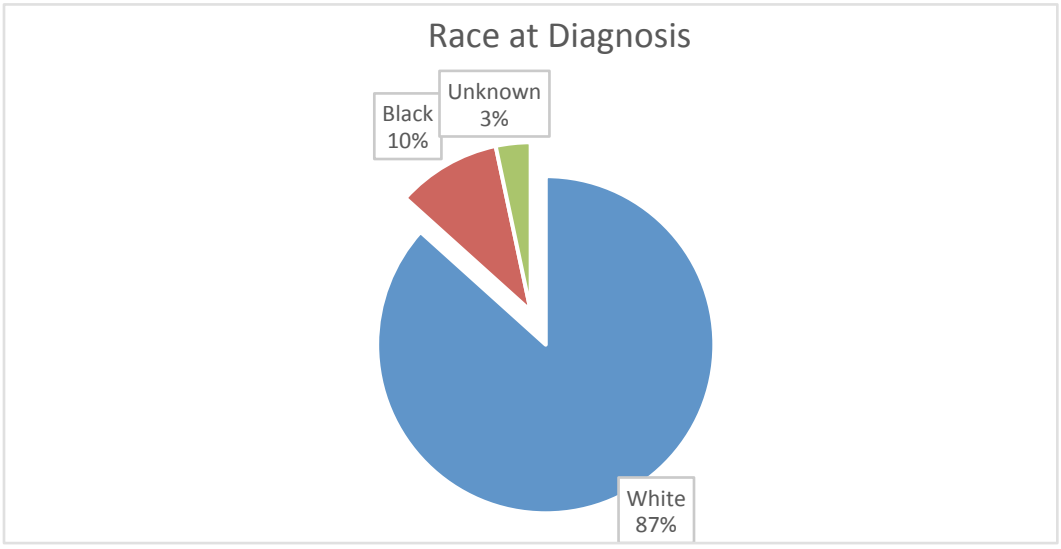

COMMUNITY OUTREACH
Programs

CANCER SCREENINGS: : Dr. Lin provided skin screenings in April and Dr. Miller and Dr. Chappell provided pelvic exams as well. There were 6 males and 22 women participated in the skin screenings. Average age of participants was 63.3 with range from 28-87 years of age. All skin screenings were negative. Twelve women participated in the pelvic exams with pap smear testing. Breast exams were also done. Ten pelvic exams were negative and two were found to have abnormalities. One breast exam revealed an abnormality. The average age of the participant was 54.9 with a range of 32-66 years of age.

TWENTY-EIGHTH ANNUAL CANCER SYMPOSIUM: Coffeyville Regional Medical Center and Kansas University Medical Center Area Health Education Center, and the CRMC Cancer Committee sponsored and coordinated the 28th Annual Cancer Symposium. This didactic program offers continuing education to physicians and health care professionals in Southeast Kansas and Northeast Oklahoma. Topics were chosen and approved by the Cancer Committee.

The conferece was held September 12, 2015 at Coffeyville Regional Medical Center in the 4th Floor Education and Conference Room. The topics/lectures included:

Psychosocial Needs of Cancer Survivors
presented by Susan Krigel, Ph.D, Assistant Professor of Psychology, Midwest Cancer Alliance, University of Kansas Medical Center

Lung Cancer: To screen or not to screen
presented by Franklin R. Quijano, M.D., Assistant Professor, Department of Internal Medicine Division of Pulmonary and Critical Care Medicine, University of Kansas Medical Center.

Current Approaches to Breast Reconstruction and Post-Mastectomy Lymphedema
presented by James A. Butterworth, M.D., MB Bch, Assistant Professor , Department of Plastic Surgery, University of Kansas Medical Center

Approximately 20 healthcare professionals attended the symposium and everyone felt that the conference went well.

COMMUNITY CANCER AWARENESS –Throughout 2015, a number of radio programs were presented on KGGF Radio in Coffeyville regarding CRMC's Cancer Program and cancer related subjects. April 6th featured Vicky Portwood, Director of Medical Oncology who discussed National Cancer Control Month and cancer screenings scheduled that month. On June 5th, Robin Doty, CRMC Relay Team Chair talked about plans for the community Relay for Life event in June. On October 2nd, Trudi Vail, Mammography Technologist and Ashley Tatman, Community Relations discussed National Breast Cancer Awareness Month, getting annual mammograms and CRMC's Annual Pretty in Pink Event.

SMOKING CESSATION: The Nurse Care Managers at CRMC offer smoking cessation information to smokers who want to stop for life. Every patient who smokes and is admitted to our inpatient facility receives smoking cessation information. Our Oncologists also counsel the cancer patients in smoking cessation.

CANCER SUPPORT GROUP: This support group is offered to anyone who has been diagnosed is in treatment or a caregiver of someone with cancer. The group meets every third Thursday of the month. Don Lawyer is the Support Group Leader and he was diagnosed with Bladder Cancer in 2009 and Director of Medical Oncology, Vicky Portwood, helps with these meetings as well.

COMMUNITY OUTREACH

Events

PRETTY IN PINK- October 2015 Two Locations

INDEPENDENCE, KS

Pretty in Pink, was held in Independence Community College Thursday, October 8th and nearly 100 people attended the event this year and listened to Dean Ohmart, Chief Financial Officer speak why he wears pink the whole month of October in honor of his late wife and why early detection is really important in all women's lives. Kathryn Cornell, APRN, CRMC Primary Care Center talked about Cancer Prevention and handed out flyers with statistics about informative tips on how you can detect the signs of Breast Cancer. The evening was filled with door prizes, great food catered by Ane Mae's Coffee and Sandwich Shop, Fashion Show by Cato's and 12 vendors came with various products.

The Brighton Bracelet Fundraiser made $56 to go to the Care 'N' Share Fund. In total the Care 'N' Share fund from both events for the Brighton bracelet made $200. There were a total of 133 shirts sold and the proceeds of the shirt sales went to the Care 'N' Share Fund as well.

COFFEYVILLE, KS

CRMC's annual Breast Cancer Awareness Event, Pretty in Pink, was held in Coffeyville at Community Elementary on Thursday, October 15th and a total of 167 people attended the lovely affair and listened to Vicky Portwood, Director of Medical Oncology and Outpatient Services, speak about CRMC Cancer Services and what CRMC can do for anyone who has gotten diagnosed with cancer or is being treated for Cancer. Kathryn Cornell, APRN, CRMC Primary Care Center, talked about Cancer Prevention and handed out flyers with statistics about informative tips about how you can recognize the signs of Breast Cancer. The evening was filled with door prizes, great food catered by Lannings Downtown Grill, Fashion Show by Cato's, and 12 vendors came with various products at their booths.

The Brighton Bracelet Fundraiser made $144 to go the Care 'N' Share Fund. The Care 'N' Share Fund is almost to their goal of $10,000 to start helping CRMC Patients. This fund will allow patients to receive gas cards, special cream for Radiation treatments and to get Boost or Ensure; The American Cancer Society isn't giving those items to cancer patients anymore. CRMC wanted to give back to our patients and this is a great way to do that.

TOUGH ENOUGH TO WEAR PINK--Thursday, August 13, 2015

Thursday has traditionally become CRMC's night to sponsor the PRCA Rodeo which is a night encouraged for all to wear pink which brings awareness to breast cancer. Luck was with us for mild temperatures and one of the nicest summer evenings this year. The Tatman Cancer Center and the Jerry Marquette Radiation Oncology Center staff hosted the VIP Booth for a number of special guests who are our cancer survivors. The last 2 weeks in the month of July, cancer patients were invited to enter their name into a drawing for VIP Booth tickets. The winners were our guests for the evening, treated to not only the best seats in the house, but they also received a "Give Cancer th Horns" pink t-shirt, along with refreshments served by their hosts. In addition, one hundred and fifty lucky spectators received pink shirts that were thrown into the grandstands during intermission as part of our sponsorship night. Give Cancer the Horns Pink T-Shirts were sold to employees and the community proceeds of the shirt sales went to the Care 'N Share Fund. The Care 'N Share fund helps CRMC cancer patients who are receiving treatment at CRMC.

COMMUNITY OUTREACH
Fundraisers

RELAY FOR LIFE 2015

June 26th, 2015, marks the 3rd year that Relay for Life was held at Veteran's stadium. The CRMC Relay for Life team's theme this year was "Celebrating Birthdays" and they served Strawberry Shortcake Cake to all the survivors and guests out at Relay. There was a total of 100 survivors registered and participated in the 2015 Relay and CRMC's very own Kris Penco, IT Director, participated in the Queen Relay contest that raised money during the event.

Overall CRMC took third place with raising $12,363.29--Jade Level and the Community raised a total of $98,177.08. CRMC's $1000 Fundraisers were Mary Freedle, Vicky Portwood and Robin Doty and our Outstanding Commitee Member was Robin Doty. During the Luminaria Ceremony, Lyndene Oldham, former CRMC employee, was honored with a memorial tribute and was given the RFL recipient, "Golden Globe" Award (Spirit of Relay) in memory of her and accepted by her husband Kelly Oldham and family. a BIG THANK YOU, goes out to everyone who is on the Relay team, Dietary for supplying us the cakes, Alice and Jennifer for registering the survivors and getting them shirts, Robin Doty for heading the CRMC Team for over 20 years and Pilar Davis and Mary Freedle for coming oup with new Fundraiser ideas a Shannon Uhrmacher for making CRMC being a CAN team, Relay team who came out and helped the night of the event and for EMS to let the Relay team used the Hazmat Trailor and with helping load/unload the Relay goods. Without all the team's efforts we couldn't have done what we accopmplished this year with out any of you. THANK YOU!!

CARE N' SHARE FUND

In 2013 the Care N' Share fund was established through the Foundation to help cancer patients who are currently in the care of CRMC. After much discussion, staff wanted to do something that could impact our patients at a very local, personal level. Working with the CRMC Foundation, a fund was established to give direct and immediate help to our cancer patients. It was decided that a goal of $10,000 was to be met before we would start providing help. This would guarantee a solid base for this humanitarian project. Due to changes within the American Cancer Society, things like gas cards and nutritional supplements are no longer available to cancer patients. With Care 'N Share, we will be able to help people who have to drive in everyday with gas money, we can provide Boost or Ensure at no cost to them, skin care products they need during radiation therapy treatments, even help with some of the medicines they need. Our cancer patients will know that WE, as a group of hospital employees, CARE about them. They will know that WE, as hospital employees, KNOW that our livelihood depends on making this the BEST PLACE POSSIBLE for their cancer care. Since the Care N' Share fund has been in existence they are still continuing to do fundraisers to meet the $10,000 amount needed to start helping CRMC patients. In 2015, there was a flower sale, a Pink shirt Sale and a Pasta Sale; all the proceeds from all three fundraisers went to the Care N' Share Fund.

COMMUNITY OUTREACH

Look Good Feel Better

The Look Good...Feel Better program was founded and developed in 1989 by the Personal Care Products Council (at the time called the Cosmetic, Toiletry and Fragrance Association, or CTFA), a charitable organization supported by the cosmetic industry, in cooperation with the American Cancer Society (ACS) and the Professional Beauty Association/National Cosmetology Association, or PBA/NCA, a national organization that represents hairstylists, wig experts, estheticians, makeup artists, and other professionals in the cosmetic industry.

All cosmetology volunteers who are part of the program attend a 4-hour certification class to become a Look Good...Feel Better volunteer.

Look Good...Feel Better is free, non-medical, and salon and product neutral. Volunteers and program participants do not promote any cosmetic product line or manufacturer. All cosmetics used in the group program have been donated.

FOR WOMEN:
It teaches female cancer patients beauty tips to look good and feel better about their appearance during chemotherapy and radiation treatments. It also teaches them about wigs, how to care for them, style and help pick the right wig that matches their lifestyle. For more info: http://lookgoodfeelbetter.org or call 1-800-395-LOOK (1-800-395-5665)

FOR TEENS:
Look Good… Feel Better for Teens is a hospital-based public service program created by the Personal Care Products Council Foundation and its collaborators to help girls and guys aged 13-17 deal with their appearance, health and social side effects of cancer treatment. Launched in 1996, the program now offers on-site sessions in 14 cities, as well as the 2bMe web site to reach teens everywhere.
For more info: http://lookgoodfeelbetter.org/audience/teens/program.htm or call 1-800-395-LOOK (1-800-395-5665)

FOR MEN:
Look Good...Feel Better for Men is a practical guide to help men deal with some of the side-effects of cancer treatment including skin changes, hair loss, stress, and other issues. Created by the cosmetic industry in partnership with the American Cancer Society and the National Cosmetology Association, information on Look Good...Feel Better for Men is also available in a brochure available through American Cancer Society offices. For more info: http://lookgoodfeelbetter.org/audience/men/men.htm or call 1-800-395-LOOK (1-800-395-5665)

COMMUNITY OUTREACH

Smoking Quitline

The American Cancer Society has taken a strong stance nationwide to reduce cancer deaths by eliminating tobacco use. Through the ACS Quitline they offer their assistance to employers and organizations that wish to establish similar policies.

The American Cancer Society Quitline tobacco cessation program was launched in May of 2000 to expand services available to smokers--specifically telephone cessation counseling. The American Cancer Society has quickly become the top provider of Quitline services in the United States, and in 2007 alone 80,000 people received help.

WHEN CALLING THE QUITLINE

Quitting tobacco isn't easy. It can take up to seven attempts or more to successfully quit. But by calling the American Cancer Society Quitline, you'll receive personalized support and the tools and strategies to help you become smoke-free.

When people call the Quitline they receive counseling and mentoring by English and Spanish speaking counselors. Callers can also utilize a confidential translation service in almost every other common language.

Our clinically proven program is free and confidential, helping you stay focused on your personal reasons for quitting. You'll have someone to talk to who understands what you're going through. And best of all, this program of professional support can double your chances of successfully quitting smoking.

The Quitline includes:

- Counseling sessions tailored to you, with a focus on your preparation for the quit attempt and long-term success.
- Access to self-help booklets designed to keep you motivated and prepared for life without tobacco.
- Advice about support programs available in your community.

You can find more information:

http://yesquit.com/call.php ***1-877-YES-QUIT (877-937-7848)***

Coffeyville Regional Medical Center

www.crmcinc.org

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