'11 ONCOLOGY REPORT
with 2010 Data

OLBH Urologists
Brian DeFade, D.O. and
E.W. Unnikrishnan, M.D.

A Look at Prostate Cancer

OUR LADY OF BELLEFONTE HOSPITAL
Bon Secours Kentucky Health System

Fadi Hayek, M.D.

Cancer Committee Chairman Report

"Most men, once they are diagnosed with prostate cancer, live with it for a long time. It's like breast cancer in that way – something they are dealing with for a long time." – Harry Belafonte.

This year, the cancer program at OLBH has taken up prostate cancer for its annual theme for prevention and community education and for a good reason. Prostate cancer is the second most common cancer among men worldwide. Like other cancers, it is intimate, crude and intrusive.

One word that is less associated with prostate cancer is despair, as more than two million men in the US count themselves as prostate cancer survivors. The widespread availability of PSA screening tests have allowed the discovery of more and earlier cases of this cancer and the paradigm of management has recently undergone a significant shift. (Please read Dr. Brian DeFade's excellent article "To Screen or Not to Screen?" in this report.) Beginning in 2011, the management of this cancer has witnessed the introduction of multiple exciting new and novel therapeutic options that meaningfully improved patients' survival.

The number of prostate cancer treatment options available in our armamentarium rose dramatically from only two in pre-2011 to five in that year alone. Many exciting new products are being currently developed and tested.

The story of this cancer is one of resilience and compassion. An example of this would be the wonderful essay contained in this report by Mr. Andrew Wright. Mr. Wright spearheaded the initiative to establish OLBH's prostate cancer support group: "Man to Man" out of an intimate personal experience. The group has been essential in helping a number of patients navigate through the straits of their new diagnosis.

The Commission on Cancer survey in 2011 was a success, which reflects our ongoing pursuit for excellence. The program was commended for many successful aspects including a very active outreach program, data submission process and continuous improvement. This is a testament to the hard work done by many excellent employees. I specifically thank Ms. Barbara Fitzpatrick, CTR and Ms. Christi McKinney, RN, MSN,OCN for the diligent, thorough and generous output they have provided. Their role has been imperative, not only to the success of the survey but also to the program in general.

We also welcome Dr. Bryan Saltz as head of the palliative care program. The program is integral to the hospital's mission in providing relief from suffering. Our program helps patients and their families during difficult times, and improves the quality of life of patients with advanced illnesses. Dr. Saltz brings to the program an infectious compassion, valuable experience and tremendous amount of enthusiasm for the cause of palliative care.

A new structure of the tumor board meeting continues to take shape with the addition of Thoracic and Breast Cancer Conferences. This is another step in the right direction in optimizing cancer care for OLBH patients. In 2011, OLBH added a new tool in the fight against lung cancer: the Lung Nodule Program. Headed by Dr. Diego Maldonado, it represents an important initiative for the early detection of cancer using systematic, evidence-based and multi-disciplinary approach to dealing with innocent-appearing nodules discovered on routine chest X-rays. These cases are followed by the team of clinicians, nurse navigator, radiologist and pathologist. Cases of interest are then presented at the Thoracic Cancer Conference that takes place every two weeks and attended by the oncologist and thoracic surgeon.

It has been an exciting year. Many challenges lie ahead but also many opportunities to fulfill our role in improving cancer care in our region.

Dr. Fadi Hayek,
Chairman, Oncology/Hematology

Speaking Man to Man

about Prostate Cancer

Andrew Wright

by Andrew K. Wright, M.Ed. LSW

The end of my journey was the beginning of another when it comes to my experience with prostate symptoms. After a two-year period of watchful waiting during which my PSA numbers increased, I found myself in the office of Brian DeFade, D.O., waiting for the results of my second prostate biopsy. Unable to sit down in the examination room or even look at my wife, Debra, I read and re-read pages from a notebook that I assembled – pages of questions about treatments, the development of a team, and what supports I would need. I was anticipating a fight for my life.

Like many, I had researched prostate cancer and was anticipating receiving the worst news. Upon arrival and after a short greeting, the doctor turned his attention to my medical chart. After what felt like an eternity, he turned to face me and said, "I have good news – none of the core samples from the biopsy contained cancer cells." Debra shared with me that the look on my face was one of shock. I had beaten the odds with the diagnosis of an enlarged prostate, which is quite treatable.

Upon exiting, I noticed three men seated alone in the waiting room. I turned to Debra and said, "Men should not have to face this alone; these men may not be getting the same news I just received." I knew from my previous research there were no local support groups for men with prostate cancer. I decided I was going to help make a change.

I made an appointment with an American Cancer Society Health Initiative representative. I learned of the American Cancer Society (ACS) initiatives for men with prostate cancer called Man to Man, a support group for those diagnosed with prostate cancer. These groups offered community-based education and support for men and their family members that must learn about complex medical treatment options and side effects while under the stress of feeling overwhelmed, vulnerable and alone.

In March 2011 a group of identified stakeholders met in the office of Dr. DeFade for the purpose of organizing and developing a Man to Man support group at OLBH. It was decided the group would include the presentation of educational materials, an invited speaker to share topics relative to prostate treatments, and an opportunity for men to share their own process and story of survival and recovery. My professional training and personal experiences as a counselor have taught me the importance of finding hope and motivation to take action by the process of talking and listening to the stories of other men. I believed that these opportunities would be a valuable asset for men within a group setting.

The group began meeting in July 2011 and has become an outlet for men who have demonstrated extraordinary courage and willingness to share their journey of knowledge, hope, and strength with other men. Below are three accounts of men who wanted to tell their stories of diagnosis and treatments.

Larry Stanley, age 62, went to his physician after experiencing frequent urination at night. His exam revealed a PSA of 6.8. Thus began a period of monitoring his PSA levels and watchful waiting until his PSA level topped 7 and the decision was made for a biopsy of the prostate. The biopsy revealed that eight out of 18 core samples contained cancer cells. After seeking second opinions, Larry decided radiation treatments were his best option. He would have a total of 42 treatments. To date the only side effects have been some fatigue and "urgency to go." Larry is positive about his condition and through the support of his wife is looking to a future that includes time with her and their grandchildren.

Roger McClanahan, age 62, was symptom free when a sharp increase in his PSA level dictated a prostate biopsy. The initial biopsy was negative for cancer cells and Roger decided to continue to monitor his PSA levels. It was a later, second biopsy that discovered prostate cancer in four out of 18 core samples tested. Roger recalls not expecting cancer since the first biopsy did not reveal cancer cells. Roger said he was fortunate to have his wife with him for support, and together, they began to search for a course of treatment. Roger initially gave consideration to radioactive seed implants but has elected to pursue robotic surgery. Roger expressed appreciation for being able to attend his first Man to Man group one day after diagnosis. He noted how

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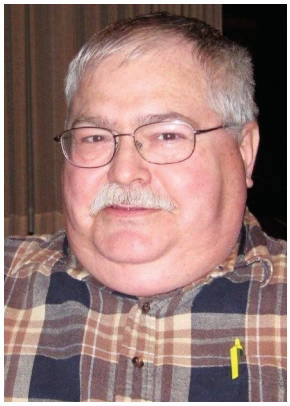
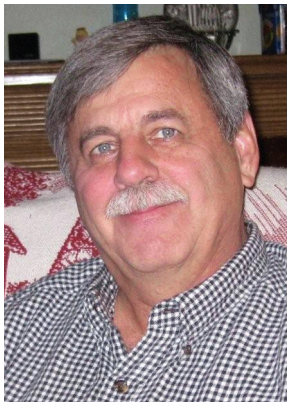
Larry Stanley



Ronald Spence



Roger McClanahan

important it was to listen to what others were going through along with obtaining additional reading literature on prostate cancer and treatment provided by the group.

Ronald Spence, age 64, has attended OLBH's Man to Man group since the very first meeting. In 1998, with no other symptoms, Ron had routine blood work that showed an elevated PSA over 3.0. In 2003, after consultation with his physician, he had a prostate biopsy that revealed four out of 12 samples positive for cancer. In collaboration with his doctor, Ron elected for radiation treatment. Ron first completed 25 external beam radiation treatments along with taking injections that "shut down" his production of testosterone. Following the external beam radiation treatments, Ron followed up with the radiation seed implants. It's been a journey of nearly nine years and Ron is thrilled that a group now exists to help others whose lives have been touched by prostate cancer. "At one time, it was hard to find a support group," Ron said. "It's been a positive experience to give back from my experiences."

The common thread that joins the members of Man to Man is the willingness to share and reach out to others about their individual experiences and hope for the future. I was recently asked, "Do you guys get together and talk about dying?" While somewhat surprised by this question, I recall remembering that cancer is considered by many a death sentence. My answer to this person and anyone else is that this group is about sharing and moving on with our lives, to be able to live our lives fully and well, even in the face of adversity, with the love and support of others. It just doesn't get any better than this!

2011 OLBH Cancer Committee

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By Brian DeFade, D.O.

Prostate Cancer:
To Screen or Not to Screen?

Brian DeFade, D.O.

Other than skin cancer, prostate cancer is the most common cancer in American men. The latest American Cancer Society estimates for prostate cancer in 2011 for the United States indicate 240,890 newly diagnosed cases of prostate cancer with 33,720 men dying of the disease. Prostate cancer is the second leading cause of cancer death in American men, behind only lung cancer. Approximately one man in 36 will die of prostate cancer, with one in six diagnosed with prostate cancer during his lifetime. The estimated lifetime risk of disease is 16.72 percent, with a lifetime risk of death of 2.57 percent (Campbell's Urology).

The incidence of prostate cancer has been falling since the introduction of PSA screening in 1987. This fall cannot be completely explained by PSA screening alone, but also to the more aggressive treatments for prostate cancer that began in the 1980s. The incidence does vary by race/ethnicity with African Americans at the highest risk. African American men have the highest reported incidence of prostate cancer in the world, with a relative incidence of 1.6 compared with white men in the United States. The same study indicates African American men have experienced a greater reduction in mortality than white men since the early 1990s, but their death rates from prostate cancer still remain more than 2.4 times higher than white men. The lowest incidence of prostate cancer is found in Asian-American, Pacific Islanders, American Indians, and Alaska Natives. These variations in incidence are probably not completely reflective of genetic background, but more likely environmental exposure, diet, lifestyle, and attitudes towards healthcare.

Worldwide incidence shows that prostate cancer is the fifth most common malignancy worldwide and the second most common cancer in men. The lowest yearly incidence rates are in Asia, and the highest are in North America and Scandinavia.

Only 2 percent of men are diagnosed before the age of 50 years with the median age at diagnosis being 68 years and 63 percent of those persons after the age of 65. With the decrease in incidence and mortality of prostate cancer since the induction of PSA testing, there has also been a clinical stage migration where the incidence of local-regional disease has increased and the incidence of metastatic disease has decreased. PSA testing also has resulted in substantial downward pathological stage migration as evidenced by an increased proportion of patient with organ-confined disease, and a decrease in seminal vesicle invasion. Please see the AJCC, TNM staging guidelines as published in the NCCN guidelines for prostate cancer (NCCN 4.2011 Chart). This important stage migration, decrease in incidence in prostate cancer, and decreased rate of metastatic disease since the induction of PSA screening begs the question, "Why the controversy over PSA screening?"

Prostate Screening Controversy:

The recent debate concerning prostate cancer screening has been ignited by recent recommendations made by the U.S. Preventative Service Task Force (USPSTF) that stated current evidence is insufficient to assess the benefits and harms of screening in men younger than the age of 75, and therefore the task force recommend against PSA screening in men older than 75 (AUA update 2011). There are multiple studies that have been reviewed, all of which do not support the recommendation made by the USPSTF. These studies would include the Swedish Trial, European Randomized Study of Screening for Prostate Cancer (ERSPC), Prostate, Lung, Colon and Ovary Trial (PLCO), and the Goteborg Study.

The AUA update for 2011 compared these studies. The Swedish Trial showed a 47 percent higher rate of prostate cancer diagnosis in the screened population, but no

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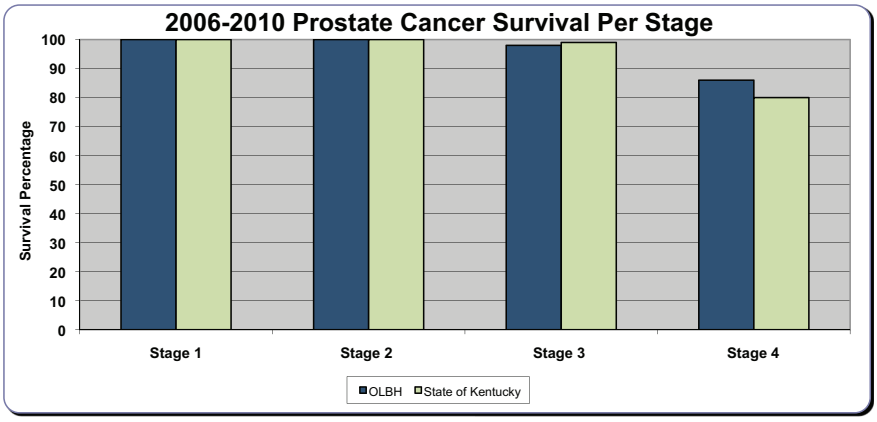
difference in the risk of death compared to the unscreened population.



The ERSPC showed a 20 percent reduction in prostate cancer deaths among those patients screened with PSA compared with those who were not after a nine-year follow-up. There was a 20 percent contamination rate, which means that patients in this trial got PSAs checked outside of the study. If this contamination rate is factored in, the authors of this study suggest the mortality rates may have actually been reduced by 31 percent and metastatic disease by 53 percent with screening.

The PLCO study showed no difference in the screened and unscreened group at seven to 10 years of follow-up. Up to 44 percent of men in this study had PSA testing before enrollment, and there was 52 percent contamination rate for this study. This fact suggests that if these numbers were taken into account, there may be a reduction in prostate cancer related deaths.

The Goteborg study had a 14-year follow-up, and showed a 50 percent reduction in prostate cancer. Only 12 patients had to be screened to prevent one prostate cancer death.

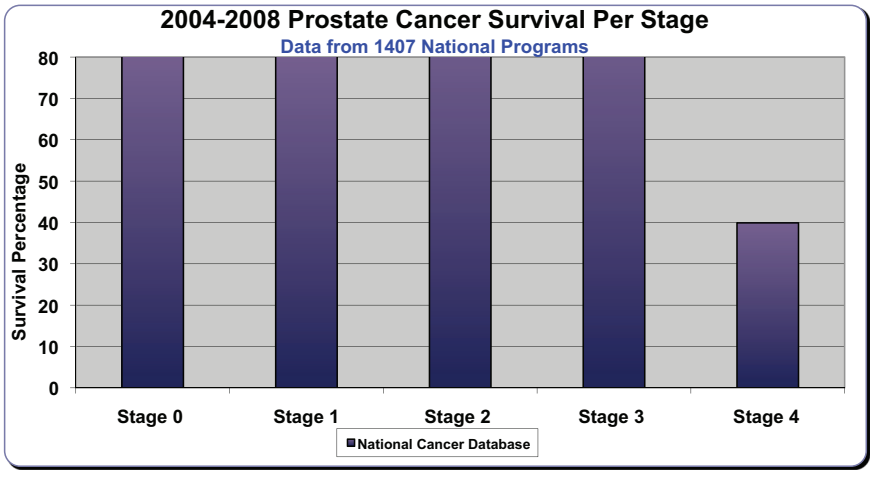
Overall these studies show prostate cancer is an indolent disease and that the morbidity of treatment needs to be considered. Furthermore, they show that those studies with longer follow-up and less contamination supported PSA screening.

Guidelines:

There are multiple guidelines published. I follow the NCCN guidelines, and I will briefly review their recommendations. Every patient should be informed of the risks and benefits of screening. Those who choose to be screened should have a PSA and digital rectal exam (DRE) performed initially at the age of 40. Men at 40 with a PSA greater than or equal to one, or who are African American should be screened annually. Those men with a PSA of less than one may be rescreened at the age of 45. If the PSA remain less than one, these men may begin yearly screening at 50 years. A prostate biopsy is recommended in any man with a PSA greater than 10, or any abnormal DRE.

Our Experience:

Utilizing data that compares survival based on prostate cancer stage between the state of Kentucky and OLBH, it can be derived that our hospital's cancer survival rates per stage are equivalent to the survival data for the state of Kentucky except in one category. OLBH patients have better survival for stage IV disease. It is interesting the majority of patients diagnosed with prostate cancer between the years of 2006 and 2010 at OLBH were stage III and stage IV prostate cancer. This fact goes against the current literature, which has shown a stage progression to predominately organ confined disease – stage II. Furthermore, this high number of stage III and stage IV prostate cancer suggests that the physicians in our area are not screening for prostate cancer appropriately, or that our rural population does not have access to preventative healthcare for whatever reason. The important message here is that screening can make a difference.



2010 Cancer Data Summary

Percentage of OLBH Cancer Incidence by Primary Site

TRACHEA, BRONCHUS, LUNG NSC	20%
BREAST, FEMALE & MALE	18%
COLON	12%
NON-HODGKIN'S LYMPHOMAS	9%
RECTUM/ANUS	4%
BLADDER	4%
PROSTATE	4%
MALIGNANT MELANOMA	4%
SMALL INTESTINE	3%
THYROID	3%
KIDNEY	2%
PANCREAS	2%
STOMACH	2%
UNKNOWN PRIMARY	2%
ENDOMETRIUM	1%
HYPOPHARYNX	1%
LARYNX	1%
LIVER	1%
OROPHARYNX	1%
OVARY	1%
PLASMA CELL TUMORS	1%
TRACHEA, BRONCHUS, LUNG SMALL CELL	1%
TESTIS	1%
BUCCAL MUCOSA	.5%
CERVIX	.5%
MYELOID LEUKEMIAS	.5%
TONGUE	.5%

Registrar's Report

OLBH began its cancer registry in 1991 to collect data from every patient diagnosed or treated for cancer at the hospital. The data plays an important role in the ongoing evaluation of cancer care. The cancer registry is a computerized data collection and analysis center that contributes to patient treatment, planning, staging, and continuity of care through data retrieval, annual analysis, and long-term follow-up.

The OLBH cancer registry is a member of Kentucky Cancer Registry (KCR) and the American College of Surgeons (ACOS). Information is submitted annually to KCR for the Kentucky Cancer Incidence Report. The registry also participates in the "Call for Data" by the National Cancer Data Base, which is designed to provide an annual review of patient care, a comparative summary of hospital cancer statistics and data edit report.

All information collected for the registry is kept strictly confidential. General data is available for presentation, publication, reports, etc. For more information regarding the OLBH cancer registry, call **Barb Fitzpatrick, CTR,** at **(606) 833-3252.**