Leading the way in cancer care

Center for Cancer Care & Research
An affiliate of H. Lee Moffitt Cancer Center & Research Institute

The Cancer Committee at the Center for Cancer Care & Research (CCCR) is proud to present our annual report for 2011-12, a guide that outlines our services, accomplishments and cancer registry data from 2011.

One of only six freestanding cancer centers in the country to be accredited by the American College of Surgeons Commission on Cancer (CoC) and the only local affiliate of **Moffitt Cancer Center** in Tampa, FL, CCCR is a collaboration between **Watson Clinic LLP**, **Clark & Daughtrey**, and the finest independent physicians in the area.

Throughout the past year, we've embarked on a number of efforts and accomplished much in our pursuit to elevate the level of cancer care, prevention and awareness in our community, including:

- We added a second linear accelerator to our fleet of highly advanced cancer treatment tools. The new system - the TrueBeam linear accelerator - allows for more precise and effective radiation treatments in less time than ever before. Additional technologies in our inventory include PET scans, ultra-speed CT scanners, access to 3D mammography, 3D conformal radiation therapy, Image Guided Radiation Therapy, Stereotactic Body Radiation Therapy (SBRT), Stereotactic Radiosurgery, AccuBoost non-invasive radiotherapy treatment for women with breast cancer, Intensity Modulated Radiation Therapy, high rate dose brachytherapy, partial breast irradiation (PBI) and prostate seed therapy.
- Led by highly trained medical professionals, our latest community education and patient support groups include: ***Cancer Crossroads*** – a quarterly gathering designed to guide patients through their diagnosis and treatment. **Conquering Chemotherapy** – an interactive experience that educates patients and their loved ones on what they can expect from the chemotherapy process, as well as advice on techniques to manage side effects. ***Your Inner Hero: Life After Cancer Treatment & Beyond*** – an inspiring group tailored to offer support to patients who are entering the next phase of their lives after chemotherapy. Additional efforts include our monthly Cancer Caregiver Support Group, Breast Cancer Support Group, Cancer Survivor Education Series, Man to Man Prostate Cancer Support Group, and Young Adults Conquering Cancer, as well as a regular series of smoking cessation classes, frequent community lectures related to cancer-specific topics, and our free annual community skin cancer screening day.
- When a patient is diagnosed with cancer, their road to survivorship can be a confusing one. That's why we offer the personalized services of a highly qualified nurse navigator every step of the way. This compassionate and attentive specialist is available to offer guidance and information to the patient through every stage of their treatment, and eases the burden on each of them as they undertake the daunting process of living with cancer.
- Our team maintains a flourishing community outreach program designed to make a difference in the fight against cancer. We continue to nurture our collaborations through participation and sponsorship in organizations like the **Leukemia and Lymphoma Society**, the **American Cancer**

Society, Susan G. Komen Breast Cancer Foundation, Good Shepherd Hospice, United Way, and Volunteers in Service to the Elderly. Events in which we play a major role include Making Strides Against Breast Cancer, Relay for Life, the Breast Cancer Awareness Luncheon, Bartow Cancer Survivor's Dinner, Cancer Survivor's Day and Komen's 3-Day Walk event, and the 200-mile Tour de Pink.

- We remain attentive to every detail that may benefit our patients and provide the most comprehensive and efficient treatment experience possible. This includes our specially-designed high-dose rate (HDR) brachytherapy suite, a soothing and welcoming treatment room featuring calming pink walls and an ornately tiled breast cancer ribbon on the floor of the entranceway; our process-improvement program, which continues to reevaluate and eliminate waste and redundancy in the care process; and our operation of the Watson Clinic Foundation's *Arts in Medicine* program, which encourages healing by integrating the expressive arts, such as music, painting, beading, journaling and storytelling, into the healthcare setting.
- The quality of care provided by the radiation department of the Center for Cancer Care & Research has been recognized with a three-year accreditation by the American College of Radiology. This accomplishment indicates the highest practice standards in patient care, personnel qualifications, facility equipment, quality control procedures, and patient safety.
- We operate one of the most comprehensive clinical trial and research programs in the region, and investigate the latest emerging cancer treatments for patients in both early and advanced stages. Our designation as an affiliate of both the Southwest Oncology Group and Moffitt Cancer Center ensure a wide array of clinical research trials and innovations will be available to each qualified patient.

Further details on all of these accomplishments and more are provided within the pages of this report, and speak to our commitment to improving the cancer care landscape throughout our community and beyond.

Mission Statement:

The CCCR Cancer Committee is dedicated to being the leader in establishing and maintaining high quality cancer care in our community through a Center for Excellence for multidisciplinary oncology services.

Vision:

To be a leader in the delivery of patient-centered cancer care:

- By forming a partnership between our patients and staff, ensuring greater choice and involvement in decision making; and
- By providing access to the latest medical advances through the innovative use of emerging technology.

2012 Annual Report of CCCR:

Dr. Fred J. Schreiber

Hematologist/Oncologist
Co-Medical Director of the Center for Cancer Care & Research
Cancer Committee Chairman

A Message from Fred J. Schreiber, MD

2013 represents the 10 year anniversary of the opening of the Center for Cancer Care & Research. Over this 10 year period, we have seen a lot of change. In surgical oncology, robotic surgery has expanded and become much more common place, allowing for surgeries with better ease and improved outcomes. Radiation therapy has seen the development of stereotactic radiosurgery, allowing higher dose with greater safety and better sparing healthy tissue. In chemotherapy, the last decade has seen an explosion in targeted agents. I am sure the next 10 years will see further expansion of these technologies and the likely evolution of a more personalized care.

Cancers are as individual as people. Perhaps no two cancers are identical and each cancer has a unique mutation responsible for that illness. As targeted therapies expand and proliferate, the potential for personalized treatment becomes real. A personalized care regimen acknowledges that this uniqueness seeks to match the right treatment to the right cancer for better outcomes. Achieving this is going to require collaboration between many specialists including anesthesiologists, breast surgeons, cardiologists, critical care intensivists, dermatologists, dietitians, facial plastic surgeons, family practitioners, gastroenterologists, general surgeons, gynecologists, hospitalists, internal medicine physicians, nephrologists, neurologists, obstetricians, oncologists, ophthalmologists, orthopaedists, otolaryngologists, pain management physicians, pathologists, plastic surgeons, psychiatrists, pulmonologists, radiation oncologists, radiologists, surgical oncologists, thoracic surgeons, urologists and many more. The Center for Cancer Care & Research provides a great framework for this multi-specialty collaboration, and in fact, our patients are already reaping the rewards of this ongoing teamwork.

Also central to the movement toward personalized care is the clinical trial process. Over the last decade, the Center for Cancer Care & Research has entered 3200 patients on clinical trials, exploring new technologies, new techniques. Our affiliation with Moffitt Cancer Center and participation in the Total Cancer Care program, in conjunction with the efforts of Watson Clinic's Center for Research, has helped us to reach this level of participation.

Cancer is a life changing event. We strive to be therapeutic – not only medically, but also supportive helping with both physical and mental needs. Our Cancer Center has extensive resources designed to help patients, including social workers, nurse navigators, educational programs, support groups, and an Arts in Medicine program. If we've learned anything since we opened the doors 10 years ago, it's that the healing process involves the body, mind and spirit. The Center for Cancer Care & Research offers programs that comprehensively help the needs of the 'whole' person, and we proudly do so with compassion, confidence and expertise.

Fred J. Schreiber, MD
Hematologist/Oncologist

Dr. Luis A. Franco

Hematologist/Oncologist for the Center for Cancer Care & Research
Cancer Liaison Physician

A Message from Luis A. Franco, MD

It is my privilege to communicate with you through our yearly report from the Center for Cancer Care & Research (CCCR).

We have experienced an exciting year as we've implemented the latest advancements in cancer prevention and early detection.

The importance of mammography and its role in early detection has now evolved to produce our most effective diagnostic tool yet: breast tomosynthesis, otherwise known as 3D mammography. This 3D technology allows us to detect potential tumors in their earliest stages, facilitates a more accurate diagnosis of breast cancer in dense breasts, and is helpful in differentiating fibrocystic disease, a condition which has frequently posed diagnostic problems when attempting to detect malignant lesions.

In the field of research, CCCR, in collaboration with Watson Clinic's breast health services division, is currently engaged in a study to observe the frequency in which our elderly residents schedule a regular annual mammogram, and the impact of breast cancer on this group of patients.

Unfortunately two out of every three cancer deaths in the United States is still due to preventable causes. Here in Polk County, we have a low incidence of colonoscopy screenings on healthy individuals aged fifty or older; therefore, we see a 60% incidence of stage III and IV carcinomas of the colon. To combat this sobering statistic, CCCR has improved educational offerings for primary care providers and patients alike with the goal of raising the percentage of residents over 50 who schedule their colonoscopy to 80%.

Since most cancers result from genetic changes, we make arrangements for our patients to consult with genetic counselors. As we continue to learn more about the timing, sequence, and frequency of these changes, we now have unique opportunities for earlier identification of chromosomal aberrations, which improves our prospects for earlier intervention.

Finally, we continue our commitment to our tumor boards, promoting the multidisciplinary approach we work to embody, and collaborating with our colleagues in a group setting to build individualized treatment plans for each patient. We believe this approach optimizes patient care, and increases survival outcomes.

Luis A. Franco, MD
Hematologist/Oncologist

Center for Cancer Care & Research (CCCR)
2011 & 2012 Community Outreach and Events at a Glance

Today's outreach climate requires a creative approach - not just in our programs - but in the way we build lasting relationships in our community and provide critical education and ongoing outreach to those most in need. At the "Center for Cancer Care & Research" we take that commitment down to our core values. Many of our efforts are built around the question, "how will this improve the wellness of those who live right here at home?"

At the CCCR we are constantly striving to take our passion for service and outreach to the next level. "Our people are our most important asset." You've heard these words many times, if you work in an organization. Yet how many organizations act as if they really believe these words? Not many. These words are the clear expression of a value, and values are visible through the actions people take, not their talk. At the CCCR We Take Action! Here are a few samples of how our actions are making the difference:

- Continuing a long-standing partnership with one of the nation's most well-known cancer fighting organizations, the American Cancer Society (ACS), strengthens the communities awareness of the value ACS has in every community.
- Hosting an annual skin screening prevention program by using the talents of local dermatologists to partner with the finest at Watson Clinic and bringing skin cancer to the forefront for hundreds who attend.
- Offering a free speaker's bureau where hundreds of physicians and clinical staff are at the ready to present information in our community and who specialize in topics that range from cancer to other chronic health conditions.
- Bringing critical events to our local community that help elevate awareness and education such as the Susan G. Komen Race for the Cure. With the leadership involvement of the CCCR, this event is now a staple in Polk County and helped generate over $100,000 to help offset the costs of mammograms for women who cannot otherwise afford them.
- Staying active in team events that also help raise awareness such as the Komen 3- Day Walk which helps support critical cancer research, participating in the American Cancer Society's Cattlebaron's Ball, Relay For Life and Making Strides which are additional cancer awareness fundraisers, along with events such as the Watson Clinic Foundation's Annual Health Summit and Men's Health Conferences where colon cancer, breast cancer and other cancers are always part of the dialogue and presentations.
- Conducting monthly education programs on Tobacco Control to help our areas youth learn the importance of never starting to smoke and to assist smokers who have a desire to quit to better understand their options.
- Working in partnership with the Watson Clinic Foundation and the Watson Clinic Foundation Auxiliary to raise much needed funds to help continue the necessary research to find cures and implement patient trials.

Values form the foundation for everything that happens at the Center for Cancer Care & Research and we value our community involvement as much as we value the care we provide our patients. You will never see us slow down in this effort and you will always see this permeate throughout our center.

Center for Cancer Care & Research (CCCR)
2011-2012 Cancer Committee Members

This Cancer Committee is an advisory body at CCCR, 1730 Lakeland Hills Boulevard, Lakeland, Florida, and is subject to such regulations that proceed from the Watson Clinic LLP Management Committee that reports directly to the Watson Clinic Board of Directors and the Clark & Daughtrey Medical Group, P.A. that reports directly to the Clark & Daughtrey Board of Directors.

Cancer Committee Physician Members:

Dr. John Barrett, Radiation Oncology
Dr. Elisabeth Dupont, Breast Surgery
Dr. Luis Franco, Medical Oncology/Hematology, Cancer Liaison Physician
Dr. Edward Garcia, Pathology
Dr. Howard Gorell, Radiology
Dr. Kamal Haider, Medical Oncology/Hematology
Dr. Thomas Moskal, Surgical Oncology
Dr. Shalini Mulaparthi, Medical Oncology/Hematology
Dr. Fred Schreiber, Medical Oncology Hematology, Chairman
Dr. Sandra Sha, Radiation Oncology
Dr. Antonio Trindade, Medical Oncology/Hematology
Dr. Galina Vugman, Medical Oncology/Hematology

Physician-Associate Members:

Dr. Michael Addonizio, Interventional Radiology
Dr. Richard Cardosi, GYN Oncology
Dr. Jens Carlsen, Urology
Dr. Randy Heysek, Radiation Oncology
Dr. Rakesh Patel, Urology
Dr. Jack Thigpen, General Surgery

Activity Coordinators:

Cauney Bamberg, Director Watson Clinic Foundation, Community Outreach
Cindy Bruton, Administrative Assistant, Cancer Conference
Monique Hakins, MSW, Social Services, Psychosocial Services
Jerri Huntt, MSW, LCSW, Social Services, Psychosocial Services
Helen Lewis, Cancer Program Coordinator, Cancer Registry Quality
Noreen McGowan, BSN, CCRC, Administrative Research Coordinator, Clinical Research
Tracey Mensing, RN, BSN, OCN, Chemotherapy/Oncology Nursing, Quality Improvement

Allied Health-Core Members:

Cheryl Bell, Director of Satellite Services
Mary Ann Blanchard, RN, BS, Director, Clinical Services
Kim Stetson, BHM, Site Manager
Patty Strickland, Community Outreach Manager
Linda Wolf, RN, Clinical Director
Pam Herbert, RN,OCN, Department Manager
Sheila Coile, RN, OCN, Oncology Nursing Team Lead
Shannon Barlow, MS, DABR, Radiation Physics
Ishiuan Hargrove, MMSc, DABR, Radiation Physics
Dr. Zejian Liu, PhD, DABR, Radiation Physics
Debora Hunt, BSW, Social Services
Ann Lehman, BSW, Social Services

Allied Health-Associate Members:

Adil Khan, M.H.A., CAO
Alisa Robbins, Staffing Secretary
Susan Woodward, ARNP
Michelle Dove, R.T.T, Radiation Therapy
Carol Martin, RN, Women's Center
Eunice Hutto, American Cancer Society
Nancy Nethery, American Cancer Society Area Patient Representative

Cancer Registry Members:

Paula Buck, CTR, Abstractor
Valerie Fisher, Follow-up
Helen Lewis, BS, CTR, Cancer Program Coordinator
Blanche Myers, CPC, CT, RHIT, Lead Abstractor
Aprill Rease, CTR, Abstractor
Angie Simmons, CTR, Abstractor

Center for Cancer Care & Research (CCCR)
2012 Nurse Committee Report

The concept of “Network Weaving” is to connect multiple groups of individuals and have the participants work together to provide more cohesive and "threaded" patient-driven care. This "tapestry of care" will be uniquely that of the Center for Cancer Care & Research and will help distinguish this center's nursing professionals as top in their field.

Here is a snapshot of our accomplishments:

Empowering collaboration:

- Monthly committee meetings to monitor, evaluate and improve the patient experience.
- Bi-annual clinical simulation drills for emergency situations to assure competency of medical staff.
- Fostering open communications and ensuring that the culture of shared attitudes, values, goals and practices reflect the Center for Cancer Care & Research mission.

Developing quality control initiatives:

- Utilizing the guidelines provided by the Oncology Nursing Society (ONS) and the Commission on Cancer (CoC), the nurse committee implements necessary improvements relative to:
    1. Safe handling of chemotherapy.
    2. Administration of chemotherapeutic, biologic and immunotherapeutic agents.
    3. Extravasation management.
    4. Oncological emergencies.
    5. Patient education.
    6. Radiation therapy.
    7. Care of the immunocompromised patient.
    8. Side effect management.
- Established a systematic approach to support efficient and effective patient-driven care in all settings and in every program.

Goals:

- To continually improve collaboration with our peers.
- To improve communication and problem solving approaches to enhance the safety and quality care of patients.
- To develop a variety of initiatives to facilitate Quality Assurance issues.
- Remain an advocate for improving patient care and serve as a liaison between patient and physician.
- Promote an environment whereby each patient’s dignity and rights are recognized and respected and always a priority.
- Provide staff development and on-going oncology nursing education programs.
- Promote empowering patients with education and community resources that are designed to enhance positive outcomes and survival.
- Improve patient's access to healthcare by eliminating barriers through creating navigation processes.
- Heighten awareness of cancer prevention by providing education to the local community.

Center for Cancer Care & Research (CCCR)
2011 - 2012 Cancer Conferences

Cancer Conferences not only serve as a forum for prospective review of cancer cases, involving a multidisciplinary team in the patient care process, but also offer education for the physicians and staff as well. Our multidisciplinary team, which includes physicians in the departments of hematology/medical oncology, radiation oncology, surgical oncology, pathology, diagnostic radiology, and other specialties as well as allied health professionals from research, nursing, social services, cancer registry and administration, attend Cancer Conference three times a week for collaborative discussion of diagnosis, stage, prognostic factors, and national treatment guidelines pertaining to the cases presented and cancer related educational activities.

Year End 2011	
Total # of Cancer Conferences	92
Total # of Cases Presented (70% of Analytic Caseload)	777
Total # of Cases Presented Prospectively (99% of Cases Presented)	773
Total # of Cancer Related Educational Activities	33

YTD September 30, 2012	
Total # of Cancer Conferences	72
Total # of Cases Presented (56% of Analytic Caseload)	614
Total # of Cases Presented Prospectively (99% of Cases Presented)	607
Total # of Cancer Related Educational Activities	24

Center for Cancer Care & Research
Cancer Registry Activity Report on 2011 Data

Florida state statute requires cancer and benign central nervous system tumors to be reported to the state cancer registry, Florida Cancer Data Systems (FCDS). The Cancer Registry performs this function for three facilities: Watson Clinic, LLP (WC); Center for Cancer Care & Research (CCCR) and Clark & Daughtrey Medical Group, P.A. (C&D). Only the CCCR, a joint project of WC and C&D providing radiation and medical oncology therapies, is accredited by the American College of Surgeons Commission on Cancer (CoC) as a Freestanding Cancer Center Program (FCCP). The Cancer Registry reports de-identified CCCR analytic cases to the National Cancer Data Base (NCDB), a joint project of the CoC and American Cancer Society, as required by its CoC accreditation.

Cancer Registry activities this past year also included:

- Reported to NCDB all analytic cases from years 2004-2010 that had been added or modified. Cases had to be updated to many of the current data standards prior to being submitted. A total 4,462 cases were updated and reported to NCDB in the month of January. Each year of data was reported by NCDB to be error-free on the first submission. This was the third year of error-free submissions to NCDB which qualifies the CCCR for a commendation at their reaccreditation survey next year.
- Provided data to the Watson Clinic Women's Center to assist them in maintaining their accreditation by the National Approvals Program for Breast Centers (NAPBC).
- Continued the waiver from the Department of Health's newly mandated dermatology-reporting program from last year that recognizes the Cancer Registry's routine reporting full abstracts of malignant skin cancers (excluding squamous cell and basal cell types) to FCDS. Without the waiver, each dermatologist would have to register with the program and report these skin cancers to FCDS individually.
- Continued to be challenged by annual and even more frequent changes in data requirements mandated by the CoC and FCDS. Some changes are applied retroactively before being able to report cases to either governing body.
- Created a new Cancer Registry Policy and Procedure Manual.
- Provided leadership in interpreting and implementing changes in CoC Cancer Program standards for 2012. Participated in educational activities provided by the Cancer Committee Subcommittee to help the CCCR cancer care team become familiar with the new requirements. Also participated on the Subcommittee in updating the Cancer Program Policies and Procedures Manual to be consistent with 2012 standards.

The CoC definition of "analytic cases" creates an issue for outpatient facilities like the CCCR. The issue exists much less frequently for hospital cancer programs. The CoC definition restricts analytic to only those newly diagnosed cases that receive cancer-directed treatment at the facility. Only analytic cases are reported to NCDB. This omits many of our cancer patients who receive their actual treatment by our physicians at an area surgical center or hospital. Examples are seed brachytherapy by our radiation oncologists and breast surgeries by our surgical oncologist. All newly diagnosed patients are important at our facilities for research, quality studies and tracking patterns of care. Fortunately, the CoC created a new class 30 for newly diagnosed cases that do not meet the definition of analytic. This group, although classified by the CoC as non-analytic, includes cases where our physicians participated in staging, first-course treatment planning and supportive care.

The Cancer Registry database is restricted to those cases with active cancer and those, without active cancer, receiving adjuvant therapy. Some cancer sites, notably colon, GYN and soft tissue may be diagnosed and/or treated elsewhere by our physicians but not seen at our facility until after the cancer is removed. These usually do not meet criteria for including in the Cancer Registry. Consequently, our physicians see many more cancer patients than are represented on the following tables.

The four site-distribution tables in this report list "analytic" cases which follow the CoC definition and "analytic plus" cases which include class 30 cases. The analytic-plus numbers are our newly diagnosed cases. Non-analytic cases in the tables include only those cases that were diagnosed and received all first-course treatment elsewhere prior to presenting with recurrent or persistent cancer or a new

diagnosis. A decision for watchful waiting or to not treat for any other reason is considered treatment. The CoC classifies no-treatment cases as analytic for the facility where the decision was made.

The first three tables display cancer site, gender and class of case distributions for each of our facilities for 2011. A fourth table includes only newly diagnosed CCCR cancer cases for 2011 but displays TNM stage at diagnosis. Primary peritoneal cancer, which uses the ovarian AJCC staging schema, was added to the GYN category this year. State and national standards require cancer registries to abstract (create a record) for each primary cancer and benign central nervous system tumor and for each facility where the reportable tumor is seen. Consequently, a single patient may be counted more than once if he/she has more than one diagnosis of cancer and/or is seen at more than one of our facilities for the same cancer. The Cancer Registry abstracted 3590 cases for 2011: 1394 for CCCR, 1843 for WC and 353 for C&D. These totals represent 2135 unique patients.

Also included are several graphical analyses of 2011 CCCR newly diagnosed cancer cases:

- Five most frequent CCCR cancer sites
- Five most frequent female CCCR cancer sites
- Five most frequent male CCCR cancer sites
- Five most frequent CCCR cancer sites compared to Florida and national incidence
- Age at diagnosis
- Stage at diagnosis for all CCCR cancer sites combined
- County of residence at time of diagnosis

Table 1. Total 2011 Cases for CCCR

PRIMARY SITE	CASES	MALE	FEMALE	ANALYTIC	ANALYTIC PLUS*	NON-ANALYTIC
ALL SITES	**1394**	**672**	**722**	**856**	**1060**	**334**
LIP	0	0	0	0	0	0
TONGUE	10	9	1	8	9	1
OROPHARYNX	3	3	0	2	2	1
HYPOPHARYNX	0	0	0	0	0	0
OTHER ORAL CAVITY	22	12	10	15	19	3
ESOPHAGUS	23	20	3	15	20	3
STOMACH	15	12	3	10	12	3
COLON	74	40	34	29	51	23
RECTUM	35	21	14	21	29	6
ANUS/ANAL CANAL	5	1	4	5	5	0
LIVER	12	7	5	6	11	1
PANCREAS	34	16	18	17	28	6
OTHER DIGESTIVE	5	2	3	1	3	2
NASAL/SINUS	1	1	0	1	1	0
LARYNX	19	15	4	14	15	4
LUNG/BRONCHUS	223	115	108	153	200	23
OTHER RESPIRATORY	0	0	0	0	0	0
LEUKEMIA	52	32	20	30	32	20
MULTIPLE MYELOMA	17	12	5	13	15	2
OTHER BLOOD & BONE MARROW	14	7	7	10	10	4
BONE	0	0	0	0	0	0
CONNECT/SOFT TISSUE	2	1	1	0	0	2
MELANOMA	80	57	23	27	37	43
OTHER CUTANEOUS	2	1	1	1	1	1
BREAST	320	3	317	245	264	56
CERVIX UTERI	14	0	14	8	8	6
CORPUS UTERI	28	0	28	20	20	8
OVARY	20	0	20	18	18	2
PRIMARY PERITONEAL	5	0	5	4	5	0
VULVA	1	0	1	0	0	1
OTHER FEMALE GENITAL	1	0	1	1	1	0
PROSTATE	192	192	0	95	129	63
TESTIS	7	7	0	4	4	3
OTHER MALE GENITAL	1	1	0	0	0	1
BLADDER	23	21	2	7	8	15
KIDNEY/RENAL PELVIS	18	13	5	6	11	7
OTHER URINARY	1	0	1	0	1	0
BRAIN (BENIGN)	1	0	1	0	0	1

BRAIN (MALIGNANT)	15	8	7	10	13	2
OTHER CNS	2	1	1	1	1	1
THYROID	4	0	4	1	2	2
OTHER ENDOCRINE	2	0	2	0	0	2
HODGKIN LYMPHOMA	5	2	3	5	5	0
NON-HODGKIN LYMPHOMA	62	28	34	38	50	12
UNKNOWN PRIMARY	17	10	7	10	15	2
OTHER & ILL-DEFINED SITES	7	2	5	5	5	2

*Total newly diagnosed cases; includes analytic plus class 30 per Commission on Cancer definitions

Table 2. Total 2011 Cases for Watson Clinic LLP

PRIMARY SITE	CASES	MALE	FEMALE	ANALYTIC	ANALYTIC PLUS*	NON-ANALYTIC
ALL SITES	**1843**	**914**	**929**	**1021**	**1525**	**318**
LIP	0	0	0	0	0	0
TONGUE	8	7	1	4	7	1
OROPHARYNX	5	4	1	0	3	2
HYPOPHARYNX	1	0	1	0	1	0
OTHER ORAL CAVITY	25	13	12	7	20	5
ESOPHAGUS	25	23	2	1	21	4
STOMACH	10	9	1	2	9	1
COLON	66	31	35	3	47	19
RECTUM	26	19	7	1	22	4
ANUS/ANAL CANAL	5	0	5	1	4	1
LIVER	13	6	7	6	11	2
PANCREAS	27	14	13	3	24	3
OTHER DIGESTIVE	2	1	1	0	2	0
NASAL/SINUS	0	0	0	0	0	0
LARYNX	11	9	2	0	9	2
LUNG/BRONCHUS	159	82	77	38	136	23
OTHER RESPIRATORY	0	0	0	0	0	0
LEUKEMIA	31	21	10	10	17	14
MULTIPLE MYELOMA	13	10	3	2	7	6
OTHER BLOOD & BONE MARROW	4	1	3	0	1	3
BONE	1	1	0	1	1	0
CONNECT/SOFT TISSUE	2	2	0	0	1	1
MELANOMA	520	312	208	455	462	58
OTHER CUTANEOUS	2	1	1	0	1	1
BREAST	288	1	287	191	244	44
CERVIX UTERI	19	0	19	8	16	3
CORPUS UTERI	73	0	73	17	69	4
OVARY	28	0	28	8	26	2
PRIMARY PERITONEAL	6	0	6	1	6	0
VULVA	13	0	13	2	6	7
OTHER FEMALE GENITAL	3	0	3	2	3	0
PROSTATE	219	219	0	136	160	59
TESTIS	6	6	0	2	3	3
OTHER MALE GENITAL	3	3	0	1	2	1
BLADDER	60	46	14	32	46	14
KIDNEY/RENAL PELVIS	30	16	14	14	24	6
OTHER URINARY	2	1	1	0	2	0
BRAIN (BENIGN)	4	1	3	2	3	1

BRAIN (MALIGNANT)	10	6	4	3	9	1
OTHER CNS	18	1	17	11	12	6
THYROID	25	9	16	16	23	2
OTHER ENDOCRINE	21	11	10	13	16	5
HODGKIN LYMPHOMA	12	6	6	3	10	2
NON-HODGKIN LYMPHOMA	3	0	3	2	3	0
UNKNOWN PRIMARY	44	24	20	22	35	9
OTHER & ILL-DEFINED SITES	7	3	4	4	6	1
	5	1	4	0	5	0

*Total newly diagnosed cases; includes analytic plus class 30 per Commission on Cancer definitions

Table 3. Total 2011 Cases for Clark & Daughtrey Medical Group, P.A.

PRIMARY SITE	CASES	MALE	FEMALE	ANALYTIC	ANALYTIC PLUS*	NON-ANALYTIC
ALL SITES	**353**	**189**	**164**	**89**	**253**	**100**
LIP	0	0	0	0	0	0
TONGUE	3	3	0	0	3	0
OROPHARYNX	2	2	0	1	1	1
HYPOPHARYNX	0	0	0	0	0	0
OTHER ORAL CAVITY	2	2	0	1	2	0
ESOPHAGUS	3	3	0	0	2	1
STOMACH	2	1	1	0	1	1
COLON	23	14	9	0	12	11
RECTUM	5	2	3	0	3	2
ANUS/ANAL CANAL	0	0	0	0	0	0
LIVER	1	1	0	0	1	0
PANCREAS	3	2	1	0	3	0
OTHER DIGESTIVE	0	0	0	0	0	0
NASAL/SINUS	0	0	0	0	0	0
LARYNX	10	7	3	0	8	2
LUNG/BRONCHUS	83	30	53	12	70	13
OTHER RESPIRATORY	0	0	0	0	0	0
LEUKEMIA	12	8	4	2	4	8
MULTIPLE MYELOMA	9	7	2	0	3	6
OTHER BLOOD & BONE MARROW	1	0	1	0	0	1
BONE	0	0	0	0	0	0
CONNECT/SOFT TISSUE	0	0	0	0	0	0
MELANOMA	12	11	1	0	4	8
OTHER CUTANEOUS	1	0	1	0	0	1
BREAST	47	0	47	3	32	15
CERVIX UTERI	1	0	1	1	1	0
CORPUS UTERI	7	0	7	4	5	2
OVARY	1	0	1	0	0	1
PRIMARY PERITONEAL	0	0	0	0	0	0
VULVA	1	0	1	1	1	0
OTHER FEMALE GENITAL	0	0	0	0	0	0
PROSTATE	58	58	0	42	45	13
TESTIS	3	3	0	0	2	1
OTHER MALE GENITAL	0	0	0	0	0	0
BLADDER	19	15	4	12	15	4
KIDNEY/RENAL PELVIS	9	5	4	3	6	3
OTHER URINARY	0	0	0	0	0	0
BRAIN (BENIGN)	0	0	0	0	0	0
BRAIN (MALIGNANT)	1	0	1	0	1	0

OTHER CNS	2	0	2	2	2	0
THYROID	5	1	4	2	5	0
OTHER ENDOCRINE	0	0	0	0	0	0
HODGKIN LYMPHOMA	4	3	1	0	4	0
NON-HODGKIN LYMPHOMA	16	9	7	2	14	2
UNKNOWN PRIMARY	2	1	1	1	1	1
OTHER & ILL-DEFINED SITES	5	1	4	0	2	3

*Total newly diagnosed cases; includes analytic plus class 30 per Commission on Cancer definitions

Table 4. CCCR 2011 Primary Site Distribution of Newly Diagnosed Cancer Cases

PRIMARY SITE	CLASS		GENDER		AJCC STAGE AT DIAGNOSIS						
	Analytic Plus*	Analytic	Male	Female	0	I	II	III	IV	UNK**	N/A***
ALL SITES	**1060**	**856**	**484**	**576**	**54**	**250**	**243**	**185**	**198**	**27**	**103**
ORAL CAVITY	**30**	**25**	**20**	**10**	**0**	**5**	**3**	**6**	**16**	**0**	**0**
Lip	0	0	0	0	0	0	0	0	0	0	0
Tongue	9	8	8	1	0	1	0	3	5	0	0
Oropharynx	2	2	2	0	0	0	0	1	1	0	0
Hypopharynx	0	0	0	0	0	0	0	0	0	0	0
Other	19	15	10	9	0	4	3	2	10	0	0
DIGESTIVE SYSTEM	**159**	**104**	**96**	**63**	**3**	**24**	**39**	**48**	**41**	**2**	**2**
Esophagus	20	15	17	3	0	0	5	7	8	0	0
Stomach	12	10	9	3	0	3	1	3	4	0	1
Colon	51	29	29	22	2	6	12	22	9	0	0
Rectum	29	21	19	10	1	4	10	6	8	0	0
Anus/Anal Canal	5	5	1	4	0	1	1	3	0	0	0
Liver	11	6	6	5	0	4	1	3	1	2	0
Pancreas	28	17	14	14	0	6	8	4	10	0	0
Other	3	1	1	2	0	0	1	0	1	0	1
RESPIRATORY SYSTEM	**216**	**168**	**118**	**98**	**2**	**61**	**14**	**59**	**79**	**0**	**1**
Nasal/Sinus	1	1	1	0	0	1	0	0	0	0	0
Larynx	15	14	12	3	2	8	2	0	3	0	0
Lung/Bronchus	200	153	105	95	0	52	12	59	76	0	1
Other	0	0	0	0	0	0	0	0	0	0	0
BLOOD & BONE MARROW	**57**	**53**	**34**	**23**	**0**	**0**	**0**	**0**	**1**	**0**	**56**
Leukemia	32	30	20	12	0	0	0	0	1	0	31
Multiple Myeloma	15	13	10	5	0	0	0	0	0	0	15
Other	10	10	4	6	0	0	0	0	0	0	10
BONE	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
CONNECT/SOFT TISSUE	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
SKIN	**38**	**28**	**23**	**15**	**3**	**22**	**6**	**2**	**4**	**0**	**1**
Melanoma	37	27	22	15	3	22	6	2	3	0	1
Other	1	1	1	0	0	0	0	0	1	0	0
BREAST	**264**	**245**	**2**	**262**	**46**	**113**	**64**	**25**	**8**	**8**	**0**
FEMALE GENITAL	**52**	**51**	**0**	**52**	**0**	**9**	**5**	**24**	**9**	**1**	**4**
Cervix Uteri	8	8	0	8	0	2	1	4	1	0	0
Corpus Uteri	20	20	0	20	0	6	3	6	1	0	4
Ovary	18	18	0	18	0	1	1	9	6	1	0
Other	5	4	0	5	0	0	0	5	0	0	0
Vulva	0	0	0	0	0	0	0	0	0	0	0
Other	1	1	0	1	0	0	0	0	1	0	0
MALE GENITAL	**133**	**99**	**133**	**0**	**0**	**1**	**101**	**9**	**11**	**11**	**0**
Prostate	129	95	129	0	0	0	100	8	11	10	0
Testis	4	4	4	0	0	1	1	1	0	1	0
Other	0	0	0	0	0	0	0	0	0	0	0
URINARY SYSTEM	**20**	**13**	**14**	**6**	**0**	**0**	**4**	**5**	**10**	**0**	**1**
Bladder	8	7	6	2	0	0	3	2	3	0	0

Kidney/Renal Pelvis	11	6	8	3	0	0	1	3	6	0	1
Other	1	0	0	1	0	0	0	0	1	0	0
BRAIN & CNS	**14**	**11**	**7**	**7**	**0**	**0**	**0**	**0**	**0**	**0**	**14**
Brain (Benign)	0	0	0	0	0	0	0	0	0	0	0
Brain (Malignant)	13	10	7	6	0	0	0	0	0	0	13
Other	1	1	0	1	0	0	0	0	0	0	1
ENDOCRINE	**2**	**1**	**0**	**2**	**0**	**2**	**0**	**0**	**0**	**0**	**0**
Thyroid	2	1	0	2	0	2	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0
LYMPHATIC SYSTEM	**55**	**43**	**26**	**29**	**0**	**13**	**7**	**12**	**18**	**5**	**0**
Hodgkin Lymphoma	5	5	2	3	0	0	1	2	2	0	0
Non-Hodgkin Lymphoma	50	38	24	26	0	13	6	10	16	5	0
UNKNOWN PRIMARY	**15**	**10**	**9**	**6**	**0**	**0**	**0**	**0**	**0**	**0**	**15**
OTHER & ILL-DEFINED SITES	**5**	**5**	**2**	**3**	**0**	**0**	**0**	**0**	**1**	**0**	**4**

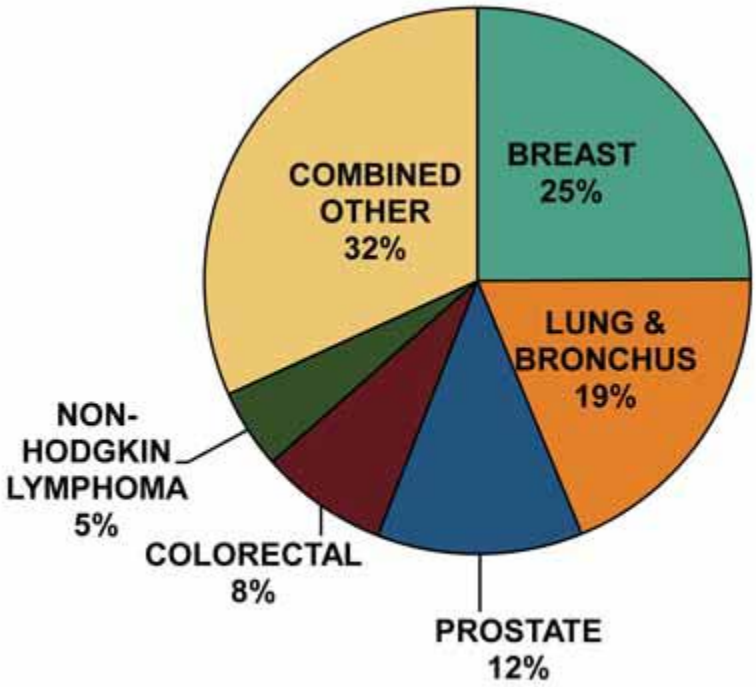
*Total newly diagnosed cases; includes analytic plus class 30 per Commission on Cancer definitions
**UNK - Unknown stage, case unable to be staged
***N/A - Not applicable, no AJCC staging schema exists for this cancer site/histology combination

Five Most Frequent Cancer Sites in 2011

The five most frequent cancer sites seen at CCCR in 2011 were breast (25%) of newly diagnosed cases), lung (19%), prostate (12%), colorectal (8%) and non-Hodgkin lymphoma (5%). This shows an increase of 3% in prostate cancer over the 9% seen in 2010. More than two-thirds (69%) of CCCR newly diagnosed cases were these five sites. The 1060 newly diagnosed cases represented 76% of total cases seen at CCCR.

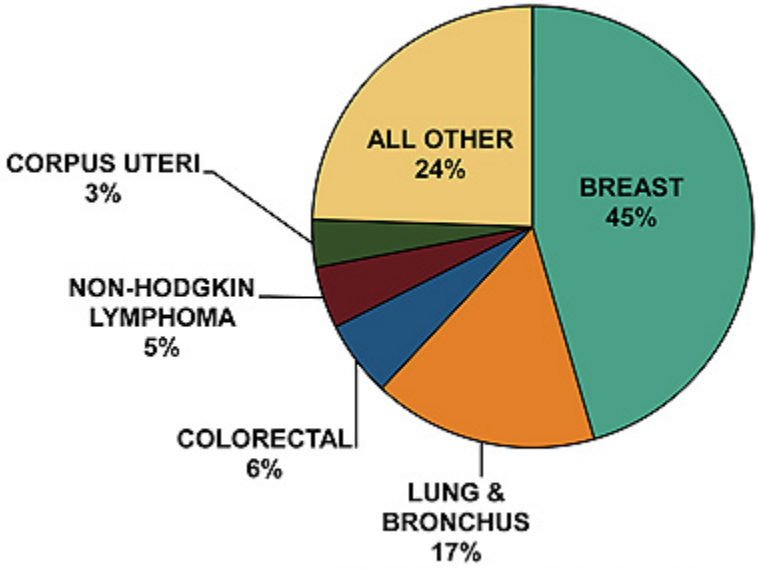
Male cancer distribution showed the most changes for 2011. Prostate cancer increased from 21% in 2010 to 27% in 2011, replacing lung cancer as the most frequent male cancer even though lung cancer stayed the same at 22%. Also melanoma (5%) appeared for the first time, replacing leukemia as the fifth most frequent male cancer.

Distribution of 2011 CCCR Cases



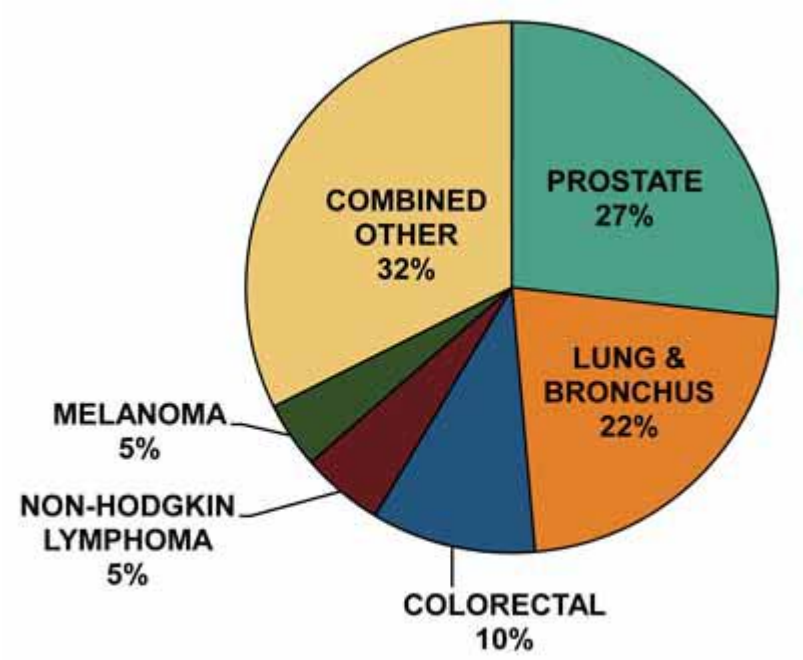
Note: Total more than 100% due to rounding.

Distribution of 2011 CCCR Female Cases



Note: Total less than 100% due to rounding.

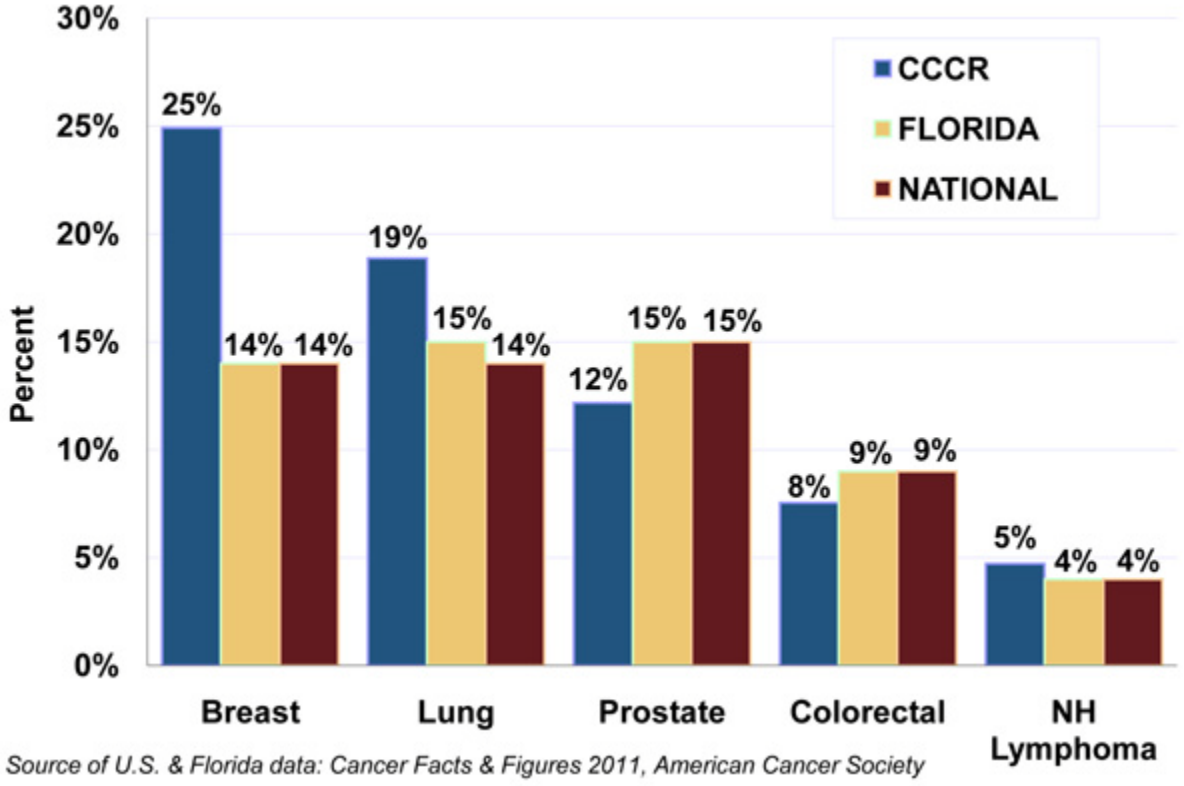
Distribution of 2011 CCCR Male Cases



Note: Total more than 100% due to rounding.

CCCR 2011 Frequency Compared to Incidence

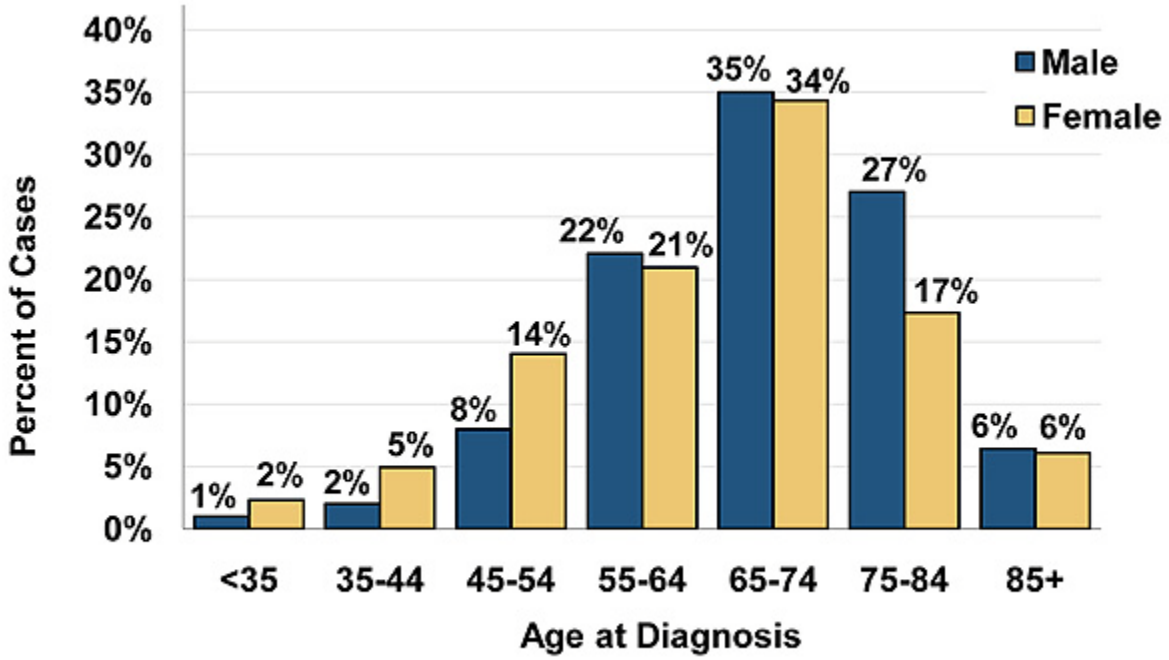
Incidence represents all newly diagnosed cancer cases within a geographic area, for example a state. Facilities can only count frequency, the number of cancer cases that come to the facility. The following graph compares state and national incidence to the top five CCCR cancer sites. The comparison shows we see much more than our "share" of breast cancer and slightly more than our share of lung cancer.



Source of U.S. & Florida data: Cancer Facts & Figures 2011, American Cancer Society

Age at Diagnosis by Gender of CCCR 2011 Analytic Cases

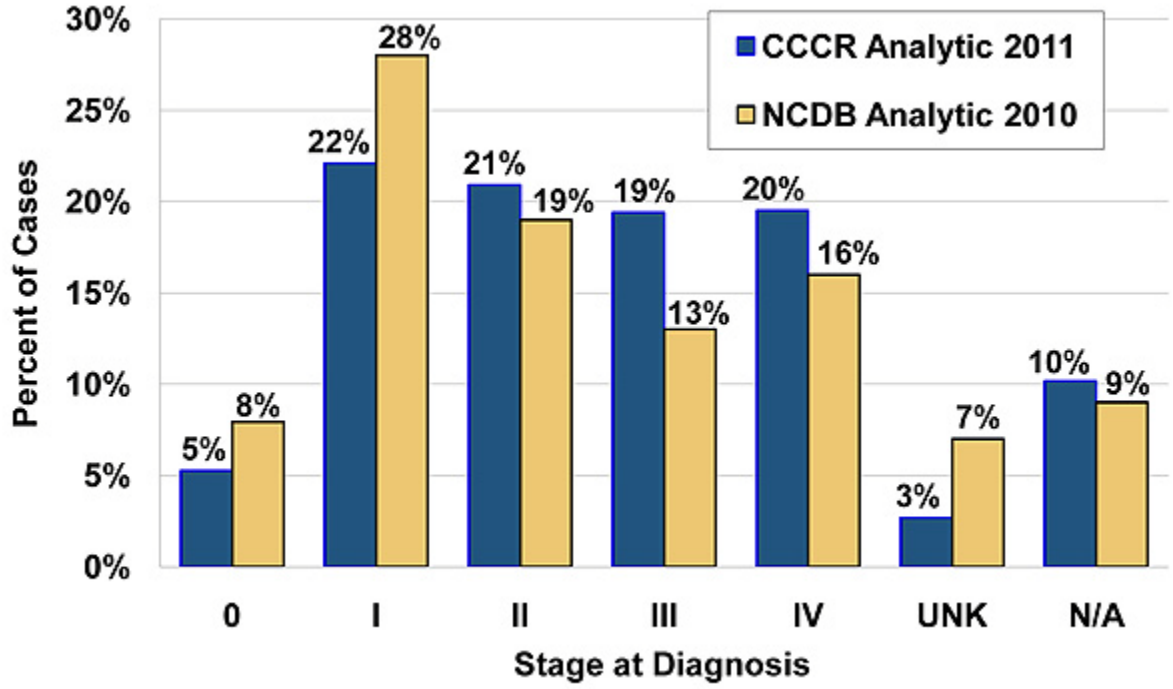
Of the 1060 newly diagnosed 2011 CCCR cases, 46% were male and 54% were female. Over half (62%) were age 65 or older, approximately the same as last year. Of the 484 male patients, 326 (67%) were age 65 or older. Of the 576 female patients, 327 (57%) were 65 or older. Average age of male patients was 69. Average age of female patients was 66. Average age for both combined was 67.



Note: Totals do not equal exactly 100% due to rounding.

CCCR 2011 Stage at Diagnosis Compared to NCDB

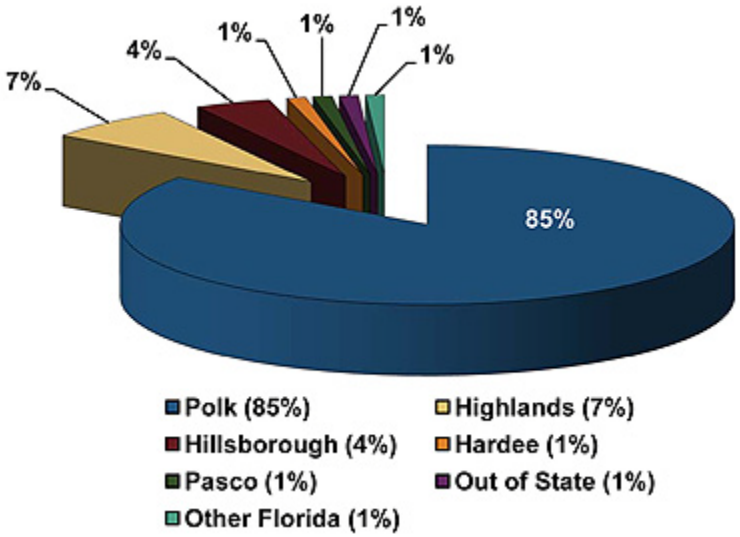
The NCDB database includes only analytic cancer cases as defined by the CoC. Consequently only CCCR analytic cases—using the same CoC definition—were used for this comparison of stage at diagnosis. The most recent data year available from NCDB was 2010 (1,123,652 cases), which was compared to 2011 CCCR (856 cases). Of the 856 CCCR analytic cases, 413 (48%) were early stage (stages 0, I & II), similar to the previous three years; NCDB early stage was 55%. Later stages (stages III & IV) accounted for 39% of CCCR cases but only 29% of NCDB cases. However, stage was unknown for 9% of NCDB cases but only 3% of CCCR cases. Cases for which there were no staging schemes were similar: 10% for CCCR and 9% for NCDB. The Collaborative Staging System, which may combine AJCC clinical and pathological TNM staging components, was used for all stage designations in this report.



Source of NCDB data: 2012 National Cancer Data Base/CoC Benchmark Reports

County of Residence at Diagnosis of CCCR 2011 Cases

The source of CCCR newly diagnosed patients remained the same as last year. The majority of patients (85%) resided in Polk County at the time of their diagnosis. Another 13% came from surrounding counties and 2% came from outside the region.



Center for Cancer Care and Research
Impact of Mediastinal Node Resection and Examination on Prognosis in NSCLC Treated Surgically in 2011

Edward Kerr, Research Student, Southern Methodist University
F. Schreiber, M.D.; Watson Clinic LLP; Center for Cancer Care and Research

Background:
Lung cancer is the leading cause of cancer death in men and women. It is estimated nation-wide in 2011 that 221,000 were diagnosed with lung cancer and 157,000 died of it. Lung cancer develops within the lung tissue or in the supportive tissue around the bronchial region. Several types of lung cancer exist. They are subdivided into groups based on biologic behavior and general treatment approaches. The most common types are non-small cell lung carcinoma(NSCLC) and small cell lung carcinoma. Approximately 80% of cases of lung cancer are the non-small cell variety.

Locally, 200 cases of newly diagnosed lung cancer were seen at the Center for Cancer Care & Research (CCCR) in the year 2011. Among these, 33 NSCLC cases had surgery. Of the entire 200 cases, 52 were stage I, 12 were stage II, 59 were stage III, and 76 were stage IV. One could not be staged. Staging refers to the extent of disease. By staging a cancer, a physician can categorize them into groups predictive of prognosis and success with various treatments. Stage I generally refers to cancer of limited size, confined to the lung itself; stage II refers to somewhat larger tumors; stage III refers to lymph node involvement or, much less frequently, to extension outside the lung into nearby tissue; and stage IV refers to those that have metastatic spread. As a general rule, localized lung cancer has a 50% chance of five-year survival; regional cancer (lymph node involvement) cancer has a 24% chance of five-year survival and distant spread lung cancer has a 4% chance of five-year survival.

Staging generally starts with CAT scans and PET scans. The significance of lymph node involvement is considerable. Usually a lot of effort is made to evaluate them as accurately as possible. To a large extent, as lymph node involvement increases, survival decreases. To categorize how much lymph node involvement is present, the lymph nodes within the chest are subdivided into various groups (labeled stations).

Surgery is usually performed for those healthy enough to tolerate it and when the lung cancer could be completely removed and lymph node involvement is felt to be unlikely. Following surgery, the tissues, including lymph nodes, are examined microscopically.

Of the 200 lung cancer treated at CCCR in 2011, only 33 NSCLC cases were treated with surgery. Most (25 cases) had a lobe of the lung removed with lymph node sampling. One had a lobe removed but no lymph nodes were found. Two cases had an entire lung removed (pneumonectomy). Five cases had less than a lobe removed because of underlying lung disease. On reviewing the 33 cases that had surgery, there were five unique individuals who had special circumstances. One had a pre-invasive cancer and lymph nodes were not sampled. Another was elderly and had major comorbidities. Surgery was limited to a lobectomy only. A third case had lymph node areas removed but no nodes were found. Two others had only small portions of lung excised without further resection.

Of these 33 surgical cases, 64% turned out to be stage I, 15% were stage II, 21% were stage III, and none were stage IV. The average primary tumor size removed was 2.7 cm and the average number of lymph nodes removed was 5. The average number of positive lymph nodes per case was 0.3. The average number of lymph node stations sampled was 2.5. Over 51% had three or more lymph node stations sampled.

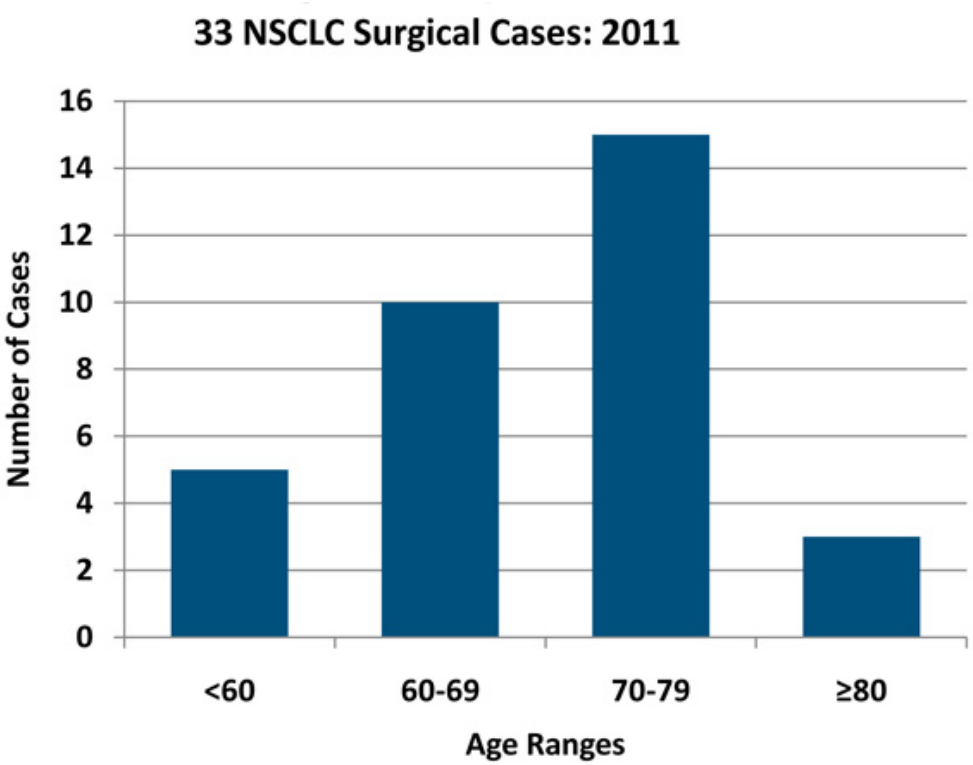
Survival of patients at CCCR was compared to the National Cancer Data Base of the Commission on Cancer. The five-year survivals of CCCR NSCLC treated surgically was 54% for stage I, 36% for stage II, 37% for stage III and 20% for stage IV.

Conclusions:
Clearly, the future looks for improvement in dealing with lung cancer. Hopefully over time, screening efforts will find cancers at earlier stages with better success rates. Currently, it is felt that individuals over the age of 55 with a more than 30-pack-year history of smoking who have not stopped smoking more than 15 years ago are at particular risk for lung cancer and ought to consider screening with yearly CAT scans. Additional risk factors do include radon exposure, occupational asbestos exposure, a family history of lung cancer, a personal history of lung cancer, or a history of underlying lung disease such COPD or pulmonary fibrosis. In addition, second-hand smoke exposure is a risk factor.

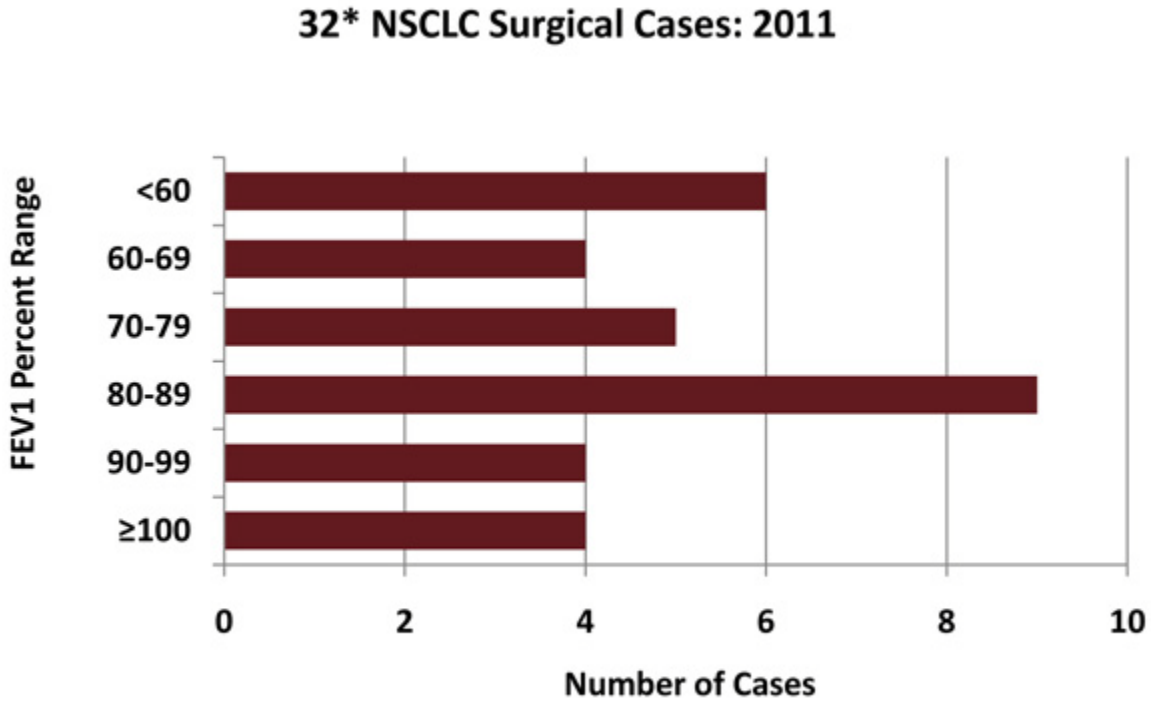
A second recommendation would be tobacco cessation since clearly the vast majority of lung cancers are associated with the use of tobacco. Another recommendation is continued research into the biology of lung cancer, looking for the driving mutations that cause lung cancer. This type research will lead to better treatments and better success.

Observations:

Age at Diagnosis

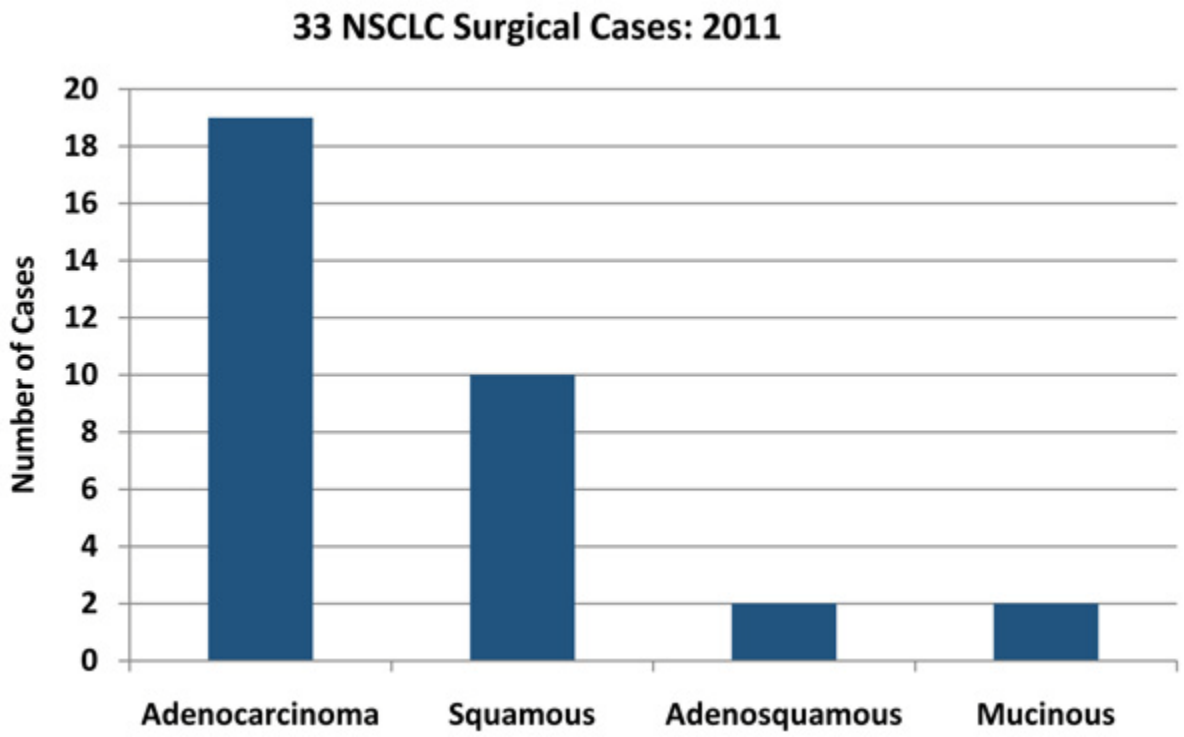


FEV1 Status

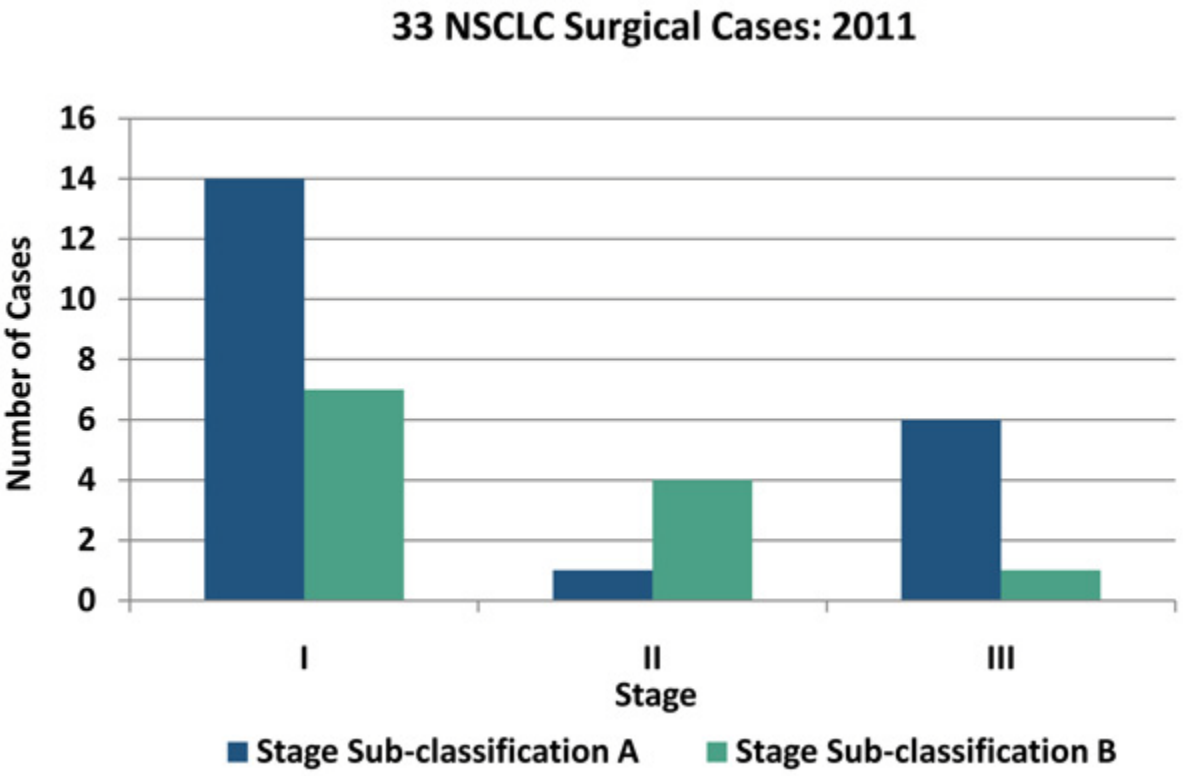


** One case did not have FEV1 documented (workup and surgery not done locally).*

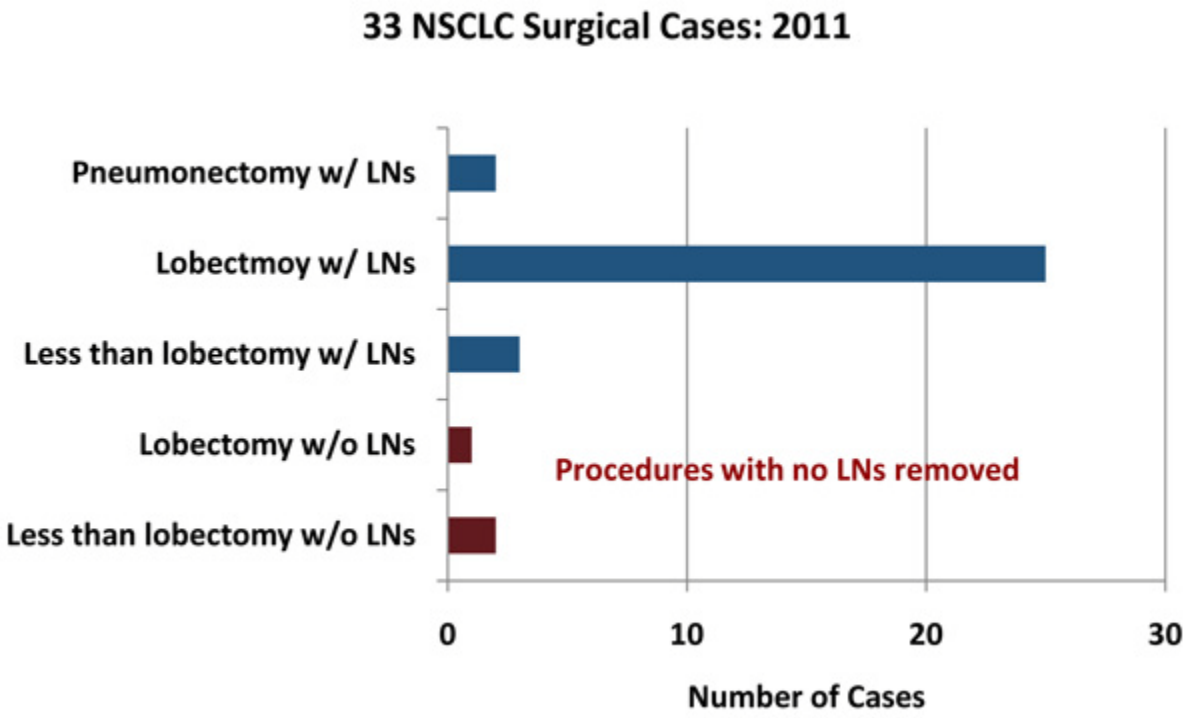
Histology Subtype



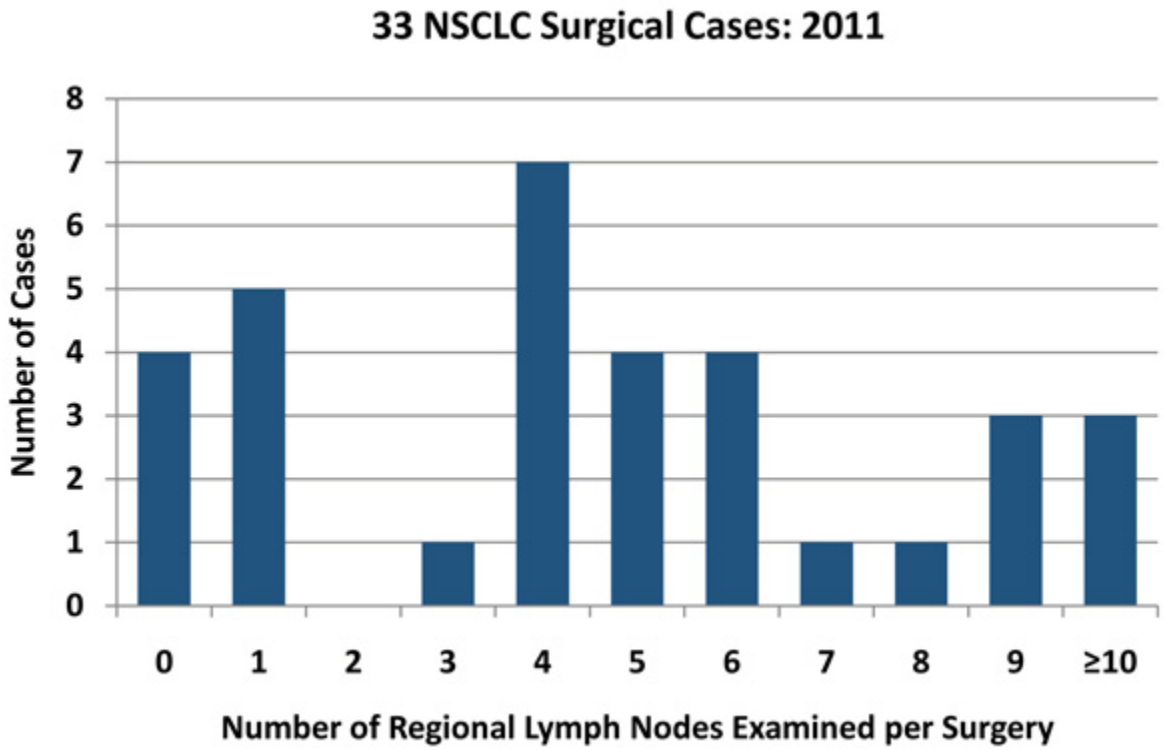
Stage at Diagnosis



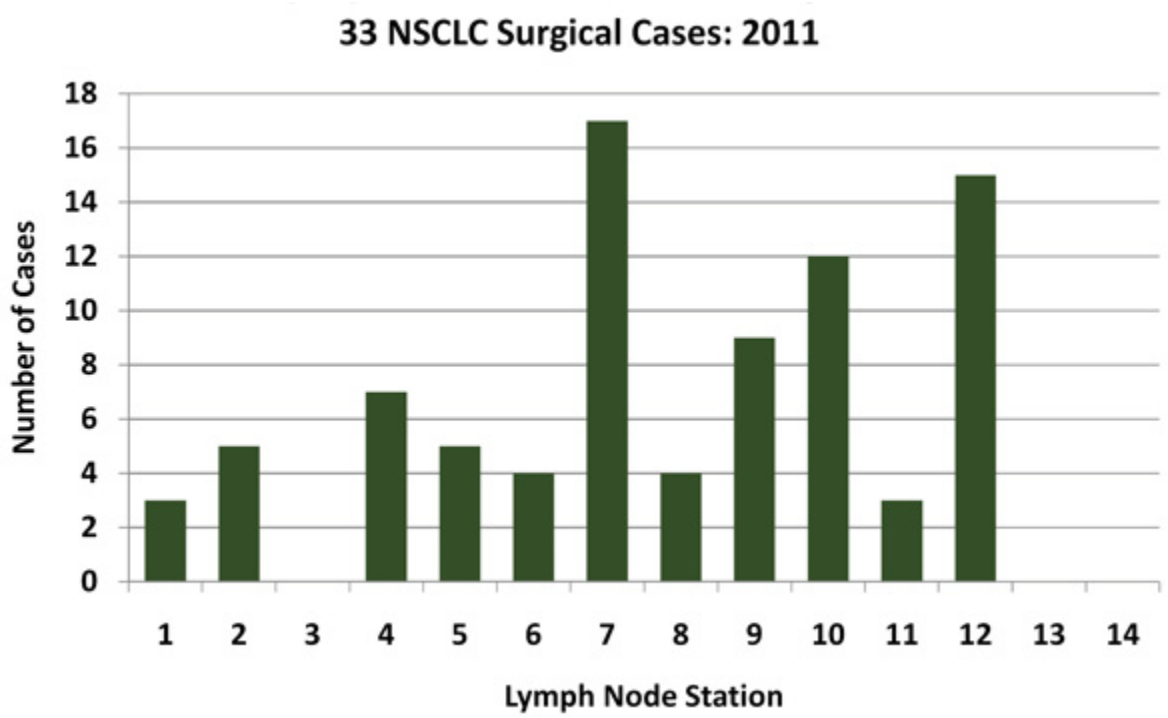
Surgical Procedures



Number of Lymph Nodes Examined



Lymph Node Stations Sampled

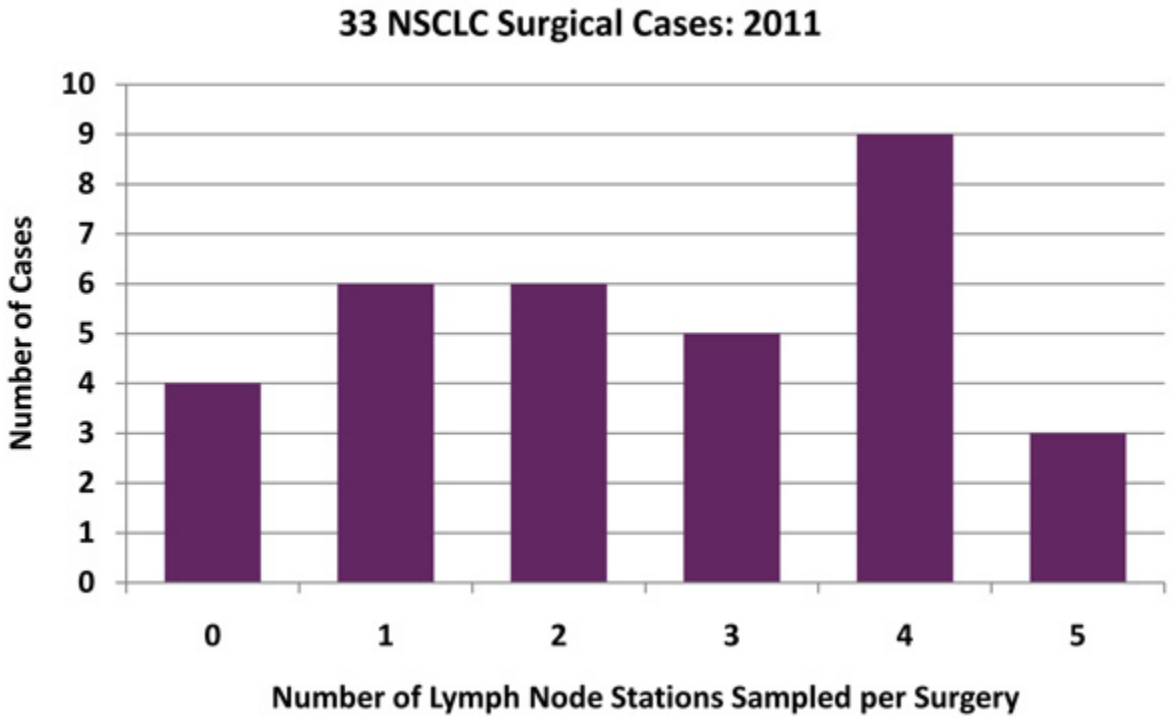


Regional Lymph Node Stations for Lung Cancer (AJCC Cancer Staging Manual, 7th ed.)

Mediastinal Lymph Node Stations (N2):
1 Highest mediastinal
2 Upper mediastinal
3 Pre-vascular & retrotracheal (includes Azygos nodes)
5 Subaortic (A-P windows)
6 Para-aortic (ascending aorta or phrenic)
7 Subcarinal
8 Paraesophageal (below carina)
9 Pulmonary ligament

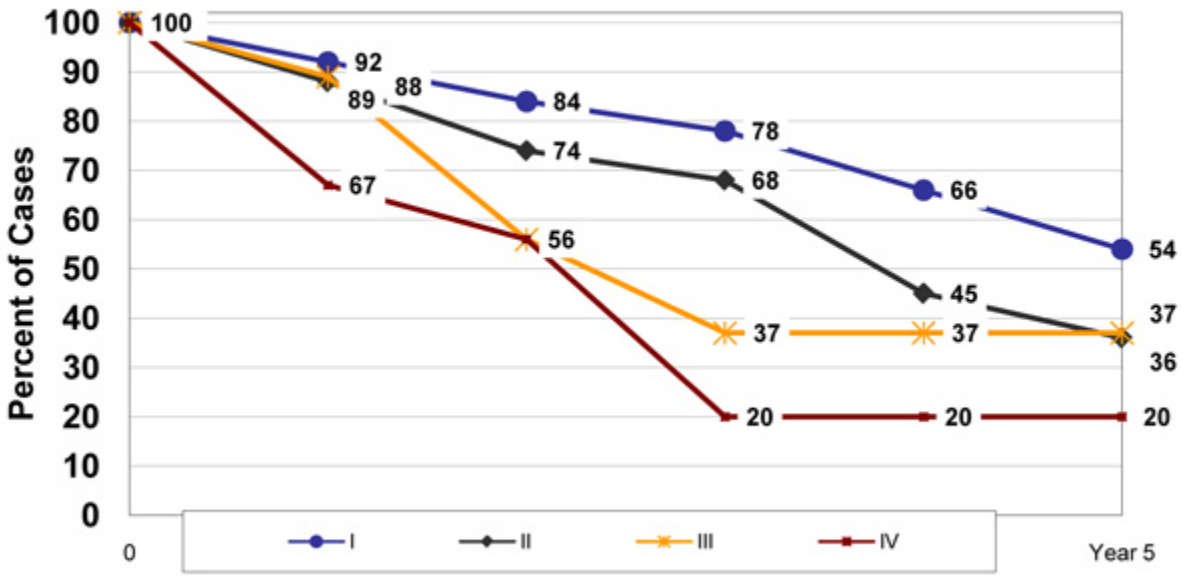
Peripheral Lymph Node Stations (N1):
10 Hilar
11 Interlobar
12 Lobar
13 Segmental
14 Subsegmental

Numbers of Lymph Node Stations Sampled



Survivals by Stage:
CCCR patients who meet the criteria for surgical resection of their NSCLC demonstrate an improved survival over the general population of lung cancer patients. The 225 CCCR surgical NSCLC cases from 2004-2011 included in the survivals below used AJCC staging from the 6th edition unlike the 33 recent cases in the study which used AJCC 7th edition staging criteria. It was necessary to convert 2010 and 2011 NSCLC cases from AJCC 7th edition staging, as originally staged, to AJCC 6th edition so all cases in the survivals would be consistently staged.

NSCLC 5-YR Observed* Survivals by Stage
225 CCCR NSCLC Surgical Cases: 2004-2011



*Observed survivals include deaths from any cause.

Data from the National Cancer Data Base (NCDB), Commission on Cancer, Survival Reports were used to show the following comparison of 5-year observed survivals. The NCDB data used for the comparison was from research & teaching hospitals in Florida. Available NCDB survival data does not provide for splitting out surgical cases only. The NCDB survivals below include all modalities of first-course treatment, including surgery. NCDB data are used here to represent the general population of NSCLC patients. The following table demonstrates markedly better survivals when NSCLC lung cancer is able to be treated surgically compared to survivals of the general population of NSCLC cancer patients.

Observed 5-year survivals by stage:

	CCCR Surgical Cases	NCDB All Treatments
Stage I	54%	46%
Stage II	36%	27%
Stage III	37%	11%
Stage IV	20%	3%

Center for Cancer Care & Research (CCCR)
Total Cancer Care™

According to the American Cancer Society, approximately **117,580** Florida residents will be diagnosed with cancer in **2012** and 42,170 will die from the disease, ranking our state second in cancer mortality and incidence nationwide.

To serve the needs of this growing population, The Center for Cancer Care & Research and Moffitt Cancer Care have joined forces on an exciting new research project that could affect future generations of cancer patients here in Florida and all over the world.

A new frontier in cancer research has arrived.

Discover:

We all know that cancer is generally classified by its site of origin (lung, breast, prostate), but did you know that there are many different types of each of these cancers? In fact, with a total of over 200 different types of cancer, standard protocols and drugs seldom work in a similar manner for everyone. Physicians are struggling to find appropriate treatments that can be of benefit to every patient. For many years, the technology has been lacking to sufficiently determine why some patients respond to a certain cancer-fighting drug while others do not.

The answers could potentially lie in genetic research.

Recent advancements have made it possible to detect and test over 30,000 genes from any cancer tumor tissue. In a broad, sweeping initiative called Total Cancer Care™, top researchers, physicians and clinicians from across the country will determine and study each tumor's molecular "fingerprint." These fingerprints are unique to every tumor just as your fingerprints are unique in identifying you. Through the collection of hundreds of thousands of genetic profiles, researchers hope to develop drug therapies that are more personalized to work for each individual.

None of this will be possible, of course, without the assistance of our area residents who have cancer.

Translate:

Participants in the study are making an invaluable contribution to the future of cancer care, but their involvement will be minimal and will require no additional testing or cost. In accordance with HIPAA regulations, the patient's medical information will remain private. Here's how Total Cancer Care™ works:

- Patient information regarding treatment modalities and response to treatment are collected to provide a "real world look" at treatment outcomes. Excess tumor specimens might be collected from certain disease cohorts in addition to the treatment data to provide genetic information to enhance the clinical data.

As the study expands and evolves, new clinical trials will be made available to participants of the program. The information compiled from these trials, as well as the genetic research, will be interpreted to create simpler and more effective treatments.

Deliver:

The Moffitt Cancer Center in Tampa serves as the study's epicenter and has enlisted 17 consortium sites throughout the country to assist in this endeavor. These consortium sites ensure that patients will be able to reap the benefits of Moffitt's world-renowned expertise and resources without leaving their own communities.

The Center for Cancer Care & Research, which has been an affiliate of Moffitt since its inception, is the only cancer clinic in the area involved in this groundbreaking project. During **2011**, CCCR enrolled **407**

participants in the program. There are currently more than **2,400** patients enrolled at the Center for Cancer Care & Research.

Through expert care, advanced technologies, clinical trials and the progressive research made possible through studies like Total Cancer Care™, CCCR remains committed to improving the odds in the fight against cancer.

Sources for Information on Cancer:

American Cancer Society (ACS)
800-227-2345 • www.cancer.org

American College of Surgeons (ACoS)
800-621-4111 • www.facs.org

American Institute for Cancer Research (AICR)
800-843-8114 • www.aicr.org

American Lung Association
www.lungassociation.org

Centers for Disease Control and Prevention (CDC)
www.cdc.gov

Commission on Cancer (CoC))
312-202-5009 • http://facs.org/cancer

Florida Cancer Data System (FCDS)
305-243-4600 • http://fcds.med.miami.edu/

Florida Department of Health (FDH)
www.doh.state.fl.us

Leukemia Lymphoma Society
800-955-4572 • www.leukemia-lymphoma.org

National Cancer Institute (NCI)
800-4CANCER • www.cancer.gov

Susan G. Komen
800-468-9273 • www.komen.org

Glossary of Terms:

Cancer Case – a single primary cancer; a patient diagnosed with more than one primary cancer will represent more than one case in a cancer registry database.

Chemotherapy – drugs that work directly on cancer cells to kill them or slow their growth.

Class of Case – categories of cases based on their relationship to the reporting facility; classes relevant to the CCCR are as follows:

- **Analytic (classes 00-22)** – diagnosed and/or received first-course, cancer-directed treatment at the reporting facility.
- **Class 30** – newly diagnosed cases but first diagnosis and all first-course treatment elsewhere, includes cases where further diagnostic workup, staging workup or treatment planning is performed at the reporting facility or any care provided while patient has newly diagnosed active disease; new category for 2010 cases. Several types of cases once considered analytic by the CoC were moved into class 30 and are no longer reported to NCDB. Class 30 cases are required to be reported to FCDS.
- **Non-analytic (classes 30-37)** – diagnosed and all first-course treatment provided elsewhere before patient presented with persistent or recurrent disease.

Collaborative Staging (CS) System – staging system developed by the Surveillance, Epidemiology and End Results (SEER) program of the National Cancer Institute (NCI). CS is based on extent of disease and AJCC cancer staging guidelines. CS differs from AJCC staging in that CS stages may mix clinical and pathological T, N, and M to arrive at a complete "best" stage. While AJCC staging applies strict guidelines for identifying homogeneous populations for research, CS staging is more similar to how clinicians stage when developing a treatment plan.

- **T** – defines extent, and sometimes the size, of the primary tumor.
- **N** – defines involvement of regional lymph nodes.
- **M** – defines contiguous or noncontiguous spread to distant site.
- **Stage grouping** – based on the combination of T, N, M and sometimes other prognostic factors; represented by a concise group-stage code that indicates overall cancer extent and expected prognosis.

Hormone Therapy – drugs that work indirectly on hormone-sensitive cancer cells by modifying specific hormones in the body's hormone system.

Initial Therapy – first planned course of treatment designed to eliminate, control or palliate a patient's cancer. Initial therapy may also be active surveillance or a decision for comfort and support measures only.

Metastasis – cancer cells that have spread from the initial primary site to site(s) elsewhere in the body, usually by way of the lymphatic or circulatory system; may be regional or distant:

- **Regional Metastases** – cancer that has spread to tissues, lymph nodes or organs that are close to the primary site and are listed as regional in a standard staging system.
- **Distant Metastases** – cancer that has spread to tissues, lymph nodes or organs that are usually not in proximity to the primary site and are listed as distant in a standard staging system.

Reportable Tumor – tumor that meets criteria for reporting to the CoC and/or FCDS; most reportable tumors are malignant but benign central nervous system tumors were added to the list of reportable tumors beginning January 1, 2004. Chronic myeloproliferative disorders and myelodysplastic syndromes were added beginning January 1, 2001.

Acronyms:

ACS	American Cancer Society
ACOS	American College of Surgeons
AJCC	American Joint Committee on Cancer
CCCR	Center for Cancer Care & Research
CoC	ACOS Commission on Cancer
DOH	Department of Health
FCDS	Florida Cancer Data System (State Cancer Registry), Program of the DOH
NCCN	National Comprehensive Cancer Network
NCDB	National Cancer Data Base
NCI	National Cancer Institute
SEER	Surveillance, Epidemiology and End Results program of the NCI