



The Center for Cancer Care 2016 Cancer Program Annual Report

CHAIRMAN'S MESSAGE

The focus site for the annual Cancer Committee report for 2016 is colon cancer.

Dr. Chad Cabral DO reviewed the Exeter Hospital community experience with colon cancer and presents an update on changes to recommendations for screening, treatment, and follow up for patients with colon cancer.

Dr. Cabral joined the Exeter Hospital staff in June, 2012. After a Bachelor of Science Cum Laude degree in Medical Laboratory Science from University of Massachusetts at Dartmouth, he obtained his medical degree at the University Of New England College Of Osteopathic Medicine. He completed medical internship, residency, Chief Resident year, and Gastroenterology fellowship at Lahey Clinic Medical Center in Burlington, Massachusetts. His academic awards include the Medical Laboratory Science Freshman Book Award, the Chancellor's Merit Scholarship Award, Charter Membership in the Delta Mu Chapter of Lambda Tau National Honorary Medical Technologist Society, the Women & Infants' Hospital Service Award, and an Excellence in Teaching Award. He is a Clinical Instructor of Medicine at Tufts University School of Medicine, with extensive clinical teaching and preceptorship. He has given multiple continuing medical education presentations on various topics in gastroenterology and has multiple medical publications.

The Cancer Committee thanks Dr. Cabral for providing his insight to our current progress in managing colon cancer. As always, we are grateful for the support of Exeter Health Resources and the community at large to the cancer programs at Exeter Hospital and the Center for Cancer Care.

Respectfully submitted,

Kathleen Kelly, MD, CWSP



"Tropical Beach" – Artist Melanie R.

CANCER COMMITTEE

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Exeter Hospital, Inc., Cancer Registry

Heather Ciccarelli

American Cancer Society, Community Executive

Cancer Registries are a powerful, essential tool in the battle against cancer. Successful cancer programs mine the data contained within their cancer registries to identify areas where they can improve health for patients, at-risk populations, and their communities.

Cancer Registries maintain a wide range of demographic and medical information such as:

- Demographic information includes age, gender, race/ethnicity, birthplace, and residence.
- Medical history includes physical findings, screening information, occupation, and any history of previous cancer.
- Diagnostic findings including types, dates, and results of procedures used to diagnose cancer.
- Cancer information, including primary site, cell type, and extent of disease.
- Cancer therapy, including surgery, radiation therapy, chemotherapy, hormone, or immunotherapy.
- Follow up, including annual information about treatment, recurrence, and patient status.

Cancer registrars ensure that timely accurate and complete data are maintained on all types of cancer diagnosed and / or treated within a health care institution or within a population.

Confidentiality of patient identifying information and related medical data is strictly maintained. The data is then sent to the central cancer registry. Every year the central cancer registries electronically submit demographic and clinical information to CDC National Program of Cancer Registries (NPCR) or National Cancer Institute (NPI's) Surveillance, epidemiology, and End Results (SEER). None of the information submitted contains identifying information about individual patients.

In brief, the importance of cancer registries lies in the fact that they collect accurate and complete cancer data that can be used for cancer control and epidemiological research, public health program planning, and patient care improvement. Ultimately, all of these activities reduce the burden of cancer.

Cancer Registry staff

Autumn Bridges, CTR
Marie Wilcox, Registry Admin Assistant



"English Robin" – Artist Val R.

Overview of the Thoracic Multidisciplinary Clinic

The Center for Cancer Care at Exeter Hospital has a strong commitment to the multidisciplinary approach of every cancer patient. It offers patients and their families the opportunity to be evaluated by a team of physicians on the same day, which results in a faster and more comprehensive plan. It also allows for a better communication among the physician team members and a multi-layered review of each case by experts.

Patients with a new diagnosis of a thoracic malignancy are guided through the process by the nurse navigator. After the initial work up, each case is reviewed during a conference attended by radiology, pathology, pulmonary, thoracic surgery, medical and radiation oncology, as well as nursing, physical therapy, and clinical research members. Following this review, the patients are seen by the appropriate physicians, depending on the individual's needs.

The thoracic clinic, now in its fourth year, can evaluate patients within one week of referral and offers a large gamut of procedures and treatments for every case. This includes biopsies for diagnosis and staging by the interventional radiology and pulmonary groups (through CT guidance, endobronchial ultrasound or navigational bronchoscopy), thoracic surgery, radiation therapy (standard or stereotactic), chemotherapy, targeted therapy, immunotherapy and clinical trials.

Access to complex thoracic surgical procedures and an expanded array of trials is also available through our affiliation with the Massachusetts General Hospital Cancer Center.

As of 2017, Dr. Doug Mathisen, the Chief of Thoracic Surgery at the Massachusetts General Hospital, will be attending every conference of the multidisciplinary clinic to offer his invaluable insight.

Lung Cancer Screening Program

Screening for lung cancer can detect tumors at an earlier stage, with a higher chance for cure. Exeter Hospital has an established Lung Cancer Screening program with low dose CT scans in high risk populations. Patients are referred through their primary care physicians, or specialists to the screening program. After the CT scan is performed, results are relayed to the referring physician. Larger lesions are also reviewed in a dedicated conference, attended by radiology, pulmonary, medical oncology, thoracic surgery and nurse navigation. All scans undergo both physician and automated software-based evaluation and all results are reported to the national database maintained by the American College of Radiology.

By Dr. Panos Fidas

2016 EXETER HOSPITAL CANCER CARE DATA

EXETER HOSPITAL PRIMARY SITES 2015

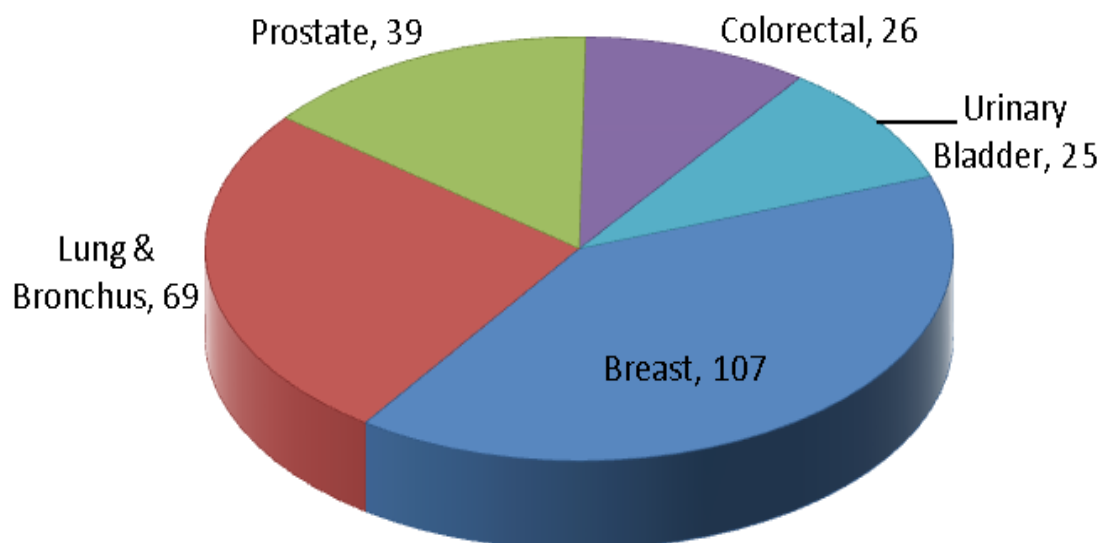
Primary Site	Total	Male	Female
ORAL CAVITY & PHARYNX	18	11	7
Tongue	6	4	2
Salivary Glands	1	0	1
Gum & Other Mouth	2	1	1
Tonsil	3	3	0
Oropharynx	1	1	0
Hypopharynx	3	2	1
Other Oral Cavity & Pharynx	1		1
DIGESTIVE SYSTEM	77	53	24
Esophagus	10	9	1
Stomach	6	3	3
Small Intestine	5	4	1
Colon Excluding Rectum	14	10	4
<i>Cecum</i>	2	2	0
<i>Appendix</i>	2	2	0
<i>Ascending Colon</i>	1	0	1
<i>Hepatic Flexure</i>	1	1	0
<i>Transverse Colon</i>	2	2	0
<i>Descending Colon</i>	1	1	0
<i>Sigmoid Colon</i>	4	2	2
<i>Large Intestine, NOS</i>	1	0	1
Rectum & Rectosigmoid	9	5	4
Anus, Anal Canal & Anorectum	5	2	3
Liver & Intrahepatic Bile Duct	8	6	1
<i>Liver</i>	7	6	1
<i>Intrahepatic Bile Duct</i>	1	0	1
Gallbladder	1	0	1
Other Biliary	3	3	0
Pancreas	15	11	4
Other Digestive Organs	1	0	1
RESPIRATORY SYSTEM	76	35	41
Nose, Nasal Cavity & Middle Ear	2	0	2
Larynx	5	5	0
Lung & Bronchus	69	30	39
SOFT TISSUE	2	2	0
Soft Tissue (including Heart)	2	2	0
SKIN EXCLUDING BASAL & SQUAMOUS	18	10	8
Melanoma -- Skin	17	9	8
Other Non-Epithelial Skin	1	1	0
BREAST	106	2	104
Breast	106	2	104
FEMALE GENITAL SYSTEM	13	0	13
Cervix Uteri	2	0	2
Corpus & Uterus, NOS	5	0	5
Ovary	3	0	3
Vulva	3	0	3
MALE GENITAL SYSTEM	62	62	0
Prostate	58	58	0
Testis	4	4	0
URINARY SYSTEM	28	21	7
Urinary Bladder	25	18	7
Kidney & Renal Pelvis	3	3	0
BRAIN & OTHER NERVOUS SYSTEM	19	8	11
Brain	7	5	2
Cranial Nerves and Other Nervous System	12	3	9

ENDOCRINE SYSTEM	21	5	16
Thyroid	18	5	13
Other Endocrine including Thymus	3	0	3
LYMPHOMA	19	9	10
Hodgkin Lymphoma	1	0	1
Non-Hodgkin Lymphoma	18	9	9
<i>NHL – Nodal</i>	16	9	7
<i>NHL – Extranodal</i>	2	0	2
MYELOMA	15	12	3
Myeloma	15	12	3
LEUKEMIA	10	4	6
Lymphocytic Leukemia	5	1	4
Myeloid & Monocytic Leukemia	2	1	1
<i>Acute Myeloid Leukemia</i>	1	1	0
<i>Chronic Myeloid Leukemia</i>	1	0	1
MESOTHELIOMA	4	2	2
Mesothelioma	4	2	2
MISCELLANEOUS	22	7	15
Miscellaneous	22	7	15
TOTAL	491	224	267

2015 Cancer Care Data

CASES	
Initial diagnosis at our facility AND all treatment or decision not to treat was done elsewhere.	66
Initial diagnosis at our facility or in an office of a physician with admitting privileges AND part or all of first course treatment or a decision not to treat was at our facility.	7
Initial diagnosis in an office of a physician with admitting privileges AND part of first course treatment was done at our facility.	11
Initial diagnosis in an office of a physician with admitting privileges AND all first course treatment or decision not to treat was done at our facility.	66
Initial diagnosis in an office of a physician with admitting privileges AND part of first course treatment or decision not to treat was done at our facility; part of first course treatment was done elsewhere.	30
Initial diagnosis at the reporting facility AND all first course treatment or decision not to treat was done at our facility.	213
Initial diagnosis elsewhere AND part of the first course treatment was done at our facility; part of the first course treatment was done elsewhere.	67
Initial diagnosis elsewhere AND all the first course treatment or decision not to treat was done at our facility; part of the first course treatment was done elsewhere.	27

Top Five Sites for 2015



"Autumn Barn" – Artist Ila F.

Community outreach, prevention and screening programs are essential components of a comprehensive cancer program. The Executive Cancer Committee uses Exeter Hospital's annual community needs assessment to identify cancer prevention, screening and community outreach activities and collaborate across our system of care to deliver these activities to patients and members of our community. In 2015 and 2016, there were a combined total of 5,458 encounters in our system-wide community outreach, prevention and screening programs.

Community Outreach: 5,075 encounters (2015: 2,712 encounters; 2016: 2,363 encounters)

Community education and outreach focus on events and educational activities that are free of charge, and are augmented by newspaper articles and social media. The goals of these activities range from promoting healthful lifestyle behaviors that reduce cancer risk to helping people understand the importance of advance care planning and advance directives for end-of-life care. Health fairs and health education at local schools and businesses, the Exeter Hospital/Core Physicians Health and Wellness Lecture Series, and advance care planning classes are some examples of the live educational activities offered. Events include our annual participation in National Healthcare Decisions Day, and the American Cancer Society's™ Making Strides Against Breast Cancer-- -Exeter Hospital has been the lead sponsor for the Exeter event--and The Great American Smoke-Out.

Prevention Programs: 288 encounters (2015: 128 encounters; 2016: 160 encounters)

- **Your Weigh to Wellness:** An 8-week weight management program for adults, this program emphasizes making healthy food choices, exercise and physical activity, and mindful behaviors to reach and/or maintain a healthy weight. Of the 26 participants who turned in evaluations, 22 reported weight loss at the end of 8 weeks averaging 6.5 pounds with a range of 2 to 22 pounds.
- **Better Choices, Better Health:** Stanford University developed this evidence-based self-management program for adults with chronic health conditions. Topics and tools addressed in the 6-week workshop are common to self-management of all chronic conditions and include healthy eating, exercise and physical activity, stress management /relaxation techniques, and action planning.

Because tobacco use is a chronic condition, the workshop is a resource for adults who are thinking about or preparing to quit smoking. The workshop also has a cancer survivorship benefit: 35 of 184 participants who completed a voluntary demographics survey reported a history of cancer among the chronic conditions they were managing.

Screening Programs: 95 encounters (2015: 20 encounters; 2016: 75 encounters)

In April, 2015, we collaborated with Core Physicians to offer free oral, head and neck cancer screenings to observe Oral Head and Neck Cancer Week. The physicians of Core Comprehensive Otolaryngology and Audiology screened 20 adults aged 25 to 85 at two locations in our service area. Articles in Seacoast Newspapers augmented the educational outreach for this endeavor and featured the spouse of one of our head and neck cancer patients, whose mission to raise awareness of oral head and neck cancers inspired us to offer these screenings.

The National Lung Screening Trial proved that low dose computed tomography (LDCT) can find lung cancer at its earliest stages in adults at high risk for lung cancer. The National Lung Screening Trial showed 20 percent fewer lung cancer deaths in study subjects who were screened with LDCT, making LDCT the first and only cost-effective screening test shown to reduce lung cancer deaths. In April, 2016, Exeter Hospital launched its Lung Cancer Screening Program. Developed and implemented by a multidisciplinary team of Exeter Hospital/Center for Cancer Care leadership, physicians representing primary care, radiology, oncology, pulmonology, thoracic surgery, and nurses and other clinicians, the program follows national, evidence-based guidelines to ensure that eligible adults have access to LDCT, one of the most important breakthroughs in cancer screening and early detection. As of December 31, 2016, 75 high-risk adults have been screened.

By Wendy Lannon, MS, RN, ACSM-CEP

Colon Cancer: Overview and Updates in 2016

By Chad M. Cabral, MD
Core Gastroenterology
Exeter Hospital Center for Cancer Care

Colorectal cancer is a common disease. It is estimated that about 134,490 new cases of colon cancer are diagnosed annually in the United States (approximately 95,270 cases of colon cancer and 39,220 cases of rectal cancer). About 49,190 Americans are expected to die of colon cancer each year. It still remains the third most common cause of cancer death in the United States.

Patients with colorectal cancer may present with suspicious symptoms or be asymptomatic (discovered by routine screening). Although the increasing uptake of colorectal screening has led to more patients being diagnosed at an asymptomatic stage, 80 percent are diagnosed after the onset of symptoms. Typical symptoms associated with colorectal cancer include hematochezia (or melena), change in bowel movements, abdominal pain, or iron deficiency anemia.

Most colorectal cancers start as a growth on the inner lining of the colon or rectum called a polyp. Some types of polyps can change into cancer over the course of several years, but not all polyps become cancer. The ones that can sometimes change into cancer are called adenomatous polyps or adenomas. Dysplasia is another pre-cancerous condition where an area of a polyp or the lining of the colon or rectum shows cells that look abnormal. Adenocarcinomas make up more than 95 percent of colorectal cancers. Other, less common types of tumors can also start in the colon and rectum. These include carcinoid tumors, gastrointestinal stromal tumors (GISTs), lymphomas, and sarcomas.

Although most colorectal cancers are sporadic, specific genetic disorders have been identified, most of which are autosomal dominant. Familial adenomatous polyposis (FAP) and Lynch syndrome (hereditary nonpolyposis colorectal cancer or HNPCC) are the most common of the familial colorectal cancer syndromes, but together these two conditions account for only about 5 percent of cases. FAP carries a 90 percent risk of colorectal cancer by the age of 45 in the absence of prophylactic colectomy. HNPCC carries a 25 to 75 percent lifetime risk of colorectal cancer.

Colonoscopy is the most accurate and versatile diagnostic test for colorectal cancer because it can localize and biopsy lesions throughout the colon, detect synchronous neoplasms, and remove polyps. The vast majority of colorectal cancers are endoluminal masses that arise from the mucosa and protrude into the lumen. A minority of cancerous lesions in the colon or rectum are nonpolypoid and flat (or depressed). Other modalities for colorectal screening include flexible sigmoidoscopy, CT colonography (virtual colonoscopy), guaiac-based fecal occult blood test, fecal immunochemical test (FIT), and the FIT-DNA (Cologuard) assay.

The stage (extent of spread) of a colorectal cancer depends on how deeply it grows into the wall and if it has spread outside the colon or rectum. The Tumor Node Metastases (TNM) staging system of the American Joint Committee on Cancer/Union for International Cancer Control is the preferred staging system for colorectal cancer. The three components include primary tumor (T), status of the regional nodes (N), and distant metastasis (M), which together are combined to form stage groupings, from I to IV. The stage is one of the most important factors in deciding how to treat the cancer and determining how successful treatment might be.

Approximately 80 percent of cancers are localized to the colon wall and/or regional lymph nodes. Surgery is the only curative modality for localized colon cancer. Restoration of bowel continuity using a primary anastomosis can be accomplished in most patients undergoing an uncomplicated colectomy. The goal of surgery for invasive colon cancer is complete removal of the tumor, the major vascular pedicle, and the lymphatic drainage basin of the affected colonic segment.

Neoadjuvant (preoperative) chemoradiotherapy rather than initial surgery is a common approach for locally advanced rectal cancer. For patients who have undergone potentially curative resection of a colon cancer, the goal of adjuvant (postoperative) chemotherapy is to eradicate micrometastases, thereby reducing the likelihood of disease recurrence and increasing the cure rate (clearly demonstrated in patients with stage III disease). For patients with node positive colon cancer, a six month course of oxaliplatin-containing chemotherapy is generally recommended for most patients. The most commonly used oxaliplatin-based regimens are FOLFOX (oxaliplatin plus short term infusional fluorouracil and leucovorin) and CAPOX (also known as XELOX: oxaliplatin plus oral capecitabine). Patients with stage II disease are more often offered a regimen that does not include oxaliplatin (typically leucovorin-modulated fluorouracil or single agent oral capecitabine).

Approximately 20 percent of newly diagnosed colon cancers are metastatic at presentation. The most common distant metastatic sites are liver, lungs, lymph nodes, and peritoneum. Although major advances in systemic chemotherapy have expanded the therapeutic options for these patients, only a few are free of disease unless resection or ablation of metastases has been performed. Surgery provides a potentially curative option for selected patients with limited metastatic disease (predominantly in the liver and lung). Even patients who are not candidates for a curative resection can benefit from surgical palliation for symptoms of obstruction and bleeding from the primary tumor.

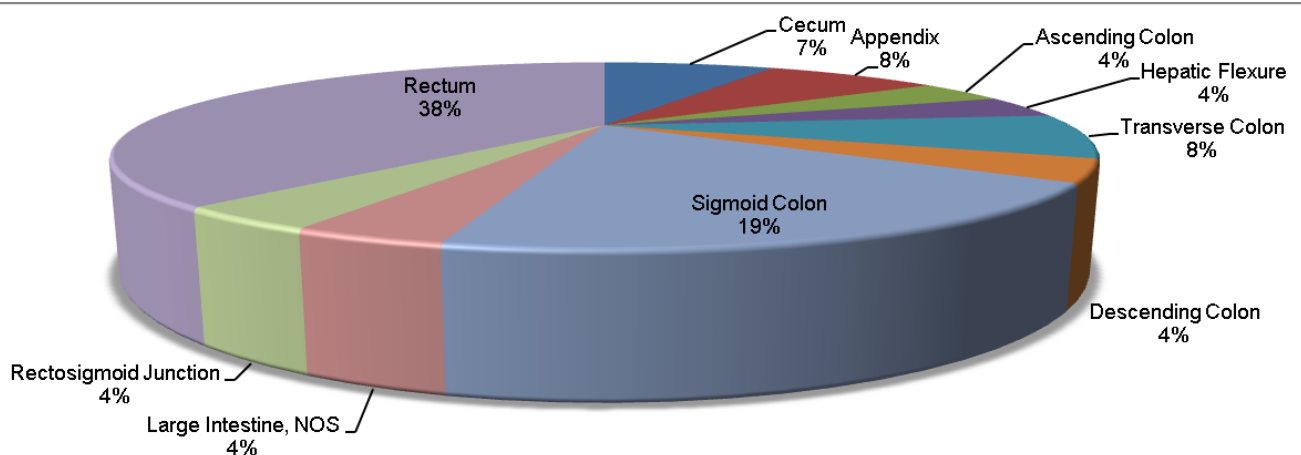
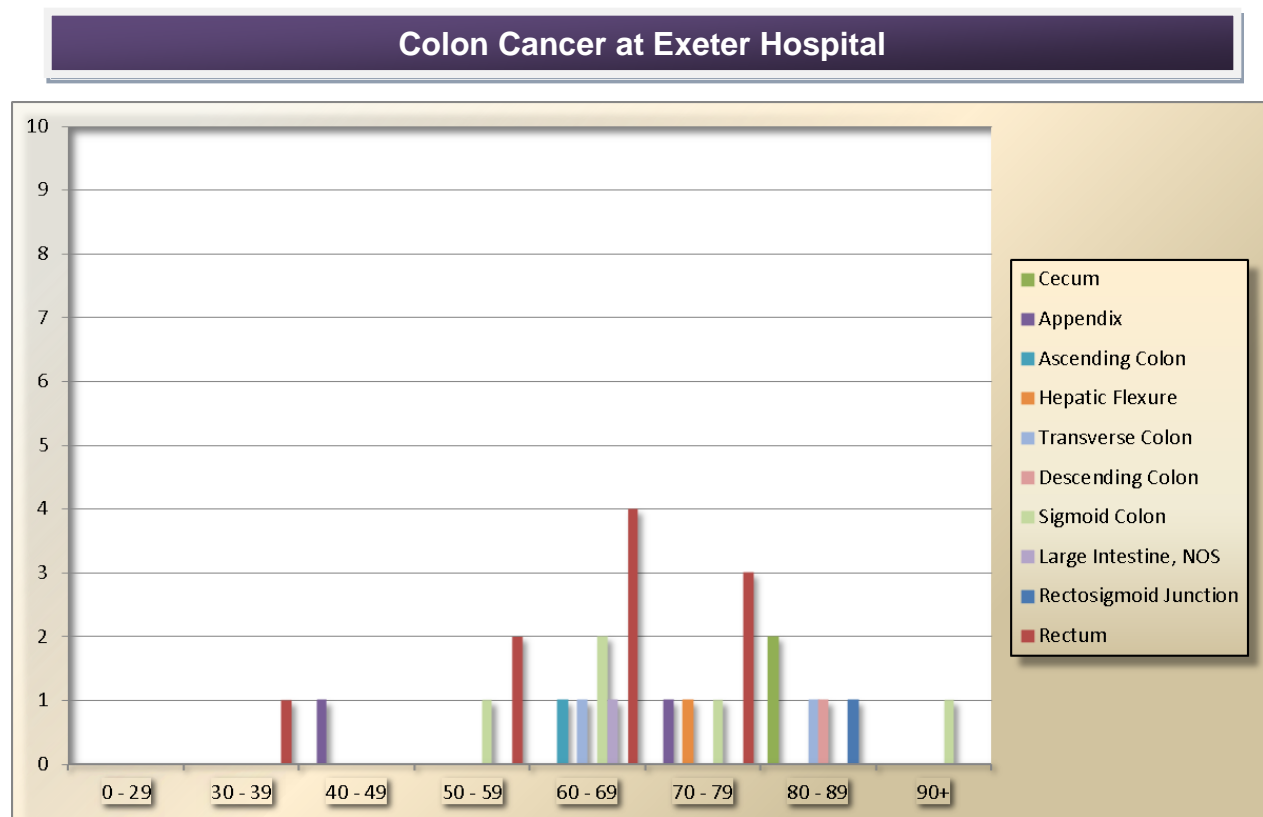
The most important indicator of outcome following resection of colon cancer is the pathologic stage at presentation. Most of the available prognostic estimates use five-year survival as the endpoint, given that most recurrences develop within this time frame. In data derived from the 20,800 patient ACCENT database of patients undergoing adjuvant

COLON CANCER cont.

chemotherapy for stage II or III colon cancer, recurrence rates after five years never exceeded 1.5 percent annually, and after eight years, they were 0.5 percent per year. As a result, the survival probability after a given length of survival improves dramatically after 5 years.

Following treatment for a stage II or III colon cancer, post treatment surveillance usually consists of periodic history

and physical examination with serial CEA (carcinoembryonic antigen) tests, annual surveillance CT scans, and colonoscopy to detect metachronous primaries. Whether or not post treatment surveillance is needed after a resection of a stage I colon cancer is controversial. However, most recommend only periodic history and physical examination and colonoscopy.





"Pumpkin Still Life" – Artist Paul F.

Mission

The mission of the Center for Cancer Care at Exeter Hospital is to improve the health of our community by providing care to individuals as well as their families, and to prevent the development of cancer when possible.

THE CENTER FOR CANCER CARE CONTACT INFORMATION

Toll Free	866-939-3837	
Medical Oncology	603-580-7336	Fax 603-580-6747
Radiation Oncology	603-580-7337	Fax 603-580-7107



ARTWORK

Kathleen Robbins, MFA, is an artist and instructor to cancer survivors who participate in the Healing Arts Program, a weekly class available to adults interested in learning basic art technique. Kathleen also provides twice weekly one-on-one art sessions to patients in the infusion area and weekly painting demonstrations.

Watercolor – "Fuchsia Blooms" – Artist Melanie Robert

A Community Hospital Comprehensive Cancer Program

Published by Exeter Hospital Cancer Committee

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