KENT HOSPITAL CANCER PROGRAM
ANNUAL REPORT
2021/2013

Commission on Cancer®
ACCREDITED PROGRAM

Kent Hospital 455 Toll Gate Rd, Warwick, RI 02886
401-737-7000

THE CANCER PROGRAM AT KENT HOSPITAL

The Cancer Program at Kent Hospital offers a comprehensive range of services delivered by a dedicated team of professionals using the latest technology, offering patients and their families hope and compassion.

A multi-disciplinary team of cancer professionals work with patients to create an individual treatment plan based on the diagnosis.

Services

- Inpatient/Outpatient surgical facilities
- Medical Oncology
- Radiation Therapy
- Rehabilitation Therapy
- Home Care

Inpatient care is provided in our 29-bed oncology unit, an outpatient chemotherapy/infusion unit and a full range of diagnostic imaging and laboratory services. Both oncology units feature an experienced team of physicians and oncology certified nurses.

The Cancer Committee at Kent Hospital meets quarterly to oversee the program and to develop public education and screening programs. Our program is accredited with commendation by the American College of Surgeons Commission on Cancer, as a Community Hospital Cancer Program, and the American College of Radiology accredits our Mammography Program.

Research

Kent's Cancer Program participates in a number of clinical research trials, offering cutting edge treatments to our patients.

Emotional Support

While the physical struggle in the fight against cancer is not easy, the emotional struggle can be equally challenging. All cancer patients have access to clinical social workers for complete psychosocial assessment of physical, psychological, social, spiritual, financial, survivorship and resource needs. Clinical social work services are also available to support patient caregivers and families.

Complete Care, Close to Home

With the Cancer Program at Kent Hospital, the facilities and treatment you need are conveniently located in central Rhode Island. Which means patients, families and friends can remain close, which is important during treatment.

Care, Compassion, Hope

Care, Compassion and Hope are more than just words, they are the foundation of our program. With the proper resources, including a dedicated medical staff, up-to-date treatment and caring support close to home, the Cancer Program at Kent Hospital has everything you and your family need.

CANCER COMMITTEE MEMBERSHIP

Jim Beardsworth, Public Relations

Joanne Carlson, RN, Outpatient Infusion

Angela DeRobertis, MD, Radiation Oncology

Candace Dyer, MD, Breast Health Center

Sharon D'Ambrosia, Ms, EdD, Social Services

Maureen Casey, MBA, RN, CPHQm Quality Improvement

Fran Falsey, Administration

Alexandra Fiore, American Cancer Society

Pam Hill, RD, Nutrition

John Isaac, MD, Cancer Liaison Physician

Kate Lally, MD, Palliative Care

Philip Maddock, MD, Radiation Oncologist

Kim McDonough, RN, Breast Health Center

Paul McKenney, MD, Administration

Laurie Miller, CTR Cancer Registry/Research Office

Linda Millerick, Cancer Registry/Research Office

Naveed Rana, MD, Medical Oncology

Courtney Nelson, Oncology Social Work

Deborah Nenno, RN, Inpatient Oncology

Patricia Racioppi, RPh, Pharmacy

Laurie Reeder, MD Thoracic Surgery

Rev. David Ricard, Pastoral Care

David Rowe, MD, Diagnostic Imaging

Bachir Sakr, MD, Cancer Committee Chair

Jennifer Wilbur-Scalia, Genetics

Nancy Whitaker, RN, Community Representative

Jane White, LPN, Research

Cunxian Zhang, MD, Pathology

2012 Cancer Management Conferences

Kent Hospital is approved by the American College of Surgeons, Commission on Cancer as a Community Hospital Cancer Program.

One of the ways in which we can insure quality of cancer care is by conducting weekly cancer conferences. All specialties are present to discuss the various aspects of cancer patients care including, Diagnostic Radiology, Radiation Oncology, Medical Oncology, Surgery and other Allied Health Professionals.

Case presentations cover all major cancer sites seen at Kent Hospital. Presenting physicians discuss the patient's current findings, and past medical history. Radiological studies that have been done are presented to the group by the attending radiologist. Findings are reviewed as well as discussion as to types of additional studies that may be done to help with the diagnosis and/or treatment planning process. Pathology is presented to the team, including current as well as past malignancies if applicable.

Physicians from all disciplines are encouraged to present cases at these conferences. Discussion includes AJCC staging information, treatment plans, clinical trial eligibility as well as follow up care.

Three conferences per month focus on pulmonary malignancies, and are held on Monday at 7:30 am in the Auditorium. General Case Conferences are held on Wednesdays at 7:30 am in the Auditorium and the Breast Health Center Tumor Board is held every Friday at 7:30 am in the Breast Health Center Conference Room. A schedule of meetings is posted outside of the doctors cloak room.

Cancer Management Conferences are awarded 1.0 hours in category 1 credits towards the AMA Physician's Recognition Award.

Please contact the Cancer Registry at extension 1864 if you would like to present a case at this conference.

2012 Kent Hospital Tumor Board Conferences

101 Total Meetings Held

261 Total Cases Discussed

100% Cases Were Prospective In 2012

Anus – 1	**Lung - 52**
Bladder - 12	**Lymphoma - 4**
Breast - 128	**Melanoma - 1**
Colon - 23	**Pharynx - 1**
Corpus Uteri - 1	**Prostate - 4**
Endometrium -3	**Rectum - 3**
Gallbladder - 2	**Skin: MCC - 1**
Gastrointestinal - 1	**Testis - 3**
Kidney - 4	**Thyroid - 2**
Larynx - 3	**Unknown - 5**
Liver - 7	

Clinical Trials

Clinical Trials are available to all patients with a diagnosis of cancer depending on eligibility. The Cancer program participates in clinical trials as an affiliate member of the Gynecologic Oncology Group (GOG) through Woman and Infants Hospital. This gives us access to the GOG trials as well as trials offered through the Cancer Trials Support Unit (CTSU). Through this site many trials are available to our patients. These include Breast Cancer, Gastrointestinal Cancers, Genitourinary Cancers, Gynecological Cancers, Head and Neck Cancers, Leukemia, Lung Cancer, Lymphoma, Melanoma, Myeloma and Metastatic Cancers. In 2012 four patients were enrolled on clinical trials through the CTSU.

The following is a list of the clinical research trials currently open to enrollment. If you need any information regarding these trials, or other trials that may be available, please contact Jane White, at 401-737-7010 extension 31503.

Open Trials At Kent Hospital:

BREAST

NSABP B 47 - A Randomized Phase III Trial of Adjuvant Therapy Comparing Chemotherapy Alone (Six Cycles of TC or Four Cycles of AC Followed by Four Cycles of Weekly Paclitaxel) to Chemotherapy Plus Trastuzumab in Women with Node-Positive or High-Risk Node-Negative HER2-Normal Invasive Breast Cancer

NSABP B49 - Phase III Clinical Trial Comparing the Combination of Docetaxel Plus Cyclophosphamide to Anthracycline-Based Chemotherapy Regimens for Women with Node-Positive or High-Risk Node-Negative, HER2-Negative Breast Cancer

CALGB S1007 - A Phase III Randomized Clinical Trial of Standard Adjuvant Endocrine Therapy +/- Chemotherapy in Patients with 1-3 Positive Nodes, Hormone Receptor-Positive and HER2-Negative Breast Cancer with Recurrence Score (RS) of 25 or Less.

2012 Cancer Program Activity

2012 Educational Programs:

Maximizing Benefits; Minimizing Risks in Metastatic Breast Cancer, May 2, 2012 Monica Fornier from Memorial Sloan-Kettering Cancer Center.

Targeting T-Cell Lymphoma's Current Challenges, Recent Findings and Emerging Treatment Options, May 23, 2012 Francine Foss, MD

2012 Screenings:

Skin Cancer Screening – The annual screening was held on May 23rd and 24th. Seventy two patients were seen with thirteen recommended for follow up.

Breast Health Screening – The annual Breast Health Screening was held on September 26th, October 10th, and November 27th. There were eighty three participants and follow up was recommended for three of the patients. Each participant received a mammogram as well as a clinical breast exam. This year's event was held during the day, and received positive response by participants.

Lung Cancer Prevention and Early Detection Program Low-dose CAT scan – a lower radiation imaging scan – that can be helpful in finding small, abnormal nodules in the lungs, may be offered to patients based on their risk factors and primary care physician input. Because this program is not yet covered by insurance there is a fee of $300 to cover testing costs. If abnormalities are found, future testing or procedures should be covered by insurance. Doctors from Kent's multidisciplinary team will provide consult and additional referrals based on testing outcomes.

Support Groups, Resources & Special Events

ACS, Look Good…Feel Better Program- Four workshops were held during 2012.

Kent Hospital Breast Cancer Support Group – Group meets once per month and is held in the Breast Health Center Conference Room. For more information call 401-737-7010 extension 33737.

Daffodil Days- March 30, 2012

National Cancer Survivors Day

Relay for Life- Held June 15, 2012

Making Strides Against Breast Cancer – Held on October 21st at Roger Williams Park. Several Fundraisers were held leading up to this event.

Lung Cancer Awareness Fair – Held on Friday November 9, 2012

For more information on these or other programs and services, please call the Cancer Registry at 401-737-7010 extension 31864.

CHEMOTHERAPY AND STAGE III COLON CANCER AT KCMH

Michael Coburn, MD

INTRODUCTION

In the United States colon cancer continues to be both one of the most commonly diagnosed malignancies (141,210 cases diagnosed in 2011), and a leading cause of cancer death (49,380) (ref.1). Fortunately numerous studies have established the value of adjuvant chemotherapy for Stage III colon cancer after curative surgical resection (ref. 2-8). Moreover, the Commission on Cancer division of the American College of Surgeons has mandated that all such patients be considered for post-operative chemotherapy. Hence the purpose of this retrospective study was to collect data for Stage III colon cancer patients at Kent County Memorial Hospital (KCMH, to evaluate the use of chemotherapy, and to compare survival data with that of the National Cancer Data Base (NCDB).

MATERIALS AND METHODS

All patients diagnosed with stage III colon cancer between the years 2007 and 2011 at KCMH were identified. Rectal cancers were excluded from this study. The Cancer Registry, supplemented by the individual patient records when required, provided the following demographic, pathologic, and staging, treatment and outcome data for these patients: age, gender, year of diagnosis, segment of colon involved with cancer, tumor grade, number of nodes retrieved, TNM staging, and the use of adjuvant chemotherapy, recurrences, and survival. Five year survival was then compared to equivalent patients from the NCDB from over an equivalent 5 year period (2003 to 2007). For purposes of brevity, NCDB data will not be detailed in "Results", but rather presented for comparison in the "Discussion" section.

RESULTS

Between the years 2007 and 2011, 60 patients at KCMH were identified with Stage III colon cancer. Thirty-six of the patients were female (60%) and 24 male (40%). Age distribution is demonstrated in Table 1, with a range of 37 to 95 years old and a mean age of 73.2. More than half the patients were 70 to 90 years of age. Year of diagnosis appeared roughly equal for each increment of time (Table 2). In addition of all patients diagnosed with colon cancer, approximately 22% were stage III.

The most common locations of the malignancy in the colon were the ascending colon (19), sigmoid colon (17), and cecum (11), followed by the transverse colon (7) and the descending colon (6)(Table 3). The size of the cancers ranged from 1.5 cm. to 12.0 cm with a mean of 8.5 cm. The vast majority of malignancies were grade 2 (49), with only 11 cancers poorly differentiated (grade 3-4). In 48 instances (80%) 12 or more nodes were retrieved from the

pathologic specimen for analysis and in 12 cases (20%) less than 12 nodes were identified. The least number of nodes found was 5 and the most was 43, mean 17.3 nodes. By definition, stage III patients manifest positive nodes and the number of nodes involved by cancer per patient is depicted in Table 4. The largest number of positive nodes in a single patient was 17. Eighteen patients had a single positive node (30%), 12 had two to three nodes (20%), 12 had four to six involved nodes (20%), and greater than 7 nodes was seen in 18 patients (30%).

Three patients were stage IIIA (5%), 31 were stage IIIB (52%), and 26 were stage IIIC (43%). Specific distribution of T and N status is demonstrated in Table 5 and was as follows: T1N1- 1 (2%), T2N1- 2 (3%), T3N1- 24 (40%), T4N1- 4 (7%), T1N2- 0 (0%), T2N2- 3 (5%), T3N2- 23 (38%), and T4N2- 3 (5%).

All patients underwent surgical resection and no patients received radiation therapy. Thirty-five patients (58%) received post-operative chemotherapy, 24 (40%) did not, and in 1 circumstance (2%) it was unclear whether the patient received chemotherapy (Table 6). Of the patients who were not treated with post-operative chemotherapy, 9 were deemed to be too frail for chemotherapy, 8 were felt to be too old for chemotherapy, 4 patients refused treatment, 2 died post-operatively, and in 1 case the oncologist regarded the added benefit of chemotherapy as minimal.

As of last follow-up, 39 patients (65%) are alive with no existing disease (NED), eight (13%) are dead of other causes (DOC), 7 (12%) are alive with disease (AWD), and 6 patients (10%) are dead of disease (DOD) (see Table 7). Recurrences developed in 13 patients (22%): liver (4), diffuse metastases (4), lung (2), abdominal wall (2), and retroperitoneal (1). Depending upon the calendar year overall 5 year survival for patients at KCMH ranged from 15.5 % to 22.1 %, with an average of 19.5 % (see Table 8).

DISCUSSION

This retrospective study was performed to answer three questions. First, what are the demographic and pathologic characteristics of patients with stage III colon cancer diagnosed and treated at KCMH? Second are all the patients with stage III colon cancer offered chemotherapy? And lastly, are the 5 year survivals of patients at KCMH with stage III colon cancer comparable to similar patients in the NCDB?

Examination of the demographics of patients with stage III colon cancer at KCMH revealed some difference with that of similar patients from the NCDB. Sixty percent of patients at KCMH were female compared to 51% of patients in the NCDB. Whether this represents a greater preponderance of females or fewer males diagnosed is unknown. An additional finding is the more advanced age of patients treated at KCMH. Forty-three percent of patients treated at KCMH were between 80 and 89 years old, compared to only 18% of such patients in the NCDB (see table 1). Since females live longer than males, perhaps the increased incidence of females diagnosed with stage III colon cancer at KCMH represents this age factor. Regardless, the finding of an older group of patients with more advanced disease is concerning since it may represent a problem with inadequate screening. Perhaps earlier screening may have resulted in earlier stage disease. Number of cases diagnosed per year has not changed appreciably in the 5 years studied.

In addition, 22.2% of all patients diagnosed with colon cancer in the past decade at KCMH were stage III (Table 2). This correlates well with data from the NCDB (22.5%).

Pathologic data are presented in Tables 3, 4, and 5. There was a propensity for stage III colon cancers at KCMH to be located on the right side (cecum 18%, and ascending colon 32%) when compared to the left side (descending colon 10%, and sigmoid colon 28%). This is distinctly different than the usual distribution of colon cancers in which left sided lesions predominate over right sided lesions. This is probably a result of the ability of right sided lesions to be present for a longer period of time due to the larger diameter and hence delayed symptom presentation. This again makes a case for more intensive screening in order to intercept these cancers before they progress to stage III. In 20 % of patients less than 12 nodes were retrieved. Both the surgical and pathology departments have addressed this in the past and the problem has been subsequently resolved. The number of lymph nodes involved by cancer in this patient population also raises some concerns. In 30% of patients greater than 6 nodes were cancerous and the mean number of involved nodes was 4.6, portending a poor prognosis. On the other hand 30% of stage III patients manifested only one positive node. Tumor (T) and node (N) status is shown in Table 5. The vast majority of pathologic presentation was either T3N1 or T3N2. Only a small number of patients with positive nodes presented with T4 disease. Hence this group of stage III colon cancers are ideal candidates for chemotherapy.

Chemotherapy was administered to 58% of patients at KCMH with stage III colon cancer compared to 58.1% in the NCDB (see Table 6). Forty percent of patients at KCMH did not receive chemotherapy for various reasons: patient had poor performance status in 9 instances, patient deemed to be too old in 8 cases, patient or family refused chemotherapy in 4, patient died prior to administration of chemotherapy in 2, and the oncologist felt that the benefit of chemotherapy was minimal in 1. In the NCDB 30.1% of patients did not receive chemotherapy. Unknown chemotherapy status was present in 2% of KCMH patients and in 11.5% of NCDB patients. Reviewing this data it would appear the chemotherapy is slightly under-utilized at KCMH for stage III colon cancer patients. However the cohort of stage III colon cancer patients at KCMH are older than those of the NCDB which might explain the apparent reluctance to administer chemotherapy at KCMH.

Despite the apparent conservative use of chemotherapy patients at KCMH seem to have favorable outcomes. Seventy eight percent of patients are either alive without disease (NED) or have died of other causes, cancer-free (DOC), while 12% are alive with cancer (AWD) and 10% have died with cancer (DOD) (see Table 7). When compared to the NCDB, patients with stage III colon cancer have slightly poorer 5 year survival, 19.5% compared to 21.4% (see Table 8). Whether this represents inadequate treatment for the KCMH patients or is simply a reflection of the older patient population diagnosed at KCMH remains unclear.

In conclusion, this retrospective study of patients with stage III colon cancer treated at KCMH revealed the following: 1) there is a higher percentage of women than men with stage III cancers, 2) patients at KCMH are older than those in the NCDB, 3) there is a propensity for right sided lesions, 4) there were very few T4 lesions, and 5) chemotherapy was utilized slightly less than in the NCDB. These results suggest that care of our colon cancer patients can be improved

by implementing the following: 1) optimization of screening to diagnose these cancers earlier, particularly in women, 2) diligently examining patients for right sided lesions, 3) insuring that at least 12 nodes are retrieved at the time of surgery, and 4) broadening the use of chemotherapy even in the face of an older population since the majority of these lesions are T3 and hence particularly vulnerable to chemotherapy.

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4. Panettiere FJ, Goodman PJ, Costanzi JJ, et al.: Adjuvant therapy in large bowel adenocarcinoma: long-term results of a Southwest Oncology Group Study. J Clin Oncol 6 (6): 947-54, 1988.

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7. Laurie JA, Moertel CG, Fleming TR, et al.: Surgical adjuvant therapy of large-bowel carcinoma: an evaluation of levamisole and the combination of levamisole and fluorouracil. The North Central Cancer Treatment Group and the Mayo Clinic. J Clin Oncol 7 (10): 1447-56, 1989.

8. Moertel CG, Fleming TR, Macdonald JS, et al.: Levamisole and fluorouracil for adjuvant therapy of resected colon carcinoma. N Engl J Med 322 (6): 352-8, 1990.

TABLE 1 AGE DISTRIBUTION

AGE*	NUMBER OF PTS.	% OF PATIENTS	**% NCDB#**
< 40	**1**	**2%**	**3%**
40 - 49	**3**	**5%**	**8%**
50 - 59	**9**	**15%**	**17%**
60 - 69	**7**	**12%**	**23%**
70 - 79	**12**	**20%**	**26%**
80 - 89	**26**	**43 %**	**18%**
90 - 95	**2**	**3%**	**4%**

***RANGE 37 TO 95 YEARS OLD (KCMH) MEAN AGE 73.2 YEARS OLD (KCMH)**

TABLE 2 - YEAR OF DIAGNOSIS

YEAR OF *DIAGNOSIS	**NO. OF PATIENTS**	**% OF TOTAL COLON CA**	**NO. PTS NCDB**	**% NCDB**
2007	14	23%	18021	22.9%
2008	11	18%	17905	22.7%
2009	13	22%	17187	22.6%
2010	10	17%	16988	23.9%
2011	12	20%		
2000-2010	**160**	**22.2%**	**195,847**	**22.5%**

TABLE 3 – LOCATION OF TUMOR

LOCATION	NO. OF PTS.	% OF PTS.
CECUM	11	18%
ASC. COLON	19	32%
TRANSVERSE	7	12%
DESC. COLON	6	10%
SIGMOID	17	28%

TABLE 4 – NUMBER OF INVOLVED NODES

NO. OF + NODES*	NO. OF PTS.	% OF PTS.
1	18	30%
2 - 3	12	20%
4 - 6	12	20%
>6	18	30%

*RANGE 1 – 17 (KCMH) MEAN 4.6 (KCMH)

TABLE 5 – T, N STATUS

T, N STATUS	NO. OF PTS.	% OF PTS.
T1 N1	1	2%
T2 N1	2	3%
T3 N1	24	40%
T4 N1	4	7%
T1 N2	0	0%
T2 N2	3	5%
T3 N2	23	38%
T4 N2	3	5%

TABLE 6 – ADJUVANT CHEMOTHERAPY

ADJUVANT	NO. OF PTS.	% OF PTS. KCMH	% NCDB 2000-2010
YES	35	58%	58.4%
NO	24	40%	30.1%
frail	9	----	--------
old	8	----	--------
refused	4	----	--------
died	2	----	--------
no benefit	1	----	--------
UNKNOWN	1	2%	11.5%

TABLE 7 – PATIENT OUTCOME

STATUS	NO. OF PTS.	% OF PTS.
NED	39	65%
DOC	8	13%
AWD	7	12%
DOD	6	10%

TABLE 8 - SURVIVAL (2003 – 2007)

YEAR	KCMH # PTS	NCDB # PTS	5 YR KCMH	5 YR NCDB
2003	17	17999	15.5%	17.5%
2004	15	17660	18.5%	22.2%
2005	17	17658	22.4%	22.3%
2006	12	17619	19.4%	22.24%
2007	16	18021	21.9%	22.86%
TOTAL/AVG	**75**	**88957**	**19.5%**	**21.4%**

Cancer Committee, Kent Hospital

Time to Treatment Study

Patient records for the first quarter of 2012 were reviewed to determine the length of time that elapsed from diagnosis to treatment.

A total of 78 records were included in review.

Of those, 23 patients were treated within two weeks of diagnosis.

Another 24 patients were treated within 4 weeks of diagnosis.

Two patients expired before treatment could be started.

For 10 patients no treatment was indicated, pathology reports only.

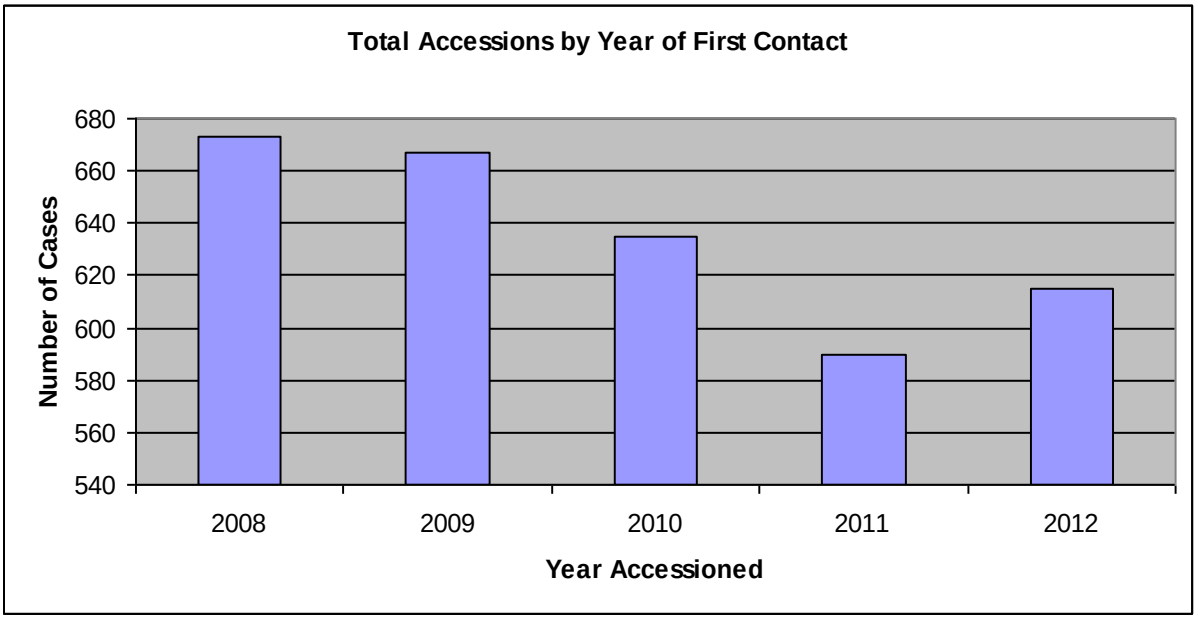
Eight of the patients were treated elsewhere.

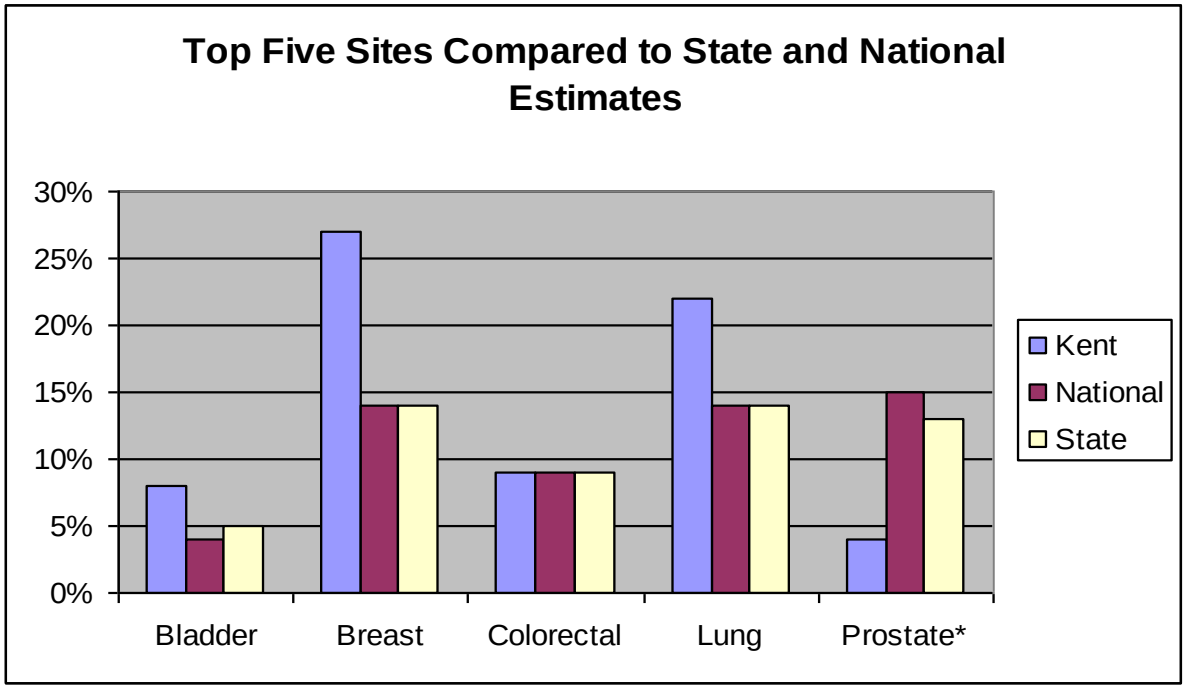
For the remaining 11 patients, it was unknown when treatment was started.

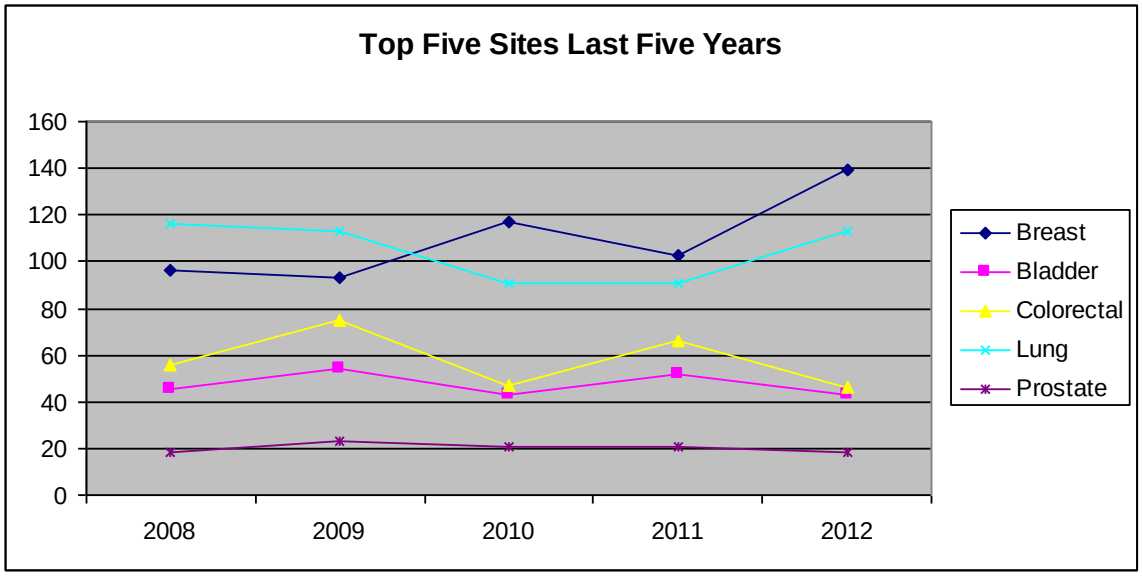
For the patients that waited 4 or more weeks for treatment, most was due to multiple diagnostics that needed to be completed. For 4 patients, it was the patient request.

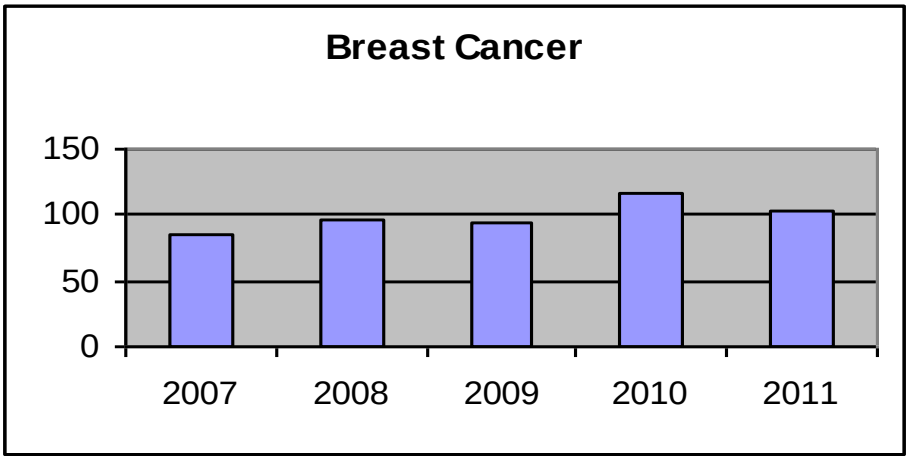
2012 Kent Hospital Analytic Accessions

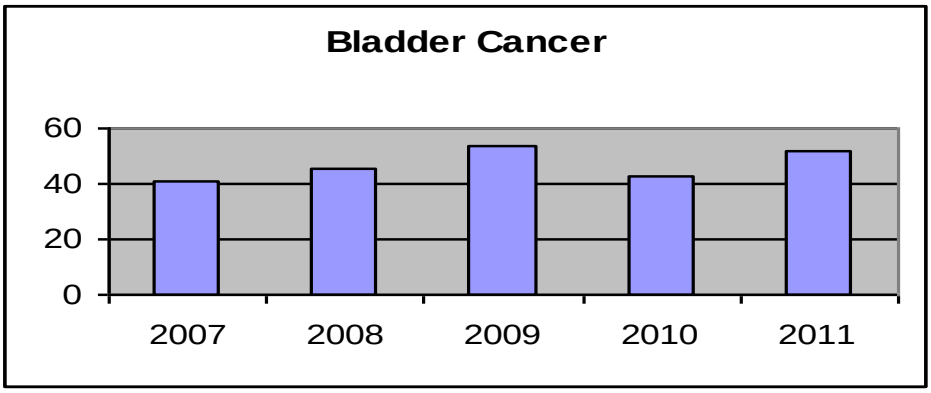
Primary Site	Total	M	F	Stg 0	Stg I	Stg II	Stg III	Stg IV	88	Unk
Oral Cavity	2	1	1	0	0	0	0	0	0	2
Esophagus	4	3	1	0	0	0	0	3	0	1
Stomach	5	2	3	0	0	0	0	1	1	3
Colon	34	16	18	1	5	7	10	10	0	1
Rectum	12	9	3	1	1	4	1	2	0	3
Anus	2	0	2	0	0	1	0	0	0	1
Liver	7	6	1	0	1	1	1	2	0	2
Pancreas	9	1	8	0	1	0	1	6	0	1
Digestive,NOS	6	4	2	0	0	1	0	2	1	2
Larynx	6	5	1	2	1	1	0	1	0	1
Lung	113	50	63	0	25	6	27	46	1	8
Nasal/Sinus	1	0	1	0	1	0	0	0	0	0
Respiratory, NOS	2	2	0	0	0	0	0	0	0	2
Melanoma	8	7	1	1	2	1	0	2	0	2
Skin, other	4	2	2	0	2	0	1	0	1	0
Breast	139	2	137	19	63	35	10	4	0	8
Cervix Uteri	1	0	1	0	0	0	0	1	0	0
Corpus Uteri	16	0	16	0	11	0	1	2	0	2
Female Genital, NOS	1	0	1	0	0	0	0	1	0	0
Prostate	18	18	0	0	4	8	2	3	0	1
Testis	3	3	0	0	2	0	0	0	0	1
Bladder	43	36	7	23	10	4	1	2	0	3
Kidney	14	9	5	0	11	0	2	1	0	0
Urinary NOS	1	1	0	1	0	0	0	0	0	0
Brain	2	0	2	0	0	0	0	0	2	0
Brain (benign)	1	0	1	0	0	0	0	0	1	0
Hodgkins	2	0	2	0	0	1	0	0	0	1
Non-Hodgkin Lymphoma	21	10	11	0	9	3	0	6	0	3
Myeloma	6	4	2	0	0	0	0	0	6	0
Leukemia	4	1	3	0	0	0	0	0	4	0
Blood&Marrow other	5	2	3	0	0	0	0	0	5	0
Connective/Soft tissue	2	1	1	0	1	0	0	1	0	0
Unkown	17	8	9	0	0	0	0	0	17	0
Other/ill defined	1	1	0	0	0	0	1	0	0	0
Total	**512**	**204**	**308**	**48**	**150**	**73**	**58**	**96**	**39**	**48**

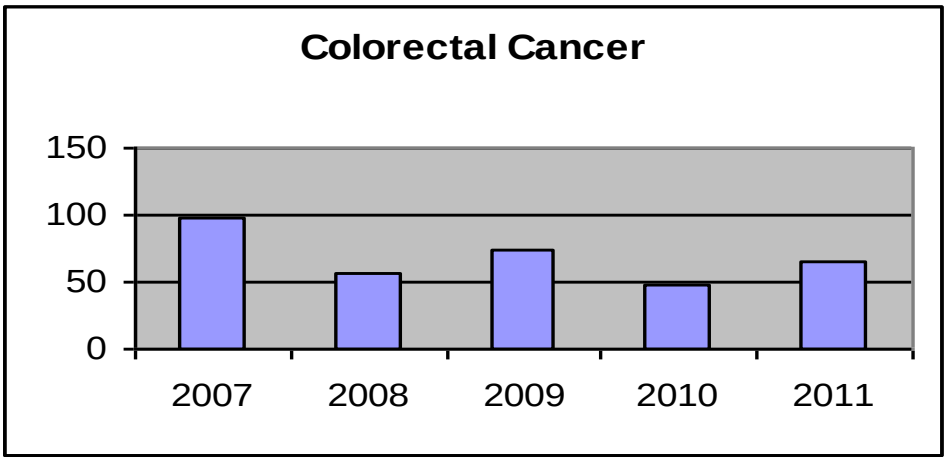

Total Accessions by Year of First Contact
Number of Cases
680
660
640
620
600
580
560
540
2008
2009
2010
2011
2012
Year Accessioned

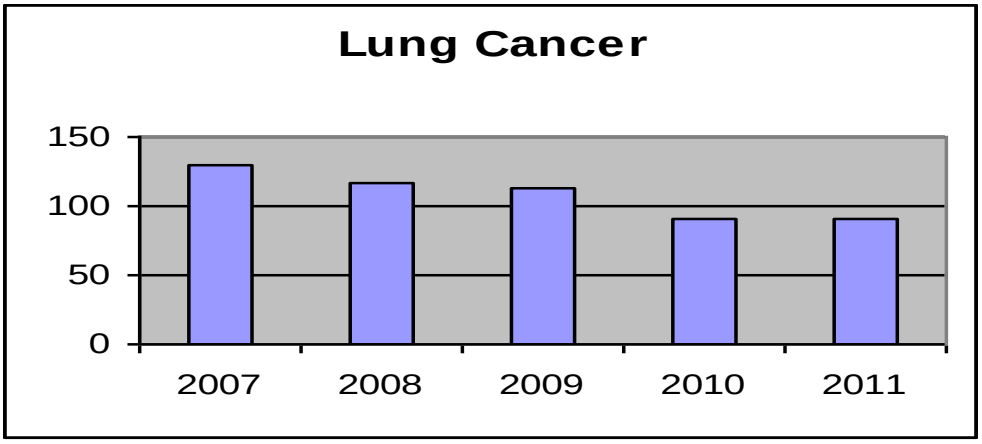

Top Five Sites Compared to State and National Estimates
30%
25%
20%
15%
10%
5%
0%
Bladder
Breast
Colorectal
Lung
Prostate*
Kent
National
State

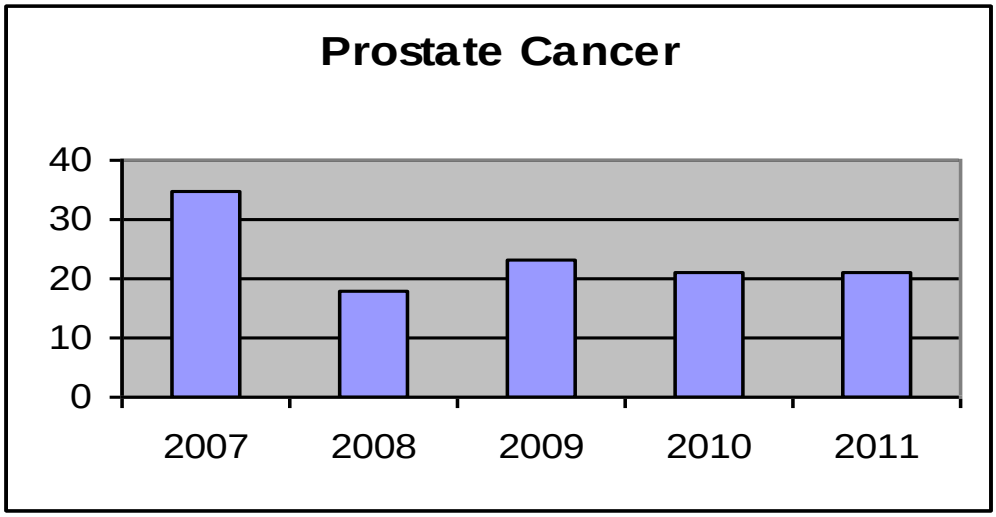

Top Five Sites Last Five Years
160
140
120
100
80
60
40
20
0
2008
2009
2010
2011
2012
Breast
Bladder
Colorectal
Lung
Prostate


Breast Cancer
150
100
50
0
2007
2008
2009
2010
2011


Bladder Cancer
60
40
20
0
2007
2008
2009
2010
2011


Colorectal Cancer
150
100
50
0
2007
2008
2009
2010
2011


Lung Cancer
150
100
50
0
2007
2008
2009
2010
2011


Prostate Cancer
40
30
20
10
0
2007
2008
2009
2010
2011

The Registry Staff would like to thank

the physicians and their office

staff for providing us with vital information

regarding treatment and

follow-up on their patients.