

Cape Canaveral Hospital

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2002 Cancer Program Annual Report

October 2003



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Cancer Committee Chairman's Report

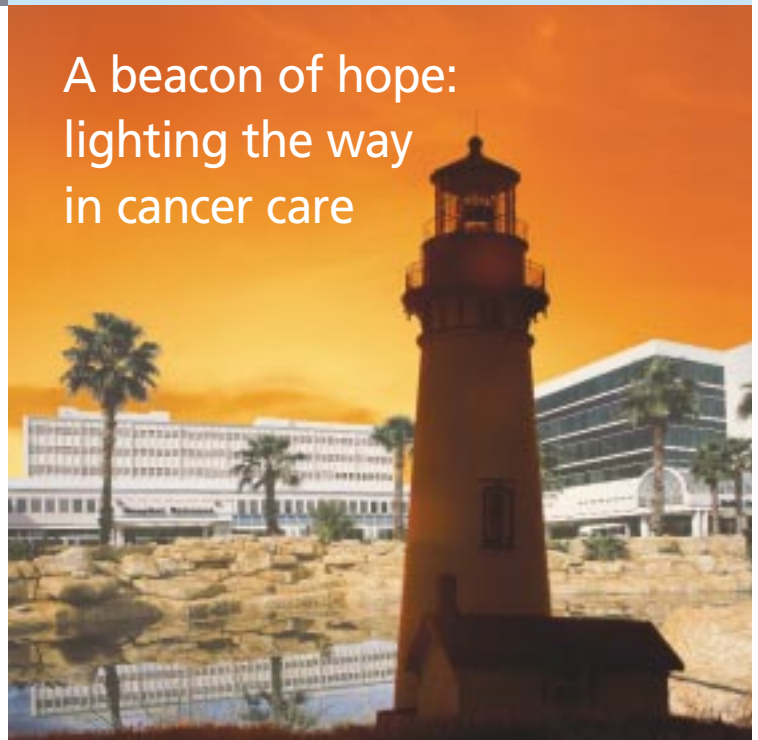
By Richard M. Levine, MD



The Cancer Committee plays a key role in the oversight of the Cancer Program at Cape Canaveral Hospital. The Cancer Committee meets quarterly to plan, develop, and evaluate a wide range of programs and services for cancer patients and families, as well as to assist and supervise compliance with the requirements of the ACoS CoC standards. This multidisciplinary team consists of the following membership: Committee Chairman/Cancer Liaison Physician, Medical and Radiation Oncology Physicians, Surgeons, Radiologists, Pathologists, Urologists, Dermatologists, Certified Tumor Registrar, Nursing Administration, and Cancer Care Unit staff members. Additionally, representatives from the following organizations and departments are included on the Cancer Committee: American Cancer Society, Case Management, Health First Center for Learning (education), Food & Nutrition, Health First Home Care, Hospice of Health First, Marketing and Public Relations, Pastoral Care, Pharmacy, Pro-Health & Fitness Center (Wellness Office), Quality & Outcomes, Rehabilitative Services, Respiratory Therapy, Social Work, and Speech Pathology.

The members of Cape Canaveral Hospital's Cancer Committee as well as the medical and hospital staff continue to advance and improve care that cancer patients and their families receive at Cape Canaveral Hospital. 2002 was a very exciting and productive year for our Cancer Program. In September 2002, the Cancer Program underwent a successful re-accreditation survey by the **American College of Surgeon's Commission on Cancer (ACoS CoC)**. This national accreditation confirms our commitment to our cancer program as we continue to maintain the high standards of this agency. We are dedicated to ensuring that the Cancer Program at Cape Canaveral Hospital continues to grow and be successful. Our multidisciplinary approach to cancer care and expanding support services are vital to our program and patients.

A beacon of hope:
lighting the way
in cancer care



As part of our compliance with ACoS CoC standards, we select and monitor quality improvement opportunities for patient care enhancements as well as identify possible research studies for improving outcomes in our patient population. Many of our 2002 quality initiatives, studies, and enhancements are outlined below:

◆ **Formal affiliation with Shands Cancer Center (affiliated with University of Florida, Gainesville)**

was established: The goal of offering clinical trials in our community is to facilitate cancer care opportunities for cancer patients. Linking with our state university system provides our clients with a mechanism to avoid the inconvenience, expense, and time of traveling to distant cancer centers for care. Our professional collaboration with Shands Cancer Center in Gainesville, Florida, has increased the number and type of cancer services we are able to offer at Cape Canaveral Hospital. This includes the sharing of information regarding clinical protocols for oncology nursing, rehabilitation, pharmacy, wellness programs, as well as chemotherapy and radiation therapy. Partnering with a state-of-the-art cancer center at the state level also provides educational opportunities for our medical and nursing staff through multidisciplinary Grand Rounds conducted on-site at our facility, as well as career-shadowing opportunities for the nursing staff at Shands Cancer Center.

◆ **Evaluation of timeliness of diagnostic procedures for the newly diagnosed cancer patient:**

An example of the effort made to respond to our patients' needs is demonstrated by our evaluation of the process for diagnostic testing and procedures in the newly diagnosed cancer patient. Our goal was to streamline the process to initiate earlier treatment and improve survival potential. The Radiology and Pathology Departments established guidelines, which provide priority, rapid turn-around times for patients undergoing a diagnostic work-up for cancer. The Radiology Department now schedules all studies requested by the patient's physician to be completed within seven days, with reports made available the day after the test is completed. The Pathology Department provides results of biopsies within 24 to 48 hours, special stain reports within 96 hours, and if requested, a second-opinion report within 96 hours. These efforts directly benefit patients by reporting diagnoses and completing necessary staging studies in a prompt, efficient manner.

◆ **Cancer Care Unit Patient Education Room:** Another patient care enhancement is the establishment of the Cancer Care Unit Patient Education Room, which provides reference material for patients and families as well as a direct phone link to the American Cancer Society. This room also offers a computer with Internet access for patient and family use and is provided by the Cape Canaveral Hospital Foundation through fund-raising activities to benefit the Cancer Care Unit.

◆ **Retail massage therapy:** The establishment of inpatient retail massage therapy by licensed massage therapists is a service that enhances the comfort measures available to our patients. Patients and/or their family members may request this service.

◆ **Improving access to Pastoral Care:** A process was established for accessing a Pastoral Care consultation via our computer system. Additionally, the hospital's Chaplain has become an integral part of our weekly multidisciplinary care plan rounds on the Cancer Care Unit.

◆ **Identification of patients with a previous history of cancer:** Strategies were developed to identify those patients who are admitted under another diagnosis with a history of cancer so that we can educate, support, and refer when appropriate.

◆ **Oral assessment and care in the cancer patient:**

A performance improvement study was conducted on the Cancer Care Unit to improve the oral hygiene and comfort of cancer patients.

◆ **Site-Specific Comparison Study:** This study was designed to compare national averages for treatment modalities and survival rates with the experience of Cape Canaveral Hospital cancer patients. Results are presented by the Certified Tumor Registrar to the Cancer Committee on a quarterly basis.

◆ **Infusaport Study:** Assessment of ports relative to patency was conducted with the final outcome resulting in development of a policy with evidence-based interventions to be implemented.

◆ **Pharmacy Studies:** Several initial and retrospective studies have been conducted by the hospital's Pharmacy, involving Demerol, Epogen, Aredia, and Zometa.

The Cancer Program at Cape Canaveral Hospital continues to provide cancer screening and education programs for the community. Screenings have been conducted for skin and prostate cancer, and information has also been provided in colon cancer educational programs. Cape Canaveral Hospital continues to participate in a wide variety of community service and fund-raising activities, which are detailed in this report. In addition, we provide a broad array of cancer education, rehabilitation, and support group opportunities to the community. These include:

- ◆ Monthly breast cancer support groups
- ◆ Post-laryngectomy “New Voice” support group
- ◆ Hospice of Health First Camp Bright Star— a support program for grieving children and families
- ◆ SWAT — A school-based adolescent anti-smoking program
- ◆ BISH —Brevard Inter-agency of Smoking and Health

The success and the quality of the Cancer Program and the depth of services offered is illustrated by its growth. In 2002, more than 500 cancer patients were diagnosed and/or treated at Cape Canaveral Hospital. The Cape Canaveral Hospital Cancer Registry monitors all cancer patients seen at this hospital, helping to ensure proper diagnosis, staging, treatment, and follow-up. Monthly Tumor Boards of a mixed-case nature as well as ongoing quality assurance measures are an integral part of our overall program.

The Cancer Program at Cape Canaveral Hospital is a collaboration of members of the hospital’s medical and hospital staff and the community we serve, with everyone focusing on providing the best cancer care possible. If you have any questions or wish to be involved, please contact Sharon Labbate, CTR, at **799-7125**.

Respectfully submitted,

Richard M. Levine, MD
Chairman, Cancer Committee

January

Cape Canaveral Hospital’s Foundation Grand Prix Fund-raiser and Practice Safe Sun Program helped raise funds for the Cape Canaveral Hospital Cancer Care Unit. Free single-use packets of sunscreen were also distributed at this event.

March

Hosted the **American Cancer Society’s “Who We Are and What We Do”** education program.

April

Participated in the American Cancer Society’s **“Relay For Life”** annual fund-raiser to provide cancer education, awareness, advocacy, and research information in our local community.

May

Cape Canaveral Hospital sponsored a **Skin Cancer Screening** event. Thirty people attended the annual screening, which was performed at the Pro-Health & Fitness Center on Merritt Island (close to Cape Canaveral Hospital). Attendees who had abnormal screenings were referred to local Dermatologists.

June

Participated in the **American Cancer Society’s “Men’s Health Summit”** event. Health First and Cape Canaveral Hospital provided labs and DRE tests in collaboration with other local hospitals. Local physicians volunteered to perform prostate screenings.

September

At Cape Canaveral Hospital’s annual **Prostate Cancer Screening** 73 men were screened for prostate cancer; PSAs and manual examination were performed by urologists. Those who were screened were given their results and instructed to visit their physician if results were abnormal.

October

Cape Canaveral Hospital presented a **Colorectal Cancer Education Program** for the community with presentations by local gastroenterologists on the importance of colon cancer screening and knowing the symptoms.

Participated in the **American Cancer Society’s (ACS) “Tell-A-Friend Tuesday”**: Cape Canaveral Hospital and ACS worked together to promote “Breast Cancer Awareness.” Participants telephoned friends and relatives reminding and encouraging them to have regular breast examinations and mammograms.

About Cape Canaveral Hospital's Cancer Registry

Requests for data are welcomed and should be directed to:

*Cape Canaveral Hospital Cancer Registry
PO Box 320069
Cocoa Beach, FL 32932-9989
321-799-7125 (telephone)
321-799-7106 (fax)*

Since January of 1994, Cape Canaveral Hospital's Cancer Registry has more than 4,900 cases accessioned in its database. Cape Canaveral Hospital Cancer Registry utilizes the Impath Cancer Registry System, formerly called Medical Registry Services, a computerized cancer registry system designed for collecting, following, managing, and analyzing cancer data. The Cancer Registrar analyzes data based on the patient's medical record and enters the information into the Cancer Registry software. All cancer cases must be completed within six months from their diagnosis data. Cancer patients are given accession numbers based on the year in which they were diagnosed.

The Cancer Registry develops a detailed, cancer-focused record on every patient who has an active cancer diagnosed and/or treated at Cape Canaveral Hospital. This hospital is required to report its cancer cases to the **Florida Cancer Data System (FCDS)**, the state's cancer registry. In addition, the Cancer Registry is required to report any historical primary cancers. **Analytic cases** are reported annually to the **National Cancer Data Base (NCDB)**, a joint project of the **American College of Surgeons** and the **American Cancer Society**. Data reported to these state and national organizations are used to support research, track trends, initiate epidemiologic studies, generate journal articles, and provide data for allocation of services.

The Cancer Registry's Certified Tumor Registrar coordinates the hospital's monthly multi-disciplinary Tumor Board meetings. These meetings cover all major cancer sites for patients diagnosed and/or treated at Cape Canaveral Hospital, and focus on pre-treatment evaluation, staging, treatment strategy, and rehabilitation. There were 60 cases presented at the Tumor Board during 2002. Some of the cases presented

were cancers of the breast, lung, colon, bladder, prostate, head and neck, as well as lymphoma and melanoma.

The Cancer Registry conducts annual follow-up on all patients treated for cancer at Cape Canaveral Hospital. The Cancer Registry is required to maintain a 90 percent follow-up rate to be in compliance with the American College of Surgeons' Cancer Program Standards. Regular follow-up visits for a cancer patient is important not only for the Cancer Registry to be able to maintain accurate follow-up, but more importantly for the patient, since early detection is linked to longer survival. The Cancer Registry currently maintains a follow-up rate of 95 percent, which exceeds the target rate of 90 percent.

2002 American Cancer Society Support Services*

Reach to Recovery: A peer support group for women who have had breast cancer surgery.

Road to Recovery: Free transportation services for treatment and doctors appointments.

Man to Man: A peer support group for men with prostate cancer.

Look Good/Feel Better: Periodic sessions demonstrating makeovers for cancer patients.

I Can Cope: A six-week educational support program for cancer patients, families, and friends.

Information on these and other programs is available by calling the local American Cancer Society office at **321-723-7737** or **1-800-ACS-2345**, or visit **www.cancer.org**.

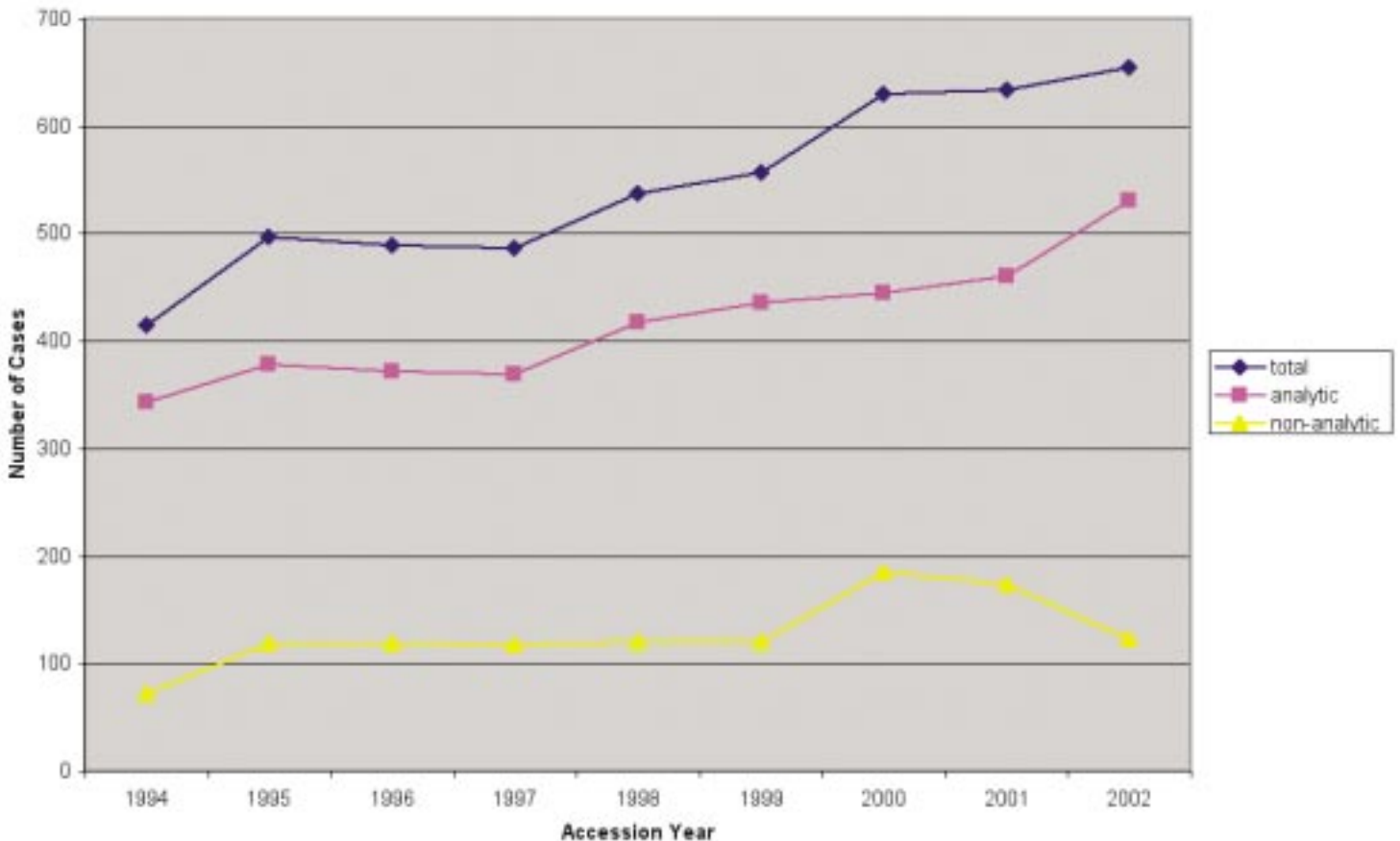
**Cape Canaveral Hospital also provides leadership locally on the American Cancer Society Community Board.*

Summary of Cancer Registry Data for 2002

In 2002 there were 654 new cancer cases accessioned into Cape Canaveral Hospital's Cancer Registry. Of these, 531 (81%) were **analytic cases** (initially diagnosed and/or treated at this hospital). The remaining 123 (19%) were **non-analytic cases** (receiving subsequent treatment then only). The registry has a total number of 4,897 cases entered since the reference date of January 1994. Overall, Cape Canaveral Hospital data revealed a 65 percent increase of **analytic cases** (188) per year compared to when the Cancer Registry began in 1994. (See Chart 1.)

In addition, 98 percent of the patients diagnosed and/or treated during 2002 were residents of Brevard County. Residents of Orange County, Volusia County, as well as those from out-of-state comprised the remaining two percent of patients.

CHART 1: CAPE CANAVERAL HOSPITAL CANCER CASE TREND 1994-2002



2002 Primary Cancer Sites at Cape Canaveral Hospital

The Primary Site Table (*below*) reveals anatomical sites for all cancers that were either diagnosed and/or treated at Cape Canaveral Hospital (*analytic cases*) or cancer sites diagnosed and treated elsewhere (*non-analytic cases*) but seen at Cape Canaveral Hospital for subsequent treatment or recurrence of the original cancer.

Primary Site	Total	Male	Female	Analytic	Non-Analytic
BREAST	166	2	164	139	27
BRONCHUS AND LUNG	99	54	45	85	14
PROSTATE GLAND	67	67	0	46	21
COLON	48	26	22	42	6
MELANOMA	46	33	13	41	5
BLADDER	33	28	5	27	6
NON-HODGKIN'S LYMPHOMA	24	12	12	21	3
LEUKEMIA	24	15	9	17	7
RECTUM	14	9	5	12	2
CORPUS UTERI	12	0	12	11	1
THYROID GLAND	11	4	7	10	1
OVARY	11	0	11	7	4
PANCREAS	10	8	2	8	2
UNKNOWN PRIMARY SITE	7	4	3	6	1
KIDNEY	7	6	1	5	2
STOMACH	7	3	4	6	1
ESOPHAGUS	6	5	1	6	0
BRAIN	6	1	5	4	2
OTHER AND UNSPECIFIED PARTS OF TONGUE	6	4	2	5	1
CERVIX UTERI*	5	0	5	4	1
HODGKIN'S DISEASE	4	1	3	3	1
RECTOSIGMOID JUNCTION	4	1	3	3	1
LIVER-INTRAHEPATIC BILE DUCTS	4	3	1	3	1
LARYNX	4	4	0	4	0
MULTIPLE MYELOMA	3	2	1	1	2
TESTIS	3	3	0	1	2
TONSIL	3	3	0	2	1
OTHER & UNSPECIFIED PARTS OF BILIARY TRACT	3	3	0	3	0
CONNECTIVE, SUBCUTANEOUS, AND SOFT TISSUE	3	1	2	1	2
ANUS & ANAL CANAL	3	3	0	2	1
VULVA	2	0	2	0	2
PYRIFORM SINUS	2	2	0	1	1
SMALL INTESTINE	1	1	0	0	1
LIP	1	1	0	1	0
RETROPERITONEUM AND PERITONEUM	1	1	0	1	0
GALLBLADDER	1	1	0	1	0
PAROTID GLAND	1	1	0	1	0
NASOPHARYNX	1	1	0	0	1
NASAL CAVITY/MIDDLE EAR	1	0	1	1	0
TOTAL	654	313	341	531	123

*Invasive cases only

The frequency of cancer (see Graph 1 below) represents the most common cancers diagnosed and/or treated at Cape Canaveral Hospital in 2002. **Of our top six analytic sites, breast cancer (26%) comprised the highest incidence, followed by lung (16%), prostate (9%), colon (8%), melanoma (8%) and bladder (6%) cancers.**

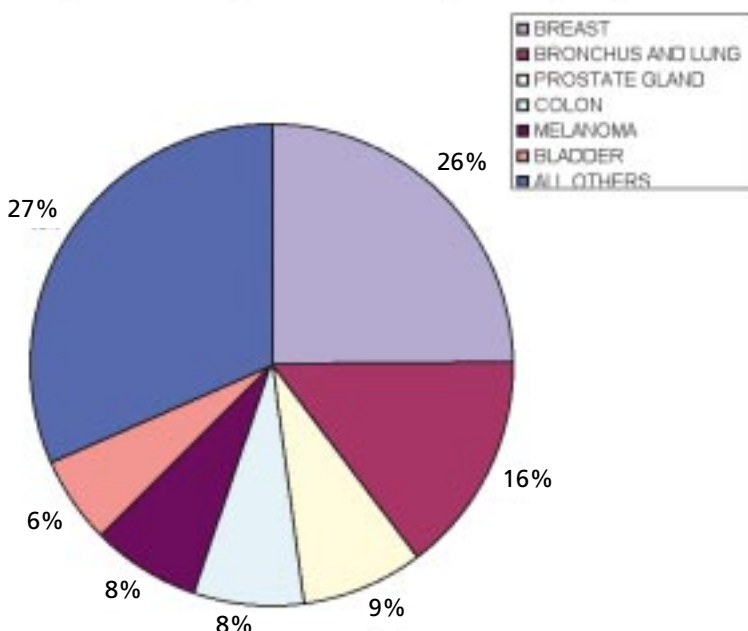
The most frequent cancers seen at our institution (both *analytic* and *non-analytic cases*) are compared in Chart 2 to those expected across Florida and the United States according to the *American Cancer Society 2002 Facts and*

Figures. Our incidence rates (%) of breast cancer and melanoma were higher than national and state figures, while lung, colon and bladder cancers were approximately the same as national and state figures. Incident rates (%) for prostate cancers were lower than national and state figures, however incidence has increased three percent when compared to 2001 Cape Canaveral Hospital prostate cancer data. Of note, a majority of our prostate cancers are diagnosed in the Urologist's office and treated at Cape Canaveral Hospital for prostatectomy or brachytherapy procedures.

CHART 2: NEW CANCER CASES IN THE UNITED STATES, FLORIDA, AND AT CAPE CANAVERAL HOSPITAL

Major Cancer Sites	United States*	Florida	Cape Canaveral Hospital**
Breast (female)	205,000	13,100	166
% of Total	16%	14%	25%
Lung	183,200	13,000	99
% of Total	14%	14%	15%
Prostate	189,000	13,600	67
% of Total	15%	15%	10%
Colon/Rectum	148,300	10,400	62
% of Total	12%	11%	9%
Melanoma	53,600	4,100	46
% of Total	4%	4%	7%
Bladder	56,500	4,300	33
% of Total	4%	5%	5%
All Sites Total	1,284,900	92,000	654

Graph 1: 2002 Cape Canaveral Hospital Frequency of Cancer



Key to Chart 2:

* These estimates are offered as a rough guide. They are calculated according to the distribution of estimated new cancer cases based on incidence rates from the NCI SEER program 1978-1998 for the year 2002. These figures were obtained from the 2002 Cancer Facts & Figures, published by the American Cancer Society. Carcinoma in-situ (except urinary bladder) and non-melanoma skin cancers are not included.

** Cape Canaveral Hospital figures were obtained from the total number of accessioned cases during 2001.

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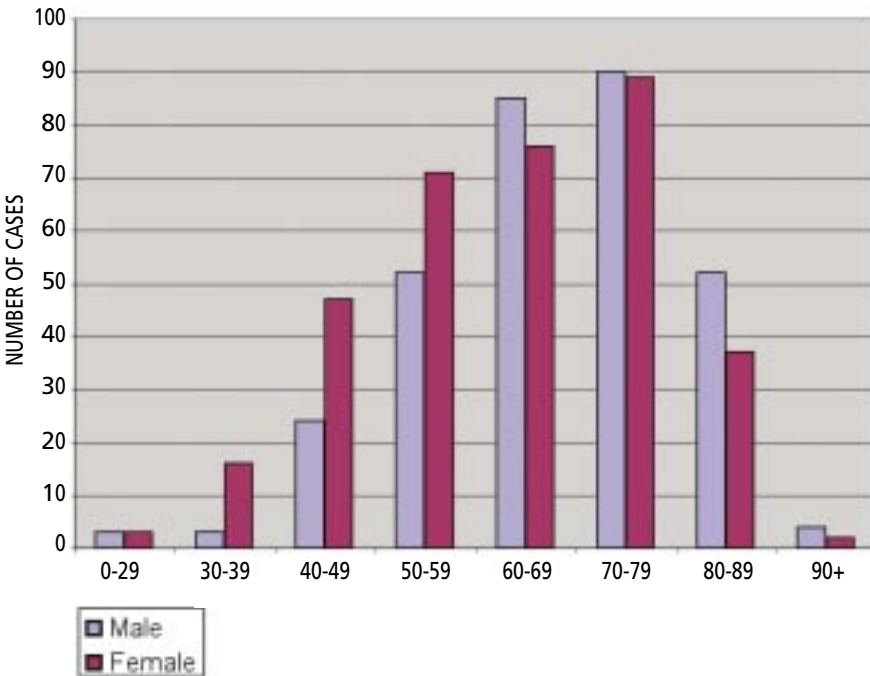
CHART 3: CAPE CANAVERAL HOSPITAL 2002 TOP CANCER SITES BY AJCC STAGE*

	TOTAL	AJCC 0	AJCC I	AJCC II	AJCC III	AJCC IV	AJCC 99**	AJCC 88***
BREAST	139	39	54	34	5	2	5	0
BRONCHUS AND LUNG	85	0	14	7	23	36	4	1
PROSTATE GLAND	46	0	2	40	1	3	0	0
COLON	42	14	7	7	8	3	3	0
MELANOMA	41	21	13	2	4	1	0	0
TOTAL	353	74	90	90	41	45	12	1
PERCENT OF TOTAL CASES	100%	21%	25%	25%	12%	13%	3%	1%

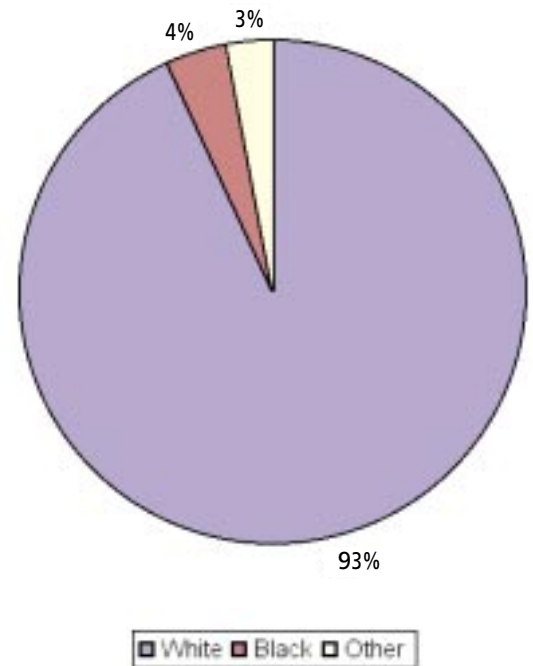
*American Joint Committee on Cancer stages. **AJCC Stage 99 = Unknown stage. ***AJCC Stage 88 = Not applicable.

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GRAPH 2: 2002 CAPE CANAVERAL HOSPITAL CANCER PATIENT AGE DISTRIBUTION



GRAPH 3: 2002 CAPE CANAVERAL HOSPITAL RACE DISTRIBUTION AMONG CANCER PATIENTS



Early detection of cancer is key to survival, and determining the stage of disease and how far it has advanced assists physicians in assessing the type of treatment best suited for patients who are diagnosed with cancer. Stages range from 0-IV, with higher stages representing more advanced cancer. The top five analytic sites treated at Cape Canaveral Hospital by stage were: Stage I & II—localized (25%), followed by Stage 0—in situ (21%)* Stage III—regional (12%), Stage IV—distant metastasis (13%), and Unstaged (4%). (See Chart 3 above.)

The majority of Stage 0 and I cases (93) were breast cancer patients. A majority of Stage IV cases were lung cancer patients.

The gender distribution of all cancer patients at Cape Canaveral Hospital was 48 percent male and 52 percent female. The largest proportion of patients was between the ages of 70 and 79 years (27%), followed by the 60 to 69 age group (25%). The race distribution included Caucasian (93%), African-American (4%), and other race (3%). (See Graphs 2 and 3.)

Definitions and Abbreviations



American College of Surgeons (ACoS): The ACoS Commission on Cancer (CoC) is referenced in this report in the prostate cancer site study. The ACoS CoC surveys and approves cancer programs nationally.

AJCC TNM Stage: A staging system developed by the American Joint Committee on Cancer (AJCC). The size and/or depth of the tumor's invasion determines the tumor (T) stage. The (N) signifies lymph node involvement. Distant metastasis (M) is the spreading of the cancer to sites other than the primary site. For applicable sites, the T, N, and M determine whether the cancer is Stage I, II, III, IV, or Unknown Stage. The higher the stage of the cancer usually correlates with a poorer prognosis.

Analytic case: Cancer cases diagnosed and/or treated for all or part of the first course of therapy at Cape Canaveral Hospital.

Florida Cancer Data System (FCDS): The FCDS is a cancer incidence registry for the State of Florida that is administered by the Florida Department of Health operated and maintained by the Sylvester Comprehensive Cancer Center at the University of Miami School of Medicine.

Non-analytic case: Cancer cases diagnosed and treated elsewhere (not at Cape Canaveral Hospital) for the first course of therapy.

Reference date: The date in which a cancer registry begins collecting cases. The date is usually January 1 of a given year.

From left: Cancer Care Unit support staff Audrey Pacetti, LPN, Lynda Hoogerbyde, RN, Case Manager, and Rita McCarty, RN, Manager of Case Management in the Cancer Care Unit during the unit's grand opening in June 2001.



2002 Site-Specific Report: Prostate Cancer

Prostate cancer is the most frequently diagnosed cancer among men, excluding nonmelanoma skin cancer, and the second leading cause of cancer death overall in men in the United States. It's the sixth most common cancer in the world. In the United States, a man's lifetime risk of developing prostate cancer is 16 percent and he has a 3 percent risk of dying from prostate cancer. In the United States in 2002 there will be approximately 220,900 cases diagnosed and 28,900 deaths will occur from prostate cancer.

The incidence of prostate cancer varies as much as 90-fold among different populations. Of the several known risk factors, the most important appear to be age, ethnicity, genetic factors, and diet. Prostate cancer rarely occurs before age 45, and as men live longer their risk increases. Prostate cancer is more common in African-Americans than in whites or Hispanics, but the reason for this difference is not known. Genetic factors appear to play a role, with 10 percent to 15 percent of men with prostate cancer having at least one affected relative. Genetic mutations in the androgen receptor gene (AR), breast cancer gene 1 & 2 (BRCA 1&2) defects in

the androgen receptor, vitamin D receptor, CYP 17, and 5a-reductase also account for increased susceptibility to develop prostate cancer.

Additionally, a diet high in animal fat, intake of large amounts of alpha-linoleic acid, calcium, and vitamin D, have been shown to be associated with an increased incidence of prostate cancer. A protective benefit appears to be associated in diets high in fish consumption, Omega III fatty acids, selenium, vegetables, vitamin E, and beta-carotene.

Screening for prostate cancer includes combining digital rectal exams (DREs) and PSA testing. Although prostate cancer screening remains controversial by some in the medical community, its goal is to detect disease early, at a more curable stage. Further study is ongoing to help to find the role and potential benefit of prostate cancer screening.

At Cape Canaveral Hospital prostate cancer was the most common cancer diagnosed in men, with 67 cases reported during 2002. It was the highest diagnosed overall in men, representing nine percent of patients diagnosed and treated for cancer at Cape Canaveral Hospital in 2002. Table 1 illustrates the age at diagnosis and Table 2 the stage at diagnosis. The majority of patients (39%) were 60 years or older at time of diagnosis. At Cape Canaveral Hospital most patients presented with disease confined to the prostate (Stage 0, I, or II), which are the most curable stages. Graph 2 identifies patients by race as Caucasian (63), African-American (3), and Hispanic (1) diagnosed with prostate cancer at Cape Canaveral Hospital.

TABLE 1: PROSTATE CANCER AGE AT DIAGNOSIS

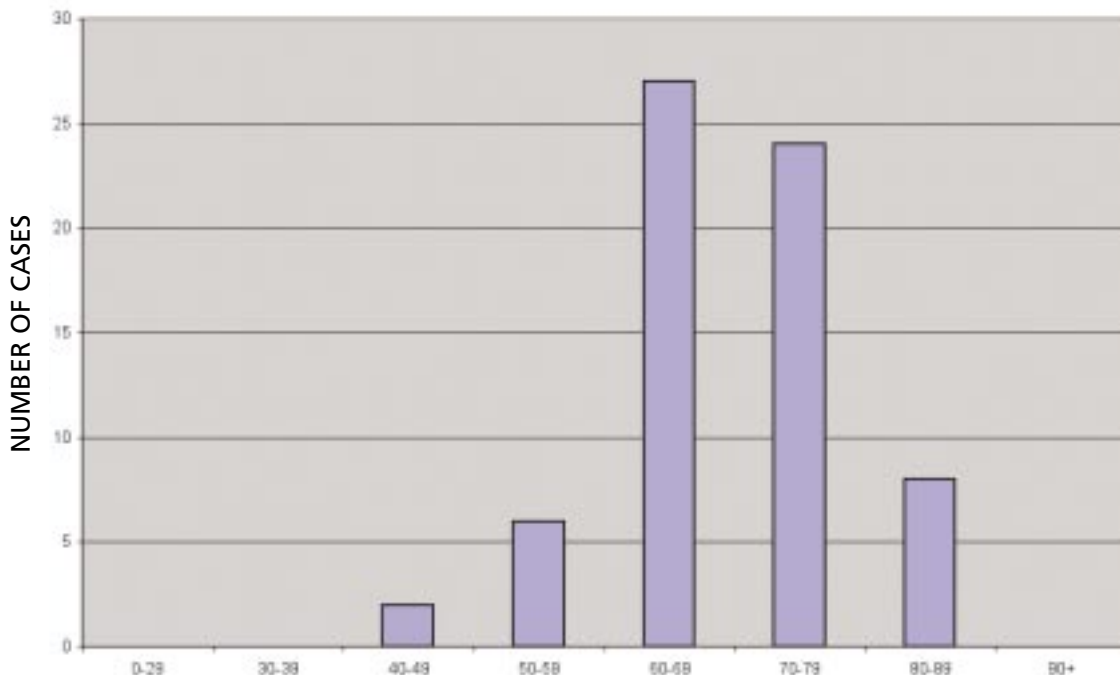
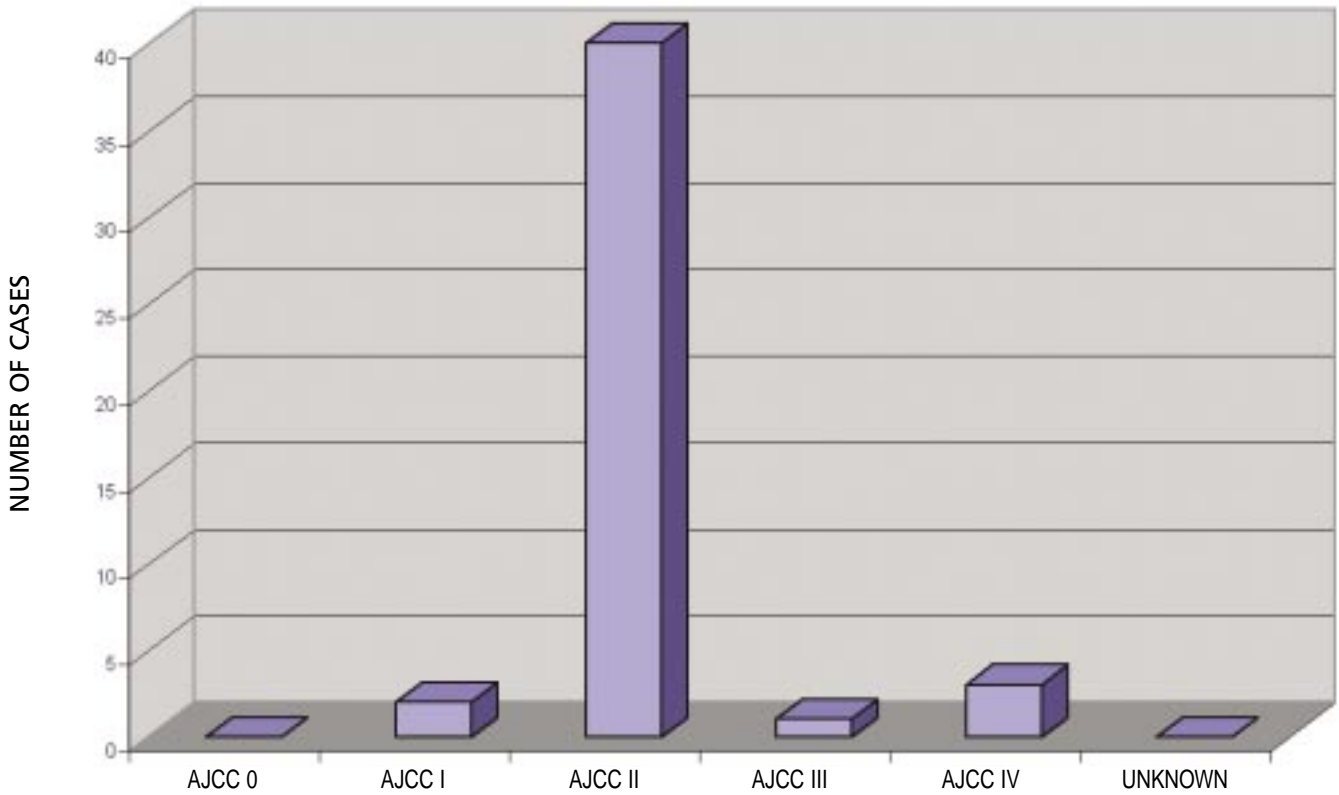
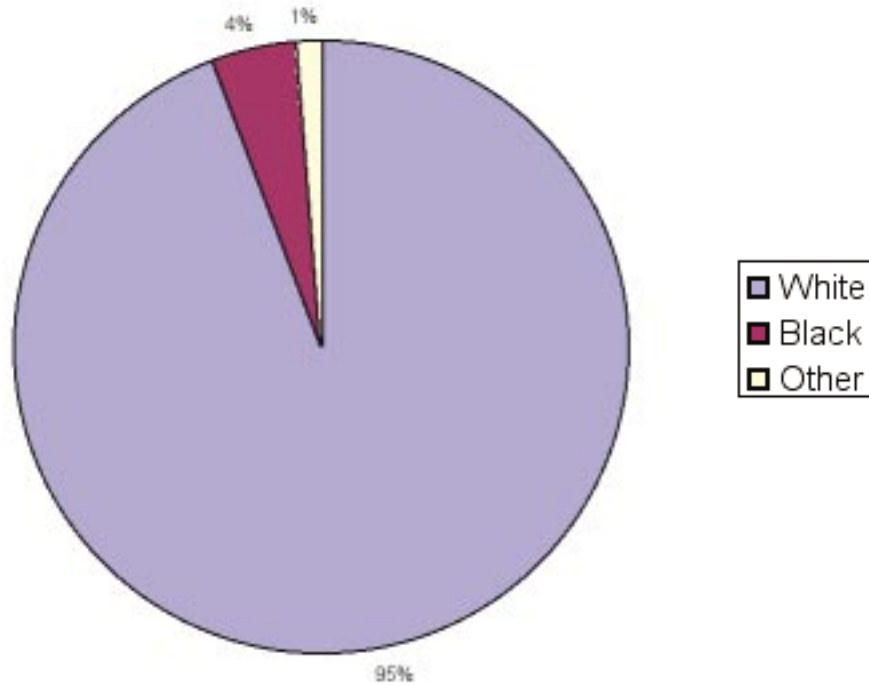


TABLE 2: CAPE CANAVERAL HOSPITAL PROSTATE CANCER STAGE AT DIAGNOSIS IN 2002



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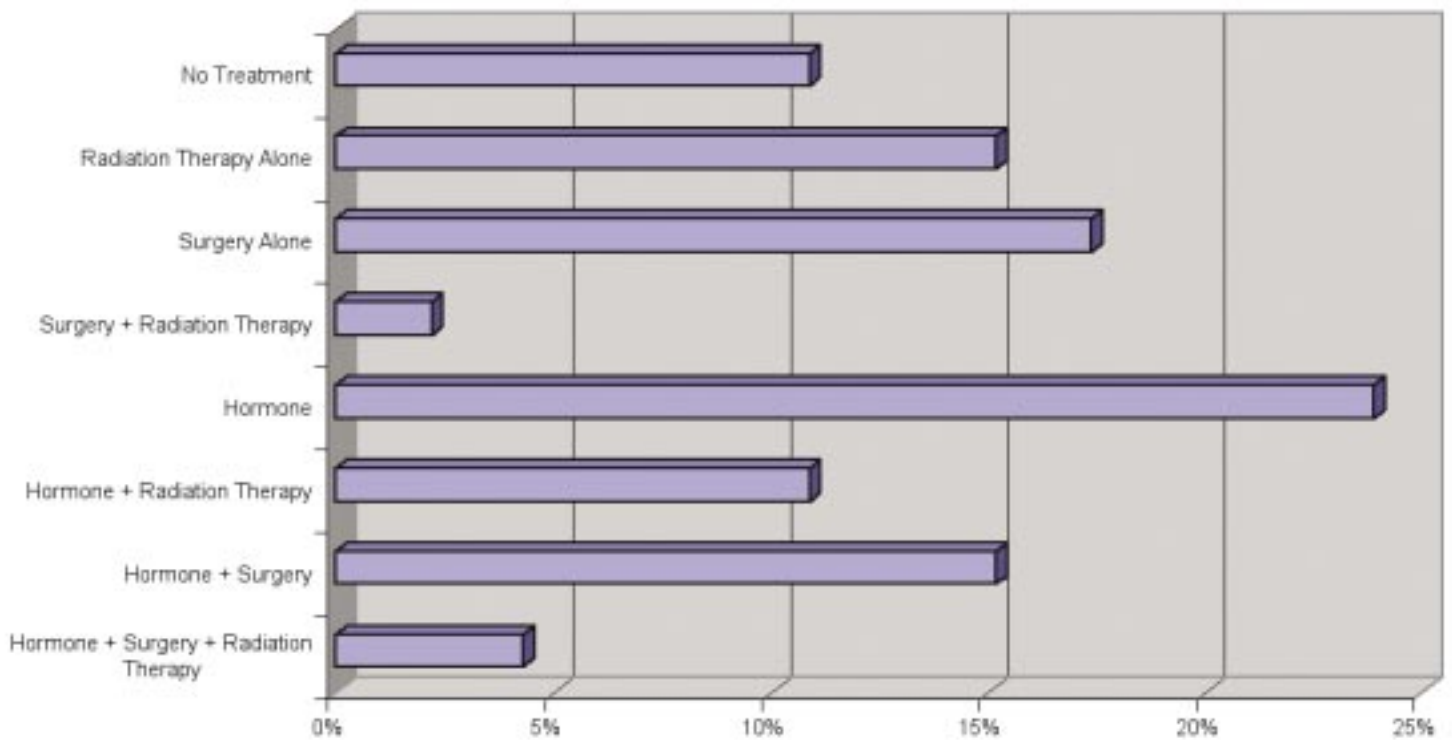
GRAPH 1: CAPE CANAVERAL HOSPITAL 2002 PROSTATE CANCER PATIENTS BY RACE



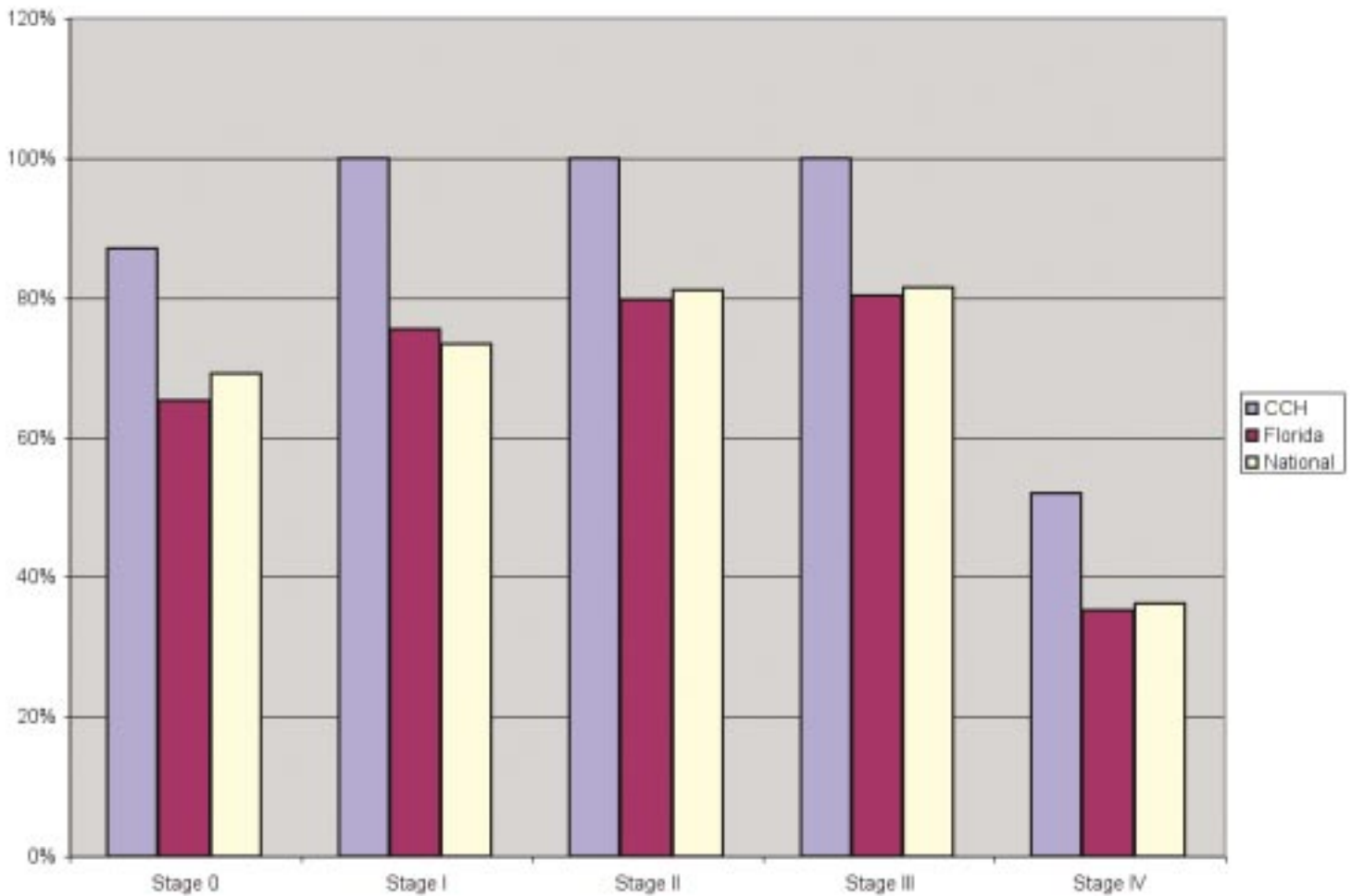
Initial treatment options for prostate cancer include observation, surgery (radical prostatectomy), radiation therapy (seed implant or external beam), cryosurgery, hormone therapy, chemotherapy, or a combination of these treatments. The treatment chosen is determined by

the stage and grade of the tumor, the age and comorbid conditions of the patient, as well as patient preference. Table 3 shows the type and percentage of each treatment patients received at Cape Canaveral Hospital.

TABLE 3: PROSTATE CANCER TREATMENTS AT CAPE CANAVERAL HOSPITAL IN 2002



**TABLE 4: 5-YEAR SURVIVAL OF PROSTATE CANCER PATIENTS
COMPARED TO CAPE CANAVERAL HOSPITAL PATIENTS**



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Five-year survival data is outlined in Table 4. It's compared to five-year survival data in Florida and the United States.

In summary, prostate cancer remains a significant cause of cancer morbidity and mortality in men in the United States. Advances in prevention, early detection, and treatment will improve the prognosis and survival of patients with prostate

cancer, and we at Cape Canaveral Hospital are involved in helping to reach these goals.

Respectfully submitted,

Richard M. Levine, MD
Chairman, Cancer Committee
Cancer Physician Liaison

2002 – 2003 Cancer Committee Members

Physicians:

CHAIRMAN

Richard Levine, MD

Medical Oncology

Diane Bergau, MD

Radiology

David Cohen, MD

Radiology

Peter Dovgan, MD

Vascular Surgery

James Giebink, MD

Radiation Oncology

Cynthia Halcin, MD

Dermatology

Francis Kaszuba, MD

Pulmonary Medicine

Elliot Kornberg, MD

General Surgery

Fe Pancito, MD

Radiation Oncology

Alphonse Pecoraro, MD

General Surgery

Magaly Perez-Blanco, MD

Pathology

Ovid Vitas, MD

Urology

Professional Staff Members:

Cyndi Ayres, RN

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Judith Botkin, RN

Health First Home Care

Cheryl Cournoyer, RN

Health First Center

for Learning

Linda Donohoe, RN

Cancer Care Unit

Debbie Helton

Director

Health First Marketing

and Public Relations

Debra Hemphill

Rehabilitative Services

Alyssa Hickson

American Cancer Society

Jody Hickson

American Cancer Society

Sandra Ingle, RN, BSN

Director

Cancer Care Unit

Sharon Labbate, CTR

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Janice McCoy, RN, MS

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Patient Care Services

**Susan McDonough-
Stackpoole, MSN, RN**

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Nursing Operations

Carol Ann Muir

Cancer Registry

Jody Payne, BSN, RNC

Education Coordinator

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Lori Roche, RD, LD

Food & Nutrition

Janet Rooks, BSW

Social Services,

Case Management

Jodie Rooks, RN

Health First Center

for Learning

Donna Shaw, RN

Quality & Outcomes

Judy Simpson, RN

Quality & Outcomes

Rev. Jerald Smith

Pastoral Care

Anne Marie Trese,

PharmD

Pharmacy

Diane Valentin, RN

Cancer Care Unit

Roberta Van Dusen

Executive Director

Hospice of Health First

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