

2010

Reflecting 2009 Data

Annual Report



HCA

**Regional Medical
Center Bayonet
Point**

Mission Statement

Above all else, we are committed to the care and improvement of human life. In recognition of this commitment, we strive to deliver high quality, cost effective healthcare in the communities we serve. In pursuit of our mission, we believe the following value statements are essential and timeless.

- We recognize and affirm the unique and intrinsic worth of each individual.
 - We treat all those we serve with compassion and kindness.
- We act with absolute honesty, integrity and fairness in the way we conduct our business and the way we live our lives.
- We trust our colleagues as valuable members of our healthcare team and pledge to treat one another with loyalty, respect and dignity.

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A Message From the CEO



At Regional Medical Center Bayonet Point, the war against cancer continues to be waged on all fronts – with education, prevention, diagnosis, treatment, and support.

Regional Medical Center Bayonet Point is committed to making a difference for those whose lives have been affected by this disease. In an effort to continue to improve the care of these patients, studies are done and data is collected and reviewed. As you review this annual report you will agree that RMCBP has made a significant contribution to the war on cancer.

The Cancer Registry is a component of our cancer program that collects, maintains and analyzes the data pertaining to cancer patients' diagnoses or treatment at Regional Medical Center Bayonet Point. The information from the registry helps evaluate the success of specific treatment modalities by reviewing outcomes and survival statistics.

Since our registry began in 2000 we have achieved a total of 11,207 cases in our registry. 623 were recorded in 2009, of which 400 cases were analytic. The top five cancer sites are lung (118), breast (57), colon-rectal (50), thyroid (22), and brain and bladder (15) in that order.

Regional Medical Center Bayonet Point's cancer program has been accredited by the Commission on Cancer of the American College of Surgeons (ACOS) since 2000 and is designated as an approved, with commendation, community cancer program.

A significant portion of Regional Medical Center Bayonet Point's outreach to the community focuses on raising awareness of the factors that increase the risk of developing cancer, identifying ways to reduce that risk, and taking proactive steps to increase early detection through educational presentations, cooperative forums, and community screenings.

We have also increased our commitment as a community partner by being a major sponsor of *Relay for Life*.

Prevention is a significant factor in our battle. In partnership with the American Cancer Society, we provide recurring activities that include informational and educational programs ranging from smoking cessation classes to cancer-screening opportunities.

Regional Medical Center Bayonet Point has in recent years accomplished many things previously thought to be beyond its reach. Through it all, the hospital has continued to care for community with compassion, empathy, and excellence. It is upon this strong and stable foundation that Regional Medical Center Bayonet Point's cancer program has been built and continues to grow.

Steve Rector, CEO

A Message From the Chairperson



During 2010 The Cancer Committee at Regional Medical Center Bayonet Point continued under American College of Surgeons certification as an American College of Surgeons Cancer Program with commendation. During the past year the Cancer Committee continued to promote “a long-term commitment to providing and improving the care of patients with cancer.” The Tumor Registry continues to strive for timely and accurate staging of cancer patients seen at the facility. The stringent standards put forth by the Commission on Cancer are maintained by our program administration, clinical management, supportive care services, data management and education. A total of 11,207 cases comprise our registry, with 623 added in 2009. Our staff continues its dedication to providing excellence in our cancer program. We continue to strive to demonstrate that state-of-the-art cancer care can

be delivered in our community.

A key element of providing exceptional cancer care is our multidisciplinary Cancer Conference held the first and third Fridays of each month. This meeting is attended by Medical Oncologists, Radiation Oncologists, surgeons, radiology and pathology, as well as any other physicians who care to attend, to allow for the exchange of information and ideas to arrive at the best plan of evaluation and treatment for our oncology patient population.

This year the Cancer Committee monitored the results of procedures implemented last year including an order set for patients admitted with fever and neutropenia following chemotherapy. This monitoring has included collecting data on time to first dose of antibiotic for these patients.

This year the Cancer Committee also addressed the process for patient education and follow up for cancer patients requiring PEG tube placement while undergoing radiation and/or chemotherapy.

The Cancer Committee meets quarterly and did schedule successful prostate cancer screening, colorectal cancer screening, and skin cancer screening events this year. We also re-established the Look Good Feel Better program for female cancer patients to receive support and better improve their self-image. We also continue to have our breast cancer support group every other month. The dedication of our physicians and staff was critical for these successful outreach events.

Goals for 2011 include

- Continuing multidisciplinary Cancer Conferences and our Cancer Committee meetings,
- Expanding educational opportunities in Oncology for physicians and staff
- Continued monitoring of the recognition and treatment of chemotherapy patients with fever and neutropenia
- Monitoring success of procedures to facilitate education of PEG tube management for patients
- Continuing to sponsor cancer screening related events
- Expanding opportunities for patient education in oncology as pertains to their experiences in the hospital
- Continue to make support groups available for cancer patients
- Continue to increase access to clinical trials through collaboration with physician office programs

Committee Members

Gail Wright M.D.

Committee Chairperson, Medical Oncologist

Jorge Ayub, M.D.

Physician Liaison, Medical Oncologist

K.S. Kumar, M.D.

Medical Oncologist

Sanjay Emandi, M.D.

Radiation Oncologist

Arthur Matzkowitz, M.D.

Radiation Oncologist

Mark McMullen, M.D.

Pathologist

Hugo Mendonca, M.D.

Surgery

Janice Harvey, R.N.

Nursing

Carol Corder

Radiology

Jennifer Kachurak

Nutrition

Francine Baia, R.N.

Quality

Linda Budzilek, R.N.

Director Nursing

Carolyn Quinlan, R.N.

CNO

Susan Bearden, R.N.

Case Management

Kurt Conover

Marketing

Jill Corriveau, R.N.

Education

Mike Imbimbo

Rehabilitation

Rev Jack Long

Pastoral Care

Annette Murray, R.N.

Hospice

Joseph Walker, PharmD

Pharmacy

Bubblela Simmons, RHIA, CTR

Director Cancer Registry

Stephanie Fox, CTR

Cancer Market Coordinator

Colette Bender, RHIT

Director HIM

Nancy Netherly

American Cancer Society

Cancer Registry Report

The cancer program at Bayonet Point Hospital has been a Commission on Cancer approved cancer program since 2000. The cancer registry at Bayonet Point Hospital has continued to be an active part of the cancer program at the hospital. The registry is in charge of data management, we collect and analyze all active cancer cases at Bayonet Point. Those cases that are analytic are submitted to the Commission on Cancer yearly and Florida Cancer Database System monthly. Non-analytic cases are submitted to the Florida Cancer Database System monthly as well as those analytic cases. The cancer registry collects treatment information, extent of disease at diagnosis, and survival data.

The cancer registry performs quality checks on the accuracy of the data collected on a monthly basis by having physicians review the data collected for specific elements. Quality is also reviewed by FCDS when each 25th record is reviewed when being submitted. The registry also reviews the top 5 main sites treatment information with NCCN guidelines and this information is reported quarterly at the cancer committee meetings. Our software program also has quality checks built into the program so every-time a case is completed by the registry the information is reviewed by the software for quality assurance.

The data that the registry collects is used by the hospital for the possible purchase of new equipment and for population review. The data is also used by physicians for treatment review and for the annual reports. Occasionally data is requested from outside sources for purposes of knowing where there is a type of cancer that is prevalent.

The registry is also required to complete lifetime follow-up on all patients that are diagnosed within the hospital. The Commission on Cancer requires that 90% of all cases diagnosed within the last five years must be followed. It also requires that 80% of all cases ever diagnosed at the hospital must be followed.

In 2009 there were 623 cases abstracted at Bayonet Point Hospital, with 400 cases being analytic. These cases added to the registry make the total number of registry cases (since 2000) to 11,207. The top five main sites in 2009 were lung, breast, colo-rectal, thyroid and brain/bladder.

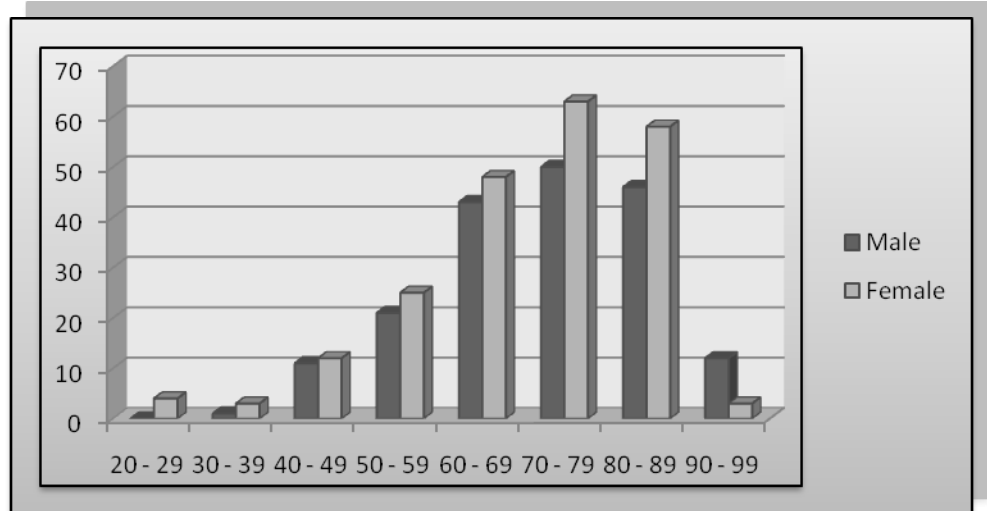
Figure 1:

Data Requests Bayonet Point Hospital 2010:

- 3/11/2010: Glioblastoma Data for pharmaceutical company.
- 8/2/2010: Colo-rectal annual report data
- 9/16/2010: 2009 Analytic case numbers for annual report.
- 9/16/2010: 2009 Total case numbers for annual report.

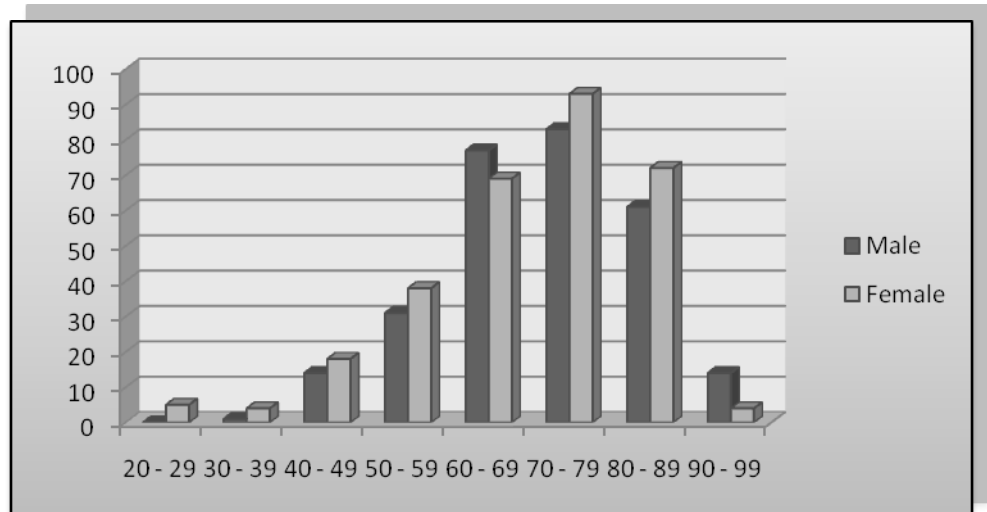
The following chart and graph shows the age range and sex of patients that were diagnosed at Bayonet Point Hospital in 2009.

Age Range	Male	Female
20 - 29	0	4
30 - 39	1	3
40 - 49	11	12
50 - 59	21	25
60 - 69	43	48
70 - 79	50	63
80 - 89	46	58
90 - 99	12	3
TOTALS	184	216



The following chart and graph shows the age range and sex of all cancer patients that were seen at Bayonet Point Hospital in 2009.

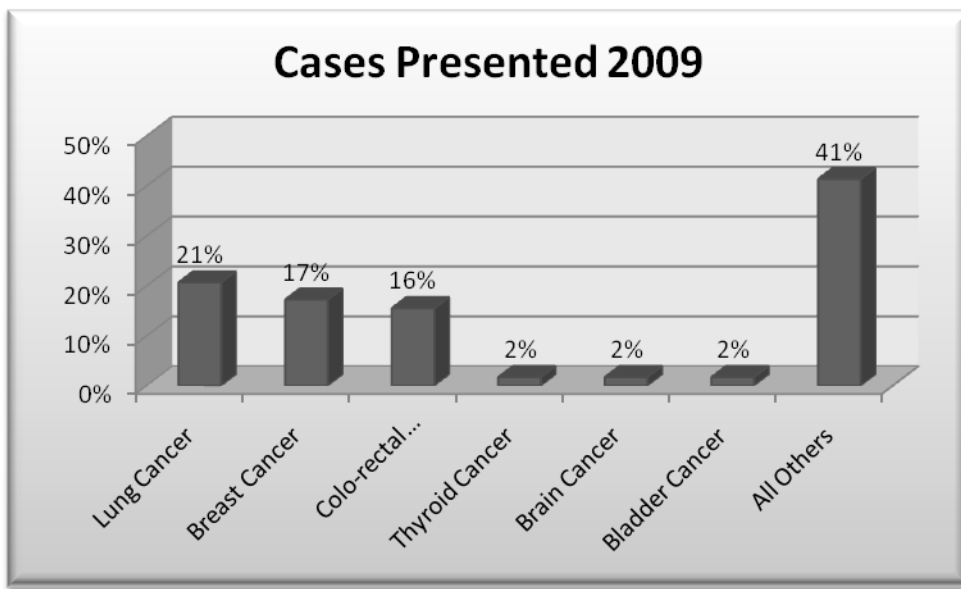
Age Range	Male	Female
20 - 29	0	5
30 - 39	1	4
40 - 49	14	18
50 - 59	31	38
60 - 69	77	69
70 - 79	83	93
80 - 89	61	72
90 - 99	14	4
TOTALS	281	303



Cancer Conference Report

The cancer registrar is also in charge of organizing bi-monthly cancer conference and quarterly cancer committee meetings. The cancer conference meetings are when the physicians can bring cancer cases to the attention of other physicians to discuss treatment options. The cancer committee meetings are for the committee members to review the goals for the year, to make sure the standards required by the CoC are being met, and to bring up and review any quality issues that the physicians may see while treating patients.

Cancer Conference meetings are held on the first and third Friday of each month at 7:30 am. These meetings are attended by a multidisciplinary group of physicians that includes medical oncology, radiation oncology, surgeons, pathologists, and radiologists. They discuss treatment options and compare these options to NCCN guidelines. Clinical and pathological staging are also discussed by using pathology and all imaging studies done whether in the hospital or as an outpatient.



TOTAL SITES (year)	
Breast	10
Colon	8
Lung	12
Lymphoma	8
Unknown	4
Anal Canal	1
MDS	1
Kaposi's Sarcoma	1
Thyroid	1
Kidney	2
Sarcoma	1
Rectum	1
Endometrium	1
Leimyosarcoma	1
Glioblastoma	1
Multiple Myeloma	1
Merkel Cell	1
Hodgkin's Lymphoma	1
Melanoma	1
Bladder	1
TOTAL	58
2008 Analytic Cases	398
Percentage	14.6%

2009 Summary:

Total Number of conferences:

Total Number of Cases Presented:

Prospective Cases Presented:

Retrospective Cases Presented:

Total Physician Attendance:

Please contact the Tumor Registry at (727) 848-1733 ex. 2220 to schedule a case for presentation at Bayonet Point Hospital.

Services and Education

- Mammography
- CT scans
- MRI
- Breast Cancer Support Group
- Look Good Feel Better
- Physical Therapy
- Speech Therapy
- Occupational Therapy
- Smoking Cessation Classes
- Prostate Screening Event
- Skin Cancer Screening Event
- Prostate Education
- Breast Cancer Education
- Breast Self Exam Shower Cards
- Pain Management
- Hospice Care
- Nutritional Support
- Social Services

Radiation Therapy for Rectal Cancer

By Arthur Matzkowitz, M.D.



Cancer of the colon and rectum constitute the third most commonly diagnosed malignancy in the United States. The incidence of colorectal carcinomas continues to rise over the years. In 2008, for example, nearly 110,000 colon and over 40,000 rectal cancer were reported and, over nearly a decade, that is a ten per cent increase.

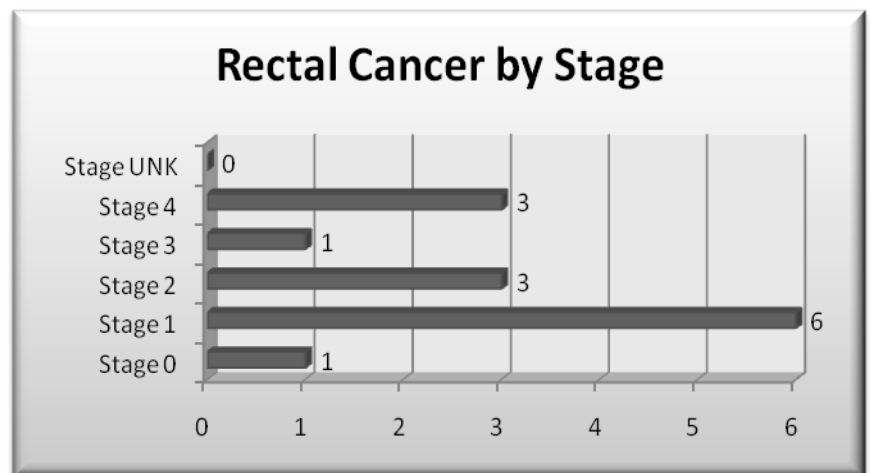
Radiation therapy's primary role in treating rectal cancer is, postoperatively, to treat residual microscopic disease in the tumor bed and the lymphatics. In the preoperative scenario, it is given to downsize inoperable tumors, thus rendering them resectable as well as provide for a less radical, sphincter-sparing operation. Typically, radiation therapy is administered with chemotherapy integration. For tumors that extend through the muscularis propria or into the perirectal tissues, local recurrence rates are about 30% and for nodal involvement it climbs to 50% with surgery alone.

There are pros and cons for both preoperative and postoperative radiation. With the latter, pathologic staging better determines the indication for adjuvant therapy. There are two basic radiobiological disadvantages. The first is operative bed hypoxia which increases radiation resistance and the second is that during the postoperative period before the initiation of radiation therapy, there could be growth of residual microscopic disease. Finally, after surgery, there is often less mobility of the small intestine which could increase the risk of radiation enteritis. There are techniques, however, of displacing and avoiding the small bowel during the course of treatment.

Advantages of preoperative radiation therapy is tumor shrinkage, thus allowing for a sphincter-sparing operation that would otherwise not be possible. Secondly, preoperative therapy avoids hypoxic areas since the blood supply has not been compromised by surgery. Disadvantages include no pathologic staging and possible perioperative morbidity.

As stated, a major purpose and advantage of preoperative radiation therapy is sphincter preservation. A number of investigators have shown the efficacy of combined modality chemoradiation therapy over radiation therapy alone in this regard. Downstaging rates ranged generally from 60 to 70 per cent with sphincter preservation rates from 30 to 85 per cent.

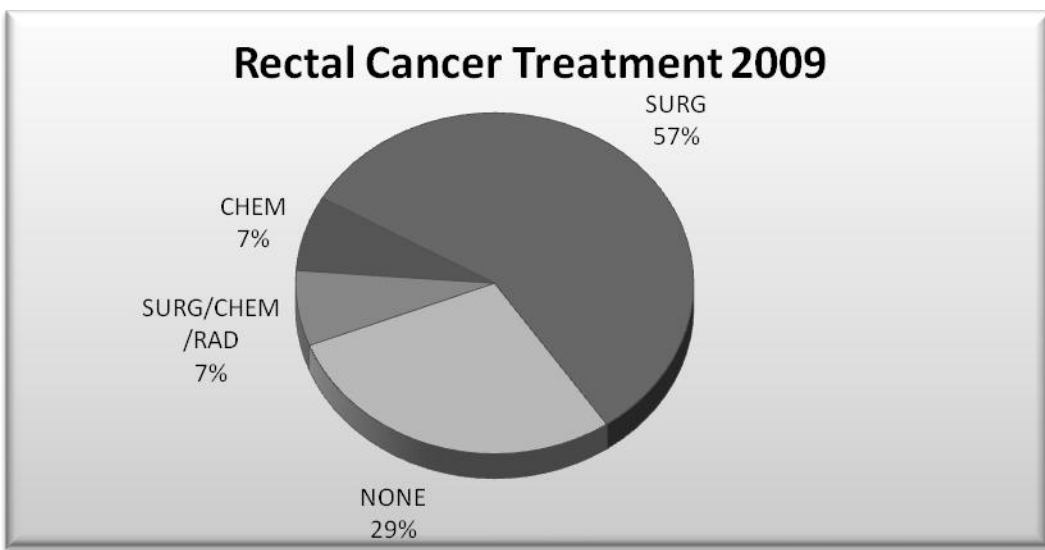
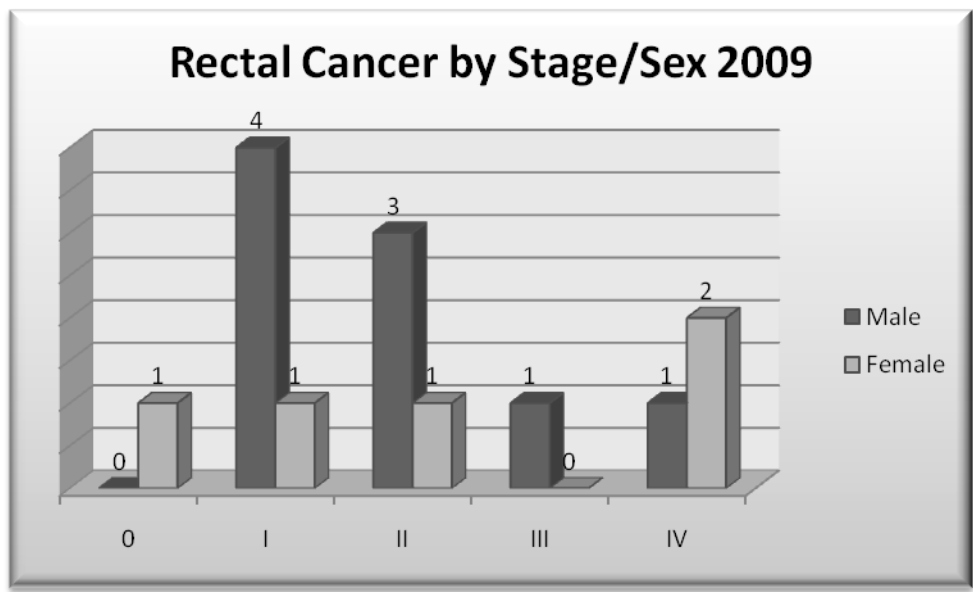
Postoperative radiation therapy sometimes plays a role in those patients who undergo a local excision of a distal rectal lesion. It is extremely important, however, to carefully select



patients for this procedure. Those tumors that are ulcerative or which have pathologic evidence of lymphovascular invasion are not good candidates. The consensus is that locally-excised tumors should be 3 cm or less and not involve more than one half of the circumference of the rectum. For tumors that are T1 (submucosal invasion only) and those with favorable clinicopathologic features, postoperative adjuvant treatment is not indicated. Radiation therapy is recommended for T1 tumors with unfavorable features or for T2 tumors.

Finally, radiation therapy has a palliative role in some cases. When local or regional failure occurs, rather severe consequences can result such as obstruction, bleeding and pain, the latter two of which radiation therapy is especially efficacious. More times than not, sufficient shrinkage is obtained to allow for a good palliative effect.

In conclusion, the use of multimodality therapy is the standard of care for rectal cancer the good majority of the time. Chemotherapy in conjunction with radiation therapy has improved local control and disease-free and overall survival rates. Newer chemotherapy drugs are being tested as radiosensitizers and biologic agents with chemotherapy and radiation are also being investigated.



Medical Oncology and Colon Cancer

By David Wenk, M.D.



Colorectal cancer is the 3rd most common cancer diagnosed in the United States and the 2nd most common cause of cancer death. However, over the past 30 years, mortality from colorectal cancer has declined. Advances in pharmacologic therapy has enabled patients with metastatic disease to live significantly longer than they had in the past.

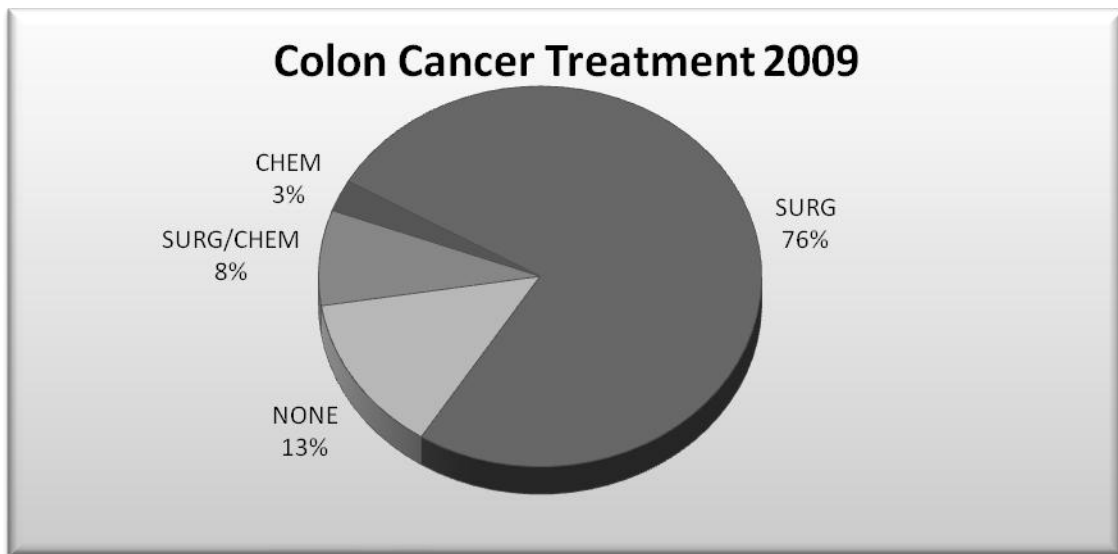
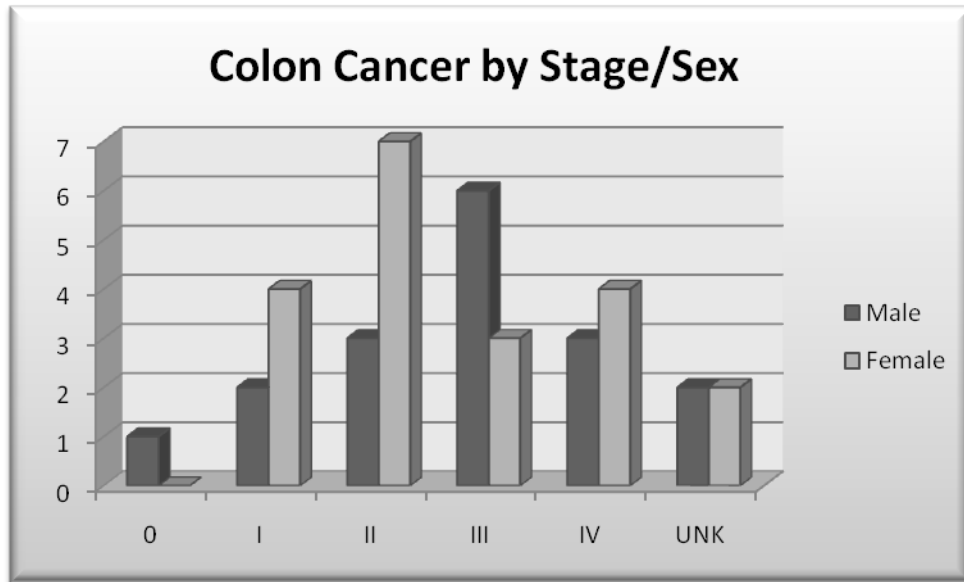
The role of medical oncology in colon cancer has grown over the past several years. In the past chemotherapy was employed in the post-operative setting to reduce the risk of recurrence. The typical agents employed were 5-Fluorouracil and Leucovorin. In 2004 the MOSAIC trial was published in the NEJM which demonstrated an advantage of adding Oxaliplatin and this has become the standard adjuvant therapy since. More recently a multigene expression test (Oncotype DX) has been developed to assess the risk for recurrence in patients with early stage colon cancer.

Medical oncology also is frequently involved with colon cancer in the metastatic setting. Over the past several years, new targeted agents have been developed. These agents include Cetuximab, Panitumumab, and Bevacizumab. Cetuximab and Panitumumab are both monoclonal antibodies directed at the epidermal growth factor receptor. Bevacizumab is a murine antihuman monoclonal antibody against vascular endothelial growth factor (VEGF). Bevacizumab was originally approved in the metastatic setting after a ground breaking trial published in the NEJM in 2004 as part of the IFL regimen. It has subsequently been approved in a variety of disease states since. The addition of these targeted therapies to our chemotherapy backbone drugs of 5-Fluorouracil, Irinotecan, and Oxaliplatin have led to median survivals of nearly 30 months in patients with metastatic colon cancer today.

More recently, chemotherapy has been employed in the neo-adjuvant setting to make previously unresectable patients resectable. Often colon cancer patients present with isolated metastatic disease to the liver. Previously these patients would have been deemed to not be surgical candidates. However, data has now demonstrated that with neo-adjuvant chemotherapy these metastatic patients could be converted to surgical candidates and still be potentially cured. This approach employs the typical drugs that we use in the metastatic setting. Most institutions employ a combination of 5-Fluorouracil, Oxaliplatin, and Leucovorin, a regimen commonly referred to as FOLFOX as well as Bevacizumab. Treatment employs a multi-disciplinary approach with neo-adjuvant chemotherapy for a few cycles followed by surgical resection. These patients are then treated with chemotherapy afterwards as well.

Medical oncology's role in the treatment of colon cancer continues to grow. With the development of new targeted therapies and combination chemotherapy we have taken a disease that in the metastatic setting had a median survival of 14 months in 1990 to nearly 30 months today.

Colon Cancer Graphs/Tables



Hospital Breakdown

PRIMARY SITE	TOTAL	CLASS		SEX		CS STAGE GROUP						UNK	N/A
		A	N/A	M	F	0	I	II	III	IV			
ALL SITES	623	400	223	302	321	23	90	67	50	90	185	118	
ORAL CAVITY	7	2	5	5	2	0	0	0	0	2	4	1	
LIP	0	0	0	0	0	0	0	0	0	0	0	0	
TONGUE	2	0	2	1	1	0	0	0	0	0	2	0	
OROPHARYNX	0	0	0	0	0	0	0	0	0	0	0	0	
HYPOPHARYNX	2	1	1	2	0	0	0	0	0	1	1	0	
OTHER	3	1	2	2	1	0	0	0	0	1	1	1	
DIGESTIVE SYSTEM	108	76	32	59	49	3	12	15	12	23	43	0	
ESOPHAGUS	5	1	4	4	1	1	0	0	0	0	4	0	
STOMACH	7	3	4	4	3	0	0	0	0	2	5	0	
COLON	44	32	12	21	23	1	6	8	9	10	10	0	
RECTUM	21	18	3	13	8	1	5	6	2	4	3	0	
ANUS/ANAL CANAL	5	3	2	1	4	0	0	1	0	0	4	0	
LIVER	6	4	2	5	1	0	0	0	0	1	5	0	
PANCREAS	15	11	4	7	8	0	1	0	1	5	8	0	
OTHER	5	4	1	4	1	0	0	0	0	1	4	0	
RESPIRATORY SYSTEM	160	124	36	80	80	1	31	2	25	49	49	3	
NASAL/SINUS	0	0	0	0	0	0	0	0	0	0	0	0	
LARYNX	4	2	2	4	0	1	0	0	0	0	3	0	
LUNG/BRONCHUS	152	118	34	72	80	0	30	2	25	48	44	3	
OTHER	4	4	0	4	0	0	1	0	0	1	2	0	
BLOOD & BONE MARROW	58	13	45	31	27	0	0	0	0	0	0	58	
LEUKEMIA	13	6	7	6	7	0	0	0	0	0	0	13	
MULTIPLE MYELOMA	14	4	10	7	7	0	0	0	0	0	0	14	
OTHER	31	3	28	18	13	0	0	0	0	0	0	31	
BONE	0	0	0	0	0	0	0	0	0	0	0	0	
CONNECT/SOFT TISSUE	3	0	3	0	3	0	0	0	0	0	3	0	
SKIN	5	2	3	4	1	0	0	0	0	1	4	0	
MELANOMA	3	1	2	3	0	0	0	0	0	1	2	0	
OTHER	2	1	1	1	1	0	0	0	0	0	2	0	
BREAST	84	57	27	0	84	10	26	16	6	4	22	0	
FEMALE GENITAL	12	6	6	0	12	0	0	0	0	2	10	0	
CERVIX UTERI	1	1	0	0	1	0	0	0	0	0	1	0	
CORPUS UTERI	6	2	4	0	6	0	0	0	0	1	5	0	
OVARY	5	3	2	0	5	0	0	0	0	1	4	0	
VULVA	0	0	0	0	0	0	0	0	0	0	0	0	
OTHER	0	0	0	0	0	0	0	0	0	0	0	0	
MALE GENITAL	37	10	27	37	0	0	1	6	0	2	28	0	
PROSTATE	36	9	27	36	0	0	0	6	0	2	28	0	
TESTIS	1	1	0	1	0	0	1	0	0	0	0	0	
OTHER	0	0	0	0	0	0	0	0	0	0	0	0	
URINARY SYSTEM	45	26	19	36	9	9	6	5	4	6	15	0	
BLADDER	29	15	14	25	4	9	3	5	1	3	8	0	
KIDNEY/RENAL	15	10	5	11	4	0	3	0	3	2	7	0	
OTHER	1	1	0	0	1	0	0	0	0	1	0	0	
BRAIN & CNS	34	30	4	16	18	0	0	0	0	0	0	34	
BRAIN (BENIGN)	0	0	0	0	0	0	0	0	0	0	0	0	
BRAIN (MALIGNANT)	16	15	1	9	7	0	0	0	0	0	0	16	
OTHER	18	15	3	7	11	0	0	0	0	0	0	18	
ENDOCRINE	25	22	3	5	20	0	12	5	2	1	4	1	
THYROID	24	22	2	5	19	0	12	5	2	1	4	0	
OTHER	1	0	1	0	1	0	0	0	0	0	0	1	
LYMPHATIC SYSTEM	24	15	9	14	10	0	2	18	1	0	3	0	
HODGKIN'S DISEASE	2	2	0	0	2	0	0	2	0	0	0	0	
NON-HODGKIN'S	22	13	9	14	8	0	2	16	1	0	3	0	
UNKNOWN PRIMARY	16	15	1	11	5	0	0	0	0	0	0	16	
OTHER/ILL-DEFINED	5	2	3	4	1	0	0	0	0	0	0	5	

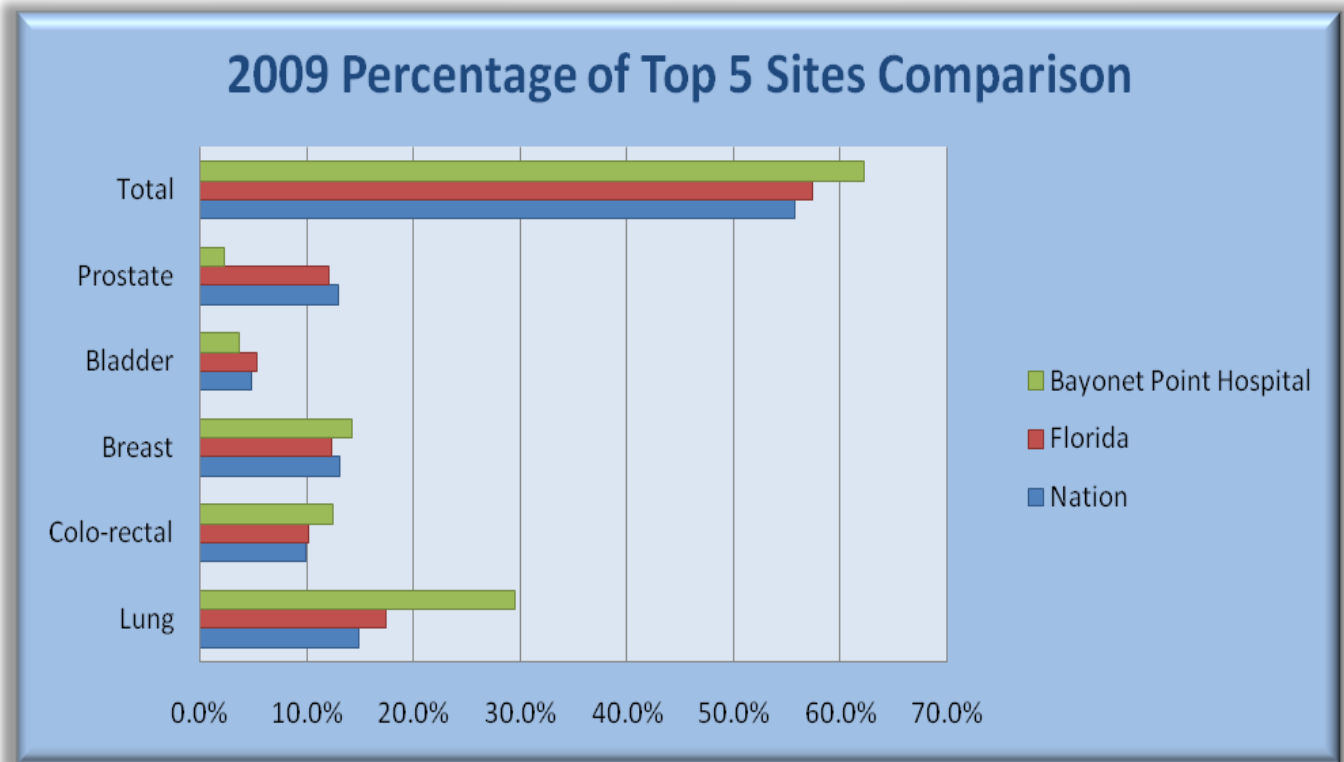
Number of cases excluded: 0

This report EXCLUDES CA in-situ cervix cases, squamous and basal cell skin cases, and intraepithelial neoplasia cases

Bayonet Point Compared to State and Nation

2009 Bayonet Point Hospital cancer sites compared to American Cancer Society						
	All Sites	Lung	Colo-rectal	Breast	Bladder	Prostate
Nation	1,479,350	219,440	146,970	194,280	70,980	192,280
Florida	102,210	17,790	10,420	12,650	5,490	12,380
Bayonet Point Hospital	400	118	50	57	15	9

2009 Bayonet Point Hospital Cancer Sites Compared to American Cancer Society						
	Lung	Colo-rectal	Breast	Bladder	Prostate	Total
Nation	14.8%	9.9%	13.1%	4.8%	13.0%	55.7%
Florida	17.4%	10.2%	12.4%	5.4%	12.1%	57.5%
Bayonet Point Hospital	29.5%	12.5%	14.3%	3.8%	2.3%	62.3%



Contacts and Definitions

www.rmchealth.com

American Cancer Society: www.cancer.org or 1-800-227-2345

Commission on Cancer: www.facs.org/cancer

National Cancer Institute: www.cancer.gov

Analytic cases: Cases that are diagnosed and or treated at the reporting facility.

Non-analytic cases: Cases in which the patient had an active cancer of some type while admitted at the reporting facility.

NCDB: National Cancer Database, where analytic cases are submitted quarterly.

FCDS: Florida Cancer Data System, where all cases are submitted monthly.

CoC: Commission on Cancer, where standards for cancer programs are created and the governing body in charge of surveying and approving hospitals.



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MEDICAL CENTER
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