



It's top-of-the-line technology that makes Thibodaux Regional the clear leader in cancer treatment.



CANCER CENTER
OF THIBODAUX REGIONAL

2 0 0 2 A N N U A L R E P O R T



2002 Cancer Committee Members

James Schweitzer, M.D. (Chairman)
Medical Oncologist

Greg Dobard, M.D.
Radiologist

R. Clay Gould, M.D.
Radiation Oncologist

Mark Hebert, M.D. (Liaison Physician)
Surgeon

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Julie Portier, CTR
Tumor Registrar

Dana Rodrigue, RN
Quality Assurance

Greg Stock
Chief Executive Officer

Recent improvements in the diagnosis and treatment of cancer are largely due to new technology. Technology developed for early diagnosis of cancer, and the extent to which it has invaded the body, can be critical in saving a person's life—not to mention the possible avoidance of unnecessary pain and suffering.

Once cancer has been clearly diagnosed, technology developed to provide treatment is critical to the healing process. While improvements in technology continually occur in small increments, periodically significant advances in both diagnosis and treatment capabilities are realized. When this happens, patient care is greatly improved.

Thibodaux Regional Medical Center has acquired a new state-of-the-art PET/CT (Positron Emission Tomography/Computed Tomography) scanner and an IMRT (Intensity Modulated Radiation Therapy) unit. I believe this outstanding new technology is setting a higher standard of care for the treatment of cancer. In my opinion, older equipment clearly does not compare—a patient would want to seriously consider whether or not to receive diagnostic studies and radiation treatment from a cancer center not having PET/CT and IMRT capabilities.

PET/CT is two superb diagnostic machines combined into one. By taking a new generation CT scanner and an advanced PET scanner—and “marrying” them together—a fused image is created. The result is unbelievable detail that provides physicians with an immense amount of information previously not available. Our new PET/CT can detect things in the human body—in amazing detail—that could not be seen before. Thibodaux Regional's fused technology is quite different from facilities having only PET. There is a clear difference between a PET/CT scanner and only a PET scanner.

IMRT is the ultimate radiation therapy unit. It delivers radiation beams with such precision that nothing can compare. The tremendous advantage to the patient is that “collateral damage” to vital organs, the spinal cord, or key areas of the body are lessened or avoided altogether. In addition, treatments are much shorter and fewer treatments are required.



Greg Stock
Chief Executive Officer
Thibodaux Regional

message from the chief executive officer

At Thibodaux Regional, we have installed a powerful computer system designed to maximize the capabilities of our PET/CT scanner and IMRT. We have learned that when an organization wants to realize all the benefits of powerful new technology, it is necessary to acquire supporting and enabling technologies as well. We have gone to a higher level by installing a CT scanner in our Cancer Center for treatment planning; by acquiring a powerful treatment-planning computer; and, by “wiring the entire system.”

Digital images created with a PET/CT scanner are transported electronically to Thibodaux Regional's Cancer Center from the hospital's imaging department. Treatment simulation and planning are completed and the digital information is sent to the IMRT in a format specific for that purpose.

At Thibodaux Regional Medical Center, PET/CT and IMRT technology have been permanently installed in special facilities in order to insure this sensitive equipment is available daily. It does not arrive on a truck—we have made a serious commitment to the community by investing in the very best technology available anywhere today and we have installed it in modern, state-of-the-art facilities.

In Louisiana, to my knowledge, there are only two PET/CT scanners installed; and there are only a few IMRT units currently in operation. Because of the significant financial investment necessary to acquire the buildings and technology, not many cancer programs will be offering cancer services at this level.

Thibodaux Regional has made the commitment and taken the steps necessary to make the best cancer treatment available. This service is a differentiating characteristic that should command the attention of current and future cancer patients—and their families and friends.

Breast cancer was the most common malignancy diagnosed at Thibodaux Regional Medical Center in the year 2002. Nearly one in eight women nationally will develop breast cancer during their lifetime. Breast cancer is the second leading cause of cancer-related deaths among U.S. women. According to the American Cancer Society surveillance research, death rates of breast cancer have shown a steady decline from years 1990 to 2000. This reduction in mortality has been attributed to improvements in early detection and treatment.



Mark Hebert, MD
Surgeon
Thibodaux Regional

Early detection of breast cancer is the emphasis of screening programs. Breast cancer screening involves three distinctive parts—monthly breast self-exam, yearly physical exam by a health care provider, and yearly mammograms. The current American Cancer Society breast cancer screening guidelines for women include an optional monthly breast self-exam beginning at age 20. The American Cancer Society also recommends a clinical breast exam by a health care provider every three years for women age 20-39, and yearly for women 40 years or older. Beginning at age 40, annual screening mammograms are also recommended. Monthly self-exam instruction, a yearly physical exam and ordering of yearly mammograms can be obtained through your primary physician or gynecologist.

breast cancer report

The goal of breast cancer screening is to identify breast cancer at its earliest possible moment of existence. Current breast cancer growth models indicate breast cancer may take more than five years to reach one centimeter in size. Breast cancers can be identified by touch or by exam as small as one centimeter. However, a mammogram can identify cancer half that size, before it can even be felt. Patients with breast cancer identified at a small size or early stage have a better survival chance over patients with breast cancer of large size or late stage. Data also indicates that patients with breast cancer identified by mammogram alone have a decided survival advantage over patients with breast cancer found by only touch. The Cancer Program at Thibodaux Regional has been a strong advocate of breast cancer screening since its establishment. Screening mammograms performed yearly at Thibodaux Regional have increased dramatically over the past 13 yrs, from nearly 400 in 1990 to 7,231 in 2002. Based on the data from breast cancers seen at Thibodaux Regional over the past five years, 86.2% of all cancers diagnosed have been early stage (Stage 0, I, or II). Most notable is the large number of Stage I breast cancers identified in year 2002 as well as the decline in the number of patients with metastatic disease at the time of diagnosis. The emphasis on breast cancer screening persists with the current availability of Digital Mammography at Thibodaux Regional.

Breast cancer treatment involves multiple medical specialties for diagnosis and treatment. Primary physicians and gynecologists oversee the screening of breast cancer. Surgeons typically diagnose breast cancer and initiate the treatment process. This typically includes removal of the tumor only or mastectomy, as well as evaluation of axillary lymph nodes. Radiation oncologists may give radiation to the breast or chest wall in certain instances. Some patients may require treatment by a Medical Oncologist to include chemotherapy, hormone therapy or immunotherapy. All of these specialties participate in the Cancer Program at Thibodaux Regional and are available to patients with breast cancer.

Breast cancer treatment continues to be ever changing. The Thibodaux Regional Cancer Program has made a strong commitment to the community it serves to keep up with these changes. We expect this commitment to be reflected in improved survival rates in the future for patients with breast cancer treated at Thibodaux Regional.

—by Mark Hebert, MD, Surgeon

breast cancer data 2002

Breast Cancer Cases 1998-2002 (Analytic)

1998	36
1999	61
2000	56
2001	50
2002	58

Age At Diagnosis 2002

0-29	0
30-39	2
40-49	10
50-59	14
60-69	9
70-79	16
80-89	6
90+	1

Race 2002

White	51
Black	7

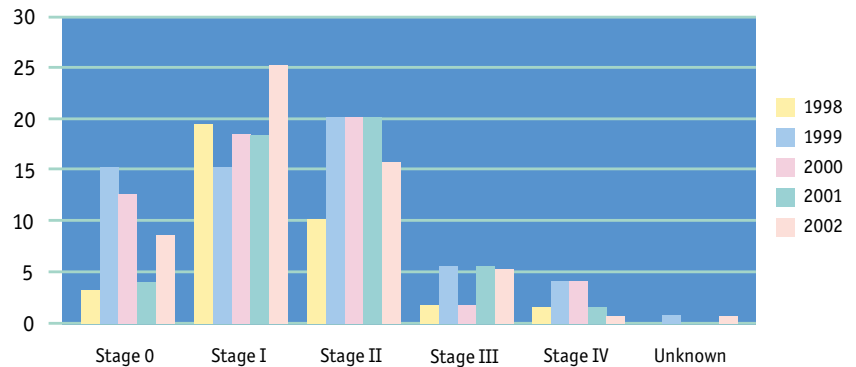
Stage At Diagnosis 2002

Stage 0	8
Stage I	25
Stage II	16
Stage III	6
Stage IV	1
Unknown	2

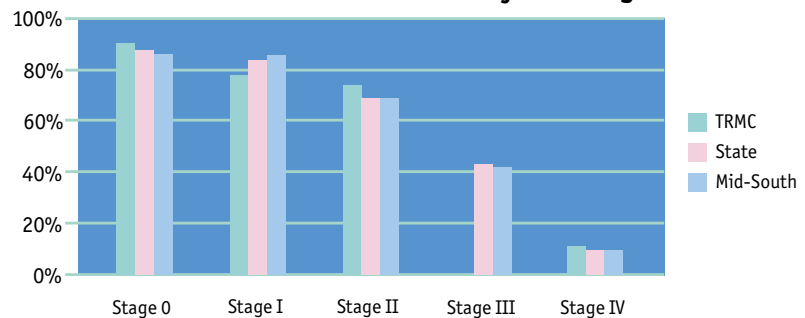
Five Year Observed Survival Rates AJCC Stage at Diagnosis

	TRMC	STATE	MID-SOUTH
Stage 0	94%	92%	91%
Stage I	79%	84%	85%
Stage II	76%	72%	72%
Stage III	*	43%	42%
Stage IV	13%	12%	12%

AJCC Stage at Diagnosis 1998-2002



Five Year Observed Survival Rates by AJCC Stage



*Five-year survival could not be calculated for Stage III because of low number of patients in this category. Thibodaux Regional Medical Center Data includes 1994-1998. Louisiana and Mid-South Statistics obtained from National Cancer Database (1994 & 1995).

primary site tables

Primary Site	Cases	CLASS OF CASE		SEX		AJCC STAGE AT DIAGNOSIS					
		A	N/A	M	F	0	I	II	III	IV	UNK
All Sites	342	300	42	191	151	32	55	71	40	48	28
Lip & Oral Cavity	12	9	3	8	4	0	2	3	2	1	1
Lip	1	1	0	0	1	0	1	0	0	0	0
Tongue	2	1	1	1	1	0	0	1	0	0	0
Mouth	3	3	0	1	2	0	0	2	1	0	0
Major Salivary	1	1	0	1	0	0	1	0	0	0	0
Tonsil	2	1	1	2	0	0	0	0	0	1	0
Oropharynx	2	1	1	2	0	0	0	0	0	0	1
Hypopharynx	1	1	0	1	0	0	0	0	1	0	0
Digestive System	56	53	3	31	25	5	5	8	8	16	9
Esophagus	3	3	0	3	0	0	0	1	0	1	1
Stomach	6	6	0	3	3	0	0	0	0	2	4
Colon	20	17	3	9	1	1	2	4	5	4	1
Rectum, Rectosig Junction	17	17	0	9	8	4	3	1	3	3	2
Anus	3	3	0	1	2	0	0	2	0	0	0
Liver/Bile Ducts	2	2	0	2	0	0	0	0	0	1	1
Gallbladder	1	1	0	1	0	0	0	0	0	1	0
Pancreas	4	4	0	3	1	0	0	0	0	4	0
Respiratory System	55	55	0	32	23	0	5	4	14	22	8
Larynx	4	4	0	2	2	0	0	1	0	1	2
Lung	49	49	0	29	20	0	5	3	14	21	5
Thymus	1	1	0	0	1	0	0	0	0	0	0
Pleura	1	1	0	1	0	0	0	0	0	0	1
Blood & Bone Marrow	12	8	4	9	3	N/A	N/A	N/A	N/A	N/A	N/A

A = Analytic N/A = Non-analytic Distribution for Stage at Diagnosis includes analytic cases only.
 There is no AJCC stage for Leukemia, Multiple Myeloma, Unknown Primary Site, Brain and Carcinoid tumors of the colon/rectum and small intestine.

primary site tables

Primary Site	Cases	CLASS OF CASE		SEX		AJCC STAGE AT DIAGNOSIS					
		A	N/A	M	F	0	I	II	III	IV	UNK
Soft Tissue	2	1	1	0	2	0	0	0	0	0	0
Skin	2	1	1	2	0	0	0	0	0	0	0
Breast	61	58	3	0	61	8	25	16	6	1	2
Female Genital	15	13	2	0	15	0	4	3	3	2	1
Cervix Uteri	5	3	2	0	5	0	1	1	1	1	0
Corpus Uteri	9	9	0	0	9	0	3	2	2	1	1
Ovary	1	1	0	0	1	0	0	0	0	0	0
Male Genital	70	48	22	70	0	0	3	33	6	3	3
Prostate	66	45	21	66	0	0	0	33	6	3	3
Testis	3	3	0	3	0	0	3	0	0	0	0
Penis	1	0	1	1	0	0	0	0	0	0	0
Urinary	38	36	2	30	8	19	9	3	0	2	3
Bladder	25	23	2	21	4	18	1	2	0	0	2
Kidney & Renal Pelvis	12	12	0	8	4	0	8	1	0	2	1
Ureter	1	1	0	1	0	1	0	0	0	0	0
Brain & Nervous System	4	3	1	2	2	N/A	N/A	N/A	N/A	N/A	N/A
Endocrine	3	3	0	1	2	0	2	0	1	0	0
Thyroid	3	3	0	1	2	0	2	0	1	0	0
Lymphatic System	5	5	0	2	3	0	0	1	0	1	1
Unknown Primary Site	7	7	0	4	3	N/A	N/A	N/A	N/A	N/A	N/A

A = Analytic N/A = Non-analytic Distribution for Stage at Diagnosis includes analytic cases only.
 There is no AJCC stage for Leukemia, Multiple Myeloma, Unknown Primary Site, Brain and Carcinoid tumors of the colon/rectum and small intestine.

The Thibodaux Regional Medical Center Tumor Registry is a system of collecting data on all cancer patients diagnosed and/or treated at Thibodaux Regional. The registry collects demographic, treatment and staging data on all cancer patients. This data, in turn, is used for special studies conducted at Thibodaux Regional and is also reported to the State of Louisiana and the National Cancer Data Base to assist in compiling state and regional cancer statistics.

The Thibodaux Regional Medical Center Tumor Registry began accessioning cases in 1993. The registry currently contains 2846 patient abstracts. The registry operates under the direction of the Cancer Committee and follows guidelines set by the American College of Surgeons and the Surveillance, Epidemiology, and End Results Program (SEER) of the National Cancer Institute. All patients in the database are followed for life. The registry maintains a follow-up rate of 94% for all patients, exceeding the 90% minimum standard set by the American College of Surgeons. Follow-up data is important in calculating survival rates.

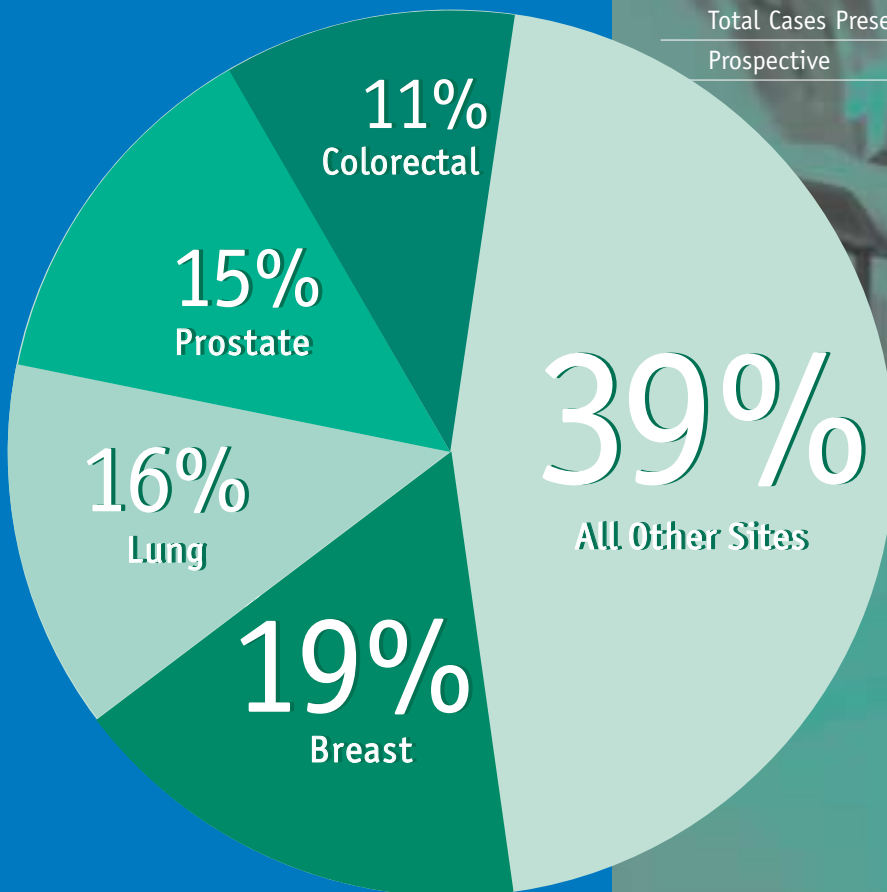
The Tumor Registrar is certified by the National Cancer Registrar's Association and is a member of the Louisiana Cancer Registrar's Association. The registrar attends Tumor Conference and actively participates in Cancer Committee as well as outside cancer-related events.

2002 tumor registry data

In 2002 the registry accessioned 342 cases with 300 being analytic (diagnosed and treated at Thibodaux Regional or diagnosed elsewhere and treated at Thibodaux Regional) and 42 non-analytical (second course of therapy at Thibodaux Regional after being diagnosed and treated elsewhere or diagnosed in a physician's office). Of the total number of cases seen, 191 were male and 151 were female. The most common sites for 2002 were breast (58), lung (49), prostate (45) and colorectal (34). Thirty-nine cases were presented at monthly Tumor Conference. Tumor Conference is a meeting of all physicians involved in treating cancer patients (medical oncology, radiation oncology, radiology, pathology and surgery). It is designed for multidisciplinary case discussion of patients recently diagnosed with cancer or currently undergoing cancer treatment. There were 23 prospective presentations in 2002. Prospective presentations are cases presented at a time when management of the patient could be influenced by case discussion. This interdisciplinary meeting is integral to the patient management process and patient outcomes. Tumor Conference is approved for continuing education credits and all physicians and allied health professionals are invited to attend.

As required by the American College of Surgeons Commission on Cancer, the Cancer Committee completed two patient care evaluations in 2002. These evaluations focused on sentinel lymph node biopsies performed at Thibodaux Regional and the lapse of time between mammography and definitive treatment for breast cancer. Quality improvements in 2002 were made in radiation therapy chart documentation; cancer committee with additional members added from nursing and case management; support groups were moved to one night monthly in an effort to improve attendance and the acquisition of a PET/CT scanner, a 16-slice Lightspeed CT scanner, and an IMRT radiation unit.

top sites 2002 analytic cases only



Total Cases in Registry (1993-2002)	2846
Follow-up Success Rate	94%
New Cancer Cases Accessioned in 2002	342
Analytic	300
Non-analytic	42
Race Distribution	
White	290
Black	49
Not Specified	3
Tumor Board Conferences	12
Total Cases Presented	39
Prospective	23

Progress continues to be made in Thibodaux Regional Medical Center's commitment to provide the best technology and equipment necessary to provide superior cancer care to the people of this community.

Screening mammograms in symptom-free women can provide early detection of breast cancer at a stage when it is most curable. Our Imaging Department now has digital mammography equipment, which provides improved imaging of the breast compared to previous routine techniques. Thibodaux Regional exclusively uses digital mammography.



Prostate cancer continues to be prevalent in the community. Dr. Clay Gould, our radiation oncologist, along with our three urologists, Drs. Leonard, Ray and Weimer, are now able to provide another option for effective management of prostate cancer in certain situations. This involves placement of small radioactive "seeds" into the prostate gland itself. The seeds administer radiation internally to the surrounding prostate tissue and kill prostate cancer cells. This provides an alternative option, along with traditional surgery and external beam radiation therapy for our prostate cancer patients.

A next generation PET/CT scanner is now in place at Thibodaux Regional. This device uses detection of radioactive sugar that can be concentrated in certain types of tumors and appears as "hotspots" on the scan. This is proven helpful in evaluating patients with a variety of types of cancer including lung, throat, breast and esophageal cancers as well as lymph node malignancies.

message to the community

In addition to the quality of the equipment available for managing cancer patients, we are also very proud of the people involved in providing care. This ranges from the personnel at the hospital (including virtually all hospital departments) to the staff at the Cancer Center. Nurses who are interested in oncology and administer chemotherapy can seek certification through experience, education and examination to be specifically certified in oncology. Only four nurses in this region have achieved oncology certification, and three of them work at Thibodaux Regional's Cancer Center.

Through technology, treatments and caregivers, the Cancer Center of Thibodaux Regional offers a higher level of care for its patients.

Sincerely,

James M. Schweitzer, MD
Cancer Committee Chairman

**Thibodaux Regional has made
the commitment and taken the
steps necessary to make the best
cancer treatment available.
This service is a differentiating
characteristic that should
command the attention of current
and future cancer patients—
and their families and friends.**

—Greg Stock
Chief Executive Officer
Thibodaux Regional





the **Best**  of Health



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