

REX CANCER CENTER

Annual Report 2012



Rex Cancer Care Committee 2012

On behalf of the Rex Cancer Center & Rex Health Care

*An American College of Surgeons – Commission on Cancer Accredited
Comprehensive Community Cancer Center*

<http://www.rexhealth.com/cancer>

Rex Cancer Center: Annual Study 2012

Table of Contents

| | | |
|------|--|----------------|
| I. | Annual Study 2012: Head & Neck Cancers | Page 3 |
| II. | National Cancer Data Base Comparatives | Page 9 |
| III. | Rex Tumor Registry Analytic Cases | Page 10 |
| IV. | Rex Clinical Trial Research | Page 11 |
| V. | Rex Outreach & Support Services | Page 12 |
| VI. | <i>References & Key Contributors</i> | <i>Page 16</i> |



Rex Cancer Center: Annual Study: Treatment of Head & Neck Carcinoma 2011

INTRODUCTION:

Head and neck cancer describes a range of tumors that arise in the head and neck region, which includes the oral cavity, pharynx, larynx, nasal cavity, paranasal sinuses, thyroid, and salivary glands. The incidence of head and neck cancer exceeds 50,000 cases per year (over 38,000 men and 14,000 women). It accounts for 3%-5% of all cancers.

The head and neck region is divided into 5 sites by which cancers are classified.

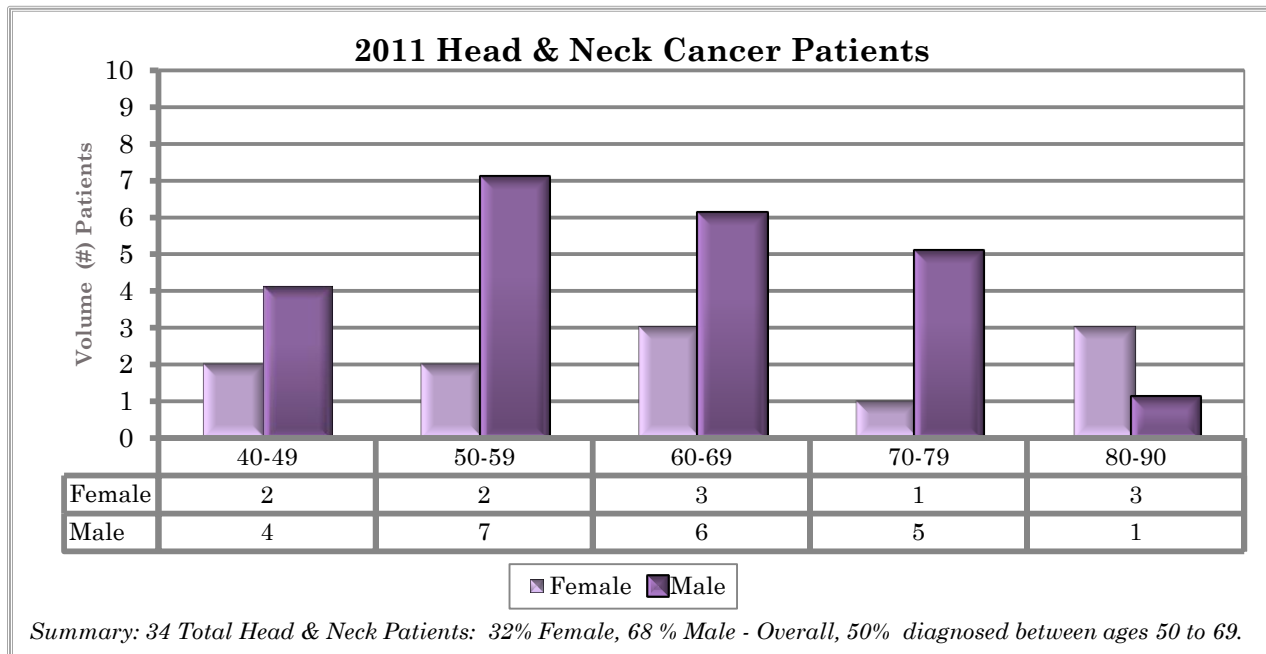


They include the oral cavity, the pharynx, which is divided into the nasopharynx, oropharynx, and hypopharynx. The larynx, or voice box, contains the vocal cords and epiglottis. It is divided into 3 regions; the supraglottic larynx, the glottic larynx, and the subglottic larynx. The major salivary glands are parotid, submandibular, and sublingual and the minor salivary glands, which are located throughout the submucosa of the mouth and upper aerodigestive tract, especially the palate, paranasal sinuses, larynx, and pharynx. Although there are wide varieties of histopathologic types that may arise, the predominant histopathologic type is squamous cell carcinoma. This report will primarily comprise squamous cell carcinoma of the head and neck at Rex Hospital in the year 2011.

EPIDEMIOLOGY AND ETIOLOGY:

The most common risks factors for head and neck cancers are tobacco and alcohol consumption, and there are ethnic and genetic differences among populations at risk using these substances. Although the highest rates of head and neck cancer have been in elderly males, the incidence has been increasing in females as more women use tobacco and in young nonsmokers. The human papilloma virus, (HPV) plays an increasingly prominent role as an etiologic factor in the development of oropharyngeal head and neck cancer.

Table 1: 2011 Head & Neck Patients



In our Rex Cancer Center 2011 statistics, however, the prevalence of HPV is much higher in males than females (7 of 8). Twenty-three of 34 head and neck patients in the Rex Cancer Center statistics were male and of 8 patients with HPV, 7 were male. All of these were advanced stage III or IV.

Table 2: HPV Status Summary

| HPV Positive Patients By Age, Sex & Stage | Age: 40-49 | Age: 50-59 | Age: 60-69 | Age: 70-79 | Age: 80-90 | Grand Total |
|--|---------------|---------------|---------------|---------------|---------------|----------------|
| Female: Total | | | | | 1 | 1 |
| <i>Stage 3</i> | | | | | <i>1</i> | <i>1</i> |
| Male: Total | 3 | 2 | 1 | 1 | | 7 |
| <i>Stage 3</i> | <i>1</i> | <i>1</i> | | <i>1</i> | | <i>3</i> |
| <i>Stage 4</i> | <i>1</i> | <i>1</i> | | | | <i>2</i> |
| <i>Stage 4A</i> | | | <i>1</i> | | | <i>1</i> |
| <i>Stage 4C</i> | <i>1</i> | | | | | <i>1</i> |
| Grand Total | 3 | 2 | 1 | 1 | 1 | 8 |

Tobacco both smoked and smoke-less is the most important known risk factor for the development of head and neck cancer. There is some evidence for a genetic predisposition to the carcinogenic effects of tobacco. In addition, tobacco and alcohol consumption appear to have a synergistic effect. The repeated exposure of the mucosa of the upper aerodigestive tract to the carcinogenic effects of tobacco and alcohol appears to cause multiple primary and secondary tumors in this "condemned mucosa," a concept known as "field cancerization," a distinct neoplastic phenomenon.

Other risk factors include HPV, radiation exposure, certain vitamin deficiencies, periodontal disease, and occupational exposures.

SCREENING:

Several noninvasive lesions such as leukoplakia, erythroplakia, and leukoerythroplakia may develop within this squamous mucosa that lines many of the structures of the head and neck. These clonally independent premalignant lesions may transform into invasive carcinoma although each at different rates. The process of transformation is thought to progress in a multistep fashion through hyperplasia and dysplasia to in situ and then invasive carcinomas. Dentists, oral surgeons, and primary care physicians are excellent participants in screening for these cancers.

DIAGNOSIS AND STAGING:

The clinical presentation of head and neck cancer varies with the primary site. Common symptoms include non-healing mucosal ulcers, pain including sore throat and ear pain, hoarseness, painful swallowing, chronic cough, and a mass or lump in the neck or throat. It is always possible that another primary cancer has spread to the neck and could be the cause of the lump. The physician will do a careful medical history and physical examination with a careful assessment of the nasal and oral cavity with full visual examination and palpation of mucous membranes throughout the mouth.

Imaging studies include CT scans, magnetic resonance imaging (MRI), and positron emission tomography (PET) scans. These augment the physical examination and evaluation of patients with head and neck cancer, particularly for assessing the degree of local invasion, and involvement of regional lymph nodes. The presence of distant metastases and secondary primary malignancies will also be evaluated. It may be necessary to place the patient under anesthesia in order to get a complete evaluation of the aerodigestive tract at risk through the head and neck surgeon's tools for evaluation.

The tumor-node-metastasis (TNM) staging system of the American Joint Committee on Cancer (AJCC) and the International Union for Cancer Control (UICC) is used to classify cancers of the head and neck.

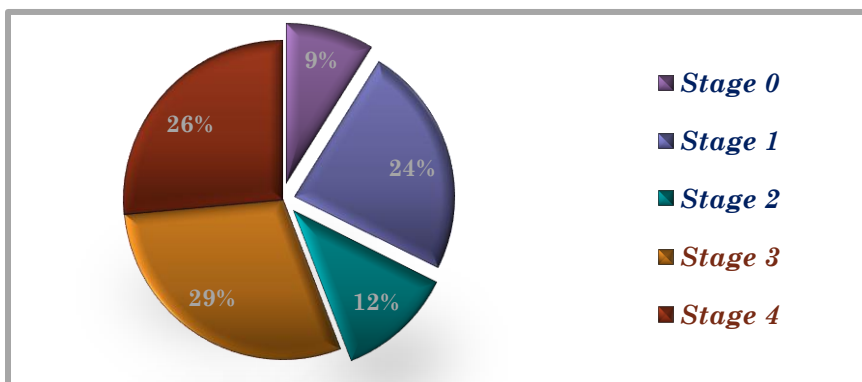
The T classifications indicate the extent of the primary tumor and they are site specific. The N indicates lymph node status and there is considerable overlap in the cervical node classifications amongst the different sites.

TREATMENT:

Treatment for head and neck cancer is complex due to the variety of tumor sub-sites, the anatomic constraints of the head and neck region, and the importance of maintaining organ function. Rex Cancer Center has a multi-disciplinary approach, which is needed for the good care of these patients. This multi-disciplinary approach includes surgeons, medical and radiation oncologist as well as dentists, dietitians, and rehabilitation therapists.

Table 3: Stage at Diagnosis

Approximately 44% of patients with Head and Neck cancer present with early disease (Stage 0, I, and II)



Data from the year 2011 showed cases at Rex Cancer Center, 15 of 34 cases were diagnosed early - stage 0 to II, while 19 of 34 were advanced, stage III or IV.

The same data shows that the majority of cases were tongue or tonsil or larynx origin with 2 cases from the hypopharynx, 1 from the oropharynx, and 5 each from the larynx, tongue, and 6 cases of tonsil origin (see chart 2).

The multi-disciplinary care and evidenced based practices approach fostered here is apparent. Seventeen of 19 patients with advanced stage III or IV cancers were treated with a combination of chemotherapy and radiation therapy after surgical biopsy and surgical management.

Table 4: Standard of Care -Chemotherapy + Radiation

| Head & Neck (Stage 3 + 4 Pts by site) | Chemo- therapy + Radiation | No | Total |
|---|----------------------------------|----------|-----------|
| Hypopharynx | 2 | | 2 |
| Larynx | 4 | 1* | 5 |
| Oropharynx | 1 | | 1 |
| Tongue | 5 | | 5 |
| Tonsil | 5 | 1** | 6 |
| Total | 17 | 2 | 19 |

Stage 3 & 4 Patients = 19 Total. Standard of Care indicates combo Chemotherapy & Radiation tx. 17 pts (89%) received chemo/rad,

Review of 2 outliers:
 * Stage 4A Larynx=64 yo F refused tx
 ** Stage 3 Tonsil= 89 yo F w/multiple severe co-morbidities

Conclusion: 2 pts contraindicated
 100% met Standard of Care

Chemotherapy is usually given by infusion at the Rex Hematology Oncology Associates Infusion Center and then the patients move one floor down, often on the same day, to begin and progress to radiation therapy delivered at the Rex-UNC Radiation Oncology Clinic.

Often times, chemotherapy is given on a weekly schedule, though several of the newer regimens give consecutive days of chemotherapy during the first week and the fourth week of a typical 6 to 7-week radiation course. As biologic agents such as cetuximab move to the forefront of combined chemo and radiation therapy treatments, more patients are receiving these targeted therapies for their treatments.

Despite multimodality therapy, local and distant recurrences remain a problem with a 5-year overall survival up to 55% in stages III, IVA, and IVB patients, although it is higher in patients with HPV-related oropharynx cancers. Surveillance for relapse must continue for at least 5 years both within the irradiated neck and for blood borne spread to other body organs. Given the prevalence of cigarette exposure in these patients, the risks of new, second malignancies exist.

At the Rex Cancer Center, our results for these stages are demonstrated below (*see Table 5*).

At this time, 14 of 19 patients are alive and 12 of 19 are alive and free of any disease. Two patients are too early to discern completeness of remission, and 3 patients died of relapsed disease. One patient did not complete therapy and 2 died of treatment-related causes. The patient in the center is too early to evaluate but has had an abnormal follow-up scan.

Table 5: Current Disease Status:

| Current Disease Status <i>Stage 3 & 4</i> | Alive | Expired | Total |
|---|-----------|----------|-----------|
| No Evidence of Recurrence | 10 | 1 | 11 |
| Complete Clinical Response | 1 | | 1 |
| No Clinical Evidence of Recurrence (<i>pending re-eval ?.mass</i>) | 1 | | 1 |
| Not Dx free, Did not complete tx | | 1 | 1 |
| Lung Mets SCC | 1 | | 1 |
| Diffuse Liver Mets | 1 | | 1 |
| Recurrence | | 1 | 1 |
| Expired | | 2 | 2 |
| Grand Total | 14 | 5 | 19 |

Remission from head and neck cancer is proven both by direct and fiberoptic exam and total body PET Scan imaging. After approximately 8 weeks following completion of combined modality therapies, all patients undergo a post treatment direct and fiberoptic exams, and a PET scan to delineate the degree of response. Complete responses are indicated by normalization of the PET scan in the face of regression of palpable and visible tumors. Concerns for local and distant spread of recurrent cancer is noted in our results showing 2 of 19 patients, relapsing distantly in lung and liver.

POST TREATMENT SURVEILLANCE:

Patients will be followed for up to 5 years or more by their treatment team, and now in development, by the Rex Survivorship Program. Patients will be aware of the alarms that may be a sign of relapse, including return of hoarseness, neck swelling, painful swallowing or bleeding.

In the Rex Cancer Center, a formal Survivorship Program is in its infancy. This program will assume the important role of ensuring head and neck cancer patients access to those programs which foster healthy lifestyles (i.e. tobacco and alcohol abstinence), palliation of treatment related toxicities such as hypothyroidism, xerostomia (dry mouth), and dysgeusia (altered taste), and other neuropathies. The focus on lifestyle will also include coping skills, relaxation techniques, and dietary and exercise programs. We look forward a Rex Healthcare Survivorship program, in alliance with the robust Survivorship Program already in place at UNC.

Since approximately 90% of all relapses will occur within 2-4 years after completion of therapies, these are critical time frames for careful surveillance. Most often, the patients are followed by the radiation oncologist, who has the capacity to undertake fiberoptic visualization of the sites of primary disease and possible sites of relapse. The medical oncologist is available to assess abnormal findings, and if relapse occurs in an area that can undergo surgical resection, the ENT surgeon may undertake a definitive resection of relapse, and direct entry of the patient into salvage therapies, currently available.

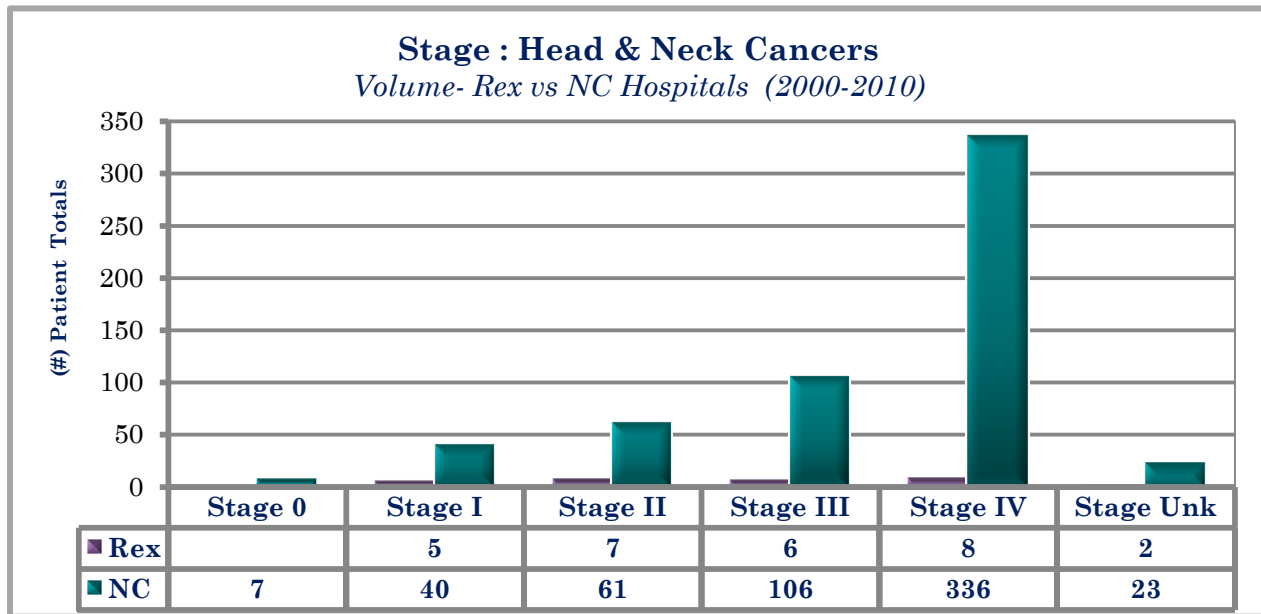
The discontinuance of tobacco and alcohol are highly sought goals of the surveillance and survivorship team, as second malignancies are frequent in the non-abstinent survivors and to a lesser extent, in the non-users as well.

It is essential that regular follow up examinations continue by the patient's treatment team and then their primary physician team beyond 5 years. The risk for new cancers is even greater 5 years post completion of treatment.

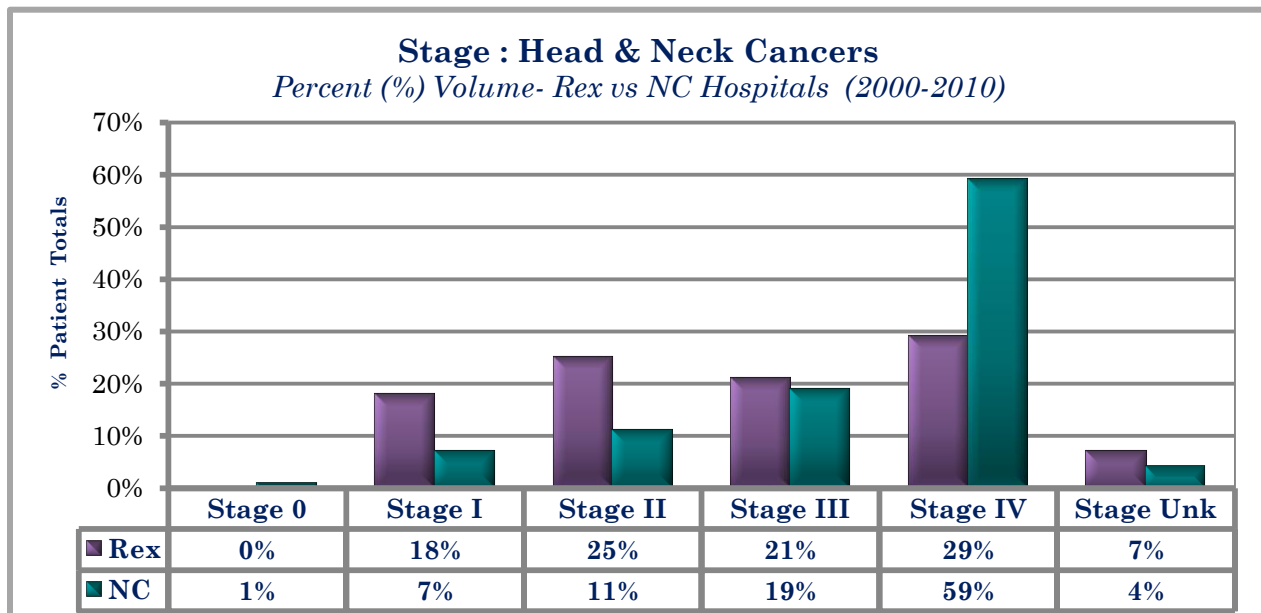
NATIONAL CANCER DATABASE (NCDB) COMPARATIVES:

- ⌘ *Head & Neck Cancer (Oropharynx) Diagnosed 2000 to 2010*
- ⌘ *Total Cases: Rex Healthcare (n=28) NC Hospitals(n=573)*

NCDB Chart A



NCDB Chart B



REX CANCER CENTER TUMOR REGISTRY

& Analytic Cases for 2011 – Total 2249 Cases

Rex Tumor Registry Table A

| REX ANALYTIC CASES 2011 <i>Distribution: Volume By Site & Sex</i> | | | | | |
|--|--------------|-------------|-------------|---------------|-------------|
| PRIMARY | TOTAL | SEX | | | |
| SITE | Cases | Male | % | Female | % |
| BREAST | 742 | 7 | 1% | 735 | 99% |
| PROSTATE | 324 | 324 | 100% | 0 | 0% |
| LUNG | 209 | 123 | 59% | 86 | 41% |
| COLORECTAL | 177 | 84 | 47% | 93 | 53% |
| BLADDER | 114 | 88 | 77% | 26 | 23% |
| LYMPHATIC SYSTEM | 93 | 58 | 62% | 35 | 38% |
| <i>Hodgkin's</i> | <i>13</i> | <i>8</i> | <i>62%</i> | <i>5</i> | <i>38%</i> |
| <i>Non-Hodgkin's</i> | <i>80</i> | <i>50</i> | <i>63%</i> | <i>30</i> | <i>38%</i> |
| BLOOD & BONE MARROW | 93 | 64 | 69% | 29 | 31% |
| <i>Leukemia</i> | <i>34</i> | <i>22</i> | <i>65%</i> | <i>12</i> | <i>35%</i> |
| <i>Multiple Myeloma</i> | <i>25</i> | <i>19</i> | <i>76%</i> | <i>6</i> | <i>24%</i> |
| <i>Other</i> | <i>34</i> | <i>23</i> | <i>68%</i> | <i>11</i> | <i>32%</i> |
| THYROID | 70 | 20 | 29% | 50 | 71% |
| KIDNEY/RENAL | 69 | 41 | 59% | 28 | 41% |
| SKIN MELANOMA | 50 | 29 | 58% | 21 | 42% |
| PANCREAS | 41 | 16 | 39% | 25 | 61% |
| UTERINE | 39 | 0 | 0% | 39 | 100% |
| TOTAL VOLUME (ALL SITES) | 2249 | 966 | 43% | 1283 | 57% |

Rex Tumor Registry Table B

| REX ANALYTIC CASES 2011 <i>Distribution: Volume By Site & Stage</i> | | | | | | | |
|--|-------------------|------------|------------|------------|------------|------------|------------|
| PRIMARY | AJCC STAGE | | | | | | |
| SITE | 0 | I | II | III | IV | UNK | N/A |
| BREAST | 150 | 308 | 161 | 46 | 17 | 60 | 0 |
| PROSTATE | 0 | 101 | 173 | 33 | 9 | 8 | 0 |
| LUNG | 1 | 41 | 16 | 46 | 97 | 8 | 0 |
| COLORECTAL | 12 | 45 | 28 | 38 | 30 | 24 | 0 |
| BLADDER | 73 | 20 | 15 | 3 | 3 | 0 | 0 |
| LYMPHATIC SYSTEM | 1 | 19 | 19 | 15 | 31 | 4 | 4 |
| <i>Hodgkin's</i> | <i>0</i> | <i>3</i> | <i>7</i> | <i>0</i> | <i>3</i> | <i>0</i> | <i>0</i> |
| <i>Non-Hodgkin's</i> | <i>1</i> | <i>16</i> | <i>12</i> | <i>15</i> | <i>28</i> | <i>4</i> | <i>4</i> |
| BLOOD & BONE MARROW | | | | | | 1 | 92 |
| <i>Leukemia</i> | | | | | | <i>1</i> | <i>33</i> |
| <i>Multiple Myeloma</i> | | | | | | <i>0</i> | <i>25</i> |
| <i>Other</i> | | | | | | <i>0</i> | <i>34</i> |
| THYROID | 0 | 52 | 2 | 6 | 6 | 4 | 0 |
| KIDNEY/RENAL | 2 | 44 | 6 | 3 | 9 | 5 | 0 |
| SKIN MELANOMA | 8 | 28 | 3 | 3 | 1 | 3 | 4 |
| PANCREAS | 0 | 2 | 15 | 3 | 19 | 2 | 0 |
| UTERINE | 0 | 28 | 0 | 3 | 4 | 4 | 0 |
| TOTAL VOLUME (ALL SITES) | 257 | 738 | 460 | 236 | 266 | 141 | 151 |

Rex Tumor Registry Table C

| REX ANALYTIC CASES 2011 <i>Distribution: Percent By Site & Stage</i> | | | | | | | | |
|--|----------------|-------|-------|-------|-------|-------|-------|--------|
| PRIMARY | AJCC STAGE (%) | | | | | | | |
| SITE | Total | 0 | I | II | III | IV | UNK | N/A |
| BREAST | 742 | 20.2% | 41.5% | 21.7% | 6.2% | 2.3% | 8.1% | 0.0% |
| PROSTATE | 324 | 0.0% | 31.2% | 53.4% | 10.2% | 2.8% | 2.5% | 0.0% |
| LUNG | 209 | 0.5% | 19.6% | 7.7% | 22.0% | 46.4% | 3.8% | 0.0% |
| COLORECTAL | 177 | 6.8% | 25.4% | 15.8% | 21.5% | 16.9% | 13.6% | 0.0% |
| BLADDER | 114 | 64% | 18% | 13% | 3% | 3% | 0% | 0% |
| LYMPHATIC SYSTEM | 93 | 1.1% | 20.4% | 20.4% | 16.1% | 33.3% | 4.3% | 4.3% |
| <i>Hodgkin's</i> | 13 | 0.0% | 23.1% | 53.8% | 0.0% | 23.1% | 0.0% | 0.0% |
| <i>Non-Hodgkin's</i> | 80 | 1.3% | 20.0% | 15.0% | 18.8% | 35.0% | 5.0% | 5.0% |
| BLOOD/ BONE MARROW | 93 | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 1.1% | 98.9% |
| <i>Leukemia</i> | 34 | | | | | | 2.9% | 97.1% |
| <i>Multiple Myeloma</i> | 25 | | | | | | 0.0% | 73.5% |
| <i>Other</i> | 34 | | | | | | 0.0% | 100.0% |
| THYROID | 70 | 0.0% | 74.3% | 2.9% | 8.6% | 8.6% | 5.7% | 0.0% |
| KIDNEY/RENAL | 69 | 2.9% | 63.8% | 8.7% | 4.3% | 13.0% | 7.2% | 0.0% |
| SKIN MELANOMA | 50 | 16.0% | 56.0% | 6.0% | 6.0% | 2.0% | 6.0% | 8.0% |
| PANCREAS | 41 | 0.0% | 4.9% | 36.6% | 7.3% | 46.3% | 4.9% | 0.0% |
| UTERINE | 39 | 0.0% | 71.8% | 0.0% | 7.7% | 10.3% | 10.3% | 0.0% |
| TOTAL VOLUME (ALL SITES) | 2249 | 11.4% | 32.8% | 20.5% | 10.5% | 11.8% | 6.3% | 6.7% |

REX CANCER CENTER CLINICAL RESEARCH:

ACOS CoC Standard 1.9: Clinical Trial Accrual:

- ⌘ Minimum requirement for a accreditation is 4%
- ⌘ Minimum requirement for commendation is 6%
- ⌘ Rex Cancer Center accrual rate is 14.9%

Clinical Research

| Rex Cancer Center - Clinical Research | | | |
|---|--------------------|--------------------------------|---------------------|
| # | Clinical Trial | # | Clinical Trial |
| 1 | CALGB | 2 | RTOG |
| 8 | CTSU | 1 | SWOG |
| 10 | NSABP | 7 | Locally Developed |
| 13 | Pharma | 261 | University -Related |
| 5 | Primary Prevention | 19 | Research NOS |
| 7 | Quality of Life | | |
| 334 Total Patients | | 2249 Analytic Case Load | |
| 14.9% Analytic Cases Enrolled in Clinical Trials | | | |

REX OUTREACH & SPECIALTY SERVICES

PROVIDING INDIVIDUALIZED SUPPORTIVE CARE- 2012

Cancer Care Navigation

Rex Cancer Care Navigators function in a variety of ways to ensure the highest quality of care for patients along the cancer continuum, including serving as an advocate and team member, coordinator of patient care, liaison between patients, providers, and family members, educator, problem solver, and resource coordinator. Cancer Care Navigation includes breast, GI, and thoracic cancers.

Cancer Navigation Consults

Navigators provide consults to patients after initial diagnosis to provide an overview of surgery options, pre- and post-operative care, resources and special support and guidance for newly diagnosed individuals.

Social Work

The Rex Cancer Center social work team is available to assist patients and their families with needs related to cancer diagnosis and treatment. The social work team assists with crisis management, practical and financial resources, coping and adjustment, support groups and other related issues.

The Social Work Team also administers Rex Angel Fund, a patient financial resource available through The Rex Healthcare Foundation to provide assistance to patients to meet nominal needs to facilitate transportation, nutritional supplements, prescriptions, and other needs that impact a patient's ability to receive care.

Patient and Family Counseling

Individual counseling and support groups are offered to assist in coping with a cancer diagnosis. The opportunity to explore the challenges and changes that diagnosis can bring leads to patients to learning techniques for coping and communicating through the experience.

Nutritional Management

During and following cancer treatment, good nutrition is an important component of healing and maintained health. The Rex Cancer Center Registered Dietician team offers individual consults, management throughout treatment and workshops to assist in learning about good nutritional choices.

Outreach & Support Table A

| SUPPORT & OUTREACH PROGRAMS | 1st Qtr | 2nd Qtr | 3rd Qtr | 4th Qtr | 2012 Total |
|------------------------------------|-------------|------------|------------|------------|-------------|
| Clinical Programs | | | | | |
| Breast Navigation Patients | 752 | 624 | 589 | 687 | 2652 |
| Thoracic Navigation Patients | 122 | 120 | 157 | 137 | 536 |
| GI Navigation Patients | 112 | 179 | 170 | 123 | 584 |
| Nutrition Consults | 638 | 798 | 1111 | 950 | 3497 |
| Social Work Patients | 1021 | 943 | 1013 | 994 | 3971 |
| Breast Surgery Consults | 96 | 90 | 76 | 118 | 380 |
| Ongoing Programs | | | | | |
| Support Program Participants | 916 | 710 | 499 | 277 | 2402 |
| Community Events | | | | | |
| Outreach Programs # Reached | 3508 | 650 | 411 | 572 | 5141 |

SUPPORT PROGRAMS

Rex Cancer Center offers a variety of services and programs to help patients and their families cope with diagnosis, treatment, and recovery from cancer.

⌘ Patient & Family Resource Center:

- Information and Image Recovery Services are available in the Patient & Family Resource Center. Individuals can receive information on a particular diagnosis, treatment, recovery, clinical trials, genetic testing and prevention. Image Recovery appointments are scheduled to assist patients in wig, hat, and scarf selection from complementary resources available in the Resource Center.

⌘ Support Programs

- Rex Cancer Center offers integrative programs to support healing, reduce stress, and assist with side effect management.
- The following services and programs were offered at Rex Cancer Center in 2012:
 - Look Good, Feel Better
 - Get Real & Heel
 - Healing Touch
 - Massage Therapy
 - Art Cart

⌘ Support Groups

- Monthly support groups offer the education, support, and understanding needed to cope with a cancer diagnosis. The following support groups were offered at Rex Cancer Center.
 - Coping with Cancer Support Group
 - Sharing Hope Support Group
 - kidscan! Family Support Group
 - Breast Cancer Network
 - Wake County Prostate Cancer Network

COMMUNITY SUPPORT EVENTS & SERIES

⌘ Cancer Survivors Day

- Each year Rex Cancer Center continues to reach a large number of survivors and their loved ones throughout and beyond Wake County. A nationally recognized day, this survivorship program educates the community that cancer is a survivable disease and offers the opportunity for survivors to celebrate life together

⌘ Living With & Beyond Series

- An annual update in treatment and management of cancer is provided every year for a variety of diagnoses.

⌘ Breast

- Living With & Beyond Breast Cancer has served a unique educational and psychosocial need for newly diagnosed individuals and breast cancer survivors throughout this community since 1993.

⌘ Lymphoma

- The Annual Weber Lecture Series was established through an endowment with The Rex Healthcare Foundation by Dr. Andrew Weber and his sister, in honor of their father.

⌘ Lung

- For a second year, an annual update was provided in conjunction with the Thoracic Multidisciplinary Care Program at Rex which provides a comprehensive diagnostic and treatment team for thoracic cancers.



COMMUNITY OUTREACH PROGRAMS

Community Health Fairs & Talks

Rex Cancer Center provides resources at numerous health fairs throughout the year to provide information to the community and increase awareness of cancer prevention, detection, and treatment. Interactive workshops and presentations are also provided to educate adults about the early detection of cancer.

- ⌘ Brothers and Sisters of Rex is a program that combines awareness about breast, prostate and colorectal cancer. The group, made up of both men and women, shares information in the community about prevention and early detection of these cancers. These specially trained volunteers have made a commitment to provide local citizens with the most current health information and support resources at workshops, health fairs, businesses, churches, community service groups and other community events.

- ⌘ Save Our Sisters of Rex is a group of specially trained volunteers from the community and Rex who have made a commitment to provide local citizens with the most current breast health information, resources and support. Many members of the Save Our Sisters team are breast cancer survivors.



Community Programs Table B

| Events 2012 | Event Beneficiary |
|---|--|
| Le Tour de Femme | The Rex Healthcare Foundation Cancer Center Angel Fund |
| Hoops for Hope | Kay Yow/WBCA Cancer Foundation |
| Race for the Cure | Susan G. Komen for the Cure |
| Raleigh Round Up | American Cancer Society |
| Light the Night | The Leukemia & Lymphoma Society |
| Devil's Ridge Charity Golf Classic | Prostate Cancer Coalition |
| Devil's Ridge Pretty in Pink Golf Rally | Pretty In Pink Foundation |
| Free to Breathe Lung Cancer 5K | National Lung Cancer Partnership |
| Pay-It-Forward Party | The Caring Community Foundation |

References, Guidelines, & Data Sources

References, Guideline, and Data Sources:



- Cancer Program Standards 2012: *Ensuring Patient-Centered Care*. American College of Surgeons Commission on Cancer (ACOS-CoC).2012.
 - National Comprehensive Cancer Network (NCCN): Disease Management Module. Head and Neck Cancer. 2012.
 - National Cancer Data Base(NCDB). Commission on Cancer Datalinks 2012.
 - Rex Cancer Center Tumor Registry. A) Head & Neck Cases 2011. B) Analytic Cases 2012. Electronic Registry Systems (ERS)
 - Up To Date; Topic 3398, Version 13.0 : Brockstein BE, Stenson KM and Sher DJ UTD 2012

Key Contributors:

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