Baptist Cancer Center

ANNUAL REPORT 2019

Carrie McNair –outstanding nurse and cancer survivor

BAPTIST®

CANCER CENTER

Baptist Cancer Center...
we only treat **one patient at a time.**

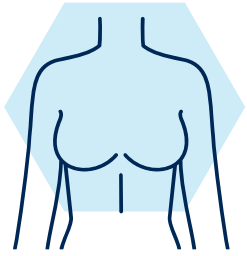
In the world of medical science, it's useful to study large groups of people to detect significant trends in how a disease process works. That's why the larger the group in a scientific study, the greater the validity of the results, and the greater the value for the medical community.

But the truth is, cancer's impact is most strongly felt one person at a time.

- **One person's determination** to work and undergo radiation treatment at the same time.
- **One person's struggle** to explain to her kids that she's OK with losing her hair.
- **One person's effort** to reassure aging parents while coping with his own anxiety.
- **One person's realization** that there is more to life than cancer and cancer treatment.
- And **one person's shout of joy** at the words, "It's gone."

While it's true that Baptist Cancer Center treats more adult cancer patients than any other hospital in Mississippi, it's also true that we only treat one patient at a time. We also strive to communicate preventive measures so others won't have to hear the words "You have cancer."

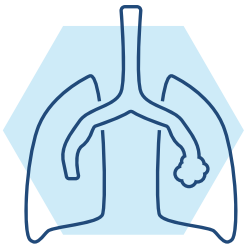
Baptist Cancer Center seeks to pull all our considerable resources together into one place to meet the needs of our patients. Our services extend beyond the doors of the Cancer Center with valuable screenings for cancer detection. Three cancer screenings are offered year-round: **Breast Basic, Lung Select and Save Your Skin.**



Breast Basic is offered through the Center for Breast Health at Mississippi Baptist Medical Center. A screening mammogram often detects the smallest cancers and can enable the care team to diagnose and treat breast cancer at the earliest stages for the best outcomes. With same-day results and surgeon consults available within 48 hours, we not only provide results quickly, but also offer more opportunity for prevention.

Breast Basic is offered for a flat fee of $180, payable by cash only. The price includes the radiologist's fee, and insurance is not filed for this program. Women who have either no insurance or high deductibles for wellness services now have an affordable option for mammograms, the most recognized method for detecting breast cancer at its earliest, most treatable stage.

The Center for Breast Health at Mississippi Baptist Medical Center offers advanced digital technology; same-day results when previous films are available; an all-female staff; a private, comfortable setting; and soft, full-length robes to use during the screening.



Lung Select is recommended for adults ages 55-77 who:

- Currently smoke and have smoked one pack a day for 30 years or two packs a day for 15 years
- Quit smoking within the last 15 years after smoking one pack a day for 30 years or two packs a day for 15 years

Medicare or your insurance plan typically pays for this screening if participants:

- Are 55-77 years old
- Have no symptoms of lung cancer
- Currently smoke and have smoked one pack a day for 30 years or two packs a day for 15 years
- Quit smoking within the past 15 years after smoking one pack a day for 30 years or two packs a day for 15 years
- Have a doctor's order for the screening

The screening includes a Low Dose CT (LDCT) scan to detect abnormalities that may be too small to see on a routine X-ray. The goal of LDCT lung screenings is to save lives. Without an LDCT lung screening, lung cancer is usually not found until a person develops symptoms. At that time, the cancer is much harder to treat. Studies have shown that LDCT lung screenings can lower the risk of death from lung cancer by 20% in people who are at high risk. Early detection is the key.

Approximately 500 new cases of skin melanoma (cancerous growths) are diagnosed in Mississippi each year. Most skin cancers are associated with exposure to the sun. Childhood and adolescent sunburn is an almost universal risk factor for melanoma among Caucasian-Americans. Other risk factors that may contribute to the development of skin cancer include: fair to light skin complexion.; gender (men are more likely to develop skin cancer than women); age; race (risk of melanoma is more than 85 times higher for Caucasian-Americans than for African-Americans); heredity (numerous moles, as well as certain types of high-risk moles, often run in families).

Save Your Skin screenings are offered twice a year in two metro Jackson Baptist Medical Group clinics. They are open to anyone 18 and older, and the clinic providers volunteer their services for the free community screenings. Registration is required, and appointments fill up quickly. A recap of findings is included in the Cancer Committee reports.

IF CANCER IS DETECTED

If cancer is detected through one of the screenings or otherwise, Baptist Cancer Center is ready to treat the whole patient with a range of support programs for our patients and their caregivers. Services include a clinical psychologist who provides individual and group counseling to help patients through the challenges of their diagnoses. Additionally, we offer nutrition counseling with a dedicated dietitian. Orientation is offered two days a week and is a complete overview of cancer treatment, including information about radiation therapy, chemotherapy, nutrition and several other important topics, along with a handbook for each patient.

Practical advice and guidance from our Cancer Center navigators help ensure patients get to the right place at the right time. Our navigators are certified by the Oncology Nursing Certification Corporation and serve as the center's single point of contact for patients and caregivers. They make it easy for patients and their families to access services and information. The navigator follows each patient throughout every aspect of treatment, helping to dispel fear, directing patients to financial and emotional support resources, and addressing the psychological and social needs of patients and families. She provides education about benign and malignant diseases, treatments and side effects. The navigator also coordinates all cancer support groups and activities.

WE TREAT COMPREHENSIVELY

It seems like such a simple statement, but at Baptist Cancer Center we treat the whole patient. And we do whatever we can to deliver on our promise of providing comprehensive, convenient care. Our physician offices, outpatient infusion therapy, inpatient and outpatient radiation therapy, and the extensive range of support services we provide are all accessible conveniently in one building. No crossing the street. No going outside. No moving the car. Once patients come through the door, they're just steps away from every tool we have to provide the best possible outcome.

While colorectal cancer survival rates have continued to climb nationally in the last 45 years, Mississippi still has one of the highest colon cancer death rates in the U.S. In fact, our state's death rate is 40 percent higher than the rest of the country according to a 2015 study

published in Cancer Epidemiology, Biomarkers & Prevention, a journal of the American Association for Cancer Research. More alarmingly, the highest rates of colon cancer deaths are concentrated in 27 counties in the Mississippi Delta region.

At Baptist Cancer Center, we're working hard to reverse that. We are an accredited program of the Commission on Cancer, part of the American College of Surgeons (ACS). Baptist Cancer Center physicians and patients know that our exceptional care is matched only by our dedication to treating all forms of cancer. Our gastrointestinal specialists and oncologists bring the same leading-edge diagnostic tools, advanced research and innovative treatments for colorectal cancer patients that we do for all cancer patients in Mississippi, in one location. It's complete care, and it's the only way we know how to serve the whole patient.

WE TREAT SPIRITUALLY

As a Christian healing ministry, we are followers in faith, guided by the example of Christ. We strive to provide our cancer services in a way that reflects the traditions and compassion of the Christian faith.

Our pastoral care staff includes a chaplain dedicated to Baptist Cancer Center, ministering to cancer patients. For patients who seek spiritual support as part of their cancer care, Baptist provides appropriate avenues for encouragement, prayer and counsel.

CARRIE'S STORY

The Power of Baptist

When Carrie McNair thinks back on the journey she took after her cancer diagnosis, she has but one regret.

"I would much rather have had elbow cancer. Just sounds better," she said, laughing.

Carrie is well-known for her positivity and her infectious sense of humor, and she admits those personality traits helped her through her diagnosis and treatment for colorectal cancer. But she gives the most credit for her current cancer-free status to the doctors and nurses at the Baptist Cancer Center and the specialized, personal and nurturing care she received there.

In 2014, Carrie, herself a registered nurse at Mississippi Home Care, noticed a small area near her anus that didn't seem right, and it never went away. One day at work, she stopped a gastroenterology M.D. in the hallway and asked her if she'd mind taking a look at it.

"She led me to a small room to take a picture of it and we just got to laughing," she recalls. "It was a little uncomfortable and I was genuinely scared, but she assured me that whatever it was we could deal with it. She made me just accept it was a part of life. We just had to laugh about it."

Carrie's fears, however, were quickly confirmed. A biopsy revealed she had squamous cell carcinoma. Two days later, the team at Baptist Cancer Center set her up with a plan.

"Because of the tumor's location, surgery was not ideal," she says. "So instead I was to have two strong doses of chemotherapy, which would probably make my hair fall out, followed by a regimen of 32 doses of radiation."

Throughout the entire process, Carrie said she received a level of care that she had never seen in her 24 years as a nurse.

"The Baptist system is truly dedicated to delivering quality care," says Carrie. "And it's not because I work here and know a lot of the people. None of that mattered because they didn't see me as a co-worker. They treated me like they do every person who comes through here who is scared, suffering and needing a reassuring touch. And a good laugh every now and then. There's not one thing I would change about the care I received there, up to this very day."

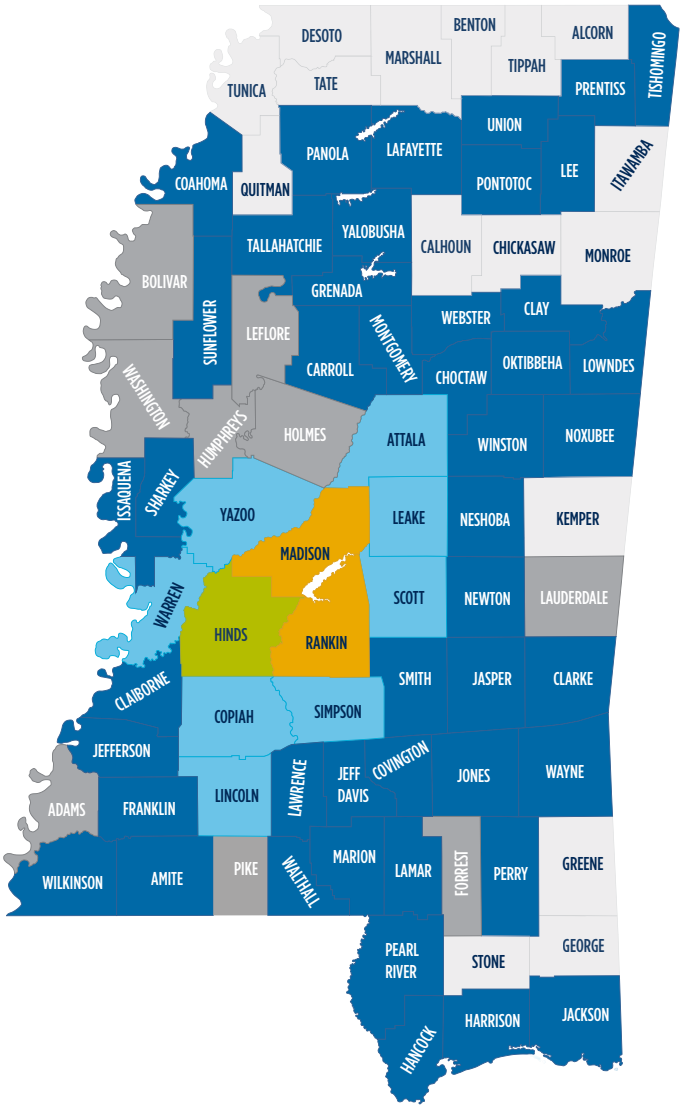
Carrie never did lose her hair, but the cancer was 100% gone. Now five years cancer-free, she is back at work helping others heal and being a mother to her two children. And having survived cancer with the help of her friends at Baptist, she has a greater appreciation of what a special place Baptist is.

"There is a sense of power here that you feel, and it ultimately lifts you whether you're a patient, nurse, doctor or administrator," says Carrie. "Whether it's the power of each individual here, the power of God, the power of hope, or all three, it's that power that allows Baptist to provide the best possible care. And I know that from both sides of the hospital bed."


October
Mississippi
HomeCare

2018 CANCER CASES

Treated at Baptist Cancer Center – Mississippi Baptist Medical Center



Cases by County

Total Cases 2,288

- More Than 400 Patients
- 200-399 Patients
- 50-199 Patients
- 20-49 Patients
- 19 and under
- None

Out-of-State Cases (30)

Alabama - 4
Arkansas - 1
California - 1
Colorado - 1
Louisiana - 21
Missouri - 1
Tennessee - 1

PRIMARY SITE STUDY – COLON CANCER

Colorectal cancer is the third most common cancer, affecting both men and women in the United States with about 70 percent of cases arising in the colon. The American Cancer Society estimates for the United States in 2019 there will be 101,420 new cases of colon cancer and 44,180 new cases of rectal cancer. An estimated 51,020 deaths from colorectal cancer are anticipated during 2019 accounting for 9% of all cancer deaths.[1] Overall, the colorectal cancer death rate in 2016 (13.7 per 100,000) was less than half of that in 1970 (29.2 per 100,000) because of changing patterns in risk factors, increased screening, and improvements in treatment. From 2007 to 2016, the death rate declined by 2.7% per year among individuals ages 55 and older and increased by 1% per year among adults younger than age 55. Overall, the lifetime risk of developing colorectal cancer is about 1 in 23 (4.4%).[2]

Purpose

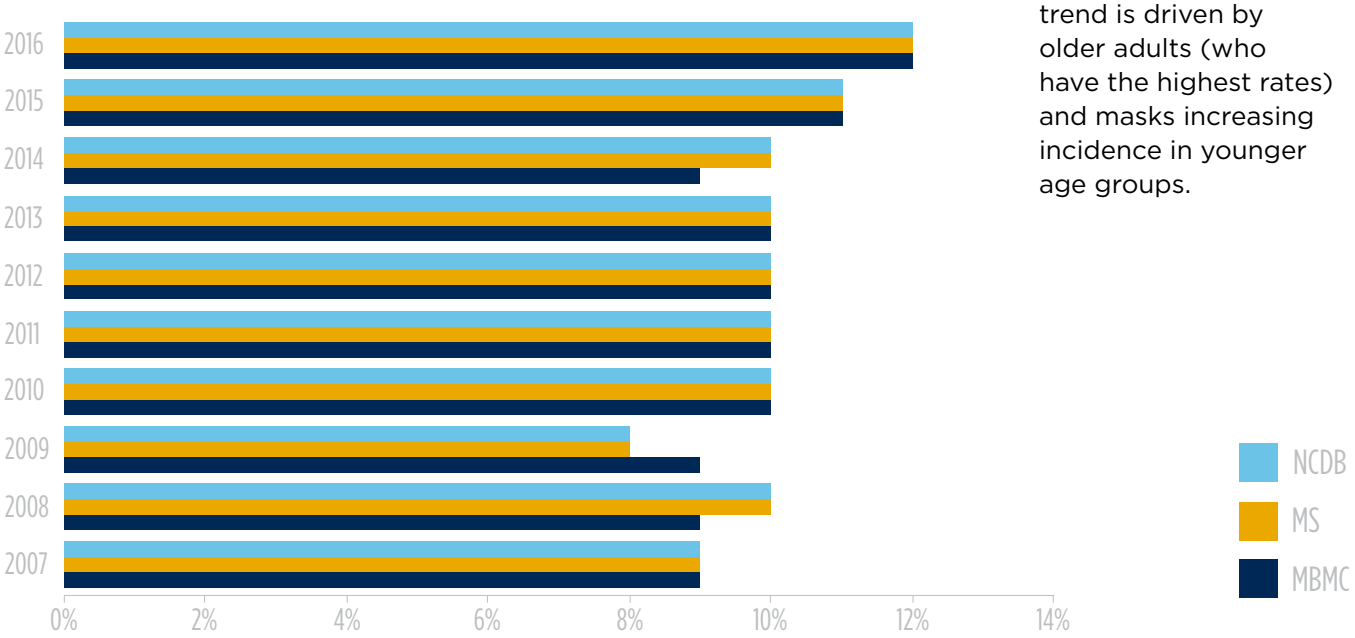
The purpose of this review is to look at patterns of care and outcomes of colon cancer for the cases treated at Mississippi Baptist Medical Center (MBMC) as well as to review United States statistics from the National Cancer Data Base (NCDB). NCDB is a nation-wide oncology database for over 1500 hospitals from 50 states, a joint project between the Commission on Cancer of the American College of Surgeons and the American Cancer Society (ACS). Criteria used for this review of colon cancer cases was the NCDB from Comprehensive Community Cancer Centers in the ACS Region South diagnosed in the years 2007-2016 from 90 non-Mississippi hospitals and 6 hospitals in Mississippi.[3]

Incidence

For this review, the NCDB accessioned 20,745 colon cancer cases; Mississippi (MS) accessioned 4,118 cases and MBMC accessioned 1311 cases. Colon cancer represents 9-12% of all cancer cases for the NCDB, MS and MBMC data. *(Graph 1)*

Colorectal cancer incidence has been declining for several decades due to changes in risk factor exposures and increased screening and public awareness. However, the overall trend is driven by older adults (who have the highest rates) and masks increasing incidence in younger age groups.

Graph 1: Incidence of Colon Cancer



Risk Factors

According to a study by the American Cancer Society researchers, more than half (55%) of colorectal cancers in the US are attributable to potentially modifiable risk factors. Modifiable factors that increase risk include lifestyles to include obesity, physical inactivity, smoking, high consumption of red or processed meat, low calcium intake, heavy alcohol consumption, and very low intake of fruits and vegetables and whole-grain fiber. Risk factors for colon cancer that you cannot change include age over 50, personal history of adenomatous polyps, inflammatory bowel disease, inherited gene mutations such as familial adenomatous polyposis (FAP) and hereditary non-polyposis colorectal cancer (HNPCC or Lynch syndrome). Those with a family history in two or more first-degree relatives have a two to threefold greater risk of disease and account for about 20% of all cases. Current clinical practice guidelines from ASCO and others recommend testing of all colorectal cancer patients for the loss of mismatch repair protein expression (the underlying defect in Lynch syndrome) or microsatellite instability, the biologic footprint of mismatch repair protein deficiency.[4] More than 55% of colorectal cancers should be preventable through increased surveillance and lifestyle changes.[2]

Signs & Symptoms

Regular screening can often detect colorectal cancer early when most are likely "curable". Early stage colon cancer does not typically have signs and symptoms and screening is necessary. Advanced stage disease may include symptoms depending on the location of the cancer in the bowel and whether it has metastasized to other parts of the body. Classic warning signs include: worsening constipation, blood in stool, decrease in stool caliber, loss of appetite, loss of weight, nausea or vomiting, rectal bleeding and anemia (which can cause fatigue and weakness) usually in someone over the age of 50. Increasing incidence of colorectal cancer in young individuals, often diagnosed with advanced disease, reinforces the need for timely evaluation of persistent symptoms in all patients.[3]

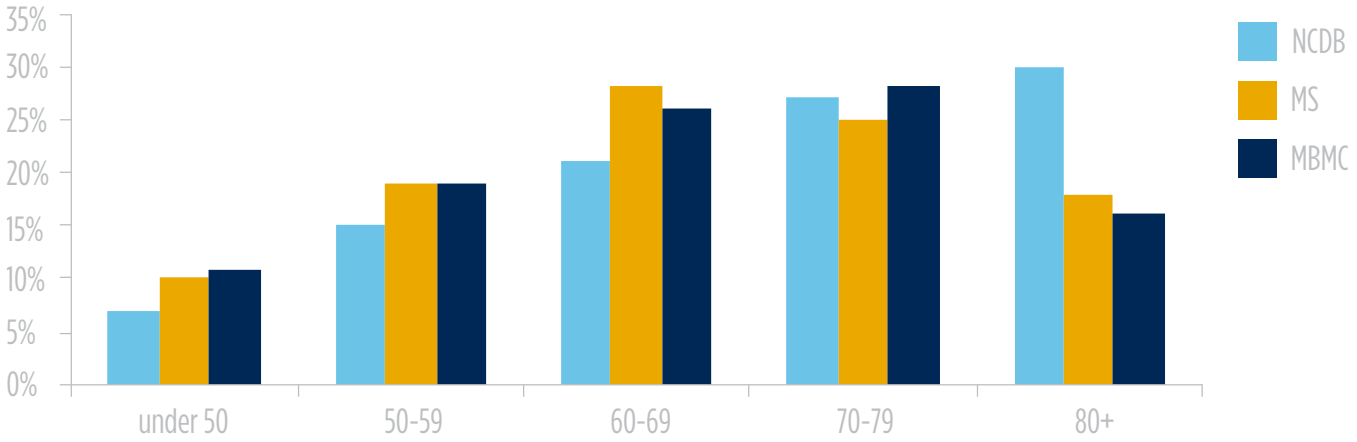
Screening

More than 80% of colorectal cancers arise from adenomatous polyps which makes this cancer amenable to screening. Cases of colorectal cancer diagnosed by screening methods tend to occur 2-3 years before diagnosed symptoms. Regular adherence to either stool testing or colonoscopy over a lifetime results in reducing colorectal cancer deaths. New guidelines from the American Cancer Society recommend that men and women at average risk for colorectal cancer begin screening at 45 years of age and continue up to age 85 depending on health status/life expectancy, with more individualized decision making from ages 76 to 85 based on patient preferences and prior screening history. Colonoscopy use among US adults aged 50 years and older tripled from 21% in 2000 to 60% in 2015.[1]

Age/Sex

Colon cancer incidence increases with age and the majority of cases are diagnosed after age 50. Review of the male to female ratio shows Males: 49% NCDB, 52% MS and 46% MBMC and Females: 51% NCDB, 48% MS and 54% MBMC. MBMC has a little higher female incidence than NCDB or MS. Review of the age at diagnosis reveals 90% over age 50. MBMC has a slightly higher percentage in the 60-69 age group and NCDB higher in 80 and older group. All three data sets are very comparable. *(Graph 2)*

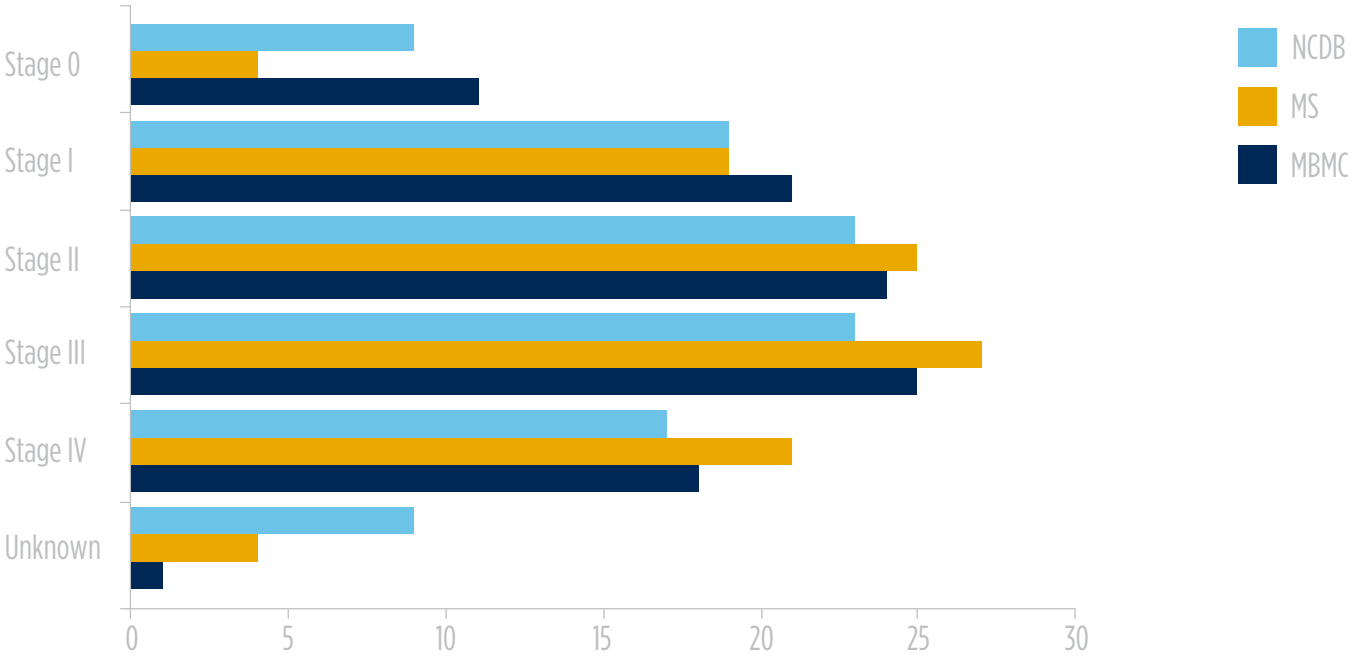
Graph 2: Age at Diagnosis



Stage of Disease

The most common histology for colon cancer is adenocarcinoma accounting for over 90% of the cases. The tumor, node and metastasis (TNM) staging system of the American Joint Committee on Cancer (AJCC) is the preferred staging system for colon cancer.[5] The stage is based on the tumor (T), regional lymph nodes (N) and distant metastasis (M) and the stages range from 0 to IV. Stage 0 is noninvasive (in situ), intramucosal carcinoma (involvement of the lamina propria with no extension through muscularis mucosae); Stage I is a tumor that invades submucosa (T1) or muscularis propria (T2) and without spread to lymph nodes. Stage II is a tumor that invades through muscularis propria into pericolic tissue (T3), a tumor that penetrates to the surface of the visceral peritoneum (T4a), or directly invades or is adherent to other organs (T4b) but without spread to lymph nodes. Stage III has positive regional lymph nodes and Stage IV is distant disease involving the liver, lung, or other organs. Early stage disease is considered Stage 0 - II and MBMC has a slightly higher percentage. NCDB is 51%, 48% for MS and 56% for MBMC. Advanced disease (Stage III and IV) for NCDB is 40%; MS is 48% and MBMC 43%. *(Graph 3)*

Graph 3: Stage of Disease



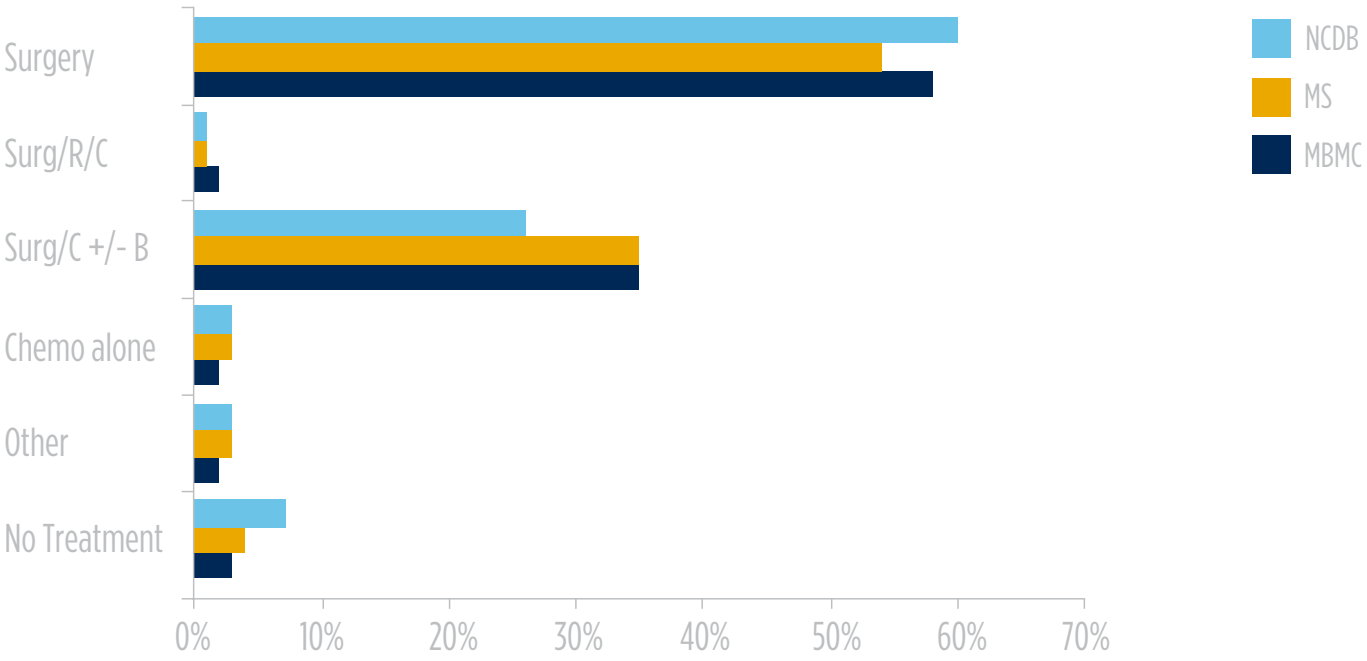
Treatment

Treatment of colon cancer depends on the stage of disease. Surgical resection may be considered "curative" treatment with complete surgical removal of the tumor, major vascular pedicles and lymphatic drainage basin of the affected colon and adequate margins[4], in early presentations. Resection can be performed by "open" surgery or laparoscopically. Regional lymph node dissection provides prognostic information and guides post-op management. There is a direct correlation between the number of lymph nodes evaluated per patient after surgical resection and survival. In addition, the concensus guidelines recommend that at least 12 lymph nodes be assessed for adequate staging. Surgery may be performed for palliation, if the cancer is obstructing the colon, invading or compressing the duodenum or colon (Stage III & IV). In these cases, bypass surgery to overcome the obstruction is to improve quality of life and function.

Spread to regional lymph nodes (Stage III) may reduce 5 year survival depending on the number of positive lymph nodes and the size of the tumor. Adjuvant chemotherapy has shown, in large studies, to increase 5-year survival in these patients approximately 10 to 20% and should be offered after surgery. Chemotherapy regimens most commonly used for colon cancer including: FOLFOX (Oxaliplatin, Fluorouracil, Leucovorin calcium (folinic acid), XELOX (Capecitabine and Oxaliplatin). Biological therapy may be offered using monoclonal antibody antiepidermal growth factors such as Vectibix or Erbitux. Postop radiation is not usually considered as an adjuvant to surgery for colon cancer but is commonly used to treat rectal cancers. (Chemotherapy/ radiotherapy may be offered before or after surgery for rectal cancers.) Palliative care is given for patients with incurable colon cancer to include surgery, radiation and/or chemotherapy for relief of symptoms and improving quality of life.

Reviewing the first course of treatment data for all stages of colon cancer reveals surgery alone for 60% NCDB, 54% MS and 58% MBMC patients which correlates with the majority of early stage cancer. Surgery, chemotherapy, with or without biologic therapy, shows 26% NCDB, 35% MS and 35% MBMC. Chemotherapy alone was 3% NCDB, 3% MS and MBMC 2%. "No treatment" given was 7% for NCDB, 4% for MS, and 3% for MBMC. *(Graph 4)*

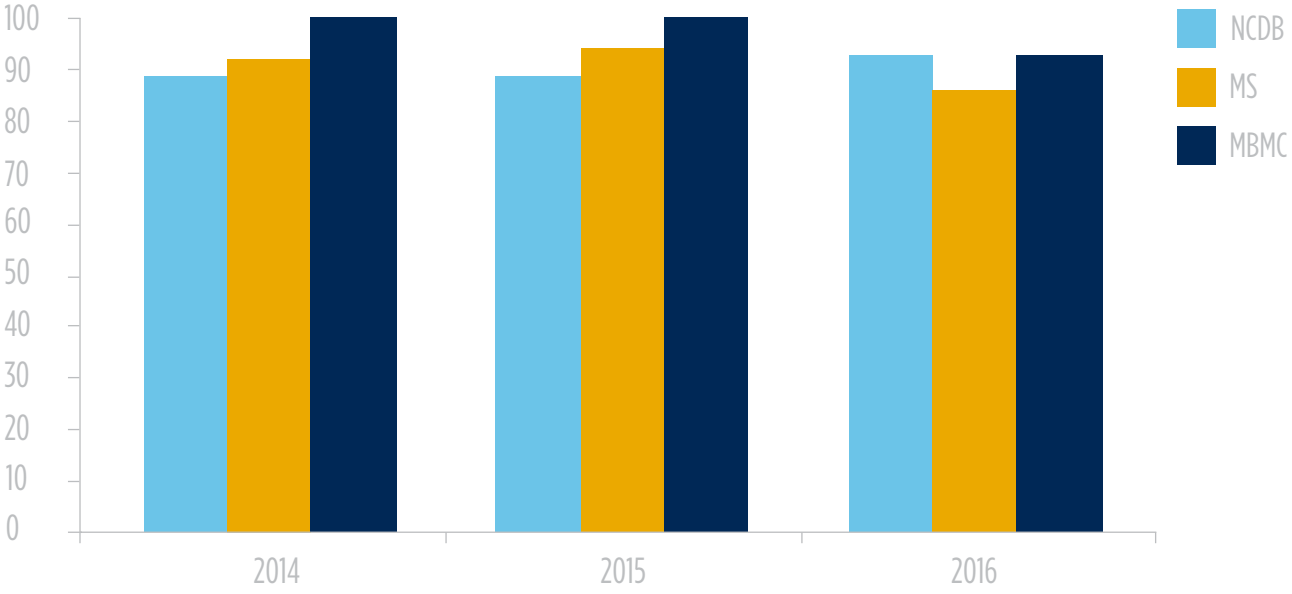
Graph 4: First Course Treatment for Colon Cancer



Quality Measures

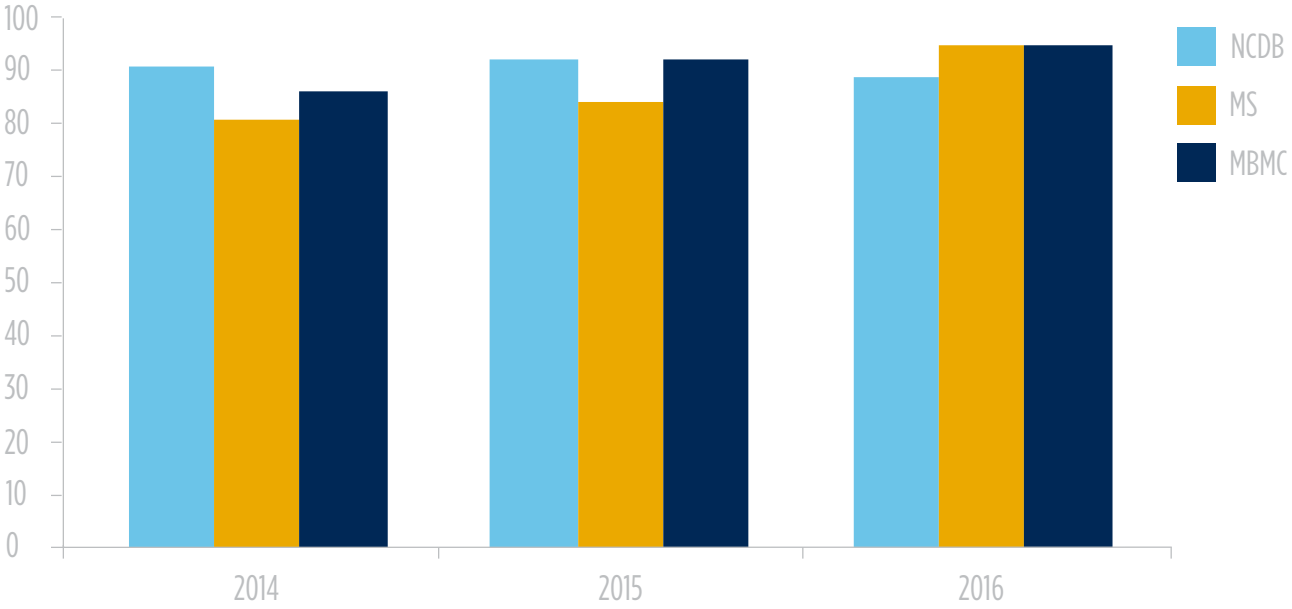
Two quality monitors are reported to the Commission on Cancer through the Cancer Registry, Cancer Program Practice Profile Reports (CP³R). These monitors reflect standard of care for colon cancer and provide compliance rates for the facility, state and national findings.[6] The first monitor is adjuvant chemotherapy (ACT), which is considered or administered within 4 months (120 days) of diagnosis for patients under the age of 80 with AJCC Stage III (lymph node positive) colon cancer. MBMC compliance is slightly higher for each year. *(Graph 5)*

Graph 5: CP3R Adjuvant Chemotherapy for Stage III Colon Cancer



The second colon monitor suggests that at least 12 regional lymph nodes (12RLN) be removed and pathologically examined for colon cancer. *(Graph 6)*

Graph 6: CP3R - 12 Regional Lymph Node Removal (12RL)



Compliance to these standards of care helps meet the current CoC Cancer Program Standards. MBMC participates in the Commission on Cancer, Rapid Quality Reporting System (RQRS) to allow access to clinical real time performance rates. This information will allow more timely interventions to enhance quality of care. The current RQRS program is under revision and final percentage rates are not currently available but the data is monitored and tabulated throughout the year.

Summary

The incidence of colon cancer for all the data sets is about 9% to 10% of all cases per year. The age at diagnosis reveals 90% over age 50. MBMC has slightly higher percentage of cases in the 60-69 age group and NCDB higher in the 80+ age ranges. Most common histology for colon cancer is adenocarcinoma, which accounts for over 90% of the cases. MBMC has a higher percentage of early stage disease for the study period. Surgery alone was comparable for the data sets but multi-modality therapy at MBMC is reported to be slightly higher in the data comparison. Concurrent monitoring reveals good compliance with adjuvant chemotherapy for Stage III and "12 regional lymph nodes resected" as reported by CP3R program. Participation in the RQRS program allows improved quality of care through concurrent monitoring.

Mississippi Baptist Medical Center has maintained accreditation as a "Comprehensive Community Cancer Program" for years through the Commission on Cancer with our latest survey in the fall of 2018. Our center offers a full complement of services. MBMC has easy access to a wide range of services with board certified physicians and certified technicians for services that include state-of-the-art diagnostic imaging and treatment. Physician specialists including gastroenterologists, radiologists and pathologists participate in work-up, biopsy, staging and diagnosis of disease. Surgeons perform the various surgeries (curative and palliative); both open and laparoscopic, recommended for managing colon cancer. MBMC has medical and radiation oncologists in addition to gastroenterologists, pathologists and radiologists. Baptist Cancer Center Services include oncology nurses, registered dietitians, chaplains, a board certified clinical psychologist and navigators - all dedicated to caring for patients with cancer. Services include genetic testing, chemotherapy and biological drugs, radiation services and clinical trials to help make MBMC a leader in treating cancer. To further enhance patient care, weekly multidisciplinary patient care conferences are held; specialists in all disciplines discuss the patient's case, review pathology and radiology findings and discuss the plan of care. Appearances, a boutique which carries wigs, hats, scarves and skin care products for patients undergoing therapy, is there to assist patients with their physical appearance. It is located at the Baptist Cancer Center entrance on the ground floor.

For more information about Baptist Cancer Center services, please visit **baptistcancercenter.com.**

Summary prepared by Richard B. Friedman, MD and Pam Barlow, CTR.

References

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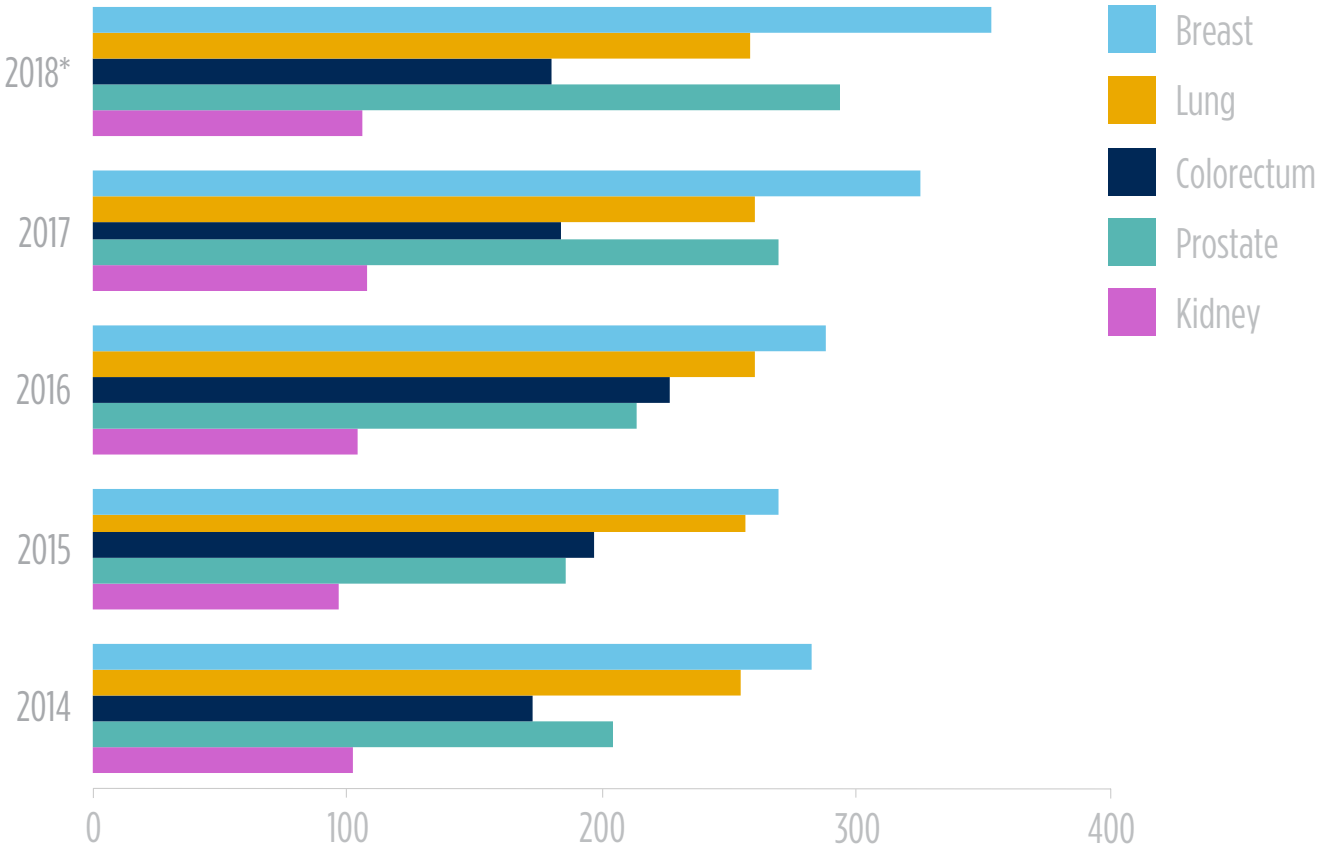
2. American Cancer Society: Colon and Rectum. 2019 Facts & Figures. Page 13-15.
3. Commission on Cancer, American College of Surgeons. NCDB Hospital Comparison Benchmark Reports, Cases 2007 – 2016. Chicago, IL, 2018
4. 2018 UpToDate: Overview of the management of primary colon cancer, Literature Review current through July 2019 and last up dated: Jul 11, 2019, online.
5. American Joint Committee on Cancer Staging Manual, 8th Edition, 3rd printing, Springer pages 268-269.
6. Commission on Cancer, American College of Surgeons, Cancer Quality Improvement Program (CQIP) MBMC Annual Reports 2017-2019, slides 28-30.

CANCER REGISTRY

The Cancer Registry is an important part of the cancer program at Mississippi Baptist Medical Center with the primary goal to maintain an accurate comprehensive database for patients diagnosed and/or treated with cancer or a reportable tumor since January 1982. The registry collects cancer related data from diagnosis through treatment as well as lifetime follow-up. The Baptist database includes more than 67,000 cases. Registry data reports the incidence of cancer seen at MBMC for educational purposes, and evaluating patient care provided, as well as treatment outcomes and survival results. The registry submits data annually to the National Cancer Data Base (NCDB), the Mississippi Cancer Registry monthly and to the Rapid Quality Reporting System monthly. Annual patient follow up is essential to assess treatment outcomes. The Baptist Cancer Registry exceeds the standards for follow up with a rate of 93% for the patients in last 5 years and 83% for patients since the reference year of 1982.

MBMC Top Cancer Sites 2014-2018*



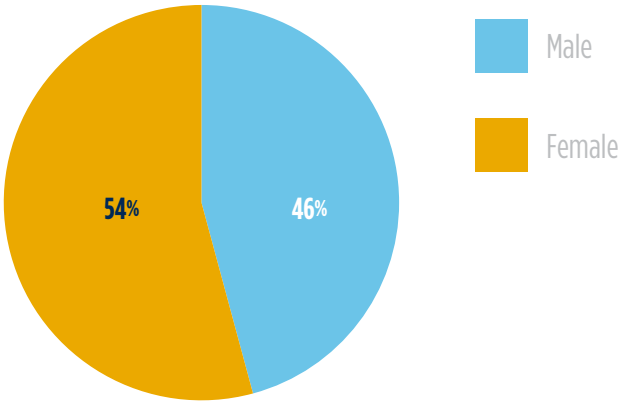
Summary of 2018 Cases*

Total new cancer registry cases	2288
Analytic (diagnosed and treated at Baptist)	1850
Non-Analytic (1st seen at Baptist on recurrence)	438

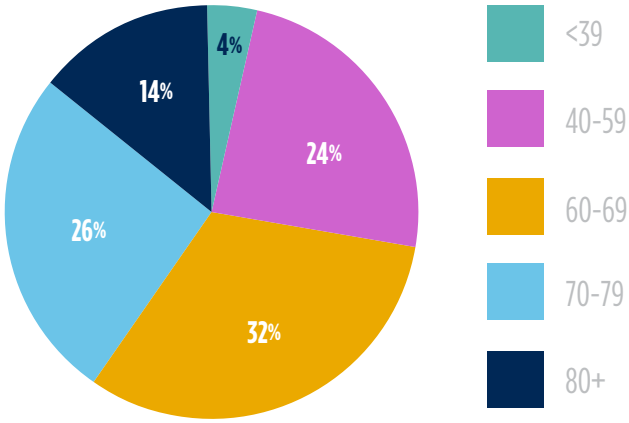
**abstracting of all cases not complete at this time*

Statistics for 2018 Analytic Cases (1850)

Sex



Age of Diagnosis

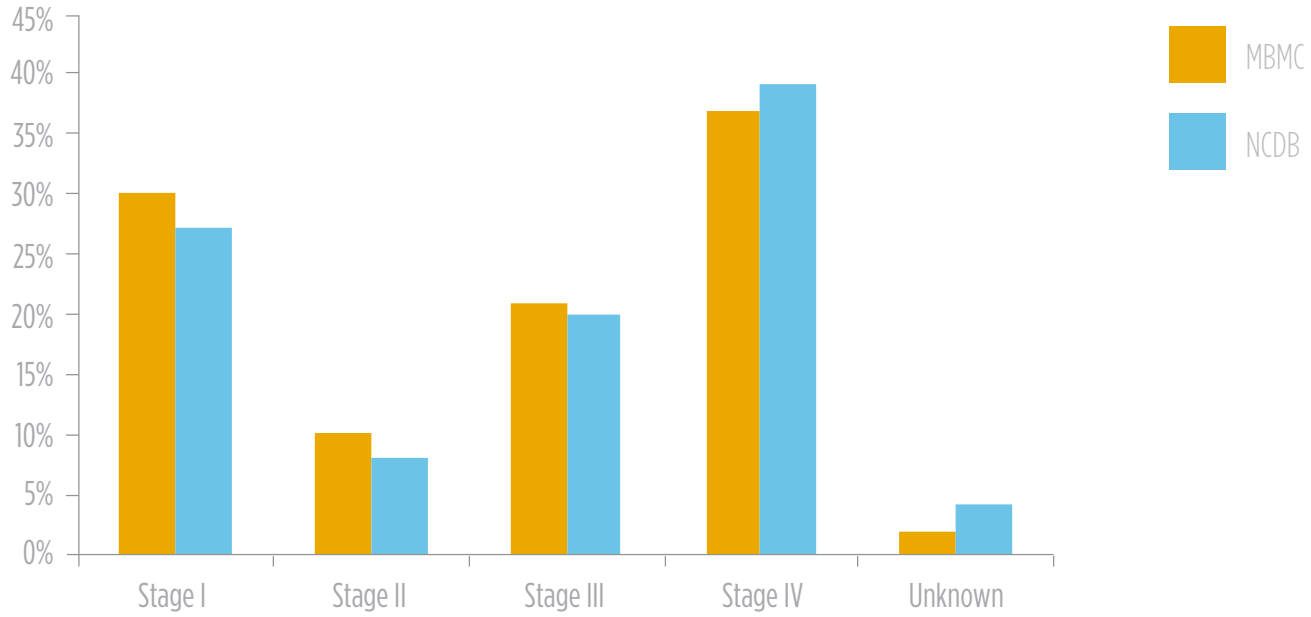


The 2018 analytic primary sites for Mississippi Baptist Medical Center (MBMC) reveal the top five to be breast, lung, prostate, colorectal and kidney. The NCDB data reveals the top sites in the U.S. to be lung, breast, colorectal and prostate as well as the major sites for Mississippi data correlates with the MBMC top sites.

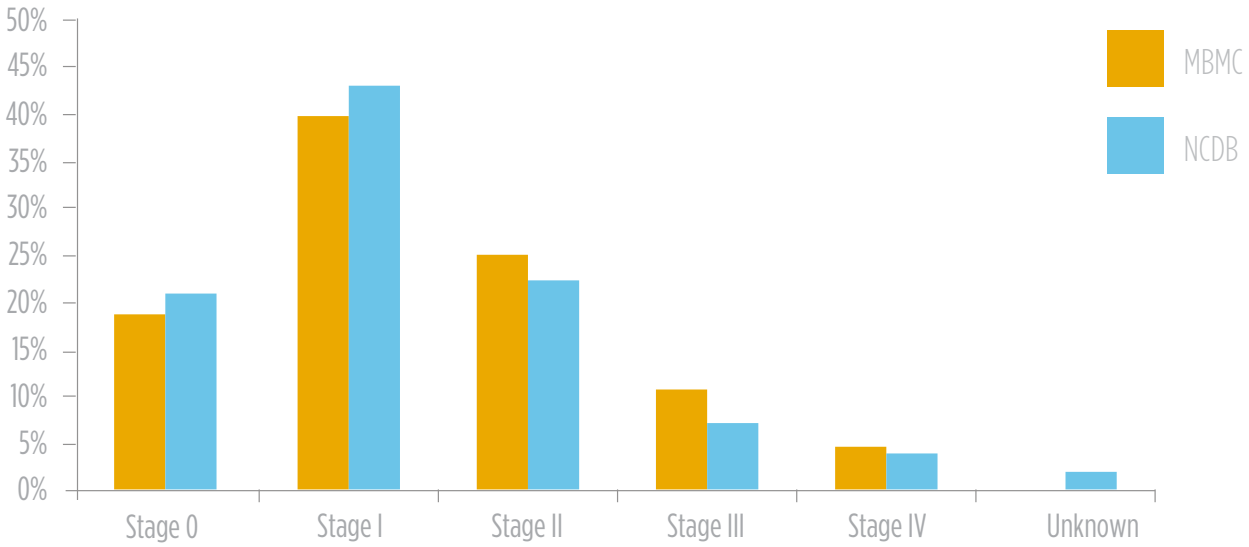
Stage of Disease

The AJCC Stage of Disease for some of the top primary sites for MBMC and NCDB 2007-2016 cases were reviewed for non-small cell lung, breast and prostate cancer. Data reveals very similar stage of disease between the two data sets. See graphs for details.

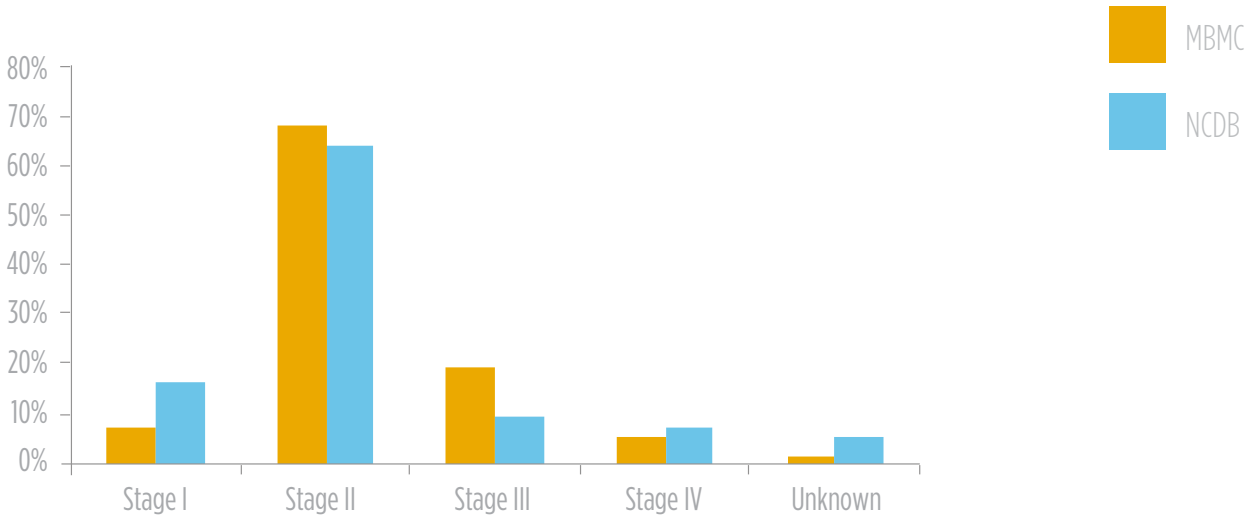
Non-small Cell Lung Cancer



Breast Cancer



Prostate Cancer



Quality Data

MBMC has been participating with the **Cancer Program Practice Program (CP3R)** since 2004. This covers the quality measures reported through the National Cancer Data Base Call for Data annually. The sites include breast, colon, non-small cell lung, prostate, endometrium, cervix, ovary, gastric and bladder. The most current available data from 2016 reveals good compliance with all measures above CoC standards. No new information released.

MBMC has been participating with the **Rapid Quality Reporting System (RQRS)** since 2014. A web-based, systematic data collection and reporting system that advances evidence-based treatment through a prospective alert system for anticipated care that supports care coordination required for breast and colorectal cancer patients at the local level.

CANCER CONFERENCES

Tumor Board and Comprehensive Breast Patient Care conferences are held at Mississippi Baptist Medical Center in the Baptist Cancer Center Conference Room every Monday at 5:00 p.m. The Neurology/ Neurosurgery/Radiology meetings are held every Tuesday at 7:30 a.m. The Lung Nodule conference meets at 12:00 p.m. on Tuesday as needed to review abnormal Low Dose CT Chest screenings. These patient care conferences offer multidisciplinary consultative services for patients along with an educational opportunity for the cancer support professionals. Discussions include the use of AJCC stage of disease, prognostic indicators and evidence-based national treatment guidelines in planning for optimal treatment strategies and expected outcomes.

In 2018, 263 cases, or 15% of analytic cases were discussed at the meetings with 100% of the discussions for prospective treatment options and management. The major primary sites discussed were breast, lung, CNS tumors, colon, rectum, endometrium and melanoma cases.

Mississippi Baptist Medical Center is accredited by the Mississippi State Medical Association to provide continuing medical educational (CME) for physicians. Participation in the conference earns one hour of Category I Continuing Education credit. Conferences are open to all the medical staff and appropriate ancillary personnel. Anyone interested in presenting a case or receiving a weekly agenda, may contact the Cancer Registry at 601-968-1339.

Physicians Presenting at Cancer Conferences in 2018

Justin T. Baker, MD
Scott M. Berry, MD
H. Gregory Fiser, MD
Richard B. Friedman, MD
Alexander J. Haick, MD
Gina Heath, MD
A. Michael Koury, MD
Derek Letort, MD
Phillip B. Ley, MD
Kara Logan, MD
James L. Moore, MD
Jason G. Murphy, MD
Martin Newcomb, MD
Natale Sheehan, MD
Grace G. Shumaker, MD
David Sinclair, MD
W. Lynn Stringer, MD
M. Jeanann Suggs, MD, PhD
Matthew A. Vanlandingham, MD
Richard E. Weddle, MD
Tammy H. Young, MD

Pathologists:

Steven Bigler, MD
Kathryn Brown, MD
Nanette Pinkard, MD
William Payne, MD

Radiologists:

E. J. Blanchard, MD
Larkin Carter, MD
Gary A. Cirilli, MD
J. Mack Haltom, III, MD
R. Houston Hardin, MD
Jason R. Hosey, MD
Edward K. Phillips, MD
Charles K. Pringle, MD
C. Dallas Sorrell, MD
J. Dean Tanner, MD
Timothy G. Usey, MD

2019 CANCER COMMITTEE

Richard B. Friedman, MD
Radiation Oncology
Chairman

A. Michael Koury, MD
Thoracic Surgery
American College of Surgeons
Cancer Liaison Physician

Justin Baker, MD
Medical Oncology

Steven Bigler, MD
Pathology

Alexander Haick, MD
Surgery

Jason Hosey, MD
Diagnostic Radiology

Michael Maples, MD
Chief Medical Officer

James L. Moore, MD
Gynecologic Oncology

William Payne, MD
Pathology

Dallas Sorrell, MD
Radiology

Natale Sheehan, MD
Medical Oncology

M. Jeanann Suggs, MD, PhD
Radiation Oncology

Margaret Wadsworth, MD
Radiation Oncology

Bob Wilkerson, MD
Medical Oncology

Tammy Young, MD
Medical Oncology

Tonya Ball, BSN, RN, OCN
Cancer Center Patient Navigator
Community Outreach Coordinator

Pam Barlow, CTR
Cancer Registry Coordinator
Quality of Cancer Registry Data Coordinator

Deborah Campbell, CTR
Cancer Registrar
Cancer Conference Coordinator

Teresa Davis, BSN, RN, OCN
Clinical Trials Coordinator

Roberta Day, RN, OCN
Cancer Center Patient Navigator

Harold Gore, PharmD
Bryan Miller, PharmD
Oncology Pharmacists

Michael Hall, MBA, BS, R.T.(R)(N), CNMT
Director of Radiation Oncology
Quality Improvement Coordinator

Brenda Howie, Ph.D., MSN, RN-BC
Chief Nursing Officer

Amanda James, BSN, RN
Nurse Manager, Oncology Inpatient and Outpatient

Bufkin Moore, PsyD
Oncology Counselor

Jeff Parker, B.C.C.
Chaplain

Deniece Ponder, MHSA, BSN, RN, OCN
Administrative Director of Oncology Services

Dana Price, RD
Clinical Dietitian

Karen Ross, LSW
Social Worker/Discharge Planning

Adrienne Russell, RN, MSN, CN-BN
Breast Health Patient Navigator

Ginger Stover, PT, DPT, CLT
Lymphedema Coordinator

Bobbie Ware, MHSA, BSN, RN, NEA-BC, FACHE
Chief Executive Officer

Robert Ware, MHA, MSN, CEN, ACNPC-AG
Director of Clinical Improvement
Palliative Care

PRIMARY SITE 2018 ALL CASES*

	Total	Class		Sex	
		Analytic	N/A	M	F
All Sites	**2288**	**1850**	**438**	**1052**	**1236**
Oral Cavity	**18**	**9**	**9**	**10**	**8**
Lip	0	0	0	0	0
Tongue	7	4	3	3	4
Oropharynx	0	0	0	0	0
Hypopharynx	2	1	1	2	0
Other	9	4	5	5	4
Digestive System	**428**	**359**	**69**	**205**	**223**
Esophagus	21	17	4	16	5
Stomach	38	31	7	18	20
Colon	166	144	22	72	94
Rectum	47	36	11	28	19
Anus/Anal Canal	9	8	1	2	7
Liver	21	17	4	12	9
Pancreas	89	74	15	42	47
Other	37	32	5	15	22
Respiratory System	**325**	**267**	**58**	**178**	**147**
Nasal/Sinus	2	1	1	0	2
Larynx	10	8	2	6	4
Lung/Bronc-Small Cell	55	50	5	30	25
Lung/Bronc-Non Small Cell	218	191	27	122	96
Other Bronchus & Lung	40	17	23	20	20
Blood & Bone Marrow	**66**	**54**	**12**	**26**	**40**
Leukemia	33	25	8	14	19
Multiple Myeloma	30	26	4	9	21
Other	3	3	0	3	0
Bone	**3**	**1**	**2**	**2**	**1**
Connect/Soft Tissue	**7**	**6**	**1**	**6**	**1**
Skin	**45**	**19**	**26**	**27**	**18**
Melanoma	31	17	14	17	14
Other	14	2	12	10	4

**abstracting of all cases not complete at this time*

	Total	Class		Sex	
		Analytic	N/A	M	F
Breast	**415**	**353**	**64**	**1**	**416**
Female Genital	**145**	**113**	**32**	**0**	**145**
Cervix Uteri	22	19	3	0	22
Corpus Uteri	76	65	11	0	76
Ovary	17	14	3	0	17
Vulva	16	6	10	0	16
Other	14	9	5	0	14
Male Genital	**362**	**296**	**66**	**362**	**0**
Prostate	359	293	66	359	0
Testis	2	2	0	2	0
Other	1	1	0	1	0
Urinary System	**209**	**156**	**53**	**127**	**82**
Bladder	90	44	46	58	32
Kidney/Renal	112	106	6	67	45
Other	7	6	1	2	5
Brain & CNS	**31**	**25**	**6**	**11**	**20**
Brain (Benign)	5	5	0	3	2
Brain (Malignant)	10	8	2	4	6
Other	16	12	4	4	12
Endocrine	**84**	**74**	**10**	**27**	**57**
Thyroid	58	54	4	15	43
Other	26	20	6	12	14
Lymphatic System	**87**	**66**	**21**	**45**	**42**
Hodgkin's	11	11	0	5	6
Non-Hodgkin's	76	55	21	40	36
Unknown Primary	**43**	**38**	**5**	**19**	**24**
Other/Ill-Defined	**18**	**14**	**4**	**6**	**12**

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