

2008

Sutter Health Cancer Services and Programs
Focus on Non-small Cell Lung Cancer



Sutter Health
With You. For Life.

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Cancer services and programs



Michael J. Cassidy, MD
Chair, Cancer Program Group

Dear Colleagues:

The members of the Sutter Oncology Division, whose programs have been approved by the American College of Surgeons (ACoS), are pleased to present our 2008 Annual Report. This report features a statistical overview of the Sutter Health 2007 Cancer Registry data, summarizing over 9,900 new cases of cancer seen in 2007 at our ten American College of Surgeons accredited institutions. Our cancer registries are responsible for collecting comprehensive data on all these patients, providing demographic, diagnostic, treatment, and long-term follow-up information. The most common cancers are detailed in particular and their prevalence compared with trends seen across California and nationally.

Each year our report provides a detailed study of one of the five most common malignancies seen within our system. During recent years our annual reports have reviewed demographic, treatment and outcome trends for patients with breast cancer (2007) prostate cancer (2006), colorectal cancer (2005), and non-Hodgkin's lymphoma (2004). This year lung cancer is our focus, it being the leading cause of death from cancer in both men and women. From 1993 to 2007 our cancer registries have tracked almost 12,700 cases of non-small cell lung cancer and page 14 report of this report presents our examination of these data. We appreciate the work of Dr. E. Wayne Torigoe and Eric Gold, Oncology Analyst, in providing us an excellent review and analysis with comparisons to national data.

Our ten American College of Surgeons accredited hospitals are proud of the efforts continually made in providing comprehensive care to our cancer patients. Our centers emphasize state-of-art diagnostic and therapeutic programs, provided conveniently in the patient's local community. We appreciate the efforts of all caregivers at our institutions who provide ongoing, high-quality compassionate care to our patients.

We hope you will enjoy and learn from our presentation of this Sutter Health lung cancer report and, at the same time, appreciate the extent of services available at each of our member institutions which are detailed in this report.

Michael J. Cassidy, MD
Chair, Cancer Program Group

Sutter Health Cancer Program Facilities

Many dedicated individuals make this report, and the programs and services described in it, possible. Their contributions are gratefully acknowledged.

ABSMC-Alta Bates

Michael Cassidy, MD, Medical Director
Norman Cohen, MD, Cancer Committee Chair
Jeffrey Wolf, MD, Medical Director, BMT Program
Pam Davis, RN, Director Oncology Services
Stephen Bishop, CTR, Manager, Cancer Data Services
Eric Gold, Oncology Analyst/Programmer

CPMC

Margo Cusack, RTT, Director of Oncology and Imaging Services
Terry Pierce, RTT, Manager of Radiation Oncology and Oncology Services
Joyce Louie, RHIT, CTR, Cancer Registrar
Daniel Glaubiger, MD, Cancer Committee Chair
Kathleen Grant, MD Chair, Division of Hematology-Oncology

EMC

Ostap Melnyk, MD, Cancer Committee Chair
Bryan Daylor, Vice President, Ancillary & Support Services
Margaret H. Espitalier, CTR, Manager, Tumor Registry (EMC & SLH)

MGH

Lloyd Miyawaki, MD, MPH, Medical Director
Linda Tavaszi, Executive Director of Physician Services and Marin Cancer Institute
Jenny Shaw, CTR, Director Cancer Center Services
Wendi Canlett, Cancer Registry Data Specialist
Lois Infrerra, CTR, Coordinator, Cancer Data/Registry Services
Cheryl Nightengale, CTR, Coordinator, Cancer Data Registry Services

MMC

David Shiba, MD, Medical Director and Cancer Committee Chair
Beverly Paderes, Cancer Services Manager
Cheryl Casey, Cancer Registry and Special Projects Coordinator
Annette Glass, CTR, Certified Tumor Registrar

MPHS

Brian Henderson, MD, Cancer Committee Chair
Sheila Littrell, RN, Director of Cancer Program
Lisa Syrett, CTR, Cancer Registry Coordinator

ABSMC - Summit

Lisa Bailey, MD, Medical Director
Larry Strieff, MD, Medical Director
Pam Davis, RN, Director Oncology Services
Stephen Bishop, CTR, Cancer Data Services Coordinator

SAFH

Barton Bradshaw, MD, Cancer Committee Chair
Coleen Kuelper, Cancer Program Administrator
Lindsey Holloway, Cancer Research and Data Services Manager
Pat Elder, CTR, Tumor Registrar

SMCS

Gregory Graves, MD, Medical Director
Michael Carroll, MD, Medical Director, BMT Program
Margaret Mette, Assistant Administrator
Lindsey Holloway, Cancer Research and Data Services Manager
Marilyn Diehl, CTR, Tumor Registrar

SRMC

Uma Gowda, MD, Medical Director
Deborah Dix, RN, Oncology Director
Diana Pope, CTR, Cancer Center Supervisor

SSMC

Patricia Seid, MD, Medical Director
Rachael L. Albertson, MHA, Administrative Director
Marissa Salvatin, RHIT, CTR, Cancer Registry Coordinator

Data analyses contributed by Eric Gold, Oncology Analyst/Programmer at Alta Bates Summit Medical Center

The Sutter Health Cancer Programs offer a complete array of services for cancer patients, including screening, diagnosis, treatment, education and support. These services include advanced treatments such as bone marrow transplants, specialized treatments such as cryosurgery, and complementary medicine approaches such as interactive guided imagery.

Services are available in ten geographic locations throughout the Sacramento/Sierra Region, the Central Valley and the San Francisco Bay Area. See page 3 for a complete listing of services offered at each organization.

SUTTER HEALTH CANCER PROGRAMS ARE AVAILABLE AT:

Alta Bates Summit Medical Center – Alta Bates (ABSMC)

2450 Ashby Avenue
Berkeley, CA 94705
510-204-2793

California Pacific Medical Center (CPMC)

2333 Buchanan Street
P.O. Box 7999
San Francisco, CA 94115
415-600-2080

Eden Medical Center (EMC)

20103 Lake Chabot Road
Castro Valley, CA 94546
510-537-1234

Marin General Hospital (MGH)

250 Bon Air Road
Greenbrae, CA 94904
415-925-7000

Memorial Medical Center (MMC)

1700 Coffee Road
Modesto, CA 95355
209-526-4500

Mills-Peninsula Health Services (MPHS)

Dorothy E. Schneider Cancer Center
100 South San Mateo Dr.
San Mateo, CA 94401
650-696-4509

Sutter Auburn Faith Hospital (SAFH)

11815 Education Street
Auburn, CA 95602
530-888-4500

Sutter Medical Center, Sacramento (SMCS)

2800 L Street
Sacramento, CA 95816
916-454-6500

Sutter Roseville Medical Center (SRMC)

One Medical Plaza
Roseville, CA 95661
916-781-1617

Sutter Solano Medical Center (SSMC)

100 Hospital Drive
Vallejo, CA 94589
707-554-4444

Introduction

Cancer Support Services

This table displays the broad range of services available from the Sutter Health ACoS Cancer Programs. For specific facility locations and contact information, see page 2. Although this table is reflective of actual services physically at the locations, we understand that many of you offer these services through referrals within your region and other Sutter Affiliates.

SERVICES	ABSMC	CPMC	EMC	MGH	MMC	MPHS	SAFH	SMCS	SRMC	SSMC	PAMF
American College of Surgeons Accredited Cancer Center	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
Bone Marrow Transplants	Y							Y			
Brachytherapy	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
Cancer Surgery	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Cancer Clinical Trials & Prevention Trials	Y	Y		Y	Y	Y		Y	Y	Y	Y
Cancer Education Programs	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Cancer Support Groups	Y	Y	Y	Y	Y	Y		Y	Y	Y	
Community Screenings for Cancer	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
Indoor Pool for Patient/Rehab		Y	Y			Y			Y		
Core Needle Biopsy - Ultrasound	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
Core Needle Biopsy - Stereotactic	Y	Y	Y	Y		Y		Y	Y		
Stereotactic Radiosurgery & Radiotherapy on Site	Y	Y	Y	Y				Y			
Cryosurgery	Y	Y	Y		Y	Y		Y		Y	
Gamma Knife on Site		Y						Y			
Infusion Therapy	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y
Interventional Radiology	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
Liver Transplant for Hepatoma		Y									
Mammography	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y
Minimally Invasive Surgery	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
Pediatric Cancer Care and Surgery	Y	Y						Y			
PET – Positron Emission Tomography on Site	Y	Y	Y	Y	Y	Y		Y	Y		Y
Image-Guided Prostate Radiation Therapy	Y	Y	Y	Y	Y			Y	Y	Y	
Radiation Oncology Services	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y
Radiofrequency Ablation on Site	Y	Y				Y		Y			
IMRT	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y
SPECT	Y	Y	Y	Y		Y		Y	Y		
Tumor Board	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
Tumor Registry (in-house)	Y	Y	Y	Y	Y	Y		Y	Y	Y	
OUTPATIENT SERVICES											
Valet Parking	Y	Y		Y		Y		Y	Y		
Comprehensive Breast Center	Y	Y	Y	Y		Y		Y	Y	Y	
Cancer Treatment Center	Y		Y	Y	Y	Y		Y	Y	Y	Y
Chemotherapy Treatment	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Home Care & Hospice	Y	Y	Y	Y	Y	Y	Y	Y	Y		
Nutrition Services	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Pain Management	Y	Y	Y	Y	Y		Y	Y	Y	Y	
Complementary Medicine Program	Y	Y		Y	Y	Y	Y	Y	Y		

ABS^{MC} Alta Bates Summit Medical Center

*Charles C. Jenkins, M.D., F.A.C.S.
Chairman, ABSMC Cancer Committee*

Alta Bates Summit Medical Center (ABSMC) provides comprehensive care for more than 2,100 newly diagnosed cancer patients each year. The services provided vary from technically sophisticated diagnostic and therapeutic resources to caring social support services. A full range of inpatient and outpatient services for all phases of malignant disease are offered at its Alta Bates and Summit campuses and at the Comprehensive Cancer Center (ABCCC) on the Herrick campus.

In 2007, the most recent complete reporting year, 2188 cancer cases were accessioned into the ABSMC Cancer Registry. The top five primary cancer diagnoses were Breast (22%), Prostate (17%), Lung (11%), Colorectal (9%), and Uterus (4%), totaling 64% of all cases reported by the medical center.

The ABSMC Cancer Program is accredited by the Commission on Cancer (COC) of the American College of Surgeons (ACOS). The program was resurveyed by the COC in May and received a full 3 year certification with commendation as a Community Hospital Comprehensive Cancer Program (COMP).

2008 CANCER PROGRAM HIGHLIGHTS

CLINICAL AND SITE-SPECIFIC PROGRAMS:

- The ABSMC Lung Cancer Program launched its own Early Detection Screening Program in March and was accepted as a participating member of the International Early Lung Cancer Action Program (I-LCAP) in April.
- A Minimally Invasive Lung Cancer Surgery Program was initiated on the Summit campus.

CAROL ANN READ BREAST HEALTH CENTER (CARBHC)

- The CARBHC opened in April, 2008, offering a full spectrum of diagnostic and treatment services for breast disease, especially for malignancies of the breast.

BLOOD AND MARROW TRANSPLANT (BMT)

- The ABSMC BMT Program received a full 3-year re-accreditation by the Foundation for the Accreditation of Cellular Therapy (FACT), a mark of excellence in both the patient care and laboratory components of the BMT program.
- Dr. Oleg Krijanovski joined the program as Clinical Director in November.

CLINICAL RESEARCH

- Through the Bay Area Tumor Institute on the Summit Campus and the Comprehensive Cancer Center on the Herrick campus patients have access to a full range of NCI-sponsored, cooperative group, and pharmaceutical trials specific to their primary sites and stage of disease.

RADIATION ONCOLOGY

- In 2008 the Summit campus Radiation Oncology Department expanded its facilities in response to rising patient volume, and a new radiation oncologist was added to the staff. In January a new tomotherapy linear accelerator became operational.
- The Radiation Oncology Department at the ABCCC installed the new Varian RapidArc system that enables a dramatically reduces the length of radiation treatments for its patients.

COMMUNITY OUTREACH AND SUPPORT SERVICES:

- A widely varied assortment of patient outreach and support services are offered at the Markstein Cancer Education and Prevention Center (MCEPC) on the Summit campus and at the ABCCC on the Herrick campus.
- In cooperation with the CARBHC, many breast cancer outreach and education activities are available on both campuses.

AMERICAN CANCER SOCIETY:

- The medical center participated in the ACS-sponsored events "Relay for Life" in August and "Making Strides Against Breast Cancer" in October.

CPMC California Pacific Medical Center

Kathleen Grant, M.D.
Chief, Division of Hematology and Medical Oncology

California Pacific Medical Center (CPMC) Oncology Services has experienced a year of departmental expansion and program growth emphasizing our commitment to providing the highest level of patient care. Over the past year, the department staff grew from two to nine dedicated administrators, specialists, and clinicians. We launched the Cancer Care Navigation Program in June of 2008 and marketed this service to over 20 hospital departments and physicians practices. Through offering patient education and supportive service referrals, the Cancer Care Navigation Program improved the health experience of 276 patients. The Cancer Genetic Risk Assessment Program expanded to a full-time program assisting patients with identifying their cancer risk while promoting early detection and screening.

The department gained national recognition for its dynamic marketing materials by receiving a Gold Award for the Cancer Supportive Services booklet and a Silver Award for the Health Journal from the Aster Awards for excellence in Marketing for Health Care Organizations. The Commission on Cancer gave CPMC an approval award certificate as a 'Teaching Hospital Cancer Program.'

Oncology Services' strength lies in the practice of multidisciplinary collaboration. This past year we partnered with the Breast Health Center, Radiation Oncology, private oncology practices, Women's Health Resource Center, African American Breast Health Program, IHH, and Community Health Resource Center, to align our rich resources to meet each individual patient's needs. We accomplished this through initiating weekly Chemotherapy education classes and creating the first ever comprehensive CPMC Cancer Supportive Services calendar. The Health Psychology department facilitated psychosocial services in Radiation Oncology to support the psychological needs of patients. The IHH offered integrative medicine, massage therapy, acupuncture and guided imagery to enhance patients' health and well-being. Through recognizing patients' long term care needs

of after finishing treatment, we pioneered a Survivorship Program. The Oncology Services expanded into the community by raising funds for the American Cancer Society's Relay for Life, Making Strides Against Breast Cancer events, the Lance Armstrong Livestrong Challenge, and the Susan G. Komen Race for the Cure.

California Pacific Medical Center saw almost 18,000 cancer patients in 2008. As one of San Francisco's primary Medical Center's for cancer care, we are proud to offer these new programs and innovative integration of services. Our department has achieved many great accomplishments over the year and our success is founded in each individual's dedication to meeting the needs of every cancer patient in a timely manner and to facilitate a comforting and supportive journey.

The Cancer Care Center is in final design development. This project has been made possible with the generous donation from Mr. Bryan Hemming and many other donors; occupancy is scheduled for spring 2010.

EMC Eden Medical Center

Ostap Melnyk, M.D.
Medical Oncology Chair, Cancer Committee

In 2007, Eden Medical Center (EMC) and San Leandro Hospital (SLH) provided a comprehensive, multidisciplinary cancer care to its 430 newly diagnosed analytic cases. Major sites included Breast (100), Lung (66) and Colorectal (66).

Our multidisciplinary cancer conferences (General Oncology at both Eden and San Leandro campuses, and Neuro-Oncology at Eden) presented 209 newly diagnosed cases, covering all major sites, including discussions on available clinical trials for protocol-eligible patients.

Cancer Education Program and Community Outreach at EMC continued its successes in 2007, as multiple Lectures/symposiums were held such as the Power of Prevention, a special GYN-ONC educational seminar geared toward women, presented by Drs. Melnyk and McGlynn, Jr, (targeting uterine, ovarian, cervical and breast cancer), Breast Cancer Symposium, Prostate Cancer Education, presented by Dr. Van Wey at the Marina Community Center, IMPACT (Improving Access Counseling and treatment for Californians with Prostate Cancer) a new free service for prostate cancer patients, Smoking Cessation Programs, the ACS-“Look Good, Feel Better” program, “The Power of Positive Eating” and “Coping with Loss”, including a new Grief Support Group. All were advertised in newspapers, on Eden’s website, and Eden’s “Your Health” publication in order to meet the Cancer Committee’s goal for expanding our Community Outreach Program.

QUALITY IMPROVEMENT GOALS SET AND ACCOMPLISHED IN 2007 INCLUDED:

- 1) Concurrent pathologic review of all new malignant cases with co-signature by a 2nd pathologist to confirm accuracy of diagnosis.
- 2) Improved lymphedema services, with acquisition of a new Perometer via Eden Foundation.
- 3) Communication of preliminary diagnosis to the Managing Physician by Pathology within 72 hours, reached 97%.

- 4) Increased participation in Neuro-Oncology Tumor Boards with increasing implementation of Neuro-Oncology Protocols.
- 5) Site specific presentations done for major sites (e.g., breast and colon cancer).

Nursing education in oncology is emphasized with ongoing chemotherapy education Seminars at EMC and SLH, as well as Bio-ethics classes.

FINALLY, AS PER ACOS RECOMMENDATIONS, WE COMPLETED 2 ANNUAL HOSPITAL STUDIES:

- 1) Bladder Cancer: incidence, staging, treatment and outcome patterns in 2006. Of 21 cases identified, 13 early stage (Ta or T1) treated with TURBT alone. Of remaining 8 cases of T2-T3 cases, 3 expired early of co-morbid disease, leaving 5 high risk patients as potential candidates for multi-modality treatment: 2 underwent cystectomy without additional treatment, 2 underwent post-TURBT XRT alone, and 1 underwent no post-TURBT treatment. In conclusion, small numbers of advanced disease cases confounded by significant comorbidities and early death prevent assessment of utilization of multi-modality treatment in appropriate cases.
- 2) Head and Neck Cancer: incidence, staging, treatment and outcome patterns in 2006. 5 total cases identified, appropriately staged and treated, 1 stage II case with post-op XRT, and 4 locally-advanced stage III/IV cases treated with definitive chemo-radiation.

For more information, please visit our website at <http://www.edenmedcenter.org/>.

MGH Marin General Hospital

Lloyd Miyawaki, M.D., M.P.H.

Medical Director, Marin Cancer Institute Chair, Cancer Committee

The Marin Cancer Institute (MCI) provides comprehensive cancer care through the integration of innovative multidisciplinary programs, state-of-the-art technology, holistic complementary care, patient and family support services, and community health education and promotion.

MCI RENOVATION AND ENHANCEMENTS

The Cancer Center installed a new Varian iX linear accelerator. With an integrated On Board Imaging system (OBI), it is capable of delivering Intensity Modulated Radiation Therapy (IMRT) targeted with precise Image Guidance (IGRT). The reception area, patient waiting room and healing garden were beautifully remodeled.

CANCER SURVIVORSHIP PROGRAM

Cancer Survivorship remained a major focus for MCI. We surveyed breast cancer patients 1 to 2 years post-treatment using the Lance Armstrong Foundation (LAF) survivorship survey instrument. A national survey by the LAF revealed significant unmet medical and non-medical needs among patients following treatment: Similarly, 40% of our patients indicated a continuing need. The results were used to improve post-treatment plan development, support services, and survivor retreats, including our 1st retreat for women with metastatic disease. We shared our results at a Cancer Survivorship Summit we developed for cancer survivors, oncology staff, and primary care providers. The program featured Patricia Ganz, M.D., a national leader in cancer survivorship issues. We also organized a Lymphedema Summit for cancer survivors and clinicians, featuring Stanley Rockson, M.D., co-director of the Stanford Lymphedema center.

BREAST HEALTH PROGRAM

Breast surgeons Alison Smith, M.D. and Lydia Schrader, M.D. relocated, and the program thanks them for their service to our community. We recruited Cheryl Ewing, M.D., breast surgeon and associate professor of surgery at UCSF. She will work at both Marin General Hospital and UCSF and brings breast oncology expertise and new advanced surgical techniques to Marin. She will serve as Medical Director of the Breast Health Program.

The breast cancer advocacy group Zero Breast Cancer awarded Cindi Cantril, R.N., O.C.N., M.P.H. the 2007 Healing Professional Award in recognition of her dedication and compassion as a nurse navigator, breast program coordinator, and leader of the cancer survivor program.

GENITOURINARY ONCOLOGY/PROSTATE CANCER PROGRAM

We launched a prostate cancer database, which will prospectively collect clinical and quality of life data throughout the continuum of diagnosis, treatment, and survivorship.

GASTROINTESTINAL ONCOLOGY PROGRAM

We continued to promote multidisciplinary care through our GI tumor board and educational events, including a conference on the integration of endobronchial ultrasound (EBUS) in the staging of upper GI malignancies.

PALLIATIVE CARE PROGRAM

We developed an inpatient hospice care program, a joint effort between the palliative care program and Hospice.

COMMUNITY SERVICE

We sponsored low cost mammograms and with a grant from the To Celebrate Life Cancer Foundation-Harbor Point Fund we offered further diagnostic studies for women in financial need. We promoted healthy eating through cooking classes with our oncology dietician and guest chefs. Other community education events included programs on Healthy Menopause (Ricki Pollycove M.D.) and non-hodgkins lymphoma (Jennifer Lucas M.D.).

MCI GOALS FOR 2008

- Complete installation of Varian Trilogy System linear accelerator
- Initiate Stereotactic Radiosurgery Program
- Install third digital mammography machine
- Launch in hospital hospice care program

MMC Memorial Medical Center

David Shiba, M.D., Ph.D.
Medical Director, Cancer Services
Chair, Cancer Committee

In 2008, MMC's American College of Surgeons accredited Community Hospital Comprehensive Cancer Program continues to provide State-of-the-Art cancer care for the patients of Stanislaus and surrounding counties.

QUALITY IMPROVEMENT ACTIVITIES

- Patient satisfaction and pain management continues to be a major focus of our cancer program and both continue to be above 90%.
- Nationally recognized speakers brought the latest in cancer care to our professional community.
- Our 24th Annual Cancer Symposium focused on colorectal cancer including screening, surveillance, surgery of metastatic disease, chemotherapy, and the management of malignant ascites and pleural effusions. Also, quality of TNM staging focused on educating the entire medical staff on accurate staging.
- Clinical research through our ECOG affiliation with Stanford and the Cancer Trials.
- Support Unit (CTSU) provides opportunities for the latest treatments for our patients with 2.9% of newly diagnosed patients being treated on protocols in 2008.
- Our Cancer Registry had an analytic case load of 910 in 2008 with an accuracy rate of 99% and a follow-up rate of > 92%. The registry continues abstracting for Sutter Tracy and Sutter Los Banos hospitals.

NEW PROGRAM SERVICES, TECHNOLOGY AND EQUIPMENT

Complementary Therapy continues to expand having again been chosen for the MMC Foundation's fund-raising campaign for 2009. In 2008, the Triumph Fitness Program began in March with a 10-week strength and training program being offered to cancer survivors so that they could regain strength after treatment. A Walking Club and Cycling Team were added as well. New this year is the Sound of the Heart Music Group and Hope Blooms Garden Club which have rounded out the community-based complementary therapy classes already offered to cancer survivors and their caregivers.

A pain and palliative care consultative service continues with the addition of another Nurse Practitioner along with physician directors to coordinate and develop the service.

COMMUNITY COLLABORATION AND BENEFIT

The monthly television program "The Cancer Report" is into its 5th season and continues to serve as a source of education and inspiration to our community. Our staff continues to be actively involved with various cancer-related organizations including the ACS, Community Hospice, Make-A-Wish Foundation, Leukemia and Lymphoma Society and the Lance Armstrong Foundation.

We continue to provide community education on colon, prostate, breast and other cancers as well as information on cancer prevention and early detection. We participate in community events and health fairs as well as put on our own programs, prostate screening and signature events to celebrate survivorship like Daffodil Delight and the Evening of Hope fashion show featuring breast cancer survivors. We continued sponsorship of ROCK (Recreational Opportunities for Cancer Kids).

Our website: www.memorialmedicalcenter.org/cancer.

MPHS Mills-Peninsula Health Services

Brian Henderson, M.D.

Medical Director, Cancer Program

Andrea Metkus, M.D.

Medical Director, Breast Cancer Services

2008 SUMMARY

In 2007 Mills-Peninsula's Dorothy E. Schneider Cancer Center continued to provide our community with the region's most advanced cancer care. Our physicians introduced advanced procedures and technology, and we were able to recruit a talented oncology surgeon, making the Schneider Center the only community program with this expertise.

Our Women's Center continues to detect breast cancer at its earliest possible stage – with approximately 80% of women who received screening mammography detecting their breast cancer when it is at Stage 0 or Stage 1.

RADIATION THERAPY ADVANCES

In 2007, The Dorothy E. Schneider Cancer Center introduced laser guided radiation therapy, technology that helps guide radiation during prostate cancer treatment. Like a "GPS" system, it works by guiding radiation to radioactive "seeds" implanted in the patient's prostate. This makes treatment more accurate because the prostate gland may move during treatment. The GPS system automatically stops treatment if the laser moves off target by as little as one millimeter.

NEW EXPERTISE ON THE TEAM

We welcomed a new oncology surgeon, Aziz Ahmad, M.D., to the cancer team. Dr. Ahmad received his medical degree from The Chicago Medical School in 2000 and completed his residency in surgery at Lenox Hill Hospital in New York in 2005. He completed his surgical oncology fellowship at John Wayne Cancer Institute in Santa Monica. His expertise brings two enhancements to the Dorothy E. Schneider Center:

- Microwave ablation of liver tumors: Mills-Peninsula's Dorothy E. Schneider Cancer Center is the only provider in the mid-Peninsula to offer this minimally invasive technique for treatment of metastatic or primary liver cancer. The procedure destroys cancer cells by heating them with microwaves. It is used for tumors in locations inaccessible by standard surgery alone or in patients who cannot tolerate a significant loss of liver tissue.

- Pancreatic surgery: The Cancer Center now offers comprehensive treatment for patients with pancreatic tumors. From diagnosis with CT scan, PET scan, endoscopic ultrasound with biopsy; operative procedures including laparoscopic pancreatic surgery and the Whipple procedure: and post operative care consisting of chemotherapy and radiation

The cancer program also was able to add a nutritionist. This health care professional recommends diet changes to help patients get the proper nutrition before, during and after treatment.

CONNECTED TO THE COMMUNITY

During 2007, Mills-Peninsula's cancer team strengthened community ties through a renewed relationship with the American Cancer Society to offer its "Look Good, Feel Good" and "I Can Cope" programs to our patients

In collaboration with our Women's Center, we also developed a highly successful partnership with the San Mateo business community to stage "San Mateo Loves It's Women," a broad-based campaign to raise awareness of the importance of mammography.

The campaign included lectures by our expert breast cancer physicians, point-of-purchase mammography reminders in local stores, street banners with the breast cancer ribbon and a beautiful calendar featuring prominent local women, each with a message about mammography.

SAFH Sutter Auburn Faith Hospital

*Barton G.G. Bradshaw, M.D., F.A.C.S.
Chairman of the Cancer Committee*

2008 was a watershed year for our cancer program at Sutter Auburn Faith Hospital. Following three years of hard work on the part of the Cancer Committee, cancer care staff, cancer registry and administration, our cancer program underwent its first accreditation visit by the American College of Surgeons Commission on Cancer in November 2007. Based on this survey, we were awarded a full three-year approval with commendation in January 2008.

Throughout 2008 the Cancer Committee has continued to work to improve the quality of the cancer care at Sutter Auburn Faith Hospital in multiple areas. We have continued to evaluate the quality of our care with ongoing collection and evaluation of our Oncology Quality Dashboard measures, documenting several quality indicators for breast, colorectal, lung and prostate cancer with comparison to national benchmarks.

In addition, we have conducted quality improvement studies to evaluate care of our cancer patients. In one of these we reviewed the records of all patients undergoing colectomy at SAFH from 2006 to mid 2007 to assess whether an adequate lymphadenectomy was performed. We had an 80% compliance rate using the NCCN guideline of 12 lymph nodes excised and our surgeons have used this information to improve their colectomy technique with the goal of 100% compliance for appropriate patients. Another study of estrogen/progesterone receptor status documentation for breast cancer patients resulted in improved documentation from 43% to 100% in two quarters.

The cancer conferences at SAFH have continued to be very successful and play an important role in facilitating communication and collaboration between medical specialties in the care of cancer patients. These conferences met twice each month and provided multidisciplinary review of over 30% of our total cancer cases in 2008.

The cancer committee has also worked with our department of physical therapy to create a post operative exercise regimen for mastectomy patients in 2008 that will be finalized and implemented in 2009.

We have worked to improve access for stage IV cancer patients to our palliative care team of specialists.

We have also made improvements in patient access to education and clinical trial information by creating a patient education room in our infusion center which contains all of our patient education material related to cancer care along with internet access.

Our recently opened infusion therapy center has continued to be a valuable resource to our cancer patients receiving chemotherapy and continues to generate rave reviews from patients and providers alike.

Sutter Auburn Faith Hospital is in the early phases of a large renovation project of patient rooms and the physical facilities. We expect these ongoing changes to improve our cancer patient's experience in the hospital with private rooms and state of the art equipment and facilities. Our operating room is also in the planning stages for major improvements in equipment and technology.

The SAFH staff continues to participate in numerous community activities in partnership with our local cancer and business organizations: American Cancer Society Relay for Life and Survivors Dinner, Auburn Business Expo, Rotary Fun Run, and Auburn Community Festival.

For more information, please visit our website at www.sutterauburnfaith.org.

SMCS Sutter Medical Center, Sacramento

Gregory M. Graves, M.D.
Medical Director

At Sutter Cancer Center, Sacramento we continue to provide comprehensive, site specific programs and services designed to address the physical, mental and emotional aspects of cancer care to patients and their caregivers.

2008 has been an active and rewarding year for Sutter Medical Center, Sacramento (SMCS). In the statistical year 2007, over 1900 patients received care at SMCS with a 15% increase in analytic case volumes. Our top five diagnoses continue to be breast, lung, prostate, colon/rectal and bladder. A community education event on screening and nutrition for breast, lung and colorectal cancers, the Breast Cancer Navigator program and our complimentary programs of Art, Music, patient/family counseling, Nutrition and Massage continue to provide valuable support to the patient and family.

The Cancer Center further refined our specialty team approach started in 2006 by embarking on a program of site-specific tumor treatment teams utilizing a new group of medical oncologists recruited to SMCS. This allowed us to expand site-specific tumor boards to include breast, thoracic, gastrointestinal/genitourinary/gynecology-oncology, and hematologic. Throughout the year, 396 patients were presented at 120 conferences.

In early 2008 we were surveyed by the American College of Surgeons (ACOS) and received an approval award of three years with commendations in all possible areas as well as the outstanding Achievement Award.

SMCS received FACT accreditation renewal for our Autologous Transplant Program in 2008. Our BMT/Leukemia Program under the direction of Michael P. Carroll, MD increased from five autologous patients transplanted in 2007 to 28 transplants in 2008 with significant increase in the number of allogeneic transplants and our first Matched Unrelated Donor transplant. This will position us to apply for Center of Excellence status with multiple insurance companies and seek allogeneic FACT accreditation.

Many programs saw significant growth in 2008. Our Genitourinary robotic surgical program, under the direction of Brian Naftulin, MD, saw a greater than 75% increase in the number of robotic prostatectomies in 2008 (72 cases in 2007 and 125 cases in 2008). We continue to expand the use of this advanced technology to gynecologic cancer surgeries. Our infusion center opened a second site, specific to treating cancer patients and had a 61% increase in visits for the year. The Palliative Care program expanded into pediatrics allowing them to provide services to both pediatric and adult oncology patients.

Clinical research continues to be a strong component of our cancer program. In 2008 we opened 20 new protocols through the National Cancer Institute (NCI), pharmaceutical and investigational trials covering lung, breast, colon, hematology, pancreas and melanoma diagnoses and companion trials and enrolled 15 patients.

The cancer center staff continue to participate in numerous community activities in partnership with our local cancer organizations: Komen Race for the Cure, American Cancer Society Strides for Breast Cancer, Relay for Life, and Leukemia/Lymphoma Society's Light the Night.

The momentum we have gained in 2008, bringing new physician leadership along with dedicated and supportive administration allows us to continue bringing individualized care to our cancer patients into the future.

For more information, please visit our website at <http://www.suttercancer.org>

Sutter Roseville Medical Center

*Uma Gowda, MD
Cancer Committee Chair,
Medical Director of Oncology*

The Sutter Cancer Center, Roseville maintains a tradition of providing state of the art, interdisciplinary cancer care close to home. In 2007 our cancer registry reported 1219 patients seen at our facility, 882 of which were analytic patients. The most frequently seen cancers at our facility were Breast 165, Lung 133 Colorectal 94, Prostate 70 and Bladder 55. Our weekly tumor board presented 139 patients for review at tumor board and 39 patients were presented at our breast conference.

Our Cancer Committee Goals for 2008 included evaluation of chemotherapy administration documentation utilizing NCCN, ASCO, and the ONS guidelines. We also analyzed medication reconciliation and chemotherapy documentation, utilizing the National Patient Safety Goals from JCAHO and ONS guidelines.

The chemotherapy documentation evaluation allowed us to integrate physician and nursing documentation, merging expectations from respective professional societies with best practice for our cancer center. Our study identified improvement opportunities for physicians and nurses.. With this information, we educated and refined our documentation procedures. We plan to continue to evaluate this process for further improvements.

Evaluating the Medication Reconciliation documentation within our Infusion Center also promoted improved patient safety. We determined we were in compliance with the national patient safety goals, but identified several opportunities to make our processes easier for nursing and safer for our patients. On-going auditing with direct feedback to nurses and physicians, improved order sets and changes in documentation instruments improved practice. We integrated these findings with our project on chemotherapy documentation. This study will also be repeated to demonstrate continued improvement.

Several patient care improvements were implemented in 2008. We offered a children's art therapy group for children of parents in active treatment. We discovered that while bereavement services were available to children, therapy while your parent receives treatment were non-existent in our community. We opened this support group to children of parents with

any life threatening disease and marketed it to our pediatricians and family practice physicians. Our first therapy group resulted in 100% of participants completing the program and 100% reporting satisfaction with the process.

The Vascular Access Team (VAT), consisting of RNs with advance training in PICC placement and management, completed Sutter Roseville Medical Center's third year with zero central line infections. The VAT team expanded their practice by working with our radiology colleagues to provide an initial interpretation of central line tip placement, with subsequent verification by the radiologist. Each RN attended training for this procedure with a proctorship and validation of skill by a radiologist. This process has resulted in decreasing the delay between central line placement and the availability of the line for therapeutic intervention, a win for our patients and physicians.

Our cancer center also benefited from new and improved equipment in 2008. New ultrasound equipment was purchased for our Breast Health Center. Four hundred-twenty-nine patients utilized this new equipment and patients will continue to benefit from the improved image quality and improved physician satisfaction.

The Sutter Cancer Center, Roseville, also benefited from the installation of an Elekta Synergy Linear Accelerator by our Radiation Oncology Colleagues. Our collaborative team of Radiation Oncologists led our region in implementing this newest modality for the benefit of our patients and providing the latest diagnostic resources to our physicians.

Our cancer program is well supported by an experienced and collaborative group of sub-specialty physicians, as well as an entire team of professionals devoted to the diverse and various needs of cancer patients. 2008 was a very successful year for our cancer program. We continue to grow, expand, explore and improve to meet the needs of our patients.

SSMC Sutter Solano Medical Center

James R. Krasno, M.D.
Chair, Cancer Committee

The Sutter Solano Cancer Center (SSCC) built on the successes of its first three years by offering patients a unique combination of state-of-the-art treatment and compassionate care. Skilled practitioners provide a wide range of cancer treatment and support services; medical and radiation oncology, outpatient infusion, clinical trials, community education, and a resource library in one convenient location.

The Cancer Registry accessioned 387 cancer cases, 293 of which were analytic. The top five diagnoses were breast, prostate, lung, colorectal, and pancreatic cancer. More than 50 percent of patients' cancers were in the early stages.

The Tumor Board did 72 prospective cases, discussing national treatment guidelines to reach consensus recommendations for patients' care plans. SSCC also continued to expand its cancer genetic risk program, working with families dealing primarily with breast or colorectal cancer diagnoses.

ACHIEVEMENT

SSCC became a Radiation Therapy Oncology Group (RTOG) member-approved institution. To qualify for enrollment into an RTOG protocol, rigorous treatment planning and physics requirements must be met. Multiple staff members—physicians, nurses, clinical research associates, physicists and dosimetrists—are vital to implementing and supporting RTOG case studies.

NEW TREATMENT OPTIONS

SSCC began using 4-D CT scanning to account for tumor motion with respiration. During CT scanning, multiple sets of CTs are taken while tracking abdominal motion (as a surrogate for the respiratory cycle) with an infrared camera. After scanning is completed, the computer software compiles the CT image sets to show tumor and normal structure motion, so tumor motion is accounted for when planning radiation treatments. This process can also account for normal tissue movement (such as the kidneys), so clinicians are certain these structures remain outside the radiation field.

NEW PROGRAMS/SERVICES

In the quest to find cancer cures, SSCC added more protocols to its clinical trials and continued to actively recruit enrollees. Much progress has been made toward treating cancer and improving patients' quality of life, and work is ongoing to build on the achievements already attained.

COMMITMENT TO THE COMMUNITY

Community involvement continued to be a major focus at SSCC, which sponsored the following events:

- Colorectal awareness event, which included touring the inside of a mega size model of a colon to learn about healthy versus abnormal tissues. Other activities were a lecture, healthy cooking demonstration and educational tables.
- Skin cancer screening, which resulted in the diagnosis of one melanoma, eight squamous cell cancers and 10 basal cell carcinoma cancers
- "You Are Beautiful," an event that pampered cancer survivors with hand and feet massages, makeup, hair styling and gifts
- Cancer Survivors' Day Celebration during the ACS Relay for Life, which provided 200 survivors/caregivers with lunch, entertainment and gifts
- The South Vallejo Neighborhood Association's National Night Out and Health Fair, where cancer-related information and community resources were provided
- Various lectures for staff and community on prostate, breast and lung cancer
- Prostate cancer screening

SSCC also hosted cancer support groups and the American Cancer Society's "Look Good Feel Better" program, and participated in events sponsored by various community organizations.

More information about SSCC is available at www.suttersolano.org/cancer.

Focus on Non-small Cell Lung Cancer

E. Wayne Torigoe, M.D., Marin Cancer Institute, Marin General Hospital
Eric Gold, Oncology Analyst/Programmer, Alta Bates Summit Medical Center

See page two for abbreviations for Sutter Health institutions.

INTRODUCTION

While lung cancer is not the most common form of cancer, it remains by far the leading cause of cancer death for both men and women. In 2008 in the United States, the number of deaths due to lung cancer is estimated to be 161,840, accounting for 29% of all cancer deaths.¹ In comparison, the corresponding figures for female breast cancer and prostate cancer are 40,480 (7% of all cancer deaths) and 28,660 (5% of all cancer deaths), respectively.

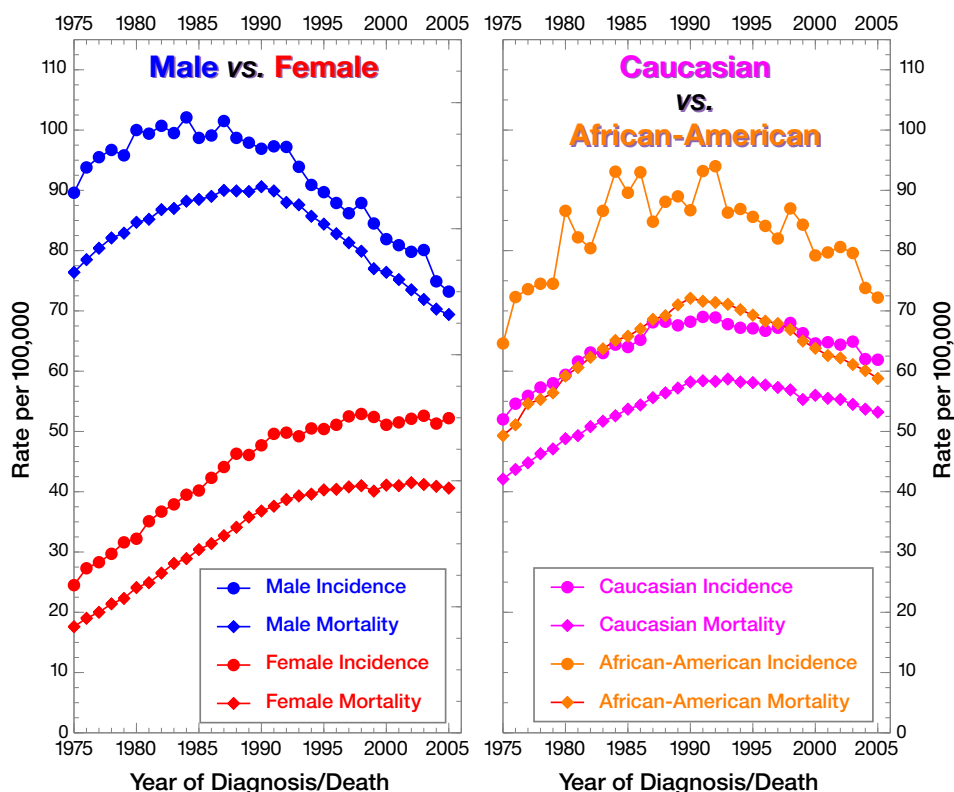


Figure 1
Focus on Non-small Cell Lung Cancer (1993-2007)
Sutter Health 2008 Cancer Programs Annual Report

U.S. Non-small Cell Lung Cancer Incidence and Mortality

By Gender and Race
1975-2005 (SEER data, NCI, 2008)

Fortunately, the age-adjusted death rate for lung cancer in the U.S. is on the decline. This decrease highly correlates with a fall in the age-adjusted incidence of lung cancer, and therefore is attributable primarily to a reduction in the prevalence of smoking rather than early detection or treatment advances.

There are significant gender and racial differences in lung cancer (Figure 1). The age-adjusted incidence and death rate for men have been on the decline since about 1986. On the other hand, these parameters have leveled out but have not yet shown a definite downward trend for women. Regarding racial differences, African-Americans have appreciably higher rates for lung cancer than Caucasians.

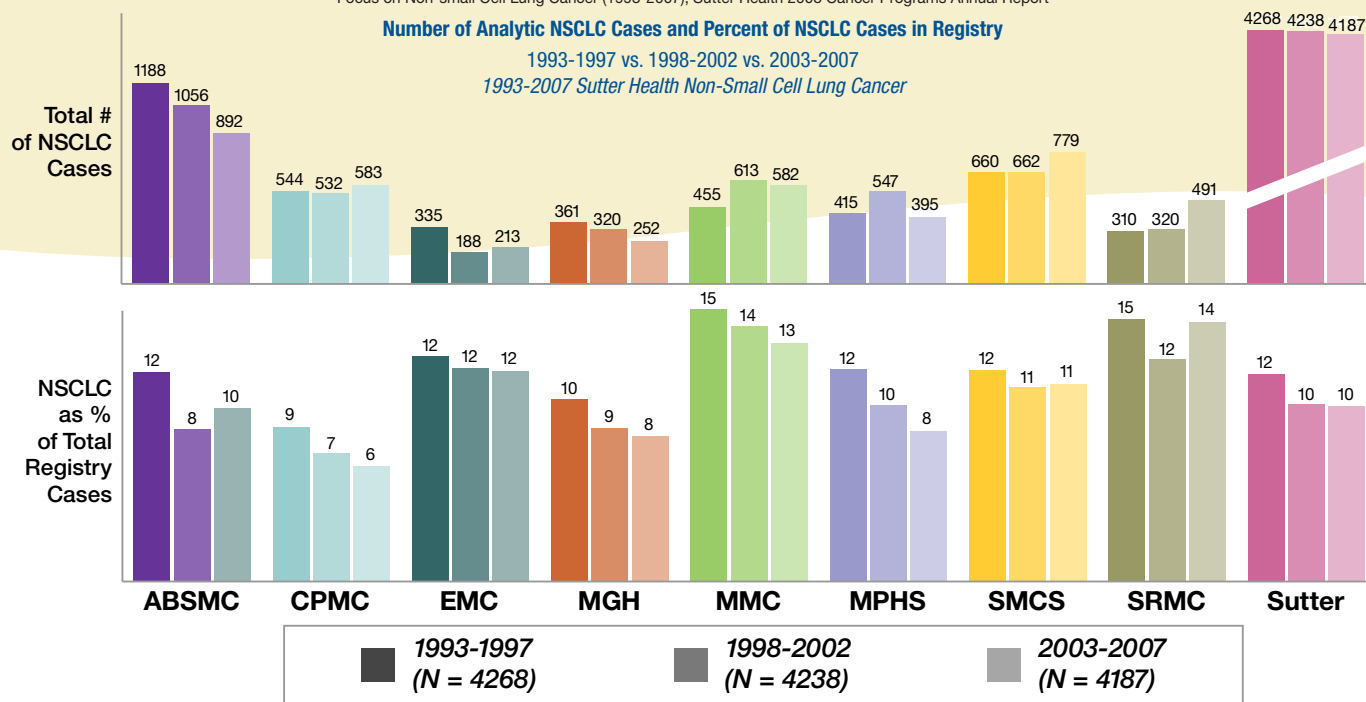
Patients with lung cancer often present with advanced disease and have a relatively low survival, even with early stage disease, compared with many other cancers. Improvements in treatment have so far had only a modest effect on survival.

Also, early detection of the disease, which would greatly reduce the death rate, remains an elusive goal.

Lung cancers are divided into two major groups based upon tumor histology: non-small cell lung carcinoma (NSCLC) and small cell lung carcinoma. Most lung cancer cases fall into the NSCLC group, a heterogeneous aggregate of histological types including adenocarcinoma, squamous cell carcinoma, and large-cell undifferentiated carcinoma. These forms of lung cancer are generally evaluated and treated in the same manner and thus are frequently grouped together in studies. In contrast, small cell lung carcinomas have a

¹ Cancer Statistics, 2008, American Cancer Society.

Figure 2
Focus on Non-small Cell Lung Cancer (1993-2007), Sutter Health 2008 Cancer Programs Annual Report



different clinical course and management than NSCLC and are usually reported on separately.

The Sutter Health experience with NSCLC was last analyzed in the Sutter Health 2003 Annual Cancer Programs Report, which covered the ten-year period from 1993-2002. The present report extends the study period, covering the 15-year period from 1993-2007. In order to evaluate changes over time, this time frame was divided into three five-year time periods: 1993-1997, 1998-2002 and 2003-2007. Included in this review are all analytic cases of NSCLC either diagnosed or first treated at one of the eight Sutter Health institutions accredited by the American College of Surgeons². As before, small cell lung carcinoma and histologies other than carcinoma were excluded from the analysis.

For this report, results for the San Francisco Bay Area and the U. S. were derived from the most current available National Cancer Institute SEER data (1993-2005). The San Francisco Bay Area comparison was included because it was the closest geographically defined data subset available which could give us an approximation of a “regional” comparison for our results.

² There are two additional ACoS-accredited institutions within Sutter Health whose data could not be included in this report – Sutter Solano Medical Center and Sutter Auburn Faith Medical Center. The relative recency of their cancer registries means they do not have the comparable historical data required for appropriate integration into this study.

³ Surveillance, Epidemiology, and End Results (SEER) Program (www.seer.cancer.gov) SEER*Stat Database: National Cancer Institute, DCCPS, Surveillance Research Program, Cancer Statistics Branch, released April 2008.

CASE VOLUME

As seen in **Figure 2**, over the time span of this study the number of analytic NSCLC cases declined for half of the Sutter institutions and increased for the other half. For Sutter Health overall, the number of cases dropped from 4,268 in 1993-1997 to 4,187 in 2003-2007, a 2% decrease. **Figure 2** also charts the number of NSCLC cases relative to the total number of registry cases. The proportion of NSCLC cases relative to all cancers decreased slightly over time at all institutions, a decrease for Sutter overall of 17% from 0.12 to 0.10.

However, there was an increase of 8.2% in all new cancer cases for Sutter Health as a whole, comparing 1993-1997 vs. 2003-2007, which is probably due to the rising incidence of breast cancer and prostate cancer. Therefore, in order to better assess the incidence of NSCLC, lung cancer cases should be compared to cancers with more stable incidence. The number of cancer cases excluding lung, breast, and prostate cancer is illustrated in **Figure 3 (next page)**. Institutions are split on whether this has increased or decreased over time (four institutions with increases, four with decreases). Overall, there was a 15.3% increase in such cases for Sutter Health. **Figure 3** also shows that the ratio of lung cancer cases to cancer cases excluding lung, breast, and prostate decreased over the study’s time span at all institutions except SMCS. This ratio decreased from 0.22 to 0.18 (an 18% decrease) for Sutter Health as a whole, supporting an actual overall decline in the incidence of lung cancer.

Figure 3
Focus on Non-small Cell Lung Cancer (1993-2007), Sutter Health 2008 Cancer Programs Annual Report

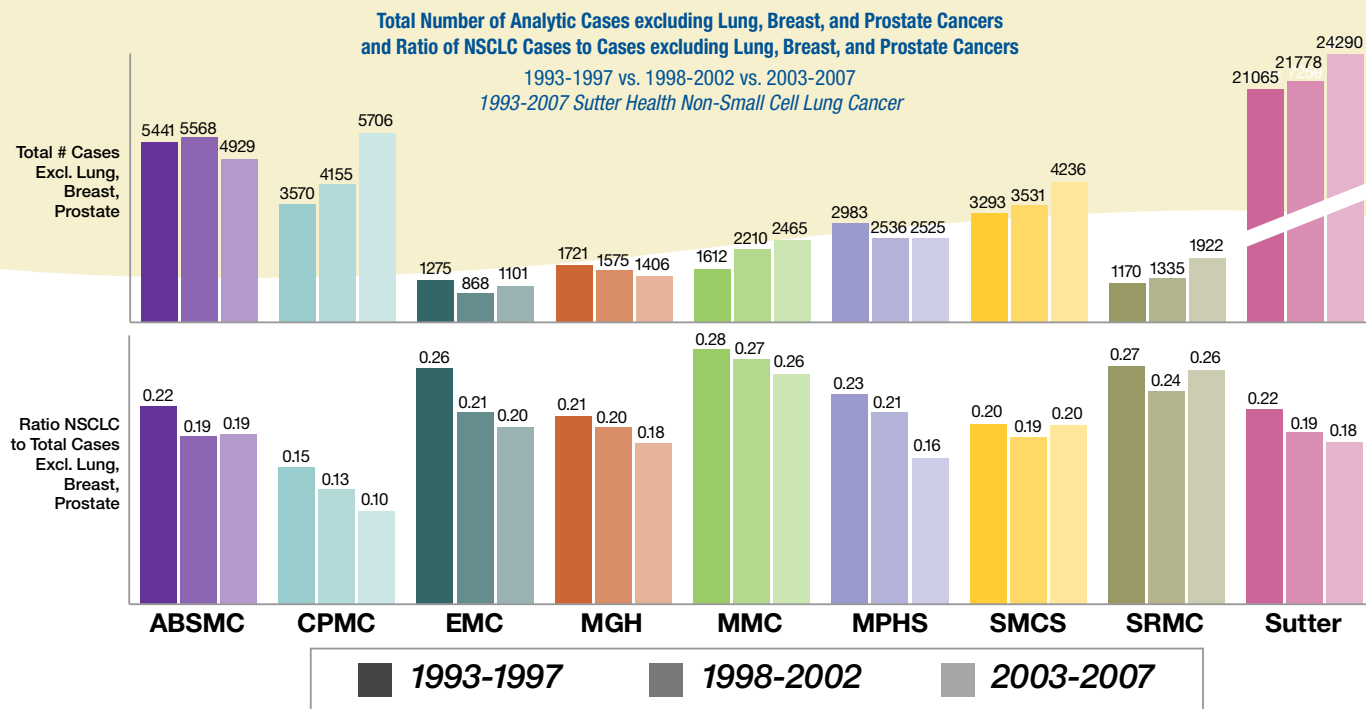
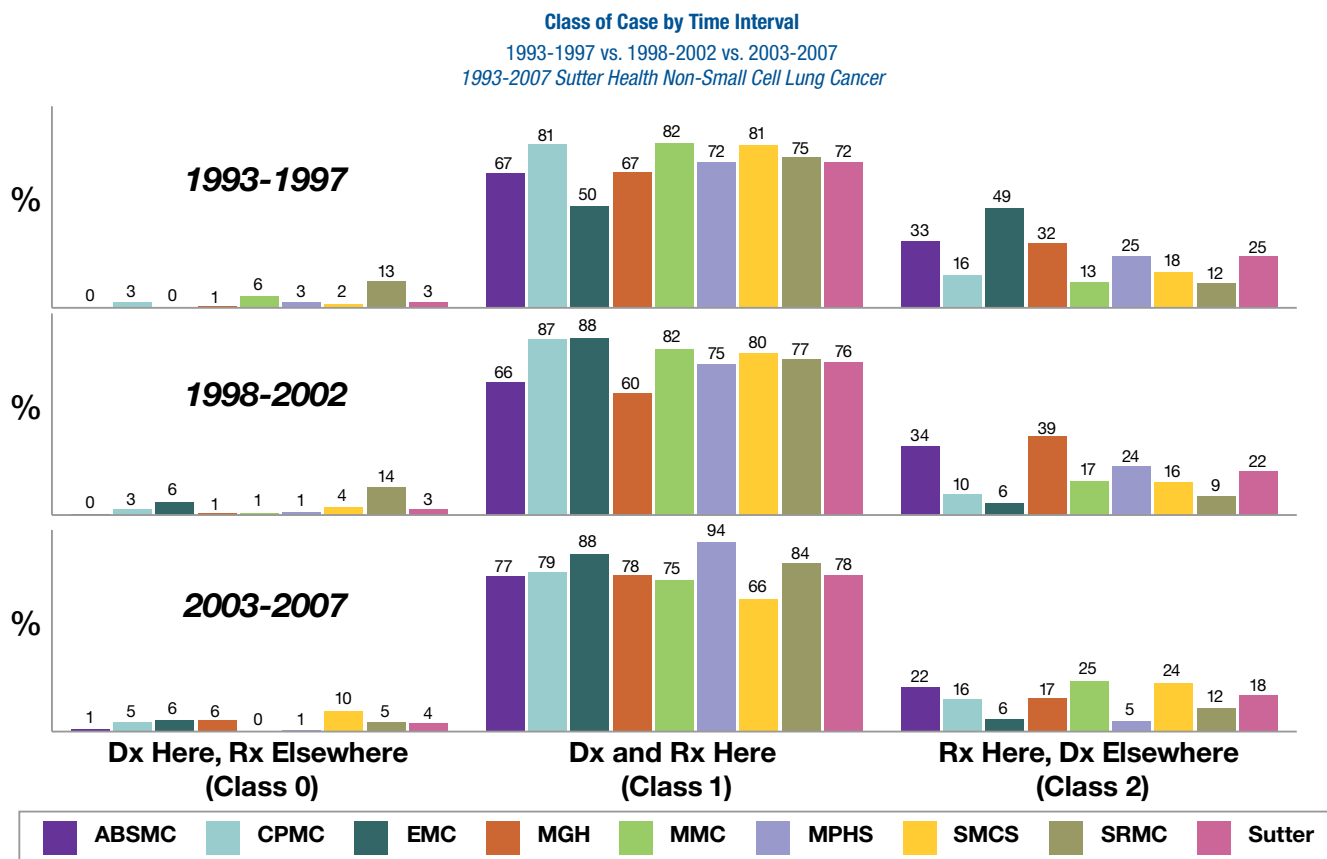


Figure 4
Focus on Non-small Cell Lung Cancer (1993-2007), Sutter Health 2008 Cancer Programs Annual Report



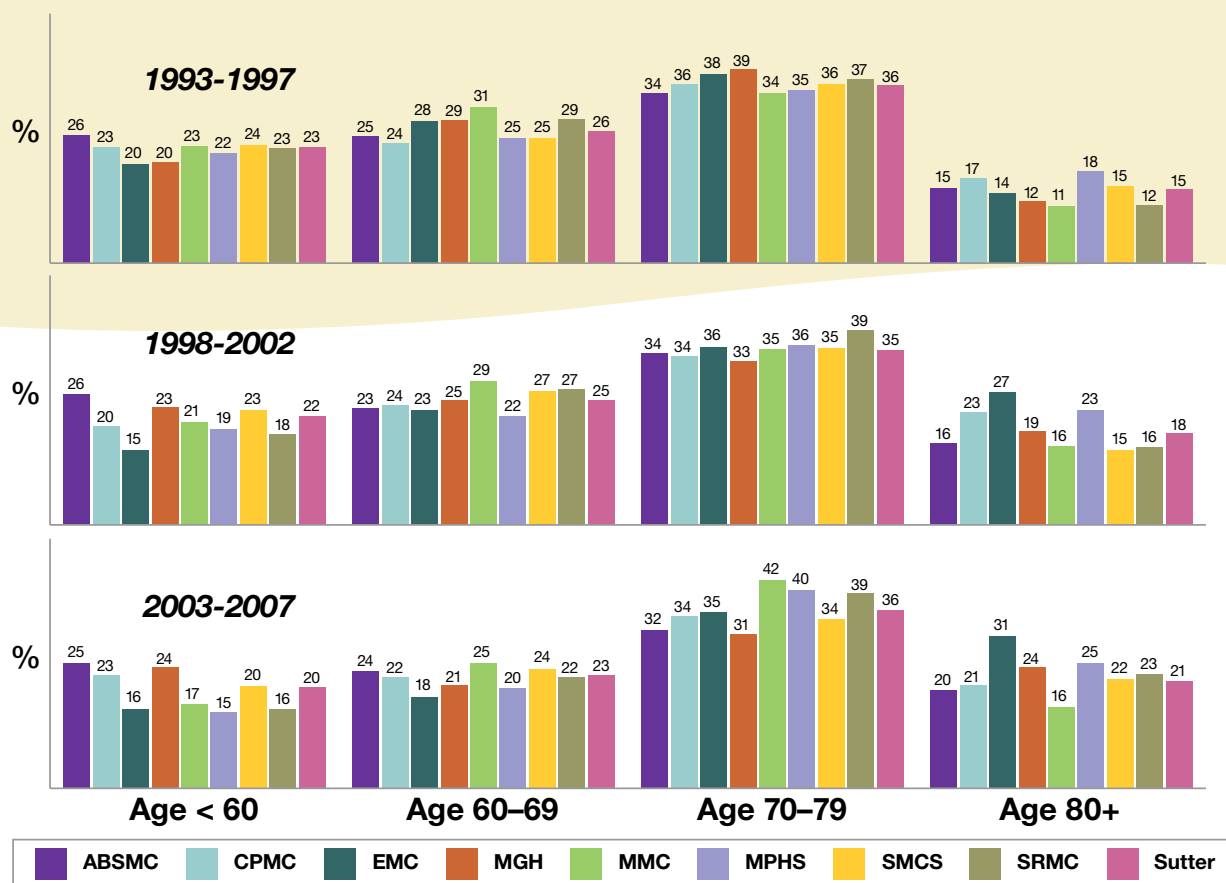


Figure 5
Focus on Non-small Cell Lung Cancer (1993-2007), Sutter Health 2008 Cancer Programs Annual Report
Age at Diagnosis by Time Interval
1993-1997 vs. 1998-2002 vs. 2003-2007
1993-2007 Sutter Health Non-Small Cell Lung Cancer

CLASS OF CASE

Cancer registry cases are categorized into classes based upon the role that the member institution plays in the patient’s diagnosis and treatment. This study included only cases that were diagnosed and/or first treated at a member institution (“analytic” cases), which were divided into groups as defined below:

- Class 0 Diagnosed at the member institution but first treated elsewhere
- Class 1 Diagnosed and first treated at the member institution
- Class 2 Diagnosed elsewhere but first treated at the member institution

Overall about three-quarters of the cases were both diagnosed and first treated at Sutter institutions (Class 1). Only a small percentage (3%) were diagnosed at Sutter but received first treatment elsewhere (Class 0). **Figure 4 (previous page)** shows that over time there was a slight increase in Class 1 cases (from 72% to 78%) and a concomitant decrease in Class 2 cases

The considerable variability seen among individual institutions probably reflects differences in contractual arrangements with outside entities and/or the presence of free-standing oncology clinics. For example, the number of Class 2 cases is relatively high at several institutions due to contracts with outside entities for the provision of radiation treatments. There has been a marked drop in these cases for some institutions, which is explained by loss of such contracts.

AGE AT DIAGNOSIS

Overall at Sutter Health the number of NSCLC cases increased with age, with marked fall off for the 80-and-older group (**Figure 5**). The greatest number of cases (just over one-third of total cases) were found in the 70-79 age group, with negligible change over the 15-year time span of this study. The lower numbers for the oldest group are explained by the smaller referral population expected for this age group due to attrition. **Figure 5** also shows a steady shift over time towards more patients in the 80+ age group, which is explained by aging of the referral population.

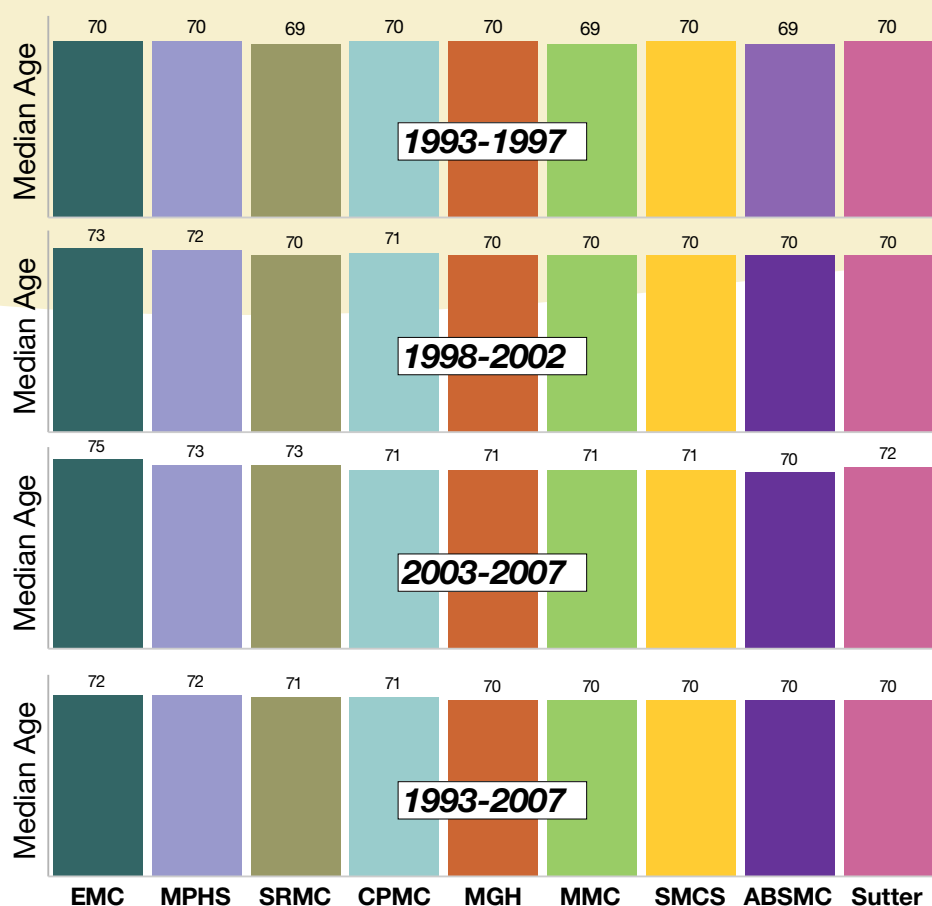


Figure 6
Focus on Non-small Cell Lung Cancer (1993-2007)
Sutter Health 2008 Cancer Programs Annual Report
Median Age at Diagnosis by Time Interval
1993-1997 vs. 1998-2002 vs. 2003-2007
1993-2007 Sutter Health Non-Small Cell Lung Cancer

There is minimal variability in the median age at diagnosis among the individual hospitals, with median ages for the entire period ranging from 70 to 72 (Figure 6). There is a slight rise over time in the median age at diagnosis, from 70 to 72 for Sutter overall, which is consistent with aging of the referral population. An examination of age at diagnosis by gender revealed no appreciable difference between males and females.

GENDER

Over the entire 15-year course of this study, men with NSCLC lung cancer slightly outnumber women at most Sutter Health institutions (51% male, 49% female overall). However, the gap has been narrowing over time, such that for the most recent time period (2003-2007), the gender ratio is 50:50 (Figure 7, next page).

This narrowing is consistent with the nationally observed trend in the incidence of lung cancer for men compared with women (Figure 1, page 1). The incidence for men has recently been on the decline while that for women has been level. The gender narrowing seen at Sutter Health is both the result of an increase in the number of women with lung cancer and a decrease in the number of men, as expected from national incidence data. Comparing the genders in terms of absolute numbers for the 1993-1997 time period

with 2003-2007, there was an increase of 3% in the number of Sutter Health women with NSCLC (2,015 to 2,085) and a decrease of 7% in the number of men (2,253 to 2,102).

Note that the gap between men and women is smaller than that for the San Francisco Bay Area as well as the U.S. This difference is probably due to a lower proportion of male smokers in the Sutter Health population compared with the larger populations.

RACE/ETHNICITY

Overall, about three-quarters of the patients with NSCLC in the Sutter Health system over the last 15 years were Caucasian. The racial/ethnic mix has been stable with the exception of a time trend of increasing percentages of Asian/Pacific Islander patients (from 8% in 1993-1997 to 12% in 2003-2007, Figure 8, next page). The racial/ethnic mix for NSCLC patients at individual Sutter hospitals reflects the underlying patient demographics for each institution. ABSMC, located in the Oakland area, has the highest racial diversity with relatively large African American and Asian/Pacific Islander components. CPMC, located in San Francisco proper, has the largest Asian/Pacific Islander component. MGH and SRMC are the least diverse with consistently close to 95% of NSCLC patients being Caucasian.

Lung Cancer (1993-2007)

Figure 7
Focus on Non-small Cell Lung Cancer (1993-2007), Sutter Health 2008 Cancer Programs Annual Report

Gender Ratios by Time Interval

1993-1997 vs. 1998-2002 vs. 2003-2007*

1993-2007 Sutter Health Non-Small Cell Lung Cancer

* San Francisco Bay Area and U.S. SEER data, 2003-2005

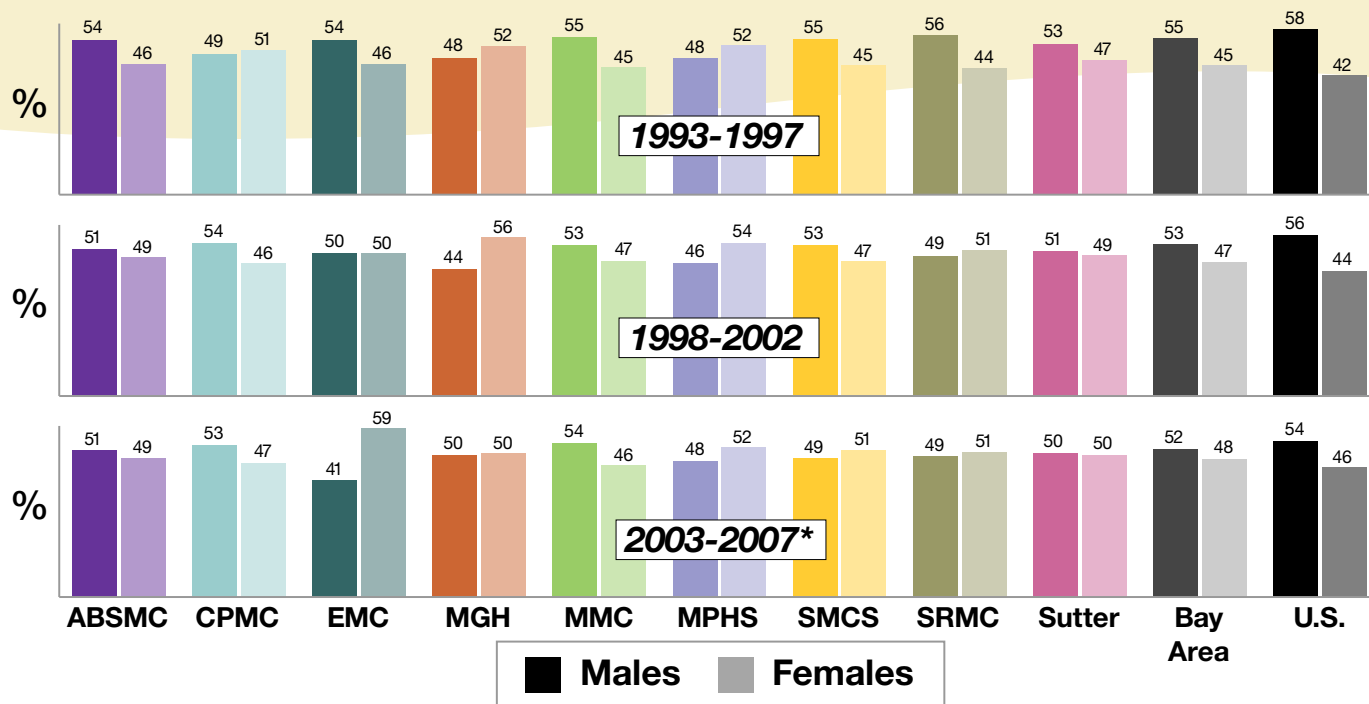


Figure 8
Focus on Non-small Cell Lung Cancer (1993-2007), Sutter Health 2008 Cancer Programs Annual Report

Race/Ethnicity by Time Interval

1993-1997 vs. 1998-2002 vs. 2003-2007

1993-2007 Sutter Health Non-Small Cell Lung Cancer

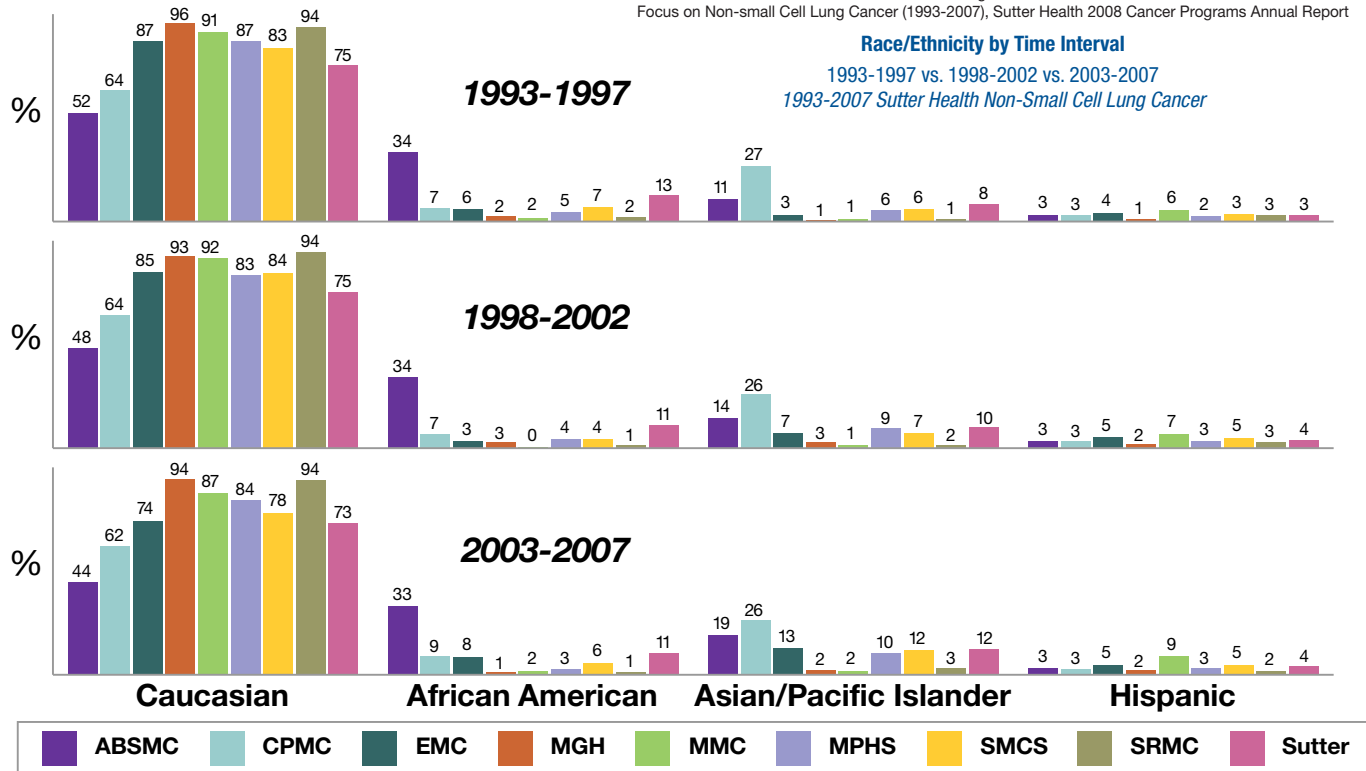
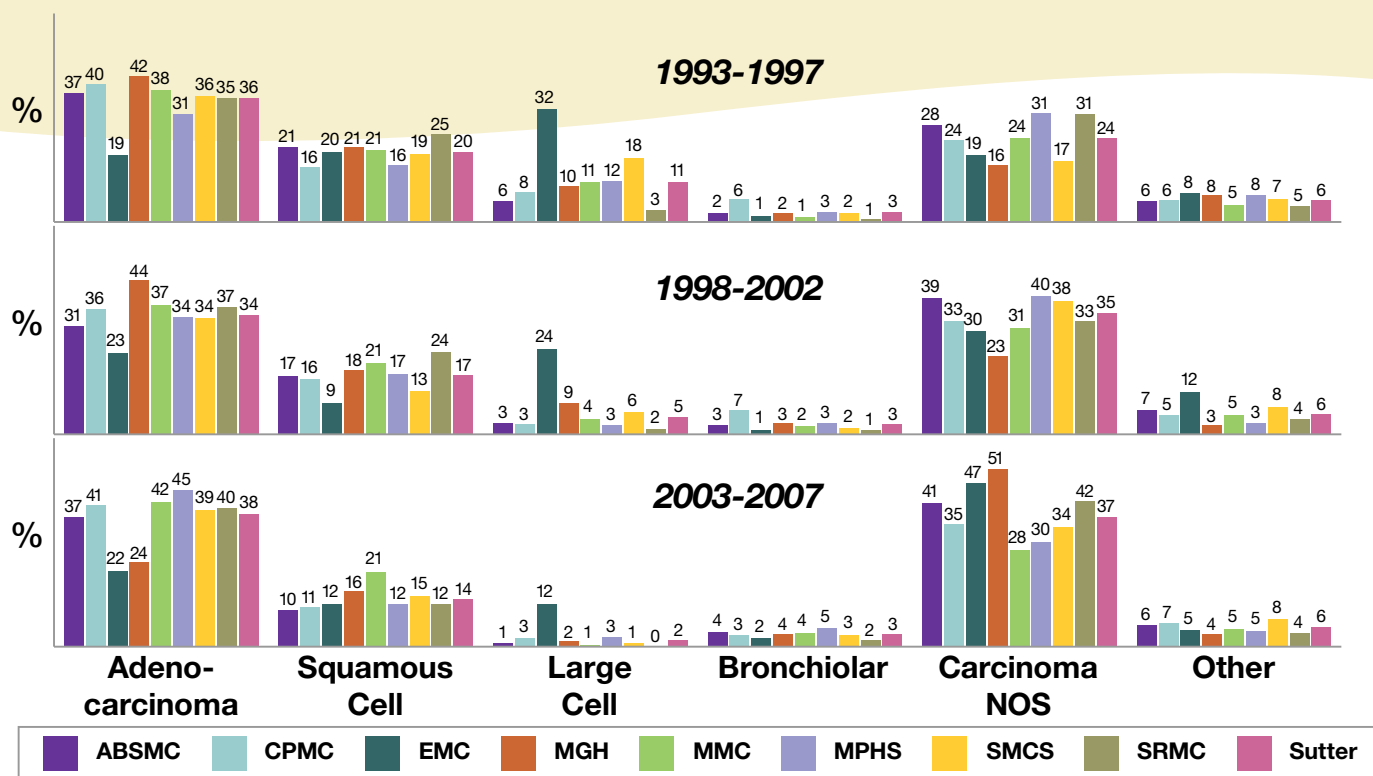


Figure 9
Focus on Non-small Cell Lung Cancer (1993-2007), Sutter Health 2008 Cancer Programs Annual Report

Histologic Type by Time Interval
1993-1997 vs. 1998-2002 vs. 2003-2007
1993-2007 Sutter Health Non-Small Cell Lung Cancer



HISTOLOGIC TYPE AND GRADE

The frequency of various histologic types is shown in **Figure 9**. For Sutter Health as a whole, the most common specific histologic type is adenocarcinoma (just over one-third), followed by squamous cell carcinoma (17%). Other specific histologic types are uncommon, but a substantial proportion (about one-third) of Sutter Health cases fall into the category of carcinoma NOS. There is a fair amount of variability in the proportions of the histology types among the various institutions, which is probably due to differences among pathologists in the way cases without a clear-cut diagnosis are handled.

The category of carcinoma NOS includes cases in which the pathologist is unable to make a more specific diagnosis. Cases of carcinoma NOS tend to occur when there is limited tissue for pathologic evaluation or when the cancer is poorly differentiated. However, the pathologist can almost always differentiate small cell carcinoma from the other carcinomas. Therefore, there should be very few instances of small cell carcinoma among the cases of carcinoma NOS, and it would be appropriate to include these cases in a study of NSCLC.

Noteworthy time trends include the following. There has been a decrease in the proportion of squamous cell ca and large cell carcinoma over time, from 20% to 14% and from 11% to 2%, respectively). On the other hand, the proportion of carcinoma NOS has trended upward (24% in 1993-1997, 35% in 1998-2002 and 37% in 2003-2007), probably due to the use of less invasive biopsy procedures.

Restricting the analysis to stage I and stage II patients only, the overall frequency of carcinoma NOS was 12% in 1993-1997, 20% in 1998-2002, and 26% in 2003-2007, which are substantially lower than the results for all stages combined. This latter finding is consistent with the fact that Stage I and stage II patients are much more likely to undergo definitive surgery, which would yield more tissue for pathologic review.

Figure 10
Focus on Non-small Cell Lung Cancer (1993-2007), Sutter Health 2008 Cancer Programs Annual Report

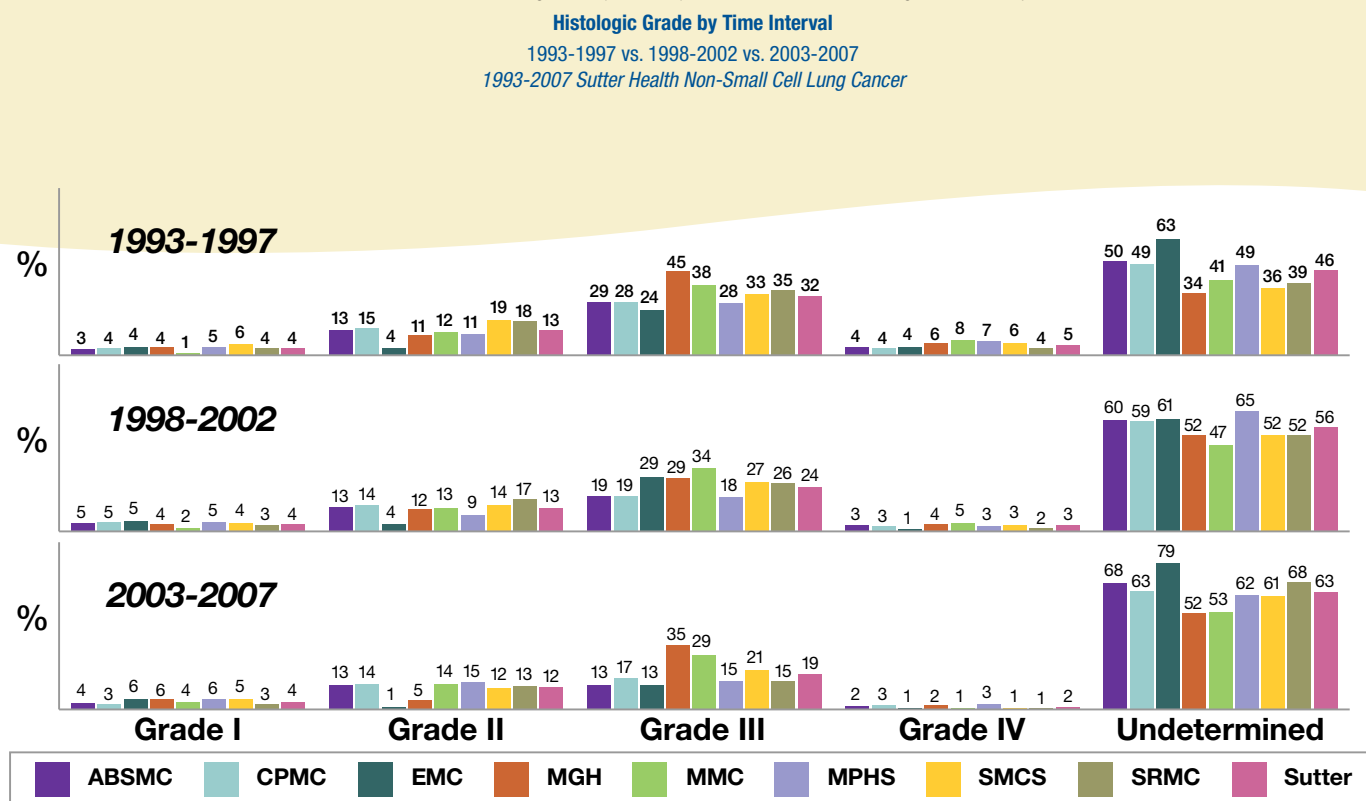


Figure 10 shows the distribution of histological grade for each institution and Sutter Health as a whole. Grade III (on a scale of I-IV) is the most common grade when the grade is known (25% for Sutter overall). However, a high percentage of cases have undetermined grade. For Sutter Health as a whole, this has increased from 46% in 1993-1997 to 56% in 1998-2002 to 63% in 2003-2007. There was a corresponding decrease in high grade disease (grade III and IV) from 37% to 21%. Low grade disease (grade I and II) remained stable at 16-17%. The rise in cases of undetermined grade may be due to increasing use of needle biopsies, for which grading can be more difficult.

TNM STAGE AT DIAGNOSIS

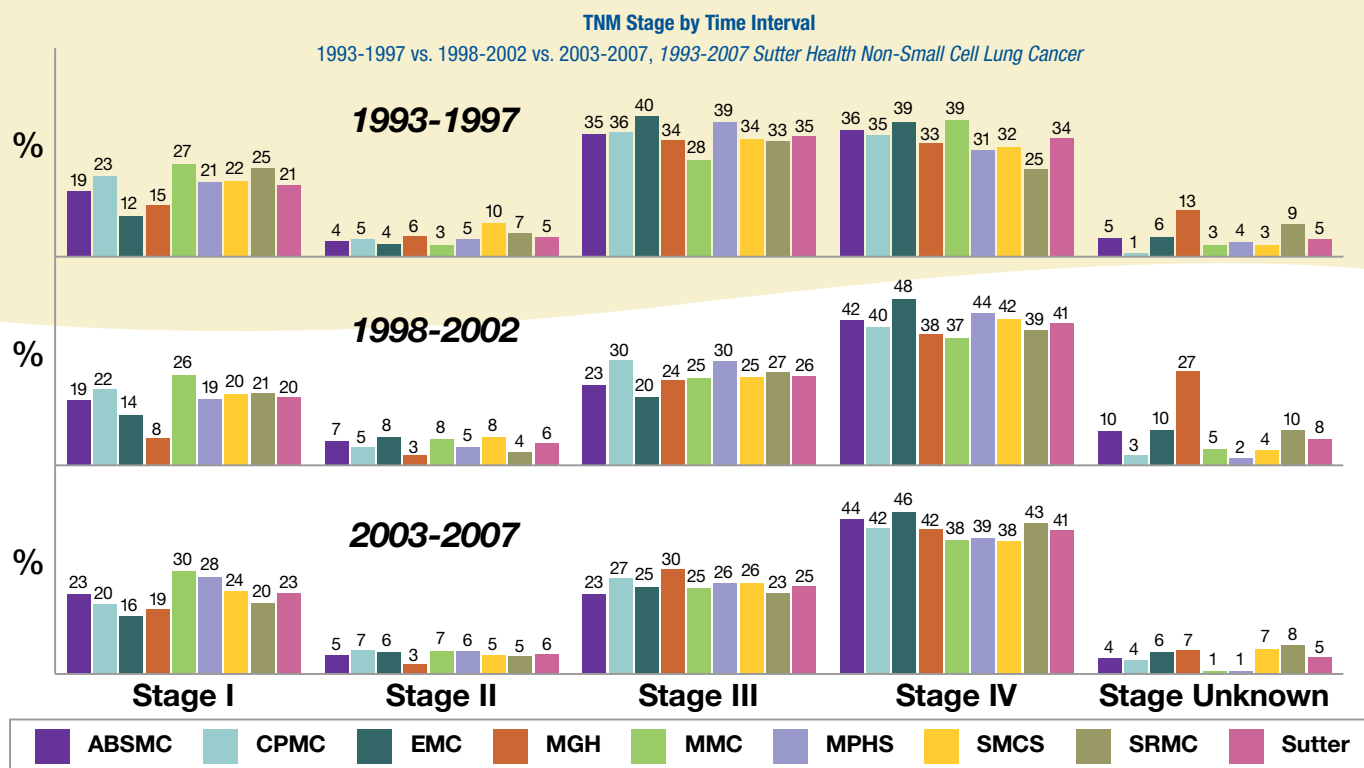
Results for TNM stage at diagnosis are shown in Figure 11 (next page). There is considerable variability among institutions, especially in the stage I and stage unknown categories. The most common reason that cases are coded as stage-unknown is the lack of sufficient documentation of staging work-up available to cancer registrars. This figure illustrates that lung cancer most commonly presents

at an advanced stage (two-thirds of patients had stage III or IV disease at diagnosis) and that stage II disease is uncommon (only about 6% of cases). Three institutions (ABSMC, EMC, and MGH) had a low proportion of stage I disease in past years due to contractual arrangements with outside facilities to provide radiation therapy. There would be a relative paucity of these patients since few patients with stage I disease would have been referred for treatment by these facilities (see discussion of Treatment Modalities below).

Comparing the three time periods, the frequency of both stage I disease and stage II disease remained stable for Sutter as a whole, but there was a drop in the proportion of stage III cases with a corresponding rise in stage IV disease. The proportion of late-stage disease (stage III and stage IV combined) remained stable (69% in 1993-1997, 67% in 1998-2002 and 66% in 2003-2007). The shift in patients from stage III into stage IV can be attributed to more aggressive staging of patients and technological advances such as PET scans. There was no appreciable shift in patients from late-stage disease (stages III and IV) to early-stage disease (I and II) to suggest an improvement in early diagnosis.

Lung Cancer (1993-2007)

Figure 11
Focus on Non-small Cell Lung Cancer (1993-2007), Sutter Health 2008 Cancer Programs Annual Report



The effect of demographic factors on stage at diagnosis is illustrated in **Figure 12**. The subset of Sutter Health cases diagnosed in 1993-2005 were used in this analysis in order to facilitate direct comparison with available regional and national SEER data. Stage III and stage IV disease were combined as late-stage disease in light of the above shift and the poor prognosis for both stages, and stage I and stage II disease were grouped together as “early-stage” disease since there were relatively few cases of stage II disease.

This figure shows that the proportion of early-stage disease is lower for men compared with women and for African-Americans compared with Caucasians for Sutter Health patients. The results are comparable to those for the Bay Area and the U.S. Whether these findings are the result of differences in disease aggressiveness, early detection, or other factors is uncertain.

Except for the 80-and-above group, the percentage of early-stage disease increases with age, suggesting that younger patients have more aggressive disease. This applies to Sutter Health, the Bay Area, and the U.S. The reason for the lower percentage of early-stage disease for the 80-and-above age group is unclear. There may be a tendency put off evaluation of disease symptoms because of very advanced age, which would result in diagnosis later in the disease process.

Figure 12
Focus on Non-small Cell Lung Cancer (1993-2007)
Sutter Health 2008 Cancer Programs Annual Report
“Early Stage” by Gender, Race, and Age
1993-2005 Cohort
1993-2007 Sutter Health Non-Small Cell Lung Cancer

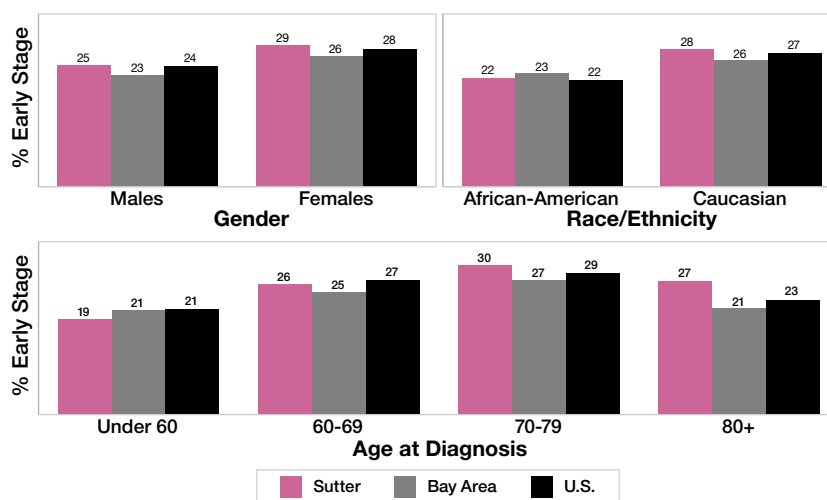
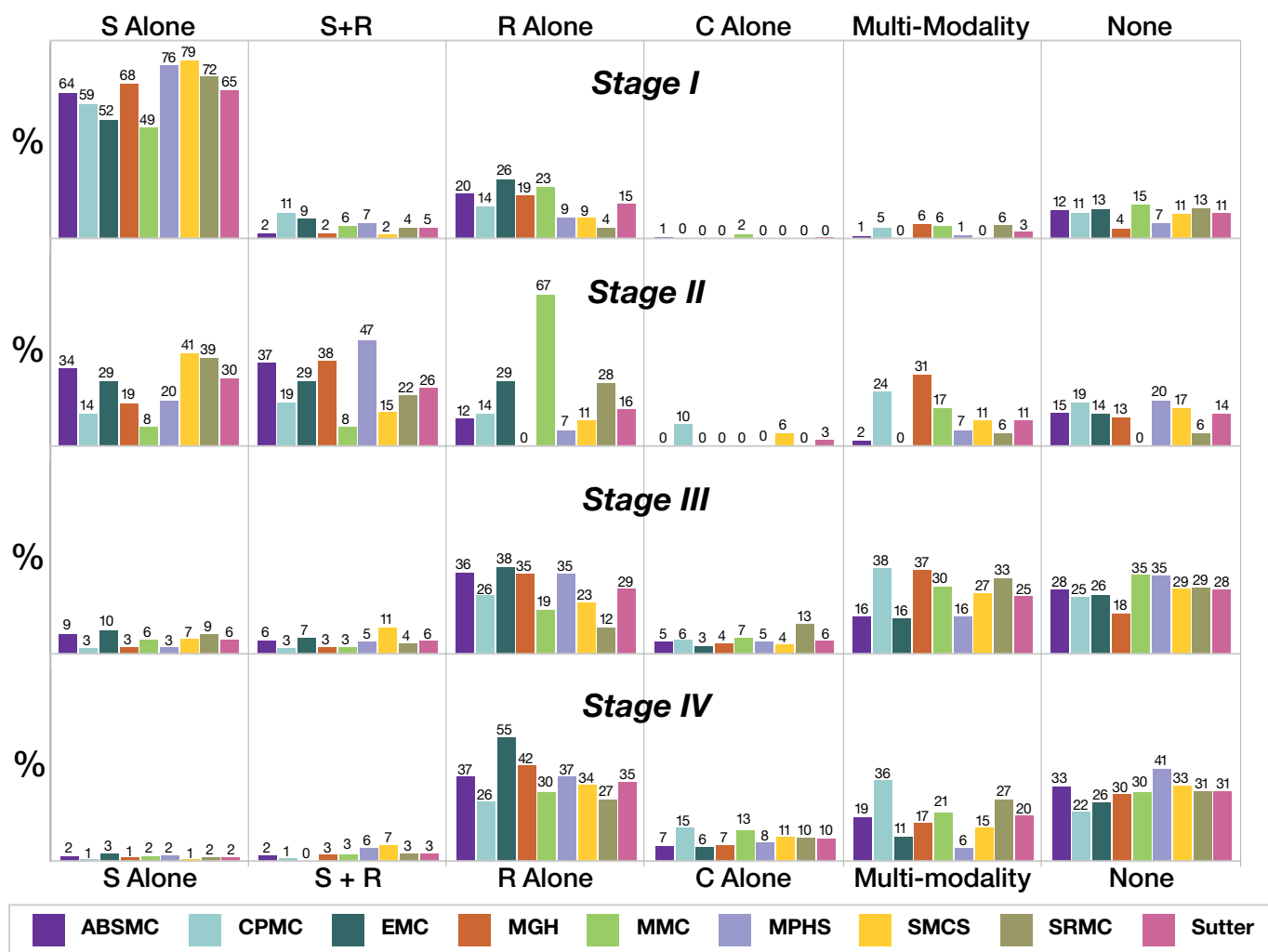


Figure 13
Focus on Non-small Cell Lung Cancer (1993-2007), Sutter Health 2008 Cancer Programs Annual Report

Treatment Modality by TNM Stage: 1993-97 — Class 1 Cases Only

1993-2007 Sutter Health Non-Small Cell Lung Cancer



TREATMENT MODALITIES

As is true for many cancers, treatment of NSCLC is highly dependent on the stage of disease at presentation. Figures 13-15 (this page and the next two pages) show the type of treatment received for each stage of disease. In order to facilitate the analysis, the treatment options have been grouped into six categories: surgery alone, surgery+radiation (without systemic therapy), radiation alone, chemotherapy alone (all forms of systemic treatment), multi-modality (patients treated with surgery and/or radiation along with systemic therapy), and none (patients receiving no cancer-directed therapy). The results for each institution and Sutter Health as whole are provided for each of three time periods (1993-1997, 1998-2002, and 2003-2007). As noted in the analyses of class of case and stage at diagnosis (Figures 4 and 11, respectively), some Sutter Health institutions have treated relatively large numbers of NSCLC patients referred for radiation therapy from outside facilities (Class 2 cases), and this has resulted in a skewed distribution of stage at diagnosis. In order to minimize the effect of this confounding factor, analysis of treatment patterns was restricted to Class 1 cases (cases both diagnosed and first treated at each Sutter facility).

Figure 14
Focus on Non-small Cell Lung Cancer (1993-2007), Sutter Health 2008 Cancer Programs Annual Report

Treatment Modality by TNM Stage: 1998-2002 — Class 1 Cases Only

1993-2007 Sutter Health Non-Small Cell Lung Cancer

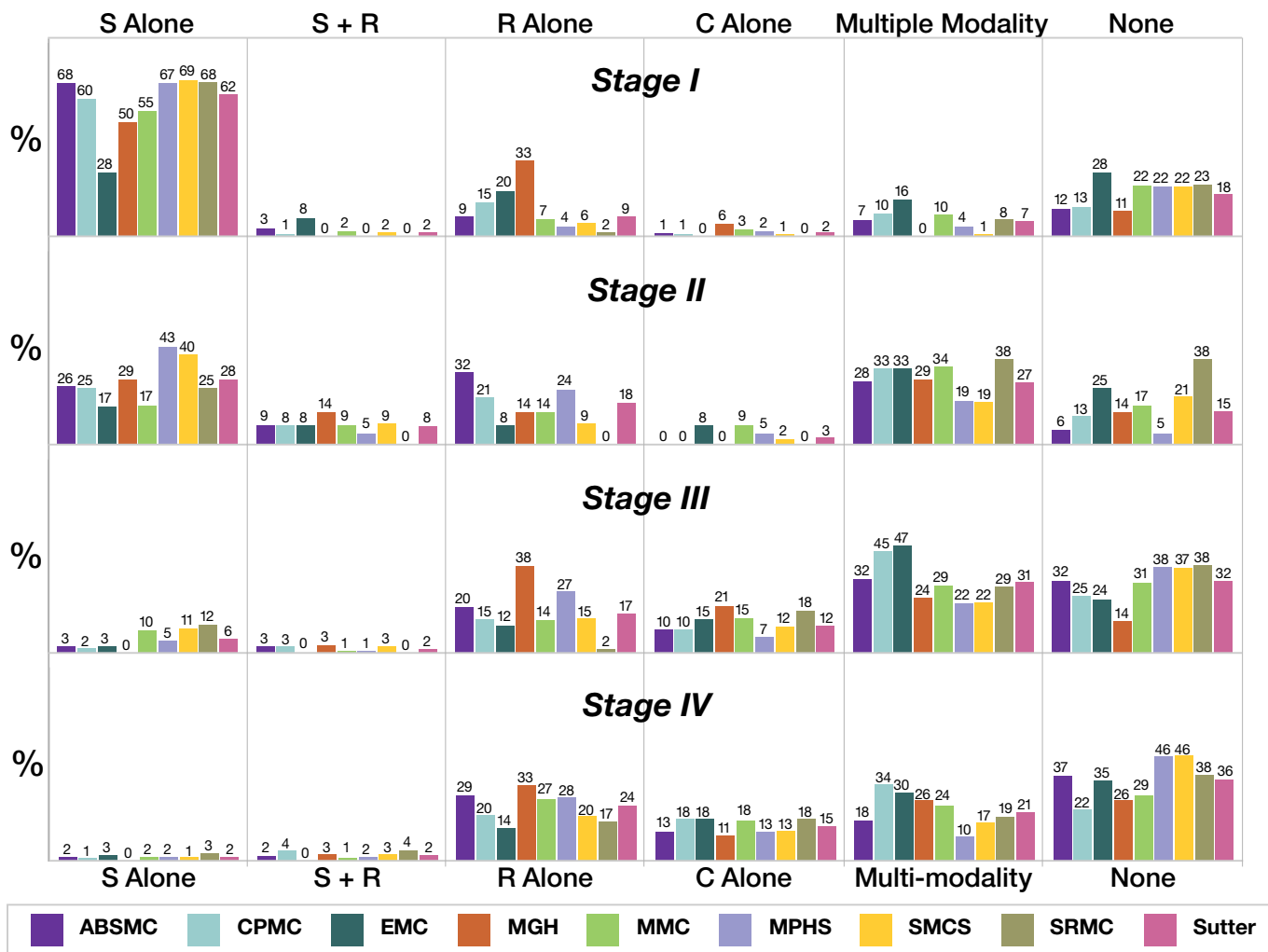


Figure 15
 Focus on Non-small Cell Lung Cancer (1993-2007), Sutter Health 2008 Cancer Programs Annual Report
Treatment Modality by TNM Stage: 2003-2007 — Class 1 Cases Only
 1993-2007 Sutter Health Non-Small Cell Lung Cancer

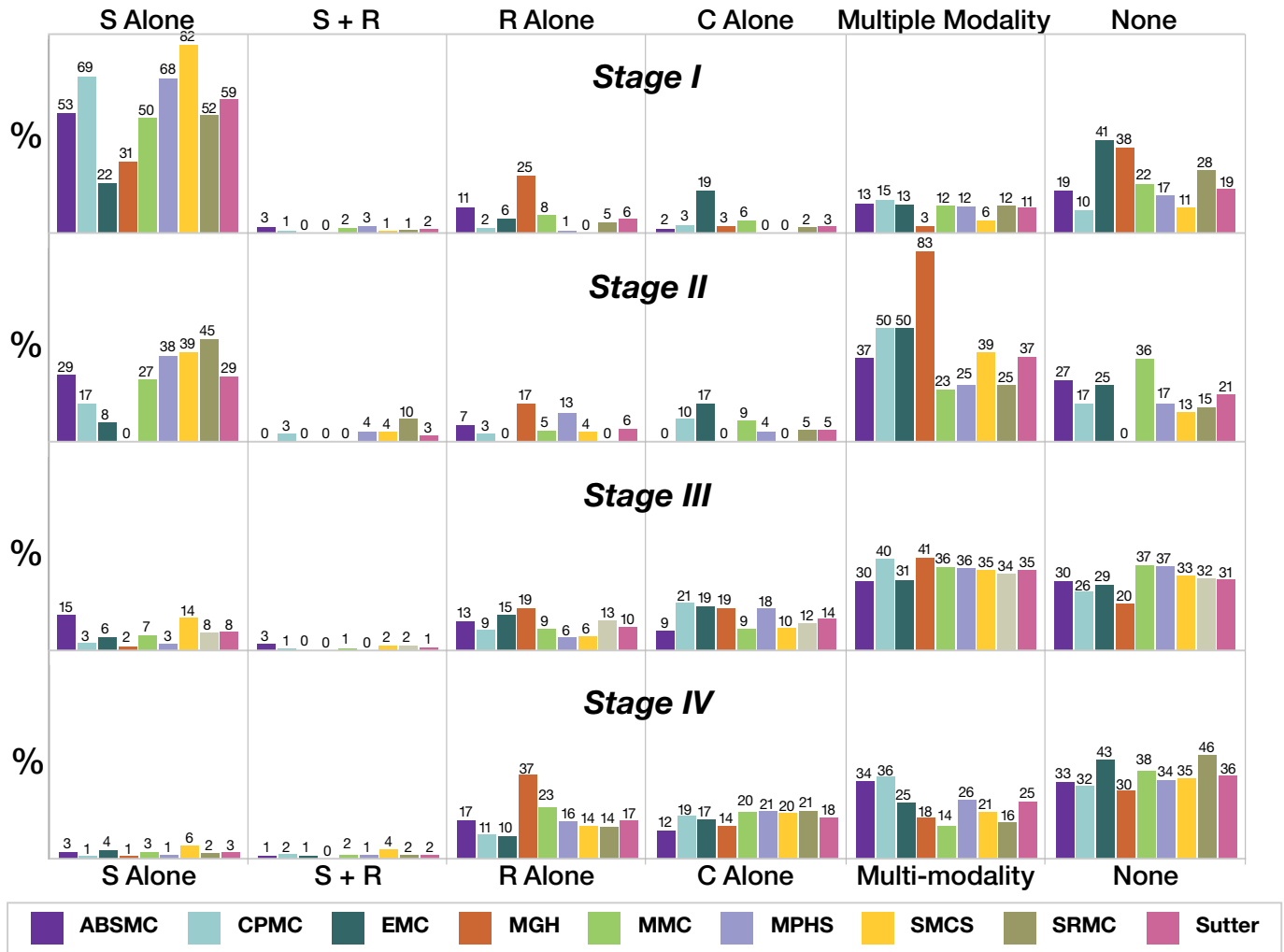


Figure 16
Focus on Non-small Cell Lung Cancer (1993-2007), Sutter Health 2008 Cancer Programs Annual Report

Treatment Modality by TNM Stage: 1993-2007 — Class 1 Cases Only
1993-1997 vs. 1998-2002 vs. 2003-2007; All Sutter Hospitals Combined
1993-2007 Sutter Health Non-Small Cell Lung Cancer

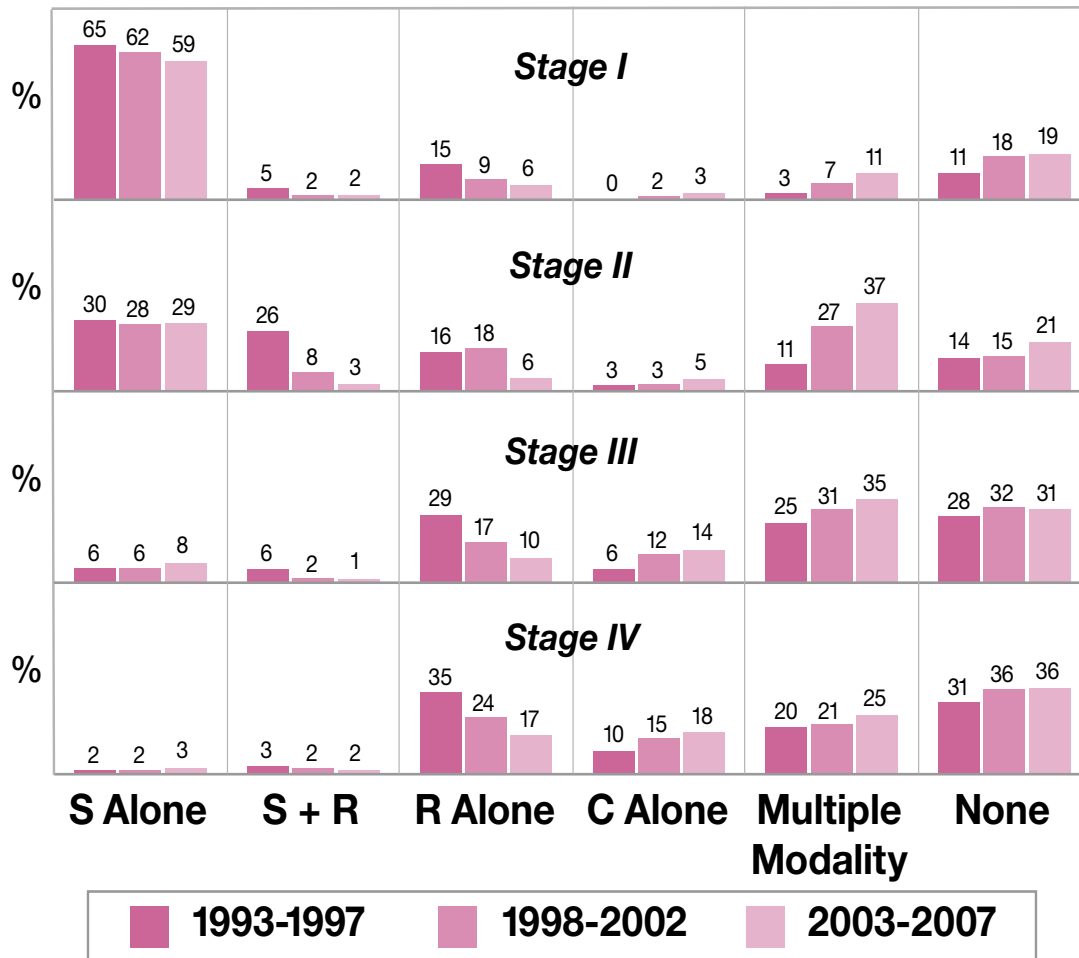
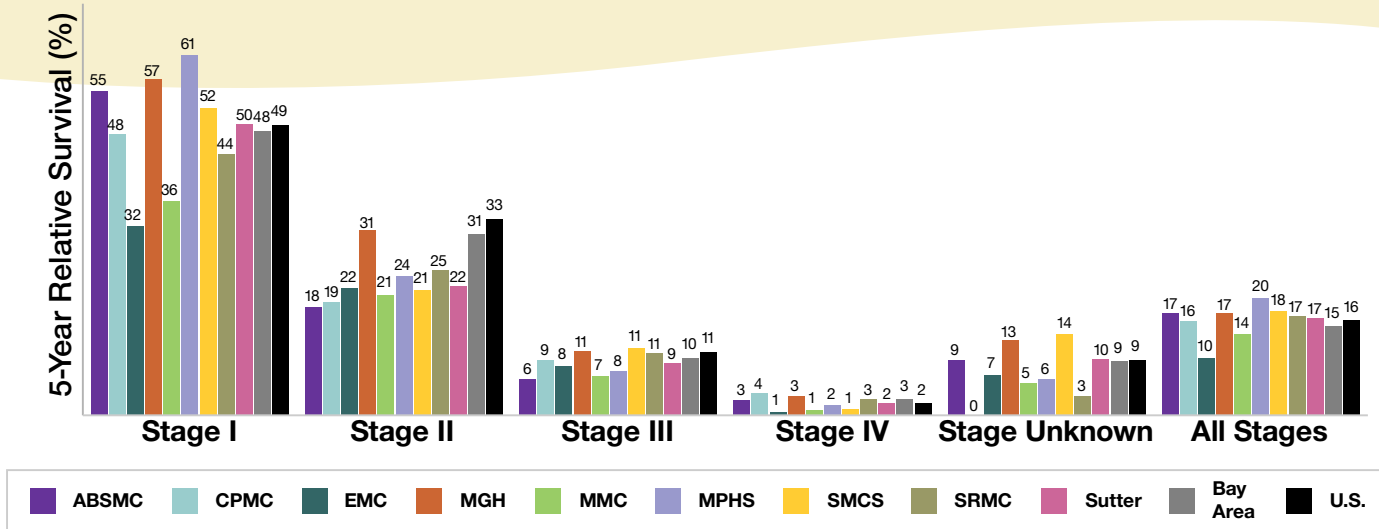


Figure 16 shows the results for Sutter overall. Most patients with stage I disease were treated with surgery alone. For this stage, there was a slight decline over time in surgery only and in radiation therapy only and increase in multi-modality treatment and no treatment. The decrease in surgery alone suggests greater use of adjuvant chemotherapy for patients undergoing surgery. For stage II disease, there is not a single predominant treatment modality. This reflects the lack of consensus on optimal treatment for this group of patients. Time trends for stage II disease include a marked drop in surgery with radiation therapy after the first five-year period, a drop in radiation therapy alone after the second five-year period, and a rapid increase in multi-modality therapy throughout the study period. During the final five-year period, the most common treatment options were surgery alone, multi-modality treatment, and no treatment.

Patients with stage III and IV disease were infrequently treated with surgery alone or with surgery and radiation therapy without chemotherapy. Also, a substantial proportion of these patients received no cancer-directed treatment, which increased slightly over time. Among the remaining treatment modalities, multi-modality therapy was favored. For stage III and IV patients a major time trend was decrease in the use of radiation therapy only. There was increasing use of chemotherapy, either alone or as part of multi-modality treatment, over time.

Figure 17
Focus on Non-small Cell Lung Cancer (1993-2007), Sutter Health 2008 Cancer Programs Annual Report

Five-Year Relative Survival by TNM Stage
1993-2005 Cohort; Class 1 Cases Only
1993-2007 Sutter Health Non-Small Cell Lung Cancer



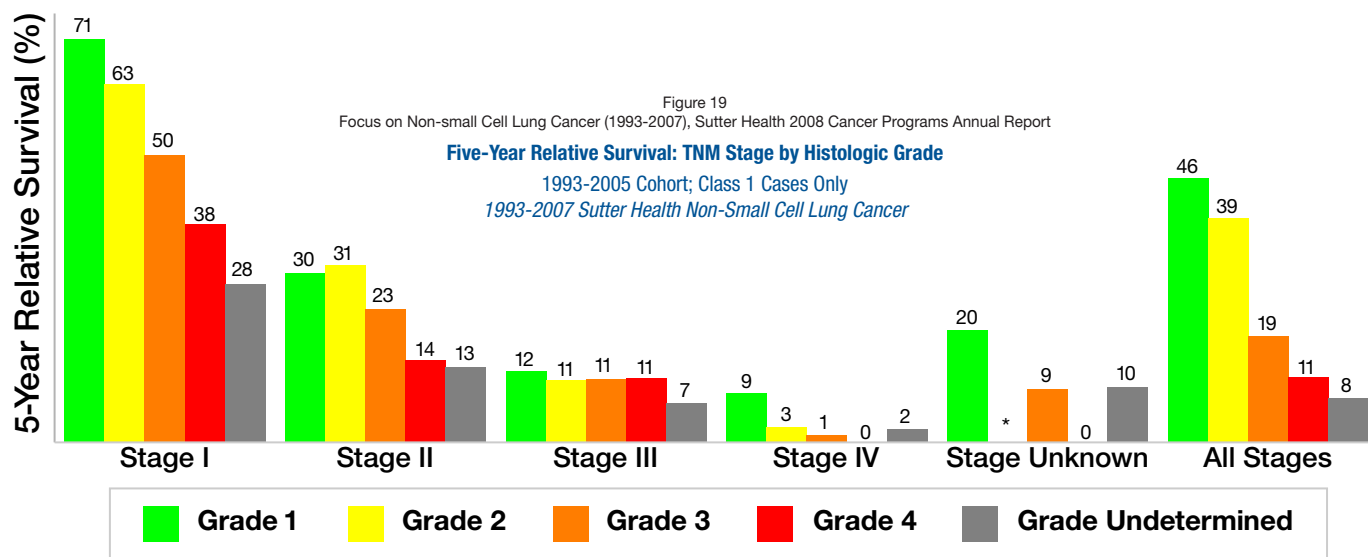
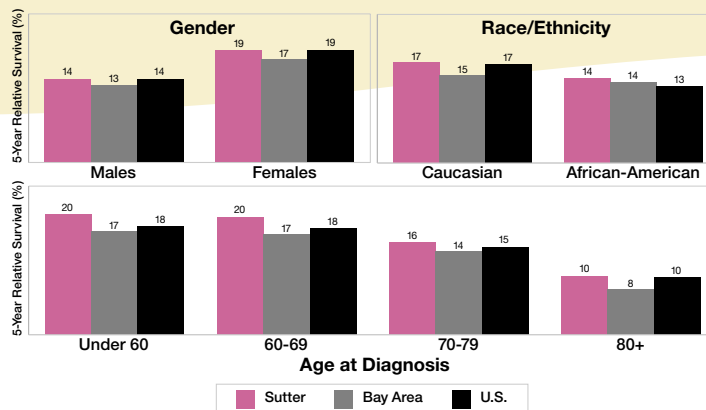
FIVE-YEAR RELATIVE SURVIVAL⁴

In order to have adequate follow-up and to facilitate valid comparison with regional and national results, analyses of NSCLC patient survival was restricted to the cohort of patients diagnosed during the 1993-2005 time period. In addition, only Class 1 cases were included to minimize bias from outside patient referrals (discussed above). The 5-year relative survival by stage and institution is shown in **Figure 17**, which also includes estimates for the Bay Area and U.S. derived from SEER data. As shown in this figure, survival is highly correlated with stage of disease, with rapid fall-off in survival with increasing stage of disease. Overall, the 5-year survival is 17%, which is comparable to the estimates of 15% for the Bay Area and 16% for the U.S. derived from SEER data.

There is wide variability among the Sutter institutions in five year survival. This is not unexpected since the outcome for lung cancer depends on a complex interaction among a number of factors rather than simply the stage of disease. The patient’s pulmonary status, general medical condition and compliance are important factors, as well as histological grade of the cancer. In addition, the results are dependent on staging accuracy, which probably is variable due to differences in staging procedures. For Stage II disease, variability in survival is likely of statistical origin due to the relatively small number of patients.

⁴Relative survival data must be interpreted with caution. The relative survival rate facilitates comparison of survival data from different groups of patients by taking into consideration the likelihood that patients in a given age group will die from causes unrelated to their cancer. Relative survival adjusts the actual observed survival rates of a given patient population for the population’s age and gender structure relative to a “standard” U.S. population. This adjustment doesn’t take into account factors such as race and socioeconomic status, which are known to affect survival rates for persons with colorectal cancer. Also, the U.S. five-year relative survival value used in this report for comparison purposes is based upon SEER data obtained from population-based cancer registries covering only about 10% of the U.S. population. To the extent that the patients seen at Sutter Health facilities during the 1993-2005 period differ from the U.S. sub-population utilized for the SEER statistics, comparisons must be made with caution. Finally, comparisons among Sutter Health facilities with respect to survival rates must take into account the demographic variability seen across Sutter Health institutions.

Figure 18
Focus on Non-small Cell Lung Cancer (1993-2007), Sutter Health 2008 Cancer Programs Annual Report
Five-Year Relative Survival and Demographic Factors: Gender, Race/Ethnicity, and Age
1993-2005 Cohort; Class 1 Cases Only
1993-2007 Sutter Health Non-Small Cell Lung Cancer

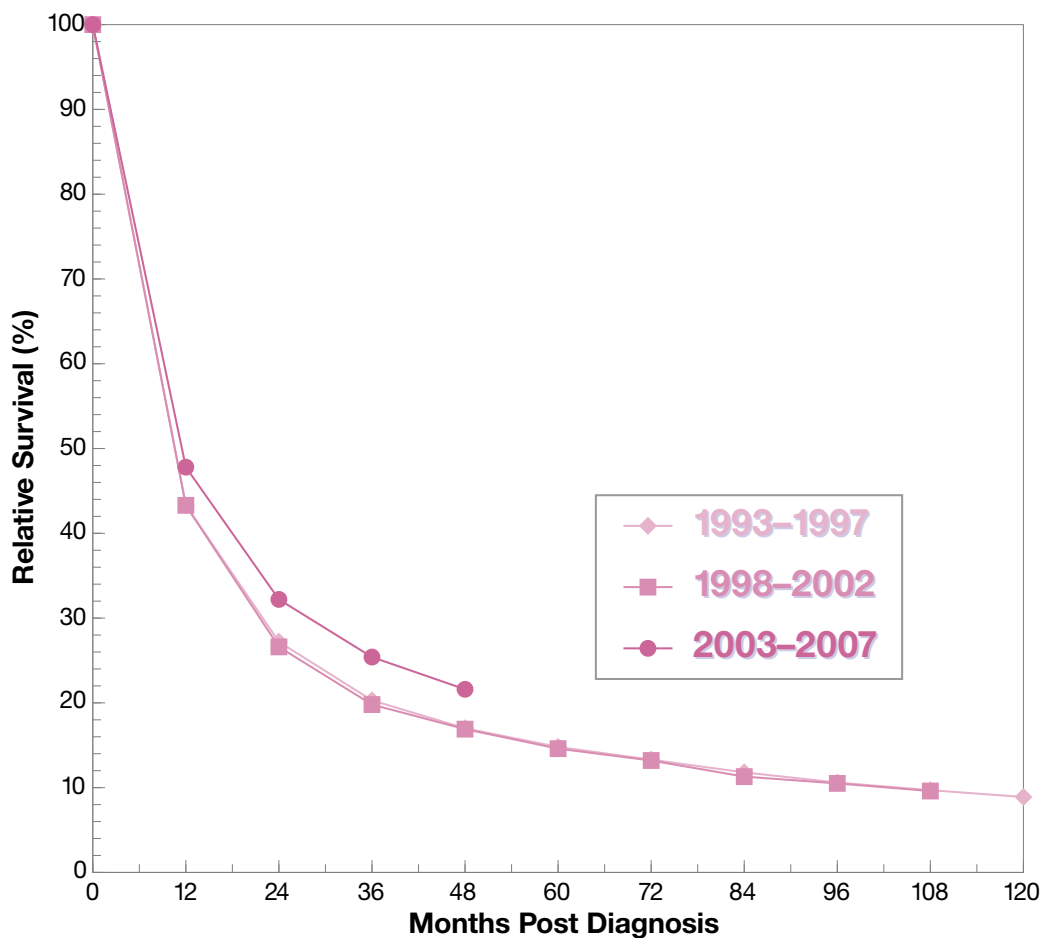


The effect of demographic factors on survival is shown in **Figure 18**. Males have a lower survival than females and African-Americans have a lower survival than Caucasians. These results are consistent with the prior finding that men and African-Americans have higher stage disease than women and Caucasians, respectively (**Figure 12**). Figure 18 also shows that survival decreases with age. This does not correlate with the increase in early-stage disease with age (excluding the 80+ age group) seen in **Figure 12**. It appears that the survival advantage of early-stage disease is not seen in older patients due to the difficulty in giving full treatment to older patients, who may decline or have poor tolerance for such treatment.

The influence of histologic grade on survival is seen in **Figure 19**, which reveals that grade is a major prognostic factor in addition to stage. For early-stage disease there is marked improvement in survival for low-grade disease. Interestingly, patients for whom the grade is undetermined tend to have a poor prognosis. As noted previously, there is a fairly high percentage of patients in this group. One possible explanation for their poor prognosis is that a higher proportion of these patients are elderly or in poor general health. Such patients would undergo a more limited biopsy (which would be more likely to result in an undetermined grade) and would tend to receive lesser or no treatment (which would result in lower survival).

Figure 20
Focus on Non-small Cell Lung Cancer (1993-2007), Sutter Health 2008 Cancer Programs Annual Report

Five-Year Relative Survival by Time Period
1993-1997 vs. 1998-2002 vs. 2003-2007; All Sutter Hospitals Combined
1993-2007 Sutter Health Non-Small Cell Lung Cancer



The relative survival for each of the three time periods is shown in **Figure 20**. The curves for the first two time periods are virtually identical. There is better survival for the most recent time period, with the caveat of shorter follow-up for this period. Since the proportions of early stage and low grade disease have been stable, the better recent survival is suggestive of a benefit from treatment improvements, most notably the greater use of multi-modality treatment and the advent of new drugs. Re-analysis after longer follow-up is indicated to confirm this conclusion.

CONCLUSION

This review of the Sutter Health experience with non-small cell lung cancer, which included analysis of 12,693 cases diagnosed and/or first treated at Sutter institutions over a fifteen-year span (1993-2007), revealed a number of trends over time:

- Decrease in the number of lung cancer cases
- Increase in patients 80 years of age or older
- Increase in the female-to-male ratio (equalizing of gender ratio)
- More undetermined histologic grade
- Decline in stage III disease
- Increase in stage IV and stage-unknown disease
- Increase in the use of multi-modality therapy

This study also confirmed several demographic patterns seen at regional and national levels:

- Higher stage of disease for men compared with women
- Lower survival for men compared with women
- Higher stage of disease for African-Americans compared with Caucasians
- Lower survival for African-Americans compared with Caucasians
- Higher stage of disease for younger patients
- Better survival for younger patients

Survival results for Sutter Health as a whole were comparable to those for the Bay Area and the U.S. However, there was considerable variability in treatment patterns and survival results among the Sutter Health institutions. This variability is probably a reflection of differences in the underlying patient populations and the evolving nature of care for lung cancer.

One especially encouraging finding is better survival for recently diagnosed patients following a long period of no improvement. Since this is not explained by earlier detection of disease, it appears that this finding reflects a significant survival benefit from treatment advances such as new drugs for lung cancer. Further follow-up on patients for the most recent time period would be helpful in confirming this conclusion.

Lung cancer remains a major health problem in the U.S. because of its high incidence and low curability. Fortunately, the incidence of this cancer is on the decline, and greater use of multi-modality therapies should lead to better survival. Possibilities for future advances include more aggressive smoking-cessation programs, evaluation of screening procedures such as spiral CT scanning, and implementation of geriatric oncology programs.

Registries

Sutter Cancer Program

*Stephen Bishop - Cancer Data Services Coordinator
Alta Bates Summit Medical Center*

CANCER REGISTRY DATA COLLECTION AND ANALYSIS

The cancer registries of the Sutter Cancer Program provide data management services to comply with mandatory state cancer reporting regulations, as well as the data needs of clinicians, administrators, and other qualified users across the Sutter Network. In addition, Sutter cancer registries also provide data to national-level cancer surveillance organizations for incidence measurement and epidemiological studies. As of the date of this report, the Sutter Cancer Registries have collected data for a total of 225,976 cases, with 11,555 new cases entered for the calendar year 2007, the last complete year of data collection.

The local registry databases contain demographic and clinical information from diagnosis through treatment, as well as annual lifetime follow-up data. The follow-up process, in addition to providing critical information about disease status and treatment outcomes, also performs a valuable service for physicians and patients by reminding them that regular reassessment of the disease is vital for early detection of recurrences or subsequent primaries. As of the end of 2007, the Sutter Cancer Registries are actively following 77,421 living patients.

Data collected by each hospital are shared and aggregated for reports, studies, and cancer statistics for the Sutter Cancer Program as a whole. The ability to look at our combined Sutter Health data provides a unique opportunity to evaluate care across our network. At present, system-wide studies and quality assurance projects are accomplished through data exports and manual aggregation and statistical analysis of the data. Through comparison with regional and national statistics, the combined data enables Sutter clinicians to more

effectively monitor trends in the incidence, staging, treatment, outcome and survival of cancer patients treated within our network.

In addition to their routine cancer registry responsibilities, Sutter Cancer Registrars are often asked or volunteer to coordinate or participate in other Cancer Program activities outside of the Cancer Registry. At any of the ten ACOS accredited facilities in the Sutter Cancer Program, the Cancer Registrar may be involved in the coordination or supervision of:

- Cancer Screening Programs;
- Cancer Support Groups for patients and families;
- Continuing Medical Education (CME) for Oncology;
- Cancer Research Projects;
- Volunteers and Auxillary Staff Members;
- Cancer Survivorship Celebrations.

Sutter Cancer Registrars are often members of other standing medical staff or hospital committees, especially Quality Improvement Committees, which often use Registry data for clinical indicators and quality improvement measures.

Cancer Registrars often participate in or coordinate American Cancer Society (ACS) activities such as “Relay for Life”, “Look Good, Feel Better”, or “Making Strides Against Breast Cancer”. They are also frequently involved in community health fairs and public education activities such as Breast Cancer Awareness Month events in October, and Prostate Cancer Awareness Month events in November.

Registries

Sutter Cancer Program

Each Sutter Cancer Program facility is accredited by the American College of Surgeons and is periodically re-surveyed to assure continuous compliance with its accreditation standards. In most cases, Sutter Cancer Registrars serve as the ACOS Certification Coordinators at their facilities, devoting many hours outside of their data management responsibilities to insure that their cancer programs meet or exceed all ACOS Cancer Program standards for their respective categories of approval.

In 2008, the Cancer Programs of Alta Bates Summit, California Pacific Medical Center, Marin General Medical Center, Mills-Peninsula Medical Center, Sutter Roseville Medical Center, and Sutter Solano Medical Center were

surveyed by the ACOS and all were granted 3-year approvals "With Commendation". In addition, Marin General Hospital and Sutter Medical Center Sacramento both received an "Outstanding Achievement Award" (OAA) from the COC--two of only ten hospitals in the state of California to be so honored. The OAA is given to cancer programs that achieve commendations on all seven of the seven standards for which commendation is awarded. "With Commendation" is awarded to programs attaining commendations on 1 to 6 standards.

The following table summarizes the volume of activity of each registry for calendar year 2007 (Table 1):

Table 1
2007 Sutter Cancer Registry Statistics

Sutter Cancer Registry Statistics

	ABSMC	CPMC	EMC	MGH	MHA	MPHS	SAFH	SMCS	SRMC	SSMC
Reference Date	1/1/1985	1/1/1993	1/1/1998	1/1/1983	1/1/1990	1/1/1995	1/1/2004	1/1/1992	1/1/1990	1/1/2002
Total Cases in Database	50,835	46,018	11,588	23,610	26,111	28,127	1,686	18,782	19,219	5,527
Total Cases in 2006	2,184	2,556	511	751	910	1,146	342	1,939	1,216	423
Total Active Follow-Up	18,032	13,649	1,901	7,735	15,714	7,166	501	9,255	3,486	1,238
Follow-up Success %	89%	98%	95%	96%	90%	92%	95.4	93%	91%	98%
Tumor Board Case Presentations	457	338	209	752	166	369	96	275	178	70
■ General Tumor Board	187	59	160	282	166	101	96	71	132	70
■ Breast Tumor Board	270	56	7	161	0	206	0	95	46	0
■ Other Special Tumor Boards	0	223	42	309	0	62	0	109	0	0
Total Data Requests	9	36	93	12	7	7	1	8	5	12

Sutter Health 2007 Cancer Registry Data

Eric Gold, Oncology Analyst/Programmer, Alta Bates Summit Medical Center

See page two for abbreviations for Sutter Health institutions.

This overview presents an analysis of 9,901 new cases of cancer¹ diagnosed and/or treated at the ten American College of Surgeons accredited Sutter Health institutions during 2007. This represents an 9% increase in system-wide volume over last year's totals.²

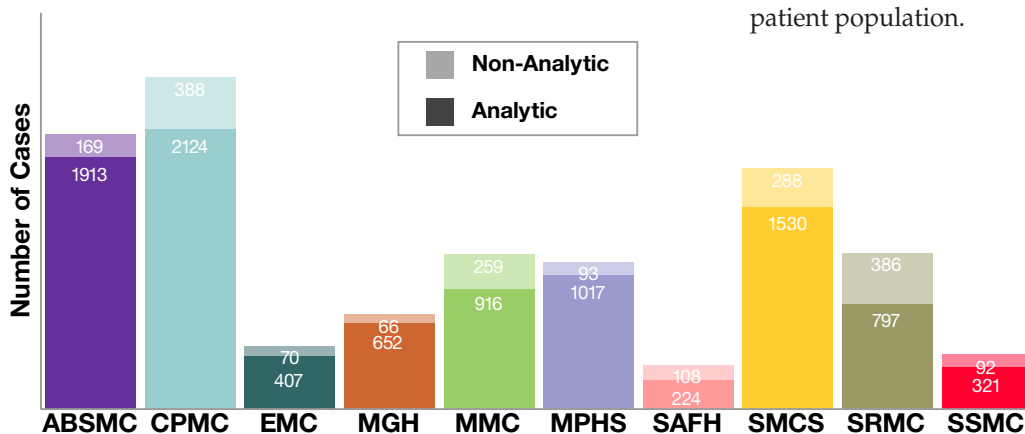
PATIENT VOLUME BY CLASS OF CASE (Figure 1)

Figure 1 shows the variability in the total number of cancer cases reported in 2007 at each of the ten Sutter Health hospitals. Year 2007 overall case volume ranged from 332 at SAFH to 2,512 at CPMC for a total of 11,820 cases system-wide. Eighty-four percent of these cases (9,901) were newly diagnosed and/or received the first course of treatment at one of the ten Sutter centers. These are designated as “analytic” cases and all further analyses are restricted to these data.

AGE AT DIAGNOSIS

Overall – Generally similar patterns of age distribution were seen among all institutions, with the number of cancer patients peaking in the 60-79 age range at all institutions except EMC, where the 80-89 age group was predominant. Over two-thirds of cancer patients were diagnosed in the 50-79 age range and 85% were age 50 or over at the time of diagnosis. The median age at diagnosis was 65 years overall and ranged from 63 (SMCS, CPMC) to 72 (EMC). SMCS, CPMC, and SSMC had the youngest cancer patient populations and MPHS, SAFH and EMC had the oldest. These trends reflect differences in both the underlying demographics of the communities served and the relative incidence of the most prevalent cancers seen at each institution. The male cancer patient population is slightly older than the female cancer patient population (median age 67 vs. 64). These data are consistent with those seen over the last twelve years in the Sutter Health cancer patient population.

Figure 1
2007 Sutter Health Analytic Cancer Cases
Patient Volume by Class of Case



¹ In order to be consistent with previous Sutter Health Cancer Programs Annual Reports, which included only malignant neoplasms, this analysis does not include benign neoplasms of the brain and central nervous system, which are reportable in the state of California beginning with cases diagnosed 01/01/2001 and later. However, these cases have been included in the primary site tables for each facility at the end of this report.

²A significant part of this increase (2.5%) is attributable to the addition of the recently ACoS-accredited Sutter Auburn Faith Hospital (SAFH). It is also important to note that hospital cancer registry data reflect patients diagnosed and treated in the hospital, unlike population-based cancer registry data such as those reported by the California Cancer Registry and at the SEER registry of the National Cancer Institute, which represent all patients diagnosed in a defined population.

Overview

2007 Cancer Registry Data

AGE DISTRIBUTION BY GENDER (Figure 2)

Males – The ten hospitals show modest differences. For ABSMC, MGH, MMC, SMCS, and SSMC the greatest number of cases fell into the 60-69 age group. For CPMC, MPHS, SAFH, and SRMC cases peaked in the 70-79 age group, while at EMC the 80-89 age range was the single largest group. Overall, 54% of the males were diagnosed in the 60-79 age range.

Females - Overall females show a flatter and somewhat more varied distribution than males. Age distribution peaked in the 50-59 range for females at ABSMC, CPMC, and SMCS, in the 60-69 range at MGH and SSMC, in the 70-79 range for women at MMC, MPHS, SAFH and SRMC, and in the 80-89 range for EMC. Overall, only 42% of the females were diagnosed in the 60-79 age range, contrasted with 54% in males. These gender differences probably reflect differences in the age at diagnosis for the two most dominant gender-specific cancers: prostate and breast cancer (see Figure 5). Within each gender, prostate and breast cancer account for 30% and 41%, respectively, of all newly-diagnosed cases. The median age at diagnosis for prostate cancer was 66 vs. 59 for female breast cancer.

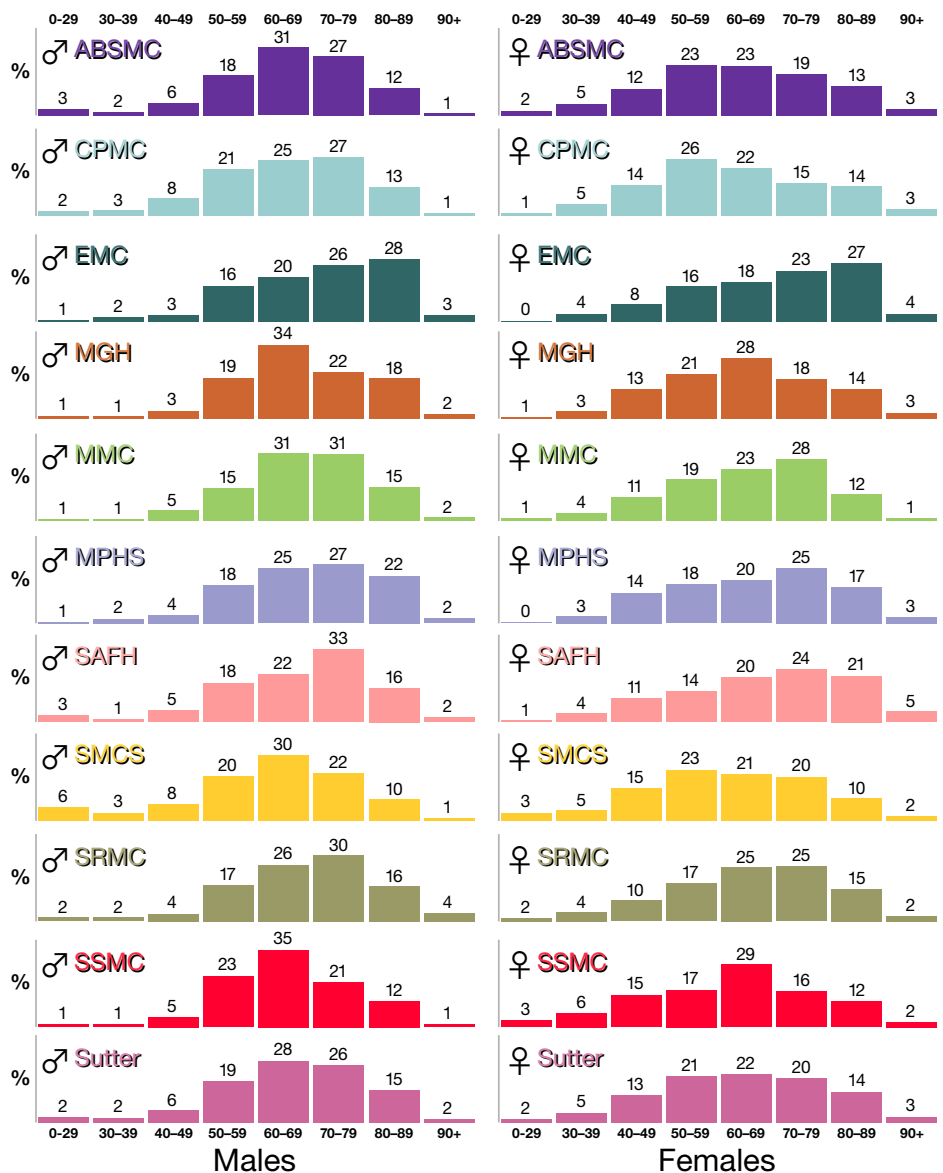


Figure 2
2007 Sutter Health Analytic Cancer Cases
Age Distribution by Gender

Sutter Health

2007 Cancer Registry Data

GENDER RATIO (Figure 3)

As seen in past years in the Sutter Health system, the female cancer patient population is significantly larger than the male population, a trend observed at all institutions. Females account for 55% and males account for 45% of the newly diagnosed cancers seen in 2007. The largest disparity in gender ratio was at EMC, SMCS and SRMC while gender proportions were most similar at MMC. These differences are mostly a reflection of the relative incidence of male-specific cancers (mostly prostate) and female-specific cancers (mostly breast, uterus, and ovary). For example, EMC, SRMC and SMCS have the highest incidence of breast, uterine, and ovarian cancers relative to prostate cancer, while MMC had the lowest

incidence of breast, uterine, and ovarian cancers relative to prostate cancer.

It is important to note that the female-to-male ratio in population-based registries such as the California Cancer Registry is 1:1, whereas our Sutter hospital-based registries record a preponderance of female patients. These differences are due to hospital referral patterns and the inherent nature of these two different types of cancer registries.

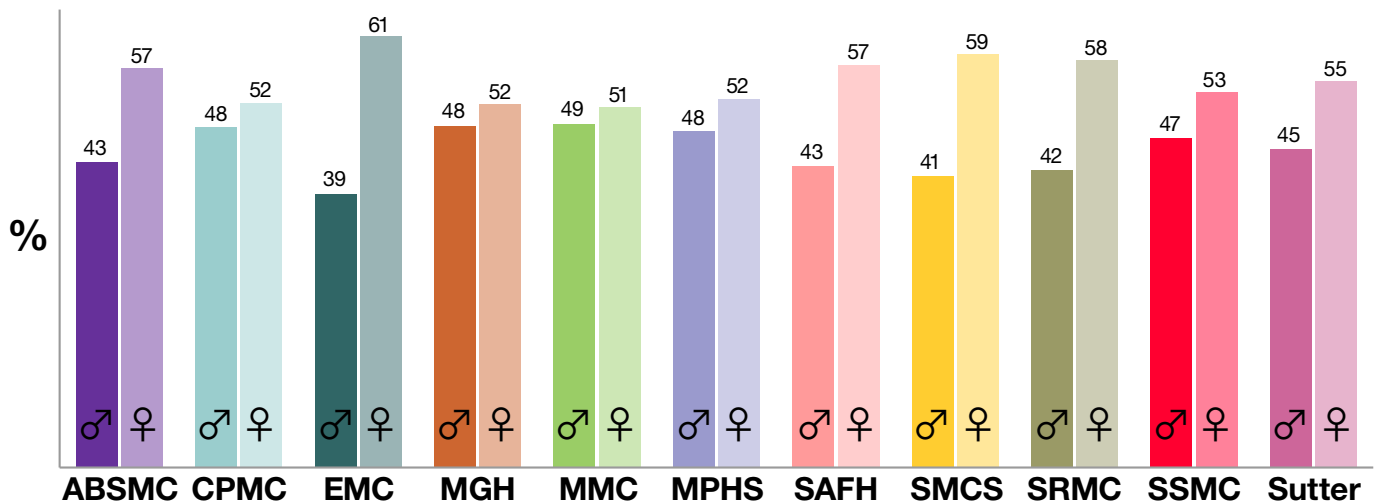


Figure 3
2007 Sutter Health Analytic Cancer Cases
Gender Ratio

Overview

2007 Cancer Registry Data

RACE/ETHNICITY (Figure 4)

The distribution of patients by race/ethnic group reflects the diversity seen in the communities served by each institution. The ABSMC and SSMC cancer patient populations are the most ethnically diverse with the fewest Caucasians (56% and 59%, respectively) and large African-American (21% and 16%, respectively) and Asian³ (16% and 17%, respectively) components. ABSMC alone accounts for 53% of the entire Sutter Health African-American cancer patient population. CPMC also has a relatively diverse patient population with the largest Asian

component (21%). CPMC and ABSMC together account for almost two-thirds of the Asian Sutter Health population. A relatively large Hispanic component is seen at MMC (15%). The cancer patient populations at SAFH, SRMC and MGH are the least ethnically diverse (94%, 93% and 90% Caucasian, respectively).

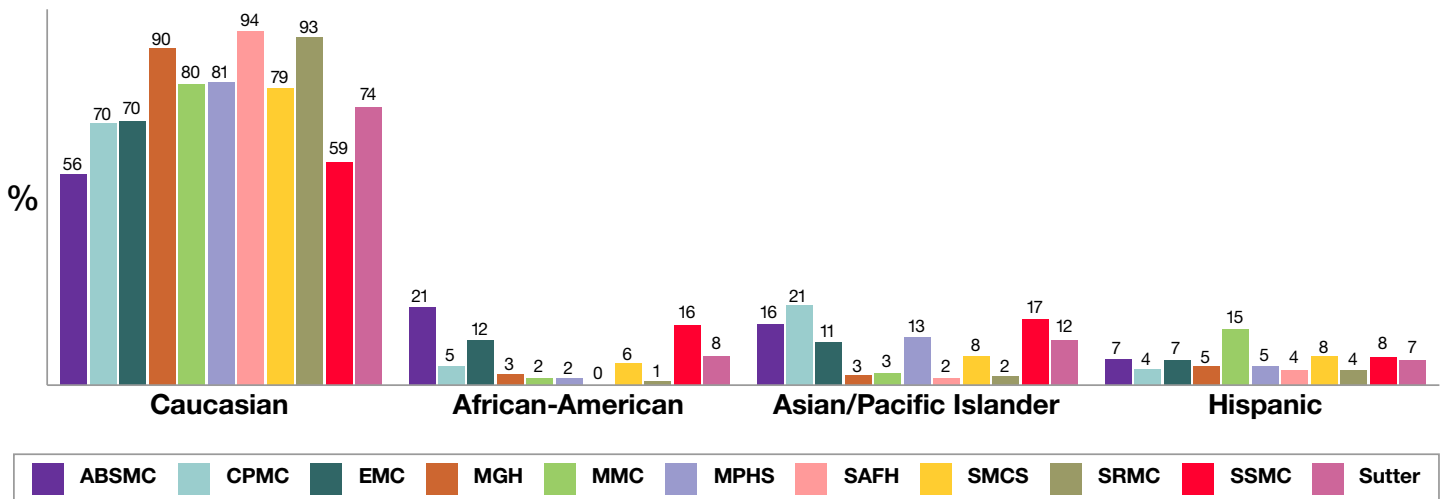


Figure 4
2007 Sutter Health Analytic Cancer Cases
Race/Ethnicity

³ Asian includes Asian and Pacific Islander.

Sutter Health

2007 Cancer Registry Data

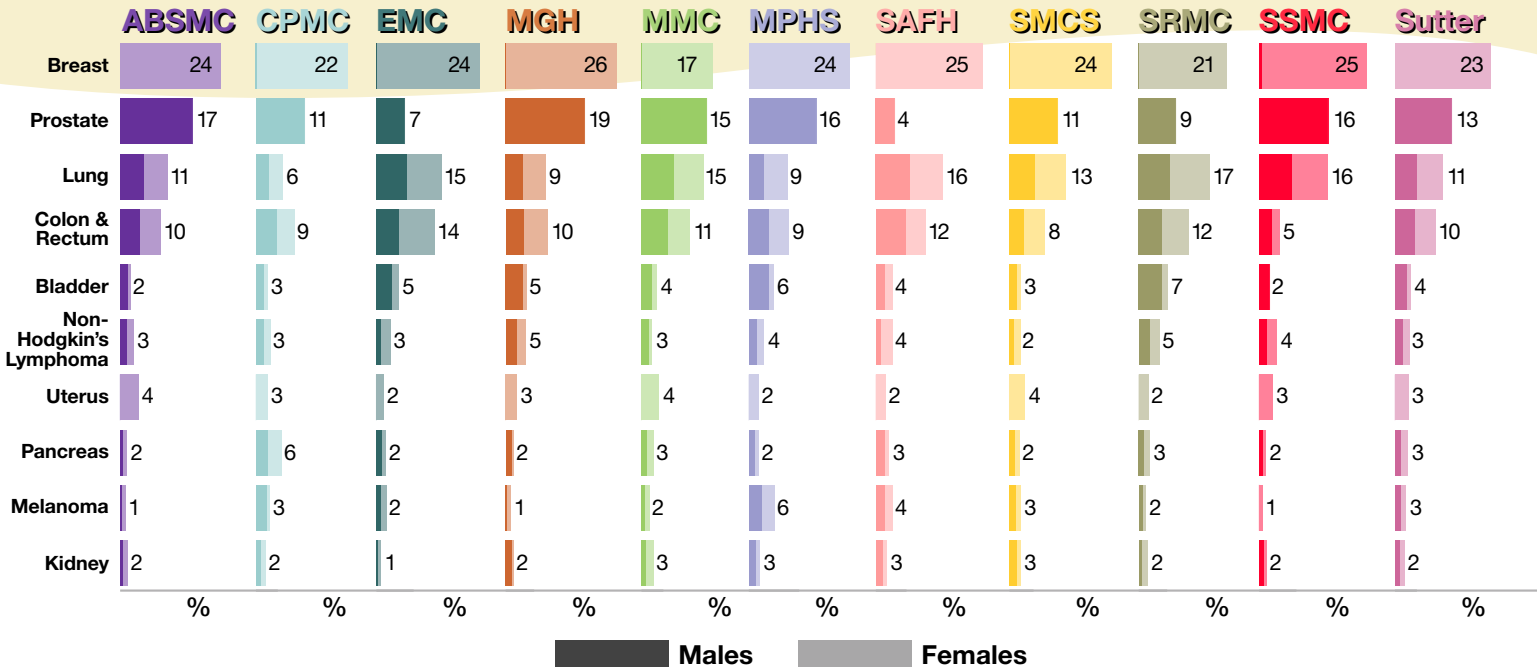


Figure 5
2007 Sutter Health Analytic Cancer Cases
Top 10 Primary Cancer Sites (Overall) by Gender

TOP 10 PRIMARY CANCER SITES (Figure 5)

The distribution of the most prevalent cancers seen in the Sutter Health system has changed very little over the past fifteen years. The top five cancer sites account for 61% and the top ten cancer sites encompass 75% of the newly-diagnosed cancers seen in the Sutter Health system. Female breast cancer accounts for over one-fifth of all new cancers seen in the Sutter Health System (23%). Prostate (13%), lung (11%), colorectal (10%), and bladder (4%) account for 38% of cancers newly diagnosed in 2007.

Some additional hospital-specific trends observed were:

- **Breast Cancer:** Highest relative incidence seen at MGH (26%), and the lowest at MMC (17%)
- **Prostate Cancer:** There are many possible factors that affect the relative incidence of prostate cancer at community hospitals. The relatively high incidence seen at MGH (19%) may be due to the fact that it has a relatively older underlying patient population and also socioeconomic factors leading to higher PSA screening penetrance and thus higher detection/overdetection of Marin County men with prostate cancer. SAFH had the lowest incidence (4%) and in this case it is likely result of community referral patterns. Many of the prostate cancer cases are diagnosed in physician offices and referred for treatment at a large independent radiation oncology practice in the community. Appropriately, the SAFH cancer registry does not record these patients and the result is an under-representation of prostate cancer in their database.
- **Lung Cancer:** Highest relative incidence at SRMC (17%), and the lowest at CPMC (6%)
- **Colorectal Cancer:** Highest relative incidence at EMC (14%), and the lowest at SSMC (5%)
- **Bladder Cancer:** Highest relative incidence at SRMC (7%)
- **Non-Hodgkin's Lymphoma:** Highest relative incidence at MGH and SRMC (5%) and the lowest at SMCS (2%)
- **Uterine Cancer:** Very small range of variability among the Sutter institutions (2%-4%)
- **Pancreatic Cancer:** Highest relative incidence at CPMC (6%)
- **Melanoma of the Skin:** Highest relative incidence at MPHS (6%) and lowest relative incidence at SSMC (<1%)
- **Renal Cancer:** Very small range of variability among the Sutter institutions (1%-3%)

Overview

2007 Cancer Registry Data

RELATIVE INCIDENCE OF MAJOR INVASIVE CANCERS — COMPARISON WITH STATE AND NATIONAL ESTIMATES⁴ (See Figure 6, next page)

OVERALL SUTTER HEALTH COMPARED WITH CALIFORNIA AND THE UNITED STATES:

Oral, Pancreas, Colon & Rectum, Urinary, Uterus, and Ovary	— Sutter Health was generally similar to statewide and national estimates
Lung	— Sutter Health male and female rates slightly lower than national estimates (12% vs. 15%)
Leukemia/ Lymphomas	— Sutter Health females slightly lower than seen in California and the U.S. (5% vs. 8%)
Female Breast	— Slightly higher than seen in California and the U.S. (35% vs. 33% and 31%)
Prostate	— Slightly higher than seen in California (30% vs. 27%)

INDIVIDUAL SUTTER HEALTH INSTITUTIONS COMPARED WITH CALIFORNIA AND THE UNITED STATES:

Oral	— No significant deviations for males or females from patterns seen with California and the U.S.
Lung	— Relatively high rates in EMC (19%), SAFH (19%), SRMC (18%), and SSMC (17%) males compared with California and the U.S. (13% and 15%) — Relatively low rates in CPMC (7%), MGH (8%), and MPHS (8%) males compared with California and the U.S. (13% and 15%) — Relatively high rates in SRMC (18%) and SSMC (17%) females compared with California and the U.S. (13% and 15%) — Relatively low rates in CPMC (7%) and ABSMC (11%) females compared with California and the U.S. (13% and 15%)
Pancreas	— Relatively high rate in CPMC males compared with California and the U.S. (6% vs. 2% and 3%) — Relatively high rate in CPMC females compared with California and the U.S. (7% vs. 3%)
Colorectal	— Relatively high rates in SAFH (16%), EMC (14%), MMC (13%), and SRMC (13%) males compared with California and the U.S. (11% and 10%) — Relatively low rates in SSMC (6%), MGH (8%), and SMCS (8%) males compared with California and the U.S. (11% and 10%) — Relatively high rate in EMC females compared with California and the U.S. (14% vs. 11%) — Relatively low rate in SSMC females compared with California and the U.S. (4% vs. 11%)
Urinary	— Relatively high rates in SRMC (15%) and MPHS (14%) males compared with California and the U.S. (11%) — Relatively low rates in ABSMC (6%) and CPMC (7%) males compared with California and the U.S. (11%) — Relatively low rate in SSMC females compared with California and the U.S. (1% vs. 5% and 6%)
Leukemia/ Lymphomas	— Relatively low rate in MMC males compared with California and the U.S. (3% vs. 8%)
Uterus	— Relatively high rates at ABSMC and MMC compared with California and the U.S. (9% vs. 6%) — Relatively low rate at EMC compared with California and the U.S. (3% vs. 6%)
Ovary	— Relatively high rate at SRMC compared with California and the U.S. (7% vs. 4% and 3%) — Relatively low rate at MMC compared with California and the U.S. (2% vs. 4% and 3%)
Female Breast	— MGH and SSMC had very high rates compared with California and the U.S. Percentages ranged from 46% at MGH and 43% at SSMC down to 31% at MMC (vs. 31% for California and 26% for the U.S.)
Prostate	— The most variable of any of the major sites examined. Percentages ranged from 39% at ABSMC and MGH down to 11% at SAFH (vs. 27% and 29% for California and the U.S.)

⁴ Both state and national estimates are derived from 2007 NCI SEER data published by the American Cancer Society.

Sutter Health

2007 Cancer Registry Data

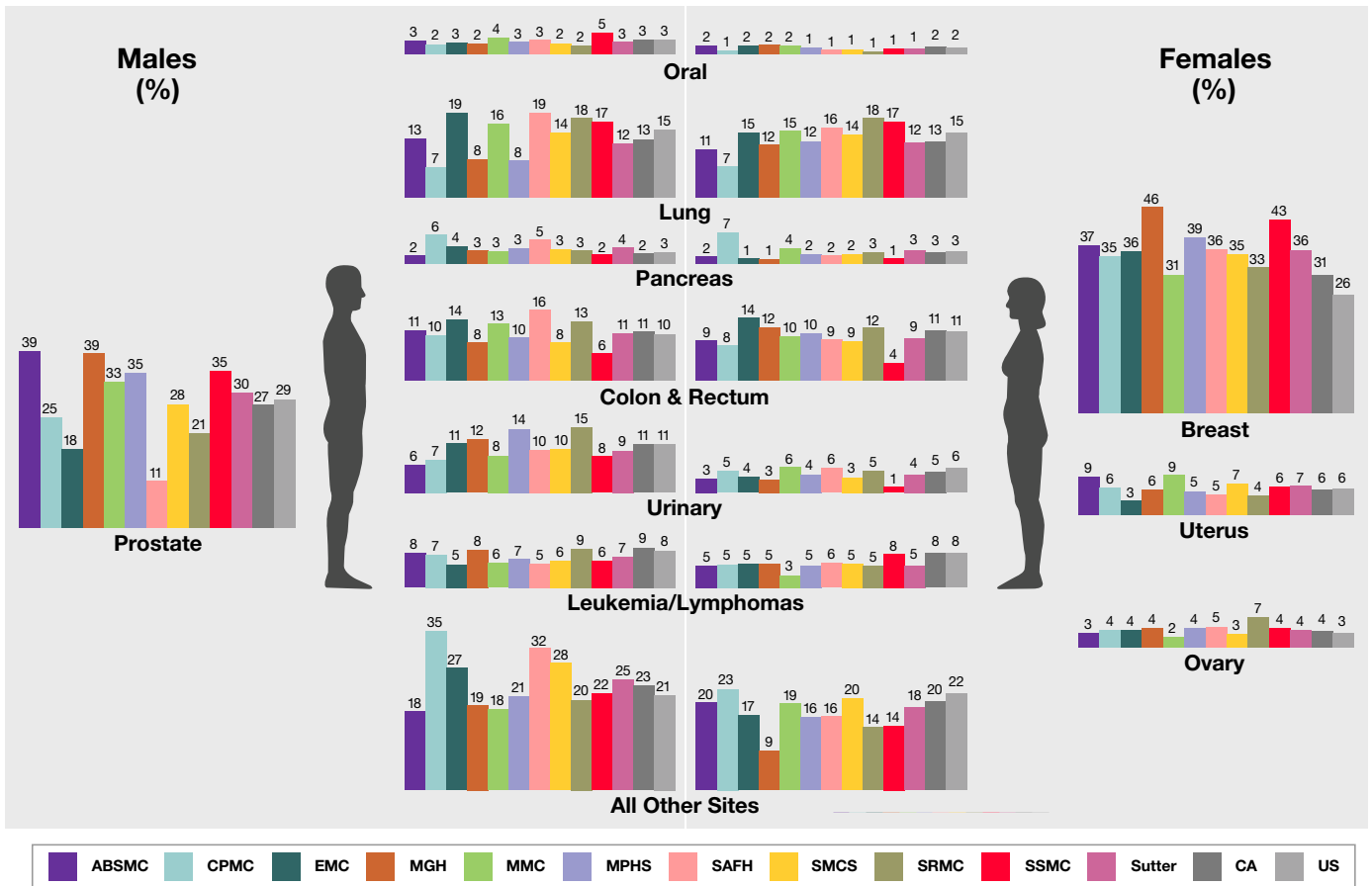


Figure 6
 2007 Sutter Health Analytic Cancer Cases
Relative Incidence of Major Invasive Cancers — Comparison with State and National Estimates

2007 Cancer Registry Data

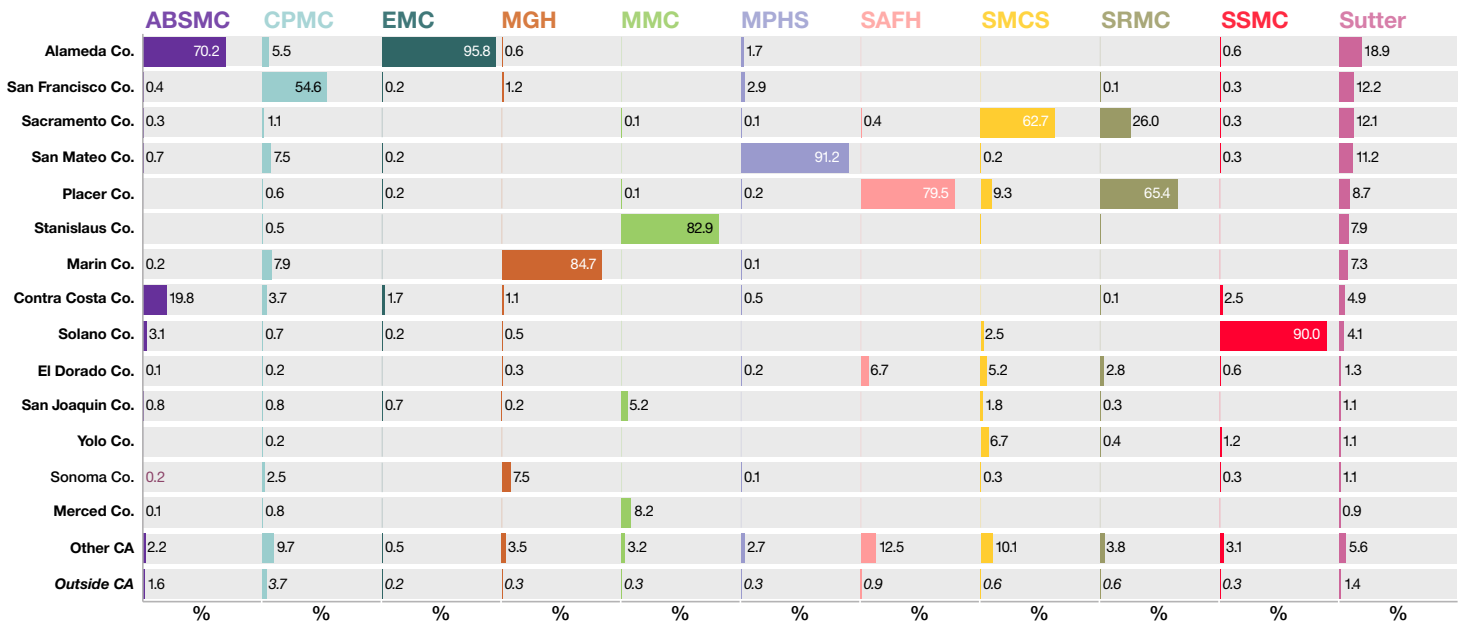


Figure 7
2007 Sutter Health Analytic Cancer Cases
Geographic Distribution by California County

GEOGRAPHIC DISTRIBUTION (FIGURES 7-18)

Figure 7 displays the distribution of cases by California county. In 2007 nearly one in five cases were diagnosed in Alameda County. 9,757 (98.5%) of the cases were diagnosed in California, 135 (1.4%) were diagnosed in the United States, outside California, and 9 (0.1%) were diagnosed outside of the United States. New cancer cases originated in 33 different states and in nine countries outside the U.S. including Algeria, Canada, El Salvador, England, Guam, Mexico, Philippines, Puerto Rico, and the Virgin Islands.

The geographic distribution of cases by California county can be summarized as follows:

ABSMC – 70% Alameda County, 20% Contra Costa County

CPMC – 55% San Francisco County, 8% Marin County, 8% San Mateo County, and 6% Alameda County

EMC – 96% Alameda County, 2% Contra Costa County

MGH – 85% Marin County, 8% Sonoma County

MMC – 83% Stanislaus County, 8% Merced County, and 5% San Joaquin Country

MPHS – 91% San Mateo County and 3% San Francisco County

SAFH – 80% Placer County and 7% El Dorado County

SMCS – 63% Sacramento County, 9% Placer County, 7% Yolo County

SRMC – 67% 65% Placer County, 26% Sacramento County

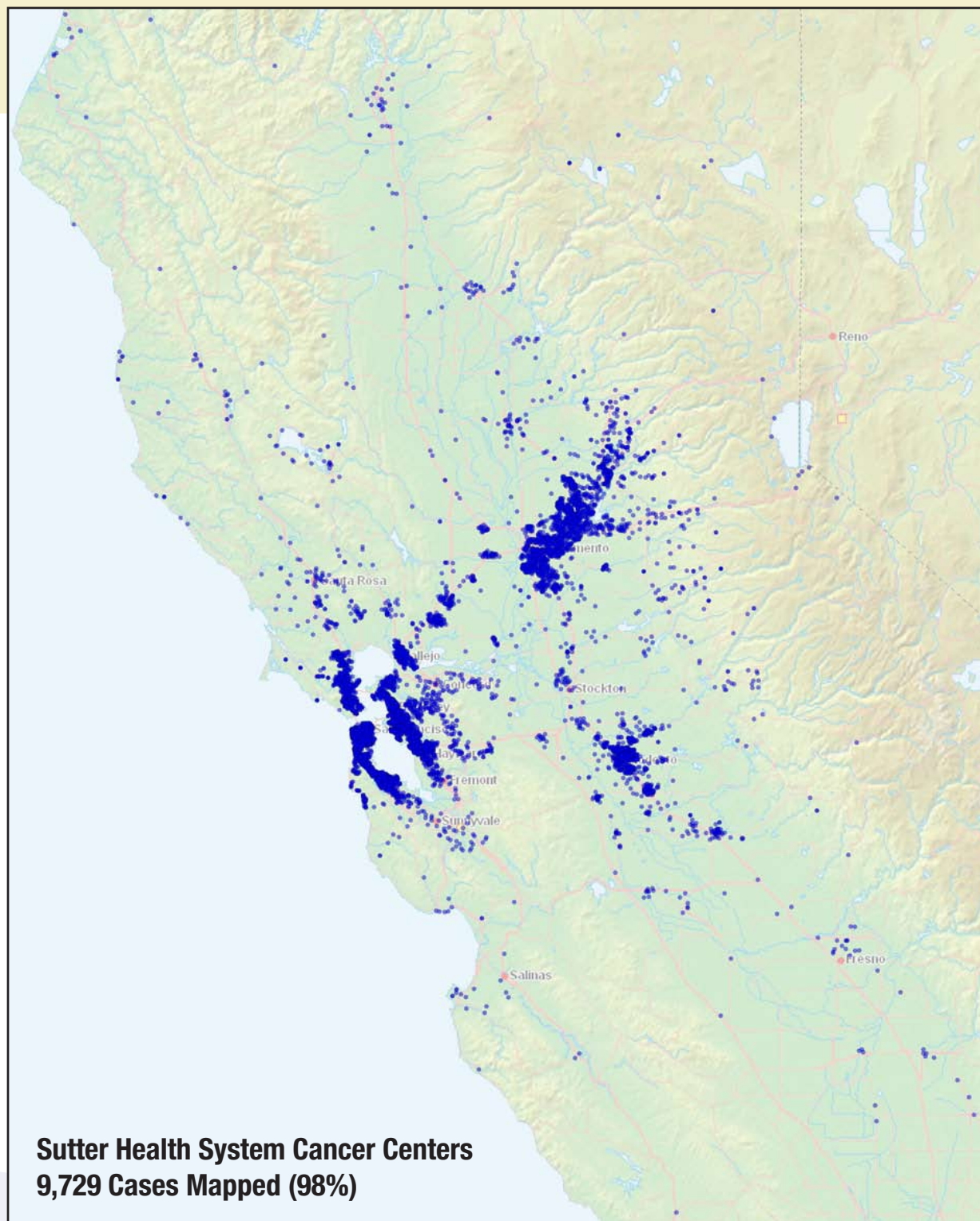
SSMC – 90% Solano County and 3% Contra Costa County

Figures 8-18 display 9,746 (98%) of the 9,901 analytic cases examined in this analysis, mapped via geocoding.⁵

Sutter Health

Mapping

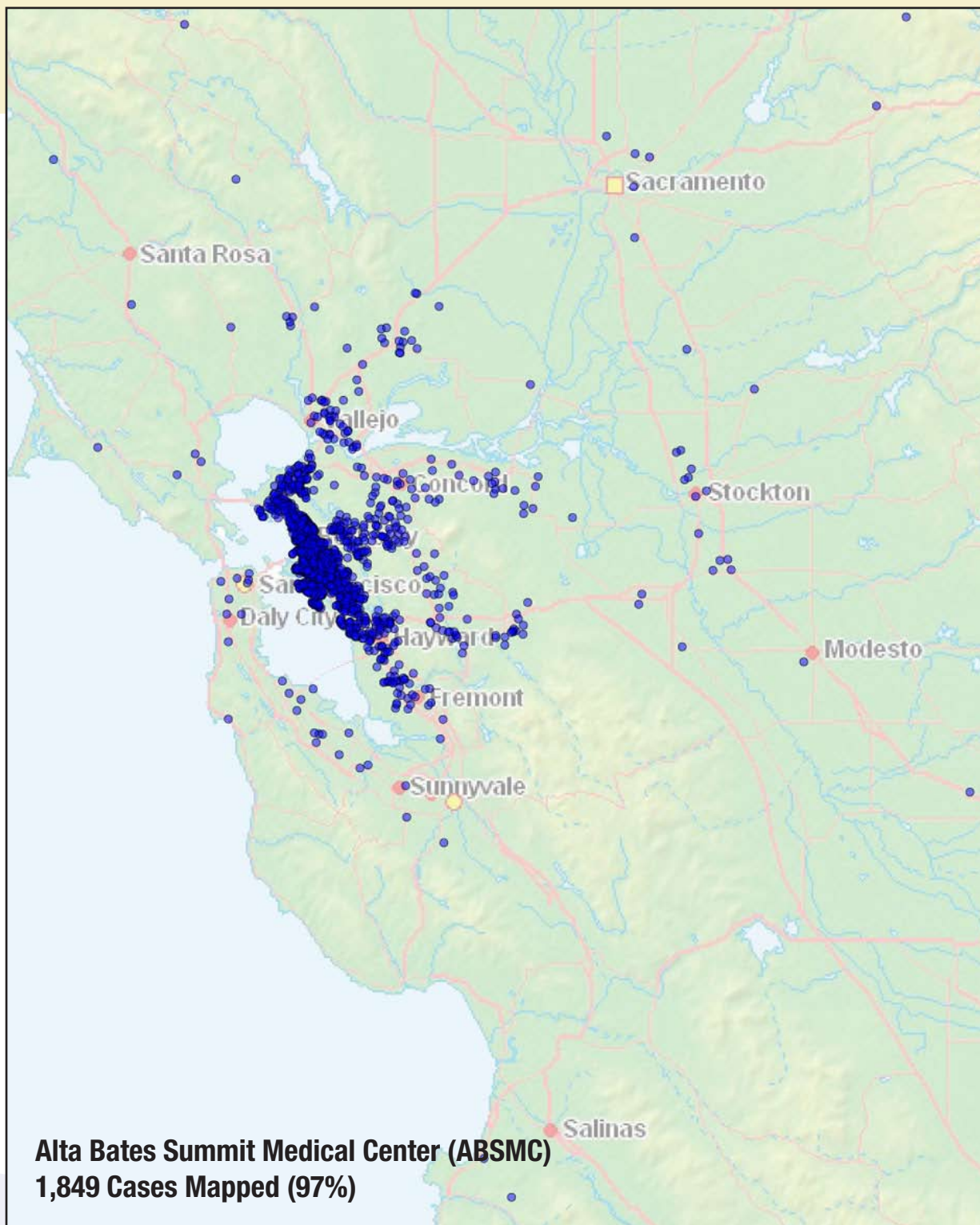
Figure 8
Geographic Mapping of Residence at Time of Diagnosis
2007 Sutter Health Analytic Cancer Cases



⁵ Geocoding is the process of assigning a precise latitude-longitude based on street address. The cases are then mapped graphically based on these geographic coordinates using Geographic Information System (GIS) software.

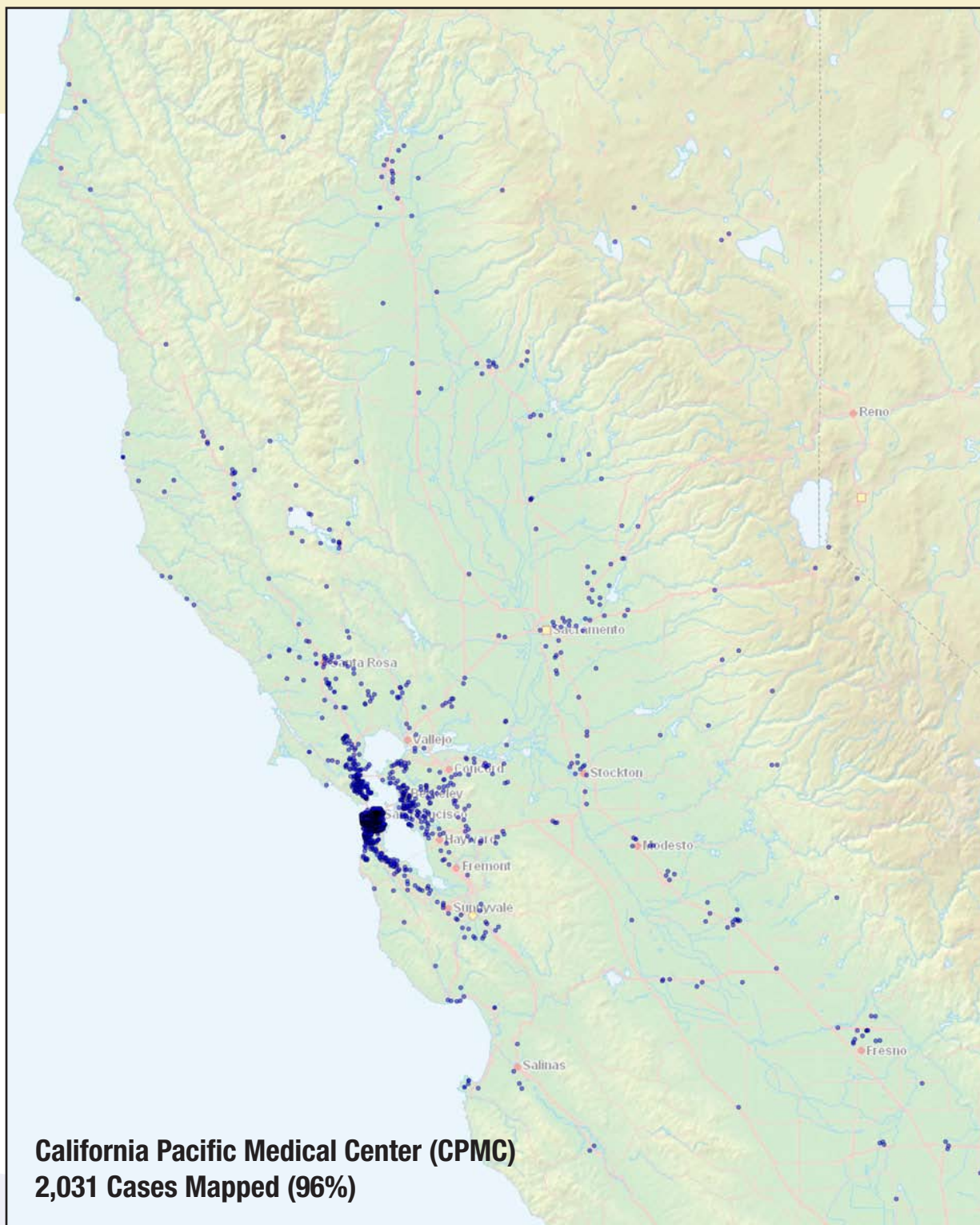
ABS^{SMC} Mapping

Figure 9
Geographic Mapping of Residence at Time of Diagnosis
2007 Sutter Health Analytic Cancer Cases



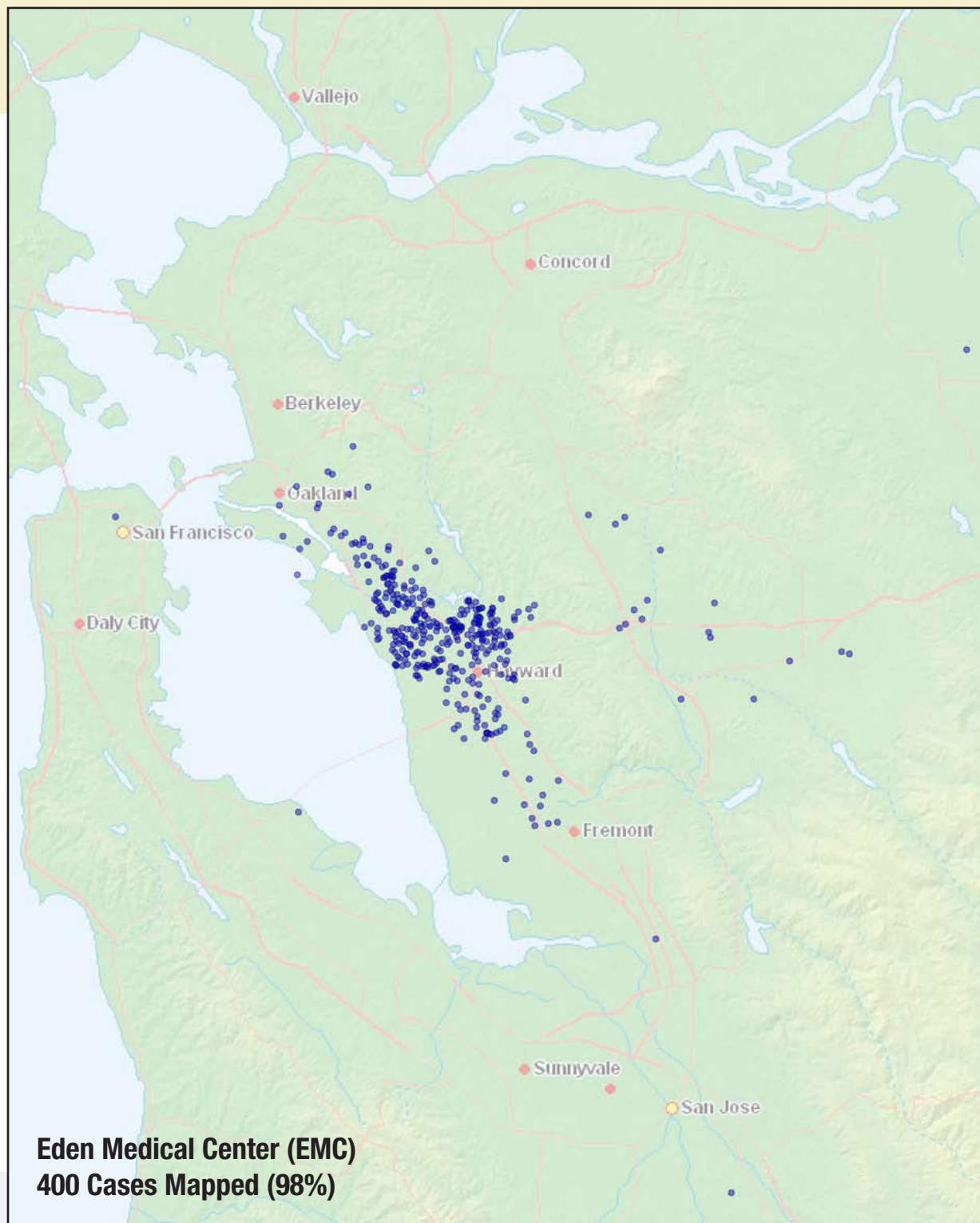
CPMC **geographic** Mapping

Figure 10
Geographic Mapping of Residence at Time of Diagnosis
2007 Sutter Health Analytic Cancer Cases



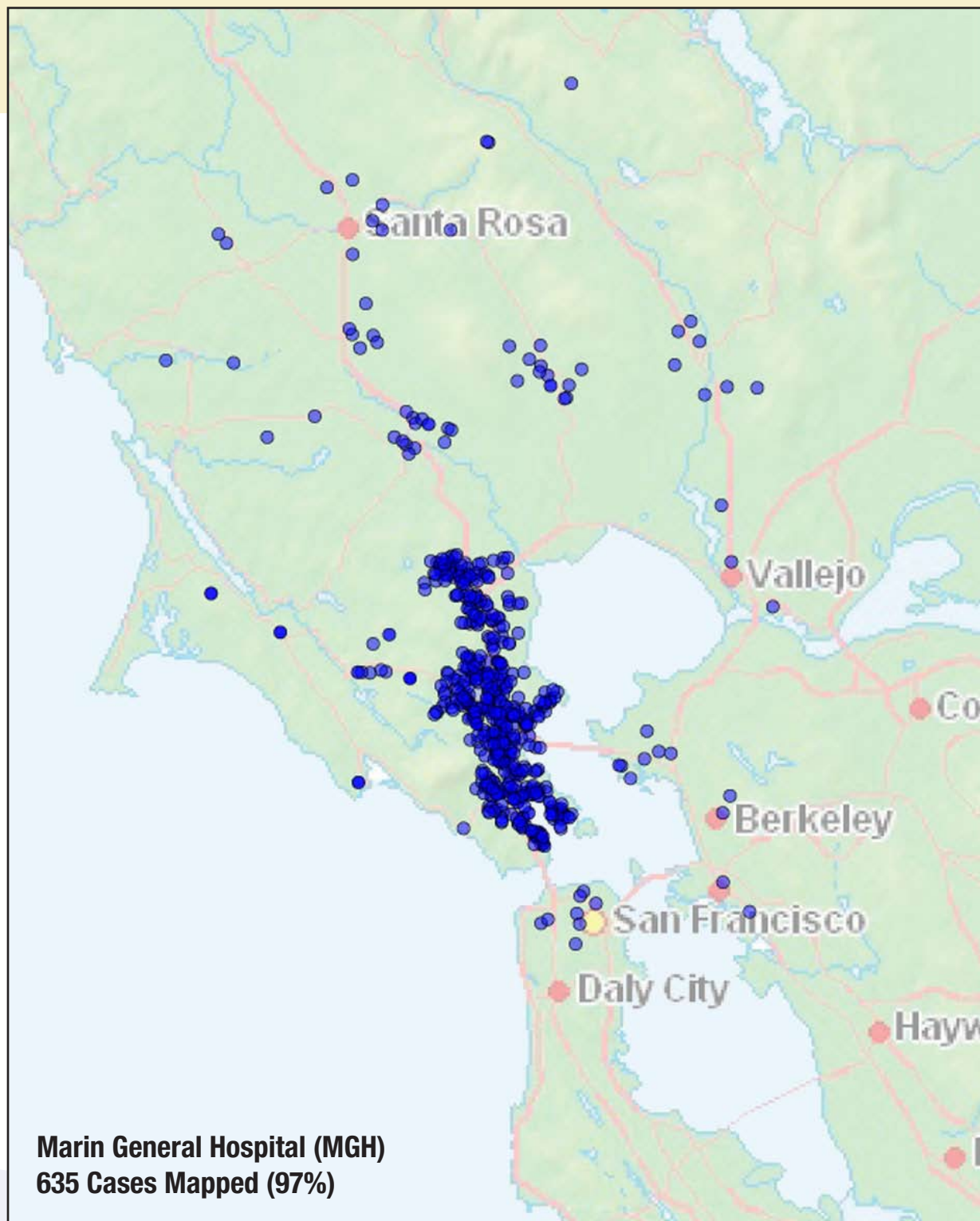
EMC geographic Mapping

Figure 11
Geographic Mapping of Residence at Time of Diagnosis
2007 Sutter Health Analytic Cancer Cases



MGH **geographic** Mapping

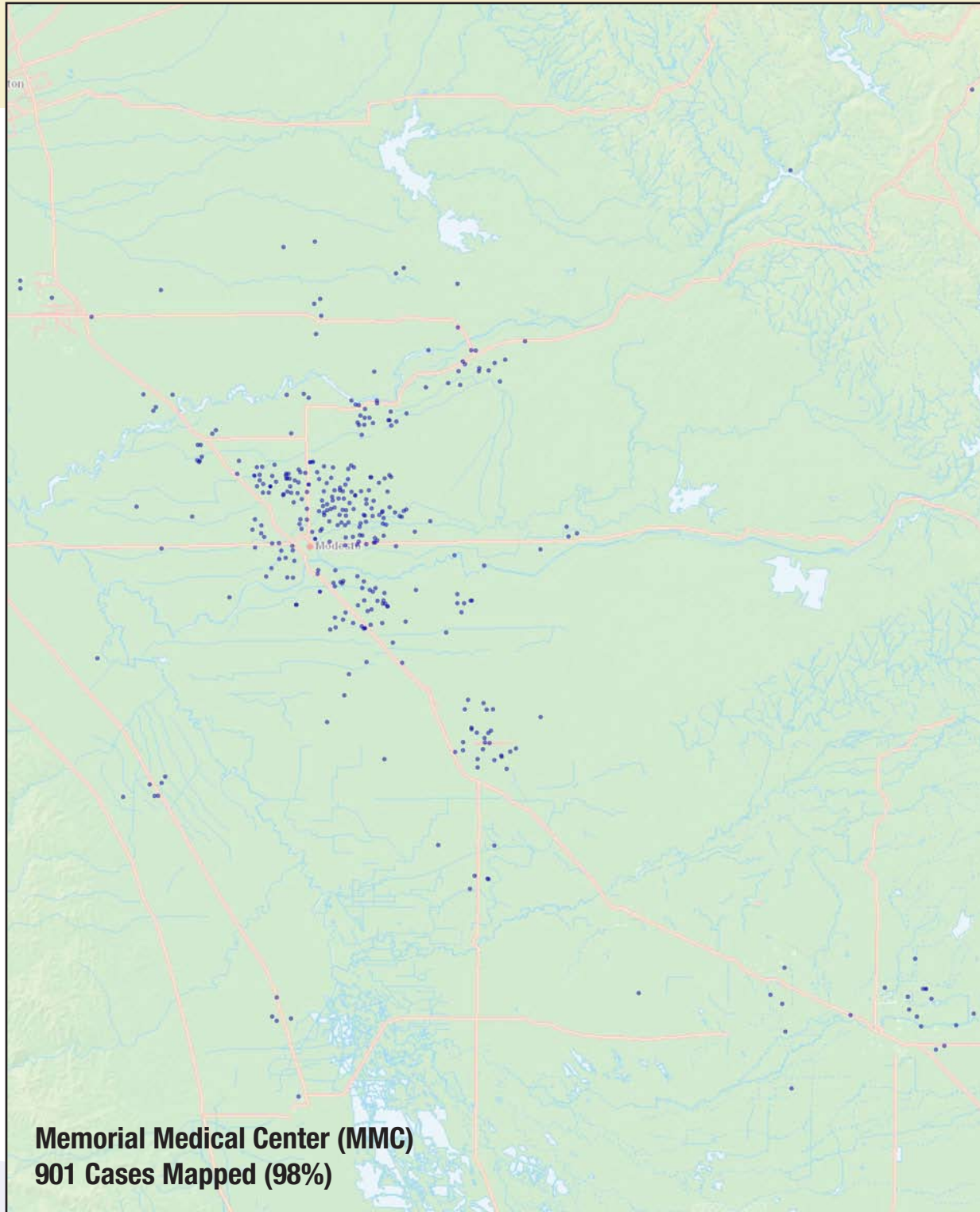
Figure 12
Geographic Mapping of Residence at Time of Diagnosis
2007 Sutter Health Analytic Cancer Cases



MMC

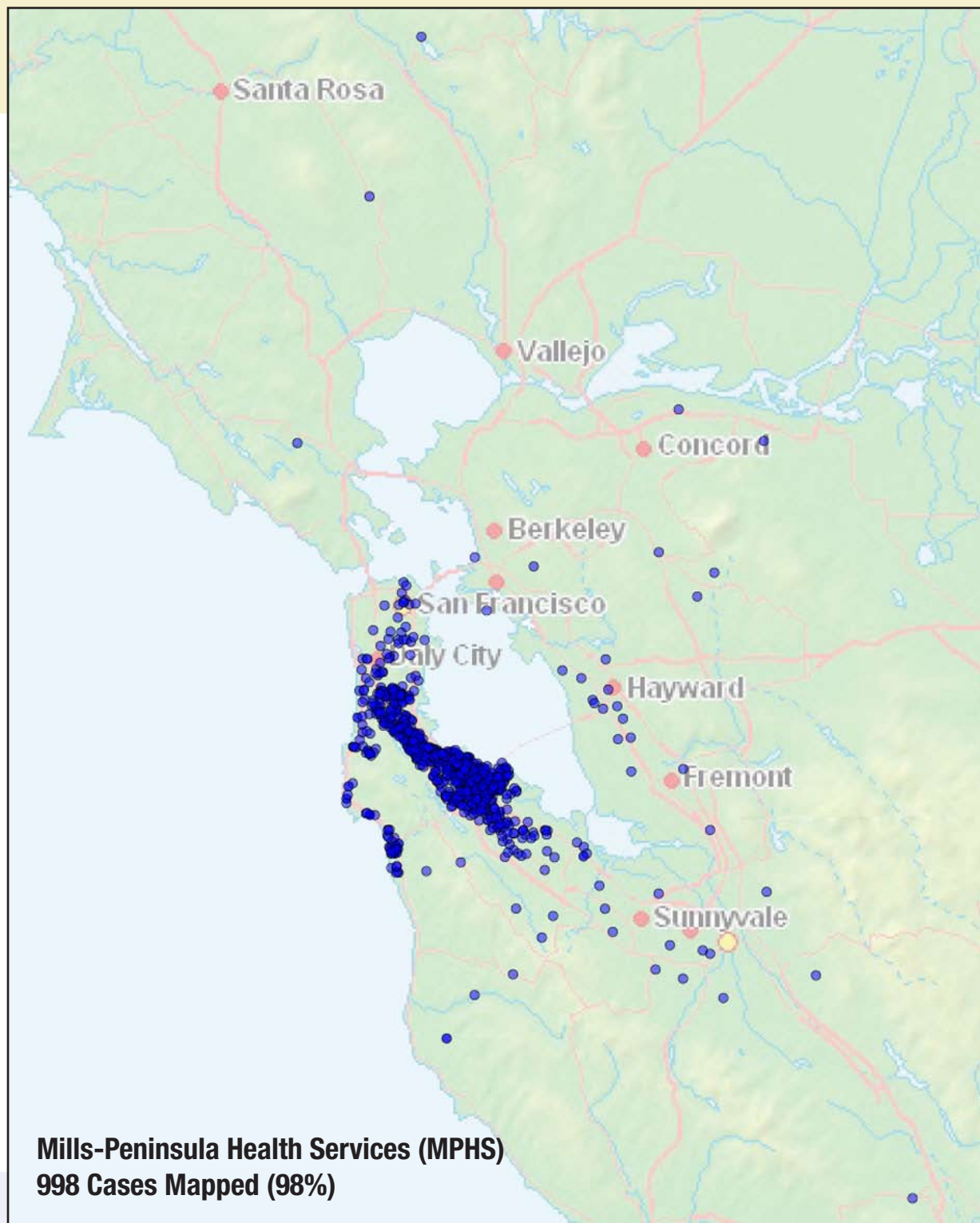
geographic Mapping

Figure 13
Geographic Mapping of Residence at Time of Diagnosis
2007 Sutter Health Analytic Cancer Cases



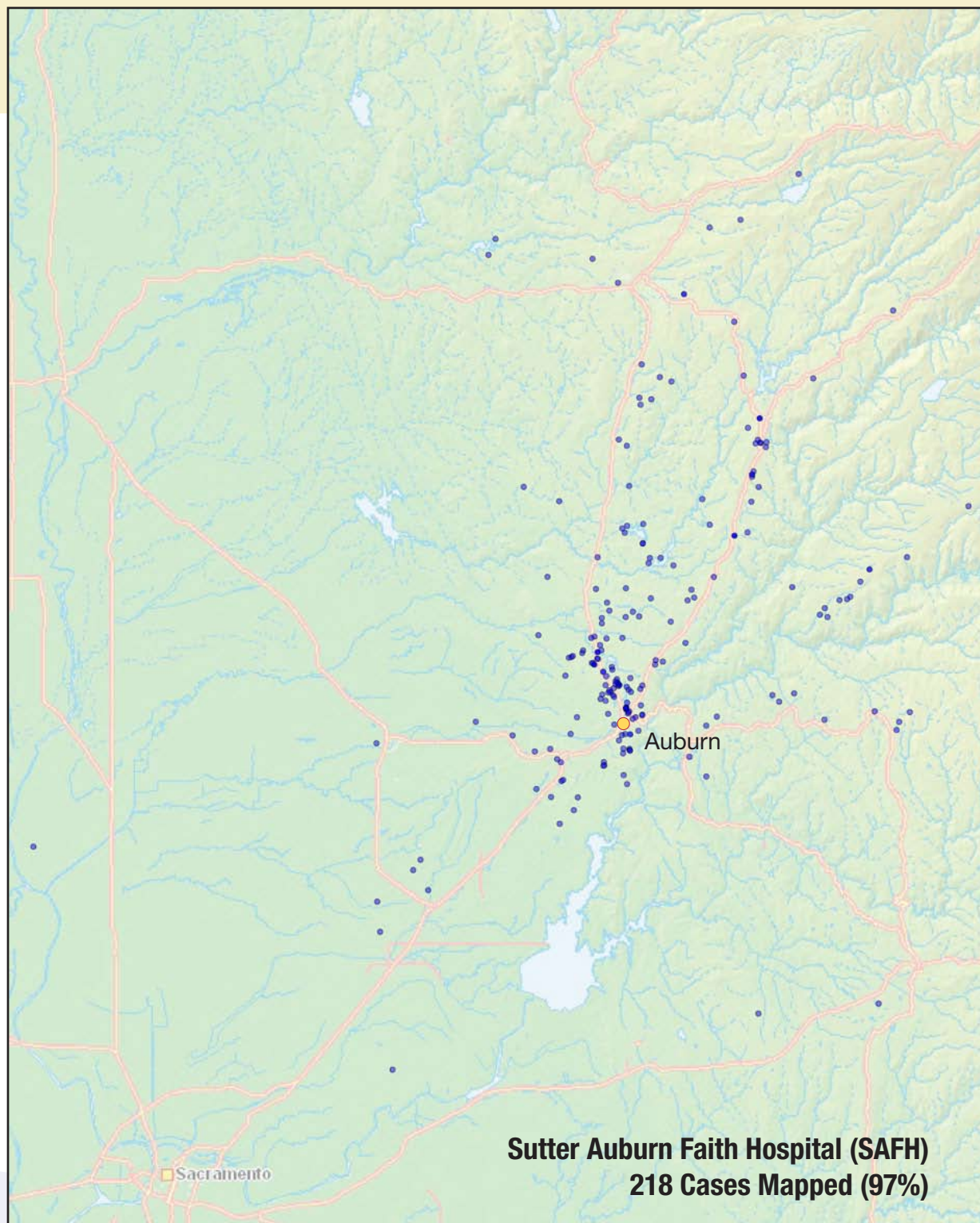
MPHS **Mapping** geographic

Figure 14
Geographic Mapping of Residence at Time of Diagnosis
2007 Sutter Health Analytic Cancer Cases



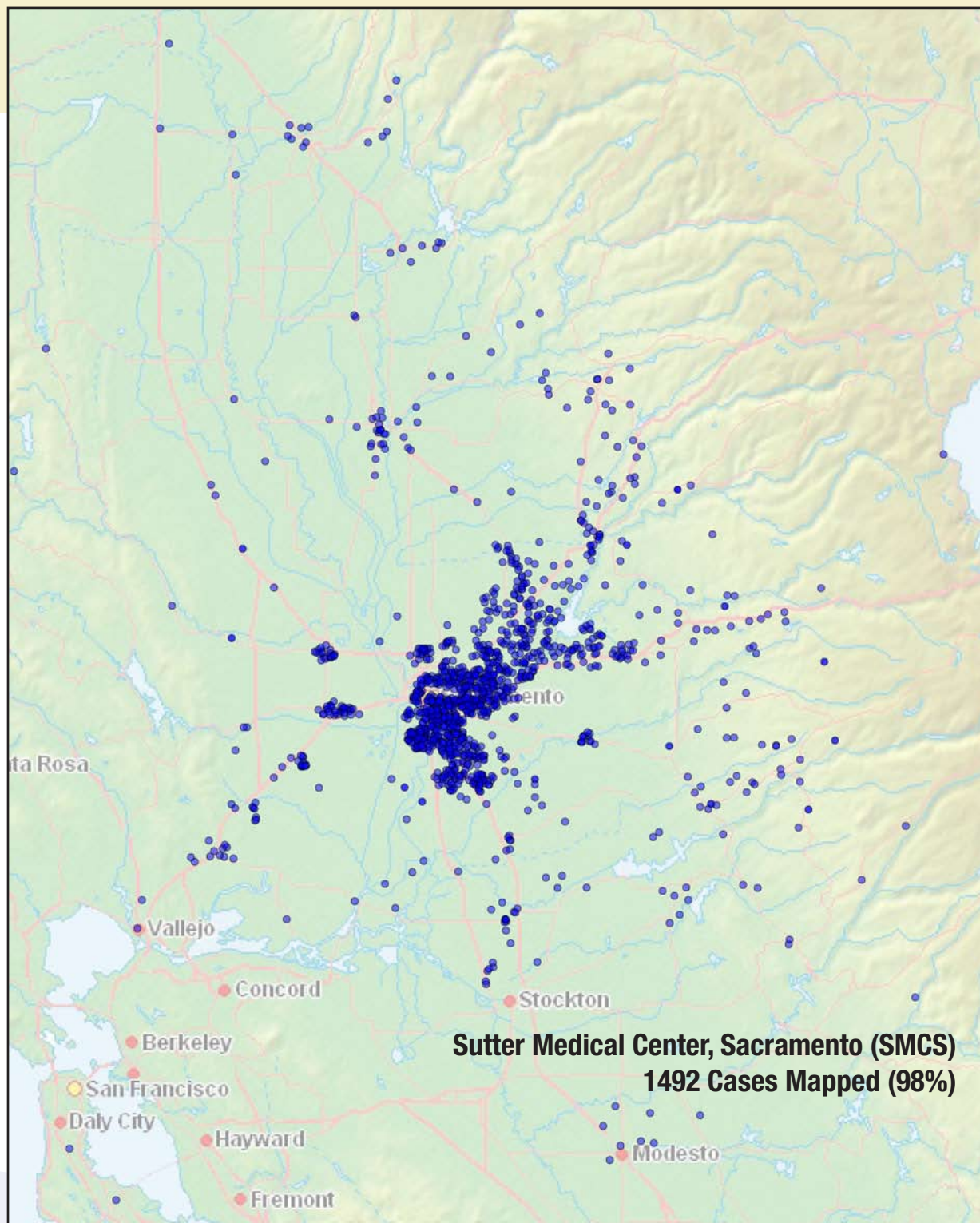
SAFH **geographic** Mapping

Figure 14
Geographic Mapping of Residence at Time of Diagnosis
2007 Sutter Health Analytic Cancer Cases



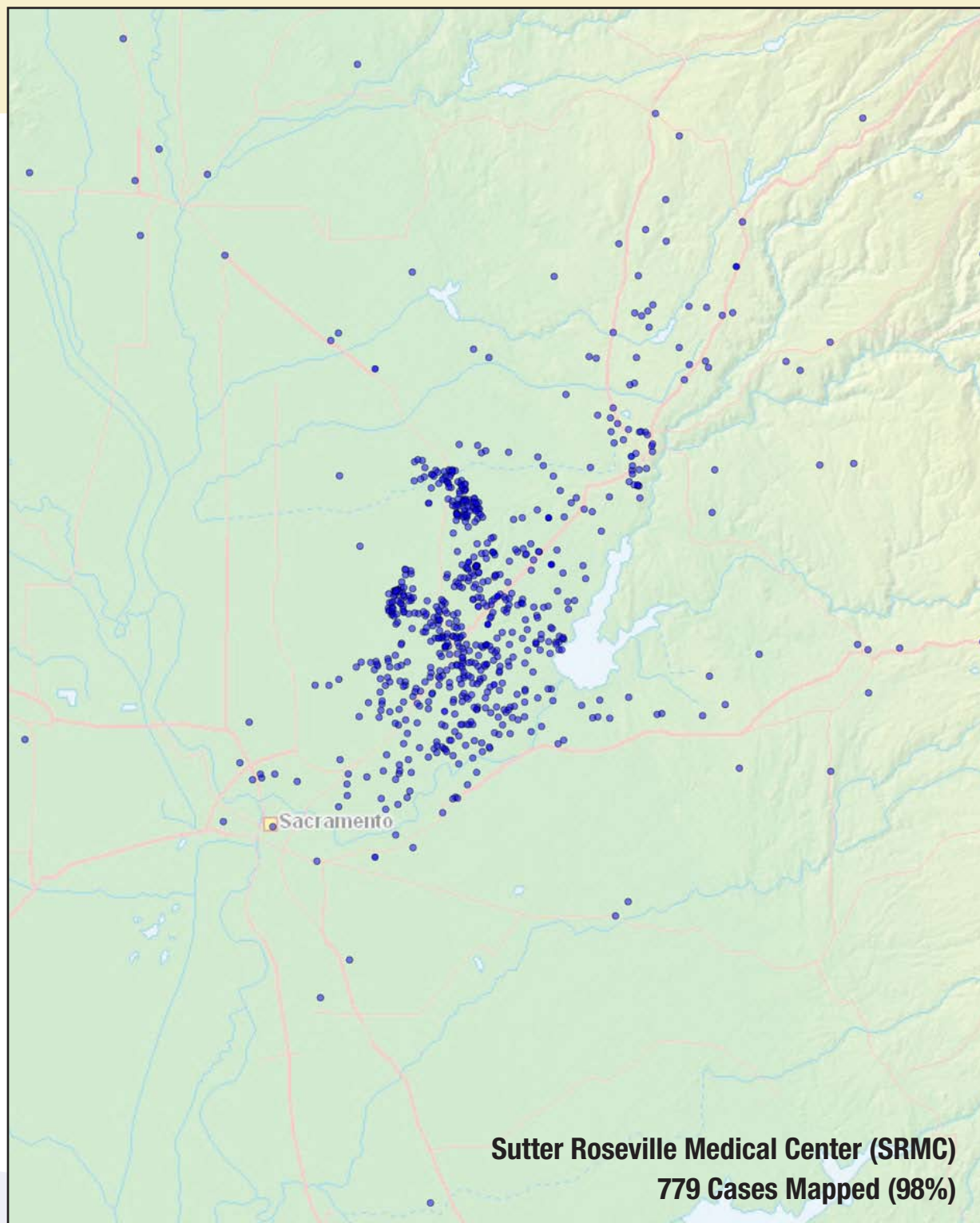
SMCS **geographic** Mapping

Figure 15
Geographic Mapping of Residence at Time of Diagnosis
2007 Sutter Health Analytic Cancer Cases



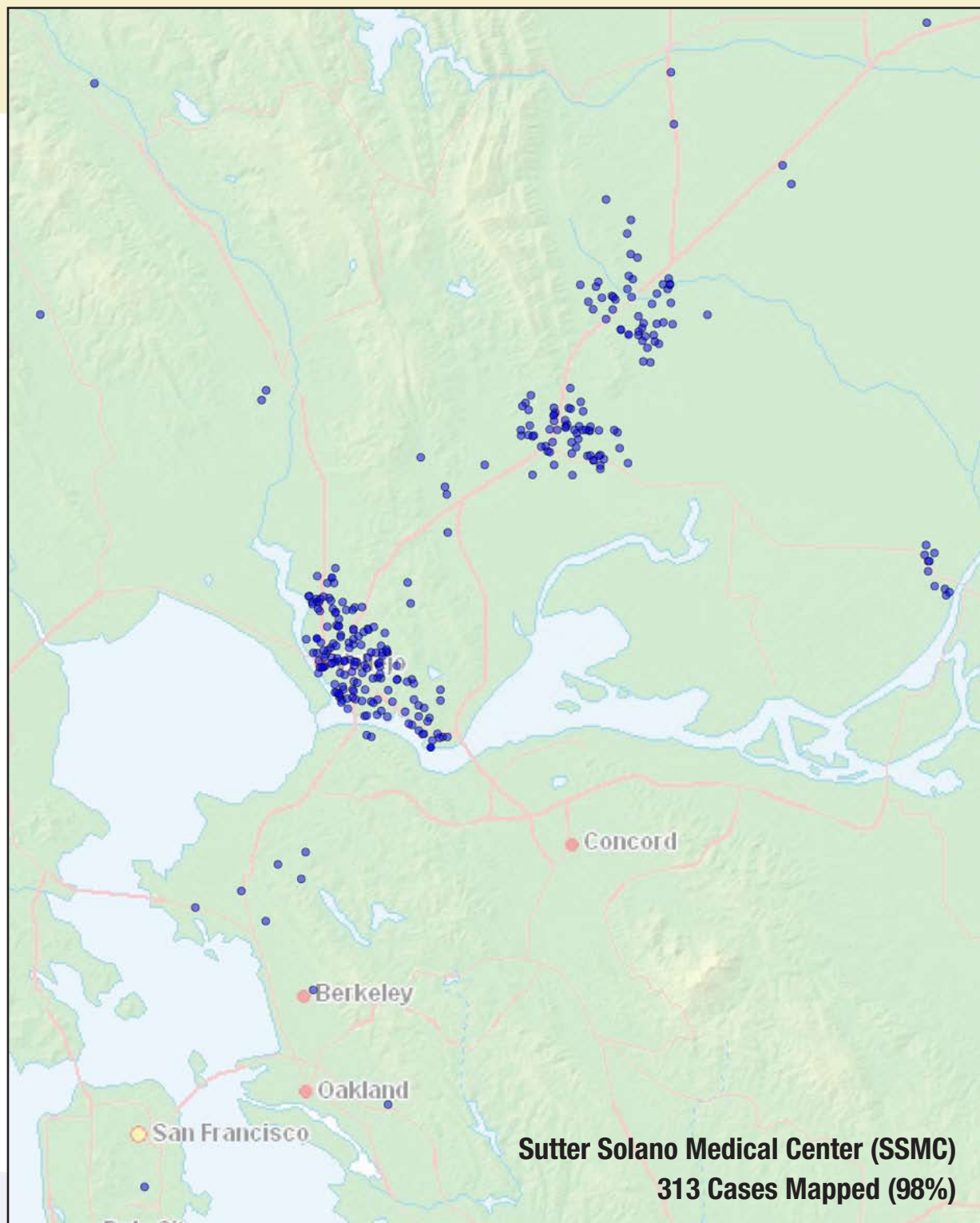
SRMC **geographic** Mapping

Figure 16
Geographic Mapping of Residence at Time of Diagnosis
2007 Sutter Health Analytic Cancer Cases



SSMC **geographic** Mapping

Figure 17
Geographic Mapping of Residence at Time of Diagnosis
2007 Sutter Health Analytic Cancer Cases



Alta Bates Summit Medical Center *primary site tables*

ABSMC 2007 Primary Site Table			Class of Case		Gender		Distribution of Stage at Diagnosis *					
Primary Cancer Site	Cases	%	A	N/A	M	F	0	I	II	III	IV	N/R
<i>All Sites</i>	2105	100.0%	1931	174	927	1178	139	423	568	257	280	264
Lip	2	0.1%	1	1	1	1	1	0	0	0	0	0
Tongue	12	0.6%	12	0	7	5	0	0	2	2	6	2
Salivary Glands	3	0.1%	2	1	1	2	0	1	0	1	0	0
Gum	0	0.0%	0	0	0	0	0	0	0	0	0	0
Floor of Mouth	1	0.0%	1	0	1	0	0	0	1	0	0	0
Mouth, Other & NOS	3	0.1%	3	0	2	1	0	0	0	2	1	0
Tonsil	6	0.3%	6	0	5	1	0	0	0	1	4	1
Oropharynx	3	0.1%	3	0	1	2	0	0	1	1	1	0
Nasopharynx	11	0.5%	11	0	6	5	0	1	0	5	5	0
Hypopharynx	2	0.1%	2	0	1	1	0	0	0	1	0	1
Pharynx & Ill-defined	1	0.0%	1	0	1	0	0	0	0	0	0	1
Esophagus	14	0.7%	13	1	9	5	2	2	2	2	4	1
Stomach	20	1.0%	18	2	10	10	0	6	2	4	4	2
Small Intestine	4	0.2%	4	0	1	3	0	0	0	0	1	3
Colon	144	6.8%	132	12	68	76	4	29	33	33	29	4
Rectum & Rectosigmoid	53	2.5%	50	3	30	23	2	6	15	13	8	6
Anus,Anal Canal,Anorectum	8	0.4%	8	0	1	7	1	2	2	1	1	1
Liver	26	1.2%	24	2	19	7	0	9	2	3	7	3
Gallbladder	7	0.3%	6	1	3	4	1	3	1	0	1	0
Bile Ducts	13	0.6%	12	1	9	4	0	2	3	2	4	1
Pancreas	35	1.7%	30	5	16	19	0	3	8	2	14	3
Retroperitoneum	0	0.0%	0	0	0	0	0	0	0	0	0	0
Peritoneum,Omentum,Mesen	2	0.1%	2	0	0	2	0	0	0	0	0	2
Other Digestive	1	0.0%	1	0	0	1	0	0	0	0	0	1
Nasal Cavity,Sinus,Ear	3	0.1%	3	0	2	1	0	1	0	0	2	0
Larynx	15	0.7%	15	0	11	4	2	5	2	3	3	0
Lung/Bronchus-Small Cell	27	1.3%	26	1	12	15	0	4	0	9	13	0
Lung/Bronchus-Large Cell	200	9.5%	186	14	106	94	0	45	9	39	82	11
Pleura	2	0.1%	2	0	1	1	0	0	0	0	2	0
Other Respiratory & Thoracic	2	0.1%	1	1	1	1	0	1	0	0	0	0
Leukemia	44	2.1%	37	7	28	16	0	0	0	0	0	37
Myeloma	24	1.1%	17	7	13	11	0	0	0	0	0	17
Other Hematopoietic	17	0.8%	16	1	11	6	0	0	0	0	0	16
Bone	2	0.1%	1	1	0	2	0	0	0	0	0	1
Soft Tissue	16	0.8%	13	3	7	9	0	3	1	1	2	6
Melanoma of Skin	32	1.5%	26	6	16	16	5	12	5	2	0	2
Kaposi Sarcoma	2	0.1%	2	0	2	0	0	0	0	0	0	2
Other Skin Ca	2	0.1%	2	0	1	1	0	0	0	0	0	2
Breast	482	22.9%	453	29	1	481	89	141	149	50	12	12
Cervix, In Situ	1	0.0%	1	0	0	1	1	0	0	0	0	0
Cervix Uteri	34	1.6%	34	0	0	34	0	12	7	10	4	1
Corpus Uteri	95	4.5%	84	11	0	95	3	42	10	15	3	11
Uterus NOS	3	0.1%	1	2	0	3	0	0	0	0	0	1
Ovary	45	2.1%	42	3	0	45	0	8	3	12	8	11
Vagina	9	0.4%	7	2	0	9	0	1	3	2	1	0
Vulva	8	0.4%	7	1	0	8	5	1	0	1	0	0
Other Female Genital	4	0.2%	4	0	0	4	0	1	0	2	1	0
Prostate	353	16.8%	324	29	353	0	0	7	283	17	15	2
Testis	3	0.1%	3	0	3	0	0	3	0	0	0	0
Penis	2	0.1%	2	0	2	0	0	0	1	1	0	0
Other Male Genital	0	0.0%	0	0	0	0	0	0	0	0	0	0
Bladder	50	2.4%	47	3	37	13	22	17	4	1	3	0
Kidney & Renal Pelvis	37	1.8%	34	3	19	18	1	14	2	6	7	4
Ureter	1	0.0%	1	0	0	1	0	0	0	1	0	0
Other Urinary	0	0.0%	0	0	0	0	0	0	0	0	0	0
Eye	1	0.0%	1	0	1	0	0	0	0	0	0	1
Brain	43	2.0%	34	9	27	16	0	0	0	0	0	34
Other Nervous System	14	0.7%	13	1	5	9	0	0	0	0	0	13
Thyroid	37	1.8%	37	0	10	27	0	24	2	4	2	5
Other Endocrine	5	0.2%	3	2	2	3	0	0	0	0	0	3
Hodgkin's Disease	13	0.6%	13	0	7	6	0	5	3	0	5	0
Non-Hodgkin's Lymphoma	70	3.3%	61	9	40	30	0	12	12	8	25	4
Unknown or Ill-defined	36	1.7%	36	0	17	19	0	0	0	0	0	36

* Includes analytic cases only

Legend: N/R = not recorded Includes analytic cases that could not be staged because no AJCC staging exists for the particular primary site or histologic type. This includes most hematopoietic cancers (leukemia, myeloma, etc.), endocrine cancers, cancers of the brain and nervous system, sarcomas, cancers of the peritoneum, thymoma, and cancers where the primary site is ill-defined or unknown. Abbreviations: A = analytic; N/A = non-analytic; M = male; F = female.

California Pacific Medical Center **primary site tables**

CPMC 2007 Primary Site Table			Class of Case		Gender		Distribution of Stage at Diagnosis *					
Primary Cancer Site	Cases	%	A	N/A	M	F	0	I	II	III	IV	N/R
All Sites	2545	100.0%	2156	389	1255	1290	199	617	537	252	227	324
Lip	3	0.1%	2	1	2	1	0	1	1	0	0	0
Tongue	18	0.7%	12	6	13	5	1	2	1	1	7	0
Salivary Glands	5	0.2%	4	1	4	1	0	2	0	0	2	0
Gum	1	0.0%	1	0	1	0	0	0	0	0	1	0
Floor of Mouth	0	0.0%	0	0	0	0	0	0	0	0	0	0
Mouth, Other & NOS	3	0.1%	3	0	1	2	0	2	0	0	0	1
Tonsil	6	0.2%	5	1	5	1	0	1	0	0	4	0
Oropharynx	1	0.0%	1	0	0	1	0	0	0	0	1	0
Nasopharynx	3	0.1%	1	2	3	0	0	0	0	0	1	0
Hypopharynx	2	0.1%	2	0	2	0	0	0	0	1	0	1
Pharynx & Ill-defined	1	0.0%	0	1	1	0	0	0	0	0	0	0
Esophagus	36	1.4%	29	7	27	9	6	4	6	5	5	3
Stomach	55	2.2%	50	5	35	20	3	14	5	9	12	7
Small Intestine	8	0.3%	7	1	2	6	0	0	1	0	2	4
Colon	132	5.2%	121	11	69	63	15	35	24	22	16	9
Rectum & Rectosigmoid	86	3.4%	72	14	52	34	10	22	15	15	8	2
Anus,Anal Canal,Anorectum	19	0.7%	15	4	14	5	3	5	2	5	0	0
Liver	150	5.9%	136	14	106	44	0	49	32	34	13	8
Gallbladder	5	0.2%	4	1	0	5	0	0	3	0	1	0
Bile Ducts	28	1.1%	25	3	17	11	1	8	10	2	2	2
Pancreas	142	5.6%	131	11	69	73	0	21	40	22	21	27
Retroperitoneum	1	0.0%	1	0	1	0	0	0	0	1	0	0
Peritoneum,Omentum,Mesen	3	0.1%	3	0	0	3	0	0	0	0	0	3
Other Digestive	2	0.1%	2	0	2	0	0	0	0	0	0	2
Nasal Cavity,Sinus,Ear	4	0.2%	3	1	1	3	0	0	1	0	0	2
Larynx	7	0.3%	6	1	5	2	0	3	2	0	1	0
Lung/Bronchus-Small Cell	15	0.6%	14	1	7	8	0	2	2	3	7	0
Lung/Bronchus-Large Cell	145	5.7%	119	26	78	67	0	31	3	25	45	15
Pleura	0	0.0%	0	0	0	0	0	0	0	0	0	0
Other Respiratory & Thoracic	3	0.1%	3	0	3	0	0	1	0	0	0	2
Leukemia	62	2.4%	39	23	41	21	0	0	0	0	0	39
Myeloma	30	1.2%	20	10	16	14	0	0	0	0	0	20
Other Hematopoietic	26	1.0%	21	5	18	8	0	0	0	0	0	21
Bone	1	0.0%	0	1	1	0	0	0	0	0	0	0
Soft Tissue	19	0.7%	11	8	8	11	0	1	3	4	1	2
Melanoma of Skin	111	4.4%	67	44	78	33	13	24	14	5	7	4
Kaposi Sarcoma	16	0.6%	7	9	16	0	0	0	0	0	0	7
Other Skin Ca	15	0.6%	10	5	8	7	0	1	0	1	0	8
Breast	499	19.6%	458	41	5	494	120	198	99	26	12	3
Cervix, In Situ	0	0.0%	0	0	0	0	0	0	0	0	0	0
Cervix Uteri	14	0.6%	10	4	0	14	0	6	2	1	1	0
Corpus Uteri	60	2.4%	57	3	0	60	0	35	2	12	6	2
Uterus NOS	1	0.0%	0	1	0	1	0	0	0	0	0	0
Ovary	43	1.7%	38	5	0	43	0	14	7	14	1	2
Vagina	2	0.1%	2	0	0	2	1	0	1	0	0	0
Vulva	7	0.3%	5	2	0	7	4	1	0	0	0	0
Other Female Genital	3	0.1%	3	0	0	3	0	0	0	3	0	0
Prostate	281	11.0%	243	38	281	0	0	2	221	13	3	4
Testis	8	0.3%	8	0	8	0	0	6	1	1	0	0
Penis	3	0.1%	3	0	3	0	1	0	0	1	1	0
Other Male Genital	0	0.0%	0	0	0	0	0	0	0	0	0	0
Bladder	73	2.9%	60	13	48	25	21	16	16	1	4	2
Kidney & Renal Pelvis	66	2.6%	51	15	38	28	0	26	2	12	8	3
Ureter	6	0.2%	6	0	3	3	0	2	1	2	1	0
Other Urinary	1	0.0%	1	0	1	0	0	1	0	0	0	0
Eye	84	3.3%	70	14	46	38	0	45	3	5	0	17
Brain	29	1.1%	28	1	17	12	0	0	0	0	0	28
Other Nervous System	22	0.9%	20	2	10	12	0	0	0	0	0	20
Thyroid	16	0.6%	12	4	5	11	0	8	1	0	3	0
Other Endocrine	17	0.7%	15	2	12	5	0	0	0	0	1	14
Hodgkin's Disease	12	0.5%	9	3	6	6	0	3	3	1	2	0
Non-Hodgkin's Lymphoma	89	3.5%	74	15	49	40	0	25	13	5	27	4
Unknown or Ill-defined	45	1.8%	36	9	17	28	0	0	0	0	0	36

* Includes analytic cases only

Legend: N/R = not recorded Includes analytic cases that could not be staged because no AJCC staging exists for the particular primary site or histologic type. This includes most hematopoietic cancers (leukemia, myeloma, etc.), endocrine cancers, cancers of the brain and nervous system, sarcomas, cancers of the peritoneum, thymoma, and cancers where the primary site is ill-defined or unknown. Abbreviations: A = analytic; N/A = non-analytic; M = male; F = female.

Eden Medical Center primary site tables

EMC 2007 Primary Site Table			Class of Case		Gender		Distribution of Stage at Diagnosis *					
Primary Cancer Site	Cases	%	A	N/A	M	F	0	I	II	III	IV	N/R
All Sites	496	100.0%	423	73	209	287	33	90	86	54	81	79
Lip	1	0.2%	1	0	0	1	0	1	0	0	0	0
Tongue	3	0.6%	2	1	3	0	0	0	0	0	2	0
Salivary Glands	0	0.0%	0	0	0	0	0	0	0	0	0	0
Gum	0	0.0%	0	0	0	0	0	0	0	0	0	0
Floor of Mouth	0	0.0%	0	0	0	0	0	0	0	0	0	0
Mouth, Other & NOS	0	0.0%	0	0	0	0	0	0	0	0	0	0
Tonsil	3	0.6%	3	0	1	2	0	1	0	1	1	0
Oropharynx	0	0.0%	0	0	0	0	0	0	0	0	0	0
Nasopharynx	1	0.2%	1	0	0	1	0	0	1	0	0	0
Hypopharynx	2	0.4%	1	1	2	0	0	0	0	1	0	0
Pharynx & Ill-defined	0	0.0%	0	0	0	0	0	0	0	0	0	0
Esophagus	4	0.8%	3	1	4	0	0	0	1	1	0	1
Stomach	6	1.2%	6	0	3	3	0	2	1	0	3	0
Small Intestine	3	0.6%	3	0	2	1	0	1	0	0	0	2
Colon	48	9.7%	44	4	19	29	2	7	19	10	5	1
Rectum & Rectosigmoid	13	2.6%	12	1	6	7	1	5	0	3	2	1
Anus,Anal Canal,Anorectum	6	1.2%	6	0	2	4	0	2	2	0	1	1
Liver	6	1.2%	4	2	5	1	0	1	0	2	1	0
Gallbladder	1	0.2%	1	0	1	0	0	0	0	0	1	0
Bile Ducts	0	0.0%	0	0	0	0	0	0	0	0	0	0
Pancreas	13	2.6%	9	4	8	5	0	1	0	0	7	1
Retroperitoneum	0	0.0%	0	0	0	0	0	0	0	0	0	0
Peritoneum,Omentum,Mesen	0	0.0%	0	0	0	0	0	0	0	0	0	0
Other Digestive	1	0.2%	1	0	0	1	0	0	0	0	0	1
Nasal Cavity,Sinus,Ear	0	0.0%	0	0	0	0	0	0	0	0	0	0
Larynx	3	0.6%	3	0	3	0	0	1	0	0	2	0
Lung/Bronchus-Small Cell	16	3.2%	16	0	7	9	0	1	1	5	8	1
Lung/Bronchus-Large Cell	56	11.3%	46	10	29	27	0	8	3	12	19	4
Pleura	2	0.4%	2	0	2	0	0	0	0	0	1	1
Other Respiratory & Thoracic	0	0.0%	0	0	0	0	0	0	0	0	0	0
Leukemia	6	1.2%	4	2	3	3	0	0	0	0	0	4
Myeloma	8	1.6%	4	4	3	5	0	0	0	0	0	4
Other Hematopoietic	6	1.2%	3	3	2	4	0	0	0	0	0	3
Bone	1	0.2%	0	1	0	1	0	0	0	0	0	0
Soft Tissue	2	0.4%	2	0	1	1	0	0	0	1	1	0
Melanoma of Skin	12	2.4%	10	2	6	6	2	2	2	1	2	1
Kaposi Sarcoma	0	0.0%	0	0	0	0	0	0	0	0	0	0
Other Skin Ca	3	0.6%	1	2	2	1	0	0	0	0	1	0
Breast	106	21.4%	100	6	1	105	17	39	25	8	10	1
Cervix, In Situ	1	0.2%	1	0	0	1	1	0	0	0	0	0
Cervix Uteri	1	0.2%	1	0	0	1	0	1	0	0	0	0
Corpus Uteri	7	1.4%	7	0	0	7	0	6	1	0	0	0
Uterus NOS	0	0.0%	0	0	0	0	0	0	0	0	0	0
Ovary	12	2.4%	9	3	0	12	0	1	1	1	4	2
Vagina	0	0.0%	0	0	0	0	0	0	0	0	0	0
Vulva	2	0.4%	1	1	0	2	1	0	0	0	0	0
Other Female Genital	0	0.0%	0	0	0	0	0	0	0	0	0	0
Prostate	44	8.9%	27	17	44	0	0	1	18	2	3	3
Testis	1	0.2%	0	1	1	0	0	0	0	0	0	0
Penis	1	0.2%	1	0	1	0	1	0	0	0	0	0
Other Male Genital	0	0.0%	0	0	0	0	0	0	0	0	0	0
Bladder	23	4.6%	21	2	17	6	8	4	7	2	0	0
Kidney & Renal Pelvis	4	0.8%	4	0	2	2	0	2	0	0	1	1
Ureter	0	0.0%	0	0	0	0	0	0	0	0	0	0
Other Urinary	0	0.0%	0	0	0	0	0	0	0	0	0	0
Eye	0	0.0%	0	0	0	0	0	0	0	0	0	0
Brain	13	2.6%	13	0	3	10	0	0	0	0	0	13
Other Nervous System	9	1.8%	8	1	2	7	0	0	0	0	0	8
Thyroid	1	0.2%	1	0	0	1	0	0	1	0	0	0
Other Endocrine	7	1.4%	5	2	4	3	0	0	0	0	0	5
Hodgkin's Disease	2	0.4%	2	0	1	1	0	0	0	2	0	0
Non-Hodgkin's Lymphoma	15	3.0%	14	1	6	9	0	3	3	2	6	0
Unknown or Ill-defined	21	4.2%	20	1	13	8	0	0	0	0	0	20

* Includes analytic cases only

Legend: N/R = not recorded Includes analytic cases that could not be staged because no AJCC staging exists for the particular primary site or histologic type. This includes most hematopoietic cancers (leukemia, myeloma, etc.), endocrine cancers, cancers of the brain and nervous system, sarcomas, cancers of the peritoneum, thymoma, and cancers where the primary site is ill-defined or unknown. Abbreviations: A = analytic; N/A = non-analytic; M = male; F = female.

Marin General Hospital primary site tables

MGH 2007 Primary Site Table			Class of Case		Gender		Distribution of Stage at Diagnosis *					
Primary Cancer Site	Cases	%	A	N/A	M	F	0	I	II	III	IV	N/R
All Sites	725	100.0%	657	68	357	368	58	160	175	95	89	80
Lip	0	0.0%	0	0	0	0	0	0	0	0	0	0
Tongue	6	0.8%	6	0	4	2	0	0	2	1	2	1
Salivary Glands	1	0.1%	1	0	0	1	0	1	0	0	0	0
Gum	0	0.0%	0	0	0	0	0	0	0	0	0	0
Floor of Mouth	1	0.1%	1	0	1	0	1	0	0	0	0	0
Mouth, Other & NOS	0	0.0%	0	0	0	0	0	0	0	0	0	0
Tonsil	5	0.7%	5	0	2	3	0	0	0	2	3	0
Oropharynx	1	0.1%	1	0	1	0	0	1	0	0	0	0
Nasopharynx	0	0.0%	0	0	0	0	0	0	0	0	0	0
Hypopharynx	0	0.0%	0	0	0	0	0	0	0	0	0	0
Pharynx & Ill-defined	0	0.0%	0	0	0	0	0	0	0	0	0	0
Esophagus	8	1.1%	8	0	7	1	0	2	1	2	3	0
Stomach	11	1.5%	11	0	10	1	0	2	2	2	3	2
Small Intestine	3	0.4%	3	0	3	0	0	1	1	0	0	1
Colon	43	5.9%	41	2	16	27	2	10	7	11	10	1
Rectum & Rectosigmoid	25	3.4%	24	1	14	11	2	3	4	10	3	2
Anus,Anal Canal,Anorectum	4	0.6%	2	2	2	2	1	0	0	0	0	1
Liver	2	0.3%	2	0	2	0	0	0	0	0	0	2
Gallbladder	0	0.0%	0	0	0	0	0	0	0	0	0	0
Bile Ducts	1	0.1%	1	0	1	0	0	0	0	1	0	0
Pancreas	15	2.1%	12	3	9	6	0	2	3	0	6	1
Retroperitoneum	0	0.0%	0	0	0	0	0	0	0	0	0	0
Peritoneum,Omentum,Mesen	2	0.3%	2	0	0	2	0	0	0	0	0	2
Other Digestive	0	0.0%	0	0	0	0	0	0	0	0	0	0
Nasal Cavity,Sinus,Ear	0	0.0%	0	0	0	0	0	0	0	0	0	0
Larynx	3	0.4%	3	0	3	0	0	1	1	1	0	0
Lung/Bronchus-Small Cell	11	1.5%	11	0	5	6	1	2	0	2	6	0
Lung/Bronchus-Large Cell	54	7.4%	50	4	22	32	0	11	0	14	19	6
Pleura	2	0.3%	1	1	2	0	0	0	1	0	0	0
Other Respiratory & Thoracic	0	0.0%	0	0	0	0	0	0	0	0	0	0
Leukemia	11	1.5%	7	4	9	2	0	0	0	0	0	7
Myeloma	6	0.8%	5	1	5	1	0	0	0	0	0	5
Other Hematopoietic	0	0.0%	0	0	0	0	0	0	0	0	0	0
Bone	1	0.1%	1	0	0	1	0	0	0	0	0	1
Soft Tissue	3	0.4%	3	0	2	1	0	0	0	1	2	0
Melanoma of Skin	12	1.7%	7	5	5	7	2	2	0	0	1	2
Kaposi Sarcoma	0	0.0%	0	0	0	0	0	0	0	0	0	0
Other Skin Ca	4	0.6%	2	2	3	1	0	0	1	0	0	1
Breast	178	24.6%	170	8	1	177	32	71	42	17	5	3
Cervix, In Situ	1	0.1%	1	0	0	1	1	0	0	0	0	0
Cervix Uteri	5	0.7%	4	1	0	5	0	3	1	0	0	0
Corpus Uteri	18	2.5%	17	1	0	18	0	12	0	3	0	2
Uterus NOS	0	0.0%	0	0	0	0	0	0	0	0	0	0
Ovary	15	2.1%	14	1	0	15	0	2	1	5	2	4
Vagina	1	0.1%	1	0	0	1	0	0	0	0	0	1
Vulva	1	0.1%	1	0	0	1	1	0	0	0	0	0
Other Female Genital	0	0.0%	0	0	0	0	0	0	0	0	0	0
Prostate	135	18.6%	121	14	135	0	0	2	96	13	6	4
Testis	7	1.0%	7	0	7	0	0	5	1	0	0	1
Penis	1	0.1%	1	0	1	0	0	1	0	0	0	0
Other Male Genital	0	0.0%	0	0	0	0	0	0	0	0	0	0
Bladder	36	5.0%	32	4	30	6	14	3	5	4	6	0
Kidney & Renal Pelvis	16	2.2%	13	3	13	3	0	8	1	1	3	0
Ureter	2	0.3%	2	0	1	1	1	0	1	0	0	0
Other Urinary	0	0.0%	0	0	0	0	0	0	0	0	0	0
Eye	0	0.0%	0	0	0	0	0	0	0	0	0	0
Brain	13	1.8%	13	0	7	6	0	0	0	0	0	13
Other Nervous System	4	0.6%	2	2	2	2	0	0	0	0	0	2
Thyroid	1	0.1%	1	0	0	1	0	1	0	0	0	0
Other Endocrine	0	0.0%	0	0	0	0	0	0	0	0	0	0
Hodgkin's Disease	4	0.6%	4	0	2	2	0	2	2	0	0	0
Non-Hodgkin's Lymphoma	40	5.5%	31	9	23	17	0	12	2	5	9	3
Unknown or Ill-defined	12	1.7%	12	0	7	5	0	0	0	0	0	12

* Includes analytic cases only

Legend: N/R = not recorded Includes analytic cases that could not be staged because no AJCC staging exists for the particular primary site or histologic type. This includes most hematopoietic cancers (leukemia, myeloma, etc.), endocrine cancers, cancers of the brain and nervous system, sarcomas, cancers of the peritoneum, thymoma, and cancers where the primary site is ill-defined or unknown. Abbreviations: **A** = analytic; **N/A** = non-analytic; **M** = male; **F** = female.

Memorial Medical Center primary site tables

MMC 2007 Primary Site Table			Class of Case		Gender		Distribution of Stage at Diagnosis *					
Primary Cancer Site	Cases	%	A	N/A	M	F	0	I	II	III	IV	N/R
All Sites	1191	100.0%	929	262	594	597	74	203	233	132	170	117
Lip	5	0.4%	5	0	3	2	0	5	0	0	0	0
Tongue	6	0.5%	5	1	5	1	0	0	1	0	4	0
Salivary Glands	3	0.3%	3	0	2	1	0	0	1	1	0	1
Gum	1	0.1%	1	0	0	1	0	0	0	0	1	0
Floor of Mouth	1	0.1%	1	0	1	0	0	0	1	0	0	0
Mouth, Other & NOS	4	0.3%	2	2	3	1	0	1	0	0	1	0
Tonsil	6	0.5%	6	0	4	2	0	0	0	3	3	0
Oropharynx	0	0.0%	0	0	0	0	0	0	0	0	0	0
Nasopharynx	0	0.0%	0	0	0	0	0	0	0	0	0	0
Hypopharynx	1	0.1%	1	0	0	1	0	0	0	1	0	0
Pharynx & Ill-defined	0	0.0%	0	0	0	0	0	0	0	0	0	0
Esophagus	10	0.8%	8	2	8	2	0	0	3	2	2	1
Stomach	10	0.8%	9	1	9	1	0	2	3	0	3	1
Small Intestine	2	0.2%	2	0	0	2	0	0	0	2	0	0
Colon	88	7.4%	79	9	46	42	8	11	21	17	21	1
Rectum & Rectosigmoid	30	2.5%	26	4	19	11	4	5	5	6	5	1
Anus,Anal Canal,Anorectum	6	0.5%	5	1	1	5	2	1	0	2	0	0
Liver	9	0.8%	5	4	8	1	0	1	0	3	0	1
Gallbladder	3	0.3%	3	0	1	2	1	1	1	0	0	0
Bile Ducts	5	0.4%	5	0	3	2	0	1	1	0	3	0
Pancreas	29	2.4%	27	2	12	17	0	8	2	3	13	1
Retroperitoneum	1	0.1%	1	0	0	1	0	0	0	0	0	1
Peritoneum,Omentum,Mesen	0	0.0%	0	0	0	0	0	0	0	0	0	0
Other Digestive	1	0.1%	1	0	1	0	0	0	0	0	0	1
Nasal Cavity,Sinus,Ear	5	0.4%	5	0	2	3	0	1	0	0	2	2
Larynx	8	0.7%	6	2	6	2	0	4	0	1	1	0
Lung/Bronchus-Small Cell	22	1.8%	19	3	7	15	0	2	0	6	11	0
Lung/Bronchus-Large Cell	152	12.8%	116	36	88	64	0	30	4	27	49	6
Pleura	1	0.1%	1	0	1	0	0	0	1	0	0	0
Other Respiratory & Thoracic	0	0.0%	0	0	0	0	0	0	0	0	0	0
Leukemia	26	2.2%	11	15	13	13	0	0	0	0	0	11
Myeloma	12	1.0%	7	5	7	5	0	0	0	0	0	7
Other Hematopoietic	47	3.9%	12	35	24	23	0	0	0	0	0	12
Bone	2	0.2%	1	1	0	2	0	0	0	0	0	1
Soft Tissue	3	0.3%	3	0	3	0	0	0	2	1	0	0
Melanoma of Skin	18	1.5%	17	1	9	9	12	2	0	1	1	1
Kaposi Sarcoma	1	0.1%	0	1	1	0	0	0	0	0	0	0
Other Skin Ca	4	0.3%	4	0	2	2	1	0	1	0	1	1
Breast	184	15.4%	152	32	1	183	19	55	51	20	6	1
Cervix, In Situ	2	0.2%	2	0	0	2	2	0	0	0	0	0
Cervix Uteri	12	1.0%	11	1	0	12	0	9	0	1	1	0
Corpus Uteri	39	3.3%	37	2	0	39	0	25	4	5	2	1
Uterus NOS	2	0.2%	1	1	0	2	0	0	0	0	1	0
Ovary	17	1.4%	14	3	0	17	0	1	1	3	4	5
Vagina	1	0.1%	1	0	0	1	1	0	0	0	0	0
Vulva	4	0.3%	3	1	0	4	0	1	0	1	1	0
Other Female Genital	3	0.3%	3	0	0	3	0	0	0	0	2	1
Prostate	188	15.8%	141	47	188	0	0	0	118	13	9	1
Testis	4	0.3%	3	1	4	0	0	2	0	1	0	0
Penis	0	0.0%	0	0	0	0	0	0	0	0	0	0
Other Male Genital	0	0.0%	0	0	0	0	0	0	0	0	0	0
Bladder	44	3.7%	33	11	32	12	21	6	4	0	2	0
Kidney & Renal Pelvis	34	2.9%	27	7	15	19	2	11	4	4	4	2
Ureter	3	0.3%	3	0	2	1	1	0	1	1	0	0
Other Urinary	1	0.1%	1	0	1	0	0	0	0	0	0	1
Eye	1	0.1%	1	0	1	0	0	0	0	0	0	1
Brain	21	1.8%	14	7	10	11	0	0	0	0	0	14
Other Nervous System	13	1.1%	12	1	3	10	0	0	0	0	0	12
Thyroid	21	1.8%	20	1	5	16	0	13	1	3	3	0
Other Endocrine	5	0.4%	4	1	3	2	0	0	0	0	0	4
Hodgkin's Disease	6	0.5%	2	4	4	2	0	2	0	0	0	0
Non-Hodgkin's Lymphoma	36	3.0%	23	13	21	15	0	3	2	4	14	0
Unknown or Ill-defined	28	2.4%	24	4	15	13	0	0	0	0	0	24

* Includes analytic cases only

Legend: N/R = not recorded Includes analytic cases that could not be staged because no AJCC staging exists for the particular primary site or histologic type. This includes most hematopoietic cancers (leukemia, myeloma, etc.), endocrine cancers, cancers of the brain and nervous system, sarcomas, cancers of the peritoneum, thymoma, and cancers where the primary site is ill-defined or unknown. Abbreviations: A = analytic; N/A = non-analytic; M = male; F = female.

Mills-Peninsula Health Services **primary site tables**

MPHS 2007 Primary Site Table			Class of Case		Gender		Distribution of Stage at Diagnosis *					
Primary Cancer Site	Cases	%	A	N/A	M	F	0	I	II	III	IV	N/R
All Sites	1131	100.0%	1035	96	532	599	141	263	277	127	125	102
Lip	0	0.0%	0	0	0	0	0	0	0	0	0	0
Tongue	9	0.8%	9	0	4	5	0	1	1	4	3	0
Salivary Glands	3	0.3%	3	0	3	0	0	2	1	0	0	0
Gum	0	0.0%	0	0	0	0	0	0	0	0	0	0
Floor of Mouth	2	0.2%	2	0	1	1	2	0	0	0	0	0
Mouth, Other & NOS	2	0.2%	2	0	1	1	0	1	1	0	0	0
Tonsil	2	0.2%	2	0	2	0	0	0	0	2	0	0
Oropharynx	0	0.0%	0	0	0	0	0	0	0	0	0	0
Nasopharynx	2	0.2%	2	0	1	1	0	1	0	1	0	0
Hypopharynx	2	0.2%	2	0	2	0	0	0	0	1	0	1
Pharynx & Ill-defined	0	0.0%	0	0	0	0	0	0	0	0	0	0
Esophagus	11	1.0%	10	1	8	3	0	1	5	0	4	0
Stomach	13	1.1%	13	0	8	5	0	4	0	6	3	0
Small Intestine	3	0.3%	3	0	2	1	0	1	0	2	0	0
Colon	71	6.3%	66	5	39	32	2	16	16	19	12	1
Rectum & Rectosigmoid	33	2.9%	29	4	13	20	4	9	5	7	1	3
Anus,Anal Canal,Anorectum	0	0.0%	0	0	0	0	0	0	0	0	0	0
Liver	9	0.8%	8	1	5	4	0	4	0	3	1	0
Gallbladder	1	0.1%	1	0	1	0	0	0	0	0	1	0
Bile Ducts	3	0.3%	3	0	2	1	0	1	1	1	0	0
Pancreas	26	2.3%	25	1	17	9	0	5	5	3	11	1
Retroperitoneum	0	0.0%	0	0	0	0	0	0	0	0	0	0
Peritoneum,Omentum,Mesen	4	0.4%	2	2	0	4	0	1	0	1	0	0
Other Digestive	3	0.3%	2	1	0	3	0	0	0	0	0	2
Nasal Cavity,Sinus,Ear	0	0.0%	0	0	0	0	0	0	0	0	0	0
Larynx	8	0.7%	8	0	4	4	1	0	1	2	4	0
Lung/Bronchus-Small Cell	16	1.4%	13	3	7	9	0	2	1	2	8	0
Lung/Bronchus-Large Cell	91	8.0%	80	11	38	53	0	15	7	20	38	0
Pleura	1	0.1%	1	0	1	0	0	1	0	0	0	0
Other Respiratory & Thoracic	0	0.0%	0	0	0	0	0	0	0	0	0	0
Leukemia	18	1.6%	11	7	13	5	0	0	0	0	0	11
Myeloma	7	0.6%	4	3	3	4	0	0	0	0	0	4
Other Hematopoietic	14	1.2%	7	7	8	6	0	0	0	0	0	7
Bone	2	0.2%	2	0	1	1	0	0	0	0	1	1
Soft Tissue	4	0.4%	4	0	3	1	0	2	1	1	0	0
Melanoma of Skin	64	5.7%	62	2	33	31	28	24	4	2	0	4
Kaposi Sarcoma	1	0.1%	1	0	1	0	0	0	0	0	0	1
Other Skin Ca	5	0.4%	5	0	3	2	0	0	0	0	0	5
Breast	251	22.2%	240	11	2	249	66	86	64	17	2	5
Cervix, In Situ	0	0.0%	0	0	0	0	0	0	0	0	0	0
Cervix Uteri	0	0.0%	0	0	0	0	0	0	0	0	0	0
Corpus Uteri	25	2.2%	23	2	0	25	0	15	2	2	2	2
Uterus NOS	0	0.0%	0	0	0	0	0	0	0	0	0	0
Ovary	20	1.8%	19	1	0	20	0	2	3	7	6	1
Vagina	1	0.1%	1	0	0	1	0	1	0	0	0	0
Vulva	4	0.4%	3	1	0	4	2	1	0	0	0	0
Other Female Genital	2	0.2%	2	0	0	2	0	0	0	0	1	1
Prostate	170	15.0%	161	9	170	0	0	4	141	8	7	1
Testis	8	0.7%	7	1	8	0	0	6	1	0	0	0
Penis	0	0.0%	0	0	0	0	0	0	0	0	0	0
Other Male Genital	1	0.1%	1	0	1	0	0	0	0	0	0	1
Bladder	62	5.5%	59	3	50	12	33	17	4	2	3	0
Kidney & Renal Pelvis	30	2.7%	26	4	20	10	2	15	4	3	2	0
Ureter	1	0.1%	1	0	1	0	0	0	0	1	0	0
Other Urinary	1	0.1%	1	0	1	0	1	0	0	0	0	0
Eye	0	0.0%	0	0	0	0	0	0	0	0	0	0
Brain	11	1.0%	8	3	6	5	0	0	0	0	0	8
Other Nervous System	15	1.3%	14	1	2	13	0	0	0	0	0	14
Thyroid	20	1.8%	19	1	6	14	0	12	3	3	0	1
Other Endocrine	4	0.4%	4	0	0	4	0	0	0	0	0	4
Hodgkin's Disease	7	0.6%	4	3	4	3	0	1	0	2	1	0
Non-Hodgkin's Lymphoma	45	4.0%	37	8	23	22	0	12	6	5	14	0
Unknown or Ill-defined	23	2.0%	23	0	14	9	0	0	0	0	0	23

* Includes analytic cases only

Legend: N/R = not recorded Includes analytic cases that could not be staged because no AJCC staging exists for the particular primary site or histologic type. This includes most hematopoietic cancers (leukemia, myeloma, etc.), endocrine cancers, cancers of the brain and nervous system, sarcomas, cancers of the peritoneum, thymoma, and cancers where the primary site is ill-defined or unknown. Abbreviations: A = analytic; N/A = non-analytic; M = male; F = female.

Sutter Auburn Faith Hospital **primary** site tables

SAFH 2007 Primary Site Table			Class of Case		Gender		Distribution of Stage at Diagnosis *					
Primary Cancer Site	Cases	%	A	N/A	M	F	0	I	II	III	IV	N/R
All Sites	339	100.0%	225	114	153	186	26	47	40	29	41	42
Lip	0	0.0%	0	0	0	0	0	0	0	0	0	0
Tongue	3	0.9%	1	2	1	2	0	1	0	0	0	0
Salivary Glands	0	0.0%	0	0	0	0	0	0	0	0	0	0
Gum	0	0.0%	0	0	0	0	0	0	0	0	0	0
Floor of Mouth	0	0.0%	0	0	0	0	0	0	0	0	0	0
Mouth, Other & NOS	0	0.0%	0	0	0	0	0	0	0	0	0	0
Tonsil	2	0.6%	2	0	2	0	0	0	1	0	1	0
Oropharynx	0	0.0%	0	0	0	0	0	0	0	0	0	0
Nasopharynx	1	0.3%	1	0	1	0	0	0	0	0	1	0
Hypopharynx	0	0.0%	0	0	0	0	0	0	0	0	0	0
Pharynx & Ill-defined	1	0.3%	0	1	1	0	0	0	0	0	0	0
Esophagus	4	1.2%	3	1	4	0	0	0	1	1	1	1
Stomach	4	1.2%	4	0	3	1	0	0	0	0	0	4
Small Intestine	3	0.9%	3	0	2	1	0	0	0	0	0	3
Colon	22	6.5%	21	1	12	10	2	5	5	7	2	0
Rectum & Rectosigmoid	5	1.5%	5	0	4	1	0	1	0	2	2	0
Anus,Anal Canal,Anorectum	1	0.3%	1	0	0	1	1	0	0	0	0	0
Liver	3	0.9%	1	2	2	1	0	1	0	0	0	0
Gallbladder	2	0.6%	1	1	0	2	0	0	1	0	0	0
Bile Ducts	2	0.6%	2	0	2	0	0	0	1	0	1	0
Pancreas	14	4.1%	7	7	8	6	0	0	0	0	4	3
Retroperitoneum	0	0.0%	0	0	0	0	0	0	0	0	0	0
Peritoneum,Omentum,Mesen	1	0.3%	1	0	0	1	0	0	0	0	0	1
Other Digestive	1	0.3%	1	0	0	1	0	0	0	0	0	1
Nasal Cavity,Sinus,Ear	0	0.0%	0	0	0	0	0	0	0	0	0	0
Larynx	0	0.0%	0	0	0	0	0	0	0	0	0	0
Lung/Bronchus-Small Cell	9	2.7%	8	1	5	4	0	0	1	3	4	0
Lung/Bronchus-Large Cell	45	13.3%	27	18	24	21	0	6	0	3	15	3
Pleura	1	0.3%	0	1	0	1	0	0	0	0	0	0
Other Respiratory & Thoracic	0	0.0%	0	0	0	0	0	0	0	0	0	0
Leukemia	2	0.6%	1	1	2	0	0	0	0	0	0	1
Myeloma	7	2.1%	3	4	3	4	0	0	0	0	0	3
Other Hematopoietic	1	0.3%	0	1	0	1	0	0	0	0	0	0
Bone	1	0.3%	0	1	0	1	0	0	0	0	0	0
Soft Tissue	4	1.2%	3	1	2	2	0	2	0	0	1	0
Melanoma of Skin	12	3.5%	9	3	6	6	1	3	3	0	1	1
Kaposi Sarcoma	0	0.0%	0	0	0	0	0	0	0	0	0	0
Other Skin Ca	0	0.0%	0	0	0	0	0	0	0	0	0	0
Breast	69	20.4%	56	13	0	69	16	16	15	5	1	3
Cervix, In Situ	0	0.0%	0	0	0	0	0	0	0	0	0	0
Cervix Uteri	3	0.9%	1	2	0	3	0	1	0	0	0	0
Corpus Uteri	6	1.8%	5	1	0	6	0	3	0	1	0	1
Uterus NOS	1	0.3%	0	1	0	1	0	0	0	0	0	0
Ovary	8	2.4%	5	3	0	8	0	0	0	2	1	2
Vagina	0	0.0%	0	0	0	0	0	0	0	0	0	0
Vulva	0	0.0%	0	0	0	0	0	0	0	0	0	0
Other Female Genital	0	0.0%	0	0	0	0	0	0	0	0	0	0
Prostate	27	8.0%	10	17	27	0	0	1	8	0	0	1
Testis	3	0.9%	3	0	3	0	0	0	1	0	0	2
Penis	0	0.0%	0	0	0	0	0	0	0	0	0	0
Other Male Genital	0	0.0%	0	0	0	0	0	0	0	0	0	0
Bladder	11	3.2%	9	2	7	4	6	1	1	0	1	0
Kidney & Renal Pelvis	12	3.5%	6	6	5	7	0	3	0	2	1	0
Ureter	0	0.0%	0	0	0	0	0	0	0	0	0	0
Other Urinary	0	0.0%	0	0	0	0	0	0	0	0	0	0
Eye	0	0.0%	0	0	0	0	0	0	0	0	0	0
Brain	9	2.7%	2	7	6	3	0	0	0	0	0	2
Other Nervous System	3	0.9%	1	2	1	2	0	0	0	0	0	1
Thyroid	6	1.8%	4	2	3	3	0	1	2	0	1	0
Other Endocrine	2	0.6%	0	2	1	1	0	0	0	0	0	0
Hodgkin's Disease	3	0.9%	1	2	3	0	0	0	0	0	1	0
Non-Hodgkin's Lymphoma	14	4.1%	9	5	5	9	0	2	1	3	2	1
Unknown or Ill-defined	11	3.2%	8	3	8	3	0	0	0	0	0	8

* Includes analytic cases only

Legend: N/R = not recorded Includes analytic cases that could not be staged because no AJCC staging exists for the particular primary site or histologic type. This includes most hematopoietic cancers (leukemia, myeloma, etc.), endocrine cancers, cancers of the brain and nervous system, sarcomas, cancers of the peritoneum, thymoma, and cancers where the primary site is ill-defined or unknown. Abbreviations: A = analytic; N/A = non-analytic; M = male; F = female.

Sutter Medical Center, Sacramento primary site tables

SMCS 2007 Primary Site Table			Class of Case		Gender		Distribution of Stage at Diagnosis *					
Primary Cancer Site	Cases	%	A	N/A	M	F	0	I	II	III	IV	N/R
All Sites	1912	100.0%	1604	308	832	1080	125	391	361	248	209	270
Lip	2	0.1%	2	0	2	0	0	1	1	0	0	0
Tongue	12	0.6%	8	4	6	6	0	3	3	0	2	0
Salivary Glands	4	0.2%	4	0	3	1	0	1	1	1	1	0
Gum	0	0.0%	0	0	0	0	0	0	0	0	0	0
Floor of Mouth	1	0.1%	1	0	1	0	0	0	0	0	1	0
Mouth, Other & NOS	3	0.2%	3	0	2	1	1	1	0	0	1	0
Tonsil	4	0.2%	2	2	4	0	0	0	0	0	2	0
Oropharynx	0	0.0%	0	0	0	0	0	0	0	0	0	0
Nasopharynx	2	0.1%	2	0	2	0	0	0	0	0	1	1
Hypopharynx	2	0.1%	1	1	2	0	0	0	0	0	1	0
Pharynx & Ill-defined	0	0.0%	0	0	0	0	0	0	0	0	0	0
Esophagus	9	0.5%	7	2	7	2	0	0	3	2	1	1
Stomach	20	1.0%	14	6	14	6	1	5	2	1	3	2
Small Intestine	15	0.8%	14	1	8	7	0	0	3	2	5	4
Colon	105	5.5%	83	22	39	66	1	20	19	26	17	0
Rectum & Rectosigmoid	47	2.5%	42	5	26	21	2	13	6	12	8	1
Anus,Anal Canal,Anorectum	14	0.7%	11	3	5	9	1	0	4	3	2	1
Liver	28	1.5%	23	5	21	7	0	6	2	7	4	4
Gallbladder	2	0.1%	1	1	0	2	0	0	1	0	0	0
Bile Ducts	4	0.2%	4	0	2	2	0	0	0	1	2	1
Pancreas	41	2.1%	36	5	23	18	0	1	7	5	20	3
Retroperitoneum	6	0.3%	5	1	3	3	0	0	1	1	2	1
Peritoneum,Omentum,Mesen	5	0.3%	5	0	0	5	0	0	0	0	0	5
Other Digestive	4	0.2%	3	1	1	3	0	0	0	0	0	3
Nasal Cavity,Sinus,Ear	0	0.0%	0	0	0	0	0	0	0	0	0	0
Larynx	12	0.6%	6	6	10	2	1	1	1	0	2	1
Lung/Bronchus-Small Cell	25	1.3%	19	6	11	14	0	1	0	7	10	1
Lung/Bronchus-Large Cell	223	11.7%	182	41	105	118	0	49	11	43	69	10
Pleura	1	0.1%	1	0	1	0	0	0	0	1	0	0
Other Respiratory & Thoracic	1	0.1%	1	0	1	0	0	0	0	0	0	1
Leukemia	37	1.9%	29	8	20	17	0	0	0	0	0	29
Myeloma	14	0.7%	4	10	4	10	0	0	0	0	0	4
Other Hematopoietic	13	0.7%	3	10	7	6	0	0	0	0	0	3
Bone	6	0.3%	5	1	4	2	0	0	3	0	1	1
Soft Tissue	18	0.9%	13	5	11	7	0	2	1	6	1	3
Melanoma of Skin	49	2.6%	39	10	30	19	2	16	9	10	0	2
Kaposi Sarcoma	0	0.0%	0	0	0	0	0	0	0	0	0	0
Other Skin Ca	9	0.5%	7	2	6	3	0	3	0	0	0	4
Breast	396	20.7%	366	30	1	395	86	127	100	40	10	3
Cervix, In Situ	1	0.1%	1	0	0	1	1	0	0	0	0	0
Cervix Uteri	23	1.2%	19	4	0	23	0	12	2	3	0	2
Corpus Uteri	56	2.9%	54	2	0	56	0	35	2	11	2	4
Uterus NOS	1	0.1%	1	0	0	1	0	0	0	0	0	1
Ovary	33	1.7%	31	2	0	33	0	6	3	9	6	7
Vagina	6	0.3%	5	1	0	6	4	0	0	0	1	0
Vulva	7	0.4%	6	1	0	7	3	2	0	1	0	0
Other Female Genital	0	0.0%	0	0	0	0	0	0	0	0	0	0
Prostate	214	11.2%	173	41	214	0	0	1	140	27	5	0
Testis	12	0.6%	12	0	12	0	1	5	1	5	0	0
Penis	1	0.1%	1	0	1	0	0	1	0	0	0	0
Other Male Genital	1	0.1%	1	0	1	0	0	1	0	0	0	0
Bladder	51	2.7%	42	9	35	16	20	7	9	1	5	0
Kidney & Renal Pelvis	53	2.8%	42	11	38	15	0	25	3	4	6	4
Ureter	3	0.2%	1	2	2	1	0	0	1	0	0	0
Other Urinary	4	0.2%	4	0	4	0	1	1	1	0	0	1
Eye	1	0.1%	0	1	1	0	0	0	0	0	0	0
Brain	74	3.9%	66	8	50	24	0	0	0	0	0	66
Other Nervous System	50	2.6%	41	9	11	39	0	0	0	0	0	41
Thyroid	60	3.1%	57	3	18	42	0	36	8	8	4	1
Other Endocrine	28	1.5%	19	9	15	13	0	0	0	0	0	19
Hodgkin's Disease	14	0.7%	13	1	8	6	0	0	6	4	2	1
Non-Hodgkin's Lymphoma	51	2.7%	38	13	20	31	0	9	7	7	12	3
Unknown or Ill-defined	34	1.8%	31	3	20	14	0	0	0	0	0	31

* Includes analytic cases only

Legend: N/R = not recorded Includes analytic cases that could not be staged because no AJCC staging exists for the particular primary site or histologic type. This includes most hematopoietic cancers (leukemia, myeloma, etc.), endocrine cancers, cancers of the brain and nervous system, sarcomas, cancers of the peritoneum, thymoma, and cancers where the primary site is ill-defined or unknown. Abbreviations: A = analytic; N/A = non-analytic; M = male; F = female.

Sutter Roseville Medical Center **primary site tables**

SRMC 2007 Primary Site Table			Class of Case		Gender		Distribution of Stage at Diagnosis *					
Primary Cancer Site	Cases	%	A	N/A	M	F	0	I	II	III	IV	N/R
All Sites	1216	100.0%	819	397	530	686	73	157	193	108	172	116
Lip	0	0.0%	0	0	0	0	0	0	0	0	0	0
Tongue	8	0.7%	5	3	6	2	0	0	0	2	1	2
Salivary Glands	0	0.0%	0	0	0	0	0	0	0	0	0	0
Gum	0	0.0%	0	0	0	0	0	0	0	0	0	0
Floor of Mouth	1	0.1%	1	0	1	0	0	0	0	0	1	0
Mouth, Other & NOS	1	0.1%	0	1	0	1	0	0	0	0	0	0
Tonsil	3	0.2%	1	2	3	0	0	0	0	0	1	0
Oropharynx	0	0.0%	0	0	0	0	0	0	0	0	0	0
Nasopharynx	2	0.2%	1	1	1	1	0	0	0	0	1	0
Hypopharynx	1	0.1%	0	1	1	0	0	0	0	0	0	0
Pharynx & Ill-defined	1	0.1%	0	1	0	1	0	0	0	0	0	0
Esophagus	8	0.7%	6	2	4	4	0	0	2	0	4	0
Stomach	6	0.5%	5	1	5	1	0	0	2	0	1	2
Small Intestine	5	0.4%	3	2	3	2	0	1	1	0	0	1
Colon	84	6.9%	58	26	35	49	1	10	19	15	9	4
Rectum & Rectosigmoid	39	3.2%	35	4	21	18	1	7	8	9	9	1
Anus,Anal Canal,Anorectum	4	0.3%	4	0	1	3	0	1	0	2	0	1
Liver	16	1.3%	11	5	6	10	1	2	0	0	4	4
Gallbladder	2	0.2%	1	1	1	1	0	0	0	0	1	0
Bile Ducts	1	0.1%	1	0	0	1	0	1	0	0	0	0
Pancreas	29	2.4%	21	8	11	18	0	2	4	2	12	1
Retroperitoneum	0	0.0%	0	0	0	0	0	0	0	0	0	0
Peritoneum,Omentum,Mesen	0	0.0%	0	0	0	0	0	0	0	0	0	0
Other Digestive	0	0.0%	0	0	0	0	0	0	0	0	0	0
Nasal Cavity,Sinus,Ear	1	0.1%	0	1	1	0	0	0	0	0	0	0
Larynx	3	0.2%	1	2	3	0	0	0	0	0	1	0
Lung/Bronchus-Small Cell	17	1.4%	15	2	8	9	0	0	0	1	14	0
Lung/Bronchus-Large Cell	158	13.0%	118	40	72	86	0	19	7	29	58	5
Pleura	1	0.1%	0	1	1	0	0	0	0	0	0	0
Other Respiratory & Thoracic	0	0.0%	0	0	0	0	0	0	0	0	0	0
Leukemia	12	1.0%	6	6	7	5	0	0	0	0	0	6
Myeloma	23	1.9%	9	14	14	9	0	0	0	0	0	9
Other Hematopoietic	11	0.9%	3	8	6	5	0	0	0	0	0	3
Bone	2	0.2%	0	2	0	2	0	0	0	0	0	0
Soft Tissue	13	1.1%	8	5	9	4	0	0	0	0	4	4
Melanoma of Skin	21	1.7%	14	7	14	7	0	7	3	0	3	1
Kaposi Sarcoma	0	0.0%	0	0	0	0	0	0	0	0	0	0
Other Skin Ca	1	0.1%	1	0	0	1	0	0	0	1	0	0
Breast	252	20.7%	165	87	3	249	30	41	61	20	8	5
Cervix, In Situ	4	0.3%	4	0	0	4	4	0	0	0	0	0
Cervix Uteri	5	0.4%	2	3	0	5	0	1	1	0	0	0
Corpus Uteri	13	1.1%	13	0	0	13	0	11	1	1	0	0
Uterus NOS	9	0.7%	5	4	0	9	0	0	0	0	3	2
Ovary	38	3.1%	31	7	0	38	0	1	2	11	12	5
Vagina	3	0.2%	2	1	0	3	2	0	0	0	0	0
Vulva	11	0.9%	9	2	0	11	5	1	1	1	0	1
Other Female Genital	0	0.0%	0	0	0	0	0	0	0	0	0	0
Prostate	136	11.2%	70	66	136	0	0	2	59	2	7	0
Testis	6	0.5%	4	2	6	0	0	4	0	0	0	0
Penis	2	0.2%	2	0	2	0	0	2	0	0	0	0
Other Male Genital	0	0.0%	0	0	0	0	0	0	0	0	0	0
Bladder	70	5.8%	54	16	55	15	28	14	6	3	1	2
Kidney & Renal Pelvis	24	2.0%	17	7	13	11	1	10	3	0	2	1
Ureter	1	0.1%	0	1	1	0	0	0	0	0	0	0
Other Urinary	0	0.0%	0	0	0	0	0	0	0	0	0	0
Eye	2	0.2%	0	2	0	2	0	0	0	0	0	0
Brain	24	2.0%	13	11	14	10	0	0	0	0	0	13
Other Nervous System	22	1.8%	18	4	9	13	0	0	0	0	0	18
Thyroid	24	2.0%	19	5	7	17	0	13	2	1	1	2
Other Endocrine	5	0.4%	1	4	3	2	0	0	0	0	0	1
Hodgkin's Disease	5	0.4%	4	1	3	2	0	0	4	0	0	0
Non-Hodgkin's Lymphoma	60	4.9%	40	20	32	28	0	7	7	8	14	4
Unknown or Ill-defined	26	2.1%	18	8	12	14	0	0	0	0	0	18

* Includes analytic cases only

Legend: N/R = not recorded Includes analytic cases that could not be staged because no AJCC staging exists for the particular primary site or histologic type. This includes most hematopoietic cancers (leukemia, myeloma, etc.), endocrine cancers, cancers of the brain and nervous system, sarcomas, cancers of the peritoneum, thymoma, and cancers where the primary site is ill-defined or unknown. Abbreviations: **A** = analytic; **N/A** = non-analytic; **M** = male; **F** = female.

Sutter Solano Medical Center primary site tables

SSMC 2007 Primary Site Table			Class of Case		Gender		Distribution of Stage at Diagnosis *					
Primary Cancer Site	Cases	%	A	N/A	M	F	0	I	II	III	IV	N/R
All Sites	421	100.0%	326	95	206	215	10	70	89	59	54	44
Lip	0	0.0%	0	0	0	0	0	0	0	0	0	0
Tongue	4	1.0%	4	0	3	1	0	0	1	1	1	1
Salivary Glands	2	0.5%	1	1	1	1	0	0	0	1	0	0
Gum	0	0.0%	0	0	0	0	0	0	0	0	0	0
Floor of Mouth	2	0.5%	0	2	1	1	0	0	0	0	0	0
Mouth, Other & NOS	0	0.0%	0	0	0	0	0	0	0	0	0	0
Tonsil	2	0.5%	2	0	2	0	0	0	0	1	1	0
Oropharynx	1	0.2%	1	0	1	0	0	1	0	0	0	0
Nasopharynx	2	0.5%	1	1	2	0	0	1	0	0	0	0
Hypopharynx	0	0.0%	0	0	0	0	0	0	0	0	0	0
Pharynx & Ill-defined	0	0.0%	0	0	0	0	0	0	0	0	0	0
Esophagus	1	0.2%	1	0	1	0	0	0	0	0	0	1
Stomach	10	2.4%	10	0	7	3	0	1	1	3	3	2
Small Intestine	0	0.0%	0	0	0	0	0	0	0	0	0	0
Colon	15	3.6%	8	7	9	6	0	2	4	0	1	1
Rectum & Rectosigmoid	10	2.4%	9	1	6	4	0	3	3	3	0	0
Anus,Anal Canal,Anorectum	0	0.0%	0	0	0	0	0	0	0	0	0	0
Liver	7	1.7%	5	2	6	1	0	1	0	0	1	3
Gallbladder	0	0.0%	0	0	0	0	0	0	0	0	0	0
Bile Ducts	2	0.5%	1	1	1	1	0	0	0	0	1	0
Pancreas	5	1.2%	5	0	3	2	0	0	0	2	3	0
Retroperitoneum	0	0.0%	0	0	0	0	0	0	0	0	0	0
Peritoneum,Omentum,Mesen	0	0.0%	0	0	0	0	0	0	0	0	0	0
Other Digestive	0	0.0%	0	0	0	0	0	0	0	0	0	0
Nasal Cavity,Sinus,Ear	0	0.0%	0	0	0	0	0	0	0	0	0	0
Larynx	5	1.2%	4	1	3	2	0	1	1	0	2	0
Lung/Bronchus-Small Cell	7	1.7%	7	0	3	4	0	0	1	2	4	0
Lung/Bronchus-Large Cell	59	14.0%	45	14	31	28	0	6	1	17	19	2
Pleura	3	0.7%	2	1	2	1	0	0	1	0	0	1
Other Respiratory & Thoracic	0	0.0%	0	0	0	0	0	0	0	0	0	0
Leukemia	5	1.2%	5	0	2	3	0	0	0	0	0	5
Myeloma	5	1.2%	3	2	5	0	0	0	0	0	0	3
Other Hematopoietic	3	0.7%	2	1	3	0	0	0	0	0	0	2
Bone	1	0.2%	0	1	1	0	0	0	0	0	0	0
Soft Tissue	2	0.5%	2	0	1	1	0	0	1	0	0	1
Melanoma of Skin	5	1.2%	3	2	1	4	0	2	0	1	0	0
Kaposi Sarcoma	0	0.0%	0	0	0	0	0	0	0	0	0	0
Other Skin Ca	1	0.2%	1	0	0	1	0	0	0	1	0	0
Breast	98	23.3%	81	17	2	96	10	29	25	12	5	0
Cervix, In Situ	0	0.0%	0	0	0	0	0	0	0	0	0	0
Cervix Uteri	3	0.7%	2	1	0	3	0	1	0	1	0	0
Corpus Uteri	10	2.4%	10	0	0	10	0	5	0	2	1	2
Uterus NOS	0	0.0%	0	0	0	0	0	0	0	0	0	0
Ovary	11	2.6%	8	3	0	11	0	1	2	2	2	1
Vagina	2	0.5%	0	2	0	2	0	0	0	0	0	0
Vulva	0	0.0%	0	0	0	0	0	0	0	0	0	0
Other Female Genital	0	0.0%	0	0	0	0	0	0	0	0	0	0
Prostate	70	16.6%	52	18	70	0	0	1	42	4	1	4
Testis	2	0.5%	2	0	2	0	0	2	0	0	0	0
Penis	0	0.0%	0	0	0	0	0	0	0	0	0	0
Other Male Genital	0	0.0%	0	0	0	0	0	0	0	0	0	0
Bladder	10	2.4%	8	2	9	1	0	6	1	0	1	0
Kidney & Renal Pelvis	12	2.9%	6	6	8	4	0	2	1	1	2	0
Ureter	0	0.0%	0	0	0	0	0	0	0	0	0	0
Other Urinary	0	0.0%	0	0	0	0	0	0	0	0	0	0
Eye	0	0.0%	0	0	0	0	0	0	0	0	0	0
Brain	1	0.2%	0	1	0	1	0	0	0	0	0	0
Other Nervous System	4	1.0%	2	2	0	4	0	0	0	0	0	2
Thyroid	5	1.2%	5	0	1	4	0	2	0	2	1	0
Other Endocrine	1	0.2%	1	0	1	0	0	0	0	0	0	1
Hodgkin's Disease	4	1.0%	3	1	1	3	0	0	2	0	1	0
Non-Hodgkin's Lymphoma	17	4.0%	13	4	10	7	0	3	2	3	4	1
Unknown or Ill-defined	12	2.9%	11	1	7	5	0	0	0	0	0	11

* Includes analytic cases only

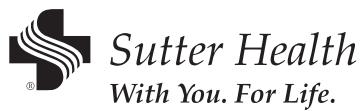
Legend: N/R = not recorded Includes analytic cases that could not be staged because no AJCC staging exists for the particular primary site or histologic type. This includes most hematopoietic cancers (leukemia, myeloma, etc.), endocrine cancers, cancers of the brain and nervous system, sarcomas, cancers of the peritoneum, thymoma, and cancers where the primary site is ill-defined or unknown. Abbreviations: A = analytic; N/A = non-analytic; M = male; F = female.

Sutter Health System **primary site tables**

Sutter Health System 2007 Primary Site Table			Class of Case		Gender		Distribution of Stage at Diagnosis *					
Primary Cancer Site	Cases	%	A	N/A	M	F	0	I	II	III	IV	N/R
<i>All Sites</i>	12081	100.0%	10105	1976	5595	6486	878	2421	2559	1361	1448	1438
Lip	13	0.1%	11	2	8	5	1	8	2	0	0	0
Tongue	81	0.7%	64	17	52	29	1	7	11	11	28	6
Salivary Glands	21	0.2%	18	3	14	7	0	7	3	4	3	1
Gum	2	0.0%	2	0	1	1	0	0	0	0	2	0
Floor of Mouth	9	0.1%	7	2	7	2	3	0	2	0	2	0
Mouth, Other & NOS	16	0.1%	13	3	9	7	1	5	1	2	3	1
Tonsil	39	0.3%	34	5	30	9	0	2	1	10	20	1
Oropharynx	6	0.0%	6	0	3	3	0	2	1	1	2	0
Nasopharynx	24	0.2%	20	4	16	8	0	3	1	6	9	1
Hypopharynx	12	0.1%	9	3	10	2	0	0	0	5	1	3
Pharynx & Ill-defined	4	0.0%	1	3	3	1	0	0	0	0	0	1
Esophagus	105	0.9%	88	17	79	26	8	9	23	15	24	9
Stomach	155	1.3%	140	15	104	51	4	36	18	25	35	22
Small Intestine	46	0.4%	42	4	23	23	0	4	6	6	8	18
Colon	752	6.2%	653	99	352	400	37	145	167	160	122	22
Rectum & Rectosigmoid	341	2.8%	304	37	191	150	26	74	61	80	46	17
Anus, Anal Canal, Anorectum	62	0.5%	52	10	26	36	9	11	10	13	4	5
Liver	256	2.1%	219	37	180	76	1	74	36	52	31	25
Gallbladder	23	0.2%	18	5	7	16	2	4	7	0	5	0
Bile Ducts	59	0.5%	54	5	37	22	1	13	16	7	13	4
Pancreas	349	2.9%	303	46	176	173	0	43	69	39	111	41
Retroperitoneum	8	0.1%	7	1	4	4	0	0	1	2	2	2
Peritoneum, Omentum, Mesen	17	0.1%	15	2	0	17	0	1	0	1	0	13
Other Digestive	13	0.1%	11	2	4	9	0	0	0	0	0	11
Nasal Cavity, Sinus, Ear	13	0.1%	11	2	6	7	0	2	1	0	4	4
Larynx	64	0.5%	52	12	48	16	4	16	8	7	16	1
Lung/Bronchus-Small Cell	165	1.4%	148	17	72	93	1	14	6	40	85	2
Lung/Bronchus-Large Cell	1183	9.8%	969	214	593	590	0	220	45	229	413	62
Pleura	14	0.1%	10	4	11	3	0	1	3	1	3	2
Other Respiratory & Thoracic	6	0.0%	5	1	5	1	0	2	0	0	0	3
Leukemia	223	1.8%	150	73	138	85	0	0	0	0	0	150
Myeloma	136	1.1%	76	60	73	63	0	0	0	0	0	76
Other Hematopoietic	138	1.1%	67	71	79	59	0	0	0	0	0	67
Bone	19	0.2%	10	9	7	12	0	0	3	0	2	5
Soft Tissue	84	0.7%	62	22	47	37	0	10	9	15	12	16
Melanoma of Skin	336	2.8%	254	82	198	138	65	94	40	22	15	18
Kaposi Sarcoma	20	0.2%	10	10	20	0	0	0	0	0	0	10
Other Skin Ca	44	0.4%	33	11	25	19	1	4	2	3	2	21
Breast	2515	20.8%	2241	274	17	2498	485	803	631	215	71	36
Cervix, In Situ	10	0.1%	10	0	0	10	10	0	0	0	0	0
Cervix Uteri	100	0.8%	84	16	0	100	0	46	13	16	6	3
Corpus Uteri	329	2.7%	307	22	0	329	3	189	22	52	16	25
Uterus NOS	17	0.1%	8	9	0	17	0	0	0	0	4	4
Ovary	242	2.0%	211	31	0	242	0	36	23	66	46	40
Vagina	25	0.2%	19	6	0	25	8	2	4	2	2	1
Vulva	44	0.4%	35	9	0	44	21	7	1	4	1	1
Other Female Genital	12	0.1%	12	0	0	12	0	1	0	5	4	2
Prostate	1618	13.4%	1322	296	1618	0	0	21	1126	99	56	20
Testis	54	0.4%	49	5	54	0	1	33	5	7	0	3
Penis	10	0.1%	10	0	10	0	2	4	1	2	1	0
Other Male Genital	2	0.0%	2	0	2	0	0	1	0	0	0	1
Bladder	430	3.6%	365	65	320	110	173	91	57	14	26	4
Kidney & Renal Pelvis	288	2.4%	226	62	171	117	6	116	20	33	36	15
Ureter	17	0.1%	14	3	10	7	2	2	4	5	1	0
Other Urinary	7	0.1%	7	0	7	0	2	2	1	0	0	2
Eye	89	0.7%	72	17	49	40	0	45	3	5	0	19
Brain	238	2.0%	191	47	140	98	0	0	0	0	0	191
Other Nervous System	156	1.3%	131	25	45	111	0	0	0	0	0	131
Thyroid	191	1.6%	175	16	55	136	0	110	20	21	15	9
Other Endocrine	74	0.6%	52	22	41	33	0	0	0	0	1	51
Hodgkin's Disease	70	0.6%	55	15	39	31	0	13	20	9	12	1
Non-Hodgkin's Lymphoma	437	3.6%	340	97	229	208	0	88	55	50	127	20
Unknown or Ill-defined	248	2.1%	219	29	130	118	0	0	0	0	0	219

* Includes analytic cases only

Legend: N/R = not recorded Includes analytic cases that could not be staged because no AJCC staging exists for the particular primary site or histologic type. This includes most hematopoietic cancers (leukemia, myeloma, etc.), endocrine cancers, cancers of the brain and nervous system, sarcomas, cancers of the peritoneum, thymoma, and cancers where the primary site is ill-defined or unknown. Abbreviations: A = analytic; N/A = non-analytic; M = male; F = female.



SUTTER HEALTH ACOS CANCER PROGRAMS

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California Pacific Medical Center

Eden Medical Center

Marin General Hospital

Memorial Medical Center

Mills-Peninsula Health Services

Sutter Auburn Faith Hospital

Sutter Medical Center, Sacramento

Sutter Roseville Medical Center

Sutter Solano Medical Center

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