

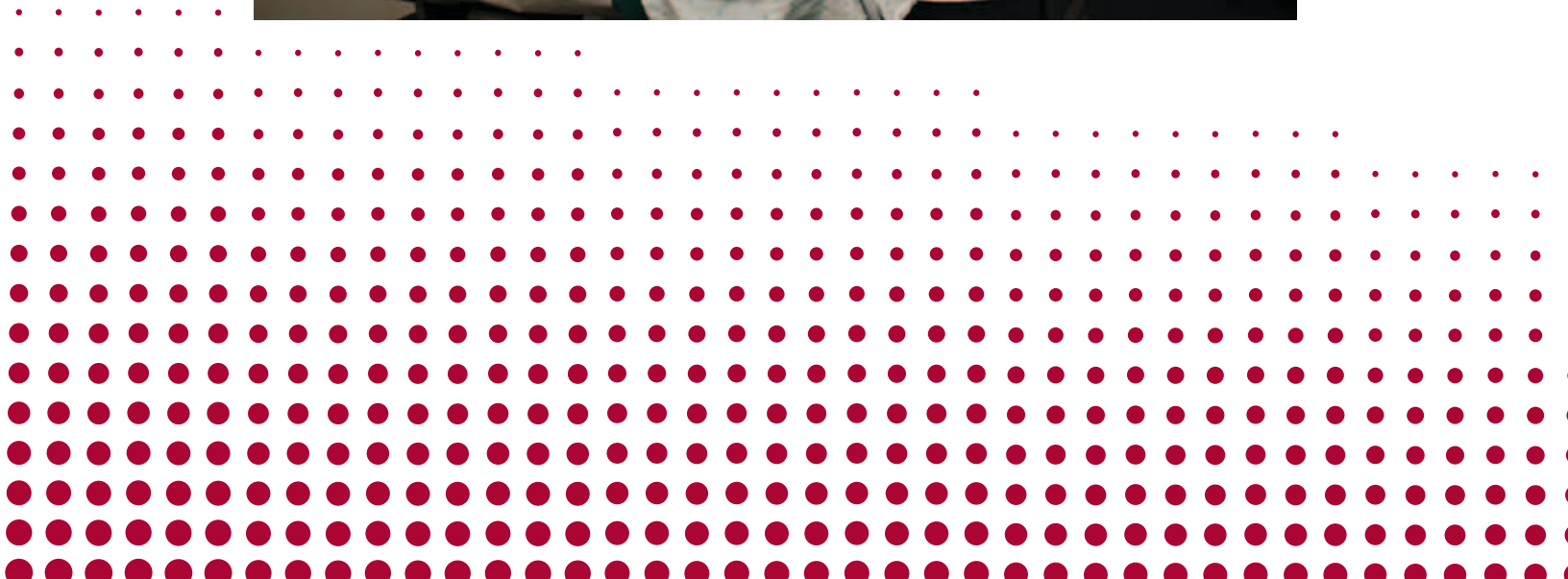
SAMARITAN CANCER PROGRAM | Annual Report *2010-2011*



About Samaritan Cancer Program

The Samaritan Cancer Program is a full-service cancer treatment network. The main facility is located in Corvallis on the campus of Good Samaritan Regional Medical Center, with services provided across the mid-Willamette Valley and central Oregon Coast. The Samaritan Cancer Program encompasses the physician practice of Samaritan Hematology & Oncology Consultants, which provides medical oncology services, and Samaritan Regional Cancer Center, where patients undergo radiation treatments. The program also partners with each local Samaritan hospital to provide chemotherapy and other supportive treatments for patients, close to home.

The Samaritan Cancer Program also benefits from partnering with neighboring health care experts. Oncologists, dermatologists, urologists, surgeons and other specialists all contribute to the multi-disciplinary team approach to cancer care.



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Letter from the chair

Cancer care continues to be a major focus of the medical activities at Samaritan Health Services. It is our continuing goal that patients and families have access to comprehensive, compassionate and high quality care throughout our area.

Periodically, we analyze how we are doing. This annual report is the product of that effort. It comes from the Cancer Committee, which is composed of participants from multiple services involved in the education, support, diagnosis and treatment of cancer. The committee meets at Good Samaritan Regional Medical Center regularly to monitor and improve cancer care. Members include physicians, nurses, social services, pharmacists, therapists, hospice workers and administration. Specific activities of the committee include maintaining the tumor registry, promoting medical education and participating in community outreach activities.

The tumor registry tracks cancer cases within Samaritan Health Services and compiles data to allow for the analysis of cancer incidence, distribution and care throughout the region. That annual summary is included in this report. Each year, commonly in collaboration with the National Commission on Cancer, we analyze in-depth a specific type of cancer. This year, we've looked at colon cancer and the statistics in this report have been reviewed by Dr. Surin Vasdev.

Medical education activities are sponsored regularly. One activity is the tumor board, which is a weekly multidisciplinary meeting to review current cancer cases. There is broad participation by the medical staff, medical students and ancillary services, all for the purpose of improving patient care.

Community outreach activities continue under the sponsorship of the committee and are provided through the Samaritan Regional Cancer Center. These include cancer screening programs and education.

Our goal is to help each person with cancer with the knowledge and expertise of many. Many of the outreach programs Samaritan has been able to provide are due to the generous donors who help support cancer care in our communities. The services we are able to provide are inextricably linked to the support we receive from the community – thank you to all of those who are committed to helping us provide outstanding cancer care locally.

I am proud of the growth and development of cancer care services in the Samaritan region. I hope that this annual report conveys the breadth and dedication of the many providers that form your cancer care team.



Peter Kenyon, MD
Cancer Committee Chairman

2010 brings expanded support services to the Samaritan Cancer Program

It's an agonizing decision to make in the midst of a major health crisis: Do you choose your own life-saving cancer radiation treatment, or do you put food on your family's table?

For those of means, it would never be an issue. But for patients struggling financially, six weeks of treatment means lost wages, less food in the refrigerator, and not enough money to get to the treatments in the first place.

"I'll hear patients say, 'I can't afford the gas to get to treatment. I'm barely making it as it is. There's just no room in my budget for more expenses,'" said Jan Spencer, an oncology social worker for the Samaritan Cancer Program. "We then give them gas cards or waive the daily fee for staying at the Pastega House. We do everything we can to help them stay on track with their treatment schedule."

The Samaritan Cancer Program features two full-time oncology social workers. Spencer and her colleague, Jeanette Hansen, are credentialed and experienced in identifying and addressing patients' life needs. First, they help patients navigate the labyrinth of insurance and other financial assistance programs. Then they focus on tangibles such as transportation, lodging groceries — sometimes even dentures or simply a warm hat.

"Once we address a patient's financial crises, some of their worries are lifted, allowing them to focus on their treatment," said Spencer.

And focusing on treatment often brings waves of emotional challenges. Oncology social workers help by offering counseling for patients and their loved ones, as well as facilitating a wide network of support groups, seminars and programs for people impacted by cancer.

In 2010, two new support groups were added: one for young adults with cancer and another for patients with metastatic breast cancer. "Originally, patients with metastatic/advanced breast cancer attended the main breast cancer support group, but we found that they needed their own space and time to better address their end-of-life emotional needs," said Spencer.

"Once we address a patient's financial crises, some of their worries are lifted, allowing them to focus on their treatment."



The cancer support group for young adults is aimed at patients ages 25 to 40. "These are patients who go into the infusion room and feel like they don't belong, like they are too young to be there," said Spencer. "Younger patients wrestle with issues such as dating, fertility and body image." The support group provides vital education, support, and connection.

The social programs in Samaritan's Cancer Program network often exceed those of many larger, metropolitan hospitals. The value of these services is immeasurable, helping patients cope and return to their lives as contributing members of our communities.

There is an ongoing need for new support groups. In fact, two more are in the works for 2011: Children's Lives Include Moments of Bravery (CLIMB) is for children whose parent or loved one is being treated for cancer. The other forthcoming support group is for caregivers (see page 6).

Funding comes from donations made to the Good Samaritan Hospital Foundation, such as Corvallis High School's annual "Mr. Spartan" charity event. Proceeds from the sale of bracelets crafted by cancer patients also contribute to support groups and patients in need.

Brad Betz, manager of radiation oncology for Samaritan Regional Cancer Center knows the value of support groups. "We've had patients tell us that their last day of radiation was the worst day of their lives—that when there's no more fighting their cancer, they think, 'Now what?'" said Betz. "That's where our support groups come in."

"We want our patients to be healthy, happy and alive," continued Betz, who, along with many others in the Samaritan Cancer Program, believes he has the best job in the world. "We're a family here—and our patients become our family."

Prosthesis boutique helps women "renew" after surgery

Fear, anger, worry — women who've undergone breast surgery face many challenging emotions. The Samaritan Cancer Resource Center strives to offer cancer survivors a way to address these feelings and to experience renewal through many forms — support groups, classes, a library, a salon offering wigs, skin care and massage — and now, a mastectomy fitting service called Contours.

With post-surgery camisoles, mastectomy bras, breast forms and customized breast prostheses, a fitting at Contours is designed to address each woman's individual needs.

This service also offers the community an opportunity to donate new or gently used items that will go to women with little or no health insurance.

"From pre-surgery consults to post-surgery fittings, Contours is warm and welcoming," said Clare Rollings, a certified mastectomy fitter. "I talk each woman through the whole process and make sure she is comfortable and pleased with her entire experience, regardless of her ability to pay."



For more information about Contours or other services available at Samaritan Cancer Resource Center, call (541) 812-5888.

Clinical trials bring hope to local cancer patients

Since the first clinical trial took place in 1990, physicians at Good Samaritan Regional Medical Center have participated in more than 20 different cancer-related studies for patients throughout the region.

Today, there are several cancer-specific clinical trials available for patients with HER-2 positive breast cancer, and studies for the treatment of lung cancer and non-Hodgkin's Lymphoma in 2011.

Clinical trials are research studies that may offer cancer patients additional treatment options that are specific to their disease and situation, and help researchers gain a better understanding of the disease in question.

"We're proud to offer our patients the opportunity to participate in research studies, so close to home," said Linda Fox-Wasson, RN, clinical research supervisor for the Samaritan Health Services Center for Health Research & Quality. "These trials are generally limited to large medical research institutions, and our oncologists really strive to bring that level of care to our local community."

One of those oncologists is Peter Kenyon, MD, who is the local principle investigator for cancer trials and has overseen all of Samaritan's cancer-related research since he first joined Samaritan.

"We have seen significant advancement in both our understanding of cancer and its treatment," said Dr. Kenyon. "These advancements are possible because patients choose to participate in clinical trials. Many may gain from the trial itself, but they also feel empowered by the opportunity to contribute to the wellbeing of future generations."

For more information regarding clinical trials, contact the Center for Health Research & Quality at (541) 768-5908.



Nutrition care important for cancer patients



During cancer treatment, diet and nutrition become an integral part of the process. In the same way that doctors and nurses have specialized training in their area of expertise, dietitians have specialized training in how to help people with nutrition-related health issues. Samaritan Health Services offers individualized nutritional counseling to patients during the course of cancer treatment, helping them know the best way to prepare for their treatment and cope with difficult side effects. This often results in patients feeling better, tolerating treatments with less difficulty and promoting better quality of life.

As an added important function, dietitians are also able to provide nutritional counseling to cancer survivors after treatment, giving advice on how to eat healthfully to reduce risk of recurrence and other chronic diseases.

Donors support cancer outreach and education efforts

Donors to the five Samaritan hospital foundations gave more than \$255,000 to cancer-related projects and programs in 2010. In turn, the foundations use these funds to support a variety of important efforts aimed at early cancer detection, cancer treatment and research, and resources for cancer patients, survivors and loved ones.

One unique way that donor funds are used to benefit cancer care is through community outreach programs, support groups and educational materials and classes. For example, several of the Samaritan foundations fund workshops called “From Surviving to Thriving” that connect cancer survivors and their loved ones with professional artists who help them process their cancer journey through the creation of original art. Patients have created beautiful sculptures, paintings, calligraphy pieces and more through these workshops.



Several of the foundations also fund local voucher programs that provide free mammograms for local low-income women. The vouchers encourage women to get an annual mammogram – one of the most important tools in the early detection of breast cancer.

Other examples from across Samaritan include:

- The Albany General Hospital Foundation funded Contours, the new mastectomy fitting service at Samaritan Cancer Resource Center.
- The Good Samaritan Hospital Foundation helped fund a “Puttin’ on the Pink” breast cancer education event that was open to all community members.
- The Lebanon Community Hospital Foundation supported the production of a cancer education DVD for patients at the hospital’s Emehiser Infusion Center.
- The North Lincoln Hospital Foundation provided financial assistance to help with prescription costs for low-income cancer patients.
- The Pacific Communities Health District Foundation provided financial assistance to cover travel costs for coastal patients needing to travel to Samaritan Regional Cancer Center in Corvallis.

For more information about how donations make a difference in the health of our communities, visit www.samhealth.org/foundations.

New support group will help caregivers

Jeanette Hansen, MSW, and Caroline Zaworski, RN, OCN, who both work at the Samaritan Regional Cancer Center, have been accepted into a national program aimed at improving the quality of life and quality of care for family caregivers who are impacted by a loved one’s cancer across the trajectory of the illness.

Under the guidance of City of Hope and the National Cancer Institute staff, the program aims to accomplish three goals related to implementing family support activities. The goals will address the four domains of quality of life: physical, psychological, social and spiritual well-being.

MEDICAL FOCUS: Examining colon cancer

Surin Vasdev, MD
Mid-Valley Gastroenterology

Introduction

Colorectal cancer (CRC) is the third most common cancer and is the second-most common cause of cancer death in the U.S. There were 142,570 new cases of CRC in 2010 and 51,370 deaths from it. While there has been a 3 percent per year decline in mortality since 1990, more than 1 million Americans live with colorectal cancer and yet it is now established that CRC can be preventable with appropriate screening interventions, and is considered curable if caught early enough.

Incidence

Ninety percent of cases occur in people age 50 and greater and there is a slight male predominance. African-Americans have the highest incidence and mortality rate of all groups in the U.S., and Hispanics the lowest, depending on country of origin. There is an increased rate in Alaskan Natives, Native Americans and Ashkenazi Jews.

Risk factors

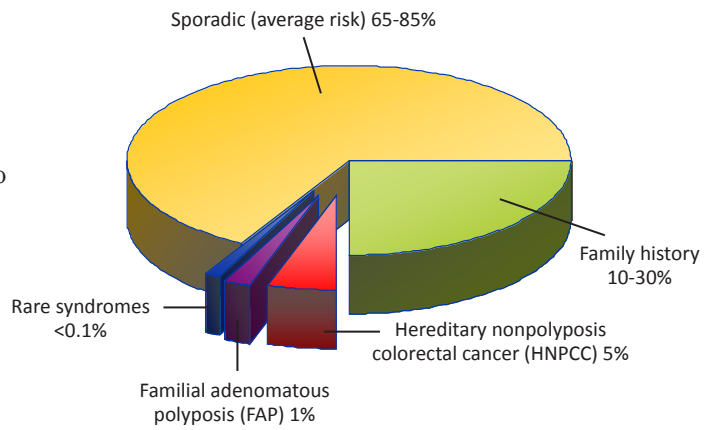
There is a 6 percent lifetime risk of developing CRC and a 2.6 percent risk of dying from it. A personal history of inflammatory bowel disease (Ulcerative or Crohn's colitis), adenomatous polyps or prior colon cancer increases the risk of developing CRC. Family history of colon polyps or colon cancer is a significant risk factor and impacts screening techniques and frequency of screening.

Family history	Lifetime risk
None	1
One 2nd or 3rd degree relative	1.5
One 1st degree relative	2 to 3
Two 1st degree relatives or one 1st degree relative <50 at diagnosis	3 to 4

Other established risk factors include primary sclerosing cholangitis, obesity, alcohol, smoking and diabetes.

Colorectal cancer syndromes

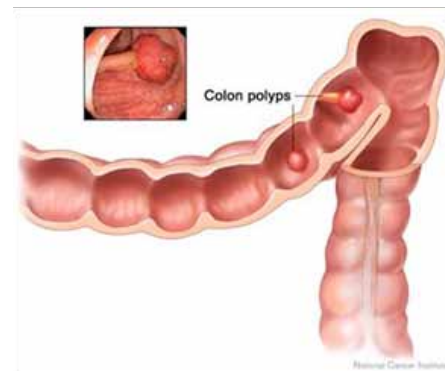
Familial Adenomatous Polyposis accounts for 1 to 2 percent of CRC, occurs in 1/11,000 live births, is an autosomal dominant condition that results in CRC by the age of 45, warranting prophylactic colectomy in affected patients. It is associated with extracolonic abnormalities related to the FAP gene on chromosome 5.



Hereditary nonpolyposis colorectal cancer syndrome (HNPCC) accounts for 6 percent of CRC, is an autosomal dominant condition with several known and identifiable mutations. It affects younger patients and is often associated with multiple colon cancers and extra-colonic cancers (uterus, ovary, urinary, breast).

Colon polyps, colon cancer and survival

The progression of adenomatous colon polyps to colon cancer has been well studied and is the basis for preventative intervention. Removing pre-cancerous polyps prevents colon cancer, and early cancer detection markedly improves the chance of long-term survival. There is a 90 percent five-year survival rate for localized colon cancer and 70 percent for colon cancer that has regionally metastasized. Only 10 percent of people with distant metastases survive five years. Only 40 percent of CRC is detected at the earliest stages. Symptoms and signs of colon cancer usually do not occur until it is advanced and can include rectal bleeding, abdominal pain, weight loss, change in bowel habit and anemia.



Colon cancer screening

Screening rates have improved, but still an unacceptable number of people go unscreened. Colonoscopy has superior single-test accuracy compared with other screening modalities. It allows for the opportunity to remove polyps at the same time as detection. Other modalities include stool hemoccult tests, fecal immunohistochemical tests, fecal DNA tests, flexible sigmoidoscopy, air contrast barium enema and CT colonography.

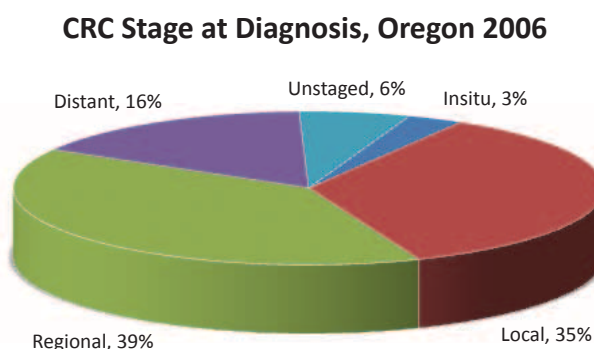
Screening guidelines

Recommendations are to begin screening average-risk patients at the age of 50 (45 for African-Americans), repeated every 10 years. Those with a family history are screened every five years, starting at 50 years old, or 10 years below the age of the youngest affected first-degree relative. Patients with a personal history of CRC or polyps or those who fall into special risk groups (e.g. IBD) may need more frequent screening.

Treatment of colon cancer

Upon diagnosis, a CT scan and PET scan can help stage the disease. Long-term survival depends on the stage at diagnosis, with 90 percent five-year survival for early stages.

Surgical intervention and resection is the most common treatment for CRC. This may be performed alone or in conjunction with chemotherapy and radiation therapy, depending on the stage. In some circumstances, chemotherapy, radiation therapy and biologic agents may be used alone or in combination to relieve symptoms or prolong survival. Hepatic lobectomy, cryotherapy, or radio frequency ablation can be used for certain situations where there may be liver metastases.



Summary

CRC is a common yet highly preventable condition. Colon polyp detection and removal remains the mainstay of intervention. Lifestyle changes that may help prevent colon polyps include limiting or eliminating red meat, smoking cessation, management of obesity, exercise, decreasing alcohol intake, and supplementing diet with vitamin D and calcium. These interventions can help with other disease prevention as well.

**Images from the American Cancer Society.*

SAMARITAN REGIONAL TUMOR REGISTRY

2009 Summary

The tumor registry is a database of information collected from all five Samaritan Health Services' hospitals. This information is reported to the Oregon State Cancer Registry (OSCaR) to track the incidence, treatment and outcomes for cancer and benign brain tumors. The tumor registry facilitates cancer conferences and responds to data requests.

Cancer conferences are multidisciplinary meetings that discuss treatment options for prospective cancer patients. Cancer conference attendance increased from 2008 to 2009. About 200 more people attended the conferences from 2008 to 2009.

The tumor registry provides the community with data. Our data requests normally come from researchers, physicians and students. The information provided by our cancer registry promotes cancer awareness and research. The following information is a sample of data collected from 2009.

Table 1 outlines the total number of cancer cases the tumor registry abstracted in 2009 and how this data has changed since 2008. The tumor registry abstracted 1,525 cases in 2009. The number of annual cases abstracted from 2008 to 2009 decreased slightly by 30 cases. (See Table 1)

Table 2 shows the top ten most common cancers diagnosed or treated at Good Samaritan Regional Medical Center and the percentage of increase or decrease of the cancer incidence rates from 2008 to 2009. The top five most common cancers diagnosed at SHS are breast, lung, colon/rectum, prostate and bladder, respectively. Breast cancer remains the most common cancer in our community. The incidence of breast cancer has increased 1 percent over the last year. There were 199 new breast cancer cases diagnosed and/or treated at GSRMC in 2009.

Lung cancer remains the second most common cancer in our community. The incidence of new lung cancer cases has decreased by 9 percent over the last year. Colon and rectum cancer remains the third most common cancer and the incidence of this type of cancer increased by 1 percent in 2009. Prostate cancer is the fourth common cancer. Prostate cancer incidence has decreased by 30 percent over the last year—the highest incidence decrease over the top five most common sites. Bladder cancer remains the fifth most common cancer in our community. The incidence of bladder cancer has decreased by 24 percent over the last year. Breast and colon cancer incidence rates are slightly increasing while lung, prostate and bladder cancer rates are declining in incidence. (See Table 2)

Table 3 highlights the counties that we serve and the percentage of our cancer cases that were residing in that specific county at diagnosis or treatment. Forty-three percent of our 2009 cancer patients were living in Linn County. Thirty-three percent of cases resided in Benton County and 19 percent resided in Lincoln County. We also served patients currently residing in California, Alaska and Montana. (See Table 3)

Tables 4 through 8 illustrate the top five cancers diagnosed or treated at each SHS facility in 2009 and their stage at diagnosis. Breast cancer cases were often detected at stage 1 of the disease. Lung cancer cases were detected at stage 4. Colon and prostate cancer cases were frequently diagnosed at stage 2. Bladder cases were often detected at stage 0 or 1. Stomach cancer was commonly diagnosed or treated at stage 3. (See Tables 4-8)

Table 1: Annual Accessions per SHS Facility and the Change in Accessions from 2008 to 2009

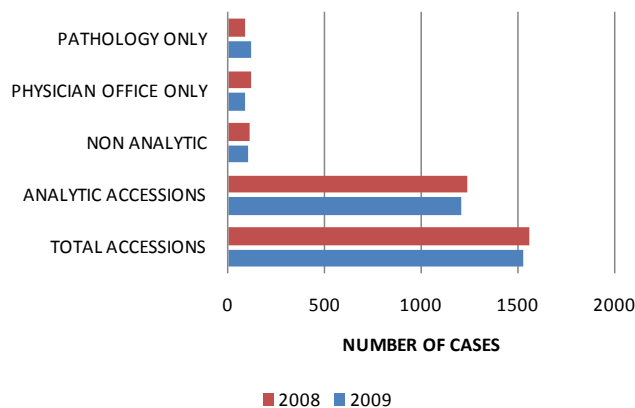
2009 SAMARITAN REGIONAL TUMOR REGISTRY YEARLY ACCESSIONS PER FACILITY

	GSRMC	SAGH	SLCH	SNLH	SPCH	TOTAL
TOTAL ACCESSIONS	942	263	164	70	86	1525
ANALYTIC ACCESSIONS	737	220	132	58	62	1209
NON ANALYTIC	62	8	15	7	16	108
PHYSICIAN OFFICE ONLY	80	0	0	0	7	87
PATHOLOGY ONLY	63	35	17	5	1	121

SAMARITAN REGIONAL TUMOR REGISTRY CHANGE IN ACCESSIONS FROM 2008

	2009	2008
TOTAL ACCESSIONS	1525	1555
ANALYTIC ACCESSIONS	1209	1238
NON ANALYTIC	108	114
PHYSICIAN OFFICE ONLY	87	118
PATHOLOGY ONLY	121	85

SAMARITAN REGIONAL TUMOR REGISTRY 2009 VS 2008



GSRMC = Good Samaritan Regional Medical Center
 SAGH = Samaritan Albany General Hospital
 SLCH = Samaritan Lebanon Community Hospital

SNLH = Samaritan North Lincoln Hospital
 SPCH = Samaritan Pacific Communities Hospital

Table 2: Top Ten Most Common Cancers and Percentage Differential from 2008 to 2009**TOP 5 SITES FOR GSRMC**

2008		2009		CHANGE
Breast	197	Breast	199	1%+
Lung	141	Lung	128	9%-
Colon/Rectum	73	Colon/Rectum	74	1%+
Prostate	67	Prostate	47	30%-
Urinary Bladder	34	Urinary Bladder	26	24%-
Lymphoma/NH	27	Lymphoma/NH (6th Ed)	31	13%+
		Pancreas	22	
		Kidney	18	
		Thyroid (6th Ed)	16	
		Corpus Uteri - Carcinoma	16	

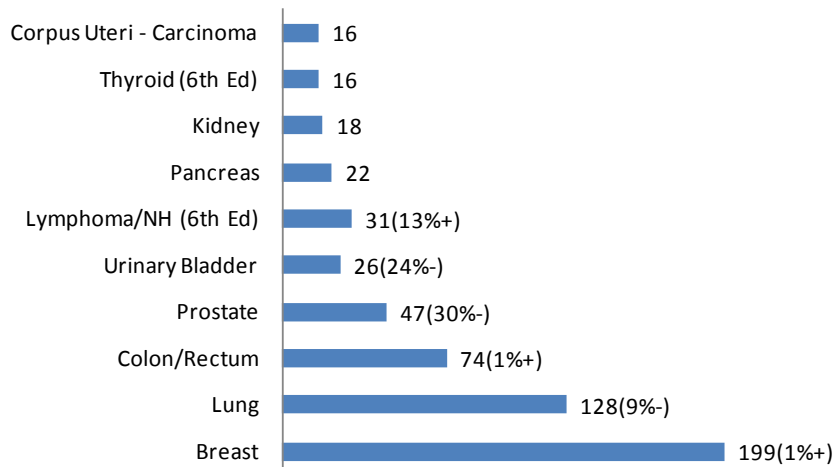
GSRMC TOP 10 SITES

Table 3: County Of Residence At Cancer Diagnosis

County	STATE	CASES
Juneau Borough	AK	1
San Joaquin	CA	1
Musselshell	MT	1
Yamhill	OR	1
Umatilla	OR	1
Tillamook	OR	5
Polk	OR	15
Marion	OR	10
Linn	OR	321
Lincoln	OR	138
Lane	OR	4
Jackson	OR	1
Clackamas	OR	1
Benton	OR	242
Total		742

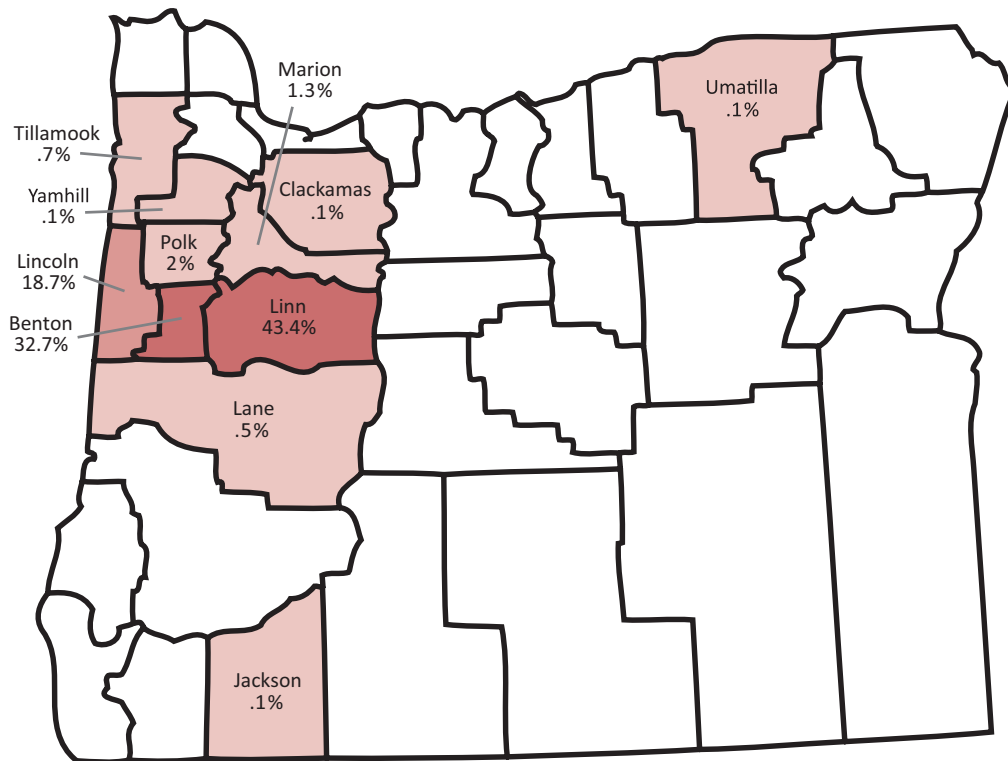


Table 4: The Top 5 GSRMC Cancers of 2009 and Stage of Cancer at Diagnosis

	STAGE					
	0	1	2	3	4	Unknown
Breast (199 cases)	36	97	40	9	5	2
Lung (128 cases)	0	27	7	30	62	2
Colon/Rectum (74 cases)	2	16	14	13	19	10
Prostate (67 cases)	0	0	42	2	2	1
Lymphoma/Non-Hodgkins (31 cases)	0	7	4	9	11	0

GSRMC TOP 5 AND STAGE

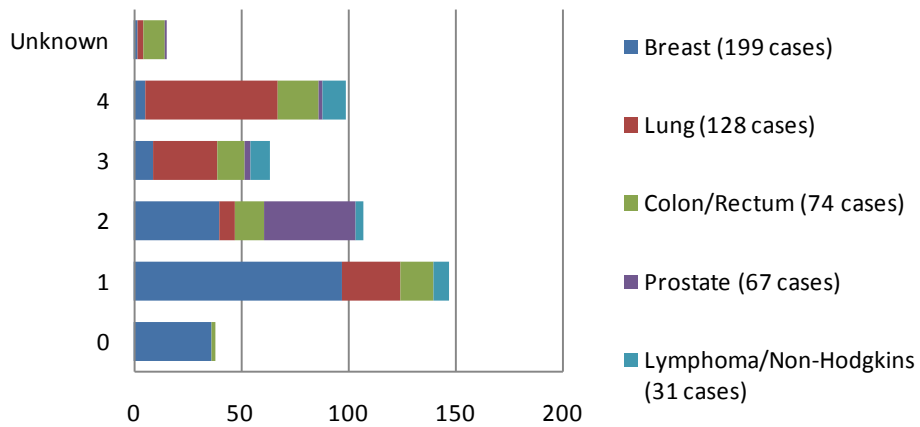


Table 5: The Top 5 SAGH cancers of 2009 and Stage of Cancer at Diagnosis.

	STAGE					
	0	1	2	3	4	Unknown
Breast (89 cases)	24	39	18	4	3	1
Lung (23 cases)	0	6	0	8	9	0
Urinary Bladder (20 cases)	8	7	2	2	1	0
Lymphoma/Non-Hodkins (16 cases)	0	3	2	9	2	0
Colon/Rectum (16 cases)	0	3	5	2	3	1

SAGH TOP 5 AND STAGE

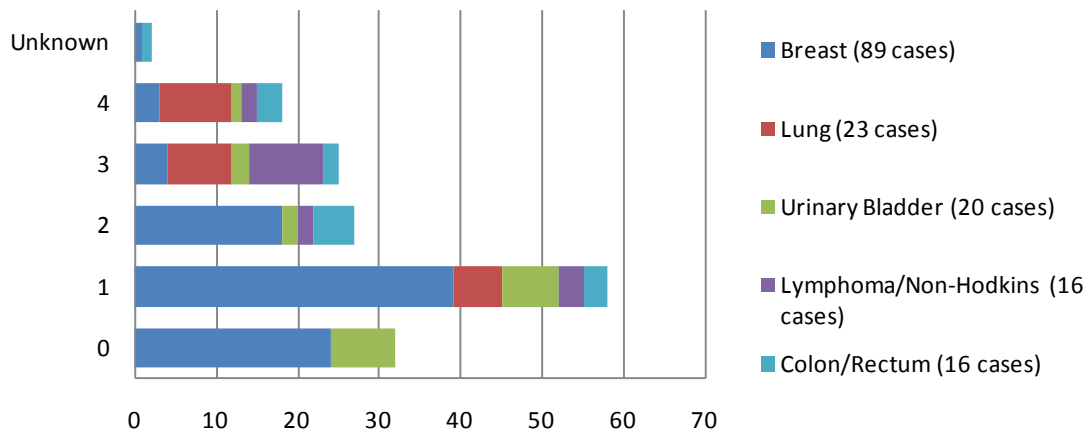


Table 6: The Top 5 SLCH Cancers of 2009 and Stage of Cancer at Diagnosis

	STAGE					
	0	1	2	3	4	Unknown
Breast (30 cases)	4	14	8	3	0	1
Lung (22 cases)	0	2	1	3	16	0
Colon/Rectum (21 cases)	0	4	2	7	5	0
Lymphoma/Non-Hodgkins (11 cases)	0	4	0	4	3	0
Urinary Bladder (7 cases)	2	3	1	0	0	0

SLCH TOP 5 AND STAGE

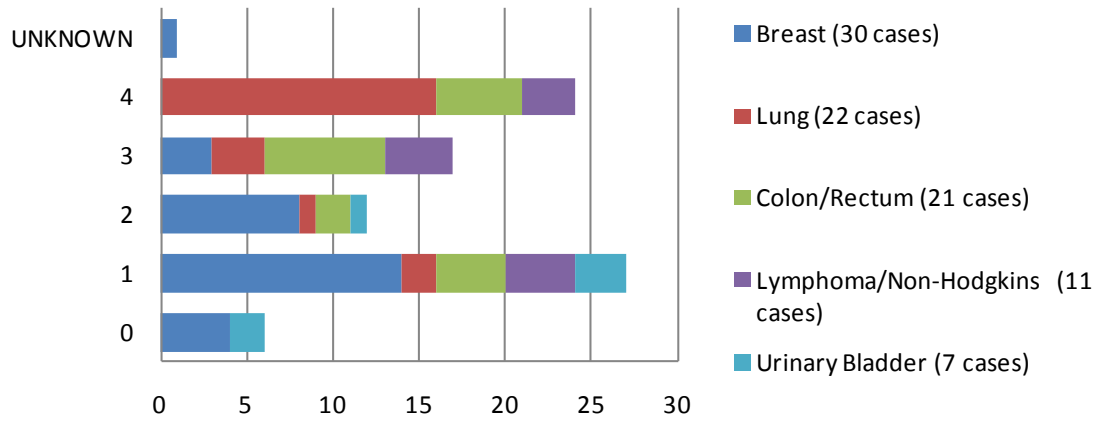


Table 7: The Top 5 SNLH cancers of 2009 and Stage of Cancer at Diagnosis

	STAGE					
	0	1	2	3	4	Unknown
Colon/Rectum (11 cases)	0	4	4	0	3	0
Breast (10 cases)	1	3	3	2	1	0
Prostate (8 cases)	0	1	7	0	0	0
Lung (6 cases)	0	1	0	1	4	0
Urinary Bladder (4 cases)	4	0	0	0	0	0

SNLH TOP 5 AND STAGE

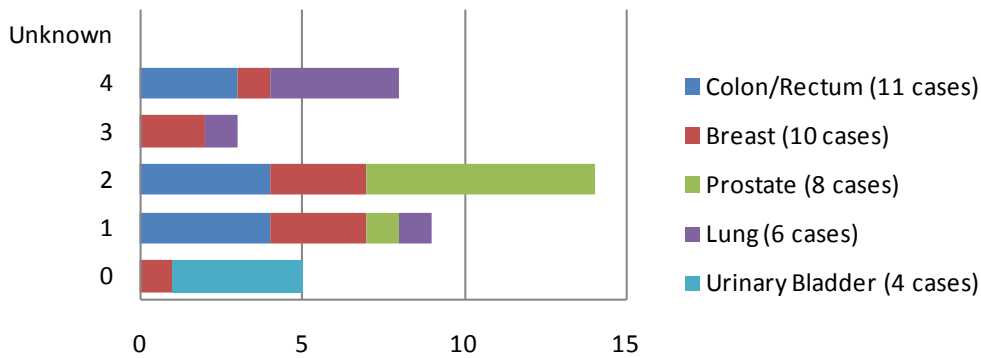


Table 8: The Top 5 SPCH Cancers of 2009 and Stage of Cancer of Diagnosis

	STAGE					
	0	1	2	3	4	Unknown
Breast (14 cases)	2	4	4	4	0	0
Lung (8 cases)	0	2	0	3	3	0
Colon/Rectum (6 cases)	0	1	2	2	0	0
Stomach (5 cases)	0	1	0	1	3	0
Urinary Bladder (4 cases)	1	2	1	0	0	0

SPCH TOP 5 AND STAGE

