

The background of the cover features a complex, abstract design. It consists of numerous thin, curved lines in various shades of blue and white, creating a sense of movement and depth. In the upper right quadrant, there is a grid-like pattern of small dots, which transitions into the curved lines. The overall effect is a modern, high-tech aesthetic.

**Saint John's Cancer Center
Annual Report
for 2007**

SAINT JOHN'S CANCER CENTER

At Saint John's Cancer Center, we approach cancer diagnosis and treatment in a holistic way with care of the body mind and spirit. People might be surprised to find world class cancer services in a community the size of Anderson. Yet, in this city of 57,000, Saint John's Health System has assembled the latest technology and services for the detection and treatment of cancer.

5-Day Radiation Treatment for Post-Lumpectomy

This past year, we were one of only a few in the country to begin offering Mammosite and SAVI, the newest 5-day radiation treatment for post-lumpectomy breast cancer.

MammoSite therapy is a partial breast irradiation, in which the radiation is concentrated to the area where a lump was removed. The radiation device is actually a small, soft balloon attached to a thin catheter and inflated inside the lumpectomy cavity. Twice a day for five days, a radioactive seed is placed inside the balloon by an electronic device connected to the catheter. The seed is removed after about 10 minutes, leaving no radioactive material in the patient's body between sessions.

After the final dose of radiation, the catheter and deflated balloon are removed and the incision is covered with a small bandage. Most women who've had the procedure said they felt no pain during or after the treatment. These results are attained with minimal side effects, including occasional redness, bruising, breast pain, or drainage from the treatment site.

Saint John's was one of the first hospitals in the country to use the SAVI applicator as an alternative to MammoSite in treating early-stage breast cancer. The applicator contains multiple catheters and is inserted within the breast where the tumor was removed. It is a single-entry device, and limits the damage to healthy tissue.

Dr. Darrel Ross, Radiation Oncologist at Saint John's Cancer Center, explained that the new applicator allows greater precision during post-lumpectomy radiation. "In patients whose tumor was close to the skin or chest wall, the SAVI allows us to decrease the dose to these critical structures," said Ross. "The multiple catheters allow us to more strategically place the dose where we need it."

Aside from SAVI's precision and preservation of healthy tissue, another advantage is the treatment's speed. Like the MammoSite procedure, radiation is administered with SAVI twice a day for 5 days—not the typical 7 weeks. "At Saint John's, we treated 3 out of the first 8 SAVI patients in all of Indiana," Ross said. These patients were among the first 25 in the country to be treated with SAVI. "We are happy with the outcome of these treatments, and are pleased to be able to let women in our community know of their options."

Research Protocols

We are in the top 5% of hospitals our size nationwide for research through Radiation Therapy Oncology Group.

Saint John's Health System committed to care for everyone, regardless of ability to pay. Free mammograms, pap tests and osteoporosis screenings are provided for women who qualify financially through Marie's Hope.

Saint John's has been recognized for excellence in cancer care by earning accreditation from the American College of Surgeons Commission on Cancer.

Cancer is so limited, and we are so much stronger for our fight against it.

2007 Cancer Frequency of Top Sites SJHS compared to National

Men			Women		
	SJHS	National		SJHS	National
Prostate	21%	29%	Breast	33%	26%
Lung	17%	15%	Lung	14%	15%
Colorectal	11%	10%	Colorectal	14%	11%
Hematopoietic	9%	7%	Hematopoietic	12%	7%

Total number of analytic cases 2007 SJHS = 358

Saint John's Cancer Registry maintains a 95% follow-up rate out of a target 90% rate to meet national standards.

Stage of Disease	ENTER	0.0 yr	1.0 yr	2.0 yr	3.0 yr	4.0 yr	5.0 yr	95% Confidence Interval
Stage 0	2322	100.0	99.5	98.7	97.6	96.0	94.7	93.7 - 95.7
Stage I	5539	100.0	98.9	97.3	94.9	92.9	90.2	89.4 - 91
Stage II	4349	100.0	97.6	93.5	89.0	84.7	80.6	79.4 - 81.9
Stage III	950	100.0	94.4	82.0	71.8	64.9	58.3	55.1 - 61.5
Stage IV	459	100.0	65.3	45.8	35.0	25.8	21.3	17.5 - 25
Stage of Disease	ENTER	0.0 yr	1.0 yr	2.0 yr	3.0 yr	4.0 yr	5.0 yr	
Stage 0	77	100.0	97.4	96.1	93.4	90.7	89.2	
Stage I	183	100.0	96.7	95.6	91.6	89.9	85.7	
Stage II	108	100.0	100.0	96.3	98.0	94.9	93.1	
Stage III	29	100.0	96.5	81.1	85.7	83.3	57.1	
Stage IV	15	100.0	60.0	77.8	57.1	75.0	66.7	

National Cancer Data Base Stats from 1998 to 2002
 including 47 facilities in Indiana
 Compared to
 Saint John's Data
 Breast Cancer Survival Comparison Data

We continue to monitor our Breast Cancer Data in
 preparation to be a National Accredited Breast Cancer
 Center in the future.

Meet Our Team:

Every patient is under the care of a radiation oncologist or a medical oncologist, cancer specialists with expertise in the application of radiation therapy or chemotherapy drugs as they are used in the management of cancer.

In Radiation Therapy, our goal is to develop and implement treatment programs geared toward maximizing the chances of curing cancer while minimizing the radiation dose to normal organs, thus attempting to maintain your quality of life and preserve your normal organ function. Our radiation oncologists maintain a commitment to your well being.

Patient-focused chemotherapy is provided on an outpatient basis in the Chemotherapy, IV Injections and Transfusion Unit.

Darrel Ross, M.D.

Clinical Director, Saint John's Cancer Center
Specialty: Board Certified in Radiation Oncology
Medical School: Wayne State University School of Medicine
Internship: Internal Medicine, Oakwood Healthcare System, Mich.
Residency: Radiation Oncology, Henry Ford Hospital, Detroit, Mich.
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Robert Ash, MD

Specialty: Board Certified in Hematology and Medical Oncology
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Head and Neck Cancer

Primary cancers of the head and neck region are relatively rare. Approximately 40,000 patients are newly diagnosed annually with squamous cell carcinoma of the head and neck. This represents 4-5% of the total number of cancers diagnosed per year in the United States. Nearly sixty percent of the newly diagnosed head and neck population presents with locally advanced but non-metastatic disease. Locoregional failure constitutes the predominant recurrence pattern, and most fatalities result from uncontrolled local and regional disease. Although the vast majority of head and neck cancers arise from epithelial elements, their natural history differs considerably according to disease location. This is related to regional anatomical differences that dictate patterns of contiguous and lymphatic spread. The extent of the lesion and the presence of numerous critical normal tissues in the head and neck area, injury to which could result in serious functional impairment, are obstacles to local-regional disease eradication.

Given that the majority of patients present with locally advanced disease, surgical resection is often not an option. Radiation therapy alone has long been the standard non-surgical therapy. However, chemotherapy has played an increasing role in sensitization as well as decreasing metastatic disease in recent years. Beyond concurrent chemotherapy and radiation therapy are the newer targeted agents that appear to benefit local control and survival while decreasing toxicity. In addition, radiotherapy techniques are improving to minimize dose to normal structures while maximizing dose to the tumor volumes. All of these recent advances have helped to result in a decline in the mortality rate for patients with head and neck cancer.

Head and Neck Clinical Trial Protocols

Currently, Saint John's Research Institute has two open RTOG clinical trial protocols for the treatment of head and neck cancer. RTOG 514 is a head and neck tissue bank. Patients with head and neck cancer consent to have their cancerous tissue sent to a tissue bank for analysis and to promote future cancer research. Patients may also consent to have normal tissue from the inside of the cheek, saliva sample and blood work sent to the research tissue bank for studies. The purpose of this study is to find out better ways to find and treat head and neck cancers by collecting and storing tissue and bodily fluids for future research. This will hopefully assist doctors and other medical scientists to find better ways to:

1. Find cancer early
2. Determine how cancer spreads and resists current types of treatment
3. Treat cancer
4. If possible, cure people who have cancer

To date, Saint John's has enrolled 23 patients into the head and neck tissue bank.

The second study open is an Advanced Head and Neck Protocol. This is a randomized Phase III trial using Accelerated Radiation and a chemotherapy agent – Cisplatin VS Accelerated radiation with – Cisplatin and Cetuximab [followed by surgery for selected patients for treatment of stage III and IV head and neck cancer. The purpose of this study is to compare the effects of radiation and chemotherapy with radiation, chemotherapy and Cetuximab on head and neck cancer to find out which one is a better treatment. Cetuximab may delay or prevent tumor growth by blocking certain cellular chemical pathways that lead to tumor development.

Head & Neck Sites Diagnosed in 2007

	Male	Female
Base of Tongue	3	0
Unspecified parts of tongue	4	0
Floor of mouth	1	0
Parotid Gland	0	1
Tonsil	1	0
Oropharynx	2	0
Pyriform Sinus	3	0
Hypopharynx	1	0
Larynx	3	0
Total:	18	1

There are 14 head and neck sites with 71 sub-sites. This makes it difficult to compare our data with national statistics. In 2007 SJHS diagnosed 19 cases of head and neck cancers with two unknown primaries of the head and neck.

BESTSTG	ENTER	0.0 yr	1.0 yr	2.0 yr	3.0 yr	4.0 yr	5.0 yr	95% Confidence Interval
0	291	100.0	97.8	94.1	91.4	86.2	84.1	79.1 - 89
I	2870	100.0	94.0	84.6	78.7	73.1	68.8	66.8 - 70.7
II	2045	100.0	86.7	71.5	63.0	57.1	52.8	50.4 - 55.3
III	2321	100.0	78.7	63.0	56.4	52.6	49.1	46.9 - 51.4
IV	5974	100.0	69.3	53.5	46.5	41.7	38.6	37.2 - 39.9

Observed survival for tongue

BESTSTG	ENTER	0.0 yr	1.0 yr	2.0 yr	3.0 yr	4.0 yr	5.0 yr	95% Confidence Interval
0	1638	100.0	96.5	93.2	89.2	83.7	79.8	77.5 - 82.1
I	9134	100.0	95.6	89.2	83.7	78.6	73.4	72.3 - 74.4
II	4367	100.0	89.4	78.2	70.2	63.6	57.4	55.7 - 59.1
III	4303	100.0	82.1	68.2	58.6	52.4	47.2	45.5 - 48.8
IV	6600	100.0	70.9	50.9	42.2	36.1	32.0	30.7 - 33.2

Observed survival for larynx

BESTSTG	ENTER	0.0 yr	1.0 yr	2.0 yr	3.0 yr	4.0 yr	5.0 yr	95% Confidence Interval
I	2700	100.0	96.3	91.9	88.5	85.2	81.6	79.9 - 83.3
II	634	100.0	89.4	79.3	73.6	69.1	62.3	58 - 66.5
III	370	100.0	89.0	77.0	69.0	62.9	56.7	51 - 62.4
IV	1691	100.0	71.0	52.9	42.1	35.7	31.1	28.7 - 33.5

Salivary Gland (Parotid Gland)

BESTSTG	ENTER	0.0 yr	1.0 yr	2.0 yr	3.0 yr	4.0 yr	5.0 yr	95% Confidence Interval
0	205	100.0	94.5	87.5	84.0	78.8	74.1	66.9 - 81.3
I	1032	100.0	94.2	85.3	77.8	71.5	66.0	62.6 - 69.4
II	770	100.0	87.4	74.7	67.6	59.0	53.3	49.3 - 57.4
III	534	100.0	81.1	60.5	53.9	47.9	40.7	36 - 45.3
IV	1711	100.0	64.6	42.5	34.1	29.1	25.5	23.2 - 27.8

Floor of Mouth

BESTSTG	ENTER	0.0 yr	1.0 yr	2.0 yr	3.0 yr	4.0 yr	5.0 yr	95% Confidence Interval
0	56	100.0	90.9	81.7	79.3	76.7	70.4	56.5 - 84.4
I	445	100.0	92.5	83.5	76.3	70.7	65.8	60.7 - 70.8
II	893	100.0	92.6	80.9	76.1	71.6	67.9	64.4 - 71.3
III	1793	100.0	88.3	78.8	71.5	66.7	63.4	60.9 - 65.9
IV	4539	100.0	79.8	66.3	59.8	55.2	51.7	50.1 - 53.3

Tonsil

BESTSTG	ENTER	0.0 yr	1.0 yr	2.0 yr	3.0 yr	4.0 yr	5.0 yr	95% Confidence Interval
0	24	✖ Insufficient cases to display survival information						
I	181	100.0	89.7	75.7	68.0	57.9	54.1	46 - 62.2
II	257	100.0	85.5	70.6	58.3	50.4	45.4	38.6 - 52.1
III	425	100.0	72.6	55.6	45.2	40.6	36.6	31.6 - 41.7
IV	1286	100.0	62.2	42.8	35.2	30.5	28.0	25.3 - 30.6

Oropharynx

BESTSTG	ENTER	0.0 yr	1.0 yr	2.0 yr	3.0 yr	4.0 yr	5.0 yr	95% Confidence Interval
0	29	✖ Insufficient cases to display survival information						
I	229	100.0	90.9	77.8	67.1	60.1	54.2	46.8 - 61.6
II	494	100.0	78.9	59.3	50.3	42.8	38.1	33.4 - 42.8
III	910	100.0	75.5	55.0	42.9	36.0	29.9	26.5 - 33.3
IV	2955	100.0	59.1	37.8	28.9	24.5	21.6	19.9 - 23.2

Hypopharynx

BESTSTG	ENTER	0.0 yr	1.0 yr	2.0 yr	3.0 yr	4.0 yr	5.0 yr	95% Confidence Interval
0	14	✖ Insufficient cases to display survival information						
I	81	100.0	76.7	62.0	48.9	41.9	36.7	25 - 48.4
II	155	100.0	77.3	63.7	52.5	45.0	40.7	31.8 - 49.5
III	242	100.0	69.6	53.1	45.1	36.1	29.8	23.3 - 36.4
IV	661	100.0	57.0	35.4	28.4	24.3	20.9	17.4 - 24.3

Pyramiform sinus (Pharynx)