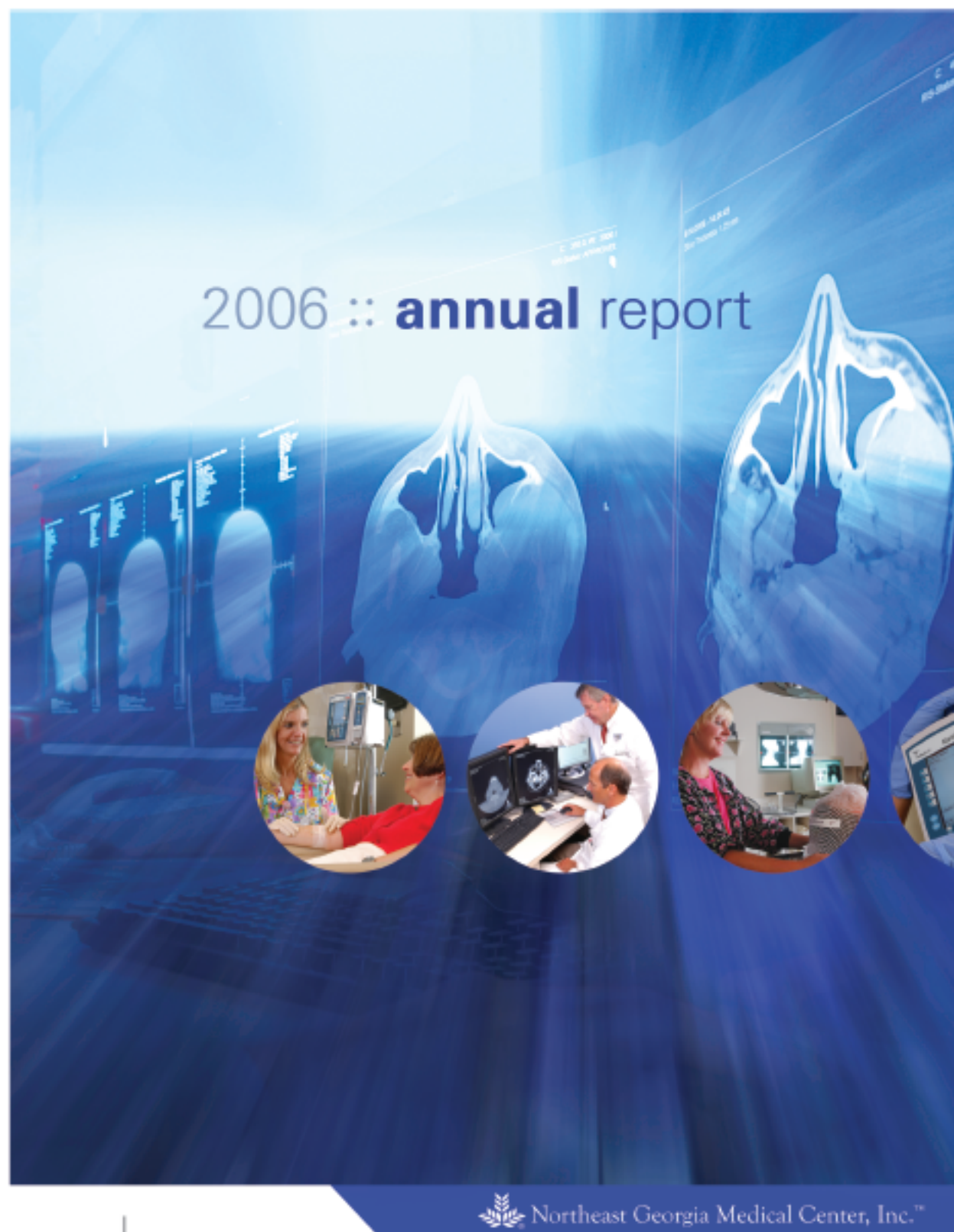


Cancer Services Overview

for Northeast Georgia Medical Center



The
Cancer Center

The Cancer Center at Northeast Georgia Medical Center continues to grow as it provides state-of-the-art treatment and compassionate care close to home. As technologic advances and new cancer therapies become available, the Cancer Center has become a leader in delivering cancer care in north-east Georgia.

This year, the American College of Surgeons awarded a three-year accreditation with commendation to the Cancer Center. This designation recognizes that our cancer program exceeded national standards in delivering cancer care. For patients, that means they can expect to receive the best cancer care possible here.

This year, the Cancer Center implemented digital mammography, and by the end of the year, will be providing breast MRI. Additional upgrades to MRI capabilities will enhance diagnostic imaging for GI and GU malignancies including hepatocellular, rectal and prostate cancers. With the rapid growth of the Cancer Center, Radiation Oncology will require physical expansion, to accomodate plans for the radiosurgery program and Image Guided Radiation Therapy.

The clinical trials program at the Cancer Center continues to be strong, again exceeding the previous years' number of patient accruals. This year, more than eight percent of patients participate in clinical trials, a proportion quadruple national averages.

The strength and reputation of the Cancer Center is due to the dedicated physicians, nurses and healthcare professionals committed to a multi-disciplinary team approach to cancer care. We strive to provide compassionate and cutting edge care to the community we serve.

Richard LoCicero, MD, Medical Oncologist
2006 Chairman, Cancer Committee

*2006 Annual Report reflects data from 2005

2006 Cancer Committee Members

Carson Agee, MD	Surgeon
Bradley Auffarth, MD	Surgeon
Pierpont Brown, MD	Surgeon
Allen Butts, MD	Surgeon
David Carroll, MD	Radiologist
Joe Conway, MD	Pathologist
Ken Dixon, MD	Surgeon
Casey Graybeal, MD	Surgeon
Jack Griffith, MD	Radiation Oncologist
Andre Kallab, MD	Medical Oncologist
Anup Lahiry, MD	Medical Oncologist
Frank Lake, MD	Radiation Oncologist
Ron Lewis, MD	Surgeon
Richard LoCicero, MD – Chairman	Medical Oncologist
Chris Malone, MD	Surgeon
Charles Nash, MD	Medical Oncologist
Richard Olson, MD – Co-Chairman	Surgeon
Antonio Rios, MD	Internist
Nancy Stead, MD	Medical Oncologist
Priscilla Strom, MD	Surgeon
Randall Thomas, MD	Medical Oncologist
Geoff Weidner, MD	Radiation Oncologist
Dan Winston, MD	Surgeon
David Woo, MD	Urologist
Natalie Allison	Outpatient Case Management
Tom Enright	Oncology Administration
Kimberly Kamppi	Performance Improvement
Dianne Kosmala	Cancer Registrar
Beth Meers	Chief Radiation Therapist
Randall Miller	Chief Radiation Physicist
Vicki Miller	Regional Network Marketing
Jolinda Martin	Administration
Paula Pitts	Inpatient/OP Manager
Patti Rotunda	Registry/Research Manager
Jeff Thompson	Clergy
Donna Topping	Pharmacy
Teresa Warren	Hospice

2005 Registry Overview

Nancy Stead, MD, Medical Oncologist

The number of cases entered into the NGMC cancer registry continues to increase (Figure 1). Twelve hundred cases were identified during 2005.

The most frequent cancers continue to be breast, prostate and lung with primaries in the colon being almost fifty percent less frequent (Figure 2). These primaries comprise 61 percent of analytic cases. Non-Hodgkin lymphoma, melanoma, hematologic malignancy, bladder and thyroid primaries each represent four percent of cases. With the exception of lung cancer, the rank order of malignancies at NGMC parallels that of the country as a whole.

Soft tissue sarcomas are a mixed group of malignancies which have in common their origin in the non-bone musculoskeletal tissues; fat, muscle, fibrous tissue and blood vessel are included. The frequency of gastrointestinal stromal tumor is increasing because immunohistochemical staining for c-kit protein enables its differentiation from other soft tissue sarcomas. NGMC doctors have entered enough patients in the American College of Surgeons adjuvant chemotherapy trial for this disease that awareness of this hospital's cancer program is occurring outside of Georgia.

The frequency of cancers in women again parallels that of men when the sixth decade is reached; however, in the fourth and fifth decades there are more cases in women than in men (Figure 3). Eighty percent of malignancies in the fourth decade and more than 50 percent of

Figure 1
1980 – 2005 Annual Analytic Case Load Total

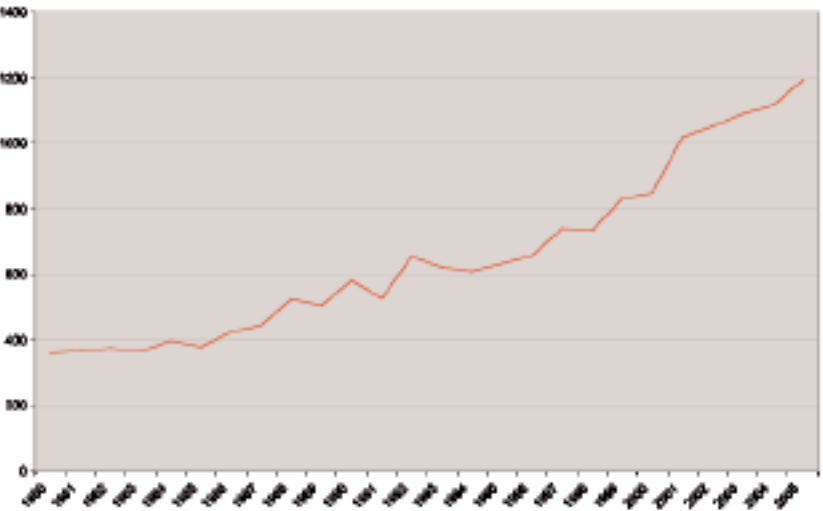
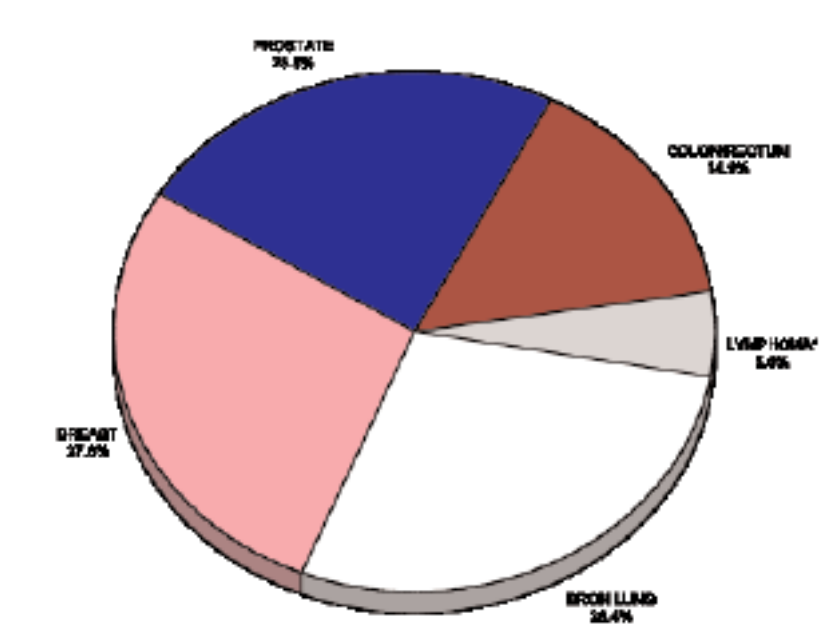


Figure 2
Northeast Georgia Medical Center
Top Five Sites

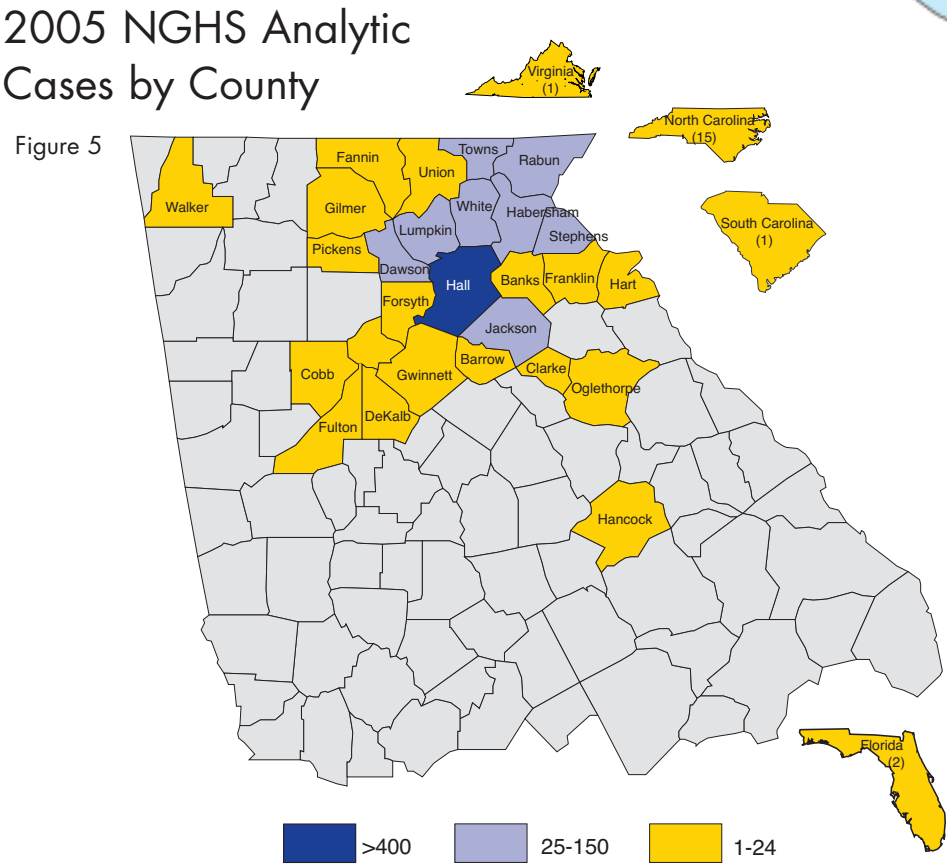
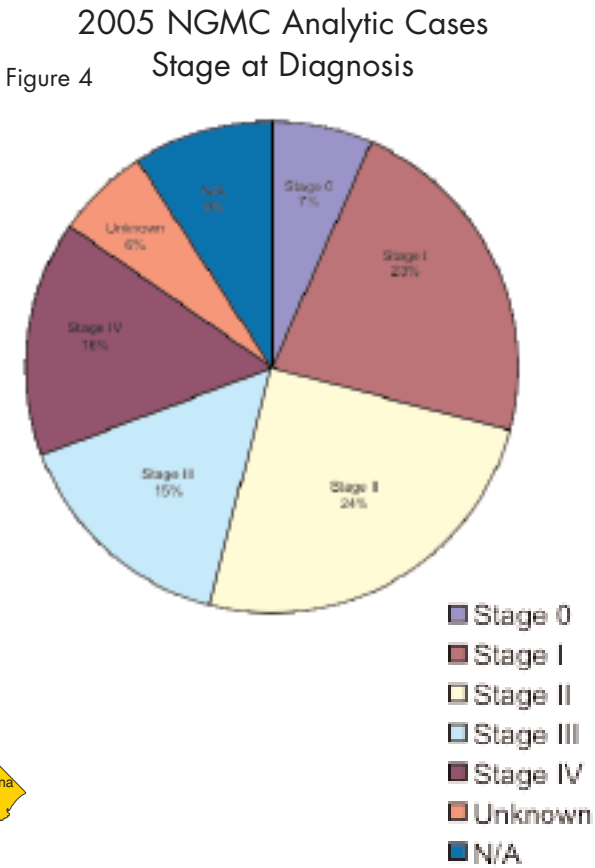
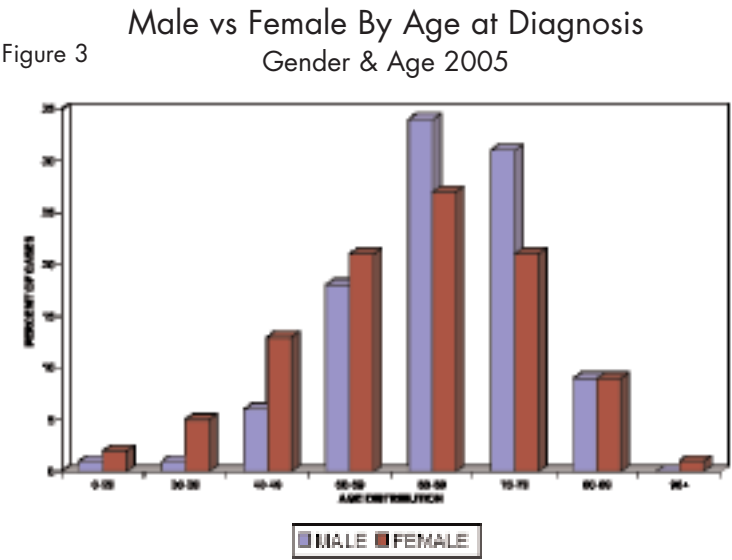


those in the fifth decade occur in females. Ninety to 100 percent of the excess frequency of cancer results from breast adenocarcinomas.

Cancer screening is effective. Only nine patients had invasive cervical carcinoma. The percentage of prostate and breast malignancies identified at stages 0 – 2 is 88 and 79.6 respectively. Only 52 percent of colon malignancies present at stages 0 – 2 disease probably because people are more willing to undergo

screening by mammography or measurement of PSA level than by colonoscopy. There is no proven screening test for lung cancer. Stage 0 – 2 disease occurs only 26 percent of the time (Figure 4).

The Cancer Center at NGMC is a regional resource. Fifty-four percent of patients reside outside Hall County. Thirty percent reside in counties served by the Toccoa Cancer Center (Figure 4).



Site Overview: Thyroid

Ken Dixon, MD, FACS, surgical oncologist

The thyroid gland lies low in the neck in front of the windpipe, guarding it like a shield, after the Greek word for shield, “thyreos.” Its function is to produce thyroid hormone, an iodine containing protein which is secreted into the bloodstream. This hormone then acts as a governor on the degree of activity of the other organs in the body.

Most cancers of the thyroid are within the well-differentiated family of cancers called papillary or follicular cancers. These comprise 95 percent of the total 30,000 cancers of the thyroid that occur annually within the U.S. Most thyroid cancers are diagnosed by the presence of an otherwise asymptomatic mass within the thyroid. While most of these nodules are benign, one of the issues with management of these patients is the relative inability to tell which thyroid nodules are cancerous and which are benign.

Aspiration of some thyroid cells with a small needle can often give guidance about whether the nodule is benign or suspicious for cancer. However, while less than 10% of all solitary nodules are cancerous, because of uncertainty as to the diagnosis, surgeons not infrequently end up operating and removing the thyroid, or part of it, in many patients in whom the ultimate diagnosis turns out to be benign (see Figure 1). Fortunately, surgeons across the world and here in Gainesville are able to do this surgery with a very low complication rate. And, best of all, the success rate in curing thyroid cancers is excellent with a long term cure rate of well over 90 percent.

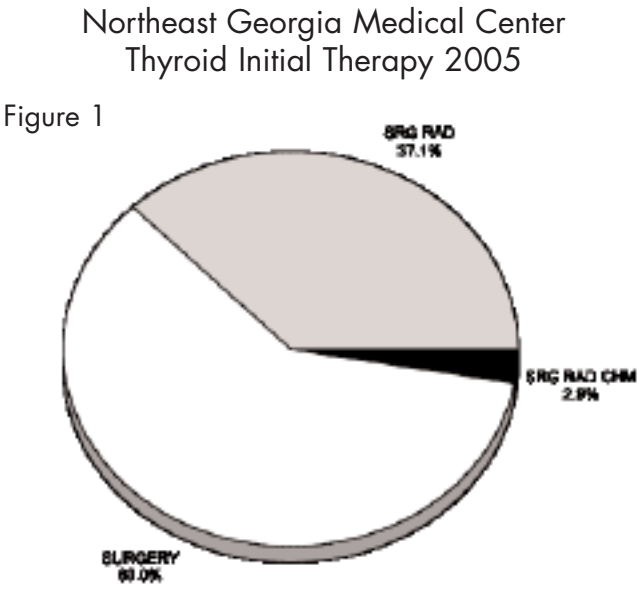
In the patient who ends up having the thyroid, or part of it, removed because of a thyroid cancer, some-

times the only other treatment is replacement of the thyroid hormone that the patient is no longer able to make. However, many patients also receive additional treatment in the form of a tablet of radioactive iodine. This iodine is preferentially taken up by any remaining thyroid cells, thus wiping out potential residual malignancy.

Thirty-five patients had thyroid cancer treated here at Northeast Georgia Medical Center in 2005. Of these, 31 were of the less aggressive papillary and follicular types. One was a medullary carcinoma, one an oxyphilic carcinoma, one lymphoma, and one anaplastic carcinoma.

Twenty patients underwent a total thyroidectomy, three a subtotal thyroidectomy, and 12 a thyroid lobectomy only. As is the case across the rest of the U.S. and world, this non-uniformity of degree of surgical resection reflects the fact that most patients do well with these cancers, even if different treatment regimens are utilized. Thirteen patients then were additionally treated with radioactive Iodine 131.

On a programmatic note, over the last two years, two endocrinologists, Drs. Matthey Harris and Carla Suarez-Welch, have joined the medical staff at NGMC. They bring welcome additional expertise in the management of the thyroid patient. Also, Dr. David Carroll has assumed the leadership of the nuclear medicine department, which is central to the delivery of radioiodine to these patients. These positive additions at NGMC will allow further expertise in the delivery of radioactive iodine to the thyroid patient that needs it, as well as clarification of which patients should be viewed as candidates for



radioactive iodine and which should be observed only.

This writer holds the hope that, with the evolution of our local medical community and hospital system to the sophisticated level of tertiary healthcare provision which our region deserves, we will work diligently together to further standardize and optimize our treatment agendas for this and other malignancies. In this way, we can ultimately fulfill the motto of NGMC – to improve the health of this community in all that we do.

Thyroid Cancer Overview

- 95% of the total 30,000 cancers of the thyroid that occur annually within the U. S. are within the family of cancers called papillary or follicular cancers.
- Thirty-five patients had thyroid cancer treated at Northeast Georgia Medical Center in 2005. Of these, 31 were of the less aggressive papillary and follicular types.
- Aspiration of some thyroid cells with a small needle can often give guidance about whether the nodule is benign or suspicious for cancer.
- While less than 10 percent of all solitary nodules are cancerous, because of uncertainty as to the diagnosis, surgeons often remove the thyroid, or part of it, in many patients in whom the ultimate diagnosis turns out to be benign.



2005 Primary Site Table

for the Cancer Center at Northeast Georgia Medical Center

	Total Cases	Class of Case		Male	Female	AJCC TNM Stage							
		Analytic	Non-Analytic			Analytic Only							
				all cases		0	1	2	3	4	99*	88**	
Oral Cavity***	37	33	4	27	10	0	5	2	6	13	7	0	
Lip	5	4	1	5	0	0	2	1	0	0	1	0	
Base of Tongue	3	2	1	1	2	0	0	0	0	1	1	0	
Other parts of tongue	6	6	0	4	2	0	1	1	2	1	1	0	
Other parts of mouth	3	3	0	3	0	0	1	0	0	2	0	0	
Tonsil	6	5	1	5	1	0	0	0	1	2	2	0	
Pyriform Sinus	3	3	0	2	1	0	0	0	2	1	0	0	
Digestive Cavity	216	199	17	133	83	8	37	45	37	51	17	4	
Esophagus	20	19	1	15	5	0	2	5	2	6	4	0	
Stomach	17	16	1	12	5	1	5	2	1	3	3	1	
Small Intestine	8	7	1	4	4	0	1	2	1	0	1	2	
Colon	87	79	8	49	38	5	14	18	19	21	2	0	
Rectosigmoid JCT	3	3	0	2	1	0	0	1	2	0	0	0	
Rectum	27	24	3	20	7	2	7	8	3	4	0	0	
Anus and Anal Canal	3	3	0	2	1	0	0	1	0	0	2	0	
Liver - Intrahep Bile Ducts	9	8	1	4	5	0	1	0	2	2	3	0	
Gallbladder	2	2	0	1	1	0	1	0	0	1	0	0	
Pancreas	22	20	2	12	10	0	0	6	2	10	2	0	
Respiratory	254	237	17	152	102	0	55	12	73	84	8	5	
Larynx	15	15	0	11	4	0	6	2	4	3	0	0	
Bronchus/Lung	239	222	17	141	98	0	49	10	69	81	8	5	
Heart	9	7	2	6	3	0	1	1	1	0	3	1	
Heart	7	6	1	4	3	0	1	1	1	0	3	0	
Bones/Jnts/Art Cart OT	2	0	2	1	1	0	0	0	0	0	0	0	
Blood/Bone Marrow	102	66	36	71	31	N/A	N/A	N/A	N/A	N/A	N/A	66	
Hematopoietic/Reticuloen	57	38	19	38	19	N/A	N/A	N/A	N/A	N/A	N/A	38	
Multi Myeloma	20	15	5	16	4	N/A	N/A	N/A	N/A	N/A	N/A	15	
Leukemia	25	13	12	17	8	N/A	N/A	N/A	N/A	N/A	N/A	13	
Skin	41	35	6	22	19	2	14	3	5	4	7	0	
Conn, Subq & Oth Soft	12	9	3	8	4	0	1	1	3	0	4	0	
Breast	239	216	23	4	235	38	80	54	22	9	12	1	
Female Genital	60	47	13	0	60	3	15	5	7	5	9	3	
Vulva	4	2	2	0	4	0	0	0	1	1	0	0	
Cervix Uteri	9	9	0	0	9	0	3	1	3	0	2	0	

Corpus Uteri	25	21	4	0	25	0	9	3	2	1	4	2
Ovary	20	13	7	0	20	1	3	1	1	3	3	1
Male Genital***	226	194	32	226	0	0	4	167	16	6	0	1
Prostate Gland	219	187	32	219	0	0	0	167	13	6	0	1
Testis	6	6	0	6	0	0	4	0	2	0	0	0
Urinary	88	74	14	67	21	26	32	6	4	4	2	0
Kidney	39	33	6	27	12	0	23	1	3	4	2	0
Renal Pelvis	3	2	1	2	1	2	0	0	0	0	0	0
Bladder	42	35	7	35	7	21	8	5	1	0	0	0
Meninges	8	7	1	2	6	0	0	0	0	0	0	0
Brain	15	11	4	7	8	0	1	0	0	0	0	10
Thyroid Gland	37	35	2	5	32	1	28	0	2	2	2	0
Adrenal Gland	2	2	0	1	1	0	0	0	0	0	0	2
Other Endocrine Glands	1	1	0	1	0	0	0	0	0	0	0	0
Hodgkin Disease	5	4	1	2	3	0	1	0	1	2	0	0
Non-Hodgkin Lym.	47	38	9	27	20	0	13	8	4	11	2	0
Unknown Primary Site	38	37	1	21	17	0	0	0	0	0	0	37

Totals 1362 1193 169 728 634 78 270 299 177 188 73 101

* Stage unknown
** Stage not applicable
***Total includes cases not listed by site



Kidney/Renal Pelvis Cancer

By David Woo, MD, urologist

Kidney cancers include malignancies that affect the concentrating portion of the kidney – renal cell carcinoma – and the collecting portion of the kidney – transitional cell carcinoma of the renal pelvis. Kidney and renal pelvis cancers account for about three percent of all cancer cases in the U.S.

Kidney cancer incidence has been rising at a rate of about two percent a year for the last 65 years with men having about twice the incidence as women. This rising trend is thought to be, at least partly, due to the increased number of tumors found incidentally from abdominal imaging such as computerized tomography (CT) before the cancer is symptomatic. (Figure 1)

Mortality from kidney cancer has increased slightly over the past two decades, though not as rapidly as the incidence. In 2006, an estimated 38,890 new cases of renal cancer are expected to be diagnosed and about 12,840 are expected to die.

Locally, the incidence of kidney cancers in northeast Georgia has been on the rise as well. In 2005, there were 42 new cases of renal cancers, up from 19 in 2000. The five year survival by stage of patients at NGMC diagnosed with kidney cancers compares favorably with the national averages (see Figures 2 and 3).

The overall five year survival rate for all stages is about 50 percent both locally and nationally.

The traditional treatment for renal cancers has been complete surgical removal of the involved organ through an extensive open incision (radical nephrectomy). Selected patients with malignant tumors, particularly those in whom the removal of large amounts of renal tissue would result in the significant loss of renal function, are appropriately treated with removal of only the involved portion of the kidney (partial nephrectomy).

In this era of minimally invasive surgery, many of these same procedures can be performed laparoscopically through smaller and less morbid incisions. Novel approaches, such as radiofrequency ablation of renal tumors, have shown promise in treating these cancers effectively with minimal blood loss or change in renal function.

Currently, these ablative techniques are reserved for patients who cannot tolerate the traditional surgical treatments. All of these therapies are in use at NGMC and the specific procedure chosen is based on multiple factors: size and location of tumor, number of tumors, renal function, and co-morbid conditions.

Patients with metastatic disease benefit from a multi-disciplinary approach where

Fig. 1
Northeast Georgia Medical Center
Gender and Stage at Diagnosis • Kidney Cases 2005

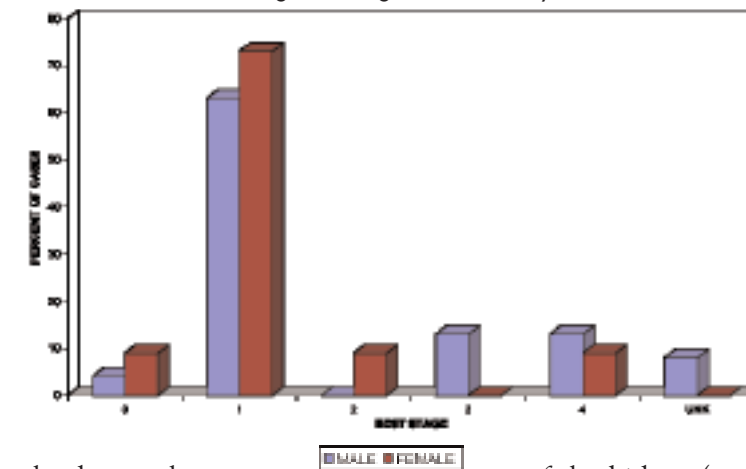
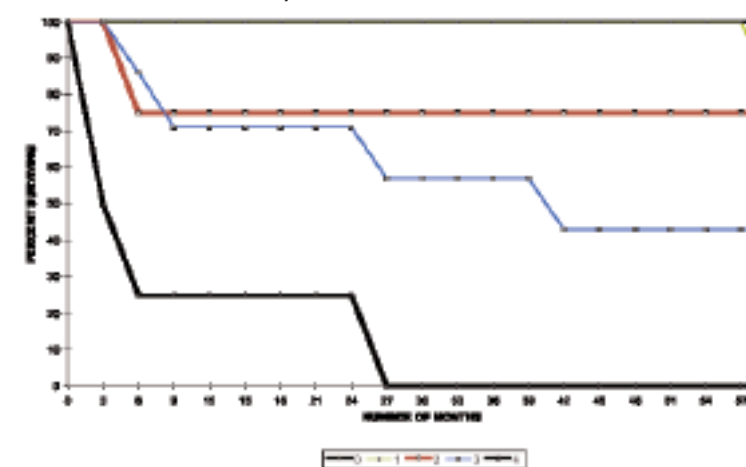


Fig. 2
Northeast Georgia Medical Center
Kidney/Renal Pelvis Survival 2000

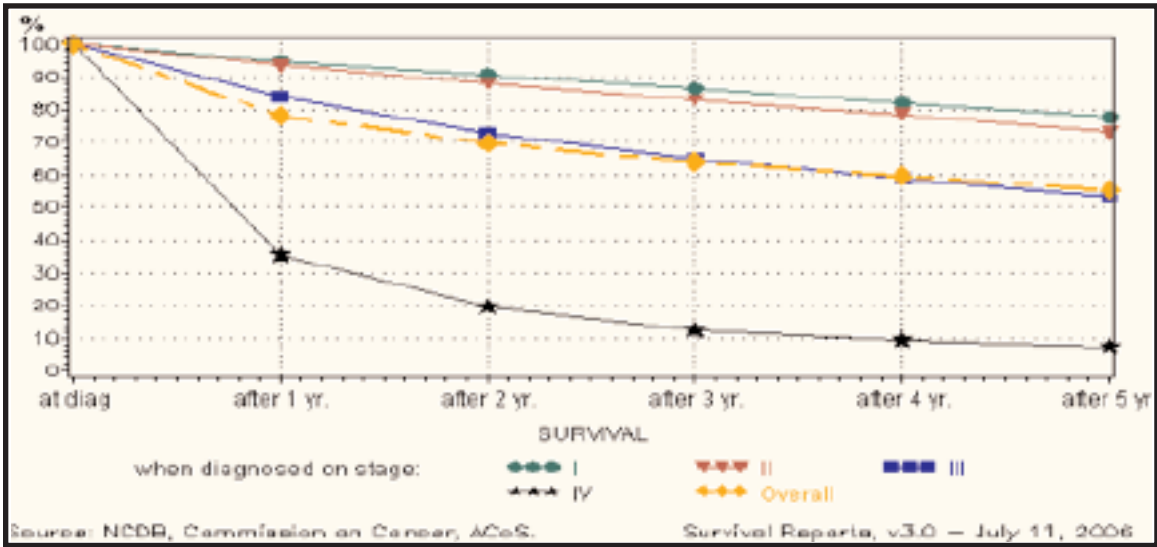


Five Year Surv. Rates for Kidney and Renal Pelvis
Cancer Cases Diagnosed in 1998
All States / Data Reported from 1251 Hospitals
Hospitals of Type: All

input from medical oncologists, radiation oncologists, surgeons, pathologists, radiologists and ancillary services are shared. Combination therapy involving immunotherapy, chemotherapy, radiation and surgical debulking often

is required in treating and palliating the spread of kidney cancer. Newer and more promising therapeutic approaches for advanced kidney and renal pelvis cancers have been developed as our understanding of the body’s natural immune response to malignancy grows.

Figure 3



New Breakthroughs in Kidney Cancer Therapy

Charles H. Nash, III, MD, medical oncologist

At the recent annual meeting of the American Society of Clinical Oncology held in Atlanta in June 2006, exciting new results of clinical trials were reported in front of a standing-room only crowd of thousands of physicians and researchers. Noted authorities labeled that presentation session a “banner day for kidney cancer.”

Two new agents, sunitinib (marketed as Sutent) and sorafenib (Nexavar), known in the medical oncology world as “targeted therapy,” were shown to have eclipsed previous therapies by impressive margins. The “target” appears to be the vascular endothelial growth factor and its related biochemical pathways. The mechanism of action seems to be their ability to control certain aspects of the growth and development and blood supply of cancers. These drugs were FDA approved in January 2006 and December 2005, respectively.



Sunitinib bested interferon therapy in terms of progression-free survival durations, 11 months vs. five months, and rate of response by 31 percent vs. 6 percent in patients with good to intermediate risk features. Sorafenib significantly improved overall survival duration by 39 percent compared to placebo and doubled progression-free survival duration to 24 weeks. These improved results also came with less toxicity than previous therapies. Both agents are oral medications as well. A third drug, temsirolimus, also improved overall and progression-free survival by 49 percent and 95 percent, respectively in poor risk patients.

These results also form the basis for new clinical trials that use the agents in combination with other therapies. Improved results also are expected when patient “cross over” from one drug to the next. It seems clear that a new reference standard for kidney cancer therapy has been achieved, and the future appears quite promising indeed.

Clinical Trials at the Cancer Center

Andre Kallab, MD, medical oncologist

As the Oncology Research Committee Chair for Northeast Georgia Health System (NGHS), I would like to express appreciation to the numerous physicians dedicated to offering their patients every option possible in regard to cancer treatment by referral to a clinical trial.

Through your diligence, 2005 was a record year for accrual to oncology clinical trials at NGHS with an enrollment of 8.5 percent of local analytical cases into clinical trials, compared to the national average of approximately four percent.

NGHS currently offers oncology clinical trials for all major cancer sites and, at any given time, approximately 50 to 60 trials are available for patient accrual. Many patients have had the opportunity to be treated with cutting edge therapies that would have otherwise been unavailable to them. The trials offered involve components such as chemotherapy, radiation therapy, surgery, hormone therapy, and more, performed in both adjuvant and neo-adjuvant settings.

In 2005, the Oncology Research department was approved to participate in two large-scale national clinical trials. The first is a Phase III trial for recurrent metastatic prostate cancer from Novacea, a pharmaceutical company.

This trial is one of the largest prostate trials ever conducted and involves U.S. as well as Canadian research sites. Anticipated patient enrollment is 900 males, and the study involves collaboration of both the patient’s urologist and a medical oncologist.

The second is the TAILORx trial, also known as Trial Assigning Individualized Options for Treatment (Rx). TAILORx examines whether genes that are frequently associated with risk of recurrence for women with early-stage breast cancer can be used to assign patients to the most appropriate and effective treatment.

The study will enroll more than 10,000 women at 900 sites in the U. S. and Canada. Women recently diagnosed with estrogen-receptor and/or progesterone-receptor positive, Her2/neu-negative breast cancer that has not yet spread to the lymph nodes are eligible for the study. TAILORx is sponsored by the National Cancer Institute (NCI), part of the National Institutes of Health (NIH), and is coordinated by the Eastern Cooperative Oncology Group.

For more information about these trials, or any other trials we are currently conducting, contact the NGHS Oncology Research department at 770-533-8820.

The Cancer Center

at Northeast Georgia Medical Center

Advanced care to help your patients in their fight against cancer.

When your patient is fighting cancer, he or she needs all the weapons possible. The physician specialists who practice at the Cancer Center at Northeast Georgia Medical Center want to work with you in providing the top-quality cancer care your patients need. Advanced diagnostic and treatment options available at the Cancer Center include:

Advanced Diagnostics

- PET/CT scans
- Endoscopic ultrasound staging for gastrointestinal and lung cancers
- Full range of other diagnostic technologies including breast MRI, digital mammography, interventional radiology and nuclear medicine

Medical Oncology

- Chemotherapy, hormone and biologic therapies

Radiation Oncology

- Intensity Modulated Radiation Therapy (IMRT)
- External beam conformal therapy and simulation
- Low Dose Rate (LDR) brachytherapy including prostate seed implants
- High Dose Rate (HDR) brachytherapy

Surgical Oncology

- Radiofrequency liver ablation (RFA)
- Sentinel lymph node mapping for breast cancer and melanoma
- Stereotactic breast biopsy

Research (Clinical Trials)

- Innovative, progressive therapies endorsed by the National Cancer Institute
- Multiple treatment options available through national research cooperative group and pharmaceutical companies

No longer do your patients have to travel to Atlanta – they can receive high-quality cancer care close to home through the physician specialists who practice at the Cancer Center.

To refer a patient or consult with a specialist at the Cancer Center, call 800-404-6400.

2006 Community Health Activities

The Cancer Center Community Outreach Programs reached a wide variety of people with cancer messages and screenings in 2006. Tobacco use prevention programs were provided to more than 450 4th and 5th grade students in the region. Prostate screenings served just over 110 men in three screenings. Messages of skin cancer prevention and cervical cancer awareness were promoted during the Tour de Georgia's Healthy Expo, and community events, like the Harvest of Hope and Relay for Life, provided opportunities to reach out to cancer survivors. Below is a sampling of some of the activities for the 2006 calendar year:

2006 Community Outreach & Education

DATE	Topic	Targeted Group	County(s) Served
March	Di De la Mujer: Breast Exams & Breast Health	Underserved Latina Women	Hall
	Beulah Rusker Health Fair: Breast Self-Exams & Tobacco-Use Prevention	Underserved African Americans	Hall
	Oncology & Hospice Nursing	Liberty Middle School Students	Forsyth
	Breast Exam Screenings & Breast Health Education	Underserved Women	Lumpkin
April	Tour de Georgia: Skin Cancer Prevention & Healthy Eating Habits	General Public	Lumpkin
	Tour de Georgia: Skin Cancer Prevention & Healthy Eating Habits	General Public	Towns
May	Cancer Screenings: Breast, Prostate, Skin & Oral	Underserved Men & Women	Stephens
	Senior Expo: Skin & Colon Cancer Information	Seniors	Stephens
June	Prostate Cancer Screening	Men	Hall
July	Breast Exam Screenings & Breast Health Education	Underserved Women	Hall
August	Breast Exam Screenings & Breast Health Education	Underserved Women	Hall
	Glory Radio Program: Prostate Cancer Awareness	General Public	Hall
Sept	Mall Walkers: Living Healthy Georgia	Seniors	Hall
	Prostate Cancer Screenings	Men	South Hall
	Prostate Cancer Screenings	Men	Hall
	Prostate Cancer Screenings	Men	White
	Women's Expo: Breast Exam Screenings & Breast Health Education	Women	Hall

2005 Tumor Board Education Conferences

SITES REVIEWED IN 2005 CANCER CONFERENCES

Bladder	5
Breast	67
Colon	21
Lung	23
Prostate	9
Head & Neck	7
Blood & Bone Marrow	1
Skin	6
Kidney	9
Thyroid	1
Liver/Pancreas	10
Sarcoma	5
GI Stromal	1
Other	29
Total	213

Tumor conferences provide physicians a venue for discussion that is invaluable to quality patient care. Cases are selected for presentation because immediate treatment decisions are needed, the case has unique and/or educational value, or follow-up information is being provided on a previously presented case. Tumor board conferences benefit physicians and patients by providing access to the latest information on treatment options and related issues.

In addition, continuing medical education (CME) seminars allow our expert cancer physicians to educate other members of our medical and clinical staff regarding new technology, advanced treatment options or other topics of interest.

An average of more than 20 physicians and 15 staff members attended 40 tumor board conferences or continuing education seminars. In the course of the year, 213 cancer cases were presented.

2006: A Year of Accomplishments

In 2006, the Cancer Center at Northeast Georgia Medical Center (NGMC) made significant progress. Our leadership developed a process for increased physician involvement through the development of a Physician Advisory Group and finalized Radiation Therapy's plans for a new linear accelerator (linac). The addition of a new linac at NGMC's Main Campus in Gainesville will allow us to provide stereotactic radiosurgery and imaged guided radiation therapy. Image guided radiation therapy also will be added at the satellite facility in Toccoa.

In addition, breast cancer diagnosis advanced significantly with the installation of digital mammography and breast MRI, improving our capability to diagnose breast cancers earlier which, in turn, improves our patient's chances for a positive outcome.

Our staff continues to log countless volunteer hours through expanded community outreach and, in 2006, served more than 1,500 individuals throughout northeast Georgia through cancer screenings and education. Through these various screenings, we have identified many cancers and assisted with coordinating follow-up treatment for those individuals.

Our research department staff also continues to maintain accruals at twice the national level. Our remarkable accrual rates are a credit to not only our study selection process but also the staff's commitment to making the process as easy as possible for the patient and physician. I also credit our medical staff who are willing to exert the extra effort to identify potential patients. We expect our clinical trials component to continue to grow and anticipate streamlining the process as much as possible through computerization.

Hospice of NGMC also had a record year. In addition to celebrating their 20th anniversary in November 2006, the Hospice program experienced phenomenal growth in patient days and was successful with increasing non-cancer patients to 52 percent of the total patient base, a direct result of educating physicians and case managers on appropriate Hospice referrals. Also, the oncology inpatient unit staff (5 East) was awarded an Oncology Nurse Society (ONS) grant for education on end-of-life care. Two nurses received advanced education on end-of-life issues and, following their training, held a well-received and attended course to educate nurses throughout NGMC.

On a whole, 2006 was a year of advancement and growth for the Cancer Center at NGMC. As our patient volumes increase, so will our expertise and ability to offer the most advanced care possible. We expect continued challenges in 2007, but with our commitment to the patient, I know we will accomplish our goals in 2007.



Thomas J. Enright, RN, MSN, MBA
Oncology Service Line Director



Congratulations to NGMC's Cancer Center recognized for excellence in cancer care

The boards of Northeast Georgia Medical Center and Northeast Georgia Health System congratulate the physicians and staff of The Cancer Center at Northeast Georgia Medical Center for their accomplishment in being granted **three-year accreditation with commendation** from the Commission on Cancer (COC) of the American College of Surgeons.

Approval by the COC is given only to those facilities that have voluntarily committed to **providing the highest level of cancer care** and that undergo a **rigorous evaluation and review of their performance and processes**.

Three-year accreditation with commendation is awarded when the program complies

with all COC standards and receives a commendation rating for at least one or more of the eligible categories of standards. Currently, the COC has eight categories of standards, and **the Cancer Center at NGMC received commendation in all eight categories**.

We want to express our gratitude to the **experienced physician specialists and highly trained clinical staff** whose hard work and dedication helped achieve this recognition of our comprehensive, multidisciplinary cancer care. We're proud to be a part of an organization that is committed to offering excellence in cancer care and **the latest in cancer treatment, close to home**.

The
Cancer Center
at Northeast Georgia Medical Center

