



All for One

2009 annual report/
statistical data for 2008

Baptist
CANCER SERVICES

All for One

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

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

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

While it's true that Baptist Cancer Services treats more cancer patients than any other hospital in Mississippi, it's also true that we only treat one patient--one patient at a time. We treat each patient like they were the only one.

From the ground up, Baptist Cancer Services seeks to pull all of our considerable resources together into one place to meet the needs of our patients. The very design of the Hederman Cancer Center emphasizes this: a patient walks through one door, and has immediate access to all the cancer services we offer.

WE ARE TRULY ALL FOR ONE.

On the cover: Hopes, prayers and joy go up along with the pink balloons as Baptist Cancer Services participates in the "Power of Pink," a community awareness and education initiative for breast cancer sponsored by the Baptist Breast Health Center and WLBT-TV3. The campaign brought a new level of awareness to central Mississippi for breast cancer warning signs and the importance of mammograms. Cancer Services staff and physicians were featured in community service spots and remote broadcasts. The month ended with an all-day event at Highland Village that featured a breakfast with Sweet Potato Queen Jill Connor-Browne, a fashion show, and the "Strength in Pink" awards presented by Mississippi's First Lady Marsha Barbour.



One Handprint, One Life at a Time

On Cancer Survivors Day, cancer survivors literally mark the occasion: they leave the mark of their handprints on a banner that proclaims to everyone that they have survived cancer.

Baptist Cancer Services has been celebrating with these remarkable individuals on Cancer Survivors Day each year for more than 20 years. It is our reward for everything we do to see so many of our patients come back and celebrate year after year. But this day is not just for our patients: it is our gift to the community to recognize and celebrate anyone who has been touched by cancer.

Just as no two people have the same handprints, no two people go through cancer treatment the same way. At Baptist Cancer Services, we work hard to build a relationship with each patient that recognizes that person's unique challenges, goals, and spirit. All of us celebrate their successes, whatever form that might take.

Opposite: Dennis Sheffield, a cancer survivor, leaves his handprint on the banner. In 2009, more than 250 people attended Cancer Survivors Day at Baptist.

The Difference One Person Can Make

Caring for cancer patients and supporting them through the rigors of treatment, can be overwhelming. It's a serious disease. The needs—physical, spiritual and emotional—are great. It can make you feel powerless at times.

That's why Baptist Cancer Services takes an active role in efforts to raise funds for the Patient Care Fund and the Serenity Garden at the Hederman Cancer Center. It gives individuals a chance to do something that can make a difference. One person's efforts can impact many people.

Take Gerry Ann Houston, MD, for example. She was instrumental in organizing and propelling efforts for the Cyclists Curing Cancer event. Proceeds are used for the ongoing maintenance of the Serenity Garden, pictured on pages 10-11, at the Hederman Cancer Center. The garden gives our cancer patients and their families a quiet, peaceful place to escape during sometimes long days of treatment.

But many individuals contribute to the Cancer Community Outreach Fund, which provides wigs, prostheses, and other items of a personal nature for cancer patients who do not have the resources to purchase them. These gifts help restore dignity to patients during a time when they may feel robbed of securities and comforts most of us take for granted.

One person can make a difference. And many people working together can make a big difference.

Opposite: Cyclists come from all over the state to participate in Cyclists Curing Cancer. This year's event included more than 175 cyclists.





It All Matters

Although each person's cancer journey is unique, cancer is by no means a one-dimensional experience. It affects the physical, emotional, mental and spiritual aspects of a person's life. And each facet affects all the others. When a person feels bad physically, it's not unusual for her to feel blue emotionally, or to struggle with doubts spiritually.

At Baptist Cancer Services, we do our best to meet all the needs of every individual, one person at a time. This is why we offer a variety of support services and programs throughout the week.

- Pet therapy dogs are frequent messengers of hope and light at the Hederman Cancer Center. As they pause for visits in waiting and treatment areas, their calm, happy natures relieve stress and bring joy to our patients and their families.
- Cancer Rehab provides cancer patients with a supervised, structured exercise program that harnesses the body's natural abilities to relieve stress, lift moods and empower patients in their own treatment and recovery.
- In Art Therapy, patients find emotional release as they capture their cancer journey in powerful artistic expression.
- As patients, employees and volunteers work on scarves, hats and other items in KnitTogether, they provide much-needed physical warmth for cancer patients, and heart-warming encouragement to one another.
- On staff at the Hederman Cancer Center is a clinical psychologist, who can provide individual, family or group counseling related to cancer treatment, recovery and survival. This counseling program is offered free of charge to patients at Baptist.

Opposite: Colorful hats and scarves from the KnitTogether group are a visible reminder to patients that they are not going through treatment alone.

All Eyes on One Case

Perhaps nowhere is the reality of our “all for one” mindset displayed more clearly than in the weekly Tumor Board meetings. Physicians and other clinical staff from every discipline involved in the care of cancer patients meet to review individual cases. All of them together bring their considerable expertise, experience and judgment to determine the best possible course of treatment for that person.

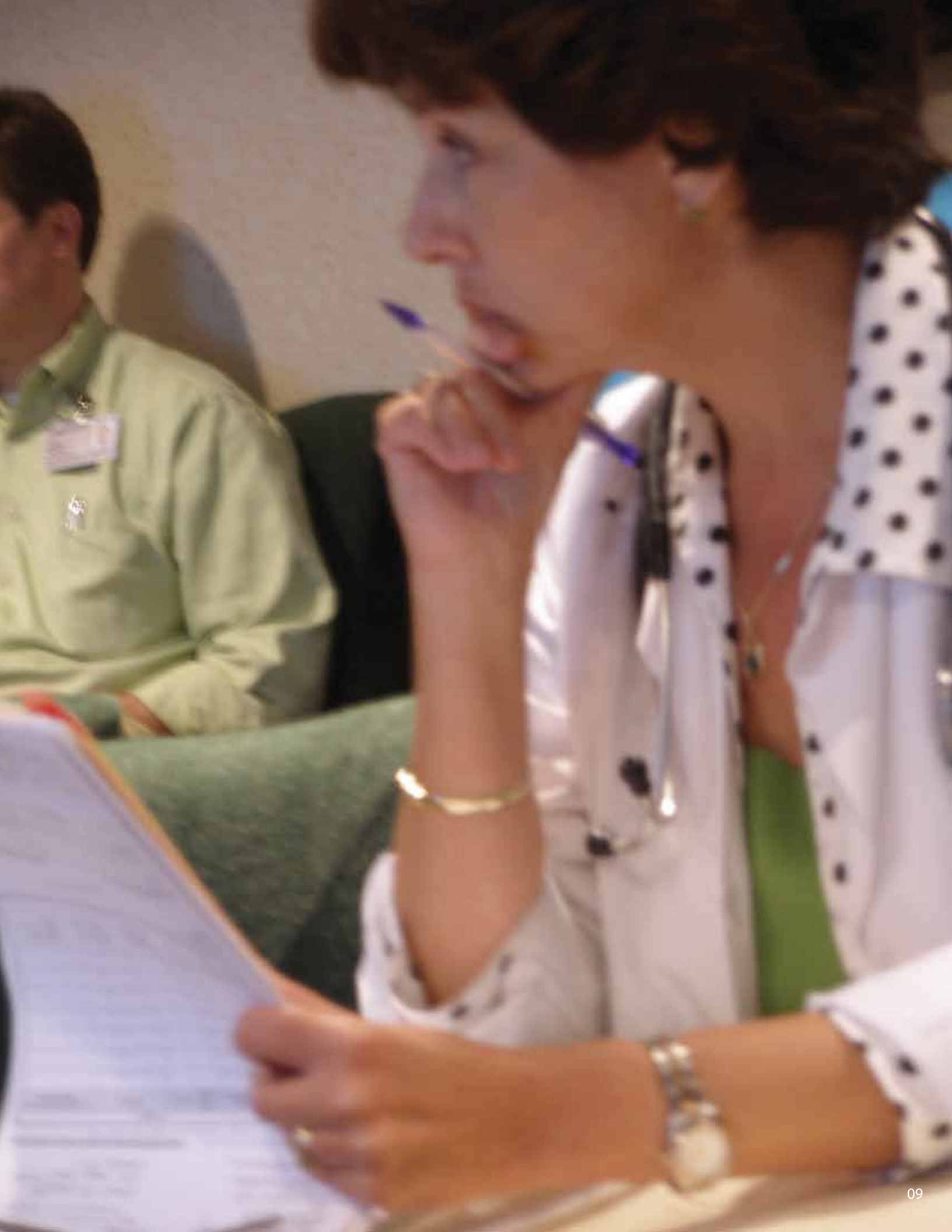
Surgeons, medical oncologists, radiation oncologists, radiologists, pathologists and support staff meet every Monday night to discuss cases. After a case is presented, robust discussion begins. Often, a very straightforward presentation with a seemingly obvious conclusion turns in a completely different direction based on one member’s observation and input.

And in a wonderful symmetry of ideas and practice, what they learn together as a group for one person helps each of these physicians as they treat other patients who have similar conditions.

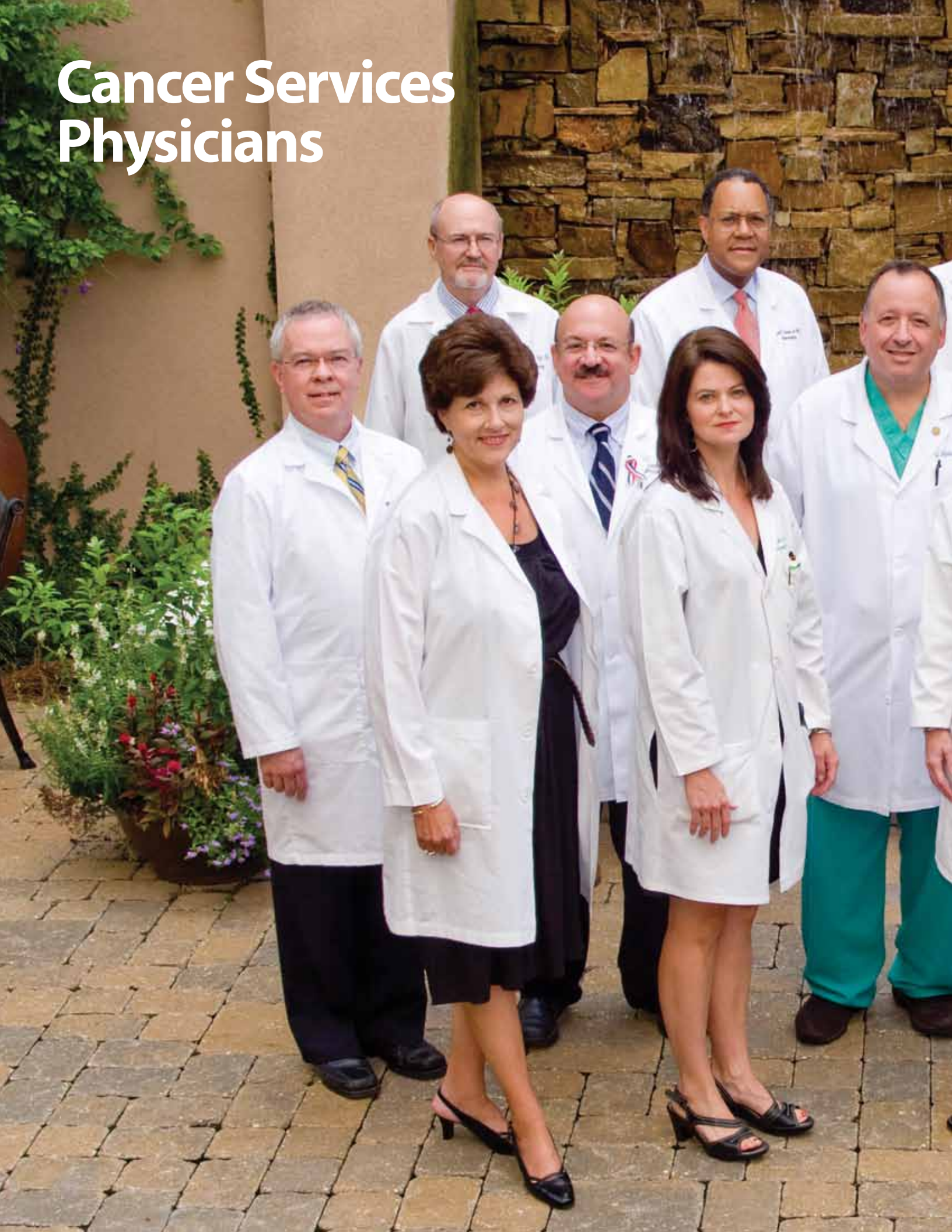
Baptist is fortunate to be staffed with physicians who look beyond the treatment room and routinely volunteer for community cancer screenings, educational seminars, webcasts, podcasts and other venues where their expertise helps minimize the impact of cancer in Mississippi.

During 2008, 1,775 new cases were added to the cancer registry. There were 1,578 analytic cases diagnosed and/or treated and 197 non-analytic cases seen at Baptist for recurrent disease. The geographic distribution of cases accessioned during 2008 reveals patients from 72 Mississippi counties. Additionally, there were 38 cases from out of state.

Opposite: Tumor Board meetings give physicians a forum for collegial discussion and review of complex cancer cases.



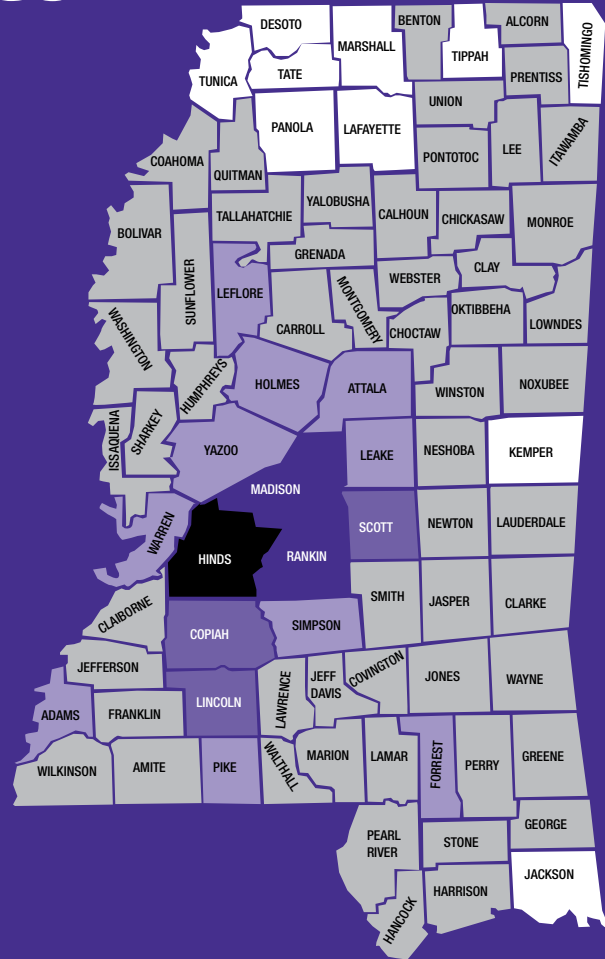
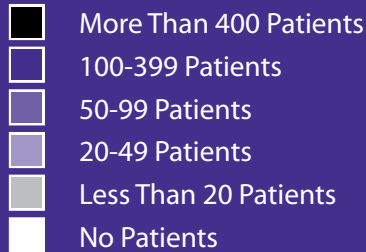
Cancer Services Physicians





2008 Cancer Cases

CASES BY COUNTY (1,775)



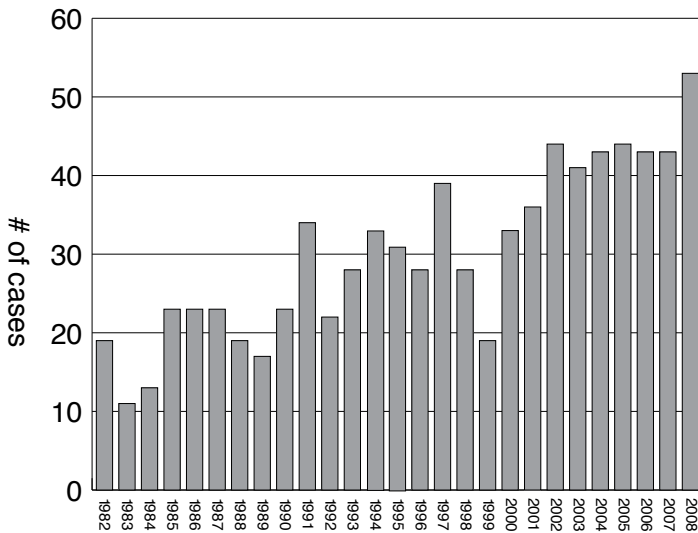
OUT-OF-STATE CASES (38)

- Louisiana - 25
- Arkansas - 4
- Florida - 2
- Alabama - 1
- California - 1
- Michigan - 1
- North Carolina - 1
- Tennessee - 1
- Texas - 1
- Washington - 1



INCIDENCE

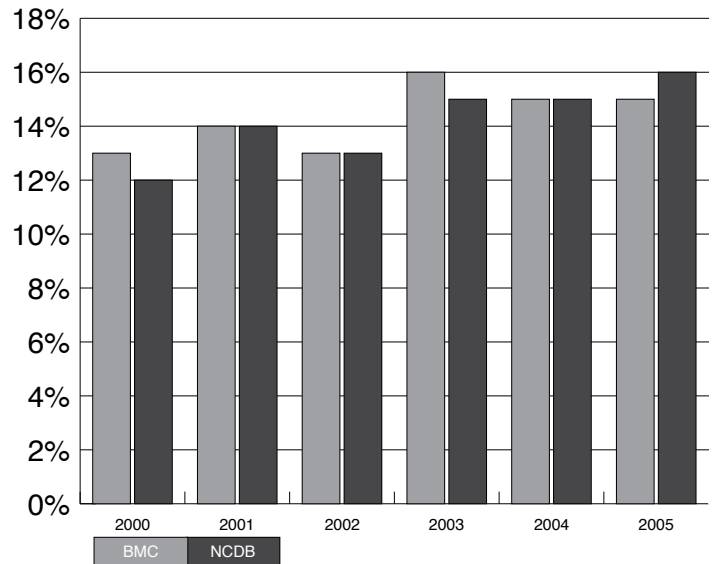
Renal cell carcinoma (RCC) accounts for approximately 3.5% of all malignancies and is the third most common cancer of the urinary tract. The American Cancer Society estimates 54,390 new cases of RCC will be diagnosed in 2008 and will cause 13,010 deaths in the U. S. (1)The Mississippi Cancer Registry accessioned 1781 new cases of RCC from 2003 to 2006 accounting for approximately 3.5% of all cancers in Mississippi. (2) Baptist Medical Center (BMC) Cancer Registry has accessioned 813 new cases of RCC between January 1982 and December 2008 which accounts for 2% of cases. (Graph 1)



BMC Incidence of Kidney Cancer

(Graph 1)

This review examines patterns of care and outcomes of RCC treated at BMC, as well as statistics from the National Cancer Data Base (NCDB). The NCDB is a nationwide oncology database of over 1500 hospitals founded as a joint project between the Commission on Cancer of the American College of Surgeons and American Cancer Society. The data comparison for this review is from Comprehensive Community Cancer Centers in the Mid-South Division which includes 9,170 RCC and renal pelvis cancer cases from 2000 to 2006 and survival data from 1998 and 2001. (3) BMC data includes 308 RCC and renal cell pelvis cancer cases that are newly diagnosed or treated from 2000 to 2006 and survival data from 1998 and 2001. Incidence of disease for BMC and NCDB groups is very similar. (Graph 2)



Incidence (Graph 2)

RISK FACTORS

Renal Cell Cancer is more common in men than women, and most patients diagnosed are between the ages of 50 and 70. The most prominent risk factor is cigarette smoking, which increases the risk of developing RCC twofold. Persons with a first-degree relative with RCC have a fourfold risk. Other less common risks include obesity (especially in women), analgesic abuse, high blood pressure and some hereditary diseases such as von Hippel-Lindau disease and polycystic kidney disease.

SYMPTOMS

There is no standard screening for RCC. The use of CT scan and ultrasound has enhanced early detection of RCC (25-40% are usually found incidentally during workup for another problem).

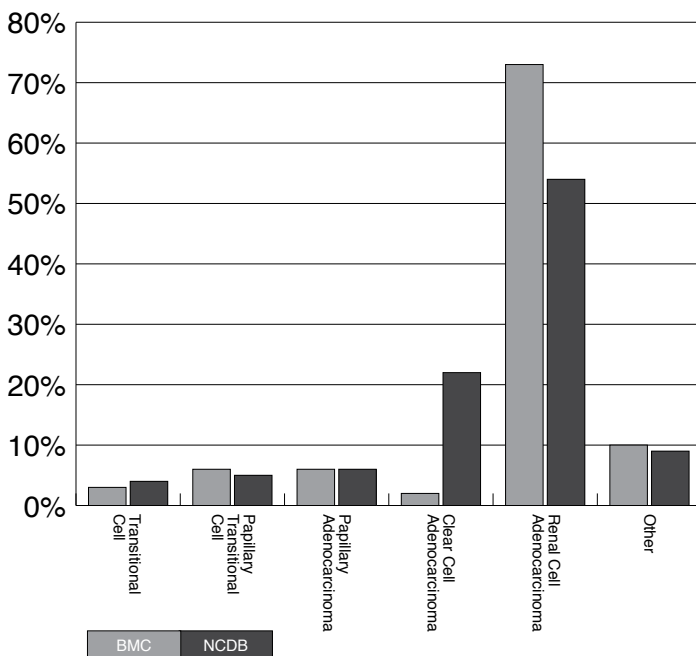
The most common symptom is hematuria, with other signs/symptoms to include abdominal pain, flank mass, hypertension, elevated blood calcium, and liver problems. Metastatic disease may produce weight loss, fever, and night sweats.

DIAGNOSIS

With the exception of those found incidentally, work up for RCC usually starts after patients develop complaints. The most sensitive test to determine the extent of tumor is CT scan. MRI has been helpful in detecting involvement of any of the large blood vessels. Chest x-ray and bone scan are usually included with the initial workup with CT guided needle biopsy performed to obtain a tissue diagnosis.

HISTOLOGY

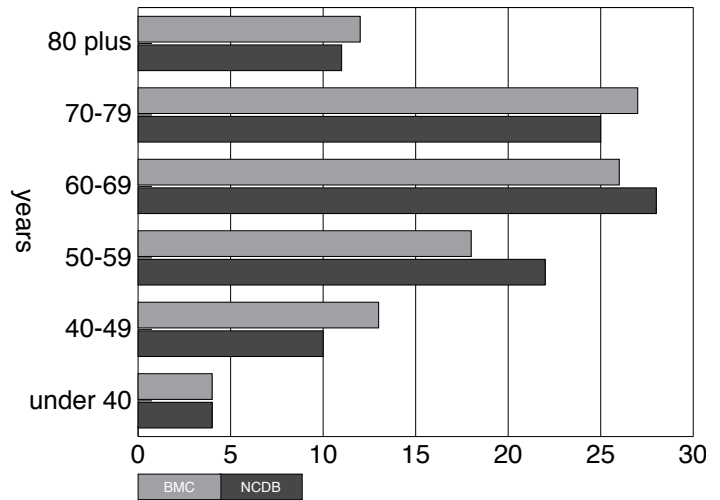
Approximately 85% of RCC tumors are adenocarcinomas of proximal tubular origin and are divided into two varieties, clear cell and granular carcinoma. The other 15% of cases are transitional cell carcinomas of the renal pelvis. Histological subtypes are similar for BMC and NCDB cases especially if clear cell and renal cell cases are grouped together. (Graph 3)



Histology (Graph 3)

AGE

Review of the age at diagnosis for BMC and NCDB showed similar results with 70% of patients being between 50 and 70 years old at BMC and 75% for NCDB. (Graph 4)

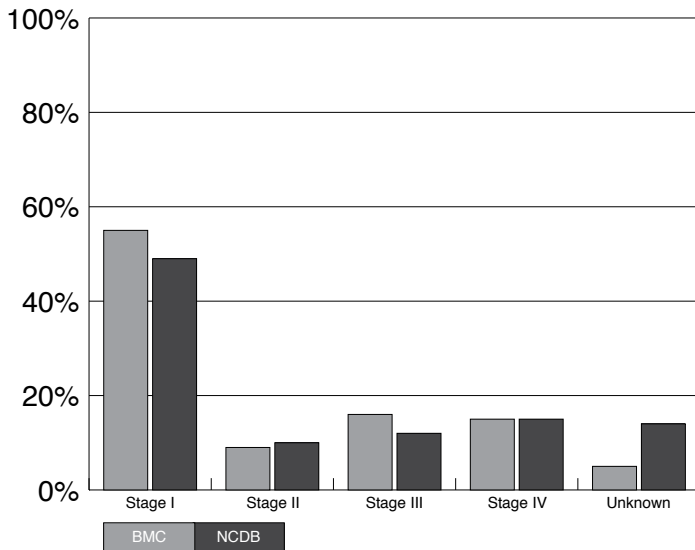


Age (Graph 4)

STAGE OF DISEASE

RCC can often be cured if diagnosed and treated when localized to the kidney. Staging is based on the extent of the tumor spread beyond the kidney with involvement of blood vessels being a poor prognostic factor. Extension of cancer into the adrenal gland is common. Disease may spread through the lymphatic system to the perirenal lymph nodes as well as through the bloodstream to cause distant metastases in lungs and bone most commonly.

Our current staging system is the American Joint Committee on Cancer (AJCC) TNM Staging System 6th Edition.(4) (Table 1) The stage of disease reported by BMC and NCDB for this review reveals Stage I as 55% of BMC cases and 49% of NCDB cases. Stage II disease accounts for 9% of BMC and 10% of NCDB cases. Stage III is 16% for BMC and 12% for NCDB. Stage IV accounts for 15% of cases in both data sets. Comparison by stage is very similar for BMC and NCDB with BMC having a slightly higher percentage of Stage I cases. (NCDB has 13% stage "unknown".) (Graph 5)



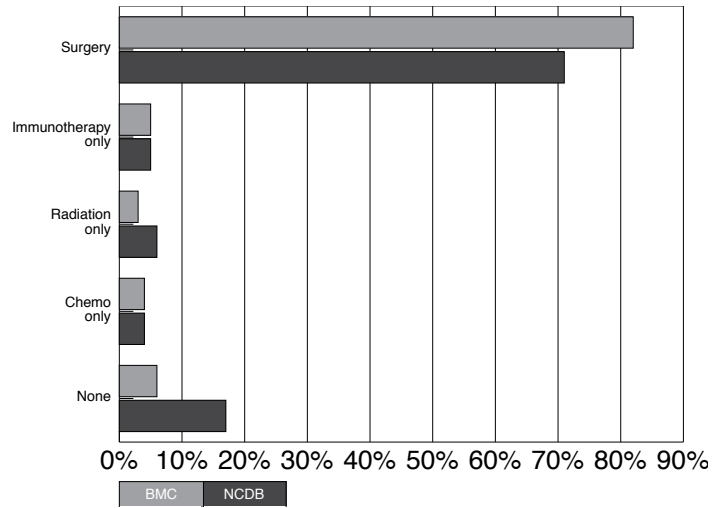
Stage (Graph 5)

TREATMENT

Nephrectomy is the only known curative treatment for RCC. More than 50% of patients with Stage I disease will be cured by surgery alone. Partial nephrectomy may be performed for smaller peripheral tumors (4 cm or less), but larger tumors require total nephrectomy that includes removal of the adrenal gland, the surrounding fat and Gerota’s fascia with or without lymph node dissection. For nonsurgical candidates, external beam radiation, chemotherapy or arterial embolization may provide palliation. Stage IV patients, who are deemed “incurable”, may benefit from surgical resection (cytoreductive nephrectomy) and resection of localized metastatic disease followed by systemic therapy.

Radiation therapy is not routinely recommended for initial therapy unless with palliative intent. Traditional chemotherapy has not been shown to be efficacious with curative intent. Immunotherapy with Interferon has shown about a 15% objective response rate. Review of treatment between BMC and NCDB is comparable with the majority of patients receiving surgery. Immunotherapy is slightly more common at BMC.

(Graph 6)

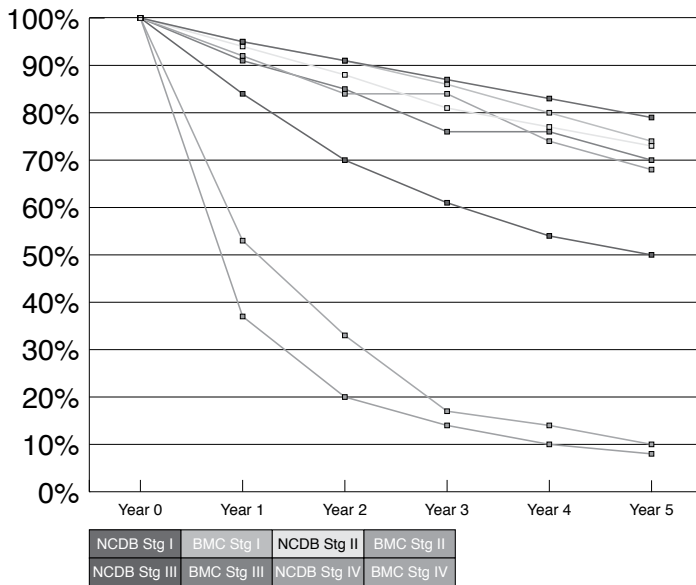


Treatment (Graph 6)

New-targeted therapies have shown promise in treating metastatic renal cell. Sunitinib (Sutent), Sorafenib (Nexavar), temsirolimus (Torisel), everolimus (Afinitor), and bevacizumab (Avastin) have all been approved for the treatment of advanced RCC and have shown improvement in survival. (5)

SURVIVAL

The five-year survival data for BMC and NCDB cases is reported using the observed survival rate, which includes non-cancer deaths. Five-year survival for each stage of disease is comparable. Stage I is 74% for BMC, and 79% for NCDB. Stage II is 68% for BMC, and 73% for NCDB. Stage III disease 70% for BMC, and 50% for NCDB, and Stage IV is 10% for BMC and 8% for NCDB. BMC has overall fewer cases than NCDB. (Graph 7)



Survival (Graph 7)

SUMMARY

Renal Cell Cancer accounts for 3.5% of all Mississippi cancers and is the third most common urinary tract cancer. RCC is more common in men than women, and most diagnosed individuals are between 50 and 70 years of age. Smoking increases risk of RCC. There is no screening test available, but incidental diagnosis has increased with the use of CT scan and ultrasound when evaluating other complaints. Approximately 85% of kidney malignancies will be renal cell. Over 50% of the cases will be Stage I at diagnosis; about 20% Stage II and III; and 15-20% will be Stage IV. Nephrectomy or partial nephrectomy is the primary treatment modality. Newer targeted therapies are improving survival for metastatic disease, and ongoing clinical trials are investigating the use of adjuvant therapies. Review of BMC data compares favorably with NCDB data in incidence, age, histology, stage, treatment and survival.

More information regarding clinical trials is found on NCI's PDQ Cancer Clinical Trials Registry website (www.cancer.gov/cancertopics/pdq) and general information about clinical trials is also available from the NCI website (www.cancer.gov/clinicaltrials).

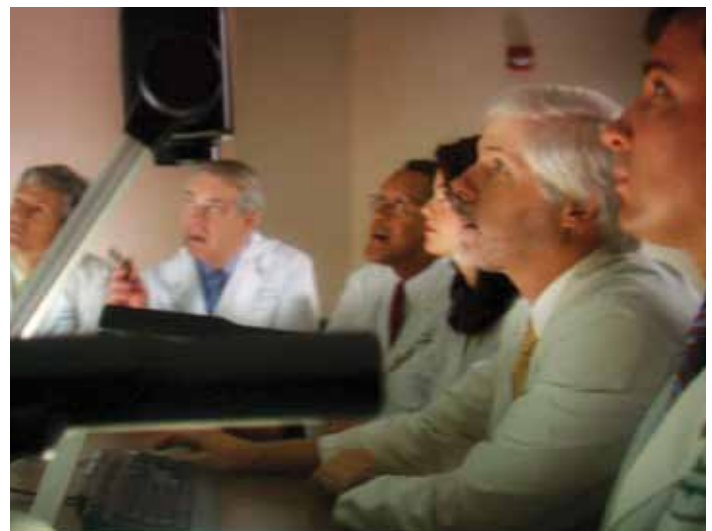
Baptist Cancer Services offers patients with RCC a number of treatment options. Board certified surgeons are available to perform radical nephrectomy as well as the new, minimally invasive robotic-assisted surgery using the da Vinci Surgical System. Radiation therapy, chemotherapy, and new-targeted therapies are available. Participation in clinical trial studies is possible through Jackson Oncology Associates.

For more information see the following web sites: www.mbhs.org or www.cancer.org or call the Baptist Cancer Services at 601-948-6262 or 1-800-948-6262 for information.

Prepared by Richard B. Friedman, MD, Gerry Ann Houston, MD and Pam Barlow, CTR

REFERENCES

1. American Cancer Society. Cancer Facts and Figures 2009. Atlanta, GA. American Cancer Society, 2008 available online. Last accessed October 11, 2008.
2. Mississippi Cancer Registry; www.mcr.umc.edu
3. Commission on Cancer, American College of Surgeons. NCDB Benchmark Reports, v9.0.Chicago, IL, 2009
4. American Committee on Cancer 2005, 6th Edition, Springer-Verlag New York, page 323
5. National Comprehensive Cancer Network Practice Guidelines in Oncology – v.1.2010, Kidney Cancer. MS-4-MS-8.



AJCC STAGING DEFINITIONS (Table 1)

<i>Clinical</i>	<i>Pathologic</i>	Primary Tumor (T)	
<input type="checkbox"/>	<input type="checkbox"/>	TX	Primary tumor cannot be assessed
<input type="checkbox"/>	<input type="checkbox"/>	T0	No evidence of primary tumor
<input type="checkbox"/>	<input type="checkbox"/>	T1	Tumor 7 cm or less in greatest dimension, limited to the kidney
<input type="checkbox"/>	<input type="checkbox"/>	T1a	Tumor 4 cm or less in greatest dimension, limited to the kidney
<input type="checkbox"/>	<input type="checkbox"/>	T1b	Tumor more than 4 cm but not more than 7 cm in greatest dimension, limited to the kidney
<input type="checkbox"/>	<input type="checkbox"/>	T2	Tumor more than 7 cm in greatest dimension, limited to the kidney
<input type="checkbox"/>	<input type="checkbox"/>	T3	Tumor extends into major veins or invades adrenal gland or perinephric tissues but not beyond Gerota's fascia
<input type="checkbox"/>	<input type="checkbox"/>	T3a	Tumor directly invades adrenal gland or perirenal and/or renal sinus fat but not beyond Gerota's fascia
<input type="checkbox"/>	<input type="checkbox"/>	T3b	Tumor grossly extends into the renal vein or its segmental (muscle-containing) branches, or vena cava below the diaphragm
<input type="checkbox"/>	<input type="checkbox"/>	T3c	Tumor grossly extends into vena cava above diaphragm or invades the wall of the vena cava
<input type="checkbox"/>	<input type="checkbox"/>	T4	Tumor invades beyond Gerota's fascia

Regional Lymph Nodes (N)

<input type="checkbox"/>	<input type="checkbox"/>	NX	Regional lymph nodes cannot be assessed
<input type="checkbox"/>	<input type="checkbox"/>	N0	No regional lymph node metastases
<input type="checkbox"/>	<input type="checkbox"/>	N1	Metastases in a single regional lymph node
<input type="checkbox"/>	<input type="checkbox"/>	N2	Metastasis in more than one regional lymph node

Distant Metastasis (M)

<input type="checkbox"/>	<input type="checkbox"/>	MX	Distant metastasis cannot be assessed
<input type="checkbox"/>	<input type="checkbox"/>	M0	No distant metastasis
<input type="checkbox"/>	<input type="checkbox"/>	M1	Distant metastasis

Biopsy of metastatic site performed Y N

Source of pathologic metastatic specimen _____

Stage Grouping

<input type="checkbox"/>	<input type="checkbox"/>	I	T1	N0	M0
<input type="checkbox"/>	<input type="checkbox"/>	II	T2	N0	M0
<input type="checkbox"/>	<input type="checkbox"/>	III	T1	N1	M0
			T2	N1	M0
			T3	N0	M0
			T3	N1	M0
			T3a	N0	M0
			T3a	N1	M0
			T3b	N0	M0
			T3b	N1	M0
			T3c	N0	M0
		T3c	N1	M0	
<input type="checkbox"/>	<input type="checkbox"/>	IV	T4	N0	M0
			T4	N1	M0
			Any T	N2	M0
			Any T	Any N	M1

PRIMARY SITE TABLE 2008 (Table 2)

PRIMARY SITE	NUMBER OF CASES	PERCENT
Oral Cavity & Pharynx	22	1%
Mouth.....	5	
Pharynx.....	4	
Tongue.....	5	
Other oral.....	8	
Digestive System	310	20%
Esophagus.....	11	
Stomach.....	23	
Small Intestine.....	8	
Large Intestine.....	120	
Rectum.....	36	
Liver/Biliary.....	29	
Pancreas.....	63	
Gallbladder.....	3	
Other.....	17	
Respiratory System	250	16%
Larynx.....	10	
Lung-Small Cell.....	37	
Lung-Non-Small Cell.....	203	
Bone/Connective Tissue	6	1%
Melanoma – Skin	37	2%
Other Skin*	5	1%
Breast	238	15%
Female Genital Organs	200	12%
Cervix Uteri #.....	41	
Corpus Uteri.....	94	
Ovary.....	35	
Vagina/Vulva.....	27	
Other Female.....	3	
Male Genital Organs	152	10%
Prostate.....	140	
Testis/Other.....	12	
Urinary Tract	125	8%
Bladder.....	64	
Kidney/Other.....	61	
Brain/CNS	25	1%
Endocrine	43	3%
Lymphatics & Hematopoietic	126	8%
Leukemia.....	39	
Hodgkin Lymphoma.....	8	
Non-Hodgkin Lymphoma.....	60	
Multiple Myeloma.....	19	
All Others	39	2%
Total Cases	1,578	

*Excludes all localized basal and squamous cell carcinomas

#Includes 16 carcinoma in situ

THE CANCER REGISTRY

The Cancer Registry is a major component of the cancer program at Baptist. The registry goals include timely, accurate and comprehensive database for patients diagnosed and/or treated with cancer or a reportable tumor since January 1982. This database records primary site, tumor histology, AJCC and SEER stage of disease, treatment modalities and lifetime follow-up. The registry received a Gold Certificate from the Mississippi Cancer Registry in December 2008 for submitting timely, complete and high quality data.

The data is utilized in many ways including documentation of the incidence of cancer seen at Baptist, education, evaluation of patient care, treatment results and survival trends.

Registry activities in 2008 include data requests from physicians, administration, and other departments, along with the coordination and distribution of the 2008 Cancer Services Annual report.

The registry has participated in the following studies and monitors: Baptist Ovarian Cancer, Cancer Program Practice Profiles (electronic quality improvement reports) from the National Cancer Data Base (NCDB) for Breast, Colon and Rectum Cancers for 2004 – 2006, Oncology Bloodstream Infections, Radiation Oncology chart monitor, Negative Tissue Review, College of American Pathology (CAP) Cancer checklist monitor, Neo-adjuvant Therapy for the Breast & Rectal Cases 2004 & 2005, TNM Staging Monitor, and yearly update of the Facility Information Profile System (FIPS) for the ACS website.

The registry submitted data on 7787 cases to the NCDB covering the diagnostic years of 1987/1992/1997/2002/2007.

The registry maintains a 90% follow-up rate for the patients diagnosed in the last five years and an 88% follow-up rate for all patients which meets the cancer program standards. The registrars reviewed over 8,000 charts; 23,400 pathology reports; 12,000 calls and mailed 17,400 letters.

SUMMARY OF CASES

During 2008, there were 1,775 new cases added to the registry. There were 1,578 analytic cases diagnosed and/or treated and 197 non-analytic cases seen at Baptist for recurrent disease. Geographic distribution of cases accessioned during 2008 reveal patients from all but ten counties and 38 from out of state.

Review of the 2008 primary sites for Baptist Medical Center reveals lung as the most common site with 240 cases or 15%, followed by breast with 238 cases or 15%, colorectal 156 cases or 10%, prostate with 140 cases or 9%, and corpus uteri (endometrium) with 94 cases or 6%. Data from the National Cancer Data Base from 2006 cases reveal the major sites in U.S. to be breast, prostate, lung and colorectal which correlates with the major sites for Mississippi and BMC.

AGE/SEX

The age at diagnosis for 62% of patients is greater than 60 years of age. The female to male ratio is 60:40 consistent with previous years.

STAGE OF DISEASE

The AJCC Stage of Disease for the major primary sites has been reviewed for BMC for 2008 and NCDB 2006 cases. This review reveals the stage of disease for breast cancer BMC to NCDB: Stage 0 14% / 19%, Stage I 33% / 37%, Stage II 32% / 25%, Stage III 14% / 9%, Stage IV 4% / 3% & Unknown 3% / 7%. Percentage of BMC Stage 0, II & III are slightly higher than NCDB and Stage I is slightly lower. The BMC / NCDB stage of disease for the non-small cell lung cancer is Stage 0 0% / 0.3%, Stage I 30% / 23%, Stage II 9% / 7%, Stage III 24% / 23%, Stage IV 31% / 34% and Unknown 6% / 12%. These are very similar stage. The BMC/NCDB stage of disease for prostate cancer is Stage I 0% / 1%, Stage II 83% / 76%, Stage III 11% / 5%, Stage IV 5% / 5% and Unknown 0% / 10%. For colon cancer, the BMC / NCDB Stage 0 14%/ 7%, Stage 1 18%/19%, Stage II 30% / 24%, Stage III 23% / 23%, Stage IV 15 / 17% and unknown 0% / 10%. The stages for prostate cancer are similar with Stage II and III slightly higher. For colon cancer stages are similar except for Stage 0 which is slightly higher at BMC.

TUMOR BOARD CONFERENCES

Tumor board conferences provide a multidisciplinary approach to the care of the cancer patient. The patient's clinical history is reviewed, the pathologist shows pathologic findings and the radiologist appropriate radiographic studies. Following this, the oncology specialists (medical, surgical, radiation) discuss optimal management strategies and expected outcomes.

In 2008, 330 cases were discussed at the meetings. Ninety-two percent focused on prospective treatment options and management. The major sites reviewed were breast, lung, brain, colon/rectum and gynecologic

sites. Physicians attending receive one hour Category I Continuing Medical Education credit from the American Medical Association.

Meetings are held in the Hederman Cancer Center Conference room every Monday at 5:00 p.m. Weekly Neuro/Neurosurgery/Radiology meetings are held on Tuesday at 7:30 a.m. Conferences are open to all the medical staff and appropriate ancillary personnel. Anyone interested in presenting a case may contact the Cancer Registry at 601-968-1339.

THE FOLLOWING PHYSICIANS PRESENTED CASES AT THE CONFERENCES IN 2008.

John D. Adams, MD
Vinod K. Anand, MD
Eric L. Balfour, MD
Nicole D. Cleveland, MD
Elio D. DeMeira, MD
Richard B. Friedman, MD
Krishna J. Goli, MD
Alexander J. Haick, MD
Gerry Ann Houston, MD
Keith O. Jones, MD
Moses C. Jones, Jr., MD
Michael Koury, MD
Van L. Lackey, MD
Phillip B. Ley, MD
James L. Moore, MD
Jason G. Murphy, MD
Manubhai S. Patel, MD
Gerald P. Randle, MD
Mildred R. Ridgway, MD
Grace G. Shumaker, MD
Robert Allen Smith, MD
Randy C. Voyles, MD

David A. Wahl, MD
Richard E. Weddle, MD
Tammy H. Young, MD

PATHOLOGISTS

AnaMaria Andrei, MD
James R. Cavett, MD
Edward V. Egorshin, MD
Nanette B. Pinkard, MD
Delia A. Smith, MD

RADIOLOGISTS

E. J. Blanchard, MD
James L. Burkhalter, MD
Larkin Carter, MD
Gary A. Cirilli, MD
J. Mack Haltom, III, MD
R. Houston Hardin, MD
Jason R. Hosey, MD
Edward K. Phillips, MD
Charles K. Pringle, MD
C. Dallas Sorrell, MD

William E. Studdard, MD
J. Dean Tanner, MD
Timothy G. Usey, MD

Cancer Committee Members

PHYSICIANS

CANCER COMMITTEE MEMBERS

Richard B. Friedman, MD
Radiation Oncology
2008/2009 Chairman

Gerry Ann Houston, MD
Medical Oncology
American College of Surgeons
Cancer Liaison Physician

Vinod Anand, MD
Otolaryngology

James R. Cavett, MD
Pathology

Patrick Daily, MD
Urology

Alexander J. Haick, MD
General Surgery

Moses C. Jones, Jr., MD
Neurosurgery

Michael Koury, MD
Thoracic Surgery

Van L. Lackey, MD
Medical Oncology

James L. Moore, MD
Gynecologic Oncology

Mildred R. Ridgway, MD
Gynecologic Oncology

Timothy G. Usey, MD
Director, Radiology

David A. Wahl, MD
Radiation Oncology

Tammy H. Young, MD
Medical Oncology

Bobbie Ware, RN, MHSA
Vice President/Chief Nursing Officer

Chasity Thames, RD, LD
Clinical Dietitian

Trudye Garraway, RN, MSN, OCN
Mental Health Services/Hospice
Coordinator

Harold Gore, PharmD
Oncology Pharmacy

Bryan Miller, PharmD
Oncology Pharmacy

Mary Ellen Yarbrough, RN, MSN
Director, Oncology Services

Mary Ann Hood
Community Outreach Coordinator/
Navigator

Alice Lee
Director, Radiation Oncology

Deniece Ponder, RN, OCN
Pain Management Coordinator/
Neuroscience Service Line

Bufkin Moore, Psy.D
Oncology Counselor

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

Anna Derrick, CTR
Quality Improvement Coordinator

Wanda Lett, CTR
Cancer Conference Coordinator

Beverly Sheriff, RHIT
Cancer Registrar

Samantha Delaney, RN
IP Oncology Nurse Manager

Ella Jackson, RN
Case Manager,
Clinical Resource Management

Donna Lustig, R.T. (R) (M)
Manager, Breast Center

