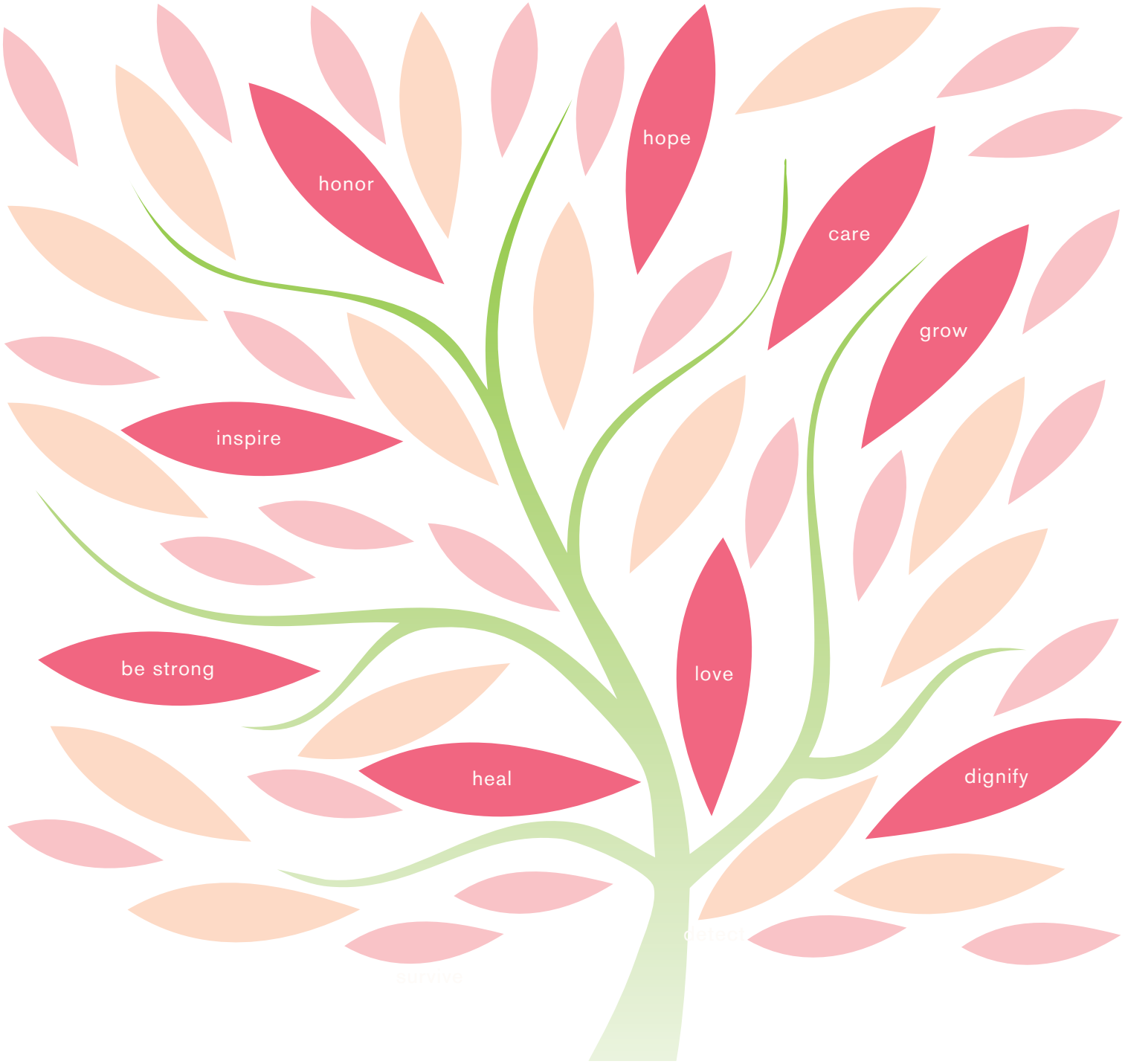


CELEBRATING EIGHT YEARS of HOPE

MaineGeneral CancerCare

2015 Annual Report

Commission on Cancer®

Certified

ACR American College of Radiology Radiology

MaineGeneral Medical Center

Cancer Care Committee

Laurie Bourgoin, RN, MBA
Administrative Director, MaineGeneral HomeCare and Hospice

Debbie Bowden, RN, MSN
Administrative Director, Oncology Services

Cathy Bourque, PT
Director of STAR Program®, Rehabilitation Services

Robert Dohner, MD
Medical Director, Palliative Care

Rev. Joe Dressler
Patient /Family Advisory Council Representative

Marietta Dyer, LMSW, ACHP-SW
Palliative Care

Monica Beaulieu, BA
Performance Improvement
Administrative Director, Quality Care Management & Safety

Paul Gagliardi, MD, FACR
Radiology

Nicole Heanssler, RN
American Cancer Society Liaison

Glenn A. Healey, MD
Chairperson, Medical Director, Radiation Oncology

Kerri Medeiros, RN, BSN, OCN
Research Nurse

Carol Maxwell, LCSW
Case Management, Social Services

Laura Nelsen, MD
Pathology

Richard Polkinghorn, MD
Medical Director, Medical Oncology

Anita Praba-Egge, MD
Cancer Liaison/Surgeon

Paul Stein
Senior Vice President, Oncology Services, COO

Kim Smith, RN, MSN
Manager, Medical Oncology

Derrick Tooth, MD
Urologist, Specialty Physician

Steven Townsend, PharmD, BCOP
Oncology Pharmacist

Donna Walsh, MS, RD, CSO
Community Outreach Coordinator

Jennifer Yurges, MFA, CTR
Cancer Registry Quality Coordinator
Manager, Radiation Oncology and Cancer Registry

Contents

In Memoriam

David Clark
1941-2015

As a volunteer driver for the American Cancer Society (ACS), David was our most often used driver. He drove more than 10,000 miles last year taking patients to treatment appointments as far away as Boston, using his own money for gas and tolls. As our ACS navigator Dan Bahr wrote upon hearing of his passing,

"So many of our patients arrived here due to David's kindness. I cannot begin to describe how much he will be missed."

Overview

The diagnosis of cancer initiates a journey that has far-reaching physical, emotional, spiritual and financial consequences for the cancer patient and the caregiving family and friends.

2015 Cancer Committee Report

We celebrate our eighth year of service at the Harold Alfond Center for Cancer Care (HACCC). Currently we are renovating the Radiation Oncology Department with the installation of a new linear accelerator, which came online in January 2016. This latest technology complements our current repertoire of high-precision radiation therapy treatment modalities in the management and care of our patients.

This year I want to focus on our ancillary programs in our annual report. The diagnosis of cancer initiates a journey that has far-reaching physical, emotional, spiritual and financial consequences for the cancer patient and the caregiving family and friends. We strive to meet the needs of patients and family through navigation and symptom management services, integrative health services, behavioral and mental health programs, spiritual and palliative care services, and financial and liaison services. These programs and services surround the patient and family within an environment that emphasizes well-being.

In addition to my work as chairman of the Cancer Committee and MaineGeneral's Tumor Board, I also chair the MaineHealth Breast Care Treatment WorkGroup. This group of representative physicians and ancillary health professionals from hospitals throughout the state is working to develop guidelines for the diagnosis, treatment and aftercare of patients with breast cancer and high-risk breast conditions. Our work this year has focused on such topics as timely prospective review of cases prior to definitive management; survivorship and shared decision-making protocols; high-risk management and care guidelines; use of national guidelines in the detection, evaluation and management of invasive and non-invasive breast cancer; and individual and familial risk assessment and risk reduction interventions. This framework of breast care will help ensure that breast cancer patients throughout Maine are managed with consistent and consensus-driven guidance.

While I did not touch on other aspects of this report, I encourage you to read on. There is a wealth of information contained within that I hope you will find both informative and inspiring.

Glenn A. Healey, MD
Cancer Committee Chair

MGH PILLAR:

Better Care and Service

Oncology Research — Clinical Trials

Clinical trials are an important treatment option for many people with cancer. Clinical trials can offer new drugs, new combinations of drugs, surgical and radiation treatments to improve cancer care and lessen the burden of cancer on society. Without clinical trials, cancer care cannot improve. Many of today's widely used cancer tests and treatments exist because of clinical trials.

HACCC physicians and research nurses have enrolled 13 new patients in clinical trials since January 2015. HACCC provides local access to more than 30 clinical trials offered nationally by The National Cancer Institute–supported research groups.

John T. Gorman Foundation Grant for Nurse Navigation

A nurse navigation program can serve as the umbrella for the whole center and heighten staff engagement in systems thinking. If a patient's journey starts from this global vantage point, we can confidently say we are working as a whole toward the same goal — giving excellent, compassionate and coordinated patient care. The navigator works to alleviate and manage patient anxiety and to steer patients to the correct points of contact specific to their disease.

The John T. Gorman Foundation's 2015 Direct Services Grant Program is open to non-profit organizations working in Maine to address the immediate needs of disadvantaged people. One area the foundation supports is resources for cancer patients, survivors and affected families.

The Foundation granted HACCC $25,000 over a 12-month period to help develop the Oncology Nursing Navigation Program which now employs three specific nurses to be the initial point of contact for every patient with a potential cancer diagnosis. The HACCC has created a department space for the navigators on the cancer administrative floor, placing a focus on specialized nursing training and development and implementing a specific software program called OncoNav. This program will enable our nurse navigator to pull patient demographics from our existing electronic medical records, ease the burden of administrative tasks and focus on patients.

The nurse navigation program development is focused on both improving direct patient care and reducing outmigration. Studies show better patient support and ancillary services lower costs of care. If processes are streamlined, the result is fewer complications, ER visits or long-term hospital stays — and less patient fear. Having one person as a point of contact for a much larger system is expected to reduce duplicative tests and appointments, and to increase ancillary referrals (STAR Program®, genetics counseling, symptom management and palliative care referrals, mental health specialists, etc.). The result is better overall care with fewer treatment breaks due to complications or comorbidities.

Tissue Repository Program

In 2014 the research department at the Harold Alfond Center for Cancer Care (HACCC) expanded its services to include tissue banking. Eligible surgical patients now can donate remaining tissue samples from their surgery to be used in research studies. Researchers use samples from tissue donors to look for ways to find, prevent and treat health problems like diabetes, heart disease and cancer. People find comfort knowing that by donating their samples, they help researchers make discoveries that can advance medicine and improve treatment for others.

Since October 2014, a total of 54 patients have consented to donate their tissue and we have successfully collected tumor tissue from 36 of these patients to send for use in research studies. On Aug. 31, 2015 we began collecting blood from chronic lymphocytic leukemia (CLL) patients to be used for CLL research by Eastern Maine Medical Center and Jackson Lab. As of October 2015, Jackson Lab reported that MaineGeneral now has three active models in the PDX (patient-derived xenograft) program there. This means tissue from three of our patients has been successfully engrafted into mice and therefore these models are available to researchers interested in pursuing studies involving these tumor types. The process for bone marrow collection for banking is in the works.

MGH PILLAR:

Better Care and Service *continued*

The STAR Program®

The STAR Program® is a cancer rehabilitation program comprised of a multidisciplinary team of physical therapists, occupational therapists, nurses, speech language pathologists and registered dietitians. MaineGeneral is the first hospital in Maine to be STAR Program® certified. The goal of the STAR Program® is to help cancer survivors approach their pre-cancer diagnosis level of conditioning and address side effects from therapy such as fatigue, weakness, balance problems, musculoskeletal pain, memory problems or problems with speech or swallowing. Since implementing the STAR Program® in the spring of 2013, oncology referrals to rehab have more than tripled compared to referrals in 2012, and they continue to increase.

STAR Program® staff were present at this year's Relay for Life, Cancer Survivors Day and MaineGeneral's Walk for Hope to provide awareness of the program, answer questions and provide hope. A satisfaction survey and outcome study have been initiated, with a desire to study the data to determine next steps of service to best meet patients' needs.

Margaret Shore, STAR Program®participant, and her husband, Rob

MGH PILLAR:

Superior Workforce

Meet our oncology provider team

With a total of five full-time and two part-time physicians and three full-time physician assistants and a nurse practitioner, we have a great potential to meet the needs of our communities. In collaboration with physicians in primary care and specialty practices throughout the MaineGeneral service area, we are making a difference, every day, in the lives of many touched by cancer each year.

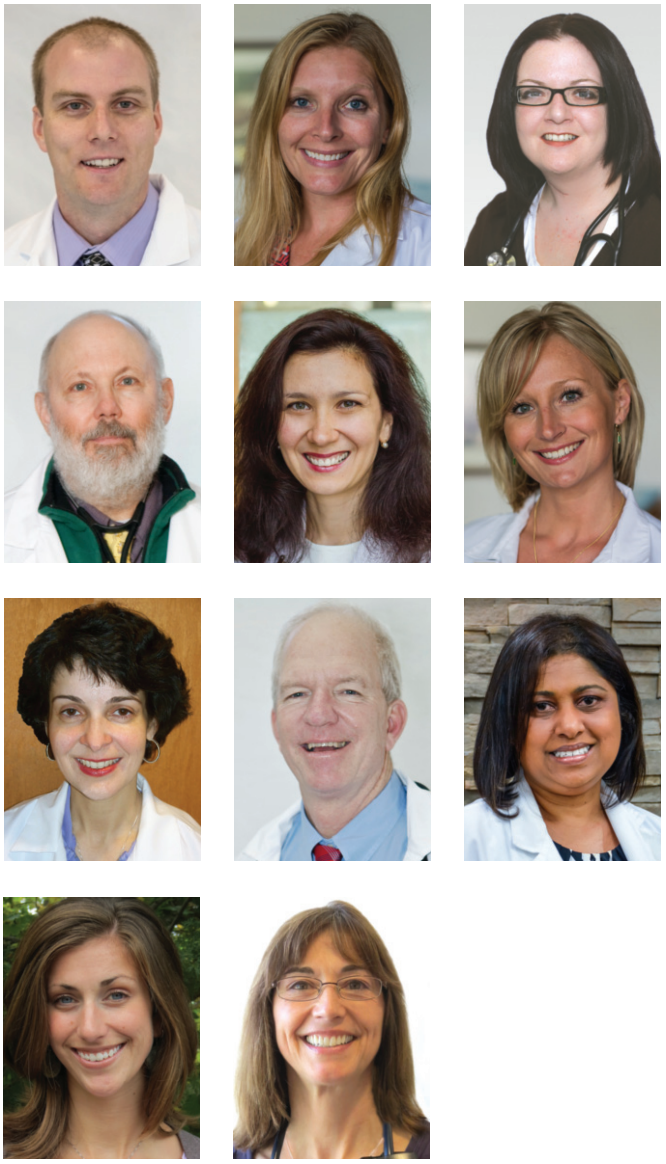
Medical Oncology: (top from left to right)
Gregory Emmons, DO; Lauren LaBrecque, PA-C; Robin Locke, MD; Donald Magioncalda, MD; Julia Moukharskaya, MD; Amanda Napolitano, NP, Elena Nawfel, MD; Richard Polkinghorn, MD, Medical Director, Medical Oncology; Nadia Ramdin, MD; Elizabeth Teague, PA-C; Susan Trafton, PA-C.

Radiation Oncology: (bottom from left to right)
Glenn Healey, MD, Medical Director, Radiation Oncology; Grenville Jones, MD

Our Nursing Team

This year has been incredibly eventful for the nursing staff of both outpatient and inpatient oncology. With the goal of 100 percent oncology certification within their reach, our nurses have spent countless hours in preparation for this accolade. Their goal is to demonstrate their dedication to the oncology field, and especially to providing the best care to our patients. As of 2015, our current percentage of oncology-certified nursing care at HACCC is 71 percent, ensuring our nurses are providing the most up-to-date care.

Medical Oncology Team



Radiation Oncology Team

MGH PILLAR:

Community Outreach

Integrative Health Services

Studies show that evidence-based integrative therapies can help cancer patients be more active participants in their care. These services can also reduce side effects of conventional cancer treatments and improve quality of life by helping to heal mind, body and spirit.

To make integrative health services more accessible to patients at HACCC, we conducted a survey in the summer of 2015 to determine what services our patients would like to have available and would be likely to participate in. HACCC patients indicated they would be likely to participate in yoga classes, massage, acupuncture, nutrition and cooking classes, Tai Chi, mindfulness and meditation, Reiki, stretching and the use of herbs and botanicals. As a result of the survey, we expanded our integrative health offerings in the fall of 2015 to include classes in meditation, Tai Chi, essential oils, nutrition and journaling. These classes are available to our patients free of charge. We continued to offer complementary nutrition counseling and various support groups for cancer patients.

In addition, HACCC continued our collaboration with community partners. Our friends at School Street Yoga in Waterville offer yoga classes free of charge for patients undergoing cancer treatment. The Kennebec Valley YMCA continues to offer the popular LIVESTRONG® exercise program for cancer survivors. Onsite individual and group acupuncture is available at HACCC for a nominal fee.

Plans for 2016 include a resource guide of area integrative health providers; the availability of resources and tools for patients on mindfulness, breathing and guided imagery for stress management; and a weight loss program for cancer survivors.

Our 12th annual Walk for Hope raised $119,500 in support of MaineGeneral's Breast Care Program. Those dollars will help provide important preventive screenings for members of our community.

MGH PILLAR:

Community Outreach *continued*

Cancer Survivors Day

More than 1,000 people came to the Harold Alfond Center for Cancer Care on a warm sunny day Saturday, Sept. 12, 2015 for MaineGeneral's Cancer Survivors Day.

Maine comedian and cancer survivor Tim Sample shared his experiences and great humor at the opening ceremony.

Dozens of vendors gave free information at the event and great food and entertainment filled the day.

But it was our cancer survivors themselves who shown brightest during the event.

Inspiration for Life Cancer Survivors Day

At MaineGeneral, we value each and every patient and family member. It was a great joy to share smiles, encouragement, laughter and love.

Thank you to all who dedicated time, services and other contributions to make this day a special one. We appreciate the support of so many in the Kennebec Valley for those who are facing or have faced cancer.







Community Outreach *continued*

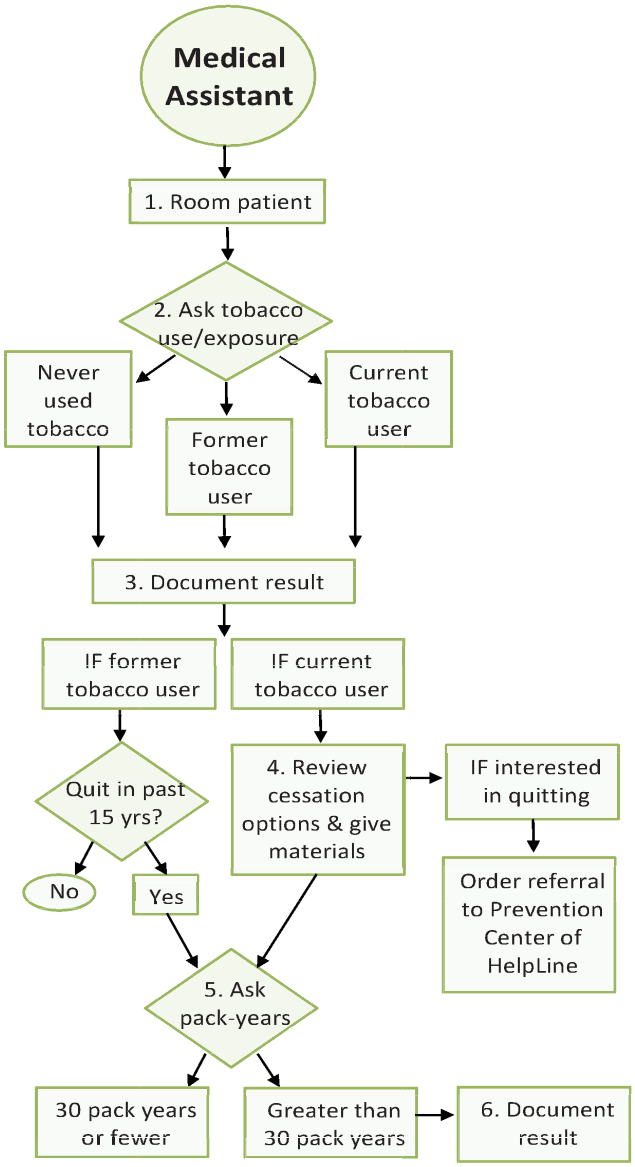
Lung Screenings

This year Medicare has expanded its coverage for low-dose CT lung screenings. As a result, the Imaging and HACCC teams have combined resources and worked with the Prevention Center and primary care practices to identify the patient population at high risk for lung cancer. The following is a diagram of the proposed primary care workflow that Dr. Melanie Thompson and the Prevention Center are working on with their teams. Also included is our patient information pamphlet on the exams. As we move forward, we will do more community outreach and improve our lung cancer outcomes by catching the disease in earlier stages when it is easier to treat.

Screenings in Our Community

MaineGeneral's Center for Prevention and Healthy Living received a grant to improve and facilitate cancer screenings in our community. Two community health workers (1.5 FTE) were hired to help patients identify and address barriers to receiving appropriate cancer screenings — especially screenings for colon, breast and cervical cancer. These employees used data from outpatient health records to identify patients aged 50-75 who were due for colorectal cancer screening. They sent letters to these patients and followed up by telephone calls to educate patients about their screening options and address barriers to screening. In 2015, the program helped 189 patients receive colorectal cancer screening. Fifteen of these patients were screened through the Maine Colorectal Cancer Control Program in 2015. These community health workers also helped 10 patients to complete their mammogram and two patients to complete cervical cancer screening.

Office Workflow
Tobacco use & exposure documentation



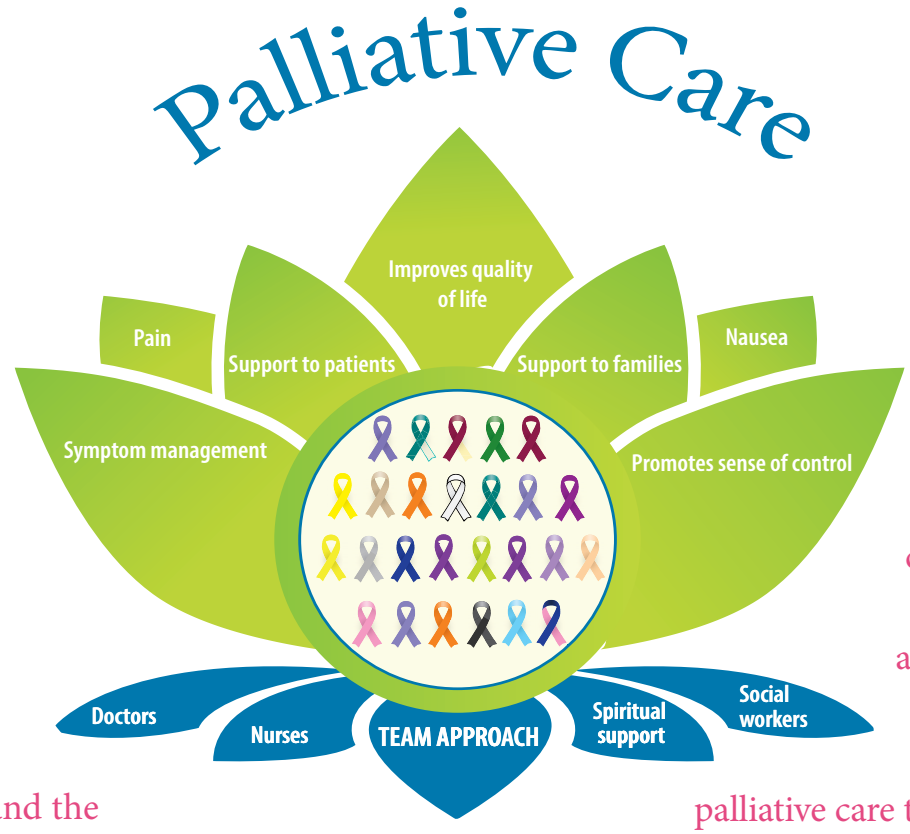
MGH PILLAR:

Better Health and Quality

Palliative Care

Palliative care, also called supportive care, is specialized medical care for people with serious illness. It focuses on providing patients with relief from the symptoms, and stress of a serious illness — whatever the diagnosis. The goal is to improve quality of life for both the patient and the family. It is appropriate at any stage of a serious illness. Palliative care does not replace primary treatment; it works together with the treatment and other providers by anticipating, preventing and treating symptoms of serious illness.

MaineGeneral Medical Center oncologists are trained in primary palliative care and provide these services in conjunction with treatments. MaineGeneral Medical Center also has a palliative care specialty service that focuses on improving the quality of life of patients either on-site or by referral. Dr. Robert Dohner, board certified in hospice and palliative care, and Marietta Dyer, LMSW advanced certified hospice and palliative care, provide comprehensive multidisciplinary care to patients and loved ones by focusing on relieving pain, stress and other symptoms of cancer and its treatments.



"When my husband, Leroy, was diagnosed with stage II esophageal cancer, we knew we had a tough road ahead. Leroy's pain was considerable, and the palliative care team at MaineGeneral Health was able to quickly help get his pain under control."

"While many people think cancer and pain go hand in hand, we learned that cancer patients should never accept pain as a normal part of cancer. Our palliative care team helped us to understand that all pain can be treated, and most pain can be controlled or relieved."

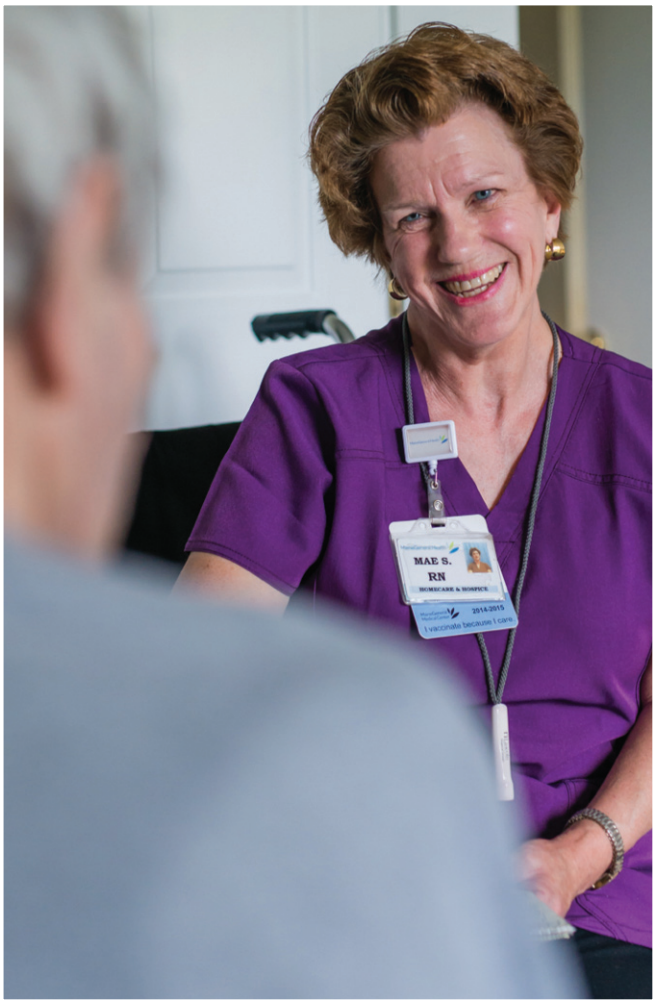
Margaret Harrington

MGH PILLAR:

Better Health and Quality *continued*

Palliative Care and Hospice

To palliate means to relieve symptoms. Palliative care can occur at the same time as curative care and helps patients by relieving symptoms such as pain, nausea and breathing issues. All of MaineGeneral's oncologists are trained in palliative care and provide this along with other treatments. MaineGeneral also has a palliative care physician, Dr. Robert Dohner, and social workers who specialize in providing supportive comfort care for our patients and families. MaineGeneral HomeCare provides palliative care nurses who are specially trained in symptom control. They help patients who are still seeking curative treatment but need comfort care as well.



Hospice care is palliative care that occurs in the last 6-12 months of life when it has become clear that curative treatments are no longer working, and that the treatment side effects are causing such distress that the patient would prefer to stay at home and be comfortable. Hospice helps the patient and the family with not only physical symptoms, but emotional, social and spiritual issues as well.

MaineGeneral Hospice consists of a team of highly trained professionals and volunteers who treat patients with dignity and respect while supporting the patient's goals of care. We offer care at home or in other settings, such as nursing homes and residential care facilities. Grief support and bereavement services are also available for the family.

Hospice neither prolongs nor hastens death, but rather focuses on a high quality of life and living.

As Maine's first certified hospice, MaineGeneral Hospice has a long tradition of providing high quality patient and family care. We are a local, not-for-profit hospice caring for friends and neighbors in our community.

To learn more or make a referral, call our intake office at 1-800-HOMECARE. You may also visit mainegeneral.org and click on the HomeCare and Hospice link.

Better Health and Quality *continued*

Quality Reports

Managing Lung Cancer

A basic tenet in the best practice management of lung cancer is to prevent lung cancer through education and smoking cessation. Our smoking cessation programs are robust and we are sensitive to direct smokers to the available programs. Unfortunately, the number of patients who actually get smoking cessation assistance is poor. Our efforts in this area may need re-examination.

A snapshot into the data is presented below. This past spring we evaluated 57 charts. In all cases, the patient was asked about smoking or tobacco use. Of them, 18 were current smokers. Of that 18, only 11 (61%) patients had a documented discussion on tobacco cessation. This fall the numbers were similar: there were 17 current smokers identified; cessation strategies were discussed in only 12 of the 17 (71%).

It is true that some folks will refuse assistance to quit tobacco, even with appropriate counseling. However, it is incumbent upon health care professionals to ensure that all current smokers under our care have a documented discussion about strategies of smoking cessation. The trend from 61% to 71% is an improvement, but there is no good reason the percentage should be anything other than 100%.

The number of new lung cancers continues to inexorably increase year after year, with a preponderance of late-stage cancer. We set out to identify barriers to smoking cessation and this data reminds us that we providers can sometimes be part of the problem. We have to prove that we offer tobacco cessation assistance to all current smokers and we will begin working on staff education initiatives to reach that goal.

QOPI Staging

Precise, tailored, error-free, patient-centered treatment is fundamental to the management and care of our patients with cancer. From diagnosis and treatment planning, through treatment delivery and aftercare, the stage of a cancer is pivotal. Staging provides an understanding of the extent of disease at initial presentation, helps determine the best treatment, helps define eligibility for clinical trials, and is an important determinant of prognosis.

While accurate staging of cancer is important, timely staging is of critical importance to the clinical oncologist. Clinical staging is based on data acquired before the initiation of definitive treatment and is used to define initial treatment.

As such, it is required to complete clinical staging in order to determine the role and timing of such modalities as surgery, systemic therapy, radiation therapy, active surveillance and palliative care in the strategies of management and care.

The Quality Oncology Performance Initiative (QOPI) is a useful tool to benchmark metrics of performance of an individual institution against aggregate institutions. A core measure is the documentation of completed clinical staging within one month of the initial office visit with a member of the cancer care team. One month is somewhat arbitrary but has been selected by QOPI in order to give the managing clinician time to order and collect information from biopsy, imaging, endoscopy, history, physical examination and other relevant examinations.

To assess our performance against a benchmark, we reviewed 106 charts of newly diagnosed cancers. Of these, 80 (75%) had staging completed within one month of the first office visit. The QOPI benchmark of aggregate institutions for this core measure is 85%. We are below average. While there can be many reasons why only 75% of charts had documented clinical staging (and chart review may elucidate this), our next step is to bring this information to the Cancer Committee to define ways to meet or exceed the QOPI benchmark in the coming year.

Better Health and Quality *continued*

Quality Reports

Review of 2014 Bilateral Mastectomy Data

According to multiple studies, the rates of mastectomies in women who are eligible for breast conservation surgery have been increasing over the past decade. According to a recent article from *JAMA Surgery*, the proportion of women with early-stage breast cancer (T0—2, N0-3 lesions, M0) undergoing mastectomies increased from 34.3 percent in 1998 to 37.8 percent in 2011. Bilateral mastectomy rates for unilateral disease increased from 1.9 percent of BCS eligible women in 1998 to 11.2 percent in 2011. In fact, the increasing rates of mastectomies are in large part due to the performance of bilateral mastectomy. Reconstruction rates have also increased from 11.6 percent in 1998 to 36.4 percent in 2011.

Here at MaineGeneral, we had a total of 192 breast cases diagnosed and or treated in 2014. Of these 192 patients, 98 had surgery at MaineGeneral. Fourteen (roughly 14 percent) of these patients underwent bilateral mastectomies. This past year we elected to review the reasons for these procedures and to verify that patients had appropriate counseling regarding treatment options.

Of the 14 patients, two had bilateral breast cancers. Four patients had triple negative breast cancers. One of these patients who developed breast cancer on her left side had been previously treated with BCS/radiation and chemotherapy for a right-sided cancer. At least one patient had documented multifocal DCIS and had undergone two previous attempts at lumpectomy. At least two additional patients had MRIs with findings suspicious for multifocal or bilateral disease. Several patients had relatively large tumors in relationship to their breast size.

The unifying reason for the majority of our patients undergoing bilateral mastectomies was the patient's request. Many patients were noted, on chart review, to have asked their providers to offer bilateral mastectomies. Providers DID recommend prophylactic contralateral mastectomy in patients with suspicious findings on MRI.

On review of charts, written informed consent was documented to have occurred prior to surgical intervention, although the exact details are not documented.

As noted, multiple studies in not only surgical literature reveal that mastectomy rates, breast reconstruction and bilateral mastectomy rates are increasing. These same studies are unable to determine the specific reasons for these trends. Historically, BRCA positivity or strong family history has been the traditional reason to recommend prophylactic bilateral mastectomies. There is not enough data to recommend to all women that a prophylactic mastectomy on the contralateral side will improve their long-term outcome or survival.

References:

Kristy et al. Nationwide Trends in Mastectomy for Early-Stage Breast Cancer. JAMA Surgery. 2015; 150(1) 9-16.

Lostumbo et al. Prophylactic mastectomy for the prevention of breast cancer. Cochrane Database Syst Rev. 2010 Nov 10;(11):CD002748.

MGH PILLAR:

Better Access and Growth

Linear Accelerator Installation

MaineGeneral's Harold Alfond Center for Cancer Care is dedicated to providing you the best care possible with compassion and comfort. We are excited to tell you about new equipment we are installing in the radiation oncology department that will benefit our patients. The new radiation machines will give you access to the latest in technology, making your radiation treatments more comfortable.

Radiation team: Alicia Curtis, Lead Radiation Therapist; Holly Andrews, Radiation Therapist; Dr. Grenville Jones, Juanita Begin, Oncology Nurse Navigator; and Michael Bartels, Medical Physicist

Social Work/Care Management

Our oncology clinical social workers (LCSW) and care management associate are integral members of the health care team who contribute to the development and coordination of the treatment plan. In collaboration with the patient, family and other disciplines, they provide counseling, education, case management and navigation which link patients with other services necessary to meet their multiple needs. They have increased delivery of therapy and counseling services to patients, families and significant others facing the impact of cancer. They have also increased the number of cancer support group meetings throughout the month due to increased response and demand. These services are available to patients and families throughout all phases of the cancer continuum including diagnosis, treatment, palliative care, end-of-life care and bereavement. We hope to add a survivorship group in the future to address survivors' therapeutic, social and educational needs.

Cancer Registry Report

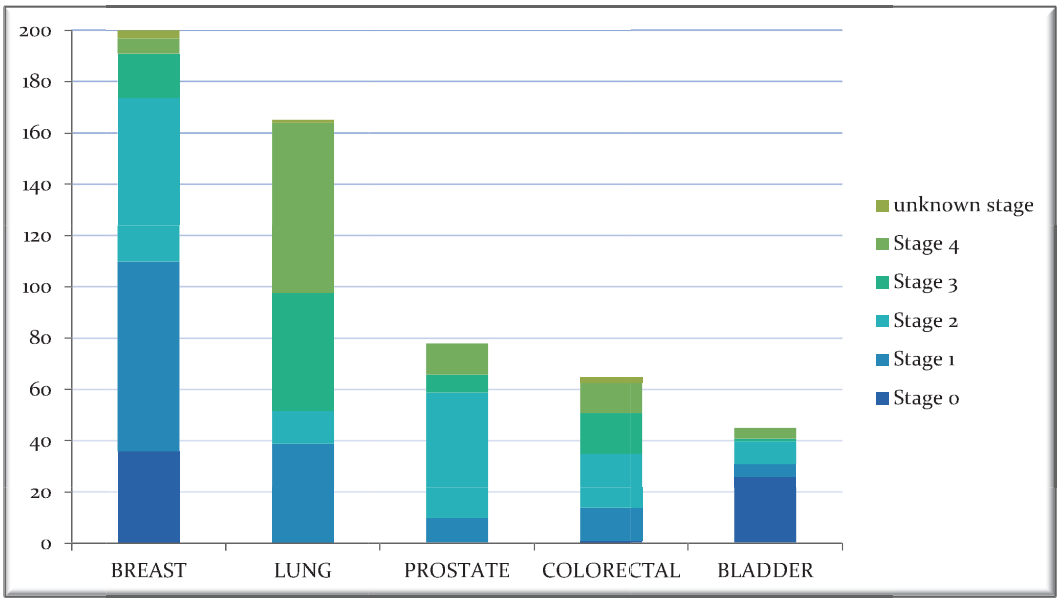
In 2014 MaineGeneral diagnosed and treated 1,118 patients with malignancies (either newly diagnosed or referred to MaineGeneral with recurrence or progression). 983 of the cases reported were newly diagnosed. The five largest diagnostic areas of these new cases were:

		Breast	Lung	Prostate	Colorectal	Bladder
	Total	200	165	78	65	45
Stage at Diagnosis	Unknown	3	1	0	2	0
	Stage IV	6	66	12	12	4
	Stage III	17	46	7	16	1
	Stage II	64	13	49	21	9
	Stage I	74	39	10	13	5
	Stage 0	36	0	0	1	26

The cancer registry at the Harold Alfond Center for Cancer Care reports approximately 1,000 newly diagnosed cases every year to report to the Maine State Cancer Registry, as well as to the Commission on Cancer's National Cancer Database, a joint program of the American College of Surgeons and the American Cancer Society. Cancer registrars analyze and abstract a variety of information, including cancer primary site and histology, treatment, stage and survival. They also annually follow up on each newly diagnosed cancer patient for his/her entire lifetime to track overall survival. Being a cancer registrar is a behind-the-scenes, complex job that requires voluminous study, expertise in cancer staging and treatment, and eventual certification through the National Cancer Registrars Association. This year, we will developi a Quality Council for the cancer center, with the registry at its core.

The registry's role has expanded to report on all components of quality, from the legally mandated aspects of cancer reporting, to overall quality initiatives including QOPI® and Lung Cancer Screening Registry reporting. The registry would like to especially thank Dr. Glenn Healey and Dr. Laura Nelsen for reviewing abstracts this year, ensuring accurate and valuable data reporting.

Top Five Sites 2014 by Stage



Cancer Registry 2014 Caseload Summary

PRIMARY SITE	TOTAL	% CHANGE FROM 2013		MALE	FEMALE	NEWLY DX	NONANALYTIC	ALIVE	EXPIRED	STAGE 0	STAGE I	STAGE II	STAGE III	STAGE IV	UNKNOWN OR N/A
ORAL CAVITY & PHARYNX	**39 (3.5%)**	**-11%**	↓	**30**	**9**	**37**	**2**	**27**	**12**	**2**	7	**7**	**3**	**17**	**1**
Lip	5 (0.4%)	150%	↑	3	2	5	0	5	0	1	4	0	0	0	0
Tongue	15 (1.3%)	36%	↑	13	2	14	1	10	5	0	1	3	2	8	0
Salivary Glands	3 (0.3%)	-57%	↓	2	1	3	0	2	1	0	0	2	0	1	0
Floor of Mouth	1 (0.1%)	-67%	↓	1	0	1	0	1	0	0	0	0	1	0	0
Gum & Other Mouth	6 (0.5%)	50%	↑	3	3	6	0	4	2	0	2	0	0	4	0
Nasopharynx	1 (0.1%)	100%	↑	1	0	1	0	1	0	0	0	0	0	0	1
Tonsil	3 (0.3%)	-73%	↓	2	1	3	0	2	1	0	0	1	0	2	0
Oropharynx	2 (0.2%)	-33%	↓	2	0	2	0	1	1	1	0	1	0	0	0
Hypopharynx	3 (0.3%)	0%	=	3	0	2	1	1	2	0	0	0	0	2	0
DIGESTIVE SYSTEM	**165 (14.8%)**	**-8%**	↓	**86**	**79**	**144**	**21**	**84**	**81**	**1**	**27**	**44**	**29**	**37**	**6**
Esophagus	14 (1.3%)	-18%	↓	9	5	12	2	3	11	0	2	3	3	4	0
Stomach	18 (1.6%)	13%	↑	10	8	15	3	2	16	0	1	6	1	6	1
Small Intestine	6 (0.5%)	-25%	↓	4	2	6	0	5	1	0	4	0	1	0	1
Colon Excluding Rectum	47 (4.2%)	-18%	↓	22	25	42	5	31	16	1	10	11	9	9	2
Rectum & Rectosigmoid	25 (2.2%)	4%	↑	14	11	23	2	22	3	0	3	10	7	3	0
Anus, Anal Canal & Anorectum	10 (0.9%)	25%	↑	5	5	6	4	8	2	0	1	3	2	0	0
Liver & Intrahepatic Bile Duct	7 (0.6%)	0%	=	5	2	5	2	2	5	0	1	1	1	1	1
Other Biliary	4 (0.4%)	0%	=	2	2	4	0	1	3	0	1	0	0	2	1
Pancreas	31 (2.8%)	-9%	↓	13	18	29	2	8	23	0	4	10	4	11	0
Retroperitoneum	1 (0.1%)	0%	=	1	0	1	0	0	1	0	0	0	1	0	0
Peritoneum, Omentum & Mesentery	1 (0.1%)	0%	=	0	1	1	0	1	0	0	0	0	0	1	0
Other Digestive Organs	1 (0.1%)	0%	=	1	0	0	1	1	0	0	0	0	0	0	0
RESPIRATORY SYSTEM	**190 (17.0%)**	**-16%**	↓	**114**	**76**	**177**	**13**	**77**	**113**	**0**	**45**	**15**	**49**	**67**	**1**
Nose, Nasal Cavity & Middle Ear	3 (0.3%)	0%	=	1	2	2	1	3	0	0	2	0	0	0	0
Larynx	10 (0.9%)	-17%	↓	9	1	10	0	6	4	0	4	2	3	1	0
Lung & Bronchus	177 (15.8%)	-16%	↓	104	73	165	12	68	109	0	39	13	46	66	1
SOFT TISSUE (Including Heart)	**9 (0.8%)**	**0%**	=	**4**	**5**	**6**	**3**	**5**	**4**	**0**	**3**	**0**	**1**	**2**	**0**
SKIN EXCLUDING BASAL & SQUAMOUS	**41 (3.7%)**	**-16%**	↓	**26**	**15**	**37**	**4**	**36**	**5**	**14**	**15**	**4**	**3**	**1**	**0**
Melanoma -- Skin	38 (3.4%)	-17%	↓	24	14	34	4	35	3	14	15	3	1	1	0
Other Non-Epithelial Skin	3 (0.3%)	0%	=	2	1	3	0	1	2	0	0	1	2	0	0
BASAL & SQUAMOUS	**1 (0.1%)**	**100%**	↑	**0**	**1**	**0**	**1**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
BREAST	**210 (18.8%)**	**14%**	↑	5	205	200	10	206	4	36	74	64	17	6	3
FEMALE GENITAL SYSTEM	**68 (6.1%)**	**31%**	↑	0	68	54	14	51	17	0	27	6	12	9	0
Cervix Uteri	5 (0.4%)	-29%	↓	0	5	4	1	2	3	0	1	1	1	1	0
Corpus & Uterus, NOS	34 (3.0%)	62%	↑	0	34	31	3	32	2	0	24	2	4	1	0
Ovary	16 (1.4%)	14%	↑	0	16	13	3	9	7	0	2	1	5	5	0
Vagina	1 (0.1%)	-50%	↓	0	1	0	1	0	1	0	0	0	0	0	0
Vulva	10 (0.9%)	67%	↑	0	10	4	6	7	3	0	0	2	1	1	0
Other Female Genital Organs	2 (0.2%)	0%	=	0	2	2	0	1	1	0	0	0	1	1	0
MALE GENITAL SYSTEM	**108 (9.7%)**	**5%**	↑	**108**	**0**	**83**	**25**	**100**	**8**	**1**	**11**	**52**	**7**	**12**	**0**
Prostate	101 (9.0%)	5%	↑	101	0	78	23	93	8	0	10	49	7	12	0
Testis	2 (0.2%)	-67%	↓	2	0	2	0	2	0	0	1	1	0	0	0
Penis	5 (0.4%)	400%	↑	5	0	3	2	5	0	1	0	2	0	0	0

Cancer Registry 2014 Caseload Summary

PRIMARY SITE	TOTAL	% CHANGE FROM 2013		MALE	FEMALE	NEWLY DX	NONANALYTIC	ALIVE	EXPIRED	STAGE 0	STAGE I	STAGE II	STAGE III	STAGE IV	UNKNOWN OR N/A
URINARY SYSTEM	**83 (7.4%)**	**-12%**	↓	**69**	**14**	**75**	**8**	**65**	**18**	**28**	**17**	**14**	**5**	**7**	**4**
Urinary Bladder	49 (4.4%)	-18%	↓	45	4	45	4	39	10	26	5	9	1	4	0
Kidney & Renal Pelvis	32 (2.9%)	-3%	↓	23	9	29	3	24	8	1	12	5	4	3	4
Ureter	2 (0.2%)	100%	↑	1	1	1	1	2	0	1	0	0	0	0	0
EYE & ORBIT	**1 (0.1%)**	**0%**	=	**0**	**1**	**0**	**1**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
BRAIN & OTHER NERVOUS SY	**28 (2.5%)**	**0%**	=	**14**	**14**	**22**	**6**	**20**	**8**	**0**	**0**	**0**	**0**	**0**	**22**
Brain	16 (1.4%)	-11%	↓	8	8	11	5	8	8	0	0	0	0	0	11
Cranial Nerves Other Nervous Systen	12 (1.1%)	20%	↑	6	6	11	1	12	0	0	0	0	0	0	11
ENDOCRINE SYSTEM	**20 (1.8%)**	**54%**	↑	**8**	**12**	**18**	**2**	**20**	**0**	**0**	**6**	**1**	**1**	**0**	**10**
Thyroid	10 (0.9%)	100%	↑	1	9	8	2	10	0	0	6	1	1	0	0
Other Endocrine including Thymus	10 (0.9%)	25%	↑	7	3	10	0	10	0	0	0	0	0	0	10
LYMPHOMA	**55 (4.9%)**	**8%**	↑	**26**	**29**	**46**	**9**	**44**	**11**	**0**	**7**	**15**	**10**	**13**	**1**
Hodgkin Lymphoma	9 (0.8%)	13%	↑	3	6	9	0	9	0	0	2	5	1	1	0
Non-Hodgkin Lymphoma	46 (4.1%)	7%	↑	23	23	37	9	35	11	0	5	10	9	12	1
MYELOMA	13 (1.2%)	-32%	↓	6	7	12	1	10	3	0	0	0	0	0	12
LEUKEMIA	36 (3.2%)	16%	↑	17	19	31	5	19	17	0	0	0	0	0	31
Lymphocytic Leukemia	14 (1.3%)	-18%	↓	7	7	12	2	11	3	0	0	0	0	0	12
Myeloid & Monocytic Leukemia	19 (1.7%)	36%	↑	8	11	16	3	6	13	0	0	0	0	0	16
Other Leukemia	3 (0.3%)	100%	↑	2	1	3	0	2	1	0	0	0	0	0	3
MESOTHELIOMA	51 (4.6%)	538%	↑	21	30	41	10	28	23	0	0	0	0	0	41
MISCELLANEOUS	51 (4.6%)	65%	↑	21	30	41	10	28	23	0	0	0	0	0	41
															0
Total	**1,118**	**-1%**	↓	**534**	**584**	**983**	**135**	**794**	**324**	**82**	**239**	**222**	**137**	**171**	**132**

MaineGeneral
Harold Alfond Center
for Cancer Care
www.mainegeneral.org