

OHSU Cancer Committee

2008 Annual Report



Knight Cancer Institute
at Oregon Health & Science University



Brian Druker, M.D., Director of the OHSU Knight Cancer Institute and Kevin Billingsley, M.D., Chairman, OHSU Cancer Committee collaborate closely on cancer institute services.

OHSU Cancer Committee

2008 Annual Report

TABLE OF CONTENTS

A message from the chairman of the OHSU Cancer Committee.....	2
Curing lung cancer at OHSU.....	3
Summary of cancer registry activities.....	13
2007 Analytic Cases – Site and stage distribution	15
OHSU Cancer Committee and OHSU Leadership Teams.....	16

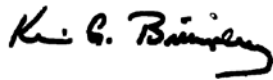
Dear Colleagues,

I am pleased and honored to present the 2008 Annual Report of the OHSU Cancer Committee. This year's brief report focuses on specific thoracic oncology clinical activities and does not cover the breadth of services and programs we offer. As our broad range of oncology services continue to expand we are even better positioned serve the people of Oregon and throughout the Pacific Northwest.

Over the past year we have devoted substantial effort to forging partnerships with our community counterparts throughout the region. We have been delighted to announce that Pacific Oncology, a large community oncology group with offices throughout the Portland metro area, will become part of the OHSU Knight Cancer Institute as of January 1, 2009. This alliance will allow us to optimize the delivery of convenient patient-centered care as well as improve access to OHSU clinical trials and specialty expertise to patients throughout the region.

2008 has been a transformational year for our institute, highlighted by the recent \$100 million gift from Phil and Penny Knight. This gift will support the development of a wide range of cancer clinical programs and research efforts.

As Oregon's only National Cancer Institute-designated cancer center for more than 10 years, we continue to press ahead with the goal of making Oregon's death rate from cancer the lowest in the nation.



Kevin Billingsley, M.D.

Chairman, OHSU Cancer Committee

Hedinger Associate Professor of Surgery and Chief of the Division of Surgical Oncology

OHSU Knight Cancer Institute

At the OHSU Knight Cancer Institute, we have more than 500 medical experts and staff working together to reduce the impact of cancer. Through their efforts hundreds of research findings are published each year.

Our investigators seek to develop innovative, less toxic and more effective strategies for cancer prevention, treatment, diagnosis and control. Our multidisciplinary clinical teams deliver the region's broadest array of care, and provide access to clinical trials, including Phase 1 trials. We are active in federally funded, multicenter cancer study groups as a part of our commitment to developing institutional clinical trials of a translational nature.

Our faculty trains tomorrow's cancer experts, teaches advanced specialty courses to community oncologists, and partners with healthcare organizations throughout the region.



Curing lung cancer at OHSU

The OHSU Thoracic Oncology program partners with physicians, researchers, patients and families to bring state-of-the-art lung cancer care to Oregon. Together we are working to find new approaches to reduce the number of lung cancer deaths in our region.

More women will die of lung cancer than ovarian, breast, and uterine cancer combined.

Although the death rate for lung cancer has declined by about 1 percent per year since 1990,¹ lung cancer is still the most common deadly cancer in the United States and in Oregon. In 2008, lung cancer will be diagnosed in more than 215,000 Americans and 2,500 Oregonians. It will kill 166,000 Americans and 2,160 Oregonians. This year, more Oregonians will die of lung cancer than any other cancer. More women will die of lung cancer than ovarian, breast and uterine cancer combined.¹ Although there are declining rates of lung cancer deaths, not all Oregonians fall under these statistics. Significant disparity remains in the chances of surviving lung cancer based on where one lives. (Figure 1)

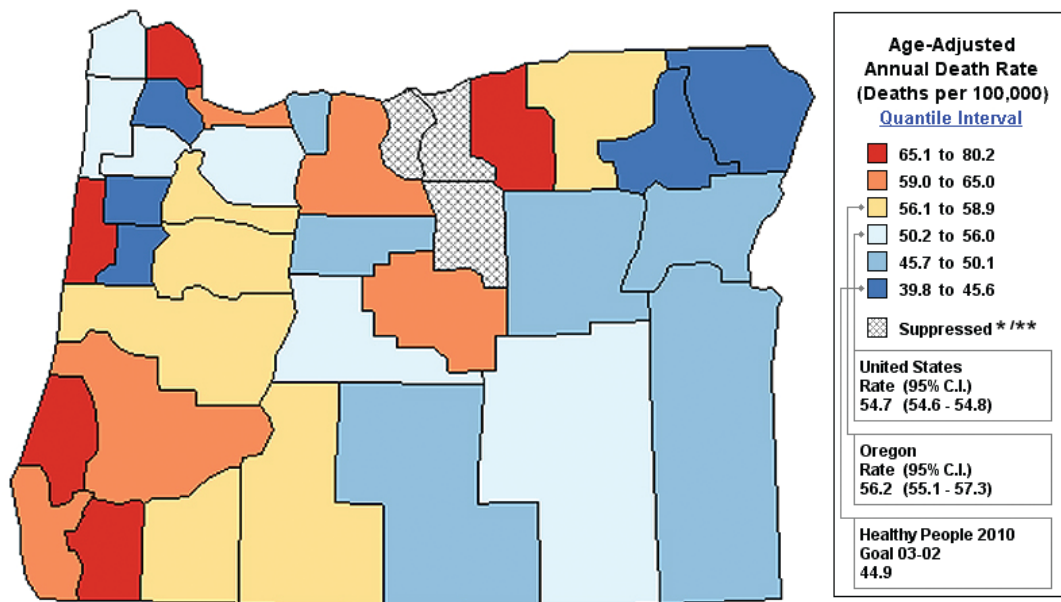
While cigarette smoking remains the predominant cause of lung cancer, we now know that “never smokers” are at risk as well. The incidence of lung cancer in never smokers is 21

per 100,000 person years in women and 14 per 100,000 person years in men. To put these statistics in perspective, the risk of myeloma in men is 13 per 100,000 and the risk of cervical or thyroid cancer in women is 17 per 100,000. A woman who has never smoked is just as likely as, or more likely to develop lung cancer than cervical cancer.²

MULTIDISCIPLINARY APPROACH TO EVALUATION AND TREATMENT AT OHSU

No screening method for lung cancer has yet proven to increase survival, although national trials are ongoing. The majority of lung cancer patients present with advanced stage disease. For patients with both early and late stage disease, multiple treatment options exist. Our philosophy is no two patients and no two lung cancers are exactly alike. Each person and each disease must be evaluated individually to determine the best possible treatment.

Figure 1 State of Oregon lung cancer annual death rate



Age-adjusted death rates, all races, both sexes, all ages. Created by statecancerprofiles.gov from death rates calculated by the National Cancer Institute using SEERStat.

At OHSU, our multidisciplinary and multispecialty team evaluates lung cancer patients at a weekly conference. This meeting brings together thoracic surgeons, radiation oncologists, medical oncologists, thoracic radiologists, pathologists, physician assistants and nurses, each with specific perspectives and specialized knowledge and skills. This multidisciplinary approach ensures every patient is thoroughly evaluated, and has the opportunity to receive the best known treatment for their individual needs.

At present, surgical resection remains the foundation for the cure of lung cancer and is the recognized gold standard of care for eligible patients. There has been, however, a national trend away from surgical resection. While the reasons for this trend are unclear, they may include lack of access to thoracic surgeons and a generally nihilistic view of lung cancer treatment.³

STAGING

Our thorough, multidisciplinary evaluation of each case involves non invasive staging, including whole body FDG-PET and CT Chest. Jeff Stevens M.D. and Robert Nance M.D. perform whole body FDG-PET scanning on a Phillips Gemini Time-of-Flight PET/CT. In addition, one Phillip Precedence Spect/CT and three 4 Spect Cameras with Planar capability are

available. These machines allow them to perform state-of-the-art imaging as a routine part of lung cancer care.

Steven Primack M.D., Marc Gosselin M.D. and Martha Maier M.D., thoracic radiologists and regular contributors to our multidisciplinary conference, interpret information gained from CT and PET scans to help determine clinical stage and formulate treatment plans. Often imaging identifies areas suspicious for metastatic disease. CT and PET, however, depending on the patient population and pre-test probability, have false positive rates of 20 to 40 percent. The team strives to offer every patient an opportunity for cure while avoiding therapies of little benefit or unnecessarily invasive staging procedures.

Endobronchial ultrasound and needle biopsy –

This procedure, brought to OHSU by Mark Deffenbach M.D. and Paul Schipper M.D., introduces an ultrasound machine into the airway on the tip of a bronchoscope. Under real-time ultrasound guidance, needle biopsies of mediastinal lymph nodes and other mediastinal masses can be obtained (Figures 2 and 3). Previously these needle biopsies were done “blindly” using a bronchoscope or more invasively with cervical mediastinoscopy. Endobronchial ultrasound and

Under real-time ultrasound guidance, needle biopsies of mediastinal lymph nodes and other mediastinal masses can be obtained.

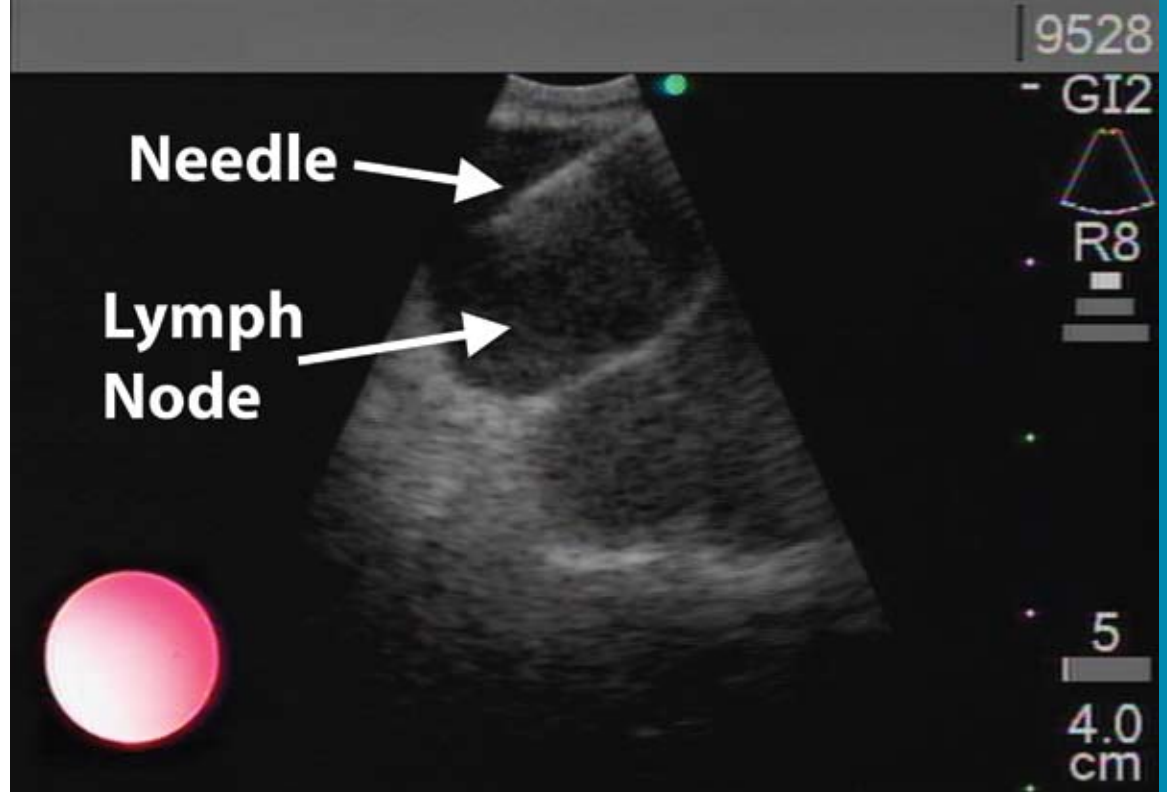


Figure 2 Endobronchial ultrasound and needle biopsy of a mediastinal lymph node being performed at OHSU.

needle biopsy greatly increases the success rate of biopsying the suspicious lymph node while decreasing the chance of injuring a large blood vessel or other structure.

Other techniques – Other staging techniques commonly offered are cervical mediastinoscopy, transthoracic CT or ultrasound-guided needle biopsy, endoscopic esophageal ultrasound and needle biopsy, and thoracoscopy. Clinicians at OHSU meet regularly to discuss which of the multiple techniques available will best suit a particular patient. This collaboration assures high standards of care without long delays in treatment planning.

THORACIC SURGERY

The Section of General Thoracic Surgery at OHSU was established in 2001, and is the first of its kind in Oregon with board-certified cardiothoracic surgeons specializing exclusively in general thoracic surgery and thoracic oncology in particular. The program was established in 2001 by Mithran Sukumar M.D., and joined by Paul Schipper M.D. in 2004.

OUTCOMES-BASED MEDICINE

Thoracic surgeons at OHSU strive to provide high quality, comprehensive and compassionate care. Since July 2004 we have voluntarily participated with the national Society of Thoracic Surgeons

General Thoracic Surgery (STS) database, which allows us to measure our outcomes, compare them against standard benchmarks, and constantly improve the quality of care delivered. Because participation in this database is voluntary, institutions choosing to participate have an interest in quality improvement, and their outcomes are generally better than those observed in non-voluntary national administrative databases.

The data – From July 2004 to July 2007, 30-day perioperative mortality for all general thoracic surgery at OHSU was 2.9 percent, which is below the 30-day mortality of 3.2 percent for all participants in the STS database. Morbidity in the STS database is risk adjusted and tracked using rate of hospital length-of-stay greater than 14 days. OHSU thoracic surgery had a risk adjusted rate of length-of-stay greater than 14 days of 7.4 percent (95percent CI 4.1percent, 12.4 percent). This rate represents a standardized incidence ratio of 1.05 (95 percent CI 0.57 to 1.74) showing OHSU meets the benchmark set by the participants in this database. The standard of care for lung cancer resection and survival is anatomic resection. During this time period, 86 percent of all lung cancer surgeries at OHSU were performed with an anatomic resection. Reason for not performing an anatomic resection was overwhelmingly poor pulmonary



Figure 3 Endobronchial ultrasound and needle biopsy

function and patient inability to tolerate any resection greater than a wedge resection. Thirty-day mortality for lung cancer resection surgery at OHSU for the four years from July 2004 to July 2008 is 2.7 percent.

In addition to tracking clinical data, OHSU thoracic surgeons also track administrative data, which are obtained largely from hospital billing records. According to the University Health System Consortium, which tracks outcomes for academic medical centers, OHSU had the lowest perioperative mortality on the West Coast, including Washington, Oregon, California and Colorado, for major chest procedures (DRG 075) for the year from April 2005 to March 2006. TRIDENT data for calendar year 2005 showed OHSU actual mortality of 0.5 percent compared to a risk adjusted expected mortality of 2.1 percent. This mortality is the lowest in the Portland area. TRIDENT data also showed a clinically adjusted length of stay per case of 6.9 days, compared to a range of 6.2 days to 7.6 days for Portland area hospitals.

LUNG CANCER SURGERY

Lung cancer surgery at OHSU is performed in state-of-the-art endoscopic operating suites. Many procedures traditionally performed through a larger incision are accomplished using minimally

invasive techniques. A common procedure for early lung cancer and the gold standard treatment for eligible patients is anatomic lobectomy. In the past, this procedure involved a 10-inch incision, spreading the ribs apart and considerable recovery and discomfort. Mithran Sukumar M.D., and Paul Schipper M.D. introduced minimally invasive Thoracoscopic Lobectomy to OHSU in 2004. This procedure is the same high level oncologic procedure with dissection of the hilum, mediastinal lymph node dissection of three or more separate zones, and complete resection of the involved lobe. It is done, however, using a 2-inch incision, two half-inch incisions, and no rib spreading. Nationwide, this technique has been shown to speed recovery. More importantly, in patients who would benefit from post-operative chemotherapy, this technique significantly increases their chances of getting to that therapy and tolerating the full course.

Patients receiving chemotherapy at OHSU are treated by OHSU medical oncologists at the OHSU Center for Health & Healing, located at Portland's South Waterfront. Our medical oncologists regularly consult with clinicians and oncologists throughout Oregon on treatment plans. Patients receive chemotherapy in the chemotherapy infusion room at the Center for Health & Healing, adjacent to the clinics.

OHSU has the lowest perioperative mortality on the West Coast.

Table 1

All lung cancer patients receiving radiation therapy at OHSU:
Stage at diagnosis by year of diagnosis

Stage At Dx	Year					
	2003	2004	2005	2006	2007	TOTAL
IA	3	1	1	3	13	21
IB	3	0	1	2	12	18
IIA	2	1	1	1	1	6
IIB	1	3	0	2	0	6
IIIA	11	11	6	12	8	48
IIIB	13	7	6	21	15	62
IV	23	29	21	30	51	154
Unstaged	0	3	2	0	0	5
TOTAL	56	55	38	71	100	320

The radiation medicine department has nearly doubled the number of lung cancer patients treated at OHSU in recent years.

Anesthesia – Anesthesia at OHSU is performed by dedicated thoracic anesthesiologists. Post-operative ICU care benefits from a board-certified cardiothoracic intensivist present in the ICU 24 hours a day, 7 days a week. Patients eligible for floor care recover in the Peter O. Kohler Pavilion on a floor dedicated to the care of cardiothoracic patients, giving nursing and staff at all levels specific expertise in thoracic surgery.

RADIATION ONCOLOGY

The Department of Radiation Medicine at OHSU was established in 1973, and was the first independent department of its discipline in the United States. Under the leadership of Charles R. Thomas, Jr. M.D. and John Holland M.D., the department has nearly doubled the number of lung cancer patients treated at OHSU in recent years (**Table 1**). With the long-anticipated department relocation to the 4th floor of the Peter O. Kohler pavilion in July 2007, radiation oncologists at OHSU continue to provide high quality and compassionate care for lung cancer patients in a state-of-the-art facility. Today, all radiation therapy simulation and treatment planning is based on three-dimensional CT image data. Recently, both a CT-PET as well as a CT-SPECT unit have been equipped to provide radiation therapy planning images, enabling better delineation of radiation

therapy target volumes through the implementation of metabolic tumor information into the therapy plan. Four-dimensional CT data (4DCT), allowing a movie-like representation of the motion of lung tumors with respiration is routinely employed and integrated into the radiation plan. The department continues to utilize 3D-CT based treatment planning, but can also deliver intensity-modulated radiotherapy (IMRT). Lung brachytherapy is delivered using endobronchial Ir-192 HDR. More recently, I-125 permanent mesh interstitial brachytherapy has been added as a treatment option after sublobar resection of early-stage non-small cell cancers.

ADVANCED EQUIPMENT AND TREATMENTS

New, cutting-edge radiation therapy equipment allows OHSU physicians to offer patients the most advanced treatments, such as Image-Guided Radiation Therapy (IGRT) and Stereotactic Body Radiation Therapy (SBRT). In addition to two Varian Trilogy™ linear accelerators, one of the nation's first Varian/BrainLAB Novalis TX™ stereotactic linear accelerators was recently commissioned for clinical use. This uniquely capable equipment features the highest resolution multi-leaf collimator or radiation beam shaping device, robotic table-tops, stereoscopic X-ray image-guidance, on-board cone-beam CT

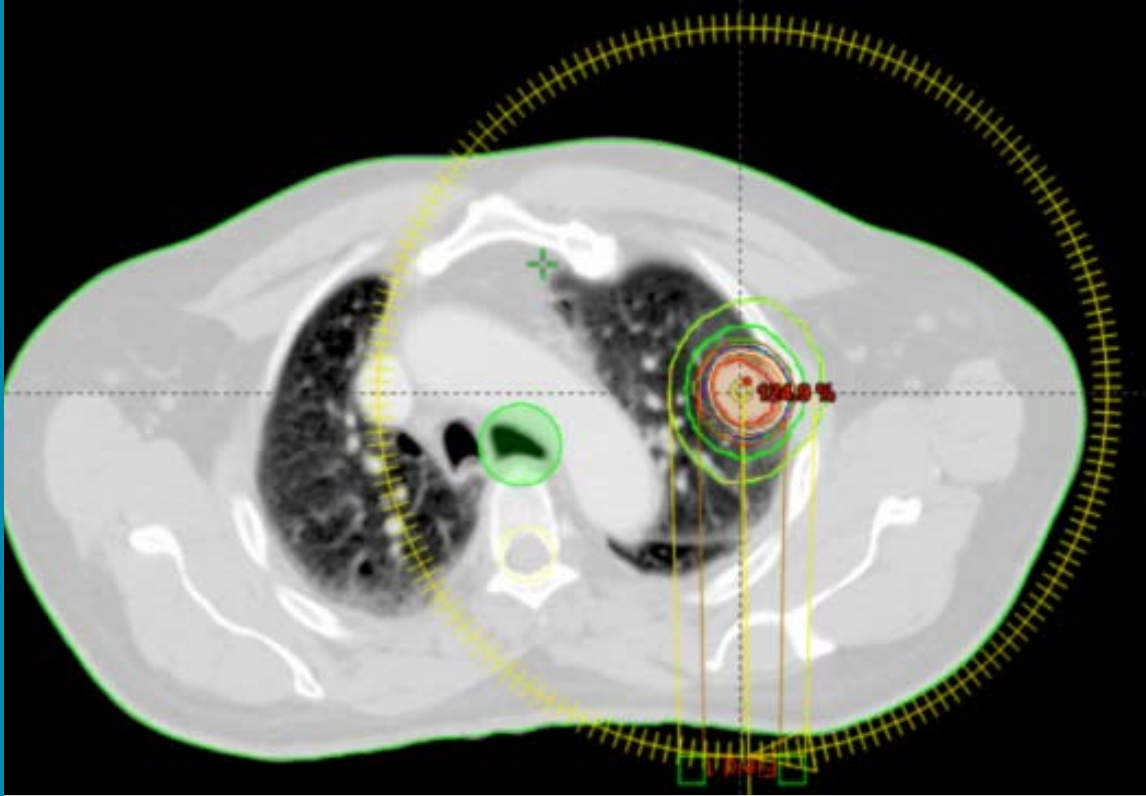


Figure 4 Typical SBRT radiation treatment plan of a Stage 1 NSCLC.

The nation's first installation of a fully equipped 16-slice Philips big-bore CT scanner along with the Novalis TX unit in one treatment vault.

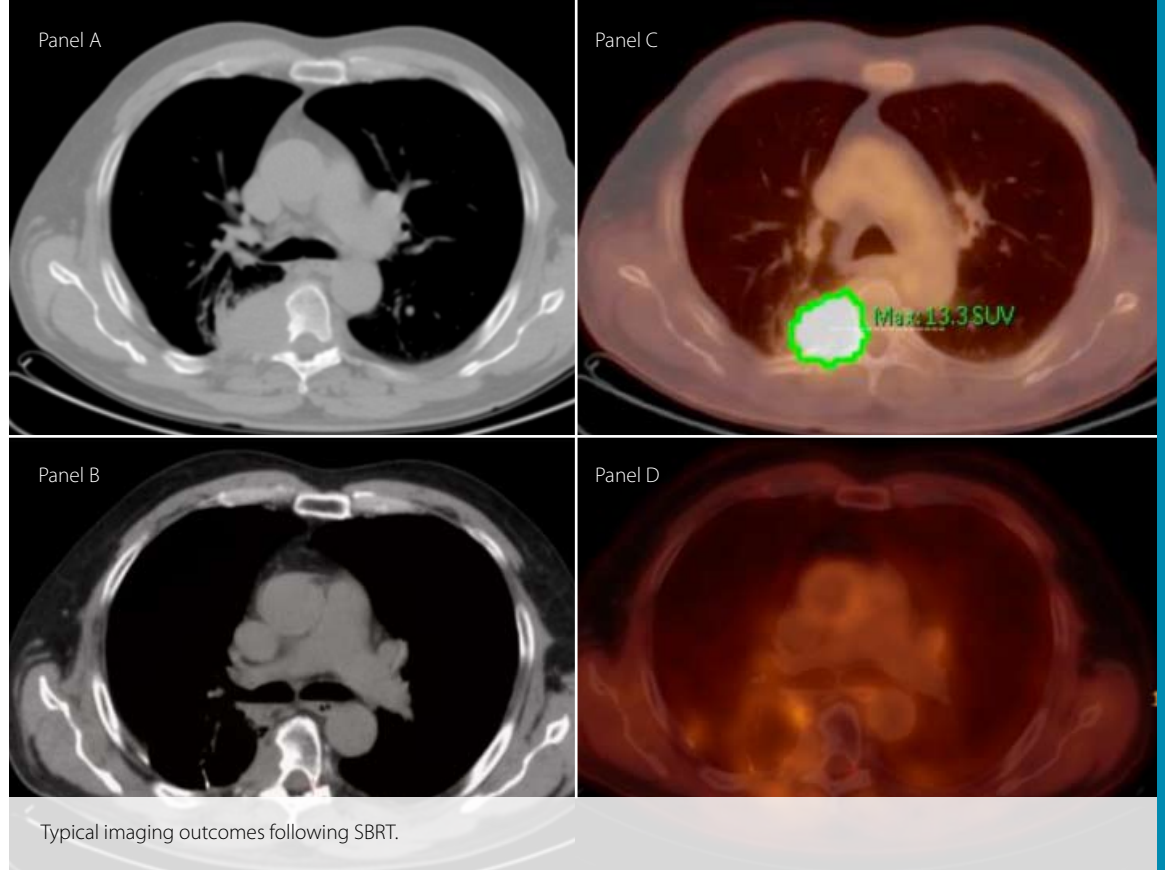
imaging and optical image-guidance. The nation's first installation of a fully equipped 16-slice Philips big-bore CT scanner along with the Novalis TX unit in one treatment vault allows physicians to target early-stage lung tumors with sub-millimeter precision and assess treatment response in real-time.

Stereotactic Body Radiation Therapy (SBRT) – for medically inoperable early-stage non-small cell lung tumors has been a recent focus of the department under the auspices of Martin Fuss, M.D., vice chairman and director of image-guided radiotherapy. This new treatment concept allows lung cancers to be treated in only 5 days compared to a 7- to 8-week conventional treatment course. The outcomes in terms of local tumor control are also far superior to outcomes observed in the past. Because SBRT can focus the tumor-killing high-dose radiation close to the outline of small lung tumors (see Figure 4), control of early stage lung cancer with radiation therapy has increased from roughly 50 percent to over 85 percent, providing the opportunity for curative treatment to patients unfit to undergo a surgical procedure. A significant increase in the use of radiotherapy to treat Stage I disease was experienced because of SBRT. Since July 2007, Fuss has treated 33 patients with newly diagnosed or recurrent small volume lung cancer. As of September 2008, a

significant tumor reduction or complete treatment response was assessed in 26 of 28 patients with imaging follow-up, with two patients showing stable disease. While local control was very favorable, five patients still developed nodal or distant metastases, indicating the need to identify patients at risk for early regional or distant failure. Such cases might warrant combined chemotherapy and SBRT treatment or adjuvant chemotherapy. Similarly favorable results were achieved in nine patients treated for limited volume metastatic lung metastases.

Typical SBRT radiation treatment plan of a stage 1 NSCLC – Prescribed dose was 60 Gy in five fractions delivered every other day. The radiation was delivered using a conformal arc delivery mode, in which the outline of the radiation field is continuously adjusted according to the respective beams-eye-view projection as the linear accelerator gantry moves about the patient. The depicted isodose lines represent the prescribed dose (100 percent) in blue, 90 percent in red, 70 percent in green and 50 percent in yellow.

Typical imaging outcomes following SBRT – Panels A and B show the tumor and corresponding PET at the time of SBRT treatment simulation. Panels C and D show treatment response seven months following delivery of 60 Gy in five fractions.



Typical imaging outcomes following SBRT.

There are more than 200 open cancer clinical trials at the OHSU Knight Cancer Institute.

LUNG CANCER RESEARCH AT OHSU

Lung cancer research is an integral part of the OHSU Thoracic Oncology team's work. Questions about the diagnosis and treatment at every stage of lung cancer are being asked and answers being sought.

Clinical Trials *(The following clinical trials are open for recruitment, unless otherwise noted.)*

CALGB 140503, lobectomy versus sublobar resection – Patients with peripheral cancers less than two centimeters in size and no clinical evidence of metastatic disease can participate in this study, to determine if removal of the entire lobe is necessary for these small local cancers.

American College of Surgeons Oncology Group study Z4032 – Patients with poor lung function who cannot tolerate a lobectomy can enroll in this study performing a sublobar resection and randomizing patients to receive or not receive brachytherapy seeds placed at the time of surgery. Intraoperative brachytherapy seed placement is a joint procedure performed by OHSU thoracic surgeons and radiation oncologists working together, each bringing their unique skills.

Both of the above trials are available by contacting Paul Schipper M.D..

SWOG-0533 – This study is examining the integration of Bevacizumab (a new anti-angiogenic agent) into the treatment of inoperable locally advanced Stage III lung cancer.

SWOG-0220 – This study is examining Cisplatin/Etoposide followed by surgical resection followed by Docetaxol for pancoast lung cancer (now closed to recruitment). Charles Thomas Jr. M.D. of Radiation Oncology is the national co-chairman of SWOG-0533 and SWOG-0220, in addition to other clinical trials.

Other chemotherapy and radiation trials – for Stage III and IV lung cancer are examining current best known therapy and comparing it to promising new medications and treatment modalities. OHSU participated in tissue banking under South West Oncology Group S0424 study examining the molecular epidemiology of lung cancer in smokers versus non-smokers and men versus women.

Table 2
Histology of Primary Lung Cancer at OHSU for Year 2007

	N	%
Adenocarcinoma	65	35%
Non-small cell carcinoma NOS	42	22%
Squamous cell carcinoma	35	19%
Small cell carcinoma	25	13%
Carcinoid	4	2%
Neuroendocrine carcinoma	2	1%
Mucoepidermoid carcinoma	1	<1%
Pulmonary blastoma	1	<1%
Malignancy NOS	13	7%

Table 3
Stage of Primary Lung Cancer at OHSU for Year 2007

	N	%
Stage I	44	23%
Stage II	4	2%
Stage III	40	21%
Stage IV	91	48%
Unstaged	3	2%

OHSU CANCER REGISTRY LUNG AND BRONCHUS SITE-SPECIFIC REVIEW

The OHSU Cancer Registry contains more than 40,000 cases, some with detailed data reaching back as far as 30 years. The registry tracks demographics, diagnostics, treatment and outcomes data to support the missions of the hospital. Teresa Mason, CTR and Paul Schipper M.D. examined this data for lung and bronchus cancer for calendar year 2007 for demographics, and years 1998 to 2003 for observed 5-year survivals.

For calendar year 2007, 188 analytic lung cancer cases were treated at OHSU. An analytic case is one in which the patient was either diagnosed at OHSU or received part or their entire first course of treatment at OHSU. Of the patients studied, there were 123 male, 64 female and one transsexual. Seventy percent were 60 or older. Ten percent were 80 years old or older. Histology and Stage are shown in **Tables 2 and 3** respectively.

Five-year actual survival for all cases diagnosed between 1998 and 2003 is reported in **Figure 5** for Non-small Cell Lung Cancer and **Figure 7** for Small Cell Lung Cancer. For comparison, 5-year survival for similar cases from 267 Nationwide Teaching Facilities as recorded in the National Cancer Database are shown in **Figures 6 and 8**. As expected, the

5-year survival for small cell cancer is much shorter than 5-year survival for non-small cancer both at OHSU and nationwide. Stage for stage, 5-year survival at OHSU is similar and uniformly longer at OHSU compared to nationwide standards.

This dataset, while representing the most recent observed 5-year data available from OHSU, pre-dates many substantial changes in the expertise and approach to lung cancer at OHSU. It will be exciting to see this data for the next five years and for the five years after that. More importantly, there are survivors at every stage of lung cancer.

BIBLIOGRAPHY

1. A Jemal, R Siegel, E Ward et al. Cancer Statistics 2008. *CA: A Cancer Journal for Clinicians* 2008; 58: 71-96.
2. H Wakelee, ET Chang, SL Gomez et al. Lung Cancer Incidence in Never Smokers. *Journal of Clinical Oncology* 2007; 25: 472 – 478.
3. NF Esnaola, M Gebregziabher, K Knott et al. Underuse of Surgical Resection for Localized, Non-Small Cell Lung Cancer Among Whites and African Americans in South Carolina. *Annals of Thoracic Surgery* 2008; 86: 220-6.

— Authored by Paul Schipper M.D.

The OHSU Cancer Registry contains more than 40,000 cases, some with detailed data reaching back as far as 30 years.

OHSU Observed Five Year Survival
For Lung, Bronchus - Non-Small Cell Carcinoma

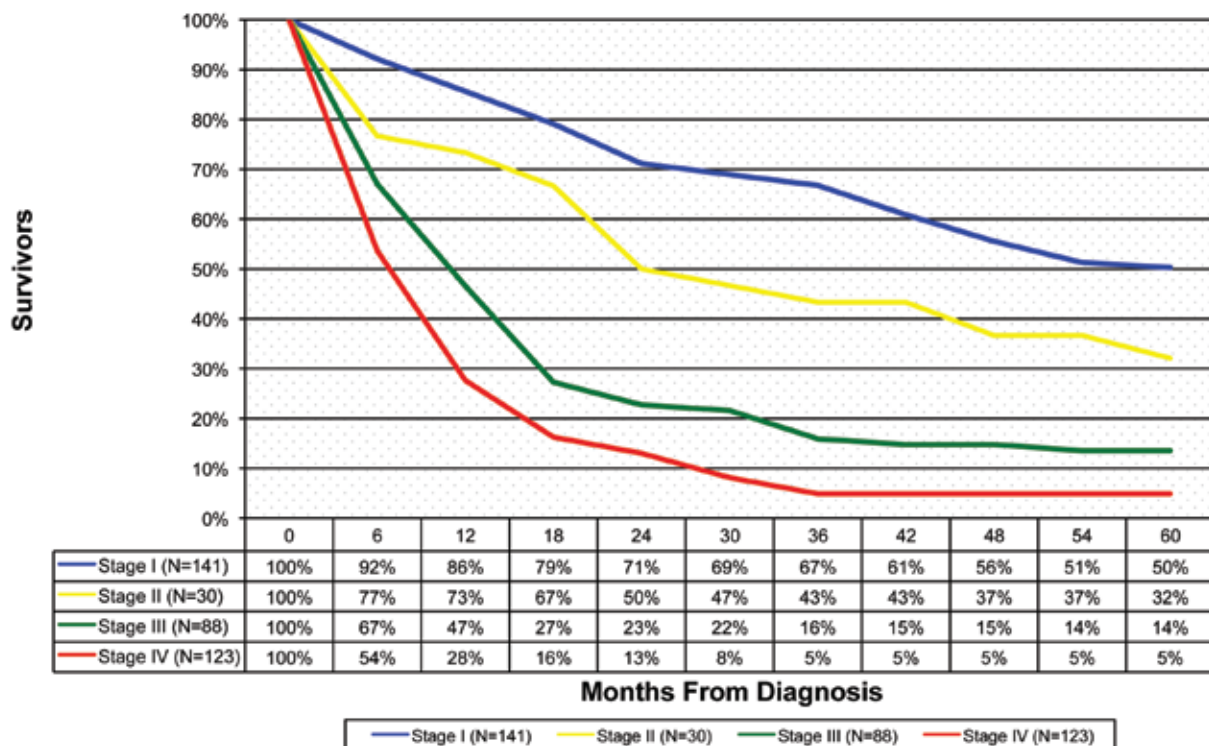
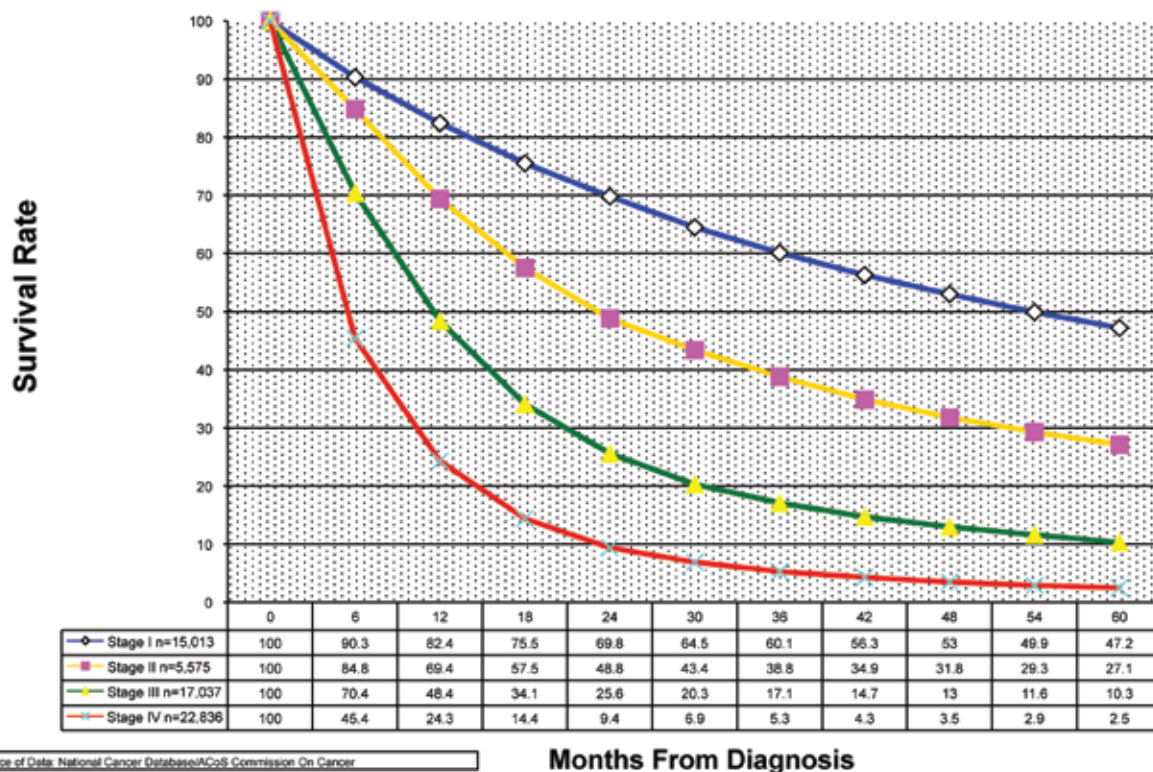


Figure 5

Comparison Survival: Observed Survival
For Lung, Bronchus - Non-Small Cell Carcinoma
Data From 267 Nationwide Teaching Facilities*



*Source of Data: National Cancer Database/ACoS; Commission On Cancer

Figure 6

OHSU Observed Five Year Survival For Lung, Bronchus - Small Cell Carcinoma

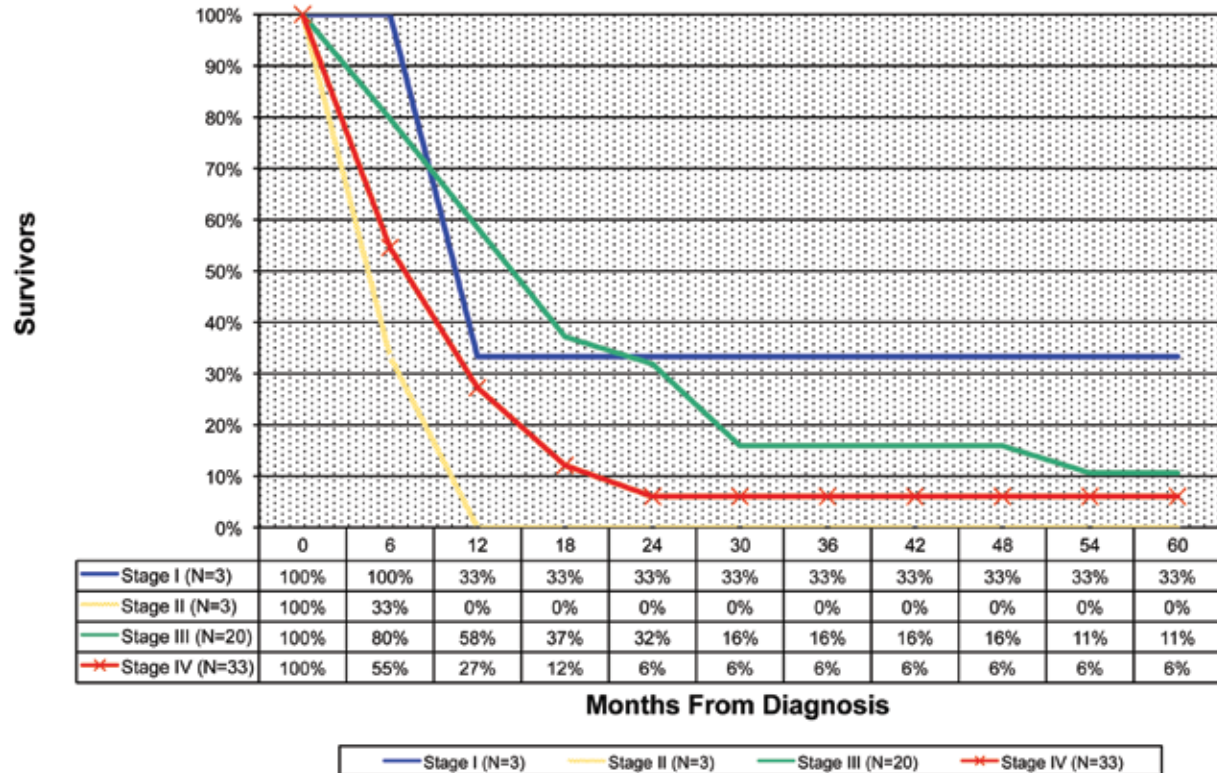
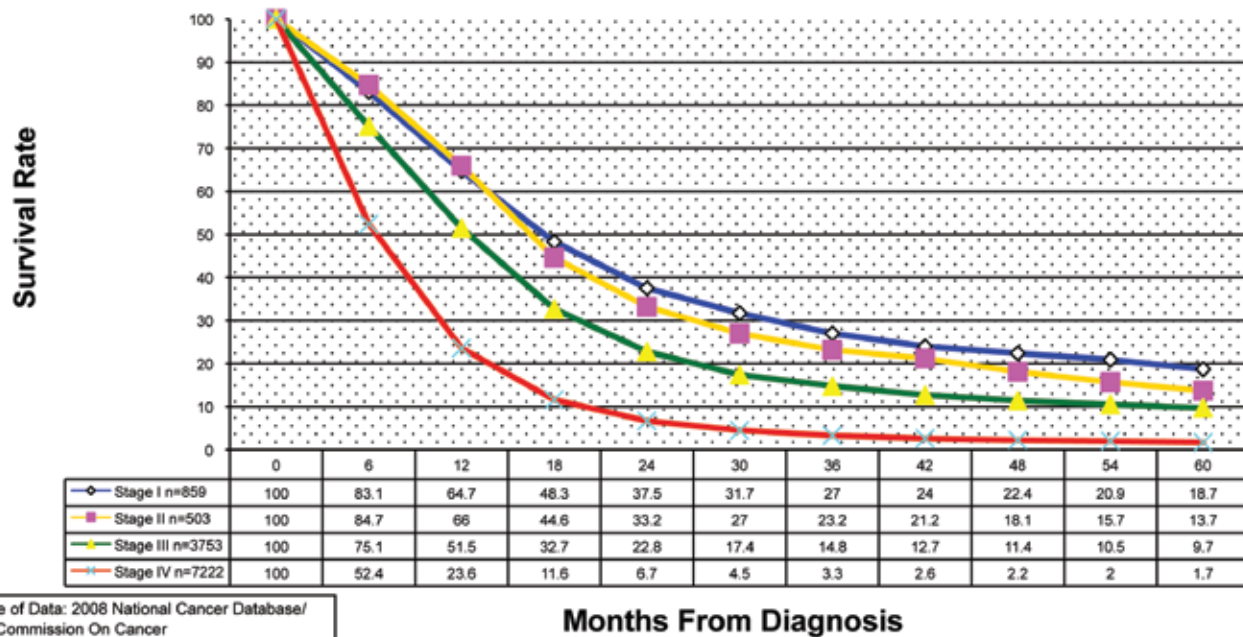


Figure 7

Comparison Survival: Observed Survival For Lung, Bronchus - Small Cell Carcinoma Data From 267 Nationwide Teaching Facilities*



*Source of Data: 2008 National Cancer Database/ ACoS Commission On Cancer

Figure 8



Cancer registry activities

The cancer registry at OHSU is an integral part of the OHSU Knight Cancer Institute's cancer program. The registry collects and maintains information on all cancer patients (as well as those with benign brain/CNS tumors) who come to any OHSU facility for diagnosis or treatment. The registry records extensive demographic, diagnostic, treatment and outcome data and is used by physicians for retrospective studies.

Over 43,000 patient records are currently housed in the cancer registry database.

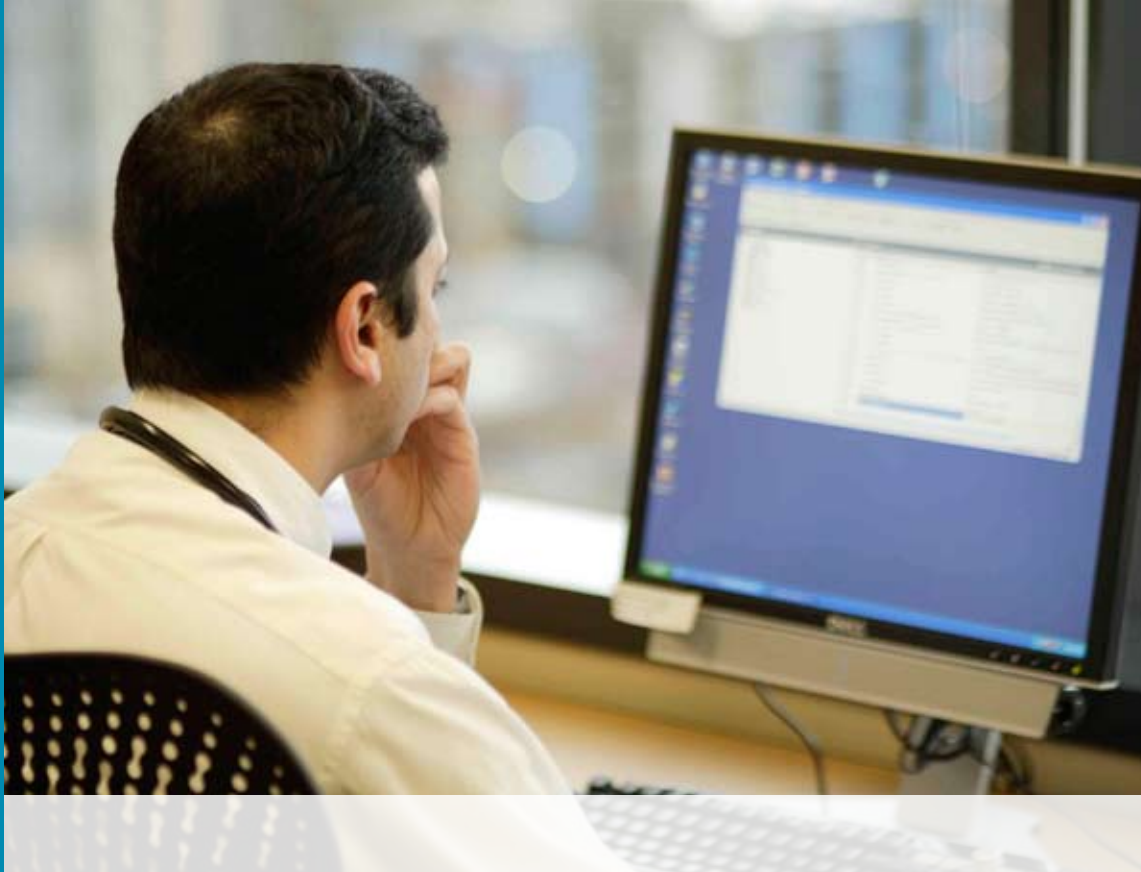
For the abstracting year of 2007, 3,850 new cases were added to the database. Of this number, 2,585 were analytic cases, defined as either diagnosed here and/or received all or part of first course treatment here. The remainder of these cases were non-analytic, defined as diagnosed elsewhere and all first course treatment elsewhere. Non-analytic cases are typically patients who come to OHSU for treatment of recurrent or progressive disease, or those patients who come to OHSU for consultation and treatment planning, but receive first course treatment elsewhere.

The 2007 caseload represents a significant increase of approximately 13 percent over 2006 figures. The registry now employs six full-time

registrars as well as a college student to assist with clerical tasks.

Over the course of this year, the registry was consistently able to meet the Commission on Cancer (CoC) requirements for abstracting timeliness and patient follow-up rates.

In 2008, we distributed pocket cards to all OHSU oncology physicians and new residents to promote the use of registry data. The number of requests for registry data increased by nearly 100 percent over the previous year. The increased awareness of the cancer registry led to more OHSU oncology physicians using cancer registry data for their research studies.



The registry is poised for another busy and exciting year and we anticipate a very successful ACoS CoC survey in Fall 2009.

In addition to maintaining the patient database, the registry also supports the Cancer Committee in a variety of activities. The cancer registry tracks, monitors and reports attendance and case presentation to the Cancer Committee for all 14 site-focused cancer conferences. The registry staff coordinates Cancer Committee meeting activities and works closely with the Committee to ensure all CoC standards are in full compliance. In 2008, the CoC mandated several substantial changes to the standards for cancer program approval. Some of the most important changes involve physician and registrar staging. The registry is currently playing an active role in the tracking, monitoring and reporting to the Cancer Committee the results of the new staging mandate audits. This year, the use of cancer registry data played an integral role in OHSU being named a Blue Distinction Center for Complex and Rare Cancers by Regence BlueCross BlueShield.

Next year already promises more challenges and an ever-changing patient makeup. The registry is poised for another busy and exciting year and

we anticipate a very successful ACoS CoC survey in Fall 2009.

For more information, or cancer registry data requests, contact Teresa Mason, C.T.R. at 503 494-6367 or masont@ohsu.edu.

2007 Analytic Cases - site and stage distribution

SITE	MALE	FEMALE	OTHER	TOTAL	0	I	II	III	IV	UNK	N/A
Lip/Oral	32	20	0	52	2	12	5	2	28	3	0
Pharynx	40	8	0	48	1	6	4	5	31	1	0
Larynx	21	6	0	27	3	5	6	5	8	0	0
Nasal Cavity/Sinus	2	5	0	7	0	2	0	0	3	0	2
Salivary Gland	8	5	0	13	0	0	2	2	9	0	0
Thyroid	22	53	0	75	0	44	5	7	19	0	0
Esophagus	41	3	0	44	5	6	13	10	8	2	0
Stomach	20	10	0	30	2	3	2	5	6	2	10
Small Intestine	12	5	0	17	0	0	0	2	2	0	13
Colon/Rectum	52	25	0	77	2	16	15	27	17	0	0
Anal Canal	9	5	0	14	3	3	6	2	0	0	0
Liver/Bile Duct	57	27	0	84	0	33	24	16	9	2	0
Other Biliary	3	4	0	7	0	3	3	0	1	0	0
Gallbladder	2	4	0	6	0	0	2	0	4	0	0
Pancreas	41	45	0	86	4	3	29	11	26	5	8
Lung	128	64	1	193	0	46	4	44	92	1	6
Bone	21	23	0	44	0	10	26	0	4	2	2
Soft Tissue	42	22	0	64	0	21	6	14	3	0	20
Melanoma	180	136	0	316	137	116	31	21	1	1	9
Skin (Other)	8	2	0	10	0	1	2	3	0	0	4
Breast	2	163	0	165	20	56	58	14	10	4	3
Cervix Uteri	0	10	0	10	0	5	2	1	2	0	0
Corpus Uteri	0	27	0	27	0	21	2	4	0	0	0
Ovary	0	32	0	32	0	4	3	18	5	1	1
Other Female	0	17	0	17	10	2	3	0	0	2	0
Prostate	178	0	0	178	0	0	144	22	11	1	0
Testis	25	0	0	25	0	14	3	8	0	0	0
Other Male	7	0	0	7	3	1	1	1	0	0	1
Kidney/Renal	42	32	0	74	2	40	5	16	10	0	1
Bladder	46	15	0	61	21	11	11	8	8	0	2
Eye	31	21	0	52	0	13	17	3	0	1	18
Brain/Cns (Benign)	106	127	0	233	0	0	0	0	0	0	233
Brain/Cns (Malig)	63	38	0	101	0	0	0	0	0	0	101
Lymphoma (Hodgkin)	8	4	0	12	0	3	6	0	3	0	0
Lymphoma (Nh)	59	39	0	98	0	38	13	13	32	2	0
Leukemia	69	60	0	129	0	0	0	0	0	0	129
Multiple Myeloma	13	10	0	23	0	0	0	0	0	0	23
Other Blood	17	17	0	34	0	0	0	0	0	0	34
Unknown Primary	17	14	0	31	0	0	0	0	0	0	31
Other/III-Defined	30	32	0	62	0	0	0	0	0	0	62
Total	1454	1130	1	2585	215	538	453	284	352	30	713

Note: Figures above represent analytic cases only (diagnosed here and/or received part or all first course treatment). Basal and squamous cell carcinoma of the skin and CIS of the cervix are not collected.

OHSU Cancer Committee and Leadership Teams 2008

OHSU CANCER COMMITTEE

Kevin Billingsley, M.D.
Surgical Oncology

Neil Gross, M.D.
Otolaryngology/Head and Neck Surgery

Brad Koslin, M.D.
Diagnostic Radiology

Ken Lee, M.D.
Surgical Dermatology

Steve Chui, M.D.
Medical Oncology

Erik Fromme, M.D.
Palliative Medicine

Daniel Herzig, M.D.
General Surgery

Christopher Corless, M.D.
Pathology

Charles Thomas, M.D.
Radiation Medicine

Linda Stork, M.D.
Pediatric Hematology/Oncology

Joe Bubalo, Pharm.D.
Pharmacy

Shelley Buettner, R.N.
Clinical Nurse Specialist

Bonnie Cox, B.S.N., R.N.
Nurse Manager, Adult Inpatient Oncology

Lori Ellingson, R.N., A.O.C.N.®
Adult Inpatient Oncology, Administration

Debra Erickson
Administrative Coordinator, Surgical Oncology

Gail Harper, R.N., B.S.N., M.P.A.-H.A.
Oncology Service Line Director

Susan Harris, R.N.
Nurse Manager, Inpatient BMT/Apheresis

Katie Hennessey, L.C.S.W.
Adult Outpatient Oncology Social Work

Ivy Ingram, M.A.
Community Relations Manager

Pat Ivie, M.B.A., M.T.(A.S.C.P.), C.P.H.Q.
Quality Improvement Specialist

Teresa Mason, C.T.R.
Cancer Registry Manager

Katie McRae, M.S., R.N.
Clinical Nurse Specialist

Kristin Atkinson
American Cancer Society

Kendra Todd, B.S., C.C.R.P.
OCI Clinical Research Manager

Connie Amos, M.S.
Rehabilitation Services Director

PROGRAM ACTIVITY COORDINATORS

Cancer Physician Liaison:
Daniel Herzig, M.D.

Cancer Conference Coordinator:
Kevin Billingsley, M.D.

Cancer Registry Data Quality Coordinator:
Teresa Mason, C.T.R.

Community Outreach Coordinators:
Katie Hennessey and Ivy Ingram

Cancer Quality Improvement Coordinator:
Pat Ivie, M.B.A., M.T. (A.S.C.P.), C.P.H.Q.

OHSU EXECUTIVE LEADERSHIP

President
Joseph Robertson Jr., M.D., M.B.A.

Executive Vice President
Steven D. Stadum, J.D.

Vice President for Academic Affairs and Provost
Lesley M. Hallick, Ph.D.

Executive Vice President and Executive Director,
Hospitals & Clinics
Peter F. Rapp

Dean, School of Medicine
Mark Richardson, M.D., M.ScB, M.B.A

Vice President and Chief Financial Officer
Bradley N. King, CPA, M.B.A, M.P.A

Vice President for Research
Daniel M. Dorsa, Ph.D.

Vice President of Human Resources
Rick Bentzinger

Vice President and General Counsel
Amy M. Wayson, J.D.

OHSU MEDICAL GROUP

President
Neil Swanson, M.D.

Chief Executive Officer
Tom Heckler

Chief Medical Officer
Mike Bonazzola, M.D.

Chief Financial Officer
David Crawford

Chief Compliance Officer
Bobbie Clawson

Chief Operations Officer
Matt Navigato

OHSU BOARD OF DIRECTORS

Chairman
Keith Thomson

Vice Chairman
Scott Gibson

Kirby Dyess
Román D. Hernández, Esq.
Joseph Robertson, Jr., M.D., M.B.A.
Lawrence Gray
Jay Waldron
Charles Wilhoite
Meredith Wilson
Jon Yunker

Board Secretary
Steven D. Stadum, J.D.

Assistant Secretary to the Board
Amy M. Wayson, J.D.

THE KNIGHT CANCER INSTITUTE COUNCIL

Eric Parsons, Chair
Dick Rubinstein, Vice Chairman
John Blackwell
Brian G. Booth
Cecil Drinkward
Wayne Drinkward
Alex Druker
John D. Eskildsen
Nancy Fischer
Ruth J. Fisher
Bill Foster
Julie Leuvrey
Charles Lilley
Tim C. Phillips
James H. Rudd
Nicholas Stanley
Rob Shick
Malia Wasson
Dwight E. Weber
Ben Whiteley
Christina Williams



Knight Cancer Institute
at Oregon Health & Science University

OHSU Knight Cancer Institute
Mail Code: BTE 355
3181 S.W. Sam Jackson Park Road
Portland, Oregon 97239-3098
www.ohsucancer.com
503 494-1617

CAN 09079 12/08