

Riverside Community Hospital

Cancer Program Annual Report 2011



Focus on Breast Cancer

2005 - 2010

Mission

Riverside Community Hospital is committed to the care and comfort of our patients and improving the overall health of our community by providing healthcare services with integrity, compassion and excellence.

Vision

Riverside Community Hospital will be the employer and provider of choice by offering comprehensive healthcare services whose cornerstones are quality, safety, compassion, and service excellence.

Values

Passion for Excellence
Integrity
Dignity
Teamwork
Diversity
Initiative
Community Partner
Financial Responsibility



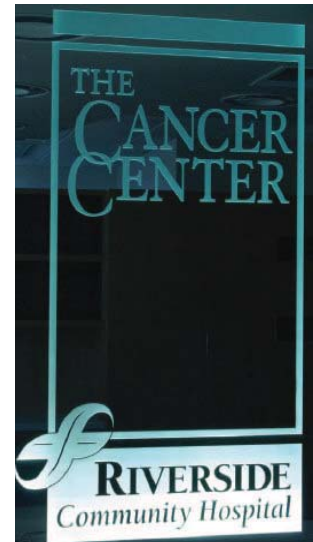
Executive Summary

Riverside Community Hospital is a 373-bed facility committed to the care and comfort of our patients and improving the overall health of our community by providing healthcare services with integrity, compassion and excellence.

The Cancer Center at Riverside Community Hospital is a milestone for our residents. In 2003 we opened our 8,200 square foot facility and, since that time, patients have been seeking the high caliber services we offer close to home.

Through a collaborative, multidisciplinary approach, we offer uncompromised dedication to the health and quality of the community we serve. Our physicians, surgeons, and medical professionals are highly trained in the management and recognition of our patients healthcare needs.

Our dedicated team of specialists at The Cancer Center coordinate all aspects of care such as pre-treatment financial arrangements and education for patients and families. Dietitians and social workers collaborate to ensure optimal health. Chaplains provide a spiritual support system for patients and their families. Our staff also includes pharmacists, clinical coordinators, nurses, radiation therapists and other professionals, who provide guidance and support through the treatment process. Working together, we create a caring environment designed to ensure excellence in medicine, while minimizing the stress of illness.



Our commitment to excellence continues long after patients leave our care. We have implemented a rigorous follow-up schedule and our support network goes beyond our community to provide ongoing education and emotional support to our patients, families, staff and physicians. Support programs are offered through Riverside Community Hospital and the American Cancer Society. We sponsor many outreach events designed to improve the overall health and well-being of our community as well as the unique needs of each patient.

We are proud to feature breast cancer in this year's annual report. Breast cancer is the second leading cause of death in women following lung cancer and one in eight will be diagnosed with breast cancer in their lifetime. RCH is committed to providing ongoing support to our Breast Imaging Center and offers patient-centered treatment options.

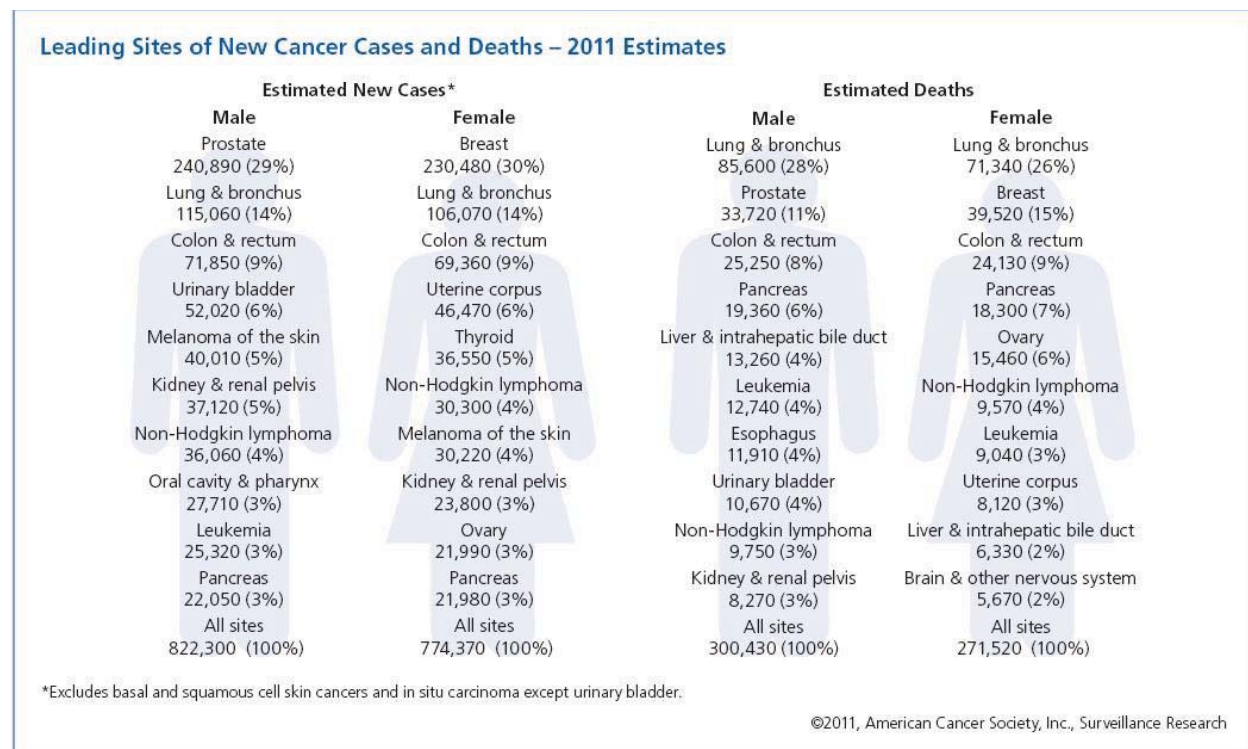
The Cancer Center at Riverside Community Hospital is accredited by the American College of Surgeons, Commission on Cancer and received the prestigious Outstanding Achievement Award in 2008 and is again eligible to receive this award in 2012.

Haresh S. Jhangiani, MD, FACP, MBA
Chairman, Cancer Committee

Breast Cancer Outcomes

In the United States, the American Cancer Society estimates that 230,480 new cases of invasive breast cancer are expected to occur in the United States in 2011, and approximately 2,140 new cases are expected in men. Excluding cancer of the skin, breast cancer is the most frequently diagnosed cancer in women. Beginning in the year 2000 the rate of female breast cancer began to decline and in 2002 to 2003 there was a dramatic 7% decrease reported and attributed to reductions in the use of hormone replacement therapy (HRT). Since 2003 the national rate of breast cancer incidence has been generally stable.

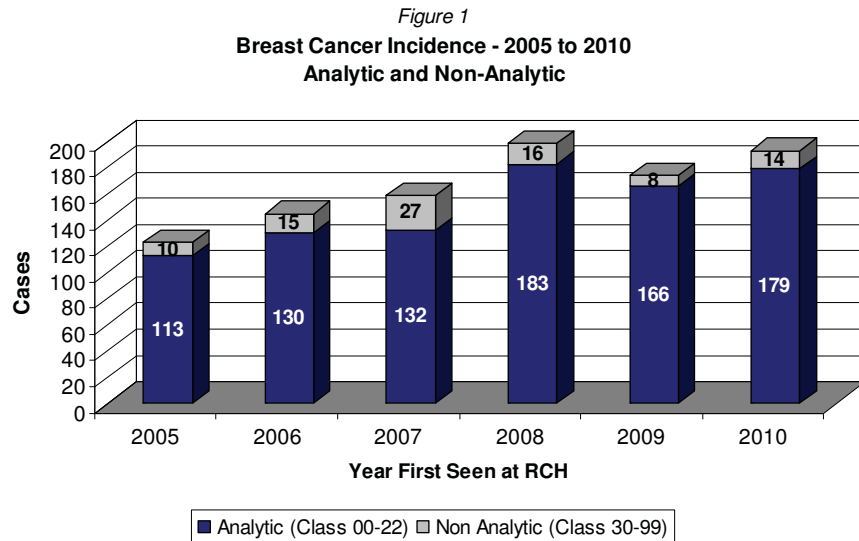
In addition to invasive breast cancer, approximately 57,650 new cases of in situ breast cancer is expected to occur among American women in 2011. Of this group, approximately 85% will be ductal carcinoma in situ (DCIS). Since 1998 DCIS breast cancer rates have been stable in white women while increasing in African American women by 1.6% per year.



Leading Sites of New Cancer Cases and Deaths – 2011 Estimates
Source: *Cancer Facts and Figures 2011*, American Cancer Society

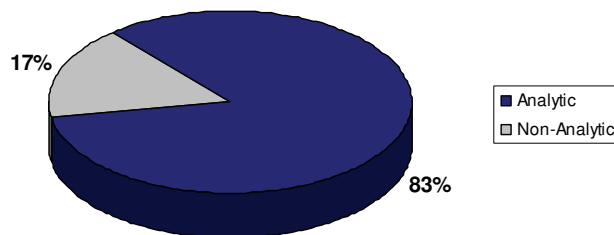
In the California Cancer Facts & Figures 2012 report, female breast cancer remains the most frequently diagnosed cancer in women, excluding non-melanoma skin cancers, with an expected 23,280 new cases expected to occur in 2012. This represents approximately 32% of the female population, regardless of race or ethnicity. Much like the rates reported above, breast cancer incidence in California State has been fairly stable since 1988.

At Riverside Community Hospital (RCH) incidence of breast cancer in both men and women from 2005 to 2010, for all classes of case (see Figure 2 below) demonstrates a slight increase in incidence from 2005 to 2008 but has remained fairly stable since that time. The increased incidence rate at RCH may be attributed to the 41.7% increase in population between the years 2000 to 2010 in Riverside County as reported by the U.S. Census Bureau in 2011 as compared to a modest 10% increase in population statewide.



Incidence by class of case is classified as either analytic (class of case 00-22) or non-analytical (class of case 30-99). Looking at the aggregate distribution of cases from 2005-2010 see Figure 3 below, we find that 83% of new breast cases at RCH are initially diagnosed or treated with at least part of first course of treatment at our facility. Seventeen (17%) of all breast cancer patients were initially diagnosed and treated elsewhere and then seen at RCH for subsequent courses of treatment and care.

Figure 2
CLASS OF CASE - BREAST CANCER 2005 - 2010
Analytic (Class 00-22) and Non-Analytic (Class 30-99)



Breast cancer incidence by race or ethnicity in the State of California has been declining among non-Hispanic white women and statistically significant declines are now being reported for African-American and Hispanic women as well. From 1988 to 2009 California State reported a 12% decline among African-American women, 8% among Hispanic women and 30% among non-Hispanic white women.

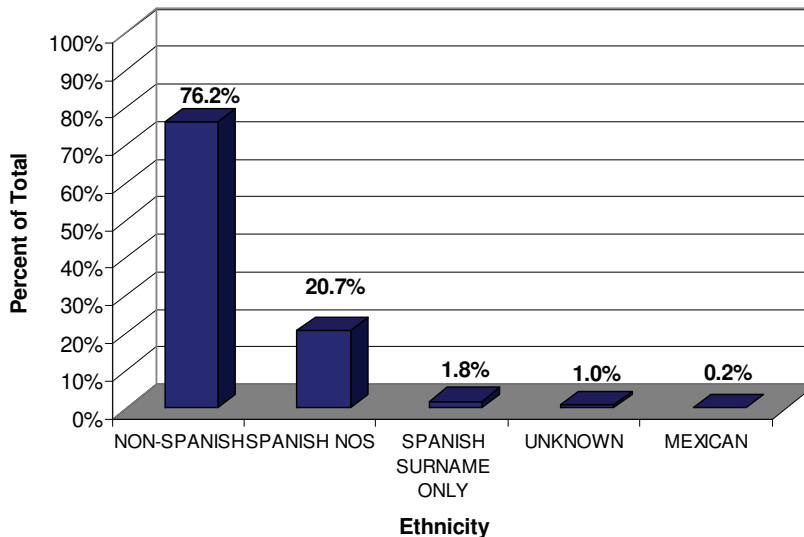
At RCH, incidence rates (Table 1) have been comparable to what is reported statewide and looking at aggregate incidence the ratio of non-Hispanic white women as compared to African-American, and other races appears to be comparable.

Table 1
RACE DISTRIBUTION-BREAST CANCER - 2005-2010
 Analytic Cases (Class 00-22)

Race	Cases	% of Total
WHITE	700	84.4%
BLACK	72	8.7%
ASIAN OTHER/NOS	21	2.5%
OTHER	11	1.3%
FILIPINO	5	0.6%
CHINESE	4	0.5%
UNKNOWN	4	0.5%
JAPANESE	3	0.4%
KOREAN	3	0.4%
AM INDIAN	2	0.2%
ASIAN INDIAN OR PAKISTANI NOS	2	0.2%
VIETNAMESE	1	0.1%
OTHER SOUTH ASIAN	1	0.1%
Total Cases	829	

What is statistically significant at RCH (see Figure 3 below) is the lesser incidence among Hispanic women which can be attributed to the referral patterns and socioeconomic status amongst this subpopulation. For many women of Hispanic origin, the treatment facility of choice is determined largely by the primary insurance payors or the clinicians who provide the diagnosis and treatment at other local outpatient, regional, or county healthcare facilities.

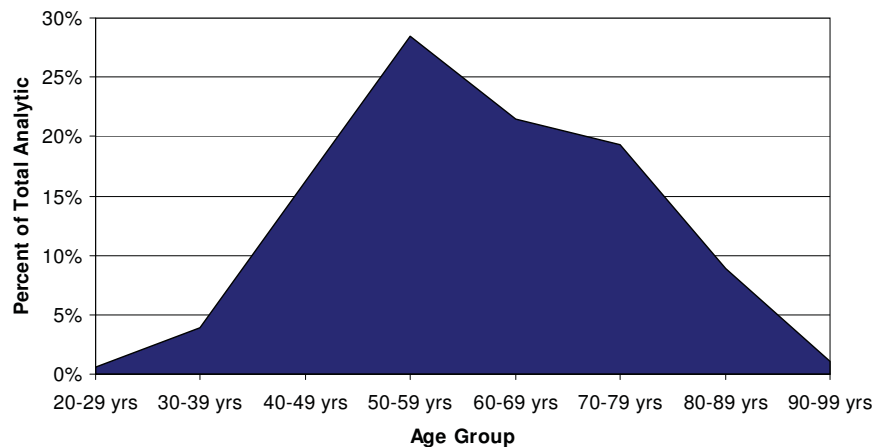
Figure 3
HISPANIC vs. NON-HISPANIC RACE - BREAST CANCER - 2005-2010
 Analytic Cases (Class 00-22) ~ n=829



While the decline in breast cancer incidence in the United States and California shows that the combined effects of better treatment and earlier diagnosis are having the desired effect on the population. Incidence rates may begin to rise in the next decade as a large number of women born after World War II (i.e., Baby Boomers) reach the age in which breast cancer becomes more common. Women in this age group may be at higher risk for breast cancer than their mothers due to earlier menarche, smaller family size, delayed childbearing and other factors.

Indeed, as we look at the RCH breast cancer incidence by age group (Figure 4), we find an increase in diagnosis for women in their late forties and early fifties suggesting that we are already seeing this shift occur at our facility. At least for the time being, and as RCH conducts future ongoing analysis of breast cancer by age and stage groups, RCH demonstrates that the majority of new breast cancer cases are classified as early stage (see Table 2 below).

Figure 4
Age at Diagnosis ~ Breast Cancer ~ 2005 to 2010
Analytic Cases (Class 00-22)
 Mean = 61 years ~ Median = 60 years



Early Detection

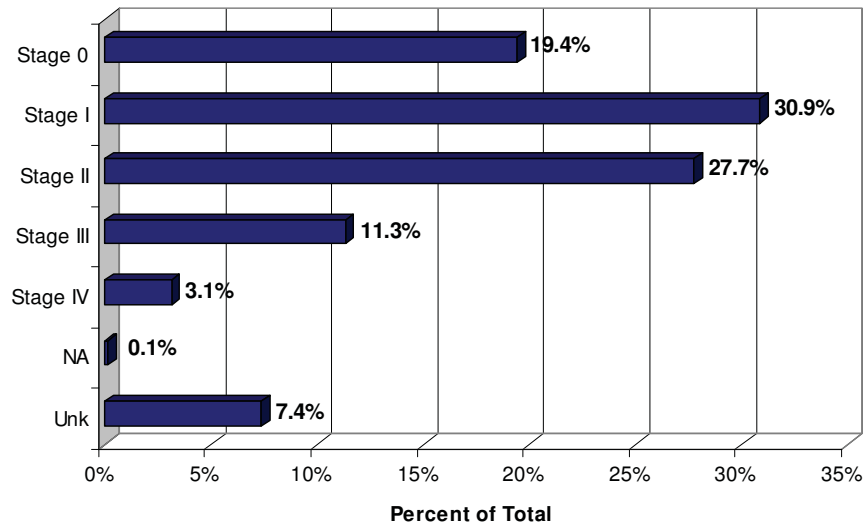
Nationwide emphasis is on early detection of breast cancer to allow clinicians and patients to select optimal treatment plans and patient-centered of clinical management that will improve the patient's quality of life as well as survival. A total of 829 analytic breast cancer cases were diagnosed and treated at RCH from 2005 to 2010, as shown in Table 2 below.

Table 2
BREAST CANCER INCIDENCE BY GENDER AND AJCC DERIVED STAGE GROUP
 2005 to 2010, All Classes of Case (00-99)

	Sex		Stage Group								
	Male	Female	Sub-Total	Stage 0	Stage I	Stage II	Stage III	Stage IV	NA	Unk	Sub-Total
Analytic	4	825	829	161	256	230	94	26	1	61	829
Non-Analytic	3	162	165	11	18	11	10	11	0	104	165
Total	7	987	994	172	274	241	104	37	1	165	994

In California State in 2009 approximately 71% of female breast cancers were diagnosed at an early stage. Out of the 829 analytic cases for 2005-2010 at RCH (Figure 5 below), a total of 647 (78%) patients were diagnosed as Stage 0, I or II which is slightly higher than the statewide figures.

Figure 5
Breast Cancer Incidence by AJCC Stage Group
2005 - 2010 Analytical Cases (Class 00-22)
 n = 829



Breast Cancer Conferences are held each month where the physician members review the histologic characteristics of each patient presented. Discussion includes relevant immuno-histochemical studies, tumor markers or oncogene testing performed or needed in order for the managing physician(s) to accurately determine the best course of care for the patient. Histologic type for all analytical cases at RCH (class 00-22) is shown in Table 3 below.

Table 3
HISTOLOGIC TYPE - BREAST CANCER - 2005 TO 2010
 Analytic Cases (Class 00-22)

<i>Histologic Type</i>	<i>Cases</i>	<i>% of Total</i>
INFILTRATING DUCT CARCINOMA NOS	474	60.8%
INTRADUCTAL CARCINOMA NONINFILTRATING NOS	96	12.3%
LOBULAR CARCINOMA NOS	64	8.2%
INFILTRATING DUCT AND LOBULAR CARCINOMA	33	4.2%
LOBULAR CARCINOMA IN SITU NOS	14	1.8%
CARCINOMA NOS	63	7.6%
ADENOCARCINOMA NOS	13	1.7%
MUCINOUS ADENOCARCINOMA	13	1.7%
INFLAMMATORY CARCINOMA	12	1.5%
DCIS & MIXED W/OTHER IN SITU	10	1.3%
INFILTRATING DUCT MIXED /w OTHER TYPES OF CARCINOMA	10	1.3%
CRIBRIFORM CARCINOMA IN SITU	8	1.0%
CRIBRIFORM CARCINOMA NOS	7	0.9%
MEDULLARY CARCINOMA NOS	6	0.8%
INTRADUCTAL MICROPAPILLARY CARCINOMA	6	0.8%
Total Cases	829	

Risk Factors

Besides being female, the most important risk factor for breast cancer is increasing age. Risk factors that are potentially modifiable, and addressed by the RCH community outreach programs include: weight gain after age 18, being overweight or obese in middle age, use of combined estrogen and progestin hormone therapy, physical inactivity, and consumption of one or more alcoholic beverages per day.

The relationship between height and weight, in combination with other risk factors, is currently under study in the State of California and, in some regions, required by the cancer registrar to report. In the Inland Empire (Region 5) this information is not yet required, however the RCH Cancer Registry has proactively begun to collect and report this data for future studies.

Medical findings that can be used to predict a high risk of breast cancer include: high breast tissue density as noted on mammography, high bone mineral density and biopsy-confirmed hyperplasia. High dose radiation to the chest, typically given as a cancer-related therapy, also increases a woman's risk. Reproductive factors include a long menstrual history (i.e., early menarche or ending later in life), recent use of oral contraceptives, never having children, and in women having their first child after the age of 30 years.

Risk is also increased with a personal or family history of breast cancer and inherited genetic mutations in the breast cancer susceptibility genes BRCA1 and BRCA2. Clinicians at RCH make every effort to identify a patient's risk factors and conduct studies to determine prognosis using tumor markers and genetic studies whenever possible.

It is widely accepted that early detection is the best defense against breast cancer. Current recommendations are that a clinical breast examination by a qualified healthcare provider should be performed every three years beginning at the age of 20, with annual mammograms combined with clinical breast examinations starting at age 40. Women with known increased risk factors should talk to their healthcare provider about starting mammography screening earlier or having additional testing or more frequent clinical examinations.

Treatment

Treatment considerations include the tumor size, extent of spread and other characteristics along with a patient's preference. Following diagnosis, treatment usually involves lumpectomy or mastectomy. For women whose cancer has not spread to the skin, chest wall or other distant organs, studies have shown that long-term survival after lumpectomy plus radiation are similar to the survival rates with mastectomy alone and follows NCCN guidelines..

Lymph node removal during surgery is usually recommended to determine if the tumor has spread beyond the breast. As part of standard therapy currently, sentinel lymph node biopsy (SNLB) is generally used in women with early stage disease as it is as effective as and less harmful than a full axillary lymph node dissection where many axillary lymph nodes are removed. For women with small tumors who cancer has spread to only one or two regional lymph nodes, use of SLNB combined with whole-breast radiation and chemotherapy or hormone therapy provides the same outcomes and few complications than patients who received an axillary node dissection.

Treatment may also involve radiation therapy, chemotherapy (before or after surgery), hormone therapy (Tamoxifen, aromatase inhibitors) or targeted therapy. Postmenopausal women who test positive for hormone receptors (i.e., ER or PR) may benefit from treatment with an aromatase inhibitor given either after, or instead of, Tamoxifen. Women who test positive for HER2/neu may be given targeted therapies such as Herceptin or Lapatinib (for advanced disease).

Patients with ductal carcinoma in situ (DCIS) are recommended to undergo treatment to avoid potential development of invasive cancer. Options include lumpectomy with radiation therapy or mastectomy and either of these options may be followed by treatment with Tamoxifen if the tumor is hormone receptor positive. While many treating physicians feel removal of axillary lymph nodes for DCIS is generally not necessary, it is individualized to the patient by their managing physician.

First course of treatment for 828 patients at RCH between the years 2005 to 2010 is summarized in Table 4 below.

Table 4
FIRST COURSE OF TREATMENT - BREAST CANCER 2005 to 2010
 Analytic Cases (Class 10-22, Excludes Class 00-Biopsy Only)

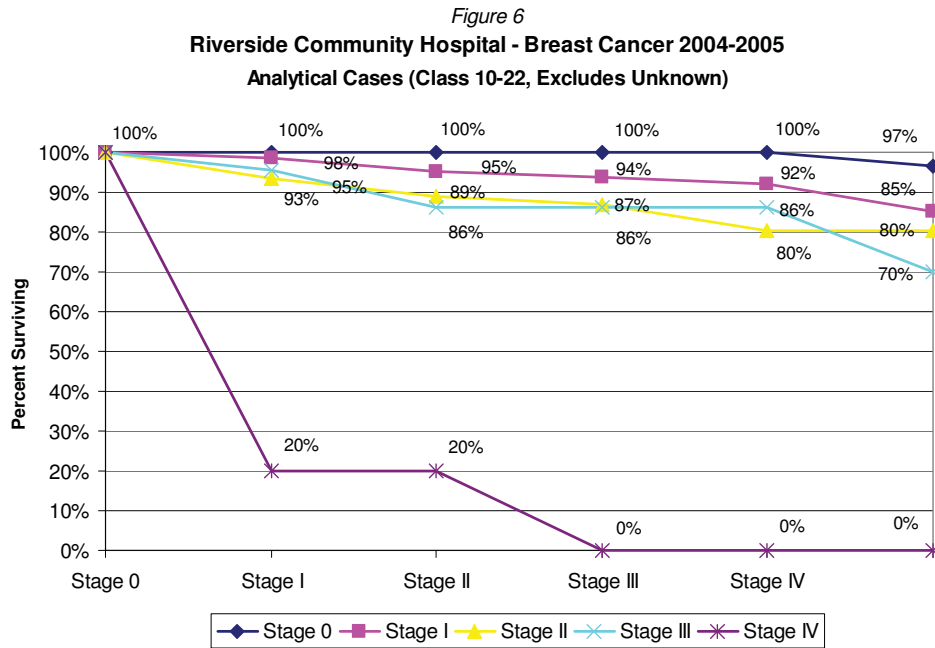
	Stage 0	Stage I	Stage II	Stage III	Stage IV	NA	Unk	TOTAL
Surgery Only	96	111	105	23	0	1	16	352
Surgery + Radiation + Hormone	16	50	14	3	1	0	0	84
Surgery + Radiation	20	27	12	4	1	0	5	69
Surgery + Chemotherapy	0	7	26	19	1	0	9	62
Surgery + Hormone	22	22	10	3	0	0	3	60
Surgery + Radiation + Chemotherapy	1	13	17	19	0	0	5	55
Surgery + Radiation + Chemotherapy + Hormone	0	8	25	15	1	0	3	52
Observation or No Treatment	5	10	4	0	8	0	14	42
Surgery + Chemotherapy + Hormone	0	4	17	8	0	0	0	29
Chemotherapy Only	0	0	0	0	5	0	3	8
Radiation Only	0	3	0	0	3	0	1	7
Radiation + Chemotherapy	0	0	0	0	3	0	1	4
Radiation + Chemotherapy + Hormone	0	0	0	0	1	0	1	2
Hormone Only	0	0	0	0	1	0	0	1
Radiation + Hormone	0	0	0	0	1	0	0	1
Chemotherapy + Hormone	0	1	0	0	0	0	0	1
TOTAL	160	256	230	94	26	1	61	829

Breast Cancer Survival

The American Cancer Society reported in 2011 that the 5-year relative survival rate for female breast cancer patients has improved from 63% in the early 1960's to 90% today. Relative survival continues to decline after 5 years, for all stages combined, with rates at 10 and 15 years after diagnosis being 82% and 75% respectively. It is important to note that when interpreting long-term survival rates from state and national sources that these rates represent patients who were diagnosed and treated up to 22 years ago.

At RCH the reference date and years used for survival begin in 2005 and are reported through 2010 as shown in the figures below using comparative data from the National Cancer Database (NCDB) provided by the Commission on Cancer (CoC).

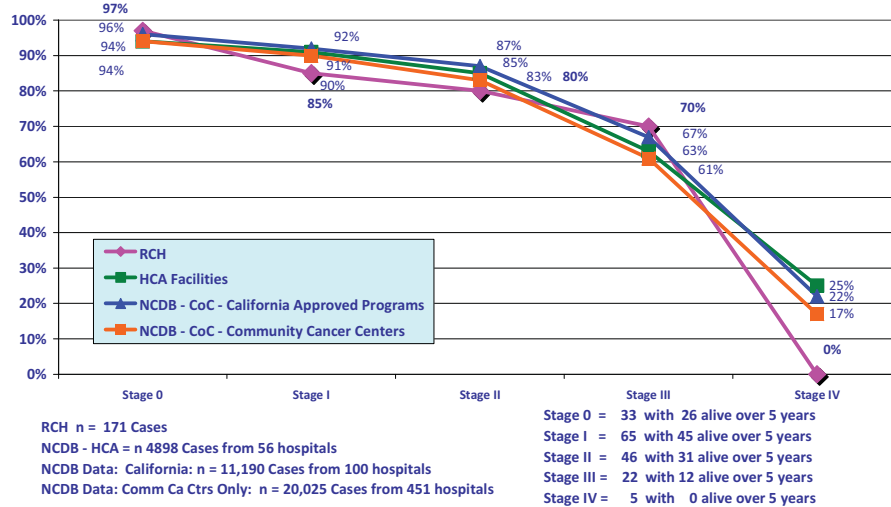
RCH 5-year observed survival rates are shown in Figure 7 below. Of note, only one patient in this specific group was determined to be Stage IV at time of diagnosis. Given the comorbid conditions this patient also presented with the 5-year survival rate is poor and the patient expired after three years.



Using the NCDB observed comparative data for Community Cancer Centers, such as RCH, the observed 5-year survival rates for RCH are 96% for Stage 0, 85% for Stage I, 80% for Stage II, 70% for Stage III disease and 0% for Stage IV (see comments above). Because RCH reference date begins in 2004 the NCDB 2003 comparative analysis data was chosen to more closely aligned than older comparisons.

Observed survival rates for patients with Stage I and II disease are lower than the NCDB comparative community hospital cancer centers. This may be attributed to in part, by the transient nature and other socioeconomic characteristics in this region. For early Stage 0 and late Stage III disease the RCH observed 5-year survival rates are compatible with those of other CoC-approved community cancer centers.

Riverside Community Hospital - Breast Center - 2004 & 2005 Survival Data
 NCDB Community Cancer Centers - Breast Cancer 2003 vs
 NCDB HCA & California - Breast Cancer 2003
 Five Year Observed Survival Rate by AJCC Stage
 All Stages Ending at Five Years



Conclusions

Using the American Cancer Society, California Cancer Registry and NCDB benchmark data, this analysis indicates that RCH is performing at a higher level for stage at diagnosis for Stage 0 and Stage III disease and only slightly below the national average for Stage I and II disease. The healthcare provided by RCH physicians and support staff include a team of highly skilled radiologists, surgeons, plastic surgeons, pathologists and others who are among the region's most respected. Ongoing education and screening efforts by our team and the RCH Breast Imaging Center continue to be focused at enhancing and improving breast cancer outcomes.



“It’s not the bricks, mortar and equipment that make a good hospital.”
 It is the warmth, compassion and attitude of good employees
 that lead to quality care.”
 ~ Thomas Frist, Sr., MD

The Cancer Center A Milestone for Our Community

The Cancer Center at Riverside Community Hospital is a milestone for the community. In the past residents have traveled to hospitals in outlying areas to seek high caliber cancer services. Our Cancer Center offers residents superior cancer care close to home. This \$8.2 million, 8,200 square foot facility opened in 2003 and gives local patients the benefit of Riverside Community's uncompromised dedication to the health of the community it serves.



Multidisciplinary Approach to Patient Care

Collaborative diagnosis and treatment leads to more effective outcomes



The RCH approach to the patient is truly multidisciplinary in nature. The Cancer Center comprises physicians in diverse fields that include medical oncology, surgery, radiation oncology, radiology, and pathology as well as representatives from nursing and other supportive services. All are committed to a team approach that provides the finest and most advanced treatments available.

Diagnosis and Staging

Precise staging tailors cancer treatment

Proper staging for cancer begins with advanced imaging techniques. Radiologic imaging is rapidly evolving and RCH is continuing to enhance the diagnosis and treatment of their patients with cancer, while reducing the associated risks and side effects of traditional imaging techniques.

Treatment

Multidisciplinary care combines surgery, chemotherapy, radiation – and clinical trials.

Surgery: The philosophy of the surgical team and oncology program at RCH is to build upon a foundation of careful preoperative cancer staging and pursue aggressive, stage-specific treatment.





Medical Oncology: Chemotherapy may complement surgery, and in some cases, a patient's treatment plan may combine a regimen of chemotherapy with radiation therapy.

Radiation Oncology: Radiation Oncology offers a comprehensive array of radiation treatments for the management of patients with cancer. Depending on the pathology and the patient's individual stage of disease, radiation may be delivered with curative intent before, during or after surgery, or administered in palliation to patients with advanced or metastatic disease.



Women's Imaging Center / Breast Center: Women at risk or concerned about breast cancer have convenient access to numerous prevention and early detection services at RCH. Mammograms and state-of-the-art stereotactic detection, a more comfortable alternative to surgical biopsy, are available. RCH also offers digital mammography.

Cancer Support Services: Patients have direct access to nutritional, social and spiritual services. In addition, patients benefit from a rehabilitation program that includes lymphedema therapy. Other amenities include a dedicated patient education room with the latest information in cancer treatment. Patients also benefit from many American Cancer Society programs such as Look Good, Feel Better and Reach to Recovery.



Patient and Community Events at RCH

Love Yourself.

This Valentine's Day, give yourself the gift of health.

Mammograms are the best chance of detecting breast cancer early. Early detection means earlier treatment and saving more lives.

Through the month of February, **The Breast Imaging Center at Riverside Community Hospital** is offering:

\$100 Screening Mammograms to qualifying women.

The Breast Imaging Center is committed to providing you with the best technology and care available. Our center provides every woman with a digital mammogram that includes the MammoPad® breast cushion for a more relaxing, comfortable and softer mammogram.

- You must be 40 years of age or older to qualify. The offer includes only screening mammograms. The results of your test will be forwarded to your personal physician.
- Please call for an appointment: (951) 276-7550**
- Women who are pregnant, nursing, or silicone injections, have no personal physician or have had a previous breast cancer or current breast problems are ineligible for this offer.

The American Cancer Society recommends annual mammograms beginning at age 40.

BREAST IMAGING CENTER

RIVERSIDE Community Hospital
 4500 Brockton Ave., Suite 219, Riverside, CA 92501
 Mammography is on the 2nd floor
 (951) 276-7550
 www.riversidecommunityhospital.com

The Breast Imaging Center at Riverside Community Hospital is committed to the care and comfort of our patients. Our focus is improving the overall health of our community by providing healthcare services with Integrity, Compassion and Excellence.

When did you have your last Mammogram?

When did you have your last Mammogram?

Join us in honor of... National Mammography Day

Mammograms are the best chance of detecting breast cancer early. And early detection means earlier treatment and saving more lives.

The Breast Imaging Center at Riverside Community Hospital is offering:

\$50 Screening Mammograms to qualifying women **Friday, October 21, 2011**

The Breast Imaging Center is committed to providing you with the best technology and care available. Our center provides every woman with a digital mammography that includes the MammoPad® breast cushion for a more relaxing, comfortable and a softer mammogram.

- You must be 40 years of age or older to qualify. The offer includes only screening mammograms. The results of your test will be forwarded to your personal physician.
- Only 50 appointments available
- Please call for an appointment: (951) 276-7550**
- Women who are pregnant, nursing, have breast implants or silicone injections, have no personal physician or have had a previous breast cancer or current breast problems are ineligible for this offer.

The Breast Imaging Center at Riverside Community Hospital is committed to the care and comfort of our patients. Our focus is improving the overall health of our community by providing healthcare services with Integrity, Compassion and Excellence.

BREAST IMAGING CENTER

RIVERSIDE Community Hospital

4500 Brockton Avenue, Suite 219
 Mammography is on the 2nd floor
 Riverside, CA 92501
 (951) 276-7550

“Understanding Breast Health,” October 26, 2011

Understanding Breast Health

Program Chair
 - Germaine Strother, M.D.
 Family Medicine

“Breast Imaging, Including Breast Ultrasound & Breast MRI”
 - Ayodale Odulate, M.D.
 Radiology

“Understanding Your Surgical Options”
 - Anna Houterman, M.D.
 Surgery

“Advances in Breast Reconstruction”
 - Robert Hardesty, M.D.
 Plastic Surgery

“After Surgery, What’s Next?”
 - Evangeline Reyes, M.D.
 Medical Oncology

Knowledge is Power

Join us for a candid conversation about Breast Health.

The Cancer Center at Riverside Community Hospital presents

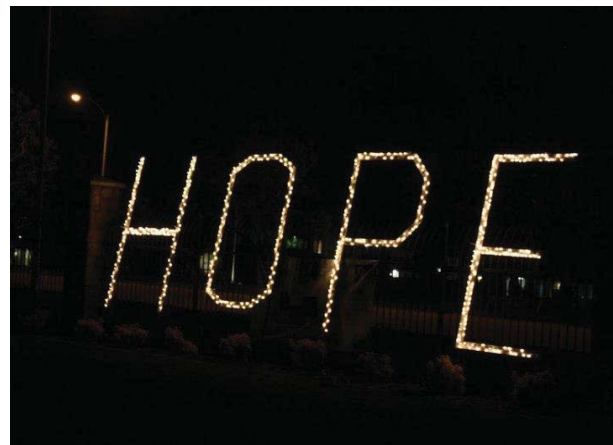
2011 Breast Cancer Forum
 Wednesday, October 26, 2011
 Dinner: 6:00 p.m.
 Program: 7:00 p.m.

Riverside Community Hospital's Health Education Center
 {4445 Magnolia Avenue, Riverside, CA 92501}
 Space is Limited • Please R.S.V.P. by Friday, October 21st
 951.788.3463





ACS Relay for Life 2011
June 3-4, 2011
Arlington Sports Complex



Men's Health Game Day, September 8, 2011

Complimentary Lecture & Dinner on Risk Factors for Prostate Cancer

40

Know Your Stats
About Prostate Cancer

The American Urological Association Foundation and the National Football League want you to Know Your Stats about prostate cancer. So all men over 40 should talk with their doctors about their PSA (prostate-specific antigen) score and get regular physical exams.

For more information, call 1-800-828-7866 or visit www.KnowYourStats.org

RIVERSIDE Community Hospital

Men's Health Game Day

Thursday
September 8, 2011
Dinner at 6:00 p.m.
Program at 7:00 p.m.

Riverside Community Hospital's HEC
4445 Magnolia Ave., Riverside, CA

Guest Speakers:
Ron Brown
Former NFL Star
Kermit Alexander
Former NFL Star
RCH Physician Speakers:
Benjamin Yang, M.D.
Alex Batta, M.D.
Ralph Highshaw, M.D.

Topics:
- Understanding Prostate Cancer
- Treatment Options
- Prostate Cancer in 2011
- Robotic Surgery for Prostate Cancer at RCH

Come dressed in your favorite jersey.
Reservations required. Call (951) 788-3463.

Intuitive Surgical® proudly supports this community education program.



Cancer Related CME Events

**“Advances in the Management of Multiple Myeloma,” Amrita Krishnan MD
August 10, 2011**

“Da Vinci Robot,” Alex Batta MD, November 9, 2011

Statistics

Riverside Community Hospital
2010 Primary Site Table
 Sorted from Most to Least Common

Site Group	Total Cases	Class			Sex			Stage						
		Analytic	Non Analytic	Other	M	F	Other	Stage 0	Stage I	Stage II	Stage III	Stage IV	NA	Unknown
ALL SITES	958	796	162	0	426	532	0	73	164	158	97	152	88	64

Top Five Sites

BREAST	193	179	14	0	2	191	0	45	57	42	12	9	0	14
LUNG/BRONCHUS-NON SM CELL	112	98	14	0	58	54	0	5	10	10	19	51	0	3
PROSTATE	91	71	20	0	91	0	0	0	3	56	9	2	0	1
COLON	74	69	5	0	40	34	0	4	14	17	22	7	0	5
KIDNEY AND RENAL PELVIS	43	34	9	0	29	14	0	1	13	4	4	10	0	2

BLADDER	34	25	9	0	20	14	0	8	4	7	1	4	0	1
RECTUM & RECTOSIGMOID	32	28	4	0	14	18	0	0	8	4	8	2	0	6
NON-HODGKIN'S LYMPHOMA	30	21	9	0	18	12	0	0	7	2	4	6	0	2
PANCREAS	27	20	7	0	12	15	0	1	0	1	1	14	0	3
MELANOMA OF SKIN	25	24	1	0	9	16	0	4	14	2	1	2	0	1
THYROID	25	21	4	0	8	17	0	0	10	0	2	4	0	5
STOMACH	22	19	3	0	12	10	0	0	1	3	1	11	0	3
LEUKEMIA	21	11	10	0	15	6	0	0	0	0	0	0	11	0
UNKNOWN OR ILL-DEFINED	21	19	2	0	11	10	0	0	0	0	0	0	19	0
CORPUS UTERI	20	17	3	0	0	20	0	2	6	3	1	2	0	3
BRAIN	20	18	2	0	8	12	0	0	0	0	0	0	18	0
OTHER HEMATOPOIETIC	18	9	9	0	8	10	0	0	0	0	0	0	9	0
MYELOMA	17	9	8	0	6	11	0	0	0	0	0	0	9	0
OTHER NERVOUS SYSTEM	17	14	3	0	6	11	0	0	0	0	0	0	14	0
LIVER	14	13	1	0	10	4	0	0	2	3	2	2	1	3
OVARY	14	10	4	0	0	14	0	0	1	0	0	5	0	4
LUNG/BRONCHUS-SMALL CELL	12	9	3	0	4	8	0	0	0	1	2	6	0	0
ESOPHAGUS	7	6	1	0	6	1	0	0	0	0	1	3	0	2
ANUS,ANAL CANAL,ANORECTUM	6	5	1	0	3	3	0	2	1	0	2	0	0	0
GALLBLADDER	6	5	1	0	0	6	0	0	1	1	0	3	0	0
LARYNX	5	4	1	0	4	1	0	1	1	0	0	2	0	0
TESTIS	5	5	0	0	5	0	0	0	3	0	1	0	0	1
SMALL INTESTINE	4	4	0	0	3	1	0	0	0	2	1	0	0	1
SOFT TISSUE	4	3	1	0	1	3	0	0	2	0	0	1	0	0
TONGUE	3	3	0	0	3	0	0	0	0	0	1	2	0	0
MOUTH, OTHER & NOS	3	2	1	0	1	2	0	0	0	0	0	1	0	1
OTHER DIGESTIVE	3	3	0	0	1	2	0	0	0	0	0	0	3	0
CERVIX UTERI	3	3	0	0	0	3	0	0	2	0	0	0	0	1
HODGKIN'S DISEASE	3	2	1	0	2	1	0	0	1	0	0	1	0	0
SALIVARY GLANDS, MAJOR	2	1	1	0	2	0	0	0	1	0	0	0	0	0
TONSIL	2	1	1	0	2	0	0	0	0	0	0	1	0	0
PHARYNX & ILL-DEFINED	2	1	1	0	2	0	0	0	0	0	0	0	1	0
OTHER RESPIR & THORACIC	2	1	1	0	1	1	0	0	0	0	0	0	0	1
BONE	2	1	1	0	2	0	0	0	0	0	0	0	0	1
OTHER ENDOCRINE	2	2	0	0	1	1	0	0	0	0	0	0	2	0
LIP	1	0	1	0	1	0	0	0	0	0	0	0	0	0
GUM	1	1	0	0	0	1	0	0	0	0	1	0	0	0
FLOOR OF MOUTH	1	0	1	0	1	0	0	0	0	0	0	0	0	0
NASOPHARYNX	1	1	0	0	0	1	0	0	0	0	0	1	0	0
BILE DUCTS	1	0	1	0	0	1	0	0	0	0	0	0	0	0
PLEURA	1	0	1	0	1	0	0	0	0	0	0	0	0	0
OTHER SKIN CA	1	0	1	0	1	0	0	0	0	0	0	0	0	0
UTERUS NOS	1	0	1	0	0	1	0	0	0	0	0	0	0	0
VAGINA	1	1	0	0	0	1	0	0	1	0	0	0	0	0
VULVA	1	1	0	0	0	1	0	0	1	0	0	0	0	0
PENIS	1	1	0	0	1	0	0	0	0	0	1	0	0	0
OTHER URINARY	1	1	0	0	1	0	0	0	0	0	0	0	1	0

Statistics

Table 6
CLASS OF CASE DISTRIBUTION - 2010
 All Cases (Class 00-99)

Type	Class	Description	Cases	% of Total	Total by Type	% by Type
Class 0	0	Diagnosis Here, Treatment Elsewhere	53	5.5%	53	5.5%
Class 1	10	Diagnosis Here by Staff MD, Treatment Here	138	14.4%	547	57.1%
	11	Diagnosis Here by Staff MD, Part of Treatment Here	18	1.9%		
	12	Diagnosis Here by Staff MD, All Treatment Here	48	5.0%		
	13	Diagnosis Here, Part of Treatment Here	64	6.7%		
	14	Diagnosis Here, All of Treatment Here	279	29.1%		
Class 2	20	Diagnosis Elsewhere, Treatment Here	64	6.7%	196	20.5%
	21	Diagnosis Elsewhere, Part of Treatment Here	61	6.4%		
	22	Diagnosis Elsewhere, All of Treatment Here	71	7.4%		
Class 3	30	Diagnosis & Treatment Elsewhere, Workup Here	8	0.8%	162	16.9%
	31	Diagnosis & Treatment Elsewhere, In Transit Here	13	1.4%		
	32	Diagnosis & Treatment Elsewhere, Disease Recurrence Here	135	14.1%		
	33	Diagnosis & Treatment Elsewhere, History Only Here	5	0.5%		
	35	Prior to Reference Date, Diagnosis & Treatment Here	1	0.1%		
Totals			958			

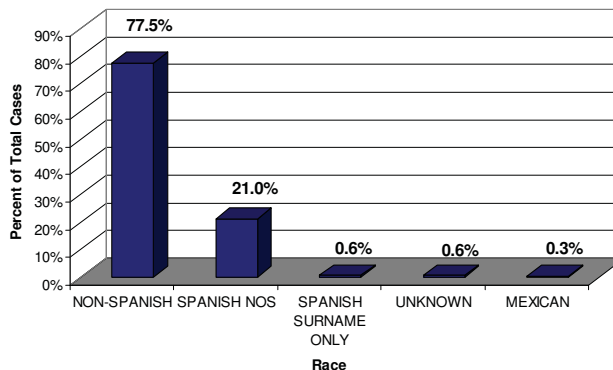
Table 7
CANCER CASES BY ETHNICITY - 2010
 Analytic Cases (Class 00-99)

Race	Cases	% of Total
WHITE	800	83.5%
BLACK	99	10.3%
ASIAN OTHER/NOS	22	2.3%
FILIPINO	7	0.7%
JAPANESE	6	0.6%
OTHER	5	0.5%
UNKNOWN	4	0.4%
CHINESE	3	0.3%
ASIAN INDIAN OR PAKISTANI NOS	3	0.3%
ASIAN INDIAN	3	0.3%
AM INDIAN	2	0.2%
HAWAIIAN	1	0.1%
KOREAN	1	0.1%
VIETNAMESE	1	0.1%
SAMOAN	1	0.1%
Total Cases	958	

Figure 8
GENDER DISTRIBUTION 2010
 All Cases (Class 00-99)



Figure 9
HISPANIC vs NON-HISPANIC RACE - ALL SITES 2010
 Analytic Cases (Class 00-22) n = 958



Statistics

Figure 10
AGE AT DIAGNOSIS - 2010
 n = 958

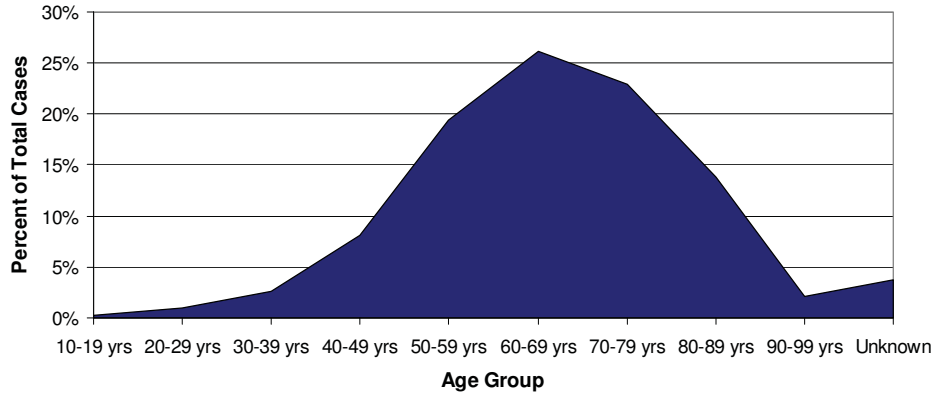


Table 8
PAYOR DISTRIBUTION 2010
 All Cases (Class 00-99)

Payor	Cases	% of Total
HMO	193	20.1%
Medicare	186	19.4%
Managed Care HMO/PPO	162	16.9%
Medicare Managed Care	127	13.3%
PPO	88	9.2%
Medicaid	51	5.3%
Insurance NOS	51	5.3%
Medicare w Medicaid Supp	36	3.8%
Medicare Private Supp	35	3.7%
Medicare w Supp	9	0.9%
Tricare	8	0.8%
Self Pay Not Insured	7	0.7%
Unknown	2	0.2%
Not Insured	2	0.2%
County NOS	1	0.1%
Total Cases	958	



Executive Team

<i>Patrick Brilliant</i>	<i>President and CEO</i>
<i>Kenneth Dozier, M.D.</i>	<i>President, Medical Staff</i>
<i>Doug Long</i>	<i>Senior Vice President, Chief Operating Officer</i>
<i>Fran Paschall</i>	<i>Senior Vice President, Chief Nursing Officer</i>
<i>Tracey Fernandez</i>	<i>Senior Vice President, Chief Financial Officer</i>
<i>Ben Russo</i>	<i>Vice President, Business Development</i>
<i>Famy Bialon, RN</i>	<i>Vice President, Patient Care Services</i>
<i>Ria Berger</i>	<i>Vice President, Human Resources</i>
<i>Barbara Everett</i>	<i>Vice President, Quality and Safety</i>

Cancer Committee

<i>Haresh Jhangiani, MD</i>	<i>Medical Oncology, Chairman</i>
<i>Evangeline Reyes, MD</i>	<i>Medical Oncology</i>
<i>Ronald Lau, MD</i>	<i>Radiation Oncology</i>
<i>Steven Aragon, MD</i>	<i>Pathology</i>
<i>Germaine Strother MD</i>	<i>Family Medicine</i>
<i>Donald Masee, MD</i>	<i>Radiology</i>
<i>Michelle Meyer, MD</i>	<i>Pathology</i>
<i>Brian Choi, MD</i>	<i>Medical Oncology</i>
<i>Ayodale Odulate, MD</i>	<i>Radiology</i>
<i>Darren Okada, MD</i>	<i>Pathology</i>
<i>Gustavo Lara, MD</i>	<i>Surgery</i>
<i>Nicholas Zekos, MD</i>	<i>Surgery</i>
<i>Misagh Karimi, MD</i>	<i>Medical Oncology</i>
<i>Lori Arias, MBA</i>	<i>Cancer Center, Director</i>
<i>Audrey Barry, RD, CNSD</i>	<i>Clinical Nutrition</i>
<i>Famy Bialon, RN</i>	<i>Vice President, Patient Care Services</i>
<i>Chris Breyer, DDiv</i>	<i>Chaplin</i>
<i>Pat Bridenstine, RN</i>	<i>Nursing</i>
<i>Diane Caruso, RN</i>	<i>Radiation Oncology</i>
<i>Delaina Davis, RTM</i>	<i>BIC Supervisor</i>
<i>Sallie D'Anna, RN</i>	<i>Manager, D-2 Medical</i>
<i>Diane Dietrich, RN</i>	<i>Radiation Oncology</i>
<i>Brian Eggleton, PharmD</i>	<i>Director, Pharmacy</i>
<i>Yolanda Harriman</i>	<i>Pathology</i>
<i>Joellyn Hiller, OTR</i>	<i>Director, Rehabilitation</i>
<i>Robin Jaques, CTR</i>	<i>Cancer Registry</i>
<i>Linda Jund, BS, CTR</i>	<i>Cancer Program</i>
<i>Michele Webb, CTR</i>	<i>Cancer Registry</i>
<i>Sue Negrette, RHIT, CCS, CPC</i>	<i>Manager, Health Information Management</i>
<i>Judy O'Neill, RTT</i>	<i>Radiation Oncology</i>
<i>Sharon Nelson</i>	<i>Director, California Division, ACS</i>
<i>Susan Page</i>	<i>Laboratory</i>
<i>Pamela Randall, RHIT, CTR</i>	<i>Cancer Program</i>
<i>Christina Reid-Brown</i>	<i>AVP, Physician Relations</i>
<i>Gayle Snow, CHAM</i>	<i>Manager, Health Information Management</i>
<i>David Stanley, RHIA, MHL</i>	<i>Health Information Management</i>
<i>Julie Stefan, LCSW</i>	<i>Social Services</i>
<i>Elizabeth Young, PharmD</i>	<i>Pharmacy</i>
<i>Marcia Derro, CPMSM</i>	<i>Medical Staff</i>



THE **CANCER CENTER**

RIVERSIDE
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