



DeKalb
Medical
Pushing Beyond®



MOVING TOWARDS A CURE

2009 ANNUAL
REPORT
DEKALB MEDICAL CANCER CENTER



A cancer program is a multi-faceted structure that creates and implements all the programs that help each patient with his or her journey. We want each patient to have the possibility of cure, to feel supported throughout the various stages of their treatments and to know that DeKalb Medical is not about bricks and mortar but is a place where an extraordinary group of healthcare professionals come together with the common objective of taking care of patients in a way that provides the greatest hope for recovery.

If there is a working definition of a team, that team concept can be visualized within the walls of our program. Our cancer team has one component that is visual throughout the journey, from the tests that lead to a suspected problem, to the scans and pathology that confirm a diagnosis, to the assembling of a treatment team, to the execution of the agreed upon game plan - the one thing that always stands out is that the patient is in the center of every person's vision.

Watching the team in action, listening to their dialog about treatment possibilities, seeing their concern about the patient and his or her family, watching the support staff working tirelessly to make certain that each step is carefully executed - it is reminiscent of the finest symphony creating a perfect musical experience.

There is an infrastructure at DeKalb Medical that makes it all possible. Through the years we have put together all the necessary pieces to assure each patient the best possible outcome. We have sought and trained support staff of the highest caliber. Their love for our patients makes it possible for us to give them care beyond all expectations.

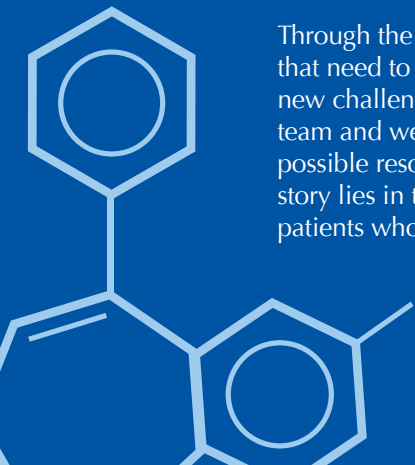
MOVING TOWARDS A CURE

We have a weekly tumor conference that is attended by all specialties and staff to receive feedback from a wide range of disciplines including:

- A breast cancer conference to look at the different types of breast cancer and to custom design a treatment for each patient.
- A cancer executive team made up of the leaders in each specialty that guides the growth and development of The Cancer Center service line.
- A cancer committee that makes certain we are meeting all the guidelines required for our designation as a Comprehensive Community Cancer Program, accredited by the Commission on Cancer of the American College of Surgeons.

We have one of the leading genetics programs in the state to look at cancers with a genetic component, and a clinical trials program that screens patients for their eligibility for trials in a wide range of research groups. We have programs designed to enable patients to get the support services they need. There are four weekly support groups, a children's group for our patients' children, an exercise class to help patients return to wellness once they complete their treatments, and individual counseling for patients who want to make certain they have all the information they need to make good decisions.

Through the years, our program has changed dramatically as we have identified new programs that need to be added, new research that needs to become a part of our standard of care and new challenges identified by our patients. Our patients are always a part of our remarkable team and we strive to constantly raise the bar on what we can do to ensure they have the best possible resources on their difficult journey. This report tells you about our numbers, but the real story lies in the lives we touch and the difference we make in traveling the cancer journey with patients who choose DeKalb Medical for their care.



Cancer Data Services

The cancer registry at DeKalb Medical has been in existence since January 1, 1973. Our cancer registry reference date is January 1, 1986, coinciding with the transition from a paper abstract to using a database to capture our data. Our cancer registry is both American College of Surgeons (ACoS), and Commission on Cancer (CoC) approved and is a Surveillance, Epidemiology and End Results (SEER) program registry. The cancer registry database has a total of 33,469 cases; 26,867 analytic cases and 6,602 non-analytic cases.

Cancer Registry Staff

The cancer registry is currently staffed with six full-time personnel; 3 Certified Tumor Registrars (CTR) and 3 staff members in training to become certified.

Annual Case Trends

In 2009, 76 percent of our cases were analytic meaning the patient was either diagnosed at DeKalb Medical or received some portion of their

first course of treatment at our facility. The other 24 percent were patients who came to DeKalb Medical for treatment of recurrence or disease progression (as shown in Chart 1).

2009 AJCC Stage at Diagnosis

During 2009, 9 percent of our analytic cases were Stage 0; 24 percent, Stage I; 24 percent, Stage II; 11 percent Stage III; 15 percent, Stage IV. The stage at diagnosis was unknown in 8 percent of our analytic cases and AJCC stage was not applicable in 9 percent of our analytic cases (as shown in Chart 2).

Cancer Incidence by Race

The patient population seen at DeKalb Medical is still fairly evenly divided between Caucasian and African American. However, in 2009, the African American population increased from 48 percent to 54 percent and the Caucasian population has decreased from 47 percent to 43 percent. The other 3 percent includes all other races.

CHART 1. Annual Case Trends ● Analytic Cases ● Non-Analytic Cases

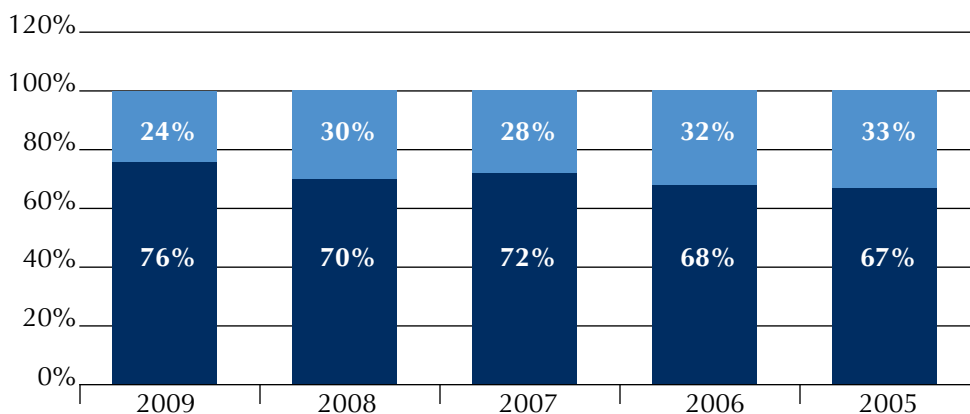
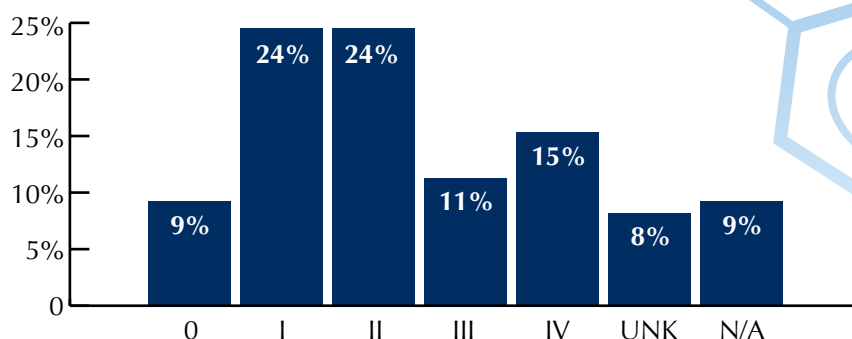


CHART 2. AJCC Stage at Diagnosis



Cancer Incidence by Site

Cancer Incidence by Site compares DeKalb Medical figures with the American Cancer Society (ACS) and Georgia figures. In 2009, breast cancer was once again the number one site for DeKalb Medical followed by lung, then prostate cancer. Colorectal cancer followed by uterine cancer make up the remaining top-five sites. Prostate cancer is the number one site for Georgia followed by lung then breast cancer. Nationally breast cancer was the number one site followed by lung and then prostate cancer (as reflected in Table 1).

Cancer Incidence by County at Diagnosis

In 2009, 63.6 percent of our patients were residents of DeKalb County. 9.8 percent resided in Gwinnett County. This is followed by 8.4 percent in Fulton County, 3.6 percent in Clayton County, 3.3 percent in Newton County and 3 percent in Rockdale County. The remaining 8.3 percent resided either in other Georgia counties or out of state (as shown in Chart 3).

2009 Analytic Cases

A complete list of our 2009 analytic cases by sex and AJCC stage at diagnosis shows that there were 400 male and 768 female analytic cases this year (as shown in Table 2).

Cancer Incidence (Other)

The Cancer Registry at DeKalb Medical is also responsible for Incidence reporting on two other non-Commission on Cancer (CoC) facilities: DeKalb Medical at Hillandale and DeKalb Medical at Downtown Decatur. In 2009 we reported a total of 160 analytic and 138 non-analytic cases for our Hillandale hospital and 3 analytic and 15 non-analytic cases for our Downtown Decatur facility (as shown in Chart 4).

CHART 3. 2009 County at Diagnosis

DeKalb (747)	63.6%
Gwinnett (115)	9.8%
Fulton (99)	8.4%
Clayton (42)	3.6%
Newton (38)	3.3%
Rockdale (36)	3.0%
Other (98)	8.3%
	100%

TABLE 1. Cancer Incidence by Site

(Comparison of DeKalb Medical Cases Diagnosed in 2009 with ACS and State of Georgia)

DEKALB MEDICAL CANCER CASES DIAGNOSED 2009						
*NATIONAL COMPARISON OF THE TEN MOST PREVALENT CANCER SITES						
PRIMARY SITE	DEKALB MEDICAL		GEORGIA		NATIONAL	
	CASES	PERCENT	CASES	PERCENT	CASES	PERCENT
BREAST	386	33.0%	6,130	15.1%	207,090	13.5%
LUNG	138	11.8%	6,280	15.5%	222,520	14.5%
PROSTATE	112	9.6%	6,380	15.8%	217,730	14.2%
COLORECTAL	104	8.9%	3,840	9.5%	142,570	9.3%
CORPUS UTERI	41	3.5%	950	2.3%	43,470	2.8%
NH LYMPHOMA	37	3.2%	1,600	4.0%	65,540	4.3%
BLADDER	29	2.5%	1,470	3.6%	70,530	4.6%
MELANOMA	15	1.3%	2,020	5.0%	68,130	4.5%
LEUKEMIA	22	1.9%	1,040	2.6%	43,050	2.8%
CERVIX	12	1.0%	390	1.0%	12,200	0.8%
ALL OTHERS	272	23.3%	10,380	25.6%	436,730	28.6%
TOTAL CASES	1,168	100.0%	40,480	100.0%	1,529,560	100.0%

*Estimated Cancer Cases from: The American Cancer Society Cancer Fact & Figures 2010

TABLE 2. Primary Site Tabulation for 2009 Cases (Analytic)

PRIMARY SITE	CLASS			SEX			AJCC STAGE				
	A	M	F	0	I	II	III	IV	UNK	N/A	
ALL SITES	1168	400	768	99	285	281	126	175	98	104	
ORAL CAVITY	5	3	2	0	0	0	1	2	1	1	
TONGUE	3	2	1	0	0	0	1	1	1	0	
OTHER	2	1	1	0	0	0	0	1	0	1	
DIGESTIVE SYSTEM	192	94	98	6	29	33	34	56	28	6	
ESOPHAGUS	8	8	0	1	1	1	0	2	3	0	
STOMACH	16	10	6	0	2	4	0	8	1	1	
COLON	68	26	42	1	15	15	14	16	6	1	
RECTUM	36	19	17	1	9	6	7	6	7	0	
ANUS/ANAL CANAL	8	3	5	2	2	1	2	0	1	0	
LIVER	10	6	4	0	0	0	5	2	3	0	
PANCREAS	24	10	14	1	0	4	4	13	2	0	
OTHER	22	12	10	0	0	2	2	9	5	4	
RESPIRATORY SYSTEM	146	78	68	0	37	11	30	57	11	0	
NASAL/SINUS	1	1	0	0	0	0	0	0	1	0	
LARYNX	7	7	0	0	3	1	2	0	1	0	
LUNG/BRONCHUS	138	70	68	0	34	10	28	57	9	0	
BLOOD & BONE MARROW	50	24	26	0	0	0	0	0	0	50	
LEUKEMIA	22	13	9	0	0	0	0	0	0	22	
MULTIPLE MYELOMA	20	8	12	0	0	0	0	0	0	20	
OTHER	8	3	5	0	0	0	0	0	0	8	
CONNECT/SOFT TISSUE	6	3	3	0	1	1	0	1	3	0	
SKIN	17	7	10	1	5	3	2	1	2	3	
MELANOMA	15	6	9	1	5	3	2	1	2	1	
OTHER	2	1	1	0	0	0	0	0	0	2	
BREAST	386	2	384	78	134	123	28	19	3	1	
FEMALE GENITAL	84	0	84	1	44	7	17	9	5	1	
CERVIX UTERI	12	0	12	0	8	1	0	1	2	0	
CORPUS UTERI	41	0	41	0	26	4	7	1	2	1	
OVARY	20	0	20	0	4	1	8	6	1	0	
VULVA	4	0	4	1	1	1	1	0	0	0	
OTHER	7	0	7	0	5	0	1	1	0	0	
MALE GENITAL	117	117	0	0	3	84	3	9	18	0	
PROSTATE	112	112	0	0	0	82	3	9	18	0	
TESTIS	4	4	0	0	2	2	0	0	0	0	
OTHER	1	1	0	0	1	0	0	0	0	0	
URINARY SYSTEM	56	34	22	13	15	9	2	4	12	1	
BLADDER	29	25	4	13	6	4	1	1	4	0	
KIDNEY/RENAL	25	8	17	0	9	5	1	3	7	0	
OTHER	2	1	1	0	0	0	0	0	1	1	
BRAIN & CNS	32	6	26	0	0	0	0	0	0	32	
BRAIN (BENIGN)	2	0	2	0	0	0	0	0	0	2	
BRAIN (MALIGNANT)	4	2	2	0	0	0	0	0	0	4	
OTHER	26	4	22	0	0	0	0	0	0	26	
ENDOCRINE	22	2	20	0	13	3	2	0	4	0	
THYROID	22	2	20	0	13	3	2	0	4	0	
LYMPHATIC SYSTEM	44	27	17	0	4	7	6	17	10	0	
HODGKIN'S DISEASE	7	3	4	0	0	2	0	3	2	0	
NON-HODGKIN'S	37	24	13	0	4	5	6	14	8	0	
UNKNOWN PRIMARY	4	0	4	0	0	0	0	0	0	4	
OTHER/ILL-DEFINED	7	3	4	0	0	0	1	0	1	5	

Number of cases excluded: 7

"This report EXCLUDES CA in-situ cervix cases, squamous and basal cell skin cases, and intraepithelial neoplasia cases."

CHART 4. Incidence All Facilities

	DeKalb	Hillandale	Decatur	Combined
Analytic	1175	160	3	1338
Non-analytic	377	138	15	530
Total	1552	298	18	1868

TABLE 3. Site Distribution of Cases Presented

SITE	1stQ	2ndQ	3rdQ	4thQ	Total
Lip, Oral Cavity & Pharynx,					
Head & Neck NOS	1	0	0	0	1
Parotid Gland	0	0	0	0	0
Major Salivary Glands	0	0	0	0	0
Tonsil	0	0	0	0	0
Esophagus	0	1	0	0	1
Stomach	2	2	2	0	6
Small Intestine	0	0	0	0	0
Colorectal	2	3	3	1	9
Anus & Anal Canal	2	0	3	0	5
Appendix	0	0	1	1	2
Liver & Intrahepatic Bile Ducts	0	0	0	1	1
Gallbladder/Biliary Tract, NOS	0	0	0	0	0
Pancreas	0	0	0	3	3
Nasal Cavity & Sinuses	1	0	0	0	1
Larynx	1	0	1	0	2
Bronchus & Lung	1	5	5	1	11
Thymus	0	0	0	1	1
Bones, Joints & Articular Cartilage	0	0	0	0	0
Hematoepoietic & Reticuloendothelial					
System	0	1	1	0	2
Skin (Other)	0	0	0	0	0
Skin (Melanoma)	1	3	2	0	6
Adrenal Gland	0	0	0	0	0
Connective, Subcutaneous					
& Other Soft Tissue	2	1	0	1	4
Breast	6	14	15	11	46
Ovary	6	4	1	5	16
Corpus Uteri/Endometrium	0	2	1	2	5
Vagina	0	0	0	1	1
Cervix	0	1	0	2	3
Other Female Genital Organs	1	0	0	3	4
Prostate	0	0	0	2	2
Testis	0	1	0	1	3
Other Male Genital Organs	0	0	0	0	0
Kidney	0	0	1	0	1
Renal Pelvis/Ureter	1	0	0	0	1
Bladder	0	0	0	0	0
Eye, Brain & Other CNS	1	1	0	0	2
Thyroid & Other Endocrine Glands	0	0	0	0	0
Other & Ill-defined Sites	0	0	0	1	1
Lymph Nodes	4	5	1	3	13
Unknown Primary Site	0	0	1	1	2
Total	32	44	38	41	155

DeKalb Medical Cases: 148 Prospective Cases: 146 *Benign Cases: 1 Outside Cases: 7 Retrospective Cases: 9

Weekly Tumor Conferences

Site Distribution for Cases Presented in 2009

The primary objective of cancer conferences is twofold: the education of healthcare professionals on how to treat recently diagnosed cancer patients and how to improve the quality of life of cancer patients. A total of 42 weekly tumor conferences were held in 2009 to help meet these goals. There were a total of 155 cases presented for discussion. Of this number, 146 were for prospective discussion and 9 were retrospective in nature (Table 3).

Percentage of Annual Analytic Caseload

The number of analytic cases accessioned in 2009 was 1168. There were 7 cases that were not reported. The excluded cases were cervix in situ cases, squamous and basal cell skin cases, and intraepithelial neoplasia cases. We presented 13.3 percent of our analytic caseload during 2009 based upon this figure. 94.1 percent of the cases presented were prospective.

Average Weekly Conference Attendance

Physicians:	21
Medical Oncologists:	3
Radiation Oncologists:	3
Surgeons:	4
Pathologists:	1
Radiologists:	1

Other Medical Specialties:

Ancillary Personnel:	29
Guests:	2

Terri Richardson, RHIA, CTR
Cancer Data Services Manager

2009 Cancer CMEs

January 6, 2009 Joseph Boveri, MD, GYN/ONC “*Robotic Hysterectomy for Endometrial Cancer with Staging*”

February 3, 2009 Pramod Kaila, MD, Radiologist “*PET-CT In Oncology – Current Indications and Techniques*”

March 3, 2009 Michael Grupka, MD “*Barrett’s Esophagus*”

March 30, 2009 Stephen Szabo, MD, Medical Oncologist “*Prostate Cancer*”

May 5, 2009 Michael Quinones, MD, Oncology/General Surgeon “*Hyperthermic Intraoperative Intraperitoneal Chemotherapy (HIPEC)! – Options for Advanced Peritoneal Cancer*”

June 2, 2009 John Kennedy, MD, General Surgeon “*Cancer Staging for Dummies*”

June 29, 2009 David A. Reardon, MD, Associate Professor, Departments of Surgery and Pediatrics, Associate Deputy Director, Preston Robert Tisch Brain Tumor Center at Duke, Duke University Medical Center “*Adult Glioblastoma – Best Approaches to a Challenging Diagnosis*”

August 4, 2009 Bert Chen, MD, Urologist “*Prostate Cancer 2009 Update: PSA Screening, Chemoprevention and Robotics*”

September 1, 2009 Jayanthi Srinivasiah, MD, Medical Oncologist “*New Targets in Breast Cancer: PARP Inhibitors*”

October 6, 2009 Allen Lawhead, MD, GYN/ONC “*Early Detection of Vulvar Cancer*”

November 2, 2009 Jayanthi Srinivasiah, MD, Medical Oncologist; Shelley Smith DiCecco, PT, PhD. CSLT “*Cancer-Related Lymphedema, Early Identification and Management*”

December 1, 2009 Jayanthi Srinivasiah, MD, Medical Oncologist; Aaron Alizadeh, MD, Medical Oncologist; and Simbo Aduloju, MD, Medical Oncologist “*Overview of AJCC Stage, Site Specific Prognostic Indicators, and Evidence-based National Treatment Guidelines in Planning Treatment for Cancer Patients (Sites: Breast, Colorectal, Lung and Prostate)*”

Breast Cancer

Breast cancer continues to have a major impact on our society, and DeKalb Medical at North Decatur and DeKalb Medical at Hillendale continue to be among the leading providers in delivering breast care and breast cancer treatments. Providing efficient, quality and compassionate care is the hallmark of DeKalb Medical's breast services. We have a core group of physicians, nurses, technologists and support personnel who are dedicated to providing standard quality care to our patients and going the extra mile. As one of our breast cancer patients said: "DeKalb Medical's cancer care team not only gave me the treatment I needed to beat this cancer, they gave me the hope I needed, the restored faith which was lacking, and a future which I would

not have without their support." The future for our breast center looks bright. We are in the process of applying to become an Accredited Breast Center by the National Accreditation Program for Breast Centers (NAPBC). The NAPBC is an initiative administered by the American College of Surgeons. This body sets standards and guidelines for breast centers. There are 27 standards and guidelines which have to be integrated in our care of breast cancer patients. All standards and guidelines have been incorporated in our breast center, and we look forward to being awarded accreditation in the near future. In 2009, 386 women received breast cancer treatment at our center (as shown in Figures 1 and 2).

FIGURE 1. 2009 Breast Cancer AJCC Stage at Diagnosis

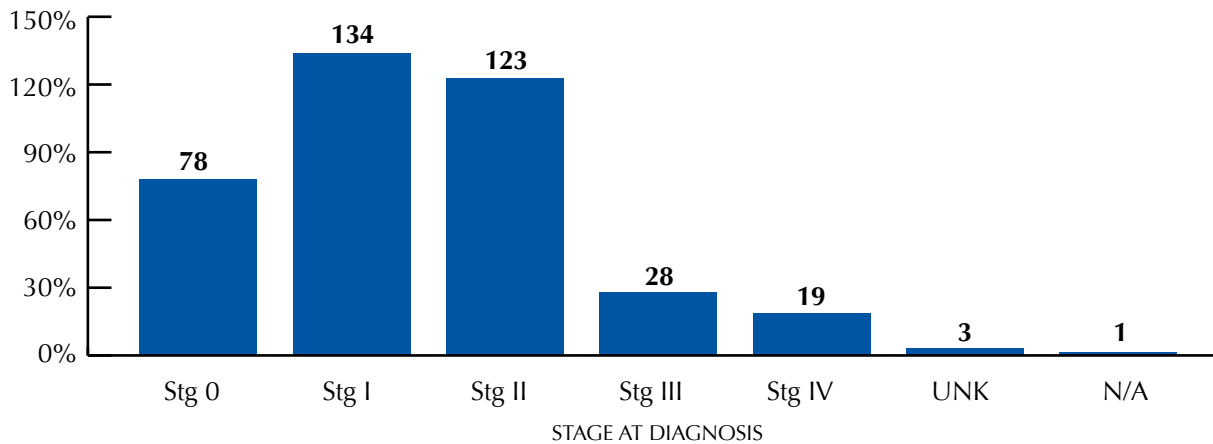


FIGURE 2. Age by Race

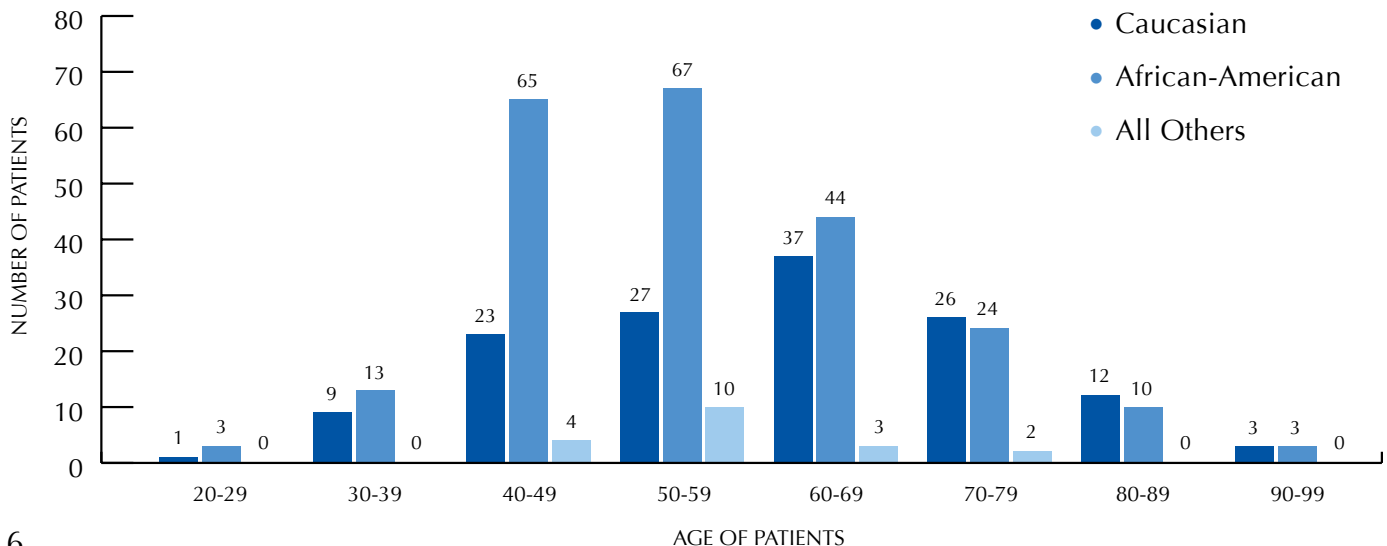


FIGURE 3. National Cancer Database (NCDB) Overall Survival by Stage

2003 Observed Survival • Breast (NCDB)

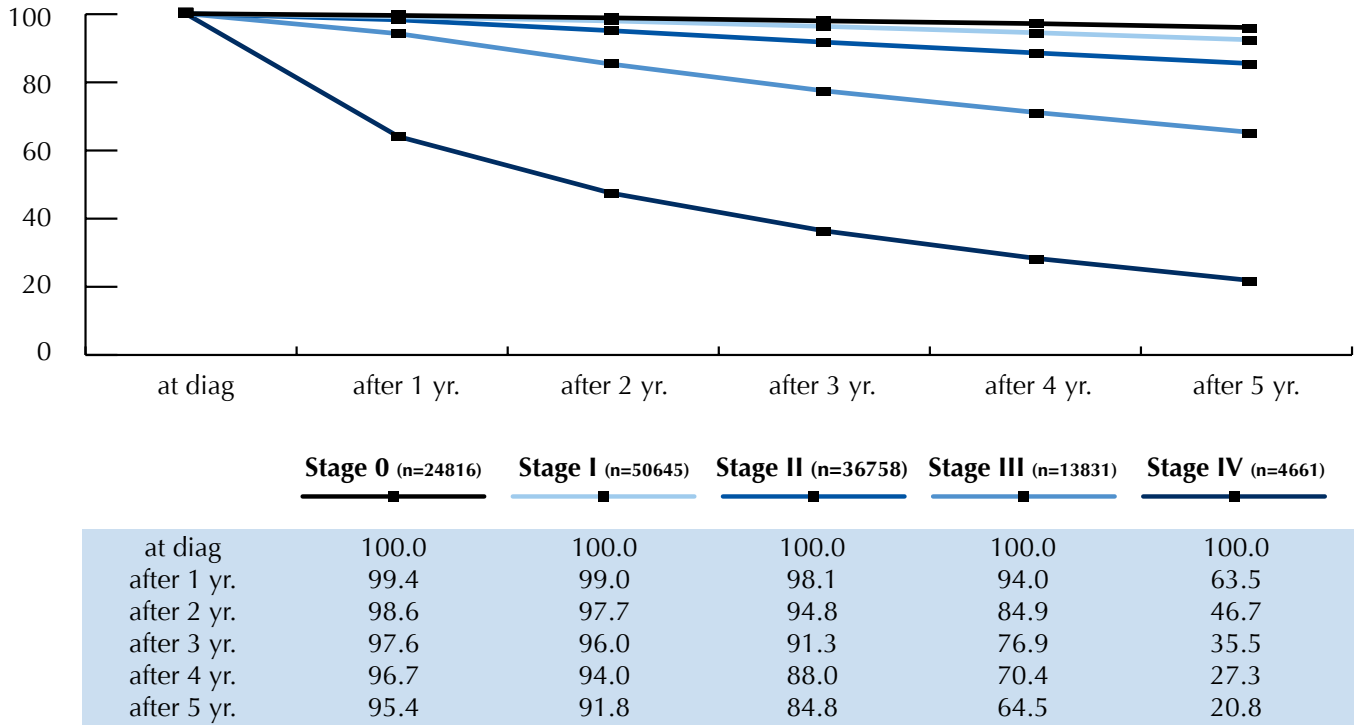
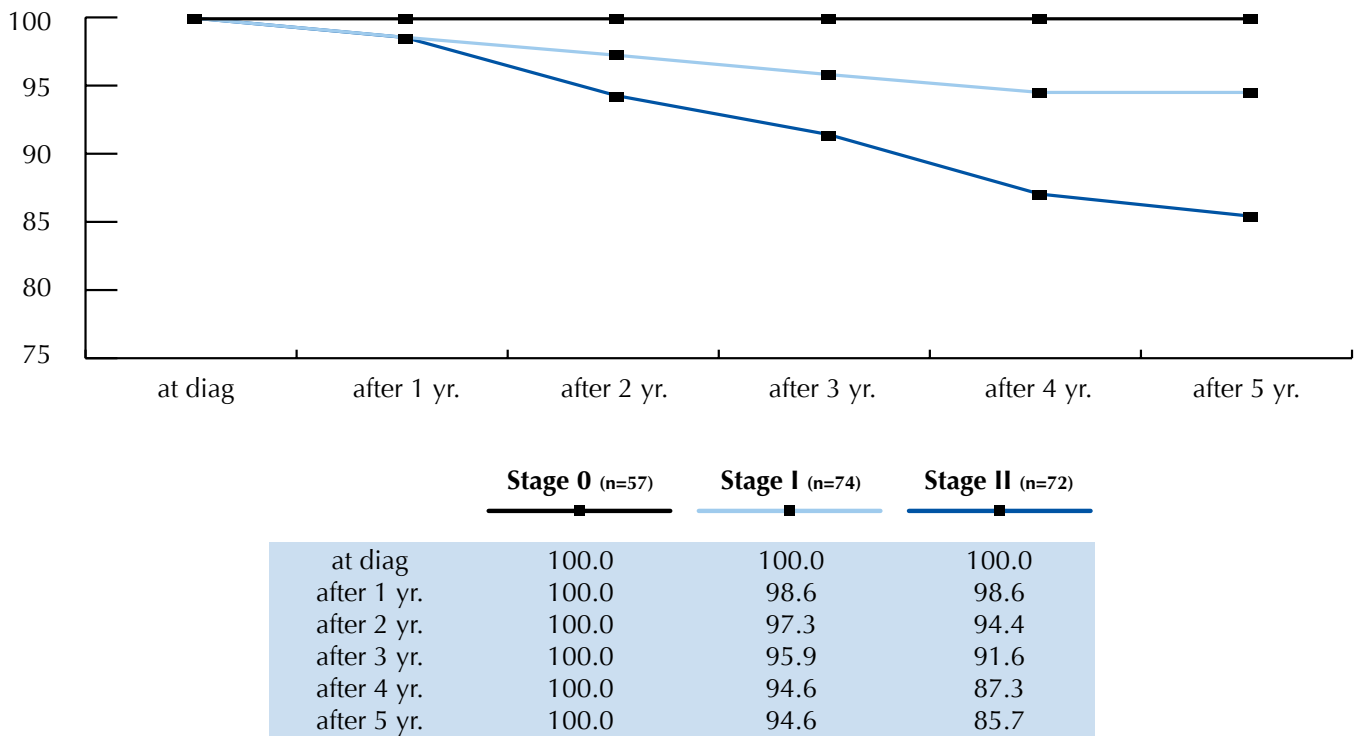


FIGURE 4. DeKalb Medical Overall Survival by Stage

2003 Observed Survival • Breast (DeKalb Medical)



Note: Stage 3&4 number of cases too small to be significant.

Eighty-five percent of these cancers were early stage cancer (Stage 0-78; Stage 1-134; Stage 2-123) with an expected good to excellent five year prognosis. If we compare this data with women treated at this institution five years earlier, one can appreciate why we are optimistic about the present 386 women treated in 2009. Data shows that patients treated in 2003 five-year survivor rate was excellent for early stage breast cancer (shown in Figures 3 and 4). More importantly, our data compares favorably with the National Cancer Data Base (NCDB). If we look at the age by race distribution of breast cancer treatment as shown in Figure 2, our data shows an increase in the African-American vs Caucasian in every age group except age over seventy. This simply reflects the population we serve. If we look at our five-year survival data by race as seen in Figures 5 and 6, it appears that except for stage "0" breast cancer, African-American women's survival rate is less than Caucasian women. This trend is similar to what is seen nationwide. Many reasons are speculated, but one which is widely accepted is that in some cases, African-American women will present with a more

aggressive breast cancer which makes it difficult to effectively treat.

Early stage breast cancer gives a woman many options. More importantly, it gives a woman the option of conserving her breast with lumpectomy and post-operative radiation or mastectomy with immediate reconstruction. In fact one of the NAPBC quality measures requires that fifty percent of early breast cancer be treated with breast conservation. However today, more women with early stage cancer are deciding to undergo mastectomy with immediate reconstruction. This trend has been seen with our patients shown in Figure 7, and it is also being shown nationwide. Our experienced plastic surgeons offer our patients state-of-the-art oncoplastic and reconstructive procedures when they decide to undergo mastectomy.

Our statistics for the percentage of treatment of early stage breast cancer are no accident. Our breast cancer leadership team has made a commitment to educating our primary care physicians, our

FIGURE 5. African-American Observed Survival Analysis

2003 AA Survival Chart

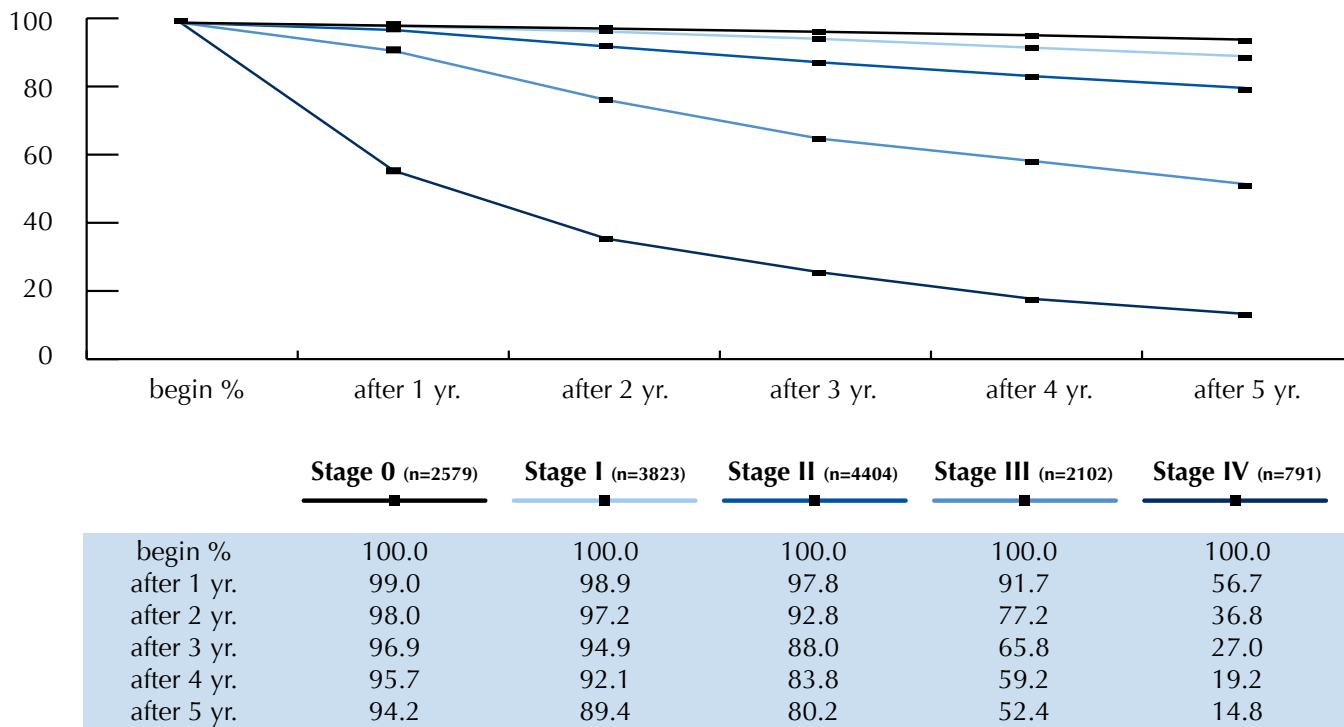
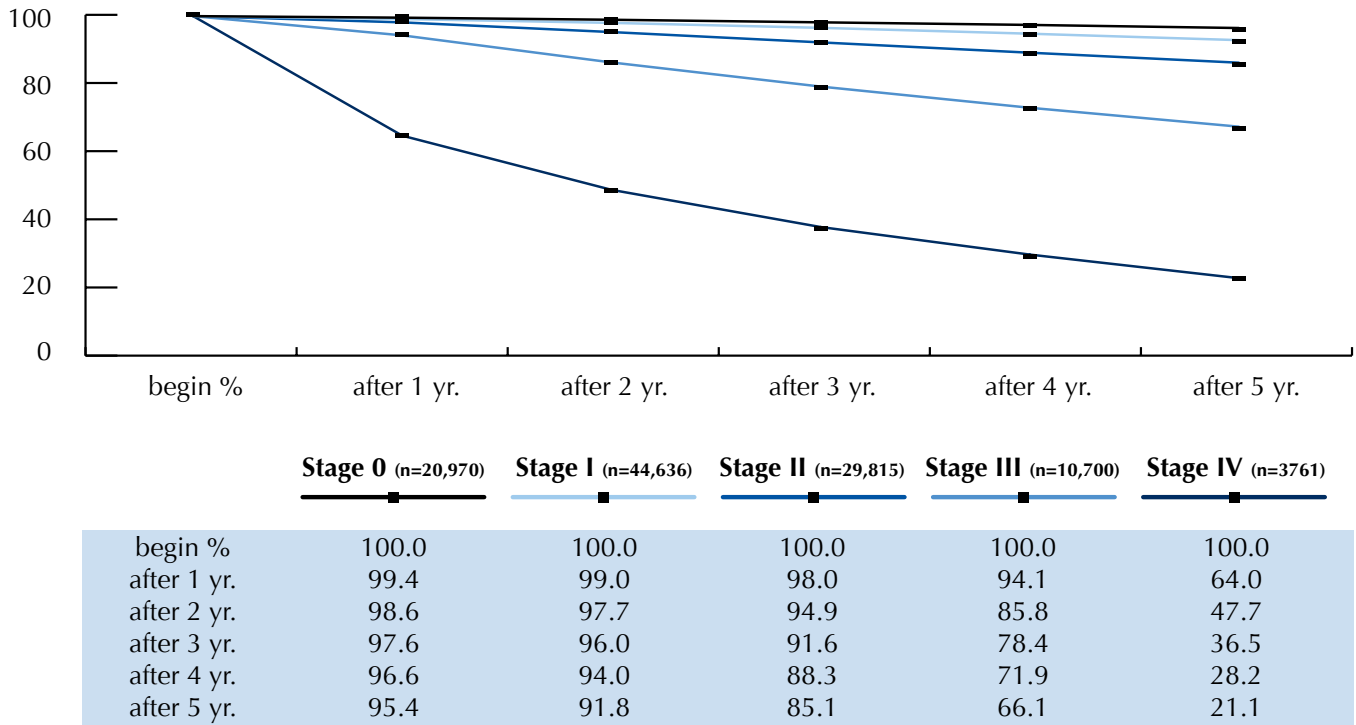


FIGURE 6. Caucasian Observed Survival Analysis

2003 CAU Survival Chart



gynecologists and the community about how important early detection is in the overall survival of breast cancer. They understand the importance of annual mammograms and breast exams. In 2009 we performed 39,125 mammograms (as shown in Figure 8). This number has been fairly consistent over the last three years. We have the state-of-the-art digital mammogram machines, ultrasound machines and MRI which aid in the detection of early breast cancer. Our technologists are well trained and compassionate about their work and sensitive to the women they serve.

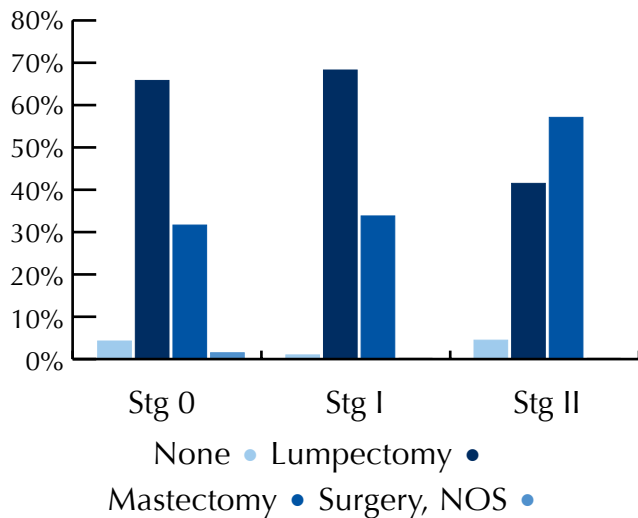
Our needle core biopsy rate statistics are shown in Figure 9. A total of 39,125 screening and diagnostic mammograms were done in 2009, and 958 of these women were recommended to have a biopsy or surgical consultation. Of these 958 patients, 258 were diagnosed with breast cancer, and 89% were diagnosed with node negative early breast cancer¹. Out of the 385 breast cancer patients treated in our center, 94% had their initial diagnosis made by a needle core biopsy (as shown in Figure 7). Needle core biopsy is the standard initial procedure for diagnosing breast cancer. This procedure gives

the breast surgeon and the oncology team the opportunity to obtain the necessary additional test results to discuss all options with the patient and her family, and to make a recommendation for treatment prior to undergoing any major surgery.

The role of MRI in evaluating the breasts after a diagnosis of breast cancer continues to be controversial. Our breast radiologists are in agreement that MRI can yield useful information and should be considered. We have a cutting-edge MRI system, and MRI is frequently offered to our breast cancer patients. Our MRI guided biopsy rate for additional malignancy is 14.8%. Although statistically this appears to be significant, more data is needed.

Breast conservation using post-op radiation combined with lumpectomy or partial mastectomy for breast cancer continues to be an option for small, localized breast cancers. The National Surgical Adjuvant Breast and Bowel Project (NSABP) showed in the B-06 trial that breast conservation with post-operative radiation treatment was equal in survival to mastectomy. In 2009, 183 women were treated in our institution

FIGURE 7. Cancer Directed Surgery



with breast conservation surgery for stages 0, I and II (as shown in Figure 7). This accounts for about 56.3% of our women treated here for breast cancer. The NSABP “B-06” trial underlined the importance of adding post-operative radiation therapy when breast conservation is desired. Since this clinical trial, how the dosage of radiation is delivered and the length of time have been investigated. Presently standard radiation is delivered over the total breast within six weeks. Partial radiation devices have been developed. These devices have proven to be effective in local control in treating breast cancer while limiting the field of radiation to the site of the breast cancer intra-operative or post-operative within one week. The most popular device and the device with

FIGURE 8. Mammography Annual Statistics

	2009	2008	2007
Total Mammos	39,125	40,554	40,523
Screenings	31,302	31,644	32,308
Diagnostics	7,828	8,910	8,215
Recall Rate ¹	8%	7.9%	7.8%
Bx. Recommended	958	942	1,216
# Cancers	258	212	238
# Screening Cancers	115	86	101
Screening Ca. Det. Rate ²	3%	2.72%	3.13%

Note 1 Desirable goal <10%, Note 2 Desirable goal 2-10

the longest clinical trial is the partial radiation device given over one week. Partial radiation treatment has become more popular with our patients who are fifty years and older with early breast cancer. It is an alternative to total breast radiation for select patients with favorable small breast cancers. The overall survival rate is statistically the same as for total breast radiation for this select group of patients. In 2009 our institution treated 49 early breast cancer patients with partial breast radiation. The advantage of partial radiation is shorter time of treatment and enhancement of cosmetic results with the same control of the cancer as total breast radiation. As the word about partial radiation continues to get out to the public, more and more women will be asking for this treatment modality. Our radiation oncologists are excited about the future.

FIGURE 9. 2009 Needle Core Biopsy Rate

385	Total breast cases
-20	Cases excluded
366	Cases remaining in study
94%	Needle core biopsy performed
22	Needle core biopsy not performed

The DeKalb Medical Breast Center takes pride in the fact that we are a full-service breast center. We have an active high-risk screening and genetics program which has been in place since 1999. In 2009 we had 262 referrals with 76 women tested for the breast cancer gene. Our research department is very active in making sure our patients are knowledgeable about clinical trials and we are one of the leaders in clinical trials participation. We have a strong support network with our breast support group, oncology nurses and breast navigator. Our 2010 goal is to consolidate all our resources delivering quality breast services. Our ultimate goal is to become an accredited breast center.

Note 1: This information was taken from the DeKalb Medical 2009 Diagnostic Breast Center Report.

2009 Cancer Committee Members

John Kennedy, MD, Chairman; Stephen Szabo, MD, Vice-Chairman; Betty Castellani, Cancer Program Director

PHYSICIAN MEMBERS

BALFOUR-WILLIAMS, Tosha MD	Radiation Oncology
BALISTRARI, Anthony MD	Gastroenterology
BELCHER, Kelvin MD	Radiology
CASTAGNO, Jacqueline C. MD	GYN/Oncology
CHAMPNEY, Michael MD	General Surgery
COLBERT, Laronna MD	Medical Oncology
CORNWELL, Michael MD	Surgeon
DIFRANCESCO, Lisa MD	Plastic Surgeon
ECHOLS, Tonya MD	Radiation Oncology
FEINBERG, Bruce DO	Medical Oncology
FRIPP, Vikisha MD	Plastic Surgeon
HARGREAVES, Hilary MD	Pathology
HARJEE, Gulshan MD	Internal Medicine
HOLLADAY, David MD (Medical Director, Radiation Oncology)	Radiation Oncology
HYATT, Sasha MD	Radiation Oncology
JARRETT, Diane MD	Pathology
KEETON, William MD	Pain Management
LAWHEAD, Allen MD (Medical Director, Cancer Center)	GYN/Oncology
MAYER, Raoul MD	Colorectal Surgery
MOORE, Melvin MD (Medical Director, Kann Center)	Medical Oncology
PELTA, Arie MD	Colorectal Surgery
PHILLIPS, Rogsbert MD	General Surgery
QUINONES, Michael MD	General Surgery
SIMON, Timothy MD	Colorectal Surgery
SIMPSON, Lijo MD	Medical Oncology
SRINIVASIAH, Jayanthi MD	Medical Oncology
STIEBER, Andrei MD	General Surgeon
STONECIPHER, Marcus MD	Dermatology
STUBBS, Michael MD	Thoracic Surgery
TAMIM, Hiba MD	Medical Oncology
WILLIAMS, Hamilton MD	Radiation Oncology

ADMINISTRATIVE & ANCILLARY STAFF

BEARD, Emily Mason RN, OCN	Breast Nurse Navigator
BRANSON, Rachele PT	Return to Wellness
BRISCO, Edna RN, OCN	4200 Manager
CANTRELL, Rebecca	Clinical Trials Data Manager
CHEEK, Angela RN, OCN	Clinical Trials Research Nurse
COMER, Cathy RN, OCN	Clinical Trials Coordinator/ Research Nurse
CORRIHER, Jacquelyn RN, OCN	Clinical Trials Research Nurse
COX, McClellon D.Min	Chaplain
CRAIG, Lisa RHIT	Cancer Registry Abstractor
CUMMINGS, Jewel RN	Case Management
DIXON, Lynn RN	Clinical Trials Research Nurse /Quality Management
GRISAFFE, Alecia RN, OCN	Stem Cell Transplant Coordinator
FLEMING, Jeralyn CTR	Cancer Registry Abstractor
HANFLAND, Sherri RPT	Rehabilitative Services
HART, Beverly RN, OCN	Case Management
HIGGINS, Laura PT	Return to Wellness
HORTON, Dena RN, OCN	Case Management
JOHNSON, Fran CTR	Cancer Registry Lead Abstractor
JONES, Doris RN, OCN	Clinical Trials Research Nurse
KONRAD, Kamilah LMSW, ACS	Patient Navigator
KUNIK, Cherie RN	Director, Medical-Surgery Services
LANDERMAN, Cathy RT	Diagnostic Breast Center 4200
LAPOINTE, JoDean RN	ACS Representative
LEE, Shanna MS	Clinical Coordinator, Kann Center
MCCULLOUGH, Cammy RN, OCN	Practice Manager/Physician Clinical Coordinator
McELHINEY, Lisa	Practice Manager/Physician Clinical Coordinator
MCKEE, Lisa	Case Management
McKEEVER, Rose LPN	M.Div., Asst. Director, Cancer Center
MIRANDA, George MBA	Social Services
OSHEROFF, Marjorie MSW	Manager, Cancer Data Services
RICHARDSON, Terri RHIA, CTR	Pathology Dept Manager, Radiation Oncology Dept
ROSENOW, Michelle MS, PA	Ca. Support Team Dietary Svs.
ROYSTER, Donna RT (R) (T)	Cancer Registry Abstractor
SCHULER, Alice RD, LD	Patient/Community Representative
SIMON, Charntrella RHIT	BCOP, Pharmacy
SMITH, Susan V.	Cancer Program Coordinator
STORY, Carol Pharm.D.	Stem Cell Lab
TINKLE, Claudia	Sr. Vice-President/Chief Quality Officer
WARD, Leanne MT (AMT)	
WHEATLEY, Cathleen	

DeKalb Medical Cancer Center

2665 North Decatur Road, Suite 130
Decatur, Georgia 30033

404.501.5701 • www.dekalbmedical.org



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