People are discovering our breakthroughs in cancer treatment.

It's Good to Know.

2011 Cancer Report
We are pleased to present the 2011 Cancer Program annual report. It has been a privilege to serve as the chairman of the North Mississippi Medical Center Cancer Committee for 2011. This has been an exciting and productive year for our team as we have reached out to serve our patients and community with the highest level of oncology care. The remarkable care that has been provided this past year has touched the lives of many individuals throughout this region. We have provided our patients and community with a wide range of medical, educational and social services in a caring and compassionate manner.

As you know, the NMMC Cancer Committee is comprised of a multidisciplinary panel of specialists and ancillary personnel, which is a very active and progressive component of the overall cancer program at NMMC. Our physicians, team members, volunteers and donors are committed to excellence in the many oncology/palliative related services we provide.

The Cancer Committee also strives to improve the care of cancer patients in our region.
Our goals for 2011 included:
• Increase awareness of all residents at NMMC about Cancer Conference
• Establish a genetic counseling/testing program at NMMC
• American Cancer Society embedded volunteer at Cancer Center to revitalize resource center
• Offer Look Good… Feel Better Program at NMMC
• Develop program to review oncology-related pathology discrepancies
• Develop program to identify VTE occurrences in oncology patients
• Palliative Care Program: Work toward inpatient hospice unit
• Increase the focus on participation in clinical research trials in preparation for the new 2012 standards

Our Vision
Provide the best patient centered care and health services in America. To fulfill our mission and vision, NMMC is recognized as meeting each of the following pillars of excellence:

Values
Compassion – Show sincere care and kindness for those I serve
Accountability – Take responsibility for my actions
Respect – Treat everyone with dignity
Excellence – Achieve excellence through innovation, teamwork and doing my best
Smile – Always be friendly

Critical Success Factors
People – Maintain high quality workforce.
Service – Improve customer service.
Quality – Improve prevention and health education services. Improve health outcomes.
Financial – Produce financial resources required to support the mission and vision.
Growth – Expand access to health services.

In keeping with NMCC’s mission, our dedicated multidisciplinary team looks confidently to the future to continue to provide excellent oncology/palliative care to the communities we serve.

Montgomery Berry, M.D.
Chairman
Cancer Committee
The North Mississippi Medical Center Cancer Program is a multidisciplinary program accredited by the American College of Surgeons (ACOS) and the American College of Radiology (ACR). Being nationally accredited assures that the NMMC Cancer Program adheres to the highest standards and allows comparison of treatment and outcomes on a local, state and national level.

The following tables and graphs are provided by the NMMC Cancer Registry for calendar year 2011. There were a total of 1,916 cases, of which 1,693 were analytic. Cancer of the lung is the most prevalent site with 306 new cases. Breast cancer is the second most prevalent site with 240, and prostate is third with 237 cases. In fourth and fifth place were colon/rectum with 146 and melanoma with 87. Overall, our top five sites represent 60 percent of the total cancer population seen at NMMC. The distribution by sex was male 937 (55 percent) and female 756 (45 percent).

Melanoma continues to be in the top five primary sites; this rate of diagnosis is most likely generated by community skin screenings, increased awareness and education.

The Cancer Committee will continue to use the Cancer Registry's data to provide effective screening programs that will increase early detection and diagnosis among residents of our communities. Early detection in the war against cancer is extremely important for long-term survival. It is the goal of the Cancer Committee to support all efforts to increase the early diagnosis of cancer and take the lead in this endeavor. NMMC's team of physicians and other health care professionals are committed to provide state-of-the-art cancer treatment in a compassionate and cost effective manner.

The following statistical data graphed in this report includes: Primary Site Table, Sex, Race, Top 5 Sites, Age at Diagnosis and Geographic Location.

Stephen Farmer, M.D.
Vice Chairman
Cancer Committee
Who is a Cancer Liaison Physician?

A Cancer Liaison Physician (CLP) is a leader of the cancer program, someone who will support the facility’s efforts in complying with and maintaining the CoCs standards, facilitate activities with the interests of the cancer patients, facility and the community in mind, and is dedicated to improving the quality of care delivered to the cancer patient.

The CLP serves as liaison between the cancer program, the hospital, the community, the Commission on Cancer (CoC) and the American Cancer Society (ACS). CLPs are volunteer physicians and a required component of the CoC accredited cancer programs. CLPs serve a three-year term with eligibility to serve an unlimited number of terms.

Established in 1963, the CoC Cancer Liaison Program was developed as a grassroots network of physician volunteers willing to manage clinically related cancer activities in their local institutions and surrounding communities. Initially, membership was limited to surgeons; however, membership was expanded in the 1970s to reflect the multidisciplinary composition of professionals who care for patients with cancer. Today, approximately 45 percent of the nearly 1,600 Cancer Liaison Physicians represent non-surgical disciplines.

During 2011, NMMC added a second Cancer Liaison Physician to assist with the tremendous variety of specialized duties.

A few of the responsibilities & goals of the CLPs:

- Spearhead CoC initiatives within the hospital’s cancer program.
- Facilitate accurate use of physician staging in treatment planning.
- Ensure timely and quality submission of National Cancer Data Base (NCDB) data.
- Demonstrate leadership and support for cancer control activities in the community and with the ACS, or serve as a role model for other staff and exhibit characteristics that truly make them a physician champion for the cancer program.
- Develop best practices, evaluate compliance with adopted guidelines, expand participation in clinical trials and improve quality of care.
- Play a role in the CoC survey preparation and participation.
- Reduce the burden of cancer in the community.
- Become involved in the state cancer plan.

Cancer Program Practice Profile Reports (CP3R)

To monitor quality initiatives, the Commission on Cancer produces the CP3R site. This allows facilities to monitor compliance with quality initiatives related to breast, colon and rectal cancers and to compare performance with other accredited facilities such as others in the state, region, same classification or all other accredited facilities. NMMC can monitor performance over time looking for trends in patient care. Many times these trends may be related to changes in data capture or difficulty obtaining information on a timely basis. The NMMC Cancer Registry audits these cases periodically and takes extra measures to collect missing data and update these reports. The Cancer Liaison Physician reports the data to the Committee, whose responsibility is to monitor the data, identify any measure that falls below required levels of compliance and work to resolve these issues appropriately. Discussions are documented in Cancer Committee minutes and subsequently shared with the medical staff and administration.

Here are a few of our accomplishments:

- Two guest speakers during 2011 offered cancer-related educational activities for the multidisciplinary team: Eben Rosenthal, M.D., Otolaryngology, University of Alabama, Birmingham, and Alexander E. Denes, M.D., Associate Professor of Medicine, Washington University, St. Louis, Mo.
- Process to evaluate accurate staging and use of stage in treatment planning for cancer patients using 7th Edition AJCC staging
- New Mobile Mammography unit

Continued accomplishments:

- Measure compliance with guidelines for patient management and treatment.
- Encourage use of National Comprehensive Cancer network (NCCN) guidelines. Guidelines are projected during Cancer Conference.
- Multiple health fairs, including the annual Live Well Health Fair.
- Project Hope’s Festival of Hope, Relay for Life, Susan G. Komen North Mississippi Race for the Cure, Hope Steps Forward brain tumor awareness run/walk
- Camp Bluebird
- Digital billboards in Tupelo to promote cancer awareness with appropriate color ribbons and website information.
- Medical record review, including several quality checks: stage, College of American Pathologists protocol, site-specific prognostic indicators and national treatment guidelines in treatment planning.

We are always looking forward to improving quality and achieve consistent growth in our cancer program without sacrificing outcomes.

The NMMC Cancer Center is continuously looking for ways to improve care and serve our community… that’s good to know.
The Cancer Registry at NMMC is a vital component of our cancer program. The cancer program at NMMC functions within the standards set by the ACOS CoC. We collect cancer-related information from diagnosis through treatment: demographics, history, work-up, AJCC staging, prognostic factors, surgery, chemotherapy, radiation, hormone, etc. – per state and national requirements. Serving as an important public health tool, cancer registries enable public health officials to make decisions on activities such as research funding allocation, screening program placement and educational program development. Further, the information is important to understanding treatment effectiveness and determining cancer occurrence and survival rates.

Registry data is submitted to the National Cancer Data Base, The Mississippi Central Cancer Registry in Jackson, as well as the Commission on Cancer Facility Information Profile System and the American Cancer Society. This data enables programs to compare treatment, trends, education, screening guidelines and outcomes with regional, stage and national statistics.

Annual patient follow up is essential to accurately assess treatment outcomes and patient survival. It is required of all analytic cases, defined as patients who were diagnosed at NMMC and/or received first course of treatment at NMMC. This contact serves as a reminder to former patients to continue their follow-up exams with physicians. We attempt to follow all patients even if they move, which can sometimes be a challenge and time consuming. Currently, NMMC has approximately 10,250 patients in active follow-up. In order to meet the ACOS CoC standards, NMMC must maintain current follow-up information on at least 80 percent of all patients diagnosed since January 1, 1997 and 90 percent of all patients diagnosed within the past five years. The NMMC Cancer Registry has maintained follow-up rates at 93 percent and 95 percent, which exceeds the requirements.

Please call the Cancer Registry to schedule a case for cancer conference at (662) 377-3053.

**Mission**

**Why we exist:**
To help increase survival rates of people in our region with cancer.

**Vision**

**What we want to be:**
The provider of the most consistent and accurate cancer data available to the North Mississippi Medical Center Cancer Program.

**NMMC Cancer Registrars**
- Shelia Jinkins, CTR
- Jewell Johnson, CTR
- Sandra Oliver, CTR

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**Cancer Registry Cases Analytical Cases**

<table>
<thead>
<tr>
<th>Year of Diagnosis</th>
<th>Number of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>1,412</td>
</tr>
<tr>
<td>2002</td>
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<td>2003</td>
<td>1,259</td>
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<td>2004</td>
<td>1,400</td>
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<td>2005</td>
<td>1,446</td>
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<td>2006</td>
<td>1,525</td>
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<td>2007</td>
<td>1,627</td>
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<tr>
<td>2008</td>
<td>1,552</td>
</tr>
<tr>
<td>2009</td>
<td>1,558</td>
</tr>
<tr>
<td>2010</td>
<td>1,634</td>
</tr>
<tr>
<td>2011</td>
<td>1,693</td>
</tr>
</tbody>
</table>

|= Number of Cases|

The NMMC Cancer Registry has maintained follow-up rates at 93 percent and 95 percent, which exceeds the requirements…

*that’s good to know.*

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**We celebrate his retirement…**
The NMMC Cancer Registry would like to thank Dr. Elbert Duncan for his many years of service as the Cancer Registry Quality Control Coordinator. He has worked diligently to ensure the highest quality of data within the cancer registry and to provide a means to monitor this collection and dissemination.

**We will miss you.**
<table>
<thead>
<tr>
<th>Primary Site</th>
<th>Total (%)</th>
<th>Sex</th>
<th>Class of Case</th>
<th>Status</th>
<th>Stage Distribution-Analytic Cases Only</th>
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<tbody>
<tr>
<td>ORAL CAVITY &amp; PHARYNX</td>
<td>38 (2.0%)</td>
<td>M</td>
<td>F</td>
<td>NA</td>
<td>Alive Exp 0 I II III IV 88 Unknown</td>
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<tr>
<td>Lip</td>
<td>5 (0.3%)</td>
<td>5</td>
<td>0</td>
<td>5</td>
<td>0 4 1 0 0 0 0</td>
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<tr>
<td>Tongue</td>
<td>13 (0.7%)</td>
<td>8</td>
<td>5</td>
<td>13</td>
<td>0 12 1 0 1 6 2 0 0</td>
</tr>
<tr>
<td>Gum &amp; Other Mouth</td>
<td>9 (0.5%)</td>
<td>7</td>
<td>2</td>
<td>9</td>
<td>0 8 1 1 1 2 4 0 0</td>
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<tr>
<td>Nasopharynx</td>
<td>3 (0.2%)</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>0 0 1 1 1 0 1 0</td>
</tr>
<tr>
<td>Tonsil</td>
<td>5 (0.3%)</td>
<td>4</td>
<td>1</td>
<td>4</td>
<td>1 3 2 0 0 0 4 0 0</td>
</tr>
<tr>
<td>Oropharynx</td>
<td>1 (0.1%)</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0 0 0 0 0 0 0 0</td>
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<tr>
<td>Hypopharynx</td>
<td>2 (0.1%)</td>
<td>2</td>
<td>0</td>
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<tr>
<td>DIGESTIVE SYSTEM</td>
<td>297 (15.5%)</td>
<td>177</td>
<td>120</td>
<td>258 39</td>
<td>193 104 2 43 65 59 71 2 16</td>
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<tr>
<td>Esophagus</td>
<td>14 (0.7%)</td>
<td>13</td>
<td>1</td>
<td>11</td>
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<tr>
<td>Stomach</td>
<td>26 (1.4%)</td>
<td>14</td>
<td>12</td>
<td>20</td>
<td>6 7 19 0 1 4 5 9 0 1</td>
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<tr>
<td>Small Intestine</td>
<td>8 (0.4%)</td>
<td>5</td>
<td>3</td>
<td>6</td>
<td>2 8 0 0 3 1 1 0</td>
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<tr>
<td>Colon Excluding Rectum</td>
<td>133 (6.9%)</td>
<td>79</td>
<td>54</td>
<td>114</td>
<td>19 107 26 0 30 30 31 22 0 1</td>
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<tr>
<td>Cecum</td>
<td>27</td>
<td>19</td>
<td>8</td>
<td>24</td>
<td>3 24 3 0 7 5 7 5 0 0</td>
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<td>2</td>
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<td>1</td>
<td>1 2 0 0 1 0 0 0 0</td>
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<tr>
<td>Ascending Colon</td>
<td>32</td>
<td>19</td>
<td>13</td>
<td>28</td>
<td>4 23 9 0 7 8 8 4 0 1</td>
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<td>Hepatic Flexure</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>0 1 2 0 0 1 0 2 0 0</td>
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<tr>
<td>Transverse Colon</td>
<td>11</td>
<td>4</td>
<td>7</td>
<td>7</td>
<td>4 6 5 0 3 2 1 1 0 0</td>
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<td>Splenic Flexure</td>
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<td>3</td>
<td>1</td>
<td>4</td>
<td>0 3 1 0 2 0 2 0 0</td>
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<tr>
<td>Descending Colon</td>
<td>9</td>
<td>4</td>
<td>5</td>
<td>8</td>
<td>1 8 1 0 1 4 2 1 0 0</td>
</tr>
<tr>
<td>Sigmoid Colon</td>
<td>41</td>
<td>25</td>
<td>16</td>
<td>37</td>
<td>4 37 4 0 11 8 12 6 0 0</td>
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<tr>
<td>Large Intestine, NOS</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2 3 1 0 0 0 1 1 0 0</td>
</tr>
<tr>
<td>Rectum &amp; Rectosigmoid</td>
<td>37 (1.9%)</td>
<td>23</td>
<td>14</td>
<td>32</td>
<td>5 31 6 1 4 8 5 7 0 7</td>
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<tr>
<td>Rectosigmoid Junction</td>
<td>8</td>
<td>5</td>
<td>3</td>
<td>7</td>
<td>1 7 1 0 1 1 1 3 0 1</td>
</tr>
<tr>
<td>Rectum</td>
<td>29</td>
<td>18</td>
<td>11</td>
<td>25</td>
<td>4 24 5 1 3 7 4 4 0 6</td>
</tr>
<tr>
<td>Anus, Anal Canal &amp; Anorectum</td>
<td>6 (0.3%)</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>0 6 0 1 1 1 2 0 0 1</td>
</tr>
<tr>
<td>Liver &amp; Intrahepatic Bile Duct</td>
<td>14 (0.7%)</td>
<td>12</td>
<td>2</td>
<td>13</td>
<td>1 6 8 0 4 0 3 4 2 0</td>
</tr>
<tr>
<td>Gallbladder</td>
<td>1 (0.1%)</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0 1 0 0 0 0 0 0 0 0</td>
</tr>
<tr>
<td>Other Biliary</td>
<td>5 (0.3%)</td>
<td>2</td>
<td>3</td>
<td>5</td>
<td>0 2 3 0 0 1 0 2 0 2</td>
</tr>
<tr>
<td>Pancreas</td>
<td>53 (2.8%)</td>
<td>27</td>
<td>26</td>
<td>51</td>
<td>2 18 35 0 2 18 7 22 0 2</td>
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<tr>
<td>RESPIRATORY SYSTEM</td>
<td>339 (17.7%)</td>
<td>220</td>
<td>119</td>
<td>324</td>
<td>15 174 165 0 58 29 93 142 0 2</td>
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<tr>
<td>Nose, Nasal Cavity &amp; Middle Ear</td>
<td>2 (0.1%)</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>0 1 1 0 0 1 0 1 0 0</td>
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<tr>
<td>Larynx</td>
<td>17 (0.9%)</td>
<td>12</td>
<td>5</td>
<td>16</td>
<td>1 11 6 0 4 1 4 7 0 0</td>
</tr>
<tr>
<td>Lung &amp; Bronchus</td>
<td>320 (16.7%)</td>
<td>206</td>
<td>114</td>
<td>306</td>
<td>14 162 158 0 53 28 89 134 0 2</td>
</tr>
<tr>
<td>BONES &amp; JOINTS</td>
<td>2 (0.1%)</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1 2 0 0 1 0 0 0 0 0 0 0</td>
</tr>
<tr>
<td>SOFT TISSUE (including Heart)</td>
<td>10 (0.5%)</td>
<td>5</td>
<td>5</td>
<td>10</td>
<td>0 8 2 0 5 2 1 1 1 1 0</td>
</tr>
<tr>
<td>SKIN (excluding basal &amp; squa.)</td>
<td>104 (5.4%)</td>
<td>62</td>
<td>42</td>
<td>91</td>
<td>13 91 13 23 36 22 6 4 0 0</td>
</tr>
<tr>
<td>Melanoma - Skin</td>
<td>98 (5.1%)</td>
<td>58</td>
<td>40</td>
<td>87</td>
<td>11 89 9 23 34 20 6 4 0 0</td>
</tr>
<tr>
<td>Other Non-Epithelial Skin</td>
<td>6 (0.3%)</td>
<td>4</td>
<td>2</td>
<td>4</td>
<td>2 2 4 0 2 2 0 0 0 0 0 0 0</td>
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<tr>
<td>BASAL &amp; SQUAMOUS SKIN</td>
<td>31 (1.6%)</td>
<td>20</td>
<td>11</td>
<td>0</td>
<td>31 28 3 0 0 0 0 0 0 0 0 0 0</td>
</tr>
<tr>
<td>BREAST</td>
<td>263 (13.7%)</td>
<td>3</td>
<td>260</td>
<td>240</td>
<td>23 253 10 35 94 63 37 11 0 0</td>
</tr>
<tr>
<td>Primary Site</td>
<td>Total (%)</td>
<td>M</td>
<td>F</td>
<td>M</td>
<td>F</td>
</tr>
<tr>
<td>------------------------------------</td>
<td>-----------</td>
<td>-----</td>
<td>-----</td>
<td>----</td>
<td>----</td>
</tr>
<tr>
<td>FEMALE GENITAL SYSTEM</td>
<td>87 (4.5%)</td>
<td>0</td>
<td>87</td>
<td>0</td>
<td>87</td>
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<tr>
<td>Corpus &amp; Uterus, NOS</td>
<td>28 (1.5%)</td>
<td>26</td>
<td>2</td>
<td>0</td>
<td>26</td>
</tr>
<tr>
<td>Uterus, NOS</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Cervix Uteri</td>
<td>24 (1.3%)</td>
<td>24</td>
<td>0</td>
<td>24</td>
<td>24</td>
</tr>
<tr>
<td>Primary Site Total (%) M F Analy NA Alive Exp 0 I II III IV 88 Unknown</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MALE GENITAL SYSTEM</td>
<td>282 (14.7%)</td>
<td>282</td>
<td>0</td>
<td>249</td>
<td>33</td>
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<tr>
<td>Prostate</td>
<td>270 (14.1%)</td>
<td>270</td>
<td>0</td>
<td>237</td>
<td>33</td>
</tr>
<tr>
<td>Testis</td>
<td>5 (0.3%)</td>
<td>5</td>
<td>0</td>
<td>5</td>
<td>0</td>
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<tr>
<td>Penis</td>
<td>6 (0.3%)</td>
<td>6</td>
<td>0</td>
<td>6</td>
<td>0</td>
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<tr>
<td>Other Male Genital Organs</td>
<td>1 (0.1%)</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
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<tr>
<td>URINARY SYSTEM</td>
<td>154 (8.0%)</td>
<td>111</td>
<td>43</td>
<td>133</td>
<td>21</td>
</tr>
<tr>
<td>Urinary Bladder</td>
<td>77 (4.0%)</td>
<td>58</td>
<td>19</td>
<td>63</td>
<td>14</td>
</tr>
<tr>
<td>Kidney &amp; Renal Pelvis</td>
<td>71 (3.7%)</td>
<td>48</td>
<td>23</td>
<td>64</td>
<td>7</td>
</tr>
<tr>
<td>Ureter</td>
<td>6 (0.3%)</td>
<td>5</td>
<td>1</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>BRAIN &amp; OTHER NERVOUS SYS.</td>
<td>60 (3.1%)</td>
<td>27</td>
<td>33</td>
<td>58</td>
<td>2</td>
</tr>
<tr>
<td>Brain</td>
<td>30 (1.6%)</td>
<td>18</td>
<td>12</td>
<td>30</td>
<td>0</td>
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<tr>
<td>Cranial Nerves Other Nerv Sys.</td>
<td>30 (1.6%)</td>
<td>9</td>
<td>21</td>
<td>28</td>
<td>2</td>
</tr>
<tr>
<td>ENDOCRINE SYSTEM</td>
<td>56 (2.9%)</td>
<td>18</td>
<td>38</td>
<td>53</td>
<td>3</td>
</tr>
<tr>
<td>Thyroid</td>
<td>41 (2.1%)</td>
<td>12</td>
<td>29</td>
<td>39</td>
<td>2</td>
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<tr>
<td>Other Endocrine incl Thymus</td>
<td>15 (0.8%)</td>
<td>6</td>
<td>9</td>
<td>14</td>
<td>1</td>
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<tr>
<td>LYMPHOMA</td>
<td>74 (3.9%)</td>
<td>35</td>
<td>39</td>
<td>68</td>
<td>6</td>
</tr>
<tr>
<td>Hodgkin Lymphoma</td>
<td>6 (0.3%)</td>
<td>4</td>
<td>2</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Non-Hodgkin Lymphoma</td>
<td>68 (3.5%)</td>
<td>31</td>
<td>37</td>
<td>63</td>
<td>5</td>
</tr>
<tr>
<td>NHL - Nodal</td>
<td>46</td>
<td>22</td>
<td>24</td>
<td>43</td>
<td>3</td>
</tr>
<tr>
<td>NHL - Extranodal</td>
<td>22</td>
<td>9</td>
<td>13</td>
<td>20</td>
<td>2</td>
</tr>
<tr>
<td>MYELOMA</td>
<td>26 (1.4%)</td>
<td>15</td>
<td>11</td>
<td>24</td>
<td>2</td>
</tr>
<tr>
<td>LEUKEMIA</td>
<td>44 (2.3%)</td>
<td>22</td>
<td>22</td>
<td>40</td>
<td>4</td>
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<tr>
<td>Lymphocytic Leukemia</td>
<td>20 (1.0%)</td>
<td>12</td>
<td>8</td>
<td>16</td>
<td>4</td>
</tr>
<tr>
<td>Acute Lymphocytic Leukemia</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Chronic Lymphocytic Leukemia</td>
<td>14</td>
<td>9</td>
<td>5</td>
<td>12</td>
<td>2</td>
</tr>
<tr>
<td>Other Lymphocytic Leukemia</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Myeloid &amp; Monocytic Leukemia</td>
<td>24 (1.3%)</td>
<td>10</td>
<td>14</td>
<td>24</td>
<td>0</td>
</tr>
<tr>
<td>Acute Myeloid Leukemia</td>
<td>18</td>
<td>9</td>
<td>9</td>
<td>18</td>
<td>0</td>
</tr>
<tr>
<td>Acute Monocytic Leukemia</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Chronic Myeloid Leukemia</td>
<td>5</td>
<td>1</td>
<td>4</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>MESOTHELIOMA</td>
<td>4 (0.2%)</td>
<td>4</td>
<td>0</td>
<td>4</td>
<td>0</td>
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<tr>
<td>MISCELLANEOUS</td>
<td>45 (2.3%)</td>
<td>25</td>
<td>20</td>
<td>41</td>
<td>4</td>
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<tr>
<td>Total</td>
<td>1,916</td>
<td>1,057</td>
<td>859</td>
<td>1,693</td>
<td>223</td>
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Demographic Data
All Analytic Patients

Top Five Primary Sites

Prostate 237
Breast 238
Lung 198
Colon 91
Melanoma 51
Bladder 49

Race
Caucasian 1,353
African-American 340

Sex
Male 937
Female 756

Top 5 Overall
Lung 306
Breast 240
Prostate 237
Colon 146
Melanoma 87

Age At Diagnosis
0-29 .28
30-39 .51
40-49 134
50-59 330
60-69 522
70-79 417
80-89 185
90+ .26

Total Mississippi 1,615
Alabama .67
Tennessee .8
Georgia 1
Texas 1
Virginia 1
Total Analytic Cases 1,693
Breast Cancer Analysis

Recent data has shown that axillary dissection with a positive sentinel lymph node may not be necessary in some patients. Breast cancer surgery has evolved from the Halstead radical mastectomy to the more recent use of lumpectomy with sentinel lymph node biopsy for early stage breast cancer. Mastectomy with sentinel lymph node biopsy is still used in some of these situations depending on patient preference and tumor characteristics. In this study we evaluated our experience over five years with mastectomy and sentinel lymph node biopsy in comparison to recent data. This review included approximately 300 cases. In these patients we reviewed the positive sentinel lymph node followed by axillary dissection to evaluate how many patients with positive sentinel lymph nodes had further metastasis in their axillary content. Our patient population consisted of T1 and T2 tumors, looking at number of nodes examined, positive nodes, negative nodes, size of mass, race, sex, stage, treatment, age at diagnosis, margins, ER, PR, HER2 status and survival data. The purpose of this study was to compare our results with recent data indicating that axillary dissection may not be indicated in this population of patients.

After reviewing our data it appears as though patients could be spared axillary dissection in many cases. Due to the multiple biologic markers and indicators that are available now to determine treatment options, we feel that our data supports reconsideration of axillary dissection in every case of a positive sentinel lymph node.

The standard of care for patients with positive sentinel lymph node continues to be axillary dissection. This results in excellent regional control and provides information that can guide treatment decisions for the radiation and medical oncologists. However, our data and recent data from The American Society of Breast Surgeons would support further study and possible implementation of new care standards, which would include no axillary dissection for positive sentinel lymph node, and further study of the possibility of no lymph node evaluation. Because systemic therapy decisions increasingly rely on tumor size, grade, receptor status, and a variety of molecular profiles, there has been less dependence on the number of positive nodes for systemic therapy decision making.

David Gilliland, M.D.
Breast Cancer

Signs & Symptoms
The earliest sign of breast cancer is often an abnormality detected on a mammogram before it can be felt by the woman or a health care professional. However, today with increased awareness of breast self-exams, more women are noticing changes and abnormalities in their breast earlier. Larger tumors may become evident as a painless mass. Less common symptoms include persistent changes to the breast such as thickening, swelling, distortion, tenderness, skin irritation, redness, scaliness or nipple abnormalities, such as ulceration, retraction or spontaneous discharge. Typically, breast pain results from benign conditions and is not an early symptom of breast cancer.

The first noticeable symptom of breast cancer is typically a lump that feels different from the rest of the breast tissue. More than 80 percent of breast cancer cases are discovered when the woman feels a lump. The earliest breast cancers are detected by a mammogram. Lumps found in lymph nodes located in the armpits can also indicate breast cancer.

Indications of breast cancer other than a lump may include thickening different from the other breast tissue, one breast becoming larger or lower, a nipple changing position or shape or becoming inverted, skin puckering or dimpling, a rash on or around a nipple, discharge from nipple(s), constant pain in part of the breast or armpit, and swelling beneath the armpit or around the collarbone. Pain is an unreliable tool in determining the presence or absence of breast cancer, but may be indicative of other breast health issues.

Risk Factors
Aside from being female, age is the most important risk factor for breast cancer. Risk is also increased by a personal or family history of breast cancer and inherited genetic mutations in the breast cancer susceptibility genes BRCA 1 and BRCA 2. Although these mutations account for approximately 5 to 10 percent of all breast cancer cases, they are very rare in the general population (less than 1 percent) and widespread genetic testing is not recommended. Women with a strong family history of breast cancer should be offered counseling to determine if genetic testing is appropriate.

The Importance of Finding Breast Cancer Early
The goal of screening exams for early breast cancer detection is to find cancers before they start to cause symptoms. Screening refers to tests and exams used to find a disease, such as cancer, in people who do not have any symptoms. Early detection means using an approach that lets breast cancer get diagnosed earlier than otherwise might have occurred.

Breast cancers that are found because they are causing symptoms tend to be larger and are more likely to have already spread beyond the breast. In contrast, breast cancers found during screening exams are more likely to be smaller and still confined to the breast. The size of a breast cancer and how far it has spread are some of the most important factors in predicting the prognosis (outlook) of a woman with this disease.

Most doctors feel that early detection tests for breast cancer save thousands of lives each year, and that many more lives could be saved if even more women and their health care providers took advantage of these tests. Following the American Cancer Society’s guidelines for the early detection of breast cancer improves the chances that breast cancer can be diagnosed at an early stage and treated successfully.

Mammogram can detect breast cancer at an early stage, when treatment is more effective and a cure is more likely. Numerous studies have shown that early detection saves lives and increases treatment options.

Outcomes
The prognosis and five-year survival for female breast cancer patients has improved over time. Improved long-term survival can be achieved by earlier detection, more effective modern therapy and healthier lifestyles.

What are Lymph Nodes?
Lymph nodes are small round organs that are part of the body’s lymphatic system. They are found widely throughout the body and are connected to one another by lymph vessels. Groups of lymph nodes are located in the neck, underarms, chest, abdomen, and groin. A clear fluid called lymph flows through lymph vessels and lymph nodes.
Lymph nodes are also important in helping to determine whether cancer cells have developed the ability to spread to other parts of the body. Many types of cancer spread through the lymphatic system, and one of the earliest sites of spread for these cancers is nearby lymph nodes.

**What is a Sentinel Lymph Node?**
A sentinel lymph node is defined as the first lymph node to which cancer cells are most likely to spread from a primary tumor. Sometimes, there can be more than one sentinel lymph node.

**What has Research Shown About the Use of SLNB in Breast Cancer?**
Breast cancer cells are most likely to spread first to lymph nodes located in the axilla, or armpit area, next to the affected breast. However, in breast cancers close to the center of the chest (near the breastbone), cancer cells may spread first to lymph nodes inside the chest (under the breastbone) before they can be detected in the axilla.

The number of lymph nodes in the axilla varies from person to person but usually ranges from 20 to 40. Historically, removal of these lymph nodes (in an operation called axillary lymph node dissection, or ALND) was done for two reasons: to help stage breast cancer and to help prevent a regional recurrence of the disease. (Regional recurrence of breast cancer occurs when breast cancer cells that have migrated to nearby lymph nodes give rise to a new tumor.)

Because removing multiple lymph nodes at the same time has been associated with adverse effects, the possibility that sentinel lymph node biopsy alone might be sufficient for staging breast cancer in women who have no clinical signs of axillary lymph node metastasis, such as swollen or “matted” (clumped or stuck together) nodes, was investigated.

**Staging (Extent of Disease) and Prognostic Factor**
Breast cancer is classified in stages according to the system developed by the American Joint Committee of Cancer (AJCC). This tumor (T), node (N), and metastasis (M) classification is used as the foundation for the overall stage, or extent of disease, of breast cancer.

Staging categories are defined on the basis of how outcomes differ according to the specific characteristics of the tumor, and treatment options vary according to the stage. Once the cancer has been classified with the TNM, an overall stage is assigned. There are five stages of breast cancer, ranging from in-situ, non-invasive, to IV where the cancer has expanded to other areas of the body. Breast cancers are further subdivided to group tumors associated with similar prognoses. Outcomes are more accurately predicted by these stage groupings.

In addition to staging, the AJCC recommends testing for estrogen and progesterone receptors (ER and PR) and human epidermal growth factor receptor-2 (HER2). Some breast cancer cells express hormone receptors, such as ER and PR that are activated by hormones, such as estrogen or progesterone, resulting in tumor growth. It is important to know whether a tumor is positive or negative for either of these hormone receptors because tumors that are ER and/or PR positive may respond to hormonal therapy.

HER2 may also be referred to as HER2/neu. HER2 is a protein found on the surface of some cells in the body. In normal cells, HER2 helps send growth signals from outside the cell to the inside of the cell. These signals tell the cell to grow and divide. In HER2 positive breast cancer, the cancer cells express an abnormally high number of HER2 receptors on their surfaces.

The managing physician considers the stage and other factors in selecting the most appropriate treatment choices, including options for chemotherapy agents, targeted therapies and hormone treatments. Breast cancer treatment options vary among women. In addition to traditional treatments, hormone therapy and targeted therapy have important roles in providing personalized treatment for many women with breast cancer.

**Surgery**
Two types of surgery are used for the primary treatment of breast cancer. A lumpectomy is less invasive than a mastectomy, with removal of only the tumor rather than the entire breast, but is usually combined with breast radiation. A mastectomy may be necessary for larger tumors, although some women with small tumors decide to have a mastectomy. Women who choose to have a mastectomy may want reconstructive surgery, which is done by a plastic surgeon, who rebuilds the breast to look similar to its preoperative appearance.

Axillary lymph nodes under the arm are removed so that a pathologist can examine the nodes for signs of cancer cells. The process of examining the nodes is known as lymph node staging, and the results are a factor in determining the final stage of breast cancer. A procedure known as sentinel lymph node biopsy has helped minimize the number of lymph nodes removed. With this procedure, the number of axillary lymph nodes removed depends on whether cancer cells are detected in the sentinel nodes, or the one or two nodes closest to the breast cancer.

**Radiation Therapy**
Breast radiation therapy is almost always done after lumpectomy to make sure that any remaining cancer cells are destroyed. Studies have shown that women with a small tumor who have a lumpectomy followed by radiation therapy live as long as women who have a mastectomy.
When a mastectomy is done, the need for adjuvant radiation therapy to the upper chest is determined primarily by the number of involved lymph nodes, or a large-size tumor, or whether cancer cells were found in the margin of healthy tissue around the tumor. If breast cancer has metastasized, radiation therapy may be given to the part of the body to which the cancer has spread.

**Chemotherapy**

Many chemotherapy drugs have been approved for the treatment of breast cancer. Chemotherapy for breast cancer is most commonly used as adjuvant treatment; it may also be used as the primary treatment for metastatic breast cancer before surgery for large tumors. Chemotherapy is usually given as a combination of two or three drugs, sometimes given together and sometimes given after one another (sequentially).

**Hormone Therapy**

Adjuvant hormone therapy is given only to women who have tumors that are found to have estrogen and/or progesterone (ER/PR positive). Estrogen drives the growth of these tumors, and anti-estrogen agents are given to lower the amount of estrogen in the body or block its action. Hormone therapy drugs differ with respect to how they work, who they can be used for and what side effects they can cause. The hormone treatment may depend upon the woman’s menopausal status.

**Targeted Therapy**

The targeted therapy agents approved for the treatment of breast cancer has made a substantial impact on the survival and quality of life for breast cancer patients. Trastuzumab (Herceptin) was the first targeted therapy to be developed for any cancer. It is effective only for breast tumors that over-express the HER2 gene. It is usually used in combination with specific chemotherapy drugs. Newer anti-HER2 agents have been approved and are being used with chemotherapy for the treatment of breast cancers, depending upon different factors of breast cancer.

NMMC offers many treatment options for breast cancer…

that’s good to know.
The Cancer Conference is held at noon each Thursday and offers multidisciplinary consultative services for patients, discussion among cancer program team members, and educational conferences for physicians and allied health professionals.

In 2011, 202 cases were discussed at Cancer Conference. Prospective cases were 97 percent. Among the leading sites presented were breast, lung, colon, prostate, bladder, pancreas, head and neck, melanoma and lymphoma. In addition to Cancer Conference, the cancer program offered two guest speakers and the Annual Oncology Conference for cancer-related educational activities to physicians, nurses and other allied health care professionals.

All of these activities related to the use of AJCC stage, other site-specific prognostic indicators and evidence-based national treatment guidelines in planning treatment for cancer patients. North Mississippi Medical Center is accredited by the Mississippi State Medical Association to provide continuing medical education (CME) for physicians. Participation in Cancer Conference, an educational activity, earns one CME credit toward the AMA Physicians Recognition Award.

Physicians may contact the Cancer Registry at (662) 377-3053 for more information, to schedule a patient to be presented at Cancer Conference or to receive a current meeting schedule.

Physicians Presenting at Cancer Conference in 2011:

John Averette, M.D.
Richard Arriola, M.D.
Robert Becker, M.D.
Montgomery Berry, M.D.
Carl Bevering, M.D.
Richard Hunt Bobo, M.D.
John Burk, M.D.
Albert Chang, M.D.
Doug Clark, M.D.
Curt Collins, M.D.
Mark Craig, M.D.
Chris Croot, M.D.
Robert Derveloy, M.D.
Jayant Dey, M.D.
Elbert Duncan, M.D.
Eric Emig, M.D.
Gideon Ewing, M.D.
Paul Farabaugh, M.D.
Stephen Farmer, M.D.
Edward Giaroli, M.D.
David Gilliland, M.D.
Richard Griswold, M.D.
Jimmy Hamilton, M.D.
Newt Harrison, M.D.
K.C. Harbour, M.D.
Ricky Hicks, M.D.
Julian Hill, M.D.
Jeff Howard, M.D.
Roger Huey, M.D.
Jeffrey Houin, M.D.
Mark Huffman, M.D.
Robert Jarrett, M.D.
C. Allen Justice, M.D.
Andrew Kellum, M.D.
Robert McAuley, M.D.
Cohra Mankey, M.D.
Rhodemarie Maron, D.O.
Hughes Milam, M.D.
David Morris, M.D.
Micah Monaghan, M.D.
Charles Montgomery, M.D.
Paul Perry, M.D.
Lyndon Perkins, M.D.
John Phillips, M.D.
Charles Pigott, M.D.
David Reed, D.O.
W Ray Reed, M.D.
James Rish, M.D.
Danny Sanders, M.D.
Susan Shambarger, M.D.
Mark Shepherd, M.D.
Ryan Simmons, M.D.
Richard Seigler, M.D.
Joseph Stinson, M.D.
Jaime Ungo, M.D.
Robert Yarber, M.D.
Kris Whitehead, M.D.
The North Mississippi Medical Center Cancer Center staff is dedicated to helping patients battle cancer—
and that goes beyond administering treatments and medications. The staff is active in the Komen North Mississippi Race for the
Cure and hosts fundraisers each year for the NMNC Cancer Center Patient Assistance Fund, which assists qualified cancer patients
with medications, transportation and other necessities while they are undergoing treatment.

Camp Bluebird
A special camp for adults who have been diagnosed with cancer, Camp Bluebird is held each April at Tombigbee State Park, about
10 minutes outside of Tupelo.

“Camp Bluebird, which is co-sponsored by North Mississippi Medical Center and the AT&T Pioneers, provides campers with a
few days of rest, recreation and the opportunity to share experiences,” said Camp Bluebird director Cheri Nipp, an occupational
therapist at Baldwyn Nursing Facility.

Campers are encouraged to participate in a variety of activities ranging from arts and crafts to educational programs. Each camper
in the medically supervised camp will be assigned a counselor, who is an NMMC staff member or AT&T Pioneer. Counselors
complete a special training session prior to their participation.

“Camp Bluebird has quite a loyal following. Many of our campers and counselors come back year after year because the experience
helped them at a time in their lives when they needed it, and they also enjoy spending time with the many special friends that they
have made,” Nipp said.

The cost of the camp is $40 per person. Scholarships are available to those who need financial assistance. All campers sleep on bunk beds in
dormitory facilities and bring their own toiletry items, linens, comfortable clothing and walking shoes. The registration fee includes meals, a Camp Bluebird T-shirt and any materials needed for special programs or activities.

Midnite Pottery Butterflies
Midnite Pottery and the NMMC Cancer Center have partnered to raise money for local cancer patients through the sale of a series of
original butterfly art. The fifth in the series is currently on sale, and the sixth will debut in January 2013.

Local artist Jennifer Hankins-Shelton created the pottery butterfly to be sold exclusively by the NMMC Cancer Center. Each butterfly
sells for $20 and benefits the NMMC Cancer Center Patient Assistance Fund, which is administered by the Health Care
Foundation of North Mississippi. Hankins-Shelton has also created a large pottery platter featuring the butterfly motif. The limited-
edition platter sells for $60 and also benefits the NMMC Cancer Center Patient Assistance Fund.

“Each of us knows someone touched by cancer,” Hankins-Shelton said. “This is a great project to help people in need. You never
know when that person could be you.”

Each of the butterflies is displayed at the NMMC Cancer Center.

“We are thrilled that Midnite Pottery has agreed to create a new limited edition piece each year to benefit our patient assistance
fund,” said NMMC Cancer Center Director Paula Turner. “This fund assists cancer patients with anti-nausea and pain medicine,
transportation to and from cancer treatment, and nutritional supplements. Once a patient’s application is approved, he or she
is added to the list of those qualified to receive assistance.”

The fund assists an average of 115 patients each month. Assistance provided to each patient ranges from $10-$2,000, depending on
individual needs. Cancer Center Patient Assistance Fund monies are raised through an annual fundraiser as well as donations given
by family members in memory or honor of a cancer patient. NMMC employees also donate approximately $7,000 each month
through payroll deduction. Additional funds are received from grants through United Way and the north Mississippi affiliate of
Susan G. Komen for the Cure.

For more information about the butterfly pottery pieces, call Cindy Edwards, NMMC Cancer Center social worker, at (662) 377-4049.

Take a Swing at Cancer Benefit Golf Tournament
Each year, The Health Care Foundation of North Mississippi spon-
sors the annual Take a Swing at Cancer Benefit Golf Tournament.

The 17th annual tournament will be held Monday, May 20, 2013
at Old Waverly in West Point. Proceeds benefit the NMMC Cancer Center Patient Assistance Fund, which provides about $220,000
annually for needy patients and their families who qualify for assistance.

The golf tournament is organized by community volunteers from
across the region, as well as representatives from the Health Care
Foundation and the NMMC Cancer Center.

The cost is $250 per player for the four-person scramble. There
will be two flights offered – one morning and one afternoon. Golfers who are cancer survivors will receive special recognition.

More information regarding registration and start time will be
available closer to the date.

The entry fee will include 18 holes of golf, cart fee, lunch,
registration gift, door prize entry and the evening social. Prizes
will be awarded for first and second place finishers as well as
for longest drive and closest to the pin. Sponsorship opportunities
are available for companies interested in helping this cause.

For more information on the Take a Swing at Cancer Benefit
Golf Tournament, call (662) 377-2376 or 1-800-THE DESK
(1-800-843-3375), or log on to www.nmhs.net/hcf.php.
Cancer Support Groups

NMCCs Cancer Center offers the following support groups for cancer patients and their families. These groups allow cancer patients the opportunity to share common experiences, problems and solutions. They also provide an avenue for patients to talk confidentially with others who are coping with and surviving cancer.

Man to Man. Helps men diagnosed with prostate cancer and their families find answers to common concerns. The group meets at 6 p.m. the first Tuesday of each month, except July, in the NMMC East Tower Education Center, 830 S. Gloster St.

Survivor 101. Open to newly diagnosed cancer patients and caregivers. The six-week program meets at 2 p.m. the fourth Thursday of each month at the NMMC Cancer Center, 990 S. Madison St.

Gray Matters. The Gray Matters Support Group is open to anyone diagnosed with a brain tumor and their caregivers. The group meets the last Tuesday of each month at the NMMC Cancer Center.

For more information, call 1-800-THE DESK (1-800-843-3375).

Support Services and Community Outreach Programs

Barbershop Talk. A collaborative community program between the NMMC Cancer Center and area barbers that targets the African-American male population and provides educational information on early screenings for prostate and colon cancers. For more information, call (662) 377-4077.

Guided Imagery. A relaxation session that can help combat some side effects associated with a cancer diagnosis and treatment by focusing on healthful changes in the body and mind. For more information, call (662) 377-4049.

Home Health. NMMC Home Health offers patients a range of services, including skilled and specialty nursing and rehabilitation. Technology has developed to the point that almost any service available in the hospital can be delivered in the home setting with some modification. For more information, call (662) 377-2499.

Hospice. Hospice care is a specialized program to help manage pain and other symptoms associated with terminal illness. Chaplains, dietitians, social workers, nurses, therapists and volunteers are available to meet with patients and speak frankly about cancer and other life-limiting illness, share ideas and offer support. Services are available regardless of ability to pay. For more information, call 1-800-852-4910.

Lymphedema. A number of breast cancer patients suffer from painful swelling in their arms, a condition called lymphedema. NMCCs Outpatient Rehabilitation Center offers manual lymphatic treatment to people with chronic lymphedema. Lymphedema is a chronic swelling that can affect any part of the body. It is caused when the lymph nodes are unable to remove and process protein-rich fluids in the normal way. Breast cancer patients who have undergone a lumpectomy or a mastectomy lose a number of their lymph nodes and are more prone to develop lymphedema in their arms. The manual lymphatic treatment combines light massage, sequential compression pumps and compression bandaging to remove the fluid and help return the arm to normal. For more information about lymphedema and manual lymphatic treatment, call Lydia Thomas, occupational therapist and lymphedema specialist at the NMMC Outpatient Rehabilitation Center, at 1-800-843-3375.

Massage Therapy. To further enhance the healing process, the Cancer Center offers free mini-massages for cancer patients.

Mobile Mammography. The mobile mammography unit travels to area communities and offers easy access to screening mammograms at hospitals, physicians’ offices, businesses and industries throughout north Mississippi and northwest Alabama. This special community service encourages preventive breast health and early detection of breast cancer. When breast cancer is caught early, survival rate increases to 90 percent. Call (662) 377-7984 or (662) 377-4910 for an appointment or more information.

Nutrition. When fighting cancer, good nutrition becomes even more important. The NMMC Cancer Center has a registered dietitian who is a board-certified specialist in oncology nutrition. She works with physicians, nurses, patients and families to develop goals for patients based on a comprehensive nutritional assessment.

Palliative Care Program. Palliative care uses an interdisciplinary approach to provide the comprehensive care and management of the physical, psychological, emotional and spiritual needs of patients of all ages, and their families with chronic debilitating or life-limiting illnesses. For more information, call (662) 377-3810.

Pastoral Care. An NMMC Pastoral Care chaplain visits the Cancer Center to assist patients with spiritual needs. For more information, call (662) 377-3439.

Radiation Oncology Clinician. The radiation oncology clinician meets with the NMMC Cancer Center treatment team to discuss patients’ treatment plans, and helps educate patients and family members.

Resource Center. The NMMC Cancer Center offers access to a cancer resource center, where patients and their family members can learn about cancer prevention, detection and treatment. The center houses a collection of information, including magazines, medical journals and reference books, self-help publications and periodicals on health and medicine as well as video and audio tapes. New information is added regularly. A computer and Internet access is available for patients and family members to do research on cancer, and the Cancer Center is a Wi-Fi hotspot.
At the NMMC Cancer Center, we know how difficult it is to hear a diagnosis of cancer, no matter what type. There's a lot of information out there, and we want to provide our patients with the best information available. Our “Cancer Has a Color” page on our website provides links to find more information on many different types of cancer. The topics are organized by month and cancer ribbon for easy use. If the one you are looking for isn’t listed, try www.cancer.org or www.cancer.gov. Also, please browse the rest of our website at www.nmhs.net/cancer_center for more information on the treatments and technology provided here.

For additional information, feel free to visit our resource library, located in the Cancer Center lobby.

Transportation Assistance. For those who qualify, transportation is available to help patients get to their treatments. For more information, call (662) 377-4077.

Social Services. An oncology certified social worker helps patients and families handle the changes associated with a cancer diagnosis. Issues can include work-related stress, marriage and family disruptions, depression, anxiety, phobias, child and adolescent problems, well being and spiritual concerns. For more information, call (662) 377-4077.

Wellness Program. Available at NMMC Wellness Centers in Baldwyn, Iuka, Pontotoc, Tupelo and West Point, the Cancer Wellness Program is for people receiving treatment for all types and stages of cancer. The program combines specifically prescribed exercise with education and support to guide a person through recovery. For more information, call (662) 377-4141.