CALL TO ACTION

- Healthcare That Works
- Healthcare That Is Safe
- Healthcare That Leaves No One Behind for Life

CORE VALUES

We are called to:
- Service of the Poor
- Reverence
- Integrity
- Wisdom
- Creativity
- Dedication

ENABLING STRENGTHS

- Inspired People
- Trusted Partnerships
- Empowering Knowledge
- Vital Presence
- Stewardship
St. Vincent’s Bruno Cancer Center experienced another year of growth in patient care and implementation of new cancer therapies. We diagnosed and managed 1,606 cancers. As expected, these were predominantly prostate, breast, colorectal, lung, lymphomas, oral cavity, and a variety of hematologic conditions. Most of the patients were primarily treated with surgery, but more than half received radiation therapy, chemotherapy, or antibody therapy as their primary or adjuvant treatments in the Bruno Cancer Center.

The Radiation Oncology Center continued to expand state-of-the-art radiation therapy procedures. Introduced in 2004, the High Dose Rate unit allows breast cancer radiation to be delivered in five days rather than the seven weeks required for traditional external beam radiation therapy. The IMRT (Intensity Modulated Radiation Therapy) program, enhanced by the Acculoc component, allows for sub millimeter localization of the radiation therapy target thus avoiding toxicity to adjacent tissues. Finally, a TomoTherapy unit was implemented in November 2006 for treatment of prostate, head and neck, and brain cancers. TomoTherapy is a new revolutionary way to treat cancer with radiation therapy. The system allows the physician to check the location of the patient’s tumor before each treatment and then deliver precise radiation therapy based on a carefully customized plan. The TomoTherapy unit combines precise 3-D imaging from computerized tomography with a highly targeted radiation beams. This cutting-edge technology, which is currently only available in two locations in the Birmingham area, allows the Bruno Cancer Center to offer our patients optimum treatment for a variety of cancers. Another radiation oncology program, BEXXAR radioimmunotherapy, is a complex modality that combines monoclonal antibody therapy with radiation. Tositumomab, combined with radioactive iodine (I 131), is used for the treatment of patients with CD-20 antigen-expressing relapsed or refractory, low-grade follicular or transformed non-Hodgkin’s lymphoma, including patients who have failed prior monoclonal antibody therapy. The recent clinical trials have established that this treatment is effective.
and offers patients a relatively short and non-toxic treatment program that is capable of suppressing certain lymphomas for many years without the need to maintain the patient on continuous treatment as is the case with most other chronic therapies for low-grade lymphoma. The Bruno Cancer Center, the only community hospital with BEXXAR therapy in the Birmingham area, is serving a vital role in offering patients a unique treatment option.

The Medical Oncology Center Census continued to grow and new treatment programs and key personnel were added. There were more than 12,500 patient visits and 6,000 treatments (primarily chemotherapy) administered in the Bruno Cancer Center facility. We are also quite pleased to announce the addition of Dr. Cara Bondly, a board certified medical oncologist and hematologist, who joined us from Mayo Clinic where she completed an internship in internal medicine, served as medical chief resident, and completed fellowship programs in hematology and oncology. With the addition of Dr. Bondly, we now have four full-time medical oncologists/hematologists in the Bruno Cancer and also provide satellite centers for clinics in Sylacauga and Talladega.

One of the most important components of the medical oncology program, clinical trials, continues to provide patients with a variety of newer treatment options. Patients participated in 10 different trials using state-of-the-art drugs for the treatment of breast, colon, and lung cancers. This program continues to give our patients access to the better treatment innovations that continue to become available. Other vital services that continue to enhance our program include The Breast Cancer Support Group, The General Cancer Support Group, Camp Bluebird, and cancer screenings.

Kathy Jackson, Cancer Center Program Director, organized and executed two very successful cancer screening clinics. The skin screening had 130 participants and 13 possible skin cancers were detected. The participating physicians were Dr. Robert Pritchard, Dr. Matthew Abele, Dr. William A. Cook and Dr. Julian Thomas. The prostate screening clinic had 76 participants which 14 had abnormal findings. The participating physicians were Dr. Leon Hamrick, Dr. Nicole Massie, Dr. Jason Moellinger, and Dr. A. Scott Tully.

We continue to operate all of the various cancer center program components that underpin our Commission on Cancer rating as a Community Hospital Comprehensive Cancer Center. This designation is awarded to comprehensive programs that meet the highest standards of practice in all components essential to provide high quality comprehensive cancer care. Everyone involved in these complex treatments, especially the patients, appreciate how fortunate we are to have our diagnostic modalities and cancer treatments conveniently housed in the same building complex. We are especially grateful to our Cancer Registry Specialist, Sheila Grant, for managing the cancer registry and continuously mapping our program activities. We would like to thank the St. Vincent’s Foundation for graciously continuing to provide funds for patients’ needs particularly the patient drug assistance program.
CANCER COMMITTEE MEMBERS 2006-2007

James Cantrell, MD, Cancer Committee Chairman

Matthew Abele, MD
J. Max Austin, MD
Mack Barnes, MD
Stephen Beck, MD
Sheldon Black, MD
Tom Brown, MD
Gray Buck, III, MD
Charles Bugg, Jr.
Philip Fischer, II, MD
John Glover, MD
Jon David Holmes, MD
Caroline McCall, MD
Jason Moellinger, MD
Robert Pritchett, MD
Jill Rutherford, MD
Sally Salter, MD
Susan Salter, MD
Debbie Cox, RN
Edsel Davis
Frank Adkins
Sheila Grant, RHIA, CTR
Rosalind Patterson, RHIT, CTR
Kathy Jackson, RTT
Nancy Lewis
Bill Paullin
Sarah Ann Higgins, MSW
Dianne Cherry, RN
Trudie Hudson, RN
Christen Price
Kimberly Rider

DERM
GYN/ONC
GYN/ONC
HEM/ONC
OTOLARYN
INMED
GEN SURG
URO
GEN SURG
RAD ONC
ORAL/MAX
PATHOLOGY
URO
DERM
DIAGNOSTIC RADIOLOGY
GEN SURG
RAD ONC
HOSPICE
PASTORAL CARE
QUALITY REVIEW
CANCER REGISTRY
CANCER REGISTRY
CANCER CENTER
ADMINISTRATION
DIRECTOR CLIN SVCS
SOCIAL SVCS
ONCO UNIT
PALLIATIVE THERAPY
ACS
GHS
St. Vincent’s Cancer Program is accredited by the Commission on Cancer (CoC) as a Community Hospital Comprehensive Cancer Program (COMP). Five key elements make it a successful program.

**Cancer Committee** leads the program through setting annual goals, monitoring activity, evaluating patient outcomes, and improving patient care. It also hosts community outreach screenings such as Prostate Cancer, Head/Neck Cancer, and Skin Cancer.

**Clinical Services** provide state-of-the-art pretreatment evaluation, staging, treatment, and clinical follow-up for cancer patients seen at the facility for primary, secondary, tertiary, or quaternary care.

**Cancer Conferences** provide a forum for patient consultation through discussion of up-to-date techniques and treatment options for cancer patients as well as education for medical staff and ancillary personnel.

**The registry continues to exceed the standard survival rate with 91 percent. This is done by collecting follow-up data on 21,000 in their database each year.**

**Quality Improvement Program** is the mechanism for evaluating and improving patient outcomes. Each year, the Cancer Committee discusses clinical areas or cancer sites to be reviewed throughout the year. As a COMP Cancer Program, each year, it is responsible for collecting data for two Quality Studies and two Quality Improvements.

**Cancer Registry** and its Database is the basis for monitoring the quality of care. The Cancer Registry staff consists of 2.0 FTE in which both are certified tumor registrars. In 2006, the Registry collected 1,693 new cases of which 1,600 were diagnosed and treated at St. Vincent’s Hospital. The top five treated sites are Prostate, Breast, Lung, Colon and Oral Cavity. The registry continues to exceed the standard survival rate with 91 percent. This is done by collecting follow-up data on 21,000 in their database each year. In efforts to maintain quality data, the cancer registry data is submitted and reviewed by the Alabama Statewide Cancer Registry on a monthly basis and annually to the National Cancer Database’s “Call for Data.”
ST. VINCENT’S CANCER INCIDENCE ANALYSIS

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Comparing St. Vincent’s cancer incidence rate to that of the State and National levels, St. Vincent’s diagnosis and treatment of prostate cancer hold a higher incidence percentage rate than estimated.

* State data for oral cavity was not available.

TOP TEN SITE AND SEX

**MALE**
- Prostate
- Lung
- Oral Cavity
- Colon & Rectum
- Hematopoietic
- Bladder
- Kidney
- Lymphoma
- Pancreas

**FEMALE**
- Breast
- Lung
- Colon & Rectum
- Oral Cavity
- Corpus Uteri
- Hematopoietic
- Ovary
- Lymphoma
- Bladder

REFERENCES:

Cancer Facts & Figures 2006-American Cancer Society


New Developments in the Treatment of Advanced Renal Cell Carcinoma
By Cara Bondly, MD

INTRODUCTION
In 2007, it is estimated that in the U.S., 51,190 people will be diagnosed with and 12,890 deaths will be attributed to cancers of the kidney and renal pelvis. The incidence of these cancers has increased by 2 percent per year over the last 2 decades. Renal cell carcinoma is the third leading cause of death among genitourinary malignancies and is the 12th leading cause of cancer death in the United States. There are a number of different types of carcinoma that occur in the kidney including clear cell (75 percent), type 1 and type 2 papillary (15 percent), chromophobe (5 percent), and oncocytoma (5 percent). Cigarette smoking represents a common risk factor for development of renal cell carcinoma. It has been estimated that 30 percent of renal carcinomas in men and 24 percent of the disease in women are directly related to smoking. Thirty percent of patients with renal cell carcinoma have metastatic disease, 25 percent have locally advanced disease, and 45 percent have localized disease. The most common site of metastases is the lung, occurring in 75 percent of patients with stage IV disease. Lack of response to traditional chemotherapy and radiation therapy has resulted in a 5-year survival rate of 5 to 10 percent of those patients with stage IV disease. Prior to the identification of vascular endothelial growth factor (VEGF) as a potential therapeutic target, the mainstay of therapy for advanced renal cell carcinoma consisted of immunotherapy with agents such as interferon and interleukin-2. The utility of immunotherapy, however, is limited by poor response rates.
ROLE OF CYTOREDUCTIVE NEPHRECTOMY IN ADVANCED DISEASE

Palliative nephrectomy is commonly performed in patients with metastatic renal cell carcinoma to relieve tumor associated symptoms such as pain, hemorrhage, hypercalcemia, or erythrocytosis. There are isolated reports of spontaneous regression of metastatic renal cell carcinoma after resection of the primary tumor. This occurred in only 0.8 percent of patients in nine large series undergoing nephrectomy. While nephrectomy alone has never been associated with improved survival in patients with metastatic renal cell carcinoma, it has been associated with improved survival in patients who go on to receive immunotherapy following debulking nephrectomy.

Two large studies documented an improved overall survival in patients with metastatic renal cell carcinoma assigned to receive surgery followed by interferon compared to patients who received interferon alone. Although the biologic mechanism for this improvement in survival is unclear, cytoreductive nephrectomy prior to immunotherapy has become routine clinical practice. The benefit of nephrectomy prior to antiangiogenic therapy is less clear but nephrectomy is commonly performed prior to anti-VEGF treatment in patients with advanced renal cell carcinoma.

VEGF IN RENAL CELL CARCINOMA

VEGF is a dimeric glycoprotein and a member of the platelet-derived growth factor (PDGF) superfamily of growth factors that includes VEGF-B, VEGF-C, VEGF-D, VEGF-E and placenta growth factor. VEGF is crucial for both normal and tumor associated angiogenesis. VEGF promotes angiogenesis through induction of endothelial cell division and migration, protection of endothelial cells from apoptosis, and reversal of endothelial cell senescence. Various transmembrane tyrosine kinase inhibitors mediate the effect of VEGF. These include VEGFR-1 and
VEGFR-2, selectively expressed on vascular endothelial cells; VEGFR-3, expressed on lymphatic and vascular endothelium; and the neurolepin receptor, expressed on vascular endothelium and neurons.

Overexpression of VEGF is seen in the majority of clear cell renal carcinomas. This is demonstrated by the level of mRNA transcripts and VEGF protein in these tumors. VEGF expression in these tumors results from the inactivation of the von Hippel-Lindau tumor suppressor gene. The biology of VEGF overexpression in renal cell carcinoma has led to the development of novel therapeutic strategies to inhibit this proangiogenic pathway required for tumor growth and proliferation.

**ANTI VEGF ANTIBODY**

Bevacizumab (Avastin) is a recombinant human monoclonal antibody against VEGF. This antibody binds and neutralizes all biologically active isoforms of VEGF. In a randomized phase II trial of bevacizumab versus placebo in pretreated patients with metastatic renal cell carcinoma, bevacizumab resulted in an overall response rate of 10 percent. While this is a low overall response rate there is hope that this medication may delay time to progression without producing dramatic response rates. Improved overall response rates have been seen with the combination of bevacizumab and erlotinib, an epidermal growth factor inhibitor. The use of bevacizumab in combination with immunotherapies such as interferon is currently being studied.

**SMALL MOLECULE VEGF RECEPTOR INHIBITORS**

Small molecule tyrosine kinase inhibitors provide an alternative approach to VEGF inhibition. These agents inhibit the VEGF receptor as well as other tyrosine kinase receptors including the platelet derived growth factor receptor expressed in pericytes that provide structural support for endothelial cells. Two orally bioavailable small molecule tyrosine kinase inhibitors are currently being used in the treatment of advanced renal cell carcinoma: sunitinib (Sutent) and sorafenib (Nexavar).

**Sunitinib**

Sunitinib is a small molecule tyrosine kinase inhibitor of VEGFR-2 and PDGFR-B that was approved by the Food and Drug Administration (FDA) for treatment of renal cell carcinoma in January 2006. In clinical trials the majority of patients who have received sunitinib had clear cell histology and 93 percent had undergone cytoreductive nephrectomy prior to treatment. Sunitinib is given once daily via oral route four out of every six weeks.

In the initial trials of sunitinib in patients previously treated with immunotherapy the overall response rate was approximately 40 percent and stable disease lasting more than three months was seen in 27 percent. Median time to progression in these studies was approximately eight months with overall survival of 16 months. The activity of sunitinib in previously untreated patients with metastatic renal cell carcinoma has also been evaluated. A large phase III study of patients with clear cell histology compared the efficacy of sunitinib to interferon. The overall response rate for sunitinib was 31 percent compared to 6 percent for interferon. The median progression free survival was 11 months versus five months favoring sunitinib. Sunitinib has also demonstrated activity in patients’ refractory to bevacizumab. Toxicities of sunitinib include fatigue, diarrhea, stomatitis, dermatitis, and hypertension. Neutropenia, elevation of lipase, and anemia are the most common laboratory abnormalities seen in patients treated with sunitinib. Rarely, decreased left ventricular function has been observed with sunitinib use.

**Sorafenib**

Sorafenib is a small molecule tyrosine kinase inhibitor with antitumorigenic activity against Ras-dependent pathways. Sorafenib is also a direct inhibitor of VEGFR-2, VEGFR-3, and PDGFR-B. This agent was approved by the FDA in December 2005 for treatment of advanced renal cell carcinoma.

A phase II randomized discontinuation study of sorafenib in refractory solid tumor patients included 202 patients with metastatic renal cell carcinoma. At 24 weeks, sorafenib-treated patients have statistically significantly improved progression free survival compared to patients receiving placebo, 50 percent versus 18 percent. A subsequent phase III study of immunotherapy refractory patients with metastatic renal cell carcinoma compared treatment with sorafenib to placebo. While objective responses were uncommon in the sorafenib-treated patients, 2 percent, the median progression free survival, was clearly superior in sorafenib patients compared to patients receiving placebo, 24 weeks versus 12 weeks.

The use of sorafenib in combination with immunotherapy in previously untreated patients with advanced renal cell carcinoma has also been investigated. Two trials
combining sorafenib with interferon showed overall response rates of 20 to 40 percent with a significant additional population of patients achieving stable disease. Sorafenib is generally well tolerated with common adverse effects including hypertension, gastrointestinal distress, and dermatologic change.

ST. VINCENT’S BIRMINGHAM DATA
Since 2002, 150 cases of renal cell carcinoma have been seen at St. Vincent’s Birmingham. Over 50 percent presented with stage I disease with only a minority presenting with metastatic disease. From 2002 until 2006, the frequency of renal cell carcinoma has been stable with 25 to 30 patients presenting each year. Approximately half of the patients underwent total nephrectomy with the other half having partial or subtotal nephrectomy. Figure 1, on page 5, depicts relative survival based on stage at presentation and figure 2, on page 6, depicts relative survival based on age at presentation. The use of small molecule tyrosine kinase inhibitors such as sorafenib or sunitinib has become more common in the recent past as the data regarding the benefits of these agents has been reported. These agents have been generally well tolerated by patients and offer the convenience of oral administration.

Figures 3 and 4 display the response seen in one patient treated with sunitinib with figure 3 being before treatment and figure 4 being after 3 months of treatment.

CONCLUSION
Better understanding of the molecular pathogenesis of renal cell carcinoma has resulted in the identification of VEGF-directed treatments with clear anti-tumor activity. As employed at St. Vincent’s Birmingham, a multidisciplinary approach is required when treating this complex group of patients. The use of anti-VEGF therapy has revolutionized the treatment of patients with advanced renal cell carcinoma but there is clear room for improvement in creating more complete and durable responses.

REFERENCES:
Cancer Principles and Practice of Oncology, 7th edition. Lippincott Williams & Wilkins, Philadelphia, PA 2005
Relative Survival Rate By Stage
Renal Cell Carcinoma 1996-2002
(Figure 1)

Relative Survival Rate By Age Diagnosis
Renal Cell Carcinoma 1996-2002
(Figure 2)
Top five counties served were Jefferson, Shelby, Walker, Cullman, and Talladega. Of the 1693 cases treated, 88 were patients who live outside of the state of Alabama.
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Care You Can Believe In

“A Sister’s Journey”

Dixie Mitchell and her sister, Tina, have always been close to their cousins Pam and Ralena. They are all like sisters – often sharing a good laugh and a cry.

A little over a decade ago, three of the four “sisters” would come to share something else, breast cancer. Dixie and both of her cousins were diagnosed with the disease. As the cousins began their fight in Florida, Dixie found herself at the St. Vincent’s Birmingham Bruno Cancer Center.

“It was a life-changing experience,” said the petite blonde wearing dangling pink ribbon earrings and the matching necklace. The staff at the Cancer Center gently led her through the scary journey.

“I had the best care and the most compassionate staff,” she said. “They are all so genuine. It was a blessing.”

In honor of Dixie’s and her cousins’ cancer fight, the cancer-free sister, Tina, quilted a blanket with the pink cancer ribbon emblazoned on the front. Tina asked Dixie to donate it for auction at the 2007 Susan G. Komen Awards luncheon in Birmingham.

“I couldn’t bear having someone getting it and putting it in their closet,” Dixie said, so she bid the $325 it was worth and gave the quilt to the Cancer Center. It is on display at the main entrance. As patients walk and are wheeled in for treatment, many of them gaze up at the quilt and smile. “It’s beautiful,” one of them remarked. “My purpose in donating it to St. Vincent’s is in hopes that someone who sees it will gain comfort,” Dixie said. She wants passersby to get what she got from the Cancer Center, she said, faith and hope.