CANCER SERVICES

Annual Report 2025

Statistical Data 2024



FORREST GENERAL HOSPITAL
Cancer Center
Forrest Health®

Message from Cancer Committee Chairman

The Forrest General Hospital Cancer Committee is proud to present our 2025 Cancer Program Annual Report. The report consists of the dedicated efforts made by the Cancer Committee, Cancer Registry, Administration, Physicians, and Cancer Team Members.

In 2025, the Cancer Care Team has continued to improve our cancer services at Forrest General Hospital. Our team maintains its focus on serving our patients, their families, and our community with the best care. Through the American College of Surgeons Commission on Cancer (CoC), we have a vision of the highest standard of patient care in every area of our patients' journeys.

In 2025, our team brought a thoughtful and insightful perspective as we worked to improve patient care, implement updated standards, introduce new phases, and maintain the foundational requirements of the Commission on Cancer Standards.

We supported our patients through several meaningful events, including the 4th Annual Fuel to Fight Cancer 5K, the Queen Cake Pink Ribbon Fund, and initiatives with the FGH Foundation. We also promoted cancer awareness in our community by encouraging colorectal cancer screenings and breast mammograms.

In partnership with the Mississippi Department of Health, Southeast Mississippi Rural Health Initiative (SEMRHI), and the American Cancer Society, we hosted an in-person Head and Neck (Oral) Cancer Education and Screening event in our meeting rooms.

Addressing barriers such as transportation, food access, and other essential resources became a primary focus for our patients. Additionally, our therapy dog continues to bring warmth and comfort to both patients and our care team.

Our team continues to learn from the CoC Cancer Forums, CoC Stands Webinars, and both hybrid and in-person trainings and meetings including cancer conferences, cancer committee, and our subgroup meetings on various standards. As we continue to learn, we constantly make progress with genetic counseling, survivorship, sexual/fertility counseling, breaking down financial support barriers, and offering psychological resources for each patient. Additionally, the Survivorship Team is currently developing survivorship patient visits for post treatment follow-up planning and care.

The Cancer Center continues to remain accredited through the American College of Surgeons Commission on Cancer, the first cancer program in the state to do so.

With ongoing dedication to those we serve,

John S. Hrom, MD
Cancer Committee Chairman

2025 Cancer Committee

Surgery
Marcos Rosado, MD
Cancer Committee Liaison

Medical Oncology
John S. Hrom, MD
Committee Chair

Pathology
Leigh Anne Strong, MD

Gastroenterology
Kevin Barker, MD

Radiation Oncology
Joseph Salloum, MD
Sophy Mangana, MD

Palliative Care Services
Rick Boyte, MD

Radiology
C. Alexander Hudson, MD

Pulmonology
Wesley Aldred, MD

Non-Medical Staff Members
Chaplain Jon Kittrell, Pastoral Care

Paula Hand
Medical Social Services

Lesley Wood
Marketing/Communications

Robin Reeves
Patient Navigator

Anne Kealhofer
Quality Management

Juliet Hinton Kolin, ODS-C, MBA
Cancer Registry

Felicia Megehee, ODS-C
Cancer Registry

Gloria Simmons, RN
Clinical Research Nurse

Shannon Vega, RN, MBA
Service Line Administrator

PCM
Home Care/Hospice

Ramata Sakhanokh
Clinical Pharmacist

Daphne Nix, BS, ODS-C
Cancer Registry

Veronica Martin
Dietician Cancer Center

Amy Ellis
American Cancer Society

Michelle Williams, RN
Clinical Specialist Oncology

Donna Wheeless
Director of Rehabilitation
Services & Wellness Services

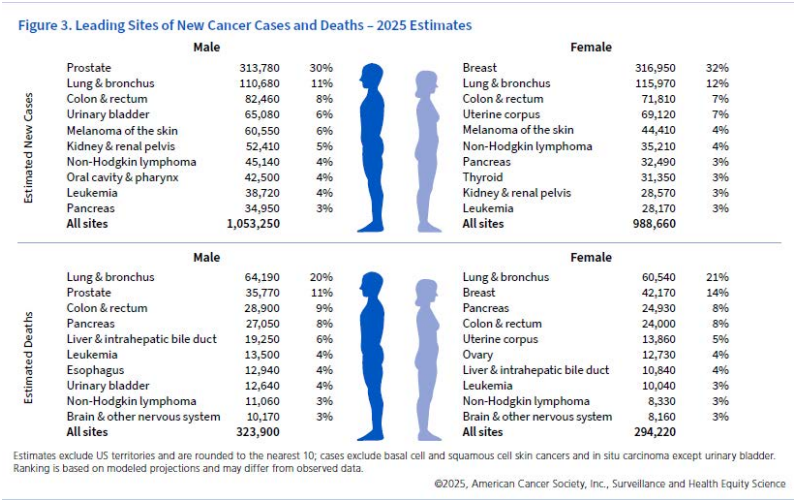
Jessica Cooley, ODS-C
Cancer Registry

Frank Hux, MD
Chair, Surgeons, Neurosurgery

Garner Bell, MD
Medical Oncology

Kecia Jones-Harris
Radiation Oncology Manager

Liaison and Resource Members for Cancer Program and Services: Michelle Bellington, Bradley Myers, NP, Whitney Wilkinson, NP, Kristen Sentell, NP, Michele Leslie, Hillary Brooke Sims, MD, Andrew Dunn, MD, Shawn LeDoux, MD, Kevin Kinloch, MD, R. Jackson Ross, MD, Marcos Rosado, MD, Rachel Rosado, Laurie Douglas, Kayla Giacona, RN and Gabrielle Andrews.



Cancer Services



The Oncology Service Line provides a continuum of compassionate, high quality, state-of-the-art services for the detection, prevention and treatment of cancer through a well-trained multidisciplinary team that maintains a personalized focus on the needs of the individual. Forrest General's Cancer Center, which ranks among the largest and most sophisticated regional cancer centers in south Mississippi, offers a place where patients can receive technologically-advanced care in an environment of beauty, caring and compassion.

Forrest General's Oncology Services strives to improve the quality and length of life for the cancer patient and to further research on the cause, prevention, treatment, and cure of cancer. We value compassion, respect, integrity, creativity, teamwork, commitment, and excellence in all that we do. The FGH Cancer Program is accredited through the American College of Surgeons Commission on Cancer and is the one of the first programs started in the state of Mississippi. For more information about Forrest General's Oncology Services, call Forrest Health Information at 1-800-844-4445.

Services

Surgery
Pastoral Services
Exercise and Wellness Services
Interventional Radiology
Pain Management
Wound Care Services
Research and Standards – CoC
Fitness and Exercise

Home Care
Mental Health Services
Plastic Surgery
Hematology/Oncology
Medical Social Services
Hostess Care & Assistance
Spiritual Care
Coping Mechanisms/Sessions

Hospice
Chemotherapy
Radiation Oncology
FH Infusion Center
Navigation
Genetic Counseling
Healing Garden
Music Therapy

Nutritional Care
Imaging
Radiology
Palliative Care Services - IP
Clinical Trials
Survivorship Care – Follow-up Treatment Plan
Asbury House-IP Hospice

Survivorship

Bereavement Support Group

Support Group

Brave, Brilliant & Resilient

FGH Foundation

FGH Foundation
www.fghfoundation.com
TreeofLife, InPatient Hospice Campaign, Healing Garden, Navigator, Clinical Trials & Research



Clinical Trials

At the Cancer Center, there are multiple ongoing clinical trials available to patients that include the newest immunotherapies, targeted therapies, as well as newer chemotherapies. Many of these trials are not available elsewhere in the state of Mississippi.
This allows patients to receive the best treatment without the need to travel outside the Pine Belt, and our program has a full-time dedicated research staff person to assist with patient care during the clinical trial.
To find out if you are a candidate or need more information, contact the Clinical Trials Coordinator, Gloria Simmons at 601-288-1700.

Forrest General Cancer Center

Forrest General Cancer Center 4th Annual
Fuel to Fight Cancer 5K and 2-mile Walk
October 18, 2025, 7:30 AM






Fuel to Fight Cancer 5K and Walk Raises Funds to Support Forrest General Cancer Center Patients. The Fuel to Fight Cancer Fund can continue providing transportation assistance to patients traveling to and from the Forrest General Cancer Center for treatment. Your steps today make a lasting difference tomorrow!






Grant from American Cancer Society for Patient Transportation

To alleviate the financial burden of cancer treatment, the American Cancer Society (ACS) recently awarded a $20,000 transportation grant to the Forrest General Cancer Center. The grant is one of 380 transportation grants totaling $6.2 million awarded to health systems nationwide. The funding will allow health systems to provide eligible patients an estimated 577,350 rides to treatment.

“We are so grateful to be the recipients of the ACS grant,” said Kecia Jones-Harris, Cancer Center director. “This will allow us to continue to support the needs of transportation for patients in our 19-county service area.”

Why Transportation Funding is Needed
Lack of transportation to treatment prevents many people living with cancer from getting high-quality care which worsens cancer outcomes.

- In a study presented at the 2022 American Society of Clinical Oncology (ASCO) Quality Care Symposium, American Cancer Society researchers found that 2.8% of cancer survivors reported delays in care due to transportation barriers. Cancer survivors who delayed care due to lack of transportation were more likely to use the emergency room and had the highest risk of all-cause and cancer-specific mortality.

- According to the American Cancer Society's Cancer Treatment and Survivorship Facts & Figures 2022-2024, cancer survivors experience greater financial hardship than the general population for many reasons including the inability to work. They also have higher out of pocket medical costs compared to people without a history of cancer. The economic burden of cancer is more profound in survivors who are younger or were diagnosed in childhood, underinsured or uninsured, and have lower incomes.

"Not having access to high-quality cancer treatment due to where you live contributes to the disparities we see in cancer outcomes," said Dr. Arif Kamal, chief patient officer for the American Cancer Society. "It's important to provide the funding and programming needed to keep a lack of transportation from impacting survival. The local health systems we partner with across the country use this funding to deliver assistance directly to the patients who need it most."

Asbury Hospice House Hosts 3rd Annual Lights for Loved Ones

Asbury Hospice House hosted its second annual Lights for Loved Ones event. At this special event, family members were invited to place an ornament in honor of someone they had lost. Attendees then sang Christmas carols, drank hot chocolate, and enjoyed cookies as they reminisced on memories they hold near and dear to their hearts.






FGH Foundation Employee Giving Campaign

Foundation's "You've Got a Friend in Me" as they raise money for the Asbury Hospice House. We also want to give a special thank you to this year's Employee Campaign Committee, pictured below.





Pictured: Regina Arnold, Jennifer Blackwell, Billie Ruth Blakeney, Tina Boquet, Debbie Bounds, Rosa Byrd, Pam Compton, Kaitlyn Cox, Dee Dee Davis, Martha Dearman, Russell Dykes, Jennifer Easley, Juliet Hinton, Jamie Hughes Paige Jenkins, Sheree Jenkins, Candi Lee, Jeremy Lilly, Melissa Martin, Terry Martin, Mary Muli, Becky Pardue, Jessica Peterson, Chuck Pierce, Susan Sanders, Danielle Silkman, Hunter Simmons, Amanda Smith, Robin Strickland, Victoria Williams Not pictured: Marissa Alexander, Carissa Bryant, Karen Butler, Jeanne Carlson, Jennifer Cheeks, Sarah Cordelle-Baxter, Ketyra Clayton, Kennedy Ducksworth, Kaprice Ferguson, Alayna Fokakis, Courtney Freeman, Donshell Harris, Lakilia Haynes, Kilee Hendry, Adreine Heully Gretchen Hodges, Kristie Holland, LaSandra Hudson, Tyra Idom, Amy Jackson, Kimberly Jarrell, Stacy Lewis, Bret Merritt, Selena Morgan, Angela Mucha-Brooks, Colleen Munkel, Thomasyne Nobles, Carlie Nunnery, Hayley Nunnery, Jonna Peters, Dallas Prather, Brittanie Sartin, Pamela Smith, Quincy St. Pierre, Buddy Thornsberry

OPACS becomes the Forrest Health Infusion Center

OPACS is now the Forrest Health Infusion Center. The Forrest Health Infusion Center is a 22-bed outpatient infusion center serving oncology, anemic, RA, MS, and other patients. This team - includes six nurses, one care tech, two pharmacists, and one registration team member.

Spiritual Grounds, FGH Foundation Breaking Ground



A project that began in 2008 on the campus of Pine Grove Behavioral Health and Addiction Services is beginning its final chapter. On Thursday, January 30, the Forrest General Healthcare Foundation broke ground on the remaining two elements of the Pine Grove Spiritual Grounds project.

With the help of generous donors, the $2 million campaign is bringing to fruition the chapel and bell tower. These final elements will join the Paul McMullan Circle of Healing Plaza and sculpture, which opened as Phase I. Mr. McMullan was a long time Hattiesburg businessman and past president of the Forrest General Hospital Board of Trustees.

“This is a project that has been a vision and part of our fundraising since we started the Foundation in 2006, said Martha Dearman, executive director, Forrest General Healthcare Foundation. “Several people – Bill Oliver, Susan Slaughter, Debbie Sanford – were key in the vision of the Spiritual Grounds at Pine Grove. In 2008, we had the dedication and ribbon cutting for the Paul McMullan Plaza, which was followed by the Medicine Wheel, Fire Circle, and Labyrinth. We concluded the fundraising campaign for these final two elements that we are breaking ground on today a couple of years ago. We are excited this day has arrived.”

“I’m a faithful guy,” Cook said. “I truly believe that spirituality gives a person a sense of purpose. From that purpose you typically can find hope. In a lot of that hope, you can find your mental health or well-being. I think this space is going to be fantastic for the services we offer here on campus. I am thankful to see this day arrive. Thank you to Forrest General employees. It’s sometimes hard to understand the impact they have on the Foundation, but many, many of our employees give to the Foundation and is a huge impact in the community. These spaces don’t happen unless the community comes together to make it happen.”

Retirement Honoree Dr. Marcus Hogan from Forrest County Board of Supervisors for Forrest Health Board
New Member FH Board is Dr. Lewis Hatten



The Forrest County Board of Supervisors has named Dr. Lewis E. Hatten, MD, FACS, RPVI, to the Forrest Health Board of Trustees. Dr. Hatten replaces Dr. Marcus L. Hogan, III, MD, who retired at the end of 2024. Members are nominated and voted on by the Supervisors and serve a five-year term. Dr. Hatten was sworn in prior to the February meeting.

Dr. Hatten, who retired at the end of 2024, had served as medical director of Forrest General Hospital's Wound Healing Center.

A 1968 graduate of the University of Mississippi School of Medicine, Dr. Hatten has been affiliated with not only Forrest General Hospital, but several of its regional facilities. He was also the recipient of the 2007 Dr. Philip E. Rogers Innovator Award.



Dr. Hatten specialized in vascular surgery, surgery, and cardiovascular disease, providing more than 20 years of service to Vascular Specialists, Hattiesburg Clinic, where he was instrumental in its growth and success. He cared for patients with conditions affecting the arteries, veins, and lymphatic systems that primarily involved circulation from the heart to the rest of the body.

His remarkable career leaves a legacy of compassion, leadership, and innovation. Dr. Hatten was also one of the founding members of the Wound Healing Center at Forrest General Hospital and of Hattiesburg Clinic's Endovascular Center, the first vascular physician-led outpatient procedure center of its type in the area.

Dr. Hatten, and his wife, Betty Bly Hatten, who will retire at the end of the month after almost 43 years as an FGH ER nurse, are the parents of two children, Andrew (Rachael) Hatten, and Stephen Hatten, who passed away in 1998, and one grandchild, Stephen Patrick Hatten, 5.

The Board of Trustees is made up of seven members who are charged with the oversight of Forrest Health, a completely self-sufficient system. Overseeing all aspects of the health system, its flagship facility, Forrest General, and its six regional facilities, the Board of Trustees makes decisions important to ensuring that patients are a top priority and receive the best possible care.

Dr. Hatten joins other Board of Trustees members, Peggy J. Ainsworth, Eric K. Steele, Andrew "Andy" B. Mercier, Harry "Chip" McArthur, III, Shea E. McNease, and Jana Causey, PhD, who serves as chairperson. Dr. Marcus L. Hogan, III, retired from the board at the end of December 2024 after 19 years of service. Appointed to the Forrest County General Hospital Board of Trustees in January 2005, Dr. Hogan shared his experience and knowledge, providing both leadership and perspective.

During his career, Dr. Hogan served more than 61 years in the field of obstetrics and gynecology, working as an OB/GYN with Hattiesburg Clinic and delivering more than 10,000 babies. He was responsible for introducing epidural anesthesia. Prior to his medical service, he served in the U.S. Army from 1954-1964, serving as a captain during 1963-64. He also served as a member of the AAA Ambulance Board of Trustees.

A 1959 graduate of the University of Mississippi Medical Center, Dr. Hogan worked with Hattiesburg Clinic's Obstetrics and Gynecology Department from 1967-2003. He is a member of the 1953 Forrest County Agriculture High School Aggie Hall of Fame.

Dr. Hogan said he first came to Forrest General Hospital in 1967 as a lab tech, but had been here earlier as an orderly, in the late 1950s, at times working two back-to-back shifts.

"The Forrest County Board of Supervisors is grateful for the service of Dr. Marcus L. Hogan, III, who has served on the Forrest Health Board of Trustees for the last 19 years," said Terri Bell, president of the Forrest County Board of Supervisors. "He has been committed to bringing excellence to healthcare in our community for many years. We wish Dr. Hogan and his wife, Billie, all the best in the years ahead."

Trustees Chairperson Causey commended Dr. Hogan during a retirement reception February 17, noting the tremendous amount of growth that has taken place under his leadership while serving on the board. "Dr. Hogan has perspective that was not only unique, but he brought a lot of experience to our board that was very important, especially concerning quality," she said. "He made sure we were taking good care of this hospital and our outlying facilities and the impact on our communities. I hope you know and understand how much we appreciate you."

With Dr. Hogan's departure, Eric Steele, vice chairman, becomes the elder member of the board. "In the military, we call them Battle Buddies," Steele said of his time on the board sitting next to Dr. Hogan. "The thing I have gathered the most from Dr. Hogan is how important family was. That was something he always talked about. You truly have been a blessing. There will always be a place in my heart for you."

Colon Tour Comes to Forrest General – Colorectal Cancer Awareness Month

In honor of Colorectal Cancer Awareness Month, a colon tour came to Forrest General. The "tour of the colon" event, hosted by Forrest General Cancer Center in partnership with the Mississippi Department of Health, was a tremendous success!



Participants explored the intricacies of colon health, delved into screening options, and learned invaluable strategies for reducing the risk of colorectal cancer. It was a truly enlightening experience that empowered everyone to take proactive steps toward better health.

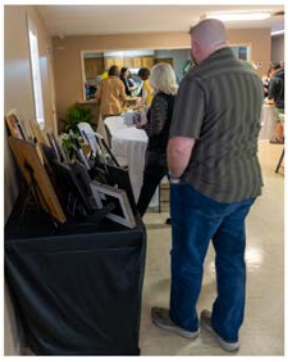
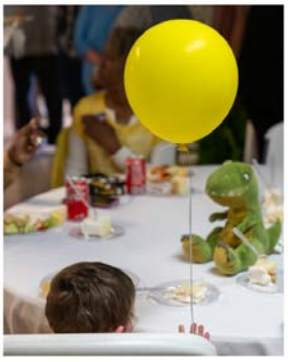








Forrest General Hospice, Asbury Hospice House, and Palliative Care hosted *A Celebration of Life and "Precious Memories"* memorial service. This special event allowed family members of those who had passed in the past year a chance to reflect, honor, and remember. During the service, hospice team members led those attending in music, prayer, and dedication. The service ended with a butterfly and balloon release.



National Volunteer Week



There's nothing stronger than the heart of a volunteer. This month marks 22 years that Annie Ford of Hattiesburg has been making her weekly trek to the Forrest General Cancer Center. Don't worry, she's perfectly healthy. Her weekly trip brings her here to volunteer, a decision she made after her own battle with cancer.

Leslie Martinez is a graduate student at Southern Miss, and has been donning the green blazer Forrest General Ambassadors wear for about a year. Like Ford, she also has a calling for the volunteer work she does on a weekly basis at Forrest General Hospital.

The Forrest Healthcare system relies on volunteers in a variety of ways. Annie Ford and Leslie Martinez are just two of many, whose happy smiles and caring ways make a big difference with patients. April was the National Volunteer Month.

"As a cancer survivor, I thank the Lord for bringing me this far," said Ford, a 24-year cancer survivor, who wanted to give back to other patients. "Everybody helped me and supported me, and I wanted to come back to the Cancer Center after I finished my treatments in 2001 and do that for others, and let them know what the Lord had done for me," she said. "My husband, family, friends, church members, pastor, everybody was very supportive, even people I didn't know. They supported and encouraged me, and I wanted to do that for the patients here, and that is what I have been doing."

Diagnosed with breast cancer in 2000, Ford had surgery in December and started chemotherapy treatments in January 2001. After eight rounds of chemo and 33 days of radiation, she completed treatment in September 2021, just nine months after her diagnosis. She has remained cancer free.

During the COVID pandemic, volunteers were sent home to wait things out, but that didn't stop Ford from carrying on with her work. "I missed the patients I saw at the Cancer Center," she said. "I had some old patient relationships, so I called and talked to them and encouraged them over the phone, knowing what they were going through."

At Forrest Health, volunteers are central to our mission, "do what is best for the patient." Every volunteer has a unique voice, perspective, and gift to share. People volunteer for a variety of reasons. You may be looking for a way to give back

or pay it forward. You may want to have your first experience in a health-care setting or begin a new chapter of your life here. Maybe you need to get out of the house and put your talents to good use. Or, you may aspire to realize a long-held dream or nurture a passion. Regardless of where you come from, we welcome you. If you aren't physically able to volunteer or unsure about volunteering, thank a volunteer for what they do to make your visits to Forrest Health facilities a little easier.

Volunteering is at the very core of being a human. No one has made it through life without someone else's help." - Heather French Henry



Veronica Martin, RD, LD, CNSC, Nutrition Support Services Coordinator, and Sydney Swilley, a Southern Miss dietetic nutrition intern, teamed up for a community outreach day at the FGH Cancer Center. They held a Smart Shake nutrition demo and were able to educate over 75 patients while offering taste testing. Patients agreed that the shakes were delicious!

Zeta Phi Beta Donates to the FG Cancer Center



The Lambda Kappa Zeta Chapter of Zeta Phi Beta Sorority Inc. recently donated 70 wigs to the Forrest General Cancer Center. The wigs were collected and donated in memory of their sorority sister, Cynthia Bell, who received her treatment at the Cancer Center, but, unfortunately, passed away earlier this year. At the time of Bell's treatment, when she was looking for a wig, there were none for African American women. Knowing that her sorority chapter served the community, she asked if they could donate wigs specifically for African American women. The chapter's older members, Zeta Helping Other People Excell (ZHope), included a variety of wigs in their donations, but catered to women of color. "It is the hope of the Lambda Kappa Zeta chapter that we have helped someone today," said Patricia Thompson, chapter member.

National Cancer Survivor's Day



The search for a new primary care physician led Valerie Fine of Hattiesburg on a journey she never planned on taking. But the Lord had other plans, and she's now immersed in a cause that's become near and dear to her heart. As National Cancer Survivors Day is celebrated on June 1, Valerie shares her story.

In 2022, Valerie and husband, Ted, were living in Houma, La., where he served as senior pastor at First United Methodist Church, Houma. A pastor's wife and a CPA, Valerie had found her niche using her accounting talents as she worked with smaller churches in the area.

A routine visit with a new primary care physician in Baton Rouge, La., led to blood work, which turned into a visit with a gastroenterologist, more blood work, and eventually, an ultrasound, which showed a 7.5cm x 3.5cm mass in her gallbladder. Surgery resulted in the removal of her gallbladder, part of her liver, and some of her lymph nodes. Originally diagnosed with Stage 3B gallbladder cancer, Valerie underwent normal treatment after surgery – oral chemo for six months with scans every three, which went well. Ted interjects a story that might have made a big difference in Valerie's entire journey.

In the year prior to Valerie's original diagnosis, she was admitted to the hospital with severe abdominal pains. At that time, they saw her gallbladder had stuff in it, sludge or something. Simultaneously, Valerie had developed a rash determined to be shingles, which they attributed her pain to, steering them away from the gallbladder. "Had they gotten the gallbladder at that point and taken it out, she might not be here with this today," Ted said.

The couple moved to Hattiesburg during the summer where Ted became senior pastor at Oak Grove Church. Valerie, cancer free, was feeling fine. "Gallbladder cancer is very aggressive, which is why they do scans so often," she explained. In September 2023, a scan discovered a reoccurrence of cancer.

Although they were living in the Hub City, Valerie returned to Baton Route for surgery to remove the lymph nodes on both sides in her aortic area; however, during surgery, her physician encountered a tumor wrapped around Valerie's portal vein, which could not be operated on. The portal vein, located in the upper right quadrant of the abdomen, is a blood vessel that carries blood from the gastrointestinal tract, gallbladder, pancreas, and spleen to the liver.

Valerie started seeing Dr. Laurie Douglas at Forrest General's Cancer Center, who she described as "fabulous, absolutely wonderful, and supportive" of treatment Valerie was getting elsewhere. However, those out-of-state trips became too difficult and Valerie was not getting anything there she was not already getting at Forrest General's Cancer Center.

Experiencing severe pain from the portal vein pressing on nerves, Dr. Douglas reached out to Dr. Joseph Salloum, a radiation oncologist at the Cancer Center, about treatment options. Under his care, Valerie had 36 radiation treatments. "I didn't do so well, but it worked," she said. "Dr. Douglas told me I would probably be on chemo the rest of my life; however, after that radiation treatment, which finished on October 15, I had six months of nothing. I started feeling better."

Valerie was having frequent scans, and everything was going well, until it wasn't. A new spot was discovered on her spine, which meant another round of radiation, which she finished just a few weeks ago on May 9. "It has worked," Valerie said, "but she is also back on chemo – two on, one off, two on, one off – and will continue to do more scans."

But Valerie's story doesn't end there.

Valerie's dad, who lived in Dallas, Texas, suffered from Parkinson's disease. There, she had found a support group for him where he got to be with people like him. Her dad got to have therapy, exercise with others, eat lunch and socialize together, while her mom met upstairs with other caregivers, social workers, and the like to get the support they needed.

Valerie noted her parents were not ones to seek help, but the support group was life changing for them. If it worked for them, she felt a support group could work for those in the Hattiesburg area with cancer. She started searching, but found nothing.

She met with Forrest General Cancer Center Director Shannon Vega, Manage Kecia Jones-Harris, and Patient Navigator, Robin Reeves, where she learned the COVID pandemic had shut down a previous cancer survivor support group.

Valerie was familiar with Cancer Companions, a nationwide non-profit, whose purpose, "We believe every cancer patient deserves a holistic experience, including a tangible way to engage the hope of Christ in the darkness of their cancer journey."

She knew about the group through a former pastor she worked for, who suffered from tongue cancer. A friend's church was also working through the Cancer Companions program. Valerie felt like all these things were signs from God, and committed to the program as a support group for local cancer patients.

Since 2011, the nationwide group has grown to 71 active churches in 24 states with more than 400 volunteers, making Cancer Companions the premiere national Christian Cancer Ministry. Valerie and Ted are excited to have the local group included among those numbers. And the FGH Cancer Center was happy to lend their support to the group, which held its first meeting in January of this year with cancer patients/caregivers at Oak Grove Church to get a feel for how it would work before opening to the public in February. The group meets the second and fourth Friday of every month at 10:30 a.m. at the church located at 4915 Old Hwy. 11, Oak Grove.

"We are slowly growing," Valerie said. "This has just been a Godsend for everyone."

The support group is for any type of cancer survivor or those who continue to go through treatment and their caregivers. "We hear from people who say, 'I'm healthy, I don't need to come," but we really want to hear from them, also, because they are an inspiration to all of us going through this."

Valerie said support group members, which currently number around 15, suffer from all types of cancer, but they don't have a breast cancer patient, which is odd, since that is one of the more common types of cancer seen today."

Most of those who attend are older members, who don't work anymore or are retired, according to Valerie. Most are couples, but there are some individuals. Many, when first going through treatment and taking oral chemo, are still able to work, so meetings during work hours aren't conducive for them to attend. She does foresee a point where they will probably be adding an evening group for those who may be younger and work.

Valerie had hoped to retire on her own terms, but cancer had other plans. On disability, she can't work anymore. She's currently a Stage 4 cancer patient, but she's outlived her prognosis, by almost a year at this point.

"I think this support group is something people need very badly," Valerie said. "I want to keep one here, as well as a second one here, when we get to that point. And I'm open if anyone would like to facilitate. I don't have any counseling or social work experience, but Ted has counseling in his past because of being a pastor.

"This is all truly God, every bit of it. God has given me a voice. I feel like this is my purpose. I really do."
For more information about the Cancer Companions Support Group meetings, email Valerie at Valerie@ogchurch.life or call 225-610-7780.

New Fluoroscopy Room in FG Radiology

We are proud to celebrate the ribbon cutting of our new radiology fluoroscopy room, a major investment in advanced imaging technology that supports patients across the entire organization. From diagnosing complex conditions to enhancing care for our bariatric program, this upgraded room brings faster, safer, more precise imaging capabilities.







New Mammography Services at Marion General – Forrest Health

Marion General Hospital recently cut the ribbon on new mammography services. These new services will open up new options for patients in Columbia and the surrounding area. The debut of advanced 3D Mammography™ technology reaffirms Marion General Hospital's commitment to providing local patients with the most advanced diagnostic tools available. This innovative technology represents a significant advancement in breast cancer detection and patient care within the medical community.



(From left to right) Tomaz McCarty (Administrator-MGH/JDCH), Todd Carrol (Regional Radiology Manager), Erica Pigeon (Mammography Technician), Abbie Turnage (Mammography Coordinator), James Turnage Jr. (Administrator- Highland Community Hospital/Regional Radiology Director), Ashley Holmes (Marion General Radiology Supervisor), Steve Jackson (Vice President)

Art is Good for the Soul



Growing up, a young Sophy Mangana, MD, remembers art always being a part of her life. “I remember drawing and painting with my grandmother on my father’s side,” she said. “She used to draw pictures of herself growing up in the Dominican Republic, and I remember her telling me stories and going through different experiences she had as she drew pictures of herself.”

It was impactful experiences such as these that instilled in Mangana, MD, a Forrest General Cancer Center radiation oncologist, a love of art, while serving as an outlet for her grandmother to weave stories of her culture for her young granddaughter to understand.

When Mangana got older, her family moved to the states, and she had the opportunity to attend classes in a school in Providence, Rhode Island, that was founded as an art school. “They had a very strong art program, starting from the 5th grade all the way up through high school,” Mangana said. “I had the opportunity to study studio art, pottery, clay, painting, charcoal, and other mediums that allowed me to have a form of expression that was different from my academics. As I transitioned more into the sciences and math, art became even more important because it allowed me that form of expression that was so different from doing the academic work.”

These days, in her job at the Cancer Center, Mangana understands how art serves as a form of expression for patients. “Art can be a way for them to express anger or pain,” she said. “It becomes a medium for them to be able to have an outlet that releases stress. It is also a way to not distract, but help a patient cope with pain or their diagnosis. It empowers the patient to create something they can control while they go through something they don’t have control over – their diagnosis or a cancer treatment therapy being delivered.”

Mangana said there is currently data which suggests that art plays a role in a patient’s overall well-being. There are some cancer centers where there are art programs such as art therapy or art classes. Studies show that patients who have undergone some form of art therapy, whether it be music or visual arts, the end result has been an overall sense of well-being, reduced stress, or in the case of some pediatric cancer patients, a better time coping with the trauma of having a diagnosis and undergoing cancer treatment.

As part of the Forrest General Cancer Center’s 25th anniversary celebration, Mangana came up with the idea for the Cancer Center to host an art contest where community members could submit works of art with the theme, Colors of Courage. The winning artwork would hang in the Cancer Center. “The art contest, for me, served as a way to allow the community to take a look inside the Cancer Center without the stigma of it being a center that treats patients undergoing this horrible disease with a horrible diagnosis and treatments,” Mangana said. “They got a chance to see how patients or their loved ones express their emotions about having a diagnosis of cancer or undergoing treatment and not focus on the difficult side of it, but highlight the emotion that it conveyed.”

The sidewalk mural leading up to the front doors of the Cancer Center, which was made possible and dedicated in 2024 by Laughs 4 Life founder Kent Oliver, provides some positive energy for patients with its many, colored ribbons representing the different types of cancer interspersed with words of encouragement. “Here at the Cancer Center, we strive to create a space where patients feel loved and cared for,” Mangana said. “Walking up to the Cancer Center and seeing the mural and reading the encouraging words allows patients to walk, look forward and meet their cancer care team and have a positive outlook before they ever walk into the building.”

For Mangana, art has been an incredible driving force. “It has been a way to relieve stress and convey emotion, and I have been very grateful that the community at the Cancer Center has welcomed and has embraced my love of art and that the community has allowed me to host and celebrate others who also share my love for art.”

New TrueBeam Linear Accelerator at Forrest General Cancer Center



Healthcare professionals at the Forrest General Cancer Center are committed to making cancer treatment as easy and timely as possible for every patient.

For patients undergoing radiation treatment, the Cancer Center recently upgraded one of its three linear accelerators to the advanced TrueBeam™ system. This new technology delivers faster, more precise treatments, enhancing both safety and comfort. A ribbon cutting for the new TrueBeam™ accelerator was held September 3 at the Cancer Center.
Zach Christ, Cancer Center chief physicist and Radiology Safety Officer, said as cancer care evolves, so does Forrest Health.

“Our new TrueBeam™ 4.1 system is the latest addition to the suite of cancer care options at Forrest Health. This linear accelerator retains the groundbreaking beam generation technology of the TrueBeam™ platform, and adds faster, more precise radiation treatments with enhanced safety,” he said. “This system is intended to provide stereotactic radiosurgery and precision radiotherapy for lesions, tumors, and conditions anywhere in the body where radiation treatment is indicated. We are excited about what this new system means for our patients.”

The main advantages of the Varian TrueBeam system are ease, precision and speed. Thanks to its pinpoint accuracy, this system can be used to treat many different types of tumors, including those in sensitive areas such as the abdomen, liver, lung, breast, and head and neck. Simple treatments that once took 10 to 30 minutes can now be completed in less than two minutes. As well as allowing for a more comfortable experience for the patient with less time on the treatment couch, faster delivery also allows for reduced chances of tumor motion during treatment, which helps protect nearby healthy tissue and critical organs. It also makes it possible to create images using 25% less X-ray dosage.

In addition to its impressive technical specifications, TrueBeam has also been designed with patient comfort in mind. It operates quietly and provides built-in music capabilities, so the patient can listen to music during their treatment. The patient is in constant two-way communication with the radiation therapists who operates the system. Plus, the radiation therapist is able to visually monitor and see the patient through two closed-circuit television systems throughout the treatment. The beam-producing system is installed in a vault in the healthcare setting to provide shielding from radiation, while the control panel that uses the device software is placed outside the treatment room.

“I am very excited about our new True Beam Varian linear accelerator (LINAC) at the Cancer Center,” said Joseph Salloum, MD, radiation oncologist. “This third LINAC system will allow for greater access to this personalized, precise radiation therapy in a timely manner for cancer patients. The new accelerator will also increase patient access to radiation oncology treatments.”

According to Salloum, the need for a new accelerator has been driven by unprecedented growth in the oncology practice at Forrest General Hospital and will ensure all patients who need radiotherapy will have timely access to treatment. “The advantage to having three linear accelerators in use on a daily basis is we will be able to treat more people each day, thus increasing the number of patients we can care for each year,” Salloum said.

Jeff Cook, Forrest Health President/CEO, noted how invaluable and important technology like the new TrueBeam linear accelerator is to our community. “Knowing the number of procedures and treatments we provide with our linear accelerators is staggering,” he said, referring to the more than 15,000 procedures during the last year. “Because of access to high-quality care, our patients don’t have to drive to a major city to get treatment. We have the technology with our TrueBeam Linear Acclerators, our physicians, and our staff to receive great cancer care here, so I am excited about what this means for us as we keep investing in our community. As we get more equipment and invest in our staff, it means that our patients and our community are being taken care of.”

FG Cancer Center ranks among the largest and most sophisticated cancer treatment centers in South Mississippi. It offers a place where patients can receive advanced care in a beautiful, compassionate environment. Forrest General operates the only comprehensive community Cancer Center in the 19-county service area, and is accredited by the American College of Surgeons Commission on Cancer. The center features the services of a multidisciplinary team led by medical oncologists and hematologists and radiation oncologists, who provide high quality medical care in a continuum of settings. In addition to medical and radiation oncologists, a complete range of physician specialists provide expertise in diagnoses, surgical removal, disease management and reconstructive procedures.

Oncology Data Specialist Received Certification Forrest General Cancer Registry, Research, and Informatics



Jessica Cooley, ODS-C received Oncology Data Specialist certification through the National Cancer Registrar Association. The Oncology Data Specialist (ODS) credential sets the standard for professional excellence in the cancer registry field. It is nationally recognized in the recruitment and retention of registry personnel. It is earned by successfully completing the ODS exam with a passing score. One maintains the credential by completing 20 continuing education hours every two years. Oncology Data Specialists collect the data that provides essential information to researchers, healthcare providers, and public health officials to better monitor and advance cancer treatments, conduct research, and improve cancer prevention and screening programs.

“Jessica Cooley has demonstrated the knowledge and professional competence needed within the Forrest Health Cancer Registry, Research and Informatics. I am grateful that her and our ODS students can excel at our Cancer Registry Management Program, said Juliet Hinton Kolin, ODS-C, MBA, FG Cancer Registry Manager, Research, and Informatics, USM, WCU and NCRA Intern Clinical Preceptor. “Our oncology data specialists earn this certification at the international level from the National Cancer Registrar Association (NCRA).”

By collecting the data that makes up the cancer history of each cancer patient, information can be provided to researchers, healthcare providers, and public health officials to help: Monitor cancer trends over time, Evaluate cancer patterns in populations and identify high-risk groups, Guide planning an evaluation of cancer control programs, Set priorities for allocating health resources, Study cancer causes and prevention strategies, and Advocate for cancer surveillance through CDC.

Most registrars work for hospitals or central cancer registries. (State registries are referred to as central registries.) A few works for federal agencies such as the Centers for Disease Control & Prevention’s (CDC) National Program of Cancer Registries or the National Cancer Institute’s (NCI) Surveillance, Epidemiology, and End Results (SEER) Program.

Forrest General Hospital Cancer Comprehensive Cancer Program is Accredited through the American College of Surgeons Commission on Cancer.

Spiritual Care



In October, appreciation for clergy, Forrest Health's two staff chaplains, Monica Webber and Jon Kittrell, also oversee a team of volunteer chaplains from a wide variety of faiths and work tirelessly to provide spiritual support and comfort to employees, patients, and visitors each and every day.

Thank you for the thriving and comforting work you do!

Cancer Registry, Research, and Informatics Presentation to HIM Programs Across the Nation

Education Foundation – National Cancer Registrar Association



Several Health Information Management (HIM) Programs at universities and colleges across the nation on December 9, 2025 viewed the presentation session on the NCRA Education Foundation, Initiatives and Educational Modules to enhance education in HIM related to Cancer Registry Resources.

The topics includes the Education Foundation mission and vision, and funding through donations, history of the Educational Foundation and resources, the new sixteen (16) modules released in 2025. The talk shared free accessible resources to strengthen classroom instruction and promote consistency across Cancer Registry, Research, and Informatics Education. It showcased NCRA Education Foundation's sixteen pre-recorded learning modules, the instructions to accessing and how to utilized the resources. Juliet shared the in depth understanding of each of the modules for cancer registry, abstracting and coding, cancer staging, casefinding, patient follow-up for lifetime, electronic data submission, release of information, cancer committee, cancer conference, quality, steps to becoming an Oncology Data Specialists, advocacy, oncology coding, treatment, and the standard setters. The path to the profession section of the website revealing the resources to assist in finding out the different directions of the eligibility requirements, career pathways, and accredited educational programs for cancer registry management.

The options to incorporate material into curriculum. The HIM programs discovered the learning modules to assist in bridging the gap between classroom knowledge and the real-time Oncology Data Specialists (ODS) profession in the Cancer Registry, Research, and Informatics. The inspiration to lead students to a career as an Oncology Data Specialist.

Juliet Hinton Kolin ODS-C, BSB, MBA is the Cancer Registry Manager, Research, and Information at Forrest General Hospital – Cancer Center for over twenty years. She serves as AJCC Liaison, and on the Education Foundation Website Team for NCRA. She has served as a mentor for many students for the last twelve years while speaking at various colleges to educate people about the profession. Her experience ranges from handling CoC accreditation, complex cancer case abstracting, state registry, NCDB, and the RCRS submissions and running reports. She has a passion for educating new ODS-Certified professionals to learn and grow within the field as well as the experienced registrars with abstracting questions, and assist them discover the calling of caring for patients.





Prevention and Screening 2025
April 7, 2025



Organizations: MSDH, MOHCA, PRCC, FGH, FGH Wellness, FGH Cancer Registry, MP3C, SEMRHI

Education Session Speakers: Virtual Video of participants from previous events that were diagnosed and then treated for Head and (Oral) Neck Cancer.

Note: FGH & MS Department of Health Head and Neck Face to Face Education & Oral Screening tentatively set for April 2026 for the community.

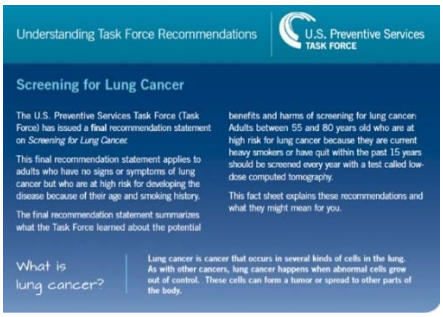




Hattiesburg Clinic CT Screening
https://www.cdc.gov/cancer/lung/pdf/guidelines.pdf

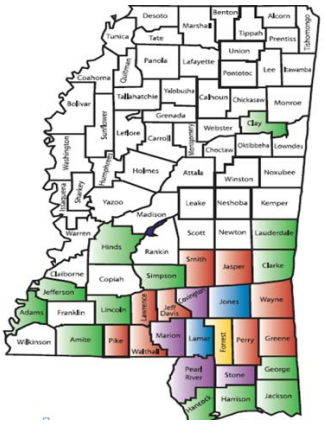
Mississippi tobaccoQUITLINE 1.800.QUITNOW 1.800.784.8669





http://www.quitlinems.com/index.php

2024 Cases Distribution by County



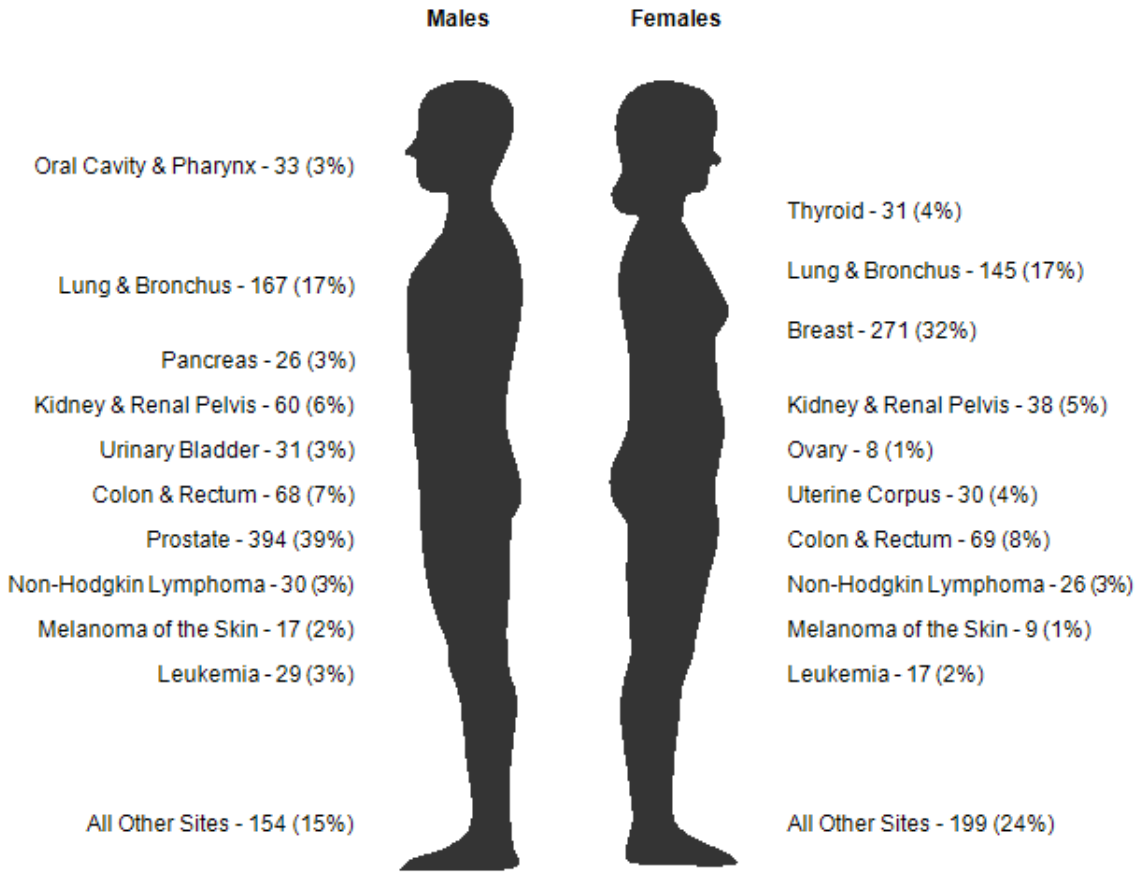
Primary Site 2024 (Analytic – 1,581 Non-analytic - 271 Total: 1,852)

Primary Site	Total	%	Male	%	Female	%
ORAL CAVITY & PHARYNX	46	2.5%	33	3.3%	13	1.5%
Lip	1	0.1%	1	0.1%	0	0.0%
Tongue	14	0.8%	11	1.1%	3	0.4%
Salivary Glands	2	0.1%	0	0.0%	2	0.2%
Floor of Mouth	1	0.1%	0	0.0%	1	0.1%
Gum & Other Mouth	3	0.2%	2	0.2%	1	0.1%
Nasopharynx	4	0.2%	4	0.4%	0	0.0%
Tonsil	7	0.4%	6	0.6%	1	0.1%
Oropharynx	7	0.4%	4	0.4%	3	0.4%
Hypopharynx	7	0.4%	5	0.5%	2	0.2%
DIGESTIVE SYSTEM	276	14.9%	146	14.5%	130	15.4%
Esophagus	14	0.8%	12	1.2%	2	0.2%
Stomach	11	0.6%	8	0.8%	3	0.4%
Small Intestine	8	0.4%	3	0.3%	5	0.6%
Colon Excluding Rectum	102	5.5%	47	4.7%	55	6.5%
Cecum	19		9		10	
Appendix	12		6		6	
Ascending Colon	18		6		12	
Hepatic Flexure	4		3		1	
Transverse Colon	12		6		6	
Splenic Flexure	3		1		2	
Descending Colon	7		3		4	
Sigmoid Colon	20		8		12	
Large Intestine, NOS	7		5		2	
Rectum & Rectosigmoid	35	1.9%	21	2.1%	14	1.7%
Rectosigmoid Junction	9		4		5	
Rectum	26		17		9	
Anus, Anal Canal & Anorectum	15	0.8%	3	0.3%	12	1.4%
Liver & Intrahepatic Bile Duct	34	1.8%	20	2.0%	14	1.7%
Liver	25		19		6	
Intrahepatic Bile Duct	9		1		8	
Gallbladder	5	0.3%	1	0.1%	4	0.5%
Other Biliary	3	0.2%	2	0.2%	1	0.1%
Pancreas	44	2.4%	26	2.6%	18	2.1%
Retroperitoneum	2	0.1%	1	0.1%	1	0.1%
Peritoneum, Omentum & Mesenter	1	0.1%	0	0.0%	1	0.1%
Other Digestive Organs	2	0.1%	2	0.2%	0	0.0%
RESPIRATORY SYSTEM	327	17.7%	178	17.6%	149	17.7%
Nose, Nasal Cavity & Middle Ear	3	0.2%	1	0.1%	2	0.2%
Larynx	12	0.6%	10	1.0%	2	0.2%
Lung & Bronchus	312	16.8%	167	16.6%	145	17.2%
SOFT TISSUE	6	0.3%	3	0.3%	3	0.4%
Soft Tissue (including Heart)	6	0.3%	3	0.3%	3	0.4%
SKIN EXCLUDING BASAL & SQU.	27	1.5%	18	1.8%	9	1.1%
Melanoma -- Skin	26	1.4%	17	1.7%	9	1.1%
Other Non-Epithelial Skin	1	0.1%	1	0.1%	0	0.0%
BREAST	272	14.7%	1	0.1%	271	32.1%
Breast	272	14.7%	1	0.1%	271	32.1%
FEMALE GENITAL SYSTEM	57	3.1%	0	0.0%	57	6.8%
Cervix Uteri	8	0.4%	0	0.0%	8	0.9%
Corpus & Uterus, NOS	30	1.6%	0	0.0%	30	3.6%
Corpus Uteri	27		0		27	
Uterus, NOS	3		0		3	

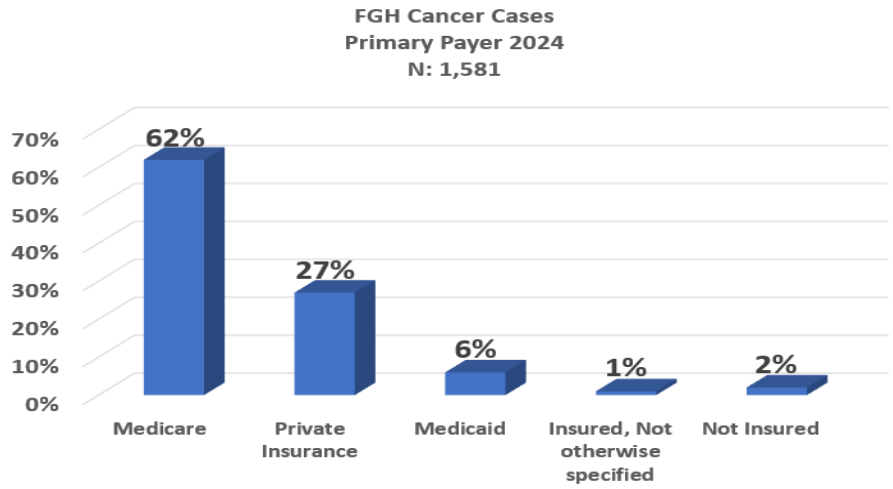
Primary Site	Total	%	Male	%	Female	%
Ovary	8	0.4%	0	0.0%	8	0.9%
Vagina	4	0.2%	0	0.0%	4	0.5%
Vulva	6	0.3%	0	0.0%	6	0.7%
Other Female Genital Organs	1	0.1%	0	0.0%	1	0.1%
MALE GENITAL SYSTEM	398	21.5%	398	39.4%	0	0.0%
Prostate	394	21.3%	394	39.0%	0	0.0%
Testis	3	0.2%	3	0.3%	0	0.0%
Penis	1	0.1%	1	0.1%	0	0.0%
URINARY SYSTEM	139	7.5%	93	9.2%	46	5.5%
Urinary Bladder	38	2.1%	31	3.1%	7	0.8%
Kidney & Renal Pelvis	98	5.3%	60	5.9%	38	4.5%
Ureter	1	0.1%	1	0.1%	0	0.0%
Other Urinary Organs	2	0.1%	1	0.1%	1	0.1%
EYE & ORBIT	1	0.1%	1	0.1%	0	0.0%
Eye & Orbit	1	0.1%	1	0.1%	0	0.0%
BRAIN & OTHER NERVOUS SYST	53	2.9%	17	1.7%	36	4.3%
Brain	17	0.9%	9	0.9%	8	0.9%
Cranial Nerves Other Nervous Syst	36	1.9%	8	0.8%	28	3.3%
ENDOCRINE SYSTEM	47	2.5%	15	1.5%	32	3.8%
Thyroid	45	2.4%	14	1.4%	31	3.7%
Other Endocrine including Thymus	2	0.1%	1	0.1%	1	0.1%
LYMPHOMA	63	3.4%	33	3.3%	30	3.6%
Hodgkin Lymphoma	7	0.4%	3	0.3%	4	0.5%
Non-Hodgkin Lymphoma	56	3.0%	30	3.0%	26	3.1%
NHL - Nodal	45		23		22	
NHL - Extranodal	11		7		4	
MYELOMA	37	2.0%	16	1.6%	21	2.5%
Myeloma	37	2.0%	16	1.6%	21	2.5%
LEUKEMIA	46	2.5%	29	2.9%	17	2.0%
Lymphocytic Leukemia	20	1.1%	14	1.4%	6	0.7%
Acute Lymphocytic Leukemia	2		2		0	
Chronic Lymphocytic Leukemia	16		10		6	
Other Lymphocytic Leukemia	2		2		0	
Myeloid & Monocytic Leukemia	26	1.4%	15	1.5%	11	1.3%
Acute Myeloid Leukemia	15		8		7	
Chronic Myeloid Leukemia	10		6		4	
Other Myeloid/Monocytic Leuke	1		1		0	
MESOTHELIOMA	4	0.2%	3	0.3%	1	0.1%
Mesothelioma	4	0.2%	3	0.3%	1	0.1%
KAPOSI SARCOMA	2	0.1%	2	0.2%	0	0.0%
Kaposi Sarcoma	2	0.1%	2	0.2%	0	0.0%
MISCELLANEOUS	51	2.8%	23	2.3%	28	3.3%
Miscellaneous	51	2.8%	23	2.3%	28	3.3%
Total	1,852		1,009		843	

Summary of Cases

There were 1,852 new cases entered into the cancer registry in 2024, 1,581 analytic cases diagnosed and/or treated at FGH, and 271 non-analytic cases seen at FGH. The top sites for 2024 were Lung 312, Prostate 394, Breast 272, Colorectal 137, Lymphatic/Hematopoietic 109, and Head and Neck 61. The distribution by sex was male 1009 (54%) and female 843 (46%) for 2024.



Primary Payer



Cancer Registry, Research and Informatics

The Cancer Registry, Research and Informatics is the cornerstone of the cancer program at Forrest General Hospital. The Research focus is to exceed the expectations of the American College of Surgeons Commission on Cancer standards and fulfill the Cancer Committee's vision. From our reference year of 2002, our goal is to guarantee accurate and timely collection of diagnosed and/or treated cancer patient data, which allows for the efficacy in evaluation of patient outcomes and identification of opportunities for improvement. Since 1968, there have been 56,763 cases entered into the database. Since our reference year of 2002, we have 32,986 cases. Lifetime follow-up of patients included in the database supports clinical follow-up and surveillance of additional primaries. Currently, the cancer registry maintains follow-up on 9,186 cases with a follow-up rate is 99%.



The Cancer Registry activities include monitoring, audit and action plans of the Accreditation by American College of Surgeons Commission on Patient Care Standards, Weekly Data Submission to the Mississippi Cancer Registry, National Cancer Database Submission, Rapid Cancer Reporting System, studies requested in 2025, Prevention and Screening Activities, completion of 2025 Cancer Program Annual Report, and maintenance of the Facility Information Profile System (FIPS) – public viewing of resources and data of the Commission on Cancer approved programs listed on the American Cancer Society website, QPort PRQ - Survey Application Record (SAR), Follow up Care: Survivorship and Patient Care Patient Surveys IRB Studies, Rapid Cancer Reporting System (RCRS) through Commission on Cancer, and Cancer Quality Improvement Program Reports.

L-R Front: Jessica Cooley, ODS-C Felicia Megehee, ODS-C, Juliet Hinton Kolin, ODS-C, MBA; L-R Back Daphne Nix, BS, ODS-C, Debra Barclay Juliet Hinton, ODS-C, BSB, MBA

Cancer Conference

The cancer (tumor) conference is held weekly on Tuesday at noon and offers multidisciplinary consultative services for patients, discussion among cancer program team members, and educational conferences for the physicians and allied health professionals. In 2024, 207 cases were discussed at conference. Prospective cases were 98%. The top sites included Breast, Lung, Colon, Prostate, Head and Neck, Brain, Unknown, and Lymphoma/Leukemia. Forrest General Hospital is accredited by the Ochsner to provide continuing medical education (CME) for physicians in this educational activity for one credit towards the AMA Physician's Recognition Award. For more information about the Cancer Conference, please contact the Cancer Registry at (601) 288-2914.

Physician Presenters at Cancer Conference 2025

Jennifer Bailey, MD OB/GYN
Garner Bell, MD, HEM/ONC
Laurie Douglas, MD, HEM/ONC
Paula Warren, MD, NEUROS
Joseph Salloum, MD, RAD ONC
Brian Berk, MD GI
Kevin Barker, MD, GI
Kevin Kinloch, MD, PULM
Wesley Aldred, MD PULM
Jackson Ross, MD PULM
Marcos Rosado, MD, Surgery
Rachel Rosado, MD, Surgery
John S. Hrom, MD, HEM/ONC
Duncan Donald MD, Surgery
Leah Rock, MD, Family
Frank Hux, MD, NEUROS
Georgia Wahl, MD, Surgery
Sophy Mangana, MD, RAD ONC

Oncology Team



John S. Hrom, MD
Hattiesburg Clinic, P.A.
Hematology/Oncology
Medical School: UMMC
Internship: UMMC
Residency: UMMC
Fellowship: University of Texas Southwestern



Laurie Douglas, MD
Hattiesburg Clinic, P.A.
Hematology/Oncology
UMMC
UMMC
University of Alabama Birmingham
Wake Forest Baptist Health



David Morris, MD
Hattiesburg Clinic, P.A.
Hematology/Oncology
Medical School: UMC
Internship: UMMC
Residency: UMMC
Fellowship: UMMC



J. Michael Herrington, MD
Hattiesburg Clinic, P.A.
Hematology/Oncology
Medical School: UMMC
Internship: UMMC
Residency: UMMC
Fellowship: UMMC



Sophy Mangana, MD
South MS Associates of Radiation Therapy
FGH Cancer Center: Radiation Oncology
The Warren Alpert Medical School of
Brown University
Roger Williams Medical Center
Loyola University Medical Center



N. Joseph Salloum, MD
South MS Associates of Radiation Therapy
FGH Cancer Center: Radiation Oncology
University of Cairo
Cairo University Hospital
(IM & RO) New York Methodist Hospital



Louis Matt Varner, MD
Hattiesburg Clinic, P.A.
Hematology/Oncology
Medical School: UMMC
Internship: UMMC
Residency: US Air Force,
San Antonio



Francis Garner Bell, MD
Hattiesburg Clinic, P.A.
Hematology/Oncology
Mississippi College
William Carey University-
College of Osteopathy Medicine
Ascension Genesys Hospital, Michigan



Bradley Myers, NP
Hattiesburg Clinic, P.A.
HBC Medical Oncology



Whitney Wilkinson, NP
FGH Cancer Center
Radiation Oncology



Kristen Sentell, NP
FGH Cancer Center
Radiation Oncology



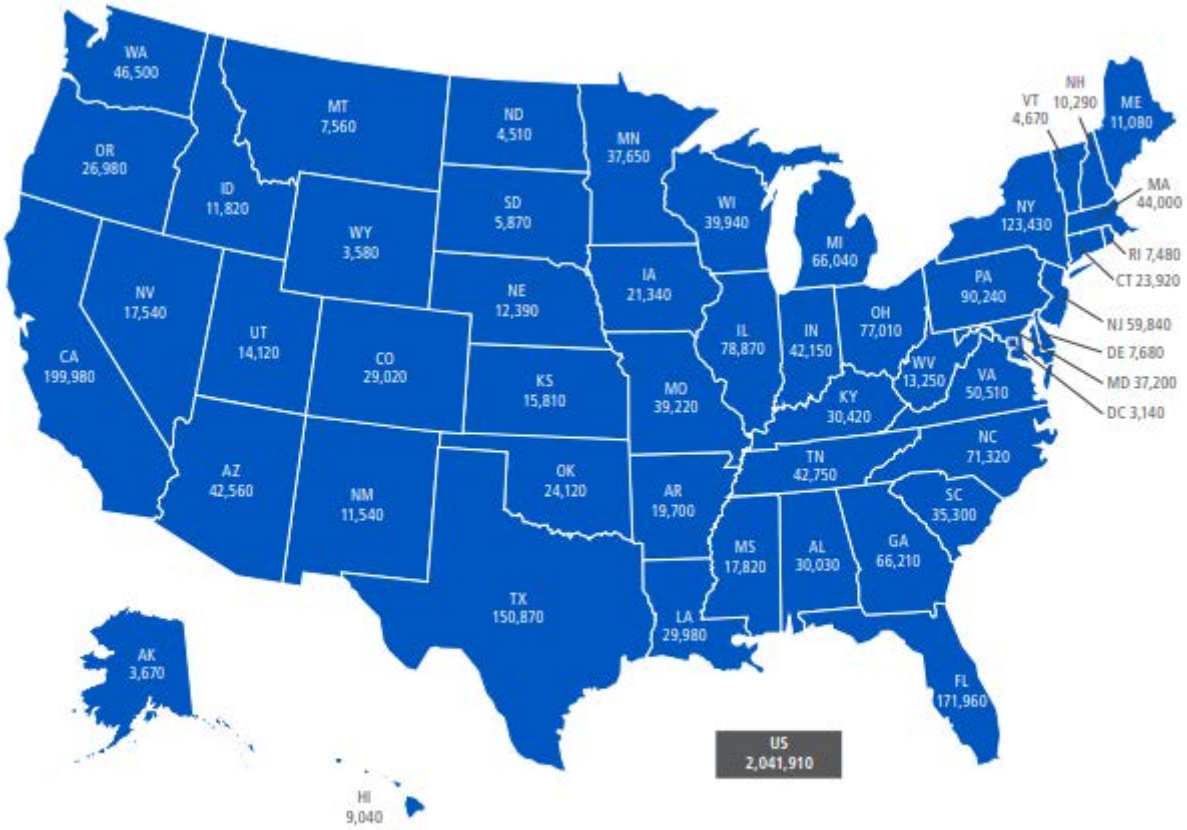
Courtney W. Tomlinson, NP
Hattiesburg Clinic, P.A
HBC Medical Oncology



T'Kylia Moss Powe, PA-C
Hattiesburg Clinic, P.A
HBC Medical Oncology



Estimated Number of New Cases for 2025 – USA



Estimated number of new cancer cases in 2025, excluding basal cell and squamous cell skin cancers and in situ carcinoma except urinary bladder.
Estimates are model-based projections and should be interpreted with caution.

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(Cancer Facts and Figures 2025 Front Page).

Over 2 million new cancer cases are expected to be diagnosed in the US in 2025 (Table 1). This estimate excludes basal cell and squamous cell skin cancers, which are not required to be reported to cancer registries, and carcinoma in situ (noninvasive cancer) except for urinary bladder. Table 2 provides estimated new cancer cases in 2025 by state.

Approximately 618, 000 deaths from cancer are expected in the US in 2025 (Table 1), which is about 1,700 deaths per day. Cancer is the second most common cause of death in the US, exceeded only by heart disease. Table 3 provides estimated cancer deaths by state in 2025.

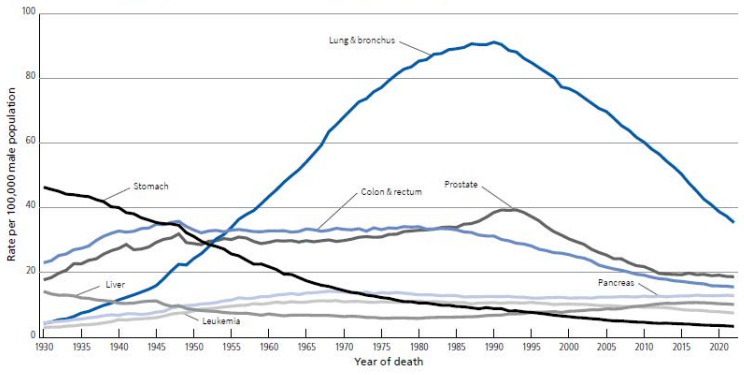
Screening can help prevent colorectal and cervical cancers by detecting and removing pre-cancers in the colon, rectum, and uterine cervix. Screening can also detect these and some other cancers early, when treatment is often less intensive and more successful. Screening is known to reduce mortality for cancers of the breast, colon, rectum, cervix, lung (among people with a history of heavy smoking), and prostate. In addition, being aware of changes in the body (such as a new mole or lump under the skin) and bringing these to the attention of a health care professional can also result in the earlier detection of cancer.

How much progress has been made against cancer?

The best measure of progress against cancer is a reduction in the likelihood of dying from the disease, referred to as the cancer mortality or death rate. This is because mortality rates are less affected by changes in detection practice than incidence (new diagnoses) and survival rates. The overall age-adjusted cancer death rate rose during most of the 20th century because of the smoking epidemic, but has dropped from its peak in 1991 by 33% as a result of reductions in smoking and advances in treatment, as well as early detection for some cancers. This translates to 4.1 million fewer cancer deaths during 1991 through 2021 than would have occurred if the death rate had remained at its peak, and is mostly driven by the four most common cancers – lung, colorectal, breast, and prostate (Figure 1 and Figure 2). Over the past decade (2012-2021), the cancer death rate dropped by 1.6% per year.

In contrast, the cancer incidence rate, the likelihood of developing cancer, increased slowly in women over the past decade largely due to continued increases in breast and uterine corpus (endometrial) cancers and melanoma, offsetting declines in lung and colorectal cancers. In men, incidence rates stabilized in recent years after declining from the mid-2000s until around 2013, largely driven by trends in prostate cancer, which have increased in recent years.

Figure 1. Trends in Age-adjusted Cancer Death Rates by Site, Males, US, 1930-2022



Rates are age adjusted to the 2000 US standard population and exclude deaths in Puerto Rico and other US territories. Due to improvements in classification, site-specific information differs from contemporary data for cancers of the liver, lung and bronchus, and colon and rectum.

Data source: US Mortality Volumes 1930 to 1959, US Mortality Data 1960 to 2022, National Center for Health Statistics, Centers for Disease Control and Prevention.

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Do Cancer Incidence and Death Rates Vary by State?

Variations in cancer rates among states differ by cancer type, with the largest for lung cancer, reflecting vast historical and continuing differences in smoking prevalence. Table 4 and Table 5 provide average annual incidence and death rates for selected cancer types by state.

Who is at Risk of Developing Cancer?

Everyone is at risk of developing cancer, although incidence increases greatly with age; 88% of people diagnosed with cancer in the US are 50 years of age or older, and 57% are 65 or older. Risk is also increased by certain behaviors and other modifiable factors, such as smoking, having excess body weight, drinking alcohol, and eating an unhealthy diet. In the US, an estimated 42 out of 100 men and 40 out of 100 women will develop cancer during their lifetime (Table 6). However, these probabilities are based on cancer occurrence in the general population and may differ in individuals because of variations in lifestyle exposures (e.g., smoking, excess body weight), family history, and/or genetic susceptibility. A family history of cancer is thought primarily to reflect similar lifestyle/environmental exposures, often in combination with inherited genetic variations that confer slight-to-moderate increased risk. Inheritance of genetic alterations that confer a very high risk occurs much less frequently.

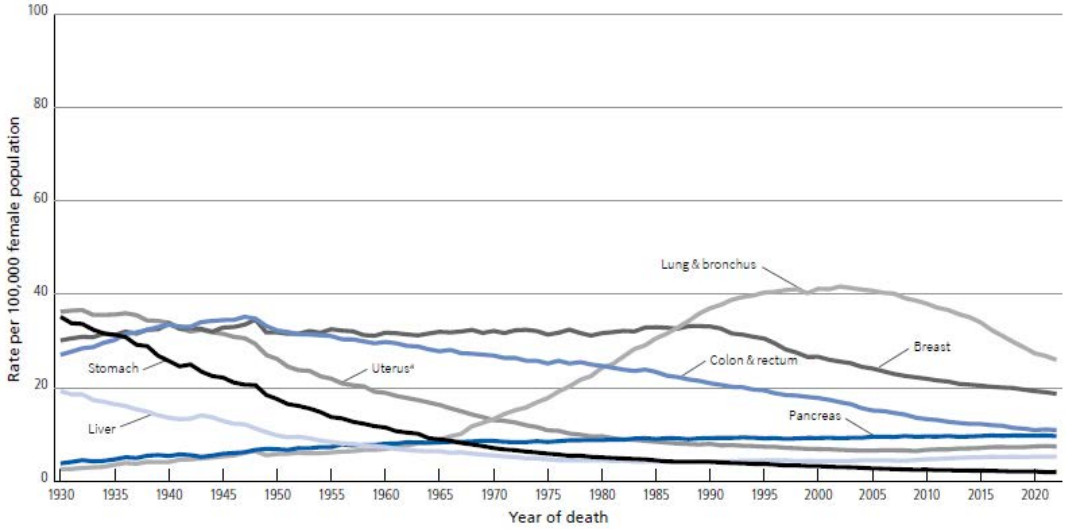
Relative risk is the strength of the relationship between exposure to a given risk factor and cancer. It is measured by comparing the rate of cancer in a group of people with a certain exposure or trait to the rate in a group of people without this characteristic. For example, individuals who smoke cigarettes are about 25 times more likely to develop lung cancer than people who never smoked, so the relative risk of lung cancer among people who smoke is 25. Most relative risks are not this large; for example, the relative risk of breast cancer among women who have a mother, sister, or daughter with a history of breast cancer is about 2. However, if they are common, even exposures associated with a relatively small excess risk can have a large influence on the number of cancers in the population (e.g., excess body weight).

What Percentage of People Survive Cancer?

Cancer survival is typically described in terms of relative survival, which is a measure of life expectancy among cancer patients compared to that among the general population of the same age, race, and sex. The 5-year relative survival rate for all cancers combined has increased substantially since the early 1960s, from 39% to 69% among White people and from 27% to 65% among Black people. Improvements in survival (Table 7) reflect advances in treatment, as well as earlier diagnosis for some cancers. Survival varies greatly by cancer type and stage (Table 8), as well as age at diagnosis.

Relative survival provides some indication about the average experience of cancer patients, but rates should be interpreted with caution for several reasons. First, they do not reflect the most recent advances in detection and treatment because they are based on cancer diagnosis several years in the past to allow time for follow-up (i.e., 2013-2019 for 5-year survival rates presented in this report). Second, they do not account for many factors that influence individual survival, such as access to high-quality cancer treatment, and biological or behavioral characteristics. Third, improvements in survival rates over time do not always indicate progress against cancer; earlier diagnosis through screening increases average survival rates by increasing the time since diagnosis (lead time) but does not always extend life. Similarly, survival rates may be artificially elevated when screening detects cancers that would never have caused harm if left undetected (overdiagnosis).

Figure 2. Trends in Age-adjusted Cancer Death Rates by Site, Females, US, 1930-2022



Rates are age adjusted to the 2000 US standard population and exclude deaths in Puerto Rico and other US territories. Due to improvements in classification, site-specific information differs from contemporary data for cancers of the liver, lung and bronchus, colon and rectum, and uterus. [a]Uterus refers to uterine cervix and uterine corpus combined.

Data source: US Mortality Volumes 1930 to 1959, US Mortality Data 1960 to 2022, National Center for Health Statistics, Centers for Disease Control and Prevention.

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Table 1. Estimated Number of New Cancer Cases and Deaths by Sex, US, 2025

	Estimated New Cases			Estimated Deaths		
	Both sexes	Male	Female	Both sexes	Male	Female
All sites	2,041,910	1,053,250	988,660	618,120	323,900	294,220
Oral cavity & pharynx	59,660	42,500	17,160	12,770	9,130	3,640
Tongue	20,040	14,120	5,920	3,270	2,210	1,060
Mouth	15,730	9,090	6,640	3,360	2,090	1,270
Pharynx	21,640	17,800	3,840	4,590	3,630	960
Other oral cavity	2,250	1,490	760	1,550	1,200	350
Digestive system	362,200	201,190	161,010	174,520	100,250	74,270
Esophagus	22,070	17,430	4,640	16,250	12,940	3,310
Stomach	30,300	17,720	12,580	10,780	6,400	4,380
Small intestine	13,920	7,190	6,730	2,060	1,190	870
Colon & rectum[a]	154,270	82,460	71,810	52,900	28,900	24,000
Colon	107,320	54,510	52,810			
Rectum	46,950	27,950	19,000			
Anus, anal canal, & anorectum	10,930	3,560	7,370	2,030	780	1,250
Liver & intrahepatic bile duct	42,240	28,220	14,020	30,090	19,250	10,840
Gallbladder & other biliary	12,610	6,040	6,570	4,400	1,950	2,450
Pancreas	67,440	34,950	32,490	51,980	27,050	24,930
Other digestive organs	8,420	3,620	4,800	4,030	1,790	2,240
Respiratory system	245,700	124,700	121,000	130,200	68,340	61,860
Larynx	13,020	10,110	2,910	3,910	3,140	770
Lung & bronchus	226,650	110,680	115,970	124,730	64,190	60,540
Other respiratory organs	6,030	3,910	2,120	1,560	1,010	550
Bones & joints	3,770	2,150	1,620	2,190	1,240	950
Soft tissue (including heart)	13,520	7,600	5,920	5,410	2,960	2,450
Skin (excluding basal & squamous)	112,690	65,740	46,950	14,110	9,550	4,560
Melanoma of the skin	104,960	60,550	44,410	8,430	5,470	2,960
Other nonepithelial skin	7,730	5,190	2,540	5,680	4,080	1,600
Breast	319,750	2,800	316,950	42,680	510	42,170
Genital system	444,610	325,690	118,920	71,510	36,880	34,630
Uterine cervix	13,360		13,360	4,320		4,320
Uterine corpus	69,120		69,120	13,860		13,860
Ovary	20,890		20,890	12,730		12,730
Vulva	7,480		7,480	1,770		1,770
Vagina & other genital, female	8,070		8,070	1,950		1,950
Prostate	313,780	313,780		35,770	35,770	
Testis	9,720	9,720		600	600	
Penis & other genital, male	2,190	2,190		510	510	
Urinary system	170,470	120,320	50,150	33,140	22,840	10,300
Urinary bladder	84,870	65,080	19,790	17,420	12,640	4,780
Kidney & renal pelvis	80,980	52,410	28,570	14,510	9,550	4,960
Ureter & other urinary organs	4,620	2,830	1,790	1,210	650	560
Eye & orbit	3,140	1,620	1,520	490	270	220
Brain & other nervous system	24,820	14,040	10,780	18,330	10,170	8,160
Endocrine system	52,140	16,450	35,690	3,440	1,680	1,760
Thyroid	44,020	12,670	31,350	2,290	1,090	1,200
Other endocrine	8,120	3,780	4,340	1,150	590	560
Lymphoma	89,070	49,980	39,090	20,540	11,780	8,760
Hodgkin lymphoma	8,720	4,840	3,880	1,150	720	430
Non-Hodgkin lymphoma	80,350	45,140	35,210	19,390	11,060	8,330
Myeloma	36,110	20,030	16,080	12,030	6,540	5,490
Leukemia	66,890	38,720	28,170	23,540	13,500	10,040
Acute lymphocytic leukemia	6,100	3,450	2,650	1,400	720	680
Chronic lymphocytic leukemia	23,690	14,340	9,350	4,460	2,810	1,650
Acute myeloid leukemia	22,010	12,060	9,950	11,090	6,130	4,960
Chronic myeloid leukemia	9,560	5,610	3,950	1,290	740	550
Other leukemia	5,530	3,260	2,270	5,300	3,100	2,200
Other & unspecified primary sites[b]	37,370	19,720	17,650	53,220	28,260	24,960

Estimates are rounded to the nearest 10; cases exclude basal cell and squamous cell skin cancers and in situ carcinoma except urinary bladder. About 59,080 cases of female breast ductal carcinoma in situ and 107,240 cases of melanoma in situ will be diagnosed in 2025. These are model-based estimates and should be interpreted with caution. [a]Deaths for colon and rectal cancers are combined because a large number of deaths from rectal cancer are misclassified as colon. [b]More deaths than cases may reflect a lack of specificity in recording the underlying cause of death on death certificates and/or an undercount in the case estimate.

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Table 2. Estimated Number of New Cases for Selected Cancers by State, US, 2025

State	All sites	Female breast	Colon & rectum	Leukemia	Lung & bronchus	Melanoma of the skin	Non-Hodgkin lymphoma	Prostate	Urinary bladder	Uterine cervix	Uterine corpus
Alabama	30,030	4,960	2,630	860	4,050	1,470	980	5,440	1,240	230	920
Alaska	3,670	550	350	110	430	90	150	710	170	[a]	110
Arizona	42,560	6,950	3,220	1,440	4,250	3,790	1,700	5,380	2,090	270	1,450
Arkansas	19,700	2,690	1,560	590	2,660	970	690	2,930	780	150	480
California	199,980	32,860	16,050	6,000	16,330	11,140	8,280	29,600	7,220	1,490	7,480
Colorado	29,020	5,250	2,130	1,030	2,520	2,060	1,210	4,400	1,220	190	910
Connecticut	23,920	3,790	1,630	770	2,740	780	990	3,570	1,150	110	860
Delaware	7,680	1,210	500	220	920	410	290	1,460	350	[a]	260
Dist. of Columbia	3,140	580	230	80	330	100	110	380	80	[a]	140
Florida	171,960	23,920	12,330	6,980	18,530	10,290	7,550	26,920	8,070	1,160	5,720
Georgia	66,210	10,180	5,160	1,980	6,810	3,520	2,150	10,360	2,390	460	2,000
Hawaii	9,040	1,510	820	270	880	570	330	1,160	290	60	440
Idaho	11,820	1,820	860	430	1,120	960	500	1,970	580	70	310
Illinois	78,870	12,160	6,110	2,430	9,270	4,220	3,090	12,350	3,220	490	2,780
Indiana	42,150	6,470	3,410	1,330	6,120	2,300	1,600	6,160	1,870	290	1,400
Iowa	21,340	3,010	1,580	810	2,490	1,660	860	3,150	920	120	710
Kansas	15,810	2,620	1,430	510	2,010	670	680	2,520	670	120	550
Kentucky	30,420	4,290	2,580	1,010	4,950	1,590	1,150	4,140	1,270	220	960
Louisiana	29,980	4,230	2,490	890	3,290	1,270	1,030	4,650	1,050	210	780
Maine	11,080	1,520	710	370	1,460	500	440	1,620	610	[a]	340
Maryland	37,200	6,270	2,620	1,090	3,940	1,780	1,380	6,680	1,380	220	1,320
Massachusetts	44,000	7,240	2,770	1,380	5,300	1,370	1,820	6,690	1,870	180	1,600
Michigan	66,040	9,900	4,710	2,100	8,460	3,040	2,590	10,230	2,970	380	2,110
Minnesota	37,650	5,620	2,600	1,300	4,110	2,900	1,590	5,700	1,510	160	1,200
Mississippi	17,820	2,710	1,710	510	2,460	700	590	2,940	710	150	550
Missouri	39,220	6,090	3,010	1,310	5,650	2,070	1,520	5,320	1,600	250	1,230
Montana	7,560	1,080	550	230	750	560	280	1,230	360	[a]	210
Nebraska	12,390	1,790	940	380	1,260	780	460	2,030	490	60	390
Nevada	17,540	2,760	1,480	560	1,800	1,050	670	2,680	800	140	560
New Hampshire	10,290	1,470	640	340	1,330	460	430	1,820	530	[a]	370
New Jersey	59,840	9,290	4,430	2,090	5,420	2,340	2,470	10,740	2,630	360	2,270
New Mexico	11,540	1,850	960	400	940	670	450	1,720	450	90	410
New York	123,430	19,170	8,920	4,020	12,770	4,030	5,100	20,490	5,210	790	4,440
North Carolina	71,320	11,320	4,890	2,270	8,810	3,850	2,550	11,210	2,860	420	2,260
North Dakota	4,510	640	360	160	520	330	190	800	190	[a]	130
Ohio	77,010	11,800	5,760	2,220	9,950	4,440	2,900	10,820	3,450	490	2,620
Oklahoma	24,120	3,460	1,970	790	3,100	1,180	860	2,930	960	190	700
Oregon	26,980	4,440	1,850	800	2,950	1,420	1,070	3,570	1,220	140	950
Pennsylvania	90,240	13,650	6,500	2,900	10,250	3,710	3,540	13,400	4,150	540	3,330
Rhode Island	7,480	1,140	480	270	930	270	300	1,060	350	[a]	260
South Carolina	35,300	5,870	2,640	1,030	4,710	1,850	1,220	6,280	1,460	240	1,110
South Dakota	5,870	830	450	200	630	440	240	950	260	[a]	160
Tennessee	42,750	6,960	3,450	1,300	6,400	1,880	1,560	6,630	1,860	300	1,310
Texas	150,870	23,880	12,710	5,660	14,030	5,700	5,940	21,070	5,160	1,420	5,270
Utah	14,120	2,290	990	540	790	1,700	600	2,700	530	100	510
Vermont	4,670	740	290	150	590	220	200	760	220	[a]	170
Virginia	50,510	8,250	3,670	1,350	6,100	2,410	1,910	9,040	1,970	290	1,750
Washington	46,500	7,680	3,240	1,470	4,860	2,440	1,920	6,730	1,970	280	1,350
West Virginia	13,250	1,690	1,020	410	2,050	530	470	1,620	590	70	500
Wisconsin	39,940	5,920	2,630	1,460	4,320	2,230	1,660	6,500	1,750	170	1,380
Wyoming	3,580	530	270	100	340	230	120	550	170	[a]	100
United States	**2,041,910**	**316,950**	**154,270**	**66,890**	**226,650**	**104,960**	**80,350**	**313,780**	**84,870**	**13,360**	**69,120**

Estimates are rounded to nearest 10. Excludes basal and squamous cell skin cancers and in situ carcinoma except urinary bladder. Estimates for Puerto Rico are unavailable. These are model-based estimates and should be interpreted with caution. State estimates may not sum to US total due to rounding and exclusion of state estimates of fewer than 50 cases. [a]Fewer than 50 cases.

Please note: Estimated cases for additional cancer sites by state can be found in Supplemental Data at cancer.org/statistics or via the Cancer Statistics Center (cancerstatisticscenter.cancer.org).

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Table 3. Estimated Number of Deaths for Selected Cancers by State, US, 2025

State	All sites	Brain/ nervous system	Female breast	Colon & rectum	Leukemia	Liver[a]	Lung & bronchus	Non-Hodgkin lymphoma	Pancreas	Prostate	Uterine corpus
Alabama	10,210	310	720	920	350	530	2,350	270	840	550	180
Alaska	1,120	[b]	70	110	[b]	70	220	[b]	80	70	[b]
Arizona	14,110	410	990	1,250	550	680	2,390	530	1,180	870	290
Arkansas	6,730	190	400	630	220	370	1,680	170	470	370	110
California	60,620	2,040	4,620	5,450	2,350	3,630	9,480	2,080	5,270	4,140	1,440
Colorado	8,620	310	700	750	450	460	1,310	270	730	520	180
Connecticut	6,760	230	420	460	260	330	1,230	220	610	430	150
Delaware	2,590	70	250	180	90	110	510	80	220	160	50
Dist. of Columbia	930	[b]	90	90	[b]	60	150	[b]	70	80	[b]
Florida	49,040	1,440	3,210	3,970	2,010	2,050	10,090	1,490	4,160	2,950	1,040
Georgia	19,090	580	1,420	1,680	690	950	3,680	510	1,520	1,110	400
Hawaii	2,700	50	200	250	90	140	470	90	240	190	70
Idaho	3,380	100	250	290	150	140	580	120	290	220	[b]
Illinois	23,170	680	1,670	2,020	880	1,060	4,880	630	1,900	1,280	570
Indiana	14,080	370	920	1,190	510	490	3,460	440	1,180	770	290
Iowa	6,260	150	380	520	260	260	1,350	220	500	370	130
Kansas	5,680	190	380	500	240	190	1,240	210	450	290	110
Kentucky	10,330	270	650	900	390	470	2,660	320	750	440	180
Louisiana	9,340	240	650	830	320	530	1,990	270	760	460	120
Maine	3,540	100	190	250	120	130	830	110	300	200	80
Maryland	10,780	310	830	950	350	500	2,050	340	920	690	330
Massachusetts	12,390	380	710	820	460	640	2,500	400	1,170	710	310
Michigan	21,530	610	1,350	1,700	810	880	4,860	710	1,880	1,100	500
Minnesota	10,490	330	620	760	440	430	2,060	370	910	660	240
Mississippi	6,740	190	480	640	260	370	1,630	160	470	380	120
Missouri	13,330	370	1,020	1,260	490	630	3,240	420	960	680	260
Montana	2,290	80	140	180	80	120	390	60	190	150	[b]
Nebraska	3,470	120	160	360	150	160	720	120	330	190	80
Nevada	5,450	140	440	520	210	260	940	200	480	380	120
New Hampshire	2,980	110	180	190	100	120	620	100	260	170	70
New Jersey	15,180	440	1,160	1,210	610	700	2,670	460	1,440	780	440
New Mexico	3,900	110	290	340	120	220	600	120	320	260	90
New York	31,190	940	1,920	2,610	1,190	1,400	6,060	950	2,980	1,660	860
North Carolina	20,910	570	1,450	1,670	770	1,020	4,690	600	1,910	1,210	510
North Dakota	1,280	[b]	70	100	60	60	260	[b]	110	70	[b]
Ohio	24,440	580	1,400	1,960	960	910	5,630	780	1,980	1,160	530
Oklahoma	8,710	240	570	780	270	350	2,080	260	590	440	160
Oregon	8,770	280	580	700	340	400	1,700	300	710	580	190
Pennsylvania	27,500	750	1,800	2,160	1,040	1,250	5,820	890	2,270	1,480	680
Rhode Island	2,110	50	120	140	70	130	410	60	150	110	50
South Carolina	11,340	350	790	1,100	420	550	2,430	390	820	640	240
South Dakota	1,790	60	100	140	70	100	390	[b]	150	100	[b]
Tennessee	14,920	410	1,040	1,360	520	700	3,730	440	1,130	790	270
Texas	45,220	1,370	3,330	4,470	1,590	3,050	8,010	1,400	3,710	2,470	1,060
Utah	3,760	170	340	320	180	180	450	130	330	290	90
Vermont	1,500	50	90	130	50	60	300	50	120	100	[b]
Virginia	16,280	500	1,160	1,390	680	800	3,370	480	1,380	1,040	370
Washington	13,870	470	800	1,280	520	700	2,620	490	1,240	920	290
West Virginia	4,750	120	280	420	180	190	1,390	120	340	230	80
Wisconsin	11,760	370	690	840	480	530	2,340	390	1,060	780	280
Wyoming	1,240	[b]	80	170	[b]	50	210	[b]	120	70	[b]
United States	**618,120**	**18,330**	**42,170**	**52,900**	**23,540**	**30,090**	**124,730**	**19,390**	**51,980**	**35,770**	**13,860**

Estimates are rounded to nearest 10. State estimates may not sum to US total due to rounding and exclusion of state estimates of fewer than 50 deaths. Estimates are not available for Puerto Rico. These are model-based estimates and should be interpreted with caution. [a]Includes intrahepatic bile duct. [b]Fewer than 50 deaths.

Please note: Estimated deaths for additional cancer sites by state can be found in Supplemental Data at cancer.org/statistics or via the Cancer Statistics Center (cancerstatisticscenter.cancer.org).

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Table 6. Probability (%) of Developing Invasive Cancer During Selected Age Intervals by Sex, US, 2018-2019, 2021

Site	Sex	Birth to 49	50 to 64	65 to 84	85 and older	Birth to death
All sites[a]	Male	3.4 (1 in 29)	11.3 (1 in 9)	31.3 (1 in 3)	18.7 (1 in 5)	39.9 (1 in 3)
	Female	5.9 (1 in 17)	10.8 (1 in 9)	24.2 (1 in 4)	14.1 (1 in 7)	39.0 (1 in 3)
Breast	Female	2.1 (1 in 47)	4.0 (1 in 25)	7.3 (1 in 14)	2.6 (1 in 38)	13.1 (1 in 8)
Colon & rectum	Male	0.4 (1 in 238)	1.2 (1 in 85)	2.6 (1 in 39)	1.7 (1 in 59)	4.1 (1 in 24)
	Female	0.4 (1 in 255)	0.9 (1 in 117)	2.1 (1 in 47)	1.6 (1 in 62)	3.8 (1 in 26)
Kidney & renal pelvis	Male	0.3 (1 in 390)	0.7 (1 in 146)	1.5 (1 in 68)	0.5 (1 in 183)	2.2 (1 in 45)
	Female	0.2 (1 in 599)	0.3 (1 in 289)	0.8 (1 in 129)	0.3 (1 in 313)	1.3 (1 in 75)
Leukemia	Male	0.3 (1 in 381)	0.3 (1 in 297)	1.2 (1 in 83)	0.8 (1 in 122)	1.8 (1 in 55)
	Female	0.2 (1 in 483)	0.2 (1 in 454)	0.7 (1 in 138)	0.5 (1 in 201)	1.3 (1 in 77)
Lung & bronchus	Male	0.1 (1 in 901)	1.1 (1 in 90)	4.8 (1 in 21)	2.5 (1 in 40)	5.8 (1 in 17)
	Female	0.1 (1 in 783)	1.1 (1 in 93)	4.1 (1 in 24)	1.8 (1 in 54)	5.6 (1 in 18)
Melanoma of the skin[b]	Male	0.4 (1 in 258)	0.8 (1 in 120)	2.3 (1 in 43)	1.4 (1 in 72)	3.5 (1 in 29)
	Female	0.6 (1 in 162)	0.7 (1 in 152)	1.1 (1 in 89)	0.6 (1 in 181)	2.5 (1 in 40)
Non-Hodgkin lymphoma	Male	0.2 (1 in 407)	0.5 (1 in 204)	1.6 (1 in 64)	0.9 (1 in 105)	2.3 (1 in 44)
	Female	0.2 (1 in 534)	0.4 (1 in 265)	1.2 (1 in 87)	0.6 (1 in 158)	1.9 (1 in 54)
Prostate	Male	0.2 (1 in 468)	3.8 (1 in 26)	10.6 (1 in 9)	3.2 (1 in 31)	12.8 (1 in 8)
Thyroid	Male	0.2 (1 in 500)	0.2 (1 in 506)	0.3 (1 in 362)	0.1 (1 in 1,434)	0.6 (1 in 160)
	Female	0.8 (1 in 126)	0.5 (1 in 207)	0.5 (1 in 220)	0.1 (1 in 1,136)	1.7 (1 in 59)
Uterine cervix	Female	0.3 (1 in 340)	0.2 (1 in 564)	0.2 (1 in 580)	0.1 (1 in 1,691)	0.6 (1 in 156)
Uterine corpus	Female	0.3 (1 in 295)	1.1 (1 in 91)	1.7 (1 in 57)	0.4 (1 in 245)	3.1 (1 in 32)

Probability is for those who are free of cancer at the beginning of each age interval. The probability of developing additional cancers and the probability of cancer death can be found in supplemental data at cancer.org/statistics. [a]Excludes basal and squamous cell skin cancers and in situ carcinoma except urinary bladder. [b]Probabilities are for non-Hispanic White individuals only.

Data source: DevCan: Probability of Developing or Dying of Cancer Software, Version 6.9.0. Statistical Research and Applications Branch, National Cancer Institute, 2024. surveillance.cancer.gov/devcan/.

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Table 7. Trends in 5-year Relative Survival Rates (%) by Race, US, 1975-2020

	All races & ethnicities			White			Black		
	1975-77	1995-97	2014-20	1975-77	1995-97	2014-20	1975-77	1995-97	2014-20
All sites	49	63	69	50	64	70	39	54	65
Brain & other nervous system	23	32	33	22	31	30	25	39	37
Breast (female)	75	87	91	76	89	93	62	75	84
Colon & rectum[a]	50	61	64	50	62	65	45	54	59
Colon[a]	51	61	63	51	62	64	45	54	57
Rectum	48	62	67	48	62	67	44	55	65
Esophagus	5	13	22	6	14	22	4	9	16
Hodgkin lymphoma	72	84	89	72	85	90	70	82	88
Kidney & renal pelvis	50	62	78	50	62	78	49	62	77
Larynx	66	66	62	67	68	63	58	52	55
Leukemia	34	48	67	35	50	68	33	42	61
Liver & intrahepatic bile duct	3	7	22	3	7	21	2	4	20
Lung & bronchus	12	15	27	12	15	27	11	13	24
Melanoma of the skin	82	91	94	82	91	94	57[b]	76[b]	70
Myeloma	25	32	61	24	32	61	29	32	62
Non-Hodgkin lymphoma	47	56	74	47	57	76	49	49	70
Oral cavity & pharynx	53	58	69	54	60	71	36	38	57
Ovary	36	43	51	35	43	50	42	36	43
Pancreas	3	4	13	3	4	13	2	4	11
Prostate	68	97	97	69	97	98	61	94	97
Stomach	15	22	36	14	20	37	16	22	38
Testis	83	96	95	83	96	96	73[b,c]	86[b,c]	89
Thyroid	92	95	98	92	96	99	90	95	97
Urinary bladder	72	80	78	73	81	79	50	63	66
Uterine cervix	69	73	67	70	74	68	65	66	58
Uterine corpus	87	84	81	88	86	84	60	62	63

Rates are age adjusted for normal life expectancy and based on cases diagnosed in the SEER 9 areas for 1975-1977 and 1995-1997 and SEER 22 areas, excluding Illinois and Massachusetts, for 2014-2020; all cases were followed through 2021. Rates for White and Black patients diagnosed during 2014-2020 are exclusive of Hispanic ethnicity. [a]Excludes appendix. [b]The standard error is between 5 and 10 percentage points. [c]Survival rate is for cases diagnosed from 1978 to 1980.

Data source: Surveillance, Epidemiology, and End Results (SEER) Program, National Cancer Institute, 2024.

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Table 8. Five-year Relative Survival Rates (%) by Stage at Diagnosis, 2014-2020

	All stages	Local	Regional	Distant		All stages	Local	Regional	Distant
Breast (female)	91	>99	87	32	Non-Hodgkin lymphoma	74	86	78	67
Colon & rectum[a]	64	91	73	15	Oral cavity & pharynx	69	87	69	38
Colon[a]	63	91	73	13	Ovary	51	92	72	31
Rectum	67	90	74	18	Pancreas	13	44	16	3
Esophagus	22	48	28	5	Prostate	97	>99	>99	37
Kidney & renal pelvis	78	93	75	18	Stomach	36	75	36	7
Larynx	62	79	48	34	Thyroid	98	>99	98	52
Liver[b]	22	37	13	3	Urinary bladder[c]	78	72	40	9
Lung & bronchus	27	64	36	9	Uterine cervix	67	91	61	19
Melanoma of the skin	94	>99	75	35	Uterine corpus	81	95	70	19

Rates are adjusted for normal life expectancy based on cases diagnosed in the SEER 22 areas, excluding Illinois and Massachusetts, from 2014-2020, all cases followed through 2021. [a]Excludes appendix. [b]Includes intrahepatic bile duct. [c]Rate for in situ carcinoma is 97%. Stage classification based on Combined Summary Stage. **Local:** invasive cancer confined entirely to the organ of origin. **Regional:** cancer that 1) has extended beyond the limits of the organ of origin directly into surrounding organs or tissues; 2) involves regional lymph nodes; or 3) has both regional extension and involvement of regional lymph nodes. **Distant:** cancer has spread to body parts remote from the primary tumor either by direct extension or by discontinuous metastasis to distant organs, tissues, or via the lymphatic system to distant lymph nodes.

Data source: Surveillance, Epidemiology, and End Results (SEER) Program, National Cancer Institute, 2024.

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The costs of cancer are estimated in several ways, including direct medical costs (total of all health care expenditures), as well as indirect costs, such as lost earnings due to missed work from illness or premature death. The National Cancer Institute estimated that cancer-related medical costs in the US were $208.9 billion in 2020, which is likely an underestimate because it does not account for the growing cost of treatment; for example, the list price for many prescription medicines is now more than $100,000 annually. Cancer related costs to patients are estimated at $21.1 billion, including $16.2 billion in total out-of-pocket costs and $4.9 billion in patient time costs (travel to/from treatment and waiting for and receiving care).

Lack of health insurance coverage is strongly associated with medical financial hardship and prevents many people from receiving optimal cancer care across the continuum, from prevention to early detection and treatment. Despite gains in health insurance coverage following the implementation of the Affordable Care Act (ACA), 17% of adults under 65 years of age were uninsured for at least part of 2022 based on National Health Interview Survey estimates, with the highest prevalence among Hispanic (34%), Native Hawaiian or other Pacific Islander (31%), American Indian or Alaska Native (29%), and Black (19%) individuals. Uninsured individuals and those from other marginalized populations are much more likely to be diagnosed with cancer at a late stage, when treatment is often more involved, costlier, and less successful. Importantly, medical financial hardship and lost income due to cancer diagnosis, treatment, and recovery are not limited to those without health insurance. Many insured individuals, especially those who are younger and/or low-income, report difficulty paying medical bills, anxiety about treatment cost, and delayed or forgone medical care due to cost.

Readmissions Receiving Outpatient Chemotherapy (ED/IP)

Data Review Date Range: May – July 2024

Manual Review of each case with chemotherapy in EPIC

16% Readmissions Receiving OP Chemotherapy – May – July 2024

Readmissions Receiving OP Chemotherapy = 20 patients

Total patients between May – July 2024 for Manual Review = 127

Updated (4/22/25) The national average for hospital readmissions is 20%. We are below the national average with 16%. Our previous QI rate (year-2016) for Readmissions for chemotherapy patients was 4%.

The last time we were prompted to perform a quality improvement review for this measure was in 2016. We have not reviewed this measure in the past 10 years.

Regarding the cases reviewed from 2024, it is a similar total number of patients. The patients from the 2024 review had several comorbidities. This is the possible reason for more readmissions than in 2016.

For oncology admissions, the national rate is 20.2%. Cancer patients have a higher ratio than the general population.

FGH Breast Cancer
2020-2024
Recurrence, Treatment and Follow-Care

Breast Cancer Follow-up, Recurrence and Survivorship
Recommended Personalized Care for Triple-Negative Breast Patients
Breast Study 2025
Treatment and Follow-up Care

Breast Cancer Triple Negative only
2020-2024 Analytical/Nonanalytical cases
N: 169 patients

Introduction

Triple-negative breast (TNBC) is a type of breast cancer that tests negative for three key receptors: Estrogen receptor (ER), Progesterone receptor (PR), and Human epidermal growth factor receptor 2 (HER2). Aggressive and fast growing, more common in younger women (under 50). The subtype disproportionately affects BRCA1 mutation carriers and young women of African origin. There are worse clinical outcomes in this patient population yet, it is unclear whether survival differences persist after adjusting for disparities in access to health-care treatment, co-morbid disease, and income.

The treatment of TNBC includes surgery (lumpectomy or mastectomy with sentinel lymph sampling), chemotherapy, radiation therapy, targeted therapies, and immunotherapy. The prognosis depends on factors such as stage, age and treatment response, generally poorer prognosis than other types of breast cancer, and with early detection and aggressive treatment, the Five-Year Survival rate can be over 80%. TNBC is more likely to spread to other organs, such as the brain, lungs, and liver. Patient with TNBC should strongly consider genetic counseling to assess their risk and family history.

There is no national imaging standard specifically for triple-negative breast cancer (TNBC) that is different than the current follow-up imaging for other subtypes of breast cancers. The American Society of Clinical Oncology (ASCO) and the National Comprehensive Cancer Network (NCCN) do not recommend routine, asymptomatic surveillance imaging (e.g., bone scans, PET/CT) because it does not improve survival and only increases costs is the standard for patient care.

The current standard for imaging is annual mammograms (patient who had lumpectomy should exam of both breasts, and mastectomy should have exam of remaining breast), timing for the first follow-up mammogram is typically performed about 6-12 months after surgery or 6 months after the completion of radiation therapy. A Breast MRI is not routinely recommended for all survivors but may be used in certain situations: 1) Patients with a high risk of recurrence, such as those with BRCA mutations and TNBC, 2) Some institutions may perform a baseline MRI one year after surgery to coincide with the annual mammogram for comparison of post treatment, 3) The MRI can be used to assess treatment response during or after neoadjuvant chemotherapy.

Follow-up Care Plan (Survivorship)
The overall follow-up schedule is guided by regular clinical evaluations, as the risk of metastatic recurrence is highest in the first five years for TNBC:

1) First 1-2 years: Visit every 3 to 6 months
2) Years 3-5: Visits every 6 to 12 months
3) After 5 years: Annual visits

Imaging for symptomatic patients
If a patient reports symptoms suggesting a metastatic recurrence, the physician may order specific imaging or lab tests for TNBC. The key is that this screening is done in response to symptoms and patient care standards. A personalized approach is recommended for follow-up visits, imaging, tests, recurrence testing, risk factors, and treatment history. The awareness of symptoms or physical changes should be educated to the patients, and clinicians to assist in indicating a recurrence or physical changes is crucial for early detection. The patient can take an active control of their health in the risk reduction for recurrence and metastatic surveillance through regular exercise, a healthy diet, maintaining a healthy weight, and regular follow-up medical visits.

Methods

METRIQ (Elekta Cancer Registry Database) Data from 2020-2024 Analytical and Non-Analytical cases and EPIC (EMR) Chart Review for Treatment, Recurrence, Physicians, Follow-up Care and Survivorship Care.

Follow-up Visits and Care



<u>73% of patients had the follow-up visits and care</u>
Patient seen for follow-up visits for breast primary: 123 (73%)

Follow-up Imaging Performed Percentage
and the Percentage of Patients Due for Imaging

<u>60% of patients had follow-up imaging performed</u>
<u>40% of patients needed follow-up imaging performed</u>
Follow-up Imaging Performed (ex. Every 3, 6, or 12 months): 102 (60%)
67 patients needed imaging

Radiation Oncology
Patients seen by Radiation Oncology Physician: 90 (53%)



Medical Oncology and Other Physicians
Patients seen by Other Physician: 148 (88%)

Radiation Therapy Received
Patients received Radiation Therapy: 86 (51%)

Recurrence of Disease

Recurrence: 16 (10%)

Diagnosis to Recurrence (Months): **25 months**

(Average = 25.56, Maximum = 63, Minimum = 0)

Expired

Number of patients expired: 25% (reported as of 7/9/25) – 43 patients

Diagnosis to Expiration (Months): Average **18 months**

(Average = 18.04 months, Maximum = 59, Minimum = 0)

Current Patient Care
Standards for Triple-Negative
Breast Cancer (TNBC)

MRI Brain, Bone density & scans

- First 3 years after treatment: Follow-up visits every 3 to 6 months.
- Years 4 and 5 after treatment: Follow-up visits every 6 to 12 months.
- Six years or more after treatment: Follow-up visits once a year.

Imaging recommendations

- Mammography: Annual mammography is recommended for patients who still have breast tissue after treatment.
- MRI: May be used as an additional screening tool, especially for patients with dense breasts or those at high risk of developing a new breast cancer.
- Consider MRI or ultrasound: If there's a contraindication to MRI (e.g., claustrophobia or limited access), bilateral ultrasound or contrast-enhanced mammography (CEM) may be considered.
- Further diagnostic work-up: Based on clinical examination and imaging, including bilateral mammography and ultrasound of both breasts and regional lymph nodes, especially in symptomatic settings.

Important considerations

- Routine testing for asymptomatic metastases: Current guidelines generally do not recommend routine imaging tests (like CT scans, bone scans, or PET scans) to detect asymptomatic metastases in patients who have been treated with curative intent, according to the National Institutes of Health (NIH).
- Symptoms warrant further investigation: If a patient experiences new or persistent symptoms (such as new lumps, skin changes, or bone pain), they should promptly report them to their doctor, and appropriate targeted imaging should be performed immediately.
- Individualized approach: The follow-up plan should be personalized based on individual factors like the patient's age, tumor characteristics, and treatment history.
- Survivorship Care Plan: It is recommended to create a comprehensive survivorship care plan that includes information about potential long-term side effects, screening and prevention recommendations, emotional and financial issues, and support resources.
- Clinical examination and patient history: A thorough clinical exam, including history-taking and palpation of the breast and regional lymph nodes, is crucial in detecting local recurrence.

Forrest General Hospital – Cancer Program
Performance Improvement
Standard 7.2

Study Topic: Adherence to National Comprehensive Cancer Network (NCCN) Guidelines for Lung Cancer
Objective: To ensure patient treatment plans meet NCCN Guidelines.
Measurement: Random sample of 30% of analytic Lung cancer cases. (1/1/2025 to 3/31/2025)
Method: Retrospective chart review. A total of **17** cases were reviewed.
Results:

Checklist	Met	Total	Percent
Bronchoscopy	13	13	76%
Pathology Review	16	16	94%
H&P (include performance status & weight loss	Performance status- 17 Weight loss-2	17 2	100% 12%
Chest X-ray	7	7	41%
Ct Chest & upper Abdomen including adrenals	17	17	100%
CBC, Platelets	17	17	100%
Smoking cessation counseling	8	8	47%
PET Scan	8	8	47%
MRI Head (small cell ca)	9	9	53%

Conclusions: Retrospective chart review revealed the following:

The raw date was analyzed and found that patients for the period of January 1, 2025 to March 31, 2025 revealed that the majority of lung patients had a performance status at the time of their H/P and consult, and a CBC was performed. In the H/P or consult, only 12% of patients showed that they had weight loss shortly before their diagnosis of lung cancer.

For a CT guided biopsy or biopsy at bronchoscopy, 94% of lung patients receive this procedure.

For clinical analysis of the patients, the majority had a CT Chest, and the Chest X-ray was performed about a third of the time. 53% of the patients had a MRI Head or Brain scan performed. Most of the patients received a PET scan in their initial plan of care.

For smoking cessation, eight of the seventeen (47%) patients were still smoking and these patients received counseling by their physician. In the analysis, we did not track how many of the patients still smoking who did not receive smoking cessation counseling specifically.

Recommendations/Actions:

The physicians could do better at observing weight loss if there was any patients presenting with the symptoms. For patients that smoke, as the CoC Standard states the physicians must perform smoking cessation counseling and referral for assistance in their visit with the patient. These NCCN Guidelines must be implemented in the patients documentation. After this final analysis, we will review again in 2026 to find out if the documentation and counseling has improved. The Standard 5.9 Smoking Cessation and Counseling and Education is required January 1, 2026 and forward. The standard information is listed in the cancer committee agenda and the minutes.

Quality Improvements

Quality Improvement 2025

Goal Description Year (yyyy): 2025	
Title of goal	Readmissions to Hospital for Chemotherapy Patients
Specifics (describe goal)	The specific number of Readmissions Receiving Outpatient Chemotherapy (ED/IP), below the national average. Decrease the number of Readmissions to Hospital for Chemotherapy Patients (comparison with national rates).
Measurable (how will you measure goal for completion)	Data Review Date Range: May – July 2024 Manual Review of each case with chemotherapy in EPIC. EPIC – EMR Admission/Discharge Notes, Physicians
Achievable (how you will attain goal)	The specific number of Readmissions Receiving Outpatient Chemotherapy (ED/IP) below the national average of readmissions of 20%.
Realistic (how it is relevant, what results can realistically be achieved)	There may be barriers to access to patient information available in the EMR.
Timely (when the results can be achieved)	Yes, it is achievable in one year.

Goal Status		
Date goal was established by cancer committee (mm/dd/yy)	06/17/25	
Date of first evaluation (mm/dd/yy)	09/16/25	
Status of goal (includes progress, road blocks, or next steps)	The Statistical Data Reviewed at our DNV and Readmission Chemotherapy Group meeting. Findings: 16% Readmissions Receiving OP Chemotherapy – May – July 2024 Readmissions Receiving OP Chemotherapy = 20 patients Total patients between May – July 2024 for Manual Review = 127. The national average for hospital readmissions is 20%. We are below the national average with 16%. Our previous QI rate (year-2016) for Readmissions for chemotherapy patients was 4%. The last time we were prompted to perform a quality improvement review for this measure was in 2016. We have not reviewed this measure in the past 10 years. Regarding the cases reviewed from 2024, it is a similar	
Date of second evaluation (mm/dd/yy)	12/16/25	
Status of goal (includes progress, road blocks, or next steps)	EPIC built an automated report that allows us to run the readmission data without any manual review. I have been working with Hunter Simmons, Performance Improvement and Public Reports Data Manager, to access the report and streamline opportunities for improvement. Additionally, we created a virtual blood infusion center where providers can call one centralized number to direct patients to the closest Regional Hospital to their home for outpatient blood infusions—avoiding unnecessary ER utilization for these visits. This initiative aligns well with the goal of reducing readmissions and improving patient throughput.	
Was goal completed within the initial calendar year? (Y/N)	Y	

IRB Study

FGH IRB Study 2024

Journey of Care
Patient Survey
N: 17

1. How were you referred to the Cancer Center?
   ☐ Physician (12) ☐ Hospital (5) ☐ Clinic ☐ Nurse ☐ Social Worker ☐ Other _____

	Poor	Fair	Good	Very Good	Excellent	Not Applicable
2. How promptly were you registered for your visits?						
Surgeon Office Visit(s)	1(0)	2(0)	3(1)	4(2)	5(12)	☐(2)
Medical Oncology Office Visit(s)	1(0)	2(0)	3(1)	4(3)	5(11)	☐(1)
Radiation Oncology Office Visit(s)	1(0)	2(0)	3(1)	4(4)	5((13)	☐(0)
Other_____	1(0)	2(0)	3(0)	4(2)	5(5)	☐(1)
3. The courteousness and helpfulness of the staff?						
Surgeon Office Visit(s)	1(0)	2(0)	3(0)	4(3)	5(13)	☐(1)
Medical Oncology Office Visit(s)	1(0)	2(0)	3(0)	4(3)	5(12)	☐(1)
Radiation Oncology Office Visit(s)	1(0)	2(0)	3(0)	4(4)	5(13)	☐(0)
Other_____	1(0)	2(0)	3(0)	4(2)	5(6)	☐(1)
Forrest General Hospital Laboratory						
4. How promptly your blood was drawn?	1(0)	2(0)	3(1)	4(1)	5(16)	☐(0)
5. How skillfully and painlessly your blood was drawn?	1(0)	2(0)	3(2)	4(2)	5(13)	☐(1)
Hattiesburg Clinic Laboratory						
6. How promptly your blood was drawn?	1(0)	2(0)	3(1)	4(4)	5(13)	☐(0)
7. How skillfully and painlessly your blood was drawn?	1(0)	2(0)	3(2)	4(3)	5(13)	☐(0)
Forrest General Hospital Radiology						
8. How conveniently your x-rays were scheduled?	1(0)	2(0)	3(1)	4(5)	5(10)	☐(2)
9. How promptly your x-rays were performed?	1(0)	2(0)	3(1)	4(5)	5(10)	☐(2)
10. The courteousness of the x-ray staff?	1(0)	2(0)	3(0)	4(5)	5(11)	☐(2)
11. The skill of the x-ray staff?	1(0)	2(0)	3(0)	4(5)	5(11)	☐(2)
Hattiesburg Clinic Radiology						
12. How conveniently your x-rays were scheduled?	1(0)	2(0)	3(1)	4(4)	5(10)	☐(2)
13. How promptly your x-rays were performed?	1(0)	2(0)	3(1)	4(3)	5(11)	☐(3)
14. The courteousness of the x-ray staff?	1(0)	2(0)	3(1)	4(2)	5(12)	☐(3)
15. The skill of the x-ray staff?	1(0)	2(0)	3(1)	4(2)	5(12)	☐(2)
Doctor Visits						
16. How promptly you were scheduled for visits with your doctors?						
Surgeon	1(0)	2(0)	3(1)	4(2)	5(12)	☐(1)
Medical Oncology	1(0)	2(0)	3(1)	4(2)	5(12)	☐(1)
Radiation Oncology	1(0)	2(0)	3(1)	4(3)	5(11)	☐(3)
Other_____	1(0)	2(0)	3(1)	4(1)	5(5)	☐(3)

17. The knowledge and skill of the doctors?

Surgeon	1(0)	2(0)	3(0)	4(1)	5(14)	□(1)
Medical Oncology	1(0)	2(0)	3(0)	4(1)	5(13)	□(2)
Radiation Oncology	1(0)	2(0)	3(0)	4(1)	5(15)	□(1)
Other_____	1(0)	2(0)	3(0)	4(0)	5(5)	□(3)

18. The courteousness of the doctors?

Surgeon	1(0)	2(0)	3(0)	4(3)	5(12)	□(1)
Medical Oncology	1(0)	2(0)	3(0)	4(2)	5(11)	□(2)
Radiation Oncology	1(0)	2(0)	3(0)	4(3)	5(14)	□(0)
Other_____	1(0)	2(0)	3(0)	4(2)	5(5)	□(4)

	Poor	Fair	Good	Very Good	Excellent	Not Applicable

19. The sensitivity of the doctors?

Surgeon	1(0)	2(0)	3(1)	4(3)	5(12)	□(1)
Medical Oncology	1(0)	2(0)	3(1)	4(2)	5(12)	□(2)
Radiation Oncology	1(0)	2(0)	3(1)	4(3)	5(13)	□(1)
Other_____	1(0)	2(0)	3(1)	4(2)	5(4)	□(3)

Care Related

20. How quickly and without delay was your diagnosis made? 1(0) 2(0) 3(2) 4(4) 5(12) □(0)
21. How fully and clearly you were informed about your diagnosis? 1(0) 2(0) 3(1) 4(4) 5(13) □(0)

Surgery

If you had surgery, please answer the questions below:
If you did not have surgery, go to question #35

22. How complete the information was about the different types of surgery? 1(0) 2(0) 3(1) 4(1) 5(12) □(0)
23. How complete the information was about the possible benefits or harm from the surgery? 1(0) 2(0) 3(1) 4(3) 5(10) □(0)
24. Your participation in the decision about the surgery was better for you? 1(0) 2(0) 3(1) 4(2) 5(11) □(0)
25. Your participation in the decision to have your surgery as an outpatient (if you did)? 1(0) 2(0) 3(1) 4(1) 5(10) □(1)
26. Were you comfortable with the guidance your doctor gave you about the surgery you could have? 1(0) 2(0) 3(1) 4(2) 5(11) □(0)
27. How promptly your surgery was performed? 1(0) 2(0) 3(1) 4(3) 5(11) □(0)
28. The preparation before the operation for how you would feel afterward? 1(0) 2(0) 3(3) 4(2) 5(10) □(0)
29. The handling of concerns you had after surgery? 1(0) 2(0) 3(1) 4(2) 5(10) □(0)
30. The competence and skill of the doctors and staff who took care of you? 1(0) 2(0) 3(0) 4(2) 5(12) □(0)
31. The surgical care you received overall? 1(0) 2(0) 3(0) 4(2) 5(12) □(0)

After Surgery

32. Did you receive home health after your surgery?
    □ Yes □ No (if no, skip to question #35)
33. How skilled were the home health nurse(s)? 1(0) 2(0) 3(2) 4(1) 5(3) □(1)
34. How sensitive to your needs were the home health nurse(s)? 1(0) 2(0) 3(1) 4(2) 5(3) □(1)

Radiation Therapy

35. Did you receive radiation therapy?
    □ Yes (10) □ No (if no, skip to question #44) (6)
    If yes, where was the radiation therapy performed? Cancer Center (4)

36. How fully informed you were about the potential benefits and harm of radiation therapy(RT)?	1(0)	2(0)	3(1)	4(2)	5(6)	□(0)
37. Your participation in the decision to receive RT?	1(0)	2(0)	3(0)	4(2)	5(7)	□(0)
38. How long you had to wait for your individual radiation treatments?	1(0)	2(0)	3(1)	4(4)	5(5)	□(0)
39. The skill of the radiation therapy technicians?	1(0)	2(0)	3(1)	4(0)	5(9)	□(0)
40. The courtesy of the radiation therapy technicians and doctors?	1(0)	2(0)	3(1)	4(0)	5(8)	□(0)
41. How promptly any concerns you had with radiation therapy were handled?	1(0)	2(0)	3(1)	4(0)	5(8)	□(0)
42. How carefully any concerns you had with radiation therapy were handled?	1(0)	2(0)	3(1)	4(0)	5(8)	□(1)
43. The radiation therapy you received overall?	1(0)	2(0)	3(1)	4(0)	5(9)	□(0)

Systemic Therapy (Chemotherapy, Hormone Therapy)

44. Did you receive chemotherapy?
    □ Yes (3) □ No (if no, skip to question #53) (10)
    If yes, where was the chemotherapy performed? Cancer Center

	Poor	Fair	Good	Very Good	Excellent	Not Applicable
45. How fully informed you were about the potential benefits and harm of chemotherapy?	1(0)	2(0)	3(1)	4(0)	5(5)	□(0)
46. Your participation in the decision-making about whether you should receive chemotherapy?	1(0)	2(0)	3(1)	4(1)	5(4)	□(0)
47. How long you had to wait for your chemotherapy treatments?	1(0)	2(0)	3 (1)	4(1)	5(4)	□(0)
48. The skill of the nurses and doctors who administered your chemotherapy?	1(0)	2(0)	3(1)	4(0)	5(5)	□(0)
49. The courteousness of the nurses who administered your therapy?	1(0)	2(0)	3(1)	4(0)	5(5)	□(0)
50. How promptly any concerns you had with chemotherapy were handled?	1(0)	2(0)	3(1)	4(0)	5(5)	□(0)
51. How carefully any concerns you had With chemotherapy were handled?	1(0)	2(0)	3(1)	4(0)	5(3)	□(0)
52. The chemotherapy you received overall?	1(0)	2(0)	3(1)	4(0)	5(4)	□(0)

53. Did you receive hormonal therapy?
    □ Yes (2) □ No (if no, skip to question #56) (8)

54. How fully informed you were about the potential benefits and harm of hormonal therapy?	1(0)	2(0)	3(1)	4(1)	5(3)	□(0)
55. Your participation in the decision about whether you should receive hormonal therapy?	1(0)	2(0)	3(1)	4(1)	5(3)	□(0)

Support Services/Education/Financial and Transportation Resources

56. How well informed you were about the psychological and social problems caused by cancer and its treatment?	1(0)	2(2)	3(1)	4(2)	5(6)	□(4)
57. How well informed you were about services at the facility and in the community for dealing with the psychological and social problems?	1(1)	2(1)	3(1)	4(1)	5(5)	□(4)

58. Have you attended any support group meetings?
    □ Yes (0) □ No (15)
    If yes, how helpful was it?_____
59. Did you talk with a social worker
    for assistance or support during your treatment?
    □ Yes (1) □ No (12)
    If yes, how helpful was it?_____
60. Did you talk with a cancer survivor where you were treated?
    □ Yes (2) □ No (12)
    If yes, how helpful was it?_____
61. How well prepared you were for any concerns
    you had after your treatment was completed? 1(0) 2(3) 3(3) 4(6) 5(4) □(1)
62. How promptly and how thoroughly any concerns
    you have had after treatment have been handled? 1(0) 2(2) 3(3) 4(4) 5(7) □(1)
63. How educated you were about your cancer and
    its treatment (this includes all sources of education
    available at the site where you received your cancer
    treatment; i.e., staff, books, pamphlets,
    audiovisual materials)? 1(3) 2(0) 3(2) 4(5) 5(6) □(1)
64. How well were your health insurance/financial
    concerns fulfilled? 1(1) 2(0) 3(3) 4(4) 5(8) □(0)

65. Did you have any health insurance/financial
    concerns not fulfilled: □ Yes (6) No (11) (If Yes, please check all that apply)
    □ Inadequate or lack of insurance coverage (2) (If No, please go to question #66)
    □ Pre-certification problems (1)
    □ Difficulty paying bills (2)
    □ Need for financial assistance from Medicaid/Medicare (2)
    □ Confusing financial paperwork (3)
    □ Need for prescription assistance (1)
    □ Need for medical equipment or supplies (wheelchairs, dressings) (0)
    □ Other:_____ (0)

66. Did you have any concerns with transportation
    to and from treatment? □ Yes (2) □ No (16) (If Yes, please check all that apply)
    □ Public transportation needed (0) (If No, please go to question #67)
    □ Private transportation needed (2)
    □ Ambulance (independent ambulance transportation) services (0)
    □ Other:_____ (0)

67. Did you have any physical needs? □ Yes (2) □ No (16) (If Yes, please check all that apply)
    □ Child/elder care (0) (If No, please go to question #68)
    □ Housing/housing problems (2)
    □ Food, clothing, other physical needs (0)
    □ Prostheses, wigs, etc. (0)
    □ Vocational support (job skills, employment skills) (0)
    □ Extended care needs: home care, hospice, long-term care (0)
    □ Other:_____ (0)

68. Did you have any communication/cultural needs? □ Yes (0) □ No (16) (If Yes, please check all that apply)
    □ Primary language other than English (0) (If No, please go to question #69)
    □ Inability to read/write (0)
    □ Poor health literacy (0)
    □ Cultural barriers (i.e., effect on lifestyle choices) (0)
    □ Other:_____ (0)

69. Did you have any treatment/care management concerns? □ Yes (2) □ No (16) (If Yes, please check all that apply)
    □ Treatment compliance issues (0) (If No, please go to question #70)
    □ Help with obtaining a second opinion (if desired) (0)
    □ Mental health services needed (0)
    □ Better understanding treatment plan and/or procedures (1)
    □ Other:_____ (0)

70. What concerns kept you from getting to all of your appointments that is not listed above (for example, child care or transportation needs, job responsibilities, or finances)? _____
    _____.

71. Were you offered referral to supportive services? □ Yes (5) □ No (12) (If Yes, please check all that apply)
    □ Social Workers (1) (If No, please go to question #72)
    □ Clergy (0)
    □ Nutritionists (1)
    □ Genetic counselors (0)
    □ Financial counselors (1)
    □ Physical, occupational, and speech therapists (0)
    □ Psychologists (0)
    □ Board-certified psychiatrists specializing in hospice/palliative medicine (0)

72. Did you have concerns regarding a support system at home? □ Yes (3) □ No (14) (If Yes, please explain on the back of page). Note: one patient listed that lived alone and unable to do daily household duties.

American Cancer Society

American Cancer Society Recommendations for the Early Detection of Cancer in Average-risk Asymptomatic People[a]

Cancer Site	Population	Test or Procedure	Recommendation
Breast	Women, ages 40-54	Mammography	Women should have the opportunity to begin annual screening between the ages of 40 and 44. Women should undergo regular screening mammography starting at age 45. Women ages 45 to 54 should be screened annually.
	Women, ages 55+		Transition to biennial screening, or have the opportunity to continue annual screening. Continue screening as long as overall health is good and life expectancy is 10+ years.
Cervix	Women, ages 25-65	Primary HPV DNA test, **OR**	**Preferred:** every 5 years with an FDA-approved primary test
		Pap & HPV DNA co-testing, **OR**	Every 5 years
		Pap test alone	Every 3 years
	Women, ages >65		Discontinue screening if results from regular screening in the past 10 years were negative, with the most recent test within the past 5 years.
	Women vaccinated against HPV		Follow age-specific screening recommendations (same as unvaccinated individuals).
	Women with total hysterectomy		Women and individuals without a cervix and without a history of cervical cancer or a history of CIN2 or a more severe diagnosis in the past 25 years should not be screened.
Colorectal[b]	Adults, ages 45+	High-sensitivity guaiac-based fecal occult blood test (gFOBT) or fecal immunochemical test (FIT), **OR**	Every year
		Multi-target stool DNA test, **OR**	Every 3 years
		Flexible sigmoidoscopy, **OR**	Every 5 years alone or combined with a high-sensitivity gFOBT or FIT annually
		Colonoscopy, **OR**	Every 10 years
		CT Colonography	Every 5 years
Endometrial	Women at menopause		Women should be informed about risks and symptoms of endometrial cancer and encouraged to report unexpected bleeding to a physician.
Lung	Adults ages 50-80 with a 20+ pack-year smoking history	Low-dose helical CT	Annual screening in generally healthy (at least 5-year life expectancy) adults who have a 20-pack- year or more smoking history (e.g., smoked 1 pack per day for 20 years or ½ pack per day for 40 years), regardless of whether or when they have quit.
Prostate	Men, ages 50+	Prostate-specific antigen test with or without digital rectal examination	Men who have at least a 10-year life expectancy should have an opportunity to make an informed decision with their health care provider about whether to be screened for prostate cancer after receiving information about the potential benefits, risks, and uncertainties. Prostate cancer screening should not occur without informed decision-making. African American men should have this conversation with their provider beginning at age 45.

CT-Computed tomography. [a]All individuals should become familiar with the potential benefits, limitations, and harms associated with cancer screening. Guidelines for cervical cancer also apply to individuals with a cervix and guidelines for endometrial cancer also apply to individuals with a uterus. [b]All positive tests (other than colonoscopy) should be followed up with a colonoscopy.

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