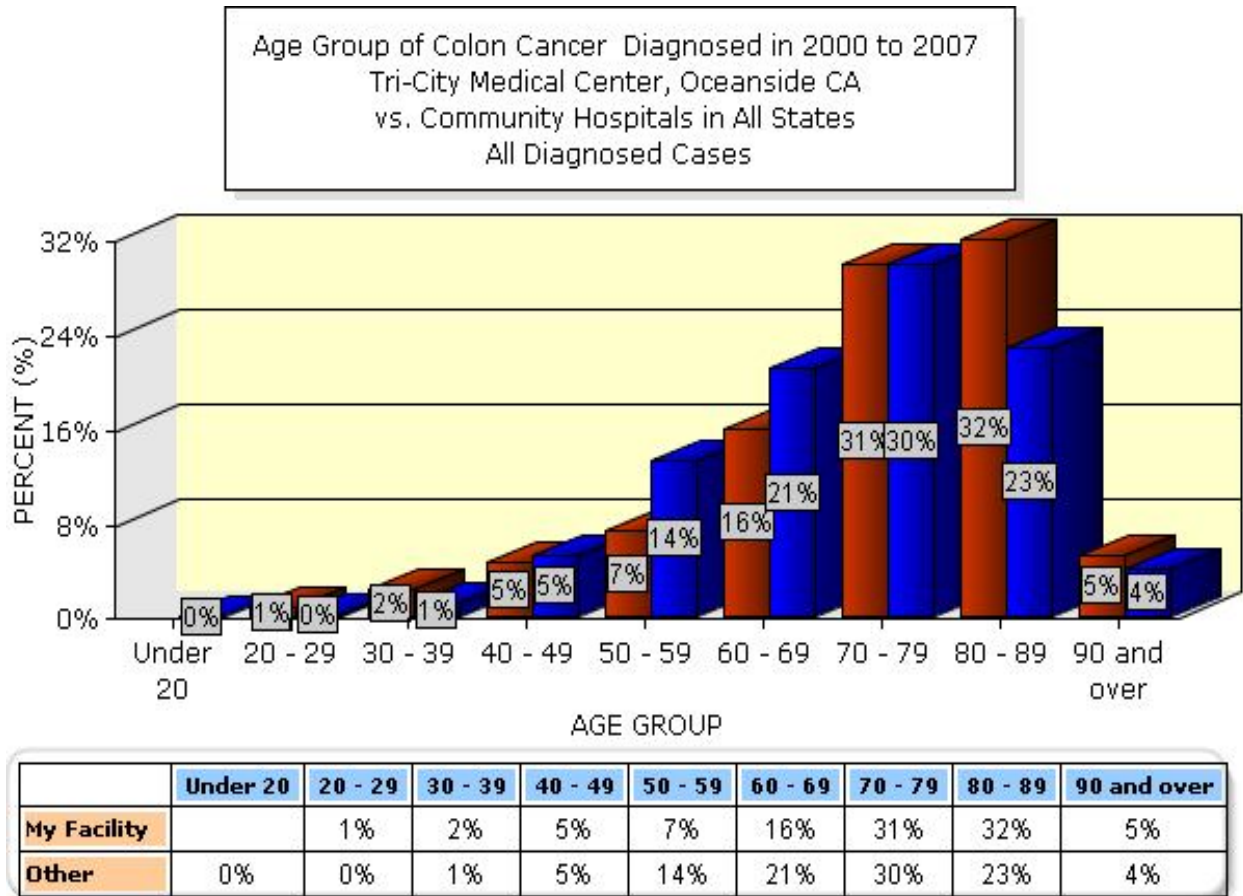


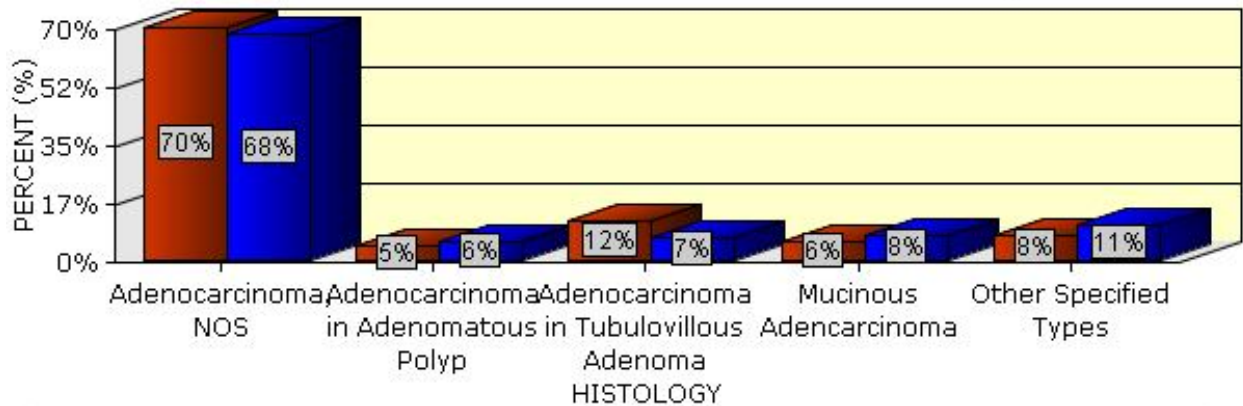
# COLON CANCER COMPARATIVE DATA



Graph # 1

This first table and graph summarizes the incidence of colon cancer by age at Tri-City Medical Center in red compared to the national incidence in blue. There is a general increasing incidence with age as would be expected. However, Tri-City Medical Center tended to have an older population diagnosed with more patients aged 80 to 89. 32% of colon cancer diagnoses at Tri City Medical Center were represented by this age group compared with 23% nationally.

Histology of Colon Cancer Diagnosed in 2000 to 2007  
 Tri-City Medical Center, Oceanside CA  
 vs. Community Hospitals in All States  
 All Diagnosed Cases

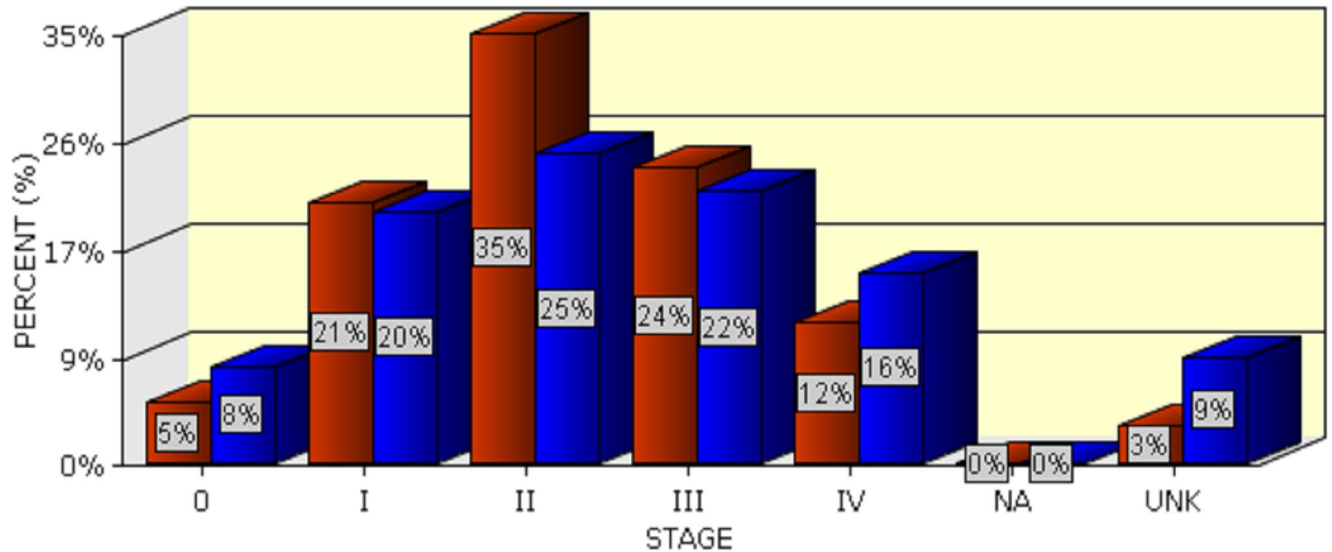


	Adenocarcinoma, NOS	Adenocarcinoma in Adenomatous Polyp	Adenocarcinoma in Tubulovillous Adenoma	Mucinous Adencarcinoma	Other Specified Types
My Facility	70%	5%	12%	6%	8%
Other	68%	6%	7%	8%	11%

Graph # 2

This second table and graph demonstrates the dominance of adenocarcinoma as the underlying histology appropriate for colon cancer, similar at TCMC in red versus nationally in blue. Generally, approximately 70% of cases were isolated adenocarcinoma. The remainder was a mix of coexisting histologies such as various adenomas and mucin-producing tumors. Most colon cancers do arise out of polyps.

Stage of Colon Cancer Diagnosed in 2000 to 2007  
 Tri-City Medical Center, Oceanside CA  
 vs. Community Hospitals in All States  
 All Diagnosed Cases

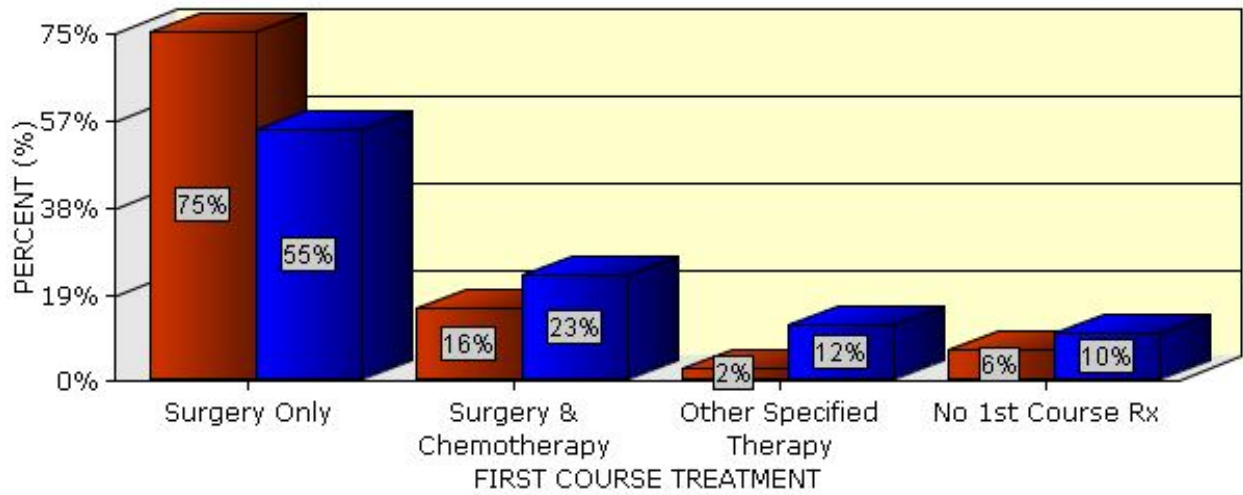


	0	I	II	III	IV	NA	UNK
<b>My Facility</b>	5%	21%	35%	24%	12%	0%	3%
<b>Other</b>	8%	20%	25%	22%	16%	0%	9%

Graph # 3

This third table and graph summarizes the stage at colon cancer diagnosis from 2000 to 2007 at TCMC in red versus nationally in blue. Stage for stage these were very similar with the exception of stage II. TCMC saw a 35% incidence in stage II diagnoses versus 25% nationally. Our numbers are small and while this difference may not be statistically significant it most certainly is a trend. Many hypotheses could explain this such as enhanced early detection as well as the possibility of less nodal sampling and less aggressive surgery in our significantly older, aged 80-89, population compared to national age averages.

First Course Treatment of Colon Cancer Diagnosed in 2000 to 2007  
 Tri-City Medical Center, Oceanside CA  
 vs. Community Hospitals in All States  
 All Diagnosed Cases



	Surgery Only	Surgery & Chemotherapy	Other Specified Therapy	No 1st Course Rx
<b>My Facility</b>	75%	16%	2%	6%
<b>Other</b>	55%	23%	12%	10%

Graph # 4

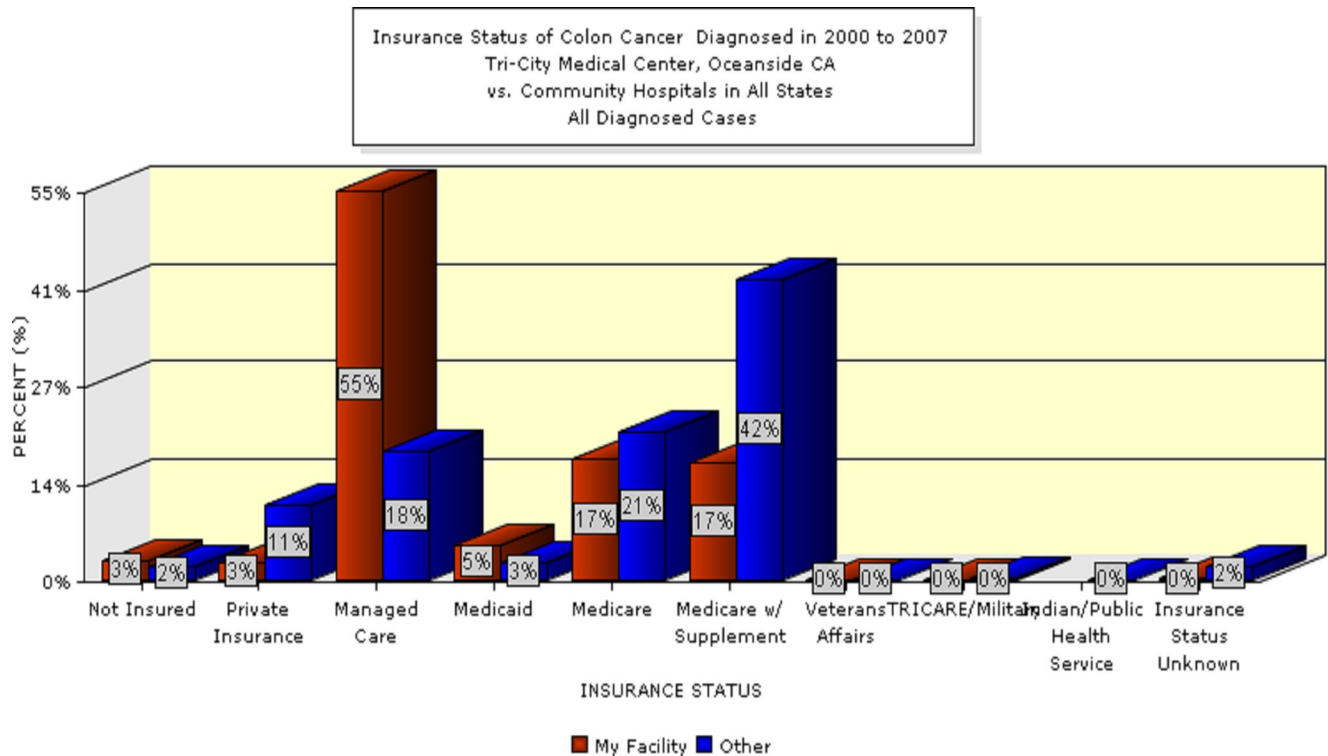
This fourth table and graph summarizes “first course of treatment” following all stage colon cancer diagnoses at TCMC in red versus nationally in blue. It appears that more TCMC patients receive surgery alone than nationally. More patients nationally receive surgery plus chemotherapy as first course of treatment.

There are problems with the definition of first course of treatment. In most settings this could be considered surgery alone. Subsequent adjuvant chemotherapy we then consider the second course of treatment. For these graph purposes it appears as though first course being surgery only implicates the patient did not receive subsequent adjuvant chemotherapy since another definition for first course includes surgery and chemotherapy. The national statistics for surgery alone at 55% may be a flawed definition since I expect some of those patients received adjuvant chemotherapy but chemotherapy was simply not considered “first course”.

Therefore, this leads to the appearance that only 16-24% of patients receive adjuvant chemotherapy following surgery as another definition of first course. The National Cancer Data Base could be benefitted by changing the definition of first course to be clearly defined as surgery only where this does not imply adjuvant chemotherapy was never given. This would leave chemotherapy to be most often defined as second course unless truly given neoadjuvantly or as initial metastatic treatment.

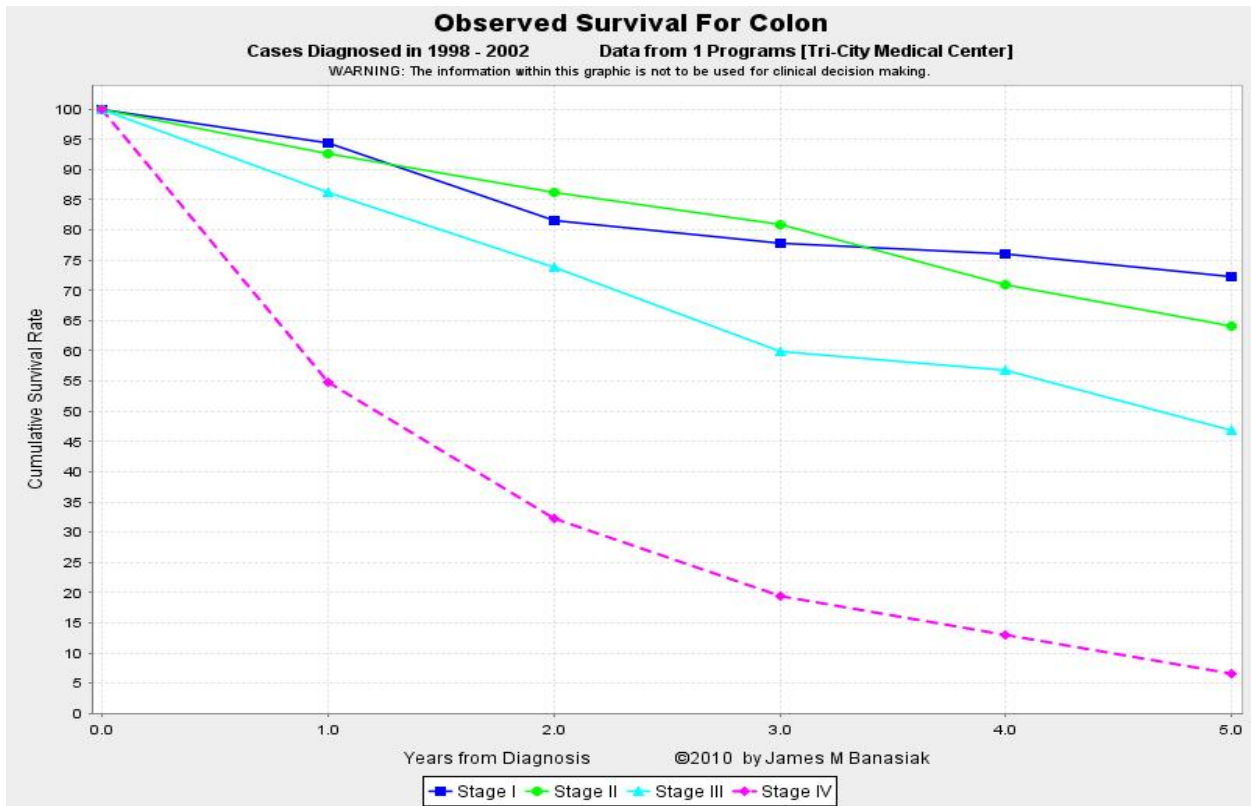
With these caveats in mind we see a trend in differences for 75% of TCMC colon cancer patients having surgery only compared to 55% nationally. Possible reasons could include the following:

- A. Delay in adjuvant treatment due to recovery from surgery.
- B. Higher incidence of aged 80-89 group at TCMC along with coexisting comorbidities may factor into adjuvant decisions.
- C. Higher incidence of stage II diagnoses at TCMC compared to nationally will mean fewer recommendations for adjuvant therapy following individual risk and benefit assessment.

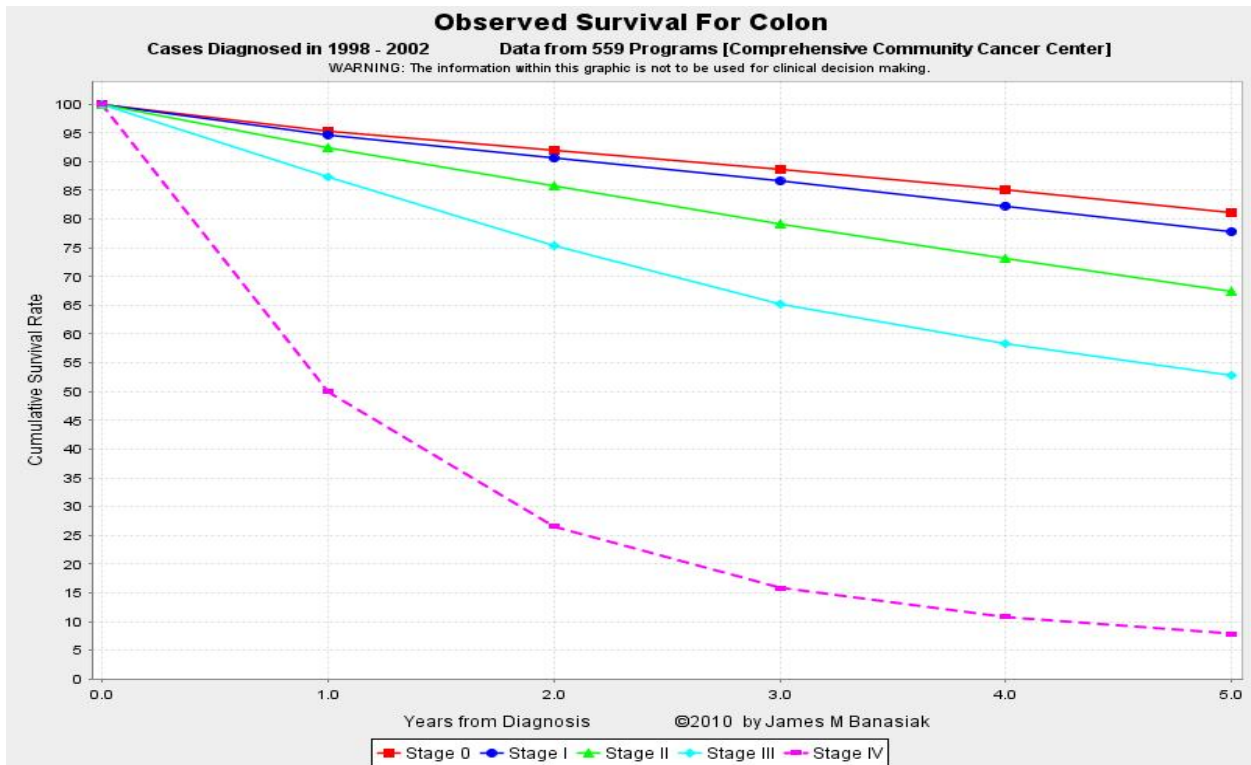


Graph # 5

This fifth graph summarizes insurance status of patients diagnosed with colon cancer at TCMC in 2000 through 2007 in red versus nationally in blue. TCMC trended to have more managed care (55% versus 41%) and less Medicare with supplement (17% versus 28%). Strikingly similarly we had only 3% with private indemnity insurance compared to 11% nationally. Altogether this reflects geographic economic patterns.



Graph # 6



Graph # 7

Observed survival curves: The sixth and seventh graphs summarize survival out to five years following colon cancer diagnoses for cases in 1998 to 2002. TCMCs graph is nearly superimposable upon the national curves. If the standard error bars could be placed for each year's data points they would likely overlap for TCMC and nationally thus demonstrating no significant difference in observed survival for our patients compared to national data. The "n" (defined as number of patients per stage) at TCMC is small. This results in lack of power to detect small statistical differences.

Respectfully submitted,

DEREK A. HELTON, M.D., F.A.C.P.  
SAN DIEGO CANCER CENTER  
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