On behalf of the dedicated physicians, nurses, volunteers and support staff at John Stoddard Cancer Center, we are proud to share our accomplishments and milestones with you. The 2018 report focuses on colorectal cancer with an in-depth look from our Medical Director Andrew Nish. This report also features several of our community outreach events and cancer prevention programs. In addition, you will read about the impact philanthropy has on the care we provide. We are proud of the high-quality, compassionate care provided by our outstanding team and thank you for your continued support of John Stoddard Cancer Center. The support of our community allows us to continue to be one of the top cancer programs across the nation and to offer patients the care they need throughout their entire cancer journey, close to home.

Sarah Zeidler, FACHE
Executive Director
John Stoddard Cancer Center
SPECIALTY SERVICES

Cancer is not an easy journey, but at John Stoddard Cancer Center, we are committed to making sure you have the services available to help make that journey as easy and positive as possible. We offer many specialty services to patients and their families, including:

- Adolescent and Young Adult Program (AYA)
- Case Management
- Chaplains
- Chemo Brain Education
- Child Life Specialists
- Clinical Trials
- Counseling Services
- Education and Outreach
- Genetic Counseling/Testing
- Home Care
- Hospice
- Lymphedema Clinic
- Multidisciplinary Programs
- Nutrition Services
- Oncology Navigation Program
- Oncology Pharmacists
- Oncology Rehabilitation
- Palliative Care
- Patient Education Classes
- Social Workers
- Support Groups
- Survivorship Program

For more information on John Stoddard Cancer Center Specialty Services, visit johnstoddardcancer.org or call (515) 241-3343.
PHILANTHROPY

Every aspect of the care provided at John Stoddard Cancer Center is impacted by philanthropy. It is the generosity of donors that makes a difference in the lives of every person who walks through the doors of the Cancer Center. The following report provides information about the charitable contributions received in 2017, and a summary of the total impact of philanthropy for John Stoddard Cancer Center last year.

2017 CHARITABLE CONTRIBUTIONS

John Stoddard Cancer Center received a total of $918,384 in charitable contributions from individuals, foundations and organizations in 2017. These were gifts of cash, stock and estate gifts which provided annual support for programs and services and gifts to support endowment funds.

- **Individuals:**
  A total of 1,361 individuals supported John Stoddard Cancer Center. ..................$517,657

- **Foundations & Organizations:**
  Gifts from 152 foundations and organizations provided funding for programs and services ..........................$400,727

  TOTAL 2017 Contributions ..................$918,384

USE OF CHARITABLE CONTRIBUTIONS

The Philanthropic Impact Summary below provides detail of how charitable gifts were used to support the programs and services of John Stoddard Cancer Center. Many of these are provided free of charge and not reimbursed through insurance.

PHILANTHROPIC IMPACT

Charitable gifts provide the medical team with the resources they need to provide the very best care possible and the free support programs and services designed to provide the extra assistance patients and families need in the fight against cancer.
### PATIENT VOLUMES BY CANCER SITE (2017)

<table>
<thead>
<tr>
<th>Primary Site</th>
<th>Total</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast</td>
<td>338</td>
<td>4</td>
<td>334</td>
</tr>
<tr>
<td>Lung/Respiratory</td>
<td>308</td>
<td>152</td>
<td>156</td>
</tr>
<tr>
<td>Female Genital</td>
<td>211</td>
<td>0</td>
<td>211</td>
</tr>
<tr>
<td>Colorectal</td>
<td>196</td>
<td>96</td>
<td>100</td>
</tr>
<tr>
<td>Prostate</td>
<td>186</td>
<td>186</td>
<td>0</td>
</tr>
<tr>
<td>Leukemia/Lymphoma</td>
<td>149</td>
<td>94</td>
<td>55</td>
</tr>
<tr>
<td>Other Digestive</td>
<td>149</td>
<td>94</td>
<td>55</td>
</tr>
<tr>
<td>Urinary</td>
<td>124</td>
<td>88</td>
<td>36</td>
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<tr>
<td>Skin</td>
<td>86</td>
<td>47</td>
<td>39</td>
</tr>
<tr>
<td>Brain/CNS</td>
<td>60</td>
<td>31</td>
<td>29</td>
</tr>
<tr>
<td>Endocrine</td>
<td>49</td>
<td>26</td>
<td>23</td>
</tr>
<tr>
<td>Oral Cavity</td>
<td>29</td>
<td>22</td>
<td>7</td>
</tr>
<tr>
<td>Unknown Primary</td>
<td>19</td>
<td>5</td>
<td>14</td>
</tr>
<tr>
<td>Other/Ill-Defined</td>
<td>19</td>
<td>5</td>
<td>14</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>1,927</strong></td>
<td><strong>811</strong></td>
<td><strong>1,116</strong></td>
</tr>
</tbody>
</table>

### PATIENT SATISFACTION SCORES (2017)

<table>
<thead>
<tr>
<th>Department</th>
<th>Score</th>
<th>Percentile Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Unit</td>
<td>88.3</td>
<td>55th</td>
</tr>
<tr>
<td>Radiation Oncology</td>
<td>94</td>
<td>76th</td>
</tr>
</tbody>
</table>
ONCOLOGY REHABILITATION

John Stoddard Cancer Center has partnered with UnityPoint Health Physical Therapy – Penn Ave. to offer services and treatments to those affected by cancer. Certified Oncology Rehabilitation Specialists at Penn Avenue Outpatient Therapy have learned through specialized training how chemotherapy, radiation therapy and surgery physically affect patients so they can more effectively treat them.

Services and treatments are tailored for those affected by, but not limited to the following: pain, restricted range of motion, scars, neuropathy, issues with balance and coordination, cancer-related fatigue, pelvic floor dysfunction, weakness and deconditioning. The overall goal of this service is to improve quality of life for cancer survivors.

SCOPE IT OUT 2018

John Stoddard Cancer Center, in collaboration with area physicians and clinics, provided 19 free screening colonoscopies to uninsured men and women in the central Iowa area on Saturday, April 7 at The Iowa Clinic Endoscopy Center and Iowa Endoscopy Center. Other eligibility criteria for the program include being between ages 50-64 as well as having no symptoms of colorectal cancer.

This collaborative effort is made possible through physicians, staff and administration at The Iowa Clinic, Iowa Digestive Disease Center, GI Pathology, Polk County Public Health Department, UnityPoint Health and John Stoddard Cancer Center. At John Stoddard Cancer Center we’re thankful to all of our partners, as screening truly does save lives.

CANCER SURVIVORS DAY 2018

On Saturday, June 9 staff at John Stoddard Cancer Center celebrated Cancer Survivors Day with cancer survivors and their family and friends. More than 600 survivors and guests attended the event by enjoying an Iowa Cubs game at Principal Park. Survivors and guests were able to enjoy snacks and games before the ballgame. During the game, survivors were given the opportunity to throw the first pitch, participate in the Seventh Inning Stretch and stand and be recognized. At John Stoddard Cancer Center we continue to enjoy celebrating survivors during this special event.

More than 600 cancer survivors and guests attended the Cancer Survivors Day picnic and baseball game at Principal Park.
CHARLIE CUTLER HEALING AND WELLNESS ENDOWMENT

Charlie Cutler faced non-Hodgkin’s lymphoma with exceptional dignity and courage and lived every day to its fullest. Inspired by Charlie’s always positive attitude and passion for life, the Cutler Family and numerous others established the Charlie Cutler Healing and Wellness Endowment. Working with medical personnel and care providers at John Stoddard Cancer Center, this endowment will provide a variety of complementary treatments not typically reimbursed by insurance. These services include massage therapy, guided imagery and aromatherapy. Just as Charlie benefited from these services, now countless others will find similar relief from symptoms and side-effects associated with cancer.
Scott Hamilton enthusiastically shared his story as the keynote speaker for the 2018 Rally Against Cancer.
RALLY AGAINST CANCER

The 2018 Rally Against Cancer featured Scott Hamilton, Olympic Gold Medal figure skater, television commentator and cancer survivor. Scott shared an inspiring message and will be remembered as one of the most impactful speakers in the history of the event.

The event raised a record $340,000 in support of the Oncology Navigator Program, which is provided free of charge to patients at John Stoddard Cancer Center.

Other programs supported through Rally Against Cancer included:

- Adolescent & Young Adult Program
- Charlie Cutler Healing and Wellness Endowment
- Stoddard Compassion Fund

FOR MORE INFORMATION and for a list of current classes, visit unitypoint.org/cancer classes and events.

GET CONNECTED.
Join our mailing list for the quarterly Stoddard Connections newsletter at unitypoint.org/desmoines/stoddard-connections-newsletter
WHAT IS COLORECTAL CANCER?

Colorectal cancer is a cancer of the lining of the colon or rectum. The colon and rectum are referred to as the large bowel or large intestine. The colon is the first part of the large bowel and is a muscular tube about five feet long and has four sections: the ascending, transverse, descending and sigmoid colon. Water and nutrients are absorbed from food as it passes through the colon. The rectum is the final six inches of the large bowel and mainly acts to absorb water.

HOW DOES COLORECTAL CANCER START?

Colorectal cancer begins as a noncancerous growth called a polyp that develops on the inner lining of the colon or rectum and grows slowly over a period of 10-20 years. Adenomas are the most common type of polyp and arise from glandular cells that lubricate the colon and rectum. About one third to one half of all individuals will develop one or more adenomas in their lifetime. Although adenomas have the potential to become cancerous, less than 10% are estimated to progress to cancer. The likelihood that an adenoma will progress to cancer increases as it becomes larger. Cancer arising from the lining of the colon and rectum is called adenocarcinoma and accounts for 96% of all colon and rectum cancers.

Key statistics: Colorectal cancer is the fourth most commonly diagnosed cancer and is the second leading cause of cancer deaths.


Colorectal cancer incidence rates (the number of cancers per 100,000 people) has declined steadily over the past 2 decades in the population aged 50 and over with a United States average of 38 colorectal cancers per 100,000 people. Unfortunately, in Iowa the incidence rate is 46.7 colorectal cancers per 100,000 people.

2017 Colon and Rectal Cancer Diagnoses in U.S.

<table>
<thead>
<tr>
<th></th>
<th>MEN</th>
<th>WOMEN</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colon Cancer</td>
<td>47,700</td>
<td>47,820</td>
<td>95,520</td>
</tr>
<tr>
<td>Rectal Cancer</td>
<td>23,720</td>
<td>16,190</td>
<td>39,910</td>
</tr>
<tr>
<td>Total</td>
<td>71,420</td>
<td>64,010</td>
<td>135,430</td>
</tr>
</tbody>
</table>

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In people between the ages of 20 and 49 there has been a dramatic, 51% increase in the incidence rate of colorectal cancer since 1994 from 2.6 cases per 100,000 people to 5.2 cases per 100,000 people. A recent analysis found that adults born around 1990 have twice the risk of colon cancer and 4 times the risk of rectal cancer compared with adults born around 1950, who have the lowest risk.

As of January 2016, there were 724,690 men and 727,350 women alive in the US with a history of colorectal cancer.

Chance of getting colorectal cancer:
In the general population without a genetic risk for colorectal cancer 4.6% of men and 4.2% of women will be diagnosed with colorectal cancer in their lifetime. Colorectal incidence and death rates are highest in African Americans and lowest in Asians.

RISK FACTORS FOR DEVELOPING COLORECTAL CANCER:

AGE – The risk of colorectal cancer increases with age; the median age of diagnosis for colon cancer in men is 68 in men and 72 in women; for rectal cancer it is 63 in both men and women.

INFLAMMATORY BOWEL DISEASE – Those with inflammatory bowel disease have almost double the risk of developing colorectal cancer compared with the general population.

DIABETES – Those with type 2 diabetes have an increased risk of colorectal cancer even after accounting for physical activity and obesity.

OVERWEIGHT AND OBESITY – Excess body weight increases the risk of colorectal cancer, with a stronger association in men than women. Compared with normal weight people, obese men have about a 50% higher risk of colon cancer and a 20% higher risk of rectal cancer, whereas women have about a 20% increased risk of colon cancer and 10% increased risk of rectal cancer. Weight gain appears to have a greater influence on colorectal cancer risk when it occurs earlier in adulthood versus later in life.

RISK FACTORS, continued on page 12
Diet – Diet strongly influences colorectal cancer occurrence. Dietary patterns influence risks directly, through specific dietary elements and indirectly, through overnutrition and obesity. The following is a summary of the current scientific evidence for dietary elements linked to colorectal cancer:

- **Calcium** – Most studies find that calcium consumption from dairy foods or supplements is associated with a decreased risk of developing adenomas and colorectal cancer.
- **Fiber** – Even though it is highly plausible that dietary fiber decreases the risk of colorectal cancer studies remain inconclusive. However, because of the overall health benefits of a high fiber diet the World Cancer Research Fund advocates a diet high in vegetables and fruit for the prevention of cancer.
- **Vegetables and Fruit** – There is not a consistent relationship between vegetable and fruit consumption and colorectal cancer risk but given the overall health benefits, increasing vegetables and fruit and vegetables in the diet is recommended.
- **Processed Meats** – Increase the risk of both colon and rectal cancer. A WHO report on meat and cancer did find that processed meat increased the risk of colorectal cancer by 20%.
- **Red Meat** – There is inconclusive evidence that red meat in and of itself increases the risk of colorectal cancer.

**Smoking** – There is sufficient evidence that smoking is associated with an increased risk of colorectal cancer and appears stronger for rectal than colon cancer.

**Alcohol** – Moderate to heavy alcohol use (>2-3 drinks per day) is associated with an increased risk of colorectal cancer and the association is stronger in men than women.

**Physical Inactivity** – Physical activity is strongly associated with a reduced risk of colon cancer but not rectal cancer. Current evidence suggests that those people who are the most sedentary have a 25-50% increased risk of colon cancer compared with those who are least sedentary. Exercise recommendations include at least 30 minutes of moderate activity (brisk walking) a minimum of 5 days per week.

**Heredity and Family History** – Thirty percent of colorectal cancer patients have a family history of the disease, about 5% are due to an inherited genetic abnormality. People with a first-degree relative (parent, sibling or child) who have been diagnosed with colorectal cancer have 2-4 times the risk of developing the disease compared to people without a family history. The highest risk is for people with multiple first-degree relatives diagnosed with colorectal cancer. Characterized hereditary syndromes account for about 5% of all colorectal cancers and are associated with specific gene mutations. The most common hereditary colorectal cancer syndrome is Lynch syndrome, which accounts for 2-4% of all cases. Other cancers associated with Lynch syndrome include, endometrial, ovarian, small bowel and stomach cancers. 45-54% of people with Lynch syndrome will develop colorectal cancer by the age of 70. Familial adenomatous polyposis (FAP) is the second most common predisposing genetic syndrome, accounting for less than 1% of all colorectal cancers. It is characterized by the development of hundreds of colorectal polyps beginning in the early teens. The lifetime risk of developing colorectal cancer approaches 100%. There is also attenuated FAP which is a less severe form with a later age of onset and fewer polyps (<100), although the lifetime risk of developing colorectal cancer remains high. Personal history of colorectal cancer or adenomatous polyps – People with a personal history of colorectal cancer are more likely to develop a subsequent cancer of the colon or rectum, especially when initially diagnosed at a young age. Those with a history of adenomatous polyps are also at increased risk.

**Prognosis and Survival**

Survival rates tell you what proportion of people with the same type and stage of cancer are still alive at a certain amount of time (usually 5 years) after they were diagnosed. Survival is dependent on the stage of the disease (staging takes into account the tumor size and location, whether the cancer has spread to lymph nodes or to other organs outside of the colon or rectum). In general, the larger the cancer and the more it has spread, the higher the stage and the shorter the survival. Average 5-year survival for all stages of colorectal cancer is 65%. For cancer confined to the colon or rectum without spread to adjacent tissues, lymph nodes or distant organs the 5-year survival is 90%. If the cancer has spread outside the colon to lymph nodes or to distant organs the 5-year survival is 71% and 14% respectively. Overall survival for rectal cancer is slightly higher than colon, 67% vs 64%.
SIGNS AND SYMPTOMS OF COLORECTAL CANCER

Early colorectal cancer often has no signs or symptoms (therefore we have screening – see below). As a tumor grows it may bleed or cause obstruction of the bowel. Common warning signs include: bleeding from the rectum, blood in the stool or in the toilet after having a bowel movement, very dark or black stools, change in bowel habits such as narrower stools, cramping or discomfort in the lower abdomen, constipation or diarrhea that lasts for more than a few days, particularly if this is a new problem, decreased appetite, unintentional weight loss, abdominal bloating, new fatigue and anemia. Many of these symptoms are not specific and can be seen with other problems and should be evaluated by your health care provider.

SCREENING AND EARLY DETECTION

Screening is the use of a test to find a disease in people who do not have symptoms of that disease. The goal of any screening test is to detect the disease at an earlier stage thus reducing the risk of dying from that disease.

The slow course of growth from a precancerous polyp to cancer provides a unique opportunity for the prevention and early detection of colorectal cancer. Screening can prevent cancer through the detection and removal of precancerous polyps and can detect cancer at an early stage, when treatment is typically more successful. As a result, screening reduces colorectal cancer mortality by both decreasing the incidence of the disease and by increasing the likelihood of survival.

Traditionally screening has been recommended beginning at age 50 for those people at average risk. Recently the American Cancer Society has recommended that routine screening begin at age 45 for those with average risk. This recommendation was based on the dramatic increase in colorectal cancers in persons under 50 years old. Screening should be continued in adults in good health until age 75 years, beyond which the decision to continue screening should be individualized based on patient preferences, health status, life expectancy and screening history. Those patients at increased risk as outlined above should discuss screening with their health care provider.

Screening tests include visual exams performed at a health care facility (colonoscopy, flexible sigmoidoscopy and computed tomography colonography (CT colonography) and stool-based tests (fecal immunochemical test (FIT), high sensitivity guaiac based fecal occult blood test (gFOBT) and FIT-DNA (Cologuard)) performed at home. All tests have a comparable ability to reduce colorectal cancer deaths when performed at the appropriate time intervals and with the recommended follow-up. Positive results from any test other than colonoscopy should be followed with a colonoscopy for complete diagnostic evaluation. Based on current recommendations for the person at average risk, colonoscopy every 10 years should be offered first and for those who decline colonoscopy fecal immunochemical test (FIT) should be offered annually. Please discuss colorectal cancer screening with your health care provider.

Screening is the best way to detect precancerous polyps and early stage colon cancer. If you are 45 and older, talk to your health care provider about colorectal cancer screening. Currently in the United States, 67.6% of eligible people 50 years and older are being appropriately screened for colorectal cancer. In Iowa, 68.2% of age appropriate people are being appropriately screened.

Colorectal cancer is a potentially preventable disease. The keys to prevention include being of normal body weight (best measured with a combination of BMI and waist circumference - BMI 19-24.9 and waist circumference < 35 inches in women and < 40 inches in men), having normal blood sugar (fasting blood sugar <100), increasing consumption of vegetables and fruit (5-7 servings of vegetables and 2 servings of fruit per day), avoiding processed meats, limiting alcohol consumption, quitting smoking and exercising at least 30 minutes, 5 days per week.

Remember that the best screening test is the one that gets done and gets done well.
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