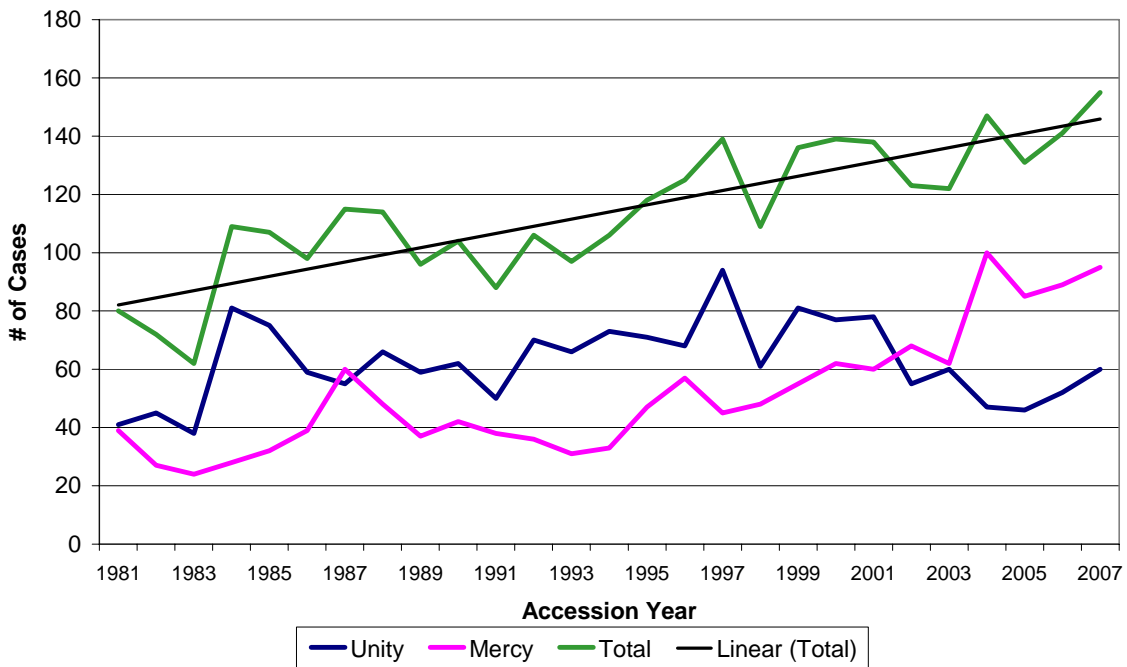


Colorectal Cancer Report
By
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Presented at the June 2, 2008 Cancer Committee Meeting

Diagnosis:

Figure 1 shows the trend in colorectal cancer cases diagnosed and/or treated in the Mercy and Unity cancer program. There has been a steady increase in cases since 1981. Since 2002, there has been a shift in the preponderance of cases from the Unity to the Mercy site. The increase in total cases from 2002 to the present results completely from growth at the Mercy site.

Figure 1
1981 to 2007 Colorectal Cancer Volume



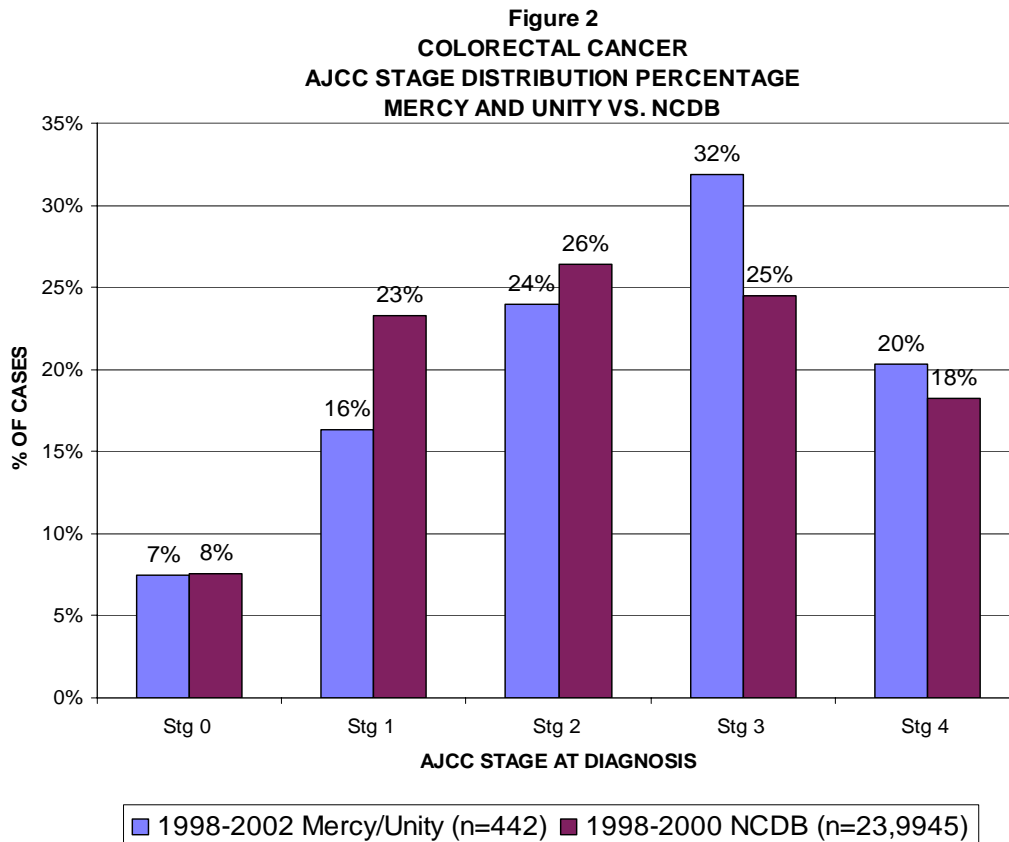


Figure 2 shows the stage distribution at diagnosis for colorectal cancers at Mercy and Unity compared to data from the National Cancer Data Base (NCDB). The graph shows a somewhat higher proportion of early stage (Stage 0,1,2) cancers diagnosed nationally than at Mercy and Unity (57% vs. 47%). Early diagnosis results from following screening recommendations. Excellent screening tests for colorectal cancer are currently available. The current colorectal cancer screening rates for asymptomatic people in the U.S. are 60.4%, while, in Minnesota, it is 64%. Screening options include endoscopy and hemocult stool testing.

The American Cancer Society (ACS) has published updated colorectal screening recommendations (May/June 2008 CA Journal). The gold standard remains colonoscopy, which is recommended every 10 years in asymptomatic adults starting at age 50.

Treatment:

Treatment of colon cancer includes surgical resection of localized disease followed by adjuvant systemic therapy if positive lymph nodes are discovered after pathological analysis.

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Treatment of rectal cancer typically involves preoperative chemoradiation therapy followed by surgery.

The Commission on Cancer (CoC) is currently collecting data on the compliance of participating programs with national standards in colorectal cancer surgery and rectal cancer radiation therapy. A recent report from Mercy and Unity 2003 to 2005 data showed that 12 or more lymph nodes were pathologically examined in 83% of our colon cancer resections; the 2006 data shows an increase in that percentage to 87%. Radiation therapy was given in 95% of our surgically resected Stage 2B and 3 rectal cancers from 2003 to 2005.

The systemic treatment of colorectal cancer has undergone major changes in recent years. Oncologists of the Mercy and Unity cancer program follow national treatment guidelines published by organizations such as the National Comprehensive
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Cancer Network (NCCN). Current systemic therapy regimens are variations on a basic treatment scheme using oxaliplatin plus a 4-6 hour 5-FU infusion, repeated every 2 weeks. Clinical trials using this regimen have demonstrated a 5-year disease free survival of 66% after resection of Stage 3 colon cancer.

Outcomes:

Figures 3A, B & C show 5-year survivals by stage for colon, rectosigmoid, and rectal cancers. Each bar graph depicts comparative results from Mercy and Unity and the NCDB. In all stages for each tumor site, Mercy and Unity results compare very favorably with the national figures.

In our colorectal cancer report from 2005, we found that our 5-year survivals for stage 2 rectal cancers were inferior to national results. This discrepancy has been overcome in our current, more recent results.

Figure 3A
COLON CANCER 5-YEAR OBSERVED SURVIVAL BY AJCC STAGE

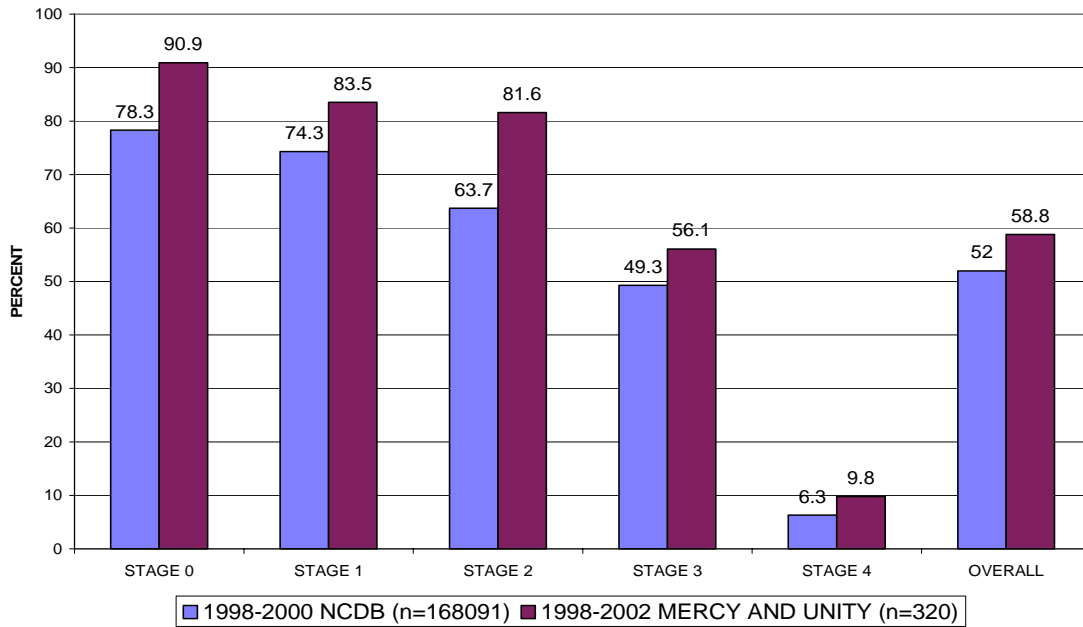


Figure 3B
RECTOSIGMOID JUNCTION 5 YEAR OBSERVED SURVIVAL

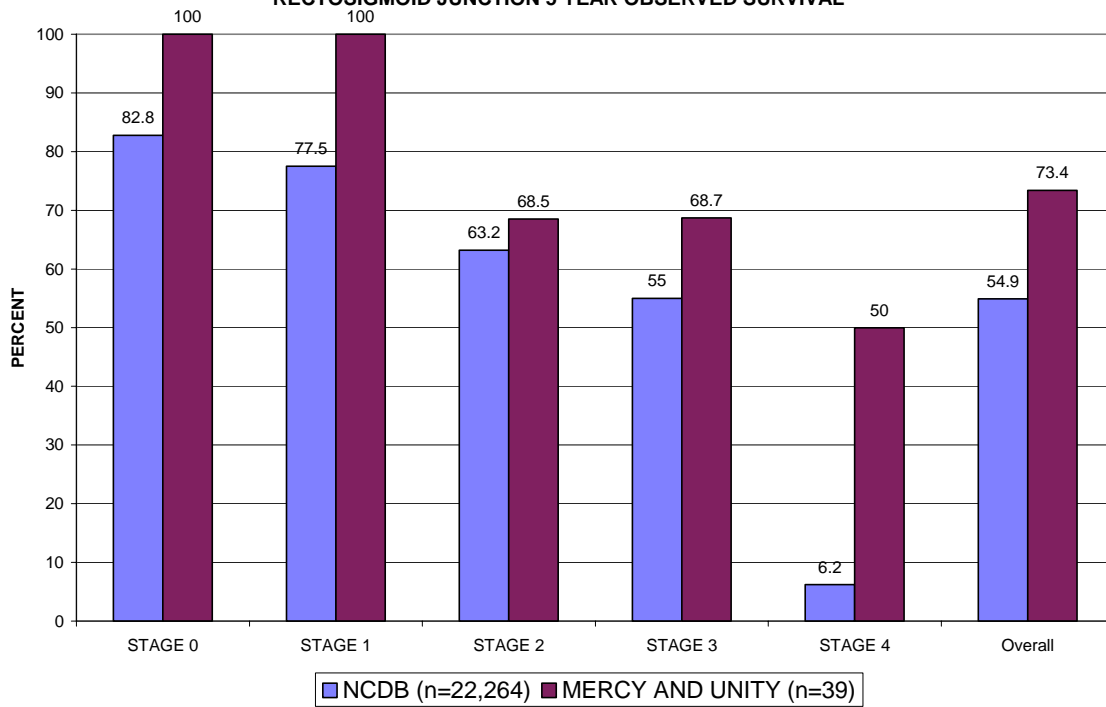


FIGURE 3C
RECTAL 5-YEAR OBSERVED SURVIVAL DATA

