



BC Surgical Oncology Network

Newsletter

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March 2006

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TUMOUR TISSUE REPOSITORY MOVING FORWARD



Dr. Peter Watson
Director, Tumour Tissue Repository

In the near future, physicians will be able to determine the likely effectiveness of specific cancer treatments due to the work of the BCCA's Tumour Tissue Repository (TTR). The TTR is a specialized infrastructure designed to collect, store and process patient blood and tissue specimens, as well as associated clinical and relevant personal data.

Established in 2003, the TTR maximizes breakthroughs in genomic and proteomic technology and will provide researchers with access to patient tissues and associated clinical data to translate into clinical advances.

Over 700 patient donors, representing many different tumour sites, have so far contributed to building this resource to the point where the TTR will soon be able to provide material for research projects. The majority of these initial donors received surgery in Victoria.

Leading the TTR toward this integral stage in its development is Dr. Peter Watson who joined the TTR last November. He was most recently a professor and scientist at the University of Manitoba in Winnipeg

and Director of the Manitoba Breast Tumour Bank. Originally from the UK, Dr. Watson received his medical degree from Cambridge University. He replaces the newly retired Dr. Juergen Vielkind.

How will the TTR benefit surgeons and their patients?

The translational research that the TTR enables will help identify properties of patients and their tumours to determine whether they will respond better to one therapy or another.

For example tamoxifen has been offered for decades to patients whose breast cancer expresses an estrogen receptor. But this single predictor is only part of the emerging story that we now realize can influence whether the tumour will respond or not. Research enabled through the TTR will allow us to measure multiple indicators and search for new ones that may help determine whether these patients will respond effectively to this treatment. Such research is the only way we will acquire the knowledge that will give us better predictive capabilities.

How does the TTR function operationally?

The TTR is comprised of two parts: the Tissue Processing and Storage Laboratory (TPSL), and the Bioinformatics Clinical Research Database (BCRDB). The TPSL is located at the BC Cancer Agency's Deeley Research Centre in Victoria and is the core site for collection and storage of blood and tissue samples.

PROMOTING BREAST CANCER INFORMATION - NEW KITS FOR NEWLY DIAGNOSED PATIENTS

By Dr. Karen Gelmon, FRCPC, Chair Breast Tumour Group, BC Cancer Agency

Breast Cancer is a devastating diagnosis even if it is early disease. But information can make a difference and the new "Breast Cancer Information Kit" can provide some of the answers and steer patients to critical resources that will help them through this cancer journey.

For over eight years, local surgeons have been providing information kits to newly diagnosed patients with breast cancer in BC and the Yukon. Many of you are familiar with the kits and have been using them faithfully. However, some physicians could make better use of these free information packages and I encourage you to take a new look at the contents.

Recently we completed an upgrade to the kits and packaging. The newly developed "Breast Cancer Companion Guide" breaks down the treatment journey into manageable decision points and interacts with the resources in the kit such as the "Intelligent Patient Guide to Breast Cancer" by Olivotto, Gelmon, Kuusk 2006. With better interaction of resources inside the kit, questions are answered without you having to address all individual needs. This can lead to less patient stress and supplements the verbal information that you already provide.

Patients respond that these new additions are very helpful. The kits are fully supported by the BC Cancer Agency and provide valuable tools to assist your patient in accessing services in their community, financial considerations and other pieces related to their overall care.

We wish to ensure patients diagnosed with breast cancer receive this resource and the best quality of care that BC offers. Therefore, please take the opportunity to provide these information kits at your patient's first visit to your office. Supporting this initiative means patients may ask more meaningful questions and will feel confident in their treatment. Call 1.800.663.3333 ext. 5819 to order kits for you office.

Enclosed in this newsletter are two small posters to post in your examination area. You will make a difference in this journey for people. The information kits are generously supported by the Canadian Breast Cancer Foundation, BC/ Yukon Chapter.

FOR MORE INFORMATION

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THE COUNCIL & NETWORK

The BC Provincial Surgical Oncology Council exists to promote and advance quality cancer surgery throughout the province by establishing an effective Network of all surgical oncology care providers and implementing specific recommendations. The Network will enable quality surgical oncology services to be integrated with the formal cancer care system. Communications to enhance decisionmaking, evidence-based guidelines, a high quality continuing education program, and regionally based research and outcome analyses are the initial priorities.



*Dr. Blair Rudston Brown,
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As I reflected on the PET article in the last issue of the SON newsletter, its always a pleasure to relate a positive anecdote from the daily practice of oncologic surgery. As we all know, the practice has its rewards in dealing with patients during this critical time in their life but also comes with frustrations related to access. With the opening of the new PET-CT in Vancouver

I was looking forward to using this service in selected patients but was also psychologically prepared for difficulties with access and perhaps long wait times given the pent up demand that must have been apparent. Having sent over a requisition for a scan on a patient

regarding possible recurrent colonic disease, I was pleasantly surprised to see not only acknowledgement of the requisition very quickly but also the scan itself being done in a very short period of time. This required no extra phone calls or enticements on my part to accomplish. What a pleasant surprise! Hats off to Dr. Wilson and his group at the Vancouver Cancer Clinic in bringing this much needed technology online for our patients and I hope there is continued success in expanding the availability of this key piece of technology in the near future. I hope you enjoy this issue of the newsletter and, as always, your comments and suggestions are welcome.

INSIGHT INTO ONTARIO'S SURGICAL ONCOLOGY PROGRAM



Dr. Hartley Stern, Provincial Head of Ontario's Surgical Oncology Program.

Dr. Hartley Stern, Provincial Head of Ontario's Surgical Oncology Program, was a guest speaker at the BC Surgical Oncology Network's Annual Planning meeting last November. He provided an introduction to his organization's goals and achievements and provided attendees with ideas for improving surgical oncology care in BC.

Cancer Care Ontario's Surgical Oncology Program was established in 2001 and shares similar objectives to the SON - to improve the quality of care for cancer patients, to increase knowledge transfer and funding, and to conduct research. "The impetus for the program," according to Dr. Stern, "is to address the significant problems caused by: variations in care and outcomes; access to care; continuity of care; the increasing cancer burden; and gaps in both funding and human resources."

Previously, Cancer Care Ontario managed cancer centres, delivered all radiation and systemic therapy, but did not include the role of surgery in cancer care. Changes to the system have resulted in divested cancer centres and establishing recognition for the importance of surgical oncology.

Pancreatic Cancer

Dr. Stern presented the impact of surgical standards developed and implemented for the treatment of pancreatic cancer.

These standards are advice documents regarding the requirements for the delivery of specific services by hospital and physician, which include - the need for advanced training of surgeons, access to a complete range of multidisciplinary staff, support services and ICU, OR and hospital commitment

Additionally, performance by surgeons, reported on at least 10 major pancreatic resections per year and

at least 25 HPB resections per year is collected. The benchmark mortality rate was set at less than 5%. By 2001, 27% of hospitals respondents to a follow-up survey had made changes to comply with these recommendations and 50% reported that at least one surgeon no longer performed pancreatic surgery.

Laparoscopic Colon Cancer

Clinical practice guidelines have also been developed for laparoscopic resection for colon cancer. These evidence-based advice documents are for clinicians and patients regarding individual clinical management decisions that represent current best practices. These guidelines provide advice specific to patients with stage I, II or III colon cancer addressing whether there are greater benefits and fewer harms associated with the use of laparoscopic surgery compared with conventional open surgery. The scope of the guideline document includes issues related to clinical factors, professional practice, and institutional and organizational resources.

Indicators

The Ontario Surgical Oncology Program is also working with Expert Panels to develop quantitative indicators that can be correlated with the quality of medical care for breast, prostate, colorectal and ovarian cancer. These are expected to improve with the implementation of quality improvement measures.

Rectal Cancer Quality Initiative

A quality initiative in rectal cancer trial is also underway to determine whether an educational strategy directed at surgeons can decrease hospital rates of permanent colostomy and local tumor recurrence for surgically treated rectal cancer patients. The strategy includes workshops, operative demonstrations, the use of opinion leaders, evaluation of post-operative questionnaires and feedback to surgeons. Seventy-one demonstrations have been given to date with over 800 patients accrued to measure primary outcomes.

To learn more about Cancer Care Ontario and the Ontario Surgical Oncology Program visit www.cancercare.on.ca/index_SurgicalOncology.htm.

VCH's Stop Smoking Before Surgery Program

The Vancouver Coastal Health Authority's (VCHA) Stop Smoking Before Surgery Program is a pilot project which began in 2004. It was developed in partnership with Health Canada, the BC Cancer Agency and Providence Health Care.

The program has evolved since its inception to become the Vancouver Cessation Program. It now accepts members of the general public with priority given to surgical patients. The program has been successful in addressing the cessation needs of surgical patients as well as the general public through its behavioural intervention groups and information resources.

Due to the great need for smoking cessation services in Vancouver Coastal Health communities, the program will continue past the project's end date of March 2006. It is common knowledge that quitting smoking can improve one's health quickly and significantly.

It has been proven that quitting smoking 6-8 weeks prior to surgery decreases the rate of pre and post operative complications (52% in smokers versus 18% in cessation group) in addition to decreasing length of stay (13 days versus 11 days). Please encourage your patients and other known smokers to participate in this effective program.

For more information about our program (ie for resources and small group counseling sessions), please call 604-675-3800.



BCCA TUMOUR TISSUE REPOSITORY MOVING FORWARD

Con't from Pg. 1

The BCRDB is located at the Vancouver Research Centre and uses computer technologies to provide dependable convergence of datasets concerning patient lifestyle, clinical history, tissue pathology and molecular/genetic profiles. This database is also designed to encrypt and securely store information, ensuring anonymity and protection of patient privacy.

In participating hospitals, patients undergoing cancer treatment are given the opportunity to donate tumour tissue and blood samples to the TTR for research. TTR nurses meet with patients to discuss tissue donation, to obtain consent, and to facilitate tissue and blood collection and processing. Storage of data and tissue samples are based on patient consent, and strict patient confidentiality processes ensure patient anonymity.

What is your vision for the TTR over the next five years?

Previously, the TTR focused on establishing its infrastructure and linkages with the clinical community on Vancouver Island. Our focus now includes enhancing the accrual process and making it easier for the medical community to flag patients and interact with the TTR.

We will also expand TTR initiatives across BC to stimulate development of a BC tumour bank network. Our goal is to harmonize and connect all tumour banking activities in the province including those supported centrally by institutions, such as the TTR, and others developed by individual research groups and investigators. Such networking will result in improved standards enabling us to learn from each other's achievements and to better communicate the contents of different banks and collections to the research community.

We are also playing a key role in the establishment of the new Canadian Tumor Repository Network (CTRNet). CTRNet (www.ctrnet.ca) represents

a concerted effort to coordinate a national tumor banking strategy that builds on the expertise and resources in provincial tumor banks to establish national standards.

What are the immediate plans for expansion?

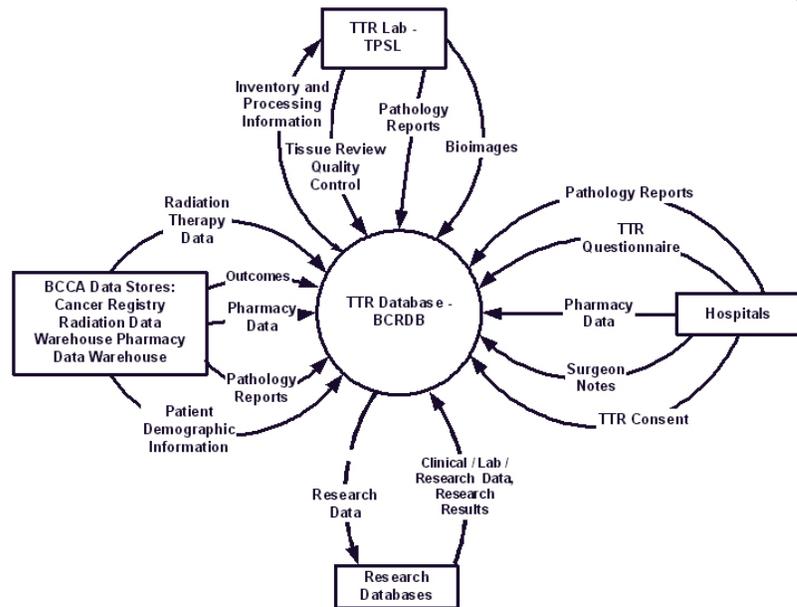
We are working now with several groups within the BCCA and at St. Paul's Hospital to create the initial tissue banking network.

use tissue and data that is otherwise disposed of – and not used for research – is of tremendous value to advancing healthcare.

How will researchers access the resources of the TTR?

We are developing a framework over the next year that will include an open and equitable application process with rules determined by a peer review system. The TTR will apply standardized protocols and the

Con't on Pg. 5



The Bioinformatics Clinical Research Database(BCDRB) is founded on world-class technologies to provide for the dependable convergence of patient, lifestyle, clinical history, tissue pathology and molecular data.

What role can surgeons play in the TTR's success?

We are very keen to talk with any surgeon about how we can make it easier for them to offer their patients the opportunity to participate in research. The process we developed with surgeons in Victoria is critically dependent on their support but requires relatively little effort from surgical clinics, and provides tremendous opportunity for their patients.

These patients can play an instrumental role to improve the understanding of their own disease and treatment and care of future generations. Giving us permission to

highest ethical and privacy standards to provide materials to researchers in the form of anonymized samples. We want to show leadership and commitment toward streamlining ethics and privacy guidelines in a manner that maintains the highest level of privacy for donors while propelling new advances in healthcare.

To learn more about the TTR please visit www.bccrc.ca/ttr/index.html.

TUMOUR TISSUE REPOSITORY: A SURGEON'S PERSPECTIVE



*Dr. Allen Hayashi,
Division Head,
General Surgery
for the Vancouver
Island Health
Authority, South
Island*

Dr. Allen Hayashi is a strong supporter of the Tumour Tissue Repository (TTR): “The TTR is recognized in Victoria as having an extremely important role in helping to discover the nature of cancer and how to best determine a cure.”

“When looking at the pathogenesis of cancer, it begins at a molecular level and this determination is often the result of an adverse change in the genetic makeup of the affected

cells that constitute that target organ. Determining what went wrong at the genomic and proteomic levels not only allows scientists to identify etiology, but can also, in the future, develop a cure. Research enabled by the TTR will assist with this quest.”

“Patients asked to participate in the TTR project have been extremely supportive in every way,” adds Dr. Hayashi. “I am absolutely amazed that despite the adversity they are under – many have been recently told that they have cancer and are in the process of trying to grasp the magnitude and significance of their disease – they have all expressed a heartfelt wish to participate and contribute to this cause such that a cure may be found for those that are diagnosed with cancer in the future.”

Dr. Hayashi describes interaction with the TTR staff as “professional, warm and caring with a strong emphasis to reassure all patients that their privacy and confidentiality will remain intact.”

“One important area I would like the TTR to explore in the future includes the collection of more in-depth clinical information to allow for the correlation of a patient’s lifestyle with the abnormalities determined at the nuclear level. A good example would be to be able to compare abnormalities found in the genes of lung cancers to the smoking history of TTR donors,” adds Dr. Hayashi. “This will require a greater role for the clinician and front line providers in the TTR program.”

IDENTIFICATION OF CLINICALLY OCCULT DISEASE IN ORAL CANCER SURGERY

Dr. Michele Williams, Oral Oncology, BC Oral Cancer Prevention Program

Surgical oncologists specializing in oral cancer may soon have a device to assist in more accurately determining resection margins.

A new BC Cancer Agency technology that detects oral cancer with greater accuracy than the current methods has received a \$2.5 million grant from the National Institute of Dental Craniofacial Research (NIDCR) as part of the BC Oral Cancer Prevention Program, led by Dr. Miriam Rosin.

Currently being used on participants recruited to a clinical trial at the BC Cancer Agency, direct multi-spectral fluorescent visualization (FV) is already demonstrating effectiveness

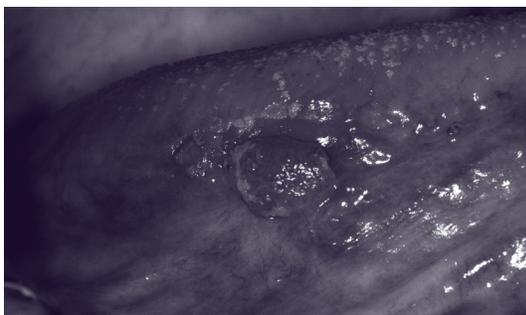
in ambulatory and operating room settings.

The blue light dispersed by this hand-held, portable device helps oral cancer specialists define the borders of a cancerous lesion that may be otherwise invisible using conventional white light. The device detects alterations to the normal autofluorescence of tissues; these alterations signal biochemical and morphological changes that are associated with the presence of cancerous and precancerous lesions. The detected changes often occur outside of the clinically apparent lesion and thus fluorescent

visualization appears to be a valuable adjunctive tool during the resection of oral cancers.

Initially developed for skin cancer, researchers discovered that it could be used to detect a number of epithelial cancers, including oral cancer.

“The beauty of this device is the ability to use it across many types of cancer,” explains Dr. Calum MacAulay, senior scientist at the BC Cancer Agency. “With oral cancer, the advantage is that you can see it early in the natural history of the disease with a device that has been validated in other cancer sites.”



Left panel: A white light image of squamous cell carcinoma (arrow) at right lateral tongue border (also showed at the shaded area in right panel).
Right panel: Determination of surgical margin (black dash line) using fluorescence visualization technique (white solid line).

UNITED STATES' NATIONAL CANCER DATA BASE

The National Cancer Data Base (NCDB) is a nation-wide oncology database founded in 1989 by the American Cancer Society and the American College of Surgeons. With information on approximately 80 percent of all newly diagnosed cancer cases and 15 million cases from 1985 - 2002, the database is a key tool in monitoring changes and variations in patterns of cancer care and patient outcomes. Data collected includes patient demographics, tumour characteristics, histology characteristics, type of first course treatment administered, disease recurrence, and survival information.

The data itself is collected and submitted from Commission on Cancer approved program registries using nationally standardized data item and coding definitions. Hypothesis-based special studies are also conducted that allow for the ad hoc collection of specific data to address important cancer problems. Another option is the ability to define benchmarking examples by which to compare treatments at specific hospitals against NCDB norms. Facility specific benchmark reports are now available for 60 cancer sites.

Data confidentiality is also of prime importance and the NCDB has pro-actively worked to continually ensure and maintain compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996 privacy regulations established by the Federal Government in 2003.

For more information on the NCDB please visit www.facs.org/cancer/ncdb/index.html.

AMERICAN COLLEGE OF SURGEONS' COMMISSION ON CANCER PRESENTATION HIGHLIGHTS



Frederick Greene,
Chair of the American
College of Surgeons'
Commission on
Cancer

Attendees of Dr. Frederick Greene's presentation at last November's BCCA Annual Conference gained an understanding of the long-established American College of Surgeons' Commission on Cancer giving insight, in turn, to the potential impact of BC's Surgical Oncology Network.

survival and quality of life for cancer patients through standard-setting, prevention, research, education, and the monitoring of comprehensive quality care". He also highlighted the Commission's evolution including the publication of the first standards to evaluate cancer clinics and registries in 1930 and the first grassroots network of surgeons identified to promote cancer programs in 1947.

Specifically, the Commission sets standards for quality multidisciplinary cancer care delivered primarily in hospital settings; surveys hospitals to assess compliance with those standards; collects standardized and quality data from approved hospitals to measure treatment

Commission on Cancer Mission

"The CoC is a consortium of professional organizations dedicated to improving survival and quality of life for cancer patients through standard-setting, prevention, research, education, and the monitoring of comprehensive quality care."

"The most far-reaching achievement by the Commission on Cancer in my opinion is the creation of a unified standard set for quality cancer care in hospitals throughout the United States. Through this mechanism and the creation of the National Cancer Data Base, we are able to give back to hospitals benchmarks that can be universally applied at these individual institutions," emphasized Dr. Greene.

Dr. Greene described the history of the Commission on Cancer established by the American College of Surgeons in 1922 as a "consortium of professional organizations dedicated to improving

patterns and outcomes; and uses the data to evaluate hospital provider performance and develop effective educational interventions to improve cancer care outcomes at the national and local level. The Commission's membership consists of over 100 individuals including surgeons representing the American College of Surgeons and representatives from the 40 national professional organizations affiliated with the Commission. The latter includes medical and radiation oncologists, radiologists, pathologists, nurses,

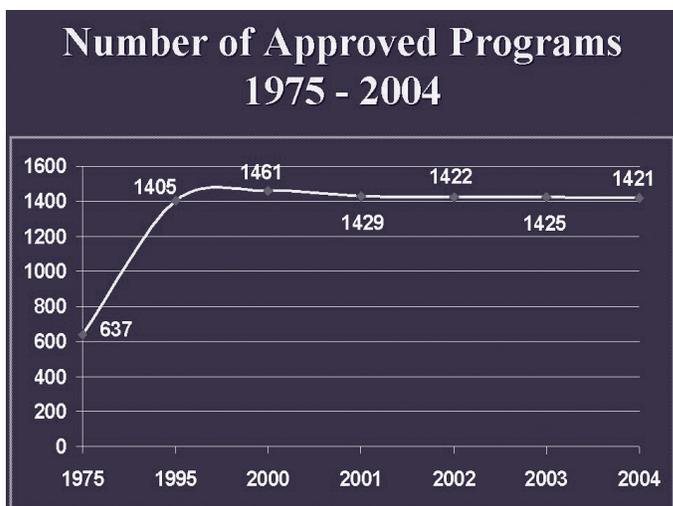
COMMISSION ON CANCER PRESENTATION HIGHLIGHTS Con't

cancer registrars, nutritionists, hospice and palliative care providers and administrators.

The Commission achieves a large portion of its mandate through its Cancer Liaison Program that includes a network of physician volunteers willing to manage clinically related cancer activities in their local institutions and surrounding communities. Initially, membership was limited to surgeons, but was expanded in the 1970s to reflect the multidisciplinary composition of professionals who care for patients with cancer. Today, 45 percent of the 1,600 Cancer Liaison Physicians represent non-surgical disciplines. There are 65 volunteer state chairs selected by the College Chapters

They strive to support the facility's efforts in complying with and maintaining the Commission's standards, facilitate activities with the interests of the cancer patients, facility, and the community in mind, and are dedicated to improving the quality of care delivered to the cancer patient. These liaison volunteers also promote participation in clinical trials, facilitate the provision of support services and early prevention and early detection programs, participate in their state cancer plan and ensure quality submissions to the National Cancer Data Base.

The National Cancer Database serves to improve the quality of cancer care by providing physicians, cancer

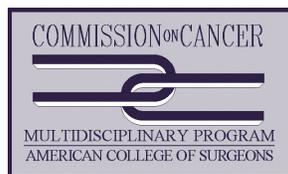


who liaise between the Commission and local members and spearhead state and regional initiatives. The American Cancer Society funds the Liaison Program.

Liaison members champion their local cancer program serving as the link to the Commission and acting as an agent of change within their community. They provide the leadership and direction to establish, maintain, and support their facility's cancer program and are charged with the task of spearheading Commission activities at the facility and community level.

registrars, and others with the means to compare their management of cancer patients with the way in which similar patients are managed in other cancer care centres around the country (see adjacent story).

To learn more about the Commission on Cancer please visit www.facs.org/cancer/index.html.



COMMUNITY PREVENTION COORDINATORS

It's a startling statistic: experts estimate that more than 50 percent of cancers are preventable. To help British Columbians reduce their risk of developing cancer, the BC Cancer Agency's Cancer Prevention Program is set to hire Community Prevention Coordinators across the province.

"As the physicians, nurses, researchers and other health care professionals who deal with cancer every day, we are dedicated to finding ways to reduce the burden of cancer in our patients and our communities," explains Dr. Carla Simon, Business Affairs Coordinator with the BC Cancer Agency's Prevention Program. "Ideally, we want to prevent it from occurring at all."

Coordinators will effectively coordinate, implement and mobilize strategies for action in cancer control within a geographic region. Particular emphasis will be on creating supportive environments for cancer prevention in communities, achieved through a combination of community action, public education, administration and teamwork.

Dr. Simon hopes to have the coordinators in place by early spring, so that each will take a proactive role in her/his community. Initiatives will be driven by specific community needs, and may include promoting the Healthy Living Schools and Sun Safe programs, along with other cancer prevention initiatives such as the Stop Smoking Before Surgery program, and the Clinical Tobacco Intervention Recognition Program, a series of online courses for health professionals.

"A key goal of the Province is to be the healthiest jurisdiction ever to host an Olympic and Paralympic Games," says Health Minister George Abbott.

Message from the Co-Chairs



Dr. Noelle Davis, Co-Chair and Provincial Program Leader for Surgical Oncology, BC Cancer Agency, Vancouver



Dr. Con Rusnak, Co-Chair and Executive Medical Director, Diagnostic and Surgical Services, Vancouver Island Health Authority

Recent articles on networks/communities of practice have cautioned members to be mindful of undergoing a “mid-life crisis”. As we approach the 5 year anniversary of the BC Surgical Oncology Network, it seems appropriate to reflect on the successes of our network and to identify the exciting challenges ahead.

CME

Under the leadership of Dr. Rona Cheifetz, the SON has developed and become known for its innovative CME program. We have hosted several conferences, measured actual learning, conducted two provincial travelling road shows and undertaken research projects. A recent survey found the program to be well known

and well respected.

Breast Cancer

The Breast Surgical Tumour Group has done considerable work in the area of Sentinel Lymph Node Biopsy

Rectal Cancer

Dr. Terry Phang, and the Colorectal Surgical Tumour Group have become well known for their rectal cancer project. The project, which aims to

National & International Recognition

Several SON members, including staff, have presented papers and posters at national and international conferences. We have established a reputation as leaders in the field of networks

Annual Planning Meeting

In November, the BC Surgical Oncology Network held its Annual Planning Meeting. This meeting was attended by surgical leaders from around the province and featured various presentations designed to elicit discussion around priorities and objectives for the Council.

Cancer Care Ontario

Dr. Hartley Stern reviewed several activities from Cancer Care Ontario (see page 5 for more information). He urged the SON to get buy in from the health authorities and to focus efforts on the CEO level. This led to a good discussion from participants on the need to involve administration when attempting to implement quality standards and quality improvement.

ACS Commission on Cancer

Dr. Rick Greene, Chairman of the American College of Surgeons Commission on Cancer (CoC), spoke about the CoC’s approval program and the 8 categories of standards that approved programs must meet. For

more information on the CoC, please see the article on pages 5 and 6.

Participants at the annual planning meeting were asked to rank the CoC categories in order of importance. Not surprisingly, Quality Improvement and Cancer Data Management were identified as the two critical areas in which the SON should focus its efforts.

Cancer leadership and institutional/programmatic resources were also identified as priority areas for the network.

Our thanks go out to the 30 plus individuals who participated in the planning session. Your insight and commitment provide great impetus to move forward.

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