



## Sarcomas of the Groin and Inguinal Canal



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### Case A

A 75-year-old man was diagnosed with a recurrent left inguinal hernia. He was taken to the operating room 10 months later, where unexpectedly he was found to have an 8-10 cm mass in the scrotum, which was excised. The pathology showed this to be a high-grade liposarcoma of the cord with positive proximal resection margin. He was taken back to the operating room where he underwent a piece-meal re-excision, including a hemiscrotectomy and orchidectomy. The pathology of the re-excision once again showed high grade liposarcoma with a 3 mm margin. Within 3 months of this surgery, he developed recurrent

nodules at the medial and lateral margins of the surgical bed. He was referred to the Cancer Agency where he was staged and then underwent radical radiation therapy. This was followed by radical excision taking the full thickness of the abdominal wall, and inguinal canal with reconstruction using mesh and a myocutaneous flap. Margins were clear on this excision and most of the residual tumour was necrotic. At 3 years follow-up there has been no local recurrence but recent imaging has suggested the development of pulmonary metastases.

### Literature Review

Sarcomas are uncommon tumours comprising about 1% of all malignancies. Soft tissue sarcomas (STS) represent even a smaller proportion of the whole group. As these lesions can occur anywhere in the body they may present to any surgical

specialist. A review by the Armed Forces Institute of Pathology reported that 12% of STS occur in the inguinal region. Overall less than 5% of STS are of GU origin.<sup>1</sup> The largest series published is by Brooks from Memorial Sloan Kettering. This was a retrospective review of 88 patients treated between 1982 and 1998. The median age was 52 and 63% were male. In their population, 16% had been given a preoperative diagnosis of hernia (there is some bias here based on the nature of referrals to MSKCC). Liposarcomas constituted the most common type (27%), followed by leiomyosarcoma and malignant fibrous histiocytoma. Sixty percent were high grade and 19% had neurovascular invasion. Their outcome data showed a 72% 5-year survival but only 49% were disease free. They identified high grade, neurovascular invasion, and positive margin as poor prognostic factors. Of lesser significance

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# From the Editor

In this newsletter we are happy to bring you new information and progress regarding the activities of the Surgical Oncology Network. A highly successful planning workshop was held in December to plot the future direction of this important initiative. Great progress has been made in selecting chairs of various tumour site groups to guide the efforts of those interested in surgical treatment of malignant disease. The structure of the Council & Network (see page 4) will give you an idea of who has been involved to date. Significant effort has gone into this and all members deserve credit.

Much remains to be done however. My role as Chair of the Communications Committee is to help to guide our efforts in communicating with those in the community with an interest in surgical oncology. The goal of this newsletter is to keep you informed of

the activities of the Surgical Oncology Network, bring you up-to-date on the work of the regular committees including Continuing Medical Education, Communications, Research Outcomes & Evaluation and Clinical Practice Guidelines. In addition you will find useful Internet links and clinical reviews that we hope you will find valuable in your day-to-day oncologic practice.

We plan to make this newsletter as user-friendly as possible. Among the ongoing initiatives we are highlighting this issue is the efforts of the Rectal Cancer Committee chaired by Dr. Terry Phang. I was fortunate enough to attend the Rectal Cancer Update held in November and organized by Dr. Phang with the assistance of the University of British Columbia and members of the Surgical Oncology Network. Their hard work resulted in an outstanding conference that

was very well attended and received by community surgeons throughout the province and indeed from across Canada. The feedback was excellent and we can look forward to more outstanding educational opportunities in this vein.

As with any endeavor, we must seek to produce a newsletter that is useful and appreciated by our audience. The newsletter is in its early stages and our goal is to make it one that you find useful and look forward to reading. I invite your feedback regarding its contents and we are always open to suggestions regarding future articles.

I hope you enjoy the spring edition.

Blair Rudston-Brown, MD FRCSC  
General Surgery, Nanaimo  
Chair, Communications Committee

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## Messages from the Co-chairs



**DR. NOELLE DAVIS,**  
Co-chair and  
Provincial Program  
Leader for Surgical  
Oncology,  
BC Cancer Agency,  
Vancouver

Considerable effort has gone into establishing an effective membership structure for the Council & Network – one that is both representative and accountable to all surgical oncology stakeholders in the province yet has the flexibility and focus to address specific issues promptly. Our 13 Surgical Tumour Site Groups exemplify this direction. All major surgical tumour sites are represented (see page 4 for a complete list). Operating principles for each of these groups are drafted and recruitment of volunteers is underway.

Once membership is finalized, Surgical Tumour Site Groups will identify challenges and concerns within their specialty and discuss potential solutions. The goal is

to work with the BCCA Tumour Groups, but focus on the surgical issues within those tumour sites. Involvement will not be onerous, mainly including periodic teleconferences and the gathering of some follow-up information. Our infrastructure and staff will work with the Surgical Tumour Site Groups to handle follow-up and implementation. The potential for impact is significant.

A prime example of this structure at work is the Rectal Tumour Group chaired by Dr. Terry Phang of St. Paul's Hospital. This advisory group formalized its role following the rectal cancer conference last November. At their decision, the group, with members from Vancouver to Prince George to Victoria, meets monthly via teleconference and is working with the Council & Network to improve local recurrence rates in rectal cancer. Working together with the BCCA Rectal Cancer Group, the committee is reviewing CME and data collection needs as well as identifying opportunities to better integrate practices with the BCCA.

The Surgical Tumour Site Groups

provide great opportunity to mobilize resources on specific issues and make a positive contribution to surgical oncology practice in BC.

Contact Dr. Noelle Davis at  
[ndavis@bccancer.bc.ca](mailto:ndavis@bccancer.bc.ca)



**DR. CON RUSNAK,**  
Co-chair and  
Chief of Surgery,  
Capital Health  
Region, Victoria

Our annual planning session, held last December, resulted in a set of realistic objectives to directly address our mandate. We defined specific priorities for action in each of our areas of focus including Continuing Medical Education, Research & Outcomes Evaluation, Clinical Practice Guidelines and Communications.

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were deep depth and patient age >50.<sup>2</sup> In a more general review of 1,736 hernia repairs (1992-1997), 22% of patients were diagnosed with cord lipomas. There were 2 sarcomas (<0.1%). On average the benign tumours were smaller (5.5cm vs. 9 cm) and occurred in younger patients (35 years vs. 60 years. In both of the sarcomas the patients had been diagnosed preoperatively with incarcerated hernias but in each case the mass was noted to be painless and non-tender, with no GI symptoms.<sup>3</sup>

## Discussion

Soft-tissue masses in any location should be approached with the possibility of sarcoma in mind (even though these are uncommon). Cure and local control is best achieved by doing the 'right' operation the first time. Salvage rates for re-operative surgery are improving but do not approach primary surgery with curative attempt. The general approach to soft tissue sarcoma is outlined in detail in the Cancer Management Guidelines section of the BCCA website [www.bccancer.bc.ca](http://www.bccancer.bc.ca). If a suspicion of a soft tissue tumour is made preoperatively these patient should have regional imaging in the form of CT and/or MRI prior to any intervention. Once imaging is obtained, a diagnosis is typically made by core tissue biopsy. The technical approach to the biopsy requires that the biopsy tract be excised

at the time of definitive surgery, so this must be discussed with the radiologist and the surgeon who will ultimately care for the patient and is best accomplished in a institution with experience with these lesions. Full staging in the form of CXR and CT chest/abdomen/pelvis is part of the routine work-up. The operative plan should be for a wide excision, as even if the tumour is low grade there is a high local recurrence rate with a positive margin. A shell-out procedure always leaves a positive margin. A consultation with a member of Sarcoma Group is strongly encouraged.

In the event of the unexpected finding of a soft tissue mass at the time of surgery (hernia repair or scrotal exploration for a 'testicular mass') the dissection should be limited so as not to contaminate the operative field. The mass should be biopsied using a core needle or via a small incisional biopsy. It is critical that hemostasis be obtained and that any tumour capsule be closed over the biopsy site to prevent contamination. No further intervention should be undertaken in the operating room at that time. The patient is then investigated and managed appropriately based on the pathology report.

## Case Presentation B

A community urologist sees a 57-year-old man regarding a solid left scrotal mass. The patient has surgery promptly and the non-testicular mass is excised. The pathology

shows a Grade II leiomyosarcoma with a microscopically positive margin. The surgeon contacts a member of the Sarcoma Tumour Group for advice. The patient is fully staged and the pathology is reviewed centrally. Imaging shows no evidence of residual tumour and no metastatic disease and the films are reviewed by the consulting surgical oncologist. After discussion regarding the extent of the recommended surgery, the patient is taken back to the operating room by the community surgeon who undertakes a wide, en-bloc resection removing the hemiscrotum and all its contents extending well beyond the proximal extent of the initial surgery. The final pathology shows no residual disease. A consultation is to be arranged with an oncologist at the local cancer agency regarding recommendations for ongoing follow-up.

## References

1. Montgomery E, Buras R. *Incidental liposarcoma identified during hernia repair operations*. Journal of Surgical Oncology 1999; 71(1): 50-53
2. Brooks AD, Bowne WB, Delgado R, et al. *Soft tissue sarcomas of the groin: Diagnosis, management and prognosis*. Journal of the American College of Surgeons 2001; 193(2): 130-136
3. Froehner R, Lossnitzer A, Manseck A, et al. *Favorable long-term outcome in adult genitourinary low-grade sarcoma*. Urology 2000; 56:373-377

Ultimately, we exist to:

- ensure expert and equitable access to surgical consultation;
- improve care outcomes through participating on multidisciplinary care teams and reducing variation in surgical care practice;
- develop research programs relating to the surgical management of cancer and academic teaching programs in surgical oncology; and
- support evidence-based decision making.

Among the deliverables you will see this year are:

- Another surgical education opportunity at the BCCA's annual conference in Vancouver and other lectures throughout the province;
- Activities that will bring educational opportunities to you through the Internet, such as MedicalRounds.com and an online tutorial helping surgeons conduct Medline searches;
- Opportunities to interact with your colleagues through a "surgeons only" Web site;

- Further development of a database to support outcomes research and specifically Phases II to IV of the BC Atlas of Surgical Oncology looking at in-hospital outcomes, BCCA linkages in terms of referrals and mortality and linkage with BCCA adjuvant therapies.

My thanks go out to the 35 plus individuals who participated in the planning session. Your insight and commitment provides great impetus to move forward.

Contact Dr. Con Rusnak at [crusnak@caphealth.org](mailto:crusnak@caphealth.org)

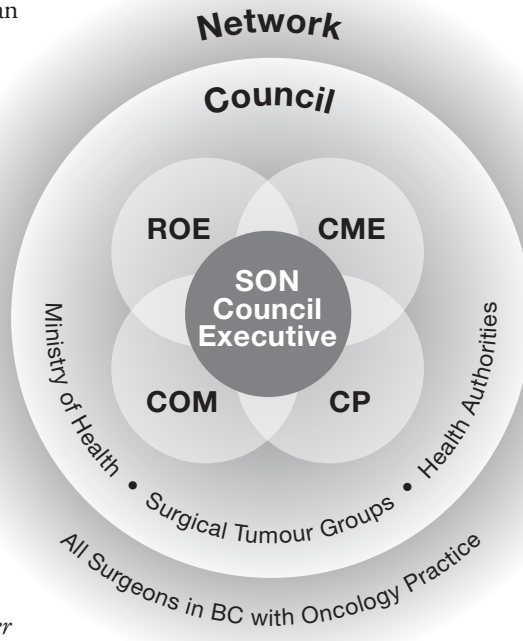
# Key Players, Roles & Opportunities

An effective structure, mandate and goals are key to the success of an organization like the BC Provincial Surgical Oncology Council & Network. After much consultation, Council members adopted formal terms of reference in September of last year.

**The Council & Network's purpose:** to assist in the planning, implementation and promotion of activities for the Surgical Oncology Network. The Council provides guidance on matters relating to improved surgical oncology practice and facilitating the efficient passage of patients through all aspects of cancer care, including the coordination of a surgical liaison function between the cancer centers, hospital, general and specialty surgeons, and family physicians.

**The Network** includes all providers of surgical oncology services in the province from surgeons in remote areas to sub-specialists.

**The Council** meets annually to plan for surgical oncology initiatives and includes:



the Executive Director of the BC Cancer Agency, the Provincial Program Leader for Surgical Oncology, a surgical oncology representative from each health region, the UBC Department of Surgery Chair, a Ministry of Health representative, rep-

representatives from the thirteen Surgical Tumour Groups, two clinical community surgeons, the Regional Operations/ Cancer Care Leader from each of the four Cancer Centres and the Provincial Program Leader for Population and Preventive Oncology.

**The Surgical Oncology Council Executive** meets monthly to establish and review priorities for the Council & Network. Membership includes a subgroup of the above and chairs of the four standing committees: Clinical Practice, Research & Outcomes Evaluation, Communications and Continuing Medical Education.

**The Surgical Tumour Groups** are currently being assembled. They will meet at least quarterly to address issues and needs within each specialty and liaise with the Council & Network overall.

**Terms of reference for all committees** are drafted and available for review at [www.bccancer.bc.ca/son](http://www.bccancer.bc.ca/son). Volunteers are being sought to serve on all groups.

## Council Executive Members

**Dr. Simon Sutcliffe**, President & CEO, BCCA

**Dr. Noelle Davis**, Co-Chair and Provincial Program Leader, Surgical Oncology, BCCA

**Dr. Con Rusnak**, Co-Chair and Victoria Island Health Authority Representative

**Dr. Garth Warnock**, Vancouver Coastal Health Authority Representative and Head, UBC Department of Surgery

**Dr. Peter Doris**, Fraser Health Authority Representative

**Dr. Gil Wankling**, Northern Health Authority Representative

**Dr. Andy Kluftinger**, Interior Health Authority Representative

**Dr. Blair Rudston-Brown**, Chair, Communications Committee and Community Surgeon Representative

**Dr. Maureen Leia-Stephen**, Community Surgeon Representative

**Dr. Rona Cheifetz**, Chair, Continuing Medical Education Committee

**Dr. Andy Coldman**, Provincial Cancer Control Strategy Leader

**Dr. Neil Fatin**, Medical Consultant, Regional Programs, Ministry of Health

**Murray Mackinnon**, Biostatistician, Surgical Oncology, BCCA

**Barbara Poole**, Provincial Surgical Oncology Process Leader, BCCA

**Tina Strack**, Council & Network Manager, BCCA

## Surgical Tumour Group Chairs

Brain - **Dr. Brian Toyota**, Vancouver Hospital

Breast - **Dr. Al Hayashi**, Victoria General Hospital

Colorectal - **Dr. Terry Phang**, St. Paul's Hospital

Endocrine - **Dr. Sam Bugis**, St. Paul's Hospital

Esophageal/Lung - **Dr. Richard Finley**, Vancouver Hospital

Gastrointestinal - **Dr. Gil Wankling**, Prince George Regional Hospital

Gynaecology - **Dr. Elissa McMurtrie**, Victoria General Hospital

Head & Neck - **Dr. Frank Wong**, Royal Jubilee Hospital

Hepatobiliary - **Dr. Charles Scudamore**, Vancouver Hospital

Melanoma and Skin - **Dr. Adrian Lee**, Surrey Memorial Hospital

Paediatrics - **Dr. Ken Brown**, Children's Hospital  
Sarcoma/Spinal - **Dr. Bas Masri**, University of BC  
Urology - pending

To become involved – and impact the future of surgical oncology in BC – please contact Council & Network Manager, Tina Strack at [tstrack@bccancer.bc.ca](mailto:tstrack@bccancer.bc.ca).

# Highlights & Outcomes: Rectal Cancer Workshops

Participants at the Council & Network's first major CME collaboration with the BC Cancer Agency explored the problem of high recurrence rates of rectal cancer in BC and began devising solutions including a recommendation to establish specific protocols and the formation of a surgeons' advisory group to address ongoing strategic issues. Significantly lower recurrence rates and new standards published in The Netherlands were also reviewed.

This progress took place at two educational workshops included as part of the BC Cancer Agency's Third Annual Cancer Care Conference last November. The workshops were offered in collaboration with the BCCA, the BC Surgical Society and the University of British Columbia Department of Surgery and featured a hands-on session on *Total Mesorectal Excision (TME) for Optimum Rectal Cancer Surgery* and a broader session on *Optimum Interdisciplinary Management of Rectal*

*Cancer*. Renowned international speakers joined the fully subscribed events bringing the total attendance to over 200 surgeons and pathologists.

"We agreed to establish protocols for preoperative staging investigations (CT, MRI, endorectal ultrasound), preoperative radiation, TME surgery and pathology and to create a system of prospective

	1996	BC Recurrence Rates	Dutch Trial Recurrence Rates
Stage 1		7%	0.5%
Stage 2		16%	1.0%
Stage 3		27%	4.3%

data collection," stated Dr. Terry Phang, Chair of the Council & Network's Colorectal Tumour Group, Associate Professor with the Department of Surgery at UBC and Head of the Division of General Surgery at St. Paul's Hospital. "The multidisciplinary group that came together as a result includes surgeons from high volume hospitals throughout the province and BCCA medical and radiation oncologists. We are also going

to be sure to involve hospital radiologists and pathologists."

Further tangible outcomes include two lecture postings from the workshops on MedicalRounds.com: *Rationale for TME* by Dr. Brendan Moran and *Locally Recurrent Rectal Cancer* by Dr. Don Buie. Surgeons and practitioners anywhere in the province can now listen to these lectures

and view the presentations at their convenience and at no cost. A manuscript on "*Practice Patterns and Appropriateness of Rectal Cancer Management in BC*," will also be

published in an upcoming edition of the BC Medical Association Journal.

Overall, participants ranked the workshops as highly relevant and exceptional in both format and content.

For further details contact Dr. Phang at [tphang@providencehealth.bc.ca](mailto:tphang@providencehealth.bc.ca). Suggestions for future CME events are welcome. Please submit ideas to Council & Network Manager, Tina Strack at [tstrack@bccancer.bc.ca](mailto:tstrack@bccancer.bc.ca)

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## Medline Internet Tutorial Update

Progress continues on the development of an Internet Course to teach surgeons to conduct online literature searches via Medline.

"We are now looking for surgeons who currently do not do their own literature searches or have tried with little success. We would like up to six surgeons to test the course and provide feedback to ensure that we are ready to launch," noted Tina Strack, Council & Network Manager. "CME credits will be granted and I would be delighted to hear from anyone who would like to take part at [tstrack@bccancer.bc.ca](mailto:tstrack@bccancer.bc.ca)."

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## Report Card Now Available

The BC Cancer Agency's Provincial Program for Surgical Oncology recently released a Report Card highlighting its accomplishments and future plans. The publication is now available on the Surgical Oncology Council & Network Web site - [www.bccancer.bc.ca/son](http://www.bccancer.bc.ca/son) under Updates.

## Opinions On Surgical Oncology Waitlists

Preliminary results are available from the waitlist survey we conducted with the last issue. A clear theme emerged from the 72 replies received to date – the interval of most concern is "the time of the decision to operate to the receipt of the operation". 43% stated that delays for this interval were of most concern compared to only 22% for the next contender, the time from the first visit to the GP to that to the surgeon. This was also reflected in respondents' written comments and the amount of time indicated that they were prepared to spend gathering information on delays.

*First time winner – Dr. Andrew Piers, a General Surgeon on the Sunshine Coast is the winner of our prize draw entered by all respondents to our waitlist survey last December. He received a \$300 gift certificate for any Fairmont Hotel & Resort. Thanks to all who participated.*

# Literature Reviews

Submitted by Dr. Samuel Bugis (1 and 2) and Dr. Terry Phang (3) of St. Paul's Hospital

## 1) Size is not the only criterion in evaluating adrenal tumours

Barnett CC, Varma DG, El-Naggar AK et al. Limitations of size as a criterion in the evaluation of adrenal tumours. *Surgery* 2000;128:973-83.

### *Objective*

Evaluation of tumour size, radiographic features and other clinical parameters to predict adrenal malignancy.

### *Study design*

Retrospective review.

### *Setting*

The University of Texas M. D. Anderson Cancer Center, Houston, Texas.

### *Patients*

One hundred and seventeen patients were evaluated for primary adrenal tumours or for metastatic adrenal malignancy over 30 years. Only two were not operated upon, leaving 115 adrenal tumours for review.

### *Outcome measures*

Tumour size (radiographic and pathologic), imaging characteristics, histology, disease free and overall survival (excluding patients who presented with distant disease) and various clinical characteristics.

### **Results**

There were 38 primary adrenal cancers, 12 metastases and numerous other diagnoses including 27 pheochromocytomas, 22 cortical adenomas, five myelolipomas, five cortical hyperplasias, four ganglioneuromas and two cysts.

Mean age of the primary adrenal carcinoma patients was 44 years and mean radiographic tumour size was 9.5 cms. There were five cancers smaller than 5 cms (13.5% of all primary cancers). Mean age in these patients was 49 years. Four of five had

some radiographic evidence of malignancy – heterogeneity, hemorrhage – and two were functioning tumours. Three of the five small primary cancers recurred. There was no difference in disease free survival or overall survival in small vs large tumours.

Thirty-eight patients (mean age of 43 years) had benign tumours (excluding pheochromocytomas) with a mean size of 4.0 cms. Ten of these (26%) were larger than 5 cms and seven of these ten were correctly identified as benign based on imaging characteristics.

### **Conclusions**

Tumours that are functioning, tumours with radiographic features suggesting malignancy and tumours greater than 4 cm should all be excised.

(Commentary follows summary of the next article)

## 2) Laparoscopic adrenalectomy may be safe for malignant tumours

Kebebew E, Siperstein AE, Clark OH, Duh QY. Results of laparoscopic adrenalectomy for suspected and unsuspected malignant adrenal neoplasms. *Arch Surg* 2002; 137:948-53.

### *Objective*

Is laparoscopic adrenalectomy for malignant adrenal tumours safe and effective?

### *Study design*

Retrospective review.

### *Setting*

University of California, San Francisco

### *Patients*

Twenty-three patients with adrenal malignancy (primary and metastatic) were studied out of 215 patients who underwent laparoscopic adrenalectomy over a nine-year period.

### *Outcome measures*

Surgical resection margins, recurrence rates and disease free survival.

### **Results**

Twenty-three patients had 24 laparoscopies, 20 for resection, three for biopsy and one for diagnosis. There was one conversion for intraoperative bleeding and two other significant perioperative complications (ileus and pulmonary embolus). Surgical margins were clear in all 20 resections. Fine needle biopsy was positive in only four of seven cases.

Six patients had primary malignancies with a mean tumour size of 6.6 cms (2.5-12 cms). Cushing syndrome was the presentation in two while four were incidentalomas. Only one was a suspected malignancy before surgery. Diagnostic laparoscopy confirmed local invasion in that patient and an open procedure was performed. Three of the five laparoscopically resected cancers recurred. All three had open reoperation and only one was disease free at last follow up.

Metastatic adrenal tumours were suspected in 17 patients and proven at surgery

in 15. Two patients had no evidence of malignancy after biopsy. Metastases were both metachronous and synchronous with lung and renal cell the commonest primary sites. Four patients in the metastatic tumour group had distant recurrences

### **Conclusions**

Laparoscopic approach to adrenal malignancy is reasonable in the absence of local invasion if a complete resection is technically feasible.

### **Commentary**

The incidentally discovered adrenal mass is the most common adrenal disorder encountered today. An adrenal incidentaloma is defined as a mass greater than one centimeter discovered at the time of imaging for a non-adrenal related problem. This occurs in 1-4% of all abdominal CT scans. There are two questions that must be asked when an adrenal mass is discov-

ered: 1) Is this mass hormonally active?  
2) Is this mass a malignancy?

Hormone screening protocols will include urinary metanephrine and catecholamines, a 1 mgm dexamethasone suppression test, plasma aldosterone and renin in patients with hypertension and sex hormone assays if clinically indicated.

Primary adrenal malignancy is very rare, with an incidence of about two per million population while occurring in about 4% of surgically treated incidentalomas. About half of all primary tumours are functioning. The majority of primary adrenal cancers are greater than 6 cms in diameter but 10-15% are smaller.

The first article by Barnett from M. D. Anderson Cancer Center addresses the issue of size as a criterion for malignancy. It spans a period both before and after the common use of high resolution imaging. The authors support the use of both radiographic features and size to assess the risk of malignancy since 13.5% of their primary cancers were less than 5 cms. The radiographic features that are suspicious for malignancy include heterogeneity, irregular shape and margins as well as hemorrhage on CT, lack of

fat suppression on MR out of phase imaging and heterogeneous signal intensity on T2-weighted MR.

If functioning adrenal tumours of any size or those with radiographic features of malignancy were removed, as well as tumours greater than 4 cms in diameter, all of the malignant tumours in this series would have been identified. These recommendations are consistent with other reports in the literature. Until a more specific marker for malignancy is identified, we will look for the best balance between discovering all cancers while limiting the number of operations for benign, non-functioning masses.

The second article from The University of California San Francisco addresses the safety and efficacy of the treatment of adrenal malignancy by laparoscopic removal. In this retrospective review, there were 215 laparoscopic adrenalectomies over nine years – only six were primary adrenal cancers and 17 more were metastatic adrenal disease.

Surgical treatment for primary vs metastatic adrenal cancers must be discussed separately. Surgical removal of primary

cancers is the mainstay of treatment and with clear margins is the best predictor of outcome – still only 40% survival at five years. The negative margins achieved in these five patients resected by laparoscopy are a function of the skill and expertise of the authors. As mentioned in the discussion following the paper, the goal needs to be complete excision. That may be performed laparoscopically or open. The individual surgeon should make that judgement based on the patient and their own experience.

Kebebew and colleagues have also demonstrated the safety of laparoscopic removal of adrenal metastases. The efficacy of such management is considerably more controversial. A multidisciplinary team may be especially helpful in making decisions about diagnosis and treatment.

Finally, almost all the surgical reports on adrenal masses are retrospective reviews, including these two articles. Given the relative rarity of surgery for adrenal masses of any kind, especially malignancies, our management and treatment guidelines will likely continue to come from case reviews by surgeons at large centers with concentrated skill and experience.

### 3) The surgeon as a prognostic factor after the introduction of total mesorectal excision in the treatment of rectal cancer

Martling B, Cedermark B, Johansson H, Rutqvist LE, Holm T. Br J Surg 2002; 89: 1008-1013.

#### Summary

Impact of the Swedish TME teaching project (workshops with surgeon Bill Heald and pathologist Phil Quirke) on the practice of rectal cancer surgery was assessed by analyzing whether surgeon participation in the workshops and surgeon case volume influenced patient outcomes. All 652 rectal cancer resections in Stockholm between 1995 and 1997 were included. There were 46 surgeons of whom 26 attended workshops. Radiotherapy, TME and sphincter-preserving surgery were more common among patients treated by surgeons attending workshops. High volume surgeons performing more than 12 rectal cancer operations per year were compared to low volume surgeons performing  $\leq$  12 operations per year. Local recurrence was 4% vs 10% and rectal cancer death was 11%

vs 18% for high vs low volume surgeons, respectively. Attendance at a TME workshop and high case volume improved clinical outcomes for rectal cancer.

#### Commentary

Bill Heald began to publish his excellent local recurrence rates of 5% in the late 1980's and he visited UBC in about 1991. Through his efforts, total mesorectal excision (TME) has increasingly become accepted as the preferred surgical technique for rectal cancer resection. Despite widespread information on TME and acceptance that TME is the surgical technique of choice, our local recurrence rates for rectal cancer in BC in 1996 are about 16% overall for stages 1-3. In contrast, the Dutch and Swedes report local recurrence of less than 5% by combining short course preoperative radiation and TME. Great effort has been taken by the Dutch and Swedes to train their surgeons to perform TME using workshops and proctoring.

In BC, we need to recognize that there is a problem with high local recurrence rates. We should adopt the strategies of preoperative radiation and TME used by the Dutch and Swedes in order to improve our outcomes. BCCA is encouraging use of short course preop radiation for rectal cancer patients preoperatively staged using CT, MR and endorectal ultrasound. Already nearly half of BC general surgeons have attended a TME workshop. Surgeons interested in continuing to do low rectal cancer surgery should attend a TME workshop. We need to organize a system of proctoring and improve pathology reporting to assure TME is being performed. Outcomes feedback to individual surgeons can occur with prospective data entry into a database system hopefully funded by BCCA and supported by surgeons. BC outcomes for rectal cancer management will improve. There remains uncertainty as to whether individual surgeons will have a high enough case volume required for the best results.

# Canadian Strategy For Cancer Control – Implementation Upcoming

“We now have a national cancer control strategy that will result in coordinated and collaborative efforts in all provinces and territories including specific actions to improve cancer prevention and the steps to take when cancer occurs,” stated Dr. Simon Sutcliffe, CEO and President of the BC Cancer Agency and Chair of the Governing Council of the Canadian Strategy for Cancer Control Council. “Our next task is determining how to most effectively implement selected aspects of the strategy within the various regions and provinces.”

These remarks summarize the workshop sponsored by the BCCA, the Canadian

Cancer Society – British Columbia and Yukon Division, and the Canadian Cancer Advocacy Network – BC and Yukon Division, and held immediately preceding the November BCCA Annual Cancer Care Conference in Vancouver. Over 250 people attended the event highlighting the Canadian Strategy and its importance to patients and health care providers. Participants focused in particular on requirements for successful implementation in BC and the Yukon.

“This strategy moves us further along the cancer continuum in that it focuses across the cancer control spectrum and takes a popula-

tion-based approach,” stated Barbara Poole, the Council & Network’s Process Leader. “It reflects our goal to enable a more fully integrated cancer care system,” she added.

The workshop also covered the role of cancer prevention, benefits of Clinical Practice Guidelines, a strategy to better provide patient support, plans to broaden the scope of translational cancer research in BC and the Yukon and a national database for cancer health care professional management.

Full details on the Canadian Strategy for Cancer Control are available at [www.cancercontrol.org](http://www.cancercontrol.org).

## Web Resources of Interest

Descriptions come directly from each website. These sites have not been reviewed by the members of the network and are provided for information only.

**Oncology Spectrum(tm)** - <https://oncology.rochecanada.com/welcome/>  
a Web site dedicated to oncology professionals who need a highly accessible source of information on breast cancer, colorectal cancer, and hematological malignancies. Sponsored by Hoffmann-La Roche Canada, the services of Oncology Spectrum(tm) are free of charge and include images to create presentations, a searchable medical-reference database, and learning resources.

**Medscape** - <http://www.medscape.com/>  
offers specialists, primary care physicians, and other health professionals the Web’s most robust and integrated medical information and education tools. After a simple, one-time, free registration, Medscape automatically delivers to you the specialty site that best fits your profile. You can also change your Medscape home page to any of our specialty and profession sites.

**MedicalRounds** - <http://www.medicalrounds.com/>  
webcasts multimedia presentations and conferences for many contributing medical groups that can be viewed with equal quality by those with the slowest of Internet connections. This site maintains an extensive database of links to other free multimedia medical presentations. If you are looking for a free online medical presentation, you will likely find it browsing through our online auditoriums or searching the database.

**The Western Canada Waiting List Project** - <http://www.wcwl.org/>  
a consortium of medical associations, regional health authorities, health research centres, and ministries of health which will develop valid reliable, clinically transparent and useful tools to assist the management of waiting lists in cataract surgery, children’s mental health, general surgery, hip and knee replacement, and MRI scanning.

**If you know of a useful Web site that you would like to share with your colleagues please e-mail the address to Tina Strack at [tstrack@bccancer.bc.ca](mailto:tstrack@bccancer.bc.ca).**

## For more information

This newsletter is published quarterly. To submit story ideas, learn more about the BC Surgical Oncology Council & Network or to become involved please contact:  
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[www.bccancer.bc.ca/son](http://www.bccancer.bc.ca/son)

## 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 decision-making, evidence-based guidelines, a high quality continuing education program, and regionally based research and outcome analyses are the initial priorities.