Family Practice Oncology Network Newsletter

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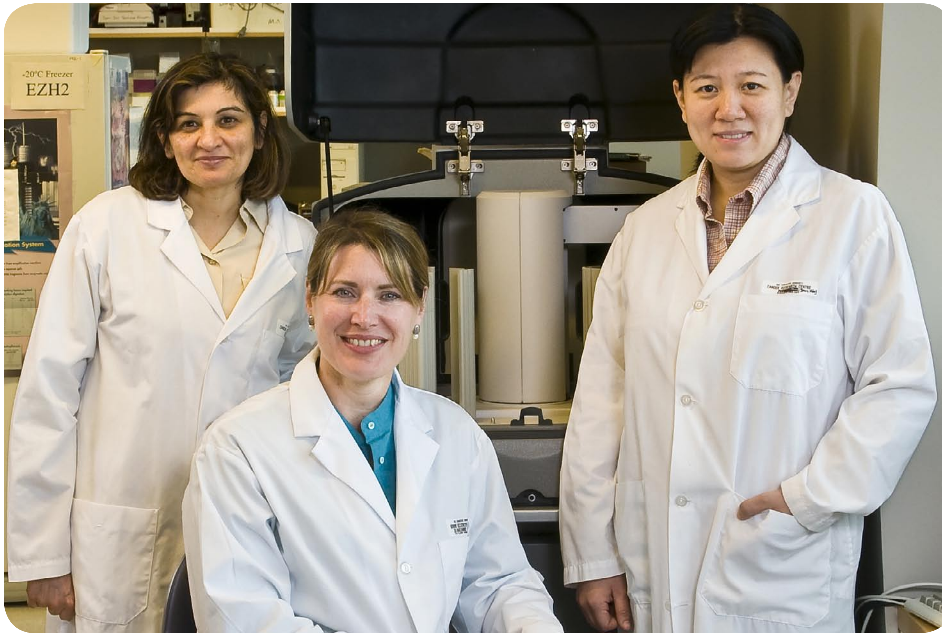
BC Cancer Agency
CARE + RESEARCH
An agency of the Provincial Health Services Authority

Pioneering Developments in Prostate Cancer Research



(Left to right) Nasrin (Rina) Mawji, Dr. Marianne Sadar and Jun Wang are part of the research team of the BC Cancer Agency's Sadar Prostate Cancer Laboratory working to develop therapies that will delay or prevent tumour progression and the emergence of hormone independence in prostate cancer.

It all started with a love for fishing and pursuits in the great outdoors of British Columbia. Armed with an undergraduate degree in biochemistry from Simon Fraser University, Dr. Marianne Sadar thrived as a Research Assistant with the Department of Fisheries and Oceans' Laboratory in West Vancouver where she studied environmental toxins in fish. Once she completed her PhD at the UK's University of Bradford, including two fellowships in Sweden, she returned to Vancouver in 1995 expecting to continue her work on chlorophenols and dioxins in fish. Instead, she applied and was thrilled to take on a postdoctoral research position with Dr. Nicholas Bruchovsky in the BC Cancer Agency's (BCCA) Department of Cancer Endocrinology.

Thirteen years later, she serves as Program Leader for Prostate Cancer Research at the BCCA, Senior Research Scientist with the Genome Sciences Centre at the BCCA, and Associate Member of Pathology and Laboratory Medicine and Honourary Associate Professor of Surgery at the University of British Columbia. Her Prostate Cancer laboratory is housed within the Genome Sciences Centre at the BC Cancer Research Centre.

Her research builds on Dr. Bruchovsky's critical discovery of dihydrotestosterone, the male hormone required for development of the prostate, and his belief that every research project should answer a clinical question and improve patients' lives.

Dr. Sadar's work began with the aim to increase the efficacy of treatment for prostate cancer patients whose cancer has progressed to a more aggressive, androgen-independent state. She continues this research today, now focusing on the development of therapies that will delay or prevent tumour progression and the emergence of hormone independence in prostate cancer. Her insights follow:

The Quest for a Target

Treatment for advanced prostate cancer involves the reduction of the patients' levels of testosterone (androgen). Unfortunately, this form of therapy is not curative, and eventually the disease will return in an androgen-independent form. Once the disease is androgen independent, the survival time is approximately two years before the patient will succumb to his disease. There are no effective therapies

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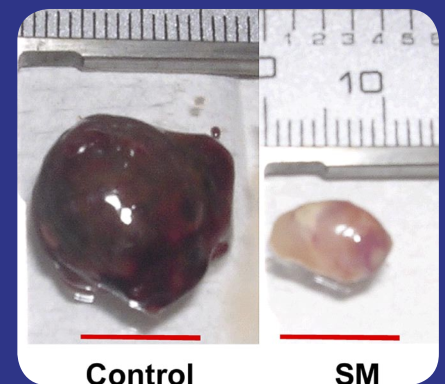
Small molecule (SM) isolated from a marine sponge blocked the growth and progression of androgen independent prostate cancer. Red bar = 10 mm



Research results last February showed remarkable changes in androgen-independent prostate cancer tumours treated with drug-like compounds from marine sponges. Tumours that were once blood engorged (as the example on the left), turned white (as the example of the right), shrank and disappeared.

Capacity-building for palliative care in BC

By Pippa Hawley, B.Med., FRCPC, Palliative Medicine Specialist at the BC Cancer Agency and Residency Program Director with the University of British Columbia's Division of Palliative Care

As winter approaches and we brace ourselves for the always busier year ahead, it is a good time to assess the progress in palliative care over recent years. Demographic changes affecting our patient population are leading to an almost exponential rise in the need for palliative care services. With the increasing success of palliative oncological treatments, and the increasing numbers of older people living with chronic illness, service provision requirements for the future are huge. We need to think ahead as to how we can cope in a climate of economic uncertainty and manpower shortages in all medical disciplines.

I (and many of my colleagues) believe that in order to meet this challenge a three-level model of care is the best, if not only workable option. I am closely involved in developing all three tiers of the model and hope that I can be confident of having access to an appropriate level of care when I need it myself – hopefully not too soon!

For the first tier of care we are improving the general level of competency in basic palliative care in all clinicians through education so that every person facing a life-threatening illness in BC can be confident that their family doctor, surgeon, internist or other specialist is trained to manage most common symptoms, recognize end of life issues, and have at least basic competency in addressing these needs.

Over the last six years, the number of hours of training that medical students receive in palliative care increased enormously. The 2008-9 fourth years will be the second cohort of students to benefit from the new course, developed through the UBC Division of Palliative Care and taught by a committed group of busy clinicians. I have seen the improvement in competence and confidence that earlier changes to the undergraduate curriculum have already made with UBC graduates going through residency, and hope that the new course will prepare our current students even better. Most Family Practice residents and many Royal College program residents now undergo at least two weeks (mostly four weeks) of palliative care training during their residency, including all medical and radiation oncology residents.

For the second tier we now have a pool of doctors with some postgraduate training in palliative medicine (formal or informal) who are prepared to support their colleagues locally when a patient's needs exceed their doctor's level of comfort. These doctors continue to practice their primary specialty, especially (but not exclusively) family medicine. In BC, we are lucky that there are so many excellent learning opportunities available, for example through the Victoria Hospice Society courses, UBC's Enhanced Skills Program, the BC Medical Association's REAP program, and the regional palliative care programs.

I am fortunate to have been involved in delivering all of these programs allowing me to get to know some great people from all over the province. In my work at the Vancouver Cancer Centre, I often find myself discussing patients from distant sites and knowing the person on the other end of the phone makes communication so much easier. The doctors I have met through the Family Practice Oncology Network's Preceptor Program, are now providing excellent palliative care support for cancer patients in their communities as well as community oncology. I witness first-hand the great impact that this has in improving the quality of care and the ability for patients to stay close to their families even with sometimes very complex symptom management and end of life needs.

Pippa Hawley (right), Palliative Medicine Specialist at the BC Cancer Agency with Catriona Aparicio, Clinical Associate in Palliative Care at the Vancouver Cancer Centre.

For the third tier, we need expert palliative care physicians to provide regional consultative support for the most difficult care situations and to provide leadership in research, program development and teaching. Though there are some people functioning highly effectively in this capacity, many regions of BC have very little access to this level of consultative support. We should be very proud of our ten UBC Year of Added Competence graduates who are providing this leadership in communities throughout the province and beyond. Their numbers are small, however, and it is difficult for established doctors to return to residency for a year. I believe that to attract our top new graduates and best practicing clinicians to the field, we need to give the subspecialty credibility and status, as a graduated process with "grandfathering in", so that physicians currently providing specialist palliative care service without formal recognition are encouraged and supported to continue to do so, and to participate in training the specialists of the future.

I hope that my Family Practice Oncology Network colleagues derive as much satisfaction as I do from helping palliative medicine continue to advance. I encourage you to join organizations such as the Canadian Society of Palliative Care Physicians (CSPCP) and the BC and Canadian Hospice Palliative Care Associations (BCHPCA and CHPCA) so that you can contribute to and benefit from the process ahead. I also hope that members share their knowledge and valuable experience by becoming involved in teaching through the UBC Division of Palliative Care and regional educational programs.

Contact Pippa Hawley at phawley@bccancer.bc.ca.

Pioneering Developments
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currently available for these patients and in order to develop new therapies, a target must be known. We needed to determine what enables these cancer cells to bypass their need for androgen.

Target Defined

Our laboratory recently identified a possible target for drug development. This target is supported by pre-existing knowledge that androgen stimulates the growth of prostate cells by activating androgen receptors located in the cell. The activation of the androgen receptor is also linked to the growth of prostate cancer cells and is the basis for androgen withdrawal therapy for patients with prostate cancer. Work in our laboratory and others yielded results verifying the existence of alternative mechanisms for activating the androgen receptor in the absence of androgens. We identified a unique region on the androgen receptor that appears to be responsible for its activation and thereby provides a novel therapeutic target. When many copies of this region (called decoy molecules) are produced in prostate cancer cells, they prevent or delay the progression of prostate cancer to androgen independence.

New Compounds, New Drugs

We are working now to identify small molecules that can be used to develop new drugs to delay or prevent the development of androgen-independent prostate cancer. One key small molecule, proving promising to date, is derived from marine sponges harvested off the coast Papua New Guinea. The equipment required for this research is costly, however, and we owe several charities our gratitude for enabling our continuing efforts – the Country Meadows Senior Men's Golf Club in Richmond, the FORE PAR charity event organized by the Parry family, and the BC Foundation for Prostate Disease.

Promising Results and Further Applications

The animal research data shows remarkable results with this emerging treatment causing advanced prostate tumours to change from blood engorged masses to white remnants that shrink and eventually disappear. The next step is to secure the approvals required to proceed to clinical trials. Once we get to this stage, we hope family physicians will assist us in encouraging their patients' participation.

We are also exploring the potential application of this knowledge and treatment to earlier stage prostate cancer and to other endocrine cancers dependent on steroid receptors such as breast cancer, endometrial and ovarian cancers. It is exciting to be the first in the world to identify and develop drugs for different regions of the androgen receptor to potentially improve the clinical management of prostate cancer.

For more information please email shalloml@bcgsc.ca

Join us at the BC Cancer Agency Annual Conference November 20-22

The BC Cancer Agency's annual conference is scheduled for November 20-22 at the Westin Bayshore in Vancouver. This year's theme is Survivorship: Creating it, Managing it. As part of the conference, the Family Practice Oncology Network will host its annual CME Day on November 22 (9:00 a.m. to 1:30 p.m.) focusing this year on office-based cancer care. Our agenda follows:

Registration and full details are available through the BC Cancer Agency website, www.bccancer.bc.ca

Time	Topics	Speakers	Room
07:00–08:00	REGISTRATION		
08:00–09:00	BCCA Plenary Session		
09:00–09:15	Welcome Preceptorship Certificate Presentation	Dr. Shirley Howdle Dr. Simon Sutcliffe Dr. Bob Newman	Salon E
09:15–10:00	Cancer – A Chronic Disease	Dr. Simon Sutcliffe	Salon E
10:20–10:50	Prevention update – HPV obesity, exercise, sun & diet Survivorship – Second Cancers	Dr. David McLean	Salon E
10:50–11:10	Screening Update – lung, colon, prostate	Dr. Andy Coldman	Salon E
11:10–11:40	Survivorship: Late Effects of Childhood Cancer	Dr. Sheila Pritchard & Dr. Chris Fryer	Salon E
11:40–12:00	Palliative Care – Non-curable Cancer: Anticipating and Preventing Care Crises	Dr. Pippa Hawley	Salon E
12:00–13:30	End of Life Care: Improving the Transition from BCCA to Community	Working Lunch Session – GPOs from each Cancer Centre Dr. Neil Hilliard Facilitator	Salon E
13:30	Closing Remarks & Evaluation Completion	Dr. Shirley Howdle & Dr. Philip White	Salon E

Insight: The Leukemia/Bone Marrow Transplant Program of BC

The Program

The Leukemia/Bone Marrow Transplant Program (BMT) at the Vancouver General Hospital (VGH) and British Columbia Cancer Agency (BCCA) offers highly specialized, expert care for all adults in British Columbia and the Yukon who have acute leukemia or a disease that requires intensive therapy and a bone marrow blood stem cell transplant.

Annually, 200-210 bone marrow transplants are performed by the Leukemia/BMT Program. Forty percent of these are related donor transplants (allogeneic transplants) and 20% are unrelated donor transplants (also allogeneic transplants). The remaining 40% are autologous transplants – where the cells to be transplanted are taken from the patient who will later receive them back again. Almost 3,000 transplants have been carried out by the Leukemia/BMT Program since 1981 when the first bone marrow transplant was performed at VGH.

The Procedure

In each type of transplant, the patient receives cells that can regenerate all of the different types of blood cells (red blood cells, white blood cells and platelets). These unique and rare "stem cells of the blood-forming system" are present in the bone marrow and can thus be obtained when cells are harvested from the pelvic bone in the lower back. Under certain conditions these cells are stimulated to enter the blood in large numbers (for example after administration of certain growth factors) and they can then be collected from the veins (peripheral blood progenitor cells). Both methods of obtaining these cells are to serve the same basic purpose – to replace a malfunctioning or non-functioning bone marrow with a source of healthy functioning blood stem cells.

Before undergoing a transplant, the patient is conditioned with chemotherapy and sometimes total body irradiation. This conditioning treatment is used to eliminate the underlying disease, and in the case of an allogeneic transplant, also serves to prevent rejection of the incoming stem cells by suppressing the recipient's immune system. Following the conditioning treatment, the patient receives the transplant to restore healthy bone marrow function.

The actual infusion of stem cells itself is a straightforward process with the cells being infused intravenously much like a blood transfusion. The transplant infusion typically takes 30 minutes to an hour with rare complications such as shortness of breath, transfusion type reactions and other typically temporary problems.

After the transplant, the infused marrow cells find their way back to the bone marrow spaces in the centre of the large bones of the body and begin to produce new blood cells. It typically takes two to three weeks for the newly transplanted marrow to start to produce new blood cells. During this time patients are very susceptible to bacterial infection and require intensive medical care. They also need red blood cell and platelet transfusions to address the anaemia and shortness of breath due to low red blood cells and bleeding caused by low platelets.

Once patients meet discharge criteria, they are asked to remain in the Vancouver area for variable periods of time so that their progress can be monitored. Patients who receive an allogeneic transplant are asked to remain in the area for approximately three months and are followed closely in the BMT outpatient clinic. Those who receive an autologous transplant are asked to remain for a few days to a few weeks. Once people are well enough, they return to their home communities but continue to be followed closely by their local physician and the BMT team for many years. It usually takes several months to even years following a transplant for the immune system to fully regenerate and until that happens, patients must be careful to try to avoid infections. In many cases, when their immune systems have sufficiently recovered, they also require a new set of vaccinations. It is also important to remember that following an allogeneic transplant, the regenerated blood cells will have the same characteristics as the blood of the donor including their blood type and sometimes their allergies.

Donor Issues

In allogeneic transplants, donor compatibility is based not on matching blood types, but on HLA antigens. Close matching of the HLA antigens of the donor to the recipient helps to ensure that the recipient does not reject the transplant and also helps ensure that donor immune cells, which are also plentiful in bone marrow and blood grafts, do not cause severe effects in the recipient (a condition called graft-versus-host disease or GvHD). The donor immune cells are typically not removed from the transplant graft because they also help protect the patient initially from infection and play an important role in attacking the patient's residual cancer cells. However, if they become overactive, GvHD occurs. For this reason, people who receive an allogeneic transplant are typically given

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Front Row (L to R): Janice Yeung (Pharmacist), Michael Barnett (Head, Division of Hematology) and Dawn Warkentin (Pharmacist) Back Row (L to R): Heather Sutherland (Physician), Matthew Wright (Leukemia/BMT Fellow), Cynthia Toze (Physician), Katie Lacaria (Pharmacist), Stephen Nantel (Physician), Thomas Nevill (Physician) and Donna Hogge (Physician)

Colorectal cancer in British Columbia: misdiagnosis and the need for systematic screening amongst GPs

*By Kirsten Bell PhD, Researcher,
Sociobehavioural Research Centre,
BC Cancer Agency*

Dr Bell's research is funded by a CIHR New and Emerging Team Grant: "Palliative Care in a Cross Cultural Context: A New and Emerging Team (NET) for Equitable and Quality Cancer Care for Culturally Diverse Populations" (PET 69768).

Colorectal cancer is the third highest prevalence cancer in Canada and is the second leading cause of cancer-related death (1). Survival is highly dependent on stage at diagnosis – when the cancer is caught early, it has a cure rate of over 90% (2). However, colorectal cancer tends to be diagnosed later than other high prevalence cancers: one Canadian study (2) found that 40% of cases of colon cancer were late stage at diagnosis.

For the average person, age is the main risk factor for colorectal cancer, with more than 90% of cases occurring in those over 50 (3). Since 2001, the Canadian Task Force on Preventive Health Care has recommended population screening for colorectal cancer in people over the age of 50 (4). The Colorectal Cancer Association of Canada (3) also recommends that all Canadians age 50 and over undergo screening with a fecal occult blood test (FOBT) every two years, with a follow-up colonoscopy if bleeding is found. Although colonoscopies are the most sensitive method of detecting colorectal cancer (3), FOBTs have been shown to reduce cancer incidence and mortality (2) and remain an invaluable and non-invasive screening tool.

Yet, despite the existence of well-established guidelines, screening in Canada remains inadequate. One study (4) found that "an exceptionally low proportion" (17.7%) of eligible Canadians over the age of 50 received colorectal cancer screening within the recommended time frame. Such screening failures are starkly highlighted in the BCCA's colorectal cancer support group, where Bell carried out research from September 2007-April 2008 as part of a larger comparative study on the dynamics of cancer support groups.

The BCCA colorectal cancer support group caters to colorectal patients and their caregivers and is aimed at providing information and emotional support to people affected by the disease. During the eight month period that Bell conducted research at the group, 30 people in total attended the monthly meetings. As only a small percentage of people diagnosed with cancer attend support groups, this group does not provide a representative sample of colorectal cancer patients in the province. However, it provides insight into the experiences of colorectal cancer patients that demonstrate the very real consequences of inadequate screening procedures.

In the majority of cases, patients in the group were diagnosed with colorectal cancer after they started to experience symptoms and their doctor was uncertain of the cause – eventually triggering a barium enema, FOBT or colonoscopy and the subsequent cancer diagnosis. However, over a third of the patients in the group (38%) were misdiagnosed with minor, benign conditions such as irritable bowel syndrome (IBS) and/or hemorrhoids – even though seven out of the eight patients misdiagnosed were over the age of 50 and at average to high risk for colorectal cancer. In several cases symptoms persisted and worsened for several years before the patients were screened for colorectal cancer.

In each of these cases the implementation of standard screening procedures would have picked up the cancers earlier. In some cases this might have made the difference between diagnosis at stage II and stage III – the former generally requiring only surgery and with substantially higher survival rates, and the latter requiring both surgery and adjuvant treatment such as chemotherapy – which itself may cause long-term side effects and complications.

Yet, while misdiagnosis was common, there were several examples in the group of GPs adopting gold standard practices around colorectal cancer screening. In one instance, a female patient in the group had a GP who biennially screened patients over the age of 50 with a FOBT. In another case, a male in his late 30s went to a GP who performed a digital rectal exam and FOBT as part of his standard physical examination. Both tests showed anomalies and he was subsequently booked in for a colonoscopy and diagnosed with stage III colon cancer. As the patient was symptom-free at diagnosis and considerably under the recommended age for screening, the doctor's actions likely saved his life.

Clearly, although substantial advances have been made in both breast and prostate cancer screening in Canada, colorectal cancer screening still lags far behind. Survey data (4) and observational findings from the BCCA colorectal cancer support group indicate that colorectal cancer screening in people over the age of 50 remains the exception rather than the norm – even in symptomatic patients. In light of the high incidence and mortality associated with colorectal cancer, and the proven efficacy of screening programs (5), regularly screening patients over the age of 50 represents an important first step in helping to prevent this disease and reducing mortality from it.

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Message from the Chair

By Dr. Philip White, Chair and Medical Director of FPON and Family Physician in Kelowna

With the advent of a cooperative alliance with the Guidelines and Protocols Advisory Committee (GPAC), a joint committee of the Medical Services Plan and the BCMA for the development of clinical practice guidelines for British Columbia, FPON is moving into a new and exciting phase of its evolution. Hitherto our major foci have been the preceptorship program to develop family practitioners with enhanced cancer skills for principally underserviced communities and a broader based CME program for all GPs.

We have always had in mind the needs of the family doctor community at large and have looked at various ways to engage that body and provide useful and useable cancer information, preferably at the point of care. We have tried to determine what would best serve those needs without putting a greater burden on family doctors than they already have. After a few false starts we believe that we have arrived upon a formula in conjunction with GPAC whereby we can provide needed information for enhanced management of cancer patients. This will take the form of relatively brief, but sufficiently comprehensive, cancer management guidelines for primary care practitioners, both in a paper and PDA format, where the information is quickly and easily accessible.

Cancer is increasingly becoming a chronic disease (most types of cancer) and lends itself to the GPAC style chronic care guideline format. As an associate of GPAC these guidelines will be produced in exactly the same way as other GPAC guidelines using working groups approved by GPAC and the same review process that GPAC uses once the working group has the completed draft.

We are pleased to be the first body to be approved as a GPAC associate and over the next 15 months hope to be able to provide guidelines on Palliative Care as well as Colorectal Cancer, Breast and Prostate Cancer. The first of these is underway and we are very pleased with its progress to date. Our hope is to be able to provide the information needed in a form and manner that not only improves the patient journey, but the life of the primary caregiver too.

Insight: BMT Program continued from page 4

immunosuppressive drugs for months to years following their transplant.

The ideal donor is a patient's sibling with the same combination of HLA antigens. When there is no family match, a search for an unrelated donor is made. The worldwide pool of people who have volunteered to donate bone marrow includes about 7 million individuals, 5 million of whom are from Northern Europe and North America. As HLA types tend to follow ethnicity, patients with an ancestry from these regions have a 70% chance of finding a suitable donor. Consequently, patients from countries such as India or China, for example, and those of First Nations origin currently have only a 30% chance or lower of finding a suitably matched donor.

Dr. Clayton Smith, Director of the Leukemia/BMT Program of BC, notes: "We are trying to encourage more people from different ethnic backgrounds to enrol as volunteers as there is an urgent need to expand the volunteer donor registry with people whose ancestors come from many different places in the world. People willing to become a donor should visit Canadian Blood Services' website at www.bloodservices.ca to learn more about the screening process and how to be added to registry."

Another Option

In the early 1990s, researchers learned how to collect blood stem cells from the umbilical cords of newly born babies and freeze them for future use. Such cells do not have to be as closely matched in HLA type with the transplant patient, but the total number present in a cord blood collection is less than what is typically obtained from an adult donor. Since the number of stem cells required for a successful transplant increases with the size of the recipient, "cord blood" transplants currently work better for children than for adults.

To this end, Drs. Connie Eaves and Keith Humphries of the Terry Fox Laboratory are leading research efforts to expand the cells present in cord blood collections so that they can be used safely and more effectively for adults. "We expect to begin clinical trials to test advances in this area in the coming years," states Dr. Smith, "and we hope that cord blood transplants will become a better option for adults who do not have a sibling or volunteer donor available." Currently in BC, there is no public bank to maintain cord blood, but discussions are underway to develop such a resource.

Encouraging Interaction

"We are always happy to answer any enquiries from family physicians," adds Dr. Smith, "and to host GPs interested in learning more about bone marrow transplants. We are also striving to deliver more patient care closer to patients' homes. Dr. John Shepherd, our Outreach Program Director, is enabling this transition by arranging for bone marrow transplant doctors to spend time each month in Abbotsford, Kelowna, Prince George and Victoria. There are also preceptorship programs for GPs in Vancouver who are interested in learning more about transplant patients. We are working as well to improve housing options for patients who require a long stay in Vancouver for treatment. Some treatments can go on for months and we realize how difficult this can be for people and their families. GPs are a critical partner in efforts to provide the best care for people needing a transplant, particularly as we try to improve our ability to deliver this care back in people's home communities. Interaction with GPs is really a high priority for our program."

For more information about the Leukemia/BMT Program including full contact information please visit www.leukemiabmtprogram.org.

Preceptor Profile: Dr. Becky Temple

Preceptor, Dr. Becky Temple rose to the Emperor's Challenge completing this Mountain Half Marathon and its 2,500 foot climb up Mount Roman near Tumbler Ridge.

With nearly 25 years of caring for patients in BC's Northeast, Dr. Becky Temple considers herself to be "from Fort St. John" where she runs a busy half-time family practice and serves as Medical Director for the Northeast Health Delivery Area. She is a graduate of the BC Cancer Agency's (BCCA) second Preceptor class completing the program in 2005.

"The Preceptor Program fit well with the changing demographics of my practice which, after 25 years, now includes a greater percentage of aging patients and more cancer diagnoses. My confidence and comfort level in dealing with these patients was heightened as a result of the program. I appreciated the ability to tailor the learning objectives to best address my patients' needs and to complete various components at the BC Cancer Agency's cancer centre in Kelowna."

"The program also enabled me to help patients better understand the steps and expectations following diagnosis plus how to use the BCCA's Website to effectively access information for patients to assist them on their journey from diagnosis, to treatment and possibly palliative care. Knowledge regarding the provision of chemotherapy is another useful, albeit small part, of what family practitioners can gain from this program. I now administer chemotherapy for my patients plus those of other physicians in the community as well as others referred by oncologists in Grande Prairie and Edmonton. I also serve as a resource for our oncology nurses should they have any chemotherapy questions plus provide support to local physicians who are managing chemotherapy for their own patients. The BCCA benefits, too, in having skilled physicians assisting with chemotherapy at a distance."

"I was encouraged to take the Preceptor Program by my long time colleague, Dr. Robert Newman, a general practitioner in oncology in Dawson Creek, and also chair of the Network's Preceptor Working Group. For others considering the program, I would emphasize the benefits of its strong organization that allows for hands-on training and, more importantly, the opportunities to network and build trusting relationships with the oncologists who still carry primary responsibility for the patient. The corresponding trust that they have in Preceptors leads to a comfort level where we can call or get in touch with them anytime."

Dr. Temple is originally from Quebec and completed her medical training at the University of British Columbia. Along with her medical role, she enjoys a busy family life with her husband and three daughters including regular ski days at Powder King Mountain Resort.

The Preceptor Program is an eight-week modular program with built-in flexibility to fit the needs and schedules of family physicians interested in building their oncology expertise. Participants take part in a two-week introductory session offered every September and February at the BCCA in Vancouver and then complete the remaining modules, selecting from a broad array of subjects, at any of the Agency's five cancer centres including Abbotsford, Kelowna, Surrey, Vancouver and Victoria. Graduates are eligible to receive Royal College of Canada credits and accommodation and travel expenses are covered plus a stipend provided by the University of British Columbia Enhanced Skills Program. The next introductory session commences February 23 in Vancouver.

Contact Dr. Becky Temple at becky.temple@northernhealth.ca for more insights on her experience with the program or Gail Compton at compton@bccancer.bc.ca for full program details.

Consider hosting a CME road show in your community

A key focus of the Family Practice Oncology Network is to provide practical and accessible continuing medical education (CME) opportunities that enhance cancer care in communities around the province. CME Road Shows, hosted by local family physicians and organized with Network staff, provide an excellent venue in this regard. Road Shows, of which numerous have been held to date, bring local medical and supporting communities together with specialists from the BC Cancer Agency (BCCA) to increase understanding and confidence in treating more common cancers such as breast, colon or prostate. We would like to encourage you to

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Nanaimo Road Show presenters (left to right): Dr. John Carr, General Surgeon in Nanaimo, Dr. Randy Marback, Road Show host and GP of Oncology at the Nanaimo Regional Hospital Cancer Clinic, Dr. Andrew Attwell, BCCA Medical Oncologist at the Vancouver Island Cancer Centre in Victoria; and Dr. John Ronald, Respirologist in Nanaimo.

Green light for Cancer Centre for the North

The Province has formally approved funding for the Northern Cancer Control Strategy, which includes the construction of a new 4,200-square-metre cancer centre in Prince George. Details of the strategy include:

- A 4,200-square-metre BC Cancer Agency (BCCA) Centre for the North, which will include two linear accelerators used in the delivery of radiation therapy treatment;
- A 1,000-square-metre addition and renovation to Prince George Regional Hospital to accommodate a new six-bed oncology unit, as well as an expansion of pathology, laboratory and diagnostic imaging services and the creation of additional office space to support the new BCCA services;
- Enhancement to up to 11 Northern Health sites in communities outside of Prince George;

- The acquisition of new equipment and information technology at these sites to accommodate expansion of community cancer clinics; and
- The cancer centre will be designed to be energy efficient and achieve LEED gold certification

Construction of the new facility is targeted to start in late 2009, with a completion goal of 2012, three years sooner than the report's recommended completion date.

The cost for the new centre, renovations to Prince George Regional Hospital, radiation and diagnostic equipment and infrastructure expansion for cancer care services throughout the North is an estimated $99.5 million. The Centre for the North will be the BCCA's sixth regional centre and a critical component of the BCCA's provincial cancer control network.

The new cancer centre will be pursued as a public-private partnership.

Host a CME road show
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consider hosting a BCCA Road Show in your community.

Network staff would work with you to plan a complementary half-day or evening CME credit program featuring speakers who will bring the perspective of patients and the local and regional cancer care teams and focus their presentations on clinical situations. Ideally, a Road Show is structured around a local patient's cancer experience enabling a comprehensive review of the primary care provided from initial diagnosis, to treatment, survivorship, relapse and palliative care. Network staff provides complete logistical support both in advance and on-site of the event.

Recently, Dr. Randy Marback, General Practitioner in Oncology of Nanaimo, hosted a successful CME Road Show focussing on the work up and treatment of suspicious breast/lung lesions. Speakers included Dr. Andrew Attwell, Medical Oncologist at the Vancouver Island Cancer Clinic, Dr. John Ronald, Respirologist, and Dr. John Carr, General Surgeon. Over 15 people took part.

To discuss CME Road Show opportunities in your community, please email Gail Compton, gcompton@bccancer.bc.ca or call her directly at 604.707.6367.

Colorectal cancer in British Columbia
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FAMILY PRACTICE ONCOLOGY NETWORK CHAIRS

NETWORK COUNCIL
Dr. Philip White
Kelowna
250.765.3139
drwhitemd@shaw.ca

CONTINUING MEDICAL EDUCATION
Dr. Shirley Howdle
Vancouver
604.877.6000
showdle@bccancer.bc.ca

PRECEPTORSHIP PROGRAM
Dr. Bob Newman
Dawson Creek
250.782.5271
rwnewman@pris.ca

FOR MORE INFORMATION

To learn more about the Family Practice Oncolgy Network or become involved please contact:
Gail Compton,
Administrative Coordinator
Tel: 604.707.6367
e-mail: gcompton@bccancer.bc.ca
Visit the Network Website:
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Newsletter Writer and Editor,
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