

Family Practice Oncology Network Newsletter

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BC Cancer Agency

CARE + RESEARCH

An agency of the Provincial Health Services Authority

Palliative care guideline: Part 1 now available

Enclosed with this edition of the Family Practice Oncology Network Newsletter you will find our first official cancer care guideline customized directly to the needs of family physicians, produced in partnership with the provincial Guidelines and Protocols Advisory Committee (GPAC), and jointly sponsored by the Ministry of Health and the BC Medical Association. The guideline follows GPAC's highly practical, familiar chronic disease management format emphasizing brevity and evidence-based information and including an external review, flow sheet and patient-hand-out.

Palliative Care for Incurable Cancer or Advanced Disease, Part 1: Approach to Care – is the first in a series and the result of a magnificent effort of a hard working group led by Dr. Neil Hilliard, Hospice Palliative

Care Physician Coordinator and Pain and Symptom Management Clinic Consultant for the BC Cancer Agency's Abbotsford Centre. The guideline addresses assessment,

GUIDELINES & PROTOCOLS ADVISORY COMMITTEE

Palliative Care for the Patient with Incurable Cancer or Advanced Disease
Part 1: Approach to Care
Effective Date: June 15, 2010

monitoring and interventions which facilitate good management of the transitions patients go through with progressive disease, and planning for the end of life. You can access this guideline and all others to come at BCGuidelines.ca where you can download it to your PDA, iPhone or Blackberry for easy use during patient consults. Full versions of all guidelines will also be posted on our Website – www.bccancer.bc.ca/HPI/FPON.

Guidelines currently under development and expected for publication by the end of this year include parts 2 and 3 of the above focussing on pain and symptom management (addressing specific symptoms such as pain, nausea, constipation, delirium, dyspnea and fatigue) and grief and bereavement. The content of these three guidelines will also be used in an upcoming session of the General Practice Services Committee's Practice Support Program.

Work is also beginning now on guidelines for colorectal, breast and prostate cancer with lymphoma, leukemia and ovarian cancer next on the agenda.

"We see these guidelines as instrumental to family physicians' ability to take on an

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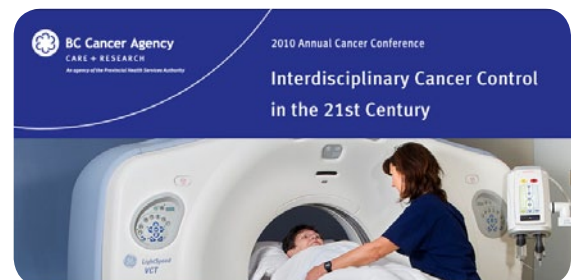
Join us @ Family Practice Oncology CME day

November 25-27 in Vancouver presents excellent opportunities for family practice oncology CME and for building useful contacts at the BC Cancer Agency. The Agency will be holding its Annual Cancer Conference on these dates at the Westin Bayshore Hotel, and as part of this event, the Family Practice Oncology Network will be holding its annual CME Day designed specifically to meet the needs of primary care physicians and their patients.

We hope you can join us at our Family Practice Oncology CME Day to be held Saturday, November 27 from 9:15 a.m. – 3:15 p.m. The program meets the accreditation criteria of The College of Family Physicians of Canada and has been accredited for *up to 1.5 Mainpro-C credits and 2 Mainpro-M1 Credits*.

The event is a practical means to strengthen your oncology skills and knowledge and to learn about new resources and support. We will also be holding a special networking reception for participants on Thursday, November 25.

"Interdisciplinary Cancer Control for the 21st Century" is the theme for both our CME Day and the conference overall. The Network's CME Day will include sessions on the Network's new palliative care guidelines for family physicians, updates on hormone therapy for breast cancer and discussions on lung and ovarian cancer. The afternoon will include a choice of case-based group workshops on either breast or gynecological cancer.



The Annual Cancer Conference features more provincial oncology professional sessions including nursing, nutrition, psychosocial oncology, pharmacy, radiation therapy, pain and symptom management and pediatric oncology plus a plenary session on recent breakthroughs in research and innovation at the Agency.

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Bisphosphonate medications and osteonecrosis of the jaw (BIONJ)

By Dr. Lina Jung, General Consultant, Dept. of Oral Oncology/Dentistry at BC Cancer Agency Centre for the Southern Interior

Bisphosphonate medications are linked to a risk of osteonecrosis of the jaw, defined as exposed bone in the maxilla or mandible that fails to heal within 8 weeks in a patient receiving/has received a systemic BPN and who has not received local radiation therapy to the jaws. Predisposing factors include: poor oral hygiene, smoking, age over 65, diabetes, history of steroid or cyclosporine use, renal insufficiency, intraoral tori, active periodontal disease and previous osteonecrosis. It can occur spontaneously, due to dental disease or secondary to dental therapy. Early BIONJ may be present with no indication of necrosis, but with symptoms such as tooth



Dr. Lina Jung

mobilities, soft tissue swelling or infection, paraesthesia, feeling of “heavy jaw”, undiagnosed oral pain, or a sudden change in periodontal/mucosal health. It is categorized into three stages which can range from being asymptomatic bony exposure to that associated with pain, soft tissue and/or bone infection to that involving pathological fracture and/or a non-manageable state with antibiotics due to the large volume of bone. The estimated incidence of IV

BIONJ is 0.8-30% while that of oral BIONJ is 0.007-0.01%.

Several dental and medical associations have published guidelines and/or statements for care, but case by case professional judgement is recommended. Prevention is the

only known way to address this complication (HBO has not proven effective) and hence a thorough oral assessment by a dentist for patients about to begin BPN therapy is recommended. For those who are already taking bisphosphonates, an assessment and frequent maintenance is still advisable and they must be informed of their potential risks for BIONJ in addition to avoiding any invasive dental treatment in favour of treatments which retain existing teeth, while routine restorative treatment should be encouraged by the physician as well. Patients taking bisphosphonate medications who develop BIONJ should be immediately seen by the dentist for either non-surgical or surgical management. If BPN was prescribed for cancer treatment, the patient can be referred to the Department of Oral Oncology/Dentistry at the BC Cancer Agency.

Contact Dr. Lina Jung at ljung@bccancer.bc.ca

Stay up to date with – accredited – CME webcasts

Every month the Family Practice Oncology Network partners with the University of British Columbia’s Division of Continuing Professional Development to present a CME Webcast to provide family physicians and health care professionals with practical information that will enhance their care of cancer patients and their families. These Webcasts provide an innovative, easy and accessible means to keep up to date without having to travel or even leave your home or office. The program also meets the accreditation criteria of the College of Family Physicians of Canada with each session accredited by the BC Chapter for up to 1 Mainpro-M1 credit.

Webcasts usually take place from 8:00 – 9:00 a.m. on the fourth Thursday of every month and include a 40 minute presentation followed by opportunity for discussion and questions. The presenter is live on camera, the presentation is on screen and participants can interact online.

Recent Webcasts featured:

- Oral Oncology Issues in Family Practice;
- An Update on Gynecological Cancers;
- Side-Effects of Chemotherapy; and
- Cancer Screening Guidelines for Colorectal, Cervical and Hereditary Cancer (parts 1 and 2).

The October 28 Webcast will feature a select update on topics presented at the Canadian Association of General Practitioners in Oncology Annual Conference held earlier this month in Halifax. The subsequent two Webcasts will be held November 18 and December 16.

Palliative Care Guideline continued from page 1

increasingly higher level of cancer care,” states Dr. Phil White, Chair and Medical Director of the Family Practice Oncology Network and family physician in Kelowna. “I liken them to the checklist every safety conscious pilot consults before take-off. Our

Following registration, you can join any Webcast by entering <http://chier.acrobat.com/fpon> into the address bar of your Internet browser. All Webcasts are recorded and available for non-credit viewing on the Network’s Website under CME Initiatives at www.bccancer.bc.ca/hpi/fpon.

To have your name added to the distribution list for emails promoting upcoming CME Webcasts, please send your name and email address to Jennifer Wolfe, jawolfe@telus.net

intent is that they become an indispensable tool for every family doctor, one that we will update as new evidence, useful treatments or other interventions come along.”

That said we would greatly value your feedback on this first result of our guideline endeavour. Please send your comments to Dr. Phil White at drwhitemd@shaw.ca.

PSA Screening Update

By Dr. Tom Pickles, Professor, Dept. of Surgery, UBC & Radiation Oncologist, BC Cancer Agency Vancouver Centre

Within the last 18 months, three landmark randomized trials have been published that shed light on the issue of PSA testing. Although the results of the first two^{1,2} are regarded by many as being inconclusive, the picture is now much clearer as more details of the trials emerge, and in particular with the recent publication of a Swedish trial.³



Dr. Tom Pickles

As background, it is now apparent that there is no 'safe' PSA level, at which prostate cancer can be ruled out. A continuum of prostate cancer risk exists with varying PSA levels. Although 'normal' levels vary by age, the published normal levels that appear on some lab reports are misleading. For example, a man in his 40's should be carefully followed for a PSA of 1ng/ml, and referred for biopsy if the result is 2ng/ml.

PSA level (ng/ml)	Prostate cancer prevalence %
<1	6-10%
1-4	17-25%
4-10	20-30%
>20	80%

The two recent European trials demonstrated a 44% and 20% relative reduction in prostate cancer deaths among those offered screening when compared to those that were not. The Swedish trial estimated that 293 men would need to be offered screening and 12 men diagnosed for the prevention of one prostate cancer death over a 14 year period. These figures are similar, or better to that accepted for other medical interventions. The ERSPC trial estimates were 1,410 and 48, respectively, but are expected to reduce as the trial matures further.

However, the NCI-US PLCO study found no difference in prostate cancer deaths at 7-10 years of follow-up when comparing unscreened men. However, in this underpowered study, 44% of men were pre-screened and screening in the control group

was very substantial (52% in the 6th year) which would have masked any impact of screening on mortality.

It is still unclear whether prostate cancer screening results in more benefit than harm, and thus a thoughtful and broad approach to PSA testing is critical. The results of the European trials identify a clinically significant benefit from PSA screening, as well as strong evidence for over-diagnosis and over-treatment. The

latter may be addressed by uncoupling treatment as an inevitable response to diagnosis, by the appropriate use of *Active Surveillance*⁴ for those with low risk cancer. Once this is done, the issue of prostate cancer screening becomes less controversial.

The optimum use of PSA testing for screening involves several issues: the appropriate time, frequency and conditions for testing, good

Age (years)	Age-specific median value
40-50 yrs	0.5ng/ml
50-60	0.9ng/ml
60-70	1.2ng/ml
>70	1.5ng/ml

methods to explain the benefits and the risks of testing to allow men to make informed decisions; appropriate, prompt and linked follow-up processes including biopsy when indicated; and the provision of appropriate treatment, with the discussion of options including active surveillance of low-risk prostate cancer.

The BC Cancer Agency and its Genito-Urinary Tumour Group, in conjunction with the Vancouver Prostate Centre and other experts, is actively exploring these issues and the new scientific findings, to develop better guidelines for prostate cancer testing and management. These developments will take into account the evidence from randomized controlled trials that prostate cancer mortality can be reduced with PSA screening and treatment, but that the decision to use

PSA for the early detection of prostate cancer should be individualized to be appropriate for well-informed men who wish to pursue early diagnosis. At present, we recommend that

- patients should be informed of the known risks and the potential benefits of PSA testing;
- early detection and risk assessment for prostate cancer should only be offered to men 50 years of age or older with an estimated life expectancy of more than 10 years, who wish to be tested.
- abnormal results should trigger referral to an appropriate specialist, usually a urologist,
- early detection of prostate cancer should be linked to a treatment algorithm that includes discussion and prioritization of active surveillance for men with low risk prostate cancer.

Contact Dr. Tom Pickles at TPickles@bccancer.bc.ca

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1. Schroder, F.H., et al., *Screening and prostate-cancer mortality in a randomized European study*. N Engl J Med, 2009. 360(13): p. 1320-8.
2. Andriole, G.L., et al., *Mortality results from a randomized prostate-cancer screening trial*. N Engl J Med, 2009. 360(13): p. 1310-9.
3. Hugosson, J., et al., *Mortality results from the Goteborg randomised population-based prostate-cancer screening trial*. The Lancet Oncology, Volume 11, Issue 8, Pages 725 - 732, August 2010
4. BCCA, *Active Surveillance Guidelines*. <http://www.bccancer.bc.ca/HPI/CancerManagementGuidelines/Genitourinary/Prostate/Management/LowRisk.htm>, 2007.

Join Us @ Family Practice Oncology CME Day continued from page 1

For further details or to register please visit www.bccanceragencyconference.com or contact Gail Compton at gcompton@bccancer.bc.ca. The cost to attend the Network's CME Day is \$149 while the cost to attend the full conference, including this event, is \$199.

EMPOWER: Education and Support for the Family of Cancer Survivors

The BC Cancer Agency Sociobehavioral Research Centre (SRC), under the team leadership of Dr. Amanda Ward, is working



Dr. Amanda Ward (left) of the BC Cancer Agency's Sociobehavioral Research Centre is working with the Agency's Heather Rennie (right) on a program for the family/support persons of cancer survivors.

on a pilot project funded by the Cancer Journey Action Group of the Canadian Partnership Against Cancer to develop and evaluate a program for the family/support persons of cancer survivors as they enter the early post-treatment phase of survivorship. The program will be delivered at four pilot sites across Canada, including Victoria and Prince George, and evaluated using a pre-and post-intervention questionnaire design.

The intention of the pilot project is to use research evidence to guide clinical practice in educating and supporting the family as they transition into survivorship with their loved ones.

The Cancer Journey Action Group of the Canadian Partnership Against Cancer has identified the development of improved approaches to cancer survivorship care planning as a major priority. Currently, in Canada, there are no evidence-based uniformly available supportive care programs for the family of cancer survivors. It is important to make available supportive care services for the family of cancer survivors, not only to help them improve their own quality of life, but also to enable them to cope and provide optimum support for the cancer survivor as they move beyond active treatment. As cancer becomes more of a chronic disease there will be a growing burden

for the family of survivors. The support that family members of cancer survivors provide has social and economic implications that positively impact the Canadian health care system.

The program is called "*EMPOWER: Education and Support for the Family of Cancer Survivors*", and was developed by Heather Rennie, Provincial Practice Leader for Patient and Family Counselling Services in Abbotsford, and the BCCA SRC team. The program was developed to compliment and run alongside Cancer Transitions, a program for cancer survivors to aid in the transition from active treatment to post-treatment

care. *EMPOWER* is a three session group intervention that will consist of educational material, support and discussion, skill building, social networking, and problem solving.

Examples of topics for the weekly sessions include:

Defining a Cancer Survivor

Returning to a New Normal

Transition: Hospital to Home

A Survivor-Family Care Plan

Family Member Role Burden: Tools and Resources for Coping

Family Member Emotional Well-Being and Self-Care

Communication in the Family – Family Roles and Shifting Responsibilities

Managing Side-Effects of Treatment (pain, fatigue, sexuality, fertility, etc)

Practical Issues: Employment Concerns, Wills, and Financial Planning

The project will provide evidence-based research to support the development of supportive care services for the family of cancer survivors in order to optimize the care giving experience for the family.

For more information about the program, please contact Joanne Magtoto at jmagtoto@bccancer.bc.ca or Dr. Amanda Ward at award2@bccancer.bc.ca

Phone – don't fax – when urgent patient referral/consultation required

What happened?

A patient was referred to the BC Cancer Agency who required urgent hospitalization and surgical intervention. The referral was faxed rather than being made through a direct phone call to an Agency physician delaying hospitalization and the correct critical interventions. Fortunately, the oncologist checked his action list prior to leaving for the weekend and the patient was then hospitalized and the interventions completed.

The patient was not harmed, but the potential for harm due to the delay in treatment could have been significant.

What actions were taken?

Team members completed a patient safety event review and the importance of community physicians communicating directly with an Agency oncologist when a patient requires an urgent or emergent referral was highlighted.

For urgent referrals

Please phone the oncologist on-call (available 24 hours) at your regional Cancer Centre:

Abbotsford Centre: 604.851.4710

Fraser Valley Centre: 604.930.2098

Centre for the S. Interior: 250.712.3900

Vancouver Centre: 604.877.6098

Vancouver Island Centre: 250.519.5500

The name of the oncologist contacted should then be added to the Referral Form available at www.bccancer.bc.ca/hpi/refer.

Hereditary Cancer Program Referral Process: Quality Improvement Project

By the BC Cancer Agency Hereditary Cancer Program's Mary McCullum, Jenna Scott and Lauren Rafuse

Thank you to all physicians who completed a survey earlier this year as part of a Hereditary Cancer Program (HCP) quality improvement project. This article provides a summary of the project and some implications for practice.

As some referring physicians will know, the HCP streamlined our referral process in 2008. A primary goal was to facilitate motivated patients' ability to "push" through the referral process, while reducing the workload associated with "pulling" reluctant patients through the system.

New Referral Process: A detailed family history form (FHF) is sent by HCP staff to each referred patient. A cover letter describes the purpose of the FHF, provides contact information for questions, and advises that the referral will be closed if the FHF is not returned within 4 months. If the referral is closed, the patient receives a standard letter and an "information copy" of all letters is sent to the referring physician.

Approximately 35% (n=529) of referrals to HCP in 2009 were closed because the FHF was not returned. While this falls within non-response rates reported by other hereditary cancer clinics (e.g. Armel et al., 2009; O'Neil et al., 2006; Schlich-Bakker et al., 2007), it represents a significant workload for HCP staff, and may suggest that some patients prefer not to be "pulled" into this process. A recent quality improvement project focus, therefore, was to gather input from some of the "non-responders" and their referring physicians. Patients were surveyed by telephone (invite sent after referral was closed) and their referring physicians received a mailed survey.

Participation

70% of eligible patients and 73% of eligible physicians completed a survey, with family physicians as the majority (63%) of physician participants.

Key outcomes

Patients identified the following barriers to completing the FHF:

- poor timing – new cancer diagnosis (self, family member) and/or other life events
- difficulty collecting family history information
- form was lost, not received or confused with research studies

They expressed understanding of the need for family history information and did not identify issues with the FHF format/content or the "referral closed" letter. The majority of participants expressed interest in re-activating the referral, and 1/3 had done so within 3 months of their interview. Almost 1/2 of participants suggested a follow-up phone call by HCP staff as a helpful reminder or a chance to ask questions.

Physicians identified the HCP waiting list as a barrier, and suggested that other formats for collecting family history information (phone, online, with MD) be considered.

HCP staff are committed to ongoing improvement of our referral and follow-up processes and will implement and evaluate strategies to address some identified barriers. Referring physicians are encouraged to consider how to address patients' readiness, as well as their eligibility, when discussing hereditary cancer referrals. We continue to welcome your suggestions for ways to enhance the effectiveness and efficiency of HCP services.

Contact information:
mmccullum@bccancer.bc.ca
www.bccancer.bc.ca/hereditarycancer

Practice Implications	Strategies
1) referring physicians need current information about HCP waiting list	<ul style="list-style-type: none">• ensure HCP website includes current info about waiting list and criteria for expedited appts (NB: an appointment is usually offered within 2-3 months of FHF return)
2) attention to life events that may suggest HCP referral should be deferred	<ul style="list-style-type: none">• physician chart flags/reminders to re-visit referral "at a better time"• HCP to acknowledge "timing" issue in revised FHF cover letter and invite interested patients to request future contact
3) difficulty completing FHF <i>phone follow-up to all patients is not possible or necessary</i>	<ul style="list-style-type: none">• revise FHF cover letter to more explicitly offer phone follow-up if assistance required• add "translation alert" when need for interpreter identified on HCP referral form

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Northern preceptors strengthen local cancer care

There are a growing number of Preceptors in Northern BC who epitomize the Family Practice Oncology Network's objective: enhancing cancer care at the community level and ensuring high quality care for patients and families close to home. Among these are Drs. Shannon Douglas of Fraser Lake and Suzanne Campbell of Vanderhoof.

Prior to their completing the Network's eight-week Preceptor Program – where they strengthened their oncology skills, knowledge and confidence – there was no oncology expertise in their area. All cancer patients previously had to travel to Prince George or Vancouver for treatment. A few short years later, these two GPOs (General Practitioners in Oncology) now run a busy regional oncology service from St. John's Hospital in Vanderhoof that meets the needs of local patients and those from the neighbouring communities of Fraser Lake, Burns Lake, Fort St. James and Fort Fraser.

Drs. Douglas and Campbell share their views with us on how cancer care in their communities has improved.

Dr. Shannon Douglas

I always had an interest in oncology and wanted to provide better general oncology care including follow-up care in my community. I never envisioned that this would grow to the scale of the clinic we have now.

It was not easy to build a Community Cancer Service. Our vision was well received by Northern Health and the community at large. We have had and continue to receive generous private donations to our clinic. It took a lot of work but with all this support at our backs, we opened the clinic in spring 2008. It greatly exceeded our expectations with regard to the number of patients served – and the amount of work required. We have a great team with two exceptional

chemotherapy nurses and a supportive medical staff. We work closely with our regional oncologist in Prince George and with oncologists at the BCCA in Vancouver. We have video link capacity and are working with the Hereditary Cancer Program at BCCA and with the thoracic team in Kelowna. This use of technology helps reduce travel and unnecessary trips to specialists.

Many people express their appreciation for having had their travel burden lifted. Many still need to travel quite a distance coming from as far as three hours away to see us. Starting this fall, I plan to run an outreach clinic twice per month at Burns Lake Hospital (1.5 hours west of Vanderhoof) to further develop our cancer service and our vision of providing high quality cancer care as close to home as possible.

The Preceptor Program provided an excellent foundation for my work here. First, I was able to develop and improve my knowledge of medical and radiation oncology. Second, I developed relationships with some of the oncologists and GPOs at the BCCA. This, along with knowing more about the referral process and how things work at the BCCA, made it much easier for me to communicate effectively. I also appreciate getting to know other GPOs at the Family Practice CME Day at the BCCA Annual Cancer Conference, through the Network and CAGPO.

I would recommend the Preceptor Program for anyone interested in furthering their career in family practice and interest in oncology. It has changed my practice in Fraser Lake. Oncology care takes up about a third of my

work time, the rest in regular office-based family practice and some emergency work. It has improved my job satisfaction and I can honestly say that I love my job. I am from this area having graduated from Ft. St. James, and it is a privilege to be able to bring my training back to my home community and provide service and care to so many families.

Contact Dr. Shannon Douglas at Shannon.Douglas@northernhealth.ca

Dr. Suzanne Campbell

I, too, have always had an interest in oncology and took the Preceptor Program after moving to Vanderhoof and deciding to work with Shannon on the new Cancer Clinic. The training was excellent and the scheduling flexibility was critical to enabling my participation. We had just adopted a newborn baby at the time and with two other kids, three horses and a practice that included obstetrics and emergency shifts, I could only manage to complete the modules one or two weeks at a time.

The information we were exposed to was outstanding, but I found the opportunity to meet and build relationships with people at the Vancouver Centre – the medical and radiation oncologists, the multidisciplinary teams, the pain and symptom management service and other support teams – to be equally valuable. We could not provide the level of service that we do without the absolute support of the bigger centres. Whenever we call, they are always available,

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Dr. Shannon Douglas of Fraser Lake is one of the initial graduates of our Preceptor Program and partners with fellow graduate, Dr. Suzanne Campbell (right), to run the busy oncology clinic in Vanderhoof.

New clinical coordinator, GPO education



Dr. Shirley Howdle

One of BC's first GPOs – General Practitioner in Oncology – Dr. Shirley Howdle is taking on a new, part-time role at the Network,

that of Clinical Coordinator, GPO Education. Her responsibilities include organizing the twice-yearly, two-week introductory module and ongoing clinical components of the Network's Preceptor Program plus leading the Network's growing CME program aimed at meeting the oncology education needs of GPOs and family physicians throughout the province.

"The Preceptor Program has made huge difference in many rural communities ensuring GPOs have the knowledge and skills to administer or oversee administration of local chemotherapy programs," stated

Dr. Howdle who is also a GPO at the Agency's Vancouver Centre. "While this will continue to be a primary focus, we are also going to explore how we can better meet the distinctly different, but equally important oncology education needs of urban family physicians. Our CME Webcast program (see story on page 2) and new oncology road show series that we are planning with UBC Continuing Professional Development will be useful resources for both."

"We also plan to work closely with the Canadian Association of General Practitioners in Oncology (CAGPO)."



Dr. Howdle succeeds GPO Dr. Judith Pike in the organization of the Network's Preceptor Program. Dr. Pike will retire from the Agency at the end of this year and is responsible for much of the initial development and ongoing success of this program.

Dr. Howdle has worked as GPO with the BC Cancer Agency since 1985. She was previously a full-service family physician in Nelson.

Contact Dr. Howdle at showdle@bccancer.bc.ca

Next preceptor course begins February 28, 2011

If you are a family physician keen to provide enhanced cancer care for your patients and their families, please consider the Family Practice Oncology Network's Preceptor Program. This program provides opportunity, especially for rural family physicians with the support of their community, to strengthen their oncology skills and knowledge and to become a GPO – General Practitioner in Oncology. A two-week introductory module is offered every spring and fall at the Agency's Vancouver Centre followed by six weeks of customized clinic experience at the Cancer Centre where your patients are normally referred. The latter can be scheduled over six months to best meet your schedule and tailored to address the particular needs of your community.

The Network also welcomes nurse practitioners to the program.

Physicians who complete the full eight weeks are eligible to receive up to 25 Mainpro-C and 50 Mainpro-M1 credits from the College of Family Physicians of Canada and those from rural communities (REAP eligible) will receive a stipend and have their travel and accommodation expenses covered. First year membership in the Canadian Association of General Practitioners in Oncology is also included. For more information please visit www.bccancer.bc.ca/HPI/FPON.

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very welcoming and happy to answer our questions.

Bringing cancer care closer to home in this region has made a huge difference to patients here. The previously required travel to Prince George was an intimidating and

often significant treatment deterrent for many patients, especially the elderly. There were time and financial costs associated with the long travel, as well as safety risks, particularly in the winter. This was compounded by the stress of dealing with cancer and the sometimes difficult side effects associated with the disease or treatment. Now, cancer patients come to a

familiar hospital where they know the whole team, from the nurses to the lab technicians, and where their families can accompany them. This removes much of the stress and anxiety that would have come from travelling to Prince George.

The challenge for me is fitting in all the responsibilities of rural medicine while keeping up to date on new developments. Cancer care in particular is changing quickly and the Family Practice Oncology Network offers great opportunities to stay current such as their monthly CME Webcasts which have moved way up on my priority list and their annual conference in Vancouver. Such resources, combined with connections at the larger Centres – including the currently expanding Prince George site – are what enable family physicians in smaller communities to provide the same level of care and access to services as those in highly populated areas.

I really enjoy working in oncology. To me, it is similar to obstetrics in that you have a significant relationship with someone and their family during an important and often stressful time in their lives. I feel I can make a difference and that is very rewarding.

Contact Dr. Suzanne Campbell at bellwig@yahoo.ca

Message from the chair

By Dr. Phil White, Chair and Medical Director of the Family Practice Oncology Network and family physician in Kelowna



Making useful oncology connections for family physicians is at the core of the Family Practice Oncology Network and there are new developments on this front. First, on behalf of the Network, I am pleased to accept appointment to the board of Ovarian Cancer Canada whose mission is to overcome ovarian cancer and provide leadership

by supporting women with the disease, raising awareness in the general public and with health care professionals and funding research to develop early detection techniques, improved treatment, and ultimately, a cure. Significant research breakthroughs in this province (described on page 10) will contribute greatly to this end.

Another ‘connecting’ Network initiative is the publication of our first cancer care guideline for family physicians produced in partnership with the BC Guidelines and Protocols Advisory Committee. The Palliative Approach to Care is the first of a set of three guidelines focussing on palliative care. This guideline, enclosed with this newsletter, is now available on our Website (bc.cancer.bc.ca/hpi/fpon) and at BCGuidelines.ca where it can be easily downloaded to your PDA, iPhone or Blackberry. A

working group, led by Agency gastroenterologist Dr. Jim Gray, is starting development now on a guideline for colorectal cancer. After that, new groups will focus on guidelines for breast and prostate cancer, lymphoma and leukemia.

I would also like to encourage you to take part in the Network’s monthly CME Webcasts which provide an online interactive connection for CME. They offer an accessible opportunity to gain up to date information on practical oncology subjects plus to interact with Agency specialists and other cancer care professionals from cancer centres and communities throughout the province. (See further details on page 2).

Finally, our Preceptor Program is also built on connections. This program, which strengthens the oncology skills and knowledge of rural physicians, GPOs and nurse practitioners, just

completed its fourteenth intake increasing total enrolment to 61 participants from 35 different BC communities. The Agency GPO responsible for the success of the program, Dr. Judith Pike, will be retiring at the end of this year and I would like to extend our gratitude for the formidable job that she has done and the impact she has had on so many physicians, their cancer patients and families. Dr. Shirley Howdle, GPO at the Agency’s Vancouver Centre, has graciously agreed to take on this role for which we are also very appreciative. We look forward as well to working with the Communities Oncology Network to meet the ongoing oncology learning needs of family physicians in BC as well as providing enhanced cancer care to communities through our Preceptor training program.

Contact Dr. Phil White at drwhitemd@shaw.ca

Cameo research program update

The Complementary Medicine Education and Outcomes (CAMEO) program, a collaborative BC Cancer Agency, UBC School of Nursing Research Program has developed some new complementary medicine (CAM) education and decision support programs and resources for patients, families, and health care professionals.

The patient education workshop, “Complementary Medicine (CAM) and Cancer: Laying the Foundation for Making Good Decisions” will be offered October 30, 08:30-13:00 at the BC Cancer Research Centre in Vancouver. This workshop is for patients and family members who would like to learn more about finding and evaluating evidence around complementary medicine, and wanting assistance in learning how to make evidence-informed decisions around the use of complementary medicine. To register, please contact Mr. Antony Porcino, Project Director,

aporcino@bccancer.bc.ca or 604.707.5960.

CAMEO also continues to provide CAM information over the telephone to patients, family members, and health care professionals. In addition, one-on-one decision support coaching for patients and families is available. This decision support coaching program is a research project that evaluates the impact of the coaching on the quality of their decisions, sense of regret over their decisions, overall satisfaction, and safe use of CAM. Patients and family members may access either of these programs directly by calling 604.707.5960 or email cameo@bccancer.bc.ca.

Further, a new written resource, “Complementary and Alternative Medicine (CAM) & Cancer in British Columbia” has been produced by the CAMEO team in consultation

with patients, family members and health care professionals. This booklet covers a variety of information areas such as what is CAM, how to make decisions about CAM, how to find a CAM practitioner in BC including re-imburement details, and CAM information and decision support services available at the BCCA. This booklet is available on the CAMEO Website at www.bccancer.bc.ca/cameo/

For health care professionals, CAMEO will be launching a new CAM education program that will provide short, easily accessible, “sound bytes” of CAM information relevant for busy practitioners. The education program will be launched in November in concert with the BC Cancer Agency’s Annual Cancer Conference (ACC). Watch for more details at the ACC, or via CAMEO’s newsletter *The Bridge*, to learn how to access this new resource! The Bridge can be accessed through the CAMEO Website.

Primary care physician education and engagement in the promotion of cancer screening in BC: completion of needs assessment study

By the Needs Assessment Study Investigative Team

Physician recommendations have been shown in the literature to have the greatest influence on cancer screening behaviour of patients, and that screening for certain cancers leads to earlier detection and reduced morbidity and mortality. To determine BC primary care physician practices, barriers, and attitudes towards cancer screening, through funding and collaboration from the BC Cancer Agency (BCCA), the UBC Division of Continuing Professional Development (UBC CPD)



BC Cancer Agency

CARE + RESEARCH

An agency of the Provincial Health Services Authority



The Division of
Continuing Professional Development
Faculty of Medicine

conducted a province-wide needs assessment study during 2009-2010. This study utilized a comprehensive survey questionnaire and follow-up focus group discussions to understand the perceptions and practice patterns of BC primary care physicians (here-in referred to as physicians) for breast, cervical, colorectal, and prostate cancers, as well as the hereditary predisposition to cancer.

An Advisory Committee with representation from UBC CPD, the BCCA Screening Programs and Family Practice Oncology Network (FPON), BC Ministry of Healthy Living and Sport, BC Medical Association, BC College of Family Physicians, Society of General Practitioners of BC, and the Guidelines and Protocols Advisory Committee, reviewed the findings and interpretations of the needs assessment study. They also ensured that varied perspectives from clinical practitioners and key stakeholder organizations on issues related to cancer screening were included in all aspects related to the study.

Close to 900 physicians in BC participated in this study either by completing the survey questionnaire and/or participating in the focus group discussions. The survey results revealed consistency in the age range physicians start recommending cancer screening; however, there was a noticeable variation in the age range physicians stop recommending screening for the respective cancers to their well patients. There was a wide range of practice and beliefs for colorectal and prostate cancer screening with low awareness about screening for the hereditary predisposition to cancer. Barriers to discussing and encouraging cancer screening for well patients included: patients with multiple health issues, language and cultural barriers, inadequate physician financial compensation, patient discomfort and inability to afford cost of procedure, as well as accessibility to screening procedures (particularly in rural areas). Demographic differences were apparent in some aspects of physicians' cancer screening practice. For example, compared to urban physicians, rural physicians found geography was more while language was less a barrier in encouraging cancer screening for well patients. Compared to female physicians, male physicians reported having more patients requesting Prostate Specific Antigen tests, were more comfortable performing Digital Rectal Examinations (DREs), but were less comfortable performing Pap tests. Compared to physicians in practice 30 years or longer, physicians in practice 10 years or shorter perceived that their knowledge in discussing the pros and cons of cancer screening with well patients was a barrier and they were less comfortable performing breast examinations and DREs.

In the in-depth focus discussions, diverse cohorts of physicians expressed their cancer screening practice needs in areas such as: i) broad reminder and follow-up system to facilitate physicians engagement of patients in cancer screening; ii) increasing accessibility and reducing patient wait times to some screening programs; iii) investigating feasibility and reliability of alternative screening procedures; iv) enhancing

educational resources (both online and in print) and CME activities for physicians on screening recommendations and screening programs; v) enhancing educational resources (both content and format) and campaigns to increase public awareness and understanding of screening recommendations and programs

A full report and a high level executive summary have been produced detailing these and other findings from the study. Also included are action orientated recommendations to influence the future direction of strategies to support best practices and support systems for improving physician/patient communication, facilitating best practices for screening, as well as for addressing possible gaps in care for recommended cancer screening practices for the BC population. The implementation of these recommendations began in the spring of 2010 with the delivery of accredited, live, online webinar educational sessions for physicians on cervical and colorectal cancer screening, as well as the hereditary predisposition to cancer. These webinars were designed to address the identified educational needs of physicians' in this study and were delivered through a partnership between UBC CPD and the FPON.

The full report and executive summary of the study findings will be available for physicians. Further information on this will be provided by UBC CPD in the coming weeks. The needs assessment study investigative team is grateful to all physicians that participated in this important study.

Dr. Bob Bluman (UBC CPD) was the principal investigator of this study, and Ms. Lisa Kan (BCCA), Dr. Brenna Lynn (UBC CPD), Mr. Tunde Olatunbosun (UBC CPD), Dr. Ruth Elwood Martin (UBC Department of Family Practice), and Ms. Laura Swaré (BCCA) were the co-investigators. Ms. Chloe Wu (UBC CPD) was a research team member.

For more information about this needs assessment study, please contact Tunde Olatunbosun at tunde.o@ubc.ca.

HPV Vaccination in British Columbia: What's new?

By Brittany Deeter, Vaccine Educator,
BC Centre for Disease Control

Starting September 2010, girls entering grade 6 will be on an extended dosing schedule of Gardasil®, the quadrivalent (types 6, 11, 16, 18) human papillomavirus (HPV) vaccine. Two doses will be offered in grade 6, six months apart. A third dose will be given in grade 11. The extended HPV schedule will be offered only to girls entering grade 6 in September 2010 and as part of the ongoing grade 6 HPV program in subsequent years.

The move to an extended schedule for grade 6 girls was made after the BC Communicable Disease Policy Advisory Committee reviewed the results at 24 months of a study of two doses of the quadrivalent HPV vaccine, given at 0 and 6 months to girls aged 9-13 years. The study, led by Dr. Simon Dobson at the Vaccine Evaluation Centre, BC Children's

Hospital, found that immune protection in girls aged 9-13 years given two doses of HPV vaccine is non-inferior to that in girls aged



16-26 years given three doses. This older group is the age group in which clinical trials for efficacy were conducted. The third dose, to be given in grade 11, is being planned to ensure sustained protection into sexually active years of life.

Girls entering grade 9 this school year, and those who were eligible for vaccine but did not get vaccinated in previous years, will continue to get the vaccine according to the 0, 2 and 6 month schedule. Additional information on this schedule change can be found on ImmunizeBC.ca.

Other HPV vaccine issues of note: In February of this year Health Canada approved Gardasil® for use in boys and men aged 9-26 years and Cervarix™, a bivalent vaccine that provides protection against infection with HPV 16 and 18, for use in girls and women ages 10-25 years.

The National Advisory Committee on Immunization (NACI) is reviewing the evidence for vaccinating boys and men, and for including Cervarix™ in future programs. These issues are being considered by infectious disease specialists, public health physicians and nurses, and other HPV disease experts. The BC Communicable Disease Policy Advisory Committee is also reviewing future recommendations for HPV vaccine program in BC.

Contact Brittany Deeter at
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Two major research breakthroughs for ovarian cancer



The Ovarian Cancer Research Program (OvCaRe), a multidisciplinary research program involving clinicians and research scientists in gynaecology, pathology, and medical oncology at VGH and the BC Cancer Agency, announced two major new developments last month that will have a significantly positive impact on the treatment of ovarian cancer.

Removing the fallopian tubes during hysterectomy or tubal ligation saves lives.

The first includes the discovery that the majority of high grade serous tumours, the most deadly form of ovarian cancer, actually arise in the fallopian tube, not the ovary. The program's highly regarded research team is now asking all BC gynecologists to change surgical practice to fully remove the fallopian tube when performing hysterectomy or tubal ligation. They note that such a change could reduce ovarian cancer deaths by 30% over

20 years. Until now, current practice left the fallopian tube in place for many types of hysterectomy and tubal ligation.

This recommendation is further supported by data from the Cheryl Brown Ovarian Cancer Outcome Unit, at VGH and BC Cancer Agency, which demonstrates that 18 percent of women who had developed ovarian cancer had a prior hysterectomy.

"This was a eureka moment for us," says Dr. Dianne Miller, gynecologic oncologist with the Ovarian Cancer Research Program; chair, Gynecology Tumour Group, BC Cancer Agency; and associate professor, University of British Columbia, Faculty of Medicine. "This told us we can have an immediate impact on saving lives by removing the fallopian tube during these routine surgeries.

The research team also made another important related discovery. They found one in five serous cancer tumours occur because of a germline BRCA genetic mutation.

"What this means is that in 20 per cent of cases, we are discovering the index case," says Dr. Blake Gilks, pathologist, Ovarian

Cancer Research Program, and professor, Pathology and Laboratory Medicine, University of British Columbia. "A woman may have no prior history of ovarian cancer in her family, but we now know that her children and their children could be at risk, and we have the ability to screen them genetically and act proactively." If all women with high grade serous cancer of the ovary are referred for genetic testing in addition to the surgical prevention program described above up to half of such cancers could be prevented.

An educational DVD is now available and has been distributed to all gynecologists in BC emphasizing the need to first remove the fallopian tube during surgery and to refer ovarian cancer patients who have a serous tumour to the Hereditary Cancer Program at the BC Cancer Agency.

Ovarian cancer gene links two types of ovarian cancer to endometriosis

The second major discovery by the OvCaRe team includes the identification of a new cancer gene – ARID1A – the frequent mutation and loss of function of which is now believed
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Colon Check on target

As of September, the BC Cancer Agency's Colon Check program – a three-year pilot colorectal screening program – is on target including 6,127 participants from the pilot communities of:

- Penticton: 3,373
- Powell River: 1,974
- Vancouver: 780

The results include 333 referrals for colonoscopy for abnormal fecal immunochemical test and 332 referrals for colonoscopy for reporting a first-degree family history of colorectal cancer.

This program was launched in January 2009 to establish and test the systems and infrastructure required for a potential, population-based, province-wide screening program for colorectal cancer, the second leading cause of cancer death in BC.

Community navigators play an important role to those Colon Check participants who receive abnormal test results or who identify a first-degree family history of colorectal cancer and their family physicians. They fast-track these patients through the program while serving as a helpful information resource and eliminate the administration

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to be an early event in the transformation of endometriosis into clear-cell and endometrioid cancer. Researchers looked at over 600 samples of ovarian cancer and ARID1A mutations were found in 46 per cent of ovarian clear-cell carcinomas and in 30 per cent of endometrioid carcinomas. Clear-cell carcinoma and endometrioid carcinoma are the second and third most common forms of ovarian cancer; together they account for one quarter of all cases in North America and a greater proportion in Asia.

“Our discovery of the dominant mutation in clear-cell ovarian cancer raises hope for much needed treatments for this little understood cancer type. Connecting ARID1A gene mutations to endometriotic lesions accelerates us toward the development of tools to determine which women with endometriosis are at increased risk for

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required by their family physicians. Navigators book patients' colonoscopies and any required specialist appointments. They also track the results and ensure all follow-up requirements are met while submitting

complete and timely reports to patients' family physicians. No referrals required.

For more information contact Laura Swaré at lsware@bccancer.bc.ca

Pathology Findings	Participants with no family history and an abnormal FIT (n=297)	Participants with a first degree family history (n=294)
Normal colonoscopy	99	191
Other findings	26	23
Low risk adenoma (s)	64	57
Multiple low risk adenomas	10	7
High risk adenoma (s)	88	16
Adenocarcinoma	10	0

New telephone advice fee codes

As of September 1, 2010, the General Practice Services Committee, introduced three new fee codes to allow GPs with specialty training – including GPOs – to access the same fees as developed by the Specialist Services Committee for FRCP certified specialists. For the purpose of these telephone advice fee items a General Practitioner (GP) with specialty training who is defined as a GP with specialty training who provides specialist services in a health authority setting and is acknowledged by the health authority to act in a specialist capacity. These fees are payable for two-way telephone communication (including other forms of electronic verbal communication) regarding assessment and management of a patient but without the consulting physician seeing the patient. If the patient is seen on the same calendar day by the GP with Specialty training, no telephone advice fee is billable.

G14021 GP with Specialty Training Telephone Advice – Initiated by a Specialist or General Practitioner, Urgent\$60

Conversation must take place within two hours of the initiating physician's request. Not payable for written communication.

G14022 GP with Specialty Training Telephone Patient Management – Initiated by a Specialist or General Practitioner, One Week\$40

Conversation must take place within 7 days of initiating physician's request. Initiation may be by phone or referral letter.

G14023 GP with Specialty Training Telephone Patient Management / Follow-Up\$20

This fee applies to two-way direct telephone communication (including other forms of electronic verbal communication) between the GP with specialty training and patient, or a patient's representative. Not payable for written communication. This fee is only payable for scheduled telephone appointments with the patient. Access to this fee is restricted to patients having received a consultation, diagnostic procedure or surgical procedure from the same GP with specialty training, within the 6 months preceding this service. There is a limit of 4 services per patient per calendar year.

Full details on these and corresponding community GP telephone consultation/ conferencing with a specialist or GP with specialty training fees are available at www.gpsc.bc.ca.

KRAS in Colorectal Cancer: A Primer for Family Doctors

By Dr. Robyn Macfarlane, MD FRCPC,
Medical Oncology Fellow, BC Cancer Agency
Vancouver Centre

Despite innumerable advances in the detection and treatment of colon cancer in recent years, it continues to be a significant problem. In 2010, it is estimated that >22,000 men and women will be diagnosed with colorectal cancer (CRC) in Canada, and ~9,100 people will die from it. Some patients are diagnosed with metastatic cancer (i.e. cancer that has spread to other areas of the body) at the time of diagnosis, and some patients develop metastatic disease after initial curative-intent treatments following diagnosis with localized disease. In the majority of cases once metastatic disease has been established, the cancer is no longer curable and treatments are palliative in intent (there are some exceptions to this, but discussion of those exceptions is beyond the scope of this article).

Palliative intent chemotherapy has been shown to not only improve symptoms and quality of life, but to also help people live longer with metastatic disease. Improvements in our understanding of the biologic underpinnings that drive the growth of CRC have resulted in the development of targeted therapies.

The epidermal growth factor (EGF) and its receptor (EGFR) mediate key pathways that signal for growth, proliferation, and metastatic potential of a tumour via a number of downstream pathways and proteins. By targeting the EGFR, the goal is to block those downstream signals that drive growth and

proliferation. One such downstream signal is mediated by KRAS (a protein derived from the KRAS oncogene). When KRAS is turned 'on', cells have a growth advantage. In a cell that has normal (or wild type) KRAS, blocking the upstream EGFR results in 'turning off' KRAS thereby eliminating the growth advantage. Unfortunately, approximately 40% of patients with metastatic CRC have a mutated KRAS. What this means is that KRAS is always 'on', and that even if you inhibit EGFR KRAS will remain 'on'. In practical terms, this means that patients with KRAS mutations will not respond to a class of anti-cancer drugs called EGFR-inhibitors (such as cetuximab or panitumumab). Both cetuximab and panitumumab are monoclonal antibodies directed against the EGFR; they interfere with ligand binding to the receptor, cause internalization of the cell surface receptor, and disrupt downstream signaling.

Recently, the EGFR inhibitor panitumumab has been approved for third-line treatment in metastatic CRC in British Columbia. Since patients with KRAS mutations will not respond to this drug, it is essential that we know the mutation status of these patients. We tend to test a patient's tumour for KRAS mutations once their cancer has progressed through first-line chemotherapy and they have been started on standard second-line chemotherapy. Patients do not require an additional biopsy in order to do this; we can test for mutations in the original biopsy or surgical specimen.

By identifying those patients who will not respond to a particular intervention, we can avoid administration of an ineffective

treatment that has potential for significant toxicity (common side effects include infusion reaction, rash, diarrhea, and fatigue). In a population where the primary goal of therapy is for maintenance of quality of life for as long as possible, this is especially relevant.

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ovarian cancer," says Dr. David Huntsman, co-founder and director of OvCaRe and Medical Director of the Centre for Translational and Applied Genomics at the BC Cancer Agency.

Huntsman explains, "Ten years ago, ovarian cancer appeared to be an unsolvable problem – the liberating moment came when we established that ovarian cancer is actually a number of distinct diseases. "We tailor our research approach to each subtype with

the hope of developing effective treatments specific to each disease."

Historically, ovarian cancer has been a difficult disease to diagnose and treat. The symptoms in early stages are often vague, leading to late stage diagnosis and poor outcomes. In BC, 310 women will be diagnosed with ovarian cancer in one year and approximately 220 will die from the disease.

For more information visit ovcare.ca