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Education Update

By Dr. Sian Shuel,
Medical Education Lead, FPON

To provide cancer care education and resources to primary care providers throughout BC and Yukon, FPON continues to host complimentary webinars for primary care providers almost monthly. Webinars since the last iteration of FPON's Journal of Family Practice Oncology included "Localized Prostate Cancer Management and Surveillance", "Reducing Ovarian Cancer Risk: Discussing Opportunistic Salpingectomy with Patients in Primary Care", "The Role of Diet and Exercise in Cancer Treatment and Survivorship" and "Oropharyngeal Cancer". The next webinar, entitled "Management of Early Breast Cancer for Primary Care: Guiding Patients While Awaiting Medical Oncology Consultation," will take place on **October 16**. Register here. Registration is also open for

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BEST PRACTICE CANCER CARE GEMS

Cancer Care on the Sunshine Coast

By Dr. Sian Shuel
Medical Education Lead, FPON

Initially answering the call for a one-year family medicine locum, for nearly four decades, Dr. John Hourigan has worked at the same primary care clinic and called the Sunshine Coast home. The roles he has held within the community exemplify the diverse opportunities afforded to family physicians in rural British Columbia. In addition to outpatient and inpatient-based family medicine, he has provided care in the emergency room, obstetrics, in diabetes education, and now, in oncology at the Community Oncology Network (CON) Clinic in Sechelt.

The Clinic opened under the leadership of internist Dr. Sara Wadge, who managed the service solo in its early days. Over time, she was joined by other physicians, though external moves eventually saw her as the solo physician again. Three years ago, she approached Dr. Hourigan about joining the CON clinic to help meet the community's ever-growing cancer care needs. "It was perfect timing," he recalls. "I had recently stopped working in the emergency department and was looking for something different." He was also inspired in part by a deeply personal experience: his spouse's

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While links to all our educational offerings can be found on our website FPON.ca, to improve our ability to communicate with community providers and healthcare partners about the latest Family Practice Oncology Network (FPON) news, educational updates, practice gems and other BC Cancer Primary Care communications including information on the electronic publishing of the twice-yearly Journal, please scan the QR code to sign up for our communications database.

Questions? Please contact us at fpon@bccancer.bc.ca

Disclaimer, If you experience difficulties with any hyperlinks, you may need to update your pdf reader.

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breast cancer diagnosis and treatment through the CON Clinic in Sechelt.

Today, the Clinic is busier than ever, thanks to a growing population along the Coast and improved prognosis for patients receiving treatments. With over 100 patients actively receiving treatment and 13–15 new patients seen monthly, the workload is considerable. The team operates on a rhythm: Mondays are for patient visits, with huddles alongside the chemo nurses on Tuesdays through Thursdays. A second internist joins the team every 7–8 weeks to provide additional support. Collaboration and camaraderie keep the Clinic running smoothly.

Dr. John Hourigan

Dr. Hourigan can't imagine working as a GPO without the support of the oncologists at the Regional Cancer Centre in Vancouver. He notes they are 'so accessible...They get back to you right away with an email and a new CON Ref (referring to the Community Oncology Network Referral system, a secure, web-based platform that enables BC Cancer physicians to electronically submit referrals for systemic therapy and medical care to CON sites). If an oncologist is not around, you know who is covering... Given the complexities of the work, I can't imagine doing the job without their connected support.'

The Clinic's catchment area serves over 30,000 residents on the Sunshine Coast and spans from Port Mellon in the south to Egmont in the north. The area is dynamic and diverse, home to retirees and young families alike. "This area has a little of everything," Dr. Hourigan notes. "Arts, outdoor adventure—you can go kayaking in the morning and snowshoeing in the afternoon. Fishing on the ocean and in the lakes. There's world class hiking and mountain biking too. No shortage of things to do and the medical community is a collaborative one. It's a great place to live and work."

The need for primary care support is also growing in the community. "We have 7,000 people without a family doctor," he explains. "So, when patients come in with secondary issues like diabetes, we often end up taking care of that too. There's no one to hand it off to." An additional family physician and GPO would be an asset to the community, and the team is keen to mentor a second GPO in the future.

The work is rewarding. "Being a GPO lets me do something that matters," he reflects. "It's not easy—but it's meaningful. Having a supportive local and regional cancer care team makes all the difference."

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the November 20 webinar, "Recognizing Hematologic Malignancies in Primary Care." Register here. In collaboration with UBC Continuing Professional Development, BC Cancer's Primary Care Program has added Cervical Cancer to its online learning module library, and it is available here. This complimentary, accredited, self-paced online module covers the most up-to-date information on cervical cancer screening, diagnosis, treatment and surveillance. It incorporates information from the recently published Cervical Cancer Prevention and Screening Primary Care Guideline (developed in collaboration between the BC Guidelines and Protocols Advisory Committee (GPAC) and the BC Cancer Primary Care Program) and includes point-of-care resources. Other accessible BC Cancer Primary Care Program online modules include Lung Cancer, Prostate Cancer, Colorectal Cancer and Breast Cancer. Visit fpon.ca for details.

Based on BC Cancer Primary Care Program's Online Breast Cancer Module, in collaboration with UBC Continuing Professional Development, planning for BC Cancer's Regional Education, Engagement and Collaboration Sessions is underway, bringing primary care providers, a GPO and an oncologist from the same region together to learn and engage on a regional level.

The BC Cancer Primary Care Program's FPON Annual Education Day working group met earlier this month to select the most relevant topics. Save the date for this event on **April 11, 2026**, and visit fpon.ca in the coming weeks for registration details.

To continue helping meet the healthcare needs of patients with cancer with high-quality cancer care as close to home as possible, the BC Cancer Primary Care Program's Family Practice Oncology Network (FPON) continues to host education for general practitioners in oncology (GPOs), primary care providers, and other healthcare providers.

In response to feedback from GPOs around British Columbia (BC), as part of ongoing work on stabilization of the GPO workforce, FPON hosted the first in a series of accredited webcasts specifically for GPOs on "An Overview of Practical Points of Lymphoma Management for the GPO". The webinar recording and slides are posted to fpon.ca for ongoing educational access. The next GPO-specific webinar, "An Overview of Practical Points of Multiple Myeloma Management for the GPO," is scheduled to take place on January 22, 2026. FPON will distribute details to GPOs, BC Cancer Nurse Practitioners (NPs) and Associate Physicians (APs) ahead of the event.

The Fall 2025 intake of GPO Education is well underway. It includes a 4-week half-day virtual didactic Clinical Practitioner in Oncology (CPO) Education program with the goal of having at least one physician in every BC community with 15,000 people who has completed this program and can support all aspects of cancer care for local patients and their families.[1] This intake of CPO Education includes around 50 participants including newly hired BC GPOs and BC Cancer NPs and APs. It also includes GPOs and oncology NPs from Nova Scotia, a GPO from Alberta, as well as UBC Palliative Medicine residents. In addition to new hires, several GPOs from across BC and BC Cancer NPs will be attending as part of a knowledge refresh, offering over 70 CME hours accredited by UBC CPD to choose from.

In addition to GPO-specific webcasts, GPO Education and GPO News, a monthly educational newsletter, FPON will continue to support learning through its yearly GPO Case Study Day at the BC Cancer Summit. Once again, this will be a hybrid event to ensure equitable access for GPOs across BC. This year's MainPro+ certified topics will include "Vertebroplasty: When is it the Right Choice for Spinal Metastases?", "Navigating Acute Myeloid Leukemia Care for GPOs", "Lu-177 PSMA Therapy for Prostate Cancer

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New Resources, Improved Fertility Care for Adolescents & Young Adults Navigating Cancer

By Drs. Alannah Smrke, BC Cancer Medical Oncologist, Kristin Marr, BC Children's Hospital Pediatric Oncologist and Cheryl Heykoop, Anew Team Lead and former AYA

Drs. Kristin Marr, Alannah Smrke and Cheryl Heykoop

Delivering Improved Fertility Care

Better access to fertility preservation and support for informed decision-making are among the top priorities of adolescents and young adults (AYAs) facing cancer treatment in BC/Yukon. According to 2022 research led by Young Adult Cancer Canada through the YACC Prime Study, only 52% of AYAs diagnosed with cancer in Canada had conversations about fertility preservation with their healthcare provider, and of these, only 13% pursued preservation measures. Now, thanks to funding from the Canadian Partnership Against Cancer, changes are underway to ensure every AYA diagnosed with cancer is asked whether they might like to have children in the future and provided with helpful support, including referrals to counselling and/or a fertility preservation specialist, to assist in making informed decisions while minimizing treatment delays.

> *"You don't realize how important your fertility is because you are just trying to stay alive. If you stay alive, it becomes very important."*
>
> ~ thoughts from a young adult post-cancer treatment

New fertility preservation resources, co-developed with AYAs and clinicians, are also now available via BC Cancer's Adolescent & Young Adult Cancer Care & Support webpage, www.bccancer.bc.ca/health-info/adolescent-young-adult (Fertility and Sexual

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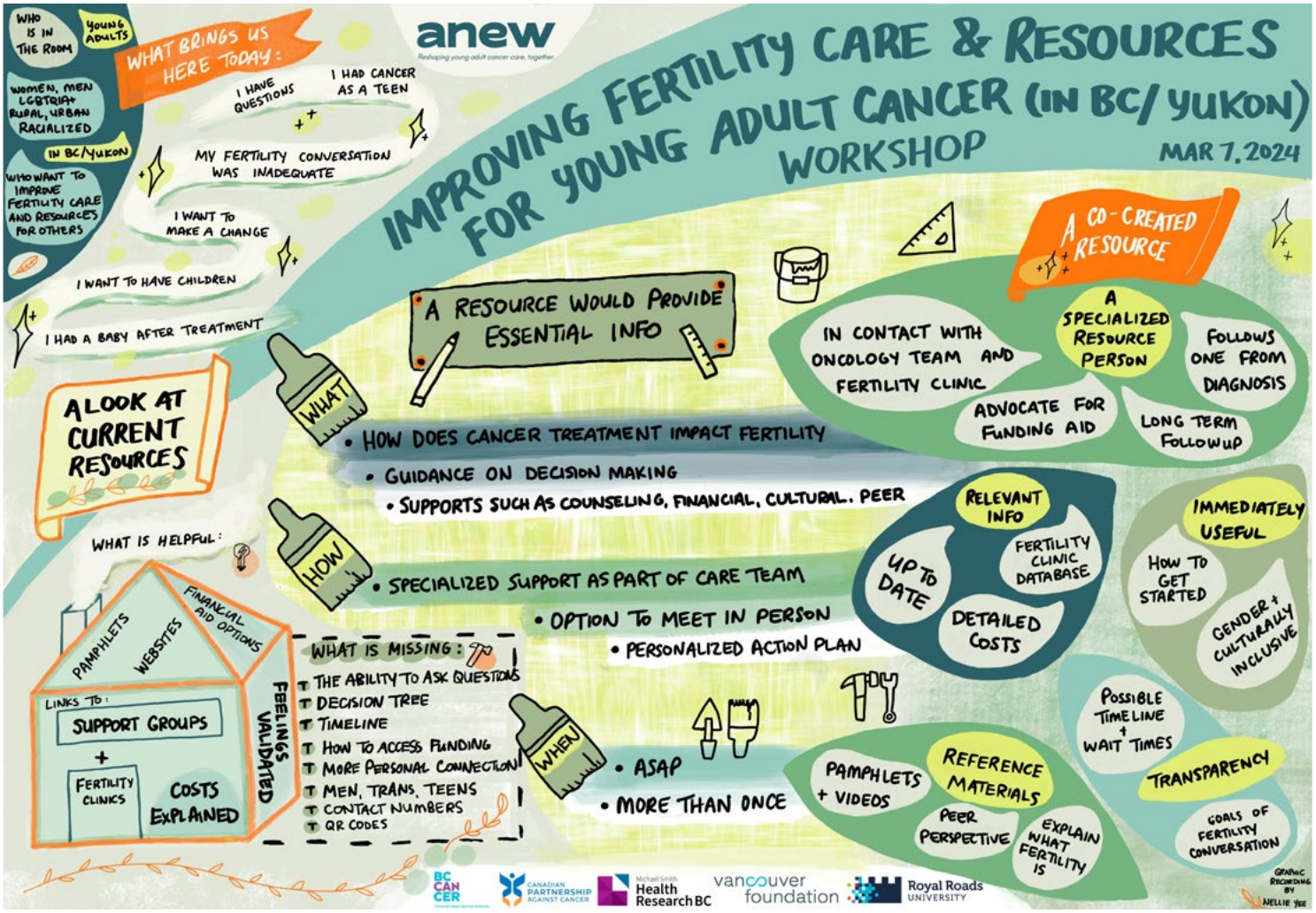

AYA Fertility
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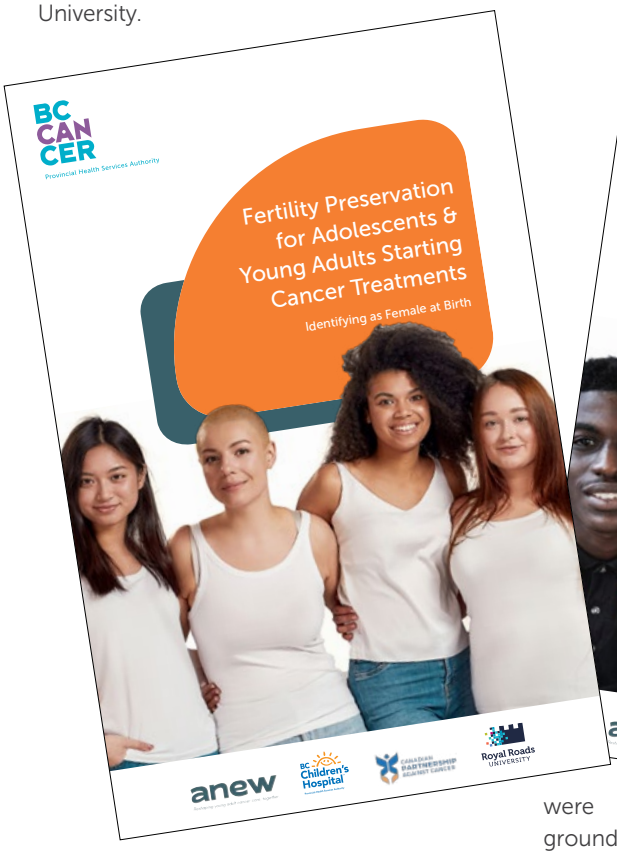
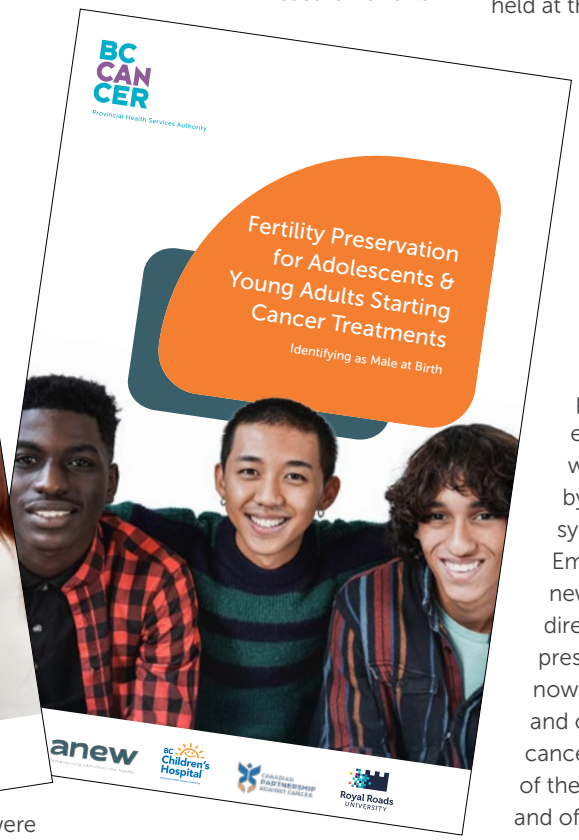
Health tab), BC Cancer's Health Professionals webpage, www.bccancer.bc.ca/health-professionals and soon via the EMR, Cerner/CST. These include:

- brochures explaining options and costs for AYAs who identify as male or female at birth;
- the ideal care pathway;
- tips for clinicians discussing fertility preservation with AYAs; and
- a fertility preservation consult referral form (also available via FormFast).

Positive Care Improvements for AYAs

These care improvements result from an important collaboration between AYAs, BC Cancer, BC Children's Hospital and the Anew Research Collaborative of Royal Roads University.





This collaboration began at the BC Cancer Summit 2022, where Anew, dedicated to improving AYA cancer care and support through creative, participatory research with AYAs, clinicians and care providers, co-facilitated a session with BC Cancer that brought together AYAs from throughout BC/Yukon along with clinicians and care providers to explore the unique challenges facing AYAs when navigating cancer care and support and to identify key priorities and tangible actions to create change.
This session created an important road map to guide improvements in AYA cancer care and support in BC/Yukon. Chief among the needs:

- Program development and research specific to the needs of AYAs, including oncofertility care and support;
- Easy access to counsellors and navigators skilled in supporting and guiding AYAs effectively through a cancer experience; and
- Comprehensive, one-stop online access to resources to support AYAs experiencing cancer.

Productive Engagement

Following the 2022 BC Cancer Summit, our efforts to improve oncofertilty practice began in earnest. To ensure our research efforts were grounded in the lived experiences and needs of AYAs in BC/Yukon, Anew facilitated two online workshops with AYAs to better understand and explore priorities to improve fertility preservation and oncofertility care which included identifying determinants of an effective first conversation with a clinician and the supportive resources and design approaches needed to support AYAs to make informed decisions. An AYA working group then co-designed a series of fertility preservation resources which were shared with clinicians and care providers, including fertility preservation specialists, for their feedback. A second collaborative session was then held at the BC Cancer 2024 Summit where groups of AYAs, clinicians and care providers reviewed the draft resources and provided additional feedback to improve effectiveness and finalizing for production.

Meanwhile, Anew researchers interviewed clinicians and care providers at BC Cancer and BC Children's Hospital to fully understand their fertility practices including the challenges experienced in supporting AYAs whose fertility could be impacted by cancer treatment and identifying system changes to improve care. Embedding fertility care and the new resources into Cerner/CST is a direct result of these efforts as are the presentations and education sessions now being held with clinician, nursing and operations teams throughout the cancer care system to increase awareness of the importance of fertility care for AYAs and of the care improvements and new resources in place.

#1 Tip for Clinicians from AYAs

Nothing about me, without me – include AYAs in decisions that affect them. AYAs recognize there is tension between medical urgency and patient autonomy AND they want to be involved in conversations about their fertility and care. *"Don't make this decision for me. I must be part of the process."*

View a related article on this topic, Fertility Preservation for Individuals Starting Cancer Treatment, in the Spring 2025 Journal of Family Practice Oncology, pp, 13-14.

To learn more about the distinct challenges of AYA cancer and creative collaborative initiatives underway to improve care, visit anewresearch.bc.ca or email hello@anewresearch.ca

HPV Immunization Program Update: Expanded Eligibility and Changes to Schedule

Dr Jia Hu

By Dr Jia Hu,
Interim Medical Director, Immunization Programs and Vaccine Preventable Disease Services,
BC Centre for Disease Control

Expanded Eligibility

Effective July 31, 2025, BC has expanded eligibility for the publicly funded HPV immunization program. This eligibility expansion ensures that many more British Columbians will be able to access publicly funded HPV vaccine. The expanded eligibility is outlined in the below table, which is drawn from the HPV page of the BC Immunization Manual.

Table 1. BC's HPV Immunization Program Eligibility

As of July 31, 2025, BC's HPV9 immunization program has expanded to include the following individuals (changes are indicated in **bold**):

- All individuals **up to 26 years of age (inclusive)****
- Individuals living with HIV between **27-45 of age (inclusive)*****
- Individuals **27-45 years of age (inclusive)** who self-identify as belonging to the gay, bisexual, and other men who have sex with men community, including Two-Spirit, transgender, and/or nonbinary people (including those who are not yet sexually active and/or are questioning their sexual orientation)***
- **Individuals who have received post-colposcopy treatment for cervical dysplasia on or after July 31, 2025**

**Those who have already turned or will be turning 27 in 2025 (i.e., birth cohort 1998) can initiate a publicly funded HPV vaccine series until the end of 2025. They must complete their publicly funded series by December 31, 2026.

***Select eligible groups who have already turned or will be turning 46 in 2025 (i.e., birth cohort 1979) can initiate a publicly funded HPV vaccine series until the end of 2025. They must complete their publicly funded series by December 31, 2026.

Changes to HPV Immunization Schedule

Alongside the expanded eligibility, there are also changes to the HPV immunization schedule, including a shift to a 1-dose schedule for those under 21 years of age and a 2-dose schedule for those over 21 years of age. Individuals who are immunocompromised remain on a 3-dose schedule. These changes are aligned with NACI's Updated Recommendations on HPV vaccines and based on several clinical trials showing that lower dose schedules provide comparable protection to higher dose schedules.

Table 2. Changes to BC's HPV Immunization Program Schedule

	Prior to July 31, 2025	On or after July 31, 2025
Immunocompetent individuals	• **9-14 years of age (inclusive)**: 2 doses separated by at least 6 months • **Individuals 15 years of age and older**: 3 doses given at 0, 2, and 6 months	• **9-20 years of age (inclusive)**: 1 dose • **21-45 years of age (inclusive):** 2 doses given at 0 and 6 months
Immunocompromised individuals	• **Individuals 9 and older**: 3 doses **given at 0, 2, and 6 months**	• **Immunocompromised individuals, including individuals living with HIV, 9-45 years of age (inclusive)**: 3 doses given at 0, 2, and 6 months
Post-colposcopy treatment for cervical dysplasia	N/A	• 3 doses given at 0, 2, and 6 months

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Opportunistic Salpingectomy

Drs. Gillian E. Hanley, Heather Stuart and Scott Cowie

By Gillian E. Hanley, Department of Gynaecology and Obstetrics, Division of Gynaecologic Oncology, University of British Columbia
Heather Stuart, Department of Surgery, Division of General Surgery, University of British Columbia
Scott Cowie, Department of Surgery, Division of General Surgery, University of British Columbia; President, General Surgeons of BC

Ovarian cancer is often lethal: A lack of effective screening means it's commonly diagnosed at an advanced stage. Increasingly, women who are past childbearing are helping prevent ovarian cancer with opportunistic salpingectomy—a simple procedure to remove the fallopian tubes when undergoing another abdominal surgery.

Data including a recent study strongly suggest opportunistic salpingectomy reduces the risk of developing ovarian cancer by up to 80%, with no difference in surgical outcomes or complications.

That's why three BC-based health care leaders are working to expand this procedure to routine abdominal and pelvic surgeries. Drs Scott Cowie, Gillian Hanley, and Heather Stuart make the case that general and urologic surgeons should consider offering opportunistic salpingectomy where indicated as best practice.

Talk to your patients

Family physicians, please talk to your patients about whether this procedure is right for them. You can find resources at sscbc.ca/os, including a downloadable consent handout, information pamphlet, decision aid, and an explanatory video for surgeons.

For more details on the data, please see the article on opportunistic salpingectomy on page 7 in the spring edition of the Journal of Family Practice Oncology.

This initiative is funded by the Specialist Services Committee, a partnership between Doctors of BC and the Ministry of Health.

HPV Immunization Program Update continued from page 5

Who is Considered Completely Immunized Based on the New Schedule

Whether an individual is considered complete for HPV immunization depends on several factors including age, immunocompetence, and HPV immunization history, with some considerations outlined in the table below.

Table 3. Populations considered fully immunized based on HPV immunization history

Population	Immunization history
1. Immunocompetent individuals	• Received one dose HPV9 under 21 years of age, regardless of interval from a dose of HPV2, HPV4, or HPV unknown **OR** • Valid 2- or 3-dose HPV series**
2. Immunocompromised individuals (except people living with HIV, and HSCT and CART therapy recipients)	• Received a valid 3-dose HPV series** **Note**: Those who received an age-appropriate HPV series** while immunocompetent are considered complete. Those who started but did not complete an age-appropriate HPV series while immunocompetent and became immunocompromised should receive a total of up to three doses of HPV vaccine.
3. Individuals living with HIV	Received a valid **3-dose** series of **HPV9**

**'HPV series' refers to a complete HPV series of any type (including any combination of HPV2, HPV4, HPV9 or HPV unknown).

Additional detailed information on HPV program changes (e.g., rationale for schedule changes, recommendations for people not eligible for publicly funded immunization, post-colposcopy treatment considerations, etc.) is available on the BCCDC healthcare provider Q&A on HPV vaccines.

Endometrial Cancer 2025: A Clinical Update

By Dr. Anna Tinker MD FRCPC
Medical Oncologist, BC Cancer Vancouver

Endometrial cancer (EC) is the most common gynecological malignancy worldwide, with its incidence rising by 132% over the past three decades. This trend is largely driven by increasing rates of obesity, diabetes, and aging populations. The trend is most apparent in high-income countries compared with low-income and middle-income countries, and mortality is closely linked to socioeconomic status (e.g., income, social class, and educational attainment) as well as access to high-quality healthcare. An awareness of this critical health issue for women is essential for those involve in primary care, as EC rates are also rising in younger women.

Dr. Anna Tinker

Risk Factors and Underlying Mechanisms

EC originates in the lining of the uterus and cannot be detected by routine Pap smears. There is no known reliable method to screen for EC. Its development is closely tied to prolonged exposure to estrogen unopposed by progesterone, which stimulates endometrial proliferation and increases the risk of malignant transformation.

Hormonal and reproductive factors play a central role. Early menarche, late menopause, nulliparity, and conditions like polycystic ovary syndrome (PCOS) contribute to prolonged estrogen exposure. Use of estrogen-only hormone replacement therapy and tamoxifen—especially in postmenopausal women—also elevates risk due to their estrogenic effects on the endometrium.

Obesity is one of the most significant modifiable risk factors. Adipose tissue promotes a hyper-estrogenic state through peripheral aromatization of adrenal androgens. Women with a BMI over 30 are ten times more likely to develop EC, and those with a BMI over 40 face a lifetime risk of 10–15%. Insulin resistance and diabetes further amplify risk by increasing the bioavailability of estrogen and insulin-like growth factor-1 (IGF-1), both of which promote endometrial cell growth.

Genetic predisposition can play a role in some patients. Lynch Syndrome, a hereditary condition affecting approximately 1 in 400 individuals, dramatically increases EC risk. Women with this syndrome have a 40% lifetime risk of developing EC and a 12% risk of ovarian cancer due to mutations in mismatch repair (MMR) genes. Lynch Syndrome also elevates the risk of cancers in the stomach, small intestine, ovaries, urinary tract, and biliary tract, and thus both male and female family members can be affected. Careful review of family history can identify those with strong family histories, and such individuals should be referred to the BC Cancer Hereditary Cancer program for germline testing. Information about eligibility for referral can be found here: www.bccancer.bc.ca/our-services/services/hereditary-cancer#Eligibility. Identification of Lynch Syndrome carriers allows for preventative and early detection strategies.

Prevention Strategies

Although no screening method has proven effective in reducing EC incidence or mortality, several prevention strategies can significantly lower risk. Weight loss and improved glycemic control are critical for obese and diabetic women. Use of combined oral contraceptives for five or more years can reduce EC risk by up to 50%, and adding progestin to estrogen therapy offers additional protection. For women with Lynch Syndrome, risk-reducing surgery—hysterectomy and bilateral salpingo-oophorectomy by age 40—is recommended to prevent both endometrial and ovarian cancers.

Symptoms and Diagnostic Approach

Postmenopausal bleeding is the hallmark symptom of EC. While this symptom can

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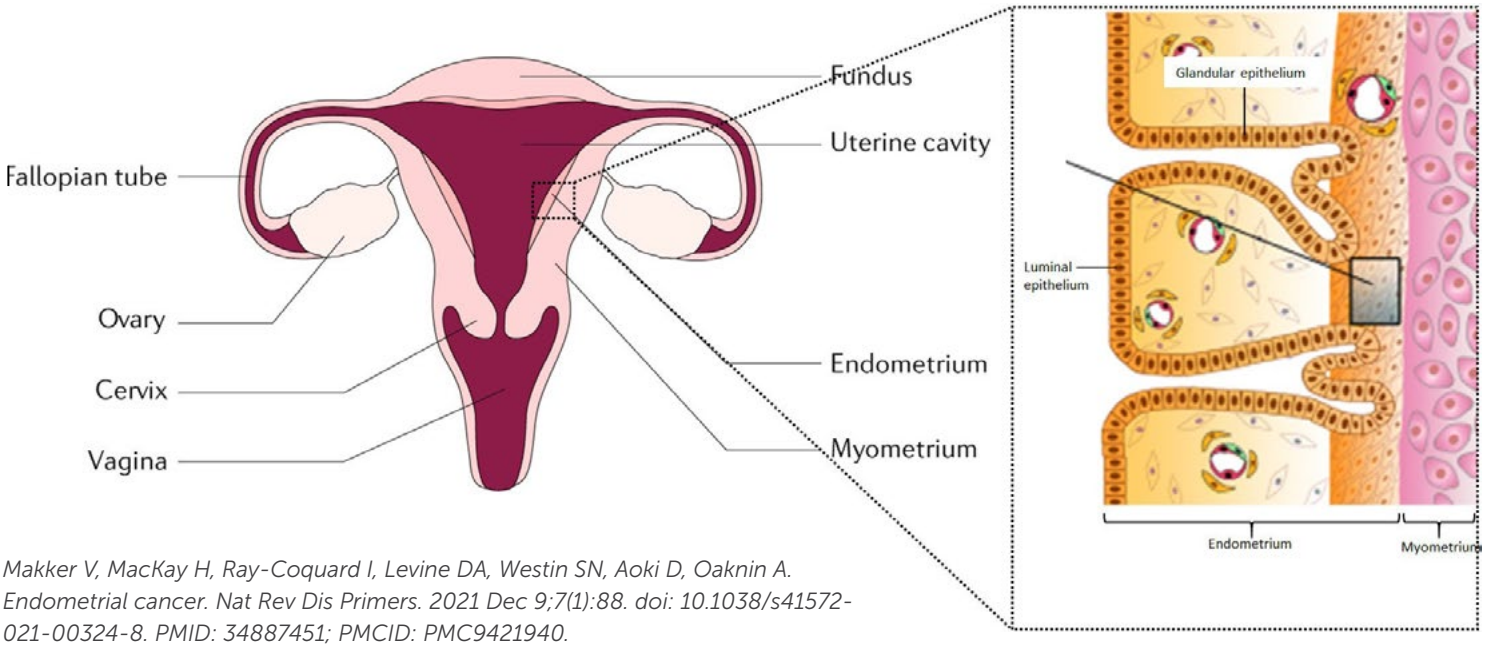

Makker V, MacKay H, Ray-Coquard I, Levine DA, Westin SN, Aoki D, Oaknin A. Endometrial cancer. Nat Rev Dis Primers. 2021 Dec 9;7(1):88. doi: 10.1038/s41572-021-00324-8. PMID: 34887451; PMCID: PMC9421940.

Endometrial Cancer 2025
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result from benign conditions such as polyps, fibroids, or vaginal atrophy, 5–10% of cases are due to underlying malignancy. The likelihood of EC increases with age: less than 1% in women under 50, around 3% at age 55, and up to 24% in women over 80.

In premenopausal women, EC rates have also been increasing as the incidence of risk factors increase. Early symptoms of EC can include heavy, prolonged, or intermenstrual bleeding. Although EC is rare in this group—occurring in only 0.3% of abnormal bleeding cases—the risk increases dramatically with obesity, PCOS, diabetes, and a family history of Lynch Syndrome. Women with a BMI over 30 are ten times more likely to be diagnosed with EC, and those with a BMI over 40 are twenty times more likely.

Diagnosis typically begins with transvaginal ultrasound (TVUS), which has a sensitivity of over 96% for detecting endometrial abnormalities. A threshold of ≥5 mm endometrial thickness in postmenopausal women warrants further investigation. If abnormalities are detected, endometrial biopsy is essential for confirming malignancy and identifying atypical endometrial hyperplasia (AEH), a precursor to EC. AEH progresses to EC in nearly 30% of untreated cases and is often found alongside EC in hysterectomy specimens.

Referral to a gynecologist is recommended for abnormal findings, and definitive surgical management is standard for AEH and early EC. Uterine-conserving options may be considered in select cases, though recurrence risk remains high.

See page 9 for the Q & A from a gynecologist for additional information.

Molecular Profiling and Subtypes

A major advance in EC understanding came with the 2013 TCGA classification, which identified four molecular subtypes: polymerase epsilon (POLE)-mutated, mismatch repair (MMR)-deficient (MMRd), no specific molecular profile (NSMP), and TP53-mutated. These subtypes have distinct prognostic and therapeutic implications.

POLE-mutated cancers have an excellent prognosis and are being studied for treatment de-escalation. MMRd tumors respond well to immunotherapy, particularly in advanced stages. NSMP tumors follow standard treatment protocols for now, and research is ongoing to refine this subtype further – something of critical need as this group represents roughly 50% of all EC cases. Patients with TP53-mutated cancers have a poor prognosis and require aggressive chemotherapy.

Molecular profiling now guides surgical decisions, identifies Lynch Syndrome carriers, and tailors adjuvant therapy. In British Columbia, all newly diagnosed EC cases are molecularly subtyped to inform treatment planning.

Management and Emerging Therapies

Most EC cases are surgically managed, with high-risk patients undergoing oncologic staging. Adjuvant therapies, including radiation and chemotherapy, are prescribed based on molecular subtype and disease stage. Radiation therapy reduces local recurrence risk and is commonly used in stages I–III. www.bccancer.bc.ca/health-professionals/clinical-resources/cancer-management-manual/gynecology/endometrium#Management-Endometrium

Immunotherapy has revolutionized treatment for MMRd tumors. Dostarlimab and pembrolizumab, both checkpoint inhibitors, have shown strong efficacy in advanced and recurrent EC, used in the first-line treatment setting (initially in combination with chemotherapy and then as maintenance therapy) these treatments have significantly improved progression-free and overall survival. For non-MMRd cancers, immune checkpoint inhibition combined with first line chemotherapy, or combination therapies such as pembrolizumab with lenvatinib are expanding options and improving outcomes.

Conclusion

EC is an emerging health crisis as the rates rise in the context of rising risk factors, in particular obesity and diabetes. Understanding the interplay between hormonal, metabolic, and genetic factors is essential for prevention and early detection. Molecular profiling is now central to personalized treatment, offering new hope for improved outcomes in a disease whose incidence continues to rise. As EC becomes more prevalent—even among younger women—clinicians must stay informed about emerging therapies and integrate molecular insights into routine care.

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– Indications, Adverse Events and Provincial Logistics", "Radiation Dermatitis: Skin Care for Breast and Perineum", "Navigating Natural Health Products in Cancer Care: Benefits, Risks and Recommendations", and more. Registration information is available at fpon.ca

If you have feedback or suggestions for future educational initiatives, please email FPON's medical education lead at sian.shuel@bccancer.bc.ca

Reference

BC Cancer. (n.d.). *General Practitioner in Oncology Education Program*. Family Practice Oncology Network. Retrieved July 15, 2025, from www.bccancer.bc.ca/health-professionals/networks/family-practice-oncology-network/general-practitioner-in-oncology-education-program

Endometrial Cancer Q&A from a Gynecologist perspective

By Dr. Melanie Altas, Obstetrics & Gynaecology, University of British Columbia

Is endometrial cancer HPV related? No, endometrial cancer is not HPV related.

Should we order CA125 as part of our work-up for post-menopausal bleeding? No, CA-125 does not need to be ordered in the evaluation of PMB.

Dr. Melanie Altas

Does endometrial thickness 5 mm on ultrasound which was done for bloating in a post menopausal woman with no post menopausal bleeding require follow up and or endometrial biopsy? Postmenopausal women without bleeding and a endometrial thickening of <11 mm do not require invasive investigations. Society of OB/Gyn Canada has a recent guideline on asymptomatic endometrial thickening in postmenopausal women. In asymptomatic women they recommend investigation if endometrial thickness is greater then 11 mm.

In primary care, if we have a positive endometrial biopsy, what additional tests should we be doing while waiting for gynecology consult? If the endometrial biopsy shows hyperplasia (precancerous cells) or malignancy a pelvic US could be helpful to order for surgical planning. Eg. to ensure there are no large fibroids / ovarian cysts.

How sensitive is a papelle endometrial biopsy? If the sample obtained is adequate then the chance of having endometrial cancer with a negative biopsy is less than 1%

How can I find out who to refer to for endometrial biopsies? Pathwaysbc.ca is an online referral resource designed by family physicians for any primary care provider. After login, under the "Select Specialty or Service" tab, go to "Obstetrics/ Gynecology" and set the search parameter for "endometrial sample" to get a list of providers based on your location settings.

Where can I find more information on abnormal bleeding in pre-menopausal women? Here are two good resources regarding abnormal uterine bleeding:

- The reaffirmed SOGC Clinical Practice Guideline No. 292-Abnormal Uterine Bleeding in Pre-Menopausal Women in the Journal of Obstetrics and Gynecology Canada Volume 40, Issue 5e391-e415May 2018: www.jogc.com/article/S1701-2163(18)30117-8/abstract
- The Provincial Adult Abnormal Uterine Bleeding Primary Care Clinical Pathway from Alberta as another good resource for primary care providers. www.albertahealthservices.ca/assets/info/aph/if-aph-prov-abnormal-uterine-bleeding-primary-care-pathway.pdf

World Congress of Prehabilitation and Perioperative Medicine, November 3-5, 2025

The theme is **Innovations in Perioperative Care: Shaping the Future of Surgery**.

The conference will provide an unparalleled opportunity to explore the latest evidence-based strategies in prehabilitation, perioperative medicine, and enhanced recovery, with insights from leading experts around the world. Whether you're a seasoned professional or new to the field, the event will offer invaluable perspectives on improving patient outcomes, reducing surgical complications, and optimizing healthcare resources.

For more details and to register: https://worldprehabcongress2025.com

The BC Shared Care Perioperative Clinical Action Network (PCAN) is happy to support 50% of your registration to the event. Submit your registration receipt to the Specialist Services Committee sscbc@doctorsofbc.ca for 50% reimbursement.

Corridor Consult: Colon Screening in BC

By Jennifer J Telford MD MPH FRCPC
Medical Director, BC Colon Screening Program
Clinical Professor of Medicine, UBC

Colorectal cancer is the third most diagnosed cancer in BC and the second leading cause of cancer death. However, when detected at an early stage through colon screening, the chances of survival are much higher. Colon screening has proven to be effective in:

Dr. Jennifer Telford

- Decreasing incidence of colorectal cancer by detecting and removing precancerous lesions; (Lin et al.)
- Decreasing deaths due to colorectal cancer by detecting cancer earlier at a stage when it is potentially curative; (Lin et al.; Bretthauer et al.) and
- Decreasing morbidity and the need for more invasive surgery, stoma, or adjuvant chemotherapy.

Health care providers play a vital role in supporting patients' participation in colon screening and follow-up care in accordance with the provincial screening guidelines. This includes answering patients' questions about the guidelines and follow-up recommendations. Some of the common questions we have heard from health care providers are:

What should I tell patients who have had low-risk polyps removed and can now wait 10 years instead of 5 years for their next colonoscopy?

Evidence suggests that people with low-risk precancerous lesions removed from the colon and rectum, are at lower risk of future colorectal cancer than previously thought. (Dubé et al.; He et al.)These individuals can wait 10 years for their next colonoscopy. If no precancerous lesion(s) are found at their next colonoscopy in 10 years, and they do not have a family history of colorectal cancer, it is safe for the patient to return to average risk screening with the fecal immunochemical test (FIT).

Share a copy of the Patient Handout: Colon Polyps and Follow-Up Recommendations with your patients who have had precancerous lesion(s) removed during their colonoscopy.

What are the colon screening recommendations for patients at higher-than-average risk?

Colonoscopy is the recommended screening test for patients with a high-risk family history of colorectal cancer:

- One first-degree relative (parent, full sibling, child) diagnosed with colorectal cancer diagnosed under the age of 60; or
- Two or more first-degree relatives with colorectal cancer diagnosed at any age

If a patient has a first-degree relative with colorectal cancer, their first screening colonoscopy should be completed at age 40 or 10 years younger than the age of diagnosis of the youngest affected relative (whichever is earliest). For example, if the patient's mother was diagnosed with colon cancer at age 55 and brother was diagnosed with colon cancer at age 40, the patient should have their first colonoscopy at age 30.

Refer to Table 1 for the recommended test, start age, and screening interval for individuals in BC with a family history of colorectal cancer. (Nuk and Telford)

When can patients stop colon screening?

In BC and across Canada, colon screening programs stop screening at the age of 75. When the patient turns 75, they will stop receiving reminder letters from the Colon Screening Program. At a population level, people who have been regularly screened with FIT or have undergone colonoscopies may not benefit from screening beyond age 75. Unscreened individuals or those who are not up to date with screening should be offered at least one time screening even if they are over 75 years of age. (Cenin et al.)

Patients aged 75 and older can discuss with a health care provider whether continuing colon screening is the right and safe choice for them. This decision will depend on the patient's personal preferences, their prior screening history, and their overall medical fitness. It is important to recognize that as the patient gets older, the probability of having a complication during a colonoscopy rises.

Where can I go for more information and point-of-care tools?

Visit www.bccancer.bc.ca/screening/health-professionals/colon for colon screening resources specifically developed for health care providers.

To stay informed about the latest resources and updates for health care providers, subscribe to BC Cancer Screening's Health Care Provider E-Newsletter. This quarterly e-newsletter highlights resources, tools, and information to help you support patients to prevent cancer and participate in breast, cervix, colon and/or lung cancer screening.

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TABLE 1. BC guidelines for screening individuals with a family history of colorectal cancer.

Family history	Test	Start age	Interval
≥ 2 FDRs* diagnosed with colorectal cancer	Colonoscopy	40 years†	5 years
1 FDR diagnosed with colorectal cancer at < 60 years of age	Colonoscopy	40 years†	5 years
1 FDR diagnosed with colorectal cancer at ≥ 60 years of age	FIT‡	50 years	2 years
≥ 1 SDR(s)§ diagnosed with colorectal cancer	FIT	50 years	2 years
≥ 1 FDR(s) diagnosed with a precancerous lesion	FIT	50 years	2 years

* FDR = first-degree relative.
† Or 10 years younger than the earliest age of diagnosis of the FDRs, whichever is earlier.
‡ FIT = fecal immunochemical test.
§ SDR = second-degree relative.

Follow-up of Persons with a Diagnosis of Early Breast Cancer

By Dr. Karen Gelmon, Medical Oncology

Breast cancer is the most common malignancy in women with an estimated 30,500 cases diagnosed in Canada in 2024 and 4135 in British Columbia and accounts for over 25% of the cancer diagnoses in women.[1] Approximately 290 men were diagnosed in Canada in 2024. The mortality from breast cancer has decreased by over 47% since the 1980s due to many factors including increased diagnosis of earlier disease through screening, improved treatments, lifestyle factors and other measures with a current overall the 5-year survival rate of over 87% and over 95% for those with Stage 1 breast cancer. The prevalence of breast cancer is therefore increasing including in women younger than 40[2] with most of the follow up landing in the hands of the primary care provider.

Dr. Karen Gelmon

The goals of follow-up of a person with a prior diagnosis of early breast cancer are to diagnose recurrence which can be local, regional or distant, as well as to monitor ongoing treatments, toxicity and the sequelae of treatment which can include physical, psychological, economic and social issues. Toxicity can be acute or chronic.

Breast cancer is not one disease. The behaviour of a cancer and the risk of recurrence depends on the biology and the extent of the disease. The size of the tumour, and involvement of regional lymph nodes and skin, defines the stage and with that the risk of recurrence. As well the biology impacts outcome. Approximately 70-75% of newly diagnosed breast cancers are estrogen positive, 15% overexpress a gene called HER2 and another 15% or so lack estrogen, progesterone and HER2 expression and are known as triple negative breast cancers (TNBC). Biology is also driven by the proliferative rate which is noted by grade (1, 2 or 3) also known as well, intermediate and poorly differentiated. Grade 3 or poorly differentiated are the most aggressive cancer and have a higher risk of relapse. Sometimes proliferation is measured by Ki67 with a higher rate (>20%) being more aggressive. Risk is also assessed in estrogen positive tumours by genomic assays such as the Oncotype Recurrence Score. Age can impact outcomes with young age often presenting as a more aggressive cancer.

The treatment of early breast cancer is determined by the extent of the cancer and the biology. It may involve surgery, radiation, chemotherapy, immune therapy, endocrine medications, bone modifying drugs as well as newer targeted therapy including drugs known as CDK4/6 inhibitors. Endocrine therapy may be prescribed for 5 years or extended to 7 or 10 years and may be part of the follow-up care by the primary health care provider. Bone modifying agents which may be oral, intravenous, or subcutaneous have been shown to decrease breast cancer recurrence as well as protect bones and may also be part of follow-up. Regular bone density examinations and dental follow-up should be done according to provincial guidelines unless there are concerns.

Local recurrence occurs in the affected breast or regional lymph nodes and is usually curable. This is most often diagnosed with a mammogram, other imaging or by examination. Persons with a prior diagnosis of breast cancer should have annual diagnostic bilateral mammograms beginning 6 months after completion of radiation to their breast and continuing until death; this may be modified it they have a diagnosis of either recurrent Stage IV breast cancer or another illness that is expected to cause death in the very near future. As local recurrence is usually curable this guideline is very important and is often confused by screening recommendations. If a person has had a mastectomy for treatment of their breast cancer, annual diagnostic mammograms of their remaining breast is recommended as they are at a higher risk of a new contralateral breast cancer. Mammograms are the standard imaging but may be supplemented by ultrasound or MRI if there is a diagnostic concern that is not solved by a mammogram, if there is very high density or if the person has an very high risk of breast cancer such as persons with an inherited cancer risk gene, a prior history of radiation to the chest, or other extreme risk factors. Ultrasounds are also important to delineate changes in the breast, lymph nodes or regional area that are found by either the patient or health care provider and may be a recurrence. Many persons get changes in their breasts after surgery or radiation that are not cancer but imaging and often biopsy are necessary to rule out recurrence.

Distant recurrence is metastatic disease that can occur anywhere in the body but common sites of recurrence after a breast cancer diagnosis are bones, lungs, liver, nodes, brain and sometimes diffusely throughout the abdomen or chest potentially presenting as effusions. Although distant recurrences are not usually curable there are many treatments now that can not only decrease symptoms but also increase survival, so it is important that it is diagnosed and that the patient is offered treatment. The risk of distant recurrence depends on the factors of the original breast cancer as well as the prior treatment for early breast cancer. There is no role for routine imaging or blood work of an asymptomatic person with a history of breast cancer and that includes monitoring of tumour markers such as CA15-3 or CEA. However, persistent symptoms with no other explanation should be investigated usually with imaging

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What are the Goals of Follow-up for Early Breast Cancer

- Provide care for both physical and psychological symptoms that are the result of cancer care
- Diagnose curable disease early so it can be treated for cure
- Diagnose advanced disease early to avoid symptoms
- Diagnose advanced disease early to improve survival potentially
- Enhance adherence/compliance with adjuvant medications
- Promote prevention and health including bone, sexual, psychological, cardiac health, neurological health

Diagnosis of Early Breast Cancer continued from page 11

especially new onset bone pain, dyspnea or other pains, changes or discomfort. There is research ongoing looking at circulating tumour DNA which may prove to be of benefit in the future but is not yet validated and should not be ordered, including not through expensive commercial sources as it cannot be interpreted at this time.

For the patient, the uncertainty about recurrence may be overwhelming and a large part of follow-up is providing support. Approximately 50% of recurrences occur within the first 5 years after a diagnosis, and distant recurrence of TNBC rarely occurs after 5 years although new local cancers can develop. Estrogen positive cancers can recur many years after a diagnosis so although the risk goes down, there is no end date. As well, chronic toxicity can include cognitive changes although 'chemo brain' is often more acute, menopausal symptoms, sexual issues, body image concerns, cardiac toxicity and bone side effects. Many of these are exacerbated by early menopause and aging, including fatigue and classic menopausal symptoms. For persons with estrogen positive cancers, hormone replacement therapy is not recommended with estrogens nor progestins due to studies showing an increased rate of recurrence, and other medications and lifestyle measures should be prescribed. If these are not effective local hormonal therapy may be necessary for sexual issues. New medications are now being developed which appear to be safe after breast cancer.

Follow-up should include questioning about adherence to their adjuvant therapy, especially hormonal therapy. Symptoms may be related to these medications or due to other health issues including recurrence. Educating patients about what to expect with their treatment and follow-up may decrease their anxiety and feelings of lack of control.

For any person with a prior history of breast cancer where there are concerns referral back to their oncologist or to a specialist to help deal with their specific issues is recommended. Follow-up care is complex and working with a multidisciplinary team is often the best to provide comprehensive care and to help persons with a prior history of early breast cancer regain their confidence and health. Every patient is different and although some may resume active productive lives quickly, a cancer diagnosis, even a curable cancer, changes most persons. Listening can provide clues to their follow-up needs and improve care.

Follow-up of Breast Cancer Patients

- History and Physical Examination every 6 months for 5 years and then annually
- Review adherence to medications, development of new symptoms,psychological health, sexual health
- Diagnostic bilateral mammograms annually for life
- If asymptomatic no routine imaging other than mammograms
- If asymptomatic no routine blood work other than usual for age
- BMD in early menopause, on endocrine therapy, other risk factors
- IF any symptoms that are persistent, image!!
- IF any physical findings that are concerning, image and biopsy!!
- IF concerns call the prior oncologist to review

Survivorship Issues

- **Neurological**
  - Chemo brain, peripheral neuropathy
- **Cardiac**
  - Cardiotoxic treatment with chemo and RT
- **Bone health**
  - Early menopause, toxicity of drugs both chemo and endocrine
- **Fertility**
  - Reproductive issues
  - Pregnancy after a diagnosis of breast cancer
- **Sexual and Menopausal issues**
  - Sudden onset, early onset, issues of HRT
  - Reproductive issues, sexuality
- **Psychological issues**
  - Losses, Issues of Uncertainty, Family/support group

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Colon Screening in BC continued from page 10

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BC Cancer Clinical Care Pathways – Helping providers and patients navigate a difficult and ever-changing path

By Dr. Christine Simmons, Medical Oncologist & Provincial Tumour Groups Chair, BC Cancer
James Loudon, Director, Provincial Programs, BC Cancer
Amilya Ladak, Manager, Tumour Groups & Pathology, Provincial Programs, BC Cancer
Kalina Nowaczek, Policy Analyst, Tumour Groups, Provincial Programs, BC Cancer
Yashpal Bhatia, Project Coordinator, Tumour Groups & Pathology, Provincial Programs, BC Cancer

Christine Simmons, James Loudon, Amilya Ladak, Kalina Nowaczek, Yashpal Bhatia

We all want the absolute best for our patients – whether it is a person we are seeing in an urgent care walk-in clinic, or a patient who has been in our practice for many years. Clinical practice guidelines and protocols are therefore integral and relied upon heavily by primary care practitioners, especially to ensure that evidence based, high quality care standards are met and maintained. Guidelines are developed by systematically reviewing all clinical trials, meta-analyses, real-world data, and literature, and summarizing this data utilizing statistical methods to assess the strength or weakness of a particular intervention in a particular disease. They are highly valuable when completed with standard rigour and can be readily appraised using tools such as the AGREE II instrument.

However, there is a problem with reliance upon guidelines in cancer care – with all the rapid changes in treatment by the time they are completed, (if done well), they may soon be out of date. In addition, the amount of work required to produce just one guideline has often led to this process being outsourced to non-clinicians, with clinical experts providing an advisory capacity only.

What if there was a better way to convey the steps in a care journey that was evidence-based, but nimbler in its ability to be reviewed and updated? What if such a tool could have the potential to be interactive and tailor information for clinicians and patients alike? What if there was a clear and transparent methodology of development, with clear authorship, date of publication, and expected date of next review?

That is the vision behind the development of BC Cancer's Clinical Care Pathways.

Over the past three years, each tumour group at BC Cancer has worked to develop evidence-based clinical care pathways which map out the entire patient journey from the point of "pre-diagnosis phase" (when there may be symptoms or a screening abnormality that needs to be worked up) right through to post-treatment care and survivorship, or, if the case may be, end of life care. Each of these pathways in their current form include additional resources imbedded by hyperlinks to allow the reader to delve into the level of detail they require. We are very pleased to announce that we now have 15 finalized clinical care pathways published on our website, with two in consultation phase, and four further pathways in development. We are on track to have every subtype of cancer mapped out completely. Highlights for our colleagues in primary care include the clear ability to identify when, how, and who to refer a patient to if there is a suspicion of cancer or diagnosis obtained already, and the ability to identify long term survivorship issues and recommendations for standardized follow-up after completion of cancer care.

The information currently available in handouts and handbooks can be overwhelming for patients. Patients are often bombarded with a tsunami of handouts after they see a cancer care specialist. While the pathways are currently framed for health care providers, we are also working with patient partners to embed additional informational hyperlinks for patients and caregivers, to tailor the information provided to patients based on their current phase along their care journey. This information would also be available for primary care practitioners to access and share with their patients even prior to seeing the cancer care specialist.

We look forward to your feedback. Any questions? Please email TGCoordinator@bccancer.bc.ca

- Each Tumour-Specific Pathway was developed by a multi-disciplinary team of specialists across health authorities in BC and approved by the relevant Provincial Tumour Group Committee.
- Each pathway is tumour specific and features references, hyperlinks and notes that will guide clinicians as they support their patients through their cancer care journey.
- Pathways can be found on our website here: Tumour-Specific Pathways
- Call to action: Please share with your teams and feel free to provide feedback. A feedback form is located at the bottom of the Consultation on Tumour-Specific Pathways page. Consultation on Tumour-Specific Pathways (bccancer.bc.ca)

Meet Dr. Paris-Ann Ingledew, Executive Vice President and Interim Chief Medical Officer, BC Cancer

My first few months as BC Cancer's interim chief medical officer have affirmed my excitement and gratitude to be leading this organization and our dedicated care teams, support staff and leaders.

Dr. Paris-Ann Ingledew

I've been with BC Cancer for more than two decades as a resident, radiation oncologist and Vancouver's radiation oncology department head. I have amplified the voices of my medical staff colleagues through groups like BC Cancer's Medical Dental Staff Association and devoted time to mentoring and improving medical education for the next generation of physicians. I've worked at our Vancouver, Surrey and Abbotsford centres, grew up in Kelowna and am raising a family in Vancouver. Through these experiences, I've gained a deep appreciation for the vital role that each and every one of us plays in delivering cancer care, the challenges of working in busy clinical environments, and the unique cultures of our cancer centres and the communities they serve.

Whether I'm acting as interim CMO or seeing patients in clinic, my driving purpose is the same: to deliver exceptional care by taking care of our patients and our people. We know our patient's cancer journeys move through many places and partners within our provincial system and that we rely on strong partnerships with primary care providers and regional health authorities to provide exceptional care.

As we move forward in our efforts to expand and improve cancer care in our province through BC's 10-Year Cancer Action Plan, I look forward to sharing further updates and opportunities to be involved in this work and encourage you to reach out to me with novel ideas and ways in which we can collaborate.

Canadian Cancer Society Virtual Cancer Care Resources

The Canadian Cancer Society, together with people living with cancer, caregivers and healthcare providers, has co-designed a series of evidence-informed resources that aims to improve the virtual care experience for people in Canada – **available now at** cancer.ca/virtualcare Virtual care has become an essential part of cancer care in Canada. It gives people living with cancer and their caregivers the option to connect with their healthcare teams remotely by phone, video call and secure messaging. But not everyone has equal access to the tools, support or training to use virtual care. This includes people in rural or remote areas, some older adults, and members of other underserved communities who may face barriers like unreliable internet access, privacy concerns or a lack of culturally relevant information.

To address these challenges, we have developed a range of resources designed to support better virtual cancer care appointments. Our **Virtual Care Resource Hub** offers tools including short videos and tips to help people feel better prepared and empowered to use virtual care.

- For people living with cancer, these resources include practical tips to help prepare for appointments, use technology effectively and remember important details.
- For caregivers, these resources include tools such as tips and communication strategies to use before, during and after virtual visits.
- For healthcare providers, these resources include best practices for delivering effective virtual care and understanding and supporting patients' needs.

Explore the Virtual Care Resource Hub and all that it has to offer by visiting cancer.ca/virtualcare **today**.

We invite you to share these resources with your professional and personal networks to help us reach a wider audience.

We'd love to hear from you

After exploring our resources, please take a quick 10-minute survey (available on the Virtual Care Resource Hub) to share your experience as a patient or caregiver. Your feedback will help us improve future tools and resources.

Thank you for helping us make a meaningful impact.

Primary Care Guidelines for Clinical Guidance

By Dr. Cathy Clelland, Medical Director, BC Cancer Primary Care Program

The BC Cancer Primary Care Program works closely with the BC Guidelines and Protocols Advisory Committee (GPAC) to develop and maintain primary care guidelines for cancer care in BC. We also collaborate with the BC Cancer Tumour Groups to develop guidelines independently and include GPAC in our external review.

Dr. Cathy Clelland

These FPON Primary Care Cancer Guidelines are considered "Partner Guidelines" by GPAC and are available at FPON.ca through a link from their website.

The goal of these primary care clinical guidelines is to provide practical and easy-to-follow advice to family physicians and other primary health care providers to enable effective patient care along the cancer care journey. Guidelines provide guidance for frontline primary care providers and are not considered a "standard of care".

2025 has seen two successful guideline projects come to completion:

1. GPAC Cervical Cancer Prevention and Screening Guideline. This guideline provides recommendations for cervical cancer screening in asymptomatic patients without a history of cervical cancer who are or have been sexually active. Screening information applies to individuals who have or have had a cervix. This includes women and Two-Spirit, Transgender, and Gender-diverse (TTGD) people. The guideline also provides recommendations for prevention of cervical cancer, including immunization for all individuals with a link to the BC Immunization website with the recently updated the publicly funded recommendations. www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/bc-guidelines/cervical-cancer-prevention-and-screening
2. Updating of the FPON Upper GI Cancer Guideline parts 1 & 2. In 2015/16, the Family Practice Oncology Network developed and published the 2-part Primary Care Upper GI Cancer guidelines. Examples of **NEW** recommendations for these updated guidelines include:
   - **Screening**: Screening in the average risk population for upper GI cancers is not recommended, but should be considered for certain high-risk groups;
   - **Hereditary Cancer Program**: Which upper GI Cancers are linked to hereditary syndromes and how to refer to the Hereditary Cancer Program (HCP);
   - **New Treatments**: A variety of systemic therapies may be available for some Upper GI cancers as determined by a multidisciplinary team approach

   Part 1 (Stomach & Gastric Cancer): www.bccancer.bc.ca/family-oncology-network-site/Documents/UpperGICancerRevision-Part1-Final-2025Sept1.pdf

   Part 2 (Pancreatic Cancer; Neuroendocrine tumours [NETs] of the pancreas & Duodenum; Extrahepatic Biliary Tract Cancer): www.bccancer.bc.ca/family-oncology-network-site/Documents/UpperGICancer-Part2-Final-2025Sept1.pdf

These guidelines and other clinical resource links can now be found on FPON.ca

Finding and Evaluating Evidence in Primary Care Oncology

By Elena Popova,
BC Cancer Clinical Librarian

Family physicians and other primary care providers are increasingly involved in the care of patients across the cancer continuum—from risk assessment and early detection to survivorship and palliative care. As cancer care becomes more complex, the need for timely, relevant, and evidence-based information has never been greater in the primary care setting. Unlike oncologists, who rely heavily on specialty literature and protocols, primary care providers must navigate a broad range of sources to inform decisions that align with both clinical guidelines and the individual needs of their patients.

Elena Popova

The process of finding and evaluating evidence in primary care oncology presents unique challenges. Peer-reviewed literature can be time-consuming to access and interpret within the constraints of primary care. At the same time, non-peer-reviewed online resources and professional society websites are often more accessible but vary widely in quality, accuracy, and applicability.

In British Columbia, primary care providers serve as the first contact for patients with suspected cancer, and as ongoing support after oncology treatment is complete. Quick access to reliable, evidence-based information is essential to guide decision making, patient counselling, and coordination with BC Cancer. By using a "local first, then expand" strategy and applying rapid critical appraisal, primary care providers can efficiently locate and evaluate evidence-based oncology information—whether preparing a referral to BC Cancer or guiding follow-up care in the community.

Start with local trusted sources

BC Cancer website provides professional clinical resources, such as the Cancer Management Manual, Tumour-specific Pathways, and Chemotherapy Protocols. These outline diagnostic pathways, initial work-up requirements, and follow-up recommendations.

The Family Practice Oncology Network (FPON) Guidelines and Protocols webpage provides concise, primary-care-focused summaries, survivorship care plan templates, and referral pathways.

BC Guidelines include provincial clinical guidelines on Oncology and cover cancer-specific and screening recommendations relevant to family practice. Using these resources ensures alignment with provincial standards and smooth referral processes.

Broaden the search when needed

If local guidance is unavailable, not recently updated, or the clinical question is highly specific, expand to high-quality evidence from international biomedical databases. These include the Cochrane Library for systematic reviews, PubMed/Medline for peer-reviewed studies, and guideline repositories such as the National Comprehensive Cancer Network (NCCN) or American Society of Clinical Oncology (ASCO).

Critical appraisal/evaluation

Before integrating information into patient care, evaluate:

- Authority — Is the source a reputable cancer agency, medical society, or peer-reviewed journal?
- Currency — Is it up to date with current standards?
- Applicability — Is it relevant to BC's referral pathways, available treatments, and patient population?
- Transparency — Are conflicts of interest disclosed?

Using non-peer reviewed resources

Some non-peer-reviewed medical websites, such as **MedlinePlus** or **Mayo Clinic**, can be helpful in clinical practice as they use simple language and cover a wide range of health topics. While they are not peer-reviewed journal articles, they can be valuable if properly evaluated. To ensure the information is reliable, accurate, and clinically applicable, check the following:

- Authority - Who is providing the information? For instance, MedlinePlus is produced by the U.S. National Library of Medicine (NLM), a government agency, and Mayo Clinic is a reputable academic medical center with physician oversight.
- Accuracy - Is the information supported by evidence? Look for citations or references to clinical guidelines or studies and cross-check with peer-reviewed sources like UpToDate, PubMed, or NCCN Guidelines.
- Currency - Check the date of last review or update, usually found at the bottom of the page. In oncology, where treatment protocols change rapidly, outdated info may mislead patient care decisions.
- Purpose and Objectivity - Determine if the content aims to inform, educate, or sell. Watch for bias or promotion of products/services (e.g., pushing alternative therapies without evidence). MedlinePlus and Mayo Clinic are generally neutral and educational.
- Coverage and Relevance - Is the content comprehensive and relevant to my clinical question? For family practice, ensure it reflects the primary care perspective (e.g., when to refer, shared decision-making, survivorship)

Tool you can use for appraisal

CRAAP Test (Currency, Relevance, Authority, Accuracy, Purpose).

This video is Creative Commons Licensed by Seneca College Libraries

Reference

Evidence-based practice improves patient outcomes and healthcare system return on investment: Findings from a scoping review. 2023

BC Cancer Summit: Moving Together from Vision to Action

By Dr. Dan Le, Ruby Gidda and Heena Vadgama, Summit co-chairs

BC Cancer is delighted to host the BC Cancer Summit this year from November 20 to 22 at the Sheraton Wall Centre in Vancouver. The BC Cancer Summit provides education, professional development and relationship building opportunities for oncology professionals from all specialties and disciplines.

The theme of this year's Summit is *"Moving together from vision to action"*. Focusing on the latest techniques and research, the Summit will cover developments in science, translational research, clinical trials, imaging, prevention, treatment, supportive care, clinical care, ethics and survivorship.

The Summit will feature Bright Spot presentations including *Rapid Diagnostic Units in BC – Breaking down barriers to improve timeliness and experience for patients and Reimagining cancer imaging: Bringing long-axial PET from Vision to Canadian Reality.*

In addition, participants can engage in a series of breakout sessions, including sessions from various tumour groups such as the Breast Tumour Group, GI Tumour Group, GU Tumour Group, Sarcoma Tumour Group, Skin Tumour Group and more, sessions from professional practice and supportive care, and professional oncology sessions.

This event is also an opportunity to recognize staff and physicians across the organization with an awards ceremony for the 2025 Doctors of BC Terry Fox Medal and BC Cancer Excellence Awards.

We hope to see you at this year's Summit! Visit bccancersummit.ca to register.

Dr. Dan Le, Ruby Gidda and Heena Vadgama

There will also be a poster session with abstracts presented in Population Health & Health Services, Translation/ Clinical, and Patient Experience & Supportive Care.

FOR MORE INFORMATION

To learn more about the Family Practice Oncology Network or become involved, please email FPON@bccancer.bc.ca or visit www.fpon.ca

The content of articles in this Journal represent the views of the named authors and do not necessarily represent the position of BC Cancer, PHSA or any other organization.

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BC Cancer, 600 West 10th Ave,
Vancouver, BC V5Z 4E6

BC Cancer provides specialized cancer care services to communities across British Columbia, the territories of many distinct First Nations. We are grateful to all the First Nations who have cared for and nurtured this land for all time, including the xʷməθkwəy̓əm (Musqueam), Sḵwx̱ wú7mesh Úxwumixw (Squamish), and səl̓ilw̓ətaɬ (Tsleil-Waututh) First Nations on whose unceded and ancestral territory our head office is located.