Family Practice Oncology Network Newsletter

Issue Number 18, Spring 2012 | www.fpon.ca

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

Prostate cancer community workshop series underway

Cancer Care Outreach Program on Education (CCOPE)

The second module of our community oncology workshop series – the Cancer Care Outreach Program on Education or CCOPE – launched earlier this month focussing on Prostate Cancer and targeted to meet the needs of busy family physicians. The prostate workshops were developed by the UBC Division of Continuing Professional Development in partnership with the BC Cancer Agency's Screening Groups and the Family Practice Oncology Network. They feature 2-hour, small group, case-based discussions over dinner led either by a local General Practitioner in Oncology or a local physician actively practicing oncology.

Topics include:

- Current screening recommendations;
- Appropriate diagnostic procedures;
- Main treatment options and their potential side-effects; and
- Ongoing management and follow-up of prostate cancer patients.

The workshops are accredited for up to 2.0 Mainpro M1 credits and are low cost ($35 registration or $25 online).

Workshops have already been held in Salmon Arm, Kelowna and Victoria with registration open for upcoming sessions in various other BC communities until the end of June 2012. Please check www.ubccpd.ca/programs/ccope to find out if there is a workshop near you!

The first module in the series focussed on Breast Cancer with workshops held in 12 BC communities. Feedback was overwhelmingly positive with:

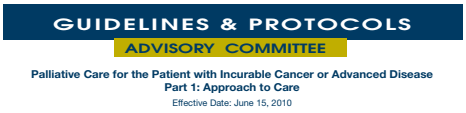
- 97% of participants noting they feel more confident working with breast cancer patients; and
- 96% commenting that the small-group, case-based discussion format is an effective way to learn about the role of family physicians across the cancer care continuum.

For further details on dates, registration and future workshops on other cancers, please visit ubccpd.ca/programs/ccope or contact Tunde Olatunbosun at tunde.o@ubc.ca, 604.875.4111 ext. 69138.

More on guidelines enclosed and upcoming

Enclosed with this newsletter you will find three more Palliative Care: Pain and Symptom Management Guidelines – Constipation, Fatigue and Delirium – all geared to meet family physicians' pressing need for practical, concise information on end-of-life care. Each is symptom and algorithm based and includes a drug table listing the medications used, dosage forms and details on the coverage or fees involved.

These guidelines along with those distributed with previous newsletters (The Palliative Approach to Care; Pain and Symptom Management: Cancer Pain, Dyspnea and Nausea) were produced by the Family Practice Oncology Network and the BC Guidelines and Protocols Advisory Committee (GPAC). All follow GPAC's practical chronic disease management format emphasizing brevity and evidence-based information and including practitioner tools and patient hand-outs.



The guideline on Depression will be distributed with the next newsletter along with the last guideline in the Palliative Care series: Grief and Bereavement. All of the above are available now @ www.bcguidelines.ca and are in the process of being converted for easy download to iPhone and iPod. Additional appendices for these guidelines are available at www.fpon.ca.

Finally, we are nearing completion on guidelines for breast and colorectal cancer and are beginning work on a guideline for female genital tract cancers focussing on prevention and screening and diagnosis and treatment of endometrial cancers (excluding ovarian). Upcoming guidelines will address HPV related oral, head and neck cancers, upper gastro intestinal cancers, lung cancer, follow-up of pediatric cancer patients, lymphoma, testicular cancer, leukemia and myeloma – all in effort to provide family physicians with the tools and resources to better care for cancer patients and their families.

Contact Dr. Phil White at drwhitemd@shaw.ca

BC Generations Project reaches 20,000 participant mark – and is looking for your help to recruit the next 20,000!

At the BC Cancer Agency Annual Conference last December, 35 BC health care professionals offered to help recruit participants to the BC Generations Project by displaying posters and brochures in their waiting rooms. With 20,000 participants already recruited to this landmark cancer prevention study, the Project is now seeking more physicians to help spread the word.

BC GENERATIONS PROJECT
Your time today builds a healthier tomorrow.

You can play a key role in encouraging your patients to join the BC Generations Project. The study is open to any BC resident aged 35-69 and aims to recruit up to 40,000 participants.

Participation involves completing an at-home questionnaire or visiting an assessment centre. Participants answer questions relating to their health, diet, and lifestyle, as well as their medical and family history. They also provide blood and urine samples at community laboratories. BC researchers are particularly interested in the role of environmental exposures in disease risk.

"I think this project has real potential to change our perceptions about and treatment of patients with cancer," said Dr. Ivo Olivotto, Vice President, Radiation Therapy and Functional Imaging at the BC Cancer Agency. "By collecting this sort of information from hundreds of thousands of people across Canada, this project will help us tease out how the interplay of genes, lifestyle, environment and other factors can be used to prevent cancer or select which treatments are really necessary for each individual."

In the past six months alone, the BC Generations Project has recruited an impressive 3,464 participants through its short-term assessment centres in Victoria and in Abbotsford. The assessment centres allow participants to provide additional health data, such as bone density, blood pressure and body fat measures. Over the next six months, the Project hopes to operate one or two more of these centres in other BC regions, with support from the BC Cancer Foundation.

The BC Generations Project is part of the Canadian Partnership for Tomorrow Project, the largest long-term health study of its kind in Canada. Nationally, this project has enlisted more than 200,000 study participants across five regional centres. The main funder of the project is the Canadian Partnership Against Cancer with regional funders contributing additional paid and in-kind support.

If you'd be willing to display a BC Generations poster or brochures in your patient areas, please call or email the Project at bcgenerationsproject@bccrc.ca or toll-free at 1-.877.675.8221. For project details, visit www.bcgenerationsproject.ca.

Bob Almasi from Langley was the 20,000th participant to join the BC Generations Project

Linking learning to practice

By Dr. Jim Thorsteinson, Executive Director, BC College of Family Physicians

How to do a practice reflection exercise (based on your recent participation in the CCOPE program or any other CME activity) for Mainpro-C credits:

Family physicians do many things that help them, either intentionally or consequentially, maintain and/or enhance their abilities. Appreciating this, the College of Family Physicians of Canada has introduced a new and innovative way to collect Mainpro-C credits. It involves an approach to answering questions through information appraisal and integration rather than just information acquisition. And it challenges you to reflect critically on your practice and/or work.

The key feature of this option is that members can now generate their own Mainpro-C credits by working through "practice reflection exercises" to answer questions they identify as being important for any aspect of their practice and/or work, such as those posed and addressed in the above CCOPE workshops and other of your information seeking and practice improvement activities.

Here is an example...

You just went to the CCOPE program on breast cancer. You learned about current approaches to breast cancer screening and management and had a chance to explore your questions. You ask yourself: *"Which recommendations apply best to my patients and how can I be sure that all of my eligible patients are being screened either by me or the local program?"*

Follow this link (www.cfpc.ca/Linking_Learning_to_Practice) to either complete your "Practice Reflection Exercise" online or to print and complete by hand and then submit for 2 Mainpro-C credits (for each one you submit).

HPV vaccine one time program for women born 1991-1993

By Brittany Deeter, Immunization and Vaccine Preventable Disease Nurse Consultant, BC Centre for Disease Control

BC is launching a limited publicly funded HPV vaccine program to protect young women born in 1991, 1992, and 1993 against HPV 16 & 18 which cause about 70% of cervical cancers.

This program will be offered in addition to the school-based HPV vaccination program in place since September 2008. Girls born in 1994 and after continue to be eligible for HPV vaccination even if they declined it when they were in grade 6 or 9.

The HPV vaccine is known to be cost-effective in preventing precancerous changes and cancer of the cervix caused by HPV 16 & 18 in women until about 25 years of age. The vaccine is preventive and does not clear already established HPV infection. Because HPV is sexually transmitted and is a common infection, the vaccine is most beneficial to use prior to onset of sexual activity. However, women in the target population (aged 19, 20 & 21) – even those who are sexually active – are unlikely to have been infected with both of the strains of HPV associated with cervical cancer covered in the vaccine and will benefit from vaccination.

HPV vaccines have now demonstrated efficacy up to 9 years after immunization. Their safety profile is excellent. Data analysis of 5 major clinical trials reflecting over 36,000 person-years at-risk demonstrated that there was no difference between vaccine and placebo groups with regard to anaphylaxis rates, the development of an autoimmune disorders or overall systemic adverse events (nausea, body aches etc.). The only significant differences found were in injection site pain, redness and swelling, and fevers. This safety profile was confirmed by analysis of passive reporting data from the Vaccine Adverse Events Reporting system, representing over 25 million doses of HPV vaccine given in the US since 2006 with no safety signals detected[1].

The vaccine program is being launched with available one-time funding and has a limited quantity of vaccine. The demand for vaccine was estimated based on uptake for similar programs in other jurisdictions. If vaccine supply is exhausted, young women will be able to purchase vaccine privately to complete their series.

The vaccine is given intramuscularly in the deltoid (upper arm). The recommended schedule is 3 doses, with the second dose given 1 month after the first, and the third dose given 6 months after the first dose. If a series is interrupted and the time between doses is longer than recommended, it does not need to be restarted.

Update on the use of HPV vaccines in males

There is a recommendation from the National Advisory Committee on Immunizations that one of the two vaccines, Gardasil® has recently been authorized for use in males 9 to 26 years of age for the prevention of HPV infection caused by HPV Types 6, 11, 16, and 18 and for anogenital warts (AGW). Gardasil® is also indicated in males 9 through 26 years of age for the prevention of anal cancer caused by HPV types 16 and 18 and anal intraepithelial neoplasia (AIN) grades 1, 2, and 3 caused by HPV types 6, 11, 16, and 18. Cervarix™. Currently, none of the publicly-funded programs in Canada provides HPV vaccination for boys. The vaccine can be purchased at pharmacies or travel clinics for approximately $150/ dose.

For additional information on the program and on HPV uptake in BC please see:

- BC HPV vaccine educational materials www.immunizebc.ca or immunizebc.ca/diseases-vaccinations/hpv
- The January 2012 NACI statement at www.phac-aspc.gc.ca/naci-ccni/index-eng.php#rec

Or contact Brittany Deeter at 604.707.2522, brittany.deeter@bccdc.ca

References:

1 Block et al. (2009). *The Pediatric Infectious Diseases Journal*, 29(2). 95-101.

Family Practice Oncology CME Day – Dec 1St

We are finalizing plans for our annual Family Practice Oncology CME Day and hope you will mark your calendar and plan to join us in Vancouver on December 1st. The event will be held as part of the BC Cancer Agency's Annual Conference, November 29 – December 1, at the Westin Bayshore with the overall theme of "Evolving Dynamics in Research and Patient Care".

Our session will feature presentations on the topics and treatment updates family physicians most requested throughout the year and include excellent opportunities to establish contacts and build relationships in primary care oncology and within the BC Cancer Agency.

The cost to attend the Network's CME Day (and the full conference) is $149. After September 28, the cost to attend the full conference as well increases to $199. Registration will be available as of June 1 at www.bccanceragencyconference.com.

Another highly recommended primary care oncology event is the Canadian Association of General Practitioners in Oncology – CAGPO – annual conference. The year's event will be held October 18-21 at the Hyatt in Calgary. Full details at www.cagpo.ca.

The power of prevention!

By BCCA Prevention Programs

Did you know that more than 50 percent of cancers are preventable? For this reason, we will be dedicating a column in each newsletter to provide evidence based facts about cancer prevention and healthy living.

As you may be aware, tobacco use itself is likely responsible for one-third of all cancer deaths. However, it is also true that many cancers and other chronic diseases could be prevented by eating a healthy diet, being physically active, maintaining a healthy body weight and staying safe in the sun (and avoiding tanning beds!).

With all of the myths, as well as misinformation found in the media and online, it can be difficult for patients to know what actions they can take to reduce the risk of cancer. With this in mind the interactive www.Hi5Living.org was created. It is an award-winning evidence based cancer prevention website. Though initially developed for youth, it has proven to be well suited for families and older adults as well. Patients and non-patients can use the website to take a Healthy Living Quiz, complete a Healthy Living Assessment and create SMART goals. As patients work their way through the website they will be asked questions about their lifestyle choices based on the five main risk factors that can help prevent more than 50 percent of cancers. The risk factors are: tobacco use, poor diet/nutrition, inactivity, obesity, and excessive sun exposure/tanning bed use. Consider recommending this site as an adjunct to your educational efforts.

If you would like to order free Hi5living bookmarks or stickers to provide to your patients, or other prevention materials, please call toll free: 1-866-451-4567 or email your request to: office@preventionprograms.org

The BCCA Prevention Programs resources and materials are all based on the latest evidence based guidelines. The latest cancer prevention dietary guidelines developed by the *World Cancer Research Fund* and the *American Institute for Cancer Research* can be found at: www.dietandcancerreport.org

Insight on chemotherapy treatment protocol codes

By Johanna den Duyf, BSN, MA, Senior Director of the Communities Oncology Network and Laurel Kovacic, BSc, PharmD, Pharmacoeconomics Pharmacist, BC Cancer Agency, Centre for the S. Interior

The BC Cancer Agency's Provincial Systemic Therapy Program (PSTP) is responsible for the planning and management of the life support budget for oncology drug treatments. The oncology drug budget supports approximately 35,000 patients being treated with anti-cancer drugs with either curative intent or chronic disease management intent throughout BC.

The PSTP develops, implements, and evaluates standards of systemic care for patients within the BC Cancer Agency and Communities Oncology Network sites based on scientific evidence derived from well-designed clinical trials in cancer patients. Therapy is standardized through the creation of treatment protocols which are regularly reviewed and updated to reflect new knowledge and practice. There are more than 350 different treatment regimens available to patients with a broad range of diagnoses of treatable cancers.

Why use BCCA treatment protocol codes:

Treatment protocol information provides BCCA with essential data used to track utilization of drugs by patient, individual drug and treatment protocol and allows us to perform sophisticated projections of trends in practice. In addition, this information allows us to predict the future use of new and costly agents and track how these predictions have performed in practice. Uptake information regarding new protocols is then adapted to predict utilization in subsequent years. This is done on a protocol-by-protocol basis and supports the continual refinement of existing modeling systems. As each protocol is identified by a unique code which indicates the tumour site, treatment intent and drugs used, access to this information is crucial to the accuracy of our budgeting process.

Contact: OSCAR: 1-888-355-0355, oscar@bccancer.bc.ca

Where are BCCA treatment protocol codes obtained?

www.bcccancer.bc.ca/chemotherapyprotocols

When should you use BCCA treatment protocol codes?

Physicians are asked to ensure the appropriate chemotherapy treatment protocol code is on the prescription or doctor's order form for each treatment.

Who is responsible for identifying the BCCA treatment protocol code?

The cancer patient's physician has the knowledge regarding the patient's tumour type and treatment intent and is the most appropriate individual to identify the BCCA treatment protocol code and ensure this information is available for the rest of the cancer care team. The Health Authority pharmacy department ensures the BCCA treatment protocol code is entered into the BCCA billing system when applying for reimbursement for oncology drugs.

Gynecologic cancers in the family

By Mary McCullum, Nurse Educator, Hereditary Cancer Program, BC Cancer Agency

Many people are aware of family history as a risk factor for breast cancer, but pay less attention to other "female" cancers. While most gynecologic cancers are NOT hereditary, they are relevant when primary care providers review family history. An important starting point is to clarify differences between cancers that originate in the cervix, uterus or ovaries – often new information to women. Method of diagnosis, treatment and outcome are clues to the most likely primary diagnosis, but pathology reports may be required for confirmation.

Cervical cancer is unlikely to be hereditary. Regular Pap test screening helps to prevent cervical cancer. The rest of this article addresses endometrial cancer and ovarian cancer, which are features of specific hereditary cancer syndromes.

EC and OC risk management for high-risk women

There are no evidence-based guidelines for EC or OC screening even for women with Lynch syndrome or HBOC. Therefore, prompt reporting of relevant symptoms and appropriate medical assessment are critical.

Women with Lynch syndrome are advised to have annual gynecologic exams. Evidence supports the efficacy of prophylactic hysterectomy and bilateral salpingo-oophorectomy (BSO) for prevention of EC and OC. This may be a reasonable option after age 35-40 or once childbearing is complete. Although its effectiveness has not been proven, consideration can be given to annual endometrial biopsy with transvaginal ultrasound starting at age 25-35.

Women with a BRCA1 or BRCA2 mutation are advised to consider prophylactic BSO at age 35-40. This surgery reduces the probability of ovarian cancer by 85-95%, and may also reduce breast cancer risk by approximately 50% if performed prior to menopause. Available ovarian cancer screening methods (transvaginal ultrasound, pelvic exam, CA-125 blood test) have not achieved acceptable sensitivity for detecting early-stage disease and are not recommended in BC.

If your patient's family history of gynecologic (and/or other) cancers suggests a specific syndrome, please refer to the Hereditary Cancer Program for more detailed assessment. If your patient reports that a close relative has a confirmed hereditary cancer gene mutation (those listed above or others), please refer to the Hereditary Cancer Program for discussion about genetic testing and cancer screening advice.

Contact Mary McCullum at mmccullum@bccancer.bc.ca

Endometrial cancer (EC)

- Abnormal vaginal bleeding is most common 1st sign.
- Most EC is NOT hereditary.
- EC is a feature of Lynch syndrome (*MLH1, MSH2, MSH6, PMS2* genes), also known as Hereditary Non-Polyposis Colorectal Cancer (HNPCC).
- EC may be the 1st cancer for a woman with **Lynch syndrome**.
- Suspect Lynch syndrome if a family history includes:
  - a woman with both EC and colorectal cancer (CRC)
  - EC in 2 or more close relatives*
  - CRC in 2 or more close relatives*
  - other cancers including ovary, stomach, small bowel, pancreas, gall bladder, kidney, ureter, brain
  - at least one "hallmark" cancer diagnosed before age 50
- Some pathology departments now test new EC samples for markers suggesting Lynch syndrome. As this becomes more common, hereditary cancer referral criteria will be revised.
- EC may also be seen in some rarer hereditary cancer syndromes. Watch for a future article on Cowden syndrome.

Ovarian cancer (OC)

- Early signs are often non-specific.
- Most OC is NOT hereditary; specific pathology is an important clue.
- OC includes primary fallopian tube and peritoneal cancers.
- Up to 20% of high-grade serous OC is due to **hereditary breast/ovarian cancer (HBOC) syndrome** (*BRCA1, BRCA2* genes).
- Mucinous and low malignant potential OC are not features of HBOC.
- HBOC syndrome may be suspected if family history includes:
  - a woman with high-grade serous OC
  - breast cancer in close female relatives* especially if diagnosed before age 50
  - male breast cancer
  - Ashkenazi Jewish heritage
- OC (clear cell or endometrioid) can be part of Lynch syndrome. (See EC section).
- Less common forms of OC may be features of rarer hereditary cancer syndromes. Contact us if your patient reports several relatives with a rare ovarian tumour.

* close relatives must be on one side of the family and include: parents, brothers, sisters, children, aunts, uncles, grandparents, grandchildren. History of cancer in cousins and more distant relatives may also be important.

Cancer survivors have a higher risk of new cancers

By Dr. David McLean, Head, Cancer Prevention, BC Cancer Agency

Dr. David McLean shares expertise on the prevention of second primary cancers.

It's astonishing to think that the number of cancer survivors in Canada today is equivalent to the population of a large city. There is a need for a greater public and professional practice understanding of the special cancer risks faced by cancer survivors and that prevention can be included as part of the survivor's new normal. Those increased risks can be from potentially carcinogenic treatments, e.g. radiation therapy and alkylating agents, behavioral risk factors, and/or a genetic propensity to cancers.

Viewed as a group, second primary cancers would be the ***6th most common cancer*** in Canada. Due to treatment advances leading to the cure of the first cancer, the incidence of second primary cancers is almost certain to grow. The BC Cancer Agency Prevention Programs educates about the prevention of cancer, not only for those who have never had cancer but also for those who have had it. The Prevention Programs is committed to helping cancer survivors, their families, and health care providers understand more about the risks of a second primary cancer, and the ways they can help to lower those risks.

The five main preventable risk factors that are focused upon are tobacco use, obesity, poor nutrition, inactivity, and overexposure to sun / use of tanning beds. To meet the need for such education and increased awareness, a Prevention of Second Primary Cancers Program is under development. The first of its kind in Canada, it will provide evidence-based information to survivors and their families and will also be a complementary tool to any survivorship program.

What is a second primary cancer? A second primary cancer is one that is not related to the first cancer, has not spread from the first cancer, and usually originates in a different tissue or organ. These second cancers often share the same modifiable risk factors as the primary cancer, which is why making healthy lifestyle choices can reduce the risk of developing cancer for the second time. It is important that patients and their family members know this. Sharing this information with patients and families will give them tools for helping survivors navigate towards a healthier future after treatment, with the support of informed families and cancer care providers. It will also help family members become informed as to what they themselves can do to prevent a first cancer.

Contact: Sonia Lamont at slamont2@bccancer.bc.ca

Update on sexual health clinic research project

The new Sexual Health Clinic at the BC Cancer Agency's Centre for the Southern Interior in Kelowna saw its first patient in April of last year and will continue to recruit for one more month. "Thank you to everyone who has referred patients to our clinic," notes Regional Professional Practice Leader, Myrna Tracy. "We have had 27 referrals to date with a very even split between males and females. Our patients report great relief at having their concerns addressed locally as many have suffered with sexual issues resulting from cancer and/or cancer treatment and have not had the resources to help before."

Sexual dysfunction is one of the more common, enduring consequences of cancer treatment:

- Sexual side-effects weigh in as the most important long-term factor during cancer remission
- about 1/2 of females who survive breast or gynecologic cancer report severe, long-lasting sexual problems
- probably 70% of men who are undergoing active treatment for localized prostate cancer will experience sexual impairment
- 1/4 of people with testicular cancer, leukemia or Hodgkin's disease are left with sexual dysfunction
- In the general population (USA 18-59 yr olds), sexual dysfunction is highly prevalent and is associated with poor physical health and emotional distress ("Counselling cancer patients about changes in sexual function", Leslie Schover, PhD. Nov '99, Oncology, pg. 1585)
- 32% of women who were experiencing vaginal dryness had lost interest in sexual relations (Stenberg, A. et. al, 1996)
- Sexuality remains important during palliative care (Rice, Int J Pall Nurs, 2000; MacElveen, Semin Oncol Nurs, 1985)

continued on page 7

(Left to right) Lucie Ouimet, Maureen Ryan and Myrna Tracy are part of the Sexual Health Clinic team at the BCCA Centre for the Southern Interior.

More psychiatric issues in oncology

The following is a continuation of an article submitted last issue by Dr. Elaine Drysdale, BA, MD, FRCPC, Clinical Associate Professor, Dept of Psychiatry, Faculty of Medicine, UBC, Consultant Psychiatrist to the BC Cancer Agency Vancouver Centre and to the Bone Marrow Transplant Program of BC. Dr. Drysdale gave a Webcast presentation on this same subject available for viewing at www.fpon.ca (under CME Initiatives, 2011 Webcasts). The first article is also available on our Website in the Fall 2011 Newsletter.

Dr. Elaine Drysdale

Hormones, Mood and Tamoxifen

Altered hormonal functioning can be an underlying factor associated with anxiety, depression, or apathy in various cancers. Much has been written about the psychological aspects of breast cancer, yet it is likely highly significant that most breast cancer patients are also simultaneously undergoing marked alterations in hormonal functioning, making it even more challenging to cope with the psychological issues. We know that in various cancers, the **abrupt onset of menopause** (due to chemotherapy, surgery, or to total body irradiation), is more difficult for patients than normal menopause, and can cause free-floating anxiety, mid-insomnia (with lighter sleeping and frequent awakenings) and difficulty in word-finding, (particularly names of objects or people).

Some women are particularly vulnerable to becoming depressed in response to a sudden drop in estrogen. Just as only some women develop post-partum depression after pregnancy, only some women develop a **depression with estrogen-blockers** such as tamoxifen. It is important to explore past and family histories of menstrual mood difficulties and post-partum disorders. Anti-depressants can be helpful in treating the patient, but some patients ultimately require a change by their oncologist in the type of estrogen-blocker.

In prescribing an antidepressant for a woman taking tamoxifen, be wary of **tamoxifen- interactions!** Tamoxifen is itself inactive and requires cytochrome p450 isoenzyme 2D6 activity to convert it into its active metabolites. Tamoxifen efficacy can be diminished when a woman has a genetic variation of 2D6 activity, or where a concurrent medication is a strong 2D6 inhibitor, preventing the conversion of tamoxifen to its active metabolites. Medications that are strong 2D6 inhibitors, and which therefore should be **avoided with tamoxifen**, include **paroxetine (Paxil), fluoxetine (Prozac), and bupropion (Wellbutrin)**. Moderate inhibitors with possible interactions that should be avoided or used with caution include duloxetine, desipramine, imipramine and trazodone. Safer options that are not likely to have tamoxifen interactions include citalopram, escitalopram, sertraline, venlafaxine, nortriptyline, and mirtazapine (Gabapentin used in treating pain is also fairly safe.).

Mirtazapine

The antidepressant **mirtazapine** is particularly beneficial for anxious and depressed patients who also have diminished appetite. It has calming (anxiolytic) effects at even 1/4 -1/2 of a 15 mgm tab, and can restore appetite and boost weight. I titrate it up to 15-45 mgm qhs for antidepressant effects.

Neuropathic Pain

Regarding **neuropathic pain**, much attention has been given to the use of gabapentin and pregabalin, but I first learned from neurologist, Dr. Barbara Allan, that another beneficial medication is **clonazepam**, which I prescribe as **.5 mgm tabs, 1/2 tab bid prn and 1/2 to 1 tab qhs regularly or prn**. The clonazepam has particular qualities beyond other anxiolytics which give it special efficacy in treating neuropathic pain. The 1/2 tab bid prn portion gives the patient some control in having something to take for bursts of pain in the daytime. This is particularly helpful in Shingles pain, and patients have expressed much gratitude for the clonazepam! The drug should later be tapered to avoid any anxiety or insomnia rebound.

It has also been observed that pain of **neuropathic type** is more likely to respond to antidepressant medication that is noradrenergic, rather than serotonergic, in action. Antidepressants with **noradrenergic activity** include nortriptyline, desipramine, and duloxetine.

Fatigue

Regarding cancer-associated **fatigue**, exercise has been shown in studies to decrease fatigue in cancer patients. It is also beneficial for some patients to take **methylphenidate** (Ritalin) onset 2.5 mgm qam, titrated to 2.5-5 mgm qam and q noon, and possibly as high as 60 mgm daily. Possible side-effects of anxiety, insomnia, tics, and paranoia are less likely to occur with small doses, such as 10 mgm daily.

Contact Elaine Drysdale: edrysdal@bccancer.bc.ca

Sexual health clinic research project continued from page 6

- 299 prostate cancer patients were asked: "Assuming you had localized prostate cancer, would you accept treatment that could lengthen your life but would lead to impaired sexual response?" 38% said "Yes". Four percent said "Yes, if it prolonged life by 1-2 years"; 12% said "Yes if it prolonged life by 3-10 years"; 28% said "Yes, if it prolonged life by 10 years"; and 19% said "No". (Helgason, 1996, Br J Cancer).
- 98% of oncologists and nurses felt sexuality should be addressed but only 21% actually discussed sexuality (Stead, 2003)

The Sexual Health Clinic provides an opportunity for patients to have their sexual health concerns addressed.

Contact Myrna Tracy: mtracy@bccancer.bc.ca

Message from the chair

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

We both give and gain significantly when it comes to sharing knowledge and experience with like-minded primary care oncology organizations across the country. The BC Family Practice Oncology Network is in many ways a Canadian leader in terms of the development of resources, tools and training to strengthen family physicians' abilities to care for cancer patients and their families. To this end, I was pleased to accept an invitation from the Alberta Family Physician Provincial Initiative to give the opening address at their Provincial Cancer Roundtable event in March and to take part in a debate on key oncology issues faced by family physicians.

We also enjoy a productive relationship with CancerCare Manitoba and benefit from Dr. Jeff Sisler's expertise on the coordination of care between the cancer community and primary care. Dr. Sisler is the Director of Primary Care Oncology at CancerCare Manitoba.

Effective national linkages are equally important to our success and as such we collaborate closely with the Canadian Association of General Practitioners in Oncology – CAGPO – led by our very own GPO, Dr. Henry Docherty of the BC Cancer Agency's Centre for the Southern Interior. In fact, we are working on a potential nationally Mainpro-C accredited online CME program in partnership with CAGPO and facilitated by Dr. Tim Huerta of Texas Tech University.

Finally, within BC, the Network is playing a key role in the BC Cancer Agency's Provincial Survivorship Project initiative, which works to address a wide range of issues that impact patients' transitions from active treatment to post-treatment life. As part of this initiative, I co-lead a sub-group that strives to improve the interface between oncologists and primary care physicians. I also serve as Deputy Chair for the steering committee that provides direction to this provincial survivorship initiative.

Contact Dr. Phil White at drwhitemd@shaw.ca

Breast cancer screening: policy review part of strategy to improve mammography access

By Dr. Christine Wilson, Medical Director, Screening Mammography Program of BC, and Provincial Breast Health Strategy Project Team Chair.

The Canadian Task Force on Preventive Health Care's recommendations on breast cancer screening published in the *Canadian Medical Journal* six months ago have refueled the debate about breast cancer screening for women of average risk. When your patient asks for advice about when to start receiving regular mammograms, what do you asay?

Recognizing that this confusion hampers our ability to recruit women into the screening program, the BC Cancer Agency (BCCA) had already initiated a review of BC's screening policy when the Task Force began its work.

With both medical and health policy specialists on board, the BC review team is now looking at evidence from a number of sources, including an evidence review completed for the BCCA, the Canadian Task Force recommendations and any other relevant data. We plan to complete this review by early June and make recommendations to the Ministry of Health. Once approved, we will communicate the recommendations to community physicians, radiologists and women in BC.

In the meantime, the scope of the Screening Mammography Program of BC (SMPBC) remains the same. Asymptomatic women of 40 to 79 may still self-refer and others at higher risk can always access the program with a referral. It's also important to note that regular screening for women aged 50 to 69 is not in question. Screening mammograms (every two years) are highly recommended for women in this age group.

The screening policy review is part of the Provincial Breast Health Strategy's work to improve access to high quality, appropriate and timely breast cancer prevention, screening and diagnostic services. We also need to address other barriers within screening, such as the current stipulation that women booking mammograms within the SMPBC must have access to a family physician for follow up. Through the PBHS, we are looking at ways to overcome this barrier.

Once the updated screening policy is released, we plan to work with health authority leaders and the BC Medical Association's Divisions of Family Practice to be able to connect "unattached" women with physicians along the newly developed diagnostic clinical pathway as needed. We also plan to talk with family physicians about how we can streamline the referral process at the various stages of the woman's diagnostic journey to ensure that the newly developed PBHS diagnostic clinical pathway will enable timely access to all the imaging services that she may require. This will include women who have received an abnormal screening result, as well as women referred for diagnostic imaging for further investigation of a physical breast abnormality.

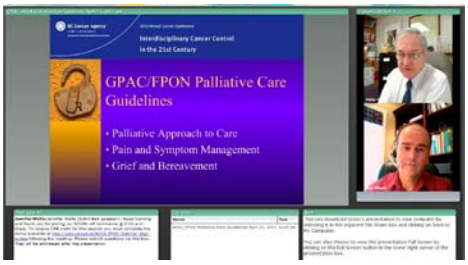
The diagnostic clinical pathway, and other information about the PBHS, is posted on the PHSA website at www.phsa.ca/HealthProfessionals/pbhs/default.htm

Contact: pbhs@phsa.ca

Oncology CME webcasts – convenient live or recorded

"It continues to be a privilege to participate from afar via a laptop with a highspeed connection... it is so wonderful just to be able to readily fit this into the day, in between other things... and enjoy sipping a hot cuppa while listening!" – Webcast feedback is always welcome.

Oncology CME at your fingertips aptly describes the Family Practice Oncology Network's monthly CME Webcast program offered in partnership with UBC's Division of Continuing Professional Development. This complimentary program features online interactive presentations by BC Cancer Agency oncologists and other specialists



designed specifically to meet the learning needs of busy family physicians. The sessions, accredited live for up to 1 M1 credit by the BC Chapter of the College of Family Physicians of Canada, take place from 8:00 – 9:00 a.m. PST on the third Thursday of every month (except summer and December).

Every session is also recorded and available on the Network's Website – www.fpon.ca – including past presentations on cancer prevention, cancer emergencies, rectal cancer, oral oncology and many more.

"The Webcasts provide an excellent means to gain the most current information on those cancer topics and treatments most requested by family physicians – and to interact with top experts," notes the Network's CME Working Chair, Dr. Shirley Howdle. "We planned this program so that family physicians can easily take part no matter where they are in the province. In fact, we also regularly attract numerous physicians from across Canada and even from other countries and continents and are planning to expand the program to provide an accredited non-live component where participants can truly take advantage of this oncology CME opportunity at their own leisure."

Contact: Jennifer Wolfe at jennifer.wolfe@bccancer.bc.ca to have your name added to the email list for Webcast notices.

Our upcoming Webcast schedule

June 21: New Breast Screening Guidelines and the Provincial Clinical Pathway with Dr. Christine Wilson and Lynne Ferrier

September 20: Lymphoma Insight for Family Physicians with Dr. Laurie Sehn

October 18: Head and Neck Cancer: An Update for Primary Care with Dr. Jonn Wu

November 22: CAGPO Recap – Presentation Reviews from the Canadian Association of General Practitioners in Oncology Annual Conference

Register at www.ubccpd.ca/Events/Webinar_Program.htm

Skin Cancer Update

By Dr. Henry Docherty, General Practitioner in Oncology at the BC Cancer Agency's Centre for the S. Interior and Chair of the Canadian Association of General Practitioners in Oncology.

TANNING IS OUT

Canadian Cancer Society
BRITISH COLUMBIA AND YUKON

With the BC health minister's recent announcement of the government's plan to legislate against people 18 years old and younger using tanning beds, and the approach of another (hopefully) wonderful BC summer, it is perhaps timely to remind ourselves of some of the deleterious effects of ultraviolet radiation on our skin.

The tanning issue is topical. Several jurisdictions are moving to restrict the use of tanning beds, and in New South Wales a total ban is planned to commence in 2014. A 2008 epidemiological study found more tanning salons than Starbucks outlets in 16 major US cities! This spring 40 high schools in BC are running a "Ban Tanning for Grad" campaign in partnership with the Canadian Cancer Society. Victor Yap, a grade 12 student at Kelowna Secondary School, pointed out to me the intention of educating young adults about UV radiation, noting that tanning is associated with a 75% increase in melanoma risk in those under 35. It is one of the more common cancers in 15 – 29 year olds and kills more women under 30 than any cancer, including breast and ovarian. Victor quoted the campaign slogan "Tanning is out". There were about 886 cases of melanoma in 2010 in BC. The BC Cancer agency estimates this number will be 1,758 by 2025.

Of course, melanoma, though serious, is not the only concern and tanning is not the only source of ultraviolet exposure, albeit a preventable one. Solar radiation is associated with about 90% of skin cancers and, along with tanning, is now associated with all the major forms of skin cancer. Skin cancer is, by far, the commonest cancer found in our society.

Non melanoma skin cancers (approximately 80% Basal Cell cancer and 20% Squamous Cell cancer) are rising in incidence by 2-3% per year in most jurisdictions. Basal Cell cancer rarely spreads, but is locally destructive while Squamous Cell cancer has the potential to metastasize. Most people do not realize how much sun reflects from water, snow, sand and grass (45 -80% of direct light), nor do they use enough sun screen/block or apply it frequently enough.

Robust public health programs aimed at prevention are beginning to yield some success in Australia and New Zealand. They reinforce sun protective behavior (SPF screen or block of 30 or higher frequently applied, SPF clothing, limit going outside between 10:00 a.m. and 4:00 p.m.) and awareness and regular checking of skin lesions.

We would do well to follow these guidelines more attentively and continue to encourage our patients to do likewise.

Contact Dr. Henry Docherty at hdochert@bccancer.bc.ca

New role, new knowledge, more variety for Smithers preceptor graduate

Dr. Mary Knight's career gained some serious breadth with the completion of the Family Practice Oncology Network's Preceptor Program last year. A full-service Smithers family physician for seven years, Dr. Knight now works three days a week in her practice, two half-days as a General Practitioner in Oncology (GPO) at the Cancer Service in Bulkley Valley District Hospital, plus serves a regular shift in the Hospital's Emergency Room. She also enjoys frequent afternoons of mountain biking and skiing.

Dr. Mary Knight enjoys the medical diversity of her new role brought about by the Preceptor Program.

Dr. Knight: "Burn-out often happens in full-time office practice due to the pace and the repetitiveness. Working part-time with the hospital's oncology team provides a completely different focus from my practice including a real team orientation and the opportunity to learn from others with years of experience – a big plus. We also work closely with the medical and radiation oncologists in Prince George and Vancouver, a BC Cancer Agency pharmacist in Prince George plus a local pharmacist who all serve as excellent resources for our Cancer Service and isolated community.

I learned about the Preceptor Program from one of our retiring GPOs. She promoted it as the chance to learn some amazing new skills and I jumped on it right away. With three GPOs (one now semi-retired), we have coverage all year round without any gaps in patient care. There are no days where patients have to travel out of town to receive care or miss chemo appointments – there is always someone here. In fact, when the one GPO in Terrace was away recently, we were able to meet his patients' needs by teleconference and help that community as well. If we weren't here, cancer patients would have to travel to Prince George four to five hours by car in a mountainous, often wintry environment.

I gained a huge amount of knowledge through the Program on cancer treatment and follow-up at a level that family physicians don't usually get into. To understand the side-effects, the benefits and the remarkably positive outcomes of so many treatments is inspiring and encouraging.

The Preceptor Program offers a great opportunity to help out your community, to take on a different medical role and benefit from a change to everyday practice. Plus it's kind of fun to go back to school when there's no exam!"

Dr. Knight previously worked as a family physician in Edmonton and is a graduate of the University of Alberta.

Contact Dr. Mary Knight at maryknight3@gmail.com

Next preceptor course begins September 24, 2012

The Preceptor Program is an eight-week course offering rural physicians and newly hired Agency GPOs the opportunity to strengthen their oncology skills and knowledge. The Program includes a two-week introductory module held twice yearly at the Vancouver Cancer Centre followed by six weeks of flexibly scheduled clinical modules at the Centre where participants' patients are normally referred. The program is accredited by the College of Family Physicians of Canada for up to 25 Mainpro-C and 50 Mainpro-M1 credits and eligible physicians 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 full details visit www.fpon.ca.

Thrombotic events in patients with cancer

Risk Factors for VTE in Cancer

Risk varies from 1 – 30% depending on:

Patient-related
- Older age
- Race
- Prior VTE
- Platelet count
- Comorbid conditions

Cancer-related
- Primary site
- Histology
- Metastatic disease
- Time interval since diagnosis

Treatment-related
- Surgery
- Chemotherapy
- Hormonal therapy
- Antiangiogenic therapy
- ESA
- Hospitalization
- Catheters

Lyman et al. J Clin Oncol 2007.

By Jill Scott, RN, VGH Thrombosis Clinic and Dr. Agnes Lee, Medical Director, Thrombosis Program, Associate Professor of Medicine, Division of Hematology, University of British Columbia and Vancouver Coastal Health

The VGH Thrombosis Clinic cares for many cancer patients with VTE (venous thrombotic events). These include deep vein thrombosis (DVT) and pulmonary embolism (PE). Although cancer is the major concern for these patients, VTE is the second leading cause of death in cancer patients and is a common complication from chemotherapy, surgery and central venous catheters.

Incidence

Overall, about 1 in 125 cancer patients develop VTE. However, the risk varies depending on the tumour type, cancer treatments and patient-related risk factors.

continued on page 11

Introducing the Association of BC GPOs

President and Vice President of the ABCGPO, Drs. Val Geddes (right) and Peter Pavlovich, GPOs at the BCCA Vancouver Centre

There is a new professional association for family physicians whose primary focus is cancer care – the Association of BC General Practitioners in Oncology – or ABCGPO. The group was formally established in December of last year with the initial objective being to represent Agency GPOs in negotiations regarding remuneration and workload issues. Support for this initiative and for an organization to connect and represent GPOs' interests overall was overwhelmingly positive as indicated in a preliminary survey of the province's 87 GPOs and attendance at the Association's inaugural meeting in December. In fact, numerous community GPOs (who are not Agency staff) expressed their support and desire to participate.

The ABCGPO's membership now includes over 40 GPOs both Agency and community-based with a groundswell of activity brewing.

Here are further details:

Who can join the ABCGPO?

Any BC family physician with a "focused practice" of oncology care in their clinical work.

What is the cost and how do I get involved?

Annual dues are $100 and membership forms are available from jennifer.wolfe@bccancer.bc.ca

Who is leading this initiative?

The Association elected its first Executive team last December including the following:

- Dr. Val Geddes – President – GPO, BCCA, Vancouver Centre
- Dr. Peter Pavlovich – Vice President – GPO, BCCA, Vancouver Centre
- Dr. Christine Blyth, GPO, BCCA, Vernon Clinic
- Dr. Suzanne Campbell, GPO, Vanderhoof
- Dr. Henry Docherty, GPO, BCCA, Centre for the S. Interior
- Dr. Dean Kolodziejczyk – Secretary / Treasurer – GPO, BCCA Vancouver Island Centre
- Dr. Randy Marback, GPO, BCCA Nanaimo Clinic
- Dr. Peter Battershill, GPO, BCCA Vancouver Island Centre

Is there a national organization?

The Canadian Association of General Practitioners in Oncology (www.cagpo.ca) was established in 2003 and includes 140 members with representation from all Canadian provinces.

What initiatives are underway and upcoming?

- a membership drive;
- Meeting with the BCCA Executive to introduce the organization, review pay scales, and develop a mechanism to be informed of newly hired GPOs;
- a general meeting during the Western Community Oncology Conference in Whistler in June 2012 to set goals and objectives;
- Continuing work with CAGPO regarding norms of practice and educational standards; and
- Ongoing collaboration with the Family Practice Oncology Network to build an effective network of GPOs province-wide

Contact Dr. Val Geddes at vgeddes@bccancer.bc.ca

Thrombotic events in patients with cancer continued from page 10

Cancers that affect the pancreas, stomach, or brain have the highest incidence of developing blood clots.

Cancer patients who undergo surgery have an even higher risk for VTE. Therapeutic agents, like cisplatin, thalidomide and bevacizumab also heighten the risk.

The use of indwelling central catheters for chemotherapy increases the risk of arm and neck DVT. Clots here can interfere with the function of the catheter and potentially delay chemotherapy administration.

Prevention Strategies

Surgical cancer patients should receive prophylaxis with once-daily LMWH (low molecular weight heparin) or thrice-daily unfractionated heparin subcutaneous injections for 7-10 days, and up to 4 weeks in patients with high risk features. Mechanical leg compression devices can be used in those with a high-risk of bleeding when anticoagulants are contraindicated.

Hospitalized medical patients with cancer are candidates for anticoagulant prophylaxis in the absence of contraindication.

For ambulatory patients, routine prophylaxis is not recommended. However, for myeloma patients on immune modulating drugs with chemotherapy or dexamethasone, LMWH or warfarin is recommended.

Treatment

Treatment for cancer- associated VTE is weight-adjusted LMWH daily injections for as long as the cancer remains active or the patient is receiving chemotherapy. The vast majority of patients can be taught to self-inject the LMWH slowly in subcutaneous abdominal tissue followed by 2 minutes of pressure applied to injection site to minimize bruising.

Coverage for dalteparin for 6 months can be obtained immediately by phoning Pharmacare at 1-800-657-1188 (press 1 for special authority). Coverage is provided for 3 months for other LMWHs.

LMWH must be stored at room temperature and is available in pre-filled syringes.

Referral to the Thrombosis Clinic is recommended if the patient develops recurrence despite LMWH. Recurrent VTE can be treated with a dose escalation of LMWH. Do not insert an IVC filter as it does not treat

continued on page 12

Featuring Fiona Walks

It would be hard to come by a stronger supporter of primary care/oncology partnerships than Fiona Walks, the BC Cancer Agency's Vice President, Safety, Quality and Supportive Care. Hers is a broad realm of responsibility which – along with the Family Practice Oncology Network – also includes survivorship, pain and symptom management/palliative care, professional practice nursing, corporate services quality risk, infection control and patient/family counseling and nutrition. She has been at the helm of this group for just over a year.

Fiona Walks is Vice President, Safety, Quality and Supportive Care at the BC Cancer Agency and is leading efforts to build a more interactive relationship between primary and tertiary cancer care.

Ms Walks:

What is so exciting about working with the Family Practice Oncology Network is the opportunity to develop relationships with family physicians in the community, to understand their needs and to support them in our common quest to provide the best cancer care possible. Family physicians are pivotal to our cancer care system and ultimately we share the same desire – to improve patient outcomes and to better care for patients and their families close to home.

The crux of our efforts at the Agency is fundamentally linked with primary care. Family physicians have a good understanding of patients' long term care needs and the key is to learn how we can best support their post-treatment care over time. It is useful for family physicians to understand the acute care that the Agency delivers and to gain insight on how we can assist with survivorship issues and/or handling disease progression. Family physicians connect with patients at pivotal points throughout their care and we are keen to provide support and better integrate tertiary services with those of primary care.

The role of the Network is important in this regard especially its development of cancer care guidelines for family physicians; its CME initiatives both online and in communities; and its training programs for up and coming General Practitioners in Oncology. Another key area will include research and evaluation to fully understand the value family physicians bring to tertiary care. This is a hugely important emerging area.

Ms. Walks is Vancouver-born registered nurse and a graduate of UBC. She also holds a Masters of Science from McGill.

Contact Fiona Walks:
fwalks@bccancer.bc.ca

Thrombotic events in patients with cancer continued from page 11

hypercoagulability or reduce symptoms. It can lead to more DVT, venous gangrene and possible limb loss. There is no data to show reduction in mortality or hospitalization with the use of IVC filters.

If the patient develops bleeding while on anticoagulation, it is important to identify the bleeding source and treat this to stop bleeding. It is important to restart anticoagulation once the bleeding stops to prevent recurrent VTE.

Referral Information

Referrals can be faxed to the VGH Thrombosis Clinic in Centennial Pavilion 6th floor @ 604.875.5071.

The phone number is 604.875.4111 ext.69275

Please include the reason for referral, a brief history, contact information, recent bloodwork (CBC, and creatinine), copy of diagnostic imaging, and state whether or not it is urgent. If it is an acute DVT, send the patient to the nearest Emergency department to start LMWH treatment.

References

Agnes Lee MD, MSc, FRCPC June 2011 presentation. Thrombosis in Cancer, An Update on Risk Assessment, Prevention and Treatment.

James, Ortel, Tapson. 100 Questions and Answers about DVT and PE.

FAMILY PRACTICE ONCOLOGY NETWORK CHAIRS

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

CONTINUING MEDICAL EDUCATION
Dr. Shirley Howdle
Vancouver
604.877.6000 ext. 2246
showdle@bccancer.bc.ca

GUIDELINES AND PROTOCOLS
Dr. Neil Hilliard
Abbotsford
604.851.4700 ext. 642921
nhilliard@bccancer.bc.ca

PRECEPTORSHIP PROGRAM
Dr. Bob Newman
Sechelt
604.885.2667
drbobnewman@gmail.com

FOR MORE INFORMATION

To learn more about the Family Practice Oncolgy Network or become involved please contact:
Gail Compton
Manager
Tel: 604.707.6367
e-mail: gcompton@bccancer.bc.ca

Visit the Network Website:
www.fpon.ca

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

Publications Mail Agreement
Number 41172510
Return all undeliverable Canadian Addresses to
BC Cancer Agency
600 West 10th Ave, Vancouver, BC
V5Z 4E6