

Family Practice Oncology Network Newsletter

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BC Cancer Agency

CARE + RESEARCH

An agency of the Provincial Health Services Authority



The Cancer Care Outreach Program on Education is a partnership between the UBC Division of Continuing Professional Development (UBC CPD), the BC Cancer Agency (BCCA) Screening Groups, and Family Practice Oncology Network (FPON).

UBC CPD



CONTINUING PROFESSIONAL DEVELOPMENT
FACULTY OF MEDICINE



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Breast and prostate cancer workshops

Since the fall of 2011, community oncology educational workshops on breast and prostate cancer care have been delivered to over 200 family physicians across 20 BC communities. This spring, with funding from the BCCA, additional workshops on

breast and prostate cancer are being delivered to family physicians in 10 additional BC communities.



CCOPE – additional community workshops underway and new module on colorectal cancer

Colorectal cancer workshops

The CCOPE steering committee, with representation from FPON, the BCCA screening groups, and UBC CPD, identified colorectal cancer care as the next module for educational rollout. A team of experts are currently working on educational content for colorectal cancer cases. Delivery will begin in the fall of 2013.

Workshop content and format

Topics included in the CCOPE breast, prostate, and colorectal modules span the spectrum of cancer care, and 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.

Workshops feature 2-hour, small group, case-based discussions over dinner, led by a local GPO or physician actively practicing oncology. Sessions are accredited for up to 2.0 Mainpro M1 credits and are low cost.

Workshop impact

Evaluation results indicate that the workshops are an effective way to learn about the role of family physicians across the cancer care continuum and increase confidence and knowledge working with cancer patients. Results showed family physicians had a self-reported increase in knowledge, particularly: the clinical implication of the pathology and staging of cancer, elements and frequency of follow-up for cancer, resources to support patient care.

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Family Practice Oncology CME Day – November 2nd

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 November 2. The event will be held as part of the BC Cancer Agency's Conference, October 31 – November 2, at the Westin Bayshore. The BC Cancer Agency is celebrating 75 years with the overall theme of "Cancer Care, Knowledge Translation & Research in BC: Legacies-Innovation-A Better Tomorrow".

Our session will feature presentations on the topics and treatment updates family physicians most requested throughout the year and include excellent opportunities to network, 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 \$169.

After September 6, the cost to attend the full conference as well increases to \$229.

Registration is available 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 17-20 at Queens Landing, Niagra-on-the-Lake, Ontario. Full details at www.cagpo.ca.

Message from the President – Let's make colon cancer history!

Did you know that the BC Cancer Agency celebrates a key milestone this year – 75 years of providing cancer care to residents across British Columbia! Then known as the British Columbia Cancer Institute, the BC Cancer Agency's first cancer treatment centre in BC officially opened on November 5, 1938. The cancer centre was a renovated house located at 11th and Heather, on part of the land where our current Vancouver Centre operates today.

Since the start of the first cancer treatment centre, the BC Cancer Agency has seen, and driven, many changes in cancer care,



Dr. Max Coppes, President,
BC Cancer Agency

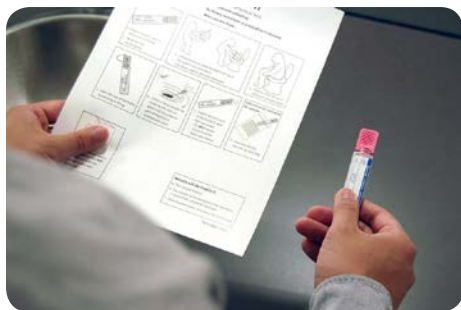
knowledge translation and research. But throughout the past seven and a half decades, what has never changed is our organization's clear focus on quality of patient care, as well as a drive to improve detection and treatment options for patients through investigative research – all of which has paved the way for how we deliver our services today.

With the introduction of the new provincial colon screening program this year, I hope we can count on your support. Colorectal cancer is one of the most preventable forms of cancer and if diagnosed early, the five-year survival rate is 90 per cent.

Since the introduction of the BC Cancer Agency's Cervical Cancer Screening Program in the early 60s – the first in the world – BC has reduced cervical cancer rates by 70 per cent. The Agency's Screening Mammography Program contributes to our province having some of the best outcomes for breast cancer survival in the world.

As a family practitioner, you are the direct link to those patients that are between the ages of 50-74, who should be participating in colon cancer screening. By working together I am confident that the new Provincial Colon Screening Program will follow in the footsteps of these successful screening programs and have a significant impact and spot in history in saving the lives of British Columbians.

New province wide colon screening program launches in BC



The fecal immunochemical test (FIT) is a safe, easy-to-use, highly-sensitive test that can find pre-cancerous and cancerous cells early – when cancer can be prevented or caught sooner. Patients can complete the FIT in the comfort of their own homes and there are no dietary or medication restrictions.

British Columbia's new Provincial Colon Screening Program started April 1, 2013 with the availability of the publicly-funded fecal immunochemical test (FIT). This easy-to-use, highly sensitive test will help save lives by supporting the early detection of colon cancer.

Colorectal cancer is the third most common type of cancer in Canada. It is estimated that close to 3,000 people will be diagnosed with colorectal cancer in BC this year.

Over 94 per cent of these are men and women age 50 or older.

Currently, only 25 per cent of eligible British Columbians get screened for colorectal cancer. As family physicians, you play a critical role as a key influencer for patients when deciding to participate in cancer screening programs. The new program model is built on the experiences of the BC Cancer Agency's Colon Check pilot program and ensures that family physicians have a stronger role in the screening patient pathway.

The Provincial Colon Screening program is primary care-based and family physicians are asked to refer asymptomatic British Columbians between the ages of 50 and 74 for testing to ensure that those at most risk of developing colorectal cancer receive regular screening.

The full Provincial Colon Screening Program will begin in the Vancouver Island Health

Authority first and will be phased in to other health authorities across the province over the spring and summer of 2013.

The program includes a number of unique features such as health authority patient coordinators to support patients being referred for colonoscopies; quality and performance standards for FIT, pathology and colonoscopy; and a recall system to remind program participants and their physicians of the need for re-screening at the appropriate interval.

NOTE: Until the program fully launches in your Health Authority, FITs can be ordered using the standard outpatient lab requisition by selecting FOBT. If your patient receives a positive FIT result, please make the necessary arrangements for follow-up.

For more information on colorectal cancer and BC's new screening program, please visit www.screeningbc.ca/colon.

Eligible Population (Ages 50 to 74)

Individuals at average risk of developing colorectal cancer

Individuals with a significant family history of colorectal cancer:
*i.e. a single first degree relative diagnosed less than 60 years
of age or at least two first degree relatives diagnosed at any age*

Screening Test

FIT once every two years

Screening colonoscopy:
*frequency will depend on
result of colonoscopy*

Lymphedema in the oncology patient

The following is a synopsis of a presentation given by Hamilton Cancer Centre nurse practitioner, Margaret Forbes, at the October 2012 CAGPO meeting. Dr. Judith Pike, locum General Practitioner in Oncology at the BC Cancer Agency Vancouver Centre, prepared the synopsis also available as a Webcast at www.fpon.ca (CME Initiatives).

Lymphedema is the accumulation of excess protein rich fluid in the interstitial space due to disruption of the lymphatic drainage system. In oncology this is most often due to lymphadenectomy or radiation therapy, malignant involvement or a combination of these factors.

The risk persists for life and is increased by:

- More extensive surgery and/or a combination of radiation and surgery
- Post operative complications e.g. infection or hematoma
- Trauma/Injury
- BMI >30
- Immobility, dependent posture
- Venous Thrombosis

Stages vary from mild, potentially reversible to elephantiasis, with fibrosis, hyperkeratosis with high infection risk.

Lymphedema leads to:

- Reduced mobility, stiffness and function.
- Chronic debility, discomfort.
- Negative impact on body image
- Financial burden
- Risk of infection, often septicemia. Abrupt onset, usually due to gram +ve cocci; may need IV antibiotics if oral not quickly effective

Assessment

Baseline limb volume calculation or measurements at 2-3 fixed points bilaterally; >2cm difference is significant. If occurs in delayed fashion, consider cancer recurrence as possible cause.

Prevention

- Newer techniques such as sentinel lymph node biopsy replacing radical lymph node dissection.
- If adjuvant radiation is anticipated irrespective of nodal involvement, avoiding node dissection may be prudent.



Stage 3 Lymphedema

- Avoid post op complications, skin or tissue trauma.
- Maintain limb strength and mobility.
- Maintain ideal body weight.

Management

Management includes patient education and self care with focus on

- Skin care, lubrication, avoidance of trauma, early recognition of infection.
- Limb exercise, (gradual isometric to increase mobility and strength)
- Weight control
- Compression * (sleeve, stocking, 2 layer bandaging, pneumatic compression) and manual lymphatic drainage
 - * Contraindications to Compression
- Arterial Insufficiency
- Congestive Heart Failure
- Recent Venous thrombosis before anticoagulation established
- Active Infection
- Paralysis
- Extreme caution required in diabetics

Points to remember

1. Diuretics are ineffective (fluid is extravascular).
2. Ensure referral therapist is accredited.
3. Garments require specialized fitting, a prescription with stated pressure.
 - a. 20-30mm/hg for sleeve as tolerated
 - b. 30-40 mm/hg for stocking as tolerated

4. In institutionalized, palliative patients with severe lower limb lymphedema **subcutaneous lower limb drainage** is often effective. A butterfly needle is inserted in the dependent lymphedematous limb and attached to a drainage bag. (Nursing protocol available at BCCA).

View the full webcast of this topic at www.fpon.ca – CME Initiatives.

Resources

www.bcphysio.org
www.bclymph.org
www.massagetherapy.bc.ca
www.canadalymp.ca
www.voderschool.com
[www.bccancer.bc.ca/PPI/Types of Cancer/Breast/Rehabilitation/default.htm](http://www.bccancer.bc.ca/PPI/Types%20of%20Cancer/Breast/Rehabilitation/default.htm)
www.providemcehealthcare.org/health/professionals/referrals
(Holy Family Hospital has a program for age >55, focuses on education and self management).
www.fraserhealth.ca (Surrey Memorial)

Contact Dr. Judith Pike at
jpike@bccancer.bc.ca

CCOPE
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Testimonials:

"Workshop format (small group nature of the workshop) allowed for interactive discussions"

"Interacting with others and learning from actual cases in a practical way"

Upcoming workshops and call for facilitators

For details and registration for upcoming workshops, or if you are a GPO or physician interested in bringing the colorectal workshops to your community, please visit www.ubccpd.ca/programs/ccope or contact Tunde Olatunbosun at tunde.o@ubc.ca, 604.875.4111 ext. 69138.

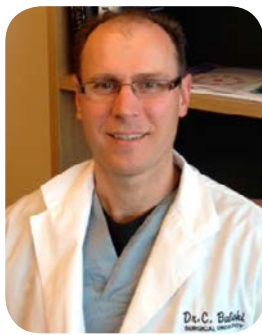


Subcutaneous tumours – a surgical oncologist’s advice

By Dr. Chris Baliski, Acting Head of the BC Cancer Agency’s Surgical Oncology Program and Surgical Oncologist at the BC Cancer Agency’s Sindi Ahluwalia Hawkins Centre for the Southern Interior.

To excise or refer?

Subcutaneous nodules are a common presenting complaint to family practitioners, and a frequent referral to surgeons. The majority of abnormalities are benign with the most common abnormalities being lipomas and epidermoid cysts. Many other such entities can manifest either within or deep to the skin including infections, inflammatory diseases, and rarely sarcomas. Lipomas generally will have a normal appearing epidermis, and tend to be soft but not hard, and have some mobility with respect to the underlying tissues, except when very large. They also tend to be symmetrical in



Dr. Chris Baliski has practised as a surgical oncologist since 2002. His research and clinical interests focus on breast and endocrine cancers and melanoma. Dr. Baliski is also Chair of the BC Surgical Oncology Network.

shape. Epidermoid cysts tend to be much firmer, but also symmetrical, and often will have a small central “pit”, and possibly a history of recurrent infections.

If a mass is less than 2-3 cm in size, soft, not growing rapidly, and the patient is asymptomatic, excision is within the purview of family physicians assuming they are comfortable with the procedure. Situations warranting increased attention include those where the mass is rapidly growing, greater than 5 cm in size, “deep to the fascia”, or has irregular or firm areas, and/or overlying skin changes. If the abnormality

meets any of the later findings, or if it is located near a joint, on the extremities or the face, I recommend referral to a general or plastic surgeon to handle the excision.

When cancer is suspected...

If cancer is suspected, key logistical issues during referral can affect the definitive management of the disease. I see patients, for example, who are not managed as quickly as needed because the referring physician’s level of concern is not clearly stated in their referral letter. This is especially important as some specialist offices use support staff for triaging. It is also helpful to provide all imaging reports for review, and an ultrasound is often an easily accessible and cost effective measure as a first investigation.

Although MRI is a valuable tool to help characterize soft tissue masses, access to this modality can be limited and can also cause prohibitively long delays. It’s not uncommon, for example, for a patient to wait 6-12 months for an MRI requested by a family physician. Surgeons often can get much quicker access to such imaging and I encourage referring physicians not to wait for an MRI before referring a patient.

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Depression in brain tumour survivors

By Dr. Douglas Ozier, PhD in Counselling Psychology, BC Cancer Agency, Psychosocial Oncology Research Division

It is estimated that 55,000 Canadians are currently living with a primary brain tumour, with 10,000 people being newly diagnosed each year. Brain tumours may either be classified as malignant or nonmalignant. The implications of a brain tumour diagnosis are diverse and profound. The 5 year survival rates for people with all kinds of glioma have recently been estimated to be 27%, (Porter et al, 2010). The comparable survival rate for people with all nonmalignant primary brain tumours has recently been estimated to be 80%, (Porter et al, 2010). In addition to these implications for mortality, a brain tumour can have diverse



Dr. Douglas Ozier

and pernicious impacts on the survivors’ quality of life (Q of L). Included among these negative impacts can be functional impairments, cognitive deficits, mood disturbances, existential distress, personality changes, sleep issues, and pain (Pelletier et al., 2003; Fox et al., 2007).

When medical professionals are caring for a brain tumour survivor, regardless of the kind of brain tumour involved, it is

crucial for them to be alert to the possible presence of depression. This is important for three reasons.

The first is that depression is a very common in brain tumour survivors. Evidence suggests that between 15% (Rooney, Carson, & Grant, 2011) and 28% (Wellisch et al., 2002) of people living with primary brain tumours would

qualify for a diagnosis of major depressive disorder. Regardless of the specific incidence rate considered, it is very clear that depression is far more prevalent in this population than in the general Canadian population.

The second reason that depression is a crucial issue to consider when caring for brain tumour survivors is that depressive symptoms have been found to be a key determinant of overall Q of L in this population. Pelletier et al. (2003) found that depression was the single largest predictor of overall Q of L in a cohort of 73 malignant brain tumour survivors. In fact, these authors found that “depression scores alone accounted for more than half of the all variance in Q of L scores” (Pelletier et al, 2003, p. 47).

The final reason is that, in glioma, depression has been linked to negative outcomes in a range of crucial domains beyond Q of L.

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Rural family physician to city GPO – perspective on the move

Allison Rankin made a big change to her career a year ago when she opted to leave her long-time family practice in Enderby and join the BC Cancer Agency team of General Practitioners in Oncology (GPOs) who work out of the Cancer Clinic at Vernon's Jubilee Hospital. To qualify for this new role, Dr. Rankin completed the Family Practice Oncology Network's eight-week GPO Training Program including an intense two-week introductory module at the Vancouver Centre followed by six weeks of clinical experience at the Cancer Centre and Clinic where her patients receive care.



Dr. Allison Rankin is now a Vernon GPO following completion of the Network's GPO Training Program.

to make connections with new colleagues who will be working in the same field, to build contacts at the Vancouver Centre and to gain an appreciation for what happens on the coast. It was helpful as well to learn about the continuing education options for primary care oncology and professional groups such as the Canadian Association of GPOs or CAGPO."

"Locally, my history in the area fostered a useful and comfortable level of interaction with physicians many of whom with I already had relationships. They can walk in and talk with any of us at anytime – and many do – plus feel free to call. We communicate regularly, in particular, when patients transition from the

clinic back to their family physician. Our team of three ensures we meet the needs of the community and that there is always someone available – no gaps in care.

Overall, I am thankful that the GPO Training Program exists – BC is the only province to have such a training program – and support its continuation and ongoing development. I highly recommend this training to family physicians who will be working in the field and especially those with the opportunity to bring cancer care to communities in need.

Dr. Rankin is originally from Ontario. She graduated from McMaster University Medical School and completed her family practice residency in Ottawa. She maintained a family practice first in rural Ontario and then in Enderby before making the move to Vernon.

Contact Allison Rankin at allison.rankin@bccancer.bc.ca.

"The time was right for a new challenge and I'd been interested in this type of work for some time especially the multidisciplinary team approach. Taking on the role of a GPO fit the bill perfectly. I now work four days a week at the Vernon Cancer Clinic with fellow GPOs Dr. Chris Cunningham and Christine Blyth and also work closely with our two medical oncologists. The learning curve was steep, but the change was good."

"I found the Family Practice Oncology Network's GPO Training Program highly valuable. The introductory module provided a great deal of information plus the chance

Next GPO training course begins September 9, 2013

The GPO Training Program is an eight-week course offering rural family 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. For full details visit www.fpon.ca.

*Subcutaneous tumours
continued from page 4*

Advice on biopsies and excisions

With regard to biopsies, I caution against performing incisional or core biopsies. These are performed when there is a need to obtain a diagnosis prior to definitive excision. Complications such as hematomas and infection can occur, or if done incorrectly can result in the need for more extensive surgery or radiation in the setting of a malignancy. They can also influence the interpretation of the lesions on later clinical examination or influence the quality of future imaging. Also, in many cases image guided biopsy is preferable as it is more reliable diagnostic modality.

If there is concern regarding the nature of a soft tissue mass, I also caution against excisional biopsies in order to "get it out". Once again this can be a disservice to the patient requiring a much greater level of intervention at a later date. In addition, if confronted with a situation in which during the actual excision there are concerns that the lesion may be more concerning than originally thought, it is better to abort the procedure rather than completing it for the reasons previously elucidated. In this situation I would recommend a small incisional biopsy.

In summary, the majority of soft tissue subcutaneous lesions are benign, and

family physicians familiar with performing minor procedures should feel comfortable removing them so long as they meet the criteria previously stated. Generally, excisions should be performed utilizing Langer's lines and locations near joints, distal extremities, and the face should be approached with caution. If practicing in a remote region, extenuating patient circumstances preclude consultation with a specialist, or you simply have a question regarding a clinical situation, I encourage discussion with a surgeon prior to any intervention.

Contact Dr. Chris Baliski at cbaliski@bccancer.bc.ca

Head and neck cancer – an update for primary care

*By Dr. Jonn Wu, Radiation Oncologist,
BC Cancer Agency Vancouver Centre*

Head and neck cancer (HNC) includes a range of tumours which includes the oral cavity, oropharynx (tonsil, base of tongue), larynx/hypopharynx, nasopharynx, nasal cavity, paranasal sinuses, thyroid, and salivary glands. The worldwide incidence of HNC exceeds half a million cases annually, ranking it as the fifth most common cancer worldwide. This update focuses on squamous cell (ie. oral cavity, oropharynx [tonsil, base of tongue], larynx and hypopharynx) and nasopharyngeal carcinomas.

Presenting symptoms are related to the anatomical site, and may include: cervical lymphadenopathy, hoarseness, dysphagia, odynophagia, referred otalgia, halitosis, ill-fitting dentures, nasal obstruction, epistaxis, headaches, diplopia (or other cranial nerve palsies), or non-healing mucosal ulcerations.

View the full webcast of this topic at www.fpon.ca – CME Initiatives.

HNC is associated with a large geographic variability in incidence and site of presentation, which reflects the distribution of risk factors (ie. tobacco, alcohol consumption), and ethnic/genetic variations among populations. Although HNC have been more common in elderly males, the incidence has been increasing in females

as more women use tobacco and in young non-smokers as human papillomavirus (HPV) plays an increasing role in tonsil and base of tongue cancers. Other risk factors include betel nut chewing, radiation exposure, vitamin deficiencies, periodontal disease, and occupational exposures (asbestos, saw dust).

Diagnosis involves physical examination and visualization of the cervical neck, oral cavity and oropharynx. Visualization of the nasopharynx, posterior pharynx and larynx is best accomplished by mirror examination and/or the use of a flexible fiberoptic endoscope. Suspicious lesions should be biopsied. Imaging studies ie. CT, MRI and/or PET/CT are useful to properly stage each new patient; the stage, in combination with the patient's performance status and personal preferences will help determine the recommended treatment regimens.

Early stage disease is typically treated with either surgery (wide local excision) or radiation therapy; choice of therapy is dependent on the tumour site and potential side effects. Surgery is commonly used in the oral cavity, whereas RT is more common in the other sites. For patients with locally advanced disease, combined modality therapy particularly with concurrent chemoradiation have improved locoregional control, survival and organ function preservation for many patients. Other options include primary



Dr. Jonn Wu chairs the BC Cancer Agency's Head and Neck Tumour Group.

surgery followed by either postoperative RT, concurrent chemoradiation, and sequential therapy (induction chemotherapy followed by concurrent chemoradiotherapy or surgery).

Patients are seen two to four weeks post-treatment to assess tumour response and review their sequelae. Imaging is usually reserved until 12 weeks afterwards to decrease the probability of a false positive finding, which may lead to unnecessary salvage surgery or interventions. Patients are seen more regularly during the first three to four years since most (80-90%) recurrences will occur during this time; patients are generally discharged from the BCCA follow-up clinics after five years.

Contact Dr. Jonn Wu at jonnwu@bccancer.bc.ca

Depression in brain tumour survivors continued from page 4

Namely, in glioma, depression has been found to be associated with higher mortality, more frequent medical complications, (Rooney & Grant, 2010), and reduced functional status (Fox et al., 2007).

If depression is identified in a brain tumour survivor then all of the usual management strategies, including pharmacological and psychotherapeutic options, can be considered in consultation with the patient.

Two general depression related resources that may be helpful are "Bounce Back", a free program offered at no charge by the Canadian Mental Health Association, (www.cmha.bc.ca/how-we-can-help/adults/bounceback)

and the online "Anti-Depression Skills Workbook" (www.comh.ca/antidepressant-skills/adult/index.cfm).

Regarding more brain tumour specific resources, The BC Cancer Agency Centers in the Lower Mainland, Victoria, and Kelowna run monthly, professionally led brain tumour support groups (www.bccancer.bc.ca). These groups are not targeted toward depression management, but instead offer a forum for mutual support and information sharing. If a patient is deemed functional enough to likely benefit from a meeting of this kind, these support groups can be an invaluable source of encouragement and hope. Survivors can also be referred to the National Brain Tumour Foundation

of Canada website (www.braintumour.ca). Again, while this organization does not offer specific support for depression, it does offer a number of services that could help to inform, support, and empower the depressed (or non-depressed) brain tumour survivor. Their web site offers: reliable information on brain tumours; a chance for survivors to connect with each other in a safe, moderated, online community; and access to qualified professionals capable of offering live telephone support.

References for this article are included with the online version of this newsletter at www.fpon.ca

Contact Dr. Douglas Ozier at dozier@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've taken a two-pronged approach to activities at the Family Practice Oncology Network of late, focussing on closer relationships with our colleagues in other provinces and building stronger partnerships within British Columbia's own cancer care system. Our Western Collaborative on Primary Care Oncology, for example, brings new connections from like-minded organizations in Alberta, Saskatchewan and Manitoba. Their presence at our Council table brings fresh insights into the development of our General Practitioner in Oncology Training



Program and other efforts – much appreciated.

We are also in regular touch with oncology groups across the country to better understand the breadth of cancer care guidelines available and to take advantage of published efforts that will complement our own guideline initiatives targeted

to primary care. The sheer volume of resources and work underway in this realm is impressive and will be useful as we move forward with our next guideline on HPV related head and neck cancers.

Here at home, we are working closely with the BC Cancer Agency's Provincial Survivorship Initiative which is admirably bringing all the

players in this field together to strategically improve the follow-up care and resources needed to enhance the health and the lives of cancer survivors. Family physicians are patients' key contact for 80% of survivorship issues and we are delighted to be involved.

Finally, I am pleased to welcome Dr. Raziya Mia to the Network team. As our new Clinical Coordinator of FPON Education, Raziya will be heading up the planning for our November 2 Family Practice Oncology CME Day as well as leading organization of our GPO Training Program along with other primary care CME offerings. Raziya will also be helping launch new initiatives such as our GPO Advanced Education Webcasts. Welcome Raziya!

Contact Dr. Phil White at drwhitemd@shaw.ca

Announcing Phase II for CAMEO



CAMEO

Complementary Medicine Education & Outcomes Program

By Dr. Lynda Balneaves and the CAMEO Research Team

The Complementary Medicine Education and Outcomes (CAMEO) research team is pleased to announce the next phase of our knowledge translation program. The CAMEO program is transitioning to an online platform from which we can translate and contextualize our findings to other settings in Canada and abroad.

Over the past 4 years, the CAMEO research

team has designed and evaluated a number of complementary medicine (CAM) education and decision support interventions for patients, families, and health care professionals throughout BC. Through these research projects, the CAMEO program has offered CAM education and decision support to over 1,200 patients, families and health care professionals. Over the coming months, a number of BC Cancer Agency rounds, conference presentations, and peer-reviewed publications are planned to share with you our research findings and recommendations for clinical practice and future research. These will be listed on our website.

Our CAM information and decision support research projects are now closed to recruitment. We are no longer able to respond to individuals' questions about CAM (via telephone, email, or in person) or accept patient referrals for CAM decision support.

Many resources still available and more to come

The CAMEO website, at www.bccancer.bc.ca/cameo, will be maintained for the use of patients, families, and health care

professionals. It contains useful links to credible, evidence-based CAM websites, tools like our CAM and Cancer in British Columbia and CAM Use Diary to help health care providers and patients make evidence-informed CAM decisions, and links to CAM-related research projects. Over the next two years, new information resources, education programs—including new on-line health care provider and patient education programs—and decision support tools will be developed and made available on a CAMEO website for all to use.

Health care provider support continues

We continue to be committed to supporting health professionals to develop CAM knowledge and decision support skills to better address patient and family CAM-related needs in the clinical setting. Please feel free to contact us at cameo@bccancer.bc.ca to discuss ways in which we may be able to support your CAM information and decision support needs. Also let us know if you would like to be added to our list for CAMEO announcements as we launch our new online resources and courses.

Hereditary breast cancer – A case study

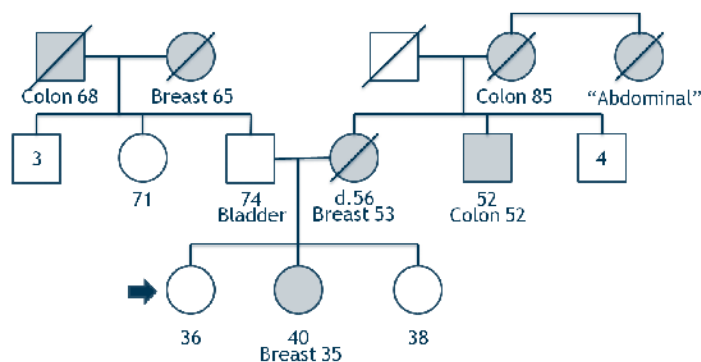
By Melanie Taylor, Clinical Coordinator, and Mary McCullum, Nurse Educator, Hereditary Cancer Program, BC Cancer Agency

Our patient was a 36 year old unaffected female referred to the Hereditary Cancer Program for possible hereditary breast and ovarian cancer syndrome (HBOC). Her family history was suspicious for HBOC with a sister diagnosed with breast cancer at age 35 and their mother diagnosed at age 53. Additional family history of cancer included a maternal uncle with colon cancer at age 52, maternal grandmother with colon cancer at age 85, and paternal grandmother with breast cancer at age 65.

The family was eligible for *BRCA1* and *BRCA2* genetic testing and because it is preferable to test

an affected family member first, testing was offered to the patient's sister. (*BRCA1* and *BRCA2* are the genes most commonly associated with hereditary breast cancer risk.) This testing was performed and was uninformative (no mutation identified). Our patient was counselled that although *BRCA1/2* didn't appear to be causing breast cancer risk in the family, we couldn't rule out a hereditary factor. She was asked to recontact her genetic counsellor with changes in the family history and for updates in testing options.

Our patient returned four years later with new information. Her sister, who previously had breast cancer, had been diagnosed with uterine cancer at age 43 and died at age 44. Our patient was



also exhibiting new symptoms including the diagnosis of multinodal goiter. During clinical reassessment it was also noted she had macrocephaly. This new clinical information along with the addition of uterine cancer in the family raised the suspicion of Cowden syndrome due to a *PTEN* gene mutation. Genetic testing identified a *PTEN* gene mutation in our patient.

Cowden syndrome (CS) is a rare cause of hereditary breast cancer. It is characterized by high risk for benign and malignant tumours of the breast, thyroid and endometrium. The majority of individuals with CS have macrocephaly and distinct skin lesions (trichilemmomas, papillomatous papules).

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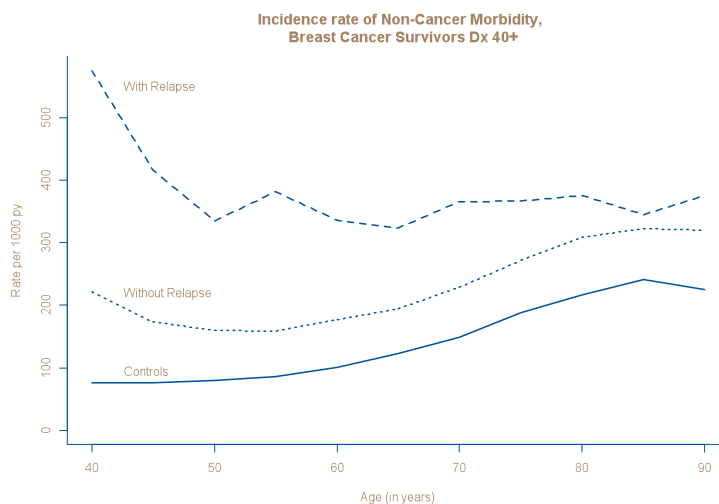
Late medical problems and additional health care needs of breast cancer survivors in BC

By Olivia Tseng, MD, MSc, PhD student, Interdisciplinary Oncology Program, UBC and Cancer Control Research, BC Cancer Agency (BCCA) and Mary McBride, Distinguished Scientist, Cancer Control Research, BCCA

Improved therapies and supportive care have dramatically improved survival of women with breast cancer. Five-year survival for women with breast cancer in BC is now almost 90%, and there are currently about 44,000 survivors in BC. However, the disease and its treatment also contribute to acute and late-occurring chronic medical problems, including second cancers,

heart failure, coronary artery disorder, diabetes, osteoporosis, premature menopause, infertility, depression, anxiety, lymphedema, fatigue, and chronic pain. Our Cancer Control Research Survivorship Program has been examining long-term medical problems and related needs for care among women with a prior breast cancer in BC; results will guide strategies and interventions to improve their ongoing health.

It appears that women surviving breast cancer are approximately 80% more likely to have a medical problem leading to hospitalization in the next 20 years than women their age



who never had a breast cancer. The most common reason for hospitalization is cancer (either a recurrence or a new cancer). However, 55% of survivors are

hospitalized for non-cancer related conditions (about 62% more often than similarly aged women without a prior breast

continued on page 9

New insights into ovarian cancer!

By Dr. Dianne Miller,
Gynaecologic Oncologist,
BC Cancer Agency,
Vancouver Centre

Epithelial ovarian cancer is becoming vanishingly rare. It would be nice if we were preventing these cancers but instead what we are doing is re-classifying based on a much better understanding of the pathophysiology which we hope will eventually lead to possible screens, prevention and better treatment.

Until recently all of the epithelial tumours were thought to arise from the surface epithelium of the ovary (OSE). We now know that for the High Grade serous cancer which account for about 70% of the total epithelial ovarian cancers, about 3/4 actually develop in the distal fallopian tube not the ovary.

In British Columbia, almost 20% of women diagnosed with ovarian cancer have had a hysterectomy done prior to the diagnosis and a similar number have had tubal ligations. In addition, over 20% of the women with high grade serous cancers will have a mutation in either BRCA 1 or 2. These two facts are the cornerstone of our "British Columbia Ovarian Cancer Prevention Initiative". Through referring all women with high grade serous cancer for genetic testing we should be able to ultimately identify most of the genetically



Dr. Dianne Miller

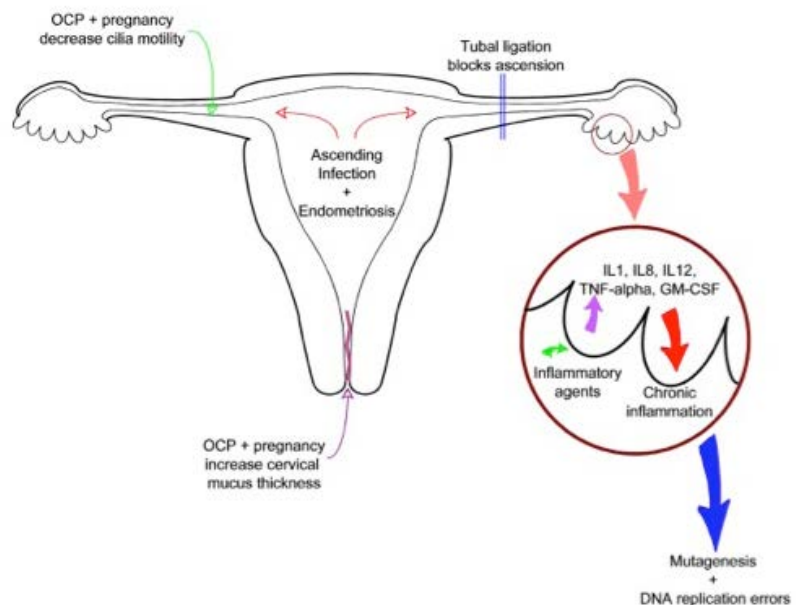
at risk families in our population and be able to offer risk reducing surgery. Removal of the tube at hysterectomy or tubal ligation has received much of the press. By combining these two initiatives we should conservatively over the next 20 years be able to decrease the incidence of this deadly cancer by up to 40%.

The second and third most common epithelial cancers, the clear cell and endometrioid cancers are cancers of

endometriosis and not true ovarian cancers either. We are currently engaged in research to determine what factors are important in the development of these malignancies. Of note, most of the decrease in ovarian cancer incidence attributed to tubal ligation is in the endometrioid and clear cell subtypes.

For more information on these and other findings visit www.ovcare.ca.

View the full webcast of this topic at www.fpon.ca – CME Initiatives.



Breast Cancer Survivors in BC continued from page 8

cancer). It appears that all organ systems are adversely affected after breast cancer. Radiation treatment is the most toxic therapy; more extensive disease at diagnosis, older age upon diagnosis, more recent diagnosis, cancer relapse and second cancers also increased the chance of later problems. Approximately 98% of breast cancer survivors visited a general practitioner in a three-year period, and 83% visited at least one specialist. Survivors were 13% more likely to visit specialists, especially general surgeons and plastic surgeons, most often

for reconstructive surgery. Breast cancer survivors were also 6%-12% more likely to receive tests such as blood work and x-rays.

This information demonstrates that subgroups of breast cancer survivors have high ongoing care needs, similar to other conditions requiring complex care. The family physician is seen as primarily responsible for survivor care. However, current survivor care is suboptimal, as general practitioners are not provided with the information and tools for risk-based care, including: awareness of high-risk patients and late effects of breast cancer; risk-based guidelines for surveillance of future cancers and late effects; a poorly

defined survivor care role for general practitioners; poor information exchange and coordination between general practitioners and oncologists; and discordant expectations of responsibility for care among general practitioners, oncologists and survivors. General practitioners however, can play a key role in survivor care, as oncologists are unable to care for non-cancer issues, and general practitioners can coordinate specialist care based on individual patient needs. Providing information to address these issues is the goal of our breast cancer survivor study.

Contact Mary McBride at
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Lymphoma overview for general practitioners – a diverse array of disorders with a multitude of treatment options

By Dr. Laurie Sehn, Medical Oncologist, BC Cancer Agency Vancouver Centre

As a group, lymphoid neoplasms, including non-Hodgkin lymphoma, Hodgkin lymphoma, multiple myeloma and chronic lymphocytic leukemia (CLL) constitute the fourth most commonly encountered malignancy in British Columbia. Clinical presentation is highly variable, ranging from asymptomatic lymphadenopathy to notable constitutional symptoms (such as fever, night sweats, weight loss, fatigue and pruritis) in association with progressive physical



Dr. Laurie Sehn

diagnosis is crucial in order to select optimal therapy.

Once the diagnosis is established, most patients undergo a series of staging investigations that include careful physical examination, laboratory tests (including screening for hepatitis B, C and HIV), CT scan of the neck/chest/abdomen/pelvis, and bone marrow biopsy. A PET/

CT scan may also be performed at diagnosis for certain subtypes of lymphoma. Clinical information including diagnostic subtype, stage of disease, age and health status of the patient, as well as patient preferences is used to tailor an appropriate treatment strategy.

Treatment approaches for lymphoma are rapidly evolving and thus consultation with a specialist in the field is highly recommended prior to instituting therapy. While some patients with asymptomatic indolent lymphoma may be appropriately observed without need for therapy for many years, patients with symptomatic or aggressive behaving lymphoma are generally treated with a combination approach, that may include cytotoxic chemotherapy, steroids,

and biologic agents (such as monoclonal antibodies). The introduction of novel agents has dramatically improved outcomes, resulting in higher cure rates and longer survival times for many patients. Supportive care, including monitoring for infection, infection prophylaxis, management of medical co-morbidities, and treatment of acute and delayed toxicities of therapy remains an important component of the overall therapeutic program.

Recent research in lymphoid malignancies has resulted in improved biologic insight into the molecular mechanisms of disease, which has allowed the identification of specific therapeutic targets. This has translated into the development of novel agents designed to more selectively target tumour cells, while minimizing toxicity to normal tissues. Ongoing clinical trials, many of which are available in BC, provide patients with the opportunity to access these promising agents and should be considered when appropriate. The ultimate goal is to move toward a personalized cancer care approach, whereby treatment is optimized and tailored for individual patients.

Contact Dr. Laurie Sehn at lsehn@bccancer.bc.ca

View the full webcast of this topic at www.fpon.ca – CME Initiatives.

findings and laboratory abnormalities such as cytopenias. Diagnosis must be confirmed with an adequate excisional tissue biopsy that should be reviewed by a qualified hematopathologist. The World Health Organization Classification of Lymphoid Neoplasms currently recognizes more than fifty subtypes of lymphoma and accurate

Hereditary breast cancer – a case study continued from page 8

Individuals with CS have a significantly increased lifetime risk of breast, renal cell, thyroid, and endometrial cancers, and a slightly increased risk of colon cancer and melanoma. Additional manifestations of CS include other thyroid lesions, fibromas, lipomas, uterine fibroids, fibrocystic breast disease, hamartomatous intestinal polyps, vascular malformations and intellectual disability.

Her family members now have the option of testing for the familial *PTEN* mutation and there are established recommendations for both initial clinical evaluations and ongoing surveillance for individuals found to be carriers. The identification of a *PTEN* mutation

in this family has led to the recognition of clinical features in additional family members. It has been noted that our patient's children have macrocephaly, and both the affected sister and their mother also had multinodal goiter. Additionally, another sister unaffected with cancer also has uterine fibroids and was found to have a pre-cancerous breast lesion.

This case illustrates the importance of updating clinical and family history on a regular basis. At the initial presentation, a *BRCA1/2* mutation seemed the most likely hereditary factor. Ruling out these genes did not rule out all possibility of a hereditary factor, but what was known about the family history at that time didn't point to *PTEN* or any of the other known breast cancer genes (e.g. *TP53*, *CDH1*, *STK11*). The addition of

uterine cancer and our patient's clinical findings helped the genetics team to identify Cowden syndrome as a possible cause and genetic testing confirmed our suspicion.

Although many of its features are common, CS is rare. The Hereditary Cancer Program currently accepts referrals for possible CS when the family history includes at least one relevant cancer in addition to other key manifestations. For more information about Cowden syndrome, visit the GeneReviews entry for *PTEN* Hamartoma Syndrome at www.ncbi.nlm.nih.gov/books/NBK1488/.

Details on the Hereditary Cancer Program are available at www.bccancer.bc.ca/hereditarycancer or by calling 604.877.6000 local 2325.

Agency GPO takes on new role of clinical coordinator, FPON education

Abbotsford Centre General Practitioner in Oncology (GPO), Dr. Raziya Mia, joined the Network last month as our new Clinical Coordinator, FPON Education. She is now the physician lead for all the Network's training and CME programming including our GPO Training Program, our Family Practice Oncology CME Day (see article on page 1), our Oncology CME Webcasts, and our community cancer care workshops – the latter two presented in partnership with the University of British Columbia's Division of Continuing Professional Development. Dr. Mia takes over these responsibilities from Dr. Shirley Howdle who retired from the Vancouver Centre in February.

Dr. Mia shares insights as she takes on this



Dr. Raziya Mia is the Network's new Clinical Coordinator, FPON Education.

new part-time role which she is fulfilling in addition to her GPO responsibilities.

"My interest in this position began with the encouragement of my GPO colleagues at the Vancouver Centre, followed by the support of Dr. Dorothy Uhlman, my Professional Practice Leader at the Abbotsford Centre. Additional inspiration was provided by my career long mentor Dr. Jack Chritchley, who had an

instrumental role in the development of the Network. Continuing medical education has always been a strong focus during my medical career. Previous involvements included several years as a board member of the BC College of Family Physicians, where education was a significant mandate, and

participation on the CME Committee at Royal Inland Hospital in Kamloops, where I maintained a family practice from 1984-2008.

I have been a GPO at the Abbotsford Centre since 2008 following completion of the Network's GPO Training Program – a program unique to British Columbia. I found this to be a very valuable experience as I changed career paths, and look forward to building on the high standard of this program. Equally important will be the further development of ongoing oncology education for all family physicians in the province."

Dr. Mia is originally from South Africa and a graduate of UBC Medical School, where she is also a Clinical Instructor with the Department of Family Practice.

Accessibility is an important mandate of this role – feel free to contact Dr. Mia at rmia@bccancer.bc.ca.

Skin cancer: insights for family physicians

By Dr. Youwen Zhou, Dermatologic Oncologist, BC Cancer Agency, and Associate Professor of Dermatology, University of British Columbia

Skin cancers are among the most common cancer types affecting humans, and the incidence of skin cancers is still rising. The major subtypes include non-melanoma skin cancers and melanomas. Although non-melanomas such as basal cell carcinomas and squamous cell carcinomas can be cured when diagnosed early, their diagnosis is often delayed. Providing care, which involves surgery for these patients, constitutes a great

challenge for physicians as well as health service payers, both public and private. In addition, patients with melanoma have high mortality when diagnosis is delayed. Therefore, it is imperative for primary care providers to develop a practical approach for diagnosing and treating these patients.

The most useful clinical tool for the diagnosis of melanoma is still the clinical impression at the time of physical examination. The parameters needing special attention include asymmetry, border irregularity (non-smooth), color variegation inside the same mole, growing diameters, and evolution (change over time, or development of symptoms such as pain or pruritus). When a clinical suspicion is present, the lesion in question should be excised in total (rather than by punch biopsies, except in situations when the lesion is unusually large). Once a diagnosis of melanoma is made, referral to a dermatologist or a tertiary cancer care center is indicated to coordinate subsequent steps of care, such as further surgery, potential lymph node mapping, staging, and

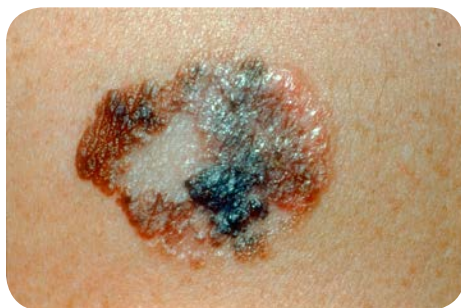
advanced treatment when indicated.

Diagnosis and treatment of non-melanoma skin cancers, such as basal cell carcinomas and squamous cell carcinomas require a high degree of clinical suspicion and biopsy when needed. The most common definitive treatment is surgical treatment, except when the patient's co-morbidity and age make surgery difficult. In these situations, radiation therapy also yields high success rates (>92% rate of remission).

View the full webcast of this topic at www.fpon.ca – CME Initiatives.

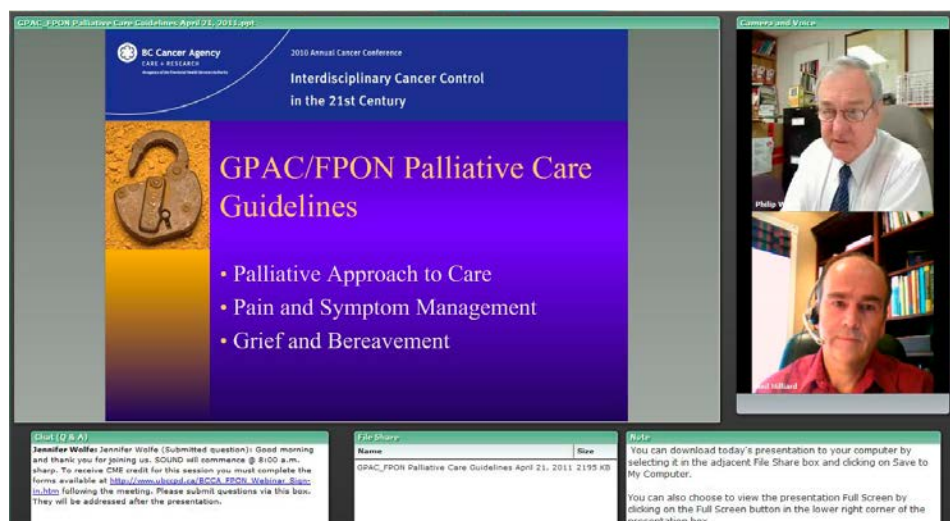
For patients with melanoma and non-melanoma skin cancers, once the definitive treatments are completed, additional surveillance will be needed including skin / node examination every 3-6 months (for melanoma) and every 6-12 months for non-melanoma cancer patients.

Contact Dr. Youwen Zhou at ywzhou@mail.ubc.ca



Melanoma

Oncology CME webcasts – convenient and practical



"I am very appreciative of this format – bringing experts to my computer in an interactive form."

"Webcasts are an excellent way to do CME – very civilized. You can eat breakfast and learn in a comfortable environment."

Every session is also recorded and available on the Network's Website – www.fpon.ca (under CME Initiatives) – including past presentations on lung cancer management, skin cancer, lymphoma, ovarian cancer and many more.

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 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).

"The Webcasts provide an easy, convenient way to gain the most current information on the cancer topics most requested by family physicians – and to interact with Agency experts," notes the Network's Chair and Medical Director, Dr. Phil White. "We designed this program so that BC family physicians can take part no matter where they live in the province. In fact, physicians

from across Canada and several international contacts regularly join in."

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

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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.

Our upcoming Webcast schedule

June 20: Neuro Oncology: Insights for Family Physicians with Dr. Brian Thiessen

September 19: Complementary and Alternative Medicine in Cancer Care with Dr. Lynda Balneaves

October 17: Cervical Cancer: An Update for Primary Care with Dr. Anna Tinker

November 21: CAGPO Recap – Top Presentation Reviews from the Canadian Association of General Practitioners in Oncology Annual Conference

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

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