

Family Practice Oncology Network Newsletter

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BC Cancer Agency

CARE + RESEARCH

An agency of the Provincial Health Services Authority

New resources to support end-of-life care

The Family Practice Oncology Network and the BC Guidelines and Protocols Advisory Committee (GPAC) are pleased to announce the publication of two new palliative care guidelines developed to meet the distinct needs of family physicians – *Pain and Symptom Management and Grief and Bereavement*. These guidelines follow the publication of the first guideline published in spring 2010, *The Approach to Care*, and complete the Palliative Care guideline series. All follow GPAC's practical chronic disease management format emphasizing brevity and evidence-based information. Each also underwent an external review and includes practitioner tools and patient hand-outs.

These new guidelines are now available at www.bcguidelines.ca and are in the process

of being converted for easy download to iPhone, Blackberry and PDA. The Network's Website – www.fpon.ca – also includes additional appendices. Hard copies of

GUIDELINES & PROTOCOLS ADVISORY COMMITTEE

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

the first three symptom based Pain and Symptom mini-guidelines are enclosed with this newsletter with the remainder to be forwarded in upcoming issues.

Dr. Neil Hilliard, Abbotsford Hospice Palliative Care Physician Coordinator and Pain and Symptom Management Clinic Consultant for the BC Cancer Agency's Abbotsford Centre, led the impressive group effort that brought

these guidelines together. "Family physicians have long rated the need for more practical, concise information on End-of-Life care among their top requirements and these guidelines were developed to meet this need. They also form the foundation of the Practice Support Program's new module on End-of-Life care now open for registration (see story on page 8)."

The first guideline, *The Approach to Care*, focuses on when to refer patients to palliative care, how to assess suffering and how best to involve the care team to support the patient and family. Part 2, *Pain and Symptom Management*, is divided into seven mini-guidelines each of which is symptom and algorithm based: cancer pain, dyspnea or shortness of breath, delirium, nausea

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You're invited! Family Practice Oncology CME Day: December 3



The Family Practice Oncology Network has organized an outstanding agenda for this year's Family Practice Oncology CME Day and invites all family physicians and community cancer care professionals throughout BC to take part. The event will be held Saturday, December 3 at the Westin Bayshore Hotel in Vancouver as part of the BC Cancer Agency's annual conference, December 1-3, and is accredited by the College of Family Physicians of Canada and the BC Chapter for up to four

Mainpro-M1 credits.

Along with current information and treatment updates, the event provides an excellent opportunity to establish relationships and renew acquaintances with your colleagues in primary care oncology plus to build useful contacts within the BC Cancer Agency.

This year's agenda includes a special presentation by Dr. Jeff Sisler of CancerCare Manitoba on the Coordination of Care between the Cancer Community and Primary Care. Other sessions will cover the BC Cancer Agency's Colon Check Program: Preparing for Launch; Bisphosphonates; Tumour Markers; and Chronic Lymphocytic Leukemia. Afternoon workshops will focus on Anal

Cancer and HPV and Lung Cancer and the Surveillance of Smokers.

The BC Cancer Agency's annual conference overall will also appeal to those in primary care oncology especially with the theme "Improving Cancer Care Through Partnerships" with a focus on collaborations across disciplines, platforms and regions. An added attraction is keynote speaker, John Furlong, CEO of the Vancouver 2010 Olympic and Paralympic Winter Games, who will be speaking on Living Leadership from 8-9:00 a.m. on Friday, December 2.

The cost to attend the Network's CME Day is \$149 while the cost to attend the full conference, including this event, is \$199. Register at www.bccanceragencyconference.com. Hope to see you there!

Prostate cancer screening: “to do, or not to do”?

By Dr. Mira Keyes, Head,
Provincial Prostate
Brachytherapy Program, BC
Cancer Agency Vancouver Centre



Dr. Mira Keyes

Prostate cancer (PC) is the most common non-skin cancer in men in Canada and the third leading cause of male cancer mortality; 550 men die from it each year in BC and 3,000 are diagnosed. Prostate cancer is a highly prevalent disease as approximately one in three men over the age of 50 years have histologic evidence of prostate cancer, however, the lifetime risk of death from PC is only about 3%. Many men with localized prostate cancer will die from other causes if left untreated and will never suffer from symptomatic disease. Most of the tumours are clinically insignificant (not at risk of causing harm in a man's lifetime). Localized prostate cancer can be cured in many patients. The treatment options include radical prostatectomy (RP), prostate brachytherapy (PB) or external beam radiation therapy (EBRT). All curative treatment options can be associated with significant side effects. Active Surveillance (AS) is now a favoured approach for men with indolent, or clinically insignificant, disease (PSA < 10, GS of ≤ 6 and 1-2 cores positive on prostate biopsy).

The purpose of a population based cancer screening program is to reduce mortality from the disease in the screened population.

Because of a very high prevalence and very low mortality, prostate cancer screening continues to be controversial. Recent publication of two large randomized controlled PC screening trials has only intensified this debate. A U.S. study showed no difference in mortality between screened and non-screened populations¹. However, the study suffered from significant cross-contamination between the 2 groups. Re-analysis of the study showed a significant survival benefit to screening, in younger and healthy men only². A European study was much larger, had slightly longer follow up (9 vs. 7 years) and did show 20% PC death risk reduction with screening³. The Göteborg population-based trial (a part of the European screening study) showed a 50% mortality risk reduction with 14 years of follow up⁴. Likewise, the Tyrol population-based screening program produced 50% mortality risk reduction when compared to the rest of Austria⁵.

Because of a very high prevalence of PC and very low overall mortality, it is still unclear whether prostate cancer screening results in more benefit than harm. Absolute reduction in overall death from the disease remains very low (fig1)⁶.

In BC, PSA testing can be offered to asymptomatic men 50 years of age or older, who are well informed about the risks of over-

diagnosis and over-treatment, but still wish to pursue the benefits of early diagnosis of prostate cancer. PSA should be done every 2-4 years, and stopped if life expectancy is less than 10 years⁸. Based on the Malmo study, a single PSA test at age 44 to 50 (if greater than median PSA for the age group i.e. >1) can potentially predict subsequent clinically diagnosed prostate cancer⁷, suggesting that men age < 50 with PSA < 1, can be screened less often. This approach, while still investigational, raises the possibility of risk stratification as well as cost benefits for prostate cancer screening programs. The decision to use PSA testing for the early detection of prostate cancer should be individualized. Patients should be informed of the known risks and the potential benefits PSA testing.

Contact Dr. Mira Keyes at
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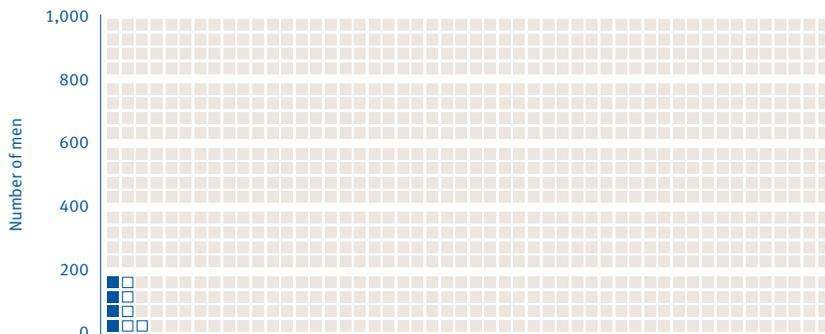


Fig 1. Absolute reduction in prostate cancer mortality. According to data from the Göteborg trial, screening would reduce prostate cancer mortality from nine to four men per 1,000 at 14-year follow-up. Beige boxes indicate men who would not die as a result of prostate cancer in this time period, regardless of screening. Solid blue boxes indicate men dying as a result of prostate cancer despite screening. Open blue boxes indicate those among whom prostate cancer-specific mortality would be prevented by screening.

Physicians can help the success of the BC generations project

“I really enjoyed learning the results of my measurements. It provided encouragement for me to keep up with what I am doing for my health and continue to work on my strength and fitness.”

A participant in the BC Generations Project had these comments after attending the project’s assessment centre in Vancouver.

The BC Generations Project is part of the Canadian Partnership for Tomorrow, a national initiative to collect health information and biological samples from 300,000 Canadians. In the future, thousands of research studies will draw on this massive collection of high quality health data.

In BC, the project is sponsored by the BC Cancer Agency, and is seeking to recruit 40,000 residents aged 35 to 69. Participants



BC GENERATIONS PROJECT
Your time today builds a healthier tomorrow.

answer questions relating to their health, diet, and lifestyle, as well as their medical and family history. They also record their height and body

measurements, and provide blood and urine samples at community laboratories. This baseline information will then be linked to provincial health records in an anonymized format. Information collected will provide the basis for answering important research questions on how lifestyle, genes and the environment contribute to chronic diseases for many years in the future. Of particular interest to BC researchers is the role of environmental exposures in disease risk.

The BC Generations Project has been very successful in recruiting participants through the use of short-term, local assessment

centres, where participants provide additional health data not covered by the questionnaire such as bone density, blood pressure and body fat measures. The first “pop-up” centre in Kelowna early in 2011 attracted 967 participants, and centres

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Participant LaDonna Fehr gets her blood pressure measured by June Song, research project assistant, at the Prince George assessment centre

Upcoming community workshops on breast cancer



BC Cancer Agency

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The Division of

**Continuing Professional Development
Faculty of Medicine**

www.ubccpd.ca

By Tunde Olatunbosun, Project Manager and Tanuja Barker, Researcher, on behalf of the Community Cancer Outreach Program on Education project team

Cancer Care Outreach Program on Education (CCOPE)

Building on recommendations from the 2009/2010 province-wide needs assessment, the UBC Division of Continuing Professional Development (UBC CPD) in joint partnership with the BC Cancer Agency’s (BCCA) Screening Group and the Family Practice Oncology Network (FPON) is pleased to announce an important educational initiative that will provide BC family physicians with a better understanding of their roles and best practices across the cancer care continuum.

Workshops on cancer care

These interactive workshops, beginning with breast cancer in the fall 2011, will be:

- Small group, ~2-hour case-based discussions with colleagues over dinner
- Facilitated by a local physician
- Contextualized to a busy practice setting with relevant resources to support patient care provided to each physician learner
- Accredited for up to 2.0 Mainpro M1 credits
- Low cost - \$25 registration fee

Topics will include

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

Communities

CCOPE workshops will be delivered to various communities across BC to facilitate accessibility, and will begin with the following

communities for breast cancer this fall:

- Castlegar
- Comox
- Cranbrook
- Dawson Creek
- Fort St. John
- Grand Forks
- 100 Mile House
- Kitimat
- Nanaimo
- Parksville
- Port Alberni
- Prince Rupert
- Quesnel
- Smithers
- South Surrey/White Rock
- Trail
- Vancouver
- Vanderhoof
- Williams Lake

Local family physicians who are actively practicing oncology and/or have gone through the Network’s Preceptor Program will be invited to facilitate the workshops.

Workshops on prostate cancer will begin in 2012. To check when a workshop will be delivered near you and to obtain further details on specific dates, registration, and future workshops on other cancers: please visit the project website: www.ubccpd.ca/programs/ccope.htm, or contact the project manager, Tunde Olatunbosun, tunde.o@ubc.ca 604.875.4111 ext. 69138.

Preceptor graduate is Northern Health's medical lead, oncology services

Long-time Terrace resident, General Practitioner in Oncology (GPO) and emergency care physician, Dr. Jaco Fourie, took on a new role this past June – that of Medical Lead, Oncology Services for the Northern Health Authority. This is a new position, the first of its kind in British Columbia, with the focus being to address cancer as a continuum through an integrative approach that supports community cancer care teams and primary care physicians.



Dr. Jaco Fourie, Northern Health's new Medical Lead, Oncology Services, confirms the Network's Preceptor Program provided the groundwork for his new role.

Cancer Control Strategy. We are working in partnership with the BC Cancer Agency, for example, on a workflow pathways system that will lead to an easily accessible digital portal to accelerate diagnosis and integrated systemic therapy delivery. We also plan to launch a survivors' management program as a part of this digital "toolkit" along with a resource website which patients can use for information and where clinic members can easily access current electronic forms and CME offerings."

cultural diversity and lifestyle issues and, as a cancer care community, we need to perform at a high level to improve our results."

"My third key focus is liaising with Northern Health's provincial colleagues and with our partners at the BCCA. I serve, for example, on the Breast Cancer Pathway Committee of BC and on the province's Colorectal Screening Steering Committee."

Along with this new role, Dr. Fourie continues to serve as a half-time GPO at Mills Memorial Hospital in Terrace and handles a weekly shift in the Emergency Department. "It's important for me to stay immersed in day-to-day clinical work so that I truly understand the issues of integrating primary care and oncology and can better support my colleagues."

"My priorities are three-fold," notes Dr. Fourie. "Most importantly, I assist all members of the community clinic teams to improve diagnostic timelines and workflow issues and to provide CME opportunities that will enable them to provide the best possible care and assure the resources they require."

"Second, my role is to develop systems that will support Northern Health's Northern

"Integration of these initiatives is a key focus of my role," adds Dr. Fourie. "It's essential to have a representative at the community level dedicated to ensuring our efforts support the region's Cancer Control Strategy in a continuous and innovative manner. We battle a higher percentage of adverse cancer outcomes in our population due to geography,

"I wouldn't be in this role if it weren't for the Family Practice Oncology Network's Preceptor Program which I completed in 2006. In eight short weeks, the program gave me a comprehensive overview of cancer care and the cancer continuum. The opportunity to work alongside some of the best oncologists in the field was inspiring and augmented by continued communication afterward. The Preceptor Program provides a real glimpse into the complicated world of oncology. With GPOs delivering up to 50% of systemic therapy in BC outside of larger centres, I would like to see this format further developed and enhanced."

Contact Dr. Fourie at Jaco.Fourie@northernhealth.ca

Next preceptor course begins February 27, 2012

If you are a family physician or nurse practitioner keen to provide enhanced cancer care for your patients and their families, please consider our Preceptor Program. You must have strong community support to apply. The program provides opportunity, especially for rural family physicians, to become a General Practitioner in Oncology. Full details at www.fpon.ca

New sexual health clinic research project in Kelowna

A new Sexual Health Clinic is open at the BC Cancer Agency's Centre for the Southern Interior (CSI) in Kelowna. The Clinic provides consultation to individuals experiencing sexual difficulties which began after having cancer and/or cancer treatment and is part of a one-year pilot research project funded by the BC Cancer Foundation, Southern Interior.

The Clinic takes place one half day per month and provides patients with assessment and teaching by an oncology RN with sexual health training and, if deemed appropriate, consultation with a urologist, gynaecologist and psychiatrist as needed.

For more information call the Patient and Family Counselling at CSI, 250.712.3963 or email Myrna Tracy, mtracy@bccancer.bc.ca.



Transitioning from Patient to Survivor

By Nancy Payeur, MSW, RSW, Regional Clinical Coordinator, Patient & Family Counselling Services, Vancouver Island Centre, BC Cancer Agency.



Nancy Payeur

Over the past several years, our provincial team of counsellors and social workers – as well as many other staff within the BC Cancer Agency – have become very aware that patients and their families frequently struggle with transitions back to post-treatment living, getting back to their own “new normal”.

Away from the structure, the routine and the support of the cancer care team – and without the clear focus of “getting through treatment” – post-treatment patients can find themselves blindsided by intense emotions, even clinical depression and sadness, as well as anger and confusion. Many patients report that they see themselves in a kind of limbo. They ask the question – now what? Some end up feeling very isolated and set apart from their peers, afraid they will continue to be immobilized by fears of cancer recurrence. No way to live.

When former patients talk to us about what has helped them make that transition, certain themes emerge.

Dealing with Fear of Recurrence

For many, dealing with fears of recurrence is overwhelming. For those that come to some peace or resolution about living with this fear, it seems that “action may be the best antidote for anxiety”. Those patients tell us that they try and take control of those factors over which they have some control (diet, exercise, stress management) and try to “let go” of the rest.

One breast cancer patient, initially diagnosed over ten years ago, notes that “Every day there is a moment when I think about the cancer. Then I get on with my day. I refuse to let those fears stop me from living my life. If it happens – I’ll deal with it then”. Others say – you face it, accept it, name it – and then that takes some of the power away. It also helps to connect and talk openly with other cancer patients who understand your fears because they’ve been there too.

Getting Clear on Life’s Priorities

Many patients tell us that cancer has given them permission to clean house – to clear the clutter in their lives, both literally and figuratively. Some end unhappy relationships, change careers that no longer fit, disengage from activities they no longer find rewarding, or simply vow to

be more selective in how they spend precious time and energy.

The bittersweet gift of cancer is to perhaps value life more intensely – and to be committed to not wasting a moment. We see many survivors begin to pursue those juicy heart-felt moments...with grandkids, with partners, travelling, being creative, puttering about in the garden...whatever is treasured and joyful.

Taking Control; Taking Charge of Personal Wellness

While everyone varies in how much medical information they need, want and find helpful, many cancer patients become self-educated experts on their cancer. Many also pursue information on a variety of complementary and alternative therapies (e.g. yoga, reiki, massage, energy work) as well as physiotherapy, nutrition, exercise programs and a range of other activities, as ways of gaining both physical and emotional comfort, including a sense of control. Once treatment is over, many want to create their own program for wellness...they want a sense that they are doing something productive to take control of their overall health and well-being.

Connection and Support

Often survivors tell us that they have a renewed appreciation of their relationships with friends and family. While certain friends and family members may have disappointed them or been unable to provide meaningful support due to their fears or personal limitations, those who have been able to stay connected with the cancer patient may find their relationship has been deepened and enhanced throughout the process. There is

an intimacy that develops through standing by someone as they go through the roller coaster that is a cancer diagnosis, treatment and the aftermath.

Making Sense, Finding Meaning

For some – there is immense comfort in drawing on personal spiritual beliefs including a sense that everything in life happens for a reason and that there is a higher purpose to our lives. Perhaps even cancer has some lessons to teach us. Astonishingly – there are those individuals who tell us that cancer has been a blessing and has made them appreciate life and their loved ones so much more than they ever would have. Of course – many patients and survivors would vehemently disagree with that perspective!

Even without a sense of spirituality, though, our most resilient patients tell us they feel they have been given a “second chance” at living their lives – and they want to do so with gusto. Carpe diem – seize the day – becomes their motto.

These are some of the messages and strategies for coping that cancer survivors have shared with us over the years...it is clear that all want to live the best quality life possible now, no matter what the future may hold.

For information on counselling and support services for cancer patients and their families – please contact Patient & Family Counselling Services at each of the BCCA Cancer Centres.

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New resources to support end-of-life care continued from page 1

and vomiting, constipation, depression, and fatigue. A drug table is included with each symptom listing the medications used, dosage forms and details on the coverage or fees involved. The third guideline, *Grief and Bereavement*, is the first of its kind in BC and includes risk factors for complicated grief, a bereavement algorithm, guidance on when to see people after the death of a loved one and recommendations on how best to support them.

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CAGPO survey helps define GPOs' evolving role



Dr. Jeff Sisler, past Chair of the Canadian Association of General Practitioners in Oncology (CAGPO) and Director of Primary Care Oncology with CancerCare Manitoba, shares new information on GPOs.

The Canadian Association of General Practitioners in Oncology (CAGPO) is a small yet rapidly growing professional association for the nation's General Practitioners in Oncology (GPOs). GPOs are general practitioners/family physicians who include a "focused practice" of oncology care in their clinical work. Established in 2003 with an initial voluntary membership of 33 GPOs, the organization now includes almost 140 members from all Canadian provinces.

To get an accurate perspective of its increasing ranks, CAGPO undertook its first membership survey in March 2011 to determine where GPOs practice, their level of training, workload, remuneration and

benefits, job satisfaction ratings and the scope of responsibilities involved.

Dr. Jeff Sisler, past CAGPO chair and a member of the Association's executive, shares key results from the survey plus insight on the organization's plans to put this new knowledge to work.

Dr. Sisler:

I am pleased to report that we had an outstanding response to our survey receiving 120 replies from our CAGPO membership and from non-member GPOs. We had responses from every province with over a third originating from Ontario and BC. Seventy-six percent of respondents are CAGPO members.

We learned:

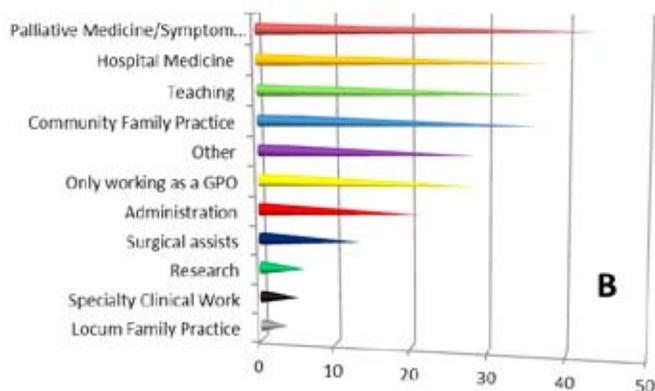
- GPO practice settings are evenly balanced throughout the country with 1/3 of respondents working in communities with populations of less than 100,000, 1/3 working in cities with over 500,000 and 1/3 working in communities with populations in between.
- BC leads the way in terms of training. Two thirds of BC respondents have completed the Family Practice Oncology Network's eight-week Preceptor Program (see story on page 4). Outside of BC, most GPOs have had no formal training, but have learned "on the job."
- GPOs do have a lot of experience: 60% of respondents have worked as a GPO for at least five years.

- 1/3 of respondents work as full-time GPOs, but the majority work part-time averaging four half days a week. Most also work elsewhere as palliative care providers, hospitalists and/or in primary care practice. Most GPOs are involved in teaching as well.
- 88% of respondents work in outpatient cancer clinics supervising the administration of chemotherapy and handling symptom management; 20% work in radiation; and 60% provide in-patient care as well.
- GPO job satisfaction is excellent with 93% of respondents stating they are satisfied or extremely satisfied with their work and 2/3 adding that their GPO work is more satisfying than their previous positions.
- 80% of respondents are in favour of CAGPO developing closer ties with the College of Family Physicians of Canada.

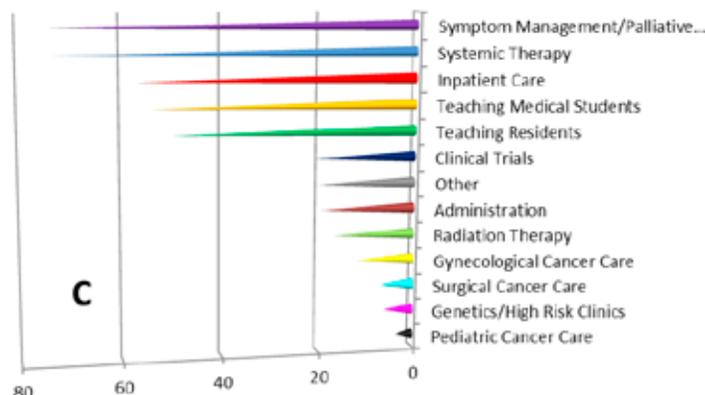
We will be formally presenting the results of this survey at an evening symposium on Thursday, October 27, 2011 at CAGPO's annual conference in Quebec City (<http://agora-event.com/cagpo2011/>). We'll also post the report on our website. Our plan is to use this information in our discussions with the CFPC to explore the creation of a "section of focused practice" for GPOs within the College.

We hope that the information will be useful to our members as well to provincial cancer *continued on page 7*

A National Survey of General Practitioners in Oncology in Canada Spring 2011, 120 Responses



Outside of GPO work, what medical activities do GPOs routinely participate in? (Other includes ER, Obstetrics etc.) N= 119



What kinds of work in the cancer system are GPOs involved in? N= 119

Psychiatric issues in oncology

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. Elaine Drysdale shares key points from her CME Webcast earlier this year. View the full recorded Webcast at www.fpon.ca (under CME Initiatives). More pearls will be published in our next issue.

Busy family practitioners wanting to know essentials of psychiatric and psychological issues of cancer do not have the time to read the major 675 page textbook, *Psycho-Oncology*, edited by J. Holland, but perhaps can benefit from some “clinical pearls” I have found useful in my 22 years of seeing cancer patients from my psychiatric perspective.

Psychiatric symptoms can develop even with initial discussions about a cancer diagnosis. Sometimes the hospital’s need for medical-legal consent can lead to a patient’s overwhelming anxiety and even to features of post-traumatic stress disorder. Staff sometimes worry more about giving “false hope” than about the possibility of “false despair,” which can be immobilizing. I suggest the classic book, *How to Break Bad News*, by Robert Buckman regarding his protocol for breaking bad news.

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CAGPO survey helps define GPOs’ role continued from page 6

agencies and other cancer organizations in understanding who GPOs are and the important contribution they make to our cancer care system. The survey demonstrates that GPOs are not only full-time physicians working in cancer centres, but that they work in communities of all sizes in our country, helping provide care to cancer patients and their families.

Contact Jeff Sisler at Jeff.Sisler@cancercare.mb.ca

“The Tyranny of Positive Thinking”

The old adage, “**Just be positive,**” should be avoided as it puts tremendous strain on the patient, who may feel inadequate that he “can’t be positive enough.” After all, it can be difficult to always “be positive” when everything is going well in life never mind when one is frightened about dying from a cancer diagnosis! Sometimes this “advice” creates a schism between patient and doctor or between patient and well-meaning family members who deal with their own feelings of helplessness by offering this “advice” and who

themselves become frustrated or even angry when the patient “isn’t positive enough!” I have discussed with my colleagues internationally since the early 1990s about “the tyranny of positive thinking,” and this has been noted to be such a wide-spread frustration for patients that it later became the title of a book chapter!

There is a solution, however! Patients, family members, and medical staff can find agreement together that what is most important is a determination to have a “fighting spirit.” Of course, I mention that even a “fighting spirit” can be difficult when one is weak, sedated, or nauseated, and so I stress that ultimately what is needed is the **decision to survive** even if one doesn’t always “feel like fighting!” This takes the pressure off both patient and care-giver!

Unique Meaning of a Symptom or Diagnosis

Any medical symptom or diagnosis might have a unique significance and meaning to a patient. One patient, for example, became unexpectedly very anxious when he developed chemotherapy-induced leg myalgias. It was then revealed that myalgias had occurred as a symptom of his initial cancer diagnosis, and so he thought that when they recurred, (as a side-effect), he was

doomed. Another patient refused to believe staff when they told her that her leukemia was treatable; it was later discovered that her fiancé had died on the same ward of a different type of leukemia. Further, fatigue and chemo-brain may be inconvenient to an unemployed person, but terrifying to an obsessive, highly skilled professional trying to work. Clarifying the significance of the symptom to the patient can be a vital step in understanding the patient’s anxiety.

More on Chemobrain

“**Chemobrain**”, the term used to describe cognitive impairment in chemotherapy, can occur even when the chemotherapy agent does not cross the blood-brain barrier, and cannot be attributed solely to psychological effects nor to hormonal/menopausal effects on cognition. Chemobrain can occur by systemic release of cytokines and induction of tumor-necrosis factor, as well as by other mechanisms, which then lead to altered CNS functioning. The mechanisms are not fully understood. (Taillibert, S. *Current Opinion in Oncology*, Nov. 2007)

Nausea and Anxiety

When a patient becomes anxious with nausea, remember that anti-emetics, such as metochlopramide (Maxeran) or prochlorperazine (Stemetil) are dopamine-blockers, and therefore can cause akathisia, (motor restlessness, often with a need to move the legs), which may be perceived by staff and the patient to be “anxiety.” This can frequently occur with dosages of metochlopramide 10 mgm q.i.d. Some patients are more vulnerable to developing akathisia than others, possibly due to genetic metabolic differences. (It is well known clinically that people of Chinese genetics are more susceptible to extra-pyramidal side-effects, such as akathisia.) This restlessness can respond to benzotropine (Cogentin) 1-2 mgm bid prn or to diphenhydramine (Benadryl) 25-50 mgm t.i.d. prn. Of course consideration should also be given to then choosing alternative anti-emetics.

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New senior director for Communities Oncology Network

In BC, up to 50% of systemic therapy is now delivered in patients' home communities and strategic planning to ensure the best care possible is becoming increasingly important. This responsibility is the focus of the recently appointed Senior Director of the Communities Oncology Network, Johanna den Duyf, former Director of Systemic Therapy for the BC Cancer Agency's Vancouver Island Centre.



Johanna den Duyf is leading the development of a new provincial business plan for the Network's 30+ systemic therapy sites in BC.

Ms. den Duyf is based in Victoria and began her new role last April providing the leadership, program planning and coordination of services to develop a provincial framework for this Network including formalizing its structure within the Agency and the Health Authorities' Communities Oncology Services. Her immediate priorities include strengthening the relationship with the Health Authorities to develop a business

plan, governance and funding models for the Network.

The Agency established the Communities Oncology Network in the late 1980s to better meet systemic therapy needs in BC communities. This Network grew over time to include over 30 delivery sites in the province now operating under various organizational models in partnership with both the Agency and the Health Authorities. General Practitioners in Oncology (GPOs), most of whom have undergone the Family Practice

Oncology Network's eight week Preceptor Program training (see story on page 4), form the core of the Network's many cancer care teams along with local pharmacists and specially trained oncology nurses.

Another long term focus of Ms. den Duyf's role will include developing a more formalized structure to maintain standards of

competencies for these GPOs which will serve as another opportunity for the Family Practice Oncology Network to assist. The development of related policies, performance agreements, metrics and outcomes will also be important.

"I am visiting the sites and beginning conversations with key leaders responsible for systemic therapy in their communities. My goal is to clearly understand the challenges and the opportunities as seen through the eyes of the individuals providing the services plus those who hold the responsibility within their portfolios. As a former nurse, I have always been involved and committed to providing cancer care closer to home. Working with communities is my way of continuing to support the concept that these services should be delivered – with appropriate resources – to ensure cancer patients have access to the best care possible within their communities."

Contact Johanna den Duyf at jdenduyf@bccancer.bc.ca

Practice support program launches end-of-life module

The well regarded Practice Support Program developed and presented by the General Practice Services Committee is launching a



A GPSC Initiative

new module this fall focussing on End-of-Life care (EOL). The module provides training and support to family physicians and their medical office assistants to improve care of patients and families living with, suffering from, and dying from life limiting and chronic illnesses.

"The focus," according to the module's Steering Committee Chair, Dr. Cathy Clelland, "is to enable physicians to learn how to

identify patients who would benefit from a palliative approach to care, to increase their confidence and communication skills with regard to advance care planning, and to improve collaboration with specialists as well as palliative care and related community services. The training is not centred on the clinical management of symptoms, but on ensuring patients benefit from a well integrated holistic approach during the last 6 – 12 months of their life, that they are connected with appropriate services in their community, and that they and their families are supported so that death takes place in the circumstances that are best for them."

The module complements the GPSC palliative planning incentive payment and was well received during pilot presentations in Chilliwack, Powell River, Fort St. John, Fraser Lake and Penticton. As per the PSP format,

the EOL module is presented by local, trained physician facilitators and involves three paid half-day group learning sessions offered in communities throughout BC. Each session is followed by an action period of six to eight weeks where participants try out what they've learned in their own practice with the support of PSP team members.

The EOL module is based on the Gold Standards Framework of the UK and includes an algorithm detailing the various professionals' responsibilities at each stage in a patient's progression. The Palliative Care Guidelines (see story on page 1) developed by the Family Practice Oncology Network and the Guidelines and Protocols Advisory Committee form part of the foundation for this module.

For more information, including PSP contacts in your community, please visit www.pspbc.ca.

Hereditary cancer genetic testing – why, when and how?

By Jennifer Nuk, genetic counsellor and Mary McCullum, nurse educator, Hereditary Cancer Program, BC Cancer Agency

One purpose of hereditary cancer genetic counselling is to assess whether genetic testing for a particular hereditary cancer syndrome is appropriate.

Case Study

Paul, now in good health at age 49, was diagnosed with an adenocarcinoma of the transverse colon at age 46. He was invited to attend a genetic counselling appointment by his sister, who was previously seen through the Hereditary Cancer Program, to discuss their family history of cancer, screening recommendations and options for genetic testing. Because of his personal cancer history, Paul's appointment will focus on the option of Lynch syndrome genetic testing as an "index" case for his family.

At Paul's appointment

The genetic counsellor (GC) describes the process of Lynch syndrome genetic testing in detail including the possible benefits, harms and limitations.

Genetic testing for Lynch syndrome

Testing begins with colorectal/endometrial tumour tissue from the person with the youngest diagnosis in the family. The tissue is assessed for features consistent with a germline (inherited) mismatch repair (aka Lynch syndrome) gene mutation.

The 2 tests done on the tissue include:

- immunohistochemistry (IHC) to detect the presence or absence of the proteins made by the *MLH1*, *MSH2*, *MSH6*, and *PMS2* genes.
- microsatellite instability (MSI) testing: microsatellites are naturally occurring repeated sequences of DNA. Microsatellite stable means the same number of "repeats" is present in both tumour and normal tissue. MSI means the number of repeats differs.

Tumours related to Lynch syndrome almost always show some degree of MSI and are most often deficient for one or more of the proteins made by a mismatch repair

gene. (Some sporadic tumours have similar features, so these results do not confirm Lynch syndrome.)

If a tumour is microsatellite stable and all proteins are intact, it is unlikely that the tumour is related to Lynch syndrome.

If a tumour is microsatellite unstable (MSI), additional genetic testing on a blood sample from the same person may be offered. Protein deficiency on IHC guides which mismatch repair gene is tested.

Paul's decision

Paul is not personally interested in genetic testing. He has concerns about how he would cope if the results confirm an increased risk for a new cancer. While his daughters seem supportive, he worries that they will blame him if he has passed on a mutation. Paul does see benefit, however, in clarifying cancer screening and risk-reduction options for himself and his family.

Paul decides that the benefits of genetic testing will likely outweigh the potential harms and signs consent to proceed. The GC assists in obtaining a stored tumour tissue sample for testing.

Paul's tumour test results

IHC: *MLH1*, *MSH6*, & *PMS2* intact; *MSH2* deficient

MSI: unstable at 7/7 markers

These results are suggestive of an *MSH2* gene mutation. The GC discusses the implications

of this result and offers *MSH2* gene testing to Paul. He wishes to proceed and the GC sends him a requisition to have a blood sample sent to the BCCA Cancer Genetics Lab.

Paul's blood test results

Paul requests an in-person GC appointment to review his results. The GC explains that a mutation has been identified in the *MSH2* gene. This confirms a diagnosis of Lynch syndrome. While Paul is not surprised by this information, it is challenging for him to hear. The GC and Paul discuss what this means for him and for his family.

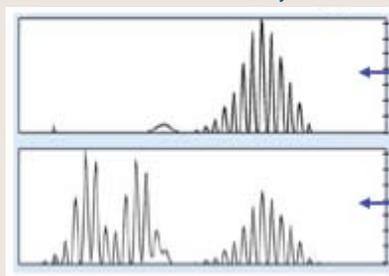
The GC explains that carrier testing for the specific *MSH2* gene mutation is now available to Paul's sister and other adult family members. Interested individuals are invited to contact the Hereditary Cancer Program to schedule a genetic counselling appointment.

Because Lynch syndrome is inherited in an autosomal dominant manner, Paul is aware that each of his first degree relatives (siblings, children) were born with a 50% chance to have inherited the same *MSH2* mutation. Those who test positive will be recommended to follow a high-risk surveillance protocol. Those who test negative can follow general population cancer screening guidelines.

A letter from the GC to Paul's primary care physician and gastroenterologist informs them of his genetic test results and related recommendations. Paul receives a copy of this letter along with resources for additional information and support.

Lynch syndrome genetic testing begins with tumour tissue – ideally colorectal tumour.

Microsatellite Analysis



CGL tests 7 markers:
3 dinucleotides
4 mononucleotides

10-15% sporadic colorectal tumours are MSI +
Up to 95% of Lynch CRC have MSI

Making BC's breast diagnostic system work better for women

By Dr. Christine Wilson, Medical Director, Screening Mammography Program of BC, and Provincial Breast Health Strategy Steering Committee member.

A newly developed breast diagnostic clinical pathway is designed to provide BC women with the best possible care after an abnormal screening result or a breast examination indicates the need for further tests.

Developed over the past year by a team of clinicians and health care leaders, this recommended clinical pathway starts with either a direct referral from the Screening Mammography Program of BC or a referral from the office of a family physician or other primary health care provider. The pathway concludes when the patient either receives her definitive diagnosis through imaging and (if needed) tissue biopsy or she requires referral to a surgeon. You will be kept informed of your patient's



An active member of the Provincial Breast Health Strategy, Dr. Wilson currently chairs the Provincial Breast Health Clinical Pathway project, and is a member of both the Provincial Breast Health Steering Committee and the Provincial Digital Mammography working group.

progress along the pathway and will be able to personally provide her with information about her diagnosis. We are also working to make provisions within the pathway to make it easier for women who do not have a family physician or other primary health care provider to access screening mammography and any necessary follow up.

The clinical pathway is part of the Provincial Breast Health Strategy (PBHS), which involves health authorities, the Ministry of Health and community partners working together to improve the current breast health system. Launched by the Provincial Health Services Authority (PHSA) in June 2010, the goal of the PBHS is to reduce

deaths from breast cancer by providing women with timely, equitable access to high-quality breast cancer screening, diagnostic and prevention services. This initiative is led by PBHS Provincial Director Lynn Pelletier and

co-chaired by Brian Schmidt, interim president of the BCCA, and Dr. Jan Christilaw, president of BC Women's Hospital and Health Centre.

In addition to the clinical pathway, the PBHS is addressing the need for digital mammography; evidence-based breast cancer prevention (including a review of BC's screening policy); and strategies to recruit and retain our breast imaging workforce. In 2010, BC's Breast Health Action Plan (BHAP) identified challenges and potential solutions in each of these areas. For example, the BHAP illustrated our ongoing challenge of attracting more high-risk women, especially women in the 50 to 69 age group, into screening. It also indicated the need for a diagnostic clinical pathway with guidelines and protocols to ensure that diagnostic care is timely and equitable across the province.

Over the next few months, we will be talking with the health authorities to plan, implement and evaluate the diagnostic clinical pathway in test sites.

If you would like more information about the clinical pathway or the PBHS, please visit www.phsa.ca/HealthProfessionals/pbhs/default.htm or send an email to pbhs@phsa.ca

WorkSafeBC: Cancers presumed to be caused by exposures in firefighting

If a firefighter who was regularly exposed to the hazards of a fire scene contracts a prescribed occupational disease, the disease must be presumed to be due to the nature of the worker's employment as a firefighter.

The Firefighters' Occupational Disease Regulation lists the following nine cancers as prescribed occupational diseases that are causally related to the occupation of firefighting:

1. primary leukemia,
2. primary non-Hodgkin's lymphoma,
3. primary bladder cancer,
4. primary site brain cancer,
5. primary colorectal cancer,
6. primary kidney cancer,
7. primary lung cancer,
8. primary testicular cancer, and
9. primary ureter cancer.



The Workers Compensation Act states that the presumption applies to a firefighter who:

- a) has worked as a firefighter for a minimum cumulative period prescribed for the disease – these periods are set out in the Regulation and are specific to each disease;
- b) throughout the period, has been regularly exposed to the hazards of a fire scene, other than a forest fire scene; and
- c) is first disabled after April 11, 2005.

The minimum cumulative period of employment as a firefighter prescribed for each of the nine cancers is set out below:

1. five years for primary leukemia
2. 20 years for primary non-Hodgkin's lymphoma
3. 15 years for Primary site bladder cancer
4. 10 years for primary site brain cancer
5. 20 years for primary site colorectal cancer
6. 20 years for primary site kidney cancer

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Join us for Pap Awareness Week, October 23-29

Cervical Cancer is Preventable –
You are part of the solution



We know that with regular screening cervical cancer is a highly preventable. Since the introduction of BC's Cervical Cancer Screening Program (CCSP) in the early 1960s – the first in the world – the province has successfully reduced cervical cancer rates by 70% .

Women in BC are generally well screened with participation rates at 78.5% , exceeding the national benchmark of 70% . However, CCSP recognizes that there are groups in BC that are not being screened at the rates they should be, including young urban women, older women in the North and new immigrants. For example, participation rates in 20-29 year olds can drop under 50% , especially in areas in the Lower Mainland such as Richmond, Vancouver and the Fraser Valley. Rates in older women are particularly low in the Northeast, Northwest, Thompson Cariboo and Fraser East.

The reasons for these disparities are varied. Many young women move frequently due to school or work and consequently often don't have a regular family doctor. Women in their fifties may believe that it's no longer important to get a regular Pap at their age, and language can be a barrier for immigrant women. Finding time is a factor for women in all communities.

Targeted initiatives to increase participation are ongoing but one of the most comprehensive of these

is Pap Awareness Week. A National initiative, Pap Awareness Week started in Manitoba and the Atlantic Provinces with the goal of increasing awareness of the life-saving benefits of screening, while also making it as simple as possible for women to get a Pap test. Last year here in BC, 120 clinics signed up to offer designated dates and times for Pap tests during the week, many on a drop-in basis – an increase from 94 clinics the previous year.

We would like to ask for your help to increase the number of clinics offering Paps during Pap Awareness Week, especially in communities where women may traditionally be under screened.

Signing up is easy at the program's LACE Campaign www.LACEcampaign.com. Once on board, you'll be contacted to discuss how we can best support you with promotion including social and traditional media, posters and postcards, and volunteers and community outreach.

Some materials will be translated into Chinese and Punjabi. These materials will include a Chinese and Punjabi phone line for women to seek help in finding a clinic in their area.

For more information, please contact Lisa Despina, BC Cancer Agency Cervical Cancer Screening Program, at ldespina@bccancer.bc.ca or 604-877-6000 ex 4622.

*WorkSafeBC
continued from page 10*

7. 15 years for primary site lung cancer
8. 20 years for primary site testicular cancer
9. 15 years for primary site ureter cancer

There is also a minimum non-smoking period prescribed for previous smokers who contract primary lung cancer. As a physician, if you have a patient who is a firefighter and is diagnosed with one of the prescribed occupational diseases, please advise your patient about the occupational disease presumption for firefighters in the *Workers Compensation Act* and the worker's potential entitlement to workers' compensation coverage. To answer any questions, a representative at WorkSafeBC can be reached at 604.279.8158.

Please advise your patients to contact WorkSafeBC to see if they are eligible for benefits. Your patient can call the WorkSafeBC Teleclaim number to apply for WorkSafeBC benefits. Teleclaim may be reached at 1 888 WORKERS (1.888.967.5377) or #5377 for Telus, Rogers, and Bell mobility customers.

The links to the relevant legislation and regulation are as follows:

The relevant section of the *Workers Compensation Act* (Part 1, Division 2, Section 6.1) may be viewed at: www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/96492_01#section6.1

The Firefighters' Occupational Disease Regulation may be viewed at: www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/11_125_2009#section2

Message from the chair

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



The key rationale for establishing the Family Practice Oncology Network back in 2002 was to provide family physicians with the tools and resources

to fill a more significant role in caring for cancer patients and their families. The most requested tool as such was practical, easy-to-use, brief cancer care guidelines customized to the needs of busy primary care professionals. Determining how to effectively meet this need took some time (and a great deal of effort), but we are now on a roll with the completion last month of the Palliative Care set of guidelines (www.bcguidelines.ca) including the Approach to Care, Pain and Symptom Management and Grief and Bereavement.

Currently, we are focussing on a two-part breast cancer guideline concentrating first on screening and diagnosis and then treatment (brief summary) and follow-up – all key primary care responsibilities. Guidelines for prostate and colorectal cancer are next on the agenda with completion targeted for March 2012. All of these guidelines are produced in partnership with the BC Guidelines and Protocols Advisory Committee and follow its well established format including input from

many subject area experts and family physicians.

Another long time focus of the Network is our Preceptor Program which provides eight weeks of enhanced oncology training to rural family physicians – with the support of their community – and to newly hired agency General Practitioners in Oncology and

nurse practitioners. We just completed our sixteenth intake for this program increasing the total number of professionals trained to 70 primary care providers from 33 BC communities. The impact of this program, which comes together thanks to the contributions of many Agency oncologists and professionals, is compounded every time we hear of a patient whose life was made easier by the ability to receive high quality care near to where they live.

Our focus on communities will continue in the coming months with the launch of our Cancer Care Outreach Program on Education developed in partnership with UBC Continuing Professional Development. A full program of cancer care workshops will be presented in 40 communities beginning later this year. We are also striving to develop a system with BC Children's Hospital to provide family physicians in all communities with relevant data and monitoring guidelines on their patients who are survivors of childhood cancer.

BC generations project continued from page 3

opened in Prince George and Coquitlam over the summer, attracted more than 1,000 participants each. An assessment centre will be operating in Victoria in October and early November, and an additional centre is planned for the Fraser Valley.

Physicians can help by encouraging their patients to join the BC Generations Project both for a review of their health measurements and to help the future of cancer research. Appointments are currently available at the project's assessment centre in Victoria and at the project's head office

centre in Vancouver. The BC Generations Project is recruiting participants until March 2012. For more details, visit www.bcgenerationsproject.ca or call 1-877-675-8221. If you are a medical practitioner and can display a BC Generations poster or brochures in your waiting area, please call or email the Project at bcgenerationsproject@bccrc.ca.

The BC Generations Project will be presenting at the 10th Annual Canadian Rural Health Research Society Conference (October 20-22, 2011 in Richmond) and at the 2011 BCCA Annual Conference (December 1-3, 2011 in Vancouver).

Cancer care support and connection for physicians in the community is what we are all about.

Contact Dr. Phil White at drwhitemd@shaw.ca

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www.fpon.ca

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