BC Cancer Agency
CARE & RESEARCH

BC Provincial
SURGICAL ONCOLOGY NETWORK

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NEWSLETTER

Spring 2004

Clinical Practice Guideline on Sentinel Lymph Node Mapping for Breast Cancer

At the request of the BCCA Breast Tumour Group, the Surgical Oncology Network's Breast Surgical Tumour Group (STG) has developed the first provincial guideline on Sentinel Lymph Node Mapping for Breast Cancer.

Dr. Allen Hayashi, the SON Breast STG chair, assembled a group of surgeons from around BC including: Drs. Gary Cuddington, Noelle Davis, Gary Kingston, David James, Roger Ring, Con Rusnak, Laurence Turner; as well as medical oncologist Vanessa Bernstein; pathologists Malcolm Hayes, James Kelly, and Nick van der Westhuizen; radiation oncologist Ivo Olivotto; and radiologists Del Pengelly and Dan Worsley. Barbara Poole of the Surgical Oncology Network acted as facilitator.

Dr. Bernstein completed a literature review and developed a draft guideline, which formed the basis of discussion for the first meeting - a teleconference held the evening of April 10, 2003 (the first game of the Canucks in the Stanley Cup playoffs). It was agreed at that time to develop two guidelines – the first a technical guideline on how to do a sentinel lymph node mapping procedure and a second guideline that would tackle the more controversial subject of whether or not this procedure

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Hot Topics in Surgical Oncology

R Cheifetz

On November 29th, 2003, the BC Surgical Oncology Network sponsored a day devoted to surgical oncology as part of the BCCA Annual Conference. The following is a synopsis of the presentations given for those of you who couldn't attend:

Current Management of Brain Metastases (Dr B Toyota)
Brain metastases are treatable. Up to 3 lesions can be treated with a combination of surgery and whole brain radiation. The addition of adjuvant radiation decreases the local recurrence rate. The survival post treatment of brain metastases is 10-12 months with significantly improved quality of life and death due to primary disease rather than disease of the CNS.

Update in the Management of Esophageal Cancer (Dr J Yee)
There is no survival advantage for thoracotomy over transhiatal esophagectomy for esophageal cancer despite the more extensive lymphadenectomy feasible with the former. There is a role for neoadjuvant chemoradiation in select patients. Fifteen to 20% will have a complete response and this is associated with a survival advantage.

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From the Editor

The difficulty in gathering and analyzing high-quality, prospective longitudinal data from our patients in the health system is an ongoing frustration. In order to make informed decisions about defects in our current standard of care and make rational changes for the future, better data collection is crucial.

In this issue, the Breast Tumour Group, which has proceeded under the energetic leadership of Dr. Allen Hayashi from Victoria, will present the first of two guidelines regarding sentinel node biopsy in breast cancer. Future discussions will take place that will further modify the guidelines as new data becomes available. This represents a cooperative and consensus-based approach using local data to emphasize outcomes in the management of this disease. I believe it also represents a template for future endeavours not only for cancer care but also for other aspects of surgical practice.

Data collection, integrated into our medical record, can and should become part of our everyday practice. If you have the opportunity, consider submitting formalized data to the appropriate tumour group as their ability to capture such data comes online. I believe your effort will be rewarded amply.

Sincerely,

B. Rudston-Brown, MD FRCSC
General Surgery, Nanaimo
Chair, Communications Committee
blair@rudston-brown.shawbiz.ca

Messages from the Co-Chairs

Dr. Noelle Davis

This past January, the BC Cancer Agency's Surgical Oncology program underwent an external review. Drs. Robert Bell (COO at the Princess Margaret Hospital/University Health Network in Toronto) and Dr. Richard Nason (Head of Surgical Oncology at Cancer Care Manitoba in Winnipeg) conducted an extensive review of the program through interviews and assessment of written plans. I'm pleased to report that the review was very positive and in particular, gave high marks to the Surgical Oncology Network. Among the reviewers' recommendations was the development of an academic surgical oncology program in BC. This will be a major focus over the coming year, and I look forward to the Network's assistance in implementing such a program.

I am also pleased to report on the progress of the Surgeon Information System Working Group. This group has been meeting over the past half year to examine the feasibility of developing an online outcome reporting system for surgeons. With Dr. Andrew Gemino's (a professor at Simon Fraser University) assistance, we have developed 5 projects for MBA students at SFU to tackle. These projects will examine how information flows in a surgeon's office; possible technological solutions to data collection and data capture issues; and how web-based solutions can enhance and improve surgical practice. The ultimate goal is to apply for grant funding that will allow us to make these exciting initiatives a reality.
noelle.davis@bccancer.bc.ca

Dr. Con Rusnak

The Surgical Oncology Network's Council had another successful planning session on February 6th of this year. The focus of this most recent meeting was on the Surgical Tumour Groups (STGs) and the issues they wish to work on in the next year. Several key themes emerged from our discussion including:

- Family practitioners are the first link in the cancer care system - how can we work with them and provide education? They now have a Family Practice Oncology Network that provides an avenue of collaboration.
- The importance of patient education materials - how can we encourage their development and dissemination?
- CME activities will rarely be attractive to all surgical sub-specialists - how can we continue to provide effective CME for all disciplines? The travelling CME seminar series has been a great success. It was agreed that the SON would get involved with STG educational sessions where possible.
- The importance of practice guidelines and that these need to be focused on quality, not volume.

My thanks go out to the Surgical Tumour Group chairs and their delegates who participated in the February meeting. The issues and themes raised at the 2004 planning session are an important part of continuing this success with the other STGs. It is important that all regions are represented in this process. I challenge us all to do our part in improving surgical practice in BC. *crusnak@caphealth.org*

Patient Navigation in British Columbia

*\Nav`i*ga"tion\, n. [L. navigatio: cf. F. navigation.] 1. The act of navigating; the act of passing on water in ships or other vessels; the state of being navigable. Webster's Revised Unabridged Dictionary, © 1996, 1998 MICRA, Inc.*

by Janet Alred

Surgeons in Nova Scotia have found that Patient Navigators save them valuable clinic time and enhance the quality of care they are able to give their patients. Could a similar service work for BC?

In May 2000, delegates at the 4th National Community Cancer Conference in Victoria stated that: "the organized cancer system is complex and cumbersome. There is a need for a 'navigator' role that would assist the community physician and the cancer patient to access and move through the cancer care system."

Navigational support has already been available for a few years at the Breast Health Centre Program in the South Region of Vancouver Island's Health Authority and, from anecdotal reports, the program has been extremely well received and successful. A team of researchers from the BC Cancer Agency and University of British Columbia received funding[1] to evaluate the success of the Breast Health Centre program. They also received funding to initiate a pilot 'Patient Navigator' model in the Kootenay/Boundary area of eastern BC, which has now been in place since the beginning of 2003. This location was chosen because a similar pilot role had been created there in 1997/98 and, although it was recommended the service continue, it ended after one year.

Surgeons and Oncologists who have benefited from the work of the Patient Navigator have welcomed the support. For them, the amount of consultation time needed to discuss treatment options has lessened and their patients arrive informed and ready to make decisions about their care. Patients have found that the task of navigating through large amounts of cancer information, at what can be a very distressing time, is made less onerous.

By reviewing the effectiveness of the Navigator project in BC, steps can be taken to eliminate discontinuity and communication difficulties currently perceived within the cancer care system. Information and data researchers collect will help define the feasibility of navigator programs and hopefully lead to more programs being set up throughout the province.

[1] Funding was obtained from the Agency, the Canadian Breast Cancer Initiative, the Canadian Strategy for Cancer Control, the Canadian Breast Cancer Foundation and the BC Satellite Research Centre

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What is a Patient Navigator?

"Navigation is used to denote a system or professional role intended primarily to expedite access to services and resources and to improve continuity and coordination of care throughout the cancer continuum," writes Richard Doll[1].

At the heart of the BCCA project are the roles played by the patient and the Navigator. They work together, sharing information to help alleviate some of the distress experienced with the cancer diagnosis. To use the Vancouver Island model as an example, the patient is put in touch with the Navigator by their surgeon after diagnosis has been confirmed.

The first contact occurs before the patient sees the surgeon for their first consultation. The Navigator provides the patient with information about support available, an understanding of the health care system, preparation for the surgical consultation and sufficient information to allow the patient to make informed decisions and choices about their treatment options.

The second contact happens prior to the surgery. The Navigator ensures the patient understands the operation date, the choice of surgical intervention, and is familiar with hospital admission and discharge procedures. Preparation for post-operative convalescence and the need for support are also discussed.

Shortly after the operation, the Navigator contacts the patient again. This time they prepare patients for their visit to the Vancouver Island Cancer Centre, ensure the patient is receiving adequate emotional and practical support, and encourage them to attend post breast surgery education sessions.

However the position can grow. Dorothy Brown is the Cancer Care Navigator employed by the Interior Health Authority/ BCCA in a 15-month pilot project. She is located in Nelson and has found that expanding the role by creating support networks for patients plays a role in fulfilling the psychosocial requirements sometimes overlooked by the health care system. The West Kootenay Boundary Region covers a large geographic area with accessibility to communities severely hampered by mountain passes and hazardous weather. With a social work background, Dorothy's instinct has been to work in partnership with individual communities on developing initiatives such as exercise, nutrition and relaxation programs for patients. She works with all areas of cancer and people at all stages of their cancer journey. Her job is intense yet powerfully rewarding. She sees the positive response of helping patients talk frankly about their fears and disease with one another in supportive group environments – experiences they often hide from relatives and friends. In her work, Dorothy helps people overcome their isolation and loneliness, and remain visible as part of their community.

[1] Lead author: Patient Navigation in Cancer Care: Program Delivery and Research in British Columbia, printed in the summer 2003 edition of Canadian Oncology Nursing Journal

Patient Navigation continued from Page 3

Here in Canada, Cancer Care Nova Scotia has just evaluated its very successful patient navigation program. Through focus groups, one-on-one interviews, surveys and review of medical records, they report that patients, families and health professionals are extremely satisfied with the program. "Because of the navigator project, I'm able to concentrate on the medical aspects of treatment, which is more cost effective and a better use of my time", says Dr. Mark Dorren, Medical Oncologist at Capital Health Cancer Care Program[1]. Communication, district commitment and strong leadership are cited as critical to the success of such a program. In California, the Contra Costa Breast Cancer Partnership recently received $200,000 US in funding to expand their services to help uninsured, non-English speaking women with breast cancer. WomenCARE is a program in Santa Cruz County that provides mentors for newly diagnosed women with breast cancer and has an outreach program specifically for the Latin American population. The Greater Baltimore Medical Centre and the Truman Medical Centre in Kansas City, Missouri, both have navigator projects established.

[1] *Patient navigation improves community cancer care. Press Release. Cancer Care Nova Scotia, 23 January 2004.*

For more information:

Researchers:
Richard Doll is the BCCA principal investigator for the navigator project. Maria Cristina Barroetavena and Joanne Stephen are research consultants. General questions about the project can be forwarded to Joanne at 604 877-6000 ext. 2187 or Maria Cristina at 604 877-6000 ext. 2185.

Navigators:
Cathy Parker works at the Breast Health Centre Program in Victoria and can be contacted at 250 727-4467. Dorothy Brown is the Cancer Care Navigator for West Kootenay Boundary Region and is contacted at 250 352-1406.

Breast Surgical Tumour Group Update

by Allen Hayashi, MD MSc FRCSC, Chair of the Group

Outcomes Initiatives (aka Surgical Information System Working Group)
Noelle Davis is spearheading this. We are interested in developing a tool for allowing outcome measures to be documented and extracted. This will allow us to make changes in our care based on hard evidence and reduce the turnaround time for integrating improvements both on a personal and provincial level.

Research
While not clear at this time, it is very possible for us to do population studies if we as provincial surgeons all pull together. I am very interested in developing a model of participation from the breast cancer group. We do need some seed money for this and at the present time it appears to be the one most important aspect that is hard to get. I am proceeding with "sweat equity" and moneys from my own pocket until additional support is obtained.

Tumour Tissue Repository
In Victoria, the TTR has opened and we breast cancer surgeons will be making significant contributions to build the DNA/RNA/protein bank so that we can identify the specific mutation errors that contribute to breast cancer. There is much excitement and fanfare and we will be working hard with good will and intellectual capital to push for a world class research facility based on this program.

Breast Cancer Guideline Continued from Page 1

should be done as a stand-alone procedure. This second guideline is in development and will be discussed at the Breast Cancer Symposium scheduled for Victoria on April 24th (see the brochure enclosed with this newsletter for more information).

In addition to the teleconference discussion, multiple drafts were circulated to the participating physicians for their comments and a second teleconference was eventually held to iron out those areas where differences of opinion occurred. During this period of time, the Canucks lost out in the playoffs, Dr. Bernstein gave birth to a beautiful baby girl, and eventually an agreed upon final draft guideline was submitted to the BCCA Breast Tumour Group for approval. The guideline was approved on November 21, 2003 and the first page summary is included as an insert in this newsletter.

Network News

CME

- Two more Melanoma regional seminars were held in Prince George (January 23rd, 2004) and Vancouver (February 20th, 2004). Plans are underway for our final session, which will be in Nanaimo, likely in late May. Feedback from the seminars has been extremely positive.
- The next travelling seminar series will be focused on Head & Neck. Representatives from the Head & Neck and Endocrine Surgical Tumour Groups are involved with planning this series. Look for more details shortly.
- Dr. Robin Woodhead of Delta won the $100 prize draw for completing the follow-up test from the 2002 TME course in Vancouver. This follow-up test was designed to assess participants' knowledge of rectal cancer management one year after they completed the course. Measuring participant learning is an important component of any CME activity and we thank everyone who completed the follow-up test for their assistance with this project. If you attended the 2002 TME course and have not yet completed the follow-up exam, we would still very much appreciate your participation. Contact Tina Strack at tstrack@bccancer.bc.ca or 604-707-5900 x. 2410 for additional copies of the test.
- The Surgical Oncology Network is pleased to report that our abstract, *BC Surgical Oncology Network - Educating the Province's Surgeons*, was accepted for presentation in May at the 2004 CME Congress in Toronto, ON.
- The next CME event is the Breast Cancer Symposium on April 24th, 2004 in Victoria, BC. Details are provided on the back page. We hope that you will join us.

Clinical Practice

Participants at the February 6th annual conference agreed that clinical guidelines should concentrate on quality, not volume. To support quality, all hospitals in BC performing cancer surgery will be contacted with an infrastructure survey. Over the past few months, STG chairs have supplied information about what equipment, space, diagnostic facilities, pathology services and personnel are needed in order to perform surgery related to their tumour site. This information will help in the development of future standards and guidelines.

A standardized format for SON Clinical Practice Guidelines was approved at this year's council meeting. Sharon Thomson, the SON's Clinical Nurse Specialist, developed this format based on the CMA's guidelines and her experience with Practice Guidelines in the UK. The SON's first guideline, *Lymphatic Mapping And Sentinel Node Biopsy For Breast Cancer*, is published in this format and is available at the SON website (www.bccancer.bc.ca/son).

Research and Outcomes Evaluation

The committee met in November and gave their support to a study submitted by Drs. Noelle Davis and Terry Phang entitled "What a centralized facility buys you with rectal cancer surgery." This project has two aims - the first to examine aspects of the dataset collected in 1996 on rectal cancer care in BC, and the second to compare morbidity and mortality for patients who were or were not referred for treatment at the Agency.

Surgical Tumour Groups

Brain - Dr. Brian Toyota, Chair

Dr. Toyota has taken on the task of chairing the Central Nervous System tumour group for the BC Cancer Agency. The CNS group is driven to investigate research and care opportunities for patients with malignant brain tumours in the province.

Colorectal - Dr. Terry Phang, Chair

This group continues to meet monthly. Dr. Phang will be presenting very early findings from the first six months of the rectal cancer monitoring study at the BC Surgical Society meeting in Kelowna, May 13-15.

Esophageal/Lung - Dr. Richard Finley, Chair

The BC Chest Surgery Association and PHSA have produced a patient oriented Website for thoracic surgery. They have also produced a video and DVD for patient education about esophageal cancer. Both tools can be found at http://thoracicsurgery.bc.ca/index.cfm.

Hepatobiliary - Dr. Charles Scudamore, Chair

Dr. Scudamore writes, "We are interested in the overall management of cancer of the pancreas in the province of British Columbia. One of our projects is to determine who, amongst the surgeons of BC, are doing resections for adenocarcinoma of the pancreas, what type of resections they are doing and learning what challenges the surgeons are facing in order to be able to deal with cancer of the pancreas. We just recently clarified the diagnostic codes for cancer of the pancreas, bile ducts and liver. Once we have these established, we will invite the local representatives for the Council in Hepatobiliary and Pancreatic Surgery to provide us with the information so that we can aid those people wishing to do surgical resections for cancer of the pancreas. In order to do this, we need wait times, diagnostic challenges, surgical OR availability, endoscopic availability, and patterns of practice of those surgeons performimg Whipples and other pancreatic resections for cancer. Should you wish to get in touch with me, please call 604 875-4063, fax 604 875-4036 or email scudamor@interchange.ubc.ca."

Skin - Dr. Adrian Lee, Chair

The first meeting of the Skin STG took place in late January. Much of the discussion was focused on melanoma. Specific issues included the need to work with Family Practitioners, excision margins, timing of Sentinel Lymph Node Biopsy (SLNBx) and wide local excision, patient's need to be better informed about SLNBx to improve informed decision-making, and funding for SLNBx (which currently does not have an associated fee code). The group will meet again later this Spring.

Surgeon Infomation System Working Group

This group continues to meet monthly. Six groups of MBA students from SFU are conducting projects that will assist in the SON's goal to develop an electronic reporting system for surgeons. These projects are designed to track the flow of patient information through surgeons' offices, the possibilities of web technology, the development of a prototype system and the feasibility and cost-benefit of such systems. The focus of these initial studies is limited to breast and rectal cancer. The projects will be completed by the first week of April and presented to the group.

Dr. Allen Hayashi

interview by Janet Alred

Allen Hayashi, MD MSc FRCP(c)
General Surgeon
Head, Division of Surgery, Vancouver Island Health Authority
Chair, Breast Surgical Tumour Group

Dr. Hayashi is a very busy man. He has been Chair of the Breast Surgical Tumour Group for the SON since last year. In that time the group has created a clinical guideline on sentinel lymph node biopsy about which he says, "It was done in a collaborative way so it very much reflects a provincial viewpoint." A second guideline, complimentary to the first, is in draft format. On April 24th, his home city of Victoria will be the location for a Breast Cancer Symposium, hosted by the SON at the Hotel Grand Pacific. "It will be our first in what one hopes will be an annual event. We have some very engaging speakers and the topics will focus on current or controversial issues. We also will have an important segment where our audience will be asked to participate in developing the second part of our Sentinel Lymph Node biopsy guidelines."

Dr. Hayashi came to Victoria in 1992, with a strong academic surgical background and a Masters degree in Experimental Surgery. He admits that prior to the Masters' training, at the University of Alberta, he was not interested in doing research, so he was surprised to find the program exciting. "They don't expect surgeons to graduate as scientist surgeons," he says, "but they expect you to at least have enough exposure to experimental methodologies that you approach things with some degree of critical appraisal and inquisition, and perhaps even look at asking yourself 'am I always doing it this way because it is the right way, or are there better ways?'"

"We are all struggling…to change dogma into evidence-based practice"

Early in his medical training, naivety led Dr. Hayashi to a career in surgery. "To see people come in basically near death and watch the surgeons, at the time when I was training, essentially pull them out of the fire – that was really compelling and extremely exciting". His first interest was in trauma and many of his early research studies looked at shock and the lymphatic system. "I then evolved into doing research in neonatal surgery, specifically, extracorporeal membrane oxygenation (ECMO), which" he explains "is taking babies who are near death with certain pulmonary problems, putting them on bypass and bringing them back to life."

His practice now combines pediatric and general surgery, which seem to work well together. "I am finding that a lot of the things we do in general surgery actually can be applied back to children and change their management positively. We are seeing younger and younger people with cancer. I am operating on kids that are 8 years old with thyroid cancer and 11 years old with breast cancer. You only include cancer as a mindset in pediatric surgery if you have been exposed to it in general surgery. And we are now seeing children growing into adult age with childhood and congenital diseases. Not many of the adult surgeons feel comfortable managing these types of kids who are adults now because they are less familiar with the pediatric surgical entities that they were originally treated for. So there is a role for that 'crossover' surgeon."

As chair of the Breast STG, Dr. Hayashi's goals are ambitious yet achievable. He strives to promote and encourage provincial surgeons to standardize the skill sets of the newer procedures currently being performed in breast cancer surgery and enable new skills to be developed. He hopes to help develop a means of data collection that will improve a surgeon's efficiency and effectiveness, and to instigate outcome measures that are meaningful and can promote timely change management. Finally, he works toward encouraging a network of provincial surgeons to collectively contribute data in a prospective manner for research and quality assurance purposes.

When asked about his future research interests, Dr. Hayashi is enthused about change management. "You start asking yourself if you are doing the right thing. You realize that of all the dogmatic things you have been taught in the past some of them did not have much foundation so how do you develop a better evidence-based practice? That is what we are all struggling to do – to change dogma into evidence-based practice. I think there is great potential in identifying how we can make that happen in a very positive way."

Hot Topics in Surgical Oncology

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Approach to the Adrenal Incidentaloma (Dr S Bugis)
The metabolic work-up of an adrenal mass should include a 1mg overnight dexamethasone suppression test, a 24 hour urine for catecholamines and metaphrines, a serum K^+ and the plasma aldosterone:renin activity (if the patient is hypertensive).

All functioning tumours should be resected. Non-functioning tumours should be resected if they are greater than 6 cm (25% are malignant) and probably if larger than 4 cm (2% are malignant). Any size tumour with suspicious features on imaging should be removed. Lesions that are not removed should be re-imaged at 3 and 12 months, with a repeat metabolic workup at 12 and 24 months.

Adjuvant Therapy and Reconstruction in Breast Cancer (Dr P Clugston)
Preoperative radiation limits the options for delayed reconstruction post mastectomy. If an implant is used, the cosmetic results are not as good, there are more complications and more revisions are needed. Better results are obtained with autologous reconstruction (TRAM flap). Radiation also increases the risk of mastectomy flap necrosis with skin sparing mastectomies.

Postoperative radiation (after breast reconstruction) increases fibrosis and capsular contractures around implants. It also increases fibrosis in autologous reconstruction (TRAM) but the aesthetic results are generally good if the radiation protocol is adjusted (long fractionation).

Current Approach to Liver Metastases (Dr C Scudamore)
Liver metastases (any type) are considered resectable if the following criteria are met: the patient's estimated survival is more than 3 years; there is a low expected operative complication rate; all macroscopic disease can be removed or ablated; the primary tumour is under control; there is no reasonable alternative; and the biologic behavior is suitable (CEA >200 is bad, >40% of liver with tumour is bad). Avoid biopsy of operable lesions.

Radiofrequency ablation is associated with a less than 15% recurrence rate. It can be used for tumours smaller than 5 cm, and if there are less than 5 tumours.

Moh's Surgery in Skin Cancer (Dr C Murray)
This technique uses horizontal oblique frozen sections to immediately assess all margins. Since routine pathology assesses less than 1% of true margin, the Moh's technique is associated with a decreased local recurrence rate. It is good for tumours that have cosmetic and functional issues, or where an increased risk of recurrence exists. For example, large basal cell carcinomas (>2 cm or >1 cm on face), critical areas (nose, ears, eyes), aggressive histology (nodular), recurrent lesions, radiated fields or immunocompromised patients. It is especially important to obtain control in squamous cell carcinoma, as local recurrence is associated with an increased risk of distant metastases. The Moh's technique is time consuming and not available everywhere, but is cost effective overall.

Adjuvant Therapy in Soft Tissue Sarcoma (Dr L Weir)
The most important predictor of survival in sarcoma is complete resection with negative margins. Marginal excisions, poor incision planning, poor drain placement and incorrect biopsy techniques all decrease the cure rate. Adjuvant radiation improves local control. It is best given preoperatively as the volume is smaller, planning easier and more tissue spared. In the retroperitoneum, postoperative radiation is virtually impossible. Adjuvant chemotherapy improves survival in high-risk sarcoma. Multidisciplinary assessment, prior to biopsy, is valuable for all patients with soft tissue masses and is available through the BCCA.

Patient Decision Making in Prostate Cancer Treatment (Dr G Steinhoff)
Patient decision making in complex cancer care is extremely challenging. It is incumbent upon us to provide patients with the tools, time and assistance they need to make educated choices about their care. Dr. Steinhoff described a system that has been set up in Victoria for patients with prostate cancer.

Adjuvant Therapy in Gastric and Pancreatic Cancer (Dr B Melosky)
In gastric cancer, adjuvant chemoradiation is beneficial for patients with Stage IB or greater tumours with 35% versus 28% 4-year survival benefit. There is significant toxicity. Preoperative imaging with CT and consultation is needed for radiation planning.

For pancreatic cancer, radiation is offered for patients with positive margins. We are not using adjuvant therapy for pancreatic cancers. Treatment protocols differ around the world with the US using both chemotherapy and radiation while Europe uses chemotherapy only. Trials are ongoing but have not shown improvement in overall survival.

Surgical Management of Ovarian Cancer (Dr D Miller)
Pelvic masses in young women and children can present as an acute abdomen.

Be conservative (biopsy or unilateral oopherectomy only) as most are borderline epithelial or germ cell tumours. The latter are treatable by chemotherapy. Frozen sections are misleading. You can always go back for a second procedure if necessary. Pre-operative tumour markers (ß-HCG, AFP, LDH) can be helpful.

There is a role for surgery in women with recurrent ovarian cancer. Results are best if at least 12 months before the recurrence, the site is solitary and all disease can be removed. In patients with a small bowel obstruction, the colon should be evaluated with barium or endoscopy to rule out concurrent obstruction. Surgery for bowel obstruction is beneficial in 71% of patients, if they have an estimated survival of more than 3 months, the obstruction involves the distal small bowel or colon, and no more than 2 sites are involved (with at least one being colon). Ascites in recurrent ovarian cancer is always associated with unresectable disease. Resection of tumours in liver and spleen is beneficial.

Primary chemotherapy is being studied in ovarian cancer. Eighty percent respond and those that don't aren't helped by surgery either! Women with Stage 3 and 4 ovarian cancer do better with multidisciplinary care.

Selective Surgery in Head and Neck Cancer (Dr F Wong)
Organ preservation is replacing more traditional radical resection for squamous cell cancers. Transoral microsurgery using the CO_2 laser allows for blockwise resections and seals the lymphatics so spread is prevented. Neck dissections are also becoming more selective for better functional results without sacrifice of control.

Thanks to all the great speakers for a fascinating day!!

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Breast Cancer Symposium

April 24th 2004, Hotel Grand Pacific, Victoria, British Columbia

The focus of the Symposium is to bring breast cancer surgeons together to review interesting and controversial topics, provide a forum for skill development and allow for a review of data collected over the past year to detail where we need to be spending our energy for research, policy and process. We have taken the liberty of including a brochure and registration form with this newsletter. Additional copies of the brochure and registration form are available for download on our Website at www.bccancer.bc.ca/son.

We have an array of local and national speakers listed below. We hope that you will join us in Victoria for what promises to be a very enjoyable, informative event.

Sharon Allan - *The Relationship of Surgery, Radiation and Sytemic Therapy*
Noelle Davis - *National Perspective on Sentinel Lymph Node Biopsy*
Patricia Hassell - *New Developments in Breast Imaging*
Allen Hayashi - *Review of Practice Guidelines; Provincial Guideline Working Groups*
Charmaine Kim-Sing - *Genetics and Breast Cancer*
Greg McKinnon - *Optimal Technique in Sentinel Node Biopsy* and *Should Sentinel Node Biopsy be the Standard of Care?*
Ivo Olivotto - *Breast Cancer Outcomes in BC*
Stuart Silver - *Current Methods in Breast Biopsy*
Walley Temple - *Current Management of DCIS*
Scott Tyldesley - *Factors in Local Control after Breast Conserving Surgery*
Lorna Weir - *Intraoperative Radiotherapy (including Brachyradiotherapy)*
Don Wilson - *PET Imaging for Breast Cancer*

For more information

This newsletter is published quarterly. To submit story ideas, learn more about the BC Surgical Oncology Network or to become involved please contact:

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The Council & Network

The BC Provincial Surgical Oncology Council exists to promote and advance quality cancer surgery throughout the province by establishing an effective Network of all surgical oncology care providers and implementing specific recommendations. The Network will enable quality surgical oncology services to be integrated with the formal cancer care system. Communications to enhance decision-making, evidence-based guidelines, a high quality continuing education program, and regionally based research and outcome analyses are the initial priorities.