

# SURGICAL ONCOLOGY NETWORK

[www.bccancer.bc.ca/son](http://www.bccancer.bc.ca/son)

NEWSLETTER

September 2004

## Leading the Way: The Changing Face of Colposcopy Clinics

For the past year, the Colposcopy Clinic at Vancouver General Hospital has been using an electronic medical record, which captures information on each patient as a complete record of their visit. Dr. Tom Ehlen, one of two Gynaecologic Oncologists for the Vancouver Cancer Centre, developed the system with help from programmers experienced in writing SQL Server Software. Currently, the system is accessible from anywhere within VGH, however, as the software has been written in HTML, the language of the Internet, the system has the future potential of being available from any point on the globe. "I first had the idea of developing the system about 8 years ago," he recalls. "At the time I was looking into what it would take to create software that would allow electronic collection of colposcopy data. As we have

30 colposcopy clinics throughout BC, I decided to look at doing it in a way that it could expand to get the whole system online so that data can be captured from all areas of the province."

The creation of a SQL Server database is expensive, but provides a very high quality database for capturing large amounts of information. The VGH Colposcopy Clinic alone sees over 3000 patients per year. With the added data from the other clinics around the province, most databases would soon become too slow to manage. The financial aspect was taken care of by two sources. "A patient of mine, who I had looked after several years prior, sent me a cheque for \$100,000. Since then, this same patient has donated half a million dollars towards the database in annual installments of \$100,000." Dr. Ehlen was also contacted by the Ismaili community who "raised money for this project through a fundraising walk."

All information on the visit is entered onto the computer by the Oncologist, much as hard-copy notes would traditionally be written into the file. A high-resolution photograph of the cervix is taken, showing the area of concern. The photo can be sent with letters, generated by the system, to the Pathologist and the referring physician. The system, therefore, saves time spent on dictating and transcribing reports, lessens the margin for error as all information is inputted only once onto the system, and provides a library of teaching examples. "It has a teaching module so that when I see a patient and find that the picture that has been taken is particularly

## Prevention — Before and After Breast Cancer

Cheri Van Patten, RD MSc

Diet has a demonstrated role in cancer prevention as well as diabetes, cardiovascular disease and osteoporosis that affects many women. Emerging evidence suggests that diet may also influence breast cancer recurrence and survival.

In a 2002 review<sup>1</sup>, clinical and epidemiologic evidence concluded that body weight and diet could alter breast cancer outcome. Since 1990, obesity at diagnosis was found to have a negative, albeit modest, prognostic effect in women with breast cancer. Since that time, 17 of 26 new studies (65%) have shown that an increased body mass index (BMI) is a significant risk factor for recurrent disease, decreased survival or both. The effect of weight gain after diagnosis (a common clinical observation) is unclear, but it is known to increase psychological distress and adversely effect risk of comorbidity. Dietary fat has long been suspected in breast cancer prognosis, but well conducted studies controlling for energy (calorie) intake have shown little association. Studies evaluating vegetable consumption suggest a protective effect, although the strength of the association is modest. A fairly consistent finding in 8 studies suggests

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# From the SON

Welcome to the September 2004 issue of the SON newsletter. In this issue you will find an article on the new electronic medical record that has been implemented at the colposcopy clinic at Vancouver Hospital. This exciting new project serves as a template for the collection of electronic medical data and subsequent data analysis that can then be done. As well, there is a brief interview with the BCCA's Provincial Colposcopy Program Leader, Tom Ehlen, on page 3.

You will also find several articles on the prevention of cancer including Dr. David McLean's efforts to reduce postoperative complications due to preoperative smoking. The enclosed poster is part of Dr. McLean's work and we encourage you to consider displaying it in your waiting area or exam room. Finally, the SON sponsored a very successful breast cancer conference in Victoria this past April and on page 6, you will find a review of the symposium and its key speakers.

It is the Surgical Oncology Network's mission to support the integration and improvement in the quality of surgical cancer practice in British Columbia. We hope that the regular publication of this newsletter, in addition to our other activities, can contribute to this goal. As always your feedback and ideas are important to us. We look forward to hearing from you.

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## BCCA Library Resources for Surgical Oncology Professionals and Patients

Providers of surgical oncology care and their patients have access to a variety of library and information resources and services through the BC Cancer Agency.

Although the BCCA Library focuses on providing services and resources to BCCA clinical and research staff and to BCCA patients and their family members, the Library also extends selected resources to health care professionals and the public throughout British Columbia.

The main Library in the Vancouver Centre is open to anyone to visit or contact by telephone Monday through Friday from 8 am to 5 pm. Resources for professionals include specialized oncology journals, books and subject files. Two computers allow access to the internet. The librarians can assist health care professionals to access publicly available resources in the BCCA Library or on the BCCA website ([www.bccancer.bc.ca](http://www.bccancer.bc.ca)) or elsewhere in the Agency.

For in-depth reference service, literature searches, electronic journals, and interlibrary loan services, health care professionals not directly affiliated with BCCA are referred to other libraries such as an individual's hospital library; the Medical Library Service of the College of Physicians and Surgeons ([www.mls.cpsbc.ca/](http://www.mls.cpsbc.ca/)), the U.B.C. Life Sciences Libraries ([www.library.ubc.ca/life/](http://www.library.ubc.ca/life/)), or the Registered Nurses Association of British Columbia ([www.rnabc.bc.ca/](http://www.rnabc.bc.ca/)).

For those wanting to search the biomedical literature, PubMed ([www.pubmed.gov](http://www.pubmed.gov)) from the U.S. National Library of Medicine provides free access to Medline and more on the internet. One of PubMed's most popular features is the Clinical Queries page which uses built-in search filters to help search the database more effectively. ([www.ncbi.nlm.nih.gov/entrez/query/static/clinical.html](http://www.ncbi.nlm.nih.gov/entrez/query/static/clinical.html)). Working through the PubMed Tutorial ([www.nlm.nih.gov/bsd/pubmed\\_tutorial/m1001.html](http://www.nlm.nih.gov/bsd/pubmed_tutorial/m1001.html)) helps one to take full advantage of the resources and features of the PubMed site.

Resources for patients and families in the library include information for new patients; patient education pamphlets, lay-person level books and videos, relaxation tapes and CDs, and a Humour collection. Librarians assist patients in accessing more technical literature and other support services as needed.

At the other BCCA centres in the Fraser Valley, Victoria, and Kelowna, smaller branch libraries support agency staff and supervise the volunteer-staffed Cancer Information Centres that provide resources to patients and families.

The BCCA website ([www.bccancer.bc.ca](http://www.bccancer.bc.ca)) is the source for a great deal of information for health professionals including the Cancer Management Guidelines; the Drug Database; the Chemotherapy Protocols; various networks; and Statistics.

For patients, the website contains information on types of cancer, treatments, drugs, and supportive care, clinical trials, and unconventional cancer therapies. The Cancer Treatment page ([www.bccancer.bc.ca/PPI/CancerTreatment/Surgery/default.htm](http://www.bccancer.bc.ca/PPI/CancerTreatment/Surgery/default.htm)) includes a list of Questions to Ask Your Surgeon.

The Library webpage ([www.bccancer.bc.ca/PPI/Library](http://www.bccancer.bc.ca/PPI/Library)) provides contact information and access to the Library Catalogue through which individuals in BC can request to borrow materials.

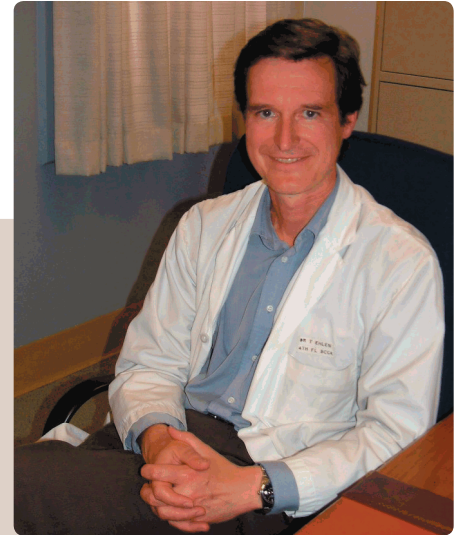
BCCA librarians select and maintain a categorized list of Recommended Links to other cancer and health websites: ([www.bccancer.bc.ca/PPI/RecommendedLinks/default.htm](http://www.bccancer.bc.ca/PPI/RecommendedLinks/default.htm)).

For more information, please contact Cathy Rayment, BCCA Provincial Library Leader, at 604-877-6000, local 2690 or the BCCA Library at 1-800-663-3333, local 2688

*by Diana Hall, Librarian, BCCA*

# Interview with Tom Ehlen

Tom Ehlen, MD PhD  
Gynaecologic Oncologist, Vancouver General Hospital  
BC Cancer Agency's Provincial Colposcopy Program Leader



*Dr. Tom Ehlen is one of two Gynaecologic Oncologists with clinics at the BC Cancer Agency in Vancouver. He has an International Baccalaureate from Wales, graduated Medical School in Frankfurt, and completed his Obs & Gynae training in Vancouver. While interviewing Dr. Ehlen about developing the colposcopy database, I took the opportunity to ask a few questions about his background.*

*What is the United World College of Atlantic, Wales?*

It is an international school that is situated in a medieval castle in a beautiful setting in the middle of nowhere on the banks of the Bristol Channel. At the time when I was there, in the early 1970's, there were over 50 different nationalities of students. It is a sixth form college (last two years of high-school) with 180 students per year. We had students there from Israel who were staying in the same dormitory as people from Palestine. The high-school exam was the International Baccalaureate, which at that time was not as common as now. Another school, based on the same template, was founded here on Vancouver Island (Lester B Pearson College of the Pacific), in 1974. Since then they have founded schools in the US, Singapore, Norway, Italy, India. The schools are all different because although it is very intensely academic, at the same time there is a very strong community service component. The only way you can get to these schools is through a government scholarship. I spent two of the most intense and best years of my life there between the ages of 16 and 18 when the world is your oyster.

*Why did you become a doctor and then specialize in Gynae Oncology?*

When I went to Atlantic College I wanted to study biochemistry but I decided that medicine with people interaction would be better. Ironically, the two areas I was determined not to go into were Dermatology and Gynaecology. I grew up in Germany and one of the options instead of doing military service was to go to a developing country as a physician. I got into premed right out of high-school and was told that in a developing country you needed to be able to do General Surgery and Obstetrics and Gynaecology. I started my year of General Surgery in Frankfurt. At about the same time I traveled to Vancouver with a couple of friends for five days and happened to run into my wife-to-be. So then I decided I was going to move to Vancouver. In my very first year in Vancouver I started my cancer agency rotation in Obstetrics and Gynaecology and felt that this was what I really wanted to do."

*Interview and colposcopy clinic article by Janet Alred*

## Colposcopy Clinics Continued from Page 1

good for teaching purposes I tick a box on the picture and the system then captures that image with all the information except the patient identifiers," explains Dr. Ehlen. "As a result, learners can go through files of thousands and thousands of cases that otherwise would not be available to them."

The Vancouver Coastal Health Authority has been so impressed by the system that they will be installing it into all colposcopy clinics in their hospitals. Hopefully, the other Health Authorities will also endorse the product, spreading the system throughout the province.

The system is unique. "We created it in such a way that we made the most use of information technology and have provided clinics with an opportunity to change workflow and enhance information capture." Ultimately, it is marketable, possibly allowing the Gynaecology Oncology division at VGH to recapture some of the investment made in its development. "The very first week we used it the clinics were running as smoothly as they did the week before, which gives you an idea of how much more smoothly they are running now."

# A Program to Address Postoperative Complications of Preoperative Smoking

by David McLean, MD, FRCPC  
Head, Cancer Prevention Programs  
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The BC Cancer Agency, in partnership with provincial Health Authorities (HA's), has developed a program to **target smokers on surgical wait lists**. The goal is to reduce postoperative morbidity and mortality, and reduce length of stay and care costs. Stopping smoking for **just eight weeks preoperatively** significantly reduces these complications.

The literature on postoperative complications arising due to preoperative smoking is conclusive: pulmonary and cardiovascular complications, as well as wound infections, are significantly more prevalent in smokers than in either non-smokers or ex-smokers. This is found to be the case across the entire spectrum of surgical specialities and settings, including ambulatory surgeries. Smoking also impairs wound healing after surgery. For example: in smokers, mastectomy flap necrosis is significantly more frequent regardless of the type of reconstruction, lumbar spinal fusion is inhibited, and the risk of anastomotic leakage after colorectal surgery is increased.

Smoking has also been identified as an independent risk factor regarding the length of time patients spend in ICU, recovery room and

ward. There appears to be a strong dose relationship between the amount of cigarette smoking and risk of postoperative ICU admission. The mean length of hospital stay was extended from 7.8 to 10.7 days in those developing postoperative chest infection, with smoking identified as the principal risk factor for such infections. One study found that of patients requiring prolonged hospitalization (>15 days) following orthopedic surgery, the ratio of smokers to non-smokers was 2:1.

Good prospective studies have shown that the risks are close to baseline if smokers stop smoking for just eight weeks prior to surgery.

Participating BC HA's are, or soon will be, asking you to record smoking status on newly revised surgical booking forms. Smokers so identified will receive information by mail that outlines the risks if they keep smoking and information about community resources to help them stop.

This summer, posters have been included with the Surgical Oncology Newsletter for general surgeons outlining the issues; posters you may chose to display in your waiting or examination rooms.

Your support for this program is essential. Fewer complications and an increased surgical volume with the same resources should be the expected outcome.

All references can be found on our website: <http://www.bccancer.bc.ca/PPI/Prevention/CaPrev/surgicalwaitlist.htm>



## External Review of the Surgical Oncology Program

This past January, a review of the Surgical Oncology Program of the BCCA/Faculty Department of Surgery/VGH was undertaken by Dr. Robert Bell (Princess Margaret Hospital, Cancer Care Ontario), Dr. Richard Nason (CancerCare Manitoba) and Dr. John Hay (Radiation Oncologist, BCCA). The reviewers were asked to provide recommendations that would enhance the role of surgical oncology in BC. They met with over 30 individuals, including Dr. Gavin Stuart, Dr. Garth Warnock, BCCA staff and members of the Surgical Oncology Network. In summary:

- The reviewers were particularly impressed with the achievements of the Surgical Oncology Network. They felt that “there has been the establishment of leadership and collegial collaboration to address key issues relating to quality of care, access, practice standards, mentoring, education, and development of practice guidelines”.

- The reviewers commented on the lack of formal surgical oncology training in general surgery. They noted that “the University Surgical leadership should recognize that surgical sub-specialty expertise must be encouraged in General Surgery and that recruitment and academic programs must follow

a sub-specialty pattern.” The reviewers recommended the creation of a surgical oncology fellowship. Such a fellowship training program would be a key element, currently missing, in bringing British Columbia to the forefront of surgical oncology worldwide. However, they noted that this would require a dedicated commitment from the University, BCCA and BC government.

- The reviewers also strongly supported the importance of academic surgical oncology. They felt that the creation of an alternative payment plan that acknowledges the extra training, complexity of surgery, clinical teaching and academic responsibilities incurred by surgeons specializing in oncologic care would be a major enabling event in establishing an academic Surgical Oncology program.

Overall, the review was positive regarding the achievements to date and, in particular, the creation of the Surgical Oncology Network. The reviewers felt that with the positive elements currently in place, and with some targeted investment, there is great opportunity to achieve excellence in surgical oncology in BC.

## CME

The last of our travelling melanoma seminars was held on July 5<sup>th</sup> in Nanaimo. Drs. Gary Kingston, Stephan Larsson, Chris Williams and Richard Robinson provided an overview of the current management of melanoma. The 2004-05 seminar series will be in the area of Head & Neck cancers, specifically the workup of the neck mass and a discussion of thyroid cancer. The first date will be October 22<sup>nd</sup> in Kelowna. Details will be finalized shortly and will be sent to all surgeons in the Interior Health Authority in September. The SON will once again be hosting a surgical oncology program at the annual BCCA conference in November. Details can be found at the back of this newsletter.

## Clinical Practice

The SON has developed an infrastructure survey that will be sent out to health care facilities around the province. The survey will collect information on the equipment, services, resources and staff available in each location. The questionnaire is currently being trialled and we plan to send it out by late September. The information gathered will assist in developing guidelines and planning for surgical capacity.

## Research and Outcomes Evaluation

Murray Mackinnon, our biostatistician, has left the SON to take on a position with Population & Preventive Oncology at the BC Cancer Agency. Murray has been an invaluable resource for the SON and, although we will miss him, we wish him all the best in his new position. We are currently in the process of hiring Murray's replacement and hope to have the position filled in September. We will then be able to continue updating our Surgical Atlas.

## Surgeon Information System Working Group

This group continues to meet regularly. The SFU MBA students presented the findings of their research projects at a meeting in April. Since then, we have developed Request for Proposals (RFPs) for two projects. The first is to develop an electronic version of the rectal cancer project template. This will allow surgeons to participate in the rectal cancer monitoring project by entering their data online (either directly or via PDA). The second

project is a redevelopment of the SON website. The website will include a surgeons-only portal that will give surgeons password protected access to additional features such as discussion forums and a customizable search feature for the surgical atlas.

## Surgical Tumour Groups

### Breast

The Breast STG is currently in the process of developing its second practice guideline on Sentinel Lymph Biopsy as a stand-alone procedure.

### Colorectal

Terry Phang has had an abstract, *BC Rectal Cancer Project Update May 2004*, accepted for the 2004 CAGS (Canadian Association of General Surgery) conference.

### Gastrointestinal

Dr. Greg McGregor has agreed to chair this STG.

## Naming the Newsletter

Are we ever going to name this newsletter? If you have any suggestions for names that would help our newsletter stand out, give it an identity, and in some clever way describe its contents, please contact the Surgical Oncology Network at [son@bccancer.bc.ca](mailto:son@bccancer.bc.ca) or by calling 604 707-5900 ext. 3269. Just to get you started, here are some suggestions:

“Getting to the Point”, “The Knife’s Edge”, or, better still, “Scraping the Barrel”.

If we select your idea, there will be a prize. We look forward to hearing from you.

# Breast Cancer Symposium Review

On April 24, 2004, just under a hundred participants from around the province attended the Surgical Oncology Network's Breast Cancer Symposium in Victoria. This meeting was organized under the able leadership of Dr. Allen Hayashi, Chair of the Breast Surgical Tumour Group. Prominent provincial and national experts provided an intense but very relevant one-day refresher in the management of breast cancer.

Dr. Rona Cheifetz distributed a pre-and post-test to ensure that we were all paying attention. Following breakfast, Dr. Ivo Olivotto provided a summary of breast cancer outcomes in British Columbia noting that there has been a 20% survival gain since 1990. Dr. Charmaine Kim-Sing reviewed the genetics of breast cancer and the various cancer family syndromes, highlighting the excellent resource that has been created in the hereditary cancer program within the BC Cancer Agency. Dr. Noelle Davis reviewed the current status with respect to Sentinel Lymph Node mapping, summarizing the national experience and comparable international data. The main message of the first sessions was that surgeon and institutional volume remain critical predictors of success.

The next group of speakers provided updates in breast imaging. Dr. Stuart Silver reviewed Victoria's experience using image-guided breast biopsy and provided an overview of the technique used for minimally invasive diagnosis of breast malignancy. He emphasized the importance of concordance between the imaging abnormality and the core biopsy histology. Dr. Pat Hassell reviewed the newer developments in breast imaging including MRI, PET and ultrasound. Dr. Don Wilson also reviewed PET imaging in breast cancer. Participants heard that MRI is not a substitute for mammography or ultrasound and has no proven efficacy as a screening tool in general. However, it is valuable in the evaluation of the difficult mammogram or for patients with metastatic disease and an occult primary. The sensitivity of PET scanning is dependent on size of the lesion. At the

moment, it cannot be recommended for initial axillary staging. It is most useful in the assessment of recurrent or metastatic disease.

Dr. Walley Temple, a nationally recognized surgical oncologist from the Tom Baker Cancer Centre in Calgary, spoke about current management of ductal carcinoma in situ (DCIS). He emphasized that DCIS is a heterogeneous lesion of variable malignant potential. The risk of relapse was greatly dependent on the margins and the volume of breast tissue excised. Other factors include younger patient age and the grade of the disease. Local recurrence remains a big problem with this disease. Although radiotherapy decreases local recurrence by 50%, rates are still lowest after mastectomy for high risk patients. There is no role for standard axillary lymph node dissection in DCIS.

Dr. Scott Tyldesley reviewed risk factors for local recurrence after breast conserving surgery for invasive cancer. He emphasized that boost radiation does not compensate for margins less than 2 mm and that re-excision should be performed in these cases. Dr. Lorna Weir reviewed current modalities of localized radiation including brachytherapy and intraoperative radiotherapy. Advantages include shorter treatment courses. Disadvantages include the infrastructure required and the need for a very high non-fractionated dose of radiotherapy.

Dr. Sharon Allen reviewed current concepts in systemic therapy of breast cancer. Successive improvements in guidelines for systemic therapy have helped to improve the survival from breast cancer over time. The role of aromatase inhibitors, representing first-line therapy in advanced disease, was also reviewed. There are few completed studies and all have fairly short follow-up periods. A modest improvement in disease free survival has been shown when these drugs are given after an initial course of Tamoxifen. There has been no change in overall survival found. Tamoxifen for five years after curative treatment of breast cancer remains the standard of care.

The cost of aromatase inhibitors is not currently covered in British Columbia but may be available for those patients who cannot tolerate Tamoxifen. Aromatase inhibitors appear to decrease bone density but have a lower level of cardiovascular and thrombotic risk than tamoxifen. A number of trials are ongoing.

A second national guest started the afternoon. Dr. Greg McKinnon is a surgical oncologist at the University of Calgary. He spoke about the optimal technique for sentinel node biopsy and whether this is the standard of care in breast cancer. He emphasized the systematic approach needed to accomplish the procedure safely and accurately. He reviewed the variable definitions of the sentinel node. The appropriate approach to the positive sentinel node was discussed. Completion axillary dissection remains the standard of care though the prognostic value of micrometastases remains controversial. He felt the use of sentinel node biopsy was acceptable in the management of breast cancer but generally a positive sentinel node biopsy should still be followed by a standard axillary dissection.

Dr. Hayashi reviewed the Provincial Guidelines for Lymphatic Mapping and Sentinel Node Biopsy for Breast Cancer published by the Breast Cancer Surgical Tumour Group. The audience then divided into working groups to discuss the role of sentinel node biopsy. Different groups considered patient factors, surgeon factors, and institutional factors and presented their findings to the audience. The Breast Cancer Surgical Tumour Group will use these findings and recommendations to develop further guidelines for Sentinel Node Biopsy.

The content and quality of the day's information and discussion was excellent and my sense was that the participants were very pleased with the conference. Overall, participants gave the conference a rating of 3.38 out of 4. The organizers and presenters are to be congratulated on a very fine effort indeed.

*Reviewed by Blair Rudston-Brown,  
General Surgeon, Nanaimo*

# Prevention... Continued from Page 1

that alcohol may not increase risk of recurrence or overall survival after the diagnosis of breast cancer despite its role in increasing the risk of developing breast cancer.

In late 2006, oncology experts can expect the role of diet in breast cancer recurrence and survival to be elucidated by two large scale randomized trials that have enrolled over 5,000 women with early stage breast cancer. These two U.S. studies are evaluating the effect of a low fat diet alone (WINS Study) or a low fat diet plus 8 servings of fruits and vegetable and 30 grams of fibre (WHEL Study) over a period of at least six years.

<sup>1</sup>Rock CL and Demark-Wahnefried W. Journal of Clinical Oncology 15: 3302-3316, 2002.

Nutrition has been widely studied as a leading environmental factor in the prevention of breast cancer (BC). Despite the challenges in relating consumption of specific nutrients to BC risk, particularly in the context of a total diet, many investigators have contributed valuable information. Dietary fat has received the most attention and also created the most uncertainty. Specific types of fat, particularly monounsaturated fat and the ratio of omega-3 to omega-6 fatty acids, demonstrate more potential to influence BC risk. A wide variety of other dietary factors have been studied in relation to BC including total energy, dietary fiber, alcohol, micronutrients, phytochemicals, specific foods, and food constituents. Results of epidemiological studies relating consumption of these dietary factors to BC have increased the knowledge base that provides rationale for various nutritional strategies to contribute to BC prevention.

*Abstract and table (below) from: Duncan AM: The Role of Nutrition in the Prevention of Breast Cancer. AACN Clinical Issues, 15(1):119-135, 2004.*

## Summary of Evidence for a Role of Nutrition in the Prevention of Breast Cancer (BC)

<b>Nutrient/Dietary Constituent</b>	<b>Summary Comments</b>
Dietary Fat	Conflicting evidence relating dietary fat to BC risk has shifted focus to specific types of fat, where more consistency has been demonstrated for increasing amounts of omega-3 and monounsaturated fatty acids in the prevention of breast cancer.
Energy	Obesity, used as a surrogate for energy intake, is dependent on menopausal status in its relationship with BC; obesity is associated with increased BC risk in postmenopausal women and decreased BC risk in premenopausal women.
Dietary Fiber	Despite convincing data of a mechanistic role of dietary fiber in the prevention of BC through decreased estrogen exposure, human studies linking dietary fiber and BC have produced inconsistent results.
Alcohol	Studies consistently provide clear support for a role of alcohol consumption in the elevation of BC risk.
Micronutrients	Several micronutrients have been studied in relation to BC risk, with most attention toward those with antioxidant properties as well as the B vitamins folate. Although data are inconsistent, some support exists for a role of consuming carotenoids and folate in the prevention of BC.
Phytochemicals	The contribution of phytochemicals to the prevention of BC is a rapidly growing area of research. Some studies show support for a role of phytoestrogens in BC prevention; however, more research is needed before definitive conclusions can be made.
Specific Foods and Food Constituents	Consumption of fruits and vegetables appear to protect against BC; data are less consistent for consumption of meat; and there appears to be no significant relationship between consumption of caffeine and BC risk.

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## BCCA SON Conference

Join us for the 2004 BCCA Annual Conference, 25th - 27th November 2004, featuring the Surgical Oncology Update "Controversies in Breast Cancer Care for the Surgeon" on Saturday 27th November.

If you are interested in attending, please visit our CME website at [www.bccancer.bc.ca/son](http://www.bccancer.bc.ca/son) for updates, registration and speaker information. We look forward to you joining us for this annual event at the Westin-Bayshore Hotel, Vancouver. Selected SON topics include:

### Management of the Axilla

- *Contraindications to Sentinel Node Biopsy*
- *Guidelines for Stand-Alone Sentinel Node Biopsy*
- *Axillary Recurrences*

### Controversies in the Management of Breast Cancer

- *Premalignant Lesions*
- *Cancer in Pregnancy*
- *Cancer in the Elderly and Infirm*
- *Locally Advanced Breast Cancer*

### Complications Following Breast Cancer Surgery

- *Breast Complications: Infections, Edema and Flap Necrosis*
- *Axillary Complication: Chronic Pain, Lymphedema and Stiffness*

Case based discussions will be featured throughout the day.

## Call For Posters: BCCA Conference

We hope to have a large contingent of SON posters on display at this year's conference. Please consider submitting any study that has either not been presented before, or that has been presented in the past year. If you require assistance with creating your poster, please contact the SON at [son@bccancer.bc.ca](mailto:son@bccancer.bc.ca). We would be happy to help.

Abstracts must describe the objectives and results so that the quality, originality and completeness of the work can be evaluated. Each abstract must contain: Objective, Design, Materials & Method, Results, Conclusion. An individual may present more than one abstract.

More information, and online submission is available at the following website: <http://www.bccancer.bc.ca/HPI/ACC2004/Posters.htm>.

Deadline for submission of your abstract is Friday, 24th September. Accepted abstract presenters will be notified by the poster session organizers.

## For more information

This newsletter is published three times a year.

To submit story ideas, learn more about the BC Surgical Oncology Network or to become involved please contact:

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Visit the SON Website:

[www.bccancer.bc.ca/son](http://www.bccancer.bc.ca/son)  
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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.