

## Education Update: Empowering Primary Care to Deliver Cancer Care Across the Continuum

By Dr. Sian Shuel,  
Medical Education Lead, FPON

The BC Cancer Primary Care Program's Family Practice Oncology Network consistently adapts to meet the dynamic educational needs of primary care providers (PCPs) and general practitioners in oncology (GPOs), supporting the delivery of high-quality cancer care close to home. Educational activities are informed by ongoing participant feedback from events and FPON working groups, as well as through incorporating the latest developments in cancer care. Here's an update of the Program's activities since the latest Fall 2025 Journal was published.

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## Recognizing Oncologic Emergencies in the Primary Care Setting – Part 1

By Dr. Sian Shuel, GP in Oncology  
Medical Education Lead, FPON

Patients with cancer frequently present to primary care providers with symptoms related to treatment toxicity or disease progression. A subset of presentations represents time-sensitive oncologic emergencies, and delayed recognition may lead to significant morbidity or mortality.

This article, the first in a 2-part series, reviews two oncologic emergencies, namely febrile neutropenia and malignant spinal cord compression, and outlines key recognition and early management strategies in the outpatient primary care setting.



Dr. Sian Shuel

### Febrile Neutropenia

Febrile Neutropenia is defined as a fever  $\geq 38.3^{\circ}\text{C}$  once or  $\geq 38.0^{\circ}\text{C}$  for more than 1 hour, with an absolute neutrophil count (ANC) less than  $0.5 \times 10^9 / \text{L}$  (or less than  $1 \times 10^9 / \text{L}$  with expected further decline).<sup>1</sup> Febrile neutropenia is an oncologic emergency as decreased neutrophil production results in an impaired immune response to bacterial infections.<sup>2</sup> As a result, infection can progress

rapidly, and the risk of sepsis is 10-15% in patients with febrile neutropenia. Rapid assessment and initiation of empiric broad-spectrum antibiotics are critical.

Febrile neutropenia should be considered in anyone with fever within six weeks of receiving cancer therapy, including but not limited to chemotherapy, select targeted therapy, radiation (especially to large areas of bone), CAR-T Therapy, and bispecific antibody therapy. Patients with hematologic malignancies (lymphoma, myeloma) are also at a particularly high risk of febrile neutropenia.

In the absence of an alternate explanation, primary care providers should assume that fever in a patient with neutropenia from cancer therapy is the result of infection.<sup>3</sup> In addition to fever, cancer diagnosis and timing of recent cancer therapy, the history and physical exam focus on identifying potential infectious foci (Box 1 & Box 2). Vascular access devices are common in patients undergoing cancer therapy and should be examined as a potential source of infection. While assessing

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While links to all our educational offerings can be found on our website FPON.ca, to improve our ability to communicate with community providers and healthcare partners about the latest Family Practice Oncology Network (FPON) news, educational updates, practice gems and other BC Cancer Primary Care communications including information on the electronic publishing of the twice-yearly Journal, please scan the QR code to sign up for our communications database.

Questions? Please contact us at [fpon@bccancer.bc.ca](mailto:fpon@bccancer.bc.ca)

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for perianal tenderness is important in identifying a potential source of infection, rectal exams are contraindicated due to the risk of introducing bacteria across mucosal barriers, which can precipitate bacteremia or sepsis.<sup>3</sup> Primary care providers should also review recent labs if available.

### Box 1 History in the Primary Care Office

- Chills
- Sore throat
- Cough
- Dyspnea
- Abdominal pain
- Diarrhea
- Vascular access devices

### Box 2 Physical Exam in the Primary Care Office

- Vitals (fever, hypotension, tachycardia)
- Oropharynx
- Chest
- Heart sounds
- Abdo exam
- Skin (ulcerations, induration, vesicular lesions, vascular access devices)
- Perianal tenderness
- Rectal exam contraindicated

If febrile neutropenia is suspected, patients should be urgently referred to the emergency department for source investigations and treatment. The management goal is to start empiric IV antibiotics within one hour of presentation.<sup>1</sup> The patient's oncologist will also want to be notified. BC Cancer has a helpful point-of-care resource to risk-stratify and help determine ongoing management (inpatient vs. outpatient).

Point of Care Resource: [BC Cancer Febrile Neutropenia Assessment and Antibiotic Treatment for Adults with Cancer Excluding Leukemia / BMT / CAR-T](#)

## Malignant Spinal Cord Compression

Malignant spinal cord compression (MSCC) occurs when a tumour presses on the

spinal cord<sup>4</sup> or when a vertebral body containing metastatic disease collapses or is compressed, disrupting normal cord function and leading to neurologic deficits. MSCC is considered an oncologic emergency because earlier recognition and intervention are associated with improved outcomes. A delay in diagnosis can lead to irreversible neurologic injury and an impact on quality of life. While almost all tumours can cause MSCC, it is most commonly seen in metastatic lung, breast and prostate cancers. Clinical presentation is often non-specific, so thorough evaluation and a high index of suspicion are important.<sup>5</sup> The most common symptom of MSCC is new or worsening back pain, present in between 83% and 95% of patients with MSCC.

In the primary care office, the history and physical exam focus on the presence of pain and neurologic symptoms (Box 3 & Box 4). Gait assessment is particularly important as a more severe gait impairment is correlated with a higher degree of spinal cord damage and often more extensive cord compression. The ability to walk is also a critical prognostic factor for long-term functional outcomes and the potential to return to daily activities.<sup>6</sup>

### Box 3 History in the Primary Care Office

- New or worsening back pain (83-95%)
- Radicular pain
- Limb weakness
- Paresthesias or sensory loss
- Bowel or bladder dysfunction

### Box 4 Physical Exam in the Primary Care Office

- Spinal percussion / palpation
- Strength
- Sensation
- Deep tendon reflexes
- Rectal sphincter tone and perianal sensation
- Gait assessment<sup>6</sup>

If MSCC is suspected, speak directly with a radiologist to arrange urgent imaging of the entire spine. Focusing on one area of the spine is known to miss more than 20% of cases. While an MRI is preferred, a contrast-enhanced CT scan may be more readily available and timely. Upon diagnosis

of MSCC, patients should be referred emergently to the on-call neurosurgeon.

A 2005 study published in *The Lancet Oncology* journal compared direct decompressive surgery plus postoperative radiation therapy to radiation alone. They found that more patients in the surgery group were able to walk after treatment compared to the radiotherapy-alone group (84% vs 57%) and more regained their ability to walk (62% vs 19%). The need for steroids and opioids was significantly reduced in the surgical group.<sup>7</sup>

Definitive treatment of MSCC depends on the clinical situation, including spinal stability, the degree of cord compression, and the tumour's sensitivity to radiation or systemic therapy. Initial therapy should also include dexamethasone (plus a proton pump inhibitor), which is thought to reduce vasogenic edema, help alleviate pain and preserve neurologic function.<sup>8</sup> Pain management, often including opioids, is also important.

Primary care providers are integral to the early detection of oncologic emergencies. Rapid recognition and timely coordination with emergency and oncology services substantially improve outcomes.

## References

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# BC Cancer and the Community Oncology Network – Caring for our patients and the planet

Dr. Cheryl Ho, Provincial Medical Director Systemic Therapy Implementation and Sustainment at BC Cancer

The Community Oncology Network (CON) partners with BC Cancer's six regional centres to make cancer care accessible all across British Columbia. With 31 locations spread out over nearly a million square kilometers, the CON helps patients get treatment close to home.

BC is split into five health regions, each with its own unique geography and population:

- Island Health: Covers Vancouver Island and nearby areas, serving over 900,000 people across 56,000 km<sup>2</sup>. Available CON sites include Campbell River, Courtenay, Nanaimo and Duncan.



Dr. Cheryl Ho

- Vancouver Coastal Health: Includes urban Vancouver, Richmond, and the North Shore,—1.25 million people in 54,000 km<sup>2</sup>. Providence Health Care falls within this region and care is provided through St. Paul's Hospital. Patients can receive cancer treatments in Powell River, Squamish, Sechelt, North Vancouver and Richmond.
  - Fraser Health: Stretches through the Fraser Valley and Lower Mainland, home to 1.9 million people in 15,700 km<sup>2</sup>. Fraser Health is served by two BC Cancer centres, Surrey and Abbotsford, and two CON sites in Burnaby and Maple Ridge.
- Interior Health: Runs from Williams Lake down to the US border, with nearly 900,000 residents over 213,500 km<sup>2</sup>.

With 10 CON sites, Salmon Arm, Williams Lake, 100 Mile, Kamloops, Vernon, Penticton, Nelson, Cranbrook, Trail and Grand Forks it serves a number of smaller communities.

- Northern Health: Covers the vast northern interior—600,000 km<sup>2</sup> with 290,000 people and 9 CON sites offering treatment in Smithers, Terrace, Prince Rupert, Kitimat, Haida Gwaii, Fort St. John, Dawson Creek, Vanderhoof and Quesnel.

By offering care closer to where people live, the CON makes the cancer journey easier and is better for the environment. Patients travel less, which means a smaller carbon footprint. To understand the difference, we looked at how many IV treatments were given in 2024/25 and calculated the travel saved and the environmental equivalent.

Getting cancer treatment at a local CON site makes a difference for patients. Many have shared how much they appreciate being able to stay close to home, surrounded by family and friends who can support them. For those who are able to keep working during treatment, having care nearby is a game-changer—it means they can keep up with their routines and responsibilities. Not having to travel long distances to a regional centre helps ease the financial stress that often comes with cancer care.

BC Cancer in partnership with the CON reduces the geographic challenge of cancer care. With almost half of systemic cancer care delivered at the CON sites, the network is an invaluable connection that is better for our patients and the environment.

Health Authority	km of car travel saved annually	Metric tonnes of CO2 equivalent	Comparable use
Island Health	5.40 million	1,325	1 year of energy for 178 homes
Vancouver Coastal	715,956	175	2,894 tree seedlings grown for 10 years
Fraser Health	312,934	77	Volume of 77 Olympic swimming pools
Interior Health	8.96 million	2,199	186,929 trash bags recycled instead of landfilled
Northern Health	4.46 million	1,094	88 million smart phones fully charged

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Building on these ongoing improvements, the last few years have seen consistent growth in registration at the virtual didactic **Clinical Practitioner in Oncology (CPO) Education Program**. This program is designed for newly hired GPOs working within a Community Oncology Network site and GPOs and NPs within a BC Cancer Centre. It helps facilitate cancer care in many geographical locations across the province, from Fort St. John in the North to Daajing Giids in the West, to Victoria in the South, and to Cranbrook in the East. CPO Education continues to attract attendees from across Canada and serves as a twice-yearly forum for educational updates for the more than 170 GPOs across BC, as well as BC Cancer Nurse Practitioner and Associate Physician colleagues.

Next, GPOs from BC and beyond gathered virtually in January for the **GPO Focused Webcast on Multiple Myeloma Management**. Once again, hosted in the evening, the session offered educational insights, practical advice, and a comprehensive review. As part of BC's Cancer Action Plan for GPO stabilization, it enabled attendees to connect and earn MainPro+ credits. Educational events such as this are needed to maintain BC Medical Quality Initiative's CPO Privileges, which require BC GPOs to accumulate an average of 10 credit hours per year. The slides and webcast recording are now in the fpon.ca resource library. The next complimentary, accredited GPO Focused Webcast, entitled *Overview of Ovarian Cancer Management for the GPO*, will be on Thursday, April 23rd, 6:45–8 PM. Register [here](#).

In terms of regular communication, FPON's **GPO News for a Friday** reaches GPOs' inboxes monthly, and includes BC Cancer's Systemic Therapy Updates, upcoming educational events, relevant journal articles, and much more. This monthly contact also encourages GPOs to contact FPON directly, an invitation that is frequently accepted. FPON delivers similar monthly **News for a Friday** to BC Cancer's Nurse Practitioners and Associate Physicians.

Furthermore, the **GPO Case Study Day**, offered on the Saturday of the BC Cancer Summit, provides another opportunity for GPOs to acquire knowledge and connect without being taken out of their

clinics during the work week. The event enables collaboration between GPO and specialist speakers on topics central to GPOs' practices and collects feedback on future educational needs. GPO Case Study Day remains an annual hybrid event, ensuring equitable access to this education for GPOs in rural and remote areas and for those unable to leave their communities due to clinical responsibilities.

Are you interested in learning more about GPO work? FPON partners with the UBC Department of Family Practice to connect family medicine residents with preceptors for a two-week **GP in Oncology Focused Family Medicine Elective**. Also, second-year UBC medical students may request to be paired with GPOs for **Focused Family Practice Exposures**. If you are a learner interested in these opportunities, please email [fpon@bccancer.bc.ca](mailto:fpon@bccancer.bc.ca) If you are a family physician interested in expanding your career to include GPO work, please email [careers@phsa.ca](mailto:careers@phsa.ca)

Many GPOs across the province also serve as community family physicians. BC Cancer's FPON provides ongoing educational support to family physicians and other primary care providers. **FPON's webcast series for primary care** offers complimentary, accredited, almost monthly learning opportunities in cancer care. Recent topics included *Recognizing Hematologic Malignancies in Primary Care*, *Breast Cancer Screening and Breast Density*, *Neuroendocrine Tumours for Primary Care*, and *Sexual Health in Cancer Care*. Access recordings and slides in the FPON resource library at [fpon.ca](http://fpon.ca). Register [here](#) for the upcoming *Trauma-Informed Cancer Care* webcast on April 16th, 8–9 AM .

April is Daffodil Month for Cancer Awareness and will feature **FPON's Annual Education Day for Primary Care Providers** on Saturday, April 11th. Primary care providers are key in identifying treatment-related toxicities when patients present with symptoms. With expanding therapy options, this year's *Cancer Treatment Related Toxicities: Practical Pearls*

for *Primary Care Providers* helps providers recognize toxicities and collaborate with oncology colleagues on next steps. Access the agenda and register [here](#).

Another opportunity for primary care to connect with oncology colleagues is the **BC Cancer Primary Care Program's Regional Education, Engagement and Collaboration Sessions**. Based on the accredited online **BC Cancer Primary Care Learning Sessions**, these five events bring together an oncologist, a GPO, and primary care providers from each health authority in British Columbia. Teams located in Vancouver Coastal, Interior, Fraser, and Northern Health catchment areas have independently convened over the past two months to learn, exchange resources, and discuss ways to strengthen care and collaboration within their regions. The session for teams located in the Island Health catchment will be held on April 30th, 5:30 PM – 7:30 PM. More details and registration information are available [here](#).

At the provincial level, engagement with primary care continues as a working group of primary care providers, oncologists, GPOs, a representative from PathwaysBC, data and analytics, and more, collaborates on a **Transition of Care Framework**. The goal is to enhance support for primary care providers to manage patients who have completed their cancer treatment and are transitioning back to primary care through consistent information sharing and clarity of care needs.

In summary, these initiatives convey a coordinated, province-wide approach to strengthen oncology capacity within primary care and help ensure patients can access safe, high-quality cancer care closer to home. Through education, collaboration, and system integration, BC Cancer's Primary Care Program continues to support workforce sustainability, equitable access across urban, rural, and remote communities, and the continuum between community and specialist care.

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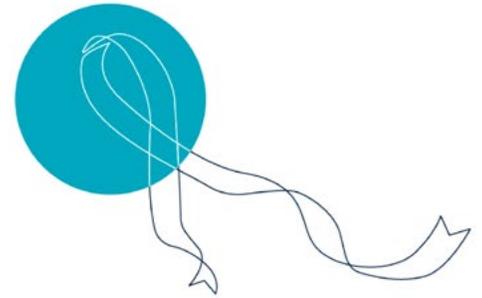
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# FPON's Annual Education Day - Cancer Treatment Related Toxicities: Practical Pearls for Primary Care Providers



Register

## Overview

When patients with cancer present to the office with symptoms, primary care providers play a key role in identifying treatment-related toxicities. With more therapy options than ever before, join FPON for this year's Annual Education Day, designed to help primary care providers recognize treatment-related toxicities and consider next steps in the primary care office setting while connecting with their oncology colleagues. Each interactive session will include 30 minutes of practical knowledge followed by 15 minutes of Q&A.



**Saturday, April 11, 2026** All times below in Pacific Time.

TIME	PRESENTATION	SPEAKER
8:00am	Welcome & Opening Remarks	Dr. Sian Shuel Dr. Paris Ingledew
8:15am	<b>Cytotoxic Chemotherapy and Beyond - Clinical Gems for Supporting Patients in Primary Care</b>	<b>Dr. Howard Lim</b>
9:00am	<b>Targeted Cancer Therapy - Office Pearls for Primary Care</b>	<b>Dr. Guliz Ozgun</b>
9:45am	<b>Immune Checkpoint Inhibitors - Recognizing Acute Issues and Navigating Chronic Toxicities</b>	<b>Dr. Peter Bull</b>
10:30am	15-Min Break	
10:45am	<b>Hormone Therapy for Prostate Cancer: Practical Primary Care Strategies to Mitigate Side Effects</b>	<b>Dr. Corinne Maurice-Dror</b>
11:05am	<b>Hormone Therapy for Breast Cancer: Practical Primary Care Strategies to Mitigate Side Effects</b>	<b>Dr. Emily Jackson</b>
11:30am	<b>Skin, Bladder, and Bowel: Addressing the Spectrum of Radiation Side Effects</b>	<b>Dr. Hamid Raziee</b>
12:15am	<b>Cancer Associated Thrombosis for Primary Care Providers</b>	<b>Dr. Erica Peterson</b>
1:00pm	Closing Remarks & Completion of Evaluations	Dr. Catherine Clelland
1:15pm	Conference Ends	

# Survivorship care: resources and support beyond cancer treatment

By Elena Popova,  
BC Cancer Clinical Librarian

Survivorship care marks the transition from active cancer treatment back to primary care and focuses on supporting patients as they adjust to life after treatment. BC Cancer describes survivorship as the link between treatment and recovery, emphasizing that patients often face a “new normal” that includes ongoing physical, emotional, and practical challenges. Follow-up care becomes the responsibility of the primary care provider, who monitors late or long-term effects, manages symptoms, addresses psychosocial needs, and coordinates supportive care.



Elena Popova

## How the BC Cancer Library supports survivors

The BC Cancer Library provides reliable, patient-friendly information that supports understanding and empowerment throughout survivorship. After discharge to primary care, patients often have questions about long-term side effects, recurrence risk, lifestyle changes, mental health, and available community support. The library guides them toward evidence-informed resources, survivorship education materials, and self-management tools that align with BC Cancer recommendations.

While many BC Cancer services are no longer available to patients once their active treatment is complete, BC Cancer Library remains open to anyone living in B.C. or Yukon at any stage of their journey.

### Practical support for survivors and clinicians

Below are local and online tools and resources designed to help manage survivorship issues, based on established survivorship programs.

#### BC Cancer resources

- **BC Cancer: Survivorship & Primary Care hub** – resources for clinicians and patients.
- **The Late Effects, Assessment and Follow-Up (LEAF) clinic** for adults who have survived childhood cancer.
- **Pain & Symptom Management / Palliative Care** clinics available at each BC Cancer centre.
- **Library Pathfinders** – curated lists of books, eBooks, websites and support programs:
  - **Life After Cancer**
  - **Lymphedema**
  - **Managing Stress, Anxiety and Depression**
  - **Fatigue and Sleep**
  - **Exercise and Fitness**

#### Canadian and US resources

##### Survivorship care plans (SCPs)

Survivorship care plans provide a summary of

treatment history and a roadmap for follow up care, helping patients and primary care providers navigate long term needs.

- **ASCO survivorship care plan templates** include disease specific tools for breast, colorectal, lung, prostate, and lymphoma survivors, supporting communication and coordination after treatment.
- **Journey Forward survivorship care plan builder** and **Oncolife survivorship care plan** allow patients and clinicians to create personalized plans outlining follow-up steps, symptom monitoring, and lifestyle recommendations.

##### Patient education & self management tools

Educational resources help survivors understand late effects, manage symptoms, and make informed decisions about their health.

- The **Survivorship checklist** from the National Coalition for Cancer Survivorship (NCCS) guides patients through key issues at each stage of survivorship, and prepares them to ask the right questions.
- **ACCC cancer survivorship resources** webpage provides self advocacy tools, especially helpful in navigating psychosocial, financial, and practical concerns.
- **Breast cancer survivorship tool** – facilitating breast cancer survivorship care for family physicians and patients. Canadian Family Physician (the official journal of the College of Family Physicians of Canada).

##### Guidelines and clinical decision tools for providers and patients

Clinical guidelines help primary care providers manage the complexities of survivorship care. Guidelines for patients offer plain-language information useful for both clinicians and survivors.

- **ASCO's survivorship care guidelines for clinicians** and associated guideline compendiums provide evidence based recommendations for long-term patient care.
- NCCN guidelines for patients: **Survivorship care for health living** and **Survivorship care for cancer-related late and long-term effects**.
- **NCCN guidelines for clinicians** (free account required)

## Common survivorship challenges

### Ongoing physical and symptom related issues

Many survivors continue to experience persistent symptoms after treatment, including pain, fatigue, organ or cardiovascular damage, infertility, osteoporosis, lymphedema, and changes in vision or hearing. These long-term effects often require continued management in primary care.

### Psychosocial and emotional challenges

Survivors frequently face anxiety, depression, fear of recurrence, cognitive challenges (e.g., chemobrain) and other psychosocial concerns. Emotional well being may require targeted support. However, many patients report difficulty accessing appropriate resources or guidance once active treatment ends.

### Lifestyle and health behavior adjustments

Life after treatment often involves adapting to new expectations related to exercise, nutrition, fatigue management, sexual health, and overall wellness planning. Without structured survivorship support, these lifestyle changes can be difficult, and many survivors benefit from guidance on integrating healthy behaviours into daily life.

# Corridor Consult: Breast Screening in BC

By Charlotte Yong-Hing MD FRCPC  
Medical Director, BC Breast Screening  
Program, Clinical Associate Professor &  
Vice Chair Equity, Diversity and Inclusion,  
Radiology, UBC

In Canada, breast cancer is the most commonly diagnosed cancer among those assigned female at birth (25%) and the second leading cause of cancer death (14%).<sup>1</sup> Fortunately, when breast cancer is detected early through organized population-based breast screening, there is a better chance for successful treatment and survival. Screening mammograms are considered the international gold standard for detecting breast cancer early.

In BC, most women and many Two-Spirit, transgender and non-binary people ages 40 and older can get a screening mammogram. Health care providers play a significant role in supporting patients' participation in breast screening, including helping patients determine whether they are eligible for a screening mammogram, supporting their decision to get screened if eligible, and encouraging adherence to follow-up testing and to return for screening when due. It also includes answering questions about the provincial screening guidelines and follow-up recommendations. Some of the common questions we have heard from health care providers are:

## 1. Does family or personal history of other cancers (ovarian, uterine, prostate, colon, pancreatic) move someone to the high-risk category for annual screening?

Having a family history of breast, ovarian, prostate and/or pancreatic cancer can be associated with genetic mutations (such as BRCA1, BRCA2, PALB2) and increased breast cancer risk.<sup>2</sup> The BC Cancer Breast Screening guidelines define higher-than-average risk as having one first-degree relative with breast cancer, which qualifies for annual screening.<sup>3</sup> For patients with family histories of other cancers that suggest hereditary cancer syndromes, genetic counseling and risk assessment should be considered. The [BC Cancer Breast Screening Referral Algorithm](#)

can help determine appropriate referral paths. Risk models (e.g., Tyrer-Cuzick) may help stratify borderline cases.

## 2. If a patient has a first-degree relative diagnosed with breast cancer before age 50, should they start getting screening mammograms 10 years earlier than the relative's age at diagnosis?



Dr. Charlotte Yong-Hing

The widely cited "10 years earlier" recommendation has limited evidence supporting its use in breast screening.<sup>4</sup> Current practice often suggests screening 5 to 10 years before the youngest affected family member's age at diagnosis for those with a strong family history.<sup>5</sup> The BC Cancer Breast Screening Program's guidelines do not apply the 10-year criteria but instead focus on annual

screening for those with a first-degree relative with breast cancer. For patients at higher risk for breast cancer, specific starting ages should be individualized through patient discussion and may warrant referral to [BC Cancer's High Risk Clinic](#) for comprehensive assessment.

## 3. For patients who have had chest radiation before age 30, when should screening mammograms begin?

The BC Cancer Breast Screening Program has specific evidence-based guidelines for patients who have had chest radiation before age 30. For those who received mantle radiation for Hodgkin lymphoma, research recommends both annual breast MRI and annual screening mammography should start at age 30 or 10 years after radiation treatment (whichever is later) and continue until age 65.<sup>6</sup>

For patients enrolled in [BC Cancer's LEAF \(Late Effects Assessment and Follow-Up\) Clinic](#), which provides surveillance for individuals at high risk due to chest radiation received before age 30, screening mammography can begin as early as age 25, depending on individual circumstances and timing of radiation exposure. The LEAF Clinic provides coordinated, specialized screening for this high-risk population, combining both MRI and mammography for optimal surveillance.

Primary care providers should refer appropriate patients to the LEAF Program for comprehensive risk assessment and coordinated screening rather than ordering screening tests independently for this population.

## 4. How does dense breast risk compare to other risk factors such as obesity or consuming alcohol?

Dense breasts (BI-RADS categories C and D) are associated with approximately a 1.5 to 2.1-fold increased risk of breast cancer compared to scattered density (BI-RADS category B).<sup>7,8</sup> Category C (heterogeneously dense) confers about a 1.5 to 1.8-fold increased risk, while category D (extremely dense) carries approximately a 1.8 to 2.1-fold increased risk.

For comparison, women who consume one alcoholic drink per day have a 7-10% increased risk (relative risk approximately 1.07 to 1.10), while those who consume 2 to 3 drinks per day have about a 20% higher risk (relative risk approximately 1.20).<sup>9</sup> In postmenopausal women, overweight is associated with a relative risk of approximately 1.13, and obesity with a relative risk of 1.25,<sup>10</sup> though other studies report the relative risk for postmenopausal breast cancer is around 1.5 for overweight women and greater than 2 for obese women.<sup>11</sup>

Therefore, dense breasts represent a similar or slightly higher independent risk factor compared to moderate alcohol consumption or overweight/obesity in postmenopausal women. However, comprehensive risk assessment should consider all modifiable and non-modifiable factors together, as breast cancer risk is multifactorial and these risk factors may interact.

## 5. Is there a role for supplemental testing in dense breasts or past breast cancer history?

In BC, since October 2018, all breast screening participants are notified of their breast density. However, in accordance with the BC Cancer Coldman Report on Breast Density, supplemental testing of women with dense breasts is not recommended as a routine, population-level policy.<sup>12</sup> This recommendation is based on several considerations:

- While supplemental testing modalities can detect additional cancers in women

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with dense breasts, there is insufficient evidence that these additional cancer detections translate into improved mortality outcomes at a population level.

- The incremental cancer detection rates, while statistically significant, result in a relatively high number needed to screen (approximately 164 women for ultrasound, 650 women for MRI) to detect one additional cancer.
- There are concerns about increased false-positive rates, which can lead to unnecessary biopsies, patient anxiety, and health care system costs.
- Questions remain about the natural history and clinical significance of some cancers detected only by supplemental testing.
- Resource limitations and accessibility issues across BC mean that widespread implementation of supplemental testing programs is not currently feasible.

However, the report acknowledges that individual cases may warrant discussion of supplemental testing based on additional risk factors such as:

- Strong family history of breast cancer;
- Personal history of high-risk breast lesions (atypical hyperplasia, lobular carcinoma in situ);
- Known genetic mutations (such as BRCA1, BRCA2, CDH1, NF1, PALB2, STK11);
- History of chest radiation; and
- Patient preferences and values after informed discussion of benefits and limitations.

For these higher-risk individuals with dense breasts, a shared decision-making approach is recommended, using tools such as the BC Cancer Breast Density Discussion Guide to facilitate conversations about the potential benefits and harms of supplemental testing. If a patient with category C or D breast density chooses to have a supplemental test after this discussion, they are eligible for an MSP-covered breast ultrasound with a provider requisition. It is important to note that access to supplemental breast ultrasound is not widely available in BC.<sup>13</sup>

### 6. How do I arrange supplemental testing for patients with dense breasts?

In BC, screening mammography is the recommended breast screening modality,

including for patients with dense breasts. Supplemental testing is not recommended as a population-wide screening approach.

Before referring a patient with dense breasts (BI-RADS category C or D) for supplemental testing, primary care providers should:

- Discuss breast density findings with the patient using the BC Cancer Breast Density Discussion Guide;
- Review the patient's overall breast cancer risk factors;
- Reassure the patient that mammography remains the gold standard for early breast cancer detection; and
- Note that availability of sites offering supplemental testing varies significantly by region.

If appropriate and the patient consents, refer the patient for supplemental ultrasound through diagnostic imaging.

### 8. Should patients receiving follow-up imaging for other cancers still get screening mammograms?

This requires individualized assessment based on the specific clinical situation. The decision should involve discussion of the benefits and limitations of continuing routine screening mammography given the patient's overall cancer surveillance plan. Factors to consider include the purpose of the surveillance imaging, and the patient's overall breast cancer risk profile. Coordination between the oncology team and primary care provider is important to ensure a comprehensive approach that avoids both duplication of imaging and potential gaps in breast screening. The discussion should be patient-centered, weighing the pros and cons specific to each patient's circumstances.

### 9. My patient is undergoing BI-RADS 3 short-interval follow-up. Should they respond to routine screening reminder (recall) notices during this follow-up period?

No. Patients undergoing BI-RADS 3 surveillance should follow the recommended diagnostic imaging schedule rather than routine screening reminders. Automated screening recall notices may still be sent during this period, but diagnostic follow-up should take precedence until surveillance is complete and the patient is formally returned to routine screening.

### 10. When a patient returns to screening after they complete the diagnostic work-up, will they start receiving reminder (recall) notices again?

Yes, once a patient completes diagnostic work-up and is recommended to return to screening, the patient's primary care provider can fax the Breast Screening Program with an update and the patient will start receiving reminder letters again when they are due to screen.

### 11. Where can I get more information about breast screening in BC?

Visit [www.bccancer.bc.ca/screening/healthprofessionals/breast](http://www.bccancer.bc.ca/screening/healthprofessionals/breast) for breast screening resources specifically developed for health care providers, as well as access to resources for patients.

To stay informed about the latest resources and updates for health care providers, subscribe to [BC Cancer Screening's Health Care Provider E-Newsletter](#). This quarterly e-newsletter highlights resources, tools, and information to help you support patients to prevent cancer and participate in breast, cervix, colon and/or lung screening.

*continued on page 7*

## Important Update: BC Cancer Breast Screening Notices

As of April 1, 2026, BC Cancer Breast Screening will mail a letter to patients only if follow-up or action is needed. Breast screening results that are normal, and no follow-up is needed, will **not** be automatically sent in the mail to patients. BC Cancer Breast Screening will continue to mail reminder letters when the patient is due for screening and when follow-up is needed.

Patients can still get their breast screening results (including normal results) in other ways: online on [Health Gateway](#), by contacting their health care provider or by calling the Breast Screening Services Centre at 1-800-663-9203.

Refer to [BC Cancer Screening's Common Reminder and Result Notices Resource](#) for the latest overview of notices sent to patients and health care providers from all four cancer screening programs

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## Educational opportunities provided by BC Cancer's Family Practice Oncology Network

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# Discussion Guide: Breast Density

## Helping Patients Understand Breast Density and Their BI-RADS Assessment

The BC Cancer Breast Screening Program includes a breast density assessment with screening mammography results. This is sent to both providers and screening program participants. This guide has been developed to support your conversation with patients about breast density.

### 1 Breast Density

Review the patient’s BI-RADS assessment with them. Explain that:

- Breasts are composed of two main types of tissue - fibroglandular tissue and fatty tissue. Normal fibroglandular tissue appears dense on a mammogram, while fatty tissue appears non-dense.
- Breast composition (the amount of fibroglandular tissue and fatty tissue) varies from person to person and can change over time and from one mammogram to the next.
- Most women’s breasts become less dense as they get older.
- Radiologists categorize breast composition using the Breast Imaging Reporting and Data System (BI-RADS) to assess the volume of normal dense breast tissue that is visible on mammography<sup>1</sup>. The density of breast tissue can only be seen on a mammogram and its categorization is commonly referred to as **breast density**.
- There are four BI-RADS categories (Figure 1) in the breast composition assessment scale, with BI-RADS A having the least amount of dense tissue and BI-RADS D having the most amount of dense tissue.
- A BI-RADS assessment can help indicate the relative possibility that a cancer could be obscured by the tissue, decreasing the sensitivity of a mammogram<sup>1</sup>. This increases the potential for a cancer to present clinically before the next mammogram is due (also known as an interval cancer). Increased dense tissue has also been identified as a risk factor for breast cancer.
- The C and D categories are commonly referred to as **dense breasts**. However, it is important to understand that breast density is a spectrum from A through D. This means, for example, that an individual with a B category will have some density, and that the risk magnitude varies between the C and D categories.

FIGURE 1: DESCRIPTION OF BREAST DENSITY CATEGORIES

BI-RADS A	BI-RADS B	BI-RADS C	BI-RADS D
Almost entirely fatty 15% of BC population 95.1% mammographic sensitivity	Scattered areas of fibroglandular density 44% of BC population 92.5% mammographic sensitivity	Heterogeneously dense, which may obscure small masses 34% of BC population 85.3% mammographic sensitivity	Extremely dense, which lowers the sensitivity of mammography 7% of BC population 72.5% mammographic sensitivity

#### Role of Mammography

- Women should continue to get regular screening mammograms regardless of their breast density.
- Mammograms are the only screening modality proven to be effective in decreasing a woman’s risk of dying from breast cancer. The ability of mammography to detect cancer remains high for all breast density categories.
- It is important to remind your patients that no screening test is perfect and dense breast tissue can make it harder to find cancer on a mammogram.
- It is important to investigate all breast changes, even if a recent mammogram was normal.

## 2 Risk of Breast Cancer Related to Breast Density and Other Risk Factors

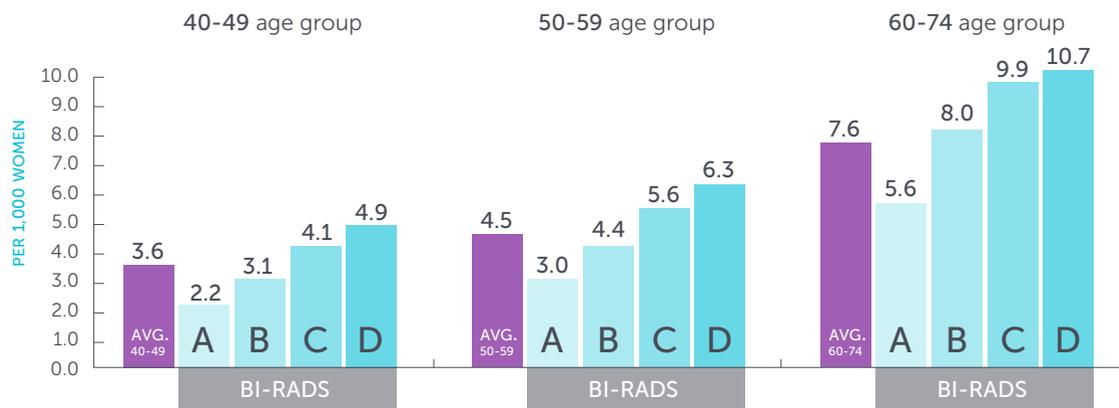
### Understanding Breast Density as a Risk Factor

Individuals with dense breast tissue are at increased risk for breast cancer and have a higher probability of an invasive breast cancer diagnosis in the two years following a screening mammogram. This risk increases with age.

If your patient is anxious about their BI-RADS category, reassure them that although dense breast tissue is a risk factor, having extremely dense breast tissue (BI-RADS D) does not necessarily mean that they are at “high” risk for developing the disease.

- ▶ A woman age 40-49 with extremely dense breasts (BI-RADS D) has a smaller risk of developing breast cancer than an average risk 60-69 year old woman (Table 1).
- ▶ Among 1,000 BC women age 60-74 in the BI-RADS D category, the estimated number of new breast cancer diagnoses over the next two years is 10.7, meaning that 989 women will not be diagnosed with breast cancer.

TABLE 1: PROBABILITY OF BEING DIAGNOSED WITH INVASIVE BREAST CANCER IN NEXT TWO YEARS FOR BREAST SCREENING PARTICIPANTS



### Relative Risk

Another way to describe the risk of breast cancer is by explaining “relative risk”. A relative risk of greater than 1 indicates a higher risk of being diagnosed with breast cancer compared to an average woman in that age group.

In Table 2 we compare the risk of breast cancer in women in each BI-RADS category to the risk of breast cancer in average BC women in the same age group (across all BI-RADS categories). For example, for BC women age 60-74, a relative risk of 1.42 in the BI-RADS D category means that the risk of breast cancer is 42% higher than the average for that age group. Women with the least dense tissue (BI-RADS A) are at the lowest breast cancer risk, regardless of age.

Based on current evidence there is no relative risk threshold where additional supplemental testing is proven to be beneficial.

TABLE 2: ESTIMATED RELATIVE RISK\* OF AN INVASIVE BREAST CANCER DIAGNOSIS WITHIN TWO YEARS FOR BC WOMEN AGES 40-74 BY AGE GROUP AND BREAST DENSITY

Breast Density	Ages 40-49	Ages 50-59	Ages 60-74
A	0.60	0.68	0.74
B	0.87	0.97	1.05
C	1.15	1.24	1.31
D	1.36	1.40	1.42

\* Relative risk compared to the average rate across all density groups

### Additional Breast Cancer Risk Factors

Speak with your patient to see if there are any additional breast cancer risk factors (Table 3). The overall risk for breast cancer is influenced by a complex combination of many different factors, including:

- Increasing age – which is the greatest risk factor after being female.
- Certain inherited gene mutations, including BRCA1 and BRCA2.
- Personal history of breast cancer.
- Prior breast biopsy showing certain non-cancerous pathologies, such as Atypical Ductal Hyperplasia, Atypical Lobular Hyperplasia, and classical Lobular Carcinoma In Situ.
- History of breast cancer in a first-degree family member, such as mother, daughter, or sister.

Healthy lifestyle choices may help lower breast cancer risk. It is important to maintain a healthy body weight and an active lifestyle, limit alcohol, breastfeed if possible and weigh the risks and benefits of hormone therapy for menopause symptoms. More information on modifiable risk factors can be found at [www.fiveplus.ca](http://www.fiveplus.ca). There are a number of online tools available to calculate risk for breast cancer based on different combinations of these factors. Two risk calculators that you may find helpful are:

- ▶ **The Breast Cancer Risk Assessment Tool**  
[www.cancer.gov/bcrisktool](http://www.cancer.gov/bcrisktool)  
This tool does not include breast density information.
- ▶ **Breast Cancer Surveillance Consortium Risk Calculator**  
<https://tools.bcsc-scc.org/bc5yearrisk>  
This tool includes information on breast density.

TABLE 3: COMPARISON OF BREAST CANCER RISK FACTORS

Risk Factor	Estimated Maximum Relative Risk
BRCA1 or BRCA2 <sup>2</sup>	15x*
Personal history of breast cancer <sup>3</sup>	7x to 10x*
Prior breast biopsy showing certain non-cancerous pathologies	
- Atypical Ductal Hyperplasia <sup>3</sup>	5x*
- Atypical Lobular Hyperplasia; classical Lobular Carcinoma In Situ <sup>4</sup>	4x to 10x*
First-degree relative (mother, sister) diagnosed with breast cancer by age 50 <sup>3</sup>	2x*
Obesity	1.3x*
Alcohol Use	1.6x*
BI-RADS C (heterogeneously dense)	1.3x <sup>†</sup>
BI-RADS D (extremely dense)	1.4x <sup>†</sup>

\* Risk compared to the risk in women without that risk factor  
† Invasive cancer within two years compared to average density

### 3

## Supplemental Testing

The purpose of breast screening is to identify cancer at a sufficiently early stage so that long term prognosis is improved and the risk of death due to breast cancer is reduced. Breast screening does not reduce an individual's risk of breast cancer.

There is currently insufficient evidence to prove that women with dense breast tissue as a sole risk factor will benefit from supplemental testing with other imaging modalities. Given this lack of evidence, the recent Canadian Task Force on Preventive Health Care guidelines and the U.S. Preventive Services Task Force do not recommend supplemental testing despite the increased risk<sup>5,6</sup>.

Available evidence does indicate that such supplemental tests do have the ability to detect additional cancers after a negative mammogram screen. While this may include small and node negative disease, it is unknown what proportion of these cases (i) represent overdiagnosis (cancer that would cause no morbidity during a patient's lifetime), (ii) might have been found at the next screening mammogram, or (iii) represent an opportunity to decrease breast cancer mortality.

A randomized study is underway to look at the value of breast ultrasound as a supplemental test, and may address some of these questions<sup>7</sup>. It is important that health care providers discuss both benefits and limitations of supplemental ultrasound testing with their patients prior to referring them. The latter include aspects similar to mammography such as false positives and limitations in sensitivity. If deemed appropriate, supplemental ultrasound is available to individuals in accordance with applicable BC Medical Services Commission Payment Schedule billing rules for breast ultrasound through diagnostic services.

There is also limited evidence regarding combinations of risk factors, but the coexistence of other risk factors may increase the value of supplemental testing. For example, the balance of benefits and limitations may be more favourable for women with extremely dense breasts and a positive family history.

### 4

## More Information

We recognize that notifying patients of their breast density may lead patients to have questions on what they should do next.

- Everyone who receives a mammogram with the BC Cancer Breast Screening Program will receive additional information on breast density when they receive their mammography result.
- Information about breast density, risk factors for breast cancer and screening mammograms can be found at [www.screeningbc.ca/breast](http://www.screeningbc.ca/breast).

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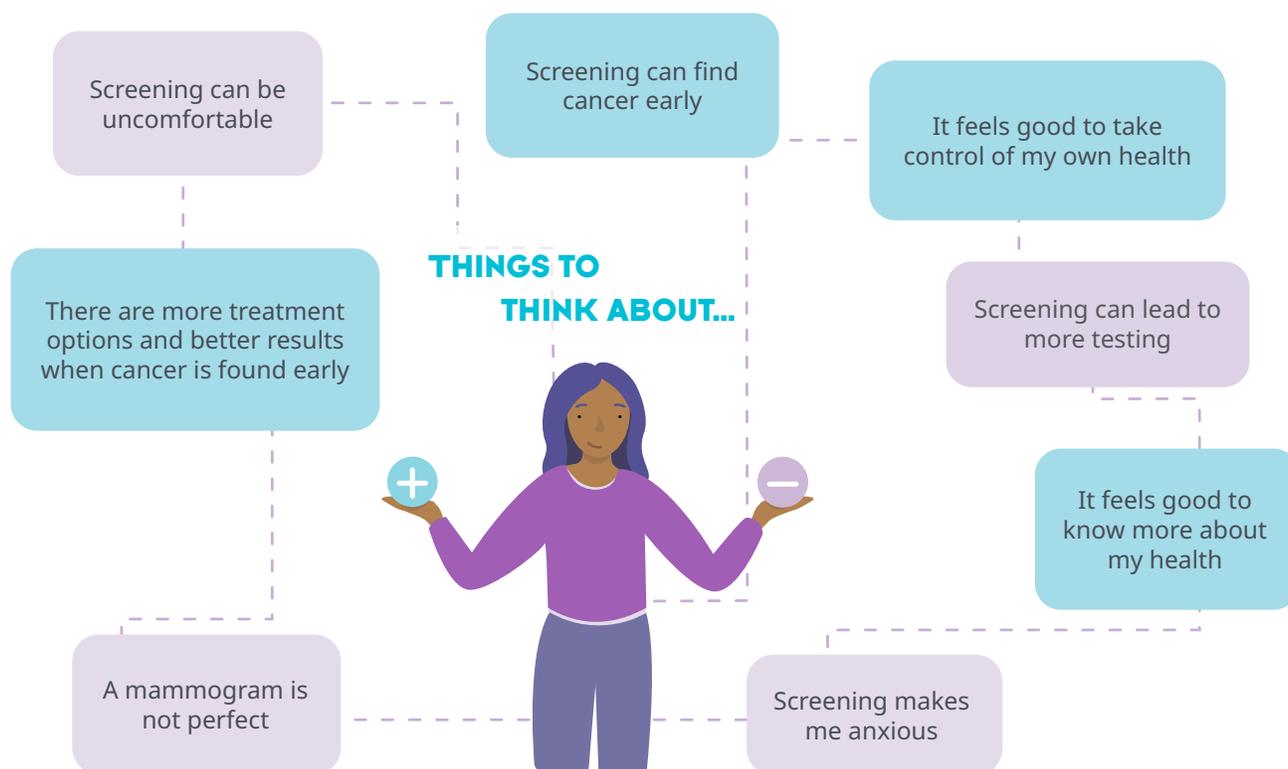
## Data Notes

1. BC Cancer Breast Screening Program data used to calculate discussion guide statistics.
2. Overall Sensitivity calculation includes DCIS and invasive breast cancers detected by digital mammography.
3. Absolute and relative risk calculated:
  - a. For all program screens completed 2011-2015, with follow-up to 2016, for women ages 40-74.
  - b. Includes digital and analog images.
  - c. For invasive cancers only (includes screen detected and interval invasive cancers).
  - d. Excludes women whose 1st screen in the study period (at the beginning of each screening round) results in a screen detected cancer (prevalent cancers).
4. BI-RADS percentage of the population estimates provided for 2018.

Version: January 2021  
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# Should I start getting screening mammograms in my 40s?

Mammograms (x-rays of the breasts) can help find breast cancer early, before you notice any changes and when it is easier to treat. Your age and family history (if your parent, child or full sibling has had breast cancer) can affect your risk.



## Why is it important to make an informed choice?

In BC, mammograms are available starting at age 40 to most women and many Two-Spirit, transgender and non-binary people, who have no symptoms. Generally, people between 40 and 49 have a lower risk than those over 50. So it's your choice whether to start now or wait. This guide helps you decide what's best for you.



**Important:** If you:

- **Have a previous history of breast cancer:** See a health care provider to arrange appropriate diagnostic breast imaging.
- **Have breast implants:** See a health care provider to arrange appropriate diagnostic breast imaging.
- **Have breast cancer symptoms, such as a lump, fluid from your nipple(s) or any other changes to your breast(s):** See a health care provider right away. You may need diagnostic testing.
- **Are pregnant or breastfeeding:** You can get a screening mammogram 3 months after you fully stop breastfeeding. See a health care provider right away if you notice any change(s) to your breast(s), since they can refer you for a diagnostic mammogram.
- **Have had a mammogram on both breasts in the last 12 months:** You must wait at least 1 year before having another screening mammogram.
- **Have a parent, child or full sibling who has or had breast cancer:** You should have a screening mammogram every year. Call 1-800-663-9203 to make an appointment (a referral is not required).

## Benefits and limitations

Think about the benefits and limitations of mammograms. Check off the points that matter to you. Add any other points in the blank rows.

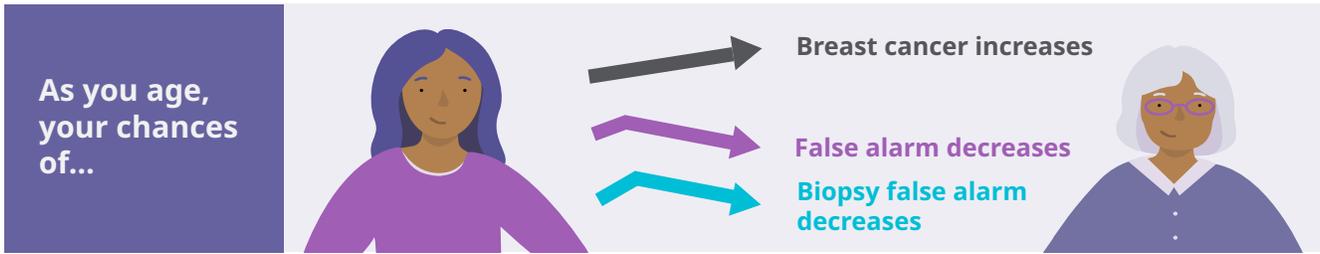
Benefits	Limitations
<p><b>Helps find cancer earlier:</b> A mammogram can find cancer when it is small, which means more treatment options and a higher chance of success. Finding and treating cancer early gives me more time and energy to spend with family and friends. <input type="checkbox"/></p>	<p><b>A mammogram is not perfect:</b> It can miss some cancers due to its location or the density of my breast tissue (false negative), or it can find cancers that would not have caused problems in my lifetime (overdiagnosis). <input type="checkbox"/></p> <p>Since I am younger, I may have denser breast tissue, so my screening mammogram may be less exact.</p>
<p><b>May help me live longer:</b> Having a mammogram can help me live longer since screening can help find cancer when it is smaller and easier to treat. <input type="checkbox"/></p>	<p><b>Screening anxiety:</b> I may feel anxious, worried or stressed during my mammogram and after when I wait for my results. <input type="checkbox"/></p>
<p><b>Feels good to take care of my health:</b> A mammogram helps me look after my breast health so that I stay aware of my overall health. Having a mammogram lets me take care of myself and that feels good. <input type="checkbox"/></p>	<p><b>Pain:</b> Having a mammogram can be uncomfortable due to the pressure placed on my breast while the x-ray images are being taken. Compression is needed to spread the breast tissue and keep my breast in place to avoid blurry images. <input type="checkbox"/></p>
<p><b>Gives me peace of mind:</b> Knowing whether or not I have breast cancer will help me better understand my health and guide my choices for the future. <input type="checkbox"/></p>	<p><b>More testing:</b> I may need more testing after my screening mammogram, such as a diagnostic mammogram, ultrasound or biopsy, to look more closely at my breast(s). <input type="checkbox"/></p>
<p><b>Less treatment/Faster recovery:</b> Finding cancer earlier may mean I will need less treatment and spend less time recovering. <input type="checkbox"/></p>	<p><b>Possible treatment:</b> I may need treatment after my screening mammogram, such as surgery, medications, radiation therapy and/or chemotherapy. <input type="checkbox"/></p>
<p><input type="checkbox"/></p>	<p><input type="checkbox"/></p>

## Why is screening available starting at age 40 but recommended at 50?

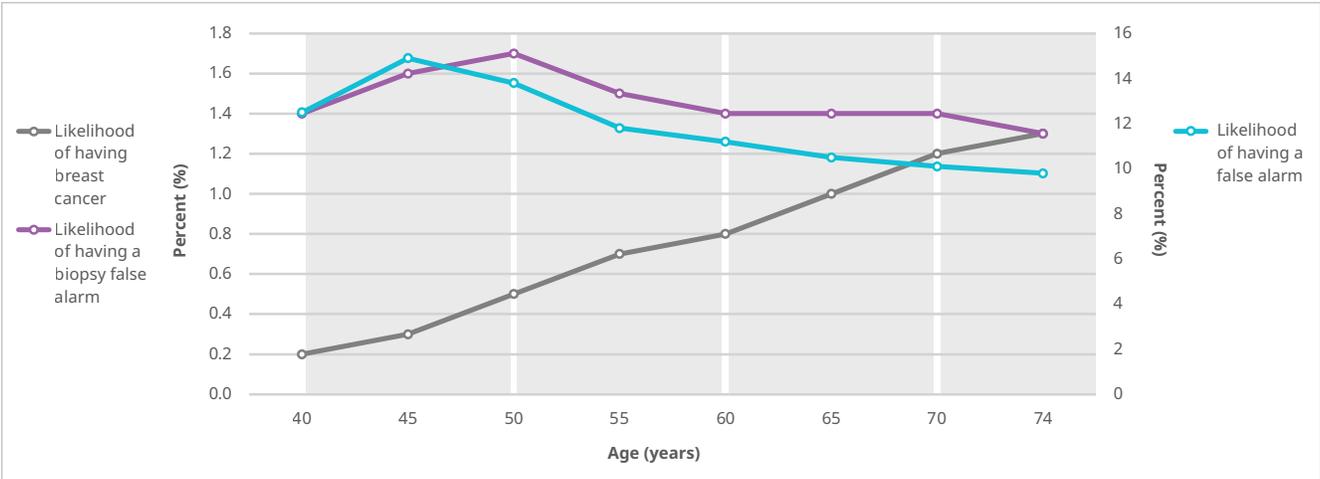
Your age and family history can affect the results of your next mammogram. As you get older, your risk of cancer goes **up** but your risk of a **false alarm** or **biopsy false alarm** goes **down**.

### Definitions

<b>False alarm</b>	An abnormal test result that's actually normal after more testing (such as other imaging, biopsy or surgery).
<b>Biopsy false alarm</b>	An abnormal result from taking a biopsy (removing a small amount of tissue, cells or fluid from the body) that's actually normal after more testing.



**What can happen if you DO NOT have a parent, child or full sibling with breast cancer:**



**Understanding the graph:**

If you are **45 years old**, you have:

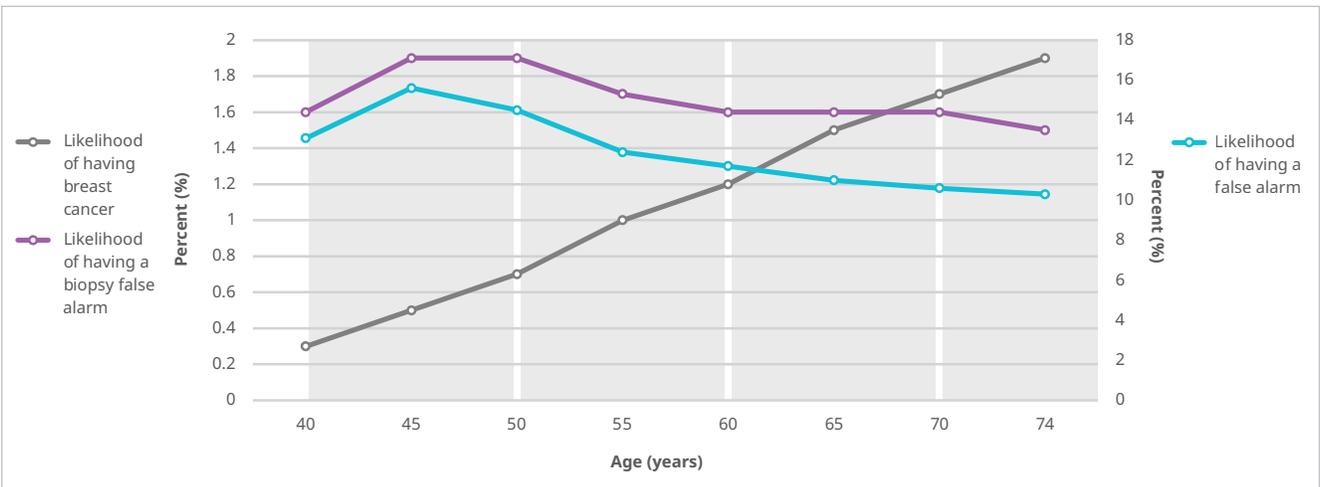
- Less than 1% chance of having cancer
- 15% chance of a false alarm
- 1.6% chance of a biopsy false alarm

**Versus**

If you are **70 years old**, you have:

- Over 1% chance of having cancer
- 10% chance of a false alarm
- 1.3% chance of a biopsy false alarm

**What can happen if you DO have a parent, child or full sibling with breast cancer:**



**Understanding the graph:**

If you are **45 years old**, you have:

- 0.5% chance of having cancer
- 16% chance of a false alarm
- 1.9% chance of a biopsy false alarm

**Versus**

If you are **70 years old**, you have:

- 1.7% chance of having cancer
- 11% chance of a false alarm
- 1.6% chance of a biopsy false alarm

## Your decision

### What is your decision?

- I want a mammogram now
- I want to wait until I turn 50
- I'm still not sure

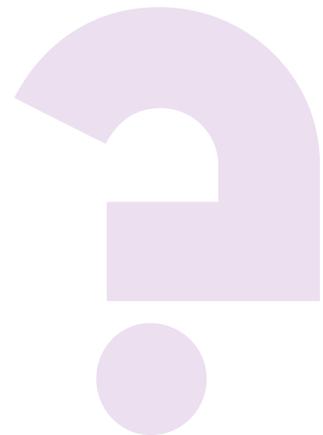
### Are you sure of your choice?

		Yes	No
<b>Sure of myself</b>	Do you feel sure about the best choice for you?	<input type="checkbox"/>	<input type="checkbox"/>
<b>Understand information</b>	Do you know the benefits and limitations of screening?	<input type="checkbox"/>	<input type="checkbox"/>
<b>Risks and benefits</b>	Are you sure about which benefits and limitations matter most to you?	<input type="checkbox"/>	<input type="checkbox"/>
<b>Encouragement</b>	Do you have enough support and advice to make an informed choice?	<input type="checkbox"/>	<input type="checkbox"/>

©SURE test; O'Connor & Légaré 2008

## Still not sure?

Take this guide to a health care provider for support. Write down any questions you may have below to ask them at your appointment:



### Disclaimer

Information shared here is for informational purposes only. It should not be interpreted as medical advice, professional diagnosis, or medical opinion without first seeing a health care provider. This information should not replace the need to see a health care provider for any health-related concerns.

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# Looking Back and Moving Forward: Retirement after more than 20 years in Cranbrook Community Oncology Clinic

Keith G. Lowden, MD (UBC 86), GPO  
Cranbrook Community Oncology Clinic

Dr. Keith Lowden is retiring after providing cancer care in the Cranbrook Community Oncology Clinic for more than 20 years. We had the opportunity to catch up with him during his last few weeks of work.

## Tell us about your journey to becoming a general practitioner in oncology (GPO).

Practicing as a GPO has been a rewarding part of my medical career. Mentally stimulating and often challenging? Yes. But also fulfilling in ways I did not expect when I began the transition from full-service family practice 22 years ago.

Our family moved to Cranbrook for my Grade 12 graduation year. Upon completion of Medical School and a Rotating Internship, I returned to Cranbrook in 1987, the year MSP numbers came with a geographic restriction, limiting my practice to the East Kootenays. The excitement of rural medicine, blending office practice, inpatients, emergency room shifts, obstetrics, operating room work, resident training, and starting a family, led me to accept a permanent position at the F. W. Green Clinic.

Prior to 2002, Cranbrook had visiting oncologists do monthly outreach clinics in whatever space could be made available. BC Cancer was expanding into Regional Centres, and Community Oncology was starting on the Island and in the Interior. Dr. Kong Khoo championed the idea of a site in Cranbrook, with visits by oncologists from Kelowna and delivery of systemic therapy and cancer care by family physicians trained in oncology. A second physician was needed to join Dr. Bob O'Brien, our first GPO in Cranbrook, and I was offered one week per month of oncology, allowing me to keep doing much of my family practice.

## What was your GPO training like, and how has it changed?

GPO training in 2003 consisted of two weeks in Kelowna, during which participants



Dr. Keith G. Lowden

learned from each tumour site-specific oncologist. There was a large paper-bound BC Cancer Management Manual for the didactic portion of the training, and I spent clinical training time with whoever I approached. I also recall pausing and enjoying the string quartet that played in the lobby on Fridays for everyone's benefit.

Training has evolved as the complexity of our work has changed much in the last twenty years. FPON has since developed a more formal didactic curriculum to be paired with 30 days of clinical training, providing a learning experience and preparation for the GPO work environment. Cranbrook now provides some clinical training weeks for GPOs planning to work at CON sites in the Interior.

## What has kept you working as a rural GPO?

Initially, patient turnover was high as limited treatment options were available, and this took some getting used to. With the progression of targeted therapies and the advent of immuno-oncology, we now have many patients for whom we are providing more longitudinal care. For me, this has kept some of that family practice feel to the work, but definitely without the avalanche of paperwork and administrative duties found in the FP office setting.

I have enjoyed interacting with physicians from our East Kootenay area and developing an appreciation for the work they do under some of the most challenging circumstances. Providing advice to a rural emergency room doctor, sharing care with the hospitalist, or helping a colleague navigate the cancer care system for their patient has been a rewarding part of the practice. I worked with a great team of highly competent and caring nurses, clerks, social services, and other support staff. Their humour, though sometimes dark, got us through many a day.

And then there were the unexpected, yet truly unforgettable moments, like when Bowen Byram of the Colorado Avalanche

took the time to bring the Stanley Cup up to our unit for the patients and staff.

## What surprised you about being a rural GPO?

I transitioned to full-time GPO work in 2009. I have always felt completely supported by the oncologists who entrust us to share the care of their patients.

One surprise to me was how appreciative our patient population is, even when dealing with a life-changing or life-limiting diagnosis of cancer. Our catchment area population of 89,000 includes communities 2.5 hours' drive from Cranbrook, which itself is 6.25 hours from our Regional Centre in Kelowna by road on a good day. There are four high mountain passes to navigate in the winter. Direct flights are "on again, off again". Patients and their families often express relief that we can provide comprehensive systemic therapy services in Cranbrook. Dr. Cheryl Ho presented data at the recent GPO Case Study Day that patients receiving IV systemic therapy in Cranbrook saved 2,678,620 km of car travel in fiscal 2024/25. Families are saved days off from work, lost wages, and living expenses. A new build is planned to open in 2029, with one floor dedicated to Oncology, allowing us to further improve the service we can provide.

## What does retirement look like for you?

As for retirement, my three young grandsons all live in Cranbrook, and I look forward to having the time to see the world through their eyes and be involved with some of their sports and other activities. I have lots of underused sporting equipment that may finally get a workout. Our hobby farm will keep me busy, and I've heard that there is this thing called reading for pleasure. And I look forward to paying the retired physicians' fee at the next Vernon Doctors' Hockey Tournament in March.

## Any parting thoughts as you leave BC Cancer?

It's an exciting time to be a GPO, providing care to patients with cancer. And it is great to feel as though I am part of a team. The

*continued on page 19*

# Navigating Natural Health Products in Cancer Care: Benefits, Risks, and Clinical Considerations

By Dr. Shirin Abadi, Pharmacy Clinical and Education Coordinator

## Introduction

Natural health products (NHPs) encompass a broad range of substances, including vitamins, minerals, herbal and homeopathic preparations, traditional Chinese and Ayurvedic medicines, probiotics, amino acids, and essential fatty acids.<sup>1,2</sup> Interest in these products is common among individuals undergoing cancer treatment, with up to 80% of patients considering their use at some point during their cancer journey.<sup>1-3</sup> Frequently-used NHPs among oncology patients include astragalus, black cohosh, cannabis, curcumin/turmeric, ginger, ginkgo biloba, ginseng, green tea extract, high-dose vitamins, milk thistle, omega-3 fatty acids, probiotics, reishi mushroom, resveratrol, saw palmetto, St. John's wort, and turkey tail mushroom, among many others.<sup>1,3-4</sup>

This article highlights examples of potential benefits and risks associated with NHP use in cancer care and provides guidance for evaluating these products within a clinical context.

## Potential Benefits

Some NHPs may offer supportive benefits for select patients, either by easing symptoms or contributing to improved tolerance of cancer therapies.

Examples include:

- Cannabis products, which may help alleviate neuropathic pain for some individuals.<sup>5-6</sup>
- Folic acid, which can lessen the toxicity of methotrexate-based treatments.<sup>2</sup>
- Lycopene, which may provide modest protective effects related to prostate cancer development or recurrence.<sup>2</sup>
- Melatonin, which has been associated with reducing the risk or severity of treatment-related side effects, such as thrombocytopenia.<sup>7-8</sup>



Dr. Shirin Abadi

- Curcumin/turmeric, which may help decrease the incidence, severity, and pain of oral mucositis associated with cancer therapies.<sup>9-11</sup>

While promising, these potential benefits are often dependent on product quality, preparation, dose, and study design.

## Potential Risks

Despite widespread use, NHPs can pose significant risks for cancer patients

due to pharmacokinetic, pharmacodynamic, physiochemical, or immunologic interactions<sup>1-2</sup>

### 1. Pharmacokinetic Interactions:

Many chemotherapy agents depend on the cytochrome P450 enzyme system (e.g., CYP3A4) and/or the P-glycoprotein pathway for metabolism and transport.

Examples of CYP3A4 substrates include doxorubicin, docetaxel, paclitaxel, imatinib, irinotecan, tamoxifen, and vincristine, among others.<sup>1-2,12</sup> NHPs that affect these pathways may alter drug levels:

- CYP3A4 inhibitors (e.g., grapefruit or grapefruit juice) may raise cancer drug concentrations.<sup>1,13-14</sup>
- CYP3A4 inducers (e.g., St. John's wort) may reduce therapeutic drug levels.<sup>1</sup>

### 2. Pharmacodynamic Interactions:

Many chemotherapy agents and radiation therapy rely on reactive oxygen species (ROS) to exert anticancer effects. High-dose antioxidant supplements (e.g., vitamins C and E, coenzyme Q10, green tea extract, melatonin, selenium, zinc, etc.) may impair treatment efficacy.<sup>1</sup>

### 3. Increased Bleeding Risk:

Some NHPs—including curcumin/turmeric, feverfew, garlic, ginger, ginkgo biloba, ginseng, and omega-3 fatty acids, among others have antiplatelet effects.<sup>1,3-4</sup> These can elevate bleeding risk, especially in patients receiving anticoagulants or antiplatelet agents.

## 4. Product Variability and Regulatory Challenges:

Many NHPs contain multiple active ingredients, increasing the potential for interactions and adverse effects. Variability in manufacturing standards and limited regulation can result in inconsistent potency, contamination, or mislabeling.<sup>1</sup>

## Clinical Considerations

Evaluating NHP use in oncology requires an evidence-based and patient-centred approach.

Key steps include:

1. Documenting a comprehensive best possible medication history (BPMH) that captures all prescription medications, non-prescription drugs, and NHPs.
2. Using high-quality evidence-based resources, such as Natural Medicines, to assess potential benefits versus risks.
3. Interpreting available evidence carefully, recognizing limitations in study quality, standardization, and follow-up duration.
4. Communicating transparently with patients, especially when evidence is inconclusive.
5. Applying a structured evaluation framework to guide clinical decision-making (Figure 1).<sup>1</sup>

Open dialogue helps patients make informed decisions and supports safe and personalized cancer care.<sup>1</sup>

Where available, pharmacists can support the assessment of NHPs during comprehensive medication reviews, in order to identify and address medication related issues.

## Summary

Natural health products are widely used by patients undergoing cancer treatment, but their effects can vary considerably. Some NHPs may provide symptom relief or support treatment tolerance, while others can interfere with drug metabolism, reduce treatment effectiveness, increase adverse drug reactions including bleeding risk, and pose safety concerns due to variability in product quality.

*continued on page 19*

*Cranbrook Community Oncology Clinic  
continued from page 17*

Association of BC GPOs (ABCGPO) is now recognized as a Section within Doctors of BC. The executive group is awesome, and the return on investment for the sectional fee is amazing. Equitable work and remuneration for BC Cancer GPOs at Centres and CON sites, and for those working in Health Authority Clinics, is an ongoing process, and we are much stronger together. There is also the Canadian Association of GPOs (CAGPO), which hosts a great annual conference that allows for networking and awareness of what GPOs do across the country. If you are interested in GPO work, contact FPON.

Finally, continue to work with care and compassion. Care for our patients who come to us with all their vulnerabilities. Care for each other, especially as we move to a more team-centred approach to the work we do. And, care for yourselves. But not in that order. I'm encouraged that the doctors with recent training are able to integrate the

care of patients, staff, and themselves into their daily lives better than my generation did. It makes for better overall physicians and

equips you to handle the challenges that will come wherever your own medical journey takes you.



**Figure 1. NHP Evaluation Framework for Cancer Patients<sup>1</sup>**

<b>Obtain</b>	<b>thorough medication &amp; NHP history from patient</b>
<b>Look up</b>	<b>information using evidence-based reliable resources</b>
<b>Review</b>	<b>potential benefits</b>
<b>Assess</b>	<b>potential risks</b>
<b>Make</b>	<b>recommendation</b>

*Navigating Natural Health Products  
continued from page 18*

A thorough, evidence-based review of each product, combined with open communication and detailed medication history-taking, is essential for patient safety.

When evidence is unclear, clinicians should provide transparent guidance to help patients weigh potential risks and benefits, while considering the patient-specific goals of therapy.

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# Toward an AYA Cancer Care & Support Program for BC/Yukon

By Dr. Cheryl Heykoop, Team Lead,  
Anew Research Collaborative,  
Dr. Alannah Smrke, Medical Oncologist,  
BC Cancer and  
Dr. Kristin Marr, Pediatric Oncologist,  
BC Children's Hospital

*"We are facing an epidemic  
of early onset cancer."*

~ Nature 2022

Significant headway is being made to co-design an adolescent and young adult (AYA) cancer care and support program for BC/Yukon – one that meets the distinct needs prioritized by those navigating cancer

between ages 15-39. Efforts to solidify the key components of this program included a collaborative session at the BC Cancer Summit last November (see graphic recording on page 21 created by AYA Nellie Yee) where a record 32 AYAs from throughout BC/Yukon came together with 50+ clinicians, care providers and researchers to map out the content and structure of the ideal AYA cancer care and support program.

Building on research with AYAs and healthcare providers led by the Anew Research Collaborative at Royal Roads University, the session was co-facilitated by BC Cancer, BC Children's Hospital

and Anew, and featured leaders of well-established AYA programs in Manitoba and Ontario, sharing development paths for their programs and expertise to ensure effective and sustainable

program development for BC/Yukon. Session participants then engaged in small group discussions exploring options to effectively provide patient navigation, peer and virtual support and survivorship care, and to address a myriad of other unmet needs such as financial and family support, support for mental and sexual health and so on. The knowledge and insights gained from this session complement those in established AYA priority areas of oncofertility and AYA specific counselling and resources.

*"Rates of AYA cancers have  
increased 79% since 1990."*

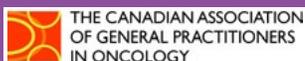
~ British Medical Journal 2023

Consolidated efforts are moving forward to develop a comprehensive program plan involving areas of focus to be led by the acute care system, by primary care, by community-based support and by AYAs themselves. Momentum and optimism have never been higher!

Visit [anewresearch.ca](http://anewresearch.ca)  
or email [hello@anewresearch.ca](mailto:hello@anewresearch.ca)



Drs. Cheryl Heykoop, Alannah Smrke and Kristin Marr



## MEDICAL STUDENTS & FAMILY MEDICINE RESIDENTS

Are you interested in attending  
CAGPO's Annual Conference?

The Canadian Association of General Practitioners in Oncology (CAGPO) provides complimentary registration to medical students and family medicine residents interested in enhancing their knowledge in cancer care.

Application deadline April 30th, 2026.

Submit to [info@cagpo.ca](mailto:info@cagpo.ca) (If applying after the deadline, contact CAGPO directly.)

Please see: [www.cagpo.ca](http://www.cagpo.ca) for more information  
or email [info@cagpo.ca](mailto:info@cagpo.ca)



## FAMILY PHYSICIANS & GENERAL PRACTITIONERS

Is funding a barrier to you pursuing  
extra training in CANCER CARE?

The Canadian Association of General Practitioners in Oncology (CAGPO) provides a scholarship program to support family physicians/general practitioners who would like to develop their knowledge and skills in cancer care in order to better serve the needs of their community.

Applications must be received at [info@cagpo.ca](mailto:info@cagpo.ca)  
by July 31, 2026.

Please see: [www.cagpo.ca/scholarship](http://www.cagpo.ca/scholarship) for more  
information or email [info@cagpo.ca](mailto:info@cagpo.ca)

**WHY?**

ADOLESCENT + YOUNG ADULTS (AYAs) ARE DIAGNOSED AT AGE 15-39 YEARS

9200 IN CANADA PER YEAR

1200 IN BC PER YEAR

AYAs EXPERIENCE A LIFE UPHEAVAL

SCHOOL

WORK

FAMILY

AYAs CAN LIVE 50-60 YEARS BEYOND DIAGNOSIS

AYAs HAVE DISTINCT CANCER CARE NEEDS

AYA CARE FALLS SHORT NOTICEABLY IN BC

WE CAN DO BETTER FOR OUR AYAs

# CO-DESIGNING AN AYA CANCER CARE PROGRAM

LEVERAGING MOMENTUM & KNOWLEDGE

TOGETHER

WITH INPUT FROM:  
AYAs & HEALTH CARE PROFESSIONALS

CURRENTLY IN BC:

PILOT PROJECTS COUNSELLING

IMPROVED FERTILITY CARE + RESOURCES

RESOURCES WEBSITE RESEARCH

**LESSONS LEARNED**

FROM MANITOBA + ONTARIO PROGRAM PARTNERS:

**IAN SCOTT CANCER CARE MANITOBA**  
 COMMIT TO EQUITY  
 PUT THE AYA PROGRAM IN THE BCCA STRATEGIC PLAN

USE IN-HOUSE EXPERTISE

AYA CLINIC SET-UP:  
 - CLINICAL NURSE SPECIALIST VS. NURSE PRACTITIONER  
 - AGE RANGE, ELIGIBILITY

ENGAGE CHAMPIONS

VIEW BC'S GEOGRAPHY AS AN ADVANTAGE

AVOID TERRITORIAL ISSUES WHEN WORKING WITH OTHER GROUPS

**CHANA KORENBLUM SICK KIDS (ONTARIO)**

PRIORITIZE AYA PARTNERSHIPS  
 CENTRALIZED CARE BASED ON POPULATION SPREAD, STRENGTHS + WEAKNESSES

ADAPT TO LOCAL NEEDS  
 COLLABORATE WITH KEY STAKEHOLDERS

MODIFY HOSPITAL SPACE  
 INCORPORATE KEY AREAS OF CARE

SEEK OUT CHAMPIONS

BE HUMBLE

BUILDING ON SUCCESS

**PEER SUPPORT & VIRTUAL SUPPORT**

SHARING SPACE WITH PEOPLE LIKE THEMSELVES

RESOURCE + INFO SHARING

YOUNG PARENTS  
 AYAs WITH RARE CANCERS  
 RACIALIZED AYAs  
 CAREGIVERS  
 GENDER IDENTITY  
 YOUNGER AYAs

FACILITATED GROUPS  
 PAIRED MENTORSHIP  
 SOCIAL EVENTS  
 ONLINE CONNECTIONS  
 PATIENT PORTALS

BUILDING COMMUNITY

ADDRESS BARRIERS TO CARE AND SUPPORT

LEVERAGE COMMUNITY SUPPORT

INTERSECTIONAL CARE

SYSTEMS NAVIGATION

CONTINUITY OF CARE

**AYA NAVIGATION**

WELCOMING

ANSWERS QUESTIONS + MAKES CONNECTIONS

INFORMATION + SYSTEMS GUIDANCE

SUPPORT THROUGH TRANSITIONS, SURVIVORSHIP + END-OF-LIFE

PEDIATRIC TO ADULT SUPPORT

REDUCE OVERWHELM

OPT-OUT REFERRAL

HELP WITH DECISION-MAKING + ADVOCACY

CONSISTENT POINT PERSON

**SURVIVORSHIP CARE**

WHEN DOES SURVIVORSHIP CARE START?

AFTER DIAGNOSIS

AFTER NO EVIDENCE OF DISEASE (NED)

AFTER REMISSION

AFTER LEAVING CANCER CARE SYSTEM

TYPES OF CARE NEEDED

TIMING + TYPE OF CARE ARE UNIQUE TO EACH AYA

POTENTIALLY GUIDED BY AYA NAVIGATOR

ONGOING SCREENING

DIET + EXERCISE

REHABILITATION

HOUSING

LONGTERM SIDE EFFECTS

MENTAL HEALTH

MENOPAUSE ONSET

SEXUAL HEALTH

ONCOFERTILITY

FAMILY PLANNING

**WHAT'S MISSING?**

- SUPPORT FOR FAMILIES + CAREGIVERS
- ACCESS TO CLINICAL TRIALS
- DEDICATED PHYSICAL SPACE
- ALLEVIATE FINANCIAL BURDEN OF FERTILITY PRESERVATION, TRAVEL ETC.
- RETURN TO SCHOOL + WORK
- HELP WITH PLANNING FOR THE FUTURE

graphic recorder  
NELLIE YEE

# Primary care is critical to BC's 10-Year Cancer Action Plan

*Dr. Paris-Ann Ingledeew, chief medical officer and executive vice president, BC Cancer*

As we wrap up the third year of BC's 10 Year Cancer Action Plan, we're moving from vision to impact. We've grown our care teams significantly, with a 20 per cent increase in medical staff and a 30 per cent increase in regional centre staff. We are providing more new patient consults and follow-up appointments than ever before, and we are meeting — and exceeding — wait-time benchmarks for systemic and radiation therapy.

The action plan is a provincial commitment to deliver the best cancer care when and where it is needed in BC. We can't improve the experiences of patients and families at every stage of their cancer journeys without meaningful engagement and strong partnerships with primary care providers.

Whether it's the initial suspicion that something is wrong or an abnormal screening result, patients rely on their primary care providers. They help families

navigate the tests, imaging and procedures often required for a diagnosis. After treatment, they support patients as they transition into life after cancer or end of life care.



Dr. Paris-Ann Ingledeew

As we look ahead to year four of the Cancer Action Plan, we are working to strengthen our relationships with providers and deepen our understanding of how to best support primary care in the community. One example of this is the development of clinical care pathways. Created by BC Cancer's Provincial Programs and

Tumour Groups, these pathways support all health care professionals caring for patients with cancer. They include information on how a person might progress through each phase of their cancer journey and key supportive services that are available. To date, 18 pathways have been created for a wide range of cancers. We are also closely looking at referral processes to streamline them for patients and providers and ensure timely access to care.

This fall, at the 2025 BC Cancer Summit, Tracy Irwin, chief operating officer, BC Cancer, and I hosted two special interactive sessions on BC's 10 Year Cancer Action Plan. These sessions brought together BC Cancer staff, medical staff, community care providers, patient partners and leaders to deepen understanding of the Cancer Plan, foster meaningful involvement and create opportunities for connection. It was energizing to see these ideas brought to life through the graphic recording (pictured), which highlights opportunities, priorities and common barriers.

The themes that emerged — the need for better communication, engagement and connection — apply across the province. As we move forward, we are continuing our work with internal and external partners to promote the progress we are making, encourage knowledge sharing and support broader involvement.

On behalf of Tracy, myself and everyone at BC Cancer, thank you for the work you do to deliver and support cancer care in our province. We look forward to sharing opportunities for engagement and collaboration in the year ahead.

## BC Cancer Summit: One vision, one system, one future



Mark your calendars for Summit 2026! This year's event will take place Nov. 19 to 21 at the Sheraton Wall Centre in Vancouver. Centered on the theme "One vision, one system, one future," the event will bring together oncology professionals from all specialties and disciplines for education, professional development and meaningful connection.

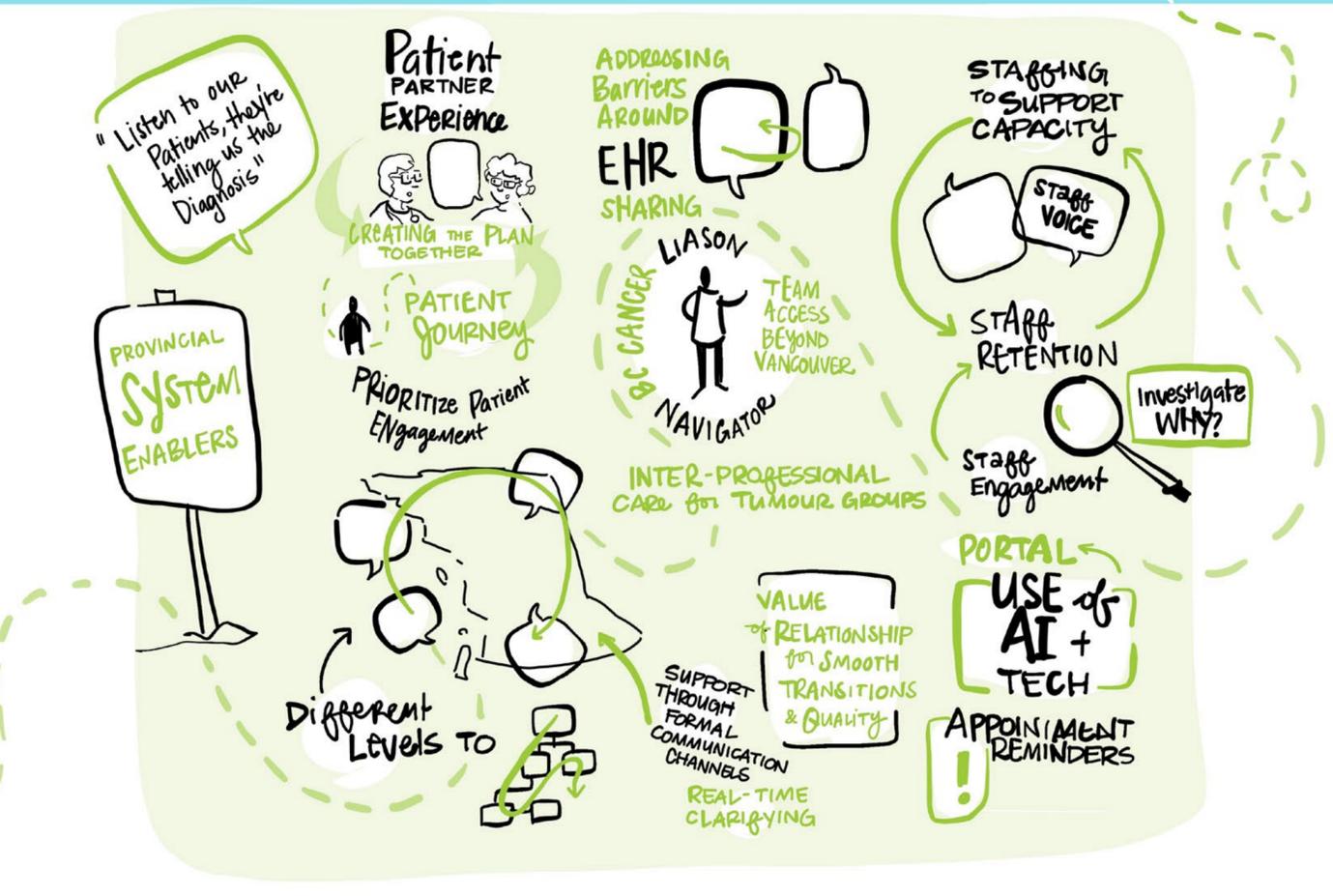
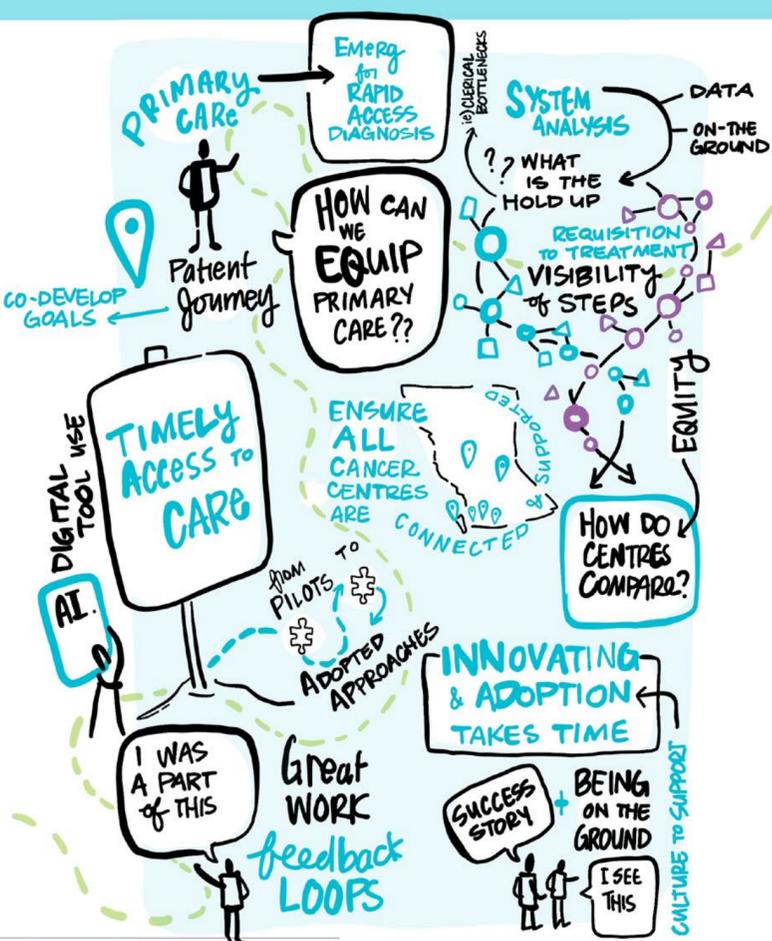
Last year's Summit had an incredible turnout of more than 1,200 attendees over the three-day event, which featured timely keynote presentations and collaborative breakout sessions. Don't miss this great opportunity to engage with colleagues, expand your knowledge and strengthen relationships across the oncology community.

More details to be announced: [bccancersummit.ca](http://bccancersummit.ca)

# FROM VISION TO ACTION AND BEYOND



STEPPING TOWARDS BUILDING SYSTEMS TO IMPROVE ACCESS + EFFICIENCY THROUGH CONNECTION & COLLABORATION



## Did you know?

Did you know that **BC Cancer's Supportive Care program** offers a range of programs to help BC Cancer patients and family members manage the physical, emotional, social and practical concerns that come with having a cancer. Services that are offered include:

### Nutrition

Registered dietitians can help address challenges with eating and nutrition during your cancer treatment. Want to learn more? [Click here.](#)

### Pain & Symptom Management/Palliative Care

Pain and Symptom Management/Palliative Care clinics help manage pain and other physical problems related to any stage of cancer. Want to learn more? [Click here.](#)

### Patient & Family Counselling

Counsellors can speak with you and/or a family member in person or over the phone about coping with emotions, challenges in relationships and dealing with the practical and financial concerns that can arise because of a cancer diagnosis. Want to learn more? [Click here.](#)

### Physiotherapy

Physiotherapy (PT) services can help with movement, pain management, fatigue, balance, lymphedema, and more. Want to learn more? [Click here.](#)

### Psychiatry

Psychiatrists are medical doctors specializing in mental health. Our psychiatrists can help if you have depression, anxiety, insomnia, overwhelming fears and changes in personality or thoughts. Want to learn more? [Click here.](#)

### Speech-Language Pathology

Speech Language Pathology (SLP) services can assist patients to maximize their communication and swallowing abilities. Want to learn more? [Click here.](#)

### Spiritual Health

Certified Spiritual Health Practitioners provide opportunities to explore connections with a Higher Power or Higher Self and to engage in spiritual practices that nurture hope and peace. Support is offered through one-to-one and group virtual sessions. Want to learn more? [Click here.](#)

\*\*Some **services** are self-referred while others require a referral from a doctor or nurse.

Please do not hesitate to contact us if you have any question about these services.

Jonathan Avery, PhD  
Manager, Provincial Programs,  
Supportive Care  
[jonathan.avery@bccancer.bc.ca](mailto:jonathan.avery@bccancer.bc.ca)

## Subscribe to the BC Cancer Supportive Care e-Bulletin

Each issue includes helpful resources, education, and support programs for people with cancer, their families, and caregivers across BC. Scan the QR code to get started.



SUPPORTIVE CARE  
PROVINCIAL PROGRAMS

Sign up for the Supportive Care e-Bulletin to learn more of the services and supports available for providers and patients:  
<https://app.cyberimpact.com/clients/28682/subscribe-forms/9375DED7-8D70-4770-899D-7A73B117EBB7>

# Shared Care Journey in Cancer Care

By Dr. Cathy Clelland, Medical Director,  
BC Cancer Primary Care Program

Family Medicine is built on relationships. Enduring relationships with our patients and their families over time. Relationships with our FP and specialty colleagues as well as relationships with other providers, particularly as our Patient Medical Home teams move toward a team-based care approach. Our role as a family physician is to support our patient's healthcare journey through



Dr. Cathy Clelland

the different stages and conditions of their life, sharing care with other providers including specialists for related issues in the context of our generalist "whole person" approach to health care. People are not simply sums of their individual conditions and to prevent silos of care, must be viewed through a balanced and integrated lens to improve overall outcomes.

As our population ages and the incidence of cancer increases, along with improving survival rates and

longer-term implications of recent advances in treatment, the FP and Primary Care role has been expanding beyond prevention and initial diagnosis. The increase in the number of cancer survivors, projected to continue, means there will need to be a significant shift in the sharing of care of these patients as they transition from acute cancer treatment to post-treatment care, to ensure a sustainable health care model that continues to meet the needs of both patients and healthcare providers into the future. The Family Physician's knowledge of the patient, their medical history and current comorbidities result in an opportunity for

*continued on page 26*



Protocol: METACIN  
Digital Poster - Version 1.0 dated 24Oct2025  
REB# H22-01702

## Nerve pain from chemo sticking around?

The METACIN Study is actively recruiting participants with ongoing nerve pain from chemo, also known as CIPN



### To be eligible, participants must\*:

- Be 18 years of age or older
- Have nerve pain only caused by chemotherapy that has lasted for at least 3 months since finishing chemo
- Currently taking little or no opioids
- Have a clinical diagnosis of cancer or are a cancer survivor

You will have a 50% chance of receiving the study treatment. Study period is approx. 8 weeks and includes a combination of remote and in-person visits.

\*Other eligibility criteria apply.

Study treatment, visits, tests, and procedures will be provided at no cost to you.

The study staff can tell you about any reimbursement for travel-related expenses or compensation that may be available.

For more information and to see if you qualify, please contact:

[METACIN@bccancer.bc.ca](mailto:METACIN@bccancer.bc.ca)



## BC Cancer METACIN study is recruiting participants

BC Cancer is recruiting adults with persistent chemotherapy-induced peripheral neuropathy (CIPN)  $\geq 3$  months post-treatment, minimal/no opioid use] for a randomized trial of methadone vs duloxetine. Total study duration ~8 weeks with mostly remote visits and up to 2 in-person visits.

CIPN is common, persistent, and often undertreated, with the most recommended medication—duloxetine—providing only modest benefit at best. The METACIN trial is a multi-centre randomized trial designed to determine whether low-dose methadone provides superior relief for painful CIPN using a rigorous blinded design. Results

are intended to directly inform future CIPN treatment practice.

Please consider referring eligible patients or [sharing the study poster!](#)

Active recruitment in Vancouver, Surrey, and Nanaimo; with Kelowna planned for Spring 2026

Contact: [METACIN@bccancer.bc.ca](mailto:METACIN@bccancer.bc.ca)

Shared Care Journey in Cancer Care  
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the provision of holistic care throughout the cancer care journey. There will be times in that journey that the majority of care will be provided by an oncologist, and times when it will mostly be provided by the family physician or other primary care provider(s). An integrated model of care, with different providers each bringing unique roles to the provision of coordinated patient care can increase family physician and other primary care provider confidence in patient management and care coordination.

To support this shared journey, there must

be role clarity, availability of appropriate tools and communication of information for primary care providers to provide quality follow-up care to patients. The BC Cancer Primary Care Program through its educational activities as the Family Practice Oncology Network (FPON), facilitates support for primary care providers through partnership with UBC CPD, the development of primary cancer care guidelines in partnership with GPAC, and advocacy for clear lines of communication between primary care and oncologists to provide adequate resources to care for this complex population. We are currently working on a “Transitions in Care Planning”

project as part of **BC’s 10-Year Cancer Action Plan**, with a goal of developing a framework for transitioning patients back to their Primary Care Provider after active cancer treatment starting with a target population of patients with breast cancer. With technology advances on the horizons, it is an exciting time with the potential to set the stage for discharge care planning that meets the needs of patients and providers through an efficient and effective process that will improve the journey and long-term outcomes. As this work progresses, we will keep you informed.

Best wishes in 2026

## SPECIAL FOCUS



# “HPV Has Been Found in Your Sample”: Explaining HPV-Detected Results Based on an Updated Understanding of the Natural History of HPV

To ensure patients understand their cervix screening results, it is essential that health care providers are up to date with the natural history of HPV and the potential clinical implications.

Clearly explaining to patients how and why HPV is detected (i.e., found) in a sample during cervix screening can help:

- Ease anxiety or fear;
- Prepare patients to successfully navigate conversations about HPV results with their sexual partner(s);
- Equip patients with information about HPV that will assist them as they go through subsequent rounds of HPV screening in the future; and
- Build trust with health care providers and this newer method for cervix screening.

## What you need to know: Natural history of HPV

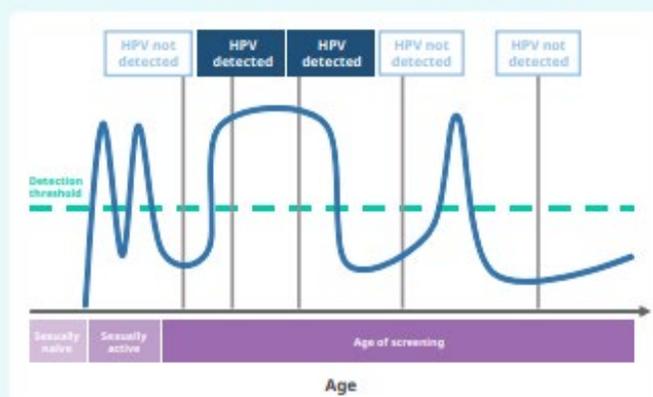
When an HPV infection is acquired, most people build a strong immune response within 1 to 2 years. This can make HPV undetectable in laboratory tests and is often referred to as “viral clearance”.

**Recent research shows that HPV may remain in the basal layers of the epithelium of the cervix as a latent or low-level, immune-controlled infection that is undetectable by HPV testing.** Periods of immune suppression may lead to increased HPV replication, and a previously immune-controlled HPV infection may become detectable or re-detectable in laboratory tests. Therefore:

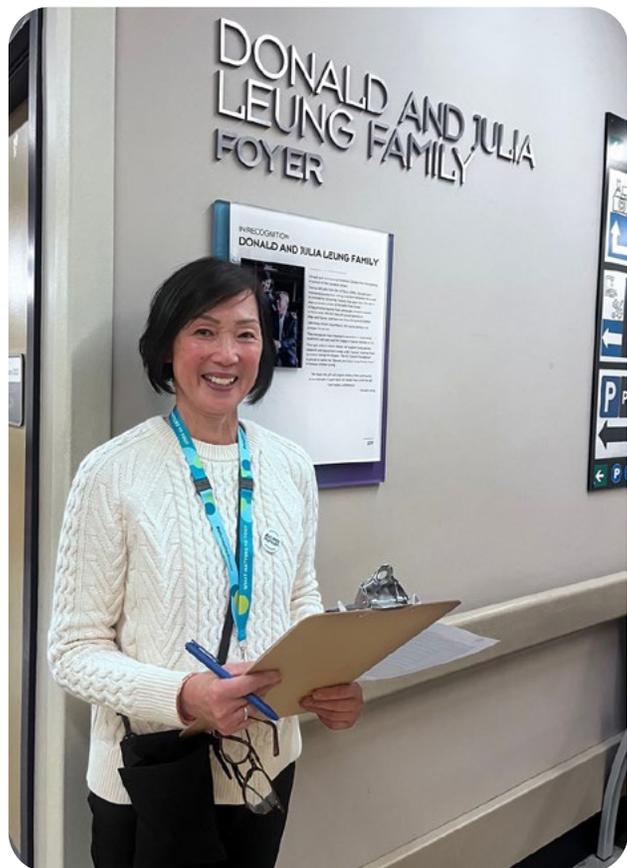
- 1 **If HPV is no longer detectable on a laboratory test, it does not mean that the virus has completely cleared nor does it mean the patient will have a detectable HPV infection again in the future.** It is important that the patient stays up to date with cervix screening to monitor and effectively address possible persistent infections that could lead to cervical precancer.
- 2 **HPV detection does not mean there is a new HPV infection:** Finding HPV in a sample, when HPV was not detected in previous tests, does not mean the patient or their sexual partner(s) had other partner(s) during their relationship. The test may have detected a previously-acquired infection, which has only now become clinically detectable due to relative immune suppression and resultant higher viral shedding.

## An example of HPV natural history across the life span for a person with a cervix

The example below shows how a patient’s HPV results can change between cervix screens. HPV may be detected due to a new infection from a new sexual partner, or as a re-detection of a previously-acquired HPV. It is undetectable when the immune system has gained control of the virus, decreasing the amount of HPV to below the test detection threshold. At these low, undetectable levels, HPV is not considered clinically significant.



# New portal gives BC Cancer patients access to upcoming appointments, diagnostic results and more



Cathy Doa, a patient partner at BC Cancer – Vancouver to help promote this new portal. “Patients are really excited about it and many are willing to sign up right away,” says Cathy. “It gives patients a new tool to get access to their lab results and doctor’s notes. They can read their records and if they have any questions, they can always take them to their health care team. I enjoy being a patient partner. It’s such a rewarding experience.”

will help remind them of what was discussed at their appointments and make it easier to manage the logistics of cancer care. All of this will help relieve some of their stress and anxiety.”

Through this portal, BC Cancer patients can view information from CST Cerner including:

- Upcoming appointments
- Medical imaging, lab and other diagnostic results
- Allergies
- Procedure history
- Select clinical documents, including discharge

summaries and clinical notes such as consults and follow-up appointments.

It is important to note that, when BC Cancer schedules consults and follow-up appointments, it is routine for our clerical teams to book and rebook appointments prior to notifying patients. Please let patients know that while their consult or follow-up appointment may be listed in AccessMyHealth, it is not confirmed until they hear from their cancer centre.

As this portal is the patient facing view of information from CST Cerner, patients receiving care at BC Cancer – Kelowna will not be able to view their records. They can view some information through MyCareCompass and the Interior Health patient portal.

Labs and medical imaging from sites outside of PHSA, Vancouver Coastal Health, and Providence Health Care will be available in Health Gateway, not AccessMyHealth. Patients in Northern Health, Interior Health and Island Health will continue to need to

access their local health authority portals for certain reports, results and services.

Eligible BC residents ages 12 and up will be able to access the portal through the provincial Health Gateway using their **BC Services Card**. Patients who need help logging in to AccessMyHealth can contact the Service BC Help Desk for assistance with BC Services Card login, send a request to the AccessMyHealth support team by filling out the form on the support page or send an email to [accessmyhealthsupport@phsa.ca](mailto:accessmyhealthsupport@phsa.ca)

**AccessMyHealth**, a new self serve digital portal launched on February 4 for patients receiving care at BC Cancer’s Abbotsford, Prince George, Surrey, Vancouver and Victoria centres as well as the Nanaimo Community Oncology Network site and at other sites and clinics across the Provincial Health Services Authority (PHSA), Vancouver Coastal Health (VCH), and Providence Health Care (PHC).

The portal is a key step forward in **BC’s 10-Year Cancer Action Plan** and BC Cancer’s commitment to delivering person- and family centred care. Giving patients secure and convenient access to a patient facing view of select information from CST Cerner helps them better understand their health information, and take a more active, informed role in their care.

“We hear time and time again from patients and their families that living with cancer is a full-time job,” says Dr. Lyly Le, associate chief medical information officer, BC Cancer. “With this new portal, we are giving them access to information that

## FOR MORE INFORMATION

To learn more about the Family Practice Oncology Network or become involved, please email [FPON@bccancer.bc.ca](mailto:FPON@bccancer.bc.ca) or visit [www.fpon.ca](http://www.fpon.ca)

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BC Cancer provides specialized cancer care services to communities across British Columbia, the territories of many distinct First Nations. We are grateful to all the First Nations who have cared for and nurtured this land for all time, including the x<sup>m</sup>məθkwa<sup>y</sup>əm (Musqueam), Skwxwú7mesh Úxwumixw (Squamish), and səliłwətał (Tsleil-Waututh) First Nations on whose unceded and ancestral territory our head office is located.