

Advances in Lymphedema Management, Prevention, & Early Detection

Sarah Buddingh Smith, Physiotherapist, Certified Lymphedema Therapist



Cancer-related lymphedema impacts 350,000 Canadians, including 17% of people with breast cancer and 60% of people with head and neck cancer (Letellier et al., 2024; [click to see image](#)). Damage to the lymphatic system from surgery, such as lymph node removal, can be compounded by radiation therapy. When lymph fluid is no longer able to drain efficiently from the affected region, chronic swelling develops. This swelling can progress to skin changes, weeping fluid, wounds and recurrent infections. Moving a swollen and potentially painful limb can become challenging, and limit function in activities of daily living such as walking, bathing, dressing and cooking. The [Canadian Lymphedema Framework](#) has created a [two page summary](#) for health care providers with the key points of lymphedema assessment, treatment and pharmacology.

Surgical de-escalation is an important component of lymphedema prevention, reducing the number of lymph nodes being removed when possible (Cabioglu et al., 2025). Dr. Claire Temple-Oberle in Calgary is a pioneer in

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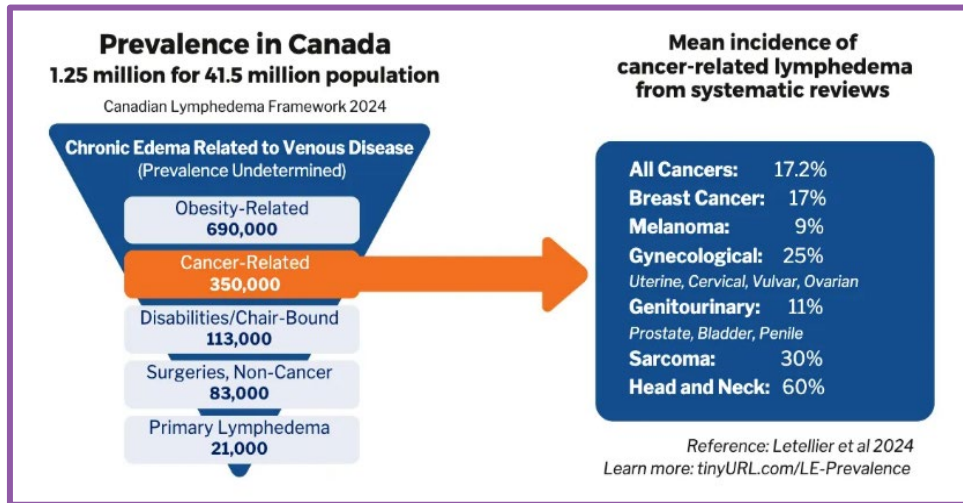
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reconstructive microsurgery techniques for the lymphatic system, such as lymphovenous anastomosis (LVA) (Deban et al., 2023). Preventative LVAs for people with high risk lymph node dissections are starting to be [performed in Kelowna](#) by Dr. Chris Baliski. The [UBC Hospital Lymphedema Clinic](#), under plastic surgeons Dr. Erin Brown and Dr. Kathryn Isaac, provides lymphatic microsurgies and liposuction to treat established upper and lower extremity lymphedema. Lymphatic microsurgies are also provided prophylactically.

When it is not possible to prevent lymphedema, early detection is the key to effective management. Self-measurement of limb circumference before and after lymph node surgery allows people at risk of developing lymphedema to independently monitor both upper and lower limbs (Rafn et al., 2019; Larsen et al., 2025). UBC has created a [self-measurement handout and video](#) for people at risk of upper extremity lymphedema, and tested implementation at Surrey Memorial Hospital. BC Cancer Physiotherapy and Physiatry are partnering with the [UBC Cancer Exercise & Physiotherapy Lab](#) and the [BC Lymphedema Association](#) to create a BC Cancer version of this handout through a Knowledge Translation Challenge. We are also planning to apply for grants to implement limb circumference self-measurement more broadly for people at

risk of developing or who have lymphedema throughout British Columbia. Please contact BC Cancer Physiotherapist Sarah Buddingh Smith (sarah.buddinghsmith@bccancer.bc.ca) if you are interested in collaborating!

If you are attending the [BC Cancer Summit](#) in November, please come to our Expanding Access to Lymphedema Care session, with presenters from BC Cancer Physiatry, Physiotherapy, and Speech Language Pathology, as well as the BC Lymphedema Association. Let's improve lymphedema outcomes together!

References for this article can be found on the [BC Cancer Network Website](#).

Surgery Network Travel Award Recipients

Dr. Claire Liu, General Surgery Resident

Comparison Of Health-Related Quality of Life Outcomes in Older Breast Cancer Patients Undergoing Breast Conserving Surgery, Mastectomy, And Reconstruction: A Prospective Study

Background

Modern day treatments have improved breast cancer survival, making health related quality of life (HRQoL) after treatment increasingly important in breast cancer survivorship. There is a knowledge gap in the HRQoL outcomes of older patients undergoing breast cancer surgery. This study evaluated the preoperative and six-month postoperative change in patient-reported HRQoL in several aspects of mental and physical health, comparing outcomes for breast conserving surgery (BCS), total mastectomy no reconstruction (TMNR), and total mastectomy with immediate reconstruction (TM+R) in older patients.

Methods

This prospective cohort study enrolled breast cancer patients between 2016 – 2023. Participants completed surveys that measured their mental and physical health. Surveys were completed preoperatively after surgical consultation and again six-months postoperatively. The BREAST-Q questionnaire was used to assess breast cancer specific outcomes including breast satisfaction, psychosocial, sexual, and chest physical well-being. General

Figure 1. Preop-to 6-month Postop Change in Core BREAST-Q Scores



patient-reported outcomes were categorized in depression, anxiety, pain, and perceived health.

Results

This study had 259 breast cancer patients ≥70 years old meeting inclusion/exclusion criteria complete their pre- and six-month postoperative surveys. Of these, 191 underwent BCS, 55 TM, and 13 TM+R. On average, patients who underwent TM and TM+R experienced clinically significant reductions in breast satisfaction (-5.8, -5.6) and sexual well-being (-5.4, -9.1). TM patients also had decreased psychosocial (-4.2) and chest physical well-being (-5.0),

while BCS patients showed no significant changes. In the multivariable linear regression model, BCS ($\beta = 13.6$, 95% CI: [4.0, 23.2], $p = 0.006$) and TM+R ($\beta = 19.1$, 95% CI: [3.1, 35.1], $p = 0.02$) were significantly associated with higher postoperative breast satisfaction scores compared to TM, controlling for tumor factors, neoadjuvant, adjuvant therapies, comorbidity disease burden, and socioeconomic status. BCS was also associated with higher postoperative chest physical well-being compared to TM ($\beta = 8.8$, 95% CI: [0.9, 16.6], $p = 0.03$). There was no significant difference in the change in depression, anxiety, or pain scores within and across the surgical modalities.

Conclusion

In breast cancer surgery patients ≥ 70 years old, BCS offers improved HRQoL outcomes overall compared to mastectomy, both with and without immediate breast reconstruction. Older breast cancer patients should be counselled to undergo BCS when feasible.

Future Direction

We aim to explore factors influencing patient decisions to undergo mastectomy and reconstruction and compare any potential decision regret and cancer worry between the BCS and mastectomy patients.

Dr. Ella Barrett-Chan, Obstetrics & Gynecology Resident

Window Of Opportunity for Cancer Prevention: Metachronous BRCA-Associated Breast and Ovarian Cancers In British Columbia

Objectives

This study aimed to evaluate patients with metachronous BRCA-associated breast and ovarian cancer in British Columbia (BC), Canada, including ages and intervals between first and secondary cancer diagnoses, and uptake and timing of genetic testing and risk-reducing interventions.

Methods

This was a retrospective population-based cohort study from the BC Cancer Hereditary Cancer Program High Risk Clinic (HCP HRC) from 1998-2022 and Provincial Pharmacy between 1995-2024. The Pharmacy database was first searched for those prescribed olaparib for advanced-stage high-grade serous ovarian carcinoma (HGSC) as a surrogate for BRCA pathogenic variant (PV) and linked to those prescribed a breast cancer treatment protocol either before or after olaparib. Patients with metachronous ovarian and breast cancer diagnoses from the HCP HRC were identified.

Results

From HCP HRC there were 235 breast and 50 ovarian cancer patients, of whom 10 and 3 developed metachronous ovarian and breast cancer, respectively (crude rates 4% and 6%). From the Pharmacy database, an additional 194 patients had HGSC, of whom 17 (8.8%) received prior breast cancer treatment, and 3 (1.5%) had subsequent breast

cancer treatment. In total there were 27 patients with breast cancer and metachronous ovarian cancer, and 6 patients with ovarian cancer and metachronous breast cancer. The median age at first cancer diagnosis was 51 years (range 32-71), and the median interval to second cancer was 6 years (range 0-31). Of the 27 with breast cancer first, 15 had BRCA testing after that initial diagnosis, and of the 15 who had BRCA testing, 10/15 (67%) subsequently had risk-reducing bilateral salpingo-oophorectomy (RRBSO) at a median age of 58.5 years (range 42-72). There were 6 patients with triple-negative breast cancer at a median age of 45 (range 41-64), and although all but one (over age 60) were eligible for BRCA testing, only 2 were tested. Of the 6 patients with ovarian cancer who had metachronous breast cancer, the median interval between cancers was 5 years (range 2-11). None had risk-reducing mastectomy, but 5/6 had breast cancer surveillance. Three of these patients subsequently died of ovarian cancer.

Conclusions

These data demonstrate a relatively long-time interval between BRCA-associated breast and ovarian cancers, suggesting a window of opportunity for earlier intervention to reduce the risk of the second cancer.

Elliott Gee, Medical School Year 1 Student

Clinical and Enhanced Recovery After Surgery Outcomes in Right Hemicolectomy for Colon Cancer Versus Ileocecal Resection for Crohn's Disease

Our project was a retrospective cohort study comparing the postoperative outcomes between patients receiving ileocecal resection for Crohn's disease and right

hemicolectomy for colon cancer, two similar operations for different diseases where the affected bowel is removed. Our goal was to compare how outcomes between Crohn's

patients differed from colon cancer patients given it is common practice to employ enhanced recovery after surgery protocols for all colorectal surgical patients. We gathered our data from the American College of Surgeons' National Surgical Quality Improvement Program (NSQIP) database, which compiles data from over 700 participating hospitals worldwide. Our study included 41,849 patients and to our knowledge, is the largest study on this topic to date. Our results demonstrated significantly lower readmission rates and superficial surgical site infection rates in colon cancer patients. We hypothesize that this is due to the increased complexity of Crohn's disease patients often having impaired nutritional status and using immunosuppressive medications pre-operation, both of which have been shown to affect wound healing. Conversely, there were significantly higher rates of pulmonary emboli, pneumonia, and urinary tract infections in colon cancer patients, which we hypothesize to be due to

the older population of colon cancer patients not being as mobile and having lower physical fitness. As such, we believe our study provides the basis for tailoring ERAS protocols to meet the unique needs of each set of patients based on diagnosis. For Crohn's disease patients, we'd propose the standardized utilization of a dietician in the care of all Crohn's disease patients to help stabilize the nutritional status of all Crohn's disease patients pre-operation. Additionally, the standardized timing of when to stop and start immunomodulating medications pre-operation and post-operation respectively. For colon cancer patients, we would recommend the standardization of "prehabilitation" in the form of adding exercise, diet, and sleep to the ERAS protocol, to provide patients with a stronger baseline and to promote early mobilization post-operation. Our study is significant in both its size and the directions it leads us for improving outcomes for both Crohn's disease and colon cancer patients.

Kieran Chalmers, Medical School Year 2 Student

Exploring Breast Density's Role in Breast Cancer Surgery Outcomes

Background

Breast cancer is the most common cancer affecting women in North America. Breast-conserving surgery (BCS) is the standard of care for early-stage breast cancer, with many benefits. However, the Achilles' heel is the potential need for additional surgery (re-excision) to ensure pathologically clear margins. Furthermore, while becoming increasingly uncommon, local recurrence is a concern that weighs greatly in patients' minds. These issues are a source of emotional distress for patients, as well as increasing healthcare costs and worse patient reported outcomes.

While patient, disease, and treatment-related factors are known to influence re-excision and recurrence rates following BCS, mammographic breast density (BD) has also been implicated as a contributing factor. BD refers to the proportion of dense tissue visible on a mammogram, with higher BD linked to both increased cancer risk and masking cancer detection. This has led to speculation that higher BD could lead to underestimation of disease extent, increasing the likelihood of re-excisions and recurrence.

Methods

We performed a retrospective, population-based review of over 1,300 patients in the British Columbia Interior who underwent BCS for invasive breast cancer. This is the largest study examining BD's role in re-excision rates and the second largest addressing its relationship with local recurrence following BCS. The aim was to clarify whether

breast density affects the need for re-excision or recurrence after surgery.

Key Findings

Higher BD did not result in higher rates of re-excision or cancer recurrence, even when adjusting for factors like age, tumour size, adjuvant treatments received and tumour type. Interestingly, patients with the densest breasts (BI-RADS category D) were less likely to undergo a re-excision when compared to those with the least dense breasts (BI-RADS category A). Otherwise, there was no significance difference in re-excision or recurrence rates. This counterintuitive result may reflect differences in surgical planning, surgeon and patient decision making or other unmeasured factors such as potential correlation between BD and breast size or BMI.

Apart from these novel findings, we also confirmed known literature that patients with denser breasts were more likely to be younger and have larger tumors at the time of diagnosis. This underscores the importance of ensuring that imaging, surgical techniques, and treatment plans are optimized for all patients.

Why This Matters

These findings provide reassurance that higher BD does not necessarily increase the likelihood of re-excision or recurrence, countering common assumptions. By addressing patient and clinician concerns, this research may help reduce patient distress and support informed decision-making.

This study represents one of the largest investigations into BD and surgical outcomes while controlling for key patient and tumour factors. It emphasizes the importance of patient-centered care, aiming to reduce preventable surgeries, conserve resources, and ultimately improve patient experiences.

This research was supported by the BC Surgeon Network who provided statistical support for the project. We were recipients of a BC Cancer Surgical Oncology Network Travel Award, enabling a presentation at the North Pacific Surgical Association Meeting. We are grateful for this opportunity to contribute to the ongoing improvement of cancer care in British Columbia.

Dr. Michael Guo, General Surgery Resident

Uncovering Surgical Disparities in Colorectal Cancer Care for Immigrants in B.C.

Immigrants make up a large and growing proportion of British Columbia's population, bringing tremendous diversity to our province. Yet, while immigrants are central to our communities, little has been known about how they fare after major cancer surgery. Our team recently conducted the first province-wide study in Canada to examine surgical outcomes for immigrants with colorectal cancer (CRC). Using comprehensive B.C. health databases and linking them with immigration data, we compared hospital length of stay, emergency department visits, readmissions, and survival between immigrant and non-immigrant patients. This work is the first of its kind to evaluate outcomes across such a large, immigrant-rich population using province-wide, high-quality data.

The findings revealed striking patterns. Immigrant patients tended to have shorter hospital stays and fewer emergency visits compared to non-immigrants. However, despite these markers of smoother recoveries, immigrants experienced higher post-operative mortality. This paradox points to the

presence of underlying barriers to care—barriers that are real, but not yet fully understood.

By uncovering these disparities, our study provides an essential first step toward addressing them. With this evidence in hand, health systems and providers can begin the crucial work of exploring why these differences occur and how to ensure equitable surgical care for all patients. The implications go well beyond colorectal cancer. This study demonstrates the power of population-based data in B.C. to reveal inequities that would otherwise remain hidden. It underscores the need to continue examining outcomes for vulnerable populations so that cancer care in our province remains not only excellent, but equitable.

In short, this research shows that while B.C. is a leader in cancer outcomes, we must remain attentive to the unique needs of immigrant patients. By continuing to study and address disparities, we can ensure that every British Columbian has the best possible chance of recovery after surgery.

RESPONSe: Using Patient-Reported Outcomes to Transform Cancer Care at Richmond Hospital

Dr. Jeremy Ho, Medical Oncologist, Richmond Hospital



Across British Columbia, cancer care teams are facing a growing challenge. Patient volumes are steadily rising, and treatments are becoming increasingly complex. Chemotherapy, targeted therapies, and immunotherapy have improved outcomes for many patients, but side effects often occur suddenly

and unpredictably, usually in the days between clinic visits. The Richmond Hospital Cancer Care team developed the RESPONSe program (Remote Symptom and Patient Monitoring System), to meet this challenge by placing patient-reported outcome measures (PROMs) at the centre of care for patients starting chemotherapy.

PROMs create a structured and proactive way for patients to share their experiences from home. Instead of waiting for a scheduled appointment or picking up the phone when problems become severe, patients complete regular surveys on their smartphone, tablet, or computer. These surveys ask about symptoms such as nausea, fatigue, or pain. The responses are monitored in real time by a symptom management nurse, who can reach out quickly if concerning symptoms are identified through automated triaging logic. This approach aims to be proactive in management of symptoms before they worsen, offering timely support and reassurance to patients.

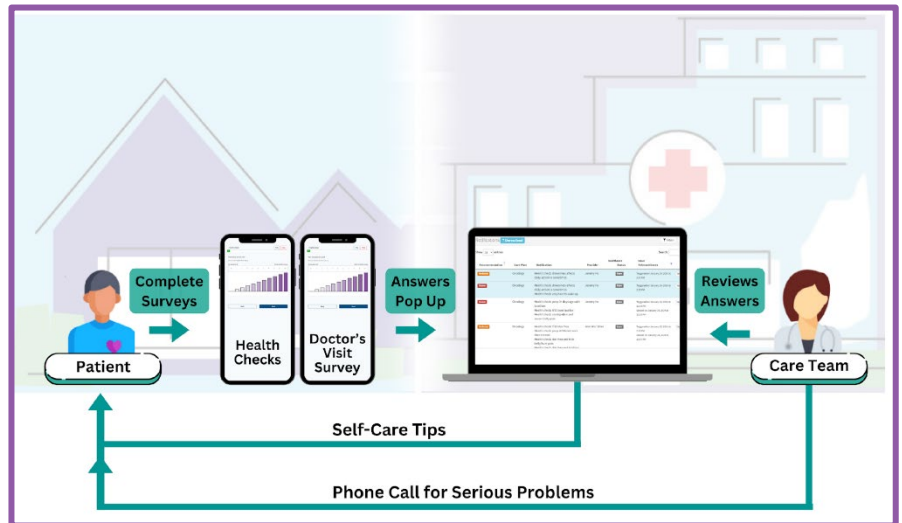
One patient described their experience: “Being able to communicate my symptoms in real-time and receive quick feedback has been incredibly reassuring. It saved me from going to the ER and gave me the immediate help I needed.”

The value of PROMs goes beyond tracking symptoms. They help build trust and a stronger sense of partnership between patients and the care team. Patients feel confident that their voices are being heard and that their experiences matter. Patient experience feedback has been uniformly positive, with patients indicating feeling extremely supported during cancer treatment, with almost all patients recommending RESPONSE to other patients undergoing chemotherapy. This is particularly important in a community like Richmond, where many people receive care in a language that is not their first. By offering surveys in Chinese since November 2024, RESPONSE makes the cancer clinic a more inclusive space.

A Chinese-speaking patient described this impact: “When the questions were in my own language, I felt like I could finally participate in my own care instead of relying on my children to translate. I could see that the cancer team was really concerned about my health. My family also felt reassured that nothing important would be missed.”

PROMs offer benefits that extend beyond individual patient care to the broader system as a whole. Patients report fewer calls to the clinic because their concerns are either addressed through automated self-management resources or managed with the assurance that a nurse will reach out if needed. The triaging system also allows nurses to direct

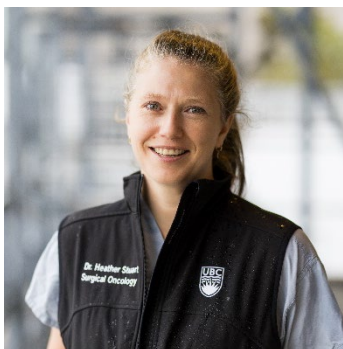
their time to patients requiring real intervention, rather than handling calls from those seeking reassurance. Physicians are able to address questions and concerns more



effectively because they have a clearer picture of what patients are experiencing between visits. This more targeted approach has also led to fewer emergency room visits and hospital admissions, showing that PROMs improve the experience for patients while creating meaningful efficiencies for the entire care team. The RESPONSE program has shown that PROMs can improve patient care, strengthen engagement, and enhance safety. It represents a model that can be adapted to other cancer clinics across British Columbia, supporting the provincial vision for a cancer system that is more connected, inclusive, and patient-centered. Most importantly, it demonstrates how listening closely to patients can create a more compassionate and responsive system, offering hope that care can continue to evolve in ways that truly meet patients’ needs.

Cancer Quality Metric Reporting in BC

Dr. Heather Stuart, Surgical Oncologist, Vancouver Coastal Health & BC Cancer Vancouver



In late 2024, PHSA internally released the inaugural British Columbia Cancer Control Quality Index Report (CCQI). The purpose was to create benchmarks for BC’s cancer system performance and inform future strategies and action plans. Indicators were selected within areas of

prevention, treatment, survivorship, and end-of-life care with special focus on indigenous populations. It is loosely modelled on similar reports issued by Cancer Care Ontario

(CCO) and included input from the BC Cancer Surgical Tumor Groups, BC Cancer tumor groups and screening programs, BC Cancer Indigenous cancer control, BC Center for Disease Control (BCCDC) and PHSA Data and Analytics teams. Specific disease sites included breast, cervix, colon, prostate and lung cancer. The goal is to expand and develop future renditions to provide relevant and timely feedback to providers on cancer quality care metrics.

Within cancer prevention, the focus was on modifiable risk factors including physical activity, fruit and vegetable consumption, obesity, alcohol misuse, tobacco use and HPV vaccination status. The data, collected up to 2022/2023,

included information on gender, socio-economic status, and post-secondary education. Metrics for overall cancer burden was reported for 2021 and included incidence, overall and cancer specific mortality and overall, 1-, 3- and 5-year survival rates. Other metrics included screening for tobacco use, attachment to a primary care practitioner within a year of diagnosis, emergency room admissions 30 days prior to a cancer diagnosis. Specific metrics were collected for malignancies with the highest incidences (breast, colon, prostate and lung). Cervix was included as it has a vaccine prevention strategy and HPV screening that are both provincial initiatives.

Breast cancer specific metrics included participation in breast screening, wait time from screening to tissue diagnosis, stage at diagnosis, time from diagnosis to first treatment, unplanned readmissions within 30 days of surgery, breast conservation rate for early stage breast cancer, adjuvant radiation in stage III patients post mastectomy, and patients with triple negative or HER2 positive disease, non-metastatic disease who received neoadjuvant and adjuvant systemic therapy. Colon cancer metrics included participation in FIT screening, colonoscopy after positive FIT, stage at diagnosis, time from diagnosis to first treatment, pre-operative MRI for rectal cancer, readmission 30 days post-surgery, surgical lymph node

harvest, radial margin and TME completeness and surveillance colonoscopy. Lung cancer specific metrics included participation in screening, stage at diagnosis, time from diagnosis to first non-surgical treatment, readmission 30 days post-surgery, time from decision for surgery to surgical date, 30 and 90 day mortality, early stage small cell lung cancer patients receiving chemoradiation, stage 2 non-small cell lung cancer (NSCLC) patients with post operative medical oncology consultation and stage 3 NSCLC patients with chemoradiation and immunotherapy. For prostate cancer, collected metrics included stage at diagnosis, time from diagnosis to first treatment, low risk patients having a bone scan, readmission 30 days post operatively, low risk patients managed with no treatment, positive margins following prostatectomy, high risk patients having androgen deprivation therapy (ADT) and radiation, metastatic patients having combined AD and targeted therapy.

End of life metrics reported included emergency room visits and systemic therapy within last 30 days of life. The report made a commitment to engage in collecting and evaluating metrics for quality for indigenous cancer care. These combined reports are a major step forward in establishing equity and quality in care across the province. The hope is that as they are refined, and current data is included that they will be reported more widely.

Immunotherapy-Related Adverse Events: A Primer for Surgeons

Dr. Vincent Poon, Medical Oncologist, BC Cancer Vancouver



Cancer immunotherapy in the form of checkpoint inhibitors (CPI) is a rapidly growing field in a variety of tumour types. New indications continue to roll out in the metastatic, adjuvant, more recently, neoadjuvant settings, such as in breast, lung and melanoma. While these agents have the potential to markedly

improve patient outcomes, there are associated risks of immunotherapy-related adverse events (IRAE's) that vary enormously in their severity (from mild to fatal) and presentation.

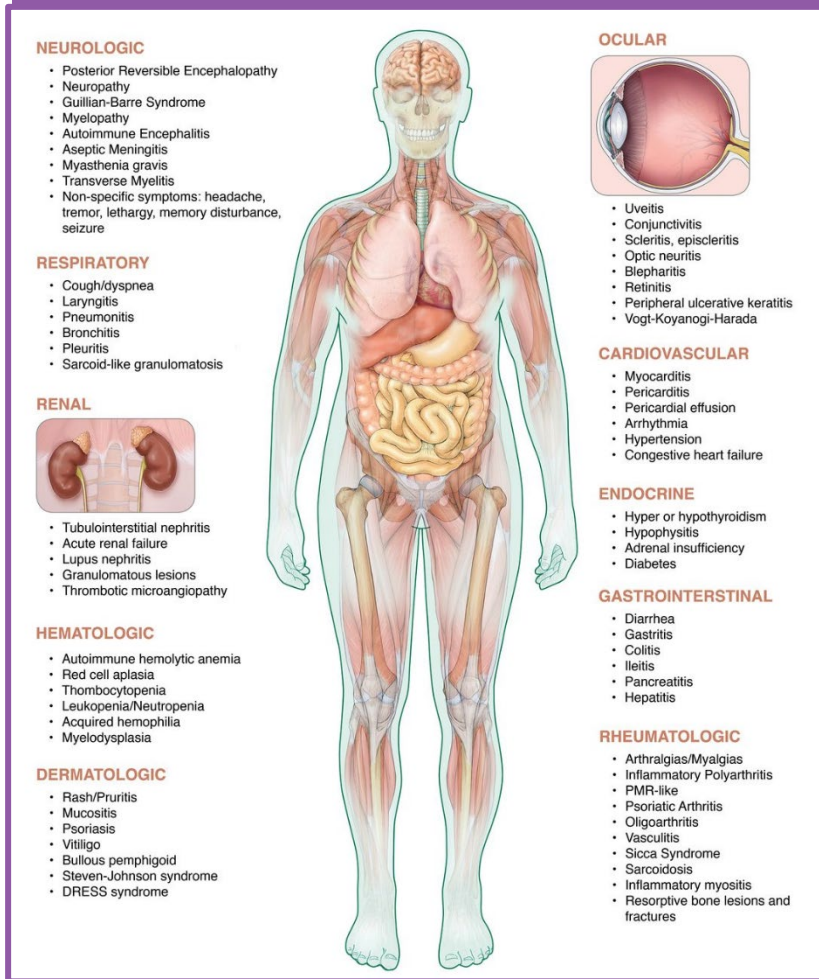
Who is at risk: Any patient treated with a CPI is at risk for developing an IRAE. These CPI have a number of targets (PD-1, PD-L1, CTLA-4, LAG-3), and common agents include (but are not limited to): Pembrolizumab, Nivolumab, Ipilimumab, Relatlimab, Atezolizumab, Durvalumab, Tremelimumab, Avelumab and Cemiplimab.

What are they at risk of: Nearly any organ system can be involved (Figure 2), though commonly affected sites include the skin, GI tract, endocrine organs, lungs and liver.

When does it happen: Acute toxicities (within hours to days of first exposure to CPI) are generally quite uncommon. While the majority of patients present with IRAE's that develop within weeks to months of initiating therapy, patients can develop late toxicities even years after exposure.

Why to be concerned: IRAE's can be severe, and rare IRAE's such as myocarditis or encephalitis have high rates of mortality, especially if recognized late. While the majority of IRAE's are associated with clinical signs or symptoms, subclinical presentations are possible. Of particular note is the risk of adrenal insufficiency; perioperative management should include an AM cortisol to rule out adrenal insufficiency prior to OR to mitigate the risk of adrenal crisis.

Figure 2. Systemic irAE associated with immune checkpoint inhibitors (from Jamal *et al.*, J Rheum, 2020)⁵



How to manage: IRAE’s are non-specific mimickers, and work-up should be done to rule out other etiologies for symptoms that arise. Glucocorticoids are often incorporated early in the management of IRAE’s, but early involvement of the prescribing medical oncologist and other specialty services is strongly recommended.

Where to go for additional guidance: Provincial guidelines are available through BC Cancer¹, and international guidelines from ASCO², ESMO³, and SITC⁴ are all available online.

References for this article can be found on the [BC Cancer Network Website](https://www.bccancer.bc.ca/Network-Website).

Fellows Introductions



Dr. Daniel Skubleny – 1st Year Surgical Oncology Fellow
Dr. Skubleny is a Surgical Oncology Fellow at the University of British Columbia (UBC). He completed his medical degree and General Surgery residency at the University of Alberta, where he also earned a PhD investigating translational

biomarkers in gastric cancer. His doctoral work included the development of patient-derived organoid cultures and the creation of a gene expression test capable of assigning molecular classification subtypes using artificial intelligence. Dr. Skubleny’s clinical and research interests focus on gastric and colorectal adenocarcinoma, as well as exploring the molecular basis of malignancy as a whole. Dr. Skubleny can be reached at daniel.skubleny1@vch.ca.



Dr. Susie Youn – 2nd Year Surgical Oncology Fellow
Dr. Youn completed her medical school and general surgery residency at the University of Alberta in Edmonton, Alberta. During her time there she also completed a Master of Science in Clinical Epidemiology through the Clinician Investigator Program,

with her thesis focusing on body composition and sarcopenia in cancer patients. Her current research interests include quality improvement in wait times for cancer patients and prognostic factors in rectal cancer. She is in her first year of the Complex General Surgical Oncology Fellowship at UBC. Dr. Youn can be reached at syoun@ualberta.ca.



Dr. Geneviève Laberge – 1st Year Urologic Oncology Fellow
 Dr. Laberge completed her medical degree in Quebec City, followed by a urology residency at Université de Sherbrooke. She has had a longstanding interest in uro-oncology, with a special focus on the surgical management of urologic cancers. She is currently

pursuing fellowship training in preparation for a future position as a uro-oncologist at Hôtel-Dieu de Lévis, in the province of Quebec. Dr. Laberge can be reached at genevieve.laberge.2@ulaval.ca.



Dr. Emma Clarebrough – 1st Year Urologic Oncology Fellow
 Dr. Clarebrough is from Melbourne, Australia, currently undertaking a one-year clinical fellowship in uro-oncology at the University of British Columbia. She completed a Bachelor of Science with Honours, a medical degree, and a Masters of Surgery in

Australia before completing her surgical training in Victoria. She went on to undertake a robotic surgery fellowship at St Vincent’s Hospital, Melbourne before making the move to Canada. Emma has a special interest in uro-oncology and is completing the fellowship to hone her skills in the medical and surgical management of complex urological cancers. She has moved to Vancouver with her husband, two-year-old, and eight-month-old, and is excited to explore BC’s mountains and waterways with hiking and other outdoor adventures. Dr. Clarebrough can be reached at e.clarebrough@gmail.com.



Dr. Christine Li – 2nd Year Colorectal Fellow
 Dr. Li completed her undergraduate and medical school training at McMaster University. She then completed general surgery residency at the University of Alberta. She is now rounding off her training in colorectal surgery.

Dr. Li will also be concurrently completing the Master of Health Administration program at UBC. Her research interests include surgical innovation, medical education, and addressing areas of need in surgery with a systems-based approach. She places a priority on mentorship within

surgery and has been extremely lucky to work with many strong personal and professional mentors through her training. Dr. Li can be reached at ccl@ualberta.ca.



Dr. Zarruch Baig – 2nd Year Colorectal Fellow
 Dr. Baig completed medical school in Calgary and surgical training in Saskatchewan. During his surgical training, he took time off to pursue research on patient-oriented outcomes. He simultaneously pursued Master’s in Epidemiology from the Harvard School of Public Health. He is currently pursuing his

colorectal fellowship at St. Paul’s Hospital. During his spare time, he likes to play tennis, cross-fit, snowboard, swim, and maintain a healthy lifestyle to keep up with the energy levels of his 3-year-old son. Dr. Baig can be reached at zbaig@providencehealth.bc.ca.



Dr. Julian Wang – 1st Year Colorectal Fellow
 Dr. Wang completed medical school at McMaster University followed by general surgery residency at the University of Ottawa. He is currently training in a colorectal fellowship at St. Paul’s Hospital along with a Master of Health Administration at UBC. He

has a research interest in optimizing OR efficiency and is an avid skier and cyclist. Dr. Wang can be reached at julwang@student.ubc.ca.



Dr. Jordan Lewis – 1st Year Gynecologic Oncology Fellow
 Dr. Lewis is originally from Vancouver and completed her medical school training at the University of Toronto before returning home to pursue residency, and now fellowship, at UBC. She has a longstanding commitment to gynecologic

oncology and a parallel interest in quality improvement. During fellowship, she will be concurrently pursuing the Master’s in Quality Improvement and Patient Safety at the University of Toronto. Her academic interests include patient survivorship and improving multidisciplinary care pathways for patients post-treatment. Outside of work, she enjoys exploring the outdoors with her two corgis, trying new restaurants, discovering local music, and traveling. Dr. Lewis can be reached at jordan.lewis@vch.ca.



Dr. Tal Milman – 2nd Year Gynecologic Oncology Fellow
 Dr. Milman grew up in Toronto after immigrating from Israel at a young age. Upon completing medical school and residency in obstetrics and gynecology at the University of Toronto he decided to make the inevitable jump to the west coast for his fellowship at

Vancouver General Hospital. He is interested in health systems and leadership and is pursuing a Master’s in Health Management through DeGroot business school. He is excited to keep exploring BC’s mountains and coast through climbing, skiing, and hiking. Dr. Milman can be reached at tal.milman@vch.ca.



Dr. Natalie Bjurman – 1st Year Gynecologic Oncology Fellow
 Dr. Bjurman was born and raised in Vancouver, BC. She completed her undergraduate and master’s degrees in Biology at Mount Allison University in Sackville, NB, followed by medical training and residency in Obstetrics and Gynecology at UBC. She is currently a first-year fellow in

the Gynecologic Oncology program at UBC. As a Métis physician, Dr. Bjurman is committed to advancing Indigenous health, culturally safe care, and quality improvement research. She intends to pursue graduate training in Indigenous Public Health at UBC. Outside of medicine, she enjoys sports, outdoor activities, and time with loved ones. Dr. Bjurman can be reached at natalie.bjurman@vch.ca.

Introducing the Oligometastatic Breast Cancer Multidisciplinary Clinic

Dr. Elizaveta Vasilyeva, Surgical Oncologist, Vancouver Coastal Health & BC Cancer Vancouver



A new provincial pilot initiative, the Oligometastatic Breast Cancer Multidisciplinary Clinic, has been launched to enhance coordinated care and advance research for patients with newly diagnosed de novo oligometastatic breast cancer. This clinic brings together a

dedicated team of Medical, Radiation, and Surgical Oncologists, along with clinical fellows and a research projects manager, all with a shared commitment to improving outcomes for patients with metastatic breast cancer.

The team meets monthly to provide comprehensive multidisciplinary assessments while patients continue to receive care from their existing oncology providers. Beyond individualized care discussions, the clinic addresses an urgent need in the systematic collection and analysis of real-world data on treatment for this unique patient group. By creating a prospective, high-quality provincial database, the clinic aims to establish a care pathway and advance the quality of care.

Participation in the clinic also facilitates enrollment into relevant clinical trials for metastases directed therapy, and supports translational research, including opportunities for circulating tumor DNA (ctDNA) collection and analysis. Referrals from Oncologists are welcome. Through this collaborative approach, the Oligometastatic Breast Cancer Multidisciplinary Clinic represents a significant step forward in optimizing care and expanding the evidence base for patients living with metastatic breast cancer in our province.

The referral form can be found by following [this link](#), or scanning the QR code below:



The Integrated BC Cancer Supportive Care Program

Did you know that BC Cancer’s Supportive Care program offers a range of services to help patients and family members manage the physical, emotional, social, and practical concerns that come with cancer?

BC Cancer Supportive care is organized into three branches that offer a wide range of services at the six regional centres and/or via online options:

a. Psychosocial Oncology: Psychiatry, Patient and Family Counselling (PFC), Chinese Language Counselling, Punjabi Language Counselling, Art Therapy, Vocational Rehabilitation, and Spiritual Care.

b. Cancer Rehabilitation: Physical & Rehabilitation Medicine (currently limited to Kelowna Centre), Nutrition, Speech Language Pathology (SLP), and Physiotherapy (limited service).

c. Pain & Symptom Management / Palliative Care (PSMPC): Interdisciplinary care from Palliative Medicine physicians, NPs, RNs, pharmacists, and other allied health professionals.

Each branch is led by one of our Supportive Care Provincial Medical Directors.

Meet our Medical Directors and hear how supportive care services can benefit your surgical oncology patients:



Dr. Nadeesha Fernando – Psychosocial Oncology

Psychosocial Oncology supports patients/family with emotional or psychological challenges such as anxiety, depression, and psychological adjustment to cancer diagnosis/treatment. BC Cancer

counsellors are also able to help with practical needs such as managing financial toxicity of cancer and how it affects ability to travel to and stay near a cancer centre. Having access to psychosocial supports can improve quality of life, patient experience, and even survival.



Dr. Lauren Capozzi – Cancer Rehabilitation

Our cancer rehabilitation services play a vital role in helping surgical oncology patients recover and adapt after treatment. We focus on addressing persisting and focal

post-surgical pain, treatment-related side effects, and functional limitations that may impact recovery. For example, a patient who underwent surgery for oral cancer presented with swallowing difficulties, deconditioning, shoulder dysfunction, and fatigue. Through coordinated care that included speech therapy to improve swallowing, physiatry to guide recovery from spinal accessory nerve injury, physiotherapy to rebuild strength, and nutrition counselling to support healing, the patient was able to eat comfortably again, improve their shoulder function and pain control, and return to activities they enjoy. Together, we help patients maximize the benefits of surgery and return to the activities they enjoy.



Dr. Julia Ridley – Pain & Symptom Management / Palliative Care (PSMPC)

We are able to support patients with complex pain and symptoms related to their cancer and cancer treatment. Our Pain and Symptom Management services work alongside patients and

families to address fatigue, nausea, and changes in mobility, using a combination of medical treatments and supportive strategies. Many of our patients have significant pain and symptoms prior to surgery and need rapid de-escalation afterwards; a recent patient had significant bulky abdominal disease with nearly intractable nausea and high level of pain as a result. Following treatment including surgery, she had much lower symptom levels - we were able to support her symptoms prior to treatment to optimize her nutritional status and functional level, bridging her to surgery, then steadily decrease and stop most of her medications in recent months.

If you would like more information about our services and how to refer your patients, please go to our website by clicking [here](#) or contact Jonathan Avery (PhD), Manager, Provincial Programs, Supportive care at Jonathan.avery@bccancer.bc.ca.

Surgical Engagement with BC Cancer Clinical Care Pathways Program



Dr. Christine Simmons, Medical Oncologist & Provincial Tumour Group Council Chair, BC Cancer Vancouver

Helping providers and patients navigate a difficult and ever-changing path is a constant challenge. Clinical practice guidelines and protocols are therefore integral and relied upon heavily by health care practitioners, especially to ensure that evidence based, high quality care standards are met and maintained. [BC Cancer's Clinical Care Pathways](#) are evidence-based protocols that start with a detailed literature review and progress through extensive collaborative multi-disciplinary review.

BC Cancer's Tumour Groups team is **pleased to announce that they have published 17 clinical care pathways** on the [website](#) with an additional 3 on their way. The pathways map out the entire patient journey from pre-diagnosis/diagnosis right through to post-treatment care and survivorship, or, if the case may be, end of life care. Each of these pathways tailor information for clinicians and



Amilya Ladak, Manager, Tumour Groups & Pathology, Provincial Programs, BC Cancer

have a clear and transparent development methodology with authorship, date of publication, and expected date of next review. Their current form includes additional resources embedded by hyperlinks to allow the reader to delve into the level of detail they require.

As guidelines are often dated before completion, BC Cancer's Tumour Groups Team has developed a nimble process to keep these pathways current and up to date. Each pathway includes clear referral instructions and survivorship care plans.

While the pathways are currently framed for health care providers, there is work being done with patient partners to embed additional informational hyperlinks for patients and caregivers, to tailor the information provided to patients based on their current phase along their care journey.

BC Cancer Clinical Care Pathways – Call to Action:

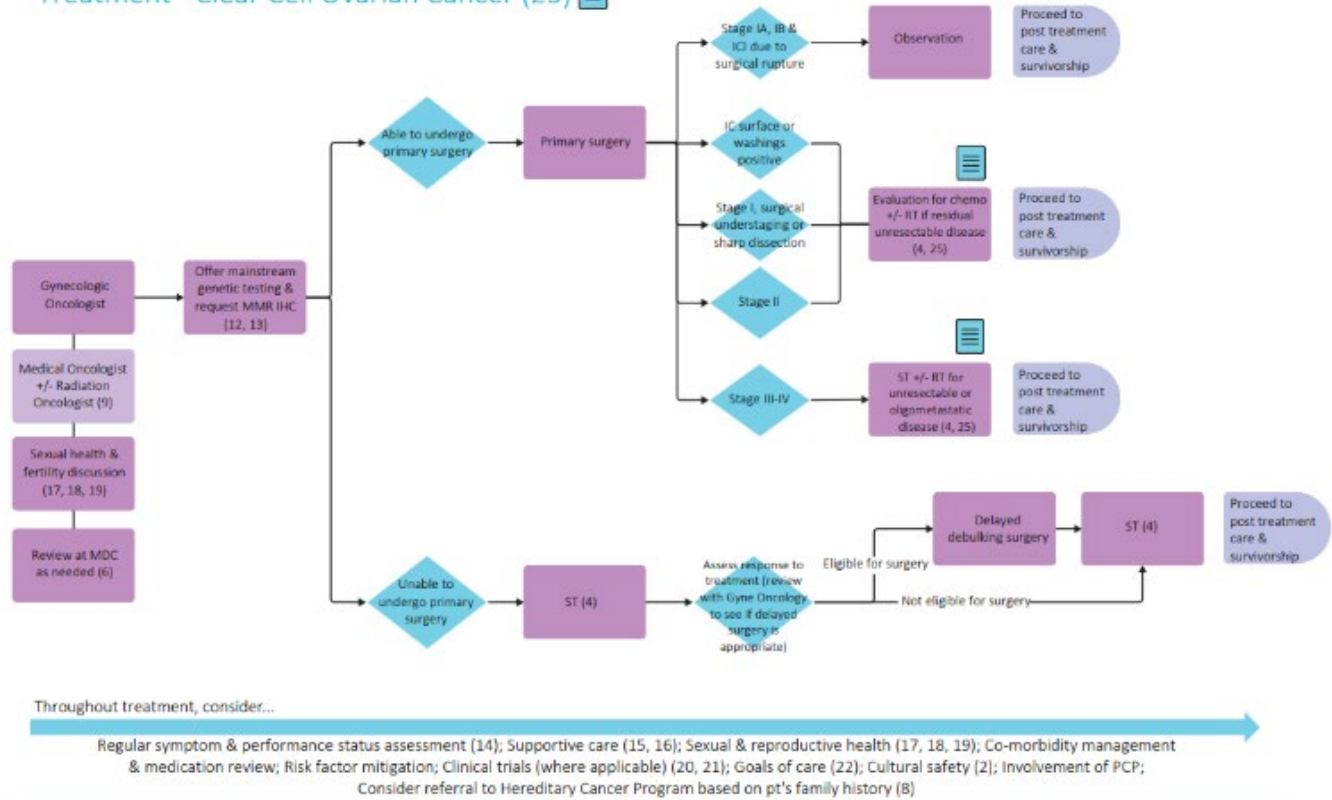
- **Share with regional surgical teams** to promote consistent practices across regions.
- **Use the Pathways** to guide referrals, treatment planning, and follow-up care.
- **Provide Feedback** to ensure surgical perspectives are reflected—especially around referral timing, operative decision points, and post-op care.

View published pathways and submit feedback through the [Consultation on Tumour-Specific Pathways](#) (bccancer.bc.ca) page or email TGCoordinator@bccancer.bc.ca

Example Pathway: Epithelial Ovarian Cancer - Clear Cell Ovarian Cancer Treatment Pathway (next page)

- Each Tumour-Specific Pathway is developed by a multi-disciplinary team of specialists, including surgeons, and approved by the relevant Provincial Tumour Group Committee.
- Each pathway features references, hyperlinks to guidelines and tools, and notes to guide clinicians as they support their patients through their cancer care journey.

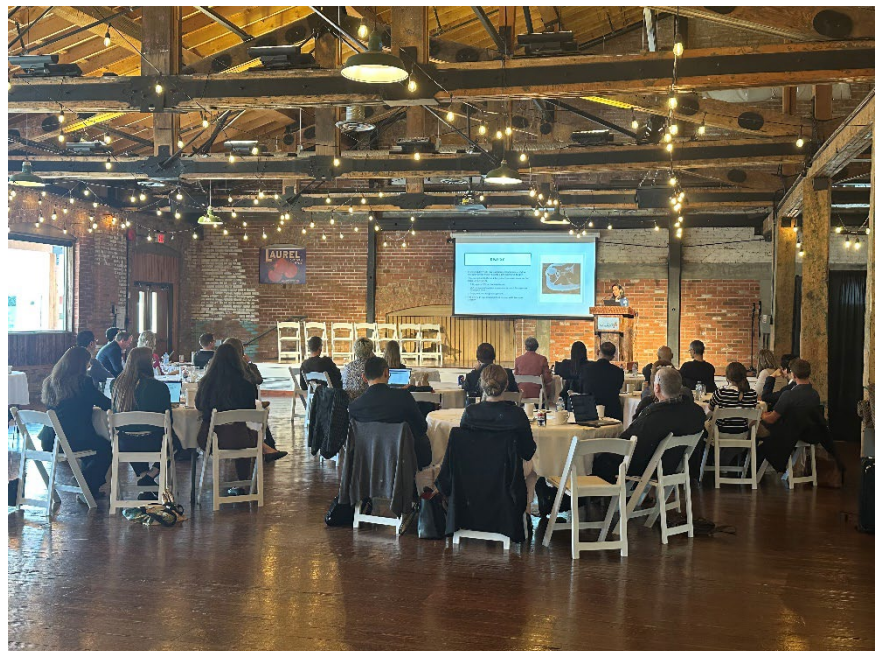
Treatment - Clear Cell Ovarian Cancer (23)



Spring Update Summary 2024/2025

In April 2025, BC Cancer – Surgery’s Continuing Professional Development & Knowledge Translation (CPD-KT) Committee held its annual Spring Update, a fully accredited MOC event designed to profile specific areas in cancer surgery and care. This year’s event was held in Kelowna, BC in collaboration with BC Surgical Society’s Annual Meeting. The Update focused on Regional Node Management and Rare Cancer and included speakers from across BC with backgrounds in surgical, radiation and medical oncology. Topics included neoadjuvant management of breast and rectal cancer; the management of regional nodes in breast, rectum, and skin cancers; the treatment of peritoneal malignancies, soft tissue masses, neuroendocrine and appendiceal tumours, alongside case presentations and panelist discussions. This event was well attended by multiple disciplines and providers from across the province, acting as a mechanism to improve

surgical oncology practice knowledge by providing the most current information in the field.



The Committee would like to extend its sincere thanks to the BC Cancer Foundation and its donors for their generous funding support, which helped make this educational event possible.

The 2026 Spring Update will be held on April 30th at the Fairmont Chateau Whistler, in continued collaboration with the BC Surgical Society's Annual Meeting. Please stay apprised of planning developments for the next Update [here](#), where further information will be posted.

SAVE THE DATE: 2026 SPRING UPDATE

Updates On Non-Epithelial Breast Lesions, Genetic Syndromes in Breast Cancer,
& Surgical Oncology Emergencies

April 30, 2026

Fairmont Chateau, Whistler

IN COLLABORATION WITH THE BC SURGICAL SOCIETY'S 79th ANNUAL SPRING MEETING

79TH ANNUAL SPRING MEETING

April 30 - May 2, 2026

Whistler, BC
Fairmont Chateau Whistler



Click [here](#) for more information on the BC Surgical Society's 79th Annual Spring Meeting

BC CANCER SURGERY NETWORK NEWSLETTER

The BC Cancer Surgery Network exists to promote and advance quality cancer surgery throughout the province, enable the integration of quality surgical oncology services into the formal cancer care system and ensure that patients have the best possible outcomes through consistent access to high quality multidisciplinary care. In enhancing appropriate, equitable and timely access to surgical services for cancer patients as close to home as possible, the Network supports communication and sharing of knowledge between subspecialty and community surgeons, their respective hospitals and BC Cancer.

To submit article ideas or for information, please contact:
SurgeryNetwork@bccancer.bc.ca

[VISIT THE SURGERY NETWORK WEBSITE](#)