

Surgical Oncology Network Newsletter

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SURGICAL ONCOLOGY NETWORK

ACTING CHAIR

Dr. Dianne Miller
604 877-6000 ext. 2354
dmiller@bccancer.bc.ca

COMMITTEE CHAIRS

CLINICAL PRACTICE

Dr. Noelle Davis
604 875-5880
noelle.davis@bccancer.bc.ca

CONTINUING PROFESSIONAL DEVELOPMENT & KNOWLEDGE TRANSFER

Dr. Rona Cheifetz
604 875-5880
cheifetz@interchange.ubc.ca

RESEARCH & OUTCOMES EVALUATION

Dr. Carl Brown
604 806-8711
cbrown@providencehealth.bc.ca

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PAEDIATRIC SURGICAL TUMOUR GROUP PROFILE

The Paediatric Surgical Tumour Group is one of 13 tumour site groups established by the Surgical Oncology Network to focus on specific areas of cancer treatment. This is the sixth in a series profiling the initiatives and plans of these groups.



Dr. Sonia Butterworth

Paediatric General Surgeon, BC Children's Hospital
Chair, Paediatric Surgical Tumour Group, SON
Assistant Clinical Professor, UBC

Dr. Butterworth, a graduate of the University of British Columbia, completed her paediatric general surgical residency at BC Children's Hospital. She then worked in Portland, Oregon for three years before returning to BC in the summer of 2008. Dr. Butterworth is a member of the Children's Oncology Group (a North American cooperative study group) as well as a Fellow of The Royal College of Physicians and Surgeons of Canada.

Childhood cancer is a rare disease, occurring in 1 in 8,000 children under age 14, with an annual incidence of 129 per million. With current treatment strategies, cure is 70-90%. There are several components of childhood cancer care which may be improved by utilizing the Surgical Oncology Network.

The Network needs to advocate for a more streamlined process by which patients over 17 years of age are transitioned to adult-oriented surgeons and oncologists. Currently, the process is often delayed for years without a clear timeline or a clear oncological team identified for follow-up.

It is important to determine early on who the adult-oriented oncologist surgeon in the patient's community will be. The appointed surgeon will then

undertake care of the patient, which among other things will include delivering comprehensive and timely information to the patient. Efforts are underway to facilitate this process.

Recently, there has been a move for children with cancer to receive some of their care closer to home, if deemed appropriate by the paediatric oncologist. The proposal is strongly supported by the BC government's "Closer to Home" initiative. For children who have completed therapy and no longer require their central venous line or venous access device, and in whom the paediatric oncologist determines would be a candidate to have the line removed closer to home, removal by the local surgeon may be supported by the BC Children's Hospital Oncology Division, if the local surgeon felt this was appropriate.

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REFERRAL REMINDER: GI STROMAL TUMOURS

Patients with GI Stromal Tumours (GIST) are eligible for one year of adjuvant imatinib, if they meet the following criteria:

1. Have a c-KIT positive GIST, or if c-KIT negative, containing a KIT mutation sensitive to imatinib, and
2. Are greater than 10 cm in diameter or have greater than 5 mitoses per 50 HPF.

Please do not forget to refer these patients, as treatment is associated with a reduced recurrence rate.

PAEDIATRIC SURGICAL TUMOUR GROUP

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For the initial evaluation of a child or adolescent suspected of having a tumour, immediate referral to a paediatric oncologist at BC Children's Hospital is recommended. Accurate and timely diagnosis of childhood cancer is best facilitated by a specialized team providing the laboratory, radiological and surgical evaluation required for diagnosis. These patients have very specific needs which are best met by a team approach directed by the paediatric oncologist. For these reasons, the BC Cancer Agency and the Provincial Paediatric Oncology/Haematology Network (PPOHN) recommend that all patients under the age of 17 who are suspected of having, or are diagnosed with cancer in BC should be referred directly to BC Children's Hospital for initial evaluation and therapy. A suspicion of cancer in these patients should prompt the surgeon to contact the paediatric oncologist before any further investigations or procedures are undertaken.

To contact the Paediatric Oncologist at BCCH call 604-875-2161 and ask for the oncologist on call.

For comments and questions contact:
Dr. Sonia Butterworth
BC Children's Hospital KO-113, ACB
4480 Oak Street, Vancouver, V6H 3V4
email: sbutterworth@cw.bc.ca

Useful Website on Paediatric Oncology:
<http://www.pedsoncologyeducation.com/>

EDUCATIONAL OUTCOMES AMONG CHILDHOOD CANCER SURVIVORS IN BC

Mary McBride, Program Leader, and Maria Lorenzi, Biostatistician, Adolescent, Young Adult Cancer Survivor Research Program

This is the first population-based study to determine educational outcomes in survivors of childhood cancer. The study found that patients with central nervous system (CNS) tumours who required cranial radiotherapy had decreased academic achievement when compared to a student sample, whereas survivors of other solid tumor malignancies did not have similar decreases in educational outcomes.

Advances in medical treatment have dramatically increased survival rates for children diagnosed with cancer: now over 80% of those diagnosed under 15 years of age in BC live five years or more post-diagnosis¹. Consequently, there is a growing population of survivors within the education system, many of whom may experience educational difficulties^{2,3,4,5}. There is evidence of adverse neurocognitive late effects of treatment, in particular cranial or craniospinal radiation therapy (CRT) and/or intrathecal methotrexate (IT MTX)^{6,7,8} which may inhibit educational performance. However, most studies to date were single-institution studies, or studies of a single diagnosis group, and were based on self-reports of a limited number of outcomes.

A recently-published BC Cancer Agency study of survivors in the BC school system has provided a comprehensive assessment of survivors' educational outcomes using standardized outcome measures, and

risk factors for poor achievement. This study is part of a larger Canadian Cancer Society Research Institute funded program to investigate survivor issues among those who were diagnosed with a cancer at a young age.

For the study, all individuals diagnosed with a cancer in BC under age 15 who survived at least five years from diagnosis were identified from the BC Cancer Registry; 782 of these survivors had administrative school records for Kindergarten to Grade 12 available from the BC Ministry of Education from 1995-2004. Treatment information for these survivors was abstracted from health records at BC Children's Hospital and BC Cancer Agency. Survivors' educational results were compared to those for a randomly-selected, age and gender-matched comparison group of 8,386 BC schoolchildren. All education data was provided to the investigators on an anonymized basis.

Survivors of CNS tumours had statistically significant Foundation Skills Assessment (FSA) test deficits in numeracy and reading (adjusted odds ratios from 0.2-0.6 in various grades, indicating 20% to 60% of the achievement of the general student population); leukemia survivors also had lower FSA scores, although most differences were not statistically significant. Survivors of other diagnoses demonstrated no significant differences in FSA scores. Survivors were three times more likely

than the general school population group to receive special education (32.5% vs. 14.1%), after adjustment for other factors, and had more physical, visual, and hearing disability designations. Females and those who had received radiation treatment, in particular cranial radiation, were at increased risk for poor educational outcomes.

Students who were enrolled in special education had worse educational outcomes, whether or not they were survivors, and the achievement differential between those with and without a special education designation was similar for both groups. Survivors who received radiation therapy, particularly CRT, were significantly more likely to have physical and hearing disabilities and poor educational achievement, compared to those who had not received radiation.

CNS survivors who received CRT had the poorest FSA outcomes, with less than 20% of this group meeting expectations on all nine FSA examinations. Survivors who received chemotherapy were almost three times more likely to have a physical disability compared to those who received no chemotherapy. Survivors who received IT MTX were more likely to be enrolled in special education than those who did not receive IT MTX.

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EDUCATIONAL OUTCOMES AMONG CHILDHOOD CANCER SURVIVORS IN BC

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CONCLUSION: This is the first population-based cohort study to utilize standardized measures to examine educational late effects of survivors of all childhood cancers. By utilizing a geographically-defined cohort and a randomly sampled comparison group, and standardized achievement measures from administrative data, potential bias due to incomplete or non-representative subject sampling and recruitment, loss to follow-up, self-report and recall are minimized.

These results have implications for the management of cancer survivors in the education system. Survivors and parents, clinicians, and educators all need to be aware of at-risk groups, potential educational difficulties and associated risk factors, so as to meet long term educational needs⁷. Sharing of risk information between clinicians, parents, and school personnel is fundamental in addressing the transition to school⁹. Early identification of problems^{10,11} and regular monitoring of progress over time¹² in the school system is essential in providing appropriate special education services or approaches to learning.

The relationship between special education programs and achievement among survivors other than those surviving a CNS tumor or leukemia needs to be further explored to address the question of the contribution of special education to achievement in this group. Finally, although studies have consistently indicated that survivors experience adverse neurocognitive late effects, this risk needs to be directly linked with poor achievement in school¹³ and educational intervention opportunities¹⁴.

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WEBSITES OF INTEREST

- SAGE is an online repository of cancer standards and guidelines. www.cancerview.ca (select SAGE from Services menu)
- PROVINCIAL CANCER PROFILES provides easy access to descriptive cancer statistics. www.cancerprofiles.ca
- CANCER CONTROL P.L.A.N.E.T. CANADA connects with data and planning resources. www.cancercontrolplanet.ca
- CANCER VIEW CANADA provides resources for cancer prevention, screening, treatment, and supportive, palliative and end-of-life care. www.cancerview.ca

UPCOMING CONFERENCES

**Canadian Association of General Surgeons
Canadian Surgery Forum 2009**
September 10 -13
Victoria, BC
www.cags-accg.ca

**Therapeutic Endoscopy Group
of St. Michael's Hospital
Twenty-Second International Course on
Therapeutic Endoscopy**
September 30 – October 3
Four Seasons Hotel, Toronto ON
www.thera-endo-toronto.com

**Colon and Rectal Surgery Association
72nd Annual Colon & Rectal Surgery:
Current Principles & Practice 2009**
September 30 – October 3
Hyatt Regency Hotel,
Minneapolis, MN
www.colonrectalcourse.org/index.htm

**American College of Surgeons
95th Annual Clinical Congress**
October 11-15
Chicago, IL
www.facs.org/clincon2009/index.html

**Surgical Oncology Network
Breast Cancer Fall Update**
October 24, 2009
Four Seasons Hotel
Vancouver, BC
www.bccancer.bc.ca/son

**University of Toronto, CME
Update in Surgical Oncology**
October 30, 2009
Metropolitan Hotel, Toronto ON
<http://events.cmetoronto.ca/website/index/SUR0901>

**Ontario Association of General Surgeons
15th O.A.G.S. Annual Meeting**
November 7, 2009
Sheraton Toronto Airport Hotel,
Toronto ON
www.oags.org

HEREDITARY CANCER PROGRAM: UPDATES FOR BC SURGEONS

Mary McCullum, Nurse Educator, Hereditary Cancer Program, BC Cancer Agency

Triple Negative Breast Cancer

Research suggests that women with “triple negative” breast cancers may be more likely to carry *BRCA1* gene mutations. Therefore, the Hereditary Cancer Program (HCP) is conducting a study that offers genetic counselling and *BRCA1/2* genetic testing to women who are diagnosed with “triple negative” breast cancer at age 36-45 and do not meet current *BRCA1/2* clinical criteria (See enclosed HBOC Reference Card or website for current criteria). The study goal is to learn whether genetic testing in this population meets a 10% mutation detection threshold. If so, this would provide evidence to revise current *BRCA1/2* testing criteria. Any physician can refer eligible patients to this study by completing the regular HCP Referral Form, with a note “for triple negative study”. Family history will be assessed by HCP staff to confirm eligibility.

Expedited *BRCA1/2* Testing

The Breast Tumour Group and the HCP are establishing a process to receive and evaluate requests for expedited *BRCA1/2* testing in cases **where the result will alter immediate clinical management**. With an approved request, genetic counselling will be provided and *BRCA1/2* index results can be available within 12 weeks. To request expedited *BRCA1/2* testing, complete the HCP Referral Form and use the “Expedited/Urgent” section to **provide detailed rationale** for the immediate clinical impact of the result. The referring physician will be informed of the reviewers’ decision.

DCIS & *BRCA1/2* Testing

| Grade | Adjustment Factor (for Approximate Age at Invasive Disease) |
|-----------------------------------|--|
| high grade DCIS (grade 3) | add 3 yrs to age at DCIS diagnosis |
| intermediate grade DCIS (grade 2) | add 5 years to age at DCIS diagnosis |
| low grade DCIS (grade 1) | add 10 years to age at DCIS diagnosis |

Developed with input from BCCA Pathology, the table on the left shows “DCIS pathology factor”, incorporating age and grade that is used by HCP staff to assess eligibility for *BRCA1/2* index testing.

HCP Referral Form

As part of a quality improvement process in 2008, major revisions were made to our Referral Form. Changes include a section to indicate the preferred location for an appointment. If your office does not have the current HCP form, it is available on the BCCA website (www.bccancer.bc.ca/hereditarycancer) or by calling 604-877-6000, local 2198. We send a detailed Family History Form to the patient who has been referred, and can usually book an appointment within three months of its return. Expedited appointments are offered when a gene mutation has already been identified in a family and for reasons of medical urgency.

Abbotsford Clinic

HCP is pleased to have staff on site at the new Abbotsford Centre. They receive referrals and provide service to people who live in that catchment area.

New Hereditary Cancer Resources

Laminated Hereditary Cancer Reference Cards

Enclosed with this newsletter are two laminated cards outlining current referral criteria for:

- Hereditary Breast/Ovarian Cancer
- Hereditary Colorectal Cancer (Lynch Syndrome/HNPCC)

The back of each card provides information about hereditary cancer risk assessment, a list of other hereditary cancer syndromes, and contact information. Additional copies are available on request. Your feedback about this resource is appreciated.

Does Cancer Run in My Family?

Copies of this new pamphlet can be ordered from the HCP office for use in your practice. Content includes: facts about cancer, possible signs of hereditary cancer, and a family tree to complete and review with a physician. We hope this tool will help to address some common misunderstandings about hereditary cancer, and to facilitate appropriate referrals.

Hereditary Cancer Program Contact Information

Mary McCullum
604-877-6000, ext. 2198; mmcullum@bccancer.bc.ca
www.bccancer.bc.ca/hereditarycancer



BEST BREAST PAPERS OF 2008

Dr. Rona Cheifetz, (adapted with permission from presentation by Dr. H. Pass, American Society of Breast Surgeons Meeting 2009)

'Best Breast Papers' is a presentation given annually at the American Society of Breast Surgeons meeting. It reviews the most clinically significant breast cancer publications from the previous year. The following is a synopsis of the presentation given May 2009 in San Diego on the 'Best Breast Papers of 2008'.

Safety of Fertility Preservation by Ovarian Stimulation with Letrozole and Gonadotropins in Patients with Breast Cancer: A Prospective Controlled Study. Azin A, et al. *J Clin Onc* 2008; 26:2630-2635.

Study: To determine the effect of Letrozole plus standard fertility medication on DFS in patients undergoing embryo or oocyte cryopreservation prior to adjuvant chemotherapy. Prospective, nonrandomized trial of 215 women with median follow-up of 23.4 months (IVF group) and 33.1 months (control) showed no difference in DFS or OS.

Clinical Importance: Women of childbearing age, requiring chemotherapy for treatment of breast cancer, can safely be offered fertility preservation. Surgeons should initiate this discussion and be aware of the resources available in their communities.

Intraoperative Radioisotope Injections for Sentinel Lymph Node Biopsy. Thompson M, et al. *Ann Surg Onc* 2008; 15: 3216-3221.

Study: Prospective study of 236 patients, showed feasibility, safety and cost savings of intraoperative injection of Tc-99 by the surgeon, after induction of general anaesthesia, with simplification of surgical scheduling and reduced patient discomfort.

Clinical Importance: Enticing because of ease, but requires radiation safety courses and approval. If feasible in Canada, this would address problems of access to SLNB in centres without nuclear medicine.

Atypical Ductal Hyperplasia at the Margin of Breast Biopsy – Is Re-excision Indicated? Arora S, et al. *Ann Surg Onc* 2008;15: 843-847.

Study: Retrospective review of 44 specimens of which 55% underwent re-excision. 27% were upstaged and 50% had residual cancer in the re-excision specimen.

Clinical Importance: This study was small with modest follow-up, but for patients with malignancy and ADH at the margin, re-excision should be strongly considered. If the lumpectomy specimen contains only ADH, re-imaging for assessment of residual disease can be used to guide management.

Presence of Lobular Carcinoma in Situ Does Not Increase Local Recurrence in Patients Treated with Breast-Conserving Therapy. Ciocca R, et al. *Ann Surg Onc* 2008;15:2263-2271.

Study: To determine whether LCIS in lumpectomy specimens, especially at the margin, increase LR. Retrospective study of 894 patients, stage 0-II. LCIS in 290, with LCIS at the final margin in 84. Median 5.2 year follow-up. Compared to 2,604 patients without LCIS,

showed no difference in LR.

Clinical Impact: While DCIS or invasive cancer at a margin does warrant re-excision, LCIS at the margin does not affect LR and does not warrant re-excision.

Novel Intraoperative Molecular Test for Sentinel Lymph Node Metastases in Patients with Early Stage Breast Cancer. Blumencranz P, et al. *J Clin Oncol* 2008; 26: 3338-3345.

Study: To evaluate a rapid intra-operative test for nodal metastases, this two part study looked first at threshold levels of mammaglobin and cytokeratin 19 correlating with mets >0.2 mm, then at clinical validation. Sens 87.6%, Spec 94.2%, PPV 86.2%, NPV 94.9%, time 36-46 minutes.

Clinical Importance: This assay, which is not widely available, was more accurate than touch prep or frozen section and requires less pathology support. May be feasible for adaptation for use in centres without on-site pathologists.

Elderly Breast Cancer Patients Treated by Conservative Surgery Alone Plus Adjuvant Tamoxifen. Martelli G, et al. *Cancer* 2008;112:481-488.

Study: To evaluate the necessity of SLNB and XRT in elderly women. Prospective follow-up of 354 women, 70 with lumpectomy with clear margins, 15 year follow-up. 4.2% axillary recurrence, 8.3 % LR, 8.8% DR. Overall mortality 76%, of which only 17% was due to breast cancer.

Clinical Importance: Elderly women with node negative, ER positive breast cancer, can be treated with lumpectomy (with clear margins) and Tamoxifen alone with acceptable long term outcomes. Axillary recurrences can be salvaged with surgery.

Role of Radiotherapy and Chemotherapy in the Development of Contralateral Breast Cancer. Hooning et al: *J Clin Oncol* 2008; 26: 5561-5568.

Study: To determine the role of XRT and chemo on the risk of future contralateral breast cancer. Registry review of 7,325 patients with follow-up on 95%, showed HR of 1.78 for women <35, and 1.09 for <45 receiving XRT. Risk was lower with use of electrons and lower with post mastectomy radiation. A positive family history had a synergistic effect. Chemo (with CMF), showed a non-significant decrease in risk.

Clinical Importance: Women <45, especially with a positive family history, need to be counseled regarding their increased risk of contralateral breast cancer with breast conserving surgery. Surgical options or increased surveillance can be considered.

Tamoxifen, Hot Flashes and Recurrences in Breast Cancer. Mortimer J, et al. *Breast Cancer Res Treat* 2008; 108: 421-426.

Study: To determine if hot flashes are an independent

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BEST BREAST PAPERS OF 2008

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predictor of Tamoxifen efficacy. Study of 864 women with stage I-IIIa cancer. 15% rate of second cancers (15%) overall. Risk was lower 12.9% vs 21% ($p=0.01$) in women who had hot flashes. Hot flashes were a stronger predictor of recurrence than age, hormone receptor status or stage (I vs II).

Clinical Importance: CYP2D6 is an enzyme required to metabolize Tamoxifen. Extensive metabolizers have more hot flashes. Patients who experience hot flashes should be reassured that this is a positive treatment effect and should be encouraged to continue therapy.

Late Extended Adjuvant Treatment with Letrozole Improves Outcome in Women with Early-Stage Breast Cancer who complete 5 years of Tamoxifen. Goss P. et al. *J Clin Oncol* 2008; 26: 1948-1955.

Study: To determine if there is a benefit to taking Letrozole after a substantial period without adjuvant therapy. In the NCIC trial of Letrozole vs placebo after 5 years of Tamoxifen, women in the placebo group were permitted to switch over to Letrozole at 2.5 years when the trial was unblinded. 1,579 women switched over, while 804 continued on placebo. Median follow-up was 5.3 years. DFS and Distant DFS were both improved (HR 0.37 and 0.39) in the Letrozole group. Fractures and osteoporosis were increased (5.2% vs 3.1%).

Clinical Importance: Long term follow-up is important for breast cancer patients as new therapeutic options can be introduced that have impact even in a delayed fashion. Methodology to facilitate dissemination of this information to patients and physicians is critical.

Matched Pair Analyses of Stage IV Breast Cancer with or Without Resection of Primary Breast Site. Cady B, et al *Ann Surg Onc* 2008: 15:3384-3395.

Study: To determine if selection bias accounts for the apparent survival benefit of resection of the primary site in women with Stage IV breast cancer. Review of 622 patients matched for age, diagnosis date, location of mets, ER status, use of systemic treatment of which 38% underwent primary surgery. Survival was improved ($p<0.0001$) in those who had surgery overall, but this benefit was eliminated when cases were matched. Survival was improved if patients received chemotherapy before surgery, but not if chemo and surgery were done simultaneously, suggesting chemo responders were being selected for surgery. Review also showed patients having surgery were more likely to have oligometastases or to have been misclassified as stage IV.

Clinical Importance: It is still not standard of care to resect the primary cancer in patients with metastatic disease. Individual consideration applies.

BC SURGICAL ONCOLOGY NETWORK BREAST CANCER FALL UPDATE 2009

The Surgical Oncology Network will be holding the **Annual Fall Update** on **October 24, 2009 in Vancouver at the Four Seasons Hotel**. The topic this year is **Breast Cancer Surgical Oncology**.

This one day event will focus on the multidisciplinary approach to management of breast cancer, including topics such as management of the axilla, breast reconstruction, and issues in radiotherapy and systemic therapy. Panel discussions will explore ways that surgeons and other specialists can work together to facilitate and optimize breast cancer care.

LEARNING OBJECTIVES:

- Review the current issues in breast cancer diagnosis, including the role of stereotactic biopsy of mammographic calcifications; changing pathologic terminology for breast atypia; indications for surgical excisions in patients with atypia; and the role of MRI in breast cancer patients.
- Review the current surgical issues in management of the axilla; the move to synoptic operative reporting and minimal datasets; and the current status of breast reconstruction.
- Review the current issues in post surgical care from a multidisciplinary perspective, including the management of close margins; the indications for post mastectomy radiation; the recommendations for adjuvant endocrine therapy and the increasing role of neoadjuvant systemic therapy.
- Define the parameters of quality breast surgery and the incorporation of multidisciplinary decision making in quality breast cancer care.

In addition to presenters from BC, the program will include visiting speakers, Dr. David McCready, Head, Breast Cancer Site Group at Princess Margaret Hospital in Toronto, and Dr. Geoffrey Porter, Head, Capital Health Cancer Care Program, QEII Health Sciences Centre, Halifax. This conference is a must attend event for general surgeons and residents and would be of value to all the other specialists.

FOR MORE INFORMATION:

Website: www.bccancer.bc.ca/son

Contact: Fatima Cengic, Program Assistant - E: fcengic@bccancer.bc.ca; T: 604 707 5900 ext. 3269

IMMUNOCHEMICAL FECAL OCCULT BLOOD TESTS AND THE BCCA'S COLON CHECK

Dr. Jennifer J. Telford, Clinical Assistant Professor, Division of Gastroenterology, UBC and Medical Practice Leader for Colon Check

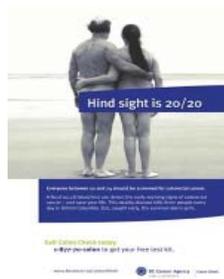
Colorectal cancer (CRC) is the fourth most common cancer diagnosed in BC and the second leading cause of cancer death. An effective population based screening program will decrease CRC mortality through earlier detection and decrease CRC incidence by removing colorectal adenomas, the precursor to most cancers. Several screening strategies are recommended^{1,2,3} but only the guaiac-based fecal occult blood test (FOBT) has been evaluated in randomized controlled trials^{4,5,6,7}.

The guaiac-based FOBT currently used in BC has a sensitivity of 36% and a specificity of 94% for the detection of CRC when colonoscopy is used as the gold standard for cancer detection^{8,9,10,11}. The sensitivity to detect an advanced adenoma (polyp > 9mm, villous features or high grade dysplasia) is only 18%^{8,9,10,11}. When the guaiac FOBT is used annually, CRC mortality is reduced by approximately 30% and the incidence by 18% in a clinical trial setting^{6, 7}.

In addition to a low detection rate of prevalent cancers, the guaiac FOBT can result in a false positive or negative from ingestion of certain foods or animal blood. Furthermore, the guaiac FOBT may detect hemoglobin originating from the upper gastrointestinal tract. The dietary restrictions and avoidance of NSAIDs during the three days of testing contribute to low compliance in screening populations.

Immunochemical fecal occult blood tests (iFOBT) are based on polyclonal or monoclonal antibodies directed against human globin. Several types of iFOBTs are in use worldwide and the test performance characteristics vary according to the test¹². Both qualitative tests, which allow simple, office-based analysis, and quantitative tests are available. As globin is digested in transit, the iFOBT is more specific for colonic blood loss and there are no dietary or medication restrictions leading to improved compliance¹³. Furthermore, the test is automated, allowing for quality control.

The iFOBT, OC Auto Micro 80® (Polymedco, NY) has recently been approved for use by Health Canada. This is a quantitative test with a manufacturer's recommended threshold of 100 ng hemoglobin/ml. The sensitivity for detecting CRC when colonoscopy is used as the gold standard is 88% and the specificity is



90%¹⁴. The sensitivity for detecting an advanced adenoma is 55%¹⁴.

The BCCA has launched Colon Check, a CRC screening pilot program using the OC Auto Micro 80®. Eligible individuals are between the ages of 50 and 74 years, asymptomatic, and without a personal history of CRC or inflammatory bowel disease. Those with a positive test and/or a first degree relative with CRC will be offered a colonoscopy.

Screening began in Penticton earlier this year and the pilot program will continue through 2010. The results from Colon Check will be used to determine the feasibility of a province-wide CRC screening program.

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iFOBT VS. THE GUAIIAC FOBT

Advantages

- Improved detection of CRC
- Improved detection of high risk adenomas
- Specific for human hemoglobin
- Will not cross-react with dietary peroxidase
- Likely more specific for colorectal sources of blood
- Automated to improve quality control
- Quantitative tests available
- Fewer stool specimens needed

Disadvantages

- Lower specificity
- Higher cost

SURGICAL ONCOLOGY NETWORK CURRENT INITIATIVES

IMPORTANCE OF CLINICAL GUIDELINES IN SURGICAL ONCOLOGY

Catalin Taraboanta, Manager, Clinical Practice Initiatives, SON

Two decades ago the Institute of Medicine, National Academy of Sciences in the US, defined Clinical Practice Guidelines (CPGs) as “systematically developed statements to assist practitioner and patient in decisions about the appropriate health care for specific clinical circumstances”¹. Based on the systematic review and synthesis of published clinical evidence, guidelines assist health care professionals and patients with making appropriate decisions about screening, prevention or treatment of a specific disease or condition. Guidelines are not fixed protocols but recommendations based on standardized best practice to support quality and consistency in health care. Salient contributors to healthcare policymaking, evidence-based clinical practice guidelines improve knowledge by educating clinicians about the latest evidence, change practice patterns, influence resource allocation, prioritize research and quality of care initiatives², improve patient access to health care services, decrease wait times and improve overall patient outcomes^{3,4,5,6}.

In 2006, the World Health Organization Advisory Committee on Health Research published a series of sixteen reviews which provided a universal framework for guideline development⁷. The greatest benefits of having guidelines are seen in healthcare areas of increased complexity, such as screening, diagnosis and treatment of cancer.

In Canada, the Canadian Partnership Against Cancer, Cancer Guidelines Action Group, leads the national cancer guideline development program CAN-ADAPTE⁸, a version of the international ADAPTE Collaboration⁹. Comprised of international

PURPOSE OF CLINICAL GUIDELINES¹¹

- To describe appropriate care based on the best available scientific evidence and broad consensus.
- To reduce inappropriate variation in practice.
- To provide a more rational basis for referral.
- To provide a focus for continuing education.
- To promote efficient use of resources.
- To act as focus for quality control, including audit.
- To highlight shortcomings of existing literature and suggest appropriate future research.

researchers, guideline developers and implementers, the ADAPTE Collaboration aims to promote the development and use of high quality clinical practice guidelines, using a systematic approach that ensures they are relevant to different countries, cultures and local practice. Based on this approach, CAN-ADAPTE is developing a standardized process and set of resources to allow more efficient development and local adaptation of high-quality guidelines in Canada.

An online repository, SAGE - Standards and Guidelines Evidence, is another initiative of the Cancer Guidelines Action Group¹⁰. Based at McMaster University, the SAGE repository, comprised of a database, tools, research articles and a registry, will help identify what standards and guidelines currently exist and reveal what areas still have gaps. The database includes a catalogue of standards and clinical practice guidelines, indicators, benchmark documents, systematic reviews, health technology assessments and research articles. The tools section provides resources for developing, adapting, implementing and appraising standards and guidelines. The registry allows standards and guideline developers to share information

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IMPROVING OPERATIVE REPORTS IN CANCER - THE SYNOPTIC REPORT

Dr. Carl J. Brown, Specialist in General and Colorectal Surgery, St. Paul's Hospital; Chair, Research & Outcomes Evaluation Committee, SON

Most surgeons remember the first time they performed a full surgery from beginning to end. They also remember the daunting task of dictating the operative report. With little or no instruction, we all struggled to remember exactly what we did and what important information to include. Often, a 20-minute appendectomy turned into a 40-minute dictation.

As a consequence, the variation in style and content of operative reports between surgeons is profound. While one surgeon may summarize a complex operation with a single paragraph report, another surgeon will create a four-page thesis detailing the same procedure. However, often neither dictation strategy creates a document in which all of the critical operative information can be accessed easily. In fact, Edhemovic et al. demonstrated that operative reports for rectal cancer reliably include less than 60% of important perioperative data¹.

The concept of a synoptic operative report is to ensure that a summary (or “synopsis”) of important operative information is clearly and reliably available in the operative document. This concept has been pioneered in pathology, where synoptic summaries of important prognostic and staging data have been advocated by the College of American Pathologists (CAP) since the early 1990s. Presently, CAP provides standard cancer specific synoptic templates for use by pathologists using either standard dictation services or electronic data entry. Most surgeons have seen this style of pathology reporting; the important data is summarized at the beginning of the report and the details of the pathologist’s assessment are contained in the body of the report.

The Surgical Oncology Network has made cancer surgery operative report quality a priority as part of its strategic plan. The SON’s Surgical Tumour Groups will be charged with using a standardized process to establish a set of operative data that are deemed critical for the present and future management of the patient with cancer. These data will be part of tumour specific provincial guidelines for the reporting of operative procedures for cancer.

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SURGICAL ONCOLOGY NETWORK CURRENT INITIATIVES

CLINICAL GUIDELINES IN SURGICAL ONCOLOGY

Continued from page 8

about their projects and enables collaboration and adaptation.

Traditionally cancer guidelines are developed by multidisciplinary panels of experts who represent various types of healthcare practitioners involved in cancer patient care, and focus on general patient management. Although surgery frequently plays a central role in cancer patient care, clinical guidelines infrequently include or inform surgical care.

To improve patient outcomes following surgery, optimal preoperative patient management, accurate staging, curative intent (RO) procedures and appropriate follow-up are critical elements that should be present in cancer clinical practice guidelines. Surgical practice guidelines should be developed by surgeons with extensive experience in surgical cancer care and reviewed for their applicability by other surgeons with expertise in common surgical diseases.

To ensure quality of care for cancer patients, surgeons and surgical organizations need to participate in the development of surgical practice guidelines and clinical pathways. The Surgical Oncology Network is actively working through its Clinical Practice Committee and Surgical Tumour Groups, along with the BC Cancer Agency Tumour Groups, to adapt, endorse and adopt surgery specific guidelines that will be appropriate for BC.

For more information please contact:

Catalin Taraboanta, Manager, Clinical Practice Initiatives - ctaraboanta@bccancer.bc.ca; (604) 707-5900 ext. 3256
Dr. Noelle Davis, Chair, Clinical Practice Committee - ndavis@bccancer.bc.ca

IMPROVING OPERATIVE REPORTS IN CANCER

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In order to pilot this process, the Colorectal Surgical Tumour Group will utilize a rectal cancer summary template used for the past three years at St. Paul's Hospital for inclusion in dictated operative reports (<http://www.providencehealthcare.org/colorectalsurgery/synoptic-operative-reports.html>). This template report will form the basis for creating a provincial minimum data set for rectal cancer surgery.

Using a Delphi process, surgeons, medical oncologists, radiation oncologists and other affiliated health professionals will contribute to the recommended minimum data set for rectal cancer. This process should be completed by November 2009. Thereafter, promotion of the minimum data set will be used to encourage its use in operative reports for rectal cancer.

This pilot project is a first step towards integrating synoptic operative reports into the cancer care process and ensure that key data elements are collected. If the trial proves to be successful, the use of the minimal data sets will be expanded to other tumour sites. In future, electronic data entry for operative reports will facilitate patient care and quality assurance for cancer surgery.

The Surgical Oncology Network/BC Cancer Agency continue to work towards developing a comprehensive provincial database that will allow operative reports, pathology, clinical and outcomes data to be efficiently collected throughout the province and used to provide important information to surgeons, physicians, health care planners and administrators about cancer care for surgical patients. A data collection system, with well-defined and communicated guidelines and standards that permit monitoring and quality assurance, is essential for the highest quality surgical program.

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SURGICAL ONCOLOGY NETWORK NEWS

7TH NATIONAL COMMUNITY CANCER CONTROL SUMMIT PRINCE GEORGE



Dr. Simon Sutcliffe, past President of the BC Cancer Agency, received the Terry Fox Award from the BC Medical Association. Established in 1980, the award is presented to an individual conducting clinical practice, research or teaching/education who has achieved national or international recognition for their work. Dr. Nadine Caron, General and Endocrine Surgeon from Prince George, and an active member of SON's Council Executive and Committees, presented the award to Dr. Sutcliffe. Dr. Caron remarked how privileged she felt to participate in celebrating Dr. Sutcliffe's remarkable achievements and contributions to the oncology field throughout his career.

The 7th National Summit on Community Cancer Control was held on June 11-13, 2009 in Prince George. Entitled *Innovative Solutions for Rural and Remote Cancer Control Issues: Today and Tomorrow*, the Summit provided an interactive, multidisciplinary environment for communities of practice to network, share ideas, and discuss innovative and workable solutions to common rural and community cancer control issues.



The Surgical Oncology Network sponsored a booth at the Summit. Colleen McGahan, Biostatistician, and Fatima Cengic, Program Assistant, provided information and brochures on the Network to Summit participants.

CORRECTION NOTICE:

Please note that the article 'Prostate Cancer: Active Surveillance or Surgery' in the Winter 2009 issue of the Newsletter was written by Dr. Peter Black, Assistant Professor, Department of Urologic Sciences, UBC. This article was incorrectly attributed to Dr. Alan So. We apologize for this error.

SURGICAL ONCOLOGY NETWORK NEWSLETTER

EXECUTIVE EDITOR: DR. RONA CHEIFETZ

Managing Editor: Yasmin Miller

Copy Editor: Fatima Cengic

To submit article ideas or for information, please contact:

Fatima Cengic
T 604 707-5900 x 3269
E fcengic@bccancer.bc.ca

VISIT THE SURGICAL ONCOLOGY WEBSITE
www.bccancer.bc.ca/son

The BC Surgical Oncology 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. To enhance 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 the BC Cancer Agency.

The Council Executive oversees the implementation of the Network's mandate and is comprised of surgeons and senior health administrators representing all the health regions across the province. The three committees - Clinical Practice, Continuing Professional Development & Knowledge Transfer and Research & Outcomes Evaluation - assist with the planning, implementation and promotion of the Network's goals and priorities. The thirteen Surgical Tumour Groups advise on the issues and challenges in the surgical management of patients within each tumour site to improve the surgical management of cancer patients.

WINNER OF THE CANCER SURGEON DIRECTORY DRAW

The Surgical Oncology Network would like to congratulate Dr. Denis Lavoie, Urologist, Vernon Jubilee Hospital, on being the lucky winner of our Cancer Surgeon Directory survey prize draw. Dr. Lavoie has won two \$100 gift certificates from Ticketmaster. The Surgical Oncology Network received 846 responses from surgeons across the province, with 540 reporting that they perform oncology procedures in their practice. If you did not receive/complete the form and you perform oncology procedures in your practice, please email us at son@bccancer.bc.ca to receive the form. To all those who completed the form, we thank you for contributing to the development of the BC Surgical Oncology Network Cancer Surgeon Directory.

SON RESIDENT TRAVEL AWARD for BC Surgery Residents and Fellows

The Surgical Oncology Network Resident Travel Award is a competitive award intended to motivate physicians, early in their training, to pursue an interest in surgical oncology and to allow them to present research findings at conferences. Approved applications may be funded up to a maximum of \$1000. Deadlines are: **May 1 and November 1.**

For more information visit our website at www.bccancer.bc.ca/son