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Education Update

By Dr. Sian Shuel, Medical Education Lead, FPON

Leveraging feedback and requests from health care providers, including primary care practitioners, general practitioners in oncology (GPOs), nurse practitioners in oncology (NPOs), oncologists and more, BC Cancer's Family Practice Oncology Network (FPON) continues to offer accredited, complimentary education sessions in a variety of formats. Here are some of the highlights since our Spring Journal.

Working in partnership with UBC Continuing Professional Development, FPON planned and facilitated the recurring accredited CME Webcast Series for primary care practitioners this year, including 'Approach to Oncologic Emergencies,' 'Breast Cancer Screening and Prevention,' 'Understanding Mental Health in Our Patients with Cancer' and more. Meanwhile, 'Nutrition and Cancer: What's the evidence?',

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BEST PRACTICE CANCER CARE GEMS

COVID-19 and respiratory viral season – Key Messages!

By Dr. Helen Anderson, Provincial Medical Director, Systemic Therapy, Community Oncology Network and Primary Care

The coming of fall reminds us that respiratory infections tend to trend up in the winter months and patients with cancer are at increased risk of infection and complications. In addition to the usual expected increase in seasonal viruses, COVID-19 continues to circulate in our communities and adds another layer of consideration when caring for patients with cancer who remain vulnerable. We encourage you to review information on management of patients with cancer and COVID-19 and be prepared as we move into cooler months.

BC CANCER COVID-19 and Cancer Information for Patients

www.bccancer.bc.ca/health-info/covid-19-and-cancer-information-for-patients

The BC Cancer website www.bccancer.bc.ca contains useful links for both patients and care providers relevant to COVID-19 and cancer. The largest repository of BC relevant information, updated regularly, is available from BCCDC. Their webpage provides weekly data updates and also comprehensive information about vaccines, treatments and testing and many useful tools to support you in the work caring for patients with cancer and COVID-19.

www.bccdc.ca/health-professionals/clinical-resources/covid-19-care

Treatments

www.bccdc.ca/health-professionals/clinical-resources/covid-19-care/treatments

Key messages

- Various novel agents have become available in B.C. for the treatment of COVID-19 in mild-moderately ill patients. These therapies include a direct-acting oral combination antiviral nirmatrelvir/ritonavir (Paxlovid) and an IV direct acting antiviral remdesivir (Veklury). These continue to be recommended for symptomatic patients with cancer. A monoclonal antibody, sotrovimab (Xevudy) is no longer in routinely used due to potential loss of activity against the BA.2 variant of concern. It likely retains some activity but it is reserved as a last-line agent.
- Paxlovid, should be considered for all patients on treatment for solid tumour and haematological cancers who are symptomatic and ideally should be started within 5 days of symptom onset. Several tools are available to support prescribing and Paxlovid is available from most community pharmacies at this time.
- Health Canada approved a monoclonal antibody cocktail tixagevimab/cilgavimab (Evusheld) for the prevention of COVID-19 in those who are severely immune compromised and unlikely to mount an adequate immune response to COVID-19 vaccination or for whom COVID-19 vaccination is not recommended.

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Education Update
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'Psychosocial Perspective on Cancer-Related Fatigue – What is it, and what can we do about it?', 'Hepatocellular Cancer' and other topics are upcoming.

The first BC Cancer Primary Care small group learning session on breast cancer was a success in the East Kootenays. The virtual pilot connected community physicians to their local GPO and regional cancer centre, helping strengthen relationships by addressing clinical questions on a locally selected topic (breast, colorectal, or prostate cancers; lung cancer tentatively available for 2023) while exploring community-based solutions. Plans for additional sessions are well on their way. Please reach out if you're interested in bringing this opportunity to your area.

Patients with cancer are at increased risk of complications of COVID, requiring assessment and access to COVID therapeutics. Earlier this year, FPON and BC COVID Therapeutics Committee hosted the first two educational webinars on 'Managing Mild-Moderate SARS-COV-2 Infection in Oncology Patients' with a third update planned as circumstances evolve.

As alluded to, work is currently underway to add lung cancer to the series of our online learning modules, developed in collaboration with UBC Division of Continuing Professional Development. The aim is to onboard in early 2023. The current online modules on breast, colorectal and prostate cancer cover best practices in screening, treatment and surveillance, and valuable resources.

Other FPON programs planned for the fall include the two-week didactic virtual GPO Education and a hybrid in-person and virtual GPO Case Study Day at the BC Cancer Summit. Both programs are geared towards meeting the learning needs and supporting new and seasoned GPOs and NPOs throughout BC and Yukon. GPO Case Study Day presentations will be facilitated by GPOs and oncologists working together. Topics will include 'What's New in Systemic Therapy – A Thematic Approach,' 'Breast Cancer Management in the Adjuvant and Neoadjuvant Settings,' 'Approach to Toxicities of Combined Cancer Therapies', and 'Multiple Myeloma in 2022'. There will be an opportunity for facilitated conversations, networking, and informal catching up with colleagues.

Spring 2023 will see another iteration of GPO Education and ongoing monthly CME webcasts for primary care. Our yearly Conference for Primary Care is planned virtually for April 1, 2023, so please mark your calendars. Stay tuned by checking fpon.ca for information as details are finalized.

As we aim to help meet the oncology learning needs of primary care practitioners, GPOs and NPOs, we continuously seek feedback from our readers and participants. Please email FPON's Medical Education Lead at sian.shuel@bccancer.bc.ca with any topic suggestions.

COVID-19 and respiratory viral season
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However, due to the prevalence of the BA 4/5 Variants of Concern, the activity of tixagevimab/cilgavimab (Evusheld) is greatly reduced and the clinical evidence for its use has been non-reassuring. The updated Practice Guide from the CTC no longer recommends use of this agent even in patients who are severely immunocompromised.

Testing

www.bccdc.ca/health-professionals/clinical-resources/covid-19-care/covid-19-testing

Key messages

- Testing for COVID-19 is recommended for people with new or worsening symptoms compatible with COVID-19 where a positive result would impact treatment or care. This includes patients who are on active treatment for a solid tumour, blood or bone marrow cancer.
- Rapid Antigen Tests are safe, effective and widely available for at home testing. They are available free at many community pharmacies. Encourage your patients to pick up the test kits and self-test if developing symptoms.

Vaccinations

Key messages

- Vaccination remains the most important intervention known to reduce risk of severe illness even in patients who are immunocompromised. People who are moderately to severely immunocompromised may have lower antibody responses to COVID-19 vaccines and many patients who are or were categorized as clinically extremely vulnerable have been offered a 3 dose primary series and a booster dose.
- Guidelines on vaccination have been recently updated for patients with solid tumours and haematologic malignancies:

  www.bccdc.ca/Health-Info-Site/Documents/COVID-19_vaccine/Solid_Cancer_Clinical_Guidance.pdf

  www.bccdc.ca/Health-Info-Site/Documents/COVID-19_vaccine/Heme_Malignancies_Clinical_Guidance.pdf
- Watch for new information from Public Health about fall vaccination schedules and recommendations

Thank-you for being vigilant and considering the special needs of patients with cancer, how COVID-19 may affect them and what we can do to protect them from the worst outcomes. Last but by no means least, please remember your health and safety is also a key priority over the coming months. Stay aware of COVID-19 in your community, keep your vaccinations up to date, test if symptomatic and look after yourself and your loved ones, if you test positive!

BC Cancer Launched the Lung Screening Program Spring 2022

Dr. Stephen Lam, Medical Director, BC Cancer Lung Screening Program

The first organized province-wide screening program for lung cancer in the country has been launched in British Columbia on May 25, 2022. Lung cancer is the leading cause of cancer death in Canada and worldwide.

In B.C., seven people die of lung cancer every day.[1] With 70 per cent of all cases diagnosed at an advanced stage, the Lung Screening Program aims to detect lung cancer at an earlier stage, when treatment is more effective. A network of lung screening clinics has been established across B.C. within each health authority, using the existing computed tomography (CT) capacity in hospitals for patients to access.

Lung screening will involve a low-dose computed tomography (LDCT) scan of the lungs. During the scan, the patient lies on a table with their arms placed above their head. The patient will hold their breath for a few seconds while the scanner takes detailed images of their lungs. The scan takes less than 10 seconds and is not painful. Patients do not need to take any medications, or receive any needles for this test.

After a patient's LDCT scan, a radiologist with expertise in early diagnosis will review the images taken at a designated reading site located within the patient's health authority. A Computer Assisted Diagnostic tool and standardized reporting format will be used to improve consistency and accuracy of reading and recommendation. Results of the patient's lung scan will be sent to the patient and their primary care provider.

Dr. Stephen Lam

Who is eligible for lung screening?

Lung screening is best for those who are at high-risk for lung cancer and who are not experiencing any symptoms. This includes people who are:

- 55 to 74 years of age;
- Currently smoking or have previously smoked;
- Have a smoking history of 20 years or more; and,
- Have a six-year lung cancer risk >1.5% (risk will be calculated by the Patient Navigator when patients call the Lung Screening Program)

Interested individuals can self-refer to the screening program. Primary care providers should encourage eligible patients to call the Lung Screening Program (1-877-717-5864) to complete a risk assessment over the phone to confirm their screening eligibility.

Role of primary care providers

Primary care providers play an important role in the Lung Screening Program, including:

- Supporting patients with their decision making, and recommending lung screening when appropriate;
- Providing smoking cessation pharmacotherapy support; and,
- Providing follow-up for additional findings and support for abnormal results.

It's expected that once the Lung Screening Program is fully implemented across B.C., approximately 20,000 patients per year will receive screening. Of these patients, the program aims to diagnose approximately 350 cases annually, with more than 75 per cent diagnosed at an earlier stage than would have previously.

For more information go to www.screeningbc.ca/lung

Reference

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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 xʷməθkwəy̓əm (Musqueam), Sḵwx wú7mesh Úxwumixw (Squamish), and səlilw̓ətaɬ (Tsleil-Waututh) First Nations on whose unceded and ancestral territory our head office is located.

Corridor Consult:
To screen or not to screen – that is the question?

By Dr. Shahana Alibhai

Dr. Shahana Alibhai is a family physician, and is one of the staff physicians at the Breast Health Clinic at the Abbotsford Regional Hospital, a role she has held for the last seven years. She has used her expertise to educate women on the importance of breast self-awareness and was involved in the provincial campaign on CTV on discussing breast health in younger women. This "Corridor Consult" is provided in follow-up to her presentation at the virtual April 2, 2022 FPON "Let's Talk Practical Cancer Care Conference".

Dr. Shahana Alibhai

Q How do you help your patients decide what age to go for screening mammography?

Screening mammograms are available for BC women 40 years and older. While those with a family history of breast cancer have a higher-than-average risk, the most significant risk factor for breast cancer is being a woman over 50 years of age. Over 80 percent of new breast cancers diagnosed each year in BC are in women age 50 or older. The Breast Cancer Screening Program makes the following recommendations:

- ✓ Women age 50 to 74 with no family history of breast cancer are recommended to have a screening mammogram every two years.
- ✓ Women age 40 to 49 with no family history of breast cancer should discuss the benefits and limitations of mammography with their primary care provider. (See www.bccancer.bc.ca/screening/breast/get-a-mammogram/benefits-and-limitations for more details). If mammography is chosen, it is available every two years.
- ✓ Women who are 75 or older are encouraged to talk to their primary care provider about the benefits and limitations of mammography. They remain eligible, but will not be automatically recalled to screen.
- ✓ *Women age 40 to 74 with a 1st degree relative (mother, daughter, sister) with breast cancer are at higher-than-average risk, should get a mammogram every year.
- ✓ *Women age 40 to 74 with a personal history of Atypical Ductal Hyperplasia, Atypical Lobular Hyperplasia or classical Lobular Carcinoma In Situ are also at higher-than-average risk, and should get a mammogram every year. For further details, please see this fact sheet: www.bccancer.bc.ca/screening/Documents/Breast-Higher-Risk.pdf
- ✓ *Women between 30 and 74 who are at high risk for breast cancer should get a screening mammogram every year. Those considered high risk have at least one of the following:
  - BRCA1 or BRCA2 carrier, or other pathogenic gene variant identified by the BC Cancer Hereditary Cancer Program
  - Untested first degree relative of the above
  - Have a very strong family history of breast cancer
  - Have had prior chest radiation
  - For further details, please see www.bccancer.bc.ca/screening/breast/get-a-mammogram/who-should-get-a-mammogram
- ✓ Transgender people
  - If no top surgery or simple reduction mammoplasty – follow guidelines above.
  - If top surgery has removed most breast tissue, screening mammography is not recommended, but should discuss with primary care provider other potential options.
  - Chest (breast) tissue as a result of gender-affirming hormone therapy with estrogen use for more than 5 years, follow guidelines above. If also on progestin and BMI is > 35, should discuss options with primary care provider.

*For those patients at increased risk listed as above, annual screening mammography is facilitated by the Screening Program. Note that for patients aged 30-39 years with High Risk, a Primary Care Provider (PCP) referral is required for the initial (only) Screening Program mammogram (just to confirm the history in this younger population). Following the initial mammogram, they will be recalled on an annual basis, just as for the 40+. Alternatively, for any patient with increased risk, their Primary Care Provider can choose to annually order diagnostic mammograms using their own EMR recall system.

Q How do you know if a patient has breasts that are considered dense?

Breast density can only be seen on a mammogram and is not related to the size or feel of the breasts. Breast density is measured by a radiologist when a mammogram is done and is reported using the Breast Imaging Reporting and Data System (BI-RADS). This includes a Four – category system with the third and fourth ("C" and "D") indicating dense breasts.

Q Is adding ultrasound for screening appropriate for patients with very dense breasts (BI-RADS D)?

In a position statement on Mammographic Breast Density and Supplemental Screening, the Canadian Association of Radiologists (CAR) and the Canadian Society of Breast Imaging (CSBI) state that supplemental screening breast ultrasound (US) may be considered for patients with dense breasts (BI-RADS C and D). Patients should be counselled on the possibility of a false alarm. In addition, access to screening US is limited.

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BC Cancer Breast Screening

www.bccancer.bc.ca/screening/breast

About 1 in 8 women will develop breast cancer in her lifetime. Regular screening mammograms can find breast cancer early, usually before it has spread. Make it part of your regular health routine.

To book a mammogram call 1-800-663-9203

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

Corridor Consult: screening mammography continued from page 4

For those patients with dense breasts who after discussion of the potential benefits and risks would like supplemental US, a referral is required with an appropriately completed diagnostic imaging requisition from their primary care provider.

A Discussion Guide on Breast Density has been developed by the BC Cancer Breast Screening Program to help guide the conversation with a patient. www.bccancer.bc.ca/screening/Documents/Breast-Density-Discussion-Guide.pdf

Q If a patient has increased breast density, should / could they go yearly for a mammogram?

Breast density has been identified as an independent risk factor for the development of breast cancer and decreases the likelihood of breast cancer being detected on a screening mammogram. In addition, dense breasts (BI-RADS C and D) have been associated with an increased risk of an interval cancer (ie cancer developing between mammograms).

While some jurisdictions do offer annual screening mammograms for patients with increased breast density, a recent analysis of the BC data did not show that a proportional decrease in interval cancer rates for those with dense breasts could be achieved with annual mammograms. As a result, the BC Cancer Screening Program has not adopted this policy for women when breast density is the only risk factor. However, if after an informed discussion of the potential benefits and harms, those patients with dense breasts who would like annual mammography would require referral from their primary care provider to access diagnostic imaging with an appropriately completed diagnostic mammography requisition. Since this is outside the Breast Screening Program, reminders will not be sent out to patients so PCPs should set reminders in their EMR. In addition, such individuals will be recalled for their next program screen in 2 years from the date of the diagnostic mammogram.

Q What is the Relative Risk of breast cancer for patients with BI-RADS C or D breast density?

The relative risk of an invasive breast cancer diagnosis within two years for BC Women ages 40 – 74 by age group and breast density are noted above (from BC Cancer Breast Density Clinical Discussion Guide available at www.bccancer.bc.ca/screening/breast

Q For patients with very little breast tissue is ultrasound an acceptable alternative?

Screening mammography using the guideline above is appropriate as an initial step for all patients, regardless of the amount of breast tissue. Additional investigations will be recommended if clinically indicated.

Q How should patients with a history of implants be screened for breast cancer? What if the implants have been removed?

Patients who have breast implants will need to see their primary care provider for mammography referral through the diagnostic pathway. A diagnostic mammogram allows for the extra time and techniques needed to ensure that the entire breast tissue is visualized. Reminders from the Breast Screening Program will not be sent out so PCPs should set reminders in their EMR. However, patients who have had implants removed are eligible for the program screening pathways as described above.

Cervical Cancer in British Columbia: a screening update

Dr. Jordan A. Lewis Dr. Lily Proctor

By Dr. Jordan A. Lewis, Obstetrics and Gynecology Resident, University of British Columbia
Dr. Lily Proctor, Gynecologic Oncologist, BC Cancer

Cervical cancer is one of the only cancers with the potential to be entirely preventable—yet despite this, the Canadian Cancer Society predicts that British Columbia will see at least 200 new cervical cancer diagnoses and 50 cervical cancer-related deaths in 2022.[1] In 2017, BC saw a similar incidence of cervical cancer, and among these patients an alarming 66% of squamous cell carcinoma and 46% of adenocarcinoma cervical cancer cases either had never been screened, or did not receive timely screening.[2]

British Columbia pioneered one of the first population-based cervix screening programs, leading to a 70% decrease in cervical cancer incidence between 1955 to 1985 by offering routine pap tests to eligible individuals.[2] It is now universally recommended that anyone with a cervix of baseline risk aged 25-69 years old undergo screening with a pap test every three years. In 2020, the Canadian Partnership Against Cancer (CPAC) organized a Canadian 'Action Plan for the Elimination of Cervical Cancer in Canada' to improve immunization and screening programs for cervical cancer by 2030. Specifically, CPAC aims to ensure 90% of eligible individuals remain current with their cervical cancer screening, and 90% of abnormal results have timely and appropriate follow up.[3] Having these effective and reliable screening protocols in place enables the opportunity to identify and diagnose cancerous or pre-cancerous lesions, ultimately increasing the chance of surgical cure.

Unfortunately, one of the many distressing side effects of the COVID-19 pandemic raised by BC practitioners is the significant delay in receiving patients' pap smear results. The BC Cancer laboratory services website estimates that current turnaround times for pap test reporting is 14-16 weeks from specimen collection – significantly longer than the previously average timeline of less than 4 weeks.[4] The Cervical Cancer Screening Laboratory (CCSL) processes up to 325,000 pap tests annually.[2] During peak isolation, it has been reported that as few as one third of eligible patients requiring cervical screening had timely appointments due to significant challenges in scheduling in-person examinations,[5] leading to an influx of "catch up" screening tests once restrictions were lifted. With specimen numbers well above baseline, we find

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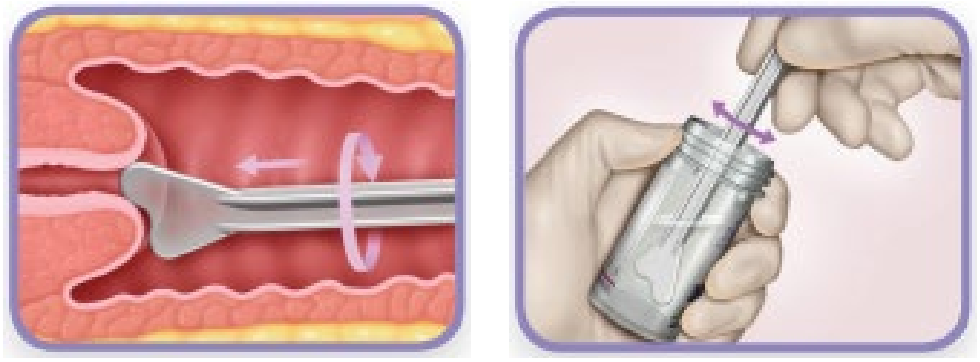
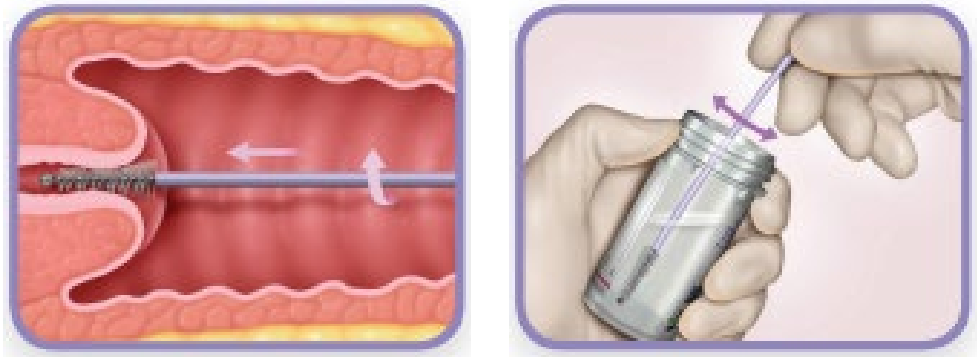
Figure 1: Endocervical brush/spatula protocol technique (adapted from Hologic Quick Reference Guide).[9]



First obtain sample from ectocervix using plastic spatula and rinse in container solution by swirling vigorously up to 10 times. Discard.



Obtain endocervix sample using brush, ensuring only bottom-fires are exposed when inserted into cervix. Rotate up to ½ turn in one direction. Rinse brush in container solution by swirling vigorously and pushing brush against vial wall. Discard.

Tighten cap securely, record patient information on the vial with cytology requisition form, and place in specimen bag for processing

Cervical Cancer in British Columbia continued from page 6

ourselves facing a significant delay in pap test reporting and timely intervention.

To combat this backlog and accelerate results, a transition to liquid-based cytology (LBC) is underway in BC.[6] LBC has been used by many provinces for primary cervical cancer screening, including Alberta, Ontario, Saskatchewan, and Manitoba.[7] LBC uses a similar spatula and/or cytobrush as in conventional cytology sample collection. Instead of submitting the sample on a glass side, the liquid sample is transferred to a container with an alcohol-based fixative (Figure 1). This allows for collaboration with off-site diagnostic laboratories to report LBC results (such as Quest and Hologic), to ultimately allow for the CCSL to focus on expedient reporting of conventional cytology pap smears still awaiting analysis. Both methods are clinically equivalent for detecting cervical lesions, and there remain no differences with respect to the follow-up algorithm based on screening result. As of July 2022, training sessions and supplies are now being offered for select clinics and providers with no added cost. Practitioners and clinics with a high volume of testing are currently being prioritized, with the goal to fully transition all 6000 providers who offer pap tests in BC as soon as possible.

As part of our provincial and national goal to fight cervical cancer, it is of utmost importance to remain committed and current with all ways we can provide accessible and equitable screening and prevention practices. In addition to updating current practice to accommodate BC's LBC transition, our greatest influence comes from active identification, screening and retention of eligible patients. This includes being mindful of patients in our practice who may be less likely to participate in screening—including, but not limited to, new immigrants, Indigenous, low income, non-English speaking, transgender, gender-diverse, and non-binary patients. To encourage screening retention, we must continue to learn and improve upon offering culturally safe and trauma-informed care, and ensure we have the resources available to promote a welcoming and inclusive clinical space. Moving forward, the ultimate goal is to transition to primary HPV-based screening to target the many barriers faced by these populations, and we encourage you to learn more about BC's at-home cervix screening pilot project as it continues to expand to BC communities.[8] Furthermore, while screening works at the level of secondary prevention, targeting primary prevention of cervical cancer through frequent counselling and recommendation for HPV vaccination continues to have the most significant impact on combatting cervical cancer.

Some of your patients or colleagues may have questions regarding current screening practices in BC and our provincial transition plan to LBC cervical screening. For further information regarding the LBC transition and specimen collection, questions may be directed to the Cervical Cancer Screening Laboratory, or you can visit the following website: www.bccancer.bc.ca/health-professionals/clinical-resources/laboratory-services/cervical-cancer-screening

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Updated BC Guidelines for Colon Screening and Surveillance

By Dr. Jennifer Telford,
BC Cancer Colon Screening Program

The British Columbia Colon Screening Program offers population-based screening with the biennial fecal immunochemical test (FIT) to average risk residents from 50 to 74 years of age, while individuals at increased risk of colorectal cancer are offered colonoscopy. The Program's screening and colonoscopy surveillance is structured to align with The Guidelines and Protocol Advisory Committee (GPAC) recommendations. This two-part guideline was updated April 13, 2022.

- Part 1: Screening for the Purposes of Colorectal Cancer Prevention and Detection in Asymptomatic Adults www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/bc-guidelines/colorectal-cancer-part1
- Part 2: Follow-up of Colorectal Cancer and Precancerous Lesions www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/bc-guidelines/colorectal-cancer-part2

BCGuidelines.ca

Major Changes in the BC Guidelines

- Replacing the term polyp with pre-cancerous lesion
- New classification of high-risk and low-risk pre-cancerous lesions
- Longer interval between colonoscopies for individuals with a personal history of low-risk precancerous lesions
- Return to FIT screening for individuals with a personal history of pre-cancerous lesions

Colon Screening

The screening recommendations for average risk individuals and those with a high-risk family history have not changed (Table 1). A high-risk family history is defined as a 1st degree relative (parent, sibling, or child) diagnosed with colorectal cancer before 60 years of age or two, or more, 1st degree relatives diagnosed with colorectal cancer at any age. Individuals with a single 1st degree relative diagnosed with colorectal cancer after 59 years of age and individuals with 2nd degree relatives diagnosed with colorectal cancer are screened as per average risk recommendations.

Table 1: Risk Stratified Colon Screening Recommendations

	Average Risk	Family History
Test	FIT	Colonoscopy
Frequency	2 years	5 years
Start	50 years	40 years, or 10 years younger than the age of diagnosis of the youngest affected relative
Stop	74 years	74 years

Screening recommendations for those with a personal or family history of a hereditary cancer syndrome known to increase an individual's risk of colorectal cancer is beyond the scope of the GPAC recommendations and should be addressed by the Hereditary Cancer Program at BC Cancer. Individuals with longstanding inflammatory bowel disease affecting the colon are at increased risk of colorectal cancer and require personalized colonoscopy surveillance through their specialist.

Early Onset Colorectal Cancer

The incidence rate of colorectal cancer diagnosed under the age of 50 years is increasing in Canada and other countries.[1] The underlying cause is not yet known but research has demonstrated an association with lower income, obesity, and a more sedentary lifestyle.[2] In response, American guidelines have recommended lowering the screening age to 45 years, acknowledging the low quality of evidence to support this decision. The other Canadian provincial programs have continued to screen from 50 years, and, to my knowledge, no other country has lowered the screening age in their programs. Justification for maintaining the screening age includes: a small increase in the absolute number of 45- to 49-year-old Canadians diagnosed with colorectal cancer, uncertain effectiveness of screening in this age group, diversion of resources from those at higher risk, and unintended harms of screening.[3]

In the context of increasing colorectal cancer incidence in this age group, clinicians should have a high index of suspicion when evaluating young adults with lower gastrointestinal symptoms and referral for flexible sigmoidoscopy or colonoscopy may be appropriate.

When not to order a FIT

- Any positive FIT requires colonoscopy, even if subsequent FIT is negative
- Do not order a FIT for individuals with symptoms, such as rectal bleeding, refer for colonoscopy.
- Do not order FIT for individuals in a colonoscopy surveillance program.
- Do not order FIT for individuals up to date with screening (FIT in past 2 years, or colonoscopy or flexible sigmoidoscopy in past 10 years).

Follow-up of Pre-cancerous Colorectal Lesions

Findings at an individual's index colonoscopy will determine their risk of developing colorectal cancer in the future. Pre-cancerous lesions can be broadly divided into adenomas and serrated lesions; increased risk is associated with larger size, larger number, and more worrisome histologic features (Table 2). It should be noted that while hyperplastic polyps are a type of serrated lesion, they are not considered to have malignant potential. However, if a large hyperplastic polyp (> 10mm) is removed, this is treated as a high-risk lesion.

Previous guidelines had classified the detection of three or more pre-cancerous lesions at colonoscopy as a high-risk scenario; however, recent publications have demonstrated that irrespective of the number of low-risk adenomas resected, these individuals have a lower incidence of colorectal cancer than the general

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Table 2: Classification of Pre-cancerous Lesion Risk

Feature	Low Risk	High Risk
Size	< 10 mm	> 10 mm
Number	1 to 4	> 5
Histology	• Adenoma with low grade dysplasia • Sessile serrated lesion with no dysplasia	• Adenoma with high grade dysplasia • Adenoma with villous features • Sessile serrated lesion with dysplasia •Traditional serrated adenoma

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population and a similar risk to individuals with no adenomas detected.[4,5] Furthermore, removal of less than 5 pre-cancerous lesions at index colonoscopy does not appear to increase the risk of high risk precancerous lesions on subsequent colonoscopy (ref, unpublished data from the BC Colon Screening Program).

Individuals with high-risk findings at index colonoscopy are recommended to have more intensive colonoscopy follow-up. On the other hand, those with low-risk findings have a future risk of developing colorectal cancer that is similar to individuals with a normal colonoscopy and lower than the risk in the general population.[4–9] Those with a high-risk family history are recommended to maintain a maximum colonoscopy interval of five years but may require a shorter interval if high-risk findings are detected.

Benefits of the Colon Screening Program

- Automated recall for FIT and colonoscopy at appropriate intervals
- Patient navigation
- Quality assurance initiatives
  - FIT, Primary Care, Colonoscopy, Pathology
- Patient and provider education

Take Home Points:

- Enroll patients in the Colon Screening Program, where available,
  - For average risk, use the Standard Outpatient Laboratory Requisition www.bccancer.bc.ca/screening/Documents/Standard-Outpatient-Lab-Requisition.pdf
  - For higher-than-average risk, use the Colonoscopy Referral Form www.bccancer.bc.ca/screening/Documents/Colonoscopy-Referral-Form.pdf
- Regularly screened individuals may cease FIT and colonoscopy at 75 years of age.

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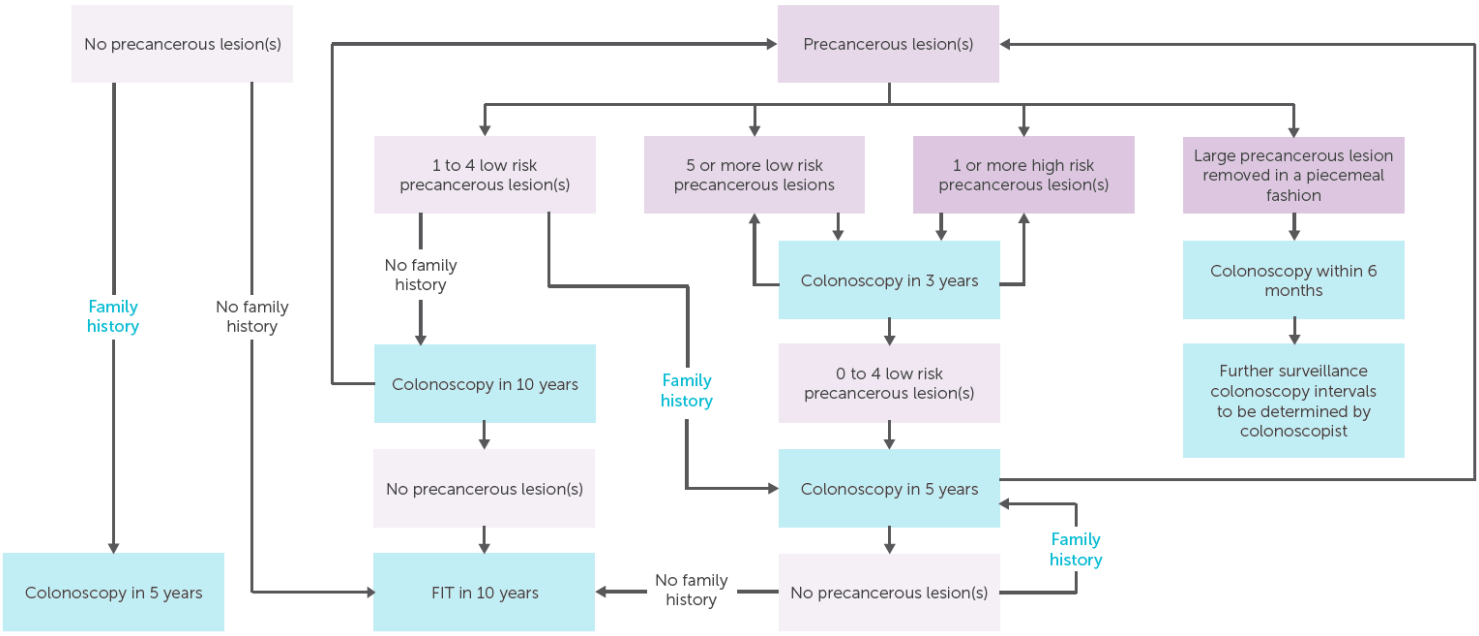
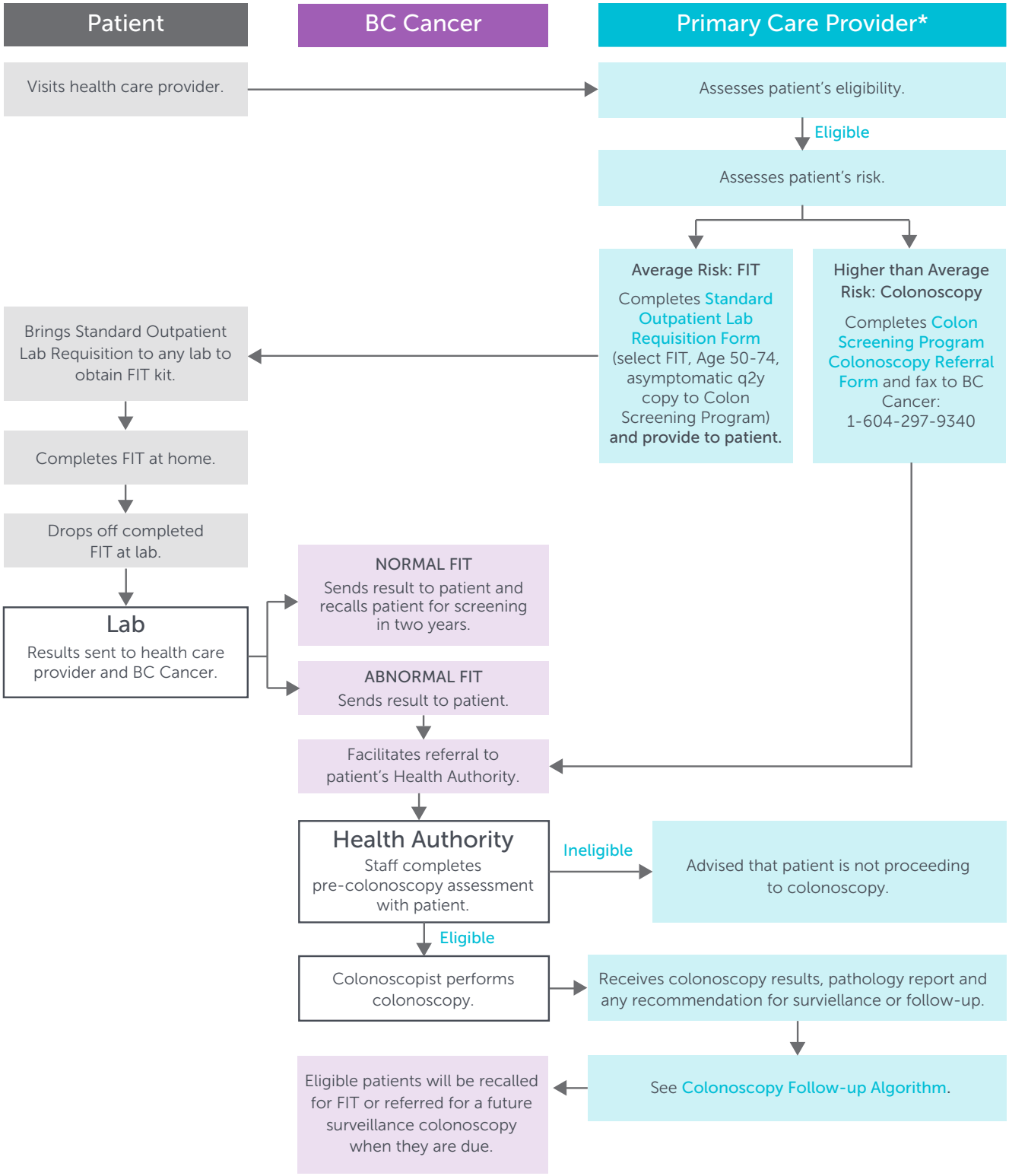


Patient Pathway



*Includes both general practitioners and nurse practitioners

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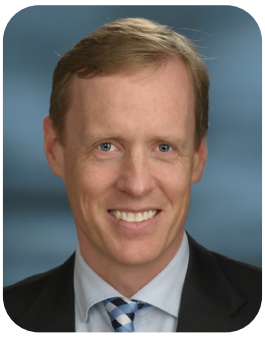
Prostate Cancer Screening

By Peter Black, MD, FACS, FRCSC
Vancouver Prostate Centre, Department of Urologic Sciences, University of British Columbia

Prostate cancer screening with Prostate Specific Antigen (PSA) remains a perennial "hot button" issue. We have gone back and forth, but the current consensus of the BC Guidelines on Prostate Cancer is that patients should be counseled on the risks and benefits of PSA screening and given the option to screen if they deem that the value outweighs the risk in their individual situation.



Dr. Peter Black

There is unequivocal evidence that PSA screening reduces death from prostate cancer. Multiple trials have been conducted, but only the European Randomized study of Screening for Prostate Cancer (ERSPC)[1] was adequately powered with long enough follow-up and protection from contaminating screening in the control arm (in contrast to the American Prostate, Lung, Colorectal and Ovarian (PLCO) Cancer Screening Trial[2] that had almost as much screening in the control as the intervention arm). It is important to remember that these trials were never powered to detect a difference in overall survival, so it should not be a criticism that this benefit has never been shown.

The crux of the matter is the potential harm caused by screening – including especially the complications of biopsy and over-treatment of low risk and favorable intermediate risk prostate cancer. Initial reports from the ERSPC reported numbers needed to screen and diagnose to save one life that were well beyond any reasonable tolerance threshold. But with longer follow-up (16 years in the 2019 update),[1] the number needed to screen has decreased to 570 and the number needed to diagnose to 18. Both should generally be considered reasonable parameters to justify screening.

It is crucial to recognize, however, that even this benefit is not yet a true reflection of the total benefit of PSA screening. These numbers are limited to the study population and the duration of the study. But modeling studies that extrapolate this trial data to the US population at large and to the projected mean life expectancy of men in this population have demonstrated even greater benefit. Modeling for 25 years reduces the number needed to screen to 186-220 and the number needed to diagnose to 2-5.[3] Modeling for lifetime estimate reduces the number need to screen to 98 and the number need to diagnose to 5.[4]

The value of screening lies not only in preventing death from prostate cancer, but also in reducing the development of metastatic cancer with its associated symptoms and treatment side effects. This is particularly important because patients can live several years on androgen deprivation and other next generation therapies. Patient morbidity during this time is often neglected in the screening debate.

Advanced technologies and practices are also reducing the toxicity of prostate cancer diagnosis and treatment. For example, the use of MRI before biopsy reduces the number of biopsies performed and the likelihood of diagnosing low risk prostate cancer. Transperineal biopsies are gradually replacing transrectal biopsies around the world, which is dramatically reducing the risk of serious infection. It is essential to link any prostate cancer screening program with a rigorous active surveillance program to reduce the risk of overtreatment. Canadian practitioners have been ahead of the curve in this regard, and the applying US risk:benefit analyses to the Canadian environment has always been problematic for this reason.

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Interventional Oncology Procedures in Pain Management

By Jasper Yoo, Medical Student, University of British Columbia
Dr. Behrang Homayoon, Interventional Radiologist, Surrey Memorial Hospital
Dr. Jun Wang, Interventional Radiologist, Surrey Memorial Hospital
Dr. Pedro Lourenço, Interventional Radiologist, Surrey Memorial Hospital

Interventional Oncology (IO) is a fast-growing field within interventional radiology that uses minimally invasive, image-guided procedures in patients with cancer. IO is progressively gaining importance in cancer management and is considered the fourth pillar of modern oncology.[1]

Chronic pain is a major source of morbidity in cancer patients, and systemic analgesia and radiotherapy may have incomplete or absent pain relief in select patients. IO procedures can help fill this unmet need, and IO procedures are now considered the fourth step of the modified WHO analgesic ladder.[2,3] This article will briefly discuss common IO procedures for pain management.

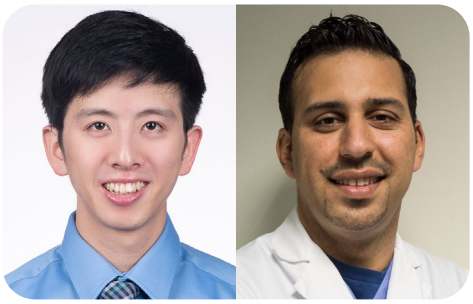
Vertebral augmentation and cementoplasty

The skeletal system is a frequent site for metastases, and the spine is most commonly affected.[4] Spinal metastases can cause extreme back pain and often locally progress, resulting in cord compression or vertebral fracture. Percutaneous vertebroplasty and kyphoplasty can be utilized to alleviate pain and stabilize fractures.

Vertebroplasty involves injection of cement into a fractured vertebral body. This reduces pain by mechanically stabilizing the fracture and searing adjacent nerves.[5] Kyphoplasty involves inflation of high-pressure balloons within the collapsed vertebral body, improving the kyphotic angle. Subsequent injection of cement stabilizes the vertebral body and restores height, reducing pain.[5,6]

Indications for vertebroplasty and kyphoplasty include osteoporotic and pathologic compression fractures with refractory pain, and treatment or palliation for certain bone tumours or osteonecrosis. Evidence of superiority for one procedure over the other is currently lacking.[7]

Percutaneous cementoplasty of non-vertebral fractures derives directly from vertebroplasty. The most common applications are in pelvic metastases, specifically in the superior acetabulum and sacrum. Cementoplasty in these sites are called acetabuloplasty and sacroplasty, respectively. These procedures are typically performed for palliation. Sacroplasty can also be performed for treatment of sacral insufficiency fractures in non-cancer patients.[8]



Jasper Yoo Dr. Behrang Homayoon

Percutaneous neurolysis

Neurolysis produces analgesia by permanently interrupting pain transmission along the sensory pathway. Interventional techniques can target specific neural pathways. Common targets are the celiac plexus, superior hypogastric plexus, ganglion impar, and stellate ganglion.[9,10]

Percutaneous neurolysis can be performed thermally or chemically. Thermal neurolysis is typically performed with ablation, and this is briefly discussed in the subsequent section. Chemical neurolysis is performed via phenol or alcohol injection, with similar efficacy of both agents.[10]

Analgesia from neurolysis lasts for months and can be lifelong in certain applications. Neurolysis can cause complications such as neuritis, particularly when treating large sensory nerve fibers. Therefore, neurolysis is typically reserved for cancer patients with advanced disease and a life expectancy of 6-12 months.[10]

Celiac plexus neurolysis is a common interventional procedure for cancer pain. It is a palliative treatment for severe upper abdominal visceral pain from advanced malignancy, particularly pancreatic cancer, and it is highly efficacious. Other indications include gastric cancer, cholangiocarcinoma, and chronic pancreatitis.[11,12]

The superior hypogastric plexus innervates the pelvic viscera, which includes the bladder, uterus, vagina, prostate, testes, urethra, descending colon, and rectum. Superior hypogastric plexus neurolysis (SHPN) is indicated in visceral pain secondary to pelvic cancer or radiation injury of these organs. Other indications include endometriosis, pelvic inflammatory disease, and adhesions. Ganglion impar neurolysis is primarily indicated for pain from perineal cancers of the anus or rectum, and it can be combined with SHPN for pain relief.[6,13]

The stellate ganglion sympathetically innervates the head, neck, upper extremities, and part of the upper thorax. Stellate ganglion neurolysis relieves nociceptive and neuropathic pain from malignancies in these regions, including post-mastectomy pain, Pancoast tumours, and neck carcinomas.[9,14]

Percutaneous ablation

Percutaneous ablation involves the direct application of chemicals, thermal energy, or nonthermal energy to induce tumour necrosis. The most common modalities are thermal and include radiofrequency ablation (RFA), microwave ablation (MWA), and cryoablation. Although RFA was the most frequently used method in the past, it has been superseded by MWA and cryoablation due to technical advantages and reduced pain.

Ablation is important in the treatment of select patients. Although it has been primarily used in malignant disease, it is now increasingly used in benign tumours. Important oncologic indications include hepatocellular carcinoma, liver metastases, renal cell carcinoma, inoperable non-small-cell lung carcinoma, lung metastases, osteolytic bony metastases, and osteoid osteoma.[15]

Ablation is cost-effective and safe. Radiotherapy and ablation together produce greater, more durable, and earlier analgesia than radiotherapy alone.[6,16,17] Ablation of symptomatic osseous metastases reduces pain by inducing neurolysis at the tumour-periosteum interface, inhibiting osteoclast activity, decreasing cytokine release by the tumour, and decompressing the tumour.[9] Ablation can also be used with curative intent. Recent literature suggests that it has immunomodulatory effects and can work synergistically with immunotherapy.[18]

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Interventional Oncology Procedures in Pain Management continued from page 12

In addition, ablation can be used with cementoplasty to treat or prevent pathologic fractures due to metastases in axial load-bearing bones such the spine and pelvis. Analgesia occurs both from stabilization of microfractures and thermal destruction of nociceptors.[6]

Conclusion

IO is important in improving the quality of life of patients with cancer. IO procedures are minimally invasive and can reduce pain burden and opioid use. Access to these procedures can be obtained through direct referral to an interventional radiology department or through various multidisciplinary tumour boards.

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Road to Becoming a Section for GP's in Oncology (GPO) at Doctors of BC

By Dr. Sian Shuel, Medical Education Lead, Family Practice Oncology Network with Dr. Steve Kulla

Dr. Steve Kulla, a general practitioner in oncology (GPO) working in Nanaimo, was instrumental in the recent support by the

Dr. Sian Shuel Dr. Steve Kulla

Doctors of BC (DOBC) Representative Assembly for formation of a section for GPOs. The process of becoming a section at DOBC was initiated for several reasons. Firstly, one of the impacts of the COVID-19 pandemic was that GPOs were no longer meeting at conferences and, as a result, were no longer networking to the same extent. Dr. Kulla explains it became clear that since GPOs in BC are spread geographically across the province, we needed improved communication around work-related issues. GPOs also work in a variety of practice settings in this province. This includes BC Cancer Centres, medium-sized outpatient clinics, rural locations where family physicians split their time between their family practice and GPO practice, and more. One-third of GPOs work within BC Cancer Centres, while two-thirds work outside the Centres. The diversity of practice settings has resulted in a need to formalize the conversation to understand the issues faced by the GPO group as a whole and how those needs can be met. A formal section at the DOBC supports the development of a platform we can use to help understand these work needs and facilitate change.

The application process started with connecting with DOBC to explore whether the GPO group would potentially fit the criteria to form a section, as well as connecting with GPOs individually to determine if they would be interested in seeking section formalization and willing to sign a letter of support. The formal application to DOBC was then made and included information such as who the GPO group is, what we do, how many GPOs there are in BC, which communities we work in and why it makes sense for this group to be a section. The application was taken to the Representative Assembly in June, supported and subsequently approved by the Board of Directors of DOBC.

While the formal name of the section is pending, the advantages are there. We will be able to use the administrative support and tools from DOBC to help communicate with our members. DOBC can help fill in knowledge gaps and in turn support physicians in contract negotiations with health authorities. GPOs will have the opportunity to sign up for the section when they pay their DOBC Dues at the end of the year and are encouraged to do so.

In addition to his work on helping the GPO group form a Section and practicing as a GPO, Dr. Kulla lends his time and expertise to several of the Family Practice Oncology Network's (FPON) working groups, including the webcast working group (an almost monthly webcast series for primary care), the CME Day working group for primary care, the GPO Education working group and the GPO Case Study Day working group. Working groups are one of the requirements to receive accreditation for educational initiatives. Dr. Kulla notes that sitting on these working groups allows him to understand the educational needs of his GPO colleagues and explains that much can be gained from learning what others in practice see as important knowledge gaps.

Dr. Kulla also explains that GPO work is specialized, different from medical oncology and family medicine, with unique educational needs. By continuing to focus many of their educational initiatives on the educational needs of GPOs, he notes that FPON is in a unique position to help provide GPOs with up-to-date, practice-relevant education on rapidly emerging treatments.

Contact:
Dr. Sian Shuel at sian.shuel@bccancer.bc.ca

BC Cancer Primary Care Learning Sessions Update

The testimonials are in – the BC Cancer Primary Care Learning Sessions successfully launched its pilot workshop in the East Kootenays to an engaged and highly receptive audience. This education, a virtual and customizable community-based small group session for primary care providers and cancer care specialists, aims to strengthen relationships amongst regional care teams while exploring community-based solutions.

These sessions build on the online BC Cancer Primary Care Learning Sessions modules on breast, colorectal, and prostate cancer. During the certified 1.5-hour workshop, a local panel of experts briefly review key learnings from the selected online module. Learners then have the opportunity to build connections and foster a community of practice with their local General Practitioner in Oncology, Medical Oncologist, Family Physician Champion, and peers by way of discussing clinical and community-specific questions.

"A huge thank you for having welcomed us with all of our questions in a very supportive and non-judgmental way," one participant said.

The overwhelmingly positive feedback speaks to the demand for this type of free programming in BC communities. With the rollout of these sessions, we hope to reach every health authority region in the province.

Interested in bringing a customized session to your community? Please contact Naeema Al-Mridha, UBC CPD Research & Events Assistant, for further details at naeema.a@ubc.ca

Supporting Tier One Services to Ensure a Sustainable Cancer-Care System in BC

By Dr. Catherine Clelland
Medical Director, Primary Care, BC Cancer

"For a long time, the role of primary care in cancer was largely seen as peripheral, but as prevention, diagnosis, survivorship, and-end-of-life care assume greater importance in cancer policy, the defining characteristics of primary care become more important"
Lancet Oncology, 2015

Dr. Cathy Clelland

Disease prevention, screening, diagnosis and management, along with longitudinal follow-up, are core tenants of Primary Healthcare. There is well-established evidence internationally of better patient outcomes and more cost-effective care when Primary Care is well integrated into and involved cross the healthcare care continuum. The cancer care system is no exception. In addition to improved prevention through lifestyle modification efforts, increased access to cancer screening and early access to diagnostic investigations are vital in reducing the downstream impact of delayed cancer diagnosis, both on the individual patient and on the cancer care system. Primary Care can also play an essential role in the psychosocial support of cancer patients and provides a more holistic approach to care, particularly in the context of co-morbidities and long-term survivorship.

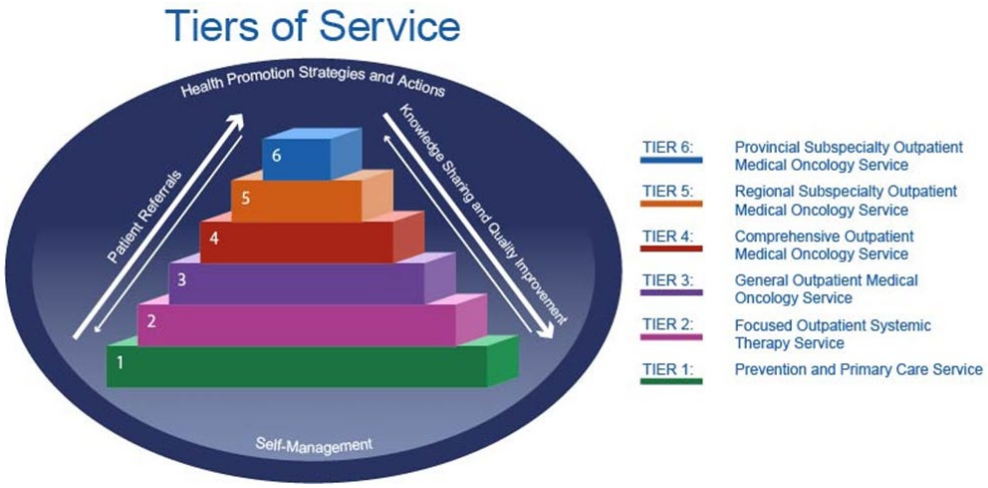
In 2021, the British Columbia (BC) population was 5.21 million people. Historically, cancer management focused on treatment delivered in specialized centres, with primary care limited to a supportive role. According to Canadian Cancer Statistics 2021 published by the Canadian Cancer Statistics Advisory Committee, the age-standardized incidence rate (ASIR) in BC in 2021 was 457.7 per 100,000 which means 28,500 new cases were diagnosed. This report also estimated "**2 in 5** Canadians will be diagnosed with cancer in their lifetime and about 1 in 4 will die from cancer." The 2022 projections for new cases in BC are 29,000 and for deaths, 11,400.

In 2019, BC Cancer in partnership with the Regional Health Authorities (Fraser Health, Interior Health, Island Health, Northern Health and Vancouver Coastal Health) and First Nations Health Authority, published Adult Outpatient Medical Oncology Services: Tiers to Support System and Operational Planning to guide the planning and standardized delivery of cancer care services across British Columbia. This framework describes Tier 1 "Prevention and Primary Care" services as the "provision of coordinated, comprehensive and quality cancer care services for adults with a cancer diagnosis to stay healthy, get better, live with cancer and cope with end of life." Tier 1 services provided in the community (e.g. family physician offices, walk-in clinics, dental offices, pharmacies, etc.) include promotion of cancer screening and early detection, support and referral of patients at risk of or diagnosed with cancer.

As Patient Medical Homes (PMH) and Primary Care Networks (PCN) continue to roll out across the province, primary care providers, especially family physicians, are well-positioned to provide comprehensive care to patients with cancer in the community. Most cancer patients begin and end their cancer journeys through the offices of primary care providers. Through the PCN and PMH, there is an opportunity to leverage the expertise of primary care providers in the province and strengthen Tier 1 community services to ensure the increasing need for cancer care in BC is met. The Family Physician's knowledge of the patient, their medical history and current co-morbidities results in an opportunity for the provision of holistic care throughout the cancer care journey.

One area of PCN focus could be on screening programs for breast, cervical, colorectal and most recently lung cancers. Despite public education and awareness campaigns, screening rates in BC continue to be suboptimal, particularly with the challenges faced during the initial phases of the COVID pandemic. Recent reports indicate ~ 20% of British Columbians are without access to longitudinal primary care, and given all four screening programs require identification of a primary care provider, the issue of unattached patients and barriers to screening program access will need collaborative solutions. There may be an opportunity to leverage the work of the PMH and PCN along with other community partners to improve the reach and ultimately patient outcomes.

Increasing the awareness of Tier 1 community cancer care services and intentional embedding of a team-based approach to support patients across the cancer care continuum as Primary Care Networks are expanded and appropriately supported will be key to improved sustainability across the broader Healthcare System and the Cancer Care System in particular.



From www.bccancer.bc.ca/health-professionals/networks/community-oncology-network

Summit 2022: Transformation, Adaptation, and Inclusion in Cancer Care and Research

By: Ruby Gidda, BC Cancer Summit co-chair and executive director, BC Cancer – Abbotsford and Provincial Professional Practice (Nursing & Allied Health).

When the Summit Advisory Committee first met to determine the theme for this year's BC Cancer Summit, we knew that change had to be at the forefront.

Change is – and always will be – a constant in health care and it must go beyond the growth and evolution of business as usual to actively improve the outcomes and experiences of our patients and their families.

At this year's BC Cancer Summit on **Friday, November 25** and **Saturday, November 26, 2022**, we'll learn about, engage with and inspire ground-breaking change. We'll feature international, national, provincial and regional **transformations** in research, clinical care, and technological innovations that pave a new path forward. We'll showcase **adaptations** in how we deliver care that equip us to respond in times of natural disasters and enable us to participate in the global efforts to tackle the climate emergency. Finally, we'll meet clinicians who are upending the status quo to provide care that is more equitable and **inclusive**, particularly when it comes to Indigenous people with cancer across our province.

An integral part of our culture at BC Cancer, this event will bring together staff and physicians across the province for education sessions, professional development and unique relationship-building opportunities. We'll kick it off with keynote presentations from:

- **Dr. Andrea McNeil**, founder and principle investigator of the UBC Planetary Healthcare Lab, and clinical associate professor in UBC faculty of medicine's department of surgery
- **Dr. Alika LaFontaine**, president elect of the Canadian Medical Association, award-winning physician, and the first Indigenous doctor listed in Medical Post's 50 Most Powerful Doctors

This year's Summit will be a hybrid event with a mix of in-person presentations at the Sheraton Wall Centre in Vancouver as well as presentations online. Participants can engage with colleagues from across the province in a series of virtual and in person breakout sessions from various tumour groups such as Head and Neck Tumour Group, Lung Tumour Group, Surgical Tumour Group, Oral Tumour Group and more, and sessions on radiation oncology, professional practice and supportive care. We'll also host a virtual poster session and in-person evening awards dinner where we celebrate our 2022 BC Cancer Excellence Award winners and Doctors of BC Terry Fox Medal recipient.

We hope you'll join us on November 25 and 26 for a summit where **transformation, adaptation**, and **inclusion** are just the beginning and be part of shaping the future of cancer care.

Ruby Gidda is a BC Cancer Summit co-chair along with Dr. Christine Simmons, medical oncologist, BC Cancer – Vancouver.

For more information and to register, visit bccancersummit.ca

If you have any questions, email conference@bccancer.bc.ca

FOR MORE INFORMATION

To learn more about the Family Practice Oncology Network or become involved, please email FPON@bccancer.bc.ca or visit www.fpon.ca

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