BC Cancer Agency
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Surgical Oncology Network Newsletter

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Surgical Oncology Network

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In This Issue...

HIGHLIGHTS FROM THE FALL UPDATE 2014: *BREAST CANCER: CURRENT CONTROVERSIES*

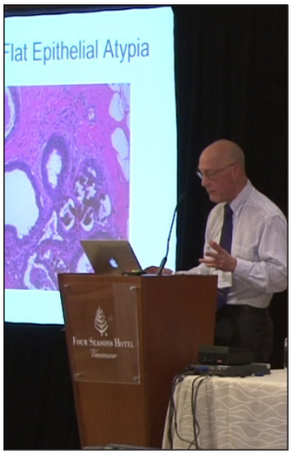
On October 18, 2014, the Surgical Oncology Network, with the UBC Department of Surgery, hosted the Annual Fall Update at the Four Seasons Hotel, downtown Vancouver. The day was focused on Breast Cancer: Current Controversies.

Dr. Elaine McKevitt
Chair, CPD-KT Committee
BC Surgical Oncology Network

The breast cancer Fall Update reviewed recent developments in the management of breast cancer, covering biology and pathology updates, quality of care issues, screening controversies, breast reconstruction and practical surgical, chemotherapy and radiotherapy issues. Dr. JF Boileau from Montreal was the BC Surgical Guest Speaker and Dr. Frances Wright from Toronto, was the Royal College Guest Speaker. Local surgeons, radiologists, oncologists and pathologists also presented.

Dr. Sam Aparicio, a respected Canadian breast cancer researcher, presented on the genetic and biological basis of breast malignancy providing a primer for surgeons on the developments in tumour sequencing. Tumour genetics are allowing tumours to be classified on the basis of genetic mutation and such grouping of tumours is increasing our understanding of tumour behaviour and modifying treatment. Four well recognized tumour subtypes are Luminal A, Luminal B, basal, Her2 positive. It is thought that these biological subtypes may play a larger role in helping select patients for surgical, radiation, and chemotherapy treatments. A commercially available assay is the Oncotype Dx, which is using tumour sequencing to predict biological behaviour of the tumour and effectiveness of chemotherapy.

Dr. Malcom Hayes, senior BCCA Vancouver breast pathologist, presented on the pathological basis of breast carcinoma. He explained that there are many different types of in-situ breast neoplasia that carry different risks of progressing to invasive carcinoma. The nomenclature for reporting in¬situ neoplasia is not standard in the province and the BCCA Vancouver is using a different system that the current WHO system, known as Mammary Intraepithelial Neoplasia (MIN). This system breaks intraductal proliferations into Hyperplasia, (usual ductal hyperplasia, papilloma, radial scar) and Neoplasia. Neoplasia is divided into ductal neoplasia and lobular neoplasia (see table on page 2).



DR. HAYES, PATHOLOGIST

It is understood that breast cancers can be divided into a low grade (better prognosis) and high grade family (poorer prognosis). Patients with lower grade in-situ neoplasia are thought to progress to lower grade invasive disease and higher grade in-situ changes to higher grade invasive disease. The low grade family includes: DIN 1a, DIN 1b, DIN 1c, low grade invasive ductal carcinoma, tubular carcinoma, cribriform carcinoma, LIN 1, LIN 2, and invasive lobular carcinoma. These tend to be found in older patients, are more often bilateral or multifocal, may have carcinoma far away from an original in-situ lesion, rarely

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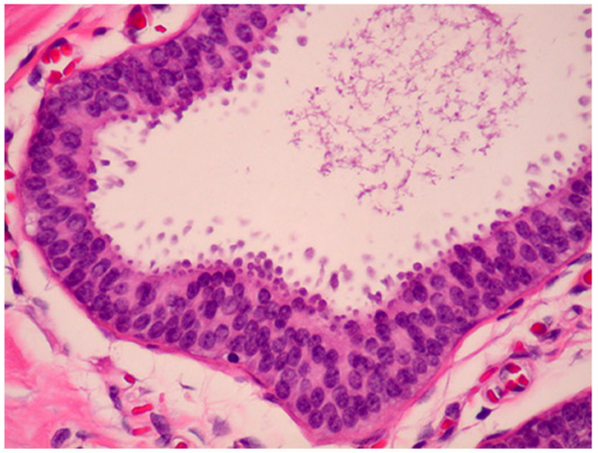
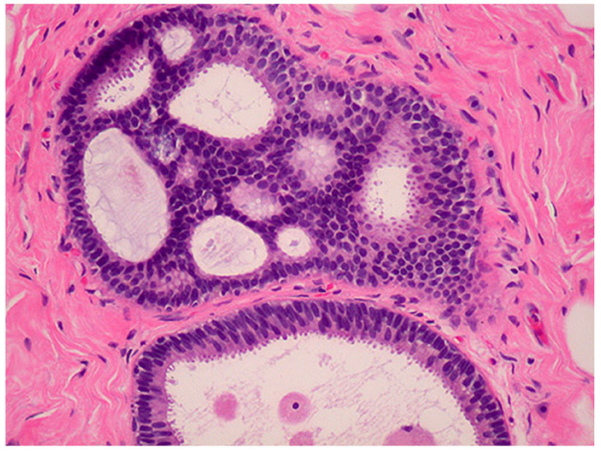
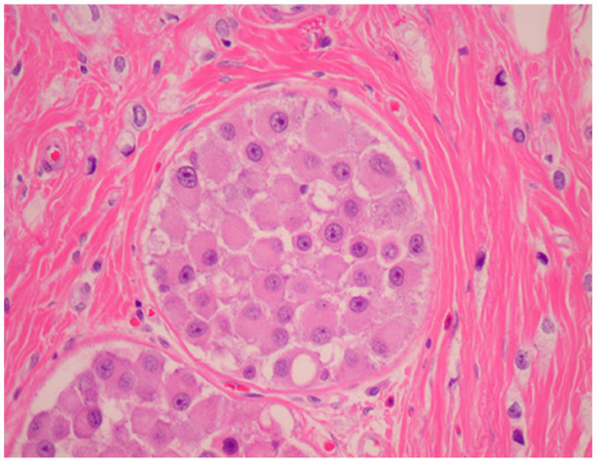
de-differentiate into high-grade lesions, and may be controlled by hormone modifying agents.



DIN1A = Flat Epithelial Atypia



DIN1B = Atypical Ductal Hyperplasia (ADH)

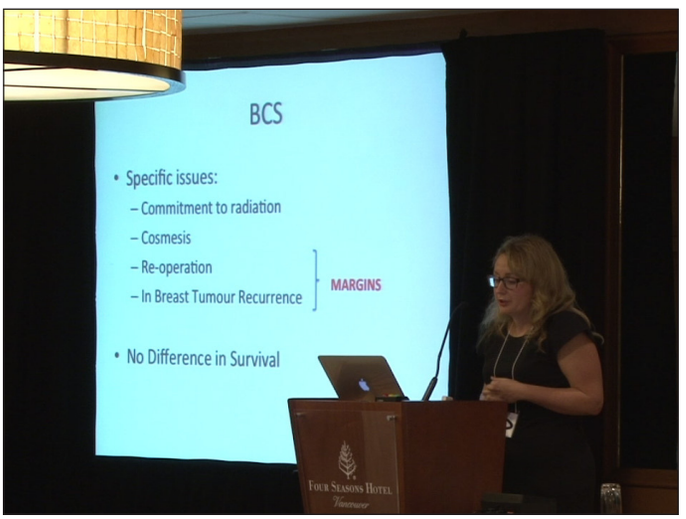


LCIS (LN3) - pleomorphic apocrine large cell type

The Tabor Theory of MIN says that Acinar type in-situ carcinoma, origin in Terminal Duct Lobular Units belongs to the low grade family and in-situ carcinoma arising in the major ducts, results in ductal neogenesis and belongs to the high grade family. Radiological patterns (such as casting calcifications) are found to be associated with either family, and may help to risk stratify in-situ cancers, which may lead to management changes. Perhaps these associations will help us identify low risk cancers and decrease overdiagnosis and overtreatment in the future.

	Mammary Intraepithelial Neoplasia	WHO/Traditional
Ductal Intraepithelial Neoplasia	DIN 1a	Flat Epithelial Atypia
	DIN 1b	Atypical Ductal Hyperplasia
	DIN 1c	Low grade DCIS
	DIN 2	Intermediate grade DCIS
	DIN 3	High grade DCIS
Lobular Intraepithelia Neoplasia	LIN 1	Atypical lobular Hyperplasia
	LIN 2	LCIS
	LIN 3	Pleomorphic LCIS

Dr. Rebecca Warburton, a breast surgeon at Mt. St Joseph, presented on the new ASCO guidelines regarding margin recommendations for breast conserving surgery. It has been recognized that since the landmark NSABP-B06 study, breast tumour recurrence has continued to decline. This has thought to be due to improved imaging and pathology, awareness of margin status, and improved adjuvant treatment (chemotherapy, endocrine, radiation). It has also been recognized that re-excisions for close and positive margins results in patient stress, treatment delays, system costs, and decreased cosmetic outcomes. The July 2001 BCCA Breast Tumour Group margin guideline recommends a 2 mm margin for both invasive tumour and DCIS. In April 2014, the Society of Surgical Oncology and American Society for Radiation Oncology published a consensus guideline that recommended re-excision only if tumour was at ink (positive) following partial mastectomy. They performed a systematic review and meta-analysis of studies from 1965-2013. Their study found that there was no benefit for additional surgery or boost of radiation if there was no tumour on ink. This statement held true independent of biological subtype, use of systemic therapy, patient age or with close but negative margins.



DR. WARBURTON PRESENTING AT THE 2014 SON FALL UPDATE

Following Dr. Warburton's presentation, our panel of speakers and surgeons reviewed cases that focused on various clinical margin issues. It was pointed out that we have been fortunate in BC to have consistent and thorough margin reporting. It was felt by our pathologist (Dr. Hayes) and our radiation oncologist (Dr. Scott Tyldesley) that reports from BC data regarding margin findings may therefore be more accurate than reports from the SSO consensus statement, in which there is great variability of practice in assessment of margins. All of this is leading to further discussion, and we expect that the Provincial Breast Tumour Group will be reviewing the margin data and guidelines to provide a more up to date local recommendation.

Dr. Christine Wilson, BCCA radiologist, presented on Screening Mammography controversies. She explained that the 2014 Screening Mammography of BC update recommends the target population is women aged 50-69, but screening is still offered to women 40-49 and 70+. The screening program has looked at the issue of overdiagnosis in breast cancer, and since cases of occult cancer cannot be identified, all patients with cancer are currently recommended treatment. A local study looking at this, and presented in the CMAJ in 2013 (Coldman et al), suggested that rates of DCIS are increased in all age groups with screening, and that the extent of overdiagnosis of invasive cancer is modest and occurred in women over 60 years.

In the United States, legislation is being introduced in many states that requires radiologists to inform patients with dense breasts of the limitations of mammography. In some states, screening ultrasounds have been added to mammography. This has raised the false negative rate by four times, as compared to mammography alone. This is not currently an issue in Canada, but may arise.

Age group	40-49	50-59	60-69	70-79
False +ve	88	67	55	50
False +ve biopsy	8.5	6.7	5.6	5.7
Cancer detected	2	4	6	8

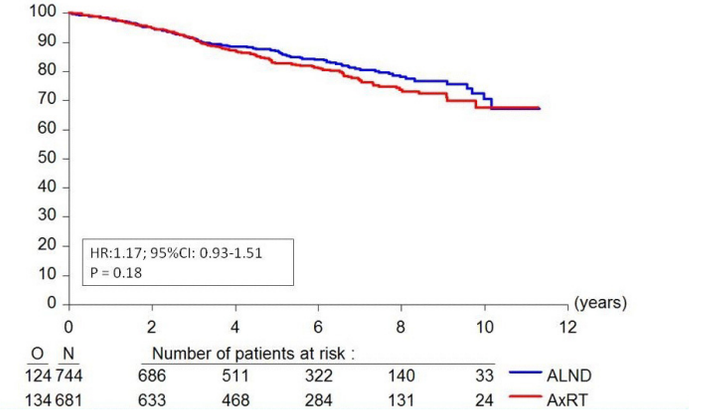
BREAST SCREENING: FALSE NEGATIVES (PER 1000 WOMEN SCREENED), BC SCREENING MAMMOGRAPHY PROGRAM

The screening program has developed online and print material for women to evaluate the benefits and risks of screening mammography, and make an informed decision with their primary care physician about whether to have screening mammograms. Women with a first degree relative with breast cancer are recommended screening mammograms annually. Women without a first degree relative with breast cancer are recommended screening mammograms every two years. The recommendations for women with other high risk characteristics (eg ADH) are currently not well covered in the current screening recommendations, and it is recommended that they have diagnostic studies ordered as appropriate.

Dr. Michelle Goecke and Dr. Elaine McKevitt presented current BC breast cancer quality indicator data and discussed current quality indicators in surgical breast cancer care. The data that was extracted from the BCCA Breast Cancer Outcomes Unit looking at surgical quality indicators was incomplete and therefore did not provide useful information on current surgical breast cancer care in the province. The May 2014 BCMJ article (Cho et al) on the utilization and impact of core biopsy in breast cancer indicated that open surgical procedures for breast cancer diagnosis were over-utilized in some parts of the province. It was discussed that data from various administrative sources was being used to estimate the quality of surgical breast cancer care in the province, but it is recognized that the administrative data is not able to calculate current breast cancer surgical quality indicators. It is hoped that synoptic reporting will allow for more accurate extraction of surgical data and that this information will allow for better understanding of surgical procedures on breast cancer outcomes. A more complete surgical dataset and database will allow for surgeons to have access to their own patient results as well as group aggregate results.

Dr. JF Boileau, a surgical oncologist from Montreal, spoke on the current management of the axilla in breast cancer focusing on current indications for axillary node dissection and management of the patient with a positive sentinel node. He presented evidence to show that sentinel node biopsy offers similar survival, regional control, and information for adjuvant therapy decision making, as an axillary node dissection. Sentinel node biopsy is now considered the standard of care in a clinically negative axilla. ACOSOG Z11 has changed practice after demonstrating that there was no survival benefit to a completion axillary node dissection after a positive sentinel node in a select patient population. Although this trial has many flaws, other studies show similar results. The MA20 trial has shown improved disease free survival with the addition of regional axillary radiation - which has prompted a recommendation that all women with positive axillary nodes be offered axillary radiation after discussion of the potential toxicities (7% lymph edema with nodal radiation, 4% without; 1.3% pneumonitis with nodal radiation, 0.2% without).

The AMAROS trial demonstrated that both axillary node dissection and axillary radiation provided excellent and comparable axillary control, but axillary radiation had significantly less lymph edema, and axillary node dissection combined with axillary radiation had very high rates of lymph edema. Following the results of these two trials, axillary radiation is now considered standard for patients that have positive axillary nodes. For a patient with a positive sentinel node biopsy post mastectomy, it may be acceptable to omit the axillary dissection if the tumour is T1/T2 and the patient will have axillary radiation. Trials are now looking at sentinel node biopsy alone following neoadjuvant chemotherapy (NAT) for patients with positive axillary nodes at diagnosis, and whether a positive sentinel node post chemotherapy can be treated with nodal radiation.



DISEASE-FREE SURVIVAL RATE (THE AMAROS TRIAL)

Axillary node dissection is still indicated for T4/inflammatory cancers and should be considered by a multidisciplinary team for patients that do not meet criteria from the Z11 or AMAROS trials. Axillary dissection is currently considered standard for pre NAT positive nodes, although results of current trials may change this recommendation.

The current status of neoadjuvant chemotherapy (NAT) was presented by Dr. Christine Simmons, a medical oncologist from the BCCA, Vancouver. In 2001, NSABP-18 showed that there was no difference in disease free or overall survival in patients receiving pre-op or post-op chemotherapy, demonstrating that there was no harm in "delaying" surgery. Neoadjuvant chemotherapy is an accepted approach to render an inoperable patient operable and to increase surgical options (allow for breast conserving surgery or reconstruction). However, there is increasing interest in NAT to know if a chemotherapy regimen is effective in a particular patient with a particular tumour.

Newer trials are also using the neoadjuvant setting - as the number of treatable patients is less than in adjuvant trials. Dr. Simmons presented the results of a Canadian National Expert Consensus on Neoadjuvant Therapy for Breast Cancer, which states that NAT is recommended in inflammatory breast cancer and locally advanced breast cancer (stages IIb and III), and can be considered in any patient that would be offered adjuvant chemotherapy. Patients with triple negative and Her 2 positive breast cancer have higher rates of complete pathological response and may be more appropriate to consider for NAT. Work up of patients prior to NAT must include receptor status on core, radiological assessment (+/- FNA) of the axilla and metastatic work up based on clinical stage. A clip should be placed in the tumour prior to NAT to allow localization in the event of a complete pathological response to NAT. The role of surgeons and medical oncologists in the work up and management of these patients varies between centers. In the setting of residual disease at the time of surgery (post NAT), no further therapy beyond adjuvant radiation and target therapy based on receptors (endocrine, Her 2) is currently needed outside of clinical trials.

Dr. Frances Wright, a Surgical Oncologist from Toronto, presented on surgical management in the setting of neo-adjuvant therapy (NAT). There is increasing use of neo-adjuvant chemotherapy for patients with operable breast cancer. NAT is being more commonly given to patients with tumours with aggressive biology, such as triple negative tumours and Her2 positive tumours, particularly in the setting of larger tumours or positive axillary nodes. The use of neo-adjuvant chemotherapy is affecting decision making and the surgical management of the breast and axilla continues to evolve. Post NAT, a tumour that may not have been appropriate for breast conserving surgery may become eligible with tumour shrinkage.

Determining the amount of residual disease after NAT can be challenging, and studies show wide range of accuracy for clinical assessment, mammograms, ultrasound, and MRI. Although imaging accuracy is variable, it is recommended to re-image the patient if breast conserving surgery is desired, and a clip should be placed prior to NAT to allow for localization in the event of a complete clinical response. Not all surgeons remove the whole pre-op tumour area, and there are currently no guidelines for margins and oncologic safety in the setting of lumpectomy post NAT. Patients with inflammatory cancer, multifocal disease on imaging or diffuse pre-op malignant calcifications should still have a total mastectomy.

A NSQIP study (2005-2011) showed that patients who had neo-adjuvant chemotherapy had a lower overall morbidity than patients that did not have NAT (surgery with and without reconstruction). The reasons for this protective effect are not understood.

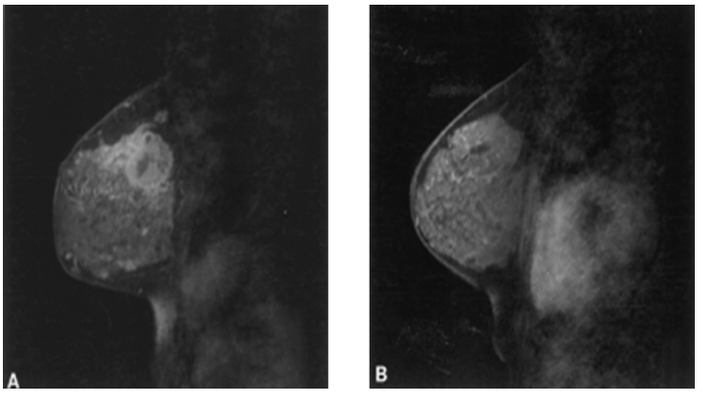
	2-5cm Node neg	2-5cm Node pos	LABC
Mammo, U/S	✓	✓	✓
MRI			✓
Core biopsy and receptors	✓	✓	✓
Clip if considering BCS	✓	✓	✓
Metastatic work up Bone scan, CT chest, abd pelvis		Maybe	✓

PRE-OPERATIVE WORK UP OF BREAST CANCER AT SUNNYBROOK HOSPITAL

For patients that are clinically and radiologically node negative before NAT, it is recommended to proceed with sentinel node biopsy. The role of SNB in node positive patients after NAT is evolving. Recent studies (Boughey 2013, Kuehn 2013, Boileau 2014) show acceptable accuracy of sentinel node biopsy post NAT, particularly if at least 2-3 nodes are obtained with SNB, two tracers are used and the pathologic assessment of the node includes IHC. It is currently unknown how to best manage patients that have a positive SNB after NAT - some centers do a completion ALND, but radiation alone is being considered. The ALLIANCE A11202 study is looking at this question.

Tumour Subtype	Percentage of type of breast cancer	Complete pathological response
ER/PR pos, Her 2 neg	40-55%	8%
ER/PR pos, Her 2 pos "Triple positive"	15-20%	19%
ER/PR neg, Her 2 pos	7-12%	39%
Triple Negative	13-25%	31%

PATHOLOGICAL COMPLETE RESPONSE AND BREAST CANCER SUBTYPE



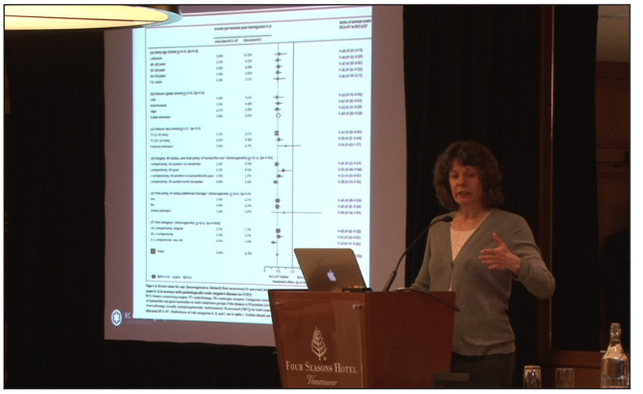
A. PRE-TREATMENT CIRCUMSCRIBED MASS WITH RIM ENHANCEMENT
B. AFTER NAT TUMOUR SHRANK TO SMALLER MASS; RESECTABLE

At Sunnybrook, NAT is offered to patients under 50 who are Her 2

Neu positive and triple negative.

Dr. Lorna Weir, a radiation oncologist from BCCA Vancouver, presented on radiotherapy for breast cancer. She explained that the Z11 study has been reviewed to look for radiation details, and when this is considered, many Z11 patients would have had radiotherapy to some or all of the axilla. The MA 20 study showed improved disease free survival, as well as a trend towards improved overall survival with the addition of axillary radiation in the setting of positive axillary nodes or high risk node negative disease. The EORTC 22922 study looked at the effect of radiation to the supraclavicular and internal mammary nodes, and showed improved overall survival and improved disease free survival for patients with positive axillary nodes or medially located node negative tumours. The AMAROS trial randomized patients with a positive sentinel node to either axillary node dissection or axillary radiation, and showed similar disease free survival and overall survival. In all three of these trials, 85-90% of patients had systemic treatment, and an increased risk of lymphedema with axillary node dissection, and an increased lung toxicity with radiotherapy (4.3% in EORTC). Taken together, there is a shift to treating the positive axilla with radiation, rather than axillary node dissection. Molecular profiling of breast cancer is also being used to try to identify a group of patients at low risk for recurrence. The Luminal A profile (ER/PR positive, HER2 negative, low Ki67) group may have a low recurrence risk, with little additional benefit from radiotherapy. Current trials are in the process of assessing this.

Presently, patients who had positive nodes prior to NAT and who are node negative after NAT are still being given axillary radiation (treating as node positive), but this is an area of active investigation, being assessed by the ALLIANCE A011202 and NSABP B51. In ALLIANCE A11202, patients with positive axillary nodes prior to NAT will have nodal radiation, and patients who have persistently positive axillary nodes after NAT are randomized to ALND or SNB. NSABP B51 trial will randomize patients to axillary RT after a negative SN post NAT).



DR. WEIR, BC CANCER AGENCY RADIATION ONCOLOGIST PRESENTING AT THE FALL UPDATE

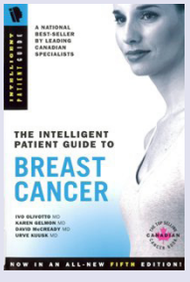
In summary, the management of breast cancer is becoming increasingly multidisciplinary and less invasive. An increasing number of patients are receiving chemotherapy (whether adjuvant or neo-adjuvant) and radiotherapy (whole breast with lumpectomy, post mastectomy chest wall radiotherapy, and nodal radiation), and management is becoming increasingly individualized. To effectively manage these patients, surgeons will need to collaborate with their local multidisciplinary teams.

BREAST CANCER INFORMATION KITS

The packages for patients with a new diagnosis of breast cancer are no longer being produced by BC Cancer Agency. An online version of the kit, including links to other websites and references to the book, *The Intelligent Patient Guide to Breast Cancer,* are available on the BC Cancer Agency website. The online information kit is maintained by the BC Cancer Agency Breast Tumour Group and the BC Cancer Agency Library.

www.bccancer.bc.ca/breastkit

The webpage includes an online copy of the Breast Cancer Companion Guide, a helpfull navigational tool which is the starting point of this kit. The guide interacts with the other resources in the kit and in the community.



Upcoming Conferences

BC Surgical Society Annual Spring Meeting, Whistler, BC
April 30-May 2, 2015
www.bcss.ca

American Society of Breast Surgeons Annual Meeting, Orlando, USA
April 29-May 3, 2015
www.breastsurgeons.org

American Society of Clinical Oncology, Chicago, IL, USA, McCormick Place
May 29–June 2, 2015
www.am.asco.org

American Society of Colorectal Surgeons Annual Meeting, Boston, MA, USA
May 30-June 3, 2015
www.fascrs.org/annual_meeting

European Society of Coloproctology 10th Anniversary Meeting, Dublin, Ireland
Sept 23-25, 2015
www.escp.eu.com/dublin

BC SON Fall Update: Upper and Lower GI, Vancouver, BC
Nov 7, 2015
www.bccancer.bc.ca

Updated guidelines for surveillance following curatively resected colorectal cancer

Manoj J. Raval, MD, MSc, FRCSC
Chair, SON Colorectal Tumour Group

The BC Cancer Agency has provided caregivers guidelines for the treatment and surveillance of patients with colorectal cancer, jointly produced by the GI Tumour Group and the Surgical Oncology Network Colorectal Surgical Tumour Group.

It has been shown that more intensive followup improves outcomes following curative resection for colorectal cancer[1]. Surveillance guidelines developed by the Program in Evidence-Based Care (PEBC) of Cancer Care Ontario[2] were recently reviewed and endorsed by the American Society of Clinical Oncology (ASCO)[3].

The BCCA has adapted these surveillance recommendations into the Cancer Management Guidelines for colon and rectal cancer. A summary of the updated surveillance recommendations for the 5 years following resection is found below. Details of the guideline development by CCO and review by ASCO may be reviewed via the references provided in the footnotes below.

As with previous guidelines, intensity of surveillance may be modified beyond these guidelines depending on presumed risk of recurrence (from final pathologic stage), comorbid status, and willingness of the patient to undergo surveillance maneuvers and potentially further therapy. It is recommended that the vast majority of patients with curatively-resected stage II or III colorectal cancer undergo this surveillance program. There is minimal data to provide guidance for stage I or resected metastatic disease, however. In general, stage I colorectal cancer should undergo colonoscopic followup as per stage II and III.

As always, coordination of caregivers is critical to ensuring adequate followup, as medical oncologists, radiation oncologists, gastroenterologists, surgeons, and family doctors all may play vital roles. Letters to family doctors with a clear followup plan should be sent by specialists once patients are discharged from their care.

Patients and their families should also be encouraged to actively take part in their followup. Finally, as per ASCO guidelines, "despite the lack of high-quality evidence on secondary prevention in CRC survivors, it is reasonable to counsel patients on maintaining a healthy body weight, being physically active, and eating a healthy diet."

BCCA Guidelines

- **History and physical examination** every 3 to 6 months for the first 3 years after surgery, then every 6 months for years 4 and 5. Rectal examination at least annually.
- Carcinoembryonic antigen **(CEA) level** at each follow-up visit as above. If CEA is elevated, repeat test within 28 days.
- **Chest, abdominal and pelvic imaging** annually for 5 years (previously recommended every 6 months for first 3 years). CT preferred or chest X-ray/liver ultrasound if CT contraindicated or not available.
- **Colonoscopy** at 1 and 4 years after surgery, then every 5 years thereafter. If complete colonoscopy was not performed at time of initial cancer diagnosis, should be completed within 6 months after resection.
- If the patient is not a candidate for metastatectomy, CEA and routine imaging studies are not recommended.
- If CEA is elevated and/or signs and symptoms of recurrent colon cancer found, imaging of the chest, abdomen and pelvis should be done and a re-referral to oncologist or surgeon is indicated.
- Other imaging (including PET) and blood work (liver enzymes, etc) are not recommended in routine follow-up, but may be appropriate in a patient with symptoms suggestive of recurrence.

References:

1. Jeffrey M et al. Followup strategies for patients treated with non-metastatic colorectal cancer. Cochrane Database Syst Rev 2002;(1):CD002200

2. https://cancercare.on.ca/common/pages/UserFile.aspx?fileId=124839

3. Meyerhardt JA et al. Follow-up care, surveillance protocol, and secondary prevention measures for survivors of colorectal cancer: American society of clinical oncology clinical practice guideline endorsement. J Clin Oncol 2013. 31(35):4465-7

Recent surgical oncology articles

Radiotherapy or surgery of the axilla after a positive sentinel node in breast cancer (EORTC 10981-22023 AMAROS): a randomised, multicentre, open-label, phase 3 non-inferiority trial
Donker, Mila et al.
The Lancet Oncology , Volume 15 , No. 12 , P. 1303 - 1310, November 2014
www.thelancet.com

Final trial report of sentinel-node biopsy versus nodal observation in melanoma
Morton, DL et al.
N Engl J Med. 2014, 370:599-609, February 13, 2014
www.nejm.org

Recent surgical oncology guidelines

In April 2014, The Society of Surgical Oncology and the American Society for Radiation Oncology, published a guideline on margins for breast conserving surgery with whole breast irradiation for stages 1 and 2 breast cancer. This guidelines state that the use of no tumour on ink should be the standard for an adequate margin in invasive cancer. Although this guideline has been published, the BCCA Provincial Breast Tumour Group has not yet changed the BC recommendation for a 2mm margin, and until the BC recommendations are updated, it is recommended that cases with close margins be reviewed on an individual basis by the multidisciplinary team.

Society of Surgical Oncology–American Society for Radiation Oncology Consensus Guideline on Margins for Breast-Conserving Surgery With Whole-Breast Irradiation in Stages I and II Invasive Breast Cancer

Moran MS et al.
Ann Surg Oncol, Vol. 21, Issue 3, March 2014
www.annsurgoncol.org

In October 2012, the American Society of Clinical Oncology and the Society of Surgical Oncology, published an evidence-based guideline on the use of lymphatic mapping and sentinel node biopsy in the staging of patients with newly diagnosed melanoma. Sentinel node biopsy is recommended for patients with intermediate thickness melanomas of any anatomic site, and can be considered on an individual basis for patients with thick and thin melanomas.

Sentinel Lymph Node Biopsy for Melanoma: American Society of Clinical Oncology and Society of Surgical Oncology Joint Clinical Practice Guideline

Wong SL et al.
Ann Surg Oncol, Vol. 19, Issue 11, October 2012
www.annsurgoncol.org

Health care: it's all about the PROs and cons?
Increasing interest in patient reported outcomes (PROs)

Update from the Patient Reported Outcomes Course, Washington, DC

Dr. Chris Baliski
SON Chair

The modern age of surgery has seen a rapid evolution in surgical techniques and technology, resulting in marked improvements in outcomes for all surgical diseases. In addition, a greater understanding of disease processes and biology, along with increasing treatment options, has changed the landscape for many diseases. While there is little doubt that a patient with an incarcerated hernia, acute cholecystitis, bowel perforation, or an obstructing colon cancer should undergo surgery, things are less clear in other non-emergent surgical areas. For instance, what about an asymptomatic inguinal hernia, herniated disc, diverticultis, or low grade DCIS of the breast? There is now increasing evidence that these conditions may not require surgical intervention, and in some cases the patient may be worse off from the intervention than the disease. This of course, not only applies to surgery, but also other areas of medicine.

In the past, concerns mostly pertained to the morbidity and mortality associated with the procedure, but now there is an increasing focus on the true change in disease status from the intervention and the patient's subjective experiences. For example, is the patient with an asymptomatic hernia truly better after surgery? What about the influence of arthroscopy on function and performance? Other examples could include: bowel function after rectal cancer surgery, patients perceptions of their appearance or psychological status after breast conserving surgery, or reconstruction with breast cancer. This has lead to increased interest in Patient Reported Outcomes (PRO's), which assess the degree to which health services increase the desired health outcome. In other words, the right treatment, in the right patient, right site and right time, done right. The measures used to assess this being patient reported outcomes measures (PROMS). PROMS come in many forms, with many familiar with the generic SF-36, or perhaps other disease specific measures. While patients experiences and perceptions of care are very subjective, these and other measurement scales have begun to proliferate and become more scientifically rigorous, providing increasingly meaningful measures for patients and physicians. This has also come to the attention of hospitals and health insurers in the form of pay for performance. While PRO's are still in their evolution, portions of hospital reimbursement are now being tied to the collection of such information, and even their results.

This has allowed increasingly sophisticated ways to look at the effect, or lack thereof from interventions. In addition to its use in comparative effectiveness research, it also has practical aspects allowing better informed decisions around interventions in the form of decision aids. This provides patients with the ability to have a truly informed consent to interventions and assists them with setting expectations. Some institutions even use PRO's in their clinical workflow much in the same way as the bedside flow sheet in an acute care setting. Patients can now fill in PROMS at clinic visits or even electronically on an outpatient basis, allowing their care providers the ability to assess their progress. This can be used to follow pain or function after orthopaedic interventions, bowel function after intestinal surgery, or appearance after reconstructive or cosmetic surgery. In the United States, some institutions have invested huge capital into information technology to support these measures for clinic efficiency, communication of patient progress and satisfaction with their recovery, evaluation of physicians and other support staff, and as a quality indicator of the intervention, as well as a method of quality assurance to identify areas for improvement

The proliferation of PRO's are related to the increasing push for patient centered care which can be solely lacking at times in our Health Care system. The proliferation south of the border has been fostered by the internet and patient websites, along with the consumerism that prevails in their system. This is further supported by billions of dollars being invested into this area by private and government funding. It appears everyone is interested in the PRO's and cons!

Surgical Oncology Network News

2015 SON FALL UPDATE - SAVE THE DATE

We would like to invite our surgeon readership to our annual one day Fall Update event. This year it will be held on Saturday November 7th in downtown Vancouver at the Four Seasons Hotel. Our topic for this year will be Upper and Lower GI Tract Cancers. We will be sending out more information regarding the event, including the program and registration information in our next newsletter. It will also be posted on our website as soon as it is available.

SON SURGEON DIRECTORY AND MEMBERSHIP UPDATE

As a Surgical Oncology Network Member, you likely received a membership update survey form in the mail in February 2014. The objective of the survey was to obtain updated contact information for each of the surgeons performing cancer surgeries in the province.

We sent out over 600 forms to surgeons across the province and the response was very gratifying: to date more than 375 of you responded to our survey. Thank you to those of you who responded to us so far.

The information from the survey is being used to update the SON Surgeon Directory: our provincial database of surgeons performing cancer surgeries. The SON Surgeon Directory contains updated contact information of all SON members, captures our members' area of surgical interest and expertise, informs us about which of our members are interested in joining Surgical Tumour Groups and Committees, and helps us to identify speakers and mentors for various events and educational initiatives.

If you did not receive a membership survey and would like to update your contact information, or if would like to become an SON member, please contact Wade Stow, SON Program Assistant at wade.stow@phsa.ca and he will be happy to email or mail one to you.

SURGICAL ONCOLOGY NETWORK NEWSLETTER

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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.

SON BREAST TUMOUR SURGICAL GROUP CHAIR

The SON would like to thank Dr. Laurence Turner for his service as the Chair of the SON Breast Cancer Surgical Tumour Group from 2009-2014. Dr. Turner was integral in many breast tumour group initiatives including the Fall Update in Breast Cancer in 2009 and 2014, the development of the breast cancer surgical checklist, breast cancer management guidelines and identifying quality indicators for breast cancer surgery. The SON thanks Dr. Turner for his commitment and contribution to the Breast STG and the Network and wishes him well in his retirement.

Dr. Elaine McKevitt has been appointed as the new Chair of the Breast STG. Dr. McKevitt spearheaded the breast cancer surgery checklist initiative and brings a wealth of experience as a breast cancer surgeon and long time member of the Breast STG.

NEW WEBSITE COMING FOR SON AND BC CANCER AGENCY

The BC Cancer Agency is launching a new website this month, with a new design and a more modern website structure. The new site will be easier to read and navigate so our members can find what they need easily. The new website will also be smartphone and tablet-friendly, which makes for easier browsing and reading while on the go.

You can anticipate plenty of useful information and resources to be posted on the site. You can find digital versions of these newsletters, presentations from our annual Fall Updates, the latest SON supported publications, guidelines, and plenty of other relevent surgical oncology content.

Please be sure to visit www.bccancer.bc.ca and follow the links under 'Health Professionals' to our Surgical Oncology Network home page. We look forward to 'welcoming' you to our new site.

SON PROJECT MANAGER

The SON would like to thank Chrystal Palaty for her service as our project manager. Chrystal was respsonsible for organising our yearly Fall Update conferences, as well as coordinating our tumour group and committee meetings and projects. We would like to welcome Shahin Mahmoodi as her replacement in this role.