Family Practice Oncology Network Journal

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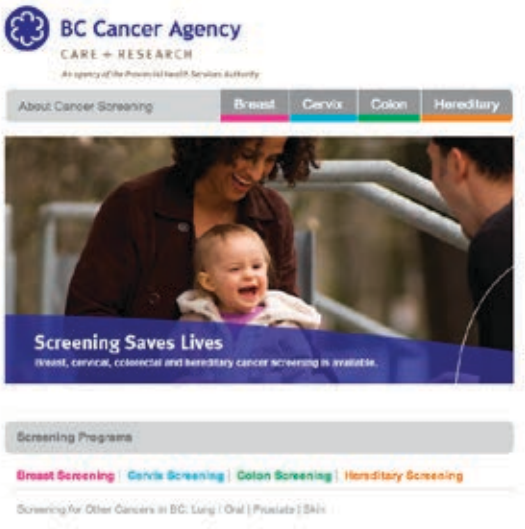
BC Cancer Agency
CARE + RESEARCH
An agency of the Provincial Health Services Authority

BC Cancer Agency launches one-stop shop cancer screening website



The BC Cancer Agency has launched a new, dedicated cancer screening website featuring an updated look, easier navigation and current information on the province's four organized screening programs – breast, cervical, colon and hereditary cancers.

The www.screeningbc.ca website was developed in response to primary care feedback raised in the *2009/2010 Report on Province-Wide Cancer Screening Needs Assessment* conducted by the University of British Columbia's Division of Continuing Professional Development. Physicians highlighted the importance of having a more streamlined BC Cancer Agency website to facilitate cancer screening discussions with patients.

You spoke. We listened, and responded.

With the new one-stop shop website, patients can now access all cancer screening related information, including screening eligibility, screening procedures, and clinic and laboratory locations.

The website also hosts a health care professionals section dedicated to keep primary

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Join us November 2 for Family Practice Oncology CME Day

This year's Family Practice Oncology CME Day – set for November 2 at the BC Cancer Agency Research Centre – will be rich in practice pearls addressing the most requested oncology topics of the year and specifically targets the needs of family physicians. The program (see enclosed flyer) meets the accreditation criteria of the College of Family Physicians of Canada and has been accredited by the BC Chapter for up to 5 Mainpro-M1 credits – 1 more than last year.

"We acted on feedback from previous years and are offering a revitalized program which is very family physician friendly with a strong academic focus," notes Dr. Raziya Mia, the Network's Clinical Coordinator of FPON Education. "Our opening highlight features updates in Cancer Screening including insights from four of the province's top screening experts with opportunity for questions afterward."

Other topics to be covered include Febrile

Neutropenia; Leukemias, Myelodysplasia, Myeloproliferative Neoplasms and Myeloma; Management of Malignant Ascites and Effusions; Fertility Issues in Survivors of Childhood Cancer; Spinal Cord Compression; Superior Vena Cava Syndrome; and Hypercalcemia and Cancer Related Electrolyte Imbalances. The afternoon includes a choice of two small-group, cased based workshops from among the following options: Breast Cancer; Colorectal Cancer; and Pain and Symptom Management. The Network appreciates UBC's Division of Continuing Professional Development's contribution to planning and delivering the first two workshops.

This year's event is further unique in that this will be the first time it is presented independently of the BC Cancer Agency Conference which was cancelled earlier this spring. We are offering a lower registration fee of $100 for family physicians and extending a warm welcome to oncology nurses, pharmacists and other primary care professionals at $50 each. Registration is open at www.fpon.ca. We hope you will join us on November 2 and take full advantage of this learning opportunity. Please contact jennifer.wolfe@bccancer.bc.ca if you have any questions at all.

Breast health program reduces patients' cancer risk

By Jennifer Parisi, Communications Director, Cancer Prevention Centre, Faculty of Medicine, University of British Columbia

Do your patients worry about breast cancer? Breast cancer is the most common cancer diagnosed in Canadian women. Over 22,000 women were diagnosed with breast cancer in 2012, and over 5,000 died of the disease.

How can your patients reduce their risk? Research shows that up to 40% of breast cancers are preventable through healthy lifestyle changes. However, lots of women don't know which behaviours increase or decrease their risk of developing breast cancer, and many believe that inherited genetic factors are responsible for most breast cancers.

We have found that women attending our program, the **Breast Cancer Prevention & Risk Assessment Clinic**, over-estimate their risk of breast cancer by an average of 300%. Our breast cancer prevention program helps women to understand their objective risks and how to reduce their risks. The program provides evidence-based information, proven risk assessment tools, and lifestyle recommendations to assist women in improving their breast health.

Katharine Proudlove is a woman in her late 30's who took part in the program. She was surprised by what she learned. "So lifestyle choices, including alcohol consumption, can increase your risk by 40%. That statistic was really shocking to me. I was just like, 'Why don't they tell women this?' I know many women in my life that probably would not drink as much as they do if they were aware of the risks."

Our program helps your patients, and it provides you with the information you need to guide them in their decision-making. We provide a breast health report to both you and your patient. You will also receive current guidelines for chemoprevention and suggestions for additional resources. The report provides an opportunity for you to counsel your patients on their progress and concerns.

There is no charge to attend the Breast Cancer Prevention & Risk Assessment Clinic. The program is a project of the Cancer Prevention Centre. Project funding is provided by the Canadian Breast Cancer Foundation - BC/Yukon Region.

Refer your patients to our program. To make an appointment, call 604-603-5140, or email info.bcprac@ubc.ca. For more information and resources, see our website (breastcancerprevention.spph.ubc.ca) and Facebook page (www.facebook.com/BCPRAC).

Participant comments

"I felt that I had the ability to deal with the 'c' thing rather than feel victimized or overwhelmed." – Jenny

photo: Cancer Prevention Centre

CANCER PREVENTION CENTRE

A partnership between the Canadian Cancer Society and the University of British Columbia

"I found the clinic to be highly informative. There is so much information that, in my opinion, is not getting heard by women, mainly because their doctors don't have enough time to spend with their patients anymore. The Breast Cancer Prevention & Risk Assessment Clinic should be considered a vital part of our health care system."
– Theresa

"I'm very glad I went to this clinic because it enabled me to question more and be more proactive and advocate for myself."
– Katharine

Resources

How to reduce your risk, Breast Cancer Prevention & Risk Assessment Clinic: breastcancerprevention.spph.ubc.ca/files/2012/12/Breast-Cancer-Prevention-educ-doc_v21.pdf

Prevention and risk reduction, Canadian Breast Cancer Foundation: www.cbcf.org/bc/AboutBreastHealth/PreventionRiskReduction/Pages/default.aspx

Who should get a mammogram, BC Cancer Agency: www.screeningbc.caBreast/GetMammogram/WhoShouldGetaMammogram.htm

Breast cancer prevention resources, Breast Cancer Prevention & Risk Assessment Clinic: breastcancerprevention.spph.ubc.ca/resources/

The Cancer Prevention Centre is a partnership of the Canadian Cancer Society and the University of British Columbia. We conduct research on primary cancer prevention which includes breast cancer risk reduction, occupational and environmental carcinogens, and social determinants of health. We also evaluate programs that promote community health and help individuals reduce their cancer risk.

Our research has provided evidence to support new workplace wellness programs, and has helped other health agencies better understand how to prevent cancer. In addition, our projects address gaps in the existing health care system and complement existing prevention programs.

The centre partners with academics, community organizations, health care organizations, policy-makers, and others to help prevent cancer. Our partners include groups such as the Canadian Cancer Society, the Canadian Breast Cancer Foundation and the BC Healthy Living Alliance. We look forward to further collaborations with BC health agencies.

New resource on natural health products for breast cancer

A newly released set of online patient/clinician monographs is available to increase patient/clinician knowledge of the top five natural health products (NHP) of interest to women living with or at risk of breast cancer. The monographs were produced by BC's Complementary Medicine Education and Outcomes (CAMEO) Research Program together with the Ottawa Integrative Cancer Centre.

"There is a recognized deficit of evidence-based information on natural health products for cancer," notes CAMEO Research Assistant Jessica Collins. "These first monographs are a good step forward summarizing such knowledge for black cohosh, soy, red clover, flax and Vitamin D. We systematically reviewed these products' safety and efficacy in the context of breast cancer and included guidelines for their use or avoidance. The patient monographs are brief, easy to understand and friendly in their approach while the clinician versions include references and more detailed information." Feedback is encouraged and the materials will be kept up to date.

CAMEO
Complementary Medicine Education & Outcomes Program

Access these printable monographs at www.bccancer.bc.ca/RES/ResearchPrograms/cameo/Documents.htm

Contact Antony Porcino at antony.porcino@nursing.ubc.ca

OICC
OTTAWA INTEGRATIVE CANCER CENTRE

CCIO
CENTRE DE CANCÉROLOGIE INTÉGRATIVE D'OTTAWA

BC Cancer Agency launches one-stop website *continued from page 1*

care providers updated about current screening recommendations and to provide easy access to resources to assist with discussions about cancer screening with patients. Resources range from patient support and physician information materials, to guidelines and forms, as well as evidence-based research and publications.

Primary care providers are key influencers in a patient's decision when patients are considering participating in screening programs. According to a focus group conducted by the Screening Mammography Program of BC in March 2012, approximately 88 per cent of women ages 40 to 79 said that a reminder from their primary care provider was effective in convincing them to book their next mammogram.

While the decision to be screened is your patient's, the decision to begin a screening discussion can be yours. Please speak with your patients about their eligibility for cancer screening programs and use the new website to help them make an informed decision.

Cervical Cancer Screening Program

Program Eligibility: Women should start having Pap tests at age 21 or three years after their first sexual contact, whichever occurs first. Pap tests should be done every year for the first three years, followed by every two years if the results are normal until age 69.

Evidence says regular screening reduces the risk of developing cervical cancer by 70 per cent.

Colon Screening Program

Program Eligibility: Men and women between the ages of 50 and 74 should complete a fecal immunochemical test (FIT) every two years. For those with a personal history of adenomas or significant family history of colon cancer, a screening colonoscopy is recommended instead.

FIT has been publicly funded in BC since April 1, 2013. The BC Cancer Agency and health authorities across the province are working to put the necessary systems in place for a provincial colon screening program. For program updates, visit www.screeningbc.ca/colon/forhealthprofessionals.

Evidence says age is the biggest risk factor for colon cancer – over 94 per cent of new cases diagnosed each year in BC are in men and women age 50 or older.

Hereditary Cancer Program

Program Eligibility: Men and women from a family with a confirmed mutation in a hereditary cancer gene can be referred for genetic counseling, regardless of a cancer diagnosis.

Evidence says that while cancer may be common, hereditary cancer is not. Less than one cancer in 10 is hereditary.

Screening Mammography Program of BC

Program Eligibility: Women between the ages of 40 and 79 with a primary care provider (doctor, nurse practitioner or naturopathic doctor) can book their screening mammograms directly with the program without a doctor's referral.

Evidence says the risk of developing breast cancer increases with age – over 80 per cent of new breast cancers diagnosed each year are in women age 50 or older.

For more information about the cancer screening programs in BC, including lung and prostate cancers, you can also visit the BC Cancer Agency website at www.bccancer.bc.ca/screening.

Don't forget to join BC Cancer Agency screening experts at the annual Family Practice Oncology CME Day on November 2, 2013 for an update on breast, cervical, colon and lung cancers.

DATE: Saturday, November 2, 2013

REGISTER: www.fpon.ca

VENUE: BC Cancer Agency Research Centre (675 West 10th Ave., Vancouver)

Major pancreatic cancer research centre established for BC

There is new hope for pancreatic cancer patients in BC with the recent launch of Pancreas Centre BC, a unique, inter-disciplinary partnership between the BC Cancer Agency, Vancouver Coastal Health and the University of British Columbia. With members of the team located within Vancouver General Hospital, the BC Cancer Agency, the BC Cancer Research Centre, and the University of British Columbia, the Centre is dedicated to making research discoveries that will rapidly translate into better treatments for this lethal cancer.

"We can save lives by focussing on research to discover the causes of pancreatic centre progression and developing new therapies and early diagnosis techniques to reduce suffering and improve survival," notes Dr. Charles Scudamore, Chair of Pancreas Centre BC's Steering Group. "We've brought together patients, researchers, clinicians, donors, governments and funding agencies creating opportunity for BC to become a world leader in the early detection and treatment of pancreatic cancer."

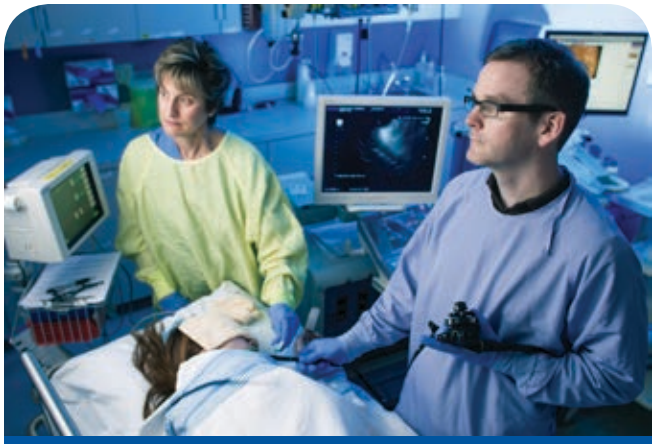
PANCREAS CENTRE BC
CANCER RESEARCH
DIAGNOSIS TREATMENT.
EARLIER.

The Centre is supported by the BC Cancer Foundation, VGH and UBC Hospital Foundations.

Statistics

4,300 Canadians died from this disease in 2012 making it the 4th leading cause of death from cancer today. A key challenge lies in the inability to detect this cancer at an early stage. Most patients have very advanced disease by the time they are diagnosed and few are cured. Among its key goals, Pancreas Centre BC is performing research into methods to detect this cancer earlier, with the ultimate goal of developing a screening test based on imaging similar to that of mammography for breast cancer or a biomarker (blood) test.

To learn more about this topic, please take part in our November 21 Webcast, 8-9:00 a.m., PST – *Pancreatic Cancer: New Hope and Insights into Pancreas Centre BC* with Drs. Charles Scudamore and Dan Renouf. Register for this complimentary, accredited session at www.ubccpd.ca/Events/Webinar_Program.htm.



- 1 in 79 Canadians will have pancreatic cancer in their lifetime
- Pancreatic cancer is the 4th leading cause of death from cancer
- 20% of patients have a family history of pancreatic cancer

Risks and symptoms for pancreatic cancer

Family physicians can have a major impact on improving early diagnosis. Consider investigating for pancreatic cancer when any of these factors are present:

- *Family history* – 15-20% of pancreatic cancer patients have a family history of this disease. Patients with a first or second degree relative with pancreatic cancer are at a higher risk and should be investigated if any symptoms occur.
- *Abdominal or back pain* – Pancreatic cancer patients usually do NOT present with painless jaundice, but 80% do experience abdominal pain, back pain, pain after eating and/or a sense of fullness while eating due to the secretion against an obstructed pancreatic duct.
- *Unexplained weight loss* – Consider cancer of the pancreas as a possible cause, especially in the context of abdominal/back pain.
- *Smokers* – Smoking is the strongest risk factor for pancreatic cancer after familial history. Consider investigating smokers who develop symptoms of abdominal/back pain or unexplained weight loss.
- *Unexpected onset of Diabetes* – Diabetes has been observed to develop in some pancreatic cancer patients prior to the cancer diagnosis. If a patient without a family history of diabetes or other risks develops the disease, especially in the context of other symptoms such as weight loss or abdominal/back pain, consider investigating for pancreatic cancer.

How family physicians can help

The only chance of cure from pancreatic cancer is if it is diagnosed and treated at an early stage. Consider investigating for this if your patients develop any of the warning signs described above. Once diagnosed, patients should be quickly assessed by a multidisciplinary team to determine the most appropriate treatment approach.

Encourage patients to take part in clinical research. Pancreas Centre BC has established the BC Gastrointestinal and Pancreatic Biobank to support research efforts through collection of blood and tissue samples plus information on the history and treatment of each person. In addition, the BC Cancer Agency has a number of ongoing clinical trials assessing new treatment strategies and novel drugs with the aim of improving survival rates and quality of life for pancreatic cancer patients.

Finally, watch for the Centre's upcoming Clinical Practice Guidelines on Pancreatic Cancer being developed to ensure the best standards of care across the spectrum.

Contact Pancreas Centre BC

To learn more about Pancreas Centre BC or become involved please visit pancreascentrebc.ca or contact Candace Carter, Manager, at candace.carter@pathology.ubc.ca.

Hematologic malignancies update – CME webcast summary

By Dr. John Shepherd, Director of the Leukemia/ Bone Marrow Transplant Program of BC

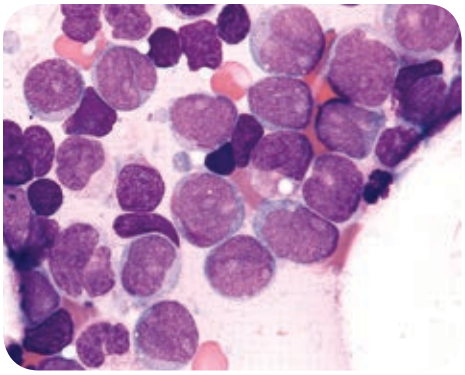
Dr. John Shepherd

The field of hematologic malignancies is broad and there is no expectation that family physicians should be conversant with the complexities of management of such patients. This Webcast presentation focused therefore on 3 specific areas where family phyisicians can impact patient care favorably:

- Prompt diagnosis and referral of acute leukemia and high grade lymphomas
- Treatment of complications of high dose chemotherapy, particularly febrile neutropenia
- Diagnosis and management of multiple myeloma

Acute Leukemia:

Acute leukemia is a medical emergency and the key points are the need for a complete diagnostic workup, referral to a tertiary centre, and understanding of the need for repeated cycles of therapy, up to and including stem cell transplant. The presence of blast cells in the blood should lead to immediate review of the patient situation and other counts/tests, particularly measurement of renal function, coagulation, uric acid, LDH, and group and screen. Blood cultures should be sent if the patient is febrile and antibiotics started promptly (usually before culture results are received). Although bone marrow examination is required for confirmation, the need for special tests is so compelling (because of their impact on treatment plans) that it is strongly suggested that this be done at the referral centre rather than the primary site. Consultation is available from specialist physicians 24/7 at Vancouver General Hospital who can provide advice on management and prompt transfer for care. As a "side-bar" the same would apply to patients who present with symptoms suggestive of very aggressive lymphomas (Burkitt's lymphoma and lymphoblastic lymphoma). These patients have a high rate of obstruction of their airways or bowel, a high incidence of tumour lysis syndrome, and renal failure. Again, immediate discussion with a tertiary centre is essential.



Replacement of marrow by leukemic blast cells (courtesy of American Society of Hematology Slide Bank)

Management of acute leukemia in the elderly poses special challenges. Biologic factors, tolerance of complications, and comorbidities often come into play. The first is particularly important to note: elderly patients have high rates of spontaneous chemotherapy resistance, poor risk cytogenetic analysis, and secondary disease. All of these contribute to survival rates which are markedly lower than for younger (<70) patients and the decision to offer aggressive therapy to older patients is one which is made on an individual basis.

Management of Chemotherapy Complications:

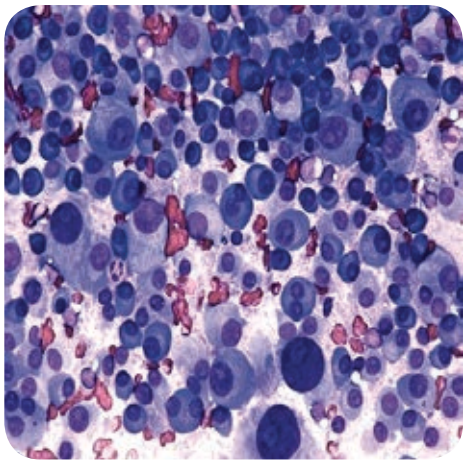
This discussion focuses on febrile neutropenia and the dictum is simple: in a patient with fever and no (or few) neutrophils the old "shoot first, ask questions later" saying holds sway. Because such patients are often managed as outpatients, they may show up at their local ER with fevers and the key is to recognize that sepsis and septic shock can develop extremely quickly in neutropenic individuals and that prompt physician assessment, sending of blood and urine cultures, and immediate institution of broad spectrum antibiotics (with anti-gram negative coverage in particular) is essential. Discussion with the treating centre physicians who are familiar with the patient's situation is essential as well.

View the full webcast of this topic at www.fpon.ca – CME Initiatives.

Dr. Shepherd will also be presenting on this topic at our Nov. 2 Family Practice CME Day (see page 1).

Multiple Myeloma:

Myeloma is discussed specifically because it is a disease which is being seen in increasing frequency, including in younger patients. Keys to diagnosis are recognition of the often subtle blood changes including anemia, renal dysfunction, hypercalcemia, and the risk of pathologic fractures, particularly of the spine. It is important to recognize that the survival of patients with MM has increased greatly over the last decade and that referral for assessment through the BCCA, local oncologists/hematologists, or the Leukemia/ BMT Program offers patients the opportunity to take advantage of these advances and potentially extend their lifespans by a number of years.



Myeloma cells almost completely replacing the bone marrow space (Kyle and Rajkumar, NEJM 2004, 351:1163)

Contact Dr. John Shepherd at JShepher@bccancer.bc.ca

Colorectal cancer workshops for family physicians offered in communities throughout BC (CCOPE)

Cancer care outreach program on education

The Cancer Care Outreach Program on Education is a partnership between the UBC Division of Continuing Professional Development (UBC CPD), the BCCA Screening Groups, and Family Practice Oncology Network (FPON).

UBC CPD
CONTINUING PROFESSIONAL DEVELOPMENT
FACULTY OF MEDICINE

BC Cancer Agency
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Family Practice Oncology Network

Colorectal workshops: new and improved format for the fall

The third module of our community oncology workshop series on colorectal cancer will be offered in 10 communities throughout BC over the coming months. We are excited to offer a new format for these workshops, with a focus on integrating learning into practice:

- **Workshops** will take place in the community with a local facilitator, either a General Practitioner in Oncology or a local physician actively practising in oncology. Sessions will be small group, interactive case-based sessions
  - Content spans the **continuum of colorectal cancer care** for family physicians, including screening options, colonoscopy preparation requirements, implications of various polyp types, staging and diagnosis, and post-treatment follow-up
  - A new feature will enable participants to explore how they can **integrate what they learned at the workshop to their practice**.
- A **Follow-up session** has been added, which will take place approximately two months following each respective workshop. The follow-up session will allow participants to:
  - Discuss outstanding and emerging questions with the facilitator and a specialist via teleconference
  - Share with the group how they applied what they learned into practice.

The workshops are accredited for up to 3 Mainpro M1 credits and are low cost ($35 registration or $25 online).

Please visit www.ubccpd.ca/programs/ccope or contact jennie.b@ubc.ca, 604.875.5075 to find out if there is a workshop near you!

Breast and prostate cancer workshops: successful spring delivery

Following the success of these workshops in 2011 and 2012, 10 additional breast and prostate cancer workshops were delivered throughout BC this spring, with the support of funding from the BCCA. 90% of participants rated the workshop as good or excellent, with many positive comments about the sessions, for example: *"Fantastic workshop! Presenter excellent!" (Workshop participant)*. Abridged versions of the breast and colorectal cancer workshops will be presented at the Nov. 2 Family Practice Oncology CME day (see page 1).

Update on new attachment fees – "a GP for me"

By Dr. Cathy Clelland, MD, CCFP, Billing Consultant

On April 1, 2013, the GP Services Committee launched "A GP for Me" aka the "Attachment" Initiative to facilitate the attachment of currently unattached complex/high-needs patients as well as better support the longitudinal, comprehensive relationship between patients (current and newly attached) and their personal family physician. The new attachment fees that are available include:

- **G14074 Unattached Complex/High Needs Patient Attachment Fee**
- **G14075 Attachment Complex Care Management Fee**
- **G14076 Attachment Telephone Management Fee**
- **G14077 Attachment Patient Conferencing Fee**

These fee codes will be available to all family doctors who participate in the Initiative and submit the GP Attachment Participation code (G14070) at the beginning of each calendar year.

The **Unattached Complex/High-needs Patient Attachment Fee (G14074)** was developed to compensate for process of integrating a new patient with higher needs into a family physician's practice. This fee is payable once at the time of intake, in addition to the visit fee, and covers the initial meetings, organization of a medical record, and organization and enactment of appropriate Clinical Action Plan(s) as discussed with the patient. **Included in the target population are those patients who have cancer and do not have a family physician in the community to support their ongoing needs, during and especially after treatment**. Patients with cancer that is of sufficient severity and potential for poor outcomes, who require ongoing monitoring and management through the planned proactive family physician approach to care, will benefit both in their quality of life, improved outcomes and a lessened impact on their lives. Having a specific diagnosis does not necessarily equate to being "Complex" or high-needs. A diagnosis of distant basal cell carcinoma completely excised would not qualify without other co-morbidities that make the patient "high-needs" or cause significant complexity. The BC Cancer Agency is included as one of

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Willliams Lake and 100 Mile House well served by GPO training grads

Cancer patients in Williams Lake and 100 Mile House used to have to travel three arduous hours for treatment – "A horrendous situation in winter," stresses Dr. Emil LaBossière, a full-service family physician and part-time GPO for both communities. Now these patients are expertly cared for in their own communities by both Dr. LaBossière and his 100 Mile House colleague, Dr. Gord Hutchinson.

Dr. LaBossière completed the Family Practice Oncology Network's GPO Training Program in 2010 at the urging of Dr. Hutchinson, who took the program previously and began looking after cancer patients in both communities in 2006. Dr. LaBossière, who is based in Williams Lake, fills in whenever Dr. Hutchinson is away – Dr. Hutchinson recently served several months on an Armed Forces' medical team in Afghanistan – and also looks after patients who cannot make Dr. Hutchinson's regular days in this community.

"Gord needed support in meeting our communities' cancer care needs," adds Dr. LaBossière. "Whenever he was away, there was a gap. Dr. Hutchinson encouraged me to take the program and together we cover a really large area. I follow my own cancer patients, fill in for him when he's away and even meet with patients via Telehealth as needed."

"The GPO Training Program is fantastic because of the breadth of knowledge and enhanced abilities gained. I'm much more comfortable with the different issues of cancer care now and have excellent working relationships with the larger cancer care teams in Kamloops and Kelowna. It was a real eye-opener to learn how the system works. It was useful to meet other GPOs as well and I appreciate the opportunity to take part ongoing training opportunities such as the CME Webcasts (see page 9)."

GPO Dr. Emil LaBossière also helps out with the Ministry of Environment's Upper Fraser River Sturgeon Project surgically implanting radio transmitters to better track these historic creatures spawning patterns.

"It was a struggle to dedicate the eight weeks the GPO Training Program requires – especially with three young children and coaching a rep hockey team – but it worked out well for me. Eventually, I plan to allocate more time to my GPO work and reduce the time in regular practice. This program's given me the skills to move in that direction. I find my GPO work very rewarding and challenging. Cancer care has a different set of issues than regular practice and the patients are very appreciative despite the circumstances."

Dr. LaBossière is originally from 100 Mile House. He graduated from UBC Medical School and completed his internship at Dalhousie University before returning to the area and building his practice in Williams Lake.

Contact Dr. LaBossière at elabwlake@shaw.ca

Next GPO training course begins February 24, 2014

The GPO Training Program is an eight-week course offering rural family physicians and newly hired Agency GPOs the opportunity to strengthen their oncology skills and knowledge. The program includes a two-week introductory module held twice yearly at the Vancouver Cancer Centre followed by six weeks of flexibly scheduled clinical modules at the Centre where participants' patients are normally referred. The program is accredited by the College of Family Physicians of Canada for up to 25 Mainpro-C and 50 Mainpro-M1 credits and eligible physicians will receive a stipend and have their travel and accommodation expenses covered. For full details visit www.fpon.ca.

Update on new attachment fees
continued from page 6

the possible referral sources for the linking of these patients with Attachment participating family physicians willing to take them into their practice.

The **Attachment Complex Care Management Fee (G14075)** is compensation for caring for patients with Frailty level 6 (moderate) or 7 (severe) as defined by the Canadian Study of Health and Aging (CSHA) Clinical Frailty Scale. While the G14074 is a one-time intake fee, once attached to a family physician, those **patients with cancer who are also frail** and who do not otherwise qualify under the dual diagnostic eligibility for original G14033 Complex Care Management Fee will be eligible for G14075 which is payable once per calendar year. Patients will qualify only for one of the Complex Care Fees, not both. Both Complex Care fees are payable upon the completion of the planning visit with the documentation of the Complex Care Plan/ Advance Care Plan (ACP) for the management of the patient over the time until the plan is reviewed in the following calendar year. The requirements for billing the Complex Care fees are: "Community Based" patients = living in their own/family home or assisted living; 30 minute Planning Visit (review of case/chart, current therapies, incorporates the patient's values and personal goals including any wishes regarding future care needs, into the clinical care plan) billed in addition to the appropriate visit code; the development of the care plan is done jointly with the patient and/or the patient representative as appropriate.

Please go to www.gpscbc.ca for more information on these GPSC initiatives.

Message from the President – Better care through research

Dr. Max Coppes, President, BC Cancer Agency

At the BC Cancer Agency we pride ourselves on offering world-class cancer care, but it's through research that we continually improve and develop better ways to prevent, detect, and treat cancer.

Studies have indicated that cancer centres involved in clinical research trials experience the "participation effect," where better outcomes are seen in the entire population and not just those directly involved in the research. Why? Well it could be that centres that actively participate in trials have to continually demonstrate adherence to basic standards of care. Those who conduct research must also be well-versed in the best current care practices. Clinical trials also offer access to treatment options that are not otherwise available.

For all of these reasons and more, research is a key component of our work at the BC Cancer Agency. We see research as an integral part of being able to offer the best cancer care. Research of course is not limited to basic (laboratory) and translational research. At the BC Cancer Agency we are involved in clinical trials, health services research, outcome research, and much more. About a year ago Dr. Bernie Eigl took over the leadership of the BC Cancer Agency Provincial Clinical Trials program. This effort provides patients across the Province with access to new and novel treatments.

Another exciting research effort is led by Dr. Peter Watson at our Vancouver Island Centre. Peter spearheaded a program called PREDICT (Personal Response Determinants in Cancer Therapy), that provides each and every patient with the opportunity to contribute to research. The program collects blood samples from newly diagnosed cancer patients and, most importantly, permission to contact patients about future studies. It is unique in Canada and is currently offered at the Agency's Vancouver Island Centre, where it was developed, and at the Centre for the Southern Interior. It's planned to expand to our other cancer centres in the future.

When you work with patients diagnosed with cancer please remember to share the options available to participate in research and clinical trials, along with the benefits of doing so. In the end, research has and will continue to ensure that tomorrow's care will be better than today. We want to learn from each and every patient because we are committed to continuing to lead in cancer survival outcomes across the country.

Lung cancer management – insight for primary care

By Dr. Janessa Laskin, MD, FRCPC, Medical Oncologist, BC Cancer Agency Vancouver Centre

View the full webcast of this topic at www.fpon.ca – CME Initiatives.

Lung cancer is the greatest cause of cancer-related mortality, accounting for more deaths than breast, prostate and colorectal cancer combined. Although recent studies have suggested that high-risk populations may benefit from CT screening, the majority of cases are detected in the advanced stage which is the primary explanation for these dismal survival rates. Approximately 3,000 new cases of lung cancer are diagnosed in BC every year and though the rates in men are stable, the incidence in women is slowly increasing over time. The vast majority of lung cancers are categorized as non-small cell lung cancer (NSCLC), only 15% are small cell cancers, a number diminishing over time as the rates of smoking drop. Recently it has also been noted that the rates of lung cancer in people with little or no smoking history have been increasing over time; the cause for this increase is multifactorial and includes second hand smoke, arsenic, and radon exposure but additional many causes are as yet undefined.

Routine CT screening for NSCLC is not yet recommended in Canada though this is likely to be implemented in the near future. However, it should be noted that at least for now screening will be limited to highly specified populations such as heavy smokers because of the difficulty in interpreting and biopsying small abnormalities that are so frequently detected on CT scans.

Adjuvant chemotherapy is the accepted standard of care for patients with early stage NSCLC who have undergone curative surgery. A survival benefit has not yet been demonstrated in stage 1 disease when the cure rates with surgery alone are quite high. However, in stage 2 and 3 disease (in which the primary cancer is larger than 5cm or local lymph nodes are affected) adjuvant chemotherapy is associated with a significant survival advantage (increasing survival rates by approximately 15%) and should be recommended to those patients well enough to receive it.

Up to 60% of patients with NSCLC have advanced or metastatic disease that is not amendable to curative therapy. In this setting palliative chemotherapy has been demonstrated to improve patients' quality of life, prolong overall survival and be cost effective compared to providing best supportive care alone. In recent years the introduction of biologically targeted therapies with less systemic toxicity and more specific tumour activity has significantly improved treatment options available for patients. In addition, these agents have helped scientists and clinicians uncover subpopulations within NSCLC whose cancers are driven by specific genomic abnormalities that can be targeted by molecular inhibitors. An example of this is the activating mutations in the epidermal growth factor receptor (EGFR) that occurs in approximately 15% of NSCLC and is

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Message from the chair

By Dr. Phil White, Chair and Medical Director of the Family Practice Oncology Network and family physician in Kelowna

This Fall marks some key milestones for the Family Practice Oncology Network. First, our popular GPO (General Practitioner in Oncology) Training Program is 10 years old. We offer the introductory session for this program twice yearly (see article on page 7) and the 20th cohort just passed through. That brings the total to 89 family physicians now applying their strengthened oncology skills and confidence in nearly 35 BC communities. Hundreds of patients and families benefit in that they can receive top quality cancer care without having to travel in often perilous conditions.

Interest in this program expands beyond our borders, too, with like minded organizations from Manitoba, Saskatchewan, New Zealand and Australia enthusiastic to model its success. We also had our first international participant this past September – Dr. Kelechi Eguzo from Nigeria – who was here for educational purposes and is now putting his new knowledge and skills to work for the people of his home country.

Another educational offering marking an anniversary is our Oncology CME Webcast Program now celebrating its 5th year in operation. This program provides monthly accredited, interactive online education sessions for primary care oncology which cover a diverse range of topics, are well attended, and offered free-of-charge. You can view recordings of all previous sessions under CME Initiatives at www.fpon.ca plus register for upcoming Webcasts.

Another CME opportunity that we hope you'll take advantage of is our Family Practice Oncology CME Day being held November 2 at the BC Cancer Agency's Research Centre in Vancouver. We've revitalized the event focussing on education rich content for family physicians that is practice pertinent and accredited. We are also inviting oncology nurses and pharmacists to join us. Register at www.fpon.ca

Finally, we continue to focus on building strong ties within the Agency particularly with the Communities Oncology Network, the Surgical Oncology Network and the Provincial Survivorship Program – all geared to improving cancer care throughout British Columbia.

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particularly common in never or light smokers. These cancers are exquisitely sensitive to EGFR tyrosine kinase inhibitors such as gefitinib (Iressa) and erlotinib (Tarceva) and if these mutations are identified at the time of diagnosis these oral chemotherapy agents with minimal toxicities can be used in the first line setting with great effect.

In the last decade advances in drug development now mean that there are several lines of relatively non-toxic chemotherapy that can be given to patients with advanced NSCLC such that the overall survival of patients is often measured in years rather than months or weeks. Historically there was a degree of therapeutic nihilism around NSCLC but with newer treatment options even patients in their late 70s can derive significant benefits from systemic treatment and unless patients have severe co-morbidities or are severely functionally impaired chemotherapy can be offered in most settings.

Contact Dr. Janessa Laskin at jlaskin@bccancer.bc.ca

Chemotherapy for patients with advanced NSCLC:

- Chemotherapy should be offered to patients with a relatively good performance status (with optimal pain control if needed)
- Advanced age alone is not a factor for consideration of chemotherapy
- Chemotherapy works best when patients feel well – don't wait until they're too sick from the disease to refer to the oncologist
- When time and tissue permits do EGFR mutation testing and, if positive, it is likely that an oral agent such as Iressa can be used as first-line therapy
  - If EGFR mutation status is negative or unknown do NOT use EGFR inhibitors first line
- Many options exist for second and third line chemotherapies
  - Participation in clinical trials should always be encouraged

Upcoming oncology CME webcasts

Our Oncology CME Webcasts, offered in partnership with the University of British Columbia's Division of Continuing Professional Development, are convenient, practical and complimentary. Each Webcast is accredited by the BC Chapter of the College of Family Physicians of Canada for up to 1 M1 credit with sessions taking place from 8-9:00 a.m. PST on the third Thursday of every month (except December, July and August). All sessions are recorded and available at www.fpon.ca (under CME Initiatives). Here's our upcoming schedule:

October 17: Cervical Cancer – An Update for Primary Care with Dr. Leah Jutzi

November 21: Pancreatic Cancer – New Hope and Insights into Pancreas Centre BC with Drs. Charles Scudamore and Dan Renouf

January 16: Breaking Bad News Skillfully with Dr. Tamara Shenkier

February 20: Melanoma – What Family Physicians Need to Know, speaker TBC

BC Cancer Agency, Patient and Family Counselling Services: A vital part of the oncology team

By Shelley Pennington, MSW, RSW, Cancer Care Resource Social Worker, BC Cancer Agency

Patient & Family Counselling Services (PFCS) under the auspices of BC Cancer Agency, Psychosocial Oncology is a part of a team of oncology professionals who work together for the best possible outcomes for cancer patients. Cancer affects all areas of a person's life and patients often require assistance with issues that influence the quality of life and have the potential to jeopardize treatment success.

Patient & Family Counsellors are professionally trained Masters or Doctorate level counsellors/social workers who assist cancer patients and their families throughout the cancer trajectory (up until 18 months post treatment). Services include providing information, education, discussion, planning and therapeutic clinical counselling related to the impact of cancer on a patient's emotions, life style and relationships. Types of concerns may involve finances and the need to stop working, caregiver burnout, dealing with distressful emotions, communicating with the healthcare team, decision-making, returning to work, preparing for end of life or any number of other issues. Counsellors can also assist with issues around advocacy and can generate referrals to other resources such as community or government programs. Counsellors not only work with individuals but also couples and diverse family groups.

PFCS also offers access to many resources, support programs and education sessions. Support programs offered may vary depending on the Cancer Centre but usually include relaxation and stress management. A Chinese-speaking counsellor (Vancouver Centre), Aboriginal Cancer Care Coordinator (Centre for the North) and Vocational Rehabilitation counsellor (via phone or in person) are some examples of additional psychosocial services offered.

To find PFCS contact information and available Support Programs for all six BC Cancer Agency Centres, refer to the BC Cancer Agency website (bccancer.bc.ca) under Coping with Cancer – Emotional Support – Support Programs. To order, view or print psychosocial oncology resources related to emotional, family or practical issues, refer to Coping with Cancer, Emotional and Practical Support sections.

Contact Shelley Pennington at spennington@bccancer.bc.ca.

Childhood cancer survivorship knowledge translation project targets family practitioners

By Shannon Vogels, Research Assistant, and Mary McBride, Distinguished Scientist, Cancer Control Research, BC Cancer Agency

Advances in the treatment of childhood cancer have resulted in a 5-year survival rate of nearly 90%. While this statistic is encouraging, childhood cancer survivors (CCS) face an excess risk of multiple health problems throughout their lives. An estimated two-thirds of CCS will suffer from a chronic condition [1], and up to 40% will require hospitalization or ongoing medical surveillance [2]. They may also suffer from neurocognitive deficits, which can mean lower educational attainment [3] and workplace challenges. Follow-up care for CCS has been difficult due to a lack of guidelines and community resources, little information on CCS's educational and vocational needs, and uncoordinated care transfer from oncologists to general practitioners. The small size of this population (there are approximately 3,000 alive in the province) is also a barrier; because most family practitioners will encounter these individuals infrequently, knowing how to provide appropriate follow-up care can be challenging.

A knowledge translation project has been funded by the Canadian Centre for Applied Research in Cancer Control, and is being conducted by the Cancer Control Research Survivorship team at the BC Cancer Agency. The objectives are to confirm the health, education, and vocation support needs of CCS in BC, identify gaps in care, and make suggestions for improving current supports. The researchers interviewed 32 individuals, including family practitioners, oncologists, BC Cancer Agency and BC Children's Hospital representatives, health authority officials, Ministry executives, educators, school district administrators, vocational counsellors, and parent and survivor representatives.

A key issue identified by family practitioner participants is the disjointed transition between pediatric oncology and primary care. Practitioners also reported having

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Skin cancer and exposure to ultraviolet radiation

By the BC Cancer Agency's Prevention Programs

Skin cancer is one of the most common types of cancer and is also one of the most preventable. It is caused by overexposure of the skin to UV radiation, the most common sources of which are the sun and tanning beds. Despite being largely preventable, there has been a dramatic increase in the number of skin cancer patients in the last few decades.

The BC Cancer Agency Prevention Programs has many resources and programs available for both early detection of skin cancer and providing information to decrease the incidence of the sometimes deadly disease.

- www.Suntips.ca, an interactive website to educate young people in particular, but suitable for any age audience, on protection against ultraviolet radiation.
- Promotional printed materials on tanning bed use and sun safety, including specialized information for infants and outdoor workers. Materials can be viewed at: www.bccancer.bc.ca/PPI/Prevention/about/PreventionProgramsPublications.htm. An order form can be accessed at: www.bccancer.bc.ca/HPI/FPON/New+Resources+and+Points+of+Interest.htm.
- Prevention Educational Leaders from the Prevention Programs promote sun safety messaging at many events across the province, as well as directly through stakeholders, such as those with an outdoor workforce.
- "Skin Cancer Prevention and Early Diagnosis" online course for healthcare professionals, available at www.bccancer.bc.ca/HPI/CE/skincancer/default.htm.

The essential messaging that the Prevention Programs shares with the public is:

- **Year-Round Protection**: UV protection for the skin and eyes is important throughout the year. Cloud cover does not provide protection against UV rays and UV reflection off snow causes double the harm. Skin damage is cumulative.
- **Cover Up**: Wear a long-sleeved shirt, a wide brimmed hat and long pants. Don't forget to put on glasses or goggles with UV protection.
- **Avoid Sun Exposure**: During summer months, avoid outdoor activities during the hours of 11:00 a.m. and 3:00 p.m. when sun is at its strongest. Seek shade and/or cover up if you are engaging in activities during these hours.
- **Apply Enough Sunscreen**: Use an SPF 30 or higher and reapply thickly and frequently. Use a waterproof sunscreen when swimming or sweating from physical activity. In winter months, remember to cover the underside of your chin and nose.
- **Turn Off the Lamp**: There are no safe tanning beds. Sun lamps can produce as much as three to eight times more UVA light than the noon-hour sun in summer.

For further information, please contact the Prevention Programs at 604 877.6227 or office@preventionprograms.org.

Childhood cancer survivorship knowledge continued from page 10

limited knowledge about important cancer-related health issues and recommended care when a patient returns to their care after cancer treatment. They emphasized their unique role of caring for the whole patient, and coordinating care between primary and specialist care. Sharing information about patients among different types of care providers was also identified as important for quality follow-up care. They suggested that concise survivor care plans with follow-up recommendations would be a valuable tool for improving care.

The next steps of this project are 1) to solicit feedback from all those involved on the issues raised, and 2) to identify and report on key priorities shared by the participants. This report is intended to lead to the development of strategies and interventions that will improve the health, education, and vocational outcomes of childhood cancer survivors across BC.

Contact Mary McBride at mmcbride@bccrc.ca

Family Practitioners' Suggestions for Improving Care

- Seamless transition between pediatric oncology and primary care
- Individual, concise survivor care plans provided by oncologists
- Multidisciplinary care
- Shareable, electronic patient information
- Survivor care training for general practitioners

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Neuro-oncology for family practice

By Dr. Brian Thiessen, Medical Oncologist, BC Cancer Agency

Dr. Brian Thiessen

Brain tumours are among the most dreaded cancers in medical practice. Fortunately they remain a rare disorder although their tendency to affect children and young adults make them one of the top cancers for potential years of life lost. While there are many different histologies that can be described as "brain tumours", there are a relatively small number of frequently seen tumours. Meningiomas, pituitary adenomas and acoustic neuromas make up the majority of benign brain tumours. The most frequent malignant brain tumours are the gliomas followed distantly by medulloblastoma, germ cell tumours and primary CNS lymphoma.

View the full webcast of this topic at www.fpon.ca – CME Initiatives.

Brain tumours usually present with 3 key symptoms: headaches, seizures and neurologic deficits. With the exception of a seizure presentation, the onset is typically subacute over weeks to a few months. Isolated headache without neurologic deficits is extraordinarily rare.

Malignant glioma management requires a multi-disciplinary approach including neurosurgeons, radiation oncologists, medical oncologists and support workers. The most common glioma is glioblastoma multiforme (a grade 4 tumour). It has a short median survival of 10-16 months. The current standard of care for GBM is concurrent chemoradiotherapy with temozolomide followed by 6 cycles of adjuvant temozolomide. In a phase 3 trial this regimen improved 5 year survival by 10% over radiotherapy (RT) alone.

Treating GBM in the elderly has become an increasing concern with an advancing elderly population. These patients tolerate radiation and chemotherapy less well and suffer more cognitive impairment compared to younger patients. There is a fine line between aggressive treatment approaches and quality of life. There is currently an ongoing phase 3 trial looking at 3 week courses of radiation with or without concurrent and adjuvant temozolomide in elderly GBM.

Lower grade gliomas present a challenging problem as many patients will survive long enough to encounter late effects of RT. Patients with tumours showing 1p/19q chromosome co-deletion are especially long survivors. We treat grade 2 tumours with co-deletion using chemotherapy alone pending the outcome of phase 3 studies. Grade 3 tumours, with or without favorable genetics, are treated with the concurrent chemoradiotherapy regimen as per GBM. Again phase 3 trials are in the works evaluating this approach and may change our treatments in the future.

Finally, supportive care is a major issue for these patients since disability is quite common. Sixty-five percent of patients will develop epilepsy at some point in their disease. The best anti-epileptic agents for these patients have minimal cognitive side effects and drug interactions. Newer agents such as levetiracetam, lamotrigine, divalproex and lacosamide are superior to older agents (phenytoin, carbamazepine) in this regard but come at a higher cost.

Dexamethasone is used frequently as an agent to reduce cerebral edema and provide symptom relief. Unfortunately long term use is associated with morbidity including proximal myopathy, sleeplessness, psychosis, diabetes, etc. Typically we start patients at a dose of 8-16 mg/day and after a few days try to start tapering to the lowest dose still affording symptom relief (often 2-4 mg/day). If prolonged use is to be expected, prophylaxis for osteopenia and pneumocystis pneumonia should be considered.

In the end most patients with malignant brain tumours will die of their disease. Few options at relapse exist although re-resection, temozolomide rechallenge or bevacizumab may offer short term palliation. As such early talks about end of life care are important and early institution of home care resources is strongly advised in these patients.

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