



Insight into BC's Colon Screening Program

By Dr. Jennifer Telford, Medical Director,
Provincial Colon Screening Program

Since November 15, 2013 the Colon Screening Program has been available across the province. Physicians can register asymptomatic patients ages 50 to 74 in the Colon Screening Program as follows:

For average risk patients: FECAL IMMUNOCHEMICAL TEST (FIT)

- Select the 'Fecal Occult Blood, age 50-74, asymptomatic q2y (copy to Colon Screening Program)' option on the updated *Standard Outpatient Laboratory Requisition*.
- A copy of the FIT report will be sent to the Colon Screening Program at the BC Cancer Agency.
- If the FIT result is abnormal, the BC Cancer Agency will facilitate the patient's referral to the appropriate health authority for colonoscopy.
- Physicians do not have to complete the *Colonoscopy Referral Form* for patients with abnormal FIT results if the Colon Screening Program is copied on the lab report.

For higher than average risk patients: SCREENING COLONOSCOPY

- Use the *Colon Screening Program Colonoscopy Referral Form* to refer patients with at least one of the following:
 - One first degree relative diagnosed with colorectal cancer diagnosed under the age of 60.
 - Two or more first degree relatives with colorectal cancer diagnosed at any age
 - A personal history of adenoma(s).
 - An abnormal FIT result when the Colon Screening Program was not copied on the lab report.

Registering eligible patients into the program ensures that the BC Cancer Agency receives FIT results and can refer patients with an abnormal FIT or those that are higher than average risk to one of 20 health authority patient coordinators for pre-colonoscopy assessments.

Abnormal FIT Results

An abnormal FIT indicates that there may be bleeding from *somewhere* in the colon or rectum. Blood can be present in the stool for many different reasons, including hemorrhoids, ulcers, anal fissures, diverticular disease, or inflammation.

Approximately 15% of individuals screened with FIT will have an abnormal FIT result and will require colonoscopy. Of those with an abnormal FIT, 4% will have cancer and approximately 60% will have a pre-cancerous polyp, an adenoma. Most adenomas will not progress to cancer, and for those that do, it will take many years for this transition to occur, which is why patients should be screened regularly.

When is FIT not appropriate?

FIT is recommended for individuals aged 50 to 74. FIT is **not** recommended in the following situations:



Watch Dr. Jennifer Telford's hour long Webcast on the BC's new Provincial Colon Screening Program at www.fpon.ca – CME Initiatives.

- For colorectal cancer screening in individuals **less than 50 years** of age.
- For colorectal cancer screening in individuals **over 74 years** of age.
 - Individuals 75-85 years can be evaluated on a case-by-case basis
- For screening individuals who are in poor health. If a patient is **not medically fit** to undergo colonoscopy, then they should not undergo FIT.

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Join us for Family Practice Oncology CME Day on Nov. 1

Please mark November 1 on your calendar as a great opportunity to gain the latest knowledge on some of the most important topics in primary care oncology. This is the date of the Network's annual Family Practice Oncology CME Day to be held once again at the BC Cancer Research Centre. We promise insightful presentations from leading oncologists; case-based workshops on colorectal screening, advanced cancers and side-effect management of cancer treatment; plus the chance to reconnect with colleagues and contacts from throughout BC. Registration will open this summer at www.fpon.ca. Hope to see you there!

Contact Jennifer Wolfe at jennifer.wolfe@bccancer.bc.ca.



CCOPE workshop success — more planned in 2014

Cancer Care Outreach Program on Education (CCOPE) is an ongoing partnership between the UBC Division of Continuing Professional Development (UBC CPD), the BCCA Screening Groups, and Family Practice Oncology Network (FPON). The overall aim of the program is to support BC family physicians in providing best practice care along the cancer continuum.

Colorectal Cancer Workshops

Ten, two-part Mainpro-C workshops on colorectal cancer were rolled out throughout BC this winter, with the last follow-up session held in Creston, BC in early March. This is the third module of our community oncology workshop series and was very well attended with 132 participants across all communities. The workshop format was well received and participants' confidence on colorectal cancer care increased; a snapshot of evaluation data is included here. In addition, as

the workshop delivery coincided with the release of the new Colon Screening Program, we were able to address questions about the new screening processes and procedures in various communities; read more about the screening program on page 1.

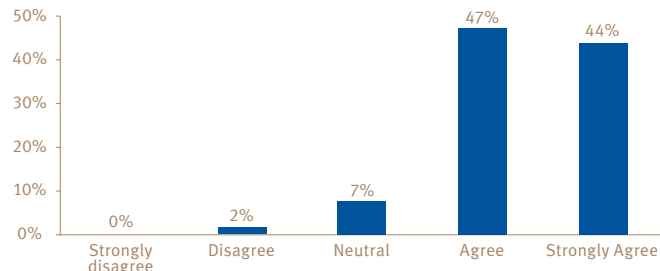
CCOPE 2014

Following the success of the CCOPE program to date, breast, colorectal and prostate cancer modules will be updated and redelivered to 15 BC communities as Mainpro-C workshops this year. Another module on family physicians' role in advanced cancer is also under development. Full details will be made available at www.ubccpd.ca/oncology-program.

Want CCOPE in Your Community?

If you are a GPO or physician interested in bringing a CCOPE workshop to your community, please contact Jennie Barrows at jennie.b@ubc.ca, 604.875.8075.

Workshop evaluation data: I am confident that I can provide patients with care and information regarding colorectal cancer that is based on provincial guidelines / recommendations and best practice approaches to care (n=122)



Testimonials:

- "Informed discussion combined with excellent course material".*
- "Open discussion of cases. Helpful to hear from colleagues regarding their issues".*
- "Group discussion was most effective. Allowed to appreciate spectrum of current care".*



Insight into BC's Colon Screening Program continued from page 1

- For individuals in a colonoscopy surveillance program.
- For individuals up to date with colorectal screening.
 - FIT within the last 2 years.
 - Colonoscopy or flexible sigmoidoscopy within the last 10 years for average risk.
- For individuals with inflammatory bowel disease.
- For individuals with gastrointestinal symptoms.

For more information about the Colon Screening Program, and to request or download the FIT requisition or colonoscopy referral form visit www.screeningbc.ca/colon.

Did You Know?

- In 2013 there were estimated to be approximately 1,700 males and 1,300 females diagnosed with colorectal cancer in BC.
- In 2011, 2,912 people in British Columbia were diagnosed with colorectal cancer.
- In 2011, 1,069 people in British Columbia died of colorectal cancer.

About the Provincial Colon Screening Program

- The full program launched province wide on November 15, 2013— linking FIT with the BC Cancer Agency, Health Authority Patient Coordinators, and a monitoring and reminder system.
- The Medical Services Plan (MSP) has paid for 305,000 FIT tests so far in 2013/14, and expects to pay for more than 400,000 tests during the next fiscal year.
- Over 500 patients with abnormal FIT results have been referred to the 23 patient coordinators around the province since the November launch.

Update on the management of oral mucositis

By Dr. Allan Hovan,
Provincial Professional Practice Leader,
Program in Oral Oncology/Dentistry,
BC Cancer Agency Vancouver Centre

Oral mucositis (OM) is one of the most significant adverse side-effects of cancer therapy and yet tends to be under-reported by patients and under-treated by physicians and dentists. OM is a significant quality of life issue for patients and their families. Left untreated, it can lead to high levels of anxiety, depression and social isolation as well as cause delays or interruptions in cancer therapy delivery.



Good oral hygiene remains the mainstay of therapy for oral mucositis.

OM is common during high-dose H&N radiotherapy/combined modality therapy (~ all patients will experience some level of OM), stem cell transplant therapy (75-100%) but is less commonly seen following standard dose chemotherapy (40%). Certain chemotherapy drugs (eg 5-FU, methotrexate, cyclophosphamide, etoposide and cisplatin) are known to more commonly cause significant OM compared to other agents. Signs and symptoms of OM may persist for many weeks following the cessation of therapy.

The development of OM is predominantly influenced by the type of malignancy and the cytotoxic therapy administered but patient factors also play a role (eg. oral health status, salivary output, age of patient, etc). As many of the risk factors cannot be controlled, the importance of establishing and maintaining excellent oral hygiene throughout cancer therapy becomes increasingly evident.

In terms of prevention, there are disappointingly few things that have been shown to be helpful. In general terms, the following strategies apply:

DOs

- Treat pre-existing dental problems (cavities, gum disease, infections, broken/sharp teeth, etc.).
- Establish comfort and excellent fit of any removable dentures; leave dentures out if mouth becomes sore during cancer therapy.
- Maintain good fluid intake; eat bland, soft foods while maintaining adequate protein and vitamin levels in the diet.
- Maintain meticulous oral hygiene during the course of cancer therapy.

DON'Ts

- Avoid commercially-available mouthwashes
- Avoid spicy, acidic or coarse food products
- Do not consume alcohol and don't smoke

Over the last several years, the Mucositis Study Group of the Multinational Association of Supportive Care in Cancer (MASCC) has updated evidence-based guidelines for OM management. The first MASCC/ISOO guidelines were published in the journal *Cancer* in 2004 and the first update of these guidelines was described in publications in 2006-2007. A summary of the most recent update of the MASCC Mucositis Guidelines is now available. In addition, a set of papers has been published in *Supportive Care in Cancer* in 2013 that details results for the different categories of interventions for mucositis. Go to www.mascc.org to view and download.

Based on this systematic review, the following strategies should be considered for RT-induced OM:

- The use of midline radiation blocks and 3-dimensional RT or IMRT to reduce mucosal injury.
- Benzylamine (Tantum) oral rinse can help prevent RT-induced OM in patients with H&N cancer receiving moderate dose (<5000 cGy) radiation therapy.
- Low Level Laser Therapy (LLLT) application may be helpful in preventing severe OM but requires specialized equipment which is not widely available.

Oral Oncology webcast with Dr. Allan Hovan

To learn more about this topic, take part in our May 15 Webcast, 8-9:00 a.m., PST. Register for this complimentary, nationally accredited session at www.ubccpd.ca/Events/Webinar_Program.htm

- There is no evidence that mucosal coating agents, antimicrobial lozenges or antibacterial rinses will be helpful in preventing OM.

Based on this systematic review, the following strategies should be considered for chemotherapy-induced OM:

- There is some evidence to support the use of ice chips (cryotherapy) for the prevention of OM, particularly when patients are receiving bolus 5-FU or high-dose melphalan as part of the conditioning for stem cell transplantation.
- Keratinocyte Growth Factor (Palifermin) has been found to be beneficial for the prevention of all categories of OM; in particular for patients receiving high-dose chemotherapy and total body irradiation (TBI) for treatment of hematologic malignancies with stem cell transplant.

In summary, OM is a common and often unavoidable side-effect of cancer therapy. OM management is based on palliation of symptoms as few agents have been shown to be helpful in preventing OM. Good oral hygiene remains the mainstay of therapy. Communication with the patient and family is important and a multidisciplinary approach (to include nursing, radiation therapy and dentistry) is important in OM management.

Contact Dr. Allan Hovan at
AHovan@bccancer.bc.ca.

Dr. Allan Hovan is part of an Oral Mucositis Guidelines Leadership team who will soon have the following significant article published in *Cancer*: MASCC=ISOO Clinical Practice Guidelines for the Management of Mucositis Secondary to Cancer Therapy. You can access this article at www.fpon.ca – Journal of Family Practice Oncology.

Breast screening recommendations for women in BC

By Dr. Christine Wilson, Medical Director, BC Cancer Agency Screening Mammography Program

On February 4, British Columbia's updated Breast Screening Policy came into effect. This policy reflects the latest evidence and the province's commitment to reducing breast cancer deaths by finding cancer at an early stage.

The updated policy has an increased emphasis on helping women make an informed decision about screening. While no

referral is required, we recommend women between the ages of 40-49 and 75+ discuss the benefits and limitations of screening mammography with their doctors. A referral is required for women under age 40 who are at high risk of developing breast cancer.

The Screening Mammography Program has updated all of its materials to reflect this new policy. To order these materials or to obtain more information on the breast screening policy or the Screening Mammography Program, please visit www.screeningbc.ca/breast.



Key policy recommendations include:

Breast Screening

RISK	AGE	POLICY
Average risk	Ages 40-49 UPDATED	Health care providers are encouraged to discuss the benefits and limitations of screening mammography with asymptomatic women in this age group. If screening mammography is chosen, it is available every two years. Patients will be recalled every two years. A health care provider's referral is not required, but is recommended.
	Ages 50-74	Routine screening mammograms are recommended every 2 years for asymptomatic women at average risk of developing breast cancer. Patients will be recalled every two years. A health care provider's referral is not required.
	Ages 75+ UPDATED	Health care providers are encouraged to discuss the benefits and limitations of screening mammography with asymptomatic women in this age group. Health care providers should discuss stopping screening when there are comorbidities associated with a limited life expectancy or physical limitations for mammography that prevent proper positioning. If screening mammography is chosen, it is available every two to three years. Patients will not be recalled by the Screening Mammography Program of BC. A health care provider's referral is not required, but is recommended.
Higher than average risk with a first degree relative with breast cancer	Ages 40-74 UPDATED	Routine screening mammograms are recommended every year. Patients will be recalled every year. A health care provider's referral is not required.
High risk with a known BRCA1 or BRCA2 mutation or prior chest wall radiation or strong family history of breast cancer	Under age 40	The Screening Mammography Program accepts women at high risk of developing breast cancer with a health care provider's referral, provided they do not have breast implants or an indication for a diagnostic mammogram. Please discuss patient with a screening program radiologist before referral.
	Age 40-74	Please refer to recommendation for "Higher than average risk" women.

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Other Procedures

PROCEDURE	RECOMMENDATION
Breast Self Exam (BSE)	Routine breast self examinations (when used as the only method to screen for breast cancer) are not recommended for asymptomatic women at average risk of developing breast cancer. Women should be familiar with their breast texture and appearance and bring any concerns to their health care provider.
Clinical Breast Exam(CBE)	There is insufficient evidence to either support or refute routine clinical breast exams (in the absence of symptoms) alone or in conjunction with mammography. The patient and her health care provider should discuss the benefits and limitations of this procedure to determine what is best for the patient. This excludes women with prior breast cancer history.
Magnetic Resonance Imaging (MRI)	Routine screening with breast MRI of women at average risk of developing breast cancer is not recommended. Exceptions are made for higher than average risk groups including: BRCA1 and/or BRCA2 carriers, first degree family relatives of BRCA1 and/or BRCA2 not tested, and prior Hodgkin's disease (or other lymphoproliferative diseases) at a young age (between the ages of 10-30 years old) treated with chest radiation.

Breast cancer information kit now online

The complete Breast Cancer Information Kit containing a navigation guide, resource booklets and the Intelligent Patient Guide to Breast Cancer is now available online at www.bccancer.bc.ca/breastkit. The Kit provides answers to common questions and steers patients to critical resources that will help them through their cancer journey.

Message from the President – Screening mammography remains the best way to detect breast cancer in women aged 50-74

In recent years there has been much debate and publicity surrounding screening women for breast cancer. The Screening Mammography Program in BC has seen a 25 per cent reduction in deaths from breast cancer among women in the province who have regular screening mammograms. Screening mammography remains important for the early detection of breast cancer and we hope you will continue to encourage women aged 50-74 to participate in regular screening every two years.



Dr. Max Coppes, President, BC Cancer Agency

In February 2014, the *British Medical Journal* (BMJ) published 25-year follow-up results from the Canadian National Breast Screening Study suggesting that annual screening in women age 40-59 does not reduce breast cancer mortality beyond that of physical examination (for the 50-59 year olds) or usual care (for 40-49 year olds). The BC Cancer

Agency does not agree with the findings in this study.

The effectiveness of screening mammography has been well established by several large clinical trials across the world. These trials have found a relative risk reduction of breast cancer deaths of between 15-25% for women aged 50-69. Of eight randomized control trials for screening mammography,

seven showed that screening mammography is beneficial. The Canadian National Breast Screening Study is the only randomized control trial that did not show a benefit.

Recent changes were made to BC's policy on breast cancer screening based on the results of an evidence review.

BC's new guidelines for women in their forties took the recommendations by Canadian Task Force on Preventive Health Care into account as well as other research, weighing

the limitations and the benefits for women in their forties. We encourage women age 40-49 to have a discussion about the limitations and benefits of screening with their primary care provider to determine whether screening is appropriate for them at that age. In consideration of the evidence for screening in this age group, BC also updated the screening interval for average risk women to every two years.

Screening mammography remains the most important tool for early detection of breast cancer. In BC, the participation rate of women in the target population of 50-69 years of age is just over 50 per cent when the national target is 70 per cent so we have a lot of room to improve.

More information and health professional resources can be found at www.screeningbc.ca. I hope we can count on you to help clarify the facts and help women in BC decide if screening mammography is right for them.

Contact Dr. Max Coppes at mcoppes@bccancer.bc.ca

Yukon — strong proponent of GPO training

Meet the four Network-trained Yukon General Practitioners in Oncology who together with a chemo nurse, navigator and oncology pharmacist are establishing a dedicated cancer care clinic at Whitehorse General Hospital.

Dr. Danusia Kanachowski

“We realized we needed to increase our capacity when we were without our chemotherapy nurse for a short time and had to consider sending all our IV chemo patients to Vancouver,” explains Dr. Danusia Kanachowski, palliative care physician in Whitehorse and 2004 graduate of the Network’s GPO Training Program. “The BC Cancer Agency was very supportive of establishing a GPO Program at Whitehorse General Hospital. We will soon have four trained GPOs and a dedicated space within the hospital to assess patients pre-chemotherapy. We are lucky to have an amazing room dedicated to the delivery of chemotherapy generously donated by members of the community.”

“We are in the development stage at present determining our support requirements, how we can best integrate within the existing system and transition patients effectively from the Agency to GPO to family physician. There are many excellent Yukon physicians, who have looked after their own patients with



Four Yukon GPOs have completed (or nearly completed) the Network’s GPO Training Program: (left to right) Robin Jamieson, Lucille Stuart, Sally MacDonald and Danusia Kanachowski.

cancer, including the ordering and monitoring of chemotherapy for many years.”

“With our new team of GPOs, cancer care navigator, chemotherapy nurse and oncology pharmacist, we will be able to provide more comprehensive care for many patients with cancer – enhancing and building on the expertise in the community.”

Contact Dr. Danusia Kanachowski at danusiak@gmail.com

Dr. Robin Jamieson

“I have nearly completed the Program’s six weeks of clinical rotation and found the learning experience incredible. I have always had a strong interest in oncology – particularly with the advances in targeted therapy – so was delighted to accept the opportunity to be part of a GPO Program here.”

“Aside from the mammoth amount of knowledge, the key benefits of the training include the networking and getting to know

the Agency oncologists in-person plus understand how they work. It is also refreshing to be in an academic centre as part of a team especially after having been my own show for so long.”

“My hat goes off to all those who have completed the training before us and to those family physicians in Whitehorse who for decades have been providing cancer care and chemotherapy in this remote setting – and doing it well.”

Contact Dr. Robin Jamieson at robinjamieson@hotmail.com

Dr. Lucille Stuart

“I just completed the full eight weeks of the program including the two-week introductory module – which was uniformly excellent – and the six weeks of clinical rotation which I found very stimulating. We had well informed speakers providing current, useful information in every lecture. Then we worked with oncologists who were very prepared to teach – friendly, open and great with patients and with us – even though our presence created extra work.”

“Being part of this new GPO Program offers a different sort of care opportunity which I really enjoy – spending dedicated time with patients sorting through problems and ensuring everything is taken care of during a really difficult time.”

“Key among the training benefits was learning how to assess patients during their chemotherapy including knowing what to ask and what to look for regarding side-effects plus understanding the required follow-up care and monitoring in the years after chemotherapy and other treatment is completed.”

“I feel more competent and confident knowing that the care we provide will be up to the Agency’s standard.”

Contact Dr. Lucille Stuart at lstuart@northwestel.net

Next GPO training course begins September 8, 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 rotation at the Centre where participants’ patients are referred. The program is accredited by the College of Family Physicians of Canada and eligible physicians will receive a stipend and have their expenses covered. Full details at www.fpon.ca

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Top ten things to think about CAM therapies

By Dr. Lynda Balneaves, Associate Professor in the UBC School of Nursing and an Affiliate Nurse Scientist at the BC Cancer Agency. She currently leads the UBC/BCCA Complementary Medicine Education and Outcomes Program (CAMEO).

Cancer patients face many tough choices. Often, they are faced with many treatment options that have both good and bad risks attached to them. These choices are even more difficult to make when patients consider using complementary and alternative medicine (CAM). A growing number of cancer patients are using CAM and are turning towards their oncology health care team, including family physicians, for support in making an informed decision.

Here is a list of the top ten things you should think about when talking to patients about CAM.

1. **HOW'S THEIR FOUNDATION?** Before patients spend time and money on CAM, they should first review their lifestyle and determine what changes could be made to their diet, activity level, stress management and exposure to tobacco and sun. The AICR/WCRF Diet and Cancer Report provides clear lifestyle recommendations that is easily accessible at: www.dietandcancerreport.org.
2. **WHAT ARE THEIR GOALS?** While some patients use CAM in the hopes of curing their cancer, many individuals use CAM



Dr. Lynda Balneaves

to cope with symptoms, improve quality of life, or to simply maintain hope. Understanding their goals will help tailor your discussion as well as direct you towards relevant evidence. Remember that goals may be physical, emotional, and/or relational.

3. **WHAT DOES THE EVIDENCE SAY?** There is a growing body of high quality evidence regarding the efficacy and safety of CAM therapies. Check out the databases or evidence-based resources at: www.bccancer.bc.ca/RES/ResearchPrograms/cameo/usefullinks.htm.
4. **WHAT ARE THE POSSIBLE SIDE EFFECTS AND CONTRAINDICATIONS?** Like any treatment, CAM therapies can come with side effects and may interact with conventional cancer therapies. CAM may also not be appropriate for some types of cancers and other health conditions. Understanding the possible side effects will allow you and your patients to know what to look for.
5. **WHEN IS THE RIGHT TIME TO USE CAM?** Because of the potential interactions between CAM therapies and chemotherapy, radiation and surgery, it is important to select the right time to use CAM. Waiting till conventional treatment is over or having a “wash out” period may be prudent.
6. **WHAT IS THE IMPACT ON QUALITY OF LIFE?** CAM therapies may not only have physiological effects but also impact

patients' quality of life. It is important to consider the positive and negative impact on patients' psychological, relational, and financial wellbeing.

7. **WHO SHOULD THEY TALK TO?** Patients may be hesitant to share their CAM use with their oncologists. For safe and comprehensive care, it is important that they discuss ALL the therapies they are using with their oncology health care team.
8. **HOW DO THEY SELECT A PRACTITIONER?** There are many different types of CAM providers out there – patients should look for a practitioner who is licensed and/or regulated and has experience caring for people with cancer. Individuals who claim to cure cancer, recommend stopping all treatment, and are very expensive should be consulted with caution.
9. **HOW WILL THEY MONITOR OUTCOMES?** Patients need a plan about how they will monitor CAM use. Encourage them to keep a diary that keeps track of the positive and negative effects over a specified period of time. Consider how scheduled tests can be included as part of the plan.
10. **WHEN WILL THEY REVISIT THE DECISION?** At some point, patients should take a step back and reflect on whether CAM therapies are helping them achieve their goals – consider arranging a follow-up visit to discuss.

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

Contact Dr. Lynda Balneaves at Lynda.Balneaves@nursing.ubc.ca.

Yukon — strong proponent of GPO training continued from page 6

Dr. Sally MacDonald

“I am the newest Yukon GPO also midway through my six weeks of clinical rotation. Having just retired after 35 years as a full service family physician, I appreciate those parts of medicine that accompany the aging process including oncology and palliative care and the advances and complexity involved. I am enjoying the challenge and the

opportunity to become immersed in these areas.”

“The major benefit that the GPO Program will bring to our community is that we can act as advisors and helpers providing education to increase the quality of care for everyone. We won't be impinging on physicians' existing relationships with their patients, but adding to their expertise while handling referrals from the Agency and caring for the many patients without family physicians.”

“I really enjoyed the program benefitting not only from the most current knowledge, but also gaining a better appreciation of functional areas such as the approach to guidelines and how to institute them effectively.”

“Agency staff were incredibly kind and generous with their time guiding us through cases and answering all our many questions.”

Contact Dr. Sally MacDonald at maccim@northwestel.net

Your role in cervical cancer prevention

By Dr. Marette Lee,
Gynecologic Oncologist,
BC Cancer Agency
Vancouver Centre



Dr. Marette Lee

Cervical cancer is almost entirely preventable with regular screening and vaccination. Since its introduction, screening with cytology in the form of the Pap smear has been extremely successful, decreasing cervical cancer rates by about 70%. However, rates have plateaued in the last 30 years and further progress is limited, mainly due to incomplete screening uptake.

Inadequate screening remains the greatest risk factor for cervical cancer. Women who are

poorly screened present with more advanced cancers and more often die of their disease. In British Columbia one in five women has an inadequate screening history. Certain populations such as South Asian women, new immigrants, First Nations women, and women who are elderly and of low socioeconomic status are at the highest risk of having either no screening or poor screening.

What can I do?

As a primary care provider, you are on the front lines of cervical cancer prevention and you have the greatest opportunity to make a difference. Aside from laboratory

performance, screening effectiveness depends on women's participation, sample quality and adequate management and treatment of abnormal results. There are several simple things you can do that will have a great impact in the fight against cervical cancer.

1. Identify eligible women for screening
2. Obtain high quality smears
 - a. SINGLE slide
 - b. Label the slide in PENCIL with NAME and DATE OF BIRTH (dd/mm/yyyy)
 - c. Use CYTOSPRAY IMMEDIATELY – even 10 seconds makes a difference!
3. Make APPROPRIATE REFERRALS for abnormal results – repeat every 6 months for up to 24 months if ASCUS or LSIL, otherwise refer for anything more severe.

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Cervical cancer screening and colposcopy

By Leah Jutzi MD FRCSC, Fellow, Gynecologic Oncology, University of British Columbia/ BC Cancer Agency

In January 2013 the Canadian Task Force on Preventive Health Care released updated cervical cancer screening guidelines. These guidelines recommend against screening women under age 20 given the exceedingly low prevalence of cervical cancer in this age group.

The guidelines also state there is moderate evidence against screening women aged 21-25. However, many Canadian professional societies do not feel it is safe to omit screening in these women. Many providers will likely opt to initiate screening at age 21; however, well-informed patients may choose to delay the initiation of screening.

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

The Task Force has not made a statement about HPV testing although it is available. In patients with a positive high-risk HPV test and normal cytology, both tests should be repeated in one year. If the HPV and cytology are both abnormal, the patient should be managed according to the cytology. If in one year both tests are negative, regular

screening can be resumed and if the HPV test is positive, the patient should be referred to colposcopy.

Colposcopic abnormalities are managed based on the risk of progression to CIN3 and cancer. The majority of CIN1 lesions will regress and the risk of progression to cancer is extremely low, thus these lesions are not treated.

The SOGC recommends that all women with CIN3 are treated. In BC, women under 24 with CIN2 or 3 are offered follow-up because there is a high rate of regression. For those who have persistence of CIN2/3 at 2 years, treatment is recommended.

HPV vaccination in 'older' women and women with a history of dysplasia

Women continue to acquire new HPV infections throughout their lives. The National Advisory Committee on Immunization recommends vaccination in women over 26 since they may have been exposed to some but not likely all HPV subtypes in the vaccine.

In a large study, women with a history of treatment for dysplasia who were vaccinated had a 46% reduction in any subsequent HPV related disease. Thus women with a history of dysplasia should be offered vaccination.

Treatment recommendations for cancer of the cervix

A cone biopsy or simple hysterectomy is sufficient treatment for 1A1 (microscopic) lesions. For patients with disease up to stage 2A, a radical hysterectomy may be offered and is the favoured treatment in earlier stages. The fallopian tubes and in some cases the ovaries are also removed. For select patients who wish to preserve fertility, a radical trachelectomy (removal of the cervix only) is an option. Based on the final pathology, adjuvant radiation is recommended to some patients.

The alternate treatment option for stages 1B1 – 2A is chemoradiotherapy. This involves 5 weeks of external beam radiotherapy with 2 or more internal treatments and weekly chemotherapy. Chemoradiotherapy is the treatment of choice for stages 2B – 4A.

If patients recur, surgery, radiation and chemotherapy can be utilized depending on prior treatment and the location and extent of recurrence.

Contact Dr. Leah Jutzi at
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Your role in cervical cancer prevention continued from page 8

4. Encourage SMOKING CESSATION
5. Encourage and provide HPV VACCINATION—recommended for women up to 45 years. Women who have a HISTORY OF DYSPLASIA are still eligible and in fact have LOWER RECURRENCE RATES if vaccinated.

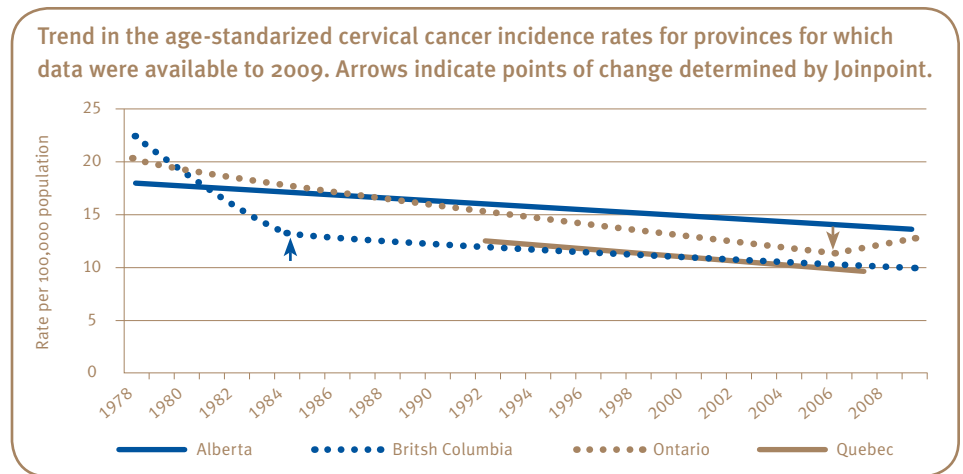
The Future of Screening

HPV testing is currently under consideration as a primary screening test in British Columbia. HPV screening technology not only offers increased sensitivity, but it also has the potential to break down barriers to screening attendance. Self-collected HPV specimens have similar sensitivity for detection of high grade dysplasia as clinician collected cytology specimens. This approach has been shown to be both feasible and acceptable in hard to reach

populations. Studies have demonstrated improved screening uptake in several populations using this strategy. If we are going to make headway in cervical cancer prevention we must utilize new innovative methods to increase screening utilization.

This potential strategy offers hope in the struggle to reach and empower those who are most at risk. www.screeningbc.ca/Cervix/ForHealthProfessionals

Contact Dr. Murette Lee at Murette.Lee@vch.ca



(from A. Mosavi-Jarrahi and E.V. Kliewer, J Obstet Gynaecol Can 2013;35(7):620-626.

Vocational rehabilitation support for cancer patients

By Maureen Parkinson, M.Ed, CCRC

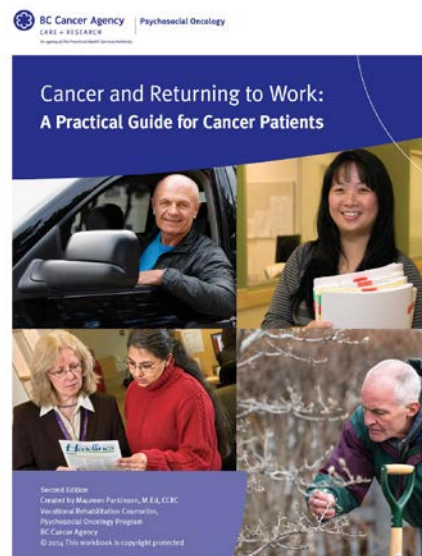
For the last 19 years, the BC Cancer Agency has offered vocational rehabilitation support for cancer patients across the province. These services include individual vocational rehabilitation counselling and consultations on job search, educational, work related insurance issues, rehabilitation services, and human rights. Online information is available to address some common concerns at: www.bccancer.bc.ca/PPI/copingwithcancer/emotional/Work+Related+Issues.htm.

In 2011, a 'Return to Work' seminar was developed for patients who expected to return to work at their former workplace. The information shared focused on three areas:

- Developing a rehabilitation plan;
- Enhancing workplace wellbeing; and
- Handling workplace transition.

Based on clinical research and participant feedback, a companion workbook was created in 2012. A more extensive second edition, **Cancer and Returning to Work: A Practical Guide for Cancer Patients** will be published later this spring. It has been designed to be helpful for patients in anticipating and problem solving around challenges regarding returning to work.

This workbook incorporates feedback from over 35 patients and 25 health care professionals including physicians, insurance providers, lawyers and employer or employer representatives. This Guide for Cancer Patients will be available for download from the Coping with Cancer section of the BC Cancer Agency website. Hard copies will be



Cancer and Returning to Work: A Practical Guide for Cancer Patients is soon to be available online and in hard copy.

for sale through the C&W Online Bookstore <http://edreg.cw.bc.ca/BookStore/public/bookstore/default.aspx>

Part of this guide, of particular interest and assistance to physicians, is the **Job Analysis Tool**. This section helps patients who want to return to their former employment to examine specific tasks that they are expected to perform in their job and to share this with their doctors. This information can be helpful to physicians in order to determine a patient's job readiness, assess rehabilitation needs, identify where modifications at the workplace are needed and explore options with patients. To see this tool go to: www.bccancer.bc.ca/PPI/copingwithcancer/emotional/Work+Related+Issues.htm.

For vocational rehabilitation counselling support, cancer patients can book in-person appointments or phone consultations with a vocational rehabilitation counsellor by calling their local cancer centres. Health care professionals can also consult with the vocational rehabilitation counsellor by calling 604-877-6000 or 1-800-663-3333 ext 672126 (Mondays and Fridays).

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Hereditary cancer genetic testing in the news

By Mary McCullum, Nurse Educator & Melanie Taylor, Genetic Counsellor, Hereditary Cancer Program

Awareness of hereditary breast cancer and the *BRCA1/2* genes, increased tremendously in mid-2013 with media coverage of Angelina Jolie's choice to have prophylactic mastectomy and breast reconstruction because she carries an inherited *BRCA1* gene mutation.

Cancer genetics clinics around the world describe significant impact on workload,

now dubbed the "Angelina effect". For example, in each of the 4 months following her announcement, the BC Cancer Agency's Hereditary Cancer Program (HCP) saw a 100% increase in new referrals. Many previous patients have also re-contacted HCP to request or provide updates and some have decided to re-consider earlier decisions to decline genetic testing. Others have new questions about options for cancer risk reduction. While increased awareness is important, the associated workload means

that wait times for appointments have also increased.

In addition to more referrals, HCP staff received many questions about hereditary cancer and genetic testing, which is likely true for physicians as well. Following are some of the common questions and the current availability of hereditary cancer services in BC:

- Q. How common is hereditary cancer?
- A. While cancer is common, hereditary cancer is not. Only 5-10% of all cancers are caused by an inherited gene mutation.
- Q. Does the Hereditary Cancer Program focus only on hereditary breast/ovarian cancer (HBOC)?
- A. No!! The HCP offers risk assessment for all hereditary cancer syndromes. Referrals for Lynch syndrome should be as common as HBOC referrals, but a large imbalance persists. This may be because hereditary colorectal cancer and other syndromes do not get the media attention given to HBOC.
- Q. My patient has a family history of cancer and asks about genetic testing. How do I arrange genetic testing?
- A. In BC, publicly funded hereditary cancer genetic testing is only available through the Hereditary Cancer Program. Individuals/families who meet eligibility criteria can be referred.
- Q. How do I know if a patient should be referred to the Hereditary Cancer Program?
- A. Take a detailed, three generation family history. Remember that if the family is large and people live to older ages, it is likely there will be some cancers, but it may not fit a hereditary pattern. Look for indications of possible hereditary cancer such as: common cancers at younger ages than usual, multiple close relatives with the same type of cancer, individuals with multiple cancers. If those features are present, compare the family history to the current referral criteria at www.screeningbc.ca/Hereditary/ForHealthProfessionals/HereditaryCancerSyndromes.
- Q. Who is eligible for hereditary cancer genetic testing?
- A. The first step is consultation with a genetic
- continued on page 11*

Message from the chair

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

As greater numbers of cancer patients become cancer survivors, the follow-up care and monitoring undertaken by family physicians becomes all the more important. The Family Practice Oncology Network develops tools and resources to support this growing responsibility and chief among them are clinical practice guidelines developed especially for family physicians. These guidelines are brief and easily accessible. They also include flow charts and patient hand-outs while following the approved Guidelines and Protocols Advisory Committee format.

Work is well underway now, for example, on a guideline for upper GI cancers which will cover diagnosis, management and follow-up of cancers of the esophagus, stomach, pancreas and biliary tract. The development of this guideline, led by Dr. Catherine Clelland of Port Coquitlam with scientific writer Leslea Duke of Victoria, is supported by the Provincial Health Services Authority's Shared Care Program.

Once completed later this spring, we anticipate that this guideline will join those already published at www.bcguidelines.ca including our suite of three palliative care guidelines; guidelines on breast cancer diagnosis, management and follow-up; guidelines on colorectal screening for cancer prevention and follow-up of colorectal polyps or cancer;



and soon guidelines on female genital tract cancers. Next on our list are guidelines for HPV related head and neck cancers.

Guidelines as such were identified as among the most important tools the Network could provide for family physicians when we started in 2002. In fact, some have been in use long enough that

we are now evaluating their effectiveness and updating content. Revisions are underway already on the Palliative Care suite while the Canadian Partnership Against Cancer is supporting evaluations of the breast and colorectal guidelines as part of an overall effort to further resources for cancer survivorship.

Community based oncology workshops for family physicians are another key resource provided by our Network. We partner with UBC's Division of Continuing Professional Development to present the Cancer Care Outreach Program on Education now entering its fourth year. This program which includes the development and delivery of community based workshops on breast, prostate, colorectal and soon advanced cancers requires significant support and I would like to thank Fiona Walks, the BC Cancer Agency's Vice President, Safety, Quality and Supportive Care for her ongoing support and commitment. Watch for an opportunity to take part in your community.

Contact Dr. Phil White at drwhitemd@shaw.ca

Managing symptoms in palliative care

By Dr. Pippa Hawley, Palliative Care Physician, BC Cancer Agency, Vancouver Centre

Cancer patients experience cancer through having symptoms. Though any one symptom can have an enormous impact on quality of life, multiple symptoms can be overwhelming. New symptoms can also be important indicators of medical problems. It is very important that symptoms are regularly assessed throughout the illness course, and that they are managed aggressively, whatever the cause. A measure of severity is important to trigger different approaches if necessary.

All physicians who have been through the General Practitioner in Oncology training program will have received teaching on how to manage the most common symptoms, and should be familiar with the BC Guidelines and Protocols Advisory Committee's Palliative Care guidelines [www.bcguidelines.ca/guideline_palliative2.html], which has algorithms for pain, dyspnea, nausea and vomiting, constipation, delirium, fatigue and depression. Other symptoms can be equally unpleasant.

Insomnia: In the absence of a clear reason for awakening, (e.g. pain, sleep apnea or need to go to the bathroom), insomnia is rarely a solitary symptom. It is usually accompanied by anxiety and/or depression. Hypnotics such as zopiclone or benzodiazepines may seem effective at first, but will not address the underlying disorder. A sedating antidepressant such as mirtazapine will have



Dr. Pippa Hawley

antidepressant, anxiolytic, sedative and appetite-stimulating effects. For those with concurrent neuropathic pain, clonazepam or a sedating tricyclic such as nortriptyline can have a co-analgesic effect. Many of my patients also report very effective use of medicinal cannabis for sleep.

Diaphoresis: clonidine, paroxetine, venlafaxine and gabapentin have been shown to be helpful in hot flash-related sweating, and cimetidine can be useful for opioid-induced sweating. All of these may be worth trying sequentially for tumour-related sweating. Acetaminophen can cause sweating and patients may not recognize the association of the drug with the side-effect.

Pruritus: Pruritus is often worst at night, and sedation from antihistamines can be useful. Pruritus due to advanced Hodgkin's disease, or from paraneoplastic syndromes can be particularly severe. Paroxetine, ondansetron and mirtazapine have been reported to be helpful. I have also had some success in use of low dose methadone.

Singultus: nerve irritation anywhere from the brain stem to the stomach can cause hiccups, including metabolic derangements such as uremia, hyponatremia and hypocalcemia. Hiccups can be associated with GERD, and can occur as a side-effect of intravenous steroids (especially in men), serotonin receptor antagonists, and some chemotherapies (e.g. cisplatin). Low dose corticosteroid therapy may conversely

be very helpful in mechanical irritation of the diaphragm. Other treatments include metoclopramide, chlorpromazine, haloperidol, sertraline, baclofen, nifedipine and intravenous lidocaine infusion.

Patients report effective use of medicinal cannabis for all of these symptoms.

In order to best manage cancer patients' symptoms I suggest:

- Ask about symptoms systematically and regularly, using a validated tool if possible
- Use a mechanism-based approach to selecting treatments, recognising that sequential trials of multiple agents may be required
- Always specify the purpose of medications on your prescriptions
- Use single drugs which target multiple symptoms wherever possible, thereby reducing polypharmacy

For further information I recommend one of the following:

The Pallium Palliative Pocketbook, available on-line for \$20 through the CHPCA's marketplace at <http://market-marche.chpca.net/The-Pallium-palliative-pocketbook-A-peer-reviewed-referenced-resource>. A revised and updated edition will be available electronically in 2015, but the 3rd print edition is still available and very current.

Symptom Management in Advanced Cancer. Twycross, Wilcock and Toller, 5th edition coming in fall of 2014, available from palliatedrugs.com. There is also a Canadian palliative care formulary companion volume.

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Hereditary cancer genetic testing continued from page 10

counsellor or MD geneticist to confirm eligibility and identify the "best testable" family member. To be most informative, genetic testing usually begins with a family member who has been diagnosed with cancer. If a gene mutation has already been identified in the family, unaffected relatives may be eligible for carrier testing.

Q. Is the cost of genetic testing covered in BC?

A. Yes, but only if the patient meets eligibility criteria.

Q. Why would somebody choose to have hereditary cancer genetic testing?

A. Results may provide information about personal cancer risks as well as risk for family members. Confirming high-risk status can inform risk management options, including enhanced screening

and risk-reducing surgery. People who do not inherit "the family gene" can follow population cancer screening guidelines and be reassured that inherited cancer risk cannot be passed on to their children.

Q. Where can patients and physicians find more information about hereditary cancer?

A. Visit the website: www.screeningbc.ca/hereditary. Call 604-877-6000 local 2325 with questions about specific cases.

Delivering serious news: a therapeutic dialogue

By Dr. Tamara Shenkier,
Medical Oncologist,
BC Cancer Agency
Vancouver Centre

How patients handle bad news - defined as any news that changes their view of the future in a negative way - depends on the gap between their perception and the reality of the situation. Even an experienced communicator can have a discussion go awry. The SPIKES protocol for delivering bad news and the NURSE acronym for responding to emotion are practical and valuable tools for navigating these potentially difficult situations with confidence.



Dr. Tamara Shenkier

discussion of serious news can become a therapeutic dialogue. This applies over the entire disease trajectory: relaying biopsy results at initial diagnosis, confirming a recurrence or transitioning from active treatment to exclusively supportive care. The latter scenario can be the most challenging and warrants additional analysis.

Notwithstanding years of practice, physicians who help patients transition from active treatment to palliative care may still experience a sense of failure and grief. When specific anti-cancer interventions become ineffective we often hear phrases like “you are giving up on me” or “isn’t there any hope”. At this stage it is useful to separate the treatment of the cancer from the care of the patient. While we cannot stop the cancer, we can still help our patients recognize and explore their values and goals. These may include dying at home free of pain, leaving a digital legacy for their children or attending their grandchild’s graduation. By listening and proposing a plan to help achieve those goals we show a commitment to caring for the person even if we can no longer manage the cancer.

We build rapport when we demonstrate understanding, respect and support and when we give patients the psychological space to explore difficult emotions. These skills can be learned and mastered. Therapeutic communication, a core skill at the heart of caring for people with cancer, deepens our relationship with our patients and enriches our practice of medicine.

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

The first step is to ensure a comfortable physical setting (“S” for set-up). Next we must ascertain what our patients understand and expect (“P” for perception) and how much detail they want to hear (“I” for invitation). Once we share the serious information (“K” for knowledge) we need to track our patients’ reactions by staying attuned to verbal and non-verbal cues. If the cues indicate the patient is experiencing strong emotions (“E”) we should stop providing factual information and offer an empathic response instead.

Non verbal expressions of support such as pausing, leaning forward, moving your chair closer or offering a tissue indicate your concern and attention. I rely on the NURSE acronym (Naming, Understanding, Respecting, Supporting and Exploring) to help me respond to emotions with words. Statements such as “I wish the results were better” or “you weren’t expecting to hear this” can align us emotionally with our patients and the phrase “tell me more” can give them the opportunity to explore their feelings. Summarising (“S”) the conversation and making explicit plans for the next contact is the crucial last step.

Bearing witness to strongly expressed emotions can in itself be salutary and the

FOR MORE INFORMATION

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