

Surgical Oncology Network Newsletter

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OPERATE, RADIATE OR NEITHER: CHANGING PARADIGMS IN THE AXILLARY MANAGEMENT OF BREAST CANCER

Dr. Rona Cheifetz, Chair, Continuing Professional Development & Knowledge Transfer Committee, Surgical Oncology Network

The last decade has seen a major shift in the surgical approach to the management of the axilla in breast cancer patients. Previously every patient with invasive breast cancer underwent routine completion axillary lymph node dissection (ALND) and we accepted the fact that the majority would be node negative and have had surgery that was non-therapeutic. The introduction of sentinel lymph node biopsy (SLNB) was a huge change in our approach to the axilla, offering a less invasive method of axillary staging with acceptable accuracy and reduced morbidity. SLNB is now considered the standard of care for axillary staging in clinically node negative patients. Still, our practice has been to recommend completion ALND for patients who are sentinel node positive.

The American College of Surgeons Oncology Group (ACOSOG) Z0011 trial, published in the Journal of the American Medical Association (JAMA) in February 2011, has shaken the ground on which we stand.¹ In this trial 891 women with T1-2 tumours and one to two positive sentinel lymph nodes were randomized to ALND vs SLNB alone. All patients underwent lumpectomy, whole breast radiation and systemic therapy (given in 96% of patients). There was no difference in overall survival, disease free survival, or locoregional recurrence at a median of 6.3 years of follow-up, suggesting that completion ALND is not necessary for patients meeting the enrollment criteria for this study.

There have been many criticisms of this study, particularly focusing on the fact that the study closed early, accruing only 891 of the planned 1,900 patients. The early closure was based on the actual mortality rate being significantly lower than what was historically expected for node positive patients. Consequently,

it would have taken more than 20 years of follow-up to observe the targeted 500 deaths. As well, critics point out that the median 6.3 years of follow-up may be short for detecting local regional recurrence. Despite these acknowledged limitations, major cancer institutions in North America, including Memorial Sloan Kettering and M.D. Anderson, no longer recommend completion ALND for patients who fit the Z0011 criteria.

Adoption of the Z0011 approach has not become routine in BC. In my experience, completion ALND is not as frequently recommended as it has been in the past, but in the absence of an ALND, radiation to the axilla is usually recommended. Patients in the Z0011 study received whole breast irradiation but did not specifically receive axillary radiation. It is known that the nodes in the lower axilla are included in the standard tangent fields for whole breast radiation. So the question has now become whether patients who are sentinel lymph node positive (with one to two nodes only) and do not have a completion ALND should have full regional

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MARK YOUR CALENDARS Malignancies of the Lower GI Tract October 20, 2012 Four Seasons Hotel, Vancouver

This accredited course features topics on surgical techniques, uncommon cancers, pathology, adjuvant therapy and imaging that relate to the lower GI tract. The program includes visiting speakers, Dr. Rob Gryfe (Toronto), Dr. Paul Johnson (Halifax) and Dr. Tony MacLean (Calgary). This conference is a must attend for colorectal and general surgeons and residents and would be of value to other related specialists.

For more information and to register contact: Fatima Cengic at fcengic@bccancer.bc.ca or visit <http://www.bccancer.bc.ca/son>

OPERATE, RADIATE OR NEITHER

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nodal radiation. There were previous studies, including one from BC, that showed a benefit to nodal radiation in patients with more than three positive axillary nodes.² The benefit of nodal radiation for patients with limited disease was not clearly established. Recently the results of the NCIC-Clinical Trials Group (CTG) MA 20 trial were presented at the American Society of Clinical Oncology meeting 2011.³ In this study, patients were randomized to receive regional nodal irradiation in addition to whole breast irradiation and stratified by nodal status as high risk node negative (defined as those having tumours > 5 cm or > 2 cm with other adverse features including <10 axillary lymph node removed and being estrogen receptor (ER) negative or high grade or lymphatic vessel invasion (LVI) positive) or node positive (based on a standard ALND). The addition of regional nodal irradiation was associated with a reduced risk of locoregional and distant recurrence and improved disease-free survival (5.7%) with a trend to improved overall survival (1.6%). This study, however, was not looking at nodal metastases identified on SLNB, which we know identifies more low volume disease than ALND.

So now we have one study that says with limited nodal disease on SLNB, you do not need to do anything additional to the axilla and another study that says even if you are node negative on ALND, but high risk, you should have your nodes radiated. Clearly, there are still questions that need to be answered. The challenge for surgeons lies in knowing what to tell our patients. There are multiple factors to be taken into consideration for some patients. The elderly woman with a small, strongly ER positive, low grade tumour is straightforward, as is the young woman with clinically node positive, high grade, ER negative locally advanced disease. It is all the patients in between that test our need for black and white answers. The possibility of requiring further surgery to either the breast or the axilla following an initial partial mastectomy and SLNB should always be part of the pre-operative discussion. Furthermore, this possibility is worth mentioning again when the patient is referred on to the BC Cancer Agency for a discussion of adjuvant therapy. Subsequent pathology reviews and multidisciplinary conference discussion may change the recommendations for what initially seemed to be quite a straight-forward case.

1. Giuliano AE, et al. JAMA 2011; 305(6): 569-575
2. Ragaz J, et al. NEJM 1997; 337:956-62
3. Whelan TJ, et al. J Clin Oncol 2011; 29(suppl): Abstract LBA 10003

HEREDITARY CANCER PROGRAM HIGH RISK SURVEILLANCE CLINIC

Melissa Laing, Nurse Practitioner & Mary McCullum, Nurse Educator, HCP, BC Cancer Agency

The Hereditary Cancer Program High Risk Surveillance Clinic at the BC Cancer Agency in Vancouver was established in 1997. The purpose of this clinic is to provide a consistent approach to screening for women who are at increased risk for breast and/or ovarian cancer.

Eligibility criteria for the High Risk Clinic includes women who are *all* of the following:

- Confirmed BRCA1/2 mutation carriers (or those at 50% risk of carrying a family BRCA1/2 mutation)
- 25-65 years of age
- Not currently under the care of an Oncologist
- Able to attend appointments in Vancouver
- Have not completed risk-reducing bilateral mastectomy

The clinic also provides breast screening for a small number of women with other hereditary cancer syndromes (eg. Ataxia TElangiectasia, Li- Fraumeni Syndrome and Dereditary Diffuse Gastric Cancer).

To date, 494 women have been assessed through the clinic and 243 women are currently attending for regular follow-up.

This includes:

- 99 (41%) BRCA1+
- 104 (43%) BRCA2+
- 2 (0.8%) both BRCA1/2+
- 29 (12%) declined genetic testing
- 9 (3.7%) have other hereditary cancer syndromes

Table 1 summarizes cancer risks for carriers of BRCA1 and BRCA2 gene mutations, compared to the general public.

Types of Cancer	Risk in General Population	Risk in BRCA1 Carrier	Risk in BRCA2 Carrier
Breast Cancer - women	11%	47%-66%	40%-57%
Ovarian Cancer	1%-2%	34%-46%	13%-23%
Breast Cancer - men	0.1%	Up to 6%	6%
Pancreatic Cancer	1%	Slight Increase	Slight Increase
Prostate Cancer	12%	24%-36%	24%-36%
Other Cancers	Varies	-	Slight Increase

Table 1: Cancer Risks for Carriers of BRCA1 and BRCA2 versus General Population

For mutation carriers with a prior history of breast cancer, the risk of developing a contralateral breast cancer is significantly increased, especially for women whose breast cancer occurred before the age of 40 (Graeser et al, 2009).

Table 2 depicts new cancer diagnoses for women followed by the High Risk Clinic.

New Cancer Diagnosis	N	BRCA1	BRCA2
Invasive breast cancer:	37	22	15
1st breast cancer	24	15	9
2nd breast cancer	12	7	4
3rd breast cancer	1	0	1
DCIS	9	5	4
LCIS	1	1	0
Ovarian Cancer	7	4	3
Fallopian Tube Cancer	2	1	1
Peritoneal Cancer (after PBSO)	3	1	2
Other Cancers	7	4	3
Total	66	38	28

Table 2: New Cancer Diagnoses for Women Followed by the High Risk Clinic

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HEREDITARY CANCER PROGRAM HIGH RISK SURVEILLANCE CLINIC

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Screening Guidelines

Breast cancer screening for these women includes detailed clinical breast examination every six months starting at age 20, annual bilateral breast MRI from 25-65 and annual mammograms beginning at the age of 30. Mammograms and MRIs alternate at six month intervals.

As MRI and mammograms are not recommended during pregnancy and while breastfeeding, routine breast screening during this time includes clinical breast examination every three months. Breast ultrasounds are arranged if recommended by the Radiologist (e.g. follow-up of abnormal MRI findings or if patient is unable to tolerate MRIs).

During pregnancy and lactation, routine breast cancer screening includes clinical breast examination every three months, as MRI and mammography are not recommended. Breast ultrasound can be used to investigate abnormalities detected on clinical breast examination. Routine imaging with MRI and mammogram is resumed three months after completion of breastfeeding.

Ovarian cancer screening methodologies (pelvic examination, transvaginal ultrasound, and CA-125) have limited sensitivity and specificity and are therefore not recommended for screening in British Columbia.

Risk-Reducing Surgery

The option of bilateral prophylactic mastectomy (BPM), which reduces the probability of breast cancer by 90%-95%, is discussed with each woman. Breast reconstructive options are briefly reviewed. After completion of bilateral prophylactic mastectomy, women are discharged to their family physicians for routine examination of regional nodes and of the chest wall/reconstructed breast. Routine imaging of the reconstructed breasts is not recommended.

Women who carry a BRCA1/2 mutation are recommended to consider prophylactic bilateral salpingo-oophorectomy (BSO) between the ages 35-40 and/or once childbearing is complete. This surgery reduces the probability of ovarian cancer by approximately 85-95%, and may also reduce the risk of breast cancer by approximately 50% when performed prior to natural menopause. The effects of surgical menopause, the impact on bone and cardiac health, as well as the use of hormone replacement therapy are reviewed with women pre-operatively; ongoing management of related concerns is provided.

Women are discharged from the High Risk Clinic upon completion of both prophylactic mastectomy and BSO. Other reasons for discharge include a new cancer diagnosis (care transferred to an Oncologist), patient preference (e.g. unable to travel to Vancouver to attend appointments, advancing age, preference for routine follow-up through family physician) and disclosure of negative BRCA carrier test results.

Table 3 illustrates risk reducing surgeries performed. These include bilateral mastectomy alone, bilateral salpingo-oophorectomy alone or both mastectomy and BSO. The categories are divided into unaffected carriers, women with a breast cancer diagnosis (either previous breast cancer or new diagnosis) and previous ovarian cancer diagnosis. There is one patient who was diagnosed with both breast and ovarian cancer.

The High Risk Clinic provides routine breast screening and consultation regarding risk reducing surgeries for women at high risk of breast and ovarian cancer. In August 2010, a Nurse Practitioner was integrated into the clinic to provide ongoing follow-up of these women. Ongoing data collection will assist in evaluating the effects of cancer risk management interventions for high risk women.

Table 3: Results for Risk Reducing Surgeries

Risk Reducing Surgery Completed	Unaffected Carriers n=320	Previous Breast Cancer	Previous Ovarian Cancer
Bilateral Mastectomy (only)	25 (8%)	3 BM as breast cancer tx 1BM after BRCA+ results 2 CPM	1 BPM 1CPM
BSO (only) (+/- hysterectomy)	101 (31%)	45	n/a (15 had BSO as part of treatment)
Both BM and BSO	45 (14%)	16 BM as br ca tx and BSO 20 CPM and BSO 10 BM and BSO (after receiving BRCA + results)	2

BSO (bilateral salpingo-oophorectomy), BPM (bilateral prophylactic mastectomy), CPM (contralateral prophylactic mastectomy)

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HIGHLIGHTS FROM THE FALL UPDATE 2011 “FROM UNCOMMON TO COMMON”

Dr. Rona Cheifetz, Chair, Continuing Professional Development & Knowledge Transfer Committee, Surgical Oncology Network

On October 22, 2011, the the Surgical Oncology Network, with the UBC Department of Surgery, hosted the Annual Fall Update at the Four Seasons Hotel, downtown Vancouver. While in previous years we have focused the day on a single tumour site or system, this year we covered a spectrum of topics to address uncommon but important tumours, as well as provide an update on current issues in common cancers. Presentations from this event are posted on the Surgical Oncology Network website at www.bccancer.bc.ca/son.

Soft Tissue Sarcoma: An Update and Review of Recent Developments

We began the day with a session focusing on soft tissue tumours. Dr. Paul Clarkson, an orthopedic surgical oncologist based at the Vancouver Centre and the Head of the BCCA MSK/Sarcoma group spoke on soft tissue sarcoma. He emphasized the need to be suspicious about any lesion that is greater than 5cm, growing, or deep to the fascia. Ultrasound is not very useful other than to assess size and depth. If a lesion is suspicious, an MRI is needed for full assessment. Core biopsy, which is 98% accurate with expert pathology review, should be discussed with a sarcoma surgeon as an inappropriate route can compromise limb salvage. If a core biopsy is non-diagnostic, and open biopsy is required, the patient should be referred. Small, superficial, slow growing lesions can be excised but always along the long axis of the extremity.

Retroperitoneal Sarcoma

Dr. Rona Cheifetz continued the theme with a talk on retroperitoneal sarcoma. She emphasized that the best management of a retroperitoneal mass is a function of the diagnosis. Not all retroperitoneal masses are sarcomas and not all need surgery.

As for soft tissue tumours, core biopsy (via retroperitoneal approach to avoid seeding the peritoneum) and expert pathology review are essential. Early referral is highly recommended. These are complex operations with multivisceral resection needed in more than 75% of cases. Complete resection improves survival and is most likely a first surgery,

whereas marginal excision is associated with an 80% local recurrence rate. Ideally, these patients should be reviewed at multidisciplinary conference preoperatively for consideration of preoperative external-beam radiation therapy (XRT) (which may improve local control) as radiation cannot be given safely postoperatively. A recent review of BC data shows higher complete resections, survival and time to local recurrence for patients referred prior to surgery, but still only half of these patients are currently referred preoperatively.

Practical Approach to Desmoid Tumours

Dr. Lloyd Mack, our first visiting speaker and a surgical oncologist from the Tom Baker Cancer Centre in Calgary, spoke on desmoid tumours. Overall, about 5%-10% of desmoids tumours occur in the mesentery, 20% in the abdominal wall and the remainder are extra-abdominal.



Abdominal Wall Desmoid

Again, core biopsy is diagnostic in more than 90% with expert pathologist review. Surgery is no longer considered the mainstay of therapy for these tumours. They have a variable natural history with about 50% being stable, 10% regressing, 10% rapidly progressing, and 30% cycling between progression and stability. Consequently, a period of observation is appropriate for most cases. For lesions growing on observation, surgery alone is reasonable if the lesion is small and the procedure easy. Local control will be achieved in 61% overall (72% if margins are clear, 42% if not). All other lesions are better managed non-surgically or with surgery as a component

of multimodal treatment. These patients benefit from referral for a multidisciplinary opinion. Nonsurgical management options include tamoxifen, anti-inflammatories (often in combination with tamoxifen), chemotherapy and radiation therapy. Stabilization of growth is the primary outcome goal. Response rates of up to 50% can be seen with these modalities.

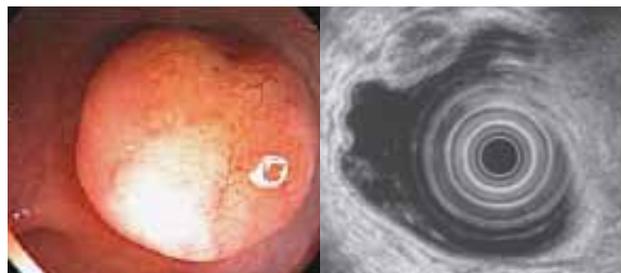
Carcinoid Tumours

We then moved to the GI tract portion of the conference, beginning with a talk on neuroendocrine tumours (NET) by Dr. Chris Baliski, surgical oncologist from Kelowna. Dr. Baliski focused his talk on gastric and rectal NET, both of which are increasing in incidence. Gastric NET come in four types and the most common is associated with hypergastrinemia and hypochlorhydria. These are typically incidental findings at the time of endoscopy. Overall, the risk of metastases is dependent on the type of lesion and the size. Investigations include fasting, gastrin levels and serum chromogranin A levels. Octreotide scanning can be helpful in looking for metastatic disease. Small, type 1-3 lesions are low risk and can be managed with either endoscopic submucosal resection or observation. Higher risk lesions require formal surgical resection including nodal resection.

Rectal NET is also increasing in incidence and 50% are incidental. Fortunately, these have a good prognosis if detected early, with an 89% five year survival. The risk of nodal metastases is similar to adenocarcinoma with low risk for lesions less than 1cm. These can be evaluated by Endoscopic Ultrasound (EUS) and considered for submucosal resection if no nodes are seen. Preoperative EUS increases the rate of RO resection. Lesions measuring more than 2cm should have a formal resection as there is a 60%-80% risk of nodal metastases.



Dedifferentiated Liposarcoma



Rectal Carcinoid- Colonoscopic and EUS Views

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HIGHLIGHTS FROM THE FALL UPDATE 2011

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Update on Cytoreductive Surgery & Heated Intraperitoneal Chemotherapy for Peritoneal Carcinomatosis

We called on Dr. Mack again, this time to discuss cytoreductive surgery and hyperthermic intraperitoneal chemotherapy (HIPEC) in appendiceal mucinous neoplasms and colorectal carcinomatosis. Historical controls for patients with pseudomyxoma peritonei show a 21% 10-year survival (most with low grade disease). For colorectal carcinomatosis there is historically only a four to six months median survival. Dr. Mack presented the Calgary experience with managing these tumours. A complete cytoreduction was possible in 84% with a 34% major complication rate. At five years, the overall survival for appendiceal lesions was 62%, and for colorectal patients was 34%. For carcinomatosis this is a huge improvement of palliative systemic chemotherapy. He does recommend a trial of preoperative systemic chemotherapy in colorectal carcinomatosis. There are important contraindications to cytoreduction and HIPEC including biliary, urinary or bowel obstruction, extensive disease in small bowel/mesentery, periportal or retroperitoneal disease, extraperitoneal disease, and poor performance status. The Calgary experience compares well with published studies which also show improved survival compared with systemic therapy alone.



Pseudomyxoma Peritonei

Screening for Colorectal Cancer

Dr. Jennifer Telford, gastroenterologist from Providence Health, brought us up to date on the current recommendations for screening for colorectal cancer (CRC). In comparison to Fecal Occult Blood Test (FOBT), the Faecal Immunochemical test (FIT) requires fewer specimens, is more sensitive and has higher patient compliance. The UK Flexible Sigmoidoscopy Trial showed that a single flexible sigmoidoscopy between ages 55 and 64 decreases CRC mortality by 31% and incidence by 23%. The Canadian Association of Gastroenterology recommends annual or biennial FIT testing

and a flexible sigmoidoscopy every 10 years for programmatic screening. In BC, the ColonCheck program is being piloted offering FIT screening and colonoscopy for positive FIT tests.

Care When There is No Cure: Palliative Surgery in Cancer

Our second visiting speaker was Dr. Alexandra Easson from Surgical Oncology at the Princess Margaret Hospital in Toronto. She gave a passionate presentation on palliative surgery. Dr. Easson pointed out that palliative surgery is common (especially in the last few months before death) but despite its common use, research in the area is still limited. She emphasized that the goal is relief or prevention of symptoms and/or improvement in quality of life and that the procedure may not prolong life. Dr. Easson discussed several categories of palliative procedures including drainage procedures, procedures to relieve obstruction, management of obstruction in the setting of carcinomatosis (including medical management of malignant bowel obstruction), relief of pain and palliative resections. It is not possible to do justice to the depth and breadth of this presentation in this brief synopsis and readers are strongly encouraged to review the presentation on the SON website for more details: <http://www.bccancer.bc.ca/HPI/SON/SONFallUpdates>

Melanoma

We left the GI tract to focus on melanoma and breast cancers. Dr. Andrew McFadden, a surgical oncologist who has recently moved to Vancouver from Saskatchewan, brought us up to date on the current management of melanoma. He discussed the significant impact of sentinel lymph node positivity on staging and survival. As well he noted the impact of sentinel lymph node biopsy (SLNB) on local control with the local recurrence rate following formal node dissection for positive sentinel lymph node of 2%-10% compared with a local recurrence rate of 20%-50% if the nodes were clinically positive. With respect to the impact on overall survival, the Multicentre Selective Lymphadenectomy trial (MLST-1) showed an improved five year survival of 75% vs 52% for patients with positive sentinel lymph node managed with axillary node dissection (ALND) compared to patients who did not have SLNB and had node dissection when they developed clinically evident nodal disease. Surgery can also be beneficial in patients with bulky



Quadrant Injection Around Biopsy Scar For Melanoma

or recurrent disease in the axilla, with improved five year survival from 16% to 35% seen in patients who are asymptomatic at presentation and good palliation in 75% of patients.

Dr. McFadden also discussed the role of adjuvant radiation post node dissection, indicating that it is associated with a decreased local recurrence rate (6% vs 27%). The decision to offer adjuvant radiation is based on the location and extent of nodal disease as these findings correlate with the risk of local recurrence. Adjuvant radiation is typically offered for parotid nodes and for large (>4cm) or multiple (>3) nodes in the axilla or groin or in the presence of extranodal extension. Careful pathology review may be required as these features are not always reported. Complete metastatectomy may be associated with prolonged survival but is a function of site of the metastases with 30%-40% five year survival if the metastases involve skin/subcutis/nodes vs 5%-30% for pulmonary metastases. GI metastases have a poor prognosis but resection for bleeding or obstructing lesions provides good palliation in 90%. For unresectable disease there are finally new drugs available with studies underway of BRAF inhibitors (vemurafenib) for V600E mutation positive patients and ipilimumab for others. Both of these drugs have shown improved survival compared with standard care with DTIC drug.

Update on the Axilla in Breast Cancer

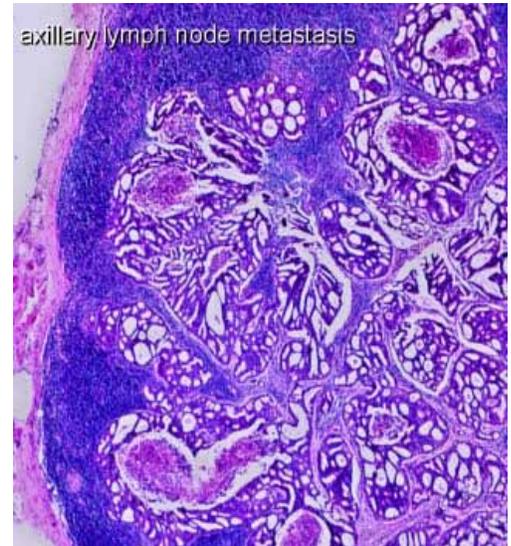
Dr. Urve Kuusk, General Surgeon from Providence Health gave an update on the management of the axilla in breast cancer. She advised us that SLNB is now the standard of care for axillary staging in clinically node negative patients with early breast cancer. Studies addressing how many nodes need to be removed at the time of SLNB note a 75.3% detection rate when only one node is removed, but a 99.1% with up to four nodes removed. While the number of nodes removed at sentinel lymph

HIGHLIGHTS FROM THE FALL UPDATE 2011

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node does not correlate with lymphedema rates, there is no significant benefit to removing more than four nodes. Intraoperative nodal assessment has become more controversial. While it is reasonably accurate (60%-87%), the question has now become whether all patients with positive intraoperative nodes (and possibly only a single positive node) should have a full ALND. Dr. Kuusk presented studies by Veronisi (2003) and Giuliano (2010) which addressed this topic.

In Veronisi's trial of SLNB alone vs SLNB and ALND, 35.5% of patients with a positive sentinel lymph node did not have ALND yet there was no difference in survival or recurrence. Similarly, Giuliano in the ACSOG Z0011 trial, showed no difference in survival or local recurrence for patients with T1-2 tumours with 1-2 positive sentinel nodes, lumpectomy, whole breast irradiation and discretionary systemic therapy. Many centres have abandoned ALND for these patients. Dr. Kuusk also addressed several other issues in SLNB. Regarding the role of immunohistochemistry in nodal assessment, the literature (ACSOG Z0010 and NSABP 32) questions whether ImmunoHistoChemistry (IHC) testing is necessary. While there is a 1%-2% survival difference for IHC positive patients, additional axillary surgery did not change this. If patients have other indications for systemic therapy, IHC testing may be unnecessary. Newer studies are looking at SLNB following neoadjuvant chemotherapy. This is still considered investigational and it remains important to get the SLNB done prior to chemotherapy for clinically node negative patients being offered neoadjuvant therapy. Dr. Kuusk also presented interesting data on SLNB in recurrent breast cancer and following mastectomy. Clearly there is a lot of research still to be done in these applications.



Axillary Nodes

Case Discussions on the Axilla in Breast Cancer

Dr. Kuusk's presentation was followed by a lively panel discussion on axillary management in breast cancer. Drs. Mira Keyes and Christina Parsons from Radiation Oncology in Vancouver Centre joined our cross country surgical representatives to discuss a number of challenging cases that highlighted the current controversies in this area. Important discussions centred around the development of standards at the BCCA and the impact of adjuvant axillary radiation on breast cancer survival. It was clear that there was no uniform consensus at this time on many of these issues and that decision making still needs to be individualized. Multidisciplinary opinions are very important in dealing with these increasingly complex patients.

Synoptic Reporting in Cancer Care

Our final session focused on synoptic reporting in cancer care, now known as Cancer Surgery Checklists. Dr. Carl Brown, Colorectal Surgeon from Providence Health, presented the synoptic summary for rectal cancer surgery. Dr. Elaine McKeivitt, General Surgeon, Providence Health, then discussed the development of the Breast Cancer Surgery Checklist and the essential or minimum data set as well as the complete synoptic report. Laminated cards have been developed by the SON to facilitate introduction and adoption of the new template for breast and rectal cancer surgeries. (Please refer to page 11 in this newsletter issue for more information on the breast and rectal surgery checklists for dictated operative reports.)

Overall, it was another great update in surgical oncology. See you all at our next Fall Update on October 20, 2012, *Malignancies of the Lower GI Tract*.

SURGICAL PALLIATIVE CARE: A RESIDENT'S GUIDE

Developed by The American College of Surgeons Palliative Task Force

Surgeons are often faced with the management of terminally ill oncology patients. Unfortunately, we have traditionally received little formal education on the spectrum of management options for what is often complex symptomatology.

The American College of Surgeons Palliative Care Task Force has collaborated on the development of educational material on palliative care for surgeons. *Surgical Palliative Care: A Resident's Guide*, was developed for surgical residents; however, it is an excellent comprehensive resource, covering a wide range of topics that we all face in practice.

This guide is available online at <http://www.facs.org/palliativecare/surgicalpalliativecareresidents.pdf>

HIGHLIGHTS FROM THE 12TH ANNUAL MEETING OF THE AMERICAN SOCIETY OF BREAST SURGEONS

Dr. Carol Dingee, Surgical Oncologist at Mount St. Joseph Hospital; Clinical Assistant Professor, Department of Surgery, UBC

The 12th annual meeting of the American Society of Breast Surgeons (ASBS) was held in Washington, DC April 27 - May 1, 2011. The program and presenters addressed many potentially practice changing developments in the field of breast surgery, as well as controversies that affect current management. These are some excerpts from that meeting.

MANAGEMENT OF THE AXILLA

A session was held on how data from the ACOSOG Z0011 study may affect management of the axilla in patients with invasive breast cancer.

Summary of the trial

The primary aim of phase three noninferiority trial was to determine the overall effects of axillary lymph node dissection (ALND) on survival of patients with sentinel lymph node (SLN) metastasis. 813 patients from 115 sites were enrolled from May 1999-Dec 2004 with clinical T1-T2 invasive breast cancer, no palpable adenopathy and who had one to two SLN containing metastases identified by frozen section, touch prep or hematoxylin and eosin (H&E) stain on permanent section. They were randomized to ALND of ten or more nodes vs. no further axillary surgery. All patients underwent lumpectomy and were to receive whole breast radiation without an axillary field. Systemic therapy was at the discretion of the treating physician. Women were ineligible if they had three or more positive SLNs, matted nodes, gross extranodal disease or if they had neoadjuvant hormonal therapy or chemotherapy. Patients undergoing mastectomy were not included.

Clinical and tumour characteristics were similar between the two groups (ALND vs no ALND). Micrometastasis (defined as H&E stained deposits no larger than 2 mm) were found in 37.5% vs. 44% of patients. Additional positive nodes beyond the sentinel nodes were found in 27.4% of ALND patients. Most patients, 96%, received systemic therapy and 89% received whole breast radiation. At a median follow up of 6.3 years, equivalent results were demonstrated between the two arms for axillary recurrence (0.5% vs. 0.9%), in breast recurrence (3.6% vs. 1.8%), overall locoregional recurrence (4.1% vs. 2.8%) and five year survival (82.2% vs. 83.9%).

The conclusion of the study was that among patients with limited SLN metastases treated with breast conservation, breast radiation and systemic therapy, the use of SLNB alone compared with ALND did not result in inferior survival.

The session speakers addressed some of the trial controversies. The trial has been criticized as underpowered. It was closed early with an enrolment of 47% of the 1,900 targeted patients.

Dr. Pat Woodworth, Surgeon and Director, Nashville Breast Center, described this trial as a landmark and practice changing trial with as much statistical validity as other landmark trials including The National Surgical Adjuvant Breast and Bowel Project (NSABP) B04 or B06. He noted that power is only germane if the p-value is not significant and target accrual is important if the study does not reach statistical significance. This is a non inferiority study. The Z0011 study design made the conservative assumption of 80% survival at five years. If it is found with 90% CI that the hazard ratio is less than 1.3 compared to ALND then SLNB only is non inferior. So for the design: 80% overall survival at 5 yrs.; HR less than 1.3 (90% 2 sided CI $p=.05$) and for the results: 92% overall survival at 5 yrs.; HR = 0.79 (90% CI. 56-1.10). The study results were better than the assumption and reached significance. If 1,000 more patients had been entered there is a less than 1% chance the outcome would be different.

It has been stated that clinicians cannot rely on one study questioning ALND. Dr. Giuliano, Surgeon and Clinical Professor, University of California, John Wayne Cancer Centre, noted that the impact of ALND on survival has been uncertain for years. The B-04 NSABP 1972 study for clinically node negative patients, now out to 25 years, showed no difference in survival in the three treatment arms.

Some claim that the follow-up was insufficient. Dr. Giuliano noted that modern randomized controlled trials of axillary treatment in breast conservation, including the work of Veronesi and the time to recurrence in the companion Z0010 study and B04 study are 15-30 months, making the 76 month follow-up in the Z0011 study sufficient to capture most recurrences.

It has been noted that most patients in this study were older and estrogen receptor (ER) positive. Dr. Giuliano noted that this is in keeping with the usual occurrence of breast cancer, since it is more common with

increasing age. However, since ER negative patients tend to recur early, have a greater likelihood of distant metastasis and fewer patients have more than four positive nodes, Z0011 results would also apply to ER negative patients.

The reason for the low axillary recurrence rate in Z0011 has also been questioned. Dr. B. G. Haffty, Chairman of the Department of Radiation Oncology, Cancer Institute of New Jersey, noted that only 27% of patients had additional positive nodes (lower than in meta-analysis of SLNB studies) and only 13% had four or more positive nodes. Assuming equal arms in the study the majority of patients had only one positive node and it was surgically removed. Therefore, low recurrence is a combination of tumour biology, presence of only one involved node in many patients, adjuvant systemic therapy and incidental radiation from the whole breast radiation.

The protocol in the study specified that the radiation oncologist should not treat the axillary or supraclavicular region, but did not specify where the superior border of the breast field should be placed, and therefore whether there was any bias in the placement of this border is not clear. The details of the radiation fields were not documented in the ACOSOG data base, but this is currently being extracted to determine the degree to which level I and II nodes were covered by the chosen radiation field. Even standard tangents deliver 95% dose to at least 50%-70% of level 1 nodes and 30% to level 2. High tangents can treat 80% of level 2 nodes depending on where the radiation oncologist sets the superior border.

In post Z0011 clinical practice, Dr. Haffty would assess the risk of additional involved lymph nodes through clinical judgement and available normograms such as from Memorial Sloan Kettering Cancer Center or MD Anderson and would personally tailor radiation field to risk. It is important to note that Z0011 results do not apply to patients having partial breast radiation, or patients treated with mastectomy who will not go on to post mastectomy radiation.

Dr. C. Hudis, Medical Oncologist, Chief Breast Cancer Medicine Service, Memorial Sloan Kettering Cancer Center, reported that the landscape for Medical Oncologists

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is also changing. The historical approach to systemic adjuvant therapy depended on an anatomic distinction of whether nodes were involved and if so how many. In 1989 the National Institute of Health (NIH) consensus statement for early stage breast cancer recommended adjuvant treatment for node negative cancer greater than 1cm. The new biology of breast cancer requires a new lexicon, where predictive factors are key. For example ER/PR status is predictive in that these patients respond better to hormone treatment and HER2/neu positive tumours predict a better response to anti HER2/neu treatment. The Oncotype DX test is a predictive test. Biology is starting to replace anatomy and therefore a number of systemic decisions can be made without information from ALND.

Dr. S. Edge, Chair in Breast Oncology, Roswell Park Cancer Institute, summarized how the Z0011 data can be applied by surgeons stating that clinically node negative patients eligible for breast conserving surgery and whole breast radiation can have a sentinel node biopsy with no intraoperative pathology. Axillary dissection can be avoided if only one or two positive nodes are positive. If bulky or multiple grossly involved nodes are present, Dr. Edge would still do an axillary dissection. Routine immunohistochemical evaluation of sentinel nodes is not warranted.

Lingering questions remain:

What is a clinically node negative patient?
The clinical exam varies between examiners and varies depending on body habitus. Surgeons will need to address the use of imaging to define a clinically node negative patient. Routine axillary ultrasound is increasing in popularity, but the scenario of a positive cytology from fine needle aspiration of non palpable, ultrasound detected nodes, was not addressed in Z0011, and remains an unresolved issue.

What is the size distribution of macromets in the trial?

This information would be useful in understanding how the study is applicable to patients with grossly enlarged nodes.

What was the extent of axillary radiation given?

Dr. Edge cautioned that there is no evidence from Z0011 that the axillary nodes in the SLNB only group need additional surgery or radiation.

In conclusion, although surgeons should not extrapolate beyond the indications of the study, if the patient fits the parameters of the study it is reasonable to not do an axillary dissection.

Subsequent to this conference, in August 2011, The American Society of Breast Surgeons issued a position statement on Management of The Axilla in Patients with Invasive Breast Cancer. The document can be viewed on <https://www.breastsurgeons.org/>

CONTROVERSIES IN BREAST CANCER SURGERY (DEBATE)

1. Breast Surgery in Stage IV Breast Cancer

Pro: Dr. Seema Khan, Professor of Surgery, Northwestern University

Local therapy is considered important in Stage I, II and III breast cancer, with one life saved at 15 years for every four local recurrences prevented at five years. However for Stage IV breast cancer, because it is assumed women will die from metastases before local control becomes a problem, local therapy is generally reserved for treatment of symptoms.

Dr. Khan believes it is time for a paradigm shift. An intact tumour may serve as a continued source of metastasis, and lead to uncontrolled chest wall disease. New biologic information suggests that the primary site may enable metastatic efficiency by playing a unique role in the release of metastatically competent circulating cancer cells which, when they recirculate through the primary tumour stroma, have enhancement of their tumour initiating capacity. The primary may also be a continuous source of tumour stem cells that initiate additional metastatic sites, and may be resistant to therapy.

Regarding clinical management and surgical timing, it is hard to discern from published data if the patient benefits from surgery before or after a metastatic diagnosis as there are only three small studies and results are mixed. Women who have a biologic target for systemic therapy, for example, ER positive HER-2/neu positive, are the ones who might benefit from local therapy. A retrospective study by Dr. Khan shows the odds of symptomatic chest wall disease is lower in a surgical vs. non surgical group with some associated improved survival. Due to the limitations of retrospective studies, is it time for a randomized trial?

Dr. Khan presented the schema for the E2108 randomized trial. This study includes women with an intact primary breast cancer and metastatic disease at any site. After four months of systemic therapy, those patients who have responsive/stable distant and controlled local disease will be randomized to palliative local therapy as needed, or local surgical and radiation therapy to mirror therapy for non-metastatic cancer. An audience response question showed that 85% of the audience would randomize patients to the E2018 study.

Con: Dr. Blake Cady, Professor of Surgery, Harvard University

Dr. Cady did one of the largest retrospective studies on this subject. He concluded case selection bias in performing breast surgery in Stage IV patients explains most if not all of apparent survival advantage seen in retrospective studies based on Cancer Registry data. Registry misinterpretation and inaccuracies include misclassification as Stage IV or use of prior The American Joint Committee on Cancer (AJCC) classification codes and coding errors prior to the core biopsy era may have coded diagnostic excisional biopsies as therapeutic resections.

Therapeutic breast surgery may be appropriate in selected patients with expected longer survival (oligometastases, excellent response to systemic management, ER positive, younger age, mainly bone disease). Patients should be selected for specific clinical indications, not with the expectation it will prolong survival.

2. Margins are like money - The more the better

Pro: Dr. Melvin J. Silverstein, Clinical Professor, University of Southern California

In his personal series of 1,705 patients with DCIS treated with surgery and radiation, he noted a small incremental reduction in local recurrence with increasing margin width in spite of radiation.

Con: Dr. Michael Dixon, Professor, Edinburgh, Scotland

For invasive cancer, a meta-analysis (Houssami, 2010) of impact of surgical margin on local recurrence in early stage invasive breast cancer treated with breast

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conserving therapy (BCT) (14,571 patients, 8.7 yrs. follow up) showed 1mm is as good as wider if radiation and adequate systemic therapy are given. In a literature review to 2002 (Singletary, 2002) a 1-2mm margin is adequate. For ductal carcinoma in situ (DCIS), a literature review (Dunne, 2009) of 4,660 patients with DCIS treated with breast conserving surgery (BCS) and radiation, showed 2mm is as good as 10mm.

In addressing which margins matter, Dr. Dixon noted that in an Edinburgh study of 1,100 patients treated with breast conserving therapy (BCT) with no skin or fascia removed and no re-excision of anteroposterior (AP) margins if less than 1mm, there were very low rates of recurrence for close AP margins. The conclusion was that skin and fascia do not require routine removal.

Furthermore, margins affect cosmesis. In Dr. Dixon's Edinburgh trial the conclusion was that when more than 10% of breast volume is removed the percent of patients who have a good to excellent result decreases dramatically. There is a direct correlation of cosmesis with well being.

MANAGEMENT OF HIGH RISK LESIONS

A 2011 survey of American Society of Breast Surgeons (ASBS) (45% response rate) indicated the following percentage of surgeons recommend excision biopsy based on a core biopsy diagnosis: papilloma without atypia (63%), atypical ductal hyperplasia (ADH) (96%), atypical lobular hyperplasia (ALH) or lobular carcinoma in situ (LCIS) (75%), flat epithelial atypia (75%). While 85% may recommend Tamoxifen in selected high risk situations, only 40% prescribe it.

Dr. A Lerner presented a discussion and recommendations for these lesions. ADH should be excised if diagnosed with an automated core, if a mass lesion is present or if necrosis is present. If a vacuum assisted device is used and the ADH is confined to one to two ducts, or if the mammographically detected calcifications are more than 95% removed, he suggests observation may be chosen but requires high risk follow up since there is a 3%-4% chance a more significant lesion could be missed.

For papillomas, all with atypia need excision. When considering whether to excise papillomas without atypia, Dr. Lerner noted that atypia may be missed on a core since it may comprise only 25% of a papilloma. This must be taken into account if observation is chosen, with imaging repeated in three

months, due to the risk of missing a more significant lesion.

With radial sclerosing lesions, the overall the rate of malignancy is 17%; if atypia is present this increases to 37%, so all with atypia need excision. All those biopsied with 14 gauge core needle need excision because of potential sampling error for identifying atypia.

Dr. Tari King, surgeon at Memorial Sloan Kettering Cancer Center, discussed LCIS, noting that there is no association of LCIS in the surgical specimen or at the margin with the incidence of local recurrence in a patient treated with breast conserving treatment which includes otherwise negative margins and radiation. In discussing which patients with LCIS go on to develop breast cancer, there seems to be a relationship between Breast Imaging Reporting and Data System (BIRADS) breast density and the likelihood of developing breast cancer. Patients with pleomorphic LCIS on core need excision. Dr. King's research shows there are two distinct clusters of LCIS at the molecular level. The end goal is to classify patients with LCIS into high and low risk by gene signature.

The American Society of Breast Surgeons (ASBS) issued a Position Statement on Concordance of Image Guided Breast Biopsies and Management of Borderline or High Risk Lesions on August 15, 2011. This document can be found at: <https://www.breastsurgeons.org/>

FUTURE DIRECTIONS

Focused Ultrasound Ablation (FUSA) for Treatment of Breast Cancer Lumpectomy is the gold standard for surgical treatment of small breast cancers. It can be done as an outpatient procedure, with local anesthetic +/- sedation, with low morbidity, outstanding local control and good-to-excellent cosmesis in 90% of patients. Therefore the bar is high for treatments that may supplant it. One modality for the future is MRI guided, FUSA. It is a non-invasive, ambulatory, single session technique that does not require a temperature mapping probe. To date there are a small number of small studies. This is a technique which requires complex technology with currently very limited availability. However, nonsurgical ablative cancer therapies will become more commonplace in future. FUSA is now the subject of an FDA approved trial (David Brenin, Division of Surgical Oncology, University of Virginia).



The MRgFUSA device embedded in the MRI table (ExAblate 2000, InSightec, Ltd, Israel)

The text from this presentation as well as the other papers from the scientific oral presentations from the 12th annual meeting and the Society Presidential Address can be found in the Annals of Surgical Oncology Volume 18, number 11, October 2011 Pages 3021-3228.

DR. PASS'S BEST BREAST PAPERS OF 2010

This is an annual presentation of a series of clinically relevant and unique papers. The presentation is available online at www.clinicaloncology.com. Enter the following in the search box: "Surgeon Unveils Picks for Top Breast Cancer Papers of 2010".

UPCOMING CONFERENCES

12th Annual Breast Surgery Symposium

April 19, 2012
Toronto, ON
www.torontoaestheticmeeting.ca

BC Surgical Society Meeting

May 3-5, 2012
Whistler, BC
<http://www.bcscs.ca>

American Society of Colon & Rectal Surgeons Annual Meeting

June 2-6, 2012
San Antonio, TX
www.fascrs.org

Canadian Surgery Forum 2012

September 13-16, 2012
Calgary, AB
www.cags-accg.ca

American College of Surgeons Clinical Congress

September 30, 2012
San Francisco, CA
<http://www.facs.org>

Malignancies of the Lower GI Tract

October 20, 2012
Vancouver, BC
www.bccancer.bc.ca/son

Toronto Cancer Conference

November 22-23, 2012
Toronto, ON
<http://www.torontocancer.ca>

EXPEDITING TIMELY REFERRALS TO MEDICAL ONCOLOGY FOLLOWING RESECTION FOR PATIENTS WITH COLON CANCER

Dr. Sharlene Gill, Chair, BCCA GI Tumour Group; Dr. Hagen Kennecke, Interim Chair, BCCA GI Tumour Group; Dr. Manoj Raval, Chair, SON Colorectal Surgical Tumour Group

Increasing evidence now exists to support the importance of early initiation of adjuvant chemotherapy for patients with resected colon cancer. In a recently published meta-analysis (Biagi JAMA 2011;305 (22):2335-2342), every 4 week delay in initiation of chemotherapy resulted in a significant decrease in overall survival (HR 1.14, 95% CI 1.10-1.18) for patients with resected colorectal cancer. Best practice currently dictates a goal of starting adjuvant chemotherapy within 8 weeks of resection. Ongoing adjuvant clinical trials also mandate initiation of chemotherapy within 8 weeks for eligibility.

The BC Cancer Agency (BCCA) GI Tumour Group recently undertook a review of initiation of adjuvant chemotherapy for our patients. In 370 patients with colon cancer referred from 2008-09, the median time from surgery to adjuvant chemotherapy was 58 days with 54% of patients starting adjuvant therapy beyond the recommended 8 weeks from surgery. Indeed, delays exist at all steps in the process including time to referral following surgery (median 15 days), time to medical oncology appointment (median 21 days) and time to first chemotherapy appointment (median 20 days). While efforts are underway within the BCCA to address the delays to triage and chemo wait-times, it is acknowledged that current measures may

be restricted in their effectiveness due to increased referrals and limited medical oncology and chemotherapy unit capacity.

Hence, in an effort to best expedite patient triage for adjuvant chemotherapy, we are requesting that our surgical colleagues consider efforts to submit referrals to BCCA Medical Oncology at the earliest opportunity following resection for patients with stage II or III colon cancer. Ideally, referrals are submitted once the final pathology report is available. However, we appreciate that, in some circumstances where there are excessive delays in receiving the pathology report, a referral to BCCA medical oncology may need to be requested prior to the availability of the final pathology. While this has the potential to result in a modest increase in the number of early-stage referrals to medical oncology, the BCCA GI Tumour Group feels this would be acceptable in order to triage patients more efficiently and facilitate the optimal standard of timely care.

Questions regarding referral may be directed to the 'GI Medical Oncologist of the Day' at your respective BCCA referral centre. Thank you in advance for your continued cooperation.

DEFINING SURGICAL ONCOLOGY IN BC

To provide greater clarity as to how surgical oncology is defined in BC, the SON Council Executive has endorsed the following definition and scope for the practice of surgical oncology in the province.

A surgeon who is a fellow of the Royal College of Physicians and Surgeons of Canada (RCPSC) (primary fellowship) and has specialized knowledge and skills related to management of patients with malignant diseases.

RCPSC recognizes General Surgical Oncology and Gynaecologic Surgical Oncology as fully certified programs with examination. In other specialties, a certified fellowship training program is usually completed following the primary specialty. The fellowship program should have formalized objectives of training and preferably be endorsed by a licensing body (i.e. RCPSC) or an active subspecialty society focused in Surgical Oncology (i.e. The Society of Surgical Oncology).

Examples include:

- Neurosurgery
- Head and neck surgery
- Ocular surgery
- Thoracic surgery
- General Surgical Oncology, including Breast, Colorectal and Hepatobiliary
- Musculoskeletal surgery
- Urologic Oncology
- Reconstructive plastic surgery

It is recognized that there are individual surgeons who are committed to the scope of Surgical Oncology practice as outlined who do not have formalized fellowship training. These individuals should be recognized by their respective Regional Cancer Center and Acute Health Service Centre Hospital as having special knowledge and expertise by way of a formalized process.

Scope of Surgical Oncology

For the purposes of this definition, surgical oncology means the following clinical services in each of the surgical oncology disciplines, which include consultations, assessments, patient management to be provided through a combination of outpatient clinics surgery, inpatient care and on call availability at the Regional Cancer Centres and Acute Health Service Center Hospitals:

1. Cancer prevention.
2. Treatment of malignancy, including diagnosis, surgery, and active therapy for cure and specific symptom control.
3. Complex treatment, including diagnosis, surgery and follow-up of both benign and malignant disease

requiring the expertise of the academic Surgical Oncologist.

4. Intra-operative emergencies, including taking emergency call for their surgical discipline on a regular basis.

Academic Responsibilities for Surgical Oncologists Include:

1. Teaching oncology to undergraduate students from the Faculty of Medicine and other health disciplines.
2. Supervising the education of surgical residents and surgical oncology Fellows.
3. Participating in surgical oncology research in the areas of basic science, epidemiology, education and health policy.

Responsibilities to the Regional Cancer Centre Include:

1. Participation in multidisciplinary tumour groups.
2. Treatment protocol development.
3. Participation in continuing education projects in order to improve the outcomes of cancer surgery.

CANCER SURGERY CHECKLISTS FOR DICTATED OPERATIVE REPORTS

The Surgical Oncology Network has made cancer surgery operative report quality a priority as part of its strategic plan and is developing cancer surgery checklists (synoptic operative report templates) for use when dictating the operative report. A cancer surgery checklist is a structured, standardized list of data items with a pre-specified choice of responses that clearly and reliably records key information related to the operative procedure.

The SON has completed checklists for breast and rectal cancer surgeries and is encouraging surgeons to use these templates when dictating their operative reports. Including the list of data elements from these checklists in the dictated report will facilitate the process of patient care by ensuring the completeness and accuracy of clinical information, improving interdisciplinary communication and increasing efficiency in treatment planning.

The SON is collaborating with transcription services across BC to adopt these checklists within the transcription systems to support the dictation process. Once the templates are in the system, surgeons will be able to state the name of the template at the start of their dictation of the checklist items. This will identify to the transcriptionists that a particular OR summary is to follow. This will expedite the dictation process by enabling the surgeon to dictate the data elements as instructed on the checklist, without having to state the item heading for each number. This will speed up the process for both the surgeons and the transcriptionists.

Currently, for breast and rectal cancer surgeries, all surgeons working at Providence Health Care, Vancouver General and UBC Hospitals can dictate their operative reports using the Breast and Rectal Cancer Surgery Checklist by stating “BCSUMMARY” (for breast cancer) or “RCSUMMARY” (for rectal cancer) at the start of the dictation of this template.

It is anticipated that checklist summaries will be incorporated into all transcription services across BC. Surgeons can help to integrate the checklists into the transcription process by providing a copy of the templates to their local transcriptionist. In the meantime, all surgeons can use the checklists when dictating the operative report by simply following the instructions provided on the laminated cards and PDF documents.

The introduction of synoptic reporting for rectal cancer will significantly improve interdisciplinary communication and lead to standardization of information. Essential data required for treatment and follow up of rectal cancer is required and would be ensured within synoptic reports.

Rectal cancer represents a particularly complex management challenge involving nurses (including ostomy nurses), dietitians, gastroenterologists, surgeons, radiation and medical oncologists. It is particularly important to describe tumour location, surgical approach and outcome in a consistent and accurate manner and synoptic reporting will significantly contribute to this.

Dr. Hagen Kennecke
Medical Oncologist, BC Cancer Agency

As a Radiation Oncologist I rely on the operative report for important information to assist me in making additional treatment recommendations for patients with breast cancer. Frequently the non-synoptic reports do not contain all of the information needed, which results in telephone calls to the surgeon. Since there is often a significant amount of time elapsed since the surgery, the questions often cannot be fully answered retrospectively.

Recently we have been receiving synoptic reports from some surgeons, and I have found them to be extremely valuable. All of the information I need is contained in the report, and it results in a much more efficient and accurate consultation process.

Dr. Lorna Weir
Radiation Oncologist, BC Cancer Agency

Enclosed with this newsletter issue are laminated cards for the Breast and Rectal Cancer Surgery Checklists, along with an informational brochure that outlines the development process.

These checklists are also available as PDF documents for download on the SON website at www.bccancer.bc.ca/son

If you require extra copies of the laminated cards, please contact Fatima Cengic at fcengic@bccancer.bc.ca

A checklist-based synoptic report will reliably capture critical data as a summary in the operative report. Adding these crucial data elements will improve the process of patient care, enhance communication of important information between health care providers and increase efficiency.

Dr. Laurence Turner
Chair, Breast Surgical Tumour Group
General Surgeon, Royal Columbian Hospital

SURGICAL ONCOLOGY NETWORK NEWS

SURGICAL ONCOLOGY NETWORK LEADERSHIP

For the past four years, the Surgical Oncology Network (SON) has been chaired on an interim basis, pending the recruitment and appointment of a permanent Provincial Leader of Surgical Oncology. Dr. Paul Clarkson has been serving as the Provincial Program Leader and Network Chair since January 2010. After completing his two-year term, Dr. Clarkson stepped down from this role January 2012.

We thank Dr. Clarkson for all his work and commitment to the SON as Chair. He was instrumental in the success of a number of SON initiatives, including the collection of oncology data elements in the Surgical Patient Registry, and increasing the SON's profile as the leading advisory and resource body for surgical oncology in BC. We value his contribution and look forward to his continued involvement with the SON.

Dr. Chris Baliski, has agreed to fill the position of SON Chair on an interim basis. Dr. Baliski is a surgical oncologist in Kelowna at the Centre for the Southern Interior. He has been an active member of the SON for over six years, where he serves on the Council Executive, the Clinical Practice Committee and as Chair of the Skin Surgical Tumour Group. Dr. Baliski's areas of clinical and research interests are focused on breast, melanoma and endocrine oncology, and he also participates in these Tumour Groups.

We welcome Dr. Baliski in his new role as SON Chair and look forward to working with him in this capacity.

SURGICAL TUMOUR GROUP CHAIRS

The terms of reference for Chairs of the Surgical Tumour Groups (STG) identify the length of the initial term as three years, with the possibility of renewal for another two years. Since most STG Chairs were originally appointed at the same time in 2003, the SON has made some changes to these roles every couple of years to stagger the turnover in these positions and to allow other surgeons the opportunity to participate in this capacity.

The following STG Chairs completed their terms in 2011:

Dr. Sam Bugis, Chair, Endocrine STG
Dr. Greg McGregor, Chair, Proximal GI STG

We thank them for their commitment and contribution to the Network over the years and value their continued input.

SON welcomes the following new STG Chairs:

Dr. Sam Wiseman, Chair, Endocrine STG
Dr. Andy McFadden, Chair, Proximal GI STG

SON RESIDENT TRAVEL AWARD for BC Surgery Residents/Fellows and Medical Students

The Surgical Oncology Network Resident Travel Award is a competitive award intended to motivate physicians and medical students, early in their training, to pursue an interest in surgical oncology and to allow them to present research findings at conferences. The application must be submitted 6 weeks prior to the start of the conference. Approved applications may be funded up to a maximum of \$1000. Forms and guidelines are available online at www.bccancer.bc.ca/son

AWARD RECIPIENTS IN 2011

Dr. Elaine Lam

Meeting: Canadian Society of Surgical Oncology 17th Annual Scientific Meeting, April 29, 2011, Toronto

Poster: Thyroid Pathology Reporting at a Canadian Centre: A Critical Appraisal

Dr. Shaila Merchant

Meeting: BC Surgical Society Annual Spring Meeting, May 6, 2011, Parksville

Presentation: Is There an Association Between Timing of Referral to a Tertiary Care Centre and Local Recurrence in Primary Retroperitoneal Sarcoma in BC?

Dr. Lucas Pugh

Meeting: North Pacific Orthopaedic Society Annual Meeting, September 15-18, 2011, Portland, Oregon

Presentation: Effect of Chemotherapy and Cement Fixation on Tumour Endoprosthesis Survival

SURGICAL ONCOLOGY NETWORK NEWSLETTER

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VISIT THE SURGICAL ONCOLOGY WEBSITE

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The BC Surgical Oncology Network exists to promote and advance quality cancer surgery throughout the province, enable the integration of quality surgical oncology services into the formal cancer care system, and ensure that patients have the best possible outcomes through consistent access to high quality multidisciplinary care. To enhance appropriate, equitable and timely access to surgical services for cancer patients as close to home as possible, the Network supports communication and sharing of knowledge between subspecialty and community surgeons, their respective hospitals and the BC Cancer Agency.

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