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

BC Surgical Oncology Network

Newsletter

www.bccancer.bc.ca/son

September 2005

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In This Issue...

PROVINCIAL PET/CT PROGRAM IN ONCOLOGY

By Papinder Rehncy - Public Relations, BC Cancer Agency

This July, the BC Cancer Agency (BCCA) – together with a number of partners (the University of British Columbia; Vancouver Hospital and Health Sciences Centre; BC's Children's Hospital and Tri-University Meson Facility) – established a Centre of Excellence for Functional Cancer Imaging. Located in the Agency's Vancouver Centre, the facility includes the first publicly funded Positron Emission Tomography (PET)/CT scanner in B.C.

PET, when combined with Computed Tomography (CT), allows more accurate diagnoses, staging and management of certain cancers. PET shows functional changes at the cellular level and fusion with CT allows more precise anatomic localization of tracer uptake abnormalities.

PET/CT technologist Rebekah Bahr at the controls of the scanner. Shilpa Shah (background) prepares the scanner bed for a patient

Before undergoing the scan, patients are injected with a radiolabelled form of glucose (18F-Fluorodeoxyglucose or 18F-FDG) that accumulates in tissues which have increased glycolytic activity as occurs in many types of malignancy. Conversely, the radiotracer will not localize in non-metabolically active tissue such as benign tumours, cysts and necrotic tissue.

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NETWORK NEWS

Council

Annual Planning Workshop
The SON recently held its annual planning meeting/workshop on Saturday November 5th, 2005 (in conjunction with the BC Cancer Agency's Annual Cancer Conference). The day featured presentations by Dr. Hartley Stern, Provincial Head of Surgical Oncology, Cancer Care Ontario, and Dr. Frederick Greene, Chair, American College of Surgeons' Commission on Cancer. Approximately 35 invited delegates offered their input and opinions on where the BC Surgical Oncology Network should focus its efforts in the coming years.

Executive Membership
We are also pleased to announce that we have had a few membership changes to our Council Executive. Brian Schmidt, VP Strategic Health Development & Performance Management, will sit on the council as a representative of the Provincial Health Services Authority (PHSA). Also, Sam Wiseman, a surgical oncologist at Providence Healthcare will sit on the council as the representative from Vancouver Coastal Health Authority. Dr. Garth Warnock will continue to sit on the Executive as the representative from UBC's Department of Surgery.

Surgical Oncology Training in BC
The SON is working on a position paper regarding surgical oncology needs in BC. The paper will deal with all aspects of surgical oncology training from postgraduate to CME to formalized fellowship training. A first draft will be circulated shortly for feedback.

Survey
Recently, the SON conducted an opinion survey of all surgeons in BC. 5 prizes of $100 gift certificates were awarded to Russ Kellett, Urve Kuusk, Chih-Ho Hong, R. Dykstra and Peter K. Yeung. Initial results of the survey were presented at the annual planning workshop and will be featured in the next SON newsletter. Sincere thanks to all who took the time to participate – your input is much appreciated!

Continuing Medical Education (CME)

Travelling Road Show
The Head & Neck Travelling Road Show was in Prince George on September 30, 2005. Rona Cheifetz and Nadine Caron were our featured speakers. The only health authority we have yet to visit is VIHA and we hope to schedule that for early in the new year.

Plans are currently underway for our next road show in the area of Hepatobiliary Cancer. These seminars will be schedule throughout 2006.

The 2005 fall update, sponsored by the BC Surgical Oncology Network, the BC Surgical Society and the UBC Department of Surgery, *Surgical Problems in Proximal GI Cancer Management* will be held on November 3rd, 2005.

Clinical Practice

The SON's infrastructure survey was presented as a poster at the CAGS conference in Montreal. Next steps for this project will include disseminating the information to health administrators in the province and using the information, as appropriate, when developing practice guidelines.

Research & Outcomes Evaluation (ROE)

Colleen McGahan, the SON's biostatistician, has been working on linking our current surgical atlas data with the cancer registry data. At the November annual planning workshop, we were able to distribute personalized reports for all surgeons that show the survival of patients operated on from 1990-2000. Although this information could not be risk adjusted for stage, it is a first step in providing surgeons with personalized information on the outcome of their cancer patients.

Data Collection Pilot Project
The SON's data collection pilot project will be going to the testing stage shortly. We hope to have the project finalized and evaluated by March 31, 2006.

Surgical Tumour Groups

Breast
The guideline on stand-alone Sentinel Lymph Node Biopsy is still in the process of being finalized. This guideline will recommend circumstances in which it is safe to perform a stand-alone Sentinel Lymph Node Biopsy without an additional axillary node dissection.

By Tina Strack, Network Manager

FOR MORE INFORMATION

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THE COUNCIL & NETWORK

The BC Provincial Surgical Oncology Council exists to promote and advance quality cancer surgery throughout the province by establishing an effective Network of all surgical oncology care providers and implementing specific recommendations. The Network will enable quality surgical oncology services to be integrated with the formal cancer care system. Communications to enhance decision making,evidence-based guidelines, a high quality continuing education program, and regionally based research and outcome analyses are the initial priorities.

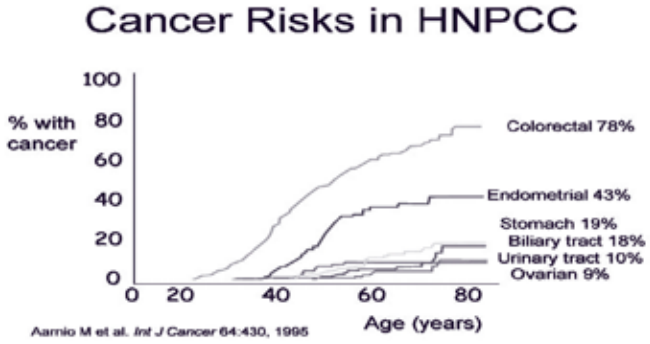

HEREDITARY NON-POLYPOSIS COLORECTAL CANCER WHAT'S NEW IN BC?

by:Karen Panabaker, MSC, CCGC, CGC *(Left)* Clinic Coordinator/Genetic Counsellor, Hereditary Cancer Program/BCCA
Sharlene Gill, MD, MPH, FRCPC *(Right)* Medical Oncologist, BCCA

Over the past 10 years, the Hereditary Cancer Program (HCP) has been providing genetic counselling and genetic testing services to women and men from families with strong histories of cancer. Such families have experienced multiple cases of cancer affecting several generations, often involving early age of onset and/or multiple primaries in the same family member. While genetic counselling and risk assessment is available for any suspected hereditary cancer syndrome, i.e. breast/ovarian cancer, colon cancer, multiple endocrine neoplasia, Von Hippel Lindau, etc., laboratory testing (mutation detection) has not been available for all of these syndromes. This has now changed for a very important hereditary cancer syndrome, known as the hereditary non-polyposis colorectal cancer syndrome or HNPCC. Genetic testing for HNPCC is now being done in the Cancer Genetics Laboratory at the BC Cancer Agency, facilitated through the genetic counselling clinic at the HCP.

HNPCC is an autosomal dominant predisposition for early onset colorectal cancer, responsible for 3-5% of all colorectal cancer. The HNPCC syndrome also carries an increased risk of developing additional malignancies such as endometrial, stomach, small bowel, ovarian, pancreas, ureter, renal pelvis, biliary tract, and brain tumours. The genetic basis is a defect in one of the DNA mismatch repair genes (mainly MLH1, MSH2, or MSH6) leading to a phenotype of microsatellite instability (MSI) which can be identified in the DNA of tumour tissue. The loss of DNA mismatch repair function may affect any of the genes involved in carcinogenesis and promotes the accumulation of mutations. Therefore, the progression of adenoma to carcinoma is accelerated in individuals with HNPCC.

Figure 1



To suspect HNPCC in a family, certain criteria have been established that help to predict the likelihood of an HNPCC predisposition. The most stringent criteria, known as Amsterdam criteria, require at least three close relatives over two generations with colorectal cancer, and at least one being diagnosed under age 50. Amsterdam criteria have the highest predictive value for identifying an HNPCC mutation (40-60%), however many HNPCC families are missed if only these criteria are used. Bethesda criteria were established in 1996 (Rodriguez-Bigas et al, JNCI 1997; 89:1758-1762) and were later revised in 2002 (Umar et al, JNCI 2004; 96:261-268), and includes patients whose tumours likely had defective mismatch repair. The likelihood of finding an HNPCC mutation in such families, however, was much reduced.

After reviewing the literature and the various testing criteria used by other Canadian HNPCC testing centres, the HCP has adopted the referral and genetic testing criteria outlined in Table 1. The modified Amsterdam criteria are essentially the same as Amsterdam criteria except that the extra-colonic manifestation of HNPCC is taken into account.

Table 1
HNPCC Referral & Genetic Testing Criteria in BC

CRITERIA	FAMILY HISTORY DETAILS
Family member with confirmed MLH1 or MSH2 mutation.	Genetic counsellor will facilitate retrieval of family member's genetic test result.
Amsterdam	3 or more relatives with colorectal cancer over two successive generations where one is a first degree relative of the other two, and at least one is diagnosed before age 50
Modified Amsterdam	3 or more relatives with an HNPCC-related cancer in two successive affected generations, where one is a first degree relative of the other two, at least one diagnosis involves colorectal cancer, and at least one diagnosis is made before age 50. [The HNPCC-related cancers include: colorectal, endometrial, small bowel, stomach, ureter, renal pelvis, hepatobiliary, ovarian, pancreas, sebaceous gland adenoma or keratoacanthomas (associated with Muir-Torre), brain tumours (i.e.glioblastoma associated with Turcot syndrome), or a history of one or more pathologically confirmed colorectal adenomas before age 40]
Other	1. Individual with colorectal cancer diagnosed before age 40 2. Individual with two or more primary HNPCC-related cancers*, with at least one diagnosed before age 50, and at least one diagnosis involving colorectal cancer 3. Two first degree relatives with an HNPCC-related cancer*, both diagnosed before age 50, and involving at least one diagnosis of colorectal cancer (*includes all cancers listed under Modified Amsterdam Criteria)

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DR. MARTIN GLEAVE NAMED BC LEADERSHIP CHAIR IN PROSTATE CANCER RESEARCH

Dr. Martin Gleave has been appointed the B.C. Leadership Chair in Prostate Cancer Research. Dr. Gleave, a native of British Columbia, is a urologist, surgeon, and Director of Clinical Research at the Prostate Centre at VGH.

This Leadership Chair will receive a total endowment of $4.5 million, cost-shared between the Leading Edge Endowment Fund and the private sector and other donors. Matching funds of $2.25 million have been committed by VGH & UBC Hospital Foundation.

The Prostate Centre's Translational Research Initiative for Accelerated Discovery and Development (PC-TRIADD) will be supported by this Chair and will apply state of the art genomic/proteomic approaches to the analysis and treatment of prostate cancer.

"PC-TRIADD will change the face of cancer treatment, not just in B.C., but world-wide," said Dr. Gleave. "Instead of using the current 'seek and destroy' approach using strong, non-specific treatments like chemotherapy and radiation therapy, doctors will be able to target the cancer cells and use very specific methods to administer cancer-killing therapies to those cells. This funding will allow the Prostate Centre to expand its capability and provide additional positions for new researchers."

The LEEF funding will leverage additional national and international funding that has contributed to the creation of Canada's largest and one of the world's top three comprehensive prostate cancer research facilities, enabling accelerated discovery, target validation, and creation of biologic-based therapeutics. It will also serve to facilitate seamless development and transfer of interventions to promote regional growth of biotechnology.

PROSTATE CANCER RESEARCH UPDATES

BC Cancer Agency Launches First-Of-Its-Kind Prostate Cancer Study In Western Canada.

Researchers at the BC Cancer Agency's Vancouver Island Centre are studying a new medical device to help provide effective radiation therapy planning for prostate cancer treatment. This study - the first of its kind in Canada - will be evaluating three-dimensional ultrasound guidance to determine if it is as accurate and better tolerated than the current technique used for pinpointing the prostate's location during treatment.

During the course of external beam radiation therapy for prostate cancer – up to eight weeks of treatment – a man's prostate gland can shift in the body, plus change in shape and size. To help identify the prostate's position, the BC Cancer Agency currently uses gold fiducial markers implanted in the prostate to identify any movement in the gland (as part of a different research study).

These markers could potentially make the radiation treatment planning more accurate in targeting the cancer, as the radiation fields can be adjusted to meet the prostate's changing position. But while the markers are safe and reliable, they require the insertion of needles, with a small risk of complications and discomfort. The BC Cancer Agency wants to determine if ultrasound is as effective and accurate in planning radiation therapy treatment as the gold markers.

Dr. Eric Berthelet, a radiation oncologist at the BC Cancer Agency, is leading the study. "We have known for more than a decade that the prostate moves during a course of radiation treatment. The insertion of gold markers to track this movement, has been studied and is currently in use in several cancer centres worldwide. We have a unique opportunity to compare the use of the gold markers to the ultrasound, as an alternative means of tracking prostate move-ment during radiation," says Dr. Berthelet. "The ultrasound has the advantage of being a non-invasive technique without risks of bleeding, infection and discomfort for our patients. Furthermore, the ultrasound technology is potentially applicable to the treatment of other types of malignancies such as cancers of the breast or the head and neck region."

The BC Cancer Agency recruited the first patient on June 15, 2005, and will be recruiting 30 patients in total for this study, all with a confirmed diagnosis of prostate cancer, and who have chosen external beam radiation therapy for their treatment. Over the course of the treatment, the ultrasound will be used to check the prostate position, and compared to the position recorded by the fiducial markers. Dr. Berthelet expects the study to take three to six months, depending on the speed of recruitment.

This is the first time this technique will be tested in Western Canada. The BC Cancer Agency is only the third cancer centre in Canada to benefit from this next-generation 3D ultrasound hardware and software system developed by Montreal-based Resonant Medical. The Vancouver Island Prostate Can-cer Research Foundation provided a grant of $100,000 to purchase the equipment.

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PROSTATE CANCER RESEARCH UPDATES

Vancouver Developed Targeted Drug-Therapy For Prostate Cancer Shows Promise

Results from Phase I Clinical Trial released in prestigious Journal of the National Cancer Institute.

Results of a Phase I prostate cancer clinical trial show that a new targeted drug significantly reduces the expression of a protein which causes tumours to become resistant to treatment. The drug, OGX-011 – a new class of smart drugs – targets cancer cells at the molecular level. OGX-011 works by sensitizing tumours that have become resistant to conventional treatment such as chemotherapy, hormone therapy and radiation therapy.

For the study, researchers from the BC Cancer Agency and the Prostate Centre at Vancouver General Hospital recruited 25 patients with localized prostate cancer (cancer contained to one site) and candidates for a prostatectomy, but who were at higher risk of their cancer relapsing. Patients received escalating doses of OGX-011 over a one-month period along with hormone therapy prior to their radical prostatectomy. At the highest dose, researchers found that clusterin expression was reduced by more than 90 per cent. Even at the highest dose the drug was well-tolerated with no severe side-effects.

"With this study, we were able to determine that OGX-011 is biologically doing what it's supposed to and at a dose that is well-tolerated by patients," says Dr. Kim N. Chi, principal investigator and medical oncologist with the BC Cancer Agency and the Prostate Centre at VGH.

Based on the strength of the Phase I clinical data, researchers at the BC Cancer Agency and the Prostate Centre at VGH are now leading Phase II clinical trials for prostate, breast and lung cancers. "We were able to identify the optimum dose of the drug in Phase I trials" says Dr. Martin Gleave, Director of Clinical Research at the Prostate Centre at VGH. "What we want to find out in Phase II trials is does this translate into a benefit for patients?" Phase II trials will be conducted in centres across Canada and the USA.

The pre-surgery study was supported through a grant from the US Department of Defense Army Medical Research and Materials Command. The study was coordinated by the Clinical Trials Group (based at Queens University) of the National Cancer Institute of Canada, which is funded by the Canadian Cancer Society. OGX-011 was discovered and patented by a team of researchers led by Dr. Martin Gleave at the Prostate Centre at VGH. OncoGenex Technologies, a Vancouver-based biotechnology company spun-out from the Prostate Centre and the University of British Columbia, has since licensed OGX-011 and is currently developing and commercializing OGX-011 with corporate partner Isis Pharmaceuticals. "The Vancouver drug development network, including leading research centres, emerging biotechnology companies, and entrepreneurs, is a model for how new knowledge and discoveries can quickly be translated from the laboratory bench to the patients' bedside," says Scott Cormack, President and CEO of OncoGenex.

In addition to Drs. Chi and Gleave, the paper's authors include Drs. Larry Goldenberg, Elizabeth Eisenhauer, Ladan Fazli, Edward Jones, Jean Powers and Dongsheng Tu.

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UPCOMING ONCOLOGY RELATED CONFERENCES

NCCN (National Comprehensive Cancer Network)
Look Into the Future of Cancer Care
March 8-12, 2006
Hollywood, FL
www.nccn.org

Canadian Society for Surgical Oncology
2006 Annual Meeting
March 23-26, 2006

Society of Surgical Oncology
Cancer Symposium
March 23-26, 2006
San Diego, California
www.surgonc.org

American College of Surgeons
34th Annual Spring Meeting
April 23-26, 2006
Dallas, TX
www.facs.org/spring_meeting/index.html

General Session Highlights:
- Current Evaluation of the Acute Abdomen
- Management of the Geriatric Surgical Patient
- Using Best Evidence to Improve the Outcomes of Your General Surgery Patients
- Suggestions for Upgrading Your General Surgery Practice

UICC World Cancer Congress 2006
Transforming Knowledge Into Action
July 8-12, 2006
Washington, DC
www.worldcancercongress.org/

2006 BC Cancer Agency Annual Cancer Conference
International Cancer Control Strategies
November 23-25, 2006
Westin Bayshore, Vancouver
www.bccancer.bc.ca

PROVINCIAL PET/CT PROGRAM IN ONCOLOGY

Continued from pg. 1

During the start-up phase of the PET/CT program, the numbers and types of patients who can be scanned will be limited. Evidence-based clinical guidelines have been established to ensure those who will benefit the most from this technology will have access to it. PET scan referrals are now being accepted for the following indications for adult oncology patients:

1. Colorectal Carcinoma

a. Determination of stage in patients with potentially resectable recurrence

2. Head and Neck Cancer (non-CNS, non-thyroid)

a. Diagnosis of primary site in patients presenting with squamous cell carcinoma metastatic to cervical lymph nodes with no obvious primary on conventional work-up

b. Staging in patients with naso-pharyngeal carcinoma and N2 or N3 nodal disease

c. Staging in patients with level IV cervical lymph node metastases

d. Diagnosis of suspected recurrence in the absence of other definitive evidence in patients being considered for salvage therapy

e. Evaluation of cervical lymph nodes in patients for whom radical neck dissection is a part of the treatment plan for advanced primary disease

3. Lymphoma

a. To plan duration of chemotherapy for patients with limited stage (IA or IIA, non-bulky) Hodgkin Lymphoma

b. To plan duration and type of treatment for limited stage (IA or IIA, non-bulky) aggressive histology (diffuse large B cell, mantle cell, peripheral T cell) lymphoma

c. Post-chemotherapy for patients with advanced stage aggressive non-Hodgkin lymphoma (includng primary mediastinal large B cell lymphoma) and Hodgkin lymphoma with residual CT abnormalities or initial bulky (bulky = 10cm or larger in any single diameter) disease to assess need for radiation therapy

4. Gynecologic Cancer

a. Staging of recurrent disease in patients being considered for pelvic exenteration

5. Testicular Carcinoma

a. Post-treatment evaluation of residual masses

6. Non-Small Cell Lung Cancer

a. Staging of patients with clinical stage I and IIA lesions

b. Staging of potentially resectable stage IIB and III disease

As clinical and operational capacities allow, the BCCA will expand access following the evidence-based recommendations of its Provincial Tumour Groups. Relevant documents including current accepted indications, referral forms, patient instructions and consent forms are available on the BCCA website under Health Professional Info at: www.bccancer.bc.ca/HPI/PET/default.htm.

Pictured at the July 25 opening of the BC Cancer Agency's new PET/CT scanner (from left to right): Colin Alden, technical manager for functional cancer imaging; Dr. Don Wilson, medical director for functional cancer imaging; the Honourable George Abbott, minister of health; Rebekah Bahr, PET technologist and Tina Alden, chief PET technologist.

This technology was made possible, in part, through a $5.1 million emerging-technology investment in PET from the Government of BC and the Provincial Health Services Authority.

For further information, please contact Don Wilson, Medical Director, BC Cancer Agency Centre of Excellence for Functional Cancer Imaging at 604.707.5979.

The Centre of Excellence for Functional Cancer Imaging is being developed in 3 phases:

Phase A:
(complete)
Acquisition and construction of the PET/CT clinical unit

Phase B:
(Estimated completion in 2007)
Acquisition and construction of a cyclotron facility and radiopharmaceutical lab, which will be used to manufacture radiopharmaceuticals for both clinical and research use.

Phase C:
(Completion date pending)
Acquisition of a research PET/CT scanner and small PET scanner that will support the BC Cancer Agency's translational research program and contribute to its world-class achievements.

HERCEPTIN FUNDED IN BC – NEW BCCA PROTOCOL

Breast cancer patients in British Columbia now have access to new drug therapy

In clinical trials, patients treated with Herceptin after completing chemotherapy had their rate of cancer recurrence reduced by more than half, as well as improved survival rates. B.C. is the first province to approve and cover the cost of the drug for all eligible breast cancer patients.

Eligible women who are currently completing chemotherapy, or who completed chemotherapy after April 1, 2005, have access to Herceptin through the BC Cancer Agency. It is expected about 160 women in B.C. can benefit from the drug each year, at an annual cost of $8 million. A course of Herceptin costs up to $50,000 per patient.

Patients who completed chemotherapy between July 1, 2004 and March 31, 2005 are being encouraged to contact their oncologist to determine whether Herceptin would be of benefit based on the clinical evidence available.

To be eligible for Herceptin, patients must test positive for HER-2, a protein that makes the cancer more aggressive and difficult to treat. Herceptin slows the growth of cancer cells that make too much HER-2, which occurs in an estimated 15 per cent of breast cancer patients.

Universal testing for HER-2 in all B.C. breast cancer specimens will be implemented as part of the Herceptin program. PHSA laboratories are able to perform this advanced genetic testing through their state-of-the-art capacity in genomics diagnostics, treatment and research.

BCCA Cancer Management Guideline for Herceptin:

Adjuvant Therapy Of High Risk HER2 Overexpressing Breast Cancer
(taken from http://www.bccancer.bc.ca/HPI/CancerManagementGuidelines/default.htm)

Eligibility:

- High risk early and locally advanced breast cancer with the invasive cancer showing overexpression of HER2
- HER-2 positive is defined as either IHC 3+ or FISH ratio of > 2 done in a central laboratory
- High risk is defined as either node positive or node negative with tumours > T1c with other features to qualify for chemotherapy with either AC-paclitaxel,AC-docetaxel, or at least four cycles of anthracycline based chemotherapy
- ECOG 0-2
- No clinically significant cardiac disease
- LVEF of > 55% after the AC portion of the chemotherapy or if being given sequentially after the completion of chemotherapy
- Adequate marrow, renal and hepatic function
- Anticipated survival of at least 5 years
- Being treated or treated within last three months for cure with adjuvant chemotherapy

Not Eligible:

Patients who are not candidates for chemotherapy and are being treated with hormonal therapy only are not candidates for Herceptin as there is no evidence at this time for the addition of Herceptin to hormonal treatment in low risk disease.

Radiation:

For patients with indications for radiation, it should be given at the usual time after the completion of the chemotherapy. Herceptin should be continued during the radiation therapy. There has been no increased toxicity reported in the clinical trials at this time, but patients should be monitored as there is no long term data yet.

Hormonal therapy:

Hormone therapy should be started in women with hormone sensitive disease after the completion of the chemotherapy and/or radiation. The choice of endocrine therapy should be based on the woman's menstrual status and risk factors. The majority of the patients in the trials received tamoxifen and there is no data that it is not effective in this setting with concurrent Herceptin.

Pregnancy and Lactation:

The safety of Herceptin in pregnancy is not fully established. As it is a large antibody it does not likely cross the placenta and has been given in pregnancy in critical situations. As per other recommendations during pregnancy, if necessary it can be given but its safety is less well studied than in non-pregnant women and if possible delivery of the baby is optimal before treatment.

Key evidence:

1. Joint Analysis of Intergroup 9831 and NSABP B31.
2. HERA first interim analysis.

Advantages to New Treatment:

1. Joint Analysis showed improved Overall Survival, Disease Free Survival.
2. HERA Analysis showed improved Disease Free Survival, Distant Disease Free Survival, Survival Data pending.

HEREDITARY NON-POLYPOSIS COLORECTAL CANCER WHAT'S NEW IN BC? Continued from pg. 3

All clinically unaffected individuals at high risk for HNPCC, as identified by a strong family history or the confirmation of a specific gene mutation, should be considered for surveillance. Fecal occult blood testing, while often recommended in the general population, is insensitive for HNPCC surveillance, particularly given the high proportion of proximal colonic cancers. Colonoscopy starting at an early age (25 years or 10 years before the age at diagnosis of the youngest affected case in the family) and completed every one to two years is the recommended colorectal cancer screening strategy in this population. After age 40, annual colonoscopy is recommended.

Evidence supporting surveillance of extracolonic HNPCC-associated cancers is lacking. Early signs of endometrial cancer should be investigated promptly. Annual endometrial biopsy beginning at age 35 may be considered. Transvaginal ultrasound and CA-125 lack sufficient sensitivity and specificity for screening purposes. Surveillance for other associated malignancies including upper GI, renal pelvis or biliary is typically not considered.

While there is no proven benefit, prophylactic colectomy or hysterectomy may be considered in appropriately selected and counselled mutation carriers. For an HNPCC-associated colon cancer, subtotal colectomy is recommended due to the high risk of metachronous cancers. Prophylactic TAH-BSO may be considered at the time of colorectal cancer surgery in mutation-positive women who have completed child-bearing. No proven chemopreventive strategy is available for HNPCC.

The HCP has genetic counselling clinics in Vancouver (Vancouver Cancer Clinic/BCCA) and Victoria (Victoria General Hospital), and provides outreach clinics to the Fraser Valley Cancer Centre, the Cancer Centre of the Southern Interior, and health units in Courtenay/Comox and Nanaimo. We are also beginning to offer genetic counselling by videoconferencing to patients in remote and rural areas, to better meet the needs of all British Columbians. For more information or to make a referral for genetic counselling and genetic testing for hereditary colon cancer (or other suspected hereditary cancer syndrome), please contact the HCP at 604-877-6000 local 2198.

RECTAL CANCER PROJECT UPDATE

Q. Is the rectal cancer project continuing?
A. Yes! This is an on-going project to assess rectal cancer outcomes in BC and provide surgeons with a means of tracking their own patients and outcomes. Please consider participating in this valuable project through submission of your cases to the database.

Q. Where can I get a copy of the current forms?
A. Forms may be obtained directly from the SON office at son@bccancer.bc.ca or by calling 604.707.5900 x3269. Forms are also available on the Surgical Oncology Network website at www.bccancer.bc.ca/SON by choosing Council and then Colorectal from the options on the left hand menu.

Q. Is my information kept confidential?
A. Absolutely. The data is tracked in a database maintained by the Surgical Oncology Network. Only the SON Network Manager and Program Assistant have access to the information. When personalized reports are produced, these are sealed in an envelope and mailed directly to each surgeon. No one else sees this information.

Q. How are you tracking follow up data?
A. You may submit follow up forms for any of your patients. However, we will automatically send the form to your office at scheduled intervals.

Q. If I am no longer following up with my patient, what should I do?
A. The follow up form provides a space for you to note who will be following up with each patient. If this is not you, please note the name of the physician that we can contact to collect longer term follow up data.

Q. Who can I contact for more information?
A. Please contact Terry Phang (tphang@providencehealth.bc.ca or 604.806.8025) or Tina Strack (tstrack@bccancer.bc.ca or 604.707.5900 x2410) for more information.

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