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

# BC Surgical Oncology Network

## Newsletter

www.bccancer.bc.ca/son

Spring 2007

**SURGICAL ONCOLOGY NETWORK**

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## *In This Issue...*



## PROFILE OF A SURGICAL TUMOUR GROUP: ENDOCRINE

Dr. Sam Bugis, General Surgeon at St. Paul's Hospital and Chair of the Endocrine Surgical Tumour Group

*The Endocrine Surgical Tumour Group is one of 13 tumour site groups the Surgical Oncology Council and Network established to focus on specific areas of cancer treatment. This is the second in a series profiling the initiatives and plans of these groups. The Colorectal Group was featured in the previous issue.*

Surgeons who specialize in endocrine oncology follow in the footsteps of surgery's historical giants. In the early 19th Century, Theodor Billroth courageously published his results of 20 thyroidectomies with a mortality rate of 40%. As advances in anaesthesia and hemostasis took hold, the mortality rate fell to 8%. Theodor Kocher is the surgeon who established the safety and effectiveness of surgical treatment for thyroid diseases with mortality rates of 0.2%.

Today, the relatively new subspecialty of endocrine surgery encompasses thyroid, parathyroid and adrenal surgery as well as management of endocrine tumors of the pancreas and gut. General Surgeons, Otolaryngologists, Urologists, Oncologists, Internists and Geneticists are all involved.

Continued on Pg. 3

## Surgical Oncology Network Fall Update

### *Mark Your Calendars*

The Surgical Oncology Network will be holding it's **Annual Fall Update Saturday October 27, 2007** at the Fairmont Waterfront Hotel in Vancouver.

The topic this year will be **Endocrine Surgical Oncology.**

A special room rate at the Fairmont Waterfront Hotel of $249 per night is available for conference participants. To take advantage of this special rate, **rooms must be booked by September 21, 2007**. Please call (604) 961-1191 to reserve and mention the Surgical Oncology Network Conference.

More information will be available soon at: www.bccancer.bc.ca/SON or contact Denise DesLauriers, Program Assistant, SON at:
Tel: (604) 707-5900 Ext. 3269 Email: ddeslauriers@bccancer.bc.ca

# TWO NEW COUNCIL EXECUTIVE MEMBERS APPOINTED

Dr. Michelle Sutter, General Surgeon from Prince George, is a new member of the Surgical Oncology Council Executive.

Dr. Nadine Caron, General and Endocrine Surgeon from Prince George, joins the Surgical Oncology Council Executive and the Endocrine Surgical Tumour Group.

Drs. Michelle Sutter and Nadine Caron, representing the Northern Health Authority, joined the Surgical Oncology Council Executive earlier this year. They will be sharing the role formerly held by Dr. Gilbert Wankling. Both are surgeons at Prince George Regional Hospital and will take part in leading the initiatives of the Council to advance quality cancer surgery throughout the province.

Dr. Michelle Sutter views the Council and Network as important developments in the province's surgical system: "This organization enables community surgeons to have input into what was a previously academic environment. My role is to maintain that community perspective."

Originally from Vancouver, Dr. Sutter completed medical school at the University of British Columbia and interned at Regina General Hospital in Saskatchewan. She spent a year working in New Zealand then completed her surgical residency at UBC. Her full-time general surgery practice includes a strong focus on breast disease and a teaching role with medical students, family practice and surgery residents. Dr. Sutter is also past president of the BC Society of Specialists (2001/02).

Dr. Nadine Caron is looking forward to contributing to the efforts of the the Council Executive, the Endocrine Surgical Tumour Group, and the Research and Outcomes Evaluation Committee. She is particularly interested in encouraging research projects that enhance cancer care in rural and remote communities, and which improve treatment and access to care for aboriginals with the unfortunate diagnosis of malignancies. "The care and treatment we provide for cancer patients in British Columbia overall is excellent," she noted. "But like the rest of Canada, we face challenges in providing that same level of care in remote and Northern communities. It is important that we look at these groups individually with regard to care and research and ensure that they meet the standards established for the whole. The BC Cancer Agency provides excellent support for the projects I am getting underway."

Prior to establishing her practice in Prince George, Dr. Caron completed an endocrine surgery fellowship at the University of California in San Francisco. Originally from Kamloops, she completed her undergraduate studies at Simon Fraser University, and medical school at the University of British Columbia. She also received a Master's degree in Public Health from Harvard University.

Dr. Caron encourages surgeons throughout BC to be proactive in their approach to care enhancement and research questions: "The BC Cancer Agency, especially the Surgical Oncology Network, is a dynamic and open organization keen to receive suggestions and ideas on how we can continue to improve on the excellent cancer care provided in BC."

## *Resident Travel Award For BC Surgery Residents & Fellows*

The BC Surgical Oncology Network Resident Travel Award is a competitive award intended to motivate physicians, early in their training, to pursue an interest in surgical oncology and to allow them to present research findings at conferences. There is no predetermined number of awards each year. The SON Council Executive will grant awards based on availability of funding. Approved applications may be funded in whole or in part up to a maximum of $1000. The total annual funding for all awards will not exceed $5000 annually.

For more information please contact:
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### 2006/2007 Award Recipients:

**Dr. Adrienne Melck**
*Conference*
Society of Surgical Oncology
March 15-18, 2007
Washington, DC

*Topic*
Evaluation of Cell Cycle Regulators in 205 Thyroid Lesions Reveals the Diagnostic Utility of p16, p21, cyclin D1 and cyclin E

**Dr. John Boutros**
*Conference*
Pacific Coast Surgical Association
February 17-20, 2007
Kohala Coast, HI

*Topic*
Defining the Role of Minimally Invasive Surgery in the Treatment of Neuroblastoma

# PROFILE OF A SURGICAL TUMOUR GROUP: ENDOCRINE Continued from Pg. 1

The challenge facing the Endocrine Surgical Tumor Group is to match the patients with the expertise and experience that is available. It is also our goal to maximize the teaching and research opportunities that these fascinating patients present.

Members of the Endocrine Surgical Tumor Group have successfully begun this work by participating in the endocrine surgery lecture series sponsored by the Surgical Oncology Network. These lectures took place in Vancouver, Kelowna, Prince George, Victoria, and Surrey. They were done in collaboration with local surgical and medical specialists. The lecture series was Royal College accredited for a Group One learning activity and the presentations are posted on the BC Cancer Agency website.

The endocrine surgical experience in the province has been on display at various national and international meetings. The subjects have included thyroid surgery, parathyroid surgery, MIS adrenal surgery, and molecular biology of thyroid cancer to name a few. These have been presented at such meetings as the Canadian Association of General Surgeons, the North Pacific Surgical Association, SAGES, and the Society of Surgical Oncology.

There are a number of initiatives underway that will hopefully consolidate and document the clinical, research, and academic activities of British Columbia's endocrine surgical experience. We have begun drafting standardized operative reports and pathology reports that will allow us to gather the who, what, when and where of endocrine surgery around the province. Having identified the surgeons interested in this field of surgery, we will include them in our future initiatives and also be in a better position to measure our outcomes.

Currently, the BC Cancer Agency provides a valuable multidisciplinary discussion about patients with thyroid cancer. Expanding this to include diseases of the adrenal, pancreas, and parathyroid would form a true endocrine oncology forum.

Fellowships in endocrine surgery are becoming increasingly popular and also standardized. There are now 12 such fellowships in a match coordinated through the American Association of Endocrine Surgeons. We would like to add our name to the list and hope to be able to offer this fellowship training in the near future.

From a research perspective, Dr. Sam Wiseman (Surgical Oncology Council Executive member as the Vancouver Coastal Health Authority representative) has a special interest in the molecular biology of thyroid cancer as well as many other aspects of surgical oncology. His research has been outstandingly successful and presented at numerous national and international meetings. We look forward to taking advantage of the link that he provides between the bench and clinical settings.

Endocrine Surgical Tumor Group Membership:

Dr. Sam Bugis, Chair
Dr. Chris Baliski, Kelowna General Hospital
Dr. Nadine Caron, Prince George Regional Hospital
Dr. Rob Irvine, St. Paul's Hospital
Dr. Sam Wiseman, St. Paul's Hospital

We look forward to working with and receiving input from all of our colleagues around British Columbia. For more information please contact Dr. Sam Bugis by email at: sbugis@providencehealth.bc.ca.

## Clinical Trial - Breast Cancer Prevention Study

The BC Cancer Agency is enrolling postmenopausal women at increased risk of breast cancer in a new clinical trial that is evaluating the role of an aromatase inhibitor, the drug exemestane (Aromasin) in the prevention of the disease. Coordinated by the National Cancer Institute of Canada Clinical Trials Group (NCIC CTG), the ExCel research study will follow more than 4,500 women from Canada, the United States and Spain, over a five-year period.

This study is open at the Vancouver Cancer Centre and at the Cancer Centre of the Southern Interior and is open to women who have an increased risk based on their age, family history, and a number of factors including age at first menstrual period and age at time of first child's birth.

Exemestane is a member of a class of drugs called aromatase inhibitors currently being used to treat breast cancer recurrence in women around the world. Results from a study published in a March 2004 issue of the New England Journal of Medicine demonstrated that exemestane was able to prevent the occurrence of new cancers in the opposite breast of women who have already had breast cancer, suggesting that it may prevent the disease in healthy women. Although we know that diet and exercise may be helpful in preventing breast cancer, this study will add to our knowledge by looking at an aromatase inhibitor.

For more information about the ExCel research study, please contact Zahra Lalani at 604-877-6000 x2199 in Vancouver or 250-712-3900 x7047 in Kelowna or visit the website at: www.excelstudy.com.

## SON Founding Co-Chair Steps Down

On January 26, 2007, the Surgical Oncology Network held its 2006 Annual Council Meeting at the Fairmont Waterfront Hotel. This year marked the fifth year since the Network was established and it marked the final year for founding Co-Chair, Dr. Con Rusnak. Dr. Rusnak was honoured with a presentation by Dr. Simon Sutcliffe, President, BC Cancer Agency, at the annual meeting.

The Network has greatly benefited from Dr. Rusnak's contribution and vision over the years. We are fortunate to have his continued input as we transition into 2007.

### Council

In 2006 several Council Executive Members and Surgical Tumour Groups Chairs completed their terms:

- Dr. Gil Wankling, Northern Health Authority Representative on the Council Executive
- Dr. Adrian Lee, Chair of the Skin Surgical Tumour Group
- Dr. Elissa McMurtrie, Chair of the Gynaecology Surgical Tumour Group
- Dr. Gary Steinhoff, Chair of the Urology Surgical Tumour Group

We thank them for their contribution to the Network.

New representatives joined the Council:

- Dr. Chris Baliski, as the Interior Health Authority Representative on the Council Executive and Chair of Skin Surgical Tumour Group
- Dr. Mark Heywood, as Chair of the Gynaecology Surgical Tumour Group

As of January 2007, the Council welcomes:

- Dr. Nadine Caron and Dr. Michelle Sutter as the Co-Representatives of the Northern Health Authority
- Dr. Alan So as Chair of the Urology Surgical Tumour Group

### Continuing Professional Development and Knowledge Transfer Committee

Effective January 2007, the Communications and Continuing Medical Education Committees merged to form the new Continuing Professional Development and Knowledge Transfer (CPD-KT) Committee.

Dr. Rona Cheifetz Chairs the CPD-KT Committee. The Co-Editors of the Newsletter continue to be Dr. Blair Rudston-Brown and Dr. Cheifetz.

Three surgeons joined the CPD-KT Committee:

- Dr. Jason Francouer from Peace Arch Hospital
- Dr. Elaine McKevitt from St. Paul's Hospital
- Dr. Nathan Schneidereit from Nanaimo Regional General Hospital

### Research and Outcomes Evaluation Committee

Colleen McGahan, Biostatistician for the Network has taken on the role as coordinator of the Committee.

Other new Committee members include:

- Dr. Carl Brown, Colorectal and General Surgeon, St. Paul's Hospital
- Dr. Nadine Caron, General Surgeon, Prince George Regional Hospital
- Dr. Sam Wiseman, General Surgeon, St. Paul's Hospital
- David Gavin, Director of Data Integration, BC Cancer Agency
- Dr. Andrew Gemino, Assistant Professor, Faculty of Business Administration, Simon Fraser University
- Paul Mak, Programmer, SON, BC Cancer Agency

### Surgical Oncology Network Physician Database

To support a more strategic approach to implementing Network activities, a Surgical Oncology Network Physician Database is being developed. The database will allow the Network to better target surgeons for mailings, CPD-KT events, and identify speakers and mentors for particular events and educational initiatives. Once the database is established, the Network will provide individual data reports for each surgeon to review, correct and complete any missing information. The database will be updated annually or as new information becomes available.

## SON Fall Update 2008

The Surgical Oncology Network Rectal Cancer Initiative with the cooperation of BC general surgeons has standardized the approach to rectal cancer management in BC. However, our recent province-wide data suggest that there are still important aspects of rectal cancer care that are suboptimal, especially our surgical techniques for cancer in the distal rectum. Thus, we plan on a follow up course on rectal cancer treatment. We are asking your help to design this update course on rectal cancer by completing the survey enclosed with this Newsletter

A copy of the survey will also be available at www.bccancer.bc.ca/SON

For background information on the SON Rectal Cancer Initiative, a presentation by Dr. Terry Phang; "*The Evolution of Programmatic Multidisciplinary Rectal Cancer Management in BC"* is available for viewing at: http://www.surgery.ubc.ca/presentarch/TPhang/TPhang.html

If you would like more information, please contact Denise DesLauriers at:
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# THE SURGICAL ONCOLOGY NETWORK HAS A NEW LEADERSHIP STRUCTURE

At the Council Executive meeting on March 9, 2007, a new leadership structure was approved. The changes were circulated to the Council for review and comments prior to approval by the Council Executive.

A call for nominations had been issued to the Council in February to identify a new Co-Chair, following Dr. Con Rusnak's announcement that he was stepping down after completing a five year term. Few responses were received and the question was raised as to why the Network needed two Co-Chairs. The Co-Chair model was implemented during the development of the Network to ensure buy-in from community surgeons, by having a general surgeon and someone outside the Vancouver region involved in the leadership. Now that the Network has been operating for five years, the community is actively engaged around the province.

The new leadership model introduces a new corporate structure which has one Chair and three Vice-Chairs – the Chairs of the three Network Committees: Continuing Professional Development & Knowledge Transfer, Research & Outcomes Evaluation and Clinical Practice. The Chair is the Provincial Program Leader of Surgical Oncology at the BC Cancer Agency.

The Provincial Program Leader is the designated Chair for the following reasons:

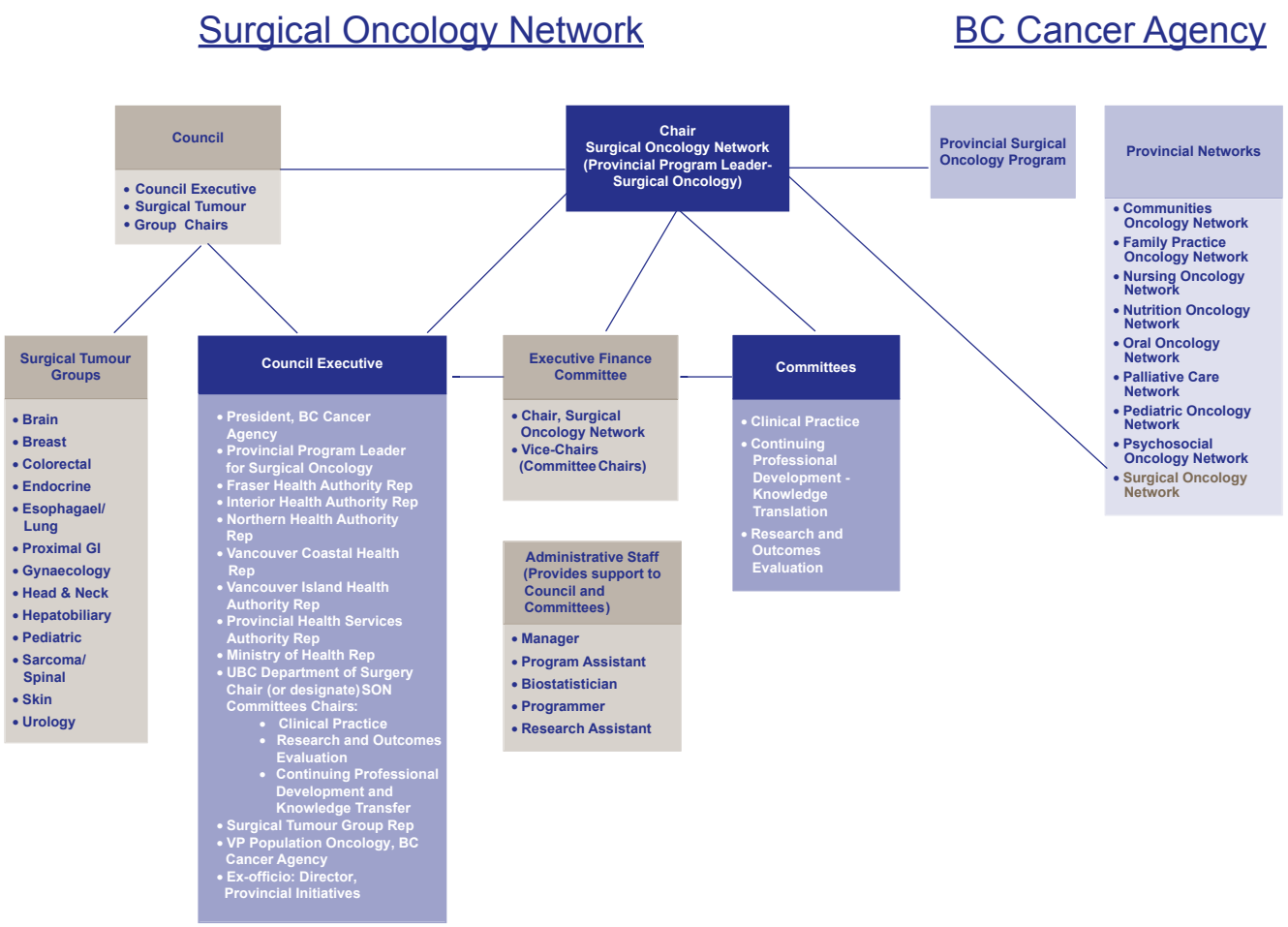
1. The Network is an initiative of the BC Cancer Agency and is funded by the Agency's operating budget. Because the Network is embedded within the BC Cancer Agency, it is critical that the Chair be directly linked with, and accountable to, the Agency.

2. The Agency's strategic plan includes expanding the Surgical Oncology Program, which is under the leadership of the Provincial Program Leader. The Network is an integral part of this process.

3. The administration and infrastructure of the Network is located at the BC Cancer Agency.

The Chair and Vice-Chairs will also form a new Executive Finance Committee, a sub-committee of the Council Executive. The planning of activities within the operating budget will be under the direction of the Executive Finance Committee. Funds will be allocated to the three Committees based on the planned activities for the year.

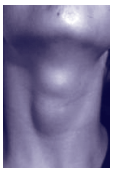
As all activities are now channelled through the Committees, the Vice-Chairs will have active involvement in the decision making around Network initiatives and will work collectively with the Chair on Network planning.



# INVESTIGATION AND MANAGEMENT OF THE SOLITARY THYROID NODULE

*By Dr. Sam Bugis, Chair of the Endocrine Surgical Tumour Group*

Palpable solitary thyroid nodules occur in up to 5% of the general population and about 5% are malignant. The goal of management is to identify those with cancer while minimizing the number of operations for benign disease. This article will review the risk factors for malignancy, the options for imaging and biopsy, the management of the thyroid incidentaloma and the principles of surgical treatment.



*Clinical photograph of a solitary thyroid nodule*

## History and Physical Exam

Most patients with solitary thyroid nodules are clinically euthyroid (confirmed by a serum TSH) and asymptomatic. Large nodules may present with compressive symptoms in the neck, whether solitary or part of a multinodular goiter. Malignancy is suggested by sudden growth, hoarseness, a hard fixed mass or associated lymphadenopathy. Male sex, age less than 20 years and greater than 60 years are factors that also increase the chance that a solitary nodule is malignant.

Family history is crucial to the risk assessment. Medullary thyroid cancer (5-10% of all thyroid cancers), is inherited about 25% of the time, either alone or as part of the multiple endocrine neoplasia syndromes. Only 5% of papillary and follicular cancers are inherited. These familial non-medullary thyroid cancers are more aggressive than the non-familial forms, are more likely to spread to lymph nodes and are almost always papillary (Hurthle cell cancer is rarely seen). When a patient has three first-degree relatives with well-differentiated thyroid cancer, there is a 99% chance of this being familial. Other inherited conditions such as Gardner's syndrome and Cowden's disease also increase the risk of thyroid cancer.

Head and neck radiation is a risk factor for thyroid malignancy including low dose radiation for benign conditions in childhood. These patients are at risk for both benign and malignant nodules of the thyroid up to 40 years after exposure. Adolescents radiated for Hodgkin's disease also may be at increased risk for benign and malignant disorders of the thyroid and for hyperthyroidism later in life. A large population based study of patients radiated for breast cancers showed no increased risk for thyroid malignancy. Malignant nodules are generally impossible to differentiate from their benign counterparts on physical examination. Lymphadenopathy, vocal cord paralysis or a fixed mass are rare but important findings suggesting malignancy.

## Fine Needle Biopsy

Fine needle aspiration biopsy remains the mainstay of investigation for patients with a thyroid nodule. This can be done as an office procedure, though there is evidence that ultrasound-guided biopsy, even for palpable nodules, may increase accuracy or at least decrease non-diagnostic specimens.

Benign cytology that is consistent with the clinical picture can be followed. Papillary thyroid cancer diagnosed by a needle biopsy should undergo appropriate surgical management. Mixed and solid cystic masses have about the same risk of malignancy as solid lesions. Pure cystic masses are quite rare, occurring less than 5% of the time. If they recur after two or three aspirations, then surgical excision is usually recommended. Non-diagnostic fine needle biopsy should be repeated. A nodule with repeated non-diagnostic cytology may require surgical excision.

The pitfall in fine needle aspiration biopsy of thyroid nodules remains the follicular lesion. Cytology cannot diagnose vascular and capsular invasion that are required to diagnose follicular carcinoma. Surgical excision is recommended for this lesion.

## Imaging

Ultrasound can identify nodules as small as 2-3 mm in diameter. Indeed, one or more thyroid nodules are identified by ultrasound in one half to two thirds of the general population. In a patient with a clinically palpable solitary nodule, ultrasound will identify multiple nodules almost half the time. The presence of multiple nodules does not appreciably reduce the risk of malignancy in the index nodule. The ability of ultrasound alone to diagnose thyroid malignancy remains controversial. There are a number of imaging characteristics that have been associated with an increased risk of thyroid malignancy, including hypoechogenicity, irregular margins, micro calcifications, intranodular vascularity and spherical shape. In most cases, a fine needle aspiration biopsy is still required before management decisions can be made.

Ultrasound examination is responsible for most thyroid incidentalomas. Most are non-palpable and small, usually less than 1.5 cm. By convention, nodules greater than 1.5 cm are recommended for ultrasound-guided biopsy. Nodules between 8 mm and 1.5 cm are recommended for image-guided biopsy when they are hypoechoic and one or more suspicious imaging characteristic is also present or when clinical risk factors are present.

Since ultrasound is so sensitive and so available, we are now faced with a barrage of subcentimetric nodules that generate both anxiety for the patient and significant costs to the health care system. Therefore, it is important to have proper guidelines for its use. These include: 1. assessing the nature and size of the index nodule, 2. baseline pre-operative assessment of the remaining gland, 3. monitoring the size of a nodule being followed non-operatively, 4. assessing and monitoring the thyroid gland in a patient with a history of radiation to the head or neck, 5. guiding fine needle biopsy.

Incidentally identified nodules in the thyroid found by PET scanning have an incidence of malignancy of almost 50%. These nodules should be aggressively investigated and there should be a relatively low threshold for surgical excision.

Nuclear medicine scanning of thyroid nodules no longer has a role in the routine investigation of thyroid nodules. Since about 80% of thyroid nodules are cold and only 10-20% of those are malignancies, it has been supplanted by history, physical examination and fine needle biopsy. In the rare circumstance where a patient has a suppressed TSH suggesting subclinical hyperthyroidism, a nuclear medicine scan may identify a hot nodule with suppression of the remaining gland. Management decisions can then be made accordingly.

*Not an "Incidentaloma"*

### Follow up of the Solitary Thyroid Nodule

When a nodule is diagnosed as benign, follow up must be advised. Since there is a low false negative of fine needle biopsy, cytologically benign, palpable nodules should be re-assessed clinically in 6 – 18 months. Fine needle biopsy, with or without ultrasound, is recommended for significant nodule enlargement, though "significant" is not very well defined. Non-palpable nodules can be followed with ultrasound using the same guidelines.

Levothyroxine suppressive therapy has been used for diagnosis and management of solitary thyroid nodules for many years – a shrinking nodule thought to represent a benign mass. Though meta–analysis has shown a trend for decrease in the size of the lesion in patients on suppression, there are also risks related to osteoporosis and arrhythmia that make this strategy unpopular at present.

### Surgical Management of the Solitary Thyroid Nodule

When a pre-operative diagnosis of malignancy has been made, total thyroidectomy can be recommended for most patients based on the fine needle biopsy diagnosis. Patients with compressive symptoms or cosmetic concerns should be treated with an operation that deals with their thyroid abnormality.

*Pathology specimen of a solitary nodule due to papillary cancer*

The largest group of patients undergoing surgical treatment will have either inconclusive or suspicious pre-operative findings. Most of these are follicular lesions and most are benign. Lobectomy is the recommended treatment. Frozen section is not generally helpful in this situation. In the 10-15% of follicular lesions that are diagnosed as malignancy (usually follicular variant of papillary cancer or follicular cancer), a completion lobectomy can be performed with about the same risk as the original operation if the contralateral side was not disturbed at that first procedure.

When the cytologic features strongly suggest papillary cancer but the pathologist cannot be definitive, frozen section may confirm the disease and allow the appropriate procedure to be done at one sitting.

In the rare instance of lymphoma or anaplastic carcinoma of the thyroid gland, open incisional biopsy may be necessary.

### Summary

Solitary thyroid nodules are commonly encountered in clinical practice. It is incumbent upon the surgeon to recognize the risk factors for malignancy and utilize imaging and fine needle biopsy appropriately. Follow up of benign nodules (the vast majority) is required and consists of physical examination, ultrasound where necessary and judicious use of repeat biopsy, often with image guidance. For patients that require surgery, the extent of the operation should be tailored to the diagnosis or suspected diagnosis, with lobectomy being the least procedure that is performed.

References Available Upon Request

## UPCOMING CONFERENCES

**Canadian Association of General Surgeons (CAGS)**
September 6-9, 2007
2007 Canadian Surgery Forum
Toronto, ON
The Fairmont Royal York, Toronto
Website: www.cags-accg.ca

**Royal College of Physicians and Surgeons**
September 27-29, 2007
Winnipeg, MB
Website: www.medical.org

**North Pacific Surgical Association**
November 9-10, 2007
Victoria, BC
Website: www.nopacsurg.org

**BC Cancer Agency Annual Cancer Conference**
November 29 - December 1, 2007
Vancouver, BC
Westin Bayshore Vancouver
Website: www.bccancer.bc.ca

**Pacific Coast Surgical Society**
February 15-18, 2008
San Diego, CA
Hotel Del Coronado
Website: pac-coast-surg.org

## *New Features for the SON Newsletter*

Two new recurring sections have been added.

The first is a ***Letter to the Editor*** section where you will be able to provide feedback and ask questions.

The second section is on ***Articles of Interest*** which will include a review or synopsis of, and reference to, the article.

If you would like to submit a letter to the editor or if you have read an interesting article for which you would like to submit a review, please send it to:
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Vancouver, BC V5Z 4E6
or by e-mail to
ddeslauriers@bccancer.bc.ca

# ARTICLES OF INTEREST

Tejirian E, DiFronzo LA, Haigh PI. **Antibiotic Prophylaxis for Preventing Wound Infection after Breast Surgery: A Systematic Review and Metaanalysis**. Journal of the American College of Surgeons. 2006. 203 (5): 729-734.

*Reviewed by Dr. Rona Cheifetz*

This review of the literature identified five randomized, controlled, double-blind trials in the past 10 years that addressed this issue. When combined, there was a relative risk of 0.6 favoring antibiotics with a statistically significant 95% confidence interval of 0.45-0.81. The number needed to treat to prevent one infection was 17. There was no significant increase in adverse events between the antibiotic and placebo groups.

While generally breast surgery is considered a clean operation with a theoretical wound infection rate of about 1%, there is evidence that the infection rates are higher, particularly with redo surgery (margin re-excisions, completion mastectomy, etc). Furthermore, infections result in poor cosmetic outcomes in breast conservation and can significantly delay adjuvant therapy. With such a small number to treat, a single pre-operative dose of antibiotics is clearly cost-effective and should be the standard of care for these patients.

## ATTENTION ALL GENERAL AND VASCULAR SURGEONS:

If you are involved in the placement of Portacaths or other indwelling devices for venous access for chemotherapy in breast cancer patients, please ensure that the port is ***not*** placed on the involved side as there are some risks associated with radiating the port.

Sippel, RS, Caron NR, Clark OH. **An Evidence-based Approach to Familial Nonmedullary Thyroid Cancer: Screening, Clinical Management, and Follow-up.** World Journal of Surgery. 2007: 31 (5); 924-933.

*Reviewed by Dr. Nadine Caron*

This article is an evidence-based approach to the screening, treatment and follow-up of patients with familial non-medullary thyroid cancer (FNMTC), based on an overview of the English language literature. FNMTC is defined as the occurrence of non-medullary thyroid cancer in two or more first-degree relatives, in the absence of other known associated syndromes. It accounts for approximately 5% of well-differentiated thyroid cancers and has been shown to have an earlier age of onset, higher multifocality rate, to be more aggressive and to have a worse prognosis than sporadic non-medullary thyroid cancer. The mode of inheritance is not known.

The authors address critical questions regarding the screening, management, and follow-up of these patients, and make recommendations based on the level of available evidence. For patients at risk, they recommend screening onset 5-10 years before the youngest age of diagnosis (and usually by age 20), cervical ultrasound as a screening tool and liberal use of total thyroidectomy in the presence of thyroid nodules (because of the high false negative rate for FNA in these patients). They recommend complete central neck dissections even for small cancers in this population, because of the high risk of nodal involvement and high local recurrence rate. For the same reasons, radioactive iodine ablation and TSH suppression is recommended for all patients with confirmed cancers, post-thyroidectomy. Rigorous follow-up is recommended even for apparent 'low-risk' disease in this population.

While these recommendations are not based on randomized studies, the article provides an excellent overview of the literature, and a sound rational for the recommendations made.

### FOR MORE INFORMATION

This newsletter is published three times a year. To submit story ideas or for any other information please contact:

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**VISIT THE SURGICAL ONCOLOGY WEBSITE**

www.bccancer.bc.ca/son

### 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 decisionmaking, evidence-based guidelines, a high quality continuing education program, and regionally based research and outcome analyses are the initial priorities.

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