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

BC Surgical Oncology Network

Newsletter

www.bccancer.bc.ca/son

September 2006

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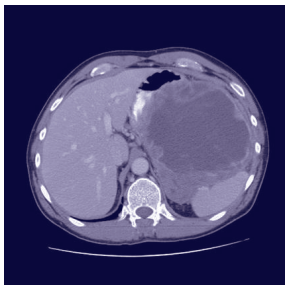
In This Issue...

Weird and Wonderful Tumours of the GI Tract

by: R. Cheifetz, MD Med CCFP FRCSC FACS

In December 2005, as part of our annual fall update we presented a panel discussion on unusual tumours of the gastrointestine, including GI stromal tumours, carcinoids and lymphomas. The following article is a synopsis of the key points presented during that session. The case presentations and slides from the conference can be viewed on the CME section of the SON Website: http://www.bccancer.bc.ca/HPI/SON/CME/GIconf.htm

GI Stromal tumour



Pre-operative CT image of Gastric GIST

GI stromal tumours are mesenchymal tumours originating from the interstitial cells of Cajal. They account for only 0.2% of all GI tumours but 80% of GI sarcomas. They occur most commonly in the stomach (60%) and small intestine (30%).

As GISTs arise from within the wall of the organ, endoscopic biopsies are typically non-diagnostic. The need for preoperative tissue diagnosis is controversial. Image guided core biopsy of lesions in the retroperitoneum is valuable to exclude a sarcoma or if neo-adjuvant therapy is being considered. Transperitoneal biopsy of intra-abdominal lesions should probably be avoided because of the risk of tumour spillage. Fine needle aspiration is not adequate for diagnostic purposes.

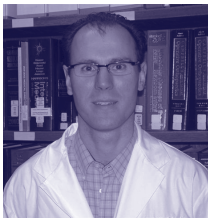
Surgery is the primary modality of therapy for these tumours. They should be handled carefully as they are very friable and easily disrupted. Intraoperative tumour spillage is associated with an extremely high risk of diffuse intraperitonal recurrence. A clear resection margin should be obtained on the organ of origin. These tumours often push away other organs and despite their large size on imaging they can often be resected without removing adjacent organs, but if the mass is adherent an en bloc resection is required. Resection does not require lymphadenectomy as nodal metastases are rare, with spread occurring either locally in the peritoneum or as hematogenous metastases to the liver.

Con't on Pg. 6

TWO NEW MEMBERS APPOINTED TO COUNCIL

Dr. Sam Wiseman, Surgical Oncologist and General Surgeon at St. Paul's Hospital and consultant to the BCCA's Surgical Oncology Program.

Photo by Brian Smith



Dr. Chris Baliski, Surgical Oncologist at Kelowna General Hospital

Drs. Sam Wiseman and Chris Baliski are the newest members of the BC Surgical Oncology Council appointed this past May. They join the existing members in leading the initiatives of the BC Surgical Oncology Network to promote and advance quality cancer surgery throughout the province.

Dr. Sam Wiseman is a Surgical Oncologist and General Surgeon at St. Paul's Hospital and an Assistant Professor of Surgery at the University of British Columbia. He is also a consultant to the BC Cancer Agency's Surgical Oncology Program.

"I see the Network as a tremendous resource – enhancing the quality of surgical oncology care in the province by disseminating standards of care and guidelines for the management of all cancers, providing useful tools to surgeons in the community and presenting forums that enable communication between surgeons."

A key focus for Dr. Wiseman is translational research – the application of clinical expertise to laboratory research and vice-versa. In fact, he established the St. Paul's Surgical Oncology Translational Research Program and is the first Surgeon/Scientist to receive the Michael Smith Scholar Award, a prestigious scholarship from the Michael Smith Foundation for Health Research. The award supports his translational research investigating molecular, diagnostic and prognostic markers and targets for therapy of breast, thyroid and colorectal cancers.

"I see the Network as a tremendous resource – enhancing the quality of surgical oncology care in the province"

Dr. Sam Wiseman

Dr. Wiseman is also collaborating on multiple site research projects involving the BCCA, Vancouver General Hospital, St. Paul's Hospital, BC Children's Hospital and the University of British Columbia and anticipates developing further collaborative efforts through the Network.

A graduate of the Roswell Park Cancer Institute in Buffalo, New York, Dr. Wiseman completed Head and Neck Surgery, Surgical Oncology, and Research fellowship training programs. His undergraduate studies, medical school and general residency took place at the University of Manitoba in Winnipeg where he hails from originally.

Dr. Wiseman's research program has been recognized locally, nationally, and internationally and he hopes these efforts will ultimately lead to an improved understanding of cancer and better outcomes for cancer patients in British Columbia and world-wide.

Dr. Chris Baliski is a Surgical Oncologist who recently relocated his practice to Kelowna General Hospital after three years at St. Paul's Hospital in Vancouver.

"My goal with regard to the Council is to contribute to the provision of high quality surgical oncology care throughout BC and to help surgeons overall meet patients' needs effectively. I am also interested in the use of research databases to support oncological care and the ability of the Surgical Oncology Network to further the application of such resources."

"My goal with regard to the Council is to contribute to the provision of high quality surgical oncology care throughout BC"

Dr. Chris Baliski

Dr. Baliski is originally from Saskatoon and completed both medical school and his general surgery residency at the University of Saskatoon. He then completed a surgical oncology fellowship at the University of Calgary followed by further subspecialty training in endocrine surgery at both the University of Calgary and Toronto.

Dr. Baliski is also involved in endocrinological clinical research and studies regarding breast cancer outcomes. He is working as well to establish a breast cancer care centre in Kelowna.

Adjuvant Treatment for Gastric and Pancreatic Carcinoma

Dr. Barb Melosky, Medical Oncologist - BC Cancer Agency

The treatment of both gastric and pancreatic carcinoma in the adjuvant setting is evolving.

Adjuvant treatment in gastric carcinoma is beneficial. Intergroup trial 0116 was performed in the U.S. with over 600 patients. A 15% improvement in 5 year survival was seen when chemotherapy with radiation was given in the post-operative adjuvant setting. Survival update shows the survival advantage still holds. The radiation component is problematic as a large field is necessary. A radiation oncologist must review a pre-operative CT scan. If the area is too large to be radiated then adjuvant therapy is not recommended as it is unsafe.

In 2005 the Magic trial from the U.K. was presented. It randomized patients to observation or pre-operative and post operative chemotherapy with ECF (epirubicin, cisplatin, 5fluorouracil). A 15% survival advantage for the chemotherapy arm was seen. Distal esophageal carcinoma accounted for one quarter of the patients. It is to note that only 40% of the patients randomized to the chemotherapy received post operative chemotherapy. The chemotherapy was difficult. Severe nausea, vomiting, hair loss, neutropenia occurred.

Surgeons and oncologists now have the choice of pre-operative versus post operative treatment. Because of the morbidity of the pre-operative chemotherapy in the Magic trial, the post operative route with chemotherapy/radiation is still preferred. However, in cancers that are large and cannot be encompassed by radiotherapy because of size, or tumors of the distal esophagus, the pre-operative regimen is an alternative. Early referral is beneficial.

Pancreatic carcinoma is difficult to treat. Few patients are candidates for curative surgery which carries a high morbidity and significant mortality. ESPAC/1 was a European trial with over 600 patients and randomized patients to post-operative observation or six months of chemotherapy with 5/FU/ Leucovorin. In 2001, it appeared that radiation had a trend to worsen survival. Their most recent update and publication in the Lancet 2004 shows a benefit of 5/FU- chemotherapy in the adjuvant setting. A detriment in survival was seen when radiation was given. There are many flaws to this trial including a non-randomized component as well as poor statistical design. Chemotherapy may have a benefit. Six months of adjuvant 5/FU and Leucovorin is the recommendation at this time with the BCCA. As patients with positive margins do universally poor this group of patients is also offered radiotherapy. Ongoing trials will clarify some of these issues. The future lies in the new drug combinations with targeted therapy.

1. *McDonald, J.S. et al, NEJM 2001; 345: 725-730*
2. *Cunningham, D. et al, ASCO Abstract 2005 No. 4008*
3. *Neoptolemos, J.P. et al, Lancet 2001, 358 (9293): 1576-85*
4. *Neoptolemos, J.P. et al, NEJM 2004; 350, 1200-1210*

First annual BC Cancer Agency Community Care Award open to nominations

It was Christmas Eve and Joe Bryde's life was already at a low point when he got the devastating news. Living on Vancouver's Downtown Eastside, and with no family beside him, he was diagnosed with cancer.

And then, unexpectedly, care and support arrived from a most unanticipated source. Bryde's community pharmacist, someone he visited every day to receive his cancer medications, became an advocate, caregiver, and friend.

That's why Bryde is nominating his pharmacist for the first annual BC Cancer Agency Community Care Award. The award is being introduced today to recognize those community caregivers who go above and beyond in providing support to cancer patients.

Any community caregiver is eligible for the award, for example, nurses, volunteers, physiotherapists, hospice workers, family doctors, or surgeons, to name a few.

One nominee will be chosen to receive the award by a panel of caregivers, community supporters, and patients. The award recipient will be announced on November 25 at the BC Cancer Agency's annual award banquet in Vancouver. Travel and accommodation will be provided. Nominations can be made online at www.bccancer.bc.ca, or by calling 604.877.6216, or toll free at 1.800.663.3333, ex 6216. The deadline for nominations is September 30, 2006.

The Surgical Oncology Network Welcomes Yasmin Miller, Program Manager

Yasmin Miller was appointed as the new Manager of the BC Surgical Oncology Network, joining the BC Cancer Agency at the end of June 2006. Previously, she was the Manager of the Women's Health Research Institute at BC Women's Hospital & Health Centre, where she was involved with developing and implementing a strategic research plan for BC Women's. Creating a research centre in women's health was a key goal of the research strategy, and last year the Women's Health Research Institute was established.

Originally from Montreal, Yasmin lived for ten years in Toronto before moving to Vancouver in 2002. In Toronto, Yasmin was the Program Officer for The Richard Ivey Foundation, where she assessed grant applications for funding in the areas of the environment, health, social services, education, arts and culture. In her previous positions, Yasmin was the Manager of Research Awards with the National Cancer Institute of Canada, where she was responsible for several research and fellowship programs, and she was also a Grants Officer at the University of Toronto, where she managed research proposals and grants in the social sciences, humanities and medicine. Yasmin has several years of experience conducting and managing health-related research projects. As a Research Officer with the Community Dental Health Services Research Unit at the University of Toronto, she was involved with several public health studies leading to publications, and she also worked as a patient interviewer for studies in the Psychosocial Oncology Program at the Princess Margaret Hospital-Ontario Cancer Institute.

Adjuvant Therapy for Resected High-Risk Colon Cancer: When Should I Refer to Medical Oncology?

by: Sharlene Gill, MD, MPH, FACP, FRCPC
BC Cancer Agency – Vancouver Clinic

In British Columbia, an estimated 1600 new cases of colon cancer are diagnosed each year. Among these, approximately 70% are clinically localized at diagnosis (stage I, II or III). However, despite curative-intent surgical resection, a significant proportion of patients will face a disease recurrence due to the presence of micrometastatic residual disease. It is now well recognized that adjuvant 5-fluorouracil based chemotherapy can significantly reduce the risk of recurrence in high-risk resected colon cancer.

So, who should be considered for adjuvant chemotherapy? At the present time, there is no proven benefit for adjuvant therapy in resected stage I (pT1 or T2, N0, M0) given the expected favourable outcome with surgery alone. Such patients typically do not require a medical oncology consultation. Adjuvant chemotherapy is recommended for selected patients with high-risk stage II disease (high-risk defined as presence of T4 status, high grade, inadequate (<12) nodal assessment and occasionally, the presence of obstruction or lymphovascular invasion).

In BC, such patients may be offered 24 weeks or 8 cycles of capecitabine (an oral 5-FU prodrug). All patients with stage III or node-positive resected colon cancer should be considered for adjuvant chemotherapy. Patients in this setting may be offered doublet chemotherapy with a 24 week course of biweekly infusional 5-FU in combination with oxaliplatin. Patients may also be considered for clinical trials where available (Table 1). The decision to ultimately proceed with chemotherapy requires a careful risk-benefit assessment by the medical oncologist considering factors such as patient functional status, comorbidities, toxicities of therapy, estimated risk of recurrence and patient preference. Adjuvant chemotherapy should be initiated within 8 weeks of resection and therefore referrals should be made early. When in doubt, please do not hesitate to contact your medical oncologist.

Table 1

Currently Available Adjuvant Colon Clinical Trials in BC

NCIC.CRC2 - 5FU plus oxaliplatin with or without cetuximab in resected stage III colon cancer, BC PI: Sharlene Gill, MD. Open in VCC, Pending in FVCC, VICC.

AVANT - 5FU plus oxaliplatin versus 5FU plus oxaliplatin plus bevacizumab versus Capecitabine plus oxaliplatin plus bevacizumab in resected high-risk colon cancer, BC PI: Sanjay Rao, MD. Open in VCC, FVCC, VICC and CCSI

VCC: Vancouver Cancer Clinic
FVCC: Fraser Valley Cancer Clinic (Surrey)
VICC: Vancouver Island Cancer Clinic (Victoria)
CCSI: Cancer Centre for the Southern Interior (Kelowna)

Postmenopausal Women at Increased Risk for Breast Cancer Can Participate in Clinical Trial

By: Dr. Karen Gelmon - Medical Oncologist VCC & Chair, Breast Tumour Group

In the last decade the survival from breast cancer has improved by approximately 30%. Much of this has been due to the development of more effective therapies and a better understanding of breast cancer subtypes and how they should be treated. This would not have occured without clinical research. The immediate reaction from many persons is that they are fearful of research and do not want to be a guinea pig. However, all research is now done with full informed consent and within the strict guidelines of ethics review boards. There are no guinea pigs with breast cancer signing consent forms. Without research we would not move ahead, but subjects must be fully informed prior to volunteering for any clinical trial. This includes understanding their options for treatment, discussing the risks and benefits of the study, having time to make an informed decision that has been discussed with their family, friends, family physician etc., and being aware that they can withdraw their consent at any time. As well, all research must be done with the best interests of the subjects in mind including providing optimal medical care.

So why do people participate in research? Most of the time, we see incredible altruism. People do understand what we have achieved so far due to the participation of patients in the past and they also want to contribute. As well, people hope that they will get a better treatment or better care by participating or have access to something new that is not yet available. We have to thank all the persons who do participate and we as physicians have to be open to our patients desire to contribute and maybe get something new. While we have to honestly admit our ignorance (if we knew the answer we would not need the research) and the risks, we have to support research, our patients and the future. Women are worried about developing breast cancer and many are interested in prevention. 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.

Women looking for more information about the ExCel research study should contact Zahra Lalani at 604-877-6000 x2199 in Vancouver or 250-712-3900 x7047 in Kelowna or visit www.excelstudy.com.

Milestone 1,000th tissue donor to Tumour Tissue Repository pushes discovery forward

By: Papinder Rehncy

From the start, Michael Wainwright was determined to turn his cancer diagnosis into a positive experience. Through radiation therapy and chemotherapy, he continued to ponder some way to make the experience better for others through volunteering.

And then, he got his answer. While scheduling a date for a procedure, Wainwright noticed a pamphlet for the BC Cancer Agency's Tumour Tissue Repository (TTR). He decided to donate tumour tissue from his surgery to the program.

In September of this year, Wainwright helped the TTR reach its milestone of gathering 1,000 tumour samples from Vancouver Island patients. Established in 2002, the TTR – housed in the BC Cancer Agency's Vancouver Island Centre Research Centre – is a unique resource that provides researchers with tumour samples and highly-detailed anonymous lifestyle information from tissue volunteers.

"It's an incredible act of altruism, a gift of generosity," says Dr. Allen Hayashi, chair of the Breast Cancer Surgical Tumour Group, and Vancouver Island Health Authority surgeon participating in the TTR. "Our patients that have enrolled, have usually only been diagnosed with cancer a few days before."
This tissue and data -currently being collected in Victoria with hopes of expanding to Vancouver in the near future- is available to qualified researchers around the world and is helping to push forward not only cancer research, but our understanding of other chronic disease and its relationship to cancer.

"We're building case studies, and they gain in value as they mature," TTR director Dr. Peter Watson explains. "As the program grows and develops, we'll not only gain very good tissue samples and clinical data, but we'll be able to provide information on outcomes."

For More information please call 250-519-5700

Weird and Wonderful Tumours of the GI Tract

by: R. Cheifetz, MD Med CCFP FRCSC FACS

Con't from Pg. 1

Pathologic assessment requires reporting of size, mitotic index, margin status and the presence or absence of c-kit (CD117) positivity. The latter is a marker of tyrosine kinase activity and mutations in this receptor are characteristic of this group of tumours. Ninety-five percent GISTs are c-kit positive. Mutational analysis can confirm the diagnosis in c-kit negative tumours. Assessment of other markers of soft tissue tumours such a smooth muscle actin, S100, and desmin are typically done to exclude other diagnoses.

Prognosis is a function of tumour size and degree of mitotic activity but even small, low grade lesions have a theoretical potential to recur and metastasize. Overall about half of lesions are low risk and about one-quarter are high risk. The overall 5 year survival is 50-65% but only 20% for tumours larger than 10 cm. Median time to recurrence is 18 months and local recurrence is considered equivalent to metastatic disease. Historically, patients with metatstatic GIST had a dismal prognosis as these tumours are both radiation and chemotherapy resistant. Imatinib, an inhibitor of tyrosine kinase signaling, has changed the outlook for these patients. Therapy at 400 mg/day is associated with a 90% response rate (stable or responsive disease). Even patients who are c-kit negative respond to imatinib. The drug is orally administered and well tolerated with a 71% progression free survival and 86% overall survival at 12 months. Common side effects are diarrhea, edema and anemia. Serious side effects include hemorrhage and neutropenia. Patients are typically followed by CT scanning which may show only a reduced density of metastatic lesions rather than a reduction in size. PET scanning is a very sensitive marker of response to therapy with decreased uptake within 2 weeks. The drug is continued as long as the disease is stable, as discontinuing the medication is associated with a 'flare' of disease.

In addition, to its role in metastatic disease, imatinib is under investigation as a post-surgical adjuvant therapy following resection of high risk tumours. It may also be considered pre-operatively in patients with 'functionally unresectable' tumours where the surgical morbidity is significant (APR, total gastrectomy, Whipple resections). Newer medications can help those patients who develop resistance to imatinib.

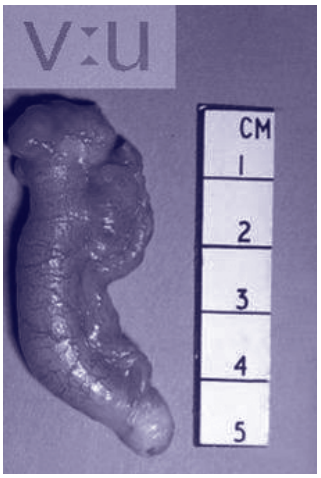
Recommended follow-up post-resection is via CT scanning every 3-6 months for 5 years and every 3 months while on imatinib. As these are uncommon malignancies, consideration should be given for referral of these patients for multidisciplinary assessment.

Reference: Blackstein, ME et al. Gastrointestinal stromal tumours: Consensus statement on diagnosis and treatment. Can J Gastro 2006; 20(3): 157-163

Carcinoid tumours

Carcinoid tumours are neuroendocrine tumours derived from enterochromaffin cells. Ninety percent of tumours occur in the GI tract, with bronchus, ovary and thymus being other reported sites. Within the GI tract the most common site of involvement is the appendix, which accounts for 36% of cases. Carcinoid tumours are pathologically identified in 0.3% of appendectomies.

Management of appendiceal carcinoid is a function of tumour size as well as pathological features. For tumours less than 1 cm, appendectomy alone is adequate treatments. For tumours greater than 2 cm, formal right hemicolectomy is recommended as these are associated with a 20-30% risk of nodal metastases. For lesions between 1 and 2 cm, a right hemicolectomy is recommended if the resection margins are positive on the appendectomy, if there is subserosal lymphatic invasion or invasion of the mesoappendix. The prognosis of appendiceal carcinoid is excellent, with a 99% overall survival.



Operative Specimen of Typical Appendiceal Carcinoid

The small bowel is the second most common site of GI involvement and occurs in 25% of patients. Unlike the appendix, these are multiple small lesions in 30-50% of cases and cause kinking and angulation of the small bowel. Nodal involvement occurs in 45% of patients with tumours less than 1 cm in size and is characterized by calcified mesenteric masses, associated with a desmoplastic reaction. Management of SB carcinoid required wide excision including the involved nodes in all cases. Five year survival overall is only 50-60%, but is 75% if the patient is node negative.

Carcinoid tumours secrete serotonin

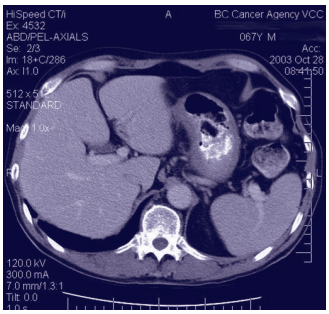
and contain dopa decarboxylase which converts 5 hydroxytryptophan (5HPT) to serotonin (5HT). The latter is metabolized into 5 hydroxy-indoleacetic acid (5HIAA). Systemic 5HIAA causes flushing, diarrhea, bronchospasm, and right heart valvular disease. Carcinoid syndrome occurs in 18% of patients overall. It is rare in appendiceal carcinoid but common in small bowel carcinoid. The syndrome is associated with large volumes of disease and with liver metastases because of direct access to the systemic circulation. Diagnosis can be made by measurement of 24 hr urine 5HIAA, though this is not sensitive or specific. Measurement of serum chromogranin A is 100% specific and 80% sensitive. Nuclear medicine scanning with I131-MIBG can detect 60% of tumours and radiolabelled octreotide has a sensitivity of greater than 80%.

Metastatic carcinoid is typically a slowly progressive disease. Multiple modalities of therapy can be used to control symptoms. Surgical debulking, ablation therapies and embolization improve symptoms in 70% of patients. Octreotide reduces flushing in 70% and diarrhea in 60%. Radiolabeled octreotide decreases symptoms and tumour load in 60% of patients.

Reference: Pasieka J, et al. Carcinoid Syndrome Symposium on Treatment Modalities for Gastrointestinal Carcinoid Tumours: symposium summary. CJS 2001;44(1)25-32

GI Lymphoma

The GI tract is the most frequent extranodal site of involvement of Non-Hodgkin's lymphoma. The most common GI primary lymphomas (50-65%) are diffuse large B cell. In Western countries the stomach is the most common site of involvement, whereas the small intestine is more common in the East and Third World. HIV infection is associated with small intestinal lymphoma. These patterns of involvement are relevant as small intestinal lymphomas present as emergencies in up to 50% of cases (obstruction, perforation or bleeding). MALT lymphomas are the second most common type, with Burkitt's, follicular, and enteropathy-type T cell lymphoma all much rarer.



Pre-treatment CT image of Gastric Lymphoma

Pre-operative diagnosis if preferred, if feasible. Surgery is reserved for the management of localized disease (particularly in young patients) and for emergency presentations. Surgical intervention should be avoided if it is only for diagnostic purposes but if surgery is undertaken, a frozen section should be obtained to ensure there is adequate tissue for diagnosis and the involved area should be marked with clips. Complete staging with CT imaging of the chest, abdomen and pelvis as well as bone-marrow biopsy is needed to rule out extra-intestinal disease.

The mainstay of treatment of GI lymphoma is chemotherapy with CHOP (doxorubicin,vincristine, cyclophosphamide, prednisone). Radiation plays a more limited role in the management of GI lymphoma because of GI toxicity and long term complications in younger patients but can be used as an adjuvant treatment for residual or limited gastric disease. Historical concerns regarding perforation risk are no longer felt to be significant. Patients are followed during treatment with serial CT scanning. The prognosis is a function of the extent of disease. A local control rate of 100% can be achieved with a 3 cm tumour compared with only 60% for a mass greater than 6 cm in diameter. Overall, there is a complete response seen in 50% and a 3 year disease free survival of 46%.

Gastric MALT Lymphoma refers to a particular type of lymphoma arising in Mucosa Associated Lymphoid Tissue. Pathologically it is characterized by a clonal population of B-cells which develop under constant stimulation. They are low grade in 75% of cases and associated with H. pylori infection in more than 90% of cases. For limited disease eradication of H.pylori may induce prolonged remission. Patients should be rescoped at 2 months to confirm control. They require close follow-up with repeat endoscopy every 6 months for two years then annually for 3 years. Persistent H.pylori infection should be retreated once. Persistent or recurrent lymphoma is managed with standard lymphoma protocols. Five year survival is greater than 95% for stage 1 and 75% for stage 2.

In contrast to the previous conditions, enteropathy-type T cell lymphoma is a much more aggressive disease. It is less common than primary gastric lymphoma and MALT lymphoma and is associated with only a 15% 5 year survival. It typically involves the jejunum and ileum and occurs in patients with underlying celiac disease.

Reference: Koniaris LG, et al. R. Management of Gastrointestinal Lymphoma. JACS 2003; 197(1):127-41.

Upcoming Events

Aromatase Inhibitors Update Video Conference

The Surgical Oncology Network will be hosting a Videoconference sponsored by AstraZeneca throughout the province to serve as an update on aromatase inhibitors. Topics will include:

Treatment with Aromatase Inhibitors
by Dr. Hagen Kennecke
Methods of Breast Irradiation
by Dr. Alan Nichol

Date: Thursday, October 26, 2006
Time: 5:00 pm – 7:00 pm
(Light snacks provided)
Location: BC Cancer Research Centre Lecture Hall

Videolinked to:

- Cancer Centre for the Southern Interior - Shuswap Room
- Fraser Valley Cancer Centre – Room 3011
- Vancouver Island Cancer Centre – Conference Room #2
- Prince George Regional Hospital
- Nanaimo General Hospital – Room G244
- Royal Inland Hospital – Boardroom 1 East
- East Kootney Regional Hospital

Cost: No charge

If you are located in an area that is not listed please contact Denise DesLauriers at ddeslauriers@bccancer.bc.ca or (604) 707-5900 Ext 3269 and we will try to make arrangements to include your area.

Annual Planning Meeting

The Surgical Oncology Network will be holding its annual planning meeting on November 25th. The topic of this meeting is: *Making Tumour Groups Work: Knowledge Transfer, Communities of Practice and Engagement*

BCCA Annual Cancer Conference

The BCCA Annual Cancer Conference is taking place on November 23 to 25, 2006 at the Westin Bayshore Resort & Marina in Vancouver.

Our theme this year is Partners in Research and Care – BC & the World. The theme creates the framework for our exploration of how the BC Cancer Agency encourages collaboration between researchers, scientists, clinicians and community resource professionals, within our provincial system of cancer control, as well as with organizations around the world.

We will also be adding to our roster of award presentations in 2006. In addition to those we have traditionally made in the past, we are introducing the new Community Care Award. Please see page 7 for more details on this award.

SLNBx course

This year's fall update will cover Sentinel Lymph Node Biopsy. The event will take place on November 24th at the Plaza 500 Hotel in Vancouver. It will be a full day didactic conference and topics will include:

- *Axillary Staging in Breast Cancer*
- *Sentinel Node Mapping*
- *Lymphoscintography and Radiopharmaceutical Safety*
- *Implications on Adjuvant Therapy in Breast Cancer*
- *Sentinel Node Biopsy in Melanoma*
- *Sentinel Node Biopsy in other Malignancies*

Due to new policies the animal lab cannot be offered as originally planned.

Registration forms will be available shortly. If you need more information please contact Denise DesLauriers at ddeslauriers@bccancer.bc.ca or (604) 707-5900 Ext 3269

TME Teaching

Two videos are now available on the SON Website. The videos consist of cadaver dissection showing dissection planes between visceral fascia of mesorectum and parietal fascia of pelvis, and showing pelvic nerves. There is also commentary on common questions of dissection and Dr Bill Heald's live OR dissection and excellent commentary. To view videos please visit www.bccancer.bc.ca/HPI/SON/.

FOR MORE INFORMATION

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Dr. Rona Cheifetz

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www.bccancer.bc.ca/son

OR EMAIL US
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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 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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