



Practice changing breast screening guidelines

Q&A from FPON webcast, Mar. 19, 2015

Following is the question and answer session from our March Webcast, “Practice Changing Breast Screening Guidelines” featuring Dr. Christine Wilson, Medical Director, Screening Mammography Program of BC (SMP) of the BC Cancer Agency.

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

Do program participants receive reminder letters if a mammogram hasn't been booked?

Yes, SMP sends recall reminders to women six weeks before they are due for their next screening interval. A second reminder is sent if there is no appointment scheduled within four to six weeks. This two-letter reminder system is repeated again the following year if there is no response.

What is the process for women without a primary care provider? How do women without a primary care provider book their mammograms?

Women without a primary care provider can

contact our Client Services Centre. The centre will make a suggestion from a list of primary care providers in British Columbia. Once a primary care provider who can receive their result is identified, women can self-refer to book their mammogram.

Do women have the option to book a mammogram online?

Due to privacy concerns, we currently do not offer online booking. However online booking is certainly a service we hope to offer in the future. To book a mammogram, women can call the Screening Programs Client Services Centre at 1-800-663-9203 or 604-877-6187 or send us an email to have a booking clerk call back at a convenient time.

Can naturopathic doctors refer patients?

Yes, naturopathic doctors can refer patients. Generally, naturopathic doctors should be working with a family doctor in the event that a woman receives a positive result. Positive results should be shared with the family doctor.

When will the Screening Mammography Program mobile screening units offer digital mammography service?

The Vancouver Island Coastal mobile digital mammography coach was the first of three Screening Mammography Program mobiles in the province to transition to digital mammography in February 2015. The other two coaches (Interior/Kootenay, Lower Mainland/Northern) are planned for replacement in early 2016.



How easy is it to access the Screening Mammography Program Decision Aid online?

The Decision Aid can be found at www.screeningbc.ca or <http://decisionaid.screeningbc.ca/>. As of March 2015, the Decision Aid has been visited 1,852 times since launch in July 2014.

Immune modulation in cancer? A new dawn

By Dr. Henry Docherty, General Practitioner in Oncology, BC Cancer Agency Sindi Ahluwalia Hawkins Centre for the S. Interior, Kelowna

Immune modulation in cancer describes treatments that utilise a patient's immune response to achieve control or stabilisation of cancer and, potentially, eradication of disease.

The genesis of Immunotherapy was in 1796 when Edward Jenner produced the first vaccine for smallpox. For many years the idea of modulation of the immune system

to facilitate cancer care was philosophically attractive but practically hard to achieve. However, with the development of effective targeted therapies (Imatinib, Rituximab, Trastuzumab) in the late nineties, the field began to flourish. More recent developments are now transforming results in several clinical areas with the promise of even better things to come.

Immunotherapy can be cell based (cancer vaccines), cytokine based (interleukin-2,

interferon alpha) or antibody based, and it is the latter group that are currently the most clinically successful.

Cancer cells use multiple mechanisms to limit detection by the host's immune system, and new developments are leading to greater understanding of these processes at the cellular level, generating multiple treatments that are radically changing the outlook for significant numbers of patients.

continued on page 5

The Bow Tie model of 21st century palliative care

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

The World Health Organization's (WHO) definition of palliative care has evolved such that the recipient's illness is no longer required to be deemed incurable. Palliative care is now described as an approach applying to "life-threatening illness", and "applicable early in the course

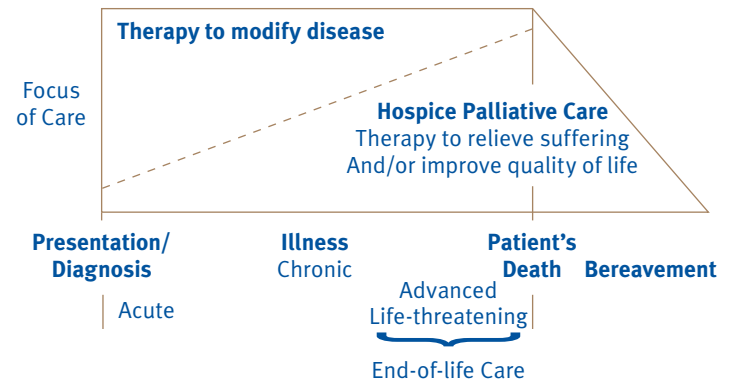
of illness, in conjunction with other therapies that are intended to prolong life". This modern definition includes when cure may be unlikely but not impossible.

Despite this evolution in understanding of our specialty, access to palliative care is still hampered by public perception that palliative care is synonymous with dying. Palliative care teams are still often only resorted to when all hope of cure or disease control has been lost. Late referrals limit our ability to achieve maximum potential for the relief of suffering and medical care cost containment.

Misunderstanding is very understandable given the relatively rapid development of the specialty and the widely varying levels of access to palliative care services across the country. Confusion also results from the plethora of terms used to describe palliative care services offered throughout the disease process, such as *supportive care*, *hospice* and *end-of-life care*. Visual models can be helpful to explain complex concepts and have helped advance the understanding of palliative care since the term was coined in Canada over thirty years ago. The Canadian Hospice Palliative Care Association's 2002 model (Fig. 1) has gradually become the world standard, but is itself already outdated.

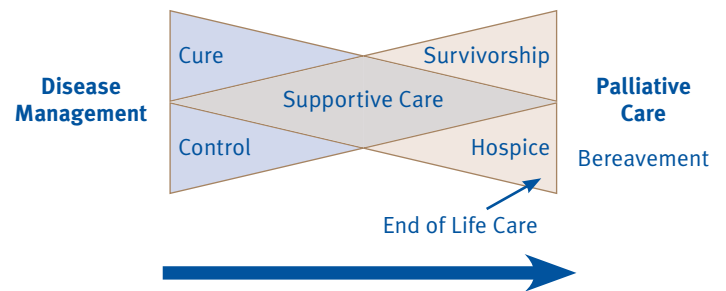
Entering a pathway in which the only possible outcome is death is not inviting to patients and their families. If early integration of palliative care with disease management is the goal, then the possibility of cure must still be recognized when considering a referral, at least in the short-term.

Figure 1: Canadian Hospice Palliative Care Association model



The "Bow Tie" model (Fig.2) acknowledges the duality of an approach that prepares patients for the worst (death) but still allows hope for the best (cure). The model is intended to be enhanced to individual situations for any life-threatening illness. The direction of the model can also be reversed for cultures with a written language which goes from right to left.

Figure 2: The Bow Tie model



I hope that readers find this helpful in encouraging patients and families not to be afraid of palliative care, and to access it early.

Contact Dr. Pippa Hawley at phawley@bccancer.bc.ca

Upcoming oncology CME events

- May 21 Webcast: Update on Lung Cancer for Primary Care with Dr. Sophie Sun – www.fpon.ca (CME Initiatives). Recording available post event.
- June 9: Survivorship Forum – bringing together survivors, patients and health care professionals to raise awareness and dialogue about cancer survivorship issues, BC Cancer Agency Research Centre, register at: <http://surveys.phsa.ca/s/2015survivorshipforum/>
- June 18 Webcast: Early Integration of Palliative Care with Dr. Pippa Hawley – www.fpon.ca (CME Initiatives). Recording available post event.
- November 20: Oncology Imaging for Primary Care, BC Cancer Agency Research Centre, registration for this afternoon event opens this summer at www.fpon.ca, contact pete.tonseth@bccancer.bc.ca
- November 21: Family Practice Oncology CME Day, BC Cancer Agency Research Centre, registration opens this summer at www.fpon.ca, contact jennifer.wolfe@bccancer.bc.ca
- December 7: UBC Division of Palliative Care CME Event, BC Cancer Agency Research Centre, contact Kathryn Inman, ksinman@mail.ubc.ca

Managing late effects in adult survivors of childhood cancer

By Drs. Chris Fryer and Sheila Pritchard, Pediatric Oncologists at BC Children's Hospital and Dr. Karen Goddard, Radiation Oncologist at the BC Cancer Agency Vancouver Centre.

Over 80% of children with cancer can expect to be cured of their disease. Sadly, many childhood cancer survivors (CCS) may have significant long-term health problems or "late effects" as a consequence of their previous cancer and the treatment they received.

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

Late effects from cancer treatment may include damage to many organ systems. Children are especially vulnerable as development and growth are affected. After treatment for brain tumours, neurocognitive deficits are common. Reduced growth may lead to musculoskeletal deformities. Cardiovascular and pulmonary diseases are common in CCS as are endocrine problems such as metabolic syndrome and pituitary dysfunction. Survivors have an increased risk of infertility. There is also an increased risk of developing a second cancer after any radiation therapy treatment and some types of chemotherapy. It is not surprising that psychosocial issues such as anxiety and depression are common in CCS.

In order to minimize these late effects, some of which may not become apparent for 10 or 20 years, surveillance and follow-up care throughout adulthood is essential. Regular assessment and counseling help to ensure that health risks can be detected early and sometimes prevented.

Primary health care providers (HCPs) such as Nurse Practitioners and General Practitioners in Oncology together with pediatric oncology experts have an important role to play in meeting the needs of CCS. The need for a long-term follow-up program in British Columbia was identified in 2010 and recently approved by the Provincial Health Services Authority and the Ministry of Health.¹ (See article below.)

This program involves collaboration between community health care providers and community services, specialists in pediatric



Drs. Chris Fryer (left), Karen Goddard (centre) and Sheila Pritchard share their expertise on long term follow-up required for survivors of childhood cancer.

oncology, the BC Cancer Agency and the BC Children's Hospital to provide the best care possible for survivors of childhood cancer.

Contact:

Dr. Chris Fryer at cfryer@cw.bc.ca

Dr. Sheila Pritchard at spritchard@cw.bc.ca

Dr. Karen Goddard at

kgoddard@bccancer.bc.ca

¹ MacDonald L, Fryer C, McBride ML, Rogers PC, Pritchard S. The need for long-term follow-up of childhood cancer survivors in British Columbia. *BC Medical Journal* 2010;52:504-9.

New program to benefit adult childhood cancer survivors

With the support of the Provincial Health Services Authority and in partnership with BC Children's Hospital, the BC Cancer Agency Provincial Survivorship and Primary Care Program is leading the implementation of a provincial program to meet the needs of adult childhood cancer survivors (ACCS).

Forward magazine is a resource for cancer survivors to help them live their best life with and beyond cancer. Please see postcard insert for subscription details for your patients and your medical office.

We know that adults, treated as children for cancer with intensive chemotherapy and radiation, face an 80% chance of significant long-term health complications and major

health risks. "These survivors are a special patient group with unique and complex needs. It is a privilege to be part of a team leading the development of a program designed to address these needs," notes Dr. Karen Goddard, radiation oncologist and medical lead for the program.

In BC, when active treatment is complete, many ACCS rely on their primary care provider to address surveillance and survivorship needs. All ACCS need access to a provider who understands the risks associated with their previous therapy and who has the knowledge and experience to provide appropriate surveillance, treatment, education and referral. This program will also provide education and support to primary

care providers caring for ACCS.

The new program will be evidence-based, dedicated to the clinical and research needs of ACCS and will build upon the existing expertise and resources in the province. It will include:

- Improved transition services for ACCS moving from pediatric to adult care for lifelong follow-up;
- A registry to track patients to ensure they receive appropriate long-term support;
- A recall of past patients who were treated when there was very limited information about the side-effects of treatment during childhood, so they can receive care, screening and counseling as needed;

continued on page 5

Looking at differences in primary care systems and behaviours to understand the international survival gap

By Dr. Martin Dawes, Head,
Department of Family Practice,
University of British Columbia

Recognising the possibility of cancer at the first presentation of symptoms is important. How well do we do that?

The results of an online survey of 200 general practitioners in a number of jurisdictions including British Columbia were published in the *British Medical Journal* last month. 2,795 family physicians (FPs) in 2012/2013 completed two of five clinical vignettes relating to the management of cases of possible lung, colorectal and ovarian cancer and a section relating to primary care structure and practice.

Striking findings from the International Cancer Benchmarking Partnership (ICBP) suggest FPs in the UK are less likely to refer or investigate a patient with symptoms when they first present with symptoms, compared to their peers in jurisdictions with higher survival (Australia, Canada, Denmark, Norway and Sweden).

The analysis did not find any factors that explained this difference (e.g. access to tests, waiting times, GP education). However, these results suggest that there may be a cultural or philosophical difference in primary care in the UK which is leading to lower levels of referral and investigation.

Having a healthcare system that allows FPs to refer people if they suspect cancer is vital to ensuring they are diagnosed early and so they can receive the treatment they need. The average FP sees hundreds if not thousands of patients a year with potential cancer symptoms – fewer than 8 of whom will actually have cancer. Referral guidelines have helped people with classic symptoms to be seen more quickly but, for patients with less typical symptoms, the decision to refer is not always as simple.

The BC Cancer Agency and the Family Practice Oncology Network are already delivering a number of initiatives to support FPs to diagnose with confidence and to manage patients with cancer and this raising of

awareness may be a contributing factor to these findings.

Visit the *British Medical Journal* for more details on the International Cancer Benchmarking Partnership.

Contact: Dr. Martin Dawes at martin.dawes@familymed.ubc.ca

.....
New program to benefit cancer survivors continued from page 4

- Research and evaluation to ensure the program is meeting the needs of survivors and their families.
- An educational program for medical and nursing students.

This is a much needed program and we are grateful for the support from the Ministry of Health, the BC Children's Hospital Foundation and the BC Cancer Foundation.

Contact: Karen Blain, Director, Provincial Survivorship and Primary Care, at karen.blain@bccancer.bc.ca

.....
Immune modulation in cancer? A new dawn continued from page 1

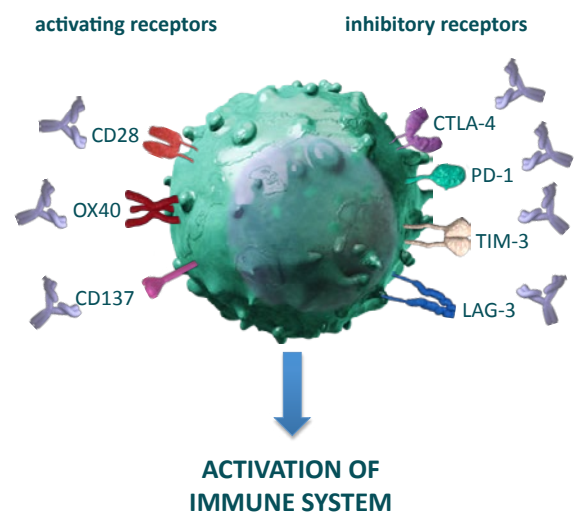
CTLA-4 is a protein receptor that interacts with T cells to down regulate their efficacy. By blocking this receptor, Ipilimumab, which was approved by Health Canada in 2012, turns off this inhibition and allows cytotoxic T lymphocytes to recognize and destroy cancer cells more efficiently. It has been trialed in melanoma, prostate cancer and lung cancer, and has been available for clinical use for advanced melanoma in BC since 2012. There is a cohort of 15-20% of patients involved in early clinical trials with this agent, who have now survived 10 years with metastatic melanoma, which is unprecedented in this condition. Characteristically patients will initially worsen prior to the onset of improvement. Side-effects are also characteristic and mainly immune mediated. Some of them, especially immune mediated colitis, can be severe and even fatal, making prompt recognition (with the onset of diarrhea) and management with corticosteroids crucial.

PD-1 (programmed death-1) ligands on cell surfaces can bind to PD-1 receptors on T cells causing a reduction in T cell mediated inflammatory response. The anti PD-1 agent, Nivolumab, shows activity and safety profile substantially improved when compared to Ipilimumab, and is coming into clinical practise in BC this year. It has shown a response rate of 87% in patients with Hodgkins Lymphoma who relapsed after other chemotherapy protocols. Another anti PD-1 agent, Pembrolizumab, was granted accelerated approval in the U.S. by the FDA in September 2014.

With the promise of improved efficacy and safety using combinations of these agents, and with an array of novel drugs in development which target both CTLA-4 and PD-1 receptors, as well as other immune checkpoints, the future

management of a number of cancers looks to be significantly enhanced.

Contact Dr. Henry Docherty at hdochert@bccancer.bc.ca



Adapted from Mellman I, et al. *Nature*. 2011;480:481-489; Pardoll DM. *Nat Rev Cancer*. 2012;12:252-264.

Reflections from a Queen Charlotte GPO

Queen Charlotte General Practitioner in Oncology (GPO), Dr. Caroline Shooner, is exploring how the arts and humanities can enrich medical education and improve clinical care. She is also developing a program to improve community connection with Haida Gwaii health care providers through reflective activities and creative writing. Dr. Shooner completed the Family Practice Oncology Network's GPO Training Program in 2011 and shares her insights while on sabbatical in London, England:



Dr. Caroline Shooner

Community Role

As a GPO, I oversee the administration of chemotherapy for patients who live anywhere on Haida Gwaii, and who have the option (and preference) of getting their treatments locally. I share this responsibility with three other local GPOs, two based in Queen Charlotte and one in Masset. Last year, we had 15 to 20 patients receiving treatment (half adjuvant, half palliative) at any given time.

More Northern GPOs needed

GPOs fill a crucial role in many rural communities especially those where patients would otherwise have to travel great distance in unsafe conditions for treatment. Several northern communities are facing acute shortages of GPOs and Dr. Jaco Fourie, Oncology Lead for the Northern Health Authority and Terrace GPO, is encouraging family physicians to consider this career opportunity: "Northern GPOs enjoy a wide spectrum of practice, are well supported by our Northern Health Authority and have high job satisfaction." Dr. Stacy Miller, Regional Leader for Radiation Oncology at the BC Cancer Agency Centre for the North, adds: "GPOs become the eyes and ears that ensure patients get back to the Centre for assessment if needed. Every day, I work with a patient whose care is optimized by having a GPO on the team."

Contact Jaco Fourie at Jaco.Fourie@northernhealth.ca

The Haida Gwaii Cancer Care team meets every two months to review the list of active patients and discuss new referrals. Each patient is assigned to a particular GPO (in my case, this responsibility is shared with my practice

partner, Dr. Tracy Morton) who becomes responsible for all follow-up and pre-printed orders. We have one oncology nurse for the Islands who administers all chemotherapy at the Queen Charlotte Islands General Hospital (unfortunately, having only one person in this key position leaves us vulnerable). Masset patients must travel to Queen Charlotte for their treatments (a three hour round trip).

We are all in close contact with each patient's primary oncologist (usually based in Vancouver) who decides on chemotherapy regimens and offers advice when we have concerns. We dictate progress notes after each patient encounter, and in this way we keep the oncologists apprised of any significant events.

Community Benefit

Although our numbers seem small, they really underestimate the benefit to our community. For patients and their loved ones, to be able to get treatment close to home is invaluable. The benefit of having one's friends and family close by while undergoing chemotherapy is hard to overestimate. For some, having to travel off-island would be emotionally and financially devastating, and perhaps impossible.

Career Impact

Training in oncology has made me more

competent in helping my patients navigate what is often the most serious health issue of their lives. In this way, it has contributed significantly to my career satisfaction.

I appreciate the continuity of care that I am able to offer Haida Gwaii patients. In the past, when people had to travel to Vancouver or elsewhere off island for their chemo treatments, the loss of connection at such an emotionally intense time was very trying. It left me feeling like I was not able to support them as much as I wished to. Having a local cancer program allows most patients to benefit from the personalized care that a small hospital and community can provide, and I think that many of us appreciate this and are proud of it.

Top Benefits from the GPO Training Program

- increased competence in guiding patients through the cancer maze
- valuable personal connections with the cancer care specialists I most often refer to
- hands-on experience in the oncology clinics
- I also had the opportunity to spend two weeks on the St. Paul's Hospital Palliative Care Unit which was very rewarding and relevant to my GPO work (many of my patients are palliative, and all of them need good symptom management)

Advice to others considering becoming a GPO

Seriously consider the role. You will contribute to an important and meaningful legacy.

Contact Dr. Caroline Shooner at Caroline.Shooner@northernhealth.ca

Next GPO training course begins September 14, 2015

The GPO Training Program is an eight-week course offering rural family physicians and newly hired Agency GPOs and Nurse Practitioners the opportunity to strengthen their oncology skills and knowledge. The program covers BC and the Yukon and includes a two-week introductory module held twice yearly at the Vancouver Cancer Centre followed by six weeks of flexibly scheduled clinical rotation at the Centre where participants' patients are referred. The program is accredited by the College of Family Physicians of Canada and eligible physicians will receive a stipend and have their expenses covered. Full details at www.fpon.ca

Bone and soft tissue tumours

By Dr. Paul Clarkson, Orthopaedic Oncology Surgeon, and Chair, Bone and Soft Tissue Tumour Group, BC Cancer Agency

Soft tissue sarcomas are a complex and diverse group of neoplasms with varying degrees of malignant potential. The complexity of this group is increasing exponentially with new research, and management recommendations are rapidly changing. As such, sarcomas are best referred to a multidisciplinary centre where experienced pathologists, radiologists, medical and radiation oncologists and surgeons can work together to provide an individualized treatment plan that reflects the latest advances.

Soft tissue lumps are common, but only a small percentage represent malignant conditions. The major challenge for the primary care provider is identifying which patients will benefit from early referral amongst the legions of benign lipomas. No



Dr. Paul Clarkson

set of clinical criteria can completely separate benign and malignant soft tissue tumours but there are certainly guidelines that can assist.

Tumours that are deep to the deep fascia, larger than 5-8 cm or growing rapidly are more likely to represent malignant tumours and warrant early investigation with an MRI scan and/or referral to a multidisciplinary centre.

Conversely, tumours that are superficial, small and stable do not need referral and can be excised in the office or by a local surgeon. The vast majority of these tumours will be benign, and in the occasional event that a sarcoma is identified, these tumours generally have an excellent prognosis once referred for re-excision.

Ultrasound scans can be useful to document the extent and size of a soft tissue tumour but cannot reliably exclude malignancy. MRI scan is the imaging modality of choice for soft tissue neoplasms but is expensive and inaccessible, and for small superficial

tumours it is probably not warranted. As sarcomas are highly transplantable, biopsies are best performed under the supervision of the treating surgeon. Biopsy of suspicious tumours should be open or core needle, never an FNA, and read by an experienced pathologist.

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

Malignant bone tumours typically present with pain and swelling around or near a joint, most commonly the knee, hip or shoulder. With early diagnosis bone sarcomas are often curable and clinical vigilance is required not to miss these in the younger population. A plain X-Ray will make the diagnosis in almost all cases, and should be ordered if symptoms persist for more than 6 weeks or are not explainable by another cause. Any suspicious finding on an X-Ray should prompt referral to a multidisciplinary centre where the imaging is easily reviewed electronically.

Contact Dr. Paul Clarkson at pclarkson@bccancer.bc.ca

Oncology scholarships for family physicians: May 30 deadline

The Canadian Association of General Practitioners in Oncology (CAGPO) provides a scholarship program intended to support family physicians/general practitioners in enhancing their knowledge and skills in oncology and related areas to better serve the needs of their communities.

CAGPO scholarships are available to community-based family physicians/general practitioners as well as those currently employed full or part time by cancer agencies or programs. Applicants must possess a license to practice medicine in a Canadian province or territory and must be CAGPO members at the time of application.

The learning activity generally takes the



THE CANADIAN ASSOCIATION
OF GENERAL PRACTITIONERS
IN ONCOLOGY

form of a clinical traineeship from one to four weeks' duration and consists of an active, individualized, practical experience related to clearly defined educational objectives. It is expected that recipients will forego all or part of their usual clinical duties for the duration of the traineeship.

The traineeship is to occur in Canada in a formal cancer program that is able to offer suitable supervision and clinical experience. Applicants are expected to contact the cancer program to arrange the timing, supervision and content of their proposed traineeship.

A report is to be submitted to CAGPO upon completion of the program. It will outline the extent to which the educational objectives were achieved and the impact of the training on the physician's practice.

The total number of weeks of scholarship funding awarded may vary from year to year and is limited to a maximum of four weeks for any individual.

The training scholarship may be eligible for MainPro M1 or MainPro C credits from the College of Family Physicians of Canada (www.cfpc.ca) based on individual application.

For full details and an application form, please visit the CAGPO website at http://cagpo.ca/wp/?page_id=80

Upper GI cancer guidelines coming for primary care

Over the past few months, the Family Practice Oncology Network has been working to develop a set of Upper Gastro Intestinal Cancer guidelines for primary care providers. The Guideline Working Group focussing on this initiative includes practicing family physicians as well as specialists in gastroenterology, general surgery and oncology. Due to the size of this topic, there will be two guidelines: 1) Esophagus and Stomach; and 2) Duodenum, Pancreas and Cancer of the Extra-Hepatic Biliary Tract. The guidelines are based on medical evidence, have been adapted for use in British Columbia, and will be completed for release later this year.

These new primary care guidelines outline recommendations for the prevention, screening, diagnosis, treatment and follow-up

of upper gastro intestinal disease and cancer. The goal is to provide practical and easy-to-follow advice for general practitioners and other primary health care providers to enable effective patient care. They were developed to support practitioner and patient understanding of the spectrum of cancers in the upper GI tract, outline recommended approaches to the investigation and management of the problem from the time of presentation to post treatment survivorship, including appropriate advance care planning. The intended outcome is to improve early detection of upper gastro intestinal cancers, resulting in improved patient outcomes, patient experience and quality of care provided.

These guidelines are part of the Network's commitment to producing cancer care

guidelines specific to the needs of primary care – evidence-based, succinct, including a flow chart and patient hand-out and all accessible online. The Network has already published two sets of guidelines in partnership with the BC Guidelines and Protocols Advisory Committee (GPAC) including a suite on Palliative Care: the Palliative Approach, Pain and Symptom Management, and Grief and Bereavement; and a set on Female Genital Tract Cancers including Cervical, Endometrial, and Ovarian Cancers. Significant contribution was also made to GPAC guidelines on Breast and Colorectal Cancer. The Network will focus next on guidelines for HPV Related Head and Neck Cancers and Prostate Cancer.

Visit www.fpon.ca for full details and guidelines links.

New EMR-based end-of-life care toolkit for primary care

eHealth Observatory



A team of researchers, physicians, and developers from the University of Victoria, Fraser Health, Island Health, and Victoria Hospice has created an EMR-based End-of-Life (EOL) care toolkit to support primary care providers caring for patients at risk of dying within the next year. The specifications are based on the Palliative Care Guidelines published in 2010/11 by the Family Practice Oncology Network and BC Guidelines and Protocols Committee as well as the Practice Support Program's EOL Module Algorithm.

The toolkit is integrated within EMRs (Med Access, OSCAR and Profile versions of the

toolkit are available now), is tailored for primary care physicians and oncologists, and includes automated assessment tools, online pain and symptom guides and information resources to assist palliative care specialists, primary care providers, patients and their caregivers. The aim is to improve patients' journeys by improving transitions in care and shared care between primary care providers and oncologists, through increased access to EOL resources, guidelines and practice support tools.

Providers are welcome to freely access this toolkit and are encouraged to provide

feedback on how well the tool facilitates providing EOL care. (Download the toolkit: <http://ehealth.uvic.ca/eolmodule/index.php>).

Physicians who use the tool will be asked to complete a survey and, in exchange, will receive a \$100 gift card plus an invitation to a focus group to share feedback for one Mainpro M1 CME credit.

In providing the primary care provider and oncologist with this toolkit, we hope to improve the quality of EOL care as our population ages and primary care physicians are faced with an increased number of patients with complex EOL care needs.

To access the EOL EMR toolkit, visit ehealth.uvic.ca/eolmodule. Contact the research team at ehealthk@uvic.ca or project coordinator Joanna Pyke toll free at 1.855.999.4731.

A physician led demonstration of the EOL EMR toolkit will be held via Webcast in partnership with the Family Practice Oncology Network on May 28, 2015 from 8:00-9:00 a.m. | PDT. Complimentary registration at: ehealth.uvic.ca/eolmodule/sessions/sign.php

Hereditary cancer program priorities and direction

Demand for the BC Cancer Agency's Hereditary Cancer Program's services and expertise is growing by leaps and bounds – and their relationship with family physicians is increasingly important.

Dr. Gillian Mitchell took on the leadership of the program in April 2014 leaving her role as Head of the Familial Cancer Centre and medical oncologist at the Peter MacCallum Cancer Centre in Australia. She also served at The Royal Marsden in England and holds a PhD in cancer genetics. We spoke with Dr. Mitchell on the current status of the program and their plans going forward.



Dr. Gillian Mitchell is Medical Director and lead physician with the BC Cancer Agency's Hereditary Cancer Program

What is the Hereditary Cancer Program's focus with regard to family physicians?

Our program provides cancer genetic services for all of British Columbia. A team of genetic counsellors, medical geneticists and a nurse educator provide genetic counselling and testing for hereditary cancer syndromes such as Lynch Syndrome, Gorlin Syndrome and hereditary breast and ovarian cancers. We also provide clinical management advice for patients with these conditions, and focus on research and education.

A priority is to ensure all BC family physicians know when and how to refer at risk patients to our program. Our Website – www.screening.bc.ca/hereditary – explains the referral criteria and includes our referral form. Every referred patient is asked to complete a detailed family history questionnaire which we then use to determine their eligibility for an appointment. Appointments take place either in-person at the province's Cancer Centres or by Telehealth using a range of community facilities.

Family physicians' knowledge of their patients' current family history is key and just as important to maintaining health as their understanding of each patient's medical and medication history. We are striving to build awareness and capabilities

in this area through online tools.

What is the demand for the program's services?

May 2013 saw demand for our services – and for those of similar programs throughout North America – triple overnight. This was the date *The New York Times* published news of Angelina Jolie's risk-reducing mastectomy. "The Angelina Effect" increased our wait time from four months to one year with no

sign of abating. The positive factor is that the influx of referrals is not comprised of the worried well, but mainly of individuals who are at risk of a hereditary cancer. This sudden demand came on top of an already steady increase in referrals due to the power of genetic information for predicting cancer risk and directing cancer treatment becoming increasingly understood. Consequently wait times are a problem we are working to address.

Are there new research developments that will have an impact?

Genetics are now being used to direct cancer treatment decisions such as whether women should choose a mastectomy or conservation surgery for breast cancer and whether pancreatic, breast and ovarian cancers can be treated with new or different classes of drugs that target the inherited genetic weakness in the tumours. We are working with the oncologists to streamline how we deliver service and this will improve wait times.

- Hereditary cancer is uncommon but variable for different cancers (5% for lung cancer and 15-20% for ovarian cancer).
- Most hereditary cancer syndromes are inherited in an autosomal dominant manner, but not all.
- Not everyone with a hereditary risk will develop cancer.
- Options for risk reduction and/or early detection are available.
- Hereditary risk can come from either the maternal or paternal side.
- Genetic testing usually starts with a family member who is already affected by cancer.

Is there a further role for family physicians?

We are asking a great deal of family physicians when we release high risk patients back to them for the ongoing management of their cancer risks. These patients require specialized care and it can be challenging for family physicians to keep up with the demands. We need to better understand those areas where family physicians need more support from us so that we can provide information and resources that are meaningful. There is much that can be done for people at risk and we are here to help.

Contact: gillian.mitchell@bccancer.bc.ca

Online Tools to Assess Family History

- <https://familyhistory.hhs.gov/fhh-web/home.action>
Patient enters family history to print, review with provider and share with family
- <http://www.yourdiseaserisk.wustl.edu/>
Interactive tool provides risk estimates, prevention advice for cancer and other common chronic diseases
- <http://www.ems-trials.org/riskevaluator/>
Download IBIS Breast Cancer Risk Evaluation Tool (UK)
- <http://www.hughesriskapps.com/>
Suite of software modules to download

Message from Interim Vice President, BC Cancer Agency: Building for the future

Last November the BC Cancer Agency identified ten focus areas to help build a sustainable cancer control system. These areas recognize the challenges brought by the increasing incidence and prevalence of cancer, patients seeking care close to home, longer-term treatment for survivors, and medical advances. The plan acknowledges the need to:

- expand and provide services differently,
- strengthen how we serve BC as a provincial resource,
- integrate research
- deliver patient-centered care
- engage staff.

There are three focus areas I want to draw to your attention:

1. Provincially plan, develop, implement and evaluate how cancer care is delivered.



Dr. Nick Foster

We are committed to providing all patients in BC access to a full range of quality cancer services, regardless of where they live. We do many things well, but can always strengthen how we serve BC as a truly provincial resource with consistent patient-centred care. The Family Practice Oncology Network (FPON) is an important link as it plays a key role in the

continuity, transition and delivery of care between the Agency and community-based primary care providers.

2. Develop and invest in the Communities Oncology Network (CON).

We recognize the CON needs investment to build capacity for increased services. A core component of this area is to improve links with FPON, recognizing how critical FPON is to this work. The Agency has just appointed a CON director starting on May

4. The director will provide operational and strategic support to the CON and will link closely with FPON to ensure efforts are coordinated appropriately.

3. Continue to lead the development of supports for the survivorship community

About 210 new adult survivors of childhood cancer transition from pediatric to adult care each year in BC. In this issue you'll read about a new provincial program to benefit adult childhood cancer survivors. We recognize that the concepts of survivorship and primary care are important to FPON so will keep you apprised of our efforts and progress.

Primary care and family practitioners are key to ensuring a sustainable and effective cancer control program for BC. The Agency looks forward to working with you as we move forward to meet the challenges we share.

Contact Nick Foster at
nick.foster@bccancer.bc.ca

Message from the Chair and Medical Director of the Family Practice Oncology Network

A sense of renewal and optimism accompany this spring as we celebrate new milestones at the Family Practice Oncology Network.

Earlier this year, we graduated our 21st group of family physicians and nurse practitioners from the Introductory Module of our GPO Training Program. Participating physicians from Fort St. John, Comox, Golden, and the

BC Cancer Agency's Vancouver Centre are now well on their way to becoming General Practitioners in Oncology who will enhance the cancer care provided in their communities. We were also pleased to welcome newly hired nurse practitioners from the Agency's Vancouver and Kelowna Centres and the Leukemia/Bone



Dr. Phil White

Marrow Transplant Program at Vancouver General Hospital.

Since 2004, our Network has provided this training for all BC and Yukon GPOs as well as a wealth of continuing medical education opportunities to share the most current knowledge in cancer care and ensure maintenance of competency. Our expertise fits well with the Agency's new strategic direction to more

closely coordinate the focus of our Network with that of the Communities Oncology Network which is responsible for community based care and treatment. This is a natural alliance to which we will bring all our connections, resources and energy to ensure success.

Another area experiencing renewal is our

Council itself which welcomes new member, Dr. Christie Newton, President Elect of the BC College of Family Physicians. She joins fellow recent recruit, Mary McBride, Senior Scientist with the BC Cancer Agency Research Centre who together with esteemed representatives from UBC's Faculty of Medicine, the Agency, the Association of BC General Practitioners in Oncology and family physician and GPO representatives, provide the Network's vision.

Finally, along with other guideline development, we are updating our suite of Palliative Care Guidelines first published in 2010/11 in partnership with the BC Guidelines and Protocols Committee. These guidelines, in such great demand at the time, have proved an invaluable resource which we are committed to maintaining. Until next time!

Contact Dr. Phil White at
drwhitemd@shaw.ca

Prostate cancer screening

By Dr. Nevin Murray, Medical Oncologist,
BC Cancer Agency Vancouver Centre

The BC Cancer Agency and the Prostate Centre at VGH recommends that men should be informed about the benefits and limitations of use of PSA (Prostate-Specific Antigen) and DRE (Digital Rectal Exam) for early detection of prostate cancer. Two randomized trials are available for evidence. The most useful is the European Randomized Screening Trial of Prostate Cancer where 162,400 men between 55 and 69 years of age were screened with PSA. The prostate cancer diagnosis rate was 6% in the control group versus 9.6% in the screened group. There was a considerable stage shift with metastases found in 8.2% in the control group versus 3% in the screened group and 41% of cancers were non-palpable in the screened group versus 54% in the screened group. This translates into a prostate cancer death rate of 0.4% for screened versus 0.5% for the control group. The relative risk of



Dr. Nevin Murray

dying of prostate cancer is 0.79 ($p=0.001$) and it takes 10 years for this benefit to manifest. In order to prevent a prostate cancer death, 781 men need to be invited for screening and 27 prostate cancers must be managed. There is no hint of an overall survival benefit.

The risks of PSA screening include false negative and false positive results, biopsy procedure with occasional complications, distress, and anxiety. Over-diagnosis and treatment of indolent cancers is the main potential harm. At this time there is no genomic test that identifies the high risk prostate cancers that require aggressive management. Treatment continues to be guided by tumor stage, Gleason grade and PSA behaviour. Radiation and surgery are associated with risks including urinary problems, incontinence, sexual dysfunction and bowel problems.

If screening a patient is a consideration, the start age is 50-55 years of age. It may be

useful to have a base-line PSA in the mid-40s. Life expectancy should be over 10 years. The patient should be well informed about the risks of over-diagnosis and over-treatment. It is hard to completely discuss all the pros and cons of prostate cancer screening in a

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

short office visit. We strongly recommend obtaining copies of the BCCA brochure “The Pros and Cons of PSA Screening for Prostate Cancer”. Reprint requests can be made to the BCCA Library (1-888-675-8001) or printer friendly copies of the pamphlet from our web site at www.bccancer.bc.ca/PSAScreening. It is recommended that you give the patient a copy of the pamphlet and answer questions before sending the patient for the blood test. If any age adjusted PSA is high, double-check it and, if confirmed, refer to a urologist. Any patient with an abnormal DRE should be referred. Stop PSA screening when life expectancy is less than 10 years.

Contact Dr. Nevin Murray at
nmurray@bccancer.bc.ca

Colon screening program update

The provincial Colon Screening Program is an organized population-based program that offers colorectal cancer screening to asymptomatic men and women between the ages of 50 and 74. Launched in November 2013, the program aims to reduce colon cancer incidence and mortality by promoting early detection and prevention of colon cancer.

In over a year, the program has registered 185,813 fecal immunochemical tests from eligible participants. The Health Authorities have performed a total of 15,807 colonoscopies for registered patients, of which 7,349 colonoscopies have had pathology provided to the BCCA which have the following outcomes: 3,680 cases of any neoplasia, 1,492 advanced adenomas, and 114 instances of cancers have been identified.¹

¹Program statistics are generated as of December 31, 2014.

To support the uptake in colorectal cancer screening, the program continues to focus on education by expanding its offering of educational and promotional materials in primary care settings, as well as making content more accessible for those who do not speak English as their first language. Some of the existing materials include:

- **The Abnormal Fecal Immunochemical Test (FIT) brochure:** The brochure contains information on what causes an abnormal result and details what to expect after receiving an abnormal result. This brochure is now available in multiple languages; English, Punjabi, Traditional Chinese, and Simplified Chinese.
- **The FIT Instruction Sheet:** The instruction sheet is a step-by-step guide showing patients how to take a FIT test in the comfort of their home. The tool is now available in

multiple languages; English, Farsi, French, Korean, Punjabi, Traditional Chinese, Simplified Chinese and Vietnamese.

- **The FIT Decision Table:** The decision table is a tool designed to help physicians determine when a patient should have a FIT and how to order screening.
- **Preparing for your Colonoscopy Brochure:** The brochure features a visual checklist with tips on how one needs to prepare for a colonoscopy in the week leading up to the procedure.

For more information on the Colon Screening Program, or to access program education and promotional materials such as the FIT Decision Table and program standards, please visit www.screeningbc.ca/colon. Program materials are available at no charge from the Colon Screening Program.

Prostate Cancer – Q&A on managing side-effects of androgen deprivation therapy

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



**VANCOUVER
PROSTATE CENTRE**
A UBC & VGH Centre of Excellence

1. What are the main drugs used in ADT (Androgen Deprivation Therapy) and what special precautions should be pointed out?

- LHRH (Luteinizing Hormone Releasing Hormone) agonists
 - i.e. buserelin, goserelin, histrelin, leuprolide, triptorelin
 - MOA (Mechanism of Action): over-stimulate the hypothalamus-pituitary-adrenal-testes axis stopping the production of testosterone via a feedback loop;
 - Used to treat: rising PSA (Prostate-Specific Antigen) despite local therapy or CaP (Prostate Cancer) that cannot be treated with local therapy
- LHRH antagonists
 - i.e. degarelix, cetrotorelix, ganirelix, abarelix
 - MOA: inhibit activation of the entire axis reducing the production of testosterone
 - Indication: rising PSA despite local therapy; CaP that cannot be treated with local therapy
- Androgen biosynthesis inhibitors
 - i.e. abiraterone, ketoconazole, cyproterone acetate
 - MOA: inhibit the production of adrenal and intra-tumoral synthesis of testosterone
 - Indication: CRPC (Castration-Resistant Prostate Cancer) with evidence of metastasis or rising PSA on ADT
- Androgen receptor antagonist
 - i.e. bicalutamide, flutamide, nilutamide, enzalutamide
 - MOA: inhibit the activation of the androgen receptor
 - Indication: CRPC with evidence of metastasis or rising PSA on ADT; occasionally adjunct to ADT

2. What is the best thing a patient can do to counteract ADT effects?

- Evidence suggests that promoting exercise (at least 3 hours per week) and lifestyle changes (healthy diet and smoking cessation) are the best things to counteract ADT effects in general.

3. How can we manage the most prevalent symptoms a patient can expect to experience?

- Hot flashes (exercise, gabapentin, venlafaxine)
- Fatigue/weight gain (exercise)
- Low libido/erectile dysfunction (acknowledge issue, encouraging partnership intimacy, referral to urologist/sexual expert for further management)
- Mental and cognitive effects (exercise and acknowledgement)
- Large psychosocial impact/ partner issues

4. What are the biggest risk factors and how do we mitigate against them?

- Cardiovascular events in men with pre-existing coronary artery disease (exercise, diet changes, use LHRH antagonists over LHRH agonists)
- Metabolic changes (exercise, diet changes, no indication to add metformin in patients who do not have diabetes)
- Bone fractures (calcium, vitamin D, bisphosphonates, denosumab)

5. What blood tests/imaging should we be doing and why?

- Blood test: Lipids, HbA1c, hemoglobin, total testosterone
- Other investigations: bone density scan

6. What resources can help manage this in a busy office?

- Vancouver Prostate Centre Supportive Care Program's Module: Androgen Deprivation Therapy: An essential guide for prostate cancer patients and their loved ones: email PCSC@vch.ca
- Online access for patients and physicians:
 - <http://www.cancer.org/cancer/prostatecancer/detailedguide/prostate-cancer-treating-hormone-therapy>

– <http://www.medscape.com/viewarticle/738378>

Contact Dr. Jennifer Locke at jennlocke@gmail.com

FAMILY PRACTICE ONCOLOGY NETWORK CHAIRS

NETWORK COUNCIL

Dr. Philip White
Kelowna
250.765.3139
drwhitemd@shaw.ca

CONTINUING MEDICAL EDUCATION

Dr. Raziya Mia
Abbotsford
604.851.4710 ext. 644744
rmia@bccancer.bc.ca

GUIDELINES AND PROTOCOLS

Dr. Catherine Clelland
survivorship@bccancer.bc.ca

GPO TRAINING PROGRAM

Dr. Bob Newman
Sechelt
604.885.2667
drbobnewman@gmail.com

FOR MORE INFORMATION

To learn more about the Family Practice Oncology Network or become involved please contact: Jennifer Wolfe
Tel. 604.219.9579
email: jennifer.wolfe@bccancer.bc.ca

Visit the Network Website:
www.fpon.ca

The content of articles in this Journal represent the views of the named authors and do not necessarily represent the position of BCCA, PHSA or any other organization.

Publications Mail Agreement
Number 41172510
Return all undeliverable Canadian Addresses to
BC Cancer Agency
600 West 10th Ave, Vancouver, BC
V5Z 4E6