

Education Update

By Dr. Sian Shuel,
Medical Education Lead, FPON

BC Cancer's Family Practice Oncology Network (FPON) hit 2022 running with its complimentary, accredited webcasts for primary care on 'Case Studies in Cancer Related Thrombosis,' 'Minimally Invasive Procedures in Cancer Management,' and 'Return to Work for Cancer Survivors'. In the coming months, the proposed webcast lineup will see 'Approach to Oncologic Emergencies,' 'Breast Cancer Screening and Prevention,' and 'Understanding Mental Health in Our Patients with Cancer,' among other topics. Check back to the FPON.ca website for more details as the schedule is finalized.

continued on page 8

BEST PRACTICE CANCER CARE GEMS

- 1 Journal of Family Practice Oncology going Digital
- 3 GPOs in BC's Cancer Care System
- 4 Return to Work
- 5 Cervix Screening for HPV Pilot Expands
- 6 Breaking Bad News in a Good Way
- 7 New Recommendations for Physical Activity with Bone Metastases
- 9 Beyond Angelina Jolie: Hereditary Cancer Update
- 10 Patient and Family Support Services
- 11 Survivorship Care of Patients with Low Grade Lymphoma
- 12 Opportunistic Salpingectomy: A safe and Effective Contraceptive Choice that Prevents Ovarian Cancer

The beginning of a NEW ERA ... FPON Communications and Journal Going Digital, Fall 2022!

By Dr. Cathy Clelland, Medical Director,
Primary Care, BC Cancer

The impact of changes in our environment are in the news daily. The effects of environmental changes on chronic diseases including cancer, from exposures to ultraviolet radiation, air pollution, environmental toxicants, and infectious agents, is becoming a focus of more and more research.

As outlined in the recently published GPAC "Suspected Lung Cancer in Primary Care" www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/bc-guidelines/lung-cancer, "there is increasing recognition of the rise in number of cases of lung cancer in people who have never smoked". Much of this increase is likely attributable to other environmental exposures. At the beginning of the COVID pandemic, when virtually everything went on pause, the volume of local traffic decreased dramatically while "emissions of air pollutants fell drastically across the globe due to travel" according to the World Meteorological Organization in the Air Quality and Climate Bulletin – No. 1, September 2021. The improvement in air quality, even though temporary, is an example of what can be achieved if we all reconsider our activities and recognize our role in caring for the environment. I am sure that how those changes have affected health in the short term will be the subject of research in the near future.

As we learn more about the broader impacts of changes in our environment, there are things we can all do to decrease our

carbon footprint to positively impact our personal and organizational role. The COVID pandemic forced healthcare to pivot quickly to virtual care through telehealth, reducing the need for patients to travel to our office for care that did not require in-person assessment. It has become easier to collaborate with others online through the electronic group sharing of documents, attending virtual meetings, and attending educational events through video conferencing instead of travelling. Additionally, moving away from printed documents and journals that are distributed in hard copy to a digital format can contribute to reduce our carbon footprint by decreasing the amount of paper waste (even though it can be recycled) and reduction of delivery emissions.

To support a move to lower emissions and reduced carbon footprint, as well as save costs to the system, the BC Cancer Primary Care "Journal of Family Practice Oncology" will be moving to a digital only format effective with our next issue in the fall of 2022. Additionally, you will be able to receive communications with the latest Family Practice Oncology Network (FPON) news, educational updates, practice gems and other BC Cancer Primary Care communications. To subscribe, please scan the QR code below to sign up for our communications database and receive the Journal and other communications directly to your digital device. Questions? Please contact us at fpon@bccancer.bc.ca



Dr. Cathy Clelland



Laying the Foundation for the 10-year Provincial Cancer Action Plan

"A 10-year provincial cancer plan announced in 2020 will make British Columbia a leader in the full continuum of cancer care. This commitment includes new cancer centres in Burnaby and Surrey, as well as expansions of existing cancer centres. New centres for Kamloops and Nanaimo are in the concept planning stage."

– Premier John Horgan, Premier's statement on World Cancer Day, February 4, 2022

In celebration of World Cancer Day, Premier John Horgan highlighted that, every day, 85 British Columbians are diagnosed with cancer. He shared his gratitude for the care he received and emphasized the importance of new investments in care and the 10-year provincial cancer action plan.

At BC Cancer, we've been working with the Ministry of Health and our health authority partners to support the progress of the 10-year plan through the government approval process. While this work continues, we are actively laying the foundation to revitalize, expand and enhance care across B.C.

Thanks to new investments from the province, including 25 new alternative payment program-funded physician positions and \$25 million for a range of clinical and support staff positions, we are bolstering our care team, addressing workload pressures and preparing for the future. Recruitment is now underway for all roles.

These investments are the latest in a series of efforts to address our human resources challenges. These new physician roles, for example, when combined with the 12 we received in early 2021, add up to 37 new physician positions last year and 48 over the last three years.

Unlike previous funding allocations which, while appreciated and needed, were intended to fill gaps; this funding enables us to shift to a refreshed team-based care model. Team-based care puts the patient and their family at the centre of the care team. It is a collaborative approach that brings doctors, nurses, specialized clinical

and clerical staff together to deliver more comprehensive, coordinated and accessible care. Significantly, it is also the foundation for a larger series of initiatives aimed at synthesizing and coordinating care across the patient journey. BC Cancer will roll out team-based care at our centres in the coming year.

In the longer-term, we are working on exciting capital projects that will expand cancer care in some of B.C.'s fastest growing communities.

We are working closely with Provincial Health Services Authority and Fraser Health Authority on Phase 2 of the Burnaby Hospital Redevelopment project and a new Surrey Hospital. The Burnaby Redevelopment Project includes a new patient-care tower with 160 beds and an integrated cancer centre. The new Surrey hospital will also have an integrated cancer centre along with 168 in-patient beds, five operating rooms, an emergency department and more.

Finally, we are moving ahead with plans to expand services in Nanaimo and Kelowna. We are currently preparing the business plans to bring additional treatment options and beginning early-stage planning for these new centres.

Planning for capital projects is an extensive process that requires tremendous effort. While each project is at a different stage, we have



Dr. Kim Chi

Heather Findlay

been working with regional health authorities and other partners, to develop the business and concept plans to move these forward.

We recognize this is just one part of the work that's needed. Caring for patients with cancer doesn't start or end in our cancer centres. For the one in two British Columbians who will develop cancer in their lifetime, the entire health care system in B.C. is involved. In the coming months, we look forward to sharing the 10-year provincial cancer action plan and how we will support patients through the entire cancer journey.

Contact Dr. Kim Chi at kchi@bccancer.bc.ca and Heather Findlay at heather.findlay@bccancer.bc.ca

Read the Premier's statement on World Cancer Day at <https://news.gov.bc.ca/releases/2022PREM0005-000151>

BC CANCER
Provincial Health Services Authority

Save the date
Virtual & in-person conference
November 24-26, 2022

SUMMIT 2022
Transformation, Adaptation, & Inclusion
in Cancer Care & Research

More details will be available soon on the Summit website bccancersummit.ca and in the Fall 2022 online Journal of Family Practice Oncology

GPOs in BC's Cancer Care System

By Dr. Sian Shuel, GPO and Medical Education Lead FPON

The public is often familiar with the role of their family physician and their oncologist in their cancer care. But when told they'll be seeing a general practitioner in oncology (GPO) for one, or all, of their cancer treatments, the question often arises as to what a GPO is and what they do.

A GPO is a family physician with additional education and experience in cancer care. The initial extra education varies from province to province but, in British Columbia, it consists of an accredited two weeks of didactic sessions and six weeks of clinical rotations. In addition to this initial education, officially named 'BC Cancer Primary Care Program's General Practitioner in Oncology Education Program,' GPOs in BC undertake a minimum of 10 hours per year of oncology related education to maintain their oncology privileges.¹ They have a minimum of 24 weeks of providing relevant clinical services over the previous 36 months. (For details, see the BC Medical Quality Initiative's Clinical Practitioner in Oncology Privileging Dictionary.)

With the advent of COVID-19, the GPO Education Program's two-week didactic was converted to an online format, and clinical rotations were recognized at BC Cancer as essential to continue to help meet the needs of patients with cancer throughout the province. These clinical rotations often occur at both the regional BC Cancer Centre and community oncology site where the GPO will be working.

In a November 2021 Current Oncology editorial, BC Cancer was recognized for its 'educational expertise and clinical integration of GPOs' in the province and 'renowned for its General Practitioner in Oncology Education Program'.² In addition to meeting the needs of BC, BC Cancer's GPO Education Program has seen trainees from all over Canada join the two-week didactic session, including from Alberta, Nunavut, Ontario, Quebec and New Brunswick when capacity allows.

Once a GPO in BC satisfactorily completes the 8-week GPO Education Program, they take on a variety of roles, depending on the needs of each local community.

The community GPO will often work at a Community Oncology Network (CON) site. The CON is a 'collaborative voluntary partnership with hospitals

in the health authorities and with the BC Cancer regional centres and its systemic and radiation therapy programs' (Figure 1). It works 'to ensure that cancer care throughout the province meets the standards of BC Cancer'.³

It also helps ensure patients get the care they need as close to home as possible, where their supports are. The GPO

acts as a local cancer care resource within the community. The GPO role can include supporting primary care providers in the most current screening recommendations, advice on the workup of potential cancer presentations, staging investigations. Once a medical oncologist assesses patients, they are referred to their local CON site with a treatment plan for specific systemic therapy protocols and ongoing disease monitoring. At this point, the patient's care is shared between the community GPO and the medical oncologist, with the GPO being the eyes and ears on the ground and the medical oncologist being easily accessed as required. The medical oncologist also receives clinic notes from each GPO encounter to help ensure ongoing communication. Should the need arise, for example, when there is evidence of cancer progression, the patient is often re-assessed by the medical oncologist to decide on the next steps. At the community oncology sites, GPOs often act as a pain and symptom management palliative care resource, working with the primary care providers in their community to assist in facilitating care closest to home.

BC Cancer Regional Centres in Prince George, Kelowna, Abbotsford, Surrey, Vancouver and Victoria have GPOs working in-house. The GPO role may include



Dr. Sian Shuel

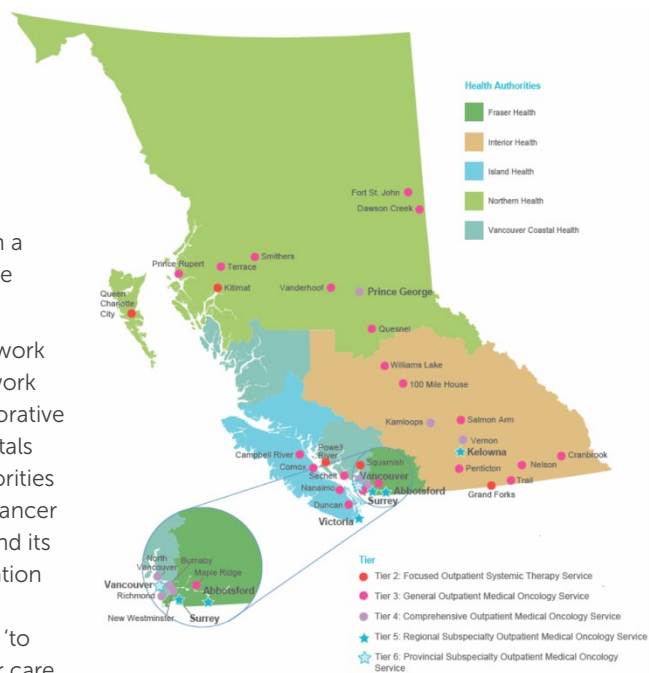


Figure 1: Community Oncology Network in BC

assessing patients before their next cycle of systemic therapy or next radiation treatment, helping manage treatment-related side effects and cancer-related symptoms, providing post-treatment follow up care, and performing procedures.

According to the Canadian Cancer Society, the number of new cancer cases diagnosed each year rose steadily by an estimated 153% in males and 161% in females between 1984 and 2021, primarily due to the growing, ageing population.⁴ This increased incidence, combined with patients with cancer living longer due to an increasing number of therapeutic options, poses a significant challenge on the health care system to meet patients' needs. It is recognized within BC that 'meeting the full range of needs of patients and a community is beyond the capability of one team or organization'.³ The incorporation of GPOs within the cancer care system is an innovative way to help meet the increasing need within the system and help ensure patients receive care close to home.

Contact Dr. Shuel at sian.shuel@bccancer.bc.ca

see References on page 13

Information on Canadian Association of General Practitioners in Oncology (CAGPO) training scholarships is on page 14

Supporting Patients Surviving Cancer with Return to Work

By Maureen Parkinson, Provincial Vocational Rehabilitation Counsellor and Dr. Christine Maheu, Associate Professor, Ingram School of Nursing McGill University

The Canadian Partnership Against Cancer¹ projects that, by 2031, there will be 2.2 million Canadians living with cancer. Studies show that while many will return to work,² between 26% to 53% of cancer survivors will lose their job or quit working during or after treatment.³ Over 26% of cancer survivors report deterioration in their physical work ability and 19% in their mental work ability.⁴ Among those who return to work (RTW), some still struggle with staying at work over time.⁵ These challenges with returning and maintaining work following cancer underscores the need for healthcare providers to support cancer with return to work. Primary care providers' (PCP) guidance from diagnosis and over time with respect to return to work has been found helpful by cancer survivors.⁶ While the roles of primary care providers supporting return to work is crucial, their role and responsibilities regarding RTW is not well defined.⁷ PCP report that they lack the training, knowledge and skills to advise on work related topics.⁸⁻¹⁰ Given these facts, the Canadian Partnership Against Cancer and Health Canada funded the development of Supporting Cancer Survivors with Return to Work, a free online course for primary care providers. The course was led by Maureen Parkinson, Provincial Vocational Rehabilitation Counsellor, BC Cancer and Dr. Christine Maheu, Associate Professor of Nursing, McGill University as part of their collaboration on Cancer and Work www.cancerandwork.ca Designed by the UBC Continuing Professional Development team, the free mainpro+ course is available on their platform "Supporting Cancer Survivors Return to Work".

The course helps PCPs define their roles in enabling cancer survivors' return to and remaining at work. Information in the course includes the introduction of the 10 step iCanWork framework (Parkinson and Maheu 2016), adapted for its use by primary

care providers to support planning for and fostering a successful return to work (RTW). The course content and iCanWork approach was reviewed by primary care providers, psychiatrists, rehabilitation specialists, medical oncology specialists, nurses, and

Lesson 4: Transitioning to the Workplace (Identify and foster workplace supports; contribute to the development of a return to work plan, prepare survivors for imminent return to work, manage work expectations, and monitor the work situation)



iCanWork program steps are flexible and can be tailored to the unique needs of the cancer survivors. The steps can be applied simultaneously or in different order based on the primary care provider's assessment and needs of the cancer survivor. While iCanWork was developed to support cancer survivors with a return to their former workplace, some of the steps can be used

cancer survivors. iCanWork guides PCPs on timely ways to address barriers to return to work and improve work ability.

The course is subdivided into 4 lessons.

Lesson 1: Introduction to Cancer Survivorship and Return to Work

Lesson 2: Assessment (Understand factors that can impact work, assess function, understand the job demand)

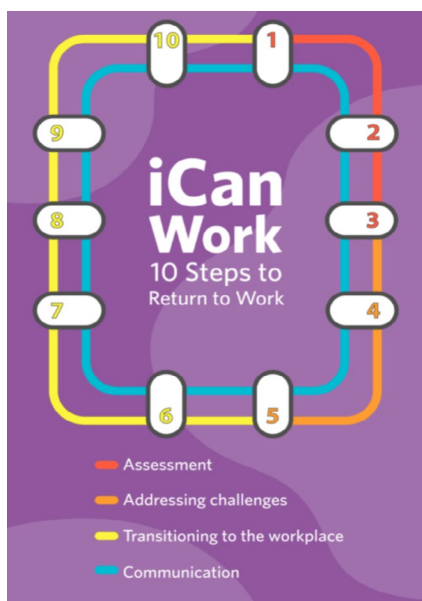
Lesson 3: Addressing Challenges (Identify, treat, and refer to support) and encourage survivors to take control

to facilitate the needs of those who are looking for a new job and with a new employer. In some steps, the primary care provider takes a leadership role, in others, they may contribute to a team-based approach to RTW. In such cases, they may make recommendations or provide cancer survivors with advice and resources to help them navigate RTW.

Communication is the central tenant of the iCanWork framework and the course

continued on page 5

Communication is the central tenant of the iCanWork framework.¹¹



iCanWork steps include:

Assessment

- 1 Understand factors that can impact work
- 2 Assess function*
- 3 Understand job demands*

Addressing Challenges

- 4 Identify, treat, and refer to support*
- 5 Encourage survivors to take control

Transitioning to the Workplace

- 6 Identify and foster workplace supports
- 7 Contribute to the development of a return to work plan
- 8 Prepare survivors for imminent return to work
- 9 Manage work expectations
- 10 Monitor the work situation

BC Cancer Expanding At-Home Cervix Screening Pilot Project to Communities in the Fraser Northwest Division of Family Practice



After the successful launch of the At-Home Cervix Screening Pilot in Central Vancouver Island and the Sunshine Coast in late 2021, BC Cancer is expanding the pilot to communities in the Fraser Northwest Division of Family Practice. This means eligible residents in New Westminster, Coquitlam, Port Coquitlam, Port Moody, Anmore and Belcarra will be invited to participate in the pilot.

The purpose of the At-Home Cervix Screening pilot is to improve screening access by providing eligible individuals with the opportunity to complete cervix screening at home. Instead of receiving a reminder or invitation for a Pap test, some individuals will receive an invitation to complete cervix screening using an at home HPV test. Screening at home removes many of the barriers associated with irregular or non-attendance for Pap tests, including inconvenient clinic hours, transportation issues, cultural barriers, previous trauma and indirect costs such as childcare and time-off work.

With at-home cervix screening, participants are mailed a screening kit that will arrive in

discreet packaging to their home. The kit will contain everything they need to collect their own sample to check for high-risk types of human papillomavirus (HPV) – the virus known to cause cervical cancer. Self-collection is quick, easy and painless. The individual will collect their sample by turning a small swab inside their vagina for 20 seconds. They will then mail back their sample to the laboratory using a prepaid return envelope included with their kit.

Screening for HPV has been shown to be more accurate than Pap testing. Pap testing detects changes to the cells of the cervix that have been caused by HPV. Whereas, HPV testing looks for the presence of high-risk types of HPV, often before cell changes have occurred, identifying individuals at risk for cervical cancer, earlier and better.

Approximately 67,000 eligible participants will be identified through B.C.'s client roster data and cross-referenced with individuals in the BC Cancer Cervix Screening Program database. Only those selected will be invited to participate at this time.

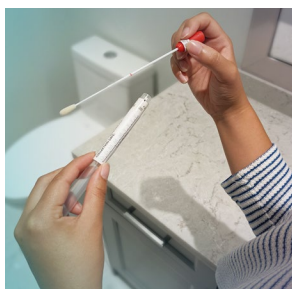
Primary care providers play an important role in supporting patients to feel comfortable with using at-home cervix screening instead

of a Pap test. For those providers in the pilot communities, some of your patients may be invited to participate in the pilot, and may have questions for you. Your patients may want to know that you support them in completing at-home cervix screening instead of a Pap test, and others may bring their kit into your office to complete the test themselves, or to have you take their sample. Primary care providers also have the important role of providing appropriate

follow-up and counselling to patients with positive HPV results. A Provider Guide containing frequently asked questions on at-home cervix screening has been created to support you and your patients. You can find this resource and other supporting information about the pilot

at: www.screeningbc.ca/cervix-pilot

This is an exciting initiative that aligns with the World Health Organization's call to eliminate cervical cancer. The pilot is expected to run for one year and will help the Cervix Screening Program fine-tune its patient communications, provider engagement strategies and internal processes to better serve patients across BC.



Supporting Patients Surviving Cancer with Return to Work continued from page 4

provides tips on how to respectfully and effectively speak to key stakeholders (cancer survivors, employers, insurance providers and other health care providers.) While most of the iCanWork steps can be applied by PCP to support others with disability, illness and injury with respect to return to work, Supporting Cancer Survivors with Return to Work provides information on how to assess and address the unique challenges that cancer survivors may experience that can impact work ability. Examples of unique challenges are cancer-related distress, sleep, cognition challenges (sometimes referred as "brain fog"), pain, and cancer-related fatigue.

The course also has a section on the unique needs of young adult cancer survivors transitioning to and maintaining work. Supporting Cancer Survivors with Return to Work was written in consideration of rural family physicians and provides ideas on how to access services within communities or online. The course also features links to downloadable information, tools and resources.

Learn More & Register

<https://ubccpd.ca/learn/learning-activities/course?eventtemplate=261-supporting-cancer-survivors-return-to-work>

see *References on page 13*

Educational opportunities provided by BC Cancer's **Family Practice Oncology Network**

made possible in part thanks to the support of the **BC Cancer Foundation**



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Breaking Bad News in a Good Way

By: Chantal Chris, MD, CCFP (PC)
Palliative Care Physician,
Pain & Symptom Management and Palliative
Care Clinic, BC Cancer, Abbotsford

Revealing that our patients' cancer is responding nicely to treatment or telling them that their disease is actually curable are not usually discussions that we need help with. The emotions that good news brings with it are easy to deal with, actually often downright pleasant. Contrast that with telling a patient their cancer is progressing or revealing to them a prognosis that is much shorter than they were hoping for. The emotions that these conversations elicit are often so hard for us to witness (let alone sit with) we often rush them or avoid them all together. Unfortunately, avoidance, delay, or breaking the news as quickly as possible do not make the conversations easier for us, and often end up making one of the worst times in our patients' lives even worse. We cannot fix our patients' pain in these circumstances, but we can fix how we deliver the message and respond to their pain using empathy, compassion and the following five tips.



Dr. Chantal Chris

'challenging' or 'difficult'. She explains that calling conversations by these 'battle-ready' terms makes us feel like we need to put on armour to prepare for them, when what we should really be doing is the opposite.

Having these conversations with our guard up, trying to protect ourselves from any vicarious unpleasant emotions, leaves our patients alone in their pain. Empathy is impossible to achieve while wearing armour.

The first step is preparing ourselves for each of these conversations by being aware of our own biases surrounding incurable illnesses, death, dying, etc. Negative past experiences in these areas often lead to over- or under-treatment, avoidance, or providing false hope. Positive past experiences often lead to more appropriate treatment options and increased empathy. Being aware of our past experiences help even those of us with more negative experiences recognize those possible biases and actively avoid those related behaviours, striving for the more positive behaviours. We should also prepare our patients for the conversation by ensuring a quiet location, sitting down, suggesting they have someone to support them if needed, asking if they are ready to talk, how much information they would like, and then giving them our full time and attention.

The second tip is to lead the conversation but not to force it, allowing people the time and the space to process their emotions. The best way to do this is to be honest and straightforward when we share information like test results or prognosis. Knowledge is power and giving information to a patient (in a kind and gentle way) about their own illness and their own bodies does not diminish hope or make things worse. Also, try to ask open-ended questions and listen, even if it creates awkward silences. A couple examples of good questions are: "what have you been told/what do you understand about your illness?" or "what worries you the most about this situation?".

The third tip is humility. Do not try to offer a 'fix' or even reassurance in these situations. We are not going to be able to fix the pain, and reassurance can often confuse the issue or offer false hope, making things worse in the near future. Trying to create silver linings is often well-intentioned, but only serves to minimize their feelings. As Dr. Brene Brown (a well-known researcher who studies empathy) has identified; "an empathic response rarely, if ever begins with the phrase 'at least...'" Now, a brief warning at this point: Empathy is what we need to connect with our patients, but it is also what can lead to burn out in the long run.

Which brings us to the *fourth tip; something that keeps us connected but allows for some emotional distance while moving us to help reduce our patients' distress by listening and supporting.* I'm talking about compassion. When the emotions start to flow it can often overwhelm rational thought and derail the conversation. We can respond to our patients' emotions compassionately by naming and exploring them with statements like: "You seem really upset. Tell me more about what you are feeling". Or "You seem surprised. Tell me about what you were expecting to hear". Other great techniques for supporting patients' emotions are "Wish, Worry, Wonder" statements. For example, imagine a patient with a short prognosis asks if they will be able

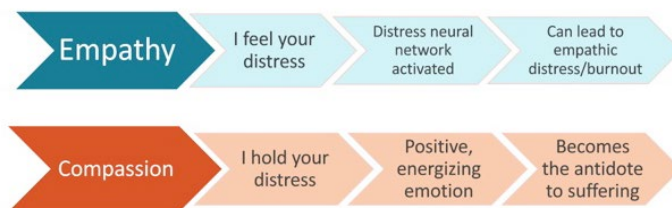
If you are looking for a good short video on empathy check out "Brene Brown on Empathy" on YouTube.

If you are looking for more information on the SPIKES mnemonic see Baile WF, et al. A six-step protocol for delivering bad news: application to the patient with cancer. *Oncologist*. 2000;5(4):302-11. doi: 10.1634/theoncologist.5-4-302.

If you would like to learn more about "wish, worry, wonder" statements please look into training with the "Serious Illness Conversation Guide (SICG)".

Kathryn Mannix (a therapist, retired palliative care specialist from the UK, and author of "Listen: How to Find the Words for Tender Conversations") refers to these types of discussions as 'tender' conversations rather than the words we usually use like

Response to another one suffering:



to make it to an important family event taking place in two years: We can respond with "I wish that I could say for sure that you will be able to go, but I worry that it may not be possible. I wonder if there are things you can do to prepare in the event you can't be there?"

The fifth and final step is closing out the conversation; this should also be done with care. Write out a summary if possible, make a concrete plan for next steps and the next time you will see the patient, and make sure to ask if they have any other questions.

continued on page 8

New Recommendations to Support Physical Activity for People with Bone Metastases

By Kristin Campbell, BSc, PT, PhD
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University of British Columbia, Affiliate
Scientist, BC Cancer Research Institute.

Encouraging people to avoid inactivity during and following cancer diagnosis and treatment is now recommended by the Canadian Cancer Society and other international cancer organizations. There is consistent evidence from randomized trials that physical activity can help to manage cancer-related fatigue, health-related quality of life, physical function, anxiety and depression,¹ and to improve survival in some types of cancer.² However, promotion of physical activity for adults with advanced or incurable disease has been underutilized, particularly with bone metastases because of concerns over skeletal complications, such as pathologic fracture, hypercalcemia, or spinal cord compression. Despite the potential of physical activity to support people with bone metastases to maintain physical function and continue to engage in usual activity of daily living,



Kristin Campbell

physical activity is often not discussed by the healthcare team. To address this situation, a team of physicians, allied health providers, researchers and people living with bone metastases, called the International Bone

Metastases Exercise Working Group (IBMEWG) was brought together to address the question, "What are the best practice recommendations for exercise programming for people with bone metastases?". The results were published in JCO Oncology Practice in January 2022.³

Best practice recommendations were developed based on published

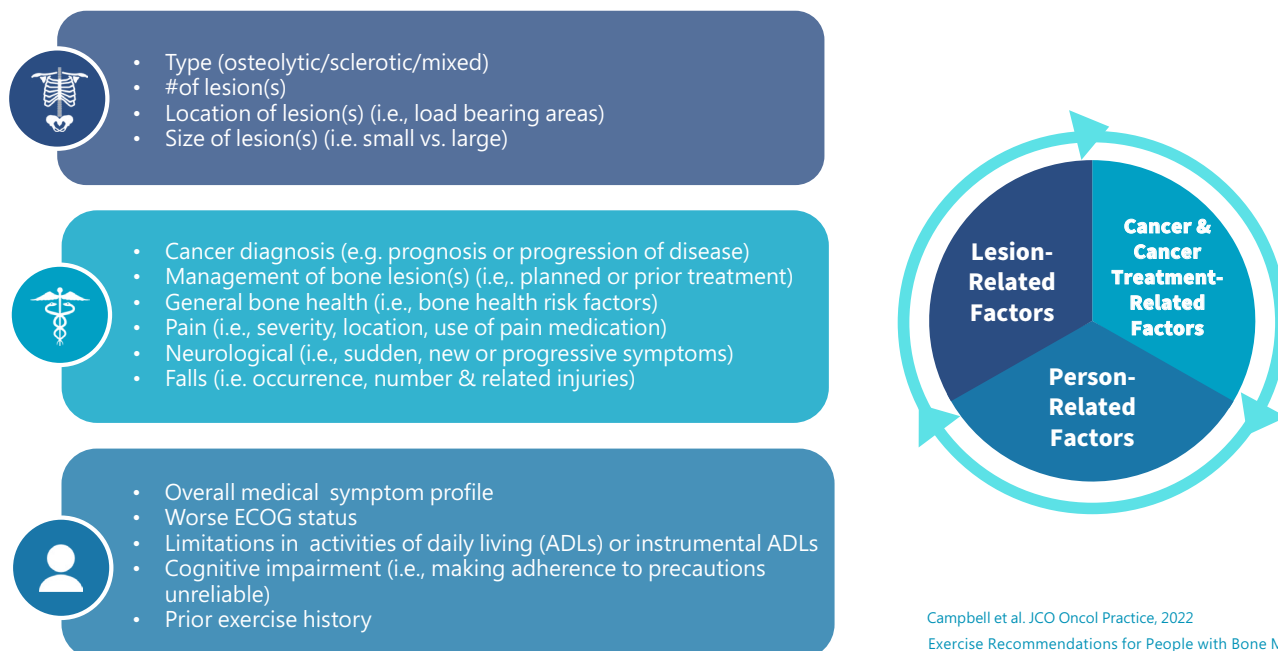
research, clinical experience and expert opinion, using a multi-step process. First, a cross-sectional survey of physicians and nurse practitioners working in oncology care in BC was conducted. There was agreement that physical activity has the potential to be beneficial and safe, but the providers did not feel that they have access to the appropriate resources required to recommend physical activity to their patients living with bone metastases.⁴

Second, to build on prior systematic reviews on exercise for people with advanced cancer,⁵ the team conducted a review specifically of controlled trials that included people with bone metastases,⁶ and reported on the safety, feasibility and efficacy of exercise. In 17 trials that included 645 people with bone metastases, only four serious adverse events (SAEs) were attributed to injuries related to an exercise intervention and none were related to bone metastases. However, three key considerations in interpreting the available data were highlighted: 1) use of exclusion criteria related to presentation of bone metastases (i.e., excluding people who presented with unstable bone metastases, or pain associated with a bone lesion); 2) elements of supervised exercise instruction; and 3) delivery by qualified exercise professionals (i.e., physiotherapist, clinical exercise physiologist, kinesiologist).

Finally the team conducted a modified Delphi survey, and brought these results along with the data gathered above, to an in-person meeting where the recommendations were developed. The IBMEWG recommended that people with

continued on page 8

Figure 1: Factors to consider in team-based approach for pre-exercise history in to provision of exercise programming for people with bone metastases



Campbell et al. JCO Oncol Practice, 2022
Exercise Recommendations for People with Bone Metastases

Support physical activity for people with bone metastases continued from page 7

bone metastases should be supported and encouraged to engage in regular physical activity, including structured exercise, to obtain the well-established general health benefits and to manage side effects related to cancer and treatments. Risks of skeletal complications should be weighed against the potential health benefits in consultation between patient, health care team, and exercise professional.

The IBMEWG acknowledged that bone metastases cause risk of an exercise-related skeletal complication. Fundamental limitations remain around a lack of definitive literature on standardized approaches to predict the risk of skeletal complications and a paucity of data on the safety and efficacy of exercise for specific people that may be at increased risk of skeletal complications with exercise (i.e., elderly individuals with multiple myeloma). Based on this, the IBMEWG proposed a risk assessment approach

that is based on clinical judgement of the healthcare team in collaboration with the exercise professional and a complex interplay of lesion-related, cancer and cancer treatment-related, and person-related factors (Figure 1). Also highlighted was the need for greater communication between members of the healthcare team and exercise professionals. Access to physical therapists and clinical exercise professionals is limited within cancer care settings in BC and often they do not have access to electronic medical records in order to effectively assess risk factors. The IBMEWG strongly encourages the development of bi-directional communication approaches between the cancer care team and exercise professionals that meet privacy and data sharing requirements.

The IBMEWG recommendations are consistent with two publications related to exercise for people with bone metastases and are anticipated to evolve as more literature is available. Sheill et al.⁷

published a review of considerations for exercise prescription for people with bone metastases, and the Macmillan Cancer Support in the United Kingdom developed a user-friendly guidance document for health care professionals.⁸ The IBMEWG aimed to address gaps in these documents by documenting the specific information gathering and decision-making processes used to generate the recommendations, and providing a framework and starting point for exercise professionals and members of the health care team to improved integration of physical activity into the care of individuals with bone metastases. The IBMEWG hopes these recommendations and the resources at the website hosted by University of British Columbia (cancerexercise.ca) help to support oncology care providers in British Columbia to start having more conversations about physical activity with people with bone metastases.

see References on page 13

Breaking Bad News in a Good Way continued from page 6

These tips can also be remembered through the mnemonic SPIKES which was actually initially designed by Baile et al in 2000 for oncology care. S stands for setting, P for perception, I for invitation or information, K for knowledge, E for empathy, and S for summarize or strategize. Plus, here's a bonus: all of this can be used for any type of tender conversation, not just professional

ones. Which means there are lots of opportunities to practice this with our family and friends, allowing us to become better communicators in all aspects of our lives. We have the privilege of playing important roles in some of the most awful and most memorable times in our patients' lives. Hopefully, these tips can help you provide your patients with the connection they need to make a world of difference during these times when they need it most.

BC Cancer provides specialized cancer care services to communities across British Columbia, the territories of many distinct First Nations. We are grateful to all the First Nations who have cared for and nurtured this land for all time, including the xʷməθkʷəy̓əm (Musqueam), Skwxwú7mesh úxwumíxw (Squamish), and səliłwətał (Tsleil-Waututh) First Nations on whose unceded and ancestral territory our head office is located.

Education Update continued from page 1

For those who joined us in early April, Daffodil Month, for our 'Let's Talk Practical Cancer Care – update on screening and post-treatment follow-up for primary care,' a big thank you. This virtual conference encompassed breast, colon, prostate and lung cancer screening and follow-up care. Keeping with this theme for Cancer Awareness Month, the April Webcast presented 'Cervical Cancer: Screening to Treatment'.

FPON's spring offerings also included our twice-yearly 'General Practitioner in Oncology (GPO) Education Program,' an 8-week educational requirement for family physicians newly hired as GPOs in

BC and the Yukon (both within community cancer clinics and at BC Cancer Centres). FPON's spring offerings also included our twice-yearly 'General Practitioner in Oncology (GPO) Education Program,' an 8-week educational requirement for family physicians newly hired as GPOs in BC and the Yukon (both within community cancer clinics and at BC Cancer Centres). **The GPO Education didactic sessions are also required for NPs who are newly hired by BC Cancer.**

Many of you may have already explored our self-directed online Primary Care Learning modules with the initial three topics of Breast Cancer, Colorectal Cancer and Prostate Cancer. We are working in collaboration with UBC CPD to develop a 4th module on Lung Cancer to add to

the Library. We are also in the prototyping phase of leveraging the online module content to support Case-based Virtual Small Group Learning Sessions as a means of connecting primary care practitioners, their local GPOs and oncologists at their Regional BC Cancer Centre. Initial sessions will be implemented in the East Kootenays with the Breast Cancer module as the clinical focus. The plan is to expand these virtual sessions to other regions of the province in the future. **If you are interested in participating in this exciting small group learning opportunity, please email us at fpon@bccancer.bc.ca**

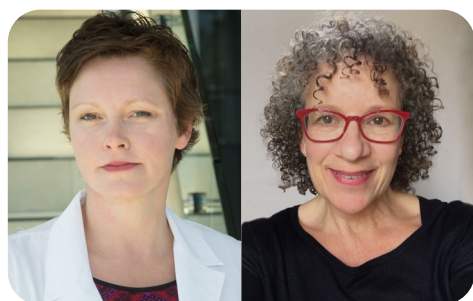
More information on FPON's accredited educational offerings and registration details can be found at www.fpon.ca

Beyond Angelina Jolie: Hereditary Breast and Ovarian Cancer Syndrome

Follow-up from FPON webinar September 16, 2021

By Lesa Dawson MD FRCSC, Gynecologic Cancer Survivorship Clinic, Vancouver, BC, Clinical Associate Professor, University of British Columbia, Associate Professor Memorial University

Rona Cheifetz MD MEd FRCSC, Hereditary Cancer Program High-Risk Clinic, Vancouver, BC, Associate Professor, University of British Columbia



Dr. Lesa Dawson Dr. Rona Cheifetz

Hereditary Breast and Ovarian Cancer (HBOC) is associated with pathogenic variants (mutations) in BRCA 1/2. HBOC however, more broadly includes other cancers; pancreas, melanoma, and male prostate. Other genes besides BRCA also increase breast and/or ovarian cancer risk, including *PALB2*, *ATM*, *CHEK2*, *RAD51C*, *RAD51D*, *BRIP1* and others.¹

Ancestry and Cancer Risk

Primary care providers are essential to the identification of patients at high genetic cancer risk. Recognition of risk, based on family history and ethnicity is especially important. Mutations in BRCA (*BRCAM*) exist in ~1% of the general population, however, certain ancestry groups have significantly increased prevalence or specific founder mutations, including those with Ashkenazi Jewish, French Canadian or Icelandic ancestry. In those with Ashkenazi Jewish ancestry (AJ) the carrier rate is 1 in 40, therefore the referral criteria for genetic testing differ. For further information about AJ hereditary cancer see: www.brcainnbc.ca

Referral Criteria

The BC Cancer Hereditary Cancer Program provides assessment, counselling and

testing services for people at risk for hereditary cancers. Families with many affected individuals, especially at younger ages, or having one individual with multiple cancers are high risk. Any AJ individual with a personal or any family history of breast, ovarian or pancreatic cancer should be referred. Regardless of ethnicity, all women with ovarian cancer, breast cancer (BC) <35y or triple-negative BC <50y, or bilateral BC should be referred, as should persons with pancreatic cancer and men with BC or metastatic prostate cancer.² Full referral criteria can be found at www.bccancer.bc.ca/coping-and-support-site/Documents/Hereditary%20Cancer%20Program/HCP_Form-ReferralForm.pdf

Risk Management: Breast Cancer (BC)

BC risk management options include surveillance or surgical risk-reduction. Decisions are highly individualized and include considerations such as previous personal cancer, family experience of cancer, tolerance of risk, and acceptance of invasiveness of surgery versus the burden of screening. Locally, 30% of *BRCAM* patients choose mastectomy.

Risk-reducing bilateral prophylactic mastectomies (RRM), provides >90% reduction in BC risk. Immediate breast reconstruction is an option for most women. Breast imaging is not required following RRM.

Women without RRM require annual clinical exam, breast MRI 25-70y and mammography starting at 30y. Breast MRI sensitivity is >90% in the earlier BC detection, providing earlier stage at diagnosis.

Chemo-prevention with tamoxifen, raloxifene or aromatase

inhibitors offers a decreased risk of >50% for estrogen receptor (ER) positive BC if taken daily for 5y. Uptake of this option is generally low across Canada.

Men with BRCA mutations should begin chest wall and axilla exams annually from age 35y.

Risk Management of ovarian cancer (OC)

No screening method for ovarian cancer is effective; Ca 125 or ultrasound are not recommended. Symptoms such as persistent bloating, early satiety, pelvic pressure, or urinary frequency should be investigated with pelvic US.

Risk reducing bilateral salpingo-oophorectomy (RRSO) is recommended for *BRCA1* 35-40y and *BRCA2* 40-45y. RRSO is associated with a 70% reduction in all-cause mortality, primarily due to decreased death from OC, but also reduced rate of BC in *BRCA2*. Hysterectomy is not routinely recommended for prophylaxis.

Premature iatrogenic menopause after RRSO causes negative effects on quality of life (QOL), vasomotor symptoms, sexual function, with long-term sequelae of osteoporosis, cardiovascular disease, and cognitive effects. Hormone replacement therapy (HRT) until the age of natural menopause is recommended and is associated with improved QOL and long-term

continued on page 10

Table 1 Cancer Risk in *BRCAM* carriers⁴

		Lifetime Cancer Risk (%)	
		Female	Male
General Population	Breast	11	0.1
	Ovarian	1.3	–
	Pancreas	1.0	1.0
	Prostate	–	5.9
<i>BRCA1</i>	Breast	72	1.2
	Ovarian	44	–
	Pancreas	Slight increase	Slight increase
	Prostate	–	8.6
<i>BRCA2</i>	Breast	69	7
	Ovarian	17	–
	Pancreas	Increased	Increased
	Prostate	–	15
	Melanoma	Increased	Increased

Supportive Cancer Care Services in BC for Patient and Family

By Jennifer Edgecombe, Manager,
BC Cancer Supportive Care

Psychological distress is common amongst people with cancer at screening, diagnosis, throughout the treatment journey and beyond.¹ Supportive cancer care is designed to help people to manage the physical, practical, emotional and spiritual challenges of the disease and its treatments.² The benefits of supportive cancer care are often realized in improvements to quality of life. But that's not all. Supportive cancer care can impact an individual's ability to participate in treatment planning, attend treatment sessions and complete a planned course of treatment.¹

The infection prevention measures employed during the COVID-19 pandemic have amplified the depression, anxiety and traumatic stress-related disorders already experienced by people with a diagnosis of cancer.³ Both social isolation and delays in testing or treatments due to the pandemic have contributed.³



Jennifer Edgecombe

To meet the increasing demand and overcome barriers created by COVID-19, many supportive cancer care services available in British Columbia have transitioned to a virtual service delivery. People with cancer no longer have to

travel to a Regional Cancer Centre to receive this vital care allowing for improved access to supportive care services across the province. Clinicians offering the services are now well-versed in the delivery of a virtual practice, making supportive cancer care more accessible than ever. Many services offered by BC Cancer can be accessed by patient self-referral up until 18-months after the

completion of treatment. There are many options for group services that are offered over the internet <http://www.bccancer.bc.ca/our-services/services/support-programs> Patients and clinicians can also sign up for a monthly eBulletin to browse services available at [https://app.cyberimpact.com/clients/28682/subscribe-forms/9375DED7-](https://app.cyberimpact.com/clients/28682/subscribe-forms/9375DED7-8D70-4770-899D-7A73B117EBB7)

8D70-4770-899D-7A73B117EBB7 . There are also community-based options to explore for online support. For example, the Canadian Cancer Society has an online support platform where people can connect to other people with cancer <https://cancer.ca/en/living-with-cancer/how-we-can-help/connect-with-our-online-community> .

Patients should be encouraged to explore the options available and to request referrals when needed. In addition to psychological support through Patient & Family Counseling, BC Cancer Supportive Care also offers Nutrition, Speech & Language Pathology, Pain & Symptom Management/ Palliative Care, Psychiatry, Vocational Counseling, Art Therapy, Spiritual Care, and other services <http://www.bccancer.bc.ca/our-services/services/supportive-care> Though virtual service can be new to some people and may feel different, both clinicians and patients agree that the services are effective for most patients.⁴ People with cancer in British Columbia do not have to suffer through psychological distress or other troubling symptoms alone.

see References on page 14

Hereditary Breast and Ovarian Cancer Syndrome continued from page 9

health and is considered standard of care. Transdermal 17 β estradiol and oral micronized progesterone regimens are preferred. HRT is contraindicated in women with a prior BC.

Ovarian cancers in *BRCAM* are high-grade serous type, originating in the fallopian tube, raising the idea that *BRCAM* women could have bilateral salpingectomy alone, avoiding the negative effects of RRSO. This research is promising, and many women consider a two-step procedure with delayed oophorectomy. This approach is not yet the standard of care and should not replace oophorectomy by the recommended age range. Salpingectomy is the recommended means of long-term contraception (rather than tubal ligation or IUD) for younger *BRCAM* women.

The oral contraceptive pill when used for at least 5 years significantly reduces the risk of ovarian cancer by 50% or more but is associated with a modest increase in BC risk. The risk-

benefit ratio for the use of OCP will depend on a woman's other risk management choices.

Risk management for other cancers

Prostate cancer in *BRCAM* presents at a younger age, higher grade and with a higher rate of metastases. Screening with annual PSA and rectal exam from age 40y is recommended.

There is no standard screening for pancreatic cancer (PC). Persistent abdominal pain or new onset of diabetes should be investigated. Locally, *BRCAM* with a first-degree relative with PC may enrol in research investigating annual endoscopic US and pancreatic MRI.

Annual skin/eye examination is recommended to screen for melanoma with biopsy of any suspicious nevi. Patients should seek medical attention for any changing moles or visual changes.

Conclusion

Hereditary cancer syndromes are now known to be more prevalent than previously reported, and the identification of a mutation carrier

before a cancer diagnosis can be lifesaving. Primary care providers play a key role in the detection and early referral of high-risk families. For a more detailed review of this topic please see: https://media.phsa.ca/home/iframe?url=BCCA/bccahealth%5cFPON_Sept_16_Webinar_Sept_16_20210916

References

1. https://www.nccn.org/professionals/physician_gls/pdf/genetics_screening.pdf
2. http://www.bccancer.bc.ca/coping-and-support-site/Documents/Hereditary%20Cancer%20Program/HCP_GuidelinesManuals_HBOC.pdf
3. https://media.phsa.ca/home/iframe?url=BCCA/bccahealth%5cFPON_Sept_16_Webinar_Sept_16_20210916
4. Risks of Breast, Ovarian, and Contralateral Breast Cancer for BRCA1 and BRCA2 Mutation Carriers *N Engl J Med* 2021;384:428-39.DOI: 10.1056/NEJMoa1913948

Survivorship Care of Patients with Low Grade Lymphoma

By Dr. Kai Luecke, MD, FRCPC
Clinical Assistant Professor
Hematology/Oncology, BC Cancer – Surrey

Low grade lymphoma is a heterogeneous group of malignancies involving the blood lymphocytes and accounts for roughly 50% of all lymphoma diagnoses. It is characterized by an indolent disease course.

Limited stage disease is often treated in curative intent with i.e. radiation.

Advanced stage disease is considered incurable but due to advances in treatment patients live for many years or decades. Treatment is only indicated if symptoms arise and is generally comprised of chemo-immunotherapy.

The current most commonly used first-line systemic therapy consists of Bendamustine + Rituximab (x6 months) and is followed by maintenance Rituximab (x 24 months). The majority of patients achieve a complete remission but 20% of patients will have an inadequate response or relapse within two years of initiating therapy which is associated with a poor prognosis.

The median progression free survival after first line therapy is 10.5 years (see graph A) and patients are usually seen infrequently by their oncologists. Selected patients achieving a complete remission might even be discharged back to the primary care provider for ongoing surveillance as their risk of disease recurrence is low in the foreseeable future.

Survivorship care is often based on expert opinion as opposed to evidence-based guidelines. In general, it is recommended that patients undergo once or twice-yearly physical exam focussing on previously



Dr. Kai Luecke

involved lymph node stations, splenomegaly, evaluation of B-symptoms (unintentional weight loss of 10% bodyweight within 6 months, drenching night-sweats, recurrent fevers/infections), and basic lab tests (CBC, differential, Creatinine, LDH). In the absence of clinical concerns, it is generally

discouraged to perform surveillance CT scans. This is in view of radiation exposure, side effects from IV contrast, as well as a high risk of false positive scans. Several trials failed to show a survival advantage with active imaging surveillance compared to observation alone. The detection of low volume lymphadenopathy by itself does usually not pose an indication to initiate

therapy again as long as the patient remains asymptomatic. Around 2/3 of patients detect relapse disease themselves as opposed to their health care provider. A waxing a waning of lymphadenopathy is not uncommon.

Around 10-15% of patients experience transformation of their indolent disease to an aggressive large cell lymphoma. This is often characterized by rapidly enlarging lymph nodes, elevated LDH, and B-symptoms. These patients are usually unwell and require urgent assessment.

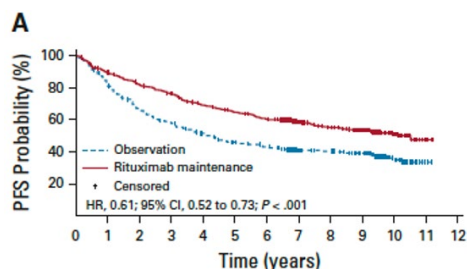
If disease recurrence is suspected, sectional imaging studies should be requested as well as a biopsy (BCCA lymphoma-protocol) to confirm the diagnosis. A referral (back) to the Oncologist is appropriate.

Patients who underwent systemic chemotherapy are at an increased risk for secondary malignancies (i.e. leukemia, skin, breast, etc.) and should continue with age

appropriate screening for malignancies. Further, patients should receive the yearly flu vaccine, strongly consider pneumonia vaccine, shingles vaccine and COVID vaccine as the risk of infections remains elevated in this population.

Patients with indolent lymphomas who completed their initial therapy are best served with a shared care model involving the primary care provider and Oncologist. Some patients may decide to transfer their care completely back to the GP/NP which in view of the expected long disease-free survival is appropriate. The patient's needs for management of their other/pre-existing comorbidities and screening procedures are naturally best met by the GP/NP. This model ensures high quality of care for those with complex chronic diseases while at the same time reduces the utilization of tertiary services and contributes to patient and provider satisfaction.

Additional resources can be found on the BC-Cancer website and patient specific questions should be discussed with the local Oncologist on call.



Kaplan Meier estimated of progression free survival of patients undergoing Maintenance Rituximab therapy compared to observation.

Journal of clinical oncology, volume 37, issue 31, "sustained progression free survival benefit of maintenance Rituximab in patients with follicular lymphoma (PRIMA study)

Recommended follow-up after end of therapy

Examination	Details	Year 1-2	Year 3-5	Year >5
History	B symptoms	Every 3-6 months	Every 6-12 months	Annually
Physical examination	B symptoms	Every 3-6 months	Every 6-12 months	Annually
Laboratory work-up	Blood and differential count	Every 3-6 months	Every 6-12 months	Annually
	LDH, IgG levels	Every 3-6 months	Every 6-12 months	If progression suspected
Imaging (optional)	Abdominal ultrasound	Every 6 months	Every 12 months	If progression suspected
	CT neck, chest, abdomen	Every 6-12 months	Every 12-24 months	If progression suspected

CT, computed tomography; IgG, immunoglobulin G; LDH, lactate dehydrogenase; LN, lymph node

Annals of Oncology, volume 32, issue 3, 2021: ESMO clinical practice guidelines for diagnosis, treatment and follow up.

Opportunistic salpingectomy: A safe and effective contraceptive choice that prevents ovarian cancer

By Alexandra Lukey, MA, School of Population and Public Health, University of British Columbia and Janice S. Kwon, MD, Lesa Dawson, MD, Gillian E. Hanley, School of Population and Public Health, University of British Columbia

Ovarian cancer is considered one of the most lethal cancers in our population, and there is still no effective screening method for this cancer. The most common type of ovarian cancer is high-grade serous carcinoma, and recently it has become apparent that most of these cancers arise in the fallopian tube.^{7,8} In 2010, British Columbia's ovarian cancer research team launched a province-wide strategy, asking gynaecologists to discuss removal of the fallopian tubes whenever there was an opportunity during pelvic surgery, such as hysterectomy for benign conditions, or instead of tubal ligation, while leaving the ovaries intact. This became an ovarian cancer prevention opportunity for the general population, namely, opportunistic salpingectomy (OS). Risk-reducing bilateral salpingo-oophorectomy remains the recommended prevention strategy for individuals at high hereditary ovarian cancer risk because of *BRCA* ½. OS was designed to prevent some of the over 80% of ovarian cancers that arise in people without genetic risk without causing premature surgical menopause and its long-term adverse sequelae.

The recommendation for OS has since been made in many countries, including across Canada and in the United States, and the UK.⁹⁻¹² Research has shown that OS is safe with no differences in major surgical outcomes, including overall hospital readmission rates, blood transfusions, and post-operative complications,^{1,2} as well as no difference in minor complications.³

Recently, we have published ovarian cancer outcomes following OS <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2788855?resultClick=3> confirming that no high grade serous ovarian cancers occurred in the OS group between 2008

and 2017. Had high grade serous ovarian cancers been arising at the same rate in the OS group as they arose in the control groups (those who had hysterectomy alone or tubal ligation), we would have expected 5.27 cancers (95% CI 1.78, 19.29). In fact, other common ovarian cancer risk and protective factors in the OS group place them at slightly higher risk (e.g., lower parity, lower gravidity, higher age) therefore suggesting that the fewer ovarian cancers in the OS group are unlikely to be explained by differences between the groups. The OS group had equal rates of breast/colorectal cancers compared to the control group, suggesting that other malignancy-related risks were not a factor in group comparison.

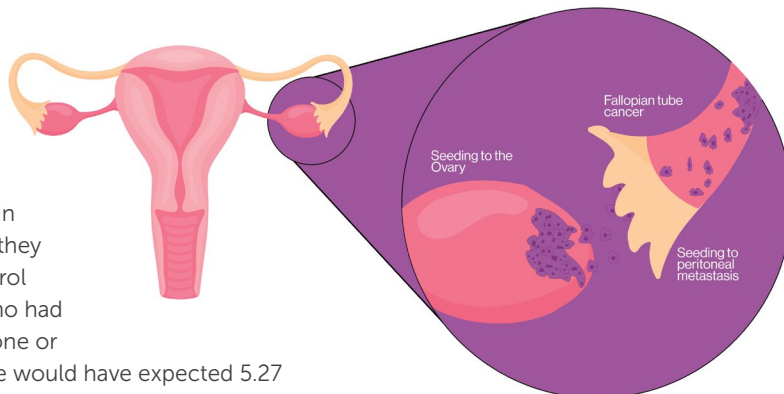


Alexandra Lukey

Our findings strengthen the evidence that patients may benefit from OS and there is value in presenting this option to individuals in the general population as an ovarian cancer prevention strategy. Importantly, this new evidence is relevant when patients are considering permanent contraception. As rates of tubal sterilizations (ligations and salpingectomies combined) have decreased by 25% between 2008 and 2017, the potential benefit of ovarian cancer prevention may influence patient choices.

We recommend that family physicians share the ovarian cancer prevention benefits of salpingectomy when discussing contraceptive options. Discussion points may include:

- Salpingectomy is a more effective form of contraception than tubal ligation.⁷ Even though tubal ligations are generally effective, there is still a small risk of tubal ectopic pregnancy, requiring either medical therapy or surgery. This risk is eliminated with salpingectomy.



- There are no increased perioperative or postoperative complications when comparing OS for sterilization to tubal ligation,^{1,3} including when OS is done at the time of cesarean section.⁴⁻⁶
- There is no evidence of earlier menopause or use of hormone replacement in patients choosing OS.⁸⁻¹²

While there are many factors to consider when choosing permanent contraception, patients should know that OS also confers some protection against high grade serous ovarian cancer.

see References on page 14

FOR MORE INFORMATION

To learn more about the Family Practice Oncology Network or become involved, please email FPON@bccancer.bc.ca or visit 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 BC Cancer, PHSA or any other organization.

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GPOs in BC's Cancer Care System
continued from page 3

References

1. BC Medical Quality Initiative. Clinical Practitioner in Oncology Privileging Dictionary. Available online: [http://bcmqi.ca/Published%20Dictionaries/ClinicalPractitionerInOncology\(2019-07\).pdf](http://bcmqi.ca/Published%20Dictionaries/ClinicalPractitionerInOncology(2019-07).pdf) (accessed January 28, 2022)
2. Chaput G, Lilly E. Oncology Care Provision: Planning for Today, Tomorrow, and Years to Come. *Current Oncology*. 2021; 28(6):4774-4775. <https://doi.org/10.3390/currconcol28060403>
3. BC Cancer. Community Oncology Network. Available online: <http://www.bccancer.bc.ca/health-professionals/networks/community-oncology-network> (accessed January 28, 2022)
4. Canadian Cancer Statistics Advisory Committee. Canadian Cancer Statistics 2021. Available online: <https://cdn.cancer.ca/-/media/files/research/cancer-statistics/2021-statistics/2021-pdf-en-final.pdf> (accessed January 28, 2022)

Supporting Patients Surviving Cancer with Return to Work continued from page 5

References

1. Canadian Partnership Against Cancer. Sustaining Action Toward a Shared Vision: 2012-2017 Strategic Plan. 2011;
2. Taskila T, Lindbohm ML. Factors affecting cancer survivors' employment and work ability. *Acta Oncol* 2007;46(4):446-51.
3. Mehnert A. Employment and work-related issues in cancer survivors. *Crit Rev Oncol Hematol* 2011;77(2):109-30.
4. Torp S, Nielsen RA, Gudbergsson SB, Dahl AA. Worksite adjustments and work ability among employed cancer survivors. *Support Care Cancer* 2012;20(9):2149-56.
5. Dorland HF, Abma FI, Van Zon SKR, et al. Fatigue and depressive symptoms improve but remain negatively related to work functioning over 18 months after return to work in cancer patients. *J Cancer Surviv* 2018;12(3):371-8.
6. Frazier LM, Miller VA, Miller BE, Horbelt DV, Delmore JE, Ahlers-Schmidt CR. Cancer-related tasks involving employment: opportunities for clinical assistance. *J Support Oncol* 2009;7(6):229-36.
7. Yagil D, Eshed-Lavi N, Carel R, Cohen M. Return to work of cancer survivors: predicting healthcare professionals' assumed role responsibility. *J Occup Rehabil* 2019;29(2):443-50.
8. Tamminga SJ, de Boer AGEM, Verbeek JHAM, Frings-Dresen MHW. Return-to-work interventions integrated into cancer care: a systematic review. *Occup Environ Med* 2010;67(9):639-48.
9. Amir Z, Wynn P, Chan F, Strauser D, Whitaker S, Luker K. Return to work after cancer in the UK: attitudes and experiences of line managers. *J Occup Rehabil* 2010;20(4):435-42.
10. Bains M, Yarker J, Amir Z, Wynn P, Munir F. Helping cancer survivors return to work: what providers tell us about the challenges in assisting cancer patients with work questions. *J Occup Rehabil* 2012;22(1):71-7.
11. Parkinson M, Maheu C. Cancer and work. *Can Oncol Nurs J* 2019;29(4):258-66.

Support physical activity for people with bone metastases continued from page 8

References

1. Campbell KL, Winters-Stone KM, Wiskemann J, et al: Exercise Guidelines for Cancer Survivors: Consensus Statement from International Multidisciplinary Roundtable. *Med Sci Sports Exerc* 51:2375-2390, 2019
2. Rock CL, Thomson CA, Sullivan KR, et al: American Cancer Society nutrition and physical activity guideline for cancer survivors. *CA Cancer J Clin*, 2022
3. Campbell KL, Cormie P, Weller S, et al: Exercise Recommendation for People With Bone Metastases: Expert Consensus for Health Care Providers and Exercise Professionals. *JCO Oncol Pract*:OP2100454, 2022
4. Adams J, Rauw J, Weller S, et al: Physical activity recommendations for cancer survivors living with bony metastases: views of oncologic healthcare providers. *J Cancer Surviv* 15:414-417, 2021
5. Nadler MB, Desnoyers A, Langelier DM, et al: The effect of exercise on quality of life, fatigue, physical function and safety in advanced solid tumor cancers: a meta-analysis of randomized control trials. *J Pain Symptom Manage*, 2019
6. Weller S, Hart NH, Bolam KA, et al: Exercise for individuals with bone metastases: A systematic review. *Crit Rev Oncol Hematol* 166:103433, 2021
7. Sheill G, Guinan EM, Peat N, et al: Considerations for Exercise Prescription in Patients With Bone Metastases: A Comprehensive Narrative Review. *PM R* 10:843-864, 2018
8. Support MC: Physical Activity for People with Metastatic Bone Disease, 2018

Supportive Cancer Care Services in BC for Patient and Family continued from page 10

References

1. Holland, J., Alici, Y. Management of Distress in Cancer Patients. *The Journal of Supportive Oncology* [Internet]. 2010 01 [cited 2022 03 09]; 8(1). Available from <https://europepmc.org/article/med/20235417>
2. Fitch, M. Supportive Care Framework. *Can Oncol Nurs J*. [Internet]. 2008 [cited 2022 03 08]; 18(1). Available from: <https://pubmed.ncbi.nlm.nih.gov/18512565/>
3. Wang, Y., Duan, Z., Ma, Z., et al. Epidemiology of mental health problems among patients with cancer during COVID-19 pandemic. *Translational Psychiatry* [Internet]. 2020 07 [cited 2022 03 09]; 263(2020). Available from <https://www.nature.com/articles/s41398-020-00950-y#citeas>
4. Islam, J., Vidot, D., Camacho-Rivera, M. Evaluating Mental Health-Related Symptoms Among Cancer Survivors During the COVID-19 Pandemic: An Analysis of the COVID Impact Survey. *JCO Oncology Practice* [Internet]. 2021 09 [cited 2022 03 09] 17(9). Available from <https://ascopubs.org/doi/abs/10.1200/OP.20.00752>

Opportunistic salpingectomy continued from page 12

References

1. McAlpine JN, Hanley GE, Woo MM, et al. Opportunistic salpingectomy: uptake, risks, and complications of a regional initiative for ovarian cancer prevention. *American journal of obstetrics and gynecology* 2014; **210**(5): 471 e1-11.
2. Hanley GE, McAlpine JN, Pearce CL, Miller D. The performance and safety of bilateral salpingectomy for ovarian cancer prevention in the United States. *American journal of obstetrics and gynecology* 2017; **216**(3): 270 e1- e9.
3. Hanley GE, Kwon JS, Finlayson SJ, Huntsman DG, Miller D, McAlpine JN. Extending the safety evidence for opportunistic salpingectomy in prevention of ovarian cancer: a cohort study from British Columbia, Canada. *American journal of obstetrics and gynecology* 2018; **219**(2): 172 e1- e8.
4. Garcia C, Moskowitz OM, Chisholm CA, et al. Salpingectomy Compared With Tubal Ligation at Cesarean Delivery: A Randomized Controlled Trial. *Obstetrics and gynecology* 2018; **132**(1): 29-34.
5. Duncan JR, Jones HL, Hoffer SO, Schenone MH, Mari G. Bilateral salpingectomy versus bilateral partial salpingectomy during cesarean delivery. *International Journal of Women's Health* 2018; **10**: 649-53.
6. Roeckner JT, Sawangkum P, Sanchez-Ramos L, Duncan JR. Salpingectomy at the Time of Cesarean Delivery: A Systematic Review and Meta-analysis. *Obstetrics and gynecology* 2020; **135**(3): 550-7.
7. Chakravarti S, Shardlow J. Tubal pregnancy after sterilization. *Br J Obstet Gynaecol* 1975; **82**(1): 58-60.
8. Morelli M, Venturella R, Mocchiari R, et al. Prophylactic salpingectomy in premenopausal low-risk women for ovarian cancer: primum non nocere. *Gynecologic oncology* 2013; **129**(3): 448-51.
9. Venturella R, Morelli M, Lico D, et al. Wide excision of soft tissues adjacent to the ovary and fallopian tube does not impair the ovarian reserve in women undergoing prophylactic bilateral salpingectomy: results from a randomized, controlled trial. *Fertility and sterility* 2015; **104**(5): 1332-9.
10. Naaman Y, Hazan Y, Gillor M, et al. Does the addition of salpingectomy or fimbriectomy to hysterectomy in premenopausal patients compromise ovarian reserve? A prospective study. *European journal of obstetrics, gynecology, and reproductive biology* 2017; **210**: 270-4.
11. Tehranian A, Zangbar RH, Aghajani F, Sepidarkish M, Rafiei S, Esfidani T. Effects of salpingectomy during abdominal hysterectomy on ovarian reserve: a randomized controlled trial. *Gynecol Surg* 2017; **14**(1): 17.
12. Venturella R, Lico D, Borelli M, et al. 3 to 5 Years Later: Long-term Effects of Prophylactic Bilateral Salpingectomy on Ovarian Function. *Journal of minimally invasive gynecology* 2017; **24**(1): 145-50.

FAMILY PHYSICIANS & GENERAL PRACTITIONERS

Is funding a barrier to you pursuing extra training in CANCER CARE?

The Canadian Association of General Practitioners in Oncology (CAGPO) offers training scholarships of up to one month in duration for FPs/GPs interested in cancer care. Please visit our website www.cagpo.ca for information about our scholarship program and the application process. If you have further questions please contact:

Dr. Lori Ann Hayward Lori.Hayward@easternhealth.ca
Applications must be received by June 15, 2022.
Please join us for our annual 2022 CAGPO conference.
Details at www.cagpo-annual-conference.ca



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