

Surgical Oncology Network Newsletter

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PROXIMAL GI SURGICAL TUMOUR GROUP

The Proximal GI Surgical Tumour Group is one of 13 tumour site groups established by the Surgical Oncology Network to focus on specific areas of cancer treatment. This is the eighth in a series profiling the initiatives and plans of these groups.



Dr. Greg McGregor
Chair, Proximal GI Surgical Tumour Group, SON
Surgical Oncologist, Vancouver General Hospital and BC Cancer Agency

Dr. McGregor completed his MD at the University of Western Ontario after receiving a BSc from the University of Toronto. He went on to complete General Surgical Residency Training at the Vancouver General Hospital and Health Sciences Centre. From there he completed a Surgical Oncology Fellowship at MD Anderson Hospital and Tumour Centre in Houston, Texas. His practice currently encompasses a broad range of Surgical Oncology, including thyroid, breast, melanoma and gastrointestinal cancer.

The Proximal GI Surgical Tumour Group (STG) represents those gastrointestinal sites not covered by hepatobiliary, lung, esophageal, and colorectal STGs. There are areas of overlap in the duodenum and in the lower esophageal/cardia region. The stomach and small bowel are the main focus of interest for this group.

Adenocarcinoma of the stomach, although relatively uncommon, is still a significant problem in British Columbia. In 2007 there were 396 new cases and it is projected that there will be 436 new cases in the year 2015. The overall 5-year survival rate for adenocarcinoma of the stomach is only 25%. For colon cancer, the corresponding figure is 61%. Therefore, one of the main objectives for this group is to try to improve these outcomes.

With this in mind, a major focus of the most recent SON Fall Update was on gastric adenocarcinoma. A summary of the event, provided by Dr. Rona Cheifetz, can be found in this newsletter. Until relatively recently, there was little other than surgery to offer patients with gastric adenocarcinoma. However, at the Update it was pointed out that there is substantial survival benefit for neoadjuvant therapy. A major MRC trial published in 2006 in the New England Journal of Medicine reported that 5-year

survival improved from 23% to 36% with preoperative therapy. Hence, surgeons are encouraged to refer gastric cancer patients, who are being treated with curative intent, for preoperative consultation at the BC Cancer Agency wherever possible.

Other improvements in management include more widespread use of PET scanning,

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MARK YOUR CALENDARS SON Fall Update in Surgical Oncology: From Uncommon to Common October 22, 2011 Four Seasons Vancouver

This accredited course will feature multiple topics in surgical oncology, including soft tissue sarcomas, melanoma, peritoneal carcinomatosis, desmoid tumours, carcinoid, screening for colon cancer, update on the management of the axilla, palliative surgery and the current status of synoptic reporting in BC. The program includes visiting speakers, Dr. Alexandra Eason, Surgical Oncologist, Mount Sinai Hospital, Toronto and Dr. Lloyd Mack, Surgical Oncologist, Tom Baker Cancer Centre, Calgary. This conference is a must attend event for general surgeons and residents and would be of value to other related specialists.

For more information and to register contact:
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visit <http://www.bccancer.bc.ca/son>

PROXIMAL GI SURGICAL TUMOUR GROUP

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increased use of endoscopic ultrasound, and hopefully increased awareness leading to earlier stage detection. In addition, the BC Cancer Agency is in the process of attempting to establish a better registry so that patients can be entered with appropriate staging and results can be interpreted more readily.

Other major malignancies involving the proximal GI tract are lymphomas and the GIST tumours. Here there is clearly overlap with other tumour sites, but the surgical aspect of managing these tumours lies with the Proximal GI STG. Again, preoperative multidisciplinary review for these cases is strongly encouraged. There are now indications for neoadjuvant treatment of GIST tumours as well as postoperative therapy. Lymphoma will often respond to chemoradiation without any need for surgery.

The SON plays an important role in collecting and coordinating more complete outcome data for GI cancer. Comprehensive outcomes data will enable surgeons to make more informed treatment decisions in the future and help improve outcomes for our patients. The SON rectal cancer management initiative has demonstrated the benefit of adopting this approach, and it is hoped that similar strides can be made with gastric cancer. We look forward to working with and receiving input from all our colleagues in BC.

For comments and questions please contact: Dr. Greg McGregor, Chair, Proximal GI Surgical Tumour Group; T: 604-875-5770; E: gregor.mcgregor@vch.ca

IMPROVING THE HEREDITARY CANCER PROGRAM REFERRAL PROCESS

Mary McCullum, Nurse Educator, Jenna Scott, Genetic Counsellor & Lauren Rafuse, Genetic Counselling Assistant, HCP, BC Cancer Agency

Thank you to all surgeons who completed a survey last year as part of a Hereditary Cancer Program (HCP) quality improvement project. This article provides a summary of the project and some implications for practice.

As some referring physicians will know, the HCP referral process was streamlined in 2008. A major goal was to facilitate motivated patients' ability to efficiently "push" through the referral process, while reducing the workload associated with "pulling" reluctant patients through the system.

New Referral Process: A detailed family history form (FHF) is sent by HCP staff to each referred patient. A cover letter describes the purpose of the FHF, provides contact information for questions, and advises that the referral will be closed if the FHF is not returned within four months. If the referral is closed, the patient receives a standard letter. An "information copy" of all letters is sent to the referring physician.

Approximately 35% of the 1500 referrals to HCP in 2009 were closed because the FHF was not returned. While this falls within non-response rates reported by other hereditary cancer clinics¹⁻³, it represents a significant workload for HCP staff, and may suggest that some patients prefer not to be "pulled" into this process. A quality improvement project was undertaken to gather input from some "non-responders" and their referring physicians. Patients who were referred in a two-month period and did not return a FHF were invited to complete a telephone survey about their experience (invitation sent one month after referral closed). Their referring physicians received a mailed survey.

Participation: 70% of eligible patients and 73% of eligible physicians completed a survey. Physician participants included surgeons (15%), oncologists (13%) and GPs (63%).

Key Outcomes: The top three patient-identified barriers to completing the FHF were:

1. Poor timing – new cancer diagnosis (self, family member), other life events
2. Difficulty collecting family history
3. Form was lost or confused with research studies

Patients did not identify issues with FHF format. The majority expressed interest in reactivating their referral, and a third did so within three months of their interview. Almost half of participants suggested a reminder phone call by HCP staff would be helpful.

Physicians identified the HCP waiting list as a barrier, and suggested that other formats for collecting family history (phone, online, with MD) be considered.

Practice Implications	Improvement Strategies
1. HCP referral may need to be deferred in light of current life events	<ul style="list-style-type: none">• HCP to revise FHF cover letter to include a "not now, future re-contact" option.• Referring physician could flag chart to re-visit HCP referral "at a better time".• Oncologist to review option of HCP referral on discharge.
2. Difficulty completing FHF (A phone follow-up to all referred patients is not possible)	<ul style="list-style-type: none">• Revise FHF cover letter to offer phone follow-up if assistance required.• Add "translation alert" when need for interpreter identified on HCP referral.
3. Referring physicians need current information about HCP waiting list (The appointment usually offered within 2-3 months of FHF return)	<ul style="list-style-type: none">• Regular updates to HCP website on waiting lists and criteria & process for expedited appointments.

HCP staff are committed to ongoing improvement of our referral process and will implement and evaluate strategies to address some identified barriers. Referring physicians are encouraged to consider how to address patients' readiness, as well as their eligibility, when discussing hereditary cancer referrals. We continue to welcome suggestions for ways to enhance the effectiveness and efficiency of HCP services.

Contact information: Mary McCullum at mmccullum@bccancer.bc.ca or visit www.bccancer.bc.ca/hereditarycancer

Full references are available at: www.bccancer.bc.ca/HPI/SON/Newsletter.htm

OVARIAN CANCER PREVENTION: SIMPLE SALPINGECTOMY

Dr. Sarah Finlayson, Gynaecologic Oncologist at VGH & BC Cancer Agency; Assistant Professor, Department of Medicine, UBC

High grade serous ovarian cancer is the most common subtype of ovarian cancer, accounting for two thirds of epithelial ovarian malignancies. In contrast to other types of epithelial malignancies (clear cell, endometrioid, and mucinous), this subtype is rarely confined to the pelvis at the time of diagnosis. It is the most lethal gynecologic malignancy in Canada; most patients present with advanced stage disease. The goal of cure for high grade serous cancer remains elusive.¹

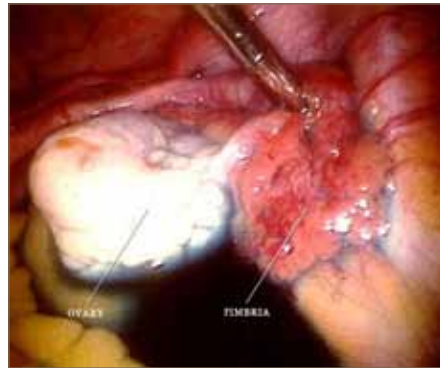
The absence of effective screening tools for early detection of ovarian cancer in both high-risk (BRCA1/2 mutation carriers) and the general population has led to increased interest in prevention and identification of precursor lesions. It is hoped that identified precursor lesions could be the target for screening and early detection efforts as well as possible prevention strategies.

Until recently, the ovarian surface epithelium and epithelial inclusions within the ovarian cortex have been the purported origin for these malignancies.² High grade serous carcinoma is the subtype most commonly found in BRCA1/2 mutation carriers and up to 20% of these cancers occur in women with germline BRCA1/2 mutations. It was believed that meticulous inspection of the ovaries from BRCA1/2 mutation carriers would reveal "ovarian" cancer precursors. However, careful histological examination of the ovaries and fallopian tubes from BRCA1/2 mutation carriers has identified cancer precursors not in the ovary, but in the distal fallopian tube epithelium.^{3,4,5,6}

What about the origin of high grade serous carcinoma in the general population? Ongoing research has demonstrated that the majority of these malignancies also likely arise from the fallopian tube epithelium.^{7,8,9} In addition, bench research has been able to demonstrate the transformation of fallopian tube epithelial cells into pathologically credible high grade serous carcinomas.¹⁰ Therefore, both clinical and experimental data are more supportive of a fallopian tube origin for high grade serous carcinomas.

The identification of a precursor lesion within the fallopian tube opens up new avenues for possible prevention. Each year, women undergo gynecologic surgery for benign and malignant conditions. Among the most common surgeries a Canadian woman will undergo in her lifetime are hysterectomy and tubal ligation. In

2008–2009, the most frequent indications for hysterectomy included uterine fibroids (35%); menstrual disorders (19%); genital prolapse (15%); gynecological cancers (15%); and endometriosis (8%).¹¹ While most of these surgeries are performed by gynecologists, in many communities general surgeons will have the opportunity to perform hysterectomies.



Removing the fallopian tube

Traditionally, when hysterectomy was performed and the ovaries were being conserved, the fallopian tubes were also left inside. This is typically done in premenopausal women for whom ovarian conservation is important. Knowing that most of these cancers likely begin in the fallopian tube means that our surgical convention should be changed. There is strong evidence that removal of the ovaries and the fallopian tubes in the high risk BRCA1/2 mutation carrier population decreases the risk of fallopian tube/ovarian cancer.¹²⁻¹⁵ The fallopian tube should be considered part of the uterus and removed at the time of hysterectomy, regardless of whether the ovaries are being removed or not. Salpingectomy could also be considered at the time of tubal ligation in a woman requesting permanent, irreversible contraception. In this circumstance we recommend removing the fallopian tube from the fibria to the insertion at the uterus, but not the intramural/uterine segment.

In September 2010, during Ovarian Cancer Awareness month, the Ovarian Cancer Research Program of BC (www.ovcare.ca) launched a province-wide education program aimed at changing surgical practice. Each gynecologist in BC received an educational DVD which outlined the background to this request for surgical practice change.

We currently do not have data showing the benefit of risk reducing salpingectomy in the general population. However, due to the minimal added complexity and morbidity associated with salpingectomy at the time of hysterectomy, the net potential benefit favours removal of the fallopian tubes at the time of

hysterectomy.

Ongoing studies will determine if this strategy is successful at preventing many cases of high grade serous carcinoma. Until such time as we have reliable screening tools or improved treatment protocols, prevention remains our current best hope at lowering the incidence of this deadly cancer.

The Society of Gynecologic Oncology of Canada is working to encourage national uptake of this surgical practice change. We have also committed to examining the effect of this change. We believe that the risk of developing high grade serous carcinoma could be reduced by up to 70% based on a conservative estimate of the portion of such cancers arising from the fallopian tube. In addition, it is understood that 20% of patients with high grade serous carcinoma have a germline mutation in BRCA1/2. We also recommend that all patients with a diagnosis of high grade serous carcinoma be referred for hereditary cancer counselling and possible genetic testing. This will identify future generations at risk and allow them to access surgical prevention.

Full references are available at:
www.bccancer.bc.ca/HPI/SON/Newsletter.htm

UPCOMING CONFERENCES

2011 Gastrointestinal Oncology Conference

September 15-17, 2011
Arlington, VA
<http://www.isgio.org/isgio2011/program.html>

Canadian Surgery Forum 2011

September 15-18, 2011
London, ON
www.cags-accg.ca/

SON Fall Update 2011

October 22, 2011
Vancouver, BC
<http://www.bccancer.bc.ca/son>

ACS - Clinical Congress/Surgical Forum

October 23 -27, 2011
San Francisco, CA
<http://www.facs.org>

North Pacific Surgical Association

November 11-12, 2011
Vancouver, BC
<http://www.nopacsurg.org>

HIGHLIGHTS FROM THE SON UPPER GI AND HEPATOBILIARY CANCERS UPDATE 2010

Dr. Rona Cheifetz, Chair, Continuing Professional Development & Knowledge Transfer Committee, Surgical Oncology Network

On October 23, 2010 the Surgical Oncology Network hosted the Annual Fall Update at the Four Seasons Hotel, downtown Vancouver. The topic was Upper GI and Hepatobiliary Cancers. There were close to 50 attendees, primarily general surgeons, but also medical oncologists and radiation oncologists. Presentations from this event are posted on the Surgical Oncology Network website at www.bccancer.bc.ca/son

Use of Endoscopic Ultrasound in Gastric Cancer

Dr. Greg McGregor, Chair of the SON Proximal GI Surgical Tumour Group, chaired the morning session. Dr. Jennifer Telford, a gastroenterologist from St. Paul's Hospital, opened with a presentation of the use of endoscopic ultrasound (EUS) in gastric lesions. Dr. Telford indicated that EUS may be helpful in distinguishing benign from malignant gastric ulcers but generally does not change management of gastric cancer (unless considering mucosal resection for early tumors). EUS can be useful in evaluating submucosal masses. An increased risk of malignancy is found if lesions are >3cm, have irregular extraluminal borders, echogenic foci, cystic spaces, or enlarged nodes. **EUS with FNA can be diagnostic for GIST** in 62% of cases if C-kit staining is done. She recommended that low risk GISTs <3 cm in size be followed, but pointed out that 14% will enlarge.

Adjuvant and Neoadjuvant Therapy for Gastric Cancer

Dr. Howard Lim, from GI Medical Oncology at the Vancouver Centre reviewed the role of adjuvant and neoadjuvant therapy in the management of gastric cancer. He noted the limitations of surgery alone for gastric cancer, indicating that the probability of R0 resection with surgery alone decreases as tumour depth increases from 100% for a T1 lesion to 40% for a T4 lesion. With regards to nodal involvement, even more aggressive surgery with extended lymphadenectomy does not improve overall survival, though subset analysis does show survival improvement in patients with N2 disease. While good surgery is the key and chemoradiation does not make up for a bad operation, there is evidence that it does confer a survival benefit. He reviewed the results of the MAGIC trial which gave three cycles of ECF (epirubicin, cisplatin, 5-FU) before and after resection of stage 2 or 3 gastric cancer. The 5-year survival was 36% for the treatment group vs 23% for the surgery alone group. This has since been confirmed in other trials. Adjuvant radiation therapy trials have shown an improved 3-year overall survival of 23% vs 27%. In addition, trials of adjuvant chemoradiation have also shown benefits. He concluded that **all patients with resectable gastric/GE junction tumours should be referred preoperatively for consideration of perioperative adjuvant therapy.**

Surgery of Gastric Cancer and Premalignant Lesions

The first session ended with our guest speaker, Dr. Carol Swallow, Surgical Oncologist from Toronto, and a comprehensive update on the surgical management of gastric cancer. Dr. Swallow began by discussing staging in gastric cancer and noted that **laparoscopy changes management in 20%-30% of cases.** EUS can be useful in the assessment of resectability with high sensitivity (90%) and specificity (85%). PET scanning is more controversial as 30% of gastric cancers are not FDG avid. As was discussed by Dr. Lim, Dr. Swallow indicated that the NCCN guidelines recommend preoperative chemo for all >T2 or N+ patients and chemoradiation for fit patients with unresectable, but nonmetastatic tumours. She noted that preoperative treatment increased the probability of a R0 resection in the MAGIC trial.

Dr. Swallow spent some time addressing the evidence regarding the extent of lymphadenectomy in gastric cancer resections. **She emphasized the importance of obtaining >15 nodes for adequate**

staging. While earlier studies showed no benefit to D2 dissection at five years, current studies show significant improved survival in node positive patients at ten years. In a Cochrane review, D2 dissections showed increased morbidity and mortality if the spleen or pancreas was resected, and if the surgeon was inexperienced, but may benefit T3+, Stage II or IIIa (unproven). Dr. Swallow indicated that at least a D1-1.5 was indicated in all cases.

With regards to resection margins, Dr. Swallow indicated that positive margins are associated with significantly reduced survival and are seen more commonly with deeper tumours. Therefore, for T1-2 lesions, a 3 cm gross margin is adequate but if T3-4, a 6 cm margin is needed. Frozen section analysis and re-excision of positive margins is beneficial only if <5 nodes are positive.



D2 Dissection for Gastric Cancer

Dr. Swallow covered a number of additional topics in her talk. Regarding gastric polyps, both hyperplastic and adenomatous polyps are associated with malignancy and should be removed. For the latter, the apparently 'normal' mucosa should also be biopsied. She discussed the **role of laparoscopic resection in gastric cancer indicating that four RCTs favour open surgery based on the adequacy on nodal harvest** (one showed no survival advantage). Laparoscopic resection is acceptable in early gastric cancer with 5-year DFS >95%. Endoscopic approaches to early gastric cancer show that submucosal resection is associated with a better outcome than mucosal resection only. Early gastric cancer remains uncommon in the west. Genetic mutations in e-cadherin are associated with a 70% lifetime gastric cancer risk and a 40% lifetime risk of lobular breast cancer. Total gastrectomy is recommended at five years earlier than the youngest affected member for mutation carriers. Regarding the role of total gastrectomy as a palliative procedure, Dr. Swallow indicated that this has significant morbidity (50%) and mortality (6%) rates and benefits <50% of patients. There are other palliative options that should be considered rather than noncurative resections. In an emergency situation there is high morbidity and mortality associated with gastrectomy. Perforated gastric ulcers should be biopsied and followed endoscopically. Finally, Dr. Swallow noted that GE junction cancers are

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HIGHLIGHTS FROM THE SON UPPER GI AND HEPATOBILIARY CANCERS UPDATE 2010

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increasing in incidence. They benefit from preoperative chemoradiation if T3-4. There is a significant incidence of nodal involvement even with 'early' disease and these patients benefit from careful staging including PET scanning.

GI Lymphomas, with Focus on *H. pylori* and Gastric Lymphoma

Following the coffee break we continued with a presentation on GI Lymphoma by Dr. Abdul Al-Tourah, Medical Oncologist, Fraser Valley Centre. Dr. Al-Tourah indicated that incidence of lymphoma is increasing. Involvement of the GI tract may be primary or secondary. In the west, the stomach is the most common site of GI tract involvement (75%). Patients usually present with pain, anorexia and weight loss. The stomach is the most common site of involvement of MALT lymphoma (85%) which is usually early stage 1 or 2. There is a 90% prevalence of associated *H. pylori* infection. **Gastric MALT is multifocal disease so surgery is not the primary mode of therapy.** Antibiotics, radiation, chemotherapy alone or in combination are preferred to surgery. Overall 5-year survival is 90% with antibiotics alone and 70% are disease free at five years. Importantly, there is a poor response to antibiotics if more than the mucosa is involved, if nodes are involved, if *H. pylori* is negative, if higher grade or associated chromosomal abnormalities are identified. Ongoing follow-up is critical. For stage 1E the recommended follow-up is every six months for two years then annually for three years once *H. pylori* and MALT are cleared. If stage 1E and *H. pylori* negative, the preferred modality of treatment is XRT. Higher stage tumours are treated with chemotherapy.

Update on GIST

The last lecture of the morning was an update on GIST by Dr. Rona Cheifetz. She emphasized that while adjuvant treatment is available, **surgery is the only curative therapy for GIST.** Consequently, needle biopsy should be used selectively, only if it will make a difference to the management. Similarly, transperitoneal biopsy should be avoided, but EUS and biopsy is appropriate. The pathologic interpretation of these biopsies can be challenging and benefits from an expert review before surgical intervention is considered. In addition to C-kit, which is positive in 95%, newer markers are also available to facilitate diagnosis in C-kit negative lesions.

Dr. Cheifetz indicated that **intraoperative rupture is associated with a significant increased risk of recurrence** and that recurrence is equivalent to metastatic disease (i.e. generally not curable). Laparoscopic resection can be considered for gastric tumours between 2-5 cm using an extraction bag and careful tissue handling to avoid rupture. The recommended resection margins are 1-2 cm for gastric lesions and 2-3 cm for small bowel lesions.

The overall risk of recurrence following resection is >50%, but is a function of tumour size, mitotic rate and site of origin with particularly high risk associated with lesions >10cm, those with >10 mitosis per 50 hpf, and those of small bowel or rectal origin. Imatinib, a tyrosine kinase inhibitor, when used in an adjuvant setting for one year was associated with a significant improvement in disease free survival (HR 65%) with RR of 8% vs 20% at 19.7 months. The optimum duration of adjuvant therapy is not known and currently being studied. Neoadjuvant therapy for functionally unresectable tumours (those that would require a total gastrectomy or APR) is beneficial with a significant decrease in tumour size if used for 6-9 months and an increased probability of R0 resection (77%).



Endoscopic Image and EUS. Left: Ulcerated submucosal mass in gastric body. Right: Irregular homogenous submucosal mass.

Mutation analysis shows different sensitivity to imatinib as a function of the type of mutation and is important in the management of patients with recurrent/metastatic disease, particularly if they are not responding to treatment. Dose escalation is effective in the setting of certain mutations. Assessing the response to treatment can be challenging as simple measurements of tumour size is not reliable. Changes in density or loss of FDG uptake on PET are more suitable for these tumours.

Recurrent disease should be treated medically. In general, those who progress on treatment will not benefit from resection. The role of surgery in recurrent/metastatic disease is controversial. There is no evidence yet that resection improves survival; however, if it is undertaken, medical therapy should be continued post resection. Ultimately, patients will stop responding to treatment, even with dose escalation. Localized, single site progression may be considered for resection. Newer second and third line therapies are available now, including sunitinib and nilotinib. Local therapy such as RFA and embolization is an option for unresectable liver disease, but does not replace medical therapy. We ended the morning with a lively panel based case discussion of gastric tumours.

Pancreatic Conundrums, Benign and Malignant

After lunch, we changed gears for a hepatobiliary review chaired by Dr. Charles Scudamore, Chair of the Hepatobiliary Surgical Tumour Group. Dr. Calvin Law, our second visiting speaker and a Surgical Oncologist from Toronto, began with a comprehensive review of benign and malignant pancreatic masses. In approaching solid lesions of the pancreas, Dr. Law indicated the need for dedicated imaging in the form of a "CT with pancreas protocol". Newer technology like MRI/MRCP can define relationships to ducts and interpretation is enhanced with the use of contrast. EUS can further define the vascularity, density, relationship to other structure and can be used for tissue diagnosis (FNA, tru-cut). He noted that it is critical to identify symptoms associated with solid lesions (to rule-out functional tumours).



Dr. Calvin Law presenting on pancreatic conundrums

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If truly asymptomatic and resectable, but not resected, solid pancreatic lesions must be followed for growth as 71% of solid lesions are either malignant or harbour a malignant risk. Follow up includes imaging and clinical reassessment for the development of symptoms. Frequency of imaging will depend on degree of suspicion (6 months for low suspicion, 3 months for non functional possible NET) and the duration of follow-up (1-2 years for NET).

Dr. Law went on to address mucinous pancreatic lesions. Intraductal papillary mucinous tumours (IPMT) are subclassified as to whether they involve the main or branch ducts or both. Main duct involvement (identified by the presence of a dilated duct) is associated with higher risk of malignancy and should be resected. These are slowly progressive lesions with a 5-10 year lag time to become invasive. In contrast, mucinous cystic neoplasms (MCN) originate from ovarian rests and do not recur once resected. It is important to differentiate IPMT from MCN as the treatment and prognosis differ. The criteria for malignancy (best assessed by MRI/MRCP) in IPMT is a duct dilated >15 mm (for Branch duct IPMT lesion >3cm or main duct >7mm), thick enhancing wall, or soft tissue nodules. EUS can provide supplemental information in the evaluation of cystic lesions including appearance, amylase, CEA and cytology. IPMT is associated with a 60% 5-year survival post resection with follow-up imaging recommended every 6 to 12 months for the 5-10 years.

Finally, Dr. Law discussed the management of pancreatic adenocarcinoma, noting that adenocarcinomas make up 85%-90% of all pancreatic tumours. Unfortunately, only 10%-20% are resectable and still most of these are not cured. The NCCN criteria for resectability defines resectable as having no metastases and having a clear fat plane around the celiac and SMA. There are strict criteria for 'borderline resectable' related to the extent of involvement of portal vein, SMA, SMV, hepatic artery and the ability to resect and reconstruct these structures. Adjuvant therapy is being increasingly applied to pancreatic cancer patients. Trials with adjuvant gemcitabine show improved 5-year survival (21% vs 9%) post resection but not everyone is well enough to receive adjuvant therapy and this does not address all the unresectable patients. Neoadjuvant chemoradiation trials show promise for improving resectability and outcomes. He **strongly recommended that all patients being considered for surgery for pancreatic adenocarcinoma should have a multidisciplinary conference review prior to surgery.** If clearly resectable, they should have surgery, if borderline or suboptimal, they should have neoadjuvant chemoradiation. Options for palliative chemotherapy have improved with folfirinix vs gemcitabine with prolongation in survival and maintenance of quality of life.

Isolated Liver Mass: Imaging and When to Biopsy

Our final speaker was Dr. Silvia Chang, radiologist from Vancouver General, who reviewed radiology and the liver mass. She noted that the majority of hepatic lesions can be diagnosed without a biopsy (98%) unless they are less than 1 cm in size (in which case they are usually benign). Overall, MRI is the best single test and triple phase CT is the best alternate. Dr. Chang presented a spectacular review of characteristic imaging features of common masses (please see the presentation on the SON website). **Regarding the role of FNA in the diagnosis of liver lesions, Dr. Chang summarized by saying "think about it, then don't do it".** She noted the risk of bleeding with hemangiomas and adenomas, the risk of seeding with HCC (2.7%) and the commonly nondiagnostic results with FNH and adenomas. The indications for FNA are really limited to unresectable lesions or diagnostic dilemmas. Dr. Chang also discussed the increasing role of interventional radiology in the management of non-resectable hepatic tumours with RFA, transcatheter chemoembolization and selective radiation.



Dr. Silvia Chang presenting on the isolated liver mass

SUPPORTING CHINESE-SPEAKING CANCER PATIENTS

Sandy Kwong MSW RSW, Patient and Family Counselling Services, BC Cancer Agency

British Columbia is a multicultural community. According to the 2006 Census, BC has a population of 4 million, where 25% are visible minorities. Chinese as the largest visible minority make up 10% (407,225) of the population. In the psychosocial oncology literature, estimates for significant distress (depression and anxiety) range from 25% to 50%. Non-English speaking cancer patients with language and cultural barriers experience additional challenges in coping with their disease.

I am Chinese and I was brought up in a Chinese culture (Hong Kong). I have worked with Chinese-speaking cancer patients at the BC Cancer Agency for ten years. I provide counselling for patients and their families in Cantonese and Mandarin, facilitate the Chinese Cancer Support Group and develop bilingual English-Chinese patient materials. This article is written based on both my personal and clinical experience as well as the knowledge generated from the ethnographic study of the BCCA's Chinese

Cancer Support Group¹⁻² and a psychosocial needs study³ involving focus groups conducted in BC with Cantonese and Mandarin speaking cancer patients.

Family is very important in Chinese culture. The close, interdependent family relationship allows us to seek help, support, and advice to make decisions. This is particularly essential and valuable at times of distress, especially in instances where a family member has been diagnosed with cancer. In addition, many Chinese cancer patients in BC are also immigrants. This means that their family support may be significantly decreased after migration. In general, Chinese people try not to seek help outside of the family, to avoid burdening others – we are raised with this cultural value. Chinese are also raised to attend to our family needs over our personal needs. Chinese cancer patients are often hesitant to ask for help from outside their family circle. In many Chinese families, men are often defined as the main breadwinners and women as the

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SUPPORTING CHINESE-SPEAKING CANCER PATIENTS TO COPE WITH A CANCER

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caregivers and home makers. If a Chinese woman has breast cancer and has to go through a long treatment process or undergo surgery that affects her daily functioning abilities, she often experiences strong feelings of guilt. This guilt stems from not being able to care for the children, for not being able to cook for the family, and for being a burden on the family. Dealing with practical issues within the family seems more important than personal and emotional concerns. Without knowing what community resources are available to help them to cope with their disease, their distress level is further heightened.

Many Chinese-speaking cancer patients report that they have inadequate knowledge of their cancer, its treatment, the health care system and the community resources. It is not uncommon to hear that they associate cancer with terminal disease or death. Their inability to speak or communicate comfortably in English impacts their communication with health care providers, ability to access resources, and their understanding of the diagnosis and treatment, which further adds to their distress. In addition, there are differences in health values and health care systems between BC and their home countries. They often wonder why they are being referred to see their doctors and/or receive their treatments at different locations. They also wonder why their hospital stays are only a few days long, instead of until full recovery. They describe themselves as being lost in this cancer 'maze.' Many Chinese patients also perceive surgery as a means to remove the 'bomb' from their body. They regard surgery as the best and the only way to cure their cancer. When they are told that surgery is not suitable, not feasible or they need other post-surgery treatment, they will think that their health prognosis is very poor.

How to become self-reliant? Which particular foods to eat and which to avoid? These are the frequently asked questions by the majority of Chinese cancer patients in counselling sessions and in the Chinese Cancer Support Group. For them, food is being perceived as having curative value to improve their health and as a means to fight the disease. They are keen to take an active role in self care to regain their independence and to minimize the burden on their family. They have strong needs for information to help them strengthen their overall health, to manage their treatment side effects and to speed-up their recovery process.

Greater understanding of Chinese patients' concerns allows health care providers to be more sensitive to individual patient's needs. As there are different factors that influence a person's values and help seeking behaviours, assessment is needed to avoid generalization.

Full references are available at:
www.bccancer.bc.ca/HPI/SON/Newsletter.htm

Suggestions and resources to help Chinese patients cope with cancer and help minimize their distress

SUGGESTIONS

- Suggest to patients to bring a family member to medical appointments.
- Arrange for professional interpretation services for consultation, pre and post surgery appointments.
- Encourage patients to use the community's support to cope with the transition and, if needed, arrange for assistance to access the resources.
- Refer patients to psychosocial professionals in cancer centers and hospitals for counselling support and to liaise with community resources – a Chinese-speaking social worker is available at BCCA (Vancouver Center); interpreters could be arranged for patients to see English-speaking counsellors at other cancer centres or regional hospitals.
- Provide or direct patients to patient education materials, including self-care information.

RESOURCES

BCCA Resource Guide for Chinese Cancer Patients

- Information on emotional support, financial assistance, community care, transportation, child care, nutrition information and meal services.
- Available at: <http://www.bccancer.bc.ca/PPI/copingwithcancer/practical/default.htm> or call Patient & Family Counselling Services at 604.877.6000 or 1.800.663.3333 local 672194 (English) or 672375 (Chinese).

BCCA Chinese Cancer Support Group

- The only professionally-led support group in Cantonese.
- Call 604.877.6000 or 1.800.663.3333 x 672375.

BCCA Chinese Peer Navigator Program

- Trained Chinese-speaking cancer survivors who meet new cancer patients at Vancouver Centre to provide them with directional guidance and emotional support.
- Call 604.877.6000 or 1.800.663.3333 x 673063.

BCCA Navigation Guide for Chinese Cancer Patients

- Information on Vancouver Centre, tips to prepare for medical appointments and communication with healthcare providers.
- Available at www.bccancer.bc.ca/copingwithcancer.

BCCA Library

- Resource checklist available to assist Chinese cancer patients.
- Call 604.675.8001 or 1.888.675.8001 x 8001

Canadian Cancer Society Hotline

- Cancer information, peer support program and referral to community services. Interpretation service available upon request.
- Call 604.675.7148 or 1.888.939.3333

HealthLink BC (Dial 811)

- Phone service for nurses, dietitians and pharmacists for non-emergency health concerns. Interpretation service available upon request.

SURGICAL ONCOLOGY NETWORK NEWS

CONGRATULATIONS TO DR. RONA CHEIFETZ ON RECEIVING THE 2010-11 UBC FACULTY OF MEDICINE AWARD FOR DISTINGUISHED SERVICE TO CME/CPD!



Left: Dr. Rona Cheifetz,
Chair, SON CPD-KT and
Right: Robert Bluman,
Associate Dean, CME UBC

Dr. Cheifetz was honoured at the Faculty of Medicine Awards ceremony May 31, in recognition of her outstanding commitment and contribution to the continuing professional development of surgeons in BC.

Dr. Cheifetz has been an innovative and influential leader in surgical education for over 12 years. From the time of her first appointment as a junior faculty member at UBC, she has been a dedicated academic surgical educator, first as the Department of Surgery Clerkship Director, then as the CME Director for both the Department of Surgery and the BC Surgical Oncology Network.

Only a decade ago, Dr. Cheifetz was the only surgical oncologist in Canada with an advanced degree in education in Canada. She was then asked by the Head of Surgical Oncology at the BC Cancer Agency to develop a CME program for the newly formed Surgical Oncology Network. At the time no other formal surgical oncology focused CME programs existed anywhere in North America. The Surgical Oncology Network Fall Update is a UBC sponsored and accredited educational event that Dr. Cheifetz developed and organized to educate surgeons about cancer surgery and optimal patient care. This educational program is now nationally recognized as the most successful and community integrated surgical oncology curriculum in the country.

Dr. Cheifetz is also the Executive Editor of the SON Newsletter. Serving as an educational tool and communications vehicle, each issue of the Newsletter contains a variety of articles highlighting recent developments, publication reviews and important information in the field of surgical oncology.

As an academic surgical oncologist and as an educator, Dr. Cheifetz has made a significant impact on the provision of cancer care in the province of BC and nationally. She is one of only three academic General Surgical Oncologists at UBC and one of the few surgical oncologists from BC actively involved in the Canadian Society of Surgical Oncology.

Dr. Cheifetz's outstanding contribution to the ongoing education of surgeons throughout BC has been innovative and greatly influential to the practice patterns of surgeons across this province. BC continues to lead the country in cancer patient outcomes, and the Surgical Oncology Network CME program has been a key component in this regard. Her leadership, dedication and commitment to continuing professional development have been instrumental to surgeons across BC, and in turn to their patients.

SURGICAL ONCOLOGY NETWORK SURVEY WINNERS

Congratulations to Dr. William Orrom and Dr. John Cooper who each have won a \$100 London Drugs gift card. Dr. Orrom was selected in a random draw for completing the Breast Cancer Synoptic Operative Report Survey. The survey was conducted to assess physician agreement on key synoptic elements to be included at the end of the traditional dictated operative report. The survey was distributed to 102 surgeons who perform breast cancer procedures in BC. The overall response rate was 61%. The survey results were presented by Dr. Elaine McKeivitt at the SON Annual Council meeting held March 18 and at the BC Surgical Society meeting on May 6, 2011.

Dr. Cooper was selected in a random draw for completing the Cancer Management Guidelines survey. The survey was conducted to determine the level and format of information that surgeons would like to see in the BC Cancer Agency's cancer management guidelines and to identify their preferences for accessing cancer care information. The survey was distributed to over 500 surgeons across the province and had a response rate of 58%. The results will be reviewed by the Network's Clinical Practice Committee and a report will be provided to the Surgical and Provincial Tumour Groups as well as to the BC Cancer Agency Executive. SON would like to thank all surgeons who completed the surveys.

SON RESIDENT TRAVEL AWARD

for BC Surgery Residents/Fellows and Medical Students

The Surgical Oncology Network Resident Travel Award is a competitive award intended to motivate physicians and medical students, early in their training, to pursue an interest in surgical oncology and to allow them to present research findings at conferences. The application must be submitted 6 weeks prior to the start of the conference. Approved applications may be funded up to a maximum of \$1000. Forms and guidelines are available online at www.bccancer.bc.ca/son

SURGICAL ONCOLOGY NETWORK NEWSLETTER

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VISIT THE SURGICAL ONCOLOGY WEBSITE

www.bccancer.bc.ca/son

The BC Surgical Oncology Network exists to promote and advance quality cancer surgery throughout the province, enable the integration of quality surgical oncology services into the formal cancer care system, and ensure that patients have the best possible outcomes through consistent access to high quality multidisciplinary care. To enhance appropriate, equitable and timely access to surgical services for cancer patients as close to home as possible, the Network supports communication and sharing of knowledge between subspecialty and community surgeons, their respective hospitals and the BC Cancer Agency.

The Council Executive oversees the implementation of the Network's mandate and is comprised of surgeons and senior health administrators representing all the health regions across the province. The three committees - Clinical Practice, Continuing Professional Development & Knowledge Transfer and Research & Outcomes Evaluation - assist with the planning, implementation and promotion of the Network's goals and priorities. The thirteen Surgical Tumour Groups advise on the issues and challenges in the surgical management of patients within each tumour site to improve the surgical management of cancer patients.