BC Cancer Agency
CARE & RESEARCH
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BC Surgical Oncology Network

Newsletter

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Spring 2008

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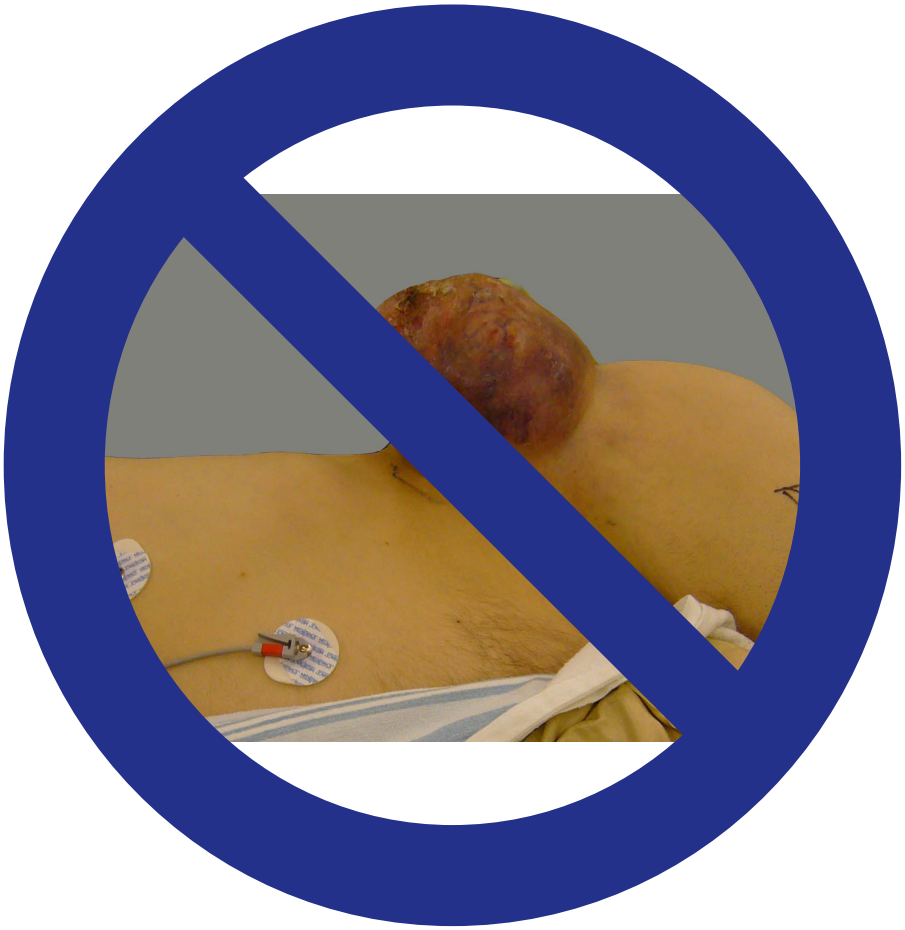
PROCEED WITH CAUTION



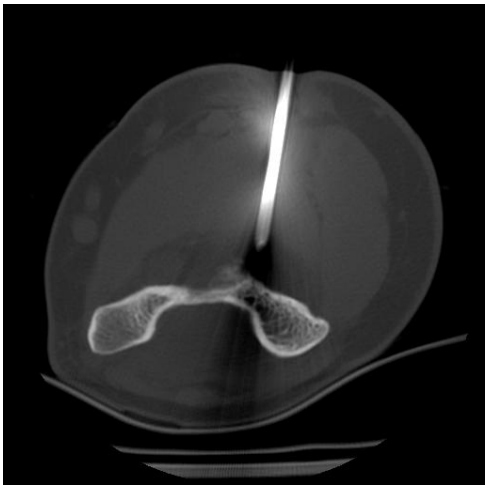
PROFILE OF A SURGICAL TUMOUR GROUP: SARCOMA

The Sarcoma Surgical Group is chaired by Vancouver-based surgeon Dr Bas Masri. Dr Masri has been involved with sarcoma management and the BC Cancer Agency for 14 years.

Sarcomas are a rare and a difficult group of tumours to manage. Due to their rarity (1% of all cancers), treatment in highly specialized centres is the accepted standard of care in the Western world. This allows surgeons to develop and maintain the experience necessary to achieve the best possible outcomes. The occasional surgeon will likely not obtain the same results as surgeons who specialize in this rare group of tumours. The majority of sarcomas occur in the extremities, but they can occur anywhere in the body. As such, surgery may involve any number of different subspecialists, each dedicated to the management of sarcomas within their anatomical area of surgical expertise, although the vast majority of sarcomas are treated by an oncological orthopaedic surgeon.

Optimal treatment can involve surgery, radiation therapy and chemotherapy or any combination thereof. This makes a multidisciplinary approach to management imperative to achieve the best possible outcomes for this challenging group of patients. Our practice is for all patients to be presented to a multidisciplinary conference prior to management so that all team members that will be involved in the patient's care can discuss the surrounding issues.

Delay in referral is unfortunately commonplace with bone tumours, leading to higher rates of amputation and death. Our recommendation to general practitioners is that any patient, especially an adolescent, with unexplained pain or swelling around a joint that persists for more than 6 weeks needs a radiograph of the area as well the joints above and below. Plain radiographs are the gold standard for the diagnosis of bone tumours



This biopsy was done for a suspected osteochondroma prior to referral. The errors here are:

1. Osteochondromas are not diagnosable by biopsy
2. This is not an osteochondroma
3. The approach used (as the limb was not marked by the requesting surgeon) makes limb salvage virtually impossible if this lesion is malignant

A simple review of the Xray by an orthopaedic sarcoma surgeon could have made the correct diagnosis and management much more simple (an osteoblastoma treated with curretage).

The other common error in bone sarcoma management is failure to obtain a correctly performed biopsy prior to surgical intervention. This often happens in the setting of an older patient with a pathological fracture that undergoes internal fixation on the assumption that the lesion represents a metastasis, or a patient who undergoes a biopsy using incorrect techniques or surgical approaches. The latter is a real problem, and has been shown to adversely affect outcomes. No sarcoma biopsy should be performed without the direct supervision of an experienced orthopaedic oncologist working at a tertiary care cancer centre. Any patient who has a symptomatic solitary lesion of bone should be considered to have a sarcoma until proven otherwise.

Management of bone tumours, whether they are benign or malignant, should be undertaken by a surgeon experienced with these lesions. The mainstay of local management is surgical resection with wide margins and reconstruction of the skeletal defect. Some are responsive to chemotherapy while some also respond to radiation and receive all three treatment modalities. Typically patients receive three cycles of chemotherapy and then have their resection, followed by a further three cycles. If radiation is required, it is given preoperatively. Although preoperative treatment does not improve survival, it allows assessment of treatment response, preoperative planning (which is less important with modular implants) and reduces the amount of time that the patient is immunocompromised while a new major joint replacement is in situ. Survival rates can be as high as 80 per cent, depending on the specific pathology.

Soft tissue sarcomas are also a rare group of tumours that require early detection and prompt referral to achieve the best patient outcomes. In the case of extremity soft tissue sarcomas, that means a specialized orthopaedic sarcoma clinic, while retroperitoneal or abdominopelvic lesions should be referred to the general surgical oncology service. The term, soft tissue sarcoma, actually represents a diverse group of tumours that are only now being fully characterized by modern

molecular techniques. They range from low grade well-differentiated liposarcoma to high grade malignant fibrous histiocytoma.

The key to detecting soft tissue sarcomas is to maintain a high level of suspicion. Any lesion that is deep to the deep fascia, greater than 5 cm in maximum diameter or is rapidly expanding should be assessed by a sarcoma surgeon prior to any surgical intervention on the lesion. An MRI or biopsy prior to referral is not required and is actively discouraged. Delay or inappropriate biopsy can lead to unnecessary amputation and increased mortality.

Sarcoma Surgical Tumour Group Membership

- Dr. Bas Masri (Chair) UBC Hospital
- Dr. Paul Clarkson, BC Cancer Agency

Management of soft tissue sarcoma is also multidisciplinary, with treatment generally involving preoperative radiation and sometimes chemotherapy. Wide surgical resection is required and the complexity of achieving this while minimizing morbidity means that these patients should be managed by surgeons undertaking these resections frequently. In the extremity, resection requires intimate familiarity with complex anatomy, as well as a thorough understanding of limb function and biomechanics, and soft tissue and even skeletal reconstruction is often required.

Both bone and soft tissue sarcomas are triaged and managed according to their anatomical site. Soft tissue tumours arising in the retroperitoneum or abdominal cavity should be referred to a General Surgical Oncologist for the same reasons discussed for extremity tumours. Laparotomy and excision with positive margins is often not a salvageable situation. Pre-operative referral and multidisciplinary management is in the patient's best interest.

For extremity sarcomas, both bone and soft tissue, a full-time service is provided from the BCCA Vancouver centre. Dr Paul Clarkson works solely as an extremity sarcoma surgeon with the assistance and experience of Dr Masri to allow for a seamless service. Dr Clarkson completed three years of fellowship dedicated to extremity sarcoma and limb salvage surgery before being recruited to Vancouver two years ago. Dr Ken Brown provides paediatric sarcoma care at the BC Children's hospital.

Patients are seen from across the province in a timely and efficient manner. Extremity sarcoma outreach clinics are offered every three months in Kelowna, but urgent referrals at other times are seen in Vancouver. If necessary patients are seen immediately, otherwise in the next week's clinic or after urgent imaging has been completed. For patients traveling from far away an MRI, clinic visit and core biopsy can all be combined in the same visit.The high volumes concentrated in one centre allow for rapid assessment, treatment and expert surgical care in a multidisciplinary environment. It is axiomatic that a surgeon working in one area continually will have better results than those with less experience. Our aim is to provide access to our expertise to all patients in the province, regardless of where they choose to live.

For any further information please contact either Dr Bas Masri or Dr Paul Clarkson through the BC Cancer Agency at 604 877 6000 x 2396.

RECTAL CANCER UPDATE: THE LAST 5CM - DISTAL TME AND BEYOND

The 2008 Surgical Oncology Network Fall Update will be taking place on **October 25, 2008** and will focus on Rectal Cancer and "The Last 5 CM - Distal TME and Beyond"

Learning Objectives

- Review technical aspects of distal TME dissection – abdominoperineal, abdominosacral, transsphincteric.
- Review preoperative imaging techniques.
- Review indications for preoperative adjuvant radiation and chemotherapy.
- Discuss and plan best practice protocols for rectal cancer management.

Features:

- World expert speakers.
- Touch-pad learning – Each presenter will begin/ end with 3 multiple-choice questions that contain the main points for the presentation.
- Opportunity for lively discussion sessions.

An optional Live OR case on MIS Spincter-Preserving APR will be offered at an additional cost on Friday October 24.

Registration brochures and information are available at: www.bccancer.bc.ca/HPI/SON

Clinical Conundrums

Case: A 62 year old hospital worker presented with early satiety, associated with a 30 lb weight loss. Physical examination was normal. CT Imaging demonstrated a diffuse thickening of the gastric walls with no associated lymphadenopathy, distant metastases or ascites. At upper GI endoscopy, the stomach did not distend well, the mucosa was erythematous with thickened folds, but there was no discrete mucosal lesion seen. Multiple biopsies were non-diagnostic. The question raised was whether this patient has gastric lymphoma or gastric adenocarcinoma, and how to best make the diagnosis.

Discussion: Differentiating gastric lymphoma from linitis plastica due to gastric adenocarcinoma can be challenging endoscopically, as in both cases the mucosal biopsies may be normal. In linitis plastica due to gastric adenocarcinoma the malignant signet cells infiltrate the submucosa causing a stromal reaction resulting in the typical leather- bottle stomach. As gastric lymphoma can be managed non-surgically, obtaining a tissue diagnosis without resorting to laparotomy, is preferred. Endoscopic ultrasound with biopsy is the ideal solution to this problem. Either fine needle aspiration or tru-cut biopsies (taken obliquely through the gastric wall to avoid transgressing the serosa) can be taken using this technique. EUS and biopsy has been shown to be highly sensitive for the diagnosis of gastric submucosal lesions. While the technology is not widely available in BC, this patient did travel to Vancouver for the procedure and was diagnosed with gastric adenocarcinoma by FNA.

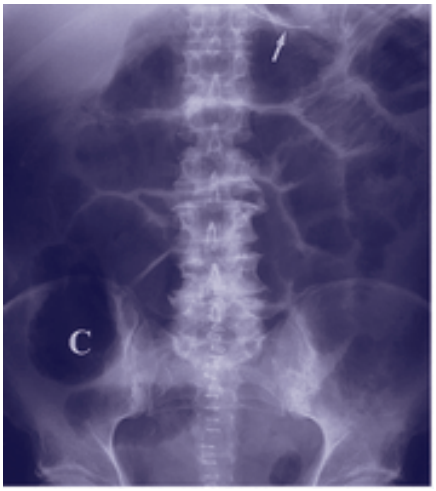
Reference: Jones, D. Brian. Endoscopic Ultrasound in the Staging of Upper Gastrointestinal Cancers. ANZ Journal of Surgery Mar 2007. 77(3): 166-172

Managing Malignant Bowel Obstructions

Jason Francoeur, MSc MD FRCPS Peace Arch Hospital White Rock BC

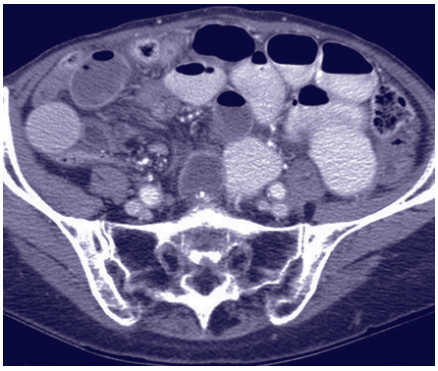
Being asked to see a patient with a malignant bowel obstruction can generate an initial response of "oh no, not another one". I think this stems from two underlying concerns. The first is that I often find the patients are underprepared or informed about their condition and that I often feel that I am the one left with having that difficult discussion about survival time etc with a patient I just met. The second is that initial feeling of "why are they calling me, I can't do anything for these people anyways".

These are without a doubt difficult clinical problems. The pathology itself can be unyielding and surgical intervention is risky and at times very unrewarding. The patients often present after previous surgical procedures, extensive chemotherapy regimens, and not infrequently, adjuvant radiotherapy. Patients may or may not have accepted the palliative state of their disease, so the dialogue between patient and surgeon is often emotional and time consuming. The care required for these patients is multimodal and multidisciplinary. Recently, we have experienced a cluster of these cases at our institution and it presented a chance to review the literature on this subject and perhaps question my own personal bias towards this problem.



Plain film showing a small bowel obstruction

Malignant bowel obstructions most commonly present in people with previous ovarian cancer (5 – 51%) or colorectal cancer (10 – 28%). Other common etiologies include breast cancer, lung cancer, and melanoma. Importantly though, a benign cause is present in up to 1/3 of cases. CT imaging is usually the best diagnostic test as it can determine the site and/or number of obstruction points, the status of the liver, the extent of carcinomatosis, and the presence of ascites.



CT abdomen showing dilated loops of small bowel

While initial management should consist of nasogastric decompression and intravenous fluids, the NG tube should really be viewed as a temporizing measure and the idea of leaving the patient to succumb with a nasally placed tube should be discouraged. The surgeon, primary care physician, oncologist, and the palliative care specialist all play a role in the management of these patients. A frank discussion regarding to treatment goals, palliative objectives, risks, and prognosis is a must early on in care. The surgical morbidity for operating on the malignant bowel obstruction is high (40%) and the operative mortality is significant (up to 30%). Overall survival at the time of diagnosis of malignant bowel obstruction is 4 to 9 months.

In contemplating surgery, the surgeon must carefully consider the physiologic state of the patient

and review the treatment goals. It is prudent to discuss the possibility of failed surgery and the likelihood that repeat procedures will not be considered. For localized obstructions, resection is optimal. In most cases, however, there is diffuse disease and the surgeon must consider bypass procedures such entero-enterostomy or proximal stomas. One should avoid over aggressive dissections especially in a radiated bowel. A gastrostomy tube is usually indicated to help manage future symptoms and is 90% effective in controlling nausea and vomiting. A percutaneously placed gastrostomy tube should be considered in patients not amenable to laparotomy. Laparoscopy may be an option chosen by some surgeons but this should be considered with care. Pharmacologic management of obstruction can often provide good palliation for paients who are not surgical candidates.

In terms of outcomes, the surgeon should be sensitive to quality of life and not survival. Patients are most often satisfied with being able to eat, the absence of nausea, and the possibility of going home. The malignant bowel obstruction is an entity that taxes the surgeons technical abilities but even more so, the ability to communicate with patients, set realistic goals, and define success in terms of improving the patients emotional state. One cannot hope for cure but often the healing process involved in managing these patients can be very satisfying, rewarding, and patients and families are very grateful for the dignity that proper care and attention to their illness brings. My maturation as a surgeon combined with reviewing the literature has led to my belief that perhaps as a surgeon I am the best person to have the frank discussion and leave the patient with realistic expectations. In addition, one can help the patient - we can't cure but we can help and I do take satisfaction in this.

Update on SON Synoptic Operative Reporting (WebSMR) Project

Last fall, the BC Surgical Oncology Network (SON) was invited to submit a proposal to the Canadian Partnership Against Cancer (CPAC) for a pilot project to implement a web-based surgical medical record, WebSMR (Web-based Synoptic Medical Record), now in use in Alberta. CPAC has approved funding in principle to the SON to pilot WebSMR for breast and colorectal cancer as an alternate operative reporting system at three hospital sites: Vancouver General Hospital, St. Paul's Hospital and Vancouver Cancer Centre, BC Cancer Agency. This project is part of a larger national initiative to implement synoptic reporting tools in various hospitals across the country in a coordinated effort to create a national minimal dataset for cancer surgeries.

The aim of this project is to implement an integrated data collection and outcomes reporting system that will enable the collection of surgical, clinical, pathology and outcomes data, and generate reports that demonstrate how surgical and clinical factors directly affect patient outcomes such as survival, quality of life and recurrence. The proposed system would allow surgeons to enter data, which would then become part of the electronic health record and sent to a central server. An operative report could also be printed and added to the patient file. This project will determine the processes, feasibility and utility of implementing this system on a wider scale across BC.

CPAC has appointed Dr. Walley Temple and Evangeline Tamano from Cancer Surgery Alberta, Alberta Cancer Board as the national operational leaders of the CPAC synoptic reporting initiative. WebSMR was developed in Alberta and is jointly owned by the Alberta Cancer Board and Softworks Group, a private company in Alberta.

CPAC has established certain principles for this initiative. Projects must be multidisciplinary, involve collaboration between at least two provinces and adhere to national standards. CPAC has organized the synoptic reporting projects nationally by tumour site (breast, colorectal, head and neck, and ovarian cancers), with a national leader for each. The national leader for the colorectal cancer surgery synoptic reporting project is Dr. Carl Brown at St. Paul's Hospital. He is also the provincial lead for this tumour site in BC. The national leader for the breast cancer surgery synoptic reporting project is Dr. Geoff Porter in Nova Scotia, and Dr. Noelle Davis is the provincial lead in BC.

To date, CPAC has held two national meetings for these projects. A synoptic reporting tools project kick off meeting was held in Banff in February and an IT workshop was held in Montreal in May.

The next step in this process is to hold a planning meeting with Dr. Temple and Evangeline Tamano to determine the resources required to implement WebSMR at the pilot hospital sites in BC. Invited participants include heads of surgery, OR administrators, IT, health records services, privacy and security, and risk management staff. It is anticipated that further details about funding and the implementation process will be determined by CPAC following this planning meeting. We are in the process of scheduling this meeting and hope to hold it at the end of July. In addition, CPAC has provided some initial funding for a project coordinator, and we hope to have this position filled in the near future.

Updates on this project will be provided through the SON Newsletter. For more information on CPAC, please refer to the website at www.partnershipagainstcancer.ca.

SURGICAL MANAGEMENT OF MALIGNANT BOWEL OBSTRUCTION IN PATIENTS WITH ADVANCED OVARIAN CARCINOMA

By: Mona Mazgani, MD and J. Salvador Saldivar, MD

Due to the intraperitoneal location of the ovaries, epithelial ovarian cancer (EOC) has a tendency to spread throughout the abdominal cavity. It is not surprising then, that many patients with advanced or recurrent disease present with malignant bowel obstruction [1]. Its management can present a challenge to the clinician, and the outcome of management decisions may adversely affect patient survival and quality of life. Reports of the incidence of bowel obstruction in advanced EOC range from 5% to 51% [2], with an increase per advancing stage of disease. In the majority of cases, obstructive symptoms signal disease progression with accompanying malabsorption, malnutrition and anorexia.

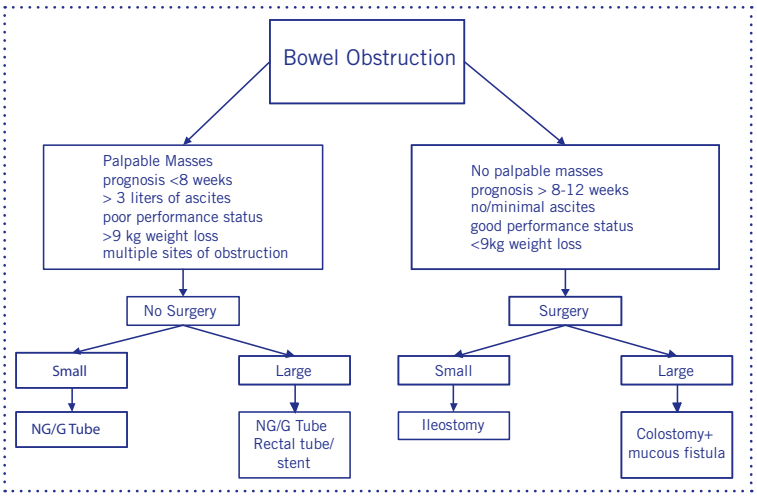
Malignant bowel obstruction in patients with EOC may occur through different mechanisms and an understanding of the etiology is necessary to better address therapeutic options. The cause is often a combination of factors. Mechanical obstruction may result from extrinsic occlusion by tumour compression, post-operative adhesions or radiation-induced fibrosis [3]. Less commonly, intraluminal occlusion may occur as a result of tumour infiltration through the bowel wall. Further spread to the mesentery and retroperitoneal space with resultant bowel inflammation and edema, affects intestinal motility, causing a superimposed functional obstruction, so that even adequately bypassed bowel may not function normally.

Clinical Features

The extent and location of obstruction is an important consideration before instituting therapy. In several studies, approximately 54% of obstructions were isolated to the small intestine, 32% to the large intestine, and importantly, 14% involved both. Isolated gastric and duodenal involvement appears to be uncommon and rarely documented in large series [1-3].

Suspected bowel obstruction in ovarian cancer rarely presents as a surgical emergency. The clinical course tends to occur insidiously and often remains partial [4]. The majority of patients report constant abdominal or colicky pain and commonly present with anorexia [5]. Despite these symptoms, most patients are alert and have relatively normal function of other organ systems, allowing ample time for pre-operative evaluation. Assessment of the colon with a hypaque enema, for example, is a critical step prior to undertaking laparotomy for an apparent small bowel obstruction, and should not be eliminated in a rush to the operating room.

Figure 1



Surgical Management

Once the presence and location of malignant bowel obstruction has been verified by radiographic studies, any treatment decisions must take into consideration not only the patient's medical condition, tumor burden, response to previous anti-tumor therapy, but also importantly, the patient's values and goals. The primary aim of intervention at this point, whether medical or surgical, is palliation of symptoms, with improvement in survival a secondary gain.

The role of surgery as palliation for malignant bowel obstruction is controversial. Management of these patients is difficult due to the fact that they have a deteriorating performance status and a high morbidity (5% to 32%) and mortality (30% to 65%) associated with palliative surgery [6]. Most series report complications such as wound infection, anastomotic leak, recurrent obstruction and enterocutaneous fistulae. Even if there is a possibility of relieving the obstruction, the likelihood of re-occlusion ranges between 10 to 50%. Often there is a short post-operative median survival in the 3 to 6 month range [7].

Successful palliation can be achieved surgically in a subset of women, but identification of those women who might benefit from surgery can be quite challenging. To make informed decisions, the patient and physician must have realistic goals for a given intervention. Unfortunately, there are no uniform reliable indicators of a good outcome after surgery and most surgical options have proved to be of value in non-randomized, retrospective studies. Some studies propose that patients with limited tumor burden, a single site of obstruction, and a potential for chemotherapeutic response may benefit from surgery [8]. In a report [4] of 53 patients

with advanced EOC who had a complete bowel resection, 50% had a successful palliation by surgery if there was an absence of 1) palpable abdominal or pelvic masses, 2) more than 3 litres of ascites, 3) multiple intestinal obstructive sites, and 4) preoperative weight loss of more than 9 kilograms. Additional poor prognostic factors worth mentioning include involvement of the proximal stomach, previous surgery showing diffuse metastatic disease, extensive extra-abdominal metastases, malignant pleural effusion, and a history of prior pelvic and/or abdominal radiation [4]. Although, there are a lot of different opinions as to the management of malignant bowel obstruction, we offer a simplified algorithm based on our review of the literature (see figure 1).

Non-surgical palliative options

If a patient is not deemed suitable for surgery or they decline surgical intervention, then symptom control is of paramount importance. A percutaneous gastrostomy (PEG) or open gastrostomy can be performed [9]. A nasogastric tube may be permanently placed in terminal patients. Distal single-site large bowel obstruction can be palliated with the use of a colorectal stent. A high success rate for placement of stents to correct malignant colorectal obstruction, with symptom relief in 64% to 100% of patients, has been reported [10]. Finally, concurrent with gastrointestinal decompression, pharmacologic approaches for palliation of symptoms are available and should be aggressively pursued. The armamentarium includes narcotics, antiemetics, anticholinergics, phenothiazines, promotility agents, antisecretory agents (particularly octreotide) and corticosteroids.[11]

Most patients with advanced EOC eventually develop chemo-resistant disease, with malignant bowel obstruction a common occurrence. With careful consideration, surgeons must use their best judgment based on experience and the existing literature, to select appropriate patients for surgical as well as medical options in the palliation of symptoms. Moreover, these strategies must be developed with the upmost regard for patient's wishes and their remaining quality of life.

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SOFT TISSUE TUMOURS- A COMMUNITY SURGEON'S PERSPECTIVE

Elaine McKevitt, Mt. St. Joseph's Hospital

As I have settled into my role as a community general surgeon, I have found that in addition to my role in managing patient problems, I have a role in facilitating care for patients with problems outside of my areas of expertise; namely those that need the care of a surgical subspecialist. Soft tissue tumours have become one such area.

In the past year I have seen a number of patients with soft tissue tumours. This has been educational for me because I don't think I had seen any such patients (except intraabdominal sarcomas) during my training and only one patient in my first five years of practice with FAP and a desmoid tumor. Patients referred with a "mass" usually had sebaceous cysts, lipomas, or lymph nodes.

I have now seen some very large, atypical lipomas, a liposarcoma, myxoid tumours, schwanomas, a granular cell tumour, desmoid tumours, and a mass within the transversus abdominus that turned out to be an endometrioma. I have been struck at how my initial impression of "benign" may not always be the case.

Many of these soft tissue tumor patients had been referred with imaging and usually the radiologist had recommended an excisional biopsy. From my training, I knew that soft tissue tumours needed an MR scan and a core biopsy, but the challenge I faced was how to arrange for these tests and how to have the results correlated. For some patients that had small masses with core biopsy diagnoses such as myxoma, I was faced with the decision whether I should just excise this as was being recommended or not? I would do a literature search on the diagnosis, but I found insufficient information to make decisions such as, how large of a margin, incision planning and the accuracy of the core biopsy.

Initially I tried to work up these patients and then send patients to the Cancer Agency through the main intake number using standard referral forms. Since these patient did not yet have a malignant diagnosis, this proved to be problematic. I have since found that referring these patients to directly to the Sarcoma Clinic at 604-877-6000 x 2396 allows for more streamlined care.

Resident Travel Award For BC Surgery Residents & Fellows

The BC Surgical Oncology Network Resident Travel Award is a competitive award intended to motivate physicians, early in their training, to pursue an interest in surgical oncology and to allow them to present research findings at conferences. There is no predetermined number of awards each year. The SON Council Executive will grant awards based on availability of funding. Approved applications may be funded in whole or in part up to a maximum of $1000. The total annual funding for all awards will not exceed $5000 annually. Deadlines are: May 1 and November 1 of each year.

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Upcoming Conferences

Canadian Surgery Forum 2008
September 11 - 14, 2008
Location: Halifax, NS
Website: www.cags-accg.ca

Update in Surgical Oncology
October 31st, 2008
Website: www.cme.utoronto.ca
For further information:
416-978-2719
Toll free 1.888.512.8173

BC Cancer Agency Annual Cancer Conference
November 20-22, 2008
Location: Westin Bayshore Hotel, Vancouver, BC
Website: www.bccancer.bc.ca/HPI/ACC2008/

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VISIT THE SURGICAL ONCOLOGY WEBSITE
www.bccancer.bc.ca/son

The BC Provincial Surgical Oncology Council exists to promote and advance quality cancer surgery throughout the province by establishing an effective Network of all surgical oncology care providers and implementing specific recommendations. The Network will enable quality surgical oncology services to be integrated with the formal cancer care system. Communications to enhance decisionmaking, evidence-based guidelines, a high quality continuing education program, and regionally based research and outcome analyses are the initial priorities.