



Prime opportunities for oncology CME – November 20-21

This November offers unprecedented opportunities for oncology CME and we invite you to seize them. Saturday, November 21 is the Family Practice Oncology Network's annual Family Practice Oncology CME Day to be held once again at the BC Cancer Agency Research Centre.



The day will feature presentations from leading oncologists and experts on the cancer topics where information is most in demand by family physicians. Case-based workshops on lymphoma, advanced breast cancer and oncologic emergencies will also be included.

Register for both events today at www.fpon.ca

Friday, November 20 will feature an afternoon session focusing on Oncology Imaging for Primary Care, aiming to increase understanding of the use of imaging in diagnosing and managing breast cancer, colorectal cancer, lung cancer and lymphoma. This event will also be held at the Research Centre (see page 11).

Together, these two events are accredited by the College of Family Physicians of Canada and the BC Chapter for up to 10 Mainpro-M1 credits. See the enclosed flyer for full details on the content and pricing. We are committed to providing all practical information to strengthen your oncology skills and enhance the care you provide. Please join us.

Meet Malcolm Moore – President of the BC Cancer Agency

Dr. Malcolm Moore has some ambitious goals. As the new President for the BC Cancer Agency, he understands the big picture challenges facing cancer care in British Columbia. As a personal priority, he cites the need to restore confidence in the organization amongst the general public, government, and agency staff. Dr. Moore also appreciates the importance of community-based cancer care. He shares his insight below.

Views on Primary Care

Family physicians play a critical role in the cancer patient's journey. I want to better understand how the BCCA interacts with family physicians and how we make sure they are supported as part of the cancer care team with the appropriate resources and the tools. Ideally, we want cancer patients to get as much care as possible closer to home, where they will be well supported by family

and friends. Family physicians can enable this to happen and are an essential part of the cancer care team.

The Family Practice Oncology Network has a more sophisticated and organized program than other provinces, and is a big ally in this regard.

The Issue of Sustainability

We also need to focus on sustainability particularly with the soaring increase in cancer cases expected over the next decade due to population growth and aging. We can do so much more for patients than we could even as little as 10 years ago, but the cost of these new interventions is extraordinary and must be accommodated within a budget affordable to the taxpayer.

It will become increasingly difficult to provide
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Dr. Malcolm Moore took on the presidency of the BC Cancer Agency in mid September.

Evaluating cancer care clinical practice guidelines in BC

Over the past decade, the Family Practice Oncology Network (FPON) has worked with the Guidelines and Protocols Advisory Committee (GPAC) to develop oncology related clinical practice guidelines for use in primary care. Guidelines play an important role in quality of care and are a key resource for physicians for evidence-based information. There is now increasing international focus on evaluation of guidelines.

As part of a multi-jurisdictional initiative in order to explore ways to improve the patient experience during transitions in cancer care, the BC Cancer Agency developed and implemented an evaluation of the GPAC breast and colorectal cancer guidelines. The goal of this evaluation was to investigate how these guidelines are utilized in the primary care setting.

The results of the evaluation showed that most practitioners were aware of the GPAC breast and colorectal cancer guidelines and reported following the guideline recommendations when providing care

for their patients. Inclusion of up-to-date evidence was found to be an important theme for practitioners. Practitioners reported that the guidelines were generally well organized and felt that they helped to clarify the roles of primary care providers and specialists. Most practitioners were satisfied with the guidelines and indicated that the GPAC breast and colorectal cancer guidelines were their first choice in a clinical practice guideline. One participant commented:

“Excellent work and wonderful initiative. This will form a foundation and support for ancillary work for the future. Well done!”

Practitioners identified guideline related CME as an opportunity to integrate recommendations into practice.

The following recommendations were developed based on the results of this evaluation:

1. Include a statement on the evidence reviewed in individual guidelines;

2. Include a guideline implementation strategy for new or revised guidelines;
3. Improve access to clinical practice guidelines;
4. Increase collaboration between specialty and primary care to clarify roles and develop tools to improve communications around transitions in care;
5. Integrate guideline development with other provincial programs/committees to address barriers to implementation of clinical recommendations.

The evaluation report is available at <http://www.bccancer.bc.ca/health-professionals/networks/family-practice-oncology-network/guidelines-protocols>.

We would like to thank all those practitioners who donated their time by developing or participating in this evaluation. The Canadian Partnership Against Cancer sponsored this evaluation.

Contact survivorship@bccancer.bc.ca

Meet Malcolm Moore continued from page 1

all of the care through the cancer centres where there are not enough oncologists to meet the demand. A team approach, including the family physician, has proven to be more cost effective and a better way of providing care. Family physicians already play a major role in cancer screening and prevention, for example, but there is opportunity for greater involvement in follow-up care and in meeting the survivorship needs of patients who have completed treatment. We need to engage in a dialogue about how to most effectively transition to this approach, how best the Cancer Agency can support primary care providers who deal with cancer patients and to ensure we have a funding model to support this new reality.

Going Forward

I will spend much of my initial months as President visiting our different cancer centres, as well as our Communities Oncology Network and our First Nations health care facilities. I am looking forward to meeting people and to learning more about their

challenges so that we can work together to formulate solutions for the future.

When I was interviewing for this position I was struck by how everyone at the Agency takes tremendous pride in the work that they do. Agency staff need the system to work

effectively so that they can provide consistent excellence in patient care. As leaders within the system, we have to create the structure and organization to allow this to happen.

Contact Dr. Malcolm Moore at malcolm.moore@bccancer.bc.ca

The Bio:

- most recently a practicing medical oncologist at Princess Margaret Cancer Centre and the University of Toronto;
- served as head of the Division of Medical Oncology and Hematology at Princess Margaret Cancer Centre and as a member of the Executive Team for the Princess Margaret Cancer Centre and the University Health Network's Department of Medicine;
- involved for over 20 years in drug development work for cancer therapy including serving as a principal investigator for many studies in gastrointestinal and genitourinary cancer;
- instrumental in the development of several agents approved for clinical use in the treatment of pancreatic cancer;
- originally trained in Chartered Accounting prior to entering Medicine;
- recently completed the EXTRA Fellowship Training Program with the Canadian Health Services Research Foundation and the Program for Chiefs of Clinical Services at the Harvard School of Public Health;
- holds academic appointments at the University of British Columbia and Simon Fraser University and carries the title of President of the BC Cancer Agency.

East Kootenay benefits from homegrown GPO

Cancer patients in East Kootenay communities – and Cranbrook in particular – have a unique advantage in that the care they receive is often led by their very own, Dr. Keith Lowden, a General Practitioner in Oncology (GPO) with a local history. He finished high school in the community, graduated from the University of British Columbia (UBC) School of Medicine, and returned to build a busy family practice for almost two decades before training to become one of the region's initial GPOs. Dr. Lowden shares his insight into the role:

Evolution of a GPO

Before I joined the program in 2003, chemotherapy was administered by family physicians in our East Kootenay Hospital's Emergency Department which doubled as an Ambulatory Care Unit. I took on the role of GPO with the establishment of the Cranbrook Oncology Clinic, a satellite centre for the BC Cancer Agency's Kelowna Centre located within our hospital. Initially, I worked one week per month on the chemotherapy unit and maintained my family practice including obstetrics. This eventually grew to a 0.9 FTE position and, together with recent GPO Training Program graduate Dr. Shawna Dawe, we provide outpatient chemotherapy five days a week for patients throughout the East Kootenay region, a catchment area of about 70,000 people.

My training took place just prior to the launch of the Family Practice Oncology Network's GPO Training Program in 2004. I completed rotations with most of the Oncologists and pain and symptom management physicians at the Kelowna Centre, and benefited from numerous one-on-one teaching sessions. I also focused my CME at the time on oncology conferences and gained valuable insight from spending time with Dr. Bob O'Brien, the now retired first GPO in Cranbrook.



Drs. Keith Lowden and Shawna Dawe share GPO cancer care responsibilities for Cranbrook and the East Kootenay.

Thoughts on the Role

I really enjoy the variety of work that comes with looking after cancer patients. It's a much different way of providing care than family practice – a true team approach. We benefit, for example, from working with dedicated pharmacists, social workers, nutritionists, BC Cancer Foundation volunteers, and of course, some of the best nurses in the hospital. Dr. Shawna Dawe completed the GPO Training Program earlier this year and is extremely well trained for her role as a partner in our busy clinic.

We also have the time to spend with patients in our clinic and resolve complex care issues. Our patients are very grateful for this local support which is a reward in itself. Some still have to travel up to 2.5 hours to see us, but this is a much better option than a 9 hour journey to Kelowna.

Our expertise is appreciated as well by our Family Physician colleagues who don't have

to navigate all the intricacies of cancer care alone in a rural community. We focus only on cancer patients and have developed knowledge and skills that we are happy to share. Further, our clinic is strongly supported by the medical and radiation Oncologists from the Kelowna Centre through Telehealth and by phone or email.

Reaching Outward

I am also a clinical faculty member with UBC and regularly host residents to provide them with a community oncology

experience and the chance to interact with patients. I really enjoy teaching and, in fact, have facilitated the joint Network/ UBC Continuing Professional Development Cancer Care Outreach Program on Education modules both in Cranbrook and in our surrounding communities.

I am also active in the Association of BC GPOs which provides a forum for those of us throughout the province to connect and voice our shared concerns to improve the care we provide. There is also a national association – the Canadian Association of GPOs – which further strengthens our position. There is no reason to feel isolated as a GPO. Our work is valued in our community and I would encourage anyone interested in enhancing their cancer care knowledge and skills to contact the Network for information on the GPO Training Program.

Contact Dr. Keith Lowden at klowden@bccancer.bc.ca

Next GPO training course begins February 22, 2016

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

Breast cancer: prolonged hormone therapy awareness

By Dr. Vanessa Bernstein, Breast Cancer Systemic Program Chair, BC Cancer Agency

Recently the BC Cancer Agency changed its policy on the duration of hormone therapy for patients with breast cancer. This change impacts patients who have recently completed (within the past 18 months) or are nearing completion of a 5 year program of adjuvant tamoxifen 20 mg po daily for hormone sensitive breast cancer. This change is based on evidence from the ATLAS₁ and the ATTOM₃ trials. These studies demonstrated that continuing tamoxifen for a total of 10 years may prevent additional breast cancer recurrences and breast cancer mortality compared to staying on therapy for 5 years. The ATLAS study reported that women randomized to continued tamoxifen for 10 years had a 16% reduction in the risk of cancer recurrence (RR 0.84, 95% CI 0.76-0.94). After 10 years, the risk of recurrence was reduced by 25% (RR 0.75, 95% CI 0.62-0.90) and the risk of breast cancer mortality was reduced by 29% (RR 0.71, 95% CI 0.58-0.88). The ATTOM study demonstrated a similar 15% reduction in the risk of

recurrence for 10 years of tamoxifen (RR 0.85, 95% CI 0.76-0.95). Patients who become permanently menopausal during their 5 years on tamoxifen may consider switching to an aromatase inhibitor (eg letrozole 2.5 mg po daily) for another 5 years. The MA17 trial demonstrated improved disease-free survival (HR 0.68, 95% CI 0.45-0.61) and overall survival (HR 0.51, 95% CI 0.42-0.61) for this approach.

Deciding to continue tamoxifen for 5 more years, switching to letrozole, or stopping therapy is a balance of risks and benefits. Significant benefits for both extended programs were predominantly seen in patients with stage II and III disease (tumors >2 cm or node positive). The benefits for stage I breast cancer are modest, although some people with higher risk stage I breast cancers (grade 2 or grade 3, HER2+, presence of lymphovascular invasion) who are tolerating tamoxifen might opt to continue therapy for another 5 years. People with no high risk features are less likely to benefit from extended therapy but may access this treatment if they choose. Tolerance

and quality of life on the initial 5 years of therapy are important considerations, as are competing health risks. Women who are at increased risk of blood clots, or who have experienced abnormal vaginal bleeding or abnormalities of their uterus might want to avoid extended tamoxifen. The ATLAS study reported increased cumulative incidences of endometrial cancer (3.1 versus 1.6 percent), pulmonary embolus (1.2 versus 0.6 percent), and ischemic heart disease (4 versus 2 percent) in the extended tamoxifen arm.

Prescriptions for extended tamoxifen and letrozole can be written by the family physician or oncologists and should be filled at a BC Cancer Agency or local hospital pharmacy where the drug will continue to be provided free of charge.

If you have questions regarding whether your patient should continue to receive endocrine therapy for their breast cancer please feel free to contact the oncologist involved in their care.

See references on page 13

New counselling and support group initiatives at the BC Cancer Agency

By Elaine Shearer, Community Education Coordinator, Provincial Psychosocial Oncology Program, BC Cancer Agency

Mindfulness Based Stress Reduction groups based on the work of Dr. Jon Kabat Zinn at the University of Massachusetts Medical School are offered in-person at the BC Cancer Agency's Vancouver Centre and

Sindi Ahluwalia Hawkins Centre for the Southern Interior. This eight-week program teaches mindfulness practices to reduce the effects of stress on participants during or following their cancer treatment. Call 604.877.2194 in Vancouver or 250.712.3963 in Kelowna.

Relaxation resources can also be sent by Agency Library Services anywhere in BC free of charge. See <http://www.bccancer.bc.ca/library-site/Documents/Mindfulness-General.pdf> for further information.

Sleeping Well with Cancer and Beyond – Insomnia is very common with about 10% of North American adults reporting serious insomnia. For cancer patients, the rate is even higher: 30-50%.

The Agency has been screening patients at their initial appointment using the Canadian Problem Checklist for the past two years, and sleep is consistently reported as one of the top three problems for cancer patients.

A cognitive behavioral approach for insomnia (CBT-I) is the “gold standard” for treating sleep problems. The Tom Baker Cancer Centre in Alberta has offered face-to-face CBT-I groups for several years. The approach teaches several different

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Colorectal cancer update for primary care

By Dr. Barbara Melosky, Medical Oncologist, BC Cancer Agency Vancouver Centre

Colorectal cancer is the third most commonly diagnosed cancer in British Columbia affecting men and women equally. Most family physicians will encounter many



Dr. Barbara Melosky

colorectal cancer cases during their careers. Patients with metastatic disease are now living *years not months*. BC has one of the best colorectal cancer survival outcomes.

Counselling and support group initiatives continued from page 4

strategies for improving sleep including: relaxation and imagery, sleep restriction, stimulus control, problem solving, and improving overall sleep hygiene. Research shows that improvements made during a self-management program for insomnia are actually better than those obtained from the longer-term use of sleeping pills.

We will offer the first pilot group of this program at the Centre for the Southern Interior this fall. The Vancouver Island Cancer Centre offers an educational session entitled: Tools to Relax and Improve Sleep. The other cancer centres will offer similar educational sessions for cancer patients and their family members this fall and winter as well.

For more information, please contact the Patient and Family Counselling Services at your regional cancer centre, www.bccancer.bc.ca/our-services/services/patient-family-counselling

Colon cancer and rectal cancer are differentiated by their location; colon cancer is located above the peritoneal reflection, and rectal cancer is located below. This is important in that radiation plays a major role in rectal cancer both in the curative and adjuvant settings. In early stages, surgery is still the primary treatment for both.

For colon cancer, oxaliplatin based chemotherapy remains the standard of care for patients with nodal involvement or T4 perforated tumors. Almost 60 years ago, 5-Fluorouracil (5FU) was discovered and remains an important backbone in the adjuvant setting (FOLFOX). Its oral form, capecitabine, is an attractive alternative in unfit patients. A world wide trial IDEA will address treatment duration.

For rectal cancer, radiation is an important modality as it has been shown to reduce locoregional recurrence. It is given preoperatively before surgery. A short duration (5 days of radiation) followed one week later by surgery benefits most patients. A longer duration (5 weeks) with concurrent capecitabine is given if tumour shrinkage is necessary for surgical success. Post operatively in both cases, adjuvant chemotherapy may be administered although evidence based guidelines are lacking.

Metastatic colon and rectal cancers are treated similarly. First line chemotherapy with 5FU, irinotecan and bevacizumab (a biologic against the vascular endothelial growth factor) is the standard today in BC. Second line treatment with FOLFOX is given upon progression. RAS testing predicts a possible benefit from EGFR inhibitors panitumumab and cetuximab. A large trial examining which chemotherapy backbone with which biologic should be given first was negative. The lesson we learned is

that the sequence was not important but that patients should receive all drugs and all lines of therapy to benefit from the best survival outcome. In that trial, the median survival was 30 months, a new milestone for metastatic colorectal cancer.

View the full webcast of this topic at www.fpon.ca – Continuing Medical Education

Exciting new treatments are on the horizon. Regorafenib, an oral inhibitor of multiple cell signaling kinases, demonstrated a survival advantage in the last line setting in the CORRECT Trial. We hope to offer our patients this line of therapy in the future.

We now expect our metastatic colorectal patients to experience a median survival of near three years. We have come a long way. May the progress continue!

Decision-making for Adjuvant Rx

Online resources

- www.mayoclinic.com/calcs/colon/input.cfm
- www.adjuvantonline.com/colon.jsp

Contact Dr. Barbara Melosky at bmelosky@bccancer.bc.ca

Progress in Metastatic Colorectal Cancer Results from Intergroup CALGB trial ASCO 2014

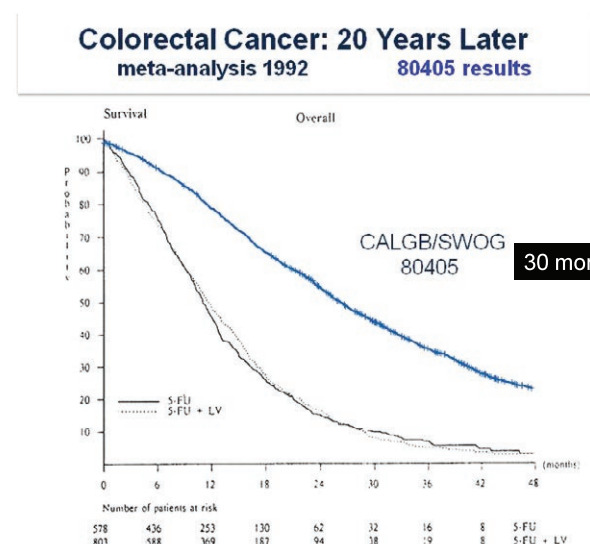


Fig 2. Overall survival. J Clin Oncol, 1992

A transformational road map for survivorship & primary care

The BC Cancer Agency's Survivorship & Primary Care Program, of which the Family Practice Oncology Network is a part, recently completed a comprehensive strategic planning process with stakeholders from across the province.

The plan details the burgeoning number of cancers survivors expected by 2020 and identifies objectives and requirements for a model of care to ensure their needs are met.

There are eight focus areas:

1. Increase awareness of cancer survivors as a distinct population with specific primary healthcare needs related to their cancer treatment;
2. Understand survivor information needs post-treatment and beyond;
3. Achieve consensus regarding primary care provider information needs and ensure the flow and ease of access of this information is supported;
4. Enable seamless patient transition from cancer care to primary care;
5. Seek, nurture and maintain strategic partnerships across the ministries, health authorities, agencies, and patient networks involved in care of cancer patients post-diagnosis;
6. Ensure opportunity for provider learning and improved communication for and between oncology and primary care;
7. Develop a provincial agenda for survivorship research and quality improvement;
8. Establish a plan and structure for collecting, storing and sharing provincial health data.

Request a copy of the Survivorship & Primary Care Program Strategic Plan: survivorship@bccancer.bc.ca.

NEW CHAIR IN CANCER SURVIVORSHIP

The BC Cancer Agency and Simon Fraser University announced in July that Dr. Stuart Peacock will hold the new Leslie



Diamond Chair in Cancer Survivorship. The Chair is supported with \$5 million in funding from the BC Cancer Foundation and Simon Fraser University including a \$1 million gift from Gordon Diamond honouring his wife Leslie's 30 years of cancer survivorship. Dr. Peacock's appointment is within SFU's Faculty of Health Sciences in partnership with the Agency's Survivorship & Primary Care Program.

Contact Dr. Stuart Peacock at speacock@bccrc.ca

Message from the co-chairs of the Family Practice Oncology Network

One of the great strengths of the Family Practice Oncology Network is creating opportunities for connections and collaborations that improve cancer care in BC. Bringing together professionals from primary and specialty care sparks long term relationships that strengthen communications and enhance the care we provide.



Dr. Phil White, Co-Chair and Medical Director, and Karen Blain, Co-Chair, and Provincial Director, Survivorship & Primary Care Program

An important new collaboration is the alignment of our Network, now benefitting from both medical and administrative co-chairs, with the BC Cancer Agency's Survivorship & Primary Care Program. The

Our premise of connectivity forms the basis as well for another major new initiative led by the Survivorship & Primary Care Program and supported by the province's Shared Care Committee. Its focus is to determine how primary and specialty care can best work together to ensure the post-treatment needs of patients are met in the community, while optimizing the cancer care system's capacity to address the care needs of those in active

latter, together with its partners, will provide leadership, invest in research and innovation and build system capacity to support high quality, integrated care, and improved experience for cancer survivors in BC and the Yukon.

treatment. Among the project's objectives are the intention to engage, for the first time, primary care and oncology together to identify shared solutions to shared problems and to create local relationships, improve communication, and build trust between oncologists and primary care within communities.

Other new developments include the evolution of our Cancer Care Outreach Program on Education delivered in partnership with the University of British Columbia's Division of Continuing Professional Development. Together, we developed and presented modules on breast, colorectal, prostate and advanced cancers to over 700 family physicians in 31 different BC communities. We are now updating these modules for redelivery along with conducting an education needs assessment for the Shared Care project above.

Contact Dr. Phil White at drwhitemd@shaw.ca or Karen Blain at karen.blain@bccancer.bc.ca

Monitoring for late effects in adult survivors of childhood cancer: an overview

By Dr. Chris Fryer, Pediatric Oncologist, BC Children's Hospital and Dr. Karen Goddard, Radiation Oncologist, BC Cancer Agency, Vancouver Centre

While 80% of children with cancer can expect to be cured, many have significant long-term health problems or "late effects" related to their previous cancer and treatment. Modifiable factors such as smoking, hypertension, obesity, diabetes and dyslipidemia increase these risks.

Survivors should be seen every year to update their health status. The history should include their current lifestyle (e.g. smoking) and updated family history of cancer. A physical examination should always include blood pressure as hypertension is common. Specific surveillance recommendations are based on their prior cancer and therapy. Implementation of the newly funded BC Cancer Agency Adult Childhood Cancer Survivorship Program will offer consultative advice for complex cases. Here we address the more common and serious potential late effects.^[1]

Second Malignancies: Screening patients who had previous radiation therapy (RT) is based on the region exposed.

Breast RT: Screen females for breast cancer starting at age 25 or eight years after RT. The current recommendations are screening mammography and breast MRI yearly^[2].

Head and Neck RT: Thyroid ultrasound every 3 to 5 years^[3]. Screen for hypothyroidism with annual TSH.

Brain RT: MRI screening for second tumours including meningiomas starting 10 years after RT.^[4] If pituitary within high dose RT field, refer to an endocrinologist^[5].

Abdominal/Pelvic RT: Patients given >30 Gy should have a colonoscopy aged 35 years or 10 years after RT^[6].

Cardiovascular Disease: Anthracycline chemotherapy is associated with cardiomyopathy^[7]. Current recommendations are for echocardiogram every 3 – 5 years for patients receiving > 250mg/m² or treated prior to age 5yrs^[8]. Radiation increases the risk of cardiovascular disease and strokes but

there are no currently effective interventional strategies and hence no screening recommendations^[9].

Male Fertility Issues: Patients exposed to pituitary or gonadal RT or receiving high dose alkylating therapy (Cyclophosphamide equivalent dose 8 g/m²) should be advised of infertility risk and hypogonadism and consider age appropriate sperm analysis and LH and testosterone levels^[10].

Female Fertility issues: In addition there is a risk of early menopause. Consider referring to a fertility specialist (anti mullerian hormone levels are used to monitor)^[11].

View the full webcast of this topic at www.fpon.ca – Continuing Medical Education

Contact Dr. Chris Fryer at cfryer@cw.bc.ca or Dr. Karen Goddard at kgoddard@bccancer.bc.ca

References

- 1 Armenian SH, Kremer LC, Sklar C. Approaches to reduce the long-term burden of treatment-related complications in survivors of childhood cancer. *Am Soc Clin Oncol Educ Book*. 2015;35:196-204.
- 2 Koo E, Henderson MA, Dwyer M, Skandarajah AR. Management and Prevention of Breast Cancer After Radiation to the Chest for Childhood, Adolescent, and Young Adulthood Malignancy. *Ann Surg Oncol*. 2015 May 14 [Epub ahead of print]
- 3 Brignardello E, Corrias A, Isolato G et al. Ultrasound screening for thyroid carcinoma in childhood cancer survivors: a case series. *J Clin Endocrinol Metab*. 2015;93:4840-3
- 4 Bowers DC, Nathan PC, Constine L et al. Subsequent neoplasms of the CNS among survivors: a case series. *J Clin Endocrinol Metab* 2008;93:4840-3
- 5 Spoudas HA, Charmandari E, Brook CG. Hypothalamic-pituitary-adrenal axis integrity after cranial irradiation for childhood posterior fossa tumours. *Med Pediatr Oncol* 2003;40:224-9.
- 6 Henderson TO, Oeffinger KC, Whitton J, Leisenring W et al. Secondary gastrointestinal malignancies in childhood cancer survivors: a cohort study. *Ann Int Med* 2012;156:757-66.
- 7 Chow EJ, Chen Y, Kremer LC, Breslow NE et al. Individual prediction of heart failure among childhood cancer survivors. *J Clin Oncol* 2015;33:394-402
- 8 Ramjaun A, AlDuhaiby E, Ahmed S, Lang L et al. Echocardiographic detection of cardiac dysfunction in childhood cancer survivors; how long is screening required? *Pediatr Blood Cancer* 2015;Jul 6 [Epub ahead of print]
- 9 Stewart FA, Seeman I, Hoving S, Russell NS. Understanding radiation-induced cardiovascular damage and strategies for intervention. *Clin Oncol* 2013;25:617-24.
- 10 Green DM, Nolan VG, Goodman PJ, Whitton JA, et al. The cyclophosphamide equivalent dose approach for quantifying alkylating agent exposure: a report from the childhood cancer survivor study. *Pediatr Blood Cancer* 2014;61:53-67.
- 11 Charpentier AM, Chong AL, Gingras-Hill G, Ahmed S, et al. Anti-mullerian hormone screening to assess ovarian reserve among female survivors of childhood cancer. *J Cancer Surviv*. 2014;8:548-54.

ONCOLOGY CME WEBCASTS UPCOMING

The Family Practice Oncology Network hosts nationally accredited monthly oncology CME Webcasts the third Thursday of every month with our partner, the University of British Columbia's Division of Continuing Professional Development. These complimentary sessions run from 8-9:00 a.m., Pacific time, and are accredited by the College of Family Physicians of Canada for one Mainpro M1 credit each.

Register for these Webcasts at <http://ubccpd.ca/webinars> :

- October 15 – Malignant Melanoma: Insight for Primary Care presented by Dr. Sanjay Rao of the BC Cancer Agency Centre for the Southern Interior
- November 19 – Ovarian Cancer: Primary Care Update presented by Dr. Anna Tinker of the BC Cancer Agency Vancouver Centre

All Webcasts are recorded and available at www.fpon.ca. You have the option to earn two Mainpro C credits by taking part in the College's Linking Learning to Practice initiative: www.cfpc.ca/Linking_Learning_to_Practice/

Naturopathic doctors and cancer care

By Chris Spooner, Naturopathic Doctor, Vernon

The number of patients using naturopathic therapies is significant. Patients are often reluctant, however, to divulge their use of these therapies to their oncologists and medical doctors.

Advanced cases often present themselves at naturopathic offices. It is in these situations that a constructive working relationship with the local oncologists and Cancer Agency is essential. Naturopathic doctors (ND) recognize that in order to build these relationships the inevitable question of ‘Where’s the evidence?’ needs to be addressed.

A large amount of in vitro and animal research supports integrative, complementary or naturopathic therapies, but there are few large scale clinical trials. In recent months, there have been several announcements regarding initiatives to investigate naturopathic therapies including:

1. Canadian/US Integrative Oncology Study (CUSIOS) is a North American observational



Chris Spooner,
Naturopathic Doctor

study that will assess integrative therapies in 400 people with advanced breast, colorectal, pancreatic and ovarian cancer in seven clinics across North America over three years. Its goals are to observe and measure the overall survival of cancer patients who receive integrative treatments and to describe integrative therapies provided by naturopathic doctors across the cohort.

2. Thoracic Peri-Operative Integrative Surgical Care Evaluation: Thoracic POISE will study of the effectiveness of naturopathic medicine used in combination with conventional medicine. This study is a collaborative project

with the Ottawa Integrative Cancer Centre, an arm of the Canadian College of Naturopathic Medicine and the Ottawa Hospital Research Institute. A network of Canadian thoracic surgery centres, in partnership with naturopathic doctors, will collaborate over the next 11 years in this 300-patient study.

This project will pioneer integrative care interventions for use before and after cancer surgery and will fund a randomized controlled trial to evaluate if the integrative

care approach reduces adverse events and improves disease-free survival.

Naturopathic doctors are seeing an increasing demand for naturopathic cancer care. In response, the profession is working to strengthen clinicians’ ability to address this demand with stronger core cancer education in the College’s four year curriculum. In addition, there are numerous opportunities a clinician can follow to get additional training. The most focused and intensive coverage is through the Oncology Association of Naturopathic Physicians (OncANP).

Naturopathic doctors do not discourage patients from using conventional therapies. In fact, the ND, with a focus in cancer care, will work to help patients understand the risks and benefits of both conventional, (radiation, surgery or chemotherapy), and complementary therapies, (nutritional supplementation, botanical agents and IV therapies). NDs seek to work collaboratively and only ask for the opportunity to engage in professional dialogue to help those patients who choose to incorporate aspects of complementary and alternative medicine into their care.

Contact Chris Spooner, ND, at drchrisspooner@gmail.com

Naturopathic cancer care: a medical oncologist’s perspective

By Dr. Tamara Shenkier, Medical Oncologist, BC Cancer Agency Vancouver Centre

Patients diagnosed with cancer often seek advice from naturopathic physicians (ND), practitioners of complementary and alternative medicine (CAM)⁽¹⁾. While all health care professionals would agree that health is, “...a state of complete...well-being and not merely the absence of disease...”⁽²⁾, there is a divide between MDs and NDs regarding treatment of diseases and



Dr. Tamara Shenkier

the interpretation of biomedical evidence. The multidisciplinary Society for Integrative Oncology was established in 2003 “to

advance evidence-based, comprehensive, integrative healthcare to improve the lives of people affected by cancer.” The SIO recently published a guideline for breast cancer patients supporting meditation, yoga, and relaxation with imagery for anxiety and mood disorders⁽³⁾. This is a recommendation both MDs and NDs can endorse. The benefit of physical exercise is another example

where our two disciplines intersect.

Cancer behavior is extraordinarily complex. Countless conventional anti-cancer compounds have failed to deliver in human trials after demonstrating activity in vitro and in animal models. Without support from randomized controlled human trials, extrapolating evidence from pre-clinical data is misleading at best and harmful at worst. Patients with advanced cancer may feel comforted and empowered by suggestions such as restricting your diet because “sugar feeds cancer” or using hyperthermia with chemotherapy because “heat stimulates blood flow”, however, interventions should be clinically validated before they are employed.

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Introducing Brenda Lynn, new director of the Communities Oncology Network

The BC Cancer Agency's Communities Oncology Network has a new leader – Brenda Lynn – who became Director of this Network last May. Her focus is to develop and implement a strategic plan to support the Network's growth and sustainability. The Communities Oncology Network (CON) includes all of the community cancer clinics in BC and the Yukon delivering systemic therapy and supportive care in partnership with the Agency and Health Authorities. Staffed by General Practitioners in Oncology (GPOs), chemotherapy certified nurses, pharmacists and social workers, and funded through the BCCA and Health Authorities, these clinics enable cancer patients to receive much of their care in the communities where they live.



Brenda Lynn is leading strategic planning efforts to strengthen the Communities Oncology Network.

Brenda Lynn is striving to take this Network to the next stage in its development providing the leadership, planning and coordination to strengthen the partnership with the Health Authorities and community health

care providers and ensuring collaboration, shared decision-making and accountability to improve the quality and safety of cancer care.

Insights from Brenda Lynn

I've been travelling extensively, beginning conversations with leaders responsible for systemic therapy, staff and patients. Patients emphasize their desire to receive care in their communities and our Network provides the means and the expertise to make this possible. We have the added strength of our partnership with the Family Practice Oncology Network which provides the training for our

GPOs along with continuing medical education and evidence-based cancer care guidelines.

My goal is to understand the challenges and opportunities through the lens of the CON health care teams and to appreciate the diversity within each region as a strength going forward.

Our CON sites are a valuable resource that

needs to be supported and preserved to meet the increasing demand (57% growth in cancer diagnoses expected by 2030), diminishing workforce availability, and increasing complexity and escalating costs of cancer treatments. This requires moving forward with our partners to develop a strong business plan including a governance model, workforce plan and funding reform.

Contact Brenda Lynn at brenda.lynn@bccancer.bc.ca

The Bio:

- registered nurse with over 20 years in health care;
- experienced administrator in surgical, oncology and renal programs in Ontario and Alberta;
- most recently with the Sault Area Hospital (Sault St. Marie, Ontario) as Director, Oncology, Renal and Telemedicine;
- holds a Master of Science from the California College of Health Sciences, San Diego, California and a Bachelor of Science in Nursing from the University of Victoria.

A medical oncologist's perspective continued from page 8

Unfortunately, the CUSIOS initiative described by Dr. Spooner is an observational descriptive study without a randomized contemporaneous control group and hence it cannot generate any convincing conclusions.

In order for NDs to acquire the professional qualifications to help patients understand the risks and benefits of conventional cancer treatment, the undergraduate curriculum must include scientifically proven principles of human tumour biology and treatment. After undergraduate medical training, oncologists have five years of standardized formalized externally accredited postgraduate training. There are no residencies for NDs with comparative rigor in Canada and the designation Fellow to the American Board of Naturopathic Oncology (FABNO) is not recognized by the College of

Naturopathic Physicians of BC (CNPBC). In fact, the CNPBC prohibits NDs from calling themselves "naturopathic oncologists".

The overriding interest of both the CNPBC and the College of Physicians and Surgeons of BC is the protection and safety of patients. The Medical Advisory Committee of the BC Cancer Agency recently facilitated a meeting between these groups to begin a professional dialogue toward this mutual goal. A second meeting is being planned.

Oncologists don't have all the answers. Our patients need multidisciplinary care and healing methods that mitigate suffering by addressing fear and despair. There are resources outside the BCCA and naturopathic medicine that incorporate techniques such as art, music, writing, movement and group therapy to help patients meet these needs, one of which is the Callanish Society⁽⁴⁾. I

have personally witnessed the power of the integrative care it provides and strongly endorse it as complementary therapy.

Disclosure: I have been a monthly charitable donor to The Callanish Society for 15 years.

Contact Dr. Tamara Shenkier at tshenkie@bccancer.bc.ca

References

1. Truant, Tracy L., et al. "Complementary and alternative medicine (CAM) use in advanced cancer: a systematic review." *J Support Oncol* 11.3 (2013): 105-13.
2. Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19 June - 22 July 1946
3. Greenlee, Heather, et al. "Clinical practice guidelines on the use of integrative therapies as supportive care in patients treated for breast cancer." *J Natl Cancer Inst Monogr* 50 (2014): 346-358.
4. www.callanish.org

New human papillomavirus (HPV) vaccination program for vulnerable males in BC

By Shaila Jiwa, Vaccine Educator, Dr. Monika Naus, Medical Director Immunization Programs and Vaccine Preventable Diseases Service, and Dr. Gina Ogilvie, Medical Director, Clinical Prevention Services, BC Centre for Disease Control

On September 1, 2015, BC launched a publicly funded, targeted HPV vaccine program using quadrivalent HPV vaccine (GARDASIL®, Merck Canada Inc.) for boys and young men who are at a higher risk of contracting the virus. This program expansion aims to provide protection to those who are most vulnerable to HPV infection and related disease:

- Males 9 to 26 years of age (inclusive) at the time of series commencement who are:
 - Men who have sex with men (including those not yet sexually active and those questioning their sexual orientation)
 - Street involved
 - Living with HIV
- Males 9 to 18 years of age (inclusive) in the care of the Ministry of Children and Family Development (MCFD)

- Males 12 to 17 years of age (inclusive) in youth custody

The decision to offer publicly funded HPV vaccine to high risk males in BC was made by the Ministry of Health. Targeted male vaccination is likely to be cost effective based on published analyses. In contrast, analyses of routine male vaccination suggest that it is not cost effective when female vaccination rates are over 50% as immunization of girls and young women provides indirect protection to heterosexual males. About 66% of Grade 6 BC girls completed the HPV vaccine series in 2014 and efforts at improving uptake are ongoing.

The new 9-valent HPV vaccine (GARDASIL®9, Merck Canada Inc.) will not be used upon the launch of this program as the incremental benefit of this vaccine for oncogenic strains in males is small; it offers no additional protection against genital warts. The National Advisory Committee on Immunization (NACI) has not yet issued a statement on the use of the 9-valent vaccine.

The success of the high risk male HPV

program depends on a variety of health care providers promoting and administering the vaccine to eligible males. Those who offer immunization services to high risk males should contact their local public health unit for information on how to access the vaccine. Providers are encouraged to implement strategies to help recipients complete the series as there is no evidence to suggest that one dose of the vaccine offers adequate long term protection. However, the vaccine should be recommended and a series initiated even in individuals who cannot be guaranteed to complete the series.



BC Centre for Disease Control
An agency of the Provincial Health Services Authority

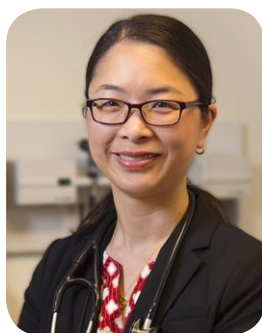
For more information, please refer to the BC Ministry of Health's news release: <https://news.gov.bc.ca/stories/hpv-immunization-program-expanded-to-vulnerable-boys>

HPV related head and neck cancers

By Dr. Cheryl Ho, Medical Oncologist, BC Cancer Agency Vancouver Centre

The incidence of HPV-related head and neck cancer is on the rise. Trends demonstrate that over 70% of squamous cell carcinomas of the oropharynx are related to HPV with projections to increase over the next decade. While HPV has been identified in other sites of head and neck cancers, it is typically associated with tumors involving the base of tongue and tonsil.

HPV associated head and neck cancers are recognized to have a different clinical presentation compared to the classic patient of the 1980s and 1990s. The median



Dr. Cheryl Ho

age of diagnosis is younger and patients are often non smokers and non drinkers. The primary tumour may be small with prominent

cervical lymphadenopathy. Due to the anatomy of the base tongue and tonsil, it is often difficult to visual the primary site directly. Common presentation includes a painless neck mass although local symptoms like sore throat, otalgia, hoarse voice or dysphagia may also be present.

The standard therapy for HPV oropharyngeal carcinoma is radiotherapy daily over 6-7 weeks. For patients with locally advanced disease and/or lymphadenopathy,

radio-sensitizing systemic therapy delivered concurrently with radiotherapy is recommended. Clinical trials are also exploring other treatment regimens including transoral robotic surgery and less intense chemo-radiotherapy protocols.

HPV positivity is a positive prognostic factor with patients having markedly better outcomes and survival. A retrospective study of locally advanced head and neck squamous cell carcinoma with nodal involvement treated with cisplatin and radiotherapy with known HPV status facilitated the development of a risk stratification algorithm. In simplified terms, low risk encompassed patients with HPV positive disease with less than 10 pack years of smoking, intermediate risk includes HPV positive patients with greater than 10

continued on page 11

Oncology imaging for primary care – November 20 primer

As integral members of the health care team, it is important for all of us to have an understanding of the strengths and limitations of medical imaging modalities used in medicine today.

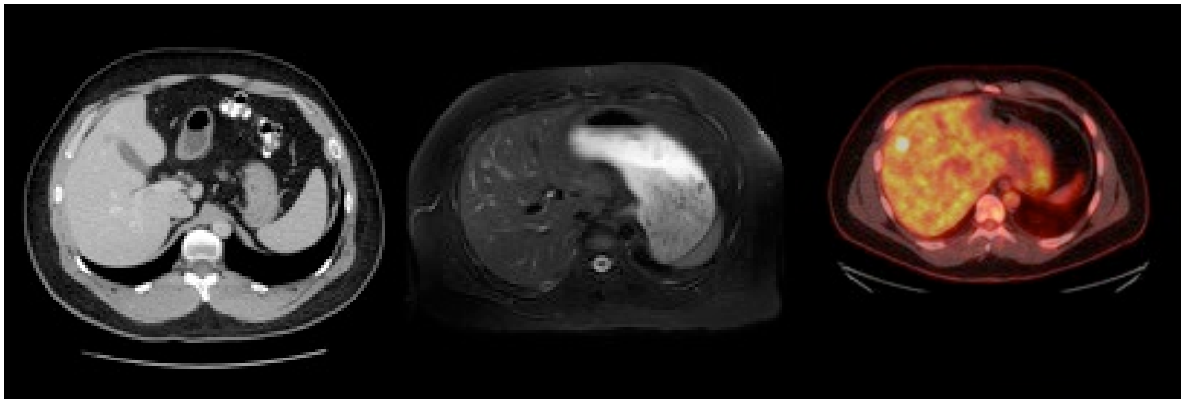
Nowhere is this more important than in oncology where patients are exposed to

medical imaging from the outset. Screening modalities are used to detect disease while other techniques are used throughout their treatment to assess response, and then in follow-up after treatment is complete.

On November 20th, the Family Practice Oncology Network is partnering with the

Dr. Pete Tonseth, Radiologist and Nuclear Medicine Physician at the BCCA Vancouver Centre, is one of the lead planners for the November 20 event: “There’s been a dramatic

Register for one or both events today at www.fpon.ca



evolution in medical imaging over the last decade and new innovations are occurring almost weekly. This event will provide a snapshot of the current state of oncology imaging in BC delving into applications and case studies for

.....
HPV related head and neck cancers continued from page 10

pack years of smoking, and high risk were HPV negative patients with a significant smoking history. The approximate 3 year overall survival were low risk – over 90%, intermediate risk – 70% and high risk – 45%. HPV associated diseases have dramatically improved survival outcomes in head and neck cancers.

While the cure rates are high in HPV positive oropharyngeal cancers, there remains significant long term toxicity with treatment. These side-effects include xerostomia with increased risk of dental caries, risk of osteoradionecrosis of the mandible with dental procedures, local tissue fibrosis and difficulty swallowing. Awareness of the importance of good dental hygiene and caution regarding invasive dental procedures is important in the long term care of these patients.

With the improved outcomes in HPV positive head and neck cancers, current research is focused on de-escalating therapy by using decreased doses of radiotherapy and chemotherapy. The challenge will be to maintain the excellent patient outcomes while reducing the short and long term side effects of therapy.

Contact Dr. Chery Ho at cho@bccancer.bc.ca

BC Cancer Agency’s Medical Imaging staff and the UBC Department of Radiology to present – ***Oncology Imaging for Primary Care***. The event takes place from noon - 5:00 p.m. and offers a unique opportunity to gain a current, practical understanding of oncology imaging and its pivotal role in cancer care.

This event precedes the Network’s November 21 Family Practice Oncology CME Day and is designed to provide primary care professionals with practice-ready insight emphasizing screening, diagnosis, staging and follow-up imaging applications in selected oncology settings.

Both the November 20 and 21 events are accredited by the College of Family Physicians of Canada and the BC Chapter (3.5 and 6.5 M1 credits respectively) and will be held at the BC Cancer Agency’s Research Centre in Vancouver.

breast cancer, colorectal cancer, lung cancer and lymphoma. We will discuss the most appropriate imaging modality to use for each with a focus on screening and follow-up applications as these pertain most directly to primary care.”

“We will also cover the use of advanced imaging techniques such as MRI and PET CT from a perspective that provides additional information on which to base decisions.”

Got an imaging question or challenge you’d like addressed?

The planners for the November 20 Oncology Imaging in Primary Care welcome your patient related queries in advance and will be sure to address them at the event. Please email any questions or comments to jennifer.wolfe@bccancer.bc.ca.

Oncology Imaging Resources

Breast Cancer Screening - <http://www.screeningbc.ca/Breast/default.htm>

Colon Cancer Screening - <http://www.screeningbc.ca/Colon>

BCCA Radiology - [http://www.bccancer.bc.ca/our-services/centres-clinics/vancouver-centre/cancer-care-team-and-services/treatment-services/radiology-\(diagnostic-imaging\)](http://www.bccancer.bc.ca/our-services/centres-clinics/vancouver-centre/cancer-care-team-and-services/treatment-services/radiology-(diagnostic-imaging))

Functional Imaging (PET/CT) - <http://www.bccancer.bc.ca/our-services/services/pet-functional-imaging>

Communicating about the integration of palliative care with oncology

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

Thanks to all who attended my June 18 webinar about the early integration of palliative care with oncology. I was pleased that more than half of the participants were from outside the Lower Mainland, including some from other provinces, and about half were from the allied health professions. Thanks also for your comments and questions. I hope the following responses will contribute to further discussion.

First, the BC Palliative Care Hotline is 1.877.711.5757. This 24/7 telephone resource is available to all BC and Yukon physicians and will reach a specialist palliative care physician willing to offer advice on challenging clinical problems.

View the full webcast of this topic at www.fpon.ca – Continuing Medical Education

Next, there is no such thing as a “palliative patient”. There are only “patients with palliative care needs”. Most palliative care services were set up when the term “palliative care” was used according to the old WHO definition – as applying to life-limiting illnesses. The 21st Century definition refers to life-threatening instead. This seemingly minor change has enormous implications.

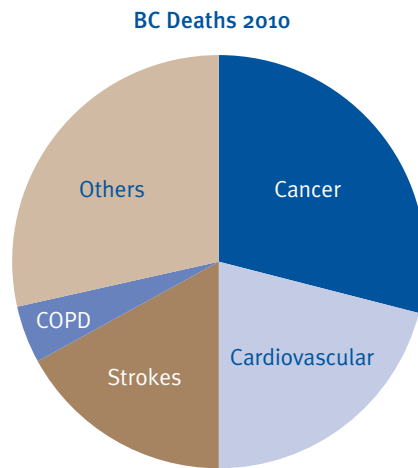
Survivorship is now included as a possible outcome of receiving a palliative approach to care. Hospice is now only one part of palliative care. It will take time for specific services to adjust their titles to reflect this change including items such as billing codes, benefits programs, national and provincial societies. In the meantime, using the terms “Palliative Care” and “Hospice” correctly will gradually change the way patients think about palliative care. This will lead to being more open to discussing a palliative approach early in the course of illness, understanding that hospice will be there for them when they are nearing end of life.



Dr. Pippa Hawley

What has changed to necessitate the palliative approach to care? Advances in medical treatments have changed the way we die. Over 80% of British Columbians now die from chronic illnesses, more from cancer than any other single cause. Most of us will die in hospital, whereas most of us say we would prefer to die at home. Acute hospital care is expensive and for many of us will not be where we want to spend a large proportion of our last months of life. Economic and demographic challenges require us to care for patients not only the way they want to be cared for, but in the most sustainable manner possible.

We can now see most deaths coming. Our society currently values autonomy over all other ethical principles and patients want control over how they live, and how they die. We need to be ready to meet the patients’ needs wherever they are in their disease trajectory.



We are designing a poster illustrating the 21st Century meaning of the terms palliative care and hospice and to help open the dialogue. Educating our colleagues is key to progress. Educating the public will make this so much easier!

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

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Visit the Network Website:
www.fpon.ca

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*Breast cancer:
prolonged hormone therapy awareness
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References

1. Long-term effects of continuing adjuvant tamoxifen to 10 years versus stopping at 5 years after diagnosis of oestrogen receptor-positive breast cancer: ATLAS, a randomised trial. *The Lancet*, Volume 381, Issue 9869, Pages 805 - 816, 9 March 2013
2. aTTom: Long-term effects of continuing adjuvant tamoxifen to 10 years versus stopping at 5 years in 6,953 women with early breast cancer. *J Clin Oncol* 31, 2013 (suppl; abstr 5)
3. Goss PE, Ingle JN, Martino S, Robert NJ, Muss HB, Piccart MJ, Castiglione M, Tu D, Shepherd LE, Pritchard KI, Livingston RB, Davidson NE, Norton L, Perez EA, Abrams JS, Therasse P, Palmer MJ, Pater JL. A randomized trial of letrozole in postmenopausal women after five years of tamoxifen therapy for early-stage breast cancer. *N Engl J Med* 349: 1793-802, 2003.