BC CANCER

Provincial Health Services Authority

Journal of Family Practice Oncology

Issue Number 33, Fall 2019 | www.fpon.ca

BEST PRACTICE CANCER CARE GEMS *IN THIS ISSUE*

Nov. 22 & 23, 2019: Join us @ the BC Cancer Summit For Primary Care Oncology CME

This November 22-23, BC Cancer celebrates excellence in cancer care and will mark the occasion once again with the BC Cancer Summit, a two-day conference at the Sheraton Vancouver Wall Centre. The event provides critical education, professional development, and relationship building opportunities for oncology professionals from all specialties and disciplines. The Family Practice Oncology Network's two most significant oncology CME events for primary care, GPO Case Study Day (November 22) and Family Practice Oncology CME Day (November 23), will be held as part of the Summit. Our format will follow that of previous years, with the content and organization enriched by feedback from last year's participants (we listen!). Register today at bccancersummit.ca and take advantage of this plethora of learning and networking opportunities!

Nov. 23: Family Practice Oncology CME Day – 5.75 Mainpro+ Credits

Learn about new developments and practice changing guidelines in cancer care:

- Density Matters: Breast Screening Guidelines
- Cervical Cancer: Screening and Management Updates
- Childhood Cancer Insights:
  - CAR T-Cells Explained
  - Cannabis in Kids with Cancer
- Hereditary Cancer Resources
- Serious Illness Conversation Primer
- Tinkering with TSH: Thyroid Cancer Follow-up Guidelines
- Cancer Care Resource Gems

Full details and registration at www.fpon.ca

Nov. 22: GPO Case Study Day – 5.5 Mainpro+ Credits

Designed for General Practitioners in Oncology (GPOs), Nurse Practitioners, and primary care providers keen to tackle prevalent and emerging challenges in cancer care through case-based discussion, this year's GPO Case Study Day will focus on breast, endometrial, pancreatic, and renal cancer, and cancer related thromboembolism. Presentations and discussions will be led by a GPO(s) accompanied by a supporting specialist.

GPO Case Study Day provides an excellent environment to learn and connect with colleagues who provide a similar level of cancer care in communities throughout BC and the Yukon. Full details and registration at www.fpon.ca. This event sold-out in 2018 so be sure to register early!

Contact Jennifer Wolfe, jennifer.wolfe@bccancer.bc.ca or 604.219.9579

New BC Cancer Leadership: Meet Dr. Kim Nguyen Chi and Heather Findlay

Effective July 1, Dr. Kim Nguyen Chi took on the role as BC Cancer's Vice President and Chief Medical Officer and Heather Findlay as BC Cancer's Chief Operating Officer. In this new dyad leadership model, Dr. Chi and Heather will work collaboratively on BC Cancer's strategic priorities to support patient care across the province.

Dr. Kim Nguyen Chi

Dr. Kim Nguyen Chi

Dr. Chi will be focused on moving forward with the BC Cancer provincial strategy responsible for ensuring the cancer priorities are well positioned in the health authorities' network across the province. Dr. Chi is a Medical Oncologist, and previously served as both Regional Medical Director for BC Cancer – Vancouver and Director of Clinical Research. He is also a Professor of Medicine at UBC. His list of professional achievements includes clinical and translational research with a focus on prostate cancer, leadership roles on national and international research organizations and committees, and publications in high impact journals.

Both Dr. Chi and Heather value where BC Cancer has come from and know that success going forward lies in partnerships and the strength that comes from a team united. One key partnership the new dyad leadership plans to focus on is that with community cancer care particularly the Community Oncology Network (CON) which includes 31 clinics led by General Practitioners in Oncology and related primary care professionals offering varying levels of care based on community need.

"In partnership with BC Cancer oncologists, our CONs deliver much of the cancer care in BC and the Yukon. Together, they represent our biggest opportunity to expand capacity quickly, and we will be looking to this Network to determine how best to support them in meeting the growing needs of our patients. Working in collaboration with our regional health authority partners we must ensure services for our patients are available closer to home where possible, today and into the future. A new classification system detailing community needs and service availability, entitled Tiers of Service, will provide a helpful starting point for this effort," says Dr. Chi.

Heather Findlay

Heather Findlay

As Chief Operating Officer, Heather is accountable for day-to-day operations and execution on organizational action plans that move BC Cancer forward with respect to the provincial cancer care strategy.

Heather has been serving as Senior Director, Regional Clinical Operations for BC Cancer – Vancouver since 2017. She has more than 19 years of operational leadership experience within Vancouver Coastal Health and Fraser Health in a number of roles including Clinical Manager, Clinical Director and prior to joining PHSA, Executive Director of Tri-Cities Health Services and Eagle Ridge Hospital. She is recognized as collaborative leader who demonstrates system thinking and is strongly committed to quality and exceptional patient care.

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

5 tips to help you talk to your patients about oncology biosimilars

By Dr. Helen Anderson, Provincial Lead Systemic Therapy, BC Cancer

Oncology biosimilars have entered the Canadian market. Biosimilars that have been approved by Health Canada are safe and effective and offer significant savings to the cancer system. BC Cancer will be implementing biosimilars for cancer patients in British Columbia starting October 2019. Each subsequent product will become available following Health Canada review and after BC Cancer funding decisions have been completed.

With oncology biosimilars entering the market, your patients may have questions. Below are tips when speaking to your patients about oncology biosimilars:

1. **A biosimilar is a new, highly similar version of a biologic drug**. Biosimilars were previously called subsequent entry biologics (SEBs) in Canada.
2. **Biosimilars are safe and effective**. There are no differences between biosimilars and their reference biologic drugs in terms of quality, safety, and efficacy. Health Canada must review and approve all drug products before they can be sold in Canada. Biosimilars are approved based on a thorough comparison to a reference drug and can be made available after the expiry of reference drug patent and data protection.
3. **At this time, only cancer patients starting a new treatment regime in BC will be required to receive a biosimilar if available**. Patients on a current treatment therapy will not be switched over to the biosimilar product unless they wish to do so, after discussion with their treating oncologist. Requests for funding of the reference biologic in any new starts will require a Compassionate Access Program (CAP) request.
4. **A Bevacizumab biosimilar will be available in September 2019 and BC Cancer will fund new patients eligible for this treatment after October 1, 2019**. Initial indications will be colorectal cancer, brain cancer, ovarian and cervix cancer. Two additional oncology

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Empowering smoking cessation in patients with cancer

By Dr. Shirin Abadi, Pharmacy Clinical and Education Coordinator, BC Cancer – Vancouver

Tobacco use, including cigarette smoking, is the greatest preventable cause of death, killing more than 7 million people every year globally.[1] One in 5 deaths in Canada is attributed to cigarette smoking.[2] The health-economic cost associated with smoking in Canada is about 16.2 billion dollars per year.[2-3] Not only is cigarette smoking a significant contributor to cancer-related mortality, it also increases all-cause mortality and cancer recurrence.[4-6] Furthermore, cigarette smoking reduces the response rate to cancer treatment, while increasing treatment-related toxicities.[4-8]

In a prospective cohort study of 388 patients diagnosed with lung cancer, the median overall survival of patients was significantly better (by 9 months) for those who stopped smoking upon diagnosis, compared to those who continued to smoke (HR=1.79; 95% CI, 1.14-2.82).[10] Additionally, in a retrospective cohort study of 2,882 patients with lung cancer, all-cause mortality was significantly reduced in patients who quit smoking upon diagnosis compared to those who continued to smoke (HR=0.82; 95% CI, 0.74-0.92).[11] Furthermore, in a prospective, observational study in 20,691 women with localized or invasive breast cancer, there was a significantly greater mortality rate from breast cancer, respiratory cancer, respiratory disease, and cardiovascular disease in patients who were smokers at 1 year prior to their cancer diagnosis, compared to those patients who never smoked.[12] In addition, patients who continued to smoke after their diagnosis had a significantly greater morality rate from breast cancer than those who never smoked (HR=1.72; 95% CI, 1.13-2.60).[12] Women who quit smoking after their diagnosis had a significantly lower mortality rate associated with respiratory cancer compared to patients who continued to smoke (HR=0.39; 95% CI, 0.16-0.95).[12] It is never too late for patients with cancer to consider quitting the habit, particularly once they are informed about the favourable outcomes associated with smoking cessation.

> Smoking cessation can reduce cancer death rates by 30-40%.[4-9]

There are a number of medications that can successfully assist patients with their quit attempt, including nicotine replacement therapy – NRT (e.g., patch, gum, lozenge, inhaler, mouth spray), prescription agents (e.g., bupropion, varenicline, nortriptyline) and natural health products (e.g., cytisine). Pharmacotherapy should be individualized to ensure efficacy and safety, with instructions provided on proper technique and use. Patients can access free NRT in BC pharmacies. Counselling can also positively impact smoking cessation and is available free of charge at https://www.quitnow.ca/. Through its new Smoking Cessation Initiative, supported by the Canadian Partnership Against Cancer, BC Cancer now screens every new patient for tobacco use, advising them of the benefits of quitting, while providing referral to counselling and NRT services.

Smoking cessation improves health outcomes for patients with cancer, particularly if they are encouraged to do so at every transition point of care.

Contact Dr. Shirin Abadi at sabadi@bccancer.bc.ca

see References on page 14

Oncology biosimilars continued from page 2

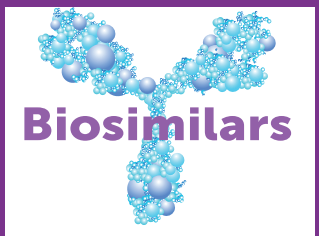
biosimilars for trastuzumab and rituximab are expected to become available over the next 8 to 10 months. These biologic agents are used in the treatment of breast cancer and lymphoma.

5. **Oncology biosimilars offer the potential to bring significant savings to cancer system budgets without compromising patient care**. The money saved by using oncology biosimilars can be put back into the cancer system to help improve access to new treatments.

Questions? Contact Dr. Helen Anderson at handerso@bccancer.bc.ca

Resources:

- BC Cancer Biosimilars Information and Resources: www.bccancer.bc.ca/biosimilars
- Biosimilar Drugs: Your Questions Answered (Canadian Agency for Drugs and Technologies in Health) www.cadth.ca/sites/default/files/pdf/biosimilar_drugs_patient_en.pdf
- Biosimilars: What You Need to Know (Cancer Care Ontario) www.cancercareontario.ca/en/cancer-treatments/chemotherapy/about/biosimilars
- Biosimilar Biologic Drugs (Health Canada) www.canada.ca/en/health-canada/services/drugs-health-products/biologics-radiopharmaceuticals-genetic-therapies/biosimilar-biologic-drugs.html



Oncology biosimilars have entered the Canadian market.

Find resources about oncology biosimilars at:

bccancer.bc.ca/biosimilars

Breast screening for transgender, gender-diverse and non-binary people

By Dr. Colin Mar, Medical Director, BC Cancer Breast Screening Program

The goal of breast cancer screening is to reduce related mortality and morbidity through earlier detection of the disease. Encouraging participation in screening should include the identification of vulnerable sub-populations, and adoption of specific strategies to address barriers to screening.

One such group is the transgender or trans, Two-Spirit, and gender diverse population of British Columbia. A *transgender man* is a person whose sex at birth was assigned as female, but whose gender (sense of self) is male. A *transgender woman* is a person whose assigned sex at birth was male, but whose gender is female.

The term *genderqueer* is sometimes used by people with non-binary genders.

Table 1: Screening Strategy Based on Anatomy Present

Anatomy	Screening Recommendations
Chest (Breast) Tissue :	
• Trans patient with **NO** history of Top Surgery (bilateral subcutaneous mastectomy) or with history of simple reduction mammoplasty.	• Screen as per cisgender (non-transgender) BC Cancer Breast Screening policy.
Chest Tissue *after* Top Surgery:	
• Trans patient with removal of most, but not all, breast tissue (some tissue used to contour shape of the chest).	• Screening mammography is not feasible. • Recommend follow-up with primary care provider (PCP). • If high risk or patient/PCP concern, then may require physical exam and consideration of diagnostic ultrasound or other modality.
Breast tissue associated with gender-affirming hormone therapy (estrogen use):	
• Trans patient with breast tissue growth associated with estrogen use.	• There are no evidence-based guidelines for screening in transgender women relative to hormone usage. • Transgender women are thought to be at lower risk than cisgender women. • Limited evidence regarding how to incorporate risk factors including duration of hormone use, family history and BMI. • **Average risk:** – If estrogen > 5 years and age 40 – 74, then screen as per cisgender (non-transgender) BC Cancer Breast Screening policy. • **Higher than average risk:** – If estrogen > 5 years and age 40 - 74, and one or more higher than average risk factors (e.g. first-degree relative with breast cancer), then screen as per cisgender (non-transgender) BC Cancer Breast Screening policy for higher than average risk. – Recommend discussion of other possible risk factors such as progestin use and BMI > 35 with PCP.

The relatively limited understanding of this portion of our society contributes to a cycle of marginalization through multiple social and healthcare issues. Indeed, the size alone of this population is difficult to measure, but estimates are at least 0.5% of the adult population (Winter).

The risk of under-screening is now recognized. (Gatos, Kiran)

Assessing eligibility for the transgender population may be challenging due to the various types of transition available to these individuals. These include social (lifestyle alteration), medical (hormone therapy) and surgical (gender-affirming surgery) (Kiran). *Top surgery* refers to breast construction (augmentation) or chest construction surgery (bilateral subcutaneous mastectomy). The basic screening strategy though is to screen based on the anatomy present, and is summarized in Table 1. This policy was developed in collaboration with Trans Care BC, a new Provincial Health Services Authority program designed to enhance the coordination of trans health services across the province.

The current trend is an increasing role for the primary provider in the healthcare of the trans population, rather than solely specialist care (Lane). This will be facilitated by familiarity with the above terminology, and adoption of pronouns and name used by the patient, which may differ from their identification and medical chart. Gender affirming language extends to discussion of signs and symptoms. For example, regardless of any surgery, a trans man would likely refer to his upper body as his chest, while a trans woman would likely refer to her upper body as her breasts. Provider knowledge of this breast screening policy, and such affirming language will contribute to best healthcare practices for our transgender community.

All eligible transgender, Two-Spirit, and gender diverse persons may directly self-refer to the program to book an appointment: 1-800-663-9203

see References on page 14

ABC's of opioid prescribing

By Dr. Julia Ridley, Pain and Symptom/Palliative Care Physician, BC Cancer – Vancouver

Patients with advanced cancer often have pain necessitating opioid treatment. Recent guidelines from regional and national bodies, the fentanyl crisis, and anecdotal experiences can make prescribers wary of prescribing opioids. Of note, the BC College of Physicians guidelines, revised in 2016, explicitly state that standard does NOT apply to active cancer care, palliative care, or management of substance use disorders. Most patients will not get addicted to opioids, and will have manageable side-effects.

Screening for risk of misuse and addiction helps to identify patients at higher risk, and can be reassuring to those who are fearful of taking opioids. The Opioid Risk Tool is validated and simple: http://nationalpaincentre.mcmaster.ca/opioid/cgop_b_app_b02.html

The BC Centre for Palliative Care also has excellent guidelines on pain management: https://www.bc-cpc.ca/cpc/symptom-management-guidelines/

Initiating an opioid

When initiating an opioid, start with an as needed (PRN) dose of a short acting opioid. For oral medications, this can be given as often as q1hr PRN, as the medication will be fully effective at this point. If the patient still has pain, they'll need to take another dose to get better analgesia. For patients with relative frailty, including renal dysfunction, a longer interval may be appropriate. A q4hr PRN order will allow patients to maintain a steady-state of the medication, as most opioids have a half-life of 4 hours, but will not allow patients to dose-find, as doses will not overlap significantly.

For opioid naïve patients, consider a starting dose of 10mg PO morphine, 2mg of PO hydromorphone or 5mg of oxycodone for severe pain. Lower the dose by as much as 50% for each of frailty, renal impairment, and/or moderate pain. For example, for a frail patient with colon cancer who is limited in bending by pain, a dose of 2.5mg of morphine, or 0.5mg of hydromorphone would likely be appropriate.

And always recommend a laxative when prescribing opioids!

"ins-and-outs of cancer" by Heidi Bam

Reassess, reassess, reassess

How effective is the current opioid? Is it causing side-effects? If pain is well controlled, it's usually best to switch to a long acting formulation with an PRN of 10% of their total daily dose (e.g. 5mg morphine 6x/day → 15mg long acting morphine q12hrs + 2.5mg q2hr PRN). If pain is partially controlled, consider increasing the short acting dose (e.g. 5mg morphine q2hr PRN → 10mg morphine q2hr PRN) or starting a long acting formulation at a slightly higher dose than their total daily dose with a PRN (e.g. 5mg of morphine 6x/day → 20mg long acting morphine q12hrs + 5mg q2hr PRN).

Offer treatment of side-effects, or rotation to a different opioid if they are intolerable. Opioid induced neurotoxicity (OIN) including hallucinations, confusion, myoclonus and allodynia, is an indication for opioid rotation.

To rotate, calculate the total daily dose of their current opioid, rotate to the new opioid using your favourite equianalgesic chart and then reduce the dose by 25-50%; 25% if pain is poorly controlled, up to 50% if pain well controlled and OIN (Opioid Induced Neurotoxicity) is present. For example, 20mg of long acting morphine q12hrs + 5mg PRN morphine taken 3x/day = 55mg morphine total per day. If the patient is myoclonic, but and has good pain control, divide by 5 for the hydromorphone dose, then reduce: 55mg/5 = 11mg; 3mg of long acting hydromorphone q12hrs + 1mg q2hr PRN is an appropriate rotation.

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

Pearls

- Morphine and hydromorphone are good opioids to start as they are robust in dosing forms, including parenteral formulations.
- For those with renal impairment, avoid morphine, as metabolites can cause increased side-effects. Consider fentanyl or methadone as these do not require renal clearance.
- Discuss expectations of improved pain control, function and sleep with the patient – not complete amelioration of the pain.

Contact Dr. Julia Ridley at jridley@bccancer.bc.ca

Insight into male breast cancer

By, Dr. Karen Gelmon, Medical Oncologist, BC Cancer – Vancouver

When we think about breast cancer we usually only consider women, but in Canada this year about 250 men will be diagnosed with breast cancer. Although less than 1% of all breast cancers occur in men, we need to be both aware of the signs and symptoms and also strive to do more research into this entity.

Dr. Karen Gelmon

Almost all breast cancers diagnosed in men are the common ductal carcinoma, which are sensitive to estrogen and progesterone. Most men present with a lump in their breast, which they often ignore as they are not expecting or aware that they are at risk of getting a cancer. Most men do not think they have breast tissue, but they do; less than women, but still tissue. Occasionally, a male breast cancer presents as a bloody nipple discharge, crusting of the nipple, or a sore that will not heal.

As with women, in the majority of cases we are not able to define what caused the cancer. In about 10% of men the risk is a mutated gene inherited from their mother or father, which increases the risk of developing breast cancer as well as prostate, colon, pancreatic and other cancers. This is commonly the same BRCA 2 gene that is a risk factor for a minority of women with breast cancer. In affected families there may be multiple cases of breast, ovarian, pancreatic and prostate cancers. Other rare genetic changes can also increase the risk of male breast cancer, including a very rare disorder called Klinefelter's syndrome.

As in women, age is a risk factor with the incidence of male breast cancer increasing after age 60. Other suspected risk factors include exposure to radiation to the chest, cirrhosis, and other factors associated with high levels of estrogen including obesity.

Breast cancer is treated the same in both men and women with surgery, radiation, chemotherapy and hormonal therapy. As in women, the treatment depends on the biological features of the tumour, the stage, the health of the person and their wishes. The prognosis depends on the stage, the biology and the response to treatment, but is usually good. Because most male breast cancers are hormone sensitive, hormone therapy is commonly given which can have side-effects and quality of life issues.

There is minimal research into the causes, treatment, impact of therapy and supportive care for male breast cancer. In BC, we are very fortunate that this is changing. This year, the Neil Macrae Grant competition generously initiated by Neil's widow, Laurie Rix, was held. Three grants were funded to promote research into this area, and provide BC scientists with the opportunity to improve our understanding of male breast cancer. Dr. Connie Eaves, fortuitously collected specimens over the last few decades from cosmetic mastectomies on men, and has been funded to look at specific molecular changes, which may help unravel why the cells become cancerous. Dr. Steven Jones is developing a novel laboratory technique to look at the genetic changes in cells. Dr. Intan Schrader was funded to develop an enhanced process for testing men through the Hereditary Cancer Program. Each of these studies is unique and has the potential to impact the outcomes of men with breast cancer in BC and internationally.

What can we do? Educate the public and patients to be aware of male breast cancer so men are diagnosed earlier and not ashamed or unaware when they get a breast lump, most of which will not be cancer. Also, support the BC Cancer Foundation in their work to support research into male breast cancer with their special campaign this year and all the other work they do for cancer research in BC.

Contact Dr. Karen Gelmon at kgelmon@bccancer.bc.ca

New symptom screening program pilot launched at BC Cancer

During the cancer journey, many cancer patients need palliative care support consisting of symptom identification and management. Historically, late utilization meant "palliative care" became equated with end-of-life care. Research shows, however, that early assessment and management of symptoms in serious illness has significant positive impact on patient health and well-being, including less depression and anxiety, better quality of life, better symptom control, longer life span, and lower costs of care.

With a new BC Cancer pilot project, family physicians will have additional support for their cancer patients' symptom management. The Early Palliative Integration into Cancer Care (EPICC) project, funded by the Canadian Partnership Against Cancer, involves staff education followed by implementation of repeat symptom screening for patients receiving palliative radiation, or with metastatic breast or gastrointestinal cancers. EPICC is starting with pilots in Prince George (launched) and Vancouver (later this year), with a goal to expand over time to more populations and centres. Details: www.bccancer.bc.ca/EPICCPrinceGeorge

Repeat symptom screening assesses key patient symptoms and issues using the Edmonton Symptom Assessment System (ESAS) and Canadian Problem Checklist (CPC) (see above EPICC website). Patients complete their screening using iPads before

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Breast implant associated anaplastic large cell lymphoma

By Dr. Rebecca Nelson, Plastic and Reconstructive Surgeon, Burnaby, and Dr. Peter Lennox, Plastic and Reconstructive Surgeon, Vancouver

Dr. Rebecca Nelson

Breast implant associated large cell lymphoma or BIA-ALCL was first described in 1997[1], with the number of cases on the rise. It is now a distinct entity recognized by the World Health Organization, with 656 cases worldwide reported to date, including 17 deaths[2]. Textured breast implants were first introduced in 1968 as a way to reduce the formation of capsular scarring around the implant[3]. The cause of BIA-ALCL is not fully understood but is likely the result of multiple factors, including the high surface area of textured implants, genetic factors, gram negative bacteria, and chronic peri-implant inflammation[4].

Incidence and risk in Canada

A total of 31 cases have been reported in Canada as of May 2019, with no deaths[5].

At-risk population

Patients with textured surface breast implants, including both reconstructive and cosmetic patients, are at risk for developing BIA-ALCL.

The incidence is 1 in 3,565 for patients with Allergan Biocell macro-textured implants, and 1 in 98,000 for patients with Mentor Siltex micro-textured implants[5]. These rates are evolving as we learn more about the disease and improve our ability to monitor and detect it.

Etiology

BIA-ALCL is a T-cell lymphoma characterized by CD30+ and Anaplastic Lymphoma Kinase (ALK) negative cells[4]. Susceptible patients may also have specific genetic disruptions, such as mutations in the JAK-STAT signalling pathway.

Clinical presentation

Patients typically present in the early stage, with a large seroma or effusion around the implant that occurs >1 year postop[2], on average 8 years post-implantation[6]. Approximately one third of patients present with, or have an associated capsular mass, and the remaining few with distant metastasis.

Diagnosis

The majority of cases are detected via aspiration of peri-implant fluid, which typically shows CD30+ staining T lymphocytes and a lack of ALK, with a number of other tumour antigens present[4].

Ultrasound investigation may demonstrate a capsular mass, which can be biopsied. CT, MRI and PET scanning can be used in select cases to diagnose distant disease. (PET CT is standard in pre-op assessment.)

Management

The NCCN has defined a standardized treatment protocol for patients, including urgent referral to a plastic surgeon, and complete surgical removal of the breast implant and capsule (i.e. en bloc resection), which is the mainstay of disease management[6]. Involved nodes may also be resected. Chemotherapy (brentuximab vedotin, an anti-CD30+ immunotherapy drug combination, as well as antracycline-based therapies) may be indicated for disseminated disease. Removal of textured implants without clinical suspicion of disease is not recommended. Plastic surgeons, however, are happy to discuss the risks with patients in office consultation[5].

Outcomes

With an indolent course, and disease limited to the effusion and capsule, cure rates approach 100%[7]. For later disease stages, including lymph node or distant metastases, cure rates are lower. The recurrence rate when complete surgical resection is performed is reported as 4% at 5 years[8].

Contact Dr. Rebecca Nelson at rebecca.nelson@fraserhealth.ca

see References on page 14

New symptom screening program pilot continued from page 6

each appointment with results trended over time. Participating patients immediately receive a copy and review their trended results with their oncology team.

Patients are also encouraged to share these results with family and community care providers to facilitate symptom discussions: What symptom care are they receiving? Are their self-care strategies working? What additional support, information, or care might they need? BCGuidelines.ca published a palliative care guideline (http://bit.ly/2YYMeo0) in partnership with the Family Practice Oncology Network, which serves as a useful resource in this regard. Some care issues should be referred back to the patient's oncology care team, or may need coordinated care.

Training in the Serious Illness Conversation (SIC) guide and the Learning Essential Approaches to Palliative Care (LEAP) programs is being coordinated across BC Cancer centres to increase palliative care skills. BC Cancer and many health authorities have staff able to provide SIC training (www.bc-cpc.ca/cpc/serious-illness-conversations); local LEAP courses can be found on www.pallium.ca

Patient information and self-care tips can be found at: www.bccancer.bc.ca/health-info/coping-with-cancer under "Managing Symptoms & Side effects" (or at www.bccancer.bc.ca search for "coping"). Patients are encouraged to talk with their care providers if symptoms worsen or self-care strategies are not working.

Dr. Sian Shuel: incoming Medical Education lead for Primary Care Program

Oncology CME for family physicians and primary care providers has been a core focus of the Family Practice Oncology Network (now BC Cancer's Primary Care Program) since the Network's establishment in 2002. With the appointment of Dr. Sian Shuel as the incoming Medical Education Lead – to succeed the retiring Dr. Raziya Mia – this role will continue to grow, defining and addressing the distinct learning needs of this important group on the cancer care spectrum while building educational and provider partnerships with acute care providers. Over the coming months, Dr. Shuel will transition into the role, working in tandem with Dr. Mia who retires fully next spring.

Dr. Shuel brings an ideal mix of experience and expertise to the program. She is a family physician and General Practitioner in Oncology (GPO) by training, having filled both roles in Campbell River for seven years before relocating to the Lower Mainland, and taking on the role of GPO at BC Cancer – Abbotsford. She also works with Fraser Health as a palliative care physician, is a Clinical Instructor with UBC's Department of Family Medicine, and a volunteer on the Family Practice Oncology Network's CME and GPO Education Working Groups.

Dr. Shuel shares her perspective and vision for the role below:

What is most important to you about this role?

The opportunity to support primary care providers in their growing cancer care role and help improve patients' experience is really exciting. Family physicians, in particular, share a long-built sense of trust with their patients that enables us – with effective support – to smooth a cancer patient's journey with compassion, navigating with them through their disease trajectory, managing symptoms and follow-up care, and ensuring they understand their cancer, and its treatment, from a perspective that leads to peace of mind. Patients are often most comfortable and open with their family physician ideally positioning us to significantly enhance cancer care, from prevention and diagnosis through to survivorship and end-of-life care.

Transitioning Leads: Dr. Sian Shuel (right) will succeed Dr. Raziya Mia as the Family Practice Oncology Network's Medical Education Lead.

What do GPOs bring to cancer care in the community?

GPOs are family physicians with enhanced oncology skills and expertise. As such, we help bridge the relationship between primary care and oncology specialists, easing navigation through the system for both patients and family physicians. If a family physician is at a loss as to next steps in a patient's care, their local GPO likely can advise on the best route forward.

Like many GPOs in the community, I covered all tumour sites as a GPO in Campbell River, which I continue to do in my GPO role at BC Cancer – Abbotsford. This experience brings helpful insight to a wide range of cancers along with an understanding of the nuances and challenges faced by both GPOs and family physicians.

In communities, GPOs serve as a local resource bringing the comfort of long-standing relationships, an ease of communication, and an understanding of the patients' needs in the context of the local community. For patients undergoing chemotherapy in rural communities, GPOs take on all aspects of cancer care. Patients and their family physicians can have direct face-to-face conversations with us at any time throughout their care.

Where will you initially focus your energy?

Our aim is to deliver on the recommendations made in the Network's Primary Care Needs Assessment of late 2018 (see fpon.ca). I plan to learn the ropes of this role carefully, and to add my strengths to those of the team. We are here to support primary care providers by doing a good job of listening, and then working to meet their learning and resource needs to help provide effective, sustainable, person-centred oncology care.

Dr. Shuel originally hails from South Africa, then rural Manitoba.

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

Oncology CME Programs for Primary Care

Visit fpon.ca to learn more about our:

- 8-week GPO Education Program (see adjacent)
- No-charge monthly Oncology CME Webcasts – Don't miss our October 17 Webcast: Upper GI Malignancies with Dr. JP McGhie
- November 22 GPO Case Study Day and November 23 Family Practice Oncology CME Day @ the BC Cancer Summit (see page 1).

Next GPO education course begins February 3, 2020

The GPO Education Program is an eight-week course offering rural family physicians and newly hired BC Cancer GPOs the opportunity to strengthen their oncology skills and knowledge, and provide enhanced cancer care. The program covers BC and the Yukon and includes a two-week Introductory Module held twice yearly at the Vancouver Cancer Centre followed by 30 days of flexibly scheduled clinical rotation. Completion of this program is a requirement for all new GPOs.
Full details at www.fpon.ca

Serious illness conversation guide: more, better, and earlier conversations to improve patient care outcomes

By Dr. Charlie Chen, Palliative Care Consultant, Clinical Associate Professor, Division of Palliative Care, Department of Medicine, UBC

Marianne is a 52 year-old mother of 2 boys in their late teens. She arrives with her husband to the Emergency Department (ED) where she is complaining of 3 days of non-stop nausea and vomiting, abdominal pain and bloating. She was diagnosed with metastatic ovarian cancer 14 months ago and has been undergoing treatment at BC Cancer. After being assessed, she is shocked to learn that her newly diagnosed bowel obstruction is not only a common complication from her disease, but that she is at risk of dying.

Although the majority of patients with advanced cancer have documentation of a discussion with health care providers about their goals before the end of their lives, 55% of these discussions took place in an acute care setting. On average, these first conversations about end-of-life occurred 33 days before death, and only 27% of these conversations took place with their oncologist.[1]

Recent publications promote the systematic adoption of a communications strategy to enhance clinician-patient communication in the setting of serious illness.[2,3] Reductions in anxiety and depression are significant findings.[4] More, earlier, better, and more accessible documented conversations were also noted.[5] The use of a standardized communication tool resulted in the documentation of important patient-centred elements, such as their goals and values.[6]

One such communication strategy is the Serious Illness Conversation Guide (SICG: Figure 1). The suggested trigger for use of this tool is a "no" to the question: *Would I be surprised if the patient dies in the next 12 months?*[7,8]

The Guide assists the clinician in having a fulsome discussion with the patient about what is most important as time runs short. The focus is on how the patient would like to live their life in the context of limited time, and leaves medical treatment decisions for a

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Figure 1: Serious Illness Conversation Guide

CONVERSATION FLOW	PATIENT-TESTED LANGUAGE
1. *Set up the conversation* · Introduce purpose · Prepare for future decisions · Ask permission	"I'd like to talk about what is ahead with your illness and do some thinking in advance about what is important to you so that I can make sure we provide you with the care you want — **is this okay?**"
2. *Assess understanding and preferences*	"What is your **understanding** now of where you are with your illness?" "How much **information** about what is likely to be ahead with your illness would you like from me?"
3. *Share prognosis* · Share prognosis · Frame as a "wish...worry", "hope...worry" statement · Allow silence, explore emotion	"I want to share with you **my understanding** of where things are with your illness..." *Uncertain:* "It can be difficult to predict what will happen with your illness. I **hope** you will continue to live well for a long time but I'm **worried** that you could get sick quickly, and I think it is important to prepare for that possibility." OR *Time:* "I **wish** we were not in this situation, but I am **worried** that time may be as short as ___ *(express as a range, e.g. days to weeks, weeks to months, months to a year)*." OR *Function:* "I **hope** that this is not the case, but I'm **worried** that this may be as strong as you will feel, and things are likely to get more difficult."
4. *Explore key topics* · Goals · Fears and worries · Sources of strength · Critical abilities · Tradeoffs · Family	"What are your most important **goals** if your health situation worsens?" "What are your biggest **fears and worries** about the future with your health?" "What gives you **strength** as you think about the future with your illness?" "What **abilities** are so critical to your life that you can't imagine living without them?" "If you become sicker, **how much are you willing to go through** for the possibility of gaining more time?" "How much does your **family** know about your priorities and wishes?"
5. *Close the conversation* · Summarize · Make a recommendation · Check in with patient · Affirm commitment	"I've heard you say that ___ is really important to you. Keeping that in mind, and what we know about your illness, I **recommend** that we ___. This will help us make sure that your treatment plans reflect what's important to you." "How does this plan seem to you?" "I will do everything I can to help you through this."
6. *Document your conversation*	
7. *Communicate with key clinicians*	

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Figure 2: Sample Serious Illness Conversation Documentation

August 11, 2019

Marianne is a 52 year-old female with metastatic ovarian cancer and known liver and peritoneal involvement. She agreed to have a serious illness conversation to learn more about her values, goals, and priorities.

Marianne has full understanding of the terminal nature of her cancer and that her prognosis is measured in months.

Goals: Her main goals are to finish some legacy work for her family.

Fears and worries: She is scared of significant pain and symptoms at the end of life and worries that she may become heavily reliant on her family for personal care. She would prefer to have professionals provide such care.

Sources of strength: She derives strength from her Christian faith, her family, and her large community of friends.

Critical abilities: She names her ability to think clearly and to enjoy food as the functions that she would find difficult to live without in the context of limited time.

Trade-offs: She is willing to enter acute care to treat reversible problems, but not to prolong a debilitated, artificial life-supported condition of existence.

Family: Her family is fully aware of these priorities and wishes.

A strategic proposal for primary care and care of patients with cancer in BC

By Dr. Cathy Clelland, Provincial Lead, BC Cancer Primary Care Program

Dr. Cathy Clelland

Since early 2018, BC Cancer's Provincial Primary Care Program (PPCP) has been developing a strategic proposal to support Primary Care and the care of patients with cancer in British Columbia. We took into account recent reports from the BC Ministry of Health, BC Cancer, First Nations Health Authority, Métis Nation BC, the BC Association of Aboriginal Friendship Centres, and the Canadian Partnership Against Cancer outlining recommendations to improve patient experience across the cancer care system and including the common theme of enabling greater coordination between partners, particularly primary care providers and health authorities.

Primary care providers, especially family physicians, are well-positioned to provide comprehensive care to patients with cancer in the community. Their longitudinal relationship and knowledge of each patient's history, social circumstances, and co-morbidities, are crucial to the management of cancer. Coordination of specialized cancer care with primary care, however, requires collaboration, connected leadership, and shared tools to support a sustainable cancer care system.

With this goal in mind, our proposal focuses on four objectives:

- Supporting patient experience of a seamless cancer care journey integrated with holistic health care needs;
- Facilitating system capacity building for primary care providers in the support and provision of care for their patients enabling expanded ability for oncologists to focus on assessment and management of patients needing their expertise;
- Enhancing prevention and early intervention to improve outcomes; and
- Ensuring appropriate capacity and resources of the PPCP to execute the above.

To ensure primary care providers are supported and equipped to care for their patients through the cancer care journey, we have been sharing the results of our Needs Assessment (see fpon.ca) as well as our strategic proposal with BC Cancer and PHSA leadership, Divisions of Family Practice (particularly those in the process of developing Primary Care Networks), and Doctors of BC/Ministry of Health Joint Clinical Committees. We are hopeful that the PPCP will soon be in a position to collaborate with partners to develop the tools and processes that incorporate the above priorities into daily practice, improving the experience of cancer patients across BC. Please send us your thoughts and ideas on making this a reality.

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Follow-up care of lung cancer patients

By Dr. Georgia Geller, Medical Oncologist, BC Cancer – Victoria

Management of non-small cell lung cancer is dependent on stage at presentation, and is often multidisciplinary benefitting from discussion at multidisciplinary lung rounds. Stage 1 disease is typically treated with surgery. For some patients, however, stereotactic body radiation therapy (SBRT) is another option. Stage II and IIIa disease, if amenable, are treated with surgery followed by 4 cycles of adjuvant cisplatin and vinorelbine chemotherapy. Stage IIIb/c disease, if the site can be encompassed in a high dose radiation field, is treated with curative intent chemoradiation. Recent evidence suggests an additional 10.7% improvement in 24 month overall survival with 1 year of adjuvant durvalumab immunotherapy following chemoradiation (not funded in BC, but available through a special access program).

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

The goal of surveillance is to detect early recurrence and identify a second lung malignancy. The majority of lung cancers recur within 2 years with 75-85% presenting as distant metastases. There is little quality data to guide the decision regarding surveillance. The IFCT-0302 trial of patients with early or locally advanced NSCLCa compared clinical exam in combination with CXR versus the addition of CT scans and, when indicated, bronchoscopy. The trial demonstrated a numerical improvement in median overall survival which was not statistically significant.

Further, there is a large discrepancy regarding the recommendations of surveillance following curative intent

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Current picture:

- In 2017, 28,600 Canadians were diagnosed with lung cancer;
- The 5-year survival remains low at 15-20%;
- From 2011 to 2015, 51% of new non-small cell lung cancer (NSCLCa) cases in Canada were diagnosed at stage 1-3 and therefore potentially curable;
- The 2016 Canadian Task Force on Preventative Healthcare recommended annual low dose computed tomography (LDCT) for three consecutive years for people age 55-74 years with ≥ 30 pack-year smoking history who smoke or who quit smoking less than 15 years ago;
- BC is developing a screening program to detect cancers earlier and improve patient outcomes.

Corridor Consult – Oncology Q&A

Q *Can patients on immunotherapies receive vaccines such as influenza and pneumococcal?*

A *Answer from Dr. Alissa Wright, Director, Transplant Infectious Disease Program, Vancouver General Hospital*

Dr. Alissa Wright

Patients with cancer are at increased risk of complications from influenza, including secondary bacterial pneumonia, hospitalization, and death. Most guidelines, including the Canadian National Advisory Committee on Immunization and the Canadian Cancer Society, recommend that patients with cancer receive yearly influenza vaccination. Similarly, patients with cancer are at increased risk of invasive pneumococcal disease caused by *Streptoccocus pneumoniae*. Vaccination with the pneumococcal polysaccharide 23-valent (PPV-23) vaccine is also recommended.

Cancer immunotherapies work by stimulating the immune system to eliminate the tumor. This has caused re-evaluation of vaccination recommendations given the concern that these patients may be at risk of an increased rate and severity of immune-related adverse events with vaccination. The most common of these drugs are immune checkpoint inhibitors, which include the PD-1 inhibitors (e.g. pembrolizumab, nivolumab), the PD-L1 inhibitors (e.g. atezolizumab), and the CTLA-4 inhibitors (e.g. ipilimumab).

At present, there is limited data on the efficacy of the influenza vaccine or the ideal timing of vaccination for patients on cancer immunotherapies. In several small studies, the influenza vaccine has not been associated with an increased risk of immune-related adverse events. For patients on PD-1 inhibitors or PD-L1 inhibitors, vaccination can be done at any point in therapy. Although data are limited, it is generally recommended to not administer influenza vaccine during therapy that includes a CTLA4 inhibitor (primarily ipilimumab). Patients on ipilimumab monotherapy or combination therapy should wait 6-8 weeks from their last dose before vaccination, and patients on maintenance nivolumab following combination therapy should wait 6-8 weeks from their last dose of ipilimumab.

Patients may receive the standard dose inactive trivalent or quadrivalent seasonal influenza vaccine. High dose seasonal influenza vaccine would not be recommended. Similar to other patients with malignancy, these patients should not receive the live intranasal influenza vaccine (FluMist).

Although it is an inactive vaccine, vaccination with PPV-23 would ideally be done two weeks prior to starting immunotherapy given the lack of data about the effects of the vaccine while on treatment. If patients are felt to be at particularly high risk, vaccination could be considered. More data will likely be available in the future on this vaccine. A similar recommendation would also apply to other inactive vaccines at present, while other live vaccines would be contraindicated.

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Follow-up care of lung cancer patients continued from page 10

treatment of NSCLCa. BC Cancer guidelines (2013) recommend history and physical exam every 3 months for 2 years, then every 6 months for 3 years, then annually with no routine imaging, although CXR can be considered. Given the Canadian Task Force recommendations and evolving new treatments for recurrent and metastatic lung cancer, I recommend discussing the addition of CT imaging. It is also important to consider and discuss potential risks with surveillance including radiation exposure, false positive results, and anxiety.

Other guidelines such as Cancer Care Ontario's recommend CT chest every 3 months for 2 years, then every 6 months for 1 year, then every 12 months. The European Society of Medical Oncology recommends CT chest every 12 months (except for patients treated with SBRT alone for whom they recommend CT chest every 6 months for 3 years, then yearly). There is no role for the use of PET scan as part of routine surveillance.

Smoking cessation, exercise, and avoidance of other known lung cancer carcinogens is recommended. In addition, if patients develop symptoms, it is important to evaluate for recurrence.

Contact Dr. Georgia Geller at ggeller@bccancer.bc.ca (She is on leave until July 2020, but checks her email periodically.)

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later discussion. Embedded in the guide is the well-known SPIKES[9] approach to breaking bad news. After setting the scene, exploring the patient's perception of what the medical situation is, getting permission to receive more information and seeking clarity as to how much, the clinician shares prognostic information choosing a statement from one of three buckets: uncertain (i.e., CHF, COPD), time-based (i.e., terminal cancer), function (i.e., frailty). The clinician then asks a series of key topic questions: goals, fears and worries, strengths, critical abilities, trade-offs, and family communication. This is followed by a summary and any recommendations that the clinician may have. Documentation of this conversation is crucial. Timely review is also required.

Imagine if Marianne arrived in the ED and SICG documentation was available for the treating team (Figure 2). Appropriate medical treatment recommendations can be made contextualized by Marianne's stated goals, values, and priorities.

The routine, systematic use of the *Serious Illness Conversation Guide* for appropriate patients (those who are at risk of dying in the next 12 months) can result in improved patient-centred, goal-concordant care, reduce anxiety and depression, and assist our patients to live the way they'd want for their final time.

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The importance of the pelvic exam for oncologic diagnoses in primary care

By Dr. Kathryn McRae, PGY3 Obstetrics and Gynecology, University of British Columbia and Dr. Anna Tinker, Medical Oncologist, BC Cancer - Vancouver

The pelvic exam comes with a variable amount of apprehension from patients and health care professionals alike [1]. It is a sensitive exam with many technical and social subtleties. In this article, we explore the importance of the pelvic exam, and ways to perform the right exam at the right time to best care for our patients.

In a busy clinical practice, the history is focused, and the physical exam tailored to the working differential and clinical expertise. While a common etiology for vaginal bleeding is abnormal uterine bleeding, cervical pathology should be considered. Findings of a cervical mass, in particular, change the working diagnosis and management plan. A recent publication from the CMPA raises an important question: "What Happened to the Physical Exam?"[3]. Following is a clinical vignette where physical exams were omitted leading to poor patient outcome.

A recent clinical case exemplifies the need for a proper and timely pelvic exam. A 46-year-old Asian female, recently immigrated to Canada, presented to her Family Practitioner (FP) with intermenstrual and post coital bleeding. A pelvic exam was not performed, but an abdominal ultrasound was requested and performed weeks later. The patient returned to her FP approximately 8 months later with progressive symptoms associated with low pelvic pain. Again, the pelvic exam was omitted, and a repeat abdominal ultrasound was ordered. A trans-vaginal ultrasound was finally ordered, as advised by radiology, and showed a 5 cm cervical mass. Ultimately, the patient was diagnosed with cervical cancer. This patient may have been spared a 12-month delay in diagnosis had she had the necessary physical exam at the time of her initial presentation.

A pelvic exam in the primary care office is warranted while investigating any gynecologic complaint; more specifically signs and symptoms of cervical cancer. These include abnormal vaginal bleeding, abnormal vaginal discharge, unusually long or heavy periods, dyspareunia, pelvic/back pain with or without changes in bowel or bladder habits, and constitutional symptoms.

If a practitioner is unable to provide a safe pelvic exam, either for cultural or religious reasons or because of a specific request from the patient, there is a duty to refer so the patient receives appropriate medical care. We recommend offering a chaperone to all patients for patient comfort and ease during the exam. The Pap test, by contrast, is a screening test for asymptomatic women with a normal appearing cervix. It is not a diagnostic test for women presenting with abnormal vaginal bleeding and/or an abnormal appearing cervix. Those patients should be referred for colposcopy[2]. If you are unsure about whether to refer, call the colposcopy clinic.

BC colposcopy clinics: www.bccancer.bc.ca/screening/health-professionals/cervix/colposcopy-clinic-locator.

A helpful patient education video on colposcopy: https://www.youtube.com/watch?time_continue=148&v=m8jHiAtK2uQ

Tips for a more comfortable pelvic assessment prior to the exam[1]

- Explain the rationale of the exam, before the patient changes – use images, pelvic models, offer patients an opportunity examine the speculum.
- Communicate clearly during the exam – position the patient with verbal cues, keep torso and legs draped, alert patient to examiners touch before they occur, reassure patient with normal findings.
- Ask patient to void prior to exam.
- Be aware of special populations – patients with: Atrophic vaginitis, vaginal stenosis, vulvodynia/vestibulitis, vaginismus, history of trauma, women with disabilities.

Tips for a more comfortable pelvic assessment during the exam[1]

- Use water-based gel on the outer or inferior bill of the speculum – does not affect cervical cytology.
- Try to select a proper type and size speculum.
- Fully retract pubic hair and labia for visualization and avoid entrapment in the bill.
- Avoid sensitive anterior structures (urethra, clitoris).
- During speculum insertion – gentle downward pressure of the speculum against the rectovaginal septum can ease opening of vaginal vault.
- Speculum should be inserted fully to the hub before opening – open bills slowly.
- Minimize contact between the tip of the speculum and the cervix, which causes pain and/or bleeding. A digital examination prior to speculum insertion can be useful in cases of suspected cervical cancer.
- Close speculum loosely prior to withdrawal.
- If the cervix cannot be visualized – conduct a bimanual exam to determine location.

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see References on page 15

FOR MORE INFORMATION

To learn more about the Family Practice Oncology Network or become involved please contact:
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The content of articles in this Journal represent the views of the named authors and do not necessarily represent the position of BC Cancer, PHSA or any other organization.

ISSN 2369-4165 (Print)
ISSN 2369-4173 (Online)
Key title:
Journal of family practice oncology

Publications Mail Agreement Number 41172510

Return all undeliverable Canadian Addresses to
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Serious Illness Conversation Guide

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2. *Assess understanding and preferences*	"What is your **understanding** now of where you are with your illness?" "How much **information** about what is likely to be ahead with your illness would you like from me?"
3. *Share prognosis* · Share prognosis · Frame as a "wish…worry", "hope...worry" statement · Allow silence, explore emotion	"I want to share with you **my understanding** of where things are with your illness..." *Uncertain:* "It can be difficult to predict what will happen with your illness. I **hope** you will continue to live well for a long time but I'm **worried** that you could get sick quickly, and I think it is important to prepare for that possibility." OR *Time:* "I **wish** we were not in this situation, but I am **worried** that time may be as short as ___ *(express as a range, e.g. days to weeks, weeks to months, months to a year)*." OR *Function:* "I **hope** that this is not the case, but I'm **worried** that this may be as strong as you will feel, and things are likely to get more difficult."
4. *Explore key topics* · Goals · Fears and worries · Sources of strength · Critical abilities · Tradeoffs · Family	"What are your most important **goals** if your health situation worsens?" "What are your biggest **fears and worries** about the future with your health?" "What gives you **strength** as you think about the future with your illness?" "What **abilities** are so critical to your life that you can't imagine living without them?" "If you become sicker, **how much are you willing to go through** for the possibility of gaining more time?" "How much does your **family** know about your priorities and wishes?"
5. *Close the conversation* · Summarize · Make a recommendation · Check in with patient · Affirm commitment	"I've heard you say that ___ is really important to you. Keeping that in mind, and what we know about your illness, I **recommend** that we ___. This will help us make sure that your treatment plans reflect what's important to you." "How does this plan seem to you?" "I will do everything I can to help you through this."
6. *Document your conversation*	
7. *Communicate with key clinicians*	

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