BC CANCER

Provincial Health Services Authority

Journal of Family Practice Oncology

Issue Number 42, Spring 2024 | www.fpon.ca

Education Update

By Dr. Sian Shuel,
Medical Education Lead, FPON

BC Cancer Primary Care Program's Family Practice Oncology Network (FPON) hosts consistent educational opportunities throughout the year. The start of 2024 was no exception, kicking it off with 'Colorectal Cancer Current Screening Recommendations and Follow-Up Care' followed by 'Management of Surgically Induced

continued on page 2

BEST PRACTICE CANCER CARE GEMS

Disclaimer, If you experience difficulties with any hyperlinks, you may need to update your pdf reader.

New program aims to reduce the financial burden of cancer treatment

By Mona Rozdale,
Director, Cancer Support, Integration,
Canadian Cancer Society

It's estimated that 30,400 people living in British Columbia were diagnosed with cancer last year.[1] Many of you have supported your patients through their cancer experience. I know you see firsthand how difficult it is to navigate a cancer diagnosis and, unfortunately, we know the burden goes far beyond the emotional and physical hardship. The logistics, and cost, of navigating cancer care in a province like British Columbia, where many people must travel to receive care, can be overwhelming.

In fact, a recent survey we conducted in partnership with the Angus Reid Group[2] found that a staggering 90 per cent of people in British Columbia feel a sudden cancer diagnosis would impact their household finances. Sixty-six per cent said that the financial burden of cancer-related expenses would have a significant impact on their stress and mental health. For underserved populations, like people living in rural and remote communities, the costs can be even greater.

That's why, with our partners at Hope Air and with the generous support of the Government of British Columbia, we're expanding our **Cancer Travel and Accommodation Services** program to support more people in British Columbia. We hope this program will help reduce some of the financial burden of a cancer diagnosis.

What support can your patients access through the program?

We know each person's cancer experience is unique, and the Cancer Travel and **Accommodation Services** program includes a range of options to support your patients. We aim to provide as much support as possible to as many people as possible. Through the expanded program, we are:

- Increasing access and eligibility for travel grants through our Travel Treatment

continued on page 2

How your patients can access support

- Visit the Cancer Travel and Accommodation Services page on our website
- Call 1-888-939-3333 to speak with a dedicated Client Support Specialist

While links to all our educational offerings can be found on our website FPON.ca, to improve our ability to communicate with community providers and healthcare partners about the latest Family Practice Oncology Network (FPON) news, educational updates, practice gems and other BC Cancer Primary Care communications including information on the electronic publishing of the twice-yearly Journal, please scan the QR code to sign up for our communications database.

Questions? Please contact us at fpon@bccancer.bc.ca

Education Update
continued from page 1

Menopause', 'Radiation 101: What's Available and Side Effect Management' and 'Bone Health in Cancer Care'. These complimentary, accredited webinars are hosted on the third Thursday of each month (except July, August and December) in partnership with UBC Continuing Professional Development. FPON's Webcast Working Group, composed of Family Physicians and General Practitioners in Oncology (GPOs), meets each February to determine the most relevant topics for Primary Care Providers for the educational year based on feedback received the year prior from webinar attendees and on recent practice-changing advances. One can often find webcast content summaries and unanswered questions from webcasts in the Journal of Family Practice Oncology. Visit fpon.ca to view presentations and webcast recordings. Potential topics over the next several months may include 'Skin Cancer Tips and Pitfalls', 'Fertility Issues in Cancer Management', 'Post-Breast Cancer Treatment Follow-up Care', and much more. Visit fpon.ca for an up-to-date webcast schedule, subscribe here, or use the QR code on page 1 to receive future FPON communications.

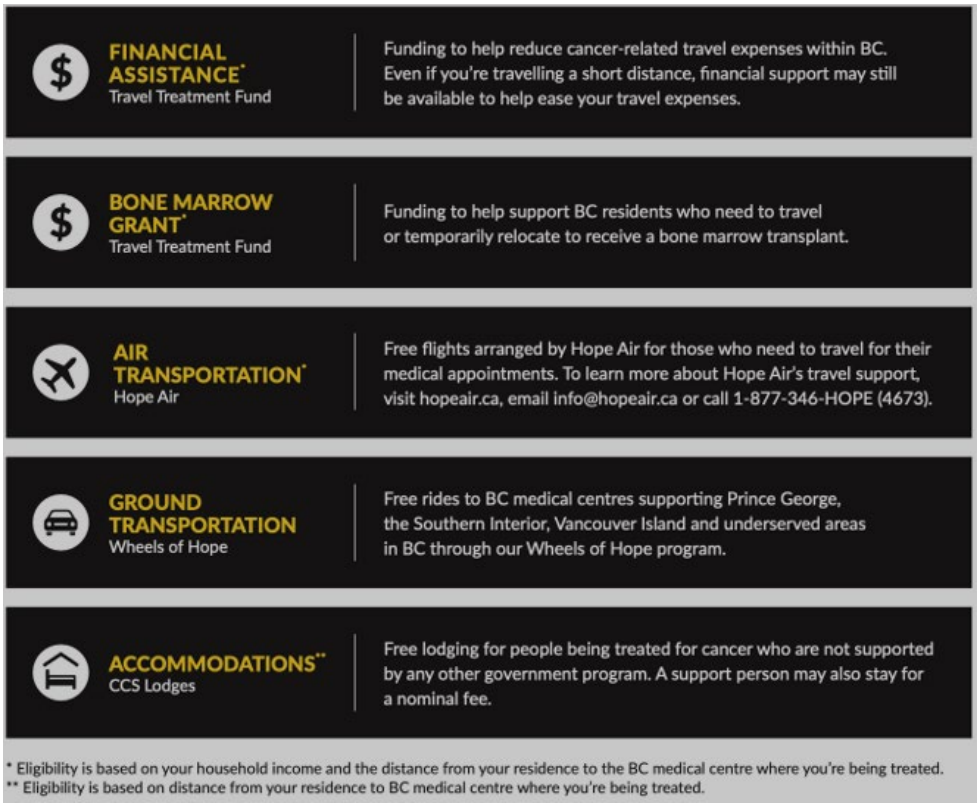
The virtual didactic Spring 2024 Clinical Practitioner in Oncology Education recently ended. This four-week half-day education program hosted newly hired BC Cancer and community GPOs, BC Cancer Nurse Practitioners, UBC Palliative Medicine Residents, and BC Cancer Associate Physicians. The program, once again, was happy to host GPOs and Nurse Practitioners from Nova Scotia and GPOs from Nunavut and Northwest Territories. With over 67 MainPro+ accredited hours to choose from, currently practicing GPOs from around BC joined sessions of their choice as a complimentary knowledge update. For newly hired GPOs in BC, this four-week half-day didactic education program is followed by six weeks of clinical rotations to round out the GPO Education Program.

A key focus area in BC's 10-year Cancer Action Plan is 'Prevent and Detect' with the first two Actions being to improve HPV immunization and expand HPV self-testing province-wide. As a result, this year's virtual FPON Annual Education Day for Primary Care theme was Human Papilloma Virus and Related Cancers. The lineup included HPV Prevention and Vaccination, HPV and Oropharyngeal Cancer, HPV and Cervical Cancer Screening Update, HPV Vulvar Lesions and Cancer, Psychosexual Perspective on an HPV Related Cancer Diagnosis and Anal Cancer Screening.

BC Cancer Primary Care Learning Sessions, complimentary accredited online modules on breast, colorectal, lung and prostate cancer screening, management and follow-up care, remain available. These modules also form the basis for Primary Care Small Group Learning Sessions, an accredited opportunity to build connections with peers by discussing clinical and community-specific questions. Sessional funding is available for a local GPO, Medical Oncologist and Family Physician Champion to host a 1.5-hour certified workshop for primary care providers in your community.

As we continue working to provide oncology education, we seek feedback from our readers and participants on educational topics and needs. Please email FPON's Medical Education Lead at sian.shuel@bccancer.bc.ca with any suggestions.

Figure 1: Overview of support available to your patients through the Cancer Travel and Accommodation Services program



New program to reduce financial burden
continued from page 1

Fund while providing more funding to each eligible applicant and establishing a leukemia/bone marrow transplant grant for patients needing to travel for transplants

- Working with our partners at Hope Air to provide air transportation, ensuring people can get the support they need to get to and from their medical appointments however and whenever they need
- Eliminating patients' out-of-pocket costs to stay at our BC-based Lodges for those who are not supported by any other government program (a nominal fee still remains for caregivers). We operate lodges in Vancouver, Victoria, Prince George and Kelowna
- Expanding our Wheels of Hope volunteer driving service to underserved areas in Vancouver Island and the Kootenay region

Who is eligible for the program?

Anyone who received cancer treatment in British Columbia on or after April 1, 2023,

continued on page 3

Female sexual health & breast cancer survivorship: options for addressing genitourinary syndrome of menopause

By Dr. Melanie Altas, Obstetrics & Gynaecology, University of British Columbia

Breast cancer is one of the most prevalent cancers affecting women worldwide. While advances in treatment have improved survival rates, many experience long-term adverse effects. Chemotherapy related premature menopause, oophorectomy, medically induced ovarian suppression and endocrine therapy lead to significant decreases in circulating estrogen and subsequent vulvovaginal issues.

Dr. Melanie Altas

In 2014, the term Genitourinary Syndrome of Menopause (GSM) was introduced and encompasses the previously used vaginal atrophy and urogenital atrophy. Symptoms include vulvovaginal dryness, irritation, dyspareunia as well as urinary symptoms. These symptoms worsen over time and do not improve spontaneously. GSM impacts more than 50% of postmenopausal women and is more prevalent in breast cancer survivors.[1] In this population GSM is frequently unaddressed, even while having a deleterious impact on overall quality of life.[2]

This article provides an overview for addressing GSM in breast cancer patients.

Recognizing GSM

The first step is recognizing and validating the impact of GSM on quality of life. Having a routine standard question can be helpful such as "It is common for women to experience vulvovaginal discomfort or painful sex in menopause. Is this something you experience?"

Moisturizers and Lubricants

Nonhormonal options, such as lubricants and moisturizers, are first line treatment for GSM. While not reversing atrophy once it occurs, these products help alleviate the symptoms of GSM. Moisturizers, such as polycarbophil-based products (Replens) or those containing hyaluronic acid (Gynatrof, Repagyn or Feels Amazing), have been shown to relieve symptoms in non-cancer patients. Lubricants can alleviate friction and rubbing during vaginal intercourse.

When using water-based products it is important to consider the pH and osmolality.[3] Currently available water-based lubricants and moisturizers are either unknown or have a wide range. In my experience, silicone or oil-based lubricants are preferable to water-based products.

Hormonal options

Local estrogen therapy remains the gold standard for treating GSM. When nonhormonal therapies fail to improve symptoms, topical estrogen may be an option. Local estrogen therapy involves tablets, suppositories, rings and creams. Given the hormone-sensitive nature of many breast cancers, there is understandable apprehension regarding the potential for estrogen exposure to stimulate cancer recurrence or progression.

Definitive placebo controlled RCT data regarding the safety of local estrogen treatment post breast cancer are lacking. Several observational studies have explored the association between topical estrogen use and the risk of breast cancer recurrence or mortality. Overall, the evidence suggests that the use of local estrogen is not associated with an increased risk of disease recurrence or cancer-specific mortality in breast cancer survivors taking tamoxifen or aromatase inhibitors (AI).[4,5,6] One recent observational cohort study reported an increased risk of recurrence, but not mortality, in patients on AI.[7] Patients in this study were on intermediate doses of vaginal estrogen rather than the low dose preferred today. Interestingly, this study did not show an increased risk of recurrence in breast cancer patients on systemic hormone therapy. It's unclear why the increased risk was noted in

continued on page 4

New program to reduce financial burden continued from page 2

or is in treatment now, can apply to the program. Eligibility criteria for travel grants are based on your patient's household income and how far they need to travel to receive care. Some of our programs, like Wheels of Hope and our Lodges, are open to anyone receiving cancer treatment, regardless of income.

How are travel grants paid out?

It takes approximately two weeks for applications to be processed. People who qualify for a travel grant will receive a cheque by mail at the address provided on the application form. There is no need for your patients to keep receipts, as this is a grant, and people can apply for the program as long as they were in treatment on or after April 1, 2023, even if their treatment is now finished.

How can you help?

If you have a patient who has been diagnosed with cancer, please tell them about this program. Our goal is to provide as much support as possible to as many people as possible, and we can only do that with your support. If you want to learn more, please visit the Cancer Travel and Accommodation Services page on our website, email us at BCTravelFund@cancer.ca or call 1-888-939-3333.

References

1. Canadian Cancer Statistics Advisory Committee in collaboration with the Canadian Cancer Society, Statistics Canada and the Public Health Agency of Canada. Canadian Cancer Statistics 2023. Toronto, ON: Canadian Cancer Society;2023. Available at: cancer.ca/Canadian-Cancer-Statistics-2023-EN (accessed February 6, 2024).
2. New Canadian Cancer Society survey reveals the financial cost of cancer is one many in Canada cannot afford. Available at: https://www.newswire.ca/news-releases/new-canadian-cancer-society-survey-reveals-the-financial-cost-of-cancer-is-one-many-in-canada-cannot-afford-888434686.html#:~:text=A%202021%20systematic%20literature%20review,estimated%20at%20%24290%20per%20month (accessed February 6, 2024).

Female sexual health & breast cancer survivorship continued from page 3

the AI subgroup analysis.

Overall, guidelines support the use of local estrogen in breast cancer survivors with severe atrophy refractory to nonhormonal treatment. Patients on AIs should be aware that most research supports the safety, however we do not have long term RCTs. Shared decision making aligned with patient's goal and preferences is important.

Practical tips for safest estrogen use[8]

- Treat only the area of discomfort. Many patients experience external dryness or dyspareunia superficially at the vulvar vestibule. Applying an estrogen cream alone on the vulvar vestibule may significantly improve symptoms.
- Use the lowest dose products vaginally: tablet (10 mcg), ring (7.5 mcg) and newly available suppository (4 mcg, 10 mcg)
- Vaginal creams have the highest systemic absorption.
- Placement in the lower 1/3 of the vagina results in lowest systemic absorption.
- Manage expectations: it may take two months to see improvement of systems.

Other options

- Pelvic floor physiotherapy: should be considered in patients who have developed dysfunction in response to dyspareunia.
- DHEA (Prasterone): limited studies support safety in breast cancer patients. There has been no direct comparison with local estrogen evaluating systemic estradiol levels nor breast cancer recurrence.[6]
- Vaginal laser: A recent well designed RCT demonstrated that laser did not improve symptoms of GSM compared to placebo.[9] Therefore, laser is not recommended as a treatment option.

In conclusion, as GSM can have a significantly deleterious impact on quality-of-life exploring the symptoms should be a routine part of post breast cancer care. Validating patient's symptoms and discussing evidence-based treatment strategies can be a first step. By promoting a patient-centered approach that values quality of life and addresses the unique needs of breast cancer survivors, we can strive to optimize outcomes and enhance overall well-being in this patient population.

References

1) Faubian et al. Management of genitourinary syndrome of menopause in women with or at high risk for breast cancer: consensus recommendations from The North American Menopause Society and The International Society for the Study of Women's Sexual Health. Menopause. 2018; 25(6):1-13.
2) Kingsberg S, Larkin L. Shining the light on genitourinary syndrome of menopause in survivors of breast cancer. Menopause 2017; 24:1336-1337.
3) Edwards D, Panay N. Treating vulvovaginal atrophy/genitourinary syndrome of menopause: how important is vaginal lubricant and moisturizer composition? Climacteric. 2016; 19(2): 151-161.
4) Le Ray I, Dell'Aniello S, et al. Local estrogen therapy and risk of breast cancer recurrence among hormone-treated patients: a nested case-control study. Breast Cancer Res Treat. 2012;135(2):603-9.
5) McVicker L, Labeit AM, et al. Vaginal Estrogen Therapy Use and Survival in Females With Breast Cancer. JAMA Oncol. 2024;10(1):103-108.
6) Merlino L, D'Ovidio G et al. Therapeutic Choices for Genitourinary Syndrome of Menopause (GSM) in Breast Cancer Survivors: A Systematic Review and Update. Pharmaceuticals. 2023;16(4):550
7) Cold S, Cold F, et al. Systemic or Vaginal Hormone Therapy After Early Breast Cancer: A Danish Observational Cohort Study. J Natl Cancer Inst. 2022;114(10):1347-1354
8) Santen RJ, Mirkin S et al. Systemic estradiol levels with low-dose vaginal estrogens. Menopause. 2020; (3):361-370.
9) Li FG, Maheux-Lacroix S, et al. Effect of Fractional Carbon Dioxide Laser vs Sham Treatment on Symptom Severity in Women With Postmenopausal Vaginal Symptoms: A Randomized Clinical Trial. JAMA. 2021;326(14):1381-1389.

BC CANCER CERVIX SCREENING
Provincial Health Services Authority

Should my patient **self-screen** or get a **provider-collected liquid-based cytology (LBC)** sample?

The transition to HPV screening in BC allows more choice for patients and providers regarding how samples for cervix screening can be collected.

Self-screening involves using a swab to collect a sample from the vaginal secretions. Swabs collected through self-screening can only be used for HPV testing. A sample of cells from the cervix is not required for self-screening swabs. If a self-screening test is positive for HPV, cytology may be recommended, and the patient will need to see a provider for a liquid-based cytology (LBC) sample. LBC collection can only be performed by a provider because the sample needs to be collected from the cervix, and so the patient needs to undergo a pelvic examination. It involves collection of a cervical sample and can be used for cytology and/or HPV testing.

There are **several factors that can influence whether a patient can or should self-screen or have a provider-collected LBC sample**. Some factors that may come into consideration as you and your patient decide on the collection method for screening include:

- Clinical history: Some patients require both cytology and HPV testing (cotest) for their screening and this is most efficiently accomplished with a single LBC collection. Or, patients using a pessary should have a provider-collected LBC sample, in case HPV-infected secretions do not sufficiently present in the vagina.
- Speculum exam: For a variety of reasons, some patients find speculum exams difficult to undergo, and this may have historically prevented them from keeping up to date with screening or cause stress and anxiety. These patients can be recommended for self-screening.
- Time for appointments: For some patients, attending an in-person appointment can be difficult due to reasons such as having to take time off work, travel distance, arranging childcare, etc. Self-screening is an option that enables patients to screen without an in-person clinic appointment. However, when a patient is ***already*** in the clinic, an LBC collection may be preferred by the patient, as they will not have to return a second time if their self-screening result recommends cytology collection.
- Physical aspects such as a disability, limited motility or body habitus may also direct whether a vaginal swab or cervical sample may be best for the patient.

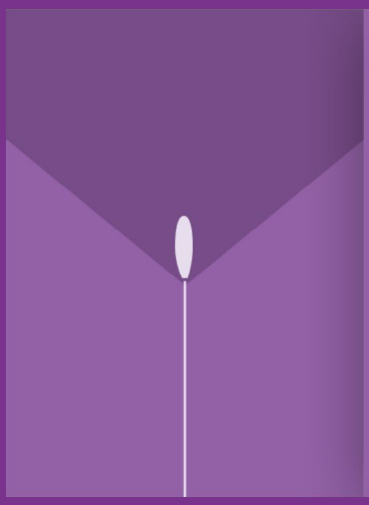
Patients will have varying and different values for these considerations, which will contribute to their collection preference. In addition, clinicians will review patient history and circumstances, to use their clinical judgment to ensure the most appropriate sample collection choice for the patient. There may be circumstances where the provider may feel self-screening is the most appropriate choice for their patient, and the clinician should use clinical judgment to determine the best screening method for the patient.

Patients who call BC Cancer to request a self-screening kit will be sent a kit if they are due to. BC Cancer Client Service Centre Screening staff are not able to assess clinical eligibility for self-screening. The laboratory has established processes to identify patients with relevant clinical histories to have provider-collected samples triaged to primary HPV screening (e.g. previous ASCUS or LSIL result) or for cotesting (e.g., previous AIS diagnosis). Patients who complete self-screening and who should have cotesting based on their clinical history, will receive a recommendation for cytology follow-up and will be directed to see a provider for a Pap test.

Refer to the flow diagram on the next page to help decide on the most appropriate sample collection method.

Version: February 13, 2024

Cervix

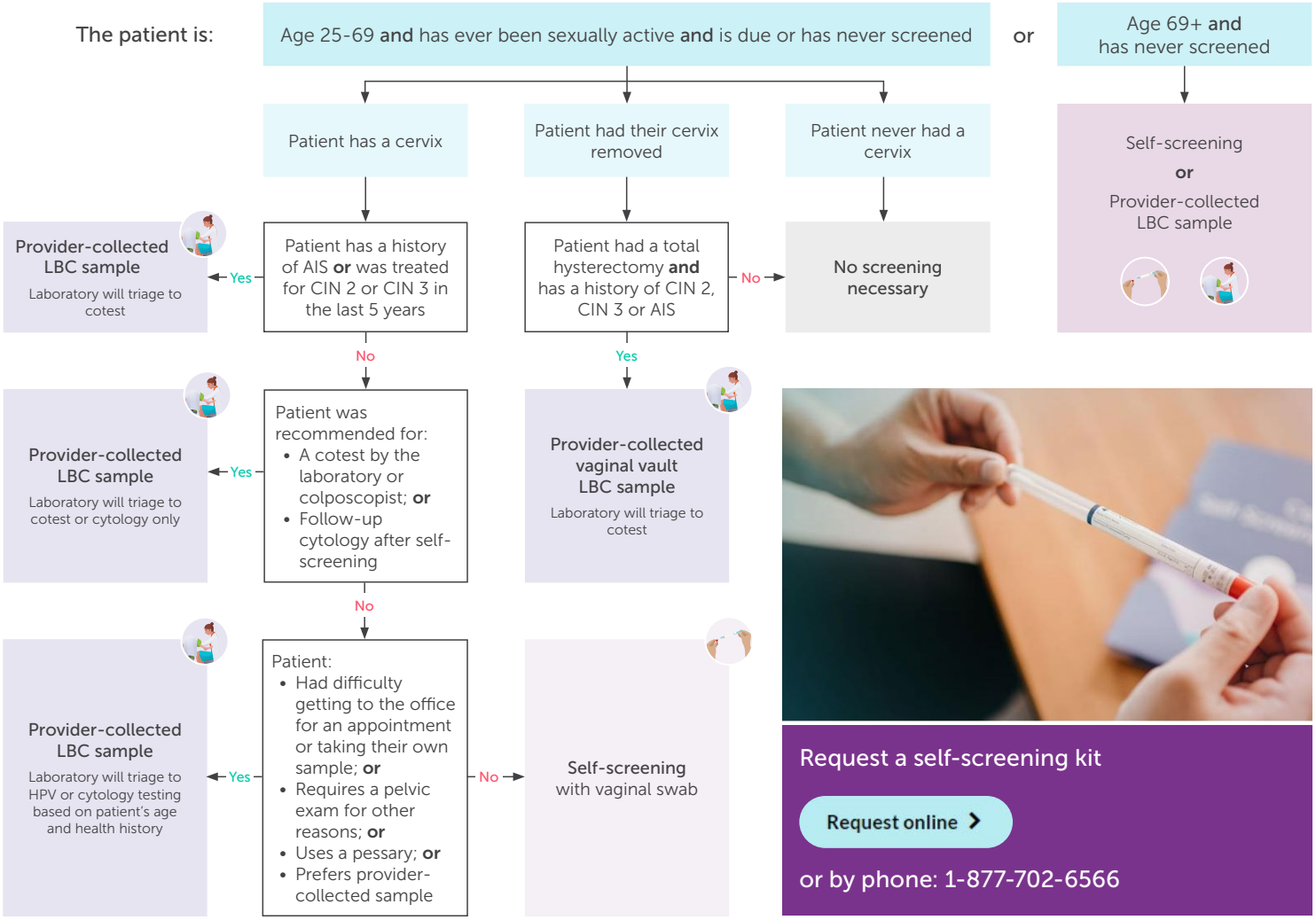


Goodbye, Pap. Hello, swab.

There's a new way to screen for cervical cancer that can be done wherever you feel safe and comfortable, such as in your home or at a health care provider's office. Cervix self-screening is an alternative to the Pap for routine cervical cancer screening.

www.bccancer.bc.ca/screening/cervix

Should my patient **self-screen** or get a **provider-collected liquid-based cytology (LBC)** sample?

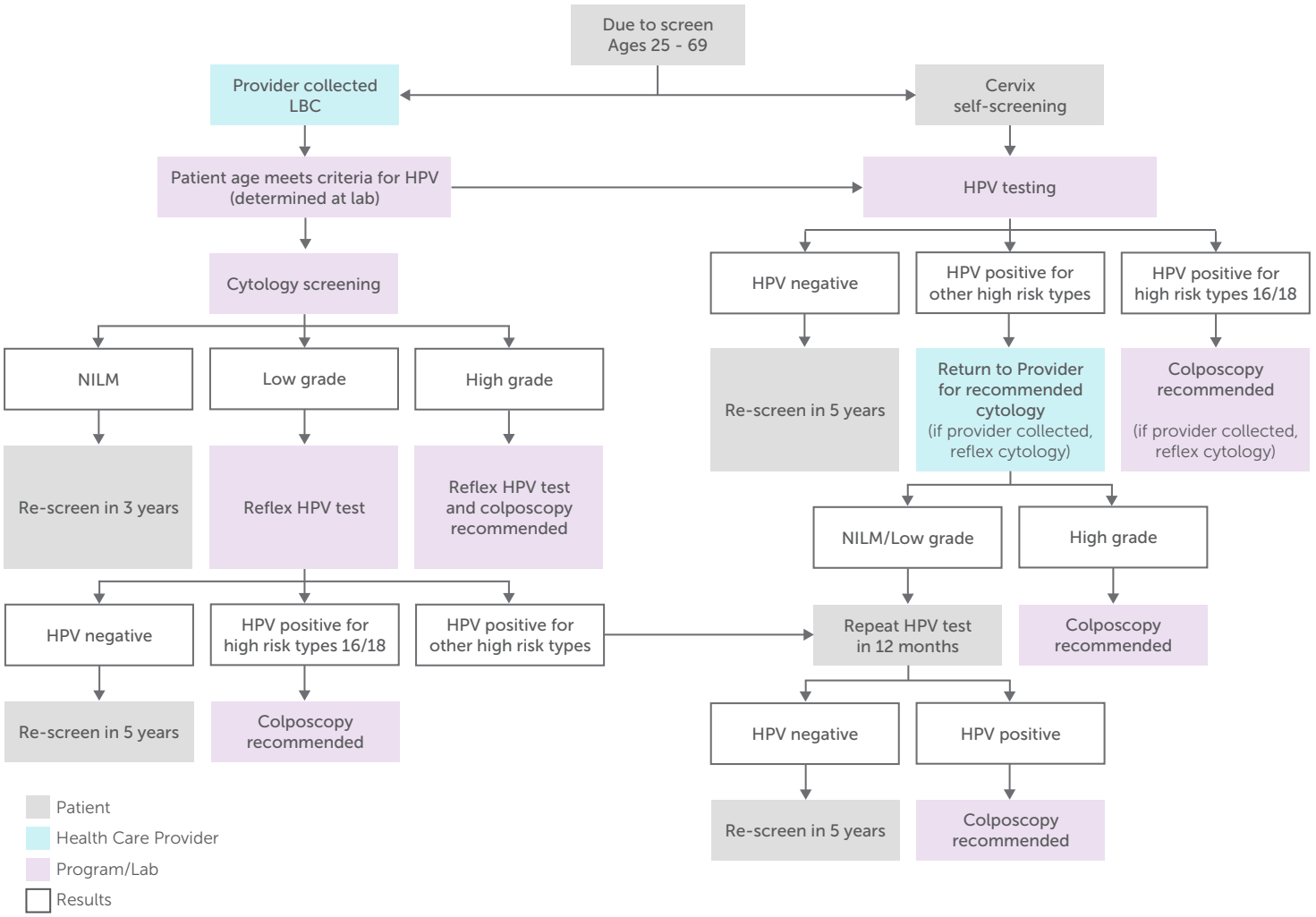


Request a self-screening kit

Request online ›

or by phone: 1-877-702-6566

Cervix Screening Algorithm



Hear about why it's important to participate in cervix screening:

If you don't want to do cervix self-screening, you can still choose to have a Pap test. Talk to a health care provider to discuss cervix screening options and when to screen.

Cervix screening is recommended for anyone with a cervix, including women and TTGD (Two-Spirit, transgender and gender diverse) people, between the ages of 25 and 69.

https://www.youtube.com/watch?v=hrH5ynMVm8w&t=11s

Watch this video to learn more about cervix self-screening:

Video available in Mandarin, Cantonese, Punjabi, and French.

https://www.youtube.com/watch?v=okGf7D3teXM&t=2s

Overview of post-treatment care for patients with prostate cancer

By Dr. Marie-Pier St-Laurent, Department of Urologic Sciences, University of British-Columbia

Prostate Cancer (PCa) exhibits a lower mortality rate with early detection through screening. Major urologic and oncologic associations recommend engaging in shared decision-making about PCa screening for men aged 50 to 69 years (Mason et al., 2022; Mottet et al., 2023; Wei et al., 2023). The decision to proceed with PCa screening is influenced by patient's values, preferences, life expectancy, competing comorbidities, and the recognition of the need to balance the benefits of reducing metastatic PCa rates and preventing PCa death against potential harms associated with screening and treatment. Mitigating overdiagnosis harms involves judicious treatment, with active surveillance being the recommended approach for patients with very low and low PCa (Gleason 6 or Group Grade 1). Additionally, a meticulous approach to post-treatment care is crucial for improving patient recovery and minimizing the impact of treatment. This paper aims to provide primary care physicians with an overview of follow-up care for patients who have undergone radical prostatectomy (RP) or radiation therapy (RT), offering valuable insights to enhance their capabilities.

Dr. Marie-Pier St-Laurent

Oncology-Specific Monitoring

PSA serves as the cornerstone of follow-up. While not disease-specific in the pre-treatment setting, it is prostate-specific and constitutes a reliable and ultra-sensitive test for monitoring PCa recurrence post treatment. Anticipated undetectable measures occur within approximately 3 months following RP, and is undetectable or stable 'low' levels following RT.
With newer available ultrasensitive PSA assays, understanding the definition of biochemical recurrence (BCR) is crucial to avoid contributing to patient anxiety with erroneous information on cancer status. BCR post-RP is defined as two consecutive increases in PSA to a level of ≥0.2µg/L, and post-RT either External Beam RT (EBRT) or brachytherapy, as nadir plus 2 µg/L. Post-RT nadir corresponds to the lowest post-therapy PSA value, which often takes 3 years to reach. A nadir < 0.5 ng/mL is associated with a favorable outcome, but no optimal cutoff achieves consensus (Ray et al., 2006). Anything below those values is of **low significance** and should be communicated to the patient as **"of no concern"**. PSA should be measured at least every 6 months for the first three years, then yearly in men without recurrence. Schedules should be adjusted with clinical judgment by the urologist or radiation oncologist based on the patient's risk factors and previous values.

Surgical margin status following RP often raises concerns among patients. While it represents a risk factor for BCR, not every patient with a positive margin will experience a recurrence or have an impact on longevity. Additionally, some disease at the margin site may exhibit a more benign pattern (Gleason 6) and may not necessarily require treatment. Recent randomized control trials comparing early salvage pelvic RT at the time of BCR to adjuvant RT have shown comparable recurrence-free survival with early salvage RT (target PSA of 0.2), along with reduced toxicity and overtreatment in patients in the salvage arm. Therefore, early salvage RT is recommended as the preferred treatment for most patients (Kneebone et al., 2020; Parker et al., 2020; Sargos et al., 2020).

Management of Functional Outcomes

Erectile Function

The recovery of erectile function post-treatment is a significant aspect that demands attention. Among men with preserved erectile function pre-surgery, approximately 50% will experience recovery by 18 months (Rabbani et al., 2000). Overall, 2-year post-treatment erectile dysfunction (ED) following RT is of similar prevalence to RP, but it often takes 2 years to manifest, in contrast to surgery where the onset is more abrupt, with the potential for recovery. The most crucial risk factor for post-RP ED is pre-operative erectile function. Additional risk factors, such as patient age (>60 yrs), vascular disease, diabetes, dyslipidemia, smoking, high disease stage, and obesity, play pivotal roles. Assessing a patient's preoperative erectile function is, therefore, important. Primary care physicians can help address post-operative ED by managing comorbidities and initiating PDE5 inhibitors and/or vacuum pumps (alone or in combination with PDE5i), which can be introduced early following surgery. The sexual impact of treatment may result from more than just blood supplies or nerve damage, and the role of counseling and sexual therapists is of great importance in improving patient health and couple satisfaction. Involving the partner whenever possible in discussions of sexual rehabilitation after treatment is crucial. Referring patients to available resources such as the Prostate Cancer Supportive Care (PCSC) program www.pcscprogram.ca is recommended before and after PCa treatment (email pcsc@vch.ca with the patient's name and phone number). Educational information is also provided through this resource, along with a review of other possible side effects of treatment such as climaturia, anejaculation, anorgasmia, dysorgasmia, penile shortening, or penile curvature.

Urinary Incontinence

Urinary incontinence is common in the first 3 months post-surgery, with approximately 30% of men experiencing some level of urinary leakage at one year postoperatively. Bothersome leakage, however, affects about 10%, and serious leakage requiring surgery is observed in 1-2% of cases. First-line management options, including penile clamps, Kegel exercises, and pelvic floor physiotherapy, should be discussed. Recognizing risk factors for incontinence, such as overactive bladder (OAB), increased age, prior radiotherapy, prior transurethral resection of the prostate, pre-operative incontinence, surgical expertise, and urethral length, is essential for tailored interventions. Pelvic floor physiotherapists, PCSC, and

continued on page 9

Prostate cancer post-treatment care continued from page 8

urologists are valuable resources to help manage these symptoms.

External Beam Radiation Therapy (EBRT) Side Effects

Early side effects from RT, including fatigue of varying degrees, irritation of the bowel (diarrhea), and bladder issues (frequency), are usually temporary, recovering within weeks after end of treatment, but may require dietary adjustments or the use of anti-diarrheal or anticholinergic medications. Late side effects, such as ED, may occur ≥2 years after RT and can be more permanent. Bladder complications (frequency, urgency, hematuria) and rectal bleeding may be observed, albeit in a small percentage. Any bleeding should be identified by primary care physicians, and adequate referral should be initiated to exclude the presence of a second malignancy. Primary care physicians can also assist in evaluating the concomitant medications of the patient and safely withhold anticoagulant or antiplatelet agents, using clinical judgment, in case of bleeding.

Brachytherapy (BT) Side Effects

Brachytherapy has a side effect profile that includes an increased incidence of urinary symptoms. Urinary retention can occur, and 5-10% of men may require a urinary catheter for a few days to weeks following BT implants. OAB symptoms (frequency and urgency), or pain during urination are common after BT and can persist up to 2-6 months post-treatment. These symptoms can be addressed similarly to OAB by avoiding irritants and considering anticholinergic or beta-3 agonist medications (if there is a negative post-void residue and no contraindication). Rectal bleeding may occur in 5% of cases and can rarely necessitate surgical treatment. Similar to EBRT, a gradual decline in erectile function will occur in about half of the patients, and it can be managed as described previously.

Conclusion

This brief overview aims to equip primary care physicians with the knowledge and strategies essential for navigating the complexities of post-treatment care for patients with PCa. Adequate oncologic monitoring and understanding of recurrence definitions are a primordial first step in helping patients in the aftermath of PCa treatment. Primary care plays a crucial role in identifying side effects and mental health issues, enabling the initiation of certain treatments, and facilitating referrals to available resources such as the PCSC program, physiotherapists, urologic-oncologists, radiation-oncologists, or other specialists.

References

Kneebone, A., Fraser-Browne, C., Duchesne, G. M., et al. Adjuvant radiotherapy versus early salvage radiotherapy following radical prostatectomy (TROG 08.03/ANZUP RAVES): a randomised, controlled, phase 3, non-inferiority trial. Lancet Oncol2020 Oct;21(10):1331-1340.

Mason, R. J., Marzouk, K., Finelli, A., et al. UPDATE - 2022 Canadian Urological Association recommendations on prostate cancer screening and early diagnosis Endorsement of the 2021 Cancer Care Ontario guidelines on prostate multiparametric magnetic resonance imaging. Can Urol Assoc J2022 Apr;16(4):E184-E196.

Mottet, N., Cornford, P., van den Bergh, R. C. N., et al. EAU-EANM-ESTRO-ESUR-ISUP-SIOG Guidelines on Prostate Cancer. Edn. presented at the EAU Annual Congress Milan2023.

Parker, C. C., Clarke, N. W., Cook, A. D., et al. Timing of radiotherapy after radical prostatectomy (RADICALS-RT): a randomised, controlled phase 3 trial. Lancet2020 Oct 31;396(10260):1413-1421.

Rabbani, F., Stapleton, A. M., Kattan, M. W., Wheeler, T. M., & Scardino, P. T. Factors predicting recovery of erections after radical prostatectomy. J Urol2000 Dec;164(6):1929-1934.

Ray, M. E., Thames, H. D., Levy, L. B., et al. PSA nadir predicts biochemical and distant failures after external beam radiotherapy for prostate cancer: a multi-institutional analysis. Int J Radiat Oncol Biol Phys2006 Mar 15;64(4):1140-1150.

Sargos, P., Chabaud, S., Latorzeff, I., et al. Adjuvant radiotherapy versus early salvage radiotherapy plus short-term androgen deprivation therapy in men with localised prostate cancer after radical prostatectomy (GETUG-AFU 17): a randomised, phase 3 trial. Lancet Oncol2020 Oct;21(10):1341-1352.

Wei, J. T., Barocas, D., Carlsson, S., et al. Early Detection of Prostate Cancer: AUA/SUO Guideline Part I: Prostate Cancer Screening. J Urol2023 Jul;210(1):46-53.

Incidentaloma: The management of ovarian lesions found on pelvic ultrasound

By Dr. Kenneth Wong, Clinical Associate Professor, UBC, Faculty of Medicine, Department of Radiology

Ovarian lesions are a very common finding on pelvic ultrasound. The vast majority of these lesions are physiological or benign neoplasms, however a minority of these lesions can be malignant ovarian neoplasms requiring referral to a gynecologic oncologist. Every year 3100 women in Canada will be diagnosed with an ovarian cancer and about two thirds will die from this diagnosis.[1]

Dr. Kenneth Wong

Multiple guidelines have been developed to help characterize and assess risk for malignancy based on pelvic US findings.[2,3,4] At this time no single guideline is being used but they are all somewhat similar in identifying the ultrasound characteristics to help differentiate benign from malignant ovarian lesions.

In 2019, the American College of Radiologists published a risk stratification and management system for ovarian lesions found on US.[2] This is the most current and comprehensive guideline to date. This was developed by an international multi-disciplinary committee aimed at eliminating

continued on page 10

O-RADS Score	Risk Category [IOTA Model]	Lexicon Descriptors		Management	
				Pre-menopausal	Post-menopausal
0	Incomplete Evaluation [N/A]	N/A		Repeat study or alternate study	
1	Normal Ovary [N/A]	Follicle defined as a simple cyst ≤ 3 cm		None	N/A
		Corpus Luteum ≤ 3cm			
2	Almost Certainly Benign [< 1%]	Simple cyst	≤ 3 cm	N/A	None
			> 3 cm to 5 cm	None	Follow up in 1 year. *
			> 5 cm but < 10 cm	Follow up in 8 - 12 weeks	
		Classic Benign Lesions	See **Figure 3** for separate descriptors	See **Figure 3** for management strategies	
		Non-simple unilocular cyst, smooth inner margin	≤ 3 cm	None	Follow up in 1 year * If concerning, US specialist or MRI
			> 3 cm but < 10 cm	Follow-up in 8 - 12 weeks If concerning, US specialist	US specialist or MRI
3	Low Risk Malignancy [1-<10%]	Unilocular cyst ≥ 10 cm (simple or non-simple)		US specialist or MRI Management by gynecologist	
		Typical dermoid cysts, endometriomas, hemorrhagic cysts ≥ 10 cm			
		Unilocular cyst, any size with irregular inner wall <3 mm height			
		Multilocular cyst < 10 cm, smooth inner wall, CS = 1-3			
		Solid smooth, any size, CS = 1			
4	Intermediate Risk [10- < 50%]	Multilocular cyst, no solid component	≥ 10 cm, smooth inner wall, CS = 1-3	US specialist or MRI Management by gynecologist with GYN-oncologist consultation or solely by GYN-oncologist	
			Any size, smooth inner wall, CS = 4		
			Any size, irregular inner wall and/or irregular septation, any color score		
		Unilocular cyst with solid component	Any size, 0-3 papillary projections, CS = any		
		Multilocular cyst with solid component	Any size, CS = 1-2		
		Solid	Smooth, any size, CS = 2-3		
5	High Risk [≥ 50%]	Unilocular cyst, any size, ≥ 4 papillary projections, CS = any		GYN-oncologist	
		Multilocular cyst with solid component, any size, CS = 3-4			
		Solid smooth, any size, CS = 4			
		Solid irregular, any size, CS = any			
		Ascites and/or peritoneal nodules**			

Fig 1. Ovarian-Adnexal Reporting and Data System (O-RADS) US risk stratification and management system.

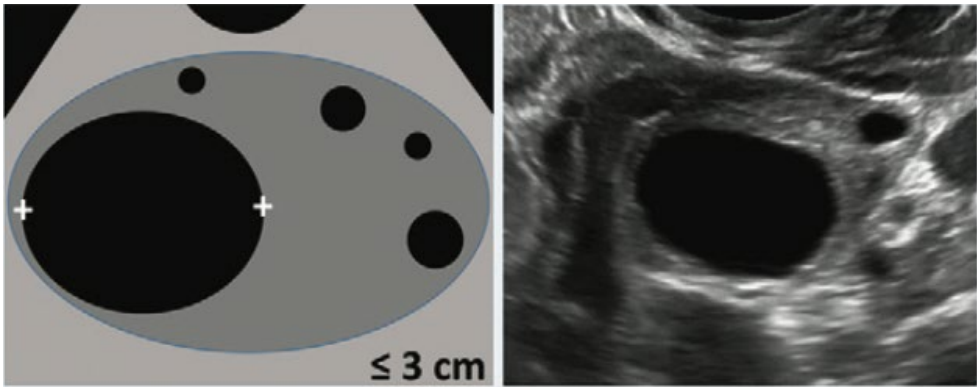


Fig 2. Anechoic thin walled unilocular lesion indicating a simple cyst in keeping with an O-RADS US 1 lesion. No follow up suggested.

Incidentaloma
continued from page 9

ambiguity in US reporting, increasing accuracy in assigning risk of malignancy and provide management recommendations. The Ovarian-Adnexal Reporting and Data System for Ultrasound (O-RADS US) has five categories and each category has a specific risk of malignancy, lexicon descriptors and management recommendations (Fig 1).

O-RADS US Category 1: These lesions have no malignant potential. We use the word lesion instead of mass as a more neutral

continued on page 11

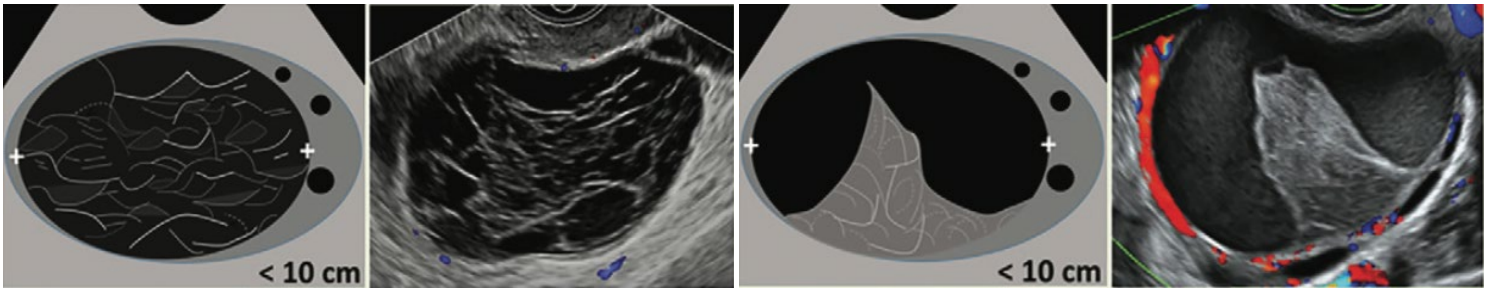


Fig 3. Hemorrhagic cyst with a reticular or retracting clot pattern in keeping with an O-RADS US 2 lesions. Given the smaller size no follow up suggested if premenopausal but follow up suggested if postmenopausal.

Incidentaloma continued from page 10

term. This includes the vast majority of lesions seen on US and are considered ***"physiological"***. These are often follicles or corpus luteum, often appearing as simple or thick-walled cysts measuring less than 3cm (Fig 2). Commonly these lesions would not even be describe in the imaging report with the ovaries described as normal in appearance.

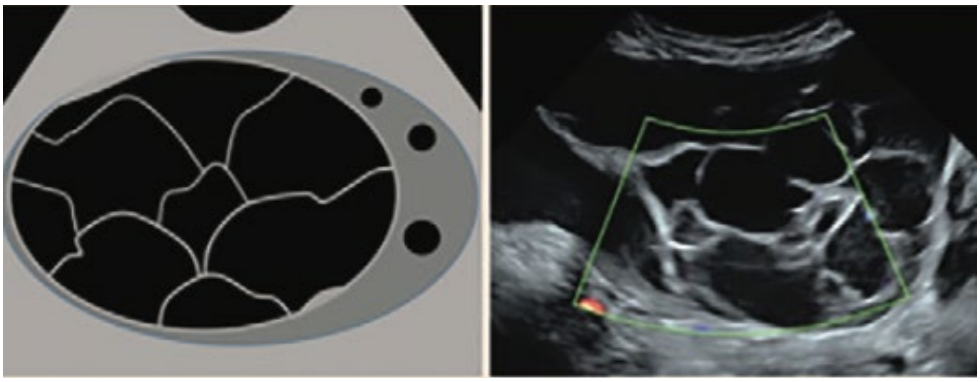


Fig 4. Multilocular pattern lesion less than 10cm, no solid components and color score 0 is in keeping with an O-RADS US 3 lesion. MRI suggested for further evaluation and gynecology consultation.

O-RADS US Category 2: This category contains simple/unilocular cysts between 3 to 10 cm in size and the classical benign lesions consisting of hemorrhagic cysts, typical endometriomas or dermoid cyst measuring less than 10 cm. These are considered ***"almost certainly benign"*** with less than a 1% chance of malignancy. Hemorrhagic cysts are common and described as having a reticular or retracting clot pattern (Fig 3). Typical endometriomas have a ground glass/low level echo pattern. Dermoid cysts a have hyperechoic component with posterior acoustic shadowing or hyperechoic lines and dots. Depending on the appearance and size these are usually followed with US in either 12 weeks time or in 1 year time. Any enlargement warrants referral to gynecologist and/or MRI.

O-RADS US Category 3: This category has a ***"low risk malignancy"*** of 1-10%. In this category the descriptors multilocular, solid and colour score are included on ultrasound reports. Unilocular refers to a cyst with no septations. Multilocular refers to a cyst with septations breaking the cyst until multiple compartments (Fig 4). Solid components refer to non anechoic components usually with blood flow. Solid lesions refer to lesions that are more than 80% solid. A colour score from 1 to 4 was developed that would indicate the amount of blood flow in a lesion. ***The higher the colour score the more likely the lesion would be malignant*** (Fig 5). Larger unilocular cysts or classical benign lesions greater than 10cm are in this category. Multilocular cysts less than 10cm or solid lesions of any size with a low colour score are included in this category Figure 8. In most cases, an MRI would be suggested for further characterization of this lesion with referral to a gynecologist.

O-RADS US Category 4: This category has an ***"intermediate risk malignancy"*** of 10-50%. In this category the term papillary projections is introduced. A papillary projection is a solid component measuring

continued on page 13

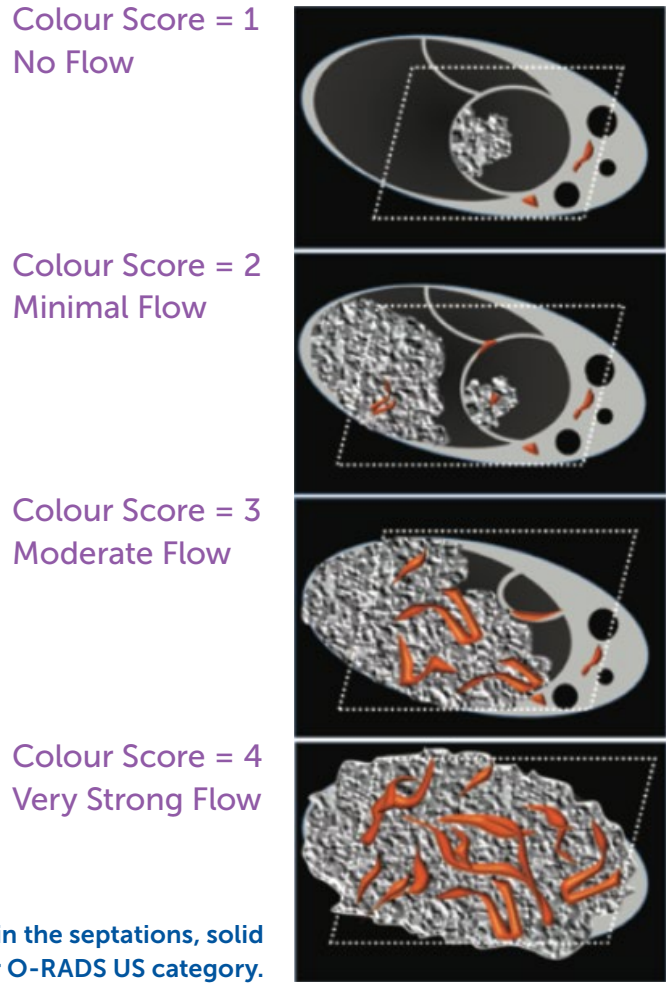


Fig 5. Color Scale. Can be subjective but any amount of flow in the septations, solid components or walls usually places the lesion in a higher O-RADS US category.

Enhancing support and empowerment: library resources for adolescent and young adult cancer survivors

By Elena Popova, Reference Librarian at BC Cancer Library
elena.popova@bccancer.bc.ca

Adolescent and young adult (AYA) cancer survivors face unique challenges long after completing their cancer treatment. They often have diverse needs that require tailored support systems. This article highlights how the BC Cancer Library can contribute to the well-being and empowerment of AYA cancer survivors through our services and resources.

Elena Popova

Successful therapy cures many childhood and AYA cancers, but survivors often face future health issues known as Late Effects (LEs). These can emerge months or years later, with risks increasing over time. Additionally, many survivors experience psychological challenges, such as post-traumatic stress, chronic anxiety, and depression. Addressing these challenges should be a combined effort of healthcare providers and various support programs including library services.

While health care providers focus on the management of ongoing health problems, long-term screening and lifestyle recommendations, libraries can empower survivors by connecting them to available services, facilitating access to resources, and promoting a sense of normalcy.

The BC Cancer Library can play a crucial role in assisting adult survivors of childhood cancers by offering a range of specialized services and resources tailored to their unique needs. The library doesn't limit its services to BC Cancer patients only; we serve everyone in British Columbia and Yukon.

Here are several ways in which the library can provide support and assistance:

Comprehensive information resources:

- Books: Available for borrowing from any of the 6 branches of the library. We accept book requests in person or through our online catalogue, and books can be mailed to patients' home address free of charge.
- eBooks: Accessible on any electronic device in the comfort of your home. Contact the library for user account and access information.
- Library Pathfinders: Curated collections of print and digital resources specifically addressing selected topics. Pathfinders include links to websites, programs, support groups and local practical resources available in BC.

Personalized research assistance:

- **Librarian support**: Librarians are skilled in conducting research and can assist individuals in finding information tailored to their specific needs and preferences. We can help navigate complex medical literature, clarify terminology, and locate evidence-based resources to support decision-making.
- **Information requests**: Patients can submit information requests on the library webpage, email or call the library with any health-related questions. A librarian will find print and online resources that answer those questions. Privacy and confidentiality of all requests is always guaranteed.
- **Access to research publications**: When patients wish to read scientific articles on specific health topics, a librarian will search reputable databases and academic journals that cover the latest research on survivorship issues, treatment options, and healthcare advancements.

continued on page 13

Library resources
continued from page 12

This article features the **"Young adults and teenagers with cancer"** pathfinder and some of the key resources (click on the pathfinder link to see more):

Websites, reviewed and approved by the BC Cancer librarians:

- Adolescent & Young Adult Cancer Care & Support (BC Cancer) – links to resources available in BC.
- Stupidcancer.org - an award-winning website that focuses on building community, improving quality of life, and providing meaningful survivorship.
- Young Adult Cancer Canada – offers connection to peers, bridge out of isolation, and source of inspiration.
- Rethink Breast Cancer - helps young people who are affected by breast cancer. Provides information on support, research, and awareness. Members will also get access to a Facebook group of young women from across Canada who have a personal experience with breast cancer.

Support programs offered by community organizations and BC Cancer:

- Young Adults Group (BC Cancer) - a creative support group for younger adults with cancer, who are about 20 to 40 years old.
- CancerConnection.ca - an online community for cancer patients, caregivers, friends, and family. A safe place to connect and find support.
- Young Adult Cancer Canada Web Chats - offer live chats for young adults aged 18-39 years old affected by cancer.

BC Cancer Medical Library is not just a passive book repository but a dynamic hub where knowledge meets patient care, innovation, and support. Through our services, meticulously curated collections and expert guidance, the library ensures that patients, families, and survivors are empowered with access to the most current, reliable, evidence-based- information.

You can contact the library by email: library@bccancer.bc.ca or by phone: 604-675-8001 or toll-free in BC and Yukon 1-888-675-8001 x 8001.

Incidentaloma
continued from page 11

more than 3mm projecting into a cystic cavity. ***The more papillary projections the more likely the lesion is malignant*** (Fig 6). This category contains unilocular or multilocular lesions with solid components/ papillary projections or a solid lesion with high colour score. MRI with gynecological/ gynecological oncology referral would be recommended.

O-RADS US Category 5: This final category has a ***"high risk"*** of malignancy of over 50%. This category contains cysts or solid lesions multiple solid components or high colour score. These lesions are so worrisome that further characterization with MRI would unlikely sway the gynecologic oncologist from surgery.

The adoption of O-RADS US has not been fully accepted by all radiologists in BC given its relatively recent introduction in 2019. Most are still using the guidelines put out in 2009 by the Society of Radiologists in Ultrasound but these guidelines do not stratify risk.[3] Education at conferences such as the one put on by the BC Radiological Society in 2022 with highlighted available online education and O-RADS US calculators[5] on the internet or mobile apps has increased its use over time. Regardless which guideline is used, radiologists use the combination of size, presence of septations, presence of solid components and colour flow to guide management of these lesions even if not specifically using the O-RADS US categorization. In time the use of O-RADS US will become more prevalent. The shift in reporting protocols will be similar to that with risk stratification and management systems in other areas such as Bi-RADS for breast lesions and Ti-RADS for thyroid nodules which have a stronger uptake at this time.[6,7]

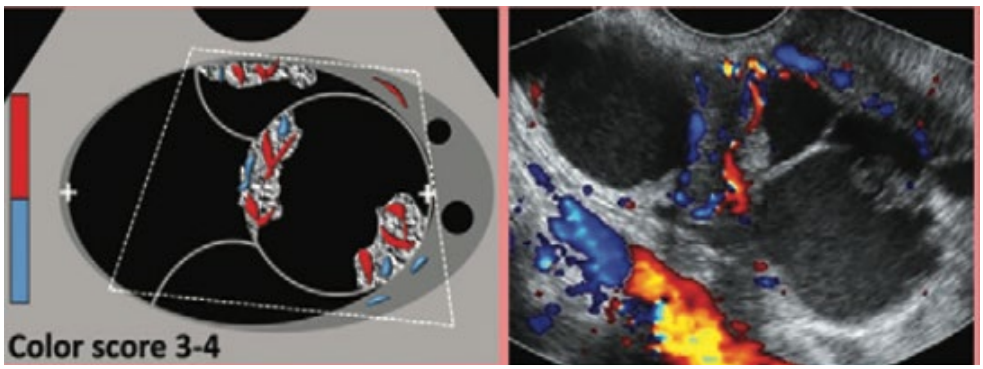


Fig 6. Mulitlocular lesion demonstrating papillary/solid components with high color score in keeping with an O-RADS US 5 lesion. Referal to gynecology oncologist recommended. MRI does not change management of these lesions.

References

1. https://cancer.ca/en/cancer-information/cancer-types/ovarian/statistics#
2. Radiology 2020; 294:168–185
3. Radiology: Volume 256: Number 3—September 2010
4. Timmerman D, Ameye L, Fischerova D et-al. Simple ultrasound rules to distinguish between benign and malignant adnexal masses before surgery: prospective validation by IOTA group. BMJ. 2010;341 (dec14 1): c6839. doi:10.1136/bmj.c6839
5. https://radiogyan.com/o-rads-ultrasound-calculator/
6. https://www.acr.org/Clinical-Resources/Reporting-and-Data-Systems/Bi-Rads
7. https://www.acr.org/Clinical-Resources/Reporting-and-Data-Systems/TI-RADS

Clinical Care Pathways help improve the cancer journey for all patients

By Dr. Christine Simmons, Medical Oncologist & Provincial Tumour Groups Chair
Amilya Ladak, Tumour Groups Policy Analyst, Provincial Programs
Sonia Panesar, Tumour Groups, Medical Imaging & Pathology Project Coordinator, Provincial Programs
Shaifa Nanji, Tumour Groups, Medical Imaging & Pathology Manager, Provincial Programs

Dr. Christine Simmons, Amilya Ladak, Sonia Panesar and Shaifa Nanj

BC Cancer Tumour Groups & Provincial Programs work towards improving the cancer journey for all patients through the development of Clinical Care Pathways.

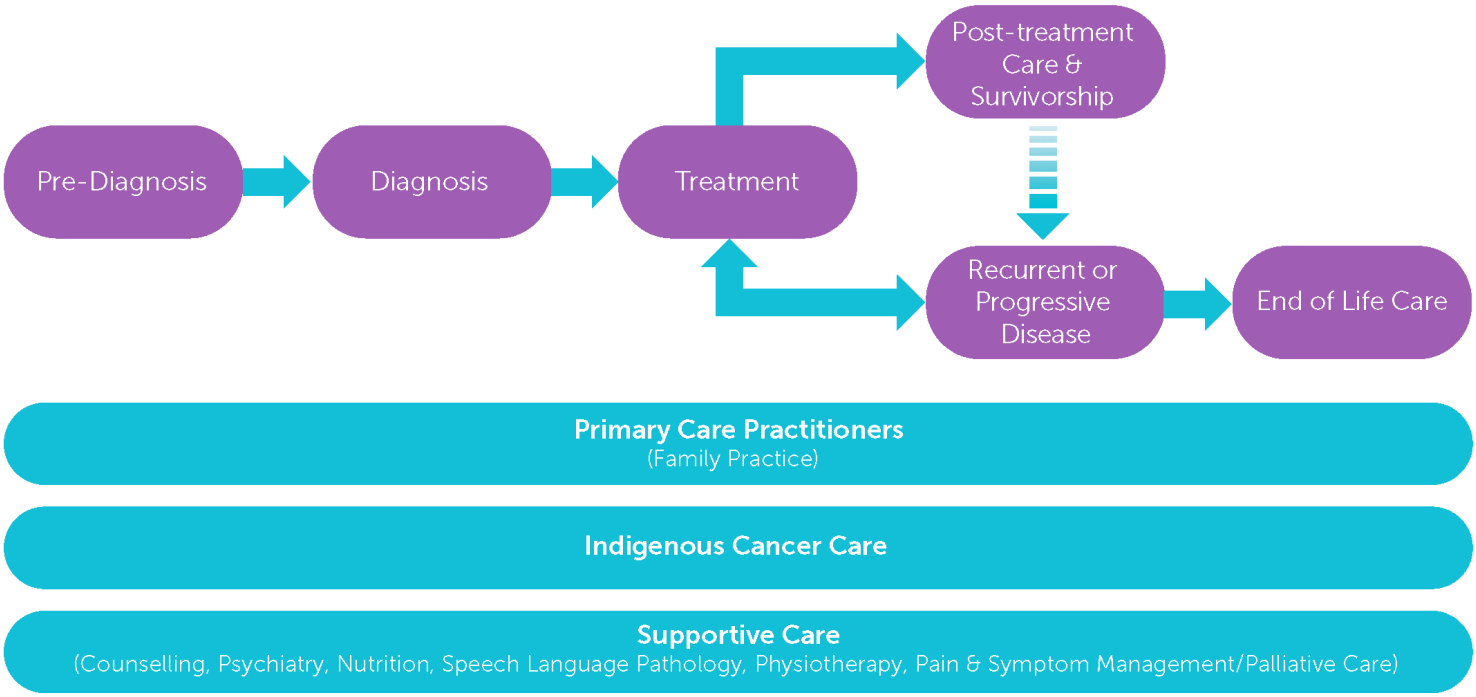
BC Cancer's Tumour Groups are collaborating to create Tumour-Specific Cancer Care Pathways to support all health care professionals in the delivery of high-quality care, consistently, efficiently, and efficaciously to all patients with cancer.

BC Cancer has currently published four clinical care pathways: Oropharyngeal, Prostate, Bone Sarcoma, and Soft Tissue Sarcoma.

- Tumour-Specific Pathways will help guide health care professionals by improving the ability to identify who, how and when to refer patients to BC Cancer, and in ensuring that evidence based, high quality care is received by all patients.
- Each Tumour-Specific Pathway was developed with a rigorous methodology, by a multi-disciplinary team of specialists across all health authorities in BC and approved by the relevant Provincial Tumour Group Committee.
- Each pathway is tumor specific, and features references, hyperlinks to information and evidence summaries, and notes that will provide helpful information to clinicians as they support their patients through their cancer care journey.
- The overall vision is that any clinician providing care to a patient (primary care, emergency care, cancer care) would be able to identify easily where in the pathway of care this patient is currently, and what issues might be facing them.

continued on page 15

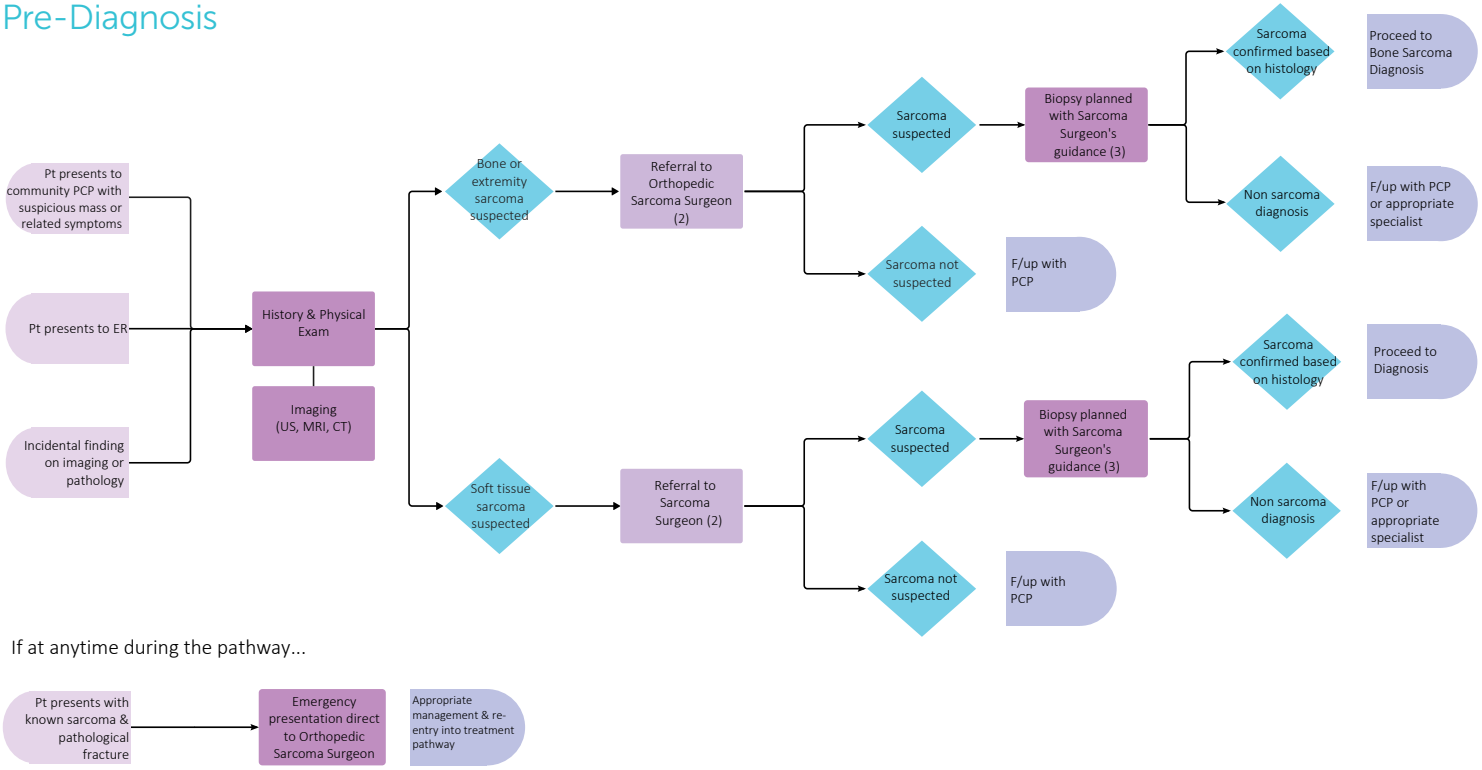
Clinical Care Pathways for Health Professionals



BC Cancer now has an overarching pathway of care for all patients with cancer and tumour specific pathways.
Clinical Care Pathways

Sarcoma Tumour Group – Soft Tissue Pathway

Pre-Diagnosis



Example of Pre-Diagnosis – Soft Tissue Sarcoma Clinical Care Pathway

Clinical Care Pathways continued from page 14

- Each pathway aligns with the stages of the Overarching Clinical Care Pathway: Pre-diagnosis, Diagnosis, Treatment, Post Treatment Care & Survivorship, Recurrent or Progressive Disease and End of Life Care.
- Additional tumour specific pathways will be added over the next year.
- The pathways are now available on our website for Health Authority and community engagement.
- Patient-oriented companion information for the tumour specific clinical care pathways will follow and will help support patients and their family members with patient-oriented resources.

These pathways were developed in collaboration with members of the Family Practice Oncology Network, Surgical Oncology Network, and Supportive Care teams. The intended audience is truly for anyone involved in the treatment of cancer patients in BC – which by definition would include all of family practice. It is therefore incredibly important to hear from members of our intended audience to ensure that YOUR needs are being met.

Please share with your teams and feel free to provide feedback. A feedback form is located at the bottom of the Consultation on Tumour-Specific Pathways page.

Consultation on Tumour-Specific Pathways

We look forward to your feedback. Any questions? Please email TGCoordinator@bccancer.bc.ca

Bowel care primer

By Dr. Pippa Hawley FRCPC (Pall Med), Provincial Medical Director for Pain & Symptom Management/Palliative Care, BC Cancer; Vancouver PSMPC Team leader, Clinical Professor, UBC Department of Medicine

Dr. Pippa Hawley

Constipation is a very frequent complication of cancer care. Despite a plethora of bowel care medications being available, people living with cancer frequently have unmanaged or poorly managed constipation. This affects not only the quality of life due to symptoms such as nausea, loss of appetite and abdominal/rectal discomfort, but can also lead to life-threatening complications, such as sepsis, rectal bleeding, bowel obstruction and/or perforation.

Good bowel care is much more than liberal distribution of handouts, though that helps! People are frequently unable to read it, lose it, or to just ignore it. Conflicting advice from family, friends or ill-informed health care professionals may be well-meant, but lead to failure to follow instructions correctly, or not at all.

The recommended patient information source is BC Cancer's "How to Treat Constipation Caused by your Medications" webpage www.bccancer.bc.ca/health-info/coping-with-cancer/managing-symptoms-side-effects/constipation-caused-by-your-medications This page has a downloadable handout in English, Farsi, French, Punjabi, Traditional Chinese and Vietnamese. It provides two basic stepwise protocols: one for Sennosides, and one for PEG.

The default "Bowel Protocol" should be Sennosides-based because Sennosides are cheap, easy to swallow, and work well in the majority. Some individuals experience cramps with stimulant laxatives, and these may prefer PEG, especially those with Irritable Bowel Syndrome (IBS) or partial bowel obstruction. PEG and senna work equally well in cancer patients who are eating and drinking normally,[1] but PEG is not covered by BC Palliative Benefits and is significantly more expensive than sennosides. It is less easily adjusted than sennosides and requires a lot of fluid to be taken along with it, which may displace vital nutritional intake when there is anorexia or early satiety.

For those who need but who cannot handle the volume of PEG, or who require a more rapid response, lactulose or sorbitol can be a good osmotic alternative, though the sickly-sweet taste and the gas generation that they often cause are unpopular.

Please don't advise patients with opioid-induced constipation to increase their fibre intake. With impaired motility fibre tends to swell up in the bowel causing bloating, and to then dry out, creating hard stools that are painful to pass. It is also important to note that docusate has been shown to be ineffective and potentially even harmful in opioid-induced constipation.[2]

One of the myths about laxatives are that using them can be habit-forming, in an addiction-like model, especially sennosides. This is an unfounded fear but can be hard to dispel when entrenched for life. For those with constipation caused by opioids or any other constipating medication, sennosides can be used long-term with no fear of adverse long-term effects.

Another myth about sennosides is the limit of 4 tablets per day, which is what is advised on the packaging of most brands. You need to explain to patients that this caution is intended for people who have not sought medical attention and may be self-medicating constipation as a possible symptom of undiagnosed bowel cancer. We know that this is not relevant to them, and that doses up to 9 of the 12mg strength tablets (3, three times a day) are safe.

Do not dismiss the constipating effect of medications other than opioids, especially ondansetron. Excessive use can cause prolonged nausea, leading to more ondansetron, causing more constipation, more nausea and so on ad infinitum. Use other antiemetics unless you are sure that the chemoreceptor trigger zone (CTZ) is the current primary mediator of emetogenicity and consider laxative prophylaxis just the same as you would when starting an opioid.

Sennosides protocol

Step 1	2 sennosides at bedtime
Step 2	2 sennosides at breakfast and 2 sennosides at bedtime
Step 3	2 sennosides at breakfast and 2 sennosides at lunch and 2 sennosides at bedtime
Step 4	3 sennosides at breakfast and 3 sennosides at lunch and 3 sennosides at bedtime
Step 5	3 sennosides at breakfast and 3 sennosides at lunch and 3 sennosides at bedtime. Also, one Glycerin suppository.

PEG protocol

Step 1	17g of PEG at bedtime
Step 2	17g of PEG at breakfast and 17g PEG at bedtime
Step 3	17g of PEG at breakfast and 17g PEG at bedtime and start sennosides protocol

If adding sennosides to the PEG protocol:

Keep taking 17g of PEG at breakfast and 17g of PEG at bedtime with the sennosides at each step.

My final note is to check in about bowel performance with all your patients every time you see them. It only takes a few seconds if all is well. Document what their normal/Goal bowel habit would be and personalize management to achieve that goal. The Victoria Bowel Performance Scale (BPS)[3] is an excellent scale. It may not always be you that sees the patient, so document what their goal is, and what they are taking, ideally using the BPS, adjusting the protocol level accordingly.

continued on page 17

Opioid prescribing for cancer pain in Primary Care

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

Introduction

Dr. Chantal Chris

Cancer pain management is a critical aspect of oncological care, yet it poses unique challenges due to the evolving nature of cancer care and the complex interplay between cancer-related and chronic pain. Despite its prevalence, cancer pain, in so many guidelines and organizational/public policies, is 'exempted' from available dosing and safety guidelines. This can lead to inconsistencies in treatment approaches. This article aims to equip primary care providers with a framework for navigating the complexities of cancer pain management while addressing common misconceptions and barriers. See Figure 1 for some further resources. In addition, your friendly local BC Cancer Pain and Symptom Management & Palliative Care (PSMPC) Specialists are here for you. Call us up for advice and/or refer the more complex patients our way.

Understanding "Cancer Pain"

The line between "cancer pain" and "chronic pain" is not as clear-cut as many guidelines make it out to be. It's easy to categorize, for example, a patient with metastatic breast cancer to bone as having bony "cancer pain". But what about the patient with bone pain from multiple myeloma and a potential prognosis of 7 years or more? Or the patient with pain from immune-mediated arthritis secondary to immunotherapy which has successfully stabilized their metastatic melanoma? Are those also classified as "cancer pain"? Improvements in cancer treatment are improving survival, but survival sometimes comes at a cost, with almost half of all cancer survivors reporting ongoing chronic pain.[1]

To understand why we treat "cancer pain" differently, we must address several misconceptions. It's not because there's more research supporting opioids for long-term cancer pain over chronic non-cancer pain, nor is cancer pain inherently more deserving of opioid therapy. While cancer-related pain often stems from tissue damage and inflammation which seems to respond better to long term opioids than some other pain mechanisms, this is similar to other chronic non-cancer pain conditions and doesn't fully explain the disparity either. The main reason "cancer pain" often bypasses opioid guidelines is due to outdated perceptions that cancer care is synonymous with end-of-life care.[2] This overlooks the evolving nature of cancer treatment and palliative care. However, this explanation is closest to the truth because for patients with limited time left, opioids may be more appropriate due to their immediate pain relief benefits, lack of time for alternative strategies, and lack of time for opioid side effects and risks to outweigh their benefits. Conversely, for chronic pain patients with longer prognoses, the significant risks of opioids almost always eventually outweigh the benefits. This complexity underscores the necessity of individualized and evidence-based approaches to pain management, rather than relying on oversimplified categories like "cancer" or "non-cancer" pain.

continued on page 18

- B.C. Inter-professional Palliative Symptom Management Guidelines, 2017: https://www.oc-cpc.ca/cpc/symptom-management-guidelines/
- Fraser Health Hospice Palliative Care Symptom Guidelines: https://www.fraserhealth.ca/employees/clinical-resources/hospice-palliative-care#.XCAD M17nlU
- BC Guidelines.ca, Palliative Care: https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/oc-guidelines/palliative-care
- Opioid Safety Recommendations in Adult Palliative Medicine. Summary Version: https://archive.cspcp.ca/opioid-safety-recommendations-in-adult-palliative-medicine
- Pallium Canada: https://pallium.ca/
  - LEAP Courses
  - Pallium Handbook
- Virtual Hospice: http://www.virtualhospice.ca
  - KidsGrief.ca, MyGrief.ca and lots of other bereavement support
  - Patient handouts on symptoms, goals of care, etc.
  - Practice tools and videos for physicians
  - http://www.methadone4pain.ca/

Figure 1: Symptom Management Resources

Bowel care primer
continued from page 16

References

1. Hawley P, MacKenzie H, Gobbo M. PEG vs. sennosides for opioid-induced constipation in cancer care. Support Care Cancer. 2020 Apr;28(4):1775-1782. https://link.springer.com/article/10.1007/s00520-019-04944-5 (free full text).
2. Hawley PH, Byeon JJ. A comparison of sennosides-based bowel protocols with and without docusate in hospitalized patients with cancer. J Palliat Med. 2008;11(4):575–581. https://www.liebertpub.com/doi/10.1089/jpm.2007.0178 (free full text)
3. Hawley P, Barwich D, Kirk L, Implementation of the Victoria Bowel Performance Scale, Journal of Pain and Symptom Management 2011, 42(6): 946-953, https://doi.org/10.1016/j.jpainsymman.2011.02.021 (free full text).

Opioid prescribing for cancer pain continued from page 17

Initiating Pain Assessment and Management

Effective pain management begins with a comprehensive assessment that includes a thorough pain history and targeted physical examination. Utilizing standardized screening tools, such as the Edmonton Symptom Assessment System (ESAS) and the Canadian Problem Checklist (see Figure 2), enhances the evaluation of pain and associated symptoms, enabling clinicians to identify and address moderate to severe cancer-related pain promptly.

Implementing WHO Principles of Pain Management

Adhering to the five main World Health Organization (WHO) principles of pain management in cancer provides a structured approach to treatment initiation. See Figure 3 for more details.

A Step-wise Approach to Initiating Opioid Therapy

Opioids are first line for treatment of moderate to severe cancer-related pain, especially for patients with a life-limiting cancer diagnosis.

1. Choice of Opioid: A typical initial prescription for an opioid naïve patient would be: Morphine 2.5mg po q4h regular + 2.5mg po q1h prn (you can always titrate up the baseline q4h dose quickly if the patient needs a higher dose than that based on prn usage). Morphine is just as effective and safe as hydromorphone and the main reason to choose hydromorphone over morphine is if your patient has reduced renal function.[3]
2. Safe Opioid Prescribing: See Box 4 for some general safe prescribing tips as well as some ways to mitigate the risks of opioid prescribing for patients at higher risk of opioid misuse or abuse.[4] Prior to initiating opioids for any patient ensure to screen for risk of

continued on page 19

Figure 2: BC Cancer EPICC Screening Tool Document

ESAS-r

Commentary: The ESAS-r is the Edmonton Symptom Assessment System, revised. It is a national standard for assessing key symptom in cancer care. Based on EPICC patient data, sleep and constipation have been added to the ESAS-r, using research-tested wording.

Please select the number that best describes how you feel NOW:												
	0	1	2	3	4	5	6	7	8	9	10	
No pain												Worst possible pain
No tiredness (tiredness = lack of energy)												Worst possible tiredness
No drowsiness (drowsiness = feeling sleepy)												Worst possible drowsiness
No nausea												Worst possible nausea
No lack of appetite (0 = full appetite, 10 = complete loss)												Worst possible lack of appetite
No shortness of breath												Worst possible shortness of breath
No depression (= feeling sad)												Worst possible depression
No anxiety (anxiety = feeling nervous)												Worst possible anxiety
Best feeling of wellbeing (wellbeing = how you feel overall)												Worst possible wellbeing
Best sleep (in last 24 hours)												Worst possible sleep
No constipation												Worst possible constipation
No _____ other problem (for example, diarrhea)												Worst possible other problem

CPC (Canadian Problem Checklist)

Commentary: Items in the CPC are adapted based on local needs and available services. Several of these items produce alerts for specific supportive cancer care services and pharmacy check-ins.

Please check all of the following items that have been of concern or a problem for you in the past week including today:

Emotional
- ☐ Fears / Worries
- ☐ Sadness
- ☐ Frustration / Anger
- ☐ Changes in appearance
- ☐ Intimacy / Sexuality
- ☐ Coping
- ☐ Changes in a sense of self
- ☐ Loss of interest in everyday things

Informational
- ☐ Understanding my illness / treatment
- ☐ Talking with my health care team
- ☐ Making treatment decisions
- ☐ Knowing about available resources
- ☐ Quitting smoking
- ☐ Taking Medications

- ☐ I have considered suicide
- ☐ I want information on medical assistance in dying (MAiD)

Practical
- ☐ Returning to work / school
- ☐ Affording costs or loss of income
- ☐ Getting to & from appointments
- ☐ Where to stay during treatment
- ☐ Drug costs
- ☐ Child / family / elder care

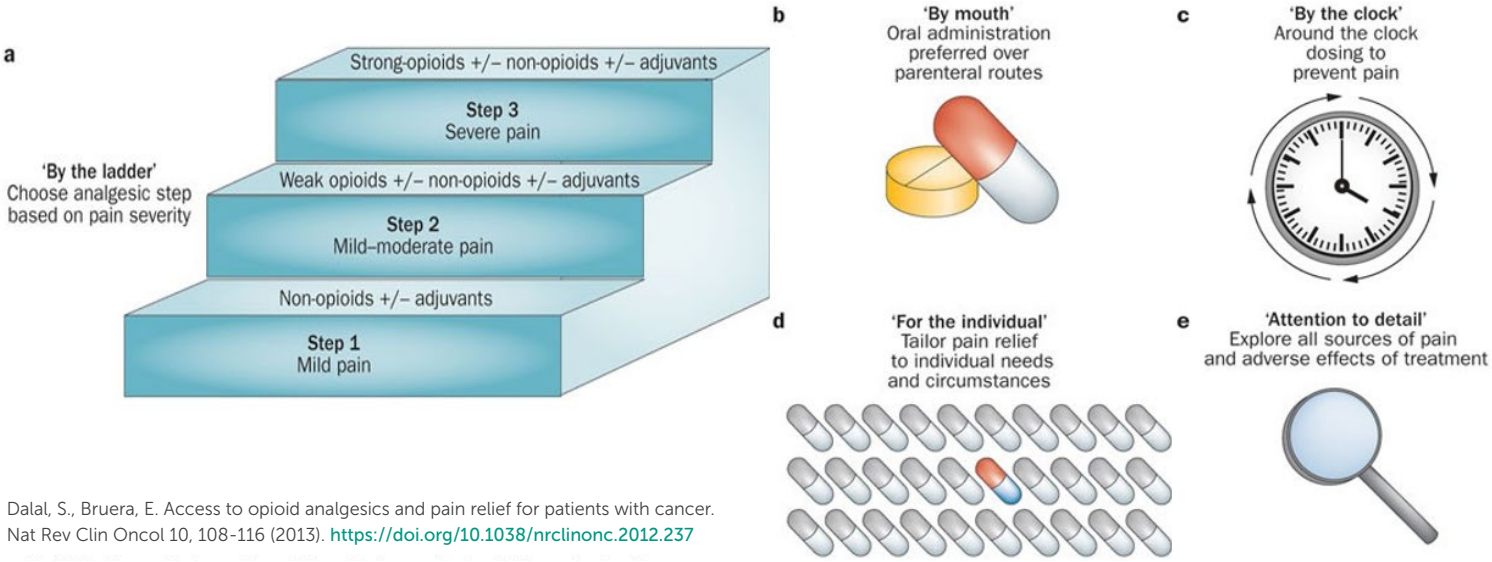
Spiritual
- ☐ Meaning / purpose of life
- ☐ Faith

Social / Family
- ☐ Feeling a burden to others
- ☐ Worry about family / friends
- ☐ Feeling alone
- ☐ Relationship difficulties

Physical
- ☐ Concentration / Memory
- ☐ Diarrhea
- ☐ Swallowing
- ☐ Communication difficulties
- ☐ Falling / Loss of balance
- ☐ Tingling / numbness

http://www.bccancer.bc.ca/coping-and-support-site/Documents/EPICC-ScreeningTool.pdf

Figure 3: WHO Principles of Pain Management in Cancer



Dalal, S., Bruera, E. Access to opioid analgesics and pain relief for patients with cancer. Nat Rev Clin Oncol 10, 108-116 (2013). https://doi.org/10.1038/nrclinonc.2012.237

Figure 4: Risk of Opioid Misuse or Abuse

General safe prescribing tips for everyone:

- Single prescriber, single pharmacy
- Blister pack all regular meds
- Limit prn availability
- Small quantity prescribing or partial dispensing

If High Risk, mitigate risk by:

- Opioid Contracts
- Smaller dosing amounts and frequency (med dispensing machines, daily dispensing or DWI)
- Limit prn dosing (use prn blister pack)
- UDS (for misuse of other substances and ensuring no diversion of Rx'ed med)
- Monitor closely
- Interdisciplinary approach, using Addictions
- Medicine also

Opioid Risk Tool

Mark each box that applies	Female	Male
Family history of substance abuse		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
Age between 16—45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
Scoring totals		

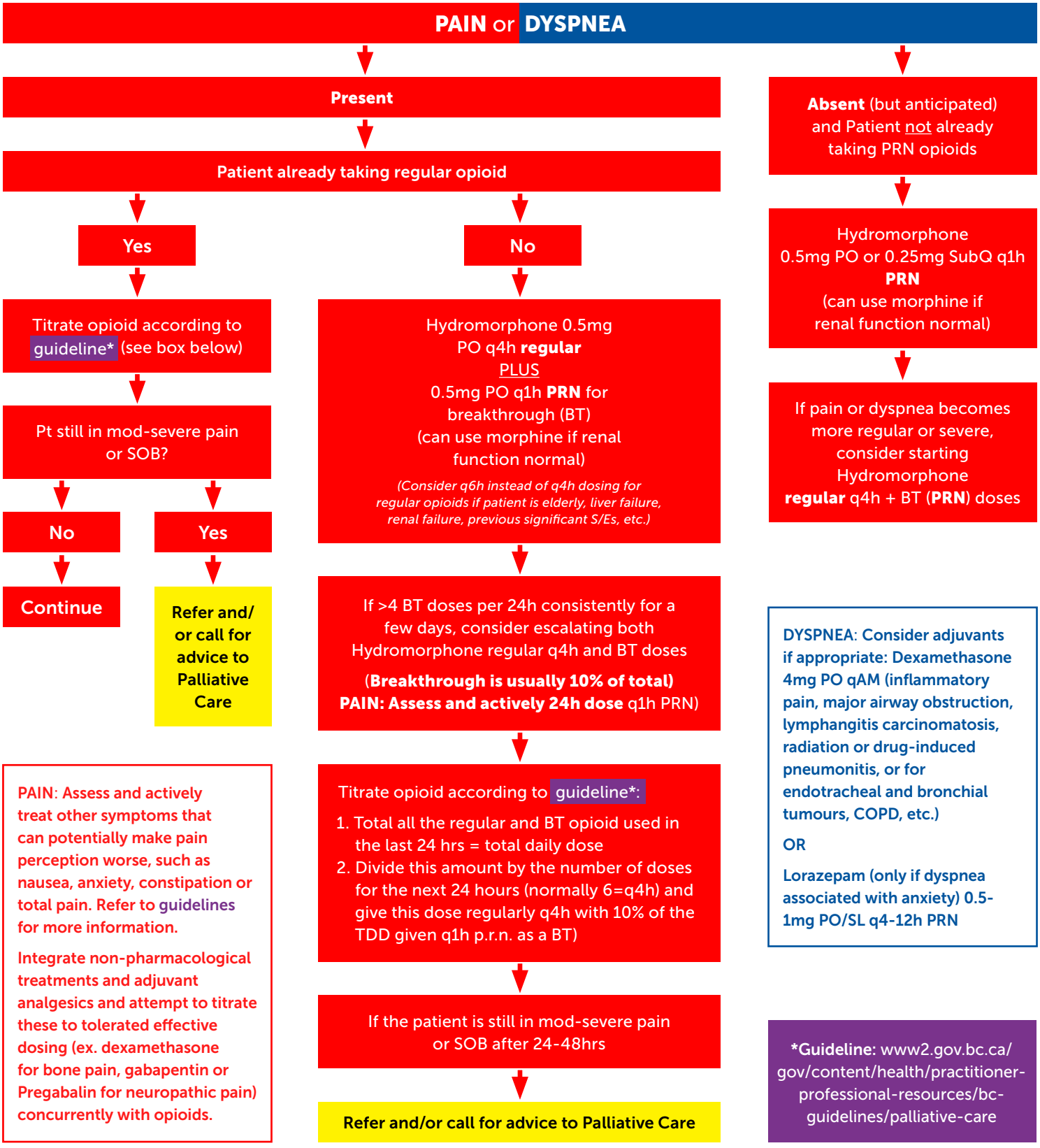
Opioid prescribing for cancer pain continued from page 18

opioid use disorder (The Opioid Risk Tool, also in Figure 4, is helpful for this).

3. Patient Education: When initially prescribing a patient opioids, there are several things it is important to make sure you discuss with them, including: addressing concerns/fears/ misconceptions around addiction, overdose, and withdrawal, advising no driving with any dose adjustments or breakthrough use, advising not to share medications, to keep opioids locked up, and to return all un-used medications to the pharmacy. Also discuss side effects to watch for (nausea, somnolence, foggy brain) and reassure them these side-effects are transient, should resolve in 3-5 days, and are not an adverse reaction or a reason not to take the medication. Don't forget to discuss constipation, which is the only side effect that will continue as long as the opioids do. When prescribing opioids always prescribe a first-line antiemetic as needed (metoclopramide

continued on page 20

Figure 5



Compiled by Dr. C.Chris. Rev. Jan 2024

References used: bc-cpc.ca/cpc/publications/symptom-management-guidelines

Opioid prescribing for cancer pain continued from page 20

or haloperidol... not ondansetron as it is expensive and constipating) and stimulant laxatives (eg. sennosides), to help manage these most common opioid-related side effects.

4. Breakthrough Pain Management: The scheduled q4h opioid dosing should be supplemented with breakthrough doses. These should be about 10% of the total daily regular dose, administered q1h on an as-needed (prn) basis. Advise patients to keep a pain diary, track prn use, and to contact you if they are consistently needing greater than 3 breakthroughs per day so you can adjust their baseline dose accordingly. When following-up, make sure to ask about what type of breakthrough pain they are getting (spontaneous or incident pain). Incident pain (breakthrough pain associated with a specific activity) is harder to control with most oral medications as it needs quick onset and quick off set. Non-pharmacological treatments (like mobilization aids, radiation therapy, and nerve blocks) can help. Also ask about end of dose failure pain: If the patient's pain seems to be increasing just before the next regular dose is due, it is not usually that the medication is actually wearing off too soon or that that patient is a rapid-metabolizer, it is that the overall baseline dose needs to be increased.[5]
5. Follow-up: You should follow-up at least every 2-3 days (over the phone is fine) to titrate their regular short-acting opioid q4h dose as efficiently as possible and answer questions as well as address any concerns. Functional status assessments should guide this titration.
6. Long-Acting Opioids: We use regular short-acting opioids when pain is uncontrolled because their shorter half-lives make it possible to actually titrate them as often as every 12-24 hours. Whereas a long-acting opioid can only be titrated every 48 hours at most. The goal is for frequent follow-ups to allow for efficient titration over several days to a week. Once pain is stabilized, the regular q4h short-acting opioid can then be switched to a long-acting formulation for convenience and consistency.
7. Opioid Rotations: There are only a few reasons to rotate an opioid once it has been initiated and titrated: If it is ineffective despite adequate titration, intolerance from persistent side effects or adverse effects (more likely as doses increase), medication interactions, and opioid neurotoxicity. If you do need to rotate a patient's opioid to a different one for any of these reasons; use an accurate equianalgesic table, reduce the dose by 20-30% after the calculation, and don't forget you can always ask for help from a pharmacist and/or a palliative care specialist.
8. Notes on Specific Opioids: a) Fentanyl patches should not be used in acute or un-controlled pain, they are contraindicated in these situations.[6] b) Methadone is more and more commonly used for analgesia, especially neuropathic pain and pain from cancer. It is not recommended to initiate methadone in patients considered opioid-naïve. Prescribers with limited experience in the use of methadone for analgesia are strongly encouraged to consult with an experienced colleague before starting a patient on methadone. However, once initiated and patients are on a stable dose, primary care providers play a key role in regular ongoing follow-up and prescribing. There is an excellent Canadian CME-accredited free 1-hour online module available to learn the key points about methadone at http://www.methadone4pain.ca/
9. Adjuvant Therapies: In conjunction with opioid therapy, adjuvant treatments tailored to the specific characteristics of pain experienced by the patient can help augment pain management outcomes. Non-pharmacological interventions such as interventional techniques (nerve blocks and vertebroplasty), radiation therapy, physical therapy, and mindfulness-based stress reduction techniques offer complementary approaches to pain relief and functional improvement. Compounded topical analgesics, including formulations containing morphine, methadone, ketamine, gabapentin, and lidocaine, provide localized relief for pain. Some examples of medications that offer more targeted adjunctive analgesia include sufentanil for incident pain, dexamethasone for inflammatory and bone pain, and duloxetine, tricyclic antidepressants, and gabapentinoids for neuropathic pain.

See Figure 5 for a pain and dyspnea management quick reference algorithm summarizing the above step-wise approach, which you can use to refer back to while caring for your patients.

Conclusion

Effective management of cancer-related pain requires a multidisciplinary approach, with primary care providers playing a central role in initial symptom assessment, treatment initiation, and ongoing follow-up. By adhering to evidence-based guidelines and addressing common misconceptions, primary care providers can empower themselves to provide optimal pain relief for patients with cancer. Hopefully this framework will help pain management change from one of the most dreaded parts of your practice to one of the most gratifying.

References

1. Mestdagh F, Steyaert A, Lavand'homme P. Cancer Pain Management: A Narrative Review of Current Concepts, Strategies, and Techniques. Curr Oncol. 2023 Jul 18;30(7):6838-6858. doi: 10.3390/curroncol30070500. PMID: 37504360; PMCID: PMC10378332.
2. https://www.pallimed.org/2019/10/part-6-why-is-cancer-pain-so-special.html
3. The Pallium Palliative Pocketbook: a peer reviewed, referenced resource. (2016). 2nd Cdn ed. Ottawa, Canada: Pallium Canada; 2016.
4. Lau J, Mazzotta P, Whelan C, Abdelaal M, Clarke H, Furlan AD, Smith A, Husain A, Fainsinger R, Hui D, Sunderji N, Zimmermann C. Opioid safety recommendations in adult palliative medicine: a North American Delphi expert consensus. BMJ Support Palliat Care. 2022 Mar;12(1):81-90. doi: 10.1136/bmjspcare-2021-003178.
5. Daeninck, Paul & Gagnon, Bruno & Gallagher, Romayne & Henderson, J.D. & Shir, Y. & Zimmermann, Camilla & Lapointe, B.. (2016). Canadian Recommendations for the Management of Breakthrough Cancer Pain. Current Oncology. 23. 96. 10.3747/co.23.2865.
6. Fraser Health Authority Hospice Palliative Care Symptom Guidelines: https://www.fraserhealth.ca/employees/clinical-resources/hospice-palliative-care

Follow-Up of patients with pre-cancerous lesions in the colon and rectum

By Jennifer J Telford MD MPH FRCPC
Medical Director, BC Colon Screening Program, Clinical Professor of Medicine, UBC

Dr. Jennifer Telford

Individuals who have pre-cancerous lesions (e.g. polyps) removed from the colon and rectum during colonoscopy may not be at increased risk for colorectal cancer (CRC) as previously believed. Prior guidelines recommending surveillance were based largely on expert consensus and studies using surrogate outcomes; however, more recent studies assessing large cohorts of screening patients have demonstrated that the risk of future CRC is similar or lower than the general population for individuals with a history of low-risk precancerous lesions. To incorporate this new evidence the British, European, American, and Asian endoscopy societies have updated their surveillance colonoscopy guidelines. In 2022, the British Columbia (BC) Guidelines and Protocol Advisory Committee (GPAC) also revised their colonoscopy surveillance recommendations which the BC Colon Screening Program has adopted (Figure 1).[1]

Precancerous lesions include conventional adenomas and serrated lesions. While all adenomas are dysplastic, either low- or high-grade, serrated lesions may or may not demonstrate dysplasia. Serrated lesions are classified as hyperplastic polyps, sessile serrated lesions with or without cytologic dysplasia, and traditional serrated adenomas. Small hyperplastic polyps in the rectum are considered to have no malignant potential. Larger hyperplastic polyps are managed in a similar fashion to sessile serrated lesions.

Colonoscopy findings can be divided into low or high-risk findings (Table 1). High risk findings incorporate one or more high risk precancerous lesions or the removal of multiple low risk precancerous lesions. High risk precancerous lesions are defined by size > 10 mm or by histologic characteristics. An individual with 10 or more precancerous lesions removed, cumulatively, during their lifetime may have an inherited predisposition to CRC and is eligible for assessment by the BC Hereditary Cancer Program.

On the other hand, following the removal of 1 or 2 low risk adenomas, CRC incidence and mortality is lower than the general population.[2–7] Furthermore, in some of these studies, the risk of CRC is reduced regardless of the number of low-risk adenomas resected at the initial colonoscopy. These finding have led the guideline committees, in varying degrees, to recommend no surveillance or less intensive colonoscopy surveillance for individuals with a personal history of low-risk precancerous lesions. The data for high- and low risk serrated lesions follows a similar pattern to adenomatous lesions, but the evidence is not as strong.[3]

Figure 1 shows the updated BC Guidelines for colonoscopy surveillance. Individuals who require colonoscopy surveillance can be registered in the Colon Screening Program using the Colonoscopy Referral Form available on the program website. http://www.bccancer.bc.ca/screening/health-professionals/colon

Table 1: Classification of Low and High Risk Precancerous Colorectal Lesions[1]

Feature	Low Risk	High Risk
Size	< 10 mm	≥ 10 mm
Number	1 to 4	≥ 5
Histology	• Adenoma with low grade dysplasia • Sessile serrated lesion with no dysplasia	• Adenoma with high grade dysplasia • Adenoma with villous features • Sessile serrated lesion with dysplasia • Traditional serrated adenoma

BCGuidelines.ca

Part 2: Follow-up of Colorectal Cancer and Precancerous Lesions (Polyps)

Effective Date: April 13, 2022

www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/bc-guidelines/colorectal-cancer-part 2

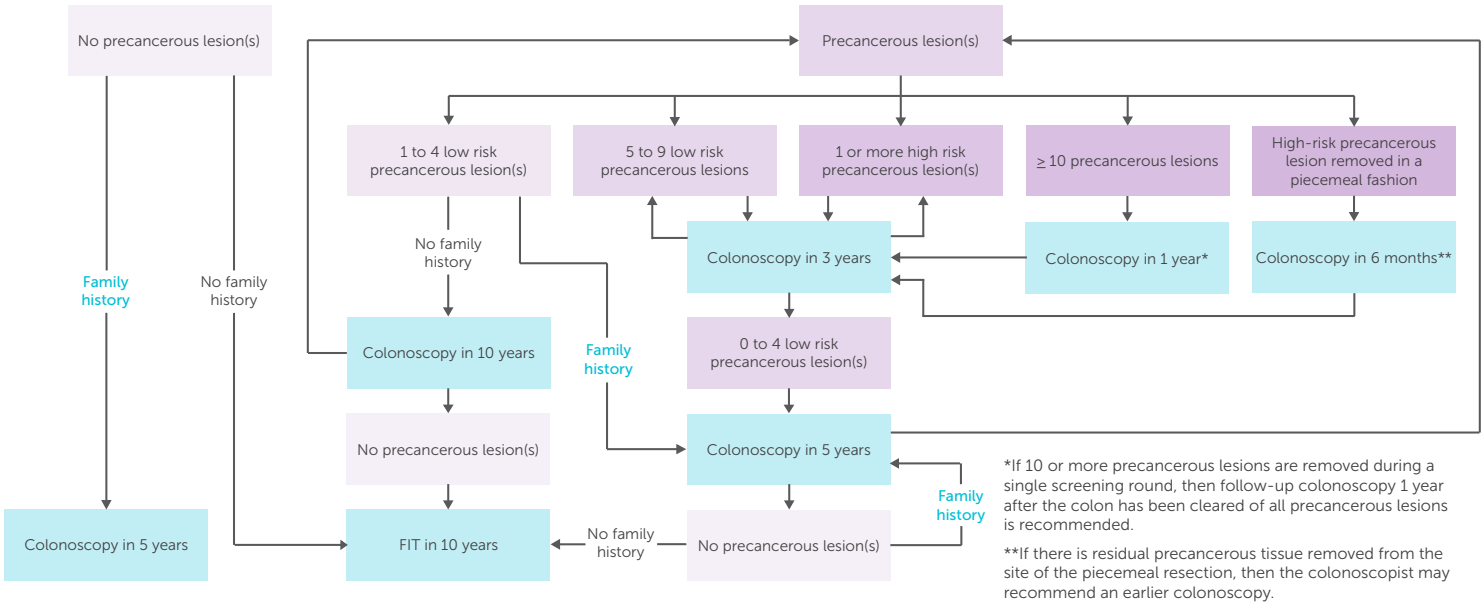
Individuals with a high-risk adenomas removed are at increased risk of future CRC and CRC-related mortality when compared to individuals with no adenomas at colonoscopy, individuals with low-risk adenomas, or to the general population.[2–5] Following surveillance colonoscopy the risk of future CRC decreases to the same risk as the general population and a second surveillance colonoscopy reduces the incidence of CRC below that of the general population.[6]

An individual's future risk of CRC must be taken in the context of their index colonoscopy and balanced against the potential harms. Colonoscopy also has inherent risks affecting 44 per 10,000 individuals undergoing the procedure, including perforation in 6 per 10,000, bleeding in 26 per 10,000, and death in 3 per 100,000.[10] A high-quality baseline colonoscopy which is complete, with adequate bowel cleansing, thorough inspection and complete resection of pre-cancerous lesions may provide more protection against the development of CRC than subsequent surveillance colonoscopies.[8,9]

continued on page 23

Figure 1. BC Colon Screening Program Colonoscopy Follow-up Algorithm

The findings at colonoscopy will determine the timing of further colonoscopies or whether the indivdiual returns to screening with FIT. Patients followed by colonoscopy do not require FIT. The following flowchart outlines the patient follow-up pathway after colonoscopy.



*If 10 or more precancerous lesions are removed during a single screening round, then follow-up colonoscopy 1 year after the colon has been cleared of all precancerous lesions is recommended.

**If there is residual precancerous tissue removed from the site of the piecemeal resection, then the colonoscopist may recommend an earlier colonoscopy.

High Risk Lesions

☐ Adenomas with:
- ☐ Villous features
- ☐ High-grade dysplasia
- ☐ ≥ 10mm

☐ Sessile serrated lesions ≥ 10 mm
☐ Sessile serrated lesions with cytologic dysplasia
☐ Traditional serrated adenomas
☐ Hyperplastic polyps ≥ 10mm

Precancerous lesions that do not meet the above criteria are classified as low-risk.

Low Risk Lesions

☐ Tubular adenomas <10 mm with low-grade dysplasia
☐ Sessile serrated lesions <10 mm without dysplasia

If the number of precancerous lesions removed during an individual's lifetime is 10 or more, then referral to the **Hereditary Cancer Program** for evaluation of a potential genetic predisposition to CRC is recommended.

Family History: one first degree relative diagnosed with CRC under age 60, **OR** 2 or more first degree relatives diagnosed with CRC at any age.

February 2023

Colon and rectum pre-cancerous lesions continued from page 22

References

1. Guidelines and Protocols Advisory Committee. Part 2: Follow-up of Colorectal Cancer and Precancerous Lesions (Polyps). Published online April 2022. https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/bc-guidelines/colorectal-cancer-part2
2. Lee JK, Jensen CD, Levin TR, et al. Long-term Risk of Colorectal Cancer and Related Death After Adenoma Removal in a Large, Community-based Population. *Gastroenterology*. 2020;158(4):884-894.e5. doi:10.1053/j.gastro.2019.09.039
3. He X, Hang D, Wu K, et al. Long-term Risk of Colorectal Cancer After Removal of Conventional Adenomas and Serrated Polyps. *Gastroenterology*. 2020;158(4):852-861.e4. doi:10.1053/j.gastro.2019.06.039
4. Click B, Pinsky PF, Hickey T, Doroudi M, Schoen RE. Association of Colonoscopy Adenoma Findings With Long-term Colorectal Cancer Incidence. *JAMA*. 2018;319(19):2021. doi:10.1001/jama.2018.5809
5. Løberg M, Kalager M, Holme Ø, Hoff G, Adami HO, Bretthauer M. Long-Term Colorectal-Cancer Mortality after Adenoma Removal. *N Engl J Med*. 2014;371(9):799-807. doi:10.1056/NEJMoa1315870
6. Cross AJ, Robbins EC, Pack K, et al. Long-term colorectal cancer incidence after adenoma removal and the effects of surveillance on incidence: a multicentre, retrospective, cohort study. *Gut*. Published online January 17, 2020:gutjnl-2019-320036. doi:10.1136/gutjnl-2019-320036
7. Dubé C, Yakubu M, McCurdy BR, et al. Risk of Advanced Adenoma, Colorectal Cancer, and Colorectal Cancer Mortality in People With Low-Risk Adenomas at Baseline Colonoscopy: A Systematic Review and Meta-Analysis. *American Journal of Gastroenterology*. 2017;112(12):1790-1801. doi:10.1038/ajg.2017.360
8. Corley DA, Jensen CD, Marks AR, et al. Adenoma Detection Rate and Risk of Colorectal Cancer and Death. *New England Journal of Medicine*. 2014;370(14):1298-1306. doi:10.1056/NEJMoa1309086
9. Lieberman D, Sullivan BA, Hauser ER, et al. Baseline Colonoscopy Findings Associated With 10-Year Outcomes in a Screening Cohort Undergoing Colonoscopy Surveillance. *Gastroenterology*. 2020;158(4):862-874.e8. doi:10.1053/j.gastro.2019.07.052
10. Tomaszewski M, Sanders D, Enns R, et al. Risks associated with colonoscopy in a population-based colon screening program: an observational cohort study. *cmajo*. 2021;9(4):E940-E947. doi:10.9778/cmajo.20200192

The importance of partnership: Cancer care during wildfire season

By Dr. Kim Nguyen Chi, executive vice president and chief medical officer, BC Cancer and Tracy Irwin, chief operating officer, BC Cancer

Last year, a total of 2,126 fires burned across B.C., impacting patients and health care workers throughout our province. At the best of times, travelling in B.C. can involve vast distances, inclement weather, and hazardous driving through mountain passes. When disaster hits, people with cancer can end up cut off from the care they need.

B.C.'s cancer care system has always relied on strong partnerships between BC Cancer, primary care providers, and regional health authorities to support patients from the first suspicion of cancer through to treatment and beyond. As we look ahead to what's predicted to be another active wildfire season, we want to recognize the exemplary contributions of the physicians and staff who have stepped up, finding compassionate and innovative ways to support patients through emergency situations.

Vancouver Island wildfires

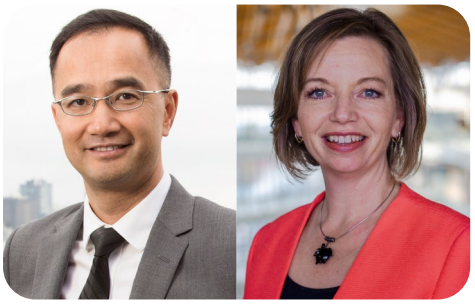
During the Cameron Bluffs wildfire and subsequent Highway 4 closure on Vancouver Island last summer, people with cancer living in the Port Alberni, Tofino and Ucluelet regions suddenly found themselves unable to access the care they needed at the Nanaimo Regional General Hospital (NRGH) Community Oncology Network Clinic and BC Cancer – Victoria.

BC Cancer – Victoria, Island Health, and partners like Health Emergency Management BC (HEMBC), immediately stepped in to minimize, wherever possible, disruptions to treatment and care.

Staff and physicians worked quickly to identify patients requiring urgent cancer care and overcome logistical hurdles. For those undergoing radiation therapy, this meant coordinating air transportation and accommodation. For those in need of chemotherapy, it meant bringing the treatment to them by establishing a temporary chemotherapy clinic at West Coast General Hospital (WCGH) in Port Alberni. Despite the challenges with the transportation of chemotherapy medicine and patient scheduling, the collaborative efforts of medical professionals ensured patients in this region could get the care they need, when they needed it.

Kelowna area wildfires

This past summer, wildfires in the Kelowna area impacted many staff and patients directly. Some lost their homes and many were under evacuation orders or alerts. Those living in Summerland and Penticton also had to contend with a rockslide and highway closure that made it difficult to get to BC Cancer – Kelowna.



Dr. Kim Nguyen Chi Tracy Irwin

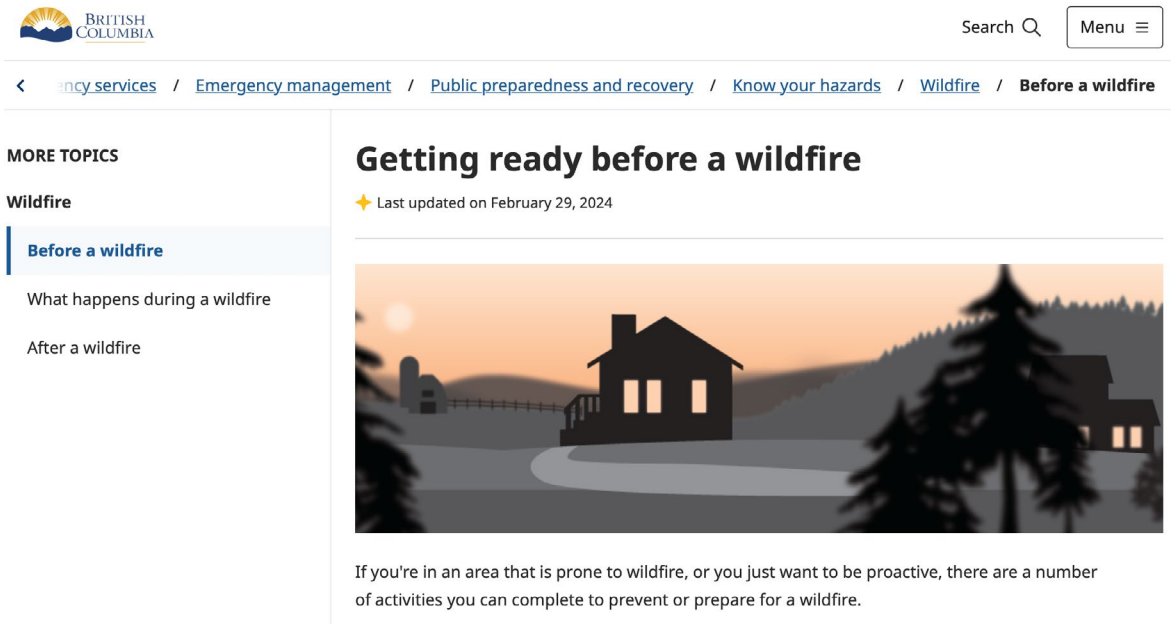
Despite the personal impacts, BC Cancer – Kelowna staff and physicians rose to the occasion to support their patients and each other. They helped to reschedule or move appointments, find temporary accommodations, and offered whatever support was needed to ensure patients could continue receive cancer care.

Looking forward

Our disaster response and the work we do, hand-in-hand with regional health authorities, has been honed through the years as we learn from our successes and take steps to improve how we respond next time.

With a potentially busy 2024 wildfire season to come, there are steps we can take now to be prepared personally and professionally. To get started, we encourage you to visit Get prepared for a wildfire of the Government of BC website.

While we hope for an uneventful wildfire season, we are confident that the commitment and support of our teams and partners will enable to us weather whatever comes our way. Thank you for everything you do – every day – to support patients and help them access critical cancer care.



Prince George: these GPOs wear many hats

By Dr. Sian Shuel,
Medical Education Lead, FPON

I recently had the opportunity to connect with Dr. Jo Collins, Dr. Shannon King and Dr. Nicole Touhey, 3 General Practitioners in Oncology (GPOs) who work at BC Cancer Centre for the North in Prince George (PG). These three colleagues exemplify the generalist skills of family medicine training. I went into the interviews to learn more about their role as a GPO in PG. I came out with an understanding that, in addition to a broad scope of GPO work, the majority of GPOs (6 in total plus two currently undergoing GPO Education) have additional roles within the local medical community.

Within their GPO role, these physicians cover systemic and radiation therapy across all tumour sites, including sarcoma and haematologic cancers. They have a Doctor of the Day rota, which includes assessing patients with cancer who walk into the Centre with acute concerns and covering the chemo reaction pager. While narrowing the number of tumour sites is appealing, these GPOs note the need for more generalist coverage skills to cover staff absences. After an initial virtual consult from supportive medical oncologists in Vancouver, these GPOs perform the initial in-person assessment and physical exam assessing fitness to treat, providing supportive care prescriptions, reviewing the treatment plans with their patients and working to optimize other health care issues with the help of patients' family physicians. Since its opening in 2012, the number of GPOs and their role within the Centre have expanded due to medical oncology staffing shortages. In addition to GPOs, the in-house medical staff at Centre for the North includes four radiation oncologists, one medical oncologist and four nurse practitioners. A couple of medical oncologists from Vancouver and Victoria fly out to PG to support in-person care. The team will also follow patients post-treatment, depending on whether they have a family physician or primary care nurse practitioner.

Teaching is another component of the GPO role in PG. Learners include GPOs who will be working at Community Oncology Network (CON) clinics in the Northern Health Authority and on-site, medical oncology residents, medical students from the Northern Medical Program, and family medicine residents. Four members of the GPO team graduated from the family medicine residency program in PG.

Drs. Nicole Touhey, Shannon King and Jo Collins

In addition to the GPO work noted above, Dr. King, who has a 3rd year of training in the Care of the Elderly, provides geriatric consults for Northern Health and home visits for home-bound seniors, often bringing learners along. She also teaches clinical skills and case-based learning for medical students in the Northern Medical Program.

Dr. Collins is an emergency physician at the University Hospital of Northern BC in PG. After splitting time between BC Cancer and the emergency department, she has recently moved on from her GPO role to Head of the Emergency Department, which continues supporting cancer patients in the community.

Dr. Touhey works at the Blue Pine Primary Health Care Clinic, which includes but is not limited to providing care for patients experiencing homelessness or substance use and those recently discharged from inpatient psychiatry or with complex medical issues without a Primary Care Provider.

Dr. Touhey, a Diplomate of the American Board of Obesity Medicine, also covers an eating disorders clinic and provides on-call support for the sexual assault team.

Roles filled by other GPOs in PG include dermatology clinics, penicillin allergy de-labelling clinics, breast screening programs and procedures such as bone marrow biopsies and thoracenteses within the Northern Health Authority.

Several themes stood out during these interviews. I could write about the large geographic area BC Cancer Centre for the North covers to ensure patients receive cancer care as close to home as possible, the local team collaboration to minimize the time from pre-chemo assessment to treatment for patients coming from outside the community so they can get back home, the innovative local and virtual collaboration when facing staffing challenges and limited local access to subspecialist care, or the benefits of being part of the small medical community in Prince George. However, this time around, what is most noticeable is the breadth and scope of practice of these GPOs.

Trauma-informed care and people with cancer

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

I recently had the privilege of attending a BC Perinatal Community of Practice event in which the opening speaker, Dr. Hillary McBride presented on "Working with Unseen Wounds" and how taking a Trauma-informed approach in caring for this patient population helps to improve patient experiences and outcomes. My biggest take away was that "words and reactions matter". Not only what we as providers say and how we ask questions, but also how we interpret the responses we may get from our patients.

Dr. Cathy Clelland

The implementation of trauma-informed care in fields such as addiction and mental health as well as pediatrics and family medicine has been expanding, particularly as we undertake the journey of Truth and Reconciliation with our First Nations, Inuit and Métis populations. The impact of intergenerational trauma and documentation of systemic racism within our healthcare system and incidents of multi-cultural racism through the pandemic over the last few years have added an additional layer of factors that can have a significant negative impact on patient experiences of care and outcomes.

In reviewing available literature, the Five Guiding Principles of Trauma Informed Care are:

- Safety,
- Choice,
- Collaboration,
- Trustworthiness and
- Empowerment.

From the University of Buffalo Centre for Social Research: "Ensuring that the physical and emotional safety of an individual is addressed is the first important step to providing Trauma-Informed Care. Next, the individual needs to know that the provider is trustworthy. Trustworthiness can be evident in the establishment and consistency of boundaries and the clarity of what is expected in regard to tasks. Additionally, the more choice an individual has and the more control they have over their service experience through a collaborative effort with service providers, the more likely the individual will participate in services and the more effective the services may be. Finally, focusing on an individual's strengths and empowering them to build on those strengths while developing stronger coping skills provides a healthy foundation for individuals to fall back on if and when they stop receiving services."[1]

This started me thinking about cancer and how those of us in the healthcare system usually approach it as a physical condition. Clinicians are trained in taking histories, asking about symptoms, examining, and then developing a differential diagnosis list to guide investigations and help identify conditions that need treatment. Unfortunately, we often fail to consider how other experiences, including previous adverse childhood and adult experiences can shape the presentation of conditions and impact the management and recovery for the individual person. How we ask a question and the words we use can help us to see more than just the surface of the patient's current condition. Considering what past experiences and resulting fears may be at play when discussing management options can help us understand and address the many anxieties people may have regarding our recommendations.

The experience of cancer is often psychologically and emotionally challenging and has potential to be traumatic, not only for the patient, but also for their family. Some people may experience re-traumatization during the process of investigation and treatment of cancer because of previous experiences of watching a family member go through the cancer journey, or non-cancer-related traumas such as intimate partner violence or adverse childhood experiences. With trauma informed care we can strive to reduce re-traumatization and support better relationships with our patients. As health care providers, our approach to caring can help patients develop resiliency and improve well-being by empowering them on their path to cancer remission and recovery with the goal of improving overall outcomes.

To be effective, changing our care patterns will need to involve everyone in the health care system including all public facing support staff, nurses, physicians (including learners) and other allied healthcare professionals. Trauma-informed care is not targeting the healing of the specific trauma nor is it even addressing the trauma directly and it does not mean that all providers need to become "trauma specialists". However, as Dr. McBride so poignantly pointed out in her talk "When trauma informed care is the standard of care, all care becomes transformative care: Protective, corrective, empowering."

Reference

1. https://socialwork.buffalo.edu/social-research/institutes-centers/institute-on-trauma-and-trauma-informed-care/what-is-trauma-informed-care.html

FOR MORE INFORMATION

To learn more about the Family Practice Oncology Network or become involved, please email FPON@bccancer.bc.ca or visit www.fpon.ca

The content of articles in this Journal represent the views of the named authors and do not necessarily represent the position of BC Cancer, PHSA or any other organization.

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

Publications Mail Agreement Number 41172510

Return all undeliverable Canadian Addresses to
BC Cancer, 600 West 10th Ave, Vancouver, BC V5Z 4E6

BC Cancer provides specialized cancer care services to communities across British Columbia, the territories of many distinct First Nations. We are grateful to all the First Nations who have cared for and nurtured this land for all time, including the xʷməθkwəy̓əm (Musqueam), Sḵwx̱ wú7mesh Úxwumixw (Squamish), and səlilw̓ətaɬ (Tsleil-Waututh) First Nations on whose unceded and ancestral territory our head office is located.