Hello Primary Care Colleagues,

Happy New Year! Thank you for taking the time to read the first edition of the Regional Oncology Update - the cancer care newsletter for primary care. This newsletter will be your source for both provincial and regional updates on cancer care pertinent to you and your patients.

I appreciate that your time is precious so I am hoping that this quarterly installment will meet your needs in a succinct manner. Don’t worry if you don’t have time to read it the instant it arrives in your inbox as the newsletter issues will be archived on our website: www.cancercare4primarycare.ca for future reference. In the newsletter you will find links pertinent to the topics discussed. I would encourage you to subscribe to this newsletter electronically by emailing me at rachael.halligan@grhosp.on.ca to take advantage of this feature!

To tailor this newsletter to your needs, I welcome your feedback. Please email me with any suggestions, requests for future content and submissions for our “Ask the Expert” column (see page 3).

Rachael Halligan, MD FCFP
Regional Primary Care Cancer Lead
Waterloo Wellington Regional Cancer Program

Breast Screening Guidelines: Should screening begin at 40?......50? Or screen at all?

The landmark mammographic breast screening trials were 20-30 years ago. These were randomized control trials in which women were split into groups of intent to screen and not to screen. (Note these didn’t actually indicate if the women were actually screened in the intent to screen group, and in the unscreened group, they weren’t invited to screen but may have had mammography during the course of the study). Multiple metaanalysis have shown there is a mortality benefit in these trials in women aged 40-84 of 21%.

Several studies have actually looked at women who were screened (had a mammogram) versus women who didn’t have a mammogram (often case control studies), and the mortality benefit of mammography for women age 40-84 in this type of study is almost 50%.

There are confounding variables, such as improved treatments during this time period and marked improved technology. In addition, the set up of the randomized control trial minimizes the positive effect of screening mammography and there is evidence to suggest that screening mammography may be more effective in the clinical setting than in the RCT.

However, currently there is a lot of press about the harms of screening which include the anxiety surrounding false positives and overdiagnosis.

Mammography has been shown to have benefit in multiple trials. Participating in an organized screening program, allows up to detect cancers early when they are smaller and before they have metastasized. This allows improved treatment options including less toxic chemotherapy treatments and less morbid surgery.

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Save the Date / New Initiatives

My CancerIQ - Two new cancers launched on Feb 4, 2016 (see pg 3)

10th Annual Oncology Conference Gala - Wednesday, April 6, 2016, Whistle Bear Golf Club (for registration info, contact diane.stephenson@grhosp.on.ca)

Advance Care Planning Day - April 16, 2016

3rd Annual Cancer Care for Primary Care Conference - Wednesday, October 26, 2016

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False positives are a reality of screening mammography. 5-10% of women are recalled from mammography for further assessment. In 90% of these women, the finding will be resolved from an extra mammogram and US and return to screening. This does cause anxiety but otherwise, the risk is minimal from the extra imaging. Image guided breast biopsy is a straightforward extremely low risk procedure. Some of the “false positives” can also provide important risk information such as atypical lesions or LCIS. A very small percentage go on to excisional biopsy however it is not very common and its often for atypia on core biopsy (which would be considered a false positive, but a clinician would consider a lesion) that has a high chance of being upgraded to a more aggressive lesion at surgery.

In terms of overdiagnosis, there is a lot of research into better directing treatment type to specific types of cancer. However, at this time no pathologist or oncologist are able to identify which tumors are indolent and which ones aggressive and all would recommend treating all identified cancers. In the future, I feel that there will be better testing of tissue samples which will allow us to better target treatments for different tumour types.

Why age 50? Most research indicates breast cancer incidence and prevalence increases in women starting at age 40. However, studies have shown that biennial screening at age 50 allows the most cancers diagnosed per mammogram. It’s a cost benefit ratio. Starting earlier and annually does allow more cancers to be diagnosed earlier with less interval cancers.

American cancer society recently changed their guidelines to recognize the harms of screening and allow more women more choice. The new guidelines state women aged 40-44 should choose whether to start screening and annual screening should begin at 45. Women over 55 should have annual or biennial screening. There is a recognition of the harms of screening and the updated recommendation give women the choice to start screening at 40 or 45. I don’t think this is a huge shift in recommendations from previous (women begin annual screening at age 40), nor do I think this will change the Ontario Breast Screening Program (OBSP) - biennial screening for women between ages of 50-74. The OBSP bases its guidelines on the Canadian Preventative Task force. The Canadian Association of Radiology recommends women begin annual screening at age 40, and annual or biennial screening from 50-74 if they are in good health.

The OBSP has been an effective program for our population and mortality from breast cancer in women aged 50-74 has improved 37%. There are real risks from screening but to be honest, I feel the CPT guidelines over emphasize the harms of screening and minimize the benefits of screening. Having an effective screening program in our province is a major public health accomplishment which shouldn't be minimized.

Women should have a discussion with their family doctor about the risks and benefits of screening mammography and whether they would want to begin screening before 50 or continue after 74.

Samantha Fienberg MD FRCP<br>Regional Lead for Breast Imaging<br>Radiologist, Grand River Hospital<br>Adjunct Professor, McMaster University

Conference Gets Rave Review by the Audience in the House

The 2nd annual Cancer Care for Primary Care conference was a great success on September 25, 2015 with Stratford as its backdrop. The event drew primary care providers and allied health professionals from Waterloo Wellington and South West regions, who provided rave reviews.

The focus this year was on palliative care, with interactive presentations on topics that included “Prostate Cancer: To Screen or Not To Screen”, “Even At the Turning Of The Tide”: The Changing Face Of Palliative Care, and “We Have Seen Better Days: A Pain and Symptom Management Case Study”. Before the curtain call, a keynote address about the current state of palliative care was shared by Andre Picard, The Globe & Mail’s public health reporter and columnist. Presentations from the conference can be watched at http://ow.ly/YEZlx

Stage crew from the Waterloo Wellington and South West Regional Cancer Programs are planning the next conference on Wednesday, October 26, 2016. Mark your calendars, and stay tuned for details.

SAR Update

Did you know you can get accurate and up-to-date information on your patient’s cancer screening activity through an online portal?

The Screening Activity Report from CancerCareOntario allows you to conveniently access your patient’s cancer screening history quickly and easily – and now the reports will update every month meaning your information is more accurate and up-to-date than previously possible and easier to corroborate with the data from your practice’s EMR.

Contact your local Registration Authority, Amanda Hertel at 519-749-4370 ext. 6977 to book a 15 minute appointment to get your practice registered for the SAR and start better managing your patient’s cancer screening data.
Dear Expert: I recently ordered a mammogram plus ultrasound for one of my 50 year old patients. However, ultrasound wasn’t performed. Is there ever an indication for breast screening ultrasound?

Dear Primary Care Provider,

Thank you for your question. Breast ultrasound (US) is an invaluable tool for a breast imager. It characterizes masses, can help us confidently identify cysts and is an important modality for biopsy planning. When used in conjunction with mammography, there is a high sensitivity and specificity.

Diagnostic breast US differs from screening, in that the imager is focused on a certain area of the breast either a clinical (i.e., palpable finding) or based on mammogram. It is a very targeted exam with high sensitivity and specificity. The radiologist can have a high confidence in the interpretation of the exam. Often subtle lesions can be visualized due to the high pre-test probability based on the mammographic findings or clinical findings.

There have been some studies showing that screening ultrasound does pick up a small amount of cancers in addition to mammography. These studies involve often one or two principle investigators, usually radiologists at academic centres, who do a very high number of screening exams.

However, recent studies which have been born out of the American legislation, mandating women be notified and offered further testing for dense breasts, mammography, there is a very high call back rate (up to 30%) which also leads to high rate of serial follow up and biopsy. Breast biopsy is a straightforward low risk procedure but should be used judiciously.

When done at our institution, bilateral whole breast US is a 45-60 minute examination. Mammography is 5-10 minutes. Mammography has an acceptable callback rate (5-10%) with a low rate of unnecessary biopsy. Mammography is the only screening tool that has been shown to reduce mortality from breast cancer in large blinded studies.

Women who are high risk for breast cancer (>25% lifetime risk) and cannot have MRI are recommended to have US in addition to mammography. Otherwise, the OBSP (Ontario Breast Screening Program) does not recommended bilateral breast US for screening in most average risk women.

Breast US is an integral part of our practice. However, based on current evidence, bilateral breast US for screening may do more harm than good in average risk women.

Samantha Fienberg MD FRCPC
Regional Lead for Breast Imaging
Radiologist, Grand River Hospital
Adjunct Professor, McMaster University

New Symptom Management Guides for Your Patients

Cancer Care Ontario has developed a series of symptom management guides for patients, families and caregivers to help manage cancer-related symptoms. The two newest guides available are on fatigue, and nausea and vomiting.

For a complete list of all resources, please check out the guides at www.cancercare.on.ca/symptoms

Two New Cancers Added to My Cancer IQ

Two new cancers - kidney and melanoma - will be launched to the www.MyCancerIQ.ca online cancer risk assessment tool on February 4, 2016 - on World Cancer Day.

A launch and awareness plan for My Cancer IQ will be rolled out across Ontario, with a media blitz on February 4.

HR Changes at Grand River Regional Cancer Centre

Dr. Mario Valdes - joined the GRRCC team as a Medical Oncologist. Currently practicing as a locum in both the inpatient and outpatient setting.

Dr. Karen Lumsden - joined the GRRCC team as a Medical Oncologist when Dr. Carolyn Campbell retired.

Dr. Joanna Graczyk - joined the GRRCC team as a Haematologist when Dr. Carolyn Campbell retired.

Dr. Sara Leonard - joined the GRH inpatient oncology team as a General Practitioner.

Lia Kutzscher - Nurse Practitioner on the GRH inpatient oncology team.
E-Learning Modules
Reminder - Online Mainpro Courses Available Free of Charge
Enrich your professional development by completing e-learning courses offered by Cancer Care Ontario. Visit https://elearning.cancercare.on.ca

Cancer Screening Courses (Mainpro-M1) - provides an overview of Ontario’s breast, cervical and colorectal cancer screening guidelines, including the limitations and benefits of screening

Aboriginal Relationship and Cultural Competency Courses (Mainpro-M1) - enhances your knowledge of First Nations, Inuit and Metis history, culture and health landscape to improve health outcomes and person-centred care

Motivating Patients to get Screened Through Physician-Linked Correspondence
Cancer Care Ontario is inviting all patient enrollment model (PEM) physicians across Ontario to enroll in an important initiative to help motivate your patients to get screened for cancer.

As Primary Care Practitioners (PCPs), we have significant ability to influence our patients’ participation in cancer screening. Research has shown that patients who receive a personal recommendation from their PCP are more motivated to get screened for cancer than those who do not. Results of a two-phase pilot study conducted by the Colon-CancerCheck (CCC) program, demonstrated that physician-linked correspondence is an effective way to motivate eligible Ontarians to get screened for cancer.

PEM physicians can enroll by completing a consent form available at www.cancercare.on.ca/pcresources. Consent will apply to all three cancer screening programs, which means physicians will not need to re-enroll when physician-linked correspondence expands to breast and cervical cancer screening in the future. Upon enrollment, screen-eligible patients will receive CCC letters (invitations, recalls and reminders) that include their physician’s name, starting in February 2016.

Colorectal Screening Questions?
Have you ever wondered about when to restart average risk colon cancer screening after a negative colonoscopy?

Cancer Care Ontario has been sending out patient correspondence after average risk screening. The current recommendation from Cancer Care Ontario to restart screening after a normal colonoscopy reads as follows:

“If you had a colonoscopy because of an abnormal FOBT and your colonoscopy was normal (no abnormalities found), ColonCancerCheck recommends that you start screening again in 10 years using the FOBT.”

To view the entire patient letter, please visit http://bit.ly/1OZTyzS

UW LIVING-FIT For Your Patients
The UW LIVING-FIT program is a six week, small group program for women undergoing hormone therapy for breast cancer. The focus is to encourage and empower participants to make healthy lifestyle changes. Our qualified staff at the University of Waterloo have experience working with women diagnosed with breast cancer and can adapt exercise to all levels.

What does the program include?
- Group sessions for 1-hour/week for 6 sessions
- Workbook and pedometer to aid and track progress
- Home-based resistance training program taught by our staff to ensure proper form
- Guidance on setting physical activity goals

There is no fee for this program. The only cost is parking at the University of Waterloo (discounted parking pass available).

Contact us with questions or to inquire about future sessions at:
Phone: (519) 888-4567 x 38058
Email: fitness@uwaterloo.ca
Website: www.uwfitness.uwaterloo.ca