

CANCER *talk*

CONNECTING WITH MANITOBA'S PRIMARY CARE PROVIDERS

ASK the Expert

Belynda Salter-Oliver, MD, CCFP



HAVE YOU SEEN THIS PATIENT?

A 48-year-old woman comes to your office feeling unwell. She has a history of metastatic melanoma for which she is on the immune checkpoint inhibitors (ICPIs) ipilimumab and nivolumab. She mentions for the last three days she has had nausea and vomiting with poor oral intake. She has had some generalized abdominal pain. Her last bowel movement was yesterday. She describes generalized weakness, fatigue and feeling lightheaded when she stands up. She denies fever; her temperature at home today was 36.8 C. She has no other significant comorbidities and is on no other medications.

On physical exam, she is pale and looks unwell, she is somewhat somnolent though is able to respond appropriately to questions. Her vitals are as follows: BP 88/56 sitting, BP 70/40 standing, HR 94 sitting, 110 standing, T 36.5, O2 sat 98%. She has normal heart sounds. No adventitious sounds are noted on respiratory exam. On abdominal exam bowel sounds are present, she has generalized tenderness, but no guarding or rebound. You have a glucometer available; her random blood glucose is 2.5 mmol/L.

You are understandably quite concerned and arrange for her transfer to the nearest hospital. Given her poor oral intake and vomiting you suspect she is dehydrated and will require IV fluids. While you are waiting, she mentions she went for her scheduled bloodwork prior to coming to your office today. You call the lab to see if the results are available. They are as follows: normal CBC; Na⁺ 128, K⁺ 5.0; Cl⁻ 95; urea 8;

creatinine 85; TSH 4.2; and cortisol 18.

You are concerned about a possible adrenal crisis and have her taken by ambulance to the nearest emergency. You notify the emergency of her presentation and findings. She receives IV fluids and dexamethasone 4 mg IV. Further blood tests confirm the low cortisol; her ACTH comes back elevated, consistent with primary adrenal insufficiency. She does well and is discharged home on oral hydrocortisone 20 mg am and 10 mg pm after a week in hospital.

Insofar as any auto-immune disease can potentially complicate the use of ICPIs, immunotherapy can cause various endocrinopathies. In adrenal insufficiency, the initial presentation may be nonspecific with symptoms of fatigue, dizziness, nausea, and abdominal pain. Patients may be hypotensive or have a postural drop. Biochemical abnormalities can include hyponatremia, hyperkalemia and hypoglycemia. Renal function, T4, TSH, and an am cortisol should also be checked. Obtaining an ACTH will help differentiate between primary and secondary adrenal insufficiency. In an unwell patient, such as the one described above it is also important to assess for underlying infections. For emergency therapy, in an adrenal crisis, it is best to give dexamethasone 4 mg IV so not to interfere with an ACTH stimulation test. If the diagnosis is already known hydrocortisone 100 mg IV can be given.

If you have questions regarding the work-up of suspected cancer or any other cancer-related questions, please contact The CancerQuestion Helpline for Healthcare Professionals

204-226-2262 or cancer.question@cancercare.mb.ca

Monday to Friday 8:30 a.m. to 4:30 p.m.



Pierre Plourde, MD FRCPC



UNTANGLING TUBERCULOSIS (TB) AND LATENT TB INFECTION (LTBI)

One in every four people on the planet has LTBI; there is a very large global LTBI reservoir. Tuberculin skin testing or interferon gamma release assay (blood test) are used to find hidden treatable reservoirs of asymptomatic LTBI that could fuel future TB outbreaks. LTBI testing is recommended only for individuals who have both a high risk of past or recent exposure to TB and a high risk of progressing to active TB disease, in addition to the absence of contraindications to the available treatments. LTBI testing is therefore primarily indicated for close contacts to a recently confirmed TB case, HIV infected persons, anticipated immunosuppression, hemodialysis, recent immigrants from high TB incidence countries, incarcerated persons, persons who inject drugs, and persons who are homeless. TB elimination in Manitoba will only be achieved after successful reduction of the LTBI reservoirs. Several primary care clinics in Winnipeg offer LTBI treatment including Klinik, BridgeCare, Access Downtown, and Access Fort Garry.

The diagnosis of active, potentially contagious TB disease requires a high index of suspicion for persons presenting with subacute or chronic pulmonary symptoms such as cough or hemoptysis in combination with constitutional symptoms (fever, night sweats, weight loss and fatigue) that might equally suggest a malignancy such as lymphoma. In Manitoba, anyone with an epidemiologic risk of TB (i.e., born and/or lived in a high TB incidence region such as a northern Manitoba First Nations community, or a person from the Philippines, India, or sub-Saharan Africa) who has lymphoma on the differential diagnosis should also have TB ruled out. Active TB disease can only be ruled out with acid fast bacilli (AFB) smears and TB cultures (of sputum or lymph node specimens). If active TB disease is strongly suspected or confirmed, consultation should be obtained from Chest Medicine (for respiratory TB in adults) or Pediatric Infectious Diseases (for TB in children) by calling HCS paging at 204-787-2071.



Sri Navaratnam, MBBS, PhD, FRCPC
President & CEO, CancerCare Manitoba



Tunji Fatoye, MD, CCFP
Head, Department of Primary Care Oncology

Urgent Cancer Care Clinic at CCMB

Urgent Cancer Care clinic (UCC) was established in November 2013 with a mandate to provide timely access to assessment, investigations, and treatment for patients experiencing complications from their disease and/or their treatment. Common presenting complaints include pain, fever, other infectious symptoms, dyspnea, limb swelling/redness, GI symptoms, skin reactions etc. We are not equipped to deal with emergencies such as cardiac, cerebrovascular, acute respiratory, severe hemorrhagic and skeletal emergencies (especially obvious fractures).

We have a same (or next) day appointment model. Patients, support persons or healthcare providers may call 204-787-8900 for an appointment and telephone triage.

Hours of operation are 8:00am to 4:30pm, closed on weekends and holidays.



E.J. Bow, MD, MSc., D. Bacteriol., FRCPC
Infectious Diseases & Hematology, CancerCare Manitoba



SARS-COV-2 VACCINATION OF CANCER PATIENTS: CONSIDERATIONS FOR THE NEAR FUTURE AT CANCERCARE MANITOBA

Cancer patients contracting SARS-CoV-2 infection are at higher risk for severe COVID-19 disease. Immunization of this vulnerable population is confounded by the lack of experience with COVID-19 vaccines in oncology. The published clinical trials specifically excluded patients with immune suppressing conditions such as cancer. Following a single COVID-19 mRNA vaccine dose, anti-Spike protein antibody seroconversion has been observed in only approximately one-in-three solid tumour patients and approximately one-in-ten patients with haematological malignancies. In contrast, almost all solid tumour patients and just over half of haematological malignancy patients have responded by 14 days following the second dose at day 21, respectively.

The National Advisory Committee on Immunization (NACI) has advised that the COVID-19 vaccine may be offered to individuals who are immunosuppressed and/or those who have an autoimmune condition if:

- a risk assessment deems that the benefits outweigh the potential risk for the individual and;
- Informed consent includes discussion about the absence of evidence on the use of COVID-19 vaccine in this population. (<https://www.canada.ca/en/public-health/services/immunization/national-advisory-committee-on-immunization-naci/recommendations-use-covid-19-vaccines.html#a7> publication date January 12, 2021)

The American Society for Hematology (ASH) and the American Society for Clinical Oncology (ASCO) have recommended that immunocompromised patients should receive vaccination if there is no contraindication, with timing varying depending on the degree and anticipated duration of immunosuppression.

Where the benefit outweighs the potential risk, a 2-dose mRNA COVID-19 vaccine may be considered for cancer patients who satisfy the age group recommendations and with informed consent, acknowledging the absence of evidence of safety and efficacy in this population.

Pending evidence-based recommendations for cancer patients, the most important protective strategies for patients, families, and household members are strict adherence to public health

guidelines focusing upon physical distancing, masking, and hand hygiene. COVID-19 immunization of families and household members in accordance with public health guidelines will provide vulnerable cancer patients with a circle of protection.

COVID-19 immunization planning for cancer patients is guided by a number of principles. However, vaccination at any time during patients' treatments may offer at least some protection against severe COVID-19, the following considerations notwithstanding.

Vaccine immune responsiveness is greatest before cancer therapy is initiated and least during and for at least 3 months after chemotherapy. Accordingly, the currently available vaccines, including the two-dose SARS-CoV-2 mRNA vaccines, and the Astra Zeneca adenovirus vector vaccine (available for patients 50-64 who meet the high-risk criteria) should preferably be started a minimum of 35-42 days prior to initiation of immune suppressive therapy in order to permit primary and booster IgG humoral and cellular T-lymphocyte responses. Otherwise, for optimal response immunization should be delayed until at least 3 months (6 months post B-cell antibody therapy) after end-of-treatment where possible. Further, consideration might be given to vaccine administration at any time under circumstances of inactive cancer, cancer in remission, or cancer requiring on-going therapy with minimal immune suppression (defined, in part, by absence of hypogammaglobulinaemia, and absolute neutrophil and lymphocyte counts of $1.0 \times 10^9/L$) when multiple sequential vaccine dosing schedules, such as the two-dose COVID-19 vaccines administered 3 to 4 weeks apart, may be more feasible. Since SARS-CoV-2 neutralisation antibody titres, like the endemic coronaviruses, may wane over time, a timely second vaccine dose may be particularly important for immune suppressed cancer patients. Moreover, on-going studies may inform a future recommendation for a third dose to enhance sustained responses for these patients.

CancerCare Manitoba Infection Control Services remains available to provide updates regarding the status of COVID-19 vaccines and guidance for specific cases.

UPCOMING VIRTUAL EDUCATION EVENTS

For more information, please contact Rhona Porter - rporter@cancercare.mb.ca

HPV Triage: Enhancing Cervical Cancer Screening in Manitoba

Join Dr. S. Kean, CervixCheck Medical Lead, on Friday October 22, 2021 from 12:00 – 1:00pm (central daylight time) for an interactive webinar about how the implementation of HPV Triage changes the cervical cancer screening pathway and primary care practice. To register visit <https://www.cancercare.mb.ca/screening/hcp>

Reminder to all Primary Care Providers

Cancer screening should continue during the COVID-19 pandemic. CancerCare Manitoba encourages primary care to facilitate cancer screening and follow-up in all eligible patients.

Your patients can continue to get a mammogram appointment or request an FOBT kit by calling 1-855-952-4325 or requesting online at <https://www.cancercare.mb.ca/screening/colon#testrequest>

- Continue to screening eligible patients for cervical cancer.
- All follow-up for abnormal screening results continues to occur in the healthcare system. See the Guidelines for Cancer Screening in Manitoba for more information available at https://www.cancercare.mb.ca/export/sites/default/screening/_galleries/files/getcheckedmb/g-hcp-guidelines.pdf

For more information, visit <https://www.cancercare.mb.ca/screening/hcp>

We need your help!

The Department of Primary Care Oncology recognizes the current schedule of CME sessions may not accommodate for busy clinic schedules. To better understand the needs of Primary Care Providers, we are reaching out to determine interest and availability for attending education sessions outside typical business hours. To help us with our planning, please consider completing this [brief survey](#).

Link: <https://www.surveymonkey.com/r/WF6LDNM>

PROVINCIAL CANCER REFERRAL & NAVIGATION SERVICES (PCRN)

CCMB CENTRAL REFERRAL:

NEW: Toll Free 1-844-320-4545

FAX: 204-786-0621

M-F, 0830-1630, closed Stat Holidays

Emergency Referrals:

HSC PAGING: 204-787-2071

ST. BONIFACE PAGING: 204-237-2053

CONTACT US!

REGIONAL NAVIGATION SERVICES:

Winnipeg Navigation Services: 1-855-837-5400

Interlake Eastern: 1-855-557-2273

Prairie Mountain Health: 1-855-346-3710

Southern Health-Sante Sud: 1-855-623-1533

Northern Health: 1-855-740-9322

DEPARTMENT OF PRIMARY CARE ONCOLOGY COMMUNITY ONCOLOGY PROGRAM CANCERCARE MANITOBA

204-784-0223 or 204-784-0224

MEDICAL & RADIATION ONCOLOGISTS & HEMATOLOGISTS

FOR PRIMARY CARE PROVIDERS

Need to contact an Oncologist?

PLEASE NOTE THAT ALL PERSONAL PAGERS HAVE BEEN DISCONTINUED.

PLEASE USE HOSPITAL PAGING TO CONTACT AN ONCOLOGIST.

HSC PAGING: 204-787-2071

ST. BONIFACE PAGING: 204-237-2053

WELCOME TO CANCERCARE



Effective February 16th, 2021, Dr. Brett Houston joined the Section of Haematology/Oncology, Department of Internal Medicine and the Department of Medical Oncology and Haematology at CancerCare Manitoba. Dr. Houston completed her Hematology training in 2018 and recently completed the Clinician Investigator Program at the University of Manitoba. She is currently completing her PhD in Pharmacy with a focus on clinical pharmacoepidemiology and clinical trials. As a Hematologist and Clinician Investigator, Dr. Houston will focus on myelodysplastic syndromes and transplant ineligible AML.