

CANCER *talk*

CONNECTING WITH MANITOBA'S PRIMARY CARE PROVIDERS



Message from the CEO

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

INVESTMENT IN CANCER CARE

It was my pleasure to bring greetings at the Cancer Day for Primary Care in May. My congratulations to CCMB's Primary Care program who developed this full day of learning. I greatly appreciate the opportunity to share some of CCMB's activity through this newsletter. We could not provide cancer services without you. Primary care providers are critical players in cancer control from prevention, diagnosis, treatment, survivorship, and end-of-life care. CCMB is advancing its cancer screening technologies as highlighted within these pages; your participation is key to bringing these new advances to Manitobans.

As the numbers of cancer cases continue to rise and the number of Manitobans with cancer increases, ensuring the sustainability of cancer services through investment is critical. We are at an exciting juncture where we are investing in (i) recruitment and development of our staff including cancer specialists and researchers, (ii) increasing our infrastructure capacity through capital projects, and (iii) improving the patient experience.

CCMB's *Early Works and Immediate Needs* addresses our immediate capacity needs. On approval of funding, we are working with government on these projects which will allow for increased capacity through expansion and/or renovation at several CCMB sites; at MacCharles, VGH,

Grace Hospital and in Brandon at the Western Manitoba Cancer Centre. We are grateful for these opportunities and look forward to enhancements at these sites. We are also fortunate to be part of the HSC/UofM Campus Master Plan which will include additional new space for CCMB MacCharles site.

Increased capacity at CCMB sites will facilitate the expansion of CCMB's patient support programs to more CCMB sites, including Brandon. This means more patients will be able to access support closer to home when they need it most. This impacts a positive patient experience which is critical to cancer outcomes. We are very excited about this development.

CCMB is very fortunate to have a Research Institute; we know that research and innovation are foundational to the care we provide and to further advance care. CCMB's research will be further strengthened through a rebuild of the research laboratories, bringing in new technologies and equipment, and reinforcing efforts in researcher recruitment. We are very grateful to CancerCare Manitoba Foundation for their investment in both research and patient support programs.

By all of us working together, we can bring better cancer control to Manitobans.

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.



Dr. Sarah Kean
CervixCheck Medical Lead

CAN MY PATIENT SCREEN FOR CERVICAL CANCER AT HOME?




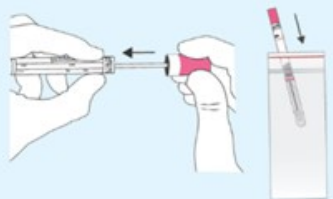
In some cases, yes.

CancerCare Manitoba's CervixCheck is collaborating with the Canadian Partnership Against Cancer (CPAC) to increase cervical cancer screening during the COVID pandemic. The purpose of the project is to increase cervical cancer screening participation among those who are at least two years overdue for screening. Instead of seeing their healthcare provider for a Pap, individuals are invited to complete a cervical cancer screening kit at home to test for high-risk human papilloma virus (HPV). High-risk HPV can cause cervical cancer.

Who is eligible?

Individuals aged 30-69 who have not had a Pap test in at least five years have been randomly selected to participate. Fifteen thousand eligible individuals have been sent a letter from CervixCheck. Patients cannot self-select for this project. Half of the individuals are sent a kit to complete self-collection at home. The other half of the individuals are sent a letter inviting them to request a kit from CervixCheck. Here is a sample excerpt from the bilingual cervical cancer screening kit instructions:

3. Collect sample. Prélevez l'échantillon.

 <p>Hold at red line. <i>Tenez l'écouvillon en plaçant les doigts sur la ligne rouge.</i></p>	 <p>Insert into vagina up to the red line. <i>Insérez l'écouvillon dans le vagin jusqu'à la ligne rouge.</i></p>	 <p>Turn four times. <i>Tournez quatre fois.</i></p>	 <p>Snap shut. Put into bag. <i>Fermez le flacon en pressant. Rangez le flacon dans le sac.</i></p>
--	---	--	--

Just like with HPV test used to triage patients to colposcopy (launched March 2022), the cervical cancer screening kit tests for:

- › HPV type 16
- › HPV type 18
- › HPV type other (12 other types of high-risk HPV)

If any of these HPV types are detected, the result is positive, and the patient will be referred for colposcopy. CervixCheck will facilitate the colposcopy referrals and maintain communication with the patient's healthcare provider.

To learn more, visit [CervixKit.ca](https://www.cervixkit.ca)

Stay informed about cancer screening guidelines, resource updates, and education opportunities; sign-up for e-news at <https://www.cancercare.mb.ca/screening/enews>.

If you have questions regarding cancer screening email screening@cancercare.mb.ca



Dr. Ross Stimpson
ColonCheck Medical Lead

FIT FOR COLORECTAL CANCER SCREENING

CancerCare Manitoba is excited to announce that in the near future, the gFOBT will be replaced with the more accurate fecal immunochemical test (FIT). The FIT has a higher sensitivity for cancer and precancerous adenomas, and an increased cancer detection rate within the population compared to the gFOBT. It is also a 1-sample test that is easy to use, and other jurisdictions have shown that there is increased screening participation with the FIT compared to the gFOBT.

Due to its accuracy, FIT will be used to:

- › screen individuals at average risk of CRC, as well as
- › individuals with a prior diagnosis of low-risk adenomas and
- › individuals with a slightly increased risk for CRC due to family history, in keeping with new [ColonCheck guidelines](#) for screening and surveillance.

As we work towards full FIT implementation, we look forward to sharing resources and news with you.

In support of reducing the current colonoscopy waitlist, a new project was recently launched to expedite the interim use of FIT. During this short period, the FIT will be offered to eligible elective colonoscopy cases that meet the above screening guidelines. Additionally, all incoming eligible elective cases will be diverted to FIT at the time of colonoscopy referral intake.

We are proud to share this news with you and will be updating our screening website as we get ready for full FIT implementation. Visit our website or sign-up for e-news to be notified of any changes at <https://www.cancercare.mb.ca/screening/enews>.



Dr. James Bras
Lung Cancer Screening Project
Medical Lead

THE IMPORTANCE OF LUNG CANCER SCREENING AND UPDATES ON CANCERCARE MANITOBA'S LUNG CANCER SCREENING PROJECT

Lung cancer causes 23% of all cancer deaths in Manitoba and causes more deaths annually than colorectal and breast cancer combined. Lung cancer is often asymptomatic until it reaches advanced stages and 47% of lung cancer in Manitoba is diagnosed at Stage IV. Detecting lung cancer early is a critical step in improving lung cancer mortality.

The National Lung Screening Trial (2011) and the NELSON trial (2020) demonstrated reductions in lung cancer mortality with the use of low-dose computed tomography (CT) screening. There is now enough evidence of efficacy with low dose CT that there is a global movement toward programmatic lung cancer screening, with many Canadian and international jurisdictions implementing or working towards organized programs.

The Canadian Partnership Against Cancer funded CancerCare Manitoba for the pre-implementation activities needed for a provincial lung cancer screening program. While there is currently no organized program in Manitoba, work is underway on all areas of the screening pathway, from public awareness and education to screening and diagnosis, to evaluation and monitoring.

An organized lung screening program should have several important and unique components. The program has to select the population by determining their risk, using a set of validated eligibility criteria, and help them understand this in the context of screening. Those who are eligible will be scheduled for a low-dose CT and be referred for smoking cessation, if needed. The low dose CT scan will use a specific protocol and findings will be interpreted and audited by specially trained radiologists. Any lung cancer-related findings will be managed by the program to minimize burdens for primary care providers.

Lung cancer screening is a dynamic field and we are designing a program that can respond to the expected evolution of evidence and practice. Sign-up for e-news to stay informed about lung cancer screening in Manitoba <https://www.cancercare.mb.ca/screening/enews>.

Bryan W. Janzen, MD
PGY-5, Radiation Oncology

DEVELOPMENT OF GUIDELINES FOR ADVANCED HEPATOCELLULAR CARCINOMA AT CANCERCARE MANITOBA

At CancerCare Manitoba, the Clinical Practice Guidelines Initiative was developed to improve patient outcomes through the development of guidelines for the management of common clinical diseases. Hepatocellular carcinoma (HCC) incidence has been rising over the past 3 decades and current modelling predicts a continued upward trend. Non-surgical management of advanced HCC was focused on for this guideline document as this is a patient population found to be underserved in Manitoba, with our 5-year survival rates lagging behind the national standards. HCC is known to be a complex disease requiring complex multidisciplinary management due to both the poor function at baseline and also due to the multiple therapeutic options available for treatment.

The guidelines were developed with input from Radiation Oncology, Medical Oncology, Surgical Oncology, Family Physician in Oncology, Hepatology, Pathology, Radiology, and a Clinical Operations Specialist. Multiple external guideline documents were reviewed, including guidelines from CancerCare Ontario (CCO), and were refined and updated with the most recent data. Our patient population of interest was limited to adults (18 years or older) with advanced HCC defined as Barcelona Clinic Liver Classification (BCLC) Stage B and higher who are not candidates for transplant or surgery. Questions were generated to conduct the literature search and guidelines were created. Each question and recommendation are summarized below.

1. Transarterial Chemoembolization (TACE) vs. other Local Therapies

As there are many different local therapies available for the treatment of the liver itself, we sought to determine if any proved equivalent or more advantageous than the current standard of care (TACE). After an extensive literature review, we elected to adopt the COO recommendation stating that there is insufficient evidence to recommend for or against other therapies instead of TACE.

2. Combining TACE with External Beam Radiotherapy (EBRT)

Combining TACE with EBRT treatments was not addressed in the COO guidelines, and although there have been no randomized

trials comparing the addition of EBRT to TACE, multiple retrospectives matched analyses have been done showing the benefit of adding radiotherapy. The group therefore cautiously recommends treating with TACE followed by EBRT, particularly if the tumour is associated with a portal vein tumour.

3. What is the best 1st line of systemic therapy for advanced HCC

Following the publication of the IMBrave 150 trial, the combination of atezolizumab and bevacizumab has been recommended to be the first-line therapy in advanced HCC. If there are contraindications to this, then sorafenib or lenvatinib can be used as an alternative.

4. What is the best 2nd line of systemic therapy for advanced HCC

Following progression on first-line systemic therapy (atezolizumab and bevacizumab), they could be trialled on a tyrosine kinase inhibitor (TKI) such as sorafenib or lenvatinib. If they received a TKI as first-line therapy, then they could be considered for any of cabozantinib, regorafenib, or ramucirumab.

5. What is the benefit of eradicating viral hepatitis (HCV / HBV) in patients with advanced HCC

As there was no new data regarding HBV since the publication of the COO guidelines, we agreed with the recommendation that hepatitis B surface antigen-positive patients should be treated as it prevents reactivation of HBV. Treatment of HCC with direct antiviral agents (DAA) remains controversial, but recent retrospective data is suggesting a survival advantage for treating with DAA therapy.

These guidelines have been compiled into a document that is undergoing external review. Following this, the document will be ratified and added to the clinical guidelines for practice. The completed document (once published) will be available on the website, along with other disease site guidelines, at <https://www.cancercare.mb.ca/For-Health-Professionals/treatment-guidelines-regimen-reference-orders>.



@CancerCareMB



@CancerCareMB

www.cancercare.mb.ca