Cancer Talk

Connecting with Manitoba's Health Professionals

Issue 9, Fall 2009

Screening for Prostate Cancer:

Making Sense of New Evidence

Two large, long awaited PSA screening trials reported in the same March 26, 2009 edition of the NEJM and, disappointingly, they don't come to the same conclusion! To help us make sense of this important research, we present a summary of the two trials, and the analysis of Dr. Piotr Czaykowski, a noted medical oncologist specializing in GU cancer at CCMB.

Trial	ERSPC (European)	PLCO (USA)
Subjects	77,000 men age 55-69	162,000 men age 55-69
Intervention	PSA every 4 years vs Control	Annual PSA/DRE vs Usual Care
PSA Cutoff	Various: Most 3.0 ng/ml	4.0 ng/ml
Median Follow-Up	9 years	11.5 years
Compliance	82% had ≥ 1 screen	85% in Screening arm screened 40-52% in Usual Care arm screened
Outcomes		
• No. of cancers diagnosed	• 5990 (8.2%) Screening vs 4307 (4.8 %) Control	• 2820 cases (Screening) vs 2322 (Usual Care): Rate ratio =1.2, Significant
• Deaths from prostate cancer	• 214 (Screening) vs 326 (Usual Care): Rate Ratio 0.80, p=0.04	• 50 (Screening) vs 44 (Usual Care): Rate ratio = 1.1, Not significant
• PPV of an elevated PSA for cancer	• 24%	
• To prevent ONE prostate cancer death	• 1410 men screened • 48 men treated	

These two studies may well sound the death knell for population-based **PSA** screening for prostate cancer. Both studies essentially present results of interim analyses. One study (PLCO, a homogeneous American study) is negative, with a suggestion of harm from screening; the other (ERSPC, a "pragmatic" study comprised of collated data from several similar but not identical European studies) is only equivocally positive, and yields a large "number-needed-to-treat" which has yet to be put in context with cost, and quality of life information.

Dr. Piotr Czaykowski

It is well recognized that prostate cancer is particularly susceptible to over-diagnosis and over-treatment, which raises the bar for any screening test to prove its value. Over-diagnosis refers to the fact that many prostate cancers never become clinically meaningful in the patient's lifetime. By definition, treatment of such cancers is "over-treatment". Over-diagnosis of prostate cancer is felt to occur in as many as 23-43% of men diagnosed through PSA-screening[1].

Taken together, these studies do not convincingly demonstrate that PSA-based population screening provides a meaningful reduction in prostate-cancer specific mortality. Neither dispels the

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Announcements

Community Cancer Care 2009 - Sept 25-26,2009

Plan on attending this year's conference in Winnipeg aimed at rural and urban health professionals interested in cancer care.This year features a lung cancer panel, a look at how patients and health care workers can navigate the sometimes difficult transitions from active treatment to palliative and supportive care, and other informative sessions. **Dr. David Kuhl**, author of "What Dying People Want" will be doing a pre-conference workshop as well as an evening presentation aimed at helping health care professionals learn how to take care of themselves, to better be able to look after their patients. Go to **www.cancercare.mb.ca/educationandtraining** to register.

Training Opportunities in Cancer Care

The Community Cancer Programs Network (CCPN) and Uniting Primary Care and Oncology (UPCON) CCMB is pleased to offer **Community Cancer Care scholarships** designed for health professionals affiliated with Community Cancer Programs (CCPs) and for family physicians and nurse practitioners in primary care practice.

This is *YOUR* opportunity to pursue **one to two weeks of individualized study / training** in the care of patients with cancer or blood disorders. This training is eligible for Mainpro - C or other professional development credits.

Supported by **CancerCare Manitoba Foundation,** recipients will receive an honorarium and other expenses may be funded with prior approval.

For more information, please contact Evelyn Leferink at 787-1347 or evelyn.leferink@cancercare.mb.ca or go to **www.cancercare.mb.ca**

Applications close **October 9, 2009**

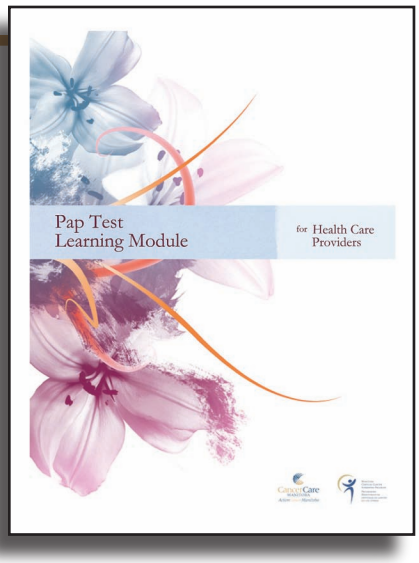
Congratulation to the 2008-2009 CCMF Scholarship winners!

The 2008-2009 Primary Care Scholarships, funded by the CancerCare Manitoba Foundation, were awarded to two primary care providers to enhance their knowledge and skills in cancer care.

- **Jane MacDonald, NP,** a nurse practitioner at the Corydon Primary Care Clinic, will be spending two weeks this fall with several oncologists and haematologists at CCMB with a focus on the clinical presentations of common cancers, diagnostic work-up and minor procedure skills.
- **Dr. Tim Ross,** a family physician at Family Matters Medical Centre in Winnipeg, will be spending one week this fall with the WRHA Palliative Care program. He will also spend time with supportive care professionals and several oncologists to enhance knowledge on the clinical presentations of common cancers, diagnostic work-up and minor procedure skills.

Both scholarship recipients look forward to applying their knowledge and skills in caring for patients with cancer, and sharing their "newly acquired" knowledge with colleagues when they complete their training. See *Announcements* at left for information about this year's scholarships.

New Pap Test Learning Module Increases Access to Service in Manitoba



The Manitoba Cervical Cancer Screening Program (MCCSP) has a new resource for health care providers - **The Pap Test Learning Module**. This free, online document is accompanied by a DVD, both illustrating practical "how-to" skills and management components of cervical cancer screening in Manitoba.

The MCCSP Pap Test Learning Module is for health care providers seeking to become competent in cervical cancer screening. The module also functions as a teaching tool for physicians and nurses seeking to facilitate the training of other health care providers to perform Pap tests.

"This resource is our new 'bible' for the MCCSP," says Kim Templeton, Program Manager. "We hope that by providing a standardized provincial document we will support grassroots clinical training initiatives, using local expertise to facilitate Pap test competency.

All components of the MCCSP Pap Test Learning Module for Health Care Providers are available online. Visit **EveryTwoYears.ca**

Mark Your Calendars!

The 6th **Annual Cancer Day for Primary Care** will be held on Friday, January 22, 2010 at CCMB. Topics include cancer anorexia /cachexia, cancer treatment vs. palliation, managing elevated PSA's and more! All family physicians, primary care nurses, nurse practitioners and other primary care providers are invited to attend. Registration forms will be on - line by early November 2009 at **www.cancercare.mb.ca/educationandtraining**

"I'm worried about getting breast cancer"

by Kim Serfas, Genetic Counsellor, Hereditary Breast and Ovarian Cancer Clinic and Katie Watters, Education Coordinator, MB Breast Screening Program

Breast cancer (BC) is the most commonly diagnosed cancer in women in Canada. So it is not surprising that women are concerned about getting it and are turning to their FP/NP for guidance regarding when to be screened. Most women who develop BC have no risk factors other than simply being female and aging (especially being over 50). Another major risk factor is a family history of the disease. By using a women's age and her family history of BC, one can estimate risk and recommend screening practices.

AVERAGE WOMAN'S RISK (11% lifetime risk)

- no family history of breast cancer or personal history of breast lumps requiring biopsy
- women can participate in the Manitoba Breast Screening Program (MBSP) at age 50 and are recalled every 2 years

LOW RISK (<25% lifetime risk)

- woman with a family history of one 1st or 2nd degree relatives with BC
- FP/NP discuss risks and benefits of mammography prior to age 50, and if appropriate refers to a diagnostic center for yearly mammograms (often at age 40)
- women 50 yrs and over will be recalled every two years by the MBSP but on request could be screened yearly

MODERATE RISK (greater than 25% lifetime risk)

- woman with a family history of two 1st or 2nd degree relative with BC diagnosed under age 60 or ovarian cancer any age
- women 50 yrs and over screened via MBSP are recalled for yearly mammograms; consider starting yearly mammograms at age 40 in a diagnostic centre.

HIGH OR INHERITED RISK (40-80% lifetime risk)

- women with strong family history of breast cancer such as:
  - two or more 1st/2nd degree relatives on the same side of the family with BC diagnosed < 50 years old, or ovarian cancer (any age)
  - one 1st/2nd degree relative with:
    - bilateral BC (first one before age 50) or
    - diagnosed with both breast and ovarian cancer
    - male breast cancer
- FP/NP should discuss referral for Genetic Evaluation for personalized risk assessment, screening and prevention recommendations

For further information visit the following websites:

1. MBSP - www.cancercare.mb.ca/home/health_care_professionals/screening/breast_cancer_screening/
2. GAIL Model Risk Assessment Tool - www.cancer.gov/bcrisktool/
3. WHRA Genetics & Metabolism program - www.wrha.mb.ca/prog/index.php and click on genetics
4. On-line breast screening decision aid for women age 40 to 49 (Australian) - www.mammogram.med.usyd.edu.au

Ask the Cancer Expert

Dr. Darrel Drachenberg
Urologic Oncologist
Chair of the GU Disease Site Group
Director of Research,
Dr. Ernest W. Ramsey
MB Prostate Centre

Question:

What are the next steps for a patient who has an asymptomatic 4 cm renal tumour on an abdominal CT scan?

Answer:

Kidney cancer comprises 3 percent of all cancers diagnosed in Canada with a 2.6:1 male predominance and up to 40% diagnosed incidentally. 45% are localized at time of diagnosis, however 25% are locally advanced and 30% are metastatic at diagnosis. Up to 5% of kidney cancers are hereditary in nature and we have a significant number of Manitoba patients with renal cancer syndromes. Kidney cancer is known as the "internists tumour".It usually persists with flank pain/mass and hematuria, but may also present with anemia, fever of unknown origin, hypertension, hypercalcemia, liver dysfunction and neuropathy.

A directed history and physical examination should be performed, questioning about symptoms from local and possible metastatic disease and family history of kidney cancer. Physical exam should include palpation for lymphadenopathy and abdominal and flank palpation. The workup would include CXR, LFT's, Ca, and Alk Phos, and the patients referred urgently to a urologist.

Renal biopsy is not routinely advocated for renal mass diagnosis because of the risk of bleeding, non diagnostic results, and the risk of seeding. One may consider biopsy in special circumstances such as an appearance of suggested lymphoma or with metastatic disease prior to treatment. Treatment would include laparoscopic or open "nephron sparing" (preferred) or radical nephrectomy. Up to 20% of these small lesions may be benign and patients should be informed of this. Surgery is advocated in the face of metastatic disease if the patient is fit and surgery is deemed possible, since a survival advantage is seen with removal of primary tumor followed by systemic therapies.

Where to find us

CCMB Referral Centre
(204) 787-2176
FAX: (204) 786-0621
Consult Nurse Clinician: (204) 787-4215
M-F, 0830-1630, closed Stat Holidays
Emergency Referrals:
HSC paging: (204) 787-2071
St Boniface paging: (204)237-2053
http://www.cancercare.mb.ca

UPCON Helpline
1 (204) 226-2262 (CCM-CCMB)
0830-1630 M-F; after hours page Oncologist on call

CancerCare Manitoba
Toll-Free Number 1-866-561-1026

Inquiry & Reception
MacCharles Unit (204) 787-2197
St. Boniface Unit (204) 237-2559
Health Records - Medico legal Correspondent:
(204) 787-2266 Fax: (204) 786-0185
Pharmacy: (204) 787-1902

Breast Cancer Centre of Hope
691 Wolseley Street (204) 788-8080
Winnipeg, Manitoba R3C 1C3
Toll Free 1-888-660-4866

Community Cancer Programs Network (CCPN)
16 Locations throughout Manitoba
(204) 787-5159
Toll Free: 1-866-561-1026

Manitoba Breast Screening
25 Sherbrook Street, Unit #5
Winnipeg, Manitoba R3C 2B1
(204) 788-8000:
Toll Free 1-800-903-9290
Brandon - (204) 726-2453

Manitoba Cervical Screening
25 Sherbrook Street, Unit #5
Winnipeg, Manitoba R3C 2B1
(204) 788-8626: Toll Free 1-866-616-8805

ColonCheck Manitoba
(formerly Colorectal Screening Program)
5 - 25 Sherbrook St.
Winnipeg, Manitoba
R3C 2B1
General: (204) 788-8635
Toll Free: 1-866-744-8961
Fax: (204) 774-0341

Dr. Ernest W. Ramsey Manitoba Prostate Centre
(204) 787 - 4461
FAX (204) 786-0631

Patient and Family Information and Resource Centre
(204) 787-4357

Patient and Family Support Services
(204) 787-2109

Patient Representative
(204) 787-2065

Other Numbers:
CancerCare Manitoba Foundation
787-4143
(Donations), Toll Free 1-877-407-2223

Canadian Cancer Society
Volunteer Drivers 787-4121
Cancer Information Service
(Toll Free) 1-888-939-3333

Grey Nuns Hostel
237-8941
151 Despins Street

Lennox Bell Lodge
787-4271
60 Pearl Street

Info for Health Professionals on our web site at www.cancercare.mb.ca

UPCON
Uniting Primary Care and Oncology

Prostate Cancer from P. 1

by Dr. Piotr Czaykowski

concern about over-diagnosis and over-treatment, and the many costs associated with these.

There are additional concerns about the false-negative rates with PSA screening. The Prostate Cancer Prevention Trial demonstrated that prostate cancer can be present at any PSA level, and even at low levels of PSA (<0.5 ng/ml), aggressive cancers can be found at biopsy[2]. Furthermore, even the PSA success stories, picking up an aggressive cancer at an apparently early stage, often prove overly optimistic when standard treatment subsequently fails.

Thomas Stamey, who first identified PSA as a serum marker for prostate cancer, has now come to the conclusion that PSA is primarily an indicator of prostate weight, reflecting the age-related increase in benign prostatic tissue, not prostate cancer. He has become an outspoken critic of PSA screening (3)[3].

Considerable effort is now being expended to find a better screening test for prostate cancer, one that will help reliably, inexpensively, and with low morbidity, identify clinically important disease at a potentially treatable stage.

Until such a test is found, should our health care system implement population-based PSA screening? I think the answer is no, despite the protestations of vested interest groups. PSA screening should still be discussed on an individual basis with patients, weighing the pros and cons for the individual, and considering what the patient would be willing to do with the results. For more info see the July/Aug edition of *Cancer* at **http://cajournal.org**

(Footnotes)

[1] Draisma, et al. J Natl Cancer Inst 2009 ; 101 : 374-83.

[2] Thompson IM et al NEJM 2004; 350: 2239-2246.

3 Stamey, TA. Prostate cancer: the last twenty years. In Prostate Cancer: Principles and Practice, pp 3-5. Ed. Kirby et al. Taylor and Francis. 2006.