Cancer Talk

Connecting with Manitoba's Health Professionals

Issue 15, Fall 2011

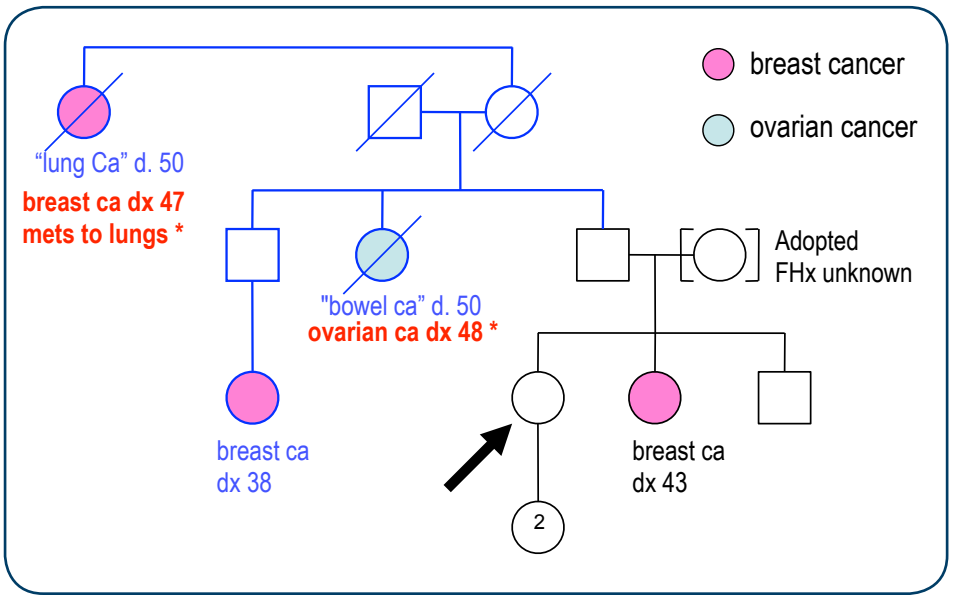
Spotting cancer risk: Take a careful FHx !

Kim Serfas, Genetic Counsellor, Hereditary Breast Cancer Clinic

Patricia Bocangel, Community Cancer Program Network

A positive family history is a risk factor for many chronic diseases, including cancer, as it reflects the influence of genetic susceptibilities, shared environment and common behaviors. Family histories taken in primary care are often brief, but like a review of systems, we need to know when more detailed questioning is needed. While taking a more complete family history takes time, it can be done over more than one visit and is a valuable tool in preventive medicine and in the identification of inherited risk.

It is estimated that only **5** to **10%** of all cancers are **hereditary**; that is, that mutations in specific genes are passed from one blood relative to another. Individuals who inherit one of these gene changes will have a higher likelihood of developing cancer within their lifetime. A detailed and accurate family history includes information on the patient's children, siblings, parents, aunts, uncles, nieces, nephews, grandparents, and first cousins on both sides of their family. Patients may not volunteer important medical information regarding their relatives because they think it is irrelevant, so it's important to ask!



A woman (↗) tells her FP that her sister has been diagnosed with breast cancer at age 43. The woman is concerned about her and her two daughters' risk of getting breast cancer. Genetics referral is initiated. During the consult, patient's FHx is expanded (in blue) to reveal more relatives with cancer on Dad's side. After pathology review, cancer diagnoses prove to be different and more concerning (in red*). The cancers seen in this family suggests Hereditary Breast and Ovarian Cancer Syndrome and gene testing may be helpful accessing this woman's risk of not only breast cancer but ovarian cancer as well.

It is crucial to know who in the family had cancer, what kind of cancer they had, age at diagnosis, and how closely they are related to your patient. The presence of the "red flags" listed in the table on page 4 may suggest the possibility of a **hereditary cancer predisposition syndrome** (ex. Colon Cancer Predisposition Syndromes – FAP or Lynch). The figure above is an example of the importance of obtaining information regarding **both** sides of the family and how a genetic assessment can clarify a patient's risk of cancer. In this case, the expanded family history suggests Hereditary Breast and Ovarian Cancer. Depending on the type(s) of cancers involved, specific surveillance or risk reducing options for patients may be

> ***"Patients may not volunteer important medical information regarding their relatives because they think it is irrelevant, so it's important to ask!"***

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Coming Up

Manitoba Blood and Marrow Transplant Program Symposium for Health Care Professionals

Friday November 4, 2011
8:30 a.m. to 4:00 p.m.
Norwood Hotel, Winnipeg

This symposium is for all health care professionals interested in blood and marrow transplants. This celebration of the 20th Anniversary of the Manitoba Blood and Marrow Transplant Program features keynote speakers: Dan Shapiro, Annette Shultz, Dr. Donna Wall, and a multidisciplinary team of clinical experts. Contact: Jennie at 787-4918, email jennie.pitura@cancercare.mb.ca.

Cancer Day for Primary Care

is a full day cancer education event that will be held on Friday, **January 27, 2012** at CCMB (675 McDermot Ave.) and in rural Manitoba through MBTeleheath. It's our 8th year, and all family physicians, primary care nurses, nurse practitioners and other primary care providers are invited to attend this terrific Mainpro-M1 accredited event. Watch www.cancercare.mb.ca/healthcareprofessionals for further information.

The Western Manitoba Cancer Centre in Brandon officially opened its doors on June 30th, bringing care closer to home for patients in the Westman area. The WMCC is now fully staffed in radiation therapy and has added support positions for the patients. To learn more about the WMCC, please visit www.cancercare.mb.ca

Pictured at the official opening are (from left) Mr. Brian Schoonbaert, Chief Executive Officer, Brandon RHA; Drew Caldwell, MLA, Brandon East; Premier Greg Selinger; Dr. Bashir Bashir, WMCC; Dr. Dhali Dhaliwal, President & CEO, CancerCare Manitoba; WMCC staff members.

New Physicians Join CCMB!

We would like to welcome the following new physicians to CancerCare Manitoba:

Dr. Versha Banerji
General Hematology (CLL)

Dr. Shantanu Banerji
Medical Oncology
(Lung & Sarcoma)

Dr. Vallerie Gordon -
Medical Oncology
(Head & Neck, GI, Breast)

CancerCare Manitoba is on Twitter

@CancerCareMB is the newest source of information on cancer services, prevention, care and treatment for CancerCare Manitoba. CCMB's Twitter account carries a steady stream of easily accessed information on CCMB, prevention and events. Through our followers and those we follow online, CCMB's messages reach right across North America.

It Matters to Them!

"It Matters to Them!" is a campaign to increase health care provider knowledge about screening for breast, cervical and colon cancer. Learn more about Manitoba's guidelines, get up to speed on what's new in screening, and understand how BreastCheck, CervixCheck and ColonCheck can help you. Register at GetCheckedManitoba.ca and start making the most out of your screening recommendations.

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Please ask, they'll tell:

Sexuality and Cancer Survivorship

Anne Katz RN PhD
Nurse Counsellor, Patient and Family Support Services, CancerCare Manitoba

Fact: 80% of cancer survivors have sexual issues related to treatment.

Fact: There are almost 1 million cancer survivors in Canada.

Fact: You have cancer survivors in your practice who have sexual problems that aren't being addressed.

Sexuality remains somewhat of a taboo in cancer survivorship care despite the statistics that show that these problems are real and that they affect quality of life and relationships. Health care providers wait for the survivor to raise the topic, and the survivor waits for us to ask them if they are having any problems in this area of their lives. The result is silence.

YOU can break that silence. A simple enquiry into how their sex life has been affected by the cancer and its treatment usually opens the door to at least one problem. The major issues for women are body image, loss of libido, vaginal dryness or atrophy, and to a lesser extent orgasmic changes. For men it is erectile difficulties, changes in orgasm, loss of libido, and body image. These changes are not restricted to the cancers usually associated with cancer of the sexual organs (breast, gynecological and prostate) but also to colorectal, hematological and many other cancers.

How do you break the silence? This simple model may help. The **PLISSIT** Model (Anon, 1974) offers a simple approach to dealing with sexual issues. All family physicians and nurse practitioners should be able to address the **P** and **LI** levels, most will be able to address the **SS** level, and referral for the **IT** level is available at CancerCare Manitoba.

Permission (P)
By asking about sexual function you give the survivor permission to talk about their issues.

Limited Information (LI)
Most survivors are looking for validation of their concerns. Acknowledge their experience. Indicate that the problem is a common one amongst cancer survivors.

Specific Suggestion (SS)
Some survivors need guidance on how to deal with the problem or a prescription of a medication that might help (e.g. vaginal estrogen or a PDE5-inhibitor)

Intensive Therapy (IT)
Dr. Anne Katz at CCMB (fax 786 0637; phone 787 4495) will see cancer survivors and their partners on referral from you.

Errata

In the previous issue of CancerTalk several references from Dr. Czaykowski's article on pancreatic cancer were inadvertently omitted.

[1] Canadian Cancer Society's Steering Committee: Canadian Cancer Statistics 2010. Toronto: Canadian Cancer Society, 2010
[2] Bilimoria et al Cancer 2007; 110: 738.
[3] Horton. Curr Concepts in Oncology 1989; 1: 37
[4] Burris et al. J Clin Oncol 1997; 15: 2403
[5] Moore et al. J Clin Oncol 2007 ; 25 : 1960
[6] Riess et al. ASCO Proceedings, 2007
[7] Conroy et al. N Engl J Med 2011; 364: 1817
[8] Neoptelemos et al. JAMA 2010; 304: 1073-1081.
[9] Neoptelemos et al. N Engl J Med 2004; 350: 12
[10] Oettle et al. JAMA 2007; 297: 267
[10] Jones et al. Science 2008; 321: 1801
[12] Hermann et al. Cell Stem Cell 2007; 1: 313

Ask the Cancer Expert

Dr. Piotr Czaykowski,
Medical Oncologist, CCMB

Question:

A 27-year-old male, otherwise well, reports that his right testicle feels uncomfortable. I am not convinced I can appreciate a mass in his testicle. What should I do?

Answer:

Testicular cancer is the most common cancer in young men. It generally presents as a painless testicular mass (within the testicular parenchyma). Occasionally there can be discomfort associated with it. This is often a rapidly progressive cancer, but is also highly curable, especially if caught early.

If you can feel a testicular mass in a young man, the most important step you can take is to pick-up the phone and speak personally to a urologist. Most urologists will see such a patient within 48 hours – certainly in less than a week. If the clinical suspicion is high, your patient will undergo an urgent orchiectomy for both diagnostic and, with luck, curative purposes. Note that percutaneous testicular biopsy is generally felt to be contraindicated.

If you cannot feel a mass, as in this case, assume the patient is right, err on the side of caution, and obtain an urgent bilateral scrotal ultrasound. The test will usually be done within 1-2 working days if you phone and indicate the reason it is needed (i.e. to rule out testis cancer). If the ultrasound is suspicious of malignancy, an urgent referral to urology is again indicated.

If your patient has testis cancer, he will need pre-operative tumor markers (alpha-fetoprotein, quantitative beta-HCG, LDH), and a peri-operative CXR and abdominal/pelvic CT scan, so if your level of suspicion is high, you could think about getting those tests organized.

Mammograms and the 40-something woman: What's best?

Katie Watters PHEc
Manager, Program Development & Education,
BreastCheck, CancerCare Manitoba

Recent media reports are yet again debating the benefits of screening mammography for 40 to 49 year old women. Those against screening cite over- diagnosis and false positives and they question the mortality benefit. Those in favour of screening cite lowered mortality, acceptability of false positive, and simpler treatment for screen-detected cancer in their argument. The Public Health Agency of Canada has an excellent resource that can aid clinicians and women in understanding the harms and benefits of screening called **Information on Mammography for Women Age 40 and Older: A Decision Aid for Breast Cancer Screening in Canada**. The resource presents the expected screening outcomes for women in three age groups: 40-49, 50-69 and 70-79. The numbers show that benefits outweigh harms for women age 50 to 69. BreastCheck at CancerCare Manitoba actively promotes in this age group and women 50 and older can self refer to the program.

Asymptomatic women in their 40's can also obtain a screening mammogram in Manitoba but require referral to a diagnostic center. The Decision Aid assists women to consider both the harms and benefits and to make an informed decision. The aid can be viewed or ordered from cancercare.mb.ca/breasthealthresources.

Symptomatic women of any age are always referred to a diagnostic centre.

Watch for new Guidelines on Screening for Breast Cancer soon to be released by the Canadian Task Force on Preventive Health Care at ctfphc.ca

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recommended. These recommendations rely on an accurate family history and thus patient care may be compromised if this information is not available. Studies have shown that patients routinely overestimate their risk of cancer. Review of their family history is an opportunity not only to identify which patients might benefit from a further genetic assessment, but it may also serve to dispel some of the misconceptions patients may have about their risk of cancer.

If you suspect that your patient's family history makes him/her at an increased risk for cancer, refer your patient to the WHRA Genetics and Metabolic Program for a genetic assessment. For further information contact our program at (204) 787-2494 or fax a referral to (204) 787-1419.

Table: Red Flags:
Family History Features Suggesting a Hereditary Cancer Predisposition Syndrome

- Multiple closely related individuals with cancer (of any type)
- Persons affected in each generation (autosomal dominant pattern)
- Early age of onset, examples:
  - Premenopausal breast cancer
  - Colon cancer < age 50
  - Uterine cancer < age 50
  - Prostate cancer < age 60
- Bilateral disease in paired organs
- Gastric polyps or multiple colon polyps (>10 polyps)
- More than one primary tumor
- Rare cancers or tumors, such as:
  - Male breast cancer
  - Ovarian cancer
  - Pheochromocytoma
  - Paraganglioma
  - Adrenal cortical cancer
  - Pancreatic cancer (<age 50, non smoker)
  - Diffuse gastric cancer
- Absence of occupational or environmental risk factors.

(adapted from Table 5.1 in Robin L. Bennett's textbook The Practical Guide to The Genetic Family History)

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