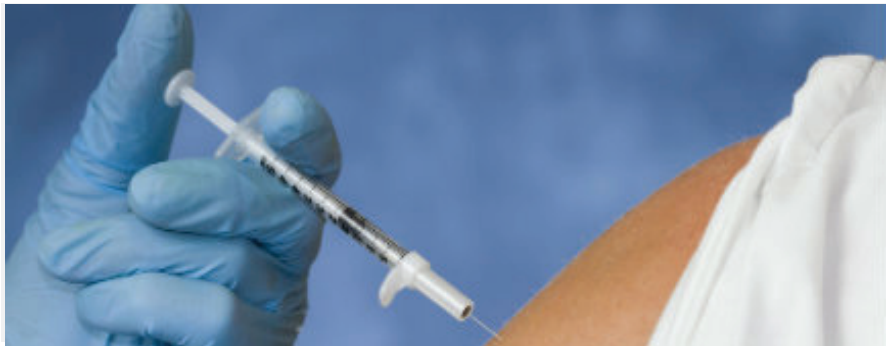
CANCER talk
› CONNECTING WITH MANITOBA'S HEALTH PROFESSIONALS
ISSUE 22› SPRING 2014

IMMUNIZATION OF ADULT CANCER PATIENTS

Dr. Eric Bow, DIRECTOR, INFECTION CONTROL SERVICES AND URGENT CANCER CARE, CANCERCARE MANITOBA



Many cancer patients are not protected against vaccine-preventable infectious diseases. The inactivated vaccines include the bacterial vaccines (tetanus toxoid, diphtheria toxoid, and pertussis vaccines - Tdap; the conjugate vaccines against Haemophilus influenza type B (Hib) and Neisseria meningitidis types ACYW (Men-C-ACYW-135), the pneumococcal vaccines (PNEUMOVAX-23®, PREVNAR-13®) and the viral vaccines against Polio, Influenza, Human Papilloma Virus, and Hepatitis A and Hepatitis B. The live vaccines include the Measles, Mumps, and Rubella vaccine (MMR); the Varicella vaccine (VARIVAX®); and the Herpes zoster vaccine (ZOSTAVAX®).

The influenza vaccine should be administered to all patients

Consider the inactivated vaccines for patients that are not current with recommendations for immunocompetent persons. The trivalent influenza vaccine should be administered to all cancer patients every autumn. Adult cancer patients who have never received the 23-valent polysaccharide pneumococcal vaccine (PPV-23, PNEUMOVAX-23®) should receive a single 0.5mL intramuscular dose of 13-valent conjugate pneumococcal vaccine (PCV-13, PREVNAR-13®), followed after at least 8 weeks by a single 0.5mL intramuscular dose of PPV-23, then in 5 years another 0.5mL intramuscular dose of PPV-23, plus another dose at age ≥ 65 years if at least 5 years have lapsed since the previous PPV-23 dose.

The live virus vaccines, including MMR, VARIVAX®, and ZOSTAVAX®, are not indicated for cancer patients receiving active immunosuppressive therapy;

CONTINUED ON NEXT PAGE

PAGE 1 CONTINUED

however, they may be considered for administration starting 3 or more months after completion of chemotherapy (and 6 or more months following anti-B-cell antibody therapy) among susceptible patients.

The shingles vaccine may be considered to prevent Herpes zoster and post-herpetic neuralgia for all adult cancer patients ≥ 50 years who are in remission and who have been free of any immunosuppressive therapy for at least 3 months and of any on-going T-lymphocyte deficiencies. The chickenpox vaccine may be considered for susceptible household contacts of susceptible immunosuppressed cancer patients prior to beginning chemotherapy.

Susceptible (not previously immunized) adult cancer patients should be offered a single 0.5mL intramuscular dose of Tdap-IPV, then Td-IPV in two subsequent 0.5mL intramuscular doses at 2 months and 6-12 months, respectively, from the initial dose, and then a single 0.5mL intramuscular dose every 10 years. Similarly, such patients should be considered for a single 0.5mL intramuscular dose of Hib conjugate vaccine.

WRHA BREAST HEALTH CENTRE LYMPHEDEMA PROGRAM

WRHA Breast Health Centre Lymphedema Program
100 – 400 Taché Avenue
Winnipeg, MB R2H 3C3
Phone: 204-235-3684 or 204-237-2034
Toll Free: 1-888-501-5219

The Winnipeg Regional Health Authority Breast Health Centre has a multi-disciplinary team of experts who specialize in breast health. The Centre's focus is serving women and men of all ages who have breast problems or signs and symptoms of breast cancer.

The team uses a client-focused approach that encompasses high quality care and state of the art equipment to ensure the best possible experience for clients. With a commitment to evidence based information, the latest, most accurate and most appropriate education, support and links are provided to clients at the Breast Health Centre.

The Breast Health Centre coordinates clinical assessment, diagnostic tests, treatment, education and support through a variety of specialized programs.

The Centre also provides treatment and management of upper body lymphedema as a result of breast problems. A physician's referral is required. There is no cost to the patient for this service.

The program includes: assessment and treatment of lymphedema; education about lymphedema and management, and axillary web syndrome; and nutrition, exercise and psychosocial services are also available.

What causes lymphedema?

Lymphedema can occur when sentinel and/or axillary lymph nodes and vessels are damaged or removed during surgery. Other risk factors include: radiation therapy; cording or axillary web syndrome; trauma or injury; infection; malignant tumour; immobility; and a Body Mass Index (BMI) over 25.

Signs and symptoms

Areas that could be affected are arm, hand, chest, armpit, and trunk. Patients can feel: swelling/fullness; heaviness; tightness; aching; and clothing/jewellery becoming tighter.

URGENT CANCER CARE AND CANCER HELPLINE FOR PATIENTS NOW OPEN

Patients experiencing acute complications of their cancer or their treatment can wait for many hours in a busy ER. With the opening on November 4th, the goal of the UCC and the Cancer Helpline is to reduce the number of cancer patients who must access care through hospital emergency rooms.

The UCC clinic has a multidisciplinary team which includes registered nurses, support staff, a nurse practitioner, a registered clinical assistant, oncologists, and family physicians with ER, oncology, and symptom control expertise.

The Cancer Helpline is available to answer questions and provide telephone triage and advice to patients. Cancer Helpline can be accessed 8am-5pm at 204-787-8900.

Urgent Cancer Care services may include, but are not limited to, clinical assessment, hydration, nausea and pain control, or antimicrobial therapy. The UCC is located on the first floor at CancerCare's McCharles unit at 675 McDermot Avenue –just follow the signs!

2013-2014 COMMUNITY CANCER SCHOLARSHIP WINNERS!

Dr. Michel Bruneau: Family physician, Pinawa Community Cancer Program hub

Dr. Nermeen Samir Hanna: Family physician, Pinawa Community Cancer Program hub

Dr. Michael Stephensen: Family physician, Assiniboine Clinic, Winnipeg

Ron Kozak: Pharmacist, Neepawa and Russell Community Cancer Program hubs

Cindy Funk: Psychosocial Oncology Clinician, Boundary Trails Regional Cancer Program hub – Southern Health - Santé Sud region

Kirsten Eskildsen: Psychosocial Oncology Clinician, Dauphin Regional Cancer Program hub

Susan Barnett: Oncology Social Worker, Pinawa Community Cancer Program hub

Kelsey Russill, Registered Nurse: Western Manitoba Cancer Centre, Brandon Regional Cancer Program hub

Karen McPhee, Registered Nurse: Dauphin Regional Cancer Program hub

Cheryl Longmuir, Registered Nurse: Portage Community Cancer Program hub

CancerCare Manitoba FOUNDATION
All funds raised stay in Manitoba.

Three Family Physicians or Nurse Practitioners will receive registration to attend the Ca-PRI (Cancer and Primary Care Research International) Conference in June, 2014.

The Community Oncology Program would like to thank the CancerCare Manitoba Foundation for providing generous funding for these scholarships.

Thank you all for your participation and for being a resource to the patients and other health care professionals in your community. They will all benefit from your training.

Details on the 2014-15 Community Oncology Scholarships will be included in the next issue of CancerTalk.

TALKING TO FAMILIES ABOUT CANCER: Start the Talk

Developed by the Canadian Association of Psychosocial Oncology, with support from the de Souza Institute, there are four, 15 minute, interactive modules to guide health care professionals and educators to support children and teens when a family member has cancer.

The online modules contain a combination of video, audio, and text along with reference lists and printable resources.

Excellent professional development available 24/7 online at www.startthetalk.ca

UPDATE: COLORECTAL CANCER FOLLOW-UP CARE & SURVEILLANCE PROTOCOL

In December 2013, the follow-up care and surveillance protocol for survivors of colorectal cancer, stages II and III (not stage I or resected metastatic disease) was updated:

- A medical history, physical examination, and CEA testing should be performed every 3 to 6 months for 5 years. Previously, CEA testing finished at the end of year 3.
- A surveillance colonoscopy should be performed 1 year after the initial surgery and then every 5 years, dictated by the findings of the previous one. Previously, a surveillance colonoscopy was done at years 1 and 4.
- If a patient is not a candidate for surgery or systemic therapy because of severe co-morbid conditions, surveillance tests should not be performed. A treatment plan from the specialist should have clear directions on appropriate follow-up by a non-specialist.

These recommendations have been adopted by CancerCare Manitoba and its partners in the community oncology sites. To access the new follow-up recommendation sheets to use in your clinic, go to http://www.cancercare.mb.ca/follow-upcare then click on 'Cancer-Specific Follow-Up Care Resources'

If you have questions about these recommendations, please contact us at: transitions@cancercare.mb.ca

ASK THE Cancer Expert

Don Houston, MD, FRCPC
CHAIR, HEMATOLOGY/HEMOSTASIS DISEASE SITE GROUP, CANCERCARE MANITOBA

QUESTION: MY PATIENT HAS AN ASYMPTOMATIC MICROCYTIC ANEMIA. HOW DO I PROCEED?

CO-AUTHORED BY DR. MARK KRISTJANSON, MD, CCFP, DIRECTOR OF PRIMARY CARE ONCOLOGY, CANCERCARE MANITOBA

Take as an example a CBC with a Hb of 124 g/L, down from a Hb of 148 last year, a mild microcytosis (MCV 79 fl) and hypochromia (MCHC 290 g/L).

First perform a careful review of systems, family history and physical exam. The next step involves delineation of this patient's iron status. The story suggests the possibility of a new (and as yet unexplained) iron deficiency. An unexplained iron deficiency in an adult, especially for men and post-menopausal women, obliges the family physician or nurse practitioner to rule out GI pathology as a source of chronic blood loss. First check the serum ferritin. In the absence of other contributors to anemia, the ferritin will be low (less than 20 ug/L) in iron deficiency anemia.

If the ferritin is low, initiate an urgent consultation with an endoscopist. Some practitioners will choose at this point to test for fecal occult blood. However, a negative test should not reassure in this scenario, as bleeding can be intermittent, and should not delay an urgent referral for endoscopy in the face of proven iron deficiency.

You should start the patient on an iron supplement while awaiting the consult, starting with ferrous gluconate 300 mg od, and working up gradually (to minimize GI intolerance) to 300 mg TID. This will prevent worsening of his anemia, and should confirm whether iron deficiency is indeed the cause.

An unexplained iron deficiency obliges the family physician or nurse practitioner to rule out GI pathology

What if the patient has a normal esophagogastroscopy (with negative biopsies for H. pylori) and a normal colonoscopy? Gluten enteropathy may present as an iron deficiency anemia refractory to oral iron supplementation. A celiac screen, and (at the discretion of the gastroenterologist) a small bowel biopsy should be considered. Neoplasms and angiodysplasias of the small intestine are other possibilities. A post menopausal female presenting with a similar story should be considered for an endometrial biopsy and gynecologic ultrasound if there is a history of vaginal bleeding.

Remember that iron loss during menstruation, pregnancy, delivery, and lactation are common causes of iron deficiency. Iron-poor diets (especially among vegetarians), may contribute to iron deficiency, but should never be assumed to be the cause, or delay investigation, in patients eating a Western diet with iron-fortified staple foods. Iatrogenic causes of iron deficiency anemia include blood donation, blood letting (especially in hospitalized patients undergoing extensive investigations), and poor absorption following gastric bypass for morbid obesity. Less commonly, iron deficiency can develop secondary to intravascular hemolysis from cardiac valvular disease, or from paroxysmal nocturnal hemoglobinuria. Rarely, urinary blood loss (e.g. from urothelial malignancy) can present as iron deficiency.

What if the patient's serum ferritin had come back within the normal range? Iron deficiency is not excluded, as the ferritin can be elevated by inflammation or liver disease. Or the anemia could be due entirely to an inflammatory process (a.k.a. anemia of chronic disease). [The normal counts a year ago excludes any consideration of thalassemia]. It would be reasonable at this point to check his serum iron and TIBC. In iron deficiency the iron will be low but the TIBC elevated; in anemia of inflammation, the iron will again be low but the TIBC will also be below normal, while the ferritin should be above normal. What should you do if anemia of chronic inflammation is on the differential? Tune in to the next issue of CancerTalk for the answer!

Finally, remember that anemia is often multifactorial. Renal failure is associated with diminished erythropoietin production and diminished red cell production, so checking the creatinine is worthwhile in any but the most straightforward cases. Likewise a reticulocyte count is useful to rule out a hemolytic process. Because of multiple comorbidities, it is common for patients of advanced age to have a mild anemia, and it is a matter of clinical judgement how extensively to work up such patients. A chronic, mild anemia characterized by a normal or high ferritin and which is stable over time in such a patient does not necessarily require extensive work up.

ColonCheck and EMR: What do they have in common?

ColonCheck values the partnerships we have built with primary care providers, our shared goals of providing access to colorectal cancer screening, and the importance of prevention and early detection of the disease.

We have simple and effective methods to track your distribution of ColonCheck Fecal Occult Blood Test (FOBT) kits to patients using your electronic medical records (EMRs).

The tracking and recording of kits distributed allows ColonCheck to send out reminder letters and other patient follow up.

More importantly, once we have entered your patients into our program data base, ColonCheck will recall eligible individuals every two years to be screened with the FOBT. Other benefits to collaborating with ColonCheck include:

- providing a high quality FOBT to distribute,
- rapid communication of FOBT test results and,
- six to eight weeks wait time from positive FOBT to colonoscopy for Winnipeg referrals.

If you are interested in learning more about how you can use your EMR to help increase colorectal screening rates, please contact Linda Starodub (Health Educator working with Primary Care) at linda.starodub@cancercare.mb.ca or (204) 788-8480.

CervixCheck to host clinician education event and Pap test competency training

This spring, CervixCheck will be hosting Pap test competency training for clinicians.

As part of this training, an evening of presentations will be open to all clinicians in Manitoba interested in cervical cancer screening.

Dr. Robert Lotocki will present on abnormalities of the cervix, and Kim Templeton will provide updates on the current landscape of cervical cancer screening in Manitoba.

For more information and to register, visit TellEveryWoman.ca/education

Identifying nurses as smear takers

Are you a nurse performing Pap tests in Manitoba?

If so, CervixCheck would like to issue you a nurse provider number in order to identify you as the smear taker on your patient's Pap test reports.

Contact CervixCheck at 1-866-616-8805 or visit TellEveryWoman.ca/resources to get your number.

The Customer Cervix Representative

FREE!

Friday, May 9, 2014

5pm: dinner

6pm-8:30pm: presentations

This program has been accredited by the College of Family Physicians of Canada and the Manitoba Chapter for up to 2.5 Mainpro M1 credits.

HOW TO REACH US

CCMB REFERRAL CENTRE
204-787-2176
fax: 204-786-0621
M-F, 0800-1600, closed Stat Holidays
Emergency Referrals:
hsc paging: 204-787-2071
st boniface paging: 204-237-2053

CANCER QUESTION? HELPLINE FOR HEALTH CARE PROVIDERS
204-226-2262 (call or text / sms)
email: cancer.question@cancercare.mb.ca
web form: cancercare.mb.ca/cancerquestion
M-F, 0830-1630, closed Stat Holidays

CCMB SCREENING PROGRAMS BREASTCHECK – CERVIXCHECK – COLONCHECK
1-855-952-4325
GetCheckedManitoba.ca

CANCERCARE MANITOBA
toll free: 1-866-561-1026
(ALL DEPARTMENTS + CLINICS)
www.cancercare.mb.ca

Inquiry & Reception
maccharles unit (HSC) 204-787-2197
st. boniface unit 204-237-2559

Pharmacy: 204-787-1902

COMMUNITY CANCER PROGRAMS NETWORK (CCPN) OFFICE, CCMB
204-787-5159

MANITOBA PROSTATE CENTRE, CCMB
204-787-4461
fax: 204-786-0637

PALLIATIVE CARE CLINICAL NURSE SPECIALIST
204-235-3363

PATIENT AND FAMILY SUPPORT SERVICES, CCMB
Psychosocial Oncology, Dietitians, Speech Language Pathology, Guardian Angel Caring Room, Patient Programs, Navigator Newsletter
204-787-2109

BREAST CANCER CENTRE OF HOPE
204-788-8080
toll free: 1-888-660-4866
691 Wolseley St.
Winnipeg, MB R3C 1C3

WESTERN MANITOBA CANCER CENTRE
204-578-2222
fax: 204-578-4991
300 McTavish Ave. East
Brandon, Manitoba R7A 2B3

OTHER NUMBERS:

CANCERCARE MANITOBA FOUNDATION
donations & inquiries 204-787-4143
toll free: 1-877-407-2223
fax: 204-786-0627

CANADIAN CANCER SOCIETY
volunteer drivers 204-787-4121
toll free: 1-888-532-6982

cancer information service
toll free: 1-888-939-3333

CANADIAN VIRTUAL HOSPICE
virtualhospice.ca

WRHA BREAST HEALTH CENTRE
204-235-3906
toll free: 1-888-501-5219

UPCOMING EDUCATION EVENTS

www.cancercare.mb.ca/cpd

MAY 9TH - 9:00AM-3:30PM

Be a CancerPro: Cancer System Essentials for Primary Care

Lecture Theatre, 675 McDermot Ave. This session has been reviewed by the College of Family Physicians of Canada and is awaiting final accreditation by the Manitoba chapter. www.cancercare.mb.ca/cpd for registration and information.

ANNOUNCEMENTS

CA-PRI
The Cancer and Primary Care Research International Network

New Partnerships in Primary Care Cancer Research
JUNE 10-13, 2014 | Winnipeg, Manitoba Canada

Cancer Research Conference for Primary Care

Cancer and Primary Care Research International (Ca-PRI) is having its annual conference in Winnipeg from June 10-12, 2014.

The Ca-PRI conference is an international meeting of family physicians focusing on cancer care research in the primary care setting. International experts in research on the diagnosis of symptomatic cancer, cancer screening, and follow-up care will attend and present.

An additional CPD event on Friday, June 13th will focus on clinical topics for primary care clinicians featuring leaders in primary care research from around the world.

Visit www.cancercare.mb.ca/cpd and http://www.ca-pri.com

Ca-PRI 2014 CancerDay for Primary Care International Edition

Special UPCON 10th Anniversary CME event featuring leaders in primary care cancer research from around the world.

June 13, 2014, Frederick Gaspard Theatre- University of Manitoba Bannatyne Campus, Winnipeg

MBTelehealth Broadcast Available. This program meets the accreditation criteria of the College of Family Physicians of Canada and has been accredited for a maximum of 5.0 Mainpro-M1 credits.

http://events.cpdumanitoba.ca/website/index/CaPRIjun13