CancerTalk
Connecting with Manitoba's Health Professionals *Issue 16, Winter 2012*

Non-Hodgkin Lymphoma: What You Need to Know

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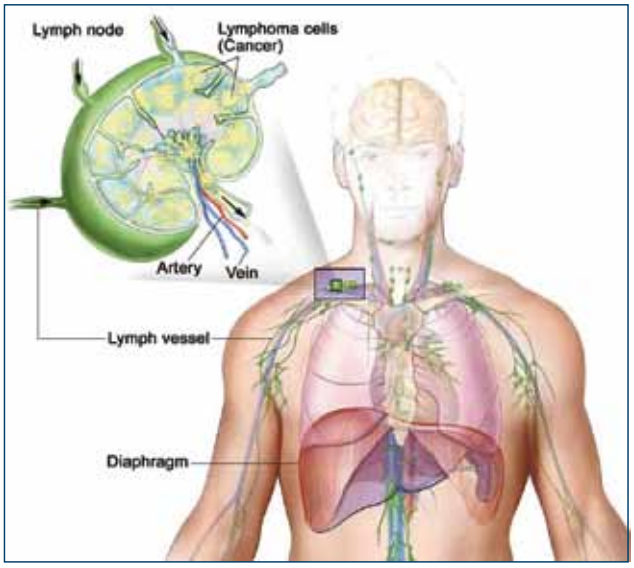
The most common types of non-Hodgkin lymphomas (NHLs) are diffuse large B-cell lymphomas (DLBCL), an aggressive type of NHL which constitutes 25-30% of all lymphomas, and follicular lymphomas (FL), comprising 30% of all lymphomas, that are less clinically aggressive, thus called "indolent" lymphomas. Both lymphomas present at a median age of 60 and have equal distribution in both genders.

Primary treatment of lymphomas is with immuno-chemotherapy: Rituximab + CHOP for DLBCL and Rituximab + CVP for the majority of FL. Rituximab is a specific monoclonal antibody that binds to B lymphocytes, leading to cell lysis.

The primary treatment intent in NHL is to achieve a remission, preferably complete, which is the first step towards prolongation of life without disease. DLBCL are very responsive to R-CHOP therapy with cure rates of about 65% or higher. Relapsed patients may be salvaged by the use of high dose chemotherapy and autologous stem cell transplantation.

FL are highly responsive to initial therapy attaining an overall response rate of 81%. Further improvements in FL outcomes have been achieved by the administration of "maintenance" Rituximab, given every 2 months, for a period of 24 months. Unfortunately FL natural history is to relapse over time and, more rarely, to transform to DLBCL (rate 3%/yr). FL is considered an incurable, "chronic malignancy", except for a small subset of patients that are eligible to receive allogeneic transplantation.



healthlinkbc.ca

Follow-up Care

After treatment DLBCL and FL patients are monitored in the oncology clinic during the first 4-5 years. Due to an increase in relapse rate in DLBCL during the first 24 months post-remission, more frequent monitoring is done initially (every 3 months in the first year, then every 6 months x 2 years, then yearly). FL are more likely to relapse 36-42 months after therapy, but they have a continuous risk of relapse and therefore monitoring is indicated at 6 month intervals indefinitely. Their follow-up requires a higher index of suspicion.

Patients are **discharged** from oncology clinics to their FP for follow-up after 4-5 years. At this point, NHL patients continue to need a yearly clinical and lab evaluation, with attention to

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Announcements

Cancer Education:
Save the Date!

May 29th Clinical Trials Day at CCMB. For more information go **www.cancercare.mb.ca** and look under the "Research" tab.

June 8th - Cancer Screening CME. More information to follow at **www.GetCheckedManitoba.ca**

June 15th - Be a Cancer Pro: Cancer System Navigation for Primary Care at CCMB in Winnipeg. Call Shelley Ringland at 787-1225 for information.

October 18-20th - Community Cancer Conference, Victoria Inn, Winnipeg. Call Debra Oberman at 787-5159 for information.

January 25, 2013 - Cancer Day for Primary Care. Call Lynne Savage at 787-1229 for information.

Do you have a TV in your clinic waiting area…?

ColonCheck, CancerCare Manitoba has great educational DVDs for your patients:

- Animated FOBT Instructions
- Reduce Your Cancer Risk

March is National Colorectal Cancer Awareness Month! To order these and other great educational resources such as pamphlets and posters call 788-8635 or visit **ColonCheckMB.ca**

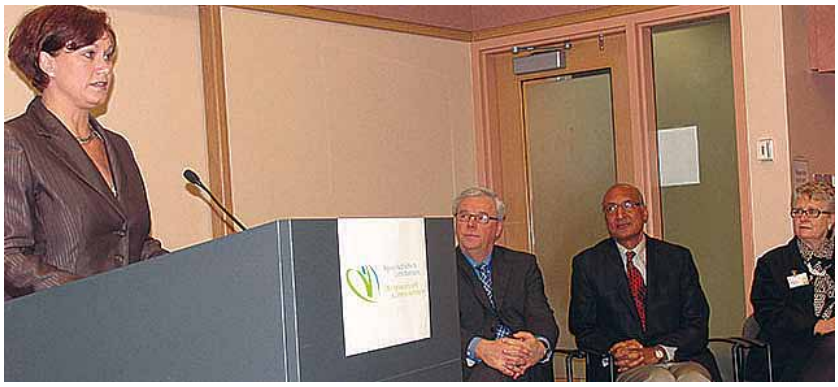
The Health Innovation Award 2011

for Partnership was presented to the Uniting Primary Care and Oncology (UPCON) Program by the Manitoba Patient Access Network (MPAN) of Manitoba Health at their conference on November 22, 2011.

Production of CancerTalk is supported by

CancerCare Manitoba FOUNDATION

Boundary Trails - The First Hub



(from left to right): Minister of Health, The Hon. Theresa Oswald; Premier Greg Selinger; Dr. Dhali Dhaliwal, President & CEO, CancerCare Manitoba; Kathy McPhail, CEO, Regional Health Authority Central Manitoba Inc.

Boundary Trails Health Centre in Morden-Winkler will soon house Manitoba's first regional CancerCare hub that will improve diagnostics, treatment, and wait times for Manitobans facing cancer.

The hub represents the beginnings of the recently announced $40-million, system wide cancer strategy designed to streamline the patient journey from when a family doctor first suspects a diagnosis of cancer until the time treatment starts. It is estimated this journey now takes three to nine months but Manitoba's goal is to achieve a benchmark of two months or less.

The new CancerCare hub will expand on the chemotherapy services currently available by connecting patients, patient navigators, doctors, nurses and other health-care providers to provide faster access to care.

"This announcement continues the transformation of the cancer system, so that Manitoba patients benefit from rapid, compassionate cancer care in action," said Dr. Dhali Dhaliwal, President and CEO, CancerCare Manitoba. "The system will be re-engineered to connect state-of-the-art cancer expertise with primary care to provide rapid treatment and to offer increased support services at community cancer sites, to ease the worry and wait of those facing this disease."

Anne Katz, RN PhD has written a new book for cancer survivors. *After You Ring the Bell: Ten Challenges for the Cancer Survivor* describes key issues that survivors face with advice and guidance on how to manage problems and maximize wellness. Based on the latest evidence, this is an important resource for patients once treatment is over.

Available on **www.amazon.ca** by searching for the title.

To CT or not to CT?– Screening for Lung Cancer

David Dawe BASc, MD, FRCPC
Fellow, Medical Oncology, University of Manitoba

Many of you have likely heard that the recent National Lung Screening Trial has shown that screening with CT leads to a 20% reduction in lung cancer specific mortality!(1) An overview of this important new trial found in the table. This is the first time a screening test prevented people from dying of lung cancer. Should this trial lead us to adopt screening low dose computed tomography (LDCT) scans in Manitoba? While the answer in the popular press and in the United States appears to be a resounding yes, I have some concerns.

Almost 40% of patients receiving LDCT screening had at least one positive scan and 96.4% of those positive scans did not show a cancer – they were false positives. This high rate of false positives is a concern for three reasons. First, investigating a positive scan means more CT scans, biopsy, or surgery. It would be extremely difficult for Manitoba to manage such a large increase in these services. Second, the cost associated with preventing one lung cancer related death is currently unclear. Generally, we would like to see a cost of less than $100,000 per life-year gained and some estimates put LDCT's cost as high as $160,000.(2) Third, the large number of invasive tests due to screening may result in patient death from the screening itself.

The trial in some ways is a victim of its own success. Compliance with testing was 95% in the LDCT group. Considering that only 61.7% of eligible women get mammograms in Manitoba(3), a compliance rate of 95% seems unattainable, reducing the expected benefit of the screening test.

The results of the National Lung Screening Trial are exciting, but not yet ready for widespread adoption. We may need to wait until the population benefiting from screening is more narrowly defined to maximize the benefit in those screened, allowing us to better manage the additional follow-up diagnostic tests, and to make screening with LDCT affordable.

National Lung Screening Trial - Characteristics and Results

Subjects	53 454 pts: 26, 722 LDCT, 26,732 CXR	
Inclusion	55-74 years with ≥30 pack-year smoking hx, current smokers or had quit within 15 years	
Exclusions	Previous lung cancer, hemoptysis, 15 lbs wt loss, CT chest within 18 months	
Intervention	Low-dose CT chest yearly x 3 years vs CXR	
Positive CT	Non-calcified nodule ≥4mm, any nodule considered "suspicious for cancer", effusion or lymphadenopathy	
Median Follow-up	6.5 years	
Outcomes	LDCT	CXR
Compliance	95%	93%
Portion of patients with positive screen	39.1%	16%
False positive rate	96.4%	94.5%
Number of cancers diagnosed	649	279
Deaths from lung cancer	356	443
Deaths related to diagnostic tests	16	10
To prevent ONE lung cancer death	Screen 320 patients	

Could it be Cancer?

Diagnosing CRC in Primary Care

Dr. Jeff Sisler
Director, Primary Care Oncology, CCMB

Although colorectal cancer (CRC) is common, the average FP or NP will only see one new case each year. In addition to a positive family history, which must be sought, older age remains the most potent risk factor. Almost 95% of CRC is diagnosed in those >50 years, and risk goes up continuously with age. The top 4 symptoms in primary care are rectal bleeding (42% of cases), abdominal pain (42%), diarrhea (37%) and weight loss (27%). The likelihood of finding CRC goes up when a cluster of symptoms and signs is identified. Rectal bleeding (RB) is the "best" symptom to hang your hat on. In your office, only about 2-3% of those 50-59 years of age with RB alone will have cancer, but that number rises to 21% for patients in their 70s. What kind of bleeding matters the most? Blood mixed with stool and dark blood are more likely to indicate cancer. Patients describing a RECENT change in bowel habit, especially towards looser stools, need to be taken seriously. In one study, when change in bowel habits was added to RB, the likelihood of finding cancer rose from 4% to 9.2%. All patients need an abdominal and rectal exam and a hemoglobin / MCV / ferritin. Iron deficiency anemia merits an endoscopic workup: about 14% of anemic patients will have CRC. In the absence of RB, a FOBT may be done and is useful if positive, but if negative does not replace consideration of endoscopy.

REFERENCES

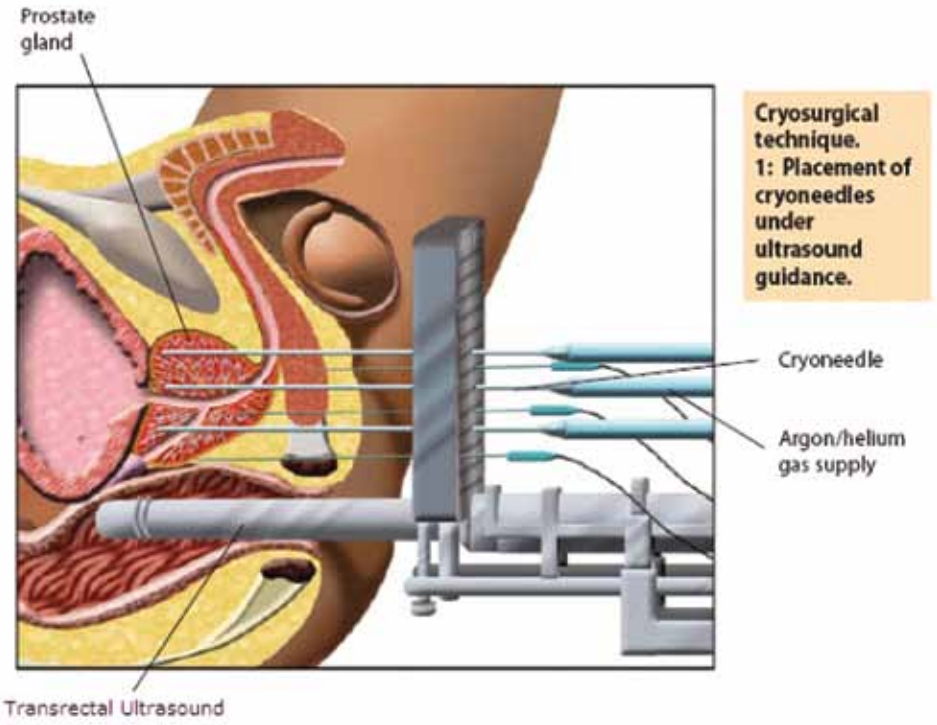
1. National Lung Screening Trial Research Team, Aberle DR, Adams AM, et al: Reduced lung-cancer mortality with low-dose computed tomographic screening. N Engl J Med 365:395-409, 2011
2. McMahon PM, Kong CY, Bouzan C, et al: Cost-effectiveness of computed tomography screening for lung cancer in the united states. J Thorac Oncol 6:1841-1848, 2011
3. Fransoo R, Martens P, Burland E, The Need To Know Team, Prior H, Burchill C: Manitoba RHA Indicators Atlas 2009. Winnipeg, MB, Manitoba Centre for Health Policy, 2009

Cryotherapy at the Manitoba Prostate Centre

Dr. Jeff Saranchuk, MD
Medical Director
Dr. Ernest W. Ramsey Prostate Centre,
CancerCare Manitoba

Cryotherapy is a new treatment option for some men with prostate cancer. It is a minimally invasive technique using sophisticated prostate ultrasound scanning techniques. It can be used for men with prostate cancer which is localized to the gland, just on the edge of the gland (locally advanced) and in cases where recurrence of prostate cancer occurs post radiation therapy (including after brachytherapy). Cryotherapy is best used in situations where the PSA is less than 20 and the Gleason grade of the pathology is grade 7 or below. It can also be used in high risk prostate cancer (Gleason grade 8 or above or PSA more than 20) if there has been no spread outside the prostate. These patients will need also androgen ablation therapy for 2 to 3 years as well.

During the procedure, the prostate tissue is frozen to -40°C using argon. The gas is introduced into the prostate through fine needles that are inserted through the perineum under ultrasound guidance using a template guide for accuracy. There are no incisions. Temperature needles are used to monitor the process particularly around the sphincter muscle below the prostate and also the wall of the rectum. A warming catheter in the urethra is used throughout the procedure to protect the inner lining of the urethra and sphincter muscle area.



http://www.avantgardeurology.com/p-p-salvage-cryotherapy-en.html

Cryotherapy is minimally invasive and is usually carried out as a day case. There is very little pain after the procedure although there may be bruising and tenderness in the perineum for a day or two.

Men who have severe urinary symptoms or those who have had previous prostate surgery may not be suitable for cryotherapy. Some men may have a large prostate gland which can make cryotherapy difficult. However, it is usually possible to shrink the gland first with androgen ablation therapy. Cryotherapy is very likely to cause permanent loss of erections. Incontinence is also quite common after this treatment as is hematuria.

Cryotherapy may be an option for your patient with prostate cancer. This can be discussed with the team at the Manitoba Prostate Centre. Referrals should be faxed to the Centre at 204-786-0637. In addition to the urologists on staff, Dr Anne Katz is a PhD prepared nurse who is available to assist men and their partners make a treatment decision amongst the various options available. Referrals can be faxed to Dr. Katz at the number above.

Scholarship recipients Dr. Bruce Kowaluk, Louise Rawluk, and Dr. David Haligowski at the 8th annual Cancer Day for Primary Care, along with Annitta Stenning, CancerCare Manitoba Foundation; Dr. Jeff Sisler and Ruth Loewen, CancerCare Manitoba.

UPCON and CCPN are pleased to announce the 2011 Community Cancer Scholarship winners:

Congratulations to:

Dr. Rasool Askarifar: Hospitalist at Beausejour Hospital

Dr. David Haligowski: Family Physician at Rivergrove Medical Clinic in Winnipeg.

Dr. Bruce Kowaluk: UPCON Lead at Kin Place Primary Health Care Centre in Oakbank and family physician in oncology (FPO) at the St. Boniface site of CCMB in Winnipeg.

Zofia Perlikowski: Social worker at the Eriksdale Community Cancer Resource and Support Program.

Connie Randell: CCP nurse at the Pinawa Community Cancer Program

Louise Rawluk: Nurse Practitioner and UPCON Lead at the Burntwood Community Health Resource Centre in Thompson.

Gerri Scott: Pharmacist at the Brandon Regional Health Centre.

We thank the CancerCare Manitoba Foundation and its donors for providing funding for this scholarship program.

(from left to right): Jennifer Wellborn, NP, Winnipeg Regional Health Authority; Janelle Quinto, NP, NorWest Co-op Community Health Centre; Erin Brickman, RN; Rhea Mossman-Simms, NP, Klinic Community Health Centre.

CCMB hosts 8th Annual Cancer Day for Primary Care

Another highly successful Cancer Day was held on January 27! Over 90 family physicians, nurse practitioners and other professionals attended this popular annual in Winnipeg, and many others linked in at 13 sites by MBTelehealth.

Visit www.cancercare.mb.ca. to view these terrific presentations!

The full day symposium featured informative presentations by Drs. Pitz, Drachenberg, Yanofsky, and Popowich who focused on "Getting to the Diagnosis" in the office when patients present with headaches, hematuria, lymphadenopathy, and pelvic masses respectively. Other highlights included a presentation by Dr. Harlos on care during the last hours of life, a practical demonstration of punch biopsies by Dr. Kvern, a review of strategies for improving health literacy presented by Andrea Szwajcer and Kerry MacDonald, a consideration by Megan McLeod about the unique experience of young adults with cancer, and an overview of treatment-induced menopausal symptoms by Drs. Pan and Holowenko of the Mature Women's Centre.

A highlight of the day was an interactive panel of experts, Drs. Lotocki, Pathak and Smith who "Explored the HPV –Cancer Connection" and the role of HPV immunization as it relates to cervical, head and neck and anal cancers.

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Non-Hodgkin Lymphoma from P. 1

their symptoms (particularly B-symptoms: drenching night sweats, unexplained weight loss and persistent fevers), enlarged nodes, abdominal distension or early satiety (due to an enlarged spleen), leg swelling (due to lymphatic obstruction), and fatigue (due to anemia or underlying disease). Most lymphomas relapse at the initial sites, unless that site was irradiated. Physical exam should focus on lymph nodes, detection of organomegaly, and presence of leg edema. A CBC with differential is recommended annually in NHL survivors. Routine biochemistry including LDH is also indicated yearly. However, LDH elevations may be non-specific and need to be evaluated in context. The degree of LDH elevation, persistence with retesting, and associated symptoms/signs should raise concerns of relapse. Imaging studies, such as CXR or CT's are recommended only if clinical examination raises suspicion of thoracic or intra-abdominal lymphoma. There is no role for PET scanning in the follow-up of any patient with lymphoma. Patients who received neck irradiation should have yearly TSH to detect hypothyroidism.

Lymphoma survivors are at risk for "second cancers" particularly if they received a combination of chemotherapy and radiotherapy.

Follow-up recommendations include:

- Pneumococcal vaccination every 5 years and annual flu shots
- Counselling re good health habits, including smoking cessation
- Monitoring and modification of cardiovascular risks (particularly in those who received chest radiation)
- Monitoring for skin cancer, which is more common in these patients
- Annual mammography – starting 10 years post-chest irradiation or at the age of 40, whichever comes first
- Exercise stress test and echocardiogram at 10 years post-completion of therapy to assess for cardiomyopathy.

CancerCare Manitoba announces

Integrated Community Oncology Program

The program will integrate the current Community Cancer Program Network (CCPN) and the Uniting Primary Care and Oncology Program (UPCON). Both are nationally respected as leading models of delivery of community based cancer care in rural and northern settings and development of cancer care and the development of cancer expertise in the primary care sector.

The leadership team will be: Ruth Loewen, Program Director, Dr. Joel Gingerich, Medical Director, and Dr. Jeff Sisler, Medical Lead, Primary Care.