ISSUE 20 › WINTER 2014-15

CANCER talk
› CONNECTING WITH MANITOBA'S HEALTH PROFESSIONALS

TEM: THE CUTTING EDGE

Dr. Mark Kristjanson, COMMUNITY ONCOLOGY PROGRAM

There are approximately 7,000 new cases of rectal and rectosigmoid cancers reported every year in Canada, for an annual incidence of about 20 per 100,000. With an overall five year survival of about 65%, colorectal cancer is also one of the malignancies amenable to prevention through screening, and is more likely to be cured, with less morbidity for the patient and at a lower cost to the taxpayer, when it is diagnosed early. Small rectal polyps can be resected endoscopically. Larger polyps, if sufficiently low in the rectum, have traditionally been treated by transanal excision (TAE); dysplastic adenomas that are too high in the rectum for TAE have required radical excision. Unfortunately, TAE is associated with significant disease recurrence rates, and radical excision is a big procedure that typically requires several post-operative days in hospital. On July 8th this past summer, I had the privilege of observing Dr. David Hochman perform a state-of-the-art surgical procedure that represents a significant improvement over these traditionally available options.

> TEM is now the preferred method of removing rectal adenomas when colonoscopic removal is not possible

Transanal endoscopic microsurgery (TEM) was initially performed by Buess and colleagues in the 1980s, when they developed a transanal operating proctoscope with modified laparoscopic instruments. Subsequent refinements and numerous studies later, TEM is now the preferred method of removing rectal adenomas when colonoscopic removal is not possible. Having trained at the Mayo Clinic with additional training at the University of Minnesota, David Hochman now performs TEM regularly at the Victoria General Hospital, and trains junior colleagues in this highly specialized technique. With the patient under

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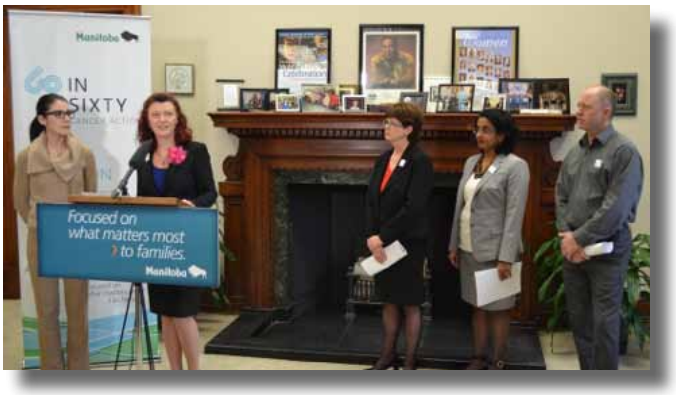
general anaesthesia, the operating proctoscope (4 cm in diameter and 20 cm long) is advanced per ano into the rectum. Incorporated into this same operating 'platform' are a fibreoptic camera and several ports for the introduction of laparoscopic instruments, insufflation of the bowel with CO2, water to wash the operating field, and removal of vapours generated by electrocautery. Dr. Hochman performs 50-60 TEM procedures per year and has done over 200 such procedures since establishing the TEM program at the Victoria General Hospital in 2010.

In the operating theatre, I watched Dr. Hochman and his PGY6 fellow, Dr. Neuman, removed a serrated rectal adenoma from an elderly gentleman who would otherwise have had to undergo a radical excision with its attendant post operative risks and morbidity. Thanks to Dr. Hochman and TEM, patients who have rectal adenomas excised at the Victoria General can often be discharged on the same day as the procedure. A study by Cocilovo, et. al. suggests that total costs associated with TEM are about a third of those associated with low anterior resection - a saving of thousands of dollars per procedure.

FIRST PHASE OF WINNIPEG CANCER HUB LAUNCHES IN DECEMBER

Ruth Loewen, COMMUNITY ONCOLOGY PROGRAM



As part of the *In Sixty* Initiative, Winnipeg Regional Health Authority (WRHA), Cancer Care Manitoba (CCMB) and Manitoba Health have approved funding for a Winnipeg Cancer Hub. This virtual hub is staffed 7 days a week by Nurse Navigators, 5 days a week by a Psychosocial Oncology Clinician and offers access to Family Physician in Oncology (FPO) services.

Phase one of the Winnipeg Cancer Hub begins December 8th, 2014 with the WRHA Emergency Departments and Urgent Care Centre, targeting patients that come through Winnipeg emergency departments. The goal of the virtual Cancer Hub is to connect the emergency, primary care, diagnostic, specialist and oncology services to ensure patients get to a timely diagnosis and management plan. The hub will connect patients and families to the right service at the right time, move the patient's care forward along the diagnostic and intervention pathways, and provide emotional, physical and practical support as needed.

> the goal is to connect services to ensure patients get to a timely diagnosis and management plan.

If the patient does not have a primary care provider, the Cancer Hub will connect the patient to a Primary Care home using the *Family Doctor Finder*. The hub team will not be the direct care providers - they will ensure that communication with the primary care provider occurs, support the health care team to move towards a diagnosis and provide continuity during transitions between providers involved in determining the diagnosis and plan of care. If the primary care provider requires additional support or consultation in managing the care of these clients, or during the time when the patient does not yet have a primary care provider, a Family Physician in Oncology is available to ensure that medical expertise is available to maintain continuity of care.

When a patient has an encounter with any of Winnipeg's Emergency Departments that results in a referral for Cancer Navigation Services, the Navigation team will respond to both the primary care provider and the patient within 48 hours of receipt of referral.

HOW CANCER NAVIGATION SUPPORTS PRIMARY CARE

- Patients and families provided additional support, information and continuity of care during this anxious time in their lives
- Helps primary care provider and staff ensure that all the recommended tests / interventions are done based on the clinical pathways
- Someone to connect with if you have questions

HOW CAN PRIMARY CARE CAN ASSIST CANCER NAVIGATION?

- Be open to calls from the Navigation team and work with them for your patients that are referred through the emergency departments
- For questions, concerns, feedback and improvements contact the Navigation lead at 204-787-2155 (Do not send patients to emergency in order to access this service)

AVOID REFERRAL PITFALLS TO GET OUT THE DOOR IN TWENTY-FOUR

IN SIXTY CANCER ACTION

How long does it take to get referrals and requisitions out of your office? Measuring this time to see what changes are necessary can help you meet the 24 hour referral goal to improve the suspicion phase of the cancer patient journey.

Together with clerical/office staff, note when the patient's appointment was and then the time the referral was sent using date stamp, fax or electronic record. A week's worth of information will give you a good measure for how things are going in your clinic.

From other primary care clinics in Manitoba who have measured their referral time, below are the top five referral process problems encountered and ways that solved the problem.

Top 5 Referral Problems and the FIX

Problem 1 - BATCHING BY CLINICIAN: Every clinic has patients waiting, so instead of dictating, typing or entering the referral or requisition immediately, clinicians wait until the end of the day (or week) to do them all at once.	*THE FIX: Clinicians can schedule daily time to complete, sign off and send the referral the same day the patient was seen. If the referral or requisition is sent by another staff member, ensure they know to dedicate time daily to get the referrals and requisitions forwarded.*
Problem 2 - BATCHING BY SUPPORT/ CLERICAL STAFF – Staff may also be batching the referrals and requisitions. They may have a dedicated a specific day in which they type, fax, etc. the referrals. There may be one staff person or team that does the work.	*THE FIX: Know the process the staff use regarding referrals and ensure they know what is expected. It is important that staff know who specifically the work is assigned to every day and they have dedicated time throughout the day to get the referrals and requisitions sent out.*
Problem 3 - USE OF OLD FORMS: Forms are occasionally updated to ensure the receiver is collecting the information necessary for their updated processes. Using the old or wrong form results in it being sent back and delaying the patient's journey.	*THE FIX: When updated forms arrive, make time to remove old forms from the filing cabinet, wall, folders, etc. and off the computer or EMR.*
Problem 4 - INCOMPLETE FORMS: Missing patient information, incomplete areas and not attaching necessary tests or prior medical information results in the referral being delayed, often until the form is appropriately completed.	*THE FIX: Sending a complete referral the first time reduces the time patient's wait and decreases clerical staff time (and frustration) on both sides of the referral.*
Problem 5 - SENDING INFORMATION TO THE INCORRECT PERSON/PLACE: Fax numbers change and providers move, so it's up to you to know where your patient information is going. Resending referrals takes longer than updating contact lists.	*THE FIX: Ensure that the place or specialist you send the referral to actually provides the service you are requesting. Keep names and contact information up-to-date by scheduling regular reviews of contact information.*

In Sixty's Primary Care Working Group has developed a program called *LEAN on cME* to assist clinics who want help in streamlining their work flows to get those crucial referrals Out the Door in 24. Using a methodology called a LEAN Kaizen, *In Sixty*'s Rapid Improvement Leads guide clinicians and staff through an internal audit of clinic work-flows to identify and correct those work routines that are impeding referral turn-around times. *LEAN on cME* events combine this review of clinic work flows with a small group, case-based Cancer Diagnosis module that has been developed to help primary care providers apply the new Cancer Pathways in their setting.

If you would like to be part of a *LEAN on cME* event, call the Cancer Question Helpline (UPCON) at 204-226-2262.

EMR LINKS FOR WORK-UP PATHWAYS

ACCURO: Click on "CDS" in top menu bar > CancerCare Manitoba link is located at the bottom of your list

MED ACCESS: Click on "Help" icon from anywhere in Med Access > Select "Open Reference Material links" > List is in alphabetical order

JONOKE: Contact your vendor for access

BREAST CANCER FOLLOW-UP

Moving Forward after Breast Cancer

CancerCare Manitoba has initiated Moving Forward after Breast Cancer care plans and transitional appointments for breast cancer patients. Primary Care providers can expect a cover letter and report outlining the patient's follow-up surveillance, information on their hormonal therapy, diagnosis and treatment summary and direction on re-referrals.

Patients will be given the same report and Manitoba-specific resources on survivorship and programs.

For more information, please visit www.cancercare.mb.ca/followupcare for more information and to access sample reports and patient resources.

UPCON WELCOMES

Dr. Bruce Kowaluk

We are pleased to announce that Dr. Kowaluk has accepted the position of Medical Lead – Family Physicians in Oncology in the Community Oncology Program at CancerCare Manitoba. Dr. Kowaluk has worked as an FPO at the St. Boniface, Concordia and Grace Hospitals since 2009. Bruce has a wide range of experience working as a primary care, emergency room, hospital based, northern fly-in and Community Cancer Program physician.

Bruce is a past president of the College of Physicians and Surgeons of Manitoba and has extensive experience working on a variety of committees including the standards, complaints, audit and executive committees of the CPSM.

As the Medical Lead, Family Physicians in Oncology Bruce will oversee FPO services and programs at CancerCare Manitoba. He will serve as a manager for FPOs in the CCMB/WRHA system, support training and education for FPOs provincially and help develop, implement and evaluate education and outreach initiatives of the Community Oncology Program. Bruce will continue his FPO clinical work at the CCMB St. Boniface unit and Concordia Hospital, and will be working at the CCMB MacCharles site two days a week as the Medical Lead for FPOs.

CANCERQUESTION? HELPLINE FOR PRIMARY CARE

Dr. Bruce Kowaluk, COMMUNITY ONCOLOGY PROGRAM

Conceived in 2008, the CancerQuestion Helpline for Primary Care's mandate was to help medical and allied health care professionals access and navigate services available from CancerCare Manitoba and the various partners involved in Manitoba's cancer system. A database has been maintained since April of 2008 so that utilization of services can be tracked, both for reporting purposes, but also to help design educational sessions and to improve on systems issues.

Initially queries were received by telephone, with the addition of email, text, and a web based submission form offered in later years. Questions received over the years involved topics such as requests for release of information, help accessing ARIA, help with referrals, and help with working up patients with a potential malignant process. Depending on the complexity of the issue, some questions have been addressed by UPCON staff, whereas in other cases CCMB consultants have been contacted for a definitive response. The goal has been to respond to queries within 48 hours. The vast majority of responses have met this goal.

From an initial response of 17 telephone calls in 2008, 94 requests were received in 2013. While in the beginning most of the queries were from UPCON or Winnipeg-based clinics, the service is now utilized by practitioners throughout the province. In addition, the complexity of the topics has increased along with the number of requests as well. The feedback received regarding the service has been both positive and appreciative.

Cancer Question? Helpline

EXPERT HELP FOR PRIMARY CARE

MONDAY - FRIDAY 8:30AM - 4:30PM
CALL OR TEXT: 204-226-2262
EMAIL: cancerquestion@cancercare.mb.ca
Online: www.cancercare.mb.ca/cancerquestion

oncology • hematology • work-up • referrals • screening
treatment • pain & symptom • shared care • patient supports

ASK THE Cancer Expert

Dr. Mike Harlos

PROFESSOR AND SECTION HEAD, PALLIATIVE MEDICINE, UNIVERSITY OF MANITOBA

MEDICAL DIRECTOR, ADULT AND PEDIATRIC PALLIATIVE CARE PROGRAM, WINNIPEG REGIONAL HEALTH AUTHORITY

QUESTION: How do I recognize and manage opiod-induced neurotixity?

ANSWER: Opioid-induced neurotoxicity (OIN) is a spectrum of neuroexcitatory effects (delirium, myoclonus, hyperalgesia, seizures) usually attributed to renally-excreted metabolites of morphine and hydromorphone, although there have been reports with opioids without known active metabolites, such as methadone and fentanyl. The term "opioid toxicity" is vague and potentially confused with opioid overdose (with sedation and respiratory depression), which is managed differently.

An important early clue to OIN is rapid escalation of opioids when misinterpreting agitated delirium and opioid-induced hyperalgesia as disease-related pain, worsening the situation. Hyperalgesic pain is typically felt "everywhere", and tends not to make sense in the context of the known pathology.

Treatment involves discontinuing the offending opioid and hydrating if possible; symptoms usually improve over several hours. Opioid conversion tables will overestimate opioid needs and should not be used for dosing alternative opioids in OIN. Rather, aggressive as-needed dosing beginning with opioid-naïve doses can inform opioid needs.

Naloxone should not be administered unless there is respiratory depression; it may worsen symptoms by blocking the parent opioid, facilitating receptor binding of its neurotoxic metabolites. Benzodiazepines may reduce myoclonus, but complicate the assessment of cognition.

Prevention includes caution in prescribing opioids with known active metabolites (particularly morphine and to some degree hydromorphone) in renal insufficiency, and vigilance for early signs.

SCREENING CORNER

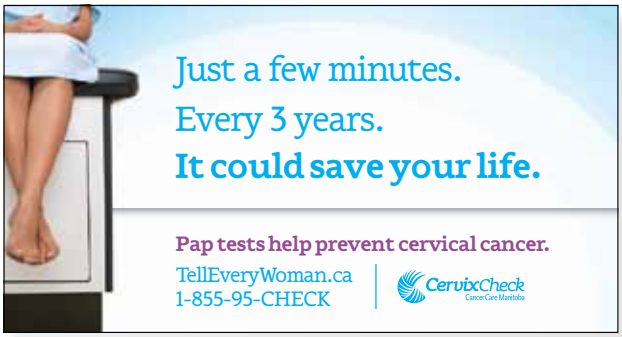
REDUCING TIME TO COLPOSCOPY: CervixCheck to send result letters

In 2011 and 2012, only 35.1% of Manitoba women with a high-grade Pap test result (AGC, ASC-H, or HSIL+) had colposcopy within six weeks of the report date. The national target is 90% (Canadian Partnership Against Cancer). In an effort to reduce the time to colposcopy, CervixCheck will be sending result letters to women starting in 2015. Letters will notify women of their high-grade test result and need for colposcopy, and encourage them to contact their health care provider. The smear taker is still responsible to notify patients of all abnormal Pap test results.

How much time do you need to communicate abnormal results to your patients before CervixCheck issues a result letter?

Please let us know by responding to our survey at: www.TellEveryWoman.ca/feedback

CervixCheck will continue to send letters to clinicians in the absence of follow up for unsatisfactory and low-grade Pap test results, but will no longer do so for high-grade abnormal results. For questions about this initiative, please contact Kim Templeton, Manager, CervixCheck at (204) 788-8648.



NEWS FROM BREASTCHECK

A new study by the Canadian Breast Cancer Screening Initiative (CBCSI) shows that mammography screening substantially reduces the risk of dying from breast cancer[1]. The study compares the outcomes of nearly 2.8 million women aged 40-79 years who participated in screening programs in British Columbia, Manitoba, Ontario, Québec, New Brunswick, Nova Scotia, or Newfoundland and Labrador between 1990 and 2009 to those of non-participants. Overall, the average breast cancer mortality among participants was 40% (95% CI = 33% to 48%) lower than expected. The reduction for Manitoba was also 40% (95% CI = 32% to 48%) for women 50 to 69 years of age.

1. Coldman A, Phillips N, Wildon C, Decker K, Chiarelli AM, Brisson J et al. Pan-Canadian Study of Mammography Screening and Mortality from Breast Cancer. JNCI J Natl Cancer Inst (2014) 106(11): dju261

COLONCHECK ANNOUNCES FIT PILOT PROJECT

Over the next year, ColonCheck is conducting a pilot project to determine the feasibility of using fecal immunochemical tests (FIT) for population-based colon cancer screening in Manitoba. This test requires a single stool sample and has no dietary restrictions. A limited number of tests will be mailed to individuals 50-74 years of age. Some of your patients may receive this test.

If you or your patients have any questions about the FIT, please call ColonCheck at (204)788-8635 or 1-866-744-8961.

FOR MORE INFORMATION PLEASE VISIT www.GetCheckedManitoba.ca

HOW TO REACH US

CCMB REFERRAL CENTRE
204-787-2176
fax: 204-786-0621
M-F, 0830-1630, 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

PAIN & SYMPTOM MANAGEMENT
204-235-2033 ask for pain & symptom physician on call
M-F, 0830-1630

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, MB R7A 2B3

OTHER NUMBERS:

CANCERCARE MANITOBA FOUNDATION
DONATIONS & INQUIRIES 204-787-4143
TOLL FREE: 1-877-407-2223
FAX: 204-787-1607

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

ANNOUNCEMENTS

Dr. Piotr Czaykowski has been named Interim Head for the Department/Section of Medical Oncology and Hematology effective August 1, 2014, ending January 2015. Dr. Czaykowski is well-known as a Medical Oncologist specializing in GI and GU malignancies. Dr. Matthew Seftel will be returning to CancerCare Manitoba in January 2015 to take on the role of Department/ Section Head for Medical Oncology and Hematology.

Dr. Rami Kotb joined the Department of Medical Oncology & Haematology in September 2014. Dr. Kotb will be providing outpatient services in the Lymphoproliferative Disease Site Group, specifically Multiple Myeloma and Lymphoma; and will be participating in the Haematology Consult Service at the Health Sciences Centre.

Dr. Saranya Kakumanu joined the Department of Radiation Oncology in November 2014. He will be providing outpatient services in the gynecological and breast disease site groups at the MacCharles (HSC) site.

Dr. Eren Beshara has taken over for Dr. Bruce Kowaluk as the Family Physician in Oncology (FPO) at the Grace Hospital's Oncology Program. Dr. Beshara also works at CCMB's Urgent Care Clinic and works in Family Practice at St. Boniface Clinic.

UPCOMING EDUCATION EVENTS
www.cancercare.mb.ca/cpd

FEBRUARY 6, 2015
CancerDay for Primary Care
Special Theme - Blood Day for Primary Care

8:30am - 3:45pm
U of M Bannatyne Campus, Winnipeg. MBTelehealth broadcast.

Topics targeted to Primary Care with an interest in Hematology & Oncology. In partnership with the University of Manitoba's CPD Bannatyne Campus Primary Care Program Workshops.

Information and links to registration at:
www.cancercare.mb.ca/cancerday

FEBRUARY 28, 2015
Adjuvant Therapies for Breast Cancer Consensus Meeting

For all health care providers including primary care, specialists and allied health professionals.

8:00am - 4:30pm
Join CCMB's Breast Oncology Specialists and Clinical Practice Guidelines Initiative to develop consensus recommendations and a clinical guideline for the adjuvant treatment of breast cancer patients with chemotherapy, biological agents and/or endocrine therapies.
For more information, please contact Daile Unruh-Peters at dunruhpeters@cancercare.mb.ca