CANCERtalk
› CONNECTING WITH MANITOBA'S HEALTH PROFESSIONALS
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DIAGNOSING PANCREATIC CANCER

Dr. Dana Moffatt

Pancreatic cancer, a disease with a very high mortality and extremely high morbidity, is difficult to diagnose at a curable stage. Over 75% of all pancreatic cancers are unresectable at diagnosis, 10-15% relapse after surgery, and long term disease free survival is <10%. Most patients with pancreatic cancer have no identifiable antecedent risk factors for the disease, and there are no effective screening programs for the general population.

Clinically, patients with pancreatic cancer often present with non-specific symptoms such as asthenia (86%), anorexia (83%), abdominal pain (79%), and diarrhea/steatorrhea (44%). Signs such as jaundice, hepatomegaly, ascites, Courvoisier's sign (palpable gallbladder) and Trousseau's sign (superficial thrombophlebitis) are commonly found only after the disease is advanced.[1]

The diagnosis of pancreatic cancer is based on a combination of diagnostic imaging and histologic confirmation.

Diagnosis: when pancreatic cancer is suspected, the first test should be a CT abdomen, with IV contrast, with a dedicated pancreatic phase (sensitivity of 100% for tumors >2cm, and >75% for 1-2cm).[2] Trans-abdominal ultrasound lacks sensitivity (<50%) or specificity (<70%) when looking for pancreatic neoplasms. MRI/MRCP has largely replaced ERCP for diagnostic assessment of pancreatic cancers, having a sensitivity equivalent to CT without the radiation or contrast exposure or the risks of ERCP. Tumor markers such as Ca19-9 and CEA can support (but not confirm) a diagnosis, and have a role in monitoring for disease relapse.[3]

Confirmation/ tissue sampling: Endoscopic ultrasound (EUS) with biopsy/FNA has a sensitivity and specificity >95%, and is the recommended modality of choice for histologic confirmation of suspicious pancreatic lesions.[4]

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ERCP, no longer the gold standard for tissue acquisition, is still used for palliative biliary stent placement. Direct pancreatoscopy & cholangioscopy are now available in Manitoba (Dr. Moffatt); current use is limited to specific types of indeterminate pancreatic and biliary neoplasms.[5]

New diagnostic techniques including metabolic and proteomic assays using blood, urine, bile and even saliva have sensitivity and specificity approaching 80-90%. If these new techniques can be validated on large enough cohorts and the cost can be brought down, they might soon completely change the diagnostic work up for pancreatic cancer.

In the near future, all outpatient EUS, ERCP and cholangioscopy/ pancreatoscopy referrals will be received, triaged and booked through WRHA endoscopy central intake (2nd quarter of 2016). See below for details on the new WRHA Endoscopy Central Intake for gastroscopy, colonoscopy, and sigmoidoscopy.

References:

[1] Porta M et al. "Exocrine pancreatic cancer: symptoms at presentation and their relation to tumour site and stage", Clin Transl oncol, 2005 Jun;7(5):1989-97

[2] Valls C et al. "Dual-phase helical CT of pancreatic adenocarcinoma: assessment of resectability before surgery" AJR, 2002 Apr. 178(4):821-6

[3] Locker GY et al. "ASCO 2006 update of recommendations for the use of tumor markers in GI cancer" J Clin Onc 2006; 24(33)

[4] Gress F et al. "Role of EUS in the preoperative staging of pancreatic cancer: a large single center experience" Gastrointest Endosc. 1999;50(6)

[5] Chen YK et al."Single operator cholangioscopy in patients requiring evaluation of bile duct disease or therapy of biliary stones" Gastrointest Endosc. 2011;74(4):805

CANCER PATIENT JOURNEY INITIATIVE: *IN SIXTY* KEY ACHIEVEMENTS

Since this initiative was announced in June 2011, with the collaboration of every partner in the cancer patient journey in Manitoba, enormous progress has been made in shortening wait times and improving the cancer patient's experience.

System-wide processes have been streamlined to shorten patient wait times: Out the Door in 24, Direct Referral and Central Referral.

Now every Manitoban has access to an expert Navigation Team who will guide them through the cancer journey.

With a Cancer Navigation Team's support, 67% of patients go from suspicion to treatment in 60 days or less. Patient satisfaction surveys indicate that 97 per cent of patients would recommend navigation services to others and 99 per cent were satisfied with the services.

IN SIXTY
CANCER ACTION

Data shows the CPJI has already shortened wait times. For example, in 2011, 18% of all breast cancer patients met the 60-day target.

As of the first quarter of 2014, 41% were meeting this target.

For more information go to *www.insixty.ca*

New! WRHA Central Intake for Endoscopy Procedures

Over the last six years the WRHA, Manitoba Health, and CancerCare Manitoba have collaborated with the Departments of Medicine and Surgery to redesign gastrointestinal endoscopy services.

The main goals of the new Central Intake for Endoscopy are:

- To improve patient access to timely endoscopy
- To ensure patients get the right test, performed by the right endoscopist
- To improve communication, record keeping and continuity with patients and referring physicians.

WRHA Endoscopy Central Intake will prioritize and assign endoscopy referrals to the next available and appropriate provider in the WRHA system.

Along with ColonCheck Manitoba, CCMB and the "In-Sixty" initiative we have developed a standardized referral form for endoscopy procedures, which will be used region wide starting Dec 1st.

INCIDENTALOMAS - A DISEASE OF MODERN TECHNOLOGY?

Dr. Bruce Kowaluk, FPO LEAD, COMMUNITY ONCOLOGY PROGRAM

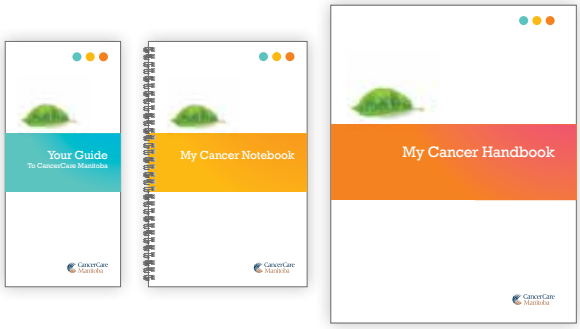
Anyone who orders diagnostic tests will eventually be confronted with incidental findings on x-ray, or CT, or some other form of imaging. Some sources have quoted rates of incidental findings on CT scans in older adults to be as high as 40%. Balancing the need for diagnosis versus the potential harm from further invasive testing is a challenge. The management of these incidental findings can be vexing, and the clinical context needs to be considered carefully. Certainly, in patients with a biopsy proven diagnosis of cancer these incidental findings need to be taken seriously. Many of our patients have whole body CT scans done as part of their staging, and depending on where their primary tumor is, and its pattern of metastasis, the index of suspicion may be increased substantially.

Conferring with the reporting radiologist is often key to planning further tests and follow-up.

NEW RESOURCES FOR PATIENTS

CCMB recently launched made-in-Manitoba cancer resources developed by patients for patients with current information about cancer services and supports and including a tool for them to track their own journey. The three part series includes *Your Guide to CancerCare Manitoba*, *My Cancer Notebook,* and *My Cancer Handbook*. Funding for this project was provided by the CancerCare Manitoba Foundation. They are downloadable at:

http://tinyurl.com/cancercare-patient-info



Primary Care-Cancer Website: One Stop for Cancer Info

gov.mb.ca/health/primarycare/providers/cancer.html

This page pulls together links to information and resources for primary care providers. The PC-Cancer webpage includes sections on clinical information, office and EMR supports, patient and interprofessional provider communication and professional development and training. The latest cancer and health system changes that affect primary care providers will be highlighted.

NOW AVAILABLE: THE *2015 GUIDE TO CANCER SERVICES IN MANITOBA FOR HEALTH CARE PROVIDERS*

cancercare.mb.ca/servicesguide

Don't try to remember it all - this handy booklet is the *"Coles Notes"* of the cancer system in Manitoba. Updated annually, the Guide can be used by clinicians and office staff alike to quickly find the right numbers and faxes, resources, information or programs for you and your patients.

Be a CancerPro: Navigating the Cancer and Blood Disorders System one hour, in clinic sessions are available for free and on request to interested primary care providers and office staff.

For for more information on the Guide and CancerPro sessions call the Cancer Question helpline at (204) 226-2262.

To request printed copies call Lynne Savage at (204) 787-1229.

PROVINCIAL CONSENSUS RECOMMENDATIONS FOR ADJUVANT SYSTEMIC THERAPY FOR BREAST CANCER IN MANITOBA 2015

Dr. Saroj Niraula, CHAIR, BREAST DISEASE SITE GROUP

The Breast Disease Site Group recently analyzed currently available evidence and relevant guidelines to formulate the proposed provincially suitable guidelines for systemic treatment of early breast cancer. Below are key summaries of the guidelines for distinct sub-populations of breast cancer patients:

1. **Her-2 Positives:** Tumors ≤ 0.5 cm, no further chemotherapy or trastuzumab is recommended. Adjuvant chemotherapy and trastuzumab should be considered for tumors >0.5-1.0 cm, and be offered for tumors >1cm.
2. **Triple Negative:** No adjuvant chemotherapy is recommended tumors ≤ 0.5 cm, it should be considered for tumors >0.5-1.0cm, and is recommended for tumors >1cm.
3. **Node Positive:** Adjuvant chemotherapy should be considered for patients with tumors ≤ 0.5 cm and micrometastasis (≤ 2 mm) to axillary lymph node(s), and it should be recommended for patients with macrometastasis (>2 mm) regardless of tumor size.
4. **Node Negative:** For low-risk tumors (≤ 2cm, grade 1, no adverse prognostic factors, OncotypeDx® Score <18), endocrine therapy alone is recommended. For tumors with OncotypeDx® score 18-30 and no other high risk factors, second generation chemotherapy such as docetaxel/cyclophosphamide should be considered. For high risk tumors (>1cm with any adverse prognostic factors, >3cm, OncotypeDx® Score >30), third generation chemotherapy should be recommended.
5. **Endocrine therapy for ER/PR+:**
   a. Pre- or peri-menopausal women should be offered 5 years of adjuvant hormonal therapy with tamoxifen. This should continue for 10 years for those who remain pre or peri menopausal at 5 years. A switch to an aromatase inhibitor for 5 years should be offered to post-menopausal women. Post-menopausal women may start with and remain on 5 years of aromatase inhibitor.
   b. Premenopausal women <35 years and/or those who required chemotherapy for their breast cancer should be offered combination of ovarian function suppression and an aromatase inhibitor.

TO SCREEN OR NOT TO SCREEN?

Dr. Jeff Saranchuk

PSA screening for prostate cancer remains controversial. The Canadian and American Urologic Associations advocate its use; the Canadian Task Force on Preventative Health Care and the US Preventative Services Task Force advise against it. The benefit of PSA screening is limited. Physicians and patients must weigh the benefits of preventing one prostate cancer-related death for every 1,000 men screened over a decade against the known potential harms associated with screening and treatment.

If it is to be done it should be performed every two years in men between the ages of 55 and 70 with a life expectancy of at least 10 years, in conjunction with a digital rectal examination.

Long gone should be the days of PSA tests being performed without the patient's knowledge, let alone done without a proper discussion of the risks and benefits. Too many PSA tests are done on men above the age of seventy years or in younger patients with morbid obesity, significant stroke and/or cardiac disease, poorly controlled diabetes or other significant illnesses who are extremely unlikely to benefit. Patients with a urinary catheter indwelling or who have a urinary tract infection will have an elevated PSA from inflammation so it should not be ordered in those situations. A serum PSA is not part of the routine investigations for hematuria. Discriminate use of PSA testing would help improve health care provision, prevent unnecessary patient anxiety, and decrease health care costs.

EARN WHILE YOU LEARN!

2015-2016 Professional Development in Cancer Care and Blood Disorders

Are you a Health Care Professional affiliated with a Community Oncology Program, or a Family Physician / NP in Primary Care? Submit your application online at: *https://www.surveymonkey.com/s/PDinCancerCare*

REPLY BY DECEMBER 14, 2015 Supported by CCMF
Questions, contact Evelyn at 204.787.4355 or *eleferink@cancercare.mb.ca*

SCREENING CORNER

CELEBRATING 20 YEARS OF BREAST CANCER SCREENING

BreastCheck
CancerCare Manitoba

BreastCheck is turning 20!

Our program started in 1995 with the goal to reduce the number of deaths from breast cancer in women 50 to 69 years of age through early detection with mammography. In 1995 there were 100,348 women in this age group, and over the first 2 years the program provided 24,285 mammograms. Twenty years later the population of women 50 to 69 has grown to 179,308, and BreastCheck provides over 92,500 mammograms every two years. We now have 53 staff members, at four permanent sites, and visit 90 sites with our mobile units, which have travelled an accumulated distance of 812,922 km to provide 179,468 mammograms over the past twenty years. In total, from 1995 to 2015, BreastCheck staff have performed 661,428 mammograms and found 3,891 breast cancers.

"Throughout the 20 years of our program, our incredible staff, with the help of our partners throughout the province, continue to work together towards one common goal—benefiting women through the early detection of breast cancer." – *Marion Harrison*, DIRECTOR, SCREENING PROGRAMS

LIQUID BASED CYTOLOGY MEANS LESS PAP TESTING FOR MANITOBA WOMEN!

CervixCheck
CancerCare Manitoba

Since the introduction of Liquid Based Cytology (LBC) in Manitoba in 2014, the Unsatisfactory Pap test rate has declined from 2.6% in 2013 to 2.0% in 2014. This rate is anticipated to decline further since all cytology labs have now converted to LBC. Reductions in Unsatisfactory Pap tests mean less testing for women and less exposure to potential harms associated with cervical screening.

Your cervical cancer screening quality indicators report is ready!

If you performed Pap tests in 2013 and/or 2014, CervixCheck has feedback for you on your cervical screening activity.

Watch for your report in the mail this month!

CHECK OUT OUR NEW WEBSITE...

GetChecked Manitoba.ca

Check out BreastCheck, CervixCheck, and ColonCheck's new website at:

GetCheckedManitoba.ca

Find all the up-to-date cancer screening information you need to provide your patients with the best care.

ASK THE Cancer Expert

Dr. Ross Stimpson MEDICAL LEAD
COLONCHECK, CANCERCARE MANITOBA

QUESTION: How should average risk Manitobans be screened for colorectal cancer?

ANSWER: ColonCheck invites eligible individuals of average risk 50-74 years of age to have fecal occult blood testing every two years. Research has found that individuals are most likely to be screened if they are encouraged by someone they know and trust (especially their primary care provider).

QUESTION: How does family history influence screening recommendations for colorectal cancer (CRC)?

ANSWER: For patients 40+ years of age with no symptoms of CRC and:

- one first-degree relative (parent, brother, sister, or child) diagnosed with CRC or advanced adenomatous polyps at 60 years of age or older, or
- 2 or more second-degree relatives (grandparent, aunt, uncle) diagnosed with CRC or advanced adenomatous polyps: ColonCheck recommends FOBT every 2 years, starting at age 40.

On an individual basis, other screening tests may be appropriate based on clinical judgment, risk assessment or patient concerns.

For patients who have one first-degree relative with CRC or advanced adenomatous polyps before 60 years of age, or 2 or more first-degree relatives diagnosed with CRC or advanced adenomatous polyps at any age, colonoscopy, every 5 years is recommended, to begin at 40 years of age or 10 years earlier than the youngest diagnosis of CRC or polyps in the family.

QUESTION: What other conditions warrant enhanced screening and surveillance?

ANSWER: Please visit the Screening page on CCMB's website for recommendations pertaining to screening individuals with inflammatory bowel disease or a hereditary colon cancer syndrome.

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 AND GYNE 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

ANNOUNCEMENTS

CancerCare Manitoba welcomes **Dr. Roopesh Kansara**. Dr. Kansara joined the Lymhoproliferative Disease Site Group on September 14, 2015. Dr. Kansara, who hails originally from Tanzania, obtained his degree in Medicine here at the University of Manitoba before pursuing specialty training as a hematologist-oncologist at the University of British Columbia. His clinical interests include the lymphomas, myeloma, and CLL; he is also engaged in research focusing on CNS lymphomas. Welcome Dr. Kanasara!

Nardia Maharaj has been appointed Chief Operating Officer for CancerCare Manitoba effective 2 November 2015. Nardia comes to CancerCare Manitoba from Manitoba Health, Healthy Living and Seniors where she was Assistant Deputy Minister and Chief Financial Officer.

Paul Penner as Chief of Clinical Operations Officer for CancerCare Manitoba, starting 2 November 2015. Paul has extensive experience managing a variety of clinical programs. For the past seven years, Paul has been Chief Operating Officer at Diagnostic Services of Manitoba.

Al Artaman, is the new Director of Epidemiology. He is a research scientist with years of experience in clinical and pharmaco-epidemiology, as well as public and global health epidemiology.

Kathleen Decker is a senior epidemiologist in the Epidemiology and Cancer Registry Department. Previously, she worked with CCMB's screening programs conducting program evaluation and research.

TRANSITIONS NEWS!

New follow up guidelines are available for lymphoma, ovarian, fallopian tube, and peritoneal cancers.

Please go to *www.cancercare.mb.ca/followupcare* to view them.

New care plans and resource booklets have been developed for patients with advanced cancer.

Please go to *www.livingwithadvancedcancer.ca* to view them.