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CANCER talk

› CONNECTING WITH MANITOBA'S HEALTH PROFESSIONALS

Challenges and opportunities in the care of older cancer patients

David Dawe, MD, FRCPC, Medical Oncologist, CancerCare Manitoba

As our population ages, more emphasis is being placed on Geriatric Oncology

In Canada, the number of people ≥65 years old is projected to double between 2005 and 2036. This demographic shift is especially important to consider in policy planning for cancer care because aging is the number one risk factor for cancer. In Manitoba, 45% of new cancers are diagnosed in people ≥70 years old, so we expect a dramatic increase in the number of cancers diagnosed in older people over the next 20 years.

Decision-making for cancer treatment in elderly patients is complicated by the interplay of physiologic changes associated with aging, comorbidities, polypharmacy, competing mortality, and potential differences in priorities among younger versus older people. These issues are compounded by difficulty in predicting both benefit from treatment and risk of toxicity in older patients due to historical underrepresentation in clinical trials.

There is mounting evidence that carefully selected older people may benefit from aggressive cancer treatment and can tolerate the potential side-effects. Conversely, there is a large literature demonstrating the importance of co-morbidity, functional impairment, cognitive impairment, and frailty in predicting outcomes for older adults. Currently, only fit elderly patients have been shown to benefit from chemotherapy in trials and over half of elderly cancer patients are either frail or vulnerable to frailty, potentially shifting the risk/benefit balance towards harm.

Frailty is a complex construct, defined as increased difficulty in regaining homeostasis after a stressor. There is ongoing debate about whether frailty represents a distinct physiologic syndrome or results from the slow

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accumulation of deficits due to habits and health conditions throughout life. It appears to be an important determinant of both tolerability of cancer treatment and survival. However, frailty is not always clinically obvious. The best method to identify frailty is through a comprehensive geriatric assessment (CGA). A CGA involves a formal multi-disciplinary assessment of an elderly person's medical, psychological, and functional status. While typical oncologic assessment includes components of the CGA, structured evaluation of nutritional deficits, polypharmacy, undiagnosed mental health conditions, measures of cognitive status, and social functioning are not consistently included.

It would be ideal to have all elderly cancer patients complete the process of a CGA, but this is a specialized skill set of geriatricians and geriatric care teams. Unfortunately, geriatric resources are already stretched too thin for the needs of the elderly population without cancer. Therefore, within the current structure of cancer treatment in Manitoba and throughout Canada, completion of a CGA for all elderly patients is not possible. Other approaches are being investigated and are urgently needed to inform decision-making.

To start addressing these challenges for Manitobans, the Manitoba Cancer Plan includes improved care for elderly cancer patients as a strategic priority. CancerCare Manitoba has started an initiative aimed to improve the experience and outcomes for frail and elderly patients through a combination of research, clinical practice change, education, and both patient and community engagement. Patient selection and integration of geriatric oncology principles into everyone's practice is essential.

CancerCare Manitoba is pleased to offer a one day education program on Geriatric Oncology Principles. Please save the date to attend on March 9, 2018. For more information and to register, visit: https://www.cpd-umanitoba.com/events/geriatric-oncology-day-march-9-2018/

Inflammatory Comments about Immunotherapy

Dr. Mark Kristjanson, Medical Lead, Primary Care , Community Oncology Program, CancerCare Manitoba

Would you take a drug if you knew that one person in every 100 on the drug would perforate their colon? What if combining two drugs in that class was associated with a 95% chance of experiencing an adverse event?

Oncologists have been on a steep learning curve over the past few years, as indications for immunotherapy increase at an explosive rate. Along with spectacular success stories in treating (and perhaps even curing?) once fatal conditions such as metastatic melanoma, immunotherapy agents come along with the risk of a wide range of immune-related adverse events (irAEs). Experts in the field have established guidelines for diagnosing, grading, and managing irAEs. Immune-related AEs can emerge early in therapy – or as long as a year after completion of treatment, so family physicians and nurse practitioners in Primary Care need to have a working knowledge of how to detect and initiate treatment for these potentially dangerous complications of immune therapies.

The immune check point inhibitors are all monoclonal antibodies. They include agents such as ipilimumab (a CTLA-4 inhibitor), the PD-1 inhibitors nivolumab and pembrolizumab, and the PD-L1 inhibitors atezolizumab, avelumab and durvalumab. If you have a patient who is currently on an immune check-point inhibitor, or who has completed therapy with such an agent in the past 12 months, be on the lookout for autoimmune inflammatory AEs such as rashes (especially maculopapular), pneumonitis, enterocolitis, or autoimmune hepatitis. If you think your patient is suffering an irAE, contact his or her medical oncologist – or call the CancerQuestion helpline at 204-226-2262, and we will connect you with expert help. Once you have made the crucial first step of detecting the complication, the next steps typically include grading its severity, deciding on the basis of that grade whether or not to discontinue or hold the immune check-point inhibitor, and starting the patient on appropriate steroid therapy – all of which should be done in consultation with the medical oncologist.

Autoimmune endocrinopathies such as hypo- or hyperthyroidism, or even hypophysitis (an inflammation of the anterior pituitary) can present more subtly, but can be just as dangerous. Patients on immune check-point inhibitors are monitored regularly for the emergence of thyroid dysfunction. If your patient presents with fatigue and a TSH that is abnormally low, or trending down on repeat assays, consider hypophysitis and check a 9:00 am cortisol level. For more information on the new immunotherapy agents and on irAEs, visit the CancerCare Manitoba Education and Training page: http://www.cancercare.mb.ca/resource/File/UPCON/CancerDay2017/The_dark_side_of_immunotherapy_J_Gingerich.pdf

ZOLEDRONIC ACID

Dr. Mark Kristjanson

CancerCare Manitoba's Breast Cancer Disease Site Group has approved the use of zoledronic acid in early stage breast cancer patients who are either postmenopausal, or pre-menopausal at diagnosis but receiving ovarian suppression, to be given every six months for a total of five years.

In a meta-analysis published by the Early Breast Cancer Trialists' Collaborative Group in the October 3, 2015 issue of the Lancet, significant reductions were documented for post-menopausal patients placed on bisphosphonates with respect to breast cancer mortality, as well as in breast cancer recurrence rates, distant recurrences, bone recurrences and fractures.
Patients who have been transitioned following treatment with curative intent back to the care of their family physician or nurse practitioner should be alerted to the fact that their oncologist will be responsible for ordering the first dose of zoledronic acid and a Family Physician-Oncology (FPO) led team will be responsible for ordering subsequent doses (including the relevant blood work and weight) and assessing for toxicity; but all other breast cancer survivorship care will remain the responsibility of the primary care clinician.
Patients receiving zoledronic acid might experience fatigue, myalgias, arthralgias and joint swelling starting within three days of administration of the drug and resolving a few days later.

Nausea, diarrhea, headache, dizziness, cough or shortness of breath are less likely but possible side effects.
Osteonecrosis of the jaw is a rare but recognized complication of bisphosphonates. If patients require dental work of any kind, they must notify their dentist/dental hygienist that they are on zoledronic acid. CancerCare Manitoba will undertake routine monitoring for hypocalcemia and renal dysfunction, two other potential complications of bisphosphonate use.

CancerCare Manitoba

Ensuring Quality Care, Driven by Research

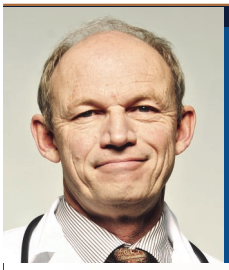
Dr. Sri Navaratnam, President & CEO, CancerCare Manitoba

CancerCare Manitoba has completed the first year of the Manitoba Cancer Plan 2016 -2021, a comprehensive blueprint for the delivery of cancer services to Manitobans. The Annual Progress Report summarizing CCMB's progress on this plan is now posted on the CancerCare Manitoba website.
CCMB is encouraged by the progress made in many areas. Improvement in radiation therapy including an upgraded CT simulator, radiosurgery system and brachytherapy has strengthened radiation treatment delivery to Manitobans.
In chemotherapy, treatments previously given intravenously are increasingly available as oral drugs, reducing the time patients spend at CCMB. And because molecular testing can result in more effective treatments and improved outcomes, CCMB is working with partners to increase access to these tests for cancer patients.
Reporting on performance and quality is a strategic priority for CCMB. The report includes the organization's efforts at measuring key performance indicators and reporting them publicly.
For the first time in the annual report, CCMB is featuring the Research Institute at CancerCare Manitoba, a joint institute with the University of Manitoba. With the support of CancerCare Manitoba Foundation and other funding agencies, more than $10 million in cancer research is being undertaken in Manitoba.

For more about CCMB's progress check out cancercare.mb.ca

Psychosocial Support Available for Families Affected by Cancer

It is normal for patients and families affected by cancer to experience distress, and targeted psychosocial support is available to all Manitobans. You can refer patients and family members who are in need of psychological, emotional or practical assistance to the social worker working with your CCP, or to the Psychosocial Oncology Program at CancerCare Manitoba.
Call 204-787-2109.



ASK THE Cancer Expert

Dr. Ross Stimpson
Assistant Professor, Department of Surgery, University of Manitoba
Medical Lead, ColonCheck Manitoba

QUESTION: **"How often does my patient need surveillance colonoscopy after treatment for colorectal cancer?"**

ANSWER:

There is good evidence for a disease free survival benefit and a mortality benefit with the use of adjuvant chemotherapy for Stage III (i.e. node positive) colorectal cancer, and suggestive evidence for a more modest benefit from chemotherapy for patients with Stage II disease with high risk features (e.g. large primary tumor, high grade tumor, mucinous histology, tumor budding, lymphovascular invasion, obstruction or perforation in the bowel at time of surgery, and elevated CEA post op). For those patients who are offered adjuvant chemotherapy, CCMB has developed surveillance guidelines which are detailed in Part I of the Moving Forward After Colorectal Cancer document. Colorectal cancers that are Stage I (confined to the gut mucosa) or low-risk Stage II are generally managed with curative intent by surgery alone. Typically, patients in this group are followed with surveillance colonoscopy on a schedule like that of the Stage III and high-risk Stage II cancers. Ongoing surveillance colonoscopy is recommended for all treatable patients after colorectal cancer resection. Surveillance colonoscopy is not recommended in individuals with incurable metastatic disease or in those with significant co-morbidities that would preclude further treatment for disease discovered on surveillance colonoscopy.

Whenever possible, patients undergoing curative resection for colorectal cancer should have a high-quality (i.e. good mucosal visualization of complete and clean colon) "clearing colonoscopy" examination prior to surgery. This is required to remove any synchronous pre-malignant polyps and more importantly diagnose any synchronous colon cancers, which can also be resected at the time of the surgical treatment. When obstructive lesions are present and a clearing colonoscopy cannot be completed prior to surgery, it should be performed within 3 to 6 months after surgery.

Individuals with colon cancer are at high risk of metachronous polyps and second colon cancers and hence close ongoing colonoscopy follow-up is recommended.

The second colonoscopy should be performed 1 year post surgery (or 1 year post clearing perioperative colonoscopy if that colonoscopy was completed after surgery, as in the case of obstruction). The next colonoscopy should be performed 3 years later (usually 4 years post-surgery), and if normal, at 5 year intervals thereafter indefinitely.

Significant findings on colonoscopy such as adenomas and/or serrated polyps may require that the surveillance intervals be shortened, to match those recommended in the existing guidelines for polyp surveillance.

Some rectal cancer patients are deemed to be at increased risk (compared with other rectal cancer patients) for local disease recurrence after initial surgery and adjuvant therapy. Although pelvic radiotherapy reduces the risk of loco-regional recurrence, this increased-risk group can also include some individuals who have received radiation therapy. The treating oncologist or surgeon may recommend sigmoidoscopy at 6 month intervals for the first 2 to 3 years after surgery, in the increased risk individuals.

For the latest follow-up guidelines visit: http://www.cancercare.mb.ca/followupcare

GO PAPERLESS!

If you would like to receive Cancer Talk electronically, please email **rporter@cancercare.mb.ca**

NEWS FROM GetChecked Manitoba

BreastCheck Recall Guidelines resource has been updated. Find a copy at: www.GetCheckedManitoba.ca/provider.html

March is colorectal cancer awareness month! Keep an eye out for our promotional activities or order resources to use with your patients.

Lung Cancer Screening In Manitoba

Should I recommend lung cancer screening for my patients?

In 2016, the Canadian Task Force on Preventive Health Care (CTFPHC) issued guidelines recommending lung cancer screening for high-risk individuals. This guideline was based on research that demonstrated up to a 20% reduction in lung cancer mortality with screening low-dose CT scans of the chest. The recommendation was considered weak because the benefits of lung cancer screening are small, but likely outweigh the undesirable effects in the target population.

Who should be screened?

Screening is only for asymptomatic individuals who meet all of the following criteria:

- Adults ages 55-74 AND
- Current smokers or former smokers who quit within the last 15 years AND
- Individuals with a 30 “pack-year” history of smoking, where a pack-year is defined as the product of the number of packs smoked per day multiplied by the number of years (e.g., 1 pack per day for 30 years or 2 packs per day for 15 years)

Patients who have symptoms suggestive of lung cancer are not eligible for screening and should be appropriately investigated.

What is the screening protocol?

The patient should commit to the full recommended screening protocol, which is low-dose CT once per year for 3 years in a row. The patient should also be counselled on smoking cessation and be encouraged to enroll in a cessation program.

How do I make a referral?

Screening must be by low dose CT and not chest X-ray. The image requisition should clearly request a low dose CT scan for lung cancer screening and include:

- patient age,
- smoking status (current smoker or years since quitting), and
- number of pack-years.

Referrals can be made to the radiologist of your choice or to the WRHA Diagnostic Imaging Central Intake (fax 204-787-8910, www.wrha.mb.ca/prog/diagnostic/forms.php). CT scan resources are in heavy demand and requests should be submitted well in advance of the required date.

What are the potential benefits and harms of lung cancer screening?

Benefits

- Lung cancer mortality reduction
- Early detection, resulting in potentially simpler treatment or more treatment options

Harms

- False positives resulting in invasive investigations
- False negatives resulting in missed cancer
- Screening and follow up may cause anxiety
- Over diagnosis of conditions that that may not have become clinically significant in a person's lifetime
- Complications from assessing and treating possible lung cancer and incidental findings, including injury or death
- Radiation exposure

Key Messages

- **Lung cancer screening may reduce mortality in high-risk individuals (55-74 years with a 30 pack-year smoking history)**
- **For eligible individuals, lung cancer screening should be done by low-dose CT, three years in a row**
- **Referrals can be made to the radiologist of your choice or WRHA Diagnostic Imaging Central Intake**
- **Counsel patients on smoking cessation to reduce their lung cancer risk**

For more information on the lung screening guidelines and resources for patients, visit www.canadiantaskforce.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
MCDERMOT UNIT (HSC) 204-787-2197
ST. BONIFACE UNIT 204-237-2559

Pharmacy: 204-787-1902

COMMUNITY CANCER PROGRAMS NETWORK (CCPN) OFFICE, CCMB
204-784-0225

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: 08:30-16:30

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

UNDERSERVED POPULATIONS
204-784-0223

BREAST & 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 MB 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: 1888-532-6982

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

Effective November 6th, 2017, Dr. Craig Speziali has joined the Section of Haematology/ Oncology, Department of Internal Medicine and the Department of Medical Oncology and Haematology at CancerCare Manitoba.

Dr. Speziali has his BSc (Hons.) and MSc degrees in Microbiology and Immunology from Western University. He completed his MD at the University of Toronto in 2011, and a residency in Internal Medicine at the University of Calgary before coming to Winnipeg in 2014 for specialty training in adult hematology at the University of Manitoba. Most recently, he completed a fellowship in Blood and Marrow Transplant at CancerCare Manitoba/ University of Manitoba.

He is interested in clinical outcomes research in leukemia and blood and marrow transplantation, and joins us as a full time faculty member within the leukemia DSG and Manitoba Blood and Marrow Transplant Program. Welcome Dr. Speziali!

Effective January 8th, 2018, Dr. Lin Yang will join the Section of Haematology/Oncology, Department of Internal Medicine and the Department of Medical Oncology and Haematology at CancerCare Manitoba.

Dr. Yang completed her medical degree at McMaster University and trained in Internal Medicine and Hematology at the University of Manitoba. She completed her PhD at the University of Toronto, prior to her medical training, with the focus on molecular genesis in acute leukemia.

During her residency training, she has focused on translational and clinical research in CLL, and joins us as a full time faculty member within the hematology and lymphoproliferative DSGs. We are looking forward to her clinical and academic contributions, and offer her a warm welcome.

Geriatric Oncology Principles - A One Day Educational Event

Save the date to attend on March 9, 2018.

For more information and to register, visit https://www.cpd-umanitoba.com/events/geriatric-oncology-day-march-9-2018/