A NEWSLETTER FOR PRIMARY CARE PROVIDERS

THE QUARTERLY

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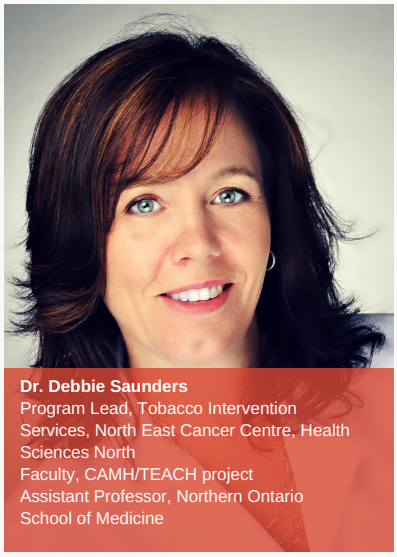
APRIL 2018

CHANGING PERSPECTIVES ON TOBACCO INTERVENTION IN PATIENTS WITH CANCER >



Dr. Debbie Saunders
Program Lead, Tobacco Intervention Services, North East Cancer Centre, Health Sciences North
Faculty, CAMH/TEACH project
Assistant Professor, Northern Ontario School of Medicine

From a patient perspective, it has been proven that cancer diagnosis itself can motivate quitting. From the provider perspective, this means we have an opportunity to use their diagnosis as a teachable moment. If we simply offer the advice to quit to our patients, their quit rates can increase by 68%. If we further offer support to quit by referring or doing it ourselves, our patients' success rates can increase to 217%.[1]

At the time of diagnosis, there are many potential health benefits of cessation; there is a reported decrease in all cause and cancer specific mortality, risk of wound complications, post-operative surgical infections, risk of recurrence and second primaries. What increases with cessation is the responsiveness to anticancer therapies in a variety of cancer types, some upwards of 30%, due to the increased effectiveness of molecular targeted drugs. This inevitably leads to increased survival and quality of life. It is known that the patients who continue to smoke will hinder the efficacy of their medications, while increasing the toxicity of their therapy.[2]

Our perceptions as clinicians have been well documented. We think our patients dealing with cancer don't want to hear us address their tobacco use. We may go so far as to think that it isn't our job to address this, or we think that we just don't have the time. Yet many studies have shown that upwards of 83% of patients are happy that their physician and nurse addressed their tobacco use. With smoking accounting for 30% of all cancer deaths and 87% of lung cancer deaths, it could be the primary reason they are undergoing cancer therapy.[3]

The impact of true success in cessation for our patients involves our two cents. It involves us advocating for our patients by making them aware of the impact that continued tobacco use could have on their care and cure. It involves the multi-disciplinary approach of taking tobacco intervention as seriously as we do other aspects of their treatment. It is as simple as stating, "Stopping smoking will enable the cancer treatments to work better and reduce the side effects. To get the best results from the treatment that you are going to receive, I need you to stop smoking. I'm going to refer you to..."

No one is asking us to be tobacco specialists. But, the power of advising on the benefits of cessation with respect to their cancer treatment and offering pharmacotherapy and /or nicotine replacement with follow up can make all the difference in their treatment and long-term survivorship.

3As of Brief Contact Intervention: Adapted for Patients Who are Newly Diagnosed with Cancer

ASK (all patients)	Ask patients: "Do you smoke cigarettes? Have you used any form of tobacco in the last 6 months?"
ADVISE (current smokers/recent quitters)	Find an empathetic but clear way of recommending that the patient reduce, quit and/or stay quit. Personalize the advice to their condition.
ACT (current smokers/recent quitters)	Arrange for future follow-up with yourself and/or initiate a referral to other smoking cessation service(s) in their community

Sources: 1 Nayan, S., Gupta, M., & Sommer, D. (2011). Evaluating Smoking Cessation Interventions and Cessation Rates in Cancer Patients: A Systematic Review and Meta-Analysis. ISRN Oncology, 2011; 2.Zon, R., Goss, E., Vogel, V., Chlebowski, R., Jatoi, I., & Robson, M. et al. (2008). American Society of Clinical Oncology Policy Statement: The Role of the Oncologist in Cancer Prevention and Risk Assessment. Journal Of Clinical Oncology, 27(6), 986-993.; 3. Ncsct.co.uk. (2015). NCSCT- National Centre fo Smoking Cessation and Training. Retrieved 1 December 2015
4. Westmaas JL et al. J Clin Oncol 33:1647-1652, 2015; 5. Florou, A., Gkiozos, I., Tsagouli, S., Souliotis, K., & Syrigos, K. (2014). Clinical Significance of Smoking Cessation in Subjects With Cancer: A 30-Year Review. Respiratory Care, 59(12), 1924-1936. 6. cancercareontario.ca/Quitting-Smoking

CERVICAL CANCER SCREENING METRICS >

WHAT HAS CHANGED? WHAT CAN BE MEASURED? WHAT CAN YOU DO?

Dr. Erica Mantay, MD, FRCSC, Regional Cervical Screening & Colposcopy Lead and Dr. Marla Ash, MD, CCFP, Regional Primary Care Lead

In 2016, approximately 600 Ontario women were diagnosed with cervical cancer and 150 died from this mostly preventable disease.

Recent efforts have been aimed at organizing and integrating Cervical Screening and Colposcopy and monitoring quality of care. In 2016, the Clinical Guidance Document for Best Practices in Colposcopy was published by CCO. It provides recommendations for entry into and discharge from colposcopy care, as well as best practice algorithms.

There are some changes for primary care as patients who have previously remained in colposcopy care indefinitely will be returned to primary care if conditions are appropriate, even if there are still low grade changes (ASCUS/LSIL) on their cervix.

In addition to clarifying best practices, CCO and OCSP are also monitoring quality of care through metrics chosen to represent aspects of care. As Pearson's Law tells us: "When performance is measured, performance improves. When performance is measured and reported back, the rate of improvement accelerates."

Remember to review your Screening Activity Report (SAR) regularly to identify patients overdue or those with abnormal tests without follow-up.

Two of the metrics of interest to Primary Care include:

1. ONTARIO CANCER SCREENING PARTICIPATION RATE

The number of screen eligible women who have had screening done in the last 42 months.

Our current LHIN and provincial rate is about 61% while our goal is 85%. There are about 628,600 screen-eligible women in our LHIN at this time. Thirty-nine percent overdue (39%) equals 245,200 women.

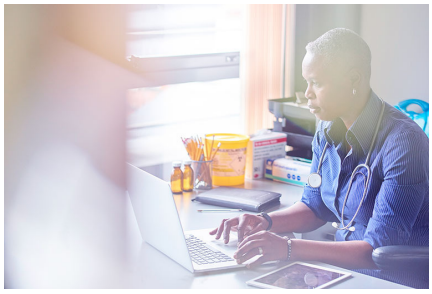
2. HIGH GRADE PAP WITH NO FOLLOW UP WITHIN 6 MONTHS

The percentage of women with a high-grade abnormality (HSIL, AGC, ASC:H, AIS) who were not seen and/or treated within 6 months.

The Central LHIN rate was about 13% in the last year. The provincial target is 10% or less. Our data as a region shows that women whose referral cytology showed AGC or ASC-H were less frequently seen within 6 months.

AGC and ASC-H are considered high grade abnormalities along with HSIL and require direct referral to colpsocopy. To facilitate ease of referral to colposcopy, an updated list of Colposcopy providers is enclosed with this newsletter.

COLON CANCER CHECK - TRANSITION TO FIT >



FIT TRANSITION RESOURCE HUB

To help ensure a successful transition to FIT, please visit the FIT Resource Hub regularly, It is updated with the latest news, changes, and tools relevant to your practice and stakeholders. Please continue to screen people at average risk for colorectal cancer with gFOBT until FIT is implemented.

Visit bit.ly/2FAw4rT to get information about the transition to FIT.

NEW INFORMATION AND RESOURCES >

ONTARIO CANCER STATISTICS 2018

Cancer Care Ontario (CCO) has released Ontario Cancer Statistics 2018, the second report in a series that takes a comprehensive look at the state of cancer in the province. Using data from the Ontario Cancer Registry, it focuses on the incidence, mortality, survival and prevalence of 23 of the most common cancers in Ontario. Emerging issues in cancer control are are also examined.

The report estimates that in 2018:

- 90,483 new cases of cancer will be diagnosed
- 30,574 people will die from the disease
- The greatest number of new cancer cases expected to be diagnosed in people ages 60 to 79, which accounts for more than half of all cancers diagnosed
- More than half of all cancer deaths are expected to occur in the 60-79 age group
- More than one third of all cancer deaths are expected to occur in people aged 80+

The report is available online at **cancercareontario.ca/cancerstatsreport**

DECOMMISSIONING OF THE CCO CANCER SCREENING MOBILE APP

With the launch of the new CCO website, the Cancer Screening Mobile App has been decommissioned and should be deleted off your devices. The app will no longer be available in app stores and will no longer be updated. All content previously available on the Cancer Screening Mobile App will now be available on the new CCO website. You are encouraged to bookmark relevant, regularly updated web links on your phones, tablets and computers.

Relevant Web Links to Bookmark

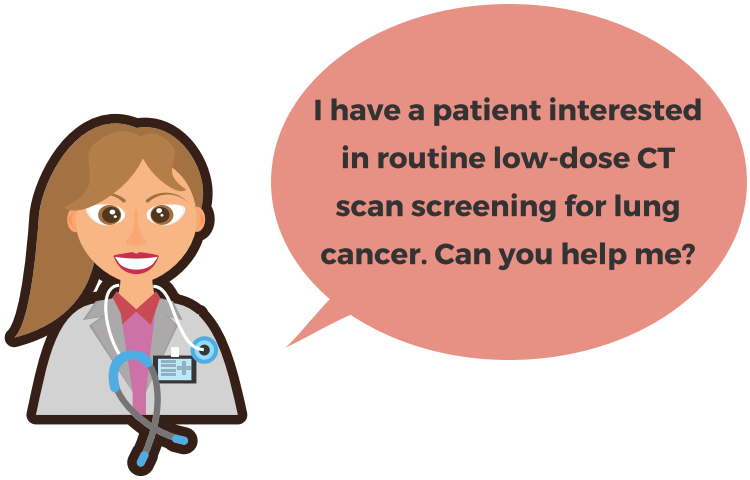
- Primary Care Resources (http://bit.ly/2FRp0qm)
- FIT Resource Hub (http://bit.ly/2FAw4rT)
- SAR (http://bit.ly/2GtWBVd)
- E-learning (http://bit.ly/1MDPKqs)
- Cancer Screening Resources (http://bit.ly/2Gt8YAN)
  - Breast, Cervical, & Colorectal Screening Guidelines
  - OBSP Requisition for High Risk Screening
  - Follow-up of Abnormal Cervical Cytology (https://bit.ly/2GaOhbP)

E-LEARNING: ABORIGINAL RELATIONSHIP & CULTURAL COMPETENCY COURSES

CCO has newly updated Aborginal Relationship and Cultural Competency courses. They provide a self-paced method of learning about the history and culture of First Nations, Inuit and Métis peoples. These free courses are certified by the College of Family Physicians of Canada for up to 13 Mainpro+ credits

For more information and to register, visit cancercareontario.ca/culturalsafety

LUNG CANCER SCREENING - FREQUENTLY ASKED QUESTION >



In 2017, Cancer Care Ontario launched the Lung Cancer Screening Pilot for People at High Risk. Specific sites were selected for this pilot to help determine how best to implement organized lung cancer screening for people at high risk in Ontario.

Screening should only occur through this pilot. CCO advises against lung cancer screening of asymptomatic people on an opportunistic or ad hoc basis, due to the additional risks posed to patients outside of an organized program.

Furthermore, physicians should not encourage patients to travel outside of their region to participate in the pilot as the full benefits of organized lung cancer screening are realized through end-to-end continuity of care which requires significant travel and commitment to the screening process. Additionally, to ensure pilot sites can properly assess the effectiveness of recruitment and follow through of screening, it is critical to ensure there is capacity for pilot sites to meet the needs of the population within their designated catchment areas.

Further information about the pilot and lung cancer screening for people at high risk is available through the Frequently Asked Questions for Healthcare Providers on the Cancer Care Ontario website. You may also send additional questions you have to screenforlife@cancercare.on.ca.

JUDY MURRAY >

NEW: INTERIM MANAGER

I spent most of my 30 years of clinical experience as a physiotherapist with seniors, promoting independence and mobility in various hospital and community settings. In 2004, I became a Master Trainer for the Stanford Chronic Disease Self-Management Program (CDSMP) and moved into furthering the philosophy and programs that help patients prevent and manage their chronic diseases.

I am a strong believer in screening for cancers. My mother was diagnosed with advanced bowel cancer. Being detected so late meant she had no options to fight it and she died 3 months later. In 2012, I went for my routine mammogram and was found to have early breast cancer. I had two lumpectomies and five weeks of radiotherapy and happy to be cancer free five years later!

I am excited to work with the Regional Prevention and Screening team this year to encourage activities that will lead to early detection and much improved outcomes for patients in Central LHIN.

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Central Regional Cancer Program
in partnership with Cancer Care Ontario

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