

CANCER *talk*

CONNECTING WITH MANITOBA'S PRIMARY CARE PROVIDERS

ASK the Expert

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NEW CHANGES TO COLORECTAL CANCER SURVEILLANCE IN MANITOBA

For a number of years now, follow up surveillance for colorectal cancer has included visits to the primary care provider/surveillance provider every 3 months for the first 3 years after surgery and every 6 months for years 4 and 5. At these visits in addition to a physical exam, blood work including a CEA is routinely done and CT scans are also done annually for the first three years.

There are now new recommendations (see table below) for Colorectal cancer surveillance. These are based on recent

evidence which looked at, among other outcomes, the survival advantage to patients.

Changes to previous guidelines include: decreasing the number of medical appointments: reducing the frequency of CT imaging; removing the recommendation for routine Q3 monthly CEA bloodwork; as well as expanding our recommendations to include patients with stage I colon or rectal cancers.

**5 -Year Follow-Up Recommendations
Stage I - III Colon and Rectal Cancer**

| FOLLOW-UP STARTING ON DATE OF SURGERY → | YEAR 1, 2, 3 | YEAR 4, 5 |
|---|---|--|
| Medical Follow-Up Care Appointment: <i>Focused history & physical + rectal / perineal exam</i> | Every 6 months | Annually |
| Bloodwork: <i>Carcinoembryonic Antigen (CEA)</i> <i>(no other blood tests are recommended routinely)</i> | At discretion of treating physician | |
| CT Imaging (infused): <i>Chest / Abdomen / Pelvis</i> | At Year 1 and Year 3 (Or once at 18 months, if this is more tolerable for the patient) | Not routine |
| Chest X-Ray, FOBT | Not routine | Not routine |
| Colonoscopy | 1 year after initial surgery or after first complete clearing colonoscopy if done after surgery | 4 years after initial surgery (i.e. 3 years after the year 1 colonoscopy), Then every 5 years indefinitely (if no polyps on colonoscopy) |
| Monitoring: <i>Possible Side Effects of Treatment</i> | Rectal Cancer: Bowel, Bladder and Sexual Function; Peripheral Neuropathy (nerve pain) Colon Cancer: Peripheral Neuropathy (nerve pain); Change in Bowel Habits | |

Recent evidence compared the overall survival advantages for patients undergoing high and low intensity follow-up schedules and found that there is no overall survival difference or increased detection of recurrence with high and low intensity follow-up schedules^{1,2,3}. Furthermore, there is more harm to the patient with higher intensity follow-up schedules because it led to more surgical procedures with limited survival advantage^{1,2,3}. Studies examined CEA testing frequencies and number of CT scans for patients with non-metastatic colorectal cancer and found that

use of CEA in combination with CT imaging does not lead to a survival advantage compared to CT imaging alone^{1,2,3}.

Therefore, our new recommendations propose that CEA is optional in patients who had an elevated CEA prior to treatment, provided that CT imaging is being performed. It is now left to the discretion of the physician whether to perform CEA testing, based on patient preferences/needs as well as, provider preference etc.

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Finally, for those patients who are unable or unwilling to undergo further surgery or treatments, routine surveillance should be replaced with assessments performed on an as-needed basis for the evaluation of symptoms. You can contact the cancer question for support if you are unsure whether to perform surveillance

with your patient, either call/text 204-226-2262 or email cancerquestion@cancercare.mb.ca

See the full guideline or learn more at cancercare.mb.ca/followupcare/

References

1. Jeffery M, Hickey BE, Hider PN. Follow-up strategies for patients treated for non-metastatic colorectal cancer. Cochrane Database Syst Rev. 2019;9:CD002200.
2. Wille-Jorgensen P, Syk I, Smedh K, Laurberg S, Nielsen DT, Petersen SH, et al. Effect of More vs Less Frequent Follow-up Testing on Overall and Colorectal Cancer-Specific Mortality in Patients with Stage II or III Colorectal Cancer: The COLOFOL Randomized Clinical Trial. JAMA. 2018;319(20):2095-103.
3. Mant D, Gray A, Pugh S, Campbell H, George S, Fuller A, et al. A randomized controlled trial to assess the cost-effectiveness of intensive versus no scheduled follow-up in patients who have undergone resection for colorectal cancer with curative intent. Health Technology Assessment (Winchester, England). 2017;21(32):1-86.

CANCERCARE MANITOBA PREVENTION & SCREENING UPDATE

CervixCheck

HPV Triage: Enhancing Cervical Cancer Screening in Manitoba

Effective March 14, 2022, cervical cytology labs will automatically perform high-risk human papillomavirus (hrHPV) testing on the Pap test specimens of patients:

- 30 years of age and older with atypical squamous cells of undetermined significance (ASCUS) Pap test results, and
- 50 years of age and older with low-grade squamous intraepithelial lesion (LSIL) Pap test results.

HPV triage:

- identifies and prioritizes the patients that would most benefit from colposcopy,
- decreases time to colposcopy and treatment by eliminating extra Pap tests,
- avoids unnecessary treatment for patients who do not need colposcopy, and
- reduces anxiety for those who do not need follow-up.

The lab report will contain the cytology interpretation, high-risk HPV test result, follow-up recommendation, and educational note. Revised screening guidelines will be posted at www.cancercare.mb.ca/screening/hcp.

Other resources are available at <https://www.cancercare.mb.ca/screening/hcp/education>, including a clinical practice change and recorded webinar by Dr. S. Kean, CervixCheck Medical Lead, and panelists.

ColonCheck

Increased Risk Management for Colorectal Cancer

On March 2, 2022, ColonCheck hosted an informative webinar about screening and surveillance management for individuals at increased risk for colorectal cancer.

Topics discussed included:

- screening guidelines,
- case studies, and
- how a personal or family history of colorectal cancer can impact a patient’s screening recommendation.

To view the webinar and participant questions and answers visit <https://www.cancercare.mb.ca/screening/hcp/education>

If you have questions regarding the work-up of suspected cancer or any other cancer-related questions, please contact The CancerQuestion Helpline for Healthcare Professionals

(204) 226-2262 or cancer.question@cancercare.mb.ca

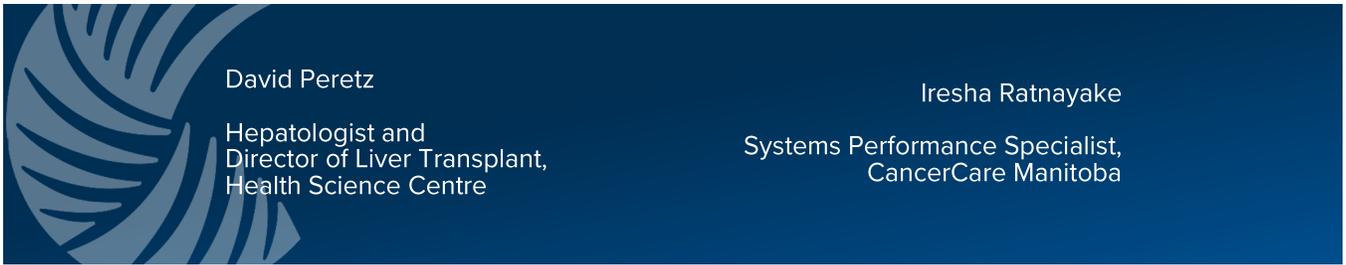
Monday to Friday 8:30 a.m. to 4:30 p.m.

UPCOMING VIRTUAL EDUCATION EVENTS

Friday, April 8, 2022, 1:00 p.m. - 4:00 p.m.
Cases in Cancer: Lung Cancer Diagnostic Work-up - Drs. Biniam Kidane and James Bras. [Register here.](#)

Friday, April 22, 2022, 12:00 p.m. - 1:00 p.m.
Cases in Cancer: Management of Comorbidities - Dr. Davinder Jassal. [Register here.](#)

Friday, May 27, 2022, 8:00 a.m. - 4:00 p.m.
Cancer Day for Primary Care 2022 - A full day symposium dedicated to primary care and oncology. [Register here.](#)



David Peretz

Hepatologist and
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HEPATOCELLULAR CANCER

Hepatocellular carcinoma (HCC) is the most common type of primary liver cancer in adults.¹ In 2020, 905,677 liver cancer cases were reported worldwide accounting for 5% of all cancers.² Most of these cancers were reported in Asia (72.5%) and only 5% were in North America.³ In Canada, the age-standardized incidence rate (ASIR) of liver cancer has increased from 6.0 per 100,000 in 2000 to 11.5 per 100,000 in 2021 for males, and 2.0 per 100,000 in 2000 to 3.1 per 100,000 for females in 2021.⁴ In Manitoba, the ASIR is 8.9 and 2.9 per 100,000 respectively for males and females.

The primary risk factors for HCC are Hepatitis B or C infection, cirrhosis of the liver, alcohol, tobacco, metabolic disorders (e.g., hemochromatosis), non-alcoholic steatohepatitis (NASH), a complication of non-alcoholic fatty liver disease (NAFLD), and excess weight.^{5,6} In North America, the prevalence of NAFLD is approaching 30% and is continuing to rise.⁷ Approximately 20% of NAFLD patients will go on to develop NASH, which is the inflammatory form of NAFLD.⁷ Over time, many of these individuals will progress to advanced hepatic fibrosis and cirrhosis, putting them at risk of HCC.⁸ The primary risk factors for developing NAFLD are diabetes and obesity.⁷ Currently, no effective treatments exist for NAFLD outside of lifestyle measures such as diet and exercise. Due to the tremendous regenerative capacity of the liver, a weight loss of 7-10% of body weight can resolve NAFLD, and even regress hepatic fibrosis. Other lifestyle changes such as adopting a Mediterranean diet, limiting carbohydrates and fatty foods, avoiding foods containing fructose and processed foods, portion control, not eating right before bedtime, drinking 2-3 cups of coffee per day, and exercising 5 days per week for at least 30 minutes have shown to slow NAFLD progression.⁸

However, the efficacy of various types of systemic therapy offered to HCC patients may be dependent on the etiology of the disease. While sorafenib was the first drug approved for systemic therapy in advanced HCC, other drugs are now available. For example, the SHARP study⁹ reported that Hepatitis C patients may benefit from sorafenib, while the REFLECT study¹⁰ reported lenvatinib may be more effective in Hepatitis B patients and those with elevated alpha fetoprotein. Until recently, the tyrosine kinase inhibitors sorafenib and lenvatinib have been first line agents for the treatment of HCC. Since 2021, at least in Europe and North America, first-line systemic therapy for metastatic or unresectable advanced HCC now consists of an immune checkpoint inhibitor (atezolizumab) given in combination with an anti-VEGF antibody (bevacizumab)¹¹. Studies have also reported that patients with NASH may not respond as well to checkpoint inhibitors¹². Liver disease, fibrosis of the liver, and cirrhosis development are directly linked to HCC; however, approximately 59% of liver cancers in Canada are considered preventable.⁶ Although Hepatitis C is now highly treatable, an effective vaccine would probably be needed to accomplish its complete eradication. In light of how prevalent NAFLD is, reducing the incidence of NAFLD would likely have an even greater impact on the incidence of HCC in North America than would the eradication of Hepatitis C. In addition, screening for alcohol use disorder, maintaining healthy body weight, screening and treating other metabolic syndromes, and avoiding high-risk behaviour that could lead to Hepatitis B or C infection remain important.

References

1. Venook AP, Papandreou C, Furuse J, et al. The Incidence and Epidemiology of Hepatocellular Carcinoma: A Global and Regional Perspective. *The Oncologist* 2010;15 (S4):5-13. doi: 10.1634/theoncologist.2010-s4-05.
2. International Agency for Research on Cancer. Estimated number of new cases in 2020, worldwide, both sexes, all ages 2020 [Available from: [Cancer Today \(iarc.fr\)](https://gco.iarc.fr/today/data-viewers/cancer-today)].
3. International Agency for Research on Cancer. Estimated number of new cases in 2020, liver, both sexes, all ages 2020 [Available from: [Cancer Today \(iarc.fr\)](https://gco.iarc.fr/today/data-viewers/cancer-today)].
4. Canadian Cancer Statistics Advisory Committee in collaboration with the Canadian Cancer Society. Canadian Cancer Statistics. Toronto, ON: Canadian Cancer Society, 2021.
5. Canadian Cancer Society. Risks for liver cancer 2021 [Available from: [Risks for liver cancer | Canadian Cancer Society](https://www.cancer.ca/en/living-with/cancer-prevention/prevention-of-liver-cancer/)].
6. Canadian Population Attributable Risk of Cancer (ComPARE) Study. Percentage of cancers that are preventable in Canada, 2019.
7. Uhanova J, Minuk G, Lopez Ficher F, et al. Nonalcoholic Fatty Liver Disease in Canadian First Nations and Non-First Nations Patients. *Canadian Journal of Gastroenterology and Hepatology* 2016;2016:6420408. doi: 10.1155/2016/6420408.
8. Peterson KF, Dufour S, Bdfroy D, Lehrke M, Hendler RE, Shulman GI. Reversal of nonalcoholic hepatic steatosis, hepatic insulin resistance, and hyperglycemia by moderate weight reduction in patients with type 2 diabetes. Canadian Population Attributable Risk of Cancer (ComPARE) Study. Percentage of cancers that are preventable in Canada, 2019.
9. J.M. Llovet, S. Ricci, V. Mazzaferro, P. Hilgard, E. Gane, J.-F. Blanc, et al. Sorafenib in advanced hepatocellular carcinoma *N Engl J Med*, 359 (2008), pp. 378-390.
10. M. Kudo, R.S. Finn, S. Qin, K.-H. Han, K. Ikeda, F. Piscaglia, et al. Lenvatinib versus sorafenib in first-line treatment of patients with unresectable hepatocellular carcinoma: a randomised phase 3 non-inferiority trial.
11. Finn RS, Qin S, Ikeda M, et al. Atezolizumab plus bevacizumab in unresectable hepatocellular carcinoma. *N Engl J Med* 2020;382:1894–905.
12. Finn RS, Qin S, Ikeda M, Galle PR, Ducreux M, Kim T.-Y, et al. IMbrave150: updated overall survival (OS) data from a global, randomized, open-label phase III study of atezolizumab (atezo) + bevacizumab (bev) versus sorafenib (sor) in patients (pts) with unresectable hepatocellular carcinoma (HCC) *JCO*, 39 (3_suppl) (2021), p. 26.
13. Mitra S, De A, Chowdhury A. Epidemiology of non-alcoholic and alcoholic fatty liver diseases. *Translational Gastroenterology and Hepatology* 2020;5:16-16. doi: 10.21037/tgh.2019.09.08.



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MESSAGE FROM CCMB PRESIDENT AND CEO, DR. SRI NAVARATNAM

Close the Care Gap through Equitable Care and Research

World Cancer Day was recognized on February 4 2022 with the theme of Close the Care Gap. Around the globe and even in Manitoba, there are gaps in the care provided to cancer patients. At CancerCare Manitoba, we can close the care gap by providing equitable care for all patients. Regardless of where patients live, their education level, ethnicity or age, we want to ensure they receive equitable care – care that is focused on the individual patient and their specific needs, including those of their family and community of support.

Manitobans with cancer can know they will be taken care of through a model of care that is patient focused and driven by research and innovation. Bringing the best care to each patient is our commitment and our goal. We want CancerCare Manitoba and its Research Institute to be a world leading comprehensive cancer centre for all Manitobans.

Research and innovation are also key to closing the care gap and achieving cancer control in our province. Through research and clinical trials at CancerCare Manitoba, we bring research close to patient care and offer tomorrow’s treatments to patients today.

And finally, as individuals we need to think about, what can I do to reduce the cancer risk in my life and the community I live in? How can I close the gap? Can I do more exercise? Can I stop smoking? Can I eat healthier meals? CCMB’s Practice Prevention campaign launched on World Cancer Day, encouraging all Manitobans to take action in their lives towards healthy lifestyle choices. As primary care providers, you play an important role in reinforcing these messages to your patients.

As we all work together, we can close the care gap and enjoy healthier lives, the best healthcare possible, the best cancer services, and the latest research and treatments.

For World Cancer Day and every day, that is our message to all Manitobans to reflect on and contribute to as we work towards a better Manitoba and a better world.

[CCMB World Cancer Day 2022 FINAL - YouTube](#)

www.practiceprevention.ca

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