ISSUE 43 • SUMMER 2023

CANCER *talk*

CONNECTING WITH MANITOBA'S PRIMARY CARE PROVIDERS

UPwords

NETWORK NEWS FOR PRIMARY CARE PROVIDERS

Why is UpWords in Cancer Talk?

In this issue of CancerTalk, we are piloting something new! To streamline our information distribution, we are incorporating the information and updates in our UPWords e-newsletter into our CancerTalk newsletter in a dedicated 'UPWords' section. That way, readers can find all information in one place and maybe check out something new in the process!

We are open to hearing from our readers about whether UPWords and CancerTalk combined works for you.

Feel free to send your feedback by email to CCMBPrimaryCareEducation@cancercare.mb.ca.

Community Profiles

First Nations ◦ Métis ◦ Inuit

The Indigenous Community Profiles webpage helps healthcare providers develop safer and more realistic care plans for patients returning to their communities by describing geographical and travel information in the community, including healthcare and community resources.

CancerCare Manitoba worked with First Nation, Métis and Inuit partners to gather community information for these profiles.

Visit ccmbindigenouscommunityprofiles.ca

SAVE THE DATE

Provincial Cancer Care Conference 2023

October 12-13, 2023

See our poster inside for more details.

UPDATE ON FECAL IMMUNOCHEMICAL TEST (FIT)

Check out page 3 for more information about prevention and screening.

THE NAVIGATOR

CCMB provides support groups and services to assist patients and families through their cancer journey.

Click here for more.

Message from CCMB President and CEO

May 31st was truly an exceptional day for all of us here at CancerCare Manitoba, and for our province, with the announcement of the Paul Albrechtsen Foundation's extraordinary donation of $27 million to CancerCare Manitoba. The significance and enormity of this generous gift cannot be overstated and we are so grateful.

A gift like this brings hope and light to a cancer diagnosis, where there is often despair and darkness. It is a testament to the dedication, compassion and profound impact each of us has on the lives of those with cancer whom we serve. We want Manitobans with cancer to approach their life with hope and to live their life to the fullest.

I share Mr. Albrechtsen's vision and passion for excellence in research and clinical care. To honour this significant donation, I commit to all Manitobans that we will continue to build CancerCare Manitoba as a leading comprehensive cancer centre in Canada and globally. The donation enables us to fulfill our commitment by investing in research, which is the pathway to discovery and excellence in cancer care.

$23.5 million will be directed towards research at CancerCare Manitoba in specific areas of renewal of our research laboratories, genomics, and single -cell technology – a suite of equipment unique in Canada! In recognition of this gift towards research, the CancerCare Manitoba Research Institute will be renamed the **Paul Albrechtsen Research Institute CancerCare Manitoba.**

As announced in Brandon earlier this year, $3.5 million will be directed to a new dedicated space for hope and healing at the Western Manitoba Cancer Centre. The space will house physical and emotional care programs for the wider Westman region. The centre will be named the **Paul Albrechtsen Centre for Hope.**

We express our deepest gratitude to the Paul Albrechtsen Foundation for their very generous gift, to the CancerCare Manitoba Foundation for their work in making this possible, and to all healthcare providers who care for cancer patients in Manitoba for your unwavering commitment, tireless effort, and remarkable achievements that have undoubtedly influenced this unprecedented act of philanthropy.

Dr. Sri Navaratnam MBBS PhD FRCPC
President and Chief Executive Officer,
CancerCare Manitoba
Professor, Department of Internal Medicine,
Rady Faculty of Health Sciences,
University of Manitoba

CANCERCARE MANITOBA PREVENTION & SCREENING

ColonCheck

In the summer of 2023, ColonCheck will begin distributing the fecal immunochemical test (FIT) to screen for colorectal cancer throughout Manitoba. The FIT can be done at home and requires only one sample from the patient. Other advantages to using FIT include:

- Increased patient participation.
- No dietary or medication restrictions for the patient before or during completion of the test.
- Tests specifically for human blood from the colon.
- Improved sensitivity for colorectal cancer and advanced adenomas.

To learn more, sign up for a ColonCheck webinar on June 20, 2023. To register for the webinar visit cancercare.mb.ca/screening/hcp/education

CervixCheck

To increase screening rates, CervixCheck sent out nearly 25,000 screening invitations with HPV self-collection kits. There were three arms to the project:

1. Patient sent kit in the mail with invitation letter.
2. Patient sent an invitation letter to request a kit online or by phone.
3. No intervention.

The invitations were sent to randomly selected females age 30-69 who had not had a Pap test in five years or more. To date, about 25% of people who were sent a kit completed the HPV test or had a Pap test. Among those who had to request a kit, 17% have been screened. Additionally, we invited participants to provide survey feedback about their experience using the kit and of the 744 respondents:

- ✓ 95% of respondents said the cervix kit was easy or very easy to use.
- ✓ 93% of respondents would be likely or very likely to recommend this test to a friend.

CancerCare Manitoba Prevention to remind eligible patients to get vaccinated against HPV

This summer, CancerCare Manitoba Prevention is sending notification letters to eligible adult women who have not been vaccinated against HPV.

The purpose of the letter is to remind those who are eligible that they can access the HPV vaccine for free through their healthcare provider, local pharmacy, or public health office. Resources to support your patient conversations around HPV vaccination include:

- CancerCare Manitoba's PreventHPVCancers.ca
- CancerCare Manitoba's HPV Vaccine Frequently Asked Questions (pdf)
  cancercare.mb.ca/export/sites/default/screening/.galleries/files/prevention-files/p-vaccine-hpv-letter-insert-ef.pdf
- Manitoba Health HPV Vaccination Information
  manitoba.ca/health/publichealth/cdc/div/index.html

BreastCheck

Early detection of breast cancers can increase treatment options and provide better outcomes. Eligible Manitobans can make breast cancer screening appointments by calling 1-855-95-CHECK. No referral is required. BreastCheck has six clinics that accept appointments year-round: Brandon, Boundary Trails, Thompson, Winnipeg, and two mobile clinics that travel throughout the province.

To review upcoming clinics, visit our website at cancercare.mb.ca/screening/info/breast#clinics

What is Health Equity?

A Tool for Health & Social Service Organizations and Providers

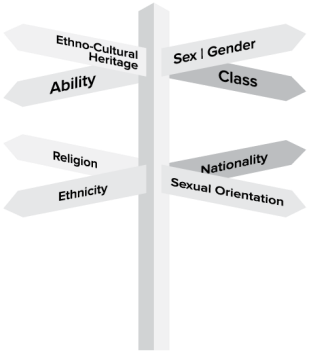
EQUIP Health Care. (2020). *What is Health Equity: A Tool for Health & Social Service Organizations and Providers.* Vancouver, BC. Retrieved from www.equiphealthcare.ca **Version | December 2020**.

Defining Health Equity

Health equity is a social justice goal focused on pursuing the highest possible standard of health and healthcare for all people, paying special attention to those in the context of greater risk of poor health, and taking into account broad social, political, and economic influences and access to care.

It is defined as the **absence of avoidable** or **remediable differences** among groups of people, ensuring that all people have **full access** to opportunities that enable them to lead healthy lives, such as:

Quality affordable healthcare	**Social support networks**
Education	**Public policies**
Safe housing	**Stable income & job security**
Environmental quality	**Food security**



However, evidence shows that people's daily experiences and their access to these services intersect in ways that are highly dependent on their sex/gender, ethno-cultural heritage, socioeconomic status or class, sexual orientation, religion, ability, nationality and other fluid intersections.

Defining Health Equity

Health inequities refer to socially constructed, unjust and avoidable differences in health and healthcare between and within groups of people, whether those groups are defined socially, economically, demographically, or geographically. These can include differences due to socially and structurally modifiable barriers such as poverty, discrimination, cultural barriers to accessing healthcare, and poor governance. Interventions that aim to redress inequities typically **go beyond remedying a particular health inequality** and further attempt to empower individuals through systematic and structural changes.

This toolkit offers actions you can take to implement equity-oriented care in your primary health care practice. Harm reduction, cultural safety, and trauma and violence informed care (TVIC) are interrelated concepts that can help promote equity.

For other tools in the toolkit, see: https://equiphealthcare.ca/toolkit

CIHR IRSC
Canadian Institutes of Health Research | Instituts de recherche en santé du Canada

Equality ≠ Equity

Health Equity is Not the same as Health Equality

Health equality aims to ensure that everyone gets the same things in order to enjoy full, healthy lives. Like equity, equality promotes fairness and justice, however, it can only work if everyone starts from the same place and needs the same things.

Health equity focuses on ensuring and treating those who require care in ways that are appropriate to *what they need* to enjoy full, healthy lives. It aims to remove unjust and unnecessary differences, requiring us to consider the possibility of making different arrangements for resource allocation, or social institutions or policies.

Why is it important to attend to health equity?

CLOSE UNJUST GAPS IN HEALTH STATUS

- Persistent and growing health and healthcare inequities continue to affect marginalized populations.
- In Canada, increasing homelessness, and systemic discrimination toward Indigenous people and new immigrants are instances of systematic health and social inequities that can be addressed through equity-oriented care.

IMPROVE OUTCOMES
in a primary health care context

- Equity-oriented processes of care lead to increases in patients' comfort and confidence in care.
- This increases their confidence to manage and prevent health problems.

As a result, their quality of life increases, while their symptoms of depression, chronic pain, and PTSD go down.

REDUCE COSTS

- People experiencing the greatest socio-economic inequities often have the poorest health.
- Improving healthcare experiences and outcomes for this group will, therefore, result in the greatest gains, reducing costs to the system.

By removing avoidable, unjust differences in healthcare among groups of people (whether they are defined socially, economically, demographically, or geographically), all people can have full access to opportunities that will enable them to lead healthy lives.

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WHAT'S NEW IN RECTAL CANCER - TOTAL NEOADJUVANT THERAPY

As new data emerges, the management of locally advanced rectal cancer (LARC) is shifting. Conventional treatment of LARC consists of long-course chemoradiation (CRT) (5.5 weeks of radiation with concurrent 5-fluorouracil or capecitabine chemotherapy), followed by surgical resection and consideration of adjuvant chemotherapy. A Total Neoadjuvant Therapy (TNT) approach consists of delivering chemotherapy and radiation in the neoadjuvant setting, before surgical resection. There are several potential benefits to a TNT approach, including improving tumour downstaging, increasing chemotherapy uptake, eradicating micrometastases and increasing clinical and pathologic responses, which may facilitate non-operative management. With TNT, one can also assess tumour biology and tumour response to treatment while the disease is in situ.

Some of the pivotal studies assessing the TNT approach will be highlighted below. Studies have used different TNT approaches and have looked at different endpoints, making interpretation of the data complex. Systematic reviews and meta-analyses[1,2] have shown that TNT is associated with improved rates of pathologic complete response (pCR) and potential improvements in disease-free and overall survival (OS).

RAPIDO Trial

The RAPIDO [*Rectal Cancer And Pre-operative Induction Therapy Followed by Dedicated Operation*] trial[3] was a phase III randomized controlled trial of >900 patients with LARC with at least one high-risk feature identified on pelvic MRI (clinical T4, clinical N2, extramural vascular invasion, involved mesorectal fascia, enlarged lateral lymph nodes). Before surgery, patients were randomized to short-course radiation followed by combination chemotherapy (CAPOX x 6 or FOLFOX x 9) or standard long-course CRT. The primary endpoint was disease-related treatment failure (locoregional recurrence, distant metastasis, new primary colorectal tumour or treatment-related death) at three years. Disease-related treatment failure occurred in 23.7% of those in the TNT group, compared to 30.4% in the standard of care group (hazard ratio 0·75, 95% CI 0·60–0·95; p=0·019). However, after five years of follow up[4], more patients in the TNT group had a locoregional failure or a local regional recurrence, compared to those who received standard CRT (12% vs 8% and 10% vs 6%). Factors associated with the development of a local regional recurrence included: enlarged lateral lymph nodes, positive circumferential resection margin, tumour deposits and pathologic node positivity. The risk of distant metastases was higher in the standard of care group and there was no difference in OS between the two groups.

OPRA Trial

The OPRA [*Organ Preservation in Patients with Rectal Adenocarcinoma Treated with Total Neoadjuvant Therapy*] trial[5] was a phase II trial of >300 patients with clinical stage II and III rectal cancer. Patients were randomized to receive four months of induction CAPOX or FOLFOX chemotherapy followed by CRT versus CRT followed by consolidation CAPOX or FOLFOX. Patients were restaged 8-12 weeks after completion of treatment and would then go onto total mesorectal excision (TME). Patients who had an excellent response to treatment were given the option of proceeding to surgery or a watch-and-wait approach.

The primary aim of OPRA was to compare DFS with TNT to that of historical controls and at 3 years, the DFS was no different between these groups. A secondary endpoint was the proportion of patients who were alive without having undergone TME. The TME-free survival (also known as the organ preservation rate) was 41% amongst those who had induction chemotherapy followed by CRT, compared to 53% amongst those who had CRT first followed by chemotherapy. Interestingly, there was no difference in OS based on whether patients underwent TME. An intriguing takeaway from the OPRA study was that some patients may be able to avoid surgery with the use of TNT, with a preference for CRT followed by chemotherapy.

PRODIGE 23 Trial

The phase III randomized controlled PRODIGE 23 [*Partneriat de Recherche en Oncologie Digestive*] trial enrolled patients with clinical T3 and T4 rectal cancer. Patients were randomized to receive 6 cycles of triplet FOLFIRINOX chemotherapy followed by CRT followed by TME and then adjuvant FOLFORX or CAPOX chemotherapy versus standard of care. The 3-year DFS was 76% in the TNT group compared to 69% in the standard of care group. There was also a higher rate of pCR in the TNT group. A recent update[7] shows improvements in DFS, OS and metastatic recurrence in the TNT group.

PROSPECT Trial

Just this month, the results of the PROSPECT trial[8] were presented and published. CancerCare Manitoba contributed significantly to this potentially practice-changing study, with 47 Manitoba patients enrolled. Patients with clinical T2 node-positive, T3 node-negative and T3 node-positive disease were randomized to receive standard CRT or six cycles of neoadjuvant FOLFOX chemotherapy. In the neoadjuvant chemotherapy arm, if patients had ≤20% tumour response or if they were unable to tolerate FOLFOX, they went on to receive CRT before surgery. Adjuvant therapy was given as per physician's discretion. At five years, no difference in DFS was seen between the two arms. Local recurrences were very low in both groups, and no differences were seen in pCR rates and OS. There was no statistically significant difference in quality of life between the two groups and patients in the FOLFOX arm reported better bowel and sexual function than those in the CRT arm.

The authors concluded that omitting CRT minimized radiotherapy-associated toxicities and did not compromise oncologic outcomes, therefore most patients with intermediate-risk rectal cancer can be treated with neoadjuvant chemotherapy with the omission of CRT. However, it should be noted that this trial excluded many high-risk patients, including those with clinical T4 and clinical N2 disease, as well as those requiring APR.

Take Home Messages

What is the take-home message from trials investigating the TNT approach? First, it is exciting to see the benefits of TNT in improving outcomes and minimizing toxicity for patients with LARC and to see that non-operative management may be an option for some patients. However, refining which patients require TNT is critical. While the outcomes of the above studies are intriguing, there are differences in the populations included and treatment regimens used. Is it possible that some patients were over-treated? Which patients require a more aggressive approach to reduce the risk of local recurrence? Clinical trials are ongoing to help understand which patients benefit from TNT and the optimal treatment protocol for specific populations. Enrollment in clinical trials is essential to answer these questions. At present, all cases of LARC should be reviewed in a Multidisciplinary Case Conference discussion. One must consider the goals of TNT in each case, and engage in shared decision-making with patients, taking into consideration the clinical stage, the presence of high-risk features on pelvic MRI, long-term outcomes and the patient's surgical goals.

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CancerCare Manitoba
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SAVE THE DATE:

Provincial Cancer Care Conference 2023

October 12-13, 2023

Venue: Canad Inns
Destination Centre Polo Park

DSG Focus: Lymphoproliferative (Lymphoma & Multiple Myeloma)

More information to follow.

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