Northeast Cancer Centre
Health Sciences North
a Cancer Care Ontario partner

Northeast ONCOLOGY News

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As we head into Spring 2022, I will be heading into retirement, having spent the last 31 years in leadership positions at Health Sciences North (HSN) and 36 years as a Registered Nurse. It has been an honour and a privilege leading the Northeast Regional Cancer Program since the Fall of 2018.

I am pleased to introduce you to my successor, Dr. Natalie Aubin. Natalie starts in the Regional Vice-President role for Northeast Cancer Care and as Vice-President Social Accountability at HSN on April 18th.

Natalie has an extensive knowledge of the Northeast region, having provided many years of strategic leadership as Administrative Director of the Northeast Cancer Centre from 2012-2016 and more recently, leading HSN's Mental Health and Addictions Program from 2016 to present.

Natalie holds a PhD in Human Studies, MA, in Human Development and BA in Psychology. Fluently bilingual and highly respected by colleagues across the region, Natalie will continue to work with teams from across the region to advance our Regional Cancer Plan.

Dr. Natalie Aubin

I invite you all to review the refreshed Regional Cancer Plan so that you will have a glimpse into the priorities Natalie will continue to advance in her role. To request an e-copy, please contact Merci Miron-Black at neoncologynews@hsnsudbury.ca

Please accept my gratitude for your ongoing commitment, collaboration and support in improving cancer care for the people of our region.

Maureen McLelland BScN, MHSc, CHE
Vice-President Social Accountability, Health Sciences North
Regional Vice-President, Ontario Health (Cancer Care Ontario)

Reviewing COVID-19 Vaccination Status for Cancer Patients

As of March 2022, Ontario continued to ease public health measures related to the COVID-19 pandemic, lifting capacity limits in indoor public settings and lifting proof of vaccination requirements for all settings.

This has left some of our more vulnerable and immunocompromised patients feeling increasingly concerned about being infected with COVID-19.

Particularly impacted by this shift in restrictions are patients currently receiving treatment through the Northeast Regional Cancer Program. Regardless of where they may be in their cancer treatment journey, patients may benefit from being reminded of the continued importance of receiving their COVID-19 vaccines.

At the time of this publication, the following timelines are recommended for moderately to severe immunocompromised patients who are pursuing vaccination:

- If the patient (five years of age or older) has not yet had any doses of vaccine, it is very important for them to be immunized with their first dose as soon as possible after their cancer diagnosis.
- If the patient is on active treatment and in the process of completing their initial 2-dose vaccine series, they should follow the manufacturer recommended dosing interval, rather than the NACI recommended 8-week interval for immunocompetent patients.
- If the patient is five years of age or older, a third dose is recommended as part of their primary series, and should be provided at least 56 days after their second vaccine.
- A fourth dose (booster) is currently recommended for patients 18 and older at an interval of 84 days, or 168 days for individuals 12-17 years old.

Evidence around timing of COVID-19 vaccination in specialized populations continues to evolve rapidly.

For additional information on conditions and medications that may lead to immunocompromised states, and for up to date guidance on eligibility criteria, visit the Ministry of Health website at: www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/covid19_vaccine.aspx
or the Ontario Health (Cancer Care Ontario) website at: www.cancercareontario.ca/sites/ccocancercare/files/assets/COVID-19VaccineClinicianFAQ.pdf

Dr. Jason Sutherland MD, PhD, CCFP
Regional Primary Care Lead
Northeast Regional Cancer Program

Northeast Cancer Centre
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Five Points Primary Care Should Consider When a Pathology Report Reads: MELANOMA

Dr. Lacey Pitre

Dr. Nathan Thangaroopan

1. Does the patient need a wide local excision?

This heavily depends on the margins achieved (see Fig.1):

a. Melanoma in situ: Goal margins 5 mm - 1 cm

b. All melanoma: If under 1 mm: 1 cm. If 1-2 mm: 1 cm, ideally 2 cm. Over 2 mm: 2 cm margin.

Essentially, if the pathology report indicates margins **under** these values – the patient does require wide excision. Any physician can do a wide local excision if they have the skills (primary care, dermatology, general surgery, etc.). However, ideally if a patient requires a concomitant sentinel lymph node biopsy – the practitioner would do both (wide excision + sentinel node procedure) at the same time. For this reason it is important to know which specialists in your region perform sentinel node procedures.

Figure 1: Primary Excision Margins in Cutaneous Melanoma

Melanoma Depth/Thickness	Margin
pTis melanoma in situ	5 mm -1 cm
pT1 melanoma ≤1.0 mm	1 cm
pT2 melanoma 1.01 - 2.0 mm	1 - 2 cm
pT3 melanoma 2.01 - 4.0 mm	2 cm
pT4 melanoma >4.01 mm	2 cm

Wright F, Souter LH, Easson A, Murray C, Toye J, McCready D, et al. Primary excision margins and sentinel lymph node biopsy in cutaneous melanoma. Toronto (ON): Cancer Care Ontario; 2017 November 13. Program in EvidenceBased Care Guideline No.: 8-2 Version 2.

2. Does the patient need general surgery referral for consideration of sentinel lymph node sampling?

This heavily depends on **depth** of invasion and for 'shallow melanomas' some other critical prognostic factors (see Fig. 2):

a. Melanoma in situ: no referral for sentinel lymph node sampling required

b. Melanoma less than 0.75 mm with mitotic rate of zero, no ulceration, no microsatellites and Clark level III or lower: no referral for sentinel lymph node sampling required

c. Any melanoma with Clark level IV/V, mitotic rate of 1 or more, positive ulceration or microsatellites: consider referral for sentinel node sampling

3. Should a patient with melanoma in situ or melanoma be referred to the Northeast Cancer Centre (NECC)?

Yes. We will see melanoma in situ to make surveillance recommendations. We will see all other melanoma patients but ideally a referral for wide excision +/- sentinel lymph node biopsy would have been initiated at the same time or before the referral to the NECC.

Figure 2: Sentinel Lymph Node Biopsy (SLNB) in Cutaneous Melanoma

Melanoma Depth/Thickness	Use of SLNB
pTis melanoma in situ	Not recommended
pT1 melanoma ≤1.0 mm	If melanoma is ≥0.75 mm, has a Clark level IV/V, high mitotic rate (≥1 mitosis/ mm²), ulceration, or microsatellites, physicians should discuss SLNB with these patients. If the results of SLNB indicate these patients have melanoma metastases in their sentinel node, they may benefit from adjuvant therapy and/or entry into adjuvant clinical trials and therefore may have an improved melanoma-specific survival (MSS).
pT2 melanoma 1.01 - 2.0 mm and pT3 melanoma 2.01 - 4.0 mm	SLNB is recommended for these patients to provide locoregional control and to identify patients who may benefit from adjuvant therapy and/or entry into adjuvant clinical trials. SLNB does provide an MSS benefit if the sentinel node contains melanoma metastases.
pT4 melanoma >4.01 mm	Physicians should discuss SLNB with these patients and to identify patients who may benefit from adjuvant therapy and/or entry into adjuvant clinical trials. SLNB will provide prognostic information and may provide locoregional control but not MSS benefit.

Wright F, Souter LH, Easson A, Murray C, Toye J, McCready D, et al. Primary excision margins and sentinel lymph node biopsy in cutaneous melanoma. Toronto (ON): Cancer Care Ontario; 2017 November 13. Program in EvidenceBased Care Guideline No.: 8-2 Version 2.

4. Should a patient with a melanoma on the face or head and neck region be referred to the NECC?

Yes. We have an internal triage process to ensure that decisions about wide excision and sentinel node sampling procedures are done through our team. The patient may be seen by the ENT service or by plastic surgery at the NECC Skin Clinic. Because these patients are so complex we follow a different process for them.

5. Can I predict if my patient will be offered therapy at the NECC?

Systemic Therapy: If a patient has a positive sentinel node biopsy or a melanoma with other high risk features, we will sometimes offer one year of IV immunotherapy as adjuvant or preventative therapy. With metastatic or Stage IV melanoma we use IV immunotherapy or pill-form targeted therapy and many patients can live years even in this advanced setting.

MELANOMA continued...

Radiation Therapy: Radiation without surgery is considered in the palliative setting, as typically melanoma was thought to be radioresistant. Nowadays high doses per fraction may overcome this resistance, particularly in the oligometastatic setting as determined by CT or PET-based imaging.

In the adjuvant setting post excision, radiation can be considered when:

Role of Adjuvant Radiation
Close/Positive margin not suitable for further excision
Recurrence after previous excision
Neurotropism/Perineural Invasion
Desmoplasia
Microsatellites

After lymph node dissection primarily, or sentinel node evaluation if applicable, radiation may be considered when one or more of the following are identified:

Basin	High Risk Criteria
Cervical	>2 cm size or >2 positive nodes or extra capsular extension
Axilla	>3 cm size or >4 positive nodes or extra capsular extension
Epitrochlear	>3 cm size or >4 positive nodes or extra capsular extension
Inguinal	>3 cm size or >4 positive nodes or extra capsular extension

Burmeister BH, Henderson MA, Ainslie J, et al. Adjuvant radiotherapy versus observation alone for patients at risk of lymph-node field relapse after therapeutic lymphadenectomy for melanoma: a randomised trial. Lancet Oncol. 2012;13(6):589-597. doi:10.1016/S1470-2045(12)70138-9

Dr. Lacey Pitre FRCP(C)
Northeast Regional Quality Systemic Therapy Lead
Ontario Health (Cancer Care Ontario)

Dr. Nathan Thangaroopan MD MBA FRCP(C)
Radiation Oncologist
Northeast Cancer Centre

Stephanie Winn

Pediatric Oncology Group of Ontario: Managing Patient After-Care

Sylvie Kozlowskyj

The Pediatric Oncology Group of Ontario (POGO) has supported a pediatric oncology clinic within the Northeast Cancer Centre since 1999. This satellite clinic is operated by specialty trained pediatric oncology nurses, pediatricians and supportive care partners, and aims at bringing care closer to home from tertiary centres as far as SickKids (Toronto), Children's Hospital of Eastern Ontario (Ottawa) and London Health Sciences Centre. The satellite clinic has approximately 600 visits per year from children under the age of 18 and sees families from all over northeastern Ontario.

After the age of 18, children who have actively completed all their cancer treatment can return to the care of their primary care provider (PCP) when they meet the following eligibility:

- have a PCP
- absence of need for complex medical monitoring
- require medical monitoring that can be performed by a PCP
- low risk of recurrence and /or secondary malignancies
- have psychosocial issues that can be addressed through primary care and/or local community services at a normal cost to the survivor
- have minimal treatment-related risks e.g. have had minimal/ focal radiation exposure that is unlikely to cause risk of second cancer, have had chemotherapy exposures that are: unlikely to cause infertility/subfertility, unlikely to be associated with impaired cardiac function, or have had surgery only (no requirement for radiation or chemotherapy)

Those who do not meet the above criteria would be considered complex and would be required to remain linked and seen through an Adult After-Care Program. The team of pediatricians and nurses at the tertiary centre would determine eligibility and facilitate transfers of care to the correct provider (i.e. PCP or After-Care Program).

Discussions with the patient/family would also occur along with extensive discharge summaries for PCP.

More information about long term follow-up for childhood cancer survivors is available at: www.survivorshipguidelines.org/pdf/2018/COG_LTFU_Guidelines_v5.pdf

Stephanie Winn
Administrative Director, Northeast Cancer Centre
Regional Director, Ontario Health (CCO)
Northeast Regional Cancer Program

Sylvie Kozlowskyj
Nurse Coordinator
POGO Pediatric Oncology Satellite
Northeast Cancer Centre

Decrease in Referral Rates to the High Risk Ontario Breast Screening Program

The COVID-19 pandemic has had widespread impacts on cancer screening rates across Ontario. With resumption of screening programs well underway, the Northeast has done well relative to other areas of the province.

Unfortunately, our rates of referral to the High Risk Ontario Breast Screening Program (HR-OBSP) are significantly lagging relative to the rest of Ontario. This could have important implications by delaying the early detection of breast cancer in our highest risk patients. When comparing the percentage of referrals to the Northeast HR-OBSP from April 1 - December 31, 2019 to April 1 - December 31, 2021, our volume has decreased by 34.4%. In comparison, the percentage of referrals to the HR-OBSP across Ontario for the same period of time is 8.5% lower.

For interest, referral volumes by area are listed below:

HR-OBSP Site	2014-2021 (avg)	2021/22
Sudbury	143	122
Sault Ste. Marie	63	22
Timmins	53	26
TOTALS	**259**	**170**

Recognizing that communities face their own unique barriers and challenges to referrals, let's challenge ourselves as primary care providers to identify individuals that could benefit from the program.

Individuals between the ages of 30-69 with one of the following risk factors can be directly referred to the program from their primary care provider:

1. Known carrier of a gene mutation (e.g. BRCA1/BRCA2)
2. First degree relative of a carrier of BRCA1/BRCA2, who engaged in genetic counselling but declined genetic testing
3. Received chest radiation (e.g. treatment for Hodgkin's lymphoma) before the age of 30 and at least eight years ago
4. Individuals assessed by a genetic counsellor using a validated risk assessment tool and determined to have a 25% or greater lifetime risk of breast cancer.

To help primary care providers identify which individuals may benefit from a referral to a genetic counsellor to determine lifetime risk of breast cancer, personal and family risk factors that qualify the patient for genetic counselling are listed on the HR-OBSP referral form.

The referral form for the HR-OBSP can be found on the Ontario Health (Cancer Care Ontario) website at: www.cancercareontario.ca/sites/ccocancercare/files/assets/OBSPHighRiskForm.pdf

Dr. Jason Sutherland, MD, PhD, CCFP
Regional Primary Care Lead
Northeast Regional Cancer Program

Expanding Patient Access to Cancer Clinical Trials

Currently, rural cancer patients are largely excluded from available clinical trials due to eligibility criteria related to geographic boundaries. This affects the roughly 50 per cent of northeastern cancer patients who receive systemic therapy through the Community Oncology Clinic Network (COCN) 12 satellite sites.

Launching this year through the Canadian Remote Access Framework for Clinical Trials (CRAFT), a pan-Canadian working group established to improve access to clinical trials in rural areas of Canada, the Northeast Cancer Centre (NECC) will attempt to expand access to cancer clinical trials by partnering with two regional hospitals.

As one of three locations in Canada engaging in multi-site clinical trial agreements with hospitals in outlying areas, the NECC has partnered with the Timmins and District Hospital and is in negotiations with Sault Area Hospital which will see patients from those areas participate in one selected lung cancer trial.

The sites will monitor these patients closely and receive guidance on study requirements with the support of the NECC oncologist, study coordinator and virtual coordinator. The same processes will be in place as for any oncology patient getting systemic treatment, with extra layers of supervision, data collection and ensuring adherence to the study protocol. For any concerns which may arise for these patients, the primary care provider should always contact the NECC oncologist via (705) 522-6237 extension 2320.

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Dr. Lacey Pitre FRCP(C)
Northeast Regional Quality Systemic Therapy Lead
Ontario Health (Cancer Care Ontario)

NORTHEAST ONCOLOGY NEWS PRODUCTION TEAM
Editor: Maureen McLelland
Assistant Editor: Dr. Jason Sutherland
Production Coordinator: Merci Miron-Black
Production Assistant: Chantal Duval
41 Ramsey Lake Road - Sudbury, ON P3E 5J1
Phone: 705-522-6237 - Fax: 705-671-5496
neoncologynews@hsnsudbury.ca

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References used for this issue of Northeast Oncology News are available upon request from the editor. Articles may be reprinted without permission, provided the source is acknowledged.

Available online at www.hsnsudbury.ca/primarycare