

Winter/Spring 2001

CANCER Care

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Viruses AND *vaccines:* hope on the horizon?

Most of us think of viruses as something we'd rather avoid. These submicroscopic agents cause disease in plants, animals and people. But for years we've used weakened viruses as vaccines to stimulate our immune systems to prevent us from getting diseases such as polio, smallpox, mumps and influenza.

Now researchers are using viruses as delivery agents in new vaccines to be used to prevent and treat cancer. Prophylactic vaccines stimulate the immune system to prevent cancer, while therapeutic vaccines stimulate the immune system to fight cancer that has already started.

Other scientists are testing a completely different approach—using otherwise harmless viruses to directly attack cancer cells.

With all this innovative research under way, the question is: can viruses actually help in the fight against cancer?

“Our researchers are conducting a variety of studies in this area,” says

Dr. Roger Deeley, head of Cancer Care Ontario's Division of Research. “We've had some tremendously encouraging results in the laboratory. Over the next few years, the results of clinical trials will begin to tell us how well these approaches work in people.”

Last July, in the prestigious international journal *Nature Medicine*, Dr. John Bell reported that his research team at Ottawa Regional Cancer Centre had used the vesicular stomatitis virus (VSV) to kill human melanoma (skin cancer) cells in mice, and human lung, breast, prostate and ovarian cancer cells and leukemia in the test tube. VSV rarely is found in people. When it is, it results in a mild flu or no symptoms at all.

“The tumour cells we infected were completely blown away



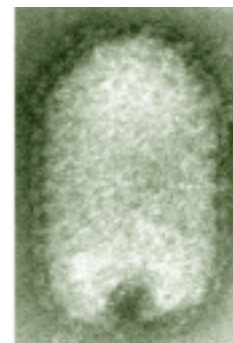
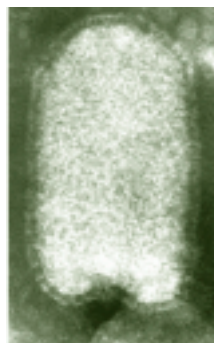
by this virus very quickly, whereas normal cells were quite resistant to the virus,” says Dr. Bell. The genetic defect that allows cells to become cancerous also lets VSV infect and destroy them. “Once you know these cells can be killed by viruses, it’s a matter of picking the best virus for the job.”

is almost never found in people. “So when we try to treat mice—and hopefully when we try to treat people—there won’t be a pre-existing immune response, and the virus will have a better chance of growing and eliminating the tumour,” says Dr. Bell.

VSV grows very quickly. The

Cancer vaccines undergo clinical trials

Researchers worldwide—including some at Cancer Care Ontario’s regional cancer centres—are developing, testing and refining vaccines for the prevention and treatment of cancer. A form of immunotherapy, vaccines are designed to stimulate a patient’s



Dr. John Bell

“Over the next few years, the results of clinical trials will begin to tell us how well these approaches work in people.”

Unlike vaccines, VSV does not rely on help from the immune system. In the laboratory, “the virus can kill tumour cells whether or not there is an immune system present,” Dr. Bell explains. But when one is present, VSV stimulates the immune system, delivering a “double-whammy” attack on the cancer cells.

Plans call for human trials using VSV to begin within 12 to 18 months.

Several other common human viruses have previously been shown to kill human cancer cells in mice and are now being tested in clinical trials. Their success could be limited by existing antibodies in the patient’s immune system. But VSV

idea is that it could be given intravenously, spread throughout the body and kill cancer cells, but leave healthy cells intact. If this occurs, the virus could “provide a new therapy to hit metastatic tumours (cancer that has spread), which are really the big problem in cancer,” Dr. Bell explains.

“Our dream is that this is going to be an important therapy—and that our virus or another research team’s virus is going to be a good way to target and kill tumour cells without the side effects of radiation and chemotherapy. I think people need to know there is progress, and there is hope on the horizon.”

immune system to prevent cancer, or to recognize and eliminate cancer cells.

- In collaboration with the Gene Therapy Group at McMaster University, Dr. Richard Tozer, of Hamilton Regional Cancer Centre, and Dr. Ronan Foley, of Hamilton Health Sciences Corporation, have completed a phase I clinical trial and are now conducting a phase II trial of a vaccine for patients with melanoma. Phase I confirmed the safety of the vaccine and phase II will begin to test how well it works. The vaccine uses immune-stimulating cells known as dendritic cells. “These cells can be purified from a patient’s blood, grown in the

laboratory and manipulated using adenoviral gene transfer technology, so they stimulate specific anticancer responses when they are injected back into the patient,” explains Dr. Tozer. “Although we have focused on melanoma, we anticipate that this treatment approach will be beneficial in a variety of



Dr. Richard Tozer vaccinates a patient while clinical trials nurse Brenda Kowaleski looks on.

other cancers.” The phase II trial—involving 25 patients with advanced melanoma—will be completed in about 18 months.

- Toronto-Sunnybrook Regional Cancer Centre’s Drs. David Spaner and Neill Iscoe are leading a phase I trial of another vaccine for melanoma that delivers a modified version of a protein commonly found in melanoma tumours. “As melanomas, and other cancers, are derived from a person’s own tissues, they do not lead to a strong immune response,” explains Dr. Iscoe. “By modifying the vaccine and administering it in a novel manner, we hope to provoke the body into

producing a prompt and useful immune response that could lead to enhanced control of the disease.” The vaccine was developed by Aventis Pasteur as part of its Cancer Vaccine Network’s \$350-million, 10-year effort to find therapeutic vaccines against several common forms of cancer. Although the phase I trial is designed to ensure safety, researchers also hope to see how well the vaccine activates the immune system. “We actually hope to make an impact on some of these patients’ disease,” says Dr. Spaner. Between 24 and 30 patients with melanoma will participate in the trial, which should be complete later this year.

- A vaccine that has the “potential to be one of the most important developments in disease prevention

estimated that 50 to 80% of women will get one of the many types of HPV. The virus must be present for genital cancers to develop. Fortunately, only a very small percentage of women actually develop cervical, vaginal or vulvar cancers. The vaccine is made up of virus-like particles from the shell of the two most common types of HPV, but does not contain the DNA that increases cancer risk. If successful, the vaccine or a similar one “could eliminate virtually all cervical and vaginal cancers and up to 75% of vulvar cancers,” says Dr. Shier.

- Dr. Paul Ritvo, a behavioural scientist in the Division of Preventive Oncology and an investigator with the Canadian

“If successful, the vaccine or a similar one could eliminate virtually all cervical and vaginal cancers and up to 75% of vulvar cancers.”

since the polio vaccine” is also being tested at Toronto-Sunnybrook. A phase IIB clinical trial of a vaccine to prevent the human papillomavirus (HPV) will involve 1,000 women in Canada, the United States and Brazil, says Dr. Michael Shier, a Canadian principal investigator. “HPV is one of the commonest causes of cancer deaths worldwide.” The virus is transmitted mainly through skin contact, such as during sexual intercourse. Men carry the virus but it has a much greater effect on women. Over a lifetime, it is

Vaccine Network, is researching how vaccines have been distributed in the past and how delivery can be improved in the future. “Advances of biotechnology will produce vaccines with varying levels of effectiveness and risk,” says Dr. Ritvo. “We need to know how to overcome barriers disrupting the delivery of these treatments to the people who can benefit.” The Canadian Vaccine Network includes more than 70 scientists of multiple disciplines—from microbiology to social science. ▼

Cancer TRENDS *in* young adults

Fred Ashbury, 40, hopes that by the time his 7- and 4-year-old sons become young adults, much more will be known about the causes, prevention and early detection of testis cancer—the most common cancer among Canadian men ages 20 to 44. “I am also interested in research that uncovers the long-term consequences of treatments, including physical, psychosocial and quality-of-life issues,” says Dr. Ashbury, a behavioural scientist with a focus on cancer. In 1985, at age 24, he was diagnosed with testis cancer. He had surgery to remove one testicle and radiation to help prevent a recurrence. Sixteen years later, he remains cancer-free.

Dr. Ashbury’s story is similar to those of other young adults who are diagnosed with cancer. Early detection and successful treatment often result in a good prognosis. In 2000, about 13% of Canadians diagnosed with cancer were young adults. “Although cancer is largely a disease of older adults, there are several reasons to monitor cancer trends in young adults,” says Dr. Loraine Marrett, a senior epidemiologist with Cancer Care Ontario. Together with Health Canada’s Dr. Anne-Marie Ugnat and a team of researchers from across the country, they are leading a two-year study supported by Cancer Care Ontario and Health Canada to investigate cancer trends in young adults.

While it is believed that most childhood cancers are the result of events prior to birth or during very early infancy,

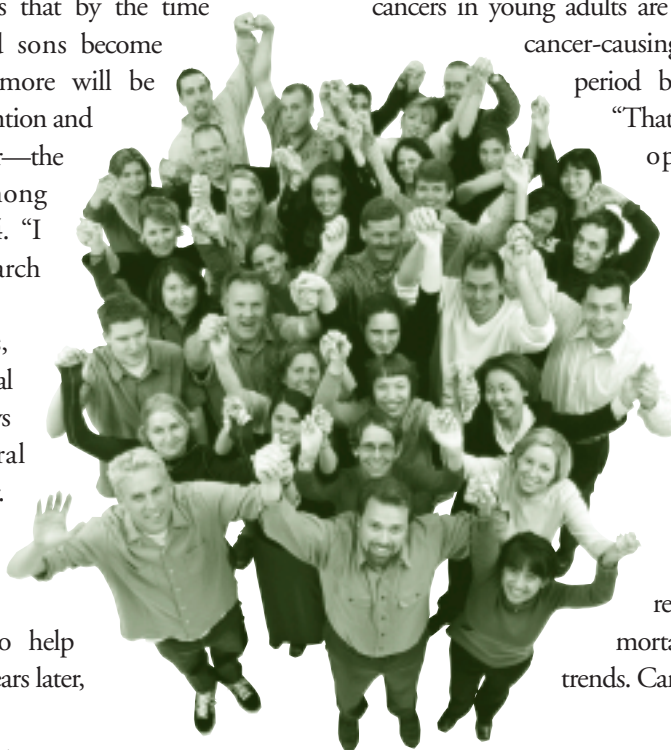
cancers in young adults are more likely due to exposure to cancer-causing agents (carcinogens) in the period between infancy and diagnosis.

“That’s a relatively small window of opportunity for exposure—so theoretically, it should be easier to figure out what important exposures are causing the trends. Cancers in young adults also may provide a warning of new or changing exposures,” explains Dr. Marrett.

The study will identify and describe important cancers in young adults across Canada, report on cancer incidence and mortality trends, and interpret these trends. Cancer rates will be compared across regions of the country, and with data from the United States. Trends in cancer among young adults also may be useful for forecasting future cancer experience in older adults.

The study focuses on trends for cancers most commonly found in young adults, including breast, cervix, testis, melanoma, thyroid, non-Hodgkin’s lymphoma, ovary, colon, lung, brain, Hodgkin’s disease and leukemia. “A number of these cancers are hormonal cancers. Overall, it’s quite a different group of cancers than we see in the older adult population,” says Dr. Marrett.

Another reason to focus on cancer trends in young adults is that “this is a group of people with a lifetime ahead of them,” she adds. “They have issues around quality of life—physically, emotionally, psychologically and spiritually.” ▼



*“...this is a group of people with
a lifetime ahead of them.”*

“Cancer doesn’t just happen to an individual, it also happens to the family,” says Dr. Margaret Fitch, coordinator of Supportive Care for Cancer Care Ontario.

That’s no surprise to Debby Sutton, a resident of Thunder Bay, and one of seven siblings. In February 2000, her father, John Oger, was diagnosed with mesothelioma, a rare type of lung cancer. The entire family rallied around. As his illness progressed, she took a leave from work to help care for her father at home. The experience, she says, “changed the way I think about death and dying.” John Oger and his family received help from a palliative care team, specially trained to help patients and their families deal with advanced illness.

Palliative care is often misunderstood, says Dr. Larry Librach, director of Palliative Care at Toronto-Sunnybrook Regional Cancer Centre. “We’re there to help patients and their families cope. We’re not there to take away hope.”

Dr. Fitch describes palliative care as an integral part of supportive care. “If you’ve got good supportive care,” she explains, “the palliative care expertise will come in when it’s needed.” And that’s not just at the end of life. Some people will want to talk about facing their own mortality when they’re diagnosed. In addition to psychosocial and spiritual counselling, services include pain and symptom management, and practical support, and range from

Palliative CARE:

discussing the meaning of life, to administering medication, to helping patients bathe. “We’re talking about total care,” she says, “with a focus on quality of life.”

“Good palliative care is simply good care,” agrees Dr. Scott Sellick, a clinical psychologist, and coordinator of the Northwestern

advances,” explains Dr. Fitch, “some of the interventions need to be tailored for the physiology that is occurring at that time. That’s when the expertise comes into play.”

Dr. Librach has been involved in palliative care for 23 years. “Things are getting better,” he says. “People seem to understand it better. There’s

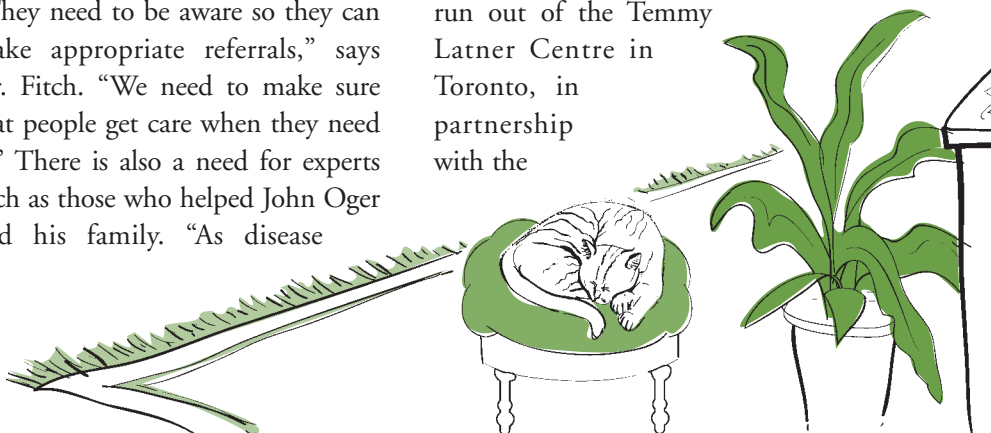
“I cannot say enough for the palliative care team. They helped not only my dad, they helped our whole family.”

Ontario Region Supportive Care Network. “We deal with the most pressing concerns of the day. That is what good health care should be.”

Every physician and nurse should have some basic palliative care skills. “They need to be aware so they can make appropriate referrals,” says Dr. Fitch. “We need to make sure that people get care when they need it.” There is also a need for experts such as those who helped John Oger and his family. “As disease

more interest among physicians and nurses to get education in this area. And Canada is the first country to develop standards of palliative care.”

Dr. Librach heads a pilot for a regional palliative care program run out of the Temmy Latner Centre in Toronto, in partnership with the



a family affair

Toronto Community Care Access Centre. The pilot, funded by the Ministry of Health and Long-Term Care, aims to care for more people at home. "We're trying to link community agencies and integrate services in a way that's never been done before in Ontario." Dr. Librach believes the pilot program could become a template for the rest of the province.

The Ministry of Health has appointed pain and symptom management coordinators in most regions, who are helping to organize and coordinate palliative care services. According to Dr. Sellick, palliative care has a strong presence in the Northwest through Palliative Care Network Northwest, a committee representing a broad range of community partners. At Northwestern Ontario Regional Cancer Centre, palliative care services are an essential part of the treatment programs. "We see this as an extension of the good care that we have

endeavoured to provide," Dr. Sellick explains.

Staff at Toronto-Sunnybrook Regional Cancer Centre also consider palliative care an integral part of what cancer care professionals call the "continuum of care." Patients there for treatment can see professionals from Sunnybrook & Women's palliative care unit. Once assessed, there is no wait for further palliative services or referrals to a home care program.

Cancer Care Ontario's Provincial Supportive Care Committee has made several recommendations to improve palliative care services in the province: 1) ensuring a palliative care presence at each of the regional cancer centres; 2) developing regional palliative care programs based on the needs in each region; and 3) working with other groups to identify gaps and recommend solutions to the Ministry of Health. The committee is now working on an action plan to implement these recommendations.

Patients and their families have a right to access palliative care services, says Dr. Fitch. "Palliative care experts have knowledge and skills that will help people live the quality of life they'd like to."

"People shouldn't fear us from the point of view that we represent dying and death," says Dr. Librach. "Our major goal is to reduce suffering."

John Oger died in November 2000, surrounded by family. "I cannot say enough for the palliative care team," says Debby Sutton, who cherishes the time she spent caring for her father. "They helped not only my dad, they helped our whole family.

I can't imagine having done it any other way." ▼

For information about palliative and supportive care services in your area, contact Cancer Information Service at 1-888-939-3333.





portal

Family

DOCTORS:

to the cancer system

coordinator of the Family Physician Initiative for Cancer Care Ontario. “Our patients know a lot, and they have questions and concerns that must be addressed.”

The family physician’s role in cancer care begins with prevention. He or she is in the best position of any player in the health care system to influence a patient’s lifestyle changes—including smoking cessation and improvements in diet and sun protection.

Family physicians also have a key role to play in cancer screening. “We know that most people visit their family physician at least once every two years. That fits well with the intervals recommended for most screening programs,” says Dr. Walter Rosser, chair of Family and Community Medicine at the University of Toronto.

Screening for colorectal cancer—through fecal occult blood testing—is now recommended for all adults over the age of 50. Women over 50 should undergo breast screening with mammography every two years. And women who have ever been sexually active should have regular Pap tests to check for cervical cancer.

Thorough and consistent screening improves the chances of early detection and successful treatment. Cancer Care Ontario has established province-wide screening programs that support and enhance the efforts of family physicians to provide the best early detection services to their patients.

The Ontario Breast Screening Program operates in 72 sites across the province and provides mammography, physical examination of the breasts, information on breast self-examination, and a reminder to return for screening.

Cancer care: those words bring to mind pictures of highly trained specialists providing sophisticated services in cancer centres. While that may be what happens to many patients eventually, it’s not how they begin their cancer journey. Their portal to the cancer care system is their family physician. He or she is the first caregiver to evaluate their symptoms. And, as their treatment goes on, cancer patients often return to their family physician for information and reassurance.

For the family physician, challenges increase as medical guidelines change. “Patient care is always evolving. What we tell our patients this year is not necessarily what we tell them next year,” says Dr. Gillian Howarth, a family physician in Dundas.

Patients, too, are changing. “Patients are more educated and are less taken with authority figures than in the past,” says Dr. Bob Sauls, a family physician in Mississauga and

Family physicians can refer patients to the program, or patients can book their own appointments. In the case of an abnormal screen, the family physician is contacted so that he or she can refer the patient for additional diagnostic tests.

“Obviously our intention is to continue to enroll more women,” says Dr. Howarth, who also serves as family physician coordinator for the Ontario Breast Screening Program in the Central West region of Ontario. “Family physicians are interested in ways to provide effective care in a systematic way. The breast screening program meets this need.” That’s borne out by the increasing number of family physicians who are referring patients to the program. In 2000, more than 1,500 doctors across Ontario each referred more than 20 new patients.

Cancer Care Ontario launched the Ontario Cervical

Like the other two screening programs, the colorectal program will work closely with family physicians to ensure that patients are well served. “Family physicians have been concerned about possible fragmentation of care and Cancer Care Ontario has heard us,” says Dr. Kathryn Lockington, a family physician in Kingston and vice-chair of the Ontario Medical Association’s section on family practice. “Patients really want their family physician involved. The physician knows each patient as a person and understands their individual needs.”

After patients receive treatment for cancer, they must be closely monitored. “The family physician should be involved in the follow-up of all patients along with the oncologist,” adds Dr. Sauls. “Research has shown that for some patients, the family physician may be able to provide the majority of follow-up care with very successful outcomes and excellent patient satisfaction.”

Patients often want their family physician involved during palliative or end-of-life care. “We need more family physicians to provide palliative care,” adds

Dr. Sauls, who is also director of the Palliative Care Unit at Credit Valley Hospital in Mississauga. “But it’s unrealistic to ask them to assume the care of these patients without support. The average family physician has little or no exposure to the whole variety of unusual problems related to palliative care.”

An initiative in Central West Ontario is attempting to address this need. Family physicians, palliative care physicians, academic family physicians and specialists from Hamilton Regional Cancer Centre have joined forces to promote and support a Family Physician Network. Dr. Joanna Hope, a family physician from Fenwick, coordinates the network.

Improving palliative care is one of the network’s four priorities. Its other goals are to improve communication between family physicians and cancer specialists, offer family physicians educational opportunities in cancer care, and encourage family physicians to participate in the regional planning and implementation of provincial screening programs. It’s a model of cooperation and collaboration that may be adopted throughout the province. ▼

“Patients really want their family physician involved. The physician knows each patient as a person and understands their individual needs.”



Dr. Walter Rosser examines a patient.

Screening Program in June 2000. The program maintains a central registry of Pap tests performed in the majority of private laboratories in the province. In the future, a recall system will work with physicians and other health care providers to help remind their patients to return for Pap tests.

Cancer Care Ontario has submitted a proposal to the Ministry of Health and Long-Term Care for a colorectal cancer screening program aimed at everyone in Ontario over the age of 50—approximately 2.6-million people. A pilot project is planned.

Comprehensive care can affect



SURVIVAL

Breast cancer patients who received their initial treatment in teaching hospitals had better survival than those who received treatment in community hospitals, according to a new study published recently in the *Canadian Medical Association Journal*. Using 1991 data, the study found that five-year survival for Ontario women with small cancers who were initially treated at a teaching hospital was 93% compared to 89% for women treated at a community hospital.

variations between teaching and community hospitals. Many community hospitals have launched comprehensive breast cancer centres similar to those that existed in teaching hospitals 10 years ago. Since the early 1990s, links also have been established between regional cancer centres and community hospitals to ensure that cancer patients have access to the most appropriate care. More than 100 hospitals are now formally affiliated with Cancer Care Ontario.

During the last decade, new knowledge and the

“...a comprehensive approach to cancer care including diagnostic, surgical, systemic, radiation and support services can improve survival.”

The authors concluded that the breast cancer surgery itself and the skills of the surgeon likely do not contribute to the variation. “The study suggests that a comprehensive approach to cancer care including diagnostic, surgical, systemic, radiation and support services can improve survival,” says Dr. Vivek Goel, a study author and chair of the University of Toronto’s Department of Health Administration.

“There is no reason for women to change where they have their breast cancer surgery,” adds Dr. Denny DePetrillo, coordinator of Cancer Care Ontario’s Surgical Oncology Network. “Community surgeons have the necessary skills to perform breast cancer surgery.”

Since the study began, there have been clinical practice and system level changes that should have reduced practice

development and use of practice guidelines likely have contributed to a reduction in the variation in practices. For example, it is now standard practice for women with early-stage breast cancer to be considered for systemic therapy as well as radiation treatment. In 1997, Cancer Care Ontario established the Surgical Oncology Network—a surgeon-led initiative made up of both community and specialty surgeons, and aimed at better integrating cancer surgery with the rest of the cancer system.

“Based on research in other countries, I believe these changes in Ontario over the past 10 years likely have reduced the variation in survival shown in the study,” says Dr. Carol Sawka, a study author and CEO of Toronto-Sunnybrook Regional Cancer Centre. ▼

Carmen Jones

Aboriginal Cancer Care Unit: first in Canada

Five years ago, Cancer Care Ontario recognized that conventional cancer care services did not adequately reach Aboriginal people. Research shows that the rates of cervical, gallbladder and kidney cancers are significantly higher in the Aboriginal population than in the general population, and that cancers in Aboriginal people are diagnosed much later.

Cancer Care Ontario and Aboriginal organizations in Ontario broke new ground by coming together to find ways to improve cancer care for Aboriginal people. Through continuing support and commitment of Cancer Care Ontario and Aboriginal people, we've made significant progress since that first important step.

In 2000, the Aboriginal Cancer Care Unit was established to enhance and improve the quality of life of Aboriginal individuals, families, extended families and communities living with and affected by cancer through traditional Aboriginal methodologies, research, education, awareness, prevention, supportive care and screening.



“Research shows that the rates of cervical, gallbladder and kidney cancers are significantly higher in the Aboriginal population...”

The Aboriginal Cancer Care Unit is the first of its kind in Canada. One of our first priorities is to build awareness and trust between Aboriginal communities and Cancer Care Ontario. We need to provide education and links to cancer services for Aboriginal communities, and we need to become more aware of Aboriginal issues and the barriers that prevent Aboriginal people from getting care.

As a first step, the unit is conducting a needs assessment. Regional coordinators are gathering information within Aboriginal communities and at regional cancer centres to help us understand what

types of programs we need and what the priorities are. Then we can move ahead to plan appropriate cancer programs for Aboriginal people.

We've partnered with Cancer Care Ontario's surveillance unit, and hope to form partnerships with other programs, such as the Ontario Cervical Screening Program.

Many Aboriginal communities are in crisis, and health workers are being overwhelmed by health strategies. In many cases, we're trying to deliver the same messages. We plan to link with these strategies for a more coordinated approach.

To succeed, we need individuals

throughout the organization who understand Aboriginal communities, and who can be a bridge between Cancer Care Ontario, the communities and government. Cancer Care Ontario is committed to recruiting Aboriginal people across the province to help achieve our goals.

What is most important is the health and quality of life of Aboriginal people. We're here to help. ♡

Carmen Jones, manager of Cancer Care Ontario's Aboriginal Cancer Care Unit, is a member of the Serpent River First Nation. She received an eagle feather for her work in bridging the gap between Aboriginal and non-Aboriginal populations.

On the Cover



VICTORIA WHALEN: PAP TEST SAVED MY LIFE

“Fore!” is a word shouted out by a golfer to warn those up ahead that a ball is flying in their direction. As an avid golfer and a 24-year survivor of cervical cancer, I’d like women to think of the Pap test as the same kind of preventive measure against cervical cancer. Back in 1977 when I was 37, my husband, Norm, and I were busy raising two children. Our world changed when a Pap test detected my cervical cancer. Following a biopsy, it was determined that I needed a total hysterectomy.

In the years since my surgery, I’ve been monitored carefully with regular vaginal Pap tests to make sure I remain free of cancer. A test in the spring of last year showed an irregular result and I was referred to Northeastern Ontario Regional Cancer Centre in Sudbury. Further testing gave me a clean bill of health, but I will continue to receive regular vaginal Pap tests. I encourage all women to have Pap tests for the detection of precancerous conditions and to detect cervical cancer early—before it spreads and becomes life threatening. Mammograms are important for the early detection of breast cancer, but don’t forget your Pap test. It could save your life as it saved mine.

Because of that Pap test 24 years ago, I’ll be around to proudly celebrate my 61st birthday in May at the golf club with Norm; my children, Michael and Norma; and my grandchildren, Crystal and William. And as soon as the weather permits, I’ll be out on the course aiming to recapture the women’s title at our club—and trying to repeat the golden moment of April 27, 1997, when I hit a hole-in-one on the very difficult 17th hole! ♣

For more information about cervical cancer screening, talk to your health care provider, visit the Web site at www.cancercare.on.ca or call a cancer information specialist at 1-888-939-3333.

“Mammograms are important for the early detection of breast cancer, but don’t forget your Pap test.”

CANCER CARE ONTARIO

Cancer Care Ontario is the province’s leader in the integration and coordination of cancer control services, and the Ministry of Health and Long-Term Care’s principal adviser on cancer issues. Cancer Care Ontario’s work includes cancer prevention, screening, treatment, supportive care, research, education and the development of treatment guidelines. Eight Cancer Care Ontario regional councils (CCORs) plan and coordinate regional cancer services. Cancer Care Ontario manages the province’s eight regional cancer centres, the New Drug Funding Program, the Ontario Breast Screening Program, the Ontario Cervical Screening Program, the Ontario Cancer Genetics Network and the Ontario Cancer Registry. ♣



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