Winter 2002

CANCER Care

INSIDE

QUALITY: *it's* EVERYBODY'S business

It's about how a patient is greeted when they come for their first appointment at the cancer centre. Or how well a physician listens to a patient's questions and concerns. It's about timely, appropriate care based on the latest available evidence, support to patients and families, and about using resources wisely—human, financial and technological. It's about every aspect of every activity in the delivery of cancer care and service. But the thing about quality is that you never get it 100% right.

"That's because quality improvement is about continuous change and continuous improvement," says Dr. Bill Evans, Cancer Care Ontario's executive vice-president and chair of the Quality Advisory Committee, a group with representation from each of Cancer Care Ontario's nine regional cancer centres. "Our goal is for everyone associated with Cancer Care Ontario to continuously think about how we can do things better."

This commitment to quality cancer care and service in Ontario was evident in the recent report of the Cancer Services Implementation Committee to the Minister of Health and Long-Term Care. The committee recommended that a Cancer Quality Council be established within Cancer Care Ontario to monitor, assess and improve the clinical and health system performance of all cancer services in the province. These services include health promotion and disease prevention, screening and early detection, primary care, diagnosis, treatment, rehabilitation, home/community care, palliative and supportive care.

To highlight some of the quality activities now under way at the regional cancer centres, *Cancer Care* magazine asked each centre to share with our readers one example of the many quality breakthrough projects they have recently undertaken. These creative projects reflect a range of cancer centre activities, but all have a common focus: to enhance the quality of care and service for patients and their families.

MARTHA LARSEN (RIGHT), SHOWN WITH HAMILTON REGIONAL CANCER CENTRE NURSE JANET POIRIER AND DR. HAL HIRTE, IS A BIG SUPPORTER OF THE CENTRE'S EXPRESS LINE CHEMOTHERAPY PROGRAM.

One of the lessons of successful quality improvement is to look within and outside of your industry for solutions that can be customized to meet your needs.

- One of the lessons of successful quality improvement is to look within and outside of your industry for solutions that can be customized to meet your needs. **Hamilton Regional Cancer Centre** has done just that with its **express line chemotherapy** project. It's modelled after the express line in the grocery store, where customers with only a few purchases have a designated check-out. By applying the same principle, patients whose chemotherapy takes only a few minutes to administer have been separated from patients who require lengthier forms of the treatment. "Now we don't have patients with short chemotherapy stuck in long lines," says Dr. Hal Hirte, head of Medical Oncology. By treating express line patients from 9 to 11 a.m. and from 2 to 4 p.m.—the times that Centre staff identified in a time study as the least busy—"we actually shorten their wait, and this allows us to treat a larger volume of patients more efficiently," says Dr. Hirte. "Express line chemo is a good idea," adds Martha Larsen, who received chemotherapy for colon cancer at the Centre last year. "I really appreciated the shorter waits."

- The new **Grand River Regional Cancer Centre** is set to open in Kitchener in the fall of 2002. Opening an **interim cancer centre** in February 2001, while construction of the new Centre was under way, has greatly benefited patients and staff, says Sue Robertson, director of Regional Planning and Administration. "One of the major reasons we went this route was to start to provide radiation oncology here. Before the interim centre opened, anyone who required radiation oncology had to go to Hamilton or London." By recruiting radiation oncologists before the new building opens, patients avoid the travel for clinic visits and follow-up. In addition, patients benefit from the early formation of a multidisciplinary team at the interim centre, including medical and radiation oncologists, nurses and supportive care coordinators. Early recruitment of six medical oncologists and two radiation oncologists for the interim centre means that patient wait times to see an oncologist in Kitchener have dropped significantly.

BOB AND MARTHA O'DAISKEY CHECK OUT THE PATIENT INFORMATION KIOSK AT NORTHEASTERN ONTARIO REGIONAL CANCER CENTRE IN SUDBURY.

- "Any time people can have access to more information and have the choice to independently look up information, I think that's a good thing," says Stephen Lloyd, Information Systems team leader at **Northeastern Ontario Regional Cancer Centre** in Sudbury. That's the idea behind the **patient information kiosk** located in the Centre's main lobby. The kiosk uses touch-screen technology to help patients and visitors navigate the Centre and obtain printed directional maps. They can learn about cancer centre activities and services, search the internal phone directory, and—with a swipe of their OHIP card—even look up their appointment information. Designed in English and French for a non-technical user, the kiosk offers patients and visitors one more source in their quest for information. "It's not meant to replace personal interaction with volunteers on our information desk or printed materials such as our patient hand book," Stephen Lloyd adds. "It's just another option." Funded through the Northern Cancer Research Foundation by the Rotary Club of Sudbury Sunrisers and the Trillium Fund, the kiosk has been well received by many patients and visitors.

- Caring for patients as close to home as possible is one of the goals of Cancer Care Ontario. In partnership with the Geographic Information Systems Lab at Queen's University, **Kingston Regional Cancer Centre** is working on a **mapping project** that will help to identify appropriate locations in Southeast Ontario for

"It decreases the number of revisits to the cancer centre for patients and they can begin their treatments sooner."

the establishment of community chemotherapy clinics. "This project allows us to map, using postal codes, where patients treated at the cancer centre come from, and to identify in a more scientific way the most appropriate locations for these clinics," says Alastair Lamb, the Centre's director of Regional Planning and Administration. Community chemotherapy clinics help patients avoid travelling to Kingston for treatment, and ensure that they have access to high-cost drugs and the most appropriate, evidence-based treatment for their particular disease. The mapping project is under way, and preliminary results are expected in the first quarter of 2002. Expansion of the project to other regions of the province is being explored.

FOLLOWING SURGERY, PATIENTS ARE SEEN AT NORTHWESTERN ONTARIO REGIONAL CANCER CENTRE'S SURGICAL ONCOLOGY CLINIC.

- In 1996, less than half of patients in Northwest Ontario who had surgery for prostate cancer were referred to a cancer centre for assessment. "Many of our area prostate cancer patients were being referred only to a urologist and were therefore not having access to a multidisciplinary opinion. Through the introduction of the Cancer Care Ontario regional surgical oncology network, we evaluated the situation and attempted to change the way we did business," says Michael Power, director of Regional Planning and Administration at **Northwestern Ontario Regional Cancer Centre** in Thunder Bay. By 2000, almost 70% of prostate cancer patients in the Northwest were being referred thanks to the Centre's launch of a series of **surgical oncology clinics**. Surgeons from the region were invited to join the clinics, which provide patients with the benefit of a multidisciplinary opinion by a team of cancer care professionals. Surgical clinics have now been created for patients with breast, head and neck, and prostate cancers, says Susan Pilatzke, director, Clinical Systems. "Patients tell us they like the information sharing and they aren't overwhelmed by seeing the multidisciplinary team all together. They feel that their needs are being addressed." Other benefits to patients include a shorter wait time for treatment following surgery, and access to the supportive care services of the cancer centre.

- **Care for the Professional Caregiver** is a program of renewal and self-care for in-patient and out-patient oncology nurses at **Toronto-Sunnybrook Regional Cancer Centre**. Offered by Wellspring, the program provides nurses with an opportunity to support one another through education and discussion about some of the common factors that contribute to caregiver stress. Oncology nurses also experience a sense of renewal by participating in relaxation, visualization and yoga exercises, and discovering ways to maintain helpful self-care practices. To date, approximately 90 oncology nurses have attended the program. "Through this program, the nurses gain a deeper understanding of themselves and of their colleagues, and feel more energized to continue their work," says Yvette Matyas, director of operations, Oncology. Vicki Harris, a chemotherapy and oncology clinic nurse, says the program is "terrific. I found it helpful to have the opportunity to discuss the stresses of the job with other nurses, and I enjoyed the relaxation and yoga exercises."

- At **Windsor Regional Cancer Centre**, patients routinely see oncologists and nurses carry around laptop computers. It's their wireless link to **E-chart**—the Centre's electronic patient chart system. Not only can they call up a chart to review information about a patient, but they also can input new information that

instantly is available to other members of the patient care team. "The E-chart project is a communication tool," explains Julie Durocher, coordinator, Health Information Services. "It makes scanned reports available to all team members, and transcription can be put right next to those reports. The E-chart includes diagnosis and staging information, and it keeps track of diagnostic tests and results." That means no more trying to share a hard copy patient chart among a team of health professionals involved in a patient's care. It also means that test results are reported sooner, which allows treatment to begin sooner. The Centre has formal arrangements and connectivity agreements in place with other hospitals and cancer service providers in Essex County. "When patients are referred, these health professionals have immediate access to their E-chart," says Moyez Jadavji, the Centre's director of Regional Planning and Administration. "It's really been beneficial to the quality of patient care."

- Patients should know their treatment options after their first visit to see an oncologist at **London Regional Cancer Centre**, says Anne Marie McIlmoyl, supervisor, Clinic Operations. "We recognize that patients' anxiety levels are very high. We want them to leave their first appointment knowing they can go on to a clinical trial, have standard treatment, or have time to go away and consider their options." To accomplish this, all diagnostic tests need to be arranged and completed in advance by the referring physician. Through the cancer centre's **patient intake guidelines** initiative, staff are visiting the offices of referring physicians across Southwest Ontario to review the intake guidelines with doctors and their support staff. "It decreases the number of revisits to the cancer centre for patients and they can begin their treatments sooner," says Anne Marie McIlmoyl. "It also allows us to build community partnerships and move toward an integrated cancer service in the region." To date, 250 copies of the patient intake guidelines have been delivered outside of London. The next step is to deliver the guidelines to referring physicians in the city.

- Through a project funded by Siemens Canada, staff at **Ottawa Regional Cancer Centre** are improving the **efficiency of processes in radiation oncology**. "We were experiencing some bottlenecks, particularly in radiation therapy," explains Antonio Estable, program manager, Radiation Oncology. "This project helped the Centre to experiment with grassroots initiatives in a way that really was a first in terms of giving staff the opportunity to come up with not only ideas, but solutions." The project was based on "the assumption that individuals who do the day-to-day work are the content experts and they—when properly facilitated, encouraged and empowered—come up with concrete recommendations." In addition to potential operational gains, staff identified patient and employee satisfaction, operational capability, risk management and financial impact as performance measures of success. They are now in the process of implementing solutions to some of the key issues they identified that affect overall throughput of patients to the different functional areas in the program. These include beam matching between radiation treatment machines, reducing the number of hand calculations, creating machine breakdown policies and procedures, investigating reasons for machine downtime, and a variety of issues concerning documentation, films, ergonomics and scheduling.

Cancer: *the genetic link*

It's probably nothing more than a cruel twist of fate, but Bill Hopps isn't taking any chances. He wants to do everything possible to make sure he's around to raise his three young children and to protect their health. In 1998—still grieving the 1996 death of his 38-year-old wife from colon cancer—he, too, was diagnosed with the disease. Bill was 41. On the day of his diagnosis, his mother learned she had ovarian cancer. She died several months later while Bill was still undergoing chemotherapy.

Is there a genetic link between Bill's cancer and his mother's? It's possible, he is told, but unlikely as there are no other known cases of cancer in his family. And his wife was the only person with the disease in her family. But what does it mean for the future health of Bill's three children when both of their parents had colon cancer at a young age?

For the Hopps family, there are more questions than answers. So when Bill learned of the Ontario Cancer Genetics Network—a program of Cancer Care Ontario that focuses on research into inherited cancers and the transfer of this knowledge from the laboratory into the clinical setting—he jumped at the chance to be involved.

"Anything I can do to give some hope, inspiration or further knowledge through research, I'll do it," says Bill. "It's got to help my kids. To have a younger married couple contract a type of cancer that typically affects people over 50—that tells me this thing is getting out of control and we've got to get a handle on it. If I can help in any way, shape or form, I want to be part of that.

"I called the Ontario Cancer Genetics Network and we reviewed my family history, I filled out some questionnaires and had some blood work done," Bill adds. "I've signed releases so they can test tumour samples from me, my wife and my mother." This information will become part of the network's Ontario Familial Colorectal Cancer Registry, a population-based study funded by the National Institutes of Health in the U.S. The network has funding from the same source to study inherited forms of breast/ovarian cancer through its Ontario Familial Breast Cancer Registry. The U.S. grants for the two registries total $20-million (Can.) since 1994. (In addition, Cancer Care Ontario has provided infrastructure and research support.)

"Of all the proposals that went into the National Institutes of Health, there's only one other group, in Australia, that is part of both the breast/ovarian and colon cancer registries," explains Dr. Irene Andrulis, director of the Ontario Cancer Genetics Network.

…a small percentage of cancers, perhaps between 2% and 10% of cases, are inherited.

The Ontario Familial Breast Cancer Registry and the Ontario Familial Colorectal Cancer Registry aim to "identify large groups of newly diagnosed cancer cases in Ontario for future epidemiologic, genetic, screening, prevention, psychosocial and health services research," says Dr. Steve Gallinger, principal investigator with the colorectal registry. "When completed, the infrastructure of each registry will contain data and biologic samples from over 1,500 people with cancer and 5,000 relatives."

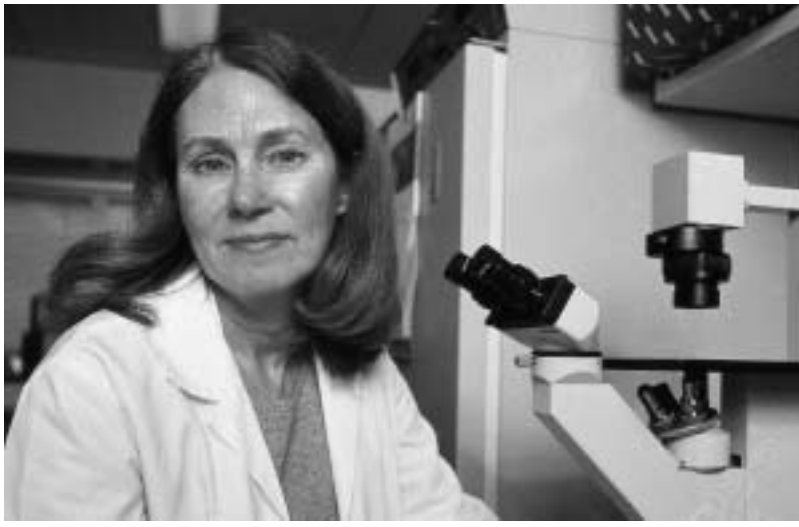
"We started out studying predisposition to breast, ovarian and colon cancer because from the molecular biology point of view, these genes either had just recently been cloned or were close to being cloned," Dr. Andrulis says. "Within a few years, we had the two breast cancer susceptibility genes (BRCA 1 and BRCA 2) and a number of the colon cancer genes."

Network investigators hope to expand their work by taking advantage of other funding sources, such as Genome Canada. Proposals have been submitted to study inherited forms of breast/ovarian, colon and childhood cancers, and melanoma.

Although most cancer diagnoses are considered sporadic—meaning they are not caused by a gene mutation passed from generation to generation—a small percentage of cancers, perhaps between 2% and 10% of cases, are inherited.

People concerned about inherited cancers in their family should review the situation with their family doctor, who can refer them to genetic service clinics located across the province. These clinics—operated by the Ontario Ministry of Health and Long-Term Care through its Predictive Cancer Genetic Service—will work with the patient to map out the family history of cancer. Patients and families may be offered the opportunity to participate in research. Genetic counselling is also available as genetic testing raises a variety of complex issues.

"People who participate in our studies aren't necessarily going to get something out of it for themselves," says Dr. Andrulis, "yet we have excellent participation. Obviously there's a concern about their own families. But the thing we found in our research studies—and one of the things that was a very pleasant surprise to me—was that most people just wanted to participate in research to advance science."



DR. IRENE ANDRULIS

For further information, call the Ontario Familial Colorectal Cancer Registry at 416-971-5100, ext. 1250 or toll-free at 1-866-225-2728, or the Ontario Familial Breast Cancer Registry at 416-946-4501, ext. 5226 or toll-free at 1-800-832-5949.

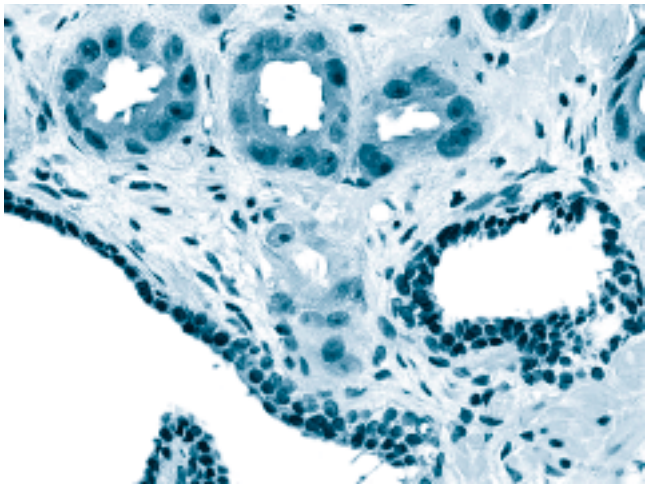
The diagnostic *oncologist*

When Dr. John Srigley tells people that he's a pathologist, they often imagine the gritty and glamorous lives of fictional forensic pathologists made popular in novels and television shows such as Quincy, and Crossing Jordan.

Few pathologists practice the forensic (criminal) pathology that is so often portrayed in the media, but many are involved in cancer care. In fact, cancer patients may be surprised to find out just how integral the role of the pathologist is. "In nearly all cases, an oncologist or surgeon will not treat a patient for cancer unless a pathologist has looked at a slide and made a diagnosis of cancer," says Dr. Srigley, chair of Cancer Care Ontario's Laboratory Medicine Advisory Committee, and chief of the Department of Laboratory Medicine at Credit Valley Hospital. "The anatomical pathologist is essentially society's diagnostic oncologist."

Pathologists—physicians with five or more years of specialty training—work closely with highly skilled laboratory technologists. While cancer is only one of many areas in which anatomical pathologists are involved, Dr. Srigley estimates that most spend at least half of their time dealing with cancer. "More information is required to make treatment decisions about cancer than for most other diseases diagnosed under the microscope," he explains.

Anatomical pathologists examine surgical specimens or biopsies (small samples of tumours or organs) to determine whether cancer is present. If it is, they then must deduce its type, grade (severity), stage (amount) and margin status (whether any cancer remains following surgical removal of a tumour). This information is included in the pathologist's report, and is used by oncologists and others when making treatment decisions. Anatomical pathologists also study cells (cytology) and perform autopsies.



A HIGHLY MAGNIFIED MICROSCOPIC IMAGE OF ADENOCARCINOMA (CANCER) INVADING THE PROSTATE GLAND

Pathologists also work in other areas of laboratory medicine, such as medical microbiology, hematology and chemistry. Their role in cancer care includes monitoring blood counts before and after treatments, and diagnosing complications such as infections.

"It is important for patients to know that their diagnosis, treatment and ongoing care cannot go on without the pathologist," says Dr. Wedad Hanna, leader of Cancer Care Ontario's laboratory medicine network in Central East Ontario, and chief of Pathology at Sunnybrook & Women's.

Rapid technological advances, especially in areas such as molecular testing, mean that pathology reports are becoming increasingly complex. Standardization of these reports is important, says Dr. Srigley, "so that all oncologists and surgeons across the system can understand it quite clearly, and find all the information they need in that report."

"Every day we have new knowledge, so we have to keep updating and bringing the new knowledge to the forefront," says Dr. Hanna. "The Central East network's main initiative is continuing education in order to raise the standard of practice and bring forward new technology or tests." Educational efforts include regular grand rounds, where current topics are reviewed and pathologists can bring difficult cases for discussion. And each fall, the network partners with the University of Toronto to hold a two-day conference for its members. These efforts ensure that pathologists have access to the "enormous, continuous growth of information," and lead to enhanced patient care.

"In nearly all cases, an oncologist or surgeon will not treat a patient for cancer unless a pathologist has looked at a slide and made a diagnosis of cancer."

Cancer centres throughout the province conduct tumour boards, regular meetings of multidisciplinary care teams—radiation, medical and surgical oncologists, pathologists, radiologists and others involved in patient care. Together, the group decides the best course of treatment for each patient. Tumour boards, says Dr. Hanna, "are helpful in providing the proper treatment, and are educational for everybody."

But no matter how well educated they are, there are not enough pathologists in the province to carry the workload.

According to Dr. Srigley, the number of anatomical pathologists in Ontario has dropped from 33 per million population in 1993 to 26 in 2001. At the same time, there is also a severe shortage of laboratory technologists. "This is occurring at a time of huge technological advancement, and at a time when there's more cancer being diagnosed because of the aging population and the increase in early detection programs," he says. "As well, oncologists and their patients are more informed; they're questioning things, and sometimes asking for a secondary review. That's good—patients have a right to see their pathology reports and understand the information in them. But we just don't have enough people to do the work."

A long-term solution, says Dr. Srigley, requires more graduates from Canadian and Ontario programs in pathology. To relieve the immediate crisis, though, he advocates easing the immigration process for qualified people. In the meantime, he says, "people might not be able to get pathology results as quickly as they want."

Despite these human resource problems, Dr. Srigley is excited and optimistic about the future. "Pathology is the bridge between basic science and patient care, and we are at the dawn of a new era in this field. I'm hopeful that medical students will see pathology as an exciting career choice."

DR. JOHN SRIGLEY VIEWS A GLASS SLIDE FROM A SPECIMEN OF A SURGICALLY REMOVED PROSTATE GLAND CONTAINING CANCER.

Dr. Alan Hudson *named* president *and* CEO

DR. ALAN HUDSON

Dr. Alan Hudson, OC, has been appointed president and chief executive officer of Cancer Care Ontario.

Dr. Hudson, a neurosurgeon, was president and chief executive officer of the University Health Network from 1991 to 2000. Last year, he chaired the Cancer Services Implementation Committee, a committee set up by the provincial government to review the organization of cancer services across the province.

"Alan not only brings substantial experience as a leader in Canadian health care, he also has a unique appreciation of Cancer Care Ontario's potential to lead a cancer system that is among the best in the world," said Cancer Care Ontario's chairman, Peter Crossgrove.

"I am looking forward with enthusiasm to assuming my duties as president and CEO and to working with the highly dedicated and talented individuals who make up the CCO team," Dr. Hudson said. "Cancer Care Ontario's regional cancer centres are an invaluable resource for cancer patients and their families. There is no doubt in my mind that this value is derived from the expertise and commitment of the people who work in the centres."

Dr. Hudson's appointment is effective April 1, 2002.

CCO researchers honoured

Five Cancer Care Ontario researchers have been awarded Canada Research Chairs by the Government of Canada. This distinguished group of senior scientists together lead a network of specialists committed to advancing innovations in cancer control and prevention. The awards, based on nominations from Canadian universities, honour innovative research excellence.

• Dr. Susan Cole (Kingston Regional Cancer Centre) is an international authority on molecular mechanisms that cause resistance to anticancer drugs. She was recognized for her groundbreaking research into anticancer drugs.

• Dr. R. Mark Henkelman (Toronto-Sunnybrook Regional Cancer Centre) spearheaded the building of Canada's new imaging research centre, which will play a major diagnostic role in furthering disease research.

• Dr. Joyce Slingerland (Toronto-Sunnybrook Regional Cancer Centre) and her group of researchers provide groundbreaking work on improving diagnostic and therapeutic strategies for breast, prostate and other cancers.

• Dr. Timothy Whelan (Hamilton Regional Cancer Centre) is widely recognized for his significant contributions in breast cancer and supportive care research.

• Dr. Robert Kerbel (Toronto-Sunnybrook Regional Cancer Centre) is a leader in the promising area of anti-angiogenisis. This approach targets tumours by cutting off their blood supply.

Cordell Parsons

Addressing spiritual needs

In the year that I have been spiritual and multifaith care chaplain at London Regional Cancer Centre, I have observed that many patients and their families express common spiritual concerns. Principle among them is the important issue of life with dignity. Patients appear to be more concerned about quality of life than about life after death.

Associated with this are the issues of adaptability to the cancer centre, and the reduced freedom and limited independence that are often part of the cancer experience. Patients are often concerned about family dynamics relating to support, which can affect everyone's quality of life.

In attempting to address these concerns, I begin by establishing relationships with patients and their families. This gives me the opportunity to assess, define, and support the spiritual and multifaith concerns of each person. Throughout, I maintain a listening ear while also actively addressing each concern. I will also become an advocate for those patients who need one—what I call being a voice for the voiceless.

Whenever possible, I seek the involvement of the wider community in supporting patients and their families. They may find comfort in a familiar face or voice of compassion and reason.

I believe that a constructive and cooperative relationship between chaplain and other members of the care team is indispensable to ensure that the goals of the care team match those of the patients and families. I can help by nurturing the lines of communication, in addition to addressing spiritual needs. As chaplain, and as a visible and integral part of the total ministry of health care, I provide a listening ear and a reasoned voice in the decision-making process. Everyone must assume some responsibility in dealing with the many uncertainties that accompany life with cancer if concerns and questions relating to quality of life are to be addressed with openness, understanding and compassion.

By maintaining a consistent, professional approach through my daily relationships with patients, their families and staff, I will fulfill my mandate of reaching out to people with confidence, effectiveness, encouragement and hope.

Cordell Parsons has been a chaplain at London Regional Cancer Centre since February 2001. Chaplaincy services are also available at Northwestern Ontario Regional Cancer Centre in Thunder Bay. Patients of other regional cancer centres who would like spiritual guidance and advice can ask supportive care staff for help in finding these services in their communities.

"Whenever possible, I seek the involvement of the wider community in supporting patients and their families."

On the Cover

Betty Lockhart: cancer and choices

When you get a cancer diagnosis, it's a natural reaction to feel that all control and choice in life have suddenly disappeared—like a rug being pulled out from under your feet. That's how my family and I first reacted when I was diagnosed in January 2001 with squamous cell cancer of the hypopharynx with positive nodes.

After a particularly nasty cold, the swelling on one side of my neck remained. A biopsy showed I had cancer. Once the news sunk in, my husband, Syd, and I talked things over with our four grown children. We went into positive-thinking mode. That's the choice we made as a family: to put our energies toward getting me well. Once that choice was made, there was no turning back.

I was treated with radiation and chemotherapy at Kingston Regional Cancer Centre. By the fall, there was no sign of cancer, and Syd and I resumed our regular life at home with our 19-year-old dog, Bear. Eleven years ago, we took an early retirement and moved to our cottage on Maple Lake near Haliburton.

In 1997, my older sister died after living seven years with breast cancer. So a cancer diagnosis could have put me in an emotional downward spiral. But my sister's courage and strength, and her passion to go on with her life during those years taught me to treasure each day.

I can now honestly say that I do.

To contact Cancer Care Ontario in your region, call:

Central East Region
Toronto-Sunnybrook Regional Cancer Centre: 416-480-4566

Central West Region
Hamilton Regional Cancer Centre: 905-387-9711, ext. 63060

Eastern Region
Ottawa Regional Cancer Centre: 613-737-7700, ext. 5-6857

Northeast Region
Northeastern Ontario Regional Cancer Centre: 705-522-6237, ext. 2084

Northwest Region
Northwestern Ontario Regional Cancer Centre: 807-343-1572

South Region
Windsor Regional Cancer Centre: 519-253-5253, ext. 58540

Southeast Region
Kingston Regional Cancer Centre: 613-544-2631, ext. 4517

Southwest Region
London Regional Cancer Centre: 519-685-8615
Grand River Regional Cancer Centre: 519-749-4370, ext. 5710

Cancer Care Winter 2002 Volume 6, Number 1

Cancer Care is a publication of Cancer Care Ontario.
Inquiries, story ideas and requests should be directed to:

Public Affairs
Cancer Care Ontario
620 University Avenue
Toronto, Ontario M5G 2L7

Tel: 416-971-5100, ext. 1605
Fax: 416-971-6888

E-mail: publicaffairs@cancercare.on.ca
Web site: www.cancercare.on.ca
Cancer Care On-Line is available on the Cancer Care Ontario Web site.

Ce magazine *Action Cancer* est disponible en français.

Printed on recyclable paper

Agreement Number 1604902

Cancer Information Service: 1-888-939-3333

Ontario Breast Screening Program: 1-800-668-9304