cancer care ontario | action cancer ontario

March 2006, Volume 4, Number 2

Ontario Cancer News

Mark your calendar for Cancer Care Ontario's 2006 Annual General Meeting

Join Cancer Care Ontario President and CEO Terrence Sullivan in Toronto on May 2, 2006, for his second annual public address, focusing on quality, accountability and innovation in Ontario's cancer system. Details will be posted on CCO's Web site when available.

Ontario budget announcement includes significant commitments to cancer care

The Ontario government announced its third budget on Thursday March 23.

In contrast to the first two provincial budgets, this budget focused on new infrastructure investment, while staying the course on health care and education.

The government is concentrating its health care investments in three priority areas -- increasing access to doctors and nurses, reducing wait times, keeping Ontarians healthy through prevention and health promotion. Another prominent theme is making the health care system more accountable and effective through Local Health Integration Networks and balancing hospital budgets.

This year's budget lays out, in broad strokes, spending priorities for the year ahead (and in some areas, such as hospitals, for multiple years) and includes significant commitments to cancer care.

Most notably, the government has committed to increase funding for the Ontario Breast Cancer Screening Program starting in 2006-2007 and ramping up over the following two years. The budget states that the province will provide:

> "total funding of almost $35 million in 2006-07, growing to $42 million in 2008-09, to the Ontario Breast Cancer Screening Program (OBSP) to increase access to screening for women between the ages of 50 and 74. this funding will support the completion of over 320,000 screens in 2007-07, growing to approximately 385,000 screens in 2008"

This promising investment will enable the OBSP to continue to expand toward the target of 70% women aged 50-74 screened through OBSP by 2010.

Also worth noting, the 16% reduction in provincial median wait times for radiation therapy between fall 04-05 and fall 05-06 is highlighted as one of the government's four key results in health care in the introduction in Minister Duncan's speech.

More specifics about funding for cancer-related services (including treatments, surgical wait times, prevention, other screening programs, capital and end-of-life care) will become available in the coming weeks when the government tables its detailed budget estimates.

Premier gives the go-ahead for Ottawa cancer centre construction

In keeping with the priorities of the *Ontario Cancer Plan* -- the province's roadmap to improve the quality of cancer services now and prepare for the future -- Premier Dalton McGuinty announced earlier this month the expansion of cancer services at The Ottawa Hospital and the Queensway Carleton Hospital. Following are excerpts from the government's news release.

“By expanding cancer care in Ottawa, we’re giving people more opportunities to lead healthier, fuller lives,” said Premier McGuinty.

The Ottawa Hospital Regional Cancer Centre project is an integrated cancer program that aims to improve cancer treatment by expanding radiation and associated cancer services at the two local hospitals.

At the Ottawa Hospital, the project includes adding two new radiation machines and enhancing radiation therapy equipment at the General site. This will improve access to cancer treatment by increasing the total number of radiation machines from six to eight.

At the Queensway Carleton Hospital, renovations will create space for three radiation machines. This will make it possible to provide more Ottawa area patients with radiation therapy and related cancer services. Renovations and new construction are expected to begin in 2007-08.

These improvements are part of ReNew Ontario, the government’s $30-billion, five-year investment in infrastructure. Under this plan, the McGuinty government and its partners are investing $5-billion over the next five years to improve Ontario’s health care facilities.

“We congratulate the government for committing to build a new cancer centre in Ottawa,” said Terry Sullivan, president and CEO of Cancer Care Ontario. “This is very good news for the people in this area who will be diagnosed with cancer in the years to come. It means that patients in Ottawa and the surrounding area will have better and more timely cancer care.”

The government has approved the cancer centre program as an alternative financing and procurement project. This means the construction work will be financed and carried out by the private sector, which will assume the financial risks for ensuring that the project is finished on time and on budget. The completed facility will be publicly owned, controlled and accountable.

For more information, go to the Premier’s Web site at http://www.premier.gov.on.ca/english/news/OttawaCancerCare030906.asp

---

New software to help cancer centre provide snapshot of wait times

The integrated cancer program at Kingston General Hospital hopes to debunk some of the mystery around treatment wait times and establish benchmarks through a new computerized tracking system, one that Cancer Care Ontario hopes will serve as a model for others.

With recent funding from the 2004-05 Access to Cancer Services Innovation Fund administered by Cancer Care Ontario, the cancer program worked with the hospital’s information management department to pull together data from various clinical systems to create the new electronic wait list software. It’s been up and running since last spring.

“Wait times have been on our radar for a while but we had no feasible way of tracking them comprehensively throughout a patient’s care experience,” says Alastair Lamb, oncology program operational director. “The information was already out there, in many of our systems, but we needed a way to put it all together. The money from Cancer Care Ontario allowed us to fast track the development of the wait list application to move it forward.”

The web-based software tracks data from a variety of clinical databases including Oncology Patient Information System (OPIS), the Ontario Breast Screening Program, the breast assessment program at Hotel Dieu Hospital and surgical wait time data. Embedded into the existing eChart system, the wait list application provides a snapshot of a patient’s journey through the cancer care system, from the detection of an abnormality to treatment and all points in between.

The new application, which currently focuses on patients undergoing diagnosis and/or treatment for lung and breast cancer, tracks all patients receiving treatment by program, physician, disease site and/or waiting status. Key dates and events are used by the cancer care team to manage individual patients while the aggregated wait time data will be used to identify system bottlenecks and develop benchmarks.

It allows any member of the cancer care team to add comments and introduce flags or alerts when a target has been met, surpassed or exceeded.

Now 10 months old, the new application is being audited to determine if the information being monitored is accurate and how the system might be improved. Once sufficient data has been gathered, the cancer program will work with Cancer Care

Ontario to establish provincial wait time benchmarks.

For more information, send an e-mail to Karen Smith, Kingston General Hospital, at smithk8@KGH.KARI.NET

Research update

PLCO trial results suggest antioxidant supplements not associated with decreased risk of prostate cancer

Results of a study led by Cancer Care Ontario scientist Vicki Kirsh suggest that taking antioxidant supplements does not decrease the risk of prostate cancer. The study did find that vitamin E and beta-carotene supplements may be associated with reduced prostate cancer risk in certain population subgroups.

Researchers assessed the risk of prostate cancer for 29,361 men ages 55 to 74 enrolled in the Prostate, Lung, Colorectal, and Ovarian (PLCO) Cancer Screening Trial, based on their daily intake of the antioxidant micronutrients beta-carotene, vitamin E, and vitamin C. The researchers looked at intake of antioxidants from both dietary sources and from supplements.

The authors found that, overall, dietary or supplemental intake of vitamin E, vitamin C, or beta-carotene was not associated with prostate cancer incidence in this group of PLCO trial participants. However, certain micronutrients were associated with prostate cancer risk in specific subgroups of men. For current or recent smokers, high-dose, long-duration vitamin E supplementation was associated with a reduced risk of advanced prostate cancer. For men with a low dietary intake of beta-carotene, high-dose supplements of beta-carotene were associated with a reduced risk of prostate cancer.

Research suggests that antioxidant micronutrients such as vitamin E, vitamin C, and carotenoids may play a role in preventing cancer development because of their ability to combat free radicals, agents that can damage cellular DNA, lipid membranes, and proteins. Vitamin E has been associated with a reduced risk of prostate cancer and beta-carotene has been associated with increased lung cancer risk in previous studies; however, no studies have definitively examined associations between intakes of three antioxidant micronutrients and the risk of prostate cancer.

The study was published in the February 15 issue of the *Journal of the National Cancer Institute*.

The influence of friends, family, and older peers on smoking among elementary school students: Low-risk students in high-risk schools

A study led by CCO researcher Scott Leatherdale has found that low-risk grade 6 and 7 students are at significantly greater risk of smoking if they attend an elementary school with a relatively high prevalence of smoking among senior students. (Low-risk students are defined as those with no close family members or friends who smoke.)

Researchers collected data from students at 57 Ontario schools for the study, which examined how older smoking peers at school and the smoking behaviour of friends and family members are related to youth smoking. The findings support previous studies that have found that elementary school students are more likely to try smoking if they have close family members or friends who smoke.

In addition, researchers found that a student with no family or friends who smoke was almost three times more likely to try smoking if he/she attended an elementary school with a relatively high prevalence of senior students who smoke than if he/she attended a school with a low prevalence of senior students who smoke.

These findings confirm that there is a need to target not only high-risk students, but high-risk elementary schools with prevention activities.

The study was published in the March 2006 issue of *Preventive Medicine*.

Study aims to improve patient outcomes following rectal cancer surgery

Hamilton surgeon and colorectal cancer specialist Dr. Marko Simunovic is leading a six-year study – the Quality Initiative in Rectal Cancer Trial – involving 106 surgeons at sixteen hospitals across the province. The goal of the study is to improve patient outcomes following rectal cancer surgery by helping surgeons learn or perfect a new method of rectal surgery called total mesorectal excision.

“There are often quality gaps between optimal treatment standards versus actual care delivered to patients, gaps which often are beyond the control of the treating doctors. Our team is interested in identifying and addressing such quality gaps among patients undergoing cancer surgery,” says Dr. Simunovic.

Surgeons at eight hospitals received informational materials on rectal cancer. Surgeons at the other eight hospitals could participate in a set of interventions such as an information workshop to discuss quality issues in rectal cancer care in Ontario, an exercise to review surgeon specific results of rectal surgery, and the completion of a postoperative questionnaire designed to remind surgeons of key rectal surgery operative steps.

Surgeons could also invite a study team surgeon into their operating room to assist them with an actual rectal cancer surgery. During this intervention, known as an operative demonstration, the study team surgeon would demonstrate the new techniques for rectal surgery that may lead to improvements in patient outcomes.

The study, funded by the Canadian Institutes in Health Research, is now in the sixth and final year. Dr. Simunovic and his team are analyzing patient outcomes and will compare results for the control and intervention groups. They will examine what worked well and what did not, and develop ways to implement quality improvement strategies broadly across the province and beyond.

“Every process can be improved in a large or small way. Surgeons participated with enthusiasm in our rectal cancer trial – to me this suggests we need better tools or approaches to help surgeons optimize their performance. We have to integrate quality improvements into cancer care because the potential benefits are immense for patients and the health care system,” says Dr. Simunovic.

For more information, send e-mail to Roxanne Kantzavelos, Juravinski Cancer Centre, at kantzave@hhsc.ca.

Study finds gaps in breast cancer knowledge among Ontario women
A recent survey by the Ontario Chapter of the Canadian Breast Cancer Foundation has revealed that many women in Ontario have misconceptions about breast cancer, specifically incidence and risk, signs and symptoms and breast screening practices. The findings highlight the need to promote regular breast mammography screening through an organized screening program for women aged 50-69.

Surveyors polled 800 women in Ontario who have not been diagnosed with breast cancer. Only 34% of the women surveyed correctly identified 50 as the age at which women should begin having bi-annual mammograms, and most respondents could only name one symptom of breast cancer, a lump in the breast.

The survey revealed that more educational initiatives need to be targeted to women of non-European descent and women in low income brackets, as these groups are both less informed about breast cancer and less likely to participate in risk reduction behaviours.

The survey is part of Up Front: New Perspectives on Breast Cancer, a project led by the Ontario Chapter of the Canadian Breast Cancer Foundation in partnership with several breast cancer stakeholders including Cancer Care Ontario's Ontario Breast Screening Program. Up Front aims to identify and create opportunities for improved coordination of breast cancer care and information in Ontario. A final report with recommendations will be released in fall 2006.

For more information, send e-mail to Victoria Pearson, CBCF Ontario Chapter, at vpearson@cbcf.org.

Third annual CQCO signature event addresses palliative care
Every person living in Ontario, when faced with a cancer diagnosis, should have the opportunity to live life fully, to receive optimal symptom management, to be supported with dignity and respect throughout the course of their illness, and in the face of incurable disease, each person should have the opportunity to die in a setting of his/her choice.
- Cancer Care Ontario’s vision for palliative care

The Cancer Quality Council of Ontario (CQCO), in partnership with Cancer Care Ontario (CCO), held its 3rd Annual Signature Event: Toward seamless transitions in palliative care for cancer patients, on March 6.

Representatives from regional end-of-life networks, regional cancer programs, LHINs, CCACs, hospices and home care agencies, hospital CEOs, national and provincial health care agencies, the CQCO and CCO came together to discuss strategies for a palliative cancer care plan in Ontario.

“…you only have a few weeks left to live, what do you hope for? What will your choices be?” asked Dr. Frank Ferris, medical director, palliative care, San Diego Hospice.

Of cancer patients surveyed, 80% to 90% report they would rather die outside of a hospital, but only 44% of Ontario cancer patients currently do so.

Palliative care experts in attendance -- including Dr. Joanne Lynn, senior natural scientist, RAND Corporation; Dr. Frank Ferris, medical director, palliative care, San Diego Hospice; and Dr. Deborah Dudgeon, provincial program head, palliative care, Cancer Care Ontario -- agreed that the assessment of cancer patient needs for palliative care, including early identification of pain and other symptoms, should begin from the time of diagnosis to help patients live fully and manage symptoms optimally throughout the patient journey.

“A palliative cancer care strategy is important because 80% to 85% of palliative patients have cancer, and palliative care can happen simultaneously with therapies that help to treat cancer,” said Dr. Dudgeon.

The CCO palliative care strategy, presented at the event by Dr. Dudgeon, is intended to build on the efforts of the many organizations working to improve the quality of palliative care for patients in Ontario, and to implement quality improvement actions specific to cancer patients. The strategy encourages a simultaneous model of care for cancer patients where palliative care to relieve pain and other physical and psychosocial problems is provided in conjunction with therapies meant to prolong life, including chemotherapy and radiation treatment. Palliative care in this model is not confined only to patients who have been identified as terminal.

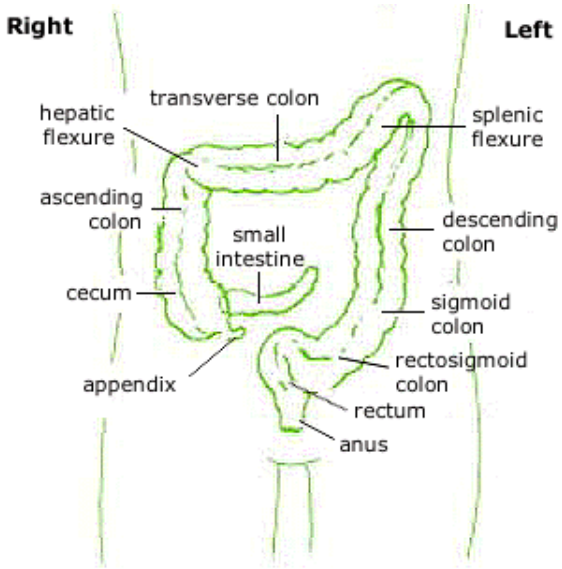
Core components of CCO's palliative care strategy include:

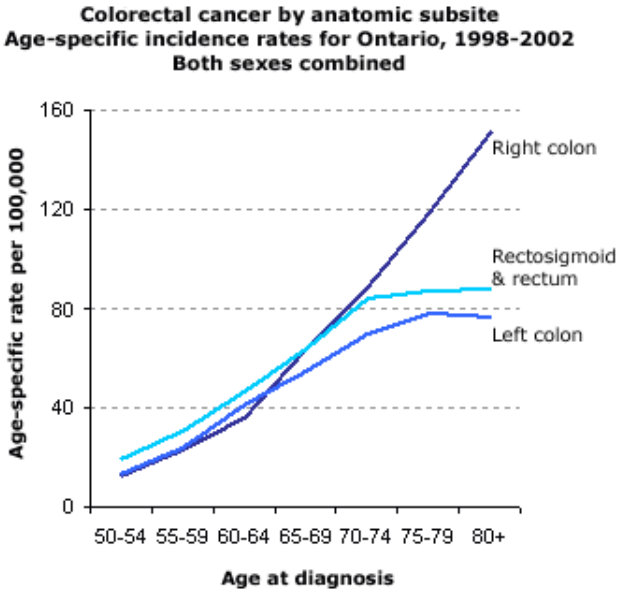
- Developing, disseminating and using indicators to measure and improve access and quality
- Developing and implementing evidence-based standards and guidelines
- Working to bridge the gap between service availability and demand. Introducing tools to accurately identify palliative patient needs in a timely fashion
- Implementing standardized patient assessment tools and standards for documentation and communication

Next steps
CQCO Signature Event participants engaged in breakout sessions by LHIN to provide feedback on the strategy. The strategy is being revised based on participant feedback and will be widely disseminated in the coming months, followed by implementation of the strategy by CCO and regional cancer programs in conjunction with key partners in palliative care, including regional end-of-life networks, LHINs and CCACs.

For more information, send an e-mail to anna.greenberg@cancercare.on.ca.

Ontario Cancer Fact
In older Ontarians colorectal cancer is more likely to arise in the right side of the colon than in the left colon or the rectum. The right colon includes the cecum, ascending colon, hepatic flexure and transverse colon. The left colon includes the splenic flexure, descending colon and sigmoid colon. The rectosigmoid colon and rectum are the lowest parts of the large bowel.





The graph shows age at diagnosis by anatomic subsite for both sexes combined. After age 65, incidence rates for left-sided colorectal cancers begin to drop below the rates for right-sided cancers. The change to more right-sided colon cancers begins earlier for women and is more pronounced in women than in men (data not shown). The reason for this pattern is unknown; a similar pattern is seen in other developed countries.

Right-sided colon cancers may differ from left-sided colon cancers in terms of genetic and behavioural risk factors and tumour characteristics, and may have a better prognosis and better response to chemotherapy.

In addition to finding cancers early, screening can prevent colorectal cancers by finding and removing precancerous polyps. Cancer Care Ontario, the Canadian Cancer Society, the Canadian Task Force on Preventive Health Care, Health Canada, and the Canadian Association of Gastroenterology recommend that all persons aged 50 years and older with no family history of the disease and without symptoms should be screened regularly for colorectal cancer. Screening recommendations are different for those with a family history of colorectal cancer or polyps. These individuals should talk to their doctors about starting screening before age 50.

For more information on colorectal screening, see http://www.cancercare.on.ca/index_colorectalScreening.htm#q6, talk to your health care provider, or call the Canadian Cancer Society's Cancer Information Service (1-888-939-3333).
For more information on colorectal cancer in Ontario, see Insight on cancer: News and information about colorectal cancer, at http://www.cancercare.on.ca/documents/InsightColorectal.pdf

If you have questions about this Cancer Fact, contact cancerfacts@cancercare.on.ca. If you have questions about cancer statistics, please go to www.cancercare.on.ca/index_requestDatafromCCO.htm#Forms.

People news

Dr. Deborah Dudgeon, head of Palliative Care for Cancer Care Ontario and director of palliative medicine and supportive care at the Cancer Centre of Southeastern Ontario at Kingston General Hospital, has been recognized with one of six Premier's Awards for Graduates of Ontario's Colleges of Applied Arts and Technology for her extraordinary contribution to health care.

The medical oncologist, who is also a professor of medicine and oncology at Queen's University in Kingston, received the health sciences award for demonstrated career success related to her college training and subsequent contribution to her community. Nominees in six categories: creative arts and design, community services, business, health sciences, technology and recent graduates are chosen annually by Ontario's 24 colleges. There were over 90 nominees for the 2005 award.

Dr. Dudgeon will receive a Premier's Award medal and a $5,000 bursary will be directed to her alma mater, George Brown College.

"It is a great honour and surprise to receive this award," says Dr. Dudgeon, who started her health care career in nursing before becoming a doctor. "It reflects on the tremendous support I have received over the years from my mentors, teachers, colleagues and family and friends."

Dr. Dudgeon's recent accomplishments include addressing the varying quality of palliative care as the lead on a provincially-funded integration project -- the first of its kind in Canada involving the use of common assessment tools, collaborative care plans and symptom management guidelines for palliative cancer patients.

Dr. Dudgeon is also an internationally recognized expert in dyspnea, or shortness of breath, in cancer patients and has received numerous grants from organizations around the world to pursue this important research.

University of Toronto offers new master's and doctoral research training program in palliative and supportive care

Beginning this September, the University of Toronto will offer a new and unique multidisciplinary master's and doctoral research training program in palliative and supportive care. This research training program will be based on the U of T collaborative program, "Ageing, Palliative and Supportive Care Across the Life Course."

Students (who may be health professionals) enrolled in a primary graduate department (e.g., the Institute of Medical Science, Nursing, Law, Religious Studies, Anthropology, Health Policy Management and Evaluation, Adult Education and Counseling Psychology, Sociology, Social Work, Public Health Sciences etc) can apply to this collaborative program for specialized research training in palliative and supportive care at the master's or doctoral level.

The program will include faculty with special expertise, specifically designed courses, and access to relevant existing courses within the participating departments.

For more information about the program or application process, send an e-mail to susan.murphy@utoronto.ca.

Contact Us

All enquiries and article suggestions should be directed to:

Christine Naugler
Public Affairs
Cancer Care Ontario
620 University Avenue
Toronto, ON M5G 2L7
phone: (416) 971-9800 x 1605
fax: (416) 217-1249
e-mail: publicaffairs@cancercare.on.ca

return

Contact Information | Printable Newsletter | Subscribe | Unsubscribe | Copyright & Privacy Policy | Archives | <%bottom_link_end%>