Question & Answer Summary: November 12, 2021

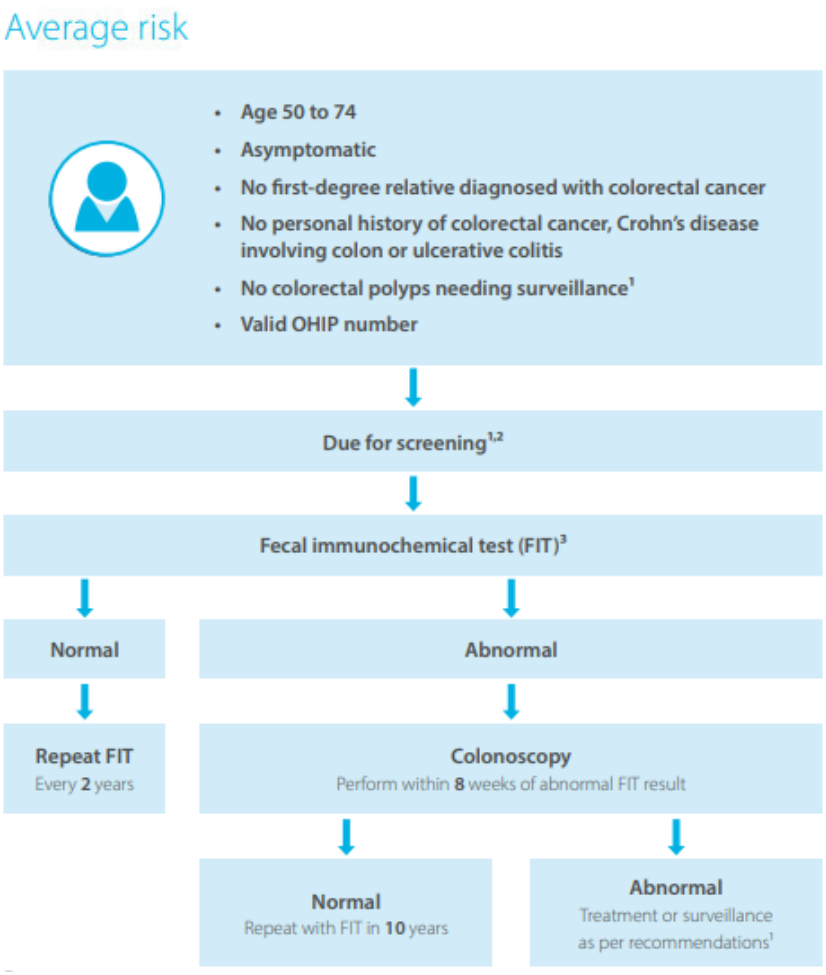
Colorectal Screening Program - ColonCancerCheck

- **Question:** I know the colorectal cancer screening guidelines for those at average risk (i.e., no first-degree relative diagnosed with colorectal cancer, no history of pre-cancerous polyps requiring surveillance, no history of inflammatory bowel disease and no symptoms of colorectal cancer) recommends screening with FIT from 50-74 years old. How do I screen an average risk patient that is over 74 years old and would like to continue screening?
    - **Answer from Dr. Siddall and Dr. Haddad:** The ColonCancerCheck program does not recommend regular screening for people older than age 74. Generally, people older than age 74 do not benefit as much from screening and are at greater risk of having complications. Some people ages 75 to 85 may benefit from screening, especially those who have never been screened for colorectal cancer and are very healthy. Considerations for deciding when to screen people ages 75 to 85 for colorectal cancer include how long someone is expected to live, their screening history, and whether they are willing and able to have a follow-up colonoscopy. People expected to live less than 5 years should not get screened. The same guidelines and referral pathways that apply to 50-74 year olds would be followed for 75-85 year olds. Keep in mind that the ColonCancerCheck program strongly recommends against colorectal cancer screening in people older than age 85. LifeLabs will reject FIT requisitions submitted for people older than age 85.

- **Question:** Can I use the old gFOBT test for average risk patients over 74 years old that are healthy and wish to continue screening?
    - **Answer from Dr. Siddall and Dr. Haddad:** No, gFOBT should no longer be in use. ColonCancerCheck has transitioned from the guaiac fecal occult blood test (gFOBT) to the fecal immunochemical test (FIT) as its recommended screening test for people at average risk. FIT is a more sensitive screening test than gFOBT, which means that it is better at detecting colorectal cancer and some pre-cancerous polyps.

- **Question:** If my patient is going for a colonoscopy every 5 years because they had polyps removed, should I also have them do a FIT every 2 years in between the colonoscopies?
    - **Answer from Dr. Siddall and Dr. Haddad:** No.

- **Question:** What is the recommendation following a normal FIT+ colonoscopy done after an abnormal (i.e., FIT+) result? Should the patient continue with colonoscopies or do another FIT in 2 years?
    - **Answer from Dr. Siddall and Dr. Haddad:** The patient should repeat FIT in 10 years. Refer to a snapshot from the CCC guidelines below.



- **Question:** Is the Galleri cancer screening test available in Ontario? If so, how is it accessed and how should family doctors use it?
    - **Answer from Ontario Health – Cancer Care Ontario:** At this time, the Galleri Test is not funded for use in Ontario. As such, OH-CCO is unable to comment on its utility and/or recommendations for access or use.

- **Question:** Are there any local statistics on stage of cancer in patients that were FIT+ versus those that presented with symptoms?
    - **Answer from Melissa Lot:** This data is something that is not routinely shared by OH-CCO. If there is interest, we can do a data request from OH-CCO to determine if this is something that we could obtain. We do receive data related to the number of colonoscopies completed for FIT+, and symptomatic patients but it does not indicate stage of cancer or cancer positivity rate.

Colorectal Cancer Surgery and Management

- **Question:** When do you recommend CT colonography for a younger patient with a family history?
    - **Answer from Dr. Ghafoor:** CT colonography is usually indicated in patients in whom colonoscopy is incomplete or failed or there are contraindications for colonoscopy.

- **Question:** Are there any robotic surgery procedures done in Canada for colorectal cancer?
    - **Answer from Dr. Howe:** We have a Da Vinci robot at Windsor Regional Hospital - Met Campus. However, it is only funded for urological procedures. Most major health care centers will have surgical robots, however, they are not used as extensively in Canada as they are in the USA.

- **Question:** Will Surgeons or Oncologists have a harder time adapting to the change in treatment if total neoadjuvant treatment becomes the standard of treatment?
    - **Answer from Dr. Ghafoor:** It always takes some time to change the standard practice. However, with more education and experience, I think TNT will become the standard treatment.

Pancreatic Cancer Surgery and Management

- **Question:** Do you have any suggestions for Primary Care Providers that could help lead to earlier diagnosis of pancreatic cancer? For example, for right upper quadrant pain we would often start with an ultrasound which may give falsely reassuring results.
    - **Answer from Dr. Ghafoor:** Pancreatic cancer is difficult to diagnose in earlier stages due to its insidious onset. If a patient presents with abdominal pain, jaundice and weight loss those are red flags for pancreatic cancer and pancreatic cancer should be ruled out.

- **Question:** How do you feel about statins as a risk factor for pancreatic cancer?
    - **Answer from Dr. Tang:** There has been a lot of work at the National Institute of Diabetes, Digestive and Kidney Diseases (NIDDK) looking at new onset of diabetes as a predictor of pancreatic cancer. I think anyone with new onset Diabetes Mellitus Type II (DMII), who does not have metabolic syndrome should have cross sectional imaging to make sure there is no tumor. I am hopeful that liquid biopsies will become more widely available. There are a few new commercial products available in the United States. Hopefully they become more mainstream once there is more data.

- **Question:** Does the etiology of the malignant bowel obstruction (e.g., tumour mass versus adhesions) impact a patient's prognosis?
    - **Answer from Dr. Ghafoor:** Bowel obstruction due to tumor (malignant) prognosis is better than benign obstruction due to surgery/adhesions.

Palliative Care for GI Cancer Patients

- **Question:** What are the main clinical factors you use to differentiate partial versus complete obstruction without imaging?
    - **Answer from Dr. Kennette:** The main clinical factor that helps me differentiate partial versus complete obstruction would be whether the patient is passing gas/flatus. If the patient is not having bowel movements AND not passing gas there is a high clinical suspicion of a complete bowel obstruction.

- **Question:** Is there still a role for celiac blocks for pain management?
    - **Answer from Dr. Kennette:** I have used celiac plexus blocks for pain management when pharmacological measures alone are ineffective.

General

- **Question:** Are there any cancer treatments we do not have access to in Windsor, resulting in patients being transferred to London, Toronto or abroad?
    - **Answer from Melissa Lot:** There are some treatments that are available to all patients in Ontario, for specific diagnoses, that are unfortunately not available locally in Erie St. Clair. Those include some types of specialized radiation therapy and, some surgical oncologic procedures. Patients that are going to have an autologous stem cell transplant will have their cells harvested and reinfused in London, but will then receive all of their post-transplant care locally in Windsor. For Allogeneic Stem Cell Transplant, patients will have the infusion of donor stem cells in Hamilton. The patient will then stay in Hamilton for 100 days to receive post-transplant care; some being inpatient and some being outpatient care. They will then return to Erie St Clair for ongoing follow up in Windsor. In terms of systemic therapy, we are able to offer a wide range of therapy locally at the Regional Centre, as well as our partner sites that provide parenteral therapy. In all cases, it is our goal to provide the best possible treatment options to patients for a given diagnosis, as close to home as possible.