LUNG CANCER CANADA
Awareness. Support. Education.

Lung Cancer Connection

Edition: 10:08:01

Thoracic Surgery for Symptom Control

By Carmine Simone, MD, FRCS(C), FCCP, LCC

Thoracic Surgeon, Department of Surgery Toronto East General Hospital
Head, Division of Critical Care, Toronto East General Hospital
Lecturer, Department of Surgery, University of Toronto
LCC volunteer writer and presenter

Many lung cancer patients undergo thoracic surgery for resection of their tumours. Surgical intervention can also be considered for symptom control or palliation as part of a multidisciplinary approach to keeping patients comfortable.

Patients frequently describe dyspnea (shortness of breath with minimal exertion) as a common symptom of their lung cancer. This is often due to multiple patient factors, but sometimes one particular problem can be contributing significantly to a patient's dyspnea.

A patient can experience breathlessness or painful breathing if an important part of the lung is collapsed. A patient can have portions of collapsed lung due to a tumour growing into and blocking a major section of the airway (Figure 1).

If left unattended, this blockage can develop into an infection or post-obstructive pneumonia. If the blockage occurs in a large enough part of the airway, a stent can be placed there, to allow air to travel to the lung and to allow mucous and secretions to drain out (Figure 2). The stent is inserted using a rigid bronchoscope (a straight hollow metal tube) under a general anesthetic. A rigid bronchoscopy can be performed to core out the airway if a stent cannot be inserted and if the tumour is occluding a proximal or large bronchus. Both cases require a general anesthetic, and can often be performed as a one day procedure.

Table of Contents

Board of Directors 2
Director Profile-Catherine Black 2
Medical Advisory Panel Appointment 2
Shortness of Breath Dyspnea 3
Message from the Volunteer Committee Chair 4
Volunteers Making a Difference 4
Story of Hope 5
Volunteer Profile. 5
New Source of Information 5
Access to PET Scanning. 6
Segal Caner Centre 7
Scotiabank Group Charity Challenge 7
Booklet Order Form 8
Survey 8
Donation Card. 8

If cancer spreads to the lining of the lung (pleura) there can be a build up of fluid around the lung. This fluid can compress or collapse parts of the lung resulting in breathlessness. If there is excessive fluid collecting around the lung, the medical team can consider a number of interventions such as:

- **Thoracocentesis:** needle drainage of the fluid (Figure 3);
- **Thoracoscopy:** placing a telescope into the chest under general anesthesia; or
- **Chest Tube Insertion:** (Figure 4).

Thoracocentesis can be done in a clinic setting with minimal discomfort. The drainage of the fluid can cause quick resolution of shortness of breath however many times the fluid returns.

With a **thoracoscopy**, the surgical team can drain the fluid, but can also instill substances that reduce the risk of the fluid returning. Talc or bleomycon, for example, can be instilled to cause irritation and then scarring in the lining of the lung. This scarring will fill the space within which the fluid would normally collect in the lungs. A thoracoscopy is usually done as a day surgery and carries minimal risk.

Chest tube insertion is called for if the patient needs drainage of the pleural effusion but is not a surgical candidate. This requires a patient to be in hospital until the tube is removed. The chest tube will drain the fluid, allow the lung to re-expand and facilitates the instillation of sclerosing agents to prevent the return of the pleural fluid (Figure 4).

Pericardiocentesis or a *pericardial window* are two procedures which can be used if cancer spreads to the sac covering the heart (pericardium). In this case, fluid can accumulate and constrict the heart. This will cause a fast heart rate, low blood pressure, weakness and shortness of breath. If left to progress, the fluid can ultimately cause the heart to stop. A pericardiocentesis can be done with echocardiography to alleviate symptoms in the short term. A pericardial window is a procedure where a hole in the sac around the heart is made to allow the fluid to drain into either the

Continued on page 3

Medical Advisory Panel

Dr. Natasha Leighl,
Medical Oncologist, Chair,
Toronto, Ontario

Dr. Jason Agulnick,
Respirologist,
Montreal, Quebec

Dr. Gwyn Bebb,
Medical Oncologist,
Calgary, Alberta

Dr. W. K. (Bill) Evans,
Medical Oncologist,
Hamilton, Ontario

Dr. Michael Johnston,
Thoracic Surgeon,
Halifax, Nova Scotia

Dr. Stephen Lam,
Respirologist,
Vancouver, British Columbia

Dr. Yee Ung,
Radiation Oncologist,
Toronto, Ontario

Honourary Board Members

Dr. Frances Shepherd,
Princess Margaret Hospital,
Toronto, Ontario

Dr. Gail E. Darling,
Toronto General Hospital,
Toronto, Ontario

Dr. W. K. (Bill) Evans,
Cancer Care Ontario,
Toronto, Ontario

Dr. Margaret Fitch,
Toronto-Sunnybrook
Regional Cancer Centre,
Toronto, Ontario

Board of Directors 2008

Morty Sacks
(President)
C.E.O., M.N.
Sacks and Associates
Toronto, ON

Dr. Gywn Bebb
Medical Oncologist,
Translational Research Unit,
Tom Baker Cancer Centre
Assistant Professor of
Medicine,
University of Calgary
Calgary Alberta

David Benoliel
VP, Enterprise Service
Cyberplex Inc.
Toronto, Ontario

Catherine Black
Retired Executive
Toronto, Ontario

Dr. W. K. (Bill) Evans
President,
Juravinski Cancer Centre
Hamilton, Ontario
Senior Medical Advisor,
Cancer Care Ontario
Hamilton, Ontario

Betty Jacoby
Retired Executive
Toronto, Ontario

Dr. Michael Johnston
Thoracic Surgeon,
Victoria General Hospital
Halifax, Nova Scotia

Dr. Natasha Leighl
Medical Oncologist
Princess Margaret Hospital
Toronto, Ontario

Peter F. MacKenzie
Retired Bank Executive
Toronto, Ontario

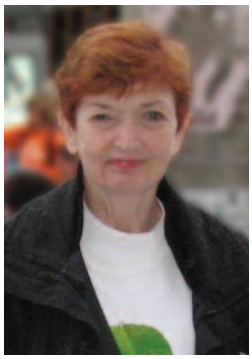
Joel Rubinovich
Chartered Accountant,
Rubinovich Newton LLP
Toronto, Ontario

Dr. Yee Ung
Radiation Oncologist,
Toronto-Sunnybrook Regional
Cancer Centre
Assistant Professor,
Department of Radiation
Oncology,
University of Toronto
Toronto, Ontario

Ted Weir
Counsel, McMillan Binch LLP
Toronto, Ontario

Magdalene Winterhoff
Oncology Social Worker,
Toronto-Sunnybrook Regional
Cancer Centre
Toronto, Ontario

Director Profile-Catherine Black



True volunteerism is based on putting the needs of others first. That comes naturally to Catherine Black. Among her family, friends and colleagues, Catherine is best known as a compassionate friend, hard worker and dedicated humanitarian.

In her professional life, Catherine worked as an executive in the field of business management and communications for over 30 years. Throughout her career she served both her employer and customers with their interests leading her actions. Now in retirement, Catherine continues to service others through her tireless volunteer efforts and contributions. At a time when she could deservedly slow down to focus more on her own interests, Catherine is giving even more of herself to causes that she cares deeply about.

Catherine's work with Lung Cancer Canada (LCC) began in 2005 shortly after losing her husband to lung cancer. She quickly became involved with many of the organizations lung cancer awareness, education and support activities. Her passion and strong work ethic led to an appointment on LCC's Board of Directors in 2005; and in 2006 she took on the role of Program Committee Chair.

Catherine's leadership as an active volunteer, board member and committee Chair has helped to further the mission Lung Cancer Canada nationally and has been an inspiration to us all.

By Catherine Rusby, LCC volunteer

Dr. Stephen Lam, M.D., FRCPC: Medical Advisory Panel Appointment

Dr. Lam obtained his medical degree from the University of Toronto in 1974 and his specialization in Internal and Respiratory Medicine from the University of British Columbia in 1978. He is a professor of medicine with the University of British Columbia, Chair of the Lung Tumour Group with the British Columbia Cancer Agency (BCCA), and is a senior scientist with BCCA's Imaging Department.

For the last 16 years, in collaboration with scientists and clinicians at BCCA, Dr. Lam has been conducting research to develop a comprehensive approach for the management of lung cancer by early detection, localization, and treatment based on novel technologies. These technologies include computer-assisted image analysis of sputum cells and a highly sensitive fluorescence bronchoscopy method (LIFE-Lung) to detect and localize pre-invasive lung cancers. Dr. Lam has also been key in the development of innovative endobronchial treatments of early lung cancer such as photo dynamic therapy. In 1984 he was the first in Canada to evaluate the role of Photo dynamic therapy with photofrin in the treatment of lung cancer.

Dr. Lam joined Lung Cancer Canada's Medical Advisory Panel in 2007.

Contact Information

Dallas Petroff,
Executive Director

Tasha Williams,
Program Manager

Lung Cancer Canada
1896A Avenue Road, Toronto, Ontario M5M 3Z8
416-785-3439 (Toronto) 1-888-445-4403 (Toll-free)
416-785-2905 (Fax)
www.lungcancercanada.ca info@lungcancercanada.ca
Charitable Registration Number: 872775119 RR0001

Thoracic Surgery for Symptom Control

Continued from page 1

chest or the abdomen. These are both one day procedures and are very effective in palliating fluid accumulation around the heart.

There are many other roles for surgery in the palliation of metastatic or locally advanced cancer. An open discussion with your oncologist about your symptoms is important in order to plan for the most effective intervention.


Figure 1

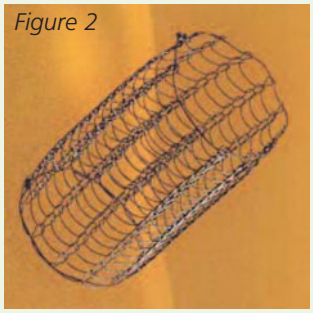


Figure 2


Figure 3


Figure 4

Shortness of Breath, Dyspnea

By Vicki Sorrenti, Oncology Nurse (Retired), *LCC Program Committee Member*

Dyspnea is a medical term that refers to shortness of breath with minimal exertion. "Hunger for air" "suffocation" or "breath constriction" are expressions sometimes used by patients to describe the uncomfortable sensations of dyspneic breathlessness. Dyspnea is a distressing symptom that accompanies many respiratory diseases. Patients with lung cancer are most commonly affected.

Dyspnea can be one of the most frightening and alarming symptoms of lung cancer. Its degree of intensity can vary from mild discomfort to severe pain at any given time. During an episode of extreme breathlessness, patients not only experience intense pain, but also feelings of panic and fear. These reactions often increase anxiety levels, which further limits oxygen intake, making breathing more difficult and painful. It is crucial to break this cycle as soon as possible. Breathing and relaxation techniques may apply some relief to breathlessness symptoms. If symptoms persist or worsen, contact your physician and proceed to the nearest hospital.

Controlled Breathing or Pursed Lip Breathing.

1) Sit up right to increase the capacity of air in your lungs. You can take the weight off your shoulders by resting your hands on the arms of a chair or on your lap
2) Purse your lips as though you are going to whistle
3) If possible, inhale through your nose with a gentle steady breath and try not force the air out of your lungs
4) Try to relax your shoulders and upper chest muscles as you breathe out
5) Breathe out gently through your pursed lips for 2 slow counts
6) Your exhale should be twice as long as your inhale to empty the "old air" out of your lungs (inhale 3 seconds, exhale 6 seconds). Keep repeating this exercise until you receive some relief from your shortness of breath.

Abdominal Breathing

1) You may sit up right or lie on your back with your knees bent and/or with a pillow under your knees
2) Place one hand on your upper chest and the other on the centre of your abdomen
3) Exhale slowly using the pursed lips breathing technique, gently squeezing your abdominal muscles
4) Inhale softly through your nose and feel your abdomen expand slowly
5) Continue this breathing technique until breathlessness subside.

Relaxation strategies

1) Stop what you are doing and sit or lay down to rest in a comfortable position
2) Close your eyes or fix your sight on an object in your environment
3) Calmly breathe in and out through your mouth as fast as necessary while trying to relax your entire body
4) After 2 minutes begin to slow your breathing using the pursed lip breathing technique
5) Continue in this position for about 5 minutes.

Use of Medical Therapies

Standard medical treatments for dyspnea can involve therapies that i) increase oxygen levels ii) reduce fluid build-up in the lungs iii) reduce anxiety and pain. Remember to keep your doctor informed and ask which treatment options are the best for you if shortness of breath has become a problem. You may be required to take a series of tests to conclude the exact cause of your breathlessness in order to determine best treatment options.

Standard sitting and resting position for all techniques

Volunteers Making a Difference

Message from the Volunteer Committee Chair

By Betty Jacoby, Volunteer Committee Chair

Lung Cancer Canada (LCC) is all about volunteers. They are the energy, hope and force that moves our organization forward. Volunteers are proudly supporting Lung Cancer Canada through their direct involvement in many varied initiatives within their communities. These volunteers are now organizing awareness and educational events and planning fundraisers with great success. Many of these events take place following a long day at work or at the expense of their family time. Volunteers have expanded their involvement to new locations thereby reaching more groups that are diverse. These volunteers are truly dedicated and have become a critical part of the team across LCC.

Last year by attending medical conferences we were able to interact and build relationships with the medical community, patient educators, lung oncology nurses and medical practitioners. From our participation at these events, over 1000 information packages were requested and sent to health care providers across the country.

Together, we can celebrate many amazing accomplishments:

- Creation of first lung cancer specific resource library in Canada
- Raising over $12,300 through the Scotiabank Charity Challenge walk/run
- Responding to peer-support calls across 9 provinces
- Collection of over 2,000 signatures supporting LCC's petition to the Ontario government to recognize November as Lung Cancer Awareness Month in perpetuity
- Organized awareness and fundraiser events in communities across Canada
- Developed the second phase of Canadian Lung Cancer Grove
- Mass mailing of national and volunteer newsletters
- Active membership in communities across Canada
- Represented LCC for media inquiries and interviews
- Coordinated the use of 4 display boards at 17 sites across Canada within one month

This year, the Board of Directors approved the appointment of an independent volunteer committee. This committee will support the identified strategies for 2008 and beyond. It is my privilege to Chair this committee for the upcoming year.

The year 2008 promises many ambitious challenges for Lung Cancer Canada. These endeavors will be successful with the support and knowledge of our Executive Director-Dallas Petroff, the Board of Directors and most importantly the individual volunteers. My time working with each volunteer encourages me and builds on my optimism that our goals and our mission will successfully continue.

Lynda Taylor and Bonnie Beaucage: Parry Sound, Ontario

Sisters Bonnie Beaucage and Lynda Taylor have been dedicated volunteers of Lung Cancer Canada (LCC) since 2006. Their work with LCC began shortly after Lynda was diagnosed with lung cancer in September 2005. "When my sister was diagnosed there didn't seem to be a lot of information or awareness about lung cancer in our small community of Parry Sound. Lynda and I wanted to change that", recalls Bonnie. In 2007, the sisters decided to commemorate Lung Cancer Awareness Month with a community fundraiser event. On November 19th, 2007 they hosted a lung cancer dinner and entertainment fundraiser at Hope United Church in a little village called Nobel in Parry Sound. The fundraiser offered a night of fun musical entertainment, theatre, a silent auction and tasty decadent desserts. "To raise awareness, we set up a lung cancer information booth and gave out information pamphlets to guests", adds Bonnie. The event was well attended and raised over $2,000 in donations. We thank Bonnie and Lynda for their many contributions to LCC as valued community outreach volunteers.

Scott Secord: Edmonton, Alberta

14 year old Scott Secord decided to shave his head to raise money and awareness for lung cancer to honour his grandfather recently diagnosed with the disease. His fundraising campaign was titled "Love Your Lungs, Like I Love My Grand-dad". With the support of his family, friends, staff and students of his school (Tom Baines Junior High), Scott and his team raised $5,000 after only two weeks of fundraising. After only two weeks of successful campaigning, Scott and his team surpassed their fundraising goal by $4,000, raising a grand total of $5,000.

The big shave took place on December 7th, 2007 at Scott's school. Scott says he was happy to make a difference and elected to donate $2500.00 to Lung Cancer Canada and $2500.00 to Dr. Gwyn Bebb's research program for Lung Cancer in Edmonton Alberta. Lung Cancer Canada salutes Scott Secord, our youngest volunteer fundraiser for his efforts and contributions to lung cancer awareness and research.

Luisa Quattrociocchi and Mary Buffone: Toronto, Ontario

Since volunteering with LCC in 2006, Luisa and Mary's flare for event planning and fundraising now benefit the cause of lung cancer. "Mary and I are the daughters of two wonderful men who lost their lives too early to lung cancer. We enjoy organizing LCC fundraisers because they allow us to raise money and awareness for such a worthy cause, while celebrating the lives of our fathers in creative ways" remarked Luisa. On February 16th 2008 they hosted their most extravagant fundraiser to date. The Moroccan themed dinner-dance event included an antipasto bar, belly dance entertainment, a silent auction, dancing and a key note address by Lung Cancer Canada's Chair of Fundraising-David Benoliel. "We raised $4300.00 and are looking forward to our next event" stated Luisa. Many thanks to Luisa, Mary and their team of helpers for their continued hard work, generosity and support of Lung Cancer Canada.

Saira Graham: Tillsonburg, Ontario

Saira Graham lost her mother to lung cancer in 2007. After experiencing first hand what little public attention and funding lung cancer receives, Saira decided that she wanted to make a difference. Putting her passion, creativity and organization skills to work, Saira planned a lung cancer awareness and fundraiser event in her community of Tillsonburg, Ontario. The event took place on February 14th 2008 and raised over $5000.00. Saira's proactive efforts to make a positive difference and change in her community is very much valued and appreciated by Lung Cancer Canada.

Denis Caspar, Montreal Quebec

The life of Denis Caspar is truly an inspirational story of hope and determination. Denis, at age 53, is an esteemed husband, father and grandfather; as well as an accomplished visual artist, author and aspiring violinist. Denis' passion for life and adventure has led him to take on many out-going activities; his newest venture- parachuting.

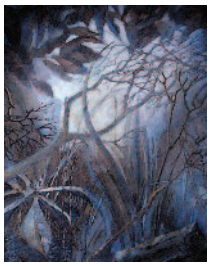
In October 2006 Denis was diagnosed with lung cancer. His symptoms began with intense pain and pressure in his chest, followed by a sudden loss of voice. At first his family doctor prescribed antibiotics which did not help. Denis was then recommended to an ear, nose and throat specialist who requested a CAT scan and x-ray of his neck and lung. The tests results revealed what Denis has suspected all along, he had lung cancer.

Further tests at the Notre Dame clinic in Montreal, Quebec confirmed a growth of two tumors on Denis' aorta (large artery leaving the heart) which were inoperable. By December 22nd, two months after his initial diagnosis, the situation appeared to be very serious and untreatable by radiation due to the proximity of the tumor to the aorta. Massive doses of chemotherapy was employed and proved to be very effective. The size of the tumors had reduced by 70% following chemo treatment cycles. His oncologist was very encouraging, impressed and pleased with the outcome of treatment and told Denis that he was possibly in partial remission.

"When I was told about the diagnosis I was not surprise being a smoker and having worked in areas of glass fiber and resin for many years. However I did feel very guilty and I remember wishing I could disappear from the face of the earth", recalls Denis. Shortly after this brief episode of despair, Denis decided to take a positive and combative attitude to live a full life, one day at a time. Denis thanks his spouse and children who were extremely supportive and encouraged him every step of the way.

Working with his wonderful team of doctors and nurses, Denis took it upon himself to take an active role in maintaining his physical and mental health. He first decided to make the effort to walk everyday. The first day he walked 100 meters, and kept increasing the distance daily. At present he walks between 2 and 8 km a day. Denis also decided to write a book and is considering making an animation film. This spring Denis plans to parachute, an adventure he has always dreamed of doing; and will continue painting portraits and creating other works of art, an interest that he is good at and enjoys immensely. Denis says "I do not believe these projects or my hopes and dreams will cure my illness, however they allow me to accept and live in harmony with my condition".

When asked for words of wisdom and encouragement to other lung cancer patients, Denis said "Speak about your illness with your family, friends and even your doctor. Find ways to understand your emotions and remember that humor can be a great help in coping with cancer. Also try not to isolate yourself. Instead, go out and meet with friends, family and your neighbors-keep as active as you can. And last but certainly not least, try occasionally to lock your cancer in a drawer. For a few hours each day, try to forget about your cancer as much as you can and liberate yourself." Bravo Denis-chapeau!



Painting by Denis Caspar

Interview by Ralph Gouda, LCC Founder and past president.

Volunteer Profile: Elizabeth Perry

Lung Cancer Canada is pleased to recognize one of our most dedicated volunteers-Elizabeth Perry. Elizabeth first volunteered with Lung Cancer Canada in 2005 to honour the memory of her sister Marilyn McKinnon. Marilyn, a non-smoker, fought not only lung cancer, but also its social stigma. Motivated and inspired by Marilyn's strength, Elizabeth devoted her volunteer work to raising lung cancer awareness and supporting the educational needs of patients and their caregivers. Over the years Elizabeth has volunteered her time, skills and expertise to several LCC awareness, fundraising and educational activities. In January 2007, she retired from a long career as a librarian at the University of Toronto, to contribute more time to the development of LCC's Resource Centre.

Lung Cancer Canada is grateful for the opportunity to work with Elizabeth. Elizabeth's many talents, inner warmth and effervescent spirit is much appreciated by all of us at LCC.

New Source of Information for Canada's Lung Cancer Community

By Elizabeth Perry, LCC Volunteer Librarian

Lung Cancer Canada has lived its mission from the start: Raising lung cancer awareness, offering support to those affected by lung cancer and providing educational resources.

Now, in 2008, we are poised to add another brick to our growing home for the lung cancer community all across Canada. A library and information service will provide accurate, current information from credible sources and in accessible language - focusing only on lung cancer - so that those affected by the disease can better understand their experiences and make informed decisions about care. Medical professionals will find our resource library to be a helpful tool in communicating with their patients.

Our belief is that lung cancer patients and caregivers deserve the best and clearest information in the easiest way possible for their individual needs. Our LCC volunteers will "do the digging" on their behalf. We will provide personalized answers to questions about diagnosis, treatment, drugs, finances, nutrition, and emotional issues.

How will it work? Since early 2007, under the direction of LCC Executive Director Dallas Petroff, a team of four volunteers has been planning, assembling and organizing the books, articles, and web resources that will form our resource library. Patients, families, and caregivers across Canada will be able to email or call toll-free to this ever-growing library at the LCC office in Toronto. Simple questions may be answered over the telephone; more complex questions will be answered by mailing out photocopied articles or providing links to helpful and reliable websites. The library will also have a section on LCC's website to provide info sheets, lists of recommended books and recommended associations and websites for further help.

Through these endeavors we will provide timely and accurate information and resources for patients, caregivers and family members.

Access to PET Scanning for Lung Cancer in Ontario

By Dr. W. K. (Bill) Evans
President, Juravinski Cancer Centre, Senior Medical Advisor, Cancer Care Ontario, Chair Provincial PET Steering Committee, LCC Board of Director

There has been considerable controversy around the introduction of PET scanning for cancer in Ontario. This imaging technology was first introduced in the 1970's and is now widely available in many countries. As distinct from computed tomography (CT) or magnetic resonance imaging (MRI), which provide images of anatomical structures, PET creates images based on the uptake of organic compounds like glucose (a sugar) linked to a radioactive substance (radioisotope). The most commonly used radioisotope is F18-fluorodeoxyglucose (FDG). Because cancer cells often use glucose at a higher rate than normal or benign tissue, FDG can sometimes localize tumors even before there is an anatomical abnormality evident on CT or MRI. One barrier to the widespread adoption of PET is the fact that the technology itself is very expensive. The radioisotope FDG needs to be prepared in a cyclotron, which costs approximately $3-4 million to build. Because the FDG is radioactive and decays at a rapid rate, cyclotrons need to be located within a few hours transportation time from a diagnostic centre. PET scanners cost between 1.5 and $3 million and modern machines integrate both PET and CT imaging. PET is also being combined with MRI technology which will probably make the machine acquisition costs even greater. In addition to these capital costs there are ongoing annual operating costs of approximately $1.5 million per machine.

...the Ministry of health agreed to fund a number of studies in the province of Ontario to help strengthen the evidence base for the use of PET.

In 2000, the Institute for Clinical Evaluative Sciences (ICES) was asked by the Ministry of Health, Ontario Medical Association and Ontario Hospital Association to review the existing medical literature about the diagnostic accuracy of PET and its impact on patient outcomes. ICES reviewed all of the available medical literature related to PET and cancer, cardiac disease and neurological disease. Although a large number of studies were found, especially related to cancer, the authors concluded that "despite the availability of PET scanning for almost 3 decades, the number of methodologically high-quality studies and the numbers of patients within these studies is distressingly small". Because the evidence base for the use of PET scanning in many cancers was considered weak at that time, the Ministry of health agreed to fund a number of studies in the province of Ontario to help strengthen the evidence base for the use of PET. ICES continued to monitor the published literature and it was agreed that if new compelling evidence emerged, the Ministry of Health would review that evidence and, as appropriate, approve funding.

The introduction of PET for cancer diagnosis and staging has been made more complicated by the fact that Health Canada, which regulates all new drugs, considers FDG to be an investigational agent. This means that for each tumor type or condition for which a PET center wants to conduct scans, there needs to be a protocol specific to that purpose called a Clinical Trials Agreement, which must be approved by Health Canada.

Despite these administrative and scientific challenges, patients with lung cancer do have access to PET scanning under a number of circumstances. In the first place, patients who present with a solitary spot on a chest x-ray which looks like cancer may be a candidate for a PET scan. The usual diagnostic approach to such patients is to do a needle biopsy to get tissue. This is the most definitive way to make a diagnosis of lung cancer. A tissue diagnosis is always better than an imaging technique which can only suggest that cancer is present. However, there are situations where a needle biopsy cannot be undertaken or where it has been undertaken but been unsuccessful. In these circumstances, a PET scan may be helpful because if the lesion "lights up", there is a high probability that the abnormality is a cancer. This is not a 100% certainty as inflammatory conditions such as a localized area of pneumonia or a granuloma from active tuberculosis or fungus infection would also be positive. A negative scan would suggest that the lung shadow is benign, such as a scar in the lung. However some slow-growing tumors such as bronchoalveolar carcinoma do not take up FDG consistently and so patients with a negative PET scan still need to be followed carefully to make sure the lesion does not grow. PET scanning for "solitary pulmonary nodules" is available and funded by the Ministry of Health in Ontario. Patient information is captured in a special registry kept at ICES and patients are asked to sign a consent that would enable researchers to determine what happened to them after the PET scan is performed (for example was a thoracotomy performed?)

A number of small studies and one randomized trial suggested that PET scanning could identify tumour spread outside the chest or to other sites that would make an operation futile in patients with, what otherwise appeared to be clinically localized lung cancer. The literature, however, has been conflicting, as an Australian trial did not show a reduction in futile thoracotomies when PET scanning was used. Because of this, the Provincial Lung Disease Site Group proposed a study to compare the standard preoperative workup for patients with apparent early lung cancer (CT chest and upper abdomen, including liver and adrenal glands, bone scan and cranial imaging) or PET/CT and cranial imaging. This trial finished the required recruitment of patients in September 2007 with 337 patients enrolled from eight treatment centers in Ontario. The results of this trial will be reported at upcoming international cancer meetings and the full results of the trial will be reported in a manuscript to be submitted to a major cancer journal. But rather than wait for the results of this trial to be reported to the scientific world, a recommendation was made to the Ontario Health Technology Assessment Committee that the early lung cancer diagnosis be included as a MOH funded indication and be made available to patients now. This recommendation was accepted OHTAC and Ontario patients with early lung cancer being considered for surgery can now get access to a publicly funded preoperative PET scan.

Another Ministry of Health funded trial is currently enrolling patients with locally advanced (stage 3) non-small cell lung cancer. Over 250 patients have been accrued to the study which has a target recruitment of 400 patients. This study will help to determine whether PET scanning identifies spread of cancer beyond the chest more commonly in stage three disease than other standard diagnostic procedures. Precisely defining the true stage of patients who appear to have inoperable lung cancer confined to the chest is important as they may be candidates for a combined chemotherapy and radiotherapy approach which yields better survival than radiation therapy (the usual treatment) alone. A study within this larger study is designed to determine whether PET helps the radiation oncologist define the treatment fields more precisely than standard anatomical imaging.

The Ontario Lung Disease Site Group recently completed a practice

Continued on page 7

Access to PET Scanning for Lung Cancer in Ontario

Continued from page 6

guideline which was published in the Journal of the National Cancer Institute. In addition to recommending PET in the diagnosis of patients with solitary pulmonary nodules and a role in the staging of patients with disease clinically confined to the chest, it also found a small literature supporting its use in small cell lung cancer. A recommendation is being taken forward to the PET Steering Committee recommending approval of PET for the staging of small cell lung cancer. Finally, a protocol is under development to evaluate whether PET is useful in diagnosing recurrent cancers of a variety of types when it is not obvious from other diagnostic tests. This is not an uncommon situation during the care of lung cancer patients who, after radiotherapy and chemotherapy to their chest lesion, often have changes on plain chest x-ray or CT scan that could be due to scarring from treatment or be due to persistent/recurrent cancer. PET scanning may help to determine whether cancer is present in these hard to sort out situations and alter therapy. It is expected that this new study will be launched in the next several months.

So lung cancer patients in Ontario has access to PET scanning for most of the key indications for which it is potentially useful. In the next few months, access may be further improved for patients with small cell lung cancer or recurrent non-small cell lung cancer and for patients who have locally advanced disease.

A Hospital's Focus on Lung Cancer: Segal Cancer Centre, Sir Mortimer B. Davis-Jewish General Hospital

The Segal Cancer Centre is a newly built clinic of Sir Mortimer B. Davis-Jewish General Hospital. It opened its doors in February 2006.

The Segal Cancer Centre is a state-of-the-art facility which provides patients with the most comprehensive approach to care, combining cancer prevention, diagnosis, treatment, psychosocial support, nutritional support and clinical and fundamental research in cancer. The multi-disciplinary team of physicians, nurses, physiotherapists, dietitians, psychologists, social workers, pharmacists, support staff and volunteers play a central role in guiding and supporting patients and their families at each step.

In addition to the pulmonary (lung) oncology clinics which take place Monday to Thursday, the Cancer Nutrition and Rehabilitation Program (CNR) provides four half-day clinics and focuses on patients with lung cancer and gastrointestinal cancer, although a number of patients with other forms of cancer (e.g. ovarian cancer), are also seen.

Patients are seen on a regular basis and follow-up visits are scheduled according to their specific needs. The pulmonary oncology team members meet weekly at a two hour tumor board to discuss all new patients and any new issues pertaining to any other patient. In addition, team members communicate frequently throughout the day to discuss issues as they arise. Through training and follow-up counseling, patients are encouraged to take control of their own nutrition and physical activities. Patients also have easy access to the psychosocial support services (social worker, psychologist, and psychiatrist) provided by the Psychosocial Oncology Program at the Segal Cancer Centre.

The clinic has forged strong ties with members of the "Hope & Cope" program (www.hopecope.jgh.ca) of the hospital. Members of the cancer program team at the Segal Cancer Centre have offered Qi Gong and healthy eating classes to patients, at Hope & Cope's newly built Wellness Centre which is located close to the hospital.

Edited by Dr. Jason Agulnick,
Seagal Comprehensive Cancer Center,
Jewish General Hospital
LCC Medical Advisory Panel

Team LCC, 2007 Scotiabank Group Charity Challenge 5k Walk

For the first time ever, on Sunday September 28th, 2007, Team Lung Cancer Canada (LCC) proudly took to the streets of downtown Toronto as participants in the 2007 Scotiabank Charity Challenge 5k walk. Of the 50 participating charities, Team LCC was the only one representing lung cancer patients. Sporting LCC t-shirts, caps and logo banner, we completed the 5k walk as 20,000 on-lookers cheered.

For some members of the Team, completing the 5k walk was a personal triumph. For Virginia Stoymenoff- a three year survivor and Nicole Hardy-a lung cancer patient, the walk was symbolic of how they have managed their lung cancer journey - one step at a time.

The collective efforts of everyone that walked, collected pledges and donated made this event a wonderful success for LCC. Thanks to their hard work, LCC's message of lung cancer awareness reached a wide audience; and within three months we exceeded our fundraising goal by 150 percent- raising a grand total of $12,400.

Team LCC is gearing up to participate in the 2008 Scotiabank Charity Challenge 5k Walk. Our 2008 fundraising goal this year is $15,000. Once again we need your support. To find out more about how you can support Team LCC in this event from anywhere in Canada, please contact LCC.

Booklet Order Form

"A Patient's Guide to Lung Cancer" is a Lung Cancer Canada publication designed to meet the educational needs of lung cancer patients and their family. **English and French version now available.**

To order your copy today please complete and return this order form to Lung Cancer Canada.

☐ English _____

☐ French _____

Please specify the quantity

I. **NUMBER OF BOOKS ORDERED** _____ @$7.00 each = _____ (Total Cost)

II. **PAYMENT INFORMATION**

☐ VISA ☐ MASTERCARD ☐ CHEQUE (Please make cheque payable to Lung Cancer Canada and send to the mailing address below)

III. **FOR PAYMENT BY CREDIT CARD**

Name of Card Holder: _____ Credit Card Number: _____

Expiry Date: _____ Signature: _____

IV. **MAILING INFORMATION**

Name: _____

Mailing Address: _____

City/Province: _____ Postal Code: _____

Telephone: _____ Email: _____

You are: ☐ Patient ☐ Caregiver ☐ Healthcare Professional

Professional Title: _____ Date: _____

Lung Cancer Canada – 1896A Avenue Road, Toronto, ON M5M 3Z8 • info@lungcancercanada.ca

Booklet Survey

If you have ordered a copy of **"A Patient's Guide to Lung Cancer"**, please provide us with your feedback by filling out the questionnaire below.

1. Was the content of the booklet comprehensive and patient friendly? _____

2. What aspects of the booklet did you value most? _____

3. Were there any key topics or information that you feel was not covered in the booklet that should have been? _____

4. If you are a healthcare professional, how have the booklets been made accessible to lung cancer patients or caregivers at you hospital/treatment centre? _____

5. Any further comments: _____

You can help make a difference...

Donation Card

For a donation by Visa or MasterCard, please complete the following information and mail it to the address shown below.

☐ Visa ☐ MasterCard

Name of card holder: _____ Card Number: _____

Address: _____ Exp: _____

_____ Signature: _____

Phone: ( ) _____ Amount $ _____

For a donation by cheque, please make cheque payable to **Lung Cancer Canada** and mail it to the address below:
1896A Avenue Road, Toronto, Ontario M5M3Z8 • 416-785-3439 1-888-445-4403

All donations are greatly appreciated. A tax receipt is issued for an amount of $25.00 or more.

LUNG CANCER CANADA

Awareness. Support. Education.