

# HOT SPOT



## Editor's corner

Welcome to the first issue of our quarterly newsletter. In this issue you will find information on the reason for initiating the Rapid Response Radiotherapy Program (RRRP), our experience over the past four years, our research plans, and the new Bone Metastases Clinic at Toronto-Sunnybrook Regional Cancer Centre (T-SRCC). The main aim of this newsletter is to provide us with an opportunity to exchange ideas and improve communication among all those involved with providing supportive care to our patients. Although produced by the RRRP, we plan to include contributions from all palliative and supportive care programs available at the Sunnybrook and Women's College Health Sciences Centre (S&WCHSC) and the community.

We would like this to be your newsletter rather than our newsletter to you. We therefore would like to hear from you and welcome your contributions to be included in future issues of this newsletter. Please send us your comments, letters and contributions. We would like to thank the companies whose financial contributions made this project feasible. We hope you find this first issue informative and useful in your practice.

**This first newsletter has been named "Hot Spot". We would like a more appropriate name for our newsletter. Please send your suggestions to Dr. Danjoux.**



*From  
Dr. Gillian  
Thomas,  
Head,  
Radiation  
Oncology*

## The first Rapid Response Radiotherapy Program newsletter

It has been four years since the idea of a RRRP was conceived. The idea grew from many roots. These roots lay in trying to provide better care and service to a large population of cancer patients whom we felt would benefit from timely palliative radiation therapy to provide symptom relief.

Historically it is widely accepted in North America and Europe that about 50% of patients will benefit from radiation therapy at some time during the course of

*continued on page 2...*

## From the Chief Executive Officer

Dear Colleagues:

Welcome to the first RRRP newsletter, designed to improve communication between the referring physicians and T-SRCC.

T-SRCC is among a small group of comprehensive cancer centres in North America that offers a complete range of inpatient and ambulatory services. T-SRCC is located at the Sunnybrook site of the newly formed S&WCHSC (an amalgamation of Sunnybrook Health Science Centre, Women's College Hospital and the Orthopedic and Arthritic Hospital). T-SRCC is a joint program of the Health Services Centre and Cancer Care Ontario, the province's new cancer agency that has the mandate to coordinate and oversee cancer services across the province. Patient care includes prevention, screening, early detection, treatment (radiation, medical and surgical), supportive care and palliation. The

RRRP is an important T-SRCC initiative which provides rapid palliative radiotherapy to patients with advanced incurable cancer. Starting in January 1999, the multidisciplinary Bone Metastases Clinic will provide elective orthopedic and radiotherapy consultation to patients with bone metastases.

T-SRCC research programs include fundamental, clinical and supportive care projects. In 1997-98, centre scientists obtained over \$9.5 million in external funding for the support of over 140 research projects. The centre is affiliated with the University of Toronto; we have an active training program for oncology residents and other health professional students.

I hope you find our first issue informative and helpful in your practice.

**Ken Shumak, MD, FRCPC,  
Chief Executive Officer**

## HOT SPOT

*The Newsletter of the  
Rapid Response Radiotherapy  
Program of Toronto-Sunnybrook  
Regional Cancer Centre*

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**In this issue:** Palliative radiotherapy rounds; New combined bone metastases clinic; Phase II trial of palliative radiotherapy for metastatic renal cell carcinoma; Prospective assessment of symptom palliation for patients attending a rapid response radiotherapy program; Speedy delivery of pain relief; Research Corner; Cancer pain and palliative care clinic

**A message from Dr. Gillian Thomas,**  
*continued from page 1...*

their disease. For many this therapy is with palliative intent. Limitation in resources including both personnel and radiation equipment, has led to a situation in Ontario where the percentage of patients with a cancer diagnosis who received radiation has declined significantly. This was a result of our declining ability to deliver timely radiation therapy to patients whose life expectancy might be short. On June 8, 1995 we met with a large group of individuals including nurses, social workers, physicians and managers involved in the delivery of palliative care in the community and in surrounding hospitals. This meeting helped us to understand better the needs of patients from our community and how the radiation oncology program at T-SRCC could integrate with other community medical care workers to deliver improved care. The model for the RRRP was drawn out of the information that we gathered and was cognizant of the fact that many patients who required the specialized service of radiation therapy in their disease already had comprehensive medical care and medical supervision delivered out in their community.

Prior to development of this specialized clinic, focus on symptom relief, consultation and palliative irradiation was conducted and prescribed by physicians involved in a specific tumour site group. This system meant that those requiring palliative care were on a waiting list with other patients requiring primary definitive radiation therapy with the result that often patients who needed treatment immediately did not access it in a timely fashion.

Thus the new model now operational in the RRRP was conceived. This model suggested that special arrangements should be made to bring patients requiring consultation and palliative irradiation into the clinic within seven days of referral.

## **New combined bone metastases clinic: *The ultimate one-stop for cancer patients with bony metastases***

**By Drs. Joel Finkelstein and Edward Chow**

An estimated 129,200 new cases of cancer and 62,700 deaths from cancer will occur in Canada in 1999. What these statistics don't describe are the physical impairments that can be associated with the disease. Metastatic lesions to the spine and extremities can result in loss of structural integrity of the bony architecture. A patient may be exposed to pain, loss of independence and a deteriorating quality of life.

Radiation and operative stabilization are effective palliative measures. Both are

Secondly, the model proposed that where appropriate and possible, the patient should be planned and treated either on the day of assessment or as soon afterwards as possible. The model also proposed that good communication be established between the T-SRCC and the referring physicians so that patients could return for further care to their own community caregivers accompanied by a very clear summary of the radiation that was prescribed and received and of any changes or suggestions that had been made in the patient's medications. A direct telephone communication between referring physicians and the centre physicians involved with the clinic was set up to circumvent the more cumbersome arrangements for referring other new patients to the clinic. Dedicated nursing support at T-SRCC was developed with Lou Andersson's interest, knowledge and commitment to the care of patients in the RRRP. Brochures were developed to explain our new service to referring physicians in the community and referring caregivers in palliative care units.

We now have a dedicated team of medical, nursing, radiation and pharmacy staff committed to continually evaluating and improving the service that we can provide for our patients requiring palliative radiation treatment. Our team now not only provides exemplary care but also develops research protocols to evaluate the outcomes of care provided in terms of patients' and referring physicians' satisfaction.

Our program has been extremely well received. After a presentation of our activities at a national Canadian radiation meeting last year, many calls were received from other centres interested in establishing a similar service.

The group of dedicated personnel in the clinic and in the radiation therapy department are owed our thanks and admiration for making the clinic work to improve patient access and clinical care.

performed by specialists: radiation oncologists and orthopedic surgeons, often independent of the other. Coordinated treatment utilizing both these specialties is lacking in cancer care. To this end, this first edition of the RRRP newsletter introduces the combined Orthopedic/Radiation Oncology Bone Metastases Clinic at T-SRCC, the first clinic of this kind in Canada.

The goals of this clinic are to provide an elective orthopedic and radiation oncology consultation service for patients with bone

# **Palliative radiotherapy rounds**

**By Dr. Ewa Szumacher**

Since September 1998 we have monthly palliative radiation oncology rounds at T-SRCC. The idea of monthly rounds came about when the RRRP was expanded and we faced several problems beyond radiation treatment such as psycho-social oncology, home care, collaboration with referring physicians, etc.. Rounds take place on the last Tuesday of each month in RDT Jenkins Auditorium from 1-2 pm. Novartis has generously sponsored lunches for these meetings.

## **Dates and Topics for 1999 are:**

- |             |  |
|-------------|--|
| January 26  | Metastatic Disease to the Spine<br><i>Speaker: Dr. Joel Finkelstein; and Metastatic Disease and Pathologic Fracture of the Extremities</i><br><i>Speaker: Dr. Dave Stephen</i> |
| February 23 | Radical Surgery for Brain Metastases<br><i>Speaker: Dr. P. Davey</i>   |
| March 30    | Pain Symptom Management<br><i>Speaker: Dr. Larry Librach</i>   |
| April 27    | Single Dose Wide Field Irradiation for Palliation of Bone Metastases<br><i>Speaker: Dr. Cyril Danjoux</i>  |
| May 25      | TBA<br><i>Speaker: Dr. Peter Kirkbride</i>   |
| June 29     | Palliative Care Information Centre of Metropolitan Toronto<br><i>Speaker: Ms Catherine M. Freer</i>  |

The meetings are open to all. Suggestions for future topics are welcome. Contact Dr. E. Szumacher at (416) 480-4982.

metastases and follow-up to oncology patients after orthopedic interventions. The clinic commenced operations on January 8, 1999 and will be held on the second and fourth Friday morning of each month. Referrals to the clinic can be made by calling the T-SRCC new patient booking desk at (416) 480-4205 or fax in the T-SRCC fax-in referral form to (416) 480-6179. We expect the primary beneficiaries will be our patients as a rational and a coordinated approach to intervention should improve their quality of life.

# A phase II trial of palliative radiotherapy for metastatic renal cell carcinoma

By Drs. Edward Chow and Pdraig Warde

## Introduction

Renal cell carcinoma (RCC) represents approximately three per cent of adult malignancies, with an annual incidence rate of 5.6/100,000 males and 4.1/100,000 females. Autopsy series suggest that over 80% of patients who die of RCC have metastases at the time of death.

Retrospective analyses, however, have suggested that 47 - 83% of patients with RCC may experience relief of bone pain after radiation treatment of their metastases. Similar response rates have been documented for soft tissue RCC metastases. Thoracic metastases have been found to respond in 50 - 67% of cases, although measurement of response is often inconsistent. Mass effects from RCC metastases were reduced in one study by 64% and similarly the resolution of painful abdominal masses has been documented.

## Objectives

This phase II study is designed to document the effect of radiotherapy on tumour regression, symptom relief, and quality of life in patients with metastatic RCC.

## Treatment

All patients will receive 3000 cGy in 10 fractions to the sites of symptomatic metastases.

## Summary

This is a collaborative study with Princess Margaret Hospital and we welcome referrals to the RRRP and GU radiation oncology site group at Toronto-Sunnybrook Regional Cancer Centre. Please call (416) 480-4806 for appointment.

# Prospective assessment of symptom palliation for patients attending a rapid response radiotherapy program

By Drs. Edward Chow, Cyril Danjoux and Rebecca Wong

## Introduction

It is essential that we evaluate the benefit of palliative radiotherapy offered in our program. Because of their advanced illness, patients seen in the program often cannot regularly visit the tertiary centre for follow-up assessment. However, assessment of symptom relief is of utmost importance to allow the health care providers to plan for the most appropriate palliative treatment modality for this group of terminally ill patients.

The majority of patients are managed by the community based supportive care. Rather than bringing the patients back to the tertiary centre, we propose a structured phone follow-up to collect symptom relief data.

Oncologists are often asked by patients and their family members the estimated survival times. Physicians estimate of survival times are often inaccurate. Survival predictions were overly optimistic in over 80% by three weeks to three months on average.

Performance status, quality of life score and clinical prediction have been associated with predictive values for survival duration in some studies. Our data collection will allow comparison of clinical prediction, Karnofsky performance status and symptoms commonly seen in terminally ill patients to determine which (if any) are predictive of survival duration.

In the multidisciplinary symptom control clinic in a cancer centre in Edmonton, positive screening for alcoholism was detected in 25% of the patients which was higher than that expected for the Canadian population, but lower than the 27% observed in a tertiary palliative care unit. A history of alcoholism increases the risk of clinical coping and has been found to be an independent poor prognostic factor for the opioid management of cancer pain. These patients may require intensive multidisciplinary management in order to achieve similar pain control as those with no history of alcoholism. It would be worthwhile to see the prevalence of alcoholism in our clinic patients and to verify if the history of alcoholism complicates pain management.

## Study design

All new patients in the RRRP will have a prospective data collection form and symptom assessment score sheet. We plan to use the Edmonton Symptom Assessment Score which has been used for over 10 years in the palliative care setting in Edmonton. It measures the intensity of different symptoms on an analogue scale (0 = best possible symptom and 10 = worst possible symptom). The score sheet asks for information on 10 - 12 symptoms (for example, pain, tiredness, nausea, depression, anxiety, drowsiness, appetite, wellbeing, shortness of breath and other symptoms), which should not be too difficult for terminally ill patients to handle. The patient / families will be given the same score sheet to take home. They will be asked the same questions in the telephone interviews as in the initial clinic visits. The CAGE questionnaire to screen for alcoholism will be completed at the initial clinic visit only.

The clinical trials assistant will phone the patient at weeks 1, 2, 4, 8 and 12 after the start of radiotherapy. Analgesics used over the preceding 24 hours will be documented at each visit and telephone interview. Our pharmacists will do the necessary conversion if the analgesics have been changed. Physicians will estimate and record the patient's survival based on their clinical condition in the initial visit. Any other co-interventions (systemic therapy or surgery) will be documented in the clinic and telephone interviews. If the patient is an inpatient, the assessment will be carried out with the help of the hospital / hospice nurse. Twice a year the clinical trials assistant will obtain from the health information department in T-SRCC and the cancer registry, the exact date of death of patients in our database. This will allow the calculation of the actual survival of each patient.

## Summary

This will allow us to evaluate the feasibility of using a phone follow-up to assess changes in the symptom profile of patients following palliative irradiation, assess the accuracy of physicians' estimates of survival time and explore the effect of alcohol consumption on pain management in terminally ill patients.



# The challenge of speedy delivery of pain relief met by the rapid response clinic at T-SRCC

By Dr. Ewa Szumacher and Ms Lou Andersson

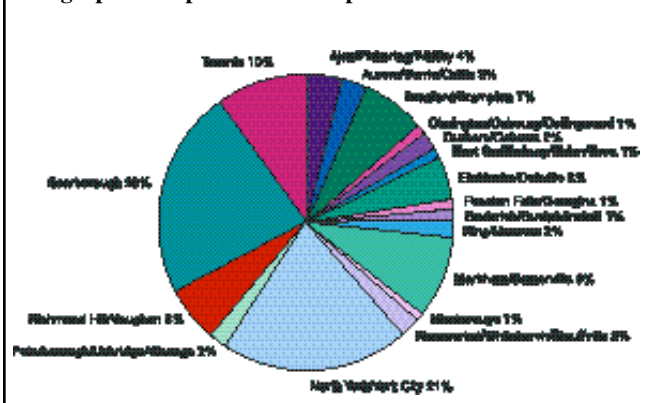
Pain control is a major part in the quality of life outcomes of palliative patients referred to T-SRCC for radiation treatment and the timing of these treatments.

The RRRP provides palliative radiotherapy consultations and treatment to patients from a large catchment area, as seen in the accompanying figure for 1996-97.

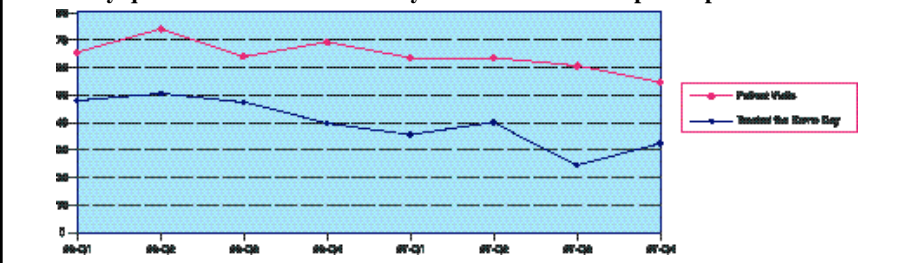
We hope to reach more family physicians within T-SRCC's catchment area to inform them of the services available for palliative patients. Although the intervention with palliative patients may be brief, it is

surprising to note that RRRP has made a significant impact on the patients and their families because the team has provided a timely performance, prioritization and coordination of a multiple complex task in its fight against intense human suffering.

Geographical representation of patients treated at T-SRCC



Trends by quarter: Visits and same day treatments in the rapid response clinic



# Research corner

By Dr. Rebecca Wong

The RRRP is committed to defining and improving our ability to palliate. One of the important ways of achieving these goals is, of course, through clinical trials. It would be easy for us to resign ourselves to the fact that the burden of illness of our patients precludes considerations for clinical trials. However, we firmly believe that with careful design of research methodology, an adequate amount of data can be captured to provide meaningful information while avoiding excessive additional burden on our patients.

One of the clinical trials we are currently conducting involves the evaluation of the effectiveness of radiotherapy alone versus radiotherapy and single dose Pamidronate in the relief of pain from bony metastasis. In this clinical trial, the change in pain intensity is the primary endpoint. The data collection methodology involves the use of clinical trials nurse telephone interviews, hence obviating the need for return visits. The initial phases of the study certainly saw modifications and deletions in the data collection process, as we learn more about what is practical and what is not.

As our clinic evolves, additional clinical trials are being formulated and drafted. We plan to address potential innovative strategies, as well as existing empirical practices. This would give us a better handle on the true impact of our current treatments, identification of innovative strategies, while all the time cognizant of the need to keep the potential adverse effects to a minimum.

Only through learning with our patients, could we truly thrive to provide the best palliative strategies that they truly deserve.

# The cancer pain and palliative care clinic at T-SRCC

By Dr. Larry Librach

The cancer pain clinic has been operating at T-SRCC for at least 10 years. In June 1998, the clinic changed its focus to both cancer pain and palliative care. This was consequent to the departure of Dr. Ian Kerr and the assuming of direction for the clinic by two physicians from The Temmy Latner Centre for Palliative Care, Dr. Larry Librach and Dr. Russell Goldman.

**Clinic day:** Every Monday afternoon.

**Who can be referred:**

- Any outpatient with cancer pain at any point in the illness (they do NOT have to be T-SRCC patients).
- Assessment of patients who may need continuous subcutaneous infusion of opioids (pain pump).
- Any patient for assessment of any symptom control problem.
- Cancer patients needing assessment for home palliative care services through the Temmy Latner Centre or other programs.

**Services provided:**

- Consultation services for cancer pain and symptom management with follow-up as required by the problem and as indicated by the referring physician.
- Palliative care consultation services.
- Linkage with community palliative care resources in the greater Toronto area.
- Linkage with the Sunnybrook Pain Clinic for interventions such as nerve blocks and epidurals.

**Referral process:**

- Appointments can be made through the usual T-SRCC appointments process (new referrals)
- (416) 480-4205, T-SRCC patients (416) 480-4640.
- Urgent referrals can be made by phoning Nancy Doyle at (416) 480-6176 or Dr. Librach at (416) 586-5133 (page).

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