

# HOT SPOT



## Bayview Support Network: Ontario's first on-site cancer support network

By Mridula Sood, BSc

In the spring of 1992, a focus group of nine cancer patients at Toronto-Sunnybrook Regional Cancer Centre (T-SRCC), was brought together to determine the gaps in support services within the cancer care system. They unanimously identified an urgent need for **peer support** for new patients and their caregivers to speak with others who had experienced cancer first hand. With the support of T-SRCC and under the direction of Dr. Ross Gray, (psychologist) and Marlene Greenberg, (manager, health promotion) this group decided to meet this need by establishing a peer support network for patients at T-SRCC. Thus the Bayview Support Network (BSN) was born.

The goal of the BSN is to share common experiences and to help manage the challenges of diagnosis, treatment and life after cancer. At present the BSN has developed into a network of over 85 dedicated volunteers and 600 members. It has established a multidimensional peer support network to help decrease the emotional burden of those facing cancer and to increase mutual support and access to resource information.

The BSN is based within the cancer centre in order to provide direct support to patients and caregivers during treatment. The network offers the following peer support services free of charge:

- **Patient Support and Resource Room** on the ground floor of T-SRCC
- **Peer Support Groups** for patients and caregivers: every second and fourth Monday from 7:00-8:30 p.m. at T-SRCC (groups are led by trained peer volunteers)
- **Evening Drop-In Breast Cancer Group:** Third Wednesday of each month from 7:00-8:30 p.m. at T-SRCC
- **Afternoon Drop-In Breast Cancer Support:** Tuesdays & Thursdays from 1:00-4:00 p.m.
- **Relaxation Group:** Fridays from 11:00 a.m. to 12 noon, Lawrence Park Community Church, 2180 Bayview Avenue
- **Bi-monthly Patient Newsletter**
- **In-Patient Visiting Program** at Sunnybrook and Women's College Health Sciences Centre (to be launched in the fall of 1999)
- **Children's Playroom** at T-SRCC
- **Patient & Family Library** at T-SRCC
- **Telephone Support**
- **Information Evenings**
- **Peer Support Educational Video: "Been There"**

For more information on Bayview Support Network programs, call (416) 480-6898.

**Mridula Sood, BSc, is program director at the Bayview Support Network.**

## Editor's comments

This issue completes our first year of publication. Your letters praising the format and content of HOT SPOT have been an incentive for us to continue to provide you with useful quality educational material in this newsletter. This issue is devoted to psychosocial support and contains contributions from the Bayview Support Network, the Temmy Latner Centre for Palliative Care and local hospice facilities. The insert deals with the management of GI complications in malignancy and is by Dr. Larry Librach and Dr. Rebecca Wong. We are pleased that Dr. Librach, Dr. Berry, Dr. Hayter and Dr. Vachon and Joan Pope have agreed to be on our advisory board starting next year. Starting with our first issue in the new year, we plan to have regular contributions on research, ethics and psychosocial issues relevant to palliative care. We would appreciate your comments and suggestions for HOT SPOT in the next millennium.

**In this issue:** Bayview Support Network; Dope and cope: It is no longer enough; Psychosocial issues with a cancer diagnosis; Cancer care at York Central Hospital; Yee Hong palliative care services: A culturally sensitive approach; Hill House - A Richmond Hill hospice; Sixth annual pain and symptom conference; Interview with Russell Goldman, MD, CCFP; Research Corner.

**Insert - Management of radiotherapy-induced gastrointestinal toxicities, Bowel obstruction**

## Dope and cope: It is no longer enough

By Michele Chaban, MSW, CSW, PhD

Care of dying patients has become a complex maze of clinical interventions. In the last decade, palliative care emphasized the importance of pain and symptom management. However, with unprecedented challenges being placed on individuals and families, pain and symptom management is only the first of many levels of intervention. Life-extending palliative therapies have given rise to a population with special bio-psycho-social-spiritual needs. One such need is "caregiver benefits". Similar in intent to maternity and paternity benefits, "eternity benefits" would help support a family in accomplishing the life cycle tasks of care for the dying. This would allow family members or significant others to take time away from employment to care for a dying person.

*continued on page 3...*

## HOT SPOT

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

**Volume 1, Issue 4, November 1999**

**Editor: Dr. C. Danjoux**  
**Associate Editors: Ms. L. Andersson,  
Dr. E. Chow, Dr. R. Wong**  
**Assistant Editor: Ms. R. Connolly**  
**Consultant: Dr. G. Thomas**  
**Advisors: Dr. E. Szumacher,  
Dr. J. Finkelstein,**  
**Editorial Manager: Ms. C. LeCoure**  
**Financial Manager: Ms. S. Petty**

Toronto-Sunnybrook  
Regional Cancer Centre,  
2075 Bayview Avenue,  
Toronto, Ontario M4N 3M5  
Tel: (416) 480-4982, Fax: (416) 480-6002  
E-mail: cyril.danjoux@tsrcc.on.ca  
Website: www.tsrcc.on.ca/  
radiotherapy\_palliative.htm

**Produced by  
Pappin Communications  
Pembroke, Ontario**

# Psychosocial issues with a cancer diagnosis

By Margaret I. Fitch, RN, PhD

The diagnosis and treatment of cancer has a significant impact upon the person affected and those close to that individual. The impact has physical, emotional, social, spiritual, informational and practical dimensions (see Figure One). Dealing with the impact creates a myriad of issues and challenges for an individual, his or her family and friends. When these issues are not handled appropriately, they interfere with the individual's ability to cope with the cancer experience, influence their quality of life and, in some instances, influence their ability to carry on with treatment.

Various reactions to the diagnosis and treatment of cancer will emerge. Shock, disbelief, confusion, sadness, despair, anger and resignation have all been reported. No two individuals will have exactly the same reaction. Some will confront the situation while others will withdraw. Some will manage the challenges within their situation while others will experience ongoing difficulties and distress. Confronting uncertainty and real or anticipated losses is a reality for all.

Individuals living with cancer are exposed to a spectrum of experiences within the cancer care delivery system which may be categorized under prediagnosis, diagnosis, dialogue and referral, treatment, rehabilitation, survivorship, recurrent disease, advanced disease (requiring palliative care) and, for the family, bereavement. Individuals may enter the cancer care system at various points and experience the spectrum in different ways over different periods of time. For some, their total experience may be related to screening. For others, they may experience diagnosis, treatment and rehabilitation and only be involved in routine follow-up. For others, their experience includes recurrent disease or advanced disease.

Regardless of how an individual and his/her family enter and proceed through the spectrum of cancer experiences, they carry their physical, social, informational, emotional, spiritual and practical needs with them. These needs will vary from person to person and vary in intensity over the course

of the illness. The challenge for health care providers is to be attuned to these variations, assessing the need for supportive care in an ongoing fashion. Some patient assessment questions that could be helpful at each clinic appointment are:

- how are you managing right now with the cancer and its treatment?
- what kinds of things are concerning you about your cancer right now?
- what would be helpful to you right now in coping with your cancer?

Some individuals living with cancer require little assistance in managing with their illness. Once in possession of information relevant to their needs, they mobilize their own support systems and cope. However, others require more intensive supportive care interventions. Individuals with unmet needs risk experiencing undue psychosocial distress and may require specialized assistance to manage this distress.

The specific interventions that best meet individual patient and family needs will vary from person to person. The interventions or set of interventions that may be helpful to one individual will not necessarily be helpful to another. The intervention that may be helpful to an individual who is newly diagnosed may be ineffective at a later phase of the illness. The very nature of coping with life-threatening illness and adapting to the aftermath is influenced by an individual's perception of the situation and the meaning that he or she assigns to the illness. Factors such as socioeconomic level, educational level, social support, culture, religion and geographic location can influence what intervention will be most effective. We need to be prepared to offer a range of interventions from which patients may select. Including other health care professionals on the care team, (i.e., nurses, social workers, psychologists, psychiatrists, occupational therapists, physiotherapists, nutritionists,

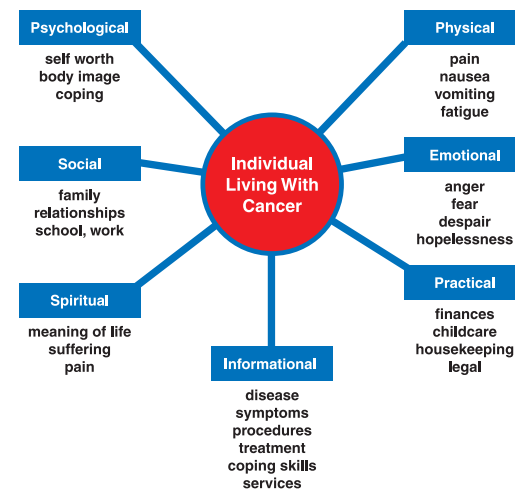
and chaplains, etc) can provide access for patients to expertise that would be of benefit.

Above all, information, communication and support are critical to patients and family members experiencing cancer. Timely access to relevant information, to peer support programs, and sensitive communication with health care professionals have been reported by cancer patients as important elements in their coping with cancer. Health care professionals have a responsibility to know about community services and be able to connect patients and families with appropriate agencies. Two services that would be of use to cancer patients and their families in finding out about other services available in their region are:

- Cancer Information Services, 1-800-263-6750: anyone may call this toll-free number for information about cancer and cancer services
- Local Community Care Access Centre: there are 43 CCACs across Ontario to provide local access to community care services, including home care.

**Dr. Margaret Fitch is head of oncology nursing at Toronto-Sunnybrook Regional Cancer Centre.**

Figure One



## Cancer care at York Central Hospital

By Jane Anderson

We strive to provide patients with access to an integrated system of programs including prevention, early detection, cancer care and education.

Our team consists of an oncologist, family physicians, nurses with expertise in oncology, a dietitian, pharmacist, social worker, hospital chaplain and Community Care Access Centre case managers.

Cancer care rounds, held weekly, are attended by case managers from the Community Care Access Centre head office, as well as nurses. We have six acute care medical beds designated for pain and symptom management and three beds for longer term complex palliative needs. A furnished lounge room is located in the cancer care area. This helps meet the needs of families who are often in the hospital for long periods of time with their relatives.

**Jane Anderson is patient care coordinator, in the oncology medicine program, at York Central Hospital.**

## Yee Hong palliative care services: A culturally sensitive approach

By Stanley Zheng,  
BSc, MD, PhD, CCFP

Most medical and health care programs often have gaps in meeting the needs of ethno-cultural populations. Linguistic and cultural barriers are identified as major obstacles by many ethnic groups, particularly Chinese patients and families, in accessing needed care.

Chinese tradition enshrines family integrity and longevity. Dying and death mean pain and loss, and are considered social taboos. There is a stigma attached to open discussions of such topics, thus making care planning difficult. Many Chinese families find dying at home too hard to manage if unsupported. In order to alleviate anxiety and stress for patients, our program encourages familial support and optimized resources.

**Stanley Zheng, MD, PhD, BSc, CCFP, is a palliative care specialist at the Yee Hong Centre for Geriatric Care.**

## Hill House - A Richmond Hill hospice

By Ann Gold, RN

The time has come, as we enter the new millennium, for communities to establish homelike settings for people with terminal illnesses who do not wish to die in hospital and cannot be cared for at home.



The original Hill family home (a three-bedroom bungalow) was leased to Hill House Hospice by the town of Richmond Hill. With round-the-clock nursing staff, supported by a core of volunteers trained in palliative care, Hill House Hospice endeavours to relieve pain and suffering, not

prolong life. There is no charge to the client. Families and friends are encouraged to participate in the care-giving process. Each visiting hospice endeavours to meet the high standards of care provided by both professional and volunteer persons. We must keep the CARE in caring.

**Ann Gold, RN, is the founder of Hill House.**

## Charles R.R. Hayter, MD, BA, MA, FRCPC joins T-SRCC

Dr. Hayter was born in Brighton, England and received his MD (Queen's University) in 1984. He did postgraduate training at Queen's and in England. He holds an MA in drama and has a major interest in the history of medicine. He is currently working on a book on the history of cancer programs and radiotherapy in Canada.

Dr. Hayter was on the staff of the Kingston Regional Cancer Centre, as an associate professor at Queen's University and a member of the radiation oncology research unit. He joined the Toronto-Sunnybrook Regional Cancer Centre in September of 1999. His areas of interest are GU, palliative oncology and the history of medicine. We are delighted to have him join our program.



## Dope and cope: It is no longer enough *continued from page 1...*

Justification of familial supports could be easily argued. Families who take on the primary caregiving role are not utilizing the same resources as offered by institutional care. Patients prefer to die at home.

Families report that this time can be a period of unprecedented closeness. Using a harm reductive paradigm, clinicians with advanced practice skills in palliative care help families develop the knowledge, skills, understanding and preparedness to negotiate a death in the family. Dying can be a time of personal growth and familial renewal, despite the presence of impending loss. Timely psycho-educational and psychotherapeutic interventions can support families.

Similar to pre-natal classes, palliative counseling that is instructive and preventive, and not simply supportive, can have a significant impact on a family's intergenerational health. Treatment goals are to minimize suffering, and maximize the benefit experienced by those involved, to search for and refine the meaning of dying and death in a family.

Clinical outcomes that further justify the need for familial support are evident in a recent study from the University of Toronto's Centre for Bio-ethics. Lavery

studied "the wish to die" in a palliative population. Anecdotal evidence suggested that requests to hasten death resulted from a history of poor pain and symptom management. Lavery found that dying persons claimed their wish to die resulted from their having become a burden to their family.

What is a burden? From my clinical impression over the last 15 years, burden is a person's sense of dependence on others, a sense of diminishing productivity and contribution to the family system, a sense of draining the family of financial and social resources. Burden progresses with time. Perceptions of burden are to be found in even the most supportive of families.

As we extend the lives of those living with life-threatening illness, time and increasing dependency on the family system depletes and diminishes even the most functional families. Life extension can often turn into death extension, taking us to new places of human suffering and endurance. Anticipatory tools, such as living wills and substitute decision-making, cannot fully support a dying person and family throughout the process of dying. As observers, family members can experience compound grief reactions resulting from the trauma of a dying family member's quality of life and death. A lack of appropriate support over time enhances

compassion fatigue and trauma in family caregivers.

How one dies can have an impact on the intergenerational health of a family. Families can have a sense of competency, nobility and strength when they have successfully negotiated a safe passage for a dying family member. Families cannot and should not be expected to know or develop these skills through the course of life. This can be taught to families by a team of palliative clinicians who understand what is possible throughout the dying process. Palliative care is family care. While palliative care is often seen as end stage treatment of the dying, Lavery's research, combined with the comparative literatures of traumatology, compassion fatigue and intergenerational family health, suggests early intervention avoids harmful outcomes. This speaks to the urgency with which we need to adapt to the current realities of dying rather than living in the infancy of palliative care theory and practice.

For further information contact the intake coordinator at (416) 586-4800, ext. 6293.

**Michele Chaban, MSW, CSW, PhD, is director of the psycho-social spiritual programs, The Temmy Latner Centre for Palliative Care, Mount Sinai Hospital.**

## Interview with Russell Goldman, MD, CCFP, palliative care physician with the Temmy Latner Centre for Palliative Care, Mount Sinai Hospital

### How did you become interested in palliative care?

Unfortunately, I had no exposure to palliative care during medical school. Initially, I became interested in palliative care during my clerkship, amidst the controversy of the Sue Rodriguez case. I thought that there must be a better way to care for people in a similar situation. As a resident, I teamed with Dr. Frank Ferris at Mount Sinai Hospital to carry out research on the attitudes of palliative patients. This eventually led me into a four-month fellowship in palliative medicine under the supervision of Dr. Larry Librach. At the end of my fellowship, I joined the division of palliative medicine at Mount Sinai Hospital as a part-time home care physician, and later became a full-time partner.

### What do you find most gratifying about your work as a home palliative care physician?

I have a very high degree of job satisfaction. This comes as a surprise to many people, as I am often asked, "Don't you get depressed doing this work all day?" In fact, the opposite is true. I find my work to be very uplifting and rewarding. Every day I have the opportunity to learn from wonderful, caring people who are coping and struggling with extremely difficult situations. This certainly has helped me keep other aspects of my life in perspective.

Being able to provide comfort and support in a time of crisis for a patient and their family is extremely rewarding. People are very grateful and I am often overwhelmed by their gestures of appreciation. From a professional point of view, pushing the envelope of how medical care can be delivered in a home setting also makes the work extremely gratifying.

### Is your job very different from other physicians?

I would say that the setting for my job is very different from most physicians. I am on the road most of the day. My car is my office and my examining room is the patient's living room or bedroom. Looking after people at home can be extremely challenging at times. We often care for very ill people with acute crises who do not wish to go to the emergency department. This occasionally requires a fair bit of creativity and ingenuity when crafting a management plan, since you don't quite have the same level of resources available to you. I also have the pleasure of working with a supportive, dedicated group of visiting nurses and Community Care Access Centre coordinators. Palliative care is truly a collective effort.

### What aspects of your work do you find frustrating?

No one really enjoys being on call, but it comes with the territory. After the

twentieth page of the day, I am ready to throw my beeper out the window. Paperwork is also something I would rather not do, but I would not escape it in any other field of medicine. Economically, home palliative care is not as lucrative as an office-based family practice, but it is a comfortable living and the situation with regards to compensation for palliative care is improving.

### What do you think are the primary issues in palliative care right now?

People do not have adequate access to an acceptable quality of palliative care. Inadequate funding and few resources are to blame. A lack of awareness and poor understanding of palliative care, both in the public and professional spheres, are also factors that slow the development of palliative care. Professional education and specialized training are essential if we are to be able to provide patients and their families with optimum palliative care. There is an increasing demand for palliative care services and not enough physicians providing palliative care to meet that demand. If even one-twentieth of the resources that we devote to birthing were dedicated to the care of the dying, then I think we would all have a lot less to worry about when considering our own mortality.

## Research Corner

By *Rebecca Wong, MBChB, FRCPC*

*In this issue, we would like to highlight an ongoing study entitled **Phase I/II study evaluating the efficacy of accelerated fractionation radiotherapy for the palliation of dysphagia in patients with carcinoma of the esophagus**. We ask for your support and referral of patients who may be suitable candidates for this study.*

For patients who are affected by esophageal carcinoma, dysphagia is usually the first and most devastating symptom. This continues to dominate the patients' remaining lifespan when the primary disease cannot be eradicated. Uncontrolled local disease not only results in progressive dysphagia, but also distressing respiratory symptoms due to involvement of the mediastinal structures causing airway obstruction, and fistulae formation. From the time of diagnosis of incurable carcinoma of the esophagus, life expectancy is in the order of 6-9 months. External beam radiotherapy is frequently the palliative treatment of choice. This is generally recommended over, or in combination with stent insertion, especially when a patient's life expectancy is long enough to warrant concerns for subsequent extraluminal progression, and stent failure due to tumour overgrowth.

The strategy of giving radiotherapy twice a day has the potential advantages of a short regimen, and delivering a moderately high dose of radiotherapy. This is the basis behind the design of this study.

The study intervention consists of external beam radiotherapy 40Gy in 20 fractions, 2 Gy per fraction, twice a day, five days a week. Patients are followed on a monthly basis after completion of treatment. Barium swallow is performed at one month and at time of dysphagia progression. The FACT quality of life questionnaire is administered pre- and post-treatment and at time of symptom progression. The primary study endpoints are probability and duration of dysphagia relief. The study is aiming to recruit 41 patients.

This study is open to patients with:

- Incurable primary or anastomotic recurrent carcinoma of the esophagus,
- Symptomatic with dysphagia ECOG performance status less than or equal to three
- Life expectancy greater than three months

Exclusion criteria:

- Previous radiotherapy to the chest

- Esophageal fistula
- Bronchial mucosal invasion
- Esophageal stent in situ

For referral of potential study patients, please call new patient referral at (416) 480-4205. Any queries about this study, please call Dr. Rebecca Wong at (416) 480-6165.

The newsletter of the Rapid Response Radiotherapy Program of Toronto-Sunnybrook Regional Cancer Centre is published through the support of:



## Types and Symptoms

Type	Symptoms
esophageal	<ul style="list-style-type: none"> <li>mild nausea</li> <li>preceding dysphagia</li> <li>vomiting or regurgitation</li> </ul>
gastric outlet	<ul style="list-style-type: none"> <li>severe nausea</li> <li>frequent vomiting</li> <li>epigastric abdominal distension</li> <li>dyspepsia</li> </ul>
small bowel	<ul style="list-style-type: none"> <li>nausea and cramps</li> <li>abdominal distension</li> <li>frequent vomiting initially, often bile stained</li> </ul>
colon	<ul style="list-style-type: none"> <li>slowly progressive abdominal distension</li> <li>nausea and vomiting as late symptoms</li> <li>vomitus may be feculent</li> <li>cramps early on</li> </ul>
rectum	<ul style="list-style-type: none"> <li>slowly progressive distension</li> <li>alternating constipation and diarrhea</li> <li>nausea and vomiting not pronounced until quite late</li> </ul>

*By Dr. Larry Librach,  
Palliative Care Specialist,  
Director of the Temmy Latner Centre for  
Palliative Care, Mount Sinai Hospital*

Supported by an educational grant from  
Novartis Pharmaceuticals Canada, Inc.

*All investigations and management options must be predicated on where the patient is at in the trajectory of this illness. Patients with very advanced disease and/or who are not surgical candidates should not be subjected to needless investigations or hospitalizations.*

## Investigations

- Three views of abdomen
- Hypaque or barium bowel studies if appropriate where surgery possible and/or where cause unknown

## Management

## I. Surgical management

- First obstruction and not in the very terminal phase of illness, surgical consultation
- Surgical possibilities include:
  - Resection of obstructed bowel,
  - Bypass procedures such as gastroenterostomy, enteroenterostomies,
  - Decompression procedures such as an ileostomy and colostomy.

## II. Esophageal obstruction

- Esophageal stents
- A gastrostomy tube to maintain nutrition and hydration. Also the option of no feeding tube.

## III. Gastric outlet or duodenal obstruction

- Early surgical intervention with bypass procedure.
- Double lumen gastrostomy tube to allow gastric drainage and feedings.
- Octreotide (see below) may decrease secretions and symptoms.
- A gastrostomy for drainage with or without another enterostomy for feeding.

## IV. Small or large bowel obstruction

- Nasogastric tubes can be avoided in most patients.
- Potent opioids by subcutaneous infusion or by intermittent subcutaneous injections using an in-situ butterfly needle with injection port or subcutaneous administration set
- Anti-emetic/anti-nauseant medication:
  - Haloperidol 0.5-5 mg q6-8h sc/IV or by sc infusion (maximum 15 mg daily)
  - Prochlorperazine 5-10 mg im or pr q6h - avoid the IV route because of dystonic reactions
  - Dimenhydrinate 50-75 mg q4-6 h im or IV - second line drug.

- 5 HT3 receptor antagonists such as Ondansetron are ineffective.
- Anti-motility/antispasmodic agents:
  - Oral Loperamide 4-6 mg po q4h for the first 24 hrs and then prn
- If ineffective:
  - Hyoscine butylbromide by constant subcutaneous infusion starting at 30-60 mg per day.
- Corticosteroids
  - Dexamethasone at an initial dose of 16 mg per day IV to reduce edema.
- Octreotide
- Many will respond to conservative management.
- Hydration support with sufficient saline and potassium.
- Once resolved, soft or liquid foods with sufficient doses of osmotic stool softeners. Avoid any bowel stimulants or pro-kinetic agents.

## V. Unresolved complete bowel obstruction

- Significant management and ethical issues and no clear answers. Careful counseling of patients and their families.
- Intravenous hydration should be short-term only. Counsel that intravenous fluids are not nutrition, the patient's condition will not improve with fluid therapy, and there is no evidence that total parenteral nutrition (TPN) is appropriate for these patients.
- Support from palliative care consultants.

## Octreotide

- An effective somatostatin analogue which is becoming one of the standard treatments in bowel obstruction.

## Effects:

- Decreases bowel motility
- Increases absorption of fluids and electrolytes from the bowel
- Decreases gastrointestinal secretions

## Dosage:

- 100 to 500 µg every 8-12 hours sc
- The higher dose range is necessary often only for a few days
- Can be given as continuous subcutaneous infusion
- Once symptoms are controlled, the dose should be gradually reduced unless symptoms reappear

# HOT SPOT

## MANAGEMENT OF RADIOTHERAPY-INDUCED ACUTE GASTROINTESTINAL TOXICITIES

Area of concern	Oral cavity	Esophagus	Stomach		Small bowel/ large bowel	Anal/rectum	Perianal skin
<b>Manifestations</b>	Dry mouth, oral mucositis, ulcers	Esophagitis	Gastritis	Nausea, Vomiting	Diarrhea, bowel obstruction	Proctitis	Skin reaction
<b>Common radiotherapy areas</b>	Head and neck cancers, mantle field	Esophagus, lung, mantle fields, T spine mediastinum	Stomach, spine T10-L3, mantle and upper abdomen, whole abdomen (e.g. ovary) hemibody or total body		Abdomen and pelvis	Pelvis, prostate, bladder, cervix endometrium	Pelvis, perianal skin
<b>Important clinical considerations</b>	Exclude and treat any oral candidiasis	Odynophagia, dysphagia	Later onset, manifest as dyspepsia, nausea and vomiting	Typically commence within 30 minutes of first fraction of XRT, resolve after completion of radiotherapy	Examine for acute abdomen and dehydration (indications that more aggressive therapy, including hospitalization and discontinuation of radiotherapy is warranted)	Careful history to differentiate between these conditions, frequently mistaken as diarrhea; 1. small, frequent bowel movements with proctitis 2. small volume watery bowel movements due to constipation with overflow (XR may be necessary)	Watch out for perianal abscesses
<b>Preventative<sup>1</sup></b>	Mouth washes with baking soda 2-3x/day Dental check-up Avoid smoking, alcohol	Dietary counselling against alcohol, diet adjustments for odynophagia	Prophylactic antiemetics, depending on degree of emetogenicity (start day of radiotherapy) • Ondansetron 8 mg od-bid • Stemetil 10 mg q4h prn • Gravol 50 mg q4h prn • (Decadron 2 mg tid in selected patients)		Counselling to reduce fibre content in their diet when loose bowel movements begin	Optimize management of any diarrhea or constipation	Ensure optimal skin condition pre-treatment, optimize treatment of any hemorrhoids, incomplete wound healing. Use of corn starch for normal skin to minimize skin reaction
<b>Treatment of symptoms<sup>2</sup></b>	Tantum mouth washes, magic mouth wash* Analgesics (e.g. codeine/morphine elixir)	Sulcrate liquid, analgesics (e.g. codeine, or morphine elixir) Mucaine	• Zantac 150 mg bid • Losec 20 mg bid	• Ondansetron 8 mg bid • Decadron 2 mg tid • ensure hydration	• Lomotil 2.5 mg od • Immodium 2 mg after each loose BM (max. 16 mg.) • Questran	• Anusol HC suppositories • Cortifoam enemas • Proctofoam enemas 2-3x/day Treat constipation or diarrhea	• Sitz baths • Dry desquamation: Corn starch to skin, hydrocortisone 1% • Moist desquamation: Flamazine, burrosol soaks 2-3x/day

1. Patients at high risk of developing toxicities should be considered for preventative interventions to minimize toxicities.

2. Patients with grade 1-2 (mild to moderate) toxicities can be managed with these interventions. Patients with grade 3-4 (severe to life-threatening) toxicities may require hospitalization and discontinuation of radiotherapy and should be managed with the radiation oncologist.

\* Magic mouth wash: Mixture of diphenhydramine, dexamethasone, nystatin, tetracycline, water (for details call T-SRCC pharmacy).

By Rebecca Wong, MBChB, FRCPC, radiation oncologist, Rapid Response Radiotherapy Program (Toronto-Sunnybrook Regional Cancer Centre)