

# Cancer :

## A Practical Guide for General Practitioners



Bruce Colwell, BSc., MD, FRCPC

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When one yells the word ‘shark’, ‘fire’, or ‘cancer’ it strikes fear into the eyes of most people, but you can retreat from the first two. Most people are paralyzed when they hear the word ‘cancer.’ It represents one third of all potential life years lost in Canada. It is estimated that about 50% of them may be due to some preventable trigger, smoking being the most common. Despite increasing programs for screening, most patients will present themselves to their family doctor with symptoms, we will be seeing a lot more of this phenomenon.

Our population demographics show that we have an increasingly aging population, and despite a better outcome and a decrease in cancer mortality from the mid 1990’s, by 2012, it is that likely our total deaths per year from what it was in 1980 because of the aging population.

### Cancer

#### Prognosis

Cancer is more than one disease. There really are some good cancers and bad cancers. The type of cancer and the stages of cancer are the major prognostic factors that make the difference in outcome. Canadian Cancer Statistics ([www.cancer.ca/statistics](http://www.cancer.ca/statistics)) allow you to see the

differences in various cancers. With cancers such as thyroid, prostate and testicular having a greater than 90% five-year relative survival ratio. Whereas esophageal, gastric, pancreas, and lung have a survival rate below 20%. You cannot be expected to know the outcomes of every cancer, however, my experience is that most people expect a much worse outcome than actually occurs. They also cannot comprehend how a healthy, fit patient has terminal cancer.

#### Screening

Primary screening refers to a test deployed to the general population and allows one to select the patients whose outcome will improve with early intervention. There has not been very successful findings in screening tests for cancer. There is evidence, that screening is successful and we can change the outcome in breast cancer, colorectal cancer, and cervical cancer. Even with these tests, the uptake by the general population is not ideal. As primary care providers, we rely on you to try to convince patients that finding cancer early does improve the cure rate, so that they should be screened. Many patients ask me, ‘what treatment would you choose if this was you or your sister or mother?’ I think that, physicians should be allowed to use a

similar question to their patients “what would you do if your brother or sister was found to have cancer; would you want to be screened?”

At present there are several randomized control trials that have left no doubt that mammograms make a difference in women between the age of 50 and 70. However, the evidence below age 50 is controversial; mammograms are less sensitive in that population and the incidence is less in that population (the relative chance of developing breast cancer in the next ten years is about 1.3% in the 40 to 49 year age group and jumps to 2.3% in the 50 to 59 age group). It is also very hard to quantify the psychological stress that the false positive creates in a young woman. There can be other factors that one may need to take into account. For those carriers of Breast Cancer1 (BRCA1) gene or Breast Cancer2 (BRCA2), we not only recommend a mammogram but also an MRI.

Colorectal Cancer is common. There are actually a number of screening tests that have been looked at including colonoscopy, double contrast barium enema, virtual colonoscopy, various fecal tests, and future tests. Blood tests may also be a promising option. Colonoscopy not only has the advantage of being a screening tool but also a diagnostic tool, however, fecal occult blood is the test for which the most evidence exists, with a proven survival advantage and stage migration (cancer found at an earlier stage). For the most part, I think it is better to do a test rather than none, and this sometimes depends on the local availability of various tests.

It has recently been estimated in the U.K. that lack of screening and delayed cancer diagnosis resulted in approximately 10000 deaths per year. Screening does save lives and should be considered for all appropriate patients.

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### *Red Flags*

Most patients will present with symptoms rather than screening tests. We see patients every day in our offices that have no serious illness. How do we differentiate between the tumor versus the rumor?

I always look for a healthy person who has changed. They often have some persistent symptom with no explanation and have lost some weight without intention or lost more weight than you would think from a simple weight loss plan. In a previous cancer patient, I always say pay attention to the patient who says, ‘I feel like my cancer is back.’ This feeling has proven right on many occasions, although no one has been able to describe the feeling well for me.

There are a couple of scenarios that should always raise a red flag.

- A breast lump in a postmenopausal woman.
- Iron deficiency- anemia in a person over age 50.
- A new persistent cough in a long-time smoker.
- A pelvic mass in a postmenopausal woman.

### *What do you say?*

Breaking bad news is never easy for the patient or the one breaking the news. You should always make sure that both you and the patient are comfortable. You should be sitting down on an equal level so you can make eye contact. I often start off by asking what they expect and what they hope to hear, and gear my statement around that. We go to medical school and learn a different language and then have to talk to patients who don't understand that language. Ask them if they understand what you said, ask if they have questions, tell them the next step, and summarize what you've said. If it is incurable cancer they will often ask how long do I have? If you tell them they will live X number of months or years, you will be wrong and they will remember that. I often explain how there is a large variation in results and if I know a good news story about a person with cancer I give it to them and then tell them that it describes a good case, however, there are also some bad cases. They often wonder, why did I get it? And is it my fault? I try to talk them out of getting into the blame game, but usually you can't tell.

**Dr. Colwell** is the program Director in Medical Oncology and Chair GI TSG at the QEII Health Science Center at Dalhousie University, Halifax, Nova Scotia

If the news is that they are terminal, there is not much you can do to delay things; they will ask what happens now. I tell them the most common scenario is that fatigue is the major problem and that they will get more and more tired. Eventually they will go to sleep. I tell them that they could have other symptoms like pain, but we will try to control it and we are usually quite good at that.

Lastly, they will ask, is there anything else? They will ask about many legitimate and not so legitimate treatments and I try to explain to them how we go about researching for consults and how we "prove" it. I will offer to call people for them. I try not to delay treatment so that they can get a second opinion, and I tell them that most treatments in cancer are based on large trials, and therefore the treatments are very much the same throughout North America.

### *Summary:*

Cancer is a common group of diseases that should not be scary. General Practitioners can help in many ways to fight it. A lot of the questions patients have can be referred to your local oncologist or surgeons. Take advantage of these resources. Get to know them and help make yourself a valuable member of the oncology durability. These agents are initiated for long-term use, often up to a few years, if not indefinitely in some cases. **Dx**