# HOT SPOT

The Newsletter of the Rapid Response Radiotherapy Program
of the Odette Cancer Centre

Sunnybrook ODETTE CANCER CENTRE
A Cancer Care Ontario Partner

Volume 13, Issue 3, August 2011

## Editorial

**By Dr. Toni Barnes, MD, FRCP(C)**

I hope everyone has been enjoying the summer! In our August issue of **Hot Spot**, one insert features Dr. Simron Singh presenting the new multidisciplinary Neuroendocrine Clinic at the Odette Cancer Centre, and he reviews the latest advances in the treatment of pancreatic neuroendocrine tumours. The insert by Dr. Carlo DeAngelis reviews the use of fentanyl for breakthrough pain. The ethics issue from Mr. Blair Henry examines the impact of medical error on hospital staff. The research article by Dr. Kristopher Dennis describes the newly opened randomized control trial of dexamethasone versus placebo in the prevention of flare pain following palliative radiotherapy for painful bone metastases. Dr. Karen Fergus reports on the role of the psychologist in the cancer post-treatment period. Dr. Patrick Cheung presents the new oligometastases stereotactic radiotherapy study at the Odette Cancer centre and gives guidelines for referring patients. Dr. Margaret Fitch writes on "distress" being the sixth vital sign and the importance of monitoring patients' symptoms during the cancer journey. Finally, Dr. Ewa Szumacher provides a list of upcoming CME events.

## Odette Cancer Research Program welcomes new director

Dr. Greg Czarnota, an Imaging Scientist at Sunnybrook Research Institute (SRI) and Radiation Oncologist at Sunnybrook, has been appointed Director of the Odette Cancer Research Program. He had served as the interim director since November 2010. Dr. Czarnota's work focuses on using ultrasound imaging for cell-death detection and as a new anti-vascular cancer therapy. As director, Dr. Czarnota will aim to strengthen connections between the Odette Cancer Program and SRI, toward providing cancer patients with leading edge, evidence-based care. Sunnybrook Research Institute recruited Dr. Czarnota in 2005, after he completed first his PhD, and then his medical training and residency at the University of Toronto. Dr. Czarnota is an Associate Professor at U. of T. in the departments of medical biophysics and radiation oncology.

## Hot Spot congratulates our colleagues

1. **Professor S. Lawrence Librach** for his appointment as the Sun Life Chair in Bioethics and Director of the Joint Centre for Bioethics at the University of Toronto, effective July 1, 2011. Dr. Librach will continue his work at the Temmy Latner Centre for Palliative Care focusing on education, quality improvement, and pain management.
2. **Dr. Margaret Fitch** for being awarded by the National Council of Canadian Cancer Society the prestigious Award for Excellence in Medicine and Health. This recognizes her longstanding continued and pioneering work in survivorship and psychosocial oncology.
3. **Drs. Monica Branigan, Amna Husain** and **Jeff Myers** from the Department of Family & Community Medicine for their promotion to the rank of Associate Professor at the University of Toronto, effective July 1, 2011.

## In this issue of Hot Spot:

# Medical error and its impact on staff

**By Blair Henry, Ethicist, Sunnybrook Health Sciences Centre**

In the May 2011 issue of **Hot Spot**, Dr. Hebert outlined the serious and fatal outcomes resulting from a delayed disclosure of potential errors in a hormone receptor status test conducted of women who had received a breast biopsy in Newfoundland between 1997 and 2005. As Dr. Philip Hebert noted, this was a large-scale adverse event where hundreds of patients were harmed and many died, as a result of not being given alternative treatments, which may have placed their cancer into remission. These patients and their families are considered to be the "primary" victims of medical error and they require a compassionate, transparent and open encounter with the medical team throughout the disclosure process and follow-up stages.

In this article, I have tried to pick up on the theme of medical error, but turned the focus around to look specifically at its secondary victims: the clinical team directly involved with the care of the patient in which the error occurred. In most situations, the patient and family rightly become the focus of attention following an event. However, the team directly involved needs also to be given support by the hospital or health centre involved.

My interest in writing on the issue of medical error and its impact on the staff comes from recent debriefings with staff following a couple of serious medical errors at our own hospital—and seeing firsthand the impact of these events on the people involved.

I was curious to learn more about how frequently error and serious events happen within the health care setting. I came across an article, published in the Canadian Medical Association Journal (Baker et al., 2004), on the incidence of adverse events in acute care hospitals in Canada. The study concluded that as many as 87,500 patients admitted annually to Canadian acute care hospitals experience an adverse event. This translates to an odds ratio of one in 13 for adult patients admitted to a Canadian hospital for encountering an adverse event during their stay! Regrettably, of this total, 24,000 patients die each year due to "adverse events."

Medical errors or serious adverse events rarely have a malicious or direct intentionality to them. Typically they are a result of a system or human factor error that is not intentional and, yet, can result in grave consequences to patients and families. A famous research study conducted by Harvard Medical School (Brennan et al., 1991) determined that more than half of all injuries caused by medical management (in other words, not caused by the patient's initial injury or disease) were preventable, and another quarter of those incidents were caused by negligence.

The statistics I've quoted could translate into a harsh reality at the level of care provision; namely, that every week hundreds (approximately 460 based on the CMAJ study) of Canadians die due to an adverse event—of which up to 50% could have been prevented! This sobering statistic points to a significant stressor for all clinical staff involved and at a much higher frequency rate than I'd originally suspected.

A highly recommended read for those interested in the downstream effects on staff who are involved with medical error would be Dr. Patrice Weiss's article, Medical Errors and the Second Victim (Weiss, 2011). In this article, Dr. Weiss addresses the concern some staff encounter when dealing with the outcomes of a medical error: namely, feeling singled out, agonizing over the events, replaying of the event many times over in their mind, and seriously questioning their own competency. Those without healthy coping mechanisms in place may turn to more dysfunctional responses to protect themselves from this psychic assault.

Much of what has been written on how errors impact staff has generally focused on medical staff (i.e., residents) (West, 2008) and, therefore, more research is needed to better understand the impact to nursing and allied health staff who also work at the front lines and are often intimately involved in the events leading up to the medical error/adverse event. In the wake of recent events that happened at Sunnybrook, we used a debrief model to bring staff members together shortly after the event to provide a more formal emotional support geared towards avoiding the more counterproductive responses to stress. A safe place needs to be provided for the staff to express the typical emotional responses to medical error: guilt, shame, distress and depression. The more serious the patient outcome is, and the higher the degree of personal responsibility to the event the staff may feel are good indicators that reliance on informal supports may be insufficient to help staff deal with the after effects of a medical error or adverse event.

My intention, in writing this article, is not to take attention away from what should be two fundamental priorities in health care when it comes to serious adverse events: 1) Continued vigilance by health care providers, in cooperation with patients and families, to drive forward important quality and safety initiatives to see the numbers of serious adverse events reduced within the health care system. Though limited in its scope, a small U.S. study on follow-up to quality and safety initiatives has shown only a very modest impact on rates of medical error (Landrigan et al., 2010); and 2) To ensure each health care facility has appropriate policies and procedures in place that support timely, honest and sensitive disclosure to patients and families in the wake of medical errors and serious adverse events. However, my hope would be that a third priority might be realized: 3) Given the inevitability that medical errors will occur and knowing the impact this can have on staff, that health care facilities have programs and supports in place to assist staff in healthy coping strategies in times when errors do occur.

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# Preventing radiotherapy-induced pain flare with dexamethasone

**By Kristopher Dennis, MD, FRCPC, Research Fellow,
Rapid Response Radiotherapy Program, Sunnybrook Odette Cancer Centre**

External beam radiotherapy is the standard localized treatment for the palliation of uncomplicated bone metastases. More than two-thirds of patients derive pain relief from treatment, which can improve their level of functioning and quality of life. Treatment is generally well tolerated, and when side effects occur they are usually due to irritation of adjacent organs and tissues by the therapeutic beams.

However, new research has shown that up to 40% of patients receiving palliative radiotherapy for bone metastases may develop a 'pain flare'. This is a sudden and transient worsening of pain at the site of the irradiated bone metastasis that typically occurs in the first five to 10 days following treatment. A pain flare is distressing, it worsens quality of life, and it can deter a patient from receiving palliative radiotherapy for subsequent painful bone metastases. A pain flare is usually treated with a temporary increase in opioid analgesics, which can also lead to bothersome side effects. Although the mechanisms underlying pain flare are not completely understood, it is postulated that there is a surge in the release of inflammatory mediators following irradiation that contributes to the increased level of pain in predisposed patients.

Dexamethasone is a synthetic glucocorticoid with powerful anti-inflammatory properties. Led by investigators from the Odette Cancer Centre, an international phase II study demonstrated that a short course of low-dose prophylactic dexamethasone given at the time of palliative radiotherapy for bone metastases reduced the incidence of pain flare. The beneficial effect of dexamethasone was believed to be due at least in part to its anti-inflammatory properties and its ability to modulate cytokine-related processes. Dexamethasone was safe and well tolerated in this setting.

The National Cancer Institute of Canada Clinical Trials Group has chosen to use its infrastructure to support this important research into pain flare. The NCIC CTG SC.23 phase III double-blind randomized placebo-controlled trial, which opened in May 2011 at 16 Canadian centres, will definitively compare the effectiveness of five-day courses of prophylactic dexamethasone and placebo for the prevention of pain flare. Patients planned to receive a single 8Gy dose of palliative radiotherapy for up to two painful bone metastases will be eligible. Accrual is expected to take 2.5 years and final analyses and reporting are expected in 2014.

The primary objective is to compare the incidence of pain flare between the two arms from the time of irradiation until 10 days following treatment. Secondary objectives include comparing the incidence of pain flare at specific points in time and documenting changes in quality of life. A companion correlative biology study using patient saliva and urine samples will also investigate whether pain flare is associated with a surge of inflammatory cytokines, or with baseline levels of bone turnover markers. It will also investigate whether failure of dexamethasone prophylaxis is due to rapid metabolism of the drug in certain patients.

If dexamethasone safely reduces the incidence of pain flare in the SC.23 trial, then patients and radiation oncologists will have a standard, evidence-based therapeutic solution for preventing this common and troublesome side effect of treatment.

# Psychology's role in the post-treatment period

**By Karen Fergus, PhD, CPsych, Clinical Psychologist, Patient and Family Support Program,
Sunnybrook Odette Cancer Centre; Assistant Professor, Department of Psychology, York University**

Once the active phase of treatment is complete, there is another equally significant leg to the cancer journey. Some call this period 'survivorship,' while others think of it more practically as 'recovery' or simply 'life after cancer.' However one chooses to term it, the post-treatment period poses unique challenges affecting most life domains. It is what Magee and Scalzo (2006) referred to as "picking up the pieces" in their book of the same title. Although psychological interventions may influence many, if not all aspects of survivorship, the focus of this article is on the emotional and existential aftermath of cancer and the role psychologists play in facilitating the process of psychological recovery.

The patient's and family's primary focus during treatment is on managing the side effects and life disruptions caused by the illness to the best of their abilities. This period is what I think of as the 'nose to the grindstone' stage of the illness. Patients often adopt a task-focused approach to coping—doing what needs to be done in order to get through treatment while maintaining their other responsibilities as well as possible. The intensity and routine of treatment, combined with the intrusive side effects, ensure that the medical aspects of the illness are foregrounded. Thus, although the physical and emotional demands on the person are experienced simultaneously, the deeper emotional repercussions associated with cancer often get placed on the back burner for a period of time.

In many ways, this kind of emotional compartmentalization makes sense; treatment is, after all, a matter of survival. No one has an infinite set of coping resources, and so lines get drawn whether we are aware of it or not. Once active treatment is over, however, a lot of time and energy is freed up to address, indeed even to notice, some of the other impacts that cancer has had on the person.

One of the first challenges patients meet after active treatment ends is their own often too-high expectations about what recovery from cancer should be like. Understandably, many are eager to 'put cancer behind' them and resume their pre-cancer lives. However, on a concrete level, physical limitations such as pain, fatigue and loss of energy make this goal difficult to achieve—at least in the short term. On an emotional and more enduring level, patients often state that they don't feel like the same person any more. This shift in identity is related to permanent or prolonged bodily changes such as unsightly scars, or living with an ostomy; the loss of a breast, testicle, or prominent facial feature; or due to physical impairment such as erectile dysfunction or loss of fertility. Each of these changes has unique and profound impacts on a person's sense of self, future, and personal efficacy.

Another challenge following treatment is the feeling that one is no longer working as actively and directly to eradicate the disease. Patients often will say that as difficult as the acute phase of treatment was, there was some reassurance in knowing that everything possible was being done to rid them of their disease. Without the protection of treatment, patients often feel 'cut adrift' or 'out on a limb', as they enter the follow-up phase of care. It is at this juncture that existential concerns become particularly pronounced.

# Stereotactic radiotherapy for oligometastases: An evolving treatment option and new clinical trial at Sunnybrook Odette Cancer Centre

**By Dr. Patrick Cheung, MD, FRCPC, Staff Radiation Oncologist, Sunnybrook Odette Cancer Centre**

Stereotactic radiosurgery (SRS) and fractionated stereotactic radiotherapy (SRT) is an established non-invasive treatment option for a solitary or limited number of brain metastases. More recently, stereotactic *body* radiotherapy (SBRT) has become a treatment option for extracranial tumours. Like SRS/SRT of the brain, SBRT allows us to deliver very intense doses of radiation in a very focused manner, where the intent is eradication or long-term local control of relatively small tumour targets in the body. At the Sunnybrook Odette Cancer Centre, there are now SBRT programs for lung, liver, and spine tumours, in addition to the long-standing SRS/SRT program for brain tumours.

The most common indication for SBRT has been for solitary tumours. Examples include stage 1 lung cancer, or a solitary liver metastasis. In such scenarios, SBRT can be an effective alternative to surgical resection and radiofrequency ablation (RFA), where the goal is to eradicate a single area of known malignancy.

However, there has been increasing interest in using stereotactic radiotherapy in patients with "oligometastatic" disease, where there are a limited number of metastases (two to five) seen on imaging. If one believes that metastases can seed further metastatic deposits, then treating the known areas of disease aggressively may be beneficial for some patients in the long term, similar to surgical metastectomies that are performed in some patients with limited metastatic disease. This is becoming an active area of research in the radiation oncology field. We are receiving an increasing number of referrals for such a situation, usually for younger patients who desire a more "aggressive" approach for the treatment of their metastases. This approach of trying to eradicate visible areas of metastases is very different from classical "palliative" low-dose radiotherapy, where the intent is simply to reduce or prevent symptoms from metastatic disease.

At the Sunnybrook Odette Cancer Centre, we have just opened a new clinical trial within our Rapid Response Radiotherapy Program (RRRP) that explores the use of stereotactic radiotherapy in treating patients with five or fewer metastatic tumours. Below is a brief summary of the eligibility criteria.

- Pathologic diagnosis of a cancer (excluding leukemia, lymphoma, myeloma, primary CNS cancers, and germ cell cancers).
- Presence of five or fewer metastases as seen on conventional staging investigations.
- Baseline staging investigations complete within 30 days of study entry (CT/MRI brain, CT chest, abdomen, pelvis, bonescan, and/or PET-CT).
- Metastases confined to the lung, liver, brain and/or bone.
- Presence of three or fewer metastases in each organ system.
- All areas of gross tumour amenable to stereotactic radiotherapy (clinically felt to be safely achievable, meeting established radiation dose constraints for organs at risk).
- Primary tumour treated with no evidence of local recurrence, or planned radical treatment to primary tumour in patients who present with oligometastatic cancer at initial diagnosis.
- Performance status of ECOG 0-1.
- Written consent obtained from patient.

Endpoints of interest include toxicities, quality of life, local control of the treated tumours, and probability of developing new sites of metastases in the future.

At this time, metastatic lymphadenopathy and adrenal metastases are not eligible. Ideally, tumour targets should be relatively small (<5 cm in the lung and liver). All potential patients will be discussed at our "Oligometastases Tumour Board" to review the clinical history and imaging investigations and to determine whether patients are eligible for study entry. Once deemed to be eligible for inclusion into the study, the exact sequence and nature of treatments will be determined for each patient. Close collaboration with each patient's oncologist(s) will be necessary to coordinate the radiotherapy with any other potential therapy. Depending on the clinical scenario, stereotactic radiotherapy can be delivered as a "debulking" treatment prior to systemic therapy, as consolidation treatment to areas of residual disease after systemic therapy, or as the sole treatment in patients who have had previous systemic therapy or who are felt to be not fit enough or not appropriate for systemic therapy. For patients who are initially diagnosed with stage 4 cancer with oligometastases, stereotactic radiotherapy of the metastatic sites can be performed either before or after radical treatment of the primary tumour.

If you have a patient who may be eligible for this trial, you can fax a referral to our New Patient department at 416-480-6179, indicating "oligometastases study" on our referral form. Alternatively, you can talk to one of the study investigators directly by phone, and we will be glad to answer any questions about the study or our stereotactic radiotherapy program.

Patrick Cheung: 416-480-6165
Arjun Sahgal: 416-480-5329
Hans Chung: 416-480-4834

Learning to live with uncertainty is a common focus for psychological intervention in the transition from 'patient-hood' to survivorship. Frank (1991) describes the 'loss of innocence' that accompanies a cancer diagnosis due to the fact that we live in a death-denying culture where the norm is to suppress thoughts of mortality. In many ways there is no easy solution to living with such a 'loss of innocence.' Coping as effectively as possible with this altered worldview often entails developing a new attitude toward life and living. The shape this takes will, of course, vary from individual to individual, but may entail such shifts as reprioritizing how one spends one's days, picking up dreams or goals that got left behind, and/or focusing on nurturing one's most important relationships.

Fears of recurrence are the cognitive manifestation of living on a day-to-day basis with the possibility that cancer can come back. One of the *sine qua non* features of cancer, as an illness, is that there are never any guarantees that it is over and done. There are only probabilities. Thus, it is often hard to shake the 'what if' thinking and bodily vigilance so common during the post-treatment period. Cognitive and mindfulness-based strategies for managing intrusive, fearful thoughts can be powerful tools in coping with such existential uncertainty. One woman with a cancer history described this as cultivating 'a mental discipline.'

At a broader level, psychologists assume the role of helping patients integrate the traumatic life event of cancer into the larger context of their lives. The diagnosis and treatment of cancer imposes what Bury (1982) referred to as a biographical disruption on a person's life. Through the dialogic process of counselling and psychotherapy, this breach may be mended. Each patient need not go about 'picking up the pieces' on his or her own. By reflecting on one's history in relation to an altered present due to cancer, patients are more able to reinstate a sense of coherence in their lives and move forward.

## References

*References are available upon request.*

# Distress is the sixth vital sign

**By Margaret I. Fitch, RN, PhD**

Cancer and its treatment have more than a physical impact. There are emotional, psychosocial, spiritual, and practical consequences as well for the individuals diagnosed with the disease (Fitch, 2008). These may occur at any time throughout the person's experience with the illness, as patients confront the reality of their situation and seek ways to cope with what is happening to them. Distress is a common response for both patients and families across the cancer journey.

Distress is conceptualized as an unpleasant experience of an emotional, psychological, social or spiritual nature that interferes with the ability to cope with cancer (NCCN, 2010). It extends along a continuum, ranging form common normal feelings of vulnerability, sadness, and fears to problems that can become disabling such as depression, anxiety, social isolation, and existential crisis (NCCN, p. 5). Although all cancer patients experience distress, approximately 35% to 45% of individuals diagnosed with the disease experience a significant level of distress and would benefit from referral to an appropriate supportive care service and tailored intervention. If unchecked, this distress can result in poor quality of life, poor adherence to treatment, and increased emergency and office visits (Carlson & Bultz, 2004).

Identifying and responding to this distress is considered a critical aspect of quality cancer care (Carlson & Bultz, 2003; Jacobsen, 2009). Recently, Accreditation Canada has incorporated the expectation of routine screening for distress as a standard of care within the Qmentum Program for Cancer Care and Oncology Services (**www.accreditation.ca/accreditation-programs/qmentum**). Early identification of distress has the potential for preventing its escalation and reaching significant levels.

Over the past several years, experience has been growing in terms of how best to incorporate a standardized approach to screening for distress into routine cancer practice. Guides for implementing a programmatic approach are available on the websites for the Canadian Partnership Against Cancer (**http://canadianpartnershipagainstcancer.org**) or Cancer Care Ontario (**www.cancercare.on.ca/toolbox/symptools**).

First, using a validated, standardized screening tool is important for consistent measurement and monitoring over time. The Cancer Journey Action Group has been providing national leadership for this work and has recommended the use of the Edmonton Symptom Assessment System (ESAS) coupled with the Canadian Problem Checklist (see Figure 1). The ESAS helps to identify symptoms that may be of concern to the patient while the Problem Checklist items focus on psychosocial and practical concerns. Scores of seven and above on the ESAS items constitute a need for immediate assessment and intervention. In essence, the scores become a starting point for the conversation with the patient about what is of concern and what assistance the person would like to receive at that point in time. A critical aspect of implementing screening for distress is determining which health care professional will be designated to review and respond to the scores on a clinic-by-clinic basis.

Second, follow-up with regards to elevated scores is imperative. This follow-up will need to be tailored to the patient and the available resources. An important step in implementing a programmatic approach to screening for distress requires the staff in cancer programs to determine what resources are available and how current gaps in services can be filled through new partnerships. In many instances the partnerships may need to be with community-based cancer support agencies such as Wellspring, Gilda's, Willow, and other similar organizations.

Third, although interventions need to be tailored to the patient and the local situation regarding resources, they also need to be based on current evidence. The Cancer Journey Group has produced a number of evidence-based practice guidelines regarding supportive care topics for practitioners in cancer care. These guidelines not only contain summaries of the current research evidence, but also user-friendly algorithms (short one-page summaries) outlining the assessment and intervention options. Guidelines cover topics such as anxiety, fatigue, depression, sleeplessness, pain, dyspnea, and nausea and vomiting for palliative patients. A guideline for psychosocial care of survivors has also been produced. These documents are available on CPAC and CCO websites (see above). In addition, Cancer Care Ontario has developed applications for handheld devices to allow easy access to the algorithms wherever clinicians and patients are located.

Ultimately, screening for distress and responding effectively will require an interprofessional team effort and the team will need to include a vision for working beyond the walls of an institutional cancer program.

**Figure 1. ESAS and Canadian Problem Checklist**

**Screening for Distress**

**Edmonton Symptom Assessment System:**

Date of Completion:_____ Time:_____ Completed by: ❑ Patient ❑ Family ❑ Health Professional ❑ Assisted by family or health professional

Please circle the number that best describes:

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| No pain | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Worst possible pain |
| Not tired | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Worst possible tiredness |
| Not nauseated | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Worst possible nausea |
| Not depressed | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Worst possible depression |
| Not anxious | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Worst possible anxiety |
| Not drowsy | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Worst possible drowsiness |
| Best appetite | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Worst possible appetite |
| Best feeling of well-being | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Worst possible feeling of well-being |
| No shortness of breath | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Worst possible shortness of breath |
| Other problem | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |

**Canadian Problem Checklist:** Please check all of the following items that have been a concern or problem for you in the past week including today:

**Emotional:**
❑ Fears/Worries
❑ Sadness
❑ Frustration/Anger
❑ Changes in appearance
❑ Intimacy/Sexuality

**Practical:**
❑ Work/School
❑ Finances
❑ Getting to and from appointments
❑ Accommodation

**Informational:**
❑ Understanding my illness and/or treatment
❑ Talking with the health care team
❑ Making treatment decisions
❑ Knowing about available resources

**Spiritual:**
❑ Spiritual and/or religious concerns
❑ Faith

**Social/Family:**
❑ Feeling a burden to others
❑ Worry about family/friends
❑ Feeling alone

**Physical:**
❑ Concentration/memory
❑ Sleep
❑ Weight

## References

*References are available upon request.*

# Continuing Medical Education 2011–2012

**By Ewa Szumacher, MD, FRCP(C)**

Continuing Medical Education (CME) can update health care professionals on the latest advances for modifications to their clinical practice. At the request of the CME organizers, Hot Spot will list the national and international CME activities in palliative medicine that are of interest to our readers. Please forward details of the CME activities to: **Ewa.Szumacher@sunnybrook.ca**

- **September 14–17, 2011**
  25th Canadian Association of Radiation Oncology (CARO) Annual Scientific Meeting, Winnipeg/Manitoba, Radiation Oncology
  E-mail: **caro-acro@rcpsc.edu**
  **http://www.caro-acro.ca/**

- **October 2–6, 2011**
  American Society for Radiation Oncology's (ASTRO) 53rd Meeting, Miami/Florida, Radiation Oncology
  **http://www.astro.org/Meetings/AnnualMeetings/index.aspx**

- **October 9–12, 2011**
  19th International Congress on Palliative Care, Montreal, Quebec, Other Specialties
  E-mail: **secretariat@pal2012.com**
  **http://www.palliativecare.ca/en/index.html**

- **October 27–29, 2011**
  2nd Annual Canadian Grief & Bereavement Conference, Toronto/Ontario, Other Specialties
  E-mail: **registration@griefconference.org**
  **http://www.griefconference.org/**

- **November 27–30, 2011**
  Canadian Cancer Research Conference, Toronto/Ontario, Oncology
  E-mail: **patricia.falzon@oicr.on.ca**
  **http://www.oicr.on.ca/events/ccrc/index.htm**

- **November 29–30, 2011**
  Breast Cancer Controversies 2011, United Kingdom/London, Obstetrics/Gynecology, Oncology Surgery
  E-mail: **breastscreening@kenes.com**
  **www.breastcancermeeting.co.uk**

- **December 2, 2011**
  Best of Oncology Conference, Toronto/Ontario, Oncology
  E-mail: **info@oncologyeducation.ca**
  **http://www.regonline.ca/builder/site/Default.aspx?EventID=954549**

- **December 6–10, 2011**
  34th Annual San Antonio Breast Cancer Symposium, Texas/San Antonio, Oncology
  E-mail: **sabcs@uthscsa.edu**
  **www.sabcs.org**

- **February 23–25, 2012**
  American Psycho-social Oncology Society (APOS) 9th Annual Conference, Miami/Florida, Oncology, Supportive Care
  E-mail: **info@apos-society.org**
  **http://www.apos-society.org**

- **March 21–24, 2012**
  8th European Breast Cancer Conference, Austria/Vienna, Oncology, Other Specialities
  E-mail: **ebcc8@ecco-org.eu**
  **www.ecco-org.eu/conferences-and-events/ebcc-8/page.aspx/2163**

- **May 31–June 1, 2012**
  New Frontiers in Persistent Pain, France/Paris, Pain Management
  E-mail: **events@abcam.com**
  **www.abcam.com/index.html?pageconfig=resources&rid=12881**


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