# Oncologic Self-Assessment

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# Disclosures

- I have no relevant financial relationships.

*This presentation and/or comments will provide a balanced, non-promotional, and evidence-based approach to all diagnostic, therapeutic and/or research related content.*

# Cultural Linguistic Competency (CLC) & Implicit Bias (IB)

**STATE LAW:**

The California legislature has passed Assembly Bill (AB) 1195, which states that as of July 1, 2006, all Category 1 CME activities that relate to patient care must include a cultural diversity/linguistics component. It has also passed AB 241, which states that as of January 1, 2022, all continuing education courses for a physician and surgeon **must** contain curriculum that includes specified instruction in the understanding of implicit bias in medical treatment.

*The cultural and linguistic competency (CLC) and implicit bias (IB) definitions reiterate how patients' diverse backgrounds may impact their access to care.*

***EXEMPTION:***

Business and Professions Code 2190.1 exempts activities which are dedicated solely to research or other issues that do not contain a direct patient care component.

## *The following CLC & IB components will be addressed in this presentation:*

- *Consideration of cultural/linguistic needs for integrative care and patient communication.*
- *Disparities that may influence the health outcome of patients.*

# Case based presentations: live polling

- Go to vevox.app on a browser in your mobile device
- Type in the session ID: 123-423-095

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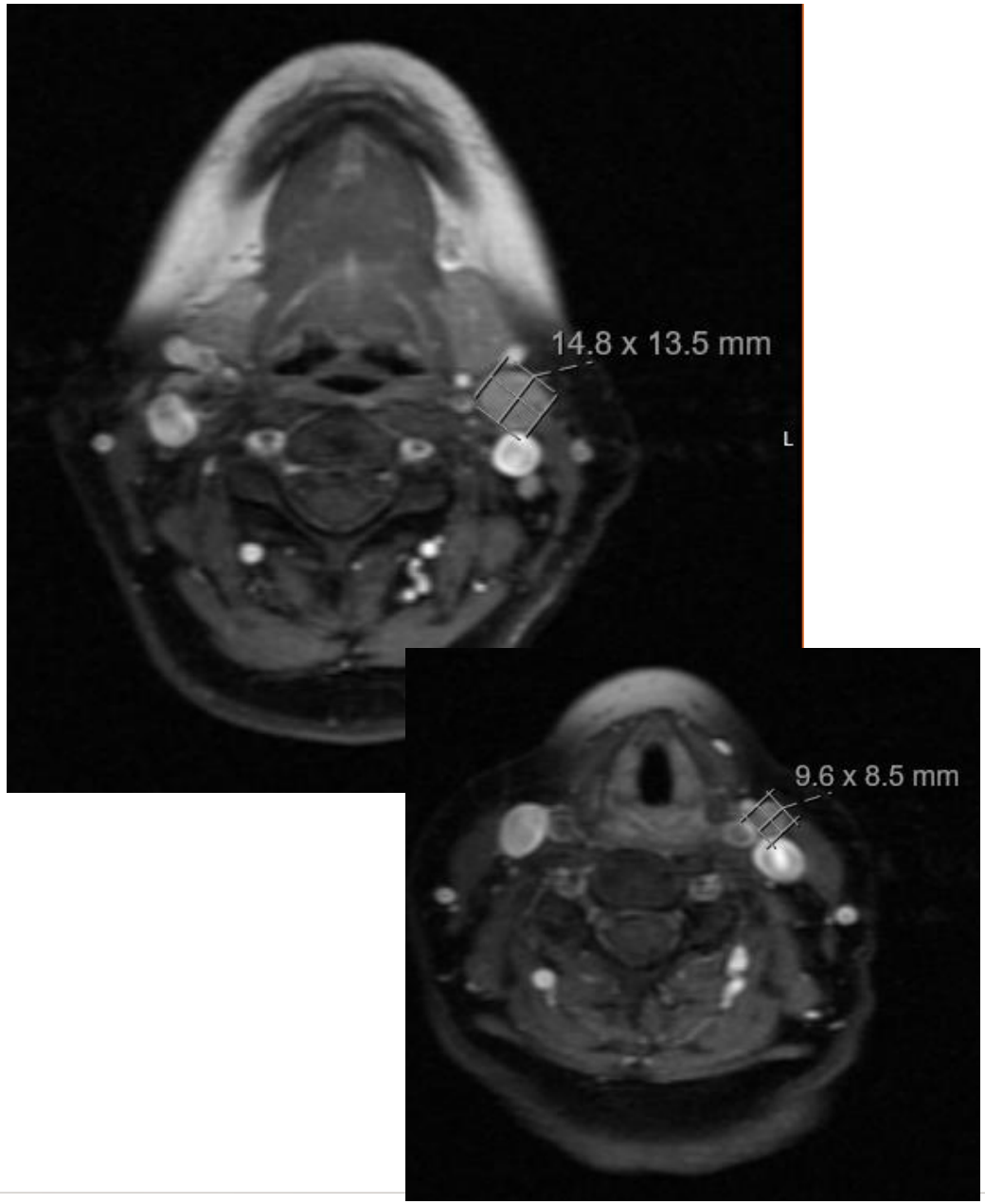
# Are you at this presentation?

1. Yes
2. No
3. I haven't had my coffee yet

# Case 1

- 62 yo F with history of Ehlers-Danlos syndrome and hypermobile neck presenting with left-sided neck mass unresponsive to antibiotics
- MRI neck: left necrotic level II node 3 x 1.5 x 1.4cm, second 1cm node inferior
- PET CT: asymmetric soft tissue fullness in left oropharynx/left palatine tonsil
- Biopsy of cervical node demonstrated p16+ squamous cell carcinoma
- Patient not considered eligible for robotic surgery due to history of Ehlers-Danlos: craniocervical instability, poor wound healing, fragile blood vessels
- Final staging (AJCC 8): cT1N1M0, stage I



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# What would the patient's overall stage be if pathology had demonstrated p16- disease?

1. I
2. II
3. III
4. IV ✓

- MRI neck: left necrotic level II node 3 x 1.5 x 1.4cm, second 1cm node, no evidence for extranodal extension
- PET CT: asymmetric soft tissue fullness in left oropharynx/left palatine tonsil

cT1N2bM0, stage IVA

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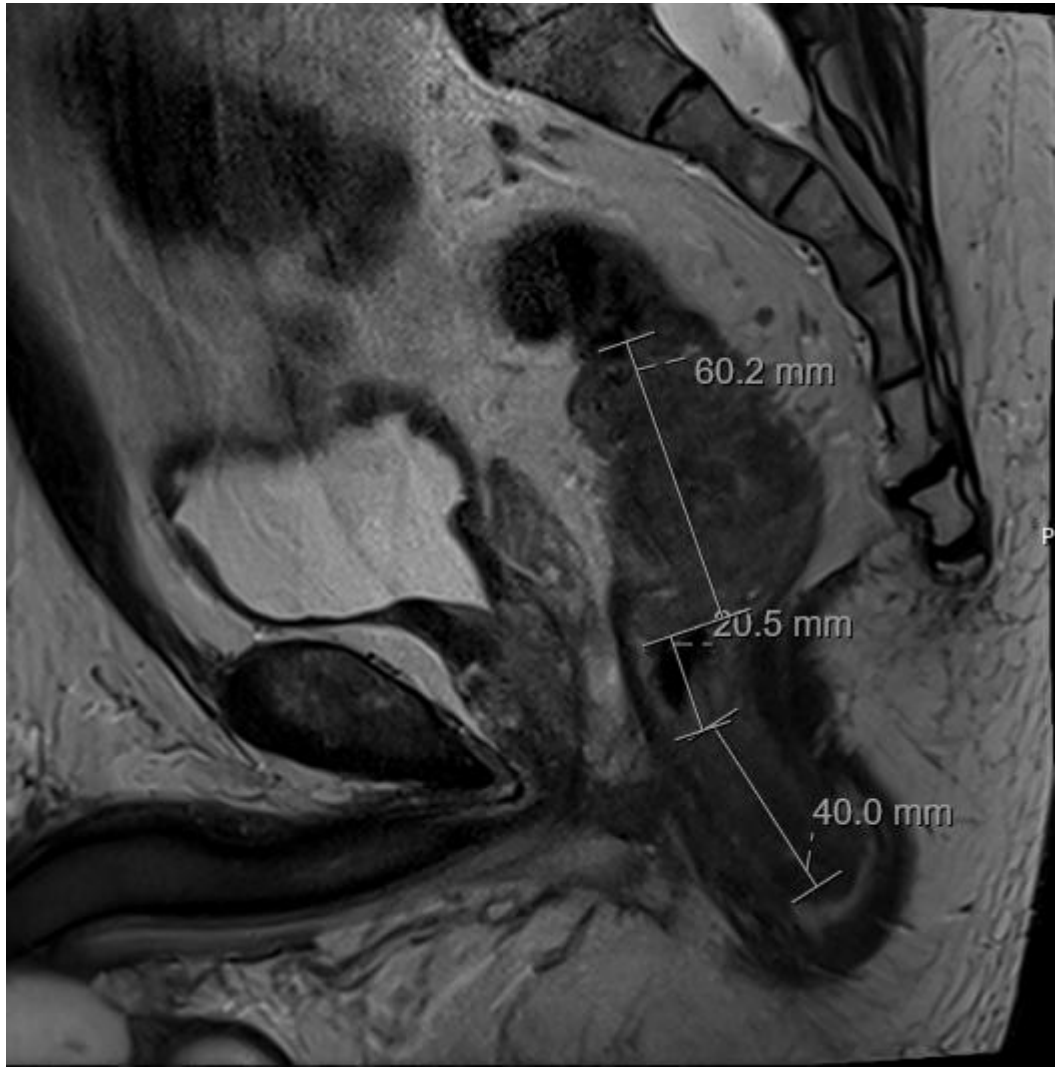
# p16+ cT1N1M0 oropharyngeal SCC: What would you recommend for definitive treatment?

1. Radiation alone
2. ✓ Chemoradiation with cisplatin
3. Chemoradiation with cetuximab
4. Radiation plus durvalumab

# Case 2

- 33 yo M with no prior medical history presenting for 8 months of progressively worsening hematochezia, abdominal pain and 30 lb weight loss
- No family history of colorectal cancer
- Colonoscopy revealed circumferential tumor 8 cm from the anal verge spanning to 16 cm
- Multiple (6) mesorectal nodes identified on MRI
- Tumor invasion of pericolorectal soft tissue
- Staging (AJCC 8): cT3N2aM0, IIIA



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# When should colon cancer screening be initiated per NCCN guidelines? Select all that apply.

1. Starting at age 50 if average risk

Starting at age 30 if positive family history

1st degree relative: age 40 or 10 years before earliest diagnosis

3. Starting at age 20-25 if personal history of MLH1 or MSH2 mutated Lynch syndrome

Starting 5 years after onset of symptoms if history of irritable bowel disease

8 years after onset of IBD symptoms

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# cT3N2aM0 rectal cancer in a 33 yo M: What treatment paradigm would you recommend?

1. chemotherapy --> chemoradiation --> surgery
2. chemoradiation --> chemotherapy --> surgery
3. chemoradiation --> surgery --> chemotherapy
4. short course radiation --> surgery --> chemotherapy

# Case 3

- 58 yo male with smoking history of 5 pack years but otherwise no reported medical history, presenting for discussion of cancer screening recommendations

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# Which of the following do you routinely ask your patients or collect via an intake form? Select all that apply.

1. Personal history of cancer
2. Family history of cancer
3. History of smoking/alcohol use
4. Sexual orientation
5. Sexual activity/history of STI including HIV
6. Gender identity
7. Gender pronouns
8. Sex assigned at birth (SAAB)
9. Affirmative steps the patient has taken/organ inventory

# Case 3, cont'd

- Your patient says he identifies as a trans man and his pronouns are he/him.
- He has been on testosterone since age 38, underwent gender affirming subcutaneous mastectomy at 40, and has not had a menstrual period since starting testosterone.
- He is in a longterm monogamous relationship with a cis-gender woman. He does not have any history of STIs.
- He has never had any prior cancer screening. His mother had breast cancer at age 75. He quit smoking 5 years ago.

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# Addressing healthcare disparities for sexual and gender minorities: Which of the following cancer screenings would you recommend to this patient?

1. Low-dose CT for lung cancer screening
   0%
2. ✓ Pelvic exam/pap smear for cervical cancer screening
   0%
3. Clinical chest wall exam for breast cancer screening
   0%
4. ✓ Colonoscopy for colorectal cancer screening
   0%
5. Transvaginal ultrasound for endometrial cancer screening
   0%

# Toward an organ-based cancer screening model (vs gender-based)

| Organ | Individual being screened | Society making recommendation |
|---|---|---|
| Chest/Breast | *Cisgender Women:* Mammography starting at age 40, every 1 to 2 years until 75 years old. *Cisgender Men:* Routine screening not recommended. *Transgender Women:* Mammography starting age 50 in those with at least 5 years of hormonal therapy. *Transgender Men:* Mammography every 2 years between ages 50-69. | National Comprehensive Cancer Network |
| Cervix | *Cisgender Women:* Starting at age 21 until 65 years old. Pap test alone every 3 years, or every 5 years with combination cytology and HPV co-testing. *Transgender Men:* Follow screening recommendations of cisgender women if a cervix is present. | National Comprehensive Cancer Network |
| Endometrium | *Cisgender Women:* Routine screening not recommended. *Transgender Men:* Routine screening not recommended. | Society of Gynecologic Oncology |

Domogauer J, Cantor T, Quinn G, Stasenko M. Disparities in cancer screenings for sexual and gender minorities. Current Problems in Cancer. 2022 Mar 25:100858.

# Follow-up questions (no poll)

- How would your recommendations change in each case if the patient was over age 80 with lower performance status?
- Would you consider escalation of standard of care chemotherapy in the 33 yo with locally advanced rectal cancer?
- In which of the cases would you ask the patient about an advance directive?
- What societal determinants of health are important to assess for each of the three cases?

# Thank you!

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