off. We accept anecdotes from residents as dogma. We seek out opportunities to add depth to our CVs even though we may lack enthusiasm for the given undertakings. And these practices lead to the development of a self-selecting population of applicants who have overachieved but may end up underwhelmed. Such is the consequence of the pressures associated with deciding on your professional trajectory three-quarters of the way through your education.

I have toyed with these notions extensively for the past few months and I will admit that I am none the wiser. No amount of discussion on this subject will lead to a decision cushioned by comfort. Each attempt to figure out what you want to do—and, by extension, who you are—yields frustration. But it is much more important to figure out who you are *not*. That is when, for the most part, who you are tends to crest the horizon.

As CaRMS approaches I am certain that many of my classmates will busy themselves with unimportant distractions to keep from choosing their desired specialty. But each student must make the decision and, regardless of how they come to it, frustration is to be expected. What brings me solace, however, is understanding that the system need not be perceived to be more than it is. In medicine we tend to be individuals who overthink every decision in fear of being wrong. But when it comes to this one decision that all of us are facing, there are no wrong answers. Thankfully, this helps me relax.

Managing cancer of the uterus and ovary: BC has the right approach

Scientists at the BC Cancer Agency, Vancouver Coastal Health Research Institute, and UBC have come to a new understanding of the origin and development of cancer that occurs in the uterus and ovary simultaneously. Known as synchronous endometrial and ovarian (SEO) cancer, tumors on the endometrial lining of the uterus appear simultaneously with tumors on the ovary, and vice versa. SEO cancers have been reported in 5% to 10% of endometrial or ovarian cancers.

The spread of a tumor from one organ to another is virtually always an indication of an advanced-stage cancer that requires aggressive treatment with chemotherapy, radiation therapy, or both. However, SEO tumors behave as if they are independent, localized early-stage tumors that often respond well to surgery alone.

Controversy regarding whether SEO cancer is metastatic has led to widely differing treatments. A new study provides evidence that each pair of SEO tumors are genetically related clones and confirms for researchers that the right approach to SEO cancers is being taken in BC, where SEO cancer patients have generally been treated conservatively by surgically removing the tumors. The findings may also influence treatment of the disease elsewhere. Worldwide, many women with SEO tumors receive aggressive treatment designed to fight late-stage metastatic cancer.

Scientists point to pseudometastasis to explain the apparent paradox of the same cancer appearing simultaneously as two independent early-stage tumors on two different organs and propose that the process is distinct from usual metastasis in that the cancer likely spreads through the fallopian tube, not the bloodstream, and the host organs (ovary and uterus) provide a unique environment where these cancers are initially constrained. Researchers in the Department of Molecular Oncology at the BC Cancer Agency are now investigating whether the initial event takes place in the ovary or the endometrium, and what keeps cells temporarily restricted to these organs without metastasizing to the rest of the body.

The article "Synchronous Endometrial and Ovarian Carcinomas: Evidence of Clonality" is published in the June 2016 issue of the *Journal of the National Cancer Institute* (available online now at http://jnci.oxfordjournals.org/content/108/6). A complementary study from the Memorial Sloan Kettering Cancer Center is published in the same issue along with an editorial about the two studies.

Rural practice: Funding to upgrade skills

If you are a new graduate, an international medical graduate, or a physician transitioning out of full-time practice who is interested in entering rural practice, you may be eligible to receive up to 20 days of funding for skills enhancement training through the Rural Skills Upgrade Program (RSUP).

RSUP funding is provided by the Rural Education Action Plan (REAP). Before applying for RSUP, physicians must be accepted into one of the Rural GP Locum Program, the Rural GPA Locum Program, or the Rural Specialist Locum Program. All applicants must be willing to complete a return of service to the locum program within 1 year of completion

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of training. The return of service will be twice as long as the training commitment.

Successful applicants will be paired with a preceptor. While physicians are encouraged to train with preceptors they know, REAP can help successful applicants connect with preceptors if they do not have any contacts. The learning structure is shaped by the applicant's educational needs and can involve a regional experience, training in a high-volume urban setting, or a combination of both.

Funding includes a stipend to cover income loss as well as travel and accommodation expenses. Training may be completed prior to providing any service to the locum programs.

While funding for courses and conferences is not available through RSUP, locum physicians may access funding for selected courses through REAP's Rural GP Locum CME Program. Locum physicians may also be eligible for funding to complete the San'yas Indigenous Cultural Safety Training Program, an online course delivered by the Provincial Health Services Authority. To learn more about any REAP program, contact the REAP program assistant at reap@familymed.ubc.ca or call 604 827-1504.

Critical illness: The financial impacts of your survival

Life expectancy in Canada is on the rise. Those born in 1920 could expect to live for 60 years, on average; this had increased to 80 years for those born in 2000. Canadians now survive previously fatal conditions, but survival often comes with a cost. During recovery from critical illness you may see your financial obligations increase, while your income decreases if you take time off work.

GPAC guidelines

Chronic Heart Failure

The Guidelines and Protocols Advisory Committee's (GPAC) guideline for improved diagnosis and management of adults with chronic heart failure (HF) in the primary care setting is available to physicians across BC at www.BCGuidelines.ca.

Key recommendations

- B-type natriuretic peptide (BNP) or N-terminal prohormone of BNP (NT-proBNP) is the biochemical test of choice for ruling-in or ruling-out the diagnosis of HF and should be considered as part of the initial evaluation of patients with dyspnea suspected of having HF.
- BNP (or NT-proBNP) testing should not be used routinely for monitoring disease severity.
- Educate the patient and family about the importance of self-monitoring to identify early decompensation at a stage where intervention may help to avoid hospitalization. Consider referral to a heart function clinic or a multidisciplinary chronic disease management clinic.
- Identify who would benefit from a palliative care assessment by using the iPall Heart Failure: Palliative Care Assessment Tool (www.bcheartfailure.ca/for-bc-healthcare-providers/end-of-life-tools/). Initiate advance care planning discussions early in the disease course.
- The goals of pharmacologic management for HF patients with preserved ejection fraction (HF-pEF) are to control heart rate, blood pressure, and volume status, as no medications have shown a mortality benefit in this patient group.
- For patients with reduced ejection fraction (HF-rEF) there is robust mortality data to support the use of pharmacological and device therapies. These treatments have also been shown to improve symptom status and quality of life, and to decrease the risk of HF-related hospitalization.

Warfarin Therapy—Management During Invasive Procedures and Surgery

The Guidelines and Protocols Advisory Committee's (GPAC) guideline provides recommendations for the management of warfarin therapy in adults aged ≥ 19 years who require invasive procedures and surgery. It is available to physicians across BC via www.BCGuidelines.ca.

Key recommendations

- It is necessary to discontinue warfarin prior to invasive procedures for all interventional procedures except for minor skin procedures, routine dental work, cataract surgery, endoscopies without biopsy, and percutaneous venous access.
- For elective procedures, warfarin should be stopped for 5 to 6 days prior to the procedure to allow gradual normalization of the international normalized ratio (INR).
- For urgent procedures, use of prothrombin complex concentrate is highly effective in rapidly reversing warfarin anticoagulant activity and has a duration of action of approximately 6 hours.
- The use of bridging heparin therapy is dependent on the risk of thrombosis.
- Discuss the risk of bleeding with the surgeon and anesthesiologist to determine optimal timing for resuming warfarin and bridging heparin therapy after surgery.

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The top three causes of death in Canada, according to Statistics Canada, are cancer, heart disease, and stroke, but medical advances mean that people are living longer after diagnosis. The Heart and Stroke Foundation notes that there are roughly 70 000 heart attacks in Canada each year, and an estimated 62 000 stroke and TIA patients admitted to Canadian emergency departments. Some 105 000 of these people survive and join the more than 1.3 million Canadians living with health impacts from heart disease or stroke.

If you were diagnosed with a critical illness would you have the financial freedom to attend to your health? The average hospital stay after a stroke is 16.1 days. This is a loss of work time and the beginning of an often a lifelong recovery. Cancer diagnosis can bring increased costs for medication, child care, housekeeping, and accommodation if you must travel for treatment. Your spouse may also have to decrease his or her workload to help with your care, child care, and home care. This can mean that your family will face higher expenses and less income, which may impact your savings.

Critical illness insurance was developed in 1983 by Dr Marius Barnard, a South African physician. As a participant in the first successful heart transplant surgery, Dr Barnard saw how medical advances were improving patient survival. He also saw that survivors often suffered financially due to their illness.

Critical illness plans cover a set number of conditions including cancer, heart attack and stroke, Alzheimer disease, Parkinson disease, coronary bypass surgery, and kidney failure. After you survive the waiting period (usually 30 days from your diagnosis), you are entitled to your full critical illness benefit. This tax-free lump sum is yours to spend. You may decide to make home modifications such as adding a shower rail, pay for medications, ask your spouse to take time off work to care for you, or focus on your emotional well-being with a vacation.

Although the conditions covered by critical illness insurance are more likely to occur as you age, it is important to think about coverage while you are young. The younger you are the more likely you are to be approved for critical illness insurance and to benefit from it because you are less likely have pre-existing conditions and more likely to survive an illness.

You may already carry disability insurance. Critical illness insurance supplements do not replace disability coverage. While disability insurance pays a monthly amount if you are disabled from work, to allow you to maintain ongoing expenses such as a mortgage and car payments, critical illness insurance pays a lump sum regardless of you continuing to work. This benefit is useful for the extra costs arising from your illness and will help protect your savings and your family's financial security during a difficult time.

Critical illness insurance supplements do not replace disability coverage. While disability insurance pays a monthly amount if you are disabled from work, to allow you to maintain ongoing expenses such as a mortgage and car payments, critical illness insurance pays a lump sum regardless of you continuing to work.

—Claire Campion Wright, BSc
UBC Medicine, Class of 2016
—Laura McLean
Insurance Client Service Administrator