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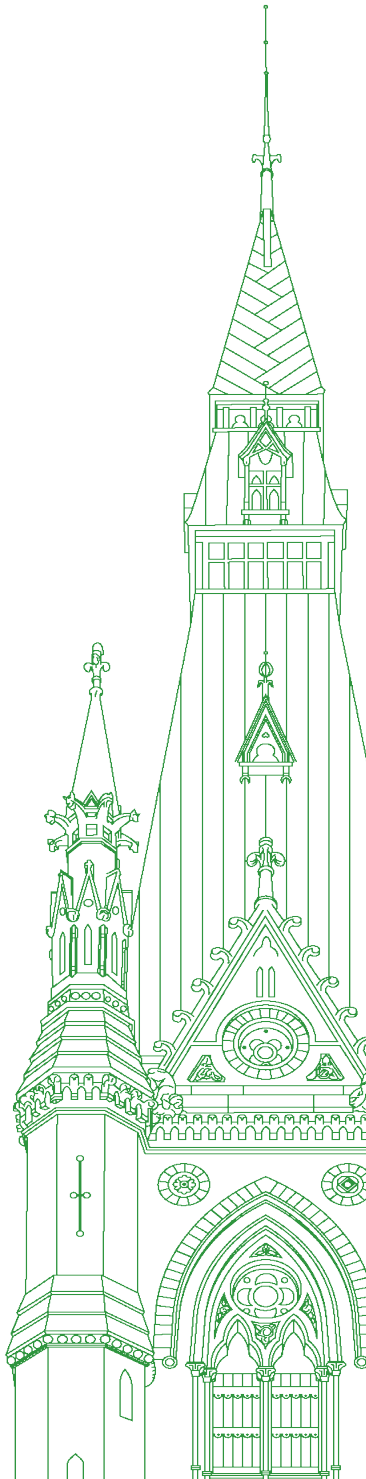

Chair: Mr. Sean Casey

Standing Committee on Health

Monday, February 12, 2024

● (1605)

[*English*]

The Chair (Mr. Sean Casey (Charlottetown, Lib.)): I call this meeting to order.

Welcome to meeting 101 of the House of Commons Standing Committee on Health. Today's meeting is taking place in a hybrid format pursuant to the Standing Orders.

I have a few comments for the benefit of members and those participating online.

You have interpretation available to you on Zoom. You have the choice at the bottom of your screen of floor, English or French. Those of you in the room may already know this: You can use the earpiece and select the desired channel. For those online, please bear in mind that screenshots or taking photos of your screen is not permitted.

In accordance with our routine motion, I'm informing the committee that all remote participants have completed the required connection tests in advance of the meeting.

Pursuant to Standing Order 108(2) and a motion adopted on May 16, 2022, the committee is resuming its study of women's health.

I'd like to welcome our panel of witnesses and thank them for their patience while they awaited democracy to run its course so that we could be here.

Appearing as individuals, we have Dr. Gillian Hanley, associate professor, department of obstetrics and gynaecology at the University of British Columbia. Dr. Hanley is appearing by video conference, as is Dr. Jessica McAlpine, professor and division head, division of gynecologic oncology at UBC.

Representing Ovarian Cancer Canada, we have Tania Vrionis, chief executive officer, and Valérie Dinh, regional director for Quebec.

Representing the Society of Gynecologic Oncology of Canada, we have Dr. Shannon Salvador, president-elect.

Thank you all for taking the time to appear today and for being generous with your time in awaiting our arrival.

Each of you will have five minutes for an opening statement, and we're going to begin with you, Dr. Hanley. You have the floor.

I don't mean this Dr. Hanley—

Some hon. members: Oh, oh!

The Chair: You'll get your turn.

Dr. Gillian Hanley, you have the floor.

[*Translation*]

Dr. Gillian Hanley (Associate Professor, Department of Obstetrics and Gynaecology, University of British Columbia, As an Individual): Good afternoon. Thank you very much for inviting me to speak with you today.

[*English*]

My name is Gillian Hanley, and I am an associate professor in the department of obstetrics and gynecology at the University of British Columbia and a tier 2 Canada research chair in population-based gynecological and perinatal outcomes.

I am also a member of the Gynecologic Cancer Initiative, along with Dr. McAlpine. The GCI is an interdisciplinary network of patients and family partners, clinicians and scientists who are all working across gynecological cancer disease sites, across institutions and across disciplines, with the goal of reducing death and suffering from gynecological cancer by 50% by 2034.

This is an important goal, since in this year alone, 12,000 Canadian women, transgender men and non-binary people will be diagnosed with a gynecological cancer. Gynecological cancers include cervical, endometrial, vulvar, vaginal and ovarian cancers, and they represent 10% of cancer deaths in women.

Importantly, funding for gynecological cancer does not reflect this disease burden. The Canadian Cancer Research Alliance has calculated that there has been a 60% higher investment per case in breast cancer research than in gynecological cancers. This disparity increases to a 270% higher investment in breast cancer when the numbers are based on cancer-related deaths. Thus, both national focus and dedicated investment are needed in this important area.

Despite these challenges, Canadian researchers have made important strides in understanding, treating and preventing gynecological cancers. There are many areas in gynecological cancer in which Canada is world-leading, including ovarian cancer prevention, which is the focus of my research.

Despite tremendous international effort, there is no effective screening method for ovarian cancer. Symptoms generally do not arise until the disease is in advanced stages, at which point five-year survival rates are well below 50%; thus, we have focused our efforts on preventing ovarian cancer.

There are five distinct types of ovarian cancer. Seventy per cent of ovarian cancers and 90% of deaths from ovarian cancer are from the high-grade serous type. Approximately 20 years ago, we discovered that most high-grade serous cancers arise in the Fallopian tube and not on the ovary, as was previously believed. Fallopian tubes connect the ovaries to the uterus, but they play no known role post-childbearing. This is not true of ovaries, which produce endogenous hormones that are important for women's long-term health. Thus, taking the opportunity to remove the Fallopian tubes during other gynecological and pelvic surgeries while leaving the ovaries behind has been a ground-breaking ovarian cancer prevention approach.

In 2010, our team in British Columbia launched the world's first population-based ovarian cancer prevention program. We recommended that salpingectomy, the removal of both Fallopian tubes, be performed at the time of hysterectomy, the removal of the uterus. We also recommended removal of Fallopian tubes rather than ligation or having one's tubes tied for permanent contraception. Recognizing that approximately 80% of ovarian cancers occur in people who have no genetically increased risk, we based this prevention effort not on risk for ovarian cancer but rather on opportunity. Hence, we called it opportunistic salpingectomy. We are taking an opportunity provided by another surgery to also conduct this important ovarian-cancer prevention strategy. This is now recommended practice in nine countries worldwide, including Canada. Through research, we've demonstrated the safety and feasibility of opportunistic salpingectomy, and in 2022, we provided the first evidence that removing Fallopian tubes does significantly reduce risk for ovarian cancer.

Despite these compelling data, a recent assessment of the pan-Canadian practice of Fallopian tube removal demonstrated considerable variation in uptake outside of B.C. The study estimated that between 2017 and 2020, nearly 80,000 Canadians received a tubal ligation or hysterectomy without Fallopian tube removal, representing a missed opportunity to stop ovarian cancer from developing and translating to a possible 1,000 future cases of ovarian cancer that could have been prevented.

My recommendations today are to increase the funding for gynecological cancer research to accurately reflect the burden of these cancers on Canadians and to target funding to groups that are multidisciplinary and working across cancer disease sites and institutions to make the fastest and most meaningful progress. We also recommend putting a focus on funding for implementation science to ensure that important research advances are available to Canadians and that the federal government consider engaging in communication strategies targeted to patients and clinicians to help get these important research advances to all Canadians.

Thank you very much.

● (1610)

The Chair: Thank you, Dr. Hanley.

Next is Dr. McAlpine for five minutes.

Welcome to the committee. You have the floor.

Dr. Jessica McAlpine (Professor and Division Head, Division of Gynecologic Oncology, University of British Columbia, As an Individual): Thank you very much. Thanks for the opportunity to be part of today's session.

I'm a surgeon, scientist and professor at UBC. I spend half of my time in surgery and seeing patients with gynecological cancers and half in translational research.

You have heard from my colleagues about the disparity of funding for gynecological cancers, and you will hear more. I'm extremely grateful to federally supported funding initiatives, such as the Canada research chairs, and institutions like CIHR, without which many of the discoveries you'll hear about today would not have been possible. However, the competition for research funding has soared, and actual funding available, particularly for multidisciplinary team projects and clinical trials, is increasingly difficult to obtain. We're at risk of losing our reputation in Canada of being innovative, creative leaders changing the landscape of gynecological cancer care. We're at risk of appearing irrelevant if the scientifically validated initiatives that we generate are not actually implemented and delivered to Canadians in a timely fashion.

I'm going to share one example of proven research advancement that was homegrown in Canada, an example of where we need to do better about ensuring equitable access for all Canadians.

Endometrial or uterine cancer is the most common gynecological cancer. Globally, it is increasing in both incidence and mortality, and it's on a trajectory to be the second most common cancer that women—including gender-diverse, trans and non-binary individuals—are likely to develop in their lifetimes. Despite these statistics, there has been little research, attention or funding related to endometrial cancer. It receives about a fifth of what prostate and breast cancer research receive.

Beginning about 10 years ago, we recognized that the way endometrial cancers were being categorized and subsequently managed was not working. There was little consensus between expert pathologists and their diagnostic reporting, meaning that a patient could get a completely different diagnosis from two different pathologists, directing them, for example, to six months of radiation or chemotherapy or to no treatment at all.

Clearly, this way of managing it was unacceptable. Our team worked to change this. We identified key molecular features in endometrial tumours that could be determined by simple methods that are achievable in most hospitals already. Within five years, we created a system that could consistently classify tumours and form molecular subtypes. They could identify which patients were most likely to have their disease recur and which patients were most likely to have an inherited cancer syndrome, and they could determine which treatments worked best.

Our classification system was adopted by the World Health Organization in 2020, and it was immediately implemented into international treatment guidelines. It is now considered the standard of care globally.

What is tremendously frustrating is that despite the international recognition, molecular classification is not uniformly available to patients across Canada. Even in British Columbia, where we developed this tool, it took two years for us to assure free testing for all endometrial cancer patients. In Canada, we have centres where they may actually have to wait eight to 10 weeks for their results. They may have to send their tissue out of province to get molecular testing. Molecular testing may never even be discussed with patients. Essentially, endometrial cancer has had one of the worst examples of health care inequities of any cancer. Our team is passionate about changing this.

My call to action is to first work to ensure that scientifically proven, value-added initiatives in prevention, diagnosis, screening and treatment of gynecological cancers are available to all Canadians. This could be by supporting provinces, for example, to fund molecular testing for endometrial cancers across Canada. We must change the current reality in this country that how you are treated depends on where you're diagnosed and must instead ensure equity for all.

Second, I call for increased funding for gynecological cancers, particularly funding for clinical trials and to support multidisciplinary team research, where it's been so successful in identifying important changes needed in clinical care. We've all witnessed what this government's rapid, impactful and successful communication actions could do in the recent COVID crisis. This proves that federal government initiatives on health communication are possible and can be effective.

I look forward to seeing what we can achieve in these initiatives for the prevention and treatment of gynecological cancers in Canada, and I commit to working hard with you to create these changes.

Thank you very much.

● (1615)

The Chair: Thank you, Dr. McAlpine.

Next is Ovarian Cancer Canada. I understand you have a joint statement, Ms. Vrionis and Madam Dinh. The next five minutes are all yours.

Ms. Tania Vrionis (Chief Executive Officer, Ovarian Cancer Canada): Thank you, Mr. Chair.

Thank you, honourable members.

On behalf of Ovarian Cancer Canada and all Canadians affected by ovarian cancer, I want to thank the House of Commons Standing Committee on Health for conducting this important women's health study and for inviting us to appear as witnesses.

Eight women a day are diagnosed with ovarian cancer in Canada, with 75% of those being diagnosed as late stage. Ovarian cancer's five-year survival rate is only 44%. Four out of the eight women diagnosed today will not be here in five years.

There is no screening test. There is no definitive diagnostic test. There are few treatment options available. Women deserve better.

My colleague and I will be highlighting for this committee three of the challenges and associated opportunities regarding this disease from prevention to diagnosis to treatment.

The most effective way to impact ovarian cancer incidents and outcomes now is through prevention. While some believe that the Pap test screens for ovarian cancer, this is not the case. There is no screening test for this disease.

With an estimated 20% to 25% of ovarian cancers known to be hereditary, identifying those at risk through genetic testing and offering preventative or risk-reducing options will have a significant impact on saving lives now.

Ovarian Cancer Canada and our partners have revealed gaps and inequities regarding access to genetic testing including but not limited to regional variations in criteria and wait times, under-representation of individuals of Asian or indigenous origin, and racialized and ethnic individuals being less likely to be referred for genetic testing and more likely to receive inconclusive genetic test results.

We must maximize and optimize the identification of individuals at increased risk for ovarian cancer through timely and equitable access to genetic testing to stop ovarian cancer before it starts.

● (1620)

[*Translation*]

Ms. Valérie Dinh (Regional Director, Quebec, Ovarian Cancer Canada): A timely ovarian cancer diagnosis begins with access to primary care. Ovarian cancer is known to be difficult to diagnose because of its vague and unspecific symptoms. While access to primary care is essential to timely diagnosis, some 6.5 million Canadians don't have a family doctor, and a third of them have been waiting for treatment for over a year. However, that's not all. Primary health care providers also need to be able to recognize symptoms of ovarian cancer and order the right tests so that patients are referred to a treatment centre and receive a formal diagnosis.

To obtain a timely ovarian cancer diagnosis, Canadian women must have access to primary care, and physicians and nurses must be equipped to recognize and respond appropriately to the symptoms of ovarian cancer.

With few exceptions, the treatments offered haven't changed much since the 1990s. The same methods are used to treat patients, namely surgery and chemotherapy. Unfortunately, these methods are ineffective in the majority of cases. Despite this, investments in ovarian cancer research lag behind investments in other cancers.

Ovarian cancer is a unique disease with unique challenges. Research on ovarian cancer hasn't had the same breakthroughs as research on many other types of cancer. Traditional research funding mechanisms haven't led to significant progress in the field of ovarian cancer. That's why Ovarian Cancer Canada and the ovarian cancer research community have proposed a new model that allows scientists to work closely together and build on the progress of their colleagues to accelerate and facilitate progress. In 2019, the Canadian government made a bold decision to invest $10 million in Ovarian Cancer Canada to fund this new research model.

[*English*]

Ms. Tania Vrionis: While $10 million may be a relatively small investment, it is enabling us to build a highly focused national research engine for ovarian cancer. We were also able to leverage the federal government's investment and attract more than $4.5 million in additional funding from research partners and two provincial governments, building in total a $14.5-million research program.

In just five years, Ovarian Cancer Canada has yielded an impressive return on the federal government's investment, fuelling research in six provinces resulting in five transformative clinical trials, 13 innovative preclinical studies and 25 projects on ovarian cancer model development, allowing scientists to test and identify more novel treatments in new ways.

In addition, we will soon be funding two translational clinical research projects that are aimed to improve and expand treatment options for women with ovarian cancer. We are now on the cusp of bringing new treatment strategies to Canada.

For ovarian cancer to be preventable, curable and ultimately eradicated, the federal government must continue and increase its investment in innovative, highly focused, comprehensive national research into this disease.

Ovarian Cancer Canada is leading the way in propelling crucial breakthroughs from the bench to the bedside faster. This work must be prioritized to change the trajectory of ovarian cancer in this country.

Ovarian Cancer Canada applauds the government's commitment to women's health.

Thank you.

The Chair: Thank you both.

Last but not least, Dr. Salvador, welcome to the committee. You have the floor.

Dr. Shannon Salvador (President-Elect, The Society of Gynecologic Oncology of Canada): Thank you. Good afternoon, Mr. Chair, committee members and fellow witnesses. I'm very honoured to be here before you to present before this committee.

I'm a practising gynecologic oncologist at the Jewish General Hospital in Montreal, and I am also the president-elect of the Society of Gynecologic Oncology of Canada, also called GOC.

GOC is a non-profit organization created 40 years ago as a forum for medical professionals to highlight issues in women's cancer care across Canada to help correct the disparities in cancer care access and to improve equity in research funding for new treatments.

Historically, women's cancers have been orphaned from the traditional cancer care models, so in the 1970s the gynecologic oncology subspecialty was created to care for women with cancers of the Fallopian tube, ovary, uterus, cervix, vulva and placenta. Unfortunately, these cancers have long been, and often still are, deemed a women's issue. Funding for clinical care and research has not kept pace with other more common cancers, such as colorectal, breast or lung cancers. Among all surgical cancer specialities, gynecologic oncology is uniquely comprehensive. Diagnosis, surgery, systemic treatments, surveillance and palliative care are all done by one physician.

GOC has identified three major concerns that need to be addressed swiftly to improve women's cancer care in Canada. First is the backsliding of performance in our prevention of cervical cancer. Second is the rise in incidence and death rates from endometrial cancer and the need for dedicated funding for endometrial cancer research. Third is the need for funding to train health care professionals dedicated to gynecologic oncologies as we start to form our multidisciplinary teams.

A report was published in November 2023 by the Government of Canada with the Canadian Cancer Society on Canadian cancer statistics. It identified cervical cancer as the fastest-growing cancer in women, with incidence rising at a rate of 3.7% per year since 2015. Frankly, to me this is shocking, because women should have easy access to effective cervical cancer prevention strategies in Canada.

Primary prevention via vaccination against the human papillomavirus, or HPV, is offered to school children in every province, as well as to women up to the age of 45, and it has been available in Canada since the 1990s, yet there are decreasing vaccination uptake rates in our population. HPV is the primary cause of cervical cancer as well as vulva, anal and throat cancer. GOC strongly recommends nationwide campaigns to increase the awareness of the burden of HPV and to help increase those vaccination uptake rates. There's also secondary prevention via screening through HPV and pap testing. Unfortunately, our most vulnerable populations are in locations that do not have an organized province-wide screening program yet, or easy access to health care professionals who offer screening, leading to disparities in identification and treatment of these precancerous cervical lesions.

We need to support for better provincial-based screening programs for cervical cancer in areas that are not on track to reach our goal of cervical cancer elimination, either through improved access to health care professionals providing screening or through access to HPV self-testing, as offered in some countries and as currently being highlighted in British Columbia.

Second, the same cancer statistics report also identified a worrisome trend of increasing incidence of mortality in endometrial cancer. This can be attributed both to our aging population and to an increase in obesity rates in Canada, which have very strong risk factors for this cancer. We need to increase the numbers of funded gynecological oncology positions in locations that have unequal access to specialized care, as well as access to operating room facilities and robotic surgery to accommodate the rising numbers of these women's cancers.

To support gynecologic cancer research, GOC has created something called the “communities of practice” forums. These forums have facilitated Canadian-based research teams such as the ones run by Dr. McAlpine and her team to collaborate nationally. However, dedicated research funding for endometrial cancer is rare, and we would benefit greatly from specifically earmarked allocations of funds.

Finally, there is a need to increase funding to train other health care professionals in gynecologic cancers in the field of medical oncology, radiation oncology, family medicine and nursing as we grow our multidisciplinary teams to provide holistic patient-centred care. Having more of these specially trained care providers, especially in remote locations, will greatly improve the ability of our patients to receive ongoing care closer to home.

● (1625)

GOC remains deeply committed to improving research opportunities, advocating timely access to health services and being a strong voice for women's cancer care in Canada.

We look forward to working with the HESA committee and other voices at the table to find solutions to these concerns.

Thank you.

● (1630)

The Chair: Thank you, Dr. Salvador.

We will now begin with rounds of questions, starting with the Conservatives for six minutes.

Mrs. Vecchio, go ahead, please.

Mrs. Karen Vecchio (Elgin—Middlesex—London, CPC): Thank you very much, Mr. Chair.

I would like to begin by thanking all the women who are here today.

To Tania specifically, I assume you work with many of the doctors we see on today's panel.

Ms. Tania Vrionis: We do, absolutely.

Mrs. Karen Vecchio: You mentioned you received $10 million in research dollars, which then increased by $4.5 million through your leveraging of that money.

Would you be working with groups and women like these to do that research?

Ms. Tania Vrionis: Absolutely. We're very strong partners with GOC. Certainly we do some work with our prevention task force friends on the screen there as well. One of the things we're most proud of at Ovarian Cancer Canada is our ability to work across the country, build these collaborative teams and participate in those.

Mrs. Karen Vecchio: Thanks so much.

I want to go online to Dr. Jessica McAlpine, and thank you very much for this information.

You indicated molecular features. When you're doing this, sometimes you don't need to have radiation and chemotherapy, which, for many people suffering from cancer, end up being the most drastic pieces they have to go through in how they are dealt with after surgery.

First of all, when you're trying to detect cancers such as cervical cancer—things that get diagnosed later on—how long does it take to start diagnosing people and getting them into these types of programs in which they might be able to look at things like this molecular piece you're talking about?

Dr. Jessica McAlpine: Cervical cancer, first of all, has probably a two-year lag period between pre-cancer and advanced cancer, with all those opportunities to either prevent it with vaccinations and screening, as Shannon Salvador mentioned, or to intervene and cure it. There are great opportunities there.

The endometrial cancer I was talking about is one that might present with spotting. It very much depends on the molecular features of that tumour and whether it is a cancer confined to the uterus and cured by surgery alone or is identified by that molecular feature and definitely needs more treatment because of a very high risk of recurrence.

In knowing that, there are opportunities to intervene and cure, and there are opportunities to spare treatment just in those two examples.

Mrs. Karen Vecchio: That's fantastic. Thank you so much.

I want to move over to Dr. Salvador.

We're talking about genetic testing when looking at breast cancer. We're talking a lot about the fact that for those high-risk groups here in Canada, maybe we should be doing it 10 years earlier. I think those are some of the things we heard—the probability at 50 or 40.

When it comes to cervical cancer, how do you ensure genetic testing is done?

Dr. Shannon Salvador: Do you mean for cervix cancer itself?

Mrs. Karen Vecchio: Yes.

Dr. Shannon Salvador: It's not genetically related.

Mrs. Karen Vecchio: For genetic testing, you were talking about some of the cancers that would be in women's organs. What would be genetically seen? If we see that with breasts, what would we see in those reproductive organs?

Dr. Shannon Salvador: For the reproductive organs, ovarian cancer is the strongest. It's related to the BRCA mutations we also see in breast cancer. This is where we have an opportunity to intercede for a lot of women. If we know they have family members who have a BRCA mutation, they can go ahead and get themselves tested.

Again, this is an opportunity to intercede earlier for women.

Mrs. Karen Vecchio: Are there any restrictions or time frames? As I said, with breast cancer, we saw that there were age verifications. What do we see when it comes to ovarian cancer and time frames?

Dr. Shannon Salvador: Typically, for ovarian cancer, we're usually asking women who have that cancer history with family members to go ahead and remove Fallopian tubes and ovaries at a minimum of about 10 years before an incidental cancer in their family or as soon as they are done child-bearing. The reason we say this is that ovarian cancer is so difficult to treat. You do not want to miss an opportunity to intercede and remove those cancers.

Endometrial cancer is also another cancer that can be genetically related through Lynch syndrome. People don't realize how strong a connection that is. About 80% of Lynch syndrome family members can get endometrial cancer. Most people associate it with colon cancer, but the connection is actually just as strong for endometrial cancer.

Mrs. Karen Vecchio: I have a quick question on this, because I'm sure my time is running out quickly: Where would you get this type of screening? We know that to get screenings, we look a lot of times at larger centres. Canada is huge, and we're talking about equity for our patients. Where are these centres available, and how do people get this type of screening and care done?

● (1635)

Dr. Shannon Salvador: Most cancer agencies in the individual provinces can run genetic testing within their own cancer agency.

What we would really like to see is family physicians being educated and having access and the ability to send them. That would be the best place be able to go to say, “I really need genetic testing. I have a family member who's been identified in another province, so can we please proceed with testing?”

Mrs. Karen Vecchio: I assume there should be no cost to this testing. It is all covered by the provinces.

Dr. Shannon Salvador: Absolutely.

Mrs. Karen Vecchio: It's fantastic to hear that too.

You were talking about the HPV vaccines. I know that they are offered in public schools, and you had mentioned up to age 45. Is there a time at which a women would be too old to have this vaccine? For instance, if a 53-year-old woman presented herself, what would you say? Would you say, “Sure, give her the HPV...”? What would you do?

Dr. Shannon Salvador: That's actually a very good question.

We don't have research trials per se to say whether you actually mount an immune response over the age of 45. I can definitely respond because I'm also the head of colposcopy in my hospital. If a woman comes to me because she has a precancerous lesion due to an HPV virus, whether it be cervix or vulva, I absolutely offer her the HPV vaccine if she would like to receive it, no matter what her age.

Mrs. Karen Vecchio: Thank you so much. I really appreciate that.

The Chair: Thank you, Mrs. Vecchio.

Next, for six minutes, we have Ms. Atwin, please.

Mrs. Jenica Atwin (Fredericton, Lib.): Thank you, Chair. Thank you so much to the witnesses for being here.

I just want to highlight something that I think Dr. Salvador said. It's that “women's cancers have been orphaned from the traditional” models.

I mean, it should be no surprise to most of us sitting around this table why that would be. I'm just really proud to be here with fellow women, and our allies as well, to really shine a light on women's health. It's been neglected for far too long.

I'm going to focus a little bit on the cervical cancer piece, because it's quite alarming to me that the rates are increasing.

The report lists various factors associated with this increase. You mentioned screening uptake and the vaccination piece. There's also a higher prevalence of HPV due to changing sexual practices. Can you maybe expand on that a little bit? What underpins these increases?

Dr. Shannon Salvador: I think one thing we're experiencing is that as people are becoming more sexually free and with divorce rates being what they are, people are re-entering sexual debut in an older generation. These are women who may not have actually had the vaccine or who had the opportunity to have the vaccine earlier.

It would be good for women to be aware that they can get the vaccination up to the age of 45. We do recommend it. It is definitely available if they wish to go to their family physician and get a prescription for it.

Mrs. Jenica Atwin: Excellent. I did not know that. That's amazing.

We know that all provinces and territories offer the school-based HPV vaccination programs. I remember that from when I was in middle school. The report also indicates that there is a variance across provinces and territories. We have numbers here of anywhere from 57% to 91%. The report also mentions a lack of disaggregated data on these rates.

Why does the uptake of HPV vaccination vary across those provinces and territories?

Dr. Shannon Salvador: I think a bit has to do with the culture that may be present in each province and perhaps even the lack of education about HPV at this current time.

When I was growing up and HPV was first discovered, and then the vaccinations first came out, there were massive nationwide campaigns. I remember them, when I was in my 20s going into my 30s, as they were doing these campaigns.

I've noticed that there seems to be a lack of these campaigns nowadays. We have to keep in mind that every family that is making a decision on whether or not to vaccinate their child changes every 10 years. You're dealing with a new generation that's going into their child-bearing years and making decisions about having children. If we don't continue to carry forward with the education and offer these pertinent points....

It's not just cervix. It's vulvar, anal and throat. It's actually quite a large cancer burden when you look at it. We need to constantly stay on top of the educational component for our Canadian population.

Mrs. Jenica Atwin: Thank you.

How about that piece on the disaggregated data? How would that help us improve informing our processes?

Dr. Shannon Salvador: I think it's about trying to identify which provinces seem to be falling behind and trying to engage the population, because it could also be due to a lack of family physicians and to disparities in being able to provide the primary education, even in the clinics, as children are growing up and going to see their pediatricians or their family physicians.

Mrs. Jenica Atwin: As far as screening goes, I think most of us are familiar with the infamous Pap test. I'm reading here that there's another way. There's the HPV testing, which is compared to the Pap test. Can you explain what the differences might be?

● (1640)

Dr. Shannon Salvador: What a Pap test looks for are changes that the HPV virus has caused in the cervix, so it looks for an active lesion. What the HPV tests looks for is an active virus, so it can be more specific and sensitive to be able to identify someone who has an active HPV virus. Not only that, but there are different subtypes of HPV. We know some of them are more likely to cause more aggressive cancers than others.

We can subtype these now. If we find out that someone has an HPV virus, there are guidelines that were just published last year about this in combination with GOC, CPAC and the Canadian colposcopy society. This was all put together through Canada-wide recommendations for HPV testing, as well as what to do when someone has a positive HPV test.

Mrs. Jenica Atwin: How many cervical screening programs currently use the HPV testing as a primary mode of screening?

Dr. Shannon Salvador: In Canada we are all doing a massive changeover right now. Each province has a plan for rollout. It's supposed to be going on, and I do believe that various provinces are at various stages right now.

Mrs. Jenica Atwin: That's very interesting.

I'll go online to Dr. Hanley.

I'm really interested, again, in the disparities that exist across different populations. I'm thinking specifically of those who might be in rural or remote communities, indigenous peoples and those with low income or poor socio-economic backgrounds.

Could you describe how these barriers to accessing cancer care services for women present themselves and what we can do as a federal government to maybe implement some changes?

Dr. Gillian Hanley: I think you've heard from some of the other witnesses as well about these inequities. Unfortunately, we do often see in research that where a woman lives dictates far too much in terms of what she gets with respect to cancer care. This goes from prevention all the way to the molecular testing that Dr. McAlpine described, which then dictates treatment.

There are really important inequities, and we do see that rural and remote communities often fall behind. Indigenous communities often fall behind, so as researchers, we're working really hard to try to close many of these gaps, but it can be very challenging without collaboration with governments and other groups to help us address these.

The Chair: Thank you, Dr. Hanley.

Thank you, Ms. Atwin.

[*Translation*]

Ms. Larouche, you have the floor for six minutes.

Ms. Andréanne Larouche (Shefford, BQ): Thank you very much, Mr. Chair.

I join my colleagues in thanking the witnesses for being with us today.

We all have women around us to whom we can send energy and dedicate the important work we do here in this committee.

Dr. Hanley, your main focus is on ovarian cancer prevention, as you clearly explained in your opening remarks, particularly through salpingectomy, surgery that involves removing one or both fallopian tubes. You also talked about contraception and healthy pregnancies.

The brief that Ovarian Cancer Canada submitted to the committee indicates that the treatments available for ovarian cancer have unfortunately not changed significantly since the 1990s, and that the survival rate for ovarian cancer hasn't improved in 50 years. That's a sad statement.

Can you explain the underlying reasons for the lack of progress in ovarian cancer treatments and the lack of improvement in survival rates?

[*English*]

Dr. Gillian Hanley: Part of this is that ovarian cancer is just a really challenging disease. I mentioned that there have been tremendous international efforts to find an effective screening approach for ovarian cancer. We've heard about the Pap test as a really effective screening approach for cervical cancer, so if women get the Pap test, Dr. McAlpine mentioned that there's a long lag from the first sign when we see the precancerous lesion in the cervix to an active cancer. However, that does not appear to be true in ovarian cancer, so that has been very challenging, because we have not been able to find effective screening.

Again, because symptoms often arise when the cancer is already in very advanced stages, we need treatments that are incredibly effective. Unfortunately, we have not been able to make a lot of progress on the treatment front either. Part of this is a result of less funding dedicated to this kind of research, as I and others have mentioned here as well.

We have had a couple of breakthroughs in ovarian cancer. PARP inhibitors have been very important. These tend to work best for the patients who have the BRCA mutations and have tumours that are homologous repair-deficient. Unfortunately, that's just a subset of ovarian cancer patients, so there's still a very large group who have no new, effective treatments for their cancers.

There is a lot of work that is ongoing, and certainly Ovarian Cancer Canada has been a great leader in terms of funding it. We've had a lot of good federally funded research as well, but we need more. We need more work in this area.

Thank you for the question.

● (1645)

[*Translation*]

Ms. Andréanne Larouche: I'd like you to tell us a little more about what was proposed in the 2019 Budget. I'm talking about the $10 million over five years that was provided to Ovarian Cancer Canada starting in 2019-20 to address existing gaps in knowledge and effective options for the prevention, screening and treatment of ovarian cancer. All of that is more difficult, as you explained so well in your remarks and in your answer to my question.

According to the brief submitted to the committee by Ovarian Cancer Canada, and according to the explanation you provided to my colleague who wanted more details on the $10 million, that investment helped fund research that led to new discoveries that would help people with ovarian cancer live better and longer.

Can you tell us a bit more about the research projects that have been funded as a result of this investment, as well as their outcomes?

[*English*]

Dr. Gillian Hanley: I would think that Tania would probably have much better information about the specific projects than I do.

Ms. Tania Vrionis: I'm happy to jump in.

As I mentioned, we were able to fund.... We currently have five clinical trials ongoing right now, all testing new and novel treatments. There is one that is launching very soon out of British Columbia that is going to challenge the way that a certain type of ovarian cancer is treated. It will be very interesting to see the results of that—giving PARP inhibitors first, prior to surgery or any other type of treatment, along with a treatment regime of three different types of drugs.

There's also been a really fantastic study in Montreal testing vaccines as treatment, and we're seeing real promise in that.

We have the five clinical trials, but we've also had those 13 preclinical studies, with the ultimate goal in those to lead to clinical trials and be able to bring more treatments to patients faster.

Then, of course, we have the core in the 25 projects based on model development, helping scientists understand how the disease is responding to different types of treatments and responses.

There is a lot of incredible work going on, but this has only been happening for five years. That's a really short time in the span of research. Just to put it in context, 25 years ago there were only three ovarian cancer scientists in all of Canada. Today there are 250-plus. We have some ground to make up, but we're making it up. However, it can only continue with the necessary funding in order to drive that forward.

[*Translation*]

The Chair: Thank you very much.

[*English*]

Next we have Ms. Barron, please, for six minutes.

Ms. Lisa Marie Barron (Nanaimo—Ladysmith, NDP): Thank you, Chair.

I'm happy to be sitting in on this committee today, as this is a big opportunity to finally be talking about an issue that has not been prioritized for a long time. For us to gather today to talk about women's health, specifically gynecological health, makes it a great day for me to be here.

I have some questions that I'd like to go through.

First, Dr. Dinh, I believe it was you who had said that 6.5 million Canadians do not have access to a family doctor across Canada. I'm wondering if you can highlight the impacts on women to be able to access the care they need, and also the preventive care they need, when it relates to gynecological health.

● (1650)

[*Translation*]

Ms. Valérie Dinh: I'd like to clarify that I'm not a doctor; I'm the Quebec regional director for Ovarian Cancer Canada. In fact, if I may, I'll answer you in French, as a Quebec representative.

We talked about the context of the lack of access to family doctors and its impact on ovarian cancer. Women who don't have a family doctor and are diagnosed with ovarian cancer often find themselves in emergency situations. They are diagnosed later, which is associated with a poorer prognosis and a lower survival rate.

In addition to the issue of access to family doctors, it's also important to talk about raising their awareness of the symptoms of ovarian cancer so that they can properly recognize the symptoms, which are very vague and not specific. Once they've recognized the symptoms, they need to order the right tests so that patients are referred to a treatment centre and can be followed in oncology gynecology.

Ms. Lisa Marie Barron: I can't ask my question in French because my French isn't good enough, but I understood your answer. Thank you very much.

[*English*]

My next question is to Dr. Hanley or perhaps Dr. McAlpine. It's to whoever is best suited to answer it.

We've been talking a lot today about the importance of national standards when it comes to women's access to health care services and also with regard to prevention and diagnosis, and I'm wondering what impacts you could foresee if there were stronger national standards in place, and specifically how would that trickle into the care available in British Columbia.

Are there any specific impacts or benefits that you can think of to having a national standard in place, rather than a patchwork approach in which the health care differs from province to province?

Dr. Jessica McAlpine: That's a wise question, and you've hit the nail on the head. I think it would go tremendously far.

What you've heard about today from all of us—and again, it's lovely to be on this panel with so many people we respect and who are all working toward the same goals—is that yes, there are things that just make sense to everyone, I'm sure, who is in the room there. There are things that are actually scientifically validated, that resonate with patients but are not universally implemented and are needing that guidance of what we call a knowledge translation and making sure people understand the value of it. Whether you lead them with a carrot or a stick or you set out guidelines that have to be followed, those are what help enable things to happen.

I'm incredibly distressed that a patient who is a 10-hour drive from me may have a conversation with their physician that is different from the one I have with the patient around the corner. I think we do a very good job of centralized care in cancer centres, but there are still challenges. There are differences in communities' awareness of disease and how to treat it, and I think national guidelines would go tremendously far in helping to say that this is the gold standard and let's all try to rise up to it.

Dr. Gillian Hanley: Yes, and I think the research that we've done nationally looking at differences and variation in uptake of opportunistic salpingectomy is really clear.

If there were national standards and opportunistic salpingectomy was being done at the same rate in other provinces in Canada that it's being done in B.C.... There are thousands of women who are going to get an ovarian cancer diagnosis that they do not need to get. They had an opportunity to have that cancer prevented and it was not taken, and that's just not acceptable. Women, wives, mothers, sisters, friends are going to die of this disease, and it's just not necessary.

Ms. Lisa Marie Barron: Thank you. It looks like this will be my last question, so perhaps I'll keep it quick.

To follow on that, Dr. Hanley or Dr. McAlpine, there was some mention today of the HPV self-screening happening in British Columbia. Can you provide some insights, since you are in British Columbia, on how that's going and how this might help to support increased screening for those who may not have access to health care for various reasons? Are there any other examples we might see that are similar to this?

● (1655)

Dr. Jessica McAlpine: We're really excited and proud in British Columbia with the self-screening. As you can imagine, it helps to reduce the barriers of tremendous geographic distance, history of trauma, those who have traditionally not been within the screening system, and the disproportionate number of minorities not getting screened. All of these opportunities are there, and it has been embraced incredibly well—even by people who have not yet entered the screening age group—with regard to how approachable and surmountable it seems now.

I think we're getting there in some other disease states as well. I'm proud to say that we have free testing for molecular classification in Canada and, again, some of the other initiatives we talked about, so we are feeling that there's empowerment in a community eight hours from Vancouver to try to do these things. We have molecular stratification in other cancers that are underfunded, like vulvar cancer 2, where we're getting to tools with more precision.

I think we can get there. I think we just have to make sure that it's across the whole country and that there is enthusiasm as well as and education for the value added.

The Chair: Thank you, Dr. McAlpine and Ms. Barron.

Next is Ms. Goodridge, please, for five minutes.

Mrs. Laila Goodridge (Fort McMurray—Cold Lake, CPC): Thank you.

I want to sincerely thank everyone for being part of this study and helping to make life better for women and girls and for Canadians in general.

At the back of our room here, I see a group of young women, and I was wanting to perhaps open this up.

Dr. Salvador, if you could give some advice to the young women at the back of the room and young women across Canada, what advice would you give them?

Dr. Shannon Salvador: I think the most important thing you can do is ensure that you're educated about your own health and what's available for you, and also what should be available for you, because sometimes what you don't know is what you should know. What can you do to improve your health? What is up and coming in the world?

It's about ensuring that you have done everything you can to maximize your health, that your vaccinations are up to date and that when you're going to see a health care professional, you have an opportunity to do some reading beforehand so that you can use the time to ask pertinent questions that are important for you and your family.

Mrs. Laila Goodridge: That's wonderful. Thank you. I appreciate that. I think it's very good advice, and I hope all women take you up on that piece of information.

In these conversations, we've had the conversation around the BRCA gene. There are screening tools in place that detect breast cancer. They're not perfect and they're not all great and they're not super-comfortable, but they exist.

What exists, as it currently stands, to take women who are diagnosed with breast cancer to make sure they have some tests done to ensure the cancer doesn't metastasize to gynecological cancers? Is anything happening in Canada that's similar to that?

Dr. Shannon Salvador: I can field that question.

I actually sat in with a breast cancer group just at the beginning of the year as they were starting to really ramp up their BRCA testing programs. It's becoming much more permissible to get BRCA testing in breast cancer. It actually used to be fairly strict, and now they realize they should really be augmenting who can get tested. Most programs in each province are opening up about really maximizing the testing.

For breast cancers, they are often doing it with blood testing, but what's interesting is that for our ovarian cancers that are at risk, we actually do tumour testing. We test the tumour itself when we're doing their surgeries. Then, once we know that a particular individual is testing positive for BRCA, whether it's in breast or ovarian cancer, we've been working very hard to try to maximize reaching out to family members and making sure that they know to contact pertinent blood family members so that they can come in and also get testing as well. The best thing we can do for anyone is prevention, by far.

Mrs. Laila Goodridge: I couldn't agree more.

I've been reflecting this week. It's a tough week. Fifteen years ago this week, I found out that my mom had breast cancer. About 11 months later, she passed away, unfortunately, and she passed away at 49. It was tough for our entire family. Because we lived in a rural and remote community, it prevented her from being able to have good screening early on.

Things have improved substantially in that time frame, but in this area, an ounce of prevention is worth a pound of cure. I'm wondering if anyone can share a bit more about best practices happening across the country that we can look to when it comes to prevention, because that's ultimately going to be where we're going to find help and save lives.

● (1700)

Dr. Gillian Hanley: I think there is a lot of really important research happening with respect to BRCA and detecting those mutations earlier. I know there are people who are part of the Gynecologic Cancer Initiative in B.C. who are looking at population-based testing.

We absolutely need to identify BRCA mutations as early as we possibly can in order to offer those people the prevention that we know works in both preventing breast cancers and preventing ovarian cancers.

There is a lot of interesting research happening on how to get people the testing they need as early as we possibly can in order to prevent the 20% to 25% of ovarian cancers in BRCA-mutated people. It should be preventable if we detect those mutations earlier. Unfortunately, often these mutations are being detected at the time of cancer diagnosis. We're really working very hard on ways that we can offer this testing to get those mutation results detected before any cancer has been diagnosed.

Mrs. Laila Goodridge: I want to thank you. That's great information.

The Chair: Thank you, Ms. Goodridge.

Next is Ms. Sidhu, please, for five minutes.

Ms. Sonia Sidhu (Brampton South, Lib.): Thank you, Mr. Chair.

I extend a heartfelt thank you to the panel from all Canadians. Thank you for the work you are doing.

We heard that eight women a day are diagnosed with ovarian cancer and 75% of them are in fourth stage. Definitely, women deserve better. Hearing that BRCA mutation is the only cause, and if the Pap test is not underlying, we can test for that, do you think the guidelines need to be changed?

My question is for Dr. McAlpine.

Can you say something about that? How can we protect women with ovarian cancer who are in the fourth stage and help them survive?

Dr. Jessica McAlpine: You're right. We don't have screening like we do for cervical cancer. We don't even have a heralding symptom like endometrial cancer, where you might spot or bleed. Usually when you have symptoms with ovarian cancer, it's already at an advanced stage.

There are very good international studies done in the U.S., the U.K. and Japan, none of which showed screening had a large enough impact on identifying people. That's really why we shifted our energies into prevention.

We talked a lot about BRCA. That's 20% of high-grade, serious ovarian cancers. That leaves 80% of patients who don't have a family history who are out in the community. They are what we call general risk. That's where we think we need to actually put our energies and motivation. When those individuals are having a surgery in their abdomen, we've moved from focusing initially on gynecologic surgeries: If you're getting a hysterectomy but they're going to leave the tubes, why don't you remove the tubes so that the cancer never develops?

We're also now moving into the general surgery forum. If you're getting gallbladder surgery or a colorectal procedure, your tubes are there and they are accessible. You have a skilled surgeon in the room. Can we remove those tubes so that the individual, 15 years later, doesn't develop ovarian cancer?

Otherwise, we're very challenged. We don't have a magic screening tool in our pocket.

Ms. Sonia Sidhu: Thank you.

Dr. Gillian Hanley: Can I add one thing to that?

Jessica did a wonderful job, but one thing I also wanted to mention is that we are now moving the research as well to try to target people who are at higher-than-average lifetime risk for ovarian cancer who might want to come in for a Fallopian tube removal surgery in order to prevent it. That's not because they have a BRCA or another genetic mutation, but just because we're able to predict risk for ovarian cancer reasonably well and identify a subset of people who could benefit from Fallopian tube removal to prevent their cancer.

Ms. Sonia Sidhu: Thank you.

Ms. Vrionis, your data suggest that only 35% of patients had prior knowledge of ovarian cancer. The majority either had limited awareness or had never heard of it.

What recommendation do you have to promote patient engagement and increased awareness about this disease to improve the chance of early detection?

● (1705)

Ms. Tania Vrionis: That is something we are focused on as an organization—improving that awareness, getting the message out and working with partners in doing that. I think it's really important to elevate this particularly with family physicians when they're recognizing these symptoms.

We do recognize that when a patient is coming in with symptoms, it is likely already late stage just because of the nature of this disease, but it's really important we keep this as a focus and make sure that we are highlighting this for all Canadians. It's an important part of women's health. It's important how it all fits in with our annual conversation with our doctors. Access to care is critical.

Ms. Sonia Sidhu: As a follow-up, research published in cancer research says that the incidence and burden of breast and ovarian cancer vary among racial groups. There's a higher incidence among white women, yet worse survival among Black women compared with other racialized or ethnic groups.

Could you share your insights on treatment based on the demographic factor?

Ms. Tania Vrionis: Yes. I wish we had more insights, to be honest. I think we're still learning. Again, this is a relatively new area of research that we're trying to understand.

When we as an organization reached out to our community in what we called our Every Woman Study, we actually that found our results came back very homogeneous. We had primarily white, well-educated women responding to our survey. We're working hard as an organization to reach into communities.

We do know, through a number of studies, that there are certainly challenges with culturally safe care. For instance, if ovarian cancer is suspected, what will happen in order to start the process of diagnosis is a pelvic exam, a transvaginal ultrasound and a CA125 blood test. They're quite invasive procedures in order to move this forward, so culturally safe care particularly is a real challenge that women stay away from. We know that a number of women are diagnosed in the ER, which is not ideal as well.

There is a lot that we still need to learn and understand. We're working hard to do that, but there are still lots of unknowns as well.

The Chair: Thank you, Ms. Vrionis.

Dr. Jessica McAlpine: May I—

The Chair: I'm sorry, Dr. McAlpine. We're well past time for this round. Hopefully, someone else will allocate some of their time to complete that topic.

[*Translation*]

Ms. Larouche, you have two and a half minutes.

Ms. Andréanne Larouche: Thank you, Mr. Chair.

Some of the witnesses touched on what's being done abroad. I'd like to come back to that with you, Ms. Dinh.

Canadian cancer statistics from 2023 suggest that increased efforts in primary prevention are needed to reduce the risk of developing cancer.

How do primary prevention measures that exist in Canada compare to those in other similar countries?

Ms. Valérie Dinh: Unfortunately, I'm not the best person to answer that question.

Ms. Andréanne Larouche: Would any of the other witnesses have a more international perspective and could answer that question?

[*English*]

Dr. Jessica McAlpine: Is that in terms of prevention or in terms of treatment?

[*Translation*]

Ms. Andréanne Larouche: Actually, I'll move on to my next question.

What evidence-based interventions used in other countries could be replicated in Canada to improve primary cancer prevention for women?

[*English*]

Dr. Jessica McAlpine: I guess in some things, I would say, for opportunistic salpingectomy, we're actually the global leaders. The statistics and uptakes on that are fantastic.

Prevention or screening is difficult anywhere in ovarian cancer. I would say that we all globally struggle. There are different models of population-based testing in other countries that I think are good examples and that I hope we move toward, and there's the risk-based assessment that Dr. Hanley touched on. I think some countries have better vaccination rates than we do that could be learned from. Some are worse.

I'll let others comment, but I don't think there's one country that's an example. I would say the defeating thing is that this lack of funding in gynecologic cancers is international, unfortunately.

● (1710)

Dr. Shannon Salvador: I would definitely agree with Dr. McAlpine.

Dr. Gillian Hanley: I agree with Jessica. As I mentioned in my speaking notes, Canada has really led the world in a lot of gynecologic cancer research and a lot of effective prevention and diagnostics. Endometrial cancer molecular classification started here. Opportunistic salpingectomy started here. With HPV-based screening, we're out ahead again. I think in that sense, we're not missing anything that's been done in other countries, but sometimes other countries have been more effective in ensuring equitable uptake and access.

The Chair: Thank you, Dr. Hanley.

We're past time, but Dr. Salvador, I don't think your mike activated when you started to speak. Please complete your thought as concisely as possible.

Dr. Shannon Salvador: Thank you.

I think the issue is that other countries might have more equal access across their entire country, whereas Canada has disparities, depending on where you are. We're quite ahead in some locations and maybe not so much in others, based on where you might be.

The Chair: Thank you.

Go ahead, Ms. Barron, please, for two and a half minutes.

Ms. Lisa Marie Barron: Thank you, Chair.

Dr. Hanley, can you tell us a little bit more about the communication strategies that you were referencing in your opening statement?

Dr. Gillian Hanley: I'm not an expert on how the federal government could communicate, but I think we have seen examples in the past of the federal government helping to get messages about health and wellness effectively out to all Canadians.

I think that it would be incredibly powerful to use that as a way to get messages out about gynecologic cancer to ensure that Canadians are aware of prevention opportunities like opportunistic salpingectomy and that all Canadians are aware that HPV-based self-screening is available to them. It's not available everywhere yet, but it soon will be.

When that is the case, it will ensure that all Canadians will know that they can order a test kit to their house, do this in the comfort of their own home when they want to, and know that this is more effective than Pap testing in terms of screening for cervical cancer. I think there's a tremendous opportunity to communicate these really important messages to Canadians.

Ms. Lisa Marie Barron: Thank you.

Dr. Vrionis, can you tell us a little bit more about the importance of appropriate training and professional development so that we continue to have practitioners with the most up-to-date information who are able to work together and ensure that the information is transferred to new practitioners coming into the field, and so on? How does that all relate to our moving forward in a more effective manner?

Ms. Tania Vrionis: I will certainly share a brief comment. I'm also not a doctor, so I might ask Dr. Salvador to comment on this.

I would say that we do know, particularly with family physicians, that many of them will not see a case of ovarian cancer in their lives. We've worked as an organization to create some connections between upcoming medical students and patients who are living with the disease. Because they don't see it that often, it's not something that is necessarily easy to detect.

I want to allow the expert to comment on that, if I may.

Dr. Shannon Salvador: When it comes to training gynecologic oncologists, quite frankly, we are an incredibly tight community. There are not many of us in Canada. I don't think people quite understand. We're talking about 250 gynecologic oncologists serving the entire population of Canada. We're training probably about anywhere from five to 10 per year. I know all of them personally. They trained me, and I've gone on to train the next generations of groups.

The field is becoming more and more complex. This is where we need the help, which traditionally hasn't happened before, to bring more medical oncologists, nursing staff and family physicians into our field of practice. We have some very dedicated medical oncologists who have been with us for the last 40 years. We're trying to get the next generation of medical oncologists to become interested in gyn-onc, which has sometimes been deemed not quite as exciting, because maybe they're not doing the most exciting treatments that they might see while they're treating their lung and colon cancers, melanomas and things like that. We are now breaking into that, and we really need our colleagues' assistance to come and join us here.

When it comes to training, the gyn-onc group people are very tight within themselves, but we need to start bringing in medical oncologists, family physicians and nurses to join our team.

● (1715)

The Chair: Thank you, Dr. Salvador.

Next is Dr. Ellis, please, for five minutes.

Mr. Stephen Ellis (Cumberland—Colchester, CPC): Thank you very much, Chair.

Thanks, everybody, for being here.

I had a couple of questions around potential years of life lost. For me as a family physician, that always had significant meaning. Often we talk about cancers happening in older folks, but aside from endometrial cancer, of course, gynecological cancers specifically have a significant impact on mainly young and middle-aged women.

Dr. Salvador, do you have some comments around that?

Dr. Shannon Salvador: Cervix cancer has some of the potentially largest impacts on that. Most women who are diagnosed with a cervix cancer are usually between the ages of 45 to 55. These women are in the prime of their lives. They're also launching their children, highlighting their careers and trying to take care of older family members, and then they are struck down by what can be quite a devastating cancer.

Cervix cancer can be really quite traumatic. Genetic-related cancers are typically also in young women and women in their mid-forties to early fifties, and this is for both ovarian and endometrial cancers. However, as our woman population is living longer and longer, we have to acknowledge that the average woman in Canada can live well into her late eighties, and it will soon probably be into her nineties. They're living well and living healthily into their seventies and eighties.

When you ask about lives lost, these are healthy women with no other medical issues who are then struck down by an ovarian cancer. Before, when their lifespan was maybe into their late seventies and early eighties and they were getting their cancers at that time, all right, but now we're talking about women who had the potential to live for another 10, 15 or even 20 years.

Mr. Stephen Ellis: Thank you very much for that.

One of the other questions is around the salpingectomy, for instance, with a vaginal hysterectomy.

I apologize, because I've forgotten who the expert is in robotic surgery.

Dr. Shannon Salvador: That would be me.

Mr. Stephen Ellis: Okay. That's you. Good. I'm sorry to pick on you again.

I practise in Nova Scotia, and we have a very robust gynecological oncology program. It's very centralized. The difficulty, of course, is travel. Certainly in smaller rural hospitals, we're not seeing robotic surgery other than for cholecystectomies. That's basically where we are. There might be appendectomies, depending on who's working.

However, the difficulty is talking about salpingectomies, for instance, with vaginal hysterectomies. Does that create a bigger issue for local gynecologists to be able to do them?

Dr. Shannon Salvador: Actually, no. The nice thing about a salpingectomy—Dr. McAlpine can definitely speak to this, as well, as they did large educational programs on it—is it's actually a fairly easy thing to add to a surgery that's being done anywhere near the pelvis. That's why they're branching out in their colorectal and general surgery teams, because if you're there to take out an appendix, it's a pretty easy thing to also pop out a couple of Fallopian tubes while you're down there. Even at the time of doing a vaginal hysterectomy, it's fairly easy to move the Fallopian tubes into the vagina to be able remove them safely and allow the ovaries to stay behind.

Mr. Stephen Ellis: Thank you for that.

For any of you who have seen it, it's not really that easy. I was not a gynecological surgeon. Anyway, that's a whole other story.

One of the other issues across this great country—whoever feels like answering this, feel free—is Pap test screening. First of all, you have the issues with access. For instance, if you are a female, do you want to see a male physician like me? Those things present some difficulties and require creative answers.

However, it's the recall process that worries me the most. First of all, we don't know who's actually getting a Pap test with respect to who should be getting one, and then once you have a Pap test, you never get the answer back. You have to rely on the physician to say this is good, bad or indifferent and say that you need a recall, etc.

Even if we create a process with HPV testing at home, the recall process is something we will have to really look into. Has anybody put any thought into that? I have some ideas, but if you have a better idea, I'd love to hear it.

● (1720)

Dr. Jessica McAlpine: I can comment a bit, as we've rolled this out in British Columbia with self-screening.

We also have a crisis, which has been mentioned by many of the members already, of a shortage of family physicians. There are clauses in there for how to deal with a result if you don't have a family physician and how to deal with the result if you do, and how to engage them. It actually piggybacks onto the same system of vaccine notification and availability that we used for COVID in the provincial program, so it comes to their phone and it comes to an app to be able to inform them. It is also sent to their physician if they have one.

I'm encouraged, because with the system before, from a couple of months ago, it became increasingly challenging if we didn't have a primary care physician. I think we have the tools now to do this and to do this well.

The Chair: Thank you, Dr. McAlpine and Dr. Ellis.

Next we're going to go to Dr. Hanley—the one from Yukon—for five minutes.

Mr. Brendan Hanley (Yukon, Lib.): Finally, I get to speak.

I'll start with Dr. Hanley.

Rather than engage on what common relatives we might have, I just want to ask about salpingectomy. You mentioned how effective it is. You referred to a study. You don't give a lot of detail, for good reasons.

I'm just wondering if you could give us an overview of what we have learned about the actual effectiveness and what the numbers are. How many do you have to do to have a positive outcome? Where are we going with the literature to really support the expansion of this technique?

Dr. Gillian Hanley: There should be a really easy answer to this question. Unfortunately, there's not, and that's partly because we're still in fairly early stages of the research.

As you may be aware, the average age of diagnosis for ovarian cancer is 61. We actually do these opportunistic salpingectomies on people who on average are in their early forties. We haven't had all the follow-up time that we need to really answer that question.

Our 2022 article in JAMA Network Open was the first prospective study of opportunistic salpingectomy done for the purpose of ovarian cancer prevention. It is important, because it means the surgeon is removing the entire fimbriated end of that Fallopian tube to really reduce the risk.

In that study, we saw zero high-grade serous cancers in the approximately 26,000 people who had an opportunistic salpingectomy. This was statistically significantly lower than the number that we would have expected to see if the cancers had been arising at the same rate as they were in the control groups, which were people who had hysterectomy or tubal ligation alone.

We haven't had enough follow-up time to give the specific number needed to treat, but we have a lot of preliminary evidence that suggests that opportunistic salpingectomy is going to be very effective at reducing the risk of high-grade serous ovarian cancers.

Mr. Brendan Hanley: Thank you.

I guess there's a common theme around implementation. How do we move forward and make things more uniform in areas where we see successes?

I'm equally...I don't know if it's “shocked”, but certainly it's quite alarming to see the recent rise in cervical cancer incidence when this is probably the most preventable cancer there is. There seems to be a bit of a disconnect here.

Dr. Salvador, I think you were talking about this as almost like an older demographic, one that would not have been in the vaccine cohort. I'd like to dig a bit more into that. Are we seeing this in peer countries?

I heard Dr. Gina Ogilvie, I think it was, talking on the radio just the other day about how amazing the Australian vaccine cohort results are. They are on track for elimination. At the same time, we're seeing this kind of separate phenomenon in the presumably older demographic.

Can you unpack that a little more for us?

● (1725)

Dr. Shannon Salvador: I think the thing that also disturbed me the most when that data came out is that the data collection ends at 2019, and we all know what happened in 2020 and the years thereafter.

If we thought there was a problem with screening going up to 2019—because I think the majority of the issue was probably that women were not getting screened or were being screened late—we're going to have a major uptick, I think, once we get the 2020 to 2024 data, because the screening dropped off drastically. It hasn't gone back up to the levels it reached before because of lack of access. People were not being screened during the COVID years, and then even when screening was restarted, people were not having access to locations to get screened.

I think we're actually on track to get another big shock with the next collection of data when it comes through, unfortunately.

Mr. Brendan Hanley: I'll have to cut you off because I'm almost finished my time.

I think this may segue into what Dr. Ellis was asking about, which was self-testing.

Is there an opportunity here that we can kind of leapfrog into expanding and widely implementing HPV self-testing as a way to get this back on track?

Dr. Shannon Salvador: I absolutely think so. That's actually one of my desired mandates when I take over as president of GOC. I want to get all the partners at the table to talk about how to bring HPV self-testing to this entire country.

As you mentioned, it really requires a strong provincial program of database collection, and again British Columbia has among the strongest programs in the country. They know who has been tested, who hasn't been tested and when they were last tested. They send recall letters to remind people that it's time for testing. The provinces that are looking to create a program, if they don't have one, should really use B.C.'s program as a model to move forward.

I agree completely that adding HPV self-testing and going in that direction is a strong recommendation.

The Chair: Thank you, Dr. Salvador.

Next we have Dr. Kitchen for five minutes.

Go ahead, please.

Mr. Robert Kitchen (Souris—Moose Mountain, CPC): Thank you, Chair.

Thank you all for being here. It's a great pleasure to have you here, and the tremendous amount of information you have provided for our report and for Canadians who are watching is greatly appreciated.

I come from Saskatchewan, very rural Saskatchewan. My riding is 43,000 square kilometres, and yet it's not the biggest riding. I had many patients who travelled quite long distances to see me. The unfortunate part for us in the southeast corner of Saskatchewan is that we don't have a lot of family practitioners who have skills and knowledge in the gynecological area, so I think a lot of things get missed.

Your comment, Dr. Salvador, about the self-screening is tremendous, because when we talk about HPV self-screening, I would say to you that I would bet that maybe only 5% of the population knows it even exists.

To further emphasize that, though, what sort of costs is that going to involve?

Dr. Shannon Salvador: That's one of the things we've debated in discussing how to a create a program and whether you create an opt-in program or an opt-out program.

As you can imagine, an opt-out program would be incredibly expensive. That would involve mailing a self-testing kit to every person who was available and then seeing who mailed it back. I don't know, from a cost analysis standpoint, whether that would actually work out.

I think if you were going for something like an HPV self-testing program, you'd have to go for letters of introduction, followed by an opt-in, and then send a test to someone who requested it. You would then be more likely to actually get that test back and be able to do that screening.

Definitely health costs are a huge consideration for those types of programs.

Mr. Robert Kitchen: Given those huge challenges, would you see this more as a national program or a provincial program?

● (1730)

Dr. Shannon Salvador: That is obviously a very huge challenge.

Currently it obviously falls under each province's responsibility to create its own program. The big issue, again, with it being just provincial is that people move. When someone crosses a provincial border, it's a little bit like starting all over again in terms of their medical health. You may not have access to records of things that were previously done. Records can't move across a provincial border unless the patient physically brings them.

The best screening program would be a national one in which access to patient information about previous screens would be available for all people across the country.

Mr. Robert Kitchen: Thank you.

As you are probably well aware—although the general public isn't well aware of this—the reality is that HPV goes back to Neanderthal times. We first found out about HPV, I believe, in 1949. Strauss et al. discovered it, and the reality was that it was done using an electron microscope.

When I started practice, the electron microscope was the testing device of the day, but the reality is that we've seen it out there. The vaccine was basically found in 2008, and again that's public knowledge that we need to get out to Canadians to truly understand the value.

The challenge we have is the cost of that HPV vaccine, because there is a perception out there that it is free, but it isn't. In some cases they're talking about $300, $400 or $500 for people who just can't afford it.

Do you have any thoughts on that?

Dr. Shannon Salvador: That's definitely a challenge.

We are currently vaccinating the majority of children across the province with something called Gardasil 9, which protects against nine types of HPV. They get two vaccinations six months apart. When someone is outside of that young children's program, then yes, the cost falls upon the individual.

Once someone is past the age of 18—which has been set as a bit of an arbitrary marker—they no longer mount the same immune response, so it requires three vaccinations. That's the point at which this starts approaching $600, and for a person who has not had the opportunity to be vaccinated as a child, that's a shame.

Mr. Robert Kitchen: Thank you.

I'll touch briefly.... I don't have much time, but one of my concerns is when we look at the rural practitioners. How do we educate them? What suggestions would you have that we can put out there for our future primary care practitioners so that they're educated enough to understand the steps that need to occur? They see it in school, but oftentimes, if it doesn't become part of their practice, it gets missed. Could you comment on that?

Dr. Shannon Salvador: Some of the groups that we are bringing to the table are the family medicine practitioner national societies so that they can help distribute the information to their bodies as well. Obviously, these physicians have to go through continuous medical education. We all do. It's a requirement as part of our practice. Whenever we get new information or have new things to inform family physicians about and to help with their education, we reach out to their conferences—we all do this—and we send experts to their conferences to speak and allow the dissemination of information in each of the provinces.

The Chair: Thank you, Dr. Salvador.

Dr. Jessica McAlpine: I would add very quickly that for each initiative, we have tool kits and education, things that we're trying to build for family practitioners and general gynecologists, not just the cancer specialists in the room. Those are things that probably could use better funding and support, but those are priorities. I agree that they are incredibly important, and that's what we're working towards.

The Chair: Thank you, Dr. McAlpine.

Next we have Dr. Powlowski, please, for five minutes.

Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.): If I could ask a kind of pre-emptive question—because I'm going to ask a whole bunch of other ones—we've heard quite a bit about the Canadian Task Force on Preventive Health Care and its recommendations with regard to breast cancer. How involved is it in making recommendations on other kinds of gynecological screening and/or treatments, like salpingectomies?

Maybe I could ask you, Dr. Salvador, since you cover all of these and you're here.

Dr. Shannon Salvador: In terms of salpingectomies, Dr. McAlpine, did they actually come out with a statement directly on that?

Dr. Jessica McAlpine: Not that I'm aware of.

Dr. Hanley, do you...?

Dr. Gillian Hanley: No.

Mr. Marcus Powlowski: Okay. That's kind of interesting, because certainly we've heard, on the breast cancer study, questions about its recommendations.

Can I go to Dr. Hanley—the real Dr. Hanley, not the useless guy sitting beside me?

Voices: Oh, oh!

Mr. Marcus Powlowski: I think it was you who talked about a JAMA study, I think it was, on salpingectomies. There were 26,000 women who had salpingectomies, and none of them got ovarian cancer. Then you did mention.... How many were in the control group? I assume there was a control group of 26,000. How many were there, and was that statistically significant?

● (1735)

Dr. Gillian Hanley: Yes, for the control group, we included basically the surgeries that women would have gotten prior to the recommendation that salpingectomy be included. Those were women who had hysterectomies alone, so their Fallopian tubes got left behind, or women who had tubal ligations, so their Fallopian tubes were tied rather than removed. That was our control group. There were 32,000 of them, and there were 15 cancers in that group.

Again, because these women are still quite young, this is not reflective of the number of cancers we expect to prevent. The average ages in these groups were 42 in the salpingectomy group and 41 in the other group, so we're nowhere near, with the follow-up that we have, the upward age of diagnosis of ovarian cancer. However, we've already seen the statistically significant difference in these groups at this very early stage, so that's very promising in terms of the risk reduction that we can expect.

Mr. Marcus Powlowski: Correct me if I'm wrong, but actually having worked quite a few years in developing countries where I did surgery, did tubal ligations and operated on a fair number of ectopics, am I right that it's not technically very much more difficult to just take out the whole tube? Is there like an extra tie? How much more work is it?

Dr. Jessica McAlpine: We did a study on it. On average, it adds about eight minutes, and it's minimal blood loss. With regard to the developing country point, my resident just came back from Kenya, where they're doing opportunistic salpingectomies.

Dr. Gillian Hanley: Yes. In our colorectal surgery trial, the colorectal surgeons see that the average additional time in the OR has been four and a half minutes to remove the Fallopian tubes, so it's not difficult and it doesn't take long.

Mr. Marcus Powlowski: My question, then, is this: What's the problem in getting greater uptake? I think you said something about.... What is the number? Is it 80,000 people per year who get tubal ligations? If those were all salpingectomies, you figured it would decrease the number of cases of ovarian cancer by 1,000. Is that right? Can you just repeat those numbers?

Dr. Gillian Hanley: That was a study we did that looked at hysterectomies and tubal sterilizations across Canada. What we found was that between 2017 and 2020, 80,000 Canadians received a tubal ligation or a hysterectomy without a salpingectomy, so they missed the opportunity to have their Fallopian tubes removed. This is well into the time when we were recommending opportunistic salpingectomy: The SOGC formally recommended it in 2015. That will translate into a possible thousand future cases of ovarian cancer that could have been prevented if that opportunity had been taken to remove those Fallopian tubes.

Mr. Marcus Powlowski: Why isn't there greater uptake of surgeons doing a salpingectomy instead of a tubal ligation? Maybe I could get several people to comment. Is it the lack of evidence, or what is it? It doesn't seem like it takes much more time at all.

Maybe I can start with you, Dr. Hanley, and then I can ask a couple of the other gynecological surgeons.

Dr. Gillian Hanley: You know, I think there was some hesitancy. There were some concerns around possible additional complications. I think the research has really addressed those concerns and shown that complications are not a risk. I do think there were some surgeons who were waiting to see the evidence of effectiveness. Now we have evidence of effectiveness, and so I hope that will change minds.

Then I think that there's just some degree to which the message still has not reached all surgeons, which is unfortunate and something that we're trying very hard to change. We've been speaking with all the provinces where rates have been lower.

The Chair: Thank you, Dr. Hanley.

Dr. Jessica McAlpine: I would say it's knowledge translation. If you're not talking about it and your patient is not asking about it and your residents aren't bugging you to do it, it's easier to just not do it. I think that speaks to some themes you've heard today—that if there's good science, you still need to talk about it and bring it to the places where people are maybe too busy to go to that national meeting or haven't been taking part in CME. How can we notify them and keep people educated?

● (1740)

The Chair: Thank you, Dr. McAlpine.

Dr. Salvador, I'll get you to hold that thought. Dr. Powlowski's actually going to get another turn, and he probably will give you some time then.

[*Translation*]

Ms. Larouche, you have the floor for two and a half minutes.

Ms. Andréanne Larouche: Thank you very much, Mr. Chair.

Dr. Salvador, you talked about HPV vaccination to prevent cervical cancer. In fact, I'd like to hear the opinion of other witnesses who would like to comment on that.

The World Health Organization has called for the global elimination of cervical cancer. Do you think Canada is on track to meet the WHO targets by 2030?

[*English*]

Dr. Shannon Salvador: That's a very good question.

Under the CPAC there is a very distinct guide and layout on Canadian goals on how to eliminate cervical cancer and meet our World Health Organization goals. Currently, if you go through year by year, you see we've fallen behind on those goals that were laid out in that very distinct and quite comprehensive document because this was first created as COVID struck.

The vaccination rate is one of the biggest concerns that they highlighted in that layout. Right now the main part of that goal is to get our vaccination rate back up to over 90% by the end of this decade, and that is not on track right now for us.

There are also parts about being screened—again to 90%—for HPV. We've fallen quite some way behind there. Access to colposcopy is the one thing we are maintaining, but that's also because we're not seeing the numbers that we were expecting to see. The colposcopy clinics are meeting their goals of being able to see people very quickly once they're diagnosed with their HPV.

For us to meet that 2040 goal with the WHO, we have a lot of work to do. I think Canada can still do it. It just requires us to really get back on track and meet together, as the invested parties at the table, to look at that document again and meet these goals that we've already set as a nation.

[*Translation*]

The Chair: Thank you, Dr. Salvador and Ms. Larouche.

[*English*]

Next is Ms. Barron, please, for two and a half minutes.

Ms. Lisa Marie Barron: Thank you.

Dr. Salvador, in your opening comments, among other things, you had mentioned.... I wrote down the words that you said. You said that there is a "backsliding" of prevention. I'm wondering if you can expand a little bit on what you meant by that.

Dr. Shannon Salvador: That is related to the cervix cancer issues. When you look at the numbers pre-2015, you'll see that our cervical cancer rate was actually dropping very nicely. It was going down right on track and in the way that we were expecting it. If you look at the projected numbers that were going out from the previous cancer report, you'll see that they were expecting it to continue to drop. That's why this report that came out in 2023, just a few months ago, was quite eye-opening to all of us, because that had not happened.

That is where I see the backsliding. We need to pay attention again. I think we've gotten a little bit lax and have thinking, "Oh, okay."

As we all commented, this is the easiest, most preventable cancer. We have a vaccination, and we have a long prodromal period in which we can identify people with precancer lesions.

I think it's just a matter of telling ourselves to wake up again. It does require all of us to re-educate ourselves.

Ms. Lisa Marie Barron: Thank you.

There's another thing that I'm curious about, if you can expand on it, Dr. Salvador. You were talking about the costs associated with the HPV vaccination after 18. I believe what you said was that there is a cost for those 18 and older. I'm wondering whether you can provide some reflections on the impacts of these costs and the ripple effects of people having to pay for these vaccinations once they are over 18 years of age.

● (1745)

Dr. Shannon Salvador: If someone has not been vaccinated as a child, then once they're past the age of 18, they will incur those costs themselves in most of our provinces. There are some provinces that will help to cover the vaccination for people who have already been diagnosed with a lesion. That's a little bit of a backstep—just because they have been diagnosed with a lesion, you don't want them to miss the boat. The hope is that they can get vaccinated before that is the case, but definitely offer it to everyone.

For some of the women I've met in the colposcopy clinic, it is a detriment to being vaccinated. They cannot afford it. We discuss it. I even have a very dedicated nurse who negotiated with our pharmacy group there to actually offer the vaccination at a reduced cost for them. This is how much we valued it and how important we thought it was to get it done. It is definitely preventing some women from being able to get vaccinated themselves.

The Chair: Thank you, Dr. Salvador.

Next is Dr. Ellis, please, for five minutes.

Mr. Stephen Ellis: Thank you very much, Chair.

I don't think I'm belabouring this point, but I do believe that this novel screening program is the future and is where we need to go. I think we need to be clear to Canadians about a couple of things.

One is those routine immunizations. They need to get them. We're falling behind on everything. I think that's incredibly important. These are well-proven immunizations, and they work. I think that's one important point.

The second point is this: What would the best program look like? Perhaps you could walk us through the steps. You do self-screening. I assume you do a swab at home. You send it in. Then what? If it's positive, do you end up going directly to colposcopy? Do you have a Pap test after that? Perhaps you could give us a very brief outline.

Dr. Shannon Salvador: Absolutely.

For HPV testing, we are currently going to be recommending that women get swabbed once every five years by whatever method that they do it. That's different from Pap testing. That has to be more frequent at that point in time.

If someone has a negative result, great: The next time they need to get swabbed is in five years. If someone has a positive, we do the subtyping on it. If it's one of the higher-risk subtypes, the 16 and 18, which are the high-risk subtypes, then those patients go directly to colposcopy.

If you had a national program that was reviewing these results, you could offer the patient the ability, if they wanted, to discuss it with a local health care professional, who would have to be employed by the province, and they could get that done if they have done self-testing. They could even be offered a virtual consult about that. They wouldn't necessarily have to physically come in; they could be offered a virtual consult. As we have seen with COVID, we managed quite nicely with a lot of virtual consults.

They could be given the information, and then they could be directed to the nearest colposcopy centre, which could, again, just be handled through a paper means of getting the consult, and they could be seen in colposcopy and then dealt with via the guidelines on what we recommend.

If it's someone who has one of the other subtypes that can be high risk, at that point in time we do offer reflex Pap testing to see if there's any development of a lesion.

If someone has had the HPV test in a clinician's office, it's often liquid-based, which means they can automatically do that cytology, the Pap test, on the liquid. It does not require someone to come in. However, if someone is self-testing at home, that is actually a dry swab. It is a different type of swab. They would then be required to come in for a visit.

Each of those things needs to be addressed in whatever area you are setting this up to make sure that all of those different components are covered.

Mr. Stephen Ellis: Great. Thank you very much.

I do apologize, but there is one thing that I would like. Hopefully, we can take of it very simply. It's seeking the unanimous consent, Chair, of the committee for this motion:

> That, given the recent situation in Belleville, Ontario, which had to declare a state of emergency after responding to 23 overdose incidents in the span of less than two days, the committee call the mayor of Belleville, Neil Ellis; the Belleville chief of police, Mike Callaghan; and other experts to appear before the committee at the earliest convenience, no later than Friday, February 23, 2024, and express its concern to the House.

Again, I apologize for that, but it needed to be said. It's an urgent situation.

Thank you all.

The Chair: I presume you're putting that on notice.

Mr. Stephen Ellis: That is correct.

The Chair: Okay. Thank you.

Mr. Stephen Ellis: I'm seeking unanimous consent for that, Chair.

The Chair: We can do anything by unanimous consent—

● (1750)

Mr. Stephen Ellis: Yes.

The Chair: —but otherwise the motion hasn't been given two days' notice.

Mr. Stephen Ellis: That is correct.

The Chair: Absent unanimous consent, it would be out of order.

Mr. Stephen Ellis: Correct.

The Chair: Do we have unanimous consent to adopt the motion presented by Dr. Ellis?

We do not.

Dr. Ellis, you still have about a minute and a half.

Mr. Stephen Ellis: Great. Thank you very much.

When we begin to look at systems here, obviously we know that there are incredible ideas that exist. This is something that I think all of us around the table suffer with, which is that the provinces are practising in silos.

Is there anybody around the table who has an idea of how we get this information out? We don't have a lot of leverage here at the federal level, but how do we encourage provinces to say, “Let's work together on this and let's make it happen.”?

I'd be happy to hear those ideas, because there's a significant difficulty.

Don't everybody raise their hand at once. I get that.

Dr. Shannon Salvador: I think it's a matter of knowing the champions in each province.

I collect names. I know people. It's a big part of what I do. It's making sure I know who the champion is in each of the provinces to reach out to because they know the issues in their province and they can bring them forward to the table.

That is how you have to break down silos.

Mr. Stephen Ellis: Excellent.

Thank you, Chair.

The Chair: Thank you, Dr. Ellis.

The last round of questions for this panel will be posed by Dr. Powlowski for the next five minutes.

Mr. Marcus Powlowski: Why don't we start with Dr. Salvador, who didn't really have a chance to address this question on ovarian cancer and salpingectomies. Should the Canadian Task Force on Preventive Health Care make a recommendation with respect to this? How much would this help to address the fact that people aren't doing them as much as perhaps they ought to be?

Dr. Shannon Salvador: I think it would absolutely be useful.

Our society of obstetricians and gynecologists, as well as the societies in the United States and most of the societies in Europe, have all come forward to make statements saying that we should be doing this, so having the Canadian task force also come forward would be useful.

Mr. Marcus Powlowski: Just for the record, Dr. Hanley and Dr. McAlpine, since this would go into our recommendations, do you recommend the same thing?

Dr. Gillian Hanley: Yes.

Dr. Jessica McAlpine: Yes.

Mr. Marcus Powlowski: Thank you.

I want to switch over to cervical cancer and our backsliding on this issue. Believe it or not, I hate to actually get into the politics of it, but why are we seeing decreased vaccination rates?

Maybe I'll just limit it to you, Dr. Salvador, since you're kind of the generic expert on it and the lead with the Canadian gynecological cancer association.

Dr. Shannon Salvador: I think a lot of it has to do with how strong the provincial message has been about cervical cancer. When you have a province has a very strong database, moms are watching themselves getting called to come and get their pap test—“Come for this, come for this, come for this.” If they themselves have then ever had to go for a colposcopy, it's really at the forefront of their brain when they're making decisions about vaccinating their own children.

If you have a very strong and robust message coming from your province that this is an important issue and that they should get screened, any woman in the room knows how it is to get screened. It's not pleasant, so if they can prevent that for their own children, they would absolutely go for it.

Mr. Marcus Powlowski: Do you want to just briefly mention the value of vaccinating boys for HPV?

I have two teenage boys. When I first read the request for consent, I kind of went, “What? Boys?” I would assume that it relates to herd immunity. How many potential deaths are you saving by vaccinating boys as well?

Dr. Shannon Salvador: It's actually related to two things. It's not just related to herd immunity, which is obviously beneficial; you're also preventing the other cancers.

Men have a high risk for anal cancer and throat cancer. Yes, they don't come until much later in life and are usually things that are now happening in their 60s and 70s, but if you ask any of the ear, nose and throat doctors, the ENTs, they'll say that because smoking has dropped so significantly, they're no longer seeing throat cancers due to smoking causes. All of them are HPV-related now.

● (1755)

Mr. Marcus Powlowski: How much time do I have left, Chair?

The Chair: You have a minute and a half.

Mr. Marcus Powlowski: Okay.

Let me get to my moon shot question. I think it was Dr. Hanley who said something about the goal of a 50% decrease in cancer deaths by 2035. Maybe you could just reiterate that for me, because I didn't really hear it.

Let me say that President Biden, in one of their moon shots, is endeavouring to decrease the number of cancer deaths in the United States by four million by 2047, which is 25 years from now. Should Canada be making a similar effort to decrease cancer deaths?

Anyhow, let me start with Dr. Hanley, and then maybe I'll move on to some of the other people in the room.

Dr. Gillian Hanley: At the gynecologic cancer initiative in British Columbia, where we're working across disease sites and across institutions and across disciplines to address all gynecologic cancers—because we can learn from each other, as I think you've seen here today—we have a goal to reduce death and suffering from gynecologic cancer by 50% by 2034. We put this in place in 2019. This includes prevention of cervical and ovarian cancers. It includes improving treatments for endometrial cancer. It includes improving survivorship for those living with and beyond gynecologic cancer.

We have a very complex plan that we would be very happy to share with you if you want to come and visit us in B.C.

Mr. Marcus Powlowski: That would be great. Thanks.

Dr. McAlpine and the others here in the room, could you give a quick answer? We're running out of time.

Dr. Jessica McAlpine: I have nothing to add over what Gillian said, except to say that the science and the initiatives are there. We need to use them.

Mr. Marcus Powlowski: Other people in the room...?

Thank you.

The Chair: Perfect. Thank you very much.

That concludes the rounds of questions for this panel, but it doesn't conclude our meeting, colleagues, so don't run away. We still have 30 minutes of in camera business to deal with.

To the expert witnesses before us today, thank you for being with us. I expect that you're incredibly busy people. We certainly appreciate the professional and patient way in which you provided such comprehensive answers. They will be of great value to us in this study. Thanks for what you do for your patients and thanks for being with us today.

We will suspend briefly while we switch to our in camera meeting.

[*Proceedings continue in camera*]