Cholangio-Hepatocellular Carcinoma Canada (CHCC)
Volume 2, No. 4 December 2025

Inspiring Hope Together

Welcome!

Welcome to the fourth issue, volume 2 of the 2025 Cholangio-Hepatocellular Carcinoma Canada (CHCC) newsletter.

Gearing up for "Light it green" campaign on Feb 19, 2026

The committee members from CHCC and C3 have been meeting regarding the Cholangiocarcinoma Awareness month and day for 2026. We will have some samples of posters and signs in January for everyone to see.

ESMO 2025: mRNA-based COVID vaccines generate improved responses to immunotherapy.

Researchers at MD Anderson Cancer Center have observed an association that "cancer patients who received mRNA COVID vaccines within 100 days of starting immunotherapy were twice as likely to be alive three years after treatment as those who never received a vaccine. This has prompted a randomized Phase III trial to determine if mRNA COVID vaccines should be part of the standard of care for this type of therapy."
Read more here.

Clinical trials that are happening across the country

All-comer trials in HCC or BTC:

ARTEMIDE-HCC01 AstraZeneca
Click link here for details.

ARTEMIDE-Biliary01 AstraZeneca
Click link here for details.

Biomarker specific Clinical Trials

IDH-1 biomarker: Tibsovo (ivosidenib) Servier
Clinical trials for cholangiocarcinoma (CCA) patients with the IDH1 biomarker are still recruiting in Calgary (Arthur E. Child), Toronto (PMH and Sunnybrook).

HER2 expressing tumours: Trastuzumab deruxtecan (T-DXd) AstraZeneca
Click on the hyperlink to clinicaltrials.gov details for DPT-02 with listing of sites across Canada and US. NCT04482309

Destiny BTC01 AstraZeneca *T-DXd and Rilvegostomig Versus SoC in* ***Advanced HER2-expressing Biliary Tract Cancer***
Click on the link here for more details.
NCT06467357

Phase 3 trial in HER2+ BTC Jazz Pharmaceuticals
An Open-label Randomized Trial of the Efficacy and Safety of Zanidatamab With Standard-of-care Therapy Against Standard-of-care Therapy Alone for Advanced HER2-positive Biliary Tract Cancer. Recruiting in 3 sites: Toronto (PMCC), London and Montreal. Click link for more details. NCT06282575

CLARITY-PanTumor01 AstraZeneca *for tumours expressing* ***Claudin 18.2*** *biomarker*
Click on link here for more details.

Phase 1 clinical trial for the Safety of BAY 3547926 Bayer
This trial is for patients with advanced liver cancer and recruiting happening in Quebec, Ontario and Alberta ClinicalTrials.gov ID NCT06764316 (click on hyperlink)

Phase 1/2 clinical trial for Cogent Trial Drug CGT4859 Cogent Biosciences Inc.
This is a FGFR2/3 inhibitor drug. For more information contact Diane Arndt RN, BScN, Lead Nurse at (phone) 780-989-8157; (fax) 780-577-8138 or email at diane.arndt2@albertahealthservices.ca

Tinengotinib access. *The success of Tinengotinib is on this link. If you wish to participate in the clinical trial in USA, please contact Priya Priyadarshini at priya.priyadarshini@syneoshealth.com.*

Clinical Trials Map that you can access yourselves, thanks to Matt Reidy at Genomic Focus..
Click on the link www.clinicaltrialsmap.org

Patient care kits

Thanks to AstraZeneca, Incyte, Merck and two local dentist's office, in Red Deer and Edmonton, we can provide patient care kits for new patients diagnosed with either cholangiocarcinoma or hepatocellular carcinoma. Your well-being is our priority. If you know anyone who is newly diagnosed or without a patient kit, please click on this link.

Mentorship program

A CHCC mentorship program started in April 2025. This program provides a supportive network for those affected by cholangiocarcinoma and hepatocellular carcinoma, offering guidance, shared experiences, and emotional support. To access a mentor (as a mentee) or to volunteer as a mentor, please click on this link. We look forward to working with both mentors and mentees.

Meet-ups across the country (Please let us know of any other local meet-ups so we can include them so everyone has a chance to join.)
Winnipeg - Meet ups on hold until the new year, 2026.

Calgary – Meet up on the last Wednesday of every month. As of January 2026, the venue will be changing monthly as the patient group wishes to try different venues across the city. Everyone is welcome to attend either meet-up. If anyone requires more information go to Cholangio-Hepatocellular Carcinoma Canada.

Register for the Canadian support groups

To register, please click on the following links:

- Bereavement Support Group (Register)
- Canadian Advocates Meeting (Register)
- Patient Support Group (Register)
- French Support Group (Register)

Thanks in advance for reaching out.

Register for the upcoming CCF conference in May 2026

Click on the link to register for the conference May 1-3, 2026 in Salt Lake City. Patients can apply for a scholarship to attend using the same link. Applications have to be submitted by Jan 13 and the successful applicants will know by Jan 31, 2026.

Register for the upcoming AMMF European Cholangiocarcinoma conference in May 2026

Click on this link to register for the conference in UK on May 12-15, 2026.

Biomarker testing

As of December 31, 2025 C3 will not be covering the cost of the biomarker testing. Information for your physicians can be obtained from C3 or CHCC. The cost is approximately $2000 -$2200.

Patient Story Corner.

In every newsletter, we invite you to share your patient stories. Thank you for sharing as your experiences of hope and encouragement can make a difference in the lives of other patients. You are not alone in this journey. If you'd like to share your story, please contact info@mychcc.ca .

TC’s Story: A Journey Through Cholangiocarcinoma

On January 3, 2025, I received a diagnosis I never expected: cholangiocarcinoma. What began as a routine follow-up CT scan after my hysterectomy revealed a golf-ball–sized tumor in the bile ducts of my liver. It was stage two — a shocking discovery, but one I’m incredibly grateful was caught early.

Because I was born with two portal veins instead of three, the tumor's location made surgery more complex. I first underwent portal vein embolization to ensure the remaining portion of my liver would function properly after resection. Two weeks after that procedure, I faced major liver surgery where 45% of my liver and my gallbladder were removed. Thankfully, there was no spread.

Recovery from the resection was one of the hardest experiences of my life — physically, mentally, and emotionally. After a month of healing, I began six months of adjuvant chemotherapy with capecitabine. I was fortunate to experience mostly manageable side effects: I lost my fingerprints (still waiting for those to return!), had mild hair thinning, swollen hands and feet with blisters, and deep fatigue. The mental rollercoaster, however, was the biggest challenge — and sometimes it continues to be.

Throughout treatment, I supported my body in every way I could. I juiced fresh vegetables, used the sauna 5–7 times a week, soaked my feet in Epsom salts, and incorporated oxygen therapy, red-light therapy, massage, acupuncture, and high-dose vitamin C IVs. I also focused on eating clean — cutting out sugar, dairy, and gluten by about 90%. I truly believe these choices helped keep my symptoms minimal.

In October, I completed chemotherapy. My scan showed NED — no evidence of disease — and ringing the gong at the Arthur Child Cancer Centre was one of the most emotional, relief-filled moments of my life.

Today, I feel good. I still navigate fear and the occasional negative thought, but I continue reminding myself: *I am healthy, I am healing, and I am profoundly grateful.*

To anyone facing their own cancer journey, I am sending you the BIGGEST hug and all the healing, healthy energy in the world. We are truly in this together.
—TC

LM's Story: My Beautiful Fatty Liver

Our journey with cancer has been about more than the life-changing diagnosis and the fear of the unknown. It has meant confronting a cancer that is rare, aggressive, and often compared to pancreatic cancer. It has been about struggling to explain to others that this is not a familiar disease, but one with a difficult and unfamiliar name - cholangiocarcinoma. At the same time, it has meant living in a remarkable window of time, where advances in medicine and genetics are coming together to offer real options—and real hope—against a disease that has long been poorly understood.

Our story begins in May 2017. LM was experiencing intense upper abdominal pain that was radiating out her right shoulder. We went to Emergency at the Health Science Centre in St. John’s where an ultrasound was ordered and we learned that she had experienced her first and only gall bladder attack. Routine follow-up ultrasounds were ordered with the results from December 2017 indicating no issues with the gall bladder and the presence of mild fatty liver disease.

Like many others, we were affected by the COVID pandemic, which delayed routine scans. Screening resumed in January 2023, and several areas of LM’s liver were noted as anomalous, most likely related to fatty liver disease. One sentence in the report would prove remarkably prophetic: “Further evaluation with liver MRI is advised.”

In mid-2023, a letter arrived scheduling an MRI for June 7, 2024—eighteen months after the previous imaging. That MRI revealed a mass with signs of malignancy, measuring 3.1 × 4.0 cm, with a maximum dimension of 5.2 cm. In the space of eighteen months, we went from no evidence of cancer to active disease.

These scans were intended to occur every six months. We questioned ourselves and the system. Could it have been detected earlier? How did the delay happen? Was responsibility missed, or was this the result of a system under strain trying to catch up from the delays of COVID? And where does the responsibility lie—with providers, with scheduling systems, or with patients themselves? In the end, there was no sense in wasting time or energy on the blame game.

We quickly met with our surgeon on June 14 who explained that the tumour was in the worst possible location - at the top dome of the liver, under the diaphragm where it was impossible to biopsy. It was interpreted to rest against or abut the inferior vena cava and appeared to be affecting 2 of the 3 critical hepatic veins. Surgeons refer to this area as The Tiger Zone and for good reason as it is the area where blood is channeled from the liver back to the heart. He showed us some of the images and said there was very little they could do.

The scene felt like something out of a movie. I was trying to create a mental image of the tumour. We looked at each other, numb, my lower lip trembling. LM found her voice and asked, “Am I going to die?”. The surgeon said the options were limited but chemo could reduce the size of the tumour and hopefully move it off the vena cava which may allow it to be resected.

We agreed with the surgeon to try shrinking the tumour with chemotherapy. He reminded us that because there was no biopsy, chemo was not an automatic treatment and that he would need to advocate for us at tumour-board meetings. We’re not sure if this bump in the road caused any delay, but LM was ultimately approved for chemo. The surgeon also ordered a PET scan with results arriving on July 10. The scan confirmed that this was indeed primary liver cancer, not metastatic disease from elsewhere. It also showed that the lesion had slightly increased in size since the June 7 MRI, now measuring 3.7 × 3.4 cm x 5.6 cm up from 3.1 × 4.0 cm and 5.2 cm previously.

The PET scan results captured the rollercoaster of living with cancer. There was relief in knowing the disease appeared confined to the liver and had not metastasized, alongside the reality that the tumour was still growing. Was it growing at the same rate, or accelerating? One doctor described cholangiocarcinoma as slow-growing, while another called it aggressive. When we were searching for clarity, we instead learned how much uncertainty exists.

We had the first meeting with our oncologist on July 30. She reminded us that there was no biopsy but imaging and the elevated blood cancer protein CA 19-9 strongly suggested cancer and chemotherapy was approved. She told us that this was her first case of cholangiocarcinoma and that treatment options were extremely limited. All that she could offer was a palliative treatment of gemcitabine and cisplatin with the immunotherapy drug durvalumab.

The term palliative was unexpected and disconcerting. Had something changed? Did we suddenly go from having options with the surgeon to a palliative treatment with the oncologist. I asked her what was meant by the term. She explained that it was more technical rather than clinical. The treatment she was offering came from a recent study from 2019-2020 where the treatment was used on advanced unresectable biliary tract cancers - hence the term palliative. I half joked and told her that if she gets any more cholangiocarcinoma patients to explain “palliative” up front.

Eight planned cycles of chemotherapy began on August 13. LM tolerated the treatments well, with hair thinning and fatigue as the main side effects. Her CA 19-9 levels had been slowly rising over time and appeared to mirror tumour growth. During the first cycle, we requested a second blood test mid-cycle along with test before starting each cycle to better monitor for any changes that might indicate whether the chemotherapy was having an effect. The oncologist agreed with this approach.

Looking back, this conversation marked a shift in how we approached care. We understood that we needed to be informed, engaged, and willing to ask questions—active participants alongside the medical team, rather than passive observers.

An MRI scan was completed on October 21. The chemo had been unsuccessful in reducing the size of the tumour and it had grown marginally. The oncologist stopped any further treatments and referred us back to our surgeon. We knew from our last conversation with him that this meeting was going to be difficult.

The meeting with our surgeon began with a summary of the tumour’s difficult location and the conclusion that there were no surgical options available within the Newfoundland and Labrador healthcare system. He then told us that, on September 7, he had referred LM’s case to Dr. Ian McGilvray at Toronto General Hospital. He explained that Dr. McGilvray is a world-renowned surgeon who had pioneered complex, life-saving liver resections and venous reconstructions using organ transplant techniques. If LM qualified, the surgery would be very long and involve techniques using ice to cool the body and flushing the liver to allow for extended and intricate surgery.

Up to this point in our journey, the first six months had been a nightmare of “hurry up and wait.” We waited for screening appointments. We waited to see whether the chemotherapy was working. We wondered whether LM would continue to tolerate the treatment, or whether it would turn on her and make life unbearable. Could we allow ourselves to believe that surgery might be possible? As the possibility emerged, our questions shifted. Was there a wait list and what would it look like? Would chemotherapy affect her eligibility for surgery in Toronto? What hurdles still needed to be cleared before surgery could become a reality?

Our initial meeting with Dr. McGilvray was scheduled for November 2 and took place by Zoom. We didn’t know what to expect. When he joined the call, he was dressed in scrubs and wearing a colourful operating-room cap. He apologized for being late, and we introduced ourselves. His attention immediately focused on LM. He asked how she was doing and whether she was experiencing any effects from the disease. LM replied that aside from some fatigue, she was feeling well, and that chemotherapy had recently been stopped. Dr. McGilvray paused and said he hadn’t realized chemotherapy had been discontinued—adding that this made it a very good time to connect. He explained that chemo had taken liver transplantation off the table, something we hadn’t known had even been a possibility. He then turned to the imaging. To his eye, the tumour appeared to be wrapped around the vena cava rather than resting alongside it. I asked whether that meant LM was not a surgical candidate. He answered calmly, “No, not at all.” He said we would need to travel to Toronto for updated imaging so his team could fully assess the case and determine whether surgery could proceed. Someone would be in touch within a few days to arrange it. He asked if that was acceptable. Of course it was - the imagery appointments were scheduled for November 13.

The follow-up meeting to determine whether surgery would proceed took place on November 26. From the moment Dr. McGilvray joined the call, we sensed a shift in tone. He explained that the tumour had continued to grow and now measured 4.5 × 4.5 cm × 6.1 cm. There was still no evidence that the disease had spread. If it had, surgery would not be an option. Before going any further, he said we needed to understand what this surgery would entail. It would be a major, twelve-hour operation involving multiple surgical teams, with a **12% risk of death during surgery**. Recovery varied widely with some patients able to go home within ten days, while others remained hospitalized for months with serious complications. He told us that, given the continued growth of the tumour, the window to remove it and reconstruct the involved blood vessels was rapidly closing. He then asked LM if she was prepared to proceed. There was no hesitation. We accepted the risk. There were no other options.

Given the urgency, surgery was scheduled as soon as possible, on December 13. We travelled to Toronto and moved into a condo just a five-minute walk from the hospital. Our daughter who was studying in India, travelled to Toronto to be with us. LM reported for intake and was prepared for surgery. Just before she was taken to the OR, a member of the surgical team came out to speak with us. She explained that the resection plan had changed and that it now appeared possible to preserve more of her liver. It was extraordinary news to hear only minutes before facing a twelve-hour operation. There were no tears as we said our goodbyes. We were simply grateful that LM had been given this chance.

After eleven hours, Dr. McGilvray called. He told us the surgery had gone according to plan and that LM was doing very well. Depending on her recovery, he said, we might be able to see her later that night. Just after midnight, my daughter and I were allowed into the ICU. Nothing could have prepared us for what we saw. Two nurses moved steadily through a wall of monitors, pumps, and equipment, carefully managing the tangle of lines, drains, and IVs. In that moment, the full gravity of the surgery truly began to sink in.

LM's recovery was nothing short of remarkable, and she was discharged on December 24. The plan was to remain in Toronto for three to four weeks to convalesce and stay close to the hospital should any complications arise. In early January, LM developed shortness of breath and pain and was readmitted on January 3 with fluid on her lung. She was discharged four days later. We met with Dr. McGilvray on January 9, who confirmed that her recovery was progressing well and cleared her to fly home. On January 11, we returned to St. John's.

After a few days at home, we both began to realize how physically and mentally exhausted we were. If I felt this way, I could only imagine how LM was feeling. In truth, she was probably in a better place mentally than I was. Her total focus was on recovery and regaining strength. I would support her in that, but there was less for me to do.

LM's oncologist called mid January for an update and to setup a meeting for February 17 to discuss next steps. We informed her that we had the pathology report and one of the findings was that one of the resected margins was scored R1 for the presence of cancer cells. This was not unexpected given the balancing act of removing the tumour and preserving as much of the liver as possible. Her initial inclination was to use radiation to destroy any remaining cancer cells. We would discuss it more at our appointment.

When we met she informed us that the radiation option was turned down in a tumour-board meeting as it could damage the nearby reconstructed vessels. This precluded that a treatment of the drug capecitabine would be taken orally for 8 cycles.

It's been one year since the surgery and LM is cancer free and healthy. We've come to understand that if it weren't for LM's fatty liver disease—and the routine imaging that followed—this cancer may have remained hidden until it was far too late. It's strange to feel gratitude for a diagnosis no one wants, but without it, we might never have been given a chance. Our journey continues and is supported by the truly amazing people at Cholangio-Hepatocellular Carcinoma Canada and the Canadian Cholangiocarcinoma Collaborative

(C3) who provide vital resources to individuals and families dealing with these rare cancers.
—LM & Spouse

<u>Editor's note</u>: We are grateful both individuals are NED currently.

Recent Webinars

All of the webinars are posted on the website and YouTube channel. Check them out!

Dr. Howard Lim held webinar on Oct. 30. It was very informative and well attended by patients and caregivers. The link to watch is here.

Dr. Ravi Ramjeesingh hosted a webinar on November 19, “The opportunity of Precision medicine in BTC.” The link to watch is here.

Upcoming Webinars

January 29 – Webinar with Dr. Maureen McCall on WellSpring at 10 am MT, 12 noon ET
March 5 – Webinar with Dr. Brandon Meyers at 4 pm MT, 6 pm ET

Education Corner

A conference on Hepatocellular carcinoma was held in Toronto in November 2025. There were several talks on hepatocellular carcinoma. Here is a summary:

- There are many tools in the toolbox. Systemic therapy is the backbone with localized “regional” therapy

- Improved progression free survival with the combination of Imfinzi (durvalumab) and bevacizumab with TACE has shown promising results in the treatment of HCC. The EMERALD-1 Phase III trial demonstrated that this combination significantly improved progression-free survival compared to TACE alone.

- Surgical resection for hepatocellular carcinoma (HCC) was discussed. The recommendation for screening of ‘at risk’ patients is every six months. The screening includes a blood test AFP (alpha- fetoprotein) levels and an ultrasound.

- Adjuvant therapy before surgery is atezolizumab (Atez) and bevacizumab (Bev), which is showing more promising outcomes vs sorafenib alone.

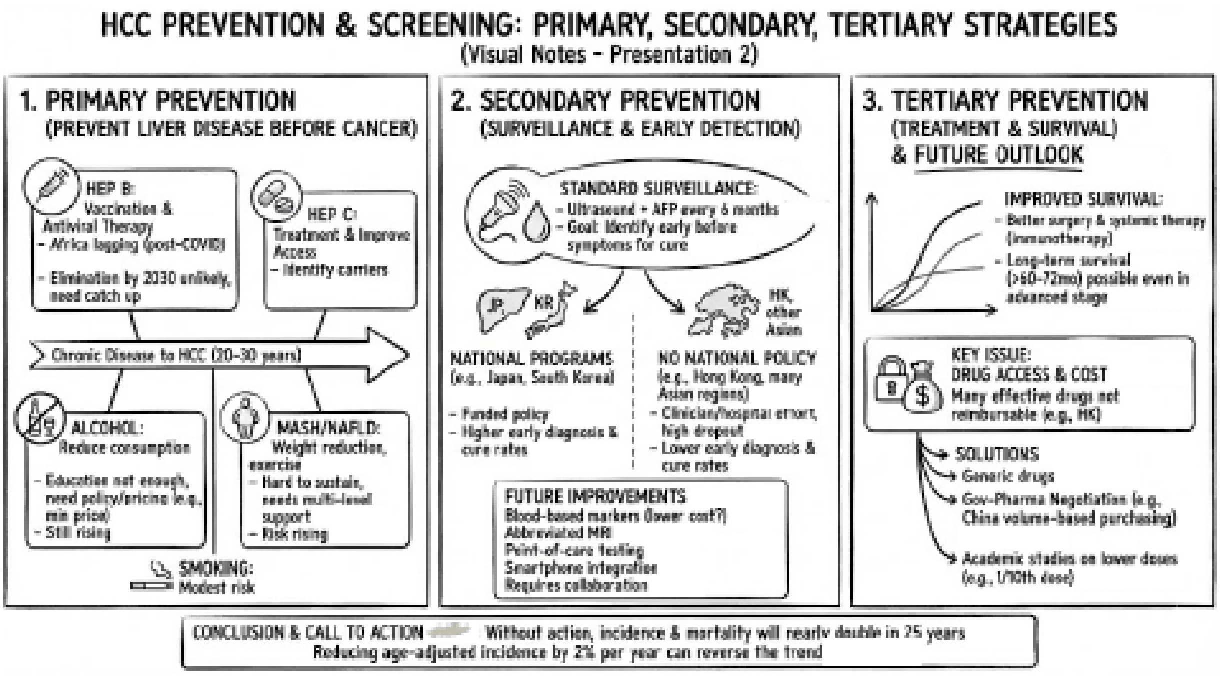
- Comparing TACE alone vs. TACE with atezolizumab/bevacizumab in unresectable HCC patients: TACE with atezolizumab/bevacizumab shows improved PFS versus TACE alone. Click on this link for the article.

Metabolic dysfunction–associated steatotic liver disease (MASLD)

- MASLD is a risk factor for HCC. This fatty liver disorder affects 30%-40% of people worldwide (JAMA). Over time this accumulation of fat in the liver can cause inflammation. Conditions that may lead to MASLD are being overweight/obesity, having diabetes/insulin resistance, having high cholesterol and high blood pressure (Cleveland Clinic). Read more about it with these links.

Visual record for HCC from ILCM (International Liver Cancer Movement)

- This is a visual sharing of some of their highlights from their ILCA/UNITE/ILCM meeting which took place last month in Hong Kong.



Ask The Registered Dietitian.with Jessica Andersen

This column will occur twice yearly, in June and December newsletters.

If you have any questions for Jessica, please email them to info@mychcc.ca. Jessica is also giving yearly webinars in May, so send us your questions so we can pass them on to her.

Do I Have to Limit sugar?[1, 2]

There have been a lot of questions about whether sugar ‘feeds’ cancer. To be very clear- cancer is a part of you. That is why it is so hard for your body to identify and fight cancer on its own, these are your own cells. Sugar (carbohydrates) feeds *you*, protein feeds *you*, fat feeds *you*- these are the building blocks of your food. So technically sugar does feed cancer, but it also feeds *you*. And there is no link stating sugar specifically feeds cancer or makes it grow faster.

Your brain’s favourite thing is carbohydrates (sugar is a simple form of carbohydrate). I do not suggest you stop feeding yourself, it is very important you feed yourself to be strong enough to get through treatment and keep your muscle mass up so you can metabolize your medications and be able to do the things you need to do. However, there are changes you can make to make sure you are getting the most out of your nutrition.

There are different types of sugar. Natural sugars come from things like fruit, vegetables, grain products and milk products. These items have fibre and vitamins and minerals your body needs, there is generally never a reason to limit these items. Added sugars however, which are often found in candy, chocolate, desserts and pop, are an area you could cut back. There are still calories for energy for your body in these items, but these are often not nutrient dense items and they often don’t fill you up or give your body other nutrition. Decreasing added sugar in your diet and focusing on less processed foods is best for your overall health.

The Canadian Cancer Society recommends 10% of your calories or less coming from added sugar. But, still live your life! At a birthday party, eat the cake. Going to the movies, get your favourite candy. There is no reason to cut out added sugars entirely. Food is social and a pleasure of life, I would never recommend removal of anything, even added sugar, from the diet entirely.

Should I Follow a Special Diet (ie Mediterranean diet)?[3]

Who has seen Canada’s Food Guide recently? Check it out here: https://food-guide.canada.ca/en/

There is no specific diet I recommend for everyone, but if you find a diet type you like, such as the Mediterranean diet, that fits the basis of Canada’s Food Guide, that might be a good dietary pattern to follow.

The basics of the food guide are this: half your plate to be fruits and/or veggies, a quarter of your plate to be your protein food, a quarter of your plate to be your whole grains (brown grains).

Take water as your number one drink.

A Mediterranean diet fits these recommendations well, with additional emphasis on unsaturated fats and increasing omega-3 fats in the diet. This could be an appropriate diet to follow, but it is not the only appropriate option.

Something like the DASH diet would also meet these recommendations and be appropriate. I like to tell people not to be too rigid with their diet, whatever they choose. And you don’t need to follow a ‘specific’ diet per se, but follow the Canada’s Food Guide most of the time and you will ensure you are getting the nutrients your body needs. If you are insistent on finding a specific diet to follow, I would caution you to pick one that is not too restrictive. If the diet cuts out whole food groups and is quite confusing and restrictive, it is probably not going to fit the above.

If it promises to cure cancer or other lofty goals and seems too good to be true, it probably is. You cannot cure cancer with nutrition. If a diet claims this, they are probably trying to sell you something.

Should I take Vitamin D?[4,5]

Generally, a vitamin D supplement is recommended in Canada as we know for many months of the year Canadian’s do not get enough sun exposure in order to synthesize their own vitamin D. As well, we generally don’t not eat a lot of food rich in vitamin D (mushrooms, some organ meats like liver, fatty fish). As such, every Canadian is recommended to take a vitamin D supplement.

From a cancer perspective, even those who do get enough sunshine, skin cancer recommendations are to seek shade, wear hats and cover exposed skin and wear sunscreen, so even those getting more sun exposure might still need a vitamin D supplement. Why do vitamin D levels matter? Well vitamin D is used in the body primarily for bone and muscle health but also immune function. So having low vitamin D levels could make it harder for you to do the things you enjoy as you age due to increased frailty or even make fighting off infections difficult.

As such, RD’s recommend most adult Canadians get at least 600-700 IU (international units) however getting 1000-2000 IU is fine for most people.

Are There Foods to limit?[6,7]

There is no absolute list of foods to limit or eliminate for someone with cancer or to decrease risk of cancer. Generally, we want to be as least restrictive as possible, because a varied diet is the best way to ensure you are getting all the vitamins and minerals your body needs. **There are truly only two foods that are agreed upon to increase cancer risk- alcohol and processed meats**. These are good things to limit in your diet, and given that neither has irreplaceable nutrition benefits, they could be eliminated entirely if you would like with no consequences.

However, if you are undergoing active treatment or starting new medications, it is always a good idea to ask if there are foods to limit or avoid due to interactions. Some chemotherapies for example require removal of citrus fruit. Other types of foods to avoid, while undergoing treatment especially, are foods that have been improperly stored or spoiling. A bout of food poisoning could require hospitalization and even set back your treatment, so be careful and store your food appropriately and if in doubt, throw it out!

Look for food safety tip here: https://www.canada.ca/en/services/health/food-safety.html

Sources

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4 Canadian Cancer Society. Eating well extras to consider, Canadian Cancer Society, 2025, https://cancer.ca/en/cancer-information/reduce-your-risk/eat-well/eating-well-extras-to-consider

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6 Hes, C., Nasrah, R., Rapier, T., Reed, R. (2024). Immunotherapy and gut health: Nutrition guide for people with cholangio or hepatocellular carcinoma. https://www.mychcc.ca/pdf/Nourish_Immunotherapy_Nutrition_Guide-EN.pdf

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Upcoming Dates:

- **Dec 16 –** Patient support group
- **Dec 24 – Christmas Eve**
- **Dec 25 – Merry Christmas**
- **Dec 26 – Boxing Day**
- **Jan 1 – Happy New Year**
- **Jan 6 –** Bereavement support group
- **Jan 13 –** Canadian advocates meeting
- **Jan 20 –** Patient support group
- **Jan 27** - French-speaking support group

- **Jan 28 – Meet-up in Calgary** (contact CHCC has the venue is changing)
- **Jan 29 – Webinar on WellSpring with Dr. Maureen McCall at 10:00 am MT (noon ET)**
- **Feb 3** - Bereavement support group
- **Feb 10** – Canadian advocates meeting
- **Feb 17** – Patient support group
- **Feb 19 – Light it up green for World Cholangiocarcinoma Awareness Day**
- **Feb 22 – Meet up in Winnipeg**
- **Feb 24** - French-speaking support group
- **Feb 25 – Meet-up in Calgary**
- **Mar 3 –** Bereavement support group
- **Mar 5 – Webinar with Dr. Brandon Meyers – 6:00 ET, (4 pm MT)**
- **March 10 –** Canadian advocates meeting
- **March 17 –** Patient support group
- **Mar 22 – Meet-up in Winnipeg**
- **March 24** - French-speaking support group
- **Mar 25 – Meet-up in Calgary**

High Level Bridge (Edmonton)

To support patient advocacy, donate here.

To volunteer with CHCC, please go to the "Contact Us" tab on our website (or click on the link) and message us.

We would love to hear from you! We are still available for you during this holiday season if you need to reach out.

All of us at CHCC wish you all the best this holiday season.
Merry Christmas and Happy New Year!