



Urological Cancer Update

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59TH UROLOGICAL SOCIETY OF
AUSTRALASIA (USA) REPORT

21ST EUROPEAN ASSOCIATION OF
UROLOGY CONGRESS REPORT

GP EDUCATION PROGRAM

XX UPDATE

Produced by the Urological Cancer Committee
of the Victorian Cooperative Oncology Group
Centre for Clinical Research in Cancer



UROLOGICAL CANCER UPDATE

June 2006

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This newsletter is produced by The Cancer Council Victoria's Urological Cancer Committee and sent to health professionals interested in management of urological cancer(s). The Victorian Cooperative Oncology Group's advisory committees on breast, gastrointestinal, gynaecological, head & neck, lung, skin and urological cancers also produce twice yearly cancer updates.

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******* Last Issue – No. 19 – December 2005 *******

The articles in the Urological Cancer Update have been published to contribute to professional debate and exchange. The opinions expressed are not necessarily those of The Cancer Council Victoria.

Contributions Welcome

The Urological Cancer Update welcomes contributions – conference reports, review of an area of interest, reviews of recent journal articles, clinical trial updates.

	Deadline	Issue Date
Mid-year issue	1 June	1 July
Year-end issue	1 November	1 December

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59th Urological Society of Australasia (USA) Annual Scientific Meeting

26 - 30 March 2006, Brisbane, Queensland

*Mr Greg Neerhut
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This year's meeting was held in March in Brisbane. In line with the society member's requests, the meeting focuses on CME requirements, and the five sponsored overseas guests conducted sessions focussing on female urology, urinary stone disease, reconstructive urology and oncology. This meeting is not a good forum for original local scientific presentations which were generally presented as posters and often not in moderated sessions. The overseas Urological Oncology guests were Michael Jewett from Toronto and Freddy Hamdy from Sheffield. Unfortunately, Professor Hamdy was unable to attend at the last minute.

Prostate Cancer

The first session of the meeting focussed on the surgical management of prostate cancer, and consisted of a panel discussing aspects of several case presentations. Issues discussed included the management of post prostatectomy impotence, strictures and incontinence. The fact that stress incontinence is under reported was emphasised. American Medicare data show that about 30% of American men need either a penile clamp or pads in the long term following radical prostatectomy. Professor Webster from Duke University suggested that if pad weights three months after surgery show leakage of over one 500 mls / day, then the incontinence is unlikely to improve significantly with time, and it is reasonable to proceed with Artificial Sphincter implantation at 6 months, rather than waiting the usually recommended 12 months.

The difficult management problem of a severe recurrent bladder neck contracture was also discussed. In cases refractory to simple endoscopic measures Professor Webster considered that placement of both a bladder neck urolume stent and a bulbar urethral artificial

urinary sphincter, the best solution. Data presented suggested that high intraoperative blood loss and construction of a tight bladder neck increased the risk of postop contracture, whereas postop urinary extravasation did not.

In another session Professor Jewett discussed the expanding role of needle biopsy of the prostate. He pointed out that prostate cancer is also common in men with normal se PSA measurements, as illustrated by the fact that 0 of the men in the placebo arm in the Prostate Cancer Prevention Trial had a positive biopsy, even though most had a normal sePSA. He challenged the audience by suggesting that we need better tools for estimating the risk of a man having prostate cancer than his se PSA. Perhaps all men should undergo biopsy and then those men with prostate cancer should be stratified according to the risk of progression, leading to a large group of men being managed by active surveillance in the first instance.

Mr Catto, substituting for the absent Professor Hamdy outlined the "Protect Study", a large multi institutional study underway in the UK, designed to assess the effectiveness of treatment for early prostate cancer. In this study patients agree to be randomised to either early treatment with either surgery or radiation therapy, versus observation before undergoing needle biopsy on entry to the study. End points include both survival and quality of life measures. This study is very exciting and should provide very useful data for patients and their doctors.

The poster sessions featured a several posters describing the results of laparoscopic radical prostatectomy from Basingstoke, UK and also the results of robotic laparoscopic prostatectomy from the Epworth Hospital, Melbourne. The indications for these techniques have been broadened to include large prostates and obese patients, without compromising the results.

Renal Cell Cancer (RCC)

Professor Jewett introduced the concept of the Small Renal Mass, which on imaging studies appear solid and are smaller than 3cm in diameter. Until now these masses have been considered to be likely small renal cell carcinomas and standard management has been surgical excision. However he pointed out that there is a place for management by observation alone as

- up to 1/3 of such masses are benign
- even if SRM is a small RCC, they are usually low grade, usually grow very slowly and metastases are rare

There may be a role for performing needle biopsy on SRMs to establish a diagnosis, determine tumour grade, and perhaps do genetic marker studies. The small risk of seeding along the needle

track can be minimised by using a plastic sheath outside the needle. Selected patients may be suitable for observation or minimally invasive therapies such as HIFU, RFA or cryotherapy.

There were a number of excellent presentations by Victorian Trainees. Danielle Delaney won the Keith Kirkland Prize for the best presentation by an Australasian trainee in a full time clinical post, for the paper “Bladder dome air bubbles in TURBT: Is there any benefit from removing the air bubbles at TURBT?”

Nathan Lawrenschuck received the Willis Marshall Prize for the best paper by trainee in a full time research post for “Invivo tumour hypoxia and carbonic anhydrase IX expression in human xenografted human renal cell carcinoma models using probes, I-G250 pet, biodistribution and immunohistochemistry immunobiodistribution, and oxygen studies”.

Clinical Practice Guidelines for the Management of Metastatic Prostate Cancer

Dr Louisa Jones has been appointed as Project Officer. Clinical questions, framing searches and systematic reviews have commenced.

Regular subcommittee meetings are being held to progress the question and search base and it is planned to accelerate this activity after a Working Party meeting in June.

Reprinted from Wongi Yabber May 2006; 12(2): 2.

Localised Prostate Cancer: A Guide for Men & their Families

A Working Party chaired by Dr Carole Pinnock has met and its revision plan is progressing well and should be completed within the six month goal. The

RACGP will be heavily involved through Dr John Litt.

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21st European Association of Urology Congress: Prostate Cancer Plenary Session

Paris, France, 5-8 April 2006

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The EAU plenary session on prostate cancer in Paris brought together several world experts in the field, for discussion around the topic of PSA testing and the role of intervention early in disease.

A state of the art lecture by Professor Peter Albertsen from Connecticut addressed the issue of over-detection and over treatment of prostate cancer. This was continued in the "round table" discussion between Professor Freddy Hamdy, Dr Anna Bill-Axelsson, Dr Liliane Boccon-Gibod, Professor Fritz Schroeder and Albertsen. This was followed by a presentation on PSA kinetics by Professor Per-Anders Abrahamsson.

Shift in Disease

Albertsen contends that the disease of 2006 is clearly different to the pre-PSA era. He backed this up with a study of a large series of pre-PSA prostate cancers, re-examined by today's pathologists which demonstrated that all Gleason 2,3,4,5 had become reclassified as Gleason 6. He then concluded that the 2006 Gleason 6 is a less aggressive entity than that of the pre-PSA era.

He also observed that the original Gleason 6 score was based on examination of large quantities of tissue and that today's pathologists work with relatively tiny amounts in their examination of prostate biopsy specimens. Hence there is now almost a drift back to the former classification of well, moderate and poorly differentiated disease. He predicted a "collapse of the richness of the original Gleason score".

His response to our ever ongoing concern that the small focus of Gleason 6 on biopsy represents the "tip of the iceberg" is that if you follow algorithms or nomograms, which were developed from biopsy data, biopsy Gleason scores remain the best pre-operative prognostic marker. As yet no biological marker has been shown to be

superior. The application of this to the individual patient is difficult as many urologists will have had more than one case where a small focus of Gleason 6 on biopsy has translated to a higher volume, higher grade cancer at Radical Prostatectomy.

Screening & the Potential for Over Diagnosis

Albertsen contends that in the screening era, there is a higher prevalence of clinically indolent disease. With annual PSA testing so prevalent in the USA, there is a high risk of being diagnosed with prostate cancer. However the relevance of this to the patient's ultimate mortality is unclear. This is supported by the data presented from the European Randomised Study of Screening being run by Schroeder (J Urol, in press). This trial shows that whereas contemporary nomograms such as the Kattan nomogram include about 20% indolent cancers the screening series detects at a rate of about 48%. This result is slightly less in older men.

To avoid over detection of indolent cancers, Albertsen suggests re-examining the trigger PSA for biopsy. For those patients who present with a PSA just over 4ng/ml, he suggests repeating the PSA along the lines of a "pre-biopsy" active surveillance protocol with further assessment of PSA kinetics in appropriate cases.

PSA Values & Kinetics

Albertsen presented, of concern to most clinicians, the statistic that in the range 3.1 to 4ng/ml, 27% of patients have prostate cancer. One third of these have a Gleason score of greater than or equal to 7.

Whilst this means those who die are often young men with high grade disease, because of the corresponding high rate of indolent disease

detected, Albertsen recommends caution and advises monitoring of the group with a PSA of 2.5 to 4ng/ml. Once the PSA is greater than or equal to 4, biopsy should be considered. This is on the basis that in the USA if you investigated all PSA's of greater than 2.5ng/ml this would amount to 2.7 million men and you would diagnose twenty-six times more prostate cancer than those who are likely to die from the disease, producing an large "number needed to treat".

He also recommends the use of nomograms, of the like discussed below, in the management of the 2.5-4 ng/ml group to attempt, in the instance where you cannot avoid over diagnosis, to avoid over treatment.

Abrahamsson discussed the role of PSA baseline levels and kinetics in contemporary prostate cancer management. His conclusions were that if PSA doubling time is used to trigger a biopsy then several PSA readings (three monthly) over two years are required to account for short term variations. He presented data from Klotz's active surveillance group demonstrating those dying of the disease had a PSA doubling time of less than 2 years (Klotz 2005).

On the question of is PSA doubling time better or worse than PSA velocity, he referred to a paper from the Mayo group (Sengupta et al 2005) in which the doubling time was shown to be a stronger predictor.

The use of PSA doubling time in the management of patients who have relapsed following definitive treatment was discussed in the context of those with negative margins, a PSA of less than 2ng/ml and at doubling time of more than 10 months should be offered salvage treatment versus those who have the reverse characteristics and in whom should go straight to hormone therapy (Stephenson et al 2004). He also noted that there is a case for the use of PSA doubling time in prediction of the timing of hormone therapy post radical prostatectomy failure (D'Amico et al 2004) and made his overall take home message, that we should use PSA kinetics, wherever possible.

Accepting if there is Over-Diagnosis, How to Avoid Over-Treatment

PSA screening and case-finding continues and continues to increase, despite the screening trial data not yet reaching a conclusion. Accepting

that this is occurring, and with the suggestion that there is an increased rate of indolent disease being detected, how do we ensure over-treatment does not occur?

Albertsen encourages the use of active surveillance protocols and registries for those with a life expectancy of less than 10 to 15 years, a Gleason score of less than or equal to 6 and a PSA velocity of = 0.7 per annum or a doubling time over baseline of more than 2 years.

The round table discussion addressed, that despite the increase in indolent disease, there is actually less active surveillance taking place (Cooperberg et al, 2005). This was felt to be probably due to concerns about medico-legal risk, where most clinicians were aware of "that case" where the application of population based statistics to an individual didn't lead to a good outcome. As we see, clinical practice does not always follow research data.

The round table discussion directly addressed the issue of "to do or not to do" in the case of active intervention with surgery. What represents significant disease based on the biopsy and other available data is again the key question.

Based on the Schroeder screening data, currently a PSA detected cancer has about a 50% chance of representing indolent disease. Schroeder therefore stressed on the assessment of a patient's cancer, as to whether it represents significant disease, the method of detection (ie PSA, positive DRE) is important.

To avoid over treatment from this point, Schroeder is developing a tool, from which he presented graphical data, that combines biopsy; Gleason score, mm of cancer, mm of non cancer and overall prostate volume with PSA, in order to predict probability of an indolent cancer based on the score from this system, which he hopes to have computer or PDA based. We await with interest the result of the application of such a tool in clinical practice.

If we Treat, are we Successful?

This section was led by a question from Boccon-Gibod on whether if we are doing too many radical prostatectomies, and there is over-treatment, then are we treating those cases that need it?

This was introduced with the scenario most urologists will have unfortunately seen, of the man in his fifties, in good health otherwise, but presents with a PSA of 4000ng/ml and a "superscan" on bone scan. How do we guard against this happening?

For organ confined disease, that is T1a to T2 treated with radical prostatectomy, after 10 years more than 30% of patients relapse (Han et al, 2001). Boccon-Gibod asks, did they have untreatable disease in the beginning? Given we know there are prostate cancer cells in the bloodstream of patients early on in disease, he contends, the emphasis needs to shift, as it has in breast cancer to chemotherapy and the search for better agents to reduce the chance of micro-metastatic disease leading to late recurrence.

To truly answer if treatment is successful, we will need to await the results of the PROTeCT trial being run by Freddy Hamdy. This is a randomised control trial design of treatment effectiveness in screen detected patients randomised to Active Surveillance, Radical Prostatectomy or Radiotherapy. It has accrued 300 patients in each arm. Early results show that 50% of patients offered a PSA undertook the test. 700,000 PSA's have been performed with 1600 prostate cancers diagnosed. 80% of these have been found to be localised and 70% of these cases have now been randomised. Initial results from treatment are expected in five years.

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Australian Cancer Network (ACN) Activities

Work is continuing with discussion and dissemination of Accreditation and Credentialling documents. There will be further fine tuning necessary.

The draft Guidelines Implementation document has met with significant approval after being piloted in Victoria. Its distribution is being planned by the National Institute of Clinical Studies (NICS). The generous support of Dr Heather Buchan of NICS has been integral to progress and is appreciated by ACN.

There is to be a major meeting with NICS in October when all three documents will be featured in discussion and decision-making, which should further embed guidelines and the evidence-based approach and hopefully further eradicate unnecessary variation in practice.

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Promoting Shared Decision Making & Informed Choice for the Early Detection of Prostate Cancer: Development & Evaluation of a GP Education Program

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Prostate cancer is the most commonly diagnosed cancer in Australian men. At present, there is no definitive data confirming that widespread screening for prostate cancer will reduce the death rate from this disease. In Australia population based screening for prostate cancer in asymptomatic men is not promoted. However, regardless of public health views on this issue, prostate-specific antigen testing in Australian men is prevalent. Most guidelines advocate that asymptomatic men seeking prostate-specific antigen testing to detect early prostate cancer should be advised of the pros and cons of testing and make an informed choice. The difficult task of managing consumer demands in the face of conflicting viewpoints and uncertain medico-legal requirements usually falls on general practitioners who until recently have had few resources to assist them. This paper describes the development and evaluation of a pilot general practitioners education program in Victoria. After attendance, participants' knowledge about prostate-specific antigen testing and level of understanding increased, they were more likely to initiate discussions with patients about the risks and benefits of testing and were more confident in doing so. Participant satisfaction with the program and materials was high. In a health topic characterized by divergent viewpoints, this program provides evidence of the benefits of taking a collaborative and consultative approach and closely linking program development to general practitioners' expressed needs.

Prostate cancer presents a significant public health concern. Cancer of the prostate is the most commonly diagnosed cancer in males. In Australia in 2001 there were 11,191 men diagnosed, while in Victoria, approximately 3000 men are diagnosed with the disease every year. Since 1989, diagnosed rates of prostate cancer cases have more than doubled. This significant rise in prostate cancer incidence is likely to be the result of increased numbers of men undergoing prostate specific antigen (PSA) testing.¹ There is controversy surrounding the value of population-based screening for prostate cancer with the PSA test. Levels of PSA in the blood only act as an indicator of the disease and there are no definitive data to confirm that PSA testing will reduce prostate cancer mortality.^{2,3} However, some research suggests there may be benefit from the early detection and treatment of localised prostate cancer.⁴⁻⁶ There is also some concern that the quality of men's health may be compromised by

not offering individuals the opportunity to be tested. Furthermore, there is support for the position that men should be able to access testing if they are fully informed of the benefits and also the uncertainties related to the efficacy of PSA testing and the risks surrounding treatment outcomes.^{7,8} Thus, at this time population-based screening with the PSA test for the early detection of prostate cancer in asymptomatic men is not recommended by The Cancer Council Australia. This position is supported the Urological Society of Australasia, the Australian Department of Health and Ageing and the Australian Prostate Cancer Collaboration (APCC). On the matter of opportunistic testing, these organisations and most clinical practice guidelines recommend that patients be fully informed of the risks and benefits before making their own choice.⁹⁻¹¹ Shared decision making is based on patients and health professionals sharing relevant information (eg. About risks, benefits, patient's characteristics and values)

and agreeing on decisions. It is most suitable for situations in which there is a diagnostic intervention of low risk and a decision involving two or more acceptable choices.¹² Patient decision aids are “interventions designed to help people make specific and deliberate choices among options by providing information on the options and outcomes relevant to the person’s health status”.¹³ They are usually reserved for circumstances in which patients need to carefully deliberate about the personal value of the benefits and harms of options.¹⁴ Shared decision making and informed choice are currently viewed as the most appropriate approach for men deciding about PSA testing for the purpose of the early detection of prostate cancer and men themselves indicate a preference for shared decision making.¹⁵ In most cases, the decision to inform men about, and initiate testing, is the responsibility of general practitioners (GPs). Some GPs are likely to perceive this task as complex, demanding and time consuming given that they must consider consumer health demands and uncertain medico-legal requirements among much controversy.^{16,17} Although many men express interest in informed choice and shared decision making in regards to PSA testing for the early detection of prostate cancer,¹⁵ others may be tested by their GP as part of routine blood checks without knowledge of the test or the implications of having a positive test. It is vital that men are informed about the advantages and disadvantages of testing and treatments and that they participate in decisions regarding their care. Since GPs are the most likely source of information for PSA testing and subsequent referral, there is also a need for GPs to fully understand screening and treatment issues so that men in their care make informed choices about prostate cancer screening. The development of workshops up-skilling GPs to provide informed choice for prostate cancer testing was initiated by the Queensland Cancer Fund (QCF) after a 2003 symposium on informed choice organised by the APCC and the National Cancer Control Initiative (NCCI).¹⁸ Recognising the complex health care service environment in which GPs operate, in 2003 the APCC supported the development of a GP education program to facilitate shared decision making and informed choice for men seeking PSA testing for the early detection of prostate cancer. In consultation with this and other medical groups, the QCF developed an education and

decision making resource program that aimed to up-skill GPs in order to promote shared decision making within their practices for men considering prostate cancer testing.

With this objective in mind, the program was designed to cover two main areas:

1. The medical context of screening, which includes information about the natural history of the disease; benefits and harm of screening for and treating prostate cancer; use and interpretation of PSA testing; and
2. Shared decision making, which covers the medicolegal requirements of: informed choice; understanding how men make decisions; and effective patient centred education to facilitate informed choice. An extensive resource kit for participants was also developed, including all relevant brochures and webbased information.

The program was designed to be presented by expert medical professionals in two-and-a-half-hour interactive workshops. The workshop format included two presentations and three case studies that were discussed in small groups, followed by larger group discussions. The medical context of screening and shared decision making presentations, along with the patient show card, aimed to develop participant capabilities in informed choice for prostate cancer testing. A multi-model learning approach was used, consisting of formal presentations, discussion of case scenarios and the role of the interactive decision/summary card in a shared decision making process.

The workshops were accredited for professional development points under the Royal Australian College of General Practitioners’ Quality Assurance and Continuing Professional Development Program and the Australian College of Rural and Remote Medicine’s Professional Development Program. Workshops were held as part of a pilot study conducted in Queensland by the QCF and in Victoria by The Cancer Council Victoria. In Victoria, three workshops were held in November 2004 in conjunction with Victorian Divisions of General Practice. It is anticipated that this education program will become part of a national strategy to deliver prostate cancer education to GPs.

This report describes findings from three pilot workshops conducted by the Cancer Education Unit of The Cancer Council Victoria.

Method

Five Victorian Divisions of General Practice (Divisions) hosted three workshops in November 2004 in

conjunction with The Cancer Council Victoria; the first workshop was held in partnership with the Northern Division in Preston (3072), the second workshop was held in partnership with Inner Eastern Melbourne Division and Melbourne Division in Hawthorn (3122) and the third workshop was held in partnership with Greater South Eastern Division and Dandenong District Division in Mount Waverley (3149). The five metropolitan divisions participated in the pilot due to their interest in prostate cancer and their capacity to deliver a workshop within the pilot timeframe. The divisions coordinated the recruitment of GP participants to the workshops using a combination of communication methods including newsletter articles, direct mail and fax streams. GP participants were recruited from within the division boundaries. The pre and post-workshop questionnaires, developed by Steginga, Pinnock and Baade,¹⁹ assessed confidence, intention to discuss, knowledge and workshop satisfaction. Confidence in and intention to discuss prostate cancer screening with asymptomatic men was assessed using four case-scenario items with five-point Likert scales. Attitude towards discussing the risks and benefits of prostate cancer testing with men was assessed with one item rated on a five-point Likert scale. Knowledge about prostate cancer screening was measured via 17 items consisting of 12 statements to which participants responded true, false, or unsure and four multiple choice questions. One further question was used to assess GPs' level of understanding about the risks and benefits of screening. Finally, participants were requested to complete five questions relating to their behaviours with regard to initiation of discussions about screening, as well as use of resources. The workshop evaluation questionnaire consisted of a number of questions regarding the usefulness of the workshops, including whether GPs' learning needs had been met. Satisfaction with the workshop's content, delivery and structure were also measured. Open-ended questions were included to give participants the opportunity to comment about ways the workshop could be modified or improved. The resource cards were

evaluated using nine items that included both multiple choice and open-ended questions. Finally, the resource kits for GPs were also evaluated to assess their usefulness in practice.

An evaluation strategy has been built into the program and includes pre and post-workshop questionnaires to assess the effectiveness of the program in improving GP knowledge about the benefits and risks of testing and their confidence in discussing this with men. GP satisfaction with the delivery, structure and content of the workshops and resources was also assessed and we observed any impact of the program on the likelihood that GPs would opportunistically discuss testing with men.

A single arm pre-post test design was used to evaluate the effectiveness of the three Victorian workshops in improving participants' knowledge about prostate cancer testing and their confidence in discussing testing with men. We also assessed self-reported intention to discuss testing opportunistically. Data regarding knowledge and confidence in and intention to discuss prostate cancer testing with asymptomatic men were collected via self-administered mailed questionnaires that participants were requested to complete prior to attending the workshops and four weeks after the workshops. At the conclusion of each workshop, participants were also requested to complete a workshop evaluation form assessing program structure and delivery and an evaluation of the resource cards used during the workshop.

Results

In total, 70 GPs attended the three workshops. There were 42 (60%) participants who completed the pre-test questionnaire, which measured confidence in and intention to discuss prostate cancer screening with asymptomatic men. Twenty-eight (40%) participants completed the post-test questionnaire, which was designed to assess change in confidence and intention to discuss prostate cancer screening issues with asymptomatic men four weeks after workshop participation. The workshop evaluation was completed by 63 (90%) participants who attended the workshops and the resource evaluation was completed by 59 (84%) participants. Before attending the workshop,

participants thought they had 'some' to a 'good' level of understanding about the benefits and risks of prostate cancer screening in asymptomatic men (M=3.56, SD=.91). Scores on the actual knowledge scale suggested that some GPs overestimated their knowledge about prostate cancer, with the average score on this scale being around the mid-point (M=8.26, SD=2.58 of a possible total score of

17). Following workshop attendance participants' knowledge scores significantly improved ($t(27)=-4.17$, $P<.01$), as did their self-rating of understanding about the benefits and risks of prostate cancer ($t(25)=-4.80$, $p<.01$). Participants' rating of the importance of making men aware of the benefits and risks of prostate cancer testing did not change ($t(27)=.21$, $p>.05$). Participants' confidence in and intention to discuss testing with an asymptomatic man significantly increased after attendance. Confidence in and intention to discuss testing with an asymptomatic man with a family history also increased after attendance but did not reach

statistical significance. Mean scores and standard deviations for these items from the pre and post-workshop questionnaire are presented in Table 1.

Fifty-nine participants rated the interactive decision card and the summary reference card. The majority of participants (61%) rated the decision card as 'easy' or 'very easy' to follow and 25% reported it as 'somewhat easy'. In line with this pattern of responses, 59% of participants reported that the card would be 'useful' or 'very useful' for their general practice and 29% thought it would be 'somewhat useful'. For the summary reference cards, two-thirds (66%) of participants rated the summary reference card as 'easy' or 'very easy' to follow and 29% reported that it was 'somewhat easy' to follow. Consistent with this finding, 63% of participants reported that the summary reference card would be 'useful' or 'very useful' for their general practice and 34% thought it would be 'somewhat useful'. Eighty six per cent rated the resource kits as 'good' or 'excellent'. Participants

Table 1: Descriptive data for confidence about and intention to initiate a discussion about testing for prostate cancer (N=28)

Intention to initiate a discussion about testing for a 45 year old asymptomatic man with a family history *					Intention to initiate a discussion about testing for a 55 year old asymptomatic man *						
Pre Test		Post Test		t value	df	Pre Test		Post Test		t value	df
Mean	Standard deviation	Mean	Standard deviation	- 2.00	27	Mean	Standard deviation	Mean	Standard deviation	- 2.74*	27
4.57	0.79	4.79	0.50			3.61	1.40	4.14	1.15		
Confidence in discussing testing for a 45 year old asymptomatic man with a family history *					Confidence in discussing testing for a 55 year old asymptomatic man *						
Pre Test		Post Test		t value	df	Pre Test		Post Test		t value	df
Mean	Standard deviation	Mean	Standard deviation	- 1.72	27	Mean	Standard deviation	Mean	Standard deviation	- 3.15*	27
4.36	0.73	4.54	0.69			3.89	0.96	4.46	0.58		

Note: * - intention to initiate a discussion about testing was assessed on a scale from: 1 not at all likely, to 3 somewhat likely, to 5 very likely. * - confidence in discussing testing was assessed on a scale from: 1 not at all confident, to 3 somewhat confident, to 5 very confident.

* $p < .05$

** $p < .01$

rated their satisfaction with a number of aspects of the workshop (Table 2). Overall most participants rated the various aspects as 'good' or 'excellent'. Overall, 59% of participants reported that the workshop was 'very useful' or 'extremely useful' and a further 32% rated it as 'generally useful'. Only 5% of participants reported that the workshop was 'a little useful' or 'not at all useful'. The vast majority of participants (89%) said they learned something new at the workshop and 92% said that they would recommend the workshop to other GPs. The majority of participants (64%) reported that 'most' or 'all' of what was learned in the workshop would lead to an improvement in the quality of care provided to patients. A further 30% said that 'some' of what was learned in the workshop would lead to an improvement in the quality of care provided to patients. Similarly, 67% of participants reported that they would try to implement 'most' or 'all' of what was learned in the workshop into their practice. A further 30% said they would try to implement 'some' of what was learned in the workshop into their practice.

A brief qualitative analysis of responses to the openended questions revealed that a small proportion of participants (14%) said that there were areas either not covered or not covered in enough detail. Most of the areas listed by participants related to the treatment of prostate cancer. Three participants mentioned screening issues and one mentioned the patient's psychological response. Many participants anticipated that there would be some barriers to implementing the knowledge obtained in the workshop. The most commonly reported barriers were lack of consultation time and patient understanding and attitudes towards prostate cancer testing. Other barriers that were less commonly mentioned included the large volume of relevant information, patient follow-up, the GP's own philosophy and being female, particularly in relation to digital rectal examination. Some participants suggested ways the program could be improved. The most common suggestions related to the workshop content, such as including a brief overview of prostate cancer issues and providing more case studies. A small number of participants commented on the length of the program.

Table 2: Participants' satisfaction ratings with various aspects of the workshop

	Good / Excellent		Fair / Poor	
	n	%	n	%
Speaker (medical content)	60	95.2	-	-
Speaker (communication content)	55	87.3	5	7.9
Workshop content	56	88.9	2	3.2
Relevance to practice	56	88.9	3	4.8
Length	54	85.7	5	7.9
Timing	54	85.7	4	6.3
Presentation slides	57	90.5	2	3.2
GP resource kits	54	85.7	2	3.2
Discussion time	53	84.1	3	4.6

Note: N = 63; Due to missing data percentages may not equal 100

Discussion

The findings from this evaluation revealed that physician knowledge about the potential risks and benefits of prostate cancer testing increased significantly after attending the workshop. Physician confidence in discussing prostate cancer testing with asymptomatic men over 50 years increased significantly after attending the workshop, as did their intention to discuss testing. There were also small but non-significant increases in physician confidence and intention to discuss prostate cancer testing with asymptomatic men who were younger than 50 years but had a significant family history of prostate cancer. Overall, the program was well received by GPs and it appeared to meet their needs on a number of levels. A possible explanation for this can be attributed to the delivery of a multi-model learning approach. The results showed that the majority of participants reported that it was very or extremely useful and a further one-third thought the program was generally useful. When participants rated their satisfaction with a number of aspects of the program (including the speaker, workshop content, relevance, length, timing, presentation slides, GP resource kit and discussion time), the vast majority rated each aspect as good or excellent. In line with their satisfaction ratings, almost all participants said that they would recommend the workshop to other GPs. Another encouraging finding was that the majority of participants thought that the information they learned through the workshop would lead to an improvement in the quality of care they provided to patients and that they would implement most or all of what they had learned. In general, the results for the interactive decision card and the summary reference card were encouraging with the vast majority finding the resources at least somewhat easy to use and at least somewhat useful. While most participants reported that both resources were easy to follow and that they would be useful for their general practice, a small proportion did not agree. These findings suggest that the interactive decision card and summary reference card may need more time dedicated to them in the workshop or they may need to be revised to make them even easier to use. As a consequence of the findings from these workshops, the interactive decision card and the summary reference card have been recently updated.

Conclusions

In conclusion, the workshops were well received by GPs and were associated with positive changes in knowledge and confidence about shared decision making and informed choice in relation to prostate cancer testing. The potential impact of the education on opportunistic testing was not explored. In this regard, the program did not advocate for or against testing, but rather aimed to educate GPs about the relevant issues and the need for shared decision making and informed choice. Feedback from the participants suggested that they were very satisfied with the workshop content and the way it was presented. Furthermore, participants reported that the resources provided within the workshop were easy to follow and appropriate for their practice. Nevertheless, there were some issues provided by participants that should be considered in order to improve the workshop. One of the key barriers to using the skills and resources provided in the workshop is the lack of consultation time. Strategies for GPs to use the skills and resources within the time constraints need to be considered. This is an area of further research and will need both changes in the GP environment and new government preventative health strategies. The findings also highlight some aspects of the workshop that might be further developed, such as providing more time for additional practical case studies and giving an initial brief overview of prostate cancer screening and treatment issues.

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Council Victoria, the National Cancer Control Initiative, the Brisbane North Division of General Practice, the Northern Division of General Practice, Inner Eastern Melbourne Division of General Practice, Melbourne Division of General Practice, Greater South Eastern Division of General Practice and Dandenong District

Division of General Practice. A PDF version of the GP/Patient Show Card and GP Reference Card can be downloaded from the NCCI website (www.ncci.org.au) or from the *Information for health professionals* page on The Cancer Council Australia's website (www.cancer.org.au).

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COSA Report

Ms Margaret McJannett
Executive Officer
COSA

COSA has been continuing to move forward on a number of issues on behalf of its membership. Key activities include:

Annual Scientific Meeting (ASM)

The AH&MR Congress, site of this year's COSA ASM, continues to gain momentum. The impressive confirmed speaker list now exceeds 150 speakers and many of them are speaking on cancer related topics.

Specifically within the COSA program, there is the normal range of symposia and sessions meeting the wide range of needs of the membership. We are in process of confirming the international speakers and COSA program. A draft program will be posted on the COSA website shortly. Please note this year's meeting will be held at the Melbourne Convention Centre, November 29-1 Dec. There will be a Consumer Forum held on Tuesday 28 November.

Professional Development Packages for Cancer Professionals

The Commonwealth DoHA called for tenders late in 2005 to look at educational needs of cancer health professionals. A consortium involving Centre for Innovation in Professional Health Education (CIPHE), COSA, TCCA, NBCC, and the RACGP successfully tendered for Phase 1 of the project, scoping current cancer professional development resources and associated needs of cancer professionals, GPs and counsellors.

A reference group is guiding the project, which includes an online survey targeting relevant professionals.

COSA Enabling Grant

Working parties have been convened to make recommendations about how to allocate funds for each component of the grant:

Protocol Development, Information Systems and Quality Assurance. Scoping exercises for each component are in progress. The protocol development working party has developed its recommendations and will be reviewed by the Steering Committee in due course.

Executive Committee has been established to oversee the work of this grant and meet more frequently than the Steering Committee. Members include: Dr Steve Ackland, Chair, Professor Alan Coates, CEO TCCA, Ms Haryana Dhillon, Project Coordinator, Ms Margaret McJannett, EO, TCCA / COSA, and Dr John Seymour and Associate Professor Martin Stockler.

Responses have been made on behalf of the Cooperative Groups through COSA to NSW Health regarding the Policy Directive on Clinical Trials – Risk Management, Insurance and Indemnity, and to the Cancer Institute NSW regarding Streamlining of Ethical Review of Cancer Research in NSW.

Alan Coates Honoured for Scientific Leadership

COSA joins the chorus of clinicians and health professional groups congratulating Professor Alan Coates for winning the prestigious Distinguished Service Award for Scientific Leadership, bestowed by the American Society for Clinical Oncology (ASCO). We have particular reason to celebrate, as ASCO is our US counterpart and the conferring of this award on Professor Coates, a member of our Executive, builds on the already strong relationship between our two organisations.

We are fortunate that Professor Coates will remain active within COSA and in cancer research after he retires from his Cancer Council Australia career later this month.

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The National Cancer Control Initiative (NCCI) Report

*Professor Mark Elwood
Director
National Cancer Control Initiative*

This is the last report from the National Cancer Control Initiative. The NCCI is disbanding, sadly, on the 31 May 2006. Since its inception in 1997, NCCI has contributed greatly to strategic developments in cancer in Australia, and has during this process produced some 36 reports based on wide consultation, and about 75 peer-reviewed papers. NCCI conducted the largest consultation to yield a national consensus on cancer priorities, developed a practical core clinical data set, produced the first evidence-based rationale for the requirements for radiotherapy, set up implementation programs based on the lung cancer and psychosocial guidelines, developed a primary care program in cancer, and jointly produced the 'Optimising Cancer Care in Australia' report. The closure of NCCI is very regrettable, and I do not think we are being conceited if we say that this is not only unfortunate for those of us who have worked with and supported NCCI, but also for the progress of effective cancer strategies in Australia. NCCI has made a major contribution and has developed considerable expertise and resources that are highly relevant to ongoing issues in cancer care. Inevitably, much of this experience will be lost.

Our position all along has been that while we support the development of Cancer Australia as a larger and more comprehensive focus for strategic efforts in cancer, it would have been simple and inexpensive to ensure that NCCI continued until it could be incorporated into or linked with Cancer Australia in an effective way. However there has been no action to ensure linkage. Some of the NCCI staff have accepted other positions, while for others there is still some uncertainty. We are making what arrangements we can to allow some aspects of continuity, for example we are trying to ensure that the NCCI website (www.ncci.org.au) continues for a reasonable time as a portal through which people can still get access to published reports and other material produced by NCCI. A final report is being prepared for the Department of Health and Ageing.

ACN would like to thank Professor Mark Elwood and his staff for their generous cooperation with a number of projects over the last nine years and wish them well for the future.

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Report of The Cancer Council Australia

*Glen Turner
Communications Manager
The Cancer Council Australia*

Changing of the guard at The Cancer Council Australia

After eight years of running Australia's largest federated health charity, The Cancer Council Australia CEO Professor Alan Coates has retired and passed the baton to the former Chair of the organisation's Medical and Scientific Committee, distinguished ex-Adelaide oncologist, Professor Ian Olver.

President of The Cancer Council Australia, Mrs Judith Roberts AO, said the transition was a good opportunity to both celebrate Professor Coates's extraordinary contribution while welcoming Professor Olver as the ideal candidate to position the organisation to address the future challenges of leading national cancer control in the non-government sector.

"We are extraordinarily fortunate to have had eight years of service from a scientist, advocate