

Urological Cancer Update

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of the Victorian Cooperative Oncology Group
Centre for Clinical Research in Cancer**

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UROLOGICAL CANCER UPDATE

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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). If you would like to have your name removed from the distribution list, please contact Leigh Williams, Ph: (03) 9635 5174.

The Victorian Cooperative Oncology Group's advisory committees on breast, gastrointestinal, gynaecological, head & neck, lung, and skin cancers also produce twice yearly cancer updates. If you are interested in receiving these updates please contact Leigh Williams, Ph: (03) 9635 5174.

***** Last Issue – No. 16 – July 2004 *****

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.



Thank you to Aventis Pharma for supporting the costs of producing this publication

Professor Don Metcalf Honoured for Outstanding Contribution to Cancer Research

*Ms Zoe Furman
Communications Manager
The Cancer Council Victoria*

The Cancer Council Victoria recently honoured leading medical researcher Professor Donald Metcalf for his outstanding contribution to cancer research. Hailed as “Australia’s most distinguished cancer researcher”, Professor Metcalf was recognised for his life-saving research at a special function at Government House, Melbourne, in late November, to celebrate his 50 years as the Cancer Council’s Carden Fellow.

Since being appointed Carden Fellow in Cancer Research in 1954, Professor Metcalf has been based at the Walter and Eliza Hall Institute for Medical Research. His research has led to the development of the major supportive cancer therapy, colony stimulating factors (CSF), which has so far benefited around five and a half million cancer patients worldwide.

Cancer Council Director Professor David Hill said the Cancer Council was proud to have supported the work of a world-class researcher over the last 50 years.

“There are very few medical researchers whose work has had such a profound impact on cancer treatment.”

Associate Professor Richard Bell said CSFs have had a major impact on the treatment of human disease.

“Clinicians have experienced a dramatic improvement in our ability to treat cancer because of Professor Metcalf’s discovery. His work has led to a large and productive network of biologic and clinical trials research. We continue to learn of new and better ways to use his discoveries to benefit our patients.”

Former Walter and Eliza Hall Institute Director Sir Gustav Nossal said Professor Metcalf is one of the few medical scientists who have seen his discoveries flourish from laboratory bench to the patient’s bedside.

Around 30 people who received CSF therapy as part of their treatment for cancer and other medical conditions attended the special celebration, and had the opportunity to meet Professor Metcalf.

As Professor Metcalf commented, this interaction between a researcher and those who have benefited from research is most unusual.

“It’s quite uncommon to discover something that gets into the clinic and is used in treating people. Not many people have the good fortune to discover something that can be applied like this.”

The opportunity to meet the man responsible for a treatment that had helped their recovery was clearly a highlight for the patients, with many

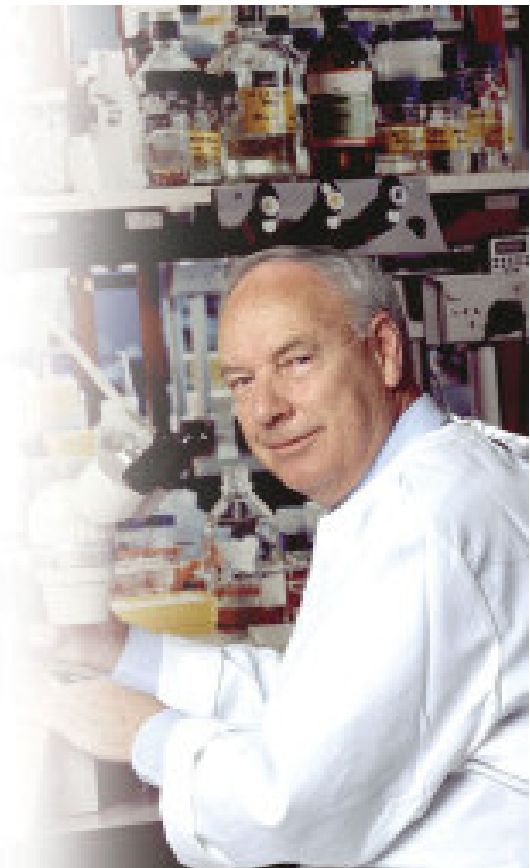


Image courtesy of Walter & Eliza Hall Institute of Medical Research

traveling from country areas to attend the jubilee celebration. Several former patients had participated in clinical trials of G-CSFs at Royal Melbourne Hospital in the early 1990's, while others had undergone cancer treatment as recently as this year.

Annie Donaldson, who has had two G-CSF supported stem cell transplants as part of her treatment for multiple myeloma, was one of the guests at the special event.

Ms Donaldson said it was an honour to be able to meet the man whose research has helped save her life.

"Professor Metcalf's discovery of CSFs is the reason I am alive today, and it is wonderful to be able to meet such a dedicated and gifted scientist whose work has helped so many people like me."

The Carden Fellowship was established as a result of an initial generous bequest to the Cancer Council in 1945 from George Frederick Carden, a prominent Melbourne businessman. The Carden family's link with the Cancer Council extends to VCOG; longstanding VCOG member Tony Carden, who has been involved in the Gastrointestinal Committees for many years, is Carden's grandson. Tony, along with a number of Carden's descendents attended the jubilee celebration at Government House.

One of the highlights of the day was a special performance by another Carden family member, renowned Australian opera singer Joan Carden. The operatic touch was fitting given the well-publicised link between G-CSF and another famous opera singer, Spanish tenor Jose Carreras. After developing acute myeloid leukaemia, which did not respond to initial treatment, Carreras received a treatment regime that included CSF therapy in 1987. He responded positively and recovered successfully. Senor Carreras was one of a number of luminaries to send congratulations for the Metcalf jubilee celebration.

Professor Metcalf's work has been acknowledged by some of the highest honours in the world of contemporary science. Still considered to be at the forefront of cancer research today, his work is a remarkable success story of cancer research, of generous philanthropy and of the benefit of prolonged, sustained and secure support from The Cancer Council Victoria in a funding relationship that is probably unique in medical research in Australia.

Professor Metcalf's career in research illustrates perfectly the significant dividends that can come from channelling long-term support into the work of a world-class researcher.

PSA Testing in the Community: The Evolving Position

Dr C Dowling¹, A/Prof L Cleeve²

1. Urologist, Alfred Hospital Melbourne

2. Urologist, Royal Melbourne Hospital / Peter MacCallum Cancer Centre

Earlier this year, clinicians from the Victorian Urologic Oncology Group and interested general practitioners and consumer representatives met to discuss that old chestnut, PSA testing. An expert panel was assembled of Urologists (Prof Tony Costello, A/Prof Mark Frydenberg) Radiation and Medical Oncologists (Prof Gill Duchesne, A/Prof Guy Toner), a general practitioner (Dr Adrian Dabscheck), a consumer representative (Mr Philip Rodda) and legal perspectives from

Professor Loane Skene from the University of Melbourne. Urologists, Mr Laurie Cleeve and Mr Jeremy Goad co-chaired the meeting with many urologists, trainees, radiation oncologists, urology nurses and general practitioners in attendance.

The same group had met in 2000 to discuss the issue. Jeremy Goad opened the 2004 session with a slide of the recommendations made in 2000. This included such statements as the "value of population screening remaining

uncertain” at that time, a note that “prostate cancer related deaths had fallen in most western countries” and as the disease in its early and potentially curable phase was asymptomatic, testing asymptomatic men would be required to have a potential impact on the course of the disease. It was therefore concluded that GPs should be encouraged to initiate a discussion about PSA testing, provide testing after giving information about testing and that it would be unwise to refuse testing if requested.

Unfortunately four years later, not much has changed in the strength of data available to support PSA population screening and there is still confusion amongst the GP community as to who should be offered testing. Mr Goad went on to present the established criteria for a condition that justify a screening program to be initiated and then presented data that supported these parameters in the case of prostate cancer.

In terms of the more recent scientific data available to support PSA testing, new information since the 2000 meeting included Labrie et al (1) who at that point had not published their now known follow up, which demonstrates a 62% reduction ($P < 0.002$, Fisher’s exact test) of cause-specific mortality in the screened men ($P = 0.005$) (2). Bartsch et al (3) in the Tyrol study demonstrated a decreased prostate cancer related mortality in the screened arm. The Holmberg study of 2002, published in the New England Journal of Medicine demonstrated a cancer specific survival 7.1% vs 13.6% in favour of RRP over watch and wait with no overall survival benefit but the study limited by its inclusion of pre-PSA era cases (higher clinical stage) and further follow up is awaited.

Mr Goad also reiterated the position of the Urological Society of Australasia (USA) which states that:

- Individual men aged 50 to 70 years with at least a 10 year life expectancy should be able to be screened by annual DRE and PSA testing, after appropriate counseling regarding the potential risks and benefits of investigations and the controversies of treatment.
- It should be left to the individual doctor to decide whether to advocate testing in a man not requesting it.

- Population screening of asymptomatic men is not recommended.

(Reviewed March 1999)

Discussion then centered around who would offer PSA testing to an asymptomatic fifty year old male as part of a general medical check-up

Men’s Health GP, Dr Adrian Dabscheck opened the discussion by defining the difference between case finding and population based screening. On current evidence a population based screening program, such as exist for breast and cervical cancer, is not justified in prostate cancer but case finding is appropriate. Dr Dabscheck emphasized that for the individual patient the application of population-based statistics is difficult and case finding for the patient who wants a PSA test is justified.

Advice Before Testing

Dr Dabscheck expressed he would certainly raise the issue of PSA testing in the context of health screening in this fifty year old man. He would provide him with brief information regarding the PSA test prior to performing the health screen. Professor Skene added valuable detail at this point regarding the obligations in relation to the information provided prior to testing.

There are three tiers of advice in relation to PSA testing. Firstly there is advice related to the blood test. Prof Skene said she envisaged this would entail a discussion of the false positive and negative rates of the test and beyond that the standard of care depended on the needs of the individual patient, with the doctor asking themselves what they know about the individual patient that would allow the doctor to judge what extra information this patient would require.

The next level of advice that needs to be discussed before the test, relates to the event of a positive PSA test and the possibility of the need for a biopsy as a result. The final level of advice relates to the ramifications of treatment. Prof Skene said the advice at this third level would be to provide a framework as a part of the overall discussion with specifics related only to the first tier (ie the blood test) and the possibility of a biopsy. Beyond this no discussion needs to be initiated unless the patient requests more specific details.

Legally, the level of information required when counseling a man prior to PSA testing depends on the scenario in which the testing was sought. Prof Skene acknowledged these discussions do take time, something we are all aware is in short supply in general practice. The provision of written material and website addresses may decrease the time taken for discussion but cannot replace the discussion. To conclude the consultation, she advised simply asking the patient if they had any further concerns.

PSA Testing Scenarios in General Practice

1. Prof Skene carefully delineated that there is an important difference between the three possible scenarios (table 1) faced by GPs. Firstly there is the patient who is symptomatic (uncommon) or who has a family history. In relation to this potential scenario, Prof Skene advised that failure to test could result in negligence being proven in the case of a missed diagnosis of prostate cancer.
2. In the second scenario, the case of the patient who requests testing, Prof Skene commented after adequate informed consent, the patient should be tested. Active discouragement in this case would not be recommended and even though a case in negligence has never been successfully tried to her knowledge (and that the Tort Law reform enacted in Victoria this year will support the GP who does so under a "reasonable doctor" defense, as the practice regarding PSA testing currently could be proven to be diverse) she would recommend the doctor proceed with testing on request after adequate provision of information.
3. The final scenario is the most difficult. This is the patient who does not request testing. Anecdotally, Dr Dabscheck feels this is the most common patient. Men do not tend to present for health screening and it was repeatedly pointed out by various panel members in the seminar that localized prostate cancer is a disease of higher socio-economic class, as these men tend to be better informed about the possibility of threats to their health and wellbeing. Case finding therefore most frequently seems opportunistic in general practice and includes

few patients who are un-insured and Prof Costello pointed out that rates of radical prostatectomy in the public and private hospitals reflect this fact.

Many urologists and radiation oncologists, including panelists, Prof Costello, Prof Duchesne and A/Prof Frydenberg, now advocate offering testing to asymptomatic men who are not seeking the test as long as they have a life expectancy that would justify radical treatment in the case of a positive diagnosis and they are properly informed.

Table 1: PSA testing scenarios in General Practice

Scenario 1: The patient who is symptomatic or who has a family history

Advice: Provide PSA testing, some recommend from age of 40 years if family history positive, after informed consent

Scenario 2: The case of the patient who requests testing

Advice: Provide PSA testing after informed consent

Scenario 3: The patient who does not request testing but presents for health screen/unrelated illness

Advice: Many urologists now support offering a PSA test after informed consent, to any man in this group who is aged 50-70yo who has a life expectancy of more than 10 years

Prof Skene says it remains unknown what the legal ramifications for not testing an asymptomatic man who does not come seeking PSA testing, who subsequently is diagnosed with prostate cancer. Given current practice in this area is so diverse, failure to test is likely to be defensible.

Mixed Messages for GPs

Prof Costello expressed his sympathy for general practitioners who have received many mixed messages regarding testing. He considered that rigorous scrutiny of PSA testing was above and beyond the sort of attention paid to other aspects of general health screening. He stated that GP's should not feel responsible for the cascade of events that ensue after a patient returns an

elevated PSA beyond establishing awareness of the next step, ie the potential for a biopsy.

Don't Test without Telling the Patient!

What was made clear though, was the notion that to order a set of tests, including a PSA, and not explain to the patient what each test was for, was both poor clinical practice and may lead to a legally difficult situation on receipt of a positive PSA test with no prior discussion with the patient.

The group then discussed further refinements of the PSA testing process including appropriate age cutoff's given the ageing population, some whom have chronological ages well below their biological age, the approach to equivocal PSA readings in urological practice using Free:Total PSA ratios and active surveillance over time of elevated PSA's to avoid unnecessary biopsies, and the role of the DRE, which the consensus feeling was it remained an important part of the general practice assessment, except perhaps where the PSA was less than 1ng/ml.

Much discussion occurred about costs. Medicine practiced at a high standard is costly, for example interventions such as cholesterol lowering drugs, cardiac surgery and liver transplantation are all expensive. If we are to reduce life years lost in the active and ageing population then an aggressive approach to PSA testing, whilst costly, is justified. Overall it was considered that practicing appropriate medicine, was of greater concern than cost.

So to summarise, there is still a great deal of work to be done in raising public awareness regarding PSA testing in the setting of case finding. A first important step in this process will be to formulate an agreed and simple message that is accepted by GPs and is easy to pass on to their patients. This message needs to be supported by the Urological Society of Australasia, the Prostate Cancer Foundation, the Australian Prostate Cancer Collaboration, the Cancer Council and Andrology Australia.

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The Timing Of Androgen Deprivation Study TOAD - VCOG PR 01-03; TROG 03.06

*Prof Gillian Duchesne
Radiation Oncologist
Peter MacCallum Cancer Centre*

Many of you will have been involved in the very long gestation of this study, which finally opened to accrual in the winter. Now that we are up and running it is timely to take the opportunity to update you on the study evolution, its progress and its continued relevance on the world stage.

About three years ago we raised the question in the VCOG Urological Cancer Committee as to the best approach to introducing androgen deprivation in patients with either a PSA relapse after definitive treatment (Study 1), or patients asymptomatic and newly diagnosed, but not considered suitable for a curative approach (Study 2). A national survey of urologic surgeons,

medical and radiation oncologists had shown much variability in the philosophies on the timing of starting treatment in these two patient groups. In the former, it is recognised that PSA failure may precede overt clinical relapse by a number of years, which raises the appropriateness of exposing men unnecessarily to the adverse effects of androgen deprivation over many years, unless there is a survival advantage. Similarly in asymptomatic men just diagnosed: should they be made symptomatic through therapy unless there is an advantage to starting treatment early? The variability in approach of experts in the field reflects the lack of evidence to guide our decision-making. The trial is looking at the solid end point of overall survival.

After discussion at VCOG we were set to work to draft the protocol. The earliest dated documents are from the beginning of 2002. Rodney Syme took on responsibility for the 'non-curables' and me for the relapsers. A Trial Management Committee with representation from all professional groups, and across Australia was formed and discussed the intricacies of the developing protocol. After many iterations the 'final' version of the protocol was ready in December 2003. The study was put forward to TROG for review and to the Urological Society of Australasia for endorsement. Through this process numerous teleconferences were held, emails exchanged and opinions expressed. Some compromises were made and the final document a testimony to collaboration of all our disciplines. However within days of opening to accrual, clinicians were asking for clarification and amendments – such as increasing the length of time between diagnosis of PSA relapse and trial entry, and amendments continue to be made – this is a living document.

The trial has now been granted approval by a number of Human Research Ethics Committees including the Cancer Council Victoria, Peter Mac, the NSW Cancer Council and about 20 other institutions. It is worth noting that both Victoria and NSW Cancer Councils have agreed that clinicians wishing to enter patients from their private rooms may do so under the auspices of their HRECs, providing the principles of good research practice are adhered to and they have appropriate professional indemnity insurance.

To refresh the memory: eligible patients are those for whom you really find it hard to advise when

they should start androgen deprivation therapy. Patients will be randomised to receive either immediate androgen deprivation (the experimental arm), or intervention when there is evidence of disease progression: the protocol strongly recommends that this should be as long as possible, certainly more than two years, unless there are compelling reasons to do otherwise. For clinicians who may be concerned at leaving patients untreated, evidence for the validity of this approach comes from a recently published but underpowered study that failed to demonstrate a survival benefit for early intervention (Studer et al, J Clin Oncol 22 4109-4118). Further evidence is clearly needed.

Clinical research is an expensive activity, and can no longer readily be carried out without specific funding. We have been fortunate to receive funding from the initiation - from a small grant from the Royal Australian and New Zealand College of Radiologists to get initial statistical advice; a multistate cancer council grant awarded to start in 2004 for data management support; a generous educational grant from Mayne Pharma enabling the Cancer Council Victoria's Clinical Trials Office to get the trial up and running to date. Finally, we heard this week that we have been awarded a project grant from NH&MRC to cover central trial management personnel, with a significant capitation fee for each patient entered.

Recruitment is now underway. Please contact Michael Harold or Deborah Howell at the Cancer Council Victoria for information and trial documentation.

Michael Harold

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or

Deborah Howell

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Prizes will be given for clinicians recruiting various 'landmark' patients: the first prize for the first patient went to Queensland, so please get moving and ensure the 50th patient prize stays with us. Thank you to everyone for all their hard work and input.

40th Annual ASCO Meeting

June 2004, New Orleans, USA

*A/Prof Mark Rosenthal
Medical Oncologist
Royal Melbourne Hospital*

ASCO 2004 in New Orleans was hot, steamy and attracted over 25,000 registrants. The city was bursting to capacity, teaming with music and fine food (if you like everything deep fried).

For Uro-Oncologists, it was one of the best meetings on record with seminal abstracts presented. Of nearly 10,000 abstracts, it was two papers on prostate cancer that made the plenary session. In addition, there were hundreds of oral presentations, poster presentations, and posters focussed on prostate, bladder, testis and renal cancer.

The two plenary papers are now well known having been presented regularly in local forums and were published back to back in the NEJM in October this year. These studies compared Taxotere regimens against Mitozantrone in hormone refractory prostate cancer. Both studies demonstrated a significant survival

benefit for those receiving Taxotere. Of course this is the first time that a survival benefit has been established in patients receiving chemotherapy for HRPC. These findings will have substantial ramifications for Australian men with HRPC.

Other highlights (in abstract form only) included:

- Bevacizumab (VEGF inhibitor) activity in RCC
- Post prostatectomy RT improves PSA and Clinical progression free survival (Bolla et al)
- Reduction in PSA following chemotherapy predicts survival (D'Amico et al)
- Activity of many novel drugs in HRPC
- Single cycle of Carbo is equivalent to RT for Stage I seminoma (Oliver et al)

Prostate Nurse Care Update

*Ms Robyn Metcalfe
Men's Cancer Program Manager
Cancer Education Unit, The Cancer Council Victoria*

The Men's Cancer Program hosted an education day for prostate nurses on 22 July. The day involved 26 prostate care nurses, consumers, support group facilitators and other health professionals. Topics covered included brachytherapy, imaging prostate cancer, tissue banking, sexual function issues and erectile dysfunction treatment options.

Evaluation of the day highlighted that having a wider, multidisciplinary audience was beneficial

for all involved, and following on from this the Men's Cancer Program have decided to change our existing model of nurse education days.

From 2005, the Men's Cancer Program will offer an annual prostate cancer update to community and health professionals, as well as interested consumers. We will contact you with more information on our 2005 annual prostate cancer update in the near future, and look forward to your continuing participation in these forums.

We extend a warm welcome to the 22 nurses enrolled in the July 2004 Prostate Nursing Care intake. Scholarships for this program are supported by the Prostate Cancer Foundation Australia

Robyn Metcalfe contact
Robyn.Metcalfe@cancervic.org.au

Forums

The Men's Cancer Program visited Rutherglen, Birregurra, Wonthaggi, Sale, Bairnsdale, Moe, Healesville, Wycheproof, Bacchus Marsh, Coburg and Geelong to deliver either a "Prostate Cancer" or "Prostate and Bowel Cancer" community forum. More than 1,120 people have attended these meetings, with 120 people coming to Birregurra. It is a great opportunity for men and women to hear accurate and reliable information about bowel and prostate cancer, and also presents an opportunity for people to ask questions of the specialists present on the night. Forums will continue in 2005.

Community Language Program

The Community Language Program (CLP) has been very busy this year with men and women from many different communities having a session in languages other than English. The program is delivered in Greek, Italian, Polish, Macedonian, Croatian, Serbian, Spanish and Chinese. Prostate Problems fact sheets have also been developed in these languages (except

Spanish at this stage) and they are available at the sessions. Fact sheets on prostate problems in many of these languages are available on www.prostatehealth.org.au

Workplace

The Cancer Council has developed new program where prostate and bowel cancer information is delivered in different workplaces across Melbourne. Health educators have recently been trained to deliver these presentations. Large Melbourne based organisations and local councils have been the first to take up the opportunity to have a session.

These sessions are being evaluated and are well received in the community.

Roadshows

The Men's Cancer Program has gone on the road this year with other Cancer Council programs and delivered health education to community health professionals in regional Victoria. The training took place in Warnambool, Bendigo, Horsham, Shepparton and Wodonga. Prostate information was a vital component of the days training, and more training is planned for next year.

The evaluations for this program were also very positive with many being very appreciative that the training took place in their towns, rather than having to drive to Melbourne for the training.

Report of The Cancer Council Australia

*Glen Turner
Communications Manager
The Cancer Council Australia*

Cancer Council Advocates National Approach to Cancer Prevention

A concerted and comprehensive national approach to cancer prevention is the theme of The Cancer Australia's *National Cancer Prevention Policy (2004–2006)*, launched in July 2004.

The *National Cancer Prevention Policy* sets out measures to help reduce the impact of preventable risk factors, such as smoking, ultraviolet radiation, inadequate diet and physical inactivity. It also outlines the benefits for screening for early detection of breast, cervical, bowel and prostate cancers and melanoma.

The Cancer Council Australia's Chief Executive Officer, Professor Alan Coates, said Australia was a world leader in the prevention of many cancers and much of that success was derived from the collaborative work of cancer councils and federal, state and territory governments.

"However, we could do much better," Professor Coates said. "Many of the 85,000 new cases of cancer diagnosed in Australia each year could be prevented through risk minimisation or treated more effectively through early detection."

The *National Cancer Prevention Policy*, which establishes a framework for governments to invest in improved cancer prevention, is the result of detailed work by the public health workers and clinicians who comprise The Cancer Council Australia's Public Health Committee and its sub-committees.

Professor Coates paid tribute to the authors of the policy, in particular Dorothy Reading (Chair of the Public Health Committee) who coordinated its development and production.

The National Cancer Prevention Policy (2004–2006) is available online at www.cancer.org.au.

Reprinted from *Wongi Yabber* August 2004; 11(3): 4.

Unprecedented Political Support

For the first time in a federal election, both the Coalition and the ALP included detailed cancer control policies among their campaign promises, with commitments that reflected much of The Cancer Council Australia's recommended policy platform.

In separate announcements in September, the ALP committed to more than \$112 million in prevention and treatment initiatives, while the Coalition launched its comprehensive \$137 million policy, *Strengthening cancer care*, in October.

The Cancer Council Australia publicly endorsed both policies, particularly the many initiatives consistent with the evidence-based position we put forward to all federal parliamentarians in June.

One of the most significant announcements was the Coalition's pledge to establish a national cancer care agency, Cancer Australia, at \$10 million over four years, which was a key Cancer Council priority.

There was unanimous support for funding independent clinical trials capacity building, with the Coalition and the ALP committing to \$15 million and \$12 million respectively over four years. The Cancer Council Australia had sought \$5 million per annum.

Both sides also committed to rolling out a national bowel cancer screening program, as well as funding for national SunSmart campaigns. The ALP allocated \$21 million for a tobacco control program aimed at a five percent decrease in national smoking rates, while the Coalition announced \$4 million to reduce smoking in pregnancy.

The ALP's commitment to introducing a Medicare Benefits Schedule item for cancer multi-disciplinary care reflected The Cancer Council Australia's overarching theme of improving multi-disciplinary care.

The Cancer Council Australia CEO, Professor Alan Coates, said considerable effort went into engaging with both sides of politics in the lead-up to the election.

"We continue to emphasise the fact that, while there have been improvements in cancer outcomes for Australians over recent years, cancer remains the nation's deadliest disease and there is great scope for federal policy makers to reduce the burden," Professor Coates said.

"We were very pleased to see both sides of politics show strong leadership in cancer control and look forward to continuing to build good relationships with our supporters in Federal Parliament."

Reprinted from *Wongi Yabber* November 2004; 11(4): 3–4.

Referral of Men Newly Diagnosed with Colorectal or Prostate cancer

Dr Trish Livingston
Centre for Behavioural Research in Cancer
The Cancer Council Victoria

Study Update

This study is designed to determine whether a specialist referral and outcall program reduces psychological morbidity associated with a cancer diagnosis. Forty-seven clinicians are committed to this study – 27 colorectal specialists and 20 urologists – and we are now accessing patients through 7 outpatients clinics across Melbourne metropolitan hospitals.

To date, 326 men have been referred to the Cancer Information & Support Service (CISS):

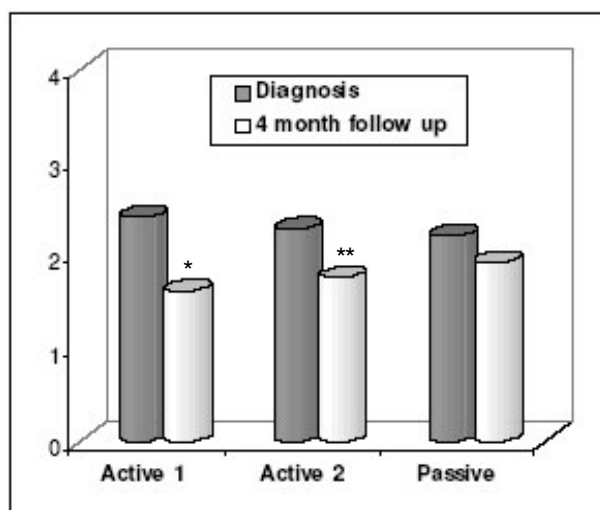
- 108 (33%) have been referred to receive four call-backs (Active Referral 1) from CISS nurse counsellors over a six-month period;

- 99 (31%) to receive one call-back (Active Referral 2) from a nurse counsellor post-diagnosis; and
- 119 (36%) who call into the service, if and when they choose to (Passive Referral).

Below are some preliminary results from the pilot study, based on the responses of 79 men who have completed surveys at baseline and 4 months post-diagnosis. *Although it is too early to draw any conclusions from the results, we are encouraged by them.*

Pilot Results

Worry About Cancer

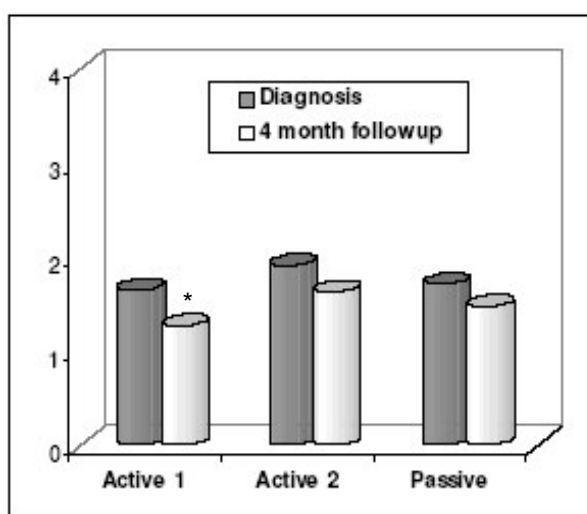


*p=0.001

**p=0.003

Men in the 1 or 4 call(s) groups were significantly less worried about their cancer diagnosis at 4 months post-diagnosis

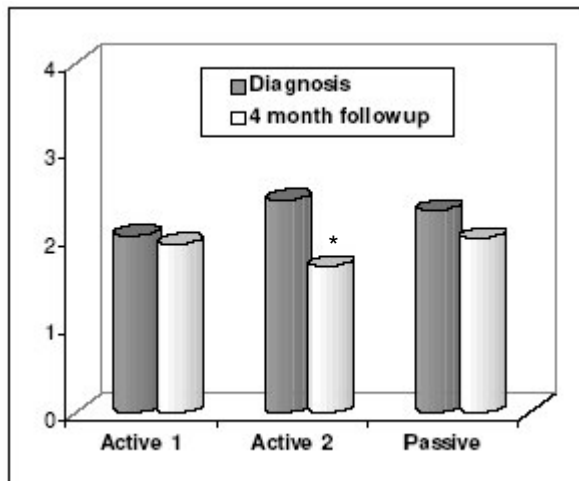
Worry About Dying



*p=0.001

Men in the 4 calls group were significantly less worried about dying at 4 months post-diagnosis

Worry About Physical Problems Associated with Surgery / Treatment



*p=0.001

Men who received 1 call were significantly less worried about physical problems associated with their treatment at 4 months post-diagnosis

Satisfaction with the Service

- 88% reported calls from CISS acceptable
- 83% found the calls helpful
- 86% of those who received outcalls said the timing of the calls was helpful

“I just thought the referral process was a matter of course, thought it was a good idea.”

“Instead of asking stupid questions, now ask sensible questions – broadened my knowledge of disease.”

“I think probably that prostate cancer is not greatly talked about by men – so the more discussions take place, the easier it becomes to talk not only to your doctor, but to other men as well.”

Recruitment will continue over the next 12 months

If you would like to participate in this study, please contact Dr Trish Livingston, Ph: 03 9635 5184 or E-mail: Trish.Livingston@cancervic.org.au

Clinical Practice Guidelines for the Management of Advanced Prostate Cancer

Reprinted from Wongi Yabber August 2004

HAC has approved the basic work plan for these Guidelines. The questions to be addressed have been developed for literature review. Steps are underway to fund and progress the project.

Reprinted from Wongi Yabber August 2004; 11(4): 2.

Clinical Practice Guidelines

There has been a widespread move towards developing clinical practice guidelines, which are designed to improve the quality of health care, to reduce the use of unnecessary, ineffective or harmful interventions, and to facilitate the treatment of patients with maximum change of benefit, with minimum risk of harm, and at an acceptable cost. Recent research has shown that clinical practice guidelines can be effective in bringing about change and improving health outcomes. But they are just one element of good medical decision making, which also takes account of patients' preferences and values, clinicians' values and experience, and the availability of resources. (Quote from NHMRC A Guide to the development, implementation, and evaluation of clinical practice guidelines, November 1998.)

The Cancer Council Victoria is supportive of the development of national clinical practice guidelines for management of cancer. The Cancer Council and members of the Victorian Cooperative Oncology Group have contributed to the development of national clinical practice guidelines through the Australian Cancer Network and National Breast Cancer Centre. Clinical practice guidelines are extensively reviewed before being endorsed by the National Health and Medical Research Council.

The following clinical practice guidelines are available from the NHMRC website (links are also provided at www.cancervic.org.au/cancer1/professionals/guidelines.htm):

Breast Cancer

- Clinical practice guidelines for the management of advanced breast cancer (Endorsed January 2001)
www.nhmrc.gov.au/publications/synopses/cp76syn.htm
- Clinical practice guidelines for the management of early breast cancer – 2nd Edition (Endorsed August 2001)
www.nhmrc.gov.au/publications/synopses/cp74syn.htm

- Psychosocial clinical practice guidelines: Providing information, support and counselling for women with breast cancer (Endorsed December 1991)
www.nhmrc.gov.au/publications/synopses/cp61syn.htm

Colorectal Cancer

- Clinical practice guidelines for the prevention, early detection and management of colorectal cancer (Endorsed March 1999)
www.nhmrc.gov.au/publications/synopses/cp62syn.htm
- Guidelines for the prevention, early detection and management of colorectal cancer: A guide for patients, their families and friends (Endorsed February 2000)
www.nhmrc.gov.au/publications/synopses/cp63syn.htm
- Guidelines for the prevention, early detection and management of colorectal cancer: A guide for general practitioners (Endorsed 1999)
www.nhmrc.gov.au/publications/synopses/cp64syn.htm

Familial Cancer

- Familial aspects of bowel cancer: A guide for health professionals (Endorsed February 2002)
www.cancer.org.au/content.cfm?randid=408243
- Clinical practice guidelines: Familial aspects of cancer: A guide to clinical practice (Endorsed November 1999)
www.nhmrc.gov.au/publications/synopses/cp67syn.htm

Lung Cancer

- Clinical practice guidelines for the prevention, diagnosis and management of lung cancer (Endorsed March 2004)

<http://www.nhmrc.gov.au/publications/pdf/cp97.pdf>

Ovarian Cancer

- Clinical practice guidelines for the management of women with epithelial ovarian cancer (Endorsed March 2004)

<http://www.ovariancancerprogram.org.au/about/guidelines.html>

Prostate Cancer

- Clinical practice guidelines: Evidence-based information and recommendations for the management of localised prostate cancer (Endorsed October 2002)

www.nhmrc.gov.au/publications/synopses/cp88syn.htm

Skin Cancer

- Clinical practice guidelines for the management of cutaneous melanoma (Endorsed December 1999)

www.nhmrc.gov.au/publications/synopses/cp68syn.htm

- Clinical practice guidelines: Non-melanoma skin cancer: Guidelines for treatment and management in Australia (Endorsed October 2002)

www.nhmrc.gov.au/publications/synopses/cp87syn.htm

Psychosocial Guidelines

- Psychosocial clinical practice guidelines: Providing information, support and counselling for women with breast cancer (Endorsed December 1999)

www.nhmrc.gov.au/publications/synopses/cp61syn.htm

- Clinical practice guidelines for the psychosocial care of adults with cancer (Endorsed April 2003)

www.nhmrc.gov.au/publications/synopses/cp90syn.htm

Clinical practice guidelines for the management of colorectal cancer and lymphoma are currently being developed under the auspice of the Australian Cancer Network (2004).

Working Parties for Accreditation, Credentialing and Guideline Implementation

The Australian Cancer Network (ACN) is developing wider, strong and active links with individuals and organisations working to strengthen the quality of care in the management of cancer patients. It is also working to ensure that cancer care is based on the best level of information available.

Working Party to Establish Accreditation of Cancer Services

This activity is progressing well. Significant discussions have occurred and the possibility of expanding interaction with state bodies is to be embraced. Elizabeth Metelovski has been appointed Project Officer and together with Dr

Karen Luxford of the National Breast Cancer Centre (NBCC) in association with the National Cancer Control Initiative (NCCI), is carrying out a scoping study following the signing of an MOU between ACN and NBCC. The first draft of this report was considered by the Steering Committee on 28 September. This was a proactive review and many members have contributed. An extension of time has been granted and the Committee will meet again by phone to finalise the document in the second week in December.

Working Party to Establish Credentialing Processes for Medical Staff of Cancer Services

Credentialing is recognised as one of the more significant steps in developing best practice in Cancer Units and the introduction of optimal multi-disciplinary care. This Working Party has made headway; however, it requires a good deal more work to produce appropriate procedures to ensure that the process has best practice outcomes. It is timely to expand activities of this Committee through a scoping study. It is hoped to appoint a Project Officer to carry this forward in the next few weeks. This appointment should lead to more substantive progress.

Working Party to Promote Implementation of Best Practice Guidelines

A Cancer Guideline Implementation Workshop was held on 14 October 2004 at Level 3, Medical Foundation Building.

The meeting was held under the auspices of the National Institute of Clinical Studies (NICS), NBCC and ACN. It was facilitated by Professor Dave Davis from Toronto and was positive in every respect.

Apart from identifying and discussing a range of issues in a positive manner, it allowed a number of people with like interests to learn of each other's existence. It will also have impact on the matrix being developed for the ACN Guideline Implementation Steering Committee.

Guideline development activities continue with progress being made in a number of important areas.

Reprinted from Wongi Yabber November 2004; 11(4): 1-2.

Report of the National Cancer Control Initiative (NCCI)

Australian Clinical Management Surveys in Cancer

In Australia, clinical management surveys have been conducted for a number of different cancers and in various locations. The NCCI was interested in identifying clinical management surveys for cancer in Australia, including surveys that have been published, are ongoing or are planned. A report *Australian Clinical Management Surveys in Cancer* identifies 25 published and 26 ongoing or planned clinical management surveys in cancer that have a large population base, ideally national or state-wide and lists the identified surveys. A table summarising the information contained in the published clinical management surveys is also provided. The report is available on the NCCI website at www.ncci.org.au

Core Clinical Data Set and Dictionary

Since 1982, Australia has had full coverage of cancer incidence by population-based state cancer registries allowing trends to be monitored. Mortality and overall survival rates by type of cancer can also be assessed but this information is insufficient to assess how the diagnosis, treatment and outcome of cancer patients compare to best practice. In 1999, the NCCI commenced a project to develop a core data set that would capture the most important data items relevant to the diagnosis and primary management and prognosis of cancer at the clinical level. A nationwide consultation was undertaken by Professor Alan Coates, on behalf of the NCCI, with input from a wide range of

clinicians, hospital staff, all Australian cancer registries, the AIHW and other groups. The items adopted for the NCCI Clinical Cancer Core Data Set reflected 'a reasonable compromise between a set too large to be attainable and one too small to be interesting' and included details of the stage of cancer at diagnosis, initial treatments and treatment outcomes. The items in the NCCI Clinical Cancer Core Data Set were submitted to the National Health Data Committee (NHDC) for inclusion in the National Health Data Dictionary (NHDD). In June 2004 all but two data items were approved under the title Cancer (clinical) Data Set Specification. The two items

not approved for inclusion in the NHDD were *Performance status score at diagnosis* and *Cause of death* but both of these are still included in the full NCCI Clinical Cancer Core Data Set. All items in the data set have been updated in line with the approved definitions and coding and are now available on the NCCI website www.ncci.org.au. The approved data items are also available via the Australian Institute of Health and Welfare knowledge base at www.aihw.gov.au/knowledgebase/index.html.

Reprinted from Wongi Yabber August 2004; 11(3): 3.

Cancer Information & Support Service (CISS)

The Cancer Information and Support Service (CISS) is a body of The Cancer Council Victoria that aims to alleviate the stresses that cancer places upon people through provision of information and support. CISS runs a number of services, including:

The Cancer Helpline

- Staffed by oncology nurse counsellors and trained enquiries officers
- A local call from anywhere in Victoria – 13 11 20
- Confidential provision of information and emotional support with referral to local community services
- Printed information on many cancer-related topics can be mailed to callers at no cost
- In 2003, the Cancer Helpline responded to over 49,000 contacts. This included over 6500 contacts with patients, 5500 contacts with family / relatives, 9200 contacts with the general public and 8000 contacts with health professionals

Multilingual Cancer Information Line

- Enabling people from non-English speaking backgrounds to access the Cancer Helpline via an interpreter

Cancer Connect

- A telephone peer support service that puts people in touch with others who have had a similar cancer experience

- Over 500 referrals and around 900 contacts were made in 2003

Cancer Support Groups

- CISS provides training and accredits nearly 120 groups within Victoria

Financial Assistance

- Including welfare grants and no interest loans

Living With Cancer Education Program / Living Well forums

- In 2003, there were 35 LWCEP run in Victoria with over 400 attendees

Look Good, Feel Better workshops

Holiday Respite Program

CISS would like to encourage you to refer your cancer patients and their carers to our professional services.

If you would like to receive brochures or any other information regarding any of the above please call the Cancer Helpline on 13 11 20. Alternatively contact the Director of CISS, Doreen Akkerman (Ph: 03 9635 5129 / E-mail: Doreen.Akkerman@cancervic.org.au) or Michael Jefford, Clinical Consultant, CISS (E-mail: Michael.Jefford@cancervic.org.au).



Information Sheet

Established treatments, treatments being trialled and alternative (unproven) treatments for cancer

If you have been diagnosed with cancer, it is possible that different treatments have been suggested to you. The Cancer Council has produced this information to help you decide between treatments that may help you and treatments that are unlikely to help you.

Your doctor will recommend one or more established treatments or suggest that you consider taking part in a clinical trial of a new treatment. You may be thinking about using complementary therapies along with treatments suggested by your doctor. You may also have read about, or been told about, an alternative treatment that may help.

How are they different?

Established treatments

These are proven treatments such as radiotherapy, chemotherapy, hormone therapy, immunotherapy and surgery. These are also known as 'medical', 'conventional' or 'mainstream' treatments.

These treatments have been tested in clinical trials and shown to be effective. (See the description of clinical trials below.) For example, it has been proven in clinical trials that:

- removing a skin cancer at an early stage prevents it from growing or spreading
- many childhood leukaemias can be cured with chemotherapy
- tamoxifen can prevent some breast cancers from recurring.

Established treatments are prescribed by general practitioners, cancer specialists (oncologists) and other medical specialists. You have these treatments in hospitals and doctors' surgeries and sometimes at home.

Treatments being trialled

These are treatments that are being tested in clinical trials. Clinical trials test new drug therapies, procedures, treatment combinations, preventative measures, screening methods and alternative treatments to see if they are better than the established treatments.

Clinical trials examine treatments that have shown promise during initial testing. For example, a researcher may think that a chemical that affects cell growth could be used to destroy cancer cells. Tests evaluating its safety and effectiveness will be done in the laboratory and then on animals. If it is thought to be safe and effective enough, it will be tested on people in a clinical trial.

There are three clinical trial phases. The cancer specialists carefully watch the effects of the new treatment on the people in the trial. If the treatment goes through to the end of the third clinical trial phase, the results of the new treatment are compared with established treatments. If the treatment that was trialled is better, and usually after it has been confirmed with other trials, it will be recommended to other doctors for their patients.

A clinical trial will only be conducted if the new treatment is thought to be at least as effective as the established treatment for a cancer.

Clinical trials are conducted and monitored according to strict guidelines. The treatments are given strictly to plan. Results are collected, analysed and published in scientific journals.

People in trials are treated according to an agreed document that sets out the terms of treatment (known as a treatment protocol). They are reviewed frequently during and for a time after the treatment phase, and so receive very high quality care. Some studies have shown that people treated in clinical trials have better outcomes than people who do not join clinical trials.

People are told about clinical trials by their doctor or they may hear about them from the media, the Internet or other sources. They can volunteer to join the trial.

Alternative (unproven) treatments

These are treatments that are said—by the people who provide them—to be alternative to established treatments. People who provide alternative (unproven) treatments say they will or may *cure* cancer, *but this has not been shown in clinical trials*.

- An alternative treatment may have been tested but 'no evidence of benefit' found. This means it is uncertain whether it works or not.
- 'Evidence of no benefit' means a treatment has been tested and shown not to work against cancer.

Alternative (unproven) treatments are also known as integrative, unproven, holistic, non-mainstream and unconventional treatments or remedies.

Alternative cancer treatments for which 'miracle cures' have been claimed include magnets, various diets, coffee enemas, fresh cell therapy, microwave therapy, oxygen therapy and laetrile and other plant products. Be wary of these claims. Ask the alternative practitioner to give you evidence to back them. One or two books by people who deliver a certain treatment is not strong evidence. Look for articles in recognised medical or scientific journals. Recognised medical journals are listed in PubMed, an international database of biomedical journals. You can search the database through <http://www.ncbi.nlm.nih.gov/entrez/query.fcgi>. It is even more important to discuss these 'apparent cures' with the doctors treating you. Your doctors will usually have up-to-date information on the claims.

Complementary therapies

These are therapies such as massage, aromatherapy and meditation. People may feel a greater sense of wellbeing while they take the treatments. These are often called 'supportive therapies'. They are not promoted as cancer treatments or cures in their own right.

Some, like massage, have been used for centuries to complement mainstream medicine. They may help people feel more relaxed and able to cope better with the impact of their illness.

Key points

- Established treatments are known to cure some cancers and provide relief from symptoms of cancer.
- Treatments being trialled are promising treatments that are tested in clinical trials. They are only tested if they are predicted, on initial testing, to be at least as effective as the established treatment for a cancer.
- Alternative treatments have not been shown in clinical trials to cure or slow cancer down because trials have not been done ('no evidence of benefit'). Others have been tested and shown to be ineffective ('evidence of no benefit').
- Complementary therapies may be used to enhance established treatments.

How can they help?

When choosing a cancer treatment, you will be seeking one or more of the following:

- cure
- relief from symptoms
- help with a problem related to your illness (like anxiety)
- reassurance that you are doing all you can.

How established treatments may help

Your doctor will tell you if there is a cure for your cancer, or treatment that may slow its process. For over half of all cancers, surgery and/or radiotherapy and/or chemotherapy will kill the cancer cells and stop them from coming back. Although the treatment itself may cause side effects and be upsetting, most people are prepared to put up with this to try to get rid of the cancer.

Sometimes, the doctor won't be able to reassure you that the cancer will be cured. Sometimes, a few cancer cells escape and slowly grow into a new spot of cancer elsewhere in the body. Many people who have established treatment for cancer won't know for several years whether their cancer has gone away. If the cancer has not reappeared (recurred) within five years of treatment, then often you have a high chance of having been cured.

It is possible that there is no cure for your cancer. There may be no effective established treatment and/or the cancer may be advanced when you are diagnosed. There are still established treatments that can help you. Established treatments may be able to

reduce the size of the cancer or delay its growth, so that it doesn't affect how your body normally functions. They can also relieve pain and other problems caused by the cancer. This is called 'palliative treatment'. Some people can still have years of high quality life even though their cancer has not been cured.

If you want more information about the treatment your doctor recommends, you can ask for a second opinion from another specialist. Your doctor should not be offended: it is quite normal to want to know that your treatment is the best available.

How treatments that are being trialled may help

Your doctor may suggest that you join a clinical trial. This might happen if:

- there is no established treatment that will cure you
- there is a promising new treatment being tested for your cancer.

Remember, treatments being trialled are not certain to cure you. They may turn out to be only as effective as the existing treatment for your cancer.

Treatments being trialled often have side effects. These will be explained in the patient information/consent sheet that you will be asked to read and sign before the trial begins. Just because a treatment is new, it does not mean it is better—that is what the trial is trying to find out.

Sometimes, people participating in a clinical trial might receive an inactive or 'placebo' treatment, or be treated to control symptoms. In these cases, no established treatment is required; in other words, you are not missing out on any treatment you should otherwise be having.

How alternative treatments may help

Some people with cancer want to experiment with alternative treatments. A questioning approach helps people make their way through the many alternative treatments on offer. See 'Questions to ask' in this brochure.

How complementary therapies may help

Complementary therapies can help you to cope better with the challenges you face as a person with cancer. Physical therapies like yoga, massage and t'ai chi can help you to feel more relaxed and stronger. Measures like aromatherapy and music therapy will help if these are the sorts of therapies that you enjoy. If you are spiritually inclined, you will find comfort and strength in formal or informal services and rituals related to your beliefs.

Key points

- Established treatments can cure many cancers and provide relief for symptoms that cannot be cured.
- A treatment being tested in a clinical trial may be an option for you if the established treatment for your cancer is not adequate or a promising new treatment is being compared with the established treatment.
- Complementary therapies can be useful in easing symptoms like anxiety or tension associated with fears and uncertainties about having cancer.

When should alternative (unproven) treatments be avoided?

When they will delay diagnosis of cancer

If you have a troubling symptom and you wish to seek the advice of an alternative therapist, it is a good idea to also see a medical practitioner. Some symptoms of cancer may not be noticed or may be misdiagnosed by an alternative therapist.

Symptoms that should always be checked by a doctor include any new or unexplainable swelling, bleeding, pain and continued hoarseness or coughing. These symptoms don't necessarily mean that you have cancer, but should be checked.

When they will interfere with established treatment

Many alternative treatments are probably harmless, but not all. Some herbs and vitamins can interact with chemotherapy and radiotherapy so that they don't work as they should, or can cause harm. Before you begin a therapy prescribed by an alternative therapist, check with your cancer specialist that it is safe and won't affect your medical treatment, reduce the effectiveness of the medical treatment, and/or increase the risk of side effects.

When they will prolong or worsen the disease experience

Some people find that complementary therapies like relaxation, yoga and massage can improve their experience of established treatment, making them feel less anxious and more in control.

For some people, alternative therapies can make the experience much worse. This can happen:

- if you rely on alternative treatments that are not proven to work
- if your alternative therapist makes you feel responsible when their treatment doesn't make you better

- if it makes you sicker
- if it upsets you or costs more than you can really afford.

When they stop you using medical treatment that could improve your health

Some alternative therapists suggest to people they treat not to have established medical treatments or to cease them. The alternative therapist may warn that medical treatment will stop the alternative therapy working. Be very wary of claims like this. Always get an opinion from a cancer specialist.

Key points

- Beware of 'magic' or 'miracle' cures. Always get an informed opinion from your cancer specialist and/or the Cancer Helpline.
- Complementary therapies can be helpful additions to established treatment for people with cancer.
- Most alternative therapists cannot diagnose cancer.
- Some alternative treatments can interfere with established treatments and worsen your experience of cancer.

Questions to ask

Whether you are choosing a cancer specialist (surgeon and/or medical oncologist and/or radiation oncologist) or an alternative therapist, you need to be able to trust and talk openly with that person. This does not mean that you need to have warm feelings for each other. The person you choose may not even be very friendly! However, you will need to feel that they are expert, approachable, respectful, supportive and able to meet your needs for information and advice.

One way of finding out if the person is expert is to ask questions about their qualifications and experience. Here are some questions that may help when you choose a medical or alternative practitioner. (You could ask your general practitioner some of these questions, if he or she is referring you to a specialist.)

- What training does the practitioner have? Is their degree from an educational institution you know of or can find out about?
- Does the practitioner treat patients in hospitals where doctors are trained?
- What will the practitioner charge for a visit? How many visits will you need to make?
- Are there additional costs, for example, for different stages of treatment or additional expertise?

- Is the practitioner willing to refer you to publications that demonstrate that the treatment works?
- Are they members of a professional group that registers and represents that group of specialists in dealing with state and federal departments of health?

Also ask yourself if you are comfortable with the practitioner. Do you feel that they are attentive, trustworthy and level-headed?

Do you know other people who have been patients or clients of the practitioner? What do they say about them?

You may wish to find out more about the treatment the practitioner recommends. To find out if a treatment is worth trying, *be cautious, ask questions and confirm claims.*

Be cautious

You don't have to uncritically accept any claims made by a person seeking to treat you. You may trust the practitioner, and still wish to independently check their advice. Beware of 'pseudoscience'—things that sound very scientific and plausible but which are not actually backed up by evidence of proven benefit.

Ask questions

You will be surer of the treatment if you get satisfactory answers to the following questions:

- In what way will this treatment benefit me?
- What results can I expect to see?
- Are there any long-term risks associated with this treatment? If so, what are they?
- What side effects do people have with this treatment?
- How much will it cost?
- Will Medicare / my private health insurance cover the cost?
- How long will the treatment take?
- When could I expect to see a result from the treatment?
- How many people have received this treatment?
- How many of them responded?
- What happened to the ones that didn't respond?
- What's in it for the person offering me this treatment?

Confirm claims

Established treatments are subjected to scientific testing. This means:

- the theory behind a proposed treatment is based on accepted scientific principles
- testing on animals usually occurs before a new treatment is tested on humans
- the results of these trial/s are published in 'peer-reviewed' medical and scientific journals. This means that other specialists with expertise in the field check that the study was conducted correctly and that the results are valid.
- the results of trials are also verified by trials from specialist cancer hospitals throughout the world.

If you want to check that a treatment has been trialled and the results published, you can do a literature search through a medical library or via Medline on the Internet. A health information service for consumers may be able to help you, for example the Cancer Helpline 13 11 20.

Key points

- Ask your cancer specialist questions that are important to you: Will the treatment work? How do they know the treatment will work? When will I see results? What side effects can occur? How much will it cost?
- Be sure that you have confidence in the practitioner. If you don't have confidence in a cancer specialist, ask your general practitioner for referral to another specialist. If you are seeking to change alternative practitioners, your general practitioner or a trusted friend or adviser may be able to refer you on.

A final word

You have the right to choose whatever treatment you want for your cancer. Most people choose established treatments for their disease, and many also choose complementary therapies for some symptoms. A few choose no treatment, or a 'miracle cure'. We recommend that you make an informed choice where you can. This will include asking the opinion of people you respect and researching your options. You are welcome to call the Cancer Helpline on 13 11 20 to talk about the choices before you.

Useful websites

You may be interested in looking for information about cancer treatments on the Internet. While there are some very good websites, you need to be aware that some websites provide wrong or biased information. The following websites contain reliable information.

National Center for Complementary and Alternative Medicine (NCCAM)

<http://nccam.nih.gov>

Includes publications, information for researchers, frequently asked questions, and links to other related resources.

Quackwatch

www.quackwatch.com

Aimed at combating health-related frauds, myths, fads and fallacies.

Therapeutic Goods Administration (TGA)

www.health.gov.au/tga

The Cancer Council Victoria

www.cancervic.org.au

Provides general information on cancer, including diagnosis, treatment and support services.

Key Published Articles Listing—Urological Cancer

Title	Author & Journal
American Society of Clinical Oncology recommendations for the initial hormonal management of androgen-sensitive metastatic, recurrent, or progressive prostate cancer	Loblaw DA, Mendelson DS, Talcott JA, et al. Journal of Clinical Oncology 15 July 2004; 22(14): 2927–2941.
Post-brachytherapy transurethral resection of the prostate in patients with localized prostate cancer	Flam TA, Peyromaure M, Chauveinc L, et al. The Journal of Urology Jul 2004; 172(1): 108–111.
To test or not to test	Skatssoon J. Sydney Morning Herald, 5 Aug 2004.
6-month androgen suppression plus radiation therapy vs radiation therapy alone for patients with clinically localized prostate cancer: A randomized controlled trial	D'Amico AV, Manola J, Loffredo M, et al. The Journal of the American Medical Association 2004; 292(7): 821–827.
Impact of the percentage of positive prostate cores on prostate cancer–specific mortality for patients with low or favorable intermediate-risk disease	D'Amico AV, Renshaw AA, Cote K, et al. Journal of Clinical Oncology 15 Sep 2004; 22(18): 3726–3732.
Five-year outcomes after prostatectomy or radiotherapy for prostate cancer: The Prostate Cancer Outcomes Study	Potosky AL, Davis WW, Hoffman RM, et al. Journal of the National Cancer Institute 15 Sep 2004; 96(18): 1358–1367.
Innovations and challenges in renal cancer: Consensus Statement from the First International Conference	Atkins MB, Avigan DE, Bukowski RM, et al. Clinical Cancer Research 15 Sep 2004; 10(18): 6277S–6281S.
Genetic basis of cancer of the kidney: Disease-specific approaches to therapy	Marston Linehan W, Vasselli J, Srinivasan R, et al. Clinical Cancer Research 15 Sep 2004; 10(18): 6282S–6289S.
The Von Hippel-Lindau tumor suppressor gene and kidney cancer	Kaelin WG Jr. Clinical Cancer Research 15 Sep 2004; 10(18): 6290S–6295S.
Molecular markers for early detection of renal carcinoma: Investigative approach	Skates S and Iliopoulos O. Clinical Cancer Research 15 Sep 2004; 10(18): 6296S–6301S.
Prognostic factors for survival of patients with stage IV renal cell carcinoma: Memorial Sloan-Kettering Cancer Center experience	Motzer RJ, Bacik J and Mazumdar M. Clinical Cancer Research 15 Sep 2004; 10(18): 6302S–6303S.

Key Published Articles Listing—Urological Cancer

Title	Author & Journal
Tissue array-based predictions of pathobiology, prognosis and response to treatment for renal cell carcinoma therapy	Lam JS, Belldegrun AS and Figlin RA. Clinical Cancer Research 15 Sep 2004; 10(18): 6304S–6309S.
Prognostic factors in patients with advanced renal cell carcinoma: Development of an International Kidney Cancer Working Group	Bukowski RM, Negrier S and Elson P. Clinical Cancer Research 15 Sep 2004; 10(18): 6310S–6314S.
Gene expression profiling of renal cell carcinoma	Tan MH, Rogers CG, Cooper JT, et al. Clinical Cancer Research 15 Sep 2004; 10(18): 6315S–6321S
Laparoscopic and partial nephrectomy	Novick AC. Clinical Cancer Research 15 Sep 2004; 10(18): 6322S–6327S.
Review of radiofrequency ablation for renal cell carcinoma	Hines-Peralta A and Nahum Goldberg S. Clinical Cancer Research 15 Sep 2004; 10(18): 6328S–6334S.
Debulking nephrectomy in metastatic renal cancer	Flanigan RC. Clinical Cancer Research 15 Sep 2004; 10(18): 6335S–6341S.
Update on the role of interleukin 2 and other cytokines in the treatment of patients with stage IV renal carcinoma	Atkins MB, Regan M and McDermott D. Clinical Cancer Research 15 Sep 2004; 10(18): 6342S–6346S.
Dendritic cell-tumor fusion vaccines for renal cell carcinoma	Avigan D. Clinical Cancer Research 15 Sep 2004; 10(18): 6347S–6352S.
Nonmyeloablative transplantation: An allogeneic-based immunotherapy for renal cell carcinoma	Takahashi Y and Childs RW. Clinical Cancer Research 15 Sep 2004; 10(18): 6353S–6359S.
Effect of renal cell carcinomas on the development of Type 1 T-cell responses	Rayman P, Wesa AK, Richmond AL. Clinical Cancer Research 15 Sep 2004; 10: 6360S–6366S.

- Bevacizumab for patients with metastatic renal cancer: An update**
Yang JC.
Clinical Cancer Research 15 Sep 2004; 10: 6367S–6370S.
- Tyrosine kinase inhibitors in renal cell carcinoma**
Potti A and George DJ.
Clinical Cancer Research 5 Sep 2004; 10(18): 6371S–6376S.
- Novel antiangiogenesis therapies for renal cell cancer**
Gordon MS.
Clinical Cancer Research 15 Sep 2004; 10(18): 6377S–6381S.
- Mammalian target of rapamycin inhibition**
Dutcher JP.
Clinical Cancer Research 15 Sep 2004; 10(18): 6382S–6387S.
- Kinase inhibition with BAY 43-9006 in renal cell carcinoma**
Ahmad T and Eisen T.
Clinical Cancer Research 15 Sep 2004; 10(18): 6388S–6392S.
- Therapeutic options for variant renal cancer: A true orphan disease**
Stadler WM.
Clinical Cancer Research 15 Sep 2004; 10(18): 6393S–6396S.
- Skeletal complications in patients with bone metastases from renal cell carcinoma and therapeutic benefits of zoledronic acid**
Lipton A, Colombo-Berra A, Bukowski RM, et al.
Clinical Cancer Research 15 Sep 2004; 10(18): 6397S–6403S.
- Docetaxel plus prednisone or mitoxantrone plus prednisone for advanced prostate cancer**
Tannock IF, de Wit R, Berry WR, et al.
The New England Journal of Medicine 7 Oct 2004; 351(15): 1502–1512.
- Docetaxel and estramustine compared with mitoxantrone and prednisone for advanced refractory prostate cancer**
Petrylak DP, Tangen CM, Hussain MHA, et al.
The New England Journal of Medicine 7 Oct 2004; 351(15): 1513–1520.
- Mechanisms of androgen-refractory prostate cancer (Editorial)**
Debes JD & Tindall DJ.
The New England Journal of Medicine 7 Oct 2004; 351(15): 1488–1490.
- Bicalutamide 150 mg in addition to standard care in patients with localized or locally advanced prostate cancer: results from the second analysis of the early prostate cancer program at median followup of 5.4 years.**
Wirth MP, See WA, McLeod DG et al.
J Urol. 2004 Nov; 172(5 Pt 1): 1865-70.

Forthcoming Meetings

Date / Place	Meeting / Contact
16–21 January 2005 Films, Switzerland	9th European Winter Oncology Conference Federation of European Cancer Societies, Av E Mounier 83, Brussels 1200 Belgium Ph: +32 2 775 0201 Fax: +32 2 775 0200 E-mail: ewoc-9@fecs.be Website: www.fecs.be
10–13 February 2005 Phillip Island, Vic	17th Lorne Cancer Conference – At Phillip Island, Victoria Secretariat: ASN Events Pty Ltd Ph: (03) 5983 2400 E-mail: cancer@asnevents.net.au Website: www.lornecancer.org
10–14 February 2005 Paris, France	16th International Congress on Anti-Cancer Treatment Travel Congress Organisation (TCO), 2 rue de Berri, Paris 72008, France Ph: +33 1 4294 8732 Fax: +33 1 4294 8733 E-mail: info@icact.com Website: www.icact.com
13–17 February 2005 Melbourne, Vic	Annual Scientific Meeting of Urological Society of Australasia (USA) / 10th Annual Meeting of the Australasian Urological Nurses Society Inc Contact: Lindy Moffat, Manager, RACS Conference & Events Department, Royal Australasian College of Surgeons Ph: (03) 9249 1224 Fax: (03) 9276 7431 E-mail: lindy.moffat@surgeons.org Website: www.usm2005.com
17–19 February 2005 Orlando, Florida, USA	2005 Multidisciplinary Prostate Cancer Symposium Jointly organised by the American Society of Clinical Oncology, Prostate Cancer Foundation, American Society for Therapeutic Radiology & Oncology and Society of Urologic Oncology Prostate Cancer Symposium Registration Center, 11212 Waples Mill Road, Suite 104, Fairfax, VA 22030 USA Ph: +1 888 788 1522 OR +1 703 449 6418 Fax: +703 818 6425 E-mail: pcregistration@jspargo.com Website: www.asco.org
18–19 February 2005 Nice, France	New Targets in Cancer Therapy III Imedex, 70 Technology Drive, Alpharetta, Georgia 30005 USA Ph: +1 770 751 7332 Fax: +1 770 751 7334 E-mail: c.chase@imedex.com Website: www.imedex.com

Forthcoming Meetings

Date / Place	Meeting / Contact
3–5 March 2005 Amsterdam, Netherlands	3rd International Symposium on Targeted Anticancer Therapies NDDO Research Foundation, c/o Convenience Conference Management, PO Box 77, Harmelen 3480 DB Netherlands Ph: +31 348 567 667 Fax: +31 348 446 057 E-mail: congress@nddo.org Website: www.nddo.org
3–6 March 2005 Atlanta, Georgia, USA	58th Annual Cancer Symposium of the Society of Surgical Oncology (SSO) Society of Surgical Oncology, 85 W Algonquin Rd, Suite 55 Arlington Heights, IL 60005, USA Ph: +1 847 427 1400 Fax: +1 847 427 9656 E-mail: diannekubis@acaai.org Website: www.surgonc.org
7–9 March 2005 Madrid, Spain	Functional Genomics and Animal Tumour Models CNIO – Spanish National Cancer Centre, C/- Melchor Fernández Almagro, 3 Madrid 28029 Spain Ph: +34 91 224 6900 Fax: +34 91 224 6980 E-mail: ccc@cnio.es Website: www.cnio.es/ccc
16–19 March 2005 Istanbul, Turkey	20th Congress of the European Association of Urology EAU Congress Office, Congress Consultants BV, PO Box 30016, 6803 AA ARNHEM, The Netherlands Ph: +31 26 389 0680 Fax: +31 26 389 0686 E-mail: congress.consultants@uroweb.org Website: www.istanbul2005.org
18–19 March 2005 New Orleans, Louisiana, USA	National Update on Advances in Urology Imedex, 70 Technology Drive, Alpharetta, Georgia 30005 USA Ph: +1 770 751 7332 Fax: +1 770 751 7334 E-mail: c.chase@imedex.com Website: www.imedex.com
21–25 March 2005 Cairo, Egypt	Cancer in Developing World Fakkous Center for Cancer and Allied Diseases, 11 Boulous Hanna Street, Dokki, Cairo Egypt Ph: +20 2 337 0721 Fax: +20 2 749 3070 E-mail: sh_omar40@hotmail.com

Forthcoming Meetings

Date / Place	Meeting / Contact
16–20 April 2005 Anaheim, California, USA	96th Annual Meeting of the American Association for Cancer Research (AACR) AACR, Public Ledger Building, Suite 826, 150 South Independence Mall West, Philadelphia PA 19106-3 USA Ph: +1 215 440 9300 Fax: +1 215 351 9165 E-mail: meetings@aacr.org Website: www.aacr.org
28 April – 1 May 2005 Orlando, Florida, USA	30th Annual Congress of the Oncology Nursing Society Oncology Nursing Society, 125 Enterprise Drive, Pittsburgh PA 15275-1214 USA Ph: +1 866 257 4667 Fax: +1 866 369 5497 E-mail: meetings@ons.org Website: www.ons.org
8–11 May 2005 Wellington, New Zealand	Annual Scientific Meeting of the Royal Australasian College of Physicians (RACP) Contact: Anne Chang E-mail: racpasm@racp.edu.au Website: www.racp.edu.au
9–13 May 2005 Perth, WA	Annual Scientific Congress of the Royal Australasian Colleges of Surgeons (RACS) Website: www.racs.edu.au
13–17 May 2005 Orlando, Florida, USA	41st Annual Meeting of the American Society of Clinical Oncology (ASCO) ASCO, 1900 Duke Street, Suite 200 Alexandria, VA 22314 USA Ph: +1 703 299 0150 E-mail: asco@asco.org Website: www.asco.org
18–21 May 2005 Darwin, NT	Annual Scientific Meeting of the Trans-Tasman Radiation Oncology Group (TROG) Ph: (02) 9280 0577 Fax: (02) 9280 0533 E-mail: conferences@pharmaevents.com.au
21–26 May 2005 San Antonio, Texas, USA	100th Annual Meeting of the American Urological Association (AUA) Secretariat: Office of Education, American Urological Association, 2425 West Loop South, Suite 333, Houston, Texas – 77027-4207, USA Ph: +1 713 622 2700 Fax: +1 713 622 2898 E-mail: registration@auanet.org Website: www.auanet.org

Forthcoming Meetings

Date / Place**Meeting / Contact**

2–5 June 2005
Budapest, Hungary

Scientific & Educational Conference of the European Society for Medical Oncology (ESMO)

ESMO Head Office, Congress Department, Via La Santa 7, CH-6962
Viganello-Lugano, Switzerland

Ph: +41 91 973 1919

Fax: +41 91 973 1918

E-mail: alessia@esmo.org

Website: www.esmo.org/congress2004/

24–27 June 2005
Paris, France

6th International Consultation on New Developments in Prostate Cancer and Prostate Diseases

Website: www.congress-urology.org/index.htm

26–29 June 2005
Ottawa, Ontario, Canada

Annual Meeting of the Canadian Urological Association

Website: www.cua.org

27 June–1 July 2005
Glasgow, Scotland

Annual Scientific Meeting of the British Association of Urological Surgeons (BAUS)

Contact: BAUS, 35-43 Lincoln's Inn Fields, London WC2A 3PE

Ph: +44 20 7869 6950

Fax: +44 20 7404 5048

E-mail: admin@baus.org.uk

The Cancer Council Victoria

The Cancer Council Victoria is a public institution set up by an Act of Parliament in 1936. It operates as a charity, relies heavily on volunteer support, and raises and spends \$3–\$4 per head of population annually. It is governed by the Council and Executive and other committees. It's mission is to lead, coordinate and evaluate action to minimise the human cost of cancer for all Victorians. The Cancer Council houses three research divisions (behavioural science, clinical research, epidemiology) and units undertaking public and professional education, cancer registration, cancer information and support services, anti-smoking campaign (QUIT), finance, administration and fund raising. It employs about 150 staff. The Cancer Council also auspices a cooperating network of cancer specialists through the Victorian Cooperative Oncology Group and resources an expert Medical & Scientific Committee to dispense studentships, scholarships, fellowships and research grants to other academic, research and medical institutions.

Centre for Clinical Research in Cancer — Victorian Cooperative Oncology Group

The Centre for Clinical Research in Cancer (CCRC) formed in 1997, provides a coordinated and effective resource for collaborative clinical research and development in Victoria. The Centre provides administrative and research support for the Victorian Cooperative Oncology Group, which brings together Victoria's cancer specialists. The Centre fosters and facilitates the development and promotion of a range of collaborative clinical measures to optimise cancer management.

The Victorian Cooperative Oncology Group (VCOG) established in 1976, provides advice to the Cancer Council Victoria, through the CCRC, on all clinical aspects of cancer control, in particular research, screening, diagnosis, treatment, palliative medicine, cancer genetics and professional education. The strategic role of VCOG is to have a 'parliament' of clinical cancer specialists with a view to promoting a range of cooperative measures to optimise cancer treatment in Victoria. VCOG consists of a primary committee, 9 cancer-site and 3 task-specific advisory committees, and 5 trial research sub-committees. These committees bring together in regular meetings approximately 400 key specialist health care professionals and scientists, representing the various treatment disciplines and centres in Victoria. VCOG has established unique linkages between public and private health care professionals, institutions and governments.

