



# Urological Cancer Update

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Issue Number: 18

PROSTATE BRACHYTHERAPY

ASCO REPORT

RTOG 85-31 RESULTS COMMENTARY

TOAD STUDY

PROSTATE CARE NURSING UPDATE

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



# UROLOGICAL CANCER UPDATE

June 2005

Issue No. 18

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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.

If you would like to have your name removed from the distribution list, or if you are interested in receiving any of the other updates please contact Leigh Williams, Ph: (03) 9635 5174.

\*\*\*\*\* **Last Issue – No. 17 – December 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.***

## Editorial

### Contributions Welcome

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

	<b>Deadline</b>	<b>Issue Date</b>
Mid-year issue	1 June	1 July
Year-end issue	1 November	1 December

Contributions should be forwarded to:

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## Prostate Brachy at the Urological Society & Australian Brachytherapy Group Meetings

*Dr Jeremy Millar  
Radiation Oncologist  
William Buckland Radiotherapy Centre, Alfred Hospital*

Two prominent American “brachytherapists” have recently been at Australian meetings, highlighting the excellent long-term results reported by multiple American centres. Dr John Sylvester, from the “Seattle Prostate Institute”, spoke at a workshop and a prostate session at the February Urology Society meeting. He is well known to many Urologists here because of the excellent Seattle course he oversees, and because of his previous visits to Australia. Within a month, Dr David Beyer from a large and well-respected brachytherapy practice in Arizona was out at another meeting, that of the Australian Brachytherapy Group.

Although the characteristics of the meetings were very different (one was—but only so far as prostate brachytherapy was concerned—like preaching to the pagans, while the other was like preaching to the priests!), the impression both speakers left behind with many in the audience was that long-term results from American centres

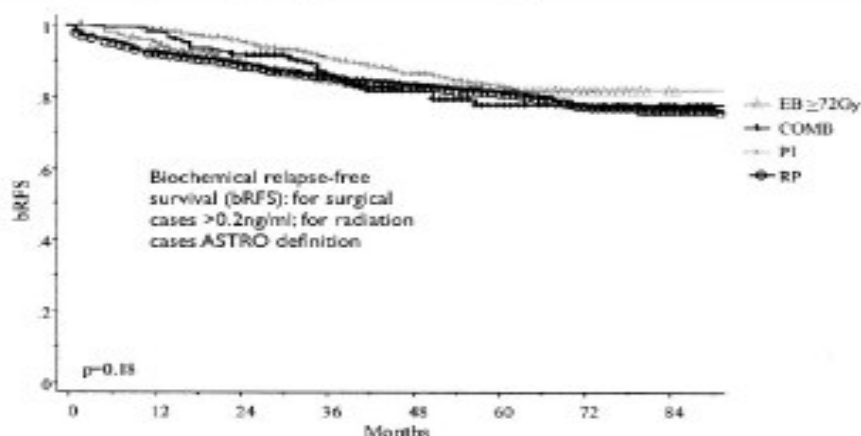
treating men with seed brachytherapy was as good as that seen after treatment with radical prostatectomy.

Data from one of Dr Sylvester’s summary slides is shown in the table below, comparing data from his group at the Seattle Prostate Institute with benchmark results from series of patients treated with either prostatectomy or high-dose conformal radiation. Notwithstanding the multiple confounding factors that make such comparisons hazardous (definition of disease control, biases in selection or reporting of treated groups, differences in follow-up etc) there is very little difference in the results treated by different modalities. This, of course, should not be surprising, since over the last five years multiple overviews have drawn the same conclusions, but Dr Sylvester emphasised recent reports with long follow-up, providing evidence that the good short-term results published over the years would hold up in the long term. These long-term results date back to the beginning of the “PSA-era”.

<b>Prostate Cancer: long-term ‘Biochemical Relapse’ Free Survival after local treatment</b>									
	HUP	B&W	UCSF	MSKCC		SPI			
Treatment	RP	RP	RP	3D-CXRT		Pd-103	I-125	EBRT + seeds	
Estimate	5y	5y	5y	5y	10y	5y	15y	15y	15y
Risk grouping*	DRG	DRG	DRG	MSK	MSK	MSK	MSK	DRG	MSK
Low risk	85%	83%	94%	90%	83%	94%	84%	80%	80%
Intermediate risk	65%	50%	81%	70%	50%	80%	85%	80%	80%
High risk	32%	28%	53%	47%	42%	65%	---	64%	53%
HUP/B&W		JCO 18;1164 (2000)							
UCSF Data		Peter Carroll presentation Swedish Hospital April 2004							
MSKCC 5 yr data		JUrol 166, 876 (2001) (39% on AD)							
SPI 5yr Pd		IntJRadiatOncolBiolPhys 46, 839 (2000)							
MSKCC 10y data		ASTRO 2003, abstract IntJRadiatOncolBiolPhys (2003)							
SPI 1-125 data		ASTRO 2004							
SPI 15y EBRT + seed data		ASCO 2004, abstract JCO 2004							

\* DRG = D’Amico risk grouping; MSK = Memorial Sloan Kettering risk grouping

### Prostate Cancer: no difference in control rates by surgery, seed implant or EB >72Gy



From Kupelian et al. *IJROBP* 58.1.25 (2004). 2991 consecutive patients treated at Memorial Sloan Kettering Cancer Centre and Cleveland Clinic. Patients had cT1-2 prostate cancer treated with radical prostatectomy (1034), external beam radiotherapy (EB) (785), permanent seed implant (PI) (950) or combination EBRT and PI (COMB) (222). Overall estimates of BRFS at 5 years were EB>72Gy 81%, RP 81%, PI 83%, and COMB 77%. If only 'favourable risk' patients were considered the 5Y BRFS estimates were COMB 93%, EB>=72 Gy 91%, PI 86%, and RP 86%. Proportional Hazards multivariate analysis showed initial PSA, Gleason score and year of treatment to be the only independent predictors of control. Modality of treatment, T category, and androgen deprivation were not independent predictors of control

Peering more deeply into the past is not very useful because of the powerful prognostic influence of PSA, not available in reports of series commencing much prior to 1990. In other words 15-year outcomes are about as far back as one can go and make valid comparisons with surgical series, because of the lack of PSA data on men prior to that.

Dr Sylvester pointed out that these 10 and 15 year results from Seattle were not the only long-term brachytherapy results available. He reviewed recent published results from Stock and Stone (at Mt Sinai, New York), Louis Potters (Memorial Sloan-Kettering, New York), and David Beyers (Arizona) which provide as good or better control rates at 10 and 12 years as his group.

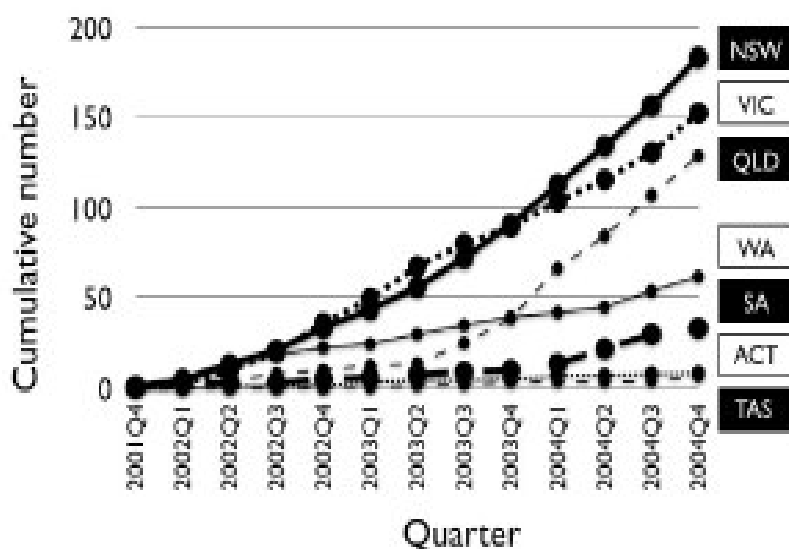
Comparisons such as these are, however, only relatively low-level evidence ("level III-2" in the NHMRC categorisation) comparing, as they do, cohorts from single institutions with other single centres. More compelling evidence comes from larger multi-institutional datasets comprising consecutive patients treated contemporaneously with different modalities, with similar follow-up lengths, and to which statistical techniques can be applied to try and remove the influence of biasing and confounding factors. Dr Sylvester

directed attention (see graph) to the recently published outcomes from nearly 3000 men from the Cleveland Clinic and the Memorial Sloan-Kettering, treated for early prostate cancer. Again, there was no discernable difference in disease-control outcomes for men treated with different modalities. There are no randomised trials available (and probably never will be), so the quality of the evidence on disease control is always going to be limited.

Dr Sylvester made the point that it was more generally accepted in the US (compared with Australia) that there were not likely to be material differences in disease control by modality, and that significant research efforts were being made to try and understand better the difference in morbidity between the different treatments, the time course of these morbidities and the impact on the patient's quality-of-life. He gave an excellent overview of recent work on this, but highlighted how little good-quality work there was in this area.

Preaching to a different audience, David Beyer's presentations to the ABG in Alice Springs were less about belabouring the point of the equivalent outcomes for men with similar disease, but more about morbidity and methods of preventing and treating implant-related morbidity.

## Growth in Seed Implants in Australia since listing MBS number, November 2001



risk" disease, but the worse outcome occurs with whichever of the treatment modality. There is no compelling empirical evidence that these higher risk men do any better with surgery compared with implants.

The focus of research and discussion in the USA for intermediate risk men, in particular (since they make up a high proportion of our patients) is somewhere else: on which factors can be used to separate the "good" intermediate risk men from the bad intermediate risk men. And does the addition of external beam radiotherapy to a seed implant in this group of men add anything?

Data from HIC payments for MBS item numbers MBS 15338 and 37220, available from [www.hic.gov.au/statistics](http://www.hic.gov.au/statistics). This data reflects the date on which claims are made, and the state from which the patient makes the claim (and not necessarily where the implant was performed).

Australian practice is very different from that seen in the US, and this was highlighted in a presentation at the preconference workshop, before the Urology Society meeting. The patient numbers in Australia have increased steadily since seed implants were listed in the MBS schedule (see graph), but still represent tiny numbers compared with those seen in North America. By the end of 2004, the total number ever implanted in Australia probably amounted to only a little over a thousand, and the numbers treated with seed implants represents only a small proportion compared with the number treated with a radical prostatectomy. One of the reasons for this is the restrictive indications allowed for payment of the MBS fee. The interim listing of prostate seed implants restricted valid claims only to men with Gleason score 6 disease or less, PSA at diagnosis of 10ng/ml or less, and to men with no clinical evidence of extracapsular extension. However most of the comparisons highlighted by the speakers at both these meetings included large numbers of men outside these restrictions. With the point being: in these series with disease-control outcomes showing similar outcomes between seed implants and radical prostatectomy, many of the men had either "intermediate" or "high risk disease". Clearly, as a group these men have worse disease-control outcomes than men with "good

Dr Sylvester summarised the recent work on these areas. It is not clear that external beam radiation (EBRT) is required, provided men receive high-quality "mono-therapy" seed implants. The combination of EBRT and seeds certainly has some obvious disadvantages: cost, inconvenience, and higher rates of likely morbidity. A large series reported by Greg Merrick in the January issue of the *International Journal of Radiation Oncology Biology & Physics* showed the addition of EBRT to a seed implant had no influence on biochemical control, on Cox proportional hazards multivariate analysis. In a smaller series from the Seattle group, Dr Sylvester showed a slide for the biochemical control rates in a series of "intermediate risk" men treated with either seeds alone or combined treatment. In that group the combined group did slightly better (77% at 10 years, vs 73%) but this was not significant statistically. And, of course, in the large Kupelian series mentioned above there was no difference. The difficulty with all this work is, however, that there are probably unknown prognostic factors that were influencing the decision to administer combined treatment, and these could not be corrected for in the analysis. Perhaps the men who received combined treatment were different from the men who did not and would have been destined to do worse if they had not had the EBRT added? Dr

Sylvester concluded then with practical advice by giving the Seattle guidelines: they considered addition of EBRT if the PSA was greater than 15, or >33% of the cores on the TRUS biopsy were positive in men with intermediate-risk disease.

It will be interesting to see how Australian clinicians interpret this work. The interim listing of iodine seed implants is currently under review by the "Medical Services Advisory Committee" (MSAC), and this will shortly lead to a publication of their assessment of the evidence supporting (or not) the efficacy, safety, and cost-effectiveness of the use of seed implants, and a recommendation for or against permanent listing

in the November 2005 MBS schedule. However, this committee will probably only address the question of seed implants for "low risk" prostate cancers, and this process will almost certainly not have any impact on HIC funding for the majority of men seen by Urologists in Australia, those with "intermediate risk" disease. In the meantime, the presentations at the Urology Society meeting in particular impressed many present and recent Seattle training courses have been well-attended by Australian Urologists. Seed implants in Australia are likely to continue steady growth in numbers as more Urologists become persuaded that this treatment is a good treatment choice for many of their patients with prostate cancer.

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## Commentary on RTOG 85-31 Results of National Prospective Randomised Trial

*Dr Keen-Hun Tai*  
*Radiation Oncologist, Chair Uro-oncology Service*  
*Peter MacCallum Cancer Centre*

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Lawton CA, Winter K, Grignon D & Pilepich MV.

Androgen Suppression plus Radiation vs Radiation Alone for Patients with  
Stage D1 / Pathologic Node-positive adenocarcinoma of the Prostate:  
Updated results on national prospective randomised trial  
Radiation Therapy Oncology Group 85-31

Journal of Clinical Oncology February 2005; 23(4): 800-807

**L**ymph node (LN) metastasis in prostate cancer is an incurable disease. Rapid progression is likely to develop even in the absence of bone metastases. Hormone therapy is the accepted treatment with bilateral orchidectomy being the standard of care for many years until the introduction of LHRH agonists in the mid-1980's in North America.

The RTOG 85-31 study randomised 977 patients to radiotherapy alone vs radiotherapy and immediate androgen suppression. This was a well conducted study that included central review of pathology, central review of radiotherapy and calibration of linear accelerators of all participating centres.

The above report is a subset analysis of 173 patients with LN positive (pN+) prostate cancer who received radiotherapy alone (n = 75) or radiotherapy plus immediate androgen suppression (n = 98). All T3 patients with any LN status and T1 or 2 patients with pN+ were eligible. Radiotherapy was with megavoltage techniques that included the extent of disease (up to L2/3 intervertebral space for para-aortic pN+), the whole pelvis and the prostate to a dose of 44 – 46 Gy followed by a boost of 29 to 25 Gy to the prostate. Total prescribed dose was 65 to 70 Gy. Forty two patients had undergone radical prostatectomy (n = 21 in each arm). These post-prostatectomy patients received a

total dose of 60 Gy. Goserelin 3.6 mg monthly (Zoladex; AstraZeneca Pharmaceuticals) was started during the last week of radiotherapy for an indefinitely for those vs at the time of relapse. The median follow-up is now 6.5 years for all patients and 9.5 years for patients still alive.

Biochemical control (PSA-relapse) favoured patients who received RT and immediate androgen deprivation ( $p < 0.0001$ ). The incidence of distant metastasis also favoured the same group of patients. There was a trend for better local control. Multi-variate analysis demonstrated a significant better absolute survival for patients who received immediate androgen suppression. The number of patients who had radical prostatectomy was small and they were equally randomised. The radical prostatectomy patients who were treated with immediate LHRH agonist and radiotherapy had a lower rate of disease-specific failure.

The major caveat is that this is a retrospective subset analysis. Quality of life was not investigated and therefore cannot be reported. With the increasing recognition of the longer term detrimental effects of androgen deprivation, there maybe significant ill-effects that have gone unnoticed. Closer attention to the veracity of figures would enhance the paper (eg Fig 3B refers to patients who had pN+ with prostatectomy: only a total of 42 patients among the 173 had prostatectomy).

The RTOG 85-31 study was an innovative study in its time and 20 year's later, the results of this study still influences the way metastatic prostate cancer is being treated today. Taken together with the results from other large studies<sup>1,2,3</sup> that have employed adjuvant androgen suppression with radical radiotherapy in patients who have a

high likelihood of extra-prostatic adenocarcinoma, the standard of care for such patients must involve some form of combination therapy. Radical radiotherapy has been an accepted form of treatment as part of this multi-modality therapy. This should include androgen deprivation in an adjuvant setting. There is as yet some uncertainty as to the optimal timing and duration of androgen suppression in various 'risk' groups. There are also on-going refinements into the delivery of radiotherapy.

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## Clinical Practice Guidelines for the Management of Advanced Prostate Cancer

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This Working Party is still seeking funding and a decision on the final format will be made very soon.

*Reprinted from Wongi Yabber May 2005 Vol. 12(2): 2*

# Prostate Cancer Nursing Update

*Ms Robyn Metcalfe  
Men's Cancer Program Manager*

## Scholarships

**T**he Cancer Council Victoria is pleased to advise that a further 14 prostate care nurse scholarships will be available for the July intake of the Prostate Care Nurse Program, thanks to the continuing support of the Prostate Cancer Foundation Australia and Novartis. For further information about scholarships and the program, go to: [http://www.latrobe.edu.au/nursing/cont\\_ed.htm#PCNP](http://www.latrobe.edu.au/nursing/cont_ed.htm#PCNP)

## Education Day

The Men's Cancer Program will be hosting an education day on 21<sup>st</sup> July 2005, for nurses who have undertaken the Prostate Nursing Care Program. On the day, consumers, support group facilitators, members and other health professionals will be invited to be part of the education day.

Community Forums continue to be delivered in regional areas across Victoria. These forums offer people in the wider community, the opportunity to hear the latest information about prostate and bowel cancer. Clinicians speak at these forums, with between 50 and 100 people present at each one.

Playwright Alan Hopgood attends the prostate forums and there is a viewing of his film about his experience of prostate cancer which is always very popular. Following this, there is a panel giving an opportunity for community members to ask questions of the Urologist, a GP, Alan Hopgood and Cancer Council representative at the conclusion of every forum.

There were 11 forums delivered in 2004 and 12 have been booked for 2005, with more bookings still being taken! So far this year there have been forums in Hamilton, Shepparton and Cobram. Still to come this year are Melton, Avoca, Mansfield, Wonthaggi, Macedon, Geelong and Rutherglen.

The Multicultural Men's Health Program delivers prostate problems sessions in seven languages other than English (Greek, Italian, Polish, Serbian,

Macedonian, Croatian and Chinese). An information sheet about prostate problems has been translated and is available in each of these languages. A minimal language flipchart has also been developed to be used in the delivery of prostate information in other languages. Fact sheets on prostate problems in these languages are available at [www.cancervic.org.au](http://www.cancervic.org.au) and [www.prostatehealth.org.au](http://www.prostatehealth.org.au)

There were 99 sessions delivered in languages other than English in 2004-2005 reaching nearly 2000 men, and it is estimated that almost 3000 men have attended a prostate session since the inception of the program.

The Workplace program now boasts three fully trained health educators who deliver men's health sessions at various workplaces within metropolitan Melbourne. The topics addressed in each session are

- What is cancer
- Prostate cancer
- Bowel cancer
- The risks, symptoms and prevention of cancer
- Personal health strategies.

There were 28 sessions delivered in 2004 and 10 sessions have been delivered to the end of April this year.

## Roadshows

The Men's Cancer Program will go on the road this year with other Cancer Council programs and deliver health education to community health professionals in regional and metropolitan Victoria. The training will take place in Morwell, Bairnsdale, Mildura, Geelong, Frankston and Carlton. Prostate information is a vital component of the training, with more training planned for next year.



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**PLEASE ENROL  
YOUR ELIGIBLE  
PATIENTS**

# TOAD

## A collaborative randomised phase III trial: The timing of intervention with androgen deprivation in prostate cancer patients with a rising PSA

### Overview

The hypothesis being tested is that early intervention with androgen deprivation in the presence of a rising PSA improves overall survival while maintaining an acceptable quality of life, when compared to delayed intervention.

### Study 1

Patient Population	Stratification
<ul style="list-style-type: none"> <li>Adenocarcinoma of the prostate</li> <li>PSA only relapse after curative treatment</li> <li>≤ 7 months neo-adjuvant ADT (≥ 12 months prior to randomisation)</li> </ul>	<ol style="list-style-type: none"> <li>Treatment type - <b>Surgery and/or Radiotherapy</b></li> <li>Relapse-free interval - <b>&lt; 2 years v 2 years +</b></li> <li>Type of planned ADT - <b>Continuous or Intermittent</b></li> <li>Treatment Centre</li> </ol>

### Study 2

Patient Population	Stratification
<ul style="list-style-type: none"> <li>Adenocarcinoma of the prostate</li> <li>Asymptomatic disease at diagnosis, either localised or metastatic</li> <li>Not suitable for curative treatment</li> <li>No prior ADT</li> </ul>	<ol style="list-style-type: none"> <li>Type of planned ADT - <b>Continuous or Intermittent</b></li> <li><b>Localised or Metastatic</b> disease</li> <li>Treatment Centre</li> </ol>

## RANDOMISATION

Treatment	Endpoints
<b>Arm A</b> → Treatment delay (Control arm)	<ul style="list-style-type: none"> <li>OS, CSS</li> <li>DFS</li> <li>Quality of life</li> <li>Morbidity of Rx</li> <li>Complications</li> </ul>
<b>Arm B</b> → Immediate ADT	

## ELIGIBILITY

### Inclusion criteria - Both study groups

1. Histologically confirmed adenocarcinoma of the prostate.
2. Accessible for follow-up.
3. Informed consent to be randomised to immediate or delayed androgen deprivation.

### Study 1

1. PSA relapse\* after definitive radical treatment. \*i)  $\geq 0.2$  ng/ml post-prostatectomy for surgical patients or ii) the ASTRO definition [18] of PSA failure for radiotherapy patients (3 rises after the nadir, with the date of relapse being scored as half way between the nadir date and the date of first elevation).

**(NB For patients who have previously received androgen deprivation, a rise in PSA associated with testosterone recovery is not counted as relapse, provided it falls again).**

2. No evidence of metastatic disease on staging investigations (bone scan, abdomino-pelvic CT scan).
3. Prior androgen deprivation limited to a maximum of seven months neo-adjuvant/concurrent treatment, completed at least 12 months prior to study entry.

### Study 2

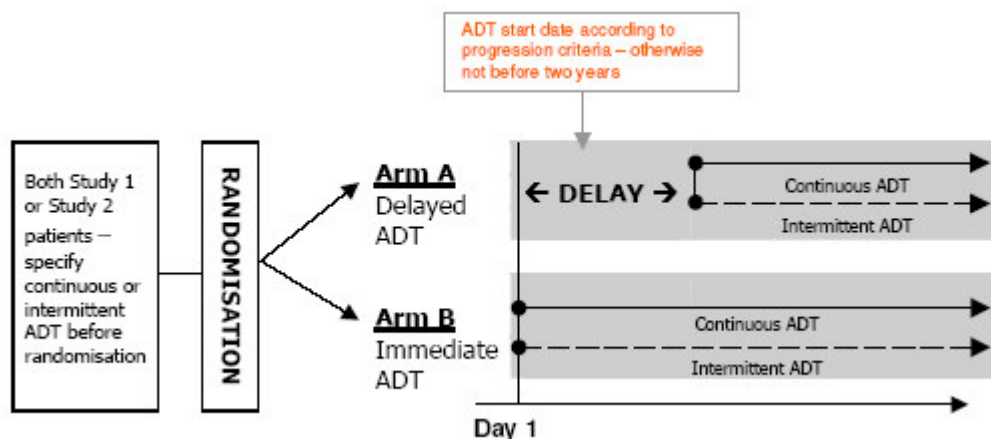
1. Not suitable for radical treatment at primary diagnosis.
2. Decision not to treat curatively.
3. No symptoms due to local or metastatic disease requiring radiation or immediate hormone therapy.
4. No prior androgen deprivation therapy

### Exclusion criteria

1. Significant co-morbidity limiting life expectancy to less than 5 years.
2. Patients with symptomatic disease requiring therapy.
3. Previous androgen deprivation for longer than 7 months (Study 1).
4. Diagnosis of PSA relapse or incurable disease more than six months prior to randomisation.
5. Patients entered into TROG studies 96.01 or RADAR.

## TREATMENT

Patients will be randomised to receive androgen deprivation therapy either immediately (experimental arm) or delayed (control arm) at least until a trigger point for treatment is exceeded. Any currently available means of androgen deprivation may be used, both for type of drug or castration, and for scheduling, either continuous or intermittent. Clinicians should state their schedule preference prior to randomisation to allow for stratification.



**THIS INFORMATION IS INTENDED TO BE USED AS A SCREENING TOOL ONLY AND SHOULD NOT BE USED IN PLACE OF THE PROTOCOL**

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# TOAD: Timing of Androgen Deprivation Private Urologists – Indemnity, Ethics and Data Collection Issues

*Mr Michael Harold  
TOAD Study Coordinator  
Clinical Trials Office, The Cancer Council Victoria*

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Crucial to the success of the TOAD study is the involvement of urologists, not only in the hospital clinics but also in private practice. The Trial Management Committee and staff at the Centre for Clinical Research in Cancer have identified a number of issues regarding private urologists participation in the trial and have come up with some ground-breaking solutions to the problems.

For private urologists, the first barrier to recruiting patients to clinical trials was the problem of ethics approval, which is normally approved through institutional ethics committees. To get around this it was negotiated with The Cancer Council Victoria (TCCV) to provide coverage under The Cancer Council's ethics committee approval. This has since been extended to NSW and requested for South Australia.

The second problem for private urologists is insurance cover for participating in clinical trials. Initially, the insurance requirement of MDAV was for each private urologist interested in participating to complete an individual submission of many pages. There was also the rumour of additional premiums being charged.

The VCOG acknowledged that these issues could deter clinicians in private practice from participating in clinical research. Following discussions with MDAV, they agreed for the submission of one application form by a nominated Principal Investigator. MDAV, on approval of the application would issue a registration number. Clinicians should then request in writing to MDAV extension of cover for participation in the same clinical trial, and quote the allocated registration number. The MDAV Registration Number for the TOAD Prostate cancer trial is CC-04/05-002. There is no cost to the clinician for registering their clinical research participation.

Private urologists insured with MIPS do not have to advise of their research participation. MIPS

members need only seek clarification if they are unsure whether their indemnity insurance covers their practice in a particular trial, or if participation in a trial involves direct association with a pharmaceutical company. There is no cost to the clinician for clinical research participation.

Another potential problem for urologists could be the lack of resources to complete the trial case report forms. We have tried to overcome this by offering data management support. As the Trial Coordinator, I am available to attend private urology clinics to demonstrate the randomisation procedure and forms completion. Otherwise I am happy to answer any queries over the phone or on email regarding any aspect of the trial. If a trial coordinator visits your clinic to complete baseline or follow-up data, the cost will be deducted from the patient capitation fee of \$600.

With these hurdles to private urologists participating now resolved, another issue has just surfaced and this could potentially affect recruitment to Study 2 of the trial. Study 2 relates to the non-curative population of prostate cancer patients. Concerns have been raised regarding the need to perform staging CT Scans in Study 2 if not used as part of standard practice for patients who are not considered for curative treatment at diagnosis. The Co-Principal Investigator Professor Gillian Duchesne says, "Although CT Scans in this group may pick up pelvic lymphadenopathy about 20% of the time, one view is that the scan is not likely to influence management and is therefore superfluous. Others consider that the trial requires full documentation of disease stage to have scientific validity."

This issue is currently being included in a brief questionnaire that will be distributed to urologists in the near future.

I look forward to an increasing number of randomisations over the coming months.

# What does the Victorian Cancer Services Framework mean for you?

*Professor Gillian Duchesne  
Director of Radiation Oncology, Peter MacCallum Cancer Centre  
& Member, Ministerial Taskforce*

Note - Prof Gillian Duchesne provided this article at the request of the VCOG Urological Cancer Committee. The VCOG Executive Committee requested that the article be re-produced in all the VCOG Update Newsletters. Prof Gillian Duchesne is a member of the Ministerial Taskforce for Cancer. This article is a personal viewpoint, it has not been endorsed by the Taskforce.

The Department of Human Services commissioned a review of Cancer Services in Victoria by the Collaboration for Cancer Outcomes Research and Evaluation, who published their report in July 2003. This was entitled "A Cancer Services Framework for Victoria and future directions for the Peter MacCallum Cancer Institute." The Minister and the DHS adopted the recommendations for the Cancer Services Framework; a Ministerial Taskforce was appointed towards the end of 2003 with a 3-year term and the responsibility to oversee the implementation of the reforms.

The Taskforce, chaired by Dick Smallwood, has representatives from all disciplines involved in the delivery of cancer care, metropolitan and regional representation, and consumer input. It is supported by the staff of the Cancer Co-ordination Unit at DHS, headed by Elise Davies. The work has been organised around three main themes: Clinical Services, Research and Data / IT, chaired by Bob Thomas (Peter Mac), Paul Mitchell (Austin) and David Hill (TCCV) respectively. The latter two committees have been reviewing the activity and resources currently available in Victoria. Discussions are underway regarding co-ordination of research throughout the state. The IT group have been

examining a project that would expand the data collection capabilities of the Cancer Council and how patient information can usefully be shared electronically between hospitals and other service providers.

The main impact that the reforms will have is obviously the delivery of clinical care. Two key components of work are running in parallel. The first component is the development of patient management pathways, which documents what resources and facilities are required by a cancer patient through the 'cancer journey', essentially from pre-diagnosis to death. This work was initiated by holding a series of workshops with clinicians and consumers mapping out the requirements in each of the designated tumour streams. These bring together specialists in multi-disciplinary care for the main tumour sites and types such as breast, colorectal, prostate, testis, lung, melanoma, ovary, oesophagogastric, pancreas, larynx, pharynx, oral-combined, malignant glioma and cerebral metastasis. Site-specific pathways and generic needs across all streams have been developed and are being further refined. The report of the workshop is available at [www.health.vic.gov.au/cancer/docs/patientmanagementframework.pdf](http://www.health.vic.gov.au/cancer/docs/patientmanagementframework.pdf).

The following may be useful links:

**DHS Website**

[www.health.vic.gov.au/cancer/](http://www.health.vic.gov.au/cancer/)

**DHS Cancer Bulletin 1**

[www.health.vic.gov.au/cancer/docs/ccubulletin1204.pdf](http://www.health.vic.gov.au/cancer/docs/ccubulletin1204.pdf)

**DHS Cancer Bulletin 2**

[www.health.vic.gov.au/cancer/docs/cancerbulletinmar05pdf.pdf](http://www.health.vic.gov.au/cancer/docs/cancerbulletinmar05pdf.pdf)

The other component is the division of Victoria into eight Integrated Cancer Services or ICS: three metropolitan (Western & Central, Southern and North Eastern) and five regional (Loddon Mallee, Grampians, Barwon South Western, Hume and Gippsland). Each has independent governance and direction. One initial task for the ICS is to identify and map the components of cancer care delivery within their region. These can then be compared with the requirements

identified in the patient management pathways workshops. Over the coming years it is hoped that resources are found where gaps are identified to ensure equitable service provision. Interaction between the ICS, especially regional and metropolitan, may be required for particular components of specialised care. This is still very much work in progress.

Further information is available via the DHS website.

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## COSA Report

*Ms Margaret McJannett  
Executive Officer, COSA*

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**C**OSA has been continuing to move forward on a number of issues on behalf of its membership. We are presently awaiting outcomes on the:

- NH&MRC enabling grant application - anticipated mid-May 2005
- Two-page proposal regarding mechanism for Clinical Trials Infrastructure put to Government.
- Cancer Australia Workshop; COSA was strongly represented
- Submission to the Senate Inquiry into services and treatment options for persons with cancer.

### Rural Health Alliance Conference Alice Springs

COSA also convened a workshop, chaired by Dr Steve Ackland, at the National Rural Health Alliance Annual Meeting in Alice Springs. This provided an excellent opportunity to reach out to our colleagues in non-metropolitan areas, update them on cancer care issues and develop networks to facilitate advocacy for improved cancer treatment and support in regional Australia. The Cancer in the Bush workshop (2001) and recommendations were discussed, in particular difficulties with patient travel and accommodation. There were additional recommendations arising from the NRHA meeting, which can be viewed on the website [www.ruralhealth.org.au](http://www.ruralhealth.org.au).

### COSA Council Meetings

COSA Council and Executive met in April and the major works being undertaken at present are the review of our Strategic Business Plan and the MOU between COSA and TCCA.

### Annual Scientific Meeting

The planning of the Annual Scientific Meeting (ASM) is well underway, with Dr Sandro Porceddu, this year's convenor, working with his enthusiastic committee to put together an exciting and stimulating program for Brisbane. The theme this year is "Crossing Cancer Boundaries". A draft program will be posted on the COSA website shortly. Please note this year's meeting will begin a week earlier, 16-18 November 2005.

### COSA Website

The COSA website continues to be enhanced and the members-only area is being finalised with more extensive facilities to enhance the value of membership including online membership renewal. Please visit the site [www.cosa.org.au](http://www.cosa.org.au).

### Asia Pacific Journal of Clinical Oncology

COSA members will soon receive free subscription to the new *Asia Pacific Journal of Clinical Oncology*. The first publication is due out in May. Members are encouraged to submit manuscripts, as the quality of the journal is highly dependent upon your quality contribution.

*Reprinted from Wongi Yabber May 2005; 12(2): 3.*

# Report of The Cancer Council Australia

Glen Turner  
Communications Manager  
The Cancer Council Australia

## New Position Statements

**T**he Cancer Council Australia has published five new position statements.

### Bowel Cancer Screening

Bowel cancer is the most common potentially fatal cancer affecting both men and women in Australia. The bowel cancer position statement reiterates The Cancer Council Australia's call for a national bowel cancer screening program targeting all Australians aged 50 and over. (In the 2004 federal election campaign, both the Government and the Opposition committed to national screening programs to commence from 2008.)

### Testicular Cancer

The testicular cancer statement promotes the evidence-based view that the present level of community awareness of testicular cancer appears appropriate and in proportion to current incidence and mortality rates.

### State and Territory Travel and Accommodation Subsidy Schemes

The travel and accommodation schemes statement calls for a Commonwealth funded taskforce to examine inequities in access to cancer treatment across jurisdictions and between rural and urban areas, with the ultimate aim of improving access to services for people in disadvantaged regions.

### Risks and benefits of sun exposure and Advertising and display of tobacco products in retail outlets

Both statements cover topics that have generated significant interest in both the health and mainstream media over recent months.

A number of SunSmart position statements have also been updated including:

- Screening and early detection of skin cancer
- Tinting of car glass and window glass

- Fake tans
- Solariums

Cancer Council Australia position statements can be found at [www.cancer.org.au/positionstatements](http://www.cancer.org.au/positionstatements).

*Reprinted from Wongi Yabber February 2005; 12(1): 5 and May 2005; 12(2): 4.*

Australia takes lead in reducing cancer deaths – mortality rates lower than other developed nations

A new report, *Cancer in Australia 2001*, from the Australian Institute of Health and Welfare, shows that Australia has a lower cancer death rate than several other developed nations. The US, UK, Canada and New Zealand all recorded higher mortality rates than Australia.

The report has been welcomed by The Cancer Council Australia, which attributed much of the good news to population initiatives in prevention and early diagnosis and good access through Australia's health system to advances in treatment.

The Cancer Council's spokesman, Dr Andrew Penman, said the cancer death rate in Australia had fallen 17 percent over 10 years and was now at its lowest level since records began in the 1970s.

"A significant part of Australia's success has been due to comprehensive programs in prevention and early detection," Dr Penman said. "Our low death rate from lung cancer and other tobacco related cancer is a dividend from three decades of tobacco control which has seen smoking rates drop to the lower levels than comparison countries; while our comprehensive approach to screening for breast and cervical cancer means that our outcomes for these cancers compares very favourably."

"Prevention has delivered extraordinary value for money," Dr Penman said. "When you look at Australia's lower rates of lung cancer incidence and mortality the argument is compelling – our death rates are 32 percent lower than the US for

males and a staggering 48 percent for females. Although at 19,000 deaths from tobacco related disease each year, Australia still has a long way to go.”

While welcoming the declining death rates, Dr Penman also sounded a note of warning about cancers where mortality or incidence are higher than in other countries. “Australia, because of its climate and lifestyle, leads the world in its high rates of melanoma yet this is one cancer whose rates could be substantially reduced by effective

sun protection.”

Dr Penman said that Australia’s good performance was not uniform across all cancers. “In contrast to our success in cervical and breast cancers, we have very high death rates from bowel cancer. An absolute priority for the nation is to expedite the rollout of a national bowel screening program, to which the Federal Government has declared its commitment.”

*Reprinted from Wongi Yabber February 2005; 12(1): 5.*

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## Senate Committee Gives Cancer Priorities a Good Hearing

*Glen Turner  
Communications Manager  
The Cancer Council Australia*

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**T**he chair of the Senate’s Community Affairs committee has publicly backed a call for the formal adoption of cancer clinical practice guidelines and the accreditation of cancer centres, following a recent public hearing in Sydney as part of a Senate inquiry into cancer services in Australia.

Professors Alan Coates (Cancer Council), David Currow (COSA) and Mark Elwood (NCCI), along with consumer Cheryl Myers, presented to the committee on 19 April in support of a joint submission to the inquiry. Later that day, the committee chair, Senator Gavin Marshall, issued a media release endorsing the recommendations made by the group.

The inquiry is investigating treatment options for people with cancer, with particular focus on the merits of multidisciplinary care, care coordination, less conventional and alternative therapies and the role of government in improving patient outcomes.

Central to the joint Cancer Council-COSA-NCCI submission, to which the National Aboriginal Community Controlled Health Organisation was also a signatory, was the need for improved access to multidisciplinary care, facilitated by national care standards, accreditation of cancer centres and credentialing of practitioners, as well as the adoption of clinical guidelines as best practice.

The submission highlighted the Australian Cancer Network’s development of clinical practice guidelines and exploration of a model for cancer care accreditation and credentialing. It also endorsed the Australian Medical Workforce Advisory Committee’s recommendations on increasing the number of cancer professionals, particularly in rural areas, and The Cancer Council Australia’s position on travel and accommodation support for non-metropolitan patients.

Professors Coates, Currow and Elwood and Ms Myers were among 70 people from more than 25 organisations to have appeared as witnesses at hearings in Perth, Melbourne, Sydney and Canberra over the past month.

Witnesses were called on the basis of the quality, depth and relevance of their written submissions, 93 of which were received since the announcement of the inquiry in February. Organisations that provided submissions included federal and state/territory health departments, medical faculties, consumer organisations, industry associations, alternative centres and private individuals.

The committee is scheduled to report its findings on 23 June, the final sitting day of the current Senate. When the Senate resumes in August, retiring Senators will have departed and the Government will have a majority.

All 93 published submissions are available on the Senate website, along with more information about the inquiry, at: [www.aph.gov.au/Senate/committee/clac\\_ctte/cancer/submissions/sublist.htm](http://www.aph.gov.au/Senate/committee/clac_ctte/cancer/submissions/sublist.htm).

### **Submissions Detail TCCA Advocacy Priorities**

It has been a busy few months for submissions to government inquiries, studies and consultations. The Cancer Council Australia has decided to publish its most comprehensive input to these recent processes on its website, to provide colleagues and stakeholders with detailed information on advocacy priorities in differing contexts.

The most substantial recent submissions relate to: the Productivity Commission's current study into the impact of medical technology; an NHMRC consultation on research aimed at breaking the link between disadvantage and poor preventive healthcare; and the Senate inquiry into cancer services. These submissions are now available on the website address below, along with submissions from 2004 relating to patents in gene technology and the Pharmaceutical Benefits Advisory Committee review process. [www.cancer.org.au/policy\\_submissions](http://www.cancer.org.au/policy_submissions)

*Reprinted from Wongi Yabber May 2005; 12(2): 3-4.*

### **Treatment: Call for End to 'Cancer Lottery'**

Cancer claims more lives in rural Australia and even more among Aborigines than in the rest of

the population, according to a coalition of peak cancer control bodies.

Speaking at a Senate inquiry into cancer services, representatives from the Cancer Council of Australia, National Cancer Control Initiative and the Clinical Oncological Society of Australia said patients want national cancer care standards to end the "cancer referral lottery" that currently exists in certain areas.

"Cancer mortality is significantly higher in rural areas and higher again among indigenous communities," the organisations stated in a joint presentation to the inquiry.

"There are no national standards of accreditation to ensure that optimal care is accessible to all patients in the system."

Greater emphasis was also needed in caring for a person's wellbeing and greater access should be granted to multidisciplinary care, they said.

The Cancer Council of Australia Chief Executive Officer, Professor Alan Coates told the committee that a greater emphasis was needed on prevention and early detection.

"Prevention is coming to be recognised but nowhere near enough, nor soon enough," he said. "We can and we should do more."

*Courier Mail, 20/4, p7; Sydney Morning Herald (online), 19/4; Illawarra Mercury and other regionals*

*Reprinted from Wongi Yabber May 2005; 12(2): 5.*

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## **Working Party to Establish Credentialing Processes for Medical Staff for Cancer Services**

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**P**rofessor Michael Frommer, Director of the University of Sydney, Health Projects Group is well advanced in the development of the scoping document. The document will be posted on our website after it is received and accepted by the ACN Credentialing

Steering Committee. Your comments will be crucial to its success.

*Reprinted from Wongi Yabber May 2005; 12(2): 1-2.*

## Report of the National Cancer Control Initiative

**C**ommunicating the risks, benefits and outcomes of elective therapeutic and diagnostic interventions between consumers and clinicians

In November 2004, funding was received from the National Health & Medical Research Council to undertake a literature review and produce a report on communicating the risks, benefits and outcomes of elective therapeutic and diagnostic interventions between consumers and clinicians. The literature review will analyse the available scientific literature to identify and collect information in relation to:

- Issues such as specific channels of communication, and barriers to exchange and utilisation of information which should be addressed when communicating the risks, benefits and outcomes of elective therapeutic and diagnostic interventions.
- Efficacy and effectiveness of different communication channels.
- Specific communication issues applicable to the following cases:
  - Diagnostic testing (screening men using PSA to detect early prostate cancer);
  - Surgical procedures (coronary angioplasty); and
  - Drug treatment (glucocorticoids in patients with chronic medical conditions).

The literature review and accompanying report will be used to inform the development of toolkits on the essential principles to be considered when communicating the risks, benefits and outcomes of elective therapeutic and diagnostic interventions. It is anticipated that the toolkits will assist in improving informed decision-making.

This project is a collaborative undertaking by Professor Brian McAvoy and Dr Faline Howes from the NCCI, and Dr Chris Peterson and Associate Professor Greg Murphy from La Trobe University. For further details, contact Dr Chris Peterson at [c.peterson@latrobe.edu.au](mailto:c.peterson@latrobe.edu.au).

*Reprinted from Wongi Yabber February 2005; 12(1): 3.*

### Cancer Stage at Diagnosis for Indigenous and Non-Indigenous People in the Northern Territory

The cancer incidence rate of Indigenous people in the Northern Territory (NT) is approximately the same as that of non-Indigenous people in Australia; however, Indigenous people have notably lower survival than non-indigenous people.

In 2002 the NT Cancer Registry, the Menzies School of Health Research and the National Cancer Control Initiative undertook a collaborative project to retrospectively identify the stage at diagnosis and survival of people in the NT diagnosed with selected types of cancer between 1 January 1991 and 31 December 2001.

The study showed that Indigenous people were more likely than non-Indigenous people to be diagnosed with advanced disease for particular cancers and with few exceptions, Indigenous people had lower survival than non-Indigenous people with the same stage at diagnosis for each cancer site. The project also demonstrated that reliable data on stage at diagnosis could be obtained from medical records.

The final report was released in late March to coincide with the publication of a journal article by the reports authors (Condon et al., MJA 2005; 182(6): 277-280). The final report can be accessed on the NCCI website [www.ncci.org.au/pdf/NT%20cancer%20staging/NT\\_report.pdf](http://www.ncci.org.au/pdf/NT%20cancer%20staging/NT_report.pdf) and hard copies can be obtained by contacting the NCCI secretariat at [enquiries@ncci.org.au](mailto:enquiries@ncci.org.au).

*Reprinted from Wongi Yabber May 2005; 12(2): 2.*

## Multilingual Cancer Information

In Victoria, 22 percent of all cancers occur in people born in countries where English is not the first language. While there is variation in the incidence of specific cancers among different cultures, cancer is a significant cause of illness and death for all migrant groups.

The Cancer Council Victoria's website now has information available on a wide range of cancer-related topics in 16 languages. The new multilingual section includes a series of information sheets and web links. Visit [www.cancervic.org.au/multilingual](http://www.cancervic.org.au/multilingual).

Topics include:

- What is cancer?
- Diagnosing cancer
- Treating cancer
- Eating well during treatment
- Learning to relax when you have cancer
- Cancer that cannot be cured
- Prostate problems
- Sun protection for all Australians
- The Pap test

All information is available in:

Arabic	Italian	Somali
Bosnian	Macedonian	Spanish
Chinese	Polish	Tigrinya
Croatian	Russian	Turkish
Filipino	Serbian	Vietnamese
Greek		

Additional fact sheets on Breast Awareness, Healthy Eating and Reducing Your Risk of Bowel Cancer will be available soon.

The availability of multilingual information supports existing programs aimed at reducing barriers to access and raising awareness of cancer issues, resources and support services.

### Programs include

- The Multilingual Cancer Information Line (MCIL)  
Adding to the accessibility of the Cancer Helpline, the MCIL enables callers who speak languages other than English to talk to oncology-trained nurse counsellors with the assistance of an on-line interpreter. The service is available in 80 languages.

- The Community Language Program  
The Community Language Program is a peer education program that provides free information sessions for community groups. Information on a range of topics is available in 22 languages.
- Quit's Multicultural Program  
Raising awareness of the health effects of smoking and passive smoking, Quit's Multicultural Program encourages people from multicultural communities to quit. Resources, telephone support and information sessions are available in a range of languages.

For additional information or to order copies of information sheets, phone the Cancer Information and Support Service on 13 11 20.

## A New Information Resource for People with Cancer of Unknown Primary & their Families and Friends

More than 3000 Australians are diagnosed with cancer of unknown primary each year. Patients and their families often find the diagnosis confusing and difficult to understand. Likewise, it can be difficult for professionals to explain the diagnosis and recommended management. A new print resource has been developed to make the subject easier for patients to comprehend. No other materials exist. Dr Michael Jefford, from Peter Mac, wrote the book. Several health professionals and patients/consumers reviewed it. The guide appears to have been well received and a second printing is underway. The Cancer Council Victoria and Sanofi Aventis, who sponsored the development and printing of the book, are distributing it. Contact the Cancer Helpline (13 11 20), for free copies.

## Key Published Articles Listing—Urological Cancer

Title	Author & Journal
<b>Estimating the optimal external-beam radiotherapy utilisation rate for genitourinary malignancies</b>	Delaney G, Jacob S & Barton M. Cancer 1 Feb 2005; 103(3): 462–473.
<b>Androgen suppression plus radiation versus radiation alone for patients with stage D1/ pathologic node-positive adenocarcinoma of the prostate: Updated results based on national prospective randomized trial Radiation Therapy Oncology Group 85-31</b>	Lawton CA, Winter K, Grignon D & Pilepich MV. Journal of Clinical Oncology Feb 2005; 23(4): 800–807.
<b>Natural history of rising serum prostate-specific androgen in men with castrate non-metastatic prostate cancer</b>	Smith MR, Kabbinavar F, Saad F, et al. Journal of Clinical Oncology 1 May 2005; 23(13): 2918–2925.
Men with rising HRPc, rising PSA and no bone metastases do relatively well. Median time to development of bone metastases is 30 months. Elevated initial PSA at time of evaluation and higher PSA velocity predict for bone PFS and overall survival.	
<b>Radical prostatectomy versus watchful waiting in early prostate cancer</b>	Bill-Axelsson A, Holmberg L, Ruutu M, et al. The New England Journal of Medicine 12 May 2005; 352(19): 1977–1984.
Follow-up paper describing more mature outcomes in a cohort study of watchful waiting versus early prostatectomy. Outcomes are worse in terms of development of metastatic disease and cancer-specific death.	

## Key Published Articles Listing—General

Title	Author & Journal
<b>Risks and benefits of phase 1 oncology trials, 1991 through 2002</b>	Horstmann E, McCabe MS, Grochow L, et al. The New England Journal of Medicine 3 Mar 2005; 352(9): 895–904.
<b>Peer support for cancer patients</b>	Tilkerdis J, O'Connor L, Pignatosa G, et al. Australian Family Physician Apr 2005; 34(4): 288–289.

## Forthcoming Meetings

Date / Place	Meeting / Contact
24–27 June 2005 Paris, France	<b>6<sup>th</sup> International Consultation on New Developments in Prostate Cancer and Prostate Diseases</b> Website: <a href="http://www.congress-urology.org/index.htm">www.congress-urology.org/index.htm</a>
26–29 June 2005 Ottawa, Ontario, Canada	<b>Annual Meeting of the Canadian Urological Association</b> Website: <a href="http://www.cua.org">www.cua.org</a>
27 June–1 July 2005 Glasgow, Scotland	<b>Annual Scientific Meeting of the British Association of Urological Surgeons (BAUS)</b> Contact: BAUS, 35-43 Lincoln's Inn Fields, London WC2A 3PE Ph: +44 20 7869 6950 Fax: +44 20 7404 5048 E-mail: <a href="mailto:admin@baus.org.uk">admin@baus.org.uk</a>
21–23 July 2005 Hobart, TAS, Australia	<b>Cancer Nurses Society of Australia (CNSA) Winter Congress</b> Pre-conference workshops on 21 July. Contact: CNSA Conference Secretariat, PO Box 265, Annandale NSW 2038 Ph: (02) 9280 0577 Fax: (02) 9280 0533 E-mail: <a href="mailto:cnsa@pharmaevents.com.au">cnsa@pharmaevents.com.au</a> Website: <a href="http://www.cnsa.org.au">www.cnsa.org.au</a>
10–13 August 2005 Hobart, TAS, Australia	<b>Annual Scientific Meeting of the Medical Oncology Group of Australia (MOGA)</b> Contact: MOGA Conference Secretariat C/- Pharma Events, PO Box 265, Annandale NSW 2038 Ph: (02) 9280 0577 Fax: (02) 9280 0533 E-mail: <a href="mailto:moga@pharmaevents.com.au">moga@pharmaevents.com.au</a> Website: <a href="http://www.racp.edu.au/moga">www.racp.edu.au/moga</a>
17–18 August 2005 Canberra, ACT, Australia	<b>11<sup>th</sup> Annual National Conference on Health Outcomes 2005: Making a difference</b> Australian Health Outcomes Collaboration. Contact: Lorna Tilley Ph: (02) 6205 0869 Fax: (02) 6244 4201 E-mail: <a href="mailto:lorna.tilley@act.gov.au">lorna.tilley@act.gov.au</a> Website: <a href="http://www.uow.edu.au/commerce/ahoc">www.uow.edu.au/commerce/ahoc</a>
2–5 October 2005 Birmingham, United Kingdom	<b>National Cancer Research Institute Cancer Conference</b> NCRI Conference Secretariat, PO Box 49709, 61 Lincoln's Inn Fields, London WC2A 3WZ United Kingdom Ph: +44 20 7269 3420 Fax: +44 20 7061 6004 E-mail: <a href="mailto:ncriconference@ncri.org.uk">ncriconference@ncri.org.uk</a>
6–9 October 2005 Sydney, NSW, Australia	<b>56<sup>th</sup> Annual Scientific Meeting of the Royal Australian and New Zealand College of Radiologists (RANZCR)</b> RANZCR, Level 9, 51 Druitt Street, Sydney NSW 2000 Ph: (02) 9268 9777 Fax: (02) 9268 9799 E-mail: <a href="mailto:ranzcr@ranzcr.edu.au">ranzcr@ranzcr.edu.au</a> Website: <a href="http://www.ranzcr.edu.au">www.ranzcr.edu.au</a>

**16–20 October 2005**  
Denver, Colorado, USA

**47<sup>th</sup> Annual Meeting of the American Society of Therapeutic Radiology and Oncology (ASTRO)**

American Society for Therapeutic Radiology and Oncology (ASTRO),  
12500 Fair Lakes Circle, Suite 375, Fairfax Virginia 22033 USA  
Ph: +1 703 227 0170  
Fax: +1 703 502 7852  
E-mail: [meetings@astro.org](mailto:meetings@astro.org)  
Website: [www.astro.org](http://www.astro.org)

**30 Oct – 3 Nov 2005**  
Paris, France

**13<sup>th</sup> European Cancer Conference (ECCO)**

Federation of European Cancer Societies (FECS), Avenue E. Mounier 83,  
Brussels 1200, Belgium  
Ph: +32 2 775 0201  
Fax: +32 2 775 0200  
E-mail: [ECCO13@fecs.be](mailto:ECCO13@fecs.be)  
Website: [www.fecs.be](http://www.fecs.be)

**7–12 November 2005**  
Chicago, Illinois, USA

**91<sup>st</sup> Meeting of the Radiological Society of North America (RSNA)**

Radiological Society of North America (RSNA), 820 Jorie Blvd, Oak Brook  
IL 60523-2251 USA  
Ph: +1 630 571 7879  
Fax: +1 630 571 7837  
E-mail: [sdrew@rsna.org](mailto:sdrew@rsna.org)

**10–12 November 2005**  
San Diego, California, USA

**2<sup>nd</sup> International Conference on Multidisciplinary Advances in Integrative Oncology**

Society for Integrative Oncology, 19 Mantua Road, Mt Royal, NJ 08061  
USA  
Ph: +1 856 423 3201  
Fax: +1 856 423 3420  
E-mail: [siohq@talley.com](mailto:siohq@talley.com) / [ggalante@talley.com](mailto:ggalante@talley.com)  
Website: [www.integrativeonc.org](http://www.integrativeonc.org)

**14–18 November 2005**  
Philadelphia, [Pennsylvania](#),  
USA

**17<sup>th</sup> International Conference on Molecular Targets and Cancer Therapeutics**

Jointly organised by AACR, NCI and EORTC  
Website: [www.aacr.org/4400m.asp](http://www.aacr.org/4400m.asp)

**16–18 November 2005**  
Brisbane, QLD, Australia

**32<sup>nd</sup> Annual Meeting of the Clinical Oncology Society of Australia (COSA) – Crossing Cancer Boundaries**

COSA Office, Medical Foundation Building, Level 5, 92 Parramatta Road,  
Camperdown NSW 2011  
Ph: (02) 9036 3100  
Fax: (02) 9036 3101  
E-mail: [cosa@cancer.org.au](mailto:cosa@cancer.org.au)  
Website: [www.cosa.org.au](http://www.cosa.org.au)

## 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.

