



Urological Cancer Update

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23RD WORLD CONGRESS ON
ENDUROLOGY

AUA MEETING REPORT

NATIONAL PROSTATE CANCER BIO
RESOURCE IN VICTORIA

A NEW WAY TO CONTROL SEVERE
STRESS URINARY INCONTINENCE IN
MEN

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



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). 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 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. 18 – June 2005** *****

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

Editorial

*Dr Caroline Dowling
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Welcome to the second Urological Cancer Update for 2005. Hopefully this will reach you in early 2006 and you will be able to sit back and relax and take it all in after the end of another hectic year. The update opens with the obituary to a truly amazing physician of our time, Dr John Colebatch. As we battle through the myriad of data in modern medicine, with trial after trial achieving small but “significant” results, Dr Colebatch’s achievements in paediatric oncology are sage reminders that we are but chipping away at the oncological puzzle, looking for leaps forward like he was able to make.

That said Dr Keen-Hun Tai provides us with an excellent summary, of the radiation oncology presentations, at this years meeting of the American Urological Association (AUA). The adjuvant treatment of patient’s post radical prostatectomy is an important current discussion as is the surveillance of those with stage I seminoma of the testis. This latter problem is further conflicted by emerging data on the use of single dose carboplatinum, an issue I hope we will hear about in this newsletter in 2006.

I continue to encourage contributions from the oncology and urology trainees and Dr Nathan Lawrentschuk has provided a summary of the meeting from the 23rd World Congress on Endourology. This meeting as Dr Lawrentschuk highlights has a strong focus on technology and the issues surrounding robotic radical prostatectomy, laparoscopic radical prostatectomy and laparoscopic partial nephrectomy continue to dominate debate. Professor Inderbir Gill again reminds us that the oncological outcomes are the important measure. New techniques will continue to need to be trialed against the accepted standards of care.

The newsletter contains a number of articles, as usual, that will hopefully keep consumers and clinicians up to date on the opportunities for participation in clinical trials and data gathering that may further enhance the individual patient’s and the community’s care. Amongst many articles is in particular, a notice that the Advanced Prostate Cancer Clinical Practice Guidelines will hopefully be progressed in 2006, that the National Bioresource has begun collecting tissue in Victoria and there is an opportunity for men with post radical prostatectomy incontinence to trial a new device through Melbourne University.

Contributions Welcome

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

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

Contributions should be forwarded to:

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In Memoriam

Dr John Houghton Colebatch AO – 1909-2005

**Paediatric Haematology
Chemotherapy Clinical Trials
The Cancer Council Victoria & Victorian Cooperative Oncology Group**

As a young physician training in London in 1938, Dr John Colebatch saw his first case of childhood leukaemia, a condition with a cruel image because it was invariably fatal within months of diagnosis. He learned to perform marrow puncture of the sternum, the flat narrow bone in the front of the chest, and undertook a project to determine the normal bone marrow profile of 50 infants and children in good health.

After returning to Australia from wartime duties, he started clinical work in Melbourne and quickly put his knowledge of bone marrow and its disorders to work. In 1946, he treated the first of what turned out to be hundreds of patients with childhood leukaemia, ordering a blood transfusion to ease the distressing symptoms.

A few years later he read reports of new drug treatments that extended the lives of leukaemia patients from about three months to five months or more after diagnosis. In 1948, he started working with these treatments, which reduced complications of the disease rather than dealing with leukaemia's immediate effects on the bone marrow.

This was a time of rapid pharmaceutical development and within a few years new types of drugs were available that attacked the abnormal white blood cells characteristic of leukaemia. Dr Colebatch was one of the first



physicians in Australia to prescribe the new treatments, collectively known as chemotherapy. Although he regarded their use in leukaemia as a major advance, he wanted to find out which chemicals, in what dose, and for what duration could bring about an improvement of symptoms in his patients most reliably. At that stage, the idea of producing a remission and curing children of their leukaemia seemed a distant hope.

The chemical therapies were difficult treatments for all concerned, involving numerous blood tests, an ever-present threat of serious side effects arising from severe bone marrow damage, and meticulous record and data handling. In seeking the consent of parents to allow the treatment, Dr Colebatch spoke along these lines: 'This treatment is new—a

man in America says it's producing improved results. He hasn't claimed any cures but you've got to start somewhere—you never know they may be curing someone in a couple of years time. We can do the same thing here now and it will involve a lot of blood tests and so on, but not an operation as a rule—nothing more serious'.¹

Dr Colebatch's efforts were controversial and raised ethical concerns which have since recurred with other chemotherapeutic agents. Was it preferable to continue with the existing approach of providing symptom relief and

allowing nature to take its course, or should attempts be made to prolong life with the ultimate aim of a cure, even though until that goal was reached many patients would die after a short reprieve and substantial discomfort?

During 1957, Dr Colebatch discussed his work informally at the Saturday medical seminars, organised by Dr EV 'Bill' Keogh, medical adviser to the Cancer Council, at the University of Melbourne medical school. Dr Keogh's interest in the statistics of cancer was evident in his use of Cancer Council Cancer Registry data to begin proceedings at such seminars, enabling him to provide statistical profiles of cancer incidence by site that formed the main subject of most meetings.

Dr Colebatch convinced some doctors about the value of chemotherapy in childhood leukaemia while others remained uncertain. By 1959, there was definite evidence that chemotherapy was prolonging life by months and sometimes years. He successfully applied for a Cancer Council research Grant-in-aid to facilitate a clinical study at the Royal Children's Hospital involving all children admitted with leukaemia. The following year he achieved his first long-term relapse—which, in retrospect, was a cure.

He had an opportunity to gauge world thinking on chemotherapy for childhood leukaemia and other cancers in 1962 when he was awarded the Cancer Council's Robert Fowler Travelling Fellowship. During a period of three-and-a-half months he visited centres in Europe, America, Asia and New Zealand and studied the US National Cancer Institute's approach to organising studies in multiple research centres.²

Flushed with enthusiasm about promising new drug therapies and new approaches to drug administration, he applied for, and won, Australian Cancer Society support for a trial of chemotherapy in childhood leukaemia involving 15 paediatric hospitals and departments nationwide. The ACS-sponsored trial proved to be a milestone in Australian medical history, being the first formal randomised clinical trials of any kind conducted nationally. The study compared the outcome for patients with acute leukaemia when given four drugs in sequence in two different ways (cyclic versus non-cyclic administration). It showed that the drug vincristine could maintain remission. Furthermore, it aroused professional interest in cooperative clinical trials.

In 1967, Dr Colebatch was appointed the Cancer Council's inaugural W J Kilpatrick Cancer Research Fellow. His consequent overseas travels convinced him of the need to create multidisciplinary clinics to improve the treatment of childhood leukaemia. It took 10 months to establish the Haematology Research Unit at the Royal Children's Hospital, but the effort was well worthwhile. The duration of remissions increased and the general comfort of the children also improved.

The unit was soon involved in six linked studies of chemotherapy for leukaemia and a study of the impact of radiotherapy to prevent or limit infiltration of leukaemia into the brain and spinal cord. By 1972, it was clear that almost all the drugs capable of destroying leukaemic cells achieved their treatment effect mainly by their action on one or more phases of the leukaemic cells' generation cycle. This understanding of the underlying process of chemotherapy opened up the possibility of timing drug administration optimally to achieve maximum cytotoxic effect. By 1973, doctors were inducing cells to enter the cycle in which they could be damaged or destroyed most readily and were synchronising chemotherapy with this most vulnerable part of the cell generation cycle. By the following year, they could advise with increased confidence when particular patients could come off their chemotherapy having been disease-free for a number of years. Not surprisingly, the Haematology Research Unit was used as a model by other Australian hospitals involved in chemotherapy research.

Studies such as those Dr Colebatch helped establish broke new ground in chemotherapy, radiotherapy and immunological therapy and highlighted the need for improved training of doctors in emerging cancer treatment methods. In response, the Cancer Council's Medical and Scientific Committee established in March 1976 a sub-committee whose brief was to explore all aspects of the development of clinical oncology. Three months later, the Victorian Chemotherapy Cooperative Group (VCCG) was established under the Chairmanship of Dr Doug Pearce, with Dr Colebatch appointed the inaugural Executive Secretary in 1977. It emphasised cooperation in the development of chemotherapy—which was still regarded as an experimental method of cancer treatment in Australia.

In 1977, Melbourne haematologist Dr Max

Whiteside was appointed VCCG Chairman. He and Dr Colebatch worked to establish a Breast Study Committee (*renamed the Breast Cancer Committee*), which advised, assisted and coordinated the running of chemotherapy studies for breast cancer (*Early & Advanced Breast Cancer, Breast Adjuvant Chemotherapy Study, Ludwig Breast Trials*). Once again, Dr Colebatch's experience with childhood leukaemia came into its own, for all the most effective drugs for breast cancer had been used for some years to treat acute leukaemia. Drs Whiteside and Colebatch also helped establish a Head and Neck Protocol Sub-Committee (1977-1978), which investigated the place of pre and post-operative chemotherapy in head and neck cancers; a Lung Cancer Study Group (1978-1982) to exchange information on methods and treatment results; and the Gastrointestinal Study Committee in 1979 (*renamed the Gastrointestinal Cancer Committee*) to act as a central coordinator of measures for improving the standard of treatment, and to disseminate information on the wider aspects of gastrointestinal cancer control.

Dr Colebatch oversaw in 1977 the formation of the Cancer Council's Clinical Trials Secretariat [which developed into the Centre for Clinical Research in Cancer] to assist the VCCG committees with detailed planning of trial protocols, form design, collection, monitoring and analysis of clinical data and the administration and organisation of meetings.³ He also steered the sub-committee to review chemotherapeutic oncology services in Victoria in 1978, which was adopted by the Health Services Commission in 1982.⁴

A name change in 1981 to the Victorian Cooperative Oncology Group (VCOG) signalled a widening of interest beyond chemotherapy to all aspects of cancer treatment, and associated medical education.

Extracted from "Gaining Ground against Cancer, Anti-Cancer Council of Victoria 1936-1996" Ann Westmore PhD, published by The Cancer Council Victoria 2005

Dr Colebatch retired from the role of VCOG Executive Secretary (*succeeded by Professor Richard Lovell*) in 1982, but remained as a consultant to the VCOG and Cancer Council

Victoria for many years. In his consultancy role, he provided sound advice on clinical trial practice procedures, particularly in the development and conduct of the COSA-UK-NZ Endometrial Cancer Trial E1/82, initiated by Victoria's gynaecological oncology community. In addition to his activities in Victoria, Dr Colebatch was also involved in a number of national and international cancer organizations. These included the Clinical Oncological Society of Australia (Inaugural Chair of Paediatric Group, Member of Council, Member of Standing Committee on Anti-Cancer Medications, Member of Standing Committee on Clinical Trials, Member of Steering Committee for National Data Centre), Haematological Society of Australia (Foundation Member, Vice-President), National Health and Medical Research Council (Regional Grants Committee Member, Haematology-oncology Research Referee Assessor)⁵

The Cancer Council Victoria is proud to announce it has established a five-year Clinical Research Fellowship in honour of Dr John Houghton Colebatch AO.

Dr John Colebatch will be remembered for his pioneering clinical research in paediatric haematology in Victoria and in establishing a firm foundation for good clinical research practice.

Susan Fitzpatrick
Executive Officer
Victorian Cooperative Oncology Group, and
Centre for Clinical Research in Cancer
The Cancer Council Victoria

¹ John Colebatch, extract of interview with Dr Nigel Gray, 29 Nov 1993

² John Colebatch, Report on Robert Fowler Travelling Fellowship, 1962

³ Obtained from record of VCOG activities, TCCV

⁴ Obtained from record of VCOG activities, TCCV

⁵ Extracted from John H Colebatch Curriculum Vitae, TCCV

23rd World Congress on Endourology

Amsterdam, Netherlands

23 – 26 August 2005

*Dr Nathan Lawrentschuk
Urological Trainee - Victoria*

I was lucky enough to be presenting a poster at the recent World Congress of Endourology in Amsterdam late August. There was a sizeable Australasian contingent at the meeting focused on all aspects of endourology including stones, BPH, and oncology with a broader focus on minimally invasive treatments of all urologic disorders. Some Australasian trainees completing fellowships including Daniel Moon (Victoria) and Troy Gianduzzo (Queensland) also presented posters on laparoscopic radical prostatectomy. I will briefly mention some highlights and take home messages from the meeting focusing on oncology.

Prostate Cancer

There was a large emphasis on laparoscopic surgery, particularly laparoscopic radical prostatectomy (lap RP) and robotic-assisted radical prostatectomy (robotic RP). Perhaps the highlight came on the last morning where a lively debate was conducted between Professors Inderbir Gill and Thomas Ahlering, both from the USA, on Man versus Robot for laparoscopic radical prostatectomy.

Inderbir Gill argued for man, and started by claiming that the term “robotic” was a misnomer and should be renamed “computer-assisted” laparoscopic radical prostatectomy, pointing out that both procedures were done by humans and were both laparoscopic radical prostatectomies. Thomas Ahlering highlighted the advantages of the robot with superior vision, dexterity, ergonomics and a shorter learning curve. To counter this Inderbir Gill demonstrated some new hand-held instruments with similar movements to the robot. He also highlighted that a centre in the USA doing 150 robotic RP a year would cost around \$US 3,000,000 over the 5 years and in that time and for that money you could train 61 trainees in lap RP. Finally he urged the focus on the debate to return to oncologic principles such as surgical margin rates and outcomes of function

such as potency and continence. In summary, both procedures seem embedded in world urology at present.

Also, in prostate cancer image-guided brachytherapy using MRI after injection of iron oxide nanoparticles that are preferentially phagocytosed by prostate cancer cells was demonstrated. This can highlight tumour deposits less than 5mm and may help future seed placement.

Finally Jean de La Rosette (The Netherlands) gave a similar presentation to that from the Melbourne USA Annual General Meeting this year highlighting new ultrasound contrast agents for prostatic ultrasound with targeting of TRUS biopsies.

Renal Cancer

Laparoscopic partial nephrectomy also featured highly and there were some excellent live surgical demonstrations of the technique. Laparoscopic assisted cryoablation of a small renal tumour was also demonstrated. HIFU and RFA were also featured. Again, minimally invasive treatment options are increasing with take-up of laparoscopic partial nephrectomy now possible with improved instrumentation and techniques. In particular, suturing by using clips at the end of sutures that also dissolve, instead of tying knots, saves time. This is essential when a kidney has its blood supply clamped so that a partial nephrectomy may be undertaken. This advance will mean the operation is more safely and readily conducted by a larger group of urological laparoscopic surgeons.

Bladder Cancer

In bladder cancer surveillance using fluorescent-labeled DNA probes on voided urine (Urovysion) has recently been approved by USA-FDA. It is being offered as an alternative to voided urinary

cytology. It tests aneuploidy of chromosomes 3,7,17 and loss of 9p21 locus (contains the p16 tumour suppressor gene) via fluorescence in situ hybridization (FISH) in patients with known TCC. The cost is around \$70 per test at present with an overall sensitivity of 81% versus 58% cytology. Again, like cytology this test is better with high-grade disease.

Laparoscopic-assisted cystectomy is being attempted with small incisions for the conduit and to remove the specimen. In terms of diagnosis, photodynamic procedures using fluorescence-enhanced endoscopy were highlighted requiring

a blue light source (light excitation-xenon light) for filtered cystoscopy after instillation of a photosensitizing drug (topical, non-toxic, selective 5-20x for tumour based on porphobilinogen pathway with photoactive porphyrins). This could lead to earlier diagnosis and detection of recurrence of TCC as guided versus random biopsies and enhancement of CIS detection is possible.

It was a relatively interesting meeting in a beautiful city although highly focused on technology. Next year it will be in the USA.

Clinical Practice Guidelines for the Management of Metastatic Prostate Cancer

This Working Party has succeeded in obtaining funding from Andrology Australia and the Prostate Cancer Foundation. The funding will support a Research Fellow to carry out the systematic reviews. The Fellow will be working at NSWCC under

direction of Drs Di O'Connor and David Smith. A meeting was held on 6 October to progress the Guidelines within the new NHMRC processes and good progress was made.

Reprinted from Wongi Yabber November 2005; 12(4): 2

Localised Prostate Cancer Guide for Men and their Families

The consumer document of June 2003 is in the process of revision. Ms Carole Pinnock is chairing the working party to carry this forward.

Reprinted from Wongi Yabber November 2005; 12(4): 2

American Urological Association (AUA) Meeting Radiation Oncology Highlights

21-26 May 2005, San Antonio, Texas USA

*Dr Keen-Hun Tai
Radiation Oncologist
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The AUA 2005 was an opportunity to update on the current clinical, basic uro-oncological and translational research. It was held from May 21-26, 2005 in San Antonio, Texas USA. This summary will focus on some of the radiation oncology related studies.

Post-radical Prostatectomy Radiotherapy

Adjuvant radiotherapy for pathologic T3 prostate cancer: Results of a randomised, prospective clinical trial with metastasis-free survival endpoint. (Abstract 1665)

IM Thompson, C Tangen, GJ Miller, MS Lucia, DA Troyer, J Paradelo, JL Chin, EM Messing, ED Canby-Hagino, J Forman, ED Crawford

There were 473 patients with pT3 disease, confirmed with central pathology review, enrolled between 1988 and 1995. Patients were randomized to adjuvant radiotherapy (ART) to a dose of 60 to 64 Gy vs observation. PSA was done 3-monthly for one year, monthly for two

years and then annually. Bone scans and other investigations were done when clinically indicated. Patients were followed until death. The median follow-up of the study was 9.7 years and 410 patients were eligible for analysis.

ART was not shown to significantly improve metastasis-free survival (the primary end-point). However, two secondary end-points of PSA-free survival (<0.4 mg/L) and relapse-free survival were found to be statistically significant. 32% of patients on observation eventually received post-operative radiotherapy at a median time of 2 years post-randomization. Refer Table 1.

Discussion:

This is a SWOG co-operative trial examining important questions on the benefits of post-operative radiotherapy. The study was powered to detect a 1.5x improvement in metastasis-free survival. This was not demonstrated because of the lower than expected of number of events. It was noted that even patients who had seminal vesicle involvement benefited from ART. Higher rate of complications in the ART group included strictures, proctitis and incontinence. The QOL in the ART group initially decreased but equalized with the observation group after 5 years. Refer Table 2.

Table 1: Kaplan-Meier Event-free Estimates

	5 years		10 years		HR (95%CI)	p-value
	ART	Observation	ART	Observation		
PSA-free survival	61%	38%	47%	23%	0.51 (0.39-0.67)	<0.001
Relapse-free survival	84%	69%	67%	48%	0.59 (0.44-0.80)	0.001
Metastasis-free survival	87%	83%	71%	61%	0.80 (0.57-1.11)	0.17
Overall survival	91%	89%	74%	63%	0.76 (0.54-1.07)	0.11

Table 2: Complications - Reported Orally

	Observation	Adjuvant RT	Odds ratio	Comments
Any complications	11.9%	23.8%	2.3	
Strictures	9.5%	17.8%	2.1	
Total incontinence	2.8%	6.5%	2.4	RT within 8 wks of surgery
Proctitis	0	3.3%		

The mediated poster session also discussed the fact that information on Gleason score was missing in ~20% of the patients; that the study started in 1988 when PSA doubling time was not taken into consideration and that 31% (66 of the 211 patients randomized to observation) received radiotherapy (at a median time of 2 years).

This study should be considered together with emerging data from the EORTC trial published recently (Lancet. 2005 Aug 13-19; 366(9485): 572-8) and the German ARO 96-02 / AUO AP 09/95 trial. These studies show that adjuvant post-operative radiotherapy for pT3 and margin positive disease after radical prostatectomy is beneficial. There is good evidence (at least Level 2 and emerging Level 1) that biochemical progression free survival and local control is improved if radiotherapy is given in an adjuvant setting.

Predictors of biochemical relapse following salvage radiation therapy for recurrent prostate cancer (Abstract 472)

AS Parker, S Buskirk, MG Heckman, T Pisansky, KA Prusak, M Wehle, RG Ferrigni, SE Schild, RP Myers

This is a retrospective review of 368 patients from July 1987 to July 2003 who had a rising PSA after node-negative radical prostatectomy. Patients received post-operative salvage radiotherapy. Relapse post-RT was defined as >0.4 ug/L and not declining. Analyses included pathologic stage, Gleason score, DNA ploidy, RT dose, pre-op PSA, pre-RT PSA, and pre-RT PSA doubling time. Independent factors were pathologic stage, Gleason score and pre-RT PSA. Using the coefficients from the multivariate model including these independent factors, a scoring system was developed to identify 4 risk groups. This enabled the authors to combine

Table 3: The Estimated Proportion Relapse - Free from Start of Radiotherapy

	1 year	2 years	3 years	4 years	5 years
Score 0-1	90%	85%	80%	75%	70%
2	80%	75%	60%	55%	50%
3	75%	55%	48%	45%	28%
4-5	55%	37%	20%	10%	7%

these 3 predictors into a scoring algorithm (0-1, 2, 3, 4-5) that gives a high degree of prognostic ability. Refer Table 3.

Post-Radiotherapy Recurrent Prostate Cancer

A number of patients relapse with local recurrent prostatic carcinoma despite radiotherapy. Salvage prostatectomy can result in significant morbidity. Many patients are observed or undergo androgen deprivation instead. The following two papers look at cryotherapy and salvage radical prostatectomy.

Salvage cryosurgical ablation for radio-recurrent prostate cancer using 3rd generation cryoneedles: the University of California-Los Angeles experience. (Abstract 665)

JS Lam, JT Leppert, ME Koski, N Vemulapalli, AS Beldegrun

With the availability of 17 gauge needles, another form of salvage treatment with cryotherapy maybe feasible.

This is a report of 22 patients who had previous brachytherapy or external beam therapy and biopsy proven recurrent prostate carcinoma.

	Mean values (range)
Age	70 (56 – 87) yrs
Pre-operative PSA	9.8 (1.2- 14.6) ug/L
Gleason score	7.5 (6 – 9)
Prostate volume	26.1 (12 – 50) ml

12 patients (54%) achieved a PSA nadir of <0.4 ug/L at 3 months follow-up. Biochemical recurrence free survival at 6 months was 90% (no definition was given). Toxicity is as follows (no definition as to the time of the events):

	Incidence
Scrotal swelling	5%
Urethral sloughing	5%
Transient pelvic pain	5%
Transient urinary retention	9%
Urinary incontinence (1-2 pads)	17.5%
post-op impotence	83.3%

It was the author's opinion that minimally invasive cryosurgery could be performed using a standard brachytherapy template and that it offered a method of treatment for patients who failed previous radiotherapy. It was thought to be an attractive alternative to salvage prostatectomy. Funding for this paper was from ONCURA.

Predictors of long-term biochemical-free survival following salvage radical prostatectomy. (Abstract 816)

KM Sanderson, G Lieskovsky, JP Stein, J Cai, D Skinner, DF Penson

In reviewing 2739 patients who had radical prostatectomy between 1983 & 2002, 51 were identified as having had prior radiotherapy (EBRT, brachytherapy or both).

	Median values (range)
Age	65 (51 – 77) yrs
Pre-operative PSA	8 (0.8- 48) ug/L

Results:

	Median
Overall survival	5.5 (0.7 – 20.2) yrs
Recurrence free survival	3.6 (0 – 18.2) yrs

One patient recurred locally, 8 relapsed with distant disease. 54.9% received androgen ablation therapy for subsequent relapse.

Complications:

	Incidence	Median
Bladder neck strictures	42%	10.1 mnths
Incontinence requiring artificial sphincter	22 (43.1%)	-

Factors that predicted for long-term disease free interval were Gleason score =7, negative margins, pre-operative PSA =5ug/L and organ confined disease.

Brachytherapy

¹²⁵I brachytherapy and localised prostate cancer: outcome results with 5 year minimum follow-up (Abstract 1009)

NN Stone, RG Stock

This reports on a group of 325 patients with T1b – T2c prostate cancer patients who underwent ¹²⁵I brachytherapy in New York.

Age	Median 67 (41-82) yrs
Proportion who had hormone therapy	75 (23.1%)
PSA	7 ug/L (0.9-189)
T1b-T2a	234 (72%)
T2b	77 (23.7%)
T2c	14 (4.3%)
Gleason score 2 - 4	64 (19.7%)
Gleason score 5 – 6	255 (78.5%)
Gleason score 7 - 8	6 (1.8%)

CT based dosimetry was done one month post-implant; PSA failure was defined as 3 consecutive rises or a PSA > 1.0ug/L

Results:

Follow-up	Median 7 yrs (5-14)
Post-implant D90%	167 Gy (15-256)
D90% < 140Gy	62 (19.9%)
PSA failure	57 (17.5%)*

*11 year biochemical freedom from failure (bFFF) survival as 82%

Multivariate analysis showed that only PSA and D90% were significant in predicting for bFFF.

24 (7.4%) of patients have died, with 2 (0.6%) from prostate cancer.

The 10-yr cause specific survival was 99.4%.

The authors concluded that their results support the use of brachytherapy in patients with T1-T2 prostate cancer.

Comparative studies: Radical prostatectomy vs Radiotherapy

Cause-specific mortality after radical prostatectomy or external beam radiation therapy for localized prostate cancer in the PSA era: results of a single-institution non-randomised comparison. (Abstract 668)

DS Sharp, H Vaghefi, CA Reddy, PA Kupelian, A Mahadevan, AM Ruther, EA Klein

The Cleveland clinic reviewed a cohort of 3121 patients treated from 1986 to 2003: 1927 radical prostatectomy (RP) and 1194 radical radiotherapy (RT, =70Gy). The endpoint was death due to prostate cancer (DOD) or death with prostate cancer (DWD), the latter requiring radiographic or biopsy-proven evidence and excluded PSA recurrence alone. Stratification was into low, intermediate and high risk groups based on T stage, PSA and grade of disease. RP patients had more favorable pre-treatment parameters. Refer Table 4.

Cause-specific survival analysis showed a small but statistically significant difference in favour of RP for both DOD and DWD at both 5 and 10 years: p = 0.008 and <0.00001 respectively.

The authors concluded that death due to prostate cancer was a rare event after RP or RT in the PSA era. While that was a small and statistically significant difference in favour of RP, this was not significant when stratified by risk group.

Table 4: Median RT dose 78Gy (70-83)

	Age (yrs)	Pre-Rx PSA (ug/L)	Follow-up (mths, range)	DOD	DWD
RP	62	6.7	72 (0.5 to 210)	59 (3.0%)	26 (1.3%)
RT	69	8.9	60 (6 to 210)	51 (4.3%)	26 (2.2%)

Quality of Life after Radical Prostatectomy or External Beam Radiotherapy for Localized Prostate Cancer: a controlled prospective study (Abstract 1017)

SM Di Stasi, A Giannantoni, L Storti, F Chiarotti, F Attisani, S Sansalone, EA Jannini, G Zampa

This paper reports on health related quality of life (HRQOL) parameters in a randomised trial comparing the outcomes for radical retropubic prostatectomy (RP) and external beam radiotherapy (EBRT) in patients with localized prostate cancer.

From 1997 to 2001, 137 patients were randomly treated with RP (n=70) or EBRT (n=67). The authors claimed matching parameters for both groups. 96 (70%) patients were evaluable (RP=47, EBRT=49): completed questionnaires on HRQOL, bowel, urinary and sexual functions. Patients were assessed pre-treatment, then at 1, 3, 6, 12 and 24 months.

At one month post-treatment, RP patients reported a significant decrease in HRQOL compared to EBRT patients ($p < 0.001$). By 12 months there was no statistical difference in the parameters for HRQOL between the groups.

For urinary function, RP patients reported a significantly lower urinary function score ($p < 0.001$) compared to EBRT patients. This improved during the first year post-treatment for the RP patients but then remained static for the 2nd year. At 2 years, 10.6% of RP patients reported incontinence compared to 2.9% of EBRT patients (OR = 3.9, 95% CI 1.4 to 5.9).

For bowel function, EBRT patients reported poorer scores compared to the RP patients throughout the 2 years of follow-up ($p < 0.001$). 26.5% of EBRT patients and 6.1% of RP patients had bowel dysfunction at 2 years (OR 0.23 in favour of RP CI 0.1 to 0.5).

Sexual function immediately after treatment was significantly better in EBRT patients compared to RP patients ($p < 0.001$) with continuous improvement in the latter over the 2 years whereas there was a continuous decline in the EBRT group. However, at 2 years, sexual

function was more prevalent in the RP group compared to EBRT (70.2% vs 61.2%).

Comment: This is a small but interesting randomised trial comparing RP to EBRT. At 2 years follow-up the toxicity data confirm the data in single modality, larger series from large institutions. The small numbers of patients in the study and those evaluable detract from the ability of this trial to report significant survival outcomes.

Seminoma of the Testis

Outcome in Stage 1 seminoma managed by radiation therapy and surveillance (Abstract 719)

Warde P, Gospodarowicz M, Panzarello T, Giuliani M, Tew-George E, Milosevic M, Bayley A, Catton C, Sturgeon J, Moore M, Jewett MAS

This group from Toronto reviewed all 630 stage 1 seminoma cases treated between January 1981 to December 1999. 348 patients were managed by surveillance and 282 received adjuvant radiotherapy (RT): patient preference determined management. Patients were assessed 4-monthly for the first year, 6-monthly for 4 years then annually. Median age was 34.5 years and median follow-up was 8.8 years for both observation and RT.

Of the surveillance group of 348 patients, 55 relapsed with a 5-yr relapse rate of 14.4%. 40 of the 55 were treated with RT (5 developed further relapse, salvaged by chemotherapy CT), 13 with chemotherapy and 2 with surgery. The actuarial risk of requiring chemotherapy for 1st or 2nd relapse on surveillance was 5.05.

Of the RT group of 282 patients, 14 relapsed with a 5-yr relapse rate of 4.9%. 10 of the 14 received CT, 3 received RT and 1 surgery. The actuarial risk of requiring chemotherapy after adjuvant RT was 3.5%.

Only one patient has died in both cohorts of patients, having relapsed while on surveillance and failed salvage chemotherapy.

The authors concluded that surveillance should be the policy of management for all patients with stage 1 seminoma of the testis.

The National Prostate Cancer Bio-resource in Victoria

Ms Courtney Bamford, State Tissue Bank Co-ordinator

Monash Institute of Medical Research (MIMR)

Dr Caroline Dowling, Senior Lecturer, Department of Surgery, Monash University.

Research Associate, MIMR

Melbourne now has its own node of the national prostate cancer Bio-resource at the Monash Institute of Medical Research. The Bio-resource is an initiative of the Australian Prostate Cancer Collaboration (APCC). Funding for the Bio-resource, which has nodes in Adelaide (Hanson Institute of Medical Research), Brisbane (Queensland University of Technology) and Sydney (Garvan Institute of Medical Research), is from an NHMRC Enabling (infrastructure) Grant obtained in July 2004.

The purpose of the Bio-resource is to allow further laboratory research to enable the development of new therapies, enhance existing therapies and advise patients which therapy will be best suited to their prostate cancer.

The Bio-Resource is a dedicated prostate cancer tissue bank, where researchers can gain access to a large number of prostate tissues to use in their hunt for better treatment options, and a cure for prostate cancer.

Collection

Where a patient is scheduled for a radical prostatectomy, their urologist will introduce the idea of the Bio-Resource, and ask if they are happy for the state tissue bank co-ordinator (in Victoria, this is Courtney Bamford) to come and talk to them about it.

The evening prior to surgery, Courtney will go and speak to the patient and obtain their informed consent for involvement, if they are happy to contribute their tissue to the bank. The patients are made aware that their involvement is entirely voluntary, and will not affect their care in any way, whether or not they choose to participate.

After the surgical specimen has been removed, Courtney, who attends theatre on the day, collects it and transports it (along with blood tubes which have been collected) to the pathology laboratory for processing, which at this stage is done by Dr John Pederson at Tissupath.

The pathologist will examine the tissue, and take a punch biopsy of suspected malignant tissue. A frozen section will be performed on this, so we can be sure that there is malignant tissue present, and also to determine the Gleason grade. The same process will happen to an area of non-malignant tissue. Each core of tissue will then be divided into up to four pieces, depending on the amount of malignant tissue present. Two are frozen in OCT (a medium which is used to make histological sections later) and two are snap frozen in cryovials. This way we will have two different types of frozen tissue on each patient. The OCT embedded tissue is suited to people wanting tissue for histological experiments. The snap frozen tissue is more suited for extractions on RNA/DNA, for molecular biology experiments. This process of tissue extraction does not in any way affect the pathologist's assessment of the remaining prostate with regard to important parameters such as surgical margins, assessment of volume and Gleason grade.

While the pathologist is examining the tissue, Courtney processes the blood tubes. Blood is stored as plasma, serum, a Guthrie card, and Buffy Coat cells. DNA/RNA can be extracted from the buffy coat cells, and also from the Guthrie card as a backup. The plasma and serum can be used for proteomics analysis, where researchers can determine if a particular protein is present in blood.

Laboratory Experiments

One example of the aims of laboratory research is to determine the presence/absence of a protein in blood which could indicate a potential to develop advanced prostate disease ie a biomarker. We could then develop a blood test which could determine a patient's likelihood of developing advanced prostate cancer and metastasis, and therefore better tailor further treatment to that patient.

Access to Tissue

The BioResource has a Tissue Access Policy, Application Forms and a Material Transfer Agreement, which researchers can obtain from the National Project Manager. Tissue access is subject to a number of conditions as outlined in the access document. There will only be limited access to fresh frozen tissue during the first 5 years of prospective collection in order to retain sufficient specimens with extended clinical outcome data. Specific Tissue Micro-Arrays will be available during that period from pathology archives.

The VTBI (Victorian Tissue Bank Initiative) is also in the process of developing prostate cancer tissue banking and it is envisaged that in time there will be collaboration with the Bio-resource Tissue Bank.

There is more information available at <http://www.apccbioresource.org.au/>.

A recent newsletter has been published and this is available on this website or Courtney can be contacted for a copy.

Courtney Bamford (03) 9594 7437, 0419 368 122 or via email courtney.bamford@med.monash.edu.au

Improving Quality of Life after Prostate Cancer Treatment

*Adapted from The Healthy Male Issue 16, Spring 2005.
Newsletter of Andrology Australia.*

There is little information in Australia concerning the relationship between sexual functioning and the quality of life of men receiving treatment for localised prostate cancer. There is also little data about how men experiencing sexual dysfunction and their partners adapt to using erectile function aids.

Andrology Australia and the Department of Psychology at Monash University are currently supporting a study into sexual dysfunction during and after prostate cancer treatment, to find out the types of issues that these men experience. Men aged between 45 and 75 years who are undergoing prostatectomy or brachytherapy treatment are being studied, as well as a comparison group of men from the general community.

Dr Sue Burney, Chief Investigator, said that prostatectomy and brachytherapy patients experiencing long-term sexual dysfunction can be distressed and this can impede their quality of life. "Many men feel very strongly about their loss of sexual functioning, particularly once the treatment is over and the fear of having cancer has diminished. It is therefore important that we look at the likely impact that this health problem has on their quality of life," said Dr Burney. "We

also need to explore how men's partners feel about this health problem. It is not uncommon for men to report periods of distress about their erection problems, self-image, and intimate relationships".

Recruitment for this prospective multi-site study, which is being conducted by Ms Fiona Newton for her PhD, commenced in June 2003 and is scheduled to finish in December 2005. Male participants complete 5 confidential surveys over an 18-month period containing validated instruments measuring their sexual functioning and mood. The men also participate in two semi-structured telephone interviews designed to gather information about their personal experiences in dealing with any sexual dysfunction they may be experiencing and their perceptions about using erectile function aids. Information about the impact of sexual dysfunction and the use of erectile function aids is also collected from the partners of male participants.

The aims of the project are to (i) determine the pre-and post-treatment incidence rates of sexual function problems among Australian men with and without a diagnosis of PCa and (ii) examine the potential relationship between erectile

dysfunction and mood. The research team also hopes to formulate a 'road map' outlining the potential sexual function issues experienced by men and their partners after treatment for localised PCa. It is hoped that the outcomes of this study will benefit both doctors and patients alike by providing more detailed information that is culturally appropriate to men in Australia. The provision of information about the ways in which

erectile dysfunction can affect the partners of men with prostate cancer is also important.

"Sexual functioning needs to be given special attention during treatment decision-making," said Dr Burney. "It's also important for the on-going management of men with prostate cancer."

*Reprinted with permission from Andrology Australia
(Australian Centre of Excellence in male reproductive health: www.andrologyaustralia.org)*

A New Way to Control Severe Stress Urinary Incontinence in Men

Authors

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A distressing consequence of an otherwise successfully treated Prostate Cancer is urinary incontinence. Though several types of intervention are available to treat post-prostatectomy urinary incontinence, there is an ongoing search for less complicated and more effective treatments for severe urinary incontinence. Researchers at Melbourne University from the departments of Anatomy and Cell Biology, Zoology, Veterinary Science and Surgery have developed a new technology to mitigate and possibly cure stress urinary incontinence both in males and females.

Stress urinary incontinence results when the urinary sphincter fails. Prostate surgery for benign or more commonly malignant conditions, radiation therapy to the prostate and other radical surgeries in the pelvis, especially ano-rectal

(most commonly for carcinoma), are the leading causes of stress urinary incontinence in males. The estimated prevalence of urinary incontinence in Australia is more than 200,000.¹

Many treatment options are available to treat male stress urinary incontinence, ranging from life-style modifications to major surgery. Timed voiding, pelvic floor exercises, biofeedback, penile sheaths and other collection methods, insert devices, functional electrical stimulation, pharmacologic therapy, periurethral injection of bulking agents (Contigen™, Macroplastique™, Durasphere™ and others), sling procedures and artificial sphincters are all in use with variable success, complications and limitations. Urinary incontinence is among the few benign conditions in which a substantial number of patients undergo repeated interventions. All treatments, other than artificial sphincters, offer static compression to the urinary passage and have the potential to cause acute or chronic bladder outlet obstruction and consequent irritative symptoms and even urge incontinence, infection, and erosion. Being a hydraulic mechanical device the artificial urinary sphincter is subject to occasional mechanical problems most of which can be successfully rectified with further surgical intervention.² The cuff that wraps around the urethra as part of the device is opened by the use of a pump that resides in the scrotum. The patient uses the pump to open the urethral cuff.

Whilst this typically permits unobstructed urination it may constitute a disincentive to implantation of a potentially curative treatment as some people do not wish to consider the use of such a pump or have dexterity limitations which make the option unfavourable.

With the limitations of the current surgical options in mind, researchers from our group undertook to design a surgical solution that uses autologous tissue to provide direct urethral compression, without the problems of an artificial urinary sphincter. This novel procedure involves the use of a small piece of smooth muscle, taken from the patient, to form a new urethral sphincter (or neosphincter). The neosphincter is then stimulated using an implanted electrode which is connected to a pacemaker-like device, to prevent urine leakage from the bladder.

The stimulation device has been developed by Cochlear Ltd under an exclusive supply agreement with Continence Control Systems International Pty Ltd. This device is a modification of a device previously used for functional electric stimulation in spinal cord injury, which has been approved for clinical investigation by the FDA (USA) and Medicines and Healthcare products Regulatory Agency (MHRA) in the UK.

To date we have shown in animals that this method of treatment can effectively prevent urine leakage. A clinical trial examining the safety and feasibility of the device is currently being undertaken. In men the definitive surgery involves raising a dartos flap (strip of healthy

smooth muscle) at the penoscrotal junction, with the vascular pedicle from the median raphe intact, and wrapping it around the adjacent urethra. The electrode is then attached to one end of the flap. These leads are connected to the stimulation device that is later buried in a subcutaneous pocket in the right iliac fossa of the lower abdominal wall secured to the rectus fascia. The first patient implanted with the device at Royal Melbourne Hospital, Department of Urology, is progressing very well and initial results suggest a significant decrease in urine leakage; at 6 weeks post-surgery, a 20 minute pad test, in which the patient performed a number of standardised exercises (eg jumping, coughing, jogging) with a full bladder, resulted in a pad weight gain of only 2g. To date there has been no adverse event related to the continued electric stimulation or compression of the urethra. The study is open to other men with sphincteric incontinence.

Communications: Dr Helen E O'Connell, Suite 12, Private Medical Centre, Royal Melbourne Hospital, PARKVILLE VIC 3050

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NCCI Update - PSA Informed Decision Making

Prostate cancer is the most common cancer in Australian men. In 2001 there were 11,191 new cases and 2,718 deaths from prostate cancer. The current consensus is that there is insufficient evidence to support population screening for prostate cancer in asymptomatic men. However, almost all national and international clinical practice guidelines on prostate cancer testing using the prostate specific antigen (PSA) test and digital rectal examination agree that men concerned about prostate cancer

should be able to access testing so long as they are fully informed of the pros and cons associated with screening and consider their own preferences and circumstances before making an informed choice.

The Queensland Cancer Fund in collaboration with the NCCI, the Australian Prostate Cancer Collaboration, the Royal Australian College of General Practitioners, the Northern Section of the Urological Society of Australasia, the

Australian Prostate Cancer Foundation, The Cancer Council Victoria, the Cancer Council Tasmania, the NSW Cancer Institute and other key medical groups have developed an educational program and a practice resource to assist General Practitioners with facilitating informed choice about testing for the early detection of prostate cancer.

The educational program consists of a two and a half hour workshop with accompanying teaching slides to provide information about prostate cancer detection and shared decision-making. The workshops cover medical, psychosocial and medico-legal issues associated with the use of PSA testing for the early detection of prostate cancer and demonstrate how to incorporate the practice resource into the consultation.

The practice resource consists of a GP/Patient show card with an anatomical diagram of the male pelvis, six decision steps, current age

based risk estimates for prostate cancer and a 'values clarification' table. The summary pages contain more detail for the informed choice discussion, an overview of age-based PSA reference ranges and non-cancer causes of elevated PSA readings. The resource was distributed with the June 2005 issue of the Australian Family Physician. The card has been designed for easy visual scanning and is suitable for use in a brief consultation.

The workshops have been well received by GPs and formal evaluation of the program has indicated it was effective in improving GP knowledge about PSA testing and confidence in discussing prostate cancer testing with asymptomatic men.

Copies of the practice resource are available from the NCCI website http://www.ncci.org.au/services/prostate_GPresources.htm or the Cancer Council Cancer Helpline on 13 11 20.

Reprinted from NCCI Newsletter, June 2005

Evaluation of Education Program on PSA Informed Decision Making

The project assessed academic detailing, that is provision of information to GP's by well trained but fully independent information providers, in improving informed shared decision-making regarding prostate specific antigen testing. The project was conducted by the Drug and Therapeutics Information Services (DATIS) with Associate Professor Frank May as principal investigator and was undertaken under the auspices of NCCI and funded by the Australian Government Department of Health & Ageing.

The project encompassed three studies. Studies in Queensland and South Australia assessed the acceptability of the academic detailing program to general practitioners. Uptake ranged from 90% to 98% of GP's, and some 99% of visited GP's expressed a willingness to receive further visits after each encounter. Surveys of the participating general practitioners showed that they rated the value of these educational visits highly, with many commenting that they were

the most convenient, effective and time efficient form of education they had experienced. General practitioners self reported positively changed clinical behaviors and objective assessments showed increased knowledge and confidence by GP's. The conclusion was that the academic detailing approach offers a workable blueprint for effective action across a range of national health priority areas.

A randomized controlled trial assessed the impact of academic detailing on better use of PSA tests by GPs, and also the effect of providing or not providing feedback on their individual PSA test usage profiles. 240 GP's in the Melbourne area were randomized into a control group, a group receiving academic detailing only, and a group receiving academic detailing plus individual feedback on PSA utilization. There was a very low level of attrition in this part of the trial. The provision of academic detailing with or without feedback on PSA utilization was shown to increase knowledge of PSA testing issues.

Other aspects of the trial assessed knowledge regarding colorectal cancer, diabetes management, and *Helicobacter pylori* infection.

The final report on this project has been made available on the Australian Government Department of Health and Ageing Website

<http://www.dhac.gov.au/internet/wcms/Publishing.nsf/Content/qupp-report-academic-detailing.htm> and a

related economic evaluation has been published separately¹.

¹ Stone CA, May FW, Pinnock CB, Elwood M, Rowett DS. Prostate cancer, the PSA test and academic detailing in Australian general practice: an economic evaluation. *Aust NZ J Public Health* 2005; 29: 349 – 357.

Reprinted from Wongi Yabber November 2005; 12(4) 3.

Timing of Androgen Deprivation (TOAD) Study

TROG 03.06 / VCOG PR 1-03

Principal Investigator News

It is now over 60 years since Charles Huggins recognized that treatment with oestrogens caused inhibition and regression of growth of prostate cancer. It is rather astonishing that even now, urologists do not know whether there is a greater overall benefit in starting androgen deprivation at diagnosis or at diagnosis when cure is not an option (when the patient is often asymptomatic) compared to delaying treatment until there is clear palliative benefit in treating symptoms.

The decision to start early or to defer is not scientific and is based purely on an emotional preference or prejudice of the doctor and the patient. The early treater may simply be exposing the patient to the side-effects of treatment without any survival benefit, while the deferrer may be depriving the patient of some significant survival time. We do not know which approach is correct.

We do know three facts. Androgen deprivation is not curative, it does provide effective symptom palliation for most people, but it does have significant side-effects that affect quality of life. We do not know if early intervention increases overall survival compared to delayed intervention. There are no satisfactory trials to answer this question. The flawed NHMC trial suggested that it did, but it was a trial comparing proper early intervention with bad delayed management. A recent small trial has suggested there might be no benefit.

TOAD is a phase three multicentre randomized trial of early compared to deferred androgen deprivation. It is actually two trials, related to the same question, but independent in that they are studying two different prostate cancer populations. The essential question occurs in two contexts – firstly in respect to the failure of intended curative treatment (Study 1), and in patients who are not candidates for cure (Study 2).

Gillian Duchesne has been the key person in Study 1, while my interest is principally in Study 2. They are actually separate studies, but are organized under a single study committee and data collection and analysis group. Urologists, radiation oncologists and medical oncologists can enter patients into either one or the other, or both.

The patients suitable for Study 2 are patients who are not suitable for curative treatment because of disease stage, age or general health (though they need to have a reasonable projected survival in order to allow sufficient time to differentiate any survival difference between treatment timing). The most important endpoint is cancer specific survival, but overall survival, disease free survival, quality of life, morbidity of therapy and complications will also be studied endpoints.

Urologists who treat prostate cancer tend to fall into either early or deferred categories. It will be easy for those used to deferred treatment to continue to do so; those who are more used to early intervention will need to exercise discipline

in order to allow sufficient time to elapse in order to find a difference if one exists. The indication to commence treatment for a randomized deferred treatment is not simply progression of PSA (all patients will be expected to progress). It will be the development of symptoms that require palliation, or the imminent development of symptoms as indicated by a high PSA (at least 60, but could be higher if rising slowly) or a rapidly doubling PSA.

The studies are designed to impact as little as possible on your usual practice, and the choice of method of androgen deprivation (continuous or intermittent) and of drug(s) is not specified, so long as it is generally accepted in practice. Investigations are designed to be in line with usual clinical practice and sufficient for scientific validity.

Significant financial support has been provided by NHMRC, State Cancer Councils and Mayne Pharma. A remuneration of \$600 is available to cover costs of each entered patient.

Although radiation and medical oncologists are highly supportive of the trial, the majority of eligible patients will lie within the ambit of urologists, who make most of the original diagnoses and will see all of the failed radical prostatectomy patients.

The study requires large numbers of study patients to be valid, and needs to acquire significant numbers relatively quickly to retain funding. The trial's success therefore depends on urologists getting on board quickly as the trial will fold if less than 100 patients are entered in the first 2 years. It will also require a commitment to follow these patients for a considerable period of time to reach an answer, but I think it is a sufficiently important question to do this. It would be very gratifying if Australian medicine could solve this 60 year old question.

Mr Rodney Syme, Urologist
Co-Principal Investigator, rodsyme@bigpond.com

Urological Survey Results

At the recent USA Victorian state meeting held in Daylesford, an abstract based on the survey of Urological Surgeons was submitted and Mr Rodney Syme presented the results. It is pleasing to report that Mr Syme won the best presentation given by a consultant at the meeting.

Investigative Sites & Accrual as at 05/01/06

Alfred Hospital	1
Barwon Health	1
Campbelltown Hospital	0
Cham, Mr Chee Wee	0
Christchurch Hospital	2
Concord Repatriation	0
Dunedin	1
East Coast Cancer Centre	0
Liverpool Hospital	1
Mater QRI	1
Nepean Cancer Care Centre	2
Newcastle Mater	0
Peter MacCallum Cancer Centre	4
Princess Alexandra Hospital	2
Queen Elizabeth Hospital	(pending)
Repatriation General Hospital SA	1
Royal Brisbane Hospital	1
Royal Prince Alfred Hospital	1
Royal Perth Hospital	(pending)
Sinclair, Mr Graham	1
Syme, Mr Rodney	0
Sir Charles Gairdner Hospital	0
Southern Health	(pending)
St. George Hospital	0
Waikato Hospital	2
West Gippsland Hospital	0
Westmead Hospital	8

TOTAL Recruited = 29 Patients

Congratulations Rodney! An excellent presentation on an excellent study.

Do Clinical Trials represent normal practice - Reflections on TOAD?

GM Duchesne¹, R Syme², M Harold³, D Howell³

¹ Peter MacCallum Cancer Centre; ² Melbourne;

³ The Cancer Council Victoria

Purpose: To determine the pattern of practice of urologists after diagnosing patients suitable for Study 2 of the TOAD trial (Timing of Androgen deprivation).

Methodology: The email survey was initiated by the TOAD Trial Management Committee because of discussion about obstacles to entry of patients into Study 2, those with newly

diagnosed, asymptomatic prostate cancer not suitable for curative therapy. Questions covered the need for staging investigations to be undertaken and the reasons patients would be considered unsuitable. The survey was sent to urologists on the Urological Society database.

Results: 74 practitioners returned completed surveys. Six urologists undertook no further tests, 35 (47%) reported using bone scans only and 28 (38%) performed bone and CT scans (31). 90% favoured complete staging for patients going on trial. Of the 35 who undertook bone scans only, 29 (88%) would request a CT scan solely for trial entry. Other reasons for not

entering patients essentially represented the factors predicting poor prognosis: the presence of extensive metastasis or disease likely to cause complications (cord compression, ureteric or urethral obstruction, fracture); high grade or high PSA; high PSA velocity; younger patients; and anxious patients.

Conclusions: Entry to TOAD Study 2 would require a change from usual practice for nearly 50% of survey participants. The survey suggested that patients entered on to Study 2 would be a selected cohort with relatively indolent disease.

Cancer Control in General Practice

Introduction

While the work of GPs spans the full spectrum of cancer control - prevention, detection, treatment and palliation - the largest component of this work involves dealing with patients who have suspicious symptoms, concerns about possible cancer or are at increased risk due to family history or lifestyle factors (smoking, nutrition, alcohol and physical activity levels).

A new report documents the wisdom of an important stakeholder consultation meeting held by The Cancer Council Victoria in partnership with the National Cancer Control Initiative in June this year to look at how to enhance cancer control activity in primary care. The experiences and insights shared and resulting recommendations have helped to inform planning for the sector and will be useful to other organisations working with general practice.

Media Release 11 November 2005

With more than 85 per cent of the population visiting a GP at least once per year, GPs are at the frontline of cancer prevention.

“The Cancer Council Victoria is committed to working with an increased focus on primary care,” said Ms Rebecca Russell, Primary Health Care Coordinator with The Cancer Council Victoria.

The Cancer Council and the National Cancer Control Initiative conducted a meeting in June with GPs, practice nurses and staff, cancer specialists and other stakeholders to look at how to enhance cancer control activity within general practice.

The recently released report of this meeting, ‘Cancer Control in General Practice’, captures the experiences and insights of participants and has informed the Cancer Council’s planning for the sector.

“This report highlights the commitment, passion and enthusiasm of the stakeholders to work collaboratively in enhancing the capacity of primary care,” said Ms Russell. “It provides a positive foundation for future cancer control work in general practice and will be useful to other organisations working with general practice.”

Professor Brian McAvoy, National Cancer Control Initiative Deputy Director and general practitioner in St Kilda said, “The majority of a cancer patient’s journey takes place in the community, with medical and psychosocial care

being provided by GPs and nurses. With cancer now seen as a chronic disease, GPs have a critical role to play across the whole continuum of cancer control.”

Professor McAvoy was one of three presenters at the meeting. He provided an overview of the National Cancer Control Initiative and its primary care strategies, information on cancer incidence, costs, mortality and survival rates, and the level of cancer related activity in general practice.

Dr Chris Hogan, a Cancer Council Councilor and general practitioner in Sunbury, looked at the changing and diverse nature of general practice and the challenges faced when undertaking

preventive activities in general practice.

Ms Russell covered the Cancer Council's primary care focus including an outline of its existing primary care strategies.

The 'Cancer Control in General Practice' report contains a synopsis of the presentations given at the meeting, a summary of key discussion points and participant recommendations covering education, communication, multidisciplinary teams and future directions.

The report is available for download at http://www.ncci.org.au/pdf/Primary%20care/GP_program_report05.pdf.

Working Party to Establish Accreditation of Cancer Services

The ACN Accreditation Development Steering Committee has considered all responses following distribution of the "Discussion paper on Accreditation of Cancer Services" produced by NBCC for ACN. A summary of the issues derived from these responses is as follows:

- A data dictionary was an essential early component of a nationwide accreditation process
- Cancer information systems local, State and National, need to be in place and functioning effectively in an operational sense otherwise effective accreditation is difficult.
- The question of which standards are to be developed and who was to develop those standards was still unanswered.
- If consumers were to be involved there was a lead-time, in order for them to obtain the appropriate skills. There were questions about who trains consumers and how they would be selected for involvement. It was accepted by the Committee that it was appropriate to have consumers in every aspect of the review process involved in accreditation activities. Further questions were raised about the training for consumers both culturally and linguistically different backgrounds.
- The time between accreditation reviews was discussed with most people feeling that 3 years was satisfactory. It was drawn to the committee's attention that the discussion document had canvassed an annual reporting by those being accredited with a 3-year interval for formal review. Because of the extent of the effort required by organization undergoing an accreditation process some committee members felt that formal review activity should be even longer than 3 years. A quality improvement culture needs to be developed in many organizations and this takes time, so anything less than 3 years is unlikely to be effective. The question of the resources that need to be devoted to effective accreditation was a real barrier in many circumstances and would need to be taken into account as it limits the option for more frequent accreditation reviews.
- Education and training standards, particularly in relation to cancer nurses was identified as a significant need. It was recognized that standards have already been set by 3 professional groups involved in radiotherapy.
- Multidisciplinary team care was identified as an important issue which would need to be assessed in any accreditation review. Issues such as the quality of the players in the team,

autonomy within the level of responsibility for nurses, other professional incentives for quality improvement and indeed funding for multidisciplinary care would all need specific activity.

- Public reporting of the results of accreditation was regarded as vital by consumer groups who made submissions and this was endorsed by the committee.
- The implication of non-accreditation needs to be plainly set out – a significant political issue.

- Further discussion would be necessary in relation to the incentives and dis-incentives applied to accreditation activity.

The Committee thanks all those who responded for their thoughtful comments and welcomes any further input. ACN also undertakes to place these issues before Cancer Australia when it is formed. The Discussion paper is available at www.cancer.org.au/can.

Reprinted from Wongi Yabber November 2005; 12 (4): 1-2.

Working Party to Promote Implementation of Best Practice Guidelines

ACN has negotiated with the National Institute of Clinical Studies (NICS) and plans to use information and methods collected by the working party to guide the development of a handbook for guidelines implementation by clinicians and clinician

managers. The committee has met recently and has had further discussions with representatives of the National Institute of Clinical Studies. NICS has appointed a project officer.

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

Professor Michael Frommer, Director of the University of Sydney, Health Projects Group, has developed a report and guidelines for the credentialing of cancer service providers in Australia.

Professor Frommer presented a draft document to the committee and some further editing will take place. The study should be available for wide dissemination within a month.

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Cancer, Sensuality, Sexuality and Self-Image

*Ms Doreen Akkerman
Director, Cancer Information & Support Service
The Cancer Council Victoria*

This information sheet provides some brief information about the impact a diagnosis of cancer may have, both psychologically and physically, and offers some suggested solutions to some very common problems.

These are just a few suggestions which may help you but we strongly advise you to obtain professional counselling either regarding physical limitations caused by the disease or treatment or the psychological effects. The suggested reading list will provide you with much more information and your own doctor can provide you with information regarding your individual case and refer you on to professional counselling.

Making Decisions

When first diagnosed with cancer, survival is one of the main concerns and often overshadows everything else. Yet it is at this time whilst you and your doctor are planning the most appropriate treatment that it is important to discuss the effect of surgery, chemotherapy, radiotherapy and hormone therapy on you as an individual and as part of a family. It is therefore appropriate that your self-esteem and sexuality should be considered and discussed. This information is vitally important if you are to make fully informed decisions about treatment which may impact on your total quality of life.

Communicating About Sexuality

In today's multicultural society, long held values and beliefs often result in barriers which influence the way that doctors and patients communicate about sexuality. For example, in some cultures fertility is more important than sexual satisfaction for the woman and it is also not deemed appropriate for a woman to discuss such things with a male doctor. A man's self-image and sense of self-worth may be affected if he can no longer sustain an erection long enough to have penetrative intercourse.

Doctors and patients need to be aware and sensitive to these types of situations. If you find

such discussion difficult or awkward, please raise your concerns with the Cancer Support Nurse who can act with you, or on your behalf, and obtain correction information for you, or call the Cancer Helpline on 13 11 20 to obtain more general advice.

Most people will live for many years after a diagnosis of cancer with their cancer treated, managed and controlled. Therefore, quality of life becomes very important and this includes good sexual health. So the appropriate time to talk about the influence of treatment for cancer on sexual desire, sexual performance and fertility is when a treatment plan is being discussed.

Improving Self-Esteem

Young, active, virile looking people are often used in advertising today. We live in a society which uses such images to sell everything from cars to walking boots. Breasts are equated with desirability, the ability to get an erection and to "go all night" is presented as the norm, so it is not surprising that scarring or the loss of any part of your body or sexual ability may cause you emotional distress.

It is important to recognise that you are loved for your personal qualities – the way you interact with those around you – your ability to love and share with those you love, rather than only for physical attributes. Fatigue, shock and anxiety can make you feel unwell and more sensitive to changes brought about by cancer treatment. Communicating your feelings to your partner, your friends and family can often lead to being reassured regarding the important place you hold in their lives.

During Treatment

During treatment for cancer you may experience one or more of the following:

- Altered body image through surgery or total body hair loss through chemotherapy
- Chronic fatigue

- Pain
- Fluid retention
- Lymphoedema
- A suppressed immune system
- Mouth ulceration
- Vaginal dryness
- Depression
- Reduced sexual desire and mood swings
- Inability to gain an erection or to sustain an erection
- Inability to ejaculate – men may also experience retrograde ejaculation whether they ejaculate into the bladder
- Reduction in intensity and/or length of orgasm
- Menopause brought on by medicine used to treat the cancer
- Potential or actual infertility

Discuss any of the above symptoms or any other symptoms or side effects with your treating doctor so that measure may be taken to ease any side effects and improve your quality of life. Make sure that you have good pain control and use it at times which will guarantee you pain-free sexual activity.

Research has shown that the marriages or partnerships of couples coping with cancer are no more likely to end than those couples in the general population. However, strains in communication about matters related to the illness and people feeling inadequate in this area are well documented. Many partners fear that they may hurt the person with cancer during sexual play or the fear of losing their loved one may affect their ability to feel erotic about that person or to be sexual.

Talk with your partner about how you are both feeling. If you do not want to be sexually active at this time, discuss how important an intimate relationship is to you, but how you need to put sexual activity on hold until you feel better. Gentle hugging and cuddling can be very satisfying for you both at this time.

Whilst many people state that their partners are a significant source of support and a major asset to their coping mechanisms, some may also, because they want to protect their partner, feel unable to share their innermost thoughts and fears related to their disease. Choose a safe place

where the two of you can have a private conversation without being interrupted and discuss issues and concerns which may be affecting your relationship.

Acceptance by her partner of the loss of a breast does not always help a woman to personally adjust to her breast loss. Problems may arise if you have considered your breast to be a significant part of sexual foreplay. You may wish to practice shifting your focus and erotic stimulation to your other breast or to another part of your body.

For people dealing with any type of cancer, if your body has changed because of surgery and you are not longer able to practice sexual activities which you used to, read and obtain advice about shifting your sensate focus and using your imagination and fantasy to enhance your sensual and sexual life. Your mind is the most erotic part of your body and with practice, you can shift your sensate focus so that sex can become pleasurable again.

After Treatment

Adapting to changes in body image takes time and it may help to discuss your feelings with the Oncology or Cancer Support Nurse at your treatment centre.

It is important to learn to love your changed self.

- Acknowledge the changes which surgery and treatment have brought about.
- Think of some positive statements about yourself to help you to accept how you now look.
- Try writing down three things which you like about yourself. They could be: I have nice eyes, I like my smile, I am a good friend, I am a caring partner.
- Pin them on the bathroom mirror and say them aloud to yourself each time you wash your hands.

Gaining Self Confidence

Before you left the hospital, the nurse may have encouraged you and your partner to look at your changed body. However, if you fear rejection from your partner or just feel somewhat reluctant to be seen naked at first, wear clothing which

covers the part you feel uncomfortable about showing.

For men, satin boxer shorts or a fancy waistcoat, or obtain specially designed underwear for people with an ostomy.

For women, a supportive, comfortable bra with a prosthesis, a pretty camisole or satin nightdress, until you feel comfortable with your new body image.

There are no set rules, how YOU feel is the most important thing.

You Are Not Alone

Talk with your partner and friends about how you feel. When a change of self-image occurs, we need help with communicating our feelings and reaching out to others.

- Remember that you are an individual who is unique and valuable.
- You may be a partner who is loving and caring.
- You are greatly valued by your network of friends.
- You may be a parent or grandparent who is essential to the well-being of your family.
- The list is endless.

Evaluating Your Relationship

A cancer diagnosis often makes us look at our lives more intensely and take stock of all that is important to us. If you are experiencing difficulties with your relationship, take a good look at what your relationship was like before your cancer diagnosis.

- How has your cancer diagnosis changed this?
- Have roles changed?
- Have ways of being intimate changed?

If you are experiencing ongoing difficulties, ask your doctor for a referral to professional counselling.

Revitalising Your Relationship

Learning to love your new self is important. If you have difficulty learning to love and accept your changed self, it is difficult to permit someone else to.

Sexuality, sensuality and erotic practices and games are FUN.

Loving together means receiving as well as giving.

- Be generous and let your lover delight in giving you pleasure.
- Change sexual routines and positions until you find one that works for you.
- Pleasuring can be done by hand, by mouth or by body contact.
- Changes brought about by menopause, surgery, chemotherapy or hormone therapy may result in a loss of sexual desire and a dry vagina for women or reduced or no erection for men.
- Use plenty of water-based lubrication. KY Jelly, Sylk, Astroglide or Wet Stuff are just a few of the personal lubricants available. Using plenty of lubrication, gently massage your partner's erotic spots.
- If you are fearful and don't know if any practices will hurt, try them yourself first, then you can tell your partner about what is pleasurable for you.

Sexuality does not just mean sexual intercourse.

- Rediscover sensuality in your relationship.
- Set the scene. Dim the lights.
- Light performed candles.
- Use fantasy – music – dress up.
- Give each other a relaxing foot massage or a sensuous back rub.
- Have a long sensuous bath together.
- There is life and love after cancer.
- Often you may find new delight in your supportive partner.

Single and Sexy

Sexuality and sensuality may be enjoyed alone or with a partner.

Indulge yourself with all of the above.

Good touch in the form of massage is beneficial, ask for a referral to a good massage therapist.

Seeking a new relationship after a cancer diagnosis may be very stressful for single people. If you experience rejection, realise that the

problem lies with the person who is rejecting you, not with you. The Nurse Counsellors on the Cancer Helpline can help with ways of telling a new partner about your cancer experience.

Where to Get Information and Support

- The ideal person to give you information is your treating doctor.
- You may wish to discuss the options of breast reconstruction for women; or injections, medication or penile implants for men; with your doctor.
- The Oncology or Cancer Support Nurse at your treatment centre is familiar with your case and may be able to offer you advice.
- The Cancer Connect Program can link you with another person who has had the same type of cancer and treatment as you for one-to-one peer support.
- This service is also available for your partner who can be linked in with a person who has partnered and/or cared for a person with cancer.
- You can also be linked in with a support group.

Calling the Cancer Information and Support Service on 13 11 20 will connect you with a trained oncology nurse who can discuss all aspects of cancer treatment including specific side effects and provide linkage with professional resources and written information.

Suggested Reading List

Heffernan, M & Quinn, M. (2003). *The gynaecological cancer guide: Sex, sanity & survival*. Michelle Anderson Publishing Pty Ltd.

Stoppard, Miriam. (1992). *The magic of sex*. Allen & Unwin, NSW.

Schover, L. (1997). *Sexuality and fertility after cancer*. John Wiley & Sons, New York.

Cass, V. (2005). *The elusive orgasm*. Brightfire Publications.

Kelly, E. (1994). *Overcoming loss of libido*. Gore & Osment Publications Pty. Ltd.

Butler Robert N & Lewis Myrna I. (1993). *Love and sex after 60*. Ballantine Books, a division of Random House, New York.

Silverstein, C & Picano, F. (1992). *The new joy of gay sex*. Harper Collins, New York.

The Cancer Council Victoria ACCCIS OnCall Database. *Sexual adaptation suggestions for people with an ostomy*.

Key Published Articles Listing—Urological Cancer

Title	Author & Journal
Randomized phase II/III trial of Interferon Alfa-2a with and without 13-<i>cis</i>-retinoic acid in patients with progressive metastatic renal cell carcinoma: The European Organisation for Research and Treatment of Cancer Genito-Urinary Tract Cancer Group (EORTC 30951)	Aass N, De Mulder PHM, Mickisch GHJ, et al. <i>Journal of Clinical Oncology</i> 20 June 2005; 23(18): 4172–4178.
Blocking testosterone to starve prostate cancer	Margo J. <i>Australian Financial Review</i> 17 Feb 2005, p. 45.
Effectiveness of Cyproterone Acetate in achieving castration and preventing luteinizing hormone releasing hormone analogue induced Testosterone surge in patients with prostate cancer	Appu S, Lawrentschuk N, Grills RJ & Neerhut G. <i>Journal of Urology</i> July 2005; 174: 140–142.
Long-term survival results of a randomized trial comparing gemcitabine plus cisplatin, with methotrexate, vinblastine, doxorubicin, plus cisplatin in patients with bladder cancer	von der Maase H, Sengelov L, Roberts JT, et al. <i>Journal of Clinical Oncology</i> 20 July 2005; 23(21): 4602–4608.
Men in Australia Telephone Survey (MATEs): A national survey of the reproductive health and concerns of middle-aged and older Australian men	Holden CA, McLachlan RI, Pitts M, et al. <i>The Lancet</i> 22 July 2005; 366(9481): 218–224.
Adjuvant cisplatin plus methotrexate versus methotrexate, vinblastine, epirubicin, and cisplatin in locally advanced bladder cancer: Results of a randomized, multicenter, phase iii trial (AUO-AB 05/95)	Lehmann J, Retz M, Wiemers C, et al. <i>Journal of Clinical Oncology</i> 1 Aug 2005; 23(22): 4963–4974.
Radiotherapy versus single dose carboplatin in adjuvant treatment of stage I seminoma: A randomised trial	Oliver RTD, Mason MD, Mead GM, et al. <i>The Lancet</i> 23 July 2005; 366(9482): 293–300.
Adjuvant carboplatin in stage I seminoma [Editorial]	Warde P & Gospodarowicz M. <i>The Lancet</i> 23 July 2005; 366(9482): 267–268.
Management of superficial bladder cancer in Victoria: 1990 and 1995	Frydenberg M, Millar JL, Toner G, et al. <i>ANZ Journal of Surgery</i> 2005 May; 75(5): 270–274.
What's new in the treatment of kidney cancer?	Mancuso A & Sternberg CN. <i>British Journal of Urology International</i> June 2005; 95(9): 1171–1180.

Key Published Articles Listing—Urological Cancer

Title	Author & Journal
Stage migration and grade inflation in prostate cancer: Will Rogers meets Garrison Keillor [Editorial]	Thompson IM, Canby-Hagino E & Lucia MS. Journal of the National Cancer Institute 7 Sep 2005; 97(17): 1236–1237.
Prostate cancer and the Will Rogers phenomenon	Albertsen PC, Hanley JA, Barrows GH, et al. Journal of the National Cancer Institute 7 Sep 2005; 97(17): 1248–1253.
Revisiting the role of radical surgery in early stage prostate cancer [Editorial]	Costello A, Corcoran NM & Van Appledorn S. The Medical Journal of Australia Sep 2005; 183(6): 286–287.
Operating Characteristics of Prostate-Specific Antigen in Men with an Initial PSA level of 3.0 ng/mL or lower	Thompson IM, Ankerst DP, Chi C, et al. The Journal of the American Medical Association July 2005; 294(1): 66–70.

Key Published Articles Listing—General

Title	Author & Journal
Australia's media reporting of health and medical matters: A question of quality [Editorial]	Van Der Weyden MB & Armstrong RA. The Medical Journal of Australia Aug 2005; 183(4): 188–189.
Evidence-based journalism: A forlorn hope? [Commentary]	Swan N. The Medical Journal of Australia Aug 2005; 183(4): 194–195.
Attitudes on oncology health professionals to information from the Internet and other media	Newnham GM, Burns WI, Snyder RD, et al. The Medical Journal of Australia Aug 2005; 183(4): 197–200.
Keynote comment: Dumbing down of complementary medicine	Ernst E. The Lancet Oncology July 2005; 6(7): 442–443.
Protecting health information privacy in research: how much law do Australians need?	Thomson CJH. The Medical Journal of Australia Sep 2005; 183(6): 315–317.

Forthcoming Meetings

Date / Place	Meeting / Contact
9–12 February 2006 Lorne, VIC, Australia	18th Lorne Cancer Conference Secretariat: ASN Events Pty Ltd Ph: (03) 5983 2400 E-mail: cancer@asnevents.net.au Website: www.lornecancer.org
11–17 February 2006 St Julians, Malta	5th Masterclass in Clinical Oncology Organised by the European School of Oncology (ESO). Secretariat: Chatrina Melcher, ESO Bellinzona Office, IOSI, Ospedale Reg. Bellinzona e Valli, CH-6500 Bellinzona, Switzerland Ph: +41 91 811 8050 Fax: +41 91 811 8051 E-mail: masterclass@esoncology.org Website: www.cancerworld.org/eso
16–18 February 2006 St Gallen, Switzerland	4th International Conference on Cancer Prevention St Gallen Oncology Conferences c/o ZeTuP, Rorschacherstr. 150 CH-9006 St Gallen / Switzerland Ph: +41 71 243 0032 Fax: +41 71 245 6805 E-mail: info@oncoconferences.ch Website: www.oncoconferences.ch
24–26 February 2006 San Francisco, California, USA	2006 Prostate Cancer Symposium Co-sponsored by the American Society of Clinical Oncology (ASCO), American Society for Therapeutic Radiology and Oncology (ASTRO), the Prostate Cancer Foundation and the Society of Urologic Oncology Website: www.asco.org/prostate2006
12–15 March 2006 Lugano, Switzerland	3rd International Conference on Translational Research and Pre-Clinical Strategies in Radiation Oncology (ICTR 2006) In collaboration with the European School of Oncology (ESO) Ph: +41 79 310 4330 Fax: +41 91 811 8678 E-mail: jacques.bernier@hcuge.ch Website: www.iosi.ch/ictr2006.htm
23–26 March 2006 San Diego, California, USA	Annual Meeting of the Society of Surgical Oncology (SSO) Website: www.surgonc.org
24–25 March 2006 Antwerp, Belgium	ESMO International Symposium (EIS) on Prostate Cancer Organised by: European Society of Medical Oncology (ESMO) Ph: +41 91 973 1919 Fax: +41 91 973 1918 E-mail: congress@esmo.org Website: www.esmo.org
26–30 March 2006 Brisbane, QLD, Australia	Annual Scientific Meeting of the Urological Society of Australasia (USA) Website: www.urosoc.org.au

Forthcoming Meetings

Date / Place	Meeting / Contact
5–8 April 2006 Paris, France	21st European Association of Urology Congress 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: info@congressconsultants.com
7–11 May 2006 Cairns, QLD, Australia	Annual Scientific Meeting of the Royal Australasian College of Physicians (RACP) Secretariat: The Meeting Planners, Kim Stevenson, 91-97 Islington Street, Collingwood VIC 3066 Ph: (03) 9417 0888 Fax: (03) 9417 0899 E-mail: racp@meetingplanners.com.au Website: www.racp.edu.au
15–19 May 2006 Sydney, NSW, Australia	Annual Scientific Congress of the Royal Australasian College of Surgeons (RACS) Coordinator: Campbell Miles Ph: (03) 9276 7420 Fax: (03) 9276 7431 E-mail: campbell.miles@surgeons.org Website: www.surgeons.org
17–20 May 2006 Lindeman Island, QLD, Australia	Annual Scientific Meeting of the Trans-Tasman Radiation Oncology Group (TROG) TROG 2006; C/- Pharma Events, PO Box 265, Annandale NSW 2038 Ph: (02) 9280 0577 Fax: (02) 92800533 E-mail: trog@pharmaevents.com.au ; Website: http://trog.ranzcr.edu.au
20–25 May 2006 Atlanta, Georgia, USA	Annual Meeting of the American Urological Association (AUA) Contact: Karen Goodall E-mail: Kgoodall@auanet.org Website: www.auanet.org
2–6 June 2006 Atlanta, Georgia, USA	42nd Annual Meeting of the American Society of Clinical Oncology (ASCO) American Society of Clinical Oncology, 1900 Duke Street, Suite 200, Alexandria Virginia 22314 USA Ph: +1 703 299 0150 Fax: +1 703 299 1044 E-mail: asco@asco.org Website: www.asco.org
26–30 June 2006 Manchester, United Kingdom	Annual 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.

