



Urological Cancer Update

Issue 22 August 2007

- A Best Practices Workshop in Urological Oncology - Sydney meeting
- The IMPACT study - Project Synopsis
- Is “Insignificant” prostate cancer truly insignificant? - Summary of AUA 2007 abstract #1403
- The Role of Adjuvant Chemotherapy in the Management of Stage 1 Seminoma
- HIFU Outcomes Study



UROLOGICAL CANCER UPDATE

Issue 22

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

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

***** **Last Issue – No. 21 – December 2006** *****

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
Urologist
Southern Health*

Welcome to this edition of the VCOG Urological Cancer Update. For those new to the publication, the committee functions to discuss pertinent issues in the management of urological cancers and acts as a conduit through which the major institutions, both scientific and clinical, can have interaction regarding up to date cancer diagnosis, prevention and management strategies. We look at new technologies and in this update issue there is a piece on High Intensity Focused Ultrasound for the management of prostate cancer. This emerging technique has yet to find its place in conventional prostate cancer treatment and ongoing assessment of its efficacy is required.

The committee also provides an interface between clinicians and epidemiologists and Mr Greg Neerhut reports in this issue on the management of Renal Cell Carcinoma. The study group is chasing up the last remaining data before finally reporting and we urge any of the clinicians who might still have information we need to complete the analysis to contact the group. This type of study provides valuable information on the patterns of practice, relevant to both clinicians and the planning of provision of services to the community.

One of the major functions of the committee is to discuss clinical trials that are at the forefront of cancer management and in some cases may offer access to particular treatments not yet available outside the trial setting. We have a summary of the landmark trial in the management of Advanced Renal Cell Carcinoma by Ian Davis. We also have a listing, by cancer, of the trials open currently and their inclusion and exclusion criteria. Cancer care clinicians are directed to the individual trial co-ordinators for more information. As not all trials are run in all centres, this provides valuable information on what treatments might be accessed across the metropolitan area for cancer patients. This information is also updated regularly on the website

and can be accessed on <http://www.cancervic.org.au/trials/default.asp?ContainerId=search-clinical-trials>.

Our general informative articles in this edition come from Mr Shomik Sengupta, who gives us an excellent summary of the multidisciplinary update in uro-oncology held recently in Sydney. There is also a summary of the role of chemotherapy in the management of early stage seminoma. This includes some of the discussion at a recent meeting of the Victorian Uro-oncology Group, a multi-disciplinary association of clinicians and scientists, which is occasionally confused with VCOG Urological Cancer Committee! The article is authored by one of the advanced surgical trainees in urology at Southern Health and provides an opportunity to update the readership and for the trainees to exercise their critical appraisal of the topic under the supervision of an experienced clinician. I invite any of the urology, radiation oncology or medical oncology trainees to contribute and we will in turn all benefit from their learning experience!

Through The Centre for Clinical Research in Cancer at the Cancer Council the committee liaises with the Australian Cancer Network and their newsletter, Wongi Yabber and Robyn Metcalfe reports on new initiatives from the Cancer Information and Support Service. Though as clinicians we may not always realise it, the resources provided for patients by such services are invaluable in their cancer journey. There is also material available in multiple languages and relevant specifically to indigenous issues. We also hope to keep you informed with the listing of key published articles in the uro-oncology field, that you might find interesting.

So these are but a few of the committee's activities and I thank the committee and the Cancer Council for their ongoing work in putting together our newsletter. I hope you enjoy it.

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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Report on “A Best Practice Workshop in Urological Oncology” Sydney, 15th-16th June 2007

*Shomik Sengupta, MS, FRACS, Consultant Urologist
Alfred Hospital, Prahran and Austin Health, Heidelberg*

This was the third such workshop, and compared to the original version in 2001, it was bigger, flashier and best of all, more up-to-date! The convention center at Darling Harbour provided an impressive venue, even if Sydney failed to provide ideal weather. International faculty including Freddie Hamdy from Sheffield, UK, Howard Sandler from the University of Michigan, MI, USA, and Australian expatriate David Quinn from the University of Southern California, CA, USA were complemented by an excellent line-up of local speakers.

The opening session focused on the perennial favorite conundrum of uro-oncology: early prostate cancer. Tom Shannon, Tony Costello, Paul Cozzi and Joseph Bucci respectively championed laparoscopic surgery, robotic surgery, open surgery and brachytherapy. As expected, each speaker provided eloquent support for their favoured treatment modality, but as always, consensus could not be reached. The panel discussion addressed the learning curve inherent in minimally-invasive surgical modalities, which are evolving thanks to the availability of skilled mentors. Additionally, the need to document and quote local results, as distinct from published results from overseas centers, was highlighted.

Continuing on the prostate cancer theme, Freddie Hamdy provided an update on the ProtecT trial, currently recruiting patients to assess population-based PSA-testing and compare surgery, radiotherapy and active surveillance in randomized fashion. Frank Gardiner comprehensively reviewed dietary factors in prostate cancer, ranging from aspirin through to green tea and red wine. To summarise, general recommendations for a healthy (as in “heart-healthy”) balanced diet and regular exercise are prudent, and NSAIDS, 5-alpha reductase inhibitors, Selenium and omega-3 fatty acids are probably preventive, but

data remain incomplete.

Peter Swindle presented biopsy and rebiopsy guidelines as suggested by the National Comprehensive Cancer Network (NCCN). Although a lot of the guidelines mirror current practice, baseline PSA measured at age 40y and biopsy based on PSA velocity for men with PSA in the range 2.5 to 4ng/mL probably do not. Henry Woo rounded out the morning with a review of active surveillance for prostate cancer, an appropriate management alternative for selected patients.

Following lunch, the alternate approaches to local therapy for high-risk prostate cancers, namely high-dose rate brachytherapy and dose-escalation by external beam, were discussed by Phillip Stricker and Howard Sandler, respectively. Continuing the theme of higher-risk disease, Freddie Hamdy discussed biochemical recurrence and its natural history. Andrew Kneebone presented data from recently published trials of post-surgical radiotherapy, which suggest that a subgroup of patients stand to benefit from such a strategy. We were also reminded of the developing Australasian trial examining the timing of post-operative radiotherapy for high-risk patients (adjuvant vs salvage).

Salvage therapy for radiorecurrent prostate cancer, by way of HIFU/cryotherapy or surgery, were discussed by Bill Lynch and myself, respectively. Data are limited, selected patients may benefit but morbidity is high. The day concluded with presentations from David Quinn and Howard Gurney on hormonal and other systemic therapies for metastatic prostate cancer.

Saturday morning saw a change of topic, with Paul Sved and Roger Watson providing excellent reviews on non-invasive (Ta and CIS) and G3T1 cancers respectively. John Yaxley addressed

the topic of cystectomy for invasive disease, confirming the increasing emphasis on accompanying lymphadenectomy (which appears to convey a therapeutic benefit) and orthotopic reconstruction for suitable patients. Recent data on partial cystectomy as a bladder-conserving approach (feasible, but fraught with a higher local recurrence risk) and minimally invasive approaches with or without robotic assistance were also reviewed.

Howard Sandler then spoke about multimodal bladder-preservation, informing us of new strategies, such as hypo- and hyper-fractionation, proton boosts, neoadjuvant chemotherapy and the use of alternative chemotherapy regimens, aimed at improving outcomes. After a review of rarer bladder cancer variants from Omid Shaye, the vexing issue of adjuvant and neo-adjuvant chemotherapy was addressed by David Quinn. Available RCTs (many of which are methodologically flawed) and meta-analyses provide evidence for a small benefit, which is more convincingly demonstrated in the neo-adjuvant than the adjuvant setting. New trials are examining targeted molecular therapies, which may hold promise.

Moving on to renal cell carcinoma, Howard Lau provided a comprehensive update on surgical management, addressing issues including

observation for small renal masses, elective nephron-sparing surgery (NSS), laparoscopic approaches to locally advanced cancers or NSS and cytoreductive nephrectomy in the presence of metastases. David Quinn then presented the data from recently published trials of the targeted molecular therapies, sunitinib and sorafenib, which have demonstrated excellent tolerability (fatigue and skin disorders main adverse effects) and a likely overall survival benefit.

The final session of the meeting focused on germ cell tumours, with Howard Sandler reviewing current strategies for Stage I seminoma, which now go beyond retroperitoneal radiotherapy to encompass the alternatives of observation and single dose carboplatin chemotherapy. Helen Gu and Anne Schukman concluded proceedings with presentations on systemic chemotherapy and post-chemotherapy masses, respectively.

The meeting was highly successful in presenting the current status in urologic oncology, encompassing all relevant disciplines. New developments included the tyrosine kinase inhibitors for renal cell carcinoma, alternative options in stage I seminoma and broadening of minimally invasive surgical options. The amount of information packed into the available time did at times lead to an overload, yet a vital aspect of uro-oncologic care, namely the role of allied health professionals, remained to be addressed.

Multi Lingual Website

Jennifer Cottrell

*Cancer Education Programs Project Officer
Cancer Council Victoria*

Did you know you can access information about cancer in 17 languages on The Cancer Council Victoria's website?

The Cancer Council Victoria provides cancer information and support for all Victorians, including a wide range of multicultural services. Our multilingual website contains up-to-date, reliable and evidence-based information.

This information is provided in an easy to read factsheet format that can be downloaded for free. Factsheet topics vary from diagnosis and

support, to early detection messages. English versions of all factsheets are also available.

Visit our website at www.cancervic.org.au/multilingual to download this information.

Is “Insignificant” Prostate Cancer Truly Insignificant? A summary of AUA 2007 abstract #1403

*Shomik Sengupta, MS, FRACS, Consultant Urologist
Alfred Hospital, Prahran & Austin Health, Heidelberg*

The disparity between the prevalence and mortality of prostate cancer has spawned the concept of “insignificant” prostate cancer. Despite the development of various clinical and pathological criteria for identifying putative “insignificant” prostate cancer, data regarding their prognosis are limited. A study undertaken at the Mayo Clinic identified 354 of 6496 (5.5%) evaluable patients treated by radical prostatectomy as having prostate cancers that could be designated as “insignificant”. Not surprisingly, this group of patients had significantly lower rates of progression (over a median follow-up of almost 10 years) compared to the remaining patients with “significant” cancers.

However, when compared to the subgroup of patients with low-risk “significant” prostate cancer, patients with “insignificant” prostate cancer had an identical risk of progression (biochemical recurrence approximately 15%). Although cancer-specific survival was 100% at 10 years for both groups, the known natural history of biochemical recurrence following surgery suggests that some of these patients will die of their cancers in future. The findings of this study show that “insignificant” prostate cancer cannot be defined purely on the basis of cancer characteristics. In young, fit men, it is questionable whether any cancer can be designated as “insignificant”, whereas in older and frailer patients, many prostate cancers are.

Surgical Management of Renal Cell Carcinoma Survey

*Mr Greg Neerhut
Urologist
Geelong Hospital*

This study, conducted by the Urological Cancer Committee of the Victorian Cooperative Oncology Group and the Cancer Epidemiology Centre, ran from 1 November 2005 until 31 May 2006, with the aim of collecting data about type of surgery performed and also patient and tumour demographics.

Thankyou to the Urologists and Trainees who have completed data forms for 88 patients. Preliminary analysis shows that 57% of patients presented with asymptomatic tumours, 49% of patients underwent laparoscopic surgery and 20% of patients were managed with a partial nephrectomy. Interestingly only 2% of the 88 patients had clinical evidence of metastatic disease pre operatively.

Records from the Victorian Cancer Registry indicate that about 80 additional patients underwent surgery for RCC (open or laparoscopic and total or partial nephrectomy) during this period, and that most of these operations were performed on the private sector. It would be appreciated if you could check your operating case schedule for this period, and if there are any such patients please contact Vicky Thursfield at the Cancer Council of Victoria (ph 96355162), who will send some data forms. The forms should only take a few minutes to complete.

Synopsis of Temsirolimus, Interferon Alfa, or both for Advanced Renal-Cell Carcinoma.

*Ian Davis
Medical Oncologist
Austin Health*

Hudes G, Carducci M, Tomczak P, et al. 2007, 'Temsirolimus, Interferon Alfa, or Both for Advanced Renal-Cell Carcinoma', *The New England Journal of Medicine*, vol. 356, no. 22, May 31, pp. 2271 – 2281.

This randomized trial is so far the only published study showing a benefit in overall survival for patients with metastatic renal cell carcinoma. It was

specifically targeted at an uncommon patient group, with poor prognostic factors, whereas the studies for sunitinib and sorafenib included patients with good prognostic factors. This trial showed a benefit only for the single agent temsirolimus arm: interferon alone or in combination with TMS (at a lower dose to avoid toxicity) were inferior. The survival benefit was small (2-3 months).

New Resources from The Cancer Council

The Cancer Council Victoria has produced a new Indigenous men's prostate problems brochure titled "**Men's Business: Prostate Problems**".

'Many men aged over 50 have problems with their prostate. Most prostate problems are not caused by prostate cancer, however it is still a common cancer in Aboriginal and Torres Strait Islander men. Reading this brochure should help you understand prostate problems. Ask your doctor, nurse or Aboriginal health worker if you would like more information'.

The brochure explains where the prostate is, what causes prostate problems, lists possible prostate problems, examinations the doctor will perform (DRE, PSA, biopsy), types of treatment

for different conditions (BPH, prostatitis, cancer) and possible side effects, as well as continuing check-ups.

The Cancer Council New South Wales have produced a new brochure for men and cancer titled '**Men and Cancer: Your guide to being cancer smart**'. The brochure covers information on prostate, bowel, lung, skin and testicular cancers and covers various issues including 'what is cancer', 'cancer smart recommendations', 'diet and cancer', 'cancer screening', 'detection of cancers early', 'connecting men with cancer-cancer connect'.

To obtain copies of these brochures, or any other Cancer Council publications or for more information on The Cancer Council's services call the Cancer Council Helpline on 13 11 20 or visit www.cancervic.org.au.

Urological Cancer Trials – Open August 2007

BLADDER CANCER

TROG 02.03 - Multicentre Phase III Study Comparing Radical Synchronous Chemo-Radiation vs Radical Radiation Alone in the Definitive Management of Muscle Invasive TCC of the Urinary Bladder following Maximal Trans-Urethral Resection.

Summary:

Radiation and chemotherapy both work in people with muscle-invasive bladder cancer. This study will determine if giving them together improves the results for people with this disease that seems to be confined to the bladder, but who are felt to be suitable candidates for bladder preserving treatment.

Primary Outcome Measures:

- Invasive local failure at 3 years [Time Frame: 3 years]

Secondary Outcome Measures:

- Complete response (CR) rate at 3 months from randomisation [Time Frame: 3 months]
- Disease-free survival [Time Frame: Final analysis when all patients have been followed for 3 years. (approx. 7 from start of trial)]
- Overall survival [Time Frame: Final analysis when all patients have been followed for three years. (approx. 7 years from the start of trial)]
- Cystectomy-free survival [Time Frame: Final analysis when all patients have been followed for three years. (approx. 7 years from the start of trial)]
- Acute and late toxicity [Time Frame: Interim analyses will be performed on an annual basis]
- Pattern of failure (local, regional, distant) [Time Frame: Final analysis when all patients have been followed for three years. (approx 7 years from start of trial)]
- Quality of life measures [Time Frame: Final analysis when all patients have been followed for 3 years. (approx. 7 years from start of trial)]

Eligibility - Inclusion criteria:

- Histologically proven TCC of the urinary bladder. Mixed tumours comprising predominantly TCC and elements of squamous or adenomatous metaplasia or carcinoma are also eligible.
- Clinically and radiologically localised T2, T3 or T4a non-bulky disease (≤ 7 cm in maximum dimension), N0, M0.
- If radiological evaluation of a lymph node is interpreted as “positive” this must be evaluated further by either lymph node sampling or percutaneous needle biopsy. Patients with histologically confirmed lymph node metastases will not be eligible.
- Maximal TUR

Recruitment target:

150.

Current accrual:

As at July 4, 2007 - 65

Victorian Participating Sites:

Alfred Hospital, Prahran, Victoria, 3181, Australia; Recruiting

Andrew Love Cancer Centre, East Melbourne, Victoria, 3002, Australia; Recruiting

Peter MacCallum Cancer Centre, East Melbourne, Victoria, 3002, Australia; Recruiting

Trial Contacts:

Trial Chairperson

Dr Kumar Gogna
Queensland Radium Institute, Mater Centre
Raymond Terrace
South Brisbane QLD 4101
Fax: +61 7 3840 3399

Trial Coordinator

Kacy Baumann
Queensland Radium Institute, Mater Centre
Raymond Terrace
South Brisbane QLD 4101
Fax: +61 7 3840 3298

PROSTATE CANCER

TROG 03.04 (RADAR) - A randomised trial investigating the effect on biochemical PSA control and survival of different durations of adjuvant androgen deprivation in association with definitive radiation treatment for localised carcinoma of the prostate.

Summary:

Six months of hormone treatment improves the results of radiotherapy for men with early prostate cancer. This trial will determine if adding another 12 months of hormone treatment after radiotherapy is even better. Bones are often affected by prostate cancer and can also be damaged by prolonged hormone treatment. Bisphosphonates are drugs that make bones stronger and may also stop secondary cancer from developing. This trial will therefore also determine if treatment with a bisphosphonate can help prevent these bone problems.

Primary Outcome Measures:

- PSA relapse free survival [Time Frame: Two main endpoint analyses are planned when five and ten years have elapsed from treatment of the last patient registered on the trial.]

Eligibility – Inclusion Criteria:

- Ages Eligible for Study: 18 Years and above, Genders Eligible for Study: Male
- Histological confirmation of adenocarcinoma of the prostate in the three months prior to randomisation
- Gleason primary and secondary pattern reported. If the volume of tumour in biopsies is too small for the pathologist to allocate a secondary pattern, the primary pattern alone is sufficient.
- Primary tumour stage T2b - 4 (UICC 2002), or T2a providing biopsies demonstrate Gleason score 7 or more, and presenting PSA 10 or more
- PSA value obtained within one month of randomisation

- No evidence of lymphatic or haematogenous metastases, as determined by negative chest x-ray, CT scan of abdomen and pelvis, and bone scan in the 3 months prior to randomisation
- ECOG performance status 0 - 1
- No concurrent medical conditions likely to significantly reduce prospects of 5 year survival
- Patient accessible to follow up at intervals specified in protocol
- Written informed consent given (signed by both patient and investigator prior to randomisation)

Recruitment Target:

being extended to 1066.

Current accrual:

As at July 4, 2007 – 1050

Victorian Participating Sites

Andrew Love Cancer Care Centre, Geelong Hospital, Geelong; Recruiting

Peter MacCallum Cancer Centre, East Melbourne; Recruiting

Trial Contacts:

Trial Chairperson

Professor Jim Denham
Newcastle Mater Hospital
Newcastle NSW 2310
Fax: +61 2 4921 1465

Trial Coordinator

Jean Ball
Radiation Oncology RADAR
Newcastle Mater Hospital
Newcastle NSW 2310
Fax: +61 2 4921 1153

TROG 03.06 (TOAD) - A Collaborative randomised phase III trial: The timing of intervention with androgen deprivation in prostate cancer patients with a rising PSA.

Summary:

Men with incurable prostate cancer often live for many years without any symptoms. Hormone treatment usually controls the disease for several years but has side effects.

This ANZ randomised trial will determine if it is better to start hormone treatment straight away or to wait and start hormone treatment only after the prostate cancer begins to cause problems.

Primary Outcome Measures:

- Death from any cause at 8 years

Eligibility Criteria - Disease characteristics:

- Histologically confirmed adenocarcinoma of the prostate
- Prostate-specific antigen (PSA) relapse OR incurable disease diagnosed within the past 2 months AND meets criteria for either of the following groups:

Group 1

In PSA relapse after definitive radical treatment (prostatectomy or radiotherapy), as evidenced by 1 the following:

- Post-prostatectomy PSA level greater than or equal to 0.2 ng/mL
- At least 3 rising PSA levels (post-radiotherapy) obtained greater than or equal to 1 month apart, with the last PSA obtained within the past 2 months
- No metastatic disease by bone scan or abdomino-pelvic CT scan

Group 2

- Not suitable for radical treatment at primary diagnosis
- Not planning to receive curative treatment
- Localized or metastatic disease
- No symptomatic disease requiring radiotherapy or immediate hormonal therapy
- No symptomatic disease requiring therapy

Recruitment Target:

450.

Current accrual:

As at August 2007 – 124 participants recruited

Victorian Participating Sites:

Alfred Hospital, Melbourne; Recruiting

Geelong Hospital, Geelong; Recruiting

Monash Medical Centre, Clayton; Recruiting

Peter MacCallum Cancer Centre, East Melbourne; Recruiting

Trial Contacts:

Trial Chairperson

Professor Gillian Duchesne
Peter MacCallum Cancer Centre
Clinical Research Associate
St Andrews Place
EAST MELBOURNE VIC 3002
Fax: +61 3 9656 1424

Trial Coordinator

Mary Kaimakamis
The Cancer Council Victoria
CARLTON VIC 3053
Fax: + 61 3 9635 5410
Email: trials@cancervic.org.au

Correlation of positron emission tomography (PET), histopathology and PSA levels in patients undergoing neoadjuvant docetaxel chemotherapy prior to radical prostatectomy

Status:

Open to accrual at Austin (2 spots remaining).

Eligibility - Inclusion Criteria

- Clinical diagnosis of carcinoma of the prostate
- Confirmation of adenocarcinoma on TRUS-guided biopsy (may occur after screening and consent)
- Medically and surgically suitable for radical prostatectomy
- Expected survival of at least 3 months
- Karnofsky performance status ≥ 70
- Haemoglobin ≥ 100 , neutrophils ≥ 1.5 , platelets ≥ 100
- Bilirubin $\leq 1.5 \times$ ULN, ALT and AST $\leq 1.5 \times$ ULN, ALP $\leq 2.5 \times$ ULN
- Creatinine ≤ 0.2 mmol/L

Eligibility - Exclusion Criteria

- Prostatic malignancy other than adenocarcinoma
- Clinically staged T3 or T4 disease
- Known lymph node involvement
- Known metastatic disease
- Diabetes mellitus
- Claustrophobia

- Mental impairment that may compromise the ability to give informed consent and comply with the requirements of the study
- Participation in any other clinical trial involving another investigational agent within 4 weeks prior to enrolment

Investigative Site:

Austin Health

Trial Contact:

Assoc Prof Ian Davis
 Medical Oncologist
 Ludwig Institute Oncology Unit
 Austin Health
 PO Box 5555
 HEIDELBERG VIC 3084

Amgen 20050147 – A randomised, double bind, placebo-controlled, multi-centre phase III study of Denosumab on prolonging bone metastasis-free survival in men with Hormone refractory prostate cancer

Summary:

Denosumab vs placebo
 Denosumab neutralizes RANKL (a major activator of osteoclast activity). Patients with hormone refractory prostate carcinoma-without metastasis

Status:

Recruiting until end of 2007

Eligibility – Inclusion criteria:

- 3 consecutive PSA's where PSA is increasing PSA doubling time less than or equal to 10 months or > 8
- No metastatic involvement – proximal lymph involvement ok

Eligibility – exclusion criteria:

- Previous bisphosphonate therapy

Investigative sites:

Monash Medical Centre, Western Hospital and the Austin Hospital

Trial Contacts:

Christine Poole

Monash Medical Centre,
 Christine.Poole@southernhealth.org.au

Assoc Prof Ian Davis
 Medical Oncologist
 Ludwig Institute Oncology Unit
 Austin Health
 PO Box 5555
 HEIDELBERG 3084

Amgen 20050103 – A randomised, double-bind multicentre study of denosumab compared with Zoledronic Acid (Zometa) in the treatment of bone metastases in men with hormone refractory prostate cancer

Summary:

Patients with hormone refractory prostate carcinoma – with bone metastasis.

Status:

Still recruiting

Eligibility – Inclusion criteria:

- Men ≥ 18 years of age with histologically-confirmed prostate cancer
- Current or prior radiographic evidence of at least one bone metastasis
- Documented failure of at least one hormonal therapy as evidenced by a rising PSA (ie. 3 consecutive determinations, taken at least 2 weeks apart from one another. The third measurement must be ≥ 0.4 ng/ml and taken 8 weeks prior to randomisation
- Serum testosterone level of > 50 ng/dL due to either surgical or chemical castration ECOG 0-2
- AST and ALT) ≤ 5 x ULN, bilirubin ≤ 2 x ULN
- Creatinine clearance (Cockcroft-Gault) > 30 ml/min
- Albumin-adjusted serum calcium ≥ 2.0 mmol/L abd ≥ 2.9 mmol/L

Eligibility - Exclusion criteria:

- Current or prior IV bisphosphonate for any reason
- Current or prior oral bisphosphonate administration for the treatment of bone metastases
- Planned radiation therapy or surgery to bone
- Prior denosumab
- Known brain metastasis

- Life expectancy > 6 months
- Prior history or current evidence of osteonecrosis/osteomyelitis of the jaw
- Active dental or jaw condition that requires oral surgery
- Non-healed dental/oral surgery
- Planned invasive dental procedures for the course of the study
- Known history of second malignancy within the past 3 years, except for BCC
- Known infection with human immunodeficiency virus
- Active infection with hepatitis B or hepatitis C virus
- Any other significant disorder
- 30 days or less since receiving an investigational product or device in another clinical trial
- Reproductive potential but not agreeing to use effective contraception
- Known sensitivity to any of the study products

Investigative sites:

Monash Medical Centre, Western Hospital and The Austin Hospital

Trial Contacts:

Christine Poole
 Monash Medical Centre
Christine.Poole@southernhealth.org.au

Assoc Prof Ian Davis
 Medical Oncologist
 Ludwig Institute Oncology Unit
 Austin Health
 PO Box 5555
 HEIDELBERG VIC 3084

Phase I study of VEL015 in patients with hormone refractory prostate cancer
Summary:

Novel oral anti-angiogenic

Eligibility - Inclusion criteria

- Carcinoma of the prostate
- Hormone refractory disease
- No prior chemotherapy
- Karnofsky performance status ≥ 70
- Normal organ function

Investigative site:

Royal Melbourne Hospital

Trial Contact:

Prof Mark Rosenthal
 Director, Medical Oncology
 Royal Melbourne Hospital
 2 Centre
 C/O Post Office
 PARKVILLE VIC 3050

Phase I study of MK0419 in patients with hormone refractory prostate cancer and bone metastases
Summary:

Novel oral integrin inhibitor

Eligibility - Inclusion criteria

- Carcinoma of the prostate
- Hormone refractory disease with bone metastasis
- No prior chemotherapy
- Karnofsky performance status ≥ 70
- No prior bisphosphonates
- Normal organ function

Investigative site:

Royal Melbourne Hospital

Trial Contact:

Prof Mark Rosenthal
 Director, Medical Oncology
 Royal Melbourne Hospital
 2 Centre
 C/O Post Office
 PARKVILLE VIC 3050

RENAL CELL (KIDNEY) CANCER
Expanded access program for sorafenib (Nexavar) for patients with advanced renal cell carcinoma
Summary:

Non-randomised, open-label treatment protocol for patients with advanced RCC, who received previous systemic therapy for advanced RCC,

and who are not eligible for or who do not have access to other clinical trials with BAY 43-9006

Status:

The drug was approved by the TGA for RCC on 28 September 2006. The trial would continue at Austin until PBS listing or the allocated number of patients was reached.

Eligibility - Inclusion Criteria:

- Age at least 18
- Advanced renal cell carcinoma
- Must have failed at least one prior systemic established therapy for advanced RCC (e.g., chemotherapy, or cytokines such as IL-2 or IFN-alpha), or must have been unable to tolerate systemic therapy for advanced RCC, or is deemed by the Investigator to be unsuited for systemic therapy for advanced RCC
- Must have completely recovered from acute toxicity prior to study entry
- The patient must be, in the Investigator's opinion, reasonably likely to benefit from treatment with BAY 43-9006 as a single agent
- ECOG 0–2
- Patient will not require other systemic anti-cancer chemotherapy, immunotherapy (including monoclonal antibodies) or hormonal therapy while taking BAY 43-9006. Treatment with bisphosphonates is permitted.
- Use of adequate contraception (both male and female patients)
- For patients who have had major surgery, the wound must be completely healed prior to receiving BAY 43-9006 treatment (4 weeks)

Eligibility - Exclusion Criteria

- Currently enrolled in or have previously participated in any other BAY 43-9006 trial and who received BAY 43-9006
- Eligible for or have access to any other BAY 43-9006 clinical trial as to the knowledge of the Investigator
- Life expectancy of less than 2 months
- Uncontrolled metastatic brain or meningeal tumours. Patients with prior brain or meningeal metastases that have been adequately treated (resection or stereotactic radiosurgery) and who show no evidence of progression are eligible.

- Patients are excluded who require any of the following:
 - l) Investigational drug therapy during the treatment with BAY 43-9006 or within 30 days prior to their first dose of BAY 43-9006
 - m) Concomitant Rifampicin
 - n) Concomitant St. John's Wort (*Hypericum perforatum*)
- Warfarin is allowed; however, for patients receiving concomitant warfarin therapy close monitoring of Prothrombin Time (PT) should be performed (please note that no laboratory data are collected in this study).
- Pregnant or breast-feeding
- Congestive heart failure greater than NYHA class II
- Cardiac arrhythmias greater than Grade 1 NCI CTCAE, Version 3.0 (conduction abnormality and supraventricular arrhythmia present but patient is asymptomatic; intervention not indicated, palpitations present and QTc > 0.45-0.47 second).
- Active coronary artery disease or ischemia. Child-Pugh class C hepatic impairment.
- Severe renal impairment (calculated creatinine clearance of <30 mL/min) or who require dialysis
- Active uncontrolled hypertension
- Recent or active bleeding diathesis
- Any medical condition which could jeopardize their safety while taking an investigational drug

Investigative site:

Austin Health

Trial Contact:

Assoc Prof Ian Davis
Ludwig Institute Oncology Unit
Austin Health
PO Box 5555
HEIDELBERG VIC 3084

Pfizer – a phase II efficacy and safety study of Sunitinib Malate (SU011248) administered in a continuous daily regimen in patients with advanced (first-line) renal cell cancer.

Status:

Open to recruitment at Monash Medical Centre

Eligibility – Inclusion criteria

- Histologically proven renal cell carcinoma

Eligibility – Exclusion criteria

- Any prior therapy for Renal Cell Carcinoma
- Various drug groups
- Any brain metastatic disease
- Adequate cardiac function

Investigative site:

Monash Medical Centre

Contact:

Christine Poole
Monash Medical Centre
Christine.Poole@southernhealth.org.au

Pfizer – Sunitinib treatment of renal adjuvant cancer: a randomised double-blind phase II study of Adjuvant Sunitinib versus Placebo with high-risk renal cell carcinoma (A6181109)

Status:

About to open

Eligibility – Inclusion criteria:

- Histologically proven renal cell carcinoma

Eligibility – Exclusion criteria:

- Any prior Renal Cell Carcinoma
- Various drug groups
- Any metastatic disease
- Adequate Cardiac function

Investigative site:

Monash medical centre

Trial Contact:

Christine Poole
Monash Medical Centre
Christine.Poole@southernhealth.org.au

LoTESS – Novartis study – A phase IV study of Zometa (Zoledronic Acid) Therapy in patients with bone metastases from breast cancer or hormone resistant prostate cancer, or bone involvement from multiple myeloma, assessing long term efficacy and safety.

Status:

About to open

Eligibility – Inclusion criteria:

- Prostate, Breast or Multiple Myeloma
- Existing treatment with Zometa for at least 9 months and no more than 18 months.

Investigative site:

Monash medical centre

Trial Contact:

Christine Poole
Monash Medical Centre
Christine.Poole@southernhealth.org.au

TESTICULAR CANCER

ANZGCTG 0106 - Chemo & Cognition study - Cognitive function and treatment for testicular cancer

Summary:

Men over 18 years being treated and followed up for testicular cancer, with approximately half having chemotherapy and half having chemotherapy alone.

Status:

Central ethics approval received. 1 Active site (RAH). 12 Planned participation centres.

Eligibility - Inclusion Criteria

- Men with known or suspected testicular cancer
- Surgery planned, or done within the last 2 months; or surgery done more than 2 months ago and chemotherapy planned.
- Age 18 years or over
- Patients must be fluent in English
- Patients must give written informed consent to the study which will involve serial testing

Outcome measures:

- Cognitive function
- Anxiety and depression
- Fatigue

Activated site:

Royal Adelaide Hospital

HREC Approved:

Concord Hospital

HREC Submitted

Princess Alexandra Hospital (QLD)

Current accrual:

0/154

Target Accrual:

154 patients in total (77 in each group), recruitment planned over 2 years

Trial Contacts:

Amy Boland, ANZGCTG Trial Coordinator

NHMRC Clinical Trials Centre

Tel: (02) 9562 5059*Fax:* (02) 9562 5094*Email:* germcell_trial@ctc.usyd.edu.au

Danielle Millar, Oncology Manager

NHMRC Clinical Trials Centre

Tel: (02) 9562 5326*Fax:* (02) 9562 5094*Email:* germcell_trial@ctc.usyd.edu.au**ANZGCTG 0206/ANZGO0630 - Accelerated BEP Trial - A feasibility study of accelerated BEP as first line chemotherapy for advanced germ cell tumours****Summary:**

Patients aged 18-40 with intermediate-and poor risk advanced germ cell tumours and selected good-risk patients with disease evident on imaging.

Status:

Central ethics approved received (FEB 2007), protocol amendment version 1.2 (APRIL 2007) approved by Central Ethics (JULY 2007).

Eligibility - Inclusion Criteria

- Male or female patients with histologically proven GCT (both NSGCT and Seminoma) arising in testis, retro-peritoneum, mediastinum or ovary
- Exceptionally raised tumour markers (AFP \geq 1000ng/nl and or b-HCG \geq 5000 IU/L) are acceptable without histologic confirmation only in male patients with appropriate clinical picture
- Relapses on surveillance are also acceptable
- Advanced stage with radiologically measurable disease according to RECIST

- Intermediate risk, poor risk, or selected good risk patients. Patients with elevated serum tumour markers as the only evidence of disease are ineligible
- Adequate bone marrow function (ANC \geq 1.0 x 10⁹/L, platelet count \geq 100 x 10⁹/L)
- Adequate hepatic function (Bilirubin must be \leq 1.5 x ULN, ALT and ALP must be \leq 2.5 x ULN except if the elevations are due to metastatic disease)
- Adequate renal function (GFR estimated with the Cockcroft Gault formula \geq 60ml/min)
- Able to commence treatment within 7 days of enrolment
- Able to comply with all treatment, assessments and follow-up

Outcome measures:

- Feasibility (ability to start 4th cycle without more than 1 week delay)
- Safety
- Efficacy

Current accrual:

In start-up (not yet recruiting)

Target accrual:

25 patients over 3 years in a 2-stage design

Trial contacts:

Amy Boland, ANZGCTG Trial Coordinator

NHMRC Clinical Trials Centre

Tel: (02) 9562 5059*Fax:* (02) 9562 5094*Email:* germcell_trial@ctc.usyd.edu.au

Danielle Millar, Oncology Manager

NHMRC Clinical Trials Centre

Tel: (02) 9562 5326*Fax:* (02) 9562 5094*Email:* germcell_trial@ctc.usyd.edu.au

The IMPACT Study – Identification of Men with a genetic predisposition to Prostate Cancer: Targeted screening in *BRCA1/2* mutation carriers and controls

Dr Gillian Mitchell
Head, Familial Cancer Centre
Peter MacCallum Cancer Centre

The IMPACT study is an international targeted prostate screening study of men at increased prostate cancer risk due to the presence of known pathogenic mutations in *BRCA1* and *BRCA2* genes.

Study Aims

- To establish an international targeted prostate cancer screening study in *BRCA1* & *BRCA2* carriers
- To determine the incidence of raised PSA and abnormal biopsy in this group
- To gain a better understanding of the pathogenesis of Prostate Cancer in men with *BRCA1/2* mutations.

What is Involved?

- Each subject's family history of cancer will be updated and a clinical history will be taken.

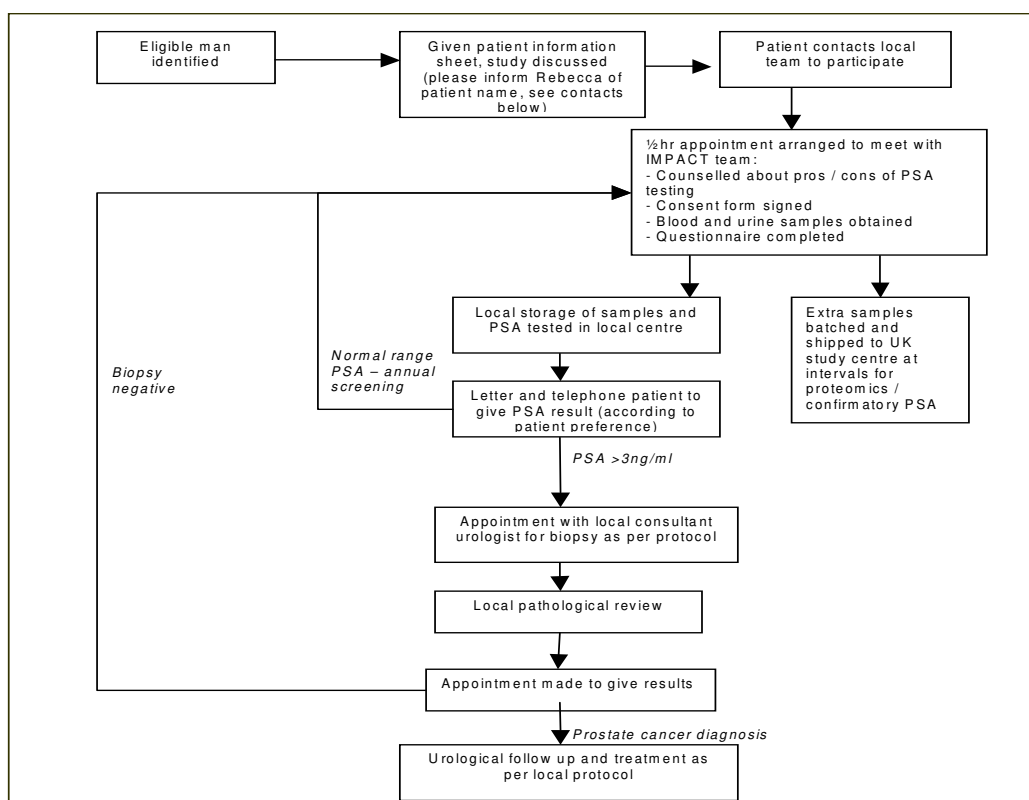
- Annual PSA test (at local and central centres) and storage of serum, plasma and urine samples for a total of 5 years, with 5 years follow-up.

Inclusion Criteria

- Men with a known *BRCA1* or *BRCA2* mutation
- Men who have tested negative for a known *BRCA1/2* mutation present within their family (Control Group)
- Age 40-69 years
- No previous history of prostate cancer
- No previous prostate biopsy for raised PSA

Exclusion Criteria

- Previous cancer with a terminal prognosis of less than five years.



Project Synopsis 400084

Background:

Prostate cancer is a significant public health problem being the most common cancer affecting men in Australia (23% of all cancers in men or 1 in 11 lifetime risk (0-74 years) in 1999) with most cancers occurring after the age of 60 years. There is strong evidence that inherited genetic factors are important, particularly when men are affected at a young age. Several candidate loci have been reported, but currently only mutations at the *BRCA2*, and to a lesser degree *BRCA1*, loci have been consistently linked to an increased relative risk (RR) of prostate cancer. The Breast Cancer Linkage Consortium, (BCLC) reported a *BRCA2* RR 4.65, 95% confidence interval (CI) 3.48-6.22 and a *BRCA1* RR 1.07, (0.75-1.54). There remains uncertainty about the level of risk conferred by *BRCA1* mutations, which may be no higher than the population risk, and by *BRCA2* mutations which may be much higher – about 23-fold by age 60 years. At present it is unclear if targeted prostate cancer screening will detect prostate cancer in *BRCA1/2* mutation-carriers at an earlier stage and whether such screening would result in an improvement in survival. In addition, the effect of *BRCA1/2* mutations on the biological aggressiveness of prostate cancer is unknown.

Aims:

To establish an Australian arm of the multinational targeted prostate screening study (The IMPACT Study) in men with germline *BRCA1/2* mutations. The immediate goal of the study is to determine the incidence of raised serum prostate specific antigen (PSA) and abnormal prostatic biopsy in this high-risk group and hence the sensitivity and specificity of targeted prostate cancer screening. Additional downstream aims include the opportunity to develop new markers of prostate cancer and/or prostate cancer predisposition genes by serially banking serum, plasma and urine and to determine if the pathology of prostate cancer detected by targeted screening in *BRCA1/2* mutation-carriers differs from that in controls.

Methodology:

Men aged 40-69 years testing positive (study group) or negative (control group) for a known familial *BRCA1/2* mutations are eligible. Serum PSA samples will be collected yearly and in

addition they will donate yearly blood and urine samples (which will be banked for future translational biomarker studies). An elevated PSA will trigger a urological referral for transrectal ultrasound and biopsy. Subsequent clinical management will depend upon the biopsy results. Two additional prostate cores will be taken for banking for future translational studies. At the end of the study all men who have not required a biopsy for a raised PSA will be offered the opportunity of a prostatic biopsy in order to fully define the sensitivity and specificity of targeted screening.

Australian Significance of this Study:

Currently there are limited options available to male Australian *BRCA1/2* mutation-carriers to manage their increased prostate cancer risk. Prostate cancer screening in Australia is patchy and there is no mechanism to audit this practice even if it exists. This study provides the opportunity to provide these men with an appropriate and necessary clinical service while answering important research questions. Additionally, as pathogenic *BRCA1/2* mutations are rare in the general population, a multinational study is the only means by which a sufficient number of men can be recruited quickly to answer these important questions. As Australia has a very well organised research-friendly set of Family Cancer Clinics and large-scale ongoing research projects on *BRCA1/2* mutation-carriers (kConFab), we are in an enviable position to recruit a significant number of eligible men.

Contact:

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The Role of Adjuvant Chemotherapy in the management of Stage 1 Seminoma

*Johan Gani - Southern Health, Urology Unit
Keen-Hun Tai - Peter MacCallum Cancer Centre*

Although rare, testicular cancer is the most common malignancy in men in the 15 – 35 year age group. It is now one of the most curable solid neoplasms due to advances in diagnostic techniques, surgical techniques, improved tumour markers, effective radiation therapy and chemotherapeutic agents.

Testicular cancer is classified as germ cell tumours (GCT) or non-germ cell tumours (NGCT). GCTs make up more than 95 percent of lesions and are in turn classified as seminomas or non-seminomas. Seminomas make up about 50% of germ cell tumours.

Stage 1 testicular seminoma is defined as tumour that is confined to the testis and without evidence of metastatic disease on radiological imaging. Tumour markers (alpha-fetoprotein and human chorionic gonadotropin beta subunit) have to be normal or to normalise after radical orchidectomy. If alpha-fetoprotein level is elevated, then the cancer is defined and managed as a non seminoma.

75% of all seminomas present as stage 1, and these patients have an excellent 5 year survival rate in excess of 97%. The management of stage 1 seminomas in the last two decades has undergone substantial changes. Advances in diagnostic imaging, especially with multi-slice computerised tomography (CT) scanners, now enable improved accuracy in the detection of lymph node involvement. Positron emission tomography (PET) scans are now increasingly used as part of baseline staging.

After inguinal orchidectomy for patients with stage 1 seminomas, adjuvant radiotherapy has been the accepted treatment of choice for more than five decades, achieving a local relapse rate of < 5%. This is given in 15 to 20 daily fractions for a total of 20 to 30 Gy, either in the dog-leg (ipsilateral pelvis and retroperitoneum) or para-aortic distribution. Contralateral pelvic and mediastinal irradiation are no longer the standard

of care. Although acute morbidity from radiation therapy is minimal, reports of long term side effects, such as possible induction of secondary malignancies, infertility and gastrointestinal complications, have led to the consideration of other management options like surveillance and more recently, single agent chemotherapy.

Surveillance is also advocated because orchidectomy alone can cure up to 85% of stage 1 seminomas. Even if the patient relapses, radiotherapy for early disease and systemic platinum-based chemotherapy can achieve cure rates of more than 90%. A meta-analysis of surveillance series has shown that rete testis invasion and tumour size > 4cm are significant predictors of relapse¹. Patients with none of these risk factors are ideal candidates for consideration of surveillance therapy.

However, long term follow up of the patient is necessary, as relapses during surveillance have been reported to occur as late as 10 years. Warde and Jewett² recommended CT scans of the abdomen and pelvis every 4 months for the first 4 years, then every 6 months until year 8, and then annually. Surveillance is not as cost effective as adjuvant radiotherapy³ and also creates a potential issue with patient compliance, often a very relevant factor in this patient population.

Carboplatin is an active agent in the treatment of metastatic GCTs. This has led to its investigation in the adjuvant setting for stage 1 seminoma. Oliver et al first described the use of 1 to 2 courses of carboplatin in 78 patients with clinical stage 1 seminoma, and reported no cancer specific deaths and 2 relapses (2%) with a median follow up of 51 months⁴. Steiner and colleagues recorded two relapses in 108 patients who were given two courses of carboplatin, with a median follow up of 59.8 months⁵. Reiter and colleagues reported no relapses in 107 patients given 2 courses of

carboplatin with a median follow up of 74 months⁶.

A joint Medical Research Council (MRC) and European Organization for Research and Treatment of Cancer (EORTC) trial randomised 1477 patients from 70 hospitals to receive radiotherapy (para-aortic or dog-leg) or one injection of carboplatin⁷. The median duration of follow-up is relatively short: the statistical analyses suggest that at 3 years, there is a 90% confidence of excluding a >3.7% difference of recurrence in the carboplatin group when compared to the radiotherapy arm. Time to recurrence and survival rates were similar in the two arms. Although carboplatin was slightly more toxic at 72 hours than radiotherapy, patients with carboplatin were significantly less lethargic and had a higher proportion returning to work.

Unexpectedly, patients who received carboplatin were also found to have a reduced incidence of a second contralateral germ cell tumour. This is presumably due to the effect of carboplatin on carcinoma in situ in the contralateral testis. Of the patients who were treated with a dog-leg field radiotherapy, none developed a contralateral testicular tumour suggesting that there is a similar effect with the extended field when compared to the group who had para-aortic field where there were 10 new contralateral tumours.

A comparison of all phase II trials giving two courses of carboplatin with phase III trials giving one course of carboplatin revealed average relapse rates of 1.8% and 4.5% respectively⁷. Hence, two courses of adjuvant carboplatin seem to further reduce the relapse rate to the order of 1 – 3%, but longer term data is still needed to confirm this. Guidelines have been published to ensure adequacy of follow-up⁸. Two cycles of carboplatin also appear to be well tolerated and associated with acute grade III-IV haematologic toxicity in only 0% to 4.7% of patients⁹. Adequate doses of chemotherapy is recommended as even in the MRC/EORTC trial, the authors pointed out that the recurrence rate of 5.2% could be improved.

In summary, adjuvant carboplatin therapy has been shown to be as effective as radiotherapy in the management of stage 1 seminoma. Long term data is still required to determine late relapses and complications. Many centers are

now offering it as an alternative to radiotherapy or surveillance for these patients. In particular, this could have important benefits in the setting of limited access to where radiotherapy.

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- 7) Oliver et al. Radiotherapy versus single-dose carboplatin in adjuvant treatment of stage 1 seminoma: a randomised trial. *Lancet* 2005;366:293-300
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- 9) Aparicio J, Garcia DMX, Murto P et al: Multicenter study evaluating a dual policy of postorchietomy surveillance and selective adjuvant single-agent carboplatin for patients with clinical stage 1 seminoma. *Ann Oncol* 2003;14:867.

HIFU Outcomes Study

*A/Prof Damien Bolton
Urologist
Austin Health*

High Intensity Focused Ultrasound has become established as a technique for the management of prostate cancer, with almost 200 patients treated to date in Australia by this technology. Most published results from treatment using this method however are single institution series' or have relatively incomplete outcome data.

The Cancer Council Victoria through the VCOG Urological Cancer Committee with the Cancer Epidemiology Centre has undertaken to evaluate the patients and outcomes of this form of treatment in Australia, supported by the manufacturers and agents for the technology. An electronic database has been developed to permit assessment of patient demographics, treatment format and outcomes data, and it is

hoped to apply this in a blinded fashion in the near future to all patients treated nationwide with the consent of the treating urologists. An initial data collection should be completed by the end of this year.

Data will be collated and stored at the Cancer Council's Cancer Epidemiology Centre in a manner analogous to that for the information obtained in the Radical Prostatectomy Register, and will be blinded by operator and patient to all epidemiologic and clinical staff involved in analysis. Hopefully in this fashion an objective assessment of outcomes in many respects will be obtained in order to more fully delineate the ideal place for this technology in the treatment of prostate cancer. Any person with questions or an interest in being involved in the study should contact Jeremy Millar, Peter Royce or Damien Bolton.

Life After Cancer

*Sophy Chirnside
Communications and Resources Officer
The Cancer Council Victoria*

More people than ever are surviving cancer thanks to advances in early detection and treatment. However survival does not always equate with well-being. Many cancer survivors face ongoing issues including psychological distress, loss of self-esteem or a body part, changes to their sexuality and fatigue.

The Cancer Council Victoria is at the forefront of addressing issues for cancer survivors. We are developing a new program for cancer survivors to help them address some of these issues.

This program has been developed following recommendations from cancer survivors who attended a special Cancer Council seminar in November 2006. At this seminar, survivors and

their family were asked to discuss what they felt was missing at diagnosis and highlight how we could best support them through their cancer experience. Their recommendations were as follows:

Information

Attendees said information was needed for cancer survivors covering topics including living with cancer: facing uncertainty, coping with change and loss and grief. A resource was also needed for carers to help them deal with the emotional and physical issues associated with their role.

Regular survivorship seminars would also be helpful, along with a well-being centre where people could access information from health professionals.

Support

Attendees said survivors support groups would be beneficial. Many attendees also felt health professionals needed to discuss the psychological challenges of living with cancer.

Key needs were ongoing emotional support and access to a psychologist or oncology social worker. Survivors also felt that it would have been helpful to speak with someone who had been through a similar experience.

Practical and financial issues

Attendees said they needed practical strategies to help them adapt to their 'new normal' life including tips for managing post-cancer fatigue, anxiety, and distress, and return-to-work strategies.

The financial burden of cancer was also frequently mentioned and attendees felt more financial assistance was needed. Many people had to leave their jobs because of ongoing fatigue, changed cognitive skills, 'chemo brain' and distress. Others had to take extended periods of unpaid sick leave. Carers also spoke of leaving paid jobs to provide care and support.

Education

Educating the general public, employees, patients, carers and health professionals emerged as an important theme. Education was seen as a constructive strategy to empower and support cancer survivors and carers and to help them move forward after cancer.

The Cancer Council has recently launched a booklet, 'Life after cancer: a guide for cancer survivors', to address some of the information needs of survivors. The booklet has been developed in conjunction with the Peter MacCallum Cancer Centre, who has also launched a DVD Just take it Day to Day: A Survivors Guide to Life After Cancer.

A Cancer Survivor's seminar is also being held on August 11, 10am–3pm at 1 Rathdowne Street, Carlton. Topics will include living with cancer: facing uncertainty, coping with change and loss and grief.

For more information, call the Cancer Council Helpline on 13 11 20 or visit www.cancervic.org.au

Cancer Information and Support Service New Initiatives

*Robyn Metcalfe
Cancer Services Promotions Coordinator
The Cancer Council Victoria*

I have recently started a new position in the Cancer Information and Support Service, to help promote the service to specialists, general practitioners and people in the community. The service has in the past relied on word of mouth and promotion linked to particular events.

Some of the important messages for promoting the service are:

- The Cancer Helpline calls are answered by qualified cancer nurses all with post graduate oncology experience
- The service aims to complement the patient/Doctor relationship

- The extended hours of the service are 8 am- 8.30 pm Monday to Friday
on 13 11 20
- The service is for specialists, general practitioners, patients, their carers and the general public
- The Multilingual Cancer Information Line is available with access to interpreters in 80 languages. For details about the multilingual line and resources in different languages visit www.cancervic.org.au/multilingual

Over the next few months I will be visiting cancer treatment centres, outpatients and general practitioners. Promotion of the service to the general community is also being planned via local media including radio and service groups.

Another initiative already underway with the VCOG Gynaecological Cancer Committee is the development of patient packs to be handed to patients when first diagnosed. These packs contain information specific to their type of cancer plus associated information on treatment, nutrition, sexuality and information about services that are available to people having cancer treatment.

Through the Cancer Helpline patients often say that they weren't aware of the Helpline when they were first diagnosed, and that they would have really appreciated the support that the Helpline provides, early in their cancer experience.

If you would like me to send you a sample of a pack relevant to the type of cancer you treat please email me your cancer specialty, address and how many packs you require.

If you have any other ideas to promote the service please call on (03) 9635 5590 or email: Robyn.Metcalf@cancervic.org.au

Extracts from Wongi Yabber, May 2007

Clinical Practice Guidelines for the Management of Metastatic Prostate Cancer

These Guidelines are progressing very satisfactorily. Project Officer, Dr Louisa Jones is now working only part-time and her full-time role has been filled by Dr Suzanne Hughes. Dr Annette Moxey from Newcastle

has also played a significant part in the literature search process. The papers retrieved in the areas of radioisotopes, brachytherapy, radiotherapy, chemotherapy, psychosocial matters and complementary and alternative medicine are prodigious. These are undergoing systematic review prior to critical assessment. The Working party under the Chair of Professor Willis Marshall will meet in Adelaide on 19 June to progress the guideline development process.

COSA Update

This year's COSA ASM will be held in Adelaide from 14-16 November. It is Australia's largest and most diverse cancer meeting, each year bringing together hundreds of Australian and international cancer care professionals and researchers from a wide range of disciplines.

The theme for the meeting is "Prevention, Palliation and Cure: Progress through Clinical Trials" Special symposia, debates and plenary lectures will explore the Australian and Asia-

Pacific clinical trials landscape; the challenge of translating results into clinical practice; barriers to accessing the best therapy (including new drugs); evaluation of alternative medicine; and many other topics. An excellent assembly of international and local speakers is set to deliver a comprehensive and stimulating program. Our convenor Dr Chris Karapetis and his committee continue to put significant effort into the ASM program and it is particularly gratifying to see how many of our South Australia colleagues are involved with and supporting the planning of this major COSA event.

Our commitment to professional development is growing, with Phase 2 of the Continuing Professional Development (CPD) project being rolled out and coming to a number of cancer centres soon. Our consortium, led by the Centre for Innovation in Professional Health, Education and Research (CIPHER), and also comprising The Cancer Council Australia (TCCA) the National Breast Cancer Centre (NBCC) and the Royal College of General Practitioners (RACGP) is engaging with practitioners at a number of demonstration sites to ensure the recommended CPD packages meet the needs of cancer specialists, GPs and counsellors, and have a high degree of support for implementation.

There is progress in cancer care coordination, with Professor Patsy Yates continuing the work of our national workshop in November with a plan to establish a working group to put some flesh around providing key principles for care coordination taking into account the different models.

Another aspect of cancer care we are moving on is the Adolescent and Young Adult (AYA) workshop coming up on 28 May. COSA, in collaboration with ANZCHOG, our paediatric oncology group, led by Frank Alvaro, and Canteen's CEO Andrew Young, have organised a meeting of adult and paediatric stakeholders to examine emerging models of care and outline an action plan for the next few years to address the issue. We acknowledge and are grateful for sponsorship from The Cancer Council Australia, Cancer Institute NSW and Cancer Australia for this important meeting.

Rural and regional service delivery remains an ongoing focus. The data demonstrating how access to cancer care services reduces as geographic isolation increases is out there in the COSA report; we really need COSA members to bring this issue to the attention of local politicians in regional areas. Dr Craig Underhill continues to promote the issue everywhere and he needs your voice as well. Most recently COSA prepared an excellent program of national opinion leaders to review current issue in cancer services in regional Australia at the National Rural Health Alliance's biannual conference. The presentations were well received and the alliance included in its priority recommendations for more uniform and better funded patients' assisted travel schemes in all jurisdictions. Patient travel and accommodation is also the subject of a current Senate inquiry; COSA will be presenting a joint submission to the Senate in partnership with The Cancer Council Australia and may also appear at public hearings. The Senate will be reporting in October.

COSA is undertaking a burnout survey as a result of a grant from Cancer Australia. This project, led by Prof Afaf Girigis, Director of CHeRP and former COSA Psycho-Oncology Chair, will be a very important snapshot of the degree to which this is an issue and then guide us on how to approach strategies to address it.

We also acknowledge the hard work of the group led by Stephen Ackland in pushing the work of the COSA & Cooperative Groups Enabling Grant. Of particular importance is the clinical trial insurance review which is being undertaken by Healthcare Risk Resources International. We expect that this report will provide guidance to all investigators involved with clinical research on the risks and how to manage them. The Quality Assurance component will be bring training resources together, with the aim of making them available to all cooperative research groups to support a standardised approach to education and training for our clinical researchers.

COSA continues to host the Luminous Award Australia which honours journalists who serve their readers/viewers by providing responsible, accurate and timely information on advances in cancer prevention, research, treatment and patient support. Desmond Yip is the COSA nominee for the Luminous Awards and they are well underway in calling for applications with the winner being announced at the ASM in November. The Luminous Award Australia is proudly supported by Eli Lilly Australia

Applications are now being called for the 2008 Haematology Oncology Targetted Therapies (HOTT) Fellowship. Roche Oncology & Haematology in conjunction with COSA, MOGA and HSAZ is delighted to announce that two new HOTT Fellowship Awards of \$50,000 each will be available in the first quarter of 2008. The awards are designed to fund, or part-fund a one year position, and are intended to assist in the conduct of high quality clinical or translational research, or other project initiatives which will be of benefit to the clinical oncology or haematology community within Australia. We are most grateful to Roche as they have generously agreed to expand the Haematology and Oncology Targetted Therapies (HOTT) fellowships to include nursing and allied health (HOTTAH) this year and we received 15 applications for this first time grant. The ubiquitous ex President Stephen Ackland leads the selection team.

In the next few months COSA's new website will be constructed. This will enhance inter and intra group activities and projects, provide forums for group development and improved and

cost effective strategies for us and organisation for on line registration and surveys.

Ms Margaret McJannett
Executive Officer, COSA

The Cancer Council Australia (TCCA)

Evidence stacking up for alcohol-cancer risk

New findings from the International Agency for Research on Cancer (IARC) have now linked alcohol consumption and two of Australia's most common cancers – breast and bowel cancer.

Earlier this year, 26 scientists met to reassess the cancer risk associated with alcohol consumption and found that even modest consumption of alcohol results in an increased risk of breast cancer.

Consuming both alcohol and tobacco products adds to the possible risk of cancer and there was no difference to risk dependent on the type of alcohol consumed. Consumption of alcohol has already been established as a risk factor for cancers of the oral cavity, pharynx, larynx, oesophagus and liver. With breast and colorectal cancer now added to this list, alcohol consumption will continue to contribute to the growing burden of cancer in Australia.

The Cancer Council Australia encourages Australians to avoid or limit their alcohol intake; stick to the recommended daily intakes (no more than two standard drinks per day for men and no more than one standard drink per day for women); have at least one or two alcohol-free days each week; and avoid binge-drinking.

The IARC advisory can be viewed at http://www.iarc.fr/ENG/Press_Releases/pr175a.html.

The Cancer Council Australia's *Alcohol and cancer prevention* fact sheet can be viewed at www.cancer.org.au/lifestyle.

Pull the plug on food advertising

In 2007, the Australian Communications and Media Authority is reviewing the Children's Television Standards. The Coalition on Food Advertising to Children (CFAC), which includes The Cancer Council Australia and other key health and consumer organisations, is calling

for a marked reduction in the commercial promotion of foods and beverages to children under 14 years old. The Pull the Plug on Food Advertising campaign is being run by The Cancer Council NSW on behalf of the coalition to help make the job of parents easier and to give our kids a healthier future. Visit www.cancercouncil.com.au/pulltheplug for more details and to sign-up to the campaign.

Health groups welcome survey to target childhood obesity

The announcement of a jointly funded nutrition and physical activity survey of Australian children is crucial in addressing a major future increase in preventable disease burden, according to an alliance of non-government health promotion organisations.

Terry Slevin, from the Australian Chronic Disease Prevention Alliance*, said research published over the past three to four years in NSW and Victoria showed around one in four Australian children was obese or overweight, but the most recent national data on Australians' eating habits was compiled in 1995, while national physical activity data was more than 20 years old.

"Obesity has been rapidly increasing in Australia, particularly among children. This threatens to impose a major disease burden over the next three to four decades, when healthcare services will already be stretched by population ageing," Mr Slevin said.

"If we are to develop programs to tackle the childhood obesity epidemic, we need a clearer picture of what Australian children are eating and drinking, and their physical activity habits.

"We welcome the joint survey program, and urge all invited families to participate in the survey. The information they provide will inform targeted measures to help reduce the childhood obesity epidemic and inform other approaches to improve Australia's health."

The survey is jointly funded by the Department of Health and Ageing, the Department of Agriculture, Fisheries and Forestry and the Australian Food and Grocery Council.

*The Australia Chronic Disease Prevention Alliance comprises The Cancer Council Australia, Diabetes Australia, Kidney Health

Australia, the National Heart Foundation of Australia and the National Stroke Foundation.

The Cancer Council Australia's new website nearing completion

The Cancer Council Australia's communications team has been working hard in recent months on the redevelopment our website to ensure greater accessibility to resources and information by those visiting the site.

Following extensive consultation, both internally and externally, we have paid particular attention to the way users navigate the site, and with our web agency, have worked hard to ensure a more positive user experience.

With the launch of our new site edging closer, we look forward to introducing the new look site to all visitors – both health professionals and the general public alike over the coming months.

Glen Turner

Communications Manager

The Cancer Council Australia

Ensuring Guidelines Translate into Better Care

The Australian Cancer Network, with the very active involvement of Prof Tom Reeve, has led the way in Australia in Cancer Guidelines development – often in association with others, including the National Breast Cancer Centre and the National Institute for Clinical Studies and with good support from numerous volunteer clinicians. These guidelines provide those caring for cancer patients with up to date information and recommendations on how to achieve best care. In other words, they are a guide as to how to provide the right care at the right time to the right person in the right way.

There are, however, many barriers that need to be overcome to achieve successful implementation of guidelines. It is simplistic to under-rate how difficult it is to change practice in complex environments. Change is not simple or quick because of system variation, a shortfall in leadership or even professional isolation or lack of knowledge.

An ACN committee worked with a team from the National Institute for Clinical Studies to

produce a concise guide for putting guidelines into practice. It is a quick, concise, reference booklet – an “aide-memoire” – evidence based and easy to read and apply everywhere.

The key steps in “*Taking Action Locally: Eight steps to putting cancer guidelines into practice*” are:

1. Appoint the team – clinical champions and executive sponsor.
2. Decide which recommendation to tackle first – size and importance of evidence / practice gap.
3. Is current practice in line with guideline recommendation? – audit.
4. Understand why we are not achieving best practice – individual and system.
5. Prepare for change – engage stakeholders.
6. Choose the right approach
7. Put your theories to the test – plan, do, study, act.
8. Keep things on track – communication – change takes time.

This guide matches the appropriate implementation strategy to the perceived barrier. For example, in step 6, “choose the right approach”, if the barrier is lack of knowledge, education and aids to decision making are likely to be the answer. If the barrier is a mismatch between perception and reality, audit and feedback is the answer. If there is lack of motivation to use guidelines, there may be a need for leadership, incentive and sanctions etc.

ACN and NICS have had increasing requests for this booklet as unit heads and clinicians working with patients find it very useful. I would strongly recommend its use to those seeking to implement guidelines. It can be accessed through the websites of NICS and ACN at www.nhmrc.gov.au/nics/asp/index.asp or www.cancer.org.au/acn under “Activities” heading.

Bruce Barraclough AO

Medical Director,

Australian Cancer Network

Australia & New Zealand TNM Committee for Tumour Staging

Progress has been slow for the ANZ committee but important developments have occurred in the last few weeks. Perhaps the most important of these developments has been the ratification by the College of Pathologists of a proposal by its Advisory Committee for synoptic reports and specifically to include the parameters necessary for TNM staging. It is expected that, in time, this will enable the additional work by the pathologists to be appropriately reimbursed by our Medicare system. This will take at least 18 months.

Other important developments have occurred. The CSIRO eHEALTH Research Center in collaboration with the Queensland cancer control analysis team have developed a cancer stage interpretation system. This is a computer-based system which enables analysis of discursive reports and conversion to synoptic reports. It is then easy to take the final step and add in a TNM classification. A trial of lung cancer reports has revealed an accuracy of 77% for T staging and 87% for N staging. Further evaluation is in progress.

A number of Australian cancer registries are now in the process of manual conversion of their reports to the TNM system. The computerized system will undoubtedly facilitate this process when it is fully validated.

There has been considerable work on the TNM classification of lung and breast cancer in Australia and it is expected that both groups will agree on the system, with some modification, in the near future. The lung group is very close to completion of their review.

Approaches have been made to the Royal Australasian College of Surgeons oncology group and a recommendation has been made to the members of the group that they encourage their pathologists to supply synoptic reports and a TNM classification.

The New South Wales Melanoma Network has formally recommended that the TNM system be applied to the reporting of melanoma.

In conclusion, the Australian and New Zealand TNM committee is pleased with these recent

developments and feels that the TNM system will gradually be introduced into Australia as standard practice.

Professor William McCarthy AM
Convenor ANZ TNM Committee

Key Published Articles Listing—Urological Cancer

Title	Author & Journal
Survival Associated with treatment vs observation of localised prostate cancer in elderly men	Wong Y, Mitra N, Hudes G, et al. Journal of the American Medical Association 2006; 296(22): 2683-2693.
Psychological adjustment of men with prostate cancer: a review of the literature	Bloch S, Love A, Macvean M, et al. BioPsychoSocial Medicine 2007; 1: 2
The psychosocial impact of prostate cancer on patients and their partners	Couper JW, Bloch S, Love A, et al. Medical Journal of Australia 2006; 185(8): 428-432
Sunitinib versus interferon alfa in metastatic renal-cell carcinoma	Motzer RJ, Hutson TE, Tomczak P, et al. The New England Journal of Medicine 2007; 356(2): 115-124
Sorafenib in advanced clear-cell renal cell carcinoma	Escudier B, Eisen T, Stadler WM, et al. The New England Journal of Medicine 2007; 356(2): 125-134
Health perceptions in patients who undergo screening and workup for prostate cancer	Katz Da, Jarrad DF, McHorney CA, et al. Urology 2007; 69(2): 215-220
Initial hormonal management of Androgen-Sensitive Metastatic, Recurrent, or Progressive Prostate Cancer: 2006 Update of an American Society of Clinical Oncology Practice Guideline	Loblaw A, Virgo KS, Nam R, et al. Journal of Clinical Oncology: ASCO Special Article 2007; 25(12): 1596-1605
Initial hormonal management of Androgen-Sensitive Metastatic, Recurrent or Progressive Prostate Cancer - 2007 update of an American Society of Clinical Oncology Practice Guideline	Loblaw DA, Virgo KS, Nam R, et al. American Society of Clinical Oncology, Alexandria VA. http://tinyurl.com/2enfr3
Guidelines for the Management of Clinically Localised Prostate Cancer: 2007 Update	Thompson I, Thrasher JB, Aus G, et al. The Journal of Urology 2007; 177(6): 2106-2131
Temsirolimus, Interferon Alfa, or both for Advanced Renal-Cell Carcinoma	Hudes G, Carducci M, Tomczak P, et al. The New England Journal of Medicine 2007; 356(22): 2271-2281
The incidence of sexual and urinary dysfunction among men for localised prostate cancer: A retrospective pilot study	Newton F, Burney S, Frydenberg M, et al. Proceedings of the 5th Quality of Life Conference, Deakin University Melbourne, Vic (November 2003)

Sexual function and mood differences among men awaiting treatment for localised prostate cancer and men in the general community

Newton F, Burney S, Frydenberg M, et al.
Proceedings of the 7th Quality of Life Conference, Deakin University Melbourne, Vic (November 2005).

Disease specific quality of life among patients with localised prostate cancer: An Australian perspective

Newton F, Burney S, Millar J, et al
British Journal of Urology International 2006; 97: 1179-1182.

Assesing mood and general health related quality of life among men treated for localised prostate cancer

Newton F, Burney S, Frydenberg M, et al.
International Journal of Urology 2007; 14(4): 311-316

Health related quality of life of patients treated for localised prostate cancer two or more years ago: Are there individual characteristics that influence the outcome?

Wootten AC, Burney S, Foroudi F & Frydenberg M.
Proceedings of the 7th Quality of Life Conference, Deakin Univesity Melbourne, Vic (November 2005).

Psychological adjustment of survivors of localised prostate cancer: Investigating the role of dyadic adjustment, cognitive appraisal and coping style.

Wootten AC, Burney S, Foroudi S, et al.
Psycho-Oncology 2007; 16: 1-9.

Long term experience of residual symptoms following treatment for localised prostate cancer: An Australian sample.

Wootten AC, Burney S, Foroudi F, et al.
Asia Pacific Journal of Clinical Oncology (in Press)

Key Published Articles Listing—General

Title	Author & Journal
Challenges in Cancer Control in Australia	Olver IN Medical Journal of Australia 2007; 186(11): 556-557

Forthcoming Meetings

Date / Place	Meeting / Contact
1-4 August 2007 Melbourne, VIC, Australia	Annual Scientific Meeting of the Medical Oncology Group of Australia (MOGA) MOGA Conference Secretariat c/o Pharma Events, PO Box 265, Annandale NSW 2038 Ph: (02) 9280 0577 Fax: (02) 9280 0533 E-mail: moga@pharmaevents.com.au Website: www.moga.org.au
2-4 August 2007 Melbourne, VIC, Australia	10th CNSA Winter Congress Joint venture with MOGA Website: www.cnsa.org.au
28-31 August 2007 Melbourne, VIC, Australia	9th Australian Palliative Care Conference – <i>Partners across the lifespan</i> Palliative Care Australia. APCC 07 Conference Secretariat, C/- ICE Australia P/L, 6 Clarendon Place, South Melbourne, VIC 3205, Australia Ph: (03) 9681 6288 Fax: (03) 9681 6653 E-mail: apcc@iceaustralia.com Website: www.iceaustralia.com/apcc2007/ / www.pallcare.org.au
23-27 September 2007 Sydney, NSW, Australia	3rd International Clinical Trials Symposium (ICTS) GPO Box 3270, Sydney NSW 2001 Ph: (02) 9254 5000 Fax: (02) 9251 3552 E-mail: info@clinicaltrials2007.com Website: www.clinicaltrials2007.com
23-27 September 2007 Barcelona, Spain	14th European Cancer Conference (ECCO) – <i>Cancer in Europe: Sharing the responsibilities</i> Federation of European Cancer Societies (FECS), Avenue E. Mounier 83, Brussels 1200, Belgium Ph: +32 2 775 0201 Fax: +32 2 775 0200 E-mail: ECCO14@fecsb.be Website: www.fecsb.be
25-28 September 2007 Budapest, Hungary	4th World Congress World Institute of Pain Kenes International, 17 Rue du Cendrier, PO Box 1726, CH-1211, Geneva, Switzerland Ph: +41 22 908 0488 Fax: +41 22 732 2850 E-mail: wip@kenes.com Website: http://kenes.com/wip/ / www.worldinstituteofpain.org

Date / Place	Meeting / Contact
4-7 October 2007 Melbourne, VIC, Australia	58th Annual Scientific Meeting of the Royal Australian and New Zealand College of Radiologists (RANZCR) Website: www.ranzcr.edu.au
8-10 November Madrid, Spain	Geriatric Oncology: Cancer in the Elderly Society for Geriatric Oncology (SIOG), Genolier, Switzerland Ph: +41 22 366 9106 Fax: +1 877 369 5497 E-mail: siog@genolier.net Website: www.cancerworld.org/siog
14-16 November Adelaide, SA, Australia	34th Annual Meeting of the Clinical Oncology Society of Australia (COSA) COSA Office, Medical Foundation Building, Level 5, 92 Parramatta Road, Camperdown NSW 2011 Ph: (02) 9036 3100 Fax: (02) 9036 3101 E-mail: cosa@cancer.org.au Website: www.cosa.org.au
12-16 April 2008 San Diego, California, USA	99th Annual Meeting of the American Association for Cancer Research (AACR) E-mail: meetings@aacr.org Website: www.aacr.org
29 April - 1 May 2008 Glasgow, United Kingdom	7th Palliative Care Congress Organised by the Palliative Care Research Society, RCN Palliative Nursing Group and Association for Palliative Medicine of Great Britain and Ireland Website: www.pccongress.org.uk
11-14 May 2008 Adelaide, SA, Australia	Annual Scientific Meeting of the Royal Australasian College of Physicians (RACP) Website: www.racp.edu.au
12-16 May 2008 Hong Kong, China	Annual Scientific Congress of the Royal Australasian College of Surgeons (RACS) Website: www.surgeons.org
17-22 May 2008 Orlando, Florida, USA	Annual Meeting of the American Urological Association (AUA) Website: www.auanet.org
7-10 September 2008 Adelaide, SA, Australia	Annual Scientific Meeting of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) Website: www.ranzcog.edu.au
10-13 September 2008 The Hague, Netherlands	ESSO 2008: 14th Congress of the European Society of Surgical Oncology Federation of European Cancer Societies (FECS), Brussels, Belgium Ph: +32 2 775 0246 Fax: 32 2 775 0200 E-mail: ESSO2008@fecs.be Website: www.esso-surgeononline.be

The Cancer Council Victoria

The **Cancer Council Victoria** is a public institution set up by an Act of Parliament in 1936, and is governed by a Council, with an Executive Board and other advisory committees. The Cancer Council's mission is to lead, coordinate and evaluate action to minimise the human cost of cancer for all Victorians. The Cancer Council operates as a charity, relies heavily on volunteer support and raises \$4–5 per head of population annually. It receives almost the same amount in competitive research grants and government contracts. The Cancer Council's core business is cancer control. It conducts and supports research, as well as delivers state-wide support and prevention programs and advocates to reduce the physical and emotional burden of cancer. It's leaders are of international standing and it is significantly and positively influencing the cancer agenda in Victoria and beyond.

Centre for Clinical Research in Cancer - The Victorian Cooperative Oncology Group

The Cancer Council auspices the **Victorian Cooperative Oncology Group (VCOG)**, a cooperative network of specialist health professionals. This has enabled Victoria's cancer specialists to regularly meet in a conducive non-partisan environment to develop multi-disciplinary clinical management protocols and policy advice for the past 30 years. The VCOG is an excellent forum for communication of new cancer treatment knowledge, promoting development and implementation of evidence-based clinical management guidelines and for the collaborative design of and participation in clinical trials. This collaboration has enabled coordinated lobbying of governments for improved services for cancer patients and cancer clinical research funding. The VCOG structure includes an executive committee, cancer-site advisory and trials committees (breast, CNS, gastrointestinal, gynaecological, haematology, head and neck, lung, sarcoma, skin, urological) and clinical advisory committees (genetics, palliative medicine, psychology, research). The VCOG's activities are supported through the Cancer Council's Centre for Clinical Research in Cancer, providing administration and clinical research development expertise and coordination.

The **VCOG Urological Cancer Committee** was established in 1994. It's membership is representative of the clinical specialties and centres involved in the treatment of urological cancers. The objectives of the Urological Cancer Committee are to :

- Advise the Cancer Council on all clinical aspects of urological cancer, in particular, prevention, screening, diagnosis, treatment and research;
- Contribute to the research objectives of the Cancer Council, which include collaboration in the development and promotion of clinical, epidemiological and behavioural research in gynaecological cancer;
- Play a part in the education of the profession and the community; and
- Promote consensus and collaboration between groups with similar objectives.

The Urological Cancer Committee has initiated, conducted and promoted clinical trials, initiated and conducted treatment audits, contributed to submissions to government inquiries and advocated for improved services, contributed to clinical practice guidelines and patient management frameworks, provided expert medical advice on patient information material, and hosted clinical educational forums.