



Breast Cancer Update

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ASCO MEETING REPORT -
ADJUVANT HERCEPTIN TRIALS

HERCEPTIN & EARLY BREAST CANCER

SENTINEL NODE BIOPSY

ANZ BCTG MEETING REPORT

NRF ORDERS IN ONCOLOGY

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



BREAST CANCER UPDATE

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

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

***** **Last Issue – No. 54 – June 2005** *****

The articles in the Breast 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 Jacquie Chirgwin
Medical Oncologist
Box Hill and Maroondah Hospitals*

It is time for another Breast Cancer Newsletter and another hectic end to the year and festive season. I hope you have some time to read some of the interesting and thought provoking articles included.

The use of Herceptin in the adjuvant setting is of course deservedly the number one issue in the breast cancer field at the present. Prue Francis has summarised the data from ASCO. There are now publications in the NEJM on these trials, as well as on cardiac toxicity from NSABPB31.

It would seem clear from this information that the benefit of adjuvant Herceptin is significant and although longer follow up is ideal, it is unlikely this benefit will be reversed. The size of the benefit far outweighs any cardiac toxicity and indeed it is unlikely that longer follow up will alter the balance of this risk benefit equation, especially considering there are already more patients alive today as a result of Herceptin than there would have been without Herceptin. It is therefore interesting to read Sue Lockwood's article that questions the interpretation of this risk: benefit balance. As a doctor, it seems such a clear cut and large benefit that a different conclusion is almost unbelievable. We must however, take heed of the value judgements of the patients, although it is imperative that these are based on accurate information.

The Cancer Council Victoria, following the suggestion by Dr Prue Francis, Chair of the Breast Trials Sub-Committee, has developed a position statement on Adjuvant Herceptin for early breast cancer. This notes the impressive trial results recently published and supports the establishment of a special mechanism to allow rapid approval for access and funding of new therapies for cancer where there is a substantial body of international scientific evidence showing significant improvement in outcomes for patients.

Other articles of note include an interesting in memoriam article that outlines the outstanding career and contribution to cancer research in Australia, made by Dr John Colebatch. There is also an excellent summary of the issues around Sentinel Node Biopsy, contained in the College of Surgeons position statement. There is a summary of the ANZ BCTG studies and the Annual Scientific meeting held in Perth in July 2005. Doreen Akkerman provides an information sheet on "Cancer, Sensuality, Sexuality and Self Image" which fulfills a need for information provision and help for our patients in a difficult area. There are many interesting reports of activities from various organisations, and a report from a 6th year medical student on how religious beliefs impact on breast cancer screening behaviour. Finally, I would also like to draw your attention to a short article on "Not For Resuscitation" Orders in Oncology patients, presented with the hope that some interesting discussion will arise.

I would like to start a section in the Newsletter especially for reader's short comments. They should be up to 250 words in length and can relate to previous Newsletter articles or be new topics you consider worthy of discussion.

Thanks go again to the indefatigable team at the Cancer Council Victoria (Leigh Williams and Susan Fitzpatrick) for getting this newsletter together again, in a timely fashion.

Contributions Welcome

The Breast 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



relieve 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, The Cancer Council Victoria

⁴ Obtained from record of VCOG activities, The Cancer Council Victoria

⁵ Extracted from John H Colebatch Curriculum Vitae, The Cancer Council Victoria

41st Annual ASCO Meeting - Adjuvant Herceptin Trials

Orlando, Florida May 2005

*Dr Prue Francis
Medical Oncologist
Peter MacCallum Cancer Centre*

At the ASCO meeting on Monday 16th May, a special session entitled "Advances in Monoclonal Antibody Therapy for Breast Cancer" was included to provide a forum for presentation of the late breaking data from three large randomized trials of adjuvant trastuzumab (Herceptin) in early breast cancer. There have been four such trials conducted internationally: NSABP 31 and NCCTG N9831 (these two North American trials were presented as a combined analysis), HERA and BCIRG 006 (in which Australia participated). Efficacy data was presented for the first three trials, while at the time of the ASCO meeting the BCIRG study had only encouraging safety data for presentation.

The efficacy data from these trials were presented with quite short median follow-up but the results were striking and herald a new era of targeted therapy for early breast cancer. Targeted therapy has been used in early breast cancer for years, with tamoxifen an early example of targeted therapy. Tamoxifen when given to women with hormone receptor positive breast cancer for 5 years almost halves the rate of recurrence (a recurrence rate ratio of 0.59 compared to control in the most recent EBCTCG overview). In the adjuvant Herceptin trials the HR for disease free survival (DFS) was 0.54 in the HERA trial and 0.48 for the combined American trial. Thus adjuvant herceptin administered for one year approximately halves the risk of recurrence in early HER2 positive breast cancer when added to standard therapies compared to standard therapy alone (surgery, chemotherapy, radiation, hormonal therapy).

In the combined American trial data the absolute difference in DFS at 4 years was large (18%) with 85% of herceptin treated patients disease-free compared with 67% of control arm patients. In recent years it has been rare for absolute differences of this order of magnitude to be seen in randomized adjuvant breast cancer trials (for example with taxanes, aromatase inhibitors or dose dense therapy). However, almost 30 years

ago, Bonnadonna published the initial results of adjuvant CMF chemotherapy versus none in node positive operable breast cancer. This trial showed an absolute difference of 19% in treatment failures after 27 months follow-up, with 5% of CMF treated women having experienced treatment failure versus 24% of control women. In the HERA trial which had a median follow-up of 2 years (shorter than the combined American trial), the absolute difference in DFS was 8% between herceptin treated women versus control. Patients on the control arm of the HERA trial have been offered the option to receive "delayed" adjuvant herceptin, with drug provided by the study. Due to this type of "cross-over" approach, data on the benefits of adjuvant herceptin after longer trial follow-up, maybe less clear.

It was notable in the American trial data presented by Romond, that in the control arm, despite receiving adjuvant anthracycline and taxane chemotherapy, along with standard hormonal therapy and radiation, within 4 years, already one third of these women with HER2 positive breast cancer were no longer disease-free. This serves as a stark reminder of the aggressive behaviour of HER2 positive early breast cancer.

Cardiac toxicity data reported at the meeting and attributable to adjuvant herceptin were significant, and if patients are to receive treatment as in the trials presented, then careful monitoring of their cardiac function is required, and at this time there is no long term safety data for this approach. The longer term relative efficacy of the non-anthracycline arm of the BCIRG 006 trial will be important to observe as more data unfolds.

At this time in Australia, adjuvant herceptin is not approved nor subsidized for early breast cancer and is therefore only available to those in a position to self fund this costly treatment. This presents a very real and distressing dilemma for oncologists and patients with HER2 positive early breast cancer.

Trade-Offs: Herceptin and Early Breast Cancer

*Ms Sue Lockwood
Chair, Breast Cancer Action Group*

When I was first diagnosed with breast cancer, many years ago now, I quickly came to understand that every decision involved a trade-off. Mastectomy versus conservative surgery plus radiotherapy seemed to be a relatively easy trade-off. A reduction in local recurrences by having radiotherapy, was offset by potential damage to my heart and/or lungs. I had to weigh up the benefit against the side effect. There was some data to help me decide this one. But as time went on, the trade-off decisions became more difficult.

I very quickly also came to understand that population statistics did not mean much to me as an individual. I assumed, like everyone else that I would have my treatment and everything would be OK. I found out that being told that I had a 90% chance of surviving revealed little about how I might live through the 5 years. So yes, this bald statistic did 'fit' me - but it said nothing about the contralateral breast cancer (only 10% of women if I remember correctly), the subsequent DCIS and the subsequent invasive disease. This led, after 10 years of regular treatments, to a bilateral mastectomy and chemotherapy.

At this point, the trade-offs became far more significant. Losing both breasts was necessary to stop the breast cancer recurring, but the trade-off in terms of my body image was devastating to contemplate and to live with.

But in this trade off there was at least long term data to guide my decision. The survival value of the different types of chemotherapy was available, side-effects such as cardiac disease, were well known and there were relatively benign means of treating most of them. The long term damage to my stomach was not something which was discussed, but it turned out to be for me, the most damaging, although manageable, consequence.

When Herceptin was brought in for advanced disease, the trade-offs were also fairly clear cut – at least to my mind. Women with advanced disease have limited options and if this option

gave them a few more months of good quality life, then the trade-off with problems like heart disease was probably worth taking.

But this is not the same for women with early disease where the weighing up of the benefits and trade-offs are arguably more crucial.

We know from the two adjuvant Herceptin studies so far, that the statistics show a benefit in terms of disease free survival. But we also know that the median time for analysis of these studies is 1 and 2 years. We know that the data on disease free survival going out to 3 years looks promising, and is statistically significant, but still there are only a few women out at 3 years included in the analysis. So although the results appear impressive, the data are still very new and the numbers are still small. But nevertheless the outcomes look really positive and certainly worth considering for every Her2+ woman.

But what are these trade-offs? I doubt that anyone really knows. I know something of what they might be, but the size and effect, at least in my mind are currently unknown.

One of the trade-offs is the cardiomyopathies which appear to develop, particularly in women who have had some form of previous anthracycline chemotherapy. We know that this can be managed by doing LVEF tests and then deciding what to do, if the results start looking bad. Then the trade-off becomes: do I risk severe heart disease or recurrent breast cancer? This is not an easy decision to have to make. This problem is clearly manageable when part of a trial, but it is much harder to manage when women are part of the normal community. This has already been pointed out in the growing literature on this topic.

Based on our experience with women with advanced breast cancer, some women with early disease will do very well on Herceptin. For others it will not be so beneficial. Some will go on to have a recurrence and develop metastatic disease. This has been demonstrated so far in the trials.

One of the other trade-offs is the potential for developing brain metastases. For approximately 30% of women there is a chance that they will develop brain metastases. This has been seen in women with advanced disease and I know of no reason why this might not happen with women with early disease who recur. This issue is acknowledged in the discussion of the Hera trial as a potential problem and in other literature.

All I know is that brain metastases is my greatest fear. I have always lived 'in my head' that is, through my intellectual ability. To lose that would be very difficult for me. And having seen the consequences of brain involvement, I know how difficult it is for family and friends to deal with. So this trade-off – potentially living longer, but dying of brain metastases would be one of the very hard trade-offs for me to deal with. I acknowledge that whilst this is a problem for me, it may not be a problem for other women.

I don't know what the other side-effects of Herceptin will be. I do know that there are many different side-effects of most drugs and that these side-effects affect some women more than others. I assume that, in this regard, Herceptin will be no different from other drugs.

But my concern is that whilst we know the benefits, or think we know the benefits, of Herceptin we don't know which groups of women are more likely to benefit than others. And we don't know the side-effects in any detail. We simply don't have the same level of understanding of the potential side-effects, and the different treatments for these side-effects, that I had when making my decision about chemotherapy. It will be years before this data is available to women.

So the Breast Cancer Action Group is expressing caution about how this drug is presented to women. Certainly present the benefits, but also, present the known side-effects and the fact that there are probably many unknowns. It is up to each woman to make her choice as I made my choices in the past. But she, and her family, must be adequately informed of all the positives and all the negatives and all the unknowns before making her choice.

References

- ¹ Piccart-Gebhart, M J., et al. (2005). "Trastuzumab after Adjuvant Chemotherapy in HER2-Positive Breast Cancer", *New England Journal of Medicine*, 353: 1659-72.
- ² Romond E H., (2005). "Trastuzumab plus Adjuvant Chemotherapy for Operable HER2-Positive Breast Cancer", *New England Journal of Medicine*, 353: 1673-84.
- ³ "We report here the results only of treatment with trastuzumab for one year or observation" cited from: Piccart-Gebhart, M J., et al. (2005). "Trastuzumab after Adjuvant Chemotherapy in HER2-Positive Breast Cancer", *New England Journal of Medicine*.;353: 1659.
- ⁴ "The median follow-up was 2.0 years" Romond E H.(2005). " Trastuzumab plus Adjuvant Chemotherapy for Operable HER2-Positive Breast Cancer", *New England Journal of Medicine*, 353:1679.
- ⁵ "Overall survival in the two groups was not significantly different (29 deaths with trastuzumab vs. 37 with observation)". Cited from: Piccart-Gebhart, M J., et al. (2005). "Trastuzumab after Adjuvant Chemotherapy in HER2-Positive Breast Cancer", *New England Journal of Medicine*, 353:1659.
- ⁶ "The absolute survival rate at three years was 94.3 percent in the trastuzumab group and 91.7 percent in the control group (absolute difference, 2.5 percentage points; 95 percent confidence interval, 0.1 to 5.0 percentage points)..." cited from: Romond E H., (2005). " Trastuzumab plus Adjuvant Chemotherapy for Operable HER2-Positive Breast Cancer", *New England Journal of Medicine*, 353:1679.
- ⁷ "The primary concern regarding the safety of trastuzumab is the increased risk of cardiac dysfunction associated with past or concurrent anthracycline treatment..... Most episodes occurred during trastuzumab treatment, but additional follow-up will be needed to define the long-term cardiotoxicity of trastuzumab" cited from: Romond E H. (2005). "Trastuzumab plus Adjuvant Chemotherapy for Operable HER2-Positive Breast Cancer", *New England Journal of Medicine* 353:1682-83.
- ⁸ "The follow-up of these trials is relatively short. Outside of clinical trials there is a tendency for there to be less stringent patient selection, management, and follow-up. So it is possible that when trastuzumab is used widely in clinical practice, the rate of cardiac dysfunction could be higher than that observed in these trials. It is unclear whether, in the long-term, cardiac dysfunction will be increased when trastuzumab is used following more intensive chemotherapy regimens than doxorubicin and cyclophosphamide followed by paclitaxel (ACT) or in

association with regional radiation." Cited from: Levine M N. (2005). "Trastuzumab Cardiac Side Effects: Only Time Will Tell", *Journal of Clinical Oncology*, Vol 23, No 31 (November 1), 2005: pp. 7775-7776

⁹ "Metastatic breast carcinoma to the CNS is common among patients receiving trastuzumab-based therapy, including patients responding to therapy outside the CNS. This may be due either to predilection for the CNS by HER-2- positive tumor cells and/or poor penetration of the CNS by trastuzumab or to improved visceral disease control leading to a longer life and onset of late tumor spread to the CNS." Cited from: Bendell J C. et al. (2003). " Central Nervous System Metastases in Women who Receive Trastuzumab-Based Therapy for Metastatic Breast Carcinoma", *Cancer*, Volume 97 Number 12 page 2972

¹⁰ "We acknowledge that we have only an incomplete picture of the risks associated with trastuzumab. The risk of cardiotoxicity is currently low in our trial, but this could change with longer followup. Another concern is that longer follow-up may show that trastuzumab is not effective in reducing the incidence of disease recurrence in the central nervous system. Brain metastases developed in approximately one third of the women receiving trastuzumab as treatment for advanced breast cancer, despite control of systemic disease. 34 It is not clear whether such central nervous system metastases reflect aggressive disease or poor penetration of trastuzumab into the brain." Cited from: Piccart-Gebhart , M J., et al. (2005). " Trastuzumab after Adjuvant Chemotherapy in HER2-Positive Breast Cancer", *New England Journal of Medicine*, 353:1668.

RACS Breast Section Position Statement on Sentinel Node Biopsy in Early Breast Cancer

Mr David Oliver, FRACS

"Individual surgeons and institution teams beginning to introduce SNB should undergo an educational program."

In 2002 the Executive Committee of the Breast Section of the RACS developed a position statement on sentinel node biopsy (SNB). At that time SNB was still being evaluated in clinical trials around the world, including our own SNAC trial. The 2002 position statement indicated that SNB should only be promoted in the context of a randomised clinical trial. If it was to be done outside of this scenario then the woman should be informed of the limitations of the technique, the lack of long term data, as well as the surgeon's own results with the technique. We now consider that the position statement needs to be updated, as new data has become available, and the SNAC trial has completed accrual. This updated statement should be reflective of the current safe use of the technique and should be noted by breast surgeons who offer the technique to women with early breast cancer, depending on their own circumstances and experience.

SNB in early breast cancer has been investigated and researched for greater than 10 years now. Four major randomised controlled trials (three multicentre) have been conducted, all of which

have completed recruitment (ALMANAC - United Kingdom, Milan, NSABP-B32 - North America, SNAC Trial - Australia and New Zealand). The Milan trial published its early results in 2003 whilst the ALMANAC and NSABP-B32 trialists have presented initial results at international meetings in 2004. The results of these trials and those from a large number of single and multi-institution validation series show remarkably similar data.

SNB appears to be an effective method for the staging assessment of the clinically negative axilla, comparable to level two axillary dissection. It seems to have significantly less morbidity than level two axillary dissection, as demonstrated by presentations from the ALMANAC trial at the San Antonio Breast Cancer Symposium in 2004.

SNB is very much operator dependent, with the literature reporting a wide range of sentinel node detection rates and wide range of false negative rates. As such, individual surgeons and institution teams beginning to introduce SNB should undergo an educational program. A period of self / institution audit is then mandatory. Individuals

should audit their success rate at identifying the sentinel node, and their false negative rate, by performing SNB followed by immediate level two axillary dissection. These results should be comparable to accepted standards (ie similar to standards set by the SNAC trial – sentinel node identification in >90 percent in 20 consecutive cases). The number of cases required to confirm competency should be 20 – 40, depending on progress. Once validated, ongoing data should be kept to monitor performance and compared to accepted rates of positive node detection and local recurrence.

The reported false negative rates range from 5 - 15 percent. This data will only be known during the validation phase where immediate axillary dissection is performed. It should be calculated in reference to the number of node positive cases, not the total group. The false negative rate appears to remain constant for an individual surgeon across all cases. The significance of the individual surgeon's false negative rate relates to the percentage chance of an individual woman having a positive lymph node in the axilla i.e. related to size, grade, and lymphovascular invasion. For small, screen-detected low grade cancers the prevalence of axillary lymph node involvement is low (< 5 percent in some cases). As such, the chance of leaving disease within the axilla after SNB is minimal. With larger tumours the incidence of positive nodes is up to 70 percent. In this scenario a surgeon with a 15 percent false negative rate has an overall chance of missing node positive disease of 10 percent. Women having SNB should understand the significance of the surgeon's false negative rate, in terms of risk of regional relapse, potential for understaging and possible impact on adjuvant therapy decisions.

The role of SNB in larger T2/T3 tumours and multicentric tumours is experimental. There is some encouraging level three evidence that SNB is reliable in these situations, but false negative rates seem to be higher. The published series tend to be smaller than the early reports of SNB in early breast cancer. Rather than offering SNB alone in these groups it would be preferable to enroll patients in a randomised controlled trial, if available. If SNB is performed outside of a clinical trial, the operator should subject these cases to the same rigorous audit and evaluation as recommended above. The use of lymph node biopsy in pure DCIS is not supported by the

NBCC Early Breast Cancer Guidelines. There is currently no high level evidence to support SNB in pure DCIS outside a clinical trial.

The assessment of extra-axillary nodal basins is controversial and remains the subject of investigation. Extra-axillary nodal status may alter individual patient management decisions. If it can be performed with minimal morbidity it would be a reasonable option to consider. The SNAC protocol recommended that an attempt be made to biopsy each sentinel node identified.

There are several international studies (e.g. IBCSG Trial 23-01) designed to assess the need for complete axillary dissection with positive sentinel node biopsy in cases of minimal involvement of the sentinel node. Until the results of such trials are available, the standard of care for a positive SNB should be level 2/3 axillary dissection. The Breast Section encourages surgeons to contribute patients to IBCSG Trial 23-01, which is being administered by the ANZ Breast Cancer Trials Group.

The significance of sentinel nodes positive on immunohistochemistry (IHC) only has not been conclusively evaluated. The prognostic implication of micrometastases (>0.2mm and <2mm) or isolated tumour cells (<0.2mm) in sentinel nodes, especially when detected by IHC alone, is unclear and remains the subject of investigation. Where possible it is recommended that pathological evaluation of the sentinel node follow the SNAC trial protocol, with IHC for each sentinel node, in addition to multiple levels on H&E. Ethically approved randomised controlled trials that further investigate the role of SNB in early breast cancer should be supported by the members of the Breast Section.

Remuneration for SNB performed in Australia is currently the subject of an application by members of the Executive Committee of the Breast Section to the Medical Services Advisory Committee of HIC. Until reviewed by the regulatory bodies within Australia, Medicare item number 30332 is the only one approved for SNB.

In conclusion sentinel node biopsy can be offered to clinically node negative women with early breast cancer as an alternative to level 2 axillary node clearance, with the aforementioned points kept in mind. The risks and potential benefits of both procedures should be discussed with

patients to allow them to make an informed decision about the surgical management of the axilla. The position statement of the Breast Section of the College is summarised in point form below.

5 POINT SUMMARY

- Many descriptive studies and several randomised controlled trials have shown sentinel node biopsy to be a viable alternative to level 2 dissection for staging the axilla in smaller, clinically node negative breast cancer, with significantly less morbidity.
- The technique is accurate, but there are a small number of false negative cases. The clinical significance of this is currently unknown, and results of randomised controlled trials are awaited.
- Surgeons commencing sentinel node biopsy should audit their results against level 2 dissection, using the SNAC trial protocol as a guide, prior to offering sentinel node biopsy as standard practice.
- The role of sentinel node biopsy in DCIS, multifocal and larger tumours requires further investigation.
- The Breast Section encourages surgeons to contribute patients into randomised controlled trials further investigating the role of sentinel node biopsy in breast cancer.

Reprinted with permission from RACS Surgical News, Vol. 6 No. 9 October 2005.

ANZ Breast Cancer Trials Group Annual Scientific Meeting

6 - 9 July 2005 – Perth, WA

*Dr Jacquie Chirgwin
Medical Oncologist
Box Hill & Maroondah Hospitals*

As in previous years, there were several distinct sections to this meeting, allowing the meeting to be of interest to a broad range of people involved in Breast Cancer Research. The first two days were used to cover the trials of the group – including a Data Management Forum, Consumer Advisory Panel, Participants Forum and Scientific Advisory Committee (SAC). The order of activities was deliberately changed for this meeting, in response to members suggestions, to allow wide membership input into trial planning, prior to endorsement by the SAC. The Scientific Program occupied the second two days of the meeting and, as usual, provided an array of high class national and international speakers, stimulating thoughts and discussions useful for the Groups further development of Breast Cancer Research, particularly translational. I will briefly summarise here the status of the Group's trial activity and future plans, as well as some

highlights of the scientific presentations. (*Where known I have updated the information on trial status to November 2005*)

Current Trials

● ANZ 02P2 (IBIS II)

This has two parts:

IBIS II Prevention: anastrozole vs placebo in postmenopausal women at increased risk of BC.

IBIS II DCIS: anastrozole vs tamoxifen in postmenopausal women with hormone sensitive DCIS treated with breast conserving surgery.

A bone sub-study looking at value of bisphosphonate will be done in some centres. The study is activated with 1 patient accrued (DCIS) at Riverina Cancer Care Centre. Newcastle Mater Misericordiae Hospital and Sir Charles Gardner Hospital WA, also have HREC

approval. Contracts, Indemnity and Radiation Safety issues still require resolution at some sites, but randomisation procedures and drug supply issues have been resolved.

② IBCSG 22 – CM Maintenance

This study is for hormone non-responsive breast cancer patients, post adjuvant chemotherapy, who are randomised to receive 12 months of maintenance oral low dose cyclophosphamide and methotrexate or not. This study is based on the CM acting as an angiogenesis inhibitor.

To date 7 Australian institutions have been activated, 25 patients have been entered, 18 during 2005. Accrual to this study internationally needs to be increased and further Australian involvement is encouraged.

③ IBCSG 23-01 Sentinel Node Micro-metastases – Adjuvant

Patients who are found at Sentinel Node biopsy to have micro-metastases are randomised to undergo axillary clearance or not.

11 ANZ centres have expressed interest. One site (Riverina Cancer Centre) has been activated (November 2005).

④ IBCSG 24-46 STP Trials

SOFT: Suppression of Ovarian Function Trial

TEXT: Tamoxifen and Exemestane Trial

PERCHE: Premenopausal Endocrine Responsive Chemotherapy Trial

25 Centres have been activated to one or more of these studies. A further 24 centres have expressed interest. Some Victorian centres are having significant legal issues delaying trial activation.

The first Australian patients were entered into SOFT and TEXT in March 2005; there are now 16 patients in SOFT and 13 in TEXT. No patients have been entered in PERCHE. US sites have closed PERCHE.

⑤ IBCSG 27 Radically resected local recurrence

Patients are randomised to receive “adjuvant” chemotherapy or not.

5 Centres are activated for this study, but as yet, there are no patients on study. The international accrual is 37.

⑥ IBCSG 30 / NCIC CTG MA.27

Postmenopausal, receptor positive patients are randomised to Exemestane or Anastrozole.

4 Australian sites are activated, all since 31/10/2005 and 3 patients have been entered. The total international accrual is 4,641, with a recently increased target of 5,800. The study is expected to close mid 2006.

Pending Trials

① IBCSG 32 (CASA)

Trial evaluating role of adjuvant Caelyx for older (>66) women with endocrine non-responsive breast cancer, who are not suitable for “standard chemotherapy”. 14 Australian institutions have expressed interest, none activated as yet.

② SWOG SO230 (IBCSG 34)

Study of LHRH analogue administration during chemotherapy to reduce ovarian function failure following standard adjuvant chemo in early stage, receptor negative breast cancer. 25 Australian institutions have expressed interest. Some regulatory issues still to be resolved and drug supply not expected before end of 2005.

③ ANZ 0502 (NeoGem)

Phase II study evaluating the efficacy and safety of EC followed by Docetaxol & Gemcitabine (+ Trastuzumab if HER2 +ve) as neoadjuvant chemotherapy for locally advanced breast cancer. 20 centres have expressed interest. Contract with Sanofi-Aventis to be finalised. Roche and Lilly also still to finalise protocol review.

④ LATER (0501)

Study of endocrine prevention treatment for patients who completed adjuvant endocrine treatment > 1 year previously. This trial is in development phase currently.

Closed Studies

1 ATLAS

Closed to accrual 1/3/2005. Approximately 15,000 patients have been randomised, including 784 from Australia and New Zealand. Results will likely be forthcoming during 2006.

2 ANZ 0001

This study of CMF versus Capecitabine as first line therapy for advanced breast cancer closed to accrual in July 2005 with around 320 patients randomised.

3 TIBER

This study of Iressa in advanced breast cancer closed to accrual in September 2004 with 66 patients accrued. Results are to be presented at San Antonio.

4 Previous Adjuvant Studies

Further sub-studies being planned include fingernail (bone density surrogate) study (study 18), trans ATAC, Cognitive function with AI's (study 18) and a Pathology sub-study (study 16).

A 5 year interim analysis is planned for study 20 as the events have not been sufficient to trigger first analysis.

Scientific Program

Jack Cuzick spoke of statistical models that help inform regarding the choice of WHEN to use adjuvant aromatase inhibitors – up front, half way switch or post 5 years of Tamoxifen. Over 10 years, this model predicts 1 in 18 recurrences will be prevented by using AI from the start of adjuvant treatment. Similar figures were obtained for switching at 2 years, but delaying to 5 years for switch was inferior, especially for PR –ve tumours.

David Hyams presented some NSABP data on cardiac toxicity of adjuvant Herceptin. Two thirds of those with cardiac dysfunction recovered symptomatically within 6 months. The risk of CCF was higher in those with LVEF of 50-54% at start of treatment and was greater for patients who were older (6.3% for those under 50, 14.1% for those over 50 years).

Prof. Raimund Jakesz gave a comprehensive summary of the work of the Austrian Breast

Cancer Study Group. Studies have included Zoladex and Anastrozole trials with results in line with other international studies. Other presentations included summaries of the recent reports on the adjuvant Herceptin studies (HERA, NSABP B31 and NCCTG N9831) and the ECOG and E2100 study of Avastin and Taxol.

A superb presentation “Bioinformatics from Oncogenes to Oncosystems” by Pablo Moscato, was saved until last! Pablo is a Senior Lecturer in Bioinformatics at the University of Newcastle and discussed mathematical models used for decades in other areas, and how they can be useful in analysis of micro assays and gene signatures. All a bit too mathematical for me, but a humorous talk, and clearly a useful collaboration for breast cancer researchers!

The next Annual Scientific Meeting (ASM) of the ANZ Breast Cancer Trials Group is 18 - 21 July 2006, to be held in Cairns. For those interested in being involved in breast cancer clinical trials, this is an excellent local meeting. The group encourages involvement in the development of new protocols, and has recently put much effort into changing organisational processes to increase participation of all Australian breast cancer clinical trialists. I thoroughly recommend attending the ASM.

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.

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

Not For Resuscitation (NFR) Orders in Oncology

*Dr Jacquie Chirgwin
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I am writing this article with the intention of starting some discussion about how this issue can be better dealt with in our hospitals.

There are many instances where the current regulations have caused considerable and unnecessary distress to terminally ill people and their families. Whilst individual institutions almost certainly have slightly different policies, they all would appear to have similar requirements for discussion with the patient. At Eastern Health, the policy states: "Except in cases where the patient is deemed incompetent and/or there is an Enduring Power of Attorney (Medical Treatment Act) or an order under the Guardianship and Administration Act, CPR status should ALWAYS be discussed with the individual patient." The CPR status is also time limited such that it needs to be re-iterated with each hospital admission.

This policy means, in practical terms, that for every admission of a patient with terminal malignancy, this issue has to be re-discussed and documented, often by a junior doctor, who may well be unfamiliar with the patient or indeed the expected natural history of the patients' illness. Often, this junior doctor is working in the

emergency department and has no experience of oncology. This is, of course, distressing to the patient, their family and the junior doctor. I think it is only fractionally less distressing for the CPR status to be repetitively discussed with the relatives only.

John Saunders' insightful article "Perspectives on CPR: resuscitation or resurrection?" (Clinical Medicine Vol.1 No.6 Nov/Dec 2001: 457-460) says it all. In cases where CPR is considered medically futile, patients should not be offered this treatment (as in all areas of medicine – patients do not have the right to useless treatment). Our role as experts in the medical care of our patients, should also extend to a decision as to whether CPR is appropriate/should be offered to an individual patient. Development of a process in our hospitals that allows for MEDICAL decision making in this area is well overdue.

"The first requirement of a hospital is that it should do the sick no harm". Florence Nightingale.

I am interested in others' views on this topic, and any solutions that have been developed.

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.

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

The Effect of Culture and Religion on Self Breast Examination and Clinical Breast Examination

*Ms Nicola Dobos
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How can we target women from all cultures and religions, educate them about their risks of breast cancer, and encourage regular self- and clinical breast examination?

Introduction

Australia in 2005 is a multicultural and growing society. Culture and religion are important components of daily living to many Australians, and it is important that our public health strategies recognise this issue and tailor screening programs accordingly. This paper will discuss how culture and religion can impact on a woman's desire and likelihood to participate in breast cancer screening programs, in particular self-breast examination and clinical breast examination, and provide some suggestions on how to further improve their participation.

It has been well documented that religion and spirituality can influence individual's health beliefs, values and care practices. In contrast, it is argued that no-one can suggest illness is the result of insufficient faith. However, there have not been many published papers describing how religion and spirituality can effect health care and screening practices in communities of different faiths.

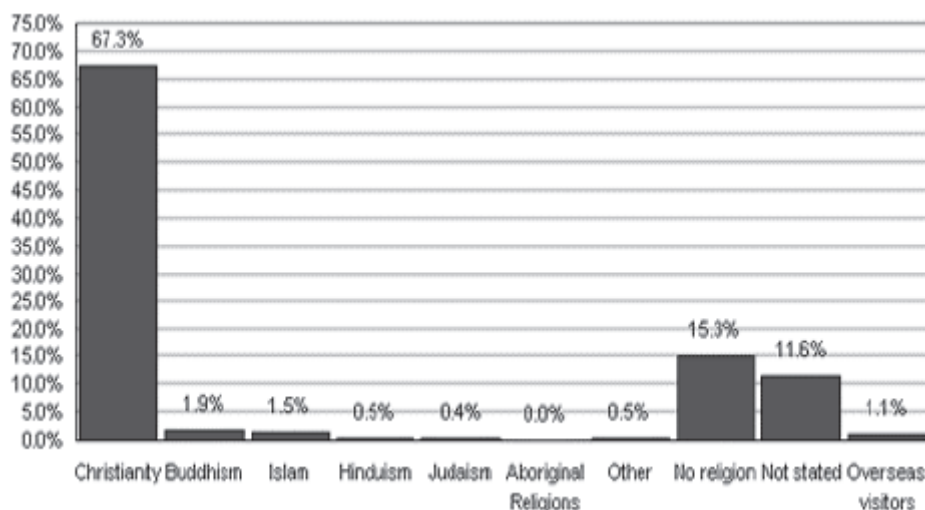
Religions in Australia

In the Australian 2001 Census, Christians represented 67% of the population and Non-Christians represented about 4.9% of the population. Around a quarter of the population stated they had no religion or did not state their religion. (Refer Table 1).

The 2001 census recorded about 100 different religious denominations. The non-Christian religions represented in Australia include Judaism, Hinduism, Buddhism and Islam.

Buddhism is the largest non-Christian religion and accounts for 1.9% of the total population. Islam, the second largest non-Christian religion represented in Australia today accounts for 1.5% of the total population.

Table 1: Religions in Australia



What Do We Know Already?

Women from minority ethnic groups have a lower incidence of breast cancer compared with white Caucasian women, but poorer 5-year survival rates. Given that the cause of breast cancer is uncertain, screening is therefore highly important, as early detection and fast treatment offer the greatest possibilities of survival. The provision and distribution of health information is central to public health prevention strategies such as this.

Islam and Muslim Women

Islam is the 2nd largest religion in the world. It has more than 1 billion followers worldwide. In Australia, there are approximately 300,000 Muslims.

Muslim women are expected to veil and cover themselves, and conceal their attractions from men. If in presence of a man not related by birth or marriage, Muslim women are encouraged to veil themselves and wear a covering-type of dress to conceal their femininity and attractiveness. In fact, Muslim men and women are dissuaded by Muslim law from even being alone together.

Due to this, it would be expected that a Muslim woman might feel uncomfortable in participating in recommended breast screening programs unless they were specifically structured in accordance with Islamic beliefs and customs. Instead they may avoid participation unless they are specifically concerned about their breast health.

In the multi-cultural society that we have here in Australia, the question we must all consider is:

How can we target women from all cultures and religions, educate them about their risks of breast cancer, and encourage regular self- and clinical breast examination?

Article Reviews

Article 1

Breast Health Information Needs of Women from Minority Ethnic Groups.
Journal Advanced Nursing
September 2004; 47 (5) :526 - 535.

Important points to consider from this article include:

- There is not a lot of research on this topic.
- Minority ethnic groups have a variety of cultural beliefs and values, and so their health information needs will differ.
- In the past, the needs of women from minority ethnic groups have been considered as an "add-on" and there has been over-reliance on translated written material, and under-utilisation of the community, the media and audio-visual resources.
- Conventional initiatives are mostly unsuccessful in informing these women from minority ethnic groups about health issues. This will, in turn, lead to decreased awareness of breast cancer and the need for screening.

Some other interesting findings from this article include:

- A British study discovered lower levels of knowledge and less frequent breast self-examination among Asian women as compared with white women.
- Studies from North America suggest that African American women are less likely to have mammograms. This is linked to cultural belief that breast cancer is asymptomatic.
- In the UK, a significant problem faced by people of minority ethnic groups was lack of information about the availability and importance of screening services.
- In Asian American women, fear of cancer and the belief that even thinking about it may cause the disease have been noted.
- Fears about the impact of cancer on personal relationships was also identified. This rendered African American women reluctant to seek treatment
- Personal modesty is taught to South Asian women as children and valued highly. There is reluctance among many women to perform breast self-examination as they consider it inappropriate to touch their bodies.

Article 2**Veiled Yet Vulnerable; Breast Cancer Screening and the Muslim Way of Life. Cancer Practice 1999; 7 (6).**

This article discussed how breast cancer screening in the wider community is viewed from the eyes of 9 Muslim women living in the United States, and how this implicated whether they themselves were screened.

The study consisted of focus groups as a primary means of gathering data and encouraged women to discuss in depth their feelings and attitudes towards breast cancer screening and how their beliefs and customs influenced their actions. Despite a small sample size and the reality that one should not generalise the findings, the information obtained is still worthy of careful consideration."

What the women said:

1. While disease prevention is very important in their culture, none knew of any woman who would visit their doctor on a regular basis.
2. The woman's body is sacred and should not be exposed. The study participants expressed concern over exposing their bodies. For some, this was due to believing that unless there were obvious symptoms of disease, the woman's body should not be exposed, and for others this was due to believing that the health care provider lacked understanding and respect for their religious beliefs, values and customs. The women stated that Muslim women prefer not to remove all of their clothing during a physical examination or medical procedure.
3. Many breast cancer screening programs within their community were not structured in a manner that was consistent with their beliefs and customs. They wanted to maintain their customs and identity and were not keen to blend into American society. A modest environment, and taking things slowly and with understanding would make all the difference. Explanation of all procedures, and giving women time to become mentally ready would help them adjust and feel more part of the process.

4. In choosing a physician to do the examination, the women stated that their first preference would be a female Muslim physician. If this was not available, their next preference would be a male Muslim physician, then a female Christian or Jewish physician. A male physician was the least desired, especially if he was not Muslim. They believed screening programs should be sensitive to this and perhaps provide day of week when only female physicians consulted.
5. The women believed that their customs and beliefs were often either disregarded to health care providers, or were stated clearly, but in the end often ignored.

Issues raised from this article:

- There is a need to educate minority communities more about health risks and promote regular health checks
- There is a need to examine the patient in a way which is sensitive to their culture
- The screening program must be structured specifically for different religions. This included ensuring the language is understandable and the program is adapted to the women's cultural beliefs and values
- There must be an attempt to have more female physicians available on request to do breast examinations
- Physicians must be educated on the needs, beliefs and values of different cultures and religions in our community.

Article 3**Breast self-examination: do religious beliefs matter? A descriptive study. Journal Public Health Medicine June 2003; 25(2): 154-5.**

This study was carried out in Tehran, Iran, where 98% of the women are Muslim. 410 Muslim women were involved.

Some of the findings from this article include:

- 90% of the women said that breast self-examination was not against their beliefs

- 58% of the women preferred to be examined clinically by a female physician, but 47% said that clinical breast examination by a male physician is not against their Islamic beliefs
- 46% of the women believed that they would not be able to detect abnormalities on breast self-examination, however only 6% performed breast self-examination regularly (monthly), and 44% stated they never examine themselves.

Issues raised from this article:

- There is a need for more education about breast cancer amongst Muslim women, especially in Muslim countries
- There is a necessity for breast self-examination in developing countries such as Iran, as mammography may not be as widely accessible.
- Breast self-examination and clinical examination should be regarded as one of the most important public health strategies in the early detection of breast cancer.

Article 4

Jewish identity and intentions to obtain breast cancer screening.
Cultur Divers Ethnic Minor Psychol.
2003 Feb; 9(1) :79-87.

This study was set in Seattle, USA, and explored the concept of religion and culture as potential predictors of intention to seek breast cancer screening.

It found that Jews who are more religious have greater ties to synagogues and other Jewish religious groups, and that these connections may increase their sense of responsibility to adhere to societal rules and comply with normative health behaviors, such as routine mammograms and regular breast self-examination.

The significance in Jewish religious law of health offers another explanation for the association between religion and intention to follow prescribed breast cancer screening behaviors. There is a strong connection between life, health and Judaism that dates back to the Middle Ages. According to religious law, life and health are of

supreme importance. It is therefore possible that Jewish women may adhere to breast cancer screening recommendations out of a religious obligation to lead healthy lives.

Support for these findings is found in the article, "Religious Beliefs and Breast Cancer Screening." *J Women's Health* 2002 11(10). This article suggests that there are implications for the role of religious authority figures and for medical personnel in women's knowledge and decisions about breast health.

Issues raised from these articles:

- Many religious leaders and ministers are not aware that the way in which religious messages are conveyed to women and others has implications for breast cancer screening
- If health practitioners are more aware of the role of religious beliefs in breast cancer screening, they could enlist women's religious beliefs as a supportive influence on women's decisions to pursue screening
- Health professionals could also work with the faith community to promote breast health and instill in women a belief that their faith can complement breast health.

Conclusion

Health care workers must accommodate the beliefs, customs and lifestyles of different religions into the design of breast cancer screening programs or compliance can be significantly affected. It is important for physicians to understand more the customs of different cultures of our community, and implement breast cancer education and screening programs that tailor for different communities. This will, in turn, increase the likelihood of participation.

Question

How can we target women from all cultures and religions, educate them about their risks of breast cancer, and encourage regular self- and clinical breast examination?

Answer

- Educate ethnic minority groups about the risks of breast cancer and the importance of screening, and teach women how to access a female provider.

- Ensure the availability of culturally-specific and sensitive screening programs in both developing and non-developing countries.
- Involve religious authority figures to enlist women's religious beliefs as a supportive influence on women's decisions to pursue screening.
- Educate physicians on the needs, beliefs and values of different cultures and religions in our community. Provide opportunities for both physicians and students to learn how to assess, respect and incorporate patients' religious perspectives.
- Always be sensitive to the cultural and religious needs of the patient. View religion and spirituality not as optional aspects of patient care, but as essential components.

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National Breast Cancer Centre Report

Breast Health Survey

The National Breast Cancer Centre (NBCC) has released the results of its Breast Health survey examining Australian women's knowledge, attitudes and behaviour in relation to breast cancer.

The results of this national telephone survey of more than 3000 women across Australia aged 30 to 69 years reveal a sobering picture of Australian women's lack of knowledge about breast cancer.

The survey showed that many Australian women are confused about risk factors for developing breast cancer. Only half of all women surveyed knew a woman's risk of developing breast cancer increases as she gets older. Even fewer

women (28 percent) thought a family history of breast cancer on their father's side was important in determining their risk of developing the disease.

Other misconceptions included:

- One in three women mistakenly rated a knock or bump to the breast as a big risk factor for developing breast cancer
- Forty-two per cent of all women surveyed mistakenly rated stress as a big risk factor for developing breast cancer.
- One in three women mistakenly thought alcohol posed no risk for developing breast cancer.
- Nearly one quarter of women mistakenly thought being overweight posed no risk for developing breast cancer.

The survey also examined women's knowledge of breast symptoms, finding ten per cent of women were unable to name any potential symptoms of breast cancer – not even a lump.

Of most concern were the results regarding women's attitudes and behaviour about breast symptoms. One in three of the women surveyed who noticed a breast change said they waited more than one month before seeking medical advice. An alarming 23 percent of women did not see a doctor about the symptom at all. The most common reason given for not seeing a doctor was not thinking the change could be due to cancer.

The key finding of the survey are available at www.nbcc.org.au and the full Breast Health Survey Technical Report is available to download from <http://www.nbcc.org.au/bestpractice/>. For more information about the survey, please contact Caroline Nehill on caroline.nehill@nbcc.org.au or (02) 9036 3033.

Public Information Campaign

In response to the concerning results of the Breast Health Survey, the NBCC has developed a new public information campaign. The campaign was launched at the annual Pink Ribbon Breakfast on Monday, 24 October and focuses on the importance of the early detection of breast cancer.

The campaign includes television, radio and print advertisements as well as a series of forums for well women. Eleven Breast Health forums will be held across regional Australia featuring talks by breast cancer experts, celebrity speakers and local breast cancer survivors providing well women with potentially life-saving breast cancer information.

The first two forums will be held in Canberra on Wednesday, 9th November and in Toowoomba on Wednesday, 30th November. For more information about the forums, visit www.nbcc.org.au or contact Fiona Booth on ceo.ea@nbcc.org.au or (02) 9036 3040.

Raising Breast Cancer Awareness Among CALD communities

The NBCC has been working with the Multicultural Health Communication Service to

develop a breast cancer awareness campaign for culturally and linguistically diverse (CALD) communities. By providing linguistically and culturally appropriate information, the campaign aims to increase well women's awareness about breast cancer symptoms and the importance of early detection, encourage women from CALD communities to take appropriate action if they notice a breast change, and assist women diagnosed with breast cancer in making decisions about their treatment and support.

A range of the NBCC's consumer resources are now available in Chinese, Arabic, Vietnamese, Greek and Italian languages. The translated resources are"

- Breast cancer – finding it early could save your life
- Do you have a breast change?
- Information for women with early breast cancer

The resources can be ordered or downloaded online at www.nbcc.org.au/resources or ordered by calling 1800 624 973. The resources can also be ordered through the Cancer Council's Multicultural Cancer Helpline. The National Breast Cancer Centre appreciated the support of the Cancer Council NSW in making this possible.

For more information about the campaign, please contact Jane Salisbury on jane.Salisbury@nbcc.org.au or (02) 9036 3055.

New Clinical Practice Guidelines & Evidence Reviews

The NBCC continues to provide evidence-based guidance to support the management of women with breast and ovarian cancer through review of new research evidence and the development of topic-specific guideline recommendations, with topics prioritized through its Advisory Groups.

The NBCC's clinical practice guidelines recommendations about the use of aromatase inhibitors as adjuvant endocrine therapy for the management of hormone receptor-positive breast cancer in post-menopausal women with breast cancer is nearing completion. In November, a multidisciplinary Working Group will meet in the first steps towards developing national evidence-based clinical practice

guideline recommendations about the use of trastuzumab (Herceptin) for the management of HER-2-positive breast cancer. For more information about the guideline updates, please contact Alison Evans on Alison.evans@nbcc.org.au or (02) 9036 3044.

As part of its ongoing system for reviewing evidence about new treatment and technologies for the management of breast and ovarian cancer, the NBCC is reviewing the evidence around three new technologies for the early detection of breast cancer: magnetic resonance imaging, immunoscintigraphy and ductal lavage. Review topics are determined in consultation with NBCC advisors and other key stakeholders.

Aboriginal and Torres Strait Islander Scholarships

In recognition of the important role that Aboriginal and Torres Strait Island (ATSI) nurses and health workers play in providing information and care to Indigenous women with breast cancer, NBCC recently offered scholarship to support the training of ATSI nurses and health workers in the area of breast cancer. Five scholarships have been awarded to fund activities that will improve knowledge and skills in the area of breast cancer.

Communication Skills Training

Communication skills training remains an important focus for the NBCC. On 18 November, the NBCC is sponsoring a breakfast 'Think Tank' as part of the 32nd Annual Scientific meeting of the Clinical Oncological Society of Australia (COSA) in Brisbane. This meeting will bring together invited national and international experts in communication skills training to discuss effective models and a national approach for communication skills training.

The NBCC is also supporting a communications skills workshop being run jointly by COSA, the American Society for Clinical Oncology and Pam McLean Cancer Communications Centre prior to the COSA meeting on 14-15 November. For further information about any of the NBCC's communication skills initiatives, please contact Caroline Nehill at caroline.nehill@nbcc.org.au or (02) 9036 3033

Ovarian Cancer Update

The Ovarian Cancer Program has made a number of key achievements since its inception, notably the collaborative development of the first Australian clinical practice guidelines for ovarian cancer; the first national guide for women diagnosed with ovarian cancer; and now a guide to assist general practitioners assess symptoms that may be ovarian cancer. The Program has also worked to raise awareness about ovarian cancer nationally and to promote evidence-based messages.

In recognition of its achievements, the Australian Government Department of Health and Ageing provides ongoing funding as part of the core business of the National Breast Cancer Centre. Projects planned for the next 12 months include: the ongoing promotion of best practice for women with ovarian cancer; modification of the NBCC's Principles of Multidisciplinary Care for women with advanced disease; promoting standardized data collection, a national ovarian cancer monitoring report with the Australian Institutes of Health and Welfare; a review of current clinician-based data collections to support the establishment of a national data set; the conduct of a national consumer forum, in collaboration with OvCa Australia; and the adaptation of information about familial aspects of breast and ovarian cancer as an online tool.

The Ovarian Cancer Program will also continue to act as a clearing house for evidence-based information about ovarian cancer for health professionals and consumers through the Ovarian e-upd@te newsletter and the Ovarian Cancer Program website www.ovariancancerprogram.org.au

Training Scholarships on Offer to Improve Care of Local Women with Breast Cancer

The National Breast Cancer Centre is offering scholarships to rural and regional nurses, community health workers and Aboriginal and Torres Strait Islander health workers to further develop their skills in caring for local women with breast cancer.

Thirty per cent of women with breast cancer live in rural and remote areas with nurses and community health workers playing a major role

in maintaining links between the woman's surgeon, oncologist and GP. The scholarships provide the funds to enable nurses and community health workers to attend conferences and participate in continuing education programs to improve their capacity to provide support and care for women with breast cancer in their communities. The scholarships cover expenses such as course registration fees, textbooks, travel and accommodation. All nurses and community health workers based in Tasmania, Northern Territory and the ACT are eligible for the scholarships. In other states, only nurses and community health workers employed in areas other than capital cities or major metropolitan centres are eligible to apply. Community health workers and nurses working in Aboriginal and Torres Strait Islander communities are encouraged to apply. Nurses and community

health workers interested in applying for a scholarship should visit www.breasthealth.com.au/pinkpony or contact the National Breast Cancer Centre on (02) 9036 3030

Applications closed Wednesday, 7 December 2005

The scholarships are funded by Polo Ralph Lauren's 'Pink Pony' initiative and administered by the National Breast Cancer Centre. Over 100 nurses and community health workers across Australia have been awarded scholarships since the program's inception in 2002.

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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.

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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.

Cancer, Sensuality, Sexuality and Self-Image

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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*.

Report of the Cancer Council Australia

Peak Cancer Groups call for Rapid PBS Listing of Life Saving Drug

Results of international trials of the drug Herceptin (trastuzumab) published in October provide strong evidence to support a listing under the Pharmaceutical Benefits Scheme, according to peak cancer organizations The Cancer Council Australia and the Clinical Oncological Society of Australia.

The Cancer Council's Chief Executive Officer, Professor Alan Coates, said rapid listing on the PBS would mean about 2000 women in Australia each year who were diagnosed with HER-2 positive breast cancer, a particularly aggressive form of cancer, could benefit from the treatment.

"The results of the HERA (HERceptin Adjuvant) study published today in the New England Journal of Medicine show that combining standard chemotherapy with Herceptin reduces disease recurrence in women with early stage HER2-positive breast cancer by 46 per cent, which is a remarkable achievement", Professor Coates said. "Similar results were obtained in two North American studies."

Professor Coates, who also chairs the Australian New Zealand Breast Cancer Trials Group Scientific Advisory Committee, said HERA was one of the biggest studies ever conducted, with

more than 5000 patients in 39 countries including Australia.

He urged the Therapeutic Goods Administration (TGA) to implement a "rapid assessment" of the results with a view to approving the indication. This needed to be done in tandem with an assessment by the Pharmaceutical Benefits Advisory Committee (PBAC) so Herceptin could be listed as quickly as possible. "One way to fast-track this process would be for both organizations to do a parallel assessment," Professor Coates said.

President of the Clinical Oncological Society of Australia (COSA), Dr Stephen Ackland, said all three trials had shown "outstanding results."

"The reduction in risk of recurrence is greater than any other treatment studied in the 30-year history of clinical trials of adjuvant therapy in breast cancer," Dr Ackland said. "These results provide a compelling argument for early consideration by both the TGA and PBAC."

Dr Ackland said it was important to stress that the evidence of Herceptin's efficacy currently applied only to women with HER2-positive breast cancer, who comprised 15-20 percent of all women with breast cancer.

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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.

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.