



Breast Cancer Update

Issue 58 July 2007

- St Gallen Meeting Report
- ASCO Meeting Report
- World First Cancer gene program launched
- Life after Cancer
- Survivorship



BREAST CANCER UPDATE

Issue 58

July 2007

Contents

Editorial	3
The Language of 'survivorship': A Personal Reflection	4
BreaCan - Gynaecological and Breast Cancer Support	5
World-first cancer gene support program launched	6
Surviving Breast Cancer	7
Life After Cancer	7
Multi Lingual Website	8
Reflections of ASCO 2007; an oncology registrar's experience.	9
St Gallen Meeting Report	11
ANZ BCTG Clinical Trials	14
Australian New Zealand Breast Trials Group: Trial Accrual Summary	17
TROG Breast Trials Summary	18
Extracts from Wongi Yabber, May 2007	18
Key Published Articles Listing – Breast Cancer	22
Forthcoming Meetings	23

This newsletter is produced by The Cancer Council Victoria's VCOG 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, lung, skin and urological cancers also produce twice yearly cancer updates.

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

***** **Last Issue – No. 57 – January 2007** *****

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 / Maroondah Hospitals*

The theme for our July 2007 issue is cancer “survivorship”. This term is intended to encompass the vast array of situations that people find themselves in after their active (and hopefully curative) cancer treatment has been completed. It is a topical issue, with many difficult connotations, and considerable recent work. A beautiful and erudite consumer view on the subject is presented by Rosetta Manasczewicz. She points out the “added meaning” (which by definition is individual, multitudinous and the responsibility of the interpreter) attached by many of us to the term survivorship, making it a sub-optimal word in some eyes, for the much needed and valuable work that has recently been undertaken in this area. Unfortunately Rosetta does not present an alternative word and despite a lot of thought, I also cannot suggest a better word. The work done by Doreen Akkerman and others with the Cancer Council on Survivorship, intended to support patients and carers is fantastic, and I am sure has (and will) provide a great deal of needed assistance and explanation to patients who are struggling to “get back to normal” after their cancer treatment. In the realm of breast cancer, the statistics continue to improve, with the government releasing figures in April showing a 23% improvement in mortality from Breast Cancer since 1990 despite an increasing incidence. The new Cancer Council booklet “Life after cancer” should be made available to as many patients as possible, to assist in the adjustment to a cancer diagnosis, especially at the most vulnerable time when active treatment has been completed. I also hear that the Cancer Helpline is not well advertised among our patients, and that this is a much valued resource by many. I have to say, after much thought, that the term “cancer survivor” does adequately describe the situation that needs to be considered in developing best care for patients, and until a better terminology is developed, I would counsel that an over-interpretive attitude to terminology is counterproductive to the development of worthwhile and innovative care improvements. After all the various dictionary definitions

describe a survivor as a person who continues to live or exist especially after coming close to dying or being destroyed or after being in a difficult or threatening situation. Other attached meanings are not mentioned – these belong to the people who criticize the use of the word. Personally, I am very pleased to see the work that has been undertaken to date, and would anticipate rewards for my patients, and indeed myself, with assistance in explanation, answering of questions and provision of support for patients and their families.

This issue also contains conference reports (St. Gallen and ASCO) to remind us of all the new data that influences our daily care of patients. Despite the already impressive mortality reductions in breast cancer (see the graph in the recent ASCO report by Rachel Roberts-Thompson), there is clearly much more to come with the targeted treatments, their combinations with chemo and other targeted agents, and the molecular (gene array) prediction of response to treatment as well as prognosis. Our aim must be to individualise treatment, thus minimizing unnecessary toxicity, providing the most efficacious treatment and taking best care of psychosocial needs including in follow up.

I would like to remind you that opinions for discussion (from the current issue or otherwise) are keenly received for publication in the next issue. I would like to continue the “Survivorship” theme in the next issue and introduce another topical issue for discussion and comment - the relationship between clinicians (especially clinical trialists) and the pharmaceutical industry. I invite comments and articles for inclusion in the next issue due in January 2008. (please contribute generously!!)

Thank you!!

Jacquie Chirgwin

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:

The Editor, Breast Cancer Update
C/- Centre for Clinical Research in Cancer
The Cancer Council Victoria
1 Rathdowne Street
CARLTON VIC 3053
Philippa.Davis@cancervic.org.au

The Language of 'survivorship': A Personal Reflection

Rosetta Manaszewicz

Consumer representative - VCOG Breast Cancer Committee

First, a confession. The following is written in the hope that it evokes some response. If you disagree with the views expressed, then please let us know why. Let's begin a dialogue that explores an important issue; let's put our heads together and try to forge a new language. Let's take the initiative and define ourselves, rather than allow others to define us!

The first time I heard the phrase "breast cancer survivor", I remember wincing. It jarred, evoking images of battle scarred lines of spectre-like women. The reaction was instinctual, atavistic, yet on reflection, revealing - especially now, when I've "earned my stripes" and been inducted into the burgeoning ranks of "survivorship".

I guess what made me wince was the fact that the term reverberated against two long held and indivisible prejudices - my loathing of labels and my reverence for language. For me, the latter has always signified intellectual freedom; the former, a shackling of thought. Sadly, 'survivorship' appears to have entered the domain of reductionist political correctness, where all the nuances of the term lose their sharpness and focus, to be replaced by a slogan-like abdication of meaning. By adopting such a label are we really doing ourselves a favour? Admittedly, part of the message is therapeutic: people can and do survive - we do not all perish as a result of cancer. Yet, is this enough to counter-balance all the other connotations?

I began with the deliberate image of battle. Cancer is invariably perceived as a 'fight to the finish'. The survivor is the one who by sheer luck, strength of will, courage, fortitude, or whatever, has managed to defeat the foe. The credit implicitly resides with the individual. Often they assume almost mythic status - superheroes who have fought the good fight and won! But what of those who have 'succumbed' - who were not 'successful'? Are they failures to be scorned because they lacked the necessary 'will to fight', or were too 'weak'? By donning the mantle of survivor are we not obscuring the incredible uniqueness and range of experiences encompassed throughout each individual's cancer journey? Are we not muffling the richness of our combined voices in favour of a muted, colourless stereotype?

Language never operates in a vacuum. It is a mirror of our mental and moral landscapes, indelible signposts of our cultural, social and

political values. What terms we use to describe each other and ourselves often determines how we think, feel, and even act. After all, isn't history literally littered with the corpses of racial and religious 'labeling'? Susan Sontag has eloquently described the power of language and its public role in portraying cancer and AIDS - "Any important disease whose causality is murky, and for which treatment is ineffectual, tends to be awash in significance....the disease itself becomes a metaphor. Then in the name of the disease....that horror is imposed on other things. The disease becomes adjectival....(and) is projected onto the world."¹

Science, for all its remarkable achievements, still has not come up with the 'answer' to cancer. In the public mind at least, cancer remains an insidious disease, striking at random, old and young, rich and famous. It is the ultimate nemesis - lethal, unpredictable, ravaging, and unconquerable. Its continued existence and growing incidence an unwelcome reminder of our powerlessness and uncertain futures. Why else would there have been a need for the "Cancer is a *word*, not a *sentence*" campaign of not so long ago? Even here, the language, despite its clever punning and intended message of hope, falls victim to the very preconception it hopes to dispel. "Sentence" implies judgement, punishment, retribution. Those with cancer become the 'criminal' in the dock. Their 'crime'? Having the misfortune to embody all that we fear and are unable to control.

If the 20th century signifies anything, then it is the hegemony of science and technology. Diseases which decimated our ancestors are now a thing of the past, thanks to our genius. Life expectancy has soared; health and happiness are automatic 'rights'. Our technological age has (or will) master the heavens, nature, human reproduction, all aberrations of the spirit. But it has consistently failed to master cancer. Hence the horror. It strikes at our core, denies our supremacy, and oh so cruelly reminds us of our mortality. For a hedonistic, largely secular society, brought up on the triple godhead of science, rationalism, and

individuality, such knowledge is anathema.

One has only to announce they have been diagnosed with cancer to witness the hushed, somber response. The impact of saying "I have breast cancer" is vastly different to proclaiming "I have heart trouble". Anatole Broyard vividly captures the awe of the aftermath - "The way my friends have rallied around me is wonderful. They remind me of a flock of birds rising from a body of water into the sunset. If that image seems a bit extravagant or tinged with satire, it's because I can't help thinking there's something comical about my friends' behaviour - all these witty men suddenly saying pious, inspirational things.....(they) are sobered. Since I refuse to, they've taken on the responsibility of being serious. They appear abashed or chagrined in their sobriety. Stripped of their playfulness these pals of mine seem plainer, homelier - even older. It's as if they had all gone bald overnight".²

If we accept that "the social context shapes and creates (the) illness experience"³, what impact and value does the term 'survivor' or 'survivorship' have? Finding a strict definition is hard. Lifton, who explored the trauma of life after the atom bomb in Hiroshima, defined survivor as one who "has touched, witnessed, encountered, or been immersed in death in a literal or symbolic way and has himself/herself remained alive...."⁴ The recently created National Cancer Institute's *Office of Survivorship* (1996) in the United States, views a survivor somewhat differently. - "An individual is considered a cancer survivor from the time of diagnosis, through the balance of his or her life. Family members, friends, and caregivers are also impacted by the survivorship experience and are therefore included in this definition."⁵ Not only has the term received myriad interpretations, it has also fallen prey to either the empiricists on the one hand, who are determined to quantify everything, or the post-modernist tradition of inducting relative 'truths', usually from qualitative studies of personal narratives.

Neither approach deals adequately with the complexity of the issues. For instance, how does a 'survivor' feel two years post-diagnosis, compared with someone at ten or 12 years? Are their emotional, psychological, physical and even spiritual needs the same? Is the passage of time the sole determinant of possible differences? In other words, what role does physical disability, cultural background, or psychological makeup have on 'survivorship'?

Seen in this context the term 'survivorship' becomes almost meaningless. Rather than clarifying and elucidating what it means to have experienced cancer at any point in time, the term obliterates all individual differences and diversities. Once again, Broyard's words speak volumes - "...I'd like my doctor(and others) to scan me, to grope for my spirit as well as my....(cancer). Without some such recognition, I am nothing but my illness."⁶

We need a language that focuses on more than the 'illness'; that recognizes and protects that 'delicious fecundity' of individual experience.

Rosetta Manaszewicz

References

- ¹ Sontag, Susan - *Illness as metaphor and AIDS and its Metaphors*, New York: Doubleday, 1989, p.58
- ² Broyard, Anatole - *Intoxicated by my illness and other writings on life and death*, New York: Clarkson-Potter, 1992, pp.5-6
- ³ Thorne, Sally E. - "the Science of meaning in chronic illness", *International Journal of Nursing Studies*, Vol.19(4), 1997, p.397
- ⁴ Lifton, R.J - *Death in Life: The Survivors of Hiroshima*, London: Weidenfeld & Nicolson, 1968, p.28
- ⁵ National Cancer Institute - *Office of Cancer Survivorship*, -<http://dccps.nci.nih.gov/ocs/definitions.html>
- ⁶ Broyard, Anatole - op,cit, - p.45

BreaCan - Gynaecological and Breast Cancer Support

As some of you may already know, on 1st May 2007 BreaCan opened its doors to women with gynaecological cancers.

As part of our ongoing funding with the

Department of Human Services it was agreed that women with gynaecological cancers should also be able to access the resources BreaCan has traditionally provided to women with breast cancer.

Our service focuses on the psycho-social, emotional and practical issues that women and their families are faced with when diagnosed with breast or a gynaecological cancer as well as the day to day issues of living with such a disease

Initially BreaCan will focus on providing an **information service** to women with gynaecological cancers. Women can access a range of information, borrow from our expanded library and attend information and group sessions specifically for them or in combination with women with breast cancer.

Prior to our expansion, we undertook a comprehensive consultation process with women with gynaecological cancers, service providers and other stakeholders to identify how we can best meet the needs of women within the scope of our service. The information gained has been

collated, if you would like a copy of this report please contact us on 1300 781 500.

BreaCan is committed to implementing a comprehensive strategy to address the issue of branding including our name which will take place over the next twelve months.

If you would like to find out more about BreaCan's expansion please contact Di Missen on 9921 0833 or Sacha L'Huillier on 9921 0837 or visit our website www.breacan.org.au.

World-first cancer gene support program launched

Sophy Chirnside

Communications and Resource Officer

Cancer Information Support Services

Cancer Council Victoria

The Cancer Council Victoria has launched a world-first telephone support program for people who carry genes that may increase their risk of developing cancer.

The Gene Support program will enable someone who has been tested and found to carry a cancer susceptibility gene to speak to a volunteer in a similar situation. This program has been developed in conjunction with the Peter MacCallum Cancer Centre and Victorian Familial Cancer Centres.

Dr Michael Jefford, Clinical Consultant for the Cancer Information and Support Service at The Cancer Council Victoria said results from recent research highlighted the need for such a support service:

"It can be frightening to discover you carry a gene that increases your risk of developing cancer. People face a range of feelings and treatment decisions and feelings of distress are common. Speaking to a Gene Support volunteer is likely to alleviate some of these concerns," said Dr Jefford.

Gene Support volunteers are men and women who carry cancer susceptibility genes and have been trained to help others feel less worried. This extends the services of the Cancer Council's 'Cancer Connect' program.

Dr Jefford urges GP's to refer people who carry the cancer susceptibility gene to this new support service:

"We know from research how helpful it is to talk to someone who has been through a similar experience. People simply call the Cancer Council Helpline on 13 11 20 to talk to a volunteer. A cancer nurse will match the caller to a volunteer who will call at home at a convenient time," said Dr Jefford.

For more information, call the Cancer Council Helpline on 13 11 20.

Surviving Breast Cancer

Doreen Akkerman, AM

*Head, Cancer Information and Support Service
The Cancer Council Victoria*

A diagnosis of breast cancer often has both a psychological and physical impact and treatment may leave women with long-term issues. When first diagnosed with breast cancer, survival is one of the main concerns and often overshadows everything else. Most women will live for many years after a diagnosis of breast cancer with their cancer treated, managed and controlled. Therefore, quality of life becomes very important, and at the time of planning treatment the effect(s) of surgery, chemotherapy, radiotherapy and hormone therapy on the individual, and on the family, should be discussed.

Improving self-esteem:

Images of women's breasts are often used in advertising today. Breasts are equated with desirability, so it is not surprising that scarring or the loss of any part of a woman's breast may cause emotional distress. It is important for women to realise that they are loved for their personal qualities, rather than only for physical attributes. Ongoing fatigue and anxiety can create a feeling of unwellness as well as being more sensitive to changes. Women should be encouraged to communicate feelings to their partner, friends and family, this often leads to them being reassured of the important place they hold in other's lives.

Research has shown that the partnerships of couples coping with breast cancer are no more likely to end than those couples in the general population. Whilst many women state that their partners and family are a significant source of support, it is important to discuss issues and concerns that may be affecting relationships.

Acceptance by her partner of the loss of a breast does not always help a woman to personally adjust to her breast loss. Adapting to changes in body image takes time and ongoing residual side effects from treatment or ongoing hormone therapy can have an impact on daily living. Women should be encouraged to discuss those feelings and issues with their clinician or the Breast Care Nurse.

A cancer diagnosis often makes us look at our lives more intensely and take stock of all that is important to us. If you consider your patient is experiencing difficulties in coping with their diagnosis, treatment or personal relationships consider referral to professional counselling.

Information and support:

Call the Cancer Helpline 13 11 20 Monday-Friday 8:30am-8pm

The Cancer Council Victoria has produced a booklet for long-term cancer survivors called "***Life after cancer-a guide for cancer survivors.***" Peter MacCallum Cancer Centre has produced a DVD called "***Just take it a day at a time-a guide for surviving cancer.***" These resources discuss and offer strategies for ongoing wellbeing after a cancer experience. Both may be obtained, cost free, by calling 13 11 20.

The **Breast Cancer Support Service** can link women with another woman who has had the same treatment for one to one peer support or with a support group.

Life After Cancer

Sophy Chirnside

*Communications and Resource Manager
Cancer Information and Support Service
The Cancer Council Victoria*

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

body part, changes to their sexuality and fatigue. The Cancer Council Victoria is at the forefront of addressing issues for cancer survivors. We are developing a new program for cancer survivors to help them address some of these issues.

This program has been developed following recommendations from cancer survivors who attended a special Cancer Council seminar in November 2006. At this seminar, survivors and their family were asked to discuss what they felt was missing at diagnosis and highlight how we could best support them through their cancer experience. Their recommendations were as follows:

Information

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

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

Support

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

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

Practical and financial issues

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

strategies.

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

Education

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

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

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

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

Multi Lingual Website

Jennifer Cottrell

*Cancer Education Programs Project Officer
Cancer Council Victoria*

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

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

This information is provided in an easy to read factsheet format that can be downloaded for free. Factsheet topics vary from diagnosis and support, to early detection messages. English versions of all factsheets are also available.

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

Cancer Information and Support Service New Initiatives

Robyn Metcalfe

Cancer Services Promotions Coordinator

Cancer Information Support Services

Cancer Council Victoria

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

Some of the important messages for promoting the service are:

- The Cancer Helpline calls are answered by qualified cancer nurses all with post graduate oncology experience
- The service aims to complement the patient/Doctor relationship
- The extended hours of the service are 8 am- 8.30 pm Monday to Friday on 13 11 20
- The service is for specialists, general practitioners, patients, their carers and the general public
- The Multilingual Cancer Information Line is available with access to interpreters in 80 languages. For details about the multilingual line and resources in different languages visit www.cancervic.org.au/multilingual

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

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

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

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

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

Reflections of ASCO 2007; an oncology registrar's experience.

Dr Rachel Roberts-Thomas

Registrar

The Royal Melbourne Hospital

American Society of Clinical Oncology's (ASCO) annual conference was held in Chicago, Illinois. I had the privilege to attend. My first international conference was an inspiring experience and a wonderful learning opportunity. The sea of people that constituted the delegates (rumoured to number approximately 25,000), wandered between the conference halls attending all that was on offer.

Sir Richard Peto from Oxford University illustrated the advances in the treatment of breast cancer with a graph (see below). This graph showed a significant decline in mortality over the years from the addition of radiotherapy, hormone therapy and chemotherapy to the treatment of breast cancer. The advances from the use of Trastuzumab were yet to be reflected in this. It was impressive and positive to view this.

The oral abstract sessions were particularly interesting. In the adjuvant setting, Dewar presented the START data (Abstract LBA 518) on hypofractionation for early breast cancer. The START A study randomised patients to 39 gray (Gy), 13 fractions (Fr) over 5 weeks or to 50Gy with 25Fr or to 41.6Gy in 13Fr. With a median follow up of 5.1 years, there was no significant difference in locoregional relapse. Fewer problems with skin and breast appearance as well as swelling occurred in the group receiving less radiotherapy. The START B randomised patients to 50Gy over 5 weeks or 40Gy over 3 weeks. Locoregional relapse was lower in the 40Gy group. Hypofractionation may prove an resource saving alternative regimen but of course caution should be advised in terms of development of long term side effects from radiotherapy.

Rastogi presented the 5 year cardiotoxicity data from the NSABP trial (Abstract LBA 513) of doxorubicin/cyclophosphamide (AC) followed by paclitaxel (P) versus AC followed by P and trastuzumab in HER2 positive patients with breast cancer. Cardiac events occurred in 0.9% of patients in the control group versus 3.8% in the trastuzumab group. These figures were similar to those at 3 years (0.8% vs 4.1%). Risk factors for cardiotoxicity were stated to be age > 49, hypertension requiring treatment and post AC ejection fraction < 54%. Storniolo (Abstract 514) concluded that their group did not consider the combination of lapatinib and trastuzumab to constitute a serious incremental cardiac risk; experience is still limited. The story of cardiotoxicity is still incomplete but further data helps with better understanding.

In the metastatic setting many abstracts were presented the majority focussing on the role of tumour growth factors and the optimal use of taxanes. The Anglo-Celtic Protocol IV trial was presented comparing weekly with 3 weekly paclitaxel. Response rates were greater in the weekly paclitaxel group (27% vs 42%, p=0.002) but no difference was found between overall survival and toxicity (Abstract LBA 1005).

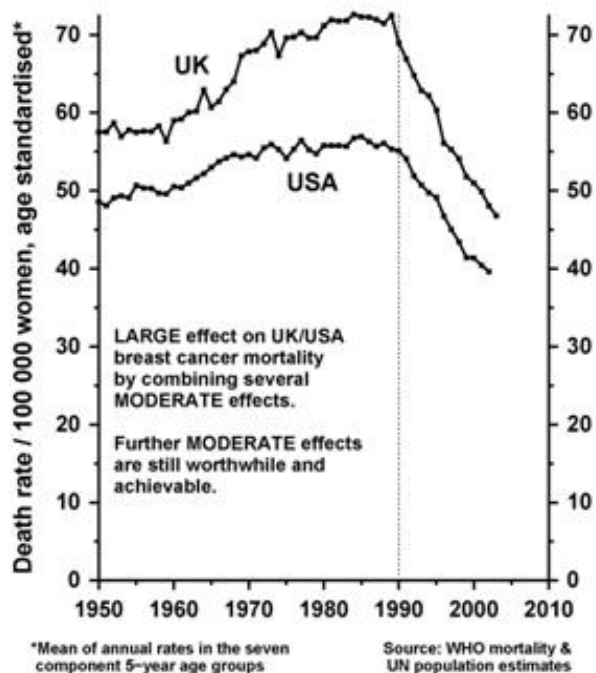
BCIRG group, protocol 007 was presented on 263 patients with HER 2 FISH positive breast cancer randomised to docetaxel (100mg/m²) and trastuzumab versus docetaxel (75mg/m²), carboplatin(AUC=6) and trastuzumab. Two patients died of sepsis in the TCH group (1.5%). At 39 months of follow up, there was no difference in overall survival. Time to progression and overall response rates were similar.

Angelo Di Leo (Abstract 1011) presented a trial comparing lapatinib and paclitaxel (175mg/m²) with placebo and paclitaxel. 580 women were randomised and their HER2 status was unknown. Side effects were greater in the lapatinib group of women. Response rates were better in the combined arm but not overall survival. Tissue blocks were retrospectively tested for HER 2 status. HER 2 positive women had a much improved response rate and a trend towards better overall survival. Interestingly, the paclitaxel and lapatinib combination resulted in increased area under the curve for both drugs by 20%.

Lin reported on the EGF 105084 data – a Phase II trial of lapatinib in HER2 positive women with brain metastases, following trastuzumab and whole brain radiotherapy. 19% of the 238 patients achieved more than 20% reduction in brain tumour burden. This suggests activity of lapatinib in patients with brain metastases.

Overall there are many positive steps forward in the management of women with breast cancer at ASCO 2007. Also an “eye opener” for a second year oncology registrar experiencing her first international oncology conference!

UK/USA, 1950–2003/2: recent decrease in breast cancer mortality at ages 35–69



References:

1. Anglo-Celtic IV: First results of a UK National Cancer Research Network randomised phase III pharmacogenetic trial of weekly versus 3 weekly paclitaxel in patients with locally advanced or metastatic breast cancer (ABC). (Abstract #LBA 1005); M.V. Verrill, J.Lee, D.A. Cameron et al.
2. BCIRG 007: First overall survival analysis of randomised phase III trial of trastuzumab plus docetaxel with or without carboplatin as first line therapy in Her 2 amplified metastatic breast cancer (MBC). (Abstract #LBA 1008); M.Pegram, J.Forbes, T. Pienkowski et al.
3. Lapatinib (L) with paclitaxel compared to paclitaxel as first line treatment for patients with metastatic breast cancer: A phase III randomised double blind study of 580 patients. (Abstract #1011); A. Di Leo, H.Gomez, Z. Aziz et al.
4. EGF 105084, a phase II study of lapatinib for brain metastases in patients (pts) with Her 2 + breast cancer following trastuzumab (H) based systemic therapy and cranial radiotherapy (RT). (Abstract #1012); N.U.Lin, V.Dieras, D.Paul et al.
5. Five year update of cardiac dysfunction on NSABP B-31, a randomised trial of sequential doxorubicin/cyclophosphamide (AC) -> paclitaxel (T) vs. AC -> T with trastuzumab (H). (Abstract #LBA513); P. Rastogi, J.Jeong, C.E. Geyer et al.
6. Cardiac safety in patients (pts) with metastatic breast cancer (MBC) treated with lapatinib (L) and trastuzumab (TRA). Abstract #514); A.M.Storniolo, M. Koehler, A.Preston et al.
7. Hypofractionation for early breast cancer: First results of the UK standardization of breast radiotherapy (START) trials. (Abstract #LBA518); J.A.Dewar, J.S. Haviland, R.K. Agarwal et al.

St Gallen Meeting Report

Dr Shirley Wong - Western Hospital

Dr Serene Foo - Austin Health

The following report on St Gallen is a combined report from Drs Shirley Wong (Western Hospital) and Serene Foo (Austin Health). Shirley discusses DCIS, cognitive decline and male breast cancers while Serene reports on the complexities of ER and Her2 targets.

It really was impossible saying "No" to Jacqui's request to do an update for the VCOG Breast Cancer update whilst having champagne in hand at dinner on the very first night of the St Gallen Primary Therapy of Early Breast Cancer 2007. Despite warnings about how bitterly cold it would be, March turned out to be a beautiful and sunny time for the meeting. Although a long trip by anyone's standards, St Gallen was a lovely and romantic town, and the chocolates were worth dying for. The hotel we stayed at sat next to Lake Constance (the third largest lake in Europe) and the view was absolutely beautiful.

One of the strong themes at this meeting was "aiming at the target" and Martine Piccart pleaded

with the audience to reconsider the "old" treatment paradigm of treating according to risk but instead to try and treat according to the "target" instead. Hence more emphasis of individual characteristics such as Her2 responsiveness, ER and PR positivity but also extent of hormone responsiveness etc etc.

Kent Osborne gave a fascinating talk entitled "Blocking crosstalk between ER and growth factor receptors to circumvent endocrine resistance". There is increasing evidence of significant interactions between ER and Her2 receptors and both ER and Her2 signalling can activate each other functionally. Her2 downregulates ER/PR expression so that ER and PR are expressed at lower levels in Her2+ve tumours. In a small study of 10 pts with Her 2 +ve/ ER -ve metastatic disease treated with weekly herceptin, rebiopsy showed that 3/10 pts became ER+ve after 9, 12 and 37 weeks. 2/3 pts were then treated with letrozole with 1 PR including 1 with sig clinical benefit. Similarly, ER decreases the expression of Her2

thus explaining why ER+ tumors tend to be Her2 –ve. There is some data that shows that acquired resistance to tamoxifen is associated with increased levels of EGFR and Her2 in preclinical models. Her2 serum conversion in patients was also discussed. In a study of 240 pts with metastatic disease, serum Her2 levels were measured both at the start and at disease progression. All patients were negative for Her2 at the start and treated with tamoxifen or letrozole. 61/240 (26%) converted to Her2+ve at disease progression (32/129 or 25% treated with tamoxifen and 29/111 or 26% treated with letrozole). Median survival from start of treatment was 47.8mths in those who remained Her2-ve whilst those who converted to Her2+ve had a poorer median survival of 26.5months. In summary, blocking ER can increase Her2 which may contribute to resistance to endocrine therapy and conversely blocking Her2 can increase ER which could contribute to resistance to Her2 targeted therapy. So in this era of targeted therapy we should have a low threshold to rebiopsy patients before changing therapy.

In a session on male breast cancer given by Jonas Bergh from Sweden, there was also a similar message with up to 29% discordance on ER and PR expression in primary and metastatic lesions upon rebiopsy (both initially ER-ve becoming ER+ve, and vice versa), once again stressing that a conversion in hormone responsiveness may not be as rare as previously assumed. Male breast cancer-specific survival is worse than in women. Greater than 90% are invasive ductal carcinoma, most are stage III and IV, 90% ER positive, 77% PgR positive, 60% node positive and 46% more than four nodes involved. There is a lack of data from randomized controlled trials but AC based chemotherapy remains the standard therapy. Historically, results from orchidectomy, adrenalectomy and anti-androgen therapy are disappointing with RR of 35 to 70%. Tamoxifen is the standard hormonal treatment and aromatase inhibitors have not been shown to sufficiently decrease oestradiol level in males. Higher doses of AI or in combination with GnRH may be indicated and as yet, the role of herceptin remains unclear.

Another session on “Combining adjuvant chemotherapy and biologicals” gave further insight into the complexity of disease and treatment. In an analysis of the DFS in N9831 as a function of Her2 overexpression or amplification, some interesting results were seen.

IHC 3+	#pts	HR	
FISH+ve	1170	0.42 (0.27-0.64)	p=sig
FISH–ve	51	0.71 (0.04-11.79)	p=NS
FISH unknown	51	0.69 (0.09-5.14)	p=NS
IHC 0/1/2 and FISH+ve	174	1.01(0.18-5.6)	p=NS

A number of mechanisms of resistance to herceptin has been postulated in the preclinical setting including co-expression of IGF-1R, pTEN deficiency, truncated Her 2, Her 2/3 heterodimers, p27 loss etc – these have yet to be validated in the clinical setting. At this stage, Edith Perez cautioned that the numbers in each of the other groups were too small to change clinical practice but is definitely food for thought!

Another theme that came through again at this meeting is to be cautious about changing our clinical practice with early interim trial results. One such example is the initial suggestion in BCIRG 006 that Her 2+ve pts with co-amplification of topo II (~30%) may be the subset of patients that do better with an anthracycline as part of their adjuvant chemotherapy but the most recent update with 36mths follow up has failed to show any difference.

Monica Morrow from the US gave a brilliant talk on major dilemmas of DCIS. The well-known dilemma of this topic is which patients will progress. The natural history remains poorly understood and invasive cancers cannot be excluded unless completely excised. If DCIS is a precursor lesion, then radiotherapy or surgery is indicated. If however, DCIS represents a risk marker then excision followed by tamoxifen or observation is indicated. A meta-analysis of 21 studies of >1500 patients treated with mastectomy for DCIS, found a local recurrence rate of 1.4%, so radical surgery such as mastectomy may not be justified. A number of randomized controlled trials of the effect of radiation after wide local excision surgery in patients with DCIS (NSABP B17, EORTC and UK and Swedish studies) have all shown similar findings of a near 50% reduction of recurrence of DCIS and invasive cancer in the ipsilateral breast with radiation. However, the pitfalls of the trials were the lack of post-excision mammography to assess calcification, the impact of margin width were not reported and the lack of

detailed pathological assessment. Two large trials (Dana Farber prospective trial and ECOG E5194) looked into the value of post surgery radiation if the excision margin is \leq 10mm (i.e. wide excision alone for DCIS). Tamoxifen was added after surgery in some patients in the trials. The results have shown a recurrence rate of 14% at 5 years in high grade DCIS and 4% at 5 years in low grade DCIS, but then by 10 years they became similar suggesting that lower grade DCIS is associated with later recurrence. High rate of recurrence was shown if using tamoxifen alone in ER positive DCIS without excision or if positive surgical margin. Interestingly when it comes to decision in management of DCIS, the study showed patient perception was more influential than surgeon recommendation.

An interesting lecture was the topic of Cognitive Decline in Chemotherapy Patients. It was presented by Harold J Burstein from USA. Various self-reported cognitive decline after chemotherapy were reported included concentration deficit, memory impairment and space-out. It was difficult to assess the magnitude of the problem due to few factors: cognitive dysfunction in multiple domains, variable association with other neuropsychiatric disorders, poor association with testing assessment and cognitive dysfunction improve over time. To make it even more complicated, there were some concerns: "baseline" always defined as after cancer diagnosis or after chemotherapy, complex cognitive testing, subjective findings not correlative with neuropsychiatric testing findings and cofounders such as medications and hormonal treatments. No consistent specific abnormal findings were shown in MRI or PET scan. In summary, cognitive side-effects of chemotherapy are a real problem but origin, definition, nature and significance was still poorly understood, multiple cofounders make it even harder for easy characterization or intervention. More studies are needed.

The last day of the meeting was "the Breast Cancer Experts" panel: seeking consensus on evidence and opinions about optimal treatment of early breast cancer". It started off with a wishlist of sorts via a program initiated in 2006 to identify through international consensus, the ten top priorities in translational research in breast cancer. Votes via a website (www.toptenresearch.org) were invited on a consolidated list of 70 proposals, selected by a steering committee from an original list of 400. The voting response yielded 2,520 in total, from 420 voters in 61 different countries.

The top ten research priorities in translational research in breast cancer are as follows:

- 1) Identification of molecular signatures to select patients who could be spared chemotherapy.
- 2) Identification of molecular features which indicate the optimal chemotherapy regimen (eg combination or sequential, anthracycline or not, taxane or not).
- 3) Determination of the factors in DCIS and/or ADH leading to progression into invasive carcinoma
- 4) Determination of the role of stem cells in breast cancer development, progression and treatment sensitivity
- 5) Identification of response/resistance mechanisms and thereby therapeutic targets for triple negative breast cancer
- 6) Development of a system (computer etc) that will integrate all the information so far gathered about breast cancer to build robust models for understanding the aetiopathogenesis, treatment and prognosis of breast cancer.
- 7) Identification of which low risk patients require NO adjuvant therapy.
- 8) Determination of whether other growth factor pathways are important targets for therapy such as EGFR, IGFR, Notch, Hedeghog, Wnt and other angiogenic pathways
- 9) Investigation of which gene mutations in a cancer lead to metastases
- 10) Identification of drugable targets that can be developed/ exploited for therapeutic gain to overcome primary/secondary endocrine resistance.

The list demonstrates how around the world, there is consensus that the way forward lies in the era of molecular signature and signalling pathways. But the rest of the discussion that morning failed to reach any consensus and it will be interesting to see the publication that will follow later.

ANZ BCTG Clinical Trials

Extracted from Newsletter – Issue 8, June 2007

PREVENTION TRIALS AND LOCAL TREATMENT

ANZ 02P2 (IBIS-II)

Status: Open to Accrual

An international multi-centre trial of anastrozole vs placebo in postmenopausal women at increased risk of breast cancer and tamoxifen vs anastrozole in postmenopausal women with hormone sensitive DCIS.

ANZ BCTG Study Chair:

Prof John F Forbes

ANZ BCTG Institutions Activated:

Prevention - 21

DCIS - 20

Bone - 11

International Target Accrual:

Prevention - 6000

DCIS - 4000

Bone Substudy - 1000

There are several more sites pending activation to the IBISII trial and accrual is gaining momentum. A recent decision taken by the international IBIS-II Steering Committee has the potential to increase accrual. A protocol addendum, soon to be released by CR-UK, will expand current eligibility criteria to permit the entry of women who have been off trial therapy for at least five years on the IBIS-I study, provided these women meet IBIS-II entry criteria.

We encourage all sites to utilise the IBIS-II Recruitment Database (<https://www.anzbctg.org/recruitment>) to assist in accruing patients to this study. Further amendments to IBIS-II protocols will be released in the near future. So far in Australia and New Zealand 89 patients have been randomised to IBIS-II Prevention, 21 to IBIS-II DCIS and 22 to the Bone Substudy.

TREATMENT TRIALS

ANZ 0502 (NeoGem)

Status: Open to Accrual

A phase II trial evaluating the efficacy and safety of epirubicin and cyclophosphamide (EC) followed by docetaxel with gemcitabine (DG) (+

trastuzumab if HER2-positive) as neoadjuvant chemotherapy for women with large operable or locally advanced breast carcinoma.

ANZ BCTG Study Chair:

Dr Nicole McCarthy

ANZ BCTG Institutions Activated:

12 (31st May 2007)

ANZ BCTG Target Accrual:

84 HER2-negative

63 HER2-positive

This study is designed for patients with newly diagnosed operable primary breast cancer, clinically (and/or, on ultrasound), T2 (= 3 cm, only) T3-4, N0-1, M0 and considered operable at first presentation.

The main objective of this study is to evaluate pathologic complete response rates of the primary breast tumour following treatment with 4 cycles of EC and 4 cycles of DG or DGT for

HER2-positive patients. It is anticipated that the target accrual will be completed within a period of two years.

Prior to registration to the study, HER2 assessments must be performed using CISH analysis at a certified reference laboratory. Assessment of HER2 overexpression via IHC is no longer an accepted method to confirm patient eligibility to enter the NeoGem study.

This study was activated in April 2006, by 31st May 2007 12 institutions had been activated and 14 patients registered. The ANZ BCTG holds an NHMRC Project Grant to support the coordination of this trial.

IBCSG 34-05 / SWOG S0230 (POEMS)

Status: Open to Accrual

A phase III trial of LHRH analogue administration during chemotherapy to reduce ovarian failure following chemotherapy in early stage, hormone receptor-negative breast cancer.

ANZ BCTG Study Chair:

A/Prof Kelly-Anne Phillips

ANZ BCTG Institutions Activated:

5 (31st May 2007)

International Target Accrual: 416

This study will randomise patients to receive goserelin (3.6 mg subcutaneously every 28 days) plus chemotherapy or to chemotherapy alone, with most types of chemotherapy regimens containing an alkylating agent allowed.

All premenopausal women who require adjuvant chemotherapy for hormone receptor-negative breast cancer may be considered for this study, regardless of childbearing status.

Premature menopause is a common side-effect of chemotherapy. Reducing the risk of chemotherapy-induced menopause, even in women who have completed their childbearing, is important in order to improve the quality of life and long-term health outcomes for breast cancer survivors. This study has the potential to change the standard of care of premenopausal women with hormone receptor-negative breast cancer.

POEMS was activated within the ANZ BCTG in March 2006. By the end of May 2007, 5 institutions had been activated and 9 patients randomised. Any investigators interested in participating in this trial should contact Mr Heath Badger email: S0230@anzbctg.newcastle.edu.au

ANZ 0501 (LATER)

Status: Open to Accrual

A randomised double-blind trial in postmenopausal women who have completed 5 years of adjuvant endocrine therapy for early, hormone sensitive breast cancer more than 1 year previous, and who are disease-free at study entry.

ANZ BCTG Study Co-chairs:

Prof John F Forbes and A/Prof Michael Green

This study is designed for postmenopausal women who were diagnosed with a confirmed invasive, hormone sensitive breast cancer 6 or more years ago, have completed approximately 5 years of adjuvant endocrine therapy and ceased treatment at least 12 months ago. Patients will be randomised to five years of letrozole therapy versus five years placebo.

The primary objective of the study is to demonstrate a superior disease-free survival in the letrozole arm as compared to the placebo arm, by preventing new breast cancer events. The study is open to accrual in Australia and New Zealand, with 2500 patients expected to be recruited over a five year period. The first ANZ BCTG institution was activated to commence recruitment on 9th May 2007, with the first patient entered into the study on 16th May 2007. 2

patients have been randomised as at 31st May 2007. 14 investigators have confirmed interest, others are considering participating in the study.

International interest has been generated following the presentation of the trial at the Breast International Group (BIG) Scientific Committee meeting and the IBCSG Annual Meeting in St Gallen in March 2007. A synopsis of the study has been provided to BIG for circulation to members.

Investigators who are interested in participating in this trial should contact Ms Debbie Preece, LATER Project Manager at email: LATER@anzbctg.newcastle.edu.au

IBCSG 32-05 / BIG 1-05 (CASA)

Status: Open to Accrual

Phase III trial evaluating the role of adjuvant pegylated liposomal doxorubicin (PLD, Caelyx®, Doxil®) for women (age 66 years or older) with endocrine nonresponsive breast cancer who are not suitable for being offered a "standard chemotherapy regimen".

ANZ BCTG Study Co-chairs:

Dr Anne Hamilton and Dr Anne Sullivan

The trial investigates the role of adjuvant chemotherapy for women over 65 years who have been diagnosed with ER-negative breast cancer and was activated in the ANZ BCTG in November 2005. Accrual has been slow internationally with a total of 57 patients randomised to the 31st May 2007: the ANZ BCTG contributed one patient.

Any investigators who would like to participate in this study and have not yet expressed interest should please email:

CASA@anzbctg.newcastle.edu.au

ANZ 0601 / CIRG / TORI 010

Status: Open to Accrual

A randomised phase II trial of double-blind placebo controlled AMG 706 in combination with paclitaxel, or open-label bevacizumab in combination with paclitaxel, as first line therapy in women with HER2-negative locally recurrent or metastatic breast cancer.

ANZ BCTG Study Chair:

Dr Nicole McCarthy

This double-blind phase II study of paclitaxel in combination with AMG 706 (a new multi-kinase inhibitor with anti-angiogenic and anti-tumour

activity), AMG 706 placebo or bevacizumab will determine if treatment with paclitaxel and AMG 706 is superior to paclitaxel plus AMG 706 placebo in patients with HER2-negative locally recurrent or metastatic breast cancer. The study will also estimate differences in progression-free survival time, clinical benefit, overall survival and duration of response between the treatment arms.

A protocol amendment was released in September 2006 to revise the dosage of AMG 706 to 125 mg orally daily following an update to safety information which indicated a possible link between the original AMG 706 dose of 75 mg BID and an increased risk for the development of cholecystitis. The study was temporarily put on hold during revision of the protocol and associated documents. Recruitment to the study in the international setting recommenced in September 2006 with the first patient entered in December 2006. 71 patients had been entered to this study as at 31st May 2007.

The target accrual of 273 patients is expected to be met by August 2007, 10 months from the date the first patient was enrolled. However, due to a number of site activation delays internationally, the recruitment period may be extended for an additional two months. 12 ANZ BCTG sites were selected to participate in this study with 7-8 sites expected to be activated for recruitment by the end of June 2007. Start-up visits were conducted at Christchurch Hospital and Waikato Hospital in May and activation of these sites is imminent.

For any queries relating to this study, please email: CIRG010@anzbctg.newcastle.edu.au

ANZ 0701 (Co-SOFT)

Status: Pending Activation

Cognitive Function Substudy for SOFT. This substudy will assess the effects on cognitive function of the addition of ovarian function suppression to adjuvant hormonal therapy for women participating in the SOFT study.

ANZ BCTG Study Chair:

A/Prof Kelly-Anne Phillips

All investigators currently participating in the SOFT study are encouraged to consider activating this cognitive function substudy at their site. Co-SOFT has been endorsed by the IBCSG and is supported by an NHMRC Project Grant, Chief Investigator A/Prof Kelly-Anne Phillips.

ANZ 0702 / BIG 2-06 (ALTTO)

Status: Pending Activation

A randomised, multi-centre, open-label, phase III study of adjuvant lapatinib, trastuzumab, their sequence and their combination in patients with HER2/ErbB2 positive breast cancer.

ANZ BCTG Study Chair:

A/Prof Frances Boyle

International Target Accrual: 8000

This study is for patients diagnosed with HER2-positive, early breast cancer who have completed surgery and (neo)adjuvant treatment with an anthracycline based chemotherapy regimen.

The main objective of the ALTTO study is to compare disease free survival (DFS) in patients with HER2-positive breast cancer randomised to trastuzumab for one year versus lapatinib for one year versus trastuzumab (12 weeks) followed by a six week washout period followed by lapatinib (34 weeks) versus trastuzumab in combination with lapatinib for one year.

The ALTTO study is expected to be activated at institutions in Australia and New Zealand in the second half of 2007. Currently, investigators from over 40 institutions have confirmed their interest in participating.

An Investigators' Meeting is scheduled in Melbourne on 31st July/1st August 2007. Queries about this study should be directed to Mr Heath Badger or Ms Dianne Lindsay, or email: ALTTO@anzbctg.newcastle.edu.au

Australian New Zealand Breast Trials Group: Trial Accrual Summary

Total accrual to trials currently open to patient accrual: to 30 June 2007

Trial	Victoria	ANZ BCTG	International	Total	Target Accrual
ANZ 02P2/IBIS II PREVENTION	9	100	1477	1577	6000
ANZ 02P2/IBIS II (DCIS)	9	24	1066	1090	4000
ANZ 02P2/IBIS II BONE SUBSTUDY	0	28	604	632	1000
ANZ 02P2/IBIS II (TOTALS)	18	124	2543	2667	10000
ANZ 0501 (LATER)	0	4	0	4	2500
ANZ 0502 (NEOGEM)	11	17	0	17	147
IBCSG 22-00	15	50	584	635	900
IBCSG 23-01	4	11	491	502	1960
IBCSG 24-02/BIG 2-02 (SOFT)	28	111	1109	1220	3000
IBCSG 25-02/BIG 3-02 (TEXT)	42	148	1563	1711	1845
IBCSG 27-02/BIG 1-02	1	2	97	99	1750
IBCSG 32-05/CASA	0	1	59	60	416
IBCSG 34-05/SWOG S0230 (POEMS)	7	11	65	76	416
BIG 1-98 FINGERNAIL PILOT SUBSTUDY	0	1	15	16	60
BIG 1-98 COGNITIVE FUNCTION SUBSTUDY	2	24	38	62	196
TOTAL	126	479	6511	6990	21690

For Further Information Please contact: Dianne Lindsay
 Head of data management
 ANZ BCTG Operations Office
 Phone: 02 49850133
 Email: d.lindsay@anzbctg.newcastle.edu.au
 Website: www.anzbctg.org.au

TROG BREAST TRIALS SUMMARY

TROG 06.02

Title: A multicentre feasibility study of three-dimensional conformal radiation therapy for accelerated partial breast irradiation (APBI).

Trial Contacts

Trial Chairperson

Associate Professor Boon Chua
Division of Radiation Oncology
Peter MacCallum Cancer Centre
St Andrews Place, East Melbourne VIC 3002
Fax: +61 3 9656 1424

Trial Coordinator

Joanne Dean
Peter MacCallum Cancer Centre
St Andrews Place, East Melbourne VIC 3002
Fax: +61 3 9656 1420

TROG 07.01

Title: A randomised phase III study of radiation doses and fractionation schedules in non-low risk ductal carcinoma in situ (DCIS) of the breast.

Trial Contacts

Trial Chairperson

Associate Professor Boon Chua
Division of Radiation Oncology
Peter MacCallum Cancer Centre
St Andrews Place, East Melbourne VIC 3002
Fax: +61 3 9656 1424

Trial Coordinator

Joanne Dean
Peter MacCallum Cancer Centre
St Andrews Place, East Melbourne VIC 3002
Fax: 61 3 9656 1420

Extracts from Wongi Yabber, May 2007

National Breast Cancer Centre (NBCC)

-Wongi Yabber, May 2007

Increased funding for NBCC

The Commonwealth Government has announced it will provide additional funding of \$500,000 to the National Breast Cancer Centre (NBCC) to improve the care of cancer patients affected by lymphoedema.

The funding will allow NBCC to undertake a comprehensive program of work on lymphoedema, and to consolidate and build on existing initiatives in Australia. NBCC's work will ensure all health professionals and patients, including Indigenous Australians, have access to evidence-based information and education about the disease including its prevention, early detection and effective treatments.

Trastuzumab (Herceptin®) guidelines released

NBCC has released clinical practice guidelines for the use of the drug trastuzumab (Herceptin®) in the treatment of women with HER2-positive breast cancer.

Trastuzumab was added to the Pharmaceutical Benefits Scheme (PBS) in October 2006 for the treatment of women with HER2-positive early breast cancer. It was previously subsidised only for women with HER2-positive advanced breast cancer.

NBCC's guidelines provide statements and recommendations for clinicians about the use of trastuzumab in the treatment of both early and advanced disease based on the best available evidence.

The guidelines were developed with input from a multidisciplinary working group chaired by Professor Ian Olver. They have been endorsed by the Royal Australasian College of Surgeons, the Royal Australasian College of Physicians and the Faculty of Radiation Oncology at the Royal Australian and New Zealand College of Radiologists.

The guidelines were widely disseminated in April. They can also be downloaded or ordered online at www.nbcc.org.au/resources or by calling 1800 624 973. Consumer information based on the guidelines is currently in development. For more information about the guidelines, contact Dr Alison

Evans on alison.evans@nbcc.org.au or 02 9036 3044.

Breast cancer specific data items

NBCC has developed a set of breast cancer specific data items and definitions to serve as a guide for specialist breast cancer data collection in Australia.

The National Health Data Dictionary (NHDD) recommends a core set of generic data items for clinical cancer registration. However this list does not include items for specific tumour streams. NBCC has developed a supplementary set of breast specific data items and definitions to serve as a guide for specialist breast cancer data collection in Australia. A multidisciplinary working group, chaired by Professor David Roder and comprising clinical and consumer representation, identified 15 breast cancer specific data items for collection. A range of items including patient data (menopausal status), diagnostic data (HER2 status, sentinel lymph node), treatment (surgical margin clearance and involvement), and breast reconstruction are included.

The data items aim to facilitate national consistency in defining, recording, and monitoring information about patients with breast cancer. This national approach will contribute to improved patient outcomes by informing planning, quality improvement and evaluation strategies for cancer services. The items will be piloted in two sites in NSW by the Cancer Institute NSW in 2007. For more information, contact Dr Alison Evans on alison.evans@nbcc.org.au or 02 9036 3044.

Medico-legal implications of multidisciplinary care

NBCC held a workshop in March to explore the medico-legal implications of a multidisciplinary approach to cancer care. Clinical and legal experts gathered at the workshop to develop guiding principles around issues such as patient consent and medical indemnity issues associated with a team approach to treatment planning.

Outcomes from the workshop will be disseminated through a summary report and a second workshop will be held in mid-2007. If you would like to receive a copy of the workshop report, please contact Janice O'Brien on janice.obrien@nbcc.org.au or 02 9036 3350. For more information contact Dr Alison Evans on alison.evans@nbcc.org.au or 02 9036 3044.

MRI systematic review

A new NBCC report *Magnetic resonance imaging for the early detection of breast cancer in women at high risk: a systematic review of the evidence* is now available to download from NBCC's website at <http://www.nbcc.org.au/resources/resource.php?code=MRI>.

The report is based on a systematic evidence review conducted by consultancy group HT Analysts and was developed with input from a multidisciplinary group of experts.

It is anticipated the report will be helpful in discussions about the future role of MRI in the early detection of breast cancer. For further information about the report, contact Rosemary Vagg on rosemary.vagg@nbcc.org.au or 02 9036 3073.

Breast cancer in Indigenous women workshop

NBCC conducted a workshop for Aboriginal and Torres Strait Islander health workers in conjunction with the 9th National Rural Health Conference in Albury in March. The workshop was attended by 40 people from diverse professional backgrounds including primary health care, service delivery, cancer control and health education.

The workshop program included a session on breast cancer incidence, survival and mortality in Indigenous women. Workshop delegates also heard about different Indigenous women's experience of breast cancer, and discussed issues around treatment, social and emotional support. Presentation slides from the workshop are available to download from NBCC's website <http://www.nbcc.org.au/atsiworkshop>. For more information about the workshop, contact Jane Francis on jane.francis@nbcc.org.au or 02 9036 3045.

Pathology Reporting of Breast Cancer (2001)

A recent meeting of ACN/NBCC Pathology Reporting of Breast Cancer Revision Working Party resulted in completion of a draft document. Ms Jenni Harman was present and will undertake the editing process.

Following review of the edit by the Executive of the Working Party, the document will be sent to a wide range of reviewers before final review and publication.

Australia & New Zealand TNM Committee for Tumour Staging

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

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

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

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

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

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

In conclusion, the Australian and New Zealand TNM committee is pleased with these recent developments and feels that the TNM system will gradually be introduced into Australia as standard practice.

*Professor William McCarthy AM
Convenor ANZ TNM Committee*

The Cancer Council Australia (TCCA)

Evidence stacking up for alcohol-cancer risk

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

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

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

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

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

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

Pull the plug on food advertising

In 2007, the Australian Communications and Media Authority is reviewing the Children's Television Standards. The Coalition on Food Advertising to Children (CFAC), which includes The Cancer Council Australia and other key health and consumer organisations, is calling for a marked reduction in the commercial promotion of foods and beverages to children under 14 years old. The Pull the Plug on Food Advertising campaign is being run by The Cancer Council NSW on behalf of the coalition to help make the job of parents easier and to give our kids a healthier future. Visit www.cancercouncil.com.au/pulltheplug for more details and to sign-up to the

campaign.

Health groups welcome survey to target childhood obesity

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

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

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

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

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

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

*The Australia Chronic Disease Prevention Alliance comprises The Cancer Council Australia, Diabetes Australia, Kidney Health Australia, the National Heart Foundation of Australia and the National Stroke Foundation.

The Cancer Council Australia's new website nearing completion

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

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

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

Glen Turner
Communications Manager
The Cancer Council Australia

Key Published Articles Listing – Breast Cancer

Title	Author
Communicating about patient sexuality and intimacy after cancer: mismatched expectations and unmet needs	Hordern AJ, Street AF The Medical Journal of Australia 2007; 186(5): 224-227 www.mja.com.au/public/issues/186_05_050307/hor10740_fm.html
CA 15-3 and alkaline phosphatase as predictors for breast cancer recurrence: a combined analysis of seven International Breast Cancer Study Group trials	Keshaviah A, Dellapasqua S, Rotmensz N, et al. Annals of Oncology 2007; 18(4): 701-708
Keeping faith with trial volunteers: How best to serve patients' interests in clinical trials?	Piccart M, Goldhirsch A, Wood W, et al. Nature 2007; 446(8): 137-138
The role of the number of uninvolved lymph nodes in predicting locoregional recurrence in breast cancer	Karlsson P, Cole BF, Price KN, et al. Journal of Clinical Oncology, 2007; 26(15): 2019-2026
Predictors of early relapse in post menopausal women with hormone receptor-positive Breast Cancer in the BIG 1-98 trial	Mauriac L, Keshaviah A, Debled M, et al. Annals of Oncology, 2007; 18(5): 859-867
Adjuvant goserelin in pre-menopausal patients with early Breast Cancer. Results from the ZIPP study	Baum M, and the ZIPP International Collaborator's Group EUR J Cancer, 2006, 42: 895-904
Use of luteinising-hormone-receptive hormone agonists as adjuvant treatment in pre-menopausal patients with hormone-receptor-positive Breast Cancer: a meta-analysis of individual patient data and randomized adjuvant trials.	LHRG-agonists in Early Breast Cancer Overview Group Lancet, 2007; 369(9574): 1711-23 www.thelancet.com
Genome-wide association study identifies breast cancer susceptibility loci	Easton DF, Pooley KA, Dunning AM, et al. Nature, 2007; 447(7148): 1087-93
ANZ BCTG Clinical Trials Newsletter	ANZ BCTG Clinical Trials Newsletter, No. 8, June 2007
Limited family structure and BRCA gene mutation status in single cases of breast cancer.	Weitzel JN, Lagos VI, Cullinane PJ, et al. JAMA, 2007; 297(23): 2587-2595 www.jama.com
Circular International Breast Cancer Study Group Letter	Karen Price IBSCG Circular Newsletter, June 2007; 13(2)

Forthcoming Meetings

Date / Place	Meeting / Contact
1–4 August 2007 Melbourne, VIC, Australia	Annual Scientific Meeting of the Medical Oncology Group of Australia (MOGA) MOGA Conference Secretariat c/o Pharma Events, PO Box 265, Annandale NSW 2038 Ph: (02) 9280 0577 Fax: (02) 9280 0533 E-mail: moga@pharmaevents.com.au Website: www.moga.org.au
9–11 August Kuala Lumpur	1st Kuala Lumpur International Breast and Colorectal Cancer Congress Malaysian Oncological Society Ph: +603 2093 0100 Fax: +603 2093 0900 Email: klbcc@malaysiaoncology.org Website: www.klbcc2007.org
2–4 August 2007 Melbourne, VIC, Australia	10th CNSA Winter Congress Joint venture with MOGA Website: www.cnsa.org.au
28–31 August 2007 Melbourne, VIC, Australia	9th Australian Palliative Care Conference – <i>Partners across the lifespan</i> Palliative Care Australia. APCC 07 Conference Secretariat, C/- ICE Australia P/L, 6 Clarendon Place, South Melbourne, VIC 3205, Australia Ph: (03) 9681 6288 Fax: (03) 9681 6653 E-mail: apcc@iceaustralia.com Website: www.iceaustralia.com/apcc2007/ / www.pallcare.org.au
7 - 8 September 2007 San Francisco, CA, United States	The 2007 Breast Cancer Symposium: Integrating Emerging Science into Clinical Practice American Society of Clinical Oncology (ASCO), Alexandria, VA, United States Ph: +1 703 299 0150 Fax: +1 703 299 1044 Email: meetings@asco.org Website: www.asco.org
23–27 September 2007 Sydney, Australia	3rd International Clinical Trials Symposium (ICTS) GPO Box 3270, Sydney NSW 2001 Ph: (02) 9254 5000 Fax: (02) 9251 3552 E-mail: info@clinicaltrials2007.com Website: www.clinicaltrials2007.com
23–27 September 2007 Barcelona, Spain	14th European Cancer Conference (ECCO) – <i>Cancer in Europe: Sharing the responsibilities</i> Federation of European Cancer Societies (FECS), Avenue E. Mounier 83, Brussels 1200, Belgium Ph: +32 2 775 0201 Fax: +32 2 775 0200 E-mail: ECCO14@fecsb.be Website: www.fecsb.be

Date / Place	Meeting / Contact
23–27 September 2007 Barcelona, Spain	European Society for Therapeutic Radiology & Oncology (ESTRO 26) During ECCO 14 Website: www.estro.be
1 - 4 October Budapest, Hungary	Global Summit on International Breast Health Care 2007 The Breast Health Global Initiative (BHGI) C/O Fred Hutchinson Cancer Research Centre, Seattle, WA, United States Ph: +1 206 6676 2454 Fax: +1 206 288 1025 Email: lsullivan@fhcrc.org Website: www.fhcrc.org/science/phs/bhgi/summits/2007
4–7 October 2007 Melbourne, Vic, Australia	58th Annual Scientific Meeting of the Royal Australian and New Zealand College of Radiologists (RANZCR) Website: www.ranzcr.edu.au
18-21 October 2007 Tianjin, China	4th Congress of the World Society for Breast Health Tianjin Medical University Cancer Institute and Hospital Ph: +86 22 2335 9337 Fax: +86 2335 9337 Email: info@2007wsbh.org Website: www.2007wsbh.org
22 October 2007	Pink Ribbon Day
28 October - 1 November 2007 Los Angeles, CA, United States of America	49th Annual Meeting of the American Society for Therapeutic Radiology and Oncology (ASTRO) 12500 Fair Lakes Circle Suite #375, Fairfax, VA 22033-3882 Phone: +1 703 502 1550 or +1 800 962 7876 Fax: +1 703 502 7852 Email: meetings@astro.org Website: www.astro.org
14-16 November 2007 Adelaide, SA, Australia	34th Annual meeting of the Clinical Oncology Society of Australia (COSA) COSA Office, Medical Foundation Building, Level 5, 92 Parramatta Road, Camperdown, NSW 2011 Ph: (02)9036 3100 Fax: (02)9036 3101 Email: cosa@cancer.org.au Website: www.cosa.org.au
19-20 November 2007 Melbourne	Australian Breast Cancer Conference 2007 VBCRC. Contact Clare Riglar Ph: (03) 9635 5227 Email: Clare.Riglar@cancervic.org.au
13-16 December San Antonio, Texas, USA	29th Annual San Antonio Breast Cancer Symposium Website: www.sabcs.org

Date / Place	Meeting / Contact
15-19 April 2008 Berlin Germany	EBCC-6: 6th European Breast Cancer Conference Federation of European Breast Cancer Societies (FECS), Brussels, Belgium Ph: +32 2 775 0210 Fax: +32 2 775 0200 Email: ebcc6@fecs.be Website: www.fecs.be
4-8 June 2008 Winnipeg, MB, Canada	5th World Conference on Breast Cancer World Conference on Breast Cancer Foundation (WCBCF), Port Robinson, ON, Canada Phone: +1 905 384 1848 Fax: +1 905 384 1675 Email: mail@wbcf.ca Website: www.wbcf.ca
11-14 December 2008 San Antonio, Texas, USA	30th Annual San Antonio Breast Cancer Symposium Website: www.sabcs.org
15-19 April 2009 Berlin, Germany	6th European Breast Cancer Conference Federation of European Cancer Societies, Avenue E, Mounier 83, Brussels 1200 Belgium Phone: +32 2 775 0201 Fax: +32 2 775 0245 Email: EBCC6@fecs.be Website: www.ebcc6.fecs.be

The Cancer Council Victoria

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

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

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

The **VCOG Breast Cancer Committee** was established in 1978. It's membership is representative of the clinical specialties and centres involved in the treatment of breast cancer. The objectives of the Breast Cancer Committee are to :

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

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