

Gastrointestinal Cancer Update

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Issue Number: 43

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GASTROINTESTINAL CANCER UPDATE

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This newsletter is produced by The Cancer Council Victoria's Gastrointestinal Cancer Committee and sent to health professionals interested in management of gastrointestinal cancer(s). The Victorian Cooperative Oncology Group's advisory committees on breast, 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 Mrs Noellyn Ngo, Ph: (03) 9635 5265.

***** **Last Issue – No. 42 – July 2004** *****

The articles in the Gastrointestinal 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

*Mr Ian Faragher
Department of Surgery
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In this issue Professor Don Metcalf, is recognised and honoured by The Cancer Council Victoria for lifetime achievement in cancer research, page 4.

On page 5, Professor Finlay Macrae discusses progress in GI oncology from the recent GESA meeting, and follows this on page 8 with an overview of topics from the recent AACR meeting in Seattle. A lot of work has focused on stratifying colon cancer by MSI status. MSI high sporadic tumours may be distinguished from MSI high HNPCC tumours by the presence of BRAF mutations. There was further discussion of the neoplastic potential of hyperplastic polyps and of the link between MSI status and subsequent response to 5FU. Epidemiological studies suggested the protective effect of fruit may be linked to MSI status. The important topic of early detection of colorectal cancer was covered with talks on FOB screening, validation of testing programs, and implications for the colonoscopy workforce.

On page 9, Stephen Bell provides an overview of laparoscopic colon resection for cancer. This technique is becoming available in many Melbourne hospitals.

On page 10, there is preliminary data on the study of the Cancer Information and Support Service. This study is ongoing. Further information about CISS is on page 14.

On page 12, the working party from the VCOG Gynaecological Cancer Committee has published a position statement on "HNPCC: Gynaecological Cancer Surveillance Screening" as of September 2004. These guidelines help manage a small group of women in Amsterdam positive families, MMR gene mutation carriers or their first degree relatives.

A copy of the information sheet from the Cancer Council on "Established treatments, treatments being trialled and alternative (unproven) treatments for cancer" commences on page 15.

National cancer bodies provide updates with the Australian Cancer Network discussing its activities on page 20. This is followed by reports from The Cancer Council Australia on page 21, and from the National Cancer Control Initiative on page 22.

A summary of published clinical practice guidelines (and their dates of publication) is provided on page 23. This is followed by the list of recent key publications recommended to the newsletter on page 24. Forthcoming meetings of potential interest to members are listed on page 25.

Contributions Welcome

The Gastrointestinal 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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Professor Don Metcalf Honoured for Outstanding Contribution to Cancer Research

*Ms Zoe Furman
Communications Manager
The Cancer Council Victoria*

The Cancer Council Victoria recently honoured leading medical researcher Professor Donald Metcalf for his outstanding contribution to cancer research. Hailed as "Australia's most distinguished cancer researcher", Professor Metcalf was recognised for his life-saving research at a special function at Government House, Melbourne, in late November, to celebrate his 50 years as the Cancer Council's Carden Fellow.

Since being appointed Carden Fellow in Cancer Research in 1954, Professor Metcalf has been based at the Walter and Eliza Hall Institute for Medical Research. His research has led to the development of the major supportive cancer therapy, colony stimulating factors (CSF), which has so far benefited around five and a half million cancer patients worldwide.

Cancer Council Director Professor David Hill said the Cancer Council was proud to have supported the work of a world-class researcher over the last 50 years.

"There are very few medical researchers whose work has had such a profound impact on cancer treatment."

Associate Professor Richard Bell said CSFs have had a major impact on the treatment of human disease.

"Clinicians have experienced a dramatic improvement in our ability to treat cancer because of Professor Metcalf's discovery. His work has led to a large and productive network of biologic and clinical trials research. We continue to learn of new and better ways to use his discoveries to benefit our patients."

Former Walter and Eliza Hall Institute Director Sir Gustav Nossal said Professor Metcalf is one of the few medical scientists who have seen his discoveries flourish from laboratory bench to the patient's bedside.

Around 30 people who received CSF therapy as part of their treatment for cancer and other medical conditions attended the special celebration, and had the opportunity to meet Professor Metcalf.

As Professor Metcalf commented, this interaction between a researcher and those who have benefited from research is most unusual.

"It's quite uncommon to discover something that gets into the clinic and is used in treating people. Not many people have the good fortune to discover something that can be applied like this."

The opportunity to meet the man responsible for a treatment that had helped their recovery was clearly a highlight for the patients, with many traveling from country areas to attend the jubilee

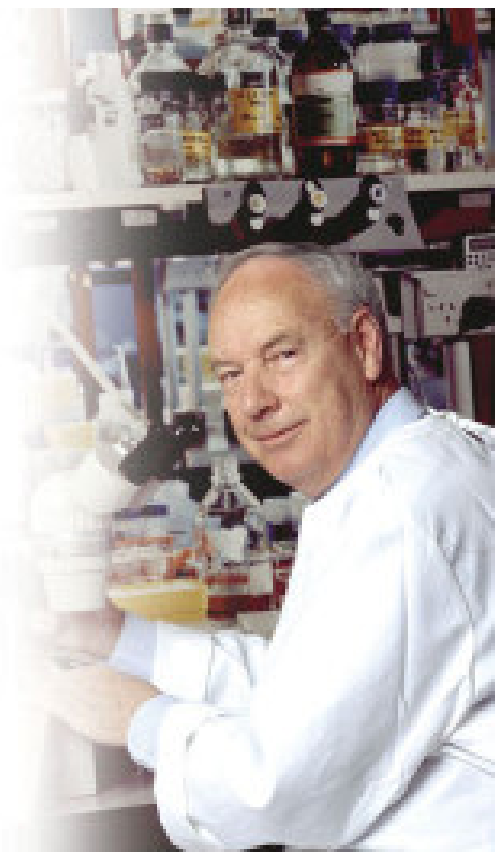


Image courtesy of Walter & Eliza Hall Institute of Medical Research

celebration. Several former patients had participated in clinical trials of G-CSFs at Royal Melbourne Hospital in the early 1990's, while others had undergone cancer treatment as recently as this year.

Annie Donaldson, who has had two G-CSF supported stem cell transplants as part of her treatment for multiple myeloma, was one of the guests at the special event.

Ms Donaldson said it was an honour to be able to meet the man whose research has helped save her life.

"Professor Metcalf's discovery of CSFs is the reason I am alive today, and it is wonderful to be able to meet such a dedicated and gifted scientist whose work has helped so many people like me."

The Carden Fellowship was established as a result of an initial generous bequest to the Cancer Council in 1945 from George Frederick Carden, a prominent Melbourne businessman. The Carden family's link with the Cancer Council extends to VCOG; longstanding VCOG member Tony Carden, who has been involved in the Gastrointestinal Committees for many years, is Carden's grandson. Tony, along with a number of Carden's descendents attended the jubilee celebration at Government House.

One of the highlights of the day was a special performance by another Carden family member, renowned Australian opera singer Joan Carden. The operatic touch was fitting given the well-publicised link between G-CSF and another famous opera singer, Spanish tenor Jose Carreras. After developing acute myeloid leukaemia, which did not respond to initial treatment, Carreras received a treatment regime that included CSF therapy in 1987. He responded positively and recovered successfully. Senor Carreras was one of a number of luminaries to send congratulations for the Metcalf jubilee celebration.

Professor Metcalf's work has been acknowledged by some of the highest honours in the world of contemporary science. Still considered to be at the forefront of cancer research today, his work is a remarkable success story of cancer research, of generous philanthropy and of the benefit of prolonged, sustained and secure support from The Cancer Council Victoria in a funding relationship that is probably unique in medical research in Australia.

Professor Metcalf's career in research illustrates perfectly the significant dividends that can come from channelling long-term support into the work of a world-class researcher.

Gastroenterological Society of Australia: Australian Gastroenterology Week

4-8 October 2004, Brisbane

*Professor Finlay A Macrae
Gastroenterologist
Royal Melbourne Hospital*

Gastrointestinal oncology is increasingly becoming a major stream of science at Australian Gastroenterology Week (AGW). Most GI cancer research attracted to AGW is basic science, especially in prevention, screening and in endoscopic therapeutics. AGW this year joined with the International Academy of Pathologists, providing an overlap day between the two scientific bodies. For

gastroenterologists, this brought a cadre of outstanding international pathologists to our meeting, providing a perspective and stimulus unparalleled in recent meetings.

Professor Jeremy Jass, one time academic pathologist at the University of Queensland and now at McGill University, Montreal is a leading scientist in the field of colorectal cancer. His

combination of skills as an extraordinarily astute histopathologist, combined with his insights and research experience in the molecular pathogenesis of colorectal cancer, repeatedly leads us to consider paradigm shifts in thinking. Currently, four pathways are shaping up in understanding, defined by microsatellite stability / instability and the methylation status of the cancer genome. Permutations of these parameters are associated with distinct clinicopathological features, molecular profiles, and responsiveness to 5FU therapy. An important discovery, presented from the Brisbane Group's Conjoint Laboratory, is the prevalence of activating BRAF mutations in the microsatellite unstable, methylated (notably of CpG promotor islands) group of tumours. This molecular phenotype has been difficult to distinguish from HNPCC tumours on clinical grounds except in that it is usually the domain of older women. The identification of BRAF mutations in over 70% of the sporadic tumours, with no BRAF mutations found in HNPCC, is an important observation which will save substantial resources by excluding patients with these MSI-H carriers from an intensive search for a germline mismatch repair mutation. Refinements in understanding of profiles of methylation in tumours also promise more accurate stratification of tumours with respect to prognosis and chemotherapy responsiveness. "Methylation in Tumour Markers" (MINIS), and methylation of promotor regions of hMLH1, MGMT, p16^{INK4A} and p14^{ARF} were studied together with the V599E activating BRAF mutation by the Brisbane Group, again providing a molecular epigenetic discrimination between the sporadic MSI-H tumours (highly methylated, BRAF positive) and germline associated HNPCC tumours (little methylation, BRAF negative).

Professor Jass has also pointed the way to identifying the serrated polyp (hyperplastic initially, then serrated adenomatous polyp), as the precursor lesion in this pathway. It may also be the precursor in the microsatellite stable, methylated tumour group. Professor Jass estimates 10% of cancers may pass along this latter pathway with 15% following the better known sporadic MSI-H pathway. 5FU responsiveness is best seen in the classic microsatellite stable unmethylated tumour pathway, with lack of responsiveness in the MSI-H methylated group. HNPCC tumours are 5FU

responsive. Responsiveness in the MS stable, methylated group is uncertain to date.

The invitation to the International Academy of Pathologists (IAP) also allowed the opportunity to hear Dr Robert Riddell from Mt Sinai Hospital in Ontario. Another pathologist of British extraction, Robert has lead efforts to standardize reporting dysplasia in the colon and is one of a few pathologists worldwide whose opinion on this question is rarely challenged. His lecture reinforced the need for expertise in interpretation, especially in research studies.

Drs Neil Shepherd (Gloucester Royal Hospital), Bryan Warren (John Radcliffe, Oxford), Gregory Lauwers (Massachusetts General), and Geraint Williams (Cardiff) completed the oncology talks covering malignant polyps, pseudo invasion, GIST's and neuroendocrine tumours. The plethora of antibodies now available to characterise tumours is increasingly providing us with detailed information on prognosis and drug responsiveness. We will undoubtedly see more of such molecular and proteomic profiling to determine treatment (surgical and drug) strategies.

The IAP collaboration at AGW was partly the initiative of the new GESA Special Interest Group in GI Cancer. Unfunded by GESA, it will be a long time before the GI Cancer SIG will have such a distinguished faculty again at AGW!

The GESA GI Cancer SIG continued in the afternoon with two themes. Population-based screening for bowel cancer was the focus for half the afternoon. The success of the pilot program of screening in Mackay, Adelaide and Melbourne was described by Andriana Koukaris who heads the Bowel Cancer Screening Pilot Program administration for the Federal Department of Health and Ageing. Andriana's enthusiasm for the program, her attractive but relaxed style of presentation, and encouragement of stakeholder ownership has, with her predecessor Sarah Major, been a major factor in the co-operative success of the pilot program. Her presentation was another example of this. Andriana, like many of us, is excited about the future, with now bipartisan political support for a national roll out of screening. It will happen! Graeme Young's presentation on immunochemical quantitative testing for faecal occult blood further reinforced the wisdom of

Australia moving ahead in screening using immunochemical testing, with high sensitivity and specificity. Positivity rates are higher than with guaiac testing, with implications for the colonoscopy workforce that will need to be addressed.

Quality assurance of colonoscopy, lead through The Bowel Cancer Screening Pilot Program (BCSPP) and based on the US Multi Society Task Force of Quality Assurance for Colonoscopy, is a world first implementation for Australia. Finlay Macrae described this initiative, its rationale, and the interest amongst key stakeholders in QA – the BCSPP, Medical Defence Organisations, the Conjoint Committee of GESA, RACS, RACP and the Consumer. The benefits of screening would be compromised by poor quality colonoscopy, so a major drive in QA comes from the BCSPP. A calculation of the balance of risks versus benefits of colonoscopy in screening the 4.4 million Australians aged 50 to 75 years, either initially filtered out with positive faecal occult blood (17 deaths from colonoscopy) or directly colonoscoped (440 deaths from colonoscopy) was telling, based on Australian complication figures in tertiary hospital practice. Of course, compliance levels would modulate these figures.

Screening outside the Pilot Program remains difficult and much in need of commercial entrepreneurial activity in provision of validated programs of faecal occult blood testing. Enterix remains the responsible sole provider of a comprehensive and validated program in this area (1800 555 6575). Factors associated with compliance and participation in screening have been the focus of psychosocial research in Adelaide. Participation is, self evidently, crucial to the success in screening programs, and has been related through factor analysis, to emotional preparedness and barrier perceptions. Steve Cole, from Flinders Medical Centre summarised his excellent work in this area.

The need for synoptic reporting of pathology has been touted for sometime, but infrequently embraced clinically by busy pathologists. Andrew Clouston, consultant pathologist to the BCSPP, endorsed the approach taken by the BCSPP in synoptic reporting. Compliance to synoptic reporting in the BCSPP is still to be assessed, but will need to be “owned” by pathologists in general in order for it to succeed.

The balance of the afternoon was a workshop for the GI Cancer SIG engaged in GI Cancer Research. MSI variable tumour phenotypes in families has been a focus of interest for Joanne Young in Brisbane. Robyn Ward at St Vincent's, Sydney has recently described individuals with apparent *germline* epigenetic silencing of tumour suppressors in multicase individuals. Hyperplastic polyposis, including familial hyperplastic polyps has been a fascinating journey at RMH. World leading strategies in colon tumour models were discussed by Maija Kohnen Corish. Australia's important contribution to the US funded Colorectal Cancer Family Study was outlined by John Hopper from the Centre for Genetic Epidemiology, Melbourne University.

Endoscopy Workshop

This two-day live transmission from Princess Alexandra Hospital was a wonderful example of CME. The nuances of clinical decision-making laced with the extraordinary technical endoscopic expertise of the faculty, left the audience in awe. Endoscopic mucosal resection of large areas of high grade dysplastic Barrett's mucosa, large flat colonic polypectomies, double balloon full length enteroscopy and endoscopic management of pancreatic and hilar tumours were demonstrated. International guests Horst Neuhaus from Dusseldorf, Germany, and Chris Gostout from the Mayo Clinic showed calmness in the face of often very challenging objectives under live camera. The double balloon enteroscope leap frogs through the small bowel, unprecedented by previous endoscopic technology. Arthur Kaffes in Bankstown, Liverpool holds to date Australia's only experience with the “Double Bubble” and provided a live demonstration. It was an outstanding workshop.

Other new technologies gaining recognition are photodynamic therapy for high grade dysplasia and Barrett's, and confocal endomicroscopy which is an Australian innovation providing in vivo optical sectioning, or virtual histology, during endoscopy.

AGW was indeed exciting and will be difficult for the GI Cancer SIG to match.

Report of 3rd Annual AACR International Conference on Frontiers in Cancer Prevention Research

16–20 October 2004, Seattle, Washington, USA

*Professor Finlay A Macrae
Gastroenterologist
Royal Melbourne Hospital*

A conference dedicated to cancer prevention research, covering molecular and cell biology, in vivo animal models, genetics, epidemiology, clinical sciences and psychosocial sciences requires a critical mass of interest probably only found in USA. Seattle was the venue, nicely hosted by The Fred Hutchinson Cancer Research Center. Ex-patriot John Potter heads Public Health Sciences at "The Hutch", so the meeting took on a special warmth for Australians. Invited or submitted papers were presented at the meeting by John Hopper (Melbourne University), David Whiteman (QIMR), John Potter, and Finlay Macrae with panel discussants including ex-patriot Graham Colditz (Harvard) and Penny Webb (QIMR).

Oral presentations were all "state of the art" submitted papers, with original work presented as posters only. This limited collected discussion of the more important original work such as epidemiological analyses of the Netherlands Cohort Study identifying the prevention of colorectal cancer by fruit restricted to MSI-H cancers and not MSS cancers. Increasing attention to molecular profiling of cancers is likely to detect stronger epidemiological signals in cohort (and case control) studies.

In vivo and in vitro studies on a raft of new and older chemo-preventative agents was presented including green tea, isoflavones, raspberries, lycopene, antioxidants, isothiocyanates, (cruciferous vegetables), polyphenols, resveratrol, curcumin, as well as calcium, NSAID's COX2 inhibitors, folate and selenium were all presented.

Dominating the meeting was the announcement the week before of the withdrawal of Vioxx (rofecoxib) by Merck Sharpe & Dohme due to an excess risk of cardiovascular events in the

rofecoxib arm of the APPROVe (sporadic adenoma) trial. This trial has been recruiting at Cabrini Hospital and Austin Hospital in Melbourne.

The withdrawal affects all uses of Vioxx including in rheumatology. Rofecoxib was a major hope in chemoprevention so its withdrawal set a tone of disappointment around the meeting. John Baron, from Dartmouth, outlined the data leading to this decision, as Chairman of the APPROVe Steering Committee.

Drugs showing promise in trials include PPAR Agonists, Statins (lots of interest), aspirin (patterns of use), and allopurinol (protective!). Data about all these were presented.

Other topics of interest included field changes in methylation in "normal" mucosa beside colorectal cancers and adenomas, insulin resistance and its associates and colorectal cancer risk. IGF-1, MTHF reductase polymorphisms and adenoma risk, and its association with C to T transitions in p53.

A theme of the meeting supported by evidence was multi-agent approaches to chemoprevention. Animal studies documented synergy with combinations of low dense interventions. Factorial designed clinical trials showed positive interactions and my own presentation captured the concept. The Australian Polyp Prevention Project to the Polypill! "One at a time or All at Once" (title courtesy of John Burn).

Update on Laparoscopic Colon Cancer Resection

Mr Stephen W Bell
Colorectal Consulting Group
Cabrini Hospital, Melbourne

There has been interest in applying the benefits of laparoscopic surgery to the field of colorectal surgery over the past decade. Early reports of port site recurrences (rates up to 21% being reported) appropriately led to a thorough investigation of the technique in resection of colon cancer. The principle is to do the same oncological operation but minimise the trauma of access with a view to reducing morbidity.

The issue of doing the same operation with equivalent oncologic results has been addressed. Numerous studies have shown that resection margin and lymph node yield are equivalent when compared to the open approach. Equally, it has now been shown that tumour recurrence and survival are not altered by the laparoscopic approach. Although still controversial, there is a reasonable sized experimental and basic science literature supporting the concept that minimally invasive procedures are associated with somewhat less immunosuppression and, possibly, some early post-operative benefits in regards to the hosts ability to deter tumour growth or prevent tumour metastasis.

With respect to morbidity there appears to be some benefits of laparoscopic surgery over open surgery in the areas of pain/analgesic requirements, respiratory function, return of GI function, length of stay and return to normal activity; although this is not universally shown in all studies. More recently there has been data appearing to support the theory that late complications are reduced with less adhesion formation and therefore possibly fewer bowel obstructions. There may also be fewer incisional herniae as a result of laparoscopic surgery.

As such, it has been shown that laparoscopic colon cancer resection is feasible and safe, and does have some benefits over the open approach. The more pressing questions to be answered now are how the introduction of this approach should be controlled and who should

be performing this complex surgery. There is no doubt that there is a learning curve, and this involves between 20 to 50 cases. It will be important for surgeons performing laparoscopic colon procedures to be appropriately trained and for there to be some form of credentialing.

Another important issue is the concept of team building. Laparoscopic surgery can be complex, with many new aspects to the set up of the operating room and operating equipment. The introduction of a laparoscopic program to a hospital will come with the need to gather a team of interested people to become familiar with the set up, the routine, the equipment, and the post-operative recovery programs. With this team approach efficiencies can develop in the operating room and in the ward leading to shorter operating times and further reductions in length of inpatient stay.

Laparoscopic colon surgery has been shown to be beneficial, including in cancer resection. In the future we must aim to maintain the high standards that have been achieved in the trial settings. Educating and training surgeons, the surgical team and the ward team are paramount to achieving this.

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Referral of Men Newly Diagnosed with Colorectal or Prostate Cancer

Dr Trish Livingston
 Centre for Behavioural Research in Cancer
 The Cancer Council Victoria

Study Update

This study is designed to determine whether a specialist referral and outcall program reduces psychological morbidity associated with a cancer diagnosis. Forty-seven clinicians are committed to this study – 27 colorectal specialists and 20 urologists – and we are now accessing patients through 7 outpatients clinics across Melbourne metropolitan hospitals.

To date, 326 men have been referred to the Cancer Information & Support Service (CISS):

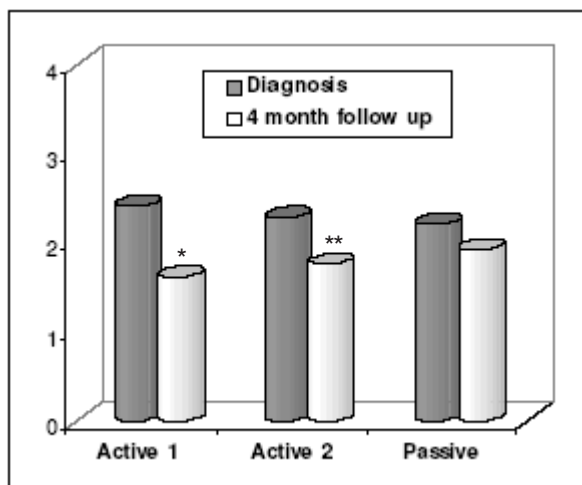
- 108 (33%) have been referred to receive four call-backs (Active Referral 1) from CISS nurse counsellors over a six-month period;

- 99 (31%) to receive one call-back (Active Referral 2) from a nurse counsellor post-diagnosis; and
- 119 (36%) who call into the service, if and when they choose to (Passive Referral).

Below are some preliminary results from the pilot study, based on the responses of 79 men who have completed surveys at baseline and 4 months post-diagnosis. *Although it is too early to draw any conclusions from the results, we are encouraged by them.*

Pilot Results

Worry about cancer

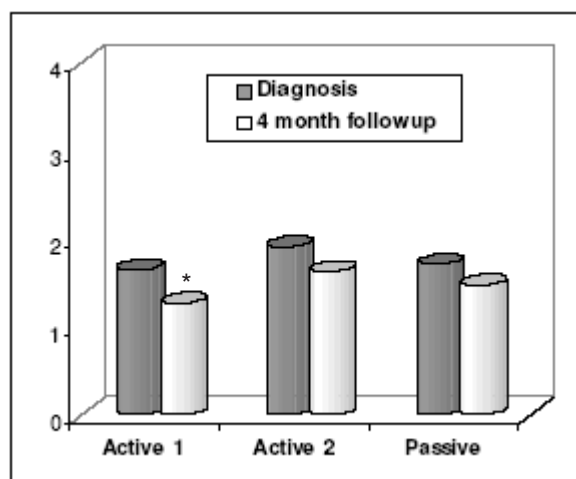


*p=0.001

**p=0.003

Men in the 1 or 4 call(s) groups were significantly less worried about their cancer diagnosis at 4 months post-diagnosis

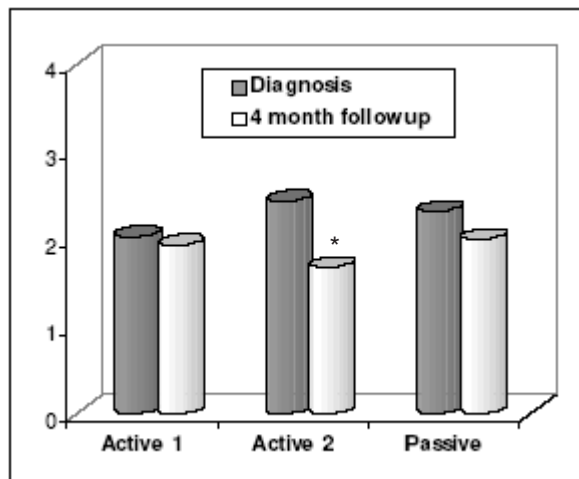
Worry about dying



*p=0.001

Men in the 4 calls group were significantly less worried about dying at 4 months post-diagnosis

Worry about physical problems associated with surgery / treatment



*p=0.001

Men who received 1 call were significantly less worried about physical problems associated with their treatment at 4 months post-diagnosis

Satisfaction with the Service

- 88% reported calls from CISS acceptable
- 83% found the calls helpful
- 86% of those who received outcalls said the timing of the calls was helpful

“I just thought the referral process was a matter of course, thought it was a good idea.”

“Instead of asking stupid questions, now ask sensible questions – broadened my knowledge of disease.”

“I think probably that prostate cancer is not greatly talked about by men – so the more discussions take place, the easier it becomes to talk not only to your doctor, but to other men as well.”

Recruitment will continue over the next 12 months

If you would like to participate in this study, please contact Dr Trish Livingston, Ph: 03 9635 5184 or E-mail: Trish.Livingston@cancervic.org.au

Guidelines for the Prevention, Early Detection & Management of Colorectal Cancer

This revision is nearing completion. Most chapters have been updated and public review is expected within the next few months. The draft document will be posted on the ACN website during this public consultation.

Reprinted from Wongji Yabber November 2004; 11(4): 2.

Position Statement – HNPCC: Gynaecological Cancer Surveillance Screening

*Prepared by a working party of, and supported by the
VCOG Gynaecological Cancer Committee – September 2004*

Introduction

The cumulative lifetime risk of endometrial cancer in women with a mismatch repair gene (MMR) germline mutation is reported to be 25–60% with most reports suggesting it is >40%.^{1,2} The highest risk is between the ages of 40–60 years with diagnosis before the age of 35 years being rare. The mean age of diagnosis is 42–49 years.^{2,3}

The lifetime risk of ovarian cancer in this same group of women has been reported to be 7–15%, significantly higher than the general community risk. The mean age of diagnosis appears to be 42–50 years, which is similar to that of endometrial cancer. However accurate age-related risk estimates are not available.^{2,3,4}

The screening modalities that have been proposed for the early detection of endometrial and ovarian cancer in HNPCC families have never been evaluated in this setting.⁵ There is still no data that shows screening for ovarian cancer in high-risk families (BRCA 1, 2) is effective.⁶

Endometrial Cancer Surveillance Screening

Transvaginal ultrasound (TVUS) to assess endometrial thickness in asymptomatic women suggests that a total thickness up to 8mm in the proliferative phase of the cycle is normal. This thickness should be measured from basalis layer to basalis layer on the other side, excluding any intrauterine fluid that may be present.^{7,8}

In the study by Rijcken, et al.⁹ endometrial biopsy was performed for premenopausal women only when there were abnormal ultrasound findings or clinical symptoms. No endometrial cancers were identified in the asymptomatic group undergoing screening. All cases of endometrial cancer identified were symptomatic.

A similar study from Dove-Edwin, et al.¹⁰ found no cases of endometrial cancer detected by surveillance scanning in 269 pre- and post-menopausal women. Two cases of endometrial cancer were found because of symptoms.

The problems with endometrial sampling in a group of young women are not insignificant. Many of these women will be nulliparous and endometrial sampling is an invasive procedure that is uncomfortable or painful, with no evidence of benefit at this time for routine use in surveillance.

Ovarian Cancer Surveillance Screening

The place of CA125 screening for ovarian cancer in this group of women is unknown. Up to 5% of women <35 years will have a CA125 above the normal range. This is often associated with endometriosis, menstruation and fibroids but can also reflect normal physiological variation. At this time there is no evidence to support the use of CA125 in the surveillance of pre-menopausal women with HNPCC except as part of prospective evaluation of this test in a familial cancer clinic.

HNPCC: Gynaecological Cancer Surveillance Screening – Position Statement

These guidelines have been developed for women with:

- 1 A known MMR gene mutation;
- 2 Affected females of Amsterdam positive families; and
- 3 Untested first degree relatives of both of the above.

HNPCC: Gynaecological Cancer Surveillance Screening

- Screening is appropriate only for asymptomatic women. The presence of abnormal vaginal bleeding warrants thorough gynaecological investigation that includes ultrasound assessment of the uterus and ovaries, hysteroscopy and endometrial biopsy.
- Screening should be performed annually. For women who decline screening regular specialist assessment and reporting of any abnormal gynaecological symptoms should be encouraged.
- Screening to start at 30–35 years in asymptomatic women. If there is a family history of gynaecological cancer prior to the age of 35 then screening should commence 5 years before that age.
- Screening should be by transvaginal ultrasound (TVUS) performed by a practitioner with specialised expertise in this field. The TVUS should determine total endometrial thickness and also assess ovarian morphology. TVUS should be performed in the proliferative phase of the menstrual cycle and total endometrial thickness should be less than 9mm.
- Endometrial sampling should be utilised where there are abnormal endometrial findings on TVUS. Hysteroscopy and curettage may be required in asymptomatic women where endometrial sampling is inconclusive.
- CA125 alone is an inappropriate screening test for ovarian cancer screening. The significant false positive and negative results suggest that this test may be performed optionally in conjunction with TVUS in pre-menopausal women.
- Removal of the uterus, ovaries and fallopian tubes should be considered from the age of 40 years or 5 years prior to the age of onset of a gynaecological cancer in a HNPCC affected relative. If for some reason surgery is not performed, then TVUS screening should continue, with an endometrial thickness of greater than 4 mm considered abnormal in post-menopausal women. CA125 follow-up should also be performed in this group of postmenopausal women.
- The place of hysterectomy and BSO should be discussed pre-operatively with women who are to undergo a colectomy where they are known to have, or there is a high risk of having a germline mutation in a mismatch repair gene.

Acknowledgements

Prepared by a Working Party of:

- Assoc Professor David Allen, Gynaecological Oncologist, Mercy Hospital for Women
- Dr Peter Grant, Gynaecological Oncologist, Mercy Hospital for Women
- Dr Thomas Manolitsis, Gynaecological Oncologist, Monash Medical Centre

On behalf of the Gynaecological Cancer Committee of the Victorian Cooperative Oncology Group of The Cancer Council Victoria.

Supported by the Gynaecological Cancer Committee and the Cancer Genetics Advisory Committee of the Victorian Cooperative Oncology Group of The Cancer Council Victoria.

Distributed to VCOG Gynaecological Cancer Committee, VCOG Cancer Genetics Advisory Committee and Hereditary Bowel Cancer Clinical Group, Department of Human Services Victoria Family Cancer Genetic Services Implementation Committee.

Review Timeline – Bi-annually from the date of ratification, or when a peer-reviewed publication provides evidence contrary to the guidelines recommended in this statement.

Approved by Professor David Hill, AM, PhD, Director, The Cancer Council Victoria (September 2004).

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Cancer Information and Support Service (CISS)

The Cancer Information and Support Service (CISS) is a body of The Cancer Council Victoria that aims to alleviate the stresses that cancer places upon people through provision of information and support. CISS runs a number of services, including:

The Cancer Helpline

- Staffed by oncology nurse counsellors and trained enquiries officers
- A local call from anywhere in Victoria – 13 1120
- Confidential provision of information and emotional support with referral to local community services
- Printed information on many cancer-related topics can be mailed to callers at no cost
- In 2003, the Cancer Helpline responded to over 49,000 contacts. This included over 6500 contacts with patients, 5500 contacts with family / relatives, 9200 contacts with the general public and 8000 contacts with health professionals

Multilingual Cancer Information Line

- enabling people from non-English speaking backgrounds to access the Cancer Helpline via an interpreter

Cancer Connect

- A telephone peer support service that puts people in touch with others who have had a similar cancer experience

- Over 500 referrals and around 900 contacts were made in 2003

Cancer Support Groups

- CISS provides training and accredits nearly 120 groups within Victoria

Financial Assistance

- Including welfare grants and no interest loans

Living With Cancer Education Program / Living Well forums

- In 2003, there were 35 LWCEP run in Victoria with over 400 attendees

Look Good, Feel Better workshops

Holiday Respite Program

CISS would like to encourage you to refer your cancer patients and their carers to our professional services.

If you would like to receive brochures or any other information regarding any of the above please call the Cancer Helpline on 13 11 20. Alternatively contact the Director of CISS, Doreen Akkerman (Ph: 03 9635 5129 / E-mail: Doreen.Akkerman@cancervic.org.au) or Michael Jefford, Clinical Consultant, CISS (E-mail: Michael.Jefford@cancervic.org.au).

Established treatments, treatments being trialled and alternative (unproven) treatments for cancer

If you have been diagnosed with cancer, it is possible that different treatments have been suggested to you. The Cancer Council has produced this information to help you decide between treatments that may help you and treatments that are unlikely to help you.

Your doctor will recommend one or more established treatments or suggest that you consider taking part in a clinical trial of a new treatment. You may be thinking about using complementary therapies along with treatments suggested by your doctor. You may also have read about, or been told about, an alternative treatment that may help.

How are they different?

Established treatments

These are proven treatments such as radiotherapy, chemotherapy, hormone therapy, immunotherapy and surgery. These are also known as 'medical', 'conventional' or 'mainstream' treatments.

These treatments have been tested in clinical trials and shown to be effective. (See the description of clinical trials below.) For example, it has been proven in clinical trials that:

- removing a skin cancer at an early stage prevents it from growing or spreading
- many childhood leukaemias can be cured with chemotherapy
- tamoxifen can prevent some breast cancers from recurring.

Established treatments are prescribed by general practitioners, cancer specialists (oncologists) and other medical specialists. You have these treatments in hospitals and doctors' surgeries and sometimes at home.

Treatments being trialled

These are treatments that are being tested in clinical trials. Clinical trials test new drug therapies, procedures, treatment combinations, preventative measures, screening methods and alternative treatments to see if they are better than the established treatments.

Clinical trials examine treatments that have shown promise during initial testing. For example, a researcher may think that a chemical that affects cell growth could be used to destroy cancer cells. Tests evaluating its safety and effectiveness will be done in the laboratory and then on animals. If it is thought to be safe and effective enough, it will be tested on people in a clinical trial.

There are three clinical trial phases. The cancer specialists carefully watch the effects of the new treatment on the people in the trial. If the treatment goes through to the end of the third clinical trial phase, the results of the new treatment are compared with established treatments. If the treatment that was trialled is better, and usually after it has been confirmed with other trials, it will be recommended to other doctors for their patients.

A clinical trial will only be conducted if the new treatment is thought to be at least as effective as the established treatment for a cancer.

Clinical trials are conducted and monitored according to strict guidelines. The treatments are given strictly to plan. Results are collected, analysed and published in scientific journals.

People in trials are treated according to an agreed document that sets out the terms of treatment (known as a treatment protocol). They are reviewed frequently during and for a time after the treatment phase, and so receive very high quality care. Some studies have shown that people treated in clinical trials have better outcomes than people who do not join clinical trials.

People are told about clinical trials by their doctor or they may hear about them from the media, the Internet or other sources. They can volunteer to join the trial.

Alternative (unproven) treatments

These are treatments that are said by the people who provide them to be alternative to established treatments. People who provide alternative (unproven) treatments say they will or may cure cancer, *but this has not been shown in clinical trials*.

- An alternative treatment may have been tested but 'no evidence of benefit' found. This means it is uncertain whether it works or not.
- 'Evidence of no benefit' means a treatment has been tested and shown not to work against cancer.

Alternative (unproven) treatments are also known as integrative, unproven, holistic, non-mainstream and unconventional treatments or remedies.

Alternative cancer treatments for which 'miracle cures' have been claimed include magnets, various diets, coffee enemas, fresh cell therapy, microwave therapy, oxygen therapy and laetrile and other plant products. Be wary of these claims. Ask the alternative practitioner to give you evidence to back them. One or two books by people who deliver a certain treatment is not strong evidence. Look for articles in recognised medical or scientific journals. Recognised medical journals are listed in PubMed, an international database of biomedical journals. You can search the database through <http://www.ncbi.nlm.nih.gov/entrez/query.fcgi>. It is even more important to discuss these 'apparent cures' with the doctors treating you. Your doctors will usually have up-to-date information on the claims.

Complementary therapies

These are therapies such as massage, aromatherapy and meditation. People may feel a greater sense of wellbeing while they take the treatments. These are often called 'supportive therapies'. They are not promoted as cancer treatments or cures in their own right.

Some, like massage, have been used for centuries to complement mainstream medicine. They may help

people feel more relaxed and able to cope better with the impact of their illness.

Key points

- Established treatments are known to cure some cancers and provide relief from symptoms of cancer.
- Treatments being trialled are promising treatments that are tested in clinical trials. They are only tested if they are predicted, on initial testing, to be at least as effective as the established treatment for a cancer.
- Alternative treatments have not been shown in clinical trials to cure or slow cancer down because trials have not been done ('no evidence of benefit'). Others have been tested and shown to be ineffective ('evidence of no benefit').
- Complementary therapies may be used to enhance established treatments.

How can they help?

When choosing a cancer treatment, you will be seeking one or more of the following:

- cure
- relief from symptoms
- help with a problem related to your illness (like anxiety)
- reassurance that you are doing all you can.

How established treatments may help

Your doctor will tell you if there is a cure for your cancer, or treatment that may slow its process. For over half of all cancers, surgery and/or radiotherapy and/or chemotherapy will kill the cancer cells and stop them from coming back. Although the treatment itself may cause side effects and be upsetting, most people are prepared to put up with this to try to get rid of the cancer.

Sometimes, the doctor won't be able to reassure you that the cancer will be cured. Sometimes, a few cancer cells escape and slowly grow into a new spot of cancer elsewhere in the body. Many people who have established treatment for cancer won't know for several years whether their cancer has gone away. If the cancer has not reappeared (recurred) within five years of treatment, then often you have a high chance of having been cured.

It is possible that there is no cure for your cancer. There may be no effective established treatment and/

or the cancer may be advanced when you are diagnosed. There are still established treatments that can help you. Established treatments may be able to reduce the size of the cancer or delay its growth, so that it doesn't affect how your body normally functions. They can also relieve pain and other problems caused by the cancer. This is called 'palliative treatment'. Some people can still have years of high quality life even though their cancer has not been cured.

If you want more information about the treatment your doctor recommends, you can ask for a second opinion from another specialist. Your doctor should not be offended: it is quite normal to want to know that your treatment is the best available.

How treatments that are being trialled may help

Your doctor may suggest that you join a clinical trial. This might happen if:

- there is no established treatment that will cure you
- there is a promising new treatment being tested for your cancer.

Remember, treatments being trialled are not certain to cure you. They may turn out to be only as effective as the existing treatment for your cancer.

Treatments being trialled often have side effects. These will be explained in the patient information/consent sheet that you will be asked to read and sign before the trial begins. Just because a treatment is new, it does not mean it is better—that is what the trial is trying to find out.

Sometimes, people participating in a clinical trial might receive an inactive or 'placebo' treatment, or be treated to control symptoms. In these cases, no established treatment is required; in other words, you are not missing out on any treatment you should otherwise be having.

How alternative treatments may help

Some people with cancer want to experiment with alternative treatments. A questioning approach helps people make their way through the many alternative treatments on offer. See 'Questions to ask' in this brochure.

How complementary therapies may help

Complementary therapies can help you to cope better with the challenges you face as a person with cancer. Physical therapies like yoga, massage and t'ai chi can help you to feel more relaxed and stronger. Measures like aromatherapy and music therapy will help if these

are the sorts of therapies that you enjoy. If you are spiritually inclined, you will find comfort and strength in formal or informal services and rituals related to your beliefs.

Key points

- Established treatments can cure many cancers and provide relief for symptoms that cannot be cured.
- A treatment being tested in a clinical trial may be an option for you if the established treatment for your cancer is not adequate or a promising new treatment is being compared with the established treatment.
- Complementary therapies can be useful in easing symptoms like anxiety or tension associated with fears and uncertainties about having cancer.

When should alternative (unproven) treatments be avoided?

When they will delay diagnosis of cancer

If you have a troubling symptom and you wish to seek the advice of an alternative therapist, it is a good idea to also see a medical practitioner. Some symptoms of cancer may not be noticed or may be misdiagnosed by an alternative therapist.

Symptoms that should always be checked by a doctor include any new or unexplainable swelling, bleeding, pain and continued hoarseness or coughing. These symptoms don't necessarily mean that you have cancer, but should be checked.

When they will interfere with established treatment

Many alternative treatments are probably harmless, but not all. Some herbs and vitamins can interact with chemotherapy and radiotherapy so that they don't work as they should, or can cause harm. Before you begin a therapy prescribed by an alternative therapist, check with your cancer specialist that it is safe and won't affect your medical treatment, reduce the effectiveness of the medical treatment, and/or increase the risk of side effects.

When they will prolong or worsen the disease experience

Some people find that complementary therapies like relaxation, yoga and massage can improve their experience of established treatment, making them feel less anxious and more in control.

For some people, alternative therapies can make the experience much worse. This can happen:

- if you rely on alternative treatments that are not proven to work
- if your alternative therapist makes you feel responsible when their treatment doesn't make you better
- if it makes you sicker
- if it upsets you or costs more than you can really afford.

When they stop you using medical treatment that could improve your health

Some alternative therapists suggest to people they treat not to have established medical treatments or to cease them. The alternative therapist may warn that medical treatment will stop the alternative therapy working. Be very wary of claims like this. Always get an opinion from a cancer specialist.

Key points

- Beware of 'magic' or 'miracle' cures. Always get an informed opinion from your cancer specialist and/or the Cancer Helpline.
- Complementary therapies can be helpful additions to established treatment for people with cancer.
- Most alternative therapists cannot diagnose cancer.
- Some alternative treatments can interfere with established treatments and worsen your experience of cancer.

Questions to ask

Whether you are choosing a cancer specialist (surgeon and/or medical oncologist and/or radiation oncologist) or an alternative therapist, you need to be able to trust and talk openly with that person. This does not mean that you need to have warm feelings for each other. The person you choose may not even be very friendly! However, you will need to feel that they are expert, approachable, respectful, supportive and able to meet your needs for information and advice.

One way of finding out if the person is expert is to ask questions about their qualifications and experience. Here are some questions that may help when you choose a medical or alternative practitioner. (You could ask your general practitioner some of these questions, if he or she is referring you to a specialist.)

- What training does the practitioner have? Is their degree from an educational institution you know of or can find out about?
- Does the practitioner treat patients in hospitals where doctors are trained?
- What will the practitioner charge for a visit? How many visits will you need to make?
- Are there additional costs, for example, for different stages of treatment or additional expertise?
- Is the practitioner willing to refer you to publications that demonstrate that the treatment works?
- Are they members of a professional group that registers and represents that group of specialists in dealing with state and federal departments of health?

Also ask yourself if you are comfortable with the practitioner. Do you feel that they are attentive, trustworthy and level-headed?

Do you know other people who have been patients or clients of the practitioner? What do they say about them?

You may wish to find out more about the treatment the practitioner recommends. To find out if a treatment is worth trying, *be cautious, ask questions and confirm claims.*

Be cautious

You don't have to uncritically accept any claims made by a person seeking to treat you. You may trust the practitioner, and still wish to independently check their advice. Beware of 'pseudoscience'—things that sound very scientific and plausible but which are not actually backed up by evidence of proven benefit.

Ask questions

You will be surer of the treatment if you get satisfactory answers to the following questions:

- In what way will this treatment benefit me?
- What results can I expect to see?
- Are there any long-term risks associated with this treatment? If so, what are they?
- What side effects do people have with this treatment?
- How much will it cost?

- Will Medicare / my private health insurance cover the cost?
- How long will the treatment take?
- When could I expect to see a result from the treatment?
- How many people have received this treatment?
- How many of them responded?
- What happened to the ones that didn't respond?
- What's in it for the person offering me this treatment?

Confirm claims

Established treatments are subjected to scientific testing. This means:

- the theory behind a proposed treatment is based on accepted scientific principles
- testing on animals usually occurs before a new treatment is tested on humans
- the results of these trial/s are published in 'peer-reviewed' medical and scientific journals. This means that other specialists with expertise in the field check that the study was conducted correctly and that the results are valid.
- the results of trials are also verified by trials from specialist cancer hospitals throughout the world.

If you want to check that a treatment has been trialled and the results published, you can do a literature search through a medical library or via Medline on the Internet. A health information service for consumers may be able to help you, for example the Cancer Helpline 13 11 20.

Key points

- Ask your cancer specialist questions that are important to you: Will the treatment work? How do they know the treatment will work? When will I see results? What side effects can occur? How much will it cost?
- Be sure that you have confidence in the practitioner. If you don't have confidence in a cancer specialist, ask your general practitioner for referral to another specialist. If you are seeking to change alternative practitioners, your general practitioner or a trusted friend or adviser may be able to refer you on.

A final word

You have the right to choose whatever treatment you want for your cancer. Most people choose established treatments for their disease, and many also choose complementary therapies for some symptoms. A few choose no treatment, or a 'miracle cure'. We recommend that you make an informed choice where you can. This will include asking the opinion of people you respect and researching your options. You are welcome to call the Cancer Helpline on 13 11 20 to talk about the choices before you.

Useful websites

You may be interested in looking for information about cancer treatments on the Internet. While there are some very good websites, you need to be aware that some websites provide wrong or biased information. The following websites contain reliable information.

National Center for Complementary and Alternative Medicine (NCCAM)

<http://nccam.nih.gov>

Includes publications, information for researchers, frequently asked questions, and links to other related resources.

Quackwatch

www.quackwatch.com

Aimed at combating health-related frauds, myths, fads and fallacies.

Therapeutic Goods Administration (TGA)

www.health.gov.au/tga

The Cancer Council Victoria

www.cancervic.org.au

Provides general information on cancer, including diagnosis, treatment and support services.

Working Parties for Accreditation, Credentialing and Guideline Implementation

The **Australian Cancer Network** (ACN) is developing wider, strong and active links with individuals and organisations working to strengthen the quality of care in the management of cancer patients. It is also working to ensure that cancer care is based on the best level of information available.

Working party to establish accreditation of cancer services

This activity is progressing well. Significant discussions have occurred and the possibility of expanding interaction with state bodies is to be embraced. Elizabeth Metelovski has been appointed Project Officer and together with Dr Karen Luxford of the National Breast Cancer Centre (NBCC) in association with the National Cancer Control Initiative (NCCI), is carrying out a scoping study following the signing of an MOU between ACN and NBCC. The first draft of this report was considered by the Steering Committee on 28 September. This was a proactive review and many members have contributed. An extension of time has been granted and the Committee will meet again by phone to finalise the document in the second week in December.

Working Party to establish credentialing processes for medical staff of cancer services

Credentialing is recognised as one of the more significant steps in developing best practice in Cancer Units and the introduction of optimal multi-disciplinary care. This Working Party has made headway; however, it requires a good deal more work to produce appropriate procedures to ensure that the process has best practice outcomes. It is timely to expand activities of this Committee through a scoping study. It is hoped to appoint a Project Officer to carry this forward in the next few weeks. This appointment should lead to more substantive progress.

Working party to promote implementation of best practice guidelines

A Cancer Guideline Implementation Workshop was held on 14 October 2004 at Level 3, Medical Foundation Building.

The meeting was held under the auspices of the National Institute of Clinical Studies (NICS), NBCC and ACN. It was facilitated by Professor Dave Davis from Toronto and was positive in every respect.

Apart from identifying and discussing a range of issues in a positive manner, it allowed a number of people with like interests to learn of each other's existence. It will also have impact on the matrix being developed for the ACN Guideline Implementation Steering Committee.

Guideline development activities continue with progress being made in a number of important areas.

Reprinted from Wongi Yabber November 2004; 11(4): 1-2.

Report of The Cancer Council Australia

Glen Turner
Communications Manager
The Cancer Council Australia

Cancer Council advocates national approach to cancer prevention

A concerted and comprehensive national approach to cancer prevention is the theme of The Cancer Council Australia's *National Cancer Prevention Policy (2004–2006)*, launched in July 2004.

The *National Cancer Prevention Policy* sets out measures to help reduce the impact of preventable risk factors, such as smoking, ultraviolet radiation, inadequate diet and physical inactivity. It also outlines the benefits for screening for early detection of breast, cervical, bowel and prostate cancers and melanoma.

The Cancer Council Australia's Chief Executive Officer, Professor Alan Coates, said Australia was a world leader in the prevention of many cancers and much of that success was derived from the collaborative work of cancer councils and federal, state and territory governments.

"However, we could do much better," Professor Coates said. "Many of the 85,000 new cases of cancer diagnosed in Australia each year could be prevented through risk minimisation or treated more effectively through early detection."

The *National Cancer Prevention Policy*, which establishes a framework for governments to invest in improved cancer prevention, is the result of detailed work by the public health workers and clinicians who comprise The Cancer Council Australia's Public Health Committee and its sub-committees.

Professor Coates paid tribute to the authors of the policy, in particular Dorothy Reading (Chair of the Public Health Committee) who coordinated its development and production.

The *National Cancer Prevention Policy (2004–2006)* is available online at www.cancer.org.au.

Reprinted from *Wongi Yabber* August 2004; 11(3): 4.

Unprecedented political support

For the first time in a federal election, both the Coalition and the ALP included detailed cancer control policies among their campaign promises, with commitments that reflected much of The Cancer Council Australia's recommended policy platform.

In separate announcements in September, the ALP committed to more than \$112 million in prevention and treatment initiatives, while the Coalition launched its comprehensive \$137 million policy, *Strengthening cancer care*, in October.

The Cancer Council Australia publicly endorsed both policies, particularly the many initiatives consistent with the evidence-based position we put forward to all federal parliamentarians in June.

One of the most significant announcements was the Coalition's pledge to establish a national cancer care agency, Cancer Australia, at \$10 million over four years, which was a key Cancer Council priority.

There was unanimous support for funding independent clinical trials capacity building, with the Coalition and the ALP committing to \$15 million and \$12 million respectively over four years. The Cancer Council Australia had sought \$5 million per annum.

Both sides also committed to rolling out a national bowel cancer screening program, as well as funding for national SunSmart campaigns. The ALP allocated \$21 million for a tobacco control program aimed at a five percent decrease in national smoking rates, while the Coalition announced \$4 million to reduce smoking in pregnancy.

The ALP's commitment to introducing a Medicare Benefits Schedule item for cancer multi-disciplinary care reflected The Cancer

Council Australia's overarching theme of improving multi-disciplinary care.

The Cancer Council Australia CEO, Professor Alan Coates, said considerable effort went into engaging with both sides of politics in the lead-up to the election.

"We continue to emphasise the fact that, while there have been improvements in cancer outcomes for Australians over recent years, cancer remains the nation's deadliest disease

and there is great scope for federal policy makers to reduce the burden," Professor Coates said.

"We were very pleased to see both sides of politics show strong leadership in cancer control and look forward to continuing to build good relationships with our supporters in Federal Parliament."

Reprinted from Wongi Yabber November 2004; 11(4): 3-4.

Report of the National Cancer Control Initiative (NCCI)

Australian Clinical Management Surveys in Cancer

In Australia, clinical management surveys have been conducted for a number of different cancers and in various locations. The NCCI was interested in identifying clinical management surveys for cancer in Australia, including surveys that have been published, are ongoing or are planned. A report *Australian Clinical Management Surveys in Cancer* identifies 25 published and 26 ongoing or planned clinical management surveys in cancer that have a large population base, ideally national or state-wide and lists the identified surveys. A table summarising the information contained in the published clinical management surveys is also provided. The report is available on the NCCI website at www.ncci.org.au

Core clinical data set and dictionary

Since 1982, Australia has had full coverage of cancer incidence by population-based state cancer registries allowing trends to be monitored. Mortality and overall survival rates by type of cancer can also be assessed but this information is insufficient to assess how the diagnosis, treatment and outcome of cancer patients compare to best practice. In 1999, the NCCI commenced a project to develop a core data set that would capture the most important data items relevant to the diagnosis and primary

management and prognosis of cancer at the clinical level. A nationwide consultation was undertaken by Professor Alan Coates, on behalf of the NCCI, with input from a wide range of clinicians, hospital staff, all Australian cancer registries, the AIHW and other groups. The items adopted for the NCCI Clinical Cancer Core Data Set reflected 'a reasonable compromise between a set too large to be attainable and one too small to be interesting' and included details of the stage of cancer at diagnosis, initial treatments and treatment outcomes.

The items in the NCCI Clinical Cancer Core Data Set were submitted to the National Health Data Committee (NHDC) for inclusion in the National Health Data Dictionary (NHDD). In June 2004 all but two data items were approved under the title Cancer (clinical) Data Set Specification. The two items not approved for inclusion in the NHDD were *Performance status score at diagnosis* and *Cause of death* but both of these are still included in the full NCCI Clinical Cancer Core Data Set. All items in the data set have been updated in line with the approved definitions and coding and are now available on the NCCI website www.ncci.org.au. The approved data items are also available via the Australian Institute of Health and Welfare knowledge base at www.aihw.gov.au/knowledgebase/index.html.

Reprinted from Wongi Yabber August 2004; 11(3): 3.

Clinical Practice Guidelines

There has been a widespread move towards developing clinical practice guidelines, which are designed to improve the quality of health care, to reduce the use of unnecessary, ineffective or harmful interventions, and to facilitate the treatment of patients with maximum change of benefit, with minimum risk of harm, and at an acceptable cost. Recent research has shown that clinical practice guidelines can be effective in bringing about change and improving health outcomes. But they are just one element of good medical decision making, which also takes account of patients' preferences and values, clinicians' values and experience, and the availability of resources. *(Quote from NHMRC A Guide to the development, implementation, and evaluation of clinical practice guidelines, November 1998.)*

The Cancer Council Victoria is supportive of the development of national clinical practice guidelines for management of cancer. The Cancer Council and members of the Victorian Cooperative Oncology Group have contributed to the development of national clinical practice guidelines through the Australian Cancer Network and National Breast Cancer Centre. Clinical practice guidelines are extensively reviewed before being endorsed by the National Health and Medical Research Council.

The following clinical practice guidelines are available from the NHMRC website (links are also provided at www.cancervic.org.au/cancer1/professionals/guidelines.htm) :

Breast Cancer

- Clinical practice guidelines for the management of advanced breast cancer (Endorsed January 2001)
www.nhmrc.gov.au/publications/synopses/cp76syn.htm
- Clinical practice guidelines for the management of early breast cancer – 2nd Edition (Endorsed August 2001)
www.nhmrc.gov.au/publications/synopses/cp74syn.htm

- Psychosocial clinical practice guidelines: Providing information, support and counselling for women with breast cancer (Endorsed December 1991)
www.nhmrc.gov.au/publications/synopses/cp61syn.htm

Colorectal Cancer

- Clinical practice guidelines for the prevention, early detection and management of colorectal cancer (Endorsed March 1999)
www.nhmrc.gov.au/publications/synopses/cp62syn.htm
- Guidelines for the prevention, early detection and management of colorectal cancer: A guide for patients, their families and friends (Endorsed February 2000)
www.nhmrc.gov.au/publications/synopses/cp63syn.htm
- Guidelines for the prevention, early detection and management of colorectal cancer: A guide for general practitioners (Endorsed 1999)
www.nhmrc.gov.au/publications/synopses/cp64syn.htm

Familial Cancer

- Familial aspects of bowel cancer: A guide for health professionals (Endorsed February 2002)
www.cancer.org.au/documents/Familial%20aspects%20of%20bowel%20cancer.pdf
- Clinical practice guidelines: Familial aspects of cancer: A guide to clinical practice (Endorsed November 1999)
www.nhmrc.gov.au/publications/synopses/cp67syn.htm

Lung Cancer

- Clinical practice guidelines for the prevention, diagnosis and management of lung cancer (Endorsed March 2004)
<http://www.nhmrc.gov.au/publications/pdf/cp97.pdf>

Ovarian Cancer

- Clinical practice guidelines for the management of women with epithelial ovarian cancer (Endorsed March 2004)
<http://www.ovariancancerprogram.org.au/about/guidelines.html>

Prostate Cancer

- Clinical practice guidelines: Evidence-based information and recommendations for the management of localised prostate cancer (Endorsed October 2002)
www.nhmrc.gov.au/publications/synopses/cp88syn.htm

Skin Cancer

- Clinical practice guidelines for the management of cutaneous melanoma (Endorsed December 1999)
www.nhmrc.gov.au/publications/synopses/cp68syn.htm

- Clinical practice guidelines: Non-melanoma skin cancer: Guidelines for treatment and management in Australia (Endorsed October 2002)
www.nhmrc.gov.au/publications/synopses/cp87syn.htm

Psychosocial Guidelines

- Psychosocial clinical practice guidelines: Providing information, support and counselling for women with breast cancer (Endorsed December 1999)
www.nhmrc.gov.au/publications/synopses/cp61syn.htm
- Clinical practice guidelines for the psychosocial care of adults with cancer (Endorsed April 20003)
www.nhmrc.gov.au/publications/synopses/cp90syn.htm

Clinical practice guidelines for the management of colorectal cancer and lymphoma are currently being developed under the auspice of the Australian Cancer Network (2004)

Key Published Articles Listing—Gastrointestinal Cancer

Title	Author & Journal
[Identification and management of HNPCC syndrome (hereditary non polyposis colon cancer), hereditary predisposition to colorectal and endometrial adenocarcinomas] <i>[Article in French]</i>	Olschwang S, Bonaiti C, Feingold J, et al. Bulletin du Cancer Apr 2004; 91(4): 303–315.
Estimation of an optimal radiotherapy utilization rate for gastrointestinal carcinoma: A review of the evidence	Delaney G, Barton M & Jacob S. Cancer 15 Aug 2004; 101(4): 657–670.
Colonoscopy screening for colorectal cancer: The outcomes of two recruitment methods	Corbett, M, Chambers SL, Shadbolt B, et al. The Medical Journal of Australia 18 Oct 2004; 181(8): 423–427.

Key Published Articles Listing—General

Title	Author & Journal
Clinical trial registration: A statement from the International Committee of Medical Journal Editors <i>[Editorial]</i>	De Angelis C, Drazen JM, Frizelle FA, et al. The New England Journal of Medicine 16 Sep 2004; 351(12): 1250–1251.

Forthcoming Meetings

Date / Place	Meeting / Contact
12–14 January 2005 Eilat, Israel	4th International Meeting of the Israeli Society for Clinical Oncology & Radiation Therapy (ISCORT) Ph: +92 286 00 680 Fax: +92 286 232 336 E-mail: wilmosh@bgumail.bgu.ac.il
16–21 January 2005 Films, Switzerland	9th European Winter Oncology Conference Federation of European Cancer Societies, Av E Mounier 83, Brussels 1200 Belgium Ph: +32 2 775 0201 Fax: +32 2 775 0200 E-mail: ewoc-9@fecs.be Website: www.fecs.be
27–29 January 2005 Phoenix, Arizona, USA	2nd Annual Conference of the American Psychosocial Oncology Society (APOS) APOS, 2365 Hunters Way, Charlottesville Virginia 22911 USA Ph: +1 434 293 5350 Fax: +1 434 977 0899 E-mail: aholcomb@apos-society.org Website: www.apos-society.org
10–13 February 2005 Phillip Island, Vic, Australia	17th Lorne Cancer Conference – At Phillip Island, Victoria Secretariat: ASN Events Pty Ltd Ph: (03) 5983 2400 E-mail: cancer@asnevents.net.au Website: www.lornecancer.org
10–14 February 2005 Paris, France	16th International Congress on Anti-Cancer Treatment Travel Congress Organisation (TCO), 2 rue de Berri, Paris 72008, France Ph: +33 1 4294 8732 Fax: +33 1 4294 8733 E-mail: info@icact.com Website: www.icact.com

Date / Place	Meeting / Contact
18–19 February 2005 Nice, France	New Targets in Cancer Therapy III Imedex, 70 Technology Drive, Alpharetta, Georgia 30005 USA Ph: +1 770 751 7332 Fax: +1 770 751 7334 E-mail: c.chase@imedex.com Website: www.imedex.com
3–5 March 2005 Amsterdam, Netherlands	3rd International Symposium on Targeted Anticancer Therapies NDDO Research Foundation, c/o Convenience Conference Management, PO Box 77, Harmelen 3480 DB Netherlands Ph: +31 348 567 667 Fax: +31 348 446 057 E-mail: congress@nddo.org Website: www.nddo.org
3–6 March 2005 Atlanta, Georgia, USA	58th Annual Cancer Symposium of the Society of Surgical Oncology (SSO) Society of Surgical Oncology, 85 W Algonquin Rd, Suite 55 Arlington Heights, IL 60005, USA Ph: +1 847 427 1400 Fax: +1 847 427 9656 E-mail: diannekubis@acaai.org Website: www.surgonc.org
7–9 March 2005 Madrid, Spain	Functional Genomics and Animal Tumour Models CNIO – Spanish National Cancer Centre, C/- Melchor Fernández Almagro, 3 Madrid 28029 Spain Ph: +34 91 224 6900 Fax: +34 91 224 6980 E-mail: ccc@cnio.es Website: www.cnio.es/ccc
11–13 March 2005 Sydney, NSW, Australia	RCPA Pathology Update Contact: Suzanne Marks, Royal College of Pathologists of Australasia (RCPA) Ph: (02) 8356 5806 E-mail: suzannem@rcpa.edu.au Website: www.rcpa.edu.au
21–25 March 2005 Cairo, Egypt	Cancer in Developing World Fakkous Center for Cancer and Allied Diseases, 11 Boulos Hanna Street, Dokki, Cairo Egypt Ph: +20 2 337 0721 Fax: +20 2 749 3070 E-mail: sh_omar40@hotmail.com
16–20 April 2005 Anaheim, California, USA	96th Annual Meeting of the American Association for Cancer Research (AACR) AACR, Public Ledger Building, Suite 826, 150 South Independence Mall West, Philadelphia PA 19106-3 USA Ph: +1 215 440 9300 Fax: +1 215 351 9165 E-mail: meetings@aacr.org Website: www.aacr.org

Date / Place	Meeting / Contact
28 April – 1 May 2005 Orlando, Florida, USA	30th Annual Congress of the Oncology Nursing Society Oncology Nursing Society, 125 Enterprise Drive, Pittsburgh PA 15275-1214 USA Ph: +1 866 257 4667 Fax: +1 866 369 5497 E-mail: meetings@ons.org Website: www.ons.org
8–11 May 2005 Wellington, New Zealand	Annual Scientific Meeting of the Royal Australasian College of Physicians (RACP) Contact: Anne Chang E-mail: racpasm@racp.edu.au Website: www.racp.edu.au
9–13 May 2005 Perth, WA, Australia	Annual Scientific Congress of the Royal Australasian College of Surgeons (RACS) Website: www.racs.edu.au
13–17 May 2005 Orlando, Florida, USA	41st Annual Meeting of the American Society of Clinical Oncology (ASCO) ASCO, 1900 Duke Street, Suite 200 Alexandria, VA 22314 USA Ph: +1 703 299 0150 E-mail: asco@asco.org Website: www.asco.org
14–19 May 2005 Chicago, IL, USA	Digestive Disease Week (DDW) DDW is jointly sponsored by four societies: the American Association for the Study of Liver Diseases (AASLD), American Gastroenterological Association (AGA), American Society of Gastrointestinal Endoscopy (ASGE) and the Society for Surgery of the Alimentary Tract (SSAT) Website: www.ddw.org
18–21 May 2005 Darwin, NT, Australia	Annual Scientific Meeting of the Trans-Tasman Radiation Oncology Group (TROG) Ph: (02) 9280 0577 Fax: (02) 9280 0533 E-mail: conferences@pharmaevents.com.au
2–5 June 2005 Budapest, Hungary	Scientific & Educational Conference of the European Society for Medical Oncology (ESMO) ESMO Head Office, Congress Department, Via La Santa 7, CH-6962 Viganello-Lugano, Switzerland Ph: +41 91 973 1919 Fax: +41 91 973 1918 E-mail: alessia@esmo.org Website: www.esmo.org/congress2004/
15–18 June 2005 Barcelona, Spain	World Congress on Gastrointestinal Cancer Imedex, 70 Technology Drive, Alpharetta 30005, Georgia USA Ph: +1 770 751 7332 Fax: +1 770 751 7334 E-mail: meetings@imedex.com Website: www.worldgicancer.com

The Cancer Council Victoria

The Cancer Council Victoria is a public institution set up by an Act of Parliament in 1936. It operates as a charity, relies heavily on volunteer support, and raises and spends \$3-\$4 per head of population annually. It is governed by the Council and Executive and other committees. It's mission is to lead, coordinate and evaluate action to minimise the human cost of cancer for all Victorians. The Cancer Council houses three research divisions (behavioural science, clinical research, epidemiology) and units undertaking public and professional education, cancer registration, cancer information and support services, anti-smoking campaign (QUIT), finance, administration and fund raising. It employs about 150 staff. The Cancer Council also auspices a cooperating network of cancer specialists through the Victorian Cooperative Oncology Group and resources an expert Medical & Scientific Committee to dispense studentships, scholarships, fellowships and research grants to other academic, research and medical institutions.

Centre for Clinical Research in Cancer — Victorian Cooperative Oncology Group

The Centre for Clinical Research in Cancer (CCRC) formed in 1997, provides a coordinated and effective resource for collaborative clinical research and development in Victoria. The Centre provides administrative and research support for the Victorian Cooperative Oncology Group, which brings together Victoria's cancer specialists. The Centre fosters and facilitates the development and promotion of a range of collaborative clinical measures to optimise cancer management.

The Victorian Cooperative Oncology Group (VCOG) established in 1976, provides advice to the Cancer Council Victoria, through the CCRC, on all clinical aspects of cancer control, in particular research, screening, diagnosis, treatment, palliative medicine, cancer genetics and professional education. The strategic role of VCOG is to have a 'parliament' of clinical cancer specialists with a view to promoting a range of cooperative measures to optimise cancer treatment in Victoria. VCOG consists of a primary committee, 9 cancer-site and 3 task-specific advisory committees, and 5 trial research sub-committees. These committees bring together in regular meetings approximately 400 key specialist health care professionals and scientists, representing the various treatment disciplines and centres in Victoria. VCOG has established unique linkages between public and private health care professionals, institutions and governments.

