



Gastrointestinal Cancer Update

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ASCO MEETING REPORT

DIGESTIVE DISEASE WEEK REPORT

INSIGHT MEETING REPORT

NATIONAL BOWEL CANCER
SCREENING PROGRAM UPDATE

VICTORIAN CANCER SERVICES
FRAMEWORK

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



GASTROINTESTINAL CANCER UPDATE

July 2005

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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.

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***** **Last Issue – No. 43 – December 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
Surgeon
Western Hospital*

Three detailed reports from the ASCO, DDW and InSiGHT meetings form the backbone of this issue.

Jeremy Shapiro reports from ASCO 2005 on Page 4. As a result of NSABP C7 and ACCORD, oxaliplatin should be added to adjuvant treatment for colon cancer; whereas PETACC was less convincing regarding irinotecan. In advanced colon cancer, Bevacizumab achieves better results in combination with Folfox than alone. In operable gastric cancer, patients benefited from a split pre- and post-operative ECF regime compared to surgery alone. Initial reports of gemcitabine in pancreatic cancer remain encouraging.

Fin Macrae reports from DDW on Page 6. He covers APPROVe (rofecoxib in adenoma patients), curcumin and folate in chemoprevention studies. There is further data on the role of MYH genotypes that predispose to colon cancer. Diligent withdrawal of the colonoscope is associated with a higher rate of finding polyps. National auditing of colonoscopy is underway in the UK and Germany. Progress with self-propelling colonoscopes and confocal colonoscopy was presented.

Fin also reports highlights from the first InSiGHT conference on Page 9.

The National Bowel Screening Program has received funding to start screening all Australians turning 55 and 65 each year commencing mid-2005. Details are on Page 12.

Also on Page 12 is The Cancer Council Victoria's media release for Bowel Cancer Awareness Week. It targets the association between excess weight and bowel cancer.

Professor Gillian Duchesne presents her view of the Victorian Cancer Services Framework on Page 14.

The report of The Cancer Council Australia is on Page 17 - this covers new position statements.

The National Cancer Control Initiative reports on two projects on Page 18 and a COSA update is on Page 19.

The provision of multi-language cancer information is promoted on Page 21. Articles of interest and forthcoming meetings are listed on Page 22.

Selected reprints from Wongi Yabber surround this issue.

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:

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

Report of the 41st Annual Meeting of the American Society of Clinical Oncology (ASCO)

13–17 May 2005, Orlando, Florida, USA

*Dr Jeremy Shapiro
Gastrointestinal Oncologist
Alfred and Cabrini Hospitals*

Close to 30,000 delegates attended ASCO 2005 in Orlando, home of several Disneyworld theme parks. An appropriate place for a meeting that could be regarded as “Disneyland for Oncologists”. The immense size, large choice of simultaneous activities, increasingly high-tech and colourful trade displays, coupled with exciting science and outstanding reviews, are enough to invigorate and excite even the most cynical.

Improvements / additions to this year’s meeting included an extra half-day, three plenary sessions, and an additional breast cancer session hurriedly squeezed in to present the exciting Herceptin data. The “daily highlights” review sessions made a welcome return. The Convention Centre was user friendly, and ASCO should be commended for providing outstanding electronic facilities including readily available free WIFI and standard Internet access, Palm schedule downloads, and many terminals for onsite virtual meeting viewing.

Whilst ASCO 2005 will be remembered for the increasing focus on targeted therapies, and exciting advances in the treatment of breast cancer, practice-altering advances were also reported in colon, gastric, and pancreatic cancer, particularly in regards to adjuvant therapy.

Adjuvant Colon Cancer

Adjuvant therapy for patients with stage III and likely high-risk stage II colon cancer will change following the presentation of early efficacy data from three large phase III studies (NSABP C7, PETACC 3, ACCORD). Updated analysis from 2 further randomised adjuvant studies – the MOSAIC (NEJM 2004) and XACT trials (ASCO 2004) were also presented.

The NSABP C7 trial (Abstract 3500) randomised 2407 patients (29% stage II) to weekly “Roswell Park” 5FU/LV (6/8 weeks × 3) +/- oxaliplatin 85 mg/m² (weeks 1, 3, 5 × 3). A total of 29 Australian sites contributed 133 patients despite initial logistic difficulties. At 34 months median follow-up, there was a 5% increase in 3-year DFS in the oxaliplatin arm (77 vs 72%, HR 0.79, p=0.004).

These results are remarkably similar to the European MOSAIC trial, which compared infusional 5FU/LV +/- oxaliplatin. At first report (ASCO 2003) the oxaliplatin arm also had a 5% increase in 3-year DFS (78 vs 73%, HR 0.77, p<0.01). Updated results from this study were presented at this meeting (Abstract 3501), demonstrating increasing benefit with longer follow up – 4-year DFS currently at 6.6% for all patients (HR 0.77, 0.65–0.90), and 8.7% for patients with stage III disease (HR 0.75, 0.62–0.89).

Comparing the two oxaliplatin regimens, the C7 bolus regimen reported a much higher rate of diarrhoea (Grade 3+ = 38%), but less neurotoxicity (Grade 3 = 8%, reducing to 0.5% at 1 year) due to a lower cumulative oxaliplatin dose. Reducing the duration of oxaliplatin treatment is an important question for future adjuvant studies that are currently evaluating the new biologics, as well as predictive and prognostic factors.

In stark contrast, both adjuvant Irinotecan studies failed to demonstrate a significant difference in the now universal primary endpoint of 3-year DFS. The PETACC study (Abstract 8), similar in design to MOSAIC, added the new agent (Irinotecan – 180 mg/m² q 2 weeks) to infusional 5FU (LV5FU2). Although 3005 (30% stage II) patients were randomised, with limited follow up (median 32 months), only stage III data (n=2094)

were presented at this meeting. Three-year DFS appeared to favour the Irinotecan arm (63.3 vs 60.3%, HR 0.89, $p=0.09$) However the data only achieved significance when adjusted in an unplanned post-hoc analysis performed due to imbalance in T and N stage (65.2 vs 60.4%, HR 0.85, $p=0.02$). Further follow up is needed.

However negative results were also reported in the ACCORD2 study (Abstract 3502), which also evaluated the addition of Irinotecan to infusional 5FU/LV. This study enriched its smaller sample size ($n=400$) by including only higher risk patients. No benefit was reported with the addition of Irinotecan. In fact, the 3-year DFS curve trended non-significantly lower in the Irinotecan arm (51 vs 60%, HR 1.19). A similar negative trend was also seen in the CALGB study presented at last year's meeting when Irinotecan was added to bolus 5FU/LV.

Oxaliplatin with infusional 5FU must now be considered the optimal adjuvant regimen, with capecitabine, being the preferred alternative option for patients unsuitable or unwilling (Abstract 3521). Currently however, IV 5FU remains the only reimbursed agent. This is an ideal time to consider the AVANT study, a three-arm trial randomising patients between different oxaliplatin schedules, +/- bevacizumab, open at several Australian centres.

Advanced Colon Cancer

There continues to be no clear role for TK inhibitors in colorectal cancer. PTK787/ZK, (an inhibitor of all VEGF receptors as well as PDGFR and c-kit) showed no clear benefit versus placebo when added to first-line FOLFOX in the optimistically titled Colorectal Oral Novel Therapy for the Inhibition of Angiogenesis and Retarding of Metastases (CONFIRM1) Study - (RR 42 vs 46%, PFS 7.7 vs 7.6 months, HR 0.88, $p=0.12$), although a small increase in PFS was observed in patients with elevated LDH. A planned adjuvant study has been shelved; at least until overall survival data is available for this study, and a parallel trial in second-line patients (CONFIRM2).

The first randomised studies comparing oral versus infusional fluoropyrimidines combined with front-line oxaliplatin were also reported (Abstracts 2, 3515 and 3524). Short follow-up and small patient numbers prevent firm

conclusions. However these regimens do appear broadly similar in toxicity and efficacy, although there is some concern that the CapOx regimens may be slightly inferior

As expected, bevacizumab also improves response rate and survival when added to oxaliplatin regimens in first- and second-line in randomised studies (Abstracts 2 and 3515). However monotherapy should be avoided, with the ECOG3200 (Abstract 2) second-line study reporting poor outcomes in comparison to FOLFOX/BV combination therapy (BV alone - RR 3%, PFS 2.7 months vs FOLFOX/BV - RR 22%, PFS 7.2 months).

The addition of cetuximab to FOLFOX in first-line also appears promising. A multi-centre phase II study (Abstract 3535) reported an 81% response rate, with only 2% patients progressing on treatment. Median progression-free survival was also encouraging at 12.3 months.

Gastric Cancer

Additional adjuvant treatment options are now available for patients with resectable gastric cancer following the presentation of survival data from the MAGIC study (Abstract 4001). A total of 503 patients with operable gastric cancer were randomised to surgery alone or three cycles of ECF chemotherapy prior to and following resection. Median survival (24 vs 20 months, HR 0.75, $p=0.009$), 2-year survival (50 vs 41%) and 5-year survival (36 vs 23%) all favoured the chemotherapy arm. Tumour downstaging, without excess surgical morbidity or mortality were reported for the combined arm, which had moderate toxicity. These benefits are similar in magnitude to post-operative chemo-radiation (McDonald, NEJM 2001), which has been widely adopted, particularly in North America. It is hoped that combining these two approaches (e.g. current TROG protocol adding adjuvant ECF to chemo-radiation) may result in further improvements.

Pancreatic Cancer

Positive results from a randomised German study (Abstract 4013), add further weight to the benefits of adjuvant chemotherapy for pancreas cancer first described in ESPAC1 (NEJM 2004). The CONKO-1 study randomised 368 patients

following a R0 or R1 (20%) pancreatic resection to Gemcitabine (for 6 months) or observation. A total of 70% were node positive, and no radiotherapy was administered. Median DFS was nearly doubled (14.2 vs 7.5 months, $p < 0.001$), benefiting both node positive (13 vs 7 months, $p < 0.05$) and node negative patients (19 vs 11 months, $p < 0.05$). Overall survival data should be available by ASCO 2006.

The current ESPAC3 study open in several Australian centres, should further clarify whether gemcitabine will be preferred to the ESPAC1 standard 5FU/LV. An ongoing EORTC study (Gemcitabine +/- XRT) should also unequivocally answer the radiotherapy question, which many in the US believe is still required despite negative data from the earlier ESPAC study. Radiotherapy continues in both arms of current US Intergroup study.

In advanced disease, negative phase III studies of gemcitabine +/- experimental therapy of choice have become all too common at recent ASCO meetings and this meeting provided three further examples. Negative results were reported with the addition of Infusional 5FU/LV (Abstract 4009), capecitabine (Abstract 4010) and G17DT (Abstract 4012), the last study had been conducted in several Australian centres.

It was therefore perhaps not surprising to see a trial with only very modest benefit being presented in a plenary session. This study, run through NCIC (AGITG 10% of patient accrual), randomised 569 patients to erlotonib (EGFR inhibitor) 100 mg/d or placebo in addition to Gemcitabine in standard dose and schedule. Tumour control ([CR+PR+SD] 57 vs 49%), median survival (6.4 vs 5.9 months, HR 0.81, $p = 0.03$), and 1-year survival (24 vs 17%) all favoured the Erlotonib arm. More Grade 2 rash and mild diarrhoea were seen with Erlotonib, but Grade 3-4 toxicities were similar.

Whilst these data (and cost issues) are unlikely to change routine practice, they will provide a platform to focus research into which patients are most likely to benefit. One notable example from this study is the favourable results in patients with Grade 2 rash. These patients had a doubling of median survival to 10.5 months, and 43% 1-year survival ($p < 0.0001$ vs patients with Grade 0/1 rash).

Despite the long travel, endless freeways and chain stores, this year's meeting was outstanding. Like Disney, ASCO has cleverly refined an extremely successful product, which appeals to all, and continues to grow more popular each year. Next year Atlanta!

Report of Digestive Disease Week (DDW)

14-19 May 2005, Chicago, Illinois, USA

*Professor Finlay A Macrae
Colorectal Medicine and Genetics
The Royal Melbourne Hospital*

The "tyranny of choice" was the challenge again at Digestive Disease Week (DDW) - 912 oral presentations, 7587 posters, together with 885 invited talks at symposia, focused updates and state of the art lectures. Not to mention superb post-graduate courses that flanked and inter-digitated with each end of the core four days. An over-whelming experience in a city proud of its lakeside, and steeped in culture and cuisine.

Colorectal cancer is a mainstream topic at DDW, especially its biology, prevention, early detection and endoscopic management.

Biology and Prevention

Several centres in Australia participated in the APPROVE study, a randomised controlled trial of rofecoxib (25mg) in 2586 adenoma patients after polypectomy. The good news is that it

worked: recurrence in the primary endpoint amongst "high risk" adenoma bearers was 41% vs 55% in the placebo treated group (RR 0.75 [0.67-0.83]) with also a reduction in size and number of adenomas. The bad news we knew already: a tripling of cardiovascular serious adverse events unexpectedly emerging after 18 months, and an increase in gastrointestinal serious adverse events (expected), leading MERCK to pull the drug from the market for all indications. The opportunity cost will be more total hip replacements and probably more colonic resections (Abstract 200).

Curcumin (in curry powder) may now have a hotter future, bolstered by more information on its chemoprevention mechanism. Coming close to home (Ludwig Institute), it was shown to suppress expression of the EGF Receptor by inhibiting the EGFR transcription factor Egr-1 (Abstract 619). In another study, folate significantly reduced mean polyp counts (0.456) versus placebo (0.851) and increased EGFR Related Protein (a negative regulator of EGFR) in rectal mucosa assessed by immunohistochemistry (Abstract 621).

Type II diabetics were found at slightly higher risk of colorectal cancer and adenomas in a large endoscopy cohort, pointing the way towards confirmation through the Bio21 MMIM database linkage project here in Melbourne. The Boston Epidemiology Group (Walt Willet, Ed Giovannucci, Charles Fuchs, et al.) confirmed a relationship between N Acetyl Transferase 2 rapid genotype, and colorectal cancer in their well-worn US Nurses Health Study, but only in those eating > 0.5 serves of beef, pork or lamb daily. This confirms Adelaide's Ian Roberts Thompson's work of a decade ago. Cooking methods were not recorded.

Screening

Stool DNA testing by the Exact Science's test is still clearly under evolution, and not ready for "prime time". Current sensitivity for any adenomas (11%) and advanced adenomas (18%), falls short of faecal immunochemical testing for occult blood, with also lower specificity (87% and 89% for any adenomas and advanced adenomas respectively), positive predictive value (55% and 17%) and negative predictive value (40% and 90%). Rapid technical advances can be expected as DNA stool extraction techniques

improve, and more molecular markers are added, including methylation specific markers. The cost (US\$700) seems less likely to improve (Abstracts 425 and 478).

Genetics

Loss of imprinting (which activates the normal silent maternal allele) with consequent increase in circulating IGF-2 levels was demonstrated, and was associated with increased labelling (proliferation) indices in normal rectal mucosa (Abstract T1435). Other studies have shown correlation between IGF-2 levels and colorectal neoplasia.

Genetic predisposition for colorectal cancer was explored through an interesting paper on MYH. Bi-allelic carriers were predictably found amongst 12% of APC negative polyposis (> 15 adenomas) patients, but interestingly, in two other people in the familial cancer clinic population. Seven of the total of nine bi-allelic carriers were either from MMR negative Amsterdam positive families (2), or met one or more Bethesda criteria. This was likely a biased sample as it was ascertained from a familial bowel cancer clinic; the Amsterdam kindreds may well have been phenocopies, as not all family members had had MYH genotyping - especially those who had died with cancer. A total of 56% of bi-allelic carriers had progressed to CRC by a mean age of 41 years. As few as 5 adenomas represented the phenotype (Abstract 889).

The Spanish Association of Gastroenterology described the risks of cancer in mismatch repair negative Amsterdam positive families, reflecting the NIH CFR study which published only moderate risks outside the nuclear Amsterdam complex, and no extra-colonic risk. This latter study has an important Australian contribution (Abstract 844).

Colonoscopy

Colonoscopy presentations were both introspective and innovative.

The German nationwide experience of average risk screening (n=303,052), made the Lieberman and Imperiale NEJM papers pale in significance. A total of 1.2% of males and 0.7% of females had colorectal cancer on incident screening colonoscopies with 7.7% and 4.4%

respectively having advanced adenomas. The scale was impressive, but the acceptance (2.2% of the eligible population) was poor, bringing a colonoscopy-based approach to population screening for CRC into question (Abstract 637).

Introspection came from careful studies from the large private "Minnesota Gastroenterology" group in their Colonoscopy Quality Initiative (Abstract 752). This initiative has placed strong evidence behind the US Multi Society Taskforce's Colon Cancer Guidelines (Rex D et al. *Am J Gastroenterology* 2002), which amongst other things sets an average 6-minute withdrawal time as a key performance indicator for quality colonoscopy. Amongst the 41 experienced partners performing 29,316 colonoscopies, there was a tenfold difference in average withdrawal times from 2–20 minutes. There was also a wide range of polyp detection rates between 0.1 – 1.1 lesions per average risk patient screened, across the gastroenterologists. There was also a wide variation in adenoma detection rates. For those withdrawing faster than an average of 6 minutes, advanced adenoma detection rates were 2.4% (0.19% for cancers), whereas those with slower withdrawal times had a 6.6% advanced adenoma detection rate (0.53% for cancers). There is now little doubt that fast colonoscopy withdrawal compromises quality performance.

"Report cards" to include withdrawal times and yields in standard situations (eg screening) was a theme of the meeting, championed by world-renowned endoscopist Peter Cotton at the meeting. The day has already arrived in the US when discriminating patients request "Report Cards" from their endoscopists before consenting to procedures.

The Australian Bowel Cancer Screening Pilot Program has introduced the same key performance indicators for colonoscopies done within the pilot. We await the data that is currently under analysis.

In Britain, the National Endoscopy Team has developed a web-based quality reporting tool which is now used in the majority of NHS endoscopy facilities (www.grs.nhs.uk). This collects, in modular form, centre- and procedural-related performance indicators with feedback to both centres and proceduralists on their performance against the national norms. The same is happening in Germany (Abstract

W1088). Australia must not neglect the importance of this as colonoscopies in particular are rolled out to asymptomatic people, albeit with positive faecal occult blood tests.

Australian Innovations

Innovation in colonoscopy was perhaps the Australian tour-de-force. The Israeli Aer-o-scope, a self propelling, self navigating, skill independent colonoscope (Abstract 90) was demonstrated to rapidly carry itself to the caecum in 12 of 20 pigs (the balance had poor prep) through an intrinsically spiralled anatomy, in a mean 16.5 minutes. But the Australian Endogene self-propelling endoscope scheduled for presentation at the parallel OMED world endoscopy meeting trumps this with quicker insertion times and therapeutic capabilities.

To me, doubtless one of the highlights was the Australian Confocal Endomicroscopy technology integrated now into Pentax prototype colonoscopes. The extraordinary images representing optical sectioning of the mucosa from surface to a depth of 250 microns at 1000 fold magnification, promises a whole new discipline of training in "virtual histopathology" for budding gastroenterologists. Its place in practice was the focus of excellent presentations from Ralf Kiesslich from Mainz, and our own from Cabrini (Abstracts 156 & 483). Ralf has already shown utility in dysplasia screening and detection in ulcerative colitis and Barrett's oesophagus with sensitivities of 95% and specificities of 98.3% for dysplasia in ulcerative colitis. Chromoscopically detected lesions can be interrogated by the optical sectioning, dysplasia then confirmed, reducing biopsy load dramatically (130 down to 19).

Our own experience at Cabrini demonstrated high negative predictive values for abnormality, securing confidence in normal colonoscopic findings. We do, however, need much more local experience with dysplastic findings assessed by confocal endomicroscopy. This report partly represents a call to colleagues to refer patients with low or high grade dysplasia to enhance this experience in both ulcerative colitis or Barrett's, prior to definitive therapy. This is a Cabrini HREC approved protocol and can accommodate both insured and un-insured patients.

More could be told of the non-neoplastic excitements of DDW, but that is for another forum. Suffice it to say, the American Gastroenterology Association's DDW remains the premier forum for presentation on the pre-diagnostic aspects of gastrointestinal cancer, a phase of the illness

in which the Cancer Council has a special stakehold and should never be overlooked in a well considered comprehensive approach to cancer control and management. Victoria should take note as the nation moves to population screening for colorectal cancer.

Report of the 1st Conference of the International Society for Gastrointestinal Hereditary Tumours (InSiGHT)

14–17 June 2005, Newcastle upon Tyne, United Kingdom

Professor Finlay A Macrae
Chair, VCOG Hereditary Bowel Cancer Clinical Group
Secretary, InSiGHT, 2005–7

InSiGHT was formed over the last two years, with the merging of the Leeds Castle Polyposis Group (LCPG), and the International Collaborative Group for Hereditary Non Polyposis Colorectal Cancer (ICG HNPCC). This is a natural and long overdue merger, as the members of each group were largely the same, as were the disciplines involved with the biology and management of the two syndromes: familial adenomatous polyposis (and rarer polyposis syndromes) and hereditary non-polyposis colorectal cancer syndrome. It was the current host chairman John Burn's flair that identified the name for the group as the *International Society for Gastrointestinal Hereditary Tumours*. There have been joint meetings of the two groups for some years, including at Lorne, Victoria, in 1999, but the formal merger and dissolution of the parent groups is now complete.

The strength of the meeting followed the traditions from which InSiGHT developed. About 400 delegates with a committed interest in familial bowel cancer participated in this outstanding meeting, which was packed with exciting molecular genetics, molecular epidemiology, cell biology, clinical genetics, surgery and psychosocial research. This meeting draws experts in all these fields; the program is unashamedly all plenary, so the opportunity to learn from other disciplines addressing the theme of familial cancer is open and a rare one indeed

amongst the ever increasing fragmentation of international meetings into concurrent sessions.

MYH-associated Polyposis

Lara Lipton's (RMH and Cabrini Familial Cancer Clinics) original landmark NEJM report of this base excision recessive genetic defect, leading to failure to correct oxidative damage especially to the APC gene, is now being followed up with confirmatory reports world wide. These included reports from Holland (Nielsen et al, F2) indicating that a classical phenotype (defined as up to 1000 adenomas) was as frequent as the attenuated phenotype (10–100) originally described and also examined in this series. However, the lower limit of adenoma number is still clearly multiple – 15 in a German analysis (Stefan et al, F3). Interestingly, seven of the 48 German families showed vertical transmission, unexpected with recessive inheritance. Perhaps this could be explained by a cancer phenocopy in the parents, but this was not clarified. Commencement of screening should be about 18 years of age in this German experience. Relative risks for colorectal cancer were described in Scotland (Teresa et al, F4) from a 2239 case: 1845 control study. Homozygotes carried a 121 RR, completely penetrant by 65 years of age. The risk in heterozygotes, which has been uncertain, was detectable, but only 1.67. MYH gene

frequency was calculated to account for 1 in 180 colorectal cancers in Scotland.

Cell Biology

Survivin is the new boy on the cell block, and complexes with betacatenin / Tcf-4, and ABK driven by wnt pathway signalling (Bowman et al, F6). Mutant APC up-regulates the pathway, catalysing mitosis and contributing to stem cell overpopulation. Whether there will be germline alterations discovered in survivin may be next year's paper.

The hyperplastic serrated adenoma pathway received much attention, with the somatic mutations described by Portuguese investigators (Dinins et al, F8), and our own analysis of MYH and MDB4 genes in the germline in this syndrome (Lipton, F7). MYH mutations overlap with this syndrome, but MDB4 is an unlikely candidate. Hyper-methylation of MLH1 (64%), mutations in Kras (20%), BRAF (40%) and in the wnt pathway genes have been previously described, but increased expression of DNA methyl transferase 1 (DNMT1) was a new finding perhaps explaining hyper-methylation commonly found in early stages of the hyperplastic-serrated adenoma pathway. This pathway now is indisputable in colorectal carcinogenesis.

The young investigator prize was awarded to a Portuguese group (Francisco et al, F25) who demonstrated that 11 of 26 MLH1 germline cancers had activating betacatenin mutations, which was a rare finding in sporadic MSI-H cancers. This together with the greater incidence of BRAF mutations (Frattani, P50; Loughy, P82 from Peter Mac) in the latter gives a high degree of differentiation of the two types at the somatic level. This is likely to be important information in the clinical decision making of whether or not to search for a germline MLH1 mutation in MSI-H cancers with MLH1 protein loss.

The role of the CHEK2 1100 del C mutation was the subject of a state of the art lecture. It appears to be a co-dominant mutation in breast / colon families, with the primary mutation as yet undiscovered. By itself, even homozygosity does not lead to a severe phenotype (van Puijenbroek, P112)

Fascinating work on the mechanism of aspirin protection at the molecular level emanates from Dunlop's lab in Scotland (F43), (Dunlop dominated the science in the meeting!), indicating that the translocation of NFkB and subsequent apoptosis was independent of MMR proficiency and p53 status: good news for CAPP2 indeed.

Somatic mosaicism in FAP was described in two papers, but only in lymphocytes (P42).

Clinical Studies

The German Registry calculated a 25% risk of gastric cancer, supporting what is still a little controversial - the place of stomach cancer in HNPCC (Goecke, F18).

The Cleveland Clinic experience (Church and Vogel, F11) managing FAP with laparoscopic or open approaches produced a surprise. Counter-intuitively, there was more desmoid formation (8 of 45 - in men especially) with laparoscopic surgery than open surgery (4 of 45). James Church's explanation was because of the greater tension placed on the mesentery in laparoscopic compared with open surgery.

Gregor Brown's (RMH Colorectal Medicine and Genetics) study of capsule endoscopy in small bowel surveillance in Peutz Jeghers Syndrome, done from St Mark's, was presented by Brian Saunders (F13) with the recommendation that capsule endoscopy should now replace radiology for surveillance in this disease. We would agree from our experience in a trial just being completed.

There was debate about the role of pancreas preserving duodenectomy in the surgical management of duodenal polyposis. On the one hand, the Cleveland Clinic experience was positive, with only one of 21 patients diagnosed with cancer (and thus at risk of local recurrence after the procedure). Recurrent adenoma formation could sometimes be rapid, and was often around the neo-ampulla. Robin Phillips (St Mark's), in a state of the art lecture, was not so supportive, pointing out that Spigelman stage IV duodenal polyposis often had cancer already present, undetectable until surgical resection. Perhaps new imaging modalities (EUS, fine cut CT, MRI or PET scanning) may allow better

patient selection for the pancreas-sparing procedure. Indeed, PET scanning was very helpful in a Dutch experience for duodenal polyposis (van Kouwen, F17), allowing selection of still benign cases with 100% accuracy. Local experience indicates high grade dysplasia can be PET positive, which makes PET less helpful.

A provocative paper from Spain (F49) suggested mutational load rather than spectrum, detectable in DNA analysis from colonic lavage, had high sensitivity and specificity for colorectal neoplasia (100% each). This clearly needs reproduction.

The clinical starting point of endometrial cancer was the subject of several papers, using registries to identify early age onset endometrial cancer. A study from several US tertiary centres showed a 9% prevalence of MMR mutations with this approach in one study, and a 1.1% incidence in a population based approach (F39, F40).

Endometrial cancer risk by genotype was presented from the large Italian Registry (Bertario et al, P22), giving the RR in MLH1 as 14, in MSH2 as 42.9. MSH 6 was not presented (but is known to be higher). Five-year survival was 78% – similar to non-HNPCC endometrial cancer.

Molecular Epidemiology

Two population-based studies – from Australia (Jenkins, P65), and Scotland (Barnetson, F20) downgraded cancer penetrance estimates and also the proportion of MMR gene carriers with an Amsterdam family history to about a third.

Another third had no family history of colorectal cancer at all in the Scottish series. Survival was no different to other colorectal cancers, suggesting the better survivals reported with MSI-H cancers may be sporadic only.

Genome wide linkage with microsatellite analysis in non-FAP, non-HNPCC colorectal cancer families in Sweden showed a weak linkage on chromosome 14 and chromosome 11 (P44).

A French comprehensive world wide ethnic study of mononucleotide repeats in lymphocytic DNA has identified a powerful set which can be used confidently, without therefore the need for normal tissue for comparison (F47).

Psychosocial Studies

The behavioural scientists and genetic counsellors were pleased with the exposure their work had at the meeting. This included an excellent talk from Clara Gaff (RMH FCC manager, now in Cardiff) on the issues of consent relating to immuno-histochemistry for MMR proteins and MSI testing. Space prohibits description of the many others including from Lesley Andrews (an FAP study) from Sydney.

Conclusion

This was a great scientific meeting. Full abstracts are published in *Familial Cancer 2005 Volume 4, Supplement 1*. I would encourage any of the readership to place the next meeting (Yokohama, Japan in March 2007) in their diaries.

Familial Aspects of Cancer: A Guide to Clinical Practice (1999)

Considerable work has been done for these Guidelines and the work ahead is to dot i's and cross t's before public consultation. Professor Judy Kirk has worked hard to produce a document that will clarify risk

based on family history. These Guidelines should be ready for public consultation in the next several months.

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

National Bowel Cancer Screening Program Update

*Alison Peipers
Manager, Cancer Education Programs
The Cancer Council Victoria*

With the announcement of the 2005/06 Budget, the Australian Government has committed \$43.4 million over 4 years for the implementation of a national bowel cancer screening program. [This includes \$7.4 million previously announced in the 2004-05 Budget for continuing the work of the Bowel Cancer Screening Pilot.]

Commencing in mid-2005, all Australians turning 55 and 65 years of age, nearly half a million people a year, will be invited to screen for bowel cancer and receive a faecal occult blood test (FOBT) in the post. Participants with a positive result will be referred by their GP for further tests, usually a colonoscopy. An evaluation of the screening program will be completed prior to the 2008 Budget to guide the Government's further consideration of the structure and shape of a future National Bowel Cancer Screening Program.

This announcement follows the completion of the National Bowel Cancer Screening Pilot Program in which approximately 57,000 people aged

between 55-74 years were invited to screen for bowel cancer. The Pilot was designed to assess the feasibility, acceptability and cost effectiveness of a national program in Australia. Although the evaluation report from the Pilot has yet to be released, we know that at least 67 people were found to have cancer and 217 people had pre-cancerous growths detected. In the next phase of screening, commencing in mid-2006, eligible participants from the Pilot will be invited to re-screen.

As we await further details on the screening program, The Cancer Council Victoria is continuing to promote the prevention and early detection of bowel cancer. During Bowel Cancer Awareness Week (6-10 June), a new prevention campaign was launched. The campaign highlights the impact of excess body weight on the risk of bowel cancer and features new television and radio advertisements. The advertisements encourage Victorians to 'avoid the cure' for bowel cancer by maintaining a healthy body weight through following a good diet and doing regular physical activity.

Measure up your risk of bowel cancer

The Cancer Council Victoria Media Release – 3 June 2005

The Cancer Council is urging Victorians to measure up their risk of bowel cancer with the launch of a new campaign during Bowel Cancer Awareness Week, 6-10 June 2005.

The new campaign aims to highlight the impact of excess body weight on the risk of bowel cancer, with a new television and radio advertisement. The advertisements encourage Victorians to 'avoid the cure' for bowel cancer by maintaining a healthy body weight through

following a good diet and doing regular physical activity.

Professor Graham Giles from the Cancer Epidemiology Centre says recent evidence has shown that around a quarter of all cases of bowel cancer can be prevented through people making these simple lifestyle changes.

"Our latest figures show around 3400 Victorians were diagnosed with bowel cancer in 2003. Therefore, we calculate around 850 cases of

bowel cancer in Victoria are caused by overweight, obesity and lack of exercise each year."

"The simple message we hope this new campaign promotes is that maintaining a health weight can be easily achieved by balancing your energy intake – which is what you eat – with your energy expenditure – which is your level of physical activity."

"While the community may associate the 'healthy weight' and 'exercise' messages with reducing their risk of other serious illnesses, this is the first time that this advice has specifically been linked to preventing bowel cancer."

Professor Giles says recent evidence shows that the more vigorous the exercise, the more beneficial it will be for reducing the risk of bowel cancer.

"However, regular moderate exercise is better than none at all. People who are currently inactive should start moderately and build up their exercise program – the key is to do something regularly."

Professor Giles says there are various ways to work out if you are a 'healthy' body weight, but a simple way is by using waist measurement as a guide, and the best place to measure your waist measurement is around your navel.

"Men should aim for a waist circumference of less than 94 cm (37 inches) and women should aim for a waist measurement of less than 80 cm (32 inches), irrespective of how tall you are," Professor Giles said.

Professor Giles said men whose waist measures between 94–101 cm have increased risk of obesity related diseases, including bowel cancer.

"Men whose waist measures more than 102 cm, 40 inches, have a substantially increased risk."

For women, a waist measurement of more than 88 cm (35 inches) substantially increases the risk of bowel cancer.

Professor Giles said the Cancer Council's Health 2000 study, a major long term study of around 40,000 Victorians aged between 40–69 found just over half the participants had optimal waist measurements (53% of men and 54% of women).

However, the waist measurement of 28% men and 22% of women placed them at increased risk of bowel cancer, and 19% men and 23% of women recorded a waist measurement that put them at significant risk of bowel cancer.

"We want to remind Victorians during Bowel Cancer Awareness Week that the best recipe for reducing your risk of bowel cancer is to maintain a healthy weight through good diet and being active every day."

"I would encourage people to call the Cancer Council's Cancer Helpline on 13 11 20 for information on how to reduce your risk of bowel cancer and other cancers, and ask for a copy of our new brochure 'Cut your cancer risk'."

Tips for reducing your risk of bowel cancer

Exercise

- Aim for at least 30 minutes of moderate exercise such as brisk walking cycling, mowing the lawn or swimming on most days of the week.



- Some evidence suggests that exercising for an hour a day, including some more vigorous exercise like football, aerobics or jogging, is more likely to reduce the risk of cancer.
- If you are starting an exercise program, build up slowly and choose an activity you like.

Lose weight if you are overweight

- If you are overweight, set targets to reduce your weight, . Make sure your goals are realistic, as you are more likely to be

successful, and will be encouraged to continue by your success.

- Cut back on foods and drinks high in fats and sugars – fast foods and pre-prepared meals are nearly always higher in fat.
- Choose non-fat or reduced fat milk and dairy products.
- Snack on fruit and vegetables if you are hungry.
- Regular exercise will also help you lose weight, and maintain a healthy weight when you reach your ideal weight.

Adopt and maintain a good diet

- Eating a lot of red meat and processed meats like ham, bacon, sausages, salami and frankfurts has been linked to bowel cancer, so limit the amount of these foods in your diet.

- Red meat is an important source of nutrients in a diet, but should be limited to three or four serves a week.



- Two good reasons to eat more fruit and vegetables – not only are they healthy and nutritious and good for your overall health but including plenty of fruit and vegetables will help you feel full, and reduce the total intake of calories you eat each day. Reducing total calories helps maintain a healthy weight.

Call the Cancer Council's Cancer Helpline on 13 11 20 for a free copy of 'Cut your cancer risk'.

What does the Victorian Cancer Services Framework mean for you?

*Professor Gillian Duchesne
Director of Radiation Oncology
Peter MacCallum Cancer Centre*

Note – Professor Gillian Duchesne provided this article at the request of the VCOG Urological Cancer Committee. The VCOG Executive Committee requested that the article be re-produced in all the VCOG Cancer Update newsletters. Professor Gillian Duchesne is a member of the Ministerial Taskforce for Cancer. This article is a personal viewpoint, it has not been endorsed by the Taskforce.

The Department of Human Services commissioned a review of Cancer Services in Victoria by the Collaboration for Cancer Outcomes Research and Evaluation, who published their report in July 2003. This was entitled "A Cancer Services Framework for Victoria and future directions for the Peter MacCallum Cancer Institute." The Minister and the DHS adopted the recommendations for the Cancer Services Framework; a Ministerial Taskforce was appointed towards the end of

2003 with a 3-year term and the responsibility to oversee the implementation of the reforms.

The Taskforce, chaired by Dick Smallwood, has representatives from all disciplines involved in the delivery of cancer care, metropolitan and regional representation, and consumer input. It is supported by the staff of the Cancer Co-ordination Unit at DHS, headed by Elise Davies. The work has been organised around three main themes: Clinical Services, Research and Data /

IT, chaired by Bob Thomas (Peter Mac), Paul Mitchell (Austin) and David Hill (TCCV) respectively. The latter two committees have been reviewing the activity and resources currently available in Victoria. Discussions are underway regarding co-ordination of research throughout the state. The IT group have been examining a project that would expand the data collection capabilities of the Cancer Council and how patient information can usefully be shared electronically between hospitals and other service providers.

The main impact that the reforms will have is obviously the delivery of clinical care. Two key components of work are running in parallel. The first component is the development of patient management pathways, which documents what resources and facilities are required by a cancer patient through the 'cancer journey', essentially from pre-diagnosis to death. This work was initiated by holding a series of workshops with clinicians and consumers mapping out the requirements in each of the designated tumour streams. These bring together specialists in multi-disciplinary care for the main tumour sites and types such as breast, colorectal, prostate, testis,

lung, melanoma, ovary, oesphagogastric, pancreas, larynx, pharynx, oral-combined, malignant glioma and cerebral metastasis. Site-specific pathways and generic needs across all streams have been developed and are being further refined. The report of the workshop is available at www.health.vic.gov.au/cancer/docs/patientmanagementframework.pdf.

The other component is the division of Victoria into eight Integrated Cancer Services or ICS: three metropolitan (Western & Central, Southern and North Eastern) and five regional (Loddon Mallee, Grampians, Barwon South Western, Hume and Gippsland). Each has independent governance and direction. One initial task for the ICS is to identify and map the components of cancer care delivery within their region. These can then be compared with the requirements identified in the patient management pathways workshops. Over the coming years it is hoped that resources are found where gaps are identified to ensure equitable service provision. Interaction between the ICS, especially regional and metropolitan, may be required for particular components of specialised care. This is still very much work in progress.

Further information is available via the DHS website. The following may be useful links:

DHS Website – www.health.vic.gov.au/cancer/

DHS Cancer Bulletin 1 – www.health.vic.gov.au/cancer/docs/ccubulletin1204.pdf

DHS Cancer Bulletin 2 – www.health.vic.gov.au/cancer/docs/cancerbulletinmar05pdf.pdf

Senate Committee Gives Cancer Priorities a Good Hearing

*Glen Turner
Communications Manager
The Cancer Council Australia*

The Chair of the Senate's Community Affairs Committee has publicly backed a call for the formal adoption of cancer clinical practice guidelines and the accreditation of cancer centres, following a recent public hearing in Sydney as part of a Senate Inquiry into cancer services in Australia.

Professors Alan Coates (Cancer Council), David Currow (COSA) and Mark Elwood (NCCI), along with consumer Cheryl Myers, presented to the committee on 19 April in support of a joint submission to the inquiry. Later that day, the Committee Chair, Senator Gavin Marshall, issued a media release endorsing the recommendations made by the group.

The inquiry is investigating treatment options for people with cancer, with particular focus on the merits of multidisciplinary care, care coordination, less conventional and alternative therapies and the role of government in improving patient outcomes.

Central to the joint Cancer Council-COSA-NCCI submission, to which the National Aboriginal Community Controlled Health Organisation was also a signatory, was the need for improved access to multidisciplinary care, facilitated by national care standards, accreditation of cancer centres and credentialing of practitioners, as well as the adoption of clinical guidelines as best practice.

The submission highlighted the Australian Cancer Network's development of clinical practice guidelines and exploration of a model for cancer care accreditation and credentialing. It also endorsed the Australian Medical Workforce Advisory Committee's recommendations on increasing the number of cancer professionals, particularly in rural areas, and The Cancer Council Australia's position on travel and accommodation support for non-metropolitan patients.

Professors Coates, Currow and Elwood and Ms Myers were among 70 people from more than 25 organisations to have appeared as witnesses at hearings in Perth, Melbourne, Sydney and Canberra over the past month.

Witnesses were called on the basis of the quality, depth and relevance of their written submissions, 93 of which were received since the announcement of the inquiry in February. Organisations that provided submissions included federal and state/territory health departments, medical faculties, consumer organisations, industry associations, alternative centres and private individuals.

The committee is scheduled to report its findings on 23 June, the final sitting day of the current Senate. When the Senate resumes in August, retiring Senators will have departed and the Government will have a majority.

All 93 published submissions are available on the Senate website, along with more information about the inquiry, at: www.aph.gov.au/Senate/committee/clac_ctte/cancer/submissions/sublist.htm.

Submissions Detail TCCA Advocacy Priorities

It has been a busy few months for submissions to government inquiries, studies and consultations. The Cancer Council Australia has decided to publish its most comprehensive input to these recent processes on its website, to provide colleagues and stakeholders with detailed information on advocacy priorities in differing contexts.

The most substantial recent submissions relate to:

- the Productivity Commission's current study into the impact of medical technology;
- an NHMRC consultation on research aimed at breaking the link between disadvantage and poor preventive healthcare; and
- the Senate inquiry into cancer services.

These submissions are now available on the website (www.cancer.org.au/policy_submissions), along with submissions from 2004 relating to patents in gene technology and the Pharmaceutical Benefits Advisory Committee review process.

Treatment: Call for End to 'Cancer Lottery'

Cancer claims more lives in rural Australia and even more among Aborigines than in the rest of the population, according to a coalition of peak cancer control bodies.

Speaking at a Senate inquiry into cancer services, representatives from the Cancer Council of Australia, National Cancer Control Initiative and the Clinical Oncological Society of Australia said patients want national cancer care standards to end the "cancer referral lottery" that currently exists in certain areas.

"Cancer mortality is significantly higher in rural areas and higher again among indigenous communities," the organisations stated in a joint presentation to the inquiry.

"There are no national standards of accreditation to ensure that optimal care is accessible to all patients in the system."

Greater emphasis was also needed in caring for a person's wellbeing and greater access should be granted to multidisciplinary care, they said.

The Cancer Council of Australia Chief Executive Officer, Professor Alan Coates told the committee that a greater emphasis was needed on prevention and early detection.

"Prevention is coming to be recognised but nowhere near enough, nor soon enough," he said. "We can and we should do more."

Courier Mail, 20/4, p7; *Sydney Morning Herald (online)*, 19/4; *Illawarra Mercury* and other regionals

Reprinted from *Wongi Yabber* May 2005; 12(2): 3-5.

Report of The Cancer Council Australia

Glen Turner
Communications Manager
The Cancer Council Australia

New Position Statements

The Cancer Council Australia has published five new position statements.

① Bowel Cancer Screening

Bowel cancer is the most common potentially fatal cancer affecting both men and women in Australia. The bowel cancer position statement reiterates The Cancer Council Australia's call for a national bowel cancer screening program targeting all Australians aged 50 and over. (In the 2004 federal election campaign, both the Government and the Opposition committed to national screening programs to commence from 2008.)

② Testicular Cancer

The testicular cancer statement promotes the evidence-based view that the present level of community awareness of testicular cancer appears appropriate and in proportion to current incidence and mortality rates.

③ State and Territory Travel and Accommodation Subsidy Schemes

The travel and accommodation schemes statement calls for a Commonwealth funded taskforce to examine inequities in access to cancer treatment across jurisdictions and between rural and urban areas, with the ultimate aim of improving access to services for people in disadvantaged regions.

④ Risks and benefits of sun exposure and ⑤ Advertising and display of tobacco products in retail outlets

Both statements cover topics that have generated significant interest in both the health and mainstream media over recent months.

A number of **SunSmart position statements** have also been updated including:

- Screening and early detection of skin cancer
- Tinting of car glass and window glass
- Fake tans
- Solariums

Cancer Council Australia position statements can be found at www.cancer.org.au/positionstatements.

Reprinted from *Wongi Yabber* Feb 2005; 12(1): 5 / May 2005; 12(2): 4.

Australia takes lead in reducing cancer deaths – mortality rates lower than other developed nations

A new report, *Cancer in Australia 2001*, from the Australian Institute of Health and Welfare, shows that Australia has a lower cancer death rate than several other developed nations. The US, UK, Canada and New Zealand all recorded higher mortality rates than Australia.

The report has been welcomed by The Cancer Council Australia, which attributed much of the good news to population initiatives in prevention

and early diagnosis and good access through Australia's health system to advances in treatment.

The Cancer Council's spokesman, Dr Andrew Penman, said the cancer death rate in Australia had fallen 17 percent over 10 years and was now at its lowest level since records began in the 1970s.

"A significant part of Australia's success has been due to comprehensive programs in prevention and early detection," Dr Penman said. "Our low death rate from lung cancer and other tobacco related cancer is a dividend from three decades of tobacco control which has seen smoking rates drop to the lower levels than comparison countries; while our comprehensive approach to screening for breast and cervical cancer means that our outcomes for these cancers compares very favourably."

"Prevention has delivered extraordinary value for money," Dr Penman said. "When you look at Australia's lower rates of lung cancer incidence and mortality the argument is compelling - our

death rates are 32 percent lower than the US for males and a staggering 48 percent for females. Although at 19,000 deaths from tobacco related disease each year, Australia still has a long way to go."

While welcoming the declining death rates, Dr Penman also sounded a note of warning about cancers where mortality or incidence are higher than in other countries. "Australia, because of its climate and lifestyle, leads the world in its high rates of melanoma yet this is one cancer whose rates could be substantially reduced by effective sun protection."

Dr Penman said that Australia's good performance was not uniform across all cancers. "In contrast to our success in cervical and breast cancers, we have very high death rates from bowel cancer. An absolute priority for the nation is to expedite the rollout of a national bowel screening program, to which the Federal Government has declared its commitment."

Reprinted from Wongi Yabber February 2005; 12(1): 5.

Report of the National Cancer Control Initiative

Communicating the risks, benefits and outcomes of elective therapeutic and diagnostic interventions between consumers and clinicians

In November 2004, funding was received from the National Health & Medical Research Council to undertake a literature review and produce a report on communicating the risks, benefits and outcomes of elective therapeutic and diagnostic interventions between consumers and clinicians. The literature review will analyse the available scientific literature to identify and collect information in relation to:

- Issues such as specific channels of communication, and barriers to exchange and utilisation of information which should be addressed when communicating the risks, benefits and outcomes of elective therapeutic and diagnostic interventions.

- Efficacy and effectiveness of different communication channels.
- Specific communication issues applicable to the following cases:
 - Diagnostic testing (screening men using PSA to detect early prostate cancer);
 - Surgical procedures (coronary angioplasty); and
 - Drug treatment (glucocorticoids in patients with chronic medical conditions).

The literature review and accompanying report will be used to inform the development of toolkits on the essential principles to be considered when communicating the risks, benefits and outcomes of elective therapeutic and diagnostic interventions. It is anticipated that the toolkits will assist in improving informed decision-making.

This project is a collaborative undertaking by Professor Brian McAvoy and Dr Faline Howes from the NCCI, and Dr Chris Peterson and Associate Professor Greg Murphy from La Trobe University. For further details, contact Dr Chris Peterson at c.Peterson@latrobe.edu.au.

Reprinted from Wongi Yabber February 2005; 12(1): 3.

Cancer stage at diagnosis for indigenous and non-indigenous people in the Northern Territory

The cancer incidence rate of Indigenous people in the Northern Territory (NT) is approximately the same as that of non-Indigenous people in Australia; however, Indigenous people have notably lower survival than non-indigenous people.

In 2002 the NT Cancer Registry, the Menzies School of Health Research and the National Cancer Control Initiative undertook a collaborative project to retrospectively identify

the stage at diagnosis and survival of people in the NT diagnosed with selected types of cancer between 1 January 1991 and 31 December 2001.

The study showed that Indigenous people were more likely than non-Indigenous people to be diagnosed with advanced disease for particular cancers and with few exceptions, Indigenous people had lower survival than non-Indigenous people with the same stage at diagnosis for each cancer site. The project also demonstrated that reliable data on stage at diagnosis could be obtained from medical records.

The final report was released in late March to coincide with the publication of a journal article by the reports authors (Condon et al., *MJA* 2005; 182(6): 277–280). The final report can be accessed on the NCCI website www.ncci.org.au/pdf/NT_cancer_staging/NT_report.pdf and hard copies can be obtained by contacting the NCCI secretariat at enquiries@ncci.org.au.

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

COSA Report

*Ms Margaret McJannett
Executive Officer, COSA*

COSA has been continuing to move forward on a number of issues on behalf of its membership. We are presently awaiting outcomes on the:

- NH&MRC enabling grant application – anticipated mid-May 2005
- Two-page proposal regarding mechanism for Clinical Trials Infrastructure put to Government.
- Cancer Australia Workshop; COSA was strongly represented
- Submission to the Senate Inquiry into services and treatment options for persons with cancer.

Rural Health Alliance Conference Alice Springs

COSA also convened a workshop, chaired by Dr Steve Ackland, at the National Rural Health Alliance Annual Meeting in Alice Springs. This provided an excellent opportunity to reach out to our colleagues in non-metropolitan areas, update them on cancer care issues and develop networks to facilitate advocacy for improved cancer treatment and support in regional Australia. The Cancer in the Bush workshop (2001) and recommendations were discussed, in particular difficulties with patient travel and accommodation. There were additional recommendations arising from the NRHA meeting, which can be viewed on the website www.ruralhealth.org.au.

COSA Council Meetings

COSA Council and Executive met in April and the major works being undertaken at present are the review of our Strategic Business Plan and the MOU between COSA and TCCA.

Annual Scientific Meeting

The planning of the Annual Scientific Meeting (ASM) is well underway, with Dr Sandro Porceddu, this year's convenor, working with his enthusiastic committee to put together an exciting and stimulating program for Brisbane. The theme this year is "Crossing Cancer Boundaries". A draft program will be posted on the COSA website shortly. Please note this year's meeting will begin a week earlier, 16-18 November 2005.

COSA Website

The COSA website continues to be enhanced and the members-only area is being finalised with more extensive facilities to enhance the value of membership including online membership renewal. Please visit the site www.cosa.org.au.

Asia Pacific Journal of Clinical Oncology

COSA members will soon receive free subscription to the new *Asia Pacific Journal of Clinical Oncology*. The first publication is due out in May. Members are encouraged to submit manuscripts, as the quality of the journal is highly dependent upon your quality contribution.

Reprinted from Wongi Yabber May 2005; 12(2): 3.

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

Professor Michael Frommer, Director of the University of Sydney, Health Projects Group is well advanced in the development of the scoping document. The document will be posted on the ACN website after

it is received and accepted by the ACN Credentialing Steering Committee. Your comments will be crucial to its success.

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

A new information resource for people with cancer of unknown primary and their families and friends

More than 3000 Australians are diagnosed with cancer of unknown primary each year. Patients and their families often find the diagnosis confusing and difficult to understand. Likewise, it can be difficult for professionals to explain the diagnosis and recommended management. A new print resource has been developed to make the subject easier for patients to comprehend. No other materials exist. Dr Michael Jefford, from

Peter MacCallum Cancer Centre, wrote the book. Several health professionals and patients / consumers reviewed it. The guide appears to have been well received and a second printing is underway. The Cancer Council Victoria and Sanofi Aventis, who sponsored the development and printing of the book, are distributing it. Contact the Cancer Helpline (13 11 20), for free copies.

Multilingual Cancer Information

In Victoria, 22 percent of all cancers occur in people born in countries where English is not the first language. While there is variation in the incidence of specific cancers among different cultures, cancer is a significant cause of illness and death for all migrant groups.

The Cancer Council Victoria's website now has information available on a wide range of cancer-related topics in 16 languages. The new multilingual section includes a series of information sheets and web links. Visit www.cancervic.org.au/multilingual.

Topics include:

- What is cancer?
- Diagnosing cancer
- Treating cancer
- Eating well during treatment
- Learning to relax when you have cancer
- Cancer that cannot be cured
- Prostate problems
- Sun protection for all Australians
- The Pap test

All information is available in:

Arabic	Italian	Somali
Bosnian	Macedonian	Spanish
Chinese	Polish	Tigrinya
Croatian	Russian	Turkish
Filipino	Serbian	Vietnamese
Greek		

Additional fact sheets on Breast Awareness, Healthy Eating and Reducing Your Risk of Bowel Cancer will be available soon.

The availability of multilingual information supports existing programs aimed at reducing barriers to access and raising awareness of cancer issues, resources and support services.

Programs include:

The Multilingual Cancer Information Line (MCIL)

Adding to the accessibility of the Cancer Helpline, the MCIL enables callers who speak languages other than English to talk to oncology-trained nurse counsellors with the assistance of an on-line interpreter. The service is available in 80 languages.

The Community Language Program

The Community Language Program is a peer education program that provides free information sessions for community groups. Information on a range of topics is available in 22 languages.

Quit's Multicultural Program

Raising awareness of the health effects of smoking and passive smoking, Quit's Multicultural Program encourages people from multicultural communities to quit. Resources, telephone support and information sessions are available in a range of languages.

For additional information or to order copies of information sheets, phone the Cancer Information and Support Service on 13 11 20.

Key Published Articles Listing—Gastrointestinal Cancer

Title	Author & Journal
Meta-analysis of randomised adjuvant therapy trials for pancreatic cancer	Stocken DD, Buchler MW, Dervenis C, et al. British Journal of Cancer 25 Apr 2005; 92(8): 1372–1381.
Chemoradiation with and without surgery in patients with locally advanced squamous cell carcinoma of the esophagus	Stahl M, Stuschke M, Lehmann N, et al. Journal of Clinical Oncology 1 Apr 2005; 23(10): 2310–2317.
Accuracy of revised Bethesda guidelines, microsatellite instability, and immunohistochemistry for the identification of patients with hereditary non-polyposis colorectal cancer	Pinol V, Castells A, Andreu M, et al. The Journal of the American Medical Association Apr 2005; 293(16): 2028–2030.
Screening for the Lynch Syndrome (Hereditary Nonpolyposis Colorectal Cancer)	Hampel H, Frankel WL, Martin E et al. N Engl J Med. 2005 May; 352(18): 1851-60.
Colorectal cancer and inherited mutations in base-excision repair	Chow E, Thirlwell C, Macrae F & Lipton L. Lancet Oncology Oct 2004; 5(10): 600–606.

Key Published Articles Listing—General

Title	Author & Journal
Risks and benefits of phase 1 oncology trials, 1991 through 2002	Horstmann E, McCabe MS, Grochow L, et al. The New England Journal of Medicine 3 Mar 2005; 352(9): 895–904.
Peer support for cancer patients	Tilkeridis J, O'Connor L, Pignalosa G, et al. Australian Family Physician Apr 2005; 34(4): 288–289.

Forthcoming Meetings

Date / Place	Meeting / Contact
5–7 July 2005 Dublin, Ireland	Tripartite Colorectal Meeting 2005 Combined meeting hosted by Association of Coloproctology of Great Britain & Ireland, Section of Coloproctology, Royal Society of Medicine with the American Society of Colon and Rectal Surgeons, Section of Colon and Rectal Surgery, RACS and CSSA Website: www.tripartite.org.uk

Date / Place	Meeting / Contact
14–16 July 2005 Arlington, Virginia, USA	2005 Gastrointestinal Oncology Conference International Society of Gastrointestinal Oncology (ISGIO), 200 Broadhollow Rd, Melville New York 11747 USA Ph: +1 631390 8390 Fax: +1 631 393 5091 E-mail: email@isgio.org Website: www.isgio.org
21–23 July 2005 Hobart, TAS, Australia	Cancer Nurses Society of Australia (CNSA) Winter Congress Pre-conference workshops on 21 July. Contact: CNSA Conference Secretariat, PO Box 265, Annandale NSW 2038 Ph: (02) 9280 0577 Fax: (02) 9280 0533 E-mail: cnsa@pharmaevents.com.au Website: www.cnsa.org.au
10–13 August 2005 Hobart, TAS, Australia	Annual Scientific Meeting of the Medical Oncology Group of Australia (MOGA) Contact: MOGA Conference Secretariat C/- Pharma Events, PO Box 265, Annandale NSW 2038 Ph: (02) 9280 0577 Fax: (02) 9280 0533 E-mail: moga@pharmaevents.com.au Website: www.racp.edu.au/moga
21–26 August 2005 Sydney, NSW, Australia	11th World Congress on Pain Organised by: International Association for the Study of Pain (IASP). Congress Secretariat: Tour Hosts Pty Limited, GPO Box 128, Sydney NSW 2001 Ph: (02) 9248 0800 Fax: (02) 9248 0894 E-mail: iasp2005@tourhosts.com.au Website: www.iasp-pain.org/05Cong.html
30 Aug – 2 Sep 2005 Sydney, NSW, Australia	8th Australian Palliative Care Conference – <i>New Horizons</i> 8 th Australian Palliative Care Conference Managers, GPO Box 128, Sydney NSW 2001 Ph: (02) 9248 0800 Fax: (02) 9248 0894 E-mail: pallcare2005@tourhosts.com.au Website: www.pallcare.org.au
30 Aug – 3 Sep 2005 Couran Cove, QLD, Australia	Familial Cancer 2005 – <i>Research and Practice</i> Combined meeting of kConFab, Australian Ovarian Cancer Study (AOCS), Family Cancer Clinics of Aust and NZ, and Australasian Colorectal Cancer Family Study (ACCFS). Contact: Heather Thorne, Research Dept, Peter Mac Ph: (03) 9656 1542 E-mail: heather.thorne@petermac.org Website: www.kconfab.org/
5–9 September 2005 Brussels, Belgium	EORTC Course: Cancer Clinical Trials – Methods and Practice EORTC, Brussels, Belgium Ph: +32 2 774 1602 Fax: +32 2 772 6233 E-mail: dzi@eortc.be Website: www.eortc.be/Seminar/Educationpgm/Programs/prog2005.htm

Date / Place	Meeting / Contact
7–9 September 2005 Seoul, Korea	18th Asia Pacific Cancer Conference (APCC) Korean Cancer Association, Seoul, Korea Ph: +82 2 726 5553 Fax: +82 2 778 2514 E-mail: apcc2005@hanjinpco.com Website: www.apcc2005.org
2–5 October 2005 Birmingham, United Kingdom	National Cancer Research Institute Cancer Conference NCRI Conference Secretariat, PO Box 49709, 61 Lincoln's Inn Fields, London WC2A 3WZ United Kingdom Ph: +44 20 7269 3420 Fax: +44 20 7061 6004 E-mail: ncriconference@ncri.org.uk
6–9 October 2005 Sydney, NSW, Australia	56th Annual Scientific Meeting of the Royal Australian and New Zealand College of Radiologists (RANZCR) RANZCR, Level 9, 51 Druitt Street, Sydney NSW 2000 Ph: (02) 9268 9777 Fax: (02) 9268 9799 E-mail: ranzcr@ranzcr.edu.au Website: www.ranzcr.edu.au
7 October 2005 Brussels, Belgium	EORTC Course: One-day introduction to EORTC trials EORTC, Brussels, Belgium Ph: +32 2 774 1602 Fax: +32 2 772 6233 E-mail: dzi@eortc.be Website: www.eortc.be
13–15 October 2005 Hersonissos, Crete, Greece	10th World Congress on Advances in Oncology and 8th International Symposium on Molecular Medicine University of Crete, Medical School – Laboratory of Virology, Athens, Greece Ph: +30 210 725 2922 Fax: +30 210 722 7809 E-mail: spandidos@spandidos.gr Website: www.spandidos.gr
16–20 October 2005 Denver, Colorado, USA	47th Annual Meeting of the American Society of Therapeutic Radiology and Oncology (ASTRO) American Society for Therapeutic Radiology and Oncology (ASTRO), 12500 Fair Lakes Circle, Suite 375, Fairfax Virginia 22033 USA Ph: +1 703 227 0170 Fax: +1 703 502 7852 E-mail: meetings@astro.org Website: www.astro.org
19–22 October 2005 Brisbane, QLD, Australia	Australian Gastroenterology Week (AGW) Hosted by the Gastroenterological Society of Australia. GESA Conference Secretariat, Gastroenterological Society of Australia, 145 Macquarie Street SYDNEY NSW 2000 Ph: (02) 9256 5454 Fax: (02) 9241 4586 E-mail: gesa@gesa.org.au Website: www.agw2005.com

Date / Place	Meeting / Contact
20–23 October 2005 Brisbane, QLD, Australia	7th Annual Scientific Meeting of the Australasian Gastrointestinal Cancer Trials Group (AGITG) Secretariat: AGITG, Locked Bag 77 CAMPERDOWN NSW 1450 Ph: (02) 9562 5072 Fax: (02) 9565 1873 E-mail: agitg@ctc.usyd.edu.au Website: www.gicancer.org.au
23–26 Oct 2005 Vancouver, Canada	1st International Cancer Control Congress International Conference Services, Vancouver, Canada Ph: +1 604 681 2153 Fax: +1 604 681 1049 E-mail: iccc05@meet-ics.com Website: www.cancercontrol2005.com
30 Oct – 1 Nov 2005 Baltimore, Maryland, USA	4th Annual AACR International Conference: Frontiers in Cancer Prevention Research AACR, Philadelphia, USA Ph: +1 215 440 9300 Fax: +1 215 351 9165 E-mail: meetings@aacr.org Website: www.aacr.org
30 Oct – 3 Nov 2005 Paris, France	13th European Cancer Conference (ECCO) 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: ECCO13@fecs.be Website: www.fecs.be
14–18 November 2005 Philadelphia, Pennsylvania, USA	17th International Conference on Molecular Targets and Cancer Therapeutics Jointly organised by AACR, NCI and EORTC Website: www.aacr.org
16–18 November 2005 Brisbane, QLD, Australia	32nd Annual Meeting of the Clinical Oncology Society of Australia (COSA) – Crossing Cancer Boundaries COSA Office, Medical Foundation Building, Level 5, 92 Parramatta Road, Camperdown NSW 2011 Ph: (02) 9036 3100 Fax: (02) 9036 3101 E-mail: cosa@cancer.org.au Website: www.cosa.org.au
17–19 November 2005 New York, New York, USA	1st Annual Oncology World Congress – Where innovation improves care Reed Medical Education, Connecticut, USA Ph: +1 203 840 5849 E-mail: gammatruda@reedmeded.com Website: www.oncologycongress.com
21–25 November 2005 Leuven, Belgium	EORTC Course: Organisation & Implementation of Cancer Clinical Trials EORTC, Brussels, Belgium E-mail: dzi@eortc.be Website: www.eortc.be

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.

