Gastrointestinal Cancer Update

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HIGHLIGHTS FROM THE AMERICAN SOCIETY OF COLON & RECTAL SURGEONS ANNUAL MEETING

BOWEL CANCER SCREENING FORUM REPORT

INSIGHT 2007, YOKOHAMA

CANCER IN VICTORIA, 2004

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

GASTROINTESTINAL CANCER UPDATE

December 2006 Issue No. 47

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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, 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. 46 – July 2006** * * * * *

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 Stephen Bell
Colorectal Surgeon
Alfred Hospital / Monash Medical Centre / Cabrini Hospital

This issue of the Gastrointestinal Cancer Update looks forward from contemporary to future directions in the management of GI cancer, with an eye on the past.

Sandy Heriot gives us an overview of the **ASCRS** meeting in Seattle (June, 2006). This included an update on laparoscopic colorectal surgery, noting that the majority of attending surgeons undertake laparoscopic procedures. The issues around training and credentialing remain at the forefront of discussions. The CR07 trial data showed a reduction in local recurrence in all stages of rectal cancer with routine pre-operative short course radiotherapy and selective post-operative long course radiotherapy.

Kate Purss updates us on discussions from the recent **Bowel Cancer Screening Forum**, hosted by The Cancer Council Australia. The introduction of this very important initiative has been steady, but issues continue to arise. The important themes that are highlighted are data collection, communication and coordination between State and Commonwealth Governments, and workforce issues.

Fin Macrae offers us a tempting invitation to the **2007 InSiGHT meeting** in Yokohama, Japan. He highlights the importance of this "boutique" meeting that discusses contemporary issues in gastrointestinal hereditary tumours, with a number of founding fathers in this field to present keynote speeches, and a special session on the Human Variome Project.

The Victorian Cancer Registry gives a brief overview of Cancer in Victoria in 2004, with specific statistics, including noting that at least one in three Victorians will develop cancer by the age of 75, but that cancer death rates continue to decrease.

A transcript of Associate Professor David Allen's speech during the VCOG 30th Anniversary reception is provided on page 11.

Susan Fitzpatrick's poster presentation at the UICC World Cancer Congress, 2006, entitled "Supporting Oncology Professional Collaboration in Cancer Control, 1976-2006" is provided on page 12.

We note that Cancer Australia has now appointed Professor David Currow as CEO, and it is expected that his expertise and experience will help this organisation quickly come to grips with national priorities and issues in cancer control.

A new online resource for familial based cancer is presented on page 15.

Finally, a list of forthcoming meetings is published for the first six months of 2007.

Enjoy your reading! I am sure there are areas of interest to all readers.

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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Highlights of the American Society of Colon and Rectal Surgeons Annual Meeting

3–7 June 2006, Seattle, USA

Mr AG Heriot
Consultant Colorectal Surgeon
Peter MacCallum Cancer Centre

The American Society of Colon and Rectal Surgeons (ASCRS) meeting was held in Seattle in June 2006. This is the largest annual colorectal surgical meeting in the world and its content probably represents the state of the art therapy for colorectal surgery. A significant proportion of the meeting is directed to colorectal cancer and this report highlights the major topics in this area.

Laparoscopic Colorectal Surgery

A morning symposium on the role of laparoscopy in colorectal cancer surgery was run, a similar symposium having been run at the meeting during the preceding 2 years. The major difference was the increase in the proportion of surgeons undertaking laparoscopic colorectal cancer resection in their practice, from around a third of the attending surgeons 2 years ago to the majority of the attending surgeons at this years meeting. The debate was over the optimum techniques that can be used and whether surgery should be completely laparoscopic or whether the use of a hand assist device was beneficial. It was interesting to note that there was a dramatic increase in industry stands supporting laparoscopic colorectal surgery, with industry realising perhaps earlier than clinicians of the potential future developments in practice with a much greater proportion of surgery likely to be performed laparoscopically. The issue of training in laparoscopic colorectal surgery, both for trainees and for older surgeons who have limited laparoscopic experience, remains unanswered but is starting to be addressed.

Adjuvant Therapy

There has been increasing evidence of the role of preoperative neoadjuvant radiotherapy in the management of primary rectal cancer and this was added to by the reporting of the CR07 trial results at the meeting. This was a randomised controlled trial comparing routine preoperative short course radiotherapy (25 Gy) with selective postoperative long course radiotherapy (for patients with tumour involvement of the circumferential resection margin of the resected rectal specimen) in patients with resectable rectal cancer of all stages. Preoperative radiotherapy resulted in a significant reduction in local recurrence and this was present across all tumour stages, even early tumours. The proportional reduction in local recurrence reduced with early stage tumours with no reduction in morbidity such that it was commented that it was probably inappropriate to irradiate early tumours as the potential benefits were outweighed by the potential iatrogenic morbidity. Interestingly, short course radiotherapy is very rarely applied in the United States and is predominantly applied within European practice. It is applied in a proportion of Australian practice, most recently as a limb of the completed TROG trial of neoadjuvant radiotherapy for rectal cancer.

Quality

The Presidential address was given by the outgoing president of ASCRS, Dr Ann Lowey, an associate Professor of Colorectal Surgery from Minneapolis. The theme of her address was the assessment of quality in colorectal surgery and the difficultly of measuring this. This is a very topical area at present and is applicable across colorectal practice in the United States, Europe, and Australasia. Recognition that there will always be a spectrum of results across a group of surgeons and rationalisation of what is an acceptable mean level of care is essential. The importance of patient stratification was raised along with what factors should be utilised to

assess risk in an individual patient. Some method of quality assessment is essential and this raises the question of what should be done with outliers that fall below the acceptable mean. A further difficulty is that although no one disagrees with the value of quality assessment of practice, the question of who should fund this remains with no body currently volunteering to provide the funding. The issue of quality assessment is likely to become increasingly important over the next few years.

Screening for Colorectal Cancer and Hereditary Colorectal Cancer

A symposium on Hereditary Colorectal Cancer stressed the value of taking an accurate family history in patients with colorectal cancer and its role in assessing the likelihood of hereditary colorectal cancer in the family. The various hereditary syndromes were discussed and the management of each of these syndromes explored. This is an area that is beginning to develop much greater awareness amongst colorectal surgeons.

The Ernestine Hambrook lecture was given by Professor Lester Rosen from Philadelphia entitled 'Past, Present, and Future of Colon and Rectal Cancer Screening'. Screening is a very controversial issue around the world at present with a variety of approaches in different countries. The United States uses screening colonoscopy every 5 years to all patients over 50 years of age but though this has high sensitivity, a significant proportion of the population are not screened. Australia and the UK are both initiating a program of faecal occult blood screening of select population group over the age of 50 years, with positive tests undergoing colonoscopy. This is a less sensitive methodology but is cheaper and has the potential of being applicable to a greater proportion of the population. The outcome of these screening programs is eagerly awaited but this will take a number of years for meaningful results to be obtained.

Conclusion

In summary, the ASCRS meeting is an excellent colorectal meeting that is highly informative and addresses topical issues and can be highly recommended to all surgeons with an interest in colorectal cancer.

Moving forward on bowel cancer screening – A forum for health professionals

Ms Kate Purss
Bowel Cancer Program Coordinator
Cancer Education Unit
The Cancer Council Victoria

The Cancer Council Australia hosted a bowel cancer screening forum on 20 November in Melbourne. *Moving Forward on Bowel Cancer Screening* brought together a range of health professionals with an interest in population-based bowel cancer screening in Australia.

Supported by the Australian Government, the forum featured nationally recognised experts who presented on topics spanning the bowel cancer screening continuum. Presentations included background information on the bowel cancer screening pilot, quality and provision of colonoscopy and the role for both nurses and general practitioners in bowel cancer screening. In addition, presentations included information around screening behaviour and the economic benefits of screening programs. The day culminated with a panel discussion.

Of particular interest to participants was the address from Dr Roland Valori– National Clinical Lead for Endoscopy Services (UK). Travelling from the UK, Dr Valori presented on his involvement in the UK bowel cancer screening

program which began in July 2006. Working closely with the Department of Health (UK), he spoke about an approach that responds to the dual challenge of implementing a screening program and achieving a maximum waiting time of less than six weeks for people waiting for a routine endoscopy. Dr Valori believed that defining what a patient might expect from an endoscopy service and aligning the agendas of those involved in the service was key to achieving success. He illustrated that a major component underpinning these principles was creating a quality assurance framework that defines standards and processes with which to monitor them. In presenting this information he spoke about the importance of training to improve the standard of endoscopy. He went into further detail and illustrated a model used in the UK called the Global Rating Scale (GRS). More information regarding the scale can be accessed at www.grs.com.uk.

Three themes emerged from discussion generated during the forum:

- **Data collection** – Given the late start of the Program in many states and territories and the varied roll-out methods, participants expressed concerns about the potential limited data collection before the evaluation process begins. In addition to this concern, participants called for consistent and comprehensive data collection systems.
- **Communication and Coordination** – The need for communication and coordination between state and Commonwealth government was a consistent theme. Participants spoke about the benefits of sharing ideas around implementation of the Program and providing feedback on learnings. Additionally there was comment on the need for different levels of government to clearly articulate their responsibilities within the screening program and to ensure at each level these responsibilities were acted on. Participants raised the importance of clear communication, engagement and consultation to inform health professionals and help maximise participation in the Program.
- **Workforce Issues** – Whilst the majority of participants agreed that the National Program was a positive step forward, the issue of a limited workforce was raised a number of times. Participants expressed concern that patients who receive a positive FOBT might have to wait a significant length of time before being able to access a colonoscopy.

Though the National Program is still in its early stages it is encouraging to see that steps are being taken to make it a success. This forum provided the first opportunity to discuss the Program and it was agreed that similar forums should continue to take place in an attempt to effectively communicate issues surrounding the roll-out and provide an opportunity for open discussion and debate.

A comprehensive report summarising the forum will be available in coming weeks from www.bowelscreeningforum.com.au. Presentations from the forum can also be accessed from this website.

2007 InSiGHT Meeting, Yokohama, Japan

Tuesday 27March – Friday 30 March 2007

Visit www.insight-group.com

Takeo Iwama
Chairman, InSiGHT

Finlay Macrae
Honorary Secretary, InSiGHT

The International Society for Gastrointestinal Hereditary Tumours (InSiGHT) formed with the merger of the Leeds Castle Polyposis Group and International Collaborative Group for Hereditary Non Polyposis Colorectal Cancer in 2005. The Yokohama meeting follows its successful first meeting in Newcastle upon Tyne.

If you have an interest in Colorectal Cancer and its genetics, this "boutique" meeting is for you. This year over 200 papers have been submitted covering the field. There are papers on molecular, clinical, basic science and psychosocial aspects of familial cancer. Papers on new molecular screening tests for HNPCC, endoscopic (including capsule), laparoscopic and radiological approaches can be expected as well as population based studies explaining the relationship of genotype to phenotype in HNPCC and the polyposis syndromes. Surgical papers from some of the world's best colorectal surgical units in USA and Europe invariably present their latest data. Algorithms for predicting mutation carriers will be presented.

There will be a special session on the Human Variome Project and its relationship to the mismatch repair mutational databases, aimed at aligning this InSiGHT database with the evolving establishment of the Human Variome Project. Medical Geneticists interested in interpretation of mismatch repair variants are particularly welcome, and indeed may wish to play a central part in this initiative (contact: Prof Finlay Macrae, E-mail: finlay.macrae@mh.org.au). Dick Cotton has been invited to keynote this session.

Founding fathers in the field will be keynote speakers, and not to be missed, as their professional lives draw to a close. Joji Utsunomiya, the first surgeon to create the popular J pouch restorative proctocolectomy and Henry Lynch, of the Lynch syndrome (Hereditary Non Polyposis Colorectal Cancer Syndrome) will be addressing the meeting. More contemporarily, Dr Yamamato, originator of double balloon enteroscopy will be at the meeting.

The CAPP investigators will be there to wind up CAPP2 and advance plans for CAPP3 and other collaborative studies will take shape at the meeting. Strong contributions from the Netherlands Foundation for Hereditary Tumours and the extraordinarily effective Finnish investigators can also be expected.

There may be lobbying efforts to secure perhaps the 2013 meeting for Australia, so a strong Australian registration would be particularly welcome. 2009 will be Dusseldorf, Germany and 2011 likely in North America.

Best of all is the opportunity to meet the names behind the advances in this field and form friendships that can often be called on to assist in difficult clinical decision making.

Yokohama is close. Do come. Visit www.insight-group.org. You'd be welcome and you'll find it stimulating, cross-disciplinary and great camaraderie. And why not join the Society at just £70 pa (initial registration, includes subscription to Familial Cancer).

Cancer in Victoria 2004

Victorian Cancer Registry

The Victorian Cancer Registry has been a population-based registry since 1982. This was enabled by amendments to the Cancer Act in 1981, which made it mandatory for all hospitals and pathology laboratories to notify the cancer registry of the presence of cancer in patients or human tissues.

All malignant neoplasms are registered, as are in situ carcinoma of breast and cervix and in situ melanoma. Basal and squamous cell carcinomas of the skin are not registered except for those occurring in genital and perianal skin and the vermilion border of lip.

Non-melanocytic skin cancers are not registered by the Victorian Cancer Registry (or most other registries) as many are treated in doctors' surgeries using destructive techniques which preclude histological confirmation and also as they vastly outnumber all other forms of cancer.

Currently, about 250 hospitals and 50 pathology laboratories notify cancer to the registry, increasingly via electronic media. In preparing the 2004 incidence data, around 100,000 notifications were processed. In addition, death certificates are obtained from the Registrar of Births, Deaths and Marriages in computerised format on a regular basis.

The minimum data set collected for each cancer consists of:

- registry identification number
- name(s)
- residential address
- date of birth
- country of birth
- sex
- vital status
- date of last contact
- number of primary tumours
- date of diagnosis
- site of cancer
- cancer histology
- method of diagnosis.

Overview of 2004 statistics

Numbers

Nearly 24,000 Victorians develop cancer, other than non-melanocytic skin cancer (NMSC), each year and over 9,000 deaths are caused by it. In 2004, 13,019 men and 10,791 women presented with new cancers and 5,283 men and 4,266 women died from cancer.

Age and sex

Cancer was very age-dependent with less than 1% of tumours occurring before age 15 and 59% in persons over 65 years. More men than women developed cancer: 121 for every 100 females. The male excess was largely due to tobacco-related cancers.

Incidence

The standardised incidence rates were 346 per 100,000 males and 265 per 100,000 females. The cumulative rates percent to age 75 were 40.7% for males and 29.5% for females. These represented risks of over 1 in 3 for men and almost 1 in 4 for women. At least one in three Victorians will develop a cancer other than non-melanocytic skin cancer by age 75.

Mortality

In 2004, more Victorians died from cancer (9,613 29.6% of all deaths) than from all heart disease (7,771, 23.9%). Cancer and heart disease caused more than half of all deaths in Victoria.

Age-standardised mortality rates for cancer were 125.8 per 100,000 males and 83.5 per 100,000 females. These rates are higher than those for both ischaemic heart disease (66.6 and 32.5 per 100,000 men and women respectively) and all heart disease (85.0 and 46.9 men and women respectively).

Cancer death rates for men and women continue to decrease at about 1.2% and 0.9% per year respectively.

More detailed statistics are available at www.cancervic.org.au/cancer1/facts/vic.htm.

Figure 1. Leading Cancer Sites in Victoria, 2004.

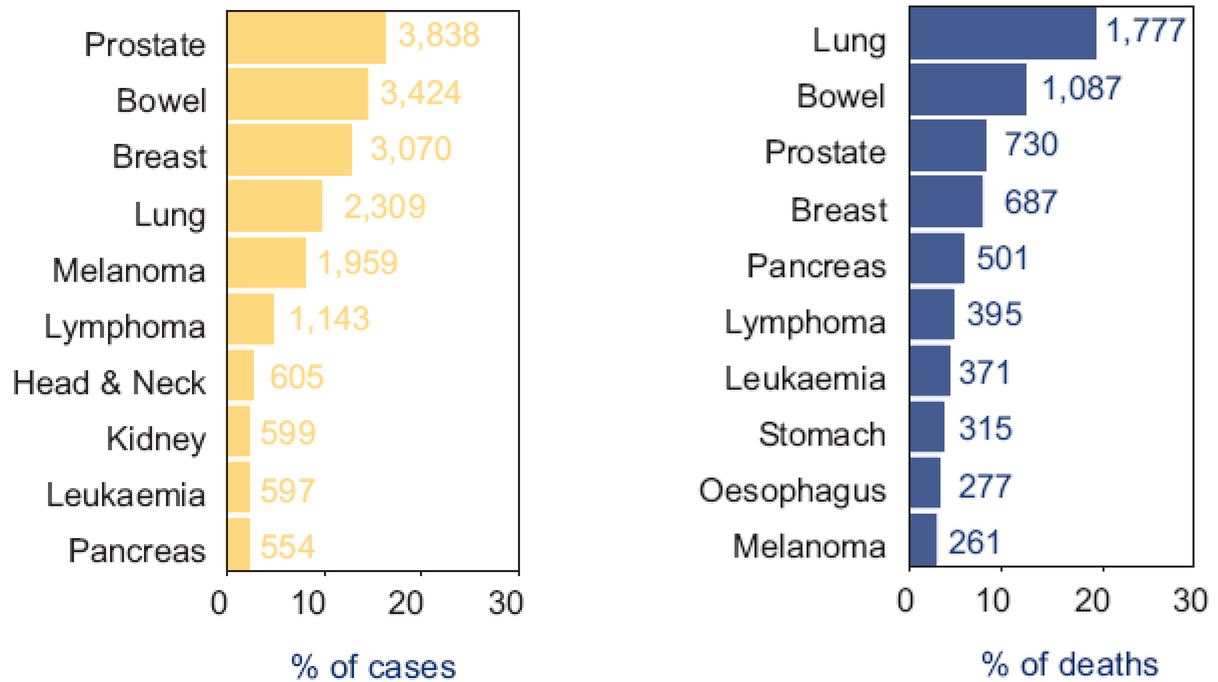


Figure 1 shows the ten top-ranking sites for cancer incidence and mortality in Victoria. The bars represent the percentages of total new cases or deaths in each site. Numbers of cases / deaths are also shown.

Figure 2. Bowel Cancer Trends in Victoria, 1982–2004.

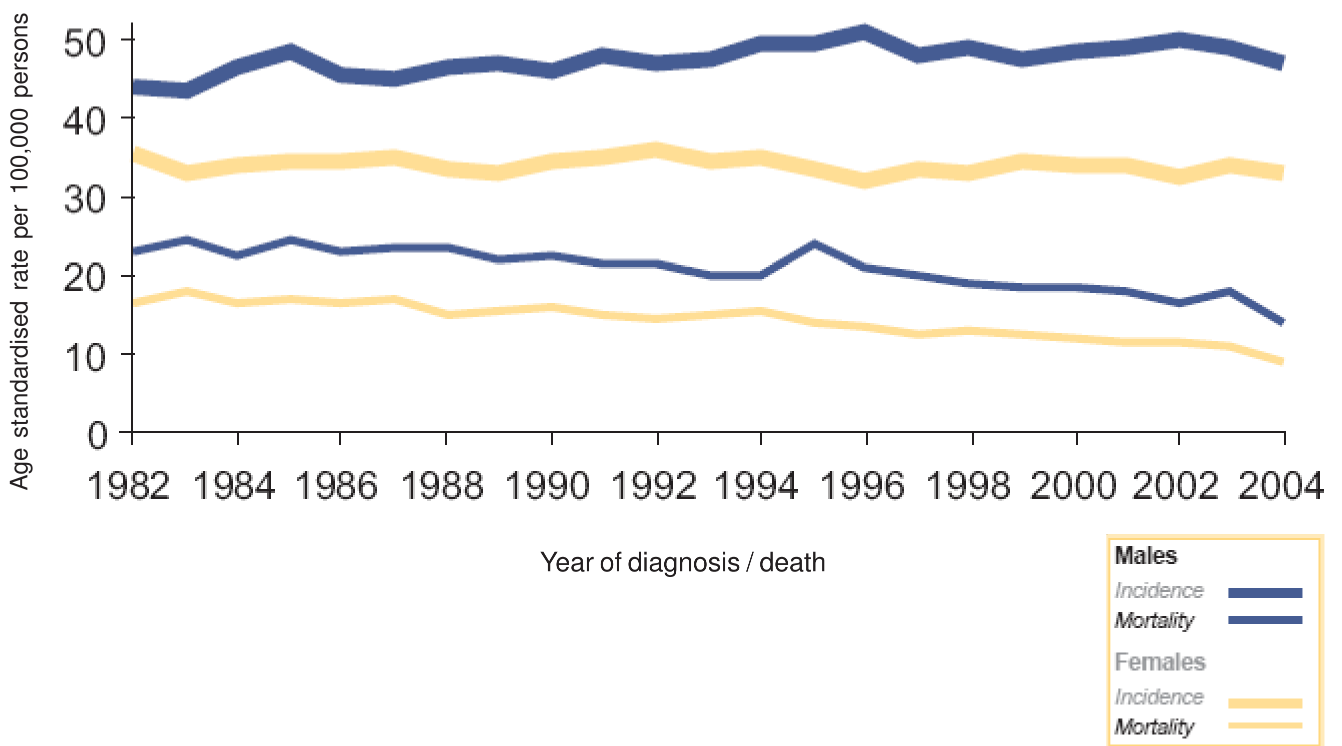


Figure 3. Stomach Cancer Trends in Victoria, 1982–2004.

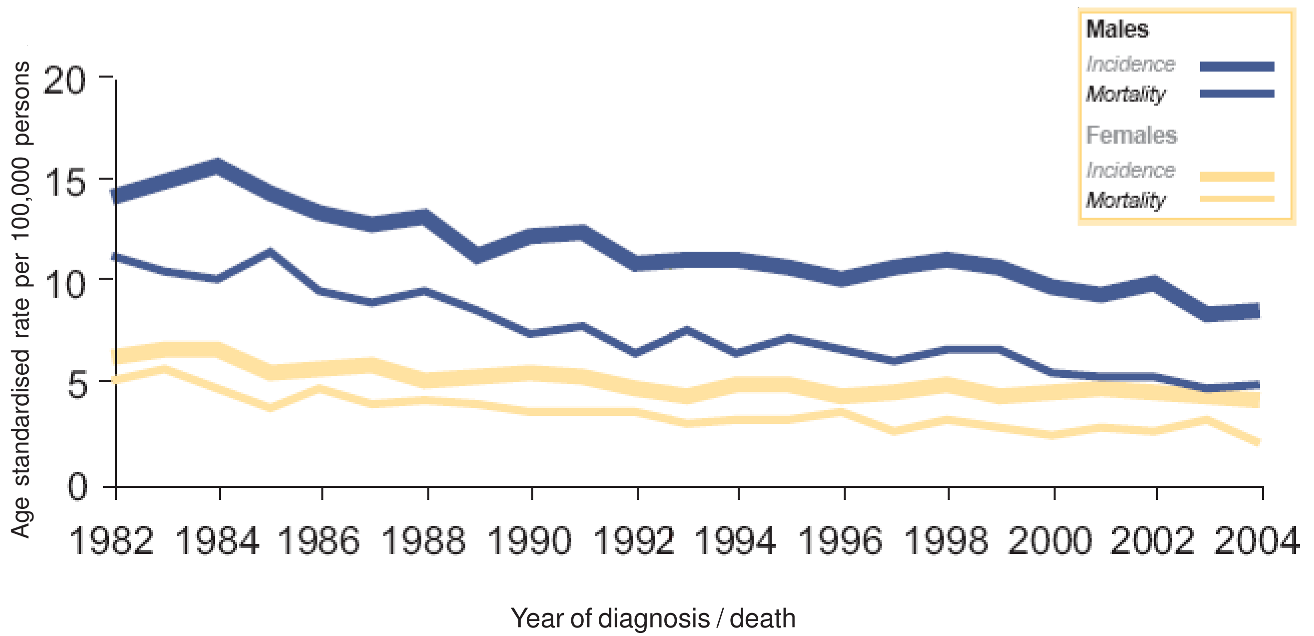
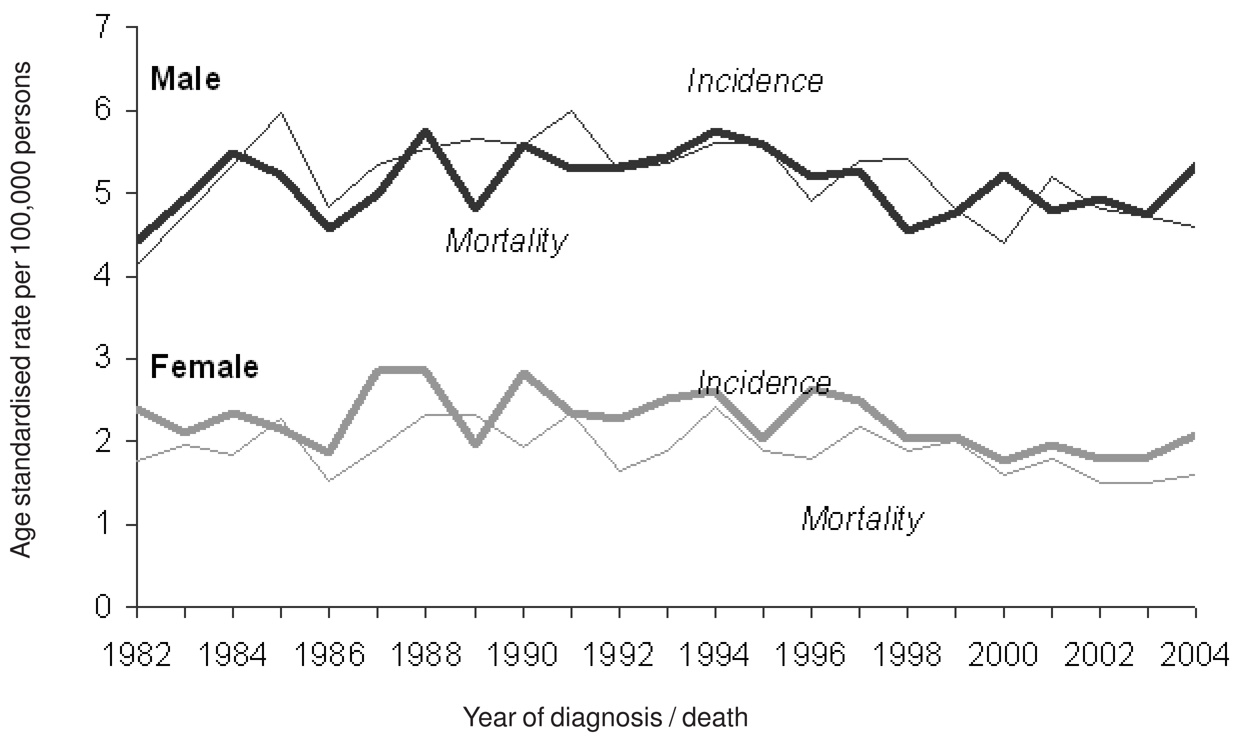


Figure 4. Oesophageal Cancer Trends in Victoria, 1982–2004.



VCOG 30th Anniversary

Speech by Assoc Professor David Allen, VCOG Chair
on 1 November 2006 during VCOG 30th Anniversary Reception

Over the last 30 years, the Victorian Cooperative Oncology Group has developed into a body with a broad multidisciplinary and cross-institutional representation.

The aim of the group has been to prevent cancer and optimise patient treatments and care through collaboration and research. VCOG is now a forum that is of value to clinicians and of importance for patient outcomes.

The VCOG and its subcommittees have developed into an authoritative body of enthusiastic experts who work across disciplines, outside of institutional boundaries, providing clinical and research advice to the Cancer Council. The approximately 450 members of the VCOG committees make an enormous contribution to clinical research and the development of patient care protocols in Victoria.

These committees provide a necessary neutral territory for discussion and will certainly continue to grow into the future. Just last week we held the inaugural meeting of the 20th committee – the sarcoma advisory committee.

As the committees expand and strengthen further, so too will the influence and relevance of this unique forum grow in its present spirit of co-operation.

Of course the work of these committees doesn't just happen – they need to be organised, agendas prepared and circulated etc. The VCOG Secretariat, consisting of the Executive Officer Susan Fitzpatrick and her team, really is the glue that binds us together, and for all their essential – and increasing – work, we thank them.

Every two years the Victorian Cooperative Oncology Group elects an Executive Committee that in turn elects a Chair. I am very proud to be the current chair of VCOG and the Executive Committee and I thank the members for their work and support – and in doing this I would also like to acknowledge the work of all past and present subcommittee chairs and members. And whilst I am thanking people, I would also like to mention David Hill for his constant support, and my deputy chair Ingrid Winship for her valuable contribution.

The achievements of VCOG over the past 30 years are enormous but the future looks even brighter with the new opportunities and directions that are constantly emerging. Working with the newly formed Integrated Cancer Services in Victoria is one such opportunity. And we look forward to other potential collaborations and synergies with the Department of Human Services and other relevant government departments and agencies in the future.

However, to remain relevant into the future we must always ensure that our efforts are of benefit to the Victorian community as a whole and that we keep our focus firmly on the fight against cancer.

I thank you all.

Supporting Oncology Professional Collaboration in Cancer Control, 1976–2006

Mrs Susan A Fitzpatrick, Executive Officer
Centre for Clinical Research in Cancer, The Cancer Council Victoria
Poster presentation at UICC World Cancer Congress, 8–12 July 2006, Washington DC, USA

The Victorian Cooperative Oncology Group

The Cancer Council Victoria's infrastructure support within a "neutral" environment for the Victorian Cooperative Oncology Group has enabled Victoria's cancer specialists to meet in a conducive, non-partisan environment to develop multi-disciplinary clinical management protocols and policy advice for 30 years.

The Victorian Cooperative Oncology Group is an excellent forum for communication of new cancer treatment knowledge, promoting development and implementation of evidence-based clinical management guidelines and for the collaborative design of and participation in clinical trials. It has also enabled the coordinated lobbying of governments for improved services for cancer patients and cancer clinical research funding.

Comment from the Chair, Assoc Professor David Allen

Developing a unique oncology professional group

In 1975, the Cancer Council's Medical & Scientific Committee expressed concern about inconsistency in the management of solid tumours requiring chemotherapy and the then lack of suitable medical training. It formed a working group to explore all aspects of chemotherapy in Victoria.

In 1976 it was resolved to invite clinical representation from all hospitals in Victoria providing cancer therapy.

The Cancer Council Victoria provided a non-partisan environment and administrative support for the gathering.

The Victorian Cooperative Oncology Group was constituted in 1976 to:

- Advise the Cancer Council Victoria on all clinical aspects of cancer.
- Promote a range of cooperative measures to optimise cancer management.
- Contribute to the design and conduct of collaborative clinical research.
- Promote development and implementation of evidence-based treatment guidelines.
- Advocate for improved cancer services
- Contribute to the education of the medical profession.
- Establish cancer advisory and research groups.

In 2006, the VCOG structure includes a primary committee, an executive committee, 9 cancer and 4 clinical advisory committees and 3 research groups. The Cancer Council supports the VCOG activities through a dedicated Clinical Research Centre providing administration and cancer trial coordination.

A group with extensive cancer expertise

- 450 honorary / volunteer health professionals – medical, scientific and community.
- Inclusive, with the power to co-opt members with specialist expertise.
- Represents medicine, radiotherapy, surgery, gastroenterology, gynaecology, dermatology, ENT, genetics, haematology, neurology, palliation, pathology, psychology, respiratory / thoracic, nursing social work, etc.

- Includes 16 consumer / community representatives
- Represents 30 public and private metropolitan and regional cancer treatments centres

An influential role in improving cancer care

- Supports evidence-based treatment, clinical research, equity and access to best cancer care
- Assists the Cancer Council in cancer registration (standard data items / site specific registers), knowledge dissemination (professional forums / newsletters), community education (patient information material), support (Cancer Call-In), media responses, and fundraising activities (Relay for Life, Daffodil Day etc)
- Has capacity to influence clinical practice and service provision
- Highly respected by oncology professionals in Victoria and Australia
- Has unique linkages between public and private health care professionals, institutions, government and NGOs

Providing authoritative advice on cancer control

Advocacy / Support for

- Cancer Service Infrastructure, Bone Marrow Transplantation, Palliative Care Services, Cancer Therapies, Pain Therapies, Clinical Research Infrastructure, Standard Cancer Data Set, Professional Education, Cancer Genetics Services, Patient Resources and Support Services

Submissions to Government Inquiries on

- Cancer Services in Victoria / Australia, Alternative / Unproven Therapies, Mammographic Screening, Prostate Cancer Screening, Protection of Cancer Genetic Information

Statements / Guidelines on

- Screening for breast, bowel, prostate cancer, Handling of cytotoxic drugs, Techniques for cervical smear, Management of gynaecological, cancer, familial ovarian cancer, non-melanocytic skin cancer, Synoptic reporting for melanoma, gynaecological and head and neck cancer, IHC testing for CRC, Gynaecological surveillance for HNPCC

Information for patients and families

- Expert medical advice on contact of Cancer Council information brochures.

Collaborating in clinical research

Clinical Trials

- Initiated – Endometrial (international), Ovarian (national), Rectal (state), Breast (international, state), Pain (state), Prostate (international)
- 7% cancer patients registered in trials in Victoria
- 12% breast cancer patients in international trials

Treatment Surveys and Audits

- Breast (1986, 1990, 1995, 1999)
- Colorectal (1988, 1998, 1994)
- Lung (1993), Prostate (1993)
- Testes (1988-1993)
- Cervical (1982, 1986, 1987, 1992), Ovarian (1993-1995), Endometrium (1995)
- Renal Cell (2000), Bladder – Superficial (1990, 1995), Bladder – Invasive (1990-95)
- Glioma (1998-2000)
- Melanoma (2000)

Outcome Registers

- Insitu & Small Breast (1988-1998), Radical Prostatectomy (1997-2002)

Achievements

- NHMRC Silver Volunteer Award for Health Organisation, Victoria, 2001.
- Peak oncology health professional advisory body – *Victoria's Cancer Parliament*.
- Maintained cohesive oncology health professional community for 30 years.
- Structure modelled in three other Australian states.

Guidelines for the Prevention, Early Detection and Management of Colorectal Cancer (CRC) 2nd Edition

The Department of Health and Ageing made a request with a limited timeline for a revision of the Familial Aspects of Bowel Cancer: a Guide for Health Professionals and a GP advisory card based on the 2nd Edition of the CRC Guidelines. 45,000 copies of each updated Guide were supplied for inclusion in the GP Information Kits to accompany the roll out of the National Bowel Cancer Screening Program which occurred in August. Both Guides are posted on our website at www.cancer.org.au/clinical_guidelines and both are also available from ACN by request acn@cancer.org.au

The revision of the Consumer document for CRC and its funding is still being negotiated.

Reprinted from Wongi Yabber Nov 2006; 13(4): 2.

Cancer Australia Ready to Tackle National Priorities

Appointment of a Chief Executive Officer to Cancer Australia has paved the way for the organisation to become operational and address a growing list of national cancer priorities, according to The Cancer Council Australia.

The Cancer Council Australia's Chief Executive Officer, Professor Ian Olver, welcomed the appointment in August of Professor David Currow as CEO of the new agency and said he would be taking on a challenging role with big expectations from the health sector.

"The establishment of Cancer Australia is a significant development and Professor Currow's expertise and experience will help the organisation quickly come to grips with national priorities and issues in cancer control," Professor Olver said.

"There is a real need in Australia for a central agency to coordinate and facilitate the considerable but fragmented research efforts into cancer at the national level. We also need more resourcing to develop and implement national guidelines and to accredit and credential cancer professionals and treatment centres."

Reprinted from Wongi Yabber Nov 2006; 13(4): 4, The Cancer Council Australia Report.

Web Resource Provides Missing Link to Genetic Cancer Information

More than 4000 Australians diagnosed each year with a familial based cancer can now access a new online resource thanks to a collaboration between The Cancer Council Australia and the National Cancer Genetics Education Group.

The web-based family cancers facility includes information on types of family cancers, genetic testing, family cancer clinics and a searchable directory of resources.

The Cancer Council's Chief Executive Officer, Professor Ian Olver, said that in around five per cent of the 88,000 cancers diagnosed each year in Australia, an inherited faulty gene is a major contributing factor.

"Family cancer can be a difficult concept to understand and there is a lot of confusing and contradictory information around," Professor Olver said. "While the Internet has provided greater access to information, it is not always the right information.

"Our new web resource provides a centralised resource of credible, evidence-based information – making it more user-friendly and reliable for the public."

Spokesperson for the National Cancer Genetics Education Group and project manager with NSW Health's Centre for Genetics Education, Kate Dunlop, said the online resource would benefit not just consumers, but support health professionals such as GPs and others working with cancer patients.

"A busy GP rarely has the time to search through volumes of web based information to provide their patients with relevant and useful support," she said. "Now they can go to one site to get what they need and can feel secure in the knowledge they are directing their patients to evidence-based information."

The new family cancers section on The Cancer Council Australia's website can be viewed at www.cancer.org.au/familycancers.

Reprinted from Wongi Yabber Nov 2006; 13(4): 4, The Cancer Council Australia Report.

Key Published Articles Listing—Gastrointestinal Cancer

Title	Author & Journal
Hyperplastic polyposis syndrome: phenotypic presentations and the role of MBD4 and MYH	**Chow E, Lipton L, Lynch E, et al.** Gastroenterology July 2006; 131(1): 30–39.

Forthcoming Meetings

Date / Place	Meeting / Contact
19–21 January 2007 Orlando, Florida, USA	**2007 Gastrointestinal Cancers Symposium – *Multidisciplinary approaches to the prevention, diagnosis and therapy of GI cancers*** Website: www.asco.org/GI2007
25–28 January 2007 Clearwater Beach, Florida, USA	**Molecular Targets in Cancer Therapy: 4th Biennial Meeting – *Mechanism & therapeutic reversal of immune suppression in cancer*** Website: www.moffitt.usf.edu/continuinged/mt2007
1–3 February 2007 San Diego, California, USA	**9th International Symposium on Anti-Angiogenic Agents** Website: www.antiangio2007.com
6–9 February 2007 Paris, France	**18th International Congress on Anti-Cancer Treatment (ICACT)** Service d'Oncologie Medicale, Salpetriere Hospital, c/o TCO Medi Holding, Paris, France Ph: +33 1 42 948 732 Fax: +33 1 42 948 733 E-mail: info@icact.com Website: www.icact.com
8–10 February 2007 Lorne, Victoria, Australia	**19th Lorne Cancer Conference – *The hallmarks of cancer*** Website: www.lornecancer.org
8–10 February 2007 Hollywood, California, USA	**9th National Conference on Cancer Nursing Research** Organised by the Oncology Nursing Society (ONS), 125 Enterprise Drive, Pittsburgh, PA 15275-1214 USA Ph: +1 412 859 6100 Fax: +1 412 859 6162 E-mail: customer.service@ons.org Website: www.ons.org
13–14 February 2007 Fort Lauderdale, Florida, USA	**2nd International Congress of Laparoscopic Colorectal Surgery** Cleveland Clinic Florida, Continuing Medical Education Department Ph: +1 954 659 5490 Fax: +1 954 659 5491 E-mail: cme@ccf.org Website: www.clevelandclinic.org/florida/research/cme/
15–17 February 2007 Fort Lauderdale, Florida, USA	**18th Annual International Colorectal Disease Symposium** Cleveland Clinic Florida, Continuing Medical Education Department Ph: +1 954 659 5490 Fax: +1 954 659 5491 E-mail: cme@ccf.org Website: www.clevelandclinic.org/florida/research/cme/ColorectalDisease2007.htm

Date / Place	Meeting / Contact
27–28 February 2007 Sydney, NSW, Australia	**3rd Australasian Redesigning Healthcare Summit – *Making patient journeys work*** With Flinders Medical Centre and NSW Health Website: www.changechampions.com.au
1–4 March 2007 Austin, Texas, USA	**4th Annual Conference of the American Psychosocial Oncology Society (APOS) – *Promoting quality psychosocial cancer care across diverse communities*** Ph: +1 434 293 5350 Fax: +1 434 977 1856 E-mail: info@apos-society.org Website: www.apos-society.org
1–4 March 2007 Sao Paulo, Brazil	**7th Annual Meeting of the International Network for Cancer Treatment & Research** Website: www.inctr.org
6–10 March 2007 Florence, Italy	**4th International Conference on Tumor Micro-environment – *Progression, therapy and prevention*** Organised by AACR and ICMS Website: www.aacr.org/page5995.aspx
15–18 March 2007 Washington DC, USA	**Annual Meeting of the Society of Surgical Oncology (SSO)** Website: www.surgonc.org
22–23 March 2007 Cairns, QLD, Australia	**Clinical decisions, ethical challenges** E-mail: change.champions@bigpond.com Website: www.changechampions.com.au
27–30 March 2007 Yokohama, Japan	**2nd Meeting of the International Society for Gastrointestinal Hereditary Tumours (InSiGHT)** Website: www.insight-group.org/
11–14 April 2007 Rotorua, New Zealand	**19th Annual Trans Tasman Radiation Oncology Group (TROG) Meeting** TROG Conference Secretariat Ph: (02) 9280 0577 Fax: (02) 9280 0533 E-mail: trog@pharmaevents.com.au Website: http://trog.ranzcr.edu.au
14–18 April 2007 Los Angeles, California, USA	**98th Annual Meeting of the American Association for Cancer Research (AACR)** Website: www.aacr.org

Date / Place	Meeting / Contact
24–27 April 2007 Las Vegas, Nevada, USA	**32nd Annual Congress of the Oncology Nursing Society (ONS)** Oncology Nursing Society (ONS), 125 Enterprise Drive, Pittsburgh, PA 15275-1214 USA Ph: +1 412 859 6100 Fax: +1 412 859 6162 E-mail: customer.service@ons.org Website: www.ons.org
6–10 May 2007 Melbourne, VIC, Australia	**Annual Scientific Meeting of the Royal Australasian College of Physicians (RACP)** Website: www.racp.edu.au
7–11 May 2007 Christchurch, New Zealand	**Annual Scientific Congress of the Royal Australasian College of Surgeons (RACS)** Ms Caroline Handley Ph: +61 3 9249 1273 E-mail: caroline.handley@surgeons.org Website: www.surgeons.org/AM/Template.cfm?Section=Annual_Scientific_Congress
9–11 May 2007 Winnipeg, Canada	**2007 Annual Conference of the Canadian Association of Psychosocial Oncology (CAPO) – *Communication, Collaboration & Creativity*** Website: www.capo.ca
1–5 June 2007 Chicago, Illinois, USA	**43rd Annual Meeting of the American Society of Clinical Oncology (ASCO)** American Society of Clinical Oncology, 1900 Duke Street, Suite 200, Alexandria Virginia 22314 USA Ph: +1 703 299 0150 Fax: +1 703 299 1044 E-mail: asco@asco.org Website: www.asco.org
2–6 June 2007 St Louis, Missouri, USA	**Annual Meeting of the American Society of Colon and Rectal Surgeons** Website: www.fascrs.org
18–19 June 2007 Nottingham, UK	**BACR Conference: Diet and Cancer** British Association for Cancer Research (BACR), Sutton, UK Ph: +44 20 8722 4208 Fax: +44 20 8770 1395 E-mail: bacr@icr.ac.uk Website: www.bacr.org.uk

Date / Place	Meeting / Contact
23–29 June 2007 Flims, Switzerland	**9th Joint FECS-AACR-ASCO Workshop – Methods in Clinical Cancer Research** Federation of European Cancer Societies, Brussels, Belgium Ph: +32 2 775 0306 Fax: +32 2 775 0245 E-mail: workshop@fecs.be Website: www.fecs.be/emc.asp?pageid=1153
27–30 June 2007 Barcelona, Spain	**9th 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
28–30 June 2007 St Gallen, Switzerland	**Supportive Care in Cancer** Website: www.oncoconferences.ch

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 300 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, 10 cancer-site and 3 task-specific advisory committees, and 5 research sub-committees. These committees bring together in regular meetings approximately 450 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.