



Gastrointestinal Cancer Update

Issue 48 August 2007

- Highlights from the American Society of Clinical Oncology Meeting
- Highlights from the 9th World Conference on Gastrointestinal Cancers
- InSIGHT 2007, Yokohama
- AGITG Clinical Trials Update



GASTROINTESTINAL CANCER UPDATE

Issue 48

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CONTENTS

Editorial	3
Highlights from the American Society of Clinical Oncology Meeting.....	4
Cancer Information and Support Services New Initiatives.....	5
Highlights from the 9th World Conference on Gastrointestinal Cancers.....	6
World-first cancer gene support program launched.....	7
AGITG Clinical Trials Update.....	8
Models of Peer Support for People with Bowel Cancer.....	9
InSIGHT update.....	10
Extracts from Wongi Yabber.....	13
Life After Cancer.....	17
Obituary: Joe Tjandra.....	18
Multi Lingual Website.....	20
Key Published Articles.....	21
Forthcoming Meetings.....	22

This newsletter is produced by The Cancer Council Victoria's VCOG 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. Liza Marsh, Ph: (03) 9635 5265.

* * * * * **Last Issue – No. 47 – December 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 / Monash / Cabrini Hospital*

*Mrs Susan Fitzpatrick
Executive Officer, CCRC-VCOG
The Cancer Council Victoria*

In this issue of the Gastrointestinal Cancer Update you will find informative reports from three international meetings highlighting various aspects of patient care, including prevention, screening, treatment, genetics and counselling.

It is with great sadness that the news of Joe Tjandra's death was received. As a tribute to Joe and his work, we have reproduced the eulogies presented at his memorial service. Whilst Joe has left a huge hole in the clinical and academic field of gastrointestinal oncology, the legacy of his enormous contribution to the field lives on.

Updates of current trials sponsored by AGITG are published for your information and consideration of referral of patients for enrolment as appropriate.

As a result of improved treatments, patients are living longer. The Cancer Council Victoria in collaboration with Peter MacCallum have developed resources to address some of the information needs and support services for

cancer survivors. Information on other resources and services to assist people with a cancer diagnosis are provided, all of which are freely available through the Cancer Council. The summary of the peer support program for people with bowel cancer highlights patients' preference for referral by their specialist to such a service. Please remember to refer your patients to the services of the Cancer Council - 13 11 20.

The list of key published articles and extracts from Wongi Yabber are provided to keep us informed of what is happening further a field.

And, finally, the list of forthcoming meetings is published for general interest.

Happy reading!

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 Clinical Oncology Meeting

1-5 June 2007, Chicago, USA

Dr Peter Gibbs
Medical Oncologist, RMH
Chair, VCOG Gastrointestinal Cancer Committee

Hepatocellular carcinoma

This landmark study is the first to show a survival benefit in patients with HCC. Patients received sorafenib (Nexavar) 400mg bd, an oral multi-targeted tyrosine kinase inhibitor, or placebo. 602 patients were randomised, with study arms well balanced. Treatment was well tolerated, with a similar incidence of adverse events in both arms. Survival was increased in patients receiving sorafenib, with median survival of 10.7 versus 7.9 months ($p=0.0006$).

Pancreatic cancer

Two large phase III studies in patients with advanced disease were presented, one examining the benefit of adding cetuximab, the other Avastin (bevacizumab), to standard gemcitabine chemotherapy. Both studies were negative and single agent gemcitabine remains the standard of care for this disease. A meta-analysis of all 16 randomised studies of gemcitabine +/- another agent suggests a modest benefit for the addition of a platinum drug or 5-FU to gemcitabine.

Gastrointestinal Stromal Tumour (GIST)

Preliminary results of the US study of adjuvant imatinib (Glivec) for GIST patients were presented. This study randomised 644 patients to 12 months of imatinib or placebo in patients with resected high-risk disease. 1-year relapse survival was markedly improved with imatinib, 96% vs. 67% ($p<0.000002$). To date there have only been 7 deaths in total, and follow-up continues.

Colorectal Cancer

Data from a large number of phase III studies was presented.

EPOC: an EORTC study examining the benefit

of adding perioperative folfox4 chemotherapy in patients with up to 4 resectable liver metastases. 364 patients were randomised. The arms were well balanced for known prognostic factors. Median follow-up is 24 months. There was no increase in surgical mortality with the addition of folfox4, but a significant increase in overall surgical morbidity (26% vs. 16%) was observed. No individual co-morbidity was significantly increased. The absolute improvement in PFS at 3 years was 7.2% (28.1% with surgery alone vs. 35.4% with perioperative folfox4 but this was not statistically significant ($p = 0.058$)). Analysis of eligible patients only (10 patients in each arm were ineligible) revealed a statistically significant result.

MOSAIC: 6-year survival data for this study which compared adjuvant folfox4 with 5-FU alone in stage II and III colon cancer was presented. Overall this was a negative study with a non-significant improvement in overall survival of 2.6%. The benefit in stage III patients (an absolute difference of 4.4%), was statistically significant, but for stage II patients overall and for high-risk stage II patients there was no significant benefit. There was an excess of non-cancer deaths (with no dominant cause) on the folfox arm and a greater number of patients alive with disease on the control arm, both of which may have contributed to the lower than expected survival benefit. Also notable was the 87% 6-year survival for stage II patients in both arms. Median survival in patients that developed recurrence was 21 months in patients treated with adjuvant folfox, and 24 months in patients treated with adjuvant 5-FU alone.

CRYSTAL: This was the first randomised study to examine the value of adding an EGFR inhibitor to standard combination chemotherapy as initial treatment for patients with metastatic CRC. 1198 patients with EGFR expressing tumours were enrolled, and randomised to FOLFIRI plus cetuximab or FOLFIRI alone. Median

progression-free survival, the primary endpoint, was increased from 8.0 to 8.9 months. The addition of cetuximab increased response rates (47% vs. 39%), and the number of patients undergoing an R0 resection (4.3% versus 1.5%), with a greater difference in those patients with liver only disease. More patients in the cetuximab arm experienced grade III/IV diarrhea (15.2% vs. 10.5%) and grade III skin reactions were increased. Skin reactions were correlated with treatment response.

Key points from other CRC studies.

The BICC study, a first-line study comparing XELIRI versus IFL vs. FOLFIRI demonstrated the inferiority of XELIRI, with a lower response rate, shorter PFS and decreased survival observed compared to FOLFIRI. Increased toxicity was also noted in the XELIRI arm. The Dutch CAIRO study, which examined the question of first-line single agent (capecitabine) compared to combination treatment (XELRI) reported similar median survivals in each group (16.3 vs. 17.4 months). This data is consistent with that seen in the FOCUS study performed by the MRC, with both studies failing to demonstrate a clear advantage for upfront combination therapy.

Cancer Information and Support Services New Initiatives

*Robyn Metcalfe
Cancer Services Promotions Coordinator
Cancer Information and Support Service
The Cancer Council Victoria*

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

Some of the important messages for promoting the service are:

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

Over the next few months I will be visiting cancer treatment centres, outpatients and general practitioners. Promotion of the service to the

general community is also being planned via local media including radio and service groups.

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

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

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

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

Highlights of the 9th World Congress on Gastrointestinal Cancer

27-30 June 2007, Barcelona, Spain

Mr Stephen Bell
Colorectal Surgeon

Alfred Hospital / Monash Medical Centre / Cabrini Hospital

This is a large forum built around the multidisciplinary approach to cancer care. It is attended primarily by oncologists, but there are significant sessions and input from surgeons, pathologists, radiologists and nurses. The conference was attended by over 3000 delegates. Sessions were held for cancers of the pancreas, liver, oesophagus, stomach, neuroendocrine, and colorectal cancer. This summary is by a colorectal surgeon, so please accept any bias and the many omissions.

Colorectal Cancer Screening

Dr. Schmigel, from Germany, outlined the various screening options and their strengths and weaknesses. He presented data from the German screening program started in 2002 that employs annual FOBT from 50 to 54, then colonoscopy at age 55. If negative this is repeated at 10 years, or biennial FOBT. There were detection rates of 0.6-0.8% (cancer), 30-32% (polyps), 18-20% (adenomas), and 5.8-6.6% (advanced adenomas). There was an associated stage shift for cancers, being detected at an earlier stage. It was noted that only 13 of 39 European countries have overview of genetic screening presented.

Chemoprevention for Colorectal Cancer

Dr. Arber, from Tel Aviv, presented the data to date relating to aspirin, NSAID, and COX 2 inhibitors. He noted that the APPROVe trial involving Vioxx lead to withdrawal of the drug because of a higher rate of cardiovascular complications. This later lead to the cessation of the APC trial (celecoxib). He also noted the PreSAP trial (celecoxib) also showed benefits in reducing adenoma rates and progression, and personally felt that there was more work to be done in this area not wanting to abandon the COX 2 inhibitors. It was also noted that although controversy persists in this area, that there may currently be a role for

chemoprevention in high-risk patient groups. Data was presented on an Ashkenazi Jew population from Northern Israel carrying the I1307K mutation showing low dose aspirin produced a relative risk of 0.3 (0.15-0.62) for the development of colorectal cancer.

Quality Assurance

A number of presentations were given promoting the beneficial effects of auditing and quality control on cancer specific outcomes. These included the results from the Swedish and Dutch rectal cancer trials introducing preoperative radiotherapy and Total Mesorectal Excision, and the importance of adequate lymph node harvest AND pathological examination.

Staging of Rectal Cancer

Robert Glynne-Jones, a radiation oncologist from London, presented the data on all staging modalities for rectal cancer, and put a strong case for mandatory staging with MRI. I believe in his setting, with good access to MRI and world leading radiologists reading the films this is probably the case. However, there is greater difficulty locally in both the areas of access and experience in accurately reading rectal MRI. I do hope that further presentations like this will improve our local situation. Of note, an application is currently before MSAC for funding for preoperative MRI in rectal cancer (as it is currently unfunded unless sacral involvement is suspected).

Neoadjuvant Therapy for Rectal Cancer

Data was presented from Germany showing higher complete pathological response rates (up to 37%) using oxaliplatin or capecitabine in addition to 5-FU in preoperative treatment regimens. An algorithm was offered for neoadjuvant rectal cancer treatment: T1/T2 N0 = surgery alone, "Early T3"/facia propria NOT threatened N1 =

short course radiotherapy, Advanced T3/T4/ threatened fascia propria = long course chemoradiotherapy.

High Risk stage 2 Colorectal Cancer

Two papers were given identifying the established clinical and histological markers of high risk stage 2 disease, and highlighting the emerging role of microsatellite instability, chromosome 18q status, and gene expression (k-ras & ERCC 1) in assessing those who may benefit more from adjuvant chemotherapy.

Metastatic Colorectal Cancer

An important dataset presented at this meeting but not ASCO was the PACCE presentation: A randomized trial showing that the addition of panitumumab (Vectibix) to Avastin (bevacizumab) and chemotherapy in the first line treatment for metastatic colorectal cancer was associated with more toxicity and less efficacy. I believe, however, that many medical oncologists knew this was the case because AMGEN had issued a press release a few months ago. A number of presentations were given on the topic of neoadjuvant and conversion therapy for liver metastases, and it appears that

combination chemotherapy (doublets & triplets), and the biologics (cetuximab & Avastin (bevacizumab) have an important role to play, but further work is required. Dominique Elias, from Villejuif, France, presented data from his unit on cytoreductive surgery combined with hyperthermic intraperitoneal chemotherapy (HIPEC) showing a median survival of 32.4 months in macroscopically completely resected patients. This highlights that in a highly specialised unit employing strict selection criteria and standardised techniques results approaching that of liver metastases can be achieved.

Anal Cancer

The EORTC 22953 trial was presented offering the new standard of care being radiotherapy (36 Gy), 5-FU & mitomycin C for 4 weeks; a 2-week pause; Radiotherapy (23 Gy), 5-FU & mitomycin C for 2.5 weeks. This led to less short-term toxicity (with the 2 week gap) and 3-year rates of: local control: 88%, colostomy free survival: 81%, overall survival: 81%. It was also noted that in the HIV +ve population having HAART that mitomycin C was more toxic, and perhaps cisplatin should replace it.

World-first cancer gene support program launched

Trish Waters

Cancer Information and Support Service

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

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

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

"It can be frightening to discover you carry a gene that increases your risk of developing cancer. People face a range of feelings and treatment decisions and feelings of distress are common.

Speaking to a Gene Support volunteer is likely to alleviate some of these concerns," said Dr Jefford.

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

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

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

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

AGITG Clinical Trials Update

1. ESPAC-3—Phase III adjuvant trial in pancreatic cancer comparing 5-fluorouracil + D-L folinic acid with gemcitabine or no adjuvant treatment

Principle Investigator - Dr Rob Padbury / A/ Prof David Goldstein

Participants - Patients who undergo surgery for pancreatic cancer

Outcome measures - Disease-free survival, overall survival, quality of life

Recruitment target - 150 from Australia and New Zealand (1090 in total)

Locations: Alfred Hospital, Austin Health, Border Medical Oncology Wodonga, Peninsula Health Frankston, St Vincent's Hospital, Western Hospital

2. GOFURTGO (AG0503P)—Phase II study of fixed dose rate gemcitabine-oxaliplatin integrated with concomitant 5-FU and 3-D conformal radiotherapy for the treatment of localised pancreatic cancer.

Principle Investigator - A/Prof David Goldstein / Dr Nigel Spry

Participants - Locally advanced untreated pancreas cancer

Outcome measures - Objective tumour response rates, progression-free survival, survival, quality of life

Recruitment target - 45

Locations: Alfred Health, Border Medical Oncology Wodonga

3. MAX (AG0501CR)—Randomised phase II/III study to evaluate the role of Mitomycin C, Avastin and Xeloda in patients with untreated metastatic colorectal cancer

Principle Investigator - Dr Niall Tebbutt

Participants - Patients with untreated metastatic colorectal cancer

Outcome measures - Phase II – treatment related toxicity and treatment response. Phase III – progression free survival, toxicity, overall survival, quality of life and cost-effectiveness

Recruitment target - 450

Locations: Austin Health, Barwon Health Geelong, Bendigo Health, Border Medical Oncology Wodonga, Box Hill Hospital, Monash Medical Centre, Peter MacCallum Cancer Centre, Peninsula Health Frankston, Royal Melbourne Hospital, St. Vincent's Hospital.

4. DaVINCI (AG0103CR)—Randomised phase III trial of DeGramont schedule 5-FU and leucovorin plus irinotecan versus single agent irinotecan in patients with previously treated metastatic colorectal cancer

Principle Investigator - Prof Stephen Clarke

Participants - Patients with metastatic colorectal cancer

Outcome measures - Progression-free survival, survival, quality of life

Recruitment target - 100

Location: Austin Health, Peninsula Health Frankston, St Vincent's Hospital.

Total recruitment as of 1 June 2007

Trial	Victoria		Australia / NZ / Singapore	
	Sites	Patients	Sites	Patients
ESPAC 3 – Adjuvant Pancreas	7	36	32	132
GOFURTGO	2	5	17	39
MAX	10	135	40	457
DaVINCI	3	13	17	67
Adjuvant GIST	2	11	17	46
Total	24	200	123	741

5. Adjuvant GIST (AG0403)—Randomised open label phase III comparison trial of adjuvant imatinib mesylate versus no further therapy for completely resected intermediate to high risk gastrointestinal stromal tumours (GIST)

Principle Investigator - Dr Dusan Kotasek

Participants - Patients with completely resected GIST at intermediate to high risk of recurrence

Outcome measures - Overall survival, relapse-free survival, relapse-free interval and adverse events

Recruitment target - 100 from Australia and New Zealand (750 in total)

Location: Peter MacCallum Cancer Centre, Royal Melbourne Hospital.

Models of Peer Support for People with Bowel Cancer: project summary

*Michael Jefford, Medical Oncologist
Peter MacCallum Cancer Centre*

Peer support is known to benefit many people with cancer. However, it appears that many people with bowel cancer do not access peer support services. This research project seeks to determine whether people feel that peer support services might help them, considers barriers to participation, and aims to assess the impact of at least one peer support program for people with bowel cancer. This project is funded (\$90k) by the Federal Government, administered by Cancer Australia. It is being conducted at the Cancer Council Victoria.

To date, a systematic literature review has been completed (submitted for publication). Currently we are in the second, investigative phase of the project. In this phase, survey and focus group/telephone interview methodologies have been used to investigate a preferred model of providing peer support.

One hundred and one people with bowel cancer were approached for the questionnaire study through Peter MacCallum Cancer Centre (East

Melbourne site) and Border Medical Oncology (Albury/Wodonga). A total of 51 completed questionnaires were returned (50.5% response rate).

Participants for the focus group study included metropolitan and regional support group facilitators and people affected by bowel cancer, from both metro and regional areas. Patients were recruited from Peter Mac, Border Medical Oncology and the Andrew Love Cancer Centre (Barwon Health). Two metropolitan and two regional focus groups have been conducted (13 participants at the metro groups, seven from the Barwon area and four from Albury/Wodonga). In addition five semi-structured one-to-one telephone interviews will be held with people affected by bowel cancer, residing in regional areas.

Preliminary results suggest that the preferred model of providing peer support to people with bowel cancer might be one-to-one face-to-face or one-to-one telephone support, provided early following diagnosis, with a face-to-face support group format thought to be more advantageous later in the illness trajectory / in the survivorship phase. The option of an online bulletin board to run consecutively with a face-to-face format was also supported. The main barriers to participation in peer support programs include: stigma, sense of embarrassment, lack of bowel-cancer specific support programs and lack of knowledge and awareness regarding peer support programs, particularly noted by those in regional areas. Perceived needs for people with bowel cancer were: greater promotion of support programs, increased public awareness of bowel cancer and, most notably, **for peer support programs to be offered to them via their specialist** or cancer care nurse (preferably in the period between initial diagnosis and commencing treatment) rather than patients having to seek out support themselves.

For more information about this project, please contact:

Dr Sandra Ieropoli, Project Officer,
Sandra.Ieropoli@cancervic.org.au or

Dr Michael Jefford, Clinical Consultant, The Cancer Council Victoria / Medical Oncologist, Peter MacCallum Cancer Centre,
Michael.Jefford@petermac.org

The 2nd Biennial Scientific Meeting of International Society for Gastrointestinal Hereditary Tumours

*The 2nd InSiGHT March 27 – March 30, 2007
Yokohama, Japan*

*Dr Lara Lipton (Ludwig Institute & Royal Melbourne Hospital),
Maira Kentwell (Peter MacCallum Cancer Centre) and Elly Lynch (Royal Melbourne Hospital)*

This was the second biennial scientific meeting of InSiGHT (International Society for Gastrointestinal Hereditary Tumours) and took place in the major port city of Yokohama. A comprehensive program which included basic science and clinical presentations covered all major aspects of hereditary GI tumours in a series of 10 minute research presentations with several invited keynote lectures from top-notch international speakers including Henry Lynch. This is a small meeting for a fairly small worldwide community with an interest in the topic including scientists, surgeons, physicians, pathologists, epidemiologists, genetic counsellors and the odd oncologist. The 'boutique' nature of the meeting provided an excellent opportunity for the large Australasian contingent to mix with well-known international colleagues.

We would encourage all who are interested in the area to consider putting the Dusseldorf meeting in 2009 on the calendar. (24 – 27.06.2009)

Polyposis Conditions (non-Familial Adenomatous Polyposis) (FAP)

We were proud to see the program kicked off the presentation of Elizabeth Chow's work in the mutation spectrum of Peutz-Jeghers Syndrome (PJS) in Australia which lead further weight to STK11 as the major predisposition gene in this syndrome with around 75% having detectable mutations including a significant number of major genomic deletions. Presentations from Finlay Macrae, Nicola Plum (Germany) and Hionori Yamamoto (Japan) discussed experience with capsule endoscopy screening and double balloon enteroscopy (DBE) for polyps in PJS and Juvenile Polyposis. Both appear to be useful modalities for screening, with polypectomy often feasible during DBE allowing laparotomy to be avoided for some patients. As regards MUTYH associated polyposis, a novel germline change G272Q was shown to be common in Japanese patients with

functional studies awaited. The known Q324H variant was shown to be associated with early onset adenoma formation in African Americans. An interesting study from Kyushu University showed that intestinal tumours in MUTYH deficient mice were triggered by oxidative stress consistent with the role of MUTYH in repair of oxidative damage and, for me, raising questions regarding the role of MUTYH as a modifier in inflammatory bowel disease.

Familial Adenomatous Polyposis (FAP)

Joji Utsunomiya, the first surgeon to create the J-pouch restorative proctocolectomy led the first day, providing an informative history of over 40 years work in polyposis.

Further evidence was given for mosaicism as a mechanism for attenuated forms of FAP and for apparent 'new' mutations where a weak mutation signal may be missed or not exist in the germline DNA of a parent. Aretz et al from Bonn estimated that around 11% of 'new' mutation carriers may in fact be mosaics with as little as 5% of lymphocytes carrying the mutation and strong mutation signal in colonic adenomas. Further evidence was presented from Ian Tomlinson's group at Cancer Research UK regarding the non-random nature of the loss of the wild-type allele in APC mutation carriers. The spectrum of 'second-hits' is selected on the basis of the optimal number of 20 amino acid beta-catenin binding and degradation repeats in the protein. Thus, if the truncating germline mutation is early in the gene, leaving no 20 amino acid repeats, the somatic 'second-hit' will tend to be more distal, leaving at least two. There appears to be a level of beta-catenin in the cell that is permissive for adenoma development.

A survey of 363 FAP patients from North England found that 47 individuals with mutations before codon 1399 with 18/47 (37%) having documented

desmoid disease. The majority of these had developed after bowel surgery – a 65% risk in all. There was discussion regarding trials of chemoprevention in patients with mutations in the desmoid region who needed surgery. Data was presented on chemotherapy for severe desmoid disease using Dacarbazine, Doxorubicin and Meloxicam showing objective tumour regression in 9/9 patients who had progressed on Tamoxifen and Sulindac. A 33% rate of grade 3 toxicity was seen with no treatment related mortality.

An international study regarding the clinical spectrum of Attenuated Familial Adenomatous Polyposis (AFAP) was presented by Anne Knudsen from Denmark. This included data from 12 polyposis registries from nine countries including Australia. 196 patients meeting the criteria of 100 adenomas at age 25 plus were ascertained. The median age at diagnosis was 41 and median adenoma number was 25. Thirty one percent developed colorectal cancer with a median age approximately 15 years later than FAP patients. Extra-colonic manifestations were rare. APC mutations were found in 69/171 (40%) of patients tested but only 52% of these mutations were in areas associated with AFAP (3' and 5' ends and exon 9). The following classification was proposed for AFAP (1) Dominant inheritance of colonic polyposis and (2) 3-99 adenomas 20= years.

Genotype-Phenotype correlations were explored in terms of appropriate initial surgery. Patients initially treated with IRA from several northern European polyposis registries were divided into groups based on mutation location in APC as follows (1) Attenuated, 3' and 5' ends, (2) Intermediate and (3) Severe, mutation cluster region codons 1250-1564. Risk of proctectomy after 20 years was 10% in group 1, 39% in group 2 and 60% in group 3. Patients in group 1 (APAP) were significantly older at the time of initial surgery (58 vs 21 years). It was suggested that those with more severe disease causing mutations undergo initial ileal pouch surgery.

Psychosocial/Genetic Counselling - FAP

Dr Lesley Andrews from The Prince of Wales in Sydney presented the findings of a study looking at the impact of FAP on young adults. Quality of life, psychological adjustment, views concerning genetic testing, information and support needs amongst young adults aged 18 to 35 years were examined. Being single was associated with increased distress and participants' highest areas

of unmet support needs were anxiety about their children having FAP and fear of developing cancer. Interestingly, in contrast to current guidelines, the preferred age for genetic testing was at birth or childhood.

There was a poster from the St Mark's Group highlighting the success of a patient information day held for families with FAP. It was held on a Saturday and registry staff and a consultant surgeon gave lectures on issues ranging from surgical options, basic anatomy and physiology and research into FAP. Better informed patients are more involved in their care, follow advice more diligently, are less anxious and more satisfied. There is now discussion taking place about whether such a day, this could be held in Victoria.

Hereditary non-Polyposis Colorectal Cancer (HNPCC) and MSI-H cancers

Several presentations dealt with the potential immune response which may be generated by the new peptides generated by frameshift mutations seen in MSI-H cancers. Populations of tumour infiltrating T cells as well as circulating T cells recognising these peptides were detected in tumours and patients with MSI-H cancers and most interestingly also in the peripheral blood of persons with HNPCC who had not developed cancer. Another group were able to detect specific circulating antibodies against some of these frame-shift neo peptides. Both approaches raise the hope of vaccine development for persons prone to MSI-H cancers. In a paper given by Mark Jenkins (Melbourne) the probability that a CRC was MSI-H was well predicted by the MsPath score which uses the following independent predictors; Tumour infiltrating lymphocytes, proximal site, mucinous histology, poor differentiation, Crohn's like reaction and diagnosis <50 years. The MsPath score was able to predict the great majority of MSI-H cancers diagnosed <60 years. An interesting presentation by Natasha Watson (Perth) utilised MSI and immunohistochemical data on a series of 1059 cancers collected over an 11-year period. 69 cases were found to be MSI-H without mutations in BRAF. Of these, 12/69 were initially reported as showing normal staining for MLH1, MSH2, MSH6 and PMS2. Seven of these were reclassified as showing loss based of protein in a heterogeneous fashion and three of these were found to be mutation carriers. Thus a significant minority of young HNPCC mutation carriers may be missed if only immunohistochemistry is performed.

A series of papers were presented regarding screening for extracolonic malignancies in HNPCC, an area in which good data are lacking. The Danish HNPCC register's audit of 25 years of screening with urine cytology in HNPCC was presented. 1868 cytologies on 990 persons revealed a 2.5% rate of abnormal test results of which 34/47 (66%) were false positives and 15/47 (32%) had no action taken. No tumours were detected and screening was not considered justified in HNPCC families. Likewise, the incidence of small bowel adenocarcinoma in persons with HNPCC (4%) was considered insufficient by Vasen's group to use invasive procedures such as push enteroscopy for screening. Cost-effectiveness of capsule endoscopy has yet to be evaluated. Several papers on endometrial cancer suggested a lack of efficacy of traditional methods of screening including gynaecological examination, transvaginal ultrasound and CA125 with the majority of cancers identified between screening and at early stages. Microcurettage has been suggested as a way to increase screening sensitivity. A study from Malcolm Dunlop's group in Edinburgh examined 103 women diagnosed <55 years with endometrial cancer and found that 7% were HNPCC mutation carriers. The risk of gynaecological cancer for women with HNPCC and efficacy of screening was debated in a couple of presentations. Karen Lu, from Texas, presented their ongoing study randomizing women to DMA or OCP, which is due to conclude this year. Dr Shirley Hodgson from the U.K, advertised the POET Study, (a randomized national and international trial of mirena intrauterine system in women with Lynch syndrome). Several Japanese presenters highlighted the importance of gastric cancer as an HNPCC-associated cancer in Japan.

Keynote speaker, Henry Lynch whose work in hereditary bowel cancer spans over the past 45 years, presented an update of Lynch syndrome (or HNPCC) describing developments in clinical, molecular genetic and pathology aspects of Lynch syndrome. He discussed recent literature describing phenotypic differences amongst the three main mismatch repair gene mutations, features of bi-allelic MMR mutation carriers, identification of "syndrome X" as another Hereditary Bowel Cancer syndrome, and outlined pathologic features which have proven to be helpful in identifying MMR mutation families. Lynch highlighted the importance of considering Lynch syndrome as a family disease so that as many at-risk members can have opportunity for targeted surveillance programs to reduce morbidity and mortality from cancer. He also described his

experience of genetic counselling of family members as a group in one setting, and the usefulness of this approach in educating family members and disseminating information about Lynch syndrome amongst relatives.

Malcolm Dunlop described current approaches in identifying MMR mutation carriers, and focused on a computer model-based approach to help define HNPCC families. This model utilises age of cancer diagnosis, gender, pathology information, Microsatellite / Immunohistochemistry information, and estimated population frequency of HNPCC alleles. A website has been created with the aim of collating international data on MMR mutation carriers to further define these variables and understand predictive factors for the presence of HNPCC in a family.

InSiGHT Mutation Databases and Human Variome Project

Dick Cotton from the Human Variome Project was invited to speak about plans for the ambitious but exciting project, with the focus of discussion on how the InSiGHT database could be linked in to the Human Variome Project, which aims to be a public catalogue of curated variation.

Paivi Peltoamki, the current curator of the InSiGHT Database (which holds a record of registered mutations and mismatch repair variants) outlined the advantages and disadvantages of the current database. Other databases curated by groups in Canada and Japan were also presented as models. InSiGHT has agreed to be involved in principle with supporting the Human Variome Project.

Extracts from Wongi Yabber Vol 14 No 2. May 2007

Australia & New Zealand TNM Committee for Tumour Staging

*Professor William McCarthy AM
Convenor ANZ TNM Committee*

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

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

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

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

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

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

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

COSA Update

*Ms Margaret McJannett
Executive Officer, COSA*

This year's **COSA ASM** will be held in **Adelaide** from **14-16 November**. It is Australia's largest and most diverse cancer meeting, each year bringing together hundreds of Australian and international cancer care professionals and researchers from a wide range of disciplines.

The theme for the meeting is "Prevention, Palliation and Cure: Progress through Clinical Trials" Special symposia, debates and plenary lectures will explore the Australian and Asia-Pacific clinical trials landscape; the challenge of translating results into clinical practice; barriers to accessing the best therapy (including new drugs); evaluation of alternative medicine; and many other topics. An excellent assembly of international and local speakers is set to deliver a comprehensive and stimulating program. Our convenor Dr Chris Karapetis and his committee continue to put significant effort into the ASM program and it is particularly gratifying to see how many of our South Australia colleagues are involved with and supporting the planning of this major COSA event.

Our commitment to professional development is growing, with Phase 2 of the **Continuing Professional Development** (CPD) project being rolled out and coming to a number of cancer centres soon. Our consortium, led by the Centre for Innovation in Professional Health, Education and Research (CIPHER), and also comprising The Cancer Council Australia (TCCA) the National Breast Cancer Centre (NBCC) and the Royal College of General Practitioners (RACGP) is engaging with practitioners at a number of demonstration sites to ensure the

recommended CPD packages meet the needs of cancer specialists, GPs and counsellors, and have a high degree of support for implementation.

There is progress in **cancer care coordination**, with Professor Patsy Yates continuing the work of our national workshop in November with a plan to establish a working group to put some flesh around providing key principles for care coordination taking into account the different models.

Another aspect of cancer care we are moving on is the **Adolescent and Young Adult (AYA)** workshop held on 28 May. COSA, in collaboration with ANZCHOG, our paediatric oncology group, led by Frank Alvaro, and Canteen's CEO Andrew Young, organised the meeting of adult and paediatric stakeholders to examine emerging models of care and outline an action plan for the next few years to address the issue. We acknowledge and are grateful for sponsorship from The Cancer Council Australia, Cancer Institute NSW and Cancer Australia for this important meeting.

Rural and regional service delivery remains an ongoing focus. The data demonstrating how access to cancer care services reduces as geographic isolation increases is out there in the COSA report; we really need COSA members to bring this issue to the attention of local politicians in regional areas. Dr Craig Underhill continues to promote the issue everywhere and he needs your voice as well. Most recently COSA prepared an excellent program of national opinion leaders to review current issue in cancer services in regional Australia at the National Rural Health Alliance's biannual conference. The presentations were well received and the alliance included in its priority recommendations for more uniform and better funded patients' assisted travel schemes in all jurisdictions. Patient travel and accommodation is also the subject of a current Senate inquiry; COSA will be presenting a joint submission to the Senate in partnership with The Cancer Council Australia and may also appear at public hearings. The Senate will be reporting in October.

COSA is undertaking a **burnout survey** as a result of a grant from Cancer Australia. This project, led by Prof Afaf Girgis, Director of CHeRP and former COSA Psycho-Oncology Chair, will be a very important snapshot of the degree to which this is an issue and then guide us on how to approach strategies to address it.

We also acknowledge the hard work of the group led by Stephen Ackland in pushing the work of the **COSA & Cooperative Groups Enabling Grant**. Of particular importance is the clinical trial insurance review which is being undertaken by Healthcare Risk Resources International. We expect that this report will provide guidance to all investigators involved with clinical research on the risks and how to manage them. The Quality Assurance component will bring training resources together, with the aim of making them available to all cooperative research groups to support a standardised approach to education and training for our clinical researchers.

COSA continues to host the **Luminous Award Australia** which honours journalists who serve their readers/viewers by providing responsible, accurate and timely information on advances in cancer prevention, research, treatment and patient support. Desmond Yip is the COSA nominee for the Luminous Awards and they are well underway in calling for applications with the winner being announced at the ASM in November. The Luminous Award Australia is proudly supported by Eli Lilly Australia

Applications are now being called for the **2008 Haematology Oncology Targeted Therapies (HOTT) Fellowship**. Roche Oncology & Haematology in conjunction with COSA, MOGA and HSAZ is delighted to announce that two new HOTT Fellowship Awards of \$50,000 each will be available in the first quarter of 2008. The awards are designed to fund, or part-fund a one year position, and are intended to assist in the conduct of high quality clinical or translational research, or other project initiatives which will be of benefit to the clinical oncology or haematology community within Australia. We are most grateful to Roche as they have generously agreed to expand the Haematology and Oncology Targeted Therapies (HOTT) fellowships to include nursing and allied health (HOTTAH) this year and we received 15 applications for this first time grant. The ubiquitous ex President Stephen Ackland leads the selection team.

In the next few months COSA's new website will be constructed. This will enhance inter and intra group activities and projects, provide forums for group development and improved and cost effective strategies for us and organisation for on line registration and surveys.

Ensuring Guidelines Translate into Better Care

Bruce Barraclough AO
Medical Director,
Australian Cancer Network

The Australian Cancer Network, with the very active involvement of Prof Tom Reeve, has led the way in Australia in Cancer Guidelines development – often in association with others, including the National Breast Cancer Centre and the National Institute for Clinical Studies and with good support from numerous volunteer clinicians. These guidelines provide those caring for cancer patients with up to date information and recommendations on how to achieve best care. In other words, they are a guide as to how to provide the right care at the right time to the right person in the right way.

There are, however, many barriers that need to be overcome to achieve successful implementation of guidelines. It is simplistic to under-rate how difficult it is to change practice in complex environments. Change is not simple or quick because of system variation, a shortfall in leadership or even professional isolation or lack of knowledge.

An ACN committee worked with a team from the National Institute for Clinical Studies to produce a concise guide for putting guidelines into practice. It is a quick, concise, reference booklet – an “aide-memoire” – evidence based and easy to read and apply everywhere.

The key steps in “*Taking Action Locally: Eight steps to putting cancer guidelines into practice*” are:

1. Appoint the team – clinical champions and executive sponsor.
2. Decide which recommendation to tackle first – size and importance of evidence / practice gap.
3. Is current practice in line with guideline recommendation? – audit.
4. Understand why we are not achieving best practice – individual and system.
5. Prepare for change – engage stakeholders.

6. Choose the right approach
7. Put your theories to the test – plan, do, study, act.
8. Keep things on track – communication – change takes time.

This guide matches the appropriate implementation strategy to the perceived barrier. For example, in step 6, “choose the right approach”, if the barrier is lack knowledge, education and aids to decision making are likely to be the answer. If the barrier is a mismatch between perception and reality, audit and feedback is the answer. If there is lack of motivation to use guidelines, there may be a need for leadership, incentive and sanctions etc.

ACN and NICS have had increasing requests for this booklet as unit heads and clinicians working with patients find it very useful. I would strongly recommend its use to those seeking to implement guidelines. It can be accessed through the websites of NICS and ACN at www.nhmrc.gov.au/nics/asp/index.asp or www.cancer.org.au/acn under “Activities” heading.

Evidence stacking up for alcohol-cancer risk

Glen Turner
Communications Manager
The Cancer Council Australia

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

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

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

will continue to contribute to the growing burden of cancer in Australia.

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

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

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

Pull the plug on food advertising

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

Health groups welcome survey to target childhood obesity

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

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

"Obesity has been rapidly increasing in Australia, particularly among children. This threatens to impose a major disease burden over the next three

to four decades, when healthcare services will already be stretched by population ageing," Mr Slevin said.

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

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

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

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

The Cancer Council Australia's new website nearing completion

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

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

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

Life After Cancer

*Sophie Chirnside
Cancer Information and Support Service
The Cancer Council Victoria*

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

The Cancer Council Victoria is at the forefront of addressing issues for cancer survivors. We are developing a new program for cancer survivors to help them address some of these issues.

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

Information

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

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

Support

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

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

Practical and financial issues

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

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

Education

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

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

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

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

Obituary: Associate Professor Joe Tjandra



Joe Janwar Tjandra, 1957-2007

MBBS, MD, FRCS, FRACS, FRCPS, FASCRS

*Mr. Campbell Penfold
Colorectal Surgeon
Royal Melbourne / Epworth Hospitals*

I have been fortunate to experience the extraordinary and amazingly talented Joe Tjandra over the last 25 years. This memorial service on Monday 2 July is to celebrate Joe's life which was full but cruelly too short.

I first met Joe as an intern in the Colorectal Unit at the Royal Melbourne Hospital in 1982. He had just graduated with a MBBS from the University of Melbourne and this was his first job as a Doctor. The Colorectal Units Head was Alan Cuthbertson. Alan soon realised we had a special exceptionally talented and hard working intern. What follows verifies Alan's astute assessment of that early stage of his career.

After his intern year, Joe went to work in the UK and subsequently obtained his fellowship in surgery from the Glasgow College and then the English College. His first publication was made in 1986 Segmental abdominal wall herpes zoster paresis – that is Shingles.

Joe returned to Australia in 1987. After consultation with Professor Gordon Clunie he decided to do a period of basic clinical research

under Professor Ian McKenzie at the Research Centre for Cancer and Transplantation at the Howard Florey Institute University of Melbourne. They worked on monoclonal antibodies against bowel and breast tumours that hopefully would target the delivery of toxins to cancer cells specifically. At the same time Joe was a senior associate to the colorectal unit and I referred one of my patients to him for this novel treatment of his liver secondaries. As it turned out he had been the Headmaster at Mentone Grammar Joe's secondary school and there was mutual admiration for one another. I remember them clearly both appearing on the TV show Quantum discussing the new treatment. The Headmaster said Joe was the most outstanding student he had ever had. As fate would have it, years later, Joe himself also received monoclonal antibody cancer treatment.

Numerous publications followed as well as a Doctor of Medicine awarded by the University of Melbourne.

In 1989 he returned to the colorectal unit, this time as the surgical Registrar and obtained his Australasian Fellowship in surgery.

He was now moving at a frenetic pace. I often wonder whether he had a dream to become the best Colorectal Surgeon in the World or at least in Australia but we will never know. He sought out further training in Colorectal Surgery with Victor Fazio, the Head of the Colorectal Department at the Cleveland Clinic in the US and has never looked back.

Joe worked relentlessly at Cleveland and published prolifically, I think at least 23 papers. He also honed his surgical skills and acquired new skills and obtained the Fellowship of the American Society of Colon & Rectal Surgeons. Yet he was still not, in his eyes fully trained, so he served another year as Senior Lecturer Consultant with Les Hughes in Cardiff. Now in 1993, armed with his diplomatosis you see on any of Joe's letterhead, he was ready for the World.

Joe arrived back in Australia in 1993 and has been flying ever since – a member of the Colorectal Unit at the Royal Melbourne Hospital, developed a huge Private Practice around Epworth, Melbourne Private and Cotham Private yet he made time to do research, publish and assist trainees in their development. Joe published over 150 peer reviewed scientific papers. He has written 70 book chapters and has edited 6 books, his pride and joy has been the Text Book of Surgery,

now in its 3rd edition and is the prescribed surgical text in most medical schools in Australia and New Zealand.

Joe was a 'sort after' lecturer/visiting professor especially in the Asian Pacific region but also in the US and Europe. He has given over 200 presentations at surgical meetings.

Joe has promoted research with the trainees at the Royal Melbourne Hospital and supervised five post-graduate students leading to higher degrees.

Joe was appointed an Associate Professor of Surgery University of Melbourne at Royal Melbourne Hospital in 2002 for his contribution to surgery, in particular the development of innovative techniques into colorectal surgery.

He has been an editor of the Australian New Zealand Journal of Surgery for years and on the editorial board of a number of international journals.

He has also held a large number of successful meetings in Australia where he has been effectively the sole convenor on topics including:

- * Colorectal Cancer
- * Endorectal Ultrasound
- * Stapled Haemorrhoidectomy
- * Pelvic Floor Disorders, and
- * New Technologies in Colorectal Surgery

You are probably all exhausted to hear what he has done and you wonder how did he fit it all in. It is alleged and has been confirmed by his wife Yvonne that he only slept for three or four hours a night. Certainly he would often ring you late in the evening if not at dinner time and on enquiry you would find that he was still in his office working. He was a very focused driven person and the pursuit of his career was his life. He aimed high and he did get a lot of satisfaction with the many awards and plaques he received which are too numerous to tabulate.

The three most significant innovations Joe developed and became an authority in recent years are sacral nerve stimulation for faecal incontinence, injectable PTQ implant for and the active promotion and teaching of laparoscopic colorectal surgery; all of which Joe was very proud Joe was an extremely energetic person with high intelligence, enormous drive and determination, he achieved a lot and one wonders what he would have done in the next ten years but that is not to be.

We salute you Joe, like the best plants in the garden they don't flower the longest yet they shine the brightest.

Brief tribute from Jeffrey Milsom

Joe's life was all about intensity, and I was privileged to enjoy his friendship since meeting him in Cleveland USA in 1991. Joe was one of the hardest workers I ever encountered. He showed up at work one day at 4am to join me in a research project which we could not do any other time. He loved the story about this, and enjoyed every single INTENSE encounter we had since, mostly centered around the care of sick patients, and making their lives better.

His friendship, too, was intense, and he of all my Australian friends, made it possible for me to understand Australia along with his wonderful family. Joe's wife Yvonne, and Douglas, Bradley, and Caitlin became my Australian family, and they always welcomed me to stay in their home when I came to Australia.

If I could wish for a lasting message about Joe's life, it would be that those of us left behind should try to emulate his passion for caring for sick people, and his brilliance for finding ways to make other's lives better.

In the firmament of Australian surgeons, there will be a very bright and intense star burning, all too briefly, which is the Tjandra star.

*Professor Jeffrey Milsom
Chief of the Section of Colon and Rectal Surgery
Department of Surgery
Weill Medical College of Cornell University, New York, USA*

Eulogy for a friend

It is with a sad heart and deep remorse that we, at Joe's alma mater in Cleveland, learned of his untimely death. Our hearts and prayers go out to Yvonne and the children, who have lost a wonderful husband and father, someone who will always be in their hearts. Those friends and family members, colleagues, students and others who at this time and in the future weeks tell of their relationships with Joe and will doubtless do so with great eloquence and deep feelings.

What can one add to what will be a flood of heartfelt condolences, of tributes to a great friend and remarkable surgeon; we admired and loved this man. Joe was the quintessential surgeon / scientist. There were none equal to his enthusiasm and native talent. If ever a person was a born surgeon, it was Joe. He was introduced to us through another Cleveland Clinic alumnus, and soon we realized that all the hyperbole about Joe was true. He DID work 100 plus hours a week; he DID research and publish on over 20 papers while here at the Cleveland Clinic; these were published in the BEST journals and he remains one of the most cited surgeons in Australia for his monumental works.

Joe was more than that; he in turn has trained many overseas surgeons in both clinical surgery as well as research and Joe lives on in their accomplishments; I know of none to his talent. When he decided laparoscopic surgery was a great advance, he became, within 2 short years, one of the leading exponents in the field. Amazing; and he could show this with live surgery (the toughest method of displaying ones talent). Within a very short period he became THE world's expert in sacral nerve stimulation. And then he became the teacher of HIS teachers!!!

And there are so many other areas in medicine where Joe has left his mark; his contributions live on.

For us, we celebrate his life. We have lost a friend; someone who we have admired through the years and for me, it has been akin to seeing a son grow in stature, in strength and in virtue. He will live on in our memories. And our members of the department share these words of condolence. As the poet wrote, when the angel said to Abou ben Adam, how he would wish to be remembered

“Write me as one loved his fellow man.”

Victor Fazio, M.D.

*Chairman, Department of Colorectal Surgery
Vice Chairman, Division of Surgery
Professor of Surgery, Ohio State University
Medical School
Cleveland Clinic, Cleveland USA*

The Cancer Council Victoria's Multi Lingual Website

*Jennifer Cottrell
Cancer Education Programs Project Officer
The Cancer Council Victoria*

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

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

This information is provided in an easy to read factsheet format that can be downloaded for free. Factsheet topics vary from diagnosis and support,

to early detection messages. English versions of all factsheets are also available.

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

Key Published Articles Listing—Gastrointestinal Cancer

Title	Author & Journal
Different professionals' knowledge and perceptions of the management of people with pancreatic cancer.	Jefford M, Jennens R, Speet T & Thursfield V. Asia Pacific Journal of Clinical Oncology. 2007;3(1):44-51
Survival benefits from neoadjuvant chemotherapy or chemotherapy in oesophageal carcinoma: a meta-analysis.	Gebski V, Burmeister B, Smithers BM, et al. Lancet Oncology. 2007;8(3):226-34
Should healthcare providers have a duty to warn family members of individuals with an HNPCC causing mutation? A survey of patients from the Ontario Familial Colon Cancer Registry.	Kohut K, Manno M, Gallinger S, Esplen MJ. J Med Genet. 2007;44(6):404-7.

Key Published Articles Listing—General

Title	Author & Journal
Challenges in cancer control in Australia.	Olver IN. Med J Aust. 2007; 186(11):556-557

Forthcoming Meetings

Date / Place	Meeting / Contact
28–31 August 2007 Melbourne, VIC, Australia	9th Australian Palliative Care Conference – <i>Partners across the lifespan</i> Palliative Care Australia. APCC 07 Conference Secretariat, C/- ICE Australia P/L, 6 Clarendon Place, South Melbourne, VIC 3205, Australia Ph: (03) 9681 6288 Fax: (03) 9681 6653 E-mail: apcc@iceaustralia.com Website: www.iceaustralia.com/apcc2007/ www.pallcare.org.au
8-13 September 2007 Barcelona, Spain	9th Biennial European Society for Therapeutic Radiology and Oncology Meeting European Society for Therapeutic Radiology and Oncology Ph: + 32 2775 9340 Fax: + 32 2779 5494 Email: agostino.barrasso@estro.be
23–27 September 2007	3rd International Clinical Trials Symposium (ICTS) GPO Box 3270, Sydney NSW 2001 Ph: (02) 9254 5000 Fax: (02) 9251 3552 E-mail: info@clinicaltrials2007.com Website: www.clinicaltrials2007.com
23–27 September 2007 Barcelona, Spain	14th European Cancer Conference (ECCO) – <i>Cancer in Europe: Sharing the responsibilities</i> Federation of European Cancer Societies (FECS), Avenue E. Mounier 83, Brussels 1200, Belgium Ph: +32 2 775 0201 Fax: +32 2 775 0200 E-mail: ECCO14@fecs.be Website: www.fecs.be
23–27 September 2007 Barcelona, Spain	European Society for Therapeutic Radiology & Oncology (ESTRO 26) During ECCO 14 Website: www.estro.be
4–7 October 2007 Melbourne, Vic, Australia	58th Annual Scientific Meeting of the Royal Australian and New Zealand College of Radiologists (RANZCR) Website: www.ranzcr.edu.au
14–17 October 2007 Brisbane, QLD, Australia	Annual Meeting of the Haematology Society of Australia and New Zealand (HSANZ) Website: www.hsanz.org.au

Date / Place	Meeting / Contact
17–20 October 2007 Melbourne, VIC, Australia	9th Annual Scientific Meeting of the Australasian Gastrointestinal Cancer Trials Group (AGITG) – <i>Translating research into practice</i> Website: www.gicancer.org.au
22–26 October 2007 Adelaide, SA, Australia	Australian Gastroenterology Week Website: www.gesa.org.au
22–26 October 2007 San Francisco, California, USA	19th International Conference on Molecular Targets and Cancer Therapeutics – <i>Discovery, biology and clinical applications</i> Jointly organised by AACR, NCI and EORTC Website: www.aacr.org/page5995.aspx
28 Oct – 1 Nov 2007 Los Angeles, California, USA	49th Annual Meeting of the American Society for Therapeutic Radiology and Oncology (ASTRO) 12500 Fair Lakes Circle Suite #375, Fairfax, VA 22033-3882 Ph: +1 703 502 1550 or 1800 962 7876 Fax: +1 703 502 7852 Website: www.astro.org
14–16 November 2007 Adelaide, SA, Australia	34th Annual Meeting of the Clinical Oncology Society of Australia (COSA) COSA Office, Medical Foundation Building, Level 5, 92 Parramatta Road, Camperdown NSW 2011 Ph: (02) 9036 3100 Fax: (02) 9036 3101 E-mail: cosa@cancer.org.au Website: www.cosa.org.au

The Cancer Council Victoria

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

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

The **VCOG Gastrointestinal Cancer Committee** was established in 1980. Its membership is representative of the clinical specialties and centres involved in the treatment of upper and lower gastrointestinal cancers. The objectives of the Gastrointestinal Cancer Committee are to:

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

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