



Gynaecological Cancer Update

Issue 28 January 2007

- IGCS Meeting Report
- PapScreen Victoria Report
- Impact of HPV Vaccination on National Cervical Screening Program
- Cancer in Victoria, 2004



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This newsletter is produced by The Cancer Council Victoria's Gynaecological Cancer Committee and sent to health professionals interested in management of gynaecological cancer(s). The Victorian Cooperative Oncology Group's advisory committees on breast, gastrointestinal, 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. 27 – July 2006** *****

The articles in the Gynaecological Cancer Update have been published to contribute to professional debate and exchange. The opinions expressed are not necessarily those of The Cancer Council Victoria.

11th Biennial Meeting of the International Gynecological Cancer Society (IGCS)

14–18 October 2006, Santa Monica, California, USA

*Dr Christopher Steer
Medical Oncologist
Murray Valley Private Hospital*

Santa Monica is a beachside suburb of the metropolis of Los Angeles and is a convenient 8 miles from LAX. It is famous for its beach and boardwalk and is the location for many Hollywood films. Of particular note is the fun-park on the pier which has appeared in movies as diverse as *The Sting* and *Titanic*. Most of the meeting was held in the Civic Auditorium. We quickly learnt that this was the venue for the annual Academy Award ceremonies between 1961 and 1968. The virtually adjacent Loews hotel was the venue for some of the academic programme but delegates became acutely aware that the LAPD is tough on jaywalkers when they tried to cross the road anywhere apart from at the traffic lights some 100m down Main Street. For the entire meeting there were armed police stationed on the roadside to prevent us from taking the shortest route.

Australia's own Michael Friedlander is president of the IGCS and he played a pivotal role in the organisation of the meeting. His presidential address about the history and future direction of the IGCS was an inspirational speech which outlined the important contribution this global alliance will make to the health of women around the world. Our very own Michael Quinn provided the introduction and certainly did his best to roast our colleague from Sydney.

At meetings such as this there is often a "buzz" about new data or treatment approaches that seems to permeate the schedule. It is the thing people are talking about at the coffee breaks. The most excitement this year revolved around the HPV vaccine. Although none of the data is essentially "new", it was exciting to see the ways in which the challenges that face the deployment of the vaccine will be addressed. The IGCS will play an important role in this. One tactic will be to lobby organisations such as GAVI (Global Alliance for Vaccines and Immunization) on the

importance of this vaccine to women's health in the developing world. The hepatitis B vaccine is now routinely given to children in 80% of all countries and is an example of a successful vaccine deployment strategy. Putting aside the cultural barriers around the discussion of adolescent sexuality, it will be difficult to get the HPV vaccine on the agenda if the public health workers and paediatricians who influence vaccination policy are not made aware of the benefits. The HPV vaccine will not benefit children immediately and the economic impact will be measured decades from its introduction but it remains a great opportunity to impact a major human cancer.

The other hot topic was the debate around the use of intraperitoneal (IP) chemotherapy in patients with ovarian cancer. Indeed the matter was raised and settled in the very first session. A formal debate was held and an audience poll taken. The two heavy hitters for IP chemotherapy, Maurie Markmann and Deb Armstrong, (the PI for GOG 172) pressed their case and were pitted against the arguments of Andreas duBois and Michael Bookman (PI for GOG182/ICON5). I will summarise by saying that the proponents for IP chemo were outgunned and conclusively lost the debate. The feeling in the room afterwards was almost unanimous - that IP chemo is not the standard of care in 2006. Andreas du Bois conceded that there was "probably something in it" ... "of the order of 5% or so" but the toxicity did not justify this benefit and that the studies did not tell us which regimen to use.

Deb Armstrong admitted that at her institution they utilised the GOG protocol regimen exactly as it is written but needed to give all patients G-CSF and aprepitant to get them through. With this regime she quoted 85% of patients were able to complete 6 cycles. Michael Bookman went as far as to say that further studies of IP

chemotherapy were not justified and that we should look to other treatments such as the biological therapies to improve results further.

It was an excellent idea to get the IP vs IV issue out in the open on day one but it meant that all other subsequent talks on the matter became obsolete. I appreciated this as it freed up time to go to lectures on other tumour types.

Summary of presentations of interest:

Ovarian Cancer

- ① Ian Jacobs and colleagues presented preliminary data from the UKCTOCS study.
 - This very large randomised trial of ovarian cancer screening methods has completed recruitment; 202,638 patients have been randomised.
 - 101,359 patients are on the control arm, 50,639 were randomised to transvaginal ultrasound (TVUS) alone and 50,640 to multi-modal screening (both Ca125 measurement and TVUS).
 - Use of a risk of ovarian cancer (ROC) Ca125 algorithm with serial measurements increases the specificity of Ca125 measurement rather than use of single CA125 measurements alone.
 - Compliance with 2-year screening was 89% for TVUS and 92% for multi-modal.
 - 1.7% of women in the TVUS alone arm underwent surgery. 30 operations were performed for each case of ovarian cancer detected.
 - 0.2% of women in the multi-modal arm underwent surgery, 4.7 operations were performed for each case of ovarian cancer detected.
 - In 1151 operations there was 1 post-operative death. This patient actually had advanced disease.
 - Specificity estimates – multi-modal screening 99.9%, TVUS 99.0%
 - PPV estimates – multi-modal screening 21.4%, TVUS 3.4%
 - With an expected incidence in the prevalence screen of 40/100,000/year, an overall lead time of 2.6 years has been estimated for screening. Such analysis

has not been performed on TVUS vs Multi-modal.

- ② Anne-Marie Swart from the MRC presented long term follow-up data from ICON1. Data were presented with a median follow up of 9 years. In summary, with longer follow up adjuvant chemotherapy for early stage disease resulted in an improvement in progression free survival with a hazard ratio of 0.72 at 10 years. This translates to an absolute difference of 9% at 10 years and remained statistically significant. There was a hazard ratio of 0.76 for overall survival in favour of the chemotherapy arm however this is now not statistically significant. Of note, 30% of deaths were not due to ovarian cancer. Further analysis is ongoing.
- ③ The GOG trial (GOG146Q) of weekly topotecan vs the current standard 5 days/month schedule is accruing poorly as most practitioners have already shifted to using 4mg/m² weekly for 3 weeks in a 28 day cycle. Anecdotal consensus would appear to suggest that the weekly schedule is less toxic and equally efficacious.

Cervix cancer

- ① Gillian Thomas presented data from the GOG191 study which was designed to investigate the importance of maintaining a haemoglobin >12g/dL during chemoradiotherapy for carcinoma of the cervix.

The study randomised 109 of a planned 230 patients. It was closed early after the drug company refused to supply the erythropoietin. This decision was based on a number of thrombotic complications in the EPO arm of the study. It is the opinion of the principal investigator that this decision was unjustified and she discussed her disappointment during the presentation. The trial is too small to produce meaningful data and no further work is being done on this issue.
- ② Perry Grigsby from St Louis presented data on the role of PET/CT in carcinoma of the cervix. This large series of 500 patients yielded very useful practical information.
 - Lymph node spread is “orderly” in this disease and “skip areas should be evaluated carefully”.

- 80% of positive nodes on PET/CT were <1cm in size.
 - 34% of patients with positive para-aortic nodes also had disease in the supra-clavicular node. (All patients with positive supraclavicular nodes on PET were proven on FNA).
 - The SUV (Standardised Uptake Value) on PET of lesions due to cervical cancer are 3 to 4 times more than seen in other cancers; eg head and neck, breast or lung.
 - In this series increased SUV predicted for local treatment failure and decreased survival.
 - Other prognostic factors are positive lymph nodes and tumour volume. A positive PET scan 3 months after chemo-radiotherapy was an important predictor for decreased survival.
 - In St Louis PET/CT is used for radiotherapy planning for cervical cancer.
- I was introduced to the concept of the phantom positive HCG test due to the fact that some test kits do not properly neutralise heterophil antibodies and lead to a false positive result. This is a problem that may have led to many unnecessary procedures and should be kept in mind if no pregnancy or tumour can be found in the presence of a positive HCG test.
 - Hyper-glycosylated-HCG (HCG-H) is independently secreted by stem cytotrophoblast cells. It is the direct promoter of trophoblast invasion in normal pregnancy and of malignancy in the case of choriocarcinoma. HCG-H can be used to detect between active and quiescent disease and help determine the need for chemotherapy. Currently HCG-H can be measured but only by sending the specimen to Dr Laurence Cole in Albuquerque.

Trophoblastic disease

At the commencement of the session on trophoblastic disease it was announced that Ed Newlands from Charing Cross hospital had died. A minute's silence was observed for this important researcher in the field. Key points from this interesting session.

The social program culminated in the customary Australian-Canadian dinner ... In true diplomatic spirit, the joke telling competition this year was won by a Canadian who now calls Australia home ... and she didn't even get to the punch line. The next IGCS is in Bangkok 25–29 October 2008. I would recommend attendance for this dinner alone.

Conflict of interest declaration: Dr Christopher Steer was sponsored to attend the meeting by Roche Pharmaceuticals.

PapScreen flags importance of Pap Tests, despite vaccine subsidy

HPV and cervical cancer have been in the media spotlight recently with the Australian Government confirming the HPV vaccine will become part of the national immunisation program from 2007.

The Government announced the vaccine will be available to girls aged 12–13 years from 2007 and a two-year catch-up program will be available to girls aged 13–18 years through schools. In addition, women aged 18–26 years will be able to access the funded vaccine through their general practitioners.

PapScreen Victoria would like to remind all Pap test providers that its brochure: *Pap tests and the human papilloma virus (HPV)* is an extremely useful resource for women, and includes a range of commonly asked questions about HPV and its link to cervical cancer. The brochure can be ordered from www.papscreen.org.au (see the Health Professionals section) or by calling 13 11 20.

PapScreen Victoria's Kate Broun says that even though the vaccine will be available free to eligible females from as early as next year, the National

Cervical Screening Program remains a critical cervical cancer prevention method.

“HPV vaccination is not routinely recommended for sexually active women and an individual decision regarding the benefit of the vaccine should be made taking into account the likelihood of a woman’s past exposure to HPV. The most important preventative strategy for women who have had sex is two-yearly cervical screening.

In any case, even females who have the vaccine will need to continue having Pap tests as the vaccine does not cover all strains of cancer-causing HPV”

Women and Pap test providers who have questions about HPV or the HPV vaccine can call The Cancer Council Victoria’s Cancer Helpline on 13 11 20 or visit www.papscreen.org.au.

PapScreen Victoria alerts women to the myths surrounding new vaccine

Media Release – 28 August 2006

PapScreen Victoria is encouraging all women aged 18–69 to continue with regular two yearly Pap tests, as the first cervical cancer vaccine becomes available on the Australian market this week.

PapScreen Victoria’s program manager Kate Broun said: “While the vaccine is an exciting prospect for future generations, in Australia, the Pap test is currently the best protection against cervical cancer for women who have ever had sex. These women should continue having a Pap test very two years.”

The first cervical cancer vaccine – Gardasil, manufactured by CSL Limited – is recommended for girls before they become sexually active, and protects against specific strains of the human papilloma virus (HPV) that cause around 70% of cervical cancers. A second vaccine, produced by GSK Limited, is also expected on the market early next year.

To ensure all women are receiving accurate information about the cervical cancer vaccine, Dr Stella Heley, Liaison Physician at the Victorian Cytology Service (VCS) and Sexual Health Physician at Melbourne Sexual Health Centre, uncovers some common misconceptions surrounding the vaccine.

Myth: Girls who are vaccinated will not require Pap tests

Dr Heley: “Even for girls who are vaccinated, Pap tests will still be important. This is because the

vaccine is effective against two specific strains of human papilloma virus (HPV), and whilst these strains cause up to 70% of cervical cancers, the vaccine does not protect against all types of cancer-causing HPV.”

Myth: All women are currently eligible to receive the vaccine

Dr Heley: “The vaccine is currently approved for use in females aged nine to 26. The vaccine will be most effective if given to girls, around the ages of nine and 12. This is when the vaccine is most immunogenic and causes a higher antibody response than in older teens. The vaccine response is 2–3 times higher between nine and 12 years than between 16 and 23 years.

“The vaccine will also be more effective if given before the start of sexual activity, ie before exposure to HPV.

“It is difficult to prove the vaccine’s effectiveness in older women who have already commenced sexual activity. Women are advised to speak to their doctor about whether or not the vaccine would be worthwhile in their situation”.

Myth: The cervical screening program will no longer be needed once the vaccine is available

Dr Heley: “All women need to remember that regular Pap tests will continue to be important

as the vaccine only protects against two types of HPV that cause around 70% of cervical cancers. Therefore, the screening program will continue to be an important Australian public health initiative.”

“Pap tests are still an effective preventative measure against cervical cancer, for women who have ever had sex.

“Regular Pap tests allow any changes to the cells of the cervix to be identified and managed well before they may become cancerous, and they reduce the incidence of cervical cancer by up to 90%.

“Australia has the lowest rate of cervical cancer mortality in the world. This reflects the success

of our national cervical screening program. Our message to parents is that there are now two preventative measures for cervical cancer, which complement each other.”

Women who want to locate a Pap test provider or have questions about HPV or the cervical cancer vaccine can call The Cancer Council Victoria's Cancer Helpline on 13 11 20 or visit www.papscreen.org.au.

PapScreen Victoria is a joint Commonwealth-State funded program coordinated by the Victorian Department of Human Services in partnership with The Cancer Council Victoria and other major Victorian health agencies.

The Impact of HPV Vaccination on the National Cervical Screening Program

*Dr Marion Saville
Director, Victorian Cytology Service*

The impact on the HPV vaccine on the cervical screening program can be thought about in three broad categories:

- Confusion about the need to continue screening
- Reduction in the number of abnormalities detected in Pap tests
- Reduction in the number of cervical cancers

Confusion about the need to continue screening

This is already occurring with a large number of queries about the need to continue having Pap tests coming from women who are already in the Pap test program, women who are vaccinated and those who are intending to be vaccinated. The need for communication strategies in this area appears to be well understood at both the State and Federal level and is being addressed.

In addition to the impact of the publicity on women and their decision to enter or continue with cervical screening, there is also an important

consideration with respect to cytology workforce. We are already identifying some reluctance on the part of students in the Bachelor of Applied Laboratory Science Course at RMIT to select cytology as a major area of study. Informally we believe this is due to the publicity about the vaccine and students belief that this skill will not be relevant for the entirety of their working lives.

It is possible that the next decade will produce a time where the decline in capacity to report Pap tests will significantly precede the decline in demand. This is an important workforce issue that will require the attention of Directors of laboratories and screening programs.

Reduction in the number of abnormalities detected in Pap tests

It is estimated that the quadrivalent vaccine will reduce the prevalence of low-grade lesions by 20% and the prevalence of high-grade lesions by 50%. This will occur as soon as significant numbers of vaccinated women enter the screening program. In light of the recently announced decision that the government will fund

vaccination of women from 12–18 years and some women between 18–26 years, this will occur quite quickly.

The reduction in the prevalence of low grade and high grade abnormalities will be positive with respect to a reduced need to work up abnormalities and a consequent reduction in the associated financial, time and psycho-social costs.

However, this reduction in the prevalence of abnormalities will also lead to a reduction in the exposure of scientific staff to the abnormalities. Currently a full time screener can expect to see approximately 200 Pap tests per week and amongst these there would typically be one high-grade abnormality. If the prevalence of high-grade abnormalities falls by 50% this will be reduced to one high-grade abnormality per working fortnight. In addition to the reduced exposure to abnormalities, there will also be a reduction in the positive predictive value of these high-grade reports purely on the basis of reduced prevalence.

Current National Performance Measures for laboratories will need to be adjusted to reflect the reduced prevalence of abnormalities in the community.

Reduction in the number of cervical cancers

Worldwide HPV 16 and 18 account for approximately 70% of all invasive squamous carcinomas. Australian specific data suggests that HPV 16 and 18 may account for 80% of cancers. Reductions of this magnitude in the cancer rate will take decades because of the natural history of the evolution of these cancers following HPV infection.

The reduction in cancer burden through primary prevention will make our existing Pap test screening program much less cost effective. This raises the issue of what shape the screening program should take in the era of HPV vaccination.

I believe that it will be far too complex to have different screening programs for vaccinated and unvaccinated

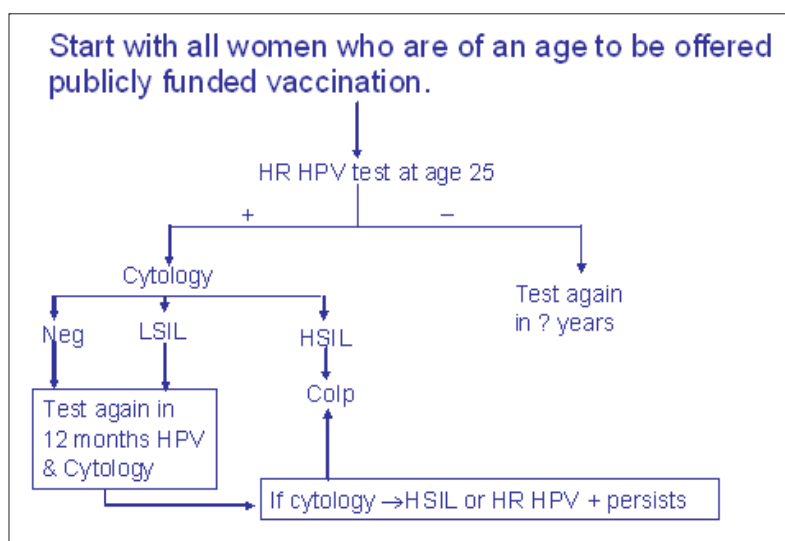
women. However, there are potentially important equity issues in screening all women less intensively, without regard to their vaccination history.

If we consider from first principles why a woman who is within a vaccinated cohort would develop cervical cancer, this may be for a variety of reasons. These could include:

- failure to be vaccinated at all;
- having missed some doses;
- having vaccine failure despite being correctly vaccinated; or
- being infected with oncogenic types of HPV not covered by the vaccine.

However, what these women will all have in common is that they will have acquired high-risk HPV (HR HPV) infections and developed persistence. Therefore it is worthwhile considering whether all women presenting for cervical screening and who are of an age to have been offered publicly funded vaccination should commence with an HPV test at 25 years. This is the age at which IARC recommends that cervical screening should commence. This strategy has the advantage that all women, regardless of their vaccination history, would enter the screening program at the same point. Their further management (see figure) would depend on the result of the HPV test rather than on their vaccination history.

This inverse screening, where HPV is the primary screening test and cytology is used as follow up for those who are HPV positive, is the subject of a number of overseas trials, some of which are nearing conclusion.



The main draw back of this strategy in the current environment is that at 25 years of age about 20% of women can be expected to test positive for high risk HPV. However, if almost all women had been vaccinated then the proportion of women testing positive to high risk HPV could be expected to dramatically decline. This will improve the specificity of HPV as a primary screening test.

Cervical screening is entering an era of major change in Australia with a number of new technologies available at a time when vaccination is also to be introduced. Decisions about changes to our very successful screening programs will need to be based on appropriate evidence.

Some of the evidence will need to be based on modeling for example studies looking at cancer outcomes would need to be too large and run for too long to be practically feasible. However, much of this evidence is amenable to direct research, for example the length of protection afforded by a negative high risk HPV test result.

It is time for stakeholders to consider the appropriate model for screening in an era of HPV vaccination and begin to assemble the available evidence, to identify evidence gaps that need to be addressed, and an appropriate strategy to move forward quickly enough to meet the screening needs of vaccinated women.

Senate Calls for Gynaecological Cancer Control

The Senate committee inquiring into the management of gynaecological cancer has called for a number of recommendations consistent with those put forward by The Cancer Council Australia, Clinical Oncological Society of Australia (COSA) and the National Aboriginal Community Controlled Health Organisation (NACCHO) in a joint submission earlier this year.

Among its recommendations released in Parliament on 19 October 2006, the Senate Community Affairs Committee sought government support for: better coordination of

patient travel and accommodation schemes; expedited use of Human Papilloma Virus immunisation to reduce cervical cancer in Indigenous communities; improvements in cancer-care referral pathways; and, greater incorporation of multidisciplinary care into cancer workforce training and planning – all of which were supported by The Cancer Council Australia, COSA and NACCHO.

The Cancer Council Australia and COSA hope to work closely with Cancer Australia to develop and implement cancer control policy that will reduce the impact of gynaecological cancer on Australian women and their families.

The Senate's full report is available at: www.aph.gov.au/Senate/committee/clac_ctte/gynaecological_cancer/index.htm.

Reprinted from Wongi Yabber Nov 2006; 13(4): 3–4, The Cancer Council Australia Report.

Ovarian Cancer Program Update

Ovarian Clinical Update

Putting research into context is one of NBCC's key roles. As part of its work in 2006–2007, NBCC's Ovarian Cancer Program will produce four issues each year of a new publication *Clinical Update – Ovarian Cancer*. Its publication will be overseen by an editorial board consisting of representatives from gynaecological oncology, medical oncology, psychosocial care and nursing.

Clinical Update – Ovarian Cancer will use a similar approach to the regular NBCC publication for health professionals *Clinical Update – Breast Cancer* that delivers timely expert comment on relevant breast cancer journal articles directly to their e-mail inbox. A brief abstract summarises key findings from a recent journal article, while commentary from an expert reviewer places the study outcomes into context for the Australian healthcare system.

To register to receive *Clinical Update – Ovarian Cancer*, complete the registration form on the Ovarian Cancer Program website www.ovariancancerprogram.org.au.

Ovarian cancer fact sheet translations

NBCC's Ovarian Cancer Program will commission the translation of its fact sheet *Ovarian cancer in Australia* into the five most commonly used languages by people from culturally and linguistically diverse backgrounds in Australia - Italian, Chinese, Greek, Arabic, and Vietnamese. It is anticipated the translations will be available as a PDF on the Ovarian Cancer Program website, with hard copies of the resource available on request.

For more information, contact Jane Francis on 02 9036 3045 or email jane.francis@nbcc.org.au.

Reprinted from *Wongi Yabber* Nov 2006; 13(4): 6..

GP Education Series

NBCC is developing a *General Practitioner Education Series* to support general practitioners in the care of women with breast and ovarian cancer and in the investigation of women who present with symptoms that may be due to breast or ovarian cancer.

The first in a series of topic-specific modules is now available. The module is based on NBCC's recently revised resource *The investigation of a new breast symptom: A guide for general practitioners*. This resource was recently distributed to GPs through the Divisions of General Practice along with the revised *Advice about Familial Aspects of Breast Cancer and Epithelial Ovarian Cancer*.

Modules are designed to be implemented through Divisions of General Practice. Divisions will be provided with a facilitator's kit containing all the resources required to host their own workshops for local members.

Two additional modules will be developed over the next 12 months about breast cancer in younger women and the assessment of symptoms that may be ovarian cancer.

To order a module, contact Janice O'Brien on 02 9036 3350 or email janice.obrien@nbcc.org.au.

Reprinted from *Wongi Yabber* Nov 2006; 13(4): 5, *National Breast Cancer Centre 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*.

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
- registry identification number.

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.

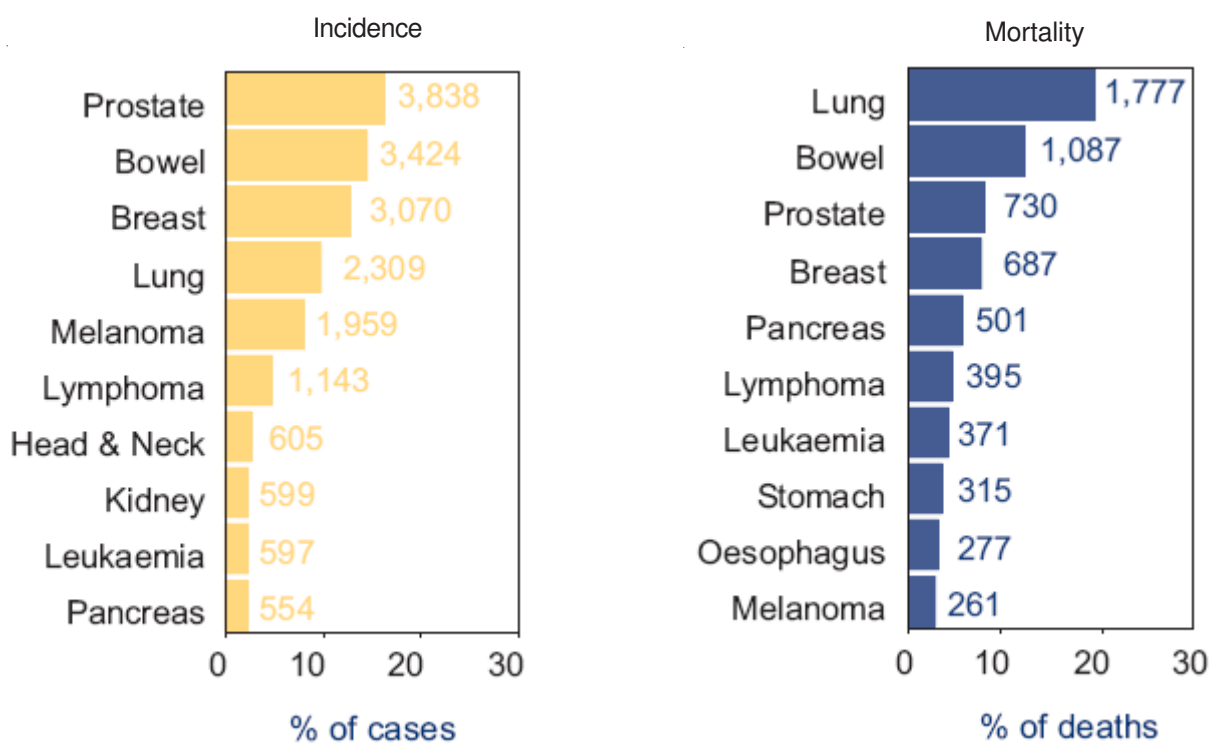


Figure 1 shows the ten top-ranking sites for cancer incidence and mortality in Victoria. The bars represent the percentages of total new cases or deaths in each site. Numbers of cases / deaths are also shown.

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

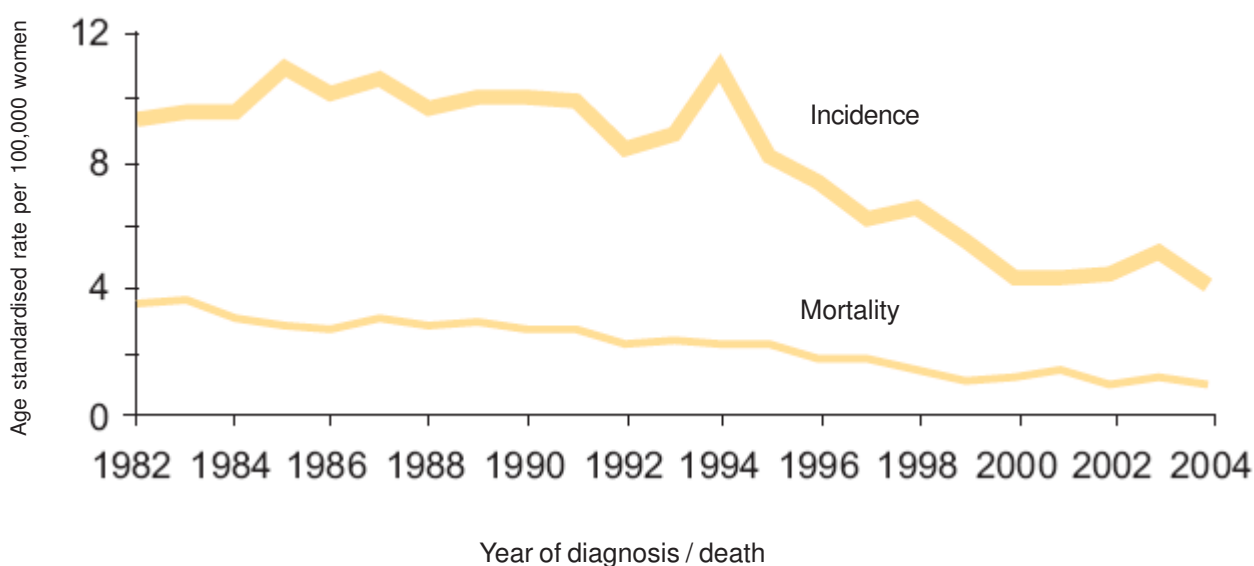


Figure 3. Ovarian Cancer Trends in Victoria, 1982–2004.

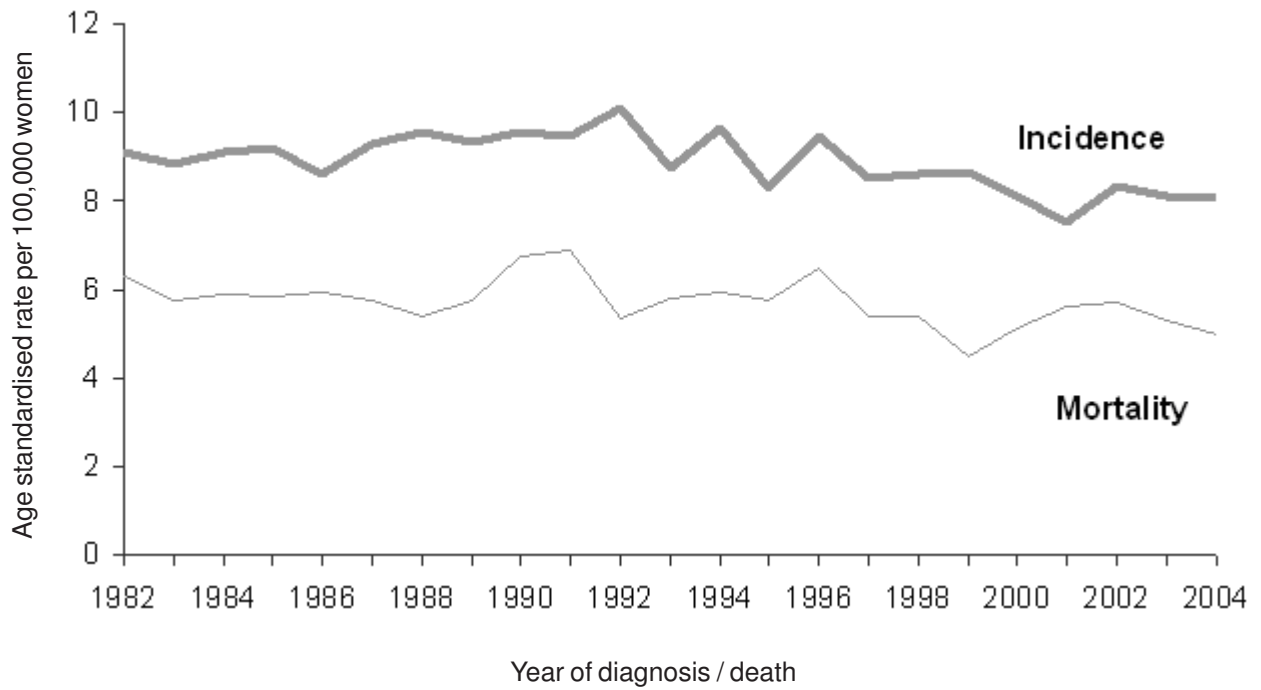
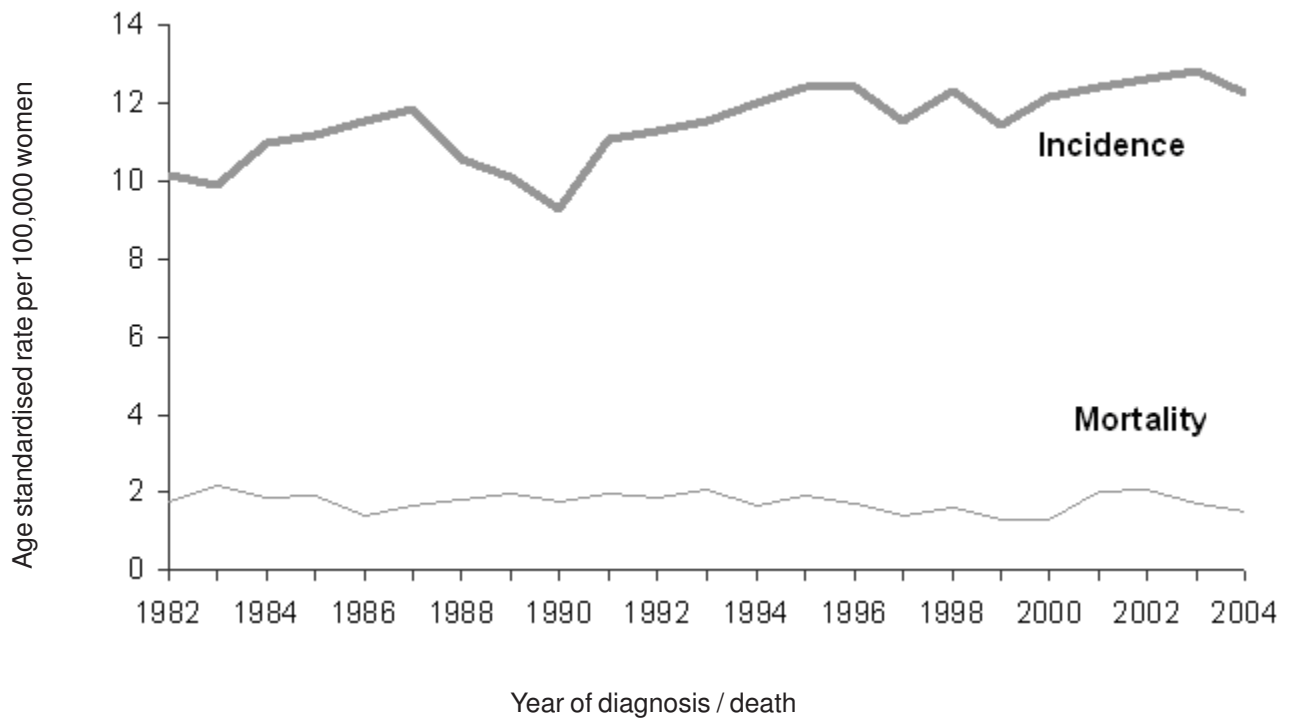


Figure 4. Endometrial Cancer Trends in Victoria, 1982–2004.



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.

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.

Key Published Articles Listing—Gynaecological Cancer

Title	Author & Journal
Chapter 20: Issues in planing cervical cancer screening in the era of HPV vaccination	Franco EL, Cuzick J, Hildesheim A & de Sanjosé S. Vaccine Aug 2006; 24S3: S3/171–S3/177.

Forthcoming Meetings

Date / Place	Meeting / Contact
1–3 February 2007 Beaver Creek, Colorado, USA	Controversies in Gynecologic Oncology XII Winter meeting of the Society of Gynecologic Oncologists (SGO) Ph: +1 312 235 4060 E-mail: sgo@sgo.org Website: www.sgo.org
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) E-mail: info@icact.com Website: www.icact.com

Date / Place	Meeting / Contact
8–10 February 2007 Lorne, Victoria, Australia	19th Lorne Cancer Conference – <i>The hallmarks of cancer</i> 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), Pittsburgh, USA E-mail: customer.service@ons.org Website: www.ons.org
22–23 February 2007 Washington DC, USA	HPV and Cervical Cancer in the USA: Outlook and Implications of a National Vaccination Policy National Cervical Cancer Coalition (NCCC), West Hills, CA, USA Ph: +1 818 909 3849 E-mail: info@nccc-online.org Website: www.nccc-online.org
27–28 February 2007 Sydney, NSW, Australia	3rd Australasian Redesigning Healthcare Summit – <i>Making patient journeys work</i> 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) – <i>Promoting quality psychosocial cancer care across diverse communities</i> 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
3–7 March 2007 San Diego, California, USA	38th Annual Meeting of the Society of Gynecologic Oncologists (SGO) Annual Meeting on Women's Cancer. E-mail: sgo@sgo.org Website: www.sgo.org
6–10 March 2007 Florence, Italy	4th International Conference on Tumor Micro-environment – <i>Progression, therapy and prevention</i> 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

Date / Place	Meeting / Contact
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
12–14 April 2007 Orlando, Florida, USA	33rd Annual Meeting of the Society of Gynecologic Surgeons (SGS) PO Box 381063, Germantown, TN 38181 Ph: +1 901 682 2079 Fax: +1 901 682 9505 Website: www.sgsonline.org
14–18 April 2007 Los Angeles, California, USA	98th Annual Meeting of the American Association for Cancer Research (AACR) Website: www.aacr.org
24–27 April 2007 Las Vegas, Nevada, USA	32nd Annual Congress of the Oncology Nursing Society (ONS) 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) E-mail: asco@asco.org Website: www.asco.org
23–29 June 2007 Flims, Switzerland	9th Joint FECS-AACR-ASCO Workshop – Methods in Clinical Cancer Research E-mail: workshop@fecsb.be Website: www.fecsb.be/emc.asp?pageid=1153
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.

