



Lung Cancer Update

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QUALITY OF LIFE AFTER HATS

ROLE OF THE SPECIALIST NURSE

20 YEARS OF QUIT VICTORIA

VICTORIAN CANCER SERVICES
FRAMEWORK

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



LUNG CANCER UPDATE

July 2005

Issue No. 18

CONTENTS

| | |
|---|----|
| Editorial | 3 |
| Quality of Life after HATS - Synopsis | 4 |
| Commentary on Guidelines on the Role of Specialist Nurse in Supporting Patients with Lung Cancer' | 6 |
| From Smoky to Smokefree - Quit Victoria Celebrates 20 years..... | 7 |
| ACN Management of Lung Cancer Working Party | 8 |
| What does the Victorian Cancer Services Framework mean for you? | 9 |
| Government Urged to Help Pacific Nations Enforce First World Tobacco Control Treaty | 10 |
| Working Party to Establish Credentialing Processes for Medical Staff for Cancer Services | 11 |
| Report of The Cancer Council Australia | 12 |
| Senate Committee Gives Cancer Priorities a Good Hearing | 13 |
| An Information Resource for People with Cancer of Unknown Primary & their Families & Friends | 14 |
| Report of the National Cancer Control Initiative | 15 |
| COSA Report | 16 |
| Multilingual Cancer Information | 18 |
| Key Published Articles Listing—Lung Cancer | 19 |
| Key Published Articles Listing—General | 19 |
| Forthcoming Meetings | 19 |

This newsletter is produced by The Cancer Council Victoria's Lung Cancer Committee and sent to health professionals interested in management of lung cancer(s). The Victorian Cooperative Oncology Group's advisory committees on breast, gastrointestinal, gynaecological, head & neck, 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 Leigh Williams, Ph: (03) 9635 5174.

***** **Last Issue – No. 17 – December 2004** *****

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



Pierre Fabre
Médicament

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for sponsoring this publication

(Insert Editorial)

Contributions Welcome

The Lung 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 |

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Quality of Life after HATS - Synopsis

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Introduction

Hand assisted thoracoscopic surgery (HATS) has been developed at St Vincent's Hospital to provide alternative access to thoracotomy, in cases where VATS alone would be inadequate. Such is the case in metastasectomy and in diagnosis of small deep lung nodules. We have previously reported that this procedure causes less post-operative pain. We hypothesised that the HATS procedure would also cause less short term reduction in quality of life (QOL).[1]

Methods

We performed a randomised controlled trial of limited thoracotomy versus HATS in 60 patients deemed suitable for HATS wedge resection of lung. Randomization was stratified based on diagnostic or metastasectomy indication. Baseline QOL was assessed using the Quality Metric SF-12v2. This was repeated at the 14th and 42nd post-operative day. Secondary endpoints were lung function (FEV1 & DLCO), diaphragm function (fluoroscopy), length of stay, length of epidural catheterization, incidence of prolonged air leak, wound complications and oncological outcomes. Intention-to-treat analysis was performed.

Results

Eighteen patients were enrolled for diagnosis of deep nodules and 43 patients were enrolled for metastasectomy. One patient declined thoracotomy after randomisation. One patient randomised to HATS was converted to thoracotomy due to pleural symphysis. Two patients in the metastasectomy group did not have metastases and one had the indication changed to diagnostic after randomisation.

Gender, age and QOL scores were similar in both arms.

Day 14 physical component scores dropped significantly for the thoracotomy group (-12.9) but not for HATS (-6.1), $p=0.001$, ANOVA. By day 42, there was no significant difference between the groups or compared to baseline scores.

Mental component scores did not change significantly for either group throughout the study.

All cause 2-year survival for metastasectomy performed by HATS or thoracotomy were similar.

Complication rates, pulmonary and diaphragm function was identical between the groups and there was no surgical mortality in the study.

Conclusion

Hand assisted thoracoscopic surgery has much less impact on early post-operative physical quality of life than limited thoracotomy.

References

1. Paiva JM, Wright GM. Hand-assisted thoracoscopic surgery causes less pain than limited thoracotomy after cessation of epidural analgesia. *Heart Lung Circ* 2005; 13(4): 374-8.

Insert Adam Broad Synopsis

Commentary on 'Guidelines on the Role of the Specialist Nurse in Supporting Patients with Lung Cancer'

Shannon Clark

Clinical Nurse Specialist, Oncology & Haematology Ward
Austin Health – Melbourne

Guidelines on the role of the specialist nurse in supporting patients with lung cancer
Moore, S; The London South East Cancer Forum for Nurses (2004)
European Journal of Cancer Care, Sept 2004; 13 (4): 344–8.

The treatment of UK patients with lung cancer has often been less than optimal. Weaknesses include uncoordinated delivery and fragmentation of services, frequent delays, occasional lack of referral to cancer specialists, and poor diagnosis and assessment. In addition, because of the attitude that patients will die quickly, health care professionals conclude that little can be done to improve survival rates despite advances in diagnosis and treatment. Nevertheless, UK Government guidelines remind health care professionals of the obligation to ensure that lung cancer patients and carers must receive high quality care and support throughout the duration of the illness, no matter how short.

One way of delivering such care and support for lung cancer patients and carers in the UK has been the attempt to refocus specialist lung cancer nursing roles in ways that 'cross traditional role and organizational boundaries' (p.345). UK Government guidelines advocate that specialist lung cancer nurses can facilitate information flow to patients, 'improve pain control', 'reduce patient distress', and 'increase satisfaction' (p. 345).

While this encouragement of the new nursing role is to be welcomed, the large increase in the UK 'site-specific' specialist lung cancer nurses is a concern for the London South East Cancer Forum for Nurses [hereafter the 'Forum'] (2004: 344–348) who posit that many of these positions and roles have developed without appropriate 'strategic planning or evaluation' (p. 345). Their paper therefore attempts, first, to identify areas of care where the specialist lung cancer nurse can significantly enhance the care experience of the lung cancer patient and, second, to provide

'evidence-based guidance' for the 'development of new and existing nurse specialist posts in lung cancer' (p.345).

The Forum discusses six main areas of care that are particularly pertinent for the lung cancer patient. In the first—communication and information—the need for nurses to supply adequate and prompt information for the patient to understand 'what is happening' and what is 'likely to happen' helps the patient to make decisions and give 'informed consent' (p.345). Follow-up care by UK specialist lung cancer nurses with good interpersonal skills has been well received by patients. Being able to access specialist help and advice when needed was also seen as vital to lung cancer patients especially between scheduled appointments. Patients are often vague about whom to contact and specialist lung cancer nurses can fill this void with speedy and appropriate advice.

In addition to physical features of lung cancer, the emotional distress and psychological and social problems of patients, family and carers need to be detected. UK evidence suggests that specialist lung cancer nursing interventions in these areas have been successful for patients and carers. Moreover, 'emotional support' and 'symptom management advice' have had to be administered where patients have suffered from 'inadequate palliation' and 'little help with their symptoms' from health teams (p. 346).

Not unexpectedly, health care professionals can defend their inadequate all-round treatment on the speed of lung cancer progression. This puts pressure on coordinating systems so the Forum is of the view that if specialist lung cancer nurses

took over as 'coordinators of care', treatment would be more in tune with patients' and carers' wishes as well as resulting in better organisation of treatment between departments (p.346).

Finally, the UK experience highlights the frustration experienced by patients when seeing so many doctors and teams without being to develop a rapport with any of them. The specialist lung cancer nurses who have worked 'across teams and organizations' have already proved that patients can get a 'sense of continuity in their care' irrespective of the variety of medical teams handling the patient (p.346).

In these six areas of care, the Forum provides convincing UK evidence that specialist lung cancer nurses can successfully address treatment, psychological, social and organisational problems in optimising care of patients and carers. However, the paper does warn that, as in Australia, 'nurse specialists are an expensive and limited resource and that patient caseloads are high' (p.347). Providing such individualised care for lung cancer patients is costly both in terms of time and emotion.

The Forum's two conclusions are therefore predictable—the need for sufficient numbers of specialist lung cancer nurses, and adequate backup with training and management and administrative support for those nurses (p. 347). But while the six areas of care are unexceptionable, the Forum's recommendations could arguably apply to the nursing care for any illness with rapid deterioration and short life expectancy after diagnosis, and would have to be justified against competing claims for resources. Moreover, the demarcation of roles between doctor, nurse and other professionals, and the intricacies of accommodating cross team and organisation centres within hospital structures are not addressed. While the Forum acknowledges that education and research components of the specialist lung cancer nurse role are outside the parameters of the paper, the useful concluding summary of the key components of the clinical role of the specialist lung cancer nurse in supporting patients with lung cancer provides a good starting point in this endeavour. From the UK evidence alone, it is an endeavour worth pursuing.

From Smoky to Smokefree Quit Victoria Celebrates 20 years

Since 1985 over half a million Victorians have called the Quitline. To celebrate the achievements we've made in helping more people – and places – to be smokefree, earlier this year a number of events brought together the groups and individuals who have contributed to the work of Quit Victoria over the last two decades.

To coincide with Quit's 20th Anniversary, two memorable television advertisements also made reappearance on Victorian television screens as part of a range of activities to mark twenty successful years of helping Victorians stop smoking.

Quit Victoria was established in 1985 by then Minister for Health, David White and the Anti-Cancer Council of Victoria (as we were then called), following a review of health promotion

that identified tobacco as the number one health priority in Victoria.

The Anti-Cancer Council of Victoria had already held a long-term interest in tobacco issues spearheaded by Dr Nigel Gray who was director from 1968 to 1995. Dr Gray has been a world leader in using behavioural research and the measurement of smoking rates to advocate for tighter tobacco control.

In 1971, Dr Gray initiated the production of a number of television commercials. These commercials, which were some of the first quit smoking television advertisements produced in Australia, were done very cheaply with almost no sets and starred an old acquaintance of Dr Gray's – comedian Warren Mitchell. These black and white ads delivered the quit message with a humorous twist, and still raise a laugh

today. On a more serious note, Nobel Prize recipient and then Director of the Walter and Eliza Hall Institute, Sir Macfarlane Burnet, also featured in television advertisements concentrating on lung cancer and teenage smoking.

The first Quit advertisements featured the now famous 'Sponge' television commercial, a simple but highly effective ad, which replicated the damage smoking causes to lungs by showing a sponge oozing thick grey gunk. This successful and timeless advertisement has been a mainstay in Quit's advertising.

The Quitline in those days was a three-minute recorded message using the voice of popular show business identity Daryl Somers and in the first three months of operation the Quitline had received approximately 80,000 calls. Today the Quitline has become a much more substantial service, operated by trained staff and supported by a large number of resources developed for a wide range of smokers.

Quit's successes haven't been limited to reducing the number of adult and teenage Victorians smokers. The smokefree environments we enjoy today at work and in public places are the results of decades of vigorous advocacy.

In the 1980's Dr Gray continued to establish Quit Victoria's reputation as the foremost tobacco control organization; he led the efforts for the benchmark 1987 legislation that not only phased out cinema and outdoor advertising, but devised an approach to tax tobacco in a way that would provide funds to replace tobacco sponsorship of sporting and cultural events.

As a result of the The Victorian Tobacco Act, and the levy it introduced on the sale of cigarettes, the Victorian Health Promotion Foundation (VicHealth) was established in 1887 to distribute funds raised by the new levy. Realising tobacco sponsorship would one day be completely outlawed, many sports clubs sought alternative sponsorships from VicHealth, who in return enlisted the help of Quit to manage health message sponsorships.

Quit Victoria's involvement with major sports clubs quickly became another channel for the smokefree messages and the sponsorship of the Fitzroy Football Club in 1987 bought the 'Quit' message to a wider audience.

Victoria is a very different place today due to the hard work of Quit Victoria. While there is much to celebrate there is much still to do. Lung cancer is still the leading cause of cancer deaths and with 4 700 Victorians dying of tobacco related illness every year, smoking is still the largest cause of preventable deaths in this state.

It is clear that in the last twenty years significant progress has been made in the area of tobacco control. Lots of people have had a part to play in Quit's success, including the community who have supported change.

The overwhelming community support for both the 'Quit' and 'Smokefree' message has often been the key factor in legislative change for tobacco control. Looking to the future Quit Victoria will continue work in partnership with the community to further reduce smoking rates and advocate for smokefree places.

ACN Management of Lung Cancer Working Party

Enquiries continue to be made for copies of these guidelines and they are still available on our website in PDF format at: www.cancer.org.au/guidelines.

The Assessment and Management of Lung Cancer Evidence-based Guidelines: A guide for general practitioners, A4 guide for GPs has now been endorsed by RACGP and the

Australian Lung Foundation. It is hoped to distribute this via Australian Family Physician in the next several months.

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

What does the Victorian Cancer Services Framework mean for you?

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

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

The Department of Human Services commissioned a review of Cancer Services in Victoria by the Collaboration for Cancer Outcomes Research and Evaluation, who published their report in July 2003. This was entitled “A Cancer Services Framework for Victoria and future directions for the Peter MacCallum Cancer Institute.” The Minister and the DHS adopted the recommendations for the Cancer Services Framework; a Ministerial Taskforce was appointed towards the end of 2003 with a 3-year term and the responsibility to oversee the implementation of the reforms.

The Taskforce, chaired by Dick Smallwood, has representatives from all disciplines involved in the delivery of cancer care, metropolitan and regional representation, and consumer input. It is supported by the staff of the Cancer Co-ordination Unit at DHS, headed by Elise Davies. The work has been organised around three main themes: Clinical Services, Research and Data / IT, chaired by Bob Thomas (Peter Mac), Paul Mitchell (Austin) and David Hill (TCCV) respectively. The latter two committees have been reviewing the activity and resources currently available in Victoria. Discussions are underway regarding co-ordination of research throughout the state. The IT group have been

examining a project that would expand the data collection capabilities of the Cancer Council and how patient information can usefully be shared electronically between hospitals and other service providers.

The main impact that the reforms will have is obviously the delivery of clinical care. Two key components of work are running in parallel. The first component is the development of patient management pathways, which documents what resources and facilities are required by a cancer patient through the ‘cancer journey’, essentially from pre-diagnosis to death. This work was initiated by holding a series of workshops with clinicians and consumers mapping out the requirements in each of the designated tumour streams. These bring together specialists in multi-disciplinary care for the main tumour sites and types such as breast, colorectal, prostate, testis, lung, melanoma, ovary, oesphagogastric, pancreas, larynx, pharynx, oral-combined, malignant glioma and cerebral metastasis. Site-specific pathways and generic needs across all streams have been developed and are being further refined. The report of the workshop is available at www.health.vic.gov.au/cancer/docs/patientmanagementframework.pdf.

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

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

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

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

The other component is the division of Victoria into eight Integrated Cancer Services or ICS: three metropolitan (Western & Central, Southern and North Eastern) and five regional (Loddon Mallee, Grampians, Barwon South Western, Hume and Gippsland). Each has independent governance and direction. One initial task for the ICS is to identify and map the components of cancer care delivery within their region. These

can then be compared with the requirements identified in the patient management pathways workshops. Over the coming years it is hoped that resources are found where gaps are identified to ensure equitable service provision. Interaction between the ICS, especially regional and metropolitan, may be required for particular components of specialised care. This is still very much work in progress.

Government Urged to Help Pacific Nations Enforce First World Tobacco Control Treaty

*Glen Turner
Communications Manager
The Cancer Council Australia*

Australia has a “moral obligation” to help its Pacific neighbours combat the rising prevalence of smoking and tobacco related disease by helping them enforce the world’s first treaty on tobacco control, which came into effect in February, according to The Cancer Council Australia.

The Cancer Council’s Chief Executive Officer, Professor Alan Coates, said the Framework Convention on Tobacco Control (FCTC), ratified by Australia and 56 other countries, was the world’s first global health treaty and offered a unique opportunity for Australia to help less resourced Pacific island and south-east Asian nations boost their tobacco control efforts.

“There are almost five million tobacco related deaths worldwide each year, 70 per cent of which occur in developing countries where legislative regimes and education campaigns are weak or non-existent,” Professor Coates said. “The tobacco industry, including Australian companies, preys on vulnerable countries, profiting from activities that have been prohibited in Australia for 20 years.”

Chair of The Cancer Council Australia’s Tobacco Issues Committee, Dr Andrew Ellerman, said Australia was well along the path to meeting the requirements of the FCTC and was ideally placed to provide technical expertise and financial support to help our neighbours meet their obligations under the FCTC, such as developing effective legislation and implementing public education programs.

Illustrating the extent of the problem, Dr Ellerman said smoking related disease claimed more than 19,000 Australian lives each year and cost the health system an estimated \$21 billion. “We need to do more in our own country, but the threat to developing nations is dire and requires urgent action. The sad fact is that unless we help our Pacific neighbours come to grips with the tobacco epidemic, they face an escalating loss of life and crippling health costs.”

Requirements under the FCTC include: elimination of tobacco advertising, promotion and sponsorship; requirements for warning labels; prohibition of misleading descriptors such as “light” and “mild”; protection of non-smokers from tobacco smoke in public places; regulation of tobacco product contents; and calls for higher tobacco taxes, global coordination to fight tobacco smuggling and promotion of tobacco prevention, cessation and research programs.

Links

- Federal Government announcement: www.health.gov.au/internet/wcms/publishing.nsf/Content/health-mediarelyr2004-cp-pyn001.htm
- Framework convention alliance: www.fctc.org
- World Health Organisation: www.who.int/tobacco/framework/en/

Health groups welcome decline in smoking rates

Health groups have welcomed data showing a decline in smoking rates in Australia as proof that a comprehensive investment in tobacco control can reduce the devastating impact of smoking in the community.

Information released by the Federal Government in April reveals that daily smoking rates for people over the age of 14 are now 17.4%, compared to 19.5% in 2001 and 21.8% in 1998.

The Cancer Council Australia, the National Heart Foundation of Australia and Quit Victoria welcomed news of the decrease in smoking rates and said that with a continued Commonwealth commitment to tobacco control, further reductions could be expected in the coming years.

The groups said the Government's new graphic health warnings on cigarette packs, to be introduced from March 2006, and the recent ratification of the WHO Framework Convention on Tobacco Control, if backed by a strong investment in mass media quitting programs, could save thousands more Australians from premature death and disease caused by smoking.

The Chief Executive Officer of The Cancer Council Australia, Professor Alan Coates, said medical evidence showed that smoking caused at least 14 types of cancer, including some of the most lethal and debilitating forms of the disease.

"This downturn in smoking prevalence means that up to 200,000 Australians have dramatically reduced their risk of developing these cancers," Professor Coates said.

"Smoking still remains the number one cause of preventable death and disability in Australia. We should build on the success of recent tobacco control programs and save thousands more Australians from premature death and disease."

The Heart Foundation's Tobacco spokesperson, Mr Maurice Swanson, said that smoking rates could continue to drop if the Government maintained its strong commitment to stemming the destructive toll of smoking on the Australian population.

"Smoking is still the nation's largest cause of death and disease, causing immeasurable grief for those who have lost a loved one to a smoking caused disease and putting

tremendous pressure on the health system," Mr Swanson said.

"However continued work in the field of tobacco control, and the support of the Government in encouraging people to quit means that we have a great opportunity to ensure the rate continues to go down."

Quit Victoria's Executive Director, Mr Todd Harper, said that the data confirmed Australia's status as a leader in tobacco control.

"There is no doubt that Australia is a world leader in tobacco control and that willingness to tackle the tobacco problem head-on has a flow on effect in that less Australians now are smoking," Mr Harper said.

"The greater the effort put into tobacco control means the greater the return we will see in long term health benefits for all Australians."

Reprinted from Wongi Yabber May 2005 Vol. 12(2): 4

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

Professor Michael Frommer, Director of the University of Sydney, Health Projects Group is well advanced in the development of the scoping document. The document will be posted on the ACN website after it is received and accepted by the ACN Credentialing Steering Committee. Your comments will be crucial to its success.

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

Report of The Cancer Council Australia

Glen Turner
Communications Manager
The Cancer Council Australia

New Position Statements

The Cancer Council Australia has published five new position statements.

Bowel Cancer Screening

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

Testicular Cancer

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

State and Territory Travel and Accommodation Subsidy Schemes

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

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

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

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

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

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

Reprinted from Wongi Yabber February 2005; 12(1): 5 and May 2005; 12(2): 4.

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

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

The report has been welcomed by The Cancer Council Australia, which attributed much of the good news to population initiatives in prevention and early diagnosis and good access through Australia's health system to advances in treatment.

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

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

"Prevention has delivered extraordinary value for money," Dr Penman said. "When you look at Australia's lower rates of lung cancer incidence and mortality the argument is compelling – our death rates are 32 percent lower than the US for males and a staggering 48 percent for females."

Although at 19,000 deaths from tobacco related disease each year, Australia still has a long way to go.”

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

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

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

Senate Committee Gives Cancer Priorities a Good Hearing

*Glen Turner
Communications Manager
The Cancer Council Australia*

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

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

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

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

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

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

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

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

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

Submissions detail TCCA advocacy priorities

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

The most substantial recent submissions relate to: the Productivity Commission's current study into the impact of medical technology; an NHMRC consultation on research aimed at breaking the link between disadvantage and poor preventive healthcare; and the Senate inquiry into cancer services. These submissions are now available on the website address below, along with submissions from 2004 relating to patents in gene technology and the Pharmaceutical Benefits Advisory Committee review process. www.cancer.org.au/policy_submissions

Reprinted from Wongji Yabber May 2005; 12(2): 3-4.

Treatment: Call for End to 'Cancer Lottery'

Cancer claims more lives in rural Australia and even more among Aborigines than in the rest of

the population, according to a coalition of peak cancer control bodies.

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

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

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

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

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

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

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

Reprinted from Wongji Yabber May 2005; 12(2): 5.

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

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

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

Report of the National Cancer Control Initiative

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

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

- Issues such as specific channels of communication, and barriers to exchange and utilisation of information which should be addressed when communicating the risks, benefits and outcomes of elective therapeutic and diagnostic interventions.
- Efficacy and effectiveness of different communication channels.
- Specific communication issues applicable to the following cases:
 - Diagnostic testing (screening men using PSA to detect early prostate cancer);
 - Surgical procedures (coronary angioplasty); and
 - Drug treatment (glucocorticoids in patients with chronic medical conditions).

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

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

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

Cancer Stage at Diagnosis for Indigenous and Non-Indigenous People in the Northern Territory

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

In 2002 the NT Cancer Registry, the Menzies School of Health Research and the National Cancer Control Initiative undertook a collaborative project to retrospectively identify the stage at diagnosis and survival of people in the NT diagnosed with selected types of cancer between 1 January 1991 and 31 December 2001.

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

The final report was released in late March to coincide with the publication of a journal article by the reports authors (Condon et al., MJA 2005; 182(6): 277-280). The final report can be accessed on the NCCI website www.ncci.org.au/pdf/NT%20cancer%20staging/NT_report.pdf and hard copies can be obtained by contacting the NCCI secretariat at enquiries@ncci.org.au.

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

COSA Report

*Ms Margaret McJannett
Executive Officer, COSA*

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

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

Rural Health Alliance Conference Alice Springs

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

COSA Council Meetings

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

Annual Scientific Meeting

The planning of the Annual Scientific Meeting (ASM) is well underway, with Dr Sandro

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

COSA Website

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

Asia Pacific Journal of Clinical Oncology

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

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

Multilingual Cancer Information

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

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

Topics include:

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

All information is available in:

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

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

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

Programs include:

- **The Multilingual Cancer Information Line (MCIL)**
Adding to the accessibility of the Cancer Helpline, the MCIL enables callers who speak languages other than English to talk to oncology-trained nurse counsellors with the assistance of an on-line interpreter. The service is available in 80 languages.
- **The Community Language Program**
The Community Language Program is a peer education program that provides free information sessions for community groups. Information on a range of topics is available in 22 languages.
- **Quit's Multicultural Program**
Raising awareness of the health effects of smoking and passive smoking, Quit's Multicultural Program encourages people from multicultural communities to quit. Resources, telephone support and information sessions are available in a range of languages.

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

Key Published Articles Listing—Lung Cancer

| Title | Author & Journal |
|---|---|
| Surgical management of lung cancer in Western Australia in 1996 and its outcomes | Mina K, Byrne MJ, Ryan G, et al. ANZ Journal of Surgery Dec 2004; 74(12): 1076–1081. |
| Hand-assisted thoracoscopic surgery causes less postoperative pain than limited thoractomy after cessation of epidural analgesia | Paiva JM & Wright GM. Heart Lung & Circulation Dec 2004; 13(4): 374–378. |
| Vinorelbine plus Cisplatin vs. Observation in Resected Non-Small-Cell Lung Cancer | Winton T, Livingston R, Johnson D, et al. N Engl J Med June 2005; 352(25): 2589-97. |

Key Published Articles Listing—General

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

Forthcoming Meetings

| Date / Place | Meeting / Contact |
|---|--|
| 10–13 August 2005 Hobart, TAS, Australia | Annual Scientific Meeting of the Medical Oncology Group of Australia (MOGA) Contact: MOGA Conference Secretariat C/- Pharma Events, PO Box 265, Annandale NSW 2038 Ph: (02) 9280 0577 Fax: (02) 9280 0533 E-mail: moga@pharmaevents.com.au Website: www.racp.edu.au/moga |

Forthcoming Meetings

| Date / Place | Meeting / Contact |
|---|---|
| 17–18 August 2005 Canberra, ACT, Australia | 11th Annual National Conference on Health Outcomes 2005: Making a difference Australian Health Outcomes Collaboration. Contact: Lorna Tilley Ph: (02) 6205 0869 Fax: (02) 6244 4201 E-mail: lorna.tilley@act.gov.au Website: www.uow.edu.au/commerce/ahoc |
| 18–19 August 2005 Sydney, NSW, Australia | Partners in Pain: Patients, Clinicians & Pain Management Official satellite of the 11th World Congress on Pain. Secretariat: DC Conferences Pty Ltd, PO Box 571, CROWS NEST NSW 1585 Ph: (02) 9954 4400 Fax: (02) 9954 0666 E-mail: pinp@dcconferences.com.au Website: http://dcconferences.com.au/pinp2005 |
| 21–26 August 2005 Sydney, NSW, Australia | 11th World Congress on Pain Organised by the International Association for the Study of Pain (IASP). Congress Secretariat: Tour Hosts Pty Limited, GPO Box 128, Sydney NSW 2001 Ph: (02) 9248 0800 Fax: (02) 9248 0894 E-mail: iasp2005@tourhosts.com.au Website: www.iasp-pain.org/05Cong.html |
| 30 Aug – 2 Sep 2005 Sydney, NSW, Australia | 8th Australian Palliative Care Conference 8 th Australian Palliative Care Conference Managers, GPO Box 128, Sydney NSW 2001 Ph: (02) 9248 0800 Fax: (02) 9248 0894 E-mail: pallcare2005@tourhosts.com.au Website: www.pallcare.org.au |
| 7–9 Sep 2005 Seoul, Korea | 18th Asia Pacific Cancer Conference (APCC) Korean Cancer Association, Seoul, Korea Ph: +82 2 726 5553 Fax: +82 2 778 2514 E-mail: apcc2005@hanjinpc.com Website: www.apcc2005.org |
| 18–22 September 2005 Las Vegas, Nevada, USA | The Pain Center 2005/2006 – <i>The Nuts & Bolts</i> Sponsored by the Society for Pain Practice Management. Contact: Connie Buechele, Executive Director, SPPM Ph: +1 913 387 3155 Fax: +1 913 387 3156 Website: www.sppm.org |
| 2–5 October 2005 Birmingham, United Kingdom | National Cancer Research Institute Cancer Conference NCRI Conference Secretariat, PO Box 49709, 61 Lincoln's Inn Fields, London WC2A 3WZ United Kingdom Ph: +44 20 7269 3420 Fax: +44 20 7061 6004 E-mail: ncriconference@ncri.org.uk |

Forthcoming Meetings

| Date / Place | Meeting / Contact |
|--|--|
| 6–9 October 2005 Sydney, NSW, Australia | 56th Annual Scientific Meeting of the Royal Australian and New Zealand College of Radiologists (RANZCR) RANZCR, Level 9, 51 Druitt Street, Sydney NSW 2000 Ph: (02) 9268 9777 Fax: (02) 9268 9799 E-mail: ranzcr@ranzcr.edu.au Website: www.ranzcr.edu.au |
| 16–20 October 2005 Denver, Colorado, USA | 47th Annual Meeting of the American Society of Therapeutic Radiology and Oncology (ASTRO) American Society for Therapeutic Radiology and Oncology (ASTRO), 12500 Fair Lakes Circle, Suite 375, Fairfax Virginia 22033 USA Ph: +1 703 227 0170 Fax: +1 703 502 7852 E-mail: meetings@astro.org Website: www.astro.org |
| 23–26 October 2005 Vancouver, Canada | 1st International Cancer Control Congress International Conference Services, Vancouver, Canada Ph: +1 604 681 2153 Fax: +1 604 681 1049 E-mail: iccc05@meet-ics.com Website: www.cancercontrol2005.com |
| 30 Oct – 3 Nov 2005 Paris, France | 13th European Cancer Conference (ECCO) Federation of European Cancer Societies (FECS), Avenue E. Mounier 83, Brussels 1200, Belgium Ph: +32 2 775 0201 Fax: +32 2 775 0200 E-mail: ECCO13@fecsb.be Website: www.fecsb.be |
| 16–18 November 2005 Brisbane, QLD, Australia | 32nd Annual Meeting of the Clinical Oncology Society of Australia (COSA) – Crossing Cancer Boundaries COSA Office, Medical Foundation Building, Level 5, 92 Parramatta Road, Camperdown NSW 2011 Ph: (02) 9036 3100 Fax: (02) 9036 3101 E-mail: cosa@cancer.org.au Website: www.cosa.org.au |
| 8–10 December 2005 Pokfulam, Hong Kong, China | 12th Hong Kong International Cancer Congress (HKICC) and 2nd Annual Meeting of the Research Centre of Cancer (RCC) University of Hong Kong Medical Centre, Queen Mary Hospital, Department of Surgery, Hong Kong, China Ph: +852 2818 0232 Fax: +852 2818 1186 E-mail: HKICC05@hku.hk Website: www.hkicc.org |

The Cancer Council Victoria

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

Centre for Clinical Research in Cancer — Victorian Cooperative Oncology Group

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

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

