



Lung Cancer Update

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Q&A ON THE INTEGRATED CANCER
SERVICES (ICS)

UNEXPECTED LONG TERM SURVIVAL
AFTER PALLIATIVE RADIOTHERAPY
AND MEDIA REPORTING

ASCO MEETING REPORT

SUPPORTIVE CARE NEEDS OF LUNG
CANCER PATIENTS

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



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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. 19 – December 2005** *****



Answers That Matter.

Eli Lilly Pty Limited is gratefully acknowledged
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Editorial

*Dr Shane White
Medical Oncologist
Austin Health*

Our daughter is tucked in bed, we have just consumed a steaming bowl or two of risotto ... all is right in the White household (not happy about Collingwood's fall to 6th on the ladder!). The study beckons however ... the VCOG needs eloquent prose! Where is James Joyce when you need him?

This issue has more tidbits for the avid reader. We have a written report following our last lung cancer forum; Michael Mac Manus regales us with his story ... one man's publication is another man's confusion, it seems.

Mary Duffy shares with us some developments at Peter Mac. In recognising the substantial unmet needs of lung cancer patients, their nurse coordinator intends to assess patients with a screening tool to better identify these gaps in care.

Yours truly, initially overcome by the sheer beauty of Atlanta, Georgia, manages to recover in time to deliver some appetizers from ASCO 2006.

We have reports from COSA, ACN, NCCI, TCCA, and the FBI (only kidding!).

Grant MacArthur was recently awarded the Dunlop Clinical Fellowship and describes his current and future projects. Congratulations to him, and I hope this is inspiration for the budding researchers out there.

On a serious note, Elise Davies and the Cancer and Palliative Care Section of DHS have provided a Q&A to the issues that concern us with the cancer reforms occurring state-wide. It is reassuring to note the comments that DHS appear to be in for the 'long haul'. This cannot come too soon, with the projected population growth (and aged population therein) in Victoria, and the explosion of cancer incidence that will undoubtedly occur. We need accurate data collection to understand what our workload is, and how our outcomes match against world standards. We also need to be able to offer our patients the optimum pathway for their cancer diagnosis and treatment, with the systems and workforce to make it happen.

Phew! Now for a nice cuppa ... speak to you again 'round Christmas!

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.

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

Contributions should be forwarded to:

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Questions and Answers on the DHS Integrated Cancer Services (ICS)

*Cancer & Palliative Care Section
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Following endorsement of the *Cancer Services Framework for Victoria* in November 2003, five regional and three metropolitan Integrated Cancer Services (ICS) have been established.

The purpose of the ICS is to develop service delivery structures that provide coordinated cancer planning and care provision across specified geographical areas, and to support the delivery of cancer care through the application of agreed best practice frameworks in ten defined tumour streams.

A program of cancer service improvement is being implemented by ICS, funded through the Department of Human Services. Those involved in the breast cancer redevelopment process will be familiar with the concept of funded service improvement initiatives, but for other areas of cancer care, this type of work is quite new.

Progress in establishing new service systems can be challenging and time consuming, and many clinicians are wondering when the results of these initiatives and the funding spent to date will flow on to improvements in care for patients.

Here Elise Davies and the Cancer and Palliative Care Section in the Department of Human Services answer some questions regarding Integrated Cancer Services, and outline plans for the future of cancer care in Victoria.

1. What do you consider to be the most valuable achievements of the first year of the ICS?

In their first year of operation, the main focus for the ICS has been to develop functional relationships between participating health services, to establish representative governance structures and processes for decision-making, to appoint staff to support the work of the ICS, and to map current service provision.

All ICS have appointed a Director (funded on a sessional basis), a Strategic Planner/Program Manager (1 EFT) and project staff (some part time, some full time). In rural regions, a Regional Cancer Nurse Coordinator has been employed (1 EFT).

A comprehensive service mapping process to identify service strengths and gaps has been undertaken. These data have informed the development of a three year Cancer Services Plan for each ICS, which were submitted to DHS in December 2005.

The ICS are establishing local collaborating tumour groups (LCTGs), and have each selected priority tumour streams for their initial focus. This has involved the identification of clinical leaders for each tumour group and a process for the group to advise on and implement the Patient Management Frameworks (championed by the Ministerial Taskforce for Cancer). Tumour groups will provide opportunities for clinical networking, multidisciplinary team development and service development with a tumour specific focus.

2. What have been the major stumbling blocks?

The configuration of some of the ICS has been challenging, with groupings based on geography and population size rather than pre-existing relationships between health services. In some cases, long-standing competition between health services initially constrained the early formation of good relationships. These issues have now been largely overcome, and ICS Executive Groups are beginning to take up their roles in cancer planning and service improvement.

The authority and accountability of the ICS has been a big issue, with emerging tensions between the status of ICS decisions versus the directions of individual health services within ICS. The reasons for this include competing organisational priorities and pressures on health services, and the variable commitment of stakeholders to the development of a new and sustainable system model in cancer. It also relates in part to the lack of clarity about the permanency of funding for ICS, which has now been resolved (see question 4). Strong clinical and managerial leadership, capable of reaching across organisational boundaries is essential if the ICS model is to flourish. The authority and accountability of ICS will be strengthened in the near future through the establishment of a new Victorian Integrated Cancer Services Committee. This high-level group will oversight state-wide ICS activities and directions, and will include health service executive level and senior clinical representation.

3. What do you believe will be achieved during the next 12 months?

The next twelve months will see:

- The establishment of the local collaborating tumour groups (LCTGs) in the priority tumour streams, with translation to other tumour streams. This will initially involve examination of the service mapping data against the patient management frameworks (PMFs), identification of gaps and the prioritisation of service improvement initiatives to be implemented.
- Monitoring implementation of initiatives and outcomes
- Achievement of agreements between health services and health care providers for the provision of the multidisciplinary (MD) approach to cancer care. This will include an increase in MD team formation, MD meetings, development of team protocols and commencement of multidisciplinary team and meeting audit processes.
- Utilising the PMFs, LCTGs will determine agreed optimal referral pathways in priority tumour streams in their ICS, including the communication mechanisms required between the treatment team (including GP) and the patient.

- The development of multidisciplinary psychosocial and supportive care networks to scope the requirements for a coordinated and collaborative supportive care service within the ICS. This may include identification of referral pathways, determination of protocols to ensure appropriate referral and access, supportive care training for cancer teams, implementation of mentoring and supervision programs across the ICS, shared appointments etc.
- Commencement of a statewide quality framework that will support service delivery and improvement via tumour streams.

4. It is clear that the funds provided by the ICS programs are non-recurrent and intended for development work. Many BSEP initiatives (supported by similar non-recurrent project funds) have resulted in innovations that no longer exist due to lack of continued funding, because of no ongoing funding by health services. How do you plan to prevent this from happening with the ICS process?

The ICS acknowledge the need to implement service improvements across the system and patient pathway to achieve coordinated quality care. They have also identified that certain ongoing core service improvement roles are critical to ensuring sustainable change and continuing engagement and commitment of key stakeholders.

The Minister for Health has recently approved a package of recurrent funding for ICS, which includes funding to support:

- ICS leadership and management
- Tumour stream development (including the capacity to fund sessional payments for the lead clinicians in each tumour stream)
- MD care coordination and development
- Initiatives to improve coordination of care.

Funding allocated against these items in 2006–07 is \$1.2 million per metropolitan ICS and \$0.77 million per regional ICS (Total metropolitan ICS=\$3.6 million, total regional ICS = \$3.85 million).

In addition, in 2006–07 the ICS will receive development funds of \$0.25 million (each metro ICS) and \$0.18 million (each regional ICS) to support quality improvement and the development of psychosocial and supportive care models.

DHS will continue to discourage ICS from utilizing their change management funds to plug service delivery gaps (such as core nursing or medical staff), which would yield minimal service development and improvement outcomes. For example, the conversion of the metropolitan ICS funding to WIES would equate to approximately 470 WIES to be distributed across a number of health services. Instead, ICS are being encouraged to utilise their program funds:

- To identify opportunities for service improvement
- To engage health service management in the review and allocation of core inpatient and outpatient funding for cancer services
- To develop evidence for funding requirements to address gaps in services.

5. It appears that much of the involvement of medical staff in the ICS program is expected to be donated. What is being done to redress this situation?

There are considerable time and management pressures on specialist cancer clinicians. This is particularly evident in regional Victoria where there are limited numbers of medical and radiation oncologists and supportive care oncology workforce to meet increasing demand. In addition, in rural and regional Victoria the majority of surgeons are generalists rather than specialists. The capacity of Regional ICS to establish tumour specific LCTGs is limited, and in some regional ICS one clinical reference group has been established to undertake the work of a LCTG across a number of tumour streams. The ICS have clearly indicated a requirement for funds to support tumour stream development, including project staff to implement service improvement initiatives and remuneration for lead clinicians. Following concerns raised by ICS on their capacity to support the ongoing work of the LCTGs, each ICS will receive recurrent funding from 06/07 specifically allocated to address the above issues.

6. What is being done to support the provision of basic care to patients (which is clearly considered to be inadequately funded in many situations) to allow clinicians to participate in projects looking at “adding the icing to the cake”?

Improving the provision of basic care to cancer patients is at the heart of all cancer reforms. The ICS initiatives aim to improve service provision through four key outcome areas: implementing MD care, improving care coordination, addressing psychosocial and supportive care needs and reducing variations in care.

The PMFs, which are guides to consistent care, will enable clinicians across the state to review how they can contribute to ensuring that cancer care and delivery of cancer services are coordinated, multidisciplinary, high quality, accessible and equitable for all Victorians with cancer.

The identification of gaps in service delivery will enable quantification of the need for service redesign and additional resources, including the case for further funding.

7. How is the Victorian Cancer Agency expected to contribute to cancer research in Victoria?

The new Victorian Cancer Agency has been funded to build research capacity and to connect research and clinical services through collaborative cancer research networks.

The key functions of the agency are:

- To build and fund cancer research capacity across Victoria, including the development of a comprehensive translational research program.
- To align cancer research and cancer services, and to connect clinical academic and cancer research organisations through the development of collaborative cancer research networks and clinical trials capacity. The networks will comprise of ICS, research institutes, universities and peak bodies such as the Cancer Council of Victoria.

- To fund and coordinate cancer research development and innovation, including support for new platform technologies and research and development functions such as the Victorian Cancer Research Tissue Bank and the new Australian Cancer Grid.

Establishment of the new Victorian Cancer Agency will commence in 2006–07. The Agency will work closely with ICS to provide a clear alignment between cancer research and cancer services and to foster translational research.

8. Are there plans to provide recurrent funding for MD care and co-ordination of care for health services? Are these to be earmarked for this purpose?

MD care has been a key focus for the ICS and is internationally recognised as best practice for treatment planning and care of cancer patients. The Cancer and Palliative Care Section has developed a MD care toolkit for use by the ICS, and a MD care policy is being developed in consultation with the ICS. Metropolitan ICS have used some of their funding to purchase essential equipment to support MD care development.

From 2006–07 the ICS will be provided with recurrent funds to support MD care development. The Australian Government, through the Australian Better Health Initiative is to introduce an MBS item for multidisciplinary meetings in November this year.

The development of information/data systems to support clinical management of patients including MD care is being progressed through the proposed appointment of a consultant to scope the issues and needs of ICS, for consideration by the Ministerial Taskforce for Cancer.

Recurrent funds have also been made available to the ICS to support care coordination. Care coordination is seen as requiring a whole of system approach that incorporates the system, health service, team and individual health provider and consumer levels, not just the development of care coordination roles. This multifaceted approach recognises the inherent interface of care coordination with other priority areas and strategies including MD care, the

development of routine psychosocial assessment, clinical protocols, referral pathways and information provision. A policy on cancer care coordination is being developed in consultation with the ICS.

9. What is envisaged for the ICS in the future: is this structure to be a continuing agency for cancer care, or like BSEP, a short term body expected to effect change?

Cancer reforms in Victoria are not a short-term strategy. It is recognised that changes as significant as these will take considerable time to establish and embed into practice. The recurrent funding that has been approved supports this premise and it is envisaged that the ICS will remain the infrastructure to enable delivery of the cancer reforms.

Establishment of a Victorian ICS Committee is being proposed. The Committee will provide a mechanism to provide a consistent statewide approach to cancer reform, and strengthen ownership and leadership of the cancer reform process at a local and statewide level. It will also foster decision making and working across organisational boundaries and over time will allow the ICS to develop as the key planning and decision making bodies for cancer services delivery in their geographic regions.

10. Are there any plans to change the mechanisms for funding of cancer care?

A number of options have been proposed about the longer term mechanisms for funding cancer care including possible per capita payments to support best practice and options for ICS fund holding for chemotherapy or other specified treatments. Review of options for funding reform will continue to be progressed in the context of the impact of such changes on the broader health funding system, although no early changes to current policy are anticipated.

However the DHS has been conducting a cost weights review in radiotherapy and chemotherapy. In radiotherapy the cost weights review will inform on requirements for updating the weights to reflect changes in technology and

practice since the model was implemented in 1998. It will also advise on how funding for the Single Machine Unit Radiotherapy services in Ballarat, Bendigo and Traralgon could be mainstreamed. Services will be expected to shadow fund against the new cost-weights in 2006–07, with a view to their implementation in 2007–08.

In chemotherapy, a number of recommendations have been made regarding funding reform. Further consideration of these proposals is required, with any changes to be made to the existing funding for chemotherapy likely to be several years away.

11. What is planned for the provision of appropriate psychosocial care for cancer patients, which is very poorly provided at present?

Assessment of psychosocial and supportive care needs, along with timely referral and access to psychosocial and supportive care services, have been identified as areas of significant concern across the State. The limited number of existing dedicated and skilled personnel necessitates the development of a broader and multifaceted approach that incorporates staff training in assessment of need and the development of referral pathways and protocols – both of which are linked to the implementation of the Patient Management Frameworks (PMFs). Detailed service mapping will enable identification of service provision gaps and areas in need of improvement.

A staged approach to addressing all interlinked factors impacting on the provision of timely and appropriate psychosocial and supportive care will support the development of sustainable and supported service delivery models to meet the needs of patients, carers and health professionals. This will be undertaken at both the state-wide and ICS level.

12. How is the DHS planning to provide appropriate data collection mechanisms? Does the DHS support the development of a statewide (and ideally national) data collection system? What is being done to facilitate a coordinated approach?

The DHS recognises the challenges faced by the ICS regarding the lack of a statewide data collection system and the pressing need to develop such a system for quality improvement, to facilitate multidisciplinary and continuity of care, to better support research and population initiatives and assist clinicians in their management of cancer patients.

The Victorian Cancer Outcomes Network (VCON) is an initiative of the Ministerial Taskforce for Cancer and Cancer Council Victoria to trial and develop systems for the statewide collection of the NCCI Clinical Cancer Core Dataset (CCCD). The system is currently being piloted at RWH and Barwon Health.

Through the Data and Information Workshop and Cancer Service Plans, health services and ICS have identified major cancer data and information issues. It was identified that a system is needed to improve clinician access to patient data to support clinician decision-making and facilitate:

- Information management of MD care, including documentation of MD meetings and recommendations.
- The clinical management of cancer patients
- Timely feedback from data systems to clinicians
- Identification of common practices and treatment pathways
- The provision of data for existing and future research and public health initiatives.

The DHS is working with ICS and the Ministerial Taskforce For Cancer to progress the work required to ensure the development of a state-wide system to address the above issues.

A national approach to data collection, analysis and usage may become possible through the establishment of Cancer Australia.

Unexpected Long-Term Survival After Palliative Radiotherapy

Description of a scientific study and how it was misrepresented by a section of the press

Associate Professor Michael Mac Manus
Radiation Oncologist
Peter MacCallum Cancer Centre

My colleague, David Ball established an enormous prospective database for lung cancer patients at the Peter MacCallum Cancer centre. Details of all patients were recorded and their treatments and outcomes were documented. Surviving patients in the database had been followed up for more than 10 years when I thought that it would be interesting to find out the percentage of long term survivors after palliative radiotherapy. Patients treated with palliative radiotherapy for non-small cell lung cancer formed the largest group in the database and it was known that a few at least had become long term survivors after a treatment that was intended only to relieve symptoms in "incurable" cases. We found that about 1% of the patients survived for 5 years and many of the 5-year survivors appeared to have been cured, many

surviving for a further 5 years without evidence of relapse of their disease. These results were very interesting to us and showed that even in such apparently hopeless cases a tiny glimmer of hope could be given. We wrote up our results and they were published in the journal *Cancer* (1). The abstract of our paper is included below.

In our paper we stated that *"Our data indicate that a chance for prolonged survival and possibly even cure exists for approximately 1% of patients with NSCLC who receive palliative RT. This is a very small proportion, but lung cancer is a very common malignancy. It is important that the frequency of this phenomenon should be appreciated, so that claims of apparent cure by novel treatment strategies or even by unconventional medicine or faith healing can be*

ABSTRACT

Background: Many experienced oncologists have encountered patients with proven non-small cell lung cancer (NSCLC) who received modest doses of palliative radiotherapy (RT) and who unexpectedly survived for > 5 years; some were apparently cured. We used a very large prospective database to estimate the frequency of this phenomenon and to look for correlative prognostic factors.

Methods: Patients with histologically or cytologically proven NSCLC, treated with palliative RT to a dose of 36Gy, were identified from a prospective database containing details of 3035 new patients registered from 1984–1990.

Results: An estimated 1.1% (95% confidence interval, 0.7–1.6%) of 2337 palliative RT patients survived for 5 or more years after commencement of RT, including 18 patients who survived

progression-free for 5 years. Estimated median survival was 4.6 months. Five-year survivors had significantly better Eastern Cooperative Oncology Group performance status at presentation than non-5-year survivors ($P=0.024$) and were less likely to have distant metastases ($P=0.020$). RT dose did not appear to be a significant prognostic factor. Patients who survived 5 years without progression had an estimated 78% probability of remaining free from progression in the next 5 years.

Conclusions: Approximately 1% of patients with proven NSCLC survived for > 5 years after palliative RT, and many of these patients appeared to have been cured by a treatment usually considered to be without curative potential. Because of the potential for long-term survival, doses to late-reacting normal tissues should be kept within tolerance when prescribing palliative RT in NSCLC.

seen in an appropriate context". The public relations team at *Cancer* also thought that the article could be of wide interest and produced a press release to coincide with electronic publishing of the article in January 2006. To our surprise and pleasure our article was widely reported in the press in Australia and overseas and appeared on many internet news services.

Unfortunately a report of our paper appeared that caused us serious dismay. I first became aware of it through the Internet site of the *Belfast Telegraph*, a paper published in my hometown. That article was a secondary publication of an article that originally appeared in the London *Independent* newspaper, apparently written by their health editor Jeremy Laurence. In our paper we could not explain the survival of our patients but suggested that unusual radiosensitivity could play a part. We went out of our way to say that we thought that natural causes were involved, so that *"claims of apparent cure by novel treatment strategies or even by unconventional medicine or faith healing can be seen in an appropriate context"*. Imagine our surprise to see our paper described in the *Independent* as follows"

"Miracle" Cures Shown to Work

Doctors have found statistical evidence that alternative treatments such as special diets, herbal potions and faith healing can cure apparently terminal illness, but they remain unsure about the reasons.

A study of patients with incurable lung cancer who were given weeks to live and received only low-dose radiotherapy to make their final weeks more comfortable found a small number recovered completely.

Researchers who followed 2,337 patients whose disease was too advanced for curative treatment found that 25 had survived five years and 18 had achieved "an apparent cure". They appeared to have been cured by treatment that "would not normally be considered to have any curative potential whatsoever".

The researchers, led by Michael Mac Manus, a consultant radiation oncologist in Melbourne, say:

"... Unorthodox cancer cures have included vitamin C, laetrile extracted from apricot stones, and the Gershon diet of raw vegetables ..."

My name was being used to support quackery in an article in a highly respected London newspaper! A search on the internet soon revealed that many other sites had taken up the *Independent* article as the long sought after proof that alternative medicines can cure cancer. The sites that reported the *Independent* version of our paper included "unexplained mysteries.com". More embarrassingly it was discussed by the *BMJ* UK health news where it was (and still is) stated that *"The Independent is the only national newspaper to report the news that Australian researchers have found evidence that alternative treatments such as herbal potions and faith healing can cure terminal illness"*. Thank goodness no other papers reported it in that way!

I received emails from a number of outraged scientists around the world and sent an email to Jeremy Laurence, author of the *Independent* article. No reply. Subsequently I sent a letter to the editor of the *Independent* that was published in an amended form, noting that we had in fact made no claims about alternative medicines in our paper. After further contact through legal representatives, the *Independent* removed the article from their website and printed a retraction that blamed errors in production (!) for the inaccuracies in the article. Not a very satisfactory outcome given that inaccurate versions of the *Independent* story are still carried on a range of sites on the Internet and there is no retraction currently on the *Independent* website to contradict them. These articles give support to unproven and potentially dangerous "therapies" for cancer and still represent a danger to vulnerable members of the public seeking effective treatments for their cancers. It has been very surprising to me to see how a respectable newspaper can produce an article that states the opposite of the truth and to see how much effort is required to even partially correct the record for posterity. How many inaccuracies go uncorrected?

Reference

Mac Manus MP, Matthews JP, Wada M, Wirth A, Worotniuk V, Ball DL. Unexpected long-term survival after low-dose palliative radiotherapy for non-small cell lung cancer. *Cancer*. 2006 Mar 1; 106(5): 1110-6.

Report of the 42nd American Society of Clinical Oncology (ASCO)

2-6 June 2006, Atlanta, Georgia, USA

*Dr Shane White
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Adjuvant Therapy

From a practice-changing perspective, the biggest grounds were made in adjuvant therapy. Previous studies (IALT, JBR10, ANITA) had established the proof of principle. It was reassuring however to see the results of the LACE meta-analysis (Abstract #7008). Combining the results of recent studies (ALPI, IALT, JBR10, ANITA, BLT, an 11% reduction in the risk of death was noted (HR 0.89 P=0.04). At 3 years an absolute benefit of 3.9% was noted, which increased to 5.3% at 5 years. A subgroup analysis also suggested the benefit was confined to stage II and III.

This supports the subgroup analyses performed in ANITA and JBR10 that demonstrated no convincing benefit for stage IB patients. The better adjuvant regimen appeared to be cisplatin and vinorelbine rather than regimens using etoposide or older generation vinca alkaloids. It should be noted that the cisplatin doses in these positive studies were consistently higher than 300 mg /m² and therefore it is not clear whether the benefit is due to vinorelbine, cisplatin dose-intensity or a combination thereof.

Where does that leave the results of CALGB 9633? This study assessing adjuvant paclitaxel and carboplatin was originally presented at ASCO 2004 and demonstrated a statistically significant survival advantage at 4 years. The longer-term results were presented at ASCO 2006 and there is now NO longer a survival advantage although the DFS remains statistically significant (Abstract #7007).

I think it would be reasonable to include that cisplatin and vinorelbine is a standard of care in all fit appropriate patients with resected stage II and III disease. Carboplatin-based regimens are

unproven and stage I patients should not be routinely offered adjuvant chemotherapy. Whether other factors such as lymphovascular invasion assist us in identifying a higher risk stage I patient remains a matter of conjecture.

Predictive and Prognostic Factors

Another abstract (Abstract #7026) gives us hints that we may in future be able to identify high risk patients who should be considered for adjuvant therapy. A multiple-gene profile ('metagene') was initially tested in 89 patients and then subsequently validated in independent validation sets (including populations from 2 cooperative group studies).

The profile was used to develop a model of recurrence that performed significantly better in predicting prognosis than T size, nodal status, age, gender and smoking status. As an example, in stage IA, the good prognosis group (as defined by the Lung Metagene Model') and the poor prognosis group had 5 year survivals of 90% and 20% respectively!

A study of stage I patients is planned where good prognosis patients are observed (current standard of care) and poor prognosis patients are randomised to no treatment or adjuvant chemotherapy. How such a study might be accepted in the US (despite the lack of data for adjuvant therapy in Stage I disease) remains an open question.

Some interesting data from the IALT study were presented (Abstract #7010). Tissue from 600/1867 patients was analysed retrospectively with immunohistochemical analysis for the presence of ERCC1. The molecule has a critical role in nucleotide excision repair which allows repair of damage from agents such as cisplatin.

High levels have previously been associated with cisplatin resistance. In this study, ERCC1 negative patients who received adjuvant cisplatin-based chemotherapy had a 37% reduction in the risk of death compared with patients in the no treatment arm. In ERCC1 positive patients, there was no evidence of benefit with chemotherapy. Interestingly, ERCC1 positivity in the observation group was associated with a better prognosis than patients with ERCC1 negative tumours.

Another candidate predictive factor may be RRM1, a regulatory subunit of ribonucleotide reductase. Some preliminary data have shown improved outcomes for advanced disease patients with low RRM1 levels treated with gemcitabine. Abstract #7054 examined its predictive role in relation to response to a gemcitabine-based neoadjuvant therapy in stage I/II disease. It was found that higher levels of RRM1 were associated with a significantly greater likelihood of response to treatment.

Previously studies in advanced disease have shown a relationship between patients with high levels of expression of β tubulin III and lower response rates to vinorelbine and poorer survival. Abstract #7051 retrospectively examined tissue for the presence of level of β tubulin III in 205 / 482 blocks from the JBR10 adjuvant study (JBR10 patients received cisplatin-vinorelbine). Beta-tubulin unfortunately was not shown to be a predictive factor but high levels did seem to point to a poorer outcome with or without treatment.

There is arguably an even greater imperative to develop predictive factors for responses to biological / targeted therapies in order to limit the tremendous cost to the community. There are much recent data on predictive factors for EGFR-TKI therapy such as EGFR over-expression (IHC) or high gene copy numbers of EGFR. Confirmatory data are clearly required, potentially from studies such as the SATURN study (maintenance erlotinib post chemotherapy).

Bevacizumab is a monoclonal antibody directed against the vascular endothelial growth factor receptor (VEGF-R), and acts as an anti-angiogenic agent. ECOG 1599 previously demonstrated that the addition of bevacizumab to carboplatin-paclitaxel in non-squamous NSCLC resulted in a survival advantage. A prospectively planned analysis of potential predictive markers was performed (lots of "P's!") including an analysis of ICAM-1 levels. ICAM-1 (Inter-Cellular Adhesion Molecule 1) is transmembrane glycoprotein that is expressed in a number of tissues including endothelial cells. The conclusion was that low baseline ICAM1 levels predicted for response and survival benefit in patients treated with the PCB combination.

This clearly is the way forward in oncology. We need to be better able to develop more sophisticated prognostic factors than existing clinical criteria (TNM), and therefore avoid toxic and expensive therapies in patients with a low risk of relapse and little to gain from extra treatment. Predictive factors such as ERCC1 may allow use to tailor our therapies better.

Translation From Research to Clinical Practice: Addressing the Supportive Care Needs of People with Lung Cancer

Mary Duffy

Nurse Coordinator, Lung Service
Peter MacCallum Cancer Centre

Evidence indicates that health care professionals consistently underestimate or overlook the needs of patients diagnosed with cancer. Given the short duration of survival of patients with lung cancer, ensuring that their needs are appropriately identified and addressed, is of paramount importance to prevent unnecessary distress and improve patient outcomes.

Few studies have explored lung cancer patients' perceptions of the help or support they need to live with their disease. A high level of unmet needs indicate that research findings have not been translated into improving clinical practice.

I would like to share with you an organisational initiative to address the needs of people with lung cancer drawing on our current practice in Peter Mac from a quality improvement project perspective.

With the increasing complexities of mixed modality therapies offered to patients with lung cancer self-navigation of the illness journey has become more complex for patients and families. At Peter Mac, care is organised around 11 clinical streams based on tumour diagnosis. One way in which we at Peter Mac have attempted to address this need has been to appoint a Nurse Coordinator (NC) to each of our tumour streams. Quality improvement involves a cycle of assessment → plan → act → review. This project, which included the introduction of the lung nurse coordinator (NC) role, has seen a number of changes introduced as part of the ongoing review of the service.

The rationale for the introduction role of the NC included the need for a clinician to be:

- Positioned to provide continuity of care. Within the lung service, the NC acts as the lynch pin around whom the team, the patient,

and the family revolve. The NC will assist plan, develop and coordinate a care pathway from diagnosis to completion of treatment and on into follow up care. The NC as a clinical expert enhances team functioning and patient care by early detection of symptoms, treatment side effects, and appropriate referral to medical and allied health staff.

- Easily identifiable resource. Provides support tailored to the individual patient or family based on detailed and ongoing assessment of physical and psychosocial needs.
- Facilitate individualised care. Communication re treatment, prognosis and the delivery of targeted self-care information is a major focus of the NC role – addressing many of the unmet needs as identified in the literature.
- Integral part of the team. Information regarding supportive care initiatives is communicated to the medical team at weekly review meetings.
- Provide anchorage for care process. The NC has more contact, in terms of time, with the patient and family than any other member of the MDT. This contact is established at diagnosis and remains a supportive influence through staging, diagnostics, surgery, RT, chemo and follow-up, including palliation.

Implementation of systematic approach to identifying supportive care needs

A search of the electronic databases Medline, CINAHL and Psychinfo using key terms including lung cancer, met and unmet needs and supportive care revealed 38 papers which met specific inclusion criteria for this project. Almost all papers retrieved were descriptive surveys, mixed method and qualitative studies. Of these 38 papers only 11 related specifically to patients

with lung cancer. Publications were limited to the English language spanning from 1980–2005.

Key findings from a literature review indicated that:

- lung cancer patients report more unmet psychosocial concerns than patients with other cancers (Houts 1986); and
- lung cancer patients' psychological concerns are more worrying than physical symptoms but less likely to have been addressed by health professionals (Hill et al 2003).

Following the introduction of the Nurse Coordinator (NC) role, an identifiable resource to facilitate individualised care and provide continuity of care it became obvious that the research findings matched the clinical findings at Peter Mac. The plethora of physical and psychosocial needs experienced by patients with lung cancer required prompt identification and effective response.

In response to the assessment of a need for early and routine identification of supportive care needs in the lung service the Supportive Needs Screening Tool (SNST) was developed. The SNST is a patient self completed questionnaire that considers 6 domains of care – communication, physical, support and coping, emotional, information and activities of daily living.

The tool was developed by an interdisciplinary team of clinicians and researchers at Peter Mac and is currently undergoing psychometric evaluation. The NC as a routine part of initial assessment of all new patients at presentation to the hospital supports patients to complete the screening tool, encouraging patients to reflect on their needs, and planning appropriate referrals in a timely manner. The NC uses the responses provided by the patient to undertake a focused interview to review the options or strategies available to best address needs identified and discuss with the patient the decisions made in response to *their* preferences.

Research has confirmed the need for a multi-disciplinary approach as evidenced by Krishnasamy et al. (a 2001) whose study indicated that lung patients (n= 209) have complex inter-related situational and personal needs including the lack of assistance in managing daily life on discharge, unmet

emotional needs, and lack of coordinated care. The needs of lung patients (n=40) reported in two broad categories by Murray et al. (2002) were:

- living with illness; and
- service provision.

A further study by Krishnasamy et al. (b 2001) of lung cancer patients (n=60) identified the needs in 11 categories within 4 key domains:

- communication of diagnosis
- treatment options and prognosis
- provision of coordinated, family-orientated care
- support away from acute services.

These studies strengthen the need for a multi-disciplinary approach to provide patient centred care. Patients may meet clinicians from as many as six or seven different professional teams within the first week or two of diagnosis. The lung NC's role to provide continuity of care and to provide anchorage for the care process, highlighted the need for change in the clinical setting in order to meet the needs of the lung patients and families identified in the multiple domains.

Further strategies introduced to enhance the multi-disciplinary service provision included:

- The instigation of formal, regular weekly multi-disciplinary team meetings of the nursing and allied health team involving a structured approach to patient review and the establishment of terms of reference for the meeting – Supportive Care Ambulatory Lung Service Meeting.
- Patients being made aware that information shared with the NC is presented at these weekly meetings ensuring that the patients voice is included in care and treatment decision making.
- The discussion of supportive care needs in addition to the cancer treatment planning at the existing patient clinical multi-disciplinary team meetings.
- The review of criteria for referral of patients and families to the allied health services
- Audit of the data from SNST used to guide further research in supportive care for patients with lung cancer.

Thus, supportive care needs of lung patients remains high on the agenda of all clinicians and ensures that care is delivered within the context of inter-disciplinary / multi-disciplinary teams dedicated to the delivery of patient-focused care. These changes have become part of routine clinical practice with documentation to encourage sustainability of the changes.

In conclusion, the research findings have supported the need for change in clinical practice. The resultant changes that have occurred have been responsive to gaps in service provision and have been at the organisational, clinician and patient level.

The introduction of changes including the Nurse Coordinator role, the Supportive Needs Screening Tool and enhanced multi-disciplinary communication processes have improved the coordination and provision of supportive care services to people with lung cancer. These activities are an important step in translating research into clinical practice. As part of the

quality improvement cycle there is a requirement for ongoing review and evaluation of these changes – an ongoing challenge!

References

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- Houts PS, Yasko JM, Kahn SB, Schelzel GW, Marconi KM. (1986) Unmet psychological, social, and economic needs of persons with cancer in Pennsylvania. *Cancer*, 62: 627-634.
- Krishnasamy M, Wilkie E, Haviland J. (2001) Lung cancer health care needs assessment: patients' and informal carers responses to a national mail questionnaire survey. *Palliative Medicine*, 15: 213-27.
- Krishnasamy M, Wells M, Wilkie E. (2001) Lung cancer health care needs: A longitudinal, follow-up interview study. Chief Scientist Office. Final Study Report.

The Sir Edward Dunlop Clinical Research Fellowship

This Fellowship is named in memory of Sir Edward 'Weary' Dunlop (1907-1993) to mark his contribution to Australia and, in particular, to the work of The Cancer Council Victoria.

The Dunlop Fellowship is the third prestigious Cancer Council fellowship recognising Sir Edward. It has been awarded to Associate Professor Grant McArthur who is Consultant Medical Oncologist, Head of the Translational Research Group and Head of the Molecular Oncology Laboratory at the Peter MacCallum Cancer Centre.

Dr McArthur's fellowship research program involves the development of targeted therapies for cancer. He will work on three different streams of research concurrently.

These streams of research all relate to the development of new treatments for cancer and encompass understanding the fundamental biology of the target and integrating this with

strategies to clinically develop novel targeted therapeutics. Dr McArthur's will also continue his clinical practice as a medical oncologist, specialising in targeted therapies and his work with patients will complement and enhance his research.

The Fellowship is for 5 years and commenced in January 2006. It will provide over \$700,000 to Peter MacCallum Cancer Centre to cover the fellowship salary and overheads as well as a conference travel allowance and research infrastructure support.

The overall aims of the fellowship are to develop and support medical researchers undertaking a program of clinical research and to provide the fellow with the mentorship and research environment to further develop their careers as leaders in cancer research.

The funding for these fellowships has been made available due to the generous donations from the Victorian public.

The Dunlop Fellowship: Development of Targeted Therapies for Cancer

*Associate Professor Grant McArthur
Sir Edward Dunlop Clinical Research Fellow
The Cancer Council Victoria*

The development of imatinib and trastuzumab have changed the paradigm for the systemic therapy of cancer. Targeting specific molecular abnormalities in human cancer by identifying genomic abnormalities that activate oncogenes such as c-ABL, c-KIT or ERB-B2 has led to dramatic results fundamentally changing the clinical course of cancer in these patients. We are now on the verge of an explosion in novel targeted therapies, however significant challenges remain to develop these therapies in a rapid manner particularly identifying patients that will get greatest benefit from these costly therapies.

With the generous support of The Cancer Council Victoria's Sir Edward Dunlop Clinical Research Fellowship, my research program will encompass:

- Novel applications of targeted therapies to the treatment of neoplasia;
- The use of positron emission tomography in monitoring response to targeted therapies; and
- Development and application of biomarker assays to predict response to targeted therapies.

Novel Applications of Targeted Therapies to the Treatment of Neoplasia

A major goal of my teams research program is to develop novel applications of targeted therapies for both common and less common malignancies. The overall approach is not disease focused, but rather is focused on the target and the application targeted therapies to a variety of diseases. As such the research program encompasses both haematological malignancies and solid tumours.

Although targeting oncogenes that are protein kinases that harbour activating mutations has

been highly successful, there a number of other interesting targets are not directly mutated that hold promise. For example agents that inhibit the vascular endothelial growth factor receptor have shown significant activity in renal cell cancer although the target is not mutated. This approach of identifying pathways important in cancer and targeting molecules that modulate activity of the pathway is a potential new application of targeted therapies.

Targeting c-MYC and Ribosome Biogenesis

High levels of protein synthesis characterize malignant cells, particularly tumours with dysregulated expression of the oncogene c-MYC. We have shown that the mTOR-inhibitor rapamycin can inhibit global protein synthesis, promoting cell cycle arrest and cell differentiation. Interestingly the c-MYC oncoprotein is selectively reduced in response to rapamycin and further research efforts will focus on combining rapamycin analogues with other agents to reduce activity of c-MYC.

Targeting DNA damage responses

The activity of both cytotoxic chemotherapy and ionising irradiation in malignant disease is dependent on altered checkpoint responses of malignant cells when compared to normal cells. We specifically hypothesise that further modulation of checkpoint responses through the use of agents that target checkpoints will enhance the response of malignant cells to cytotoxic chemotherapy and ionising irradiation. Two targets are being investigated: 1) CDK2 and 2) CHK1.

CDK2 is a cyclin-dependent kinase involved in the regulation of normal G1-S progression and DNA replication. However its activity is also modulated during DNA damage responses. We have demonstrated a role of CDK2 in DNA repair and that cells with loss of function of BRCA1 or

ATM display heightened sensitivity to small molecule inhibitors of CDK2. We now plan to extend these novel observations to evaluate small molecule inhibitors of CDK2 in a variety of pre-clinical models of combination with chemotherapy and irradiation.

CHK1 is a central protein kinase in regulation of the G2-checkpoint. In preclinical models we have demonstrated that a small molecule inhibitor of CHK1 modulates the G2-checkpoint following irradiation and cytotoxic chemotherapy enhancing DNA damage and increasing tumour responses.

The use of Positron Emission Tomography in Monitoring Response to Targeted Therapies

In partnership with Professor Rod Hicks our team have recently demonstrated the utility of using Positron Emission Tomography to monitor response of tumours in vivo to novel target therapeutic agents, both clinically and in animal models. Importantly our research strategy utilizes a variety of metabolic tracers that enable us to probe a number of biological process in vivo. Currently we utilise Fluoro-deoxyglucose (FDG), Fluorine-L-Thymidine (FLT), Fluoro-ethyltyrosine (FET) and Fluoro-azomycinarabioside (FAZA) to monitor glucose transport and metabolism, cell proliferation, amino acid transport and hypoxia respectively. This will have the greatest utility in the evaluation of targeted therapy agents that do not induce rapid tumour progression. This approach may significantly accelerate the development of these agents, as currently proof of biological activity of novel agents typically requires either demonstration of rapid tumour regression or improvements in longer-term clinical endpoints such as time-to-progression or overall survival.

Development and Application of Biomarker Assays to Predict Response to Targeted Therapies

One crucial component in the development of targeted therapeutics is to address whether the agent successfully modulates the target in vivo. A second key component to the development of these agents is to determine if the molecular profile of the tumour can predict response to the agent. This issue was critically important in the development of Trastuzumab in breast cancer, where only ERB-B2 over-expressing tumours responded to this agent. Therefore successful development of targeted therapeutic agents requires access to biomarker assays such as assays that assess target phosphorylation for drugs that inhibit protein kinases, or mutation analyses that predict activation of the target.

Our initial approach is to validate biomarker assays using pre-clinical models and archival tumour specimens from the Peter MacCallum Cancer Centre and in the near future the Victorian Tissue Bank Initiative. Having validated these assays we are extending these assays into clinical trials to demonstrate target inhibition and to address the hypothesis that activation of specific pathways in individual patients will lead to selective application of targeted therapeutics in subsets of patients.

Summary

The advent of targeted therapies for cancer is enabling us to use basic knowledge of the pathogenesis of cancer to develop new treatments for patients. In partnership with my basic and clinical research colleagues and our patients in Victoria, Australia and overseas we are entering an exciting new phase in the battle against cancer.

Clinical Oncological Society of Australia (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. Key activities include:

Annual Scientific Meeting (ASM)

The AH&MR Congress, site of this year's COSA ASM, continues to gain momentum. The impressive confirmed speaker list now exceeds 150 speakers and many of them are speaking on cancer related topics.

Specifically within the COSA program, there is the normal range of symposia and sessions meeting the wide range of needs of the membership. We are in process of confirming the international speakers and COSA program. A draft program will be posted on the COSA website shortly. Please note this year's meeting will be held at the Melbourne Convention Centre, November 29-1 December. There will be a Consumer Forum held on Tuesday 28 November.

Professional Development Packages for Cancer Professionals

The Commonwealth DoHA called for tenders late in 2005 to look at educational needs of cancer health professionals. A consortium involving Centre for Innovation in Professional Health Education (CIPHE), COSA, TCCA, NBCC, and the RACGP successfully tendered for Phase 1 of the project, scoping current cancer professional development resources and associated needs of cancer professionals, GPs and counsellors.

A reference group is guiding the project, which includes an online survey targeting relevant professionals.

COSA Enabling Grant

Working parties have been convened to make recommendations about how to allocate funds for each component of the grant:

- Protocol Development, Information Systems and Quality Assurance. Scoping exercises for each component are in progress. The protocol development working party has developed its recommendations and will be reviewed by the Steering Committee in due course.
- Executive Committee has been established to oversee the work of this grant and meet more frequently than the Steering Committee. Members include: Dr Steve Ackland, Chair, Professor Alan Coates, CEO TCCA, Ms Haryana Dhillon, Project Coordinator, Ms Margaret McJannett, EO, TCCA / COSA, and Dr John Seymour and Associate Professor Martin Stockler.
- Responses have been made on behalf of the Cooperative Groups through COSA to NSW Health regarding the Policy Directive on Clinical Trials – Risk Management, Insurance and Indemnity, and to the Cancer Institute NSW regarding Streamlining of Ethical Review of Cancer Research in NSW.

Alan Coates Honoured for Scientific Leadership

COSA joins the chorus of clinicians and health professional groups congratulating Professor Alan Coates for winning the prestigious Distinguished Service Award for Scientific Leadership, bestowed by the American Society for Clinical Oncology (ASCO). We have particular reason to celebrate, as ASCO is our US counterpart and the conferring of this award on Professor Coates, a member of our Executive, builds on the already strong relationship between our two organisations.

We are fortunate that Professor Coates will remain active within COSA and in cancer research after he retires from his Cancer Council Australia career later this month.

Reprinted from Wongi Yabber May 2006; 12(2): 3.

Report of The Cancer Council Australia

Glen Turner
Communications Manager
The Cancer Council Australia

Changing of the Guard at The Cancer Council Australia

After eight years of running Australia's largest federated health charity, The Cancer Council Australia CEO Professor Alan Coates has retired and passed the baton to the former Chair of the organisation's Medical and Scientific Committee, distinguished ex-Adelaide oncologist, Professor Ian Olver.

President of The Cancer Council Australia, Mrs Judith Roberts AO, said the transition was a good opportunity to both celebrate Professor Coates's extraordinary contribution while welcoming Professor Olver as the ideal candidate to position the organisation to address the future challenges of leading national cancer control in the non-government sector.

"We are extraordinarily fortunate to have had eight years of service from a scientist, advocate and communicator of Professor Coates's calibre and then to be able to seamlessly anoint Professor Olver as his successor," Mrs Roberts said.

"Under Professor Coates's stewardship, The Cancer Council Australia has evolved into one of the nation's most important peak bodies and has influenced a major increase in commitment to cancer control at the federal government level.

"Professor Olver is ideally placed to continue Professor Coates's invaluable work and to use his own unique skills and experience as one of

the nation's leading oncologists and healthcare administrators to take the organisation forward to meet the challenges of an expected 30% increase in cancer incidence over the next five to 10 years as Australia's population ages."

"One-stop-shop" for Primary Care Cancer Resources

A new web-based directory of cancer resources for primary care professionals provides quick and easy access to national, state and territory information. The new directory, developed by The Cancer Council Australia's General Practice Committee, will provide a single access point to a range of cancer resources including guidelines and advice on prostate, breast, bowel, ovarian and skin cancer, as well as issues associated with screening and psychosocial care for cancer patients.

The directory will be updated as new resources become available or revised resources are released - ensuring that primary care professionals have access to the most current information.

The primary care resources directory can be accessed via The Cancer Council Australia website at www.cancer.org.au/primarycare.

Reprinted from Wongi Yabber May 2006; 12(2): 3-4.

The National Cancer Control Initiative (NCCI) Report

*Professor Mark Elwood
Director
National Cancer Control Initiative*

This is the last newsletter from the National Cancer Control Initiative. The NCCI is disbanding, sadly, on the 31 May 2006. Since its inception in 1997, NCCI has contributed greatly to strategic developments in cancer in Australia, and has during this process produced some 36 reports based on wide consultation, and about 75 peer-reviewed papers. NCCI conducted the largest consultation to yield a national consensus on cancer priorities, developed a practical core clinical data set, produced the first evidence-based rationale for the requirements for radiotherapy, set up implementation programs based on the lung cancer and psychosocial guidelines, developed a primary care program in cancer, and jointly produced the 'Optimising Cancer Care in Australia' report. The closure of NCCI is very regrettable, and I do not think we are being conceited if we say that this is not only unfortunate for those of us who have worked with and supported NCCI, but also for the progress of effective cancer strategies in Australia. NCCI has made a major contribution and has developed considerable expertise and resources that are highly relevant to ongoing issues in cancer care. Inevitably, much of this experience will be lost.

Our position all along has been that while we support the development of Cancer Australia as a larger and more comprehensive focus for strategic efforts in cancer, it would have been simple and inexpensive to ensure that NCCI continued until it could be incorporated into or linked with Cancer Australia in an effective way. However there has been no action to ensure linkage. Some of the NCCI staff have accepted other positions, while for others there is still some uncertainty. We are making what arrangements we can to allow some aspects of continuity, for example we are trying to ensure that the NCCI website (www.ncci.org.au) continues for a reasonable time as a portal through which people can still get access to published reports and other material produced by NCCI. A final report is being prepared for the Department of Health and Ageing.

ACN would like to thank Professor Mark Elwood and his staff for their generous cooperation with a number of projects over the last nine years and wish them well for the future.

Reprinted from Wongi Yabber May 2006; 12(2): 2.

Australian Cancer Network (ACN) Activities

Work is continuing with discussion and dissemination of Accreditation and Credentiailling documents. There will be further fine tuning necessary.

The draft Guidelines Implementation document has met with significant approval after being piloted in Victoria. Its distribution is being planned by the National Institute of Clinical Studies (NICS). The generous support of Dr Heather Buchan of NICS has been integral to progress and is appreciated by ACN.

There is to be a major meeting with NICS in October when all three documents will be featured in discussion and decision-making, which should further embed guidelines and the evidence-based approach and hopefully further eradicate unnecessary variation in practice.

Reprinted from Wongi Yabber May 2006; 12(2): 1.

ACN Management of Lung Cancer Working Party

Copies of The Assessment and Management of Lung Cancer Evidence-based Guidelines: A guide for general practitioners, and Clinical Practice Guidelines for the Prevention, Diagnosis and Management of Lung Cancer are still available from ACN. E-mail:

acn@cancer.org.au for further copies. This card is being widely requested, particularly from nursing areas and it is hoped, this interest will facilitate earlier referral of patients for specialist care.

Reprinted from Wongi Yabber May 2006; 12(2): 1.

Key Published Articles Listing—Lung Cancer

Title	Author & Journal
Unexpected long-term survival after low-dose palliative radiotherapy for non-small cell lung cancer	Mac Manus MP, Matthews JP, Wada M, et al. <i>Cancer</i> March 2006; 106(5): 1110–1116.

Key Published Articles Listing—General

Title	Author & Journal
Religious perspectives on withdrawal of treatment from patients with multiple organ failure	Ankeny RA, Clifford R, Jordens CFC, et al. <i>The Medical Journal of Australia</i> Dec 2005; 183 (11/12): 616–621.
Clinical Cancer Advances 2005: Major research advances in cancer treatment, prevention and screening – A report from the American Society of Clinical Oncology	Herbst RS, Bajorin DF, Bleiberg H, et al. <i>Journal of Clinical Oncology</i> 1 Jan 2006; 24(1): 190–205.
Promoting the implementation of best-practice guidelines using a matrix tool	Luxford K, Hill D & Bell R. <i>Disease Management & Health Outcomes</i> 2006; 14(2): 85–90.

Forthcoming Meetings

Date / Place	Meeting / Contact
30 June – 2 July 2006 Cairns, QLD, Australia	Inaugural Australian Lung Cancer Conference 2006 – <i>Multidisciplinary Care</i> - Endorsed by the IASLC and including the mid-year ALTG meeting. Secretariat: Event Planners Australia, PO Box 1280, Intermedia House, 11/97, Castlemaine Street, Milton QLD 4064 Ph: (07) 3858 5576 Fax: (07) 3858 5499 E-mail: info@alcc.net.au Website: www.alcc.net.au
8–12 July 2006 Washington DC, USA	UICC World Cancer Congress – <i>Bridging the gap: Transforming knowledge into action</i> American Cancer Society, 1599 Clifton Road, NE, Atlanta Georgia 30329-4251 USA Ph: +1 404 417 5998 Fax: +1 404 728 0133 E-mail: secretariat2006@cancer.org Website: www.worldcancercongress.org
12–15 July 2006 Washington DC, USA	13th World Conference on Tobacco or Health American Cancer Society, 1599 Clifton Road, NE, Atlanta Georgia 30329-4251 USA Ph: +1 404 417 5998 Fax: +1 101 728 0133 E-mail: secretariat2006@cancer.org Website: www.13thwctoh.org
14–15 July 2006 Adelaide, SA, Australia	9th CNSA Winter Congress Pre-conference workshop on 13 July Ph: (02) 9280 0577 E-mail: cnsa@pharmaevents.com.au Website: www.cnsa.org.au
9–12 August 2006 Sanctuary Cove, QLD, Australia	Annual Scientific Meeting of the Medical Oncology Group Australia (MOGA) MOGA Conference Secretariat c/o Pharma Events, PO Box 265, Annandale NSW 2038 Ph: (02) 9280 0577 Fax: (02) 9280 0533 E-mail: moga@pharmaevents.com.au
3–9 September 2006 Sunshine Coast, QLD, Australia	The Australia and Asia Pacific Clinical Oncology Research Development (ACORD) Workshop – <i>A Workshop in Effective Clinical Trials Design</i> ACORD Workshop, Level 6, 52 Phillip Street. Sydney NSW 2000 Ph: (02) 8247 6207 Fax: (02) 9247 3022 E-mail: mog@racp.edu.au

Date / Place	Meeting / Contact
26–29 September 2006 Montreal, Canada	16th International Congress on Care of the Terminally Ill c/o O'Donoghue & Associates Event Management, 5486 ch. de la Côte-Saint-Luc, Montréal, Québec, Canada, H3X 2C7 Ph: +1 514 481 7408 ext. 225 Fax: +1 514 481 7379 E-mail: info@pal2006.com Website: www.pal2006.com/index-e.html
27–29 September 2006 Brisbane, QLD, Australia	8th Behavioural Research in Cancer Control Conference Hosted by the Queensland Cancer Fund
27 Sep – 1 Oct 2006 Toronto, Ontario, Canada	14th International Conference on Cancer Nursing Organised by the International Society of Nurses in Cancer Care (ISNCC), Cheshire, UK Ph: +44 11 6270 3309 Fax: +44 11 6270 3673 E-mail: conference@isncc.org Website: www.isncc.org
29 Sep – 3 Oct 2006 Istanbul, Turkey	31st Annual Congress of the European Society for Medical Oncology (ESMO) ESMO Head Office, Via la Santa 7, 6962 Viganello-Lugano, Switzerland Ph: +41 91 973 1900 Fax: +41 91 973 1902 Website: www.esmo.org
4–6 October 2006 Newcastle, NSW, Australia	Biennial Conference of the Australian and New Zealand Society of Palliative Medicine (ANZSPM) Secretariat: PO Box 180, Morisset NSW 2264 Ph: (02) 4973 6573 Fax: (02) 4973 6609 E-mail: anzspm@willorganise.com.au Website: www.anzspm.org.au / www.willorganise.com.au/anzspm
8–12 October 2006 Leipzig, Germany	European Society for Therapeutic Radiology and Oncology (ESTRO) Ph: +32 2 775 9340 Fax: +32 2 779 5494 E-mail: info@estro.be Website: www.estro.be/estro/index.html
19–20 October 2006 Melbourne, VIC, Australia	NICS Using Evidence: Using Guidelines Symposium National Institute of Clinical Studies, Level 5, 499 St Kilda Road, Melbourne VIC 3004 Ph: (03) 8866 0400 Fax: (03) 8866 0499 E-mail: info@nicl.com.au Website: www.nicl.com.au / www.usingevidence.com.au
26–28 October 2006 Dunedin, New Zealand	17th Hospice New Zealand Palliative Care and Pain Society Conference Barry Woodland, Conference Innovators Ph: +64 3 379 0390 E-mail: barry@conference.co.nz Website: www.hospice.org.nz

Date / Place	Meeting / Contact
<p>26–29 October 2006 Christchurch, New Zealand</p>	<p>57th Annual Scientific Meeting of the Royal Australian and New Zealand College of Radiologists (RANZCR) Website: www.ranzcr.edu.au</p>
<p>5–8 November 2006 Bangkok, Thailand</p>	<p>3rd General Assembly Conference of the Asia Pacific Organization for Cancer Prevention (APOCP) – <i>Empowering cancer prevention in the Asia Pacific</i> Asia Pacific Organization for Cancer Prevention (APOCP), Nagoya, Japan Ph: +66 1 809 7664 Fax: +66 2 955 9986 E-mail: ktajima@aichi-cc.jp Website: www.apocp.org</p>
<p>5–9 November 2006 Philadelphia, Pennsylvania, USA</p>	<p>48th Annual Meeting of the American Society for 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</p>
<p>7–10 November 2006 Prague, Czech Republic</p>	<p>18th International Conference on Molecular Targets and Cancer Therapeutics Jointly organised by EORTC, NCI and AACR. EORTC-NCI-AACR Conference secretariat, Federation of European Cancer Societies, Avenue E. Mounier 83, B-1200 Brussels Ph: +32 2 775 02 01 Fax: +32 2 775 02 00 E-mail: ENA2006@fecs.be Website: www.aacr.org</p>
<p>29 Nov – 1 Dec 2006 Melbourne, VIC, Australia</p>	<p>33rd Annual Meeting of the Clinical Oncology Society of Australia (COSA) COSA Office, Medical Foundation Building, Level 5, 92 Parramatta Road, Camperdown NSW 2011 Ph: (02) 9036 3100 Fax: (02) 9036 3101 E-mail: cosa@cancer.org.au Website: www.cosa.org.au</p>
<p>29 Nov – 2 Dec 2006 Venice, Italy</p>	<p>13th Congress of the European Society of Surgical Oncology (ESSO) ESSO 2006 Conference secretariat, Federation of European Cancer Societies, Avenue E Mounier 83, B-1200 Brussels Ph: +32 2 775 0205 Fax: +32 2 775 0200 E-mail: ESSO2006@fecs.be Website: www.fecs.be</p>

Cancer Council Events Calender

AUGUST


- 25 Volunteer on Daffodil Day
www.daffodilday.com.au
- 26 Daffodil Ball
www.daffodilday.com.au



SEPTEMBER


- 1 Cancer Council Mazda Raffle tickets on sale – Ph: 1300 65 6 585
- 20 Sep – 4 Oct Tour for a Cure – Trek Mont Blanc
www.tourforcure.org.au

OCTOBER

-  Host a Girls Night In Month
www.girlsnightin.com.au
- Relay for Life – Carlton, Swan Hill
www.relayforlife.com.au
- 14–27 Tour for a Cure – Race Around Asia
www.tourforcure.org.au
- 23 Pink Ribbon Day
www.pinkribbonday.com.au
- 21–22 Relay for Life – Shepparton
www.relayforlife.com.au
- 28–29 Relay for Life – Echuca, Murrumbena
www.relayforlife.com.au



NOVEMBER

-  Relay for Life – Ararat, Ballarat, Bass Coast, Dandenong Ranges, Frankston, La Trobe Valley, Whitehorse
www.relayforlife.com.au
- 10–22 Tour for a Cure – Trek India
www.tourforcure.org.au
- 12–25 Tour for a Cure – Cycle Vietnam
www.tourforcure.org.au

DECEMBER

- 6 Cancer Council Mazda Raffle drawn

Shop online at www.cancervic.org.au/shop

For information on our events or other ways to help, such as our regular giving or bequester club programs, call 1300 65 65 85 or visit www.cancervic.org.au

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, 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.

