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Lung Cancer Update

Issue 22 August 2007

- Highlights of the American Society of Clinical Oncology
- The Future of Molecular Imaging - PET update in lung cancer

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LUNG CANCER UPDATE

Issue 22

August 2007

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This newsletter is produced by The Cancer Council Victoria's VCOG 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, 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 Liza.Marsh@cancervic.org.au.

***** Last Issue – No. 21 – December 2006 *****

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.

Editorial

*Dr Shane White
Medical Oncologist
Austin Health*

Hello one and all. Its winter, although in our deranged climatic times, we have had a 25 degree winter day in Melbourne. I for one however refuse to wear shorts and start drinking chardonnay in August. On a positive note, Buck's hammy has survived the match against Sydney. Once again a feast of reports awaits the avid reader.

Paul Mitchell has provided us with the key highlights of the ASCO meeting. The results of PCI in ESCLC conceivably could change practice although it will be interesting to see whether clinicians take this on board in all, selected or no patients.

Malcolm Feigen has championed the use of radiotherapy in mesothelioma at a local level and has been instrumental in delivering the MARS trial to our shores. Recruitment to the study will be a challenge but the role of surgery in MPM remains a vitally important question.

Eddie Lau has delivered a reminder of the increasing interest in PET's potential to deliver functional assessments of tumour growth and response to therapy. An example of the research in this area is a study of LT-PET and FDG-PET in patients with advanced lung cancer receiving Tarceva. This study being run at Peter Mac and the Austin and Linda Mileskin is the Australian principal investigator.

Sophie Chirnside has summarised some issues from a recent seminar on survivorship. The Cancer Council has also introduced a booklet, and Peter Mac a DVD on this issue. As ground is being made year by year in cancer management, the psychosocial fallout from the

trauma of the cancer diagnosis and therapy is becoming increasingly relevant for cancer patients and their families. The booklet also contains information on CISS, a multilingual website, and a summary of the QUIT media releases.

July 1st was a landmark day for the health of Victorians, with the implementation of the ban on smoking in clubs and bars. In occupational health terms, it will be a huge plus for those who work in these environments who previously had to contend with the risks of passive smoking. Furthermore, it will be good news for those people trying valiantly to quit who have had the risk of lapsing due to the 'social' smoke in clubs.

Margaret McJannett reminds us of this year's forthcoming COSA meeting, but also some of the other excellent work of the group. This includes a recent workshop on adolescent and young adult cancer patients. The latter is a patient group whose physical and psychosocial needs often fall between the well-developed areas of paediatric and 'older adult' oncology. Finally, a burnout survey is planned and this is a much-needed assessment of the impact of the often-high stress environment of cancer care on its clinicians.

The final comment is that I look forward once again to the camaraderie and education of the impending World Lung Cancer Conference in Seoul. Koreans love their karaoke amongst other things. Who knows? Maybe I can spill the beans on the singing prowess of your mild mannered thoracic physician or surgeon.

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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Highlights of the American Society of Clinical Oncology Meeting

1-5 June 2007, Chicago, USA

A/Prof Paul Mitchell
Medical Oncologist
Austin Health

This years ASCO meeting had substantial lung cancer content, with several major randomised studies reported. I have focused here on 3 studies that have the greatest impact.

PCI in small-cell lung cancer (Slotman, abstract #4)

Prophylactic cranial irradiation (PCI) in extensive stage small-cell lung cancer (ES-SCLC) was examined in EORTC 08993-22993. The primary objective was to reduce the risk of symptomatic brain metastases with the use of PCI. Patients with response to first line chemotherapy, 4–6 cycles, were randomised to PCI (20–30 Gy in 5-12 fractions), or no PCI. At randomisation, 76% of patients had persistent primary disease and 70% persistent metastatic disease. It appears that no brain imaging was done at study entry, rather the protocol specified certain symptoms which would prompt brain imaging to be carried out. 143 patients were randomised to each arm.

PCI significantly reduced the risk of symptomatic brain metastases, (<0.001 , HR=0.27), with reduction from 40% to 15% at one year. Brain metastases were the first sign of progression for 9% of patients in the PCI group versus 35% control. There was no significant difference in extracranial time of progression. PCI significantly prolonged progression-free survival and overall survival, ($p=0.003$, HR 0.68); overall survival improved from 13% to 27% in one year.

Questions about this study really relate to the unexpected magnitude of the observed benefits of PCI. Previous studies in ES-SCLC have been negative or inconclusive. In limited stage SCLC, the benefit of PCI is restricted to patients with CR / very good PR of disease in the chest, with an absolute survival improvement of around 5%. Yet, in this ES study, there is a much greater

benefit in a population with substantial residual local and/or systemic disease. There is also the question of the lack of brain imaging at base line, where some patients may have had overt brain metastases yet were randomised to no cranial irradiation. For my part, I will need further details about the study and results before I change my practice.

Consolidation docetaxel in stage III NSCLC (Hanna, abstract #7512)

The phase II SWOG 9504 study, of consolidation docetaxel following chemoradiation, showed an unexpected good survival and has strongly influenced practice, at least in the United States where up to 70% of oncologists give some kind of chemotherapy consolidation. ASCO 2007 saw the first presentation of the much-awaited randomised study in stage III NSCLC examining this question, Hoosier Oncology Group LUN 01-24. Treatment was almost identical to SWOG 9504: patients were randomised to receive 2 cycles of cisplatin/etoposide chemotherapy concurrent with 59.4 Gy radiation, or the same chemoradiation plus 3 cycles of docetaxel 75mg/m² consolidation. The primary end point was overall survival, and patients were required to have FEV1 >1 litre, weight loss <5% over the preceding three months and no malignant effusion. 83% of patients completed consolidation, which was associated with significant toxicity: 11% febrile neutropenia; 10% pneumonitis (vs. 1.4% for chemo-radiation alone), hospitalisation 29% (vs. 8%, $p>0.001$), and 6% treatment-related deaths (vs. 0%, NS). There was no difference in efficacy in terms of overall survival (3-year OS 27% in both arms) or progression-free survival.

This is a very important study, emphasising that there is no benefit for consolidation single agent docetaxel, but significant toxicity. Given that current data indicate that effective post-surgery

adjuvant chemotherapy requires a cisplatin-based doublet, it was always difficult to see how single-agent docetaxel consolidation was going to make a major impact following chemotherapy-radiation in stage III disease.

Bevacizumab with first-line chemotherapy for advanced NSCLC (Manegold et al)

This was the first report of AVAIL, the companion study of the positive ECOG 4599. In 4599, patients were randomised to carboplatin and paclitaxel +/- bevacizumab 15mg/kg, with improvement in median PFS from 4.5m to 6.4m (HR 0.62; $p < 0.0001$) and OS from 10.2m to 12.5m (HR 0.77; $p = 0.007$).

In the three-armed AVAIL study, patients were randomised to either cisplatin 80mg/m² plus gemcitabine 1250mg/m² D1 & 8, q21d, or the same chemotherapy plus bevacizumab 7.5mg/kg or 15mg/kg. Eligibility included non-squamous NSCLC, PS 0-1; no worse than grade

1 haemoptysis; no invasion of major vessels, brain metastases or uncontrolled hypertension, no thrombosis or haemorrhage. The primary endpoint was PFS.

Response rate was significantly higher in the bevacizumab arms (20% vs. 30% - 34%). Median PFS was higher in the bevacizumab arms: 6.1m in the chemo arm, 6.7m with B 7.5mg (HR 0.75 $p = 0.003$) and 6.5m with B 15mg (HR 0.82 $p = 0.03$). One-year PFS was 10%, 14% and 14% respectively. There was insufficient followup to assess overall survival. Toxicity was low, including significant (grade 3+) pulmonary haemorrhage in only 0.6% chemotherapy patients and 1.5% and 0.9% in B arms.

No gender difference for the benefit of bevacizumab was seen, in contrast to the 4599 study. AVAIL was a positive study, although the small PFS differences mean that the OS data will be awaited with great interest.

Action on Mesothelioma (at last)

*Dr Malcolm Feigan
Radiation Oncologist
Austin Health*

Two Melbourne hospitals are planning to enrol patients with recently diagnosed early pleural mesothelioma into a randomised trial of multimodality treatment which includes mediastinoscopy and PET scan staging, neoadjuvant chemotherapy, extrapleural pneumonectomy (EPP) and postoperative hemithoracic radiotherapy using a complex new technique called intensity-modulated radiotherapy (IMRT). IMRT for mesothelioma patients is now available at the Austin Hospital Radiation Oncology Centre to deliver optimised radiotherapy that will target all sites of potential relapse following radical surgery in the hemithorax and costophrenic angle, to radiation doses previously unachievable without risking major toxicity from adjacent radiosensitive organs including the contralateral lung, liver, heart, and spinal cord. This new technology is used in a few major treatment centres in North America and Europe and promises to revolutionise mesothelioma therapy.

It was decided at a recent clinical workshop organised by the Australian and New Zealand Lung Cancer Trials Group to accept an invitation from the MARS (Mesothelioma and Radical Surgery) Trial Management Committee in London and recruit Australian patients to this landmark study, a randomised trial which aims to establish whether or not the radical operation of EPP as part of multimodality treatment is worthwhile in terms of survival benefit and/or quality of life. The first trial centre outside the UK will be established in Melbourne, with the surgery performed at St Vincent's Hospital and radiotherapy at the Austin, under Drs Gavin Wright and Malcolm Feigan.

More details will appear in the next edition of Lung Cancer Update.

The future of molecular imaging – PET update in Lung Cancer

Eddie Lau

Peter MacCallum Cancer Centre

Dual modality PET/CT has largely replaced the PET scanner in recent years. A PET/CT study provides both functional and anatomical information and is more accurate than PET or CT imaging alone in both assessment of pulmonary nodules and staging of lung cancer. PET/CT provides a metabolic map for biopsy guidance, both by directing biopsy to an accessible active lesion as well as to the most metabolic active region of the tumour mass, maximizing the yield of obtaining representative tumour pathology. There is increasing role of PET/CT in radiotherapy planning. The PET/CT data can be directly applied to determine planning target volume, avoiding geographic miss and minimizing irradiation of normal tissues. PET/CT imaging with respiratory gating is now available and may improve the assessment of small volume lung cancer. Respiratory gating can be simultaneously applied to planning PET/CT and radiation therapy, potentially increasing the accuracy of treatment delivery and patient outcome. Hybrid imaging by PET/MRI is on the horizon, with the first human PET/MRI system being launched in late 2006, primarily for brain imaging at this stage.

F18-fluorodeoxyglucose (FDG) has been the main clinical PET tracer, examining the degree of glucose metabolic activity of various tumours. F18-fluorothymidine (FLT) has been introduced for imaging of tumour cell proliferation by PET. Early experience suggested that it may be more specific but less sensitive than F18-FDG in the diagnosis of malignant lung tumours. It may also provide an important tool in the functional assessment of treatment response to the new targeted cancer therapies which are often cytostatic, such as EGFR tyrosine kinase inhibitor in lung cancer.

Hypoxic imaging using F18-FAZA and F18-FMISO by PET has been trialled on lung tumours. Presence of tumour hypoxia is often associated with higher failure rates of conventional treatment and radioresistance. Detection of tumour hypoxia may therefore form the basis of selecting patients for novel targeted therapy and therapeutic monitoring.

Life After Cancer

Sophie Chirnside

*Cancer Information and Support Service
The Cancer Council Victoria*

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

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

This program has been developed following recommendations from cancer survivors who attended a special Cancer Council seminar in

November 2006. At this seminar, survivors and their family were asked to discuss what they felt was missing at diagnosis and highlight how we could best support them through their cancer experience. Their recommendations were as follows:

Information

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

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

Support

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

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

Practical and financial issues

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

anxiety, and distress, and return-to-work strategies.

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

Education

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

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

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

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

Cancer Information and Support Services New Initiatives

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

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

Some of the important messages for promoting the service are:

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

Over the next few months I will be visiting cancer treatment centres, outpatients and general practitioners. Promotion of the service to the general community is also being planned via local media including radio and service groups.

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

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

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

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

Multi Lingual Website

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

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

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

This information is provided in an easy to read factsheet format that can be downloaded for free. Factsheet topics vary from diagnosis and support, to early detection messages. English versions of all factsheets are also available.

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

Quit media releases 2007

Time to quit? Over 4 out of 5 smokers not happy to keep smoking

Wednesday 3 January 2007

An overwhelming 84% of current smokers are not happy to keep smoking, according to new figures released today. The data, from The Cancer Council Victoria, revealed that just 11% of current smokers were happy to keep smoking for the rest of their lives.

Executive Director of Quit, Mr Todd Harper, said the astonishing figures gave a glimpse into the addictive nature of cigarettes and also the persuasive powers of the tobacco industry. "That so many smokers are unhappy to continue smoking illustrates not only how addictive cigarettes are, but also how adept the tobacco industry have become at making it hard for smokers to quit." "We need to be doing all that we can to help people to quit and this means restricting the ability of the tobacco industry to market their deadly product." Mr Harper pointed to packaging on cigarettes and tobacco displays at point of sale as two major areas where progress could be made to shut down tobacco marketing - and help those smokers thinking about quitting to do so successfully.

"The only way to stamp out aggressive tobacco industry tactics, using the pack as the primary method of promoting their deadly product, is to force the tobacco industry to adopt plain packaging." "Along with the removal of the tobacco products currently displayed at the point of sale, often in venues frequented by children, a move to plain packaging would be a significant step forward in reducing the exposure of both smokers and non-smokers to tobacco marketing." Mr Harper said the beginning of a new year is an ideal time for smokers unhappy to keep smoking to think about quitting. "The start of the year is a time when quitting is at the forefront of many smokers minds, and to increase the chances of quitting for good the best time to start planning is now." "Quitting smoking is perhaps the most important thing a person can do for their health, and I think for many people

a new year is the most natural time to try adapting this significant lifestyle change to their normal routine."

Mr Harper said the Quitline would work hard throughout the holiday season to ensure help is on hand to provide support and guidance to all those smokers who want to enjoy a smokefree 2007.

New report shows Vic smoking rates lower, but young adults and less advantaged groups remain resistant to change

Thursday 31 May 2007

A new report looking at tobacco use in Victoria has shown that smoking rates amongst young adults (18-29 years) have failed to drop significantly over the last eight years. Young adults were significantly more likely to be regular smokers (26.2%) than Victorians aged 50 years or more (10.5%) and tended to be more likely to smoke than those aged between 30-49 years (21.2%). The data, from The Cancer Council Victoria, reveals regular smoking among all Victorian adults has declined significantly between 1998 and 2006.

In 2006, 18.2% of Victorians surveyed were regular smokers. The proportion of Victorians surveyed who had never smoked was 52.9% in 2006. Professor Melanie Wakefield, from The Cancer Council Victoria, said although there has been an overall reduction in smoking prevalence since 1998, the decline was not rapid enough. "There has been a gradual decline in smoking rates over the last eight years in Victoria, however they are not falling as swiftly as they could be." "Given this, it may be timely to consider the benefits of greater investment in comprehensive tobacco control strategies, such as social marketing campaigns, that could help drive smoking rates lower." Professor Wakefield said the report indicated smoking rates amongst Victorians living in areas of lowest socio-economic advantage were not declining as quickly as those living in more advantaged areas. "While, in 2006, over one-fifth (21.8%) of

respondents living in areas of highest disadvantage were smokers, smoking rates for those living in the areas with the most advantage were only 16.1%.” “Despite research demonstrating Victorian anti-smoking media campaigns encourage smokers of lower and higher SES to seek help for quitting smoking equally, the rate of decline in smoking is greater among those living in higher SES areas than those living in less advantaged areas.”

Acting Director of Quit Victoria, Ms Suzie Stillman, said that more must be done to ensure Victorian smoking rates continue to fall across all demographic groups.

“Over recent years we have seen a lot of good work aimed at curbing the devastating toll of tobacco in Victoria however this data provides us with a reminder that smoking must remain a public health priority.” “In July, smoking bans will be introduced into bars and clubs offering a window of opportunity to significantly reduce smoking rates in the next twelve months.” “Research suggests that the introduction of smokefree laws in Victoria will inspire many younger smokers to quit and encourage others to smoke less.” “Bars and clubs are such popular places for younger people to smoke. There is little doubt that smoking bans will have a positive impact on the number of people quitting and on smoking behaviours in general.” “However this tremendous step forward in tobacco control must be supported by investment in quit smoking mass media campaigns if we are to make the most of this chance to see smoking rates decline,” said Ms Stillman. Key findings from ‘Smoking prevalence and consumption in Victoria: key findings from the 1998-2006 population surveys’ include:

Regular smoking among Victorian adults declined significantly between 1998 and 2006, from 21.3% to 18.2% The proportion of those who had never smoked increased from 49.9% in 1998, to 52.9% in 2006. In 2006 a higher percentage of males were regular smokers compared to female (20.1% and 16.4%, respectively)

The proportion of regular smokers living in rural Victoria was not significantly different to those living in metropolitan Melbourne (18.5% regular smokers compared with 18.1%, respectively). Heavy smokers (25+ cigarettes a day) made up

15.7% of regular smokers in 2006; medium smokers (15-24 cigarettes a day) accounted for 29.7%, and light smokers (fewer than 15 cigarettes a day) comprised over half (54.7%) of regular smokers. The percentage of heavy smokers significantly declined across the years 1998 to 2006 (ranging from 27% in 1998, down to 15.7% in 2006). There was also a significant increase in the proportion of light smokers across this period (from 46.1% in 1998, up to 54.7% in 2006).

Quit and VicHealth highlight the importance of smokefree environments on World No Tobacco Day

Thursday 31 May 2007

As Victoria’s bars and clubs prepare to go smokefree in July, Quit and VicHealth have joined forces to highlight the importance of protecting the public from exposure to second-hand smoke. Every year, World No Tobacco Day is celebrated globally on the 31st May. This year’s theme is 100% SMOKE-FREE ENVIRONMENTS. Acting Director of Quit Victoria, Ms Suzie Stillman said despite indisputable evidence on the dangers of second-hand smoke, some people still believe that exposure is more of a nuisance than an actual health hazard. “Exposure to second-hand smoke causes irritations like sore eyes and throat, but it is important to make sure people understand it can also lead to serious respiratory illnesses, and indeed cancer and heart disease.” “Children are especially vulnerable to second-hand smoke and exposure can cause the onset of asthma, as well as lower tract respiratory illness, reduced lung growth and middle ear disease in young people.’

CEO of VicHealth, Mr Todd Harper said the theme for World No Tobacco Day was particularly relevant this year with the introduction of smokefree bars and clubs just around the corner. “The introduction of smoking bans in Victorian bars and clubs on July 1st this year represents an impressive achievement in tobacco control and is something that has the overwhelming support of most Victorians.” “Smokefree pubs and clubs will protect more people from the harms of tobacco smoke and ensure a healthier and safer workplace for those working in bars and clubs.” “Other indoor

workplaces have been smokefree since March last year, so it is fantastic that hospitality workers will soon enjoy the same right to work without the fear of the health risks associated with second-hand smoke." Ms Stillman said smoking bans in pubs and clubs present tremendous potential to help smokers quit or reduce their tobacco consumption. "By making bars and clubs smokefree there is a huge opportunity to help people quit, or even prevent them from taking up smoking in the first place."

Quit calls for the withdrawal of 'Australiana' themed cigarette cartons

Thursday 14 June 2007

Quit has called for the immediate withdrawal of 'Australian' themed duty-free cartons of cigarettes, saying it is a blatant attempt of the tobacco industry to exploit Australia's image to sell a deadly product. Cartons of cigarettes bearing outback imagery and flaunting pictures of national icons like the kangaroo and koala next to marketing slogans such as "Another Proud Australian" and "Real Australian" are being offered to travellers leaving Australia. Acting Director of Quit, Ms Suzie Stillman, said the cigarette cartons were a cynical attempt by the tobacco industry to associate the laid-back, outdoorsy Australian lifestyle with their deadly products. "Cigarettes are a product that when used as directed kill up to 2 out of 3 lifetime users, which is hardly something that should be connected to the clean, fresh images of the Australian outdoors." "For the tobacco industry to dress these products up as some sort of colourful souvenir representing Australia is pretty low. Unfortunately it is not surprising behaviour from an industry that is always looking for new ways to try and associate positive attributes with their toxic products." "Australians can be justifiably upset at these quintessentially Australian images being sullied to promote cigarettes."

Cigarette cartons using images of New Zealand have just been removed from sale in New Zealand after protests from health groups branded the inclusion of national symbols on cigarette cartons an insult. Ms Stillman said this latest trick to take advantage of popular tourist images to sell cigarettes once again throws the spotlight on the sale of duty-free cigarettes in

Australia. "The Commonwealth Government must act to remove the tax exemptions that presently apply to cigarette purchases by travellers entering or leaving Australia." "Significant progress in efforts to encourage people to quit smoking have been made over the last few years, so it would certainly be consistent with other strong tobacco control initiatives to see an end to the duty-free sale of cigarettes," said Ms Stillman.

As the air clears in bars and clubs, Quit calls July 1st a day of celebration for all Victorians

Sunday 1 July 2007

Victorians will be breathing easier from today, as the State wakes up to smokefree environments in bars and clubs. Acting Director of Quit Victoria, Ms Suzie Stillman, said hospitality workers and patrons in bars and clubs could today celebrate their right to work and socialise in a healthy environment. "Today marks a landmark occasion for those in the hospitality sector who can now go to work without fear of the health risks associated with exposure to second-hand smoking." "Exposure to second-hand smoke has been found to cause lung cancer, heart disease and stroke, among other illnesses in non-smoking adults so there is no doubt that today is a tremendous step forward in public health in Victoria." Ms Stillman said those Victorians who remain sceptical about the workability of smokefree environments in bars and clubs only need think back to when smoking was banned in restaurants.

"When restaurants became smokefree there were the doubters who said the legislation would never work. However years later there were no reports of the world having ended, and indeed Victoria's restaurants continue booming to this very day." "We can expect smokefree bars and clubs to enjoy the same popularity with a recent study indicating that 8 out of 10 Victorians are in favour of the laws, including a majority of smokers." Ms Stillman said the Quitline has prepared for an anticipated surge in quitting activity by increasing staff numbers and extending hours. "One of the fabulous consequences of smokefree legislation is that many Victorian smokers have suggested they will use July 1 as motivation to try and kick the

habit." Ms Stillman suggested smokers thinking about quitting should consider the Quitline Callback program, whereby a trained advisor speaks to a caller twice before their quit date and up to four times afterwards to ensure they have the best chance possible of making a successful quit attempt.

For comments or more information contact:

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Or visit the Quit Website on <http://www.quit.org.au/>

Extracts from Wongi Yabber Vol 14 No 2. May 2007

Australia & New Zealand TNM Committee for Tumour Staging

*Professor William McCarthy AM
Convenor ANZ TNM Committee*

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

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

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

There has been considerable work on the TNM classification of lung and breast cancer in Australia and it is expected that both groups will agree on the system, with some modification, in

the near future. The lung group is very close to completion of their review.

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

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

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

COSA Update

*Ms Margaret McJannett
Executive Officer, COSA*

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

The theme for the meeting is "Prevention, Palliation and Cure: Progress through Clinical Trials." Special symposia, debates and plenary lectures will explore the Australian and Asia-Pacific clinical trials landscape; the challenge of translating results into clinical practice; barriers to accessing the best therapy (including new drugs); evaluation of alternative medicine; and many other topics. An excellent assembly of

international and local speakers is set to deliver a comprehensive and stimulating program. Our convenor Dr Chris Karapetis and his committee continue to put significant effort into the ASM program and it is particularly gratifying to see how many of our South Australia colleagues are involved with and supporting the planning of this major COSA event.

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

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

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

Rural and regional service delivery remains an ongoing focus. The data demonstrating how access to cancer care services reduces as geographic isolation increases is out there in the COSA report; we really need COSA members to bring this issue to the attention of local politicians in regional areas. Dr Craig Underhill

continues to promote the issue everywhere and he needs your voice as well. Most recently COSA prepared an excellent program of national opinion leaders to review current issues in cancer services in regional Australia at the National Rural Health Alliance's biannual conference. The presentations were well received and the alliance included in its priority recommendations for more uniform and better funded patients assisted travel schemes in all jurisdictions. Patient travel and accommodation is also the subject of a current Senate inquiry; COSA will be presenting a joint submission to the Senate in partnership with The Cancer Council Australia and may also appear at public hearings. The Senate will be reporting in October.

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

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

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

Applications are now being called for the **2008 Haematology Oncology Targetted Therapies (HOTT) Fellowship**. Roche Oncology &

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

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

Ensuring Guidelines Translate into Better Care

*Bruce Barraclough AO
Medical Director,
Australian Cancer Network*

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

There are, however, many barriers that need to be overcome to achieve successful implementation of guidelines. It is simplistic to

under-rate how difficult it is to change practice in complex environments. Change is not simple or quick because of system variation, a shortfall in leadership or even professional isolation or lack of knowledge.

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

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

1. Appoint the team – clinical champions and executive sponsor.
2. Decide which recommendation to tackle first – size and importance of evidence / practice gap.
3. Is current practice in line with guideline recommendation? – audit.
4. Understand why we are not achieving best practice – individual and system.
5. Prepare for change – engage stakeholders.
6. Choose the right approach
7. Put your theories to the test – plan, do, study, act.
8. Keep things on track – communication – change takes time.

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

ACN and NICS have had increasing requests for this booklet as unit heads and clinicians working with patients find it very useful. I would strongly recommend its use to those seeking to

implement guidelines. It can be accessed through the websites of NICS and ACN at www.nhmrc.gov.au/nics/asp/index.asp or www.cancer.org.au/acn under "Activities" heading.

Evidence stacking up for alcohol-cancer risk

Glen Turner
Communications Manager
The Cancer Council Australia

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

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

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

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

The IARC advisory can be viewed at http://www.iarc.fr/ENG/Press_Releases/pr175a.html. The Cancer Council Australia's *Alcohol and cancer prevention* fact sheet can be viewed at www.cancer.org.au/lifestyle.

Pull the plug on food advertising

In 2007, the Australian Communications and Media Authority is reviewing the Children's

Television Standards. The Coalition on Food Advertising to Children (CFAC), which includes The Cancer Council Australia and other key health and consumer organisations, is calling for a marked reduction in the commercial promotion of foods and beverages to children under 14 years old. The Pull the Plug on Food Advertising campaign is being run by The Cancer Council NSW on behalf of the coalition to help make the job of parents easier and to give our kids a healthier future.

Visit www.cancercouncil.com.au/pulltheplug for more details and to sign-up to the campaign.

Health groups welcome survey to target childhood obesity

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

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

"Obesity has been rapidly increasing in Australia, particularly among children. This threatens to impose a major disease burden over the next three to four decades, when healthcare services will already be stretched by population ageing," Mr Slevin said.

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

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

The survey is jointly funded by the Department of Health and Ageing, the Department of Agriculture, Fisheries and Forestry and the

Australian Food and Grocery Council.

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

The Cancer Council Australia's new website nearing completion

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

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

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

Extracts from Wongi Yabber – Feb 2007

Clinical Practice Guidelines for the Prevention, Diagnosis and Management of Lung Cancer

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 or view / download PDFs from the website www.cancer.org.au/clinical_guidelines.

*Reprinted from Wongi Yabber Feb 2007;
14(1): 3.*

Key Published Articles Listing—Lung Cancer

Title	Author & Journal
Prophylactic cranial irradiation in extensive small-cell lung cancer.	Slotman B, Faivre-Finn C, Kramer G et al. N Engl J Med, 2007;357(7):664-72
The IASLC Lung Cancer Staging Project: proposals for the revision of the T descriptors in the forthcoming (seventh) edition of the TNM classification for lung cancer	Rami-Porta R, Ball D, Crowley J et al. J Thorac Oncol 2007;2(7):593-602.

Key Published Articles Listing—General

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

Forthcoming Meetings

Date / Place	Meeting / Contact
2-6 September 2007 Seoul, Korea	12th World Congress on Lung Cancer International Association for the Study of Lung Cancer (IASLC) c/o International Conference Services Vancouver, BC, Canada Ph: +1 604 681 2153 Fax: +1 604 681 1049 E-mail: lungcancer@meet-ics.com Website: www.2007worldlungcancer.org
8-13 September 2007 Barcelona, Spain	9th Biennial European Society for Therapeutic Radiology and Oncology Meeting European Society for Therapeutic Radiology and Oncology Ph: + 32 2775 9340 Fax: + 32 2779 5494 Email: agostino.barrasso@estro.be
23–27 September 2007	3rd International Clinical Trials Symposium (ICTS) GPO Box 3270, Sydney NSW 2001 Ph: (02) 9254 5000 Fax: (02) 9251 3552 E-mail: info@clinicaltrials2007.com Website: www.clinicaltrials2007.com
23–27 September 2007 Barcelona, Spain	14th European Cancer Conference (ECCO) – <i>Cancer in Europe: Sharing the responsibilities</i> Federation of European Cancer Societies (FECS), Avenue E. Mounier 83, Brussels 1200, Belgium Ph: +32 2 775 0201 Fax: +32 2 775 0200 E-mail: ECCO14@fecs.be Website: www.fecs.be
23–27 September 2007 Barcelona, Spain	European Society for Therapeutic Radiology & Oncology (ESTRO 26) During ECCO 14 Website: www.estro.be

Date / Place	Meeting / Contact
4–7 October 2007 Melbourne, Vic, Australia	58th Annual Scientific Meeting of the Royal Australian and New Zealand College of Radiologists (RANZCR) Website: www.ranzcr.edu.au
14–17 October 2007 Brisbane, QLD, Australia	Annual Meeting of the Haematology Society of Australia and New Zealand (HSANZ) Website: www.hsanz.org.au
17–20 October 2007 Melbourne, VIC, Australia	9th Annual Scientific Meeting of the Australasian Gastrointestinal Cancer Trials Group (AGITG) – <i>Translating research into practice</i> Website: www.gicancer.org.au
22–26 October 2007 San Francisco, California, USA	19th International Conference on Molecular Targets and Cancer Therapeutics – <i>Discovery, biology and clinical applications</i> Jointly organised by AACR, NCI and EORTC Website: www.aacr.org/page5995.aspx
28 Oct – 1 Nov 2007 Los Angeles, California, USA	49th Annual Meeting of the American Society for Therapeutic Radiology and Oncology (ASTRO) 12500 Fair Lakes Circle Suite #375, Fairfax, VA 22033-3882 Ph: +1 703 502 1550 or 1800 962 7876 Fax: +1 703 502 7852 Website: www.astro.org
14–16 November 2007 Adelaide, SA, Australia	34th Annual Meeting of the Clinical Oncology Society of Australia (COSA) COSA Office, Medical Foundation Building, Level 5, 92 Parramatta Road, Camperdown NSW 2011 Ph: (02) 9036 3100 Fax: (02) 9036 3101 E-mail: cosa@cancer.org.au Website: www.cosa.org.au

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

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

The **VCOG Lung Cancer Committee** was established in 1993. It's membership is representative of the clinical specialties and centres involved in the treatment of lung cancer and melanoma. The objectives of the Lung Cancer Committee are to:

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

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