

# Skin Cancer Update

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# SKIN CANCER UPDATE

July 2004

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This newsletter is produced by The Cancer Council Victoria's Skin Cancer Committee and sent to health professionals interested in management of skin cancer(s). If you would like to respond to or submit an article, or have your name removed from the distribution list, please contact Mrs Noellyn Ngo, Ph: (03) 9635 5265.

The Victorian Cooperative Oncology Group's advisory committees on breast, gastrointestinal, gynaecological, head & neck, lung and urological cancers also produce twice yearly cancer updates. If you are interested in receiving these updates please contact Mrs Noellyn Ngo, Ph: (03) 9635 5265.

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

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## Editorial

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Welcome to the tenth issue of the Skin Cancer Update. In this edition we have reports from the two of the biggest surgical and medical oncology meetings, as well as some interesting updates on the odd behaviour of adolescent and adult human beings.

Michael Henderson has once again provided us with an update of the Society for Surgical Oncology meeting. Major issues include the significance of the primary site, the importance of various histopathological and other clinical features, and some interesting biology of desmoplastic melanomas. The sentinel node debate continues to rage, with Australian centres contributing some important data. There is no question that sentinel node biopsy is an effective method for inducing stage migration and for stratification of prognosis. If only there were something effective we could do about upstaged and high-risk patients.

This leads nicely into Jonathan Cebon's report of ASCO. It is increasingly apparent that more recent studies are showing that the true objective response rate of metastatic melanoma to DTIC chemotherapy is closer to 5% than to 15-20% as was previously thought. Biochemotherapy is still being used in some centres in highly selected patients but is clearly not the answer. Thinking laterally, some groups have investigated whether molecularly directed therapies either alone or in combination with conventional chemotherapy may be of benefit. Interesting candidates include the BAY 43-9006 raf kinase inhibitor, Bcl-2 antisense, specific immunotherapy combinations such as DC vaccines, and non-specific immune interventions such as removal of the inhibitory effect of CTLA-4 signalling or addition of CpG oligodeoxynucleotides. Some interesting early

work was presented at ASCO in these areas, together with some disappointing results of other approaches previously thought promising.

We include a reprinted article by John Kelly about thick and nodular melanomas. The average thickness of primary melanomas is decreasing except for nodular melanomas (NM). NM are more difficult to diagnose clinically since they often do not conform to the "ABCD" criteria. Remember the "EFG" and mind your P's and Q's!

It's not all doom and gloom. Our behavioural researchers are accumulating important data about sun exposure and sunburn protection, which will help direct public health interventions in the future. Important target groups include secondary school students as well as that strange group of people who haunt solariums. One day we hope to be able to communicate with these alien species.

We also include our regular listing of clinical trials open for accrual at Melbourne centres. We encourage you to consider referring patients for these important studies.

Finally, I would like to thank Jill Ainslie for her capable, thoughtful and tireless chairing of the VCOG Skin Cancer Committee. Jill has now retired and we wish her all the very best for the future. I will take this opportunity also to encourage interested clinicians and scientists to participate in the Skin Cancer Committee, particularly trainees. It is important to continue to inject fresh thoughts and enthusiasm and to forge new cooperative links in basic and clinical research into skin cancer. We welcome your ideas and input.

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# Report of the Society of Surgical Oncology 57<sup>th</sup> Annual Cancer Symposium

18–21 March 2004, New York, USA

*Assoc Professor Michael A Henderson  
Melanoma Unit, Peter MacCallum Cancer Centre  
University of Melbourne Department of Surgery St Vincent's Hospital*

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**A**gain not surprisingly much of the discussion from the Melanoma Section concerned sentinel node biopsy. Thompson from Sydney discussed the experience of the Sydney Melanoma Unit with sentinel node biopsy. At 5 years, sentinel node biopsy negative patients had a survival of 90% compared to 56% for sentinel node positive patients. For patients with a negative SNB, only ulceration and tumour thickness were independently predictive of outcome. He described a variety of unusual / unpredictable sites of sentinel nodes including the intra muscular space in the posterior axilla and retroperitoneal sites from melanomas on the back. Head and neck melanomas in particular were a major problem with at least 30% draining to unexpected lymph node basins. Overall he reported a 13.6% false negative rate for SNB and a rate of intransit metastases of 2%, which would be consistent with results seen in patients treated prior to the SNB era.

A poster presentation from the Sydney Melanoma Unit described a retrospective study comparing a historical group of patients who underwent elective lymph node dissection prior to the sentinel node biopsy era with patients who had undergone a sentinel node biopsy. The later group of patients had more positive nodes many of which were microscopic in size, however there was no difference in survival between the two groups.

Sentinel node biopsy for thin melanomas was discussed by several commentators. A review by Coit from Memorial Sloan Kettering summarised three previous studies from Duke, SMU and MD Anderson which confirmed the usual prognostic factors for nodal involvement including thickness, age and possibly the presence of ulceration and mitotic rate. In the

new AJCC staging system, Clark level is only included for thin melanomas (T1 <1.0mm). There have now been 7 series which have investigated sentinel node involvement in patients with thin melanomas including a further two studies presented during the meeting. The majority of studies were quite selective in that patients with thin melanomas undergoing sentinel node biopsy tended to be towards the thicker end, higher Clark level and/or ulcerated. All agreed that the rate of sentinel node involvement is significant, i.e. approaching 10% for melanomas >0.5mm and certainly >0.75mm. Clark level 4 compared to lower level melanomas <1mm in thickness was not associated with a higher rate of sentinel node involvement. (Vaquerano, Roswell Hark, Ranieri Indianapolis). Kesmodel (Philadelphia) added to the evidence indicating the possible significance of mitotic rate (MR) specifically in patients with thin melanomas. Sentinel node involvement was 11% in patients with MR >0 while no patients with a zero MR had positive sentinel nodes.

Panageas reported a multi-centre study of the significance of sentinel node biopsy in patients with thick melanoma, i.e. T4 lesions >4mm (including Sydney Melanoma Unit). Sentinel nodes were involved in 36.5% and the presence of sentinel node involvement was strongly associated with survival (81% versus 60%) and therefore it was concluded that the procedure was indicated to identify patients at increased risk.

There were two presentations on desmoplastic melanoma. Hawkings (Memorial Sloan Kettering) reported that nodal involvement in pure desmoplastic melanoma was very rare but not uncommon in patients with mixed desmoplastic tumours. As previously reported pure desmoplastic melanoma had an excellent survival (5-year melanoma specific mortality

11%) than patients with mixed desmoplastic (30%) which was worse than for patients with conventional non-desmoplastic melanoma (14% melanoma specific mortality).

Pawlik from the MD Anderson reported their experience of intransit disease after sentinel node biopsy. Higher rates of in transit disease were seen in patients with positive sentinel nodes, lower extremity primaries, thicker melanomas and ulcerated tumours. Of 1395 patients undergoing sentinel node biopsy, 6.5% developed intransit metastases and in the majority of cases this was the first site of failure. In 71% the intransit disease occurred as an isolated event. Patients with combined intransit disease and distant metastases had significantly worse survival than patients without distant disease (50% versus 26% disease free survival at 5 years). The rate of intransit disease reported was similar to historical studies from the same institution and the authors concluded that the higher rate of ITM was related to the presence of the regional node involvement and other tumour factors.

Delman from the MD Anderson reviewed their experience of epitrochlear and popliteal lymph

nodes, which comprised 2.3% of all patients with lymph node involvement. Twenty-five percent of patients with epitrochlear / popliteal node involvement were diagnosed by sentinel node biopsy and in all cases the upstream nodal basin was also mapped. Two of these 5 patients had involvement of the upstream nodal basin. Amongst the 19 patients with symptomatic epitrochlear or popliteal nodal involvement, 57% had involvement of the proximal nodal basin leading the authors to conclude that epitrochlear or popliteal lymph node involvement in patients with symptomatic recurrence should prompt an upstream node dissection.

Finally, Stetch from the Sydney Melanoma Unit presented an intriguing study of proton magnetic resonance spectroscopy of fine needle aspirates from sentinel nodes. The sensitivity of this technique was 97% with a specificity of 90% and accuracy of 94%.

*The abstracts from the meeting are available in the supplement to the latest edition of the Annals of Surgical Oncology and the majority of papers will be published in the Annals of Surgical Oncology over the next 12 months.*

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## Report of the American Society of Clinical Oncology 40<sup>th</sup> Annual Meeting

5–8 June 2004, New Orleans, Louisiana, USA

*Assoc Professor Jonathan Cebon  
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Austin Health*

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The 40<sup>th</sup> Annual Meeting of the American Society of Clinical Oncology was held in New Orleans from 5–8 June. The major excitement of the meeting was the emerging data on the clinical efficacy of novel targeting agents, particularly the kinase inhibitors. While much of the focus has been on more common cancers such as colon and lung cancer, an increasing number of the presentations showed data with these agents in melanoma. Sadly there were no standout successes, although the BRAF inhibitor

BAY 43–9006 appeared very promising in an uncontrolled study, when combined with chemotherapy. Immunology was also a highlight. A number of newer immune-directed therapies were reported as well as results of a major European randomised trial using human dendritic cells. While some of these approaches continue to hold out promise, the DC trial was disappointingly negative, and many of the other studies, showed early data that need confirmation in larger or randomised studies.

## **Molecular Inhibitors**

### **BAY 43-9006 in patients with advanced melanoma: The Royal Marsden experience**

*T Ahmad*

Approximately 70% of melanomas have an activating mutation in BRAF which increases kinase activity and cellular proliferation. BAY 43-9006 is a potent inhibitor of RAF kinase inhibitor that inhibits melanoma in pre-clinical model systems. In this phase II trial, patients with stage IV melanoma were treated with BAY 43-9006 400mg BD orally for 12 weeks after baseline imaging and tumour biopsy. At the 12-week reassessment, patients with objective tumour responses continued BAY 43-9006 until disease progression or unacceptable toxicity. Patients with stable disease were randomised in a double-blind manner between BAY 43-9006 or placebo and followed for on-going response. Tumour biopsies were performed at weeks 0, 4 and 12 for sequencing BRAF and identification of downstream activity of RAF kinase. Twenty patients were enrolled. At week 12, 1/20 PR and 3/20 SD were seen. Fifteen patients had progressive disease before or at 12 weeks. The main toxicities were skin rash and hypertension. BAY 43-9006 therefore had little activity as a single agent.

### **Phase I/II trial of BAY 43-9006, carboplatin (C) and paclitaxel (P) demonstrates preliminary anti-tumour activity in the expansion cohort of patients with metastatic melanoma**

In a second trial undertaken by *K T Flaherty* and colleagues, University of Pennsylvania, Philadelphia, BAY 43-9006 was combined with Carboplatin (AUC 6) and Paclitaxel (225 mg/m<sup>2</sup>) which were each administered on day 1 of a 3 week cycle. Three doses of Bay 43-9006 were given at 100, 200 and 400 mg twice daily. Thirty-five melanoma patients were treated for at least 6 weeks and 32 were evaluable for response. There were 11/32 (31%) partial responses, with 10 ongoing at 3-16 months. Median time to response was 3 months. Nineteen patients had stable disease as best response, and 12 remain on study for  $\geq 3$  months since entry. Median time to progression had not been reached at a median follow-up of 5 months. The combination of BAY with this chemotherapy regimen therefore had

demonstrated activity in melanoma with a favourable safety profile. A randomised trial is planned, and Australian study sites will participate in that trial.

### **Randomised multinational phase 3 trial of dacarbazine (DTIC) with or without Bcl-2 antisense (oblimersen sodium) in patients with advanced malignant melanoma (MM): Analysis of long-term survival**

*M J Millward, et al.*

This randomised trial evaluated Oblimersen (Genasense), an anti-sense oligonucleotide which targets Bcl-2 mRNA. As a consequence it is capable of increasing apoptosis following chemotherapy. Patients with advanced, evaluable melanoma received DTIC 1000mg/m<sup>2</sup> q3 weeks, with or without Genasense 7 mg/kg/d for 5 days. For all 771 randomised patients the median survival of those receiving the combination was 9.1 months compared to 7.9 months for DTIC alone ( $p=ns$ ), although survival differences at 15 and 18 months landmarks were significant ( $P<0.05$ ). Genasense treatment increased median progression free survival (74 vs 49 days,  $P=0.0003$ ) as well as the response rate (CR+PR): 11.7% vs 6.8%. It was gratifying to see randomised data demonstrating a regimen which shows superiority over DTIC alone. Nonetheless the overall impact whilst statistically significant, was modest at best, and it is not clear that these improvements really represent meaningful clinical benefit.

### **Other agents**

Clinical trials of other novel inhibitors were reported in melanoma and shown to be ineffective. These included: CCI-779, an mTOR kinase inhibitor that inhibits malignant cell cycle progression by inhibition of signal transduction pathways required for progression through the G1 phase of the cell cycle. Although CCI-779 has demonstrated activity against melanoma in preclinical models and shown clinical benefit in breast and renal cancer, it was not found to be sufficiently active in melanoma to warrant further testing as a single agent. Similarly a phase II trial of the proteasome inhibitor PS-341 (bortezomib) failed to show activity in advanced metastatic melanoma.

## Immunotherapy

### **Dacarbazine (DTIC) versus vaccination with autologous peptide-pulsed dendritic cells (DC) as first-line treatment of patients with metastatic melanoma: Results of a prospective-randomised phase III study**

*D Schadendorf, et al.*

This randomised study was performed to evaluate Dendritic Cell vaccination compared with DTIC. Patients were required to have one of the HLA types: HLA-A1, -A2, -A3, -A24 or -B44. They were randomised to receive DTIC (850mg/m<sup>2</sup> every 28 days with 4-week intervals) or intradermal vaccination with autologous peptide-pulsed dendritic cells in 2-week intervals for the first 5 vaccinations and every 4 weeks thereafter. DC were generated from peripheral blood monocytes which were cultured for 5 days in GM-CSF, IL-4, followed by a maturing cytokine cocktail (IL-1 $\beta$ , IL-6, TNF $\alpha$  and PGE<sub>2</sub>) on day 6. They were then pulsed with peptides derived from MAGE-1, MAGE-3, Melan-A, gp100, tyrosinase and influenza proteins depending on HLA-type. A total of 108 patients were treated: 55 with DTIC and 53 with DC. Accrual was halted prematurely by the data monitoring board when it was clear that the study goals could not be achieved. Responses (CR+PR) were 5.5% for DTIC and 3.8% for DC. There was no statistically significant difference for response, toxicity, overall and progression-free survival between the study arms. It was disappointing to see no impact of DC vaccination in this study. This trial was performed with a clear focus on clinical outcomes and in retrospect, was conducted prematurely. The fields of DC biology, tumour antigen expression, antigen selection immune monitoring are all rapidly evolving and it would be a shame if this study discouraged further research into DC vaccines while the learning curve is still so steep.

### **A phase II, randomised multi-centre study of MDX-010 alone or in combination with dacarbazine (DTIC) in stage IV metastatic malignant melanoma**

*E M Hersh*

MDX-010 is a monoclonal antibody against human anti-CTLA-4. It enhances immune responses by "taking the brakes off" immunity. Stage IV melanoma patients were given MDX

alone (arm A) or with DTIC (Arm B). Seventy-six patients were enrolled and 72 received drug. There were 11 Grade III/IV autoimmune toxicities: colitis (n=4), uveitis (n=2) and rash (n=3), increased ALT (n=1), and a grade IV hypersensitivity reaction (n=1). Two deaths were possibly attributed to MDX-010. Two PRs occurred in arm A and 1CR and 4PRs occurred in arm B. Four patients in arm A and 5 patients in arm B had SD (30–224+ days): MDX-010 alone or with dacarbazine can induce organ specific autoimmunity. This study suggests that combination therapy with dacarbazine may have greater clinical activity than monotherapy in patients with Stage IV melanoma. Clearly it is desirable to attempt to "direct" the autoimmunity against cancer rather than to induce non-cancer-specific immunity. For this reason, future clinical trials of MDX-010 in combination with melanoma vaccines are being planned.

### **TLR9-targeted CpG immunostimulatory treatment of metastatic melanoma: A phase II trial with CpG 7909 (ProMune)**

*S N Wagner (Vienna, Austria and Coley Pharmaceutical Group, Inc.)*

CpG 7909 is a new synthetic oligodeoxynucleotide which activates plasmacytoid dendritic cells (pDC) and B cells through specific interaction with Toll-like receptor 9 (TLR9) and is a strong activator of both innate and specific immunity. It has shown impressive antitumour activity in preclinical tumour models when used as monotherapy. Twenty patients aged between 37 and 74 years received 6mg CPG 7909 weekly by SC injection for 24 weeks or until disease progression in an outpatient setting. Two patients achieved a confirmed partial response (PR) and one has maintained this response with continuing therapy for over 13 months. Three patients achieved stable disease (SD). CPG 7909 was well tolerated. Adverse events included transient injection site reactions (erythema, swelling, induration), fever and arthralgias. Haematological and non-haematological toxicities were limited, transient and did not result in any withdrawals. A randomised phase II/III trial has been initiated to compare efficacy and safety of two dose levels of CPG 7909, CPG 7909 in combination with DTIC, and DTIC alone.

## Significant impact of HLA class I allele expression on outcome in melanoma patients treated with an allogeneic melanoma cell lysate vaccine. Final analysis of SWOG-9035

V K Sondak (Southwest Oncology Group)

SWOG-9035 compared two years of an allogeneic melanoma lysate (Melacine) to observation in patients with stage II melanoma 1.5-4.0 mm thick. The effects of expression of certain HLA antigens ( $\geq 2$  of HLA-A2, A28, B44, B45, C3) were also examined. Mature data were presented: 689 patients were entered. There was no significant benefit of vaccine therapy overall, but this prospective analysis indicates significant survival benefit of vaccine therapy among early-stage melanoma patients expressing  $\geq 2$  of these HLA antigens. HLA-A2 and C3 were the predominant alleles contributing to this effect. The impact of HLA type was previously reported and still holds in the analysis of the mature data. The mechanism is not well studied, but is presumed to relate to the capacity of these HLA molecules to present immunogenic melanoma antigens to the immune system. This study highlights the likelihood that immune manipulation will only benefit a subset of patients and therefore the importance of patient selection. A prospective confirmatory trial in patients expressing HLA-A2 and/or HLA-C3 is planned.

## A phase II trial of high-dose Allovectin-7 in patients with advanced metastatic melanoma

A plasmid encoding HLA-B7 and  $\beta$ -2 microglobulin genes formulated in liposomes is an immuno-therapeutic designed to induce inflammatory response after direct injection into tumour. Interim data showed that 12 of 91 patients (13.2%) achieved an objective response lasting a median duration of 6.4 months. One Grade 3 and no Grade 4 adverse event associated with A-7 have been reported. Conclusions: Interim results indicate that high-dose A-7 is an active, well-tolerated treatment for Stage III/IV MMpts with injectable cutaneous, subcutaneous, or nodal lesions.

## A phase II study of aerosolized GM-CSF in the treatment of metastatic melanoma to the lung

S Markovic (Mayo Clinic, Rochester Minnesota)

Aerosolised GM-CSF (250ug twice/day for 7 days of a 14-day treatment cycle) was

administered to 28 patients with melanoma pulmonary metastases from November 2000 – September 2001. One patient achieved a response (CR) that lasted 12 months. The median PFS time was 54 days and median survival time was 223 days. In 3 of 4 patients studied, increased CTL frequencies were seen – consistent with anti-tumour immunisation. Since this was well tolerated further dose escalation was proposed to increase clinical and immunological effectiveness.

## Chemotherapy

### A phase II study of epothilone B analog (EpoB)-BMS 247550

A C Pavlick, et al.

This is a new non-taxane microtubule binding agent that leads to mitotic arrest. It was found to have anti-melanoma activity in phase I trials justifying this phase II study. EpoB 20mg/m<sup>2</sup>, 1 h infusion, weekly  $\times 3$  every 4 weeks. Study drug was administered to 12 untreated and 12 pre-treated patients. Unfortunately it showed no activity in these patients.

### A phase II trial of DTIC with thalidomide in metastatic melanoma

M Fink (NYU Cancer Institute, New York, NY)

Thalidomide was added to standard dose DTIC in melanoma patients. Doses were escalated in 100mg increments every 3 weeks and ranged from 200-400mg/d. Responses were assessed after 3 cycles. The median tolerated dose of thalidomide was 200mg/d. Patients received 1-18 cycles of therapy (median = 5). 1/15 partial response was seen in subcutaneous tissue; SD occurred in 5 and the remaining progressed or were too early for evaluation. Thalidomide therefore did not appear to improve response rates to DTIC in melanoma and was poorly tolerated at doses greater than 200mg/d.

## Biochemotherapy (BCT)

### A meta-analysis of biochemotherapy (BCT) for the treatment of metastatic malignant melanoma

R El-Maraghi, et al. (Ottawa Regional Cancer Centre, Canada)

MEDLINE, CANCERLIT, Cochrane Library and Physician Data Query clinical trials databases.

Relevant articles and abstracts were reviewed including abstracts for randomised controlled trials (RCTs) and single-arm phase II trials involving BCT. An estimate of the effect of BCT on overall response rate, time to progression, and overall survival was determined using pooled data from published reports of individual RCTs. Nine RCTs, 8 randomised phase II trials and 39 single-arm phase II trials were identified. BCT is associated with higher overall response rate compared to standard therapy but does not have a meaningful impact on survival in patients with metastatic MM. Due to the toxicity of BCT, treatment should be restricted to experienced centres.

### Phase II trial of BCT with temozolomide

*I G Ron (Tel Aviv, Israel)*

Cisplatin, vinblastine, temozolomide, interferon alfa-2a, and interleukin-2 (IL-2) were administered to patients with metastatic melanoma. It was concluded that there was high overall response rates (50% CR 1/22, PR 10/22) and durable remissions in one, otherwise median TTP was 5 months. Toxicity was severe but considered manageable in the inpatient hospital environment.

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## Nodular Melanoma: How Current Approaches to Early Detection are Failing

*Associate Professor John W Kelly  
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**E**arly detection and removal, before melanoma has seeded viable metastases, remain by far our most important weapons against melanoma mortality. Over the past 20 years, great advances have been made in early diagnosis by focusing our attention on the clinical presentations of radial growth phase melanoma. These clinical features were given impact by the Melanoma Cooperative Group at New York University School of Medicine, which coined the "ABCD's of Melanoma" acronym: **A**symmetry, **B**order irregularity, **C**olor variegation, and **D**iameter greater than 6 mm.<sup>1</sup> The ABCD's were easily remembered and widely taught.

### Forty-Year Progress

It was in the late 1960's when Dr Wallace Clark distinguished radial from vertical growth phase melanoma and named the four major histologic melanoma types.

Over the past four decades, median tumor thickness in New South Wales, Australia, has declined from 2.5 mm to 0.7 mm, although this decline has slowed to a standstill over the last

5-10 years. This improvement in early detection has coincided with a period of steeply rising melanoma incidence that in Europe<sup>2</sup> and Australia<sup>3</sup> has almost entirely comprised thin (< 1.0 mm thickness) and intermediate (1.0 - 3.0 mm thickness) tumors.

However, there has been no decline in the incidence of thick tumors (> 3.0 mm),<sup>2,3</sup> which have the greatest impact on melanoma morbidity and mortality. Surveillance, Epidemiology, and End Results Program Registry data in the U.S.<sup>4</sup> show that melanoma incidence has continued to increase across the spectrum of tumor thickness, with the greatest increase in thick tumors. Correspondingly, significant declines in mortality have not occurred.

### Thick Melanomas Linked to Nodular Tumor Type

Data from several studies in Australia<sup>5,6</sup> and Europe<sup>7,8</sup> indicate that thick melanomas are overwhelmingly associated with nodular tumor type. Much weaker associations for thick tumors were noted with older age (> 50 years) and male sex. In three large databases assessed by

Chamberlain, et al.<sup>5</sup> and Hanrahan, et al.<sup>6</sup> in two Australian studies, nodular melanoma (NM) comprised 56 percent, 67 percent, and 72 percent of all melanomas thicker than 3.0 mm. In the Victorian Cancer Registry,<sup>5</sup> where 56 percent of thick tumors were nodular type, superficial spreading melanoma comprised 26 percent, lentigo maligna melanoma 10 percent and other tumor types 8 percent. In a comprehensive review conducted by Kopf, et al. using the data collected by the Melanoma Cooperative Group (four U.S. centers) and further data from New York University, NM accounted for 66 percent of melanomas greater than 3.0 mm in thickness.<sup>9</sup> Thus, while nodular melanomas comprise only 10 to 15 percent of all melanomas, they clearly dominate the thick category.

A recent follow-up study from Chamberlain, et al. at the Victorian Melanoma Service, in Australia offers an important reason for the frequent failure to detect NM earlier.<sup>10</sup> The researchers studied patients' perceptions of the presenting symptoms and signs of NM, comparing the perceptions with those of superficial spreading melanoma (SSM). NMs, when compared with SSM's were more often symmetrical (80 versus 58 percent) and were a single color (78.1 versus 50 percent), the majority being amelanotic (54.5 versus 11.3 percent). NMs were also more likely than SSMs to be elevated (90 versus 58 percent), weeping (24.2 versus 5.5 percent), crusted (27.3 versus 6.7 percent), and tender (15.2 versus 3.3 percent). In general, the findings for NM were in marked contrast to those described for SSM and other radial growth phase melanomas. Furthermore, clinical experience of NM indicates that the majority show a regular border, unlike the irregular border seen in SSM. In fact, the defining characteristics of nodular melanoma are generally the opposite of those for radial growth phase melanoma, which are so usefully summarized by the ABCD's.

As an aid to teaching the signs of NM, the ABCD's are clearly unhelpful. We suggest the acronym "EFG" for **E**levated, **F**irm, and **G**rowing progressively for more than a month.

### **Inadequate Awareness of Nodular Melanoma**

Clearly the presenting features of NM have not been adequately promoted to the health care

professions or the public. At the Victorian Melanoma Service, it is common for patients with NM, particularly amelanotic lesions, to have been falsely reassured by their doctors in the early stages of the tumor's development, critically delaying diagnosis. Typically, the patient again seeks attention only when the lesion grows significantly or develops symptoms such as repeated episodes of bleeding.

Since NM very likely is making a large and disproportionate contribution to melanoma morbidity and mortality, we must weigh how best to promote its presenting features to achieve early diagnosis. This will not be easy, because NM must be distinguished from other tumors and inflammatory lesions.

### **Another Problem: Rapid Growth**

Rapid growth is another important reason for the failure to detect NM while still thin.

A recent study showed greater average tumor thickness at diagnosis for NM than SSM (5.67 versus 1.41 mm) despite shorter delays in obtaining medical assessment.<sup>11</sup> This inverse relationship between tumor thickness and delay suggested that tumors often become thick because they are aggressive and growing rapidly rather than because they are being ignored and allowed to grow for long periods. For some of these tumors, even short delays before seeing a dermatologist or between diagnosis and excision may be critical.

### **Conclusions**

NM remains a source of controversy among histopathologists. Some advocate dropping the distinction between tumor types for several reasons. They believe in a common histogenesis though this remains a matter of controversy. There is well-accepted evidence for a similar prognosis between NM and SSM once thickness is accounted for and there are no established epidemiological differences between the two tumor types.

These arguments ignore important differences between tumor types. Whether or not they share common origins, they present with important and distinctive presenting morphological clinical features. NM is raised from very early in its course, remains one color (frequently pink or

red), is symmetric, relatively regular in shape and more often weeping, crusting or tender. SSM, on the other hand, remains flat for a substantial period, is changing and variegated in color, asymmetric, increasingly irregular in shape and less often symptomatic. Awareness of these distinctive presentations is of critical importance in the early diagnosis of NM. Its clinical presentations are so distinctive that maintenance of the currently used separate nomenclature is not only justified but essential if we are to begin recognizing NM at an earlier stage.

Who tends to find NM first? Richard showed that it is most often self-detected.<sup>11</sup> This is thought to be due to NM's relatively rapid change and early onset of symptoms. Family practice physicians and dermatologists alike must be alert to the possibility of NM even when they believe that a diagnosis of basal or squamous cell carcinoma (BCC or SCC) is more likely. Some predominantly amelanotic NMs will show areas of light or medium brown, relatively even pigmentation, which may show up only through dermoscopy and clearly differs from the patterns seen in pigmented BCC. NM may also show a disorderly vascular pattern in dermoscopy, with irregular and dot-type vessels that are quite different from the horizontal branching (arborizing) telangiectasia seen in BCC.

Neither public health screening campaigns nor routine screening at intervals of six months or more of high-risk patients by dermatologists will reliably detect early NM because of their early onset of dermal invasion and rapid growth. Opportunistic screening by alert family practitioners may be of more value, but it is patients who have the best opportunity to find NMs at an early stage. Unfortunately, they may find it difficult to distinguish them from inflammatory lesions. Better understanding is needed of the time scale over which rapidly growing melanomas evolve, so that we can develop better guidelines to help distinguish these tumors from inflammatory lesions.

It is likely that there will be significant gains from promoting the well-established presenting appearances of NM to health care practitioners. This will help correct any unnecessary delays in surgical removal that currently result from misdiagnosis by the physician. If NM is considered in the differential diagnosis of small evenly pink, red or pigmented, firm, slightly raised

lesions with a short or uncertain history and these lesions are managed with excisional biopsy or a short period of observation many NM's may be detectable at an earlier stage.

The successful promotion of these features to the public will be very much more difficult because of the similarity between NM and many benign tumors (e.g. angiomas and intradermal nevi). The changes seen with inflammatory lesions (e.g. furuncles and insect bites) may also be confused with NM. NM remains a relatively uncommon tumor. Any gains made from promotion of its clinical features to the public must be weighed against the concern, anxiety and cost that may arise in regard to many benign lesions.

Our best chance to help the public to distinguish NM from benign lesions is to emphasize **progressive and persistent change** over a period long enough to allow resolution of inflammatory lesions (a month). The "G" in the EFG acronym suggested for NM ("Growing progressively for more than a month") is of primary importance.

The ultimate measure of success will be a reduction in the very high mean thickness of NM that are currently reported to population based cancer registries.

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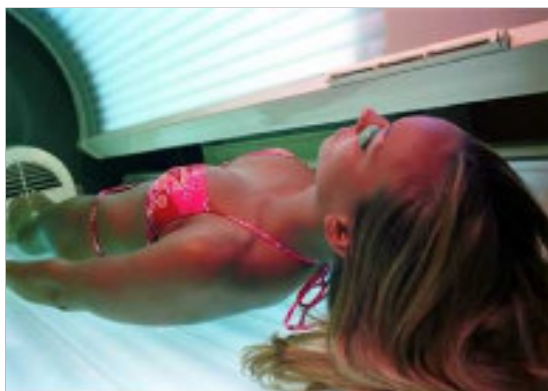
## Study of Compliance of Inner Melbourne Solarium Centres with a new Australian Standard

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 Centre for Behavioural Research in Cancer  
 The Cancer Council Victoria

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 Director  
 Centre for Behavioural Research in Cancer  
 The Cancer Council Victoria

### Rationale / Background

Melbourne has seen a rapid growth in the solarium industry over recent years (Fox, 2001) and corresponding increases in the public's desire for a tan and beliefs that solariums provide a safer tan than in the harsh Australian sun (Dobbinson, 2004).



Skin cancer control advocates have worked with the Australian Standard committee to ensure that

new guidelines for industry operators specify a requirement for adequately informing customers of risks associated with using solariums and to restrict access to solariums by high risk groups, such as, customers with Skin Type 1 or under 18 years of age. The Government warned operators that ongoing checks of compliance with the Standard would be made.

### Aims / Method

A study was conducted late 2003, designed to establish usual compliance of Melbourne solarium centre operators with the recently revised industry Standard. Thirty solarium centres in inner Melbourne were surveyed. Compliance was assessed by three surveys of each centre conducted by three different types of research assistants presenting as potential customers; namely, young adults eligible to attend a solarium, young adults with Skin Type 1, and young 16 year-old adolescents. The surveys consisted of two approaches to the centres.

Firstly, a phone interview was conducted as a booking was made to attend the solarium. This was followed by an actual visit to the centre.

The study assessed the Standard's requirement for:

- assessment of skin type and exclusion of Skin Type 1 customers;
- compliance with access by parent consent for 16 year-old adolescents;
- provision of adequate information about skin cancer risk;
- provision of eye goggles; and
- hygiene procedures and other aspects of usual practice.

## Results

The results of compliance tests for the eligible and fair-skinned customers were recently presented at the skin cancer control session of the 18th World Conference on Health Promotion and Health Education conference held in Melbourne.

A full assessment of the information provided to clients about skin cancer risk was assessed by the eligible adult research assistants. Results showed that the majority of centres provided some form of information about skin cancer risk to customers. This was often stipulated in the new customer forms or a notice; a few had mentioned it in pamphlets.

The fair-skinned research assistants had skin that burns but does not tan after 30 minutes exposure to the sun in early summer. We found that skin assessments were made at half of the centres. Skin assessments were most commonly made using a new customer form while some were assessed visually by staff (presumably based on skin, eye and hair colour).

After the final prompting by research assistants about their fair skin that usually burns in the sun, only three centres (10%) indicated these potential high-risk customers would not be permitted to use the beds.

There were few differences in compliance by centre type (see Table 1). Advice about skin cancer risk was less commonly given by solarium centres (65%) compared with health & fitness

centres (75%). However, eye protection was somewhat less commonly provided at health & fitness centres. Assessment of skin-type for fair-skinned customers was the same for both and practice of barring fair-skinned customers was rare for all types.

**Table 1. A summary of compliance by centre type.**

	Solariums (n=22)	H&F centres (n=8)	Total (n=30)
<b>Eligible adult:</b>			
Advised of skin cancer risk	64%	75%	67%
Provided with eye protection	100%	75%	93%
<b>Skin Type 1:</b>			
Skin assessed	50%	50%	50%
Reassured	80% *	50%	71%
Access given	91%	88%	90%

\* Excluding 2 unsupervised centres

Data on adolescent access to solariums will be available later in the year.

## Conclusions

Compliance was particularly low in relation to centres' practices in restricting access to clients with poor tanning ability. These findings suggest there is much room for improvement in solarium centres' current practices and further regulation may well be warranted. The results also provide an evidence base for Government to consider the merits of regulation of the industry.

## References

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- 2 Dobbins S. Reaction to the 2000/01 SunSmart Campaign: Results from a telephone survey of Victorians. SunSmart Evaluation Studies No.7: July 1998 to June 2001. The Cancer Council Victoria, Melbourne, 2004.

## Shedding Light on Adolescent Attitudes

A three-year study that will establish the effectiveness of building shade structures at secondary schools is helping to develop a clear picture of adolescent attitudes to sun protection.

The study, financed by a National Health and Medical Research Council grant of more than \$700,000, is examining the extent to which secondary school students use areas with new shade 'sails' during spring and summer.

One thousand people a year die from skin cancer in Australia, and exposure to ultraviolet (UV) radiation from the sun during adolescence is believed to increase the risk of skin cancer.

Skin cancer prevention researcher, Dr Suzanne Dobbinson, of the Cancer Council's Centre for Behavioural Research in Cancer, is the study's principal investigator. She said that adolescents tend to resist sun protection messages.

"We do quite well at primary school, where children are more compliant," she said. "But by the time they reach secondary school, a culture of tanning and a high incidence of sunburn is common, with a reliance on sunscreen only. This increases year by year until the age of fifteen or sixteen."

The study, *A Shade Intervention for Secondary Schools*, is comparing the behaviour of adolescents at similar schools with newly built

shade-sail structures to those without the structures. A total of sixty schools will be involved in the study in outer metropolitan Melbourne.

Video observations are being made during lunch breaks to measure the use made of the newly shaded areas.

Suzanne said the shade would provide at least 93% reduction in UV radiation, without affecting the adolescents' fashion trends and self-image.

"We need to establish the value of investing in shade at secondary schools, and whether it will lead to shade-seeking or shade-avoiding behaviour," she said.

The study is due to be completed by the end of 2006.

*The programs of the Centre for Behavioural Research in Cancer provide a research base which supports the role of the Cancer Council in advising and implementing cancer control strategies for the population of Victoria.*

*The centre undertakes research on smoking behaviour, sun-protective behaviour and early detection behaviours in skin, breast, cervical and prostate cancers.*

*It also undertakes research looking at the experience and needs of cancer patients. Studies vary from short-term interview or observational studies to large projects that cover many years.*

Reprinted from *The Cancer Council Victoria Annual Review 2003*

## The National Sun Behaviour Survey 2003–2004

As part of the National Sun Behaviour Survey for the summer of 2003–2004, weekly telephone interviews were conducted to describe the incidence of sunburn and sun protective behaviours of a representative proportion of Australians between the ages of 12 and 69. In addition, information about the sun protection behaviour of over 1200 children aged 0 to 11 years old was gathered.

The data collection phase has been completed and over 5700 interviews have been conducted.

It is anticipated that the reports on the findings will be made available during 2004 and will be valuable in planning national approaches to sun protection.

This study has been supported by all the state and territory Cancer Councils, The Cancer Council Australia, The Department of Health and Ageing, state and territory health authorities and the NCCI.

Reprinted from *NCCI Newsletter March / April 2004*.

## Clinical Trials Update

### LUD2002-013 – Phase II NY-ESO-1 ISCOM® in melanoma patients with ESO+ tumours and measurable disease

Open for accrual at Austin and Peter Mac.

[Contact: Ian Davis / Jonathan Cebon, Austin Health, Ph: (03) 9496 5726 / Grant McArthur, Peter Mac, Ph: (03) 9656 1195]

### LUD2003-003 – Pilot study of immunization with peptides of melanoma antigens following application of imiquimod cream in patients with resected stage II, III or IV malignant melanoma (pending)

Opening soon.

Eligibility criteria:

- Resected stage II, III or IV [or unresected N2c (in transit) or other small volume loco-regional disease], histologically proven melanoma
- HLA-A2 positive
- Expected survival  $\geq$  6 months
- Full recovery from surgery (at least 2 weeks)
- KPS  $\geq$  70%
- Age  $\geq$  18 years and able to give consent
- ANC  $\geq$  2.0, Lymphocytes  $\geq$  0.5, Platelets  $\geq$  100
- Creat  $\leq$  0.2 mmol/L
- Bilirubin  $\leq$  35 mmol/L, ALT/AST  $<$  2.5  $\times$  ULN
- No clinically significant heart disease or other serious intercurrent illness
- No CNS metastatic disease unless treated and stable
- No other malignancy within 3 years, except treated or non-melanoma skin cancer, or cervical CIS
- No history of immunodeficiency or autoimmune disease (vitiligo is permissible)
- No concomitant treatment with systemic corticosteroids, or NSAIDs (COX-2 inhibitors permitted).
- No known HIV positivity
- No chemotherapy, radiotherapy, immunotherapy within 4 weeks prior (6 weeks nitrosoureas)
- No mental impairment which may compromise consent ability

- Available for immunological and clinical follow-up assessments
- No trial with other investigational agent within 4 weeks prior
- Not pregnant or lactating, must use contraception

[Contact: Ian Davis / Jonathan Cebon, Austin Health, Ph: (03) 9496 5726]

### Comparison between low dose imiquimod with cryotherapy in the short and long term clearing of solar keratoses

Recruitment continues slowly at the Skin and Cancer Foundation.

[Contact: Robin Marks, St Vincent's Hospital, Ph: (03) 9288 3293]

### Treatment of lentigo maligna with imiquimod 5% cream

Investigation of the treatment of histologically proven lentigo maligna with imiquimod cream, over a maximum period of 12 weeks. Patients will have their lesions excised at the completion of treatment to determine whether or not imiquimod has achieved histological clearance.

Screening for accrual at Victorian Melanoma Service, Alfred Hospital.

[Contact: Martin Haskett, Frankston Rooms, Ph: (03) 9770 9788 / Tina Sutton, Alfred Hospital, Ph: 0402 439 749 / Sister Merran Tyler, Alfred Hospital, Ph: (03) 9530 5940 (AH)]

### Phase III randomised double-blind trial of immunotherapy with a polyvalent melanoma vaccine, CancerVax vaccine plus BCG versus placebo plus BCG as a post-surgical treatment for

- **stage III melanoma** – Four patients accrued at the Alfred. Open for accrual at Peter Mac.
- **stage IV melanoma** – Three patients accrued at the Alfred. Open for accrual at Peter Mac.

[Contact: Grant McArthur, Peter Mac, Ph: (03) 9656 1195 / Andrew Haydon, Alfred Hospital, Ph: (03) 9276 2000]

**Antigenics Protocol C-100-21 – Phase III study of heat shock protein peptide complex (HSPP-96) versus physician’s choice including interleukin-2 and/or dacarbazine / temozolomide-based therapy and/or complete resection in stage IV melanoma**

Patients newly diagnosed with stage IV melanoma that is amenable to biopsy or complete resection are eligible. The trial is open at Royal Melbourne, Melbourne Private and Western Hospitals. 11 patients have been recruited to the trial at Royal Melbourne / Melbourne Private Hospitals, of which 4–5 were randomised to the HSP vaccine arm.

[Contact: Bruce Mann / Peter Gibbs, Royal Melbourne Hospital, Ph: (03) 9347 6301]

**Open, parallel group, multi-centre, randomised trial of the combination of PaTrin2 and temozolomide versus temozolomide alone given orally daily for five days every four weeks in patients with advanced melanoma who have not previously received systemic chemotherapy**

Amended study (patients have to have biopsiable disease) now open for accrual at the Alfred, Austin and Peter Mac.

[Contact: Ian Davis, Austin Health, Ph: (03) 9496 5726 / Andrew Haydon, Alfred Hospital, Ph: (03) 9276 2000 / Grant McArthur, Peter Mac, Ph: (03) 9656 1195]

**Phase II study of PI-88 in advanced melanoma**

Closed. Reached target of 41 patients at the Alfred.

[Contact: Andrew Haydon, Alfred Hospital, Ph: (03) 9276 2000]

**TROG 02-01 – Adjuvant radiotherapy for regional control in patients with resected node metastatic melanoma**

Site	Accrual to 30 May	
NZ	Auckland Hospital	0
	Christchurch Hospital	1
	Dunedin Hospital	0
	Wellington Hospital	1
NSW	Illawarra Hospital	0
	Mater Hospital (Newcastle)	1
	Prince of Wales Hospital	0
	Royal Prince Alfred Hospital	20
	Westmead Hospital	0
QLD	East Coast Cancer Centre	2
	Mater QRI	2
	Princess Alexandra Hospital	24
	Royal Brisbane Hospital	0
SA	Royal Adelaide Hospital	1
TAS	Launceston General Hospital	0
VIC	Alfred Hospital	1
	Austin Hospital	0
	Geelong Hospital	0
	Peter MacCallum Cancer Centre	15
WA	Sir Charles Gairdner Hospital	0
	Royal Perth Hospital	1
<b>Total</b>		<b>69</b>

[Contact: Juliana Di Iulio, Peter Mac, Ph: (03) 9656 3786]

## Guidelines for the Management of Cutaneous Melanoma

A small Executive Working Party has met to discuss revision of these guidelines. A work plan has been sent to NHMRC for approval. (*Editorial comment: The revision by NHMRC is on hold pending assessment by The Cancer Council Australia.*)

Reprinted from Wongi Yabber May 2004; 11(2): 2.

## Non-Melanoma Skin Cancer: Guidelines for Treatment and Management in Australia

An A4 Advisory Card for General Practitioners was sent to GPs in the December 2003 edition of *Australian Doctor*. Copies are also being sent to General and Plastic Surgeons and Radiotherapists.

The Australian Cancer Network acknowledges the cooperation of the specialist groups involved in managing non-melanoma skin cancer.

The Royal Australian College of General Practitioners (RACGP), Royal Australian College of Surgeons (RACS), Australian Society of Plastic Surgeons (ASPS), Faculty of Radiation Oncology (RACR) and Royal College of Pathologists of Australasia (RCPA) have placed it on their respective websites. It can also be viewed on the ACN website [www.cancer.org.au/guidelines](http://www.cancer.org.au/guidelines) or e-mail [acn@cancer.org.au](mailto:acn@cancer.org.au) for a copy.

Reprinted from *Wongi Yabber* May 2004; 11(2): 2.

### Key Published Articles Listing—Skin Cancer

Title	Author & Journal
<b>Prevention of skin cancer</b>	<b>D Hill, JM Elwood &amp; DR English (Eds).</b> Kluwer Acad Publishers: Dordrecht, The Netherlands.
<b>Fotemustine compared with dacarbazine in patients with disseminated malignant melanoma: A phase II study</b>	<b>Avril MF, Aamdal S, Grob JJ, et al.</b> Journal of Clinical Oncology 15 March 2004; 22(6): 1118–1125.
<i>Several important points: (1) DTIC responses are less frequent than we have previously thought. (2) Fotemustine seems superior in RR and time to brain mets but not in OS. (3) Fotemustine is more toxic.</i>	
<b>Interobserver reproducibility of ulceration assessment in primary cutaneous melanomas</b>	<b>Spatz A, Cook MG, Elder DE, et al.</b> European Journal of Cancer September 2003; 39(13): 1861–1865.
<i>Important paper standardising criteria for ulceration in melanoma.</i>	
<b>Treatment of lentigo maligna with topical imiquimod</b>	<b>Naylor MF, Crowson N, Kuwahara R, et al.</b> British Journal of Dermatology November 2003; 149(Suppl 66): 66–70.

## Key Published Articles Listing—General

Title	Author & Journal
<b>Potential health risks of complementary alternative medicines in cancer patients</b>	<b>Werneke U, Earl J, Seydel C, et al.</b> British Journal of Cancer 26 January 2004; 90(2): 408–413.
<b>What's the harm? Alternative medicine is not everything to gain and nothing to lose</b>	<b>Shermer H.</b> www.scientificamerican.com 10 November 2003.
<b>The current position of complementary / alternative medicine in cancer</b>	<b>Ernst E.</b> European Journal of Cancer November 2003; 39(16): 2273–2277.
<b>The regulation of complementary health: Sacrificing integrity?</b>	<b>Parker MH.</b> Medical Journal of Australia 15 September 2003; 179(6): 316–318.
<b>It's natural so it must be safe – Editorial</b>	<b>Smith A.</b> Australian Prescriber 2002; 25(3): 50–51.
<b>Interactions between complementary medicines and warfarin</b>	<b>Myers SP.</b> Australian Prescriber 2002; 25(3): 54–56.
<b>An analysis of newspaper reports of cancer breakthroughs: Hype or hope?</b>	<b>Ooi ES &amp; Chapman S.</b> Medical Journal of Australia 1/15 December 2003; 179(11/12): 639–643.
<b>Public funding of large-scale clinical trials in Australia – Letter to Editor</b>	<b>A Rodger.</b> Medical Journal of Australia 2004; 180(5): 255.
<b>Making sense of trial results: Outcomes and estimation</b>	<b>O'Connell RL, GebSKI VJ &amp; Jeech AC.</b> Medical Journal of Australia 2004; 180(3): 128–130.
<b>Comparison of outcomes in cancer patients treated within and outside clinical trials: Conceptual framework and structured review</b>	<b>Peppercorn JM, Weeks JC, Cook EF and Joffe S.</b> The Lancet 24 January 2004; 363(9405): 263–270.
<b>The Clinical Support Systems Program</b>	<b>Leigh JA, Long PW, Phillips PA &amp; Mortimer RH.</b> Medical Journal of Australia 2004; 180(10 Suppl): S74–S75.
<b>Turning an idea into reality to improve patient care: The development of the Clinical Support Systems Program</b>	<b>Sewell J, Leigh JA &amp; Long PW.</b> Medical Journal of Australia 2004; 180(10 Suppl): S76–S78.
<b>The ethics of early stopping rules: Who is protecting whom?</b>	<b>Cannistra SA.</b> Journal of Clinical Oncology May 2004; 22(9): 1542–1545.

## Forthcoming Meetings

Date / Place	Meeting / Contact
<b>3–6 July 2004</b> Innsbruck, Austria	<b>18<sup>th</sup> Meeting of the European Association for Cancer Research (EACR)</b> EACR 18 Secretariat, Federation of European Cancer Societies, Avenue E Mounier 83, Brussels, Belgium 1200. Contact: Ms Davi Kaur Ph: +32 2 775 0201 Fax: +32 2 775 0200 E-mail: <a href="mailto:eadr18@feces.be">eadr18@feces.be</a> Website: <a href="http://www.feces.be/conferences/eadr18">www.feces.be/conferences/eadr18</a>
<b>22–24 July 2004</b> Zurich, Switzerland	<b>International Skin Cancer Congress</b> Department of Dermatology, University Hospital of Zurich, Gloriastrasse 31, Zurich 8091 Switzerland Ph: +41 1 255 8837 Fax: +41 1 255 4403 E-mail: <a href="mailto:nicole.brunner@usz.ch">nicole.brunner@usz.ch</a> Website: <a href="http://www.skincancer.ch">www.skincancer.ch</a>
<b>4–7 August 2004</b> Cairns, QLD, Australia	<b>Medical Oncology Group of Australia (MOG) Annual Scientific Meeting</b> Contact: Pharma Events, PO Box 265, Annandale NSW 2038 Ph: (02) 8247 6207 Fax: (02) 9380 9033 E-mail: <a href="mailto:conferences@pharmaevents.com.au">conferences@pharmaevents.com.au</a> Website: <a href="http://www.racp.edu.au/moga/index.html">www.racp.edu.au/moga/index.html</a>
<b>8–12 August 2004</b> Sydney, NSW, Australia	<b>13<sup>th</sup> International Conference on Cancer Nursing 2004</b> Organised in partnership between ISNCC and the Cancer Nurses Society of Australia (CNSA). Contact Liz Peim Ph: +44 116 270 3309 Fax: +44 116 270 3763 E-mail: <a href="mailto:conference@isncc.org">conference@isncc.org</a> Website: <a href="http://www.isncc.org/conference_2004/2004_Intro.html">www.isncc.org/conference_2004/2004_Intro.html</a>
<b>8–14 August 2004</b> Palm Cove, QLD, Australia	<b>Australia &amp; Asia Pacific Clinical Oncology Research Development (ACCORD) Workshop</b> Contact: Medical Oncology Group of Australia, Level 6, 52 Phillip Street, Sydney 2000 Ph: (02) 8247 6207 Fax: (02) 9247 3022 E-mail: <a href="mailto:fmarine@bigpond.com">fmarine@bigpond.com</a>
<b>25–28 August 2004</b> Copenhagen, Denmark	<b>7<sup>th</sup> World Congress of Psycho-Oncology</b> IPOS2004, Institute of Cancer Epidemiology, The Danish Cancer Society, Strandboulevarden 49, 2100 Copenhagen, Denmark Fax: + 45 3525 7731 E-mail: <a href="mailto:ipos2004@cancer.dk">ipos2004@cancer.dk</a> Website: <a href="http://www.ipos2004.dk">www.ipos2004.dk</a>

Date / Place	Meeting / Contact
<b>25–28 September 2004</b> Athens, Greece	<b>Frontiers of Novel Targets in Molecular Oncology</b> John Giannios, GHA, Sarantaporou-3, Filothei, Athens Greece 15237 Ph: +30 977 450 345 E-mail: <a href="mailto:jng@otenet.gr">jng@otenet.gr</a>
<b>28 Sep – 1 Oct 2004</b> Geneva, Switzerland	<b>16th EORTC/AACR/NCI 2004 Symposium on Molecular Targets on Cancer Therapeutics</b> Federation of European Cancer Societies, 83 Avenue E. Mounier, Brussels, Belgium Ph: +32 2 775 0201 Fax: +32 2 775 0200 Website: <a href="http://www.fecs.be/conferences/ena2004">www.fecs.be/conferences/ena2004</a>
<b>1–5 October 2004</b> Tampa, Florida, USA	<b>Molecular Targets for Cancer Therapy 3<sup>rd</sup> Biennial Meeting</b> Moffitt Cancer Center, 12902 Magnolia Drive, Tampa 33612 Florida, USA Ph: +1 813 903 4975 Fax: +1 813 979 3874 E-mail: <a href="mailto:gordonac@moffitt.usk.edu">gordonac@moffitt.usk.edu</a> Website: <a href="http://www.moffittcancercenter.com/promotions">www.moffittcancercenter.com/promotions</a>
<b>2 October 2004</b>	<b>Supportive Care in Cancer Patients Education Symposium</b> Contact information and registration: Dr Szneczana Bosnjak E-mail: <a href="mailto:nenab@sezampro.yu">nenab@sezampro.yu</a>
<b>3–7 October 2004</b> Atlanta, Georgia, USA	<b>46<sup>th</sup> Annual Meeting of the American Society for Therapeutic Radiology and Oncology (ASTRO)</b> ASTRO, 12500 Fair Lakes Circle, Suite 375, Fairfax VA 22033, USA Ph: +1 703 227 0170 Fax: +1 703 502 7852 E-mail: <a href="mailto:meetings@astro.org">meetings@astro.org</a>
<b>21–24 October 2004</b> Perth, WA, Australia	<b>55<sup>th</sup> Annual Scientific Meeting of the Royal Australian &amp; New Zealand College of Radiologists (RANZCR)</b> Website: <a href="http://www.ranzcr.edu.au">www.ranzcr.edu.au</a>
<b>24–28 October 2004</b> Amsterdam, Netherlands	<b>23<sup>rd</sup> Annual Meeting of the European Society for Therapeutic Radiology &amp; Oncology (ESTRO)</b> ESTRO Office, Av. E. Mounierlaan 83/4, Brussels, Belgium B-1200 Ph: +32 2 775 9340 Fax: +32 2 779 5494 E-mail: <a href="mailto:info@estro.be">info@estro.be</a> Website: <a href="http://www.estro.be">www.estro.be</a>
<b>25–30 October 2004</b> Corfu, Greece	<b>7<sup>th</sup> International Conference on Anticancer Research</b> Internation Institute of Anticancer Research, 1 st km Kapanditriou-Kalamou Road, Kapanditri, PO Box 22, Attiki Greece 19014 Ph: +30 22950 53389 E-mail: <a href="mailto:iiar@iiar-anticancer.org">iiar@iiar-anticancer.org</a>

Date / Place	Meeting / Contact
<b>29 Oct – 2 Nov 2004</b> Vienna, Austria	<b>29<sup>th</sup> Congress of the European Society for Medical Oncology (ESMO)</b> ESMO Congress Secretariat, Via La Santa 7, CH-6962 Viganello-Lugano, Switzerland Ph: +41 91 973 1919 Fax: +41 91 973 1918 E-mail: <a href="mailto:alessia@esmo.org">alessia@esmo.org</a> Website: <a href="http://www.esmo.org/congress2004/">www.esmo.org/congress2004/</a>
<b>10–12 November 2004</b> Hong Kong, China	<b>11<sup>th</sup> Hong Kong International Cancer Congress</b> Contact: 11 <sup>th</sup> HKICC Congress Secretariat Ph: 852 2818 0232 Fax: 852 2818 1186 E-mail: <a href="mailto:hkicc04@hku.hk">hkicc04@hku.hk</a> Website: <a href="http://www.hkicc.org">www.hkicc.org</a>
<b>17–19 November 2004</b> New York City, New York, USA	<b>1<sup>st</sup> International Conference for Oncologists and Other Health Care Leaders</b> Memorial Sloan-Kettering Cancer Center, 1275 York Avenue, New York NY 10021, USA Ph: +1 212 639 200 E-mail: <a href="mailto:cassileth@mskcc.org">cassileth@mskcc.org</a>
<b>24–26 November 2004</b> Canberra, ACT, Australia	<b>31<sup>st</sup> Annual Scientific Meeting of the Clinical Oncology Society of Australia (COSA) – Cancer Care: An Integrated Approach</b> Conference details: Pharma Events Ph: (02) 9280 0577 Fax: (02) 9280 0533 E-mail: <a href="mailto:cosa@pharmaevents.com.au">cosa@pharmaevents.com.au</a> Website: <a href="http://www.cosa.org.au">www.cosa.org.au</a>
<b>28 Nov – 3 Dec 2004</b> Chicago, Illinois, USA	<b>90<sup>th</sup> Meeting of the Radiological Society of North America</b> Radiological Society of North America, 820 Jorie Blvd, Oak Brook, IL 60521 USA Fax: +1 630 571 7837 E-mail: <a href="mailto:reginfo@rsna.org">reginfo@rsna.org</a> Website: <a href="http://www.rsna.org">www.rsna.org</a>

## The Cancer Council Victoria

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

### Centre for Clinical Research in Cancer — Victorian Cooperative Oncology Group

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

The Victorian Cooperative Oncology Group (VCOG) established in 1976, provides advice to the Cancer Council Victoria, through the CCRC, on all clinical aspects of cancer control, in particular research, screening, diagnosis, treatment, palliative medicine, cancer genetics and professional education. The strategic role of VCOG is to have a 'parliament' of clinical cancer specialists with a view to promoting a range of cooperative measures to optimise cancer treatment in Victoria. VCOG consists of a primary committee, 8 cancer-site and 5 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.

