

# Skin Cancer Update

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# SKIN CANCER UPDATE

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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). The Victorian Cooperative Oncology Group's advisory committees on breast, gastrointestinal, gynaecological, head & neck, lung and urological cancers also produce twice yearly cancer updates.

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\*\*\*\*\* **Last Issue – No. 10 – July 2004** \*\*\*\*\*

***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.***

## Editorial

*Associate Professor Ian Davis  
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Welcome to the December 2004 stocking filler bumper edition of the Skin Cancer Update. In it you will find our regular segments including a listing of clinical trials open for accrual at Melbourne centres; please continue to refer patients for these trials. We include a report from SunSmart about the dangers of incidental UV exposure – don't try this at home! There are also other information pieces regarding unproven therapies, treatment guideline development and implementation, and reports from The Cancer Council Australia and the National Cancer Control Initiative. We are also proud to include a tribute to Don Metcalf as he celebrates 50 years as The Cancer Council Victoria's Carden Fellow.

We also have a special present for you in this edition in the form of a theme that is undeniably topical. Imiquimod (Aldara, 3M Pharmaceuticals) is a cream approved in Australia for the treatment of genital and perianal warts. When applied to skin it induces expression of pro-inflammatory cytokines such as interferon alpha, IL-1, IL-8 and TNF. The mechanisms underlying this are unclear although cells such as dendritic cells are capable of responding to imiquimod through the Toll-like receptors TLR-7 and -8. Imiquimod is thought to mediate its effects on warts by inducing immune responses, so it was

logical to test it on skin malignancies. Related compounds are available for laboratory studies.

We therefore have reports from Robin Marks on the use of imiquimod for basal cell carcinomas and solar keratoses; from John Spillane on the effects of imiquimod on in-transit melanoma metastases; from Martin Haskett on its use in lentigo maligna; and from Jonathan Cebon with respect to the use of imiquimod in the context of vaccination against cancer-related antigens.

This theme illustrates very well how thinking laterally can lead to entirely new and important applications of existing technologies. It also gives an example of how interactions between scientists and clinicians can give new insights and new opportunities for research, as well as providing additional value for pre-existing projects. We would like to encourage all our readers to consider how this could be done in other areas of their own interest. Imiquimod will obviously provide fertile ground for future research in both human and animal studies, although we know from experience that the pharmacist looks at you very strangely if you try to buy it and tell them it's for your mice.

We hope you find this issue useful and informative and we encourage you to consider submitting articles for future editions.

### Contributions Welcome

The Skin Cancer Update welcomes contributions – conference report, review of an area of interest, review of recent journal article, clinical trial update.

	<b>Deadline</b>	<b>Issue Date</b>
Mid-year issue	1 June	1 July
Year-end issue	1 November	1 December

Contributions should be forwarded to:

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## Professor Don Metcalf Honoured for Outstanding Contribution to Cancer Research

*Ms Zoe Furman  
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The Cancer Council Victoria recently honoured leading medical researcher Professor Donald Metcalf for his outstanding contribution to cancer research. Hailed as "Australia's most distinguished cancer researcher", Professor Metcalf was recognised for his life-saving research at a special function at Government House, Melbourne, in late November, to celebrate his 50 years as the Cancer Council's Carden Fellow.

Since being appointed Carden Fellow in Cancer Research in 1954, Professor Metcalf has been based at the Walter and Eliza Hall Institute for Medical Research. His research has led to the development of the major supportive cancer therapy, colony stimulating factors (CSF), which has so far benefited around five and a half million cancer patients worldwide.

Cancer Council Director Professor David Hill said the Cancer Council was proud to have supported the work of a world-class researcher over the last 50 years.

"There are very few medical researchers whose work has had such a profound impact on cancer treatment."

Associate Professor Richard Bell said CSFs have had a major impact on the treatment of human disease.

"Clinicians have experienced a dramatic improvement in our ability to treat cancer because of Professor Metcalf's discovery. His work has led to a large and productive network of biologic and clinical trials research. We continue to learn of new and better ways to use his discoveries to benefit our patients."

Former Walter and Eliza Hall Institute Director Sir Gustav Nossal said Professor Metcalf is one of the few medical scientists who have seen his discoveries flourish from laboratory bench to the patient's bedside.

Around 30 people who received CSF therapy as part of their treatment for cancer and other medical conditions attended the special celebration, and had the opportunity to meet Professor Metcalf.

As Professor Metcalf commented, this interaction between a researcher and those who have benefited from research is most unusual.

"It's quite uncommon to discover something that gets into the clinic and is used in treating people. Not many people have the good fortune to discover something that can be applied like this."

The opportunity to meet the man responsible for a treatment that had helped their recovery was clearly a highlight for the patients, with many traveling from country areas to attend the jubilee

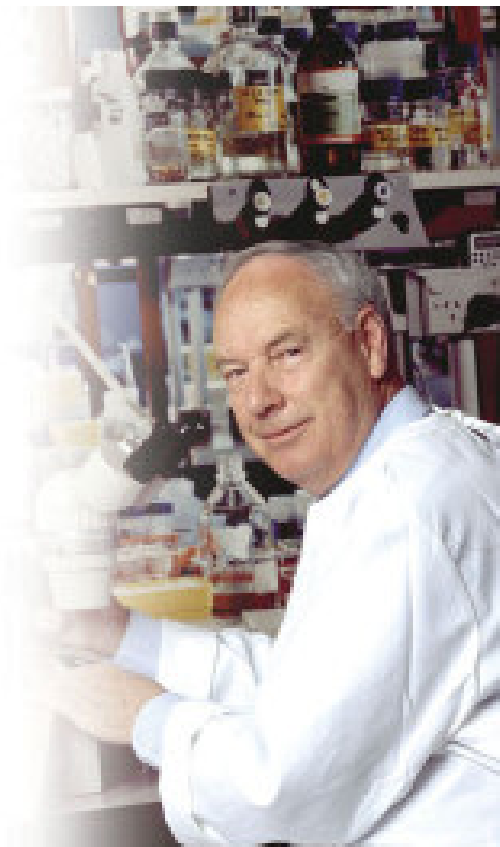


Image courtesy of Walter & Eliza Hall Institute of Medical Research

celebration. Several former patients had participated in clinical trials of G-CSFs at Royal Melbourne Hospital in the early 1990's, while others had undergone cancer treatment as recently as this year.

Annie Donaldson, who has had two G-CSF supported stem cell transplants as part of her treatment for multiple myeloma, was one of the guests at the special event.

Ms Donaldson said it was an honour to be able to meet the man whose research has helped save her life.

"Professor Metcalf's discovery of CSFs is the reason I am alive today, and it is wonderful to be able to meet such a dedicated and gifted scientist whose work has helped so many people like me."

The Carden Fellowship was established as a result of an initial generous bequest to the Cancer Council in 1945 from George Frederick Carden, a prominent Melbourne businessman. The Carden family's link with the Cancer Council extends to VCOG; longstanding VCOG member Tony Carden, who has been involved in the Gastrointestinal Committees for many years, is Carden's grandson. Tony, along with a number of Carden's descendents attended the jubilee celebration at Government House.

One of the highlights of the day was a special performance by another Carden family member, renowned Australian opera singer Joan Carden. The operatic touch was fitting given the well-publicised link between G-CSF and another famous opera singer, Spanish tenor Jose Carreras. After developing acute myeloid leukaemia, which did not respond to initial treatment, Carreras received a treatment regime that included CSF therapy in 1987. He responded positively and recovered successfully. Senor Carreras was one of a number of luminaries to send congratulations for the Metcalf jubilee celebration.

Professor Metcalf's work has been acknowledged by some of the highest honours in the world of contemporary science. Still considered to be at the forefront of cancer research today, his work is a remarkable success story of cancer research, of generous philanthropy and of the benefit of prolonged, sustained and secure support from The Cancer Council Victoria in a funding relationship that is probably unique in medical research in Australia.

Professor Metcalf's career in research illustrates perfectly the significant dividends that can come from channelling long-term support into the work of a world-class researcher.

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## Imiquimod in Non-Melanoma Skin Cancer

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The mechanism of action of imiquimod as an enhancer of both innate and cell mediated immunity has been covered in the introductory remarks by Ian Davis. Going back into the history of treatment of non-melanoma skin cancer, interferon has been used for at least 15 years with some effect, although limited, in the treatment of basal cell carcinoma when given by intralesional injection.<sup>1</sup> Thus one of the first tumours for which imiquimod was believed to have potential, because of its interferon induction, was basal cell carcinoma.

The first published report of its efficacy in non-melanoma skin cancer was in the treatment of basal cell carcinoma in 1999.<sup>2</sup> Since then, imiquimod has been reported to be of value in not only basal cell carcinoma, but actinic (solar) keratosis and Bowen's disease (squamous cell carcinoma in-situ).

### Basal Cell Carcinoma

The initial study reporting the value of imiquimod 5% cream applied topically for the treatment of

basal cell carcinoma was in a vehicle-controlled dosing study of 35 patients with both nodular and basal cell carcinomas.<sup>2</sup> They were treated for up to 16 weeks in one of five dosing regimens. They had 100% histological clearance in those treated twice daily, once daily and three times weekly. Local inflammatory reactions of the tumour site were dose dependent.

Various dosing regimens were then reported in both superficial and nodular basal cell carcinoma in separate trials. A multi-centre study from Australasia of different dose regimens in 99 patients with superficial basal cell carcinoma reported an 87.9% histological clearance in those treated daily, a 73.3% clearance in twice daily three times per week, and 69.7% clearance in those treated once daily three times per week.<sup>3</sup> Only three patients were enrolled in a twice daily regimen (all of whom had histological clearance) because the severity of local reactions was sufficient to call a halt to that arm very early in the trial.

Two subsequent phase III randomised vehicle-controlled trials involving 724 patients with superficial basal cell carcinoma revealed a histological clearance rate for daily treatment five and seven times per week being 82% and 79% respectively.<sup>4</sup> There was a clear correlation between histological clearance rates and severity of the local skin reaction consisting of erythema, erosion and scabbing/crusting. On the basis of this latter study, a standard regimen recommended for superficial basal cell carcinoma has been five times per week for six weeks.

The histological clearance rate for nodular basal cell carcinoma has been shown to be less than for superficial basal cell carcinoma. Two phase II studies, a six week randomised open-labelled dose-response evaluating four dosing regimens and a 12 week randomised vehicle-controlled double-blind dose-response evaluating four dosing regimens were reported.<sup>5</sup> The maximum response rate was 71% and 76% for the patients in the highest dosing regimen (once daily) in the six and 12 week studies respectively.

A recently published study on the use of imiquimod in 67 patients with multiple superficial basal cell carcinomas treated seven times per week or five times per week for six weeks demonstrated a 77% histological clearance rate for the 161 tumours that were treated.<sup>6</sup> One

hundred percent of 36 patients in the five times per week regimen had at least one tumour clear compared with 93% of 30 patients in the seven times per week regimen. However, the study showed that clearance of one tumour in a person with multiple tumours does not necessarily indicate that all the treated tumours will respond. There was also a site-specific likelihood of tumour response which correlated with the intensity of inflammatory reactions. The tumours least likely to respond were those on the lower limb, where there was the lowest intensity of inflammatory site reactions.

### Actinic (Solar) Keratoses

There has been increasing interest in the use of topical imiquimod in the treatment of actinic keratoses. These evanescent tumours are highly antigenic, with increasing frequency, severity and likelihood of malignant transformation to squamous cell carcinoma in chronically immunosuppressed patients. A variety of dosing regimens have been used since its efficacy was first reported in 2002.<sup>7</sup> Marked inflammatory responses have been noticed in high dosing regimens such as daily or five times per week. Consequently, cyclical therapy has been assessed, varying from 2-3 times per week for up to 16 weeks.<sup>8,9</sup>

The complete clearance rate for actinic keratoses on the face and scalp was 57.1% and 45.1% when used three times and two times per week respectively. The partial clearance (equal to or greater than 75% reduction in baseline lesions) was 72.1% and 59.1% in the 722 patients enrolled in the three times per week and two times per week regimens respectively. Even with the low dose regimens, severe erythema occurred in 30.6% and 17.7% of participants who received three times per week and the two times per week regimen respectively.

Finally, imiquimod 5% cream was used in patients with Bowen's disease in a phase II open-labelled study in 16 patients treated once daily for 16 weeks.<sup>10</sup> There was a 93% histological clearance rate in the 15 patients who completed the study (one patient died of an unrelated intercurrent illness). Six patients ceased treatment between 4-6 weeks because of severe local reactions. More recent studies have reported lower doses in cyclical treatments such as three times per week for three weeks followed by a repeat cycle

after a four week rest period, or applied alternate nights for up to six weeks, with moderate term clearance rates in small case series.<sup>11,12</sup>

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## Imiquimod and In-transit Melanoma

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*Peter MacCallum Cancer Centre*

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In-transit melanoma (ITM) is a challenging management problem because despite the use of multi-modal therapies, recurrence is a major issue. This often leaves patients with recurrent multiple, ulcerating, painful necrotic lesions requiring repeated local dressings. It becomes a major social issue often severely limiting patient's quality of life. Despite the aggressive nature of in-transit melanoma, these patients can have stable or slowly growing metastatic disease. Consequently the palliative management of in-transit melanoma is a major issue.

Current treatments for in-transit melanoma include surgery (local excision of the lesions with primary closure, local flaps, skin grafts or

amputation), radiotherapy or chemotherapy (isolated limb infusion / perfusion, or systemic chemotherapy). At least 1/3 of patients will develop symptomatic recurrence without life threatening disease elsewhere.

At the Peter MacCallum Cancer Centre, we have had a small number of patients in the last three years who have exhausted standard therapeutic options to control their in-transit melanoma. Often they have had multiple surgeries, repeated isolated limb infusions and in many cases have had recurrences develop within the radiotherapy field. We have used 5% imiquimod in a once daily dose without occlusive dressings for this group of patients.

We observed a variety of responses to the cream ranging from no response, to a complete remission of all treated lesions. The local inflammatory reaction at the application site is the most useful indicator of a potential response to therapy. Those who did not respond had no local reaction. It is important to persist with imiquimod therapy to obtain a response, despite an often intense local reaction. Treatment may be ceased for a short period of time when the reaction was most severe and reintroduced subsequently at less frequent application regimen. This limits the side effects from the local reaction while maximising the clinical response.

In reviewing the literature, there did not appear to be a consensus as to how best to apply imiquimod for melanoma. Both occlusive dressings as well as no dressings have been described with both techniques appearing to have a similar clinical outcome. Imiquimod has been applied as frequently as twice daily through to three times per week with the length of treatment varying from three to seven months. Most reports are from small case series and although a few studies have used imiquimod for cutaneous melanoma metastasis the data in this area is limited. More research is required to identify the best initial frequency of application as well as the length of treatment required. Similarly, information regarding the recurrence rate following therapy and whether imiquimod is as effective when used for a second time on a recurrent disease is also lacking. These and other questions remain and potentially provide the ideal situation for a collaborative multi-centre trial through VCOG.

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# The Use of Imiquimod 5% Cream to Treat Lentigo Maligna

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The currently agreed best treatment of a lentigo maligna is surgical excision with a 5mm margin. Other modalities that have been used include superficial X-rays, cryotherapy and Azelaic acid application.

A common management problem that lentigo maligna presents is that many patients have large lesions at sites of high functional and cosmetic importance, meaning that surgical treatment is a very significant procedure. They occur in young patients with high levels of concern for the disfigurement produced by surgery, and even more frequently in elderly people with multiple co-morbidities making surgical treatment difficult. To compound this problem the edges of a lesion are often indistinct macroscopically (even when viewed with the Woods light). This means that surgical excision is often reported as incomplete, leading to a re-excision procedure, and sometimes multiple re-excisions.

The driving force for Imiquimod cream use to manage this problem is that as a non-specific stimulant of attack on cancer cells within the skin with a proven ability to cure BCC, there is the probability that it will offer an efficacious non surgical treatment for lentigo maligna. There is no evidence of a specific effect of Imiquimod on lentigo maligna cells. Currently published evidence of this proposition is limited to case reports and small series, and anecdotally, it would seem that it has already entered some clinicians practice.

Any trial of Imiquimod use must account for the fact that lentigo maligna can be difficult to diagnose macroscopically, dermoscopically, and histologically. Histology remains the accepted standard, but even with this there is no absolute marker for the diagnosis, and there is a high rate of discordance between pathologists when assessing early lesions. Atypical melanocytes and solar damaged keratinocytes can be difficult to distinguish. (A recent paper emphasised the

possible confusion of solar damaged keratinocytes with lentigo maligna cells when stained with Melan A.) Histologic assessment is further complicated by the possibility of sampling error if partial lesion biopsy is performed (e.g. shave biopsy). This affects both the initial diagnosis for inclusion in a trial, and for assessing efficacy of treatment.

The way to properly assess the efficacy of Imiquimod is by only selecting patients where there is strong concordance of histological diagnosis between pathologists, and by fully excising the treated area after Imiquimod use to assess all the margins of the treated skin. Patients in a trial of Imiquimod use therefore have to undergo the very procedure which the trial is designed to avoid. This has presented difficulties in recruiting patients to the current trial at the Alfred Hospital.

The other method of trialling Imiquimod treatment is to use it and follow patients over time to assess outcome. As lentigo maligna can become invasive imperceptibly as assessed on clinical grounds, exposing patients to the risk of metastatic disease, this method of trial can only be ethically acceptable when a fully informed patient refuses surgical treatment.

The other issue with Imiquimod use is the dose required. The duration and severity of the inflammatory reaction necessary for removal of tumour cells remains uncertain. This is an important matter, as some patients find coping with the inflammatory reaction at the site of application quite arduous. Dosing regimes in the treatment of lentigo maligna have therefore been extrapolated from those already explored in treating BCC.

At the Alfred Hospital our experience is twofold. There has been a formal trial of treatment with a dosing regimen requiring patients to have had a marked inflammatory reaction lasting 10 days or alternatively having applied the Imiquimod for 12

weeks at 5 days a week. We also have a group of patients who have refused surgical treatment for either an untreated lesion or for an incompletely excised lesion.

From the outcome of our work, currently only reportable anecdotally, and from reading of the published work, the following observations can be offered:

- Some lentigo maligna are cured by the application of Imiquimod when a marked inflammatory reaction of the affected skin for 10 days has been present, and some are cured where the reaction has been minimal but the application has been for 12 weeks at 5 days a week.
- Some lentigo maligna are not affected by 12 weeks application of Imiquimod.
- The response to short term inflammation is not as high as that reported with longer term application.
- Imiquimod applied around the entire margin of a surgical excision of a lentigo maligna reported as incompletely excised in only one area, can produce a reaction around the entire surgical margin. (This may be a reflection of the fact that lentigo maligna occurs in sun damaged skin, and the Imiquimod is inducing a reaction to non-melanocyte solar damaged cells.)
- Marked pigmentation can remain at the site of a lentigo maligna which is later reported as

cured after Imiquimod use, with the pigment being found in dermal melanophages.

- Recurrence of lentigo maligna has been observed after Imiquimod induced clinical disappearance with partial biopsy confirmation.

These observations have led us to the following preliminary conclusions:

- 1 When possible, the best treatment for lentigo maligna remains surgical excision.
- 2 Partial biopsy of a treated lesion may miss untreated areas, and clinical follow up of treated patients is essential.
- 3 There is likely to be a role for Imiquimod treatment of lentigo maligna in two contexts:
  - a) when surgical treatment is not achievable for whatever reason; or
  - b) as a precursor to surgical treatment to try and eradicate the tumour as much as possible to the need for re-excision procedures of incompletely excised tumours. This may be particularly useful where tumours about structures like the eyelids, or when the clinical margins are very indistinct, and the decision regarding the amount of skin to excise is difficult.

A cautious approach is advocated. At this time Imiquimod is of unproven value and should be used on this basis. Imiquimod should not be applied to undiagnosed pigmented lesions as a diagnostic and therapeutic trial.

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## Imiquimod as a Vaccine Adjuvant

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The local induction of cytokines by Imiquimod also provides a rationale for its use as a vaccine adjuvant.

It is generally recognised that anti-tumour cellular immunity is mediated by antigen-specific cytotoxic CD8+ve T lymphocytes (CTL). For melanoma, a large number of antigens which are recognised by these CTL have been defined.<sup>1</sup>

Although spontaneous immune activation can sometimes result in regression, this is clearly not sufficient to eradicate melanoma in those patients who have established disease. A variety of strategies have been evaluated to induce immune responses against tumour antigens.<sup>2</sup>

Among these, is the application of imiquimod to skin at the site of intradermal peptide<sup>3</sup> or dendritic

cell (DC) injections.<sup>4</sup> By inducing cytokines in skin such as interferon (IFN)- $\alpha$ , tumour necrosis factor (TNF)- $\alpha$ , interleukin (IL)-1 $\alpha$ , IL-6, and IL-8,<sup>5-10</sup> imiquimod can induce an inflammatory micro-environment which has the potential to enhance local immunity. This most probably works by enhancing the functional capacity of DC by causing them to mature into migratory cells with increased capacity to present antigens to CTL.

This approach has attracted recent interest. Contemporary vaccine approaches with DC often utilise a maturation step in which cells are cultured *in vitro* with cytokines, prior to administration.<sup>11</sup> As an alternative approach, Nair et al.<sup>4</sup> injected DC into cancer-bearing mice whose skin had been pre-conditioned with imiquimod. Whereas others had previously found it necessary to induce DC maturation prior to injection, this study demonstrated that imiquimod was able to generate the conditions which resulted in the *in vivo* maturation of DC. Once matured *in vivo*, these cells were able to migrate and stimulate anti-cancer immunity.<sup>4</sup>

In our studies in melanoma vaccine recipients, we used the cytokine Flt3 Ligand (FL) in order to increase DC numbers. As anticipated this resulted in dramatic increases in DC in peripheral blood. We have previously reported that such DC mobilised by FL were immature<sup>12,13</sup> and unlikely to induce effective immunity in the absence of appropriate activation signals.<sup>14</sup> Indeed, antigen presentation by immature DC may lead to the induction of antigenic tolerance.<sup>15-17</sup> In view of this, we used imiquimod to pre-condition the vaccine sites of a cohort of patients receiving FL and melanoma antigen peptides. We found that the application of imiquimod increased the proportion of patients that developed both cutaneous and peptide-specific CD8+ T-cell responses to peptide vaccination. As this observation was made during an uncontrolled phase 1 study, no definitive conclusions regarding the effectiveness of imiquimod as a vaccine adjuvant can be made. Nonetheless, we have shown that *in vivo* activation of FL-generated DC has the potential to enhance immune responses in patients receiving a cancer vaccine.

In a trial currently underway at the Austin Hospital supported by the Ludwig Institute for Cancer Research (LICR), we are investigating

this approach without the prior administration of FL (trial LUD2003-003 – see next article for summary). The study is open to patients with fully resected melanoma but who nonetheless have a significant risk of relapse (high risk primary tumours, or resected stage III or IV disease). Because of the choice of peptides used in this study patients also need to have the HLA A2 haplotype. Eligible patients receive intradermal injections of peptides derived from the antigens tyrosinase, melan A, gp100, NY-ESO-1 and MAGE-10. Prior to peptide injection, skin is conditioned with imiquimod, applied 24 hours before injection and again on the day of injection. Although this is far briefer than is common practice for the treatment of established skin disease, preliminary biopsy data has shown us that changes in cutaneous immune cell populations can occur as early as 24 hours after application in humans (LICR Melbourne, unpublished). We anticipate that this and other similar trials being planned by others, will establish whether imiquimod will also prove to be helpful as a vaccine adjuvant.

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## Clinical Trials Update

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### 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

Now open. Eligibility criteria:

- Resected stage II, III or IV (or unresected N2c (in transit) or other small vol. 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 for nitrosoureas drugs)
- 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

### LUD2003-013 – Open-label single-arm pilot study of dendritic cells pulsed with NY-ESO-1 ISCOMATRIX® in patients with treated cancer and minimal residual disease at high risk of relapse

New trial now open. Eligibility criteria:

- Tumour expression of NY-ESO-1 by RT-PCR analysis or IHC, or of LAGE-1 by RT-PCR.
- Minimal disease (resected tumours). In the case of melanoma, patients with small volume locoregional disease are also eligible.

- Significant risk of tumour relapse (estimated >25% probability within 5 years)
- Completion of adjuvant chemotherapy or undergoing adjuvant hormonal therapy (where applicable)
- No other effective therapy available or appropriate. Concurrent hormone therapy is permitted where appropriate
- Fully recovery from surgery
- No other serious illnesses
- Expected survival of at least six months with Karnofsky performance status  $\geq 70\%$ .
- Lymphocytes  $\geq 1.0$ , platelets  $\geq 100$
- Creatinine  $\leq 0.2$  mmol/L
- Bilirubin  $\leq 30$  mmol/L
- Age  $\geq 18$  years
- No coexisting malignancy. Patients with prior tumours, but no clinical evidence of residual disease, may be included.
- Patients with brain metastases are eligible if they have undergone definitive therapy with curative intent (e.g. resection, stereotactic radiosurgery), with no evidence of recurrence or progression within the CNS for at least three months
- No history of immunodeficiency disease or autoimmune disease (vitiligo and treated pernicious anaemia is permitted)
- No HIV
- Not using systemic corticosteroids, anti-histaminic drugs or non-steroidal anti-inflammatory drugs (specific COX-2 inhibitors, low dose aspirin for prevention of an acute cardiovascular event, topical or inhalational steroids are permitted)
- No investigational agent, immunotherapy, chemotherapy and/or radiotherapy within 4 weeks prior to study day 1 (6 weeks for nitrosourea drugs)
- No previous severe allergic reaction to study drug or any of its constituents
- Must be available for immunological and clinical follow-up assessments
- Not pregnant or breastfeeding, must use contraceptive

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

### 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]

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

Site	Accrual to 30 November	
NZ	Auckland Hospital	0
	Christchurch Hospital	3
	Dunedin Hospital	0
	Wellington Hospital	1
NSW	Illawarra Hospital	0
	Mater Hospital (Newcastle)	1
	Prince of Wales Hospital	0
	Royal Prince Alfred Hospital	24
	Westmead Hospital	0
QLD	East Coast Cancer Centre	2
	Mater QRI	4
	Princess Alexandra Hospital	38
	Royal Brisbane Hospital	0
SA	Royal Adelaide Hospital	1
TAS	Launceston General Hospital	0
VIC	Alfred Hospital	2
	Andrew Love Cancer Centre	0
	Austin Health	0
	Peter MacCallum Cancer Centre	17
WA	Sir Charles Gairdner Hospital	0
	Royal Perth Hospital	1
	<b>Total</b>	<b>94</b>

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

### 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** – Closed.
- **stage IV melanoma** – Open for accrual at Alfred and Peter Mac.

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

### Open-label, dose escalation safety and tolerability study of recombinant human Interleukin-21 (phase 1) followed by an open-label treatment study (phase 2a) in patients with stage IV malignant melanoma

New trial open for metastatic melanoma at Cancer Trials Australia sites (Austin, Peter Mac, RMH).

#### Eligibility criteria:

- Histologically confirmed surgically incurable metastatic malignant melanoma
- Stage IV melanoma according to AJCC except resected stage IV patients with no evidence of disease
- Age  $\geq 18$  years
- Life expectancy at least 4 months
- ECOG 0-1
- Hb  $\geq 100$ , WBC  $\geq 2.5$ , neutrophils  $\geq 1.5$ , platelets  $\geq 100$ , lymphocytes  $\geq 1.0$
- Creatinine (Calculated)  $\geq 60$  mL/min
- Bilirubin  $\leq 1.25 \times$  ULN, AST  $\leq 2.5 \times$  ULN, LDH  $\leq 2 \times$  ULN
- Not pregnant or breast-feeding women
- Effective contraception required
- No active infection requiring systemic treatment
- No HIV, Hepatitis B/C, or autoimmune disease
- No history of and signs/symptoms of uncontrolled brain metastases
- No chemotherapy within 4 weeks prior to entering the study
- No radiotherapy within 4 weeks prior to entering the study
- No major surgery requiring general anaesthesia within 4 weeks prior to entering study
- No concurrent systemic corticosteroids

- No symptomatic cardiac failure (NYHA)  $\geq 2$ , no serious cardiac arrhythmias, no myocardial infarction within 12 months prior entering the study
- No prior malignancy (except BCC, SCC, carcinoma insitu of the cervix)
- No known or suspected allergy to IL-21 or related products
- No receipt of any investigational drug within 3 months prior to this trial

[Contact: Ian Davis, Austin Health, Ph: (03) 9496 5726 / Grant McArthur, Peter Mac, Ph: (03) 9656 1195 / Peter Gibbs, Royal Melbourne Hospital, Ph: (03) 9347 6301]

### Closed Trials

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

Accrual complete.

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

Recruitment at the Skin and Cancer Foundation will close end-December 2004.

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

Accrual complete. Trial closed September 2004.

#### 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

Now closed.

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

Closed. Reached target accrual of 41 patients at the Alfred, 1 patient on treatment.



## Backyard Now the Extreme UV Zone for Australians

To launch National Skin Cancer Action Week the Cancer Council Australia released research to the media showing that Australians are almost twice as likely to get sunburnt at home than at the beach and almost one in five Australians were sunburnt on weekends in summer 2003–2004.

The National Sun Survey reveals the sun-related behaviours of more than 5000 Australian adults aged 18 to 69 during peak UV times on summer weekends in 2003–04. The research was funded by the Cancer Councils across Australia and the Australian Department of Health and Ageing.

This important national study, chaired by Professor David Hill and co-ordinated by the Centre for Behavioural Research in Cancer at The Cancer Council Victoria, will assist in shaping the messages and the priorities of the SunSmart programs throughout Australia.

Of those sunburnt, the survey shows that 32% of Australians were burnt gardening or working around the home while 17% were burnt at the beach or in the water. A further 24% were burnt while enjoying outdoor activities such as picnics, BBQs and socialising.

The research shows that Australians seem to be associating sun protection with the beach but not with their incidental outdoor activity.

The survey found that 8% of Australians went to the beach over the weekend, however, 29% spent time gardening or working around the home.

The Cancer Council Australia spokesman Dr Andrew Penman said "We know that sunburn increases your risk of skin cancer later in life so we want to urge all Australians to Slip! Slop! Slap! whenever they're outdoors this summer. Find shade, wear light clothing, put on a hat and sunglasses and apply sunscreen regularly to exposed skin."

The National Sun Survey also asked respondents which part of their body was most likely to get sunburnt. The highest proportions of burns (42%) were on the arms and hands.

Associate Professor Afaf Girgis, Cancer Council researcher said, "The survey found that just under half the men who were sunburnt over the weekend were burnt on their face and head. It is not surprising that these sites are the most common sites for skin cancer in men."

"Women seem to be doing more to shield their head and face from the sun, as significantly fewer women were sunburnt on these parts of the body. This may be because of their knowledge of premature ageing, but we still have a way to go in encouraging women to protect their shoulders, arms and hands.

"Fashion may be dictating the lack of protection for women but there is nothing fashionable about a skin cancer," said Associate Professor Girgis.

According to the Cancer Council, skin cancer is predominantly caused by over-exposure to ultraviolet radiation. However, sunburn isn't the only cause – tanning or too much sun, year after year, can also lead to the disease.

"Skin cancer is one of the most preventable cancers. We hope these new findings will remind Australians not to be complacent when they're out in the sun this summer," said Dr Penman.

National Skin Cancer Action Week aims to raise awareness of skin cancer and sun protection issues at the start of the summer season.

Other activities that took place during the week were a series of presentations to secondary schools, delivered by Dermatologists in a joint partnership with the Australasian College of Dermatologists (Victoria) and SunSmart.

Community Health Centres and Divisions of General Practice received posters and resources to encourage local activities to promote greater awareness in the community of prevention and early detection messages.

For more information on National Skin Cancer Action Week and the National Sun Survey, contact Julie Hassard, SunSmart Program Manager (Ph: 03 9635 5202 or E-mail: [Julie.Hassard@cancervic.org.au](mailto:Julie.Hassard@cancervic.org.au)).

## Cancer Information and Support Service (CISS)

The Cancer Information and Support Service (CISS) is a body of The Cancer Council Victoria that aims to alleviate the stresses that cancer places upon people through provision of information and support. CISS runs a number of services, including:

### The Cancer Helpline

- Staffed by oncology nurse counsellors and trained enquiries officers
- A local call from anywhere in Victoria – 13 11 20
- Confidential provision of information and emotional support with referral to local community services
- Printed information on many cancer-related topics can be mailed to callers at no cost
- In 2003, the Cancer Helpline responded to over 49,000 contacts. This included over 6500 contacts with patients, 5500 contacts with family / relatives, 9200 contacts with the general public and 8000 contacts with health professionals

### Multilingual Cancer Information Line

- Enabling people from non-English speaking backgrounds to access the Cancer Helpline via an interpreter

### Cancer Connect

- A telephone peer support service that puts people in touch with others who have had a similar cancer experience
- Over 500 referrals and around 900 contacts were made in 2003

### Cancer Support Groups

- CISS provides training and accredits nearly 120 groups within Victoria

### Financial Assistance

- Including welfare grants and no interest loans

### Living With Cancer Education Program / Living Well forums

- In 2003, there were 35 LWCEP run in Victoria with over 400 attendees

### Look Good, Feel Better workshops

### Holiday Respite Program

*CISS would like to encourage you to refer your cancer patients and their carers to our professional services.*

If you would like to receive brochures or any other information regarding any of the above please call the Cancer Helpline on 13 11 20. Alternatively contact the Director of CISS, Doreen Akkerman (Ph: 03 9635 5129 / E-mail: [Doreen.Akkerman@cancervic.org.au](mailto:Doreen.Akkerman@cancervic.org.au)) or Michael Jefford, Clinical Consultant, CISS (E-mail: [Michael.Jefford@cancervic.org.au](mailto:Michael.Jefford@cancervic.org.au)).

## Established treatments, treatments being trialled and alternative (unproven) treatments for cancer

**If you have been diagnosed with cancer, it is possible that different treatments have been suggested to you. The Cancer Council has produced this information to help you decide between treatments that may help you and treatments that are unlikely to help you.**

Your doctor will recommend one or more established treatments or suggest that you consider taking part in a clinical trial of a new treatment. You may be thinking about using complementary therapies along with treatments suggested by your doctor. You may also have read about, or been told about, an alternative treatment that may help.

### **How are they different?**

#### **Established treatments**

These are proven treatments such as radiotherapy, chemotherapy, hormone therapy, immunotherapy and surgery. These are also known as 'medical', 'conventional' or 'mainstream' treatments.

These treatments have been tested in clinical trials and shown to be effective. (See the description of clinical trials below.) For example, it has been proven in clinical trials that:

- removing a skin cancer at an early stage prevents it from growing or spreading
- many childhood leukaemias can be cured with chemotherapy
- tamoxifen can prevent some breast cancers from recurring.

Established treatments are prescribed by general practitioners, cancer specialists (oncologists) and other medical specialists. You have these treatments in hospitals and doctors' surgeries and sometimes at home.

#### **Treatments being trialled**

These are treatments that are being tested in clinical trials. Clinical trials test new drug therapies, procedures, treatment combinations, preventative measures, screening methods and alternative treatments to see if they are better than the established treatments.

Clinical trials examine treatments that have shown promise during initial testing. For example, a researcher may think that a chemical that affects cell growth could be used to destroy cancer cells. Tests evaluating its safety and effectiveness will be done in the laboratory and then on animals. If it is thought to be safe and effective enough, it will be tested on people in a clinical trial.

There are three clinical trial phases. The cancer specialists carefully watch the effects of the new treatment on the people in the trial. If the treatment goes through to the end of the third clinical trial phase, the results of the new treatment are compared with established treatments. If the treatment that was trialled is better, and usually after it has been confirmed with other trials, it will be recommended to other doctors for their patients.

A clinical trial will only be conducted if the new treatment is thought to be at least as effective as the established treatment for a cancer.

Clinical trials are conducted and monitored according to strict guidelines. The treatments are given strictly to plan. Results are collected, analysed and published in scientific journals.

People in trials are treated according to an agreed document that sets out the terms of treatment (known as a treatment protocol). They are reviewed frequently during and for a time after the treatment phase, and so receive very high quality care. Some studies have shown that people treated in clinical trials have better outcomes than people who do not join clinical trials.

People are told about clinical trials by their doctor or they may hear about them from the media, the Internet or other sources. They can volunteer to join the trial.

### **Alternative (unproven) treatments**

These are treatments that are said by the people who provide them to be alternative to established treatments. People who provide alternative (unproven) treatments say they will or may cure cancer, *but this has not been shown in clinical trials*.

- An alternative treatment may have been tested but 'no evidence of benefit' found. This means it is uncertain whether it works or not.
- 'Evidence of no benefit' means a treatment has been tested and shown not to work against cancer.

Alternative (unproven) treatments are also known as integrative, unproven, holistic, non-mainstream and unconventional treatments or remedies.

Alternative cancer treatments for which 'miracle cures' have been claimed include magnets, various diets, coffee enemas, fresh cell therapy, microwave therapy, oxygen therapy and laetrile and other plant products. Be wary of these claims. Ask the alternative practitioner to give you evidence to back them. One or two books by people who deliver a certain treatment is not strong evidence. Look for articles in recognised medical or scientific journals. Recognised medical journals are listed in PubMed, an international database of biomedical journals. You can search the database through <http://www.ncbi.nlm.nih.gov/entrez/query.fcgi>. It is even more important to discuss these 'apparent cures' with the doctors treating you. Your doctors will usually have up-to-date information on the claims.

### **Complementary therapies**

These are therapies such as massage, aromatherapy and meditation. People may feel a greater sense of wellbeing while they take the treatments. These are often called 'supportive therapies'. They are not promoted as cancer treatments or cures in their own right.

Some, like massage, have been used for centuries to complement mainstream medicine. They may help

people feel more relaxed and able to cope better with the impact of their illness.

### **Key points**

- Established treatments are known to cure some cancers and provide relief from symptoms of cancer.
- Treatments being trialled are promising treatments that are tested in clinical trials. They are only tested if they are predicted, on initial testing, to be at least as effective as the established treatment for a cancer.
- Alternative treatments have not been shown in clinical trials to cure or slow cancer down because trials have not been done ('no evidence of benefit'). Others have been tested and shown to be ineffective ('evidence of no benefit').
- Complementary therapies may be used to enhance established treatments.

### **How can they help?**

When choosing a cancer treatment, you will be seeking one or more of the following:

- cure
- relief from symptoms
- help with a problem related to your illness (like anxiety)
- reassurance that you are doing all you can.

### **How established treatments may help**

Your doctor will tell you if there is a cure for your cancer, or treatment that may slow its process. For over half of all cancers, surgery and/or radiotherapy and/or chemotherapy will kill the cancer cells and stop them from coming back. Although the treatment itself may cause side effects and be upsetting, most people are prepared to put up with this to try to get rid of the cancer.

Sometimes, the doctor won't be able to reassure you that the cancer will be cured. Sometimes, a few cancer cells escape and slowly grow into a new spot of cancer elsewhere in the body. Many people who have established treatment for cancer won't know for several years whether their cancer has gone away. If the cancer has not reappeared (recurred) within five years of treatment, then often you have a high chance of having been cured.

It is possible that there is no cure for your cancer. There may be no effective established treatment and/or the cancer may be advanced when you are

diagnosed. There are still established treatments that can help you. Established treatments may be able to reduce the size of the cancer or delay its growth, so that it doesn't affect how your body normally functions. They can also relieve pain and other problems caused by the cancer. This is called 'palliative treatment'. Some people can still have years of high quality life even though their cancer has not been cured.

If you want more information about the treatment your doctor recommends, you can ask for a second opinion from another specialist. Your doctor should not be offended: it is quite normal to want to know that your treatment is the best available.

### **How treatments that are being trialled may help**

Your doctor may suggest that you join a clinical trial. This might happen if:

- there is no established treatment that will cure you
- there is a promising new treatment being tested for your cancer.

*Remember, treatments being trialled are not certain to cure you. They may turn out to be only as effective as the existing treatment for your cancer.*

Treatments being trialled often have side effects. These will be explained in the patient information/consent sheet that you will be asked to read and sign before the trial begins. Just because a treatment is new, it does not mean it is better—that is what the trial is trying to find out.

Sometimes, people participating in a clinical trial might receive an inactive or 'placebo' treatment, or be treated to control symptoms. In these cases, no established treatment is required; in other words, you are not missing out on any treatment you should otherwise be having.

### **How alternative treatments may help**

Some people with cancer want to experiment with alternative treatments. A questioning approach helps people make their way through the many alternative treatments on offer. See 'Questions to ask' in this brochure.

### **How complementary therapies may help**

Complementary therapies can help you to cope better with the challenges you face as a person with cancer. Physical therapies like yoga, massage and t'ai chi can help you to feel more relaxed and stronger. Measures like aromatherapy and music therapy will help if these

are the sorts of therapies that you enjoy. If you are spiritually inclined, you will find comfort and strength in formal or informal services and rituals related to your beliefs.

### **Key points**

- Established treatments can cure many cancers and provide relief for symptoms that cannot be cured.
- A treatment being tested in a clinical trial may be an option for you if the established treatment for your cancer is not adequate or a promising new treatment is being compared with the established treatment.
- Complementary therapies can be useful in easing symptoms like anxiety or tension associated with fears and uncertainties about having cancer.

### **When should alternative (unproven) treatments be avoided?**

#### **When they will delay diagnosis of cancer**

If you have a troubling symptom and you wish to seek the advice of an alternative therapist, it is a good idea to also see a medical practitioner. Some symptoms of cancer may not be noticed or may be misdiagnosed by an alternative therapist.

Symptoms that should always be checked by a doctor include any new or unexplainable swelling, bleeding, pain and continued hoarseness or coughing. These symptoms don't necessarily mean that you have cancer, but should be checked.

#### **When they will interfere with established treatment**

Many alternative treatments are probably harmless, but not all. Some herbs and vitamins can interact with chemotherapy and radiotherapy so that they don't work as they should, or can cause harm. Before you begin a therapy prescribed by an alternative therapist, check with your cancer specialist that it is safe and won't affect your medical treatment, reduce the effectiveness of the medical treatment, and/or increase the risk of side effects.

#### **When they will prolong or worsen the disease experience**

Some people find that complementary therapies like relaxation, yoga and massage can improve their experience of established treatment, making them feel less anxious and more in control.

For some people, alternative therapies can make the experience much worse. This can happen:

- if you rely on alternative treatments that are not proven to work
- if your alternative therapist makes you feel responsible when their treatment doesn't make you better
- if it makes you sicker
- if it upsets you or costs more than you can really afford.

### **When they stop you using medical treatment that could improve your health**

Some alternative therapists suggest to people they treat not to have established medical treatments or to cease them. The alternative therapist may warn that medical treatment will stop the alternative therapy working. Be very wary of claims like this. Always get an opinion from a cancer specialist.

#### **Key points**

- Beware of 'magic' or 'miracle' cures. Always get an informed opinion from your cancer specialist and/or the Cancer Helpline.
- Complementary therapies can be helpful additions to established treatment for people with cancer.
- Most alternative therapists cannot diagnose cancer.
- Some alternative treatments can interfere with established treatments and worsen your experience of cancer.

### **Questions to ask**

Whether you are choosing a cancer specialist (surgeon and/or medical oncologist and/or radiation oncologist) or an alternative therapist, you need to be able to trust and talk openly with that person. This does not mean that you need to have warm feelings for each other. The person you choose may not even be very friendly! However, you will need to feel that they are expert, approachable, respectful, supportive and able to meet your needs for information and advice.

One way of finding out if the person is expert is to ask questions about their qualifications and experience. Here are some questions that may help when you choose a medical or alternative practitioner. (You could ask your general practitioner some of these questions, if he or she is referring you to a specialist.)

- What training does the practitioner have? Is their degree from an educational institution you know of or can find out about?
- Does the practitioner treat patients in hospitals where doctors are trained?
- What will the practitioner charge for a visit? How many visits will you need to make?
- Are there additional costs, for example, for different stages of treatment or additional expertise?
- Is the practitioner willing to refer you to publications that demonstrate that the treatment works?
- Are they members of a professional group that registers and represents that group of specialists in dealing with state and federal departments of health?

Also ask yourself if you are comfortable with the practitioner. Do you feel that they are attentive, trustworthy and level-headed?

Do you know other people who have been patients or clients of the practitioner? What do they say about them?

You may wish to find out more about the treatment the practitioner recommends. To find out if a treatment is worth trying, *be cautious, ask questions and confirm claims.*

#### **Be cautious**

You don't have to uncritically accept any claims made by a person seeking to treat you. You may trust the practitioner, and still wish to independently check their advice. Beware of 'pseudoscience'—things that sound very scientific and plausible but which are not actually backed up by evidence of proven benefit.

#### **Ask questions**

You will be surer of the treatment if you get satisfactory answers to the following questions:

- In what way will this treatment benefit me?
- What results can I expect to see?
- Are there any long-term risks associated with this treatment? If so, what are they?
- What side effects do people have with this treatment?
- How much will it cost?

- Will Medicare / my private health insurance cover the cost?
- How long will the treatment take?
- When could I expect to see a result from the treatment?
- How many people have received this treatment?
- How many of them responded?
- What happened to the ones that didn't respond?
- What's in it for the person offering me this treatment?

### **Confirm claims**

Established treatments are subjected to scientific testing. This means:

- the theory behind a proposed treatment is based on accepted scientific principles
- testing on animals usually occurs before a new treatment is tested on humans
- the results of these trial/s are published in 'peer-reviewed' medical and scientific journals. This means that other specialists with expertise in the field check that the study was conducted correctly and that the results are valid.
- the results of trials are also verified by trials from specialist cancer hospitals throughout the world.

If you want to check that a treatment has been trialled and the results published, you can do a literature search through a medical library or via Medline on the Internet. A health information service for consumers may be able to help you, for example the Cancer Helpline 13 11 20.

### **Key points**

- Ask your cancer specialist questions that are important to you: Will the treatment work? How do they know the treatment will work? When will I see results? What side effects can occur? How much will it cost?
- Be sure that you have confidence in the practitioner. If you don't have confidence in a cancer specialist, ask your general practitioner for referral to another specialist. If you are seeking to change alternative practitioners, your general practitioner or a trusted friend or adviser may be able to refer you on.

### **A final word**

You have the right to choose whatever treatment you want for your cancer. Most people choose established treatments for their disease, and many also choose complementary therapies for some symptoms. A few choose no treatment, or a 'miracle cure'. We recommend that you make an informed choice where you can. This will include asking the opinion of people you respect and researching your options. You are welcome to call the Cancer Helpline on 13 11 20 to talk about the choices before you.

### **Useful websites**

You may be interested in looking for information about cancer treatments on the Internet. While there are some very good websites, you need to be aware that some websites provide wrong or biased information. The following websites contain reliable information.

#### **National Center for Complementary and Alternative Medicine (NCCAM)**

<http://nccam.nih.gov>

Includes publications, information for researchers, frequently asked questions, and links to other related resources.

#### **Quackwatch**

[www.quackwatch.com](http://www.quackwatch.com)

Aimed at combating health-related frauds, myths, fads and fallacies.

#### **Therapeutic Goods Administration (TGA)**

[www.health.gov.au/tga](http://www.health.gov.au/tga)

#### **The Cancer Council Victoria**

[www.cancervic.org.au](http://www.cancervic.org.au)

Provides general information on cancer, including diagnosis, treatment and support services.

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## Working Parties for Accreditation, Credentialing and Guideline Implementation

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The **Australian Cancer Network (ACN)** is developing wider, strong and active links with individuals and organisations working to strengthen the quality of care in the management of cancer patients. It is also working to ensure that cancer care is based on the best level of information available.

### Working party to establish accreditation of cancer services

This activity is progressing well. Significant discussions have occurred and the possibility of expanding interaction with state bodies is to be embraced. Elizabeth Metelovski has been appointed Project Officer and together with Dr Karen Luxford of the National Breast Cancer Centre (NBCC) in association with the National Cancer Control Initiative (NCCI), is carrying out a scoping study following the signing of an MOU between ACN and NBCC. The first draft of this report was considered by the Steering Committee on 28 September. This was a proactive review and many members have contributed. An extension of time has been granted and the Committee will meet again by phone to finalise the document in the second week in December.

### Working Party to establish credentialing processes for medical staff of cancer services

Credentialing is recognised as one of the more significant steps in developing best practice in Cancer Units and the introduction of optimal multi-disciplinary care. This Working Party has made headway; however, it requires a good deal more work to produce appropriate procedures to ensure that the process has best practice outcomes. It is timely to expand activities of this Committee through a scoping study. It is hoped to appoint a Project Officer to carry this forward in the next few weeks. This appointment should lead to more substantive progress.

### Working party to promote implementation of best practice guidelines

A Cancer Guideline Implementation Workshop was held on 14 October 2004 at Level 3, Medical Foundation Building.

The meeting was held under the auspices of the National Institute of Clinical Studies (NICS), NBCC and ACN. It was facilitated by Professor Dave Davis from Toronto and was positive in every respect.

Apart from identifying and discussing a range of issues in a positive manner, it allowed a number of people with like interests to learn of each other's existence. It will also have impact on the matrix being developed for the ACN Guideline Implementation Steering Committee.

Guideline development activities continue with progress being made in a number of important areas.

*Reprinted from Wongi Yabber November 2004; 11(4): 1-2.*

# Report of The Cancer Council Australia

Glen Turner  
Communications Manager  
The Cancer Council Australia

## Cancer Council advocates national approach to cancer prevention

**A** concerted and comprehensive national approach to cancer prevention is the theme of The Cancer Council Australia's *National Cancer Prevention Policy (2004-2006)*, launched in July 2004.

The *National Cancer Prevention Policy* sets out measures to help reduce the impact of preventable risk factors, such as smoking, ultraviolet radiation, inadequate diet and physical inactivity. It also outlines the benefits for screening for early detection of breast, cervical, bowel and prostate cancers and melanoma.

The Cancer Council Australia's Chief Executive Officer, Professor Alan Coates, said Australia was a world leader in the prevention of many cancers and much of that success was derived from the collaborative work of cancer councils and federal, state and territory governments.

"However, we could do much better," Professor Coates said. "Many of the 85,000 new cases of cancer diagnosed in Australia each year could be prevented through risk minimisation or treated more effectively through early detection."

The *National Cancer Prevention Policy*, which establishes a framework for governments to invest in improved cancer prevention, is the result of detailed work by the public health workers and clinicians who comprise The Cancer Council Australia's Public Health Committee and its sub-committees.

Professor Coates paid tribute to the authors of the policy, in particular Dorothy Reading (Chair of the Public Health Committee) who coordinated its development and production.

The *National Cancer Prevention Policy (2004-2006)* is available online at [www.cancer.org.au](http://www.cancer.org.au).

Reprinted from Wongji Yabber August 2004; 11(3): 4.

## Unprecedented political support

For the first time in a federal election, both the Coalition and the ALP included detailed cancer control policies among their campaign promises, with commitments that reflected much of The Cancer Council Australia's recommended policy platform.

In separate announcements in September, the ALP committed to more than \$112 million in prevention and treatment initiatives, while the Coalition launched its comprehensive \$137 million policy, *Strengthening cancer care*, in October.

The Cancer Council Australia publicly endorsed both policies, particularly the many initiatives consistent with the evidence-based position we put forward to all federal parliamentarians in June.

One of the most significant announcements was the Coalition's pledge to establish a national cancer care agency, Cancer Australia, at \$10 million over four years, which was a key Cancer Council priority.

There was unanimous support for funding independent clinical trials capacity building, with the Coalition and the ALP committing to \$15 million and \$12 million respectively over four years. The Cancer Council Australia had sought \$5 million per annum.

Both sides also committed to rolling out a national bowel cancer screening program, as well as funding for national SunSmart campaigns. The ALP allocated \$21 million for a tobacco control program aimed at a five percent decrease in national smoking rates, while the Coalition announced \$4 million to reduce smoking in pregnancy.

The ALP's commitment to introducing a Medicare Benefits Schedule item for cancer multi-disciplinary care reflected The Cancer Council Australia's overarching theme of improving multi-disciplinary care.

The Cancer Council Australia CEO, Professor Alan Coates, said considerable effort went into engaging with both sides of politics in the lead-up to the election.

“We continue to emphasise the fact that, while there have been improvements in cancer outcomes for Australians over recent years, cancer remains the nation’s deadliest disease

and there is great scope for federal policy makers to reduce the burden,” Professor Coates said.

“We were very pleased to see both sides of politics show strong leadership in cancer control and look forward to continuing to build good relationships with our supporters in Federal Parliament.”

*Reprinted from Wongi Yabber November 2004; 11(4): 3–4.*

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## Report of the National Cancer Control Initiative (NCCI)

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### Core Clinical Data Set and Dictionary

Since 1982, Australia has had full coverage of cancer incidence by population-based state cancer registries allowing trends to be monitored. Mortality and overall survival rates by type of cancer can also be assessed but this information is insufficient to assess how the diagnosis, treatment and outcome of cancer patients compare to best practice. In 1999, the National Cancer Control Initiative (NCCI) commenced a project to develop a core data set that would capture the most important data items relevant to the diagnosis and primary management and prognosis of cancer at the clinical level. A nationwide consultation was undertaken by Professor Alan Coates, on behalf of the NCCI, with input from a wide range of clinicians, hospital staff, all Australian cancer registries, the AIHW and other groups. The items adopted for the NCCI Clinical Cancer Core Data Set reflected ‘a reasonable compromise between a set too large to be attainable and one too small to be interesting’ and included details of the stage of cancer at diagnosis, initial treatments and treatment outcomes.

The items in the NCCI Clinical Cancer Core Data Set were submitted to the National Health Data Committee (NHDC) for inclusion in the National Health Data Dictionary (NHDD). In June 2004 all but two data items were approved under the title Cancer (clinical) Data Set Specification. The two items not approved for inclusion in the NHDD

were *Performance status score at diagnosis* and *Cause of death* but both of these are still included in the full NCCI Clinical Cancer Core Data Set. All items in the data set have been updated in line with the approved definitions and coding and are now available on the NCCI website [www.ncci.org.au](http://www.ncci.org.au). The approved data items are also available via the Australian Institute of Health and Welfare knowledge base at [www.aihw.gov.au/knowledgebase/index.html](http://www.aihw.gov.au/knowledgebase/index.html).

### Australian Clinical Management Surveys in Cancer

In Australia, clinical management surveys have been conducted for a number of different cancers and in various locations. The National Cancer Control Initiative (NCCI) was interested in identifying clinical management surveys for cancer in Australia, including surveys that have been published, are ongoing or are planned. A report *Australian Clinical Management Surveys in Cancer* identifies 25 published and 26 ongoing or planned clinical management surveys in cancer that have a large population base, ideally national or state-wide and lists the identified surveys. A table summarising the information contained in the published clinical management surveys is also provided. The report is available on the NCCI website at [www.ncci.org.au](http://www.ncci.org.au)

*Reprinted from Wongi Yabber August 2004; 11(3): 3.*

## Clinical Practice Guidelines

There has been a widespread move towards developing clinical practice guidelines, which are designed to improve the quality of health care, to reduce the use of unnecessary, ineffective or harmful interventions, and to facilitate the treatment of patients with maximum change of benefit, with minimum risk of harm, and at an acceptable cost. Recent research has shown that clinical practice guidelines can be effective in bringing about change and improving health outcomes. But they are just one element of good medical decision making, which also takes account of patients' preferences and values, clinicians' values and experience, and the availability of resources. *(Quote from NHMRC A Guide to the development, implementation, and evaluation of clinical practice guidelines, November 1998.)*

The Cancer Council Victoria is supportive of the development of national clinical practice guidelines for management of cancer. The Cancer Council and members of the Victorian Cooperative Oncology Group have contributed to the development of national clinical practice guidelines through the Australian Cancer Network and National Breast Cancer Centre. Clinical practice guidelines are extensively reviewed before being endorsed by the National Health and Medical Research Council.

The following clinical practice guidelines are available from the NHMRC website (links are also provided at [www.cancervic.org.au/cancer1/professionals/guidelines.htm](http://www.cancervic.org.au/cancer1/professionals/guidelines.htm)) :

### Breast Cancer

- Clinical practice guidelines for the management of advanced breast cancer (Endorsed January 2001)  
[www.nhmrc.gov.au/publications/synopses/cp76syn.htm](http://www.nhmrc.gov.au/publications/synopses/cp76syn.htm)
- Clinical practice guidelines for the management of early breast cancer – 2<sup>nd</sup> Edition (Endorsed August 2001)  
[www.nhmrc.gov.au/publications/synopses/cp74syn.htm](http://www.nhmrc.gov.au/publications/synopses/cp74syn.htm)

- Psychosocial clinical practice guidelines: Providing information, support and counselling for women with breast cancer (Endorsed December 1991)  
[www.nhmrc.gov.au/publications/synopses/cp61syn.htm](http://www.nhmrc.gov.au/publications/synopses/cp61syn.htm)

### Colorectal Cancer

- Clinical practice guidelines for the prevention, early detection and management of colorectal cancer (Endorsed March 1999)  
[www.nhmrc.gov.au/publications/synopses/cp62syn.htm](http://www.nhmrc.gov.au/publications/synopses/cp62syn.htm)
- Guidelines for the prevention, early detection and management of colorectal cancer: A guide for patients, their families and friends (Endorsed February 2000)  
[www.nhmrc.gov.au/publications/synopses/cp63syn.htm](http://www.nhmrc.gov.au/publications/synopses/cp63syn.htm)
- Guidelines for the prevention, early detection and management of colorectal cancer: A guide for general practitioners (Endorsed 1999)  
[www.nhmrc.gov.au/publications/synopses/cp64syn.htm](http://www.nhmrc.gov.au/publications/synopses/cp64syn.htm)

### Familial Cancer

- Familial aspects of bowel cancer: A guide for health professionals (Endorsed February 2002)  
[www.cancer.org.au/documents/Familial%20aspects%20of%20bowel%20cancer.pdf](http://www.cancer.org.au/documents/Familial%20aspects%20of%20bowel%20cancer.pdf)
- Clinical practice guidelines: Familial aspects of cancer: A guide to clinical practice (Endorsed November 1999)  
[www.nhmrc.gov.au/publications/synopses/cp67syn.htm](http://www.nhmrc.gov.au/publications/synopses/cp67syn.htm)

### Lung Cancer

- Clinical practice guidelines for the prevention, diagnosis and management of lung cancer (Endorsed March 2004)  
<http://www.nhmrc.gov.au/publications/pdf/cp97.pdf>

### Ovarian Cancer

- Clinical practice guidelines for the management of women with epithelial ovarian cancer (Endorsed March 2004)  
<http://www.ovariancancerprogram.org.au/about/guidelines.html>

### Prostate Cancer

- Clinical practice guidelines: Evidence-based information and recommendations for the management of localised prostate cancer (Endorsed October 2002)  
[www.nhmrc.gov.au/publications/synopses/cp88syn.htm](http://www.nhmrc.gov.au/publications/synopses/cp88syn.htm)

### Skin Cancer

- Clinical practice guidelines for the management of cutaneous melanoma (Endorsed December 1999)  
[www.nhmrc.gov.au/publications/synopses/cp68syn.htm](http://www.nhmrc.gov.au/publications/synopses/cp68syn.htm)

- Clinical practice guidelines: Non-melanoma skin cancer: Guidelines for treatment and management in Australia (Endorsed October 2002)  
[www.nhmrc.gov.au/publications/synopses/cp87syn.htm](http://www.nhmrc.gov.au/publications/synopses/cp87syn.htm)

### Psychosocial Guidelines

- Psychosocial clinical practice guidelines: Providing information, support and counselling for women with breast cancer (Endorsed December 1999)  
[www.nhmrc.gov.au/publications/synopses/cp61syn.htm](http://www.nhmrc.gov.au/publications/synopses/cp61syn.htm)
- Clinical practice guidelines for the psychosocial care of adults with cancer (Endorsed April 20003)  
[www.nhmrc.gov.au/publications/synopses/cp90syn.htm](http://www.nhmrc.gov.au/publications/synopses/cp90syn.htm)

Clinical practice guidelines for the management of colorectal cancer and lymphoma are currently being developed under the auspice of the Australian Cancer Network (2004)

## Key Published Articles Listing—Skin Cancer

Title	Author & Journal
<b>Improvement of malignant / benign ratio in excised melanocytic lesions in the 'dermoscopy era': A retrospective study 1997–2001</b>	<b>Carli P, De Giorgi V, Crocetti E, et al.</b> British Journal of Dermatology April 2004; 150(4): 687–692.
<b>Prognostic significance of molecular upstaging of paraffin-embedded sentinel lymph nodes in melanoma patients</b>	<b>Takeuchi H, Morton DL, Kuo C, et al.</b> Journal of Clinical Oncology 1 July 2004; 22(13): 2671–2680.
<b>Lessons learned from the Sunbelt Melanoma Trial</b>	<b>McMasters KM, Noyes RD, Reintgen DS, et al.</b> Journal of Surgical Oncology 1 July 2004; 56(4): 212–223.
<b>A prospective analysis of positron emission tomography and conventional imaging for detection of stage IV metastatic melanoma in patients undergoing metastasectomy</b>	<b>Finkelstein SE, Carrasquillo JA, Hoffman JM, et al.</b> Annals of Surgical Oncology 1 Aug 2004; 11:731–738.

## Key Published Articles Listing—Skin Cancer (con't)

Title	Author & Journal
<b>An evidence-based staging system for cutaneous melanoma</b>	<b>Balch M, Soong SJ, Atkins MB, et al.</b> CA – A Cancer Journal for Clinicians May/June 2004; 54(3): 131–149.
<b>A pooled analysis of Eastern Cooperative Oncology Group and Intergroup trials of adjuvant high dose interferon for melanoma</b>	<b>Kirkwood JM, Manola J, Ibrahim J, et al.</b> Clinical Cancer Research 1 Mar 2004; 10: 1670–1677.
<i>This is a pooled analysis of the ECOG high dose interferon melanoma studies. Overall it confirms improvement in DFS but not OS, although the authors still think an OS benefit seen in two of the studies is real.</i>	
<b>Management of cutaneous melanoma</b>	<b>Tsao H, Atkins MB &amp; Sober AJ.</b> The New England Journal of Medicine 2 Sep 2004; 351(10): 998–1012.
<i>Good summary of melanoma management.</i>	
<b>Thin melanoma: Still “excellent prognosis” disease? (Editorial)</b>	<b>Halpern AC &amp; Marghoob AA.</b> Journal of Clinical Oncology 15 Sep 2004; 22(18): 3651–3653.
<i>An editorial and two papers from JCO about subclassifying thin cutaneous melanomas into different prognostic groups. This group of patients (&lt;1mm) is too heterogeneous in the current revised AJCC classification but it is not clear whether the new classification methods for thin melanomas will be adopted.</i>	
<b>Prognostic factors of thin cutaneous melanoma: An analysis of the Central Malignant Melanoma Registry of the German Dermatological Society</b>	<b>Leiter U, Buettner PG, Eigentler TK &amp; Garbe C.</b> Journal of Clinical Oncology 15 Sep 2004; 22(18): 3660–3667.
<b>Thin primary cutaneous malignant melanoma: A prognostic tree for 10-year metastasis is more accurate than American Joint Committee On Cancer Staging</b>	<b>Gimotty PA, Guerry D, Ming ME, et al.</b> Journal of Clinical Oncology 15 Sep 2004; 22(18): 3668–3676.
<b>Effect of pregnancy on survival in women with cutaneous metastatic melanoma</b>	<b>Lens MB, Rosdahl I, Ahlbom A, et al.</b> Journal of Clinical Oncology 1 Nov 2004; 22(21): 4369–4375.
<i>Pregnancy during or after diagnosis of melanoma does not affect outcome.</i>	

## Key Published Articles Listing—General

Title	Author & Journal
<b>Clinical trial registration: A statement from the International Committee of Medical Journal Editors [Editorial]</b>	<b>De Angelis C, Drazen JM, Frizelle FA, et al.</b> The New England Journal of Medicine 16 Sep 2004; 351(12): 1250–1251.

## Forthcoming Meetings

Date / Place	Meeting / Contact
12–14 January 2005 Eilat, Israel	<b>4<sup>th</sup> International Meeting of the Israeli Society for Clinical Oncology &amp; Radiation Therapy (ISCORT)</b> Ph: +92 286 00 680 Fax: +92 286 232 336 E-mail: <a href="mailto:wilmosh@bgumail.bgu.ac.il">wilmosh@bgumail.bgu.ac.il</a>
16–21 January 2005 Films, Switzerland	<b>9<sup>th</sup> European Winter Oncology Conference</b> Federation of European Cancer Societies, Av E Mounier 83, Brussels 1200 Belgium Ph: +32 2 775 0201 Fax: +32 2 775 0200 E-mail: <a href="mailto:ewoc-9@fecsc.be">ewoc-9@fecsc.be</a> Website: <a href="http://www.fecsc.be">www.fecsc.be</a>
27–29 January 2005 Phoenix, Arizona, USA	<b>2<sup>nd</sup> Annual Conference of the American Psychosocial Oncology Society (APOS)</b> APOS, 2365 Hunters Way, Charlottesville Virginia 22911 USA Ph: +1 434 293 5350 Fax: +1 434 977 0899 E-mail: <a href="mailto:aholcomb@apos-society.org">aholcomb@apos-society.org</a> Website: <a href="http://www.apos-society.org">www.apos-society.org</a>
10–13 February 2005 Phillip Island, Vic, Australia	<b>17<sup>th</sup> Lorne Cancer Conference – At Phillip Island, Victoria</b> Secretariat: ASN Events Pty Ltd Ph: (03) 5983 2400 E-mail: <a href="mailto:cancer@asnevents.net.au">cancer@asnevents.net.au</a> Website: <a href="http://www.lornecancer.org">www.lornecancer.org</a>
10–14 February 2005 Paris, France	<b>16<sup>th</sup> International Congress on Anti-Cancer Treatment</b> Travel Congress Organisation (TCO), 2 rue de Berri, Paris 72008, France Ph: +33 1 4294 8732 Fax: +33 1 4294 8733 E-mail: <a href="mailto:info@icact.com">info@icact.com</a> Website: <a href="http://www.icact.com">www.icact.com</a>
18–19 February 2005 Nice, France	<b>New Targets in Cancer Therapy III</b> Imedex, 70 Technology Drive, Alpharetta, Georgia 30005 USA Ph: +1 770 751 7332 Fax: +1 770 751 7334 E-mail: <a href="mailto:c.chase@imedex.com">c.chase@imedex.com</a> Website: <a href="http://www.imedex.com">www.imedex.com</a>
3–5 March 2005 Amsterdam, Netherlands	<b>3<sup>rd</sup> International Symposium on Targeted Anticancer Therapies</b> NDDO Research Foundation, c/o Convenience Conference Management, PO Box 77, Harmelen 3480 DB Netherlands Ph: +31 348 567 667 Fax: +31 348 446 057 E-mail: <a href="mailto:congress@nddo.org">congress@nddo.org</a> Website: <a href="http://www.nddo.org">www.nddo.org</a>

Date / Place	Meeting / Contact
<b>3–6 March 2005</b> Atlanta, Georgia, USA	<b>58<sup>th</sup> Annual Cancer Symposium of the Society of Surgical Oncology (SSO)</b> Society of Surgical Oncology, 85 W Algonquin Rd, Suite 55 Arlington Heights, IL 60005, USA Ph: +1 847 427 1400 Fax: +1 847 427 9656 E-mail: <a href="mailto:diannekubis@acaai.org">diannekubis@acaai.org</a> Website: <a href="http://www.surgonc.org">www.surgonc.org</a>
<b>7–9 March 2005</b> Madrid, Spain	<b>Functional Genomics and Animal Tumour Models</b> CNIO – Spanish National Cancer Centre, C/- Melchor Fernández Almagro, 3 Madrid 28029 Spain Ph: +34 91 224 6900 Fax: +34 91 224 6980 E-mail: <a href="mailto:ccc@cnio.es">ccc@cnio.es</a> Website: <a href="http://www.cnio.es/ccc">www.cnio.es/ccc</a>
<b>11–13 March 2005</b> Sydney, NSW, Australia	<b>RCPA Pathology Update</b> Contact: Suzanne Marks, Royal College of Pathologists of Australasia (RCPA) Ph: (02) 8356 5806 E-mail: <a href="mailto:suzannem@rcpa.edu.au">suzannem@rcpa.edu.au</a> Website: <a href="http://www.rcpa.edu.au">www.rcpa.edu.au</a>
<b>21–25 March 2005</b> Cairo, Egypt	<b>Cancer in Developing World</b> Fakkous Center for Cancer and Allied Diseases, 11 Boulos Hanna Street, Dokki, Cairo Egypt Ph: +20 2 337 0721 Fax: +20 2 749 3070 E-mail: <a href="mailto:sh_omar40@hotmail.com">sh_omar40@hotmail.com</a>
<b>16–20 April 2005</b> Anaheim, California, USA	<b>96<sup>th</sup> Annual Meeting of the American Association for Cancer Research (AACR)</b> AACR, Public Ledger Building, Suite 826, 150 South Independence Mall West, Philadelphia PA 19106-3 USA Ph: +1 215 440 9300 Fax: +1 215 351 9165 E-mail: <a href="mailto:meetings@aacr.org">meetings@aacr.org</a> Website: <a href="http://www.aacr.org">www.aacr.org</a>
<b>28 April – 1 May 2005</b> Orlando, Florida, USA	<b>30<sup>th</sup> Annual Congress of the Oncology Nursing Society</b> Oncology Nursing Society, 125 Enterprise Drive, Pittsburgh PA 15275-1214 USA Ph: +1 866 257 4667 Fax: +1 866 369 5497 E-mail: <a href="mailto:meetings@ons.org">meetings@ons.org</a> Website: <a href="http://www.ons.org">www.ons.org</a>
<b>8–11 May 2005</b> Wellington, New Zealand	<b>Annual Scientific Meeting of the Royal Australasian College of Physicians (RACP)</b> Contact: Anne Chang E-mail: <a href="mailto:racpasm@racp.edu.au">racpasm@racp.edu.au</a> Website: <a href="http://www.racp.edu.au">www.racp.edu.au</a>

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<b>Date / Place</b>	<b>Meeting / Contact</b>
<b>9–13 May 2005</b> Perth, WA, Australia	<b>Annual Scientific Congress of the Royal Australasian College of Surgeons (RACS)</b> Coordinator: John Masterton Ph: (03) 9276 7420 Fax: (03) 9276 7431 E-mail: <a href="mailto:john.masterton@surgeons.org">john.masterton@surgeons.org</a> Website: <a href="http://www.racs.edu.au">www.racs.edu.au</a>
<b>13–17 May 2005</b> Orlando, Florida, USA	<b>41<sup>st</sup> Annual Meeting of the American Society of Clinical Oncology (ASCO)</b> ASCO, 1900 Duke Street, Suite 200 Alexandria, VA 22314 USA Ph: +1 703 299 0150 E-mail: <a href="mailto:asco@asco.org">asco@asco.org</a> Website: <a href="http://www.asco.org">www.asco.org</a>
<b>15–18 May 2005</b> Perth, WA, Australia	<b>Annual Scientific Meeting of the Australasian College of Dermatologists</b> Website: <a href="http://www.dermcoll.asn.au">www.dermcoll.asn.au</a>
<b>18–21 May 2005</b> Darwin, NT, Australia	<b>Annual Scientific Meeting of the Trans-Tasman Radiation Oncology Group (TROG)</b> Ph: (02) 9280 0577 Fax: (02) 9280 0533 E-mail: <a href="mailto:conferences@pharmaevents.com.au">conferences@pharmaevents.com.au</a>
<b>2–5 June 2005</b> Budapest, Hungary	<b>Scientific &amp; Educational Conference of the European Society for Medical Oncology (ESMO)</b> ESMO Head Office, Congress Department, 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>



*To all our readers*

*Best wishes for the Festive Season and  
a Happy New Year!*

*From staff of the  
Centre for Clinical Research in Cancer  
at The Cancer Council Victoria*



## The Cancer Council Victoria

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

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

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

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

