



Skin Cancer Update

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1ST CONGRESS OF THE INTERNATIONAL
DERMOSCOPY SOCIETY REPORT

SUNSMART REPORT

CANCER IN VICTORIA, 2004

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



SKIN CANCER UPDATE

December 2006

Issue No. 15

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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, lung and urological cancers also produce twice yearly cancer updates.

If you would like to have your name removed from the distribution list, or if you are interested in receiving any of the other updates please contact Mrs Noellyn Ngo, Ph: (03) 9635 5265.

******* Last Issue – No. 15 – December 2006 *******

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

*Mr David Speakman
Surgeon
Peter MacCallum Cancer Centre*

It is a pleasure to present this Christmas Edition of the Skin Cancer Update. The lead article is the report on the first major International Dermoscopy Conference held earlier this year in Naples, Italy. Alex Chamberlain sets the tone with a delightful description of the region and this draws one to his discussion of the importance of pattern recognition in dermoscopy, as well as the value of audit suggesting that an ideal benign to malignant biopsy ratio for dermatologists is in the order of 5-10:1.

The SunSmart update highlights achievements in that area this year. These particularly include the new television advertisement playing over summer, the addition of Seeking Shade and Sliding on Sunglasses to the traditional Slip, Slop, Slap campaign and the UV alert in daily papers and weather websites. The new general practice workshop package "Can you Spot the Difference?" has also been completed and launched late this year. A widespread rollout to all GP Divisions is planned for next year.

There has been the opportunity to review some excellent local statistics on cancer in Victoria in 2004. Cancer accounted for about 30% of all deaths in that year, considerably more than heart disease at 24%. Melanoma appeared 5th on the league table for incidence with about 8% of all new cancers. There are only 261 deaths from melanoma in 2004. There continues to be a lack of accurate data on non-melanomatous skin cancer rates.

For those new to or unaware of the role of VCOG in cancer care in Victoria, Susan Fitzpatrick has provided an excellent overview of the aims and activities as well as benefits of the group in her article.

Happy reading!

Contributions Welcome

The Skin Cancer Update welcomes contributions – conference reports, review of an area of interest, reviews of recent journal articles, clinical trial updates.

	Deadline	Issue Date
Mid-year issue	1 June	1 July
Year-end issue	1 November	1 December

Contributions should be forwarded to:

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Report of the First Congress of the International Dermoscopy Society

27–29 April 2006, Naples, Italy

*Dr Alex Chamberlain
Dermatologist
Alfred Hospital*

The International Dermoscopy Society (IDS) was founded in 2003 with the primary aims of promoting clinical research and improving education in dermoscopy. The first congress of the IDS was held in Naples in April this year and proved to be a most enjoyable and stimulating meeting. The congress venue was a grand old hotel on the busy seafront promenade which overlooked a pretty marina in the shadows of the historic Castell dell'Ovo, a 12th century castle.

Castell dell'Ovo



Naples is a fascinating and exciting city and certainly not as dangerous as we were cautioned. It is the official home of pizza, and the coffee and gelati are as good as you might taste elsewhere in Italy. Even better, Naples is much more affordable than Rome, Florence or Milan. The historic city centre is alive with locals and tourists alike, countless churches and cafes and grubby laneways. Most of the boutiques and lively bars were in the Santa Lucia district. The city lies on a sweeping bay with Mt Vesuvius ever ominous in the distance. Pompeii is only a short drive and a good day trip. The islands of Capri and Ischia as well as the stunning Amalfi coastline are all a short ferry ride

Picturesque Positano



away. The vertically oriented coastal town of Positano is a popular tourist destination for many Australians and I was fortunate to spend a few days there post-conference.

Whilst the origins of dermoscopy were in dermatology circles, its value is increasingly being appreciated by all clinicians who deal with pigmented lesions and skin cancer. The meeting was open to all clinicians with an interest in dermoscopy and this included mainly dermatologists but also pathologists and general practitioners. Surgical oncologists and other interested clinicians would be most welcome at the next IDS congress which is likely to be held every five years – membership is free and available via the society website. At present there are over 2000 members scattered around the world.

There were many excellent presentations from respected international authorities at the congress such as Drs Ashfaq Marghoob, Al

Kopf, Robert Johr, Susana Puig, Iris Zalaudek, Luc Thomas, Harold Kittler and Guiseppa

Argenziano. Abstracts are due to be published in an upcoming issue of *Dermatology*. The following notes are only some of the highlights.

Dermoscopy comes of age

The number of peer-reviewed publications on dermoscopy trebled between the periods 1987–2001 (160) and 2001–2006 (487), a measure of the increasing interest and broadening applications within the field.

Clarifying the role of dermoscopy

Although, dermoscopy has traditionally been used to assess pigmented lesions, newer applications were discussed and these included non-pigmented cutaneous neoplasms, infectious and inflammatory dermatoses, teledermoscopy, short term monitoring of atypical pigmented lesions and monitoring of response to treatment. The benefits of dermoscopy were re-iterated and these include improvement in diagnostic accuracy in expert hands, improvement in clinical confidence, reduction in excision of benign lesions (improved benign to malignant ratio) and increased awareness of subtle or bland looking melanomas. It was stated that dermoscopy often changes management in patients with multiple atypical pigmented lesions in identifying which ones require biopsy or monitoring. The most subtle of changes leading to a diagnosis of melanoma may be detected on skin mapping photos especially where the added dimension of dermoscopy is included.

Which diagnostic algorithm?

All dermoscopic diagnostic algorithms perform fairly similarly and this has been shown in a number of studies now. Once a familiarity has been established 90% of clinicians rely on pattern recognition or gestalt as opposed to the analytical approach.

Dermoscopic-pathologic correlation

Dermoscopy fills an important role in helping to identify suspicious foci within atypical lesions that have been excised, so that the clinician can flag these with a partial punch or suture to direct the pathologist to the most suspicious zone for step

sectioning. This technique may also help in regressed melanocytic lesions, collision lesions, asymmetric lesions or recurrent melanocytic lesions. If the partial punch technique is used, care must be taken to avoid the punch detaching totally from the ellipse of skin.

Monitoring

The ideal period for short term dermoscopic follow up of an atypical lesion is considered to be in the 3 to 6 month range. Enough change should be appreciable by that stage to make a decision as to whether the lesion is static or dynamic and therefore suspicious. Twelve-month examinations were considered to be ideal for high risk patients with abundant naevi including dysplastic naevi who are increased risk for melanoma. For a solitary atypical lesion, one should lean towards excisional biopsy over monitoring whereas patients with multiple slightly atypical lesions, a system of monitoring is warranted. Banal lesions that have changed according to the patient may also be suitable to monitor, but atypical nodular lesions should never be monitored because of the risk of missing a nodular melanoma. These are best excised.

Special sites and special hosts

An instructive presentation was given on subungual lesions by a French authority who made some salient points. Pigmented bands with multiple colours and bands of variable width and spacing are suspicious for melanoma. Subungual Bowen's disease tends to have a yellow hue with hyperkeratosis and may change the shape of the lunula from an arc to more triangular and pointed. Acral lentiginous melanoma can attain significant depth of invasion and remain relatively flat clinically – beware!

Melanoma is the commonest malignancy to metastasise to the placenta. It is well recognised that pigmented lesions frequently change on convex surfaces of pregnant women. Whilst a symmetric and homogeneous increase in size in a pigmented lesion on the abdomen or breast of a pregnant woman is less concerning, the development of new structures or expansion of pigment network should prompt a biopsy to exclude melanoma.

Novel dermoscopic features including vascular structures

A number of new dermoscopic signs have been described since the original World Congress of Dermoscopy in Rome in 2001 and these were covered in a number of presentations. On the benign front, fleshy compound naevi tend to 'wobble' under the dermoscope (the so-called 'wobble sign') and this reflects a difference in consistency when compared to seborrhoeic keratoses which tend to be sessile and firmer. Flat seborrhoeic keratoses may also show fingerprint like areas or moth-eaten borders (as may solar lentigines) and when more protruberant their gyri-like folds resemble 'fat fingers'. These 'fat fingers' may be pale, brown or blue in colour and will sometimes mimic a pigment network. A number of variants of benign naevi have been well described now and these all tend to have one or more symmetric components from either the globular, reticular or homogenous morphologies. On acral skin there are 8 benign variants and these should be distinguished from the malignant counterpart which is the 'ridge pattern' with broad parallel pigmented lines outlining eccrine gland openings.

Several basal cell carcinoma features were also discussed including spoke wheeling which is seen in pigmented variants and white maple-leaf like areas in fibroepitheliomas of Pinkus.

There has been an increasing focus on vessels and their morphology in various cutaneous neoplasms. These aren't always best appreciated at x10 magnification and will be partly obliterated with excess pressure on the contact plate of the dermoscope. Some vascular patterns are very recognisable such as red lacunes in angiomas, arborising telangiectasia in non-pigmented basal cell carcinomas and glomerular vessels in Bowen's disease. Other patterns take more experience in confidently

recognising and these include hairpin vessels and comma shaped vessels at the edge of seborrhoeic keratoses and intradermal naevi respectively. The vascular patterns observed in melanomas are not consistent and are frequently designated as polymorphous with a range of patterns including dotted, corkscrew and irregular linear vessels. It should be said that atypical vascular patterns will sometimes help to identify hypomelanotic or amelanotic melanoma especially where there is evidence of regression, ulceration or a remnant of pigment network (which may even be inverse).

Automated diagnosis?

At the present time, the consensus remains that automated diagnosis with computer assisted dermoscopy systems are no replacement for an experienced clinician's assessment. Computerised systems are not good at identifying an 'ugly duckling' lesion it was considered and therefore will fill a role as a diagnostic aid only at this stage.

Surgical audit

It has been suggested in a study published in the British Journal of Dermatology that the ideal benign to malignant ratio (BMR) when excising pigmented lesions should be in the vicinity of 5-10:1 for dermatologists. It has previously been shown to be approximately 30:1 for Australian general practitioners. If your BMR is less than 5:1 the suggestion was to excise more lesions on the assumption that some melanomas are being missed. If your BMR is greater than 10:1 then maybe more dermoscopic short-term monitoring is appropriate. This is a useful guide and all clinicians excising pigmented lesions should audit their biopsy results to see where their figures fall each year.

SunSmart Program Update

Ms Kylie Strong
Manager, SunSmart
The Cancer Council Victoria

'NEW' National skin cancer awareness campaign

On 19 November 2006, a new national skin cancer awareness campaign was launched by the Federal Government. The campaign's aim is to make a significant contribution to changing the attitudes and behaviour of young people to skin cancer and sun protection.

The campaign will run until February 2007 and includes a graphic television advertisement showing a 22-year-old woman having her skin cancer removed and her surgeon. The campaign's main target audience is young people aged 15-19. Details of the new campaign can be found at www.skincancer.gov.au/.

'NEW' National SunSmart Message

The Cancer Council Australia's SunSmart program now recommends Victorians take **five steps** to protect against sun damage when the SunSmart UV Alert indicates the UV Index is at 3 or above:

1. **Slip** on some sun-protective clothing – that covers as much skin as possible
2. **Slap** on SPF30+ sunscreen – make sure it is broad spectrum and water-resistant. Put it on 20 minutes before you go outdoors and every two hours afterwards. Sunscreen should never be used to extend the time you spend in the sun.
3. **Slap** on a hat – that protects your face, head, neck and ears
4. **Seek** shade
5. **Slide** on some sunglasses – make sure they meet Australian Standards.



Extra care should be taken between 10am to 3pm when UV index levels reach their peak.

The SunSmart UV Alert appears on the weather page of all Australian daily newspapers and is available on the Bureau of Meteorology website. Go to www.bom.gov.au/weather/uv.

For further information on sun protection and skin cancer visit www.sunsmart.com.au or call The Cancer Council Helpline on 13 11 20.

Can you spot the difference?

'NEW' The Early Detection and Treatment of Melanoma Workshop for General Practice

On 14 November 2006, a two-hour workshop was launched – a joint initiative between the Cancer Council's SunSmart and General Practice Programs. It was developed in consultation with a working group of skin cancer specialists (nominated by the VCOG Skin Cancer Committee), and is relevant to all general practice staff and GP registrars.

It provides participants with the skills they need to assess a patient's risk of melanoma based on risk factors, as well as practical information on detection and treatment.

Four pilot workshops were trialled in November and December. These sessions were delivered by a specialist, and the interactive workshops incorporated a presentation and case study discussion. A comprehensive resource kit was provided to all participants. The workshop has been approved by the RACGP and has been allocated 2 points per hour.

SunSmart plans to roll out the sessions to other divisions in the future – details will be provided to VCOG members when they are finalised.



Protecting your most important asset

‘NEW’ SunSmart’s Farmers and Rural Outdoor Workers Skin Cancer Prevention and Early Detection Campaign

On 21 November 2006, SunSmart launched a new campaign targeting farmers and rural outdoor workers.

Research indicates that farmers are a high-risk group for skin cancer because of the long hours they spend outdoors during peak UV times, and yet many do not wear sunscreen and long sleeved shirts.

The campaign consists of radio and print advertising in regional Victorian media, brochures and A4 posters and offers advice on the risks of skin cancer, encouraging farmers to use sun protection and to seek expert advice if they are concerned about spots or changes on their skin.

The campaign launch at the Shepparton sale yards generated a great deal of media coverage.

For further information on any of the SunSmart Program activities, please refer to www.sunsmart.com.au.

SunSmart Local Government Shade Awards 2007

The Cancer Council Victoria is now welcoming entries for the SunSmart Shade Awards for Victorian Local Government Authorities.

The Shade Awards encourage applications from a variety of sectors within council, including urban planning, social planning, engineering and public health. The 2007 Shade Awards program demonstrates councils’ commitment to reducing the risk of skin cancer within their municipality through shade provision and/or policy.

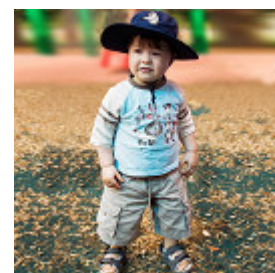
Participating Councils will be invited to a gala cocktail Awards presentation event to be hosted by The Cancer Council Victoria in April 2007. Winners will be acknowledged through a publicity strategy targeting municipal, local and mainstream media.

SunSmart Schools and Early Childhood Services Success

Although participation rates of primary schools and early childhood services in the SunSmart Schools Program are already very high, we’re pleased that following a recruitment campaign in August, even more primary schools and early childhood services have become SunSmart.

Currently 84% of primary schools are now members of the SunSmart Schools Program. Out of 1691 primary schools across Victoria, only 280 have not yet joined. We are working on strategies to encourage them to be involved.

Currently 65% of childcare centres and preschools and 51% of Family Day Care



Schemes are SunSmart. We will be conducting a local government campaign to encourage more council run early childhood services to join the SunSmart program.

A new Secondary Schools Program Coordinator has been appointed to try and encourage adoption of more sun protection policies and strategies in Secondary Schools. The coordinator will be developing a secondary school advisory committee with representatives from government departments, sporting sectors, educational organisations and schools. A survey is also being conducted in secondary schools to help determine the most appropriate approach to take in this setting.

UV Alert Update

Now that summer is here, UV Index levels in Victoria are rising, so it is a great time to get into the habit of checking the SunSmart UV Alert before you head outside. The SunSmart UV Alert tells you the times during the day you need to protect yourself from UV radiation. The

SunSmart UV Alert appears in the weather section of daily newspapers and Telstra's Pocketnews weather service. It is also available on the Bureau of Meteorology website: www.bom.gov.au/weather/uv.

We need help to source skin cancer case studies

SunSmart's media team are always looking for personal stories for our media activities from people who have had a skin cancer experience. Personal stories are a great way for us to illustrate our message and are very popular with the media. If you have patients who you consider would be comfortable to discuss their experience with the media, please contact SunSmart's media communications staff:

- Lisa Kuspira, lisa.kuspira@cancervic.org.au or phone 9635 5427
- Zoe Furman, zoe.furman@cancervic.org.au or phone 9635 5271.

Guidelines for the Management of Cutaneous Melanoma and Melanoma in Special Sites

The development of specific questions is complete and literature searching is continuing to be directed by Dr Phoebe Holt, of the Sydney Health Projects Group at Sydney University. The number of questions contracted was 38, the essayist now request 63. This requires further funding and this has been met. The questions and searches will be completed by end of October.

After the Working Party meeting on 27 September 2006, a good proportion of searches were delivered to chapter leaders and critical appraisal has begun on the planned timeline.

A public meeting will be planned to discuss the draft Guidelines for August–September 2007. The meeting is planned to be self funding.

Reprinted from Wongi Yabber Nov 2006; 13(4): 2.

Cancer in Victoria 2004

Victorian Cancer Registry

The Victorian Cancer Registry has been a population-based registry since 1982. This was enabled by amendments to the Cancer Act in 1981, which made it mandatory for all hospitals and pathology laboratories to notify the cancer registry of the presence of cancer in patients or human tissues.

All malignant neoplasms are registered, as are in situ carcinoma of breast and cervix and in situ melanoma. Basal and squamous cell carcinomas of the skin are not registered except for those occurring in genital and perianal skin and the vermilion border of lip.

Non-melanocytic skin cancers are not registered by the Victorian Cancer Registry (or most other registries) as many are treated in doctors' surgeries using destructive techniques which preclude histological confirmation and also as they vastly outnumber all other forms of cancer.

Currently, about 250 hospitals and 50 pathology laboratories notify cancer to the registry, increasingly via electronic media. In preparing the 2004 incidence data, around 100,000 notifications were processed. In addition, death certificates are obtained from the Registrar of Births, Deaths and Marriages in computerised format on a regular basis.

The minimum data set collected for each cancer consists of:

- registry identification number
- name(s)
- residential address
- date of birth
- country of birth
- sex
- vital status
- date of last contact
- number of primary tumours
- date of diagnosis
- site of cancer
- cancer histology
- method of diagnosis.

Overview of 2004 statistics

Numbers

Nearly 24,000 Victorians develop cancer, other than non-melanocytic skin cancer (NMSC), each year and over 9,000 deaths are caused by it. In 2004, 13,019 men and 10,791 women presented with new cancers and 5,283 men and 4,266 women died from cancer.

Age and sex

Cancer was very age-dependent with less than 1% of tumours occurring before age 15 and 59% in persons over 65 years. More men than women developed cancer: 121 for every 100 females. The male excess was largely due to tobacco-related cancers.

Incidence

The standardised incidence rates were 346 per 100,000 males and 265 per 100,000 females. The cumulative rates percent to age 75 were 40.7% for males and 29.5% for females. These represented risks of over 1 in 3 for men and almost 1 in 4 for women. At least one in three Victorians will develop a cancer other than non-melanocytic skin cancer by age 75.

Mortality

In 2004, more Victorians died from cancer (9,613 29.6% of all deaths) than from all heart disease (7,771, 23.9%). Cancer and heart disease caused more than half of all deaths in Victoria.

Age-standardised mortality rates for cancer were 125.8 per 100,000 males and 83.5 per 100,000 females. These rates are higher than those for both ischaemic heart disease (66.6 and 32.5 per 100,000 men and women respectively) and all heart disease (85.0 and 46.9 men and women respectively).

Cancer death rates for men and women continue to decrease at about 1.2% and 0.9% per year respectively.

More detailed statistics are available at www.cancervic.org.au/cancer1/facts/vic.htm.

Figure 1. Leading Cancer Sites in Victoria, 2004.

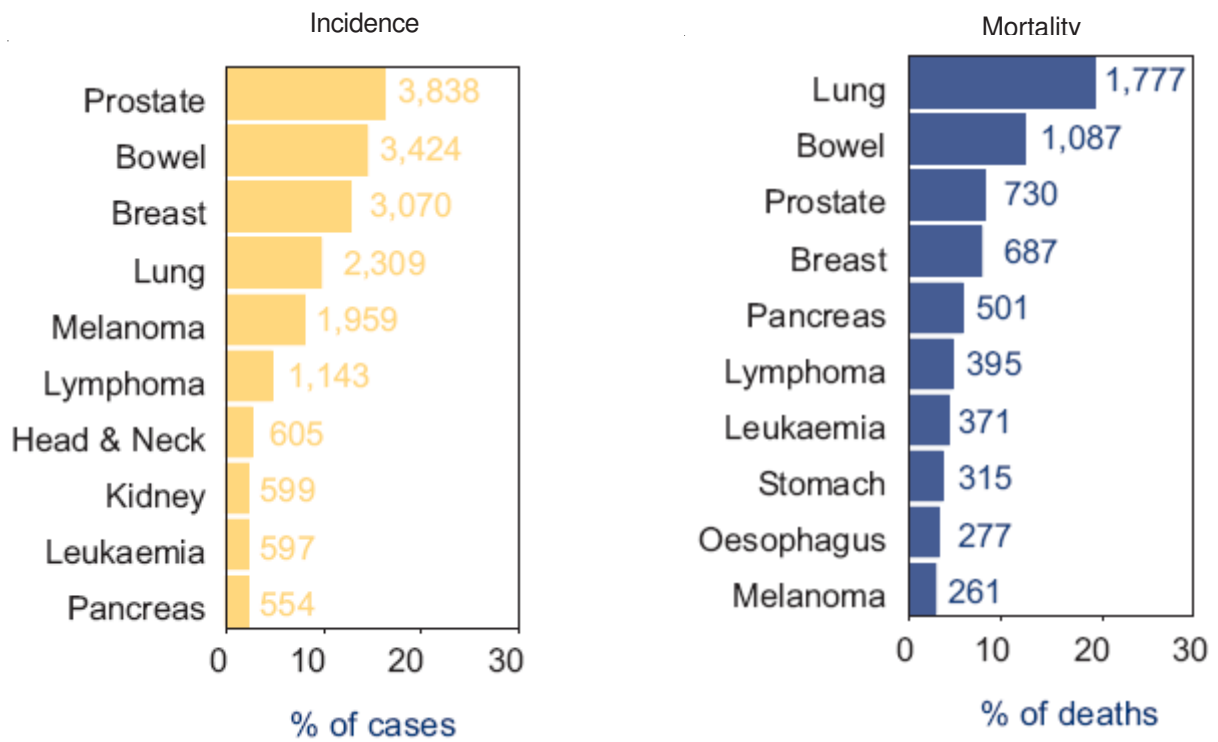
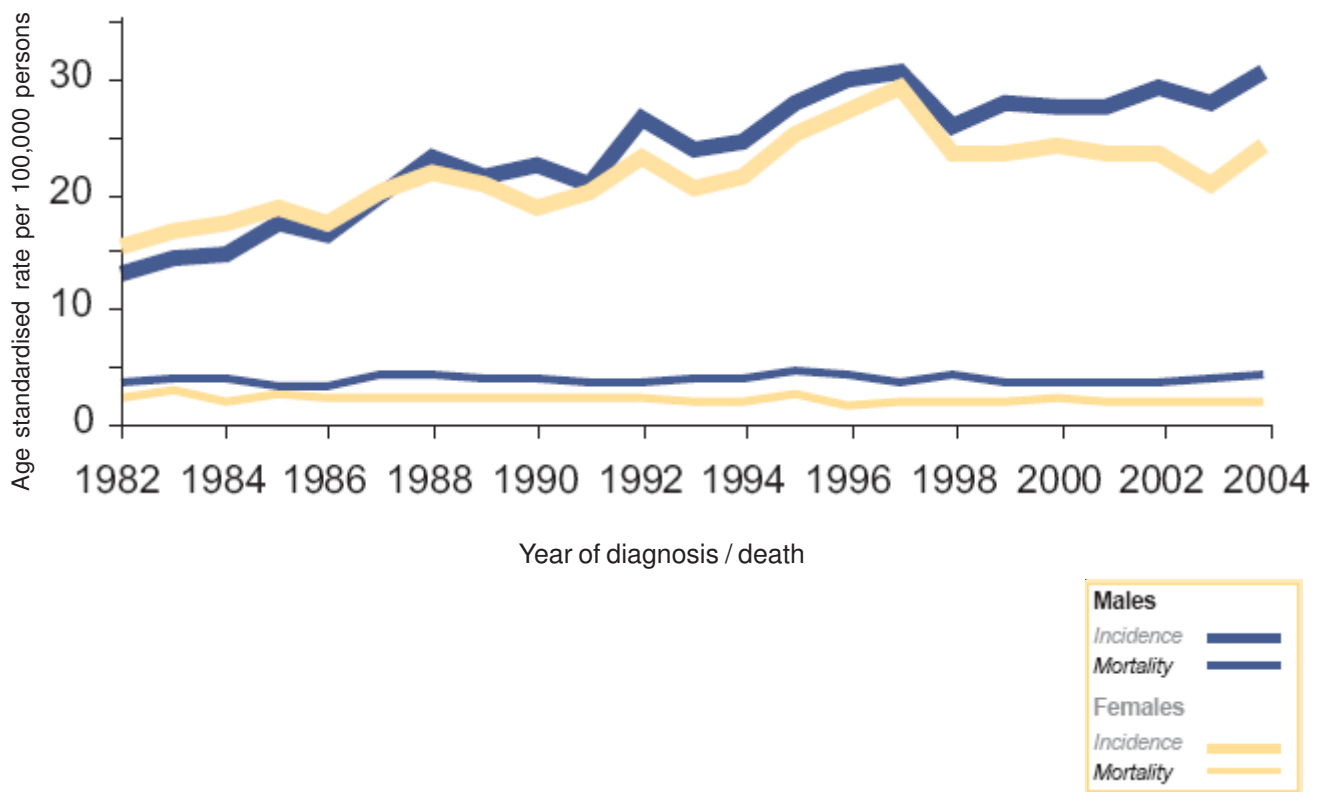


Figure 2. Melanoma Trends in Victoria, 1982–2004.



VCOG 30th Anniversary

*Speech by Assoc Professor David Allen, VCOG Chair
on 1 November 2006 during VCOG 30th Anniversary Reception*

Over the last 30 years, the Victorian Cooperative Oncology Group has developed into a body with a broad multidisciplinary and cross-institutional representation.

The aim of the group has been to prevent cancer and optimise patient treatments and care through collaboration and research. VCOG is now a forum that is of value to clinicians and of importance for patient outcomes.

The VCOG and its subcommittees have developed into an authoritative body of enthusiastic experts who work across disciplines, outside of institutional boundaries, providing clinical and research advice to the Cancer Council. The approximately 450 members of the VCOG committees make an enormous contribution to clinical research and the development of patient care protocols in Victoria.

These committees provide a necessary neutral territory for discussion and will certainly continue to grow into the future. Just last week we held the inaugural meeting of the 20th committee – the sarcoma advisory committee.

As the committees expand and strengthen further, so too will the influence and relevance of this unique forum grow in its present spirit of co-operation.

Of course the work of these committees doesn't just happen – they need to be organised, agendas prepared and circulated etc. The VCOG Secretariat, consisting of the Executive Officer Susan Fitzpatrick and her team, really is the glue that binds us together, and for all their essential – and increasing – work, we thank them.

Every two years the Victorian Cooperative Oncology Group elects an Executive Committee that in turn elects a Chair. I am very proud to be the current chair of VCOG and the Executive Committee and I thank the members for their work and support – and in doing this I would also like to acknowledge the work of all past and present subcommittee chairs and members. And whilst I am thanking people, I would also like to mention David Hill for his constant support, and my deputy chair Ingrid Winship for her valuable contribution.

The achievements of VCOG over the past 30 years are enormous but the future looks even brighter with the new opportunities and directions that are constantly emerging. Working with the newly formed Integrated Cancer Services in Victoria is one such opportunity. And we look forward to other potential collaborations and synergies with the Department of Human Services and other relevant government departments and agencies in the future.

However, to remain relevant into the future we must always ensure that our efforts are of benefit to the Victorian community as a whole and that we keep our focus firmly on the fight against cancer.

I thank you all.

Supporting Oncology Professional Collaboration in Cancer Control, 1976–2006

Mrs Susan A Fitzpatrick, Executive Officer

Centre for Clinical Research in Cancer, The Cancer Council Victoria

Poster presentation at UICC World Cancer Congress, 8–12 July 2006, Washington DC, USA

The Victorian Cooperative Oncology Group

The Cancer Council Victoria's infrastructure support within a "neutral" environment for the Victorian Cooperative Oncology Group has enabled Victoria's cancer specialists to meet in a conducive, non-partisan environment to develop multi-disciplinary clinical management protocols and policy advice for 30 years.

The Victorian Cooperative Oncology Group is an excellent forum for communication of new cancer treatment knowledge, promoting development and implementation of evidence-based clinical management guidelines and for the collaborative design of and participation in clinical trials. It has also enabled the coordinated lobbying of governments for improved services for cancer patients and cancer clinical research funding.

Comment from the Chair, Assoc Professor David Allen

Developing a unique oncology professional group

In 1975, the Cancer Council's Medical & Scientific Committee expressed concern about inconsistency in the management of solid tumours requiring chemotherapy and the then lack of suitable medical training. It formed a working group to explore all aspects of chemotherapy in Victoria.

In 1976 it was resolved to invite clinical representation from all hospitals in Victoria providing cancer therapy.

The Cancer Council Victoria provided a non-partisan environment and administrative support for the gathering.

The Victorian Cooperative Oncology Group was constituted in 1976 to:

- Advise the Cancer Council Victoria on all clinical aspects of cancer.
- Promote a range of cooperative measures to optimise cancer management.
- Contribute to the design and conduct of collaborative clinical research.
- Promote development and implementation of evidence-based treatment guidelines.

- Advocate for improved cancer services
- Contribute to the education of the medical profession.
- Establish cancer advisory and research groups.

In 2006, the VCOG structure includes a primary committee, an executive committee, 9 cancer and 4 clinical advisory committees and 3 research groups. The Cancer Council supports the VCOG activities through a dedicated Clinical Research Centre providing administration and cancer trial coordination.

A group with extensive cancer expertise

- 450 honorary / volunteer health professionals – medical, scientific and community.
- Inclusive, with the power to co-opt members with specialist expertise.
- Represents medicine, radiotherapy, surgery, gastroenterology, gynaecology, dermatology, ENT, genetics, haematology, neurology, palliation, pathology, psychology, respiratory / thoracic, nursing social work, etc.

- Includes 16 consumer / community representatives
- Represents 30 public and private metropolitan and regional cancer treatments centres

An influential role in improving cancer care

- Supports evidence-based treatment, clinical research, equity and access to best cancer care
- Assists the Cancer Council in cancer registration (standard data items / site specific registers), knowledge dissemination (professional forums / newsletters), community education (patient information material), support (Cancer Call-In), media responses, and fundraising activities (Relay for Life, Daffodil Day etc)
- Has capacity to influence clinical practice and service provision
- Highly respected by oncology professionals in Victoria and Australia
- Has unique linkages between public and private health care professionals, institutions, government and NGOs

Providing authoritative advice on cancer control

Advocacy / Support for

- Cancer Service Infrastructure, Bone Marrow Transplantation, Palliative Care Services, Cancer Therapies, Pain Therapies, Clinical Research Infrastructure, Standard Cancer Data Set, Professional Education, Cancer Genetics Services, Patient Resources and Support Services

Submissions to Government Inquiries on

- Cancer Services in Victoria / Australia, Alternative / Unproven Therapies, Mammographic Screening, Prostate Cancer Screening, Protection of Cancer Genetic Information

Statements / Guidelines on

- Screening for breast, bowel, prostate cancer, Handling of cytotoxic drugs, Techniques for cervical smear, Management of gynaecological, cancer, familial ovarian

cancer, non-melanocytic skin cancer, Synoptic reporting for melanoma, gynaecological and head and neck cancer, IHC testing for CRC, Gynaecological surveillance for HNPCC

Information for patients and families

- Expert medical advice on contact of Cancer Council information brochures.

Collaborating in clinical research

Clinical Trials

- Initiated - Endometrial (international), Ovarian (national), Rectal (state), Breast (international, state), Pain (state), Prostate (international)
- 7% cancer patients registered in trials in Victoria
- 12% breast cancer patients in international trials

Treatment Surveys and Audits

- Breast (1986, 1990, 1995, 1999)
- Colorectal (1988, 1998, 1994)
- Lung (1993), Prostate (1993)
- Testes (1988-1993)
- Cervical (1982, 1986, 1987, 1992), Ovarian (1993-1995), Endometrium (1995)
- Renal Cell (2000), Bladder - Superficial (1990, 1995), Bladder - Invasive (1990-95)
- Glioma (1998-2000)
- Melanoma (2000)

Outcome Registers

- Insitu & Small Breast (1988-1998), Radical Prostatectomy (1997-2002)

Achievements

- NHMRC Silver Volunteer Award for Health Organisation, Victoria, 2001.
- Peak oncology health professional advisory body - *Victoria's Cancer Parliament*.
- Maintained cohesive oncology health professional community for 30 years.
- Structure modelled in three other Australian states.

Cancer Australia Ready to Tackle National Priorities

Appointment of a Chief Executive Officer to Cancer Australia has paved the way for the organisation to become operational and address a growing list of national cancer priorities, according to The Cancer Council Australia.

The Cancer Council Australia's Chief Executive Officer, Professor Ian Olver, welcomed the appointment in August of Professor David Currow as CEO of the new agency and said he would be taking on a challenging role with big expectations from the health sector.

"The establishment of Cancer Australia is a significant development and Professor Currow's

expertise and experience will help the organisation quickly come to grips with national priorities and issues in cancer control," Professor Olver said.

"There is a real need in Australia for a central agency to coordinate and facilitate the considerable but fragmented research efforts into cancer at the national level. We also need more resourcing to develop and implement national guidelines and to accredit and credential cancer professionals and treatment centres."

Reprinted from Wongi Yabber Nov 2006; 13(4): 4, The Cancer Council Australia Report.

Forthcoming Meetings

Date / Place	Meeting / Contact
25–28 January 2007 Clearwater Beach, Florida, USA	Molecular Targets in Cancer Therapy: 4th Biennial Meeting – Mechanism & therapeutic reversal of immune suppression in cancer Website: www.moffitt.usf.edu/continuinged/mt2007
1–3 February 2007 San Diego, California, USA	9th International Symposium on Anti-Angiogenic Agents Website: www.antiangio2007.com
2–6 February 2007 Washington DC, USA	65th Annual Meeting of the American Academy of Dermatology Website: www.aad.org
6–9 February 2007 Paris, France	18th International Congress on Anti-Cancer Treatment (ICACT) Service d'Oncologie Medicale, Salpetriere Hospital, c/o TCO Medi Holding, Paris, France Ph: +33 1 42 948 732 Fax: +33 1 42 948 733 E-mail: info@icact.com Website: www.icact.com
8–10 February 2007 Lorne, Victoria, Australia	19th Lorne Cancer Conference – The hallmarks of cancer Website: www.lornecancer.org

Date / Place	Meeting / Contact
8–10 February 2007 Hollywood, California, USA	9th National Conference on Cancer Nursing Research Organised by the Oncology Nursing Society (ONS), Pittsburgh, USA Ph: +1 412 859 6100 Fax: +1 412 859 6162 E-mail: customer.service@ons.org Website: www.ons.org
27–28 February 2007 Sydney, NSW, Australia	3rd Australasian Redesigning Healthcare Summit – <i>Making patient journeys work</i> With Flinders Medical Centre and NSW Health Website: www.changechampions.com.au
1–4 March 2007 Austin, Texas, USA	4th Annual Conference of the American Psychosocial Oncology Society (APOS) – <i>Promoting quality psychosocial cancer care across diverse communities</i> Ph: +1 434 293 5350 Fax: +1 434 977 1856 E-mail: info@apos-society.org Website: www.apos-society.org
1–4 March 2007 Sao Paulo, Brazil	7th Annual Meeting of the International Network for Cancer Treatment & Research Website: www.inctr.org
6–10 March 2007 Florence, Italy	4th International Conference on Tumor Micro-environment – <i>Progression, therapy and prevention</i> Organised by AACR and ICMS Website: www.aacr.org/page5995.aspx
15–18 March 2007 Washington DC, USA	Annual Meeting of the Society of Surgical Oncology (SSO) Website: www.surgonc.org
16–18 March 2007 Queenscliff, VIC, Australia	Australasian College of Dermatologists Rural Dermatology Conference Website: www.dermcoll.asn.au
22–23 March 2007 Cairns, QLD, Australia	Clinical decisions, ethical challenges E-mail: change.champions@bigpond.com Website: www.changechampions.com.au
11–14 April 2007 Rotorua, New Zealand	19th Annual Trans Tasman Radiation Oncology Group (TROG) Meeting TROG Conference Secretariat Ph: (02) 9280 0577 Fax: (02) 9280 0533 E-mail: trog@pharmaevents.com.au Website: http://trog.ranzcr.edu.au

Date / Place	Meeting / Contact
14–18 April 2007 Los Angeles, California, USA	98th Annual Meeting of the American Association for Cancer Research (AACR) Website: www.aacr.org
24–27 April 2007 Las Vegas, Nevada, USA	32nd Annual Congress of the Oncology Nursing Society (ONS) Oncology Nursing Society, Pittsburgh, USA Ph: +1 412 859 6100 Fax: +1 412 859 6162 E-mail: customer.service@ons.org Website: www.ons.org
6–10 May 2007 Melbourne, VIC, Australia	Annual Scientific Meeting of the Royal Australasian College of Physicians (RACP) Website: www.racp.edu.au
7–11 May 2007 Christchurch, New Zealand	Annual Scientific Congress of the Royal Australasian College of Surgeons (RACS) Ms Caroline Handley Ph: +61 3 9249 1273 E-mail: caroline.handley@surgeons.org Website: www.surgeons.org/AM/Template.cfm?Section=Annual_Scientific_Congress
9–11 May 2007 Winnipeg, Canada	2007 Annual Conference of the Canadian Association of Psychosocial Oncology (CAPO) – <i>Communication, Collaboration & Creativity</i> Website: www.capo.ca
13–16 May 2007 Adelaide, SA, Australia	40th Annual Scientific Meeting of the Australasian College of Dermatologists Website: www.dermcoll.asn.au
1–5 June 2007 Chicago, Illinois, USA	43rd Annual Meeting of the American Society of Clinical Oncology (ASCO) Ph: +1 703 299 0150 Fax: +1 703 299 1044 E-mail: asco@asco.org Website: www.asco.org
23–29 June 2007 Flims, Switzerland	9th Joint FECS-AACR-ASCO Workshop – Methods in Clinical Cancer Research Federation of European Cancer Societies, Brussels, Belgium Ph: +32 2 775 0306 Fax: +32 2 775 0245 E-mail: workshop@fecs.be Website: www.fecs.be/emc.asp?pageid=1153

Date / Place	Meeting / Contact
28–30 June 2007 St Gallen, Switzerland	Supportive Care in Cancer Website: www.oncoconferences.ch
5–7 July 2007 Lugano, Switzerland	32nd Annual Congress of the European Society for Medical Oncology (ESMO) ESMO Head Office, Via la Santa 7, 6962 Viganello-Lugano, Switzerland Contact: Alessia Mora Ph: +41 91 973 19 19 Fax: +41 91 973 19 18 E-mail: congress@esmo.org Website: www.esmo.org
1–4 August 2007 Melbourne, VIC, Australia	Annual Scientific Congress of the Medical Oncology Group of Australia (MOGA) MOGA Conference Secretariat, c/o Pharma Events, PO Box 265, Annandale NSW 2038 Ph: (02) 9280 0577 Fax: (02) 9280 0533 E-mail: moga@pharmaevents.org.au Website: www.moga.org.au

The Cancer Council Victoria

The Cancer Council Victoria is a public institution set up by an Act of Parliament in 1936. It operates as a charity, relies heavily on volunteer support, and raises and spends \$3-\$4 per head of population annually. It is governed by the Council and Executive and other committees. It's mission is to lead, coordinate and evaluate action to minimise the human cost of cancer for all Victorians. The Cancer Council houses three research divisions (behavioural science, clinical research, epidemiology) and units undertaking public and professional education, cancer registration, cancer information and support services, anti-smoking campaign (QUIT), finance, administration and fund raising. It employs about 300 staff. The Cancer Council also auspices a cooperating network of cancer specialists through the Victorian Cooperative Oncology Group and resources an expert Medical & Scientific Committee to dispense studentships, scholarships, fellowships and research grants to other academic, research and medical institutions.

Centre for Clinical Research in Cancer — Victorian Cooperative Oncology Group

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

The Victorian Cooperative Oncology Group (VCOG) established in 1976, provides advice to the Cancer Council Victoria, through the CCRC, on all clinical aspects of cancer control, in particular research, screening, diagnosis, treatment, palliative medicine, cancer genetics and professional education. The strategic role of VCOG is to have a 'parliament' of clinical cancer specialists with a view to promoting a range of cooperative measures to optimise cancer treatment in Victoria. VCOG consists of a primary committee, 10 cancer-site and 3 task-specific advisory committees, and 5 research sub-committees. These committees bring together in regular meetings approximately 450 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.

