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Skin Cancer Update

Issue 16 August 2007

- Excision of non-melanoma skin cancer
- Radiotherapy for non-melanoma skin cancer
- TROG Trial Update
- Photodynamic Therapy



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This newsletter is produced by The Cancer Council Victoria's VCOG 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 Liza Marsh, 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

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Dear Readers, welcome to this mid-year edition of the Skin Cancer Update. This issue is packed with essential reading particularly for those involved in the treatment of non-melanoma skin cancers at the primary level. There is a series of three articles covering surgery, radiotherapy, photodynamic therapy and topical imiquimod in the management of skin cancers and together they provide an excellent synopsis of the various strengths and weaknesses of the different treatment modalities.

In particular, Tim Brown's article addresses surgical margins, the issue of incomplete excisions and follow up of these excised lesions. Andrew Hui has provided an excellent review of the indications for radiotherapy both in primary lesions and in the more difficult recurrent, nodal or distant metastatic cases. Alvin Chong gives a precise overview of the use of PDT and imiquimod with BCC's, actinic keratoses and Bowen's disease. In particular, the issue of selection of lesions for these various types of treatments is explained.

The SunSmart report highlights two important areas. The first is recent research on the number of solariums that have sprung up, particularly in Melbourne, and the strategies in place to put some regulation into this area. Of particular interest will be the position statement on vitamin D and sun exposure released as a collaborative document by several of the key stakeholders in this area including Osteoporosis

Australia and The Australasian College of Dermatologists. It provides a series of key recommendations regarding the risks and benefits of sun exposure versus sun protection and gives clear guidance for practitioners in this area.

Finally there is a series of articles on some new support systems for cancer survivors being run through the Cancer Council of Victoria along with a selection of edited highlights of a more general nature regarding activities related to cancer in general rather than specifically skin. These are well worth reading to keep abreast of developments in the wider field of oncology.

This is my final editorial of the Update as I move to the Chair's position, and I am pleased to report that Dr Andrew Haydon will take over this role from the next edition.

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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Excision of non-melanoma skin cancer – Where to draw the line?

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Those physicians who are involved primarily in the surgical removal of non-melanoma skin cancer will, to a certain degree, feel short changed by the lack of information concerning the correct surgical excision margin for BCC and SCC. Compared with the well-studied excision margins recommended for removal of cutaneous melanoma, those for non-melanoma skin cancer are variably reported, and differ by millimetres rather than centimetres. Moh's technique claims to produce better long-term cure rates, but is expensive, time consuming and for most doctors, impractical to learn.

This article addresses the following points:

- What margin of normal skin should be used to fully excise a BCC?
- What should be done if a BCC is incompletely excised?
- Should patients who have a BCC completely excised be routinely monitored?

What margin?

Many publications concerning surgical treatment of skin malignancy go to great lengths in considering the margins of normal tissue that should be excised with a tumour. The rationale is that microscopic extension of tumour extends a finite distance from the visible focus, and that removal of these foci will prevent local recurrence.

The basis for Moh's micrographic technique is that tumour margins are more completely examined than by a conventional technique. It is believed therefore that Moh's technique has an increased probability of detecting these small extensions, and therefore eradicating residual tumour.

Numerous retrospective series of both Moh's and surgical excision have demonstrated that with macroscopic margins of 2-5 mm, a complete excision rate greater than 95% should be expected. Neither technique appears

superior in producing complete surgical eradication of BCC, nor has the place where Moh's technique is advantageous, been defined.

Even with magnification and measuring devices, there is an inherent error produced by a surgeon drawing a surgical margin. The error is proportionately larger the smaller the margin, such that for an estimated margin of 2 mm, the majority of surgeons produce an error of 47%. As a result, there are major implications for research data that relies on these surgically derived margins (particularly small ones) in predicting complete excision rates and subsequent cure rates.

Despite these comments, using standard surgical excision with a margin of 3–5 mm from the edge of the tumour, 95% of BCCs will be completely excised.

What shall I do if a BCC is incompletely excised?

The largest world series of incompletely excised BCCs demonstrates that surgical re-excision will produce evidence of residual tumour in 54% of specimens. The exception is in tumours of the periorbital region, where residual tumour is much less frequently found on re-excision. The one randomised prospective controlled trial comparing complete excision rates by Moh's versus surgical excision failed to demonstrate a significant difference between the techniques. However, Moh's technique may yet have some benefit in certain circumstances such as difficult anatomical sites or recurrent tumours with poorly defined edges.

In most cases, on the balance of probability, further BCC will be found in re-excision specimens. At 5 years a clinical recurrence is seen in 40% of these cases, and it would therefore seem sensible to re-excite incompletely excised BCCs.

From a more philosophical point of view it would also seem logical to re-excite an incompletely removed tumour. Presumably, when the management decision to excise a BCC was

initially made, the plan was complete eradication through surgical means? It would be illogical to change that plan simply because the goal was not accomplished by the initial treatment. Either the choice is made to surgically remove a BCC or to treat it by another modality.

Despite this rather dogmatic statement of intent, it is not uncommon to request an opinion from a radiation oncologist when a BCC has been incompletely excised and further surgery is declined by the patient. Often a helpful forum for discussing these difficult cases is a multidisciplinary case review by a radiation oncologist, dermatologist and a plastic surgeon laying out the different therapeutic options with the patient.

Should I follow up completely excised BCCs?

There are two reasons for routine follow-up of a patient who has undergone surgical excision of a BCC where the surgical margins demonstrate complete clearance of the tumour.

Firstly, because the surgeon believes that despite histological confirmation of removal, the tumour may recur. A 5-year follow-up of histological completely excised BCCs has demonstrated that only 1% will recur within the scar, and 2% within 1 cm of the scar. From this standpoint, it would seem unnecessary to regularly review patients.

The second reason would be to examine a patient for subsequent tumours, which are known to occur in anywhere between 19–83% of individuals who have already had a BCC. These patients fall into the category of 'skin check' rather than surgical review, and may be more appropriately followed up by a dermatologist or in primary care.

As yet, the use of Moh's techniques has not demonstrated a significantly reduced rate of BCC recurrence compared with surgical excision in the case of fully excised lesions.

Conclusion

Excise BCCs with a margin of at least 3 mm from the macroscopic tumour edge.

Re-excise residual BCC or consider radiotherapy

There is no need to follow-up patients with fully excised BCCs, except for 'skin checks'

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Radiotherapy for Non-Melanoma Skin Cancer

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Cutaneous basal cell carcinoma (BCC) and squamous cell carcinoma (SCC) are arguably the most common malignancies in Australia. Over ninety percent of cases present at early stage (= 2 cm), and are highly curable. This brief article is focused on the use of radiotherapy (RT) in the treatment of cutaneous BCC and SCC only.

Although cutaneous BCC and SCC are discussed together here for convenience, one must keep in mind that there are some important differences in clinical behaviour between the two (Table 1). In essence, a small proportion of SCC has the propensity to spread beyond the primary site via several pathways (perineural, dermal lymphatic, nodal and distant), and the chance of cure is significantly diminished once this occurs.

The roles of radiotherapy

The roles of radiotherapy in the treatment of cutaneous BCC and SCC may be arbitrarily divided into five areas:

1. Definitive radiotherapy for localised BCC / SCC
2. Postoperative radiotherapy for BCC / SCC with high-risk features
3. Treatment of local recurrence
4. Postoperative radiotherapy following lymph node dissection for nodal metastases (SCC)
5. Palliation

Definitive radiotherapy for localised BCC / SCC

Radiotherapy is one of several treatment modalities for small localised BCC / SCC, especially for small lesions, often selected as an alternative to surgery. The choice of RT (versus surgery or other modalities) should take into account tumour factors (site, size or T stage, depth of invasion, histological features), patient factors (medical condition, previous treatment, patient's choice) and treatment factors (time involved, treatment availability and cost).

The advantages of radiotherapy include being a non-invasive procedure, better preservation of normal tissue contour and the availability of different RT techniques tailored to the site, size and depth of lesion. The disadvantages of radiotherapy include multiple patient visits usually and hence longer treatment time, inability to examine margins (no pathology available) and radiotherapy related side effects.

All BCC and SCC should be confirmed histologically by biopsy prior to radiotherapy treatment (NHMRC guideline).

Relative Indications of RT include:

- Patients who refuse surgery
- Patients medically unfit for surgery or reconstruction
- When surgery would be mutilating and reconstruction difficult (eg lip commissure, columella of nose, eyelid commissure)
- Multiple, especially superficial lesions when impractical to excise
- Patients prone to keloid formation

Relative Contraindications to RT include:

- Patients under 60 years of age (risk of long-term scar deterioration, second malignancy)
- Sites of poor vascularity, over bony prominences, prone to trauma (eg pretibial)
- Advanced T4 lesions invading tendon, joint, bone or cartilage (surgery +/- postoperative RT better local control)
- Previous radiotherapy to the area
- Genetic syndromes: eg ataxia telangiectasia

There are very few randomised trials on RT in cutaneous BCC/SCC. One trial by Hall et al¹ randomised 93 patients with BCC to RT versus cryotherapy. The local recurrence rate at 2 years was 4% and 39% respectively. Another trial by

Avril et al² randomised 347 patients with basal cell carcinoma of the face (less than 4 cm) to surgery or radiotherapy. The 4-year actuarial failure rate were 0.7% (0.1–3.9%) and 7.5% (4.2–13.1%) in favour of surgery. Cosmesis was reported to be significantly better with surgery. Estimates based on current literature of the local control rate of BCC and SCC following curative RT is summarised in the following table (Table 1).

Table 1: Some differences in clinical behaviour between BCC and SCC

	BCC	SCC
Local recurrence after incomplete resection	~ 30-40%	≥ 50%
Perineural invasion	~1%	2.5-10%
Nodal spread	<0.1%	2-5%
Dermal lymphatic spread	Very rare	Associated with nodal spread
Distant metastases	Very rare	Uncommon, to lung, liver, bone, brain

RT techniques

Different RT techniques or modalities are available and can be tailored to site, size and depth of the tumour. The most common modality for localised small tumours is kilovoltage or orthovoltage RT. This includes superficial x-ray therapy (SXRT, 20-100 kV) and deep x-ray therapy (DXRT, 101-225kV). Brachytherapy has also been used for localised small tumours, either in the form of a contact mould or interstitial implant. Treatment of larger tumours or nodal regions usually require the use of a linear accelerator to deliver either electron RT or megavoltage photons.

RT dose

Various dose / fractionation regimens have been used, ranging from a single fraction to multiple fractions over several weeks. The choice of a suitable regimen depends on several factors, such as the size of the irradiated area, the importance of long-term cosmesis, the ability to attend multiple visits, etc. Shorter schedules such as 24Gy in 4 fractions or 30Gy in 5 fractions are generally used for small lesions and for

patient convenience. Longer schedules such as 50Gy in 20 fractions or 60Gy in 30 fractions are used for larger lesions and to minimise late effects such as fibrosis (may provide better long term cosmesis).

Acute RT side effects

These arise from about 2 weeks after starting RT and may take several weeks to settle. They occur sequentially and include skin erythema (redness), dry desquamation (peeling), moist desquamation (patchy or confluent superficial ulceration due to loss of epidermis) and alopecia. Other side effects depend on the site treated; for example mucositis (eg lip), xerostomia (eg parotid region).

Late RT side effects

These may occur months to years after RT and are usually permanent. They include skin atrophy, pallor or pigmentation, telangiectasia, alopecia, loss of sweating, and subcutaneous fibrosis. Late skin changes tend to deteriorate with time and may affect long-term cosmesis. Other uncommon late effects include non-healing radionecrotic ulcer, bone or cartilage necrosis and second malignancy.

Postoperative radiotherapy for BCC / SCC with high-risk features

The most common indication for postoperative RT for a BCC / SCC is following incomplete or narrow excision and further excision is considered to be difficult or inappropriate. The risk of local recurrence following incomplete excision is in the order of 30-40% for BCC and over 50% for SCC. Further treatment (re-excision or postoperative RT) should always be considered in this situation, especially for SCC.

Other high-risk factors to consider include multiple local recurrences, T4 tumour (invades deep structures eg skeletal muscle, bone), perineural invasion (especially if extensive or in the head & neck region) and multiple excisions to obtain clear margins. Other risk factors worthy of consideration include lymphovascular invasion (SCC), poor differentiation (SCC), aggressive clinical behaviour (SCC) and immuno-suppressed host.

Table 2. Estimated 5-year local control rate after curative RT

	BCC	SCC
T1	95-97%	93%
T2	88-92%	65-85%
T3	50-60%	50-60%

Locally recurrent BCC / SCC

Surgery is treatment of choice for locally recurrent BCC / SCC. RT is an alternative if surgery is not an option and no prior RT has been given (although re-treatment RT may be considered occasionally). Local control is generally inferior compared with previously untreated primary.

Post-operative radiotherapy for SCC with nodal metastases

Nodal metastases occur in up to 5% of SCC and is much less common for BCC. Prognosis is significantly worse in the presence of nodal metastases with an overall 5-year survival of about 40%. The main prognostic factors include the number of lymph nodes involved and the presence of extracapsular extension (Table 3).

Table 3. Estimated 5-year survival of patients with SCC with nodal metastases.³

No. of nodes involved	5-year survival
1	49%
2	30%
3	13%
Extracapsular extension	
Absent	47%
Present	23%

Lymph node dissection is usually the initial treatment. Postoperative radiotherapy improves regional control, especially if there are multiple nodes involved, extracapsular extension, parotid

involvement, close/involved surgical margin or in the setting of nodal recurrence. Metastatic SCC is the most common parotid malignancy in Australia. Standard treatment usually consists of surgery (with facial nerve preservation unless grossly involved by tumour) followed by postoperative RT.

Another strategy currently under investigation is the use of postoperative concurrent chemo-radiotherapy. The Trans-Tasman Radiation Oncology Group (TROG) is currently conducting a trial (Post-Operative Skin Trial or POST) which is a randomised trial comparing postoperative concurrent chemo-radiotherapy versus postoperative radiotherapy in high-risk cutaneous SCC of the head and neck. Patients with high-risk nodal metastases or advanced primaries (T3-T4) are randomised to receive RT (60Gy in 30 fractions) with concurrent Carboplatin chemotherapy or RT alone.

Palliative radiotherapy

Radiotherapy can provide effective palliation in patients not suitable for radical treatment. RT may be used to palliate symptoms related to locally advanced, neglected primaries, nodal metastases or uncommonly distant metastases.

Summary

In summary, radiotherapy plays a role in the management of cutaneous BCC and SCC of all stages and in various situations. A radiotherapy opinion can be sought by referral to a radiation oncologist or a multidisciplinary skin cancer clinic with radiotherapy input.

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The role of photodynamic therapy and topical imiquimod in the management of premalignant and malignant skin conditions

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Non-melanoma skin cancer (NMSCs) incorporating basal cell carcinoma (BCC) and squamous cell carcinoma (SCC) represent a significant health burden to the Australian population. A 2002 national survey estimated that there were 374,000 cases in that year,¹ occurring in 1.8% of the Australian population overall and 8% of patients over 70-years-old¹. This represented more than 5 times the incidence of all other cancers combined¹, and involved the highest health expenditure of any cancer (\$264 million in 2000-2001).² Treatment of NMSCs in the past has generally involved surgery. However, in the last 10 years, there have been an increasing number of non-surgical treatment options with good efficacy, tolerance, and cosmesis. These include photodynamic therapy (PDT) and topical imiquimod cream.

Photodynamic Therapy *Principles of Use*

PDT involves the application of a topical photosensitiser on treatment areas, where abnormal cells selectively take up this chemical. Subsequent illumination results in activation of the photosensitiser and generation of reactive oxygen species. This process results in destruction of abnormal cells leaving healthy skin intact. Methyl-amino-levulinate (MAL, Metvix) 160 mg/g cream is the most commonly used photosensitising compound in Australia. Illumination may be with light of several different wavelengths, but most commonly, a red light is used due to its ability to penetrate deeply to the subcutaneous skin layer. PDT with MAL has been approved by the Therapeutic Goods Association (TGA) for: Primary treatment of superficial and/or nodular BCC where surgery is considered inappropriate; and thin / non-hyperkeratotic and non-pigmented actinic keratoses (AKs) on the face and scalp when other registered therapies are unacceptable.

Procedure

Treatment is usually undertaken over 3-4 hours as an outpatient procedure. Initially, the lesion is prepared with a light curette of scaly surfaces. Nodular BCCs (nBCC) are sometimes debulked under local analgesia. MAL cream is then applied, occluded and left for 3-4 hours. The lesion is then illuminated with red light for 7 minutes. Pain during the procedure can occur, and can be helped with pre-treatment analgesia utilising infiltration with local anaesthetic, or cool water sprays and/or pausing the light treatment during the procedure. After the procedure, antibacterial ointment or Vaseline ointment is applied to the area until re-epithelialisation occurs (1-2 weeks). A dressing can be applied to prevent staining of clothes by ointment. Complications are uncommon but may include oedema, erythema and crusting of the treated area. PDT offers many advantages over traditional treatment methods which include excellent cosmesis, non-invasiveness of treatment, tissue conservation, and the ability to incorporate moderately large treatment fields.³

Uses

1) BCCs

There are 2 major histological subtypes of BCC, namely superficial and nodular. While PDT is effective for both subtypes, the response for superficial BCCs (sBCC) is superior. A broad meta-analysis of existing papers with varying photosensitizers, protocols, and follow-up examining PDT treatment in different subtypes of BCC has yielded a complete response rate of 87% for 826 sBCCs, and 53 % for 208 nBCCs, with cosmesis generally rated as good or excellent.⁴ In one study, 49 sBCCs were treated with either 1 or 2 cycles of MAL PDT (1 cycle = 2 illuminations 1 week apart) within a three-month period and then followed up over 24 months⁵. At 24 months, 28/36 (77%) sustained a complete

response. In comparison, in a separate study involving 101 patients with 105 nBCCs randomised to receive surgery or MAL PDT with either 1 or 2 cycles, complete response at 24 months was only 32/53 (60%)⁶ [compared with a complete response after surgery of 44/52 (85%)]. Cosmetic outcome was consistently good to excellent in the first study,⁵ and consistently superior to surgery in the second study⁶. One study has suggested that the inferior outcome of nBCCs may be due to the greater relative thickness of these lesions.⁷

A paper examined the use of 1 to 2 cycles of MAL-PDT in 95 patients with 148 'difficult to treat' BCCs. These lesions were superficial or nodular BCCs where surgery would be difficult because lesions were either in a difficult geographical location (i.e. ear), large (i.e. > 10 mm diameter) or patients were high risk (i.e. anti-coagulated patient). Overall, there was a histologically confirmed complete response in 78% of lesions at 24 months while 86% of patients reported a good to excellent cosmetic outcome⁸. Complete response rates varied according to histology (sBCC; 82% vs. nBCC; 67%) and treatment site (trunk / neck; 88% vs. face / scalp; 54%). Thus, PDT presents a useful alternative treatment option when lesions would pose surgical challenges.

2) Actinic Keratoses

In Australia, the prevalence of AKs is 59%.⁹ Although AKs are not malignant skin conditions, they are an indicator of critical sun exposure that may itself lead to development of skin cancers. The risk of AKs themselves developing into SCCs has been variously reported as from 0.025% per year¹⁰ to 13% per year¹¹. In addition, there is currently no data that treatment of AKs reduce development of SCCs. Despite this, clinicians do treat AKs for a combination of reasons, including reduction of SCC transformation risk, cosmesis, and symptom control. PDT is proving to be a superior alternative to established treatment modalities such as cryotherapy in clearing involved areas as well as preserving optimal cosmetic outcomes.

A large randomised controlled trial (RCT) incorporated 204 patients with a total of 855 AKs which were treated either with one cycle of MAL-PDT, cryotherapy, or placebo-PDT and responses were measured at 3 months post-

treatment.¹² 91 % of PDT treated lesions responded completely and 83 % sustained a good or excellent cosmetic outcome. In comparison, only 68% of cryotherapy treated lesions completely responded and 51% of lesions sustained a good or excellent cosmetic outcome.

3) Bowen's disease

Bowen's disease is characterised by intraepithelial full thickness squamous cell dysplasia. Some dermatologists feel that this entity results from progression of an AK. Malignant transformation to invasive SCC is possible, however, the exact rate of this occurring is unclear, further complicating management. As with AKs, clinicians do treat Bowen's disease, given the theoretical risk of malignant transformation. Treatment also allows control of symptoms, especially pain and itch.

There is current evidence that PDT for Bowen's disease exhibits superior efficacy compared with traditional treatment methods such as 5-fluorouracil (5-FU). One study in 40 patients with 66 lesions of Bowen's disease randomised patients to receive either 1 to 2 cycles of PDT or topical 5-FU daily for 4 weeks.¹³ At 12 months, 27/33 (82%) patients treated with PDT sustained a complete response, whereas 18/33 (54%) patients treated with 5-FU sustained a complete response.

Cost

Although PDT is TGA approved, it is not PBS (Pharmaceutical Benefits Scheme) funded. The average expense to a patient to undergo 2 treatments to a 2x2 cm² BCC would be approximately \$500. On application, the RPBS (Repatriation Pharmaceutical Benefits Scheme) can cover costs for 2 treatments of a BCC and 1 treatment of an AK.

Summary

PDT is a practical alternative to traditional treatment modalities for treatment of superficial premalignant and malignant skin conditions such as superficial BCCs, Bowen's disease, and AKs. Compared to traditional treatments, it offers good clearance rates for superficial lesions with often-superior cosmetic outcomes. It can provide a suitable alternative to lesions that

present surgical difficulties, such as large lesions, lesions in cosmetically sensitive areas, and lesions in patients where healing may be an issue, i.e. patients with diabetes and peripheral vascular disease. Its major disadvantages currently are patient cost and potential long-term complications not yet known due to inadequate study follow-up time.

Imiquimod (Aldara™)

Imiquimod is the first in a new class of topically applied medications that are immune response modifiers, acting to induce tumour-specific apoptosis.¹⁴ It is currently TGA approved for the treatment of biopsy proven sBCCs where surgery is inappropriate, AKs on the face and scalp, and external genital and perianal warts in adults. It is currently PBS funded for treatment of previously untreated sBCCs proven by biopsy in immunocompetent patients who cannot have surgical excision, cryotherapy, or curettage with diathermy. It is patient administered and usually applied to treatment areas at bedtime, and then left on for 6–10 hours before it is washed off the following morning.

Uses for Premalignant and Malignant Skin Conditions

A. TGA approved indications

1) sBCC

The efficacy of imiquimod in sBCCs was initially demonstrated in a study utilising 6 weeks of daily imiquimod application to biopsy proven sBCCs.¹⁵ Histological clearance occurred in 27/31 (87%) tumours. Optimal dosing studies on 364 patients with sBCC revealed minimal differences between 6 week regimens utilizing imiquimod five times per week compared to seven times per week (complete responses in 152/185 (82%) and in 142/179 (79%) patients respectively).¹⁶ Hence, current recommendations are to use topical imiquimod five times a week for 6 weeks in the treatment of sBCCs.

Common local side effects reported include erythema (87%), oedema (44%), erosion (36%), and scabbing/crusting (52%).¹⁶ Systemic reactions are less common and these include headache (7.6%), upper respiratory tract infections (3.2 %) and back pain (3.8 %).¹⁶ Significantly, there is a strong correlation

between the severity of local side effects and histological clearance.

2) Actinic keratoses

A randomised double-blind placebo controlled trial on 492 patients using imiquimod three times per week compared to placebo cream for 16 weeks to AKs on the face and scalp resulted in a complete response for 48% of patients treated with imiquimod.¹⁷ The manufacturers currently recommend application of imiquimod three times a week for a maximum of 16 weeks for treatment of areas of AKs.

3) Bowen's disease

An open label study in 16 patients with biopsy proven Bowen's disease who applied daily imiquimod cream for 16 weeks showed histological clearance in 14/15 (93%) patients 6 weeks after completion of treatment.¹⁸

B. Non TGA approved indications

1) nBCCs

In a study where 6 and 12-week courses of daily imiquimod application to areas of nBCC were compared, similar respective efficacy rates of 25/35 (71%) and 16/21 (76%) were described¹⁹.

2) SCCs

There are no studies on the use of imiquimod in SCCs, however, 2 case reports of imiquimod use for 12–16 weeks cleared moderately sized SCCs in a 65 and an 87-year-old man.^{20,21}

Limitations:

Side effects, particularly local skin reactions, may limit patient tolerance. However, often patients who have particularly bad skin reactions subsequently enjoy good efficacy, thus encouragement of patients to persist with treatment if skin reactions are tolerable is important. Expense may limit acceptance of treatment, given that for a typical 4-week course of 3 treatment packets a week, the total cost is \$160. Because it is self-administered, non-compliance may contribute significantly to treatment failures.

Summary

There is evidence for good clinical efficacy of imiquimod for sBCC, with lower efficacy for AKs. It is non-invasive, can be patient administered, and can yield good cosmetic results. However, local reactions, prolonged treatment times and cost can limit patient acceptance, while long term recurrence rates are still unclear but likely to be higher than conventional surgery.

Conclusions

In an evolving era of non-surgical treatment modalities for premalignant and malignant skin conditions, PDT and imiquimod are novel options with proven clinical efficacy for selected lesions. Optimal management outcomes from their use will depend on careful lesion selection, as well as an awareness of particular treatment limitations.

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TROG Skin Trials 2007

MELANOMA TRIAL: TROG 02.01

Title: A Randomised Clinical Trial of Surgery versus Surgery plus Adjuvant Radiotherapy for Regional Control in Patients with Completely Resected Macroscopic Nodal Metastatic Melanoma.

Summary: Surgery is the standard treatment for melanoma that has spread to nearby lymph glands, but it sometimes recurs despite surgery. Radiotherapy given soon after surgery may reduce the risk of the melanoma coming back, but may also cause side effects. This national randomised trial will determine the benefits and side effects of adding radiotherapy after surgery.

Primary Outcome Measures:

- Locoregional control [Time Frame: Final analysis will occur when all patients have had 1-year follow-up. (approx. 7 years after start of trial)]

Secondary Outcome Measures:

- Disease-free survival [Time Frame: Final analysis will occur when all patients have had 1-year follow-up. (approx. 7 years after start of trial)]
- Overall survival [Time Frame: Final analysis will occur when all patients have had 1-year follow-up. (approx. 7 years after start of trial)]
- Toxicity [Time Frame: Interim analysis will occur on annual basis.]

- Quality of life [Time Frame: Final analysis will occur when all patients have had 1-year follow up. (approx. 7 years after start of trial)]

Inclusion Criteria:

- Regional macroscopic nodal metastatic melanoma in one nodal basin region only which has been completely resected.
- Melanoma involving lymph nodes at high-risk of local recurrence (details in protocol)
- No evidence of metastases
- No active major cancer within 5 years
- Normal blood tests
- WHO performance status of 0 or 1
- Radiotherapy must be able to be commenced within 12 weeks of lymphadenectomy
- Patient must not be pregnant and if fertile must use a medically acceptable contraceptive throughout treatment
- No major concurrent illnesses likely to cause death within 2 years
- Written informed consent has been given

Total Enrollment: 230

Victorian Participating Sites

Alfred Hospital, Prahran, Victoria, 3181, Australia
 Andrew Love Cancer Care Centre, Geelong Hospital, Geelong, Victoria, 3220, Australia
 Peter MacCallum Cancer Centre, East Melbourne, Victoria, 8006, Australia

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SKIN CANCER TRIAL: TROG 05.01

Title: Post-Operative concurrent chemo-radiotherapy versus post-operative radiotherapy in high-risk cutaneous squamous cell carcinoma of the head and neck.

Summary: Two in every 3 Australians will develop a skin cancer over their lifetime. While the majority are easily cured with surgery there is a proportion that become advanced or have spread to lymph nodes. The cure rate for these cancers can be as low as 50% even after surgery and postoperative radiotherapy. There is evidence in other cancers that the combination of postoperative radiotherapy and chemotherapy, given at the same time, improves cure rates. To date, there is no evidence that such a benefit exists in advanced skin cancer. Carboplatin has been shown to be safe and effective in other cancer sites. This trial is a randomised trial comparing standard postoperative radiotherapy (delivered over 6 weeks, 5 days/week) with standard radiotherapy and weekly Carboplatin (given one day/week during the radiotherapy as a 30 minute intravenous infusion). This trial is assessing whether the addition of chemotherapy to post-operative radiotherapy improves cure rates. If the addition of chemotherapy is shown to be of benefit and safe, it is likely the results will be rapidly translated into clinical practise.

Primary Outcome Measures:

- Loco-regional Control [Time Frame: The date

of primary outcome analysis will occur when the final patient has reached a minimum 2 years follow-up.]

Secondary Outcome Measures:

- Disease-free survival [Time Frame: The date of analysis will occur when the final patient has reached a minimum 2 years follow-up.]
- Overall Survival [Time Frame: The date of analysis will occur when the final patient has reached a minimum 2 years follow-up.]
- Quality of Life [Time Frame: The date of analysis will occur when the final patient has reached a minimum 2 years follow-up.]
- Treatment-related Late Effects [Time Frame: The date of analysis will occur when the final patient has reached a minimum 2 years follow-up.]

Inclusion Criteria:

- Histologically proven SCC
- Patients have undergone either:
 - Resection of the primary lesion
 - Any type of parotidectomy (superficial, total, partial, etc.)
 - Any type of neck dissection(s)
- High risk feature(s); Advanced primary disease or high risk nodal disease

Total Enrollment: 266

Victorian Participating Sites

Peter MacCallum Cancer Centre, East Melbourne, Victoria, 3002, Australia;

Andrew Love Cancer Care Centre, Geelong Hospital, Geelong, Victoria, 3220, Australia;

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SunSmart report

*Kylie Strong
SunSmart Manager
The Cancer Council Victoria*

New position statement on Vitamin D and sun exposure

The Cancer Council Australia has joined with several expert health organizations to develop new guidelines that advise Australians how much sun they need to avoid vitamin D deficiency and stay healthy without increasing their risk of skin cancer.

The new guidelines 'The risks and benefits of sun exposure' were developed by The Cancer Council Australia, Osteoporosis Australia, The Australasian College of Dermatologists and The Australian New Zealand Bone and Mineral Society.

The new guidelines update the position statement developed by the four organizations in March 2005, and reflect changes in the evidence since the first position statement was developed.

Director of the Cancer Council Victoria's Cancer Education Unit and Chair of The Cancer Council's National Skin Cancer Committee, Craig Sinclair, says the new guidelines recommend:

- Fair skinned people can maintain adequate vitamin D levels in summer from a few minutes of exposure to sunlight on their face, arms and hands or the equivalent area of skin on either side of the peak UV Index periods on most days of the week.
- In winter in the southern parts of Australia, where UV radiation levels are less intense, people need about 2-3 hours of sunlight to the face, arms and hands or equivalent area of skin over a week.

In winter most people who live in southern Australia will not need any sun protection. However people who spend time at high altitudes or near reflective surfaces such as sand, snow and water will still need to use their hats, sunglasses and SPF 30+ sunscreen, as skin and eye damage can occur in these situations.

The guidelines note sun protection is still necessary in places like the Northern Territory, Queensland and parts of Western Australia, all year round, because UV Index levels are high enough to cause significant skin damage.

Those likely to be at risk of vitamin D deficiency include people with very dark skin, people who are housebound or in institutionalised care, women who wear concealing clothing for cultural purposes, and breastfed babies of vitamin D deficient women.

The new guidelines recommend that inadequate levels of vitamin D be treated with supplements, rather than additional exposure to UV radiation. The guidelines are published in this newsletter and can be found at www.cancer.org.au/positionVitD

New Cancer Council solarium research

In April SunSmart achieved significant media coverage as the result of media activity undertaken to coincide with the publication of Cancer Council research on the growth in solariums in Australian capital cities over 1996-2006. This research, published in the Australian New Zealand Journal of Public Health, had a particularly strong news angle for Melbourne, finding Melbourne had more solariums than any capital city in Australia.

The study conducted by Cancer Council Victoria researcher Jennifer Makin found the number of solariums in Australian capital cities in 2006 had increased four fold compared to a decade earlier, rising from 97 in 1996, to 406 in 2006. The study compared listings for solariums in the Yellow Pages in all Australian capital cities.

In Melbourne solarium numbers grew from 25 in 1996 to 169 in 2006 – a 576% increase in ten years. The study found Melbourne had nearly three times more solarium listings than Sydney.

SunSmart prepared a media release for both national and Victorian distribution, resulting in a very high level of media interest. The story received significant national media coverage, with coverage in Victoria including news stories in the *Age* and *Herald Sun*, *Channel 10* news, *Channel 9* news and extensive news and talkback coverage on radio. The day after the story was released the *Herald Sun* ran a positive editorial supporting the Cancer Council's position.

VCOG Skin Cancer Committee member Associate Professor John Kelly assisted with media interviews, and was featured in both television and newspaper coverage.

School Uniform Inquiry

SunSmart made a submission as part of the Victorian Parliament's Inquiry into Dress Codes and School Uniforms, and also appeared before members of the Education and Training Committee in May to speak about its submission.

SunSmart's submission recommended that school uniform and dress code policies included the following minimum standards:

- Clothing (including a sports uniform) that covers as much of the students' skin as practical
- A sun-protective hat.

SunSmart's submission also included extensive information on why sun protection should be an important consideration for school uniforms/dress codes.

The Committee is due to table a report to Parliament by 31 March 2008.

Local councils recognised for 'shady' work

Four local councils across Victoria were recognized for their 'shady' initiatives to protect their residents from skin cancer in this year's SunSmart Shade Awards.

Shade is just as important in protecting against skin cancer as sunscreen, hats, clothing and sunglasses, and it's an important component of a council's responsibility to provide a safe, healthy environment for their community

members. The four winning councils impressed the independent judging panel which included a representative from the Municipal Association of Victoria, as well as two architects with an interest in shade design.

The winners in this year's SunSmart Shade Awards were:

- Frankston City Council received the Metropolitan Shade Award for the Waterfront Regional Playground.
- Swan Hill Rural City Council received the SunSmart Rural Shade Award for Riverside Park.
- The City of Boroondara was Highly Commended in the Metropolitan Shade Award category for Hays Paddock.
- City of Great Geelong was Highly Commended in the category of Rural Shade Award for shade structures at the Lara Swimming Pool.

The winning councils were presented with their awards at a special awards ceremony in April.

Risks and Benefits of Skin Exposure – Position Statement

APPROVED BY THE AUSTRALIAN AND NEW ZEALAND BONE AND MINERAL SOCIETY, OSTEOPOROSIS AUSTRALIA, THE AUSTRALASIAN COLLEGE OF DERMATOLOGISTS AND THE CANCER COUNCIL AUSTRALIA

Summary statement

A balance is required between avoiding an increase in the risk of skin cancer by excessive sun exposure and achieving enough sun exposure to maintain adequate vitamin D levels.

Sun exposure is the cause of around 99% of non-melanoma skin cancers and 95% of melanomas in Australia¹, however, exposure to small amounts of sunlight is also essential to good health. Ultraviolet radiation B (UVB) is the component of sunlight that is most likely to be responsible for both its beneficial and its harmful health effects. In Australia, where UVB levels are in the high to extreme range for much of the year, sun protective measures to reduce the incidence of skin cancer must continue to be a high public health priority.

The majority of Australians are thought to have sufficient UVB exposure from sunlight to ensure adequate vitamin D production – serum 25-hydroxy vitamin D levels > 50 nanomoles/Litre (nmol/L) – to form and maintain healthy, strong bones.

Vitamin D forms in the skin as a result of UVB exposure, but few studies have investigated the amount of UVB that people require to make enough vitamin D². There is evidence to suggest that prolonged sun exposure does not cause vitamin D levels to continue to increase³. Therefore, people should continue to protect themselves from overexposure, especially during peak ultraviolet radiation periods (10 am to 3 pm). Further scientific investigation of the amount of ultraviolet radiation exposure required to ensure adequate vitamin D levels for people of different skin types in Australia is needed.

People who are at risk of vitamin D deficiency may need vitamin D supplementation if their exposure to ultraviolet radiation is not adequate. People living in the southern regions of Australia have a higher risk of vitamin D deficiency, particularly during the winter months.

Recommendations

1. For most people, sun protection to prevent skin cancer is required when the UV index is moderate or above (i.e. UV index is 3 or higher). At such times sensible sun protection behaviour is warranted and is unlikely to put people at risk of vitamin D deficiency.
2. Most people probably achieve adequate vitamin D levels through the UVB exposure they receive during typical day-to-day outdoor activities. For example, it has been estimated that fair skinned people can achieve adequate vitamin D levels (> 50 nmol/L) in summer by exposing the face, arms and hands or the equivalent area of skin to a few minutes of sunlight on either side of the peak UV periods on most days of the week. In winter, in the southern regions of Australia where UV radiation levels are less intense, maintenance of vitamin D levels may require 2-3 hours of sunlight exposure to the face, arms and hands or equivalent area of skin over a week.
3. Some people are at high risk of skin cancer. They include people who have had skin cancer, have received an organ transplant or are highly sun sensitive. These people need to have more sun protection and therefore should discuss their vitamin D requirements with their medical practitioner to determine whether dietary supplementation with vitamin D would be preferable to sun exposure.
4. Some groups in the community are at increased risk of vitamin D deficiency. They include naturally dark skinned people, those who cover their skin for religious or cultural reasons, the elderly, babies of vitamin D deficient mothers, and people who are housebound or are in institutional care. Naturally dark skinned people (Fitzpatrick skin type 5 & 6⁴ – rarely or never burns) are relatively protected from skin cancer by the pigment in their skin; they could safely increase their sun exposure. Others on this list should discuss their vitamin D status with

their medical practitioner as some might benefit from dietary supplementation with vitamin D.

Vitamin D

Most vitamin D is produced in the skin by exposure to UVB (wavelength 290–320 nm) from sunlight⁵. It can also be obtained from foods where it occurs naturally such as oily fish, eggs, and meat or fortified foods such as margarine and some milks. However food sources make a relatively small contribution to total vitamin D status. Vitamin D supplements are also readily available without medical prescription over the counter in pharmacies.

Vitamin D production decreases during winter when the intensity of ultraviolet radiation is lower. The body can rely on tissue stores of vitamin D for between 30 and 60 days assuming vitamin D levels are adequate prior to winter³. In most cases, any vitamin D reduction during winter is corrected in summer when more sunlight is received with more time spent outdoors. While this correction may occur, it is still advisable to prevent deficiency during winter as fracture rates increase with deficiency, particularly in older adults⁶. For those over 40 years of age, it is conceivable that annually recurring cycles of low vitamin D during the winter months contributes, at least in part and over many years, to age-related bone loss⁷.

There is very little research available to determine exactly how much sun exposure is necessary to maintain adequate vitamin D levels. Variations in age, skin colour, latitude, time of day and time of year makes it impractical to provide prescriptive advice to the population as a whole. Based on available research, it has been estimated that fair skinned people can achieve adequate vitamin D levels (>50 nmol/L) in summer by exposing the face, arms and hands or the equivalent surface area to sunlight for only a few minutes on either side of the peak UV periods on most days of the week^{8,9}. In winter, in the southern regions of Australia where UV radiation levels are less intense, vitamin D levels may be maintained by approximately 2-3 hours of sunlight exposure accumulated over a week to the face, arms and hands or equivalent surface area. For naturally dark skinned individuals, the required amount of time in the sun will be significantly more than this.

In northern states, the amount of sunlight

exposure required to receive adequate vitamin D levels will be significantly less than for southern states because UV radiation levels are higher.

While vitamin D levels of at least 50 nmol/L are recommended, there is emerging evidence that the optimal level to maintain bone health may be as high as 75 nmol/L^{10,11}. For the Australian population to achieve this level without putting themselves at greater risk of skin cancer through increased sun exposure, there would be an increased requirement for dietary sources of vitamin D. Given foods with naturally occurring vitamin D currently contribute very little to daily intake for Australians, the fortification of core foods should be considered.

Vitamin D status in Australia has not been widely studied in the general population, however some studies have shown that up to 80% of people in 'at-risk' populations display evidence of deficiency¹². Mild vitamin D deficiency (25–50 nmol/L) was noted in 43% of females and moderate or severe vitamin D deficiency (< 25 nmol/L) in 11% of females during winter in the Victorian population of Geelong (latitude 38°S)¹³. Certain groups within the community are at higher risk of vitamin D deficiency because their level of sun exposure is inadequate. These include naturally dark skinned people (who need more sun to make vitamin D), those who cover their skin for religious or cultural reasons, the elderly and people who are housebound or are in institutional care.

Bone and musculoskeletal health

There is good evidence that vitamin D is beneficial for maintaining musculoskeletal health and reducing the risk of bone fractures^{14,15}. The human body needs vitamin D to regulate calcium levels in the blood and to make and maintain healthy, strong bones and for this reason it is important to maintain adequate vitamin D levels all year round⁷.

Vitamin D deficiency in infants and children can cause rickets, characterised by muscle and bone weakness and bone deformities. Adults with low vitamin D are at risk of bone and joint pain, muscle and bone weakness, osteoporotic fractures and falls.

Other health conditions

Recently, some studies have been published that suggest possible beneficial effects of sun

exposure in the prevention or improvement in outcome of treatment for a number of other diseases including breast, prostate, and colorectal cancer, non-Hodgkin lymphoma, diabetes and multiple sclerosis^{7,16,17,18,19,20,21}. The biological pathways underlying these observed associations are not clear. While vitamin D is likely to be a contributing factor to disease risk reduction, it is not yet clearly known whether there are factors other than vitamin D that is derived from sun exposure that may play a role. There is insufficient evidence to assume that vitamin supplementation and sun exposure are equivalent in their beneficial effects. Therefore at this stage, there is insufficient evidence for any definitive action to be taken on these findings or any recommendations to be made, as more research is needed.

Risk Factors for Vitamin D Deficiency

a. Individuals who are at high risk of skin cancer

Certain people are at high risk of skin cancer. They include individuals who have had skin cancer, have received an organ transplant or are highly sun sensitive. These people need to have more rigorous sun protection practices and therefore should discuss their vitamin D requirements with their medical practitioner to determine if dietary supplementation rather than sun exposure is appropriate.

b. People with dark skin

People with naturally very dark skin require more ultraviolet radiation exposure to produce adequate levels of vitamin D as the pigment in their skin reduces ultraviolet radiation absorption²². When people with dark skin cover themselves for religious or cultural reasons, this further reduces the ultraviolet radiation available for vitamin D production. Vitamin D supplementation is likely to be required for this population group. During early pregnancy is an important time to screen for vitamin D deficiency in this group and if necessary provide supplements.

c. Older adults

Vitamin D deficiency is a problem in frail, housebound or institutionalised older Australians. It is related to increasing age, and low levels of exposure to sunlight⁴. As the human body ages, it becomes less efficient at synthesising new

bone and making vitamin D, adding to the problem²³. For this reason, older adults who are vitamin D deficient increase their risk of osteoporosis, falls, and fractures²⁴.

The National Health and Medical Research Council recommends that older adults boost their vitamin D intake by taking a daily supplement at the recommended dose or as advised by a medical practitioner²⁵.

Older adults who are not at high risk of skin cancer and who are mobile should ensure they have incidental exposure to sunlight if vitamin D supplementation is not available or impractical, especially at times when ultraviolet radiation is less likely to cause other health problems.

d. People who wear concealing clothing

Some people, especially women who wear concealing clothing for religious or cultural reasons, are at increased risk of vitamin D deficiency because of very low skin exposure to sunlight²⁶. Vitamin D supplementation is likely to be required for this population group if culturally acceptable spaces are not available where they can expose more of their skin to sunlight. Again pregnancy is an important time to screen for vitamin D deficiency and if necessary provide supplements.

e. Babies and infants of vitamin D deficient mothers

Babies and infants of mothers with inadequate vitamin D levels are also likely to be vitamin D deficient²⁷. Babies most at risk are those who are exclusively or partially breastfed by mothers who are vitamin D deficient.

Sun protection and your risk of vitamin D deficiency

There are times during the day or year when it is safe to go outside without the need for sun protection. This would normally be when the UV index is less than 3, such as in the early morning or late afternoon or during winter in the southern regions of Australia. As a result, people in southern regions may not need to be concerned about sun protection from May to August unless they are at high altitudes, near highly reflective surfaces such as snow or water or unless they have a high risk of skin cancer.

Table 1 provides guidance as to the monthly average peak UV levels by month for selected Australian capital cities that can identify (see shaded areas) the months of the year by region when sun protection may not be required. For other months by region, sun protection will be required except for when the UV Index is less than 3, such as early morning and late afternoon.

While sun exposure is important for the production of vitamin D, it is important to keep in mind that unprotected sun exposure in Australia carries a significant risk of skin and eye damage and skin cancer. Consistent and deliberate sun exposure without any form of sun protection when the UV index is 3 or above is not recommended, even for those diagnosed with vitamin D deficiency. For fair skinned people, the small amount of sunlight received from the face, hands, arms or legs during normal outdoor daily activities is usually all that is required to absorb appropriate levels of UV radiation at these times. Therefore sensible sun protection behaviour should not put people at risk of vitamin D deficiency.

What are the alternatives?

Where there is vitamin D deficiency, oral vitamin D supplementation – rather than relying on sun exposure – may be necessary. A medical practitioner should be consulted about whether there is need for vitamin D supplementation.

Given the health risks associated with the use of solariums, it is not recommended that they be used to boost vitamin D levels²⁹.

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Table 1. UV Index* in selected Australian cities averaged over the days in each month.

Location	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec
Darwin	11	12	11	6	8	7	7	9	11	11	11	10
Brisbane	11	10	9	6	4	3	3	5	7	8	10	11
Perth	11	10	8	5	3	2	2	4	6	8	9	10
Sydney	10	9	7	5	3	2	2	3	5	7	8	8
Adelaide	11	10	7	5	2	2	2	2	5	7	9	10
Melbourne	9	9	6	4	2	1	1	2	4	6	8	9
Hobart#	8	7	4	3	1	1	1	2	3	4	6	7

* The UV (Ultraviolet Radiation) Index is a measure of the amount of UV from the sun at the earth's surface at solar noon on a particular day. Table is from Gies et al.²⁸

Hobart data is supplied from personnel communication from the Australian Radiation Protection and Nuclear Safety Agency.

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SunSmart media release

Tuesday 3 April, 2007

Solarium boom shocks skin cancer experts

Skin cancer experts are alarmed at new research that shows the number of solariums across Australia has risen by over 300% in the last decade. According to the Cancer Council Victoria study, Melbourne has significantly more solariums than any other capital city in Australia, accounting for over 40% of solariums in capital cities around the country.

The new figures published today in the Australian New Zealand Journal of Public Health, show the number of solariums in Australian capital cities in 2006 had increased four fold compared to a decade earlier. In 1996, researchers found there were 97 solariums listed in the Yellow Pages for all capital cities in Australia, but by 2006 the number had multiplied to 406.

In Melbourne solarium numbers grew from 25 in 1996 to 169 in 2006 - a 576% increase in ten years. The study found Melbourne had nearly three times more solarium listings than Sydney.

Researchers at The Cancer Council Victoria's Centre for Behavioural Research in Cancer say solarium numbers are likely to be even greater than their study indicates, as solariums located in beauty salons and fitness centres are not often listed in the Yellow Pages.

Associate Professor John Kelly, Director of the Victorian Melanoma Service at the Alfred Hospital, Melbourne, said a recent study by the International Agency for Research on Cancer concluded that using solariums regularly before the age of 35 boosted the risk of melanoma by 75%.

"This increase in solariums is particularly alarming in light of the overwhelming evidence linking solarium use and the risk of melanoma and other forms of skin cancer for those who use solariums before the age of 35." "The simple fact is that people who use solariums are increasing their risk of skin cancer, and skin cancer kills over 1500 Australians every year."

SunSmart Manager Kylie Strong said the alarming increase in solarium numbers in Melbourne highlighted the need for regulation of the solarium industry which is currently only regulated by a voluntary code.

"This dramatic increase in solarium numbers is a real cause for concern. We don't want to see this boom in solarium numbers have an impact on skin cancer rates."

"Contrary to popular misconceptions, solariums are not a 'safer' way to tan - in fact solariums emit ultraviolet radiation that can be up to five times as strong as the midday sun."

"We support the conclusion of the study authors, that there is a pressing need for government regulation of the solarium industry."

"Legislation is already in place in many parts of the United States and Europe: it's extraordinary that Australia, which has the highest rates of skin cancer in the world, is lagging behind in regulation of this industry which is proven to increase people's skin cancer risk."

"Studies in four Australian states show that the current voluntary standard for solariums is not working - for example, there is low compliance in restricting solarium access to those under 18."

"It is likely that until the solarium industry is regulated, and until people begin to understand the impact tanning has on their skin, more preventable skin cancers will be diagnosed."

"In Victoria, over 300 people die from skin cancer each year. I would urge anyone using a solarium to consider if having a tan is worth the risk of getting cancer."

Solarium/tanning centre Yellow Pages listings by Australian capital cities - 1996 compared to 2006

Ends

'The increase in solariums in Australia - 1996-2006' appears in the April issue of the Australian New Zealand Journal of Public Health. A PDF copy of the research is available.

Skin cancer statistics

Most recent figures from The Cancer Council Victoria show 1959 Victorians were diagnosed with melanoma in 2004, and 325 Victorians died from melanoma and other skin cancers.

Voluntary Australian standard for the solarium industry

Under the current voluntary standard, solarium operators must;

- Provide a consent form to solarium users that they must read and sign, outlining the risks of solarium use
- Complete a skin assessment of all customers
- Have a signed parental consent form for all customers under 18
- Ban anyone under 15 from using a solarium
- Ban people with very fair skin from using a solarium
- Train staff in carrying out skin checks and implementing the standard
- Not promote solariums as a 'safe' or 'healthy' way to tan
- Provide protective eye goggles
- Maintain strict hygiene and maintenance controls.

State	Number listed in 1996	Numbers listed in 2006	% increase since 1996
Melbourne	25	169	576%
Perth	5	55	1000%
Canberra	4	21	425%
Adelaide	12	39	225%
Brisbane	15	47	213%
Sydney	29	63	117%
Hobart	7	12	71%
Northern Territory	0	0	0
All capital cities	97	406	319%

Life After Cancer

*Sophy Chirnside
Communications and Resource Manager
The Cancer Council Victoria*

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

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

This program has been developed following recommendations from cancer survivors who attended a special Cancer Council seminar in November 2006. At this seminar, survivors and their family were asked to discuss what they felt was missing at diagnosis and highlight how we could best support them through their cancer experience. Their recommendations were as follows:

Information

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

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

Support

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

Key needs were ongoing emotional support and access to a psychologist or oncology social

worker. Survivors also felt that it would have been helpful to speak with someone who had been through a similar experience.

Practical and financial issues

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

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

Education

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

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

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

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

Cancer Information and Support Service New Initiative

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

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

Some of the important messages for promoting the service are:

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

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

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

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

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

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

Obituary: Professor Gerald Milton 1924-2007

- Bill McCarthy

It is with sadness that we report the death of Gerry Milton, one of the pioneers of melanoma research and development in Australia and a leading figure on the world melanoma scene. Born in India, educated in Adelaide, Gerry became Bosch Professor of Surgery at the University of Sydney and the first Professor of Surgery at St. Vincent's Hospital and subsequently at Sydney Hospital, where he initiated and developed the Sydney Melanoma Unit. The melanoma unit went on to become the largest, and world leading center for melanoma management, research and development.

Among his many contributions, Gerry Milton was Hunterian Professor at the Royal College of Surgeons, President of the Surgical Research Society in Australasia, and Co-director of the Garvin Institute of Medical Research. He was a dedicated and enthusiastic teacher in the undergraduate, graduate, and postgraduate medical curricula at the University of Sydney. He was the author of many important papers on melanoma, medical education and surgical research. He will be especially remembered for his energy and innovative ideas, his unqualified support of his colleagues, and his competent and caring management of his patients.

Extracts from Wongi Yabber Vol 14 No 2. May 2007

Australia & New Zealand TNM Committee for Tumour Staging

*Professor William McCarthy AM
Convenor ANZ TNM Committee*

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

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

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

There has been considerable work on the TNM classification of lung and breast cancer in Australia and it is expected that both groups will agree on the system, with some modification, in the near future. The lung group is very close to completion of their review.

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

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

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

COSA Update

*Ms Margaret McJannett
Executive Officer, COSA*

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

The theme for the meeting is "Prevention, Palliation and Cure: Progress through Clinical Trials." Special symposia, debates and plenary lectures will explore the Australian and Asia-Pacific clinical trials landscape; the challenge of translating results into clinical practice; barriers to accessing the best therapy (including new drugs); evaluation of alternative medicine; and many other topics. An excellent assembly of international and local speakers is set to deliver a comprehensive and stimulating program. Our convenor Dr Chris Karapetis and his committee continue to put significant effort into the ASM program and it is particularly gratifying to see how many of our South Australia colleagues are involved with and supporting the planning of this major COSA event.

Our commitment to professional development is growing, with Phase 2 of the **Continuing Professional Development** (CPD) project being rolled out and coming to a number of cancer centres soon. Our consortium, led by the Centre for Innovation in Professional Health, Education and Research (CIPHER), and also comprising The Cancer Council Australia

(TCCA) the National Breast Cancer Centre (NBCC) and the Royal College of General Practitioners (RACGP) is engaging with practitioners at a number of demonstration sites to ensure the recommended CPD packages meet the needs of cancer specialists, GPs and counsellors, and have a high degree of support for implementation.

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

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

Rural and regional service delivery remains an ongoing focus. The data demonstrating how access to cancer care services reduces as geographic isolation increases is out there in the COSA report; we really need COSA members to bring this issue to the attention of local politicians in regional areas. Dr Craig Underhill continues to promote the issue everywhere and he needs your voice as well. Most recently COSA prepared an excellent program of national opinion leaders to review current issues in cancer services in regional Australia at the National Rural Health Alliance's biannual conference. The presentations were well received and the alliance included in its priority recommendations for more uniform and better funded patients assisted travel schemes in all jurisdictions. Patient travel and accommodation is also the subject of a current Senate inquiry; COSA will be presenting a joint submission to the Senate in partnership with The Cancer Council Australia and may also appear at public hearings. The Senate will be reporting in October.

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

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

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

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

ubiquitous ex President Stephen Ackland leads the selection team.

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

Ensuring Guidelines Translate into Better Care

*Bruce Barraclough AO
Medical Director,
Australian Cancer Network*

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

There are, however, many barriers that need to be overcome to achieve successful implementation of guidelines. It is simplistic to under-rate how difficult it is to change practice in complex environments. Change is not simple or quick because of system variation, a shortfall in leadership or even professional isolation or lack of knowledge.

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

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

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

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

ACN and NICS have had increasing requests for this booklet as unit heads and clinicians working with patients find it very useful. I would strongly recommend its use to those seeking to implement guidelines. It can be accessed through the websites of NICS and ACN at www.nhmrc.gov.au/nics/asp/index.asp or www.cancer.org.au/acn under “Activities” heading.

Evidence stacking up for alcohol-cancer risk

Glen Turner
Communications Manager
The Cancer Council Australia

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

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

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

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

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

Pull the plug on food advertising

In 2007, the Australian Communications and Media Authority is reviewing the Children's Television Standards. The Coalition on Food Advertising to Children (CFAC), which includes The Cancer Council Australia and other key health and consumer organisations, is calling for a marked reduction in the commercial promotion

of foods and beverages to children under 14 years old. The Pull the Plug on Food Advertising campaign is being run by The Cancer Council NSW on behalf of the coalition to help make the job of parents easier and to give our kids a healthier future.

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

Health groups welcome survey to target childhood obesity

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

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

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

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

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

The survey is jointly funded by the Department of Health and Ageing, the Department of Agriculture, Fisheries and Forestry and the Australian Food and Grocery Council.

*The Australia Chronic Disease Prevention Alliance comprises The Cancer Council Australia, Diabetes Australia, Kidney Health

Australia, the National Heart Foundation of Australia and the National Stroke Foundation.

The Cancer Council Australia's new website nearing completion

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

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

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

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

The Working Party met on 23 March 2007 and noted substantial progress. The meeting endorsed integration with the New Zealand Guidelines Group (NZGG). The document will now be ANZ Guidelines.

Manuscripts are expected by end of May and a meeting in mid-July will formulate recommendations before sending the document for public review.

It is planned to hold a Public Meeting in Sydney as a penultimate step in the guideline review before submitting it to NHMRC and NZGG for approval.

Multi Lingual Website

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

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

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

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

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

Key Published Articles Listing—Skin Cancer

Title	Author & Journal
Rate of growth in melanomas: Characteristics and associations of rapidly growing melanomas	Liu W, Dowling JP, Murray WK, et al. Archives of Dermatology Dec 2006; 142(12): 1551–1558.
Management of Nonmelanoma Skin Cancer in 2007.	Neville JA, Welch, E, Leffell DJ. Nat Clin Pract Oncol, 2007;4(8):432-469

Key Published Articles Listing—General

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

Forthcoming Meetings

Date / Place	Meeting / Contact
28–31 August 2007 Melbourne, VIC, Australia	9th Australian Palliative Care Conference – <i>Partners across the lifespan</i> Palliative Care Australia. APCC 07 Conference Secretariat, C/- ICE Australia P/L, 6 Clarendon Place, South Melbourne, VIC 3205, Australia Ph: (03) 9681 6288 Fax: (03) 9681 6653 E-mail: apcc@iceaustralia.com Website: www.iceaustralia.com/apcc2007/ www.pallcare.org.au
8-13 September 2007 Barcelona, Spain	9th Biennial European Society for Therapeutic Radiology and Oncology Meeting European Society for Therapeutic Radiology and Oncology Ph: + 32 2775 9340 Fax: + 32 2779 5494 Email: agostino.barrasso@estro.be
23–27 September 2007	3rd International Clinical Trials Symposium (ICTS) GPO Box 3270, Sydney NSW 2001 Ph: (02) 9254 5000 Fax: (02) 9251 3552 E-mail: info@clinicaltrials2007.com Website: www.clinicaltrials2007.com
23–27 September 2007 Barcelona, Spain	14th European Cancer Conference (ECCO) – <i>Cancer in Europe: Sharing the responsibilities</i> Federation of European Cancer Societies (FECS), Avenue E. Mounier 83, Brussels 1200, Belgium Ph: +32 2 775 0201 Fax: +32 2 775 0200 E-mail: ECCO14@fecs.be Website: www.fecs.be
23–27 September 2007 Barcelona, Spain	European Society for Therapeutic Radiology & Oncology (ESTRO 26) During ECCO 14 Website: www.estro.be
3-4 October 2007 Huntington Beach, California, USA	Perspectives in Melanoma XI Website: www.imedex.com
4–7 October 2007 Melbourne, Vic, Australia	58th Annual Scientific Meeting of the Royal Australian and New Zealand College of Radiologists (RANZCR) Website: www.ranzcr.edu.au

Date / Place	Meeting / Contact
14–17 October 2007 Brisbane, QLD, Australia	Annual Meeting of the Haematology Society of Australia and New Zealand (HSANZ) Website: www.hsanz.org.au
17–20 October 2007 Melbourne, VIC, Australia	9th Annual Scientific Meeting of the Australasian Gastrointestinal Cancer Trials Group (AGITG) – <i>Translating research into practice</i> Website: www.gicancer.org.au
22–26 October 2007 San Francisco, California, USA	19th International Conference on Molecular Targets and Cancer Therapeutics – <i>Discovery, biology and clinical applications</i> Jointly organised by AACR, NCI and EORTC Website: www.aacr.org/page5995.aspx
28 Oct – 1 Nov 2007 Los Angeles, California, USA	49th Annual Meeting of the American Society for Therapeutic Radiology and Oncology (ASTRO) 12500 Fair Lakes Circle Suite #375, Fairfax, VA 22033-3882 Ph: +1 703 502 1550 or 1800 962 7876 Fax: +1 703 502 7852 Website: www.astro.org
14–16 November 2007 Adelaide, SA, Australia	34th Annual Meeting of the Clinical Oncology Society of Australia (COSA) COSA Office, Medical Foundation Building, Level 5, 92 Parramatta Road, Camperdown NSW 2011 Ph: (02) 9036 3100 Fax: (02) 9036 3101 E-mail: cosa@cancer.org.au Website: www.cosa.org.au
18–24 November 2007 Australia	National Skin Cancer Action Week Website: www.sunsmart.com.au

The Cancer Council Victoria

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

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

The **VCOG Skin Cancer Committee** was established in 1997. It's membership is representative of the clinical specialties and centres involved in the treatment of melanoma and skin cancers. The objectives of the Skin Cancer Committee are to :

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

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