



Gastrointestinal Cancer Update

Issue 49 February 2008

- Laparoscopic resection of colorectal cancer Update
- ICS initiatives
- National Bowel Cancer Screening Program
- Wongi Yabber newsletter extract



GASTROINTESTINAL CANCER UPDATE

Issue 49

February 2008

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***** **Last Issue – No. 48 – July 2007** *****

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

Editorial

*Mr Stephen Bell
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This edition of the Gastrointestinal Cancer Update has been somewhat delayed due to a busy period through the Christmas holidays and staff changes within Cancer Council, Victoria.

Mrs Susan Fitzpatrick, Executive Officer, VCOG/CCRC retired at the end of 2007 after 24 years with Cancer Council, Victoria. She worked tirelessly with many of the committees at CCV, and effortlessly brought the best out of the members of the committees and the people she worked with. I hope she can see the excellent work that she has contributed and she will be sorely missed.

This edition offers an update on the National Bowel Cancer Screening Program, with news on the Victorian implementation. The crude participation rate to the end of July 2007 of 35.2% is encouraging at this early stage of the program. This had yielded a positivity rate of 7%, which is within the expected rate from the pilot study. The report also highlights the National Program Register, which is extremely important to the Program and, thus far, has been low in completed data. I hope this serves as a reminder to all involved in the Program to

complete the data forms and return them promptly.

An overview of initiatives undertaken by the Victorian Integrated Cancer Services is provided. This outlines a broad range of initiatives that are being carried out in specific tumour streams within individual ICS, specifically highlighting activities in the breast, genitourinary, skin, gynaecological, lung and upper gastro-intestinal tumour streams.

The update on laparoscopic surgery for colon and rectal cancer serves to remind us that there is now overwhelming evidence that this is an appropriate treatment option with potential advantages to patients with colon cancer. More data is required to support its broader use in rectal cancer. The role of rapid post-operative recovery programs is raised. Training and accreditation remain an issue, with no accrediting body or certification currently available. The Colorectal Surgical Society of Australia and New Zealand are currently working on a consensus statement regarding this important next phase in the expansion of this technique.

Contributions Welcome

The Gastrointestinal 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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The Cancer Council Victoria
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Update on laparoscopic resection of colorectal cancer

Stephen Bell

The role of laparoscopy in the surgical treatment of colon cancer has been clearly established. There is ongoing work investigating the safety and benefits of laparoscopic resection of rectal cancer, and some studies suggest equivalent benefits. This article serves to highlight that there is now no doubt that the laparoscopic approach is oncologically equivalent in colon cancer, and is therefore a viable alternative to open surgery, while offering significant short and long term benefits to the patient. Appropriate training and accreditation remain important issues in the expansion of this technique into broader use.

Early attempts at laparoscopic colectomy for cancer resulted in higher than expected rates of wound tumour implants, and raised concerns about short and long-term compromised oncologic outcomes. Subsequent published data has shown that, with appropriate techniques and training, wound recurrence rates are the same as for open surgery. Numerous randomised controlled trials have now dealt with the issue oncological safety and equivalence, as well as short- and long-term non-oncologic outcomes.

There have been four phase III randomised controlled trials that have completed accrual and reported early data on recovery benefits for laparoscopic colectomy: Barcelona¹, Clinical Outcomes of Surgical Therapy Study Group (COSTSG)², Colon Cancer Laparoscopic or Open Resection (COLOR)³, and Conventional versus Laparoscopic-Assisted Surgery in Colorectal Cancer (CLASICC)⁴. These trials have uniformly and consistently shown a significant reduction in the use of narcotics and oral analgesics and length of hospital stay, as well as a faster return of diet and bowel function, with laparoscopic colectomy. There is also data showing improved recovery of respiratory function, and a lower wound infection rate in the laparoscopic patients⁵. Data has also been published showing fewer wound hernias, and

fewer admissions and operations for small bowel obstruction after laparoscopic surgery⁶. There has been a Cochrane review of 25 randomised controlled trials that demonstrated an improved quality of life in the laparoscopic patients⁷.

Both the Barcelona and COSTSG trials have sufficient maturation and follow-up to show that there is no survival disadvantage. The Barcelona trial in fact suggested a cancer-related survival advantage in the laparoscopic group in patients with stage III disease. This is the only trial to show a survival advantage. Results of the CLASICC and COLOR trials, as well as 5-year data from the COSTSG trial, should definitively address survival results. The European Association of Endoscopic Surgery published a consensus statement supporting laparoscopic resection of colon cancer in 2004⁸.

Published data with respect to laparoscopic rectal cancer is not as mature. The subset of 253 rectal cancer patients in the CLASICC trial provides the only available randomised controlled trial data. There are a number of single institution publications suggesting safety and efficacy, however the viability of laparoscopic rectal cancer resection requires further investigation. There has been a Cochrane review of laparoscopic resection of rectal cancer suggesting the safety and efficacy results are similar to colon cancer⁹.

A significant off-shoot from the development of laparoscopic colon resection has been the attention drawn to rapid post-operative recovery programmes. This involves a co-ordinated approach to many aspects of pre- and post-operative management to improve gastrointestinal and respiratory function, as well as general mobility and well-being. These programmes are appropriate for both open and laparoscopic surgery, and have resulted in shorter length of stay, and earlier return to

normal activities. This adds further to the stated benefits of the laparoscopic approach.

One of the significant focuses of ongoing work is establishing appropriate training and accreditation guidelines for surgeons to maintain the standards that have been set in the trial setting. It has been suggested that the learning curve is somewhere between 20 and 50 cases, and it is clear that there is an ongoing learning process. There are established courses both in Australia and overseas offered to share technical knowledge, but a steady and co-ordinated approach to training needs to be maintained. There is currently no accrediting body, nor certification, and this is left to local institutions, although the Colorectal Surgical Society of Australia and New Zealand is currently working on a consensus statement to give guidance for accreditation of surgeons for advanced laparoscopic colorectal operations.

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An overview of initiatives undertaken by the Victorian Integrated Cancer Services

The Integrated Cancer Services (ICS) are funded to support the development of integrated care and defined referral pathways for the populations they serve. The ICS are the platform through which improvements in cancer service delivery and patient care is being implemented.

The identification, development, implementation and evaluation of initiatives is guided by the Patient Management Frameworks (which describe optimal care for a range of tumour streams), the model for safety and quality in cancer care (*Clinical Excellence in cancer care: a model for safety and quality in Victorian cancer services*) and two documents that provide policy direction for cancer care coordination and multidisciplinary care (*Linking cancer care: a guide for implementing coordinated cancer care, Achieving best practice cancer care: a guide for implementing multidisciplinary care*).

Clinicians and consumers are involved in ICS initiatives in variety of ways from providing data to support the need for a particular initiative to steering or undertaking the development, implementation and evaluation of initiatives.

Outlined below is a range of initiatives that are being carried out in specific tumour streams within individual ICS. This is not an exhaustive list but an indication of the range of initiatives as reported by the ICS in August 2007.

Breast cancer initiatives

- Development of a service model for women with advanced breast cancer
- Development of tools and templates to strengthen the multidisciplinary team process and facilitate communication with General Practice
- Development of guidelines for consistent follow up care

- Development of a multidisciplinary psychosocial model of care for an integrated breast services (between two health services)
- Scoping current access to mammography for specimen analysis during hook wire localisations and removal of impalpable lesions

Genitourinary cancer initiatives

- Improving management and support for treatment morbidity (incontinence and impotence) associated with treatment for prostate cancer
- Development and implementation of a shared model of care for patient follow up between genitourinary clinicians and General Practitioners
- Process mapping of urology clinics to improve flow of cancer patients through clinics and improve primary care co-management of initial referrals and discharges

Skin cancer initiatives

- Improving patient information for patients with melanoma in the region by gaining an understanding of the consumer experience and consumer needs related to information and support
- Development of consistent follow-up guidelines for melanoma and non-melanoma skin cancers
- Investigation of requirements for synoptic pathology reporting to improve diagnosis and treatment

Gynaecological cancer initiatives

- Streamlining of referral processes for patients presenting with ovarian cancer in the ICS region
- Improving patient information
- Identification of psychosocial care needs of women with ovarian cancer three months post chemotherapy treatment
- Development of mechanisms to ensure access to multidisciplinary care meetings for all patients across the ICS region
- Improving the transition from acute care to community based palliative care for women with gynaecological cancers

Lung cancer initiatives

- Improving access to home oxygen for patients in the ICS region
- Mapping the patient journey to identify and analyse the cause and duration of delays for presentation to initial treatment
- Mapping of lung cancer services within region against ideal pathway as described in the NHMRC guidelines and Patient Management Framework
- Development of a cancer informatics program for the multidisciplinary lung cancer clinic in a specific health service

- Exploring patient expectations and preferences for follow-up after lung cancer treatment

Upper gastro-intestinal cancer initiatives

- Development of patient information
- Audit of multidisciplinary process within two health services to investigate its use and effectiveness in providing care to complex patients
- Mapping of the patient journey within the ICS region to identify key points in the journey , particularly when care coordination is required
- Development of guidelines for consistent follow-up

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National Bowel Cancer Screening Program



Victorian implementation news

Issue two December 2007



Bowel cancer in Victoria

Bowel cancer is the second most common cancer in Victorians and the second ranking site of fatal cancer—1,087 deaths (11 per cent) in 2004. In Victoria in 2004, there were 3,424 new cases (14 per cent of all cancers). (*CanStat*, No 42, November 2006, Cancer Council Victoria). Bowel cancer can be treated successfully if detected in its early stages when it is still localized within the bowel, but it is estimated currently less than 40 per cent of bowel cancers are detected early.

Victoria is collaborating with the Commonwealth Government to implement the National Bowel Cancer Screening Program (NBCSP) in an effort to reduce the health, social and economic impacts of bowel cancer through early detection and prevention.

For more information about bowel cancer in Victoria visit www.cancervic.org.au

NBCSP participation

Phase One of the NBCSP commenced in Victoria on 29 January 2007 and will conclude on 30 June 2008. All Victorians who turn 55 and 65 between 1 May 2006–30 June 2008 will be invited to participate in the screening program.

As at 31 July, over 126,900 eligible Victorians have received an invitation to be screened. Of those, 44,708 have completed and returned a screening test. Victoria's crude participation rate at this time was 35.2 per cent. The participation rate is impressive at this early stage of the program.

By the end of July, 3,156 Victorian program participants had received a positive Faecal Occult Blood Test (FOBT) result and were advised to consult their GP for further assessment and referral for colonoscopy.

Based on reports to the National Register, the Program has identified 44 adenomas and 29 suspected cancers in Australia. As yet, there is no definitive data for cancers detected specifically in Victoria.

GP education and support

The Victorian Government has funded the Cancer Council Victoria (CCV) to support Victoria's implementation of the NBCSP. CCV and General Practice Victoria (GPV) are working together to assist Divisions of General Practice educate and support GPs and general practice staff about the program.

All 30 Divisions are working locally with GPs and practice staff to:

- inform them of Victorian implementation arrangements and increase their knowledge of the NBCSP
- encourage GP referral of eligible NBCSP participants requiring procedures to the designated providers wherever possible
- utilise resources developed by CCV and GPV including workshops, short presentations and materials for practice visits
- publish articles in their newsletters and add links on their websites for further NBCSP information
- increase community awareness of the program.

Future activities planned to support implementation of the NBCSP in Victoria include:

- workshops hosted by CCV in conjunction with designated colonoscopy providers
- the development of a 'practice preparation checklist'
- additional Division workshops and local support activities in 2008.

For further information please contact Angie Deegan, GP Liaison Officer, CCV on 9635 5049 or angie.deegan@cancervic.org.au

Colonoscopy service redesign

Service redesign has been identified as one way of responding to continued growth in demand for colonoscopy, including demand attributable to the NBCSP.

A colonoscopy service redesign project will commence early next year to assist health services to identify ways in which to increase their capacity for colonoscopy service provision.

A service redesign consultant and departmental project officer will work directly with participating health services.

Colonoscopy provision

Public health services that are not designated providers are still required to provide usual care to eligible NBCSP participants referred to them. However, *with the patient's consent* they may be referred to a designated provider service.

Colonoscopies undertaken by non designated public service providers are subject to usual WIES payments and targets. Funding arrangements for public hospitals are detailed in the department's *Policy and Funding Guidelines*, which are available at www.health.vic.gov.au/pfg

To support Victorian implementation and reduce impact on colonoscopy services, extra WIES funding is provided to the 14 designated service providers for NBCSP generated colonoscopies.

The designated providers are:

- Bayside Health (Alfred)
- Southern Health (Monash and Dandenong)
- Austin Health
- St Vincent's Health
- Barwon Health (Geelong)
- South West Healthcare (Warrnambool)

- Latrobe Regional Hospital (Traralgon)
- Central Gippsland Health Service (Sale)
- Ballarat Health
- Wimmera Health Care Group (Horsham)
- Goulburn Valley Health (Shepparton)
- Northeast Health (Wangaratta)
- Bendigo Health
- Mildura Base Hospital

National Program Register

All GPs and public hospitals are expected to submit the appropriate forms to the National Program Register for eligible NBCSP participants. Submission of the forms to the Register will attract a \$6.60 payment from the Commonwealth government.

Reports to the Register need only be lodged for eligible NBCSP participants, i.e. NBCSP participants with a positive FOBT result.

Information Reports should not be completed for:

- NBCSP participants referred for further diagnostic assessment despite a negative FOBT
- non-NBCSP participants regardless of whether they have undertaken a FOBT.

The National Program Register (operated by Medicare Australia) requires the following information reports on eligible participants:

- Assessment Form – Completed by GPs to report all outcomes of medical consultations.
- Colonoscopy Form - Completed by the colonoscopy provider.
- Procedure Report – Adverse Outcomes Form - Completed in the event of an adverse outcome in relation to any procedure undertaken as part of an investigation.
- Histopathology Report – Completed on the results of tests conducted on specimens collected from NBCSP participants with positive FOBT result during procedures (to be completed by pathology providers).

Information report forms and further information about reporting procedures are available from the NBCSP Information Line on 1800 118 868, or visit the NBCSP website at www.cancerscreening.gov.au

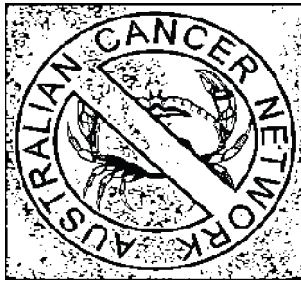
Completed forms are lodged by faxing the Register using the free fax number 1800 115 062 or (03) 6281 0554.

Further information

Further information on the NBSCP initiative is available at: www.cancerscreening.gov.au

For specific information on the Victorian implementation of the NBCSP, contact:

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Extract from WONGI YABBER
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Wongi Yabber is published in February, May, August and November as a service to all ACN supporters and interest groups
Full copy available on website: www.cancer.org.au/acn

Does positive thinking have power over Cancer?

People with cancer find considerable comfort in the notion that they can “do something” to influence their outcome. Researchers have been duly investigating the relationship between psychosocial factors and outcome in cancer for the past 30 years.

The findings of another well designed study by James Coyne and colleagues (as reported in the Australian, on Tuesday 23rd October 2007) which has found no relationship between positive thinking and cancer outcome, increases the body of evidence supporting the conclusion that mental states do not affect survival time in cancer. Recent reviews and metaanalyses have similarly reported that combined effect sizes are nonsignificant, and concluded that both mental states and psychotherapeutic interventions are unlikely to affect outcome. This is good news for those who feel that when patients have a poor outcome, they should not be burdened with guilt that they have not “been positive enough”.

However, there are two limitations to this conclusion. First, most reviewers have criticised the methodological rigor of the studies performed to date, and suggested that larger and more homogenous samples, and better measurement, design and control

of potentially confounding variables are needed. Second, a multiplicity of constructs have been discussed and measured under the term “mental state.” These have included depression, hopelessness, optimism, fighting spirit and minimization, to name but a few. Similarly, psychotherapeutic interventions have varied widely in their goals and method of delivery. Generally, these are lumped together in metaanalyses and reviews, without consideration of potential differences in their impact both theoretically and empirically. Thus I feel that to conclude once and for all that mental states have no influence over cancer outcome is premature.

Reviewers have recently suggested that the cost of funding a definitive study on this topic would not be justified, given the burden of evidence against such a relationship. Perhaps this is reasonable. The likely influence of mental states is in any case likely to be small. Of much more concern is the quality of life of those living with cancer, and research effort needs to focus on optimising that.

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Forthcoming Meetings

Date / Place	Meeting / Contact
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You can view the forthcoming committee meetings on our website via the weblink below:

http://www.cancervic.org.au/downloads/cal_2008_2009_External_mtgs.pdf

The Cancer Council Victoria

The Cancer Council Victoria was set up by an Act of Parliament in 1936. To find out more about the Cancer Council visit www.cancervic.org.au/introduction.

Victorian Cooperative Oncology Group

The Victorian Cooperative Oncology Group (VCOG) established in 1976, provides advice to the Cancer Council, on all clinical aspects of cancer control, in particular clinical research, screening diagnosis, treatment, palliative medicine, cancer genetics and professional education. The strategic role of the VCOG is to have a 'parliament' of clinical cancer specialists with a view to promoting a range of cooperative measures to optimise cancer treatment in Victoria. The VCOG consists of a primary committee, 8 cancer-site and 5 task-specific advisory committees and 5 trial research sub-committees. These committees bring together in regular meetings approximately 400 key specialist health care professionals and scientists, representing the various treatment disciplines and Centres in Victoria. The VCOG has established valuable linkages between public and private health care professionals, institutions and governments.

