



Gynaecological Cancer Update

Issue 29 February 2008

- ESGO Report
- ANZ GOG Trials Update
- Facing Ovarian Cancer DVD
- ICS Initiatives



GYNAECOLOGICAL CANCER UPDATE

Issue 29

February 2008

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* * * * * **Last Issue – No. 28 – January 2007** * * * * *

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

Contributions Welcome

The Gynaecological 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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Editorial

Simon Hyde

It has been some time since the last edition of Gynaecological Cancer Update, apologies to all.

This edition includes a sampling of the abstracts from The Gynaecological Cancer and pre-Cancer Care conference, which was held in November 2007 under the auspices of VCOG Gynaecological Cancer Committee. This conference had an excellent mix of interesting presentations, which were well received by those in attendance. The few abstracts attached hopefully will give an indication of the variety and diversity of topics covered including: The laparoscopic management of adnexal masses, Gynaecological Cancers in the setting of BRCA1 and BRCA2 germline mutations, Issues of intimacy and sexuality after cancer and Fertility Preservation issues.

In addition to the formal presentations, there were 2 excellent and entertaining debates on aspects of Endometrial Cancer including the role of adjuvant radiotherapy and the role of lymphadenectomy. Many thanks to all those individuals who contributed to the success of this conference.

This edition also includes a report by Peter Grant on the ESGO meeting, which particularly focused on the management of higher risk endometrial cancer.

I would also draw your attention to the launch of a variety of new educational resources:

(i) The new DVD: "Facing Ovarian Cancer" which has recently been launched and will become a valuable resource for women and their families.

(ii) BreaCan, which provides informational services through Women's Health Victoria. <http://www.whv.org.au/breacan> (vigorous debate continues to surround the name)

The Cancer Council has also launched a booklet developed in conjunction with educational resources from Peter MacCallum Cancer Centre focusing on issues associated with surviving cancer. This edition also includes:

(i) an overview of initiatives undertaken by the Victorian Integrated Cancer Services (ICS). <http://www.health.vic.gov.au/cancer/index.htm>

"The *Cancer Services Framework for Victoria* outlines an integrated service model for metropolitan and regional cancer services based on the following principles:

- Services will be population based
- Individuals will have access to the full range of services from prevention, screening, diagnosis, treatment, rehabilitation, supportive care and palliative care
- Referral pathways are clearly defined for the range of services required
- Care is multidisciplinary and coordinated
- High quality care requires a 'critical mass' of expertise and leadership."

The integrated service model adopted has resulted in the establishment of three metropolitan and five regional Integrated Cancer Services (ICS), based on specified geographic populations and one state-wide Paediatric service.

(ii) An update on Cancer Australia – National Centre for Gynaecological Cancers: <http://www.canceraustralia.gov.au/ngc-homepage.aspx>.

There is also a trials update from Australia New Zealand Gynaecological Oncology Group (ANZGOG).

In particular there are 2 exciting trials that many centres across Victoria (and Australia) have, or soon will have, up and running for recruitment.

(i) TRIPOD, which addresses the issue of intraperitoneal chemotherapy in optimally debulked ovarian cancer as a single phase II trial.

(ii) ICON 7, looking at the role of bevacizumab (a monoclonal antibody against vascular endothelial growth factor) in addition to standard chemotherapy.

I would encourage all the units to actively recruit to these 1st line trials if at all possible

Once again this newsletter relies heavily on those that contribute to it and I, like my previous editors are indebted to their input. Hopefully there will not be as long a delay to the next Update. Be encouraged and feel free to contribute!

Regards,

Simon Hyde

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



AUSTRALIA NEW ZEALAND GYNAECOLOGICAL ONCOLOGY GROUP

Trials Update
February 2008



New Trials

Two new trials are in the final planning stages with recruitment estimated to begin in the next few months.

PORTEC-3—Randomised Phase III Trial Comparing Concurrent Chemoradiation and Adjuvant Chemotherapy with Pelvic Radiation Alone in High Risk and Advanced Stage Endometrial Carcinoma.

PORTEC-3 is a GCIIG Intergroup study with the lead group in the Netherlands. Patients are treated after surgery with concurrent radiotherapy and chemotherapy, followed by adjuvant chemotherapy, in comparison with patients treated with pelvic radiation alone.

Method of surgery can be (i) total abdominal hysterectomy-bilateral salpingo-oophorectomy (TAH-BSO) (ii) lymphadenectomy and full surgical staging, (iii) laparoscopically assisted vaginal hysterectomy (iv) total lap hysterectomy and BSO, or (v) laparoscopic operations with lymphadenectomy.

Major eligibility criteria: Women with histologically confirmed endometrial carcinoma, with one of the following postoperative FIGO stages and grade: **(1)** stage IB grade 3 with documented LVSI, **(2)** stage IC grade 3, **(3)** stage II (occult) grade 3, **(4)** stage IIIA or IIIC (*IIIA based on cytology alone only eligible if grade 3*) or **(5)** stage IB

or IC, stage II or stage III with serous or clear cell histology.

This trial is expected to open in 18-20 sites in ANZ, including 3 sites in Victoria. The lead investigator for this trial is Dr Linda Mileskin at the Peter MacCallum Cancer Centre. The study will be open to recruitment for 5 years and ANZGOG expects to contribute approximately 50 patients per year. There will be an Investigator Meeting for this trial on Thursday Feb 21 as part of the ANZGOG Annual Scientific meeting at Noosa.

For more information, please contact Trial Coordinator Lucky Waniganayake (02 9562 5391) or ANZGOG Associate Program Manager: Julie Martyn (02 9562 5092)

SYMPTOM BENEFIT: Does Palliative Chemotherapy Improve Symptoms in Women with Recurrent Ovarian Cancer?

This is a prospective observational cohort study in women with platinum resistant / refractory ovarian cancer who are about to commence chemotherapy.

Major eligibility criteria: Women who have platinum resistant/refractory epithelial ovarian cancer with a life expectancy > 3 months who are about to start palliative chemotherapy.

This is a GCIG Intergroup study which will be conducted in 2 stages. Stage 1 will open in Australia (approx 6 sites including 1 in Victoria) and Canada and aims to recruit 50 patients. Additional countries expected to participate in stage 2 and the recruitment target will be approximately 600 patients over 2 years.

For more information, please contact Trial Coordinator Lucky Waniganayake (02 9562 5391) or ANZGOG Associate Program Manager: Julie Martyn (02 9562 5092)

Active ANZGOG Clinical Trials

TRIPOD – A single arm phase II trial of intraperitoneal chemotherapy with

paclitaxel and cisplatin after optimal debulking surgery for ovarian and related cancers

This study aims to assess the feasibility, the toxicity and the effects on quality of life, of treatment with an intraperitoneal chemotherapy regimen in patients with optimally debulked disease.

Major eligibility criteria: Women aged 18 to 75 years, considered suitable for treatment with IP chemotherapy, with optimally debulked stage III epithelial ovarian, primary peritoneal or primary fallopian tube cancer and residual disease ≤ 1 cm.

Six sites are now open to recruitment including one in Victoria. A total of 25 sites in Australia and New Zealand will participate in this study, including 3 in Victoria. The study aims to recruit a minimum of 34 patients but could continue until 100 patients have been enrolled. The current total is 4 patients.

For more information, please contact Trial Coordinator Helen Mueller (02 9562 5332) or ANZGOG Associate Program Manager: Julie Martyn (02 9562 5092)

SCOTROC4 – A prospective multi-centre randomised trial of carboplatin flat dosing versus intra-patient dose escalation in first line chemotherapy of ovarian, fallopian tube and primary peritoneal cancers

This is a randomised trial for women having carboplatin monotherapy for the treatment of ovarian, fallopian tube and primary peritoneal cancers. Results from previous studies suggest that further refining / optimising the dose for individual patients may improve their survival.

Major eligibility criteria: Patients with histologically confirmed epithelial ovarian carcinoma, or primary fallopian tube carcinoma, considered unsuitable or unwilling for treatment with platinum-taxane combination therapy.

Twenty-four of 25 sites within Australia and New Zealand have been activated with a total of 45 patients recruited, including **19** patients randomised from 7 sites in Victoria. Dr Geraldine Goss has recently taken over the role of ANZGOG Study Chair for this trial.

For more information, please contact Trial Coordinator: Ray Tangunan (02 9562 5044) or ANZGOG Associate Program Manager: Julie Martyn (02 9562 5092)

ICON7 – A randomised, two-arm, multi-centre Gynaecologic Cancer InterGroup trial of adding bevacizumab to standard chemotherapy (carboplatin and paclitaxel) in patients with epithelial ovarian cancer

Bevacizumab has been tested in combination with other chemotherapy agents in various cancers and has shown promising results. This study aims to determine whether the addition of bevacizumab to standard chemotherapy produces improved outcomes

when compared to standard chemotherapy alone in the treatment of epithelial ovarian cancer.

Major eligibility criteria: Histologically confirmed epithelial ovarian carcinoma, primary peritoneal carcinoma or fallopian tube carcinoma, surgically debulked and able to commence systemic therapy within 6 weeks of cytoreductive surgery.

This study is currently open at 6 sites in Australia and New Zealand, with 16 more sites to open in the next few months, including 5 sites in Victoria. We have recruited 5 of 90 patients, with three of these coming from Victoria. Recruitment is expected to close in 2009.

For more information, please contact Trial Coordinator: Kim Gillies (02 9562 5032) or ANZGOG Associate Program Manager: Julie Martyn (02 9562 5092).

Current Recruitment in Victoria

| Trial | Sites Participating | Study PI | Number Recruited | Total ANZGOG accrual |
|----------|--|-------------------|-----------------------------|----------------------------|
| SCOTROC4 | Ballarat Oncology & Haematology Services | Rodney Bond | 1 | 45/150 |
| | Border Medical Oncology | Christopher Steer | 0 | |
| | Box Hill Hospital | Geraldine Goss | 5 | |
| | Frankston Hospital | Vinod Ganju | 1 | Estimated close early 2010 |
| | Mercy Hospital for Women | Peter Grant | 1 | |
| | Monash Medical Centre | Geraldine Goss | 10 | |
| | Royal Women's Hospital | Michael Quinn | 1 | |
| ICON 7 | Border Medical Oncology | Christopher Steer | 0 | 5/90 |
| | Mercy Hospital for Women | Danny Rischin | 0 | Estimated close early 2009 |
| | Royal Women's Hospital | Michael Quinn | 3 | |
| TRIPOD | Royal Women's Hospital | Michael Quinn | 0 | 4/34 |
| | | | Estimated close August 2008 | |

Abstracts from November 2007 Conference Advances in Gynaecological Cancer & Pre-Cancer

ISSUES OF INTIMACY AND SEXUALITY AFTER CANCER

Dr Amanda Horden, PhD
*Deputy Director, Cancer Information &
Support Service,
The Cancer Council Victoria*

Objective

To explore issues of intimacy and sexuality in cancer and palliative care, from patient and health professional perspectives.

Design

A qualitative study using a three stage reflexive inquiry approach with semi-structured, participant interviews (n=82), textual analysis of national and international cancer and palliative care clinical practice guidelines (n=33) and participant feedback at 15 cancer patient and health professional educational forums.

Setting

The project was conducted in a large Australian public teaching hospital

Participants

Interview sample included 50 patients who had experienced a diagnosis of cancer and 32 health professionals who had worked in cancer and or palliative care for a minimum of 12 months.

Results

There were 'mismatched' expectations between patients and health professionals and unmet needs when communicating about sexuality and intimacy. The majority of patients sought information, support and practical strategies about how to live with intimate and sexual changes after treatment for cancer, even if their cancer type did not affect their fertility or sexual performance. In contrast, many health professionals

assumed patients would share their professional focus on combating the disease, irrespective of the emotional and physical costs to the patient. Health professionals overwhelmingly limited an understanding of patient sexuality to fertility, contraception, menopausal or erectile status. Many stereotypical assumptions about patient sexuality were made by health professionals, based on patient age, gender, diagnostic classification, culture and partnership status. The health care environment, including attitudes of colleagues, endorsed this kind of medicalised patient communication so that patient sexuality was largely invisible or reduced to a problem that health professionals could safely deal with in their expert capacity. There was a clear relationship between the provision of patient-centred communication about intimacy and sexuality and the capacity of health professionals to understand their own attitudes and beliefs.

Conclusion

Paramount in moving from a medicalised communication pattern to a patient-centred pattern is the requirement for health professionals to engage in a reflexive exploration of their own definitions of intimacy and sexuality and how these impact on their professional interactions with patients.



HRT & GYNAECOLOGICAL CANCER

Professor Henry G Burger AO

*Emeritus Director, Prince Henry's Institute
of Medical Research at Monash Medical
Centre & Jean Hailes Foundation for
Women's Health*

The roles of menopausal hormone therapy (HT) in the rates of diagnosis of breast, ovarian and endometrial cancers, and in the management of symptomatic women who have received treatment for these tumours are reviewed.

For breast cancer, observational and limited randomised controlled trial data suggest that short-term HT (<5 yrs) has little effect on diagnosis rate, particularly in overweight or obese women. The magnitude of any increase in risk with short-term therapy in lean women is unclear. HT is generally thought to be contraindicated after breast cancer treatment, but may be considered when quality of life is a major issue, except in women treated with aromatase inhibitors. Unopposed estrogen clearly increases endometrial cancer risk, but combined therapy, particularly with continuous progestin, is potentially protective. Hormone therapy can be indicated after treatment of earlier stages of the disease. Long-term HT appears to increase the risk of ovarian cancer, but there is no evidence that HT is contraindicated in the management of symptomatic women after treatment for this disease.

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LAPAROSCOPIC MANAGEMENT OF ADNEXAL MASSES

Dr Alison Brand, MD FRCS(C)
FRANZCOG CGO
Gynaecological Oncologist
Westmead Hospital

When considering the laparoscopic approach to adnexal masses it is essential that the surgeon ask 2 questions prior to proceeding with surgery.

1. Which masses are amenable to laparoscopic approach?
2. Will the patient be harmed by a laparoscopic approach?

Obviously the answers to those questions will vary according to the skill of the surgeon with respect to laparoscopic surgery but they also depend to a large extent on the concerns regarding malignancy, the surgeon's ability to make a diagnosis regarding the mass and his/her ability to remove the mass without rupture.

The risk of malignancy index (Jacobs, 1993) is a convenient tool to be used in estimating the likelihood of malignancy and has been recommended for use by the NHMRC in their

clinical practice guidelines for management of epithelial ovarian cancer. (Australian Cancer Network and National Breast Cancer Centre, 2004) A cut-off of 200 has been used. Below that, the risk of malignancy is felt to be low, and above that, careful consideration need to be given as to the specific surgical approach and the surgery required as malignancy may well be encountered.

Despite everyone's best efforts, there will be cases in which unexpected findings will be encountered. What should be done in these cases? Again, the surgeon should ask 2 questions

1. Can I make the specific diagnosis without compromising the patient?
2. Can I adequately manage the malignancy?

If one is concerned about malignancy, it is of paramount importance that the diagnosis be made without compromise to the patient. This means that the mass should be removed without rupture, as rupture of early stage EOC has been shown to significantly compromise overall survival (Vergoote, 2001). The decision to perform a cystectomy has to weigh up the competing issues of minimizing the extent of the operation performed, especially in young patients in whom malignancy may not yet been confirmed, with the increased likelihood of rupture and spillage if cystectomy is performed laparoscopically.

Management of ovarian malignancy requires adequate surgical staging, including removal of involved adnexa (with possible hysterectomy and contralateral salpingo-oophorectomy depending on the patient and disease circumstances), washings, multiple peritoneal biopsies, omentectomy, thorough exploration of the abdomen and retroperitoneal node dissection. It has been found that approximately 34% of apparent early stage ovarian cancers will be subsequently upstaged, with consequences for the patient in terms of necessity for adjuvant chemotherapy. (Faught, 2003) The surgeon who operates on suspicious masses should be prepared to perform an adequate staging, if needed, or be able to call

ESGO REPORT

ESGO 15 was held in Berlin from October 28 to November 1, 2007. The meeting had nearly 2000 registrants had a focus on expert lectures, overviews of some controversial topics and local, single centre studies rather than larger trial presentations.

It was apparent that some of the clinical issues causing difficulty and debate in Europe are the same ones that we struggle with in Australia. In particular there were many presentations and posters related to treatment of intermediate and high risk endometrial cancer. The ASTEC trial results showing no survival advantage, either recurrence free or disease specific survival for pelvic radiotherapy following surgery was presented and when combined with similar results in GOG 99 and PORTEC 1 the place of adjuvant pelvic radiotherapy for endometrial cancer is far from convincing.

Hogberg presented a trial of adjuvant chemotherapy for high risk endometrial cancer on behalf of the Nordic Society of Gyn Oncology that showed a small benefit in terms of disease specific survival. This was a randomised trial that enrolled 382 patients but the chemotherapy protocol changed

during the trial. The results do lend support for the need for an effective trial of adjuvant chemotherapy in high risk endometrial cancer.

Schneider presented an update on his data on sentinel node detection in cervical cancer and Delpech presented similar results from a single centre in France that once again highlight the limitation of this technique. The false negative result of sentinel lymph node removal is 5-15% and may be as high as 30% after a preceding cone biopsy or LLETZ procedure.

An interim report by Burger from The Netherlands on the long term risk of breast, ovarian and endometrial cancer in 18229 subfertile women who had undergone IVF was presented. This group have been followed for up to 11 years and so far no increased risk of breast, endometrial or ovarian cancer has been identified. There is however a significantly increased frequency of borderline ovarian tumours (x2) compared to the control group of subfertile women not treated with IVF.

The meeting was definitely well worth the long trip.

Peter Grant

PapScreen Victoria reminding women to screen, even if vaccinated

The new cervical cancer vaccine has created an additional approach to cervical cancer prevention in Australia. To dispel confusion about whether Pap tests are still important, PapScreen Victoria ran a state-wide advertising campaign, from September until November, reassuring women they are.

The campaign included metropolitan and regional television, print and radio advertising, outdoor advertising at railway stations in Melbourne, a sixteen-page information booklet in Woman's Day

(October 8 edition) and media releases announcing latest regional Pap test data

Aboriginal and Torres Strait Islander specific ads were placed in the National Indigenous Times, the Koori Mail, the National Indigenous Times website and on Melbourne's Indigenous radio station 3KND.

The multilingual component of the campaign included print and radio advertisements in Arabic, Greek, Italian, Vietnamese, Mandarin and Cantonese, as well as interviews conducted by bilingual health educators.

Before the campaign began, letters were sent to Victorian GPs, nurse Pap test providers, gynaecologists and laboratories forewarning the expected increase in Pap test appointments, as previous advertising campaigns in 2004 and 2005 increased the number of daily Pap tests by 18% and 15%.

PapScreen also awarded 35 grants to community health services and medical practices throughout Victoria. These grants enabled service providers to extend opening hours and provide specific Pap test clinics during the two-month period of the campaign.

For more information please visit our website at www.papscreen.org.au Clare Price / Emma Fay



BreaCan- Gynaecological and Breast Cancer Support

As some of you may already know, on 1st May 2007 BreaCan opened its doors to women with gynaecological cancers.

As part of our ongoing funding with the Department of Human Services it was agreed that women with gynaecological cancers should also be able to access the resources BreaCan has traditionally provided to women with breast cancer.

Our service focuses on the psycho-social, emotional and practical issues that women and their families are faced with when diagnosed with breast or a gynaecological cancer as well as the day to day issues of living with such a disease

Initially BreaCan will focus on providing an **information service** to women with gynaecological cancers. Women can access a range of information, borrow from our expanded library and attend information and group sessions specifically for them or in a combination with women with breast cancer.

Prior to our expansion, we undertook a comprehensive consultation process with women with gynaecological cancers, service providers and other stakeholders to identify how we can best meet the needs of women within the scope of our service. The information gained has been collated, if you would like a copy of this report please contact us on 1300 781 500.

BreaCan is committed to implementing a comprehensive strategy to address the issue of branding including our name which will take place over the next twelve months.

If you would like to find out more about BreaCan's expansion please contact Di Missen on 9921 0833 or Sacha L'Huillier on 9921 0837 or visit our website www.breacan.org.au.

Life After Cancer

Sophy Chirnside (Cancer Information & support Society, Communications & Resources Officer, TCCV)

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 has developed 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.

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 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.

The Cancer Council has 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, which has also launched a DVD Just take it Day to Day: A Survivors Guide to Life After Cancer.

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



Australian Government

Cancer Australia National Centre for Gynaecological Cancers

The National Centre for Gynaecological Cancers was established within Cancer Australia in 2007-08 following recommendations from the Senate Community Affairs Reference Committee's report on the Inquiry into Gynaecological Cancer in Australia, *Breaking the Silence: a National Voice for Gynaecological Cancers*. Seed funding of \$1 million was provided for one year from June 2007 to Cancer Australia for the Centre's establishment and initial operations. The Government made an election commitment of \$5.1 million over three years for the ongoing operation of the Centre.

The National Centre for Gynaecological Cancers aims to provide national leadership to improve outcomes for women affected by gynaecological cancers, their families and carers. This will be achieved by:

- providing leadership in reducing the impacts of gynaecological cancers;
- building collaboration and partnerships between key stakeholders including consumers, health professionals, researchers, and policy makers;
- building support for gynaecological cancer consumers;
- providing education and increasing awareness among medical and allied health professionals;
- building the evidence base for the control of gynaecological cancers across the cancer control continuum, including through research and clinical trials;
- informing policy development across the cancer control continuum; and
- evaluation of policies and programs.

The National Working Group for Gynaecological Cancers provides expert advice regarding issues and activities relating to gynaecological cancers including the work of the centre.

Projects currently underway include:

- development of a minimum clinical dataset for cervical, endometrial and ovarian cancers;
- development of an accredited online learning activity for general practitioners;
- development of National Centre for Gynaecological Cancers web pages within the Cancer Australia website;
- a review and quality assessment of existing resources for consumers and health professionals;
- a consultation process to identify priority areas for the development of clinical practice guidelines;
- research into patterns of care for gynaecological cancers;
- a review of the gynaecological cancers workforce, including analysis of existing workforce data, identification of gaps in existing data, interviews with the gynaecological cancers workforce and interviews with gynaecological cancer consumers.

The ongoing work of the Centre will build on this initial work. The Centre works closely with the national Breast and Ovarian Cancer Centre and will continue to do so in the future.

The centre is also supporting two grants for gynaecological cancers consumer support networks as part of the Building Support Networks grants program and is sponsoring to two places for gynaecological cancer researchers at the 2008 Australia and Asia-Pacific Clinical Oncology Research Development Workshop.

For further information about the Centre, please contact Bernie Loughrey, Project Manager, National Centre for Gynaecological Cancers on 02 6200 1777 or by email: bernadette.loughrey@canceraustralia.gov.au.

Key Published Articles Listing—Gynaecological Cancer

| Title | Author & Journal |
|--|--|
| <p>Human Papillomavirus Testing Following Loop Electrosurgical Excision Procedure Identifies Women at Risk for Posttreatment Cervical Intraepithelial Neoplasia Grade 2 or 3 Disease.</p> | <p>Kreimer, Guido, Solomon, S chiffman for the ASCUS-LSIL Triage Study (ALTS) Group. Cancer Epidemiology Biomarkers Prev 2006;15(5). May 2006 (908-14).</p> |
| <p>Caffeine, Alcohol, Smoking and the Risk of Incident epithelial Ovarian Cancer</p> | <p>Tworoger SS, Gertig DM, Gates MA, Hecht JL & Hankinson SE Cancer, 2008.</p> |

Forthcoming Meetings

| Date / Place | Meeting / Contact |
|--------------|-------------------|
|--------------|-------------------|

You can view the forthcoming meetings on our website via the website link below:
http://www.cancervic.org.au/downloads/cal_2008_2009_External_mtgs.pdf

You can view the latest Wongi Yabber newsletter (Volume 15, Issue 1, February 2008) via the link below:
<http://www.cancer.org.au/Healthprofessionals/AustCancerNetwork/WongiYabber.htm>