



Breast Cancer Update

Issue 61 April 2009

Highlights of the 31st Annual San Antonio Breast Cancer Symposium
Communicating with women with breast cancer about high cost drug treatments
Combined Breast Tumour Streams ICS Meetings Reports
Breast Cancer Clinical Trials: a new paradigm

Attention Newsletter Readers:

We are updating our distribution lists.
Please let us know if you no longer wish to receive
this newsletter, or if you would like to receive a
electronic copy.

Phone: 9635 5174 or
Email: vcog@cancervic.org.au

Cancer Council Helpline 13 11 20
www.cancervic.org.au

CONTENTS

Highlights of the 31st Annual San Antonio Breast Cancer Symposium 2008.....	4
Communicating with women with breast cancer about high cost drug treatments.....	7
Support systems for Breast Care Nurses: How do BCN's sustain their role in the ever increasing work place demands?.....	9
WCMICS Report for combined Breast Tumour Streams ICS Meeting.....	10
NEMICS Rpeort for Combines Breast Tumour Streams ICS Meeting.....	11
BSWRICS Breast Cancer Activities.....	13
Breast Cancer Clinical Trials: a new paradigm.....	15



Address:
1 Rathdowne St
Carlton 3053 Victoria
Australia

Telephone:
+613 9635 5174
Facsimile:
+613 9635 5410

Email:
vcog@cancervic.org.au
Website:
www.cancervic.org.au

Editorial

Dr Jacquie Chirgwin
Medical Oncologist
Box Hill / Maroondah Hospitals

In these times of information overload it is important to review the value of a publication. Breast News is considerably smaller than it has been, but I continue to believe it serves a useful purpose – the updates from major conferences providing a succinct summary of recent new trial results and local articles providing information pertinent to breast cancer care in Victoria. I am interested to hear other's views and invite you to comment to myself (chirgwin@tpg.com.au) or Melissa Cameron (melissa.cameron@cancervic.org.au) at the Cancer Council. It was recently suggested that the contents of Breast News be amalgamated with news items and articles from the other committees and that this would be published on line (and via hard copy if preferred). My own thoughts were that having an individual publication was preferable – saving time wading through information that is of less relevance to you to find what you are interested in. Any other comments?

Issue 61 has an excellent and comprehensive summary of the San Antonio Breast Cancer Symposium by Jacqui Thompson which I highly commend to you. Jacqui has done such a good job I think she runs the risk of being asked to do these articles on a permanent basis! Michelle Marven of BCNA has written of the consumer perspective on discussion of high cost treatments, and a group of our senior Breast Care Nurses have written an interesting and practical piece on managing the stress related to this position. Some of the ICS have provided a summary of their recent projects and I hope we will hear from some of the other ICS for our next edition. I think Breast News could be a useful vehicle for keeping us in touch across the ICS.

Best wishes,

Jacquie

Contributions Welcome

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

	<u>Deadline</u>	<u>Issue Date</u>
Year-end issue	1 August	1 September
Start-Year issue	1 January	1 February

Contributions should be forwarded to:
The editor, Breast Cancer Update
C/-Victorian Cooperative Oncology Group
The Cancer Council Victoria
1 Rathdowne Street
CARLTON VIC 3053
vcog@cancervic.org.au



Address:
1 Rathdowne St
Carlton 3053 Victoria
Australia

Telephone:
+613 9635 5174
Facsimile:
+613 9635 5410

Email:
vcog@cancervic.org.au
Website:
www.cancervic.org.au

Highlights of the 31st Annual San Antonio Breast Cancer Symposium 2008

Dr Jacqui Thompson, Medical Oncologist, Frankston Hospital

In December, whilst Melbourne was being deluged by (much needed) rain, I was in sunny San Antonio with 9000 others attending the 31st annual Breast Cancer Symposium. There were many presentations and discussions over the four days of the meeting, including a large component of basic science with emerging biological and targeted agents as well as results of several large multinational clinical trials. For me the highlights included:

Hormonal trials - BIG 1-98 update and TEAM study:

The highly anticipated BIG 1-98 study results including the first presentation of the sequential letrozole (2 years) → tamoxifen (3 years) and tamoxifen (2 years) → letrozole (3 years) arms compared to 5 years of letrozole alone as well as an update of the monotherapy component of the trial was presented. This was initially designed as a two-arm study which was then expanded to a four arm study to include sequential therapy arms. A total of 8028 patients were randomized to the study, of which Australia contributed 667. In the monotherapy arms there is now a median follow-up of 76 months and 684 breast cancer events although these arms were unblinded in 2005 with a crossover rate from tamoxifen to letrozole of 25.2%. In view of this the analysis was performed as both intention-to-treat and with censoring at crossover. In the ITT analysis there was a significant benefit in terms of DFS and time to distant recurrence in the letrozole arm which were magnified in the censored analysis. There was a trend to an OS benefit in the ITT analysis which reached significance in the censored data. This has added to the body of evidence supporting the upfront use of an aromatase inhibitor in post menopausal women with primary breast cancer. The sequential therapy v letrozole monotherapy data only looked at the three blinded arms with a median follow up of 71 months and a total of 748 events. There was no difference in 5 year DFS between the three groups (let 87.9% v let→

tam 87.6% v tam → let 86.2%) nor any difference for OS and time to distant recurrence for letrozole compared with both sequential arms. However, for node positive patients, more breast cancer recurrences were seen in patients taking tamoxifen

first, particularly in node-positive disease. This was due to more recurrences in the first two years in patients taking tamoxifen and was not seen in patients who took letrozole first and then switched to tamoxifen. This would suggest that adjuvant endocrine therapy should start with the aromatase inhibitor especially for patients at higher risk for early recurrence but that it also gives some reassurance if a patient has to be switched from letrozole to tamoxifen that they are not losing benefit.

The TEAM study was initially designed as a tamoxifen v exemestane study, but in view of the positive results of the IES study the tamoxifen arm was changed to a sequential treatment arm with 2.5-3 years of tamoxifen followed by exemestane to a total of five years. This analysis was performed after a median follow up of 2.75 years with 9775 patients having been randomized on the study to assess the benefit of upfront exemestane. There were high rates of drug discontinuation, particularly of the tamoxifen where 29% of patients ceased the drug prior to the first analysis, compared with 19% of the exemestane arm. The reasons for this were not clear, and presumably in some cases reflect patients being switched to an aromatase inhibitor. Events were low in both arms (570 overall) but have demonstrated a significant benefit in terms of on study drug DFS, relapse free survival and time to distant metastases in favour of the exemestane arm in keeping with early data in both the ATAC BIG 1-98 studies. Results from the sequential therapy arm will be available within the coming year and will be interesting following on from the BIG 1-98 results.

All these studies also highlight the need for better treatment to reduce the rate of relapses beyond five years.

A prospective planned pathology study within the TEAM trial was designed to analyze the interaction between PgR status and the efficacy of an AI versus Tam as initial endocrine therapy. The prospective hypotheses were that PgR-poor tumors derive additional benefit from AIs. When analyzed for the interaction between PgR status and exemestane versus tamoxifen, there was no evidence that PgR-poor tumors responded preferentially better to

Breast Cancer Update Issue 61 April

exemestane. However, PgR was a significant prognostic factor with PgR-poor tumours having the worst prognosis.

Her 2 positive breast cancer:

The NOAH (NeOAdjuvant Herceptin) is the largest study undertaken to assess the efficacy of the addition of trastuzumab to chemotherapy in locally advanced breast cancer which traditionally has a poor prognosis. Patients were randomized to a somewhat unusual chemotherapy regimen (4 cycles doxorubicin and paclitaxel, 4 cycles of paclitaxel, 3 cycles of CMF n=113) or with the addition of concurrent trastuzumab to all chemotherapy cycles (n=115) followed by surgery. Trastuzumab continued on a three-weekly schedule to week 52. A control arm of Her2 negative patients who received chemotherapy only were also included n=99. The primary endpoint was EFS with a median follow up of 3 years. For Her2 positive patients who received trastuzumab, EFS was significantly improved compared with Her2 positive patients who only received chemotherapy (70.1% v 53.3% HR0.56, p= 0.006). The secondary endpoint of overall survival was also improved in the trastuzumab arm but was not significant (85.3% v 80.4% HR 0.65, p=0.18). pCR rates were approximately doubled in the trastuzumab group (43% v 23% (p=0.002) v 17% in the Her2 negative control arm). Toxicity was acceptable in all groups, in particular cardiac toxicity in the trastuzumab receiving arm. This study has established the role of trastuzumab in the neoadjuvant setting and will hopefully lead to a review by the PBAC for the approval of neoadjuvant trastuzumab in Australia.

The topic of Her2 as a biomarker was presented in a poster discussion session, in particular the prognostic value of Her2 in very early stage breast cancer. A study from the University of Texas M.D. Anderson Cancer Center presented results from a study of 965 patients with T1a,bN0M0 breast cancer who had not been treated with adjuvant chemotherapy and with a median follow-up time of 74 months. Of these, 77% were HR positive, 13% were triple negative and 10% were Her 2 positive. Both recurrence-free survival and distant recurrence-free survival were significantly worse for patients with Her 2 positive disease (p< 0.0001) and Her2 status remained a significant adverse prognostic indicator after adjustments for HR status, age, tumour grade and tumour stage. Similarly, a study from Glasgow looked at the impact of Her 2

positivity on what would otherwise be considered low risk disease. A retrospective cohort of 367 grade 1 or 2 node negative Her 2 positive patients diagnosed

between 1980 and 2002 were looked at. The overall hazard ratio for Her 2 positivity was 6.78 (95% CI 2.9-15.7, p<0.001) with 5 year event free survival rates of 96% for Her 2 negative tumours compared with 68% for Her 2 positive. Thus, no Her 2 positive patient can ever be considered low risk and the role of trastuzumab and chemotherapy in these patients needs to be considered.

Also presented was the final analysis of the UK NEAT trial in which patients had been randomized to either CMF or CMF + epirubicin and 1638 tumours were analysed for Her 2/ Topo 2 alpha gene alteration, chromosome 17 polysomy and Ki67 expression. Chromosome 17 was of particular interest as in addition to containing both the Her 2 and Topo 2-alpha genes, it also contains genes particularly implicated in breast cancer such as BRCA1 and TP53. Her 2 and Topo 2-alpha were strongly predictive for poor RFS and OS (p<0.001) but showed no treatment interactions with anthracyclines. However, polysomy 17 had a significant treatment interaction (RFS p=0.002, OS p=0.06) with these patients deriving a significantly greater benefit from anthracyclines. Previous studies that suggested that Her 2 and Topo 2-alpha predicted for anthracycline response may have been underpowered, and possibly the unifying predictive marker was polysomy 17 which may be an indicator of chromosomal instability.

Zo- FAST 36 month update:

The Zo-FAST study, along with its sister study Z-FAST primarily asks whether the addition of zoledronic acid reverses the BMD loss seen with letrozole - this was demonstrated in the primary analysis of both studies presented at SABCS in 2007. The 36 month update of the Zo-FAST study with the secondary objectives of fracture rate and DFS were presented at this meeting.

1065 postmenopausal women with hormone receptor positive early breast cancer and a T score ≥ -2 were randomized to either five years of letrozole + six monthly zoledronic acid (immediate group) or letrozole with the addition of zoledronic acid if the T score fell to less than -2 or if there was a fracture within 36 months of starting letrozole (delayed group). There was no significant difference in the number of fractures in the immediate group compared with the delayed group. Of significance, however is that the disease free survival was significantly improved with the upfront use of zoledronic acid (HR 0.588, p=0.0314). There was one case of ONJ seen in the immediate group. These results, whilst early, add to the growing body of evidence that zoledronic acid can provide anti-tumor



Address:
1 Rathdowne St
Carlton 3053 Victoria
Australia

Telephone:
+613 9635 5174
Facsimile:
+613 9635 5410

Email:
vcog@cancervic.org.au
Website:
www.cancervic.org.au

Breast Cancer Update Issue 61 April

effects and may prolong DFS in patients with early BC. Similarly, in a subgroup analysis of patients receiving neoadjuvant chemotherapy in the AZURE trial a significant improvement in the pathologic response of patients also treated with zoledronic acid was demonstrated (including an approximate doubling of the pCR rate) although there was no difference in the nodal status between the groups.

Lapatinib in Combination with Letrozole:

Stephen Johnston from the Marsden presented the initial results of the EGF 30008 study which was designed as a randomized phase III trial comparing lapatinib plus letrozole versus letrozole alone. This was to assess whether combining EGFR/HER2-targeted therapy with letrozole enhances endocrine responsiveness and delays the onset of resistance in post menopausal patients with MBC. Cross talk between growth factor and ER pathways has previously been implicated in endocrine resistance. A total of 1286 patients were randomized. Of these, 219 were HER2-positive (IHC 3+ and/or FISH). Only 3 patients had received trastuzumab therapy. The median PFS for HER2-positive patients was significantly improved in the letrozole plus lapatinib arm compared to the letrozole alone arm (8.2 months vs 3.0 months; HR = 0.71, $P = .019$). In addition, the ORR for HER2-positive patients was significantly higher in the combination arm (28% vs 10%, $P = .021$). Overall, the benefit seen in both arms were lower than one might expect (although similar to that seen in the TAnDEM study) – this may in part be due to the fact that over 80% of patients had visceral metastases. No significant differences were noted between the 2 arms in the HER2-negative patients. The combination was well tolerated. Whilst showing no significant benefit in Her 2 negative patients, the combination is an attractive one for Her 2 positive patients who are candidates for endocrine therapy, particularly because it is an all oral treatment. No

The BCIRG 005 study, a phase III study comparing TAC x6 v AC x4 → T (100mg/m²) x4 in women with Her2 negative node positive disease had its main efficacy data presented. With a median follow-up of 5 years there was no significant difference between groups in terms of DFS (78.9% v 78.6%, $p = 0.98$) and OS (88.9% v 88.1% $p = 0.37$). Worse haematological toxicities were seen in the TAC arm, and worse nail changes, myalgias and neuropathy were seen in the sequential arm, presumably reflecting the higher doses of docetaxel that were used in each cycle

comment was made on the incidence of CNS metastases between the two groups in this analysis.

Taxanes in adjuvant chemotherapy – yet to determine the best regimen?

There were two presentations of the NSABP B-30 study – an update as well as menstrual history and QOL data. 5351 patients with node-positive resected breast cancer were randomized to either TAC x4, AT x4 or ACx4 → T (100) x4. There were two main objectives of the study: whether TAC x4 was superior to AC x4 → Tx4 (concurrent v sequential anthracycline and taxane) in terms of OS and DFS as well as a non-inferiority analysis of AT x4 compared with the other two arms. The median follow-up was 73 months.

For OS, AC →T was marginally superior (HR 0.86, $p = ns$) to TAC x4 and superior to AT x4 (HR 0.83, $p = 0.034$), AT and TAC were equivalent ($p = 0.67$). In terms of DFS, AC → T was superior to both TAC x4 (HR = 0.83, $p = 0.006$) and AT (HR 0.80, $p = 0.001$), there was no difference between TAC and AT ($p = 0.58$). Grade 3/4 vomiting and diarrhoea were commonest in the AT arm whereas stomatitis, febrile neutropaenia and infection were commonest in the sequential arm. There were more treatment related deaths in the TAC arm (0.7%) compared with AT (0.4%) and the sequential arm (0.3%).

In addition, based on self-reported menstrual history data, premenopausal patients who became amenorrhoeic for at least 6 months had significantly improved DFS (HR 0.70, $p = 0.00041$) and OS (HR 0.76, $p = 0.038$) across all treatment arms. The AT arm (ie not containing cyclophosphamide) had the lowest rate of amenorrhoea. Beyond 6 months QOL and symptoms were similar for all treatment arms.

(100mg/m² v 75mg/m² in the TAC arm). This study has demonstrated equivalence of these chemotherapy regimens in Her2 negative node positive disease, with a slightly different outcome seen than in the NSABP B-30 study possibly because of longer treatment with TAC. However, differing toxicity profiles and duration of treatment may influence the choice of regimen in the individual patient and provides reassurance for those concerned about the haematological toxicity of TAC that sequential therapy is an as effective regimen.



Address:
1 Rathdowne St
Carlton 3053 Victoria
Australia

Telephone:
+613 9635 5174
Facsimile:
+613 9635 5410

Email:
vcog@cancervic.org.au
Website:
www.cancervic.org.au

Communicating with women with breast cancer about high cost drug treatments

Michelle Marven, Policy Manager, Breast Cancer Network Australia

Breast Cancer Network Australia (BCNA) is the peak national breast cancer consumer organisation. We empower, inform, represent and link together people whose lives have been affected by breast cancer. BCNA also conducts research with our membership in order to improve outcomes for women. We currently have more than 32,000 members across Australia.

In this article we outline the key findings from a recent collaborative research project with the University of Sydney, about communicating with women with breast cancer about high cost drug treatments.

Increasingly, drugs used in the treatment of breast cancer are becoming more targeted, as we better understand the heterogeneous nature of this disease. These drug treatments are of course complex to develop, and the costs associated mean that by the time they reach the market place they are, according to the pharmaceutical companies, incredibly expensive.

Inclusion of these treatments on the Pharmaceutical Benefits Scheme (PBS) minimises the cost to women, but there can be significant delays in achieving PBS listing, often due to problems in meeting the current cost effectiveness criteria of the Pharmaceutical Benefits Advisory Committee (PBAC). Some high cost drug treatments will of course, never meet the criteria, and won't be listed on the PBS.

Gaining Therapeutic Goods Administration (TGA) approval for use in Australia is often swift. Thus there can be considerable time lag between approval for use of a high cost drug and successful listing on the PBS. During this time women are usually required to fund the entire cost of the drug themselves.

Recent research by Thomson et al (2006) has shown that in Australia, 28 – 41% of oncologists would not inform a patient about a high cost drug if it was not subsidised. The main reasons given by oncologists were largely driven by a desire to protect a patient from distress if they knew about a drug and could not

afford it, or that the oncologist would feel bad mentioning a drug that a patient could not afford.

Mileshkin et al (2008) conducted a survey with a sample of the general population, to ascertain

whether they would want to know about a high cost drug option, even if they couldn't afford it. Between 90 and 98% of respondents said they would want to be informed about a high cost drug.

In February 2008 BCNA began a collaborative research project with Honours student Emily Kaser, Dr Jo Shaw and Assoc. Prof. Fran Boyle from the University of Sydney, in which we asked women with breast cancer about their preferences for discussing high cost drug treatments with their oncologists.

Email invitations were sent to 317 BCNA members, all women who have experienced breast cancer. Forty-seven women participated in a telephone interview based on a structured questionnaire. Of the women who participated in the survey:

65.9% were aged between 40 and 59 years

55% were living with a diagnosis of secondary breast cancer

75% were receiving drug therapy at the time of the interview

60% were private patients

Ninety-six per cent of the women involved in the survey said that they would want to discuss an expensive drug with their oncologist, even if they were unlikely to be able to afford it. Women noted that having a choice of treatment options was far more important than any potential distress that may be caused due to the cost of the treatment.

Behaviours by oncologists such as making assumptions about the ability of a patient to pay for a drug, or withholding information about treatment options were viewed very negatively by the women surveyed, as they felt this reduced their feeling of control over their healthcare.

'I might choose to sell my house, get help from family members...there are a lot of women in the public system with money who might be able to afford it, so never make assumptions. Every woman has the right to know the best options and decide what's right for her.'

Breast Cancer Update Issue 61 April

We asked women what style of communication they would like their oncologist to take when discussing high cost drugs. Eighty-seven per cent said that they preferred their oncologist to take an honest and direct approach, when discussing expensive drugs. Women felt that open and honest communication by their oncologist created a trusting relationship, which in turn led them to feel more comfortable about their oncologist's recommendations.

'My doctor is very upfront about things. He's not warm and fuzzy, but he's very consistent and that is very reassuring.'

Women also suggested that taking an upfront approach to these discussions should include asking them how much information they want about a high cost drug option, and what kind of information they want, before beginning the discussion.

'In an ideal world it would be great if your doctor found out how much you wanted to know before diving in.'

Women noted that the feelings of trust engendered by an upfront and honest communication style ensured that the conversation about finances and the ability to afford a high cost drug was easier. In fact eighty-nine per cent of women said that they were comfortable discussing their financial situation with their oncologist, with some women noting that they had discussed far more personal issues with their doctors.

According to our participants the information that women most require to help them make a decision about whether to undergo treatment with a high cost drug, is the likely impact of the treatment on their survival. The next most important area of information for women is the side effects associated with the drug, followed by the cost of the drug.

Information on side effects was particularly important for women with secondary breast cancer who want to maintain good quality of life. They were also less likely to choose a high cost drug that would only offer minimal survival benefit.

'We all want to stay alive, but not if it's going to break everyone financially just for another six months survival.'

Women stated that they prefer to discuss the information they require with their doctor, or an allied health professional, and to receive the

information in written form as well, so that they can discuss it with their family.

These findings are currently being incorporated into communication skills training for breast cancer clinicians through the Pam McLean Cancer Communications Centre. BCNA will continue to seek opportunities to promote the research findings to women and their doctors.

For further information about BCNA or the high cost drugs research, contact Michelle Marven at BCNA on mmarven@bcna.org.au

References:

Kaser, E. (2008), 'Communication about High Cost Drugs in Oncology – the patient view', Clinical Oncology Society of Australia (COSA) 35th Annual Scientific Meeting abstract presentation, Sydney, Australia.

Mileshkin, L., Agalianos, E., Schofield, P., Levine, M., Savulescu, J., Thomson, J., Jefford, M., Zalcberg, J. (2008), 'People want to be informed by doctors about expensive anti-cancer drugs (EACD) if they are a potential treatment option', *Journal of Clinical Oncology*, 26(15(S)): 345s.

Thomson, J., Schofield, P., Mileshkin, L., Agalianos, E., Savulescu, J., Zalcberg J., Jefford, M. (2006), 'Do oncologists discuss expensive anti-cancer drugs with their patients?' *Annals of Oncology*, 17(4): 702-



Address:
1 Rathdowne St
Carlton 3053 Victoria
Australia

Telephone:
+613 9635 5174
Facsimile:
+613 9635 5410

Email:
vcog@cancervic.org.au
Website:
www.cancervic.org.au

Support systems for Breast Care Nurses: How do BCN's sustain their role in the ever increasing work place demands?

Georgina Akers, Tina Griffiths, Sarah Pratt, & Amanda Hordern, Cancer Information and Support Service, Cancer Council Victoria

The value of the specialist breast care nurse role as part of the multidisciplinary team in providing quality care for women has been increasingly recognised nationally and internationally as part of evidence-based best practice for breast care.

Breast Care Nurses are integral in the care of patients with breast cancer. Their role, in providing support, information, education, performing clinical procedures and the co-ordination of care through each treatment modality and stage of disease is complex. Often Breast Care Nurses are faced with large caseloads of patients and travel long distances between major treatment centres when employed across a number of clinical positions. Breast Care Nurses often report an increase in their workload and responsibilities with finite resources to meet these expectations. However, the commitment demonstrated by many BCN's means that they often 'soldier on' without the appropriate infrastructure or support systems in place.

The risk of work related stress, anxiety and even burnout is significant and needs to be recognised and addressed, not only by the individual, but also by their organisation.

Therefore, Breast Care Nurses need to have a number of strategies and access support at a number of levels to be able to continue to provide care to others. Self-awareness into their own levels of stress are also important. Individual Breast Care Nurses need to recognise personal signs of work related emotional and physical stress, and distress and access appropriate support when needed.

Professional supervision either built into the role by the organisation in the work setting or by using available community resources provides a structured approach to managing the cumulative stress and personal impact of working with a vulnerable group of women. (Breast Care Nurses in Victoria: A workforce study of Practice and factors influencing practice, 2001).

Regular professional supervision is a means for the nurse to develop clinical skills and knowledge, identify personal educational requirements and to

reflect on interventions made in their practice to assess their appropriateness and effectiveness.

Of note, it is important for BCN's to recognise that professional supervision does not include personal counselling and nurses should be encouraged to access services such as the Employee Assistance Program (EAP) which is offered in many workplaces and settings to explore personal life experiences to identify how these impact on and inform practice.

However, professional supervision IS about supporting and providing assistance to BCN's in managing stressful situations and negotiating complex systems and relationships within the organisational and healthcare setting in which they are working.

Informal debriefing with peers is another important source of support for some BCN's. Some BCNs have organised networks within their area with regular meetings for social interaction, peer support and a way of discussing common work related issues and concerns.

The Cancer Council of Victoria offers clinical updates twice a year for BCN's across Victoria and these are well attended, the last one in November had over 100 participants attend. Many BCNs access the Cancer Helpline 131120 and debrief with cancer nurses for the cost of a local call.

Another means of professional development and support is membership to a professional body such as the Cancer Nurses Society of Australia (CNSA). CNSA provides an avenue to network and access support from cancer nurses around Australia. The CNSA Breast Care Nurse Special Interest Group (BCN SIG) provides an opportunity for individual nurses to be involved at a national level with the dissemination of information by way of e-mail journal clubs, meetings, and invitations to be part of working parties. It also provides BCN's a means to feel that they 'belong' to a broader group of BCN's from diverse backgrounds and settings and share work related issues and concerns.

The overall objective of the BCN SIG is aligned with the mission statement of the national CNSA body - "A shared voice, A shared vision" which aims to provide



Breast Cancer Update Issue 61 April

the professional support, mentorship and means of communication with other BCN's around Australia that is very much needed to ensure that the role of the BCN continues to evolve in a sustainable manner.

The current chair of the CNSA SIG is Elisabeth Black (NSW) and can be contacted at elisabeth.black@bci.org.au and Sarah Pratt (VIC) Sarah.pratt@petermac.org is Deputy Chair.

Recently, the BCN SIG responded to calls for assistance regarding practice guidelines for nursing management of seroma post breast cancer surgery. This instigated a project that involved BCN's working collaboratively to develop a consensus based document on Seroma management post breast cancer surgery. This document has been endorsed by the CNSA executive and recently launched at the National BCN conference in Melbourne.

Work force related stress is on the agenda for further attention by the BCN SIG.

The National BCN conference held annually provides an opportunity for BCN's to network, present and access latest clinical support and practice. As we go to press, the 2009 meeting has been held in Melbourne where sessions have been provided for advanced practice Breast Care Nurses and novice practicing Breast Care Nurses.

As the specialty of breast care nursing is now considered essential in providing best practice care for people with a breast cancer diagnosis, the role will continue to expand and be implemented in a wide variety of settings across Australia, (we are already seeing this through the McGrath Foundation). The work related challenges that BCN's face will only continue to increase – the health and well being and effective quality work practices of BCN's should be considered a priority in establishing a sustainable breast care nursing workforce.

WCMICS Report For Combined Breast Tumour Stream ICS Meeting November 2008

The WCMICS is currently working on three projects: development of follow up guidelines, development of a consensus data set, and screening for anxiety and depression in breast cancer patients at Royal Melbourne and Royal Women's Hospitals. Other projects that have previously been completed include the development of a business case for lymphoedema services in the west, and strengthening of multidisciplinary meetings.

The WCMICS Breast Tumour Group is progressing well in terms of multidisciplinary and cross-

institutional working. However, areas still in need of some improvement include communication (particularly with private/community care providers), and information systems to support service delivery. Some of the current projects aim to address these issues.

For further information, please contact Michelle Fleming, WCMICS Project Officer, at michelle.fleming@wcmics.org



Address:
1 Rathdowne St
Carlton 3053 Victoria
Australia

Telephone:
+613 9635 5174
Facsimile:
+613 9635 5410

Email:
vcog@cancervic.org.au
Website:
www.cancervic.org.au

Breast Cancer Update Issue 61 April

NEMICS Report For Combined Breast Tumour Stream ICS Meeting November 2008

The NEMICS Breast Tumour Group comprises approximately 20 members representing most professional groups involved with the care of breast cancer patients: surgeons, medical oncologists, radiation oncologists, a palliative care physician, nurses (BCNs, palliative care nurses), and social workers, as well as a consumer. There is however variable attendance, and most meetings have at most 8-10 attendees. Membership of the group is currently being reviewed and additionally a GP has agreed to join the group.

Current active projects

There are two active projects:

1. Best Practice Pathway for Advanced Breast Cancer (ABC)

This project involves the development of an evidence based care pathway for ABC patients that covers all domains of care. The project began in 2007 with a literature review on the care needs for newly diagnosed ABC patients and on models of care for ABC. A working party has completed a care pathway in booklet form which is now being reviewed in light of external feedback. In conjunction with this pathway, a flowchart tool has been developed that allows routine use of the pathway in the clinic. The intention is to further develop these resources so they can be web based. The purpose of the output is to provide a tool that ensures a systematic approach to all ABC patients so that all domains of care are routinely covered and also documented in the patients medical record for optimal communication between all care providers.

The project was presented as a poster at COSA 2008

A pilot of the tool and pathway is planned for 2009.

2. Multidisciplinary Care Project and Audit

This has involved review of meeting processes, capacity and membership as well as documentation of meeting

recommendations in patients medical record. The terms of reference and

meeting documentation forms are being reviewed and updated for all NEMICS breast MDMs. Previously an inadequate level of documentation has been identified and following the review process the audit goal for documentation of meeting recommendations in the patient history is 100%.

Key achievements

We considered these to be:

1. ABC pathway project
2. Wide membership of the tumour group
3. Committed working group for the ABC project
4. Collaborative opportunity with other ICS (especially WCMICS) in the area of data collection

What's working well?

We have found the following practical arrangements to be of particular value:

1. Project specific working groups – this has allowed the ABC project to progress outside the scheduled TG meetings
2. Videoconferencing has allowed additional meeting attendees and reduced travel and time commitment
3. The multidisciplinary membership of our group has ensured wide and useful discussion of topics

What isn't working well and why not?

We have noted a number of issues that have hampered our progress and these include:

1. Slow progress on projects due to limited time – all involved have heavy clinical workloads and limited spare time
2. Minimal capacity to change or influence hospital systems or decision making processes
3. Poor communication to and from the broader health service
4. Lack of progress in the development of appropriate data collection systems
5. Difficulty in undertaking projects in a broad enough range of areas to accommodate all members areas of interest



Breast Cancer Update Issue 61 April

In conclusion, we consider our achievements have been modest and are hampered by many issues outside our control. Most particularly, we believe the current paradigm for funding cancer care ensures that any work done by the ICS will be of minimal impact. A new paradigm is required whereby the members of

the ICS and the work undertaken by the tumour groups has a significant influence on funding and on provision of human resources for cancer care. For further information, please contact Jacquie Chirgwin, NEMICS at chirgwin@tpg.com.au.

BSWRICS Breast Cancer Activities

Maggie Stowers, Program Manager, BRSWICS

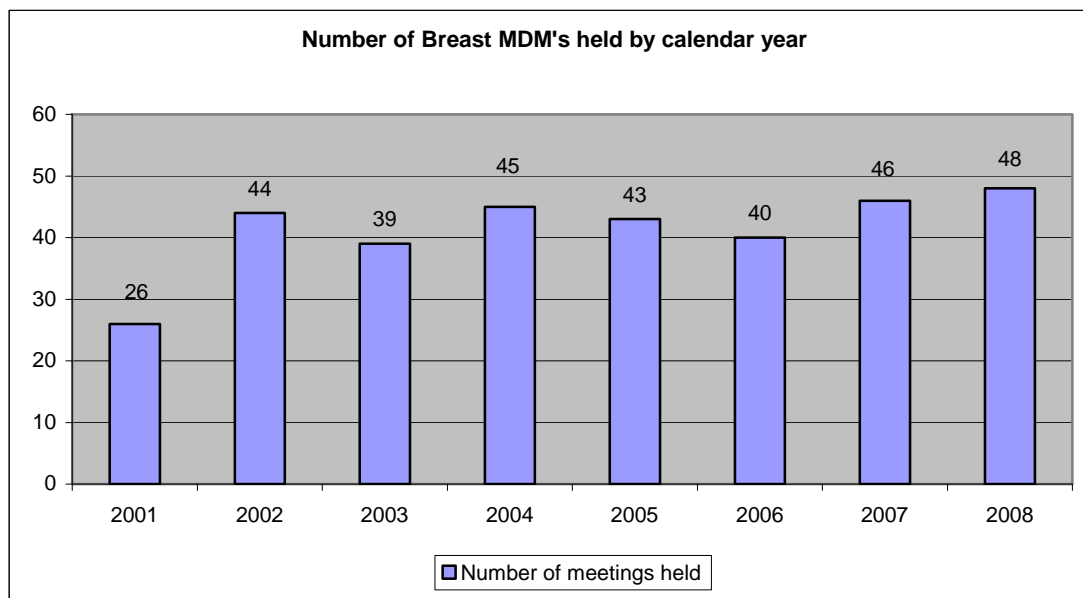
The Barwon South Western Regional Integrated Cancer Service (BSWRICS) area features one densely populated urban area with a comprehensive cancer treatment facility and a large rural region with smaller health services delivering varying levels and modalities of cancer care.

Breast Cancer Multidisciplinary Care

BSWRICS supports a Breast Cancer Multidisciplinary Meeting (MDM) based in Geelong at which both public and private patients are discussed.

Streamlining of Meeting Processes

The MDM has a dedicated Coordinator who has formalised the meeting processes into a terms of reference and instigated a yearly review meeting to improve meeting efficiencies and foster partnerships. The MDM also has a dedicated Administrator who generates the communication processes through a web-based database system. As well as agenda formatting the system allows for, personalised invitations to the patients' GP and dissemination of the meeting recommendations to the patients' entire treating team. A GP representative also attends each meeting and acts as a liaison by contacting the GP's who are unable to attend the meeting.



Breast MDM's in 2001 were held weekly from June – December. The meetings are held on a Friday therefore public holidays reduce the number of meetings held.

Breast Cancer Update Issue 61 April

Cancer Coordination Model = Improved

Breast Cancer Journeys

Regional Cancer Coordinators use the web-based database to collect patient journeys and share information. This has led to improved referral pathways to GPs and Breast Care Nurses. Data analysis led to the identification of gaps in cancer services and provided evidence to support the development of a Cancer Patient Information Centre and projects to improve supportive care. One such project, *Psychosocial Assessment Tool for Supportive Intervention (PATSI)*, is funded by the Victorian Cancer Agency. The project's primary objectives are to define the emotional and psychological needs of patients and identify patients at high risk early in their cancer journey. Patients identified as being distressed are offered support and intervention. Another project is *G'day Mum: Web cam Communication and Support for Rural Women with Breast Cancer and their Children*. Funded by a Polo Ralph Lauren Pink Pony seeding grant, this project uses web cams to visually connect women having treatment in Geelong with their distant families. The Web cam link provides emotional support as well as allowing the children to see any physical changes in mother's appearance.

Breast Cancer Clinical Trials

The Haematology and Oncology Clinical Trials Team based at the Andrew Love Cancer Centre Geelong allows for access to a broad range of studies being conducted in Breast Cancer. Currently for HER 2 Positive: Neo/Adjuvant and Metastatic and for Her 2 Negative: Adjuvant and Metastatic.

Evaluation of Cancer Outcomes (ECO) Trial

BSWRICS in partnership with The Cancer Council Victoria and Department of Human Services Victoria are conducting a world first trial of Evaluation of Cancer Outcomes (ECO). ECO involves the collection of a nationally developed and agreed set of clinical cancer data items, for all patients diagnosed with cancer across the Barwon South Western region of Victoria. The data collected includes the stage of the cancer, initial treatments, outcomes and recurrence. The data is collected using the South West Alliance Rural Health (SWARH) network and direct transfer to the Victorian Cancer Registry. This will provide for the first time the ability to report on clinical treatment and outcomes as well as any recurrences to support current incidence and surveillance data that Victorian Cancer Registry (VCR) publishes.

Newsletter Link

NBOCC: Have released new pamphlets and publications that can be viewed via the link below

<http://www.nbocc.org.au/>

WONGI YABBER: You can view the latest Wongi Yabber newsletter (Volume 15, Issue 3, August 2008) via the link below:

<http://www.cancer.org.au/Healthprofessionals/AustCancerNetwork/WongiYabber.htm>

BREAST CANCER ACTION GROUP : The March newsletter can be viewed via the link below

http://www.bcag.org.au/documents/2009_March.pdf



Address:
1 Rathdowne St
Carlton 3053 Victoria
Australia

Telephone:
+613 9635 5174
Facsimile:
+613 9635 5410

Email:
vcog@cancervic.org.au
Website:
www.cancervic.org.au

Breast Cancer Clinical Trials: a new paradigm

Professor Raymond Snyder, St Vincents Health

Over the last 40 years there has been spectacular progress in the management of early breast cancer: breast conservation, radiotherapy, adjuvant therapy with hormones and drugs (both cytotoxic and biological). This has been associated with an increased understanding of the cancer cell and the metastatic process.

Much of this progress came from an active clinical trials programme. The extension of the results into standard practice benefited the larger community.

However, clearly many women who took part in trials and were randomised to new treatments benefited personally. It is a personal belief that an appropriate trial should be one of the options for discussion with all patients if one is available.

From the early 70's until the late 90's, accrual to clinical trials was easy. Women were eligible based on the most basic criteria such as stage, menopausal status or age. This meant that clinics were able to enrol large numbers of patients over a short period.

The time of this approach has passed. Trials currently have much more restricted entry criteria. In addition to those listed above, we have biological criteria (eg triple negative), presence of new targets (eg HER2 status), provision of a suitable tumour sample, ability to attend for frequent treatments in what may be a geographically inconvenient centre, often over a prolonged period of time. HERA is a good example

where women might have received trastuzumab every 3 weeks for 1 or 2 years.

In addition, women are being treated in a greater number of clinics, further diluting the pool available in any one place.

This means that any one clinic can only accrue small numbers of patients to any one trial. However practicalities and economics means that each clinic cannot have all adjuvant trials open.

The problem now is how to make sure that patients have access to suitable trials while clinics have a manageable number of studies available.

One solution is to offer to transfer patients to where there is a suitable trial. This is against the traditional mode of practice and may be seen as threatening to the oncologist's status and self image. However this can work in an environment where the transfer of a patient from clinic A may be balanced by the referral of another patient from another clinic for trial at clinic A. In addition, there should be an agreement to refer the patient back at the first practical opportunity.

Increasingly, patients will be aware of what studies are available from the Victorian Cancer Trials Link (www.cancervic.org.au/trials/default.asp). We should recognise that trial participation is attractive to many patients and be prepared to discuss them as a legitimate treatment option where appropriate.

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.

