



Urological Cancer Update

Issue 23 February 2008

- Societe Internationale d'Urologie
- VPCRC
- COSA Meeting Report
- VICS Initiatives



UROLOGICAL CANCER UPDATE

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******* Last Issue – No. 22 – August 2007 *******

The articles in the Urological 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

*Dr Caroline Dowling
Urologist*

Southern Health

The summer edition of the newsletter comes to us late in the season and will be my last with the committee. It is good to hear from Ian Davis that the uro-oncology section of COSA had such a successful meeting with organization of their ASM. Lots of lively topics including management of renal cell carcinoma and prostate cancer management issues were addressed in a multidisciplinary format and I thank Ian for his contribution, recommend his report to you and wish him well in his chairing of the COSA Urologic Oncology Group. It is fortunate also that we can have good cross pollination between groups, such as with Ian's participation in the VCOG committee and COSA.

This seems to be the intention of the establishment of the Victorian Prostate Cancer Research Consortium (VPCRC), to provide a framework for interaction and reduce "unhelpful" competition in the research sector, with a view to creating the best possible outcome in basic and translational research in prostate cancer for the state. Certainly the premier research bodies are involved and we will watch with interest as to how this consortium moves forward.

This newsletter has been interesting and challenging to edit for the last two years. It exists to communicate with those clinicians and associated health professionals as to the functions of the committee and the dissemination of the "news" from uro-oncology practice in the state. It certainly has scope for further development and I hope that the committee will pursue this in future. Hopefully the readership finds pieces like that on the Victorian Integrated Cancer Services, reports from meetings and the trials updates useful to their practice and informative. We are always happy to receive contributions.

To finish I would like to sincerely thank the Cancer Council staff Susan Fitzpatrick, Philippa Davis and Vicki Johnston, and Greg Neerhut and Damien Bolton, the immediate past and present chairmen of the committee for their support. In particular we acknowledge Susan's enormous contribution and this is echoed in David Hill's note of thanks in this edition.

Contributions Welcome

The Urological 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:

The Editor, Urological Cancer Update
C/- Victorian Cooperative Oncology Group
The Cancer Council Victoria
1 Rathdowne Street
CARLTON VIC 3053
vcog@cancervic.org.au

The centenary meeting of the Societe Internationale d'Urologie

*Dr Caroline Dowling,
Senior Lecturer, Monash University
Department of Urology, Southern Health*

The centenary meeting of the Societe Internationale d'Urologie was held in Paris in early September this year. The SIU is an international urological society that formed with 200 urologist members in 1907 and now has in excess of five thousand members from a very broad range of countries. The meeting has a more informal feel to the major American and British meetings and the wide ranging of topics addressed the free papers reflects this inclusive objective.

The program was broad and addressed many areas of urology including paediatrics, transplantation, female urology and an extensive program on oncology. Australian Urologist, Bill Lynch from Sydney, chaired the organizing committee. There was a strong presence of international faculty including Andrew Novick, Urs Studer, Mark Solway and Harry Herr.

Few landmark papers were presented but there were succinct expert presentations highlighting important practical applications in uro-oncology. Additional to this there were the free papers with podium presentations and moderated poster sessions and some 400 unmoderated posters from all parts of the world with fascinating content including such items as "Circumcision Sunday: a Swazi study model for circumcision"!

Andrew Novick from the Glickman Urological and Kidney Institute, Cleveland Clinic, received the SIU-Astellas Award and gave an excellent lecture on the contemporary management of renal cell carcinoma. Novick has dominated the international literature on the management of renal cell carcinoma with

partial nephrectomy both in the elective and nephron sparing setting.

He began with a discussion of the new technique of laparoscopic partial nephrectomy. He concluded in relation to the use of laparoscopic versus open partial nephrectomy that the functional and oncological outcomes of the laparoscopic procedure remained only short term given the only recent introduction of the technique. There was an associated increased risk of haemorrhage and longer ischaemia time for the laparoscopic technique and currently it could not be recommended for solitary kidneys.

Minimally invasive options for small renal cancers have become an established option for patients who have co-morbidities that limit their surgical opportunities, with the mainstay of treatment being radiofrequency (RFA) or cryo-ablation. According to Novick, whilst there is no histological confirmation of success you can infer success from loss of enhancement of subsequent imaging of the lesion, shrinkage of the lesions, percutaneous biopsy 6 months later but the ultimate validation of cancer specific survival was still awaited.

At present he quotes figures of 7.4% local recurrence from cryotherapy patients and a significantly higher 25% from radiofrequency ablation using biopsy or enhancement as criteria. He quoted a paper by Uzzo, in press, examining 99 published studies in the area gives a less disparate result comparing partial nephrectomy, cryo and RFA and finding local recurrence rates in the order of 2.6%, 4.6% and 11.7% respectively. Despite the difference with established removal of the

lesion, the minimally invasive option affords an element of safety in a specific population for whom surgery is deemed high risk.

Metastatic disease management in renal cell carcinoma is clearly an area of current rapid change and development. In 2000, Novick stated, the standard of care was the best available clinical trial. An interesting statement to open with, as I felt this still to be the *staus quo!* He stated as a consequence of the gene mutation and VHL gene knowledge we now have much better agents including sorafenib which has demonstrated reduced progression of disease but few complete responders in trials and sunitinib with 40-44% partial or complete recurrence and shrinkage that in some cases included the primary which has never been previously demonstrated with the former cytokine based treatment of metastatic disease. This primary tumour shrinkage he felt created several questions for the future management of renal cell carcinoma including correct selection of monotherapy, sequential or combination therapy, the management of non clear cell pathology, adjuvant administration in the high risk setting and even neoadjuvant administration with the finding of shrinkage in the primary might be a particularly attractive option in the case of bilateral synchronous renal carcinoma. He also added that the nature of surgery after the administration of VEGF modulators remained unanswered with the potential for tumour fibrosis and altered vascularity.

A sponsored symposium on testosterone deficiency raised some interesting questions about the relationship between testosterone and prostate cancer. The influence is ill defined, despite the routine use of androgen ablation in advanced disease. Demonstrated by Morgentaler at the 2007 European Association of Urology meeting and published in *JAMA* as far back as 1996 is the finding that more patients with low testosterone have carcinoma of the prostate than BPH. This is coupled with the finding that one third of the men with carcinoma of the prostate in the finasteride preventive studies had low

testosterone and those men tended to have a higher Gleason score. There has also not been progression of disease in men with hypo-gonadism who have had radical prostatectomy and then had testosterone replacement. This is all an area for further study and discussion as there has been a hesitancy to treat with testosterone in men who have a history of prostate cancer but they are potentially missing a benefit in the well controlled situation that may place them at risk of added morbidity.

Uzzo RG. Is CT-guided percutaneous radiofrequency ablation oncologically effective in patients with renal cell carcinoma? *Nat Clin Pract Urol*. 2007 Nov 13; [Epub ahead of print]

Baccala A Jr, Hedgepeth R, Kaouk J, Magi-Galluzzi C, Gilligan T, Fergany A. Pathological evidence of necrosis in recurrent renal mass following treatment with sunitinib. *Int J Urol*. 2007 Dec;14(12):1095-7

Morgentaler A. Testosterone deficiency and prostate cancer: emerging recognition of an important and troubling relationship. *Eur Urol*. 2007 Sep;52(3):623-5. Epub 2007 Apr 9

Morgentaler A, Bruning CO 3rd, DeWolf WC. Occult prostate cancer in men with low serum testosterone levels. *JAMA*. 1996 Dec 18;276(23):1904-6.

Victorian Prostate Cancer Research Consortium ('VPCRC')

The Victorian Prostate Cancer Research Consortium is a dedicated research based consortium. It was established in 2008 with the aims of the State Govt (Victorian Cancer Agency) to improve and integrate cancer research across Victoria. The establishment of a dedicated prostate cancer research consortium in Victoria will enhance collaboration, boost translational research efforts in the field and galvanise additional complementary research groups to focus on this major disease. Importantly, the consortium will coordinate prostate cancer research more effectively and establish Victoria as the national leader and focus for prostate cancer research. This will position Victoria as a major international hub for translational research and clinical trials and serve as a conduit for attracting national and international funding and industry support.

The formation of a dedicated prostate cancer research consortium in Victoria will provide a vital boost to understanding the fundamental mechanisms underlying prostate cancer development and contributing to treatment resistance. The consortium will enhance collaboration and, through its strengths in translational research, will fast track laboratory-based discoveries into the clinical development pipeline through promoting synergies between consortium partners that span the full gamut of preclinical and clinical development of new therapies and combinations.

The objectives of the VPCRC are to provide financial resources to facilities capable of undertaking prostate cancer research; to undertake research into prostate cancer, which will enhance the understanding of prostate cancer that assists in the detection, prevention, treatment or cure and to produce outcomes which will provide health benefits to the Victorian Community;

to apply this knowledge in a practical way, leading to the development of new and better diagnostic tools and treatment methods; to facilitate the clinical trials aspect of this research; and to develop and distribute research and educational information .

The consortium will directly address these issues by integrating basic discovery research and preclinical and early clinical development of new therapeutics and biomarkers by bringing together currently disparate groups working on different aspects of the cancer research and development spectrum. The synergies that the prostate cancer research consortium will develop in fast-tracking local discoveries into preclinical and early stage clinical development will create a Victorian-based framework for broader application of this development model to other unmet medical needs.

The consortium will operate as an 'institute without walls' with its research groups located amongst the collaborating institutions supported by integrated infrastructure and intellectual sharing. The aim of the consortium is to establish vibrant and meaningful research collaborations between nodes able to span the therapeutic and diagnostic development spectrum, without investing in physical infrastructure or capital development. The intention behind the establishment of the VPCRC is to reduce competition and support effective collaboration between consortium institutions, and investment into priority areas for research.

The VPCRC has been established initially between six institutions:

- § The Royal Melbourne Hospital
- § The University of Melbourne

- § The Ludwig Institute for Cancer Research
- § Monash Institute of Medical Research
- § The Peter MacCallum Cancer Centre.
- § TissuPath Pty Ltd

Importantly, the consortium aims to be inclusive of all current and any potential future partners. In the interests of delivering on State-wide collaboration for prostate cancer research, additional institutions in both metropolitan Melbourne and regional areas of Victoria will be welcome to join the consortium once fully established.

Clinical Oncological Society of Australia (COSA) meeting report 14-16 November 2007

*A/Prof Ian Davis
Medical oncologist, Austin Health*

The formation of the COSA Urologic Oncology Group at the COSA Annual Scientific Meeting (ASM) in November 2006 provided an ideal opportunity to effectively take over the COSA ASM in 2007. This year's ASM was held in scorching environmental and intellectual heat in Adelaide from 14-16 November and the theme was "Prevention, palliation and cure: progress through clinical trials." This is a theme with which the urologic oncology community is very familiar. The COSA ASM also coincided with the launch of Cancer Voices South Australia and the theme of consumer representation was prominent throughout the conference. The COSA Urologic Oncology Group, of which I am fortunate to be Chair, enthusiastically took up the challenge and opportunity to devise a program of considerable depth and broad interest, which effectively spanned almost two full days of the program and even included concurrent sessions. Because of the wealth of expertise and the diverse membership of COSA, deliberate attempts were made to integrate other COSA interest groups into the urologic cancer program.

The job of the organisers of the urologic oncology program was made considerably easier with the quality of the international speakers, many of whom had direct clinical and research interests in this area. The international speakers included Martin Gore, a jack of many trades, who really worked hard

for his supper. He provided keynote talks on topics ranging from melanoma, renal cell carcinoma, gynaecologic oncology, and also chaired sessions. Stephen Jones is a urologist from the Cleveland Clinic who contributed to several sessions. April Fritz was until recently the manager of data quality for the SEER program of the US NCI. Ronald de Wit is a medical oncologist from the Netherlands who was co-chair of the TAX327 pivotal study of docetaxel in advanced prostate cancer. Ronald's commitment was particularly striking since the entire duration of his stay in Australia was only slightly over 24 hours. He is also roughly nine feet tall, so the trip can not have been easy for him.

The urologic oncology program commenced on Thursday 15 November at 7.30am where I had the privilege to chair a breakfast session given by Martin Gore. In the words of Tim Eisen, "Martin is at his bounciest in the morning" and this was shown to be amply true. Martin gave an overview of the previous and current state of the art of management of renal cell carcinoma. Martin not only presented the data very clearly, much of which was already familiar to the audience, but managed to bring together disparate pieces of information from several studies presented so far only in abstract form at various meetings. This led him to speculate on several issues, including the tantalising possibility that interferon may still have a role in combination with the new targeted

therapies, possibly best used in low doses for its antiangiogenic potential. Martin also presented what limited information was available with respect to key unanswered management questions, such as:

- Are the new kinase inhibitors safe in patients with brain metastases? (Probably yes, and in fact they may even offer a protective effect against the development of brain metastases).
- Are the TKIs effective against non-clear-cell RCC? (Yes, although most of these data come from expanded access trials)
- Is there cross-resistance, or it reasonable to move to another TKI after failure of the first? (Yes, some cross-resistance, but many patients still respond)
- Is the order of use of the TKIs important? (Maybe, but the definitive studies are only just commencing)
- Can the TKIs be used in poor performance status patients? (Yes, but with caution)

Some questions remain unanswered, including those relating to sequencing of treatment, “horizontal” combinations blocking multiple signalling pathways, integration of targeted therapies with other treatment modalities, use of TKIs in the adjuvant or neoadjuvant setting, and others. Many of these issues are now being addressed in clinical trials.

This session was then followed by a symposium entitled, “Is screening for prostate cancer worthwhile?” This was chaired by Raji Kooner, a urologist from Sydney and deputy chair of the COSA Urologic Oncology Group, and the speakers included April Fritz (epidemiology and implications for screening), Bettina Meiser (risk assessment of men with a strong family history), and Stephen Jones (providing a very balanced discussion from the urologist’s perspective about the

advantages and disadvantages of screening). These talks led to very vigorous discussion.

The first afternoon session was entitled, “Controversies in the management of early prostate cancer” and was chaired by our own Damien Bolton. The discussants each provided a brief presentation on the areas they saw as controversial within their own disciplines for men with early prostate cancer. Stephen Jones presented information on the complexities underlying diagnosis and highlighted the fact that the false negative rate with sextant biopsies was very high. Disconcertingly, even up to 25 biopsies in a single session still led to an unacceptably high false negative rate. He made a strong case that (a) repeat TRUS biopsies were often necessary and that patients should be warned that the first session will often be followed by another if the first is negative; (b) that biopsy techniques should specifically aim for peripheral zone and particularly apical areas of the gland; and (c) that periprostatic infiltration with local anaesthetic reduced the pain of the procedure substantially and that it was safe and feasible to perform these biopsies without general anaesthesia or an operating theatre. Gill Duchesne presented the data on use of radiation as primary therapy with or without androgen deprivation and highlighted the strengths and weaknesses of the many trials that have attempted to address this question. Dusan Kotasek, a medical oncologist from Adelaide, provided his thoughts not on early chemotherapy (as many might have expected), but on the issues of osteopenia and osteoporosis related to androgen deprivation and how these are often neglected or forgotten by the treating doctor until fractures occur. The final speaker was David Smith, an epidemiologist from TCCNSW, who provided provocative data on the epidemiology of early prostate cancer. Once again this session provoked vigorous discussion.

Continuing the theme of prostate cancer and following its natural history, the second afternoon session was entitled, “Biology and management of advanced prostate cancer”

and was chaired by Scott Williams, a radiation oncologist from Peter Mac and secretary of the COSA Urologic Oncology Group. The first talk was from Gail Risbridger, an eminent basic scientist from Monash, who presented her extraordinary data regarding tissue recombination experiments and the critical role played by fibroblasts in normal prostate differentiation and by tumour fibroblasts in maintenance of the malignant phenotype. Ronald de Wit, freshly off the plane from Amsterdam, then gave a detailed discussion of the most recently updated TAX327 results. A key point of this talk was the important effects of PSA kinetics. In the study, the median PSA was 114 and the median PSA doubling time was 55 days. By dividing the patient population down the middle according to these values, four prognostic groups could be described with different hazard ratios for death, as follows:

PSA	DT (days)	HR
<114	≥55	1.0
<114	<55	1.33
≥114	≥55	1.52
≥114	<55	2.02

Ronald also pointed out that the survival benefit in the study was seen in both symptomatic and asymptomatic patients; that the 3-weekly regimen has a biological rationale for its survival benefit and was acceptable to patients; benefits were seen in patients with soft tissue metastases as well as bone metastases; and that survival in patients crossing over from mitoxantrone was probably inferior to that of patients who had received docetaxel as first line therapy. These observations will have direct relevance as we make treatment recommendations in our multidisciplinary clinics. For example, an asymptomatic patient, who might not otherwise have been recommended for treatment, should probably receive it if the PSA kinetics are unfavourable; deferral of treatment with docetaxel may lead to missing the window of opportunity. On the other hand,

a patient with favourable PSA kinetics might reasonably defer treatment until his clinical features make it necessary, without compromising his final outcome. The exact values as shown above are probably not critical, since these just happened to be the numbers from the population in the TAX327 study; however, the principle still applies that an estimate of burden of disease and of the rate of progression should be part of the decision algorithm.

It must be emphasised that it remains entirely appropriate to refer patients for clinical trials. If all eligible men are treated off-study with docetaxel, this will substantially reduce the pool of available patients for clinical trials and may ultimately disadvantage our patients. **I strongly encourage all clinicians to continue to be aware of what trials are available and to refer patients for trials in the first line setting even though docetaxel is now freely available on the PBS.**

The final speaker in this session was Dianne O'Connell from TCCNSW, who provided an update of an important and comprehensive program being undertaken by TCCNSW to identify and address the supportive care needs of men with advanced prostate cancer.

Friday morning commenced at the ungodly hour of 7am, particularly difficult given that the conference dinner was held the night before. Attendance was surprisingly good, perhaps indicating the effects of conscience: the session was sponsored by sanofi-aventis, who had supported many delegates to attend the conference. The session was a lively interactive case-based session using responder pads to gauge the opinions of the audience. The panel included Ron de Witt, Gill Duchesne, and Alan Stapleton (Adelaide urologist). This session was then followed by Stephen Jones, who spoke to a crowded room on the multidisciplinary model adopted by the Cleveland Clinic urologic oncology team. At the same time, COSA President David Goldstein was presenting a session on

the use of sunitinib in renal cell carcinoma and GIST.

The final session for our stream was a free communications session, chaired by me, in which presentations from several junior and senior researchers were given. Guy Toner also provided an updated of the activity of the ANZ Germ Cell Trials Group.

The second annual general meeting of the COSA Urologic Oncology group was held on Thursday evening and the attendance at this meeting even outstripped the COSAAGM held earlier in the day. This is very encouraging and shows that broad multidisciplinary support for the group is alive and well. Various issues were discussed including the setting up of subcommittees to look into ways of standardising data and tissue collection for urologic cancers across Australia. The group recognises that no-one will welcome additional work and so the emphasis will be to build this in to routine clinical practice in a non-disruptive fashion and also to provide advantages to those who participate, for example in the collection of data for surgical or other audits. The meeting also discussed other opportunities, such as development of new research collaborations and competitiveness for future grant opportunities, particularly the priority-driven scheme first rolled out in 2007 and which will continue in 2008. The details of this scheme should be available as you read this and interested people are encouraged to check the Cancer Australia web site <http://www.health.gov.au/internet/wcms/publishing.nsf/Content/cancer-australia-lp1> The new COSA web site <http://www.cosa.org.au> has a wealth of information for general readers and a specific area for COSA members. The Urologic Oncology group has a web page and discussions in the online forum are expected to be wide ranging.

A key item of business was discussion of the nascent Australian Prostate and Urogenital cancer Group (APUG), a new national cooperative clinical trials group arising from the COSA group but distinct from it. An

application for seed funding to set up self-sustaining structures and governance of the group narrowly missed obtaining funding from Cancer Australia this year, however another application has been put in through the Victorian Cancer Agency. The outcome of this will be available as you read this but at the time of writing it is not known. However, I am very confident that one or other mechanism will result in success within the next few months and that this group will be functional and productive in a very short time. This will be the first time that a national group has existed in Australia covering the full range of disciplines and diseases represented by urologic oncology. It will greatly facilitate performing clinical trials and will provide other opportunities for basic and translational research also.

The first trial to be performed by the group will be the SORCE trial, a placebo-controlled study of adjuvant sorafenib in intermediate- or high-risk resected RCC. MRC UK is sponsoring this study and it will eventually be rolled out to multiple sites across Australia and New Zealand. The process of activating sites is taking longer than expected due to the need to devise sponsorship and indemnity systems in the absence of a functioning APUG; however, the study chair Tim Eisen is extremely keen to move this process forward and I will keep you all apprised of its progress.

The 2007 COSAASM was the largest yet and shows how the organisation has recently been reinvigorated. This is exemplified no better than the revolution sweeping urologic oncology, where all health professionals involved in the care of these patients are now increasingly coming together and working together productively. The advent of newer therapies such as the TKIs for renal cell carcinoma has provided an opportunity to initiate and build these relationships. However, there is also a danger that improved access to new therapies may in some areas reduce referrals and the productive multidisciplinary interaction that is known to be optimal for the care of our patients. Now more than ever it is important to ensure that we talk to our

colleagues, involve our patients in decision making, support clinical research, get used to including data and tissue collection as a routine part of our clinical care, actively seek out and support clinical trials, and listen to what advocacy groups are telling us. I strongly encourage you to join COSA and to participate in the Urologic Oncology Group and in APUG,

and to come to the next ASM in Sydney (18-20 November 2008).

Meanwhile, just wait for 2008 as the urologic oncology community goes from strength to strength.

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

Sent by:

Spiri Galetakis
 Acting Manager, Integrated Cancer Services
 Cancer and Palliative Care
 Programs Branch
 Metropolitan Health and Aged Care Services
 Department of Human Services
 50 Lonsdale Street
 Melbourne 3000, Victoria
 Phone: (03) 9096 2131/ Mobile: 0432 133 004
 Fax: (03) 9096 9204
 Email: spiridoula.galetakis@dhs.vic.gov.au
<http://www.health.vic.gov.au/cancer>



**Extract from WONGI YABBER
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Newsletter of the Australian Cancer Network**

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.

Prof Phyllis Butow
Co-Director, Medical
Psychology Research Unit,
School of Psychology,
University of Sydney

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All correspondence should be directed to:

GPO Box 4708 SYDNEY NSW 2001
email: acn@cancer.org.au

Australian Cancer Network Secretariat

Tel: +61 (2) 8063 4141 Fax: +61 (2) 8063 4101

Email: acn@cancer.org.au

Website: www.cancer.org.au/acn

Medical Director

Professor Bruce Barraclough AO FRACS

Senior Medical Advisor

Emeritus Professor Tom Reeve AC CBE FRACS

Executive Assistant & Co-Editor

Ms Christine Vuletich

Office Assistant & Circulation

Ms Alice Winter-Irving

Susan Fitzpatrick has announced her decision to leave the Cancer Council after 24 years of service, first as assistant to Prof Dick Lovell and then, from 1997, as Executive Officer of VCOG/CCRC in her own right.

Susan learnt the job under a master and applied her exemplary organisational skills to the multitude of meetings, newsletters and other tasks involved in the most reliable way. She leaves VCOG in a healthy vibrant state, which we are committed to nurturing and growing in the future. VCOG is one of The Cancer Council's most important functions; it keeps us in close contact with clinicians, developments in treatment and with a hotline to the treatment system.

I'd like to thank Susan for all the work she has done over so many years to ensure that these links are strong and that VCOG members benefit from the relationship as much as The Cancer Council does.

I will continue to oversee the work of VCOG/CCRC and Dorothy Reading, Senior Strategic Consultant in my office will act as a point of contact.

Prof David Hill AM, PhD
Director, Cancer Council Victoria

Forthcoming Meetings

Date / Place

Meeting / Contact

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.

