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Recent Developments in Cancer Nursing

Overview

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Cancer nursing is a relatively young specialty within nursing. The specialty initially emerged in response to scientific, professional and social developments in the 1950s, which saw the beginning of radical changes to the way cancer was managed, and the way professionals and the public viewed the disease. Miaskowski identifies four factors that influenced the development of cancer nursing, alongside the development of cancer medicine, as a specialty: national and international recognition of cancer as a major chronic health problem (eg national and international cancer control policies and initiatives emerged);
scientific and technological developments (eg the discovery of chemotherapy and other newer modalities of treatment);
changes in professional and public perceptions of cancer (eg increasing knowledge base about the disease and improved survival rates resulted in more positive perceptions of the outcomes for people with cancer);
changes in the nursing profession (eg development of education and research base and the increasing professional organisation of nurses).

These changes created a range of new roles and responsibilities for nurses caring for people with cancer, and over the past few decades these roles have continued to evolve in response to the changing social and health care environment. Cancer nurses today are integral members of the cancer care team, and cancer nursing has become established as a major specialty within nursing. Cancer nurses in Australia and overseas have published standards to define and guide their practice, and specialist postgraduate courses and research programs within cancer nursing have emerged in many universities and health care facilities in Australia.

However, like other health professions practising in the today's health care system, cancer nurses today are facing many challenges associated with cost containment, rapid developments in science and technology, and the changing relationships between consumers and health professionals. In addition, the nursing profession is currently experiencing unique problems associated with recruitment and retention of specialist nurses, with oncology nursing having recently been listed by the Department of Workplace Relations and Small Business as an area of skills shortage in New South Wales, the ACT, Queensland and the Northern Territory.

The series of articles presented in this edition of Cancer Forum aims to explore some of the contributions made by nurses to cancer control efforts in Australia. Specifically, the articles in this edition provide an overview of contemporary issues in the provision of education and support for people with cancer and their families. The developing evidence base underpinning nursing practice is also highlighted in a paper which uses the example of intervention strategies for treatment induced mucositis. At the broader policy level, the development of guidelines for handling cytotoxic drugs and related waste is discussed to illustrate how nurses have effectively collaborated with a range of key stakeholders to enhance safe practice for health care workers and patients. Issues faced by cancer nurses and people with cancer in rural Australia, and new roles and directions for cancer nurses are also considered in the final papers in this series. To provide some context for the articles included in this edition, a number of key issues and challenges facing contemporary cancer nursing will be discussed in this first paper.

Defining the contribution of cancer nursing

In 1996, the COSA Nurses Group published its second edition of Outcome Standards for Australian Cancer Nursing Practice. The document, along with other similar documents published in the USA, highlights the diverse and complex nature of cancer nursing practice. In particular, the Outcome Standards identify that:
cancer nursing is concerned with service to the individual patient, their families and the community;
cancer nursing occurs along a continuum of care, from prevention through to end of life care and bereavement support;
cancer care is delivered to patients and their families in a variety of settings.

More specifically, a recent qualitative study exploring the key dimensions of practice for nurses working in chemotherapy settings in Australia identified that chemotherapy nursing practice revolves around interrelated processes associated with information giving and education, emotional support, advocacy, and a range of direct caregiving interventions. These interventions require specialised knowledge and skills in managing technology, assessing responses to disease and treatments, preventing and responding to symptoms and treatment side effects, and meeting the patient's personal care needs.

A growing number of reports from randomised and case control studies are documenting the benefits of nursing intervention in terms of improved patient outcomes and consumer satisfaction with care. For example, a recent study of 1300 patients reported in the Journal of the American...
Challenges facing cancer nursing

The developments which have occurred within nursing over the past few decades provide much reason to be optimistic about the contribution that has already made by nurses to cancer services to cancer control in Australia. However, issues relating to increasing nursing workloads, and the location of nursing within the health system, have recently become major areas of concern for the profession.

There is good evidence that nursing workloads have increased substantially in recent years. The most recent Nursing Labour Force report from the Australian Institute of Health and Welfare (AIHW) provides an important opportunity to achieve a comprehensive coordinated approach to addressing the multiple factors adversely impacting on the nursing workforce. AIHW met for the first time late in 2000, and established that its initial workforce planning focus will be on the nursing subspecialties of critical care and in rural and regional mental health and midwifery. It will be important to monitor the progress of this committee, and ensure cancer nursing issues are also considered in this work.

Nurses will therefore continue to evolve, and much closer linkages will be required between nurses and other professional groups. There is increasing recognition that the barriers between different health professional groups whether these be between nurses and other health professionals, or between registered nurses and other levels of nurses, can impede patient care. The benefits of team approaches in cancer care are obvious if the complex multifaceted problems experienced by patients and their families are to be addressed more effectively.

For quality cancer care to be delivered, a number of issues relating to nursing services need to be addressed. The Commonwealth Government, in the establishment of the Australian Health Workforce Advisory Committee (AHWAC) provides an important opportunity to achieve a comprehensive coordinated approach to addressing the multiple factors adversely impacting on the nursing workforce. AHWAC met for the first time late in 2000, and established that its initial workforce planning focus will be on the nursing subspecialties of critical care and in rural and regional mental health and midwifery. It will be important to monitor the progress of this committee, and ensure cancer nursing issues are also considered in this work.

It is also important that cancer nurses strengthen their collaborative relationships with colleagues in other disciplines. This is especially critical at the present time where the practice of all health professionals is changing, so that the focus remains on the individual person (or family) rather than on the disease or disorder. The developments which have occurred within nursing over the past few decades provide much reason to be optimistic about the contribution that has already made by nurses to cancer services to cancer control in Australia. However, issues relating to increasing nursing workloads, and the location of nursing within the health system, have recently become major areas of concern for the profession.
References


Patient education strategies in ambulatory care settings

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Cancer treatments can be extremely frightening and intimidating. Patients receiving treatment therefore require adequate knowledge and skills to help them deal both with the treatment and with the side effects of these treatments. The ambulatory care setting is now routinely used for people undergoing treatment for cancer. As such, nurses working in ambulatory care need to assist patients to gain the knowledge and skills necessary in order to manage their own self-care and self-management wherever possible: Such self-care can be enhanced through the provision of easily understandable but comprehensive and skills necessary to enable self-care and self-management of information to find that which is not only credible but also relevant for that patient. Patients receive the type of information that is desired and to choose suitable methods of teaching, and ensure that it is necessary to assess patients’ physical and emotional well-being, their understanding of their diagnosis, disease progression, and treatment options. Furthermore, the literature suggests that patients may have different concerns at different stages of their disease and treatment course, and that patients may have difficulty recalling information given at certain times, such as close to the diagnosis.

Approaches to patient and family education in ambulatory cancer settings

Several issues need to be taken into account in planning and implementing strategies to meet patients’ educational needs.

General principles of patient education

Before patient teaching can begin, several factors need to be considered. Firstly, it is necessary to access patients’ physical and emotional well-being, their understanding of their diagnosis, and help them to understand the need for the planned course of treatment. It must be recognised that some patients, especially in the early stage of the treatment course may not be ready or able to understand complex technical information, while other patients may desire in-depth information about all aspects of their care. Good patient assessment and communication skills, as well as a sound knowledge base of disease progression, and treatment options. Furthermore, the literature suggests that patients may have different concerns at different stages of their disease and treatment course, and that patients may have difficulty recalling information given at certain times, such as close to the diagnosis.

Methods for patient education

In the context of cancer, nurses are often required to translate complex scientific information into meaningful explanations for patients and families. As such, nurses need to be innovative in their teaching methods. Modes of instruction may include hands-on demonstrations and written educational materials, to reinforce verbal information. A wide range of patient information booklets are available, with studies suggesting that such booklets may be most beneficial if they are written in plain English and presented to patients prior to treatment. Many centres use visual and audio aids such as videos and audiotapes, which allow the patient to take information home and digest it in a less threatening environment.

While face-to-face education sessions are a significant component of patient education, these sessions are increasingly using a range of flexible modes for delivering information. For example, telephone triage can be used as a way of assessing potential or actual treatment-related problems or symptoms of patients in their own homes, and can be used to provide appropriate advice or instruction. Similarly, the use of interactive computer information is becoming more common. In some systems, patients may have access to their own records with explanation as a further innovative method of patient teaching.

For references, see the reference list on page 7.
Patients themselves may have access to a wide range of sources for self-education. The oncology nurse can facilitate patients’ use of these sources by supplementing education provided by health professionals, by assisting them to become critical consumers of the enormous range of information available to the public. Consumers can now access clinical trial information, detailed information about treatment regimens, and online support groups at will.

Clark suggests it is important to encourage patients to communicate with health professionals about the information they find and on the Internet, and to consider how this information relates to the information provided in the treatment setting. In this way, an opportunity is provided to give patients feedback regarding information sources and assist them to interpret information that is relevant to their needs. Clark further suggests that the criteria for evaluating Internet websites is not different from evaluating written materials. The nurse, or anyone who sources information, is informed of the information, is up to date, who sponsors the information, and how patient oriented a particular site may be.

Timing for patient education

One of the most difficult issues associated with patient education is identifying appropriate timing for teaching each individual patient’s circumstances. In general, most treatment settings have standardised or structured educational and information giving sessions early in the course of treatment. For example, a radium education program may include:

- The provision of written information at the planning appointment;
- The availability of a radiation treatment video which patients can borrow and take home;
- An initial nursing interview at the beginning of treatment to discuss issues relevant to the patient;
- Ongoing weekly assessment of interventions;
- Telephone contact post-treatment to monitor progress. It is important to recognise, however, that ongoing assessment, repeated reinforcement, and supportive feedback are the keys to imparting appropriate knowledge.

Group education and support programs

Education and support programs such as the Living With Cancer program, the STRENGTH program for women who have had breast cancer, Look Good…Feel Better, and others are important. Such programs can provide structured educational material which can be an integral component of nursing care as they often have frequent and prolonged contact with the patient and family. These programs are an important source of educational information, and how patient oriented a particular site may be.

Informational needs

Caregiver needs have received much attention from researchers. Caregiver needs have been identified as important to the caregiver and is not currently being satisfied by any one source. Caregivers face complex information demands posed by various developments within an illness trajectory. Receiving information to deal with a new situation is preferred to learning new skills by trial and error.

Why focus on family caregivers?

As a result of the shift in focus from the acute hospital setting to the ambulatory and community setting more and more care is being provided on an outpatient basis and at home and this care is constantly growing in complexity. The key to this work is knowing the reasons for symptoms, and dealing with the impact and consequences of technological advancements on family members taking on the caregiver role.

The family has always been an integral member of the health care team. Major cancer care has always been a family event, and contrary to common thought, informal support such as the family provide more support to the chronically ill than formal organisations. In Australia, as in other developing countries, there is a growth in the requirements of family caregivers who are becoming an integral component of nursing care. Nurses are in an ideal position to provide this care as they often have frequent and prolonged contact with the patient and family.

References


Abstract

Over the next 20 years, with earlier detection, improved ambulatory care setting, the needs of the patient/family, and their readiness to learn and responsiveness to information offered must be considered. The provision of a variety of creative and appropriate teaching tools will assist in the successful education of patients, to promote self-care, and improve outcomes from cancer treatment and survival rates, an increased number of individuals with cancer will require assistance at home. Given that social policy has reflected the assumption that it is a family’s responsibility to care for the individual after initial diagnosis and treatment for cancer. Weisb and Carrier believe that the effect of cancer is multidirectional, the impact of the illness status on the family and the family’s impact on the illness status on the patient and the patient’s interaction with the healthcare system. Therefore the family can no longer be viewed primarily as the principal source of support, but as the unit that faces the disease.

The first step in supporting caregivers in their role is to assess their needs. Studies show that carers often ignore their own needs or fail to report them and having unmet needs can result in decreased satisfaction and stress which in turn impede family functioning. Care of the family, as well as the patient, is becoming an integral component of nursing care. Nurses are the first people to provide this care as they often have frequent and prolonged contact with the patient and family.

Caregiver needs can be described according to six categories: information, psychological, patient care, person, spiritual and support. This paper focuses on family caregivers: informational needs and suggests education strategies which may assist the health professional to address these needs.

“Learning to live with cancer is no easy task. Learning to live with someone else’s cancer may be even more difficult.”

The family has always been an integral member of the health care team. Major cancer care has always been a family event, and contrary to common thought, informal support such as the family provide more support to the chronically ill than formal organisations.

In Australia, as in other developing countries, there is a growing need for family caregivers who are caring for someone else’s cancer may be even more difficult”. 5

Consequently cancer is a disease that patients and their affected family caregivers is the rapid advancement of modern technology and treatment methods resulting in more and more care being provided on an outpatient basis and at home and this care is constantly growing in complexity. The key to this work is knowing the reasons for symptoms, and dealing with the impact and consequences of technological advancements on family members taking on the caregiver role.

Cancer is now considered a chronic illness and is less likely to be considered a diagnosis for the first time, or for those faced with constantly changing demands posed by various developments within an illness trajectory. Receiving information to deal with a new situation is preferred to learning new skills by trial and error.

Why focus on family caregivers?

As a result of the shift in focus from the acute hospital setting to the ambulatory and community setting more and more care is being provided on an outpatient basis and at home and this care is constantly growing in complexity. The key to this work is knowing the reasons for symptoms, and dealing with the impact and consequences of technological advancements on family members taking on the caregiver role.

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Education strategies: addressing family caregiver information needs

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Health care professionals and education of family caregivers.

Education of health care professionals

Health professionals should be provided with an opportunity to develop an understanding of the cancer experience from the family caregiver perspective. Therefore health professionals require education about the caregiving role, much in the same way as nurses require information to carry out their role, and include skills, behaviours, knowledge, and attitudes. Skills required to work with caregivers include communication, assessment and teaching skills. They need knowledge about what it is like to be a caregiver and about the caregivers themselves including what is important to them, what they appraise as being stressful, their coping strategies, and available supports.

Assessment of family caregiver needs

Comprehensive assessment of family caregiver needs is highly recommended. Early assessment of families who may not cope effectively can allow for follow up of additional support and can help avoid tension between health care professionals and families. Consideration must be given to:

1. the characteristics of the patient’s disease and treatment;
2. age, gender, activity level and relationship of the patient and the caregiver;
3. competing demands faced by the caregiver;
4. caregiver needs for information and skill acquisition;
5. the caregiver’s psychological health; and
6. world outside.

It is a very helpful resource for caregivers who are a little foreign to the Australian reader. Similarly, the book Caring for the Patient with Cancer at Home – A Guide for Patients and Families, produced by the American Cancer Society, is very helpful and practical. It concentrates on managing symptoms such as constipation, dry skin, shortness of breath, hair loss and swallowing problems.

The Internet and World Wide Web have opened many doors for health professionals, patients and caregivers alike. A great wealth of information is easily accessible however it must be approached with caution as there is minimal regulation over what is posted on the web. Consequently if patients or families are wanting to access information in this way it is wise to provide them with reputable websites, suggest they share information that appeals to them with a health provider or if possible be present when they access the World Wide Web.

Useful websites include:

- The Cancer Resource Centre: www.cancer-resource.org.uk
- National Family Caregivers Association: www.nfacare.org
- This is an American site.

The Carers Association also has a plethora of information for caregivers of people with a range of diseases, not just cancer. They also have a Carers Advice Line: 1800 242 636. Their website address is www.carers.asn.au. They also have a Carers Advice Line: 1800 242 636. Their website address is www.carers.asn.au.

References


The CONTRIBUTION OF THE CANCER SUPPORT NURSE TO THE CANCER CARE TEAM

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Introduction

There is increasing recognition by health professionals of the supportive and complex needs of individuals with cancer. Nursing’s contribution in addressing these needs in particular has been acknowledged as critical. A number of studies of the Breast Care Nurse (BCN) in particular have provided level one and level two evidence that the BCN can contribute to improved patient outcomes.

The recent Psychosocial Clinical Practice Guidelines recommend the presence of the specialist BCN as they reduce psychological morbidity and improve wellbeing. The purpose of this paper is to describe a model of the Cancer Support Nurse (CSN) implemented at the Austin and Repatriation Medical Centre (A&MRC). This model was established to address support needs of newly diagnosed patients with any cancer type.

Background to the Cancer Support Nurse role

The CSN position was established at the A&MRC in March 1998. The aim of the position is to provide expert resources, support and development opportunities to staff involved in the care of patients with cancer, and in consultation with the multi-disciplinary team, to provide additional and specific support to newly diagnosed patients with cancer, their families and caregivers. The role aims to deliver an integrated approach to the care of patients with cancer, across all specialties throughout the A&MRC.

The notion of a CSN was first discussed approximately four years ago at the A&MRC. Nurses in the surgical areas identified the special needs of newly diagnosed patients with cancer, and those of their family and friends. The nurses also identified their inability to address these needs, either because they did not have sufficient cancer nursing knowledge or because they did not have time within their everyday practice.

Experienced cancer nurses from the oncology wards of the Medical Centre were called upon, as a resource to nursing staff, patients and families. The subsequent appointment of the CSN has meant nursing staff are supported where there was an identified lack of oncology nursing knowledge, and patients and families have access to an experienced oncology trained nurse who brings counselling, teaching and assessment skills to their care.

Scope of practice of the CSN

1. Facilitating communication

Discussions with nursing staff often reveal a degree of anxiety and apprehension and sometimes lack of clarity regarding the care of their patient. The CSN is able to address this as soon as practicable to facilitate optimum communication among members of the team, and to patients and families.

The CSN role has an invisible feel at times, as the CSN is often involved in situations where they do not have time within their everyday practice.

The CSN intervenes when information may not have been shared between all parties involved.

Coordination and referral

It is often necessary for other supportive disciplines to intervene and the CSN facilitates timely referral where necessary. Referrals can be made to areas such as social work, clinical psychology, nutrition, physiotherapy, occupational therapy,
The specialist CSN role provides the information and social support that has long been identified as important in the adjustment to the cancer diagnosis and the patient’s search for meaning. The CSN role is not specific to one cancer type, like the role of Breast Care Nurses, but encompasses all cancer types. Cancer is age dependent with 59% of cases occurring in people older than 65 years and 35% in those under 65 years of age. fenced. More CSN roles established to identify and address the specific supportive needs of individuals and their family and friends, with any cancer type at any age, will be beneficial.

Elderly post-surgical patients with cancer need information supportive during the transition from hospital to home. The CSN role provides this information and support. The position creates and sustains a valuable link for patients and families at the time of the cancer diagnosis, and facilitates the timely provision of information and supportive resources.

One important aspect of the specialist CSN role is that it has the potential to provide significant tacit support to nursing and medical colleagues in the surgical areas. This support facilitates an individualised, patient-focused approach to the surgical needs of the patient, and the psychological, emotional needs of the patient and family. Medical and nursing staff have the opportunity to discuss and identify the immediate areas of need – patient or family. Support to the medical colleague who is giving the bad news, particularly if it is an inexperienced junior medical officer, is also provided. The presence of the CSN allows the patient and family to express their concern to the specialist CSN, and is acknowledged as an effective coping strategy for some individuals with cancer. Many issues arise where the provision of information is valuable in assisting the individual or family member. The information promotes an understanding of events throughout the cancer experience, and is supportive in mobilising coping strategies. Becoming familiar with information and emotions reinforces confidence and enables the development and appropriate coping strategies throughout the cancer experience.

Education provided takes into account, age and cultural specific needs of individuals and families. For some, general structured programs like the Living with Cancer Education Program are helpful. This program, as with the 1 Can Cope program, is proven to be effective and beneficial to people with cancer and their friends and family.

Education includes the provision of written materials, such as patient information booklets and other printed material made available through resources such as the Cancer Information Service. Information can also be visual or audio.

Responding to information needs during transition to home is important in helping patients and families to appropriately manage illness. Commonly managed include those close to the cancer site, pain management, diet, exercise and activity in the post operative period, self care, and follow up care details. Information on community resources is also provided.

Structured teaching sessions are undertaken to inform nurses in the surgical areas of the care needs of patients with a new cancer diagnosis, and also on relevant cancer types.

Conclusion
The CSN provides a vital link within the cancer care team in many ways. The role enables provision expert resources, support and development opportunities to staff involved in the care of patients with cancer. Specific needs of newly diagnosed patients with cancer, their families and carers are identified and addressed.

The CSN contributes to the knowledge of the nursing team through formal education and provides support for less experienced team members, regarding coping with reactions to a new cancer diagnosis.

The CSN provides support to medical colleagues in the confronting role they face often without a clearly identifiable supportive framework.

References

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PREVENTION AND EARLY DETECTION OF ORAL MUCOSITIS IN A CANCER SETTING
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Abstract
Oral mucositis is a common and distressing complication for patients receiving treatment for cancer. Severe mucositis resulting in the delay or cessation of cancer treatments may jeopardise the intent for cure or control. An abundance of different interventions used to prevent and manage oral mucositis appear in the literature, with little scientific evidence of their effectiveness.

This paper reports on an evidence-based study at Peter MacCallum Cancer Institute (PMCI) to develop best practice guidelines aimed at prevention of oral mucositis in a cancer population and support the elderly. The CSN performance of good oral hygiene has been shown to be more effective in reducing oral mucositis than the use of any particular oral care regimen. Integral to successful oral mucositis prevention are mechanisms to improve patient compliance with oral care, including consistent nursing assessments and frequent reinforcement of oral care instruction. Education of nurses must focus on developing skills and confidence in undertaking oral assessments, educating patients about good oral hygiene and monitoring patient outcomes.

This paper describes the process taken by the Evidence Based Nursing Practice Group (EBNPG) at PMCI in the development of consensus guidelines for the prevention and early detection of complications of oral mucositis in the cancer patient. This process involved multidisciplinary participation in the evaluation of a literature review, the acquisition of a government grant to fund the project, the development of nurse and patient education programs, and the construction of oral mucositis prevention guidelines.

Introduction
Clinical decision making in nursing is frequently based on experience, opinion, past practice and precedent resulting in the introduction of ineffective and sometimes harmful interventions and a reluctance to discontinue interventions found to be lacking.

The EBNPG was developed at PMCI and consisted of four nurses, a dental oncologist and, in the later stages of the project, a pharmacist. The goals of this group were to develop guidelines for decision-making and to enhance clinical patient care by encouraging nurses to critically examine their practices through an evidence-based approach.

The group selected the research subject of oral mucositis, as it was considered a significant complication of cancer treatments. Research had documented that prevention and management interventions were inconsistent. Findings of previous research have been somewhat equivocal, in part because issues of prevention and treatment of oral mucositis were often separate categories. For example many of the aims of interventions have frequently confused prevention with that of treating symptoms of oral mucositis. Therefore the focus of this project was restricted to prevention as a starting point in the overall management of oral mucositis.

Literature review
Definition
Mucositis is an inflammatory response of mucosal epithelial cells to cytotoxic effects of chemotherapy as well as localised radiation therapy. Epithelial cells lining the gastrointestinal tract mucosa renew rapidly, approximately every seven days. Mucositis results when mucosal cells are damaged and are unable to adequately repair and replace normal cell loss.

The primary function of the oral mucosa is to provide a first line of defence against infection and the oral cavity is a primary source in the development of septicaemia in immunosuppressed patients.

Incidence and effects
Patients most affected by oral mucositis are those receiving radiotherapy to the head and neck, those with haematological malignancies and those having complex high doses of chemotherapy, with blood cell transplantation. The indirect effects of chemotherapy on the oral mucosa includes the suppression of bone marrow cells resulting in neutropenia and thrombocytopenia, which promotes and exacerbates
infection and bleeding. Changes in oral status correlate with the timing of myelosuppression as neutrophils and oral mucosa have regenerative capacity. 

For many cancer patients the causes and exacerbation of mucositis is multifactorial. For example, multi-modality treatments for cancer are frequently given in the context of patients with a history of tobacco and/or alcohol abuse, or pre-existing poor oral hygiene. Other factors known to increase risk include the development and implementation of good existing oral disease, level of oral care and dental habits, nutritional status and numerous drugs that alter or dry the oral mucosa.

Oral mucositis is a major contributor to morbidity in the cancer patient, of which symptoms include mild discomfort, taste alterations, xerostomia, severe ulceration, pain, bleeding and infection. These factors impede the patient's capacity to eat, communicate and to adequately attend oral hygiene. Typical agents that interfere with normal oral fluid analysis are often required for pain and intravenous hydration and parenteral or gastric feeding are often necessary to maintain nutrition. In particular, xerostomia plays a significant role in the incidence of oral mucositis where absence of saliva encourages heavy plaque to accumulate on the surfaces of teeth, resulting in an increase in bacterial volume in the mouth, leading to tooth decay, fungal infections and periodontal disease.

Prevention and management of oral mucositis

The effectiveness of numerous oral care agents and regimens currently in use has not been established by reliable (Type I or II) research. In fact, much of the literature indicates that there is little consistency or agreement amongst practitioners in regard to assessment, prevention and treatment. For example, a common nursing practice, not supported by evidence, is to discourage tooth brushing during treatment which evidence does suggest increase the risks of plaque, caries and oral infection.

A number of researchers have shown that the systematic performance of good oral hygiene has been shown to be more effective in reducing oral mucositis than the use of a particular oral care regimen.

In addition, the maintenance of oral cleanliness in the form of tooth brushing and mouth rinsing is considered the most reliable means of controlling bacterial plaque, which has a direct causative link to the development of caries, gingivitis and periodontal disease. These findings are of particular relevance to studies which have shown that patients who have had dental evaluation, preventative care and treatment of pre-existing dental disease prior to chemotherapy and radiotherapy experience a reduced incidence of oral mucositis. Studies comparing mouth wash interventions have also co-incidentally compared mouthwash interventions have also co-incidentally
discouraged tooth brushing during treatment which evidence have shown to be more effective in reducing oral mucositis than the use of a particular oral care regimen.

The outcomes of an improved oral health program such as that introduced at PMCI are to standardise care and assessment interventions. In addition the project aims to improve patient outcomes relating to incidence and severity of oral mucositis and to enhance quality of life and self-care ability by acquiring new knowledge and skills. For nurses the benefits are a continued growth of knowledge, clinical expertise and a commitment to improving the care given to their patients with cancer. In addition, the guidelines for the prevention and early detection of oral mucositis at PMCI will create the best environment to generate further research on the management of oral mucositis in the future.

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Introduction

A greater understanding of the nature of cancer and the role of cytotoxic drugs in treating malignant and non-malignant disease has led to an increase use of chemotherapy in a variety of clinical and non-clinical settings. Traditionally, patients have been managed in large tertiary treatment facilities in the major cities. Oncology nursing expertise has helped in managing patients through the complex toxicities of chemotherapy. Improvements in side effect management combined with demands for cost containment, advances in technology and a greater emphasis on consumer needs has contributed to increasing numbers of smaller centres providing chemotherapy services in cities as well as in rural and remote areas.

Chemotherapeutic agents have been demonstrated to be mutagenic, teratogenic and carcinogenic. Concern about the potential risks to workers exposed to cytotoxic drugs and their waste, grows from the recognition that cell damage produced as a therapeutic effect may appear in those exposed to the drugs and their waste within the work environment. Therefore, long term low level exposure to these agents during preparation, administration and disposal may constitute an occupational hazard.

While the literature suggests that there was evidence for the concern of healthcare workers involved in the handling of cytotoxic drugs and related waste in the 1970s, guidelines were published not before 1980. Letters and the results of a number of studies alerting workers to the risks of exposure appeared in a number of journals in the late 1970’s. The data from these studies reflect practices before guidelines were published, when safe handling practices were poor and provision of personal protective clothing was inadequate.

Developing and Implementing the Guidelines for the Safe Handling of Cytotoxic Drugs and Related Waste:

THE QUEENSLAND EXPERIENCE

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In 1994, the Nursing Consultative Committee (NCC) which represents nursing concerns to the Queensland State Government, requested that the Queensland Oncology Nurses Group (QONG) to identify issues that were of concern to their membership. QONG utilised this opportunity to review the safe handling of cytotoxic drugs in a variety of healthcare settings throughout Queensland with the NCC as well as the Queensland Nursing Council, Queensland Nurses’ Union, Environmental Branch of Queensland Health and the Division of Safety.

In December 1995 QONG met with representatives from the Division of Workplace Health & Safety. This forum was an opportunity to inform the Division of the increasing use of cytotoxic drugs in the workplace and to raise concern regarding the limited legislation that specifically covered cytotoxic drugs and related waste. From this meeting it was determined that the best direction for the QONG would be to conduct a direct consultation with the Community Services Industry Workplace Health & Safety Committee to develop guidelines to minimise occupational exposure to cytotoxic drugs and related waste. This consultation occurred in 1996 and led to the establishment of the Community Services Industry Workplace Health & Safety Committee and a Working Party to develop a final document.

Guideline development

The initial Working Party included representatives from the public and private health sector, domiciliary nursing agencies, Division of Workplace Health & Safety, Department of Health, Queensland Nurses’ Union, the Queensland Cancer Fund and the Private Hospitals Association of Queensland. This committee met on a regular basis to develop guidelines and the relevant competencies associated with the safe handling of cytotoxic drugs and related waste in Queensland. The guidelines were adapted from the Guidelines for handling cytotoxic drugs and related waste in health care establishments prepared by the NSW WorkCover Authority. Committee members provided institutional policies and guidelines as part of this review process and consulted widely with industry colleagues in an effort to expand the scope of the final document.

On 21 August 1997, the guideline set out in the Workplace Health and Safety Hazardous Substances Compliance Standard 1995’ changed. That is, from that date a substance was defined as hazardous if it was listed in the List of Designated Substances or if of the substance met the Approved Criteria for Classifying Hazardous Substances. Cytotoxic drugs meet NOHSC’s Approved Criteria for Classifying Hazardous Substances because of their mutagenic, teratogenic, carcinogenic and anaphylactic potential they pose to health care workers, and were therefore hazardous substances. The Workplace Health and Safety Regulation 1997 – Part 13 Hazardous Substances, which came into force in February 1998, has replaced the Compliance Standard and cytotoxic drugs are now covered under the requirements of this legislation.

The launch of the guidelines was to coincide with the change of hazardous substances, however it was postponed to allow for broader consultation with other interested stakeholders. The committee believed that extensive consultation would ensure the final document reflected the current environment in Queensland. To this end the Working Party approached scientists, veterinarians, and representatives from Communicable Diseases Unit, along with the Queensland Health Board, Animal Medicine & Surgery, Department of Transport, Rural Doctors Association, Infection Control & Sexual Health, Environmental Protection Agency, Department of Environmental Health Services, and other aligned departments within the State Government. Bordered consultation resulted in a document that had relevance for healthcare as well laboratory settings and veterinary practices.

Dissemination and implementation of the guidelines

In recognition of the significant contribution of the QONG, the final document, Guide for Handling Cytotoxic (Antineoplastic) Drugs and Related Waste, was launched at the Annual Oncology Nurses Group Conference on 19–21 July 1997 by the Executive Director of the Workplace Health & Safety Program. The guide provides practical information for both employers and employees pertaining to the safe handling requirements of cytotoxic drugs and related waste in the workplace. The document is pertinent not only for nurses but also for other healthcare workers in hospital, community, laboratory, veterinary and home settings. While the document does not contain specific procedures for the preparation, administration, management and disposal of related waste, training modules were developed to assist institutions to develop appropriate in-house policies and procedures. It was not the scope of the document to provide practical safe handling information for patients receiving cytotoxic drugs or their families. This remains an area of uncertainty for patients as well as for healthcare workers and requires further attention.

The guidelines were published in 1997 and disseminated through the Department of Health to all public and private hospitals and domiciliary services throughout Queensland. The document is also accessible from the Department of Training and Industrial Relations Website: www.detqld.gov.au/nsguide/gde17.pdf. Review of the guidelines was to occur in 1999 however this has been postponed.

Evidence suggests that if appropriate measures are employed the potential risks associated with exposure to cytotoxic drugs and related waste will be minimised (Oncology Nursing Society, 1989). However, research has shown that in spite of guidelines and recommendations from professional groups and institutions, healthcare workers do not always practice what they know is safe practice11,12. Gullo reports that less than 40% of nurses practice safe handling measures when handling cytotoxic drugs13. While there is sufficient evidence confirms the need for health care workers to exercise vigilance when handling these drugs and their related waste. While the Guide for Handling Cytotoxic (Antineoplastic) Drugs and Related Waste is based on scientific evidence it has also taken into account what is known and what is suspected.

These guidelines are a minimum standard and are only as good as the implementation process that accompanies them. While promoting compliance will assist in reducing waste, the number of external referrals for cancer chemotherapy, to outlying rural and remote health services from larger metropolitan and provincial centres has increased significantly in recent years. It appears from the AIHW data that the majority of this is delivered by nursing staff in rural and remote areas. This trend is a response to the increasing cost burden of inpatient chemotherapy to metropolitan and provincial oncology centres. In order to defray this expense from the larger health service, there is currently an emphasis on chemotherapy administration in the outpatient setting in the patient’s home town. Advances in biotechnology have facilitated the transfer of chemotherapy to the outpatient setting, with many clients implanted with venous access devices that enhance administration of chemotherapy and continuous infusion devices that deliver pre-programmed schedules of antineoplastic agents.

Chemotherapy and cancer support from the perspective of the rural and remote client

Rural Australians are not one homogeneous group and it is difficult, therefore, to plan specific chemotherapy services from outside a given rural or remote area. This is because communities differ greatly in terms of their economic base (farming, mining, tourism – which predispose to different forms of cancer) and differ greatly in terms of their economic base (farming, mining, tourism – which predispose to different forms of cancer) and their demographic composition14. Generally, however, rural and remote Australia is characterised by economic instability and poverty due to droughts and the loss of local industry. Populations in rural areas are decreasing and are also ageing, due to the drift of younger people to metropolitan areas in search of work8,9. Those who stay behind are more likely to be low income, have poorer health, poorer educational attainment and are less likely to be able to afford private health insurance10. All of these demographic factors are influential both the cancer prevention and the cancer-treatment-seeking behaviours of rural and remote people, resulting in a reluctance to access the healthcare system. Consequently it was recommended that the cancer forum was established to facilitate improved access to healthcare and requiring more intensive chemotherapy services11.

A REVIEW OF THE EDUCATIONAL NEEDS OF NURSES ADMINISTERING CANCER CHEMOTHERAPY IN RURAL AND REMOTE AREAS OF QUEENSLAND

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Abstract

This paper describes current issues in chemotherapy nursing practice in rural and remote Australia. There is a trend to refer chemotherapy clients back to their rural and remote health care facilities when chemotherapy education and follow up is required. This research program will ascertain the nature of rural nursing education and practice with a focus on chemotherapy. Cancer Forum n Volume 25 Number 1 n March 2001

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Chemotherapy regime is only as safe as the nurses who are the final checkpoint in the administration process and it appears that mistakes will inevitably occur in these outlying areas.

Issues relating to access to education and training in rural and remote areas

While no statistics are available for Australian rural health services, it is increasingly apparent that the majority of nurses administering chemotherapy in rural areas are aware that they have a responsibility to ensure they have a sound understanding of all the drugs they administer and the principles of safe administration of cytotoxic drugs. They are also conscious of the need to ensure that the Statute and common laws related to the cytotoxins they administer to clients are up to date. Rural and remote area nurses report however, that larger health services are often unaware of the narrow range of services they can provide.

The reality is that rural and remote health services have limited staff numbers, limited budgets for specialised equipment such as Huber needles and cytotoxic waste disposal mechanisms; and restricted availability of training, which could accommodate the newer technologies that clients ‘respect and embrace’. For rural nurses, the unfortunate outcome of recent policy changes such as outpatient chemotherapy administration is a greater knowledge requirement for nursing staff in the face of financial and resource cutbacks. Many rural and remote area nurses express a desire to meet these challenges. Nurses seeking education on cytotoxic administration, however, articulate as barriers those very factors that are typical of rural clients citing as reasons for welcoming chemotherapy in their home town. For example, while clients no longer have to travel for chemotherapy administration, however, articulate as barriers those very factors which complicate the planning of chemotherapy service delivery. One is the tendency of country people to define health in terms of their ability to work, regardless of their illness. The reality is that rural and remote professionals are more likely to be exposed to the fear of pain or cosmetic disfigurement, whereas country people fear their loss of productivity. They are, therefore, more likely to place an emphasis on the maintenance of their functional abilities and on their independence. This need to help themselves is accompanied by a resistance to help from outsiders, which is occurring in a context of increasingly high turnover of healthcare professionals in non-metropolitan areas. It is well known that rural and remote people find it difficult to access services for their clients. They are often housed in one or two centres, where the only clinical training in chemotherapy administration is offered. Like their clients, they also experience isolation from family and friends for extended periods if they leave their home town for training. Rural nurses face additional difficulties because they have limited access to conferences, peer networks, libraries and information technologies; in addition to inadequate staff ratios which do not accommodate backfilling of staff who seek education outside the town.

Knowledge deficits identified amongst non-specialist nurses administering chemotherapy

There is evidence that these factors contribute to a significant knowledge deficit amongst the nursing professionals administering chemotherapy in rural areas. The specialist oncology nurses and pharmacist in one provincial health service routinely receive six calls a week from health professionals in outlying areas administering chemotherapy, spending up to one hour per call advising them on safe administration of anti-neoplastic drugs. These calls are not isolated. Nurses in the eastern Queensland and northern NSW, including Charleville, Cunnamulla, Tenterfield, Warwick and Roma. Knowledge deficits identified by oncology professionals at this referral centre, were consistent with the outcome of reports in the international literature, including:

1 Clinical knowledge of cell cycles and their relation to chemotherapy; anti-neoplastic drug actions, standard chemotherapy dosages and the rationale for dose variations; recognition and management of immediate and potential side effects; client education; and safe handling of cytotoxic drugs.

2 Technical skills such as the access and management of various venous access devices; venepuncture and cannulation.

Previous research demonstrates conclusively that well-designed chemotherapy education programs adapted to specific rural and remote contexts, which are delivered face to face, incorporating local safety and quality of care to rural clients are effective. The professional, social and financial costs for nurses of such programs are reduced if they are delivered in rural and remote areas rather than requiring the nurses to travel long distances to central metropolitan areas. Local delivery also enhances learning outcomes as it is linked to the context of rural nursing practice.

Possible solutions

The specialist oncology nurses in South East Queensland recognise their professional responsibility to ensure nurses administering cytotoxic agents to clients referred from major centres have the peer and educational support that ensures work places health and safety for clients and nurses in rural and remote contexts. They are also aware that client outcomes are significantly enhanced if nurses in outlying areas are competent to administer chemotherapy.

As a result, they have obtained funding for a two phase project. Phase 1 is a needs analysis of rural and remote area nurses in Queensland that will ascertain the education requirements of rural and remote area Registered Nurses with regard to the administration of chemotherapy. Phase 2 of the study will involve the design and delivery of an educational package that is context specific, relating to the administration of chemotherapy by rural and remote area nurses. The delivery platform will be determined by the needs analysis, but will include interactive multimedia platforms (for example CD-ROMs).

Conclusion

There are many positive outcomes to be achieved from this research. The most important is that a course designed specifically for the context of non-metropolitan health care delivery, which is consistent with the best practice standards of chemotherapy practice, will improve the chemotherapy treatment outcomes and safety of rural and remote residents, throughout Australia. Furthermore, enhancing the knowledge, competence and confidence of rural and remote area RNs administering cytotoxic agents will ensure the occupational health and safety of nurses delivering chemotherapy to rural and remote clients. It is also hoped that the project, through the delivery of the course, will develop a peer network of nurses educated about, and competent in, chemotherapy administration throughout Queensland that will be sustainable on completion of the project. This will ensure that nurses entering rural and remote contexts will be effectively mentored and educated in chemotherapy protocols.

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The dehumanising potential of cancer
The contemporary approaches to cancer treatment are informed by the dominant biomedical view of health. In this view, cancer, as a disease, is something apart from the person that ‘attacks’ the person. The human body is conceptualised as a machine in need of repair. High cost health care (real disease costs) can be attributed to technology, or ‘magic bullets’, in the form of advanced surgical techniques, more potent drugs, and advanced radiation physics. The clinical skills associated with these are the ‘tools’ used by doctors to repair and restore the body and they share common qualities. They are expensive, are geared to treating aggressively attack disease, and produce many iatrogenic effects.

The dehumanising potential of cancer treatments is illustrated in the woman with breast cancer who may experience:
1. surgical procedures that change her appearance permanently.
2. chemotherapy that result in painful mouth ulcers that bleed and cause her lips to stick together, taking away the basic pleasures associated with the lips such as eating and kissing.
3. radiation therapy that lead to burns of the skin that blister and weep for up to three weeks following completion of treatment.

The physical effects of treatment can be compounded by the attitude of health professionals. In providing a personal account, Sauter (1993) describes the dehumanisation of patients, the part of professionals, is of the utmost importance, emphasising that the professional’s words, attitudes and gestures are branded upon the vulnerable patient’s mind. This personal account is supported by research done by Kralk, Koch and Wotton who could group patients’ experiences of nursing care into two categories: engagement and detachment.

Defensive attitudes create in professionals a kind of armour-plating that prevents them relating to the patient’s emotions (detached). This translates into a relationship that is distant, cold, ascetic and, most definitely dehumanised.

In the biomedical view of health, the role of the nurse is limited to the technical skills associated with administering the treatment and prevention or management of any iatrogenic effects. In this climate, nurses are challenged to develop effective, preferably using randomised controlled trials and based on probabilities, to support their clinical decision making.

‘While nurses clearly need to be guided by the most up to date knowledge, especially in hospital settings, to allow clinical tasks to be performed with skill and consistency, the nurse-patient process is not data-based. Rather, (nursing) is a human-based engagement that must be guided by human values and theoretical principles of relevance to human engagement’.

Barker’s view is supported by Curtis who states that the goals of nursing are not solely technical; they are moral and are based on the seeking of good. Therefore, nursing actions are subject to judgement, influenced by values, as well as scientific evidence.

Values and nurses
There is mounting evidence that the values learned by nurses are not consistent with the values that nursing students learn. Research has found that senior baccalaureate nursing students in the United Kingdom valued ‘respect for the patient’ and ‘caring about little things’. Little things included getting out the mirror so patients can see themselves, fixing their water so they can reach it, and cleaning someone’s dentures or the cat they left at home. She found that this same group also valued ‘fitting in’ and ‘going along’. These students felt that their values would be in conflict with common hospital practices and saw themselves as powerless.

The finding of powerlessness, is a theme reinforced by another study completed in the USA (Raines, 1997). Over 300 neonatal nurses were surveyed and it revealed that nurses working in large tertiary centres believed the nurse-patient relationship becomes secondary to physicians’ orders, institutional policies, and other external constraints. It was found that 74% agreed that sometimes hospital policy or practice standards conflict with what the patient needs.

The result is a conflict between what the nurse should be doing, learned at nursing school, known as espoused values (somewhat reflective code of ethics or conduct), and what they are actually doing in the clinical area, values-in-use. This conflict can result in moral distress, defined as the conflict between what the nurse views to be the right course of action but constraints make it impossible to pursue the right course of action. Harriet’s descriptions institutional constraints such as lack of time, lack of supervisory support, physician power, institutional policy, and legal limits.

Two main issues that lead to moral distress for nurses are (1) the clash between professional, corporate, and societal definitions of acceptable practice and (2) nurses’ belief that they value patient autonomy more highly than physicians do.

Moral distress produces painful feelings, that can range from a feeling of anger to frustration to depression. Over time, moral distress can escalate to feelings of depression, anguish, and moral outrage. Moral distress in nurses is an important topic in cancer care as there is increasing evidence to suggest that moral distress is a powerful factor in nurses’ decisions about remaining in practice.

Implications for cancer nursing
Clinical nurses are challenged to consider and articulate how they view health and what is most important when they deliver nursing care. Reflecting on clinical experiences through journaling is one way to unravel the value assumptions that inform clinical decision making. Asking oneself questions about an incident such as: What was important to me at the time? What may have been important to others in the situation? How do I know that the decision was the right one? Would my colleagues (nursing and medical) share this view? Why or why not?

Nurses must identify the theory used to make morally defensible clinical decisions and choices, recognise the contextual nature of value judgements, and develop the art of practical deliberation with colleagues to improve practice. This process is more than knowing and understanding the nursing process or routinely implementing institutional policies derived from evidence. The evidence is not an important issue. However by focusing on evidence alone, legitimised through a biomedical view, the nurse risks creating a dehumanising experience for patients and missing the rare or unlikely responses that are rendered invisible in the research.

‘Technological evidence is important but should not distract (nurses) from the need to explore the world of the person or family, through the nurse-person process. It is within such exploration that we shall find out what exactly is happening, to the person and the family. In this sense, the cancer care setting is to recognise the potentially negative effects of the biomedical view and implement strategies that address the issues raised.

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Advanced nursing practice roles – in particular the role of the nurse practitioner, are becoming recognised as valuable and necessary in the increasingly complex health care systems of countries such as the USA, Canada, the United Kingdom and most recently Australia6,7,8. Political and social change, economic factors, the escalating cost of health care delivery, advances in research and technology impacting on medical practices, professional developments in the disciplines of medicine and nursing, and increasing consumer expectations have all contributed to the development and acceptance of these roles as the traditional boundaries between the health professions are reviewed, rethought and modified9,10,11. Essentially, the evolution of the nurse practitioner role has been an attempt to improve interdisciplinary health service delivery. The initiative is a response to individual and community demand for: improved access to health services, and increased diversity and flexibility of models in health care.

In Australia, the introduction of the nurse practitioner role is at various stages. All States are in the process of either: establishing workable models in health care2.

In the provision of lectures and tutorials: Haematology

Professor Miles Prince and Haematology Nurse Practitioner, Suzanne

Erhardt.

Phw. photo of Professor Miles Prince and Haematology Nurse Practitioner, Suzanne Erhardt.

The Peter MacCallum Cancer Institute (PMCI) participated in the Victorian State Government Nurse Practitioner Taskforce Models of Practice initiative, and aimed at further developing and extending an oncology nursing role, that of the Haematology Clinical Nurse Consultant.

Nurse Practitioner: A definition

The nurse practitioner is “at the apex of clinical nursing practice”. Nurses in advanced practice must be highly educated, have post registration qualifications, and possess expertise in their specific area of practice which may include both individual and community health, in primary and acute care settings10,11,12. In addition to traditional nursing role responsibilities nurse practitioners may: take histories, conduct physical examinations, write and interpret diagnostic imaging and pathology tests, prescribe pharmaceutical agents, treatments and non pharmacological therapies, approve admissions, discharge patients14,10,2. The PMCI Haematology Nurse Practitioner Project addressed several of the critical policy issues being explored by the Government Nurse Practitioner Taskforce Models of Practice and aimed at further developing and extending an oncology nursing role, that of the Haematology Clinical Nurse Consultant.

The Peter MacCallum Cancer Institute

Haematology Nurse Practitioner Project

The PMCI Haematology Team’s long held belief that the patient is the central focus of health care practice informed our approach to the project. Several significant driving factors influenced its development:

- Advances in technology, and basic and clinical research leading to radical changes in the practice of haematology medicine.
- Improvements in, and an increased availability of supportive therapies.
- Migration of aggressive and complex treatments from the inpatient to the outpatient setting resulting in a need for coordination and continuity of care across the patient’s care continuum. Essential elements of care include: education, psychosocial support, ease of access to the Haematology Service, close monitoring and timely interventions.
- Recognition of the contribution advanced practice nurses make to patient care. This was coupled with the Institute’s interest in developing clinical nursing roles, the Head of Haematology’s recent experience working with advanced practice nurses in Canada; the potential to expand a pre-existing haematology clinical nurse consultant role; and the “professional readiness” of the incumbent in terms of academic preparation, clinical experience and the potential to master further advanced knowledge and skills.

In Victoria, the focus of the nurse practitioner role is on the complementary nature of advanced nursing practice, rather than medical substitution. The advanced knowledge, skills and competencies of the nurse practitioner are simple tools that ensure safe, effective and expert practice in an expanded conceptualisation of clinical nursing.

The Peter MacCallum Cancer Institute

TRENDS IN CANCER NURSING: THE HAEMATOLOGY NURSE PRACTITIONER EXPERIENCE

FORUM

L. Clark, S. Erhardt, M. Prince, J. Gale and D. Spencer

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SCOPES OF PRACTICE

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HNP’s of practice encompasses conventional areas of nursing practice that are provided at an advanced level. While medical scope of practice enters the realm of medical substitution, practice boundaries may be distinguished in the areas of advanced health assessment, diagnostic and clinical management. Though still managing complex clinical situations that require highly sophisticated clinical judgment, nursing practice in the areas identified above, will be limited to focused physical assessments, standard and routine investigations, and interventions by independent assessment and decision making, rather than in a non-complicated haematological conditions and or clinical problems15.

Thus in an acute care setting patients present with a range of problems that are essential for the HNP to correctly assess, intervene and or refer. The initial formulation of solutions are either or all of the patient needs. Therefore at times the nurses work independently whilst on other occasions the nurses consult closely with the Haematology Consultant and works highly collaboratively. Clearly there is a degree of fluidity in this model, however the HNP’s educational preparation and experience will inform practice in order that the HNP may differentiate between autonomous nursing practice is appropriate, and identify high-risk, high complex and high dependency patient populations that require consultation, collaboration/co-management, or referral15.

While the development of advanced competencies in oncology nursing remains a challenge in cancer nursing practice, the need for identification of appropriate areas of competency, for the requirements of the project, led to adoption of the work of the North American Oncology Nursing Society’s Statement on the Scope and Standards of Advanced Practice in Oncology Nursing16.

The major sub-roles of a nurse practitioner – direct clinical practice, education, consultation and research – are demonstrated by these competencies. Emphasis is placed on providing clinical and professional leadership, advancing nursing practice to the “cutting edge” through education and research; and, contributing to the development of health policy, programmes and systems that meet the needs of patients and health services2. This framework also provided some direction for the educational preparation of the nurse practitioner.

Education

Major emphasis was placed on the development of an education program. It was designed to build on a requisite post registration qualification in oncology and extensive clinical experience in haematology nursing to further develop context based clinical knowledge, skills and attitudes relevant to the specialist area of haematology and necessary for advanced practice.

This clinically-driven accelerated program consisted of 12 modules conducted over the 12 months of the project. Supernumerary status was accorded the candidate to assist in the delivery of the program. The total period was equivalent of 0.6 of an effective full time (EFT) position or 32 weeks distributed over the duration of the project.

The module areas included were: advanced counselling; advanced nursing practice; calibration; clinical decision making; diagnostic imaging; diagnostic pathology; microbiology and infectious diseases; pharmacology; physical assessment and history taking; rehabilitation; and transfusion medicine. A range of acknowledged experts across disciplines participated in the provision of lectures and tutorials: Haematology, Consultants and Pathologists, Medical Physicians, Senior Medical Scientists, Pharmacists, Clinical Nurse Consultants, Clinical Nurse Specialists, Radiologists, University, Nurse Educators-Intensive Care/ Oncology, Haematology Nurse Manager. Teaching strategies, in varying combinations across the modules, comprised: formal lectures, seminars, case studies, one-on-one tuition, observational placement and self-directed learning. In addition, medical and nursing supervision was provided throughout the clinical placement/practicum17.

Selected procedures, investigations and management decisions that could be well defined and appropriately documented best practice guidelines, were identified and developed as clinical protocols. These involved bone marrow biopsy, diagnostic imaging and pathology, and transfusion medicine. A limited formulary was also developed from which the HNP was able to select and nurse-initiate medications contingent on medical authorisation18.

Responsibilities were accepted by the HNP in a graded manner commensurate with the ability of the nurse practitioner to perform at the desired level. Ongoing assessment of the HNP’s skills base to assess competency and determine degree of allocation of responsibility was performed. Mastery over practice and achievement of an advanced level of performance in all role competencies is a variable and dynamic process that develops over time. Meanwhile, it was critical that the education program produce a safe and effective practitioner. Thus initial competency (entrance level-nurse practitioner) was rigorously assessed through a combination of written and oral examinations and clinical assessment19.

In the future it is anticipated that this program may represent one major component of a Masters Degree in nursing that would provide a global view on health and advanced nursing practice and prepare the candidate for clinical and professional leadership.

Model of practice

A collaborative model of practice was identified as most suitable for the establishment of an advanced practice role in haematology nursing. Such a model is thought of as an interdisciplinary partnership or joint practice20. The professional relationship between the HNP and haematology medical staff in particular is highly collaborative.

Collaborative relationships require certain fundamentals to ensure productive alliances and the creation of an environment in which collaboration is valued and practiced. These include: shared values, a common purpose, mutual trust and respect, and effective interpersonal communication and

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negotiation skills. The diverse and complimentary knowledge, skills, experience and resources each participant brings to the collaborative effort must be understood and valued. Then, each team member may participate in a synergistic alliance that maximises the contributions of each participant and improves the quality of achievement, problem solving, and choice of intervention. Subsequently a comprehensive health service is produced that could not be achieved by individuals alone.14-17

Conclusion

Following completion of the PMCI Haematology Nurse Practitioner Project in May 2000, a limited, local evaluation demonstrated high levels of stakeholder satisfaction, and an overwhelming positive response to the role. On a broader scale recommendations enclosed in the final report of the Victorian Nurse Practitioner Taskforce to progress the implementation of the nurse practitioner role in Victoria were received favourably by the State Government. Consequently the Institute has given a firm commitment to continue this role that continues to evolve, and is currently the subject of research that aims to further explore the nature and scope of practice in advanced haematology nursing.

The PMCI Haematology Nurse Practitioner Project as part of the Victorian Government initiative is contributing to a national consideration of the nurse practitioner role. New South Wales, the first to formally establish the nurse practitioner role, has defined scope of practice, set educational and credentialing standards, developed legislation necessary for practice extension and introduced regulatory measures. Victoria now joins with South Australia and moves into an implementation stage whilst the remaining States continue in various phases of role exploration.17,18

The evolving nurse practitioner role offers enormous potential within a dynamic health system, to provide enhanced, collaborative interdisciplinary care, which is patient focused and responsive to the myriad needs of the oncology patient.

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The state and territory cancer organisations which comprise The Cancer Council Australia are the major sponsors of cancer research and related activities in Australia. Grants are made following a competitive, peer reviewed assessment from funds derived from donations and bequests. In addition, the grants for breast cancer research made by the National Breast Cancer Foundation are listed. The Foundation has been established by the Federal Government, with an independent Board of Trustees to encourage research in all aspects of breast cancer. In 2001 the value of these grants will exceed $15 million. Details of the grants are published below.

ANTI-CANCER COUNCIL OF VICTORIA RESEARCH GRANTS

A/Professor David Ball Division of Radiation Oncology Peter MacCallum Cancer Institute Tumour volume as an independent prognostic factor in non-small cell lung cancer $35,000

Dr A Brooks & Dr E Mariskovsky Dept of Microbiology & Immunology University of Melbourne MCA expression in malignant melanoma: consequences for NK and T cell activation $55,000

Dr M Brown Department of Biochemistry & Molecular Biology University of Melbourne Identification of molecular events that regulate BRCA1-mediated tumourigenesis $60,000

Dr L Campbell & Dr B Irving Victorian Cancer Cytogenetics Service St Vincent’s Hospital Search for novel tumour suppressor genes on chromosome 9p21 in lung cancer $58,232

Dr P Choon & Dr D Zhou Dept of Orthopaedics St Vincent’s Hospital The roles of the urokinase plasminogen activator system and osteoclast resorption in the development of osteosarcoma $47,000

Dr P Dancy, Dr J Tropiano & Dr M Smyth Cancer Immunology Research Laboratory Peter MacCallum Cancer Institute Immunotherapy of cancer using genetically engineered T cells $50,000

A/Professor P Gibson & A/Professor E Nice Department of Medicine Peter MacCallum Cancer Institute Molecular regulation of migration in normal and neoplastic colonic cells $55,000

Dr D Gillespie & Professor T J Martin St Vincent’s Institute of Medical Research PTH-related protein in breast cancer: its role in metastatic invasion in bone $56,000

Dr J Halliday, Dr B Meiner & Dr C Gaff Murdoch Institute Impact of genetic testing for hereditary non-polypoid colorectal cancer on psychological adjustment, screening compliance and decision-making in regards to preventative strategies $20,000

Professor J Hamilton, Dr X Cui, Dr N Wilson & Dr A Ford Dept of Medicine University of Adelaide Molecular basis for the dysregulated growth control through the proto-oncogene c-fms in myeloid leukemic cells $60,000

Dr M Harder, Dr M Hibbs & Professor A Dunn Melbourne Tumour Biology Branch Murdoch Institute An analysis of the Lyn tyrosine kinase in myeloid cell tumour suppression using both loss- and gain-of-function mutant mice $50,000

Dr J Heaster St Vincent’s Institute of Medical Research Regulation of the human tumour-suppressor protein kinase Chk2 $50,000

Professor J Hopper, Dr E Embiric, Dr A Mitchell & Dr K Waters Dept of Haematology & Oncology Royal Children’s Hospital University of Melbourne Victorian paediatric cancer family study $65,627

Dr R Hughes Department of Pharmacology University of Melbourne Molecular design and biological analysis of antagonists of vascular endothelial growth factor D $45,000

Dr R Johnstone Peter MacCallum Cancer Institute Characterisation of the anti-apoptotic function of P-glycoprotein $45,000

A/Professor R King, Dr L Vu & Mr P Delaney Department of Pharmacology Monash University Development of non-invasive imaging of subcutaneous melanomas in vivo by miniaturised fibre optic confocal microscopy $66,500

Professor D Kizana, Professor S Bloch, A/Professor D Clarke & Dr R Snyder Centre for Palliative Care Supportive-expressive group therapy for women with metastatic breast cancer $14,671

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PAGES 24 - 25
Dr G Lindeman  
Dept of Haematology & Medical Oncology  
Royal Melbourne Hospital  
*The Kathleen Cunningham Consortium for research into familial aspects of breast cancer*  
$55,000

Dr J-P Liu & Dr H Li  
Baker Medical Research Institute  
*Molecular targeting of protein kinase C-alpha-telomerase in human breast cancer cells*  
$53,563

Dr M MacManus & Dr J Seymour  
Peter MacCallum Cancer Institute  
*Randomised trial of radiotherapy (RT) vs chemo/RT for stage I-II follicular lymphoma*  
$36,000

A/Professor P Macrae, A/Professor J St John, Dr B Leggett & Professor J Jass  
Royal Melbourne Hospital  
*A trial of aspirin and/or resistant starch in people at risk of hereditary colorectal cancer*  
$65,000

Dr G Mann, Professor J Hopper, Dr J Attlein, Professor R Raffeld, Professor G Giles & Professor B Armstrong  
Dept of General Practice & Public Health  
University of Melbourne  
*The characterisation of a novel 108 kDa inositol polyphosphate 5-phosphatase: regulator of cell death*  
$50,000

Professor C Mitchell  
Dept of Biochemistry & Molecular Biology  
Monash University  
*The role of hyaluronan in brain tumour invasion*  
$58,713

Dr G Mann, Professor J Hopper, Dr J Attlein, Professor R Raffeld, Professor G Giles & Professor B Armstrong  
Dept of General Practice & Public Health  
University of Melbourne  
*The characterisation of a novel 108 kDa inositol polyphosphate 5-phosphatase: regulator of cell death*  
$50,000

Dr L Purton, Mr D Haylock & Dr P Simmons  
Peter MacCallum Cancer Institute  
*Enhancing ex vivo expansion of primitive haemopoietic cells by all-trans retinoic acid*  
$50,000

Dr I Radford  
Division of Haematology and Medical Oncology  
Peter MacCallum Cancer Institute  
*Defining aspects of the mechanism of ionising radiation-DNA rearrangement in mammalian cells*  
$56,503

Dr S Stacker & Dr M Achen  
Ludwig Institute for Cancer Research  
*The role of vascular endothelial growth factors in the metastatic spread of cancer*  
$56,000

A/Professor E Thompson, Dr L Ackland & Dr D Newgreen  
Victorian Breast Cancer Research Consortium  
*Regulation of the epithelio-mesenchymal transition in human breast cancer cells*  
$24,502

Dr I Radford  
Division of Haematology and Medical Oncology  
Peter MacCallum Cancer Institute  
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Total Grants in 2001  
$1,419,654

**POST-DOCTORAL RESEARCH FELLOWSHIPS**

Dr K Buzzard, Peter MacCallum Cancer Institute  
$21,418

Dr M Halford, Ludwig Institute for Cancer Research  
$21,418

Dr T Johnson, Dept of Biochemistry & Molecular Biology, University of Melbourne  
$42,835

Dr A Ng, Institute for Reproduction & Development, Monash University  
$42,835

Total fellowships  
$128,506

**SCHOLARSHIPS AND STUDENTSHIPS**

Ms Y Cao, Baker Medical Research Institute  
$19,875

Mr A Deans, Peter MacCallum Cancer Institute  
$21,150

Ms S Grant, Royal Melbourne Hospital Research Foundation  
$9,938

Dr M Shackleton, Victorian Breast Cancer Research Consortium  
$27,150

Ms M Smart, Dept of Physiology, University of Melbourne  
$19,875

Dr S Ting, Dept of Medicine, University of Melbourne  
$27,150

Vacation Studentships  
$19,000

Total Scholarships & Studentships  
$165,288

**FELLOWSHIPS**

Carden Fellowship  
Professor Emeritus Don Metcalf, Walter and Eliza Hall Institute of Medical Research  
$200,000

Dunlop Fellowship  
Dr Andrew Roberts, Walter and Eliza Hall Institute of Medical Research  
$90,770

K & H Fraser Fellowship  
Walter and Eliza Hall Institute of Medical Research  
$100,000

Lions Fellowship (variable)  
Dr Andrew Elefthery, Walter and Eliza Hall Institute of Medical Research  
approx $50,000

Total fellowships  
$570,770

Total fellowships and scholarships  
$738,888

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K & H Fraser Fellowship  
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$100,000

Lions Fellowship (variable)  
Dr Andrew Elefthery, Walter and Eliza Hall Institute of Medical Research  
approx $50,000

Total fellowships and scholarships  
$570,770
Tables

Total Fellowships $440,770

OTHER RESEARCH PROGRAMS

Walter & Eliza Hall Research Programs in 2001
Dr D. David Vaz, Andreas Strasser and Steve Gerondidakis $200,000
Medical & Scientific Activities $144,000
Total Other Research Programs $344,000

CANCER CONTROL RESEARCH INSTITUTE PROGRAMS

Epidemiology Research Centre $943,000
Behavioural Research Centre $803,000
Centre for Clinical Research in Cancer $807,000
VicHealth Centre for Tobacco Control (ACCV contribution to VicHealth Centre) $150,000
Total Cancer Control Research Institute Programs $3,575,000

ANTICANCER FOUNDATION OF SOUTH AUSTRALIA GRANTS

A/Professor L. Ashman, Division of Haematology, Hanson Centre for Cancer Research, Role of PETA-3/CD151 in epithelial cancer invasion and metastasis $60,308
Dr G. Booker, Department of Biochemistry University of Adelaide, Understanding the structure and function of the tumour suppressor actinin-4 $55,866
Dr M. Brown, Department of Medical Oncology Royal Adelaide Hospital, Investigation of the combined use of surgical castration and Flt-3 ligand or progenipoietin in novel dendritic cell-based immunotherapies in a murine model of prostate cancer $59,589
Dr T. Cleary, Department of Pathology University of Adelaide, Role of paps synthetase in growth of cancer cells in metastatic sites $61,278
Dr L. Coles, Division of Human Immunology Hanson Centre for Cancer Research, Cold shock domain proteins as repressors of VEGF gene transcription $56,866
Professor A. Ferrante, Department of Immunopathology Women's and Children's Hospital, The use of novel fatty acids to treat prostate cancer $49,197
A/Professor J. Findlay, Department of Orthopaedics and Trauma Royal Adelaide Hospital, Sensitisation of cancer cells to TRAIL-induced apoptosis $53,424
A/Professor J. Gamble, Vascular Biology Laboratory Hanson Centre for Cancer Research, Tight junctions as a target for angipoiostatin 1 $52,206
A/Professor T. Gonda, Hanson Centre for Cancer Research, Identification of potentially novel oncogenes capable of transforming myeloid cells $56,146
Dr P. Hart, Department of Microbiology & Infectious Diseases Flinders Medical Centre, Is a high dermal mast cell prevalence a significant predisposing factor for human melanoma? $58,657
A/Professor D. Horshall, Division of Haematology Flinders Medical Centre, Prognostic importance of androgen receptors in prostate cancer $45,843
Dr D. Hughes, Division of Haematology Hanson Centre for Cancer Research, Enhancing the activity of the ACK-specific tyrosine kinase inhibitor STI571 on the leukemic stem cells in CML $57,886
Dr D. Keeffe, Department of Medical Oncology Royal Adelaide Hospital, Further studies of mucositis in rats and humans undergoing cytotoxic chemotherapy for cancer $54,425
A/Professor S. Kumar, Recombinant autoactivating caspases for killing cancer cells $54,681

Division of Haematology Hanson Centre for Cancer Research, Role of the 14-3-3 family of proteins in human GM-CSF and IL-3 receptor signalling in leukemic cells $51,624
Professor P. Mackenzie, Department of Clinical Pharmacology Flinders Medical Centre, Colorectal cancer and the expression of chemical detoxifying UDP glucuronosyltransferases $56,452
Professor G. Maddern, Department of Surgery The Queen Elizabeth Hospital, Improving the safety and efficacy of electrolysis $18,585
Professor A. Morley, Department of Haematology & Genetic Pathology Flinders Medical Centre, Detection of point mutations in normal and cancer cells $54,546
Dr C. Ricciardelli, Flinders Cancer Centre, Flinders Medical Centre, Changes to the physicochemical structure of chondroitin sulphate side chains of versican and role in prostate cancer progression $58,700
A/Professor R. Richards, Department of Cytogenetics and Molecular Genetics Women's and Children's Hospital, Fragile sites in cancer: biological consequences of DNA instability at the FRA16D and FRA3B loci $64,906
Dr G. Suthers, Department of Medical Genetics Women's and Children's Hospital, kConFab: A national consortium for research into familial breast cancer $51,135
Professor W. Tilley, Department of Surgery Flinders Medical Centre, Investigation of a novel mechanism contributing to disease progression $59,993 in prostate cancer
A/Professor D. Wattchow, Department of Surgery Flinders Medical Centre, Follow-up of patients with colorectal cancer: A comparison of specialist and GP-based strategies $59,588
Dr B. Wattenberg, Division of Haematology IMVS, Anti-apoptotic function of Bcl-2, identification of a unique mitochondrial targeting protein $51,736
Dr C. Yandell, Division of Haematology Hanson Centre for Cancer Research, The role of the a-subunit in activation of the GM-CSF receptor $53,424
Dr E. Yeoh, Department of Radiation Oncology Royal Adelaide Hospital, The effects of therapeutic irradiation for prostatic carcinoma on anorectal and colonic function $49,296
Professor H. Zola, Child Health Research Institute, International workshop on human leucocyte differentiation antigens $48,000

Total $1,454,657

OTHER RESEARCH PROGRAMS FOR 2001

Two Associateships $99,312
Two Fellowships $119,236
Travel Grants $30,000
Distinguished Visitors $15,000
Student Vacation Scholarships $12,000
PhD Scholarship $25,000
Data Managers Program $80,000
Prostate Data Manager Program $20,000
Radiation Therapists $8,000
Chair in Cancer Care $100,000
Total of Other Research Programs $508,548
TOTAL RESEARCH FUNDED $1,963,205

THE CANCER COUNCIL TASMANIA RESEARCH GRANTS

Dr D. Woods, Characterising carcinogen induced immunosuppression and tumour escape $34,683

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**University of Tasmania**

- **Dr S Ragg**
  - Evaluation of the predictive significance of the methylator $44,603
  - Towards a novel differentiation therapy of leukaemia using Ceramide $44,603

- **Professor R Lowenthal**
  - Identification of optimum length of G-CSF administration prior to bone marrow stem cell harvesting $28,738

- **Dr G Woods, Dr S Ragg, Professor R Lowenthal**
  - Towards a novel differentiation therapy of leukaemia using Ceramide $45,000

- **Dr G Woods, Dr C Tramba**
  - Analysis of Mire-P-Glycoprotein in normal and leukaemia cells $20,716
  - Analysis of outpatient bone marrow transplantation (BMT) $10,682

**Total Amount Granted** $184,422

* In conjunction with the David Collins Leukaemia Foundation

**JEANNIE FOSTER FELLOWSHIPS**

- **J Burrows**
  - Oncology & Immunology Laboratory, University of Tasmania $230

- **W Ploeg & J Milner**
  - Joint application to undertake training course in complex physical therapy for the control of Lymphoedema $770

- **A Costin**
  - Royal Hobart Hospital Graduate Certificate of Loss, Grief and Trauma Counselling in South Australia $700

- **J Garnsey**
  - Cancer Council of Tasmania Attend 3rd Global Conference for cancer organisations “Facing the Challenge” $800

**Total Fellowships Awarded** $2,500

**CANCER FOUNDATION OF WESTERN AUSTRALIA RESEARCH GRANTS**

- **Dr D Elsaleh**
  - Depts of Radiation Oncology, Sir Charles Gairdner Hospital $50,000
  - Evaluation of the predictive significance of the methylator in the response of Dukes’ C colorectal carcinoma to adjuvant chemotherapy $50,000

- **Dr R Lake**
  - University Department of Medicine, Western Australian Institute for Medical Research $50,000
  - Combination of chemotherapy and immunotherapy in malignant mesothelioma

- **Dr L Fritschi**
  - Department of Public Health, University of Western Australia $48,000
  - Risk factors for cancer in a cohort of Australian veterinarians

- **A/Professor J Olynyk**
  - University Department of Medicine, Fremantle Hospital $49,717
  - Characterisation of the factors that affect liver stem cell proliferation, differentiation or malignant transformation in patients with chronic liver disease

- **Dr J Williams**
  - Laboratory for Cancer Medicine, Western Australian Institute for Medical Research $46,000
  - Generation of HLF5 knockout mice – an in vivo model for investigating the role of a potential tumour suppressor gene

- **Dr J Bentel**
  - Department of Pathology, Royal Perth Hospital $49,998
  - Measurement of expression of the NKO3.1 gene in prostate cancer

- **Professor R Donovan**
  - Centre for Behavioural Research in Cancer, University of Western Australia $50,000
  - Perceptions of cancer in the Australian population

- **Dr L Abraham**
  - University of Western Australia $49,300
  - Regulation of CD30 expression in Hodgkin’s and non-Hodgkin’s lymphoma

- **A/Professor G Youh**
  - Department of Biochemistry, University of Western Australia $49,723
  - Using the p53 nullizygous mouse to follow cellular and genetic changes

- **Dr E Williams**
  - Centre for Applied Cancer Research, University of Western Australia $50,000
  - Rational design and development of novel compounds for cancer treatment

- **A/Professor P Leadman**
  - Laboratory for Cancer Medicine, University Department of Medicine, Royal Perth Hospital $50,000

**TOTAL RESEARCH FUNDED** $186,922

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**THE CANCER COUNCIL NEW SOUTH WALES NEW RESEARCH GRANTS**

- **Dr J Wiggers**
  - University of Newcastle $31,605
  - A randomised controlled trial of a computerised smoking cessation intervention in a surgical pre-admission clinic

- **Professor D Axhult**
  - Centenary Institute of Cancer Medicine and Cell Biology $63,167
  - Identification of the specificity of potential myeloma specific clonal CD138 T cells using TCR transfectants

- **Dr A Rice**
  - University of New South Wales $112,544
  - Development of targeted immunotherapy of treat relapsed leukaemia post stem cell transplantation

- **A/Professor W Rawlinson**
  - University of New South Wales $72,487
  - The aetiology of breast cancer, and the involvement of diet, hormones and the human homologue of the mouse mammary tumour virus

- **Dr M Stockler**
  - University of Sydney $87,071
  - Antidepressants and subjective well-being in advanced cancer: a double blind randomised trial of Sertraline and St John’s Wort

**Total** $366,874

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**CONTINUING RESEARCH GRANTS**

- **Dr R Ward**
  - St Vincent’s Hospital $60,747
  - Analysis of the humoral immune response to HEP-2/neu in breast cancer using phage display

- **Dr A de Fazio**
  - Centre for Applied Cancer Research, University of Western Australia $56,009
  - Mechanisms underlying the protective effects of tamoxifen

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**OTHER RESEARCH GRANTS**

- **TWW Institute for Child Health Research**
  - Childhood cancer research project $55,000

- **Division of Health Sciences, Curtin University**
  - Centre for Behavioural Research in Cancer Control $125,000

- **Department of Public Health, University of WA**
  - WA Cancer Epidemiology project $25,248

- **School of Nursing and Public Health, Edith Cowan University**
  - Clinical research fellow palliative care nursing $25,000

- **Dr Moira O’Connor et al Schools of Psychology, Edith Cowan University**
  - Prevalence of depression in palliative care patients $10,000

- **Dr Charles Gardner Hospital**
  - F&P Registry $25,766

- **Hollywood Hospital**
  - Bone Tumour Registry $17,919

**TOTAL OTHER RESEARCH GRANTS** $283,933

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**CONTINUING RESEARCH GRANTS**

- **Ms S See**
  - Ferndale WA $1,200
  - Are liver stem cells related to bone marrow cells which belong to the lymphoid lineage?

- **Mr J Tan**
  - East Perth WA $1,200
  - Do inflammatory cytokines produced by the resident macrophage of the liver promote growth of precancerous liver cells?

- **Ms P Sappil**
  - Kalgoorlie WA $1,200
  - Are liver stem cells related to bone marrow cells which belong to the lymphoid lineage?

- **Ms H Wilson**
  - Cockburn WA $1,200
  - Are liver stem cells related to bone marrow cells which belong to the lymphoid lineage?

- **Mr P Bulthoo**
  - Fremantle WA $1,200
  - Do inflammatory cytokines produced by the resident macrophage of the liver promote growth of precancerous liver cells?

- **Ms A Chan**
  - Subiaco WA $1,200
  - Are liver stem cells related to bone marrow cells which belong to the lymphoid lineage?

**Total** $8,400

**TOTAL RESEARCH FUNDED** $381,702

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**THE CANCER COUNCIL NEW SOUTH WALES NEW RESEARCH GRANTS**

- **Dr J Wiggers**
  - University of Newcastle $31,605
  - A randomised controlled trial of a computerised smoking cessation intervention in a surgical pre-admission clinic

- **Professor D Axhult**
  - Centenary Institute of Cancer Medicine and Cell Biology $63,167
  - Identification of the specificity of potential myeloma specific clonal CD138 T cells using TCR transfectants

- **Dr A Rice**
  - University of New South Wales $112,544
  - Development of targeted immunotherapy of treat relapsed leukaemia post stem cell transplantation

- **A/Professor W Rawlinson**
  - University of New South Wales $72,487
  - The aetiology of breast cancer, and the involvement of diet, hormones and the human homologue of the mouse mammary tumour virus

- **Dr M Stockler**
  - University of Sydney $87,071
  - Antidepressants and subjective well-being in advanced cancer: a double blind randomised trial of Sertraline and St John’s Wort

**Total** $366,874

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- **Dr R Ward**
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  - Analysis of the humoral immune response to HEP-2/neu in breast cancer using phage display

- **Dr A de Fazio**
  - Centre for Applied Cancer Research, University of Western Australia $56,009
  - Mechanisms underlying the protective effects of tamoxifen
University of Sydney
on normal mammary gland
Dr P Hersey
Newcastle Mater Hospital
The role of TRAIL in induction of apoptosis in human melanoma and T cell responses to melanoma
$57,353
Dr M Norris
University of New South Wales
Molecular detection of residual disease in childhood leukaemia and its association with clinical outcome
$60,410
Dr R Bates
University of Newcastle
Investigation of the signalling role of variant CD44 in regulating apoptosis in colon cancer cells
$54,969
Dr L Florey
University of Sydney
Overcoming inter-individual variability in cancer chemotherapy
$62,114
A Professor P Butov
Royal Prince Alfred Hospital
Discussing prognosis and treatment goals with patients with metastatic cancer
$48,767
Dr B Fazekas De St Groth
Centenary Institute, Royal Prince Alfred Hospital
A pilot study of tumour RNA-pulsed dendritic cell immunotherapy in ovarian cancer
$73,407
Dr S Ackland
University of Sydney
Prospective meta-analysis: Quality of life data in two randomised trials of chemotherapy for asymptomatic metastatic colorectal cancer
$24,767
A Professor K Bradstock
Westmead Hospital
Analysis of cellular immune response to melanoma antigens after allogeneic haemopoietic stem cell transplantation
$71,224
Dr G Mann
University of Sydney
Austalian melanoma family study
$72,657
Dr P Hogg
University of New South Wales
Tumour Angiogenesis
$201,000
A Professor G Marshall
University of New South Wales
Defining the cause and improving the treatment of childhood neurlastoma.
$320,000
Professor R Sutherland
Garvan Institute of Medical Research
Steroid and growth factor signalling in the pathophysiology of breast and prostrate cancer
$400,000
Total Continuing Research Program Grants
$1,563,424
RESEARCH FELLOWSHIP
Professor R Reddell
Children’s Medical Research Institute
Carcinogenesis
$400,000
Total Research Fellowship
$400,000
OTHER RESEARCH PROGRAMS
Clinical Epidemiology Research Unit
$596,000
Cancer Education Research Program
$500,000
Hereditary Bowel Cancer Registers
$195,950
Total Other Research Programs
$1,291,500
TOTAL RESEARCH FUNDED
$3,621,798
QUEENSLAND CANCER FUND RESEARCH GRANTS
T Antalis, A Subherz and D Gotlieb
Queensland Institute of Medical Research
Evaluation of a new cancer immunotherapeutic target
$65,000
C Bain, M Moore and D Purdie
University of Queensland
Population and Laboratory Study of the Relationship of Xenoestrogens and Phytoestrogens to Ovarian Cancer
$53,500
CBadcock, T Ryon, G Michael and D Schlect
Queensland University of Technology
Development and investigation of radiation-sensitive polymer gels for measuring three-dimensional ionising radiation dose distributions in breast radiotherapy
$62,000
A Boyd, C Schmidt and A Nicol
Queensland Institute of Medical Research
Immune response to Eph and Ephrin proteins in tumours and blood disorders
$63,300
M Brown, K K Khanna and K Spring
University of Queensland
BRCAl in DNA repair and tumourigenesis
$66,500
A Bullock Eaton, R Bos and W Stanton
University of Queensland
Objective criteria for early identification of secondary arm lymphoma after breast cancer surgery
$32,273
G Chevneon-Trench, R Neubold, D Trott & E Baker
Queensland Institute of Medical Research
The identification of the colorectal cancer tumour suppressor gene inactivated on Chromosome 8
$58,894
Q Fong, P Zimmerman, J Yang, B Clarke and E Duhig
Prince Charles Hospital
Glutathione S transferase (GST) genotypes and non-small cell lung cancer
$52,895
Q Fong, B Clarke, E Duhig and P Zimmerman
Prince Charles Hospital
Smoking and gender differences in the molecular biology of lung cancer
$50,170
Q Fong, B Clarke, E Duhig and P Zimmerman
Prince Charles Hospital
Mapping the molecular changes in bronchial epithelium from smokers
$26,400
B Gabrilovich and S Goldkorn
Queensland Institute of Medical Research
What is the role of cyclix A during G2 phase of the cell division cycle?
$26,400
R Gardiner, K Ellien, C Schmidt, D Hart, G Seymour and J Dayley
University of Queensland
The association between human papilloma viruses and oesophageal cell carcinoma of the skin
$52,865
A Green, R Neale and K Ter Schegget
Queensland Institute of Medical Research
What role do dietary factors play in the development of skin cancer
$26,400
J Hancock and A Apoloni
University of Queensland
An investigation of the intracellular trafficking of K-Ras
$70,000
J Harris and G Muscat
University of Queensland
Selection, characterisation and evaluation of chemotherapeutic diTrase inhibitors
$64,162
N Hayward, G Kay and M Cummings
Queensland Institute of Medical Research
Development of Mouse Models of Multiple Endocrine Neoplasia Type 1
$64,500
C Bain, M Moore and D Purdie
University of Sydney
The role of GST-C in chronic GVHD after allogenic peripheral blood stem cell transplantation
$58,000
A Kelso
Queensland Institute of Medical Research
Functional flexibility of the CDB+ T cell response to tumour cells in vivo
$61,475
K Khanna and D Young
Queensland Institute of Medical Research
To investigate the functional link between ATM and Nbrin in DNA damage recognition
$70,000
K Khanna
Queensland Institute of Medical Research
To study the contribution of ATM gene in DNA–damage induced phosphorylation of BRCA1
$65,640
R Khanna
Queensland Institute of Medical Research
Molecular characterisation of novel Epstein-Barr virus encoded immunosupulators and their role in the cytokine T cell-mediated immune response
$26,400
R Khanna
Queensland Institute of Medical Research
Characterisation of genetic variants of LMP1 oncogene associated with nasopharyngeal carcinoma
$63,500
M Lavin and H Beamish
University of Queensland
Interaction between ATM and BLM and implications for tumourigenesis
$63,761
W Liu and K Zhao
University of Queensland
Interaction between papillomavirus and tubulin: a mechanism of virus translocation?
$50,170
G Mann, J Artken, J Hopper, R Kefferd, G Giles and B Armstrong
Queensland Cancer Fund
Australian Melanoma Family Study
$65,000
P Martin and R Saal
Princess Alexandra Hospital
Comprehensive assessment of minimal residual disease in patients with good prognostic acute myeloid leukaemia for the prediction of relapse and development of therapeutic algorithms
$35,675
N Martin and N Hayward
Queensland Institute of Medical Research
Linkage disequilibrium mapping of a gene for mole development
$60,987
P McGrath, E Conway, K Khadro and H Clerk
University of Queensland
An exploration of the usefulness of the concept of spiritual pain in palliative care
$50,280
N McMillan
University of Queensland
The role of the human papillomavirus E7 oncoprotein in the evasion of the antiviral effects of Interferon
$61,100
K Miles, M Wendorff, R Abraham, K Slaugher, B Clarke, E Duhig and Q Fong
Weiley Research Institute
Biological Correlates of CT Perfusion Imaging and FDG-PET in Lung Cancer
$26,400
D Moss, A Galbraith, S Bell, S Elliott, S Sifletis and M Sherriff
Queensland Institute of Medical Research
Defining the parameters of treatment and maintenance of adoptive immunotherapy for post-transplant lymphoma in solid organ transplant recipients
$65,000
D Nicol, E Walpole, A Johnson and J Jonsson
University of Queensland
Efficacy of Captaxin in the treatment of patients with advanced rectal cancer
$56,915
P Parsons, A Green and M Roberts
Queensland Institute of Medical Research
The molecular consequences of sunscreen application in vitro and in vivo
$52,013
R Reddall-Smith, J Jass, A Leggett and J Searle
RBH Research Foundation
Characterisation of key pathological events in the development of colorectal and hepatocellular neoplasms in patients with inflammatory bowel disease by detailed clinicopathological and molecular analyses
$56,565
N Saunders
University of Queensland
Biological Characterisation of Neoplastic Progression in Keratinocytes
$50,170
Reports

COMMUNICATION AND CANCER: COSA 2000 SCIENTIFIC MEETING

The success of COSA 2000 was largely due to the enthusiastic participation of those who attended and made the most of the interactions afforded by this multidisciplinary meeting. Over 500 people attended, including the number of registrants and strong support by the pharmaceutical industry and the Anti-Cancer Foundation of South Australia, a profitable result was achieved.

Of specific interest was the strength of the overseas attendances with registrants from Canada, Iran, Hong Kong, New Zealand, The Philippines, Saudi Arabia, Singapore, Thailand, USA, China and the United Kingdom. The attraction was the theme of the meeting Communication and Cancer which is seen as increasingly important throughout all cancer related specialties.

Communication and Cancer

This topic allowed innovations in the design of the meeting and could be broadly interpreted by each of the groups that constitute COSA. Right from early days of planning and the brief to the graphic designer to produce a logo which symbolised Adelaide and Communication in Cancer, through to the actual final program, innovations were evident. The logo depicted the city of Adelaide in a disk shape that could be variably interpreted as a communication dish or microphone. Underpinning the theme, we staged the first presentations by video-conference, utilizing for the first time the expertise available in Darwin, providing a tropical twist to the subject of febrile neutropenia.

A tangible manifestation of the theme was the commissioning of a new, supported by Aventis, which will be circulated among the registrants participating in the scientific sessions and international presentations. This gives the presentations more lasting impact and allows those who are unable to attend to review the highlights of the meeting.

Finally, in supporting the COSA Council’s desire to promote the multidisciplinary nature of the meeting (although each of the groups of COSA is responsible for designing their own pre-meeting package), a small team which organized a session did not have its name included in the final program, which resulted in a truly multidisciplinary mixture of participants in each of the sessions. Our feedback was that this was a positive move which facilitated the registrants participating in a greater range of sessions which in turn benefited from the lively multidisciplinary input.

A further highlight of the theme was the way of which each of the groups interpreted it. This ranged from the cell to cell communication that was a focus of a cancer research group seminar, through the use of mobile phones and cancer, to the areas of communication between health professionals and patients by the psycho-oncology group.

The program was well supported by the participation of our international faculty, Charles Balch, Jonathon Berek, Eric Cassel, Nessa Cossylec, William Darby, Theodore Lawrence, John Little, and Richard Sainsbury.

Opening Ceremony

We were delighted to have the meeting opened by the Hon

Dr Basil Hetzel, a distinguished clinician and researcher, who recently retired as Lt Governor of South Australia. He has made an enormous contribution to the control of idiopathic diseases throughout the world and brought his translational research and epidemiological expertise to a discussion on the epidemiology of cancer. He personified the value of interdisciplinary cooperation. His opening address provided a strong scientific start to the meeting.

Plenary Sessions

The plenary sessions were designed to cover as broad an area as possible with half-hour presentations. The first picked up the theme of the meeting. I reported on the evaluation of a Darwin/Adelaide teleconferencing link. Tabitha Healey, a medical oncology trainee, presented research into febrile neutropenia which she had performed while on rotation to Darwin. Then, Dale Fisher from Darwin presented via video-conference, a fascinating talk on melioidosis, a tropical disease that must be considered in the appropriate season, as a possible infectious agent in patients who present with febrile neutropenia.

Charles Balch, who is the Executive Vice-President and Chief Executive Officer of the American Society of Clinical Oncology, then highlighted ASCO’s role in the international oncology community. Relevant to the presentation was the suggestion that at a future COSA meeting, ASCO could have a joint symposium with COSA using video-conferencing.

The second day’s plenary featured three excellent presentations on diverse topics. Theodore Lawrence presented State-of-the-art radiotherapy, which served to educate a wider audience on this field, and also underpinned the relevance of research which is being undertaken in Australia in newer radiotherapeutic techniques. Stewart Grossman was unable to attend the meeting and Fran Boyle presented a paper in managing difficult cancer pain problems. To conclude, Eric Cassell brought a long clinical experience to bear on the use of information as a therapeutic tool in the communication between health professionals and patients.

In the final plenary Nessa Cossylec focused on the management of intractable symptoms at the ‘end of life’. This certainly included the increasing requirement for a multidisciplinary team. In the second part of the plenary, Martin Tatterson the recipient of the AMRAD/MOG award, presented a lecture which provided an overview of the development of oncology as a specialty in Australia.

Scientific Sessions

The outstanding session on the first day and certainly one that attracted most media attention was a symposium on mobile phones and cancer. Updates were provided on the Adelaide Pim-1 project and Pam Sykes’ work on the effect of radio-frequency radiation on intracranial tumors in PC21 mice. While J Finnie looked at vascular permeability in mouse brains in response to radiofrequency fields, Bernard Stewart reflected on cancers and mobile phones in relation to known hazards and Dr Bangar looked at compliance with standards and the exposure from hands free kits.

This session highlighted that there is still a lack of definite information in this field which remains a fruitful area for well conducted scientific research. Also on this first day, an all day symposium on cancer registries covered the roles and applications of registries to many areas.

The theme of the meeting was strongly underpinned by sessions in palliative care, cancer care and in cancer prevention and making, while the multidisciplinary nature of the meeting was underpinned by a session on sentinel node biopsies as it applied to melanoma, breast and gynaecological cancers.

The second day’s sessions continued the multidisciplinary theme with sessions on translational research from bench to bedside and the communication scheme in a session looking at the future of communication skills and training in cancer care. More specifically, this included 3D computed tomography, melanoma, melanoma staging and treatments, new drug development and sessions on breast and gynaecological cancer.

A workshop on issues and hope of prognosis by Eric Cassell and Martin Tatterson focused on this contentious issue in the literature.

The final day had a scientific focus on familial cancer and in an afternoon session to supplement that session looking at genetic pathways and cancer, while the communication theme continued with the assessment of patient needs and a session on the increasing use of electronic data management in cancer research.

Breakfast Sessions

The breakfast sessions proved incredibly popular with a session on difficult cancer patients having five times the number of people wishing to attend than there were places. This carried over to the next day where the New South Wales Cancer Council launched a video on a training package for health professionals on interactional skills.

Poster Sessions

A broad range of posters were presented this year. Having the posters central to the activities between oral sessions meant that they had good exposure to participants in the conference. That was certainly the case for the Young Investigator Award.

Australia’s Best, Sandy Yusuf, a student, won the Young Investigator Award with her presentation of research into an Australian cancer professional. There is much in the overseas literature on this topic but this was a study from the team at Royal North Shore Hospital on the burnout prevalence in Australia and its predictive factors. It is an ongoing project and Yusuf is a very capable student. She was a true winner of the award and augurs well for the future.

As I reflect upon the third COSA meeting that I have convened, there is no doubt that COSA has changed over the years and must play to its strength in being a national multidisciplinary body. The success of the multidisciplinary sessions in this meeting highlights that the pursuit of this focus will serve COSA well in the future. I also reflect on the organisation of the meeting itself; it is vital to have a strong organiser drawn from each of the specialties and a strong secretariat with years of experience in the logistics of such meeting.

My strongest impression of the year 2000 meeting was the number of young oncologists who participated in a broad range of sessions and strongly supported breakfast sessions and social functions such as the conference dinner with enthusiasm. The ability of COSA to change and the flexibility in trying new ways of achieving goals was well demonstrated. Meetings will maintain the enthusiasm of the membership into the scientific meetings of the next millennium.

AUSTRALIAN BEHAVIOURAL RESEARCH IN CANCER

This report is a regular feature in Cancer Forum describing behavioural applications in cancer prevention.

Australia has four behavioural research centres: the Centre for Health Promotion and Cancer Prevention Research (CHPCHR) at the University of Queensland, Cancer Education Research and Resource Centre (CERRC) in the Anti-Cancer Council of Victoria and the Centre for Behavioural Research in Cancer Control (CBRCC), Curtin University of Technology, Perth.

This report has been edited by Allison Boyes (CERP) from the reports received.

New Results

n From the Cancer Education Research Program (CERP), NSW

Community knowledge of cancer: What difference have we made in the last 10 years?

Concerted efforts have been made over recent decades to educate the Australian public about the importance of cancer prevention and control. To examine the effect of such educational campaigns, CERP investigated the current knowledge of cancer amongst the NSW community. A computer assisted telephone interview (CATI) survey was administered to NSW residents aged 15 years and older who were randomly selected from the NSW telephone directory.

Of the 1,113 eligible participants, 868 (82%) completed the survey. The results indicated that our society was able to accurately estimate the lifetime risk of getting each cancer. Although the majority of respondents were aware that smoking (96%) and excessive sun exposure (80%) are risk factors of lung cancer and melanoma respectively, deficiencies in knowledge of risk factors for bowel, breast, cervical and prostate cancer were evident. At least one symptom related to melanoma, breast and bowel cancer was known by over fifty percent of respondents. Pap smears (87%) and mammograms (82%) were the best-known cancer screening tests. Comparisons with data from a 1989 survey that used the same survey items indicated that although there was a moderate increase in knowledge of risk factors for melanoma, bowel and lung cancer, there was no increase in knowledge of symptoms. A large change in women’s knowledge of mammograms was observed between the two surveys, with twice as many women being aware of mammograms in the current survey. Overall, these results suggest that although there have been some modest increases in cancer knowledge, the risk factors, symptoms and tests of particular cancer remain poorly understood.

n From the Centre for Behavioural Research in...
The recently published Quit Evaluation Studies: Volume 10, includes a chapter by Tessa Letcher reporting the results of a study, conducted in April 2000, of the extent and type of tobacco advertising observed at point of sale in retail outlets, and whether this varies with the relative location of the outlet to secondary schools. Fieldworkers visited 222 outlets around Melbourne including milkbars, supermarkets, petrol stations and newsagents. The techniques of point of sale tobacco advertising observed were obvious visual displays such as cigarette dispensing units, display cases, pop-out advertising tag cards, illuminated signage and posters. All of these received very high prominence ratings. The brand of pattern advertising closely followed the patterns of brand preference found among adult and young smokers; the top four brands available for sale reflected this. Interviews with retail staff members were recently announced by the State Government including making it compulsory to display signs about legal age requirements at the point of sale. Such reforms are consistent with one of the strategy objectives highlighted in the National Tobacco Strategy: to prevent uptake of smoking among children and young people.

n From the Centre for Health Promotion and Cancer Prevention Research (CHP CPR)

Young children’s exposure to ultraviolet radiation

David O’Rordan has recently completed his PhD on the topic of young children’s exposure to ultraviolet radiation. His research was to investigate the level of young children’s exposure to UVR and attempt to establish the effects of factors that influence this, and to establish the incidence of mild sunburn in Victoria. This study involved children aged 0-4 years and their mothers. Within each sample, half of the children and their mothers were interviewed by researchers from CBRC. Issues explored in the questionnaire include: family support (in particular, the distances travelled by family members to protect children); stress, and toddlers’ levels of UVR exposure was examined. The results showed that infants who had been “pink or red” more often, received higher levels of UVR. However, for toddlers no significant relationship was identified for mild sunburn.

Association between personal UVR and estimates of exposure

In past studies estimates of UVR have been calculated from time reported outside and the levels of ambient UVR recorded during that time. The level of association between estimated exposure and the levels of UVR received by children with polysulphone dosimeters provided only moderate correlations. The age of the child was related to the level of association, with the infants data (r=0.42) showing a slightly higher correlation than toddlers (r=0.36). Mothers’ diary records of their child’s time outside resulted in a proxy measure of the child’s estimated UVR exposure. This approach was useful for the children 0-4 years of age. This study, as overall there was little difference in the correlations for estimated exposure (MPD) and the levels of UVR exposure in the mothers of young children and their mothers (r=0.45) or children (r=0.49).

Research in the Pipeline

n From CERP

Perceived needs among early breast cancer patients diagnosed with lymphoedema

Many breast cancer survivors will develop lymphoedema of the arm as a disabling treatment side effect. The physical morbidity suffered by women due to lymphoedema is significant. Dr Janice Perkins and colleagues are currently undertaking a study, funded by The National Breast Cancer Foundation, to measure the daily living needs, physical and psychological needs among women treated for breast cancer, who suffer from lymphoedema. The research team has developed the Lymphoedema Needs Questionnaire (LNQ) based on published literature, other need assessment instruments and focus groups with patients. The LNQ assesses a number of dimensions including information needs, psychological needs, physical and daily living needs, social interaction and concerns, needs for support and sexuality needs. The survey will be distributed to a random sample of 1,000 women throughout Australia who were diagnosed with breast cancer between 1995-1997 and who have clinically defined lymphoedema of the arm. Women will be recruited nationally through the relevant state breast cancer registries.

This study will provide the first population-based data on the needs of women with lymphoedema of the arm, and will guide the development of targeted intervention strategies to meet the identified needs.

Perceptions of cancer in the Australian population

n From CBRC

Tobacco advertising at point of sale

From the Centre for Health Promotion and Research (CHP CPR)

Research in the Pipeline

n From CERP

Patient transport project

CBRC, in collaboration with the Patients Services Development Unit at the Anti-Cancer Council of Victoria, has recently surveyed patients to examine the need for a volunteer driving service to assist patients to get to and from treatment. Over 490 patients from eight Victoria public hospitals were interviewed by researchers from CBRC. Issues explored in the questionnaire include: family support (in particular, the distances travelled by family members to protect children); stress, and toddlers’ levels of UVR exposure was examined. The results showed that infants who had been “pink or red” more often, received higher levels of UVR. However, for toddlers no significant relationship was identified for mild sunburn.

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Cancer in the Bush – Optimising Clinical Services

Cancer specialists from across Australia gathered in Canberra in March to identify the problems facing people with cancer who live in rural Australia.

The Cancer Council Australia, the Clinical Oncological Society of Australia and the Commonwealth Department of Health and Aged Care collaborated in organising a meeting to review access, equity and quality in the provision of cancer services in rural and remote Australia.

More than 130 medical practitioners, nurses, other health professionals, consumers and representatives of Federal and State Governments attended the first “Cancer in the Bush” conference held in March.

Delegates considered issues facing cancer patients in rural areas in accessing quality medical, surgical and radiation therapy treatments, palliative care and psychosocial support.

The outcomes of the conference are based on recommendations to be presented in the meeting report to the Federal Government.

The meeting was supported by a grant from Macquarie Bank Ltd and assistance was also given by Telstra Countrywide and Integrated Vision.

World Cancer Day

This year, around the world, 10 million people will be diagnosed with cancer. Despite advances in prevention and treatment, the World Health Organisation estimates that within 20 years there will be 20 million new cases and 11 million deaths annually.

In recognition of the increasing global burden of cancer, February 4 has been declared “World Cancer Day”. It is the anniversary of the first World Conference on Reducing the Odds is set another milestone.

The first World Cancer Day on Sunday 4 February this year was marked by a special Inter-Faith Event hosted by The Cancer Council Australia at the University of Sydney’s Great Hall.

Jewish, Christian and Islamic speakers presented religious perspectives on cancer. They were accompanied by musical or spiritual interludes, including a performance by the Greek Millennium Choir (including the Olympic Hymn, as performed at the opening of the 2000 Olympic Games), a recitation from the Holy Quran, and a performance of a Psalm from the Dead Sea Scrolls by sacred music duo Kim Cunio and Heather Lee.

Cancer survivors Joel Nathan and Robyn Wicks spoke about their personal spiritual responses to the challenge of cancer.

It was a unique and moving ceremony, incorporating an opportunity for attendees to sign the Charter of Paris Against Cancer – a pledge by individuals and associations around the world to fight cancer and improve the quality of life of people with cancer.

Professor Alan Coates, CEO of The Cancer Council Australia, said World Cancer Day was a way of drawing attention to cancer as a global public health problem. “World Cancer Day is an opportunity to reiterate commitments, organisations and individuals that unless we commit to a major investment in research and improved prevention and treatment, cancer will continue to be a major killer and will remain both here and around the world,” he said. “The fight against cancer is one of the great challenges of the next century, and it’s a fight that transcends state and national borders.”

Recognising the contribution of volunteers

More than 20,000 volunteers support the efforts of state and territory cancer organisations to reduce the impact of cancer on communities across Australia.

In recognition of the important contributions of our volunteers, last year the state and territory cancer organisations – working together as the Australian Cancer Society – developed Principles for Volunteer Involvement and Management. The Principles detail our commitment to maintaining and improving volunteer programs and ensuring effective outcomes for staff, clients, volunteers and the community.

Sandy Hollway, Chairman of the NSW Advisory Committee for the Sydney Organising Committee for the Olympic Games and a member of the Sydney Organising Committee for the Olympic Games – presented copies of the Principles to volunteers representing each of the state and territory cancer councils at a ceremony in Sydney on February 5.

State and territory cancer councils will be organising events throughout this year to acknowledge the contributions of long-serving volunteers and encourage more people to consider volunteering as a positive way to contribute to their community.
Men diagnosed with prostate cancer seek information which can help them understand the disease and make treatment decisions. They seek this preferentially from their health care professionals, who often have difficulty accessing the information they need. This book written by a Urologist with many years of experience in its treatment has the potential to be a valuable resource. Dr Stephens’ family experience with cancer should provide personal insights into the patient experience.

The first three chapters provide a clear explanation of the nature of the prostate and prostate cancer, setting the latter within the general context of cancer. The descriptions deal clearly and concisely with the subject matter, as do many of the following sections in the book. The inclusion of chapters on evidence-based medicine (EBM), the relationship between patients and doctors and case studies are useful aspects.

The author has clearly made a decision to avoid using statistics to describe rates of complications and disease recurrence after treatment, and there may be many patients who would agree with this approach. However to others needing to assess the likelihood of, for example, erectile dysfunction after treatment, this would be a disappointment.

It was sometimes not clear to the reviewer whether the author was writing for the patient or for other health professionals. The section on evidence-based medicine, for example, is more a justification of a personal view (ambivalent), than a clear description of what EBM is, and how it can aid decision-making.

Surgery and radiation treatment provide detailed descriptions which are of great value to patients trying to understand the experience of treatment. However some of these details, such as admission one to two days before the surgery, extensive bowel preparation, length of stay and post operative care reflect earlier rather than current practice.

Dr Stephens has used some outdated terminology such as “impotence” instead of erectile dysfunction and statements such as “impotence” is almost inevitable after full-dose radiotherapy (p65) are incorrect. Because the effects of treatment on erectile dysfunction are a particular concern to men, significant omissions include mention of nerve sparing radical prostatectomy and the likelihood of retrograde ejaculation after a TURP. It would have been useful to include the excellent resources provided by the NSW Cancer Council under “Further Reading”.

Many commentators on evaluation of patient education materials now recommend that these be evidence-based. No referencing is included in this book. This lack of referencing plus personal recommendations, such as that on page 28, re taking the concentrated sulfonamide tablet daily, place the book in the category of “personal view”.

Patients making difficult decisions need the best available evidence, presented to them in the way they find most useful. This book would have benefited from a more “evidence-based” approach. There is a gap for books reflecting a personal view, and despite some dated content, this book is very readable and contains much information of value. It is probably a good idea for clinicians to read it before recommending it to patients to ensure the content is consistent with their own practice.

Cancer: How Worthwhile is Non-Curative Treatment

M Slevin

Published by Springer (1998)


This 310 page book is one volume of publisher Springer-Verlag’s “Focus on Cancer” series. Each issue is devoted to a well-defined theme (i.e. basic science, clinical application, diagnostic modalities, treatment, complications of cancer and psychosocial problems). The editors, Slevin and Tait, offer this book as a concise overview of general aspects on the current state of the art in the non-curative but active treatment of cancer, intending this for the busy specialist oncologist and other medical practitioners involved in the treatment of cancer.

The contributors are 30 UK oncologists (with three token overseas guests). The paperbacks are divided into three sections (non-curative surgery, non-curative radiotherapy and non-curative chemotherapy) with each section dealing with various tumour types. All of the information presented can be obtained in most standard textbooks of oncology and there are already several currently available that are targeted at various levels of oncology experience.

This book is out of date. The latest published reference that I could find is 1995, most references are from the 1970s and 1980s. The chemotherapy section reads like ancient history. The specialist oncologist will not learn any new information by reading this book.

I do not believe this textbook adds any significant contribution to the increasing number of smaller oncology textbooks and I do not recommend it.

A Bonaventura

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Cancer Chemotherapy and Biological Response Modifiers

H M Pinedo, D L Longo & B A Chabner (Eds)

Published by Elsevier (1999)


Although it is not clear from the title, this book is actually volume 18 of an annual series. This has major implications for the nature of the text and makes it an archival volume rather than a stand-alone review of the field. This is made all the more so by the fact that the literature surveyed is that published in series 17 and 18. Of these three fields, the book starts from the premise that the reader has a good knowledge of what went before.

Consequently, it is a book for the cognicenti, and I doubt that it would make a good teaching text or provide a point of entry to the book to biological chemotherapy for the novice.

It is a compilation by many authors – about 70 are listed as contributors – and, like Gaul, it’s divided into three parts: Drugs, Biological Response Modifiers, and Tumors. The editors are particularly distinguished. Curiously, in such a large book, there are only a handful of displayed items. Whilst this is generally not a problem, articles about Drugs are easier to comprehend when the mind is focused on molecular detail by clear structural formulae. I didn’t find one in this book.

The text is of a high standard and is tightly written throughout. Under the drugs rubric there are eight chapters on antimitaboletes, bleomycins, mitomycins, taxanes and other microtubule stabilising agents, topoisomerase I poisons, topoisomerase II poisons and inhibitors, and cisplatin. The main focus is mechanism of action, experimental antitumour activity and clinical trial data. There is also a chapter on new antineoplastic agents that includes a selection of angiogenesis inhibitors, antimicrotubule agents, cyclin-dependent kinase inhibitors, DNA interactive agents, fluoropyrimidines, nucleoside analogues, platinum analogues, signal transduction inhibitors, thymidylate synthase inhibitors, and topoisomerase I inhibitors.

By its very nature, this latter chapter is exciting and its a pity not more room was devoted to it.

There are some redundancies between elements of the new agents chapter and the earlier chapters that included analogue development. Finally, there is a chapter on multidrug resistance that concentrates on the basic biology of the MDR1/PgP and MRP1 genes and their expression in tumor samples. Only a little is said about reversal agents.

The four chapters on Biological Response Modifiers are the shortest section of the book and cover monoclonal antibodies, a wide variety of BRMs, adoptive immunotherapy, and hematopoietic growth factors. This section is the least satisfactory, which may be because of the position these modalities hold in clinical therapy, or may be because of space restrictions imposed by the editors. Its not clear which holds sway, perhaps its a bit of both. In any event, one feels that the field of biological response modifiers has not been well-served by its presentation in this context.

On the whole, the 14 chapters on Tumors start with little introduction about the biology of the disease and delve straight into accounts of clinical reports from the perspective of particular tumour types. There are exceptions to this rule which appear to relate to when the tumor type was last featured in the review series. The subjects covered include leukemias and plasma cell myeloma, non-Hodgkin’s lymphoma, paediatric solid cancers, tissue and bone sarcomas, melanoma, cancers of the head and neck, lung, upper GI tract, large bowel and hepatobiliary tract, breast, and brain, and endocrine, genitourinary and gynaecological tumours. This section of the book is particularly helpful since it gives succinct, but detailed, accounts of the effectiveness, or otherwise, of chemotherapy over a wide range of diseases, and disease states.

If you have been collecting this series then it would be sensible to add this volume to your collection, if you can afford it. However, if you haven’t, there are probably better ways of spending your money. Of the four series published so far, this one is particularly since the book is now a little “out-of-time” as it describes developments in the years 1996 and 1997 and we’re already in 2001.

L WakeLin

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Cancer in the Elderly

Cancer Forum - Volume 25 Number 1 - March 2001

Hitchins

LAllamanda Medical Centre

Southport, Qld

Controversies in Neuro-Oncology

T Weigel et al (Eds)

Published by Karger (1999)


This publication is part of a series, “Frontiers of Radiation Therapy and Oncology”, originally founded by Jerome Vaeth in 1968. It represents the proceedings from the Third International Symposium on Special Aspects of Radiotherapy, Berlin, Germany, April 30 – May 2, 1998.

The aim of the symposium was to provide an update on major advances in non-invasive and minimally invasive cancer therapy, neurosurgery, chemotherapy, neuropathology, diagnostic techniques and experience with radiotherapy of the central nervous system.
The intended readers of the publication include all clinical sub-specialists of neuro-oncology, with a particular emphasis on radiation oncology.

Topics include technical innovations, management of cranio-opharyngioma and glioblastoma, radiation tolerance and the treatment of brain metastases. The section on technical advances contains an excellent overview of the role of PET scanning, the use of MRI for mapping eloquent areas of the brain, micro-multi-leaf collimators for conformal stereotactic radiosurgery and boron-neutron capture therapy and intra-operative radiotherapy.

The discussion on glioblastoma covers current best practice and explores new approaches with intracavitary drugs, gene therapy and fractionated conformal stereotactic radiosurgery. There is an excellent overview of current knowledge on the radiation tolerance of the central nervous system that revises former concepts that may have lead to overly conservative practices. The pathogenesis of radiation injury is reviewed with a focus on the care of patients with malignant brain tumours when the white matter necrosis is vascular. The section on the management of brain metastases raises the debate on why stereotactic radiosurgery should be considered the better option over surgery for solitary lesions.

The textbook mode of gaining new knowledge is limited by the fact that “cutting-edge” information is outdated by the time of publication and access by most readers. The pages were selected mainly from a local faculty and reports from single institutional studies were of limited value. For the busy clinician, a presentation in evidence-based format might have been more helpful. The book would be of most interest to those who enjoy reading about a sub-specialty area of oncology in depth although selected papers provided comprehensive overviews for generalist readers.

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Death and Dying in Australia

Allen Kellehear (Ed)
ISBN: 0 19 551150 2

This book has contributions from 29 people, mostly Australian, looking at death and dying at the end of the twentieth century in Australia. Although several books have looked at dying in Australia, this book looks at predominantly the sociology of death and dying. This book is a rich source of information which compliments the other works to come out of Australia in the late 1990s regarding death and society.

The book is divided into three. The first section looks at death and dying, including cultural diversity, gender and burial customs and the role of belief systems. The second section looks at dying and importantly concentrates on dying in predictable ways. Other than suicide, it does not look at traumatic deaths. The two subsections covered include cancer, HIV/AIDS, children and ageing. There is an important chapter by Michael Barbato on the phenomena that occur around death.

The third section looks at death and the professions. An interesting omission, especially in the context of the changes of the twentieth century in looking after the dead, is no contribution from anyone in the funeral industry. There are however contributions from palliative medicine, palliative nursing, allied health, pastoral care, law, philosophy and psychology.

The overall strength of this book is the wonderful group of contributors who have been marshalled by Professor Kellehear to contribute. Philip Adams, with the wonderful line “death helps prevent boredom”, has his usual lacunar look at society and its relationship to a difficult topic. John Collins’ chapter on childhood death is an excellent overview.

Most poignant, however, are the personal viewpoints. There are contributions by a woman dying of metastatic breast cancer and a mother who lost a teenage son to leukaemia. In the midst of erudite dissertations, it is arresting to be reminded of the overwhelmingly raw and human face of mortality. At the end, it is a personal journey and whatever society’s norms, that journey reflects the life of the person.

For a book that is about death and dying in Australia, it is sad that there isn’t a greater coverage of the belief systems and rituals surrounding indigenous death. For a uniquely Australian account this would certainly strengthen the book. There is also little discussion of the impact of maternal and neonatal mortality, traumatic death (especially war) and the attrition of social upheaval.

Overall, this book is excellent reading. The style flows well and the editing has been tight, producing a work for which there is a ready market. It is a book worth on the bookshelf for anyone associated with people facing a life-limiting illness.

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Dose and Timing: The Pillar of Successful Chemotherapy

G Rosti (Ed)
Published by Elsevier (1998)
ISBN: 0 444 89698 7

This 129 page book is the third of a series, of European School of Oncology Scientific Updates, written by various authors and edited by G Rosti. The book was on the Prognostic and Predictive Value of PS3, Volume 2 on Cancer in the Elderly: A Nursing and Medical Perspective. Although not reflected in the title, this book was on chemotherapy. The book contains 10 articles (some with single authorship, others with multiple contributors). Three deal with breast cancer, two with lymphoma, one each with testicular cancer, the EBMT database and lung cancer and a concluding article.

Unfortunately, many of the comments made in the chapters on breast cancer have already been overtaken by several abstracts presented at ASCO 1999 (Plenary Session: Abstracts 2, 3, 4, and A4) and Vol 18, 1999) and much of the discussion in the absence of completed Phase III trials is theoretical. No mention was made of the Australian Study and the literature review is not comprehensive. The presentations are very good and there is paucity of tables and lack of details of some of the studies presented. There is a bias towards American data. The three articles on breast cancer are partly repetitive, presenting similar data. The titles are enticing and interesting, e.g. Temporarily chemotherapy in lung cancer: The proper dose at the proper time, but the contents don’t reflect this.

The best (and shortest) presentation is the article on lymphoma and solid tumours. The first line tells it the way it is: “Far more is believed and hoped for in the area of high dose chemotherapy than is achievable.” The EBMT, (European Group for Blood and Marrow Transplantation) Database is interesting. Fifteen thousand patients have had autologous stem cell transplantation (ASCT) for blood cancers (2,500 patients, breast cancer 2,163, multiple myeloma 1,800). It is disappointing that such a large number of patients have been treated but not at randomised clinical trials. Selective ongoing studies are mentioned and it is interesting to see what the Europeans are doing.

This series offers some insight of ongoing research in certain institutions but fails to be an overview of current knowledge. The articles are written with no unifying themes and editing has not been tight. I would not recommend buying this book, but a copy for the library would be appropriate.

A Bonaventura
Dept of Medical Oncology
Newcastle Mater Misericordiae Hospital
Newcastle, NSW

Lung Cancer – Principles and Practice

H Pass et al (Ed)
Published by Lippincott Williams & Wilkins
ISBN: 0 87817 179 7

This second addition of Lung Cancer Principles and Practice is a three-year update of a book intended as a comprehensive reference for anybody with an interest in lung cancer. The format remains the same but the title reflects the new elements of genetic susceptibility that are in a separate chapter.

The editors note that the proliferation of information on cell biology of lung cancer has led to inclusion of details of FHT, Telomerase and erb B-2 as well as to the intricacies of the cell cycle and angiogenesis. Lung cancer immunology and gene therapy are completely updated. The newest elements of genetic susceptibility are in a separate chapter. Technical changes in processing material for molecular evaluation are discussed, as is the use of these techniques in defining pro-neoplasia on the chromosomal genetic level. The newer improved cytotoxic agents and their interaction with radiation is a welcome up date. Presentation of the book is traditional and a little dry. However all the information is there, but it is extremely well referenced at the end of each chapter and well indexed overall. For example for the chapter on Biology of Lung Cancer, General Concepts there were 574 references. Overall it is not the type of book one normally expects to cover but rather reference from time to time. In the surgery area combined cancer resection and lung volume reduction surgery is addressed but there may be a bit too pre-operative preparation of the patients. Basically surgeons don’t want patients to just scrape through surgery, and all the barrage of tests to assess patients with borderline lung function are discussed, but as we all know, the management of lung cancer is multi-disciplinary, this book certainly covers all areas and for each person managing lung cancer the details of others’ specialties is excellent.

Overall, for its price, it is very good value and having a book like this on the shelf would obviate the need for medicine searching etc, when researching special areas in lung cancer for basic and use to date information.

P Cole
Monash Medical Centre
Clayton, Vic

Methotrexate

B Constent et al (Eds)
Published by Birkhauser (2000)
ISBN: 3-7643-5995-9

It’s been said that many people have got a PhD from studying methotrexate than have been cured by the drug. However, this lacunary book is about the use of methotrexate in combination with a drug that cured the first patient with metastatic cancer and is still in routine use a half a century after its development. If methotrexate is like the 1960s rock-band the Rolling Stones then this book is like the back catalogue. A significant moment in this drug’s history is in the past, but it keeps doing world tours and has triggered off a trail of drug-discovery that has revolutionised the way we treat cancer and some inflammatory diseases.

This small book is not just about cancer. In fact over 50 per cent of the book is dedicated to methotrexate’s use in inflammatory disorders such as rheumatoid arthritis. There is even a small chapter on use in ectopic pregnancy. Even though these diseases don’t directly involve the oncologist it will be worth having these chapters available for ready reference. The next time the gynaecology registrar rings you to double check how methotrexate should be given. The chapters on rheumatoid arthritis highlight the unusual toxicities associated with chronic oral administration. They also raise the idea that the anti-inflammatory effect of methotrexate is not solely through anti-folate activity but may also involve anti-T cell activity, modulation of humoral activity and polyamine production. Could these mechanisms also be involved in its anti-cancer effect?

However, for the average oncologist and pharmacologist, the chapters relating to methotrexate and cancer are where the money is. Methotrexate – a drug we all know the back of our hand? Perhaps, but I’ve been taking the back of my hand for granted lately. There are things going on there that I haven’t been paying proper attention to. Methotrexate is laid out in the 50 page section on cancer, is like a microcosm of the development of medical oncology. Methotrexate was the first ‘designer drug,’ developed rapidly after the initial erroneous hypothesis that feeding folate to patients with leukaemia might kill the cancer was proved contrary. The labourious identification of mechanisms of action, drug resistance, drug interactions and drug elimination have laid the foundation for study of all other cytotoxic drugs. New mechanisms of resistance and transport have been at the heart of this research and the search for new targets have spurred the discovery of new drugs such as toremux and the multi-targeted anti-folates. This book should be read by every training medical oncologist and clinical pharmacologist not just for gaining knowledge about methotrexate but to gain a greater understanding of the history of cytotoxic drug development last century.

The references at the end of each chapter read like a ‘Who’s Who’ in oncology from 1960 to 1990. Like the Rolling Stones ‘best of’ CD, the story of methotrexate development keeps getting played over and over and is still just as enjoyable and probably

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Multimodality Treatment of Lung Cancer

A Skarin (Ed)
Published by Marcel Dekker (2000)

This book is volume 140 of an ongoing series with the underlying theme of lung biology in health and disease. An examination of the titles of the prior volumes plus the planned volumes in preparation indicates that lung cancer is not seen as a central topic to the target audience of these volumes. Thus, of 142 published volumes with a further 10 in preparation, only seven have been devoted to lung cancer and of these only two previous volumes have addressed the treatment of this most common cause of cancer death.

I suspect that most persons interested in lung cancer treatment would consider “multimodality” to mean the use of several different anti-cancer approaches, either concurrently or sequentially, to improve the success rate above that of single therapies alone. If this is what you expect from this book, then you will be sadly mistaken. The 18 chapters therein address all aspects of the management of non-small cell and small cell lung cancers, but are virtually all “single agent” chapters with only three chapters specifically devoted to multimodality treatment.

There is a brief first chapter on lung cancer biology, a chapter on chemo-prevention, and a couple of chapters on staging. Most chapters are referenced up to 1996 with some inclusion of other authors, who also have a significant reputation in prostate cancer. At the title indicates this book relates to predominantly the management of prostate cancer by radiotherapy. The two previous volumes have in part addressed the treatment of this malignancy, to provide individual chapters.

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The Essentials

M Bernstein et al
Published by Thieme (2000)

This book is an excellent introduction to the world of neuro-oncology and given the modest number of pages is comprehensive, although it does not attempt to be encyclopaedic. I found it well thought out and generally easy to read. A particularly attractive feature was the highlighting of key points and controversies in text boxes, as well as the highlighting of pearls in a similar manner. This was useful for browsing through a chapter. Tables are used well, and the illustrations (mostly MRI images) were clearly reproduced.

The topic coverage is wide, including epidemiology to molecular biology, general discussion on treatment modalities including surgery, radiotherapy, chemotherapy and novel therapies. The use of the various neuroimaging techniques was also covered extensively. I found the review on MRI spectroscopy to be particularly enlightening for this emerging technique.

In addition, the tumours that are dealt with include the most common such as intracranial gliomas to rarer types, such as plasmocytoma and neuroblastomas.

I found discussion of novel modalities such as hyperthermia and gene therapy to be interesting and made an appreciation of the possibilities and difficulties apparent, although they received equal space to more established forms of therapy.

The discussion of newer radiation techniques such as IMRT, stereotactic radiotherapy, proton beam radiotherapy etc were very clear and appropriate overall.

The test does not deal with many of the neurologic complications of systemic cancer, other than metastatic disease to brain. These topics have been dealt with in book form by others, so this is not a fatal flaw. Overall, I enjoyed the book and would recommend it as a guide for general practitioners.

A brief and uncritical.

The presence of a chapter on chemotherapy in this book appears to be a mystery until one comes across a statement that all patients have an hepatic artery catheter placed for regional chemotherapy: unfortunately the exact date is not stated. However the lack of any local control at all makes this one just more complicating factor in assessing the benefits of cryotherapy.

The final chapter on regional chemotherapy is also difficult to completely understand. The first part of this chapter deals with the CNS and the intrapleural space. The paragraph on the diagnosis of leptomeningeal disease ignores the use of MRI as a diagnostic modality. The subsequent section on intra-carotid infusions could have been usefully expanded as this is an area that is relatively unknown and the therapeutic potential is very limited. Sections on intrapleural therapy focus mainly on chemical pleurodesis for effusion.

In summary, this book is of limited interest except as a guide to someone inclined to write a more definitive text on this subject.

Regional Chemotherapy Theory and Practice

D J Kerr and C S McArdle (Eds)
Published by Harwood (2000)

Demonstrating the clinical benefits of regional chemotherapy remains the holy grail for some clinical researchers. A major problem is the use of data from uncontrolled clinical trials as evidence of benefit.

This short book of only 100 pages tries to supply a conceptual and scientific basis for “a revolution in the use of cytotoxic drugs”. The preface calls it a textbook but the contents are too controversial and imprecise to justify that label.

The first chapter is a rather dense and mathematical discussion of the pharmacokinetics of regional therapy. The next chapter looks at the use of intraperitoneal chemotherapy. Although not specifically stated, the clinical data is restricted to ovarian cancer. There is a comprehensive overview of the pros and cons of this specific approach.

The discussion on the use of regional chemotherapy for colorectal liver metastases mainly represents the experience of the group in Edinburgh. It lacks information about a number of recent advances. The fourth chapter is on melanoma. It appears to have been written some time ago. For example it ignores the final report on the international multi-centre randomised study of adjuvant perfusion published in the Journal of Clinical Oncology in September 1998.

The chapter on breast cancer seems to ignore the generally accepted belief that micrometastases are present in many patients at the time of presentation and therefore systemic therapy is appropriate, even for preoperative treatment.

The next chapter returns to the subject of colorectal cancer, this time examining portal vein perfusion. Why it does not follow chapter three is a mystery. It contains a good description of the basis of this technique. However the clinical data are very brief and uncritical.

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Radiotherapy of Prostate Cancer

C Grace and et (Eds)
Published by Harwood (2000)

At the title of this book relates to predominantly the management of prostate cancer by radiotherapy. The two authors, who have considerable reputations themselves in the management of prostate cancer, have collected a number of other authors, who also have significant reputation in the management of this malignancy, to provide individual chapters.

The significant strength in this book is that it is divided into

141 previous volumes of this series, then he/she will probably need to purchase one this. For the rest of us though, there are better uses for the US$159 that this book will cost.

M Millward
Royal Prince Alfred Hospital
Camperdown, NSW

Neuro-oncology: The Essentials

M Bernstein et al
Published by Thieme (2000)

This book is an excellent introduction to the world of neuro-oncology and given the modest number of pages is comprehensive, although it does not attempt to be encyclopaedic. I found it well thought out and generally easy to read. A particularly attractive feature was the highlighting of key points and controversies in text boxes, as well as the highlighting of pearls in a similar manner. This was useful for browsing through a chapter. Tables are used well, and the illustrations (mostly MRI images) were clearly reproduced.

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**November** |                                                      |           |                                                          |                                                           |
<p>| 28-30  | 28th COSA Annual Scientific Meeting                  | Brisbane | Mr Lawrie Wright Secretariat                             | Clinical Oncology Society of Australia Inc                 |
|        |                                                      | Qld       | Clinical Oncology Society of Australia Inc               |                                                           |
|        |                                                      |           | GPO Box 4708, Sydney NSW 2001                            |                                                           |
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|        |                                                      |           | Email: <a href="mailto:cosa@cancer.org.au">cosa@cancer.org.au</a>                                |                                                           |
| 28-30  | 29th Annual Scientific Meeting – COSA                | Sydney    | Mr Lawrie Wright Secretariat                             | Clinical Oncology Society of Australia Inc                 |
|        |                                                      | NSW       | Clinical Oncology Society of Australia Inc               |                                                           |
|        |                                                      |           | GPO Box 4708, Sydney NSW 2001                            |                                                           |
|        |                                                      |           | Ph: 61 2 9380 9022 Fax: 61 2 9380 9033                  |                                                           |
|        |                                                      |           | Email: <a href="mailto:cosa@cancer.org.au">cosa@cancer.org.au</a>                                |                                                           |
| 15-19  | 6th International Symposium on Paediatric Pain “Pain in Childhood: The Big Questions” | Sydney | Dianna Crebbin                                          |                                                           |
|        |                                                      | NSW       | Director, DC Conferences Pty Ltd                         |                                                           |
|        |                                                      |           | P O Box 571, St Leonards NSW 2065                        |                                                           |
|        |                                                      |           | Ph: 61 2 9439 6744 Fax: 61 2 9439 2504                  |                                                           |
|        |                                                      |           | Email: <a href="mailto:mail@dcconferences.com.au">mail@dcconferences.com.au</a>                         |                                                           |</p>
<table>
<thead>
<tr>
<th>Date</th>
<th>Name of Meeting</th>
<th>Place</th>
<th>Secretariat</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>17th International Congress Royal Thai College of Obstetricians and Gynecologists: The Fetus as a patient</td>
<td>Thailand</td>
<td>Secretariat</td>
</tr>
<tr>
<td>18-20</td>
<td>2nd Asian Congress for Gynecological Oncology</td>
<td>Bangkok, Thailand</td>
<td>2 Soi Sovawat New Petchburi Road, Bangkapi Bangkok 110320</td>
</tr>
<tr>
<td>28-2 May</td>
<td>ACOG American College of Obstetricians and Gynecologists Meeting</td>
<td>Chicago, USA</td>
<td>ACOG American College of Obstetricians and Gynecologists Meeting</td>
</tr>
<tr>
<td>1-5</td>
<td>7th Congress of the European Association for Palliative Care (EAPC)</td>
<td>Palermo, Sicily, Italy</td>
<td>7th Congress of the EAPC, Keness International, Tel Aviv, Israel</td>
</tr>
<tr>
<td>6-8</td>
<td>5th International Conference on fighting Asian Cancers in the New Century of the Asia Clinical Oncology Society</td>
<td>Taipei, Taiwan</td>
<td>N. Sung and G. J. Pu, Taiwan Cooperative Oncology Group (TCOG),</td>
</tr>
<tr>
<td>17-20</td>
<td>1st Multidisciplinary Colorectal Cancer Congress</td>
<td>Noordwijk, The Netherlands</td>
<td>Congress Care: 1st Multidisciplinary Colorectal Cancer Congress, PO Box 440, 520, AK’s Herroogenbosch, The Netherlands</td>
</tr>
<tr>
<td>21-24</td>
<td>ESGO 12 – International Meeting of Gynaecological Oncology</td>
<td>Venice, Italy</td>
<td>Key Congress and Communications S.r.l., Padova, Italy</td>
</tr>
<tr>
<td>22-26</td>
<td>7th International Congress on Oral Cancer</td>
<td>The Hague, The Netherlands</td>
<td>Advanced Travel Partners, Congresses and Meetings, The Hague, The Netherlands</td>
</tr>
<tr>
<td>22-2 May</td>
<td>21st Annual Hospice &amp; Palliative Care Study Seminar in Britain</td>
<td>London, UK</td>
<td>Hospice Education Institute, Essex, Connecticut, USA</td>
</tr>
<tr>
<td>26-30</td>
<td>4th International Congress on Lung Cancer</td>
<td>Athens, Greece</td>
<td>FORUM International Congress Organizers, Thessaloniki, Greece</td>
</tr>
<tr>
<td>30-2 May</td>
<td>30th International Gastric Cancer Congress</td>
<td>New York, USA</td>
<td>M.S. Karpeh, MD, Memorial Sloan-Kettering Cancer Center, New York, NY, USA</td>
</tr>
<tr>
<td>May</td>
<td>2-4 UICC Familial Cancer Project and International Oncology Conference</td>
<td>Beijing, China</td>
<td>Chinese Academy of Medical Sciences, Beijing, China</td>
</tr>
<tr>
<td>2-5</td>
<td>14th Annual Scientific Meeting of the European Association for Cancer Education</td>
<td>Antwerp, Belgium</td>
<td>E.M.L. Haggagdoorn, MD, Director WGO-OCCE, Haren, The Netherlands</td>
</tr>
<tr>
<td>4-8</td>
<td>8th International Myeloma Workshop</td>
<td>Banff, Alberta, Canada</td>
<td>National Research Council of Canada, Ottawa, Canada</td>
</tr>
</tbody>
</table>

### May (continued)

<table>
<thead>
<tr>
<th>Date</th>
<th>Name of Meeting</th>
<th>Place</th>
<th>Secretariat</th>
</tr>
</thead>
<tbody>
<tr>
<td>13-15</td>
<td>37th Annual Meeting of the American Society of Clinical Oncology (ASCO)</td>
<td>San Francisco, USA</td>
<td>American Society for Clinical Oncology, Alexandria, Virginia, USA</td>
</tr>
<tr>
<td>17-20</td>
<td>26th Annual Congress Oncology Nursing Society</td>
<td>San Diego, USA</td>
<td>P. Moore, Oncology Nursing Society, Pittsburgh, PA, USA</td>
</tr>
<tr>
<td>June</td>
<td>2-7 96th Annual Meeting of the American Urological Association</td>
<td>Anaheim, CA, USA</td>
<td>European Association for Urology, Arnhem, The Netherlands</td>
</tr>
<tr>
<td>3-6</td>
<td>7th Central European Lung Cancer Conference &quot;Lung Cancer: the right approach for the right patient&quot;</td>
<td>Prague, Czech Republic</td>
<td>7th CELCC, Conference Partners, Prague, Czech Republic</td>
</tr>
<tr>
<td>3-8</td>
<td>15th World Congress of Sexology</td>
<td>Paris, France</td>
<td>Regimedia Scientific Secretary Parisco</td>
</tr>
<tr>
<td>13-16</td>
<td>11th Conference of the European Society for Psychosocial Oncology</td>
<td>Heidelberg, Germany</td>
<td>Psychosoziale Nachsorgeinrichtung Chirurgische Universitätsklinik</td>
</tr>
<tr>
<td>15-3</td>
<td>3rd Milan Breast Cancer Conference European School of Oncology</td>
<td>Milan, Italy</td>
<td>European School of Oncology, Viale Beatrice d’Este 27, 20122 Milan, Italy</td>
</tr>
<tr>
<td>13-16</td>
<td>4th UICC Cancer Management Meeting &quot;European Cancer Control&quot;</td>
<td>Paris, France</td>
<td>Institut Gustave Roussy</td>
</tr>
<tr>
<td>13-16</td>
<td>11th Conference of the European Society for Psychosocial Oncology</td>
<td>Heidelberg, Germany</td>
<td>Psychosoziale Nachsorgeinrichtung Chirurgische Universitätsklinik</td>
</tr>
<tr>
<td>14-16</td>
<td>12th International Symposium &quot;Supportive Care in Cancer&quot;</td>
<td>Copenhagen, Denmark</td>
<td>Imexus USA, Inc., Alpharetta, GA, USA</td>
</tr>
<tr>
<td>17-20</td>
<td>18th International Conference on Human Tumor Markers</td>
<td>Riga, Latvia</td>
<td>Latvian Oncology Center, Riga, Latvia</td>
</tr>
<tr>
<td>21-24</td>
<td>6th European Haematology Association Congress (EHA)</td>
<td>Frankfurt, Germany</td>
<td>EHA, Eurocongress Management Conference, Amsterdam, The Netherlands</td>
</tr>
<tr>
<td>Date</td>
<td>Name of Meeting</td>
<td>Place</td>
<td>Secretariat</td>
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</tr>
<tr>
<td>August</td>
<td>6th International Summer School of Oncology for Medical Students</td>
<td>Groningen, The Netherlands</td>
<td>J. de Vries, MD, PhD, Surgical Oncologist, WHO Collaborating Centre for Cancer Education, Groningen, The Netherlands Fax: 31 50 361 4873 Email: <a href="mailto:summerschool@hchk.org.nl">summerschool@hchk.org.nl</a> <a href="http://sfa.summerschool">http://sfa.summerschool</a></td>
</tr>
<tr>
<td>October</td>
<td>Cancer Research Campaign Beatson International Conference: Genomic Regulation and Cancer</td>
<td>Glasgow, UK</td>
<td>T. Wheeler, Beatson Institute for Cancer Research, Glasgow, UK Fax: +44 141 330 6426 Email: <a href="mailto:twheeler@beatson.gla.ac.uk">twheeler@beatson.gla.ac.uk</a> <a href="http://www.beatson.gla.ac.uk/beatson/conf/">http://www.beatson.gla.ac.uk/beatson/conf/</a></td>
</tr>
<tr>
<td>October</td>
<td>50th Anniversary Conference of the UHPE</td>
<td>Paris, France</td>
<td>I LUPES Union Internationale de Promotion de la Santé et d’Éducation pour la Santé, 2 rue Auguiste Comte, 92170 Vanves, France Ph: 33 1 4645 0059</td>
</tr>
<tr>
<td>October</td>
<td>8th World Congress on Cancer of the Skin</td>
<td>Zurich, Switzerland</td>
<td>M. Luth, Dept of Dermatology, University Hospital of Zurich, Zurich, Switzerland Fax: +41 1 235 4863 Email: <a href="mailto:leuthm@derm.unizh.ch">leuthm@derm.unizh.ch</a> <a href="http://www.usz.unizh.ch/skin.cancer">http://www.usz.unizh.ch/skin.cancer</a></td>
</tr>
<tr>
<td>September</td>
<td>International Conference Seoul 2001: American Association for Cancer Research</td>
<td>Seoul, South Korea</td>
<td>Cancer Research Institute, Seoul National Medical University, Seoul, South Korea Fax: +82 2 742 4337</td>
</tr>
<tr>
<td>September</td>
<td>Germ Cell Tumour Conference V</td>
<td>Leeds, UK</td>
<td>GCTC V Secretariat, Conference Office, University of Leeds, LS2 9JT Leeds, Great Britain Fax: +44 1 113 233 6107 Email: <a href="mailto:confoffice@leeds.ac.uk">confoffice@leeds.ac.uk</a></td>
</tr>
<tr>
<td>September</td>
<td>Asian-Pacific Conference of Tumor Biology</td>
<td>Beijing, China</td>
<td>CICCT/APCTB, Beijing, China Fax: +86 10 8218 0142 Email: cicctapublic3.bta.net.cn</td>
</tr>
<tr>
<td>September</td>
<td>First ASCO-Pan Asia Cancer Conference</td>
<td>Taq Palace, New Delhi</td>
<td>Dr Rakesh Chopra Fax: +91 11 37528 0142 Email: <a href="mailto:pallavis@corlkgmc.com">pallavis@corlkgmc.com</a></td>
</tr>
<tr>
<td>September</td>
<td>4th UKCC Cancer Meeting on Global Cancer Management: Towards a European Model?</td>
<td>Paris, France</td>
<td>Institut Gustave Roussy, Villejuif Cedex, France Fax: +33 1 4211 5 552 Email: tarzige.fr</td>
</tr>
<tr>
<td>October</td>
<td>8th Hong Kong International Cancer Congress</td>
<td>Hong Kong, China</td>
<td>(8th HKICC) 8th HKICC Secretariat, Dept of Surgery, University of Hong Kong Medical Centre, Hong Kong, China Fax: +852 2818 1186 Email: <a href="mailto:mededcon@hku.hk">mededcon@hku.hk</a></td>
</tr>
<tr>
<td>October</td>
<td>Pacific Rim Laryngotraceology Conference and Voice Institute</td>
<td>Honolulu, USA</td>
<td></td>
</tr>
<tr>
<td>October</td>
<td>9th International Cochlear Colloquium</td>
<td>Lyon, France</td>
<td></td>
</tr>
<tr>
<td>October</td>
<td>ECCO 11 – The European Cancer Conference</td>
<td>Lisbon, Portugal</td>
<td>ECCO 11 Federation of European Cancer Societies Conference Unit, Brussels, Belgium Fax: +32 2 775 0200 Email: <a href="mailto:ECCO11@fecs.be">ECCO11@fecs.be</a> <a href="http://www.fecs.be">http://www.fecs.be</a></td>
</tr>
</tbody>
</table>

**November**

- **October (continued)**

- **November**

  - **4-7** Annual Meeting of the American Society for Therapeutic Radiology | San Francisco, USA | G. Smith, ASTRO, Fairfax, Virginia, USA Fax: +1 703 502 7852 Email: gsmth@astro.org http://www.astro.org
  - **7-10** 30th Chemotherapy Foundation Symposium: Innovative Cancer Therapy for Tomorrow | New York, USA | J. Silverman, Medical Oncology Dept. Mount Sinai Medical Centre, New York, NY, USA Fax: +1 212 369 6440 Email: J_silverman@smtplink.mssm.edu http://info.neoplastics.mssm.edu/CTF/sympbrochure.html
  - **15-17** 2 Curso Latinoamericano de Capacitación para Coordinadores de Voluntarios de Cancer de Mama | Buenos Aires, Argentina | APOVOLO (Asociacion Pacientes Oncologicos de Vicente Lopez) H. Yrigoyen, 1995, Buenos Aires, Argentina Fax: +54 11 4796 1912 Email: apovilo@ciudad.com.ar
  - **16-18** Japan 3rd International Conference on Cancer-Induced Bone Diseases | Awaji Island, Kobe | T. Matsumoto, MD, First Dept. of Internal Medicine, Hyogo University of Tokushima School of Medicine, Tokushima, Japan Fax: +81 88 633 7121
  - **18-21** 16 Asia Pacific Cancer Conference | Manila, Philippines | APCC Secretariat Philippine Cancer Society, 310 San Rafael Street, San Miguel, Manila, Philippines Fax: +63 2 7342 318 Email: pcsi@uplink.com.ph
  - **September**

  - **10-14** International Conference Seoul 2001: American Association for Cancer Research | Seoul, South Korea | Cancer Research Institute, Seoul National Medical University, Seoul, South Korea Fax: +82 2 742 4337
  - **13-16** Germ Cell Tumour Conference V | Leeds, UK | GCTC V Secretariat, Conference Office, University of Leeds, LS2 9JT Leeds, Great Britain Fax: +44 1 113 233 6107 Email: confoffice@leeds.ac.uk
  - **16-20** Asian-Pacific Conference of Tumor Biology | Beijing, China | CICCT/APCTB, Beijing, China Fax: +86 10 8218 0142 Email: cicctapublic3.bta.net.cn
  - **21-23** First ASCO-Pan Asia Cancer Conference | Taq Palace, New Delhi | Dr Rakesh Chopra Fax: +91 11 37528 0142 Email: pallavis@corlkgmc.com
  - **23-26** 4th UKCC Cancer Meeting on Global Cancer Management: Towards a European Model? | Paris, France | Institut Gustave Roussy, Villejuif Cedex, France Fax: +33 1 4211 5 552 Email: tarzige.fr
  - **3-6** 8th Hong Kong International Cancer Congress | Hong Kong, China | (8th HKICC) 8th HKICC Secretariat, Dept of Surgery, University of Hong Kong Medical Centre, Hong Kong, China Fax: +852 2818 1186 Email: mededcon@hku.hk
  - **9-12** Pacific Rim Laryngotraceology Conference and Voice Institute | Honolulu, USA |                                                                                 |
  - **9-13** 9th International Cochlear Colloquium | Lyon, France |                                                                                 |
  - **21-25** ECCO 11 – The European Cancer Conference | Lisbon, Portugal | ECCO 11 Federation of European Cancer Societies Conference Unit, Brussels, Belgium Fax: +32 2 775 0200 Email: ECCO11@fecs.be http://www.fecs.be

**December**

- **7-11** 43rd Annual Meeting of the American Society of Hematology (ASH) | Orlando, Florida, USA | ASH, Washington DC, USA Fax: +1 202 857 1164 Email: ashdc.uba.com http://www.ash.org
  - **8-11** 18th World Congress of Digestive Surgery | Hong Kong, China | Congress Secretariat 18th World Congress of Digestive Surgery C: Department of Surgery, University of Hong Kong Medical Centre Queen Mary Hospital, Hong Kong Tel: 852 2818-0252/052 2855 4235 Fax: 852 2818 1186 Email: isdshk@hkucc.hku.hk

**2002**

**December**

- **8-11** 18th World Congress of Digestive Surgery | Hong Kong, China | Congress Secretariat 18th World Congress of Digestive Surgery C: Department of Surgery, University of Hong Kong Medical Centre Queen Mary Hospital, Hong Kong Tel: 852 2818-0252/052 2855 4235 Fax: 852 2818 1186 Email: isdshk@hkucc.hku.hk
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The Cancer Council Tasmania
Anti-Cancer Council of Victoria
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Australasian Association of Cancer Registries
Clinical Oncological Society of Australia Inc
Palliative Care Australia
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Mrs J Roberts AM, SRN
Dr N Swan MB, ChB, DCH
Professor J Zalcberg MB BS, PhD, FRACP

THE CLINICAL ONCOLOGICAL SOCIETY OF AUSTRALIA INC

The Clinical Oncological Society of Australia (COSA) is a multi-disciplinary society for health professionals working in cancer research or the treatment, rehabilitation or palliation of cancer patients.

It conducts an annual scientific meeting, seminars and educational activities related to current cancer issues. COSA is affiliated with The Cancer Council Australia.

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Paediatric Oncology
(ANZ Childhood Cancer Study Group)
Palliative Care
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Psycho-Oncology
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Social Workers
Surgical Oncology

MEMBERSHIP
Further information about COSA and membership applications are available from
GPO Box 4708, Sydney, NSW 2001.

Membership fees for 2001
Ordinary Members: $110
Associate Members: $60
(includes GST)