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EDITORIAL
Going beyond the Marryalyan

COSA (and certainly in this context, it's not necessary to define the acronym) has a great logo: the Marryalyan. None of the other professional societies, colleges or equivalent national bodies of which I'm aware have anything that approaches this logo in terms of its singularly Australian character. This logo was formally adopted in the 1970s, rather than being prompted by any more recent consciousness of Indigenous Australian culture. Most readers may be aware that the Dreamtime story of the twin snakes, as told to us by the Warramirri people (see COSA website), is recounted at COSA dinners to overseas contributors to our Annual Scientific Meeting, who each receive a Marryalyan as a keepsake of their time with us. Good stuff. Works well.

All this is remote from the health problems of Indigenous Australians. Like me, I suspect that without exception, non-Indigenous Australian readers of this journal will be aware that the situation of Aboriginal and Torres Strait Islander people presents an appalling healthcare picture. They face a markedly shorter life expectancy than the rest of us. They suffer from a range of diseases, the onset of which can be traced to social, economic and other circumstances which are often tragically obvious. Like me, you might also have the impression that these health problems do not centre on cancer. Rather, in common with many communities in the developing world, critical health needs centre upon communicable disease and conditions related to poor nutrition, exemplified by diabetes. But occasionally there are indications that the poor health of Indigenous Australians does involve cancer. The matter had not been centre stage in a previous issue of Cancer Forum, prompting a commitment in respect of the first issue for 2005. Namely, the publication, as a Forum, of papers presented to a workshop on Indigenous cancer held in Darwin by The Cancer Council Australia in the latter part of 2004.

The Forums published over the last decade or more have established the character of Cancer Forum as a journal for cancer professionals. The Editorial Board invites investigators of national standing to develop and contribute to these Forums (a scenario which is not usually related to a conference). Usually, such invitations are accepted despite a recognised pile of professional commitments and all of us – members of COSA and other readers – are the beneficiaries. Again, it works well. The Editorial Board normally provides about nine months notice and, sometimes with the encouragement of ‘reminders’, individual contributors rarely let us down. When they do, various people pitch in and the ‘gap’ – say one paper among seven or eight – is not noticeable in the final product. At least we on the Editorial Board hope it isn’t.

Less than three months prior to the publication deadline for this issue of Cancer Forum, we knew we were in trouble. The manuscripts from the Darwin conference were not going to arrive. And I felt guilty making the associations that I did. I recalled a conference (not COSA) organising committee where an Aboriginal ‘Welcome Ceremony’ had been contemplated, then put aside on the basis on the risk that they ‘just wouldn’t turn up’. I remembered my local church attempting to involve local Indigenous representatives in a ceremony concerning traditional ownership: we never seemed able to have our invitation (and its commitments) accepted. I'm not aware whether our failure to obtain the anticipated manuscripts was actually related in any way to the Indigenous character of the conference. Even without such knowledge, the baggage I had on board was enough to influence my thinking. I was of a mind to put the matter of Indigenous cancer aside. It would be easier to find another Forum subject at short notice, and no reference need be made to the original intention.

I’m pleased that the Editorial Board did not opt for that course. Instead, we opted to address Indigenous cancer, but through a format different from that originally contemplated. In fact, we had some papers from the workshop plus an overview of proceedings. These articles follow. And through these papers, a bleak picture can be discerned. The bleakness is tempered by action in the best traditions of the profession. Beyond that, it’s preferable to let the various contributions speak for themselves without offering some summation here. What can be said, however, is that my notion, of Indigenous healthcare not being specifically concerned with cancer, was and is wrong. What can also be said is that the need for cancer care in this context involves all in the team, rather than being predicated on the perception of cultural or personal matters being confined to one sector of the cancer professional community.

Everyone involved in cancer care is aware of concerns that require attention. Urgently. Whether it’s decreasing the smoking rate, increasing participation in screening or trials, ensuring total support of the individual patient and his/her family, delivering care equitably across rural and urban communities, or something else. But the health of Indigenous Australians is an issue that runs across all these concerns and merits something more, if that’s individually and communally possible. I’m writing this as television images of Australia Day flash past. Funny that.

No clarion call is intended. To identify priorities and strategies is way beyond the scope of this Editorial. But I commend the articles that follow. And I hope, that as COSA continues to use the Marryalyan, that usage may be complemented in some way by action, through COSA members or COSA itself, that serves to improve cancer control amongst Indigenous Australians.

Bernard W Stewart
Editorial Board
Cancer Forum
To the already well-known health disadvantages of Australia’s Indigenous citizens must now be added the problem of cancer. David Roder’s paper (page 7) in this special issue of Cancer Forum brings to light previously unobtainable statistics which show that our Indigenous population suffers disproportionately from cancer in several ways. Firstly, compared with the general Australian population, Indigenous Australians have a higher incidence of cancers with poor outcomes, such as those of the lung and liver. In contrast, the rate is lower for cancers which generally respond well to treatment, such as lymphomas and breast cancer. However, even when afflicted with the same cancers, the outlook for Indigenous people is worse. Partly this is due to later diagnoses, but even stage-matched the prognosis is inferior. These disturbing statistics should ring alarm bells for those of us concerned to ensure that all Australians benefit from recent improvements in cancer management, no matter their race, background or place of residence.

The practicalities of dealing with Indigenous cancer are brought into focus in the paper from Ian Olver and his colleagues (page 10). Using a technique that is novel for a scientific publication but that will be familiar to health professionals who work in the field, namely story-telling, they describe day-to-day difficulties that need to be overcome if we are to improve the outlook for Aborigines and Torres Strait Islanders. They highlight the need for the non-Indigenous population to develop an understanding and appreciation of Indigenous culture.

In a contribution that should open the eyes of the rest of the community, Sandy Angus, an Aboriginal health worker from Queensland, gives an Indigenous perspective (page 13). She tellingly illustrates how questions of Indigenous health cannot be divorced from the broader issues of racism, neo-colonialism, community disadvantage and loss of social capital. However, on a positive note, she describes how a culturally-respectful program with community involvement has dramatically improved the outlook for cancer of the cervix for Queensland’s Indigenous women. The method by which this gratifying result has been achieved provides a model which should be noted by everyone working in this challenging field.

These three papers came out of Australia’s first ever conference focusing on Indigenous cancer, held in Darwin in August, 2004 under the auspices of The Cancer Council Australia. With the permission of the publishers of the Medical Journal of Australia, an overview of the conference (entitled “Reducing the impact of cancer in Aboriginal and Torres Strait Islander communities: ways forward”) is reprinted on page 17. Those who attended heard a series of unique presentations from workers at the ‘coal face’ - it was a privilege to be present. Some of the highlights that are not otherwise acknowledged in the papers in this issue of Cancer Forum, are given in the Summary of Presentations.

The Australian cancer establishment and the country’s federal, state and territory governments need to confront the issue of Indigenous cancer. That its importance has hitherto been overlooked and neglected shames us all; the matter is urgent. Cancers are occurring that could be prevented and lives are being lost that could be saved, now. The good news is that ‘ways forward’ were indeed identified at the conference. As described by Sandy Angus, the ‘talk-fest’ is over; now is the time for action.
Ms Maracle discussed the cancer problem in Canadian Aborigines. A particular issue is that tobacco is a local herb and its use is part of cultural tradition. She described how Aboriginal patient navigators were employed to assist in negotiating the complex health system.

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The international scientific literature points to a number of risk codes (8). People were observed to have a higher incidence of cancers of the oral cavity/pharynx/oesophagus – tobacco smoking, alcohol and unspecified organ sites, in Indigenous residents. Notably, these are all cancers with low case survivals (4, 5). In addition, Indigenous people were observed to have a higher incidence of cancers of the cervix and related female organs (i.e., organs with ICD-9 codes of 180 & 184). The international scientific literature points to a number of protective factors for these cancers (4, 5). They include:

- Lung – predominantly tobacco smoking, but also inhalation of other environmental carcinogens.
- Cervix – a lack of screening for precancerous lesions and infection with carcinogenic human papilloma virus (HPV). It is likely that HPV infection also is a factor in the vulva.
- Oral cavity/pharynx/oesophagus – tobacco smoking, alcohol consumption and a low intake of fruit and vegetables.

Cancers with a lower incidence in Indigenous people

Both the Northern Territory and South Australian data showed a relatively high incidence of cancers of the bowel, breast, prostate, and cutaneous melanomas in Indigenous residents. The international literature points to a number of protective factors (4, 5). They include:

- Female breast – Early pregnancies and multiple pregnancies.
- Bowel – Among females, a history of multiple pregnancies. In addition, lower rates of these cancers generally have been found in the lower socio-economic sectors of population groups.
- Prostate – A low frequency of PSA (Prostate Specific Antigen) testing.
- Melanoma – Protective skin colouring.

In general, these cancers had relatively high survivals, in contrast to those cancers that were over-represented in Indigenous residents (4, 5). The Northern Territory data also showed a lower incidence of lymphoma in Indigenous people, whereas the South Australian data pointed to a lower incidence of haematological cancers (including lymphomas) in this sector of the population. These findings were unexpected. Although the reasons are unknown, it is possible that the immune system of Indigenous people may be more robust and more protective against these cancers (4, 5).

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Conclusions

Indigenous and non-Indigenous Australians appear to be at a broadly similar risk of cancer, but Indigenous patients are more likely to die from their disease.

In this higher case fatality is partly due to differences in cancer type, in that Indigenous patients tend to get more lethal types.

The prognosis of Indigenous patients also is compromised, however, by more advanced stages at diagnosis.

Apart from these influences, Indigenous Australians still appear to have worse outcomes. While the reasons are speculative, it is possible that poorer access to specialised services and a higher prevalence of co-morbidity reduce prospects for cure.

Table 1: Case survivals from primary cancers among Indigenous and non-Indigenous Australians; SA 1988-94*

<table>
<thead>
<tr>
<th>Period from diagnosis (yrs.)</th>
<th>Indigenous (n=139)</th>
<th>Non-Indigenous (n=417)</th>
<th>SEER stage adjusted Indigenous (n=139)</th>
<th>Non-Indigenous (n=417)</th>
</tr>
</thead>
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<td>1</td>
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<td>5</td>
<td>37%</td>
<td>49%</td>
<td>40%</td>
<td>48%</td>
</tr>
</tbody>
</table>

*p value p=0.008 p=0.058

References

“Some of us know some things and some of us know others” – Reducing the impact of cancer care on Aboriginal and Torres Strait Islander communities

Ian N Oliver, Sid Selva-Nayagam, Olfa Fried, Margaret Davy, Michael B Barton
1 Royal Adelaide Hospital SA
2 Royal Darwin Hospital NT
3 Alice Springs Hospital NT
4 Liverpool Hospital, NSW
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This is a series of anecdotes by clinicians who, focusing on equitable access to cancer care, provide their insights to highlight the issues that have arisen in their experiences of treating cancer and providing palliative care to Aboriginal and Torres Strait Islanders to reduce the morbidity and mortality from the disease.

The medical oncologist from city cancer centre

Four stories highlighted cultural differences that impacted on communication, informed consent, treatment options and gaining trust.

“When I started my Alice Springs Oncology clinic 12 years ago very few of the patients were Aboriginal. Now they constitute a quarter of the clinic. The change seemed to be related to a senior Aboriginal woman who I treated for breast cancer. We got on well and she did well for quite some time. Was that important in the increase in numbers in the clinic or was it just coincidental?”

This experience suggested the importance of developing trust in the community which occurred by a positive experience with a highly respected community member.

“I was doing a ward round at the Royal Adelaide Cancer Centre medical oncology unit on Saturday morning with my intern and a ward nurse. We went to the bed of an Aboriginal patient who had seemed quite comfortable and was usually quite articulate. I asked him how he felt and he cutered into a ball and indicated that he was not well at all. I looked at him and said simply, “Some of us know some things, and some of us know others”. The case illustrated the necessity of being able to understand the Aboriginal patients with examples that will have meaning for them.

“In another case I was asked to explain to an Aboriginal patient with liver cancer his chances of responding to doxorubicin. I wanted to tell him that he had about a one in four chance of it shrinking his tumor. This man had seemed quite comfortable and was usually quite articulate. I asked him how he felt and he cutered into a ball and indicated that he was not well at all. I looked at him and said simply, “Some of us know some things, and some of us know others”. I began to talk about how the drug would be working up his body. He told me he was taking his home tomorrow. In the end she agreed to take Tamoxifen tablets. It was far from my idea of pinning her hips, irradiating them and other painful areas and then offering chemotheraphy. I felt that I had failed the patient. The nursing staff tried to reassure me that I had done my best and that agreeing to treat her as she wanted was important and I would probably be asked to see other such patients in the future.”

This case shows the importance of family in decision-making. Clinical authority will need to be shared with such significant family members.

The Darwin oncologist

From the epidemiological work of John Condon and others, there is good evidence that cancer mortality in the Aboriginal population is higher than the rest of the population while the cancer incidence is similar. This is likely to be due to late presentation, poor uptake of treatment, and a higher prevalence of malignancies that tend to have a worse prognosis.

From retrospective reviews of chemotherapy treatment at the Royal Darwin Hospital it is clear that the toxicity of chemotherapy is greater in Aboriginal patients, resulting in greater morbidity and mortality. This is mostly due to the high infective burden they carry and the potential for this to interact with the immunosupression of chemotherapy. This has resulted in policy being developed to minimise this complication including preemptively treating Strongyloides, ensuring eradication of scabies and securing good skin condition, and providing prompt and appropriate treatment for febrile neutropenia in every patient. It also however behoves us to be more critical in applying evidence collected in well conducted trials in urban populations to the Indigenous population, particularly where the benefits anticipated from treatment are likely to be small.

“A 20 year old young man, who spoke no English, and was from Groote Eylandt, an island approximately 600km east of Darwin was electively admitted in July 2003 to the Royal Darwin Hospital (RDH) with a 12 month history of weight loss, associated with recent diarrhoea and dysentery. He was a heavy smoker and had very poor dentition and a distended abdomen. There was no peripheral lymphadenopathy. In many ways he typified the late presentation so often talked about with Aboriginal patients. He had malabsorption, was hypalbuminaemic and folate deficient with anaemia and macrocytosis. HIV serology was negative. CT scan showed a large mesenteric lymph node and an an abnormally thickened small bowel. Endoscopic biopsy of the abnormal duodenum was initially reported as tropical sprue, a condition found in developing countries and resulting in malabsorption from chronic intestinal infection. The mesenteric lymph node biopsied were reported as reactive hyperplasia. He was due to be commenced on Doxycycline antibiotic therapy but he was sick of being in hospital and left, without it.

A month later when he re-presented with similar symptoms a review of pathology showed Immunoproliferative Small Intestinal Disease (IPSID), a type of lymphoma, formerly known in the past as heavy chain disease, or Mediterranean lymphoma. The lymphoma is likely to be derived from chronic antigenic stimulation of the gut from intestinal infection by bacteria and parasites. It has been described in two other patients in the NT, both Aboriginal.

He had brief presentations over six months but refused to stay for more extensive investigations. In January 2004, finally, he agreed to some family meeting was held which included his father (most significant person, but who needed cardiac surgery in one month), other relatives and interpreters. This was conducted in a slow and methodical fashion such that eventually they would have the opportunity to contribute. The patient however mostly remained silent except when directly questioned. Even then he was not easily forthcoming. A recommendation that he needed both antibiotic therapy and chemotherapy for his lymphoma was conveyed and agreed to. This was also discussed with the local doctor at Grootie. However the patient left the next day saying that he was concerned about his mother’s welfare.

He was admitted to hospital later in the month and was given his first cycle of chemotherapy; it was also an inpatient at the time with cardiac problems. His brother had died four days earlier following an assault, which the patient had witnessed. Due to this and possibly the effects of steroids given with his chemotherapy he became acutely suicidal and required psychiatric intervention.

He then refused to have any more chemotherapy, although he agreed to continue the Doxycycline, but compliance was uncertain. Numerous attempts to try and talk to him or to organise further family meetings were unsuccessful. This was despite using various resources available including the outreach arms of the Aboriginal liaison teams at community level and palliative care, local health clinic and family.

Despite ongoing symptoms and further family meetings he refuses further chemotherapy and has had no further contact with the hospital except for the Aboriginal liaison officer attached to palliative care.”

I find it difficult to understand why any young man would refuse life saving treatment. However, it is clear that he finds the experience of being in hospital and the process of Western medicine unacceptable. This is likely to be due to the cultural and language barriers, and impacts on his ability to take up potentially life saving treatment. We know from the renal dialysis studies that communication can be difficult despite interpreters being used, however a better understanding of the Aboriginal concepts of cancer through anthropological study would also be valuable in enabling successful communication both ways.

There is an epidemic of death in Aboriginal communities often tangibly interacting, with the person dealing with cancer, having to also deal with loved ones dying around them.

Often decisions about treatment, and consent, can be provided only after family consultation with interpreters and needs to involve the most important family member for that patient. This person often gives the consent and any decision made without their involvement is worthless.

The current model of Western health delivery which is based on efficient ward rounds and rapid clinics is not conducive to effective outcomes in Indigenous people who often require continuity of care, significant involvement of family in slow deliberation and repeated discussions, with treatment given closer to, if not at home.

The palliative care physician

As a doctor working in palliative care, I take a long-term view of cancer management. I know that decisions made at earlier stages of a person’s illness can have a profound influence on the remainder of that person’s life and on their family and community.

Palliative care is all about maintaining a sick person’s quality of life, and they determine what that quality of life is for them. In palliative care we generally try to look after people the way they want, where they want and how they want. It’s a matter of giving them the power to the person, allowing them to do things the way they want.

That also helps ensure the care is culturally safe for that person. By cultural safety I mean that a person can use a service given by someone from another culture without risk to their own.

In the Territory, the biggest cultural divide is generally between Indigenous people or non-Indigenous people, and on most doctors and nurses are non-Indigenous people. In order to get the best decisions made, we need to let patients make their own choices. The non-Indigenous health practitioner needs to acknowledge that we may know very little about our patients, their priorities and their lives. If we don’t give sufficient information to the sick person and their family about their condition or its treatment, or we fail to confer on them enough decision-making power, the wrong decisions can be made.

“An Aboriginal man was referred to our palliative care service by the Alice Springs Hospital after he returned from treatment in Adelaide. He was about 35 years of age and had just had surgery and radiotherapy for a cancer that was largely removed, so he couldn’t talk, and he also couldn’t eat. He had a tracheostomy which was discharging lots of secretions and had to be cleaned frequently. He had gastrostomy tube and this hadn’t healed well, so it was very sore. He was in a lot of pain.

In Adelaide, the decision had been made to have this operation, because without it he would have choked to death, and he had given his consent on paper, with a thumb-print. He spoke English as a second language and I never found out whether he had an interpreter present when he gave his consent. At any rate, when he got back to Alice, what he really wanted was for all the tubes that were keeping him alive to be taken out. When I asked him when he thought that this wasn’t possible, he was absolutely appalled. So clearly he had never understood properly how mutilated he would be and that he would be left with permanent tubes in his neck and who would look after these tubes, the cleaning and the feeding business, himself. He made little effort to do this, finding it difficult and distasteful, and his wife, who apparently had understood that his\n
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operation would cure him, would not, or could not help. He lived in poverty and had little access to health care, so if he and his family couldn’t move forward, that meant he had to stay in hospital, hardly a good solution.

This man had a miserable end. He wasn’t able to be discharged home and after some weeks he died in hospital. He couldn’t communicate with his family or his community. He was cut off from the language and culture that he grew up with and also because of a hospital acquired infection, so everyone coming to see him had to wear a gown and mask. He seemed really depressed, was too ashamed to go outside and had nothing to do. I lived and worked in this community for the cancer that meant the doctor in the city may not know the circumstances the person is going home to. So if the person gets a treatment that means they can no longer be looked after at home, it’s a big problem. Before the decision is made to have such a treatment, for example a big operation, its outcome needs to be talked over with those who do know, including the sick person and their primary health care workers.

The gynaecological oncologist

I started visiting Darwin and Alice Springs as a visiting gynaecological oncologist in 1988, at the invitation of the specialist gynaecologists, who were referring women with gynaecological malignancies to the nearest centre “South”. One of the big differences to health for women in obstetrics and gynaecology in the Top End has been the Specialist Outreach Service. Single-handedly, Dr Margaret O’Brien has revolutionary care for women in communities as she travels with her ultrasound machine and her colposcope. This service also means that women have continuity of care and when a woman has cancer or suspected cancer, they are already given support and information without the distress of travel often by plane.

“In one of the communities, we have found a much higher incidence of both cervical and vulvar cancers than we would expect and in younger women. We talked with the health workers about this and they organised that Margaret and I should visit the community. The plan was for a day of education and colposcopy. Women, who in many cases were already seeing me, were invited to come and bring their relations for a women’s health check-up. A feast of barramundi was put on and we found that we saw 17 relations, many of whom only came because of peer pressure. We found three new precancerous lesions. None of these women would ever have travelled to Darwin, so the lesson is that we should keep an open mind and suggestions which may produce unexpected positive results.

“A tribal woman was bleeding from an advanced cervical cancer. She was seen and advised that she would need six weeks radiation therapy in Adelaide. She was not willing to come to Darwin, let alone Adelaide and agreed to be in hospital for diagnosis or treatment and who will look after them later on. Aboriginal kinship systems are pretty mysterious to most whites, but you need to know the anthropologist out of a book. What’s more useful is to remember not to make assumptions from our own culture about how things should be done, that we don’t necessarily know the same people and their family. There is generally someone who will speak and support the sick person when they need to be in hospital. The plan was for a day of education and colposcopy. She has returned to her community, with no bleeding and no smelly discharge.”

A Model for Engaging and Empowering Indigenous Women in Cancer Screening

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Terminology

In this paper I will use the term Indigenous to refer to Australia’s Aboriginal and Torres Strait Islander peoples. I also ask readers to note that Australia’s South Sea Islander communities. The way forward requires the ongoing process of colonisation as it continues and work with Aboriginal colleagues who can complement the things we know with other things that they know.

Conclusions

These cases illustrate issues of communication and the culturally driven differences in decision-making, which impact on the delivery and outcomes of medical care to Aboriginal and Torres Strait Islander communities. The way forward requires recognition of the differences, sensitivity to those differences and a dialogue to plan the way forward. We need to listen better to Aboriginal patients and their families and advocates, and work with Aboriginal colleagues who can complement the things we know with other things that they know.

For the first few years I was concerned that I was the “hired knave” and didn’t really feel that I was or that I was a specialist. I also ask readers to note that Australia’s South Sea Islander communities. The way forward requires recognition of the differences, sensitivity to those differences and a dialogue to plan the way forward. We need to listen better to Aboriginal patients and their families and advocates, and work with Aboriginal colleagues who can complement the things we know with other things that they know.

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the appalling rate of death and dying, which usually relies on the goodwill or social capital of the community. And there is the expectation that the social capital in many communities, including Indigenous communities, is alive, robust and healthy.

Indigenous health issues

Evidence demonstrates that Indigenous people die at a much higher rate than the general community, especially from stroke and heart disease, injury, respiratory diseases such as pneumonia and chronic bronchitis, and diabetes (which alone occurs at about eight times the national rate). The gap between the two communities has increased in recent years. Factors that increase the risk of these disorders in the Indigenous community include higher tobacco and substance misuse rates and poorer nutrition. In addition location and environmental factors impact heavily, such as remoteness from, lack of and barriers to services including health, housing, education, employment and legal support. Often there is lack of access even to clean running water.

The increased incidence and death rates documented for cancer and other diseases have been linked to poor perceptions of access even to clean running water.

Cervical cancer screening rates

Figure 1 shows the current cervical screening rates according to age in 13 Indigenous Queensland communities compared to those of the general Queensland population. It can be seen that Indigenous rates are much lower, a state of affairs which is unacceptable. Figure 2 demonstrates that the participation rates in cervical screening in these communities vary from as low as 20 per cent up to 65 per cent. The average participation rate in Aboriginal communities is 31.6 per cent and in Torres Strait Islander communities, the average rate is 56 per cent. The average participation rate for 13 Indigenous communities is 41.5 per cent for 1999 – 2000. This rate is below the state average of 56.7 per cent and only one of the 13 communities has a participation rate higher than the state average. For 13 Indigenous communities, cervical cancer mortality rates are at least 10 times higher than the State average.

The evidence from Queensland demonstrates that Indigenous women are presenting and dying more often at younger ages from cancer of the cervix, a largely preventable condition. Specifically, epidemiological data from discrete or defined Indigenous communities in Queensland over the period 1982-1996 indicate that the death rate from cancer of the cervix amongst Aboriginal women was 13 times higher than the state average. Data from Torres Strait communities indicate that the death rate was 21 times higher than the state average. Other Australian states and territories also report higher levels of incidence and mortality rates of cervical cancer for Indigenous women.

Cancer Screening Services, part of the Queensland Cervical Screening Program located within Queensland Health, have worked to improve these figures within Aboriginal communities through the development and implementation of the Queensland Indigenous Women’s Cervical Screening Strategy 2000 – 2004.

The lifestyle message

The problem with the ‘lifestyle message’ approach to health promotion and other internalised messages is that not only do these approaches fail to address the primary determinants of health, they also divert public and policy attention away from more important issues. They also serve to blame individuals and communities for their diseases and illnesses, failing to shore up the support networks needed, including strengthening the social capital of each community.

The effectiveness of such an approach is questionable, particularly when health problems among Australia’s Indigenous people are exacerbated by the ongoing process of colonisation, which can be considered responsible for the introduction and provision of unhealthy foods and the destruction of the prior, healthier hunter-gatherer lifestyle.

Colonialism, paternalism and ethnocentrism cause Indigenous rules, systems and processes to be dismantled and fractured, where many Indigenous people are still living on the fringe or living segregated lives at a geographical or emotional distance from family and kin. Assimilation, dislocation, family separation, racism and discrimination are a part of everyday Indigenous life.

Removing the barriers and engaging the community

Barriers to access are created if there is failure to offer culturally safe screening services, or a failure to recognise the need for culturally sensitive follow-up after diagnosis and treatment. Indigenous people need to be involved in setting up these processes. However, being actively engaged through advisory group representation is not enough. Indigenous people need to be employed in positions which can guide these processes daily. They need to have appropriate wages, a recognised career path and access to ongoing education and training. The process needs to be inclusive.

An effective strategy is to put in place networks and systems which engage and support strong Indigenous voices at the negotiating and decision-making table. But encouraging strong voices can be difficult if people feel powerless and sense that networks and systems are tokenistic. As well, it can become extremely draining if the same person or group of people is approached whenever there is an issue to be addressed or a job to be done. Also, it can cause consternation if there is a sense of urgency, simply because there is funding available yet the issue has not been identified by the community as one deserving priority. This again leads to apathy.

Engaging a participatory process that encourages and supports the community will require continually recognising where the community is at with their own business to allow Indigenous people to have real input. The process will mean that the xenophobic practice of ‘rubber-stamping’, which often stems from government policy and which requires Indigenous people to simply endorse someone else’s ideas or notions, will not be tolerated. Rubber-stamping leaves the community disillusioned and apathetic, destroys goodwill and willingness to be involved, leaving no community or no individual to draw upon.

Once an issue is identified, timeframes for action may differ from those of non-Indigenous people. In fact, identifying an issue does not mean that it is appropriate for the community to address the issue immediately.

Building social capital

Research shows that people who actively participate in their community and who have a strong sense of belonging and...
supportive family ties, including cultural and community relationships, have more social capital and more interest in improving their health, which leads to better health outcomes, than people who are socially isolated. For clarification, the term ‘social capital’ describes features of social life and includes:

- The extent of involvement by people in their community;
- The trust people invest in each other and in governments and institutions; and
- The connections between people and their communities and families.

Social capital also describes how much we can help, or are able to help each other. Government policies and practices have historically interfered in the Indigenous way of life and living, determining that most Indigenous family structures are dislocated. The fact that many people to this day do not know other family members or where they fit within the community itself, creates feelings of anger and frustration and causes deep heartbreak and often shame.

Other factors contributing to lack of social capital and to a poor health status include: having a lower socio-economic status – or, in other words, having low incomes and no economic benefits, high rates of unemployment and a disproportionate level of poor educational attainment; and cultural and ethnicnocentric barriers to services. Improving the social capital provides a mechanism to engage and increase genuine participation and it is often only after this process that people become strong in voice and strong in health. Being strong in voice, people are more likely to engage in health planning thus increasing good health and access to services, decreasing mortality rates and morbidity burden and lowering the cost of health system.

Community capacity development approaches have shown impressive achievements when strengthening social networks, building knowledge and skills and in improving communication among sectors of the community. But how do we support this practice? People need to be involved in consultation strategies that support and encourage the community’s social capital.

Achievements in building social capital are more successful if people have a sense of belonging, a sense of control over research and program development and in having ownership of services and program.

A strategic approach

The inexcusable rates of cervical cancer in Australian Indigenous women prompted an Aboriginal woman, the late Ms Maureen Kirk, to carry out research in Queensland in order to promote change. Recommendations developed out of Ms Kirk’s research were documented in the Queensland Indigenous Women’s Cervical Screening Strategy 2000-2004. This strategy began to acknowledge and respect difference, putting in place strategies to remove barriers and to increase access to the cervical screening pathway.

It was after the completion of Ms Kirk’s research and with input through the Aboriginal and Torres Strait Islander Health Council that Indigenous people all over the country, that the Queensland strategy was developed, determining and documenting six key action areas to target specific areas of identified need, including the development of a national code of practice for screening services.

The participatory process to endorse a national code relied strongly on utilising and developing the social capital in many communities. This strategy and the code of practice were endorsed nationally by many Indigenous and non-Indigenous organisations. It took three years to develop the strategy and another three years to develop the service guidelines, but the processes and timeframes were strongly supported.

The Queensland strategy has begun to address the imbalance of health outcomes. Four years after its implementation, much work has been done. While many of the key actions have been put into practice and some improvement in cancer mortality and morbidity is evident, some actions are still outstanding. Furthermore, some do not now meet today’s health needs; new strategies may need to be developed. This process will depend on input once again from the community and support from other organisations, to assist with the development of the social capital needed to engage the community.

Cervical screening guidelines

The Principles of Practice, Standards and Guidelines for Providers of Cervical Screening Services for Indigenous Women are being implemented nationwide.

The guidelines (copies of which are available from The Cancer Council Australia) were developed to help break down some of the access barriers in cervical screening services and seek to better engage Indigenous women in the screening pathway. Readers are invited to be involved in the implementation process and constructive feedback is encouraged.

The guidelines, which are readily adaptable to other services, are being distributed to Indigenous and non-Indigenous service providers and to individuals on request. They include three useful case studies as examples of good practice and an audit tool to help determine gaps in service provision and service delivery.

Conclusion

It is vital to recognise the importance of engaging the Indigenous community in an ongoing, genuine decision-making process by encouraging and supporting the social capital needed in each community. Additionally, Indigenous Health Workers have a unique and important role and there is a need for the development of nationally accredited competency-based education and training program to support them in their role, specifically in the area of breast and cervical cancer.

There are workforce issues, as well as education and training issues for Indigenous Health Workers that require urgent attention. Health worker education and training must be offered locally. The health worker role and the importance of the participatory process to encourage and support the social capital of communities have been recognised by a number of organisations, which have made a commitment to be involved in supporting and further developing the health worker role, including education and training.

Supporting organisations of these needs include the National Aboriginal and Torres Strait Islander Women’s Forum, which has health worker representation from each state and territory, the Australian Government through the Department of Health and Ageing, the Office of Aboriginal and Torres Strait Islander Health in Canberra and the Australian Screening Advisory Committee.

Although many people have put forward similar recommendations over the years, the policies, strategies, systems, processes and networks in place today still do not fully address the issues, which are to:

- Recognise the history and stop the ongoing practice of colonisation;
- Stop the “blame the victim” mentality;
- Recognise the importance of and build up social capital within communities;
- Recognise that the community might be burnt-out or apathetic and put in place strategies to address this;
- Value the unique role of Indigenous Health Workers at all levels;
- Advocate for designated women’s health roles;
- Ensure you have a code of practice within your own organisation;
- Ensure non-Indigenous staff are culturally respectful and culturally aware;
- Stop racist, discriminative, tokenistic and assimilative policies and practices;
- Stop practices and processes which “rubber-stamp” someone else’s ideas;
- Support access to culturally effective and safe education and training;
- Build and maintain equal partnerships;
- Not support or enforce unrealistic or culturally ineffective timeframes; and

Encourage and support strong (Indigenous) voices at the negotiating and decision-making table. I encourage all readers to be involved, to make a commitment to make changes, in which Indigenous people need to work, professionally and culturally. This will require examining one’s own professional frameworks, ethics and values, including the principles of practice and of the services offered. It will require thinking about and analysing the processes, systems and policies that we all use daily to identify and address health issues. By doing this, it can make a difference.

Reducing the impact of cancer in Indigenous communities: ways forward

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Indigenous Australians with cancer are twice as likely to die from the disease than non-Indigenous Australians. Because of this stark imbalance, The Cancer Council Australia recently convened the first ever national discussion forum to address the issue.

Around 120 people from around Australia gathered in Darwin in August 2004 for the forum. “Reducing the impact of cancer in Indigenous communities: ways forward”. Originally conceived by The Cancer Council Australia as an internal event, planning for the forum tapped into a groundswell of concern about the poor outcomes for Indigenous Australians with cancer. This interest, combined with financial support from the Australian and Northern Territory governments, the National Cancer Control Initiative and The Cancer Council Northern Territory, turned the meeting into a major national event.

Why a discussion forum?

The past two decades have seen a 30% reduction in cancer mortality rates in Australia. However, at a meeting in late 2003, the board of The Cancer Council Australia reflected on the fact that recent successes in cancer control were not shared by Indigenous Australians and that we did not fully understand why.

We were familiar with the rhetoric about limited access to services, cultural barriers and existing health problems, but, before we could work towards improving Indigenous cancer outcomes, the problems needed to be better understood.

To this end, we invited Australia’s leading oncologists and epidemiologists with an Indigenous focus, academics, Aboriginal health workers and Indigenous cancer survivors to the forum. Organisational support from the National Aboriginal and Torres Strait Islander Women’s and Men’s Australian Health Council and the National Aboriginal and Torres Strait Islander Women’s and Men’s Australian Health Council (NACCHO) helped us reach Aboriginal health workers from Australia’s most remote communities. The result was an unprecedented sharing
of epidemiological, cultural and anecdotal Indigenous cancer data, with consensus on ways in which stakeholders could work together to effect measurable improvements.

Epidemiology

There is no simple answer to the question of why Indigenous people with cancer die at twice the rate of other Australians with cancer, nor is there a national dataset from which to draw. The inadequacy of data itself demonstrates the extent to which the problem has been overlooked.

However, information gathering on a state and territory basis is improving significantly, particularly in South Australia and the Northern Territory. David Roder (Head of Epidemiology, Cancer Council South Australia) and John Condon (Senior Research Fellow, Menzies School of Health Research) explained that the comparatively high mortality rate is partly the result of Indigenous Australians getting “more than their share” of cancers with poorer survival outcomes, such as cancers of the lung, oropharynx, oesophagus, liver, gallbladder and pancreas. Conversely, Indigenous Australians have lower rates of some of the more curable cancers, such as breast, prostate, bowel and skin cancers.

Delayed diagnoses in Indigenous people also contribute to poor survival rates, along with a reduced likelihood of completing treatment. These problems may explain why Indigenous Australians die at higher rates than other Australians, even when afflicted with the same cancer type. However, the forum also revealed other, less apparent factors.

Penetrating insights

Ngiiare Brown (an Aboriginal medical educator and child health specialist with the NT Government) cited institutionalised racism, bureaucratic inaction, and a disconnect between Indigenous and non-Indigenous Australians as the underlying reasons behind the so-called “double burden” of disease suffered by Indigenous people. Brown also reminded the forum of other statistical iniquities; twice the rate of low birthweight, and an overall life expectancy 20 years lower than that of non-Indigenous Australians.

A penetrating cultural insight came from Jeremy Baker Balung (an Indigenous man who works as a counsellor for Aboriginal and Torres Strait Islander cancer patients at the Royal Darwin Hospital). Among Baker Balung’s Yolgnu people, each part of the body represents a spiritual link to individual members of the extended family; to have a cancer in a certain organ of the body represents a spiritual link to individual members of the extended family; to have a cancer in a certain organ of the body represents a spiritual link to individual members of the extended family; to have a cancer in a certain organ of the body represents a spiritual link to individual members of the extended family; to have a cancer in a certain organ of the body represents a spiritual link to individual members of the extended family. He emphasised the need to respect the data to Indigenous people, many of whom have reason to be bewildered, particular for people already at the margins of Australian society.

Ways forward

The forum sought “ways forward”, and the discussions and workshops mapped out paths towards improving the poor cancer outcomes for Indigenous people.

Consistent throughout was the need for allied health agencies to form collaborative partnerships with Indigenous organisations and individuals. Our ignorance of complex yet imperative cultural and linguistic issues was laid bare at the forum and supported by the latest data. Only by engaging with people like Jacinta Elston and Jeremy Baker Balung in interface roles will we be able to break down these barriers.

In response, The Cancer Council Australia is inviting Indigenous representatives to join its principal committees, is seeking to co-opt an Indigenous Australian onto its board, and is discussing a memorandum of understanding with NACCHO.

Options will be examined to boost research on cancer in Indigenous people, ensuring it is undertaken with liaison officers and developed in ways that will give ownership of the data to Indigenous people, many of whom have reason to be sceptical about research, given the history of European paternalism.

Increased collaboration should be enhanced by efforts to build the capacity of the Aboriginal health workforce that will depend on government funding, and improved cancer control in Indigenous communities has now become a key cancer council advocacy goal. The signs are encouraging: the Coalition’s pre-election cancer policy included a national bowel cancer screening program, targeting Australians aged from 55 and Indigenous Australians aged from 45, indicating a shift towards policy adjustments consistent with the poorer health outcomes of Indigenous people.

Cancer Councils and their allies will also work towards factoring Indigenous issues into policy development and promotion at every step in the cancer journey, from prevention to palliation.

There is no better example of the challenges of cancer prevention than smoking prevalence: 50% of the Indigenous population smokes, compared with about 20% of non-Indigenous Australians. To reduce this figure, again we must connect with Indigenous people and involve their organisations and communities in spreading the public health messages.

The need to formally involve Indigenous people in service design and delivery also applies to cancer screening programs. Already there are signs of improvement, with targeted Pap smears contributing to a 50% fall in Indigenous cervical cancer mortality in the late 1990s.

Palliation is also critical, particularly among people with such high rates of mortality and premature death. The Cancer Council Australia will look at educational tools to assist in the management of pain, dying and death among Indigenous communities.

Our commitment is already well supported at state and territory level. The Cancer Council New South Wales’ recent employment of an Aboriginal liaison officer based in Dubbo and the release of a cancer information kit for Aboriginal health workers are excellent initiatives that could be applied nationally.

These are all small steps towards a distant destination. But only through setting and achieving shorter-term goals will we be able to make an impact on the appallingly poor state of cancer outcomes for Indigenous Australians.

The discussion forum reiterated the overarching themes of dispossession, hopelessness, grieving, racism, paternalism and abject socioeconomic status — seemingly insurmountable problems, but not when addressed with the sense of purpose, cooperation and strategic thinking evident at the recent national forum.

An evaluation of support groups for young women with early breast cancer

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Abstract

This study evaluated the efficacy of a support group for young women with early breast cancer. Participants were 44 women ranging in age from 23 to 50 years (mean = 40 years) who attended a ten-session support group held at one of two metropolitan teaching hospitals. Participants completed a pre- and post-group evaluation package. Significant decreases in psychological distress at completion of the program were observed (t = 3.44, p = 0.001). Those with higher levels of distress at baseline reported significantly greater decreases in distress at the post-group assessment compared to women with lower levels of psychological distress. Overall no changes were found for social support (t = 0.77, p = 0.44), although women with lower social support at baseline showed significant increases in perceived social support at completion of the program compared to those with higher levels of social support. No changes were observed for self-esteem (t = 0.55, p = 0.59) however those with lower self-esteem before the group commenced showed greater increases in self-esteem compared to those with higher levels at baseline. None of the sociodemographic variables examined (age, marital status and number of children) affected improvement from the support groups. The clinical implications of the findings are discussed.

Introduction

Approximately 10,000 Australian women are diagnosed with breast cancer each year and in NSW in 1999, 3,463 women were newly diagnosed with breast cancer. Women under 50 years of age account for approximately 26 per cent of all new cases of breast cancer in Australia.1 Research indicates that young women have unique needs in terms of potential impact of treatment options on fertility and sexuality, the interruption of career, financial concerns and how to cope with young children. In this study, several women spoke about their experience of attending breast cancer support groups and not feeling a sense of connection with the older women they encountered instead. Many of these women commented that they were not going to get breast cancer and that they felt marginalised and isolated. In a qualitative study of very young women (aged less than 36 years) with early stage breast cancer, feelings of isolation and being different were identified as one of the predominant stressors.2 Other significant stressors experienced by these women were: coping with the unemployment of the diagnosis, their feelings about the illness on their partner and on their relationship with their partner; sadness about lost opportunities for childbearing; uncertainty about their future, and anxiety about the impact of the illness on their children.3

A number of studies have found that younger age is a risk factor for the development of psychosocial morbidity in women with breast cancer.4 Women with increased morbidity across all phases of diagnosis and treatment.4 Younger women report higher levels of emotional distress, more unmet practical needs, more financial distress and greater disruption to their daily lives following treatment for breast cancer.5 Dunn and Steginga suggest a number of reasons why young women with breast cancer may experience increased psychosocial morbidity compared with older women.6 From a developmental perspective, young women differ from older women as they are still adjusting to the transition to adulthood and consider matters such as their personal identity, career, financial concerns and how to cope with young children.7 Younger women have been found to experience more disruption to self-image and sexuality.8 Subsequent infertility as a consequence of breast cancer treatments may also negatively affect the younger women’s self-concept.9 In younger women, cancer may experience premature menopause as a result of ovarian toxicity from chemotherapy, resulting in disturbing physiological and psychological symptoms, which may include vaginal dryness, hot flushes, dyspareunia, mood swings and short term memory loss.10

Hubshon and colleagues studied women for a period of two years following mastectomy and found that depression, anxiety and irritability were significantly more common in women younger than 50 years of age compared with women of age 50 years, and with a control group.11 In another study assessing the effects of mastectomy,12 younger women were identified as being at greater risk, particularly those younger than 35 years of age and as being more likely to experience a deterioration in well-being.12 A large study of women commencing chemotherapy or radiotherapy also found younger age to be associated with lower levels of emotional well-being.13 Bloom and Kessler found that being younger and having more children under the age of 21 years were predictive of women experiencing greater psychological morbidity after breast cancer treatment.14 The authors highlighted that younger breast cancer patients experience greater affective distress in the first year following diagnosis and at 12 months post treatment and that those with younger age and comorbid conditions had lower levels of social support at time of diagnosis, and that younger women have been found to experience more disruption to self-image and sexuality.15

Dunn and Steginga also found that, consistent with previous research, younger women reported feeling more isolated but not necessarily to see their children grow up, about loss of fertility, or about not being able to have children because of concerns about future cancer recurrence.5 Younger women were significantly more likely to not see their children grow up and to get breast cancer and that they felt marginalised and isolated. In a qualitative study of very young women (aged less than 36 years) with early stage breast cancer, feelings of isolation and being different were identified as one of the predominant stressors.2 Other significant stressors experienced by these women were: coping with the unemployment of the diagnosis, their feelings about the illness on their partner and on their relationship with their partner; sadness about lost opportunities for childbearing; uncertainty about their future, and anxiety about the impact of the illness on their children.3

A number of authors have argued that the provision of appropriate support services that cater to the specific needs of young women is important.16 Dunn and Steginga’s study of the supportive intervention most commonly endorsed by young women was peer support, which was seen as providing them with an opportunity to meet and share experiences with other women with breast cancer.17 The authors (p 144) state that ‘group interventions that provide women with breast cancer with the opportunity to compare themselves with others in a similar situation, receive support for their experiences of distress, and assisting women to develop resilience in the face of adversity. For this particular target group (i.e. young women), peer support programs, professionally supported and supervised, are a priority’.18

We recently carried out a systematic literature search using MEDLINE, PsycINFO, and EMBASE of studies, published in a peer-reviewed journal in the English language, which described a group therapy program for women with breast cancer.19 We provided qualitative outcome data and had a prospective design (with a pre- and at least one post-counselling assessment) or a randomised controlled trial design. This systematic search of the literature found three RCTs and three qualitative studies focused on the efficacy of support groups for women with breast cancer.20 21 22 Most studies assessing the efficacy of psycho-educational groups have demonstrated improvements in mood disturbance for groups at baseline compared with control groups.2 23 24 25 Dunn and Steginga’s study of the psycho-educational interventions reviewed showed limited or no reduction in mood disorder, but this may be affected by the incapacity to assess as a benefit finding.17 26 The positive effects of psycho-educational interventions have been demonstrated over short-term27 28 29 and longer-term periods.30

Although the unique psychosocial impact of breast cancer on younger women is a prominent issue at baseline and supported by researchers,31 32 33 34 and a number of authors have suggested that the needs of this group of women would be best addressed by the provision of groups specifically designed for younger women,35 36 very little work has been conducted to date with this group of young women. The systematic literature search found no studies evaluating the outcomes of psychosocial group therapy for groups of younger women, however two studies describing the content of groups for young women were identified. Smeardah describes a British group program for women under 35 years of age with breast cancer.37 Psycho-educational groups, aimed at reducing psychological morbidity in young women with breast cancer, were conducted for 2 hours weekly over a 6-month period. Although formal evaluation was not reported, informal evaluation indicated that young women identified the opportunity to network with women in a similar situation as one of the most important aspects of the group and that they found the educational and the social support from the group to be beneficial.37 A large project in California has commenced to develop and evaluate a psycho-educational group intervention for younger women newly diagnosed with breast cancer.38 This includes a 10-week psycho-educational group program for women 50 years and younger, and initial feedback has found that 87 per cent of participants rate the intervention as helpful.39 The majority of women in the study rated ‘being able to talk/to relate to the other women’ and ‘emotional support’ as most helpful, and also found the provision of education and information to be helpful.

Given the dearth of empirical data in this area, this study is assessing the efficacy of a support program for women diagnosed with early stage breast cancer. The study tests the following hypotheses: (i) there will be significant improvements in psychological outcomes relative to baseline; (ii) women with lower social support, lower self-esteem and higher psychological distress at baseline will experience greater improvements in each of these outcomes; (iii) younger women will experience greater improvements in distress relative to women without a partner. Outcomes will also be dependent upon whether or not women have children.

Methods

Participants

Participation in the support groups was open to young women receiving treatment for early stage breast cancer at two treatment centres in Sydney. Women were referred to the group support facilitator by health care providers at the two treatment centres (the NSW Women’s Breast Centre, a joint service of the Royal Hospital for Women and the Prince of Wales Hospital, and the Mater Hospital). Ethics approval was obtained from the two institutional ethics committees in Sydney, all participants were telephoned by the group facilitator for a pre-group interview. All women were eligible to participate, using a functional definition of young as developed by Dunn and Steginga that is not contingent upon chronological age, thereby avoiding the pitfalls of an arbitrary cut-off.3 Three indicators were utilised for defining young as applied to women with breast cancer: (i) the woman is of childbearing age; (ii) the woman has young children, that is, children not yet at secondary school; or (iii) the woman has not yet reached menopause.40

A combination of CBT and mutual aid formed the theoretical framework underlying the group program.41 The groups were facilitated by a Clinical Psychologist in group facilitation (BT) and co-facilitated by a specialist breast care nurse, social worker or pastoral care worker. The group support program consisted of ten fortnightly sessions, offered on weekday evenings. The number of group participants was limited to twelve. The first session consisted of an introduction to the program and ice-breaker activities. Baseline questionnaires were collected at the first therapeutic session. The nine therapeutic sessions covered the following topics: (i) post-treatment issues and recovery from breast cancer; (ii) feeling good about yourself; (iii) coping with fear, ...
satisfaction with group intervention
As well as the psychometric measures, post-group questionnaires included 18 purposively designed items assessing satisfaction with aspects of the group program. Response options ranged from ‘strongly agree’ to ‘strongly disagree’. Scores ranging from 1 to 5 were allocated with higher scores denoting greater satisfaction. A Total Mood Disturbance Form is calculated by adding together scores on the other five subscales except vigour. A higher score indicates poorer outcome. High internal consistency and test-retest reliability has been reported for each of the six subscales.56

The Coopersmith Self-Esteem Inventory - Adult Form
This is a 25-item unidimensional self-assessment instrument measuring self-esteem.57 It has been widely used in a range of research trials and in intervention studies with breast cancer patients.18 and has adequate psychometric properties.34 Scores range from 0 to 100 and higher scores denote greater self-esteem.

The Duke UNC Functional Social Support Questionnaire (DUFSS)
The DUFSS is an 8-item, 2-scale questionnaire that assesses four content areas: quality of support, confidant support, affective support and instrumental support. Factor analysis demonstrates that it assesses two dimensions of social support: affective support (three items) and confidant support (five items).58 Reliability and validity data have been reported and are satisfactory.59 Scores range from 8 to 40 and higher scores denote greater social support.

Changes in patient outcomes related to baseline

<table>
<thead>
<tr>
<th>Variable</th>
<th>Level</th>
<th>N per cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Socio-demographics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age (years)</td>
<td>&lt; 30</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>30-39</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>40-49</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>50+</td>
<td>2</td>
</tr>
<tr>
<td>Marital status</td>
<td>Married</td>
<td>31</td>
</tr>
<tr>
<td></td>
<td>Not married</td>
<td>72</td>
</tr>
<tr>
<td>Educational level</td>
<td>Post-school</td>
<td>37</td>
</tr>
<tr>
<td></td>
<td>No post-school</td>
<td>64</td>
</tr>
<tr>
<td>Type of surgery</td>
<td>Lumpsurgery</td>
<td>27</td>
</tr>
<tr>
<td></td>
<td>Unilateral mastectomy</td>
<td>40</td>
</tr>
<tr>
<td></td>
<td>Bilateral mastectomy</td>
<td>45</td>
</tr>
<tr>
<td>Adjutant treatment</td>
<td>Chemotherapy</td>
<td>36</td>
</tr>
<tr>
<td></td>
<td>Radiotherapy</td>
<td>31</td>
</tr>
<tr>
<td></td>
<td>Temozolomide</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>Zoladex</td>
<td>5</td>
</tr>
<tr>
<td>(a) Some women had more than one type of surgical procedure</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 2: Mean psychological outcome scores by testing group

<table>
<thead>
<tr>
<th>Measure</th>
<th>Baseline N</th>
<th>M (SD)</th>
<th>Post group N</th>
<th>M (SD)</th>
<th>Z/t</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>POMS (total score)</td>
<td>42</td>
<td>20.7 (21.5)</td>
<td>43</td>
<td>9.4 (18.9)</td>
<td>3.44</td>
<td>0.001</td>
</tr>
<tr>
<td>Anger (a)</td>
<td>43</td>
<td>3.3 (4.0)</td>
<td>43</td>
<td>2.2 (3.5)</td>
<td>3.21</td>
<td>0.026</td>
</tr>
<tr>
<td>Tension (a)</td>
<td>43</td>
<td>5.2 (4.0)</td>
<td>43</td>
<td>4.3 (4.0)</td>
<td>0.82</td>
<td>0.43</td>
</tr>
<tr>
<td>Vigour (b)</td>
<td>43</td>
<td>8.5 (5.7)</td>
<td>43</td>
<td>10.8 (4.0)</td>
<td>-2.59</td>
<td>0.013</td>
</tr>
<tr>
<td>Depression (a)</td>
<td>42</td>
<td>5.5 (6.0)</td>
<td>43</td>
<td>2.9 (3.5)</td>
<td>-2.39</td>
<td>0.017</td>
</tr>
<tr>
<td>Fatigue (a)</td>
<td>42</td>
<td>9.5 (5.8)</td>
<td>43</td>
<td>6.6 (5.4)</td>
<td>3.22</td>
<td>0.003</td>
</tr>
<tr>
<td>Confusion (a)</td>
<td>42</td>
<td>5.5 (3.9)</td>
<td>43</td>
<td>4.3 (3.6)</td>
<td>2.08</td>
<td>0.044</td>
</tr>
<tr>
<td>DUFSS (total score) (c)</td>
<td>44</td>
<td>33.2 (5.4)</td>
<td>43</td>
<td>32.6 (5.2)</td>
<td>0.77</td>
<td>0.44</td>
</tr>
<tr>
<td>Affective support</td>
<td>44</td>
<td>13.1 (2.0)</td>
<td>43</td>
<td>12.1 (2.3)</td>
<td>-2.56</td>
<td>0.10</td>
</tr>
<tr>
<td>Confident support</td>
<td>44</td>
<td>20.1 (4.1)</td>
<td>43</td>
<td>20.4 (3.6)</td>
<td>-0.030</td>
<td>0.98</td>
</tr>
</tbody>
</table>

Table 3: Means and standard deviations for satisfaction items

<table>
<thead>
<tr>
<th>Item</th>
<th>Mean</th>
<th>SD</th>
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</thead>
<tbody>
<tr>
<td>Overall satisfaction</td>
<td>4.55</td>
<td>0.63</td>
</tr>
<tr>
<td>Group taught topics were appropriate</td>
<td>3.16</td>
<td>0.74</td>
</tr>
<tr>
<td>I learned about the emotional impact of breast cancer</td>
<td>3.20</td>
<td>0.78</td>
</tr>
<tr>
<td>I would recommend the group to others in my situation</td>
<td>4.8</td>
<td>0.45</td>
</tr>
<tr>
<td>I think the group was well facilitated</td>
<td>4.8</td>
<td>0.39</td>
</tr>
<tr>
<td>I feel more supported as a result of attending the group</td>
<td>4.5</td>
<td>0.80</td>
</tr>
<tr>
<td>I have learned more about the emotional impact of breast cancer as a result of attending the group</td>
<td>4.5</td>
<td>0.66</td>
</tr>
<tr>
<td>I would recommend the group to others in my situation</td>
<td>4.4</td>
<td>0.74</td>
</tr>
<tr>
<td>I think the group was well facilitated</td>
<td>4.4</td>
<td>0.79</td>
</tr>
<tr>
<td>I feel more supported as a result of attending the group</td>
<td>4.4</td>
<td>0.66</td>
</tr>
<tr>
<td>I feel less isolated as a result of attending the group</td>
<td>4.3</td>
<td>1.03</td>
</tr>
<tr>
<td>I have learned strategies to help me feel more positive about the future as a result of attending the group</td>
<td>4.3</td>
<td>0.82</td>
</tr>
<tr>
<td>I think the meeting time (i.e. weekday/afternoons-evenings) was appropriate</td>
<td>4.3</td>
<td>0.96</td>
</tr>
<tr>
<td>I have learned more about breast cancer and its treatment as a result of attending the group</td>
<td>4.2</td>
<td>0.83</td>
</tr>
<tr>
<td>I feel I have been able to support other members of the group as a result of attending the group</td>
<td>4.0</td>
<td>0.57</td>
</tr>
<tr>
<td>I have learned strategies to better manage my fears as a result of attending the group</td>
<td>4.0</td>
<td>0.76</td>
</tr>
<tr>
<td>I have learned strategies to resolve relationship or communication problems which may have occurred during or after my treatment as a result of attending the group</td>
<td>3.8</td>
<td>0.76</td>
</tr>
</tbody>
</table>

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ARTICLES

ARTICLES
No significant associations were observed for changes in psychological distress depending on women’s age (r = 0.177, p = 0.43) or for family history of breast cancer (children: r = 0.43, p = 0.068) or a partner (r = 0.13, p = 0.90). Likewise, a test for an association between changes in social support and age showed a trend for significance (r = 0.30, p = 0.052), and having children (r = 0.240, p = 0.081) and a partner (r = 0.48) were not significantly associated with changes in social support. No significant correlations were observed for changes in self-esteem depending on age (r = 0.177, p = 0.43), having children (r = 0.240, p = 0.081), and a partner (r = 0.177, p = 0.87) were insignificant.

Discussion

This study evaluated the efficacy of a support group for young women with a diagnosis of early breast cancer. Psychological outcomes assessed were psychological distress, self-esteem and perceived social support. Consistent with our hypothesis (i) that there would be significant improvements in psychological outcomes relative to baseline, we found that participation in a group program evaluated by this study for young women with early stage breast cancer resulted in a significant decrease in psychological distress.

Although the authors know of no other group intervention evaluation conducted exclusively with young women with breast cancer to date, the finding of reduced psychological distress in women with early-stage breast cancer following participation in a short-term support group is consistent with a growing number of previous studies of women of mixed ages.13,14 Previous randomised controlled trials with women with mixed or unselected stages of cancer15-17 have also showed reductions in psychological distress following participation in support groups, as have studies with women with more advanced disease stages.18 However, all group intervention studies have shown reductions in psychological distress in women with early stage breast cancer.18,19 Interestingly, a study conducted by Spiegel and colleagues failed to find significant increases on a number of psychometric measures of emotional well-being at the end of a 12 week supportive-expressive group therapy program for women with early breast cancer, but significant improvements were evident at six and 12 months following intervention.20 Recent findings across studies could be the result of variations in the length of group programs and differences in when women join the group (i.e. short after diagnosis or towards the end of treatment).

Women with higher psychological distress at baseline showed greater decreases in psychological distress at the post-intervention assessment compared to women with lower psychological distress. The increased reductions in psychological distress for those women who were most distressed at pre-assessment are consistent with findings elsewhere.21 Women who were most in need of psychological intervention made greater gains than those who were less distressed. These findings are similar to findings in a study with older women with breast cancer in which we found that women who were more distressed benefited from a group intervention, compared to those who were less distressed, who, in that study, did not benefit from participation.22 On average, social support was not significantly improved by participation in the group. Although the potential for oncology support programs to assist women to increase their social support networks, to use their support network more effectively and to maintain quality in their interpersonal relationships, has been clearly documented,23 the effect of group interventions on perceived social support is far from clear. Some studies have found no improvement in perceived social support from group support programs,24 and the majority of evidence indicates it is small. Despite this, statistically significant findings were found in levels of psychological distress following group participation. The sample was a highly educated group compared with the general Australian population, which may limit the generalisability of the findings. It also be of interest to explore the effect of group participation for women from differing cultural backgrounds by evaluating the efficacy of culture-specific support groups. A pre-post-intervention design, rather than a randomised control design, was utilized for this study. Previous findings indicate that women who improve on psychosocial measures even without psychosocial intervention,24 so further research with young women using a control group design would overcome this limitation. Post-intervention measures were conducted following completion of the group and further-long term follow-up would be of value in ascertaining whether gains were sustained over longer periods, as previous studies have shown mixed results in terms of the sustainability of psychological benefits of support groups for women with early stage breast cancer.25-28

Clinical implications

The finding that women who participated in a psychoeducational group for young women with early stage breast cancer experienced a significant decrease in psychological distress supports suggestions that these women, who are at high risk of psychological distress, may benefit from group support. Women who were most distressed before participation in the group program experienced significantly greater improvements on a number of measures than women who were less distressed, indicating that the program was of particular benefit to those women with a greater need for intervention.

The provision of this short-term group intervention for young women was conducted with relatively limited resources. This approach thus provides cost-effective, accessible psychosocial support and promotes opportunities for young women to meet with others of their own age in similar circumstances, reducing the sense of isolation that many young women experience when faced with a diagnosis of breast cancer.

Acknowledgments

The authors would like to thank the following individuals for their contributions to this study: group co-facilitators, Anne Walsh, Judy Rickard, Margaret Sharland, Pat Burgess, Nina Mara and Selina Consandine. We would also like to acknowledge the contribution of Dr Fran Boyle and Sr Kerrie Andrews. Finally, we acknowledge the contribution of all the women who participated in this study. Belinda Thews is supported by a National Breast Cancer Foundation PhD Scholarship, and Bettina Meiser by a National Health and Medical Research Council of Australia Public Health Fellowship.

References

Continuing Research Program Grants

- P Hogg  
  University of New South Wales  
  Tumour angiogenesis  
  $209,000

- G Marshall  
  University of New South Wales  
  Defining the cause and improving the treatment of childhood neuroblastoma  
  $315,000

- R Sutherland  
  The Garvan Institute of Medical Research  
  Steroid and growth factor signalling in the pathophysiology of breast and prostate cancer  
  $377,000

Total Continuing Research Program Grants $901,000

Continuing Research Project Grants

- M Stockler  
  University of Sydney  
  The ZEST trial: A double-blind, placebo-controlled trial of Zoloft’s Effects on Symptoms and survival Time in advanced cancer  
  $65,425

- H Gurney  
  Westmead Hospital  
  A phase III study of regional radiation therapy in early breast cancer  
  $38,362

- R Reddel  
  Children’s Medical Research Institute  
  Functions of ALT-Associated PML Bodies  
  $160,750

Total Continuing Research Project Grants $1,252,143

Career Development Research Fellowship

- G O’Neill  
  Children’s Hospital Westmead  
  $150,000

Total Research Fellowships $150,000

Other Research Programs

- Cancer Trials NSW (CTN)  
  $1,317,000

- Cancer Epidemiology Research Unit (CERU)  
  $1,321,034

- Cancer for Health Research & Psycho-Oncology (CheRP)  
  $620,000

- Hereditary Bowel Cancer Registers  
  $208,694

- Quality Improvement in Cancer Care Research and Demonstration  
  $300,000

- 45 and Up Cohort Study  
  $400,000

Commissioned Research Projects  
  $243,000

Total Other Research Programs $4,409,728

TOTAL RESEARCH FUNDED $7,405,016

THE CANCER COUNCIL SOUTH AUSTRALIA

New Research Project Grants

- Dr Ross Butler, Dr Gordon Howarth  
  Gastroenterology, Women’s and Children’s Hospital  
  Prevention of chemotherapy-induced mucositis and effects on tumour burden by faecal-producing probiotics  
  $48,833

- Professor David Bowtell, Dr Anna DeFazio, Dr Penny Blomfield, Dr Nikolajs Zeps, Dr Dorota Gertig, Professor Michael Friedlander A/Professor Paul Harnett, Dr David Wyld, Dr Margaret Davy  
  Molecular Epidemiology of Ovarian Cancer: The Australian Ovarian Cancer Study – Clinical Follow-Up Core  
  $36,700
Peter MacCallum Cancer Centre

Dr Michael Brown, A/Professor Ross McKinnon
Medical Oncology
Royal Adelaide Hospital

In vivo investigation of the effects of tumour associated macropaths upon capcetabime metabolism and the subsequent effects of the 5-FU generation upon the macropaths themselves.

$60,380

Dr Brian Chua, Professor David Joseph, Dr Jennifer Harvey, Dr Verity Ahern, Department of Radiation Oncology

Peter MacCallum Cancer Institute

A phase II study of regional radiation therapy in early breast cancer.

$23,179

Professor Gillian Duicheine, Professor Nigel Spry

M Marean Spry, Dr Howard Gurney, Ms Elaine Belle.

Division of Radiation Oncology

Peter MacCallum Cancer Institute

The timing of androgen deprivation in relapsed or non-curable prostate cancer patients.

$10,650

Dr Andreas Evlokos, Dr Lisa Butler, A/Professor David Findlay

Orthopaedics and Trauma

University of Adelaide

Inhibition of breast cancer growth in, and metastasis to bone using TRAIL therapy.

$368,250

Dr R Gibson, Royal Adelaide Hospital

Professor Gillian Duchesne, Professor Nigel Spry

Medical Oncology

University of Adelaide

Characterisation of a novel angiogenesis gene endonuism.

$60,902

Dr Drs Yeesim Khew-Goodall, Professor Mathew Vadas

Vascular Biology Laboratory

Division of Human Immunology

$67,529

Dr Julie Robinson, Athena Foniadakis

Leukaemia Scholarship for professional development in $5,000

Other programs funded in 2005

Senior Fellowships

C Riccardelli, University of Adelaide

$84,245

S Stephenson, The Queen Elizabeth Hospital

$84,245

Total Senior Fellowships

$168,490

Fellowships

A Evlokos, Hanscon Centre

$37,955

S Buchanan, University of Adelaide

$37,955

R Gibson, Royal Adelaide Hospital

$37,955

Total Fellowships

$84,345

Other Research Programs for 2005

Chair in Cancer Care – Professor Ian O’Leary

$100,000

Travel Grants

$35,000

Distinguished Visitors

$75,000

Student Travel Scholarships

$13,600

The Freemasons Cancer Research Scholarship [1]

$25,000

Data Managers Program

$152,000

Almqvist Bestefroms

$46,589

Total of Other Research Programs

$387,189

TOTAL RESEARCH FUNDED

$2,139,502

Peter MacCallum Cancer Centre

Mr Alan Stapleton, Dr Howard Gurney, Ms Elaine Belle.

Division of Radiation Oncology

Peter MacCallum Cancer Institute

Invivo investigation of the effects of tumour associated macropaths upon capcetabime metabolism and the subsequent effects of the 5-FU generation upon the macropaths themselves.

$60,380

Dr Mark Guthridge

Human Immunology, Institute

The role of a novel GM-CSF signalling pathway in regulating cell survival in myeloid leukemia.

$78,205

A/Professor Timothy Hughes

Division of Haematology, MVS

Causes and significance of persistent leukaemia in CML patients treated with ABL kinase inhibitors.

$58,327

A/Professor David Honfll, Professor Wayne Tilley

Dame Roma Mitchell Cancer Research Laboratories

Hanson Institute

Versican - a cell motility-promoting proteoglycan pivotal for prostate cancer metastasis.

$73,967

Professor Sharad Kumar

Department of Haematology

Hanson Institute, MVS

Mechanism of carcapse-3 activation and its regulation during apoptosis.

$69,500

A/Professor Geoffrey Lindeman, Dr David Allor

A/Professor Judy Kirk, Dr Graeme Suthers,

Professor Jack Goldblatt, Dr Mike Gattas

RMM Cancer Centre

Sentinal lymph node biopsy versus axillary clearance in operable breast cancer.

$58,500

Professor Alexander Morley, Dr Scott Grist

Department of Haematology and Genetic Pathology

Mitochondrial mutations in clonal haematological disorders.

$72,819

Professor Howard Morris, A/Professor Brian May, Professor Wayne Tilley

MVS

Prostate cancer cell synthesis of 1,25 dihydroxystim A D cell growth.

$84,016

Professor Ian N O’Leaver, Professor Robert J Barrett

Department of Medicine

Royal Adelaide Hospital University of Adelaide

End-of-life decision making: informing policy using ‘maximum variety’ sampling and partially derived qualitative data.

$68,242

Professor R John Simes, Professor John R Zalcberg, A/Professor Paul Waring, A/Professor C Bruce Mann, A/Professor B Mark Smithers,

A/Professor Paul Waring, A/Professor, expressing kit:RCT of adjuvant imatinib mesylate

Royal Hobart Hospital – Western Australia, Tasmania, and a national clinical followup

$10,300

A/Professor Murray Whittle

School of Molecular and Biomedical Science

University of Adelaide

Targeting EPHB4 as an anticancer therapy.

$77,434

Dr Sally-Anne Stephenson, Dr Peter Bardy

Department of Haematology/Oncology

The Queen Elizabeth Hospital

Investigating the role of Sm2 in pancreatic cancer.

$62,000

A/Professor Murray Whittle

Division of Haematology

MVS

Does Stromal Derived Factor 1 - SDS - 1) Play a Role in Osteolytic Bone Disease and Increased Bone Marrow Micovessel Density in Multiple Myeloma?

$73,378

Total research grants

$1,196,413

Until the 14th Annual Meeting of the Australasian Brachytherapy Meeting to be held in Alice Springs during March 2005

$600

Angela Neville, Radiation Therapist, Holman Clinic, Launceston General Hospital

To attend the annual conference of the professional body for Radiation Therapists to be held in Auckland, New Zealand during August 2005

$700

Total Jeanne Foster Scholarships

$3,898

Jeanne Foster Scholarships

Janet Colbeck - Myer, Hobart

To attend a breast prosthesis fitting course in Melbourne during July 2004

$174

Faith-Lynn Olivers - Clinical Nurse, North West Regional Hospital

To study a Master of Nursing by coursework, Nurse Practitioner Pathway at the University of Melbourne

$1,000

Michelle Clark - Capri Body Fashions, Launceston

To attend a breast prosthesis fitting course in Melbourne during July 2004

$224

Jenny Carter, Breast Care Nurse, St Vincent’s Hospital, Launceston

To attend the 71st National Breast Care Nurses Conference in Melbourne during February 2005

$400

Susan Schwabe, Breast Care Nurse, Kings Meadows Health Centre

To attend the 71st National Breast Care Nurses Conference in Melbourne during February 2005

$400

Nola Polman, Breast Care Nurse, Hobart Community Health

To attend the 7th National Breast Care Nurses Conference in Melbourne during February 2005

$400

Anna-Marie Avery, Radiation Therapist, Holman Clinic, Launceston General Hospital

To attend the 14th Annual Meeting of the Australasian Brachytherapy Meeting to be held in Alice Springs during March 2005

$600

Angela Neville, Radiation Therapist, Holman Clinic, Launceston General Hospital

To attend the annual conference of the professional body for Radiation Therapists to be held in Auckland, New Zealand during August 2005

$700

Total Jeanne Foster Scholarships

$3,898

Other research grants

Julie Robinson, Social Worker

Launceston General Hospital

Athena Founiadakis Leukaemia Scholarship for professional development in cancer control

$5,000

Amir Tusunovic, Nurse, Royal Hobart Hospital

Athena Founiadakis Leukaemia Award

$900

Malinda Minstrell, The Cancer Council Tasmania

Athena Founiadakis Research Grant

$10,000

Launceston General Hospital & Royal Hobart Hospital

Clinical Data Managers

$39,000

To be announced

Tasmanian Award Workshop for new researcher

$2,500

Dr Penny Blomfield

Royal Hobart Hospital

Gynaecological cancer outcome data collection

$5,000

Owen Sprod

The Cancer Council Tasmania Tattersalls Award

Regulation of gene expression in cancer cells

$10,000

THE CANCER COUNCIL TASMANIA

Research grants

Dr Jo Dickinson

Study of molecular events in large Tasmanian prostate cancer families

$20,000

Dr Christina Trambas

Microscopic, biochemical and functional characterization of Natural Killer cell invasion into tumour target cells (emporipsosis)

$40,000

Dr Penny Blomfield

Molecular epidemiology of ovarian cancer: Australian ovarian cancer study – Western Australia, Tasmania, and a national clinical followup

$30,810

Dr S Green Wood

Long-term effects of UVB irradiation on neonatal Langerhans cells

$35,000

Dr David Amor

Royal Hobart Hospital

Kconfab: The Kathleen Cunningham Consortium for Research into familial aspects of breast cancer

$16,300

Total research grants

$136,150

Funded by David Collins Leukaemia Foundation (DCLF) (amount not included in total research funding)

Dr Adele Holloway

University of Tasmania

Identifying genes regulated by AML in myeloid cells

$28,000
### Research grants

<table>
<thead>
<tr>
<th>Grant Title</th>
<th>Funder</th>
<th>Funding Amount</th>
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<tr>
<td>Caveolin-1 regulation of breast cancer growth and metastasis</td>
<td>Peter MacCallum Cancer Centre</td>
<td>$65,000</td>
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<tr>
<td>Molecular epidemiology of ovarian cancer: Western Australia, Tasmania</td>
<td>Peter MacCallum Cancer Centre</td>
<td>$69,993</td>
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<tr>
<td>Postdoctoral Research Fellowships</td>
<td>Peter MacCallum Cancer Centre</td>
<td>$72,400</td>
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<td>Total research grants</td>
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<td>$212,448</td>
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### Postdoctoral Research Fellowships

- B Coker, Walter & Eliza Hall Institute of Medical Research: $11,250
- B Morgan, Ludwig Institute for Cancer Research: $18,500
- S Whitmer, University of Melbourne: $25,210
- Total postdoctoral research fellowships: $147,375

### Postgraduate Research Scholarships and Vacation Studentships

- J Becanovic, Monash University: $150
- L Dow, Peter MacCallum Cancer Centre: $21,510
- C Fedele, Monash University: $23,150
- H Gal, Ludwig Institute for Cancer Research: $23,150
- K Hornan, Monash University: $21,510
- E Lee, Walter & Eliza Hall Institute of Medical Research: $22,510
- L MacLoughlin, Peter MacCallum Cancer Centre: $22,510
- M Wall, Peter MacCallum Cancer Centre: $22,510
- E Nakh, Walter & Eliza Hall Institute of Medical Research: $22,510
- J Stone, University of Melbourne: $13,260
- R Smith, University of Melbourne: $13,260
- J Viggiano, Walter & Eliza Hall Institute of Medical Research: $13,260
- 24 six week Vacation Studentships: $23,940
- Total scholarships and stipendships: $296,012

### Fellowships

- Carden Fellowship: D Metcalf, Walter and Eliza Hall Institute of Medical Research: $200,000
- Dunlop Fellowship: A Roberts, Walter and Eliza Hall Institute of Medical Research: $46,114
- A & H Fraser Fellowship: P Colman, Walter and Eliza Hall Institute of Medical Research: $106,000
- Lions Fellowship (variable): R Anderson, Walter and Eliza Hall Institute of Medical Research: $100,000
- Total fellowships: $368,114

### Other programs

- Cancer Control Research Institute Programs: $37,000
- Medical and Scientific Activities: $37,000
- Tissue Bank Coordination Project: $37,000
- Centre for Behavioural Research in Cancer: $1,475,000
- Centre for Clinical Research in Cancer: $1,475,000
- Victorian Cancer Control Program: $1,475,000
- VicHealth Centre for Tobacco Control (Cancer Council Victoria contribution to VicHealth Centre): $495,000
- Total Cancer Control Research Institute programs: $6,494,000
- Total RESEARCHFUNDED: $9,094,855

### Research grants

- M Degli Esposti: Improving anti-tumour responses: relevance of DC mediated activation of NK cells (two year grant): $110,000
- S Devidson: Independent assessment of cigarette output and components in real life situations: $52,209
- A Currie: Cationic antimicrobial peptides as novel natural adjuvants for enhanced systemic and intratumoral cancer therapy: $55,000
- B Musc: Radiographic staging of lung cancer in Kalgoorie Goldminers: $55,250
- J Olympl: Investigating the effectiveness of anti-inflammatory drugs in preventing the progression of chronic liver disease to hepatocellular carcinoma: $55,000
- J Cianney: Ribonucleotide Reductase A: Predictive Molecular Marker for Malignant Mesothelioma: $54,910
- P Leadman: Regulation of ee8b gene expression in cancer: $55,000
- M Bialaczynski: Regulatory T cells and Mesothelioma: $46,000
- Total research grants: $527,339
Edward and Patricia Usher Student Vacation Research Scholarships

F Chua  Expression of inhibitors of apoptosis in mesothelioma and tumour cell survival  $2,000
C Kipiani  The incidence of third primary breast cancer  $2,000
S Lue  The effect of bacterial DNA treatment on FMS-1 expression and apoptosis in human breast cancer cells  $1,200
R Lee  Development of a qualitative database and preliminary analysis for the National Analysis of the Supportive and Palliative Care needs of Parents whose Children have Died from Cancer  $2,000
A Tyler  Correlation of a bioeffect model with tumour control in localised prostate cancer treated with brachytherapy  $2,000

Total vacation research scholarships  $9,200

John Nott travelling fund

P Rajput  Attend University of Pennsylvania to conduct part of PhD study in the laboratory of their paediatric cancer centre.  $5,000

Total John Nott travelling fund  $5,000

Professorial Chairs

Chair of Palliative Care Research  Edith Cowan University  $100,000
Chair of Behavioural Cancer Research  Curtin University of Technology  $120,000
Chair of Clinical Cancer Research  University of Western Australia  $250,000
Total professorial chairs  $475,000

Other research grants

kConFab: A national consortium for research into familial breast cancer  Genetic Services of WA, King Edward Memorial and Princess Margaret Hospitals  $27,000
Bone tumour registry  $27,000
Children's Cancer Research Fellowship  TVW Institute Child Health Research  $15,000
Prostate Cancer Screening  $5,000
Non-melanoma skin cancer incidence study  $15,000
Formative evaluation of a physical activity and nutrition program for Western Australian primary schools  Edith Cowan University  $5,000
Travel grants  Attend 38th Annual American Association for Cancer Education Conference  $750

Total other research grants  $95,605

TOTAL RESEARCH FUNDED  $3,112,144

QUEENSLAND CANCER FUND

Research grants 2004-2005

J Simes, T Hugh, V Gabals, S Rondan, M Fink, J Celeno, J Olynwy, D Crawford, T Price  Adjutant interferon and/or Celecoxib for hepatoma  $28,000
G Lindeman, D Amor, J Goldblatt, M Gattas  kConFab: A national consortium for research into familial breast cancer  $71,700
D Oudahene, N Spy, A Stapleton, H Gurney, J Eborall  The timing of androgen deprivation in relapsed or non-curable prostate cancer patients  $10,900
B Chua, J Joseph, J Harvey, V Ahern  A phase III study of regional radiation therapy in early breast cancer  $23,750
P Gardiner, J Clements, T Walsh, J Bailey, G O'meara, J Virtue  Proteomic approaches to the early detection of prostate cancer  $71,700
J Clements, J Gao, D Nicol  Characterisation of prostatic kallikrein gene expression during prostatic transition between osteoblasts and prostate cancer cells: a model for prostate cancer bone metastasis  $71,700
R Tindle  Novel vaccine delivery using recombinant Hepatitis B surface antigen VNP - and DNA vectors  $71,700
J Hancock, A Harding  A biochemical analysis of MAP kinase pathway activation at the plasma membrane  $71,700
B Sturm  Role of Bcl2 integrin-induced osteonectin expression in melanoma metastasis  $71,700
K-N Zhao  Using yeast model to study the functional roles of three early genes in the life cycle of bovine papillomavirus type 1  $71,700
E Ward, L Cahill  Oxyphagia (impaired swallowing) following surgical removal of the larynx: a phase II study examining the role of kallikrein in cancer metastasis  $71,700
A Boyd  The role of eph protein over-expression in colon cancer metastasis  $71,700

D Moss, D Chen, J David, S Elliott, M Sherritt  A phase I trial on adaptive transfer of cytotoxic T cells specific for EBV latent membrane proteins (LMP1 and 2) delivered to patients with nasopharyngeal carcinoma  $71,700
R Khanna, J Tellam  Molecular characterisation of genetic variants of LMP1 oncogene from EBV associated nasopharyngeal carcinomas  $71,700
T Onks, G Walker  Investigating protein pocket function in development of cancer  $71,700
M Lavin, N Gueven  Role of ATX/SMG-1 protein in responding to DNA damage and maintaining genome stability  $71,700
G Hill  The role of donor T cell derived IL-10 in the enhancement of leukaemia-free survival after allogeneic SCT  $71,700
D Hart  Purified Blood DC Vaccination with defined Tumour Antigens for Multiple Myeloma  $73,800
M Kato  Discovery of breast cancer antigens recognised by cytotoxic T lymphocytes for tumour immunotherapy  $71,700
S Ralph, A Mellick  Melanoma and resistance to interferon therapy  $71,700
J Neuzil  Cancer cell targeting using receptor-specific peptide adducts with vitamin E analogues  $71,700

2005-2006

L Chopin, A Herington  Qreline receptor isoforms in prostate cancer proliferation: roles of heterodimerisation and signalling cross-talk  $71,700
A Yap  Tiam 1: a key regulator of E-cadherin signalling and epithelial organisation  $71,700
F Gardiner, M Burger, J Trayad, H Samaratunga, M Lavin  Multiple molecular markers for prostate cancer diagnosis from ejaculate  $71,700
A Nicol, J Lucktief  Immune therapy for melanoma with dendritic cells co-pulsed with a-galactosylceramidase and peptides  $71,700
B Gabbari  G2 phase cdk4 activity regulates expression of proteins essential for the fidelity of mitosis: a target for UV induced p16 expression  $71,700
X S Liu, J Frazier  Optimising immunotherapy in tumour antigen experienced host  $71,700
G Leggatt, J Frazier  The role of NKT and CD8 cells in tumour immunotherapy using epithelial tumour models  $71,700
K Spring, B Leggett, J Young  Role of oncogenic BMF (INSP5) mutation in the molecular pathogenesis of sporadic colorectal cancer  $71,700
N Hayward  Identification of novel tumour suppressor genes in melanoma using array-CGH  $71,700
R Koffler, N Hayward  Molecular mechanisms of insulinoma development  $71,700
J Young, J Jaxis  Characterisation of a novel syndrome of familial colorectal cancer based on the serrated pathway of tumour development  $71,700
K K Khanna, M Cummings, C Furnival  Characterisation of a novel protein involved in breast cancer progression  $71,700
G Hill  Host B cells and Graft-versus-host disease  $71,700
N Karrad, A Felso  In Vivo functions of CD8 low T cells  $71,700
M Gandi, R Khanna, P Marion, G Kennedy  EBV-specific Cytotoxic T Lymphocytes as tool for EBV-positive Hodgkin Lymphoma  $71,700
M Michael, B Burmeister  Randomised Phase II study of two regimens of therapy in management of locally advanced N  $68,936
P Butow, P Webb  Quality of life and psychosocial predictors of outcome in a population based study of ovarian cancer  $68,936
M O'Rourke, M Smithers, K Ellem  Phase III trial of an Immunotherapy for Stage III (UICC) melanoma based on cultured autologous dendritic cells presenting autologous tumour cell analysis  $71,700
M McGuckin, A Lopez  CA125 (MAC16) in the immunology of ovarian cancer  $71,700
K Radford, R WInneson, P Swindle  Selection of prostate-derived kallikreins for dendritic cell immunotherapy  $71,700

2005-2007

D Boxsell, D Wyld  Molecular epidemiology of ovarian cancer: The Australian Ovarian Cancer Study - Clinical follow-up core.  $69,993
J Simes, M Smithers  Intermediate and high risk, resected gastro-intestinal stromal tumours expressing kIT: RCT of adjuvant multibl cocktail  $16,834
W Warren  The role of the “diffused” gene in the control of cell proliferation  $71,700

Total research grants  $3,001,538

Fellowships

Senior research fellow program

M McGuckin, Mater Medical Research Institute and P Webb, Queensland Institute of Medical Research, G Kay, Queensland Institute of Medical Research  $314,562

Clinical research fellow

Richard Lhiert, University of Queensland  $37,200

Total fellowships  $351,762
Cancer Epidemiology Unit  $824,700
Behavioural Research Unit  $662,200
Queensland Cancer Risk Study  $100,000
Prostate Cancer Supportive Care & Patient Outcomes Trial  $435,970
Total Epidemiology and behavioural research programs  $2,023,770

Other research grants
Q/Griffith University: Cancer Support Centre (psychosocial oncology)  $98,351
Queensland Family Bowel Cancer Registry  $50,000
Australian Paediatric Cancer Registry  $348,660
Colorectal Cancer & Quality of Life Study  $111,510
Skin Cancers Project  $192,400
Total other research grants  $520,260

PhD program 2005
2005 – 2007
John Earnshaw Scholar 2005
Michael Hsiu-Li Lei, Queensland Institute Medical Research
K Wynn, Queensland Institute Medical Research
C Marais, University of Queensland
2004 – 2006
John Earnshaw Scholar 2004
M Jones, Queensland Institute Medical Research
A Ramsay, Queensland University of Technology
S Mattarazzo, University of Queensland
2003 – 2005
John Earnshaw Scholar 2003
L Packard, Queensland Institute Medical Research
K Jawerth, Queensland Institute Medical Research
E Hucker, Queensland Institute Medical Research
P Patit, Mater Medical Research Institute
Total PhD program 2005  $212,500

Hospital Based – Data Managers
Royal Children’s Hospital
Mater Hospital – Oncology Centre
Royal Brisbane Hospital – Radiation Oncology
Medical Oncology
Princess Alexandra Hospital
Darling Downs Medical Oncology Unit
Mater Adult Hospital
Mater Children’s Hospital
Royal Women’s Hospital
Total Data Managers  $401,040

TOTAL RESEARCH FUNDING  $6,510,870

Epidemiology and behavioural research programs
Australian Behavioural Research in Cancer
This is a regular feature in Cancer Forum describing behavioural applications in cancer prevention.

New Results
• Vierteil Centre for Research in Cancer Control (VCRCC), Qld

Attitudes and intentions in relation to skin screening
This study evaluated intention to undergo a skin examination and factors associated with intentions as part of a randomised community-based trial of population screening for melanoma involving 18 Queensland communities. Data originated from a baseline cross-sectional telephone survey of 3,110 study participants aged ≥ 30 years. Forty-five per cent of participants intended to have a clinical skin examination in the next 12 months and 72 per cent intended to examine their own skin. Women were more likely to say they intended to have or undertake skin examination. In the multivariate model, intention to undergo skin examination was strongly related to a history of previous clinical skin examination. Other factors associated with intention to screen included a history of skin cancer and a high susceptibility towards skin cancer. Intention to participate in skin screening, both clinical and self-examination was high amongst populations in rural and regional Queensland.

Childhood Cancer Health Survey
This small pilot study was conducted to determine childhood cancer survivors’ current health behaviours and their level of interest in health promotion programs. The survey involved 28 Queenslanders who had completed treatment for lymphoma, leukaemia or brain/central nervous system tumours ages 14-30. Ten parents of those under age 18 were also interviewed to ascertain their interest in health programs for their children. Participants were recruited from past and present member mailing lists of two support groups for children and teens living with cancer. Only 32 per cent of survivors ate the recommended two or more serves of fruit per day and none ate the recommended five serves of vegetables per day. Forty-six per cent were overweight or obese. Thirty-six per cent met the Active Australia guideline for physical activity (150 minutes of activity per week over 5 or more days). Physical activity and Body Mass Index results were significantly related to tumour type, with brain tumour patients faring the best.

Childhood cancer respondents were extremely or very interested in the following interventions: healthy eating (61 per cent), physical activity (57 per cent), improving one’s social life (46 per cent), feeling better about oneself (43 per cent), improving school/work performance (43 per cent) and weight control (38 per cent). The most favoured intervention delivery modality was face-to-face (57 per cent), mail (51 per cent), and internet (29 per cent). The association of financial stress with subsequent smoking care for inpatient smokers. Levels of NRT prescription and discharge care were particularly low. Some predictors of greater levels of care provision were identified. A quasi-experimental study of organisational change practices to increase the provision of smoking care is being conducted.

• Centre for Behavioural Research in Cancer (CBRC), Vic

Financial stress, smoking cessation and relapse: results from a prospective study of an Australian national sample
This study, led by Mohammad Siahpush, used prospective data from a representative Australian sample to examine the association of financial stress with subsequent smoking cessation among smokers and relapse among ex-smokers. Data were drawn from the first two waves of the Household Income and Labour Dynamics in Australia (HILDA) Survey. Included

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were eight items measuring financial stress, such as “In the past six months did any of the following happen to you because of a shortage of money?” Could not pay electricity, gas or telephone bills on time, … Pawned or sold something, … Went without meals, … Was unable to heat home”. We used multivariate logistic regression and adjusted for socio-demographic variables. Of the 2076 smokers in Wave 1 of the survey, 10.7 per cent had quit by Wave 2. A one-unit increase in financial stress was associated with a decrease of 13 per cent in the odds of cessation. Of the 2717 ex-smokers in Wave 1, 10.1 per cent had started smoking by Wave 2. A one-unit increase in financial stress resulted in an increase of 19 per cent in the odds of relapse. The study suggests that smokers with financial stress are less likely to quit and that ex-smokers with more financial stress are more likely to relapse. An increase in total financial stress is recognised as one of the most effective policies for reducing smoking prevalence. Furthermore, there is evidence that these policies are more effective for lower socio-economic groups. However, given that smokers with financial stress are less prone to quit, such policies may in fact worsen the material well-being of disadvantaged smokers who are particularly vulnerable to high-risk behaviors and fail to quit smoking. Special programmes may have to be implemented to counter the potentially adverse effects of tobacco price increases for these smokers.

A study of compliance of inner Melbourne solarium centres with a new Australian Standard assessment of age and skin type on usual practice.

This study, led by Suzanne Dobbinson, assessed observed compliance with the Australian and New Zealand Standard on Solariums. The study monitored solarium operators to provide risk information about skin cancer, provide goggles for eye protection and ensure adequate cleaning of facilities. The voluntary code also requires staff to provide access to information from high-risk groups, including those with very fair skin that burns but does not tan (skin type I) and those aged under 15 years. People aged 16 or 17 years are permitted to use solariums, provided they have parental consent.

We tested a randomly selected sample of 30 solarium centres in inner and bayside suburbs of Melbourne. Each solarium centre had an approach from three different research assistants with different skin type and age characteristics who posed as potential customers. Potential customers with olive skin who already face financial difficulties and fail to quit smoking. Special programmes may have to be implemented to counter the potentially adverse effects of tobacco price increases for these smokers.

Of the strengths of this study is that the questions assessing smoking behaviours and the procedures for sampling students have been the same since the survey began. This means we are able to compare results from year to year over time. Using standard questions and sampling measures, we found that the prevalence of current smoking for 12-15 year olds and 16-17 year olds in Victoria was the lowest since the survey began in 1984 (Figure 1).

Figure 1: Trends in proportion of current (smoked in past week) smoking among secondary students in Australia (1984-2002)

centre for Cancer Control Research (CCCR) and the Tobacco Control Research Evaluation Program (TCRE), SA

Psychosocial research and terminal care

Much of the Centre for Cancer Control Research’s (CCCR) earlier work focused on population-based descriptive cancer epidemiology, on factors associated with smoking before diagnosis and the role of smoking in cancer control. The focus identified is on preventing progression to the regular, addictive, long-term smoking habits that are consolidated during young adult life transitions (particularly in the 18-24 years age group).

Action is particularly needed to change those environmental and social influences that lead first to ‘social smoking’ among young women and then to addicted smoking. Particularly strong influences are:

- environmental tobacco smoke
- social cues and incentives to smoke
- point of sale visibility of cigarette packs
- tobacco promotion activities

All of these influences act together to normalise cigarette smoking and to make it particularly attractive to children and young adults.

Changes to eliminate exposure to tobacco smoke and the availability and promotion of cigarettes will make a difference. Coordinated mass communication campaigns and setting specific and social change initiatives (particularly in nightclubs, pubs and other public settings) can do much to change how young women think and act in relation to smoking cigarettes.

Research in the Pipeline

n CRCBC (Qld)

Brain Tumour Supportive Care Needs Study

This study aims to identify the supportive care needs of Queensland brain tumour patients and their caregivers. This information will be used by professional and patients to measure the supportive care needs of patients with brain tumours and their carers, as well as to inform the

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In the July 2004 edition of Cancer Forum we outlined a research project to be conducted by the Queensland Cancer Fund and collaboratively with the Queensland Institute of Medical Research and the University of Queensland. Briefly to recap, the aims of the project are to document the volume and casemix of skin lesions examined and excised in primary care skin cancer clinics and general practice and to examine the diagnostic performance within both settings. Other aims of the project are to describe and compare characteristics of patients who undergo a skin examination and skin excision, as well as to document the direct and indirect costs of diagnosis, treatment and management of skin excisions within primary care skin cancer clinics and in general practice. Twenty-eight skin clinics and 200 general practitioners from Brisbane, Sunshine Coast, Gold Coast and Toowoomba will be involved in the study. The project has received NHMRC funding for 2005 and 2006.

Student nurses: personal health risks, attitudes towards patient interventions and training needs

Nurses have been identified as a key group in the provision of preventive health services because of the frequency and duration of their contact with patients in many healthcare settings. Together with academic nursing collaborators at the Universities of Newcastle and Western Sydney, CHERP has instigated a study of lifestyle risk factors amongst nursing students which also examines attitudes towards preventive interventions, confidence levels and perceived training needs.

The main focus of the study is on smoking-related issues, however nutritional and solar protection activities were also examined. By surveying students from all three years of the undergraduate nursing program, it is planned to assess whether significant changes occur during their training both in their attitudes towards smoking patients and in their willingness to initiate smoking cessation interventions. The evaluation involves several components including surveys to measure community support for the smoking restrictions, attitudes toward the legislation among smokers and owners of licensed premises, licensed venue compliance and, ultimately, any economic impact of the new laws.

Evaluation of Tobacco the Truth is Out There!

On 6 December 2004 laws were introduced in South Australia prohibiting smoking in enclosed public places and workplaces (with phase-in provisions for hospitality venues). TCRC is evaluating the impact of the legislation. The evaluation involves several components including surveys to measure community support for the smoking restrictions, attitudes toward the legislation among smokers and owners of licensed premises, licensed venue compliance and, ultimately, any economic impact of the new laws.

Evaluation of Tobacco the Truth is Out There!

Quint SA disseminated an updated version of the teachers’ resource, Tobacco the Truth is Out There in November 2003 to teachers who had requested it. The resource contains information about classroom exercises on tobacco and is particularly aimed at middle school. TCRC has conducted follow-up interviews with teachers and is currently analysing the data to determine use of the resource, familiarity with the resource, areas that were particularly useful and areas for improvement. A report will be available in early 2005.

Involvement in ‘Smokescreen’ II project, in collaboration with NSW

TCRC and Quint SA are participating in the ‘Smokescreen’ II project being co-ordinated by The Cancer Council NSW. This project examines the impact on young people of an anti-smoking commercial placed before movies that feature characters smoking. Surveys are currently being conducted in the field.

Investigating enhanced presentation methods of the UV Index

A qualitative investigation was conducted by Dr Owen Carter last summer of how to improve presentation methods of the UV Index. A number of hypotheses were developed from this investigation, which is currently the most widely used method based on 600 intercept interviews. The depth of peoples’ understanding of the UV Index is being tested, as well as their appreciation of and the motivation effectiveness of four alternative methods of presenting the UV Index. Interviews are expected to be commencing in late January 2005 and results to be made available by the end of March.

Audit of tobacco point-of-sale and special events promotions

Geoffrey Jalleh is conducting two studies investigating marketing and promotion of tobacco by the tobacco industry. One study is an audit of point of sale marketing of tobacco products in retail outlets to determine whether or not these activities breach the laws and membership conditions of the Code. The other study is an audit of marketing and promotional activities at events and venues patroned by young people in order to assess for below-the-line activities.

State Members of Parliament Tobacco Control Survey

To coincide with the upcoming State election in Western Australia, Geoffrey Jalleh is conducting a telephone survey of State Members of Parliament to canvass opinions on key tobacco control issues. It is anticipated that the data from these studies will assist in building a case for strengthening state and federal tobacco control legislations.

CPRC (Qld)

Physical activity, sun exposure and the sporting involvements of young Queensland adults: identifying new opportunities for social and environmental interventions (PASS)

Physical activity (which in the main takes place outdoors) may be associated with increased sun exposure. Sun exposure increases risk of skin cancer. The Cancer Council of Australia has identified physical inactivity an important new risk factor for colon and breast cancer. Cancer organisations would not wish to promote a new preventive behaviour (physical activity) at the same time increasing exposure to another established cancer risk (sun exposure).

Young adults (those aged 18 to 30 years) are an important target group for physical activity promotion initiatives. There is a well-documented decreasing prevalence of physical activity participation over the young adult years and clear patterns of difference in the physical activity habits of young men (who tend to engage in more vigorous forms of activity) and young women (whose physical activity levels are more salient). Physical activity habits during the young adult years are likely to be important influences on habitual physical activity over the longer term. Strong, consistent and significant associations have been found that particular activities have significant implications for long-term chronic disease risk, including risk of colon and breast cancer.

Sun exposure increases risk of melanoma and non-melanoma skin cancers. While the precise roles of sun exposures at different life stages is not fully understood, excessive sun exposure during the young adult years and the persistence of habitual sun exposure throughout adulthood is likely to be related to increased skin cancer risk.

The focus of this study is on:

- on identifying relevant attributes of the settings in which sun exposure takes place, for physically active young adults
- on the interrelationships between physical activity and sport participation and sun exposure in young adults
- on identifying relevant attributes and norms of the social networks (parents and family, peers and formal groups), through which sun protection behaviours may be influenced
- on making recommendations on settings-based approaches that can most appropriately address sun exposure habits in young adults

News

VCIRC (Qld)

Appointment of Associate Professor Lin Fritsch

The Queensland Cancer Fund’s Viertel Centre for Research in Cancer Control is delighted to announce the appointment of A/Professor Lin Fritsch to the position of Head, Epidemiology Unit. Lin brings to the VCIRC significant experience in the areas of cancer epidemiology and occupational epidemiology. Her specific research interest areas are cancer and occupational exposures.

CHEPR

CHEPR have been successful in attracting funds for a number of new projects:

- A/Professor Alaf Girgis, Dr Chris Paul and Claire Johnson from CHEPR, together with external collaborators Professor David Currow (University of South Australia), Professor Linda Kristjansson, Edith Cowan University and Amanda Neil (University of Newcastle) have been successful in obtaining five years funding from the Commonwealth Department of Health and Ageing to undertake a comprehensive program of work to develop specialist palliative care referral guidelines, screening and assessment tools.

In conjunction with Dr John Wiggers and colleagues from Hunter Population Health, Dr Chris Paul, Dr Raoul Walsh and A/Professor Alaf Girgis were recently awarded four years funding by the Australian Research Council to examine the effectiveness of pro-active methods of a smoking cessation telephone counselling service.

Dr Chris Paul, Dr Raoul Walsh and flora Tzelepis were awarded a one year funding from the University of Newcastle to examine the prevalence, effectiveness and non-cessation use of nicotine replacement therapy in a random community sample of smokers.

Dr Jong Li was recently awarded a one year Early Career Researcher Grant from the University of Newcastle to explore the lifestyles and cancer surveillance practices of newly diagnosed cancer patients.

Several CHEPR staff participated in the recent COSA Annual Scientific Meeting 2004. Congratulations to Allison Boyes, who received the award for best presentation (‘It’s not all doom and gloom: well-being of cancer survivors five years after diagnosis’). Other CHEPR presentations addressed the coping styles of long-term cancer survivors (Alison Zuca), physical activity and quality of life (Alison Zuca), and the role of redefinition of risk among advanced colorectal cancer (Siblah Breen) and referral practices to palliative care in Australia (Claire Johnson). A/Professor Alaf Girgis also spoke on ‘Chair the Psychosocial Oncology Symposium, which included stimulating presentations from Ms Raedene Boyle, Professor James Zabora and Dr Jane Turner.

CBRC (Vic)

CBRC has welcomed Nathalie Sambell as Research Assistant Trainee, who will be working with Suzanne Dobinson on skin cancer control projects. Also add our statistician Professor Melanie Wakefield and A/Professor Yoshi Kashima (Department of Psychology, Melbourne University) have been awarded an ARC Linkage grant to study effects of anti-smoking and other cancer control advertising on message processing.

In November 2004, CBRC was subject to external scientific review and was awarded an ARC Linkage grant for a PhD student for 3 years funding by the Australian Research Council to examine the effectiveness of pro-active methods of a smoking cessation telephone counselling service.

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Cancer Care: An integrated approach – Clinical Oncological Society of Australia 31st Annual Scientific Meeting

The 31st COSA Annual Scientific Meeting was held at the National Convention Centre in Canberra from 27-30 November 2005. The meeting “Cancer Care: An Integrated Approach” was chosen to emphasise the modern multidisciplinary and multimodality approach to coordinated cancer care. The meeting focused on bringing a national body that represents all health professionals involved in cancer care with an annual meeting that caters for all of these groups.

As with previous conferences, a consumer forum was hosted by the Cancer Council ACT and the Cancer Alliance Network on Sunday preceding the main conference and featured national and international guest speakers on the topics of colorectal cancer, breast cancer, lung cancer, palliative care and psychosocial issues, palliative care and spirituality. The forum was opened by Lady Marlena Jeffrey and 150 consumers attended.

At the opening session, Martin Tattersall Professor of Cancer Medicine at the University of Sydney spoke on the development of Integrated Care in Cancer with the evolution of multidisciplinary treatment teams and the recognition of the importance of screening programmes, clinical trials and maintenance of quality of life. Larent Grahisl from University of Canberra presented a paper on Integrated Patient Support in looking at philosophical assumptions of how current health systems are divided into treatment and support and how a shift away from medically driven health care may work in cancer care. Peter Holm from the IARC in Lyon described the formation of a model of Coordinated Oncology Research in the United Kingdom with a National Cancer Research Network to provide centralised support and management of oncology trials. This presentation was especially timely as the Australian Federal Government had just prior to the elections committed to the formation of a National Cancer Agency as well as to infrastructure funding for cooperative group clinical trials.

A strong international faculty contributed to a number of symposia and sessions. Peter Harper discussed the issues of cancer in the elderly in a breakfast session and symposium and also participated in ovarian and lung cancer sessions. Martin Gore from the Royal Marsden presented on ovarian cancer, gene therapy and biological therapies in melanoma. Pierre Hainaut from the IARC in Lyon discussed the role of p53 in the Genetics of Cancer Symposium. In the Palliative Care symposium Nicholas Christakis from Harvard Medical School talked on the impact of healthcare on surviving family members of cancer patients and Christina Mason from St Joseph’s Hospice London on the impact on carers. James Zabora from the Catholic University of America presented on psychosocial screening and programme development as well as participated in the inaugural Oncology Social Work

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peer review and we obtained a very positive evaluation of our work program. The review concluded that “CBRC has an impressive record of refereed publications, program evaluation reports, books and book chapters, as well as identified impacts on practice and policy” and that “the CBRC is a leading, internationally recognised, research centre in its field”.

Visit our website www.cancervic.org.au/cbrc for information about current CBRC research projects, details of our latest publications and access to the CBRC Research Paper Series.

CBRCC at the end of February 2005, but will continue work advertising; and investigating the effect of smoking and alcohol knowing experiences with alcohol using health promotion to investigate: the effect of junk food advertising on children’s perceptions of foods.

CBRCC was awarded two ARC and two Healthway grants in 2005, and has been involved in the Cancer Care: An integrated approach – Clinical Oncological Society of Australia 31st Annual Scientific Meeting. Members of CCCR and TCRE are participating in specialist subcommittees on research, population health, clinical care and cancer control. Attention is being given in this context to psychosocial and other support needs of people with cancer.

CBRCC (WA)

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NEWS & ANNOUNCEMENTS

Cancer Forum Editorial Board – changing of the guard

The Cancer Council Australia would like to thank Associate Professor Robyn Ward for her invaluable contribution as a member of the Cancer Forum Editorial Board over the past decade. Professor Ward stepped down from the Editorial Board at the end of 2004 to devote more time to her patients and research commitments.

Of course, with A/Professor Ward departing, the search was on to find an appropriate person to fill her sizeable shoes.

On that note, we welcome Dr Stephen Della-Fiorentina, who has kindly offered his services as a member of the Editorial Board. Dr Della-Fiorentina is a medical oncologist and currently is Director of the Macarthur Cancer Therapy Centre and Interim Area Director of Medical Oncology South West Sydney Health Service. He lives at Campbelltown, Liverpool and Bowral. He trained at Westmead and RPA. Dr Della-Fiorentina’s clinical interests are lung and breast cancer and he chairs the Research Committee and clinical trials units at Campbelltown and Liverpool hospitals. Outside of work he is married, a director of Bowral Bowling Club and patron of Bodyline Dance Academy in the Southern Highlands.

Productivity Commission advised of future squeeze on cancer dollars

Australian must use more resources in cancer prevention and treatment infrastructure to prepare for a proportional increase in cancer incidence over the next 10 years. The Cancer Council Australia and Clinical Oncological Society of Australia (COSA) have advised the Productivity Commission.

Responding to an open study into the impact of medical technology on healthcare expenditure and advances in Australia over the next 10 years, The Cancer Council Australia and COSA jointly highlighted the emerging cancer threats as our population ages in the decade ahead and beyond.

The submission focused on the prospect of a future inhabited by more Australians with cancer, yet fewer taxpayers to support the associated medical costs. This conclusion is based on the convergence of three key factors: that cancer is predominantly associated with medical costs. This conclusion is based on the convergence of three key factors: that cancer is predominantly associated with medical costs. This conclusion is based on the convergence of three key factors: that cancer is predominantly associated with medical costs. This conclusion is based on the convergence of three key factors: that cancer is predominantly associated with medical costs. This conclusion is based on the convergence of three key factors: that cancer is predominantly associated with medical costs.

However, unacceptably high numbers of Australians continue to engage in high-risk behaviours such as smoking, exposing their skin to harmful ultraviolet radiation, making poor dietary choices and being physically inactive. The submission outlined a number of evidence-based measures to boost cancer prevention through public health promotion.

The Cancer Council Australia-COSA position on screening and early detection of major cancers was also put forward in the submission, while the case for improving treatment infrastructure to prepare for emerging technologies – such as genetic screening and treatment, PET imaging, and molecular pathology – was robustly stated.

The Productivity Commission’s draft preliminary report of the study is expected in April. A copy of the Cancer Council-COSA submission is available online on the study website at: www.pc.gov.au/study/medicaltechnology/ubs/sublist.html.

New position statements

The Cancer Council Australia has published three new position statements, on bowel cancer, testicular cancer and State and territory travel and accommodation subsidy schemes.

Bowel cancer is the most common potentially fatal cancer affecting both men and women in Australia. The bowel cancer position statement reiterates The Cancer Council Australia’s call for a national bowel cancer screening program targeting all Australians aged 50 and over. (In the 2004 federal election campaign, both the Coalition and the Australian Labor Party committed to national screening programs to commence from 2008.)

The testicular cancer position statement promotes the evidence-based view that the present level of community awareness of testicular cancer appears to be adequate and in proportion to current incidence and mortality rates.

The travel and accommodation schemes position statement calls for a Commonwealth-funded taskforce to examine inequities in access to cancer treatment across jurisdictions and between rural and urban areas, with the ultimate aim of improving access to services for people in disadvantaged regions.

A number of Sunsmart position statements have also been updated, including:

- Screening and early detection of skin cancer
- Tinting of car glass and window glass
- Fake tans
- Solariums

Cancer Council Australia position statements can be found at: www.cancer.org.au/positionstatements

Backyard now the extreme UV zone for Australians

From beach burns to backyard scorches, The Cancer Council Australia has released initial findings from the first National Sun Survey that show Australians are still twice as likely to get sunburnt at home than at the beach.

The Cancer Council revealed that almost one in five Australians were sunburnt on summer weekends.

Of those sunburnt, the survey showed that 32 per cent of Australians were burnt gardening or working around the home while 17 per cent were burnt at the beach or in the water. A further 24 per cent were burnt while enjoying outdoor activities such as picnics, BBQs and socialising.

Dr Andrew Penman, spokesperson for The Cancer Council Australia said, “Australians seem to be associating sun protection with the beach but not with their incidental outdoor activity. It takes as little as 15 minutes to burn in extreme UV radiation so covering up while pulling out the weeds or walking the dog would be substantially reduced by effective sun protection.

The survey found that 8 per cent of Australians went to the beach over the weekend, however, 29 per cent spent time gardening or working around the home.

“We know that sunburn increases your risk of skin cancer later in life so we urge all Australians to Slip! Slop! Slap! whenever they’re outdoors this summer,” Dr Penman said. “Find shade, wear light clothing, put on a hat and sunglasses and apply sunscreen regularly to exposed skin.”

According to The Cancer Council, skin cancer is predominantly caused by overexposure to ultraviolet radiation. However, sunburn isn’t the only cause – tanning or too much sun, year after year, can also lead to the disease.

“Skin cancer is one of the most preventable cancers. We hope these new findings will remind Australians not to be complacent when they’re out in the sun this summer,” said Dr Penman.

A further 24 per cent were burnt while enjoying outdoor activities such as picnics, BBQs and socialising.

The National Sun Survey reveals the sun-related behaviours of more than 5000 Australian adults aged 18 to 69 during peak UV times on summer weekends in 2003-04. The research was funded by the Cancer Councils across Australia and the Australian Department of Health and Ageing.

Australia takes lead in reducing cancer deaths – mortality rates lower than other developed nations

A new report, Cancer in Australia 2001, from the Australian Institute of Health and Welfare, shows that Australia has a lower cancer death rate than several other developed nations. The US, UK, Canada and New Zealand all recorded higher mortality rates than Australia.

The report has been welcomed by The Cancer Council Australia, which attributed much of the good news to population initiatives in prevention and early diagnosis and good access through Australia’s health system to advances in treatment.

The Cancer Council’s spokesman, Dr Andrew Penman, said the cancer death rate in Australia had fallen 17 per cent over 10 years and was now at its lowest level since records began in the 1970s.

“A significant part of Australia’s success has been due to comprehensive programs in prevention and early detection, Dr Penman said. “Our low death rate from lung cancer and other tobacco related cancer is a dividend from three decades of tobacco control which has seen smoking rates drop to the lower levels than comparison countries; while our comprehensive approach to screening for breast and cervical cancers means that our outcomes for these cancers compare very favourably.

“Prevention has delivered extraordinary value for money,” Dr. Penman said. “When you look at Australia’s lower rates of lung cancer incidence and mortality the argument is compelling – our death rates are 32 per cent lower than the US for males and a staggering 48 per cent for females. Although at 15,000 deaths from tobacco related disease each year, Australia still has a long way to go.”

While welcoming the declining death rates, Dr Penman also sounded a note of warning about cancers where mortality or incidence are higher than in other countries. “Australia, because of its climate and lifestyle, leads the world in its high rates of melanoma yet this is one cancer whose rates could be substantially reduced by effective sun protection. The good news from melanoma, is that, through early detection, we achieve a much higher survival than other countries. For instance percentage of people who survive melanoma in Australia to almost double that of the US.”

Dr Penman said that Australia’s good performance was not uniform across all cancers. “In contrast to our success in cervical and breast cancers, we have very high death rates from bowel cancer. An absolute priority for the nation is to expedite the rollout of a national bowel screening program, to which the Federal Government has declared its commitment.”

Success again for Pink Ribbon Day

2004 was another successful year for Pink Ribbon Day. So far, the 2004 event has raised $1.7 million, surpassing the national target of $1.6 million, with donations still coming in.

A fantastic result!

Essential to the success of Pink Ribbon Day is the relationship with national supporters, including: 3M, Amcal, Angus & Coote, Australian Hearing, BAE Systems, Basketball Australia, Best & Less, HIC Medicare, Miller’s Retail Group (including 1626, Crossroads, Katies and Silhouette), Rockmans and Sensis.

The funds raised will continue to support The Cancer Council Australia’s breast cancer research initiatives, education programs and support services.
Cancer Council finds many Australians exposed by solariams

The Cancer Council Australia has released alarming statistics showing that over 230,000 Australians have been exposed to UV radiation in the past year due to solariams.

“A solarium can emit UV radiation that is five times as strong as the midday summer sun,” said the Chair of the National Sun Survey Research Committee, Professor David Hill.

“Subjecting skin to the excessive amounts of UV radiation that solariams emit can be dangerous. It is important that the public understand that using solariams will increase exposure to UV radiation and risk of skin cancer.”

The research found the highest users of solariams were females aged 25 – 44 years.

“It may be that more women in the 25 to 44 age group are working indoors and so have less opportunity to tan in the sun,” Professor Hill said. “They may also have more money available for solariam use than younger women.”

Recent studies have shown that there has been an explosion in the number of solariams in NSW and Victoria over the past 10 years. A voluntary code, the Australian and New Zealand Standard on Solaria for Cosmetic Purposes, is used to regulate the industry. Research released recently in Victoria showed that many of the regulations were not being met. This included solariams that were unsupervised, solariams that were providing access without written parental consent to clients under the age of 18 and access to fair skin clients who will never tan.

“We are particularly concerned about unsupervised solariams that are coin operated or self serve, and those found in Health and Fitness centres without trained staff,” said the Chair of The Cancer Council Australia’s National Skin Cancer Committee, Craig Sinclair. “These solariams provide very easy access with little or no prior information or guidance for customers.”

The Australasian College of Dermatologists spokesperson Dr Ian Hamann said Australia had the world’s worst skin cancer rates and if we did nothing to minimise the risk of excessive UV exposure, the incidence of skin cancer would continue to rise.

“There is recent research suggesting a link between solarium use and the development of melanoma,” Dr Hamann said. “Melanoma is one of the most common cancers affecting young adults and can be life threatening. There is no safe way to tan the skin using either natural or artificial UV light.

“Skin cancer is a preventable disease and dermatologists are seeing these cancers in otherwise healthy adults in their twenties and thirties.”

The solariam data is a part of the National Sun Survey, which reveals the sun-related behaviours of more than 5000 Australian adults, aged 18 to 69 during peak UV times on summer weekends in 2003-04. The research was funded by the Cancer Councils across Australia and the Australian Department of Health and Ageing.

In discussing the recommended treatments some information given in the chemistry section regarding current trends was outdated. It is very individual in the amount of side effects experienced and the level of coping in each occasion. This was well emphasised by the authors.

The final section covered Changes that Cancer brings. This provided excellent information for coping strategies for both the patient and the caregivers. It also highlighted the use of the team in the management of the cancer journey. This included the caregivers and their importance in this team.

This book does provide much valuable information for the patient with cancer and their significant others. The questions used are common questions cancer patients and their caregivers ask and the answers provided generally provide sufficient information. By using the index, answers may be obtained with ease.

Meredith Cummins
Riverina Cancer Care Centre, Wagga Wagga, NSW

Australia’s Biggest Morning Tea – will this be a record-breaking year?

2005 will be a special year for Australia’s Biggest Morning Tea – as we aim to have a world-record breaking event! The Cancer Council Australia has registered with Guinness World Records to break the record for the World’s Largest Simultaneous Tea Party.

Breast Cancer 2nd Edition

M Baum and H Schipper
Published by Health Press (2002)

Breast Cancer is a UK publication, providing easy reference for clinicians at all levels. The guide enables the reader to further source more detailed information, if required, by supplying key references at the conclusion of each segment. There are nine segments exploring the basic concepts of breast cancer care. The use of diagrams and flow charts throughout the guide ensure key concepts are highlighted. The guide was published in 2002 and as a result there are some outdated points in the surgical procedures and management of advanced cancer segments.

The overview of breast cancer epidemiology is an easy to understand summation of current risk factors associated with breast cancer providing rationales behind past and present interpretation of risk. The authors become entangled when attempting to explain the difficult topic of risks and benefits of early stage breast cancer.

The guide’s reference to rehabilitation in cancer care demonstrates the authors origin, however is beneficial in providing post-operative breast surgery education. The purpose of participating in clinical trials provides general practitioners with the basic principles to explain to their patient the rationale for considering a clinical trial. The guide acknowledges that the arena of breast cancer is changing and our approach to understanding the mechanisms behind its behaviour is challenging and there are many unanswered questions being explored.

Overall, the guide would be of interest to those involved...
CANCER OF THE HEAD AND NECK (4TH EDITION)

E N Myers et al
Published by Myers (2003) Distributed in Australia by Elsevier
ISBN: 0-7216-9409-0  285 pages plus index
RPP: A$468.60

Cancer of the Head and Neck aims to be a comprehensive review of the management of patients with tumours of the head and neck and since its first edition in 1987 has been a highly regarded reference. Although targeted principally at surgeons, the book places great emphasis on the multi-disciplinary nature of the care of this group of diseases. Reflecting the practice in Head and Neck Oncology clinics, significant contributions to the book are made by experienced medical oncologists, radiation oncologists and allied health professionals, in addition to those of well respected head and neck surgeons.

This new edition is a well-produced book now comprising 850 pages with 37 chapters contributed by 850 contributors practising in 5 countries. Since the last edition, the overall length of the book has been reduced by consolidating information given in the previous edition but adding additional information in fewer chapters. There is an updated section on head and neck pathology and a discussion of recent advances in molecular biology, with detail on the current understanding of the molecular and cellular pathways and the progression of cancer. The major component of the book remains 17 chapters on site specific cancers, each with a logical discussion through the relevant anatomy, pre-treatment evaluation, treatment options, surgical and non-surgical approaches and detailed treatment outcomes. The roles of chemoprevention of tumours and chemotherapy for treatment have now been separated into separate chapters. There is also strong emphasis on reconstruction, with more detail on practical aspects of oral rehabilitation, functional issues of rehabilitation of speech and swallowing and their impact on quality of life. The management of cancer pain and the psychological aspects of cancer care have been combined into a single chapter on supportive and palliative care.

Although the number of contributors has been slightly reduced from earlier editions, this is not at the expense of helping the editors achieve their stated aim of producing a text that reflects contemporary practice. The addition of two new editors is a step designed to keep this reference relevant to contemporary care in the future. Like the previous edition, this book is highly recommended to any surgeon practising or in training for head and neck surgery and should be in the library of any institution participating in the care of head and neck cancer patients.

Kerwin Shannon
Sydney Head and Neck Cancer Institute, Royal Prince Alfred Hospital, NSW

CLINICAL ONCOLOGY 3RD EDITION

M Abelloff, J Armitage, J Niederhuber, M Kastan, W McKenna (eds)

Reviewing a book on oncology is actually a rather daunting task and I have few qualms about admitting that this is my first oncology textbook review attempt than I do in actually doing the review. The first question I ask myself is “How can I possibly read more than 300 pages in less than a month?” and the second is “What do I actually want out of a textbook in oncology in the first place?” The answer to the first question is that I cannot do it, nor should I attempt it – I need to be focused and targeted in my approach. As a medical oncologist, I think the answer to the second question is easier (and shows the way to address the first problem). I want an authoritative reference text that is clearly and logically set out; that contains a systematic approach to the whole of clinical oncology; that is well referenced and that admits to controversy where appropriate. An online version would also be a must in the modern world! One of my pet hates is the badly done index, so that will get extra scrutiny. A constant niggle in my brain is that in certain areas, such as the correct anatomical terms for neck pathology and a discussion of recent advances in cancer management sections had very timely updates, including recommendations on treatment of prostate, breast, colon and endometrial cancer.

However, just because the planning, layout and features are excellent, does not mean that this book is perfect. I found the section on mucositis to be out of date with no new updates. I suggest that supportive care in general is considered less important than other areas, although the chapter on Cancer in the Elderly is very good.

Overall, I would highly recommend this book, as it is comprehensive, well-structured and uses modern technology to the full. I know everything in it, I would be very knowledgeable indeed!

Dorothy Keefe
Dept Medical Oncology, Royal Adelaide Hospital, South Australia

CYTOLOGY OF SOFT TISSUE TUMOURS

M Ackerman, HA Domanski
RRP: US$134.00

This monograph is the distillation of 25 years of experience encompassing over 3,000 cases of the cytological diagnosis of soft tissue tumours from a specialist referral centre in Lund, Sweden. The book is part of a series of monographs in clinical cytology edited by the ‘father’ of fine needle aspiration (FNA) cytology, Svante Orell. The two authors; Mans Ackerman and Henrik Domanski, have extensive experience in the FNA diagnosis of these tumours.

Many anatomical pathologists in this country would baulk at the prospect of diagnosing soft tissue tumours through FNA. The large number of different entities, their relative rarity and the existence of benign ‘mimics’ of malignant tumours make this a difficult area of diagnostic pathology at the best of times. The loss of architectural information that occurs when a lesion is sucked up a 22-gauge needle and then smeared on a slide, as well as the inherent problems of large tumours means that most pathologists will insist on at least a few core biopsies before venturing an opinion. However, the ever-expanding number of publications on this topic and the push for less invasive methods of diagnosis means that the primary diagnosis of soft tissue tumours is emerging as an important new target for FNA biopsy. For this reason and because this book is written would frequently demand a dedicated and well informed cytologist, with some chapters requiring a reasonable scientific grounding. As a reference piece for researchers in complementary medicine it is extremely valuable in presenting a well balanced perspective on the potential benefits of functional foods and nutraceuticals for cancer prevention, while clearly defining the limitations of current research.

The book comprises sixteen chapters divided into two parts, Part I titled “Approaches to Cancer Prevention: Role of Nutrition” and Part II titled “Fruits, Vegetables, and Herbs in Cancer Prevention”. Throughout the book there is a fair amount of duplication of topic areas, for example the topic of soy-derived isoflavones for breast cancer is addressed in both part of the book.

Interest in and use of complementary medicines that includes functional foods and nutraceuticals is expanding dramatically across the globe. This book is therefore a welcome addition to the increasing number aimed at disseminating a balanced view of current knowledge in this area. The specific aim of this book is to convey up to date information relevant to the usefulness of dietary plants and nutritional supplements for cancer prevention to interested lay readers as well as to researchers and workers in the nutrition, food science and natural products community.

It generally succeeds in this aim although the level at which it is written would frequently demand a dedicated and well informed lay reader, with some chapters requiring a reasonable scientific grounding. As a reference piece for researchers in complementary medicine it is extremely valuable in presenting a well balanced perspective on the potential benefits of functional foods and nutraceuticals for cancer prevention, while clearly defining the limitations of current research.

At just over 100 pages, this hardcover book is somewhat slimmer than others in the series. However it maintains the high standards set by the preceding edition. It is superbly illustrated with large, high-quality colour photomicrographs on almost every page. This stand out in contrast to many recent pathology texts that have used digital images with less than optimal results. Information on individual entities is very well presented with a description of the cytologic features, an adjacent summary of the pertinent features, and numerous tables comparing and contrasting features of entities within the differential diagnosis. The text is concise and not dogmatic. The overall organisation is excellent and the book is very easy to use.

This book deals with a highly specialised field within diagnostic cytology, a field that many cytopathologists are not comfortable or confident with. Its outstanding presentation and intelligent discussion make it a worthwhile reference for any cytology department which may potentially receive such specimens. Furthermore, for those who just want a complete set of this notable series, it’s worth it!

Michael Buckland
Royal North Shore Hospital, NSW

FUNCTIONAL FOOD & NUTRACEUTICALS IN CANCER PREVENTION

RR Watson
RRP: A$299.00

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Michael Buckland
Royal North Shore Hospital, NSW
The international perspective of the book is apparent throughout. The editors represent four countries: Australia, Canada, UK and United States whilst expert contributors are from some 12 countries. Thus, renowned clinicians in the field of gynaecological cancer inform the reader of contemporary views from a global viewpoint, ensuring relevance to all regardless of where they practice.

The book consists of 71 chapters, divided into nine sections. The initial four sections address the epidemiology, diagnosis, pathology and management of gynaecological malignancies by organ site whilst the following five sections explore subjects that textbooks do not routinely consider such as the reference to the ‘potential carcinogenic activity of chlorophyll’ when clearly the author intended ‘anti-carcinogenic activity’. The writing style in some chapters also differs from that employed in the bulk of the text, an almost inevitable consequence of the large number of contributors.

On the whole there are many extremely useful tables showing recommendations for appropriate food intakes and biological activities in various foods and food components and the figures are generally easy to follow. A number of important points are frequently highlighted throughout this book. Firstly the authors are to be congratulated in extrapolating in vitro and animal model research to the human situation and secondly the complex interactions and synergies that are inherent in the development of cancer, a disease that exists in the individual and is one shared by many millions of people, are clearly outlined and supported by the work of many researchers.

Overall this book is an extremely useful reference, competently describing the current in vitro, in vivo and clinical trial and epidemiological data in this area and it would make a worthwhile addition to the libraries of complementary medicine researchers.

The books ‘uniqueness’ relates to the focus on controversies that exist in the management of gynaecological cancer. Although in some chapters contentious issues are debated – an example being the role of lymph-adenectomy in the management of early stage endometrial cancer – other chapters have attempted to raise awareness of contentious issues. The editors have balanced and objective approach allowing the reader to draw their own conclusions from the current research that each chapter describes in a systematic and considered format.

The introductory chapters outline mechanisms of host defence and the composition of what is normal microbial flora in various sites of the body.

It then goes on to look at 10 distinct types of haematological lymphoreticular malignancies, detailing ALL, AML, hairy cell leukaemia, CLL, CML, Myelodysplastic Syndromes, Multiple Myeloma, Hodgkin’s and Non-Hodgkin’s Lymphomas as well as infectious complications associated with stem cell transplant recipients.

The chapters that follow are related to infectious complications of the following solid tumour malignancies; brain, head and neck, lung, breast, gastrointestinal, lymphoma, skin, soft tissue, prostate, gynaecological, sarcomas and cutaneous malignancies.

The book is well-organised and easy-to-read. It is well-referenced and has an evidence-based approach.

The book has 45 authors, 39 of whom are U.S. physicians and researchers. It is edited by John Green who is Chief of Infectious diseases at the H Lee Moffitt Cancer Center and professor of medicine at the University of South Florida.

The book is well-organised and easy-to-read. It is well-referenced and has an evidence-based approach.

Infections in Cancer Patients would be a good resource to have accessible in oncology wards and outpatient departments.
MALIGNANT LIVER TUMORS: CURRENT AND EMERGING THERAPIES (Second Edition)

P A Clavien (ed)
Published by Jones and Bartlett Publishers (2004)
ISBN: 0-7637-1857-2  469 pages plus index
RRP: $278.30

Malignant liver tumours are a major health problem throughout the world. Over the past two decades there has been a rapid growth in our understanding of the epidemiology, etiology and treatment options for these tumours. Keeping pace with this explosion of information is difficult and hence the timely release of the second edition of Malignant Liver Tumors: Current and Emerging Therapies. This text, edited by five respected clinicians in the field of hepatic oncology, provides an excellent overview of the multidisciplinary approach to primary and secondary tumours of the liver. The strict editorial process has helped make each chapter balanced and well-referenced with minimal overlap of information throughout the book. This edition contains 10 additional chapters and highlights include living-related transplantation, laparoscopic liver resection, oncaval treatments, as well as an excellent review of alternative medicine options.

This book is attractively presented in hard cover and is conveniently divided into five parts made up of chapters from contributing experts who will provide high pre-operative diagnostic efficacy and can replace CTAP in many cases.

In general, the spectrum of disease covered as well as the strategies given to evaluate the liver in this book is impressive. After reading this book, radiologists and clinicians should feel confident understanding the imaging strategies applied to screening for hepatic disease and how this differs from the pre-operative diagnostic work-up, as well as evaluating the liver after different forms of treatment.

This text can certainly help confident image interpretation and management of liver disease and will provide useful information for educating referring physicians.

Lourens Bester
Mayne Health Imaging Diagnostic
Westmead Private Hospital, NSW

I strongly recommend this book to anyone interested in malignant liver tumours. This text will be an excellent addition to any library on this subject

Tom Hugh
Royal North Shore Hospital, NSW

The sub-specialty of neuro-oncology is slowly raising its profile. Changes in the natural history of other cancer types has resulted in increasing clinical dilemmas associated with brain metastases and the appearance of temozolomide for high-grade gliomas has created renewed interest in adjuvant and palliative therapies.

As a consequence, a number of encyclopaedic textbooks have appeared including this new volume from Mitchell Burger and Mike Prados. The book is edited into essential principles, ranging from basic science, diagnosis and treatment principals through to detailed chapters on the management of specific tumours. As with many textbooks there is a serious problem with content consistency and structure.

The chapters vary in their detail and value. For example, the chapter on primary cerebral lymphoma is disappointing in its discussion of chemotherapy and the relative controversies regarding current treatment strategies. Similarly, it is difficult to understand how the chapter on glioblastoma warrants six pages whereas that of anaplastic astrocytoma required 21 pages and nine authors.

Frankly, it irritates me that many chapters were multi-authored with five or six authors for five-page chapters. Further, I don't think that unfortunately duplicates much of the information in the earlier chapters for similar diseases. Thus, for example, the chapter on glioblastoma has a flimsy (albeit knowledgeable) five pages on systemic therapy and radiotherapy compared with five chapters discussing various surgical approaches to prostatectomy.

This is a textbook for the urologist or urology trainee and details the finer points of the surgical approach to this disease group. One oasis for the non-surgeon is the discussion of combined modality therapy for bladder cancer that deals comprehensively with the common arguments against this approach. The introductory chapter on molecular and cellular biology was also well worth the read for all oncologists, not just those interested in GU cancers.

In summary, if you use a scalpel on a regular basis then this book is for you. If not, try Principals and Practices of Genitourinary Oncology (Raghavan ed).

Howard Gurney
Department of Medical Oncology, Westmead Hospital, NSW

UROLOGIC ONCOLOGY

Cancer Forum - Volume 29 Number 1 - March 2005

Cancer Forum - Volume 29 Number 1 - March 2005
This text on uterine cancer is an excellent addition to the American Cancer Society’s Atlas of Clinical Oncology, which is a series of monographs on various cancer sites. The editors are experts in gynaecologic oncology, medical oncology and pathology, and their stated aim is “to provide a comprehensive overview of epidemiologic, pathologic, biologic and treatment paradigms relevant to both epithelial cancers and mesenchymal tumours of the uterine corpus”. They have succeeded in their aim. They have produced a readable, well-organised and informative overview of their subject. A wide-range of people including gynaecologists, oncologists and anyone with an interest in endometrial carcinoma, which is the commonest gynaecological cancer in the developed world, will enjoy this book.

There are 16 chapters from 23 contributors, 18 of whom are from the Harvard Medical School, one from Vancouver, three from Toronto and one from Miami and the text naturally presents a North American perspective. However, this does not detract from the wealth of well referenced information (up to 561 references) that endometrial carcinoma is not such a ‘benign’ disease. The chapters on Pathology and Molecular Pathogenesis of endometrial cancer are beautifully written and make difficult subjects accessible to the non-expert. The text is well laid out with good clinical and pathological photographs. The accompanying CD contains the full text and images which is good for travellers. This is a book one can “dip” into or read systematically if depth of knowledge is required. I have no hesitation in recommending this text to anyone with an interest in endometrial carcinoma. Gynaecologists should own a copy and all medical and hospital libraries should have this book on their shelves.

Ian Hammond
King Edward Memorial Hospital, WA

As well as discussing the usual aspects of pathology and treatment of endometrial carcinoma, there is a thoughtful chapter by Arlan Fuller on Prognostic & Predictive Factors in Endometrial Carcinoma, which considers “the importance of prognostic factors that are independently important in predicting survival or recurrence of disease”.

One of the major strengths of this text is the inclusion of detailed discussion on controversial topics. Gynaecologists will be particularly interested in the chapters on screening for endometrial carcinoma, the value of pelvic ultrasound, the significance of positive peritoneal cytology, the evaluation and management of women who are on Tamoxifen therapy and the role of conservative hormonal treatment for women with endometrial cancer who wish to preserve fertility.

Oncologists will find helpful and critical chapters on radiation and post-surgical management, and the management of recurrent and metastatic disease, which is a reminder that endometrial carcinoma is not such a ‘benign’ disease. The chapters on Pathology and Molecular Pathogenesis of endometrial cancer are beautifully written and make difficult subjects accessible to the non-expert. The text is well laid out with good clinical and pathological photographs. The accompanying CD contains the full text and images which is good for travellers. This is a book one can “dip” into or read systematically if depth of knowledge is required. I have no hesitation in recommending this text to anyone with an interest in endometrial carcinoma. Gynaecologists should own a copy and all medical and hospital libraries should have this book on their shelves.

Ian Hammond
King Edward Memorial Hospital, WA
<table>
<thead>
<tr>
<th>Date</th>
<th>Name of Meeting</th>
<th>Place</th>
<th>Secretariat</th>
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<tr>
<td>3-5</td>
<td>3rd International Symposium on Targeted anticancer Therapies</td>
<td>Amsterdam Netherlands</td>
<td>NDDO Research Foundation</td>
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<td><a href="http://www.nddo.org">www.nddo.org</a></td>
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<td>3-6</td>
<td>58th Annual Cancer Symposium of the Society of Surgical Oncology</td>
<td>Atlanta Georgia USA</td>
<td>D.K. Kubis - Society of Surgical Oncology</td>
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<tr>
<td></td>
<td>85 W Algonquin Rd Suite 55</td>
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<td><a href="http://www.surgonc.org">www.surgonc.org</a></td>
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<tr>
<td>7-9</td>
<td>Functional Genomics and Animal Tumour Models</td>
<td>Madrid Spain</td>
<td>CNIO-Spanish National Cancer Centre</td>
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<td>C/ Melchor Fernandez Almagro, 3 Madrid 28029 Spain</td>
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<tr>
<td>11-13</td>
<td>7th Shaukat Khanum Memorial Cancer Symposium</td>
<td>Lahore Pakistan</td>
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<tr>
<td>13-16</td>
<td>13th International AEO/AIO Cancer Congress</td>
<td>Wurzburg Germany</td>
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<td><a href="http://www.biodnet">www.biodnet</a> Francis.de</td>
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<tr>
<td>15-16</td>
<td>Building Palliative Care programs in Hospitals</td>
<td>Miami USA</td>
<td>Center to Advance Palliative Care</td>
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<td></td>
<td>Mount Sinai School of Medicine</td>
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<td><a href="http://www.c2cancer.org">www.c2cancer.org</a></td>
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<tr>
<td>17-19</td>
<td>6th International Symposium and Expert Workshops on Leukemia and Lymphoma</td>
<td>Amsterdam Netherlands</td>
<td>VU University Medical Center Dept. PAOG</td>
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<td>P.O Box 707 Amsterdam 1007 MB Netherlands</td>
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<td><a href="http://www.vumc.hemonc.nl">www.vumc.hemonc.nl</a></td>
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<td>3rd Annual Atlanta Lung Cancer Symposium</td>
<td>Atlanta USA</td>
<td>Imexed 70 Technology Drive</td>
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<td>Cancer in Developing World</td>
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<td>Symosium</td>
<td>Athens Greece</td>
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<td>13th Reach to Recovery International Breast Cancer Support Conference</td>
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<td>8-11</td>
<td>9th International Conference on Malignant Lymphoma</td>
<td>Lugano, Switzerland</td>
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<td>Lymphoma Conference Secretary</td>
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<td><a href="http://www.lymphoma.ch">http://www.lymphoma.ch</a></td>
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<td>World Congress on Breast Cancer</td>
<td>Halifax, Canada</td>
<td>World Breast Cancer Organization, Inc</td>
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<td>Sarcoma Meeting Stuttgart 2005</td>
<td>Stuttgart, Germany</td>
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<td>International East-West Symposium on Nasopharyngeal Cancer</td>
<td>Toronto, Canada</td>
<td>Princess Margaret Hospital, University of Toronto</td>
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<td>Toronto Ontario M6G 2M9 Canada Tel: +1 416 946 2123 Fax: +1 416 946 4856 Email: <a href="mailto:Peo.Pat.com@medisys.ca">Peo.Pat.com@medisys.ca</a> <a href="http://www.eaono.org@eaono.org">www.eaono.org@eaono.org</a></td>
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<td>2nd Quadrennial Meeting of the World Federation of Neuro-Oncology</td>
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<td>Federation of European Cancer Societies</td>
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<td>Avenue E Mouner 83 Brüssel, Belgium 1200</td>
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<td>26-30</td>
<td>XVII World Congress on Gerontology</td>
<td>Rio de Janeiro, Brazil</td>
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<td>Kubhechke Plaza Hotel Brasilia DF CEP 70710-908 Brazil Tel: +55 61 328 691 Fax: +55 61 328 6912 Email: <a href="mailto:Secretaria@aceventos.com.br">Secretaria@aceventos.com.br</a> <a href="http://www.associa%C3%A7ao2005.org.br">www.associaçao2005.org.br</a></td>
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<td>July</td>
<td>3-6</td>
<td>11th World Conference on Lung Cancer</td>
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<td>14-16</td>
<td>2005 Gastrointestinal Oncology Conference</td>
<td>Arlington, USA</td>
<td>International Society of Gastrointestinal Oncology (ISGIO) 200 Broadhall Way Malvina New York 11274 USA Tel: +1 330 8390 Fax: +1 33 935091 Email: <a href="mailto:info@isgios.org">info@isgios.org</a> <a href="http://www.isgios.org">www.isgios.org</a></td>
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<td>25-28</td>
<td>109th Annual Meeting of the American Academy of Otolaryngology - Head and Neck Surgery</td>
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<td>31st European Congress on Cytology</td>
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<td>09-12</td>
<td>34th Congresso Brasileiro de Radiologia</td>
<td>Brazil</td>
<td>Congresso Brasileiro de Radiologia Avenida Paulista 491 130 Andar GJ 132-CEP 01311-909 Brazil Tel: +55 11 285 4022 Fax: +55 11 285 4022 Email: <a href="mailto:davidloder@cir.org.br">davidloder@cir.org.br</a> <a href="http://www.cir.org.br">www.cir.org.br</a></td>
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<td>16-20</td>
<td>ASTRO 47th Annual Meeting</td>
<td>Denver, Colorado USA</td>
<td>American Society for Therapeutic Radiology and Oncology (ASTRO) 12500 Fair Lakes Circle Suite 375 Fairfax Virginia 22033 USA Tel: +1 70 3277 0170 Email: <a href="mailto:meeting@astro.org">meeting@astro.org</a> <a href="http://www.astro.org">www.astro.org</a></td>
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<td>ECCO 13 The European Cancer Conference</td>
<td>Paris, France</td>
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<td>53rd Annual Scientific Meeting of the American Society of Cytopathology</td>
<td>San Diego, USA</td>
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<td>CNO - Spanish National Cancer Centre</td>
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<td>C/Melchor Fernandez Almargo, 3 Madrid 28029 Spain Tel: +34 91 2246000 Fax: +34 91 2246980 Email: <a href="mailto:ccoc_vcoes@www.cocvco.org">ccoc_vcoes@www.cocvco.org</a> <a href="http://www.cocvco.org">www.cocvco.org</a></td>
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<td>11-13</td>
<td>Oncology Nurses Society Institutes of Learning</td>
<td>Phoenix, USA</td>
<td>Oncology Nurses Society 125 Enterprise Drive Pittsburgh Pennsylvania 15275-1214 USA Tel: +1 866 257 4667 Fax: +1 877 369 5497 Email: <a href="mailto:meetings@ons.org">meetings@ons.org</a> <a href="http://www.ons.org">www.ons.org</a></td>
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<td>27 –</td>
<td>91st Meeting of the Radiological Society of North America (RSNA)</td>
<td>Chicago, USA</td>
<td>Radiological Society of North America (RSNA) 829 Jorie Blvd Oak Brook IL 60523-2251 USA Tel: +1 630 571 7879 Fax: +1 630 571 7837 Email: <a href="mailto:admin@rsna.org">admin@rsna.org</a> <a href="http://www.rsna.org">www.rsna.org</a></td>
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<td>28th Annual San Antonio Breast Cancer Symposium</td>
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<tr>
<td>06-10</td>
<td>47th Annual Meeting of the American Society of Hematology</td>
<td>San Diego, California</td>
<td>American Society for Hematology 1590 M Street NW Suite 200 Washington DC 20006 USA Tel: +1 202 776 0544 Email: <a href="mailto:meetings@ash.org">meetings@ash.org</a> <a href="http://www.ash.org">www.ash.org</a></td>
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<td>47th Annual Meeting of the American Society of Hematology</td>
<td>San Antonio, USA</td>
<td>San Antonio Breast Cancer Symposium c/o San Antonio Cancer Institute 7979 Wurzbach Rd Suite L31 San Antonio Texas 78229 USA Tel: +1 210 616 5912 Fax: +1 210 949 5009 Email: <a href="mailto:BM@sanantonio.org">BM@sanantonio.org</a> <a href="http://www.sabcs.org">www.sabcs.org</a></td>
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<td>10-14</td>
<td>American Society for Cell Biology (ASCB): 45th Annual Meeting</td>
<td>San Francisco, USA</td>
<td>American Society for Cell Biology (ASCB) 8120 Woodmont Avenue Suite 750 Bethesda MD 20814-2755 USA Tel: +1 301 347 9300 Fax: +1 301 347 9310 Email: <a href="mailto:ascbofe@ascb.org">ascbofe@ascb.org</a> <a href="http://www.ascb.org">www.ascb.org</a></td>
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THE CANCER COUNCIL AUSTRALIA

The Cancer Council Australia is the peak national cancer control organisation. Its members are the leading state and territory cancer councils, working together to undertake and fund cancer research, prevent and control cancer and provide information and support for people affected by cancer.

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The Cancer Council ACT
The Cancer Council New South Wales
The Cancer Council Northern Territory
The Cancer Council South Australia
The Cancer Council Tasmania
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Dr K White PhD

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CLINICAL ONCOLOGICAL SOCIETY OF AUSTRALIA INC

The Clinical Oncological Society of Australia (COSA) is a multidisciplinary 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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President Elect
Prof D Currow BMed, MPH, FRACP

Executive Officer
Ms M McJannett

Council Nominees
Ms K Cameron RN, OncCent, GrDipN, MNSc
Professor L Kristjanson RN, BN, MN, PhD
Professor B Stewart MSc, PhD, FRACI

MEMBERSHIP
Further information about COSA and membership applications are available from: www.cosa.org.au or cosa@cancer.org.au
Membership fees for 2005
Ordinary Members: $140
Associate Members: $80 (includes GST)

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Cancer Nurses Society of Australia
Cancer Research
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Epidemiological
Gastrointestinal Oncology
Gynaecological Oncology
Lung Oncology
Medical Oncology
Melanoma and Skin
Neuro-oncology
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Surgical Oncology