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It is almost 30 years since US President Nixon declared “War on Cancer”. Cynics would say it was a ploy to distract attention from the Vietnam War, then grinding to a close. A National Cancer Act led to the identification of funding for Comprehensive Cancer Centres, and a massive increase in resources for basic cell biology research with the hope of uncovering the magic bullet that would be “a” cure for cancer that wouldn’t cause collateral damage for normal cells. Until recently, the billions were pouring into the black-hole and there was little change in the types of therapy the average cancer patient received, although outcomes improved inch by inch with better application of conventional therapy in a multidisciplinary setting.

For the past five years however there has been a new sense of excitement at international research meetings, followed by ripples in the clinical world, and the first agents based on our new understandings of molecular pathways controlling cancer formation have at last emerged into the clinic. Understanding the genes controlling cellular growth, which are overactive in cancer cells, has allowed development of targeted molecules to interrupt these pathways. Some agents target cell surface receptors (Trastuzumab, Cetuximab), others the signalling pathways connecting receptor to nucleus (Imatinib, Iressa), and others nuclear structures directly (Oxaliplatin). In order to improve the therapeutic index, drugs which are preferentially activated by enzymes within malignant cells deliver a high dose to cancer cells and spare normal tissues (Capecitabine). Agents which target the normal cells that are recruited into assisting in metastasis formation (bisphosphonates) aim to render the environment hostile to cancer cell growth. Each of these agents is described in more detail in the articles in this series, and all are based on fundamental insights into cancer cell biology that have emerged within the past 30 years. Each targets better the malignant cell, and has fewer side effects than conventional chemotherapy. Antiangiogenic agents are also promising, but as yet have not entered clinical practice and are not reviewed here.

Yet it turns out that curing cancer does not require a single bullet – more a steady stream of machine-gun fire. Each of these agents is given continuously – this has become possible as their toxicity is more manageable. We anticipate that they will work even better when combined with one another, or with conventional chemotherapy and radiotherapy. Perhaps we will be maintaining control or remission, rather than “curing”? Cancer treatment may become like treatment of blood pressure or diabetes or asthma – rarely are these cured, and combination oral therapy is the norm. Nixon presumably did not envisage we would be “sleeping with the enemy”.

What is clear is that these agents challenge our paradigms – oral administration allows patients coveted freedoms, yet the potential for toxicity requires that supervision be maintained, perhaps in different ways. Prospective pharmacoeconomic evaluation will be critical as overall costs of these agents are high – they are harder to produce and have been tooled up out of expensive basic research, the markets are small for individual agents, chronic use and combinations will add to the overall outlay. For these reasons the developmental emphasis should shift to the incorporation of these agents into definitive treatment and adjuvant treatment strategies. Meanwhile improved survival and quality of life for patients with advanced cancer will be the immediate outcome of their availability in Australia, assuming we can find a mechanism to pay for the peace.
The human receptor protein-tyrosine kinases (RPTK) constitute a large family of membrane spanning receptors that govern diverse cellular functions including cell-cell communication, growth, differentiation, proliferation and death (4). Perturbation of EGFR leads to a strong survival signal and matrix metalloproteinase-9 is reduced, possibly leading to a decrease in metastases. Synergy and additive cytotoxicity have been demonstrated with radiation and cytotoxics including platinum, gemcitabine, taxanes and camptothecans.

C225 has progressed into clinical trials and has reached phase III registration studies where it is being targeted for head and neck cancer. The recommended dose is 400mg/m² intravenous loading dose followed by 200mg/m² weekly. Typical adverse events included the allergic reactions seen with other monoclonal antibody therapies such as Matbthera® and Herceptin®. An anecof rash commonly occurs on the face and trunk and tends to resolve with repeated administration.

Encouraging evidence for the activity of C225 has included the addition of C225 to therapy in patients who have failed chemotherapy. C225 has been shown to re-sensitize tumour to chemotherapy in patients with squamous cell carcinoma (SCC) of the head and neck receiving cisplatin and in colorectal cancer patients receiving irinotecan. C225 is being combined with radiation and/or cisplatin in phase II and III trials for head and neck SCC.

Tyrosine kinase inhibitors

The second class of agents that target EGFR do so by inhibiting the tyrosine kinase activity or the receptor. These agents are generally classified as small molecule inhibitors of ATP binding sites. There are two main biochemical classes of these (RPTK) by mutation or over-expression is potentially oncogenic. Examples of receptors important in oncogenesis are the epidermal growth factor receptor (EGFR), insulin receptor, platelet-derived growth factor receptor, vascular endothelial growth factor receptor and fibroblast growth factor receptor.

The epidermal growth factor receptor is one of the first proto-oncogenes recognized. Avian viral erb-B (HER2/neu) receptor is a large family of membrane spanning receptors that govern diverse cellular functions including cell-cell communication, growth, differentiation, proliferation and death. It has been demonstrated that EGFR or TGFα expression is linked with either ligand or antibody to target the receptor but these efforts have largely been superseded by the former two strategies.

Cetuximab (C225)

C225 (Cetuximab, Imclone Systems Inc., New York, NY) is a human-mouse monoclonal antibody to the immunoglobulin G1 subtype. It binds the extra-cellular domain of EGFR to inhibit binding of the ligands EGFR and TGFα. In vitro C225 has been shown to arrest G1 to S (transition) and enhanced apoptosis. In vivo studies with human xenografts have demonstrated reduced angiogenesis secondary to decreased VEGF and bFGF production by tumour cells. Matrix metalloproteinase-9 is reduced, possibly leading to a decrease in metastases. Synergy and additive cytotoxicity have been demonstrated with radiation and cytotoxics including platinum, gemcitabine, taxanes and camptothecans.

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Pharmacology

Trastuzumab (Herceptin®)

F Boyle Royal Northern Hospital St Leonards, NSW

Our understanding of cancer has progressed dramatically in the past two decades, following the discovery that changes in important growth-regulating genes within cells can alter their function and lead to unrestrained multiplication of the cell. Breast cancers with an over-expression of HER2 receptor. It induces immune attack on the cell, blocks growth factor binding, and promotes the degradation of the receptor. It also appears to enhance chemotherapy cytotoxicity.

Biological activity

Trastuzumab (Herceptin®) is a recombinant humanised mouse monoclonal antibody (IgG1) to the HER2 receptor. It contains a Fc region that can lead to the production of extra copies of a receptor on the surface of the cell. Growth factors bind to the receptors, and stimulate tyrosine kinases, leading to the activation of important growth-regulating genes within cells.

Trastuzumab is administered intravenously over 90-30 minutes, weekly, either alone or together with cytotoxic chemotherapy.

A total dose of 2mg/kg. Third weekly schedules are currently under investigation as the half life is long.

To determine suitability for treatment, over expression of HER2 needs to be determined. HER2 expression is measured on breast cancer cells, usually from a sample stored after initial surgery. There are a number of different methods. Immunohistochemistry (IHC) and fluorescence in situ hybridisation (FISH) are the best methods for measurement. By IHC, HER2 expression is characterised as 0, 1+, 2+ or patchy. These tests are expensive and do not currently have a higher risk of cardiac dysfunction when treated with trastuzumab alone, up to 10% of patients treated with trastuzumab plus paclitaxel, and up to 28% of patients treated with trastuzumab + anthracyclines (doxorubicin or epirubicin). Patients with poor baseline cardiac function and advanced age have a higher risk of cardiac dysfunction when treated with combination therapy. Cardiac monitoring is recommended.
in the combination arms experienced an improvement in (7.6 vs 4.6 months), one year survival (78% vs 67%) and alone have shown that the addition of trastuzumab significantly within two to three months of starting treatment. First line pretreated with anthracyclines, and at regular intervals. Cardiac toxicity will be of greater concern in the chronic phase, the blast crisis. CML is the product of the Philadelphia chromosome, the genetic overall response rates to standard chemotherapy and the incidence of this tumour is small, it has been notoriously to several different types of the c-kit receptor, with the same “switching off” of downstream signalling pathways that had previously been seen in CML. The preliminary results from an ongoing international study looking at two different doses of Imatinib in advanced or metastatic GIST, were presented at the annual meeting of the American Society of...
Oxaliplatin is a diaminocyclohexane analogue of platinum with chemotherapeutic properties similar to those of cisplatin. It is used in various tumor types in vivo.

Oxaliplatin is given as a two to six hour infusion; 85mg/m² every two weeks and 130mg/m² every three weeks. No intravenous hydration is required. After two hours only 15% of the platinum is present in the circulation with the remainder being distributed to the tissues. The drug binds irreversibly to naked and intracellular DNA. Proc Am Assoc Cancer Res, 38 (1997):A10-92.

Oxaliplatin has also shown promise in combination with fluorouracil/folinic acid regimen, two-weekly high dose continuous infusion in previously untreated patients with advanced colorectal cancer in a phase II study. The objective response rate was 40% and 50% respectively.

Although there is no universally accepted fluorouracil/folinic acid regimen, two-weekly high dose continuous infusion schedules have provided survival advantage and altered lives function tests being common. However unlike the other platinum there is little to no neurotoxicity, audiotoxicity or haematological dose-limiting toxicity at the recommended doses.

Phase I and II trials indicate that peripheral sensory neuropathy is the major dose limiting toxicity, associated with cold intolerance

This neuropathy is cumulative and reversible on treatment cessation. The symptoms are occasionally associated with pain and cramps. After an accumulation dose of 800mg/m² the risk of developing impairment is in the order of 10% to 15%. Oxaliplatin alters the voltage-dependent Na⁺ channel kinetics on sensory neurons. Therefore carbamazepine, which is a Na⁺ channel blocker has been investigated as a potential neuroprotectant, and preliminary results have confirmed this protective role in patients who develop WHO grade I or greater neurotoxicity.

For more information please refer to the following references:

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Capecitabine (Xeloda) is an oral fluoropyrimidine, which inhibits thymidylate synthase (TS), after activation by thymidine phosphorylase (TP). It is currently approved in Australia for use in metastatic breast cancer after failure of standard therapy, and for advanced or metastatic colorectal cancer (CRC). Trials are underway examining the efficacy of capecitabine in all the other malignancies currently treated with 5-Fluorouracil (S-FU), and in combination with other agents.

Biological activity
Thymidine phosphorylase is a tumour-associated angiogenic growth factor that induces neovascularisation and increases angiogenesis. At tumour edges cells have higher doses of TP than normal cells, capecitabine is preferentially activated to 5-Fluorouracil in tumour cells. This has the advantage of tumour selectivity with increased tumour drug concentrations but lower systemic S-FU levels. Tumour selectivity was confirmed in a colorectal cancer trial, which demonstrated that after capecitabine administration the concentration of S-FU in the tumour was 3.2 times greater than in adjacent tissue and 21 times higher in the tumour than in plasma. Preclinical studies suggest that there is a correlation between increased tumour biochemical markers (TP, DP) and sensitivity to capecitabine. If this proves to be correct this may allow for individualisation of treatment. Further to this, at the 16th annual meeting of the American Society of Clinical Oncology 2001 Park et al presented a paper reporting that patients who are homoygous for double repeats of the 28 base-pair sequence in the TS gene (S/S) respond much better to capecitabine with 80% responding compared to 10% with S/L and 14% with L/L variants. They conclude that genotyping of patients may be helpful to select patients likely to benefit from capecitabine.

Pharmacology
Capecitabine taken daily or twice daily has been shown to provide a steady plasma or tissue level to mimic continuous S-Fluorouracil (SFU) without the inconvenience of requiring central venous access, and is a produg that is metabolised via a three-step enzymatic process to the active agent fluorouracil.

It is then converted by cytidine deaminase to 5’-deoxy-5-fluorouridine (5’-DFUR) in the liver and/or tumour cells. The 5’DFUR is then activated by thymidine phosphorolysate (TP) with the help of thymidine phosphorylase (TP). As the result 5-fluorouracil (5-FU) is generated. Neutrophils converted in only three percent of patients and no alopecia was reported.

Phase III trials in metastatic colorectal cancer have been conducted comparing capecitabine with intravenous 5-Fluorouracil/leucovorin (S-FU/FA). The trials used the Mayo Clinic regimen of S-FU with bolus IV injection daily for five days in four weeks cycles. The trials were prospectively intended to enrolling 200 patients. There was no significant improvement in response rate in the capecitabine arm (25.7% vs 16.7% in the S-FU/FA arm (p=0.002), however only half the patients required treatment. Stomatitis, diarrhoea, nausea, stomatitis, neutropaenia and alopecia were all reported significantly less in the S-FU/FA arm. Vomiting, constipation, and fatigue were similar in both groups. Fewer patients required dose modification or hospitalisation for treatment related toxicity in the capecitabine arm.

Bone metastases are a major cause of morbidity in patients with solid tumours, particularly those with breast, prostate, lung, kidney and thyroid cancers.

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Bisphosphonates are available in both oral and intravenous forms. Of the oral formulations approved for use in malignancy, clodronate is the oldest. Whilst there have been published studies indicating some benefit from oral pamidronate, its poor oral bioavailability, gastrointestinal toxicity and the superior efficacy of intravenous pamidronate have kept the oral form out of the clinic. In Australia there are currently two bisphosphonates commercially available: clodronate (Bonex®, oral) and pamidronate (Aredia®, intravenous).

The recommended dose of sodium clodronate is 1,600mg p.o. daily, ½ hour before a meal or two hours after a meal, whilst that of disodium pamidronate is 90mg i.v. over one to two hours every three to four weeks. Toxicity with oral clodronate is usually mild and in the form of gastrointestinal disturbance that can be alleviated with divided dosing. Common adverse reactions with disodium pamidronate are asymptomatic hypocalcaemia, influenza-like symptoms and mild fever. These are usually mild and transient. Monitoring of electrolytes, calcium, magnesium and phosphate is nonetheless recommended.

More potent bisphosphonates under clinical evaluation or approved overseas for use in malignant states includeibandronate (1,000 times more potent than clodronate) and zoledronate (10,000 times as potent as clodronate)4. However the oral bioavailability of these new agents remains poor. Apart from the greater potency of these new agents, advances in the administration of the intravenous forms have permitted shorter infusion times without complications.

Bisphosphonates in multiple myeloma

Multiple myeloma is a plasma cell disorder characterised by lytic bone lesions, abnormal bone marrow plasmatocytosis or paraproteinaemia. In patients with MM, skeletal complications are inevitable and hypercalcaemia is common. In fact, 95-100% of patients with MM develop lytic bone lesions during the course of their illness5. Randomised controlled trial evidence has shown that in MM, bisphosphonates reduce bone pain, increase quality of life, and reduce the number of skeletal events6-8. Subgroup analyses in two oral clodronate studies have suggested that oral clodronate may prolong survival in MM patients without overt skeletal disease at diagnosis9. This observation is now the subject of ongoing study. In Australia, pamidronate 90mg i.v. every four weeks is the most commonly used intravenous bisphosphonate strategy in multiple myeloma. Use in this setting is supported by the Pharmaceutical Benefits Scheme (Highly Specialised Drugs Programme).

Bisphosphonates in advanced breast cancer

Sixty to 75% of women with advanced breast cancer suffer from bone metastases, which are a significant cause of cancer-related morbidity in these patients10. Since the 1980s there have been numerous studies investigating the role of bisphosphonates in women with advanced breast cancer11. These include oral clodronate and pamidronate, as well as intravenous pamidronate, clodronate, ibandronate and recently zoledronate. Several reviews have summarised the current status of the literature and Guidelines were published in 2000 by the American Society of Clinical Oncology (ASCO)12. A Cochrane systematic review of bisphosphonates in breast cancer was published in 2001. Interim results from this review were presented at the 2001 Annual Scientific Meeting of the Australian and New Zealand Breast Cancer Trials Group and will be referred to here.

Since 1983, there have been 16 published randomised controlled trials comparing therapy with a bisphosphonate to placebo in women with either early or advanced breast cancer. Of these, 10 studies have been in women with established bone metastases and three studies in women with advanced breast cancer but no bone metastases. Eight of these studies have been with oral bisphosphonates (six with oral clodronate and two oral pamidronate), three with i.v. pamidronate and one study with i.v. clodronate and ibandronate respectively. The largest studies in advanced breast cancer were the combined Aredia Study Group studies 18 and 19, with 751 patients included, an ibandronate study (462 patients) and two other pamidronate studies (404 and 295 patients respectively). The oral bisphosphonate studies in advanced breast cancer were all relatively small studies, with a range of 10 to 173 patients included in each.

The primary study endpoints varied across the studies but included at least one of the following outcomes: skeletal events (defined as any or all of the following: new bone metastases, pathological fractures, spinal cord compression, irradiation of surgery to bone or the development or progression of bone pain); Quality of life (QoL); bone pain; survival. A pooled comparison of efficacy across these studies is difficult because of differences in patient selection, concomitant therapies and outcome measures. Nonetheless, one can still consider the global effect of bisphosphonates on skeletal events, where the observed clinical benefits include reduced hypercalcaemic episodes, pathological fractures, the need for surgery and bone pain. Only six studies adequately evaluated QoL.

With regards to skeletal events in women with established bone metastases the strongest evidence for benefit is seen with the use of pamidronate i.v. (90mg every three to four weeks) which reduces the number of skeletal events by 35% (p<0.001), in Aredia Study Group Studies 18 and 19. There was a significant reduction in the cumulative number of skeletal events observed with 60mg pamidronate every three to four weeks for two years (p=0.017), whilst a significant delay in progression of bone metastases and reduction in bone pain was observed with 45mg pamidronate i.v. every four weeks (increase median time to progression by 48%, p = 0.02). There was a 44% reduction in the skeletal event rate observed with the use of ibandronate 6mg i.v. monthly (p = 0.025). There was a trend for improved overall QoL and significantly reduced bone pain with 90mg pamidronate i.v. and significantly improved QoL and reduced bone pain with high dose ibandronate 6mg i.v. monthly. No study showed an effect of therapy on survival.

The use of oral bisphosphonates is associated with a 36-60% reduction in skeletal events in women with advanced breast cancer. This evidence comes from the two largest clodronate studies (N= 133 and p < 0.01, and N = 173 and p = 0.001 respectively) and a single oral pamidronate study (N = 161, p < 0.001). In women with advanced breast cancer but no bone metastases, one of three studies showed that oral clodronate compared to placebo significantly reduced the incidence of bone metastases (32 vs 63, p<0.005) however the number of patients affected was not significantly different (15 vs 19 respectively)4.

From this evidence the American Society of Clinical Oncology Bisphosphonates Expert Panel recommended in 2000 the use of i.v. pamidronate over one to two hours every three to four weeks in women with metastatic breast cancer and radiographic evidence of bone metastases who are concurrently receiving hormonal therapy or chemotherapy13. In Australia, i.v. pamidronate has been approved for several years by the Pharmaceutical Benefits Scheme (Highly Specialised Drugs Programme) for patients with lytic bone disease from breast cancer, whilst the indication for oral clodronate has recently been extended to permit its use in this setting.

The optimum timing and duration of bisphosphonate treatment for women with advanced breast cancer is not known. Safety data is available beyond three years for oral clodronate and up to six years for i.v. pamidronate and zoledronate14. This data suggests that women with advanced breast cancer could be treated indefinitely.

Bisphosphonates in early breast cancer

In the adjuvant setting three studies have been presented of results to date15. Two published studies compared adjuvant oral clodronate (up to three years) in addition to standard adjuvant chemotherapy or hormonal therapy with an open control in women with high-risk early breast cancer15. These two studies showed contradictory results16. The third and largest study compared the addition of oral clodronate to placebo for two years in over 1,000 women. Results from this study are only available in abstract form with final study results in preparation17. Interim pooled analysis of these studies shows a 37% reduction in the risk of developing bone metastases with the use of oral clodronate (Relative risk of developing bone metastases 0.73 (95% CI 0.55-0.98) unpublished results15). Whilst the use of bisphosphonates as adjuvant therapy to reduce bone metastases remains open, there is some evidence indicating reduced decline in bone mineral density with the use of adjuvant clodronate15. The NSABP-34 study, a double blind randomised placebo-controlled study of oral clodronate in women with early breast cancer, has recently commenced.

References

Breast cancer: The value and meaning of breasts

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Overview

The breast is more than a biological organ; it is a symbol of femininity, motherhood, and cultural values. This article explores the cultural and societal significance of the breast, drawing on historical and contemporary perspectives to understand the impact on women's bodies and self-image. It highlights the importance of understanding the personal, cultural, and societal values associated with the breast to provide appropriate medical interventions.

Introduction

The breast is not only a biological organ but also a symbol of femininity, motherhood, and cultural values. Understanding the cultural and societal significance of the breast is crucial to providing appropriate medical interventions. This article explores the cultural and societal significance of the breast, drawing on historical and contemporary perspectives to understand the impact on women's bodies and self-image.

Abstract

Understanding the value and meaning of the female breast for women with breast cancer and their partners can assist health professionals in understanding how a woman may react to breast surgery and treatment and enable appropriate interventions to be implemented. One in eleven women in Australia will develop breast cancer by the age of 75. According to Spiegel et al. as many as 80% of breast cancer patients may report significant psychological distress during their initial treatment.

Body image is developed during the first 12 years of life, according to the schema theory and the World Health Organisation. During this time of developing body image, young girls are growing up with their cultural and societal values. It is during this time that women are influenced by fashion, magazines, television, cinema, and movies. The meaning and value of women's breasts in this post-modern and post-feminist era varies from woman to woman. What is acceptable to one woman's breast may not be acceptable to another woman's breast. Women's breasts remain to be sensual, nurturing and feminine. Women's magazines and fashion constantly reflect these themes.

Post-feminism has enabled a diversity of meaning attributed to the breast. Moorhouse suggests that the breast has been co-opted by women to signify their empowerment and female identity. Post-feminism has provided women with an opportunity to reclaim the breast.

Historical perspective

Historical research has traced the ways in which both sensuality and functionality have contributed to the meaning and value of the female breast. In literature, art and religion, the breast is more commonly portrayed as an object of sensuality and desire. For example, Shakespeare and Joyce frequently portrayed the breast as an object of sexual desire.

Contemporary meaning

Body image is developed during the first 12 years of life, according to the schema theory and the World Health Organisation. During this time of developing body image, young girls are growing up with their cultural and societal values. It is during this time that women are influenced by fashion, magazines, television, cinema, and movies. The meaning and value of women's breasts in this post-modern and post-feminist era varies from woman to woman. What is acceptable to one woman's breast may not be acceptable to another woman's breast. Women's breasts remain to be sensual, nurturing and feminine. Women's magazines and fashion constantly reflect these themes.

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Summary

Throughout history, in literature, art, religion, and contemporary Australian society, breasts have a dual meaning. On one hand they have to be symbolically feminine and sensual. On the other hand, they function to support life of the young. The amputation of a breast or breasts can alter the body image of the woman. A diagnosis of breast cancer and its associated treatments pose this same threat but also imposes changes in lifestyle.

Implications for practice

By showing an understanding of personal, cultural and societal values associated with the breast, health professionals can show their interest in providing care in context with their population of patients. This principle of contextual care goes beyond breast cancer and women, to those in need of any health intervention regardless of race, culture or gender. Caring with such empathy and understanding the “person on the mattress” perspective, may improve health outcomes and increase job satisfaction, for both the patient and the health care professional.
The Look Good...Feel Better program: A pathway to self-esteem for women with cancer

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Abstract
The Look Good...Feel Better program offers a free cosmetic workshop to women undergoing chemotherapy and/or radiotherapy for cancer. The central aim is to improve the self-image, self-esteem and confidence of each participant, through providing women with the knowledge, techniques and encouragement to use make-up to make themselves look better. This paper documents an evaluation of the Look Good...Feel Better program carried out in 1998, and further improvements to the program since that time. The evaluation showed that the program achieved modest but statistically significant gains for participants in a number of areas relating to their self-image, sense of confidence and self-esteem. Women of all ages gained from the course, but the largest overall gains were made by younger women (under 45 years), who were initially significantly more unhappy about their overall appearance. The reaction of the participants was overwhelmingly positive, and their feedback has led to further improvements in the program.

Introduction
Look Good...Feel Better, a program that offers a free cosmetic workshop to women undergoing chemotherapy and/or radiotherapy for cancer, has been offered in Australia since 1990. The central aim of the program is to improve the self-image, self-esteem and confidence of each participant.

The Look Good...Feel Better program: A pathway to self-esteem for women with cancer

They demonstrate how wigs, turbans, hats and other accessories can be used - often with flair - for dealing with partial or total hair loss. As each technique is demonstrated, the women are encouraged to practice it, and each woman receives her own complimentary kit of skincare and make-up products, tailored to her particular needs, to enable her to learn 'hands-on' the techniques being taught, and to take home.

The volunteer beauty advisors all receive basic training in working with women with cancer, with annual updates and opportunities to workshop the skills they learn. The training includes how to best work with women who are upset or emotional, but volunteers are encouraged to focus on the workshop techniques and positive aspects of the workshop, and discouraged from becoming involved with women's emotional issues. The beauty advisors are also encouraged to debrief with their State Look Good...Feel Better managers.

The program is sponsored and funded by the cosmetics industry, through the member companies of the Cosmetic, Toilettry and Fragrance Association. This covers the cost of running the program and all the products used in the workshops, a contribution worth over $1 million per year.

How does it measure up? Evaluating the program
In 1997-98, Colmar Brunton Research was contracted to evaluate the effectiveness of the Look Good...Feel Better program. The aims of the evaluation were to provide an understanding of:

- the program's immediate and longer term effects on women with cancer, specifically in terms of their self-esteem, body image and perception of attractiveness; and
- the key needs of these women, which of these needs the program met, which elements of the program met these needs, and where improvements could be made.

How was the evaluation done?
The evaluation provided quantitative data through three questionnaires, one before the course, the second three days after completing the course and the third one month later.

The questionnaires asked women to rate body satisfaction in relation to a range of indicators, using a mark on a linear scale. They were also asked to indicate their mood and feelings (eg attractiveness, self-esteem, anxiety, pain), and to express their degree of agreement with a number of statements relating to mood and feelings.

In addition, two focus group discussions, one three days after the course and the second a month later, provided qualitative insights into women's experiences of the course and their suggestions for improvements.

The women involved

Ninety-six women were recruited and completed the first questionnaire, 90 completed the second, and 78 the third. The two focus groups involved four and five course participants respectively.

Over half of the initial 96 women (55%) had a diagnosis of breast cancer, with others spanning a range of diagnoses. The large majority had been diagnosed within the previous six months, 44% within the past three months, and 33% within three to six months.

Three-quarters of the women (75%) had undergone surgery for their cancer at some stage, most at least two months ago. At the time of the evaluation, however, the majority (68%) were undergoing chemotherapy and 23% were receiving radiotherapy, and almost four in every five (78%) had had treatment within the last fortnights.

Almost three-quarters of the women (74%) were married. One-third (34%) were aged over 55 years, another third (33%) aged 46-55 years, and the remainder younger than this, including one under 18 years.

Results from the questionnaires

Before the course
Before attending the course, the women rated fairly low their satisfaction with their hair, the look and feel of their skin and eye area, and their body weight, as shown in table 1. They were more satisfied with their face and nails although even here the mean score was around five on a scale of one to 10.

For the most part, as shown in table 2, the participants did not feel particularly beautiful, attractive or desirable. Most, however, felt generally optimistic, with a moderately high quality of life and a sense of control over their lives. They were not generally feeling a great deal of pain or nausea, nor were they particularly anxious or emotionally upset, although some had significant problems in these areas.

Most of the women also felt they could still confidently communicate with others, and that their appearance had not had a negative impact on their interaction with others, particularly close family and friends. Areas of confidence that the later questionnaires showed to be maintained (see table 3).

On completion of the course

The questionnaire completed three days after the course showed a significant improvement in the women's body satisfaction in all areas other than nails and body weight (areas that had not been addressed at any length in the course) (see table 1). The improvements were not dramatic, with mean scores in the moderate range, from 4.5 for hair to 6.3 for overall appearance (a mean of 70 would be considered high). These are the sorts of gains that might be expected by a course that, rather than offering a 'miracle cure', aimed to make women feel better through helping them to cope with symptoms and side-effects of treatment.

Moods and feelings also improved, with statistically significant gains in confidence and self-esteem; feeling attractive, desirable, beautiful; and the women's sense that they 'looked more normal' (see table 2). There was also a trend towards feeling more normal, though this was not statistically significant.

The general trend was that the women felt better and more confident overall, and this was reflected in the significant increase in the level of agreement with the statements 1 feel confident about myself because I know I look good' and 'I feel better about myself because of how I look', as shown in table 3.

Women found the make-up used in the course to be very useful, and most of the make-up provided was used following the course. Many of the women were using a wider variety

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<td>Pre-course</td>
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<tr>
<td>Nails</td>
</tr>
<tr>
<td>Overall appearance*</td>
</tr>
<tr>
<td>Facial appearance*</td>
</tr>
<tr>
<td>Eye area*</td>
</tr>
<tr>
<td>Feel of my skin*</td>
</tr>
<tr>
<td>Look of my skin*</td>
</tr>
<tr>
<td>Body weight</td>
</tr>
<tr>
<td>Hair*</td>
</tr>
</tbody>
</table>

0 = very unsatisfied, 10 = very satisfied. * Significant difference, p<0.05

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Cancer Forum - Volume 25 Number 3 - November 2001
of cosmetics and skin care products, and using them more of often. This included products previously used, as well as eye shadow, eyebrow pencil, lip liner, face concealer, face powder and toner. There was also a slight increase in daily use of head wear, possibly reflecting some experimentation.

The overall reaction to the course was overwhelmingly positive, with participants finding it enjoyable, useful and relevant, and the course leader and volunteers helpful and friendly. In general, women felt that the course exceeded their expectations.

One month later

One month later, the positive gains of the course had been maintained. The women’s level of satisfaction with their bodies remained at a similar level, with a slight but statistically non-significant further gain in most areas (see table 1). All gains in mood and feelings had also been maintained, with the largest overall gains in this area being improved confidence and self-esteem (see table 2). In addition, at this stage participants felt significantly more happy, compared to their pre-course feelings - a gain not seen initially after the course. Perhaps this reflects time taken for others to notice and comment on the changes, or for feelings of happiness to grow out of increased confidence.

Women continued to use the cosmetics provided, and continued to use more cosmetics than before the workshop. Their patterns of use remained very similar to those seen immediately after the course.

Who gained most?

The largest overall gains were made by younger women. Before the course, women aged 45 years and younger were significantly more unhappy about their overall appearance, more emotionally upset, less likely to feel normal or feel they looked normal, less confident in their day-to-day lives, and more likely to feel others had taken over their lives. After the course, the only significant difference between the two groups was that the younger age group had not gained in confidence in their day-to-day life to the same extent as the older women. Their gains in all other areas had brought them to the same levels as the women aged 45 years and over.

Patterns of improvement also varied with relationship status. Before the course, there were few differences between those who were in a married or de facto relationship, compared to those not in a relationship. Immediately after the course, however, there were many significant differences. Those not in a relationship were significantly more likely to feel lower self-esteem, more emotionally upset, believe they had worse nausea and not feel good, be more pessimistic and negative about the future, be less confident about themselves, and think they looked different from their appearance before they were ill. A month later, most of these differences had disappeared. Women not in a relationship had made significant gains across a range of areas relating to appearance, moods and feelings, and the only significant difference between the two groups was that those not in a relationship were more likely to feel unsure about themselves because of the way they looked. This same pattern was seen in those not working: the benefits of the course tended to increase over the month following the course, whereas there was little difference over the month for those who were working.

The focus groups: a spur to further improvement

The two focus groups confirmed women’s positive experience of Look Good…Feel Better. Typical comments were, ‘it wasn’t a very big course but it really works’, ‘I can bring back some control that I didn’t have’, ‘it’s a boost, I feel like a new person’, ‘I feel more confident’, ‘the whole thing made you feel special… I’ve got to like myself better’, ‘if it wasn’t for Look Good…Feel Better saying “fix yourself up”, I wouldn’t have’, ‘somehow it made a big difference’. There was also a strong sense that the individual attention and the cosmetic gift bags for each woman made the women feel special.

The groups identified a number of things that could further enhance women’s experience of the program, and their comments and recommendations have led to a number of improvements.

The American video shown at the start of the session has been replaced by a new, Australian production that is culturally more relevant to the experiences of Australian women, and an Australian patient booklet has also been prepared and is given out at the workshops. Publicity for the course has improved, with new patient brochures and posters to promote the program, a website (http://www.lgfb.org.au), and a 1800 telephone line. Publishing companies have supported, free of charge, an advertising campaign that has run through 2000 and into 2001.

These developments have fostered considerable further growth in the program. The number of centres offering Look Good… Feel Better in Australia has grown from around 55 at the start of the evaluation, in 1997, to over 90 in 2001, and the number of women attending has increased from 2,975 in 1997 to 4,100 in 2000.

Conclusion

The evaluation clearly showed that the Look Good…Feel Better program is effective in improving the self-image, self-esteem and confidence of women with cancer. It provides them with the knowledge, techniques and encouragement to make up to themselves look better, and it increases women’s sense of control over their situation and their confidence in life.

For further information on the Look Good…Feel Better program, contact the national office: Freecall 1800 650 960, Ph: 02 4334 6445, or visit the website, http://www.lgfb.org.au

Acknowledgment

This paper has been written by Angela Kiriner, drawing heavily on a research report provided by Colmar Brunton Research to Look Good…Feel Better. The authors acknowledge the contribution of Sally Harrold, Look Good…Feel Better National Program Manager.

Abstract

Objectives: To document the views of trainees in medical and radiation oncology regarding the content of their training,

<table>
<thead>
<tr>
<th>Statement</th>
<th>Pre-course</th>
<th>Initially post-course</th>
<th>1 month post-course</th>
</tr>
</thead>
<tbody>
<tr>
<td>feel positive about the future</td>
<td>7.0</td>
<td>7.4</td>
<td>7.3</td>
</tr>
<tr>
<td>feel better about myself because of interaction with other cancer sufferers</td>
<td>5.4</td>
<td>6.0</td>
<td>5.9</td>
</tr>
<tr>
<td>feel unsure about myself because of how I look</td>
<td>4.4</td>
<td>3.6</td>
<td>3.5</td>
</tr>
<tr>
<td>feel confident about myself because I know I look good</td>
<td>4.4</td>
<td>5.5</td>
<td>5.6</td>
</tr>
<tr>
<td>feel better about myself because of how I look</td>
<td>4.3</td>
<td>5.9</td>
<td>5.9</td>
</tr>
<tr>
<td>feel that I look just the same as I did before I was ill</td>
<td>4.1</td>
<td>3.7</td>
<td>3.5</td>
</tr>
<tr>
<td>feel that I look good but I don’t feel good</td>
<td>3.8</td>
<td>4.7</td>
<td>4.0</td>
</tr>
<tr>
<td>feel I look just the same as I did before I was ill</td>
<td>3.8</td>
<td>4.4</td>
<td>4.4</td>
</tr>
<tr>
<td>feel that it’s obvious that I have cancer by the way I look</td>
<td>3.7</td>
<td>3.1</td>
<td>3.1</td>
</tr>
<tr>
<td>don’t feel as confident in communicating with others now</td>
<td>3.4</td>
<td>3.3</td>
<td>2.6</td>
</tr>
<tr>
<td>feel that other people have taken over control in my life</td>
<td>3.1</td>
<td>3.2</td>
<td>2.7</td>
</tr>
<tr>
<td>feel the way I look has changed the way people in my community interact with me in a negative way</td>
<td>2.6</td>
<td>2.4</td>
<td>2.3</td>
</tr>
<tr>
<td>feel the way I look affects the way my close family and friends interact with me in a negative way</td>
<td>2.1</td>
<td>2.0</td>
<td>1.9</td>
</tr>
</tbody>
</table>

0 = strongly disagree, 10 = strongly agree, * Significant difference, p=<0.05
**Training of medical and radiation oncologists: the views of Australian and New Zealand trainees**

K Fife  
Dept of Radiation Oncology, Royal Prince Alfred Hospital, Camperdown, NSW  
M Tattersall  
Department of Cancer Medicine, University of Sydney, NSW

and its assessment.

Design and setting: Postal questionnaire survey of medical oncology trainees in Australia, and radiation oncology trainees in Australia and New Zealand.

Main outcome measures: Experiences of and views about training.

Results: Currently, 40% of medical and 59% of radiation oncology trainees rotate to the other specialty during their training.

All medical oncology trainees thought it was important to train in radiation oncology (54% very important) and 97% of radiation oncology trainees thought it was important to train in medical oncology (54% very important). In addition, training in palliative care was very important by all medical and 96% of radiation oncologists (48% and 24% respectively rating it as very important).

Overall 72% of trainees considered that a common modular basic science curriculum would be useful, and 48% were in favour of joint training during the first year to a common experience for both groups of trainees. Medical oncologist trainees were not supportive of formal assessment of training, and radiation oncology trainees were supportive of the FRANZCR examinations.

Conclusions: Trainees in medical and radiation oncology favour experience in the other discipline, although the minority of medical oncology trainees have formal radiation oncology training experience. The majority of both groups also favour training in palliative medicine, for between three to six months.

They support a modular core curriculum with some form of assessment.

The views of trainees should be considered in on training in palliative medicine, for between three to six months. A large and increasing proportion of people with cancer will be assessed and treated by oncologists. The revolution in molecular biology of the past 30 years has vastly increased our understanding of the basic science and mechanisms of oncogenesis, and new biological treatments are now becoming a reality. Likewise, advances in cancer genetics have resulted in a new subspecialty. Combined treatment programs comprising both radiotherapy and chemotherapy are increasingly used, based on evidence of enhanced effectiveness. An increased diversity amongst cancer specialists seems likely to become necessary as our knowledge base increases. The quality and appropriateness of oncology training is therefore of major importance both to the medical profession and to the wider community.

The traditional division of cancer specialists into medical and radiation oncologists is a source of professional identity and pride. In Australia and New Zealand, medical oncology trainees enter the training program with part I FRACP, and have to complete a minimum of two years clinical training in oncology and a further elective year, often spent in research. Many undertake a formal research degree. Radiation oncology trainees, after completing resident training (commonly two years), enter a four-years training scheme in which they take parts I and II of the FRANZCR examination. After obtaining the FRANZCR they are eligible for consultant appointment, although many undertake a year’s further training as a research fellow.

Rotation to other oncological specialties and units

Forty percent of MOTs and 59% of ROTs said that they had rotated to the other discipline, and virtually all had found the rotation useful. For MOTs, the length of rotation was three months for 70% and four to six months for the remainder. All had attended general radiation oncology clinics, 89% had attended radiotherapy planning sessions and 78% had observed brachytherapy. Amongst ROTs, 27% had rotated to medical oncology for two to three months, 50% for four to six months and 23% for more than six months. General medical oncology clinics were attended by the majority and over half observed patients having high dose chemotherapy. All MOTs and 95% of ROTs felt it was important to spend some time in other departments and they were asked to score the importance of training in a variety of specialties (table 1).

Most MOTs and ROTs rated supervised training as fairly or very important. Similarly, most trainees felt it was unimportant or not very important for their optimal learning to be an observer without clinical responsibility.

All trainees were asked what was the optimal time for a medical oncology trainee to rotate to radiation oncology, and vice versa. The results are shown in figures 1 and 2. They were also asked about training in palliative care and most felt this was important (figure 3). Assuming trainees spend several years in the same cancer centre, rotation to other centres was thought to be necessary by all MOTs and by the majority of ROTs. The later training years was the preferred time for this rotation by 60% of MOTs and 80% of ROTs. More than two-thirds of MOTs and more than half the ROTs felt they should rotate to work for oncology consultants based at district hospitals. Most of the ROTs felt that three months was the optimal length of time for a district hospital rotation, but for MOTs, three months was favoured by 35%, three to six months by 30%, six months by 30% and 12 months by 5%.

Common core curriculum and assessment

Trainees were asked whether they felt all oncology trainees should attend a course with a common core curriculum (during assessment of training. General comments were also invited. Questionnaires sent to MOTs and ROTs were almost identical apart from specific items on rotation to other specialties.

Amendments to the questionnaire

There were three minor differences from the British questionnaire. Multidisciplinary clinics were included in the question on training in other departments (table 1), because of increasing recognition of their importance in patient management. A question on medical oncology training after completing the FRACP Part I was added because of its relevance to trainees in Australia. In the final question (figure 4), an option of ‘no planned period of research’ was included in the Australian questionnaire.

Results

Responses were received from 66% of trainees overall, including 68% of 56 radiation oncology trainees (ROTs) and 64% of 39 medical oncology trainees (MOTs). Replies were received from all Australian states with trainees. Medical oncology trainees in New Zealand were not surveyed.

**Table 1**

<table>
<thead>
<tr>
<th>How would you rate the importance of training in the following departments on a scale of 1 to 5?</th>
<th>Not important (Score 1)</th>
<th>Important (Score 5)</th>
<th>Between (Score 2-4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Oncology (for MOTs)</td>
<td>0</td>
<td>3</td>
<td>64</td>
</tr>
<tr>
<td>Radiation Oncology (for MOTs)</td>
<td>0</td>
<td>6</td>
<td>64</td>
</tr>
<tr>
<td>Palliative Care</td>
<td>0</td>
<td>6</td>
<td>63</td>
</tr>
<tr>
<td>Haematology</td>
<td>0</td>
<td>14</td>
<td>72</td>
</tr>
<tr>
<td>General surgery eg to observe an axillary dissection</td>
<td>32</td>
<td>14</td>
<td>86</td>
</tr>
<tr>
<td>Gynaecological oncology</td>
<td>32</td>
<td>12</td>
<td>86</td>
</tr>
<tr>
<td>Radiology</td>
<td>20</td>
<td>19</td>
<td>76</td>
</tr>
<tr>
<td>Pain management</td>
<td>4</td>
<td>12</td>
<td>64</td>
</tr>
<tr>
<td>Multidisciplinary clinics</td>
<td>0</td>
<td>0</td>
<td>36</td>
</tr>
</tbody>
</table>

MOT: Medical Oncology Trainee  
ROT: Radiation Oncology Trainee

**Figure 1**

How long should a medical oncology trainee in radiation oncology?

**Figure 2**

How long should a radiation oncology trainee in medical oncology?

MOT: Medical Oncology Trainee  
ROT: Radiation Oncology Trainee

**Figure 3**

The same questionnaire and to compare responses to those of UK trainees.

**Methods**

Permission to use the original questionnaire was given by Dr T Illidge. In order to make valid comparisons, the questionnaire was identical to that sent to UK trainees, apart from some very minor changes relevant to the different contexts. These changes are noted below. The questionnaire was mailed to all trainees from lists obtained from the Royal Australasian College of Physicians and the Royal Australian and New Zealand College of Radiologists, and a stamped addressed envelope was enclosed to encourage replies. A covering letter was included to explain the background to the questionnaire, and that it was a comparative study. The replies were coded to ensure a representative sample of replies from different regions was obtained, and to enable repeat mailing of the questionnaires to non-respondents in the event of a low number of replies. Fortunately the response rate was high and repeat mailings were not thought necessary. The envelopes were then discarded before reading the replies so that complete anonymity was maintained. The replies were analysed by one author (KF) using the same methods as the UK survey, and the results were compared.

**The questionnaire**

The questionnaire was divided into two sections: on rotation to other specialties and units, and on a common core curriculum.
The results are shown in figure 4.

**FIGURE 3**

How long would you like to train in palliative care?

<table>
<thead>
<tr>
<th>Months</th>
<th>MOT</th>
<th>ROT</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Discussion**

**Common core curriculum and assessment**

A course with a common core curriculum was popular with most MOTs (76%) and ROTs. Some respondents commenting that they already attend joint lectures. If a Masters degree was the outcome of such a course, a modular examination was preferred by 52% of MOTs and 66% of ROTs. In contrast 96% of MOTs were opposed to an exit FRACR exam. The FRANZCR examination was strongly supported, with 48% of MOTs in favour of keeping its current form, although 48% felt it could be improved, as a modular exam and include ROTs. Only 14% of MOTs were interested in this possibility however. Combined training during the first year was supported by 54% of MOTs and 40% of MOTs. A research year was the most popular option for both MOTs and ROTs, although 36% of MOTs and 11% of MOTs favoured no planned period of research.

**Comparison with UK trainees**

In the United Kingdom, the division between non-surgical cancer specialties has traditionally been more blurred, and clinical (radiation) oncologists are trained in the use of both radiotherapy and chemotherapy with an emphasis on cancer site specialisation. Medical oncologists, while originally mainly clinically, are increasingly involved in chemotherapy administration at a community level, as the indications for chemotherapy widen. Medical oncologists undergo four years of clinical training following general physician’s training during which MRCP Parts I and II are obtained. There are no oncology examinations, although recently more thorough assessment of training has been introduced and most trainees attend lecture courses, and undertake a formal research degree. Medical oncology trainees also enter the training scheme after a postgraduate diploma, most commonly the MRCP. There are six years of clinical training and during the first three years the FRACR examination is taken. The final two years are advanced professional training with cancer site specialisation. Up to

**Figure 4**

How long would you like to train in palliative care?

<table>
<thead>
<tr>
<th>Months</th>
<th>MOT</th>
<th>ROT</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td></td>
<td></td>
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<tr>
<td>2</td>
<td></td>
<td></td>
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<tr>
<td>3</td>
<td></td>
<td></td>
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<tr>
<td>4</td>
<td></td>
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<tr>
<td>6</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A year of this may be spent in research, and many trainees undertake a formal research degree.

Forty per cent of MOTs in Australia and 30% in the UK had experience in a radiation oncology department. Although the rotations were shorter (mostly three months in Australia rather than six months or more in the UK), the quality of training was better in Australia with most trainees observing radiotherapy planning and brachytherapy. All MOTs who rotated to radiation oncology found it useful but overall, only 36% of Australian MOTs rated radiotherapy training as ‘very important’ as opposed to 76% of UK MOTs. The ideal length of rotation to radiation oncology was stated as three months by 48% and four to six months by 45% of Australian MOTs. 70% of UK MOTs wished to train in clinical oncology for at least six months.

Rotation of (or clinical) oncology trainees to medical oncology was also more common in Australia/NZ with 59% rotatig as opposed to 43% in the UK. The experience obtained appeared to be equivalent and 50% rotated for at least six months. The vast majority of UK clinical oncology trainees and 54% of Australian/NZ MOTs rated training in medical oncology as very important. Two-thirds of UK clinical oncology trainees wanted to rotate to medical oncology for at least six months.

Training in palliative care was rated as ‘very important’ by 72% and 62% by MOTs and clinical oncology trainees in the UK. Both these figures are considerably higher than in the Australian/NZ counterparts. This difference may reflect different exposure to palliative medicine between the cancer training institutions in the two countries.

A course with a common core curriculum was a popular approach among both Australian/NZ and UK trainees. If a Masters course was to be introduced, the majority of trainees on both sides of the world favoured assessments or short exams after each module, with no examination being preferred by 35% of Australian and 20% of UK MOTs. An introductory year as a general oncology trainee before specialisation was considered appropriate by 48% of Australian/NZ and 63% of UK trainees. Most MOTs and 45% of ROTs felt that the current system encouraged extending their training time to do research whereas 40-50% of UK trainees were discouraged by the training system. However, most UK trainees were interested in undertaking a research degree.

In conclusion, training in the other oncology specialty and in palliative care was given more importance in the UK, and there was more interest in joint training initiatives than in Australia.

**Summary**

Most Australian/NZ medical and radiation oncology trainees appear to be satisfied with their training, whilst criticism of the other specialty’s training was common. Medical oncology trainees felt that the general medical knowledge of ROTs was inadequate, and ROTs felt that MOTs had too little understanding of radiotherapy. There was some enthusiasm for combined courses and training programs, which could improve understanding and cooperation between the specialties. Joint training committees between the Royal College of Physicians and Radiologists could promote such cooperative training. These findings are largely in accordance with the more rigid divisions between the specialties found in Australia/NZ and the USA5,6 as compared to the UK. There is a large area of common ground between the two specialties, and a basic knowledge of radiotherapy by medical oncologists and of cancer therapeutics by radiation oncologists, and of palliative care by both, is surely essential for comprehensive cancer care1. Some of the comments in the questionnaire reflected an adversarial rather than complimentary attitude between trainees. However, it could be questioned whether such a rigid division is of benefit to the patient, particularly in light of the increasing complexity of cancer treatments.

**References**

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

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

This report has been edited by Cathy Swart (CHPCPR) from the reports received.

New results

n Centre for Health Promotion and Cancer Prevention Research (CHPCHR), Queensland

Prevention of regular smoking among adolescents

This qualitative study aimed to determine the processes associated with the progression from experimentation to regular smoking among adolescents. The study specifically examined factors and contexts surrounding the influences on youth to become regular smokers and the resistance by other youth who have been or are experimenters and have not become regular smokers.

Results of the study indicated that the question may need to shift from how do we prevent experimentation by youth to what is the influence of how we stop the progression from experimentation to regular smoking. The study highlighted the diversity in adolescents’ progression along different smoking trajectories indicating the need to examine multiple approaches to the prevention of regular smoking by adolescents.

Specifically, participants demonstrated a broad range of themes that partly reflect those found in the literature. These themes reflected the contexts that surround the factors including regular smoking, and resistance to regular smoking, for this group of adolescents, and include the reasons for smoking and the strong social focus given to smoking.

In addition, other unique themes emerged, including:

- Initiation and experimentation with smoking were viewed as normative behaviour.
- Although firmly bedded in the lifestyle of many regular smokers, smoking itself emerged as of little conscious importance.
- Many participants were unaware of the factors associated with progression from experimentation to regular smoking.
- Regular smoking was often simply a consequence of complacency and context among young people making conscious efforts to resist regular smoking or to become a regular smoker.
- Movement from experimentation to regular smoking was defined by a change in the status of smoking from “incidental” to “instrumental”.

Stages of change in smoking for some participants reflected markers such as being offered a cigarette, movement from puffing to deep inhalation, seeking out a cigarette, sharing cigarettes, buying cigarettes and smoking alone.

Regular smokers clearly defined addiction, buying cigarettes and smoking alone as significant indicators of being a regular smoker.

While some participants made conscious efforts not to become addicted, those adolescents were in the minority. Those who did make conscious efforts reported restricting the number of cigarettes smoked, setting personal boundaries, changing peer groups, and keeping themselves occupied.

Participants located smoking as an integral part of their lifestyle and acknowledged the negative effects that it has on their physical fitness, their daily lives and their spending patterns.

n Cancer Education Research Program (CERP), NSW

Patterns and outcomes of care for advanced cancer in New South Wales: A feasibility study

For most patients with advanced cancer, the focus is not on cure but on enhancing the quality of remaining life. However, there is very little information at a population-wide level on the patterns of care for patients with advanced cancer. Even less information is available on how patients cope with life care for cancer. A/Professor Afaf Girgis and Professor Bruce Armstrong received funding from the Commonwealth Department of Health and Ageing and Cancer Councils Australia to undertake a feasibility study in preparation for a state-wide study of the patterns, pathways, outcomes, costs and predictors of care for advanced cancer.

Participants were recruited to the feasibility study through notifications to the NSW Central Cancer Registry database. Information about their physical and psychosocial well-being and cancer care was obtained by telephone interview, self-administered questionnaires, and from prescribed medications and Cancer Care Diary. Carers also completed self-administered questionnaires to assess their psychosocial well-being. Preliminary results based on 78 patients and their carers recruited from the Hunter indicated that participants appreciated the chance to discuss their own personal cancer experiences with others and a majority were supportive of the measures used and the Cancer Care Diary. In terms of pain, one-quarter of the sample reported experiencing pain related to their cancer in the previous 24 hours, with approximately half of this sub-sample reporting limited pain relief from prescribed medications. Three-quarters of those who reported pain also indicated high levels of interference with their sleep in the last 24 hours and with their enjoyment of life. Two thirds of the sample agreed that “people get addicted to pain medicine easily” and a further 55% reported that “complaints of pain could distract a physician from treating my underlying illness”. Furthermore, patients who reported experiencing pain were more likely to report higher levels of anxiety. That further research is needed to understand the reasons for the possible under-treatment of cancer-related pain and its psychosocial impact on cancer patients.

n Centre for Behavioural Research in Cancer (CBRC), Victoria

The impact of a media campaign on cervical screening knowledge and self-efficacy

A three-phase cross-sectional face-to-face interview study has recently been completed. It investigated the impact of the PapScreen Victoria media campaign, and the extent to which the media campaign can influence women’s perceived self-efficacy associated with having a Pap test. Madeline Fernbach’s paper has been accepted for publication in the January 2002 edition of the Journal of Health Psychology.

In total, 1571 women aged between 25 and 69 years were interviewed about prompted and unprompted recall of media messages, intention to have a Pap test and perceived self-efficacy associated with having Pap tests, and barriers to cervical screening. Chi-square and logistic regression analyses revealed that women’s at-risk Pap testing messages and priority of this health issue was greater at the first follow-up, and was maintained at the second. Multivariate analyses of variance indicated that it was perceived as more difficult to choose a practitioner and respect for the Pap tests at the first follow-up, and perceived self-efficacy was lower then at baseline. However, the screening rate increased over the campaign period, indicating that women become aware of the barriers to screening before overcoming them to have a Pap test.

Public reaction to the movie “The Insider”

A paper exploring public reaction to the movie “The Insider” by Dixon, Hill, Borland & Paxton was recently published in Tobacco Control. Results suggest the anti-tobacco content of the movie served to promote an anti-smoking message to viewers.

n Centre for Behavioural Research in Cancer Control (CBRCC), WA

The Healthway-funded ‘disgust project’ is into the second phase, Nadine is interviewing 14-16 year olds about what they find disgusting in general, and what they find disgusting about smoking in particular. The first phase, interviewing psychologists and other professionals working with this age group, gave us some new insights on what is a good way to approach this strategy.

After several pilot studies, we are in the data collection phase of the Healthway-funded study of people’s evaluations of the multiple consequences of health behaviours, and Sandra is delighted to note that the data are supporting the hypotheses. Data collection is still full on the population survey of people’s perceptions of cancer, and Sandra will be commencing the data analysis within a few weeks.

In 2001, the Cancer Foundation of WA (CFWA) conducted its seventh national public awareness campaign, “Cancer Update”, to raise awareness of cancer-related issues in Western Australia. Following the completion of the information campaign (in September), telephone surveys were conducted in both the metropolitan areas and country areas to measure awareness of the Foundation and the services it provide to the community. Analysis of the data is in progress.

Focus groups with 14-16 year olds are being conducted this week in a project involving a new sun protection message ad and target aged 11-17 years. We tested two previous ads (“Egg” and “Home and Away stars” ads) with a total of 280 children aged 12-17 year surveyed in schools. We found that the “Egg” ad could be run for the younger age group as it appears to perform quite well, but if the primary target is the older age group, we recommended developing a new ad.

Rob and Geoffrey have almost completed the book chapter reporting details of the tracking survey undertaken by the National Tobacco Campaign Research and Evaluation Committee, as part of a comprehensive evaluation of the National Tobacco Campaign. Rob and Nadine are working hard on completing the textbook they’re writing on Social Marketing.

Research in the pipeline

n CHPCPR

Is there a place for complementary and alternative medicine (CAM) in palliative care? The experiences of patients with advanced cancer.

The use of complementary and alternative medicine (CAM) by patients with cancer has been documented in Australia and elsewhere. However, few studies have explored cancer patients’ perceptions of the use of CAM and the role these therapies play in palliative care. Dr Ignacio Correa-Velez, a PhD candidate, and colleague are currently carrying out a study, founded by the Centre for Palliative Care Research and Education (Brisbane), to longitudinally explore the experiences of patients with advanced cancer who use CAM. Participants are being followed up at monthly intervals until close to death.

The study focuses on patient’s beliefs about CAM and their reasons for using it, the perceived risks and benefits of the modalities used, the factors affecting changes in the use of CAM over time, and patients’ views regarding the possible integration between CAM and conventional medicine in palliative care.

n CERP

Improving rates of sun protection in adolescents

Australia has the highest rate of malignant melanoma in the world. While there have been improvements in sun protection behaviour in the Australian population, the sun protection practices of those in their teens and early 20s have shown to be particularly poor. Those aged 14-29 are less likely than older groups to wear clothing covering most of their body, less likely to wear hats and more likely to wear brief clothing to get sun.

Dr Chris Paul and colleagues are undertaking qualitative research in order to explore adolescents’ perceptions about sun protection and suntans. Eighteen single sex focus groups are being conducted with students aged between 12 and 17 years, recruited through public high schools in the Newcastle region. Focus groups are being conducted within each of the following age groups: years 7 or 8 (aged 12-13); years 9 or 10 (aged 14-15) and years 11 or 12 (aged 16-17) and are single sex to enable gender specific issues to be examined. Information about participants’ age, hair, skin and eye colour and usual tanning and sun protection behaviour is collected before the commencement of focus group by a brief anonymous self-report questionnaire. This research will provide a better understanding of the current levels of sun protection among 12 to 17-year-old Australians and help guide the development of Cancer Council NSW policies and programs in this area.
Adolescents’ appraisal of anti-smoking advertisements

Melanie Wakefield is leading a group of researchers in the US, Scotland and Australia in a cross-national comparison study to examine adolescents’ appraisal of anti-smoking advertisements. The research, funded by the US National Cancer Institute, will assess main point comprehension, emotional and cognitive responses to each ad, as well as subsequent recall and cognitive processing of messages. The research aims to determine how extent adolescents from broadly similar cultures might have similar responses to advertising messages and executional styles. A wide range of anti-smoking ads produced by state and national anti-smoking campaigns, pharmaceutical companies and tobacco companies are being tested. Among other things, the study will have implications for the extent to which anti-smoking ads might be recycled across countries, thereby making the tobacco control dollar go further.

Building Stronger Families: Empowering Parents to Prevent Bullying

We have begun work on an innovative bullying prevention project, funded by the Commonwealth Family and Community Services Department over two years as part of their Stronger Families and Communities Strategy. The study takes a community-based approach, primarily using a media campaign, to recommend strategies to prevent bullying. Our intention is to change social norms about bullying from seeing it as a school-based problem to seeing it as a community issue.

The Centre was very happy to welcome back Liane McDermott in July after she decided to defer her studies in Perth. Liane has a Senior Research Assistant and is currently working on two projects: the Australian Longitudinal Study on Women’s Health (WHA) and Sun Protection in Community Settings (SPICS).

Professor John Lowe, former Centre Director, spent a couple of days at the Centre (Sept 27, 28 and Oct 1) during a recent trip to Australia. John was in Australia to attend the PHAA Conference in Sydney and talk on bioterrorism.

Dr Paul McDonald, Assistant Professor at the Department of Health Studies and Gerontology, University of Waterloo, Ontario, Canada, visited the Centre on Sept 28 to meet with like researchers. Dr McDonald gave a presentation as part of the School of Population Health Seminar Series on “Increasing the population impact of treatment programs for smoking through improved recruitment/ utilization”. This was a very interesting and well-received presentation.

The 13th Australian Health Promotion National Conference was attended by Liane McDermott and Lynette Saek. Liane McDermott presented “Collaborating with the Wiggles. Can ‘Dorothy the Dinosaur’ help parents protect their young children from the sun?”

Warren Stanton attended the first national Tobacco Control Conference in Adelaide, and presented “Predictors of adolescent smoking trajectories”.

A/Professor Afaf Girgis and PhD student Michele Bandaranayake recently attended the 8th World Congress on Cancers of the Skin in Zurich, Switzerland. Afaf gave a presentation on community practices in relation to early detection of melanoma. Michele gave a presentation on the reasons why some non-melanocytic skin cancers reach an advanced stage before they are diagnosed.

Dr Raoul Walsh and Dr Christine Paul recently attended the First National Tobacco Control Conference in Adelaide. Raoul gave two presentations, one about public practices and attitudes in relation to environmental tobacco smoke and another on smoking cessation pregnancy. Chris gave a presentation on inappropriate use of nicotine replacement therapy in the Australian community.

Congratulations are extended to Dr Raoul Walsh on his appointment as Deputy Editor of the Drug & Alcohol Review.

Dr David Hill, Director of CBRC, has been awarded an AM in the recent Queen’s Birthday Honours. David’s award is for “service to the promotion of community health, particularly in the development of cancer awareness and prevention programs.”

Nadine has joined the WA Cancer Foundation Consumer Participation Project Advisory Board. Sandra and Rob will be conducting a regular review of the literature on behavioural aspects of breast cancer for the WACOG Breast Scientific Group newsletter.

With regret, we have had to say goodbye to Liane McDermott, at least for the time being. Liane has deferred her studies and returned to Queensland but we hope to welcome her back into the CBRC fold next year.

Meanwhile, we welcome a new PhD student, Debora Brown, who has joined us. Debora completed her Masters degree at Edith Cowan University this year on attitudes of older, “hard-core” smokers to anti-smoking messages. She will also be working part-time for the Centre. We also welcome Natasha Watson and Narelle Wellar. Natasha is completing a Healthway-funded study of smoking in the media, and Narelle is working on a similar Commonwealth-funded study.

Call for bipartisan support for cancer priorities

The Cancer Council Australia has called on all major political parties to commit to action to help drive down cancer rates and reduce the impact of the disease on patients and their families.

In the lead up to the federal government election, The Cancer Council Australia wrote to the leaders and health spokespersons of the Liberal and National parties, the ALP and the Democrats seeking a commitment to national initiatives to address eight priorities:

- A comprehensive tobacco control program
- Support for clinical trials, to increase patient access and benefit
- A national skin cancer prevention program
- Enhancing palliative care, to ensure all people with cancer have access to care and support
- Improving radiation oncology services, to ensure timely access to treatment
- Increased support for cancer research, to advance prevention, detection and treatment
- Improving rural and regional services, to ensure equitable access to treatment, support services and information for all Australians with cancer
- A comprehensive colorectal cancer campaign, to reduce preventable deaths and illness caused by the most common serious cancer in Australia.

The document, Cancer prevention, control and care: Priorities for the federal agenda, includes further detail about the eight priorities and recommendations for action and funding. It also sent to every federal election candidate, seeking their support.

The Cancer Council said any party that does not include commitments to improve cancer control in its election platforms is ignoring the concerns of a majority of voters. More than 60% of Australians nominated cancer as the health issue they considered most important in a recent Roy Morgan poll.

The president of The Cancer Council Australia, Professor Ray L owenthal, said there were many actions governments could take, which would have a massive impact on cancer incidence and mortality.

“The next Federal Government will need the courage and commitment to apply the knowledge we now have to improve prevention, treatment and care,” Professor Lowenthal said. “We hope all parties will commit to doing so.”

For further information or a copy of the document, please contact Lisa-Marie Herron: (02) 9380 9022 or lisa.herron@cancer.org.au

New appointment for Cancer Foundation CEO

The chief executive of the Cancer Foundation of WA, Mike Daube, has been appointed director-general of the state’s Health Department.

A former acting health commissioner, Mr Daube this year chaired the government’s Health Administrative Review Committee. He has a long and distinguished history in the health industry both in WA and internationally, having worked in many senior roles within Government, including Assistant Commissioner, Public Health, and chief executive of Princess Margaret Hospital.

SunSmart: Twenty years on

A summary of the development and achievements of the SunSmart program has been published as a monograph by the Anti-Cancer Council of Victoria. The monograph describes the social, political and economic contexts within which the SunSmart program developed and what, importantly, have been the key factors and lessons learned since 1980.

The monograph is an edited extract from the paper “Slip! Slop! Slap!” and SunSmart 1980 to 2000: Skin Cancer Control and 20 years of Population Based Campaigning by Meg Montague, Ron Boland and Craig Sinclair, published in Health Education and Behaviour (Vol 28 No 3 June 2001).

Copies of the monograph can be obtained from the Cancer Education Unit, Anti-Cancer Council of Victoria on 172 Cancer Forum • Volume 25 Number 3 • November 2001 173 Cancer Forum • Volume 25 Number 3 • November 2001
**Herceptin decision prompts call for drug funding review**

The Cancer Council Australia welcomed Federal Health Minister Michael Wooldridge's announcement on October 12 that the Government will fund Herceptin for women with advanced breast cancer.

While welcoming the Minister's decision to make the drug available, The Cancer Council urged the next government to face the issue of new drug funding in a more comprehensive way.

The Cancer Council Australia CEO Professor Alan Coates said the current Pharmaceutical Benefit Scheme approval process seems to place too much emphasis on cost rather than value.

"Australia aspires to offer a world-class health service, as part of which government has an obligation to properly consider funding for new drugs which are proven to be effective," he said.

"I expect this will mean doubling what we're currently spending on cancer drugs, because many new drugs now in the pipeline may have the capacity to extend the lives of cancer patients.

"Increasingly the focus will shift from 'cure' to improving quality of life for people who are living with cancer, particularly those in whom the disease cannot be eradicated. In many cases this will involve drugs offering long-term disease control."

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**BOOK REVIEWS**

**Brain Tumours – An Encyclopaedic Approach, Second Edition**

A Kaye and E Laws Jr (Eds)

Published by Churchill Livingstone (2001)


RRP: $608.99

The text is designed to provide a comprehensive coverage on as the editors state, "an encyclopaedic approach." In addition to the two editors there is an extensive author panel of neuro-oncologic (principally neurosurgical) authorities.

Neurosurgeons appear to be the primary target audience of the book. The relative details and selection of authors are consistent with such a strategy. Despite this emphasis, the approach is broad, albeit at times superficial. There are examples of suboptimal review of the non-surgical literature, not only with respect to detail and depth but also prioritisation.

The text is divided into two components. Section 1, Basic Principles, covers in 23 chapters a range of subjects from the historical, through recent scientific advances to particular aspects of therapy and its complications. Section 2 is divided into 10 parts which, through 26 specific chapters, cover the range of specific tumour types and locations. The second edition seeks to systematically update the content and introduce new contributions in evolving fields.

The format is reader friendly, consistent, systematic and accompanied by helpful illustrations. The content is relatively cohesive given the multiplicity of authors with some repetition and limited discord. Despite the challenge of this enormous task the text provides a useful reference resource not only for neurosurgeons but others interested in aspects of neuro-oncology.

L White

Sydney Children's Hospital

Randwick, NSW

**Cancer Medicine - 5 Review**

R Bast

Published by Holland & Frei (2000)


RRP: $59.40

This small book of multiple choice questions is based on the Holland & Frei text book, Cancer Medicine (reviewed in the July issue).

The book is divided into three sections: cancer biology and epidemiology, treatment principles and specific neoplasms. The book includes answers which are given in some detail with an appropriate reference to the text book.

Advanced trainees may find this a useful aid to be used in association with the reading of the text book. It would allow a degree of self assessment. Basic trainees in internal medicine may also find the multiple question format helpful in their own exam preparation.

D Bell

Department of Medical Oncology

Royal North Shore Hospital

**THE EFFECTS OF LOW AND VERY LOW DOSES OF IONIZING RADIATION ON HUMAN HEALTH**

World Council of Nuclear Workers (Ed)

Published by Elsevier (2000)


RRP: $US183.50

This book contains the Proceedings of the First International Conference on the Effects of Low and Very Low Doses of Ionizing Radiation on Human Health, held at the University of Versailles in 1999. The Scientific Committee and contributors comprise a global "who's who" of low dose exposure radiation researchers and policy makers. The volume is representative of a growing trend in radiation research publications where many of the most relevant and informative publications are expansions of conference proceedings.

The subject is one of growing interest for those in policy and regulatory areas and is receiving increasing attention, as reflected in the extensive research program currently underway and funded by US authorities. A recent funding allocation from...
The transcribed narratives are quite lengthy (10-12 pages), and the theoretical framework of symbolic interactionism, focusing on the actors (nurses, doctors). The second section interprets these narratives within the context of 12 professionals (two social workers, three nurses and seven doctors). The limitations of this text are, in my view as a haematology nurse, are not covered here. Childhood leukaemias and lymphomas are covered, but in a very limited fashion. While this book does provide an excellent introduction to a broad range of issues relevant to haematological nursing, some of the topics are covered, particularly those pertaining to haematological oncology, but there is little information about patients and their families. For example, treatment modalities while section three provides useful coverage of significant patient care issues often unique to these patients.

There are several things that commend this book, written largely by and for nurses. Firstly, it clearly and uncompromisingly focuses on holistic care of the haematological oncology patient. This is particularly evident in a robust overview of approaches to management of these malignancies and the significant physical implications of various treatments. This is followed by informative and provocative chapters dealing with psychological, social and spiritual issues, for patients and families of living and dying with these diseases. Ethical decision making is covered in a very engaging manner, while the far reaching implications of curative treatments are highlighted in well researched discussions on fertility, quality of life, employment and survivorship issues.

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PRINCIPLES & PRACTICE OF ONCOLOGY 6th EDITION

J DeVita Jr et al (Eds)

Published by Lippincott Williams & Wilkins
RRP: $595.10

The latest version of this comprehensive standard text is organised in sections, which means that information on a given topic will be found in several places. As it is unlikely, due to its weight (5kg), that it would ever be read cover to cover, this means an excellent index and a willingness to cross reference are required.

Part 1: Oncology Science
Updates basic and applied molecular biology, signal transduction and immunology

Part 2: Principles of Oncology
Updates cytogenetics, the cell cycle, apoptosis, invasion and metastasis, and angiogenesis. Sections on etiology and epidemiology, surgery, radiation therapy and chemotherapy and biological therapies (including detail on all classes of anticancer drugs) are excellent.

These background areas are followed by the more applied Part 3: Practice of Oncology.

This section includes: Prevention, Screening, Diagnosis, Cancers categorised by disease site (each reviewing pathology, epidemiology and management), Oncological Emergencies, Metastatic Disease by site, Supportive Care (including management of toxicity, pain, psychosocial issues, rehabilitation), Palliative care – alternative/unproven methods, Ethics and information issues and Emerging therapies.

The scope is unlike that of more portable references, and the detail is also impressive, comparable to that seen in a well-referenced review article in a major journal. This is a book for every oncologist’s shelf and every clinic and hospital library to own as a reference.

This text would also be an invaluable resource for those aspiring in oncology or for those junior medical staff seeking answers on oncology wards. It would be easy to imagine getting lost among its 3,000+ pages, but there is a wonderful sense of order to this book (aided by a detailed index). Internally, well-explained and readable sections on the science behind cancer, through to comprehensive information on the current practice of oncology (including references from the year 2000), with effort made to incorporate knowledge of advancing technologies and emerging therapies. Put to the test, on questions as diverse as tumour lysis, PET scanning in cancer with effort made to incorporate knowledge of advancing practice of oncology (including references from the year 2000), well-explained and readable sections on the science behind sense of order to this book (aided by a detailed index). Initially, getting lost among its 3,000+ pages, but there is a wonderful answers on oncology wards. It would be easy to imagine own as a reference.

This book would have very limited interests to investigators both in the clinic and the laboratory and I cannot see it being a worthwhile acquisition.

M Rosenthal
Private Medical Centre
Royal Melbourne Hospital
Melbourne, Vic

RENA L CANCER: METHODS & PROTOCOLS

J Mydlo (Ed)

Published by Humana Press (2001)
RRP: $US119.00

According to the Editor Renal Cancer: Methods & Protocols provides an introduction to the surgeon, clinician, investigator and research scientist to the basic methods employed in the diagnosis and treatment of renal cancer. Indeed this aspect of the book represents less than 10% of its content. The bulk of the book describes in vitro and in vivo experimental techniques ranging from telomerase assays through to laser-capture microdissection and experimental models of antibody targeting. A number of angiogenesis assays and murine animal models are described. Each of these techniques is described in laboratory manual detail with precise description of experimental strategies.

There is a proportion of the book focussed on immuno-therapeutic and monoclonal antibody approaches to this type of cancer which again describe in detail the laboratory basis for such work rather than the clinical trial results themselves.

There is little to interest the clinician, and I suspect most laboratory researchers have their own protocols and this book will be of passing interest to those wishing to compare their strategies with those of the selected techniques.

This book would have very limited interests to investigators both in the clinic and the laboratory and I cannot see it being a worthwhile acquisition.

M Rosenthal
Private Medical Centre
Royal Melbourne Hospital
Melbourne, Vic

SKIN CANCER

Sober and Haluska (Eds)

Published by Sober and Haluska (2001)
RRP: $253.55

This American Cancer Society Atlas of Skin Cancer is one of a series of 23 volumes, each covering cancer of an organ system. The contributors to the skin cancer volume are very much from the Harvard Medical School/Massachusetts General Hospital with the eminent Arthur Sober and Frank Haluska as editors. It is pleasing to see that there is an Australian contribution in the shape of the important section on prevention of skin cancer by Robin Marks, Professor of Dermatology at Melbourne University, and David Hill from the Centre for Behavioural Research in Cancer at Melbourne University.

According to the publisher, the readership is “undergraduate, postgraduate, research and professional”. Inevitably such a broad target audience will leave everyone a little dissatisfied.

Although promoted as an “atlas”, this volume is really more a profusely illustrated monograph with full text and bibliography. Anyone hoping to see a host of illustrations of the different ways skin cancer can present will be disappointed. There are only nine clinical photographs of basal cell carcinoma (BCC) in the relevant chapter. BCC is extremely common and quite variable in presentation and a couple of dozen photographs would be in order in an “atlas”. Amelanotic melanoma gets no mention in the index and there is only a single illustration of this difficult diagnostic entity.

Tumours such as angiomasoma and dermatofibroma tumours are seen rarely even by dermatologists and therefore an effort to collect a number of illustrations of these tumours would seem to be a major objective for a book of this type. Indeed there is no photograph of atypical fibroxanthoma or malignant fibrous histiocytoma. The latter is mentioned only in the treatment section and is never described clinically in the text. Paget’s disease of breast or mammary sites as well as cutaneous metastases from internal organs get no mention whatsoever. Some photographs, even of common entities such as BCC, are surprisingly poor in quality as are reproductions of bar charts and diagrams.

As is now happening with a number of textbooks, the volume comes with full text and illustrations on CD-ROM, a handy facility.

C Scarpignato
Published by Karger (2001)
RRP: $US97.50

This is a brief book. It is not a compilation of papers presented at an international symposium but, as the editor indicates in his preface, it is a collection of 11 commissioned monograph reviews. The authorship interestingly is predominantly European without one US contributor. Whether this represents a bias in selection of the authors or whether truly only investigators in Europe have ever contributed substantially to this field is not addressed. However the collection of papers comprehensively reviews the Somatostatin Analogs and especially octreotide. The first chapter, which is an overview of Somatostatin Analogs, I certainly found useful. The chapter was well written and the author had obviously invested a significant effort in the writing. However other chapters were not as well constructed and only addressed the questions of biology pharmacology and therapy somewhat superficially. Moreover many of the chapters which discussed the clinical use of octreotide are somewhat dated and written in a fairly perfunctory manner. Specific chapters addressing some of the newer issues in Somatostatin Analog research would have been worthwhile.

A detailed discussion on the use of octreocans and the use of radiolabeled octreotide would have been fascinating.

I wonder whether specialised books such as this are becoming dated and whether the types of issues would be best addressed on a specific Internet website where they could be updated and published in a timely fashion.
There is no doubt this book would be of interest for someone working in the field of Somatostatin Analog research but whether the cost of $US97.50 is worth the investment for somewhat dated book is questionable. I'd rather pay this amount to an updated website rather than a book of this vintage.

M Green
Department of Haematology & Clinical Oncology
Royal Melbourne Hospital
Parkville, Vic

TARGETED MOLECULAR IMAGING IN ONCOLOGY
E Kim et al (Ed)
Published by Springer (2000)
ISBN: 0-387-95028-1
RRP: $US169.00
EKim@abacusconf.com

This book explores the current state of imaging techniques using targeted agents for the imaging of a variety of malignancies. Its aim is to demonstrate how targeted imaging is impinging on oncology practice as well as research and it foreshadows what potentially lies in the future with these agents.

The book is organised into 21 chapters. The first four chapters discuss the basic principles of cancer metabolism and molecular biology, imaging strategies in oncology and the basic nuclear medicine principles of single photon emission computer tomography (SPECT) and positron emission tomography (PET) as well as magnetic resonance imaging and magnetic resonance spectroscopy.

The next 12 chapters deal with radiopharmaceuticals, antibodies, contrast agents and targeted SPECT, PET and MRI applications. Biochemical mechanisms of a wide variety of tumour targeted imaging agents, including monoclonal antibodies, peptides and non-specific radiopharmaceuticals are explained. The last five chapters discuss new imaging approaches about angiogenesis, apoptosis/hypoxia, signal transduction/antisense, gene delivery and expression, and optical imaging. The book is well illustrated throughout with examples using animal models as well as imaging in humans. The book summarises the current state of application of these techniques and acknowledges the continuous evolution in this field due to technical development.

This book is of primary interest to medical oncologists who seek a book summarising the current status of imaging in the evaluation of a variety of malignancies, both in patients with disease as well as in animal models. It may also be of use in the library of nuclear medicine departments with a large oncology referral base. The book is well written and well illustrated but its target audience is not broad.

M Roslegher
Associate Professor of Medicine
University of New South Wales
Chairman, Department of Nuclear Medicine
The Prince of Wales and Sydney Children’s Hospital

TUMOR ANGIogenesis & MICROcirculation
E Voest & P D’Amore (Eds)

CALENDAR OF MEETINGS – AUSTRALIA AND NEW ZEALAND

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<tr>
<th>Date</th>
<th>Name of Meeting</th>
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<td>November</td>
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<td>9-10</td>
<td>The Australian and New Zealand Head &amp; Neck Society</td>
<td>Melbourne, Vic</td>
<td>Head &amp; Neck 2001 Secretariat Abacus Management Pty Limited PO Box 77 Pymble NSW 2073 Ph: +61 2 9439 7477 Fax: +61 2 9439 5616 Email: <a href="mailto:abacus@abacusconf.com">abacus@abacusconf.com</a></td>
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<tr>
<td>28-30</td>
<td>28th COSA Annual Scientific Meeting</td>
<td>Brisbane, Qld</td>
<td>Laurie Wright Clinical Oncological Society of Australia GPO Box 4708 Sydney NSW 2001 Ph: +61 (0) 2 9380 9022 Fax: +61 (0) 2 9380 9033 Email: <a href="mailto:cosa@cancer.org.au">cosa@cancer.org.au</a></td>
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<td>“Cancer – We Care” Conference</td>
<td>Canberra, ACT</td>
<td>Laurie Wright The Cancer Council Australia GPO Box 4708 Sydney NSW 2001 Ph: +61 (0) 2 9380 9022 Fax: +61 (0) 2 9380 9033 Email: <a href="mailto:info@canvec.org.au">info@canvec.org.au</a></td>
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<td>21-22</td>
<td>4th National Breast Care Nurse Conference</td>
<td>Adelaide, SA</td>
<td>Sylvia DiMotta Ph: +61 8 8222 4616 Email: <a href="mailto:sdmraia@rah.sa.gov.au">sdmraia@rah.sa.gov.au</a></td>
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<td>28 Feb - 3 Mar</td>
<td>Inaugural Quality In Practice Conference</td>
<td>Gold Coast, Qld</td>
<td>Conference Convener Quality In Practice PO Box 2038 Milton BC 06 4064 Ph: +61 (0) 7 3876 6370 Fax: +61 (0) 7 3876 6373 Website: <a href="http://www.qipau.com.au">www.qipau.com.au</a> <a href="http://www.qualityonline.com.au">www.qualityonline.com.au</a></td>
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<td>21-22</td>
<td>5th Winter Congress of the Cancer Nurses Society of Australia</td>
<td>Canberra, ACT</td>
<td>Samantha Barabasz Creative Logic 477 Warragul Road Moorabbin Vic 3189 Ph: +61 3 9555 5001 Fax: +61 3 9555 5002</td>
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<td>5-6</td>
<td>Familial &amp; Genetic Aspects of Cancer: 2002</td>
<td>Barossa Valley, SA</td>
<td>Teresa Fisher Familial Cancer Conference 2002 Email: <a href="mailto:directorate@nbcc.org.au">directorate@nbcc.org.au</a> Ph: +61 2 9334 1708</td>
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<td>October</td>
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<td>21-23</td>
<td>International Clinical Trials Symposium 2002</td>
<td>Sydney, NSW</td>
<td>ICMS Pty Ltd Ph: +61 2 9290 3366 Fax: +61 2 9290 2444 Email: <a href="mailto:trials@icms.com.au">trials@icms.com.au</a> Website: <a href="http://www.stc.usyd.edu.au">www.stc.usyd.edu.au</a></td>
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<td>25-29</td>
<td>The Australian Health &amp; Medical Research Congress</td>
<td>Melbourne, Vic</td>
<td>Initiative of Australian Society for Medical Research Website: <a href="http://www.ahmrcogress2002.conf.au">www.ahmrcogress2002.conf.au</a></td>
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<td>15-19</td>
<td>6th International Symposium on Paediatric Pain – “Pain in Childhood: The Big Questions”</td>
<td>Sydney, NSW</td>
<td>Dianna Crebbin DC Conferences Pty Ltd PO Box 571 St Leonards NSW 2065 Ph: +61 2 9439 6744 Fax: +61 2 9439 2504 Email: <a href="mailto:mail@dcconferences.com.au">mail@dcconferences.com.au</a></td>
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<tr>
<td>November</td>
<td>XIXth Chemotherapy Foundation Symposium: Innovative</td>
<td>New York, USA</td>
<td>J Silverman, Medical Oncology Dept.</td>
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<td>Cancer Therapy for Tomorrow</td>
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<td>Mount Sinai Medical Centre</td>
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<td>New York, New York, USA</td>
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<td>Fax: +1 212 369 5440</td>
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<td>Email: J.Silverman@mt Sinai.mssm.edu</td>
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<td>Website: <a href="http://www.neoplastics.mssm.edu/CTF/lymphbrochure">www.neoplastics.mssm.edu/CTF/lymphbrochure</a></td>
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<tr>
<td>9-11</td>
<td>Oncology Nursing Society 2nd Annual Institute of</td>
<td>St Louis, Missouri, USA</td>
<td>Oncology Nursing Society</td>
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<td>Learning</td>
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<td>Pittsburgh, Pennsylvania, USA</td>
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<tr>
<td>16-18</td>
<td>3rd International Conference on Cancer-Induced</td>
<td>Awaji Island, Hyogo,</td>
<td>T Matsumoto, MD, First Dept. of Internal Medicine</td>
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<tr>
<td></td>
<td>Bone Diseases</td>
<td>Japan</td>
<td>University of Tokushima, School of Medicine,</td>
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<td>Tokyo, Japan</td>
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<td>Fax: +81 883 572 123</td>
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<tr>
<td>18-21</td>
<td>16th Asia-Pacific Cancer Conference: Cancer in the</td>
<td>Manila, Philippines</td>
<td>16th APCC, Philippine Cancer Society</td>
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<td>New Millennium</td>
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<td>Email: phlcancer.com.ph</td>
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<td>Website: <a href="http://www.philcancer.org">www.philcancer.org</a></td>
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<td>26-30</td>
<td>Data Management in Cancer Clinical Trials</td>
<td>Brussels, Belgium</td>
<td>D Zimmerman, EORTC Education Office</td>
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<td>Website: <a href="http://www.eortc.be">www.eortc.be</a></td>
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<tr>
<td>December</td>
<td>43rd Annual Meeting of the American Society of</td>
<td>Orlando, Florida, USA</td>
<td>ASH, Washington DC, USA</td>
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<tr>
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<td>Haematology (ASH)</td>
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<td>Fax: +1 202 857 1164</td>
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<td>Email: <a href="mailto:ASH@haematology.org">ASH@haematology.org</a></td>
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<tr>
<td>10-13</td>
<td>24th Annual San Antonio Breast Cancer Symposium</td>
<td>San Antonio, Texas, USA</td>
<td>L Dunnington, San Antonio Cancer Therapy and</td>
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<td>Research Center San Antonio, Texas, USA</td>
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<td>2002</td>
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<tr>
<td>January</td>
<td>Molecular Imaging in Cancer: Linking Biology,</td>
<td>Lake Buena Vista, FL,</td>
<td>American Association for Cancer Research</td>
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<td></td>
<td>Function, and Clinical Applications In Vivo</td>
<td>USA</td>
<td>Fax: 215 440 9300</td>
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<td>Email: <a href="mailto:meetings@aacr.org">meetings@aacr.org</a></td>
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<td>Website: <a href="http://www.aacr.org">www.aacr.org</a></td>
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<tr>
<td>February</td>
<td>Apoptosis and Cancer: Basic Mechanisms and</td>
<td>Wailkoloa, HI, USA</td>
<td>American Association for Cancer Research</td>
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<td></td>
<td>Therapeutic Opportunities in the Post-Genomic Era</td>
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<td>Fax: 215 351 9165</td>
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<tr>
<td>March</td>
<td>The Molecular Genetics of Colon Cancer</td>
<td>Philadelphia, PA, USA</td>
<td>American Association for Cancer Research</td>
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<td>7-10</td>
<td>55th Annual Cancer Symposium of the Society of</td>
<td>Denver, Colorado, USA</td>
<td>D Rubino, Society of Surgical Oncology</td>
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<td>Surgical Oncology</td>
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<td>Arlington Heights, Illinois, USA</td>
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<td>Website: <a href="http://www.surgonc.org">www.surgonc.org</a></td>
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<td>15-16</td>
<td>4th International Conference on the Adjuvant Therapy</td>
<td>London, UK</td>
<td>American Association for Cancer Research</td>
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<td>of Malignant Melanoma</td>
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<td>Fax: +44 207 720 7177</td>
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<td>Email: <a href="mailto:cc@fconcurr.co.uk">cc@fconcurr.co.uk</a></td>
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<tr>
<td>19-23</td>
<td>3rd European Breast Cancer Conference</td>
<td>Barcelona, Spain</td>
<td>K Vantongelen, FECS Conference Unit</td>
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<td>Data Management in Cancer Clinical Trials</td>
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<td>K Vantongelen, FECS Conference Unit</td>
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<td>27-30</td>
<td>55th Annual Cancer Symposium of the Society of</td>
<td>5 July, Oslo, Norway</td>
<td>Cancer Research Norway</td>
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<td>Website: <a href="http://www.cancerres2002.org">www.cancerres2002.org</a></td>
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<td>30 June</td>
<td>18th UICC International Cancer Congress</td>
<td>Stockholm, Sweden</td>
<td>European Congress Management</td>
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<td>Date</td>
<td>Name of Meeting</td>
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<tr>
<td>28 Aug</td>
<td>12th International Conference on Cancer Nursing 2002</td>
<td>London Arena</td>
<td>Liz Piem/Clare Manning</td>
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<td>Docklands, London</td>
<td>The Conference Office</td>
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<td>UK</td>
<td>Ph: +44 0 20 7874 0294</td>
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<td>Email: <a href="mailto:healthcare.conference@emap.com">healthcare.conference@emap.com</a></td>
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<td>September</td>
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<td>1-4</td>
<td>9th Central European Lung Cancer Conference</td>
<td>Vienna</td>
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<td>17-21</td>
<td>21st Annual Meeting of the European Society for Therapeutic Radiology and Oncology (ESTRO)</td>
<td>Prague</td>
<td>ESTRO Office, Brussels, Belgium</td>
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<td>Czech Republic</td>
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<td>18-21</td>
<td>SIOP 2002: The 34th Meeting of the International Society of Paediatric Oncology: Brain Tumours</td>
<td>Porto</td>
<td>Congress Secretariat</td>
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<td>Amsterdam, The Netherlands</td>
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<td>Email: <a href="mailto:siop2002@congress.nl">siop2002@congress.nl</a></td>
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<td>29 Sep-4</td>
<td>World Assembly on Tobacco Counters Health 2002 (WATCH 2002)</td>
<td>New Delhi</td>
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<td>Oct</td>
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<td>India</td>
<td>Fax: +91 11 694 4472</td>
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<tr>
<td>6-9</td>
<td>44th Annual Meeting of the American Society for Therapeutic Radiology and Oncology (ASTRO)</td>
<td>New Orleans</td>
<td>G Smith, ASTRO</td>
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<td>Louisiana, USA</td>
<td>Fairfax, Virginia, USA</td>
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<td>Website: <a href="http://www.astro.org">www.astro.org</a></td>
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<td>13-17</td>
<td>Frontiers of Cancer Prevention Research: Genetics, Risk Modeling, and Molecular Targets</td>
<td>Boston, MA</td>
<td>American Association for Cancer Research</td>
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<td>USA</td>
<td>Ph: 215 440 9300</td>
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<td>18-22</td>
<td>27th European Society for Medical Oncology (ESMO) Congress</td>
<td>Nice</td>
<td>ESMO Congress Secretariat</td>
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<td>France</td>
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<td>November</td>
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<td>1-3</td>
<td>Oncology Nursing Society</td>
<td>Seattle</td>
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<td>Washington</td>
<td>Pittsburgh, Pennsylvania, USA</td>
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<td>10-16</td>
<td>9th Hong Kong International Cancer Conference</td>
<td>Hong Kong</td>
<td>9th HKICC Secretariat</td>
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<td>China</td>
<td>Fax: +852 2818 1186</td>
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<tr>
<td>19-22</td>
<td>2002 Meeting of the European Organisation for Research and Treatment of Cancer (EORTC), the American Association for Cancer Research (AACR) and the National Cancer Institute (NCI): Molecular Targets and Cancer Therapeutics</td>
<td>Frankfurt</td>
<td>L Hendricks, FECS Conference Unit</td>
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<td>Germany</td>
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Date: 2002

December

6-10 | 44th Annual Meeting of the American Society of Haematology (ASH) | Pennsylvania, USA | American Society of Haematology Washington, DC, USA |
|     |                                                                   |                  | Fax: +1 202 857 1164 |
|     |                                                                   |                  | Email: ASH@haematology.org |
|     |                                                                   |                  | Website: www.haematology.org/meeting/ |

8-11 | 18th World Congress of Digestive Surgery | Hong Kong, China | Congress Secretariat |
|     |                                                                   |                  | Ph: 852 2818 0232/852 2855 4235 |
|     |                                                                   |                  | Fax: 852 2818 1186 |
|     |                                                                   |                  | Email: esid@hkcc.hku.hk |

11-14 | 25th San Antonio Breast Cancer Symposium | San Antonio, Texas, USA | L. Dunnngo |
|      |                                              |                  | San Antonio Cancer Therapy and Research Center |
|      |                                              |                  | Fax: +1 210 946 5009 |
|      |                                              |                  | Email: ldunning@saci.org |
|      |                                              |                  | Website: www.sabcs.saci.org |

2003

August

3-8 | 12th World Conference on Tobacco or Health: Global Action for a Tobacco Free Future | Helsinki | Email: wctoh2003@congcreator.com |
|    |                                              |                  | Website: www.wctoh2003.org |
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.

MEMBERS
The Cancer Council ACT
The Cancer Council New South Wales
The Cancer Council Northern Territory
The Cancer Council Tasmania
Anti-Cancer Council of Victoria
Anti-Cancer Foundation of South Australia
Cancer Foundation of Western Australia
Queensland Cancer Fund

AFFILIATED ORGANISATIONS
Australasian Association of Cancer Registries
Clinical Oncological Society of Australia Inc
Palliative Care Australia
Prostate Cancer Foundation of Australia

COUNCIL
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Professor I Frazer BSc(Hons), MBChB, MD MRCP, FRCP, FRCPA
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Professor D Holman MB BS, MPH, PhD, FACE, FAFPHM
Hon S Lenehan BA, DipMan, MBA, FAICD
Professor M Quinn MB ChB, MGO, MRCP (UK), MRCoG, FRACOG, CGO
Ms L Rogan
Dr R Walters RFD BmedSc, MBBS, RACGP
Professor J Zalcberg MB BS, PhD, FRACP

THE CLINICAL ONCOLOGICAL SOCIETY OF AUSTRALIA INC

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

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

EXECUTIVE COMMITTEE
President
Professor J Zalcberg MB BS, PhD, FRACP
President Elect
Dr L Kenny MB BS, FRANZCR
Council Nominees
Dr P Butow BA(Hons), MCI in Psych, MPH, PhD
Dr D Goldstein MB BS, MRCP (UK), FRACP
Ms P Yates BA, DipAppSc, MSocSc

MEMBERSHIP
Further information about COSA and membership applications are available from
GPO Box 4708, Sydney, NSW 2001.
Membership fees for 2001
Ordinary Members: $110
Associate Members: $60
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INTEREST GROUPS
Breast Oncology
Cancer Research
Data Managers
Epidemiological
Gastrointestinal Oncology
Gynaecological Oncology
Head and Neck Oncology
Lung Oncology
Medical Oncology
Melanoma and Skin
Oncology Nursing
(Cancer Nurses Society of Australia)
Paediatric Oncology
(ANZ Childhood Cancer Study Group)
Palliative Care
Pharmacy
Psycho-Oncology
Radiation Oncology
Regional & Rutal Oncology
Social Workers
Surgical Oncology