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Recent Developments in Cancer Nursing

Overview

P Yates
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Cancer nursing is a relatively young specialty within nursing. The specialty initially emerged in response to scientific, professional and social developments in the 1950s, which saw the beginning of radical changes to the way cancer was managed, and the way professionals and the public viewed the disease. Miaskowski identifies four factors that influenced the development of cancer nursing, alongside the development of cancer medicine, as a specialty:

- national and international recognition of cancer as a major chronic health problem (eg national and international cancer control policies and initiatives emerged);
- scientific and technological developments (eg the discovery of chemotherapy and other newer modalities of treatment);
- changes in professional and public perceptions of cancer (eg increasing knowledge base about the disease and improved survival rates resulted in more positive perceptions of the outcomes for people with cancer);
- changes in the nursing profession (eg development of education and research base and the increasing professional organisation of nurses).

These changes created a range of new roles and responsibilities for nurses caring for people with cancer, and over the past few decades these roles have continued to evolve in response to the changing social and health care environment. Cancer nurses today are integral members of the cancer care team, and cancer nursing has become established as a major specialty within nursing.

In 1996, the COSA Nurses Group published its second edition of Outcome Standards for Australian Cancer Nursing Practice. The document, along with other similar documents published in the USA, highlights the diverse and complex nature of cancer nursing practice. In particular, the Outcome Standards identify that:

- cancer nursing is concerned with service to the individual patient, their families and the community;
- cancer nursing occurs along a continuum of care, from prevention through to end of life care and bereavement support;
- cancer care is delivered to patients and their families in a variety of settings.

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

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

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

Defining the contribution of cancer nursing

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

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Nursing research is making unique contributions to prevent and manage problems associated with cancer and its treatment. The developments which have occurred within nursing over the past few decades provide much reason to be optimistic about the contribution that has already made by nurses to improve services to cancer care in Australia. However, issues relating to increasing nursing workloads, and the location of nursing within the health care system, have recently become major areas of concern for the profession. There is good evidence that nursing workloads have increased substantially in recent years. The most recent Nursing Labour Force Report from the Australian Institute of Health and Welfare (AIHW) showed that in 1995-96 FTE nurses employed in public acute and psychiatric hospitals declined by 2.8% between 1995-96 and 1998-99, the number of patient separations increased by 7.4% in private acute hospitals, and the number of hospital separations increased by 11%, however, the number of patient separations increased by 16%. Cancer nurses practising in outpatient and day treatment facilities, where nurse staffing levels are determined by the needs of the patient, have had to work far longer hours than they would like. This is clear from the recent qualitative study of nurses working in chemotherapy settings in Australia identified that many cancer nurses had concerns about their ability to provide quality cancer care in the present health care environment. The benefits of team approaches in cancer care are obvious if the complex multifaceted problems experienced by patients and their families are to be addressed more effectively. Strategies for advancing research in cancer nursing are also required. The development of evidence based practice, that is grounded in a sensitive understanding of human responses to cancer and cancer care. More research training opportunities, and strategies for addressing the limited funding presently available for nursing research will be important for the future of cancer nursing in this country. This does not mean eliminating research, but rather a strategic consideration of the most effective way to utilise scarce research funds and training resources in order to achieve good outcomes of research that are necessary for a comprehensive approach to cancer control. In conclusion, it is also important to acknowledge that more meaningful collaboration with the consumers of nursing services must be a central component of future cancer care. Nurses often pride themselves on their close relationships with their patients, and their ability to “know” patients, emphasising the unique opportunities provided by the 24 hour intensive nature of nurse-patient interactions. Nurses are, however, sometimes criticised for being inflexible in their clinical roles, and for not adequately understanding about their patients, and reluctant to consider changes to the way nursing care is delivered. In doing so, it is possible that nurses may at times fail to deliver the best possible care to their patients. Nurses will need to continue to critically reflect on their practice, and be willing to ask themselves whose interests are being served by the various actions of our profession. Cancer nurses will need to continue to develop in activities that improve communication with consumers and that fosters more collaborative relationships is essential for ensuring nurses...
PATIENT EDUCATION STRATEGIES IN AMBULATORY CARE SETTINGS

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Cancer treatments can be extremely frightening and intimidating. Patients receiving treatment therefore require adequate knowledge and skills to help them deal both with the treatment and the side effects of these treatments. The ambulatory care setting is now routinely used for people undergoing treatment for cancer. As such, nurses working in ambulatory care need to assist patients to gain the knowledge and skills necessary to enable self-care and self-management wherever possible: Such self-care can be enhanced through the provision of easily understandable but comprehensive and creative patient and family education programs.

Numerous studies have demonstrated that patients who receive a structured program of information during the course of radiation therapy report significantly less disruption in usual activities during and following radiation, and that nurses can have a positive impact on patients by promoting information and support measures: The purpose of this paper is to provide an overview of education strategies for patients receiving treatment for cancer in outpatient settings.

Educational needs for people undergoing cancer treatment

Ambulatory cancer care today encompasses many situations that years ago would have been considered unthinkable. Specific programs are now aimed at patients undergoing outpatient stem cell transplant, those managing central venous catheters and infusional chemotherapy at home, and those patients requiring self-administering colonostomy stimulating factors. Outpatient blood component therapy, infusional antibiotic therapy, and home IV services for drugs such as Aredia, also keep manageable. Patients out of hospital. Ensuring that patients have the knowledge to undertake these tasks confidently and, importantly, safely outside the hospital environment, is a major responsibility of oncology nurses in collaboration with medical staff. As well as the support and input of allied health staff such as dietitians, social workers, and other specialist nurses, it can also strengthen the teaching process.

Similarly, radiation oncology nursing has evolved over the past couple of decades in Australia, due to reduced inpatient beds, more complex treatment protocols such as an increase in combination chemotherapy/radiation protocols, and advances in brachytherapy. There is now a body of nursing knowledge in this specialty that is based on nursing, scientific, and psychosocial disciplines, which is necessary to effectively care for this patient population. Radiation treatment is a highly technical form of medical treatment. While the side effects of radiation treatment are generally predictable as part of the course of treatment, each treatment course is extremely variable. As such, educational interventions need to be individualized and flexible to accommodate individual needs and responses.

The literature on educational needs of patients undergoing cancer treatment is growing. Four main areas of informational needs of patients are commonly identified in this literature: disease concerns (e.g. diagnosis, treatment, test), personal concerns (e.g. impact on disease and treatment on well-being and functioning), family concerns (impact on family), and social concerns (interaction with peers, leisure, and social interests). Relationships and health professionals. Other writers have noted that while patients with different diagnoses display specific educational requirements related to their disease, common concerns are identified relating to prognosis and disease progression, and treatment options. Furthermore, the literature suggests that patients may have different concerns at different stages of their disease and treatment course, and that patients may have difficulty recalling information given at certain times, such as close to the diagnosis.

Approaches to patient and family education in ambulatory cancer settings

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

General principles of patient education

Before patient teaching can begin, several factors need to be considered. Firstly, it is necessary to assess patients’ physical and emotional wellbeing, their understanding of their diagnosis, and help them to understand the need for the planned course of treatment: It must be recognised that some patients, especially in the early stage of the treatment course may not be ready to understand complex and technical information, while other patients may desire in-depth information about all aspects of their care. Good patient assessment and communication skills, as well as a sound knowledge base of the patients’ disease and treatments are critical. According to Harwood, one of the biggest challenges we face in the past was having access to information. She argues that now we are at the other end of the extreme, where people have access and the challenge now revolves around sifting through reams of information to find which is not only credible but also appropriate to the patient’s situation.

Secondly, it is important to evaluate the patient’s ability to understand what is being taught. Prior assessment of a patient’s educational needs and learning abilities allows nurses to choose suitable methods of teaching, and ensure that patients receive the type of information that is desired and relevant for that patient.

Thirdly, it is necessary to have some understanding of the patient’s family environment and support system.

Fourthly, ensuring patients have time to ask questions, and assistance to communicate the information needs to health professionals is important. Patients sometimes have difficulty in communicating their needs in brief consultations with health professionals, and patient education needs to be directed to developing skills in these areas.

Finally, it is essential that appropriate documentation of patient education is maintained throughout the patient’s care, as this assists in monitoring the progress of the patient and the family. Patient education is a continual process, so mechanisms to assist ongoing evaluation of patients’ information needs are critical. As many individual nurses and other members of the health care team are likely involved in the education process for any one patient, effective team communication is essential for facilitating a coordinated approach to patient education.

In many settings, a primary nurse or specialist nurse consultant oversees the education program, in order to facilitate a comprehensive approach. For example, the Roving Clinical Nurse Consultant is a valuable component of patient education. In the Hospital, there exists to provide chemotherapy education at the initial medical consultation, admission, and supervise chemotherapy in non-oncology units, offer support programs, and provide counselling and follow-up care to patients during the transition from diagnosis to the completion of the treatment phase.

Topics covered in patient education

The oncology nurse will reinforce the information provided by the oncologist and instigate a primary intervention strategy regarding the treatment process and its side effects, care activities, and other issues such as compliance with medication, comfort, nutrition, and physical care. In the chemotherapy and radiotherapy setting, individual and family education sessions may focus on treatment side effects and their management, self-help strategies and support programs, and ambulatory oncology nurses in the larger teaching hospitals are also often included in clinical trial protocols, where they will have the assistance of an experienced research clinical trials nurse who will provide extensive education, follow-up and support for patients on studies or trials.

Methods for patient education

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

While face-to-face education sessions are a significant component of patient education, these settings are increasingly using a range of flexible modes for delivering information. For example, telephone triage can be utilized as a way of assessing potential or actual treatment-related problems or symptoms of patients in their own homes, and can be used to provide appropriate advice or instruction. Similarly, the use of interactive computer information is becoming more commonplace. In these systems, patients may have access to their own records with explanation as a further innovative method of patient teaching.
Patients themselves may have access to a wide range of sources for self-education. The oncology nurse can facilitate patients’ use of these sources. The implementation of education provided by health professionals, by assisting them to become critical consumers of the enormous range of information available to the patient or caregiver, can now access clinical trial information, detailed information about treatment regimens, and online support groups at will.

Clark suggests it is important to encourage patients to communicate with health professionals about the information they find on the internet, and to consider how this information relates to the information provided in the treatment setting. In this way, an opportunity is provided to give patients feedback regarding information sources and assist them to interpret information relevant to their needs. Clark further suggests that the criteria for evaluating Internet websites is not that different from evaluating written materials.

The patient education process begins with the provision of information to the patient, and the information is the uptake data, who sponsors the information, and how patient oriented a particular site may be.

Timing for patient education

One of the most difficult issues associated with patient education is identifying appropriate timing for teaching each individual patient’s circumstances. In general, most treatment settings have standardised or structured educational and information giving sessions early in the course of treatment. For example, a radiation education program may include a) the provision of written information at the planning appointment; b) the availability of a radiation treatment video which patients can view; c) an initial discussion by the radiation ONF, nurses at the beginning of treatment to discuss issues relevant to the patient; d) ongoing weekly assessment of interventions; e) ongoing education related to the changing nature of the radiation effects, often with cumulative dose; and f) telephone contact post-treatment to monitor progress. It is important to recognise, however, that ongoing assessment, repeated reinforcement and supportive feedback are the keys to imparting appropriate knowledge.

Group education and support programs

Education and support programs such as the Living With Cancer program, the STRETCH program for women who have had breast cancer, Look Good...Feel Better, and others are available in various states and territory cancer organisations. These programs are an important source of education and information for patients and their significant others, where learning is encouraged in a supportive and friendly environment. They are often used as an important supplement to the individualised patient education strategies described above, and nurses are a key source of referral to these types of programs.

Conclusion

Nurses and health professionals must, as described by Strauss, “teach the unexperienced”, providing medical and nursing knowledge and assistance to people who are often in various degrees of distress, anger and denial. Although cancer treatment knowledge does not guarantee the performance of self-care activities, certainly participation will not occur without treatment knowledge. Oncology nurses are significant providers of patient education in all areas of oncology practice. Whatever the patient and family education strategies employed by nurses in the ambulatory care setting, the needs of the patient/family, and their readiness to learn and responsiveness to information offered must be considered. The provision of a variety of creative and appropriate teaching tools will assist in the successful education of patients, to promote self-care, and improve outcomes from cancer treatment.

Cancer is now considered a chronic illness and is less likely to be dealt with by a death sentence. Consequently cancer is a disease that patients and their families must learn to live with for long periods of time because an increasing number of patients are surviving with stable or slowly progressing disease. Patients must address the impact and consequences of technological advancements on family members taking on the caregiving at home.

EDUCATION STRATEGIES: ADDRESSING FAMILY CAREGIVER INFORMATION NEEDS

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Family caregiver needs

Caregiver needs have received much attention from researchers over recent years and caregivers have employed various methods to ascertain and describe caregiver needs. However, lack of concise definition of what constitutes a need, both in research reports and among healthcare providers, creates problems when reviewing literature about caregiver needs. For the purposes of this paper, a need refers to a condition that is important to the caregiver and is not currently being satisfied by their environment.

Current literature also indicates that the family’s cancer experience changes over time and is influenced by various stages of the illness trajectory as well as by personal, environmental and psychological variables related to their own situation (Hull, 1989). Each phase of the illness presents the family with new challenges related to information needs, ways of coping and adjustment to changes that occur.

Informational needs

Many studies report a high incidence of informational needs among family caregivers10. Hileman and colleagues10 found caregivers for the important unsatisfied informational needs related to treatment side effects, the future, symptoms and community resources. Other studies found needs related to being informed of the patient’s condition, knowing the treatments available, providing with honest information, knowing the reasons for symptoms, and dealing with unpredictability were most common11,12,13.

Researchers constantly report that caregivers seek large amounts of information and that many unsatisfied needs can be related to the lack of access to adequate amounts of information and help with the care. One problem is that information is often difficult to obtain14,15. Difficulties may be the result of the family’s limited contact with health professionals16,17 or because the family has the responsibility to seek out information, which may be problematic especially if they lack confidence or are hesitant to ask for information already given to the patient18. Provision of information is well developed within health care making the caregiver role difficult to attain19. Information is a gap in practice, such as unsatisfied needs of caregivers, is identified.

Weisman and Bloch and Singh18 suggest that information seeking is a common coping strategy used by individuals. Information helps lessen fear, removes a degree of unpredictability and permits a sense of control. According to Selder initial information seeking also reduces uncertainty, a finding supported by Lewandowski and Jones19. Information is especially important to individuals taking on the caregiving role for the first time, or for those faced with constantly changing demands posed by varying developments within an illness trajectory. Receiving information to deal with a new situation is preferred to learning new skills by trial and error20.

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Assessment of family caregiver needs

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

1. the characteristics of the patient’s disease and treatment;
2. age, gender, activity level and relationship of the patient and the caregiver;
3. competing demands faced by the caregiver;
4. caregiver needs for information and skill acquisition;
5. the caregiver’s psychological health; and
6. available supports and effectiveness of previous coping mechanisms. This in turn will inform the development and implementation of appropriate interventions.

Education of family caregivers

There are many ways to approach the education of family caregivers ranging from practical demonstrations and the provision of information in a group setting to provision of written, audio and video resources. It is beyond the scope of this paper to provide detail of each method therefore the focus will be on examples of written resources and websites known to the author.

A written resource for family caregivers, “When cancer won’t go away: For carers of people whose cancer has advanced”, is an American publication from the National Institute of Health. “Cancer and the People Who Care About Them”, is an American book

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

Useful websites include:

n The Cancer Resource Centre: www.cancer-resource.org.au
n While this Centre is based in the United Kingdom, there is helpful information on its website.

n National Family Caregivers Association: www.nfacares.org
n This is an American site.

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

Conclusion

There is no doubt family caregivers are a vital member of the health care team. Caregivers are constantly faced with competing demands and fluctuating needs. Health professionals must take up the challenge of meeting these needs by considering family caregivers as valuable individuals who are an inherent part of the unit of care. To achieve this both health professionals and caregivers need appropriate education so they can work together to care for a person with cancer.

References

FORUM

identifying the information and support needs

The specialist CSN role provides the information and social support that has long been identified as important in the adjustment to the cancer diagnosis and the patient’s search for meaning.5 The CSN role is not specific to one cancer type, like the role of Breast Care Nurses, but encompasses all cancer types. Cancer is age dependent with 59% of cases occurring in people aged 65 years or more. Breast cancer is frequently provided with more information and is acknowledged as an effective coping strategy for some individuals with cancer.6,7 Many issues arise where the provision of information is valuable in assisting the individual or family member. The information promotes an understanding of events throughout the cancer experience, and is supportive in mobilising coping strategies. Becoming familiar with information and emotions reinforces confidence and enables the development of appropriate coping strategies throughout the cancer experience.8

Educated professionals take into account, age and cultural specific needs of individuals and families. For some, general structured programs like the Living with Cancer Education Program are helpful. This program, with as the 1 Can Cop program, is proven to be effective and beneficial to people with cancer and their friends and family.1,3,4 Education includes the provision of written materials, such as patient information booklets and other printed matter made available through resources such as the Cancer Information Service. Information can also be visual or audio.

Providing emotional support

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

Structured teaching sessions are undertaken to inform nurses in the surgical areas of the care needs of patients with a new cancer diagnosis, and also on relevant cancer types. Education includes the provision of written materials, such as patient information booklets and other printed matter made available through resources such as the Cancer Information Service. Information can also be visual or audio.

Breaking bad news

The CN contributes to the knowledge of the nursing team through formal education and provides support for less experienced team members, regarding coping with reactions to a new cancer diagnosis. The CSN provides support to medical colleagues in the confronting role they face often without a clearly identifiable supportive framework.

The CSN should be present when a patient and family member receive the cancer diagnosis, regardless of whether the cancer diagnosis was expected or not. Hearing precisely what is discussed is important when clarifying patient comments and questions at a later time. It allows for the assessment of personal reactions to the cancer diagnosis and enables timely support to be provided to the patient and family. Support to the medical colleague who is giving the bad news, particularly if it is an inexperienced junior medical officer, is important. The presence of the CSN allows the identification of the immediate areas of need – patient or family – and planning for future needs can commence.

The volume and depth of information that is provided to patients by medical staff regarding diagnosis and sometimes prognosis, is acknowledged. Appropriately timed visits by the CSN to patients and their families, are based on the content of this information and their reactions.

FORUM

PREVENTION AND EARLY DETECTION OF ORAL MUCOSITIS

in a CANCER SETTING

Oral mucositis is a common and distressing complication of cancer chemotherapy and radiotherapy.9 Severe mucositis resulting in the delay or cessation of cancer treatments may jeopardise the intent for cure or control. An abundance of different interventions used to prevent and manage oral mucositis appear in the literature, with little scientific evidence of their effectiveness. This paper reports on an evidence-based study at Peter MacCallum Cancer Institute (PMCI) to develop best practice guidelines aimed at prevention of oral mucositis in a cancer popolation and support family members.10 The CSN provides a resource to areas where there are few established processes in place to address the supportive care needs of individuals with cancer.

Incidence and effects

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infection and bleeding. Changes in oral status correlate with the timing of myelosuppression as neutrophils and oral mucosa have similar cell renewal rates. Oral mucositis is often most severe at the nadir of the neutrophil count with resolution of mucositis as the count recovers.

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

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

Prevention and management of oral mucositis

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

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

In addition, the maintenance of oral cleanliness in the form of tooth brushing or gingival massage is considered the most reliable means of controlling bacterial plaque, which has a direct causative link to the development of caries, gingivitis and periodontal disease. These findings are of particular relevance to the study suggesting that patients who have had dental evaluation, preventative care and treatment of pre-existing dental disease prior to chemotherapy and radiotherapy experience a reduced incidence of oral mucositis.

Studies comparing mouth wash interventions have also co-incidentally found that when nurses performed consistent oral assessments and frequently reinforced oral care instructions, patient compliance was greater.

The literature suggests that preventing or reducing the incidence and/or severity of oral mucositis not only has positive outcomes for patients by decreasing complications and length of hospital stay but additionally reduces staff time costs and time associated with care.

Recommendations and guidelines

A review and evaluation of the literature has resulted in the formulation of consensus guidelines: Prevention and Early Detection of Oral Complications of Mucositis PMCI Consensus Guidelines. These guidelines have been formulated with multidisciplinary representation including dental oncologists, radiation and medical oncologists, a general practitioner, pharmacist, dentist, and academic and clinical nurses from within and outside PMCI.

An Oral Health Promotion Grant from the Department of Human Services Victoria was acquired to partially fund the costs involved in the project. As a result of progress to date the development and implementation of consensus guidelines and a program of education for all staff and patients has now become possible.

The guidelines for selected patients receiving chemotherapy and radiotherapy include:

1. The performance of an oral assessment on admission
2. Referral to a dentist for pre-treatment examination, and care and management of pre-existing tooth and gum disease
3. Education of patients by nurses regarding principles of good oral hygiene, signs and symptoms of oral mucositis and self-care mouth management
4. Distribution of a patient education brochure with guidelines for oral hygiene and assessment of mouth problems
5. The restriction of prophylactic mouthwashes and other agents

Guidelines©. These guidelines have been formulated with a commitment to improving the care given to their patients with cancer. Margaret Graham Building, Royal Adelaide Hospital SA, 1998.

The Joanna Briggs Institute for Evidence Based Nursing and Midwifery, University of South Australia is the current provider for incorporating and treating chemotherapy and radiation-induced oral mucositis in patients with cancer. Margaret Graham Building, Royal Adelaide Hospital SA, 1998.

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Conclusion

Questions surrounding the best practice in the prevention and treatment of oral mucositis are left unanswered due to poor quality and insufficient research. Even so there are considerable incidental findings from the literature in regard to factors, which facilitate prevention to warrant further evaluation. These findings have formed the basis on which the ENBPG have developed the enclosed guidelines.

Maintaining good oral hygiene is a first principle in the prevention of oral mucositis for patients undergoing chemotherapy and radiotherapy. The role of dental examination and treatment of pre-existing oral disease is significant in reducing the risk of complications associated with oral mucositis. Nurses caring for patients undergoing treatment for cancer require education about the effects of treatment on the oral mucosa, the effectiveness of regular mouth care and how to perform an oral assessment. Patient education about self-care measures for oral care including demonstration and reinforcement of oral care instruction by nursing staff is advocated. As the regular observation and assessment of the status of patients undergoing cancer treatments is recorded and communicated by nurses, early and appropriate intervention for the management of degree of severity of oral mucositis can be instituted.

The outcomes of an improved oral health program such as that introduced at PMCI are to standardise care and assessment interventions. In addition the project aims to improve patient outcomes relating to incidence and severity of oral mucositis and to enhance quality of life and self care ability by acquiring new knowledge and skills. For nurses the benefits are a continued growth of knowledge, clinical expertise and a commitment to improving the care given to their patients with cancer.

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

In December 1995 QONG met with representatives from the Division of Workplace Health & Safety. This forum was an opportunity to inform the Division of the increasing use of chemotherapy drugs in the workplace and to raise concerns regarding the limited legislation that specifically covered cytotoxic drugs and related waste. From this meeting it was determined that the best direction for the QONG would be to consult directly with the Community Services Industry Workplace Health & Safety Committee to develop guidelines to minimise occupational exposure to cytotoxic drugs and related waste. In 1996 the Queensland Oncology Nurses Group and the Queensland Nurses’ Union approached the Community Services Industry Workplace Health & Safety Committee and a Working Party was established.

Guideline development

The initial Working Party included representatives from the public and private health sector, domiciliary nursing agencies, Division of Workplace Health & Safety, Department of Health, Queensland Nurses’ Union, the Queensland Cancer Fund and the Private Hospitals Association of Queensland. This meeting was on a regular basis to develop guidelines and the health care competencies for the safe handling of cytotoxic drugs and related waste in Queensland. The guidelines were adapted from the Guidelines for handling cytotoxic drugs and related waste in healthcare establishments. New South Wales, 1994. However, research has shown that in uptake of guidelines and recommendations from professional groups and institutions, healthcare workers do not always practice what they know is safe practice1,2. Gullo reports that less than 40% of nurses practice safe handling measures when handling cytotoxic drugs or their families. This remains an area of uncertainty for patients as well as for healthcare workers and requires further attention.

The guidelines were published in 1997 and disseminated through the Department of Health to all public and private hospitals and domiciliary services throughout Queensland. The document is also accessible from the Department of Training and Industrial Relations Website: www.detr.qld.gov.au/nsguide/g82107.pdf. Review of the guidelines was to occur in 1999 however this has been postponed.

Evidence suggests that if appropriate measures are employed the potential risks associated with occupational exposure to cytotoxic drugs and related waste will be minimised (Oncology Nursing Society, 1989). However, research has shown that in uptake of guidelines and recommendations from professional groups and institutions, healthcare workers do not always practice what they know is safe practice1,2. Gullo reports that less than 40% of nurses practice safe handling measures when handling cytotoxic drugs or related waste in healthcare establishments. New South Wales, 1994. However, evidence suggests that if appropriate measures are employed the potential risks associated with occupational exposure to cytotoxic drugs and related waste will be minimised (Oncology Nursing Society, 1989).

In recognition of the significant contribution of the QONG, the final document, Guide for Handling Cytotoxic (Antineoplastic) Drugs and Related Waste1, was launched at the Annual Oncology Nurses Conference October 1997 by the Executive Director of the Workplace Health & Safety Program. The guide provides practical information for both employers and employees pertaining to the safe handling requirements of cytotoxic drugs and related waste in the workplace. The document is pertinent not only for nurses but also for other healthcare workers in hospital, community, laboratory, veterinary and/or home settings. While the document does not contain specific procedures for the preparation, administration, management and disposal of related waste, training modules were developed to assist institutions to develop appropriate in-house policies and procedures. It was not the scope of the document to provide practical safe handling information for patients receiving cytotoxic drugs or their families. This remains an area of uncertainty for patients as well as for healthcare workers and requires further attention.

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

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Abstract

This paper describes current issues in chemotherapy nursing practice in rural and remote Australia. There is a trend to refer chemotherapy clients back to their rural and remote health facility for treatment from major oncology centres in major cities throughout Australia. However, it is increasingly apparent that the majority of nurses administering chemotherapy in smaller centres lack the theoretical and clinical knowledge to ensure optimum chemotherapy practice. This is unique to rural and remote life which will influence optimum chemotherapy service delivery.

The research program described in this paper will ascertain the education requirements of rural and remote nurses administering chemotherapy and the design and delivery of a chemotherapy education package specific to the rural and remote context. Similar programs will ensure the best standards of chemotherapy practice in non-metropolitan areas by enhancing the practical and theoretical knowledge base of rural and remote nurses.

Introduction

While it is difficult to obtain any concrete figures relating to chemotherapy administration in rural and remote Australia, anecdotal and practical experience indicate that the number of rural chemotherapy practitioners is small and that certain nonsensical practices remain unchanged.

Conclusion

The issue of cytotoxic exposure remains controversial however sufficient evidence confirms the need for health care workers to exercise vigilance when handling these drugs and their related waste. While the Guide for Handling Cytotoxic (Antineoplastic) Drugs and Related Waste is based on scientific evidence it has also taken into account what is unknown and what is suspected.

These guidelines are a minimum standard and are only as good as the implementation process that accompanies them. While maintaining the compliance with the guidelines is important for greater compliance with the recommendations concerning safe handling practices and personal protective measures to

minimise the risk of exposure to cytotoxic drugs and related waste. The increasing use of cytotoxic therapy and demand for chemotherapy services in a district hospital or general practice has become a reality for every district and territory to ensure that the recommended facilities for preparing these drugs are available, that adequate personal protective equipment is provided and that workers are provided with adequate educational preparation.

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The response of urban people is more likely to be linked to costs; isolation from social and family networks; and from burdens rural people experience when undergoing specialist to home is that it relieves some of the social and financial An advantage of the trend to deliver chemotherapy closer to home help to themselves is accompanied by a resistance to help from others, which is occurring in a context of increasingly high turnover of health professionals in non-metropolitan areas. It is well known that rural and remote people find it difficult to access private health services because they are less likely to have access to the necessary education because of the financial barriers in travelling to and from the city, and the fact that they have limited access to conferences, peer networks, libraries and information technologies, in addition to inadequate staff ratios which do not accommodate backfilling of staff who seek education outside the town. An advantage of the trend to deliver chemotherapy closer to home is that it relieves some of the social and financial pressures on rural and remote health services that are normally associated with cancer treatment. There are many positive outcomes to be seen from this research. The most important is that a course designed specifically for the context of non-metropolitan health care delivery, which is based on current evidence and best practice standards of chemotherapy practice, will improve the chemotherapy treatment outcomes and safety of rural and remote residents, throughout Australia. Furthermore, enhancing the knowledge, competence and confidence of rural and remote area RNs administering chemotherapy will ensure the occupational health and safety of nurses delivering chemotherapy to rural and remote clients. It is also hoped that the project, through the delivery of the course, will develop a peer network of nurses educated about, and competent in, chemotherapy administration throughout Queensland that will be sustainable on completion of the project. This will ensure that nurses entering rural and remote contexts will be adequately and safely trained in chemotherapy administration. Knowledge deficits identified amongst non-specialist nurses administering chemotherapy There is evidence that these factors contribute to a significant knowledge deficit amongst the nursing professionals administering chemotherapy in rural areas. The specialist oncology nurses and pharmacist in one provincial health service routinely receive six calls a week from health professionals in outback areas administering chemotherapy, spending up to one hour per call advising them on safe administration of anti-neoplastic drugs. In 1996, in the south-east Queensland and northern NSW, including Charleville, Cunnamulla, Tenterfield, Warwick and Roma. Knowledge deficits identified by oncology professionals at this referral centre, which were corroborated by reports in the international literature, include: 1 Clinical knowledge of cell cycles and their relation to chemotherapy; anti-neoplastic drug actions; standard chemotherapy doses and the rationale for dose variations; recognition and management of immediate and potential side effects; client education, and safe handling of cytotoxic drugs. 2 Technical skills such as the access and management of various venous access devices; venepuncture and cannulation. Possible solutions The specialist oncology nurses in South East Queensland recognise their collegial responsibility to ensure nurses administering cytotoxic drugs to clients referred from major centres have the peer and educational support that ensures work place health and safety for clients and nurses in specific rural and remote contexts. They are also aware that client outcomes are significantly enhanced if nurses in outlying areas are competent to administer chemotherapy. As a result, they have obtained funding for a two phase project. Phase 1 is a needs analysis of rural and remote area nurses in Queensland that will ascertain the education requirements of rural and remote area Registered Nurses with regard to the administration of chemotherapy. Phase 2 of the study will involve the design and delivery of an educational package that is context specific, relating to the administration of chemotherapy by rural and remote area nurses. The delivery platform will be determined by the needs analysis, but will include interactive multimedia platforms (for example CD-ROMs). Conclusion There are many positive outcomes to be achieved from this research. The most important is that a course designed specifically for the context of non-metropolitan health care delivery, which is based on current evidence and best practice standards of chemotherapy practice, will improve the chemotherapy treatment outcomes and safety of rural and remote residents, throughout Australia. Furthermore, enhancing the knowledge, competence and confidence of rural and remote area RNs administering chemotherapy will ensure the occupational health and safety of nurses delivering chemotherapy to rural and remote clients. 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The dehumanising potential of cancer

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

The dehumanising potential of cancer treatments is illustrated in the woman with breast cancer who may experience:

1. surgical procedures that change her appearance permanently
2. chemotherapy that result in painful ulcerous blisters and the loss of her legs
3. radiation therapy that lead to burns of the skin that blister and weep for up to three weeks following completion of treatment

The physical effects of treatment can be compounded by the attitude of health professionals. In providing a personal account, Sauerlender (1991) describes how her personal knowledge and truth underlying most curricula is value laden but invisible. Rarely is it discussed that cancer care is dehumanising the person and creating moral distress for the professional, words, attitudes and gestures are branded upon the vulnerable patient’s mind. This personal account is supported by research done by Krall, Koch and Wotton who could group patients’ experiences of nursing care into two categories: engagement and detachment (3).

Defensive attitudes create in professionals a kind of armour-plating that prevents them relating to the patient’s emotions (detached). This translates into a relationship that is distant, cold, aseptic and, most definitely dehumanised (2).

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

“While nurses clearly need to be guided by the most up to date knowledge, especially in hospital settings, to allow clinical tasks to be performed with skill and consistency, the nurse-patient process is not data-based. Rather, (nursing) is a human-based engagement that must be guided by human values and theoretical principles of relevance to human engagement” (21).

Barker’s view is supported by Curtis who states that the goals of nursing are not science based; they are moral and are based on the seeking of good (12). Therefore, nursing actions are subject to judgement, influenced by values, as well as scientific evidence.

Values and nurses

There is mounting evidence that the values learned by nurses are not consistent with the values that nursing students are taught. Scott et al. (2006) found that senior baccalaureate nursing students in the United Kingdom valued ‘respect for the patient’ and ‘caring about little things’. Little things included getting out the mirror so patients can see themselves, fixing their water so they can reach to help themselves, washing someone’s dentures or the cat they left at home. She found that this same group also valued ‘fitting in’ and ‘going along’. These students felt that their values would be consistent with their common hospital practice and saw themselves as powerless.

The finding of powerlessness, is a theme reinforced by another study completed in the USA (13). Over 300 neonatal nurses were surveyed and it found that four nurses working in large tertiary centres believed the nurse-patient relationship becomes secondary to physicians’ orders, institutional policies, and other external constraints. Moreover, 45% of the nurses who work in large tertiary centres believed the nurse-patient relationship becomes secondary to physicians’ orders, institutional policies, and other external constraints. Furthermore, 45% of the nurses who work in large tertiary centres believed the nurse-patient relationship becomes secondary to physicians’ orders, institutional policies, and other external constraints. Finally, 45% of the nurses who work in large tertiary centres believed the nurse-patient relationship becomes secondary to physicians’ orders, institutional policies, and other external constraints. Finally, it was found that 74% agreed that sometimes hospital policy or practice standards conflict with what the patient needs (14).

The result is a conflict between what the nurse should be doing, learned at nursing school, known as espoused values (something people reflect in their code of ethics or conduct), and what they are actually doing in the clinical area, values-in-use (15). This conflict can result in moral distress, defined as the feeling of dissonance or distress when the professional’s actions and constraints make it impossible to pursue the right course of action (16).

Moral distress produces painful feelings, that can range from a feeling of helplessness to anger and frustration. Over time, moral distress can escalate to feelings of depression, anguish, and moral outrage (17). Moral distress in nurses is an important factor in nurses’ decisions about remaining in practice (18-20).

Examples for cancer nursing

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

Nurses must interpret the theory used to make morally defensible clinical decisions and choices, recognise the contextual nature of value judgements, and develop the art of practical deliberation with colleagues to improve practice (21). This process is more than knowing and understanding the nursing process or routinely implementing institutional policies derived from evidence. The evidence is not the important factor. However by focusing on evidence alone, legitimised through a biomedical view, the nurse risks creating a dehumanising experience for patients and missing the rare or unlikely responses that are rendered invisible in research.

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

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TRENDS IN CANCER NURSING: THE HAEMATOLOGY NURSE PRACTITIONER EXPERIENCE

L Clark, S Eerhard, M Prince, J Gale and D Spencer

Advanced nursing practice roles – in particular the role of the nurse practitioner, are becoming recognised as valuable and needed in the increasingly complex health care systems of countries such as the USA, Canada, the United Kingdom and most recently Australia1-6. Political and social change, economic factors, the escalating cost of health service delivery, advances in research and technology impacting on medical practice, professional developments in the disciplines of medicine and nursing, and increasing consumer expectations have all contributed to the development and acceptance of these roles as the traditional boundaries between the health professions are reviewed, rethought and modified7-9. Essentially, the evolution of the nurse practitioner role has been an attempt to improve interdisciplinary health service delivery. The initiative is a response to individual and community demand for: improved access to health services, and increased diversity and flexibility of models in health care10.

In Australia, the introduction of the nurse practitioner role is at various stages of development regardless of either: establishing working parties, conducting feasibility studies, or implementing this new and rapidly evolving role11. The purpose of this paper is to provide an overview of one nurse practitioner pilot project conducted in the field of cancer nursing. The Peter MacCallum Cancer Institute (PMCI) participated in the Victorian State Government Nurse Practitioner Taskforce Models of Practice initiative, and aimed at further developing and extending an oncology nursing role, that of the Haematology Clinical Nurse Consultant.

Nurse Practitioner: A definition

The nurse practitioner is “at the apex of clinical nursing practice”12. Nurses in advanced practice must be highly educated, have post registration qualifications, and possess expertise in their specific area of practice which may include both individual and community health, in primary and acute care settings13,14. In addition to traditional nursing role responsibilities nurse practitioners may: take histories, conduct physical examinations, interpret diagnostic imaging and pathology tests, prescribe pharmaceutical agents, treatments and non pharmaceutical therapies, approve absence from work certificates, refer to specialists, and admit and discharge patients15.

As well as demonstrating high levels of clinical decision-making, nurse practitioners integrate education, consultation, administration, research, health policy development and clinical and professional leadership into their role. It is also essential that they function in collaborative and collegial relationships with other health professionals and in partnership with patients and communities16,17.

In Victoria, the focus of the nurse practitioner role is on the complementary nature of advanced nursing practice, rather than medical substitution. The advanced knowledge, skills and competencies of the nurse practitioner are simple tools that ensure safe, effective and expert practice in an expanded conceptualisation of clinical nursing18.

The Peter MacCallum Cancer Institute

Haematology Nurse Practitioner Project

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

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

Considerable pre project consideration in the conceptualisation of a nurse practitioner role in haematology and the implications of its implementation in both the urban and rural sector.

Integral to the success and sustainability of an advanced nursing practice role was the procurement of an agreed need, and support for the role from key leadership positions in the organisation at executive, divisional, and departmental levels.

Policy issues

The PMCI Haematology Nurse Practitioner Project addressed several of the critical policy issues being explored by the Victorian Nurse Practitioner Taskforce (VNPT): scope of practice; education and credentialling; and best practice19,20.

Scope of practice

Acknowledged as a core member of the Interdisciplinary Haematology Team, the HNP maintains a practice field that includes the total care continuum and involves the entire range of patients referred to the Haematology Unit. The HNP’s primary practice setting spans across the Institute Outpatient facilities and encompasses the Inpatient Haematology Ward as required. Therefore the model provides integrated care, horizontally, within the inter-disciplinary team, and vertically, across the care continuum.

Continuity of service provision and the availability of a constant caregiver are essential components of the model, as haematological malignancies often follow chronic trajectory pathways in which care is complex, crosses several health care settings and involves a number of care providers. A real potential for fragmentation of care exists21.

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

Thus in an acute care setting patients present with a range of problems that are essential for the HNP to correctly assess, interpret and manage for the identification of resolution of some or all of the patient needs. Therefore at times the nurse works independently whilst on other occasions the nurse consults closely with the Haematology Consultant and works highly collaboratively. Given the degree of fluidity in this model however the HNP’s educational preparation and experience will inform practice in order that the HNP may differentiate when autonomous nursing practice is appropriate, and identify high-risk, complex patient populations that require consultation, collaboration/co-management, or referral.

While the development of advanced competencies in oncology nursing, remains a priority of the Oncology Nursing Society, Australia, the need for identification of appropriate areas of competency, for the requirements of the project, led to adoption of the work of the North American Oncology Nursing Society Statement on the Scope and Standards of Advanced Practice in Oncology Nursing22. The major sub-roles of a nurse practitioner – direct clinical practice, education, consultation and research – are demonstrated as these competencies. Emphasis is placed on providing clinical and professional leadership, advancing nursing practice to the “cutting edge” through education and research; and, contributing to the development of health policy, in recognition of the specialist interests of patients and health care services. This framework also provided some direction for the educational preparation of the nurse practitioner.

Education

Major emphasis was placed on the development of an education program. It was designed to build on a requisite post registration qualification in oncology and extensive clinical experience in haematology nursing to further develop context based clinical knowledge, skills and attitudes relevant to the specialist area of haematology and necessary for advanced practice23.

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

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

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

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

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

Model of practice

A collaborative model of practice was identified as most suitable for the establishment of an advanced practice role in haematology nursing. Such a collaborative model may be thought of as an interdisciplinary partnership or joint practice19. The professional relationship between the HNP and haematology medical staff in particular is highly collaborative.

Collaborative relationships require certain fundamentals to ensure productive alliances and the creation of an environment in which collaboration is valued and practised. These include: shared values, a common purpose, mutual trust and respect, and effective interpersonal communication and...
negotiation skills. The diverse and complimentary knowledge, skills, experience and resources each participant brings to the collaborative effort must be understood and valued. Then, each team member may participate in a synergetic alliance that maximises the contributions of each participant and improves the quality of assessment, decision-making, problem solving, and choice of intervention. Subsequently a comprehensive health service is produced that could not be achieved by individuals alone.2,11,12

Conclusion
Following completion of the PMCI Haematology Nurse Practitioner Project in May 2000, a limited, local evaluation demonstrated high levels of stakeholder satisfaction, and an overwhelming positive response to the role. On a broader scale recommendations enclosed in the final report of the Victorian Nurse Practitioner Taskforce to progress the implementation of the nurse practitioner role in Victoria were received favourably by the State Government. Consequently the Institute has given a firm commitment to continue this role that continues to evolve, and is currently the subject of research that aims to further explore the nature and scope of practice in advanced haematology nursing. The PMCI Haematology Nurse Practitioner Project as part of the Victorian Government initiative is contributing to a national consideration of the nurse practitioner role. New South Wales, the first to formally establish the nurse practitioner role, has defined scope of practice, set educational and credentialling standards, developed legislation necessary for practice extension and introduced regulated measures. Victoria now joins with South Australia and moves into an implementation stage whilst the remaining States continue in various phases of role exploration.1

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

References
20 Royal College of Nursing. “Nurse practitioner networks: an overview of the nurse practitioner projects in Australia.” Connections (Royal College of Nursing Australia Newsletter), 1 (1 February, 2000).
Dr G Lindeman
Dept of Haematology & Medical Oncology
Royal Melbourne Hospital

The Kathleen Cunningham Consortium for research into familial aspects of breast cancer
$55,000

Dr J-P Liu & Dr H Li
Baker Medical Research Institute

Molecular targeting of protein kinase C-alpha-telomerase in human breast cancer cells
$53,563

Dr M MacManus & Dr J Seymour
Peter MacCallum Cancer Institute

Randomised trial of radiotherapy (RT) vs chemo/RT for stage I-II follicular lymphoma
$30,000

A/Professor P MacRae, A/Professor J St John, Dr B Leggett & Professor J Jass
Royal Melbourne Hospital

A trial of aspirin and/or resistant starch in people at risk of hereditary colorectal cancer
$65,000

Dr G Mann, Professor J Hopper, Dr J Astle, Professor R Keefe, Professor G Giles & Professor B Armstrong
Dept of General Practice & Public Health
University of Melbourne

The characterisation of a novel 108 kDa inositol polyphosphate 5-phosphatase: regulator of cell death
$50,000

Dr O Novak & Professor A Kaye
Department of Surgery
University of Melbourne

The role of hyaluronan in brain tumour invasion
$58,713

Dr L Purton, Mr D Haylock & Dr P Simmons
Division of Haematology and Medical Oncology
Peter MacCallum Cancer Institute

Enhancing ex vivo expansion of primitive haemopoietic cells by all-trans retinoic acid
$50,000

Dr I Radford
Peter MacCallum Cancer Institute

Defining aspects of the mechanistic of ionising radiation-DNA rearrangement in mammalian cells
$55,000

Dr S Stacker & Dr M Achen
Department of Surgery
Ludwig Institute for Cancer Research

The role of vascular endothelial growth factors in the metastatic spread of cancer
$66,000

Dr T Tiganis
Dept of Biochemistry & Molecular Biology
Monash University

Regulation of the protein tyrosine phosphatase TCPTP
$24,502

Total Grants in 2001
$1,419,654

POST-DOCTORAL RESEARCH FELLOWSHIPS

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

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

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

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

Total fellowships
$128,506

SCHOLARSHIPS AND STUDENTSHIPS

Post-Graduate Research Scholarships

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

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

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

Mr R Redvers, Peter MacCallum Cancer Institute
$21,150

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

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

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

Vacation Studentships
$19,000

Total Scholarships & Studentships
$165,288

FELLOWSHIPS

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

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

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

Lions Fellowship (variable)
Dr Andrew Elefanty, Walter and Eliza Hall Institute of Medical Research
approx $50,000
### OTHER RESEARCH PROGRAMS

**Walter & Eliza Hall Research Programs in 2001**

- Drs David Vaux, Andreas Strasser and Steve Gerrandakis: $200,000

**Medical & Scientific Activities**

- $144,000

**Total Other Research Programs**

- $344,000

### CANCER CONTROL RESEARCH INSTITUTE PROGRAMS

**Epidemiology Research Centre**

- $943,000

**Victorian Cancer Registry**

- $872,000

**Behavioural Research Centre**

- $803,000

**Centre for Clinical Research in Cancer**

- $807,000

**VicHealth Centre for Tobacco Control (ACCV contribution to VicHealth Centre)**

- $150,000

**Total Cancer Control Research Institute Programs**

- $3,575,000

### ANTI-CANCER FOUNDATION OF SOUTH AUSTRALIA RESEARCH GRANTS

- **A/Professor L Ashman**
  - Division of Haematology, Hanson Centre for Cancer Research
  - Role of PETA-3/CD151 in epithelial cancer invasion and metastasis
  - $60,308

- **Dr G Booker**
  - Understanding the structure and function of the tumour suppressor actinin-4
  - $55,866

- **Dr M Brown**
  - Investigation of the combined use of surgical castration and Flt-3 ligand or progenipoietin in novel dendritic cell-based immunotherapies in a murine model of prostate cancer
  - $59,589

- **Dr T Cleary**
  - Role of paps synthetase in growth of cancer cells in metastatic sites
  - $61,278

- **Dr L Coles**
  - Cold shock domain proteins as repressors of VEGF gene transcription
  - $56,866

- **Professor A Ferrante**
  - The use of novel fatty acids to treat prostate cancer
  - $49,197

- **A/Professor J Gamble**
  - Vascular Biology Laboratory, Hanson Centre for Cancer Research
  - Identification of potentially novel oncogenes capable of transforming myeloid cells
  - $56,146

- **Dr T Hart**
  - Department of Microbiology & Infectious Diseases, Flinders Medical Centre
  - Is a high dermal mast cell prevalence a significant predisposing factor for human melanomas?
  - $58,857

- **A/Professor D Horsfall**
  - Prognostic importance of androgen receptors in prostatic factor for $58,857

- **A/Professor D Findlay**
  - Sensitisation of cancer cells to TRAIL-induced apoptosis
  - $53,424

- **A/Professor D Wattchow**
  - Follow-up of patients with colorectal cancer: A comparison of specialist and GP-based strategies
  - $59,588

- **Dr A Lopez**
  - Division of Human Immunology, Hanson Centre for Cancer Research
  - Role of the 14-3-3 family of proteins in human GM-CSF and IL-3 receptor signalling in leukemic cells
  - $51,624

- **Professor P Mackenie**
  - Department of Clinical Pharmacology, Flinders Medical Centre
  - Colorectal cancer and the expression of chemical detoxifying UDP glucuronosyltransferases
  - $56,452

- **Professor G Maddin**
  - Department of Surgery, The Queen Elizabeth Hospital
  - Improving the safety and efficacy of electrolysis
  - $18,585

- **Dr A Morley**
  - Department of Haematology & Genetic Pathology, Flinders Medical Centre
  - Detection of point mutations in normal and cancer cells
  - $54,946

- **Dr C Ricciardelli**
  - Flinders Cancer Centre, Flinders Medical Centre
  - Changes to the physicochemical structure of chondroitin sulphate side chains of versican and role in prostate cancer progression
  - $58,700

- **A/Professor R Richards**
  - Department of Cytogenetics and Molecular Genetics, Women’s and Children’s Hospital
  - Fragile sites in cancer: biological consequences of DNA instability at the FRA16D and FRA3B loci
  - $64,906

- **Dr G Suthers**
  - Department of Medical Genetics, Women’s and Children’s Hospital
  - Investigation of a novel mechanism contributing to disease progression
  - $59,993

- **Professor H Zola**
  - Child Health Research Institute
  - International workshop on human leucocyte differentiation antigens
  - $48,000

**Total**

- $1,454,657

### OTHER RESEARCH PROGRAMS FOR 2001

- **Two Associateships**
  - $99,312

- **Two Fellowships**
  - $119,236

- **Travel Grants**
  - $30,000

- **Distinguished Visitors**
  - $15,000

- **Student Vacation Scholarships**
  - $30,000

- **PhD Scholarship**
  - $12,000

- **Data Managers Program**
  - $80,000

- **Prostate Data Manager Program**
  - $20,000

- **Radiation Therapists**
  - $8,000

- **Chair in Cancer Care**
  - $100,000

- **Total of Other Research Programs**
  - $508,548

**TOTAL RESEARCH FUNDED**

- $1,963,205

### THE CANCER COUNCIL TASMANIA RESEARCH GRANTS

- **Dr G Woods**
  - Characterising carcinogen induced immunosuppression and tumour escape
  - $34,683
University of Tasmania

Dr S Raag
University of Tasmania
Towards a novel differentiation therapy of leukaemia using Ceramide $44,603

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

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

* Dr G Woods, Dr C Tramba
University of Tasmania
Analysis of Mire-P-Glycoprotein in normal and leukaemia cells $20,716

Professor R Lowenthal, Dr R Harrup, D Tuck
University of Tasmania
Analysis of outpatient bone marrow transplantation (BMT) $10,682

Total Amount Granted $184,422

* In conjunction with the David Collins Leukaemia Foundation

JEANNIE FOSTER FELLOWSHIPS

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

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

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

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

Total Fellowships Awarded $2,500

TOTAL RESEARCH FUNDED $186,922

CANCER FOUNDATION OF WESTERN AUSTRALIA RESEARCH GRANTS

Dr D Elsaleh
Phenotype
Dept of Radiation Oncology
Sir Charles Gardner Hospital
Evaluation of the predictive significance of the methylator phenotype $55,000 in the response of Duke’s C colorectal carcinoma to adjuvant chemotherapy

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

Dr K Litchfield
Department of Public Health
University of Western Australia
Risk factors for cancer in a cohort of Australian veterinarians $48,000

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

Dr J Williams
Laboratory for Cancer Medicine
University of Western Australia
Generation of HIL55 knockout mice – an in vivo model for investigating the role of a potential tumour suppressor gene $46,000

Dr J Bentel
Department of Pathology
Royal Perth Hospital
Loss of expression of the NOX1.1 gene in prostate cancer $49,988

Professor R Donovan
Centre for Behavioural Research in Cancer, Division of Health Sciences
Curtin University of Technology
Perceptions of cancer in the Australian population $50,000

Dr L Abraham
University of Western Australia
Regulation of CD30 expression in Hodgkin’s and non-Hodgkin’s lymphoma $49,931

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

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

A Professor P Leedman
Laboratory for Cancer Medicine, University Department of Medicine
Royal Perth Hospital
Evaluation of the predictive significance of the methylator phenotype $55,000 in the response of Duke’s C colorectal carcinoma to adjuvant chemotherapy

TOTAL RESEARCH FUNDED $543,369

OTHER RESEARCH GRANTS

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

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

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

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

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

Sir Charles Gardner Hospital
F&R Program $25,766

Hollywood Hospital
Bone Tumour Registry $17,919

TOTAL OTHER RESEARCH PROGRAMS $283,933

VACATION RESEARCH AWARDS

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

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

Ms P Sappi
Kalamunda WA
Are liver stem cells related to bone marrow cells which belong to the lymphoid lineage? $1,200

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

Mr R Gomer
Subiaco WA
Is the growth of precancerous liver cells promoted by cytokines released by resident macrophages? $1,200

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

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

Total Vacation Research Awards $8,400

TOTAL RESEARCH FUNDED $585,702

THE CANCER COUNCIL NEW SOUTH WALES

NEW RESEARCH GRANTS

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

Professor D J Axhia
Centenary Institute of Cancer Medicine and Cell Biology
Identification of the specificity of potential myeloma specific clonal CD8 T cells using TCR transfectants $63,167

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

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

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

Total $39,850

CONTINUING RESEARCH GRANTS

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

Dr A de Fazio
St Vincent’s Hospital
Mechanisms underlying the protective effects of tamoxifen $56,009
University of Sydney on normal mammary gland.

Dr P Horsey, Newcastle Mater Hospital
The role of TRL1 in induction of apoptosis in human melanoma and in T cell responses to melanoma $57,353

Dr M Norris, University of New South Wales
Molecular detection of residual disease in childhood leukemia and its association with clinical outcome $60,410

Dr R Bates, University of Newcastle
Investigation of the signaling role of variant CD44 in regulating apoptosis in colon cancer cells $54,969

Dr L Florey, University of Sydney
Overcoming inter-individual variability in cancer chemotherapy $62,114

Professor P Butow, Royal Prince Alfred Hospital
Discussing prognosis and treatment goals with patients with metastatic cancer $48,767

Dr B Fazekas De St Groth, Centenary Institute, Royal Prince Alfred Hospital
A pilot study of tumour RNA-pulsed dendritic cell immunotherapy in ovarian cancer $73,407

Dr S Ackland, University of Sydney
Prospective meta-analysis: Quality of life data in two randomised trials of chemotherapy for asymptomatic metastatic colorectal cancer $24,767

A/Professor K Bradstock, Westmead Hospital
Analysis of cellular immune response to melanoma antigens after allogeneic haematopoietic stem cell transplantation $71,224

Dr G Mann, University of Sydney
Australian melanoma family study $72,657

Dr P Hoog, University of New South Wales
Tumour Angiogenesis $201,000

A/Professor G Marshall, University of New South Wales
Defining the cause and improving the treatment of childhood neurulblastoma $320,000

Professor R Sutherland, Garvan Institute of Medical Research
Steroid and growth factor signalling in the pathophysiology of breast and prostate cancer $400,000

Total Continuing Research Program Grants $1,563,424

RESEARCH FELLOWSHIP

Professor R Reddell, Children’s Medical Research Institute
Carcinogenesis $400,000

Total Research Fellowship $400,000

OTHER RESEARCH PROGRAMS

Clinical Epidemiology Research Unit
$596,000

Cancer Education Research Program $500,000

Hereditary Bowel Cancer Research $195,500

Total Other Research Programs $1,291,500

TOTAL RESEARCH FUNDED $3,621,796

QUEENSLAND CANCER FUND RESEARCH GRANTS

T Antalis, A Subherz and D Gotlieb
Queensland Institute of Medical Research
Evaluation of a new cancer immunotherapeutic target $65,000

C Bari, M Moore and D Purdie
University of Queensland
Population and Laboratory Study of the Relationship of Xenobiotics and Phytoestrogens to Ovarian Cancer $53,500

C Baldock, T Rong, G Michael and D Schicketanz
Queensland University of Technology
Development and investigation of radiation-sensitive polymer gels for measuring three-dimensional ionising radiation dose distributions in breast radiotherapy $62,000

A Boyd, C Schmidt and A Nicolle
Queensland Institute of Medical Research
Immune response to Eph and Ephrin proteins in tumours and blood disorders $63,500

M Brown, K X Khanna and K Spring
University of Queensland
BRCAl in DNA repair and tumourigenesis $66,500

J Bullock-Gaston, R Bone and W Stanton
University of Queensland
Objective criteria for early identification of secondary arm lymphoma after breast cancer surgery $32,273

G Chenevix-Trench, R Neubold, D Trott and E Baker
Queensland Institute of Medical Research
The identification of the colorectal cancer tumour suppressor gene inactivated on Chromosome 8 $58,894

O Fong, P Zimmerman, J Yang, B Clarke and E Duhig
Prince Charles Hospital
Glutathione S transferase (GST) genotypes and non-small cell lung cancer $52,895

O Fong, B Clarke, E Duhig and P Zimmerman
Prince Charles Hospital
Smoking and gender differences in the molecular biology of lung cancer $50,170

O Fong, B Clarke, E Duhig and P Zimmerman
Prince Charles Hospital
Mapping the molecular changes in bronchial epithelium from smokers $26,400

B Gaborit and J Goldkorn
Queensland Institute of Medical Research
What is the role of cyclin A during G2 phase of the cell division cycle? $26,400

R Gardner, K Ellem, C Schmidt, D Hart, G Seymour and J Healey
University of Queensland
The association between human papilloma viruses and squamous cell carcinoma of the skin $52,865

A Green, R Neale and K Ter Schegget
Queensland Institute of Medical Research
What role do dietary factors play in the development of skin cancer $26,400

J Hancock and A Apolloni
University of Queensland
An investigation of the intracellular trafficking of K-Ras $70,000

J Harris and G Muscat
University of Queensland
Selection, characterisation and evaluation of chemotherapeutic dUTPase inhibitors $64,162

N Hayward, G Kay and M Cummings
Queensland Institute of Medical Research
Development of Mouse Models of Multiple Endocrine Neoplasia Type 1 $64,500

G Hill, D Hart and J Ferrara
Mater Medical Research Institute
The role of G-CSF in chronic GVHD after allogeneic peripheral blood stem cell transplantation $58,000

A Kelso
Queensland Institute of Medical Research
Functional flexibility of the CD8+ T cell response to tumour cells in vivo $61,475

KK Khanna and D Young
Queensland Institute of Medical Research
To investigate the functional link between ATM and Nbn in DNA damage recognition $70,000

KK Khanna
Queensland Institute of Medical Research
To study the contribution of ATM gene in DNA–damage induced phosphorylation of BRCA1 $65,640

R Khanna
Queensland Institute of Medical Research
Characterisation of novel Epstein–Barr virus encoded immunosupulators and their role in the cytotoxic T cell mediated immune response $26,400

R Khanna
Queensland Institute of Medical Research
Characterisation of genetic variants of LMP1 oncogene associated with nasopharyngeal carcinoma $63,500

M Laxon and H Beavis
University of Queensland
Interaction between ATM and BLM and implications for tumourigenesis $63,761

W Liu and K Zhao
University of Queensland
Interaction between papillomavirus and tubulin: a mechanism of virus translocation? $58,000

G Mann, J Atkin, J Hopper, R Kefford, G Giles and B Armstrong
Queensland Cancer Fund
Australian Melanoma Family Study $65,000

P Marriott and R Saal
Princess Alexandra Hospital
Comprehensive assessment of minimal residual disease in patients with good prognosis acute myeloid leukaemia for the prediction of relapse and development of therapeutic algorithms $35,675

N Martin and N Hayward
Queensland Institute of Medical Research
Linkage disequilibrium mapping of a gene for mole development $60,987

P McGrath, E Conway, Y Khodjo and H Clark
Queensland University of Technology
An exploration of the usefulness of the concept of spiritual pain in palliative care $50,280

N McMillan
University of Queensland
The role of the human papillomavirus E7 oncprotein in the evasion of the antitumour effects of Interferon $61,100

R Miles, M Windsor, R Abraham, K Slaughter, B Clarke, E Duhig and G Fong
Weiley Research Institute
Biological Correlates of CT Perfusion Imaging and FDG-PET in Lung Cancer $26,400

D Moss, A Gallbraith, S Bell, S Elliott, S Sillers and M Sherritt
Queensland Institute of Medical Research
Defining the parameters of treatment and maintenance of adoptive immunotherapy for post-transplant lymphoma in solid organ transplant recipients $65,000

D Nicol, E Walpole, A Johnson and J Jonson
Queensland Institute of Medical Research
Efficacy of Captopril in the treatment of patients with advanced renal cell carcinoma $58,915

P Parsons, A Green and M Roberts
Queensland Institute of Medical Research
The molecular consequences of sunsreen application in vitro and in vivo $52,013

R Rafdrell-Smith, J Jass, B Leggett and J Searle
RBH Research Foundation
Characterisation of key pathological events in the development of colorectal and hepatocellular neoplasms in patients with inflammatory bowel disease by detailed clinicopathological and molecular analyses $56,565

N Saunders
University of Queensland
Biological Characterisation of Neoplastic Progression in Keratinocytes $50,170
We were delighted to have the meeting opened by the Hon Cassell, Nessa Coyle, David Frame, Theodore Lawrence, John use of mobile phones and cancer, to the areas of communication that was a focus of a cancer research group seminar, through the lively multidisciplinary input. A broader range of sessions which in turn benefited from the positive move which facilitated the registrants participating in resulted in a truly multidisciplinary mixture of participants did not have its name included in the final program, which of the groups of COSA is responsible for designing their own lasting impact and allows those who are unable to attend to of a CD rom, supported by Aventis, which will be circulated logo depicts the central map grid of Adelaide in a disk shape symbolised Adelaide and Communication in Cancer, through and could be broadly interpreted by each of the groups that seen as increasingly important throughout all cancer related specialties.

Communication and Cancer
This topic allowed innovations in the design of the meeting and could be broadly interpreted by each of the groups that constitute COSA. Reports of early days of planning and the brief to the graphic designer to produce a logo which symbolised Adelaide and Communication in Cancer, through to the actual final program, innovations were evident. The logo depicts the image of the city of Adelaide in a disk shape that could be variably interpreted as a communication dish or microphone. Underpinning the theme, we staged the first presentation by video-conference, utilizing for the first time the expertise available in Darwin, providing a tropical twist to the subject of febrile neutropenia. A tangible manifestation of the theme was the commissioning of a logo, supervised by Aventis, which will be circulated to participants, it focussing on the plenary sessions and international presentations. This gives the presentations more lasting impact and allows those who are unable to attend to review the highlights of the meeting.

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

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

The program was well supported by the participation of our international faculty, Charles Balch, Jonathon Berek, Eric Caswell, Nessa Coyle, Martin Tattersall, Theodore Lawrence, John Little, and Richard Sainsbury.

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

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

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

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

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

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

This session highlighted that there is still a lack of definite information in this field which remains a fruitful area for well conducted scientific research. Also on this first day, an all day symposium on cancer registries covered the roles and applications of registries to many areas. The theme of the meeting was strongly underpinned by sessions in palliative care, which included an all day meeting, making that the multidisciplinary nature of the meeting was underpinned by a session on sentinel node biopsies as it applied to melanoma, breast and gynaecological cancers.

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

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

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

Poster Sessions
A broad range of posters were presented this year. Having the posters central to the activities between oral sessions meant that they had good exposure to participants in the conference. However, it was important to increase the exposure of the posters and a new initiative was the introduction of poster discussion sessions where groups of like posters were clustered and a discussant highlighted the topics calling upon the poster presenters to undertake the presentation of their posters.

The success of this clearly depends on the skills of the discussant and it was generally felt that it was important that the information presented in the posters should be given this additional prominence. Much interesting data was presented on a wide variety of topics.

Young Investigator Award
Sandy Yusuf, a student, won the Young Investigator Award with her presentation of research into burns in Australian oncology professionals. There is much in the overseas literature on this topic but this was a study from the team at Royal North Shore Hospital on the burnout prevalence in Australia and its predictive factors. It is a young investigator who was successful this year and augurs well for the future.

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

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

AUSTRALIAN BEHAVIOURAL RESEARCH IN CANCER

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

Australia has four behavioural research centres: the Centre for Health Promotion and Cancer Prevention Research (CHP&CPR) of the University of Queensland, Cancer Education Research Program of the Cancer Council of South Australia, the Centre for Behavioural Research in Cancer (CBR) in the Anti-Cancer Council of Victoria and the Centre for Behavioural Research in Cancer Control (CBCRC), Curtin University of Technology, Perth.

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

New Results
n From the Cancer Education Research Program (CERP), NSW
Community knowledge of cancer: What difference have we made in the last 10 years?
Concerted efforts have been made over recent decades to educate the Australian public about the importance of cancer prevention and early detection. To examine the effect of such educational campaigns, CERP investigated the current knowledge of cancer amongst the NSW community. A computer assisted telephone interview (CATI) survey was administered to NSW residents aged 15 years and older who were randomly selected from the NSW telephone directory. Of the 1,173 eligible participants, 685 (82%) completed the survey. The results indicated a large gap of knowledge was able to accurately estimate the lifetime risk of getting each cancer. Although the majority of respondents were aware that smoking increases your risk of lung cancer and melanoma respectively, deficiencies in knowledge of risk factors for bowel, breast, cervical and prostate cancer were evident. At least one symptom related to melanoma, breast and bowel cancer was known by over fifty percent of respondents. Pap smears (87%) and mammograms (82%) were the best-known cancer screening tests. Comparisons with data from a 1989 survey that used the same survey items indicated that although there was a moderate increase in knowledge of risk factors for melanoma, bowel and lung cancer, there was no increase in the knowledge of risk factors for cervical, breast and prostate cancer. An analysis of data from a 1993 survey indicated that women’s knowledge of mammograms was observed between the two surveys, with twice as many women being aware of mammograms in the current survey. Overall, these results suggest that although there have been some modest increases in cancer knowledge, the risk factors, symptoms and tests of particular cancer remain poorly understood.

n From the Centre for Behavioural Research in Cancer Forum - Volume 25 Number 1 - March 2001
Tobacco advertising at point of sale

The recently published Quit Evaluation Studies: Volume 10, includes a chapter by Tessa Letcher reporting the results of a study, conducted in April 2000, of the extent and type of tobacco advertising at point of sale in retail outlets, and whether this varies with the relative location of the outlet to secondary schools. Fieldworkers visited 222 outlets around Melbourne including milkbars, supermarkets, petrol stations and newsagents. The presentations of point of sale tobacco advertising observed were obvious visual displays such as cigarette dispensing units, display cases, pop-out advertising tags and cards, illuminated signage and posters. All of these received high prominence ratings. The pattern of brand advertising closely followed the patterns of brand preference found among adult and young smokers; the top four brands available for sale reflected this. The number of outlets and brand of popularity at the top four brands smoked by both student and adult smokers. Only 42% of outlets displayed signs inside the store regarding the legal age at which one may be sold cigarettes (18 years old) and cards, illuminated signage and posters. All of these received high prominence ratings. The association between children’s exposure to tobacco advertising from point of sale is banned: only one tobacco display point and one cigarette packet of each brand variant is allowed. Health warning or smoking cessation signs must be displayed at the point of sale. These warnings were recently announced by the State Government including making it compulsory to display signs about legal age requirements at the point of sale. Such reforms are consistent with one of the strategy objectives highlighted in the National Tobacco Strategy to prevent uptake of smoking among children and young people.

From the Centre for Health Promotion and Cancer Prevention Research (CHPCPR)

Young children’s exposure to ultraviolet radiation

David O’Rordan has recently completed his PhD on the topic of young children’s exposure to ultraviolet radiation. His research was to investigate the level of young children’s exposure to UV radiation. A number of factors were identified in this study the incidence of sunburn among children and their mothers’ levels of UV exposure. Levels of personal UV exposure based on polysulphone dosimeters.

Young children and their mothers received insufficient levels of UVR to result in an erythemal response on unprotected skin during either winter or summer months while they were outside on a single occasion on the dosimeters. The association between children’s level of UVR exposure and their levels of UVR exposure was examined. The results showed that infants who had been “pink or red” more often, received higher levels of UVR. However, for toddlers no significant relationship was identified for mild sunburn.

Association between personal UVR and estimates of exposure

In past studies estimates of UVR have been calculated from time reported outside and the levels of ambient UVR recorded during that time. The level of association between estimated exposure and the levels of UVR received by children with polysulphone dosimeters permitted only moderate correlations. The age of the child was related to the level of association, with the infants (n=42) showing a slightly higher correlation than toddlers (n=36). Mothers’ diary records of their child’s time outside resulted in a proxy measure of the child’s estimated UVR exposure. This approach was useful for the children 0-4 years of age. This in turn also suggested that, as overall there was little difference in the correlations for mothers’ diary records of their child’s UVR exposure with the infants data (r=0.43) or children (n=0.49).

Research in the Pipeline

From CERP

Perceived needs among early breast cancer patients diagnosed with lymphoedema

Many breast cancer survivors will develop lymphoedema of the arm as a disabling treat the arm. The physical morbidity suffered by women due to lymphoedema is significant. Dr Janice Perkins and colleagues are currently undertaking a study, funded by The National Breast Cancer Foundation, to measure the prevalence of perceived unmet psychosocial needs among women treated for breast cancer, who suffer from lymphoedema. The research team has developed the Lymphoedema Needs Questionnaire (LNQ) based on published literature, other needs assessment instruments and focus groups with patients. The LNQ assesses a number of dimensions including information needs, psychological needs, physical needs (including daily living needs, pain), social care and social support needs and sexuality needs. The survey will be distributed to a random sample of 1,000 women throughout Australia who were diagnosed with breast cancer 1996-1998 and who have clinically defined lymphoedema of the arm. Women will be recruited nationally through the relevant state-based cancer registries.

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

From CBRC

Patient transport project

CBRC, in collaboration with the Patient Services Development Unit at the Anti-Cancer Council of Victoria, has recently surveyed staff at the Victorian hospitals to examine the need for a volunteer driving service to assist patients to get to and from treatment. Over 490 patients from eight Victorian hospitals were interviewed by researchers from CBRC. Issues explored in the questionnaire include: family support (in particular, the distances travelled by family members); patient transport; stress and tiredness experienced by patients as a result of their mode of transport; costs incurred on a weekly basis; initial reactions of the patient and their family to the nees that 20-33 consecutive days of travel was required and to, likely of use of a volunteer service and the patient’s overall assessment of their own transport arrangements. The survey data are currently being analysed with a view to appropriate assessment and appropriate service development response.

From CHPCPR

Skin cancer and teenagers (SCAT) redevelopment of resources

It has been well documented that exposure to sun during childhood can be a contributing factor to the development of skin cancer. Considering the amount of time children spend at school, this environment can play a major role in reducing the levels of UVR exposure received by children. Children’s levels of sun protection (UVR exposure) may be reduced with the introduction of a broad range of strategies such as targeting school policies, the school environment, curriculum, and physical education departments. A school curriculum designed for secondary school principals and heads of the health and physical education departments to determine the extent of utilisation of the modules provided to secondary schools in 1995; establishing the schools priorities in terms of adolescent sun protection compared with other adolescent health issues; to determine whether formal policies exist regarding sun protection and the most appropriate media for the new modules.

From CBRC

Utility perceptions of costs & benefits associated with health risk behaviours

Funded by Healthway, the West Australian Health Promotion Foundation, the aim of the research is to investigate the applicability to health behaviour of recent research in decision making from the fields of economics and consumer research. Determining the effectiveness of sun protection messages by type of behaviour targeted.

Also funded by Healthway, the aim of this project is to investigate the relationship between message framing and learning behaviour theories in order to develop more effective communication strategies to encourage Australians to engage in sun protective behaviour.

Enhancing moralisation of tobacco amongst young people via the emotion of disgust

Another Healthway funded project, this research proposes to explore in depth how young people experience the emotion of disgust, with the aim of developing evidence based recommendations for the design of communication materials targeted at young people in an attempt to moralise smoking.

Cancer (CBRC), Vic

Tobacco advertising at point of sale

Cancer Forum - Volume 25 Number 1 - March 2001

Cancer Forum - Volume 25 Number 1 - March 2001
BOOK REVIEWS


G Kune (Ed)
Published by Allen & Unwin (1999).
302 pages plus index. RRP: A$24.95

In recent years a number of books dealing with cancer prevention and early detection have been published. A Manual for the Prevention of Cancer – Reducing the Odds is yet another one. This 302 page volume is current, readable, logically and systematically planned text on cancer prevention and early detection. Though written principally for general readership, all professionals in health promotion, health promotion practitioners, counsellors in cancer support groups and interested others will find it useful.

The book is divided into four sections. The first section deals with explanation of how cancer develops which is followed by short description of basic principles of cancer prevention. Differences between primary and secondary prevention are clearly explained using diagrams and tables. Several causes of different cancers are summarized to provide a good overview of the risks of cancer as they relate to an individual.

In the second section of the book each cancer cause is discussed in detail. The details include inherited causes, tobacco and alcohol use, exogenous sunlight, the role of diet in cancer causation, physical inactivity, sexual practices and lifestyle stress. This section also mentions some carcinogens that may be found in the environment and in the workplace that could play an important part in the aetiology of some cancers. Occupational Health personnel may find this information particularly useful as it is not readily accessible in general prevention guidelines.

The third section of the book describes screening tests and current Australian recommendations that are available for various types of cancer. Less commonly occurring cancers that are often not mentioned in general tests on prevention and early detection are also discussed in this section.

The fourth section includes a comprehensive individual cancer prevention program that advocates healthy lifestyle for those at increased risk of cancer and improves the quality of life of people with cancer.

The contributors to the book are all experts in their field but provide a balanced update on developments in the diet and cancer field. Nevertheless, while the chapters in this book are specifically written, they do not provide an integrated overview of the mechanism of protection of brassica plants or cell division inhibitors like the plant extract, asparaginase, or the role of total energy intake, various food categories, potential food processing aspects, nutrients influencing DNA metabolism, antioxidants and carcinogens in the diet. The energy issue is picked up in another chapter in relation to breast and colorectal cancers and the further chapters discuss the role of alcohol, organochlorines in relation to breast cancer and oil consumption and cancer mortality.

This book is recommended for libraries but may have limited appeal to individuals. Nevertheless, while the chapters in this book are specific in nature such as those discussing regulation of p53 function in cells, the effects of aromatase inhibition, the metabolism of brassica plants or cell division inhibitors like the plant extract, asparaginase, the role of total energy intake, various food categories, potential food processing aspects, nutrients influencing DNA metabolism, antioxidants and carcinogens in the diet, also provide a balanced update on developments in the diet and cancer field. Nevertheless, while the chapters in this book are specific in nature such as those discussing regulation of p53 function in cells, the effects of aromatase inhibition, the metabolism of brassica plants or cell division inhibitors like the plant extract, asparaginase, the role of total energy intake, various food categories, potential food processing aspects, nutrients influencing DNA metabolism, antioxidants and carcinogens in the diet. The energy issue is picked up in another chapter in relation to breast and colorectal cancers and the further chapters discuss the role of alcohol, organochlorines in relation to breast cancer and oil consumption and cancer mortality.

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book reviews

reflecting a personal view, and despite some dated content, based' approach. Nevertheless, there is a place for books in the category of "personal view". This book would have benefited from a more 'evidence-based' approach. However to others needing to assess the treatment, sections on evidence-based medicine (EBM), the relationship between patients and doctors and case studies are useful aspects.

The author has clearly made a decision to avoid using statistics to describe rates of complications and disease recurrence after treatment, and there may be many patients who would agree with this approach. However to others needing to assess the likelihood of, for example, erectile dysfunction after treatment, this would be a disappointment. It was sometimes not clear to the reviewer whether the author was writing for the patient or for other health professionals. The sections on the underlying basis of medicine, for example, is more a justification of a personal view (ambivalent), than a clear description of what EBM is, and how it can aid decision-making.

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

Dr Stephens has used some outdated terminology such as "impotence" instead of erectile dysfunction and statements such as "impotence" is almost inevitable after full-dose "impotence" instead of erectile dysfunction and statements such as "impotence" is almost inevitable after full-dose chemotherapy. There is a chapter on new antitumor agents that includes a selection of angiogenesis inhibitors, antimitube culents, cyclin-dependent kinase inhibitors, DNA interactive agents, fluoropyrimidines, nucleoside analogues, platinum analogues, signal transduction inhibitors, thymidylate synthase inhibitors, and topoisomerase I inhibitors. By its very nature, this latter chapter is exciting and its a pity not more room was devoted to it.

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

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

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

If you have been collecting this series then it would be sensible to add this volume to your collection, if you can afford it. If you have been collecting this series then it would be sensible to add this volume to your collection, if you can afford it. However, Patricia Ganz's excellent offering on assessment of comorbidities and cancer is not more room was devoted to it. It would make a good teaching text or provide a point of entry into the field for the reader outside North America.

Cancer in the Elderly

C P Hunter, K A Johnson, H B Muss (Eds)
Published by Marcel Dekker (2000)

This is the twenty-third in a series called "Basic and Clinical Oncology" edited by Bruce Cheson from the US National Cancer Institute. Several previous numbers in the series have been reviewed in these pages before. This volume is the broadest in scope of the series that I have seen so far. An attempt has been made to cover all the cancers relevant to the ageing population which, of course, means the vast majority of malignant diseases. Therefore, this book ends up looking like a comprehensive textbook of oncology in miniature.

Like all multi-author oncology textbooks, the chapter quality is variable depending on the style and emphasis of the respective authors. However, in my reading of previous numbers in this "Basic and Clinical Oncology" series, it seemed to me that a fairly tight rein has been maintained on the various authors and editors' focus on their topics. The same does apply here. Nevertheless, I felt that only a few of the chapters really managed to integrate cancer care with geriatric care in a clinically useful way.

In particular, I was disappointed that the chapter I expected to be of most interest to me entitled "Comorbidities and Cancer" accounted for only 16 pages of 583. Not enough, especially when a sensible number of pages was devoted to "Health Services Issues" in the US context, largely irrelevant information for the reader outside North America.

However, Patricia Ganz's excellent offering on assessment of comorbidities and cancer is not more room was devoted to it. It would make a good teaching text or provide a point of entry into the field for the reader outside North America.

Writing a useful tome on oncology in the elderly is a difficult job. This is a better effort than most I have seen but could have been better.

R Hitchins
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Controversies in Neuro-Oncology

T Weigel et al (Eds)
Published by Karger (1999)

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

The aim of the symposium was to provide an update on major advances in the field as well as to focus on radiation oncology, chemotherapy, neuroanatomy, diagnostic techniques and experience with radiotherapy of the central nervous system.
The intended readers of the publication include all clinical sub-specialists of neuro-oncology, with a particular emphasis on radiation oncology.

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

The discussion on glioblastoma covers current best practice and explores new approaches with intracavitary drugs, gene therapy and fractionated conformal stereotactic radiotherapy. There is an excellent overview of current knowledge on the radiation tolerance of the central nervous system that revises former concepts that may have led to overly conservative practices. The pathogenesis of radiation injury is reviewed with the conclusion that the white matter necrosis is vascular. The section on the management of brain metastases raises the debate on why stereotactic radiotherapy should not be considered the better option over surgery for solitary lesions.

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

I Barney
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Death and Dying in Australia

Allen Kellehear (Ed)  

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

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

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

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

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

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

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

D Currow  
Dept of Palliative Care  
Flinders University of South Australia

Dose and Timing:  
The Pillow of Successful Chemotherapy

G Rosti (Ed)  

This 129 page book is the third of a series, of European School of Oncology Scientific Updates, written by various authors and edited by D. Rosti (Volume 1 was on the Prognostic and Predictive Value of P53, Volume 2 on Cancer in the Elderly: A Nursing and Medical Perspective). Although not reflected in the title, this book also covers the use of chemotherapy. The book contains 10 articles (some with single authorship, others with multiple contributors). Three deal with breast cancer, two with lymphoma, one each with testicular cancer, the EBMT database and lung cancer and a concluding article.

Unfortunately, many of the comments made in the chapters on breast cancer have already been overtaken by several abstracts presented at ASCO 1999 (Plenary Session: Abstracts 1, 2, 3, and 4, and Vol 18, 1999) and much of the discussion in the absence of complete Phase III trials is theoretical. No mention was made of the Australian Study and the literature review is non-existent. The presentations are verbose and there is paucity of tables and lack of details of some of the studies presented. There is a bias towards American data. The three articles on breast cancer are partly repetitive, presenting similar data. The titles are enticing and interesting, e.g. Timely chemotherapy in lung cancer: The proper dose at the proper time, but the contents don’t reflect this. The best (and shortest) presentation is the article on lymphoma and solid tumours. The first line tells it the way it is: "far more is believed and hoped for in the area of high dose chemotherapy than anything". The British Medical Journal (European Group for Blood and Marrow Transplantation) Database is interesting, Fifteen thousand patients have had a bone marrow transplant in the United Kingdom (NHS, 2,500 patients, breast cancer 2,136, multiple myeloma 1,800). It is disappointing that such a large number of patients have been treated but not at randomised clinical trials. Selective ongoing studies are mentioned and it is interesting to see what the Europeans are doing.

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

A Bonaventura  
Dept of Medical Oncology  
Liverpool Hospital  
Newcastle

Lung Cancer – Principles and Practice

H Pass et al (Ed)  
Published by Lippincott Williams & Wilkins  
ISBN: 0 831317991 1311 pages plus index. A$539.60

This second addition of Lung Cancer Principles and Practice is a three-year update of a book intended as a comprehensive reference for anybody with an interest in lung cancer. The former editors were: Boltey of Lung Cancer Committee, Lung Cancer Aetiology/Epidemiology/Screening, Early Detection and Prevention, Pathology, Clinical Presentation/Diagnosis/Stage and Prognosis, Surgery, Radiation Therapy, Chemotherapy, Treatment of Solitary Metastases, Palliation and Special Considerations and Statistics and Trial Design. All sections have sub divisions written by experts in their field. Dr David Ball, head of Lung Unit Radiation Oncology at Peter MacCallum Clinic, Melbourne, wrote the chapter on prophylactic cranial irradiation in small cell lung cancer. The editors note that the proliferation of information on cell biology of lung cancer has led to inclusion of detailed data on FHT, Telomere and erb-B2, as well as to the intricacies of the cell cycle and angiogenesis. Lung cancer immunology and gene therapy are completely updated and the newest elements of genetic susceptibility are in a separate chapter. Technical changes in processing material for molecular evaluation are discussed, as is the use of these techniques in defining pre-neoplasia in the chromosomal/ genetic level. The never improved cytotoxic agents and their interaction with radiation is a welcome update. Presentation of the book is traditional and a little dry. However all the information is there and extremely well referenced at the end of each chapter and well indexed overall. For example for the chapter on Biology of Lung Cancer, General Concepts there were 574 references. Overall it is not the type of book one normally would cover to cover but rather reference from time to time. In the surgery area combined cancer resection and lung volume reduction surgery is addressed but there may not be too many in the pre-operative preparation of patients. Basically surgeons don’t want patients to just scrape through surgery, and all the barrage of tests to assess patients with borderline lung function are discussed, but as we all know the management of lung cancer is multi-disciplinary, this book certainly covers all areas and for each person managing lung cancer the details of others’ specialties is excellent.

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

P Cole  
Monash Medical Centre  
Clayton, Vic

Methotrexate

B Constein et al (Eds)  

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

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

However, for the average oncologist and pharmacist, the chapter relating to the use of cancer where the money is, Methotrexate - a drug we all know the back of our hand? Perhaps, but I’ve been taking the back of my hand for granted lately. There are things going on there that I haven’t been keeping up with. The most detailed and up to date laid out in the 50 page section on cancer, is like a microcosm of the development of medical oncology. Methotrexate was the first ‘designer drug’, developed rapidly after the initial erroneous hypothesis that feeding folate to patients with leukaemia might kill the cancer was proved contrary. The laborious identification of mechanism of action, of drug interactions and drug elimination have laid the foundation for study of all other cytotoxic drugs. New mechanisms of resistance and transport and the development of novel approaches to treating patients have spurred the discovery of new drugs such as tomudex and the multi-targeted anti-folates.

This book should be read by every training medical oncologist and clinical pharmacologist not just for gaining knowledge about methotrexate but to gain a greater understanding of the history of cytotoxic drug development last century. The references at the end of each chapter read like a ‘Who’s Who’ in oncology from 1960 to 1990. Like the Rolling Stones ‘best of’ CD, the story of methotrexate development keeps getting played over and over and is still just as enjoyable and probably
more significant to read now as it was in its hey-day.

H Guney
Dept of Medical Oncology & Palliative Care Westmead Hospital Westmead, NSW

Multimodality Treatment of Lung Cancer

A Skarin (Ed)

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

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

There is a brief first chapter on lung cancer biology, a chapter on chemo-prevention, and a couple of chapters on staging. Most chapters are referenced up to 1996 with some inclusion of references to abstracts presented at ASCO and the World Lung Cancer Congress in 1997. The only exception is the chapter on radiation therapy for small cell lung cancer which is referenced up to 1998. I found the review on MRI spectroscopy to be particularly enlightening for this emerging technique.

In addition, the tumours that are dealt with include the most common such as intracerebral gliomas to rarer types, such as pleomorphic xanthoastrocytomas.

I found discussion of novel modalities such as hyperthermia and gene therapy to be interesting and made an appreciation of the possibilities and difficulties apparent, although they received equal space to more established forms of therapy. The discussion of newer radiation techniques such as IMRT, stereotactic radiotherapy, proton beam radiotherapy etc were very clear and adequately covered.

The test does not deal with many of the neurologic complications of systemic cancer, other than metastatic disease to brain. These topics have been dealt with in book form by others, so this is not a fatal flaw. Overall, I enjoyed the book and would recommend it to those seeing patients with these conditions. It is likely to be well used.

C Cher
Dept of Medical Oncology Repatriation Hospital Heidelberg, Vic

Radiotherapy of Prostate Cancer

E Greco et al (Eds)

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

The significant strength in this book is that it is divided into a number of sections all of which cover the relevant aspects for the management of this malignancy. The chapter on Epidemiology is a short section and A second chapter is extensive, including assessment of prostate cancer on a worldwide basis, although there is a predominance toward American literature. Pleasingly in the chapter on Patient Selection Criteria for Radiotherapy there is recognition of patient-related as well as tumour-related features.

The references in each of the chapters are reasonably extensive, and the book contains, included articles released in 1996 and 1997, with some chapters including material from 1998. Thus it is reasonably current. There is even a chapter on the radiobiological principles looking at the impact of altered fractionation methods, as well as a description of the tolerance of normal tissues in the pelvic region to radiotherapy.

The various chapters on treatment highlight much of the available information, and certainly include the advances of 3D conformal therapy, as well as IMRT. Pleaseing the content of this book is that it is not overwhelming and that there is not a chapter on prostate anatomy, although that is a somewhat minor point.

There is inclusion of two chapters on Deferral Treatment (or Watchful Waiting). The discussion of the conservative approach (Dr Adesofin) included his own material in that chapter, however, in the subsequent chapter arguing against this approach, this material (which comprises a relatively large group of patients) is not referenced at all. I found the review on MRI spectroscopy to be particularly enlightening for this emerging technique.

Some of the illustrations in the chapters on conformal therapy are obviously computer images and do not translate well into black and white images. One loses some of the clarity of what was a very clear and appropriate overall message.

The test does not deal with many of the neurologic complications of systemic cancer, other than metastatic disease to brain. These topics have been dealt with in book form by others, so this is not a fatal flaw. Overall, I enjoyed the book and would recommend it to those seeing patients with these conditions. It is likely to be well used.

C Cher
Dept of Medical Oncology Repatriation Hospital Heidelberg, Vic

Neuro-oncology: The Essentials

M Bernstein et al

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

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

In addition, there are many other chapters that deal with intracranial tumours and their care. Some of the illustrations in the chapters on conformal therapy are obviously computer images and do not translate well into black and white images. One loses some of the clarity of what was a very clear and appropriate overall message. The text does not deal with many of the neurologic complications of systemic cancer, other than metastatic disease to brain. These topics have been dealt with in book form by others, so this is not a fatal flaw. Overall, I enjoyed the book and would recommend it to those seeing patients with these conditions. It is likely to be well used.

C Cher
Dept of Medical Oncology Repatriation Hospital Heidelberg, Vic

Regional Chemotherapy Theory and Practice

D J Kerr and C S McRdile (Eds)

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

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

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

The discussion on the use of regional chemotherapy for colorectal liver metastases mainly represents the experience of the group in Edinburgh. It lacks information about a number of recent randomized studies. The fourth chapter is on melanoma. It appears to have been written some time ago. For example it ignores the final report on the international multi-centre randomized study of adjuvant perfusion published in the Journal of Clinical Oncology in September 1999.

The chapter on breast cancer seems to ignore the generally accepted belief that micrometastases are present in many patients at the time of presentation and therefore systemic therapy is appropriate, even for preoperative treatment. The next chapter returns to the subject of colorectal cancer, this time examining portal vein perfusion. Why it does not follow chapter three is a mystery. It contains a good description of the basis of this technique. However the clinical data are very brief and uncritical.

The presence of a chapter on cryotherapy in this book appears to be a mystery until one comes across a statement that all patients have an hepatic artery catheter placed for regional chemotherapy. Unfortunately the further data on the lack of any control data at all makes this just one more complicating factor in assessing the benefits of cryotherapy.

The final chapter is on regional chemotherapy as applied to the CNS and the intrapleural space. The paragraph on the diagnosis of leptomeningeal disease ignores the use of MIB as a diagnostic modality. The subsequent section on intra-carotid infusions could have been useful expanded as this is an area that is relatively unknown by the therapeutic oncologist. Its importance is very limited. The sections on intraperitoneal therapy focus mainly on chemical pleurodesis for effusion.

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

S Snyder
Dept of Oncology St Vincent’s Hospital Fitzroy, Vic

Radiotherapy of Prostate Cancer

C Greco et al (Eds)

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

The significant strength in this book is that it is divided into 141 previous volumes of this series, then he/she will probably want to purchase this one. For the rest of us though, there are better uses for the US$159 that this book will cost.

M Millward
Royal Prince Alfred Hospital Camperdown, NSW
<table>
<thead>
<tr>
<th>Date</th>
<th>Name of Meeting</th>
<th>Place</th>
<th>Individual or Organisation Responsible for Arrangements</th>
<th>National or International Parent or Sponsoring Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>8-12 22nd Annual Scientific meeting – From Science to Pain</td>
<td>Cairns, Qld</td>
<td>DC Conferences Pty Ltd</td>
<td>Australian Pain Society</td>
</tr>
<tr>
<td></td>
<td>22-26 11th International Conference on Second Messengers &amp; Phosphopeptides</td>
<td>Melbourne, Vic</td>
<td>St Vincent's Institute of Medical Research</td>
<td>Clinical Oncological Society of Australia Inc</td>
</tr>
<tr>
<td>May</td>
<td>6-9 2001 A Colposcopic Odyssey: has the sun set on the Pap Smear?</td>
<td>Fremantle, WA</td>
<td>Conference West</td>
<td>ANZSNM</td>
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<tr>
<td>2001</td>
<td>18-22 ANZ Society of Nuclear Medicine “Exploring New Frontiers”</td>
<td>Hobart, Tas</td>
<td>Leichman &amp; Associates</td>
<td>Princess Alexandra Hospital</td>
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<td>August</td>
<td>12-17 Centenary Surgical Oncology 2001</td>
<td>Brisbane, Qld</td>
<td>CSOM Secretariat</td>
<td>HSNZ &amp; ASBT</td>
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<tr>
<td>September</td>
<td>11-14 6th Australian Palliative Care Conference</td>
<td>Hobart, Tasmania</td>
<td>Conference Secretary Conference Design</td>
<td>HSNZ &amp; ASBT</td>
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<tr>
<td>2001</td>
<td>20-22 Australasian Society for Breast Disease Meeting</td>
<td>Gold Coast, Qld</td>
<td>Sophie Gibbs Medical &amp; Health Care Public Relations</td>
<td>HSNZ &amp; ASBT</td>
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<td>October</td>
<td>7-9 &quot;Childhood Cancer: From Mechanisms to Therapeutics&quot;</td>
<td>Bondi, NSW</td>
<td>Secretariat Children's Cancer Institute Australia</td>
<td>Children's Cancer Institute Australia</td>
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<tr>
<td>2001</td>
<td>10-13 33rd Meeting of the International Society of Paediatric Oncology – Bone &amp; Soft Tissue Sarcomas Malignancy in the Adolescent Immunomodulation and cancer</td>
<td>Brisbane, Qld</td>
<td>Meeting Secretariat SIOP 2001 Secretariat</td>
<td>Clinical Oncological Society of Australia Inc</td>
</tr>
<tr>
<td>2001</td>
<td>21-24 The 2001 Joint Annual Scientific Meeting of HSNZ and ASBT</td>
<td>Brisbane, Qld</td>
<td>Secretariat P O Box 1280 Milton Qld 4064</td>
<td>Children's Cancer Institute Australia</td>
</tr>
<tr>
<td>2001</td>
<td>28-30 28th COSA Annual Scientific Meeting</td>
<td>Sydney, NSW</td>
<td>Mr Lawrie Wright Secretariat Clinical Oncological Society of Australia Inc</td>
<td>Clinical Oncological Society of Australia Inc</td>
</tr>
<tr>
<td>2001</td>
<td>15-19 6th International Symposium on Paediatric Pain “Pain in Childhood: The Big Questions”</td>
<td>Sydney, NSW</td>
<td>Dianne Crebbin Director, DC Conferences Pty Ltd</td>
<td>Clinical Oncological Society of Australia Inc</td>
</tr>
<tr>
<td>28 Oct 1 Nov</td>
<td>1001 Royal Australian and New Zealand College of Obstetricians and Gynaecologists Annual Scientific Meeting</td>
<td>Melbourne, Vic</td>
<td>RANZCOG 2001 ASM Conference Organisers</td>
<td>Clinical Oncological Society of Australia Inc</td>
</tr>
</tbody>
</table>

Cancer Forum - Volume 25 Number 1 - March 2001
## Calendar of Meetings of Interest – International

<table>
<thead>
<tr>
<th>Date</th>
<th>Name of Meeting</th>
<th>Place</th>
<th>Secretariat</th>
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<tbody>
<tr>
<td><strong>April</strong></td>
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<tr>
<td>18-20</td>
<td>17th International Congress</td>
<td>Bangkok, Thailand</td>
<td>Secretariat</td>
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<tr>
<td>28-2 May</td>
<td>ACOG American College of Obstetricians and Gynecologists Meeting</td>
<td>Chicago, USA</td>
<td>ACOG American College of Obstetricians and Gynecologists Meeting</td>
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<tr>
<td>1-5</td>
<td>7th Congress of the European Association for Palliative Care (EAPC)</td>
<td>Palermo, Italy</td>
<td>Palermo congress 1: Multidisciplinary Colorectal Cancer Congress, Tele-Ario, Israel</td>
</tr>
<tr>
<td>6-8</td>
<td>5th International Conference on Fighting Asian Cancers in the New Century of the Asia Clinical Oncology Society</td>
<td>Taipei, Taiwan</td>
<td>Taipei, Taiwan Cooperative Oncology Group (TCOG), National Health Research Institutes (NIHR)</td>
</tr>
<tr>
<td>17-20</td>
<td>1st Multidisciplinary Colorectal Cancer Congress</td>
<td>Noordwijk, The Netherlands</td>
<td>Noordwijk congress: 1st Multidisciplinary Colorectal Cancer Congress, PO Box 440, 5201, Ak's Hettenkarnboch, The Netherlands</td>
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<tr>
<td>21-24</td>
<td>ESGO 12 – International Meeting of Gynaecological Oncology</td>
<td>Venice, Italy</td>
<td>Key Congress and Communications Srl, Padova, Italy</td>
</tr>
<tr>
<td>22-26</td>
<td>7th International Congress on Oral Cancer</td>
<td>The Hague, The Netherlands</td>
<td>The Hague, The Netherlands, Tel/Fax: 31 70 427 27 70</td>
</tr>
<tr>
<td>22-2 May</td>
<td>21st Annual Hospice &amp; Palliative Care Study Seminar in Britain</td>
<td>London, UK</td>
<td>Hospice Education Institute, Essex, Connecticut, USA</td>
</tr>
<tr>
<td>24-27</td>
<td>4th Mediterranean Congress on Lung Cancer</td>
<td>Heraklion, Greece</td>
<td>FORUM International Congress Organizers, Thessaloniki, Greece</td>
</tr>
<tr>
<td>30-2 May</td>
<td>4th International Gastric Cancer Congress</td>
<td>New York, New York, USA</td>
<td>M.S. Karpel, MD, Memorial Sloan-Kettering Cancer Center, New York, NY, USA</td>
</tr>
<tr>
<td><strong>May</strong></td>
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<tr>
<td>2-4</td>
<td>4th IARC Cancer Project and International Oncology Conference</td>
<td>Beijing, China</td>
<td>Chinese Academy of Medical Sciences, Beijing, China</td>
</tr>
<tr>
<td>2-5</td>
<td>14th Annual Scientific Meeting of the European Association for Cancer Education</td>
<td>Antwerp, Belgium</td>
<td>E.M.L. Haggardman, MD, Director WHO-CCE, Haren, The Netherlands</td>
</tr>
<tr>
<td>4-8</td>
<td>8th International Myeloma Workshop</td>
<td>Barrief, Alberta, Canada</td>
<td>National Research Council of Canada, Ottawa, Canada</td>
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<tr>
<th>Date</th>
<th>Name of Meeting</th>
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<tr>
<td><strong>May</strong></td>
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<tr>
<td>13-15</td>
<td>37th Annual Meeting of the American Society of Clinical Oncology (ASCO)</td>
<td>San Francisco, USA</td>
<td>American Society for Clinical Oncology, Alexandria, Virginia, USA</td>
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<tr>
<td>17-20</td>
<td>26th Annual Congress on Oncology Nursing Society</td>
<td>San Diego, USA</td>
<td>P. Moore, Oncology Nursing Society, Pittsburgh, PA, USA</td>
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<tr>
<td><strong>June</strong></td>
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</tr>
<tr>
<td>2-7</td>
<td>9th Annual Meeting of the American Urological Association</td>
<td>Anaheim, CA, USA</td>
<td>European Association for Urology, Arnhem, The Netherlands</td>
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<tr>
<td>3-6</td>
<td>7th Central European Lung Cancer Congress &quot;Lung Cancer: the right approach for the right patient&quot;</td>
<td>Prague, Czech Republic</td>
<td>7th CECLC, Conference Partners, Prague, Czech Republic</td>
</tr>
<tr>
<td>3-8</td>
<td>15th World Congress of Sexology</td>
<td>Paris, France</td>
<td>Regimedia Scientific Secretary Parisoo</td>
</tr>
<tr>
<td>13-16</td>
<td>11th Conference of the European Society for Psychosocial Oncology</td>
<td>Heidelberg, Germany</td>
<td>Psychosoziale Nachwegeinrichtung, Chirurgische Universitätsklinik, Mrs. Solke Ludwig, Im Neuenheimer Feld 155, 69120 Heidelberg, Germany</td>
</tr>
<tr>
<td>13-16</td>
<td>4th UICC Cancer Management Meeting &quot;European Cancer Control&quot;</td>
<td>Paris, France</td>
<td>Institut Gustave Roussy, Villejuif Cedex, France</td>
</tr>
<tr>
<td>14-16</td>
<td>13th International Symposium “Supportive Care in Cancer”</td>
<td>Copenhagen, Denmark</td>
<td>Imexx USA, Inc., Alpharetta, GA, USA</td>
</tr>
<tr>
<td>17-20</td>
<td>6th International Conference on Human Tumor Markers</td>
<td>Riga, Latvia</td>
<td>Latvian Oncology Centre, Riga, Latvia, Latvia, Latvia</td>
</tr>
<tr>
<td>21-24</td>
<td>6th European Haematology Association Congress (EHA)</td>
<td>Frankfurt, Germany</td>
<td>EHA, Eurocongress Conference Management, Amsterdam, The Netherlands</td>
</tr>
<tr>
<td>24-27</td>
<td>3rd UICC Global Conference for Cancer “Working Together for Global Cancer Control”</td>
<td>Brighton, UK</td>
<td>M. Swain, MD, Assistant Director/Scientific Liaison, Imperial Cancer Research Fund, London, UK</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Date</th>
<th>Name of Meeting</th>
<th>Place</th>
<th>Secretariat</th>
</tr>
</thead>
<tbody>
<tr>
<td>October</td>
<td>6th Asia Pacific Conference on Tobacco or Health</td>
<td>Hong Kong, China</td>
<td>6th APCT, IO/F, Hong Kong Academy of Medicine Jockey Club Building, 99 Wong Chuk Hang Road, Aberdene, Hong Kong Fax: (852) 2871 8999 Email: <a href="mailto:hkam@hkam.org.hk">hkam@hkam.org.hk</a></td>
</tr>
<tr>
<td>November</td>
<td>Annual Meeting of the American Society for Therapeutic Radiology</td>
<td>San Francisco, USA</td>
<td>G. Smith, ASTRO, Fanix, Virginia, USA Fax: +1 703 502 7852 E-mail: <a href="mailto:gsmth@astro.org">gsmth@astro.org</a> <a href="http://www.astro.org">http://www.astro.org</a></td>
</tr>
<tr>
<td>7-10</td>
<td>103th Chemotherapy Foundation Symposium: Innovative Cancer Therapy for Tomorrow</td>
<td>New York, USA</td>
<td>J. Silverman, Medical Oncology Dept. Mount Sinai Medical Centre, New York, NY, USA Fax: +1 272 369 640 Email: <a href="mailto:j_silverman@mslinck.mssm.edu">j_silverman@mslinck.mssm.edu</a> <a href="http://info.neoplastics.mssm.edu/CTF/sympbrochure.html">http://info.neoplastics.mssm.edu/CTF/sympbrochure.html</a></td>
</tr>
<tr>
<td>15-17</td>
<td>2 Curso Latinoamericano de Capacitacion para Coordinadores de Voluntarios de Cancer de Mama</td>
<td>Buenos Aires, Argentina</td>
<td>APOVOLO (Asociacion Pacientes Oncologicos de Vicente Lopez) H. Yrisoyen 1995, Buenos Aires, Argentina Fax: +54 11 4796 1912 Email: <a href="mailto:apovclo@ciudad.com.ar">apovclo@ciudad.com.ar</a></td>
</tr>
<tr>
<td>16-18</td>
<td>Japan 3rd International Conference on Cancer-Induced Bone Diseases</td>
<td>Awaj Island, Hyogo, Japan</td>
<td>T. Matsumoto, MD, First Dept. of Internal Medicine, University of Tokushima School of Medicine, Tokushima, Japan Fax: +81 88 633 7121</td>
</tr>
<tr>
<td>18-21</td>
<td>16 Asia Pacific Cancer Conference</td>
<td>Manila, Philippines</td>
<td>APCC Secretariat, Philippine Cancer Society, 310 San Rafael Street, San Miguel, Manila, Philippines Fax: +63 2 7342 28 Email: <a href="mailto:psoc@philipk.com.ph">psoc@philipk.com.ph</a></td>
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<tr>
<td>December</td>
<td>43rd Annual Meeting of the American Society of Hematology (ASH)</td>
<td>Orlando, Florida, USA</td>
<td>ASH, Washington DC, USA Fax: +1 202 457 1164 E-mail: ashdrd.uba.com <a href="http://www.ash.org">http://www.ash.org</a></td>
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<tr>
<td>7-11</td>
<td>4th UICC Cancer Meeting on Global Cancer Management: Towards a European Model?</td>
<td>Brussels, Belgium</td>
<td>ECCO 11-Federation of European Cancer Societies Conference Unit, Brussels, Belgium Fax: +32 2 775 0200 Email: <a href="mailto:ECCO11@fecs.be">ECCO11@fecs.be</a> <a href="http://www.fecs.be">http://www.fecs.be</a></td>
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<tr>
<td>8-11</td>
<td>18th World Congress of Digestive Surgery</td>
<td>Hong Kong, China</td>
<td>Congress Secretariat, 18th World Congress of Digestive Surgery Cr: Department of Surgery, University of Hong Kong Medical Centre Queen Mary Hospital, Hong Kong Tel: 852 2818 0232/052 2855 4235 Fax: 852 2818 1186 Email: <a href="mailto:ids@hkcc.hku.hk">ids@hkcc.hku.hk</a></td>
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<tr>
<td>October</td>
<td>6th International Summer School of Oncology for Medical Students</td>
<td>Groningen, The Netherlands</td>
<td>J. de Vries, MD, PhD, Surgical Oncologist, WHO Collaborating Centre for Cancer Education, Groningen, The Netherlands Fax: +31 50 361 4873 Email: <a href="mailto:summerschool@cics.org.nl">summerschool@cics.org.nl</a> <a href="http://www.summerschool.nl">http://www.summerschool.nl</a></td>
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<tr>
<td>8-21</td>
<td>Cancer Research Campaign Beatson International Conference: Genomic Regulation and Cancer</td>
<td>Glasgow, UK</td>
<td>T. Wheeler, Beatson Institute for Cancer Research, Glasgow, UK Fax: +44 141 330 6426 E-mail: <a href="mailto:twheeler@beatson.gla.ac.uk">twheeler@beatson.gla.ac.uk</a> <a href="http://www.beatson.gla.ac.uk/beatson/conf/">http://www.beatson.gla.ac.uk/beatson/conf/</a></td>
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<tr>
<td>15-18</td>
<td>50th Anniversary Conference of the UHPE</td>
<td>Paris, France</td>
<td>JLPEIS Union Internationale de Promotion de la Santé et d’Éducation pour la Santé, 2 rue Auguste Comte, 92170 Vannes, France Fax: +33 1 4645 0059</td>
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<tr>
<td>18-21</td>
<td>8th World Congress on Cancer of the Skin</td>
<td>Zurich, Switzerland</td>
<td>M. Luth, Dept of Dermatology, University Hospital of Zurich, Zurich, Switzerland Fax: +41 1 255 4603 Email: <a href="mailto:leuthm@derm.unizh.ch">leuthm@derm.unizh.ch</a> <a href="http://www.uz.unizh.ch/skin.cancer">http://www.uz.unizh.ch/skin.cancer</a></td>
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<tr>
<td>September</td>
<td>International Conference Seoul 2001: American Association for Cancer Research</td>
<td>Seoul, South Korea</td>
<td>Cancer Research Institute, Seoul National Medical University, Seoul, South Korea Fax: +82 2 742 6377</td>
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<tr>
<td>10-14</td>
<td>Germ Cell Tumour Conference V</td>
<td>Leeds, UK</td>
<td>GCTC V Secretariat, Conference Office, University of Leeds, LS2 9JT Leeds, Great Britain Fax: +44 1 113 323 6107 Email: <a href="mailto:confoffice@leeds.ac.uk">confoffice@leeds.ac.uk</a></td>
</tr>
<tr>
<td>13-16</td>
<td>Asian-Pacific Conference of Tumor Biology</td>
<td>Beijing, China</td>
<td>CICCT/APCTB, Beijing, China Fax: +86 10 6218 0142 Email: <a href="mailto:cicctpub@public3.863.net.cn">cicctpub@public3.863.net.cn</a></td>
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<tr>
<td>16-20</td>
<td>First ASCO-Pan Asia Cancer Conference</td>
<td>Taj Palace, New Delhi</td>
<td>Dr Rakesh Chopra Fax: +91 11 3726916/331733 Email: <a href="mailto:rajeshch@itc.org">rajeshch@itc.org</a></td>
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</table>
THE CANCER COUNCIL AUSTRALIA
The Cancer Council Australia is the peak national cancer control organisation. Its members are the leading state and territory cancer councils, working together to undertake and fund cancer research, prevent and control cancer and provide information and support for people affected by cancer.

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The Cancer Council Northern Territory
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Anti-Cancer Foundation of South Australia
Cancer Foundation of Western Australia
Queensland Cancer Fund

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Professor J Zalcberg MB BS, PhD, FRACP

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

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

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President Elect
Dr L Kenny MB BS, FRANZCR
Council Nominees
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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
(includes GST)

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(Cancer Nurses Society of Australia)
Paediatric Oncology
(ANZ Childhood Cancer Study Group)
Palliative Care
Pharmacy
Psycho-Onology
Radiation Oncology
Social Workers
Surgical Oncology