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Clinical trials: How consumers, clinicians and researchers can initiate and participate in the best cancer trials

Overview

M Stockler
Co-Director of Cancer Trials, NHMRC Clinical Trials Centre, University of Sydney
Senior Lecturer in Cancer Medicine and Clinical Epidemiology, University of Sydney
Director, Cancer Trials NSW, The Cancer Council NSW
Medical Oncologist, Sydney Cancer Centre
Royal Prince Alfred Hospital and Concord Hospitals
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These are exciting times. The last 30 years have seen major reductions in mortality from breast cancer, childhood leukaemia and tests cancer heralding what is possible for other cancers. These improvements are a direct result of clinical trials establishing the benefits of mammographic screening, adjuvant therapy, and treatments for advanced cancer and improving their effectiveness. Changes in community attitudes to sun exposure, tobacco use, and diet should cause major reductions in skin, lung, and colorectal cancer cancers over the next 30 years. Despite these major advances, about a quarter of people in the Western world will die from cancer, and many more will be affected. Why are clinical trials crucial to improving our lot?

Recent, rapid advances in cell biology, genetics, drug development, radiation biology and physics, surgery, supportive care and diagnostics have resulted in a plethora of promising new interventions against cancer. These promising new interventions have to be tried, tested and proven before they can be adopted in clinical practice. The history of medical science shows that only a precious few will translate into real improvements. Clinical trials are the only reliable way of determining the safety, activity and benefit of these promising new interventions.

The theme of this series is ‘How consumers, clinicians and researchers can initiate and participate in the best cancer trials’. Changes in the nature of scientific progress, government involvement, commercial interests, and regulatory requirements are forcing us all to rethink our roles in oncology research.

The authors were selected because of their involvement in innovative, successful projects with lessons that I thought were applicable beyond their particular area, to other areas of oncology and medicine. Authors were asked to focus on what was innovative and interesting for a general audience, and to highlight lessons applicable to cancer trials research in general. All authors made related presentations at the International Clinical Trials Symposium held at Darling Harbour, Sydney in 2002.

Alan Coates sets the scene by describing the benefits, beneficiaries and challenges of cancer clinical trials research. He concludes that cancer trials are a good buy for patients, doctors and society.

Sue Lockwood considers collaboration between consumers and clinician researchers using the example of breast cancer, and the effects of recent controversies surrounding hormone replacement therapy. She concludes with the suggestion that researchers provide a community information abstract, summarising the results of their studies for an informed lay audience.

Mark Rosenthal reflects on the strengths and innovations of the Victorian Centre for Developmental Cancer Therapeutics. The model has been so successful in cancer that it will be applied to neurological and cardiovascular diseases through the establishment of Clinical Trials Victoria, which recently received an $8 million grant from the Victorian Government.

Nicholas Wilcken describes the opportunities and challenges associated with Australia’s participation in HERA, a large international randomised trial of trastuzumab (Herceptin™). He concludes that studies like HERA raise new questions about how trials should be designed and conducted, and reinforce the need for conducting high quality clinical trials on which to base clinical practice.

Marie Malca describes the development of Cancer Trials NSW as a model for improving participation in and access to clinical trials. She emphasises the importance of collaboration, inclusion, consumer involvement and improving access and participation. She concludes that while much needs to be done, the future looks bright.

Leonie Young describes an innovative program to acknowledge the contributions of breast cancer trial participants by providing a network, education about breast cancer research and advocacy training. She concludes that increasing the community’s awareness of the benefits of breast cancer trials will also help other areas.

Life is getting more complicated, but major improvements are on offer. Many have argued, in Australia and overseas, that increasing participation and access to high-quality cancer trials is the best way to improve outcomes for people affected by cancer. Getting cancer trials on the local political agenda may be our major battle in the war against cancer. Perseverance may be the key to helping more Australians survive the war.
Clinical trials provide the evidence basis for rational decision-making in medical therapeutics. They provide benefits to participating patients, future patients, the community, third party payers (such as governments and private health insurers) and to participating clinical researchers.

Benefits

Patients participating in clinical trials receive treatment under rigorously defined, ethically scrutinised protocols. There is some evidence that such patients survive longer than similar patients treated with similar regimens outside trials. While some evidence that such patients survive longer than similar patients participating in clinical trials receive treatment under rigorously defined, ethically scrutinised protocols. There is some evidence that such patients survive longer than similar patients treated with similar regimens outside trials. While some evidence that such patients survive longer than similar

Challenges

Geography provides problems in multi-centre trials, especially if multiple time zones are involved, though modern communication is reducing this aspect of the problem.

Consumers reasonably want access to information about available trials, but apart from the United States, few countries provide reliable access to such information. Patient recruitment is highly variable, but generally low. There are many examples to support the claim that this is not due to patients being unwilling to participate, but rather to barriers at the doctor level.

Funding is a perennial problem – especially since research grants seldom cover the infrastructure costs of maintaining cooperative trials groups. Absence of such funding tends to deliver control of the agenda to those with money to pay for trials, largely the pharmaceutical industry, whose trials may be aimed more at commercial return from early registration of new agents rather than the broader approach to clinically important questions.

Consumer participation is important in trial design, conduct and interpretation. The Australian New Zealand Breast Cancer Trials Group for example has had consumer representation on its Scientific Advisory Committee for many years, and is also advised by a Consumer Advisory Panel.

So who benefits? Participating patients receive accurate treatment, and possibly better outcomes. Future patients have evidence to assist their decisions. Third party payers (government, private health insurers) gain knowledge about which treatments are effective, acceptable and cost-effective, while participating clinical researchers have the benefits of defined regimens, and benefit from early contact with new developments from other ongoing trials group research. Clinical trials are a good buy for patients, doctors and society.

Clinical trials: Benefits and challenges

Clinical discipline in the use of defined regimens, dose modifications and documentation may be noted above led to better outcomes.

In short, trials tell us what works, such as screening for breast and bowel cancers, breast conserving surgery, adjuvant systemic therapy in breast cancer and bowel cancer, radiotherapy in breast, rectal cancers and chemo-radiotherapy for cancers of rectum, lung, head and neck, cervix and oesophagus. Trials also tell us what doesn’t work. High dose methotrexate was once popular in many tumour types but comparative trials severely limited its applicability. An early attempt to justify government support for the costs of clinical trials as a good investment was based on this highly. Lastrelle was an “alternative” medication popular in the 1980s, and more recently we have seen the influence of clinical trials in reducing the use of high dose chemotherapy with stem cell support for breast cancer.

References

5 S Lockwood Breast Cancer Action Group Fairfield, VIC

Abstract

This paper explores how the number of women in clinical trials might be increased and the extent to which researchers, clinicians and women are jointly working to improve outcomes for women. It explores the issues from the perspective of women with breast cancer, but the arguments presented here apply to all diseases. It also considers the loss of trust in the research process that results from inappropriate promotion of results. The Women’s Health Initiative trial is used as an example of how fear and loss of trust can ensue. Some mechanisms to improve trust are suggested, such as community information abstracts to complement the scientific information abstracts which are an integral part of every scientific paper.

Introduction

Women who have been diagnosed with breast cancer want the best possible treatment for themselves and other women with the disease. Clinical trials are an important mechanism for improving treatment outcomes, so women are very interested in the results of trials. Clinicians are interested in improving outcomes through research. They also want better outcomes for their patients, but many of them are also interested in the intellectual challenges which research provides. Both women and clinicians have an interest in increasing the number of women in clinical trials.

Clinical trials have been very successful to date

In 2002, 84% of women diagnosed with breast cancer survived five years, whereas just 10 years ago this figure was 72%. This is a great improvement, most of which is due to better detection and treatment. Much of the research providing these improvements has come from clinical trials. But 30% of women diagnosed with breast cancer still die of it, and some of those who are cured suffer ongoing side-effects of their treatment, eg lymphoedema. It is therefore imperative that more work be done to improve outcomes. Both the effectiveness and safety of treatments must improve.

The only way to get improved outcomes faster is to increase the number of women participating in clinical trials. Greater numbers of women means faster results over a wider range of potential treatment options.

Encouraging more people to participate in clinical trials

The literature relating to encouraging patients to participate in clinical trials focuses on the fact that patients: • don’t understand the research process; • find it difficult to deal with the concept of randomisation; • feel that they are being used as guinea pigs; and, as a result • may turn down the opportunity to participate in trials.

But there is another side to this litany of problems. Work done by the National Breast Cancer Centre surveying women who had been recently diagnosed and treated for breast cancer showed that most women were not invited to participate in a clinical trial. Only 6% of women were asked to participate, of these, half said yes. That is, 50% of women with whom a trial was discussed agreed to participate. So, while only 3% of women participated in trials, this was 50% of the women offered the chance to participate.

These figures indicate that the main problem is not with the women refusing to participate in a trial, but that so few women were asked in the first place. This experience is not unusual, and fits with data from other surveys.

But, where are the real impediments? Why aren’t women being asked to be part of a clinical trial? There are three options: • more relevant trials; • increased numbers of participants; and • increased involvement of clinicians.

Perhaps there are too few trials. It is clear that there are many trials, but they all relate to areas of interest to research scientists and clinicians. Many of these are concerned with chemotherapy and different modes of delivering therapy. Although there are important questions thought to be important to women with breast cancer as they are to researchers? There are very few trials in radiotherapy and surgery and even fewer in the area of psychosocial issues of managing cancer. Laetrile was an “alternative” medication which is a focus of much research into breast cancer which was carried by the Kathleen Cunningham Foundation and the National Breast Cancer Centre entitled “Breast cancer trials: current research and future priorities” demonstrated clearly that the views of women about what makes research projects worthwhile are very different from those of researchers or clinicians. This situation will not have changed from 1996 when the study was done. So, there need to be more relevant trials. But relevant to whom? - women, researchers, clinicians or all three parties?

Too few clinicians are involved in recruiting women to clinical trials. The actual numbers of clinicians involved with clinical trials in breast cancer is very low. But it appears to be only a small proportion of the total number of specialists who are treating women with breast cancer. Overseas studies have shown that those who are treating large numbers of women with breast cancer, or are working in larger specialty teams, are more likely to enrol women in trials. It is hoped that the increased involvement of breast cancer specialists will lead to more rumours offering women entry to clinical trials. Perhaps recruitment will continue to depend on those few clinicians who have a direct interest in trials research. Some clinicians who are very supportive of clinical trials are able to recruit half their patients into trials. Until more clinicians choose to become involved, it will be difficult to recruit increased numbers of patients to participate in trials.

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Despite the fact that so few women actually participate in clinical trials, larger numbers of Australian women are
Asking individual women to participate in any sort of research is like asking them to take a leap into the unknown. Any new assumptions will be based on what is available, and what is available is that the alternative treatment being offered is at least as good as current best practice, and offers a real prospect of improvement. But until the results of the trial are available, there is an assumption that it may be that the results of the trial do not show this, and it may be that the participants in the trial are actually at risk from some factors that are not yet known. For this reason, consumer participation in research and clinical trials depends on trust. Women must be prepared to trust the researchers and to be offered them an opportunity to make their own choices about which trials might be of interest to them and approaching their clinicians to see if participation might be possible. This tool will only be effective if it is to include consumer summaries. Similarly the New South Wales Directory of Breast Cancer Treatment and Services shows those clinicians who participate in trials. Again this gives women the option to be aware of trials that they have an interest in improving practices through clinical trials.

It appears that many of these factors may be related. Trials that appear to be relevant to clinicians, researchers and participants are capable of attracting more recruits than those that are of little interest to few participants.

Sentinel node biopsy trial in Australia: The SNAC Trial

In 1998, women in Australia identified lymphoedema as one of the key problems facing women who have been treated for breast cancer. As a result of this concern, the National Breast Cancer Centre held a summit in Adelaide in February 2000. This included discussion of the need for more research in this area. At the same time, the Royal College of Surgeons in Australia was developing a proposal to conduct a clinical trial to assess the role of sentinel node biopsy in comparison with standard axillary clearance. It was possible to combine the two needs. One of the advantages of sentinel node biopsy is to potentially reduce the need for axillary clearance, and hopefully the incidence of lymphoedema. This trial has been enormously successful. It has encouraged surgeons to become actively involved in a clinical trial and has given them an opportunity to learn and perfect new techniques. Women find the trial of interest because it has the potential to reduce lymphoedema. It is also of interest to breast nurses, occupational therapists and physiotherapists.

To date, 478 women and 35 surgeons are participating in 26 centres. This trial has recruited very quickly because it is of interest to all parties. It is a great example of how a trial can be successful if all those interested in the outcome get together, work up the proposal, arrange funding and help sell the concept.

So what can we learn?

From these experiences, we know some of the factors that encourage recruitment into clinical trials. They are:

- design win-win trials;
- use end points that are meaningful to participants;
- involve consumers in all aspects of trial design and management;
- educate and resource clinicians; and
- empower people – they are the participants, not just subjects.

The other side of the coin – loss of trust

with excellent results. The abstracts are clear, standardised and give the results in language that most people in the community can understand.

Awards for excellence in communicating the results of trials

In many areas of science there are awards for excellence in the public communication of science. Every year in Australia, the Eureka Awards acknowledge the role played by scientists and the media in presenting science to the general community. Similar awards could be put in place for excellence in communicating the results of medical research and in particular clinical trials.

The outcomes of clinical trials are of interest to many members of the community. They are not just the domain of clinicians and researchers. Consumers have a role in the development of trials which can attract many more participants. Consumers can encourage the recruitment of more women to trials and they can play an important role in the value of the results of research. Consumers can also play a role in improving the trust between researchers, clinicians and the community. Consumer participation in all aspects of clinical trials will provide better outcomes for everyone.

Conclusion

An effective partnership between researchers, clinicians and consumers will ensure that clinical trials are more relevant and practical.

Maximising opportunities for clinical research: The Centre for Developmental Cancer Therapeutics

Abstract

Clinical research provides laboratory scientists, translational scientists, clinicians and patients with the opportunity to participate in the evaluation of novel therapeutics. However, a significant proportion of patients interested in clinical trials do not have the administrative wherewithal to conduct such studies. Novel approaches are required to facilitate and enhance clinical research in Australia. In Victoria, a new entity, Clinical Trials Victoria has been established based on the successful model of the Centre for Developmental Cancer Therapeutics, a collaborative cancer and clinical research organisation.

Many oncologists seek opportunities to conduct clinical research. Clinical research and clinical trials provide intellectual stimulation, access to new therapies and additional options for their patients. Clinical trial medicine is usually conducted at the highest level of ethical and scientific standards.

The effective conduct of clinical research requires substantial administrative effort. Interesting new therapeutics must be sought, protocols written, budgets agreed, contracts drawn up, standard operating procedures established, protocols and plain language statements submitted to ethics committees, adequate data management provided, adverse events reported and accrual achieved. Few Australasian oncologists can perform such tasks in isolation. However, specialised administrative support can provide infrastructure in non-medical and non-scientific areas. Indeed, good clinical research infrastructure may provide support to basic scientists, translational scientists, clinicians and patients with the access to novel therapies by establishing efficient, streamlined and successful organisations.

Such abilities will be recognised by the pharmaceutical and biotechnology industries and will result in more opportunities to conduct clinical research.

The Centre for Developmental Cancer Therapeutics (CDCT) was formed in 1993 to provide a focus for cancer clinical research in Melbourne. Importantly, the CDCT aimed to establish a centralised administrative hub for its members in order to provide the specialised support detailed above. The CDCT is a collaboration between oncology units at four Melbourne hospitals: the Peter MacCallum Cancer Institute, Royal Melbourne Hospital and Western Hospital as well as the Walter and Eliza Hall Research Institute and the Victorian Institute of Medical Research. The six affiliates established an incorporated, not-for-profit company to conduct clinical research in cancer patients. It has over 120 members including scientists, clinicians, research nurses, data managers, research registrars and administrative staff. The CDCT clinical sites see over 2,500 new cancer patients per year, have conducted over 160 clinical trials, accrue 300 patients per year to the clinical trial program and have an international reputation, particularly in the field of early phase clinical trials. So much so that in 2003, Pharmaceuticals and the CDCT were one of only 10 “preferred providers” in the world to conduct early phase clinical trials of its products.

The CDCT has many strengths of which two will be highlighted. First, it is able to tap into a variety of disciplines and expertise. Thus, clinical trial design may include the use of functional imaging (PET scans) and translational bio-assays. Furthermore, members of the CDCT have a
The HERA trial is a large international randomised trial testing the efficacy of the new biological drug trastuzumab (Herceptin) in early breast cancer. HERA is being conducted in Australia by the Australian New Zealand Breast Cancer Trials Group in collaboration with the International Breast Cancer Study Group and the Breast International Group. This is the first time Australian centres have participated in a trial of a biological agent in the adjuvant setting and is an important learning opportunity for all those involved.

Background
HER2 (also known as erbB2 or neu) belongs to a family of receptors that are located on the surface of human cells, and when stimulated they transmit growth signals to the nucleus. In many cancers, these growth pathways become uncontrolled, contributing to cancer development or progression. For example, the receptor may mutate in a way that causes it to always be "switched on". In the case of HER2, about 15% of breast cancers have a gene amplification, so that too many receptors are expressed (and activated) on the cell surface. Cancer cell activity therefore increases and "HER2 positive" breast cancers have a worse prognosis than "HER2 negative" cancers.

However, determining the HER2 status of tumours is not as straightforward as determining the estrogen receptor (ER) status. Immunohistochemical staining is carried out (and scored from 1+ to 3+), but a more accurate and expensive test is fluorescence in situ hybridisation (FISH) which reveals the actual number of HER2 genes in the cells. Trastuzumab is a humanised monoclonal antibody that can block these overexpressed receptors.

Trastuzumab in metastatic disease
The first randomised trial involving trastuzumab compared chemotherapy with or without trastuzumab in women with newly diagnosed metastatic breast cancer. Tumour response rates, time to progression and overall survival were better with the addition of trastuzumab. An unexpected finding was that trastuzumab actually improved outcomes in any medical discipline and any therapeutic agent or device.

CTV will act as a service company for clinical researchers, providing clinical trial support, marketing, training and education, quality assurance, database management (bioinformatics), regulatory advice, legal and contractual support. CTV will establish strong links with sources of new therapeutics including the Victorian Cancer Drug Development program and Bio21, and will aggressively market Victoria as a site to conduct clinical research.

The degree to which a clinical researcher uses CTV clearly depends on experience. Thus a mature organisation such as the CTV will mainly benefit from CTV providing a strong marketing of the CDT at a national and international level. This will provide opportunities for the CDT through new liaisons with pharmaceutical and biotechnology companies. In contrast, novel clinical researchers may seek assistance with protocol writing, statistical advice, contracts and the like. CTV will encourage new collaborators between clinical researchers and provide the necessary infrastructure to assist the conduct of clinical trials.

In conclusion, conducting clinical research with new therapeutics is an exciting, stimulating and rewarding component of an oncologist’s work. Access to such opportunities is made significantly easier through collaborative networks and the provision of sponsored administrative support. The CTV is one successful example of such an organisation where the day-to-day administrative detail is taken out of the hands of clinical researchers, leaving them to focus on what they wish to do to clinical research.

The establishment of CTV moves this philosophy one step further. CTV will implement the CDT paradigm for all clinical researchers whatever their medical specialty or area of interest. CTV will provide independent administrative support to all clinical researchers, irrespective of their experience. As a consequence, clinical research in Victoria will become more streamlined, efficient and successful.

Cancer Trials NSW: A collaborative initiative to support and promote cancer clinical trials research in NSW

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People with cancer who are treated in clinical trials are more satisfied and do better than people who receive the same treatment outside of a clinical trial. Despite this, less than 3% of NSW adults with cancer are currently enrolled in trials. Recognising the need to build capacity and infrastructure for clinical trials research, The Cancer Council NSW worked with key stakeholders to reach agreement on the steps necessary to achieve the mutual aim of improving participation and access to cancer clinical trials. This resulted in the establishment of Cancer Trials NSW (CTN), a collaborative initiative to support and promote a wide range of cancer clinical trials research across NSW.

Some of the most innovative aspects of the CTN program are:
• The extensive consultation and collaboration conducted in the development and establishment of CTN.
• A unique trial selection process, developed to ensure the best trials that need the most support get this crucial boost. This means more support for trials of radiation therapy, surgery, palliative care and supportive care, not just for trials of anticancer drugs.
• A unique centre selection process to direct funds for study nurse/data management support.

Reference
1 DJ Slomski, B Lecky-Jones, S Shuk, et al. “Use of chemotherapy plus monoclonal antibody against HER2 for metastatic breast cancer that
Consultation and collaboration

Comprehensive consultation was done to help develop the most appropriate model for this collaborative initiative. Consultative committees were convened to provide advice and reach agreement on all aspects of CTN – including issues of policy, procedure, selection of trials and participating centres, finance, governance and management. All committees included consumers, health professionals and researchers. CTN is now well established with consensus from all the key stakeholders on suitable policies and procedures for a fair, rigorous and inclusive selection.

Trial selection

CTN trial selection occurs twice a year, with calls for applications in March and September. Continuing review and addition to the portfolio of CTN trials is designed to ensure that the mix of cancers and treatments in supported trials reflects the experience of cancer in NSW. The CTN portfolio now includes 47 supported trials.

Trial Selection Committee

Our inclusive Trial Selection Committee comprises 26 individuals from all relevant disciplines, including three consumers, clinicians, researchers and staff of The Cancer Council NSW. Three assessment forms are used by the committee.

At least 10 committee members review and rate each trial application using:

1. The “CTN trial and concept rating form”, an electronic form that allows raters to score each trial application against specific selection criteria developed for CTN.
2. A content expert and a methodologic expert do more detailed assessment using other forms.
3. The “Protocritical appraisal form” developed by Davina Ghera of the NHMRC Clinical Trials Centre; and
4. A modified version of the “National cancer grants ranking form”.

The results of these ratings and assessments are then summarised and form the basis of the committee’s decisions and discussions.

Trial selection criteria

To help meet the aims of CTN, selection criteria were developed and integrated into a CTN centre rating form that includes 21 aspects grouped into seven domains:

- Participation
- Access and equity
- Quality
- Economy and efficacy
- Multidisciplinary care
- Contribution to Cancer Council activities
- Overall rating

Ideal applications include substantial, realistic participation in a rational subset of CTN supported trials involving collaboration, networking and links between disciplines, centres, areas and institutions. In their application each centre outlines which trials they intend to do and their proposed recruitment figures. CTN sponsored centres are encouraged to take up new supported trials as they are approved, and patients recruited are included in the evaluation of that centre.

Vision – “research in practice”

We hope that by 2010, throughout NSW:

- Participation in cancer trials is an integral part of clinical practice.
- Everyone suitable is able to participate in cancer clinical trials, both patients and clinicians.
- World-class participation delivers world’s best cancer care and outcomes.
- 90% of eligible patients are offered participation in CTN supported trials and 25% choose to take part. The targets are that everyone is given the choice, and that people are fully informed and free to choose.

What’s in the future?

Increase funding

We plan to increase the number of CTN supported study nurse/data manager positions to 20 FTE over the next five years, contingent on the success of our fundraising efforts with The Cancer Council NSW. We anticipate future applications to support centres will be invited annually as funds become available.

Trials initiation

Our initial focus has been to improve participation and access in NSW by selecting and supporting greater participation in ongoing, high-quality trials. The next step is to identify important gaps in our cancer trials research program, and help establish high quality trials to address them. Through this initiative, CTN will provide a genuine vehicle to support locally initiated trials and build on the intellectual contribution from NSW to the global trials effort.

A national register of cancer trials

Information about each supported trial and centre is currently available on the Cancer Trials NSW website, which is part of The Cancer Council NSW website at www.cancercouncil.com.au. We aim to work with our key stakeholders and other state cancer councils to further develop this information as a basis for the establishment of a national register of cancer clinical trials.

Education and training

Educating advocates, consumers, clinicians and researchers about ongoing trials and the importance of participation is another important strategy for increasing participation and access throughout NSW. CTN has already contributed to training for consumers, and plans are in progress for educational programs for study nurses, data managers, clinicians and other researchers.

Conclusion

CTN provides a successful, effective model for building infrastructure to improve participation in and access to cancer clinical trials, and for developing a close collaboration between consumers, clinicians, researchers and funders. Effective involvement means inclusion at all levels including trial development, management and fund-raising, things that CTN will continue to champion in the future. CTN has only just begun and there is a long way to go, but with the continued support of all the key stakeholders CTN will increase its efforts in all of these areas.

Australian New Zealand Breast Cancer Trials Group: IMPACT – Improving Participation and Advocacy for Clinical Trials

L Young
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Clinical trials research

We are now in the most exciting and productive time ever in breast cancer research. The genetics of breast cancer are being unravelled, new treatments are being tested and greater understanding of the controls of cell growth and mechanisms of development of breast cancer are being explored.

The most significant obstacles to new research are low recruitment to clinical trials and lack of infrastructure funding. Relying on the generosity of the community and industry does not allow for long-term commitment. Lack of ongoing infrastructure funding makes it difficult for health professionals to make a commitment to research and the number of institutions which offer clinical trials is limited.

Community education about clinical trials research is very important if participation rates are to increase. Not only is the general community ill-informed about clinical trials, but so are many health professionals who are in a position to advise people diagnosed with cancer.

People diagnosed with cancer should be given as many opportunities as possible to participate in cancer clinical trials research. The involvement of partners, families and friends is also important in the decision of whether to participate in a clinical trial. Therefore, the whole community needs to be informed so appropriate enquiries can be made at the time of diagnosis.

There are still many myths of how trials are conducted. Perceived uncertainty or the “guinea pig” mentality is still very prominent.

Because of these misconceptions, many people still feel that their participation led to improved recruitment.”

“More relevant and clearer questions were… asked.”

“The consumers helped convince researchers and funders that the trial was possible and ethical.”

“They were important in helping to refine questions.”

“They helped make a complex trial comprehensible to most patients.”

“They provided insights into issues important to the community and patients.”

“Their participation led to improved recruitment.”

Australian New Zealand Breast Cancer Trials Group (ANZ BCTG)

Established in 1978 to create a national collaborative approach to breast cancer research through clinical trials, the ANZ BCTG collaborates with over 500 researchers in 60 leading medical and research institutions in Australia and New Zealand and with 15 countries internationally.

The ANZ BCTG invited the inclusion of consumer representation to research planning in 1994 when a breast cancer survivor and a breast nurse counsellor were invited to become members of their Scientific Advisory Committee. They were invited both because of their own life experiences with breast cancer, and their academic expertise. They have contributed to the scientific discussion and have been responsible for reviewing and commenting on new trial protocols and participating in community education.

The ANZ BCTG encourages consumer comment and input at all stages of trials, and is working to ensure that all aspects of the trials, including their validity and ethicality, are thoroughly considered.
IMPACT was established to further enhance consumer involvement. IMPACT aims to provide a positive voice in the community about breast cancer clinical trials research. The aims of IMPACT are to:

- recognise the important contributions made by women to breast cancer clinical trials research of the ANZ BCTG;
- increase participation to ANZ BCTG breast cancer clinical trials research; and
- educate women about the science of breast cancer and the processes of clinical trials research so they can become effective advocates for clinical trials research; and
- provide information on breast cancer clinical trials research.

The IMPACT Education Program is offered to members who continue to show a commitment to the clinical trials process and an interest in learning the concepts of basic science, breast cancer research and policy issues.

The Education Program runs over three to four days. Presentations are made on subjects specifically designed to give the participants an understanding of:

- the biology of breast cancer;
- genetics;
- study design, statistics and interpretation;
- diagnosis and treatment;
- conducting clinical trials; and
- advocacy and communication skills.

IMPACT allows its members to make choices. However they choose to contribute, their participation is constructive, valued and they can continue to provide a broader consumer perspective. What sets IMPACT apart is that it specifically aims to address issues relating to clinical trials research.

Inevitably, the positive messages about breast cancer trials will carry over to the benefit of other clinical trials research. This is another positive attribute of IMPACT. There is still a long way to go to eradicate breast cancer. Advocates cooperating and striving for a common cause can help achieve this sooner. IMPACT members will continue to make their contributions to the research process count.

Testing for familial cancer susceptibility gene mutations

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2 Genetic Services of WA

Abstract

Genetic testing is a useful means of identifying individuals who are at an increased risk of developing familial cancer. This information assists such individuals to make lifestyle alterations and consider surgical intervention to minimise their risk of developing cancer. In WA, genetic testing is conducted free of charge to the public through Genetic Services of WA who provide an integrated service. This includes pre- and post-test counselling, testing, family support and a surveillance registry. However, the recent granting of an exclusive gene patent licensing agreement for familial breast cancer susceptibility genes threatens free of charge public testing services Australia-wide.

In WA genetic testing is conducted through Genetic Services of WA (GSWA), which is a multidisciplinary, state-wide service based at King Edward Memorial Hospital. GSWA has a long-established Familial Cancer Program that provides a comprehensive service to families with a history of breast, bowel and ovarian cancers, other less common cancers and related syndromes. The service incorporates important pre- and post-test counselling, family support, education, genetic testing and liaison with clinical specialists where relevant, for individuals or families with a history of cancer.

Comprehensive DNA-based testing for cancer susceptibility gene mutations has been offered through the Familial Cancer Program at GSWA since 1995. This testing detected most sequence variations, but until recently testing was limited to specific known deletions or duplications. These sort of mutations are believed to be common in familial breast and bowel cancer and are now tested for in the GSWA laboratory with a novel test, the Multiplex Ligation-dependent Probe Amplification (MLPA), which identifies any exon deletions or duplications. The GSWA laboratory stores DNA and RNA from family members and when new tests appear the stored material is re-analysed. The laboratory is currently using these improved technologies to investigate for mutations in stored specimens, in which previous studies were inconclusive.

In calculating an individual’s estimated risk of developing cancer, based on mutations in the cancer susceptibility genes, a multitude of complex issues arise. Mutations in these genes increase an individual’s risk for both breast and ovarian cancer, however the estimated risk is different. For example, in BRCA1 mutation carriers the estimated risk (to age 75 years) of developing breast cancer is 40-80% and the risk of ovarian cancer is 10-60%. Male carriers of the BRCA1 mutation also have a slightly higher lifetime risk of developing cancer of the prostate.

In BRCA2 mutation carriers the estimated risk (to age 75 years) of developing breast cancer is 40-80% and the risk of ovarian cancer is 10-60%. Carriers of mutations in the BRCA2 gene also have a slightly higher lifetime risk of developing cancer of the pancreas, male breast and prostate.

Despite these complexities, there are numerous benefits of cancer susceptibility gene mutation testing. These include early detection, appropriate surveillance and sometimes the option of preventative surgery. Through the course of genetic testing an individual is often alerted to other possible lifestyle changes that may keep cancer at bay.

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The Familial Cancer Program also operates a cancer registry that provides surveillance for women identified as being at increased risk of familial breast or ovarian cancer. If no mutation is found in the family, members are still encouraged to follow screening measures due to the strong family history of disease. The Familial Cancer Program also invites such individuals to join the registry in the event that a new genetic mutation is identified in the course of future research or technological development. In addition, the program offers referral services to individuals to participate in approved clinical trials and research projects conducted through the Familial Cancer Program and the Breast Cancer Service of Royal Perth Hospital.

The holistic and multidisciplinary service in WA provides counselling and information to individuals considering undertaking genetic testing. The pre- and post-test counselling component of the program allows for the mechanisms of genetic testing to be explained, and the framework that a mutation is present in a family being assessed. It also provides counsellors with an opportunity to clarify the advantages and limitations of genetic testing, as well as possible options for risk management. A recent study of women tested for mutations in the BRCA genes suggested that counselling is effective in helping women throughout the genetic testing process, highlighting the need for a comprehensive genetic service.

An experience of genetic testing
Genetic testing for familial breast cancer mutations raises a multitude of psychosocial issues, which need to be considered before proceeding with testing services. For example, in deciding whether or not to undertake testing the individual needs to consider the impact of the information on their own psychosocial coping and issues such as life insurance and employment. Ultimately, the choice is a personal one but genetics professionals can ease the decision-making process by equipping individuals with the best information about the issues involved. They can make the best choice for themselves and their family.

In response to the high prevalence of breast cancer in her family, one woman underwent a double mastectomy in order to minimise her risk of developing breast cancer. This woman stated that “breast cancer has been cast a long shadow over the women in my family, it seems as if part of our family is devoid of women” and is therefore also currently considering participating in approved clinical trials and research projects conducted through the Familial Cancer Program and the Breast Cancer Service of Royal Perth Hospital.

The holistic and multidisciplinary service in WA provides counselling and information to individuals considering undertaking genetic testing. The pre- and post-test counselling component of the program allows for the mechanisms of genetic testing to be explained, and the framework that a mutation is present in a family being assessed. It also provides counsellors with an opportunity to clarify the advantages and limitations of genetic testing, as well as possible options for risk management. A recent study of women tested for mutations in the BRCA genes suggested that counselling is effective in helping women throughout the genetic testing process, highlighting the need for a comprehensive genetic service.

The impact of physiotherapy intervention on functional independence and quality of life in palliative patients

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Abstract
The Physiotherapy Department of the Royal Brisbane Hospital has conducted a review of physiotherapy services to palliative care patients in Australia. As part of this review, a trial was undertaken to investigate the impact of physiotherapy intervention on quality of life and functional level. The results indicated that the provision of an adequately resourced physiotherapy service incorporating early intervention and community follow-up can contribute significantly to the maintenance of functional independence and quality of life among patients receiving palliative care.

Introduction
In the mid to late 1960s, the concept of rehabilitation as a part of the cancer treatment process began to flourish. Dietz described the five phases of a framework for cancer rehabilitation which included prevention, restoration, support and palliation. Physiotherapy involvement in the treatment of cancer patients began to develop at this time, but with involvement often limited to the restorative stage1. During the 1970s, the input of physiotherapy in the support phase began to be noted. Zissis1 reported the usefulness of physiotherapy to maintain range of motion most operatively, and Mayer2 noted that physiotherapists could implement a graduated exercise program contributing to maintenance of mobility. The role of physiotherapy in cancer rehabilitation was firmly established by the 1970s, with many textbooks devoting space to the role of physiotherapy and also of the importance of a multidisciplinary approach to palliative care3. A series of publications by Doyle4 demonstrated the development of the contribution of physiotherapy to palliative care. A number of studies suggested that while physiotherapy involvement could value-add to the care of patients in the palliative stage of cancer, there was an inconsistent approach to the referral of patients to physiotherapy or even of the involvement of physiotherapists in palliative care.

The aim of this study was two-fold: (i) to understand where physiotherapists were involved in palliative care services in Australia, specifically identifying the impediments to those services, and (ii) to conduct an outcome study of physiotherapy to patients receiving palliative care in order to determine the effects of a standard physiotherapy service compared to an optimised physiotherapy service. In the context of this project, palliative care is defined as care for people in the non-curative stage of the disease process.

Method
Stage 1
In order to provide a benchmark service against which to assess physiotherapy outcomes, it was necessary to understand what constituted a standard versus optimal physiotherapy practice. Prior to the commencement of the outcome study, a survey of physiotherapy services was conducted to assess the possible options to be undertaken.

The survey identified a number of impediments to the delivery of a quality physiotherapy service, including the fact that the average time spent in providing physiotherapy to palliative patients was found to be less than 30 minutes per patient per consultation.

Other limitations included delayed or absent referral to physiotherapy during hospital admission, limited resources (such as equipment and funding) to provide adequate services, and a lack of community-based services for follow-up after hospital discharge. The specialised physiotherapy service examined during stage two of this study was designed to reduce the impact of the limitations identified in stage one.

Stage 2
The study was conducted over 12 months in an oncology ward of a major metropolitan teaching hospital. The subjects were patients admitted for symptom control (palliative care patients). Forty patients were randomly allocated to receive the optimal trial physiotherapy service (characterised by time and...
resource allocations, based on an experienced physiotherapist’s ability to provide an enhanced/optimised service). The trial group was comprised of a control group of 20 patients who received the usual physiotherapy service provided by the ward (characterised by time and resource constraints influenced by inadequate staff to patient ratios).

Subjects were allocated to the study groups in the following way. The project physiotherapist screened new admissions to the ward, and palliative patients with indications for physiotherapy intervention were identified. From this group, randomly selected patients were approached and invited to take part in the trial. These patients received the trial service by the project physiotherapist and were known as the “project group”. Patients not randomised to the project group became subjects in the “standard group” when and if they were referred for physiotherapy during their admission. In this way, the standard group was representative of the usual process of referral for physiotherapy service delivery from the ward.

Both groups received best-practice medical and nursing care provided by the physiotherapist covering topics such as:

a Pain and symptom management, including transcutaneous nerve stimulation (TENS), appropriate positioning of patients to reduce stress on joints and muscles and to prevent development of pressure areas, and the treatment of lymphoedema by a combination of massage, compression and exercise.

b Education provided by the physiotherapist covered topics including safe and comfortable transfers and handling techniques to minimise discomfort and injury to both the patient and carer, and techniques to reduce work associated with activities of daily living.

c Mobility and independence were maximised by designing exercise programs specific to the individuals’ needs, providing gait re-education and the provision of appropriate walking aids.

The trial outcomes were assessed with respect to:

d Conversion of data analysis and chi-square frequency analysis. While the group numbers were relatively low, resulting in weak levels of significance, there were distinct differences between groups.

d Length of stay, discharge destination and place of death.

Participants in the project group were more likely to be discharged home than those in the standard group (p=0.0065). Patients in the project group were also more likely to die at home (p=0.0159). There was no statistically significant difference in length of stay (LOS) between groups. Patients in the project group had a mean LOS of 17.55 days, and patients in the group that received standard care had a mean LOS of 15.6 days.

Functional level

A comparison of the functional level between the groups was performed using a post-discharge assessment score obtained at a time that was half way between the date of discharge and the date of the patients’ death. This method was chosen to ensure that the groups were comparable with respect to extent of disease and the stage of decline.

At admission and discharge, patients in the project group had mean functional independence scores of 16.5 (supervision to complete some tasks) and 15.5 while the standard group means were 14.6 (supervision with some tasks) and 14.3, respectively. The decrease in score at discharge in the project group is in the main due to the higher proportion of patients in this group who died during admission (15%). When these patients are excluded, the difference at admission is maintained at discharge (17.9). Figure one demonstrates that there was no statistically significant difference in functional ability between the groups at admission or discharge from hospital. At mid-survival follow-up assessment there were weak statistical (p=0.09) and clinically significant differences between the project and standard groups. The standard group required light to moderate assistance with all tasks, while the project group was functionally independent with the use of a walking aid in all tasks.

Quality of life

Neither the standard nor the project groups experienced significant changes in any of the function components of the QLQ-C30 questionnaire over the study period. However, noticeable trends existed within the two groups. The trend within the standard group (figure two) was towards a decline in function whereas the trend within the project group (figure three) was towards improvement in function. Comparison of the functional independence measurement tool with the physical function component of the QLQ-C30 demonstrated a weak but significant positive correlation (r= 0.629, p<0.05).
The physiotherapist was significantly better among patients in the project group. Understanding of advice and instructions given by the treating project group were significantly more satisfied (*p = 0.05) than the standard group. For the question regarding the understanding of advice and treatment, the physiotherapy services received during admission (figure 4).

**Patient satisfaction**
Both the standard and project groups were satisfied with the physiotherapy services received during admission (figure 5). For the question with the physical function component of advice and instructions given by the physiotherapist, patients in the project group were significantly more satisfied (*p = 0.05) than those in the standard group.

**Physiotherapist workload data**
The average times devoted to physiotherapy management of patients in the project group and the standard group are presented in table one. Table 1: Average duration of intervention (minutes/seconds) for each group of patients.

**Discussion**
Length of stay, discharge destination and place of death Examination of the length of stay data revealed that patients in the project group had a mean stay of two days longer than those in the standard group. The specific reason for this was not apparent from the analysis, however it was noted that in general a higher proportion of patients in the project group died during admission. This may augment a difference in severity of illness status not discernible by other means.

Patients in the standard group were more likely to be discharged to another care facility instead of home than those in the project group. In order to determine whether this outcome was a consequence of stage or severity of disease or of diagnosis, further examination of the demographics of the patients in the standard group revealed that the subjects were a representative sample of all patients normally admitted to the ward. The fact that patients assigned to the project group were more likely to be discharged home than patients in the standard group was considered to be a positive outcome of the study. Anecdotal evidence suggests that there is an increasing trend towards patients and families wishing to care for loved ones in the home environment. Where possible, and due to shortages of beds in extended care facilities, the aim of discharge facilitation on the oncology ward is to discharge the patient home where possible, if the family and patient desire this outcome and are in a position to facilitate it.

The success of follow-up community physiotherapy among project group patients was affirmed by the fact that more patients in the project group were likely to die at home than those patients in the group that received standard care limited by lack of physiotherapy time, resources and community follow-up. When considering the place of death, it is important to remember that some patients elect to be admitted to a formal care facility in preference to dying at home. While there are many factors that influence a person’s ability to remain at home until death, the ability of the carer(s) to effectively manage a primary concern. The ability of the patient to move or be moved is a major component of the ability to cope at home. The greater proportion of project group patients dying at home suggests that the contribution of physiotherapy to the maintenance of mobility and function enhanced the choice of place of death.

**Functional level**
On admission, the project group had a higher level of functional independence. This was not considered to be sampling bias but rather a reflection of referral practices on the ward. Patients were randomly recruited to the project group on the initiative of the project physiotherapist as sufficient time and resources became available through the discharge or death of other patients. Patients recruited to the project group were newly admitted patients whose medical notes identified an indication for physiotherapy intervention and who had not at that time been referred for physiotherapy. Conversely, patients in the standard group were those who may have had indications for physiotherapy intervention at admission but who were not referred to the ward physiotherapist by medical or nursing staff until time after admission. Such referral was often based on the inability of the patient to manage functionally on their own even though he or she had been managing earlier in the admission. The ward physiotherapist had 15 years of clinical experience and had been working in the field of chronic care and palliative care over a number of years leading up to this study. The increased human and material resources available to the project physiotherapist, and the palliative-specific focus of the project service increased the variety and effectiveness of the physiotherapy interventions undertaken.

While the difference in admission levels of functional independence between standard and project groups may be viewed as significant clinically, the difference reflects a crucial variable potentially affecting outcomes for physiotherapy intervention in palliative care. To provide timely intervention is essential to maximise outcomes. The results from the standard group indicate that due to referral practices in existence at the time of this study, there was a population of patients passively being denied access to physiotherapy when they clearly had indicators for physiotherapy.

While the level of statistical significance is weak, there were distinct clinical differences between groups in patients’ functional abilities. Such differences could be considered to have greater clinical significance when attached to related factors such as quality of life and ability to function effectively in the home. The comparison of the functional independence measurement tool with the measurement component of the QLQ-C30 demonstrated a significant positive correlation, suggesting that the components assessed were representative of factors contributing to the quality of life of the patients.

**Quality of life**
Patients in neither the standard nor the project group experienced significant changes in any of the function components over the study period. However, noticeable trends existed within the two groups. The trend within the standard group was toward a decline in function, whereas the trend within the project group was towards improvement in function. These trends are verified by the results acquired from the functional independence measurement tool.

While it is intuitively appealing to make sweeping claims from these results, it would be unwise to do so in the context of the lack of supporting data regarding pharmacological, dietary and other factors that may have influenced these results. It is interesting to note though, that the patients in the standard group experienced an improvement in symptoms during the inpatient period followed by a decline in five of function components assessed at follow-up to a point below the admission score. Conversely, the project group maintained or improved function in all but one component over the same period. The results for each group are similar in the scores for symptom impact over the same time course. The links between quality of life factors, well-being, follow-up and physical independence/activity have been noted by other authors10-12 and so it would seem reasonable to conclude that the maintenance of independence and physical activity, along with community follow-up, were likely to have been directly related to quality of life scores noted in the project group.

**Patient satisfaction**
While satisfaction with various aspects of physiotherapy services was high among patients of both groups, patients in the project group were significantly more satisfied with the advice...
and instructions given to them by the treating physiotherapist. As the project physiotherapist had more time and was able to adjust her workload to maintain adequate patient intervention time, it may be expected that the project group would be more satisfied with the amount of physiotherapy received. It is important to emphasise that the individual skills or approaches of the physiotherapists concerned were not the subject of this investigation but rather the way in which the service was delivered. Given the extensive knowledge base and skills of physiotherapists it is not surprising that the two groups were equally satisfied. Regardless of the communication skills of the individual physiotherapists, the increased time available to the project physiotherapist provided the ability to ensure understanding of advice and instructions contributing to this result. Where general commentary was given in the QLQ-C30, it was found that no patients reported dissatisfaction with the service provided by any of the healthcare professionals involved in their care.

Physiotherapist workload data

The individual treatment episodes provided by the project physiotherapist were longer than those of the ward physiotherapist. One must note that while the project physiotherapist was employed solely for the study and her time was quantified for the provision of enhanced patient care, the ward physiotherapist providing the standard level of care was required to provide a service to three busy medical wards and a specialist outpatient clinic. Based on the results of the nation-wide survey (stage one), the latter situation is typical of physiotherapy work allocation in Australian public hospitals providing palliative care services.

The cost of providing the physiotherapy services under the project model of care was greater than the standard service. This was due to the increased time spent with each patient as well as the addition of community follow-up. However, a comparison of discharge destination and place of death in this investigation but rather the way in which the service was provided. A project physiotherapist were longer than those of the ward physiotherapist. The cost of providing the physiotherapy services under the project model of care was greater than the standard service. This was due to the increased time spent with each patient as well as the addition of community follow-up. However, a comparison of discharge destination and place of death in this investigation but rather the way in which the service was provided. A project physiotherapist were longer than those of the ward physiotherapist.

Acknowledgements

To Ms Elaine Unkles for her sponsorship of the project and useful suggestions on the manuscript, Ms Pamela McNeil (social worker) for her support during the project, the staff of the Division of Oncology, Royal Brisbane and Royal Women's Hospitals, Health Service District, for their professionalism and interest in the study, and most of all to the patients and carers who agreed to participate in the research.

References


Conclusion

In summary, in comparison to the standard treatment group, patients in the project group were significantly more likely to be discharged home and significantly more likely to die at home. The provision of a specialised physiotherapy service resulted in significantly higher functional levels on follow-up assessment. A trend towards the maintenance or improvement of the functional component of quality of life and significant improvements in fatigue, pain and appetite were noted in patients who received optimised levels of physiotherapy time and resources. The provision of an adequately resourced physiotherapy service incorporating early intervention and community follow-up can contribute significantly to the maintenance of functional independence, patient satisfaction and quality of life among patients requiring palliative care. In turn, this may result in decreased demand for formal inpatient care and subsequent cost savings. A physiotherapist to patient ratio of 1:12 is recommended in order to produce such results.

CONTINUING RESEARCH PROJECT GRANTS

1. J Stevens. Collaborative Health Education Research Centre, St Vincent's Hospital. Sentinel node vs axillary clearance trial $13,000
2. S Tangye. Centenary Institute of Cancer Medicine and Cell Biology. Lymphocyte activation and anti-tumour immunity mediated via SAP-associated surface receptors in health and disease $76,000
3. R Allan. Children's Cancer Institute Australia for Medical Research. Molecular mechanisms of drug resistance in childhood acute lymphoblastic leukaemia $71,649
4. Q Dong. University of Sydney. The role of FH1L and SPINK1 in androgen-independent prostate cancer $69,500
5. B Henderson. Westmead Institute for Cancer Research. Regulation of beta-catenin nuclear trafficking in cancer $58,000
6. R Mason. University of Sydney. Role of 2,15-dihydroxyvitamin D3 in photoprotection $70,000
7. M Tattersall. Institute of Magnetic Resonance Research. When the treatment goal is not cure: a randomised trial of decision aids in patients with incurable metastatic cancer $141,800
8. M. Lock. Hunter Centre for Health Advancement. A randomised controlled trial of a computerised smoking cessation intervention in a surgical pre-admission clinic $31,123
10. A Rice. Children's Cancer Institute Australia for Medical Research. Development of targeted immunotherapy to treat relapsed leukaemia post stem cell transplantation $66,940
11. M. Raval. SEALs, Prince of Wales Hospital (South Eastern Area Laboratory Service). The autophagy of breast cancer and the involvement of diet, hormones and the human homologue of the mouse mammary tumour virus $75,548
13. P. Hogg. Tumour Angiogenesis. $211,000

Support for research 2003

The state and territory cancer organisations, which comprise The Cancer Council Australia, are the major sponsors of cancer research and related activities in Australia. Grants are made following a competitive, peer-reviewed assessment from funds derived from donations and bequests.

In 2003 the value of these grants is $20 million.

In addition, the grants for breast cancer research made by the National Breast Cancer Foundation are listed. The Foundation has been established by the Federal Government, with an independent Board of Trustees to encourage research in all aspects of breast cancer.

THE CANCER COUNCIL NSW

RESEARCH GRANTS

J Kirk
Westmead Hospital
kConfab: A national consortium for research into familial breast cancer $55,000
A Gruelich
National Centre in HIV Epidemiology and Clinical Research, University of NSW
Cancer in dialysis patients and kidney transplant recipients: incidence, risk factors and survival $36,200
P Mersey
Newcastle Mater Milerion Congrease Hospital
Sensation of human melanoma to killing by the immune system $134,620
R. Lock
Children's Cancer Institute Australia for Medical Research
Targeting angiogenesis signalling pathways in childhood acute lymphoblastic leukaemia $80,000
R. Ward
St Vincent's Hospital
The significance of Cpg island methylation in the pathogenesis of hyperplastic polyps and colorectal cancer $135,000
A. Dobianski
Molecular epidemiology of ovarian cancer: WA, Tasmania and a national clinical follow-up care
$69,500
Total research grants
$10,320

REPORTS

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### RESEARCH GRANTS

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<td>Defining the cause and improving the treatment of childhood neuroblastoma</td>
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<td>R Sutherland</td>
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### OTHER RESEARCH PROGRAMS

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### TOTAL RESEARCH FUNDED

**$5,749,958**

### RESEARCH GRANTS

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<td>A randomised clinical trial of surgery versus surgery plus adjuvant radiotherapy for regional control in patients with completely resected macroscopic nodal melanoma in Stage III melanoma</td>
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<td>D Ben-Tovim, A Stapleton, C Pinnock</td>
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<td>The influence of coping strategies on outcomes in prostate cancer: a longitudinal study</td>
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<td>D Bowtell, A deAraujo, M Davey</td>
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<td>Molecular epidemiology of ovarian cancer: Australian ovarian cancer study – Western Australia, Tasmania and a national clinical follow-up core</td>
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<td>A Enderle, D Findlay, B Coventry</td>
<td>Dept of Orthopaedics and Trauma, Royal Adelaide Hospital</td>
<td>A novel non-toxic approach to bone cancer therapy</td>
</tr>
<tr>
<td>G Forbes, F MacLean, P Bampton, J Edwards</td>
<td>Dept of Gastroenterology and Hepatology, Royal Perth Hospital</td>
<td>A comparison of screening tests for colorectal neoplasia in average risk asymptomatic subjects</td>
</tr>
<tr>
<td>G Gin, J Collins, M Bochner, D Walsh</td>
<td>Dept of Surgery, University of Adelaide</td>
<td>Sentinel lymph node biopsy versus axillary clearance in operable breast cancer</td>
</tr>
<tr>
<td>G Goodall</td>
<td>Hanson Centre for Cancer Research, IMVS</td>
<td>Regulation of HIF-1α by PI3K signalling in breast cancer</td>
</tr>
<tr>
<td>M Guthridge, A Lopez</td>
<td>Hanson Centre for Cancer Research, IMVS</td>
<td>Role of the 14-3-3 family of proteins in human GM-CSF and IL-3 receptor signalling in leukaemic cells</td>
</tr>
<tr>
<td>J Hardingham, P Hewitt</td>
<td>Haematology-Oncology Dept, The Queen Elizabeth Hospital</td>
<td>Detection of disseminated tumour cells in colorectal cancer using tumour-specific gene expression markers and immunohistochemical RT-PCR</td>
</tr>
<tr>
<td>P Hewitt, J Moore, C Plain, B Iacopetta, A Ruszkiewicz</td>
<td>Dept of Surgery, The Queen Elizabeth Hospital</td>
<td>Gender and anatomical site differences in the survival benefit from 5FU chemotherapy for colorectal cancer patients</td>
</tr>
<tr>
<td>D Horwill</td>
<td>Dame Roma Mitchell Cancer Research Laboratories, Hanson Institute</td>
<td>Modulation of prostate cancer cell attachment to stromal matrix by versican</td>
</tr>
<tr>
<td>Y Hu, G Young, R Le Leu</td>
<td>Flinders Centre for Digestive Health, Dept of Gastroenterology, Flinders Medical Centre</td>
<td>Do dietary interventions protect in a p53 deficient model of colorectal tumorigenesis?</td>
</tr>
</tbody>
</table>
### Reports

#### THE CANCER COUNCIL VICTORIA

**RESEARCH GRANTS**

<table>
<thead>
<tr>
<th>Name</th>
<th>Institution</th>
<th>Title</th>
<th>Funding</th>
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</thead>
<tbody>
<tr>
<td>N. Ahmad, M. Quinn</td>
<td>Royal Women's Hospital</td>
<td>EGF-dependent alpha v beta 6 integrin-mediated regulation of colon/ovarian cancer growth and metastasis</td>
<td>$65,000</td>
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<tr>
<td>D. Ball</td>
<td>Division of Radiation Oncology, Peter MacCallum Cancer Institute</td>
<td>Tumour volume as an independent prognostic factor in non-small cell lung cancer</td>
<td>$35,000</td>
</tr>
<tr>
<td>A. Brooks, E. Markovska</td>
<td>Dept of Microbiology and Immunology, University of Melbourne</td>
<td>MECA expression in malignant melanomas: consequences for NK and T cell activation</td>
<td>$55,000</td>
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<tr>
<td>Y. Chong</td>
<td>Dept of Biochemistry and Molecular Biology, University of Melbourne</td>
<td>Regulation of the tumour suppressor PTEN by phosphorylation and aligernation</td>
<td>$4,000</td>
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<tr>
<td>P. Choong, H. Zhou</td>
<td>St Vincent's Hospital</td>
<td>Urakase plasminogen activator and osteoclast systems</td>
<td>$70,000</td>
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<tr>
<td>J. Darcy, T. Trages, M. Smith</td>
<td>Cancer Immunology Research Laboratory, Peter MacCallum Cancer Institute</td>
<td>Immunotherapy of cancer using genetically engineered T cells</td>
<td>$50,000</td>
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<tr>
<td>M. Ernst, P. Waring</td>
<td>Colorectal Molecular and Cellular Biology Unit, Ludwig Institute for Cancer Research</td>
<td>The tumorigenic effect of overexpression of DNA methyltransferases on the intestinal epithelium</td>
<td>$60,000</td>
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<tr>
<td>P. Gibson, E. Nee</td>
<td>Dept of Medicine</td>
<td>Molecular regulation of migration in normal and neoplastic colonic cells</td>
<td>$55,000</td>
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**THE CANCER COUNCIL TASMANIA**

**RESEARCH GRANTS**

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<tbody>
<tr>
<td>G. Woods</td>
<td>University of Tasmania</td>
<td>Immunosuppression by carcinogen induced immature dendritic cells: Signalling molecules, potential pathways and intervention strategies</td>
<td>$30,000</td>
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<tr>
<td>J. Mackay</td>
<td>University of Tasmania</td>
<td>The molecular genetics of familial prostate cancer in Tasmania</td>
<td>$20,000</td>
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<tr>
<td>D. Amor</td>
<td>Victorian Clinical Genetic Services</td>
<td>KConfab – A consortium for research on familial breast cancer</td>
<td>$10,000</td>
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<tr>
<td>R. Lord</td>
<td>University of Tasmania</td>
<td>Analysis of breast cancer using proteomics</td>
<td>$25,000</td>
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<tr>
<td>P. Blomfield</td>
<td>Royal Hobart Hospital</td>
<td>The Australian ovarian cancer study</td>
<td>$35,000</td>
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<tr>
<td>D. Collins</td>
<td>Leukaemia Foundation and The Cancer Council Tasmania</td>
<td>Following project jointly funded by DCLF</td>
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<tr>
<td>S. Rigg</td>
<td>University of Tasmania</td>
<td>The molecular basis of cancer – mediated growth arrest and terminal differentiation</td>
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<tr>
<td>R. Louwenthal</td>
<td>Royal Hobart Hospital</td>
<td>Long-term storage of blood stem cells for transplantation – clinical results and patient outcomes</td>
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**Total research grants** | $235,000

#### JEANNE FOSTER SCHOLARSHIPS

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<tbody>
<tr>
<td>G. Woods</td>
<td>University of Tasmania</td>
<td>To attend the 7th International Symposium on Dendritic Cells in Gynaecology</td>
<td>$650</td>
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<tr>
<td>P. Davey</td>
<td>Cancer Council Victoria</td>
<td>Calvary Health Care</td>
<td>$600</td>
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<tr>
<td>D. Peet</td>
<td>University of Adelaide</td>
<td>To commence a Graduate Diploma in Genetic Counselling</td>
<td>$800</td>
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<tr>
<td>B. Baker</td>
<td>Royal Hobart Hospital</td>
<td>The Australian ovarian cancer study - Western Australia, NSW and also to attend three compulsory residential schools</td>
<td>$600</td>
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<tr>
<td>C. Wren</td>
<td>Royal Hobart Hospital</td>
<td>To attend a course on Chromosome to Genes: Toward best practice guidelines and Australasian Society of Cytogeneticists and also to attend the annual scientific meeting of the Haematology Society of Australia and New Zealand</td>
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**Total Jeanne Foster scholarships** | $3,300

#### OTHER RESEARCH PROGRAMS

<table>
<thead>
<tr>
<th>Name</th>
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<th>Title</th>
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<tr>
<td>A. More</td>
<td>Athens Foniadakos Leukaemia Scholarship</td>
<td>$5,000</td>
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<tr>
<td>J. Whinnett, C. Kidd</td>
<td>Athol Meyer Award - for excellence in media coverage of cancer issues</td>
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**Total other research programs** | $308,860

**TOTAL RESEARCH FUNDED** | $308,860

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G Lindeman, D Amor, J Kirk, G Guthrie, J Goldblatt Victorian Breast Cancer Consortium Laboratory Walter and Eliza Hall Institute

IConfab: A consortium for research on familial breast cancer $55,000

All Lyons, T Hughes Division of Haematology MEWS Analysis of the biology of mutant forms of BCRABL resistant to the tyrosine kinase inhibitor imatinib (Glivec) $60,607

P MacKerron Dept of Clinical Pharmacology Flinders Medical Centre Regulation of the chemical detoxifying UDP glucuronosyltransferases and their role in colorectal cancer $58,268

I Oliver Royal Adelaide Hospital Cancer Centre Royal Adelaide Hospital Improving informed consent to chemotherapy: Written information versus an interactive CD-ROM $47,800

P Reynolds, M Holmes Dept of Thoracic Medicine Targeting TIMP gene delivery as a strategy against pulmonary metastases $60,926

R Richards Dept of Molecular Bionics University of Adelaide Chromosomal fragile sites: The role of cis-acting elements and trans-acting factors in DNA instability in cancer $65,041

W Tiley, P Neufing, M Yang Chair in Cancer Research University of Adelaide Distinct negative androgen receptors: a novel approach to the treatment of metastatic prostate cancer $68,268

M Whittle, J Gorman, D Peet Molecular Bionics University of Adelaide Role of the hypoxia inducible factor in tumourigenesis $61,000

E Yeoh, R Holloway, A Luck, M Schnitzer, P Bartholomeusz Dept of Radiology Oncology Royal Adelaide Hospital Natural history, pathophysiology and treatment of radiation proctitis following radiotherapy for prostatic carcinoma $69,757

Total research grants $1,307,162

**SENIOR FELLOWSHIPS**

<table>
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<tr>
<th>Name</th>
<th>Institution</th>
<th>Title</th>
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<tr>
<td>C. Hall, Hansen Centre for Cancer Research</td>
<td>$62,200</td>
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<td>S. Stephenson, The Queen Elizabeth Hospital</td>
<td>$62,200</td>
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**FELLOWSHIPS**

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<tr>
<td>A. Evdokias, Hansen Centre</td>
<td>$57,860</td>
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<td>G. Buchanan, University of Adelaide</td>
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**W BRUCE HALL CANCER RESEARCH FELLOWSHIP**

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<tr>
<td>D. Peet, University of Adelaide</td>
<td>$69,000</td>
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**PETER NELSON LEUKAEMIA RESEARCH FELLOWSHIP**

R. D'Andrea, Child Health Research Institute

**OTHER RESEARCH PROGRAMS FOR 2003**

<table>
<thead>
<tr>
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<tr>
<td>Centre for Cancer Control Research</td>
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<tr>
<td>Travel grants</td>
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<tr>
<td>Distinguished visitors</td>
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<tr>
<td>Student vacation scholarships</td>
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<td>PhD Scholarship</td>
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<td>Data Managers Program</td>
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<td>Prostate Data Managers Program</td>
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<td>Radiation Therapy Scholarships</td>
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<td>Total of other research programs</td>
<td>$315,000</td>
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<tr>
<td>Total RESEARCH FUNDED</td>
<td>$2,201,447</td>
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Reports

Monash University

K Harber, M Hills, J Duns
Melbourne Tumour Biology Branch
Ludwig Institute for Cancer Research

An analysis of the Lyn tyrosine kinase in myeloid cell
tumour suppressor using both loss- and
gain-of-function mutant mice
$50,000

S Heerds
St Vincent's Institute of Medical Research

A novel human CDA response gene that interacts with the CH2 and PHL tumor suppressors
$60,000

F Johnston
Peter MacCallum Cancer Institute

Mechanism of action of histone deacetylase
inhibitors: novel anti-cancer drugs
$60,000

M Lackmann, P Gibbins
Ludwig Institute for Cancer Research

The role of Eph/ephrin-A interactions in cutaneous melanoma: effects of Eph receptor activation on cell
adhesion, mobility and viability during various stages of melanoma progression
$69,000

G Lindeman, D Amor, J Kirk,
G Suthers, G Goldblatt
Dept of Haematology and Medical Oncology
Royal Melbourne Hospital

KConFab: A consortium for research on familial
breast cancer
$55,000

P Macrae, B Leggett, J Jass
Dept of Gastroenterology
Royal Melbourne Hospital

A trial of aspirin and/or resistant starch in people at
risk of hereditary colorectal cancer (CAPP2)
$30,000

S Martin, J Hopper, A Kefford,
G Giles, B Armstrong
Dept of Public Health
University of Melbourne

Australian melanoma family study
$35,000

C Mitchell
Dept of Biochemistry and Molecular Biology
Monash University

The characterization of a novel 108 kDa mostel
polyphosphate 5-phosphatase-regulator of cell death
$50,000

S Ngan, S McClachlan, J MacKay, R Fisher
Division of Radiation Oncology
Peter MacCallum Cancer Institute

A randomised trial of preoperative radiotherapy for
stage T3 adenocarcinoma of rectum
$20,000

S Siddiqui, L Wozniak
ImmunoLOGY Division
Walter and Eliza Hall Institute of Medical Research

The role of the proto-oncogene PTL in haemopoiesis
$60,000

M Pankias, I McKenzie
Austin Research Institute

The role of a novel suppressive T cell subset, Tr1, in
breast cancer immunity
$300,000

I Purton, D Haylock, P Simmons
Division of Haematology and Medical Oncology
Peter MacCallum Cancer Institute

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

G Risbridger
Role of estrogens in prostate malignancy
$70,000

M Gattas, G Lindeman, G Suthers,
KconFab: A national consortium for research into
kConFab: A national consortium for research into
metastatic spread of cancer
$57,035

S Stacker, M Achen
Melbourne Tumour Biology Branch
Ludwig Institute for Cancer Research

The role of vascular endothelial growth factors in the
metastatic spread of cancer
$55,000

O Thomas, M Traina
Dept of Medicine
University of Melbourne

Interactions between cell cycle and differentiation
processes in normal and malignant osteoblasts
$66,000

T Tiganis
Dept of Biochemistry and Molecular Biology
Monash University

Protein phosphatases and mitosis
$60,000

J Villadoros
ImmunoLOGY Division
Walter and Eliza Hall Institute of Medical Research

Mechanisms of cross-presentation in dendritic cells
$60,000

J Vincen, W Phillips
Peter MacCallum Cancer Institute

FZD7 signalling in colon cancer
$60,000

J Visvader
Victorian Breast Cancer Research Consortium

SOCS genes in the mammary gland and other organs -
potential tumour suppressor genes
$30,000

A Ward
School of Biological and Chemical Sciences
Deakin University

Isolation and characterisation of leukaemia mutants in zebrafish
$60,000

Total research grants
$1,598,000

POST-DOCTORAL RESEARCH FELLOWSHIPS

K Haynes, Peter MacCallum Cancer Institute

S21,550

J Jamil, Monash Institute of Reproduction and Development

$55,000

Total post-doctoral research fellowships
$83,500

POSTGRADUATE RESEARCH SCHOLARSHIPS AND VACATION STUDENTSHIPS

J Becacovic, Dept of Biochemistry and Molecular Biology, Monash University

$21,150

T Can, Baker Medical Research Institute

$43,969

A Deans, Peter MacCallum Cancer Institute

$5,288

J Dow, Peter MacCallum Cancer Institute

$21,150

S Fos, Ludwig Institute for Cancer Research

$2,263

R Gan, Ludwig Institute for Cancer Research

$27,150

R Moran, Dept of Biochemistry and Molecular Biology, Monash University

$21,150

R Redders, Peter MacCallum Cancer Institute

$21,150

W Shi, Dept of Microbiology and Immunology, University of Melbourne

$27,150

J Stone, Dept of Public Health, University of Melbourne

$21,150

S Ting, Dept of Medicine, University of Melbourne

$6,788

Total scholarships and studentships
$199,763

FELLOWSHIPS

C Baldock, Y De Deene, B Healy,
A Whitaker, O Schlict
Queensland University of Technology

Development of ultrasonic scanner for evaluation of
radiotherapy polymer gel dosimetry phantom
$70,000

D Bowler
Peter MacCallum Cancer Institute

Molecular epidemiology of ovarian cancer: the
Australian ovarian cancer study: WA, Tas, and a
National Clinical Follow-up Core
$42,000

A Boyd, A Yap, G Burns
Queensland Institute of Medical Research

Investigating the role of truncated transcripts of the
Fat proto-oncogenes in T lymphocyte tumours
$72,590

M Brown
University of Queensland

Investigating the role of IRAK-1 in mammary
differentiation and morphogenesis
$70,000

J Burren
Queensland Institute of Medical Research

Investigation of peptides derived from tumour
antigens and bound to non-self-MHC molecules
$72,590

M Clark
Mater Medical Research Institute

Characterisation of a novel myeloid specific antigen as
a potential leukemic cell target
$72,590

I Frazier
University of Queensland Centre
for Immunology and Cancer Research

Evaluating therapeutic interventions to overcome
tolerance to tumour antigen
$70,000

B Gabrielli, J Hancock
University of Queensland

Mechanisms of UV induction of the melanoma
susceptibility gene product p16CDKN2A
$72,590

I Frazer
Centre for Tobacco Control (The Cancer Council Victoria contribution to VicHealth Centre)

Evaluating therapeutic interventions to overcome
tolerance to tumour antigen
$70,000

J Hancock
University of Queensland Centre
for Immunology and Cancer Research

Evaluating therapeutic interventions to overcome
tolerance to tumour antigen
$70,000

J Horwood, D Wyld, A Clavarino
Comparison of quality of life and standard end-points
$70,000

Cancer Forum - Volume 27 Number 1 - March 2003

Cancer Forum - Volume 27 Number 1 - March 2003

Cancer Forum - Volume 27 Number 1 - March 2003
Reports

QCF/School of Social Science UQ: The ethic experience of cancer in Queensland – A case study of the Chinese and Vietnamese communities in Brisbane $14,937
QCF/Griﬃth University: Cancer support centre (psychosocial oncology) $100,000
QCF/School of Population Health and Institute for Molecular Biosciences UQ: Genetic science, molecular biotechnology and the public’s perceptions of future prospects for the care and prevention of cancer $27,000
QCF/School of Public Health, QUT/School of Psychology UQ: Quality of life and unmet needs of colorectal cancer patients at the time of diagnosis and treatment $55,000
Total collaborative studies $232,000

EPIDEMIOLOGY AND BEHIOURAL RESEARCH PROGRAMS

QCF Cancer Epidemiology Unit

Total epidemiology and behavioural research programs

OTHER RESEARCH GRANTS

Familial adenomatous polyposis register $44,540
Australian paediatric cancer registry $43,679
Total other research grants $88,219

PHD SCHOLARSHIP PROGRAM

2001 – 2003

RA, Dept Physiology and Pharmacology, University of Queensland $19,500
S Duffy, Division of Cancer and Cell Biology, Queensland Institute of Medical Research $19,500
S Wright, George Roberts Scholar, QLD Dept Physiology and Pharmacology, James Cook University $19,500
2002 – 2004

M Rinaldis, 2002 John Earnshaw Scholar, School of Psychology, University of Queensland $21,500
S Joseph, Institute for Molecular Bioscience, Queensland University $19,500
L Pipp, Signal Transduction Lab, Queensland Institute of Medical Research $19,500
2003 – 2006

L Packer, 2003 John Earnshaw Scholar Division of Cancer and Cell Biology, Queensland Institute of Medical Research $21,000
K Jawerth, Division of Cancer Immunotherapy, Queensland Institute of Medical Research $19,500
E Hacker, Division of Cancer and Cell Biology, Queensland Institute of Medical Research $19,500
K Parlett, Mater Medical Research Institute $19,500
Total PhD scholarship program $198,500

TOTAL RESEARCH FUNDED $4,069,896

CANCER FOUNDATION OF WA

RESEARCH GRANTS

L Abraham, D Spagnozzi School of Biomedical and Chemical Sciences University of Western Australia $55,000
YY 1 and AP 1 expression in anaplastic large cell lymphoma
C. O’Dea, J Nott, M Rinaldis School of Biomedical and Chemical Sciences University of Western Australia $47,272
An investigation of the speciﬁc targeting of cancer cells by adenoviruses
G Forbes, J Edwards, R Mendelson, L Fritschi Curtin University of Technology $31,423
A comparison of screening tests for colorectal neoplasia in average risk asymptomatic subjects
G Galperis, S Fox School of Chemistry University of Technology $55,000
Induction of anti-tumour immunity by manipulation of endogenous antigens
G Lindenmayer, J Goldblatt Genetic Services of WA $27,500
King Edward Memorial Hospital and Princess Margaret Hospital
J Olynyk, J McHutchison, G Yeoh Department of Medicine University of Western Australia $54,800
Tea consumption and epithelial ovarian cancer survival: a prospective cohort study
K Chung, P Yuan, P Xie, W Li School of Public Health University of Technology $55,000
Enhancement of cancer gene therapy by combination of nitrosodioxime and phase II metabolism
D Nelson, B Robinson Department of Medicine University of Western Australia $55,000
Evaluating the effects of intra-tumoural cytokine therapy on tumour-inhibiting T cells and tumour growth
J Olynyk, J Hutchins, G Yeoh Department of Medicine University of Western Australia $55,000
Determining the effects of oral/parenteral therapy of chronic hepatitis C on hepatic oval cells and risk for hepatocellular carcinoma
D Bowtell, N Zepp, I Hammond Peter MacCallum Cancer Institute $36,000
Molecular epidemiology of ovarian cancer: The Australian Ovarian Cancer Study - WA, TAS and a national clinical follow-up core
The 29th annual scientific meeting of COSA was held at Darling Harbour in Sydney in November 2002. This meeting represented a departure from the previous Brisbane meeting, with a decrease in the number of concurrent group sessions and an emphasis on joint sessions and multidisciplinary presentations and symposia.

Delegates heard from a wide range of speakers, courtesy of a number of concurrent or preceding meetings. Joint sessions were held with the Second Sino Australian New Zealand Conference on Surgical Oncology, the Australian Society for Breast Diseases, the Australian Association of Cancer Registries and the Australian Society of Clinical Oncology.

The first day was devoted to individual group meetings. The most heavily attended – with standing room only – was the Second Sino Australian New Zealand Conference on Surgical Oncology, where presentations were made with equivalent contributions from Australian and Chinese surgeons in colorectal cancer, oesophageal, gastric and breast cancers. Major overseas speakers included a distinguished Chinese faculty and Professor Irving Taylor from the UK on colorectal cancer related liver metastases, and Dr Hans Bonnemkamp from the Netherlands on gastric surgery. This proved to be one of the largest surgical oncology sessions ever held at COSA, and we hope it will lead to an increased presence of surgeons at future meetings.

Concurrently, the Australian Society for Breast Diseases and the Breast Group of COSA held a day-long program. Filled to capacity, the presentations included minimally invasive surgery, diagnostic and adjuvant therapy and issues of survivorship. In addition to a stellar local cast, the overseas speakers included Professor Kathy Pritchard from Toronto who did a major presentation on hormones in adjuvant therapy and on HR, Professor Ian Tannock presenting novel work on fatigue and cognitive dysfunction after adjuvant therapy, and Jay Harnes on minimally invasive surgery and mammography-ultrasound.

All the groups had comprehensive and well-attended sessions on issues such as epidemiology, including geographic and survival analysis, communication and assessment of unmet needs, health services delivery research, a new drug research symposium, and patient care issues and innovative support programs. A wine tasting highlighting the wines of the Mudgee region capped a busy day.

The meeting was able to provide a wide range of “meet the professor” sessions including “Good practice in surgical oncology” by Professor Irving Taylor (sponsored by the Surgical Society), “Breast cancer and HIV” by Kathy Pritchard, “Management of mucositis” by Dorothy Keefe, “Advances in radiation oncology” by Andrew Turnis (sponsored by Aventis), “Assessing quality of life” by Darius Razavi (jointly sponsored by the National Breast Cancer Centre), and Ian Tannock (sponsored with the Head and Neck Society) on “Critical interpretation of medical literature”.

The formal opening by Professor Marie Bashir, Governor of NSW, on the second day of the meeting was followed by a keynote address by Professor Rick Keeford on molecular horizons in treatment. His overview of the translation of molecular knowledge to the delivery of novel therapies in the clinic was forceful and educational, with an outstanding use of multimedia.

State of the art symposia were held in management of lung and breast cancer, with participation of all disciplines from basic science to palliative care.

A highlight of the day was the “best of the best” abstracts session. Five presentations, originally nominated by each group and narrowed down by a larger panel, were presented. Our overseas guests judged the presentations. One of the major international travel prizes kindly donated by Pharmacica and Eli Lilly were Professor Paty Yates for her paper on “Behavioural intervention for cancer pain” and Professor Graham Giles for his paper on the “Risk of colorectal cancer associated with food consumption”.

A further travel prize by Mayne Pharma was given to Dr Rebecca Hagerty for her paper on “Metastatic cancers”, and book prizes to Dr Trevor Leong for “Radiation in gastric cancer” and Dr Michael Dooley for “Dosing in obese patients”.

This session highlighted like no other the great importance of COSA to cancer care delivery in Australia. A session of the best research in the meeting included an epidemiologist, a professor of nursing, a pharmacist, a psychologist and a radiation oncologist, all sharing the podium. No other cancer society in the world successfully combines the talents of so many different health professionals involved in the care of cancer patients.

The MOG Pierre Fabre award lecture was by Professor Lester Peters, one of the most famous radiation oncologists Australia has produced, on the international study headed by him and Dr Danny Rischin on a novel approach to treatment of head and neck cancer with a new radio sensitiser irapazamine.

Concurrent workshops on sexuality and cancer, clinical trials, promotion and marketing, and an emphasis on joint sessions and multidisciplinary presentations and symposia. A wine tasting highlighting the wines of the Mudgee region capped a busy day.

The meeting was also aimed at boosting understanding and awareness of clinical trials in cancer, and harnessing support for increased participation.

Meeting participants included people with cancer, representatives of cancer advocacy and support groups, researchers, clinical trials coordinators, and health professionals.

In opening the meeting the President of The Cancer Council Australia, Professor Ray Lowenthal, said the evidence shows that clinical trials lead to better health outcomes for the patients involved in them, and they contribute to all Australians receiving the best possible up-to-date medical care.

“Australia is helping lead the way in trials research, but participation rates are still low – fewer than one in 20 Australians who have cancer currently take part in clinical trials,” he told the meeting.

“We’re keen to see this change, and we want to enlist the support of as many people as possible to do this.”

Background briefings and presentations from experts including trial participants, researchers and ethicists set the scene for discussions about community perceptions of clinical trials and whether these perceptions are based on fact or fiction, as well as barriers to participation in clinical trials and how they can be overcome.

The meeting heard that many people with cancer aren’t aware they have the opportunity to take part in trials – trials are not widely publicised, and many doctors do not offer them.

Delegates agreed that some patients perceive trial participants as “guinea pigs,” and that participation includes a need for trialists to be seen as a last resort, after standard therapy has failed. Many people fear that participation in trials will increase their risk of side effects and death, and some fear they may be randomised to a placebo arm.

In each case the more cautious Australian approach won the audiences vote. A concurrent workshop on management of liver metastases, with input by major local and overseas leaders in the field was running simultaneously. This was followed by a presentation on the activities and achievements of the ALLG and ANZBCTG, and, finally, a needed debriefing session led by Professor Stewart Dunn and Paul Heinrich on Burn out in professionals with the assistance of Darius Razavi was a much needed change for all attendees.

A huge vote of thanks must go to Rozanne Gilbert and our amazing organised executive officer Lawrie Wright, his final COSA meeting pulled off as an impeccably run and efficient meeting on the usual show string budget!

The meeting attracted over 750 delegates and the format seemed much appreciated. The Perth meeting for 2003 appears to be following a similar format and should not to be missed!

Delegates said many people believe trials only relate to drugs – they aren’t aware there are also trials involving surgery and radiotherapy, as well as non-treatment cancer trials. Some people perceive that only public hospitals are involved in trials. Many of these negative perceptions are based on fiction rather than fact, and could be redressed through better information.

A lack of high quality, balanced, easily accessible information about clinical trials – both for patients and health professionals – was identified as a key barrier. A lack of clear information about what trials are and how they work as well as which trials are available, where, and how patients can become involved. Other barriers to participation included lack of health professional support for trials, geographical issues, lack of home support, inadequate government funding, and fears about being treated with something other than standard therapy.

Suggestions for overcoming barriers to participation included development of a national clinical trials registry, increased funding for trials, better information for patients (particularly at the time of diagnosis), education of clinicians, longer medical appointments to allow the opportunity to discuss trials, the development of support networks for trials participants, and public awareness campaigns.

Delegates undertook to increase awareness of clinical trials in cancer through their networks, and The Cancer Council Australia and other interested parties are working towards implementing some of the key recommendations from the meeting.

The Cancer Council Australia thanks Linda Reay, Sally Crossing and Russell McGowan for their assistance in planning the open forum and the many speakers and delegates who took part, as well as the Sydney Opera House and Truffle Group for their pro bono support.

Jennifer Denholm
The Cancer Council Australia

FROM BENCH TO BEDSIDE AND BACK AGAIN

Clinical trials in cancer: an open forum for consumers

A national register of clinical trials in cancer would be an important step forward in improving participation in trials, delegates to this meeting agreed.

About 70 people attended the open forum at the Sydney Opera House on October 24 last year.

Organised by The Cancer Council Australia, the meeting was aimed at boosting understanding and awareness of clinical trials in cancer, and harnessing support for increased participation.

Meeting participants included people with cancer, representatives of cancer advocacy and support groups, researchers, clinical trials coordinators, and health professionals.

In opening the meeting the President of The Cancer Council Australia, Professor Ray Lowenthal, said the evidence shows that clinical trials lead to better health outcomes for the patients involved in them, and they contribute to all Australians receiving the best possible up-to-date medical care.

“Support for trials participation is now greater than ever. Many people are now aware of the benefits to themselves, and are prepared to give up their time to participate in clinical trials.”

“Australia is helping lead the way in trials research, but participation rates are still low – fewer than one in 20 Australians who have cancer currently take part in clinical trials,” he told the meeting.

“We’re keen to see this change, and we want to enlist the support of as many people as possible to do this.”

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Jennifer Denholm
The Cancer Council Australia

Cancer Forum - Volume 27 Number 1 - March 2003

Cancer Forum - Volume 27 Number 1 - March 2003
This is a regular feature in Cancer Forum describing behavioural applications in cancer prevention.

Australia has five behavioural research centres: the Cancer Prevention Centre at the University of Queensland, the Centre for Health Research and Psychosociology (CHRP) of The Cancer Council New South Wales, the Centre for Behavioural Research in Cancer (CBRC) of The Cancer Council Victoria, the Centre for Behavioural Research in Cancer Control (CBRCC) at Curtin University of Technology Perth, and the Centre for Cancer Control Research (CCCC) of The Cancer Council South Australia.

This report has been edited by Anne Gibbs (CHRP) from the reports received.

New results
- Centre for Behavioural Research in Cancer (CBRC), VIC

Evaluation of the Victorian Care Nurse Distance Education Program

Nurses working with men with prostate cancer require ongoing education and training in prostate care to meet the multiplicity of needs faced by these men. The 13-week Prostate Care Nurse Distance Education Program developed by The Cancer Council Victoria and Latrobe School of Nursing and Midwifery is a tertiary-based education package for nurses, which can be undertaken as part of a degree program in advanced nursing. The program aims to educate nurses in the specialty areas of prostate cancer and prostate disease so they have access to up-to-date information, appropriate support and further education. It also enables students to develop the resources to establish a network of information and support across Australia and overseas for debriefing and professional development purposes.

An evaluation of the course, designed and conducted by staff at CBRC, was undertaken by students enrolled in the first two intakes in June and September 2001. Forty-six students participated in one or more stages of the evaluation. The topics investigated in the PBIC of the Victorian Cancer Council Distance Education Program should contact Robyn Metcalfe, Cancer Care Educatio
schools adopted an ‘any hat is better than no hat’ policy with the approval of students wearing caps or ‘bucket’ hats. The main reason for this was that having sunscreen available for student use on specific occasions such as physical education, sports days and excursions. The most common strategies encouraged were those undertaken outdoors between 10am and 3pm was the availability of indoor venues for students during lunchtimes and morning breaks.

Individual interviews and focus group discussions were also held with principals, teachers, students and parents from four schools, discussing the issues that were explored in the first phase of this study.

Reports available shortly.

of the health belief model, investigate the characteristics was kept of those who declined to participate. The study will brief questionnaire completed prior to the consultation with participate in this study. Written consent was obtained and a an understanding of the factors associated with participation will commence in early 2003. Quit rates will be investigated, and data will also be collected regarding the experiences and opinions of the program participants.

Evaluation of phase 2 of the Breatheasy project

This project was run by the South Australian Department of Human Services in 2001 and encouraged workplaces to introduce smoke-free policies. The project involved the offer of free workplace “quit smoking” courses and subsidised (half-price) nicotine patches for smoking staff at participating workplaces. Evaluation of the initial phase of this project revealed very low uptake rates for the nicotine patches; with only 15% of patches vouchers issued being redeemed. This finding prompted a letter to the editor, appearing in the December edition of Tobacco Control, warning against investing large amounts of project funds into purchasing nicotine replacement therapy (NRT), as low rates of uptake are likely. The evaluation of phase two is currently underway and indicates similarly low rates of uptake.

An audit of nutrition and cancer information in popular magazines

The aim of this project is to determine the extent to which nutrition and cancer is covered in popular magazines, and to describe the type and nature of cancer-related information. The project will review the 10 most frequently-read general, health or food related monthly or bi-monthly magazines (over a 12 month period) to identify cancer-related articles, and mention nutrition. It is intended that this study will be the first phase of a more detailed content analysis of nutrition and cancer coverage in popular magazines.

n CBCC

Testing for the early detection of bowel cancer in rural Victoria

There is level 1 evidence that screening the population using the faecal occult blood test (FOBT) can reduce colorectal cancer (CRC) mortality, by approximately 15% depending on the detection level of curable cancer within the target population, which is a product of adequate participation and the sensitivity of the test. The Commonwealth Government-funded early detection bowel screening pilot program is being implemented in rural and metropolitan sites across Australia. Little is known about the extent to which people in rural setting are likely to participate in screening if recommended by their general practitioner. A team led by Trish Livingson is aiming to gain an understanding of the factors associated with participation in the early detection of bowel cancer using FOBT.

Evaluation of Quito’s 12-week program

TCRE is currently evaluating the South Australian Quito’s 12-week program. The program is available to all callers to the Quito line, and interested follow-up interviews that are agreed will be offered to help a variety of perceptions, and attitudes to palliative care services, and the identification of triggers used to initiate the referral process. This information will then be used to develop a quantitative instrument that will explore how extensively these issues influence the referral of cancer patients nationally.

As a result of this research interventions may be implemented to increase the utilisation of palliative care services in Australia, and to ensure equitable access for patients with cancer to palliative care, at an appropriate time in the disease trajectory. Key areas that require publicity and education will be identified.

n CBCC

“Me No Fry” media campaign

Evaluation of the Cancer Foundation of Western Australia’s 2002-03 “Me No Fry” media campaign continues, and a report summarising the findings of the tracking of the National Tobacco Campaign has been completed for the third volume of Australia’s National Tobacco Campaign Evaluation Report.

n CBPC

The PLACE project

Physical inactivity has recently been identified as a behavioural risk factor for breast and colon cancer, both independently and through its influence on weight gain (see International Agency for Research on Cancer, IARC Handbooks of Cancer Prevention, Volume 6 - Weight Control and Physical Activity, Oxford, Oxford University Press). As is the case for tobacco control, and other areas of cancer prevention, successful regulatory, public policy and social and environmental initiatives will be required for population-wide reductions in risk. At CRPC, Neville Owen and Eva Leslie are conducting the PLACE project (Physical Activity in Local and Community Environments) to examine how objectively determined attributes of local community environments are likely to impact on adults walking. For middle-aged and older adults, walking contributes the most to overall activity-related energy expenditure. The findings of PLACE will inform future environmental change strategies that have the potential to increase overall physical activity levels and weight gain. PLACE is a collaborativeproject with colleagues at the NSW Centre for Physical Activity and Health, the National Centre for Social Applications of Geographic Information Systems at the University of Queensland, the University of Technology, Sydney, and the Georgia Institute of Technology in the US.

n CBPC

Appropriate and timely referral of cancer patients to palliative care: a qualitative investigation of perceptions of health professionals

There is significant evidence to suggest that in the United States and Europe, a large percentage of cancer sufferers are referred to palliative care services late in the trajectory of the disease. The provision of effective care that refers that relies on regular monitoring. It is intended that this study will be the first phase of a more detailed content analysis of nutrition and cancer coverage in popular magazines.

n CHaRP

After 14 years, the Cancer Education Research Program (CERP) has changed its name to better reflect its full range of research activities and future directions. The new title is the Centre for Health Research and Psycho-oncology (ChErP).

Congratulations to Associate Professor Afaq Girgis, Associate Professor D’Este and Mo Aye Beys, who were awarded a National Health and Medical Research Council grant of $440,000 over three years from 2003 to 2005 for a population-based longitudinal study of cancer survivors’ psychosocial and physical wellbeing.

In November 2002, ChErP hosted a workshop on “Practical aspects of needs assessment in oncology” at the Sydney Convention Centre. This workshop was conducted as the first step in the development of guidelines and procedures for scoring, analysing, interpreting and reporting data collected via the Supportive Care Needs Survey. Thirty-three participants representing consumer advocacy, health care professionals, researchers, policy makers and service administrators attended. The workshop was facilitated by Associate Professor Afaq Girgis and focused on the practical aspects of using the survey including (i) design and potential uses of the perceived needs surveys, (ii) barriers to using the survey and data and (iii) additional resources or support required to facilitate use of the survey. The outcomes of the workshop will be considered in the development of guidelines and will be used to guide the group of stallholders who will meet in March 2003 to consider ways of dataing the best to meet the identified uses of the survey.

ChErP has had a number of papers published and accepted for publication, including:


Queensland’s School of Population Health. Dr Warren Stanton has taken a research fellow position with The University of Dr Alexandra Clavarino left the Centre in December 2002 and on secondment for four months. Promotion Officer from the Wheatbelt Health Region is at the now based at Edith Cowan University. Kerry Tumak, Health Senior Research Fellow, has moved out of the CBRCC and is as a new Research Fellow in late 2002. Dr Nadine Henley, The CBRCC welcomed into its clutches Dr Owen Carter


The CBRCC welcomed into its clutches Dr Owen Carter as a new Research Fellow in late 2002. Dr Nadine Henley, Senior Research Fellow, has moved out of the CBRCC and is now based at Edith Cowan University. Kerry Tumak, Health Promotion Officer from the Wheatbelt Health Region is at the Centre on secondment for four months.

Dr Alexandra Clavarino left the Centre in December 2002 and has taken a research fellow position with The University of Queensland’s School of Population Health. Dr Warren Stanton resigned from his fractional appointment at the Centre in January 2003.

CPRC and Queensland Health sponsored a workshop on 13 February 2003, titled “Increasing people’s daily physical activity for health, social and environmental benefits”. This workshop preceded the Australian Society Behavioural Health and Medicine Conference and attracted 80 participants.

The speakers were Dr Lawrence Frank (Georgia Institute of Technology), Professor James Sallis (San Diego State University), Dr J Salmon (Deakin University), Associate Professor Billie Giles-Corti (University of Western Australia) and Professor Neville Owen (CPRC).

Thanks to Kerri Beckman (CCCR and TCRE), Narelle Mills (ChirPR), Owen Carter (CBRCC) and Cathy Swart (CHPCPR) for contributions to this report.

NEWS

New report on reform of cancer care

A blueprint for the reform of cancer care in Australia - Optimising Cancer Care in Australia - was launched in Sydney on World Cancer Day (4 February).

The collaborative report was prepared by the Clinical Oncological Society of Australia (COSA), The Cancer Council Australia, and the National Cancer Control Initiative (NCCI), with input from and the full support of consumer groups. It provides the Federal Minister for Health and Ageing and her state and territory counterparts with a national model for cancer care.

The chair of the steering committee that developed the consultative report, Professor Lester Peters, said the blueprint had emerged from a process of wide consultation with consumers, health care professionals, and policy-makers.

“Its essential message is that while cancer survival in Australia compares well with world standards, we could be doing much better in the way the services are provided,” he said.

“To achieve the best possible outcomes, we need to improve the entire cancer journey so that people can access appropriate care for their individual needs at all stages of their illness, in a coordinated and timely fashion.

“We’re proposing a new approach to cancer care in this country, with services organised around the patient.”

The report sets out three key areas where change is needed: the models of care (relating to the way care is provided and by whom, keeping in mind Australia’s unique geography and demographic); quality of care (including ensuring it is evidence-based); and resource issues (including workforce shortages, skills development, and patient access to services).

It contains 12 key recommendations addressing quality, access and resource issues, plus a proposed strategy for implementation. A further 19 action items are also listed.

The document proposes a national task force be set up to drive the reform process. Recommendations in the report will need to be assessed, costed and prioritised.

Copies of the report are available online at the NCCI website: www.ncci.org.au

Australia’s Biggest Morning Tea – hosts set to raise their cups again in May

Now in its tenth year, Australia’s Biggest Morning Tea (ABMT) looks set to capture the attention of thousands of participants yet again this May with 40,000 Australians expected to host morning teas.

The Cancer Council Australia’s member organisations are already working hard to ensure the popular event – scheduled for 22 May – is a success, and the national target of $6 million is reached.

A new creative campaign will launch ABMT in April. Anyone interested can register as a host from March onwards via the new look website at www.biggestmorningtea.com.au or by calling 1300 65 65 85.

Hosts will receive a kit containing posters, Bushells tea bags, a donation box and other materials to ensure their morning tea is a huge success.
National conference to focus on investment in tobacco control

The case for greater long-term investment to reduce smoking rates will be the focus of a national conference to be hosted by The Cancer Council Victoria in April. Delegates will hear from a group of international and Australian speakers at the 2nd Australian Tobacco Control Conference, to be held in Melbourne from 9-11 April 2003. Leading international tobacco control experts including Dr Michael Cummings and Dr Frank Chaloupka from the US, Dr Ann McNeil from the UK and New Zealand’s Professor Alastair Woodward will present keynote addresses.

A number of high profile Australian speakers will also be giving keynote addresses, including Australian Competition and Consumer Commission Chair Professor Allan Fels, and Professor Simon Chapman.

Lawyer Gordon Slater from Slater and Gordon will also give a keynote address about tobacco litigation and his firm’s representation of Ralph McCabe in her lawsuit against tobacco company British American Tobacco Australia.

The conference aims to show that tobacco control measures – like helping smokers quit and reducing the health effects of passive smoking – are one of the best investments communities can make to enhance their health – and their economic wellbeing. It will also focus on new marketing tactics of the tobacco industry.

Full details about the conference themes and program can be found at http://tobaccocontrol03.conference.net.au

In the news – prostate cancer testing

Debate about the pros and cons of testing for prostate cancer has been in the headlines in recent months.

The Cancer Council Australia’s position on this issue – that the debate to be tested is one to be made by individual men, on the basis of informed consent – is stated in a letter from CEO Alan Coates on its website (www.cancer.org.au). The Cancer Council’s National Cancer Prevention Policy, which has a chapter on prostate cancer, is also available in the ‘publications’ section of the website.

Launch of CAN Australia

A new national cancer advocacy group was launched on World Cancer Day (4 February).

CAN Australia (Cancer Alliance Network) brings together consumers, carers, clinicians and policy-makers to identify and work together on shared issues of concern.

Interim Chair Mr Russell McGowan says CAN recognises that not just individual consumers but also consumer and advocacy groups need to network.

“One benefit in bringing these groups together nationally is for them to collectively identify areas that would make a real difference to the burden of care for individuals and their families,” he says.

A fundamental principle behind the new non-government organisation is consumer participation in cancer services.

“Consumer uses services extensively and are often in a good position to identify how to produce better health outcomes,” Mr McGowan says.

Other members of the interim CAN committee are Dr Don Baumbier, Ms Marina Beach, Dr Liz Kenny, Mr Clive Deverral, Ms Merrin Oliver-Weymouth, Ms Emma Sayers, Ms Lyn Swinburne, and Professor John Zalcberg.

The launch of CAN Australia is welcomed by The Cancer Council Australia and COSA.

For more information about CAN, including an ‘expression of interest’ form, contact the Secretariat (Julie Claessens and John Ikubas) at jnj@bigpond.net.au

Common cause for prevention

The Cancer Council Australia has joined with four other major health-related NGOs to form the Australian Chronic Disease Prevention Alliance (ACDPA).

Other Alliance members are the Australian Kidney Foundation, Diabetes Australia, the National Heart Foundation of Australia and the National Stroke Foundation.

Its first focus will be to promote primary disease prevention through increased exercise and a healthy diet, especially the consumption of vegetables and fruit. These measures have the potential to reduce the incidence of all the disease types represented in the Alliance.

The Alliance has received seed funding from the Commonwealth, and established a joint secretariat in the National Heart Foundation of Australia. It will work closely with the relevant inter-government bodies, the Strategic Intergovernmental Nutritional Alliance (SIGNA), and the Strategic Intergovernmental Forum on Physical Activity and Health (SIGNAPH), as well as with the Cancer Strategies Group and the corresponding specialist committees for the other disease types.

It is encouraging to note that the Commonwealth Government has recently given higher prominence to disease prevention – now known as the ‘fourth pillar’ together with the MBS, PBS and the Commonwealth/state agreement on hospitals) of health care in Australia. Hopefully resources will follow the rhetoric.

National Breast Cancer Hospital Services Directory

The first directory of breast cancer services provided by private and public hospitals around Australia is available online.

It enables women and GPs to search by service, hospital, area, or postcode.

The directory was developed by the National Breast Cancer Centre with the support of consumer groups, medical colleges, government bodies, divisions of general practice and public and private hospital organisations.

The directory can be found at www.isourcexdirectory.com/hospitals/

Parliamentary briefing – Eat and Run

The links between cancer and nutrition, obesity and physical activity were the theme of the first meeting in 2003 of The Cancer Council Australia’s Parliamentary Cancer Information Network.

It is estimated that between 30-40% of cancers could be prevented by appropriate diet and adequate physical activity.

Speakers Terry Slavin, Chair of The Cancer Council’s Nutrition and Physical Activity Committee, and Dr Dallas English, Associate Director of The Cancer Council Victoria’s Cancer Epidemiology Centre, addressed federal MPs at the breakfast meeting at Parliament House in Canberra.

Cancer Foundation of WA

Susan Rooney

The Cancer Foundation of WA appointed Ms Susan Rooney as its new Chief Executive Officer in April 2002, following the resignation of Mike Daube.

Ms Rooney has had extensive high-level experience in the leadership and management of non-government community organisations, having served as executive with the Fire and Emergency Services Authority, the Sydney Anglican Retirement Villages, Rehabilitation Tasmania and the Royal Blind Society – NSW. In each of these positions she has successfully implemented major change management programs.

Ms Rooney has a health background in physiotherapy, graduating from Curtin University. She has since completed a MBA from the University of WA and the Advanced Program in International Management at the Copenhagen Business School.

The Cancer Council Victoria

Professor David Hill AM

Before becoming Director of The Cancer Council Victoria, Professor David Hill – a behavioural scientist – was founding Director of the Cancer Council of Victoria’s Centre for Behavioural Research in Cancer.

Prof Hill is a Professorial Fellow at the University of Melbourne, an Adjunct Professor at Deakin University and an Honorary Professor at Monash University. In 2001, he was made a Member of the Order of Australia (AM) for “services to the promotion of community health, particularly in the development of cancer awareness and prevention programs”.

Prof Hill, who received his PhD in psychology from the University of Melbourne, has authored or co-authored over 200 scientific articles and reports in the medical, public health and psychological literature. His published work includes research on the prevalence of adolescent and adult smoking, strategies for smoking cessation, reduction of smoking uptake, smoking regulation, behavioural aspects of screening mammography, management of primary operable breast cancer, efficacy of breast self-examination, monitoring trends in skin cancer prevention, and exploring determinants of behaviours related to skin cancer prevention.

In 1990 he chaired the International Union Against Cancer project on behavioural sciences, and was Secretary to the 1996 World Conference for Cancer Organisations. He holds senior positions on major national committees, including the NHMRC Health Advisory Committee.

Prof Hill has been successful in winning research grant funds in the NHMRC’s national competition, including as a member of teams of Principal Investigators which have been awarded grants totalling over $10m in 2001 and 2002.

In 1996, the Federal Minister for Health invited him to chair the Ministerial Tobacco Advisory Group to establish the first comprehensive national anti-smoking campaign launched in Australia. He is now chairman of the National Expert Advisory Committee on Tobacco, which is responsible for the National Tobacco Strategy to which all states and territories committed in June 1999.

Prof Hill’s appointment followed the resignation of Professor Robert Burton, who had been Director of The Cancer Council Victoria from December 1995.

Queensland Cancer Fund

Dr Jeff Dunn

Dr Jeff Dunn took up the position of Executive Director at the Queensland Cancer Fund in January 2003, upon the retirement of Mr Graeme Brien. Dr Dunn is only the third person to hold this office in the 41-year history of the Queensland Cancer Fund, and brings to the role substantial experience.

Dr Dunn has been a staff member of the Queensland Cancer Fund since 1989, filling the role of Director of Community
Services, a department that incorporates the Prevention and Early Detection Unit, Cancer Support Services, the Cancer Helpline and more recently, the Cancer Advocacy Program. While developing and managing these areas, he has also fulfilled key roles nationally with the Cancer Council Australia and internationally with the International Union Against Cancer. In this regard, Dr Dunn has worked extensively in supporting the development of cancer support programs in South East Asia.

Dr Dunn holds a PhD in sociology and maintains academic appointments as Adjunct Professor, School of Social Science, and Associate Professor, School of Population Health both at the University of Queensland. In addition, he is the Chairman of the Board of Management of the Queensland Cancer Fund-G Griffith University Collaborative Centre for Psychosocial Oncology – a project located in the Griffith University School of Applied Psychology.

Dr Dunn has a long commitment to volunteering, with a special interest in intellectual disability. As well as his cancer-related volunteer work, for the past 14 years he has worked as a volunteer in support of people with an intellectual disability.

The July edition of Cancer Forum will profile The Cancer Council South Australia’s CEO, Associate Professor Brenda Wilson, The

REACHING FOR THE STARS – a profile of Professor Lester Peters, winner of the 2002 MOG/ Pierre Fabre Cancer Achievement Award

One of Australia’s leading cancer specialists could have been lost to the cosmos. As a young boy in country Queensland, Lester Peters wanted to be an astronomer when he grew up.

“I was all set to go into the science faculty – I’d planned to become an astronomer,” he says. “But a family friend told me I was mad, that I’d never have any job options – I should do medicine, and if I wanted I could use that background to become a physicist or engineer.

But once Professor Peters, 60, started medical school, there was no going back – he soon became excited about a career in medicine. He decided on oncology – radiation oncology – which in the late 1960s was the only medical specialty related exclusively to cancer.

“I became fascinated with cancer as a disease – it was such a mystery at the time and most of the treatments seemed empirical. I was strongly motivated to get involved in research,” he says.

After registrar training in Brisbane, Professor Peters won a scholarship to do research work at the Gray Laboratory in the UK, which at the time was the leading radiobiology lab in the world. Four years later, with no possibility to pursue radiobiology further in Australia, he joined the prestigious MD Anderson Center in Houston for a mix of clinical and lab work.

In 1982, the chair of the radiotherapy department at MD Anderson retired, and the position was offered to Professor Peters. He stayed in this role until 1995, during which time he became internationally recognised as a leader in academic radiation oncology. At age 53, he was lured back to Australia – with his Australian wife and two children – by the creation of the first professional post in radiation oncology at the University of Melbourne at the Peter MacCallum Cancer Institute.

A year after taking up this position, he started work on research which he considers the jewel in his crown of his career.

Professor Peters and Peter Mac colleague Dr Danny Rischin, a vascular oncologist, envisaged the potential for a new treatment approach to advanced head and neck cancer while going through some pre-clinical work. Their idea was to use the triple combination of tirapazamine, cisplatin and radiotherapy. Tirapazamine is a currently unlicensed prodrug that is selectively toxic to tumour cells starved of oxygen. In experimental tumour systems, it has been shown to enhance the effect of both radiotherapy and cisplatin. Drs Rischin and Peters persuaded the company that owned the patent on tirapazamine to let them conduct an exploratory study of the triple combination.

Although this Phase I trial was aimed at simply developing a suitable treatment protocol for further testing, the results were unexpectedly good – of the 16 patients who were near the end of the road with advanced disease, 14 had durable local eradication of their disease and 11 were long term survivors.

“This was an unheard of result in my experience and I’ve worked almost exclusively in head and neck cancer for the past 20 years, so I’ve treated a lot of patients. This was definitely worth pursuing further,” Prof. Peters says.

A Phase II trial involving 123 patients then went ahead under the banner of the Trans-Transa Radiation Oncology Group (TROG) combining the combination therapy with a more standard form of chemo-radiotherapy. Preliminary results of the Phase II trial confirmed the excellent results achieved in the Phase I study and showed that patients taking the experimental therapy fared substantially better than those receiving standard therapy.”The survival rates were very good compared with anything seen before.”

Professor Peters and Dr Rischin are now leading an international Phase III registration trial which will involve 550 patients in 83 centres worldwide, including 13 in Australia and New Zealand. Interim results of this trial should be available in about 2-1/2 years.

At the beginning of 2002, Professor Peters resigned his position as Director of Radiation Oncology at Peter Mac to take on the responsibility of setting up a new Foundation to support the strategic goals of the Institute. More recently, he was elected Dean of the Faculty of Radiation Oncology.

The MOG/Pierre Fabre Cancer Achievement Award recognises a lifetime of achievement in the field of cancer. Last year’s winner was Emeritus Professor Tom Reeve AC CBE, Executive Officer of the Australasian Cancer Network.
Bladder cancer is expected to be superseded in the not too distant future. Although it is likely that the information they contain will be useful reading for radiation oncologists in training, or specialists wishing to gain a quick refresher on the current place of radiation oncology in urological cancer care, it is likely to lose its currency in the short to medium future.

G Duchesne
Peter MacCallum Cancer Institute
Melbourne, Vic

ENCYCLOPEDIA OF CANCER
2ND EDITION

J Bertino
Published by Elsevier Science (2002) ISBN: 0-12-2261-1, 2,800 pages
RRP: $1,568.60

The revised encyclopaedia now contains four rather than three volumes to accommodate the advances in cancer research in 220 articles. Typically of less than 12 pages each, they cover a range of topics from molecular biology and genetics to epidemiology and cancer treatment. The authorship is predominantly, but not exclusively, North American. The encyclopaedic format, which arranges articles in alphabetical order by title, is somewhat artificial depending on how the title is phrased. Although the results in succeeding articles often bear no relationship to each other, navigation through the volumes is made easier by the contents grouped by subject as well as listed in alphabetical order. It has an excellent index of over 7,500 entries and at the end of each article many of the entries are cross-referenced to other chapters. The format of each article, which contains a glossary, outline and defining paragraph to begin, enhances the ease of access to the information contained.

The strength of this reference is the excellent overview summaries of the state of knowledge of tumour biology including cell cycle checkpoints, signaling pathways growth factors and cytokines, which are concise and easy to comprehend. They are referenced categorically to a few selected recent references for further reading rather than an extensive bibliography, which is clearly the editorial policy of this collection. Chapters on cancer genetics, angiogenesis, oncogenes, immunology and carcinogenesis complete a comprehensive overview of basic cancer biology. The chapters on treatments include biological therapies and immunotherapies chemotherapy and radiotherapy with radiobiology and photodynamic therapy. Specific articles highlight the development and mechanisms of action of commonly used chemotherapeutic agents while a dozen articles form a useful review of the mechanisms of drug resistance. There is also a section on updates on chemoprevention. The brevity of the chapters on specific tumours means that they are of limited use in discussing treatment options in any detail, which is clearly not the focus of this collection and is better reviewed in other oncological texts. But aetiology and risk factors, when supported by the information in the basic biology chapters, are well covered. A small section on tumour imaging covers the more recent techniques of MRI, MRS and PET scanning. The editorial staff have minimised the amount of duplication despite the large number of authors, and when this does occur it examines the issues from a different viewpoint and tends to reinforce and clarify the concepts being presented.

This is an up-to-date reference that provides an excellent overview of multiple areas of the rapidly expanding field of tumour biology, while relating this to the aetiology, diagnosis and management of cancer. It will be a useful initial reference on a wide range of topics for cancer clinicians and researchers.

In Oliver
Professor of Cancer Care
University of Adelaide, SA

GENETIC DISORDERS OF ENDOCRINE NEOPLASIA

P Dahia et al
RRP: US$239.25

The main focus of the text is genetics of endocrine neoplasms. Editors, Patricia Dahia and Charis Eng, together with individual chapter authors are renowned for their research in this field. Since the identification of germline mutations for RET mutations responsible for Multiple Endocrine Neoplasia type 2 (MEN2) in 1993, there have been rapid advances in our understanding of the molecular basis for this group of conditions. In addition to expanding our understanding of the disease pathogenesis, the availability of molecular testing allows accurate information for family members, which influences medical care and management. This text provides a state of the art review on the molecular basis of inherited neoplasia, including its relevance to clinical practice. In addition to the previously well-characterised disorders such as MEN1, MEN2, and Von Hippel-Lindau disease, the text provides a comprehensive review on other conditions of emerging clinical importance such as hamartoma and lentiengues syndromes.

The introduction entices us into the body of the text by providing a brief, but interesting clinical and molecular overview of the inherited endocrine neoplasia syndromes, which are each covered in more depth in the following chapters.

The first chapter provides a succinct outline of fundamental concepts relating to cancer genetics in addition to more complex areas of importance such as gene mutation, imprinting, single-nucleotide polymorphisms (SNP) analysis, CDNA microarrays and proteomics with comprehensive referencing. The second chapter on the identification and referencing of techniques for cloning disease-associated genes, which although clearly written, is aimed at an audience with some background knowledge of molecular genetics.

The following chapters include the clinical and molecular aspects of MEN1, MEN2, Von Hippel-Lindau disease, Carney Complex, and Conn’s and Carney’s syndrome. Jannayan-Riley-Ruvalcaba, Juvenile polyposis, and Peutz-Jeghers syndromes. Large sections of the book are devoted to describing gene organisation, function and signalling pathways, which may be of particular interest to individuals with a strong molecular background or research interest. For the more clinically orientated reader, the molecular sections would serve as excellent reference material.

However, the sections covering clinical presentations, diagnosis, management of family members, treatment, genotype/phenotype correlation and molecular testing in individuals with apparently sporadic endocrine neoplasias are well presented. Potential knowledge for specialist endocrinologists or cancer geneticists working in this field. The text is well researched, referenced and indexed. The content detail makes this a specialist text, which would be of valuable addition to an endocrinology, oncology or clinical genetics department library.

T Dudding
Hunter Genetics
Waratah, NSW

HANDBOOK OF GYN ONCOLOGY

Santoso & Coleman
RRP: A$77.95

This handbook was designed for the use of medical students, residents and fellows. In the preface, the authors state their aim that “readers will use this Handbook of Gyn Oncology as a guide to test-taking, but should not replace the standard textbooks and good clinical judgement”. The book meets its brief thoroughly and is a good quick reference source for those caring for gynaecological oncology patients. As a portable resource it would enable residents to cram in the early hours of the morning prior to the arrival of senior medical staff for a ward round. Its size leads you to believe the book was designed for a white coat pocket. However, Australian residents and fellows no longer wear white coats and may find it difficult to know where to keep their book.

There are separate brief chapters for each tumour site with the management recommendations being sound, well referenced and up-to-date. Current concepts such as sentinel node biopsy for vulval and cervical carcinomas for cervical cancer are covered. There is also a balanced coverage of controversial issues, for example, lymphadenectomy in endometrial cancer, though the recommendations for bimanual examination, only surgical management and do not cover the modern medical and palliative care approaches.

A major criticism would be the disproportionately large amount of space dedicated to the diagnosis and management of breast cancer in all its forms. It is not clear why this imbalance exists, but it is an area of concern. If you need to review some aspects of breast cancer diagnosis and management, this handbook provides a comprehensive resource.
Book reviews

MANUAL OF BREAST DISEASES
J Jatoi (Ed)
Published by Lippincott Williams & Wilkins (2002)
ISBN: 0-7817-2950-5, 538 pages plus index
RPP: AS151.80

I would highly recommend this manual for any medical specialist working in the field of breast diseases. It is, as titled, a manual and therefore perfectly sized as a desktop book for quick and ready reference. It covers such a broad range within the field of breast cancers that there will undoubtedly be areas of interest even for the super-specialised breast clinician, be they a surgeon, oncologist, pathologist or radiologist. For its size, it is surprisingly comprehensive. At the present time, it’s also current and evidence-based and hopefully it will remain so with subsequent editions.

The first few chapters deal with non-malignant disease, which is refreshing to see in a text like this. The anatomy and physiology is covered reasonably comprehensively as well as the design conditions such as nipple discharge and mastalgia. There is even a chapter on management of common lactational problems and breastfeeding. This is a useful chapter, which is omitted from many books. There is an excellent practical advice about the management and evaluation of breast masses and the supporting data for that rationale. There is also an excellent overview of the risk factors (HRT etc) and the epidemiology of breast cancer. While this is pre the National Women’s Health Study, it is, not unexpectedly, fairly close to the mark. There is a number of chapters dealing with the principles of breast cancer screening, diagnostic imaging and newer techniques, which is a useful read for the clinicians amongst us. Pathology is dealt with in chapter 11, though there is a slight North American bias and not much information on less common pathologies like phylides. Surgery for primary invasive breast cancer has an historical introduction, which as the chapter title suggests, deals only with surgery (no mention of Breasto or McQuirt). These are all excellent statements regarding the surgical management of breast cancer, but I am perhaps being a little more pedantic here, having a surgical background. Overall, the author of this chapter, who is also the editor, has a balanced approach, in particular with dealing with issues of the management of the axilla and sentinel node biopsy.

There are then two excellent chapters on adjuvant systemic therapy and the role of radiation therapy, which is evidence-based overviews and reasonably current. Metastatic cancer is also well dealt with in chapter 17 and if you have the strength for it, then the super-specialist breast clinician, be they a surgeon, oncologist, pathologist or radiologist. For its size, it is surprisingly comprehensive. At the present time, it’s also current and evidence-based and hopefully it will remain so with subsequent editions.

At AS151.80, I think it represents fairly good value in terms of its content, though don’t expect too much in terms of presentation, as it is a soft cover manual. I think that’s what makes it so accessible however, and I was able to read it from cover to cover.

O Ung NSW Breast Cancer Institute Westmead, NSW

PANCREATIC CANCER
R Pollock
Published by Springer (2002)
ISBN: 0-387-95187-7, 405 pages plus index
RPP: US$169.00

Pancreatic Cancer, which is part of the MD Anderson Solid Tumour Oncology Series, is an extremely worthwhile reference book for clinicians involved in the management of pancreatic cancer. The book introduces the reader to the current understanding of the molecular pathways thought to be important in the carcinogenesis of pancreatic cancer. The hope is that these molecular markers may one day be used to identify patients with ‘early' pancreatic cancer amenable to curative surgery. Chapters dealing with the surgery of pancreatic cancer and the literature that supports current practices then follow this. The emerging role of endoscopic ultrasound in diagnosis and staging of pancreatic cancer is discussed, together with radiological and laparoscopic staging in comparison to the lesser role that ERCP is playing in diagnosis.

The factors responsible for the marked improvement in morbidity and mortality of the Whipple procedure have led to discussion of patient selection and referral to centres of specialisation for this type of surgery. Some technical aspects of surgery are compared, pylorus preserving versus non-pylorus preserving pancreaticoduodenectomy and techniques of reconstruction. The role of more aggressive surgery including nodal and circumferential resection for pancreatic head tumours is discussed as well as surgery for peripancreal, body and tail of the pancreas tumours.

The next section discusses the results of adjuvant and neoadjuvant chemotherapy trials and their differing regimes and modes of delivery. The experience of various centres involved in the development of adjuvant therapies is presented and their results discussed with a view to the running of future randomised trials.

The final section on emerging therapies takes one on a journey beginning in the laboratory with experimental models of pancreatic cancer. They are used to test the potential of various novel therapies, which may eventually be translated into the clinic. In summary, pancreatic cancer poses a difficult management problem for clinicians. An understanding of tumour biology by clinicians will assist with the introduction of these new therapies into clinical practice. This book will undoubtedly achieve its intended aim.

D Fenton-Lee

NSW Breast Cancer Institute Westmead, NSW

Some people also need a lot of support in their fight against cancer – friends, family and health professionals alike. Once the diagnosis is made and the patient has been through the various stages of treatment, it is common practice for patients to join support groups so that they can share their experiences and receive moral support. Support groups can be very valuable in helping people to cope with the emotional and physical effects of cancer.

New patient support groups are being set up all the time, and it is important to find one that is right for you. It is often helpful to attend more than one support group to find the one that suits you best.

When you are looking for a support group, you may want to consider the following:

- **Size of the group**: Smaller groups may be more intimate and easier to get to know people, while larger groups may provide more resources and opportunities for discussion.
- **Location**: Choose a support group that is convenient for you to attend.
- **Frequency of meetings**: Some support groups meet weekly, while others meet monthly or less frequently.
- **Type of support**: Some support groups focus on specific aspects of cancer, such as chemotherapy or radiation therapy, while others provide general support.
- **Cost**: Some support groups are free, while others may charge a fee.

By attending a support group, you can connect with others who are going through similar experiences, exchange information, and gain a sense of hope and support.
conquer those odds?” to reluctant acceptance that she would not (“So – that’s it. She’s dying. As they all say. She can stop acting now. I can see.”

Sonia Orchard wrote this book for herself – as an outlet for her grief in the months following Emma’s death – and for the young son she left behind. It may not be recommended reading for people who have cancer or those caring for them, as it is unapologetically honest in its portrayal of a woman’s physical and mental demise following diagnosis – and the anguish that she and those who love her go through as the disease progresses and after her death. But as someone who works in the field but has been lucky enough not to have someone close to me die from cancer, I found it an enlightening and moving insight into the cancer journey.

J Debois
The Cancer Council Australia
Sydney, NSW

**TUMOUR THE ANATOMY AND CLINICS OF METASTATIC CANCER**

J Debois
Published by Kluwer (2002)
RRP: US$230.00

Is your desk neat and tidy? Are all your articles filed away? This text will appeal to all those who have obsessive tendencies, and anatomists. It is an encyclopaedic work that examines in great detail the pattern of metastatic disease in a variety of cancers. The book is divided into two parts: (i) the metastasis and its primary, and (ii) the primary and its metastases. Chapters are arranged according to organs or organ groups, and within each chapter, the logical order of discussion is preserved: anatomical pathways, incidence, symptoms and diagnosis. More common situations such as metastases to the liver are treated in more depth, with subheadings such as imaging and special situations (eg ruptured liver metastases) included. An extensive bibliography pertaining to the relevant organ is listed at the end of each chapter. References are up-to-date (circa 2000) and contains some very complete reviews on various aspects of virology as it relates to cancer. I see clearly that my own understanding of this field was very superficial. Having waded through this text I am not sure that I am any better informed, but I am encouraged that so much work has been done and new advances have been made. As we understand these processes better we will be more able to devise appropriate therapies for cancers, even those that are not related directly to viruses.

This book is an impressive and heavy volume of 524 pages and contains some very complete reviews on various aspects of virology as it relates to cancer. I see clearly that my own understanding of this field was very superficial. Having waded through this text I am not sure that I am any better informed, but I am encouraged that so much work has been done and it is handy to have access to a reference such as this. Some of the authors have really gone overboard, with more than 500 references for several chapters. I have not checked them all for accuracy. This level of detail means that the book will be more useful as a reference text for those in the field or those who need a high level of detail. Other more superficial reviews would be more suitable for weekend viro-enthusiasts.

The book is most useful where it describes the mechanisms of interaction of viral gene products with known cellular factors such as those involved in cell cycle regulation. There are intriguing chapters on the biology of agents such as human herpesvirus-8, a relatively newly described virus involved in primary effusion lymphomas and in Kaposis’ sarcoma. Some of the later chapters of the book cover areas relating to vaccine design, with particular reference to human papilloma virus and including a discussion on VLPs, but I was disappointed to find that Ian Frazer’s work was not discussed here.

The final chapter covers the use of adenoviruses in gene transfer approaches to cancer, an odd chapter given that it covers a wide range of genes very comprehensively but restricts itself to only one vector.

All in all, this book on viruses is not to be sneezed at. Now, if only someone would invent an administrator vaccine…
26-28 30th COSA Annual Scientific Meeting  
Perth WA  
Ruth Lilian  
Pharma Events  
PO Box 265  
Amandala NSW 2038  
Tel: +61 2 9280 0577  
Fax: +61 2 9280 0533  
Email: conferences@pharmavents.com.au

2003  
April  
25-29 18th World Conference on Health Promotion and Health Education  
Melbourne VIC  
Conference Manager  
Tel: +61 3 9667 1313  
Fax: +61 3 9667 1375  
Email: jbernier@iosi.ch

August  
4-8 International Society for Nurses in Cancer Care 13th International Conference on Cancer Nursing  
Sydney NSW  
MP Events  
Tel: +61 3 9852 9941  
Fax: +61 3 9852 9961  
Email: enquiries@mpevents.com.au

November  
24-26 31st COSA Annual Scientific Meeting  
Canberra ACT  
Clinical Oncological Society of Australia  
GPO Box 4708  
Sydney NSW 2001  
Ph: +61 2 9036 3100  
Fax: +61 2 9036 3101  
Email: cosa@cancer.org.au

CALENDAR OF MEETINGS – International

<table>
<thead>
<tr>
<th>Date</th>
<th>Name of Meeting</th>
<th>Place</th>
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<tr>
<td>March</td>
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| 16-19      | ICTR 2003: 2nd International Conference on Translational Research and Pre-Clinical Strategies in Radiation Oncology | Lugano Switzerland | Jacques Bernier  
Oncoogy Institute of Southern Switzerland  
San GiovanniHospital  
Bellinzona – CH-6504, Switzerland  
Fax: +41 91 820 9044  
Email: bernier@jbc.ch  
Website: www.ogc.ch/intrc2003.html |
| 23-27      | 23rd Modern Brachytherapy Techniques | Cairo Egypt       | ESTRO Office  
avenue E. Mounierlaan 83/12  
1200 Brussels  
Tel: +32 2 775 9340  
Fax: +32 2 779 54 94  
Email: estro@estro.be  
Website: www.estro.be |
| April      |                                                                                |                  |                                                 |
| 2-5        | 8th Congress of the European Association for Palliative Care | The Hague The Netherlands | KENCES International  
PO Box 50006  
Tel Aviv – 61500, Israel  
Tel: +44 20 9800 0488  
Fax: +44 845 127 5944  
Email: eapc@kenes.com |
| 5-9        | 94th American Association for Cancer Research (AACR) Annual Meeting | Toronto Canada   | AACR  
Philadelphia, Pennsylvania, USA  
Fax: +1 215 351 9165  
Email: meetings@aacr.org  
Website: www.aacr.org |
| 23-27      | 6th World Congress in Psycho-Oncology | Banff Canada      | Congress in Psycho-Oncology  
Email: banffcongress@cancerboard.ab.ca  
Website: www.capoa.ca |
| May        |                                                                                |                  |                                                 |
| 1-4        | Oncology Nursing Society 28th Annual Congress | Denver USA       | Oncology Nursing Society  
Meeting Services Team  
Pittsburgh, Pennsylvania, USA  
Fax: +1 412 921 6565  
Email: member@ons.org  
Website: www.ons.org |
| 4-8        | Radiation Oncology: A Molecular Approach | Tenerife Spain   | ESTRO Office  
avenue E. Mounierlaan 83/12  
1200 Brussels  
Tel: +32 2 775 9340  
Fax: +32 2 779 54 94  
Email: estro@estro.be  
Website: www.estro.be |
| June       |                                                                                |                  |                                                 |
| 1-3        | 2nd ESTRO Workshop on Biology in Radiation Oncology | Berg en Dal V Nijmegen The Netherlands | ESTRO Office  
avenue E. Mounierlaan 83/12  
1200 Brussels  
Tel: +32 2 775 9340  
Fax: +32 2 779 54 94  
Email: info@estro.be  
Website: www.estro.be |
| 1-5        | Imaging for Target Volume Determination in Radiotherapy | Nice France       | ESTRO Office  
avenue E. Mounierlaan 83/12  
1200 Brussels  
Tel: +32 2 775 9340  
Fax: +32 2 779 54 94  
Email: info@estro.be  
Website: www.estro.be |
| 19-22      | National Conference of Cancer Self Help Groups Annual Conference | Manchester UK | Andrea Oz  
National Conference of SelfHelp Groups  
107 Croswater Road  
London SE26 7RD  
Tel: +44 20 8656 7520  
Fax: +44 20 8656 7910  
Email: nchsghaol.com |
| 19-28      | 23rd Congress of the International Society of Chemotherapy | Durban South Africa | International Society of Chemotherapy  
University of Natal of Durban  
Dept of Medical Microbiology  
Congoella, South Africa  
Fax: +2731 206 4431  
Email: sturm@med.un.ac.za |
| 22-26      | IMRT and Other Conformal Techniques in Practice | Amsterdam The Netherlands | ESTRO Office  
avenue E. Mounierlaan 83/12  
1200 Brussels  
Tel: +32 2 775 9340  
Fax: +32 2 779 5494  
Email: info@estro.be  
Website: www.estro.be |
| August     |                                                                                |                  |                                                 |
| 3-8        | 12th World Conference on Tobacco or Health: Global Action for a Tobacco Free Future | Helsinki Finland | Dr Lisa Elavarium, MD  
Secretary Gen  
Cancer Society of Finland &  
Pro Finsish Center for Health Promotion  
Helsinki, Finland  
Fax: +358 9 135 1093  
Email: lisa.elavarium@cancer.fi |
| 10-14      | 18th World Conference on Lung Cancer | Copenhagen Denmark | International Conference Services  
Vancouver, Canada  
Fax: +1 604 681 1049  
Email: franciskajmeet-ccs.com  
Website: www.2003worldlungcancer.org |
January
26-28 40th Annual Meeting of the Society of Thoracic Surgeons
San Antonio Texas USA
Fax: +1312 527 6635
Email: stsgdaa.com

March
18-21 57th Annual Cancer Symposium of the Society of Surgical Oncology
New York City New York USA
Fax: +1847 427 9656
Email: diannekubis@acaai.org
Website: www.surgonc.org

27-31 95th Annual Meeting of the American Association for Cancer Research
Orlando Florida USA
Fax: +1 215 351 9165
Email: meetings@aacr.org
Website: www.aacr.org

April
29 April – 2 May 29th Annual Congress
ONS, Meeting Services Team
3042 Westlake Avenue South
Suite 200
Seattle, WA 98121
USA
Fax: +1412 921 6565
Email: meetings@ons.org
Website: www.ons.org

October
8-11 SIOP 2003: International Society of Paediatric Oncology
Cairo Egypt
Fax: +31 (0)20 5040 225
Email: siop@congrex.nl
Website: www.congrex.nl

November
2-7 XVI FIGO World Congress of Gynecology and Obstetrics
Santiago de Chile Chile
Fax: +852 2818 0232
Email: mededcon@hku.hk
Website: www.hkicc.org

12-16 Basic Clinical Radiobiology
Santorini Greece
Fax: +32 2 779 5494
Email: info@estro.be
Website: www.estro.be

19-23 45th ASTRO Annual Meeting (American Society for Therapeutic Radiology and Oncology)
Salt Lake City Utah USA
Fax: +1 703 502 7852
Email: meetings@astro.org
Website: www.astro.org

December
3-6 27th Annual San Antonio Breast Cancer Symposium
San Antonio Texas USA
Fax: +1210 949 5009
Email: meetings@sabcs.org
Website: www.sabcs.org
THE CANCER COUNCIL AUSTRALIA

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

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THE CLINICAL ONCOLOGICAL SOCIETY OF AUSTRALIA INC

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

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

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GPO Box 4708, Sydney, NSW 2001.

Membership fees for 2003
Ordinary Members: $140
Associate Members: $80
(includes GST)

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Paediatric Oncology
(ANZ Childhood Cancer Study Group)
Palliative Care
Pharmacy
Psycho-Oncology
Radiation Oncology
Regional and Rural Oncology
Social Workers
Surgical Oncology