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Recent Developments in Cancer Nursing

OVERVIEW

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Over the past few decades, cancer nursing services have developed in response to major scientific and technological advances in the treatment and support for people with cancer. Cancer nursing services today are widely regarded as an essential component of a safe, quality cancer care system, with nurses making a vital contribution to the prevention and reduction of physical and psychological morbidity associated with a cancer diagnosis and the process of cancer treatment.

Like most health professions, the way in which nursing services contribute to improving the cancer experience and optimising the outcomes of cancer care is undergoing significant change. This change is being driven by many factors. In particular, the imperative to reform cancer services to create a system that is more person-centred is requiring that all health professions, including nurses, re-consider their practices and systems of care, as well as the nature of the relationships between the various cancer care professionals and with their patients, family members and community members. With its strong foundation in traditions of holistic person-centred care, its pivotal location in the system and the sheer size of its workforce, nursing services are set to play a critical role in the more responsive cancer care models of the future. There are, however, a number of challenges to realising the potential that exists for improving the experiences of people diagnosed with cancer.

The series of papers in this edition of Cancer Forum has been compiled with three objectives in mind: to provide examples of how a skilled nursing workforce can contribute to achieving a safe, high quality cancer care system that is centred around the needs of the person; to discuss some of the challenges and risks associated with realising the potential for nursing services in achieving such goals; and to consider possible solutions for addressing these challenges.

How do Cancer Nursing Services Contribute?

A growing body of evidence suggests that gaps exist in physical, psychological, social and practical support provided for people with cancer. This is despite the publication of evidence-based guidelines that provide clear guidance on practices such as providing information, discussing prognosis, facilitating choices, preparing patients for threatening procedures and for transitions in care, done with other forms of practical, emotional and social support. All health professionals have a role in supportive cancer care as such core concerns experienced by the person with cancer are complex and require responses drawn from a range of disciplines. The medical profession, for example, is uniquely placed to provide information about disease and treatment options in ways that reduce uncertainty and promote patient and family well-being. Allied health professionals are uniquely placed to respond to the many functional, practical, psychological and social needs that fall within their scope of practice.

Similarly, nurses’ contribution to the supportive care dimensions of the cancer care service has features that can be both unique and complementary to that of other health professionals. In collaboration with other health professionals, nursing services are concerned with understanding and responding to diverse patient and family experiences of cancer, for example, distress, fear, fatigue, nausea, mucositis or neutropaenia. What is especially unique about the nursing contribution to patient support, however, is that nursing care draws from a broad knowledge base from clinical, social and psychological sciences. Moreover, compared to other health professionals, the nurse often has longer and more frequent interactions with the patient during their experience of the cancer care system, at least during much of the treatment phase.

In this edition of Cancer Forum, Piggott and colleagues emphasise how these more unique features of nursing practice enable nurses to be a focal point for assessment of support needs and a linkage with other parts of the health system. Similarly, Kristjanson’s paper highlights the scope of family caregiver needs and several important supportive interventions for addressing these needs. This pivotal role that nurses play in supportive care has been highlighted in the recent report of the National Breast Cancer Centre’s Multidisciplinary Care Demonstration Project, where the presence of a breast care nurse in a multidisciplinary team was seen to be beneficial to both women and clinicians. The scope of nursing practice and their location in the system means that nurses are integral to identifying an individual’s supportive care needs and engaging an appropriate team response to address these needs.

Furthermore, the Optimising Cancer Care report emphasised that there are many places for patients to get lost in our current health system. A core feature of service models of the future will therefore be a greater emphasis on coordination of care to overcome such gaps. As such, this edition of Cancer Forum includes a timely review paper highlighting some of the issues associated with designing and implementing Cancer Care Coordinators roles. A key message to be taken from this review is that achieving continuity of care from the patient’s perspective will most likely require multifaceted system responses.

Gardner’s paper also highlights the potential contribution that may be afforded by development of advanced practice models of nursing. Using the nurse practitioner model as her example, Gardner argues that nurses working with a scope of practice that incorporates extended practice activities that can include both medical and nursing activities can be very effective when the nurse practitioner’s service fills a gap in access, efficiency or quality of service for the patient population in a specific field...
of health care. Such advanced practice roles, clearly situated within a team approach to health service delivery, present some important opportunities for cancer care. Recent UK studies of nurse-led clinics in cancer care demonstrate that such models achieve good patient outcomes.

What are the Challenges for Cancer Nursing?

While the papers in this edition of Cancer Forum highlight some important ways in which cancer nursing is responding to the pressure for system reform, Barrett’s paper reminds us of some of the challenges that exist in achieving significant gains. Barrett’s article presents quite sobering data that illustrate the workforce challenges nursing faces. Indeed, these workforce challenges are unique to nursing. The National Health Workforce Strategic Framework1 provides some unprecedented challenges.

Method

An organisational change process was required to meet the aim of the supportive care project, which involved a number of interrelated changes occurring concurrently. The changes involved:

(a) A change in the organisational approach that led to an increased awareness and understanding of the value of supportive care programs to the overall well-being of patients.

(b) A review of the management and provision of supportive care programs to ensure they were evidence-based and targeted effectively to efficiently meet the needs of the patients.

(c) A review of the core functions of the multidisciplinary team to promote hospital-wide understanding of disciplines and the need for effective use of appropriately skilled staff.

(d) The development and implementation of a routine systematic screening and referral process for the identification and addressing of supportive care needs of patients and carers.

Developmental changes are still in progress, as effective change requires ongoing review. The change cycle being used is assess-plan-do-review- reassess cycle, which is a mnemonic for testing changes in real work settings.

Introduction

A diagnosis of cancer has a profound impact on individuals and family members and is usually accompanied by a range of psychological reactions ranging from shock and disbelief to occasionally more serious psychiatric presentations. Most cancer patients describe anxiety and fear associated with an uncomfortable, yet inevitable sense of their own mortality, irrespective of prognosis. For example Kossane et al found in their research on breast cancer patients that 45% (135/303) had a psychiatric disorder and 42% had depression or anxiety, or both, and referrals were not made for review of these needs. Cancer has far reaching effects on individuals and families including sickness, long-term disability or functional loss, financial impacts, alterations in family relationships and existential and psychological challenges faced by individuals and families. The burden of cancer on the individual and the community is therefore high and the need for supportive care as well as biological management of disease is well documented.

Fitch2 defines supportive care in the context of cancer care as including the provision of physical, psychological, social, information and spiritual needs during the diagnostic, treatment and follow-up phases. Supportive care embraces the full range of issues that emerge for an individual and family as the impact of cancer and treatments are felt and they try to manage the situation. Numerous research studies have demonstrated the benefits of supportive care interventions3.

Supportive care in the oncology setting is essential to improving patient outcomes. Research suggests benefits include improvements in quality of life. There is also a growing consumer demand regarding expectations for assistance and support through the course of their experience. The term supportive care is frequently used to describe various support programs, however few organisations have shown how to implement supportive care in routine clinical practice4.

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References


7. Department of Education, Science and Training. National review of nursing education report concludes that Australian nurses should be encouraged to complete their undergraduate and postgraduate education and subsequently be established to implement recommendations from the National Review of Nursing Educations and a growing body of evidence about what patients need and want from our cancer system and about the models of care that might best address these needs. Such evidence continues to suggest that nurses will be integral to achieving a more patient-centred service. Realising this potential for service improvement through the contribution of nursing will, however, present some unprecedented challenges.

What are some Potential Solutions?

The National Health Workforce Strategic Framework1 provides a vision for the health workforce over the next decade, and sets out a blueprint for action to achieve a sustainable health workforce. The National Review of Nursing Education and a major government reports published in the last two years ‘The Patient Profession’ and National Review of Nursing Education in Australia clearly place the spotlight on nursing as a key component of the health system that requires attention if Australia is to maintain its high quality health service. The National Nursing and Education Taskforce has subsequently been established to implement recommendations from these reports. Nursing Educations and a number of projects are already underway looking at workforce planning, undergraduate and postgraduate education and nursing research and training. At the same time, the establishment of the Cancer Nurses Society of Australia in 1998 has seen the professional organisation of cancer nurses in Australia develop rapidly, providing increased opportunities for developing and disseminating resources for cancer nursing

Developments in Supportive Care: Implications for Nursing

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Introduction

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Supportive care in the oncology setting is essential to improving patient outcomes. Research suggests benefits include improvements in quality of life. There is also a growing consumer demand regarding expectations for assistance and support through the course of their experience. The term supportive care is frequently used to describe various support programs, however few organisations have shown how to implement supportive care in routine clinical practice4.

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Organisational changes are still in progress, as effective change requires ongoing review. The change cycle being used is assess-plan-do-review-reassess cycle, which is a mnemonic for testing changes in real work settings.

Discussion

A Change in the Organisational Approach

Organisational recognition of the integral value of supportive care in cancer care services provision is essential. Recognition was provided by the formation of a committee structure to oversee supportive care services provision, including sponsorship and multidisciplinary representation, including nurses, in the Supportive Care Steering Committee were required to facilitate staff ‘buy-in’ of the organisational change process. An organisational statement was developed and standards of care were adopted. These were accepted by the hospital executive committee and ensured organisation-wide recognition of supportive care services as a core function of the hospital’s cancer services.

A supportive care model (fig 1) was adopted to provide a framework for the targeting of programs to meet patient needs. The model proposes that supportive care programs should take
The Development and Implementation of a Routine Systematic Screening and Referral Process

An important step in the provision of supportive care services is the identification of the patient and family's needs. A needs assessment helps identify patient perceptions of needs for optimal health and quality of life outcomes. The identification of gaps through a needs assessment provides an indication of the relative magnitude of need for help in different domains, allowing for better targeting of support services.8

A system for routine identification of needs and a process for planning intervention was introduced. The review of literature suggested a self-completed tool has advantages over a clinician-completed tool in that they are inexpensive to produce, require minimal time and energy input from staff and yield quantifiable responses. The Supportive Needs Assessment Tool (SNA-Tool) is a patient self-completed questionnaire, was developed within input from the multidisciplinary team including nurses and medical staff.

The screening tool is a questionnaire completed by the patient, which is then followed up by a nurse who conducts a focused interview and plans appropriate interventions. Five domains of care are considered in the screening tool: physical, information, social, psychological, and spiritual needs. Between August 2003 and July 2004, 236 patients new to the hospital in the breast, lung and gastrointestinal streams completed Supportive Needs Screening Tool. From these screenings a total of 631 referrals, an average of 2.7 referrals per patient, were made. For example, the physical need was screened for by 44% (105/236 patients). Following their interview with the nurse, 15% required and agreed to referrals to occupational therapists for fatigue interventions, 5% were referred to physiotherapy and 9% agreed to ongoing monitoring or education by nurses. Psychological needs were also identified with the aid of the screening tool. Forty per cent patients indicated they were unhappy or depressed over the last two weeks and 43% indicated that there was something causing them distress. Following the interview with the nurse, 13% agreed to see a social worker for support and monitoring of their anxiety or depression, 6% agreed to monitoring of their anxiety by the nurse, 5% agreed to referral to the occupational therapist for relaxation techniques to reduce stress, 3% agreed to a psychological referral, 1% agreed to referral to a psychiatrist for management of depression and 6% patients agreed to access to support groups. This sample of results indicates that the screening tool is identifying needs that require further assessment and intervention by the multidisciplinary team. The role of the nurse provides the link between the identified need and the required supportive care intervention. Without the focused interview with the nurse, the screening tool would provide information to a clinician, but the required intervention might not be instigated. Patients are more likely to accept an intervention if they have an understanding of what is involved and it is this critical information that the nurse can provide about the various supportive services available.

Conclusion

Research indicates that the diagnosis of cancer has an impact on all aspects of a person's life, the physical, psychological, social and spiritual domains. The need for a consistent practice oncology care is to include evidence-based supportive care services as part of the core service provision.

This paper describes an organisational change to facilitate the integration of supportive care services and programs into everyday clinical practice in a tertiary oncology setting. Nurses were key players in the changes at both the organizational level, as well as in leading systematic change to help routinely identify patient need and facilitate a process that enhances access to the patient to supportive care services and programs. Using an evidenced-based care pathway, nurses can intervene more effectively and efficiently by targeting services to differing levels of need in a timely manner across the care continuum.

References
4. Owen JE, Klapow JC, Hicken B, Tucker DC. Psychosocial interventions for fatigue interventions, 5% were referred to physiotherapy and 9% agreed to ongoing monitoring or education by nurses. Psychological needs were also identified with the aid of the screening tool. Forty per cent patients indicated they were unhappy or depressed over the last two weeks and 43% indicated that there was something causing them distress. Following the interview with the nurse, 13% agreed to see a social worker for support and monitoring of their anxiety or depression, 6% agreed to monitoring of their anxiety by the nurse, 5% agreed to referral to the occupational therapist for relaxation techniques to reduce stress, 3% agreed to a psychological referral, 1% agreed to referral to a psychiatrist for management of depression and 6% patients agreed to access to support groups. This sample of results indicates that the screening tool is identifying needs that require further assessment and intervention by the multidisciplinary team. The role of the nurse provides the link between the identified need and the required supportive care intervention. Without the focused interview with the nurse, the screening tool would provide information to a clinician, but the required intervention might not be instigated. Patients are more likely to accept an intervention if they have an understanding of what is involved and it is this critical information that the nurse can provide about the various supportive services available.

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The health of the family as a unit may also be affected by the cancer illness experience. Changes in family structure, roles, relationships, and changing conflict may be evident. Central to the health of the family as a unit is the ability of family members to communicate with each other, the patient, and health professionals. It has been documented that poor communication causes many problems related to cancer patients and their families than any other problems, with the exception of their own needs for support and assistance. Family members provide support to the patient and have their families than any other problems, with the exception of their families.
and support have notable effects on the physical, mental and emotional burden placed on family members, the possible death of their relative, communication issues and the financial demands on families may be significant and may be in particular need of help to cope with the memories and regret associated with these experiences.

The role of family carer may also impose additional financial burdens. Scholar and colleagues have reported that family caregiving commitments mean that some family caregivers are unable to work or have to work fewer hours, or work a lower paid job with negative financial consequences. In the family in the cancer experience, there is a need to share these worries with other family members or friends, and to identify strategies for coping with these concerns. Family members and caregivers may find it helpful to share their concerns, or feel guilty about having worries about financial matters when the patient is ill and may be suffering. Family members may not be prepared for financial concerns may be discussed and more important. This approach may encourage family members to take time off work to attend appointments, providing assistance to the patient may also be a source of concern. Family members may be involved in the planning of medications and treatment. Indirect costs associated with providing care, or taking time off work to attend appointments, or providing assistance to the patient may also be a source of concern. Family members may be involved in the planning of medications and treatment.

Acknowledgments

The author gratefully acknowledges the support of The Cancer Council Western Australia in providing funding for the Chair of Palliative Care.

References

1. AHPHC. Cancer in Australia. 1999, Canberra, ACT.
34. McLauchlan CAJ.  Handling distressed relatives and breaking bad news. Progress in Palliative Care, 2000; 8(6), 127-148.
Cancer Care Coordinators: Realising the Potential for Improving the Patient Journey

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A person diagnosed with cancer can receive multiple treatments in a variety of different health care settings over extended periods of time. During this time, they come into contact with multiple health care providers. For example, one recent UK study reported that cancer patients with a diagnosis of less than one year had 28 doctors on average since their diagnosis and trip to the hospital. In this study, each interaction with any other health professional with whom the patient will come in contact during their illness and the complex maze that characterise the patient’s cancer journey is obvious.

The Optimising Cancer Care in Australia report published in 2003 by the peak cancer organisations in Australia concluded that there was a need for collaboration between cancer services to get lost in the system, creating unnecessary morbidity and undue distress. The lack of an integrated care system for people with cancer was identified as a major failing of today’s health system.

A number of states in Australia have appointed cancer care coordinators as a strategy to address this problem. In Queensland, cancer coordination positions have been established in a number of Health Service Districts in the Southern and Central regions. Despite the relatively large scope of patterns of care, referral pathways and to define a cancer coordination model for their regions that is consistent across the state, but able to meet the local needs of the population. To support its Cancer Clinical Service Framework, the NSW Health Department plans to recruit up to 50 cancer nurse coordinators. Cancer nurse coordinators in NSW will work through the lead Clinicians and Directors of Area Cancer Services to support oncology team meetings, develop and protocols, and provide a direct source of contact for patients and primary care physicians accessing cancer services. In Victoria, a number of program coordinators and nurses have been introduced as part of the breast services enhancement program. Individual institutions have also established nurse coordinator roles for specific tumour streams.

The cancer care coordinator role is a rapidly emerging one with many mandates to address some of the current problems in the current system of care. To ensure these developments realise their potential, it is timely to consider the most effective ways to design and implement models of care coordination that achieve the improving achievements being sought for the Australian cancer care system.

What is Care Coordination?

A variety of terms are used in the health care literature to reflect efforts to improve the patient journey, including continuum of care, discharge planning, program coordination, integration of services and seamless care. In the context of managing a chronic disease such as cancer, continuity of care has been defined as the delivery of services by different professional groups (from across a hospital, clinic, primary care and with the patient’s medical needs and personal context. A service system that facilitates continuity of care is characterised as one where all services needed (comprehensiveness) are delivered over time (longitudinally) by service providers who establish and develop relationships (relationships) and when appropriate care is available (accessibility) and flexible (flexibility).

These definitions emphasise that care coordination is an integral component of continuity of care. Care coordination ensures that someone manages the care process, including the development and coordination of the plan of care and ensures that all of the care needed is arranged and delivered. Various models for care coordination have been identified to reflect the needs of the population being served. Care management is one such example that enables patients to decrease fragmentation of services for patients whose care was complicated, being seen as a cost-effective way to provide quality care to high-risk patient groups and improve some health outcomes. While no agreed definition is evident in the literature, nurse care management roles are generally seen to encompass a very broad range of responsibilities which may include assessment and screening of patient needs, bridging gaps in care, promoting self-efficacy, enhancing self-care capabilities, coordinating care across settings, brokering and developing networks of services, and information systems which improve coordination and provide cost-effective care. The Cancer Clinical Service Framework, 13 individual studies were identified which had explored interventions involving nurse care coordinators, multidisciplinary team interventions, introduction of standardised guidelines and protocols and implementation of methods for improving coordination of care; such as patient-held records. The reviewers concluded that the evidence suggests good coordination enables services to complement each other and provide better quality care. In particular note, however, is that there is little evidence identified in this review involved coordination of services for patients receiving palliative care.

The Clinical Practice Guidelines for Psychosocial Care for Adults with Cancer published in Australia similarly discusses evidence around the development of models designed to support and improve care for patients with cancer. It recommends that such models should support the cancer care journey: identification of a care coordinator; the role of the specialist oncology nurse; multidisciplinary care; and patient recorded management. The level 2 evidence exists to support the following interventions:

- Specialist breast nurses improve and provide continuity of care throughout the treatment process for women with breast cancer; and
- Patient held records improve continuity of care.

While care coordination is not the sole focus of the Specialist Breast Nurses’ practice, the establishment of such positions in Australia has represented an important development for efforts to improve coordination and support for women with breast cancer. The National Breast Cancer Centre (NBCC) Specialist Breast Nurse Service was established in 2000 to provide a single point of contact for women with breast cancer. While care coordination is not the sole focus of the Specialist Breast Nurses’ practice, the establishment of such positions in Australia has represented an important development for efforts to improve coordination and support for women with breast cancer. The National Breast Cancer Centre (NBCC) Specialist Breast Nurse Service was established in 2000 to provide a single point of contact for women with breast cancer. For example, in the Northern Ireland study reported that cancer patients with a diagnosis of breast cancer were published in 2003. The National Institute of Clinical Excellence in the UK undertook a systematic review of literature published between 1966 and March 2003 to determine the current state of evidence on interprofessional, interorganisational and relational aspects of the health system.

What is the Evidence for Care Coordination?

Two major reviews of evidence regarding coordination of care for cancer care were published in 2003. The National Institute of Clinical Excellence in the UK undertook a systematic review of literature published between 1966 and March 2003 to determine the current state of evidence on interprofessional, interorganisational and relational aspects of the health system.

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Implementing Care Coordination Roles?

What Issues Should be Considered in Implementing Care Coordination Roles?

What is the Scope of Practice and Associated Competency Requirements for a Cancer Care Coordinator?

Who Can Best Fulfil the Role of Cancer Care Coordinator?

References


ISSUES IN NURSE PRACTITIONER DEVELOPMENTS IN AUSTRALIA

Glenn Gardner
Queensland University of Technology & Royal Brisbane and Women’s Hospital
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Introduction
The nurse practitioner level of health care is one of the most important developments in nursing in the past 30 years and marks the opportunity for significant reform in the Australian health care industry. Nurse practitioners, whilst well established in North America, the United Kingdom and parts of Europe, are a relatively recent development in Australia. The introduction of the nurse practitioner level of service is a function of state rather than national government and consequently the implementation throughout Australia has been gradual, with title protection and practice privileges now legislated in five states over a 15-year period.

Despite this rather long lead-in time, there remains confusion and uncertainty relating to the role and function of the nurse practitioner within nursing, other health disciplines and most importantly, the community of health care consumers. The aim of this paper is to reduce the confusion and uncertainty and provide information for nurses, medical and allied health professionals about this innovative level of health care.

The preparation and introduction of a new level of health care into existing systems is a complex and multifaceted undertaking. In this paper I focus on factors that are currently influencing the progress of the nurse practitioner in Australia. These are definitional issues, the research base, Australian state and national development and role development.

Defining Nurse Practitioner
There is general agreement that the introduction of the nurse practitioner as a new level of health care has been complicated by the existing nomenclature relating to advanced practice roles in nursing. Titles such as advanced specialist, clinical nurse consultant, clinical nurse specialist and advanced practice nurse are used interchangeably and at times unreasonably in the literature. Contributing to this confusion is the lack of a consensus internationally in the use of these terms. While the clarification of titles is complex and may continue to be debated for some time, the consensus gradually emerging is that the nurse practitioner role and practice. However, large scale quantitative research into nurse practitioner practice is not yet feasible because the number in practice remain relatively small. There is none-the-less an emerging research-based body of knowledge to inform ongoing developments in the introduction of the nurse practitioner role and practice.

Role Development
In addition to contributing to improvements in health service for the community, the nurse practitioner role provides an exciting and new clinical career pathway for nurses. The nurse practitioner role is open and responsive to development and currently or in Australia in the implementation of a new service for the patient population in a specific field of health care. Finally the candidate for the nurse practitioner role needs to have extensive experience in the specialty field and appropriate educational preparation.

Conclusion
This paper has attempted to clarify some of the issues related to the development of the nurse practitioner role and practice.

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practice nurse who bridges that grey area between nursing and medicine and is emerging as a new type and level of health care professional. They represent a new breed of health care professional in that they are not limited by traditional health discipline boundaries, their practice includes what has traditionally been the role of medical activities within a nursing model of care and they expand clinical practice in both medical and nursing specialty areas.

A Review of Cancer Nursing Workforce Issues in Australia

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The Diminishing Nursing Workforce

The recently released assessment of national and state skill shortages identifies that Australia has a national shortage of Registered Nurses (RNs), with oncology and palliative care registered nurses being listed as professional groups in shortage in all states and territories of Australia except the Northern Territory. The recent National Review of Nursing Education in Australia report entitled A Review of Cancer Nursing Workforce Issues in Australia indicates that the current state of affairs is that the nursing vacancy rate of 30.0% is predicted between 2001 – 2006.

Cancer nurses today face major challenges in trying to provide quality patient care in a health care environment that is experiencing such widespread nursing shortages. Nursing workforce shortages are being compounded by the Australian Institute of Health and Welfare (AIHW) that indicate that despite a 1.2% increase in nursing workforce numbers since 1999, there has been a decrease in the average nursing working hours, thus affecting the ability for nurses to deliver care. In 1999 there were 1,127 Full Time Equivalent (FTE) nurses per 100,000 population, however this number had decreased to 1,024 FTE nurses per 100,000 population in 2001. This AIHW data indicate that 48% of oncology nurses work part-time, employed an average of 32 hours per week.

A shortage of nurses compromises patient outcomes and safety and can impact on staff welfare. A number of recent US studies highlight a significant inverse relationship between nurses staffing and adverse events such as thrombosis, pulmonary and urinary complications and medication errors in hospital surgical inpatients1. These studies report that an increase of RN hours per day is associated with a reduced rate of adverse events. The aim of this paper is to examine the factors contributing to workforce shortages in cancer nursing and discuss a range of potential solutions for addressing the current challenges.

Factors Contributing to the Cancer Nursing Workforce

The current shortage of cancer nurses exists in most countries, reflecting issues in supply and demand. The problem is complex, with several factors contributing to the shortage.

The Increasing Demands for Cancer Nurses

The demand for cancer services overall has increased as a result of the increasing incidence of cancer associated with an ageing population. This combined with the increasing pressures of finite resources demand efficiency in the workplace and that overall staffing levels were a concern for them. The Queensland study further identified that cancer nurses were at high risk of burnout, with 70% of the sample categorised as experiencing moderate to high levels of emotional exhaustion on the standard burnout issues.

Issues with Nursing Recruitment and Retention

The ability to recruit young people and career switchers into nursing is essential. Almost 40% of students applying for undergraduate nursing positions fail to obtain a place, showing that there is a shortage of willing candidates, the problem lies with the number of places available.

Retention of nursing staff is arguably a more urgent concern, with recent workforce analyses undertaken by the Department of Education, Science and Training noting that it will be difficult to attract and retain a nursing workforce as exit rates increase. A recent survey of 243 oncology/hematology nurses in Queensland highlighted that nearly 48% of the sample indicated that they could not commit to remaining in the specialty. Additionally, nurses who were multifaceted, workload issues were identified as the most common reason given for considering leaving the specialty.

The Ageing Nursing Workforce

The Department of Education, Science and Training has reported that the ageing workforce is working at high exit rates from the profession over the next decade. The proportion of nurses less than 35 years is only 30 percent of the total workforce. The ageing workforce is slightly younger than the average age of 38.5 years, compared with the average age of employed clinical nurses being 41.8 years.

The increasing rate of patients with cancer, especially as completed qualifications do not necessarily delivery and outcomes from postgraduate education typically result in confusion for students, employers and academics as to which course to choose or recommend. Other reports indicate that the cost of higher education for nurses is a major barrier to entry into specialist and postgraduate courses in areas such as cancer nursing, especially as completed qualifications do not necessarily result in increased remuneration and career advancement. Without a clearly defined and accepted pathway for development of specialists in cancer nursing the development of a skilled workforce is likely to be compromised.

Developing a Sustainable Cancer Nursing Workforce

In 2002, the Cancer Nurses Society of Australia (CNSA) indicated that their concern was the nationwide shortage of cancer nurses would worsen and published a position statement on this issue. CNSA argued that, given the rising demand for cancer nurses to reducing the burden of cancer in this country, coordinated national strategies need to be implemented to recruit and retain cancer nurses to meet future workforce needs.

Cancer nurses face a number of challenges, including health promotion, screening detection, treatment, rehabilitation and palliative care.

Management of Nursing Workloads

Workloads are a source of emotional exhaustion and a dissatisfaction for oncology nurses. The current situation suggests that oncology nurses who believe they work on adequately staffed units report they are better able to care for patients and ensure quality care compared to nurses who work on inadequately staffed units. Furthermore, fully staffed units report less difficulty retaining staff, work less overtime and do not have to rely on supplemental staffing.

The management of workloads will, however, continue to be a challenge for all teams. Cancer caregivers could use validated models of care to develop models of care that foster the sharing of knowledge and expertise may assist in reducing the burden of cancer in this country, coordinated national strategies need to be implemented to recruit and retain cancer nurses to meet future workforce needs. These strategies need to be addressed in both the inpatient and ambulatory care setting.

Models of Cancer Nursing Care

Flexible team approaches to care are likely to be critical to future cancer care delivery, in order to most effectively respond to complex patient needs and increasing demands on resources. Currently the predominant model used to organise nursing work is patient allocation. This allocation model, while arguably has the potential to isolate staff from one another and result in reduced communication and co-ordination of human resources. Models of care that develop a culture of teamwork that foster the sharing of knowledge and skills will assist in the formation of supportive professional relationships. For example, the Department of Education, Science and Training has reported that the role of the nurse in the workplace could be to distribute the work across registered nurses, enrolled nurses and health care workers and articulate arrangements between health care workers of various skill levels. While such approaches may
be an appropriate response to the complex challenges faced by today’s health systems, some nurses have expressed concern that they may shift their role away from hands-on care to serve as ‘team leaders’ and that they may return nursing to a fragmented, task-oriented discipline.

Workplace Culture and Leadership

As the largest group of health care worker, nurses have considerable opportunity to shape the system itself. A significant challenge for nurse leaders is to create positive work environments in which staff feel valued. Constructive leadership behaviour can influence the culture of the work unit and the morale and retention of employees, which in turn improves patient satisfaction and outcomes15. Studies suggest that nurses’ trust in their managers has been linked to improved productivity, improved patient care, job satisfaction and commitment16. Clinical leadership roles should be developed to mentor and develop new cancer nursing practitioners and promote innovative practice in cancer care, thereby contributing to the retention of experienced and motivated cancer nurses. Nurses with leadership potential should be identified and supported, to shape and lead our profession in the future16.

Educational Strategies

Education is an essential component for the preparation of new professionals and specialist nurses. The provision of appropriate funding, flexible and responsive education and the building of collaborative relationships across academic and clinical settings are key to building the capacity of the nursing workforce17. Immediate strategies that may be implemented include relief from Higher Education Contribution Scheme and other course fees to overcome the financial barriers nurses face in undertaking postgraduate cancer courses18. The recently released NSW Cancer Plan19 identifies that cancer nursing education is required to develop a workforce that can provide optimal patient care. Specifically, the plan states that advanced practice positions need to be developed, providing clinical experts and leaders. Such initiatives may provide excellent opportunities to recruit and retain cancer nurses and also to evaluate the efficacy of specialist nurse models in improving outcomes for patients with cancer.

Coordinated National Approaches to Workforce Planning

Three important national initiatives are currently underway that have the potential to set the agenda for future directions in nursing workforce planning. Firstly, the 2002 National Review of Nursing Education21, and Senate Inquiry into Nursing22 made many recommendations emphasizing the importance of nationally coordinated approaches to addressing nursing workforce and education issues. In November 2003, state/territory and Australian Ministers for Health and Education announced the establishment of a National Nursing and Nurse Education Taskforce (N3ET). N3ET has been set up to implement the recommendations of the report Our Duty of Care23, including issues such as the skill mix and work organisation of nurses. In recognition of the current workforce, training of care assistants, funding of clinical education and national education standards. This is the first time there has been national collaboration on these issues.

Secondly, the Nursing Workforce Planning in Australia document has recently been published to guide the Australian Health Workforce Advisory Committee (AHWAC), the National Health Workforce Planning in Australia – Volume 3: 2004. This document identifies that cancer nursing education is required to develop a workforce that can provide optimal patient care. Specifically, the plan states that advanced practice positions need to be developed, providing clinical experts and leaders. Such initiatives may provide excellent opportunities to recruit and retain cancer nurses and also to evaluate the efficacy of specialist nurse models in improving outcomes for patients with cancer.

References

La Jolla

With a CI Martin NH & MRC Fellowship I was able to spend two years at UCSD with Mickey Goulain and John Mendelsohn. Mickey Goulain had come from the University of Chicago and before that was a student of Arthur Kornberg (Nobel Prize winner, DNA polymerase) who had synthesized DNA in a simple vial, representing the first in vitro synthesis of “a living organism”.

La Jolla, a northern suburb of San Diego, is similar to Sydney with its climate and beautiful beaches. We lived in a small 1920s timber cottage in a street lined by eucalyptus trees, 200 yards from the beach. The newly formed UCSD Medical School was close to the Salk Institute on the headlands overlooking the Pacific. Salk himself was still Director of the institute and I remember his vast office lined with wall to wall Piccasos. He had married one of Picasso’s former models and the couple would change cases some years later as to the ownership of those Piccasos.

At the Salk was Robert Holmes, who had won the Nobel Prize for the structure of transfer RNA, as well as Jacob Bronowski who had created the BBC Television series and book entitled The Progess of Man. I would catch the bus to the medical school, becoming acquainted with an elderly lady paediatrician. She was the widow of Leo Sazid, a physcist from the Manhattan Atomic Bomb project of the 1940s. In retirement he worked at the Salk Institute.

The Chairman of Medicine at UCSD was Eugene Braunwald. He was the doyen of American cardiology and subsequently was Head of Medicine at the Massachusetts General Hospital and Editor of Harvard’s Principles of Internal Medicine. I was able to do some work with Jay Seegmiller (rheumatology), who had pioneered the development of allopurinol at the NIH and got interested in developments in medical oncology and had started treating patients with small cell lung cancer. This caused some consternation in the local haematological community and when we presented our results there was suspicion that our pathologist had confused small cell lung cancer with malignant lymphoma.

Sydney LIRC

I spent some seven years back at RPP in the LIRC. This was a great opportunity, and I was to learn much from Martin Tattersall, who was one of the most superb clinicians I have encountered. There is no doubt that the Sydney LIRC “pump primed” Australian medical oncology.

The people who were either recruited as consultants or trained at the Sydney LIRC have made an extraordinary impact. Trainees in medical oncology have included Michael Friedlander, Michael Green, Rick Kefford, Fred Kirsten, Graeme Mann, Derek Raghavan, Roger Reddill and John Symes. Notable among the young faculty was PJ Professor of Medicine at the Westmead Hospital, Derek Raghavan as Head of Oncology at the University of Southern California; and John Symes is Director of the Clinical Trials Unit of the NH MRC, and Al Coates went on as Director of the Cancer Society in Sydney. Robert Sutherland became Deputy Director of the Garvan Institute in Sydney. It is fascinating to remember Stan Kaye, who spent a year as a Senior Medical Officer at Bankstown Toronto Hospital and then became Professor of Medicine at the Royal Marsden Hospital in London.

The Sydney LIRC was highly productive. The unit had a major role in establishing the ANZ Breast Cancer Trials Group, as well as the Sydney In vitro Fertilization Therapy Group, which went on to become the International In vitro Fertilization Therapy Group. The unit pioneered clinical studies in metastatic cancer of unknown primary publishing in the New England Journal of Medicine.

In particular, Rick Kefford’s work on the lymphocyte-toxicity of purine analogs was to provide the basis for current treatment of lymphomas and chronic lymphocytic leukaemia using antemobile therapy. His work was published in Cancer Research and the Journal of Clinical Investigation.

Melbourne

I moved to the RMH in 1985, establishing a combined Clinical Haematology and Medical Oncology Department. By linking with the Melbourne LIRC and WEHI on the RMH campus, we were able to create cross appointments where individuals could be appointed to both institutions. This subsequently allowed us to build a significant team which was also to “pump prime” medical oncology in Melbourne.

Consultant appointees included Michael Green, George Montray, Gary Lindeman, John Symes and Bill Sheridan. Trainees who returned to work in the department included Mark Rosenthal, Rick De Boer, Peter Gibbs, Russell Basser, Daryl Maher, Jonathan Ciborov, Andrew Roberts, Graeme Liesz, Llewellyn Marsden and of course, I was pleased to host for a year a young Russian trainee from what was then the All Union Cancer Research Center in Moscow, Sergai Tjulandin, who was working on the clinical pharmacology of anthacycline cardiac toxicity. Sergai returned to Moscow and is now Deputy Director of the Cancer Research Center in Moscow, a 1000 bed cancer hospital. He will clearly be his future director. He has never ceased to thank his Australian hosts and is a good ambassador for Australia in that long suffering country.

Work at the WEHI, which led to the subsequent cloning of human granulocyte colony stimulating factor (G-CSF), prompted the first clinical trials linking the research capabilities of the WEHI and the LIRC. With a team including Don Metcalf, Anthony Burgess and George Montray, we were successful able to plan and execute these phase I clinical trials. They were able to show the dramatic elevation in the neutrophil count after administration of G-CSF and the protection against neutropenia induced by chemotherapy.

An unexpected effect was the release into the peripheral blood of haemopoietic progenitor cells (CD34 cells) serendipitously observed by Ule Dursen in the WEHI. This led to leucapheresis procedures by which we could harvest these cells and use them at an alternative to bone marrow transplantation. At this time Bill Sheridan had returned from Emery University in Atlanta and demonstrated the successful use of these cells in achieving a rapid recovery of the neutrophils, as well as platelets. These findings, published sequentially in the New England Journal of Medicine, were the fourth most widely cited paper in its year of publication.

Subsequently Megakaryocyte Growth and Development Factor (MGDF) was also pioneered in Melbourne and the translational research carried out by Glenn Begley, Head of the newly created Bone Marrow Research Laboratories, a separate group founded within The Royal Melbourne Hospital. His studies were remarkably successful, although MGDF was not to go on clinically because of its antigenic characteristics.

The success of Amgen and its rapid growth as one of the world’s largest biotechnology companies, led to its recruiting many of the original Melbourne trialists, including George Montray, Bill Sheridan and subsequently Glenn Begley back to California. Russell Basser, who played a major role in the MGDF project, as well as the randomised trials of high dose chemotherapy in autologous bone marrow transplantation in breast cancer was appointed Director of Clinical Research at the CSL.

The complexity of the developments saw creation of multiple...
The use of cytotoxic drugs such as cisplatin, which caused severe nausea and vomiting unresponsive to standard antiemetics, stimulated research into the mechanisms of nausea and vomiting. Cisplatin was associated with both acute emesis in the first 24 hours and delayed emesis which could last for a week. The discovery of 5-HT3 receptors in the small intestine and brain were responsible for acute chemotherapy induced vomiting and the introduction of 5-HT3 receptor antagonists revolutionized the treatment of acute chemotherapy induced emesis, but had only minor impact on delayed emesis, which was thought to be mediated by a different mechanism. Now aprotine a new drug that is a neurokinin1 receptor antagonist, which is centrally acting and given orally, has improved the control of acute emesis when added to a 5-HT3 antagonist and dexamethasone, but more importantly, a new understanding in the control of delayed emesis when continued for two further days in combination with dexamethasone. This control of nausea and vomiting associated with chemotherapy has translated into improved quality of life of the patients receiving chemotherapy.

Nausea and vomiting have been listed by patients as amongst the most distressing side effects of chemotherapy. Much of the knowledge gained over the last two decades about the mechanisms of emesis has resulted from the need to control chemotherapy induced emesis following the introduction of cytotoxic drugs of high emetic potential, such as cisplatin.

There are three phases of emesis associated with chemotherapy. There are three phases of emesis associated with chemotherapy. The first day and can continue for a week. If a 5-HT3 antagonist is added to a 5-HT3 antagonist and dexamethasone, but more latterly Mark Rosenthal, changing its name to “Cancer Forum”.

The 5-HT3 receptors are found centrally and peripherally where the main site of activity is in the small intestine. The 5-HT3 receptors have allowed identification of the role of the vagal afferent chemoceptor cell unit in the emetic response. Cytotoxic drugs cause a calcium dependent release of hydroxytryptamine from enterochromaffin cells in the upper gastrointestinal mucosa. This is reflected by the fact that cisplatin induced emesis is associated with increases in urine 5-hydroxyindoleacetic acid (5 HIAA), a metabolite of serotonin-5-HT3, released by enterochromaffin cells which seems to be superior to high dose metoclopramide regimens for preventing chemotherapy-induced emesis and they have a favorable toxicity profile in reversible headache, constipation and mild elevations in liver transaminase side effects.12,13 The 5-HT3 receptor antagonist combined with dexamethasone had become the gold standard given prophylactically to prevent acute post chemotherapy induced emesis.14 This results in complete protection from cisplatin-induced emesis ranging from 70-90 per cent.15 These drugs are also active for radiation induced emesis.16 As a class of drugs, clinically, there is a threshold effect for the emetic response, any dose above a certain level will give a response and a plateau, there is no additional effect. Failure of response or breakthrough of the emesis on these agents may not be remedied by larger or more frequent other receptor mechanisms may be responsible.16 Currently single daily dosage regimens are most commonly used. Oral doses when adjusted for their bioavailability seem to be as intravenous dosing if there are no barriers to absorption.17,18 Usually intravenously and orally, other formulations such as ondansetron, which dissociate in the mouth and suppositories have been tried.14,15

Delayed Emesis
The 5-HT3 receptor antagonists were very effective for acute emesis, but a second mechanism of emesis was responsible for delayed emesis which begins towards the end of the first 24 hours and can last for a week. If a 5-HT3 antagonist and dexamethasone was continued the control of the delayed phase of emesis rarely exceeded 50 per cent.19 Here dexamethasone was found to be the key drug and combining it with metoclopramide yielded similar results to studies combining it with 5-HT3 antagonists.20 It is now known that the centrally located neurokinin1(NK1) receptors are important mediators of delayed post chemotherapy emesis.

Neurokinin Receptor Antagonists
Substance P is an 11 amino acid neurotransmitter which displays a strong affinity for the NK1 receptor.21 There are high concentrations of substance P, which can be imaged by postmortem autoradiograms of the brain, which are responsible for emesis such as the nucleus tractus solitarius and area postrema.22 NK1 receptor antagonists are highly selective for NK1 receptors and they act centrally, inhibiting the binding of substance P. The first of the NK1 receptor antagonists available clinically is aprepitant. Aprepitant has a pro-drug L-758298, which is an intravenous preparation, but itself is an oral formulation with 60 to 65 per cent being absorbed as a result of being food. It is recommended for once a day administration. It crosses the blood brain barrier which is necessary for its antiemetic efficacy. Its main point of action is the cytochrome F450 CYP3A4 isozyme of which it is a moderate inhibitor. This creates the potential for drug interactions. Of significance, when given with dexamethasone there was a two fold increase in dexamethasone AUC (area under the dose/time curve).22 The AUC of etinyl estradiol is decreased by 40 per cent and the manufacturer recommends alternate methods of contraception. Trough concentrations of dexamethasone have been found with 5-HT receptor antagonists or cytotoxic such as docetaxel.23 No dosage adjustments are necessary for mild to moderate hepatic or renal insufficiency, age race or gender. Based on negligible pharmacokinetic differences, standard regimens for contraception recommended on the basis of age, race and gender. Pet studies have shown correlations between receptor occupancy and plasma concentration and efficacy. Antiemetic efficacy increases with increased receptor occupancy up to a dose of 125mg but no additional benefit is seen with higher doses.22 The single agent activity of these agents was disappointing against acute cisplatin induced emesis and therefore the NK1 receptor antagonists have been combined with other emetic such as dexamethasone antagonist and steroids. Following phase I studies there were further phase II trials (two with the produg and three with aprepitant) in cisplatin induced emesis, which suggested additive activity in controlling acute emesis and good control of delayed emesis if the three drugs were given on day one (either granzastatin or ondansetron with dexamethasone and aprepitant) and the delayed emesis in the group that received dexamethasone.

The first phase III placebo controlled trials were performed in South America (Poli-Bigelli et al) and in centers from North America, Europe and Australia (Hesketh et al).24 Both studies included patients receiving their first cycles of cisplatin >70mg/m2. The patients on the standard arms of both studies received intravenous ondansetron 32mg 30 minutes before cisplatin with oral dexamethasone 20 mg on day one followed by oral dexamethasone 8mg by mouth from days two to four. The aprepitant groups received oral aprepitant 125mg one hour before cisplatin, then intravenous ondansetron 32mg 30 minutes before cisplatin with oral dexamethasone 8mg only on day one. On days two and three oral aprepitant 80mg and oral dexamethasone 8mg only once daily (because of the interaction with dexamethasone) was given and then day four oral dexamethasone. An extension phase of the study evaluated courses two to six. Combining trials 1099 patients were enrolled. The complete response rate for the days of the first cycle in the Poli-Bigelli trial was 62.7 per cent for the aprepitant group versus 43.3 per cent.
Articles

Computerised screening for anxiety, depression and radiation toxicity in cancer patients
S Jacob, M Berry, A Kneebone, G Delaney, A Fowler, S Behar, M Barton
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Liverpool Health Service, NSW
Background
Anxiety and depression associated with the diagnosis of cancer are widely prevalent. Together with the side effects associated with treatment, this has a significant negative effect on the quality of life of patients undergoing radiation therapy for cancer. Computer administered questionnaires have the potential to improve patient-provider communication and improve the detection of symptoms of anxiety and depression.

Radiotherapy is effective in the treatment of cancer, but is associated with a range of side effects that vary depending on the part of the body that is treated with radiation. While it is routine for clinicians to inquire about side effects during patient review and follow-up meetings, there may be no systematic method of recording radiation toxicity.

Inadequate recognition and response to the symptoms of radiation toxicity can adversely affect the patient’s quality of life.

In this trial computerised (touchscreen) questionnaires were used to screen for anxiety depression and the side effects of radiotherapy in patients with breast, bowel, prostate or head and neck cancer. Questionnaires were developed to screen for symptoms of radiation toxicity in each site. The Hospital Anxiety and Depression Scale (HADS) was used to measure anxiety and depression.

The program was evaluated for errors, logical inconsistencies and patient acceptability by trialling it on 50 newly diagnosed cancer patients.

Result
The computerised questionnaires were well accepted by patients. All patients found the computerised form to be user-friendly. The computer programme provided a useful method of systematically recording patient radiation toxicity.

The trials are ongoing and we are currently reviewing the questionnaires for anxiety and depression with patients undergoing radiotherapy in the major cancer sites in NSW.
trial the system on 50 patients newly diagnosed with breast, prostate, bowel and head and neck cancer.

**Methods**

**Questionnaires**

Radiation toxicity questionnaires were developed by radiation oncologists for each of the selected cancer sites (breast, prostate, bowel and head and neck cancer). Toxicity questions were based on scales developed by the Radiation Therapy Oncology Group and the European Organisation for Research and Treatment of Cancer (RTOG/EORTC)17. Three sets of questions were developed for each of the four cancer sites. The first set of questions (pre-treatment questionnaires) sought to ascertain baseline values such as the patient’s normal bowel or urinary habits prior to radiation treatment. The second set of questions was designed to be answered by the patient during the course of their radiotherapy and contained questions dealing with expected immediate or acute toxicity. The final set of questions (post-treatment questionnaires) was designed to be answered by patients during their follow-up visits to the clinic after completion of their radiotherapy and dealt with the possible long-term side-effects of radiotherapy.

The HAD scale was used to screen for anxiety and depression. This scale was specifically developed for patients with physical illness and is designed so that somatic items are largely excluded from the depression sub-scale18. The HAD scale has previously been extensively tested and validated as a screening instrument for anxiety and depression in cancer patients13-15. The patients in this trial answered the HAD questionnaire every time they answered the touchscreen questionnaires.

**Software**

A commercial software company incorporated the questionnaires into an interactive touchscreen computer program and developed a database that would interface with the hospital cancer records system. To protect the security and integrity of the hospital cancer records system, the link was designed to provide read-only access from the touchscreen database to patient identification and diagnosis details in the hospital cancer records.

The computer program opened with an introductory video clip including instructions for patients on how to use the program. Each question was presented individually on the screen. The computer was closely monitored to ensure that the patient had an opportunity to touch the screen before answering the question. The computer program generated two reports at the end of each treatment session to help patients through the program. The time taken to complete the touchscreen questionnaires and any problems encountered were recorded. A verbal patient satisfaction questionnaire was administered at the end of the first touchscreen session.

Patients were requested to answer the touchscreen questionnaires once a week during their radiation treatment and at every follow-up visit. They were instructed to hand the print-out of their touchscreen results to their oncologist during their treatment review and follow-up visits. All patients with elevated HAD scores (scores above eight) were referred to the psychosocial team, comprising a clinical psychologist, social worker and breast nurse trained in counselling.

Treatment options included provision of information, problem solving, support, reassurance, psychotherapy, social interventions or recommendation for referral to a psychiatrist for further management of depression or anxiety.

**Results**

**Patient Characteristics**

A total of 50 patients with breast, prostate, bowel and head and neck cancer were recruited into the study. Twenty-one patients (42 per cent) were female. Table 1 shows the primary cancer site and median age of patients in the trial. The time that had elapsed since the diagnosis of primary cancer was five months or less in 63 per cent of patients.

**Acceptability**

Despite the fact that many of the patients had never used a computer before, the vast majority of patients (93 per cent) found that the touchscreen survey was easy to use and all agreed that it did not take too long and was not stressful. All the patients felt that it was a good way to convey information to their treating doctor.

**Screening for Anxiety and Depression**

Out of the 50 patients who were screened for anxiety and depression, 30 per cent (15 patients) had at least one elevated HAD score. Thirteen patients had mildly elevated (8-10) HAD scores, one patient had a moderately elevated (11-14) HAD score and one patient had a severely elevated (15-21) HAD score. Four patients had one or more elevated scores on the depression subscale only, one patient scored on the anxiety subscale only and 10 patients had elevated scores on both anxiety and depression subscales.

Ten patients had an elevated HAD score on only one occasion. Out of these, seven patients had an elevated HAD score only at the first survey, with subsequent HAD scores being within normal limits. Thirty-eight per cent of female patients had one or more elevated HAD scores, compared to 24 per cent of male patients who had elevated scores on HAD.

**Screening for Radiation Toxicity**

Most patients experienced some degree of radiation toxicity, which increased in severity with the duration of treatment. The majority (80 per cent) of patients with breast cancer reported no breast pain or discomfort during their first touchscreen session, but by their fifth touchscreen session, 70 per cent of patients experienced mild or moderate degrees of breast pain or discomfort. Patients with head and neck cancer reported maximal toxicity (pain or difficulty in swallowing) at their third touchscreen session. Patients with prostate cancer reported gradually increasing levels of bowel and bladder toxicity over visits one to five and similarly patients with bowel cancer experienced increasing symptoms over the duration of their treatment.

**Patient Compliance**

Patients were asked to continue to answer the touchscreen questionnaires on their own, once a week during their course of their radiation treatment and during all follow-up visits. As can be seen from Figure 2, patient compliance fell markedly with time. The average number of touchscreen sessions completed by patients on the trial was 5.6 (ranging from a minimum of one to a maximum of eight sessions). Patient compliance during follow-up visits was extremely poor with only nine patients answering at least one follow-up questionnaire (however some patients attended follow-up visits at other hospitals).

**Discussion**

Anxiety and depression are known to be widely prevalent in cancer patients. Approximately 25 to 30 per cent of cancer patients experience anxiety and/or depression severe enough to warrant psychological intervention19. Most of these patients receive no support for their psychological condition, Maguire20 reported that only 20 to 30 per cent of cancer patients with significant anxiety or depression were diagnosed and treated. DiMatteo et al.21 found that depressed patients were three times more likely to be non-compliant with medical treatment than patients who are not depressed. Patients need more support to deal with the side effects of cancer and cancer treatment22.

Electronic self-administered questionnaires for the collection of patient information have several advantages, including increased patient privacy and confidentiality, more accurate data capture and improved storage of data. Vellios & al.23 compared touchscreen computerised administration of the HAD and EORTC QLQ-C30 with paper questionnaires and found that...
The differences between scores obtained with the two modes of administration were small, with equivalence for most of the QoL scales. On the emotional, fatigue and nausea/vomiting scales at administration, there was no difference between men and women in the proportion reporting symptoms. In both groups, most of the patients reported mild symptoms.

The majority (66 per cent) of patients in our trial who had elevated anxiety or/and depression would result in a change in patient management and ultimately in better patient outcomes. The follow-up phase of the study is currently underway.

The results reported above are similar to our findings in this trial. While 24 per cent of the patients surveyed in our study agreed that the use of computerised questionnaires to screen for mood disorders was a good method of conveying information about their symptoms to their treating doctor, patients who had never used a computer before were initially apprehensive about completing a computer questionnaire, but once they found out that it was not as difficult as they had anticipated, they were happy to participate in the trial. However, this initial enthusiasm for the project did not extend beyond the treatment course and into the follow-up phase and patient compliance declined with time. A weakness of this study is that patient satisfaction was not assessed in the study and that the reasons for the fall in patient compliance were not explored.

Possible ways of improving compliance might include issuing reminders to patients who have missed a touchscreen session and clinicians and administrative staff discussing this issue with the patient during another hospital encounter.

Screening for anxiety or depression among the cancer patients in our trial found that almost a third of the patients (30 per cent) had at least one positive result (using a HAD cutoff score of 11). Carletti et al found that 48 per cent of 950 inpatients and outpatients with cancer had scores of 8 or above on the HAD scale. In our trial, only two patients (four per cent had HAD scores of 11 or higher. Pascoe et al in a survey of oncology outpatients in four Sydney Hospitals found that 12 per cent of patients scored 11 or more in the anxiety subscale and seven per cent of patients had clinically significant depressive symptoms. The possible explanations for the comparatively lower incidence of anxiety and depression in our study may be the small sample size, the time that had elapsed since the last consultation, which led to the fact that only outpatients receiving potentially curative radiation treatment were included in our study. Several studies6-10 have shown that cancer patients with advanced disease, more metastases, pain or radiotherapy treatment were more likely to be depressed than patients without these factors. Aas et al found that the risk of psychiatric distress in hospitalised patients, measured using the HAD scale, was approximately twice that of patients in the outpatient clinic.

The majority (66 per cent) of patients in our trial who had elevated HAD scores were found to have an elevated score on only one occasion and this was often during their initial visit before the commencement of treatment. Ford et al11 studied a group of 117 newly referred outpatients with cancer and found that the incidence of both anxiety and depression was greater at initial referral than at six month follow-up.

Although other studies have looked at computerised administration of the HAD questionnaire, no previous studies have examined the use of computerised questionnaires to screen for the incidence of the side effects of radiotherapy, possibly because the questions need to be specific to the cancer site. Velikova et al12 assessed the feasibility and acceptability of computerised questionnaires to assess quality of life outcomes in oncology clinics. They found that they had symptoms and functional problems expressed quantitatively on a scale was useful for detection of change over time.

This trial has demonstrated that computerised screening for the side effects of radiation treatment is acceptable to patients. A further trial is currently being conducted to determine whether giving feedback to oncologists about their patients’ incidence of radiation toxicity and level of anxiety and/or depression would result in a change in patient management and ultimately in better patient outcomes.

References


of services were preferring to quit without help and a belief that a particular service would not help the participant. The results suggest that strategies to improve direct marketing of smoking cessation strategies and also the need for further research into the cost-effectiveness of such a strategy.

This research has recently been published by Paul CL, Wiggers J, Daly J, Green S, Walsh A, Knight L, Girgis A. Direct tele-marketing of smoking cessation interventions: will smokers take the call? Addiction 2004;99:907-913.

Smoking in Drug and Alcohol Agencies

Smoking has a huge impact on the mortality and morbidity of the general population. This impact increases considerably among individuals with other drug related problems, with smoking prevalence around 90 per cent and significantly more cigarettes smoked on a daily basis. Programs to encourage smoking cessation amongst this group of people needs to be a priority.

Dr Raoul Walsh and researchers from CHeRP undertook a cross sectional survey of all Australian drug and alcohol treatment agencies to assess their smoking cessation policies and practices and the impact of their policies and practices on smoking. Studies to stop smoking interventions were also examined. The manager and a staff member at the agency were sent questionnaires, with around 60 per cent of the agencies completing the questionnaire.

Only approximately one quarter of agencies indicated that they have a smoking cessation intervention policy. In most cases, the only cessation intervention smokers receive involves the recording of their smoking status on the client file. Based on the staff's own assessment, about two thirds of clients of such agencies receiving smoking advice had smoked less than a year ago. In summary, the survey showed that smoking cessation receives little attention from drug and alcohol agencies indicating, an urgent need for training and policy initiatives in this area.

Studies of Effect of Exposure of Young at Risk for Smoking to Television Advertising for Nicotine Replacement Therapy and Zyban®

Television advertising for nicotine replacement therapy (NRT) and Zyban® exposes the entire population, including adolescents, to persuasive messages about these smoking cessation products. There is a risk that adolescents exposed to the advertising might gain an unintended message that it is easy to quit smoking. This study suggests that although the management of early breast cancer in Victoria changed in the direction expected if the national guidelines had been incorporated into the practice of surgeons treating breast cancer. While pathological staging of cases was similar in the two study years, there was an increase in the use of breast conservation therapy (BCT) from 54 per cent of cases in 1995 to 69 per cent in 1999. The proportion of cases treated by BCT receiving radiotherapy also increased from 59 per cent in 1995 to 80 per cent in 1999. In addition more women were being seen by medical oncologists in 1999 than 1995 and this was associated with more appropriate use of endocrine therapy for women.

Evaluation of Fresh Start Smoking Cessation Courses

Fresh Start is a comprehensive quit smoking course which provides information, resources and support to smokers about quitting and staying stopped. The course consists of eight sessions of four to five hours, held over four weeks. Since August 2002 The Cancer Council WA has offered 84 Fresh Start smoking cessation courses and has also supported eight independently faciliated courses in regional Western Australia to 107 smokers. Follow-up telephone interview were conducted with participants 9-19 months after participation. A response rate of 83 per cent was achieved and a consent rate of 98 per cent. Responses were compared with pre-course and post-course questionnaires completed immediately prior to and after the courses. The Fresh Start course typically attracted long-term smokers. At the time of the follow-up survey, 83 per cent of respondents who completed the course had attempted to cut down or stop smoking. Of the 75 per cent of participants still smoking, tobacco consumption was lower than pre-course levels and a large majority of participants (85 per cent) still stated their intention to quit within the next six months. Participants thoroughly enjoyed the course, found it highly motivating and felt it had armed them with an excellent array of useful skills for quitting. Follow-up surveys are currently underway with health professionals who have attended brief intervention training courses provided by CBRPC.

Research in the Pipeline

- CCRR and TCR (SA)

Integrated Cancer Care

A key strategy of TCCSA concerns integrated cancer care. The CCRR is developing a survey tool to assess the needs and perceptions of people with cancer and their carers in relation to their hospital experience and the hospital-community interface. The survey will be in the form of a telephone questionnaire and the sample of people with cancer will be drawn from two major teaching hospitals in Adelaide. The aim is that once the data are collected clinicians in each of the hospitals will be asked to nominate their primary informal carer, who will also be invited to participate. This survey will provide information prior to an intervention strategy in each of the hospitals, which is being developed in partnership with the institutions. Qualitative analysis of the perceptions and experiences of general practitioners, in relation to smoking cessation, will form an integral part of this study.

Cancer Information Seeking: Patterns, Preferences and Needs of the South Australian Community

The Centre for Cancer Control Research is planning to undertake a study looking at cancer related information needs and current patterns of health information seeking among various client groups within the South Australian community. The study aims to determine if people currently access information about cancer (or health more generally) how they would like to access this information in the future and to identify what specific information they currently find difficult to access. Study participants will include cancer patients selected from four large hospitals in metropolitan hospitals (two public and two private), their nominated informal carers and a sample of 100 SA residents selected from the electronic white pages. The proposed method of data collection is via telephone interviews, with the possibility of focus groups to explore specific issues or communities media. Results of this study will inform the development of new technologies to enhance communication and improve on current methods of providing information and support to the community. This study with the SA Cancer Council will form part of a multi-centre evaluation of the effects of the Cancer Information Helpline.

Evaluation of the Critics’ Choice Program

TCRE is working with Quit SA to undertake a major evaluation of the Critics’ Choice tobacco education resource. Critics’ Choice is used in both primary and secondary schools across SA (and other states including WA, Vic, NSW), with the project’s aim to influence the knowledge and understanding of students and intention to smoke. This is done by showing a video featuring Australian and international smoking prevention/cessation advertisements. Students then undertake critical literacy and voting exercises. Pre and post-test questionnaires are being used by TCRE with 74 of the schools, to ascertain the effectiveness of the resource. An evaluation report of the findings will be available by the end of the year.

Surgeries Outcomes for Smokers

TCRE is working with Quit SA to investigate the risk of surgical complications for smokers using data from the hospital coding system (ICD-10 codes). Project findings will be reported on by the end of this year.

Smoke-free Pregnancy Project

Quit SA is undertaking a Smoke-free Pregnancy Project, aiming to establish an effective and sustainable set of interventions to assist the health of the pregnant and non-pregnant women in South Australia. The project has involved the establishment of a Pregnancy Quiltline, a media campaign and the training of antenatal staff at two major hospitals to deliver brief smoking cessation interventions with pregnant women who smoke. TCRE is evaluating the project and some results will be available in 2005.

Communicating Prostate Cancer Risk

Both consumer advocates and research bodies believe that Australian men need to be fully informed about their own risk of prostate cancer before making a decision about whether to be tested. We are currently exploring the implications of the risk of prostate cancer and requires clear messages about absolute and relative risk. Most published estimates of risk of diagnosis and mortality for prostate cancer are based on population based lifetime risk estimates. For a number of reasons we believe that these can give misleading estimates of risk for individual men in their 50s, 60s and 70s who are facing that decision. If men facing this decision were fully informed about their own risk of prostate cancer, then they and their general practitioners need to be aware of the many components of assessing an individual’s risk. This study investigates different ways of estimating and presenting the latest available information about risk of prostate cancer diagnosis and death among Australian men and highlights some potential difficulties when interpreting those risks.

Lifestyle Interventions in Survivors of Childhood Cancers

This pilot study is being conducted to determine the current problems with physical and functional uptake of lifestyle advice encountered by survivors of the main childhood cancers: acute lymphoblastic leukaemia, CNS tumours and lymphomas, as well as the level of interest in health promotion programs for survivors and their families. This pilot project is being undertaken in conjunction with a larger study by Dr Wendy Demark-Wahnefried of Duke University, US.

Queensland study participants are past and present members of the Queensland Cancer Fund’s ‘Seize the Day’ support program and past and present members of the Australian Organisation for Young People Living with Cancer. Data collection will be completed in 2004.

Community Views on Smoking

Smoking has been identified as the single, most preventable cause of premature mortality in Australia. Three national surveys are currently conducted to select smoking-related issues on a regular basis. However, these surveys do not cover a number of issues important for tobacco control, are conducted infrequently and are subject to long delays prior to the data being published. In Australia tobacco control is subject to the need for regular, frequent, high quality monitoring research into smoking behaviour. A need remains for a NSW vehicle which facilitates both ongoing tracking and detailed exploration of critical tobacco issues. Some of these issues include community attitudes toward environmental tobacco smoking-related issues, relapse issues among smokers, the use of pharmacotherapies in quitting and topical issues such as perceptions of recent campaign messages or proposed legislation.

Researchers at CHeRP, in conjunction with The Cancer Council NSW, are conducting the first of a series of biennial surveys to track key indicators of attitudes and practices relevant to tobacco control in NSW. The surveys will include key items for tracking over time and additional items which will be included periodically on the basis of need. Core items will include:

- prevalence and patterns of smoking behaviour for current smokers;

- reasons for and patterns of relapse during quit attempts for current smokers;

- smokers’ access to tobacco products and the influence of access on smoking and quitting behaviour;
Childrenhood Obesity: Investigating the Influence of Television Food Advertising

Reb Donovan and Owen Carter have been awarded a two-year grant to investigate the influence of television food advertising on childhood obesity. A record number of Australian children are overweight or obese, leaving them susceptible to a range of serious psychosocial and short- and long-term health problems, including a range of cancers. The causes of obesity are both genetic and environmental, yet only environmental factors can account for the recent increased prevalence of overweight and obese children. The environmental factors likely to have contributed to increases in childhood obesity include: the marked increase in Australian children’s consumption of energy dense foods that are high in fats and sugars; and the decreased energy expenditure associated with the large amount of sedentary time Australian children spend watching television. Television is also thought to be interrelated to food consumption as television ads for such foods are ubiquitous in children’s programming timeslots. Younger children have been shown to be highly susceptible to television ads and are able to greatly influence the purchasing intentions of their parents for food. It is not until around the age of 12 years that a large majority of children are able to discern the persuasive intent of advertising. Current advertising regulations within Australia do not appear capable of protecting children from junk food ads. A number of groups are advocating stricter controls of food advertising in Australia, yet much of the data to support such controls is not specifically related to food advertising, nor is it based on Australian samples of children. These weaknesses can be exploited by advertisers and manufacturers and as such it is both a public health and political imperative that advocates have Australian data to support stricter controls on food advertising.

We will be investigating the extent to which food advertising aimed at children breaches current advertising regulations over a four-week period and through a series of experiments with 600 children aged 5 to 12 years, assess their verbal and non-verbal understanding of the persuasive intent of food advertising and the ability of food advertising to alter their food preferences.

Mental Health Promotion Intervention

Poor mental health is associated with higher levels of smoking, physical inactivity and poor diet – all risk factors for cancer. We have received funding from Healthway to develop a mental health promotion intervention in regional areas of Western Australia, aiming to evaluate the relative effectiveness of various approaches to mental health promotion campaigns as identified by the Healthway Mental Health Promotion Scoping Project (Donovan et al, 2003). Two approaches were identified, including: Individual focused campaigns which aim to frame people’s perceptions of mental health as the absence of mental illness by emphasizing that proactive steps can, and should, be taken to protect and strengthen individual mental health; and Authority focused campaigns, which focus on interactions between those in authority and those under their charge (e.g. supervisors/workers; parents/children; teachers/students; coaches/trainers etc) where emphasis is placed upon replacing coercive, negative interaction styles with encouraging, positive styles under the overall message that “how you treat people under your care has significant implications for their mental health”. A cross-over study has been designed whereby three pairs of matched regional towns will receive either the individual or authority focused campaigns for one year, followed by the alternative the year after. Overall, the project will provide a blueprint for implementing a state-wide or national mental health campaign that will include lessons about appropriate campaign messages, sequences, target behaviours for target groups, partnerships with local groups and performance indicators.

Reports

- prevalence and patterns of pharmacotherapy use for current smokers and recent quitters.
- community views about and exposure to environmental tobacco smoke including smoking in cars, homes, bars, hotels and workplaces;
- community perceptions of the need for government regulation of tobacco retailing;
- community perceptions of the tobacco industry.

A market research company will be contracted to administer the computer assisted telephone interview (CATI) to 3500 New South Wales residents aged 18 years and older, with the survey being conducted on a biannual basis. This survey, used to complement existing data sources, will allow a much more timely approach to tobacco control policy development and implementation in NSW.

CBCRC (WA)

Assessing the effects of healthy and unhealthy TV food advertising on children’s food-related attitudes and preferences: research to inform policy and practice.

TV food advertising targeted at children has attracted criticism for its potential role in promoting unhealthy dietary practices among Australian children. Content analyses indicate that ‘junk food’ advertising is prevalent on Australian children’s television and that previous eating is being promoted. There is heated debate between the health and advertising sectors as to the impact of such advertising on children and whether regulation of TV food advertising is desirable. A team of researchers from the Cancer Council Victoria (Helen Dixon PhD), Melanie Wakefield and Vicki White and the Centre for Physical Activity and Nutrition Research, Deakin University (David Crawford) has been awarded a grant from The Financial Markets Foundation for Children to conduct a research study assessing the effects of healthy and unhealthy TV food advertising on children’s food-related attitudes and preferences.

The study will systematically assess the impact of varying combinations of TV advertisements for unhealthy and healthy foods on children’s dietary knowledge, attitudes and intentions, in order to evaluate the potential of various regulatory approaches to children’s food advertising to contribute to promoting healthy eating among Australian children.

Participants will be 800 grade 5 and 6 students from primary schools in Melbourne. We are focusing on children in these years because research and practice have shown that this age group is particularly vulnerable to advertising targeted at children.

The study will be randomly assigned to watch a half-hour TV program with different combinations of healthy/unhealthy foods advertised within. Baseline and post-intervention multiple-choice questionnaires will assess food preferences, perceived social norms, barriers and benefits relating to diet, dietary knowledge and intentions.

The study will yield much-needed data on the relative impact of different models for regulating TV food advertising targeted at children on children’s food-related attitudes, beliefs and intentions. It is hoped the results will help to inform public health policy and practice concerning food advertising targeted at children and offer insights into how to advertise foods to children in an ethical and responsible manner that promotes healthy dietary practices among Australian children.

CBRC (WA)
Giles presented the second plenary on Diet & cancer: Where's the evidence? A number of papers were presented by delegates covering cancer control, UV, nutrition and physical activity and cancer risk; life after cancer – understanding and meeting survivors' needs; and changing clinical practice. Copies of all presentations and photos are available at http://www.newcas.edu.au/conferences/cancer/index.html.

Congratulations to Clare Johnson, a PhD student with ChEaRP working in palliative care, who received the Pulse Education Prize ($3000) at the Hunter Medical Research Institute (HMRI) Awards Night held on the 9th September. This will contribute to her attendance at the 17th Multinational Association for Supportive Care in Cancer International Symposium in Geneva, 30-2 July 2004. PM will also enable her to visit the office of Supportive and Palliative Care, Department of Health in the UK.

ChEaRP staff and affiliates received two further HMR awards: Dr Jiong Li, A/Prof Afaf Girgis, Dr Chris Paul and Ms Allison Boyes received $10,000 funding for their study on the lifestyles and cancer surveillance practices of newly diagnosed cancer patients. Professor Jon Adams from the Centre for Clinical Epidemiology and Biostatistics, University of Newcastle, along with A/Prof Afaf Girgis and others, received a collaborative grant of $15,000, funded by the Lions Club of Adamstown and the Lions/Lionsesses Club of Toronto, for research into the use of complementary and alternative medicine amongst prostate cancer patients.

A/Prof Afaf Girgis also received the Newcastle Conference Ambassador Program Appreciation Award in recognition of her contribution as a Newcastle Conference Ambassador 2001-2004 for bringing the Behavioural Research in Cancer Control Conference to Newcastle. The award was presented by the University of Newcastle and Newcastle City Council.

ChEaRP has published a number of papers:

KConFab, Australian Ovarian Cancer Study & Familial Cancer Clinics of Australia and New Zealand: Series Two of Kith and Kin


This scientific meeting, held for the second year at Cowan Cove on South Stradbroke Island in Queensland, was the seventh national meeting organised by KConFab, and the second to be held in conjunction with Family Cancer Study (ACFS) and the Family Cancer Clinics of Australia and New Zealand. The conference organisers (Graeme Suthers, David Bowtell, Christine Clarke, Georgia Cheniev-Trench, Dorota Gertig, Joe Sammilaki, Nadia Traficante, Mary Anne Young and Heather Thorne) continued last year's successful formula, providing a program suitable for registrants with diverse clinical and research backgrounds linked by an interest in hereditary cancer or cancer biology. The format of the meeting was again restricted to members of Family Cancer Clinics. This provided a helpful opportunity for participants to discuss common challenging issues facing familial cancer clinics and should serve to further consolidate development and tumorigenesis. There were six international plenary session speakers: Valerie Beral from the University of Oxford, UK, presented an overview of findings from the UK Million Women Study, The Collaborative Group on Hormonal Factors in Breast Cancer and the Collaborative Group on Epidemiological Studies of Ovarian Cancer. Based on epidemiological data, a strong case was made for the role of parity (9 per cent reduction in risk for each additional delivery) and a reduced risk in women with family histories of breast cancer (50 per cent reduction in risk for each year of breast feeding) with respect to breast cancer risk. This (rather than other factors) may largely explain the striking difference in breast cancer incidence between developed countries and the developing world (6.3 per cent versus 1 per cent per year by age 70, respectively). Despite the many thousands of women in these studies, there still remain difficulties in understanding the interaction effect of modifiers (such as alcohol, body mass index and oral contraceptive pill use) in subgroups, such as those with a family history of breast or ovarian cancer. Bruce Ponder from Cancer Research UK, Cambridge, presented an update on efforts to evaluate Single Nucleotide Polymorphisms (SNPs) in putative cancer susceptibility genes. Analysis of patterns of familial cancer clustering suggests that the difference in relative risk between 20 per cent of women who are most highly predisposed to the 20 per cent least predisposed may be as great as 40-fold. Only a small part of familial risk is accounted for by highly penetrant mutations (eg, BRCA1 or BRCA2) and most risk within the population will be due to a large number of genes. In initial work, analysis of 295 SNPs in 74 candidate genes (such as DNA repair or oestrogen signalling pathways) in 2300 cases and controls has revealed six genes where a modifier effect may be present. These findings are to be evaluated in a prospective clinical trial. She also presented some intriguing findings using intra-ductal injection of liposomal doxorubicin to treat carcinogen induced non-invasive and established lesions, as well as mammmary tumours in Her/Neu transgenic mice. Remarkably, the ductal side branches throughout the entire mammary fat pad appear to be largely cleared using this approach. She plans to evaluate the utility of this approach in the treatment of established tumours prior to mastectomy and for pre-invasive disease in humans.

Other overseas speakers included Richard Pestell (Lombardi Comprehensive Cancer Center, Georgetown University, Washington DC) who spoke about his group's work that links the breast tumour suppressor BRCA1 with inhibition of ERα activity, an effect that is antagonised by cyclin D1.

Representations by Australian speakers was again strong, with a range of interesting talks on topics ranging from basic biology to clinical intervention studies, as listed in the conference program, which can be accessed from the KConFab website: www.kconfab.org.

Geoff Lindeman
Head, Royal Melbourne Hospital Familial Cancer Centre and Co-Head, VBRC Laboratory, The Walter and Eliza Hall Institute of Medical Research, Melbourne on behalf of the KConFab
Unprecedented Political Support

For the first time in a federal election, both the Coalition and the ALP included detailed cancer control policies among their campaign promises, with commitments that reflected much of The Cancer Council Australia’s recommended policy platform.

In separate announcements in September, the ALP committed to spending more than $112 million in prevention and treatment initiatives, while the Coalition launched its comprehensive $137 million policy, Strengthening cancer care, in October.

The Cancer Council Australia publicly endorsed both policies, particularly the many initiatives consistent with the evidence-based position we put forward to all federal politicians in June.

One of the most significant announcements was the Coalition’s pledge to establish a national cancer care agency, Cancer Australia, at $10 million over four years, which was a key Cancer Council priority.

There was unanimous support for funding independent clinical trials capacity building, with the Coalition and the ALP committing to $15 million and $12 million respectively over four years. The Cancer Council Australia had sought $5 million per annum.

Both sides also committed to rolling out a national bowel cancer screening program, as well as funding for national SunSmart campaigns. The ALP allocated $21 million for a tobacco control program aimed at five per cent decrease in national smoking rates, while the Coalition announced $4 million to reduce smoking in pregnancy.

The ALP’s commitment to introducing a Medicare Benefits Schedule item for cancer multidisciplinary care reflected The Cancer Council Australia’s overarching theme of improving multidisciplinary care.

The Cancer Council Australia CEO, Professor Alan Coates, said considerable effort went into engaging with both sides of politics in the lead-up to the election.

“We continue to emphasise the fact that, while there have been improvements in cancer outcomes for Australians over recent years, cancer remains the nation’s deadliest disease and there is great scope for federal policy makers to reduce the burden,” Professor Coates said.

“We were very pleased to see both sides of politics show strong leadership in cancer control and look forward to continuing to build good relationships with our supporters in Federal Parliament.”

Cancer Control in Indigenous Communities: Ways Forward

The Cancer Council Australia is developing a national advocacy strategy aimed at reducing the unacceptable disparities in cancer outcomes between Indigenous and non-Indigenous Australians.

The strategy will be based on the recommendations made at Australia’s first national discussion forum on cancer control in Indigenous communities, held in Darwin on 25-26 August, 2004.

Aboriginal and Torres Strait Islander peoples have markedly poorer overall cancer survival rates and higher incidence rates of some cancers than non-Indigenous Australians.

The discussion forum drew many of Australia’s leading cancer specialists, frontline Aboriginal health workers, health administrators and Indigenous cancer survivors to Darwin to examine the epidemiological data and the reasons for the disparities.

Issues explored included: language and cultural barriers affecting access to prevention, screening and treatment services; Indigenous peoples’ spiritual views about health; tobacco use; concerns about institutionalised racism; and funding availability.

Speakers noted the “double burden” on Indigenous health – infectious diseases typical of developing countries coupled with disproportionately high rates of chronic diseases prevalent in developed nations, such as cancer, diabetes and heart disease.


Health Groups Welcome Ratification of Tobacco Treaty

The Cancer Council Australian and other national health organisations have welcomed the Federal Government’s ratification of the World Health Organisation’s Framework Convention on Tobacco Control (FCTC).

Commenting that the initiative would help combat the tobacco epidemic in Australia and among our neighbours in the Asia-Pacific region, The Cancer Council Australia, National Heart Foundation of Australia and Action on Smoking and Health (ASH) all congratulated the Government for its ratification of the treaty.

The Cancer Council’s Chief Executive Officer, Professor Alan Coates, said smoking remained the world’s biggest cause of cancer and that in Australia alone it was responsible for more than 10,000 new cancer cases every year. “Ratifying the FCTC commits governments to a range of measures to improve controls on tobacco use and will help reduce smoking’s unacceptable toll in Australia and the Asia-Pacific,” Professor Coates said.

The health groups had collaborated on a submission last year supporting the signing and ratification of the FCTC.

Links


Framework convention alliance: www.fctc.org

World Health Organisation: www.who.int/tobacco/

Hope blooms on Daffodil Day

Throughout August daffodils were in full bloom helping The Cancer Council Australia spread the message of hope for all touched by cancer.

Daffodil Day is one of the largest national cancer awareness day in Australia, raising $7.3 million to fund the cancer control initiatives, patient support and education services of our eight state and territory member organisations.

Daffodil Day relies heavily on the supporting retail outlets to sell event-related merchandise. These products include silk ribbons, pens, enamel pins, magnets, balls and the popular Dougall teddy bear.

The Cancer Council Australia would like to thank its national supporters: Coles, QRX, First National Real Estate, Amcal, ANZ, Kates, Rockman, HIC network of Medicare offices and the Miller’s Retail Club.

For more information on the event, please visit the Daffodil Day website – www.daffodilday.com.au or 1300 65 65 85.

Deadly Perception of a “Healthy Tan”

New research showing half of all Australians still believe a tan is healthy has added to cancer experts’ fears of a prolonged national skin cancer epidemic.

The finding is contained in preliminary data from the first National Sun Survey, released by The Cancer Council Australia.

The Cancer Council’s Chief Executive Officer, Professor Alan Coates, described the finding as “disturbing” and said that while sun protection programs had made an impact, there was still a widespread lack of understanding about the dangers of sun exposure.

“Back in the 1980s we would have expected a much higher response to the question of a tan being healthy and while this research demonstrates we have made progress, clearly we

Pink Ribbon Day


The pink ribbon is a national symbol of support and recognition for women who have been touched by breast cancer. Through Pink Ribbon Day, The Cancer Council aim to make a difference to the lives of the 11,000 Australian women who will be diagnosed with breast cancer this year.

One in 11 Australian women are diagnosed with breast cancer, making it the most common cancer, and cause of cancer death, in women. Elisabeth Kochman, a breast cancer survivor, supported The Cancer Council Australia’s Pink Ribbon Day.

“As a breast cancer survivor, I am proud to support Pink Ribbon Day. The Cancer Council Australia not only funds research, but also helps with the day-to-day challenges of living with breast cancer by providing support services and assistance for women with cancer, and their family and friends,” said Ms Kochman.

“By buying a pink ribbon, people are investing in breast cancer research which could improve the future of thousands of Australians,” says Professor Alan Coates AM, Chief Executive Officer of The Cancer Council Australia.

“We are making progress. Since Pink Ribbon Day’s inception, we have seen a decrease in the breast cancer death rate and an increase in awareness of the disease. However, breast cancer remains the number one cancer killer of Australian women, so we still have much to do. The funds raised from Pink Ribbon Day will assist The Cancer Council to continue our vital work in breast
The JAK-STAT pathway in hemopoiesis and disease

AC Ward
Published by Kluwer/Plenum (2002)
RRP: US$147.00

The stated aim of the Editor is to describe the role of the JAK-STAT pathway in the normal development and function of haemopoietic cells and to describe how perturbations of this pathway lead to diseases, including one form of cancer - leukaemia. By all measures, this aim is well achieved. A compendium of invited chapters by seven different groups of authors, this book works particularly well as a detailed introduction to the importance and basic biology of the JAK-STAT signalling pathway. Central to our understanding of how cytokines and growth factors extrinsically influence cell proliferation, differentiation and function, the JAK-STAT pathways have been the subject of thousands of original articles in the last decade and a focused review is most welcome.

The book logically proceeds from a broad discussion of the Jak family, through a very detailed chapter on Jak3, to a chapter on non-Jak pathways to Stat activation and a superb analysis of the roles Stat signalling pathways regulate normal development and function. It is unlikely to find its way into many private collections, but is a practical way for most of us to access. The two volumes contain an impressive array of contributions from 357 eminent scientists and oncologists all of whom (with four exceptions) are from North America. One of the outstanding features of this text is the excellent tables, diagrams and pictures.

The first section describes the cardinal manifestations of cancer including the essential biological properties of cancer cells and a compendium of clinical presentations. Part two contains five chapters on the basic science of oncology ranging from tumour biology and immunology, clinical epidemiology to the fundamentals of drug development and clinical trial conduct. As well as providing an introduction to the basic science of oncology it gives an historical perspective to scientific discoveries. The second section concludes with a section describing how the findings of basic science have lead to the identification of therapeutic targets, which brings the reader back into the clinical context.

The topics are varied and the reviews are well written and do not assume detailed specific knowledge of the subjects. However solid grounding in molecular biological concepts and techniques is essential. Those with such a background will find the reviews informative. Some of the chapters are easier to read than others, with the discussion of HAMLET being particularly lucid and that of retroviral mutagenesis being much heavier.

The strength of this book is that it provides five comprehensive reviews of topics that may otherwise stay within the confines of specialist journals. The interested reader is taken through the background current research and potential implications of the findings. There is a moderate amount of speculation in the text. The distinction between data and speculation is clear and the speculative comments contribute to the strength of the book by giving the reader an insight into the thinking of experts in the areas. The future prospects are discussed with the correct balance of imagination and caution.

The five topics covered are quite diverse, ranging from the intricacies of the cell cycle regulation to a discussion of epigenetic variability in human cancer. All are focused on molecular biology, reflecting the fact that this remains the focus of most basic cancer research. It will be a very useful introduction to an area for someone embarking in research in that particular field and a good overview for anyone wanting a general understanding of these promising areas of cancer research. Those primarily interested in clinical research will find the book difficult, but may find some of it helpful in introducing them to new concepts.

The five topics covered are quite diverse, ranging from the intricacies of the cell cycle regulation to a discussion of epigenetic variability in human cancer. All are focused on molecular biology, reflecting the fact that this remains the focus of most basic cancer research. It will be a very useful introduction to an area for someone embarking in research in that particular field and a good overview for anyone wanting a general understanding of these promising areas of cancer research. Those primarily interested in clinical research will find the book difficult, but may find some of it helpful in introducing them to new concepts.

It is unlikely to find its way into many private collections, but is worth a place in university and research institute libraries.

A Roberts
Walter & Eliza Hall Institute
Melbourne, Vic

GR Vande G and G Klein
Published by Academic Press (2003)
ISBN: 0/1200-6687-4. 168 pages plus index
RRP: A$278.85

This is a book in an annual series of Advances in Cancer Research, edited by George Vande Woude and George Klein. The book consists of five lengthy reviews of new or topical areas in cancer biology. The topics are: 1) HAMLET (human alpha-lactalbumin made lethal to tumor cells); 2) Survivin and Apoptosis control; 3) Retroviral insertional mutagenesis to tag cancer pathways; 4) Ubiquitin-mediated proteolysis affecting cell cycle regulation; and 5) The role of epigenetic variability and the evolution of human cancer.

The topics are varied and the reviews are well written and do not assume detailed specific knowledge of the subjects. However solid grounding in molecular biological concepts and techniques is essential. Those with such a background will find the reviews informative. Some of the chapters are easier to read than others, with the discussion of HAMLET being particularly lucid and that of retroviral mutagenesis being much heavier.

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A Roberts
Walter & Eliza Hall Institute
Melbourne, Vic

This important two volume tome is the 6th edition of Cancer Medicine and marks the 30th anniversary of its original publication. This is one of those truly comprehensive textbooks of oncology and covers aspects of surgical oncology, radiation oncology and medical oncology. The scope of this text takes the reader through the basic science of oncology, provides a collection of recent scientific discoveries and more importantly meshes the science and the clinical applications that arise from these findings. Fortunately it comes accompanied by a CD, which is a far more portable and practical method for most of us to access. The two volumes contain an impressive array of contributions from 357 eminent scientists and oncologists all of whom (with four exceptions) are from North America. One of the outstanding features of this text is the excellent tables, diagrams and pictures.

The first section describes the cardinal manifestations of cancer including the essential biological properties of cancer cells and a compendium of clinical presentations. Part two contains five chapters on the basic science of oncology ranging from tumour biology and immunology, clinical epidemiology to the fundamentals of drug development and clinical trial conduct. As well as providing a good introduction to the basic science of oncology it gives an historical perspective to scientific discoveries. Given the vast array of contributors it is inevitable that there is some repetition in the chapters. Interestingly, there is not a good description of gene microarray technology and recent findings in this area. The majority of the scientific chapters finish with a section describing how the findings of basic science have lead to the identification of therapeutic targets, which brings the reader back into the clinical context.

There are detailed chapters on the fundamentals of clinical trial design and good description of basic statistical methods. It does not however, contain a reference to standard criteria for assessing tumour response and toxicity of treatment. Discussions on cancer screening and health care delivery have a noticeably American perspective. The chapters on medical imaging contain detailed site-specific tumour evaluation, but interestingly a detailed description of the use of PET imaging for particular tumour types is lacking. The inclusion of sections on multidisciplinary care, psycho-oncology, palliative care, paediatric oncology and oncology informatics complete a truly comprehensive oncology resource.

For a book which contains such a wealth of scientific information, it also contains surprisingly insightful sections on physician burnout and psychosocial and ethical issues relevant to the clinical practice of oncology. This book provides a firm foundation for students of oncology from any discipline and is a useful reference for the experienced clinician and educator. I was particularly impressed by the inclusion of Leod’s rules of therapeutic:

1. If what you are doing is doing good, keep doing it.
2. If what you are doing is not doing good, stop doing it.
3. If you do not know what to do, do nothing.
4. Never make the treatment worse than the disease.

It is unlikely these basic tenets will ever be surpassed by scientific advances.

C Shannon
Mater Adult Hospital
Brisbane, Qld

Handbook of colorectal surgery (2nd edition)

D Beck (Ed)
Published by Marcel Dekker (2003)
ISBN: 0-8247-4025-4. 526 pages plus index
RRP: US$99.75

This textbook is of a good size that is small, light, portable and yet very comprehensive. Aimed at the resident and fellow, it will also find a place with consultants as a useful teaching tool.

Revised and updated in this second edition, this handbook serves as a basic guide to the management of patients with colorectal diseases. It illustrates anatomical structures, examination procedures and surgical techniques.

It covers preoperative preparation, pain management, postoperative management and the care of conditions including paediatric conditions, functional disorders, diverticular disease, inflammatory bowel disease, rectal prolapse, haemorrhoids, perianal sepsis and colorectal carcinoma. Illustrations and photos are in black and white. New concepts in patient care and operative techniques, including laparoscopic surgery, are covered.

On showing this book to a few colorectal surgical colleagues it had an instant and universal appeal. The responses were all favourable and related to its size, handling, hard cover, ability to fit in a bag and the self explanatory nature of the photographs. The well organised content was also a strong point.

I anticipate that those who purchase this excellent book will use it much more than the weightier tomes, which though thorough, often inhibit use by their sheer size. It would make a welcome addition in any library.

C Young
Royal Prince Alfred Hospital Medical Centre
Newtown, NSW

Bone metastases and
MOLECULAR MECHANISMS

G Singh (Ed)
RRP: A$540.15

This book lists commonly used combination and single agent regimens used in the treatment of solid tumours and haematological malignancies. The book presents the regimens in alphabetical order, listed by tumour type. Each entry lists the drugs to be used, at which doses, on what days and how often the cycle is repeated. The last 50 pages (one third of the book) consist of the references for the regimens.

CM Washington and D Leaver (Eds)
Published by Lippincott Williams & Wilkins (2004)
Published by Lippincott Williams & Wilkins (2004)

The book is aimed at non-expert clinicians and scientists interested in recent advances regarding the pathophysiology of bone metastases. The references are extensive and reasonably current. The diagrams are well chosen and helpful.

One criticism is that although the chapters are very readable, there is a logic to the order in which they are presented. Chapters describing clinical practice, such as diagnostic methods and bisphosphonate therapy, are interspersed with research chapters seemingly randomly. This makes the flow of the book somewhat awkward.

Overall, a useful but not essential text that would be worthwhile having in a hospital or departmental library.

E Segelov
St Vincent’s Hospital
Darlinghurst, NSW

PRINCIPLES AND PRACTICE OF RADIATION THERAPY (2nd Edition)

CM Washington and D Leaver (Eds)
Published by Lippincott Williams & Wilkins (2003)

RRP: A$250.00

This textbook is primarily aimed at the radiation therapist, although some chapters provide nice overviews for a trainee radiation oncologist or medical physicist. The book has been divided into three sections. The first part of the book includes an overview of cancer management including pathology, chemotherapy and surgery, and the ethics and legal considerations of cancer management, detection and diagnosis, equipment, radiation therapy, chemotherapy and drug administration. Some chapters (eg. legal aspects of radiation therapy) are written from a US viewpoint and therefore some of the issues are not particularly useful for the non-American reader. However, some concepts such as informed consent have wider application and may prove useful for those interested.

The second section relates to physics, simulation and treatment and includes chapters on mathematical concepts, radiation physics, radiation safety, quality improvement and dosimetry. The sections on electronic charting and image management are a welcome addition, as departments are increasingly storing records electronically.

The final part discusses specific tumour or treatment sites and covers the majority of treatment sites, including sections on total body irradiation, spinal irradiation, prostate brachytherapy and paediatrics, as well as the more common treatment sites. Each chapter describes the epidemiology, prognostic factors, natural history, clinical presentation, detection and diagnosis, anatomical pathology and staging before describing treatment techniques including possible immobilisation techniques and possible field arrangements. Recent technological advances such as three-dimensional planning system and technology enhancements such as multileaf collimation have been incorporated where appropriate.

There is some discussion of non-radiation treatment modalities in each of the chapters, but one of the strengths of the book is that it focuses on the issues related to the radiotherapy and leaves other well-known oncology texts to better discuss other treatment modalities. The omission of large amounts of discussion relating to other treatment modalities maintains the size at a reasonable level for a textbook.

Most of the criticisms that could be levied at the book are relatively minor and mainly relate to layout. For instance, a helpful table on all of the Radiation Therapy Oncology Group morbidity scores is presented in the breast cancer section even though this table would be better placed in a general toxicity section.

Overall, this textbook provides a good, solid educational resource for any radiation oncology department or individual radiation therapist.

G Delaney
Liverpool and Campbelltown Hospitals
Sydney, NSW

PAIN MANAGEMENT MADE INCREDIBLY EASY

J Mundon et al (Eds)
Published by Lippincott Williams & Wilkins (2003)
RRP: A$150.00

The scope of the book is impressive; no aspect of pain management comes to mind that is not mentioned. Of particular interest to oncology/palliative care nurses is management of cancer pain. The chapter on this topic is broad, it includes current thinking about pain management, such as suggestion of a fourth rung to the WHO analgesic ladder to incorporate invasive interventions (epidural and intrathecal drugs), different routes of drug administration, adjuvant therapies, surgical intervention and complementary therapies. What is not discussed and what many practitioners are keen to know, are specifics of opioid conversion rates, opioid rotation, uses and doses of co-analgesics and costs to consumers. This level of detail however, would be necessarily limited to local and idiiosyncratic pain management strategies of specific practice settings and could not be expected in a generally text such as this.

Overall, the text provides a good overview of a wide range of topics associated with pain management and is appropriate for nurses wishing to increase their general knowledge in the area. A personal note about the whimsical additions, like the cartoon characters, aimed to increase appeal and appreciation of a complex subject. Although this format may appeal to some, I found the whimsy distracting and superfluous and incredibly annoying.

J Greaves
Royal Prince Alfred Hospital
Sydney, NSW

The book is made of the requirement of the US Joint Commission on Accreditation of Healthcare Organisations (JCAHO) for health facilities to meet standard of pain assessment and management and one assumes that the text is written to aid compliance with this requirement.

From a quick search of the internet, this book appears to be one of an incredibly Easy series; other titles covering wound care, diagnostic tests, clinical pharmacology and medical-surgical nursing. Its format is intended to be user-friendly, with annotated cartoon characters making pertinent points to reinforce the accompanying text and unique features that include “Rein in the pain” – pointers on how to manage pain, and “Myth busters” – dispelling misconceptions about stereotypes and prejudices. Each chapter ends with a quick quiz to consolidate knowledge on the chapter’s main messages.

The text provides an easy to understand discussion of pain physiology and psychological responses to pain. It is encouraging to see a chapter devoted to pain assessment, including standards introduced by JCAHO in 2000 and a comprehensive description of the range of pain assessment tools. Pharmacological and non-pharmacological treatments, including therapies such as aromatherapy, yoga and biofeedback are discussed.

Differentiation is made between acute, chronic non-malignant, cancer and HIV/AIDS pain, with a chapter on each that includes suggestions for non-pharmacological and non-pharmacological treatments within these domains. Specific areas of paediatrics and genitric pain management plus addictive disease, including understanding addiction, managing addiction and managing pain in patients with addiction, are discussed. A final chapter looks at lifestyle management for people with chronic pain.

The text provides a quick, but not comprehensive, overview of the range of pain management options. There is no mention of cancer pain in the first part of the book, and few references are made to pain management in cancer. The author suggests the book provides a handy, quick reference for physicians, nurses and health care providers. Attempting to provide a simple resource, which is relevant to such a wide range of health professionals, is problematic.

From an Australian perspective it omits some commonly used regimens, such as PCAB and C-VAMP. It includes new combinations, such as Gemcitabine and Oxaliplatin for pancreatic cancer, which have already been shown to be of limited additional benefit over single agents and new agents, such as Bortezomib, which are only used in trial situations in Australia.

The back cover claims the book to be quick access, evidence-based, up-to-date, comprehensive, authoritative and pocket-sized. Well it is certainly pocket sized, but it is hardly comprehensive and it is certainly not authoritative. In this day of net based protocols, one would hope that chemotherapy treatments are written up based on more than memory and basic prompts such as this.

B Jansens
Shoalhaven District Memorial Hospital

CHEMOTHERAPY PROTOCOLS

Published by Lippincott Williams & Wilkins (2004)
RRP: A$40.15

There are many protocol books available today and many pocket sized versions, which provide more comprehensive information. The Baxter Oncology’s Selected Schedules of Therapy for Malignant Tumors would be a good example.

The information presented does not include particular indications for regimens, guiding the user as to why one regimen would be used over another. The book states infusion administration details for a couple of regimens, but does not do this.

The author suggests the book provides a handy, quick reference for physicians, nurses and health care providers. Attempting to provide a simple resource, which is relevant to such a wide range of health professionals, is problematic.

From an Australian perspective it omits some commonly used regimens, such as PCAB and C-VAMP. It includes new combinations, such as Gemcitabine and Oxaliplatin for pancreatic cancer, which have already been shown to be of limited additional benefit over single agents and new agents, such as Bortezomib, which are only used in trial situations in Australia.

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B Jansens
Shoalhaven District Memorial Hospital
Professor Sompayrac chose nine cancers as models as he felt they offered the clearest examples of how cancer works. For each model he addressed three questions:

“What risk factors make it more likely that an individual will get this cancer?”

“How does this cancer affect a person that has it?”

“How is this cancer treated?”

The first chapter is an overview introducing cellular control growth systems, leading on to how multiple growth promoting systems within a maturing cell are corrupted. The author then outlines techniques for culturing and harvesting each group of malignancies including karyotyping. Each group of malignancies has a chapter detailing regulatory pathways and markers in oncology, the second part of the book is divided into three parts, explaining of individual steps ready translation of methods into practice and provides clear explanations of individual steps within procedures, which are as valuable to the experienced cytogeneticist as they are to the novice.

The book is not to be read in one sitting. It is to be read leisurely and savoured as Justman takes the reader into the world of Aristotle, Homer, Tolkien, Chaucer, Montaigne and Rousseau. The message he brings is for doctors who deliver bad news and researchers who design questionnaires. To the question “Would you want to know you have an incurable illness” he replies, “How is it possible to capture thought itself in an opinion survey?” How can you have an incurable illness? Can cancer cells ride out the fire of radiation, awaiting their time? I am left with a seed of doubt”.

The book is written in the form of lectures utilising metaphor, humour and diagrams, thus making some complex concepts understandable. Each lecture concludes with a concept table with examples and “thought” questions, with each new lecture starting with a review of the previous lecture before introducing new concepts.

Today, the background areas are brief but appropriate. One work best in their laboratories.

The lectures are summarised with a comprehensive table of contents and examples as well as a glossary. This book is an excellent resource for high school students, student nurses and will be utilised as part of orientation for registered nurses and new graduates undergoing orientation in our unit.

Cancer Cytogenetics, Methods and Protocols is an immensely useful book for anyone working in the field of cytogenetics. The book has filled this volume with the sort of detail that enables ready translation of methods into practice and provides clear explanations of individual steps within procedures, which are as valuable to the experienced cytogeneticist as they are to the novice.

The book is divided into three parts, the first introducing molecular markers in oncology, the second detailing regulatory pathways that are involved in disease development and the third which examines future directions in disease treatment. Together the three sections of this book make for a comprehensive treatise, bringing together a range of concepts and evidence to show that molecular approaches to cancer treatment and prevention are likely to offer the best therapeutic modalities in the near future, compared to current treatment practices.

Impressively, this book contains much information about many of the key genes that have been identified over the past decade or so and is, by this inclusion alone, an extremely useful resource for anyone wishing to get an overview of the field without having to trawl through a considerable amount of literature. There remains a level of redundancy, which is inevitable in such a volume but it does not detract from the}
overall usefulness of the book. What is surprising is how up-to-date the contents of the book are, which makes it extremely useful for the practicing oncologist to come up to speed in this ever-changing discipline.

The main drawback to a book like this is the relatively small amount of apparent thought that went into cross-referencing and the indexing system. With a more comprehensive indexing system and the removal of repeated figures from later chapters, it would become a more concise and easily referred to source of information. To emphasise this point, there are areas where certain aspects described early in the book are referred to in later chapters and these really ought to be indicated in the reference section.

Notwithstanding, this book represents an excellent edition dealing with a complex and growing area of oncology and it may well become a leading reference source for molecular oncology.

R Scott
John Hunter Hospital
Newcastle, NSW

UNDERSTANDING BREAST CANCER GENETICS

BT Zimmerman

Published by University Press of Mississippi (2004)


Breast Cancer Genetics is a relatively short book of six chapters by scientist Barbara Zimmerman. The author’s background is in cellular and molecular biology, although she is currently the director of a US-based consulting firm. She has written the book for the general audience and claims that her principal aim is to explain the genetics of both sporadic and familial breast cancer.

The book begins with an overview of the epidemiology of breast cancer before taking a step back into the science lab where normal and tumour cell biology, breast anatomy and the malignant potential of breast cancer are outlined. The third and fourth chapters are devoted to the role of specific genes known to have a role in breast cancer tumorigenesis, metastasis and resistance. The fifth chapter diverts back to the clinical side of breast cancer and describes prevention, the diagnostic process, staging and treatment possibilities. The final chapter, Breast Cancer Research, gives a brief summary of the some of the major areas of both clinical and scientific research.

The language and detail is extremely complex in parts and would be beyond the scope of many readers. However, given there are some serious information seekers in the world of breast cancer, there are likely to be some breast cancer aware readers who would persevere with the text and come out a little ahead on completion.

The biggest criticism I have with this book is that the promise of genetics is limited to two of the six chapters. There are dotted references to inherited versus sporadic cancers in the remaining chapters, however largely the book is a general overview of breast cancer with a serious but brief step into genetics. This would be an ideal text for a student (medical or nonmedical) about to undertake a project in breast cancer, who wanted a quick review of breast cancer and some of the more prominent areas of current research focus.

Y Avril
Peter MacCallum Cancer Centre

CALENDAR OF MEETINGS

Australia and New Zealand

<table>
<thead>
<tr>
<th>Date</th>
<th>Name of Meeting</th>
<th>Place</th>
<th>Secretariat</th>
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<tr>
<td>8-9 November</td>
<td>27th Annual Oncology Nurses Group Conference</td>
<td>Brisbane QLD</td>
<td>Oncology Nurses Group Conference Secretary Queensland Cancer Fund PO Box 201 Spring Hill QLD 4004 Tel: +61 7 3257 1360 Fax: +61 7 3257 1360 Email: Adm@iunpaq/cancer.com.au Web: <a href="http://www.qldcancer.com.au">www.qldcancer.com.au</a></td>
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<tr>
<td>21-26 December</td>
<td>Australian Health and Medical Research Congress</td>
<td>Sydney NSW</td>
<td>ASN Events Secretariat Tel: +61 3 5939 2340 Email: <a href="mailto:congress@pharmaevents.net.au">congress@pharmaevents.net.au</a> Web: <a href="http://www.ahncongress.org.au">www.ahncongress.org.au</a></td>
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<tr>
<td>24-26 December</td>
<td>31st COSA Annual Scientific Meeting</td>
<td>Canberra ACT</td>
<td>31st COSA Annual Scientific Meeting Pharmacy Events Ph: +61 2 9280 0577 Fax: +61 2 9280 0533 Email: cosawpharmaevents.com.au Web: <a href="http://www.cosa.org.au">www.cosa.org.au</a></td>
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2005

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<tr>
<th>March</th>
<th>17-20 Australian Brachytherapy Group</th>
<th>Alice Springs NT</th>
<th>Pharmacy Events Ph: +61 9280 0577 Fax: +61 2 9280 0533 Email: <a href="mailto:conferences@pharmaevents.com.au">conferences@pharmaevents.com.au</a></th>
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<tbody>
<tr>
<td>April</td>
<td>15-17 RACR Pediatric Oncology Course</td>
<td>Sydney NSW</td>
<td>Pharmacy Events Ph: +61 9280 0577 Fax: +61 2 9280 0533 Email: <a href="mailto:conferences@pharmaevents.com.au">conferences@pharmaevents.com.au</a></td>
</tr>
<tr>
<td>May</td>
<td>15-18 Australian College of Dermatologists Annual Scientific Meeting</td>
<td>Perth WA</td>
<td>Australian College of Dermatologists PO Box 2065 Boronia Park NSW 2111 Tel: +61 2 9879 6177 Fax: +61 2 9816 1174 Email: admin@aco/dom.au Web: <a href="http://www.dercoll.asn.au">www.dercoll.asn.au</a></td>
</tr>
<tr>
<td>July</td>
<td>25-28 Trans-Tasman Radiation Oncology Group Annual Scientific Meeting</td>
<td>Darwin NT</td>
<td>Pharmacy Events Ph: +61 2 9280 0577 Fax: +61 2 9280 0533 Email: <a href="mailto:conferences@pharmaevents.com.au">conferences@pharmaevents.com.au</a></td>
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Cancer Forum  Volume 28 Number 3  November 2004
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<tr>
<th>Date</th>
<th>Name of Meeting</th>
<th>Place</th>
<th>Secretariat</th>
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| 7-9      | Royal College of Nursing Australia National Conference | Glenelg SA             | Royal College of Nursing Australia  
PO Box 219  
Deakin West ACT 2600  
Tel: +61 2 6282 3633  
Fax: +61 2 6282 3565  
Email: Nicole@rcna.org.au  
Web: www.rcna.org.au |
| 21-23    | Cancer Nurses Society Of Australia                   | Hobart TAS             | Pharma Events  
Ph: +61 2 9280 0577  
Fax: +61 2 9280 0533  
Email: conferences@pharmaevents.com.au |
|          |                                                      |                        | **CALENDAR OF MEETINGS – International**                                      |
| 5-7      | Oncology Nursing Society Institute of Learning      | Nashville Tennessee USA | Oncology Nursing Society  
125 Enterprise Drive  
Pittsburgh, Pennsylvania 15275-1214 USA  
Tel: +1 866 6257 4667  
Email: meetings@ons.org  
Web: www.ons.org |
| 10-12    | 11th Hong Kong International Cancer Congress         | Pokfulam Hong Kong     | 11th HKCCC Congress Secretariat  
Dept of Surgery  
University of Hong Kong Medical Centre  
Queen Mary Hospital  
Hong Kong  
Tel: +852 2818 0322  
Fax: +8 52 2818 1186  
Email: hkccc@hkccc.org.hk  
Web: www.hkccc.org.hk |
| 17-19    | 1st International Conference for Oncologists and Other Health Care Leaders | New York USA          | Barnes Caisselth  
Memorial Sloan-Kettering Cancer Center  
1275 York Ave  
New York - 10021 - New York  
Tel: +1 212 639 2000 |
| 17-19    | First International Conference of the Society of Integrative Oncology | New York USA          | CIO Registration  
19 Martus Road, Mt Royal, NJ 08011, USA  
Web: www.integrativeonc.org |
| 3-7      | 46th Annual Meeting of the American Society of Hematology | San Diego California USA | American Society of Hematology  
1900 M street NW Suite 200  
Washington DC 20036 USA  
Tel: +1 20 2776 0544  
Email: meetings@hematology.org  
Web: www.hematology.org |
| 3-6      | 27th Annual San Antonio Breast Cancer Symposium      | San Antonio Texas USA  | Cancer Therapy & Research Center  
SACI, Rich Markow  
San Antonio, Texas, USA  
Fax: +1210 949 5099  
Email: Rmarkow@saci.org  
Web: www.saci.org |
| 15-16    | 4th International Meeting of Hepatocellular Carcinoma: Eastern and Western Experiences | Wanchai Hong Kong | 4th HCC EWE  
Congress Secretariat  
Department of Surgery,  
University of Hong Kong Medical Centre  
Queen Mary Hospital, Pokfulam  
Tel: + 85 2 2818 0232  
Fax: + 85 2 2818 1186  
Email: hccewe04@hku.hk  
Web: www.hcc-ewe.org |
| 12-14    | 4th International Meeting of ISCORT                  | Elat Israel            | Israeli Society for Clinical Oncology & Radiation Therapy (ISCORT)  
Elat Israel  
Tel: +97 288 - 00 860  
Fax: +97 288 212 336  
Email: wmpsh@emihsom.bgu.ac.il |
| 14-15    | Perspectives in Gynecologic Oncology                 | Nice France            | Imexco  
70 Technology Drive  
Alpharetta Georgia  
30005 USA  
Tel: +1 770 751 7332  
Fax: +1 770 751 7334  
Email: c.chase@imexco.com  
Web: www.imexco.com/calendars/oncology.htm |
| 16-21    | 9th European Winter Oncology Conference              | Films Switzerland      | Federation of European Cancer Societies  
AV. E. Monier 83  
Brussels 2000 Belgium  
Tel: +32 2 775 02 01  
Fax: +32 2 775 02 00  
Email: info@fecs.be  
Web: www.fecs.be |
<table>
<thead>
<tr>
<th>Date</th>
<th>Name of Meeting</th>
<th>Place</th>
<th>Secretariat</th>
</tr>
</thead>
<tbody>
<tr>
<td>21-22</td>
<td>Focus on Myeloma and Plasma Cell Disorders</td>
<td>Las Vegas, USA</td>
<td>Imexed 70 Technology Drive Alpharetta Georgia 30005 USA Tel: +1 770 751 7332 Fax: +1 770 751 7334 Email: <a href="mailto:chair@medex.com">chair@medex.com</a> Web: <a href="http://www.imedex.com/calendar/oncology.htm">www.imedex.com/calendar/oncology.htm</a></td>
</tr>
<tr>
<td>26-29</td>
<td>British Thoracic Oncology Group 3rd Annual National Meeting 2005</td>
<td>Dublin, Ireland</td>
<td>British Thoracic Oncology Group Hospital Management Offices, Glenfield Hospital Leicester LE3 9QP United Kingdom Tel: +44 116 2502811 Fax: +44 116 2502038 Email: <a href="mailto:enquiries@btog.org">enquiries@btog.org</a> Web: <a href="http://www.btog.org">www.btog.org</a></td>
</tr>
<tr>
<td>26-29</td>
<td>Primary Therapy of Early Breast Cancer</td>
<td>St Gallen, Switzerland</td>
<td>Hans-Jörg Senn St. Gallen Oncology Conferences Rorschacherstr. 150 St. Gallen - 9006 Switzerland Tel: +41 71 243 0032 Fax: +41 71 245 6805 Web: <a href="http://www.oncoconferences.ch/index.html">www.oncoconferences.ch/index.html</a></td>
</tr>
<tr>
<td>27-29</td>
<td>7th International Symposium on Febrile Neutropenia</td>
<td>Seville, Spain</td>
<td>Imexed 70 Technology Drive Alpharetta Georgia 30005 USA Tel: +1 770 751 7332 Fax: +1 770 751 7334 Email: <a href="mailto:meeting@medex.com">meeting@medex.com</a> Web: <a href="http://www.imedex.com/calendar/infectiousdisease.htm">www.imedex.com/calendar/infectiousdisease.htm</a></td>
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<tr>
<td>27-29</td>
<td>American Psychological Oncology Society 2nd Annual Conference</td>
<td>Charlottesville, USA</td>
<td>American Psychological Oncology Society 2355 Hunters Way Charlottesville Virginia 22911 USA Tel: +1 434 293 5350 Fax: +1 434 977 0899 Email: <a href="mailto:phil@psychaps-society.org">phil@psychaps-society.org</a> Web: <a href="http://www.paps-society.org">www.paps-society.org</a></td>
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**February**

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<tbody>
<tr>
<td>1-4</td>
<td>16th International Congress on Anti-Cancer Treatment</td>
<td>Paris, France</td>
<td>Travel Congress Organisation (TCO) 2, rue de Berri Paris 75008 France Tel: +33 1 4294 8732 Fax: +33 1 4294 8733 Email: <a href="mailto:info@tcog.com">info@tcog.com</a> Web: <a href="http://www.tcosociety.org">www.tcosociety.org</a></td>
</tr>
<tr>
<td>10-14</td>
<td>American Society for Blood and Marrow Transplantation Annual Meeting</td>
<td>Keystone, CO USA</td>
<td>American Society for Blood and Marrow Transplantation 85 West Algonquin Road Suite 550 Arlington Heights Illinois 60005 USA Tel: +1 847 742 0224 Email: <a href="mailto:mail@alstrom.org">mail@alstrom.org</a></td>
</tr>
<tr>
<td>18-19</td>
<td>New Targets in Cancer Therapy II</td>
<td>Nice, France</td>
<td>Imexed 70 Technology Drive Alpharetta Georgia 30005 USA Tel: +1 770 751 7332 Fax: +1 770 751 7334 Email: <a href="mailto:chair@medex.com">chair@medex.com</a> Web: <a href="http://www.imedex.com/calendar/oncology.htm">www.imedex.com/calendar/oncology.htm</a></td>
</tr>
<tr>
<td>23-26</td>
<td>2nd annual Miami Breast Cancer Conference Weston</td>
<td>Weston, Florida, USA</td>
<td>Miami Cancer Conference, Inc. PO Box 26948 Weston Florida 33326 USA Tel: +1 954 888 9472 Fax: +1 954 888 9472 Email: <a href="mailto:lost@smtp.com">lost@smtp.com</a> Web: <a href="http://www.cancercf.com">www.cancercf.com</a></td>
</tr>
<tr>
<td>21-22</td>
<td>3rd International Symposium on Targeted anticancer Therapies</td>
<td>Amsterdam, Netherlands</td>
<td>NDDO Research Foundation c/o Convenience Conference Management PO Box 77 Harmelen 3400 DB Netherlands Tel: +31 348 567 667 Fax: +31 348 446 057 Email: <a href="mailto:congress@nddo.org">congress@nddo.org</a> Web: <a href="http://www.nddo.org">www.nddo.org</a></td>
</tr>
<tr>
<td>3-6</td>
<td>58th Annual Cancer Symposium of the Society of Surgical Oncology</td>
<td>Atlanta, Georgia, USA</td>
<td>D.K. Kubis - Society of Surgical Oncology 85 W Algonquin Rd Suite 55 Arlington Heights IL - 60005 Tel: +1 (847) 427 1400 Fax: +1 (847) 427 9656 Email: <a href="http://www.sasoc.org">www.sasoc.org</a></td>
</tr>
<tr>
<td>7-9</td>
<td>Functional Genomics and Animal Tumour Models</td>
<td>Madrid, Spain</td>
<td>CNIO Spanish National Cancer Centre C/ Melchor Fernandez Almagro, 3 Madrid 28029 Spain Tel: +34 91 224600 Fax: +34 91 2246080 Email: <a href="mailto:cchavez@cnio.org">cchavez@cnio.org</a> Web: <a href="http://www.cnio.es/cnc">www.cnio.es/cnc</a></td>
</tr>
<tr>
<td>11-13</td>
<td>7th Shaukat Khanum Memorial Cancer Symposium</td>
<td>Lahore, Pakistan</td>
<td>Shaukat Khanum Memorial Cancer Hospital and Research Centre Jahn Toshiba Lahore Pakistan Tel: +92 42 5180 725-34 Fax: +92 42 5180 723-34 Email: <a href="mailto:training@shaukatkhanum.org.pk">training@shaukatkhanum.org.pk</a> Web: <a href="http://www.shaukatkhanum.org.pk">www.shaukatkhanum.org.pk</a></td>
</tr>
<tr>
<td>13-16</td>
<td>13th International ABK-AIO Cancer Congress</td>
<td>Wurzburg, Germany</td>
<td>BiomedTec Franken e.V. Friedrich-Bergus-Ring 15 Wurzburg 97076 Germany Tel: +49 931 298873 Fax: +49 931 299 8894 Email: <a href="mailto:skloembi@medt-franken.de">skloembi@medt-franken.de</a> Web: <a href="http://www.abk-aio-congress.de">www.abk-aio-congress.de</a></td>
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<tr>
<td>15-16</td>
<td>Building Palliative Care programs in Hospitals</td>
<td>Miami, USA</td>
<td>Center to Advance Palliative Care Mount Sinai School of Medicine 1255 Fifth Avenue, Suite C-2 New York New York 10029-6574 USA Tel: +1 212 201 2680 Email: <a href="http://www.capc.org">www.capc.org</a></td>
</tr>
<tr>
<td>17-19</td>
<td>6th International Symposium and Expert Workshops on Leukemia and Lymphoma</td>
<td>Amsterdam, Netherlands</td>
<td>VU University Medical Center Dept. PAOG P.O Box 7057 Amsterdam 1007 MB Netherlands Tel: +31 20 444844 Fax: +31 20 4448445 Email: <a href="mailto:cm.vanhaarden@vumc.nl">cm.vanhaarden@vumc.nl</a> Web: <a href="http://www.vumc.nl">www.vumc.nl</a></td>
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<tr>
<td>18-19</td>
<td>3rd Annual Atlanta Lung Cancer Symposium</td>
<td>Atlanta, USA</td>
<td>Imexed 70 Technology Drive Alpharetta Georgia 30005 USA Tel: +1 770 751 7332 Fax: +1 770 751 7334 Email: <a href="mailto:cchavez@medex.com">cchavez@medex.com</a> Web: <a href="http://www.imedex.com/calendar/oncology.htm">www.imedex.com/calendar/oncology.htm</a></td>
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<tr>
<td>18-19</td>
<td>National Update on Advances in Urology</td>
<td>New Orleans, USA</td>
<td>Imexed 70 Technology Drive Alpharetta Georgia 30005 USA Tel: +1 770 751 7332 Fax: +1 770 751 7334 Email: <a href="mailto:cchavez@medex.com">cchavez@medex.com</a> Web: <a href="http://www.imedex.com/calendar/oncology.htm">www.imedex.com/calendar/oncology.htm</a></td>
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<td>18-20</td>
<td>Second Annual Winter Lung</td>
<td>Florida, USA</td>
<td>Cadent medical Communications</td>
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<tr>
<td>Date</td>
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<td>May 05-08</td>
<td>Second quadrennial meeting of the World Federation of Neuro-Oncology EANO VI</td>
<td>Edinburgh, UK</td>
<td>Federation of European Cancer Societies</td>
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<td>Avenue E. Mounier 83, Brussels 1200 Belgium</td>
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<td>Tel: +32 2 775 0205, Fax: +32 2 775 0200</td>
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<td>Email: <a href="mailto:feds@facr.be">feds@facr.be</a>, Web: <a href="http://www.facs.be">www.facs.be</a></td>
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<tr>
<td>13-17</td>
<td>41st Annual Meeting of the American Society of Clinical Oncology (ASCO)</td>
<td>Orlando, USA</td>
<td>American Society of Clinical Oncology (ASCO)</td>
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<td>1900 Duke Street, Suite 200, Alexandria Virginia 22314 USA</td>
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<td>Tel: +1 703 299 0150, Fax: +1 703 299 1044</td>
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<td>Email: <a href="mailto:ascogo@asco.org">ascogo@asco.org</a>, Web: <a href="http://www.ascogo.org">www.ascogo.org</a></td>
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<tr>
<td>30-01</td>
<td>ONC Cancer Conference: MAP Kinases and Cancer</td>
<td>Madrid, Spain</td>
<td>CDN , Spanish National Cancer Centre</td>
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<td>C/ Melchor Fernandez Almagro, 3, Madrid 28029 Spain</td>
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<td>Tel: +34 91 224 6900, Fax: +34 91 224 6980</td>
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<td>Email: <a href="mailto:ccc@cnio.es">ccc@cnio.es</a>, Web: <a href="http://www.cnio.es/ccc">www.cnio.es/ccc</a></td>
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<tr>
<td>01-04</td>
<td>13th Reach to Recovery International Breast Cancer Support Conference</td>
<td>Athens, Greece</td>
<td>Hellenic Association of Women with Breast Cancer</td>
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<td>21-23 Leotzenheur str., Piraeus 185 36 Greece</td>
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<td>Tel: +30 210 41 80 006, Fax: +30 210 41 80 16</td>
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<td>Email: <a href="mailto:breastca@otenet.gr">breastca@otenet.gr</a>, Web: <a href="http://www.breastcancerhellas.gr">www.breastcancerhellas.gr</a></td>
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<td>2-5</td>
<td>EHA-10: 10th Annual Meeting of the European Haematology Association</td>
<td>Stockholm, Sweden</td>
<td>Eurocongress Conference Management</td>
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<td>Jan van Goyenkade 11, Amsterdam Netherland</td>
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<tr>
<td></td>
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<td></td>
<td>Tel +31 20 679 3411, <a href="mailto:Eha2005@eurocongres.com">Eha2005@eurocongres.com</a></td>
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<td>Web: <a href="http://www.ehaweb.org">www.ehaweb.org</a></td>
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<tr>
<td>08-12</td>
<td>World Congress on Breast Cancer</td>
<td>Halifax, Canada</td>
<td>World Breast Cancer Organization, Inc</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>841 Princess Street, Kingston Ontario K7L 1G7 Canada</td>
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<td></td>
<td>Tel: +1 613 549 1118, Fax: +1 613 549 1146</td>
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<td>Email: <a href="http://www.worldbreastcancerconf.ca">www.worldbreastcancerconf.ca</a></td>
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<tr>
<td>15-17</td>
<td>Sarcoma Meeting Stuttgart 2005</td>
<td>Stuttgart, Germany</td>
<td>Olghospital Stuttgart</td>
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<td></td>
<td></td>
<td></td>
<td>Postfach 103070, Stuttgart 70767 Germany</td>
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<td></td>
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<td></td>
<td>Tel: +49 711 992 2466, Fax: +49 711 992 2462</td>
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<td>Email: <a href="mailto:rashford@olghospital.de">rashford@olghospital.de</a>, Web: <a href="http://www.imedex.com">www.imedex.com</a></td>
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<tr>
<td>15-18</td>
<td>World Congress on Gastrointestinal Cancer</td>
<td>Barcelona, Spain</td>
<td>Imedex</td>
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<td></td>
<td></td>
<td>70 Technology Drive, Alpharetta Georgia 30005 USA</td>
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<td>Tel: +1 770 751 7322, Fax: +1 770 751 7324</td>
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<td>Email: <a href="mailto:meetings@imedex.com">meetings@imedex.com</a>, Web: <a href="http://www.worldgicancer.com">www.worldgicancer.com</a></td>
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**CALENDAR OF meetings**

**Cancer Forum** - Volume 28 Number 3 - November 2004
<table>
<thead>
<tr>
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<th>Name of Meeting</th>
<th>Place</th>
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<tr>
<td>16-18</td>
<td>International East-West Symposium on Nasopharyngeal Cancer</td>
<td>Toronto, Canada</td>
<td>Princess Margaret Hospital, University of Toronto 610 University Avenue, Room 5-H83 Toronto ON M6G 2S8 Canada Tel: +1 416 946 2123 Fax: +1 416 946 4586 Email: <a href="mailto:Fae-Fae.Loom@uhn.on.ca">Fae-Fae.Loom@uhn.on.ca</a></td>
</tr>
<tr>
<td>23-26</td>
<td>2nd Quadrennial Meeting of the World Federation of NeuroOncology</td>
<td>Edinburgh, Scotland</td>
<td>Federation of European Cancer Societies Avenue E Mounier 83 Brussels, Belgium 1200 Tel: +32 0 2775 0201 Email: <a href="mailto:eano6@fecs.be">eano6@fecs.be</a></td>
</tr>
<tr>
<td>26-30</td>
<td>XVIII World Congress of Gerontology</td>
<td>Rio de Janeiro, Brazil</td>
<td>ACE Events SHN Qd. 02 BL E Sobrelpia 50 Kubitschek Plaza Hotel Brasilia DF CEP 70710-908 Brazil Tel: +55 61 328 6912 Fax: +55 61 328 6912 Email: <a href="mailto:Secretariat@aceeventos.com.br">Secretariat@aceeventos.com.br</a> Web: <a href="http://www.gerontology2005.org.br">www.gerontology2005.org.br</a></td>
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July

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<tr>
<td>3-6</td>
<td>11th World Conference on Lung Cancer</td>
<td>Barcelona, Spain</td>
<td>Heather Drew Imedex 70 Technology Drive Alphabetta 30005 - Georgia Tel: +1 770 751 7332 Fax: +1 770 751 7334 Web: <a href="http://www.2005worldlungcancer.com/2005WLC/">www.2005worldlungcancer.com/2005WLC/</a></td>
</tr>
<tr>
<td>14-16</td>
<td>2005 Gastrointestinal Oncology Conference</td>
<td>Arlington, USA</td>
<td>International Society of Gastrointestinal Oncology (ISGIO) 200 Broadhollow Rd Melville New York 11747 USA Tel: +1 631 390 8390 Fax: +63 13 930691 Email: <a href="mailto:email@isgio.org">email@isgio.org</a> Web: <a href="http://www.isgio.org">www.isgio.org</a></td>
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September

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<tbody>
<tr>
<td>13-16</td>
<td>9th International Nottingham Breast Cancer Conference</td>
<td>Nottingham, UK</td>
<td>Nottingham Breast Cancer Conference City Hospital Nottingham, UK Tel: +44 11 596 257 07 Fax: +44 11 596 277 65</td>
</tr>
<tr>
<td>25-28</td>
<td>109th Annual Meeting of the American Academy of Otolaryngology – Head and Neck Surgery</td>
<td>Los Angeles, USA</td>
<td>AmericanOtolaryngology – Head and Neck Surgery c/o The AAO-HNS Foundation Inc. 1 Prince Street Alexandria VA 22314-3357 USA Tel: +1 703 836 4444 Fax: +1 703 519 1546 Email: <a href="mailto:aats@entnet.org">aats@entnet.org</a></td>
</tr>
<tr>
<td>29 –</td>
<td>10th International Conference on Geriatric Oncology &amp; 6th Meeting of the International Switzerland Society of Geriatric Oncology (ISOG)</td>
<td>Genolier, Switzerland</td>
<td>IMO, Clinique de Genolier Genolier 1271 Switzerland Tel: +41 22 366 9106 Fax: +41 22 366 9131 Email: <a href="mailto:soe@genolier.net">soe@genolier.net</a></td>
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October

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<tr>
<td>02-05</td>
<td>31st European Congress on Cytology</td>
<td>Paris, France</td>
<td>NCI France 11, rue de Solférino Paris France Tel: +33 1 53 85 8252 Fax: +33 1 53 85 8283 Email: <a href="mailto:Cytology2005@nci-group.com">Cytology2005@nci-group.com</a></td>
</tr>
<tr>
<td>09-12</td>
<td>34th Congresso Brasileiro de Radiologia</td>
<td>Brazil</td>
<td>Congresso Brasileiro de Radiologia Av, Paulaista 491, 130 Andar Cj 133-CEP 05119-009 Brazil Tel: +55 11 285 4022 Fax: +55 11 285 4022 Email: <a href="mailto:cradiologic@cbra.org.br">cradiologic@cbra.org.br</a></td>
</tr>
<tr>
<td>16-20</td>
<td>ASTRO 47th Annual Meeting</td>
<td>Denver, Colorado USA</td>
<td>American Society for Therapeutic Radiology and Oncology (ASTRO) 12500 Fair Lakes Circle Suite 375 Fairfax Virginia 22033 USA Tel: +1 70 3277 0170 Email: <a href="mailto:meeting@astro.org">meeting@astro.org</a></td>
</tr>
<tr>
<td>30 –</td>
<td>ECCO 13 The European Cancer Conference</td>
<td>Paris, France</td>
<td>Federation of European Cancer Societies Avenue E. Mounier 83 Brussels 1200 Belgium Tel: +32 2 775 0205 Fax: +33 13 930000 Email: <a href="mailto:ECO13@fecs.be">ECO13@fecs.be</a> Web: <a href="http://www.fecs.be">www.fecs.be</a></td>
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November

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<tbody>
<tr>
<td>05-09</td>
<td>33rd Annual Scientific Meeting of the American Society of Cytopathology</td>
<td>San Diego, USA</td>
<td>American Society of Cytopathology 400 West 9th Street Suite 201 Wilmington DE 19801-1555 USA Tel: +1 302 429 8807 Email: <a href="mailto:asc@cytopathology.org">asc@cytopathology.org</a> Web: <a href="http://www.cytopathology.org/meetings/index.php">www.cytopathology.org/meetings/index.php</a></td>
</tr>
<tr>
<td>07-09</td>
<td>ONS Cancer Conference: Cancer and Aging</td>
<td>Madrid, Spain</td>
<td>CNO – Spanish National Cancer Centre C/ Melchor Fernandez Almagro, 3 Madrid 28029 Spain Tel: +34 91 2246900 Fax: +34 91 2246900 Email: <a href="mailto:onc@ons.org">onc@ons.org</a> Web: <a href="http://www.cno.es/ccc">www.cno.es/ccc</a></td>
</tr>
<tr>
<td>11-13</td>
<td>Oncology Nurses Society Institutes of Learning</td>
<td>Phoenix, USA</td>
<td>Oncology Nursing Society 125 Enterprise Drive Pittsburgh Pennsylvania 15275-1214 USA Tel: +1 866 257 4677 Fax: +1 877 369 5497 Email: <a href="mailto:meetings@ons.org">meetings@ons.org</a> Web: <a href="http://www.ons.org">www.ons.org</a></td>
</tr>
<tr>
<td>27 –</td>
<td>91st Meeting of the Radiological Society of North America (RSNA)</td>
<td>Chicago, USA</td>
<td>Radiological Society of North America (RSNA) 829 Jorie Blvd Oak Brook IL 60523-2251 USA Tel: +1 630 517 7679 Fax: +1 630 571 7837 Email: <a href="mailto:ion@rsna.org">ion@rsna.org</a></td>
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December

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<tr>
<td>2-6</td>
<td>47th Annual Meeting of the American Society of Hematology</td>
<td>San Diego, California USA</td>
<td>American Society of Hematology 1900 M street NW Suite 200 Washington DC 20036 USA Tel: +1 202 776 0544 Email: <a href="mailto:meeting@ash.org">meeting@ash.org</a> Web: <a href="http://www.hematology.org">www.hematology.org</a></td>
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<tr>
<td>06-10</td>
<td>29th Annual San Antonio Breast Cancer Symposium</td>
<td>San Antonio, USA</td>
<td>San Antonio Breast Cancer Symposium c/o San Antonio Cancer Institute 7979 Wurzbach Rd, Suite-U-531 San Antonio Texas 78229 USA Tel: +1 210 616 5912 Fax: +1 210 949 5009 Email: <a href="mailto:Patients@saabcs.net">Patients@saabcs.net</a> Web: <a href="http://www.sabcs.org">www.sabcs.org</a></td>
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<tr>
<td>10-14</td>
<td>American Society for Cell Biology (ASCB): 45th Annual Meeting</td>
<td>San Francisco, USA</td>
<td>American Society for Cell Biology (ASCB) 8120 Woodmont Avenue Suite 750 Bethesda MD 20814-2755 USA Tel: +1 301 347 9300 Fax: +1 301 347 9310 Email: <a href="mailto:ascbinfo@ascb.org">ascbinfo@ascb.org</a></td>
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THE CANCER COUNCIL AUSTRALIA

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

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

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

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Professor A Coates AM, MD, FRACP, AStat

COUNCIL
Office Bearers
President
Mrs J Roberts AO SRN
Vice-President
Professor I Frazer BSc(Hons), MBChB, MD MRCP, FRCP, FRCPA

Members
Dr S Ackland MBBS, FRACP
Mr G Brien AM, MBA
Hon H Cowan
Mr H Cuthill
Professor C Gaston
Dr S Hart FRACS
Professor D Hill AM, PhD
Dr G Jennings BSc PhD Dip Ed
Hon S Lenehan BA, DipMan, MBA, FAICD
Mr R McGowan
Assoc Professor S Smiles RN, RM, ICC, BHA, GradDipPSEM
Professor J Ward MBBS, MHPed, FAFPHM, PhD
Dr K White PhD

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CLINICAL ONCOLOGICAL SOCIETY OF AUSTRALIA INC

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

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

EXECUTIVE COMMITTEE
President
Dr S Ackland MBBS, FRACP
President Elect
Prof D Currow BMed, MPH, FRACP
Executive Officer
Ms M McJannett
Council Nominees
Ms K Cameron RN, OncCent, GrDipN, MNSc
Dr D Goldstein MBBS, MRCP (UK), FRACP
Professor B Stewart MSc, PhD, FRACI

MEMBERSHIP
Further information about COSA and membership applications are available from:
www.cosa.org.au or cosa@cancer.org.au
Membership fees for 2004
Ordinary Members: $140
Associate Members: $80
(includes GST)

INTEREST GROUPS
ANZ Children’s Haematology and Oncology
Breast Oncology
Cancer Nurses Society of Australia
Cancer Research
Data Managers
Epidemiological
Gastrointestinal Oncology
Gynaecological Oncology
Lung Oncology
Medical Oncology
Melanoma and Skin
Neuro-oncology
Palliative Care
Pharmacy
Psycho-Oncology
Radiation Oncology
Regional and Rural Oncology
Social Workers
Surgical Oncology