# List of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Editorial</strong></td>
<td>Going beyond the Marryalyan</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>B Stewart</td>
<td></td>
</tr>
<tr>
<td><strong>Forum: Cancer impact on Indigenous communities</strong></td>
<td>Overview</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>R Lowenthal</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The Cancer Council Australia’s Darwin conference – summary of presentations</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>R Lowenthal</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Comparative cancer incidence, mortality and survival in Indigenous and non-Indigenous residents of South Australia and the Northern Territory</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>D Roder</td>
<td></td>
</tr>
<tr>
<td></td>
<td>“Some of us know some things and some of us know others” – Reducing the impact of cancer care on Aboriginal and Torres Strait Islander communities</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>I Olver, S Selva-Nayagam, O Fried, M Davy and M Barton</td>
<td></td>
</tr>
<tr>
<td></td>
<td>A model for engaging and empowering Indigenous women in cancer screening</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>S Angus</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reducing the impact of cancer in Indigenous communities: ways forward</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>R Lowenthal, P Grogan and E Kerrins</td>
<td></td>
</tr>
<tr>
<td><strong>Articles</strong></td>
<td>An evaluation of support groups for young women with early breast cancer</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>H Gunn, B Meiser, B Thewes, D Cairns</td>
<td></td>
</tr>
<tr>
<td><strong>Reports</strong></td>
<td>Support for research 2005</td>
<td>27</td>
</tr>
<tr>
<td></td>
<td>Australian behavioural research in cancer</td>
<td>37</td>
</tr>
<tr>
<td></td>
<td>Cancer care: An integrated approach – COSA 31st Annual Scientific Meeting</td>
<td>42</td>
</tr>
<tr>
<td><strong>News and announcements</strong></td>
<td></td>
<td>44</td>
</tr>
<tr>
<td><strong>Book reviews</strong></td>
<td></td>
<td>47</td>
</tr>
<tr>
<td><strong>Calendar of meetings</strong></td>
<td></td>
<td>55</td>
</tr>
</tbody>
</table>
EDITORIAL
Going beyond the Marryalyan

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

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

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

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

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

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

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

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

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

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

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

The Australian cancer establishment and the country’s federal, state and territory governments need to confront the issue of Indigenous cancer. That its importance has hitherto been overlooked and neglected shames us all; the matter is urgent. Cancers are occurring that could be prevented and lives are being lost that could be saved, now. The good news is that ‘ways forward’ were indeed identified at the conference. As described by Sandy Angus, the ‘talk-fest’ is over; now is the time for action.

\[\text{Cancer Forum} \, \text{Volume 29 Number 1} \, \text{March 2005}\]
A/Professor Elston spoke of her own experience dealing with his grief following his father’s death from cancer six months previously. He spoke of the importance of the grieving process and the impact on the community following the death of an elder.

Lorna Murakami-Gold
Cooperative Research Centre for Aboriginal Health, Charles Darwin University, NT

Ms Murakami-Gold spoke about the attitude of Aboriginal people to health research. She emphasised that consultation at every stage of research projects was essential to ensure Indigenous people were fully informed about why the research was important for them, Indigenous people also needed to have some ownership of the process and the data. A more cooperative approach would help to build Indigenous research capacity.

Dr John Condon
Menzies School of Health Research, Darwin, NT

Dr Condon examined cancer rates in the NT (see also Professor David Roder’s paper). Lung cancer incidence in Aboriginal males has doubled over 20 years, whereas rates in the general male population are starting to fall. Factors associated with poorer survival from cancer included remote residence, being non-English speaking, being simultaneously affected by two or more chronic diseases, being a current smoker, and having been a heavy alcohol consumer.

Since the conference Dr Condon has released additional research on stage at diagnosis and cancer survival of Indigenous and non-Indigenous people in the Northern Territory.1

Heidi Lehman
La Trobe University

Ms Lehman reported on a survey of the knowledge and attitudes of Ananth Land Aborigines to cancer. There was little knowledge of causative factors other than smoking and many held mistaken beliefs about the possible role of injuries and of black magic.

Dawn Maracle
Research and Policy Officer, Department of Health, Ontario, Canada

Ms Maracle discussed the cancer problem in Canadian Aboriginals. A particular issue is that tobacco is a local herb and its use is part of cultural tradition. She described how Aboriginal Patient Navigators were employed to assist in negotiating the complex health system.

Bev Dershow
Palliative Care Service, NT

Ms Dershow opened a session on cultural issues, pointing out that for Aborigines, family, culture and ‘country’ (ie the land to which they belong) were of overriding importance.

Jeremiah Baker-Balung
Royal Darwin Hospital

Mr Baker-Balung described how, for Aborigines, each body part can be a symbol of a family member. In radical contrast to the western sense of ‘next of kin’, for Aboriginal patients the person giving consent depends on the body part that is affected.

Viki Briggs
Centre for Excellence in Indigenous Tobacco Control, Victoria

Ms Briggs pointed out that, while in the general Australian population the smoking rate fell from 35% to 23% between 1980 and 2001, amongst Aborigines the rate in 2002 was still 50%. Encouragingly, she described promising tobacco control initiatives in Queensland (Smokescreen) and Western Australia.

Dr Christine Connors
Preventable Chronic Disease Program, NT

Dr Connors addressed the challenge of chronic diseases including cancer, in relation to lifestyle factors such as poverty, unemployment and remote residence. Control requires an organised program approach; by this means several important health measures have improved in the NT; healthy foods are becoming more widely available and alcohol consumption has stabilised.

Tony McCarty and Margaret Culbong
National Aboriginal Community Controlled Health Organisation

Mr McCarty and Ms Culbong described the Aboriginal community-controlled health services, of which there are over 130 throughout the country. They provide ‘Aboriginal space’, health promotion including provision of healthy foods, welfare services and social support.

The meeting finished with a facilitated discussion forum which identified priorities for action including: more collaborative relationships between the Indigenous and general communities; greater Indigenous participation in research programs; better access to treatments, both mainstream and traditional; a Cancer Council workforce more inclusive of Indigenous staff; capacity building among Indigenous health services; cultural education of the non-Aboriginal health care workforce; and advocacy with state, territory and federal governments to emphasise the importance of the issues.

Comparative cancer incidence, mortality and survival in Indigenous and non-Indigenous residents of South Australia and the Northern Territory

David Roder
The Cancer Council South Australia
Email: droder@cancersa.org.au

Introduction

Cancer incidence has been poorly defined by Indigenous status in Australia, due to difficulties encountered in all jurisdictions in obtaining accurate information on race. During 1988-1994, the Epidemiology Branch of the South Australian Health Commission implemented a special project, in which extensive attempts were made to record all cancers in Indigenous residents of that State and to validate Indigenous status.1

A further collaborative project to estimate incidence by race was undertaken in 2003.2 Collaborating partners included the Epidemiology Branch and Aboriginal Services Division of the Department of Human Services, the Aboriginal Health Council of South Australia, and The Cancer Council South Australia. In this project, incidence relativities (for all cancer sites combined) between Indigenous and non-Indigenous South Australians, as determined in the 1988-94 study, were generalised to the broader 1977-2001 period. Incidence rates for Indigenous cases were apportioned by site according to the age-sex distribution by site for this broader period.

Incidence

Figure 1 shows comparative Indigenous and non-Indigenous incidence estimates for the two jurisdictions. In South Australia, the Indigenous incidence appeared to be about 6% lower than the non-Indigenous incidence for all cancer sites combined. It is evident, however, from 95% confidence intervals that this difference could have arisen by chance.

In the Northern Territory, the Indigenous incidence was found to be 15% lower than the non-Indigenous incidence. Yet it was estimated that the Indigenous figure could have been about 15% lower than actually occurring due to under-ascertainment and misclassification of race.

It would appear from these figures, after considering the potential for under-ascertainment of Indigenous cancer rates, that Indigenous and non-Indigenous Australians may have broadly similar susceptibilities to cancer – at least for all cancer sites combined.

Mortality

It is evident from Figure 2 that cancer mortality appears higher in Indigenous than non-Indigenous Australians, both in South Australia and the Northern Territory. Broadly speaking, the rate appears to be about 40% higher in Indigenous residents.

The data therefore suggest that while Indigenous and non-Indigenous residents have a broadly similar risk of getting...
Cancer Forum  n Volume 29 Number 1 n March 2005

• Pancreas – tobacco smoking and potentially diabetes and a low intake of fruit and vegetables.
• Liver – endemic infection with hepatitis B and C, and possibly cirrhosis from a high alcohol intake.
• Gallbladder – possibly a history of multiple pregnancies and high body weight.
• Unspecified organs – possibly:
  - delayed diagnoses when organs of origin are no longer readily apparent; and
  - a poor access to advanced diagnostic technologies.

Cancers with a lower incidence in Indigenous people

Both the Northern Territory and South Australian data showed a relatively high incidence of cancers of the cervix and related female organs (i.e., organs with ICD-9 codes of 180 & 184). In addition, Indigenous people were observed to have a higher incidence of cancers of the cervix and related female organs (i.e., organs with ICD-9 codes of 180 & 184). The international scientific literature points to a number of risk factors for these cancers. They include:

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

In general, these cancers had relatively high survivals, in contrast to those cancers that were over-represented in Indigenous residents.

The Northern Territory data also showed a lower incidence of lymphoma in Indigenous people, whereas the South Australian data pointed to a lower incidence of haematological cancers (including lymphomas) in this sector of the population. These findings were unexpected. Although the reasons are unknown, it is possible that the immune system of Indigenous people may be more robust and more protective against these cancers.

Survival

South Australian data have shown a lower Indigenous than non-Indigenous survival for cancers of equivalent type (Table 1). A corresponding comparison of survivals by race in the Northern Territory for the 1991-2001 diagnostic period revealed lower Indigenous than non-Indigenous survivals for 12 of the 13 cancer types studied (Condon J, unpublished data). While Indigenous patients in South Australia presented with more advanced cancers at diagnosis, differences in survival were still suggested after adjusting for stage (Table 1).

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

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<th>Period from diagnosis (yrs.)</th>
<th>Indigenous (n=139)</th>
<th>Non-Indigenous (n=417)</th>
<th>SEER stage adjusted Indigenous (n=139)</th>
<th>Non-Indigenous (n=417)</th>
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References:
“Some of us know some things and some of us know others” – Reducing the impact of cancer care on Aboriginal and Torres Strait Islander communities

Ilan N Oliver, Sid Selva-Nayagam, Olfa Fried, Margaret Davy, Michael B Barton

1 Royal Adelaide Hospital SA
2 Royal Darwin Hospital NT
3 Alice Springs Hospital NT
4 Liverpool Hospital, NSW

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Cancer Forum – Volume 29 Number 1 – March 2005

Forums is a series of anecdotes by clinicians who, focusing on equitable access to care, highlight issues that have arisen in their experiences of treating cancer and providing palliative care to Aboriginal and Torres Strait Islanders to reduce the morbidity and mortality from the disease.

The medical oncologist from city cancer centre

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

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

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

“I was doing a ward round at the Royal Adelaide Cancer Centre medicine oncology on Saturday afternoon at my request and a ward nurse. We went to the bed of an Aboriginal patient who had seemed quite comfortable and was usually quite cooperative. I asked him how he felt and he curled into a ball and indicated the pain to me. While I was trying to decide what to do next the two women with me pulled the curtains and stepped outside. The man straightened himself up and started to talk to me as normal. I learned later that the man in the next bed, an opal miner from Coolbar Pedy, had called the nurse aside and told her that the man would not talk to me about his body while women were present. When I reached the opal miner’s bed I thank him for his help and said simply, “Some of us know some things, and some of us know others.”

The case illustrated the necessity of being able to understand gender and cultural aspects of care.

“Visiting Darwin before we had the telemedicine link between Adelaide and Darwin and doing a ward round with the local physicians I was asked to explain to an Aboriginal patient with liver cancer his chances of responding to doxorubicin. I wanted to tell him that he had about one in four chance of shrinking the cancer and one in four chance of no change. I told him that if there were four men and you treated all of them one would benefit. He wanted to know where the other three went. I tried to tell him that they didn’t go anywhere and that I was only using an example. He wasn’t to put off that I was odd and he wanted to know all about the other three. I was digging myself a deeper hole and the deeper it got the more my colleagues were amused.”

Information has to be provided in a form that is understood by the Aboriginal patients with examples that will have meaning for them.

“It was asked to see an Aboriginal woman who was an inpatient in Alice Springs Hospital. The woman had metastatic breast cancer with multiple bone metastases and severe pain in both hips where the lytic lesions were threatening to fracture. I did my best to speak to her. I had been told that she would be uncooperative. However, I looked directly into her eyes so I looked everywhere else. I began to talk to her about what we could offer. She stopped me. She didn’t want to hear any more because it was frightening her. At that stage her husband turned up. He told me he was taking her home tomorrow. In the end she agreed to take Tamoxifen tablets. It was a far cry from my initial of pinning her hips, irradiating them and other painful areas and then offering chemotherapy. I felt that I had failed the patient. The nursing staff tried to reassure me that I had done my best and that agreeing to treat her as she wanted was important and I would probably be asked to see other such patients in the future.”

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

The Darwin oncologist

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

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

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

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

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

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

He then refused to have any more chemotherapy, although he agreed to continue the Doxycycline, but compliance was uncertain. Numerous attempts to try and talk to him or to organize family meetings failed. This person often gives the consent and any decision made about his treatment is also done by the family members involved.

Despite ongoing symptoms and further family meetings he refuses further chemotherapy and has had no further contact with the hospital. He has since been referred to the Royal Darwin Hospital palliative care liaison team.

Palliative care is all about maintaining a sick person’s quality of life, and they determine what that quality of life is for them. In palliative care we generally try to look after people the way they want, where they want and how they want. It’s a matter of giving them the power to the patient and making them the decision maker. That also helps ensure the care is culturally safe for that person. By cultural safety I mean that a person can use a service given by someone from another culture without risk to their own.

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

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

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

This man had a miserable end. He wasn’t able to be discharged from hospital. It turned out he was a rather famous painter and I had the painting he did before he died, a painting of his home and also because of a hospital acquired infection, so everyone coming to see him had to wear a gown and mask. He seemed really depressed, was too ashamed to go outside and had nothing to do. I was not able to paint his portrait, but it was even difficult to get him paints and brushes in our public hospital. It turned out he was a rather famous painter and I still have the painting he did before he died, a painting of his country.

I have told you his sad story because it doesn’t have to be this way. If you give the power to the patient, if you give them the full information, use interpreters and cultural advocates where necessary, and let the right people decide, this sort of tragedy can be avoided.

There are some important issues to consider when helping Aboriginal patients make good treatment decisions. We need to better understand their place in their society and community, the need to work with appropriate family decision makers, the wishes of many Aboriginal patients to remain on their traditional country and the practicalities of care provision in a resource-poor environment.

Despite the known prematurity mortality in the Indigenous community, cancer is still a significant cause of death. Indigenous people may develop cancer at a relatively younger age and they are more likely to die from these cancers when compared to non-Indigenous people. They may have young families and many family, social and cultural responsibilities. So their loss is felt very deeply, and someone else will need to do their jobs when they are gone. That might mean they want to try treatments to keep themselves alive as long as possible, but also that they want to stay on in their communities with their families in the time they have, not to have treatment that takes them far away from home. Then is the matter of who will look after them, because generally it is these people who look after everybody else.

In Western societies we think of individual people as being “autonomous”, that is they are supposed to make their own decisions about their health without much interference. Aboriginal families make their decisions communally, but there are generally family members who have a special, culturally determined role in making decisions. These are usually the very same people who have accompanied the sick person into town to help look after them. Kin relationships are very important; they determine not only who makes the decisions, but also who will accompany and help out. These are the people who need to be in hospital for diagnosis or treatment and who will look after them later on. Aboriginal kinship systems are pretty mysterious to most whites, but be aware you know the anthropology out of a book. What’s more useful is to remember to not make assumptions from our own culture about how things should be done, that’s something you need to be concerned with the person, and their family. There is generally someone who will speak for the family, which is the main link you need. So when important decisions need to be made, the right people need to make them. Sometimes what is most important is that you know these people and try to get it right, you might need to arrange family meetings, and maybe talk by phone or video-link to family members still in their community.

Many Indigenous people want to remain on their country during their illness and also when they pass away. That doesn’t mean they should not have medical care in city hospitals; it means balancing the benefits of the treatment with the potential burdens and considering practical issues of transport. Again the health care team can provide the information so that the patient and their family can decide.

Many Indigenous people live in poverty and they might not always have good food, accommodation, or even access to running water and electricity needed to keep sick people comfortable, rather than just keeping cancer of the cervix under control in city hospitals; it means balancing the benefits of the treatment with the potential burdens and considering practical issues of transport. Again the health care team can provide the information so that the patient and their family can decide.

One of the big differences to health for women in Indigenous and non-Indigenous communities as International Women’s Day approaches is that the Indigenous community, the need to work with appropriate family decision makers, the wishes of many Aboriginal patients to remain on their traditional country and the practicalities of care provision in a resource-poor environment.

In this paper I will use the term Indigenous to refer to Australia’s Aboriginal and Torres Strait Islander peoples. I also ask readers to note that Australia’s South Sea Islander community’s social capital. More specifically, it has an impact on income and morbidity, and a dialogue to plan the way forward. We need to listen to Aboriginal patients and their families and advocates, and work with Aboriginal colleagues who can complement the things we know with other things that they know.
the appalling rate of death and dying, which usually relies on the goodwill or social capital of the community. And there is the expectation that the social capital in many communities, including Indigenous communities, is alive, robust and healthy.

Indigenous health issues
Evidence demonstrates that Indigenous people die at a much higher rate than the general community, especially from stroke and heart disease, injury, respiratory diseases such as pneumonia and chronic bronchitis, and diabetes (which alone occurs at about eight times the national rate)\(^5\). The gap between the two communities has increased in recent years.

Factors that increase the risk of these disorders in the Indigenous community include higher tobacco and substance misuse rates and poorer nutrition. In addition location and environmental factors impact heavily, such as remoteness from, lack of and barriers to services including health, housing, education, employment and legal support. Often there is lack of access even to clean running water.

The increased incidence and death rates documented for cancer and other diseases have been linked to poor perceptions of health and social isolation\(^2\), resulting in withdrawal from education, employment and legal support. Often there is lack of and barriers to services including health, housing, education, employment and legal support. Often there is lack of access even to clean running water.

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

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

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

Removing the barriers and engaging the community
Barriers to access are created if there is failure to offer culturally safe screening services, or a failure to recognise the need for culturally sensitive follow-up after diagnosis and treatment.

Indigenous people need to be involved in setting up these processes. However, being actively engaged through advisory group representation is not enough. Indigenous people need to be employed in positions which can guide these processes daily. They need to have appropriate wages, a recognised career path and access to ongoing education and training. The process needs to be inclusive.

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

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

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

Building social capital
Research shows that people who actively participate in their community and who have a strong sense of belonging and...
supportive family ties, including cultural and community relationships, have more social capital and more interest in improving their health and access to better health outcomes, than people who are socially isolated8.

For clarification, the term ‘social capital’ describes features of social life and includes:

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

Social capital also describes how much we can help, or are able to help each other. Government policies and practices have been hindered by high rates of unemployment and a disproportionate level of poor educational attainment; and economic base; having high rates of unemployment and a community itself, creates feelings of anger and frustration and causes deep heartbreak and often shame.

Other factors contributing to lack of social capital and to a poor health status include: having a lower socio-economic status – or, in other words, having low incomes and no economic advantage; being high rates of unemployment and a disproportionate level of poor educational attainment; and cultural and ethnicnic barriers to services.

Improving the social capital provides a mechanism to engage and increase genuine partnership and it is often only after this process that people become strong in voice and strong in health. Being strong in voice, people are more likely to engage in health planning thus increasing good health and access to services, decreasing mortality rates and morbidity burden and lowering the cost of the health system.

Community capacity development approaches have shown impressive achievements when strengthening social networks, building knowledge and skills and in improving communication among sectors of the community. But how do we support this practice? People need to be involved in consultation strategies that support and encourage the community’s social capital. Achievements in building social capital are more successful if people have a sense of belonging, a sense of control over their research and program development and in having ownership of services and programs.

A strategic approach

The inexusable rates of cervical cancer in Australian Indigenous women prompted an Aboriginal woman, the late Ms Maureen Kirk, to carry out research in Queensland in order to promote change. Recommendations developed out of Ms Kirk’s research were documented in the Queensland Indigenous Women’s Cervical Screening Program. Information Circular No 49. Health Information Centre, Queensland Health.

It was after the completion of Ms Kirk’s research and with input from Aboriginal women living in Indigenous peoples all over the country across Australia, that the Queensland strategy was developed, determining and documenting six key action areas to target specific areas of identified need, including the development of a national code of practice for screening services.

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

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

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

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

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

Conclusion

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

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

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

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

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

References

of epidemiological, cultural and anecdotal Indigenous cancer data, with consensus on ways in which stakeholders could work together to effect measurable improvements.

**Epidemiology**

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

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

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

**Penetrating insights**

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

A penetrating cultural insight came from Jeremy Baker Balung (an Indigenous man who works as a counsellor for Aboriginal and Torres Strait Islander cancer patients at the Royal Darwin Hospital). Among Baker Balung’s Yolgnu people, each part of the body represents a spiritual link to individual members of the extended family; to have a cancer in a certain organ may be the result of offending the relative whom that part of the body represents. He emphasised the need to respect such beliefs, which are underscored by a deep regard for kin. A person who believes his or her cancer is “payback” may be the result of offending the relative whom that part of the body represents.

More curable cancers, such as breast, prostate, bowel and skin cancers.

Cancer is a difficult disease to treat remotely, and many Indigenous people live vast distances from urban centres. Sid Selva (Oncologist, Royal Darwin Hospital) described treating patients for whom arduous travel exacerbated the disorientation already induced by their diagnosis. The fact that Selva is the only resident medical oncologist in the Top End underscores a general problem with service provision in regional Australia.

Michael Barton (Deputy Director of Radiation Oncology, Liverpool Hospital), who is author of a study of radiation services in the Northern Territory, expanded on the problems of distance with a reminder about the immobile and high-maintenance nature of radiotherapy hardware.

Such problems reflect overall challenges for healthcare delivery in rural and remote Australia, which are compounded by the cultural, linguistic and socioeconomic barriers unique to Indigenous communities.

Jacinta Elston (Associate Professor of Indigenous Health, James Cook University), herself an Aboriginal woman undergoing cancer chemotherapy, described the practical hurdles for anyone on the cancer journey and explained how they are considerably higher for most Indigenous people: no health insurance or income protection, limited understanding of prognosis and treatment options, the absence of an informed community, unfamiliarity with a hospital environment — all of it bewildering, particular for people already at the margins of Australian society.

**Ways forward**

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

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

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

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

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

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

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

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

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

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

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

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

ARTICLES

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

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Abstract

This study evaluated the efficacy of a support group for young women with early breast cancer. Participants were 44 women ranging in age from 23 to 50 years (mean = 40 years) who attended a ten-session support group held at one of two metropolitan teaching hospitals. Participants completed a pre- and post-group evaluation package. Significant decreases in psychological distress at completion of the program were observed (t = 3.44, p < 0.001). Those with higher levels of distress at baseline reported significantly greater decreases in distress at the post-group assessment compared to women with lower levels of psychological distress. Overall no changes were found for social support (t = 0.77, p = 0.44), although women with lower levels of social support at baseline showed significant increases in perceived social support at completion of the program compared to those with higher levels of social support. No changes were observed for self-esteem (t = -0.55, p = 0.58); however, women with lower self-esteem before the group commenced showed greater increases in self-esteem compared to those with higher levels at baseline. None of the sociodemographic variables examined (age, marital status and number of children) affected improvement from the support groups. The clinical implications of the findings are discussed.

Introduction

Approximately 10,000 Australian women are diagnosed with breast cancer each year and in NSW in 1999, 3,463 women were newly diagnosed with breast cancer.1 Women under 50 years of age account for approximately 26 per cent of all new cases of breast cancer in Australia.2 Research indicates that young women have unique needs in terms of potential impact of treatment options on fertility and sexuality, the interruption of career, financial concerns and how to cope with young children.3

A number of studies have found that younger age is a risk factor for the development of psychosocial morbidity in women with breast cancer compared to women with increased morbidity in across all phases of diagnosis and treatment.4 Younger women report higher levels of emotional distress, more unmet practical needs, more financial distress and greater disruption to their daily lives following treatment for breast cancer.5 Dunn and Steinga suggest a number of reasons why young women with breast cancer may experience increased psychosocial morbidity compared with older women. From a developmental perspective, younger women may experience premature menopause as a result of ovarian toxicity from chemotherapy, resulting in distressing physiological and psychological symptoms, which may include vaginal dryness, hot flushes, dyspareunia, mood swings and short term memory loss.2

Dunn and Steinga also found that, consistent with previous research, younger women report that not being able to see their children grow up, about loss of fertility, or about not being able to have children because of concerns about future cancer recurrence.5 Younger women also reported that they were likely to get breast cancer and that they felt marginalised and isolated. In a qualitative study of very young women (aged less than 36 years) with early stage breast cancer, feelings of isolation and being different were identified as one of the predominant stressors.6 Other significant stressors experienced by these women were: coping with the untimeliness of the diagnosis; their fear about the role of the illness on their partner and on their relationship with their partner; sadness about lost opportunities for childbearing; uncertainty about their future; and anxiety about the impact of the illness on their children. In this study, Dunn and Steinga identified the stress of cancer concurrent to the multiple stressors associated with the early stage of the family life cycle.7 Also, younger women have been found to experience more disruption to self-image and sexuality.8 Subsequent infertility as a consequence of cancer treatments may also negatively affect the younger women’s self-concept.9 In addition, younger women may experience premature menopause as a result of ovarian toxicity from chemotherapy, resulting in distressing physiological and psychological symptoms, which may include vaginal dryness, hot flushes, dyspareunia, mood swings and short term memory loss.2

The youngest sub-group in this study (<36 years) spoke about the impact of fertility, and information about choices for contraception, were major concerns identified by younger women.10 All of the women interviewed felt that the information that they received was conflicting or inadequate.10 The youngest sub-group in this study (<36 years) spoke about the need for information or support that a younger woman with breast cancer needed. Younger women did not want to talk/relate to the other women’ and ‘emotional support’ as most helpful, and also found the provision of education and information to be helpful.

Although formal evaluation was not reported, informal evaluation indicated that young women identified the opportunity to network with women in a similar situation as one of the most important aspects of the group and that they found the educational support from the group to be beneficial.10 A large project in California has commenced to develop and evaluate a psycho-educational group intervention for young women newly diagnosed with breast cancer.11 This includes a 12-week psycho-educational group program for women 50 years and younger, and initial feedback has found that 87 per cent of participants rate the intervention as helpful.11 The majority of women in the study rated ‘opportunity to talk/together other women’ and ‘emotional support’ and ‘opportunity to talk/together other women’ and ‘emotional support’ and ‘opportunity to talk/together other women’ and ‘emotional support’ as most helpful, and also found the provision of education and information to be helpful.

The objectives of this study was to evaluate the efficacy of a psycho-educational group intervention for younger women with breast cancer. We wanted to use a group program that would be beneficial.10 A large project in California has commenced to develop and evaluate a psycho-educational group program for women 50 years and younger, and initial feedback has found that 87 per cent of participants rate the intervention as helpful.11 The majority of women in the study rated ‘opportunity to talk/together other women’ and ‘emotional support’ as most helpful, and also found the provision of education and information to be helpful.

The study aimed to assess the effects of a psycho-educational group intervention for younger women with breast cancer.10 The study, the supportive intervention most commonly endorsed by young women was peer support, which was seen as providing them with an opportunity to meet and share experiences with other young women with breast cancer.10 The authors highlighted that younger breast cancer patients experience greater affective distress in the first year following diagnosis and at all sites of follow up relative to those with higher levels of social support, lower self-esteem and higher psychological distress compared with older women.12,13 The study, the supportive intervention most commonly endorsed by young women was peer support, which was seen as providing them with an opportunity to meet and share experiences with other young women with breast cancer.10 The authors highlighted that younger breast cancer patients experience greater affective distress in the first year following diagnosis and at all sites of follow up relative to those with higher levels of social support, lower self-esteem and higher psychological distress compared with older women.12,13 Therefore, additional studies assessing the efficacy of psycho-educational groups for women with breast cancer are warranted.

This systematic review supports earlier reviews that have concluded that support groups for breast cancer patients provided qualitative outcome data and had a prospective design (with a pre- and at least one post-conoursing assessment) or a randomised controlled trial design. This systematic review of the efficacy of support groups for women with breast cancer is the first to assess the efficacy of support groups for women with breast cancer.12 This systematic review of the efficacy of support groups for women with breast cancer is the first to assess the efficacy of support groups for women with breast cancer.12 This systematic review of the efficacy of support groups for women with breast cancer is the first to assess the efficacy of support groups for women with breast cancer.12 This systematic review of the efficacy of support groups for women with breast cancer is the first to assess the efficacy of support groups for women with breast cancer.12 This systematic review of the efficacy of support groups for women with breast cancer is the first to assess the efficacy of support groups for women with breast cancer.12 This systematic review of the efficacy of support groups for women with breast cancer is the first to assess the efficacy of support groups for women with breast cancer.12 This systematic review of the efficacy of support groups for women with breast cancer is the first to assess the efficacy of support groups for women with breast cancer.12 This systematic review of the efficacy of support groups for women with breast cancer is the first to assess the efficacy of support groups for women with breast cancer.12 This systematic review of the efficacy of support groups for women with breast cancer is the first to assess the efficacy of support groups for women with breast cancer.12
satisfaction, stress and worry, (v) lymphoedema, (vi) fertility and early onset menopausal symptoms; (vii) dealing with the impact of breast cancer on relationships and communication; (viii) complementary therapies in breast cancer; (viii) body image, sexuality, and the impact of breast cancer on intimate relationships; and a final session (ix) ‘how far have I come’ and ‘where to from here’. Post-group questionnaires were completed after the last session. Reminder calls were made as required to obtain post-group questionnaires.

Demographic characteristics

At baseline, age, educational level, marital status, number of children and disease related variables were assessed.

Measures

Profile of Mood States (POMS) - Brief Form

The Profile of Mood States has been widely used in intervention studies with breast cancer patients for measuring mood outcomes.54 The POMS Brief Form is a 37-item questionnaire, which contains six mood-related subscales: anxiety, depression, anger, vigour, fatigue and confusion. A Total Mood Disturbance Score is calculated by adding together scores on the other five subscales except vigour, a higher score indicates poorer outcome. High internal consistency and test-retest reliability has been reported for each of the six subscales.55

The Coopersmith Self-esteem Inventory - Adult Form

This is a 25-item unidimensional self-assessment instrument measuring self-esteem.56 It has been widely used in a range of research trials and in intervention studies with breast cancer patients18 and has adequate psychometric properties.56 Scores range from 0 to 100 and higher scores denote greater self-esteem.

The Duke UNC Functional Social Support Questionnaire (DUFSS)

The DUFSS is an 8-item, 20-point scale questionnaire that assesses four content areas: quality of support, confidant support, affective support and instrumental support. Factor analysis demonstrates that it assesses two dimensions of social support: affective support (three items) and confidant support (five items).57 Reliability and validity data have been reported are satisfactory.57 Scores range from 8 to 40 and higher scores denote greater social support.

Satisfaction with group intervention

As well as the psychometric measures, post-group questionnaires included 18 purposively designed items assessing satisfaction with aspects of the group program. Response options ranged from ‘strongly agree’ to ‘strongly disagree’. Scores ranging from 1 to 5 were allocated with higher scores denoting greater satisfaction. A mean satisfaction score was calculated by adding all individual scores and dividing by the total number of scores.

Statistical analyses

A significance level of p < 0.05 was used for statistical tests. For normally distributed related continuous variables, Wilcoxon matched pairs signed rank tests were performed to test whether there were any changes in patient outcomes from baseline to follow up. To test whether women with lower social support, lower self esteem and higher psychological distress at baseline would experience greater improvements in each of these outcomes, linear regressions were used to regress the follow up values on the baseline values for each set of outcomes. Each regression was examined to ascertain whether the confidence intervals around the regression coefficient did not include 1.0 and that the coefficient was significantly smaller than 1.0. To test whether marital status and whether or not a woman had children predicted patient outcomes, Mann-Whitney U tests were conducted for non-normally distributed dependent variables and independent t-tests were conducted for normally distributed variables, using change scores.

Results

Characteristics of the sample

Of the 53 women who participated in the support groups, none declined participation in the questionnaire assessment. Five women completed only the pre-group assessment and four only the post-group questionnaire, leaving a total of 44 women who completed both questionnaires and were included in the analysis (participation rate for both questionnaires was 83 per cent). Twenty (45 per cent) of the participants had attended groups at the NSW Women’s Breast Centre, and 24 (55 per cent) at the Mater Hospital. The mean age of the sample was 40 years, ranging from 23 to 50. Eighty-six percent had education beyond high school, compared to 37 per cent of women in the general Australian population, indicating above-average educational levels. These high educational levels could at least in part be a reflection of the catchment area of the two treatment centres where the groups were conducted. Women were diagnosed between one and 12 months prior to commencement of the group (mean = 4 months). Table 1 summarises the sociodemographic and disease related variables.

Changes in patient outcomes relative to baseline

Table 2: Sociodemographic and treatment related variables of study sample (N = 44)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Level</th>
<th>N per cent</th>
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</thead>
<tbody>
<tr>
<td>Sociodemographics</td>
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<tr>
<td>Age (years)</td>
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<td></td>
<td>30-39</td>
<td>18</td>
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<td></td>
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<td>Type of surgery (a)</td>
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<td>Adjutant treatment (a)</td>
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<td></td>
<td>Radiotherapy</td>
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<td>Tamofoxen</td>
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<tr>
<td></td>
<td>Zoladex</td>
<td>5</td>
</tr>
<tr>
<td>(a) Some women had more than one type of surgical treatment</td>
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</tbody>
</table>

At baseline, the means for the psychological outcome measures were as follows: Profile of Mood States (total mood disturbance score) = 20.7 (SD = 21.5), DUFSS = 32.2 (SD = 5.4), and Coopersmith Self-Esteem Inventory = 71.6 (SD = 18.1). At the post-group assessment, the means for the psychological outcome measures were: Profile of Mood States (total mood disturbance score) = 9.4 (SD = 18.9) and DUFSS = 32.6 (SD = 5.2), and Coopersmith Self-Esteem Inventory = 72.7 (SD = 17.7). Table 2 summarises means and standard deviations for all psychological outcome variables.

Improvements of psychological outcomes relative to baseline (Hypothesis i)

Paired samples t-tests showed a statistically significant decrease in psychological distress from baseline to follow up (t = 3.44, p = 0.001). Significant decreases were found for fatigue (t = 3.2, p = 0.003) and depression (t = 2.90, p = 0.006), and a significant increase in vigour (t = 2.59, p = 0.013). No changes were observed for the anger (t = 2.31, p = 0.026), tension (t = 0.82, p = 0.42) and confusion (t = 2.08, p = 0.044) subscales of the POMS. No significant changes were found for social support (t = 0.77, p = 0.44) and self-esteem (t = 0.55, p = 0.58).

The mean satisfaction score was 4.4 (SD=0.47), indicating very high satisfaction with the group. Table 3 shows the means and standard deviations for all satisfaction items.

Baseline levels of psychological distress as predictors of improvements (Hypothesis ii)

Women with higher psychological distress at baseline showed greater decreases in psychological distress at the post-group assessment compared to women with lower psychological distress (b = 0.112; 95 per cent CI 0.003-0.221). Women with lower social support at baseline showed significantly greater increases in social support at post-group assessment compared to women with higher social support (b = 0.505; 95 per cent CI 0.348-0.662). Women with lower self-esteem at baseline were more likely to increase their self-esteem at the post-group assessment compared to women with higher self esteem (b = 0.657; 95 per cent CI 0.413-0.900).

Association with age, and having a partner and children (Hypothesis iii)

I think that the group was well facilitated 4.8 0.39

The Younger Women’s Cancer Support Program met my expectations 4.5 0.86

I feel more supported as a result of attending the group 4.5 0.80

I have learned more about the emotional impact of breast cancer as a result of attending the group 4.6 0.86

I think the pre-group interview prepared me about what to expect from the group 4.4 0.67

I think the venue for the group was appropriate 4.4 0.79

I think the length of time allowed for the group was adequate 4.3 0.66

I feel less isolated as a result of attending the group 4.3 1.01

I have learned strategies to help me feel more positive about the future as a result of attending the group 4.3 0.82

I think the meeting time (i.e. weekday/weekends) was appropriate 4.3 0.96

I learned more about breast cancer and its treatment as a result of attending the group 4.2 0.83

I feel I have been able to help or support other members of the group as a result of attending the group 4.0 0.57

I have learned strategies to better manage my fears as a result of attending the group 4.0 0.76

I have learned strategies to resolve relationship or communication problems which may have occurred during or after my treatment as a result of attending the group 3.8 0.76
No significant associations were observed for changes in psychological distress depending on women’s age (r = 0.017, p = 0.87) or marital status (r = 0.16, p = 0.91). Previous investigations of women of mixed ages have not shown a consistent relationship; some studies have not shown any improvement in psychological distress compared to baseline is significant. Some studies have found no improvement in perceived social support from group support programs, while others have found that participants had higher social support levels. Overall, the results indicate that there would be significant improvements in psychological distress depending on women’s age (r = 0.017, p = 0.87) were significant. None of the significance tests for associations between satisfaction with the group and changes in psychological distress were significant.

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

Although the authors knew of no other group intervention evaluation conducted exclusively with young women with early stage breast cancer to date, the findings of reduced psychological distress in women with early stage breast cancer following group participation in a short-term support group is consistent with the growing number of previous studies of women of mixed ages.24 Previous randomized controlled trials with women with mixed or unselected samples have shown that participation in a support group during or following the cancer therapy course was associated with reductions in psychological distress.25,26 Our study also showed reductions in psychological distress following participation in support groups, as have studies with women with more advanced breast cancer.14,15 Not all group intervention studies have shown reductions in psychological distress in women with early stage breast cancer.16 Interestingly, a study conducted by Spiegel and colleagues found that patients on a psychometric measures of emotional well-being at the end of a 12 week supportive-expressive group therapy program for women with early breast cancer, but significant improvements were evident at six and 12 months post-treatment.17,18 Inconsistent findings across studies could be the result of variations in the length of group programs and differences in when women join the group (i.e., shortly after diagnosis or towards the end of treatment).

Women with higher psychological distress at baseline showed greater decreases in psychological distress at the post-group assessment compared to women with lower psychological distress. The increased reductions in psychological distress among women who were most distressed at pre-assessment were consistent with our hypothesis that women who were most in need of psychological intervention made greater gains than those who were less distressed. These findings are similar to findings in a study of women with metastatic breast cancer, which found that women who were most distressed benefited from a group intervention, compared to those who were less distressed, who, in that study, did not benefit from participation.20 On average, social support was not significantly improved by participation in the group. Although the potential for oncology support programs to assist women to increase their social support networks, to use their support network more effectively and to maintain their social support relationships, has not been clearly documented, the effect of group interventions on perceived social support is far from clear. Some studies have found no improvement in perceived social support from group support programs, while others have found that participants had higher social support levels.25,26 Bobain and colleagues found, in a study of a supportive group for lesbians with primary breast morbidity, that benefits of social support declined following group participation.14 The authors suggested that the participants may have become more critical of the levels of support provided to them by their social networks as contact with other women in similar situations led them to raise their expectations regarding social support.26 Factors such as these may account for our finding that perceived social support was not significantly improved overall by participation in the support group.

Our finding that women with lower social support at the commencement of the program group showed significantly greater increases in social support following the support group, compared to women with higher social support at baseline is consistent with other group intervention studies. Bobain and colleagues found that people who experience problems with stress or social isolation or are in need of social support are those most likely to benefit from participation in groups.14 Hegelson and colleagues found that when cancer patients were paired with educational and peer support group interventions, found that women who lacked emotional support from their partners, or who reported more negative interactions with their partners, benefited from peer support.25 On average we found no changes in self-esteem resulting from the support groups; however, we did find significantly greater increases in self-esteem for women with lower self-esteem before the group commenced compared to women with higher self-esteem once women were matched with the support group in self-esteem.26,27 Hegelson and colleagues in women with mixed stages of breast cancer. However, studies conducted with women with more advanced breast cancers have shown mixed results with regard to self-esteem.28,29 Our results suggest that the impact of group support on self-esteem may be more complex than has previously been anticipated. Future research should seek to clarify the patient characteristics and types and duration of group therapy most likely to lead to increases in self-esteem.

Hypothesis (iii) that women would experience greater improvements in psychological outcomes depending on their age and whether or not they have a partner, or children, was not supported. The associations between these sociodemographic variables and the benefits obtained from the support group may reflect the different, but not lesser, concerns of women in different life circumstances. While we found no association between age and psychological distress and perceived social support predicted psychological outcomes, suggesting that psychological characteristics are more powerful predictors of benefits from support programs than sociodemographic factors. The authors are not aware of previous studies that have examined the associations between these sociodemographic variables and improvement from support groups and future studies should seek to replicate our findings.

In interpreting the findings of our study the strengths and limitations of this study should be noted. Although to our knowledge this is the first study to provide empirical data on the effect of a support group conducted specifically for young women, the number of women in this sample is small. Despite this, statistically significant improvements were found in levels of psychological distress following group participation. The sample was a highly educated group compared with the general Australian population, which may limit the generalizability of the finding. It should also be of interest to explore the effect of group participation for women from differing cultural backgrounds by evaluating the efficacy of culture-specific support groups. A pre-post-intervention design, rather than a randomised control design, was used for this study. Previous research has found that women who improve on psychosocial measures even without psychosocial intervention,14 so further research with young women using a control group design would overcome this limitation. Post-intervention measures were conducted following completion of the group and further longer-term follow-up would be of value in ascertaining whether gains were sustained over longer periods, as previous studies have shown mixed results in terms of the sustainability of psychological benefits of support groups for women with early-stage breast cancer.16,17,18,28 Clinical implications
The finding that women who participated in a psychosocial support group for young women with early stage breast cancer experienced a significant decrease in psychological distress supports suggestions that these women, who are at high risk of anxiety and depression due to the decision-making process from age-specific social support needs. Women who were most distressed before participation in the group program experienced significantly greater improvements in a number of measures than women who were less distressed, indicating that the program was of particular benefit to those women with a greater need for intervention.

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

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

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<thead>
<tr>
<th>Name</th>
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<th>Amount</th>
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<tr>
<td>P Hogg</td>
<td>University of New South Wales</td>
<td>$209,000</td>
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<tr>
<td>G Marshall</td>
<td>University of New South Wales</td>
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<tr>
<td>R Sutherland</td>
<td>The Garvan Institute of Medical Research</td>
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**Total Continuing Research Program Grants**: $901,000

### Continuing Research Project Grants

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<td>M Stockler</td>
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<tr>
<td>M Abela</td>
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<tr>
<td>H Gurney</td>
<td>Westmead Hospital</td>
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<tr>
<td>R Reddel</td>
<td>Children's Medical Research Institute</td>
<td>$168,750</td>
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<tr>
<td>C Lean</td>
<td>University of Sydney</td>
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<tr>
<td>G Halliday</td>
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<tr>
<td>B Meiser</td>
<td>University of New South Wales</td>
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<td>R Lock</td>
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<td>A Grechits</td>
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<td>P Hiservey</td>
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<td>R Ward</td>
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<td>A deFazio</td>
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<tr>
<td>J Kirk</td>
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**Total Continuing Research Project Grants**: $1,252,143

### Career Development Research Fellowship

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<tr>
<td>G O'Hall</td>
<td>Children's Hospital Westmead</td>
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**Total Research Fellowships**: $150,000

### Other Research Programs

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<td>Cancer for Health Research &amp; Psycho-Oncology (ChRP)</td>
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<td>Hereditary Bowel Cancer Registers</td>
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<td>Quality Improvement in Cancer Care Research and Demonstration</td>
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<td>45 and Up Cohort Study</td>
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<td>Commissioned Research Projects</td>
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**Total Other Research Programs**: $4,409,728

**TOTAL RESEARCH FUNDED**: $7,405,016

### THE CANCER COUNCIL SOUTH AUSTRALIA

### New Research Project Grants

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<thead>
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<th>Name</th>
<th>Institutional details</th>
<th>Amount</th>
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<tbody>
<tr>
<td>Dr Ross Butler, Dr Gordon Howarth Gastroenterology, Women's and Children's Hospital</td>
<td>Prevention of chemotherapy-induced mucositis and effects on tumour burden by folate-producing probiotics</td>
<td>$48,833</td>
</tr>
<tr>
<td>Professor David Bostwick, Dr Anna DeFazio, Dr Penny Bloomfield, Dr Nikolaï Zeps, Dr Dorota Gertig, Professor Michael Friedlander A/Professor Paul Hamett, Dr David Wyld, Dr Margaret Davy Department of Research</td>
<td>Molecular Epidemiology of Ovarian Cancer: The Australian Ovarian Cancer Study – Clinical Follow-Up Core</td>
<td>$36,700</td>
</tr>
</tbody>
</table>
Peter MacCallum Cancer Centre
Dr Michael Brown, A/Professor Ross McKinnon Medical Oncology Royal Adelaide Hospital
A phase II study of regional radiotherapy in early breast cancer
Pending new appointment
Total Fellowships
$79,000
Peter Nelson Leukaemia Research Fellowship
Pending new appointment
Other Research Programs for 2005
Chair in Cancer Care – Professor Ian O’Leary
Travel Grants
$35,000
Distinguished Visitors
$75,000
Student Vacation Scholarships
$13,600
The Freemasons Cancer Research Scholarship [1]
$25,000
Data Managers Program
$152,000
Aimarey BreastScreen
$46,489
Total of Other Research Programs
$387,189
TOTAL RESEARCH FUNDED
$2,139,502

THE CANCER COUNCIL TASMANIA
Research grants
Dr Jo Dickinson
Study of molecular events in large Tasmanian prostate cancer families
$20,000
Dr Christina Trabula
Microscopic, biochemical and functional characterization of Natural Killer cell invasion into tumour target cells (emperiopolesis)
$40,000
Dr Penny Blomfield
Molecular epidemiology of ovarian cancer: Australian ovarian cancer study – Western Australia, Tasmania, and a national clinical followup
$38,810
Dr Chris Woods
Long term effects of UVB irradiation on neonatal Langerhans cells
$35,000
Dr David Amor
Royal Hobart Hospital
Kconfab: The Kathleen Cunningham Consortium for Research into familial aspects of breast cancer
$11,300
Total research grants
$136,150

Funded by David Collins Leukaemia Foundation (DCLF) (amount not included in total research funding)
Dr Adele Holloway
University of Tasmania
Identifying genes regulated by AML in myeloid cells
$28,000

Jeanne Foster Scholarships
Janet Colbeck – Myer, Hobart
To attend a breast prosthesis fitting course in Melbourne during July 2004
$174
Faith O’Keefe – Clinical Nurse, North West Regional Hospital
To study a Master of Nursing by Coursework, Nurse Practitioner Pathway at the University of Melbourne
$1,000
Michelle Clark – Capri Body Fashions, Launceston
To attend a breast prosthesis fitting course in Melbourne during July 2004
$224
Jenny Cutter, Breast Care Nurse, St Vincent’s Hospital, Launceston
To attend the 7th National Breast Care Nurses Conference in Melbourne during February 2005
$400
Susan Schwabe, Breast Care Nurse, Kings Meadows Health Centre
To attend the 7th National Breast Care Nurses Conference in Melbourne during February 2005
$400
Nela Polmear, Breast Care Nurse, Hobart Community Health
To attend the 7th National Breast Care Nurses Conference in Melbourne during February 2005
$400
Anne-Marie Avery, Radiation Therapist, Holman Clinic, Launceston General Hospital
To attend the 14th Annual Meeting of the Australasian Brachytherapy Meeting to be held in Alice Springs during March 2005
$600
Angela Neville, Radiation Therapist, Holman Clinic, Launceston General Hospital
To attend the annual conference of the professional body for Radiation Therapists to be held in Auckland, New Zealand during August 2005
$700
Total Jeanne Foster Scholarships
$3,898

Other research grants
Julie Robinsson
Social Worker Launceston General Hospital
Athens Fonadiakos Leukaemia Scholarship for professional development in cancer control
$5,000
Amir Tulumovic, Nurse, Royal Hobart Hospital
Athens Fonadiakos Leukaemia Award
$900
Malinda Mensfell, The Cancer Council Tasmania
Athens Fonadiakos Research Grant
$10,000
Launceston General Hospital & Royal Hobart Hospital
Miniscus Data Managers
$39,000
To be announced
Tasmanian Award Workshop for new researcher
$2,500
Dr Penny Blomfield
Royal Hobart Hospital
Gynaecological cancer outcome data collection
$5,000
Owen Sprod
The Cancer Council Tasmania Tattersalls Award.
Regulation of gene expression in cancer cells
$10,000

National Health and Medical Research Council
Other programs funded in 2005
Senior Fellowships
C Ricardelli, University of Adelaide
$84,245
S Stephenson, The Queen Elizabeth Hospital
$84,245
Total Senior Fellowships
$168,490
Fellowships
A Evdokiou, Hanson Centre
$73,955
S Buchanan, University of Adelaide
$73,955
R Gibson, Royal Adelaide Hospital
$73,955

Total research grants
$1,196,413

Other research programs funded in 2005

Reports
31 Cancer Forum - Volume 29 Number 1 - March 2005


Total research grants $72,400
TOTAL RESEARCH FUNDED $212,448

THE CANCER COUNCIL VICTORIA

Research grants

R Anderson, Peter MacCallum Cancer Centre

D Bovet, A de Fausto, P Blombäck, N Zopf, M Gentil, M Friedland, P Hamet, D Wyld, M Davy, Peter MacCallum Cancer Centre

T Campbell, Peter MacCallum Cancer Centre

R Anderson, A Nestor, P Blombäck, M Zopf, N Gentil, P Hamet, D Wyld, M Davy, Peter MacCallum Cancer Centre

H Cheng, Zyu, T Mulhern, University of Melbourne

I Campbell, K Mitchell, J Stimpson, Kjellén, L Chua, M Dawes, A Stephens, A Schreiber, S Thomas, University of Melbourne

P Darcy, M Kendal, T Trapani, Peter MacCallum Cancer Centre

D Duke, N Sperry, A Stapleton, G Guerney, E Beller, Peter MacCallum Cancer Centre

M Ernst, P Waring, Ludwig Institute for Cancer Research

J Heijerhorst, St Vincent’s Institute of Medical Research

J Hoppe, E Simbirt, A Mitchell, K Waters, University of Melbourne

J Flint, S Russell, H Richardson, University of Melbourne

M Jan, Monash University

R Johnstone, Peter MacCallum Cancer Centre

K Jones, F Renton, Peter MacCallum Cancer Centre

M Michael, B Barrie, A With, Peter MacCallum Cancer Centre

C Mitchell, Monash University

J Pitt, Monash University

J Hutfalk, A Rateau

A Scott, V Rayman, Ludwig Institute for Cancer Research

M Sim, G Benke, Monash University

J Simms, J Zachar, P Waring, B Mann, M Smith, D Forrester, G van Hassel, Peter MacCallum Cancer Centre

A Popham, N Smyth, Peter MacCallum Cancer Centre

T Tiganis, Monash University

D Jans, Royal Melbourne Hospital

J Villadangos, Walter & Eliza Hall Institute of Medical Research

A Vivian, Peter MacCallum Cancer Centre

Total research grants $1,744,352

Total research grants $527,339

Total postdoctoral research fellowships $147,375

Postgraduate Research Scholarships and Vacation Studentships

J Becanovic, Monash University $150

L Dowe, Peter MacCallum Cancer Centre $21,510

C Fedele, Monash University $23,150

H Gan, Ludwig Institute for Cancer Research $27,630

K Heron, Monash University $21,510

P Leedman, Peter MacCallum Cancer Centre $27,630

M Wall, Peter MacCallum Cancer Centre $27,630

J Stone, University of Melbourne $53,250

M Wang, Peter MacCallum Cancer Centre $27,630

J Tius, Walter & Eliza Hall Institute of Medical Research $23,150

Total scholarships and studentships $259,012

Fellowships

Carden Fellowship D Metcalf, Walter and Eliza Hall Institute of Medical Research $200,000

Dunlop Fellowship A Roberts, Walter and Eliza Hall Institute of Medical Research $48,114

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

Lions Fellowship (variable) B Anderson, Walter and Eliza Hall Institute of Medical Research $50,000

Total fellowships $368,114

Other Research Programs

Tissue Bank Coordination Project

Medical and Scientific Activities

Cancer Control Research Institute Programs

Cancer Epidemiology Centre Victoria Cancer Registry $1,662,000

The Melbourne Collaborative Cohort Study (Health 2000) $620,000

Centre for Behavioural Research in Cancer $1,475,000

Centre for Clinical Research in Cancer $1,328,000

VicHealth Centre for Tobacco Control (Cancer Council Victoria contribution to VicHealth Centre) $490,000

Total Cancer Control Research Institute programs $6,459,000

TOTAL RESEARCH FUNDED $9,094,853

THE CANCER COUNCIL WESTERN AUSTRALIA

Research grants

M Degli Espositi, Curtin University $110,000

S Davison, Curtin University $52,209

A Currie, Curtin University $55,000

B Musk, Curtin University $55,000

J Olynyk, Curtin University $55,000

M Bogoyevitch, Curtin University $55,000

J Creaney, Curtin University $54,930

P Lederman, Curtin University $55,000

M Beliharz, Curtin University $46,000

Total research grants $52,339
Edward and Patricia Usher Student Vacation Research Scholarships
P Chia Expression of inhibitors of apoptosis in mesothelioma and tumour cell survival $2,000
C Kipiani The incidence of third primary breast cancer $2,000
C Lee The effect of bacterial DNA treatment on HMG-1 expression and apoptosis in human breast cancer cells $1,200
R Lee Development of a qualitative database and preliminary analysis for the National Analysis of the Supportive and Palliative Care needs of Parents whose Children have Died from Cancer $2,000
A Tyler Correlation of a bioeffect model with tumour control in localised prostate cancer treated with brachytherapy $2,000

Total vacation research scholarships $9,200

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

Total John Nott travelling fund $5,000

Professorial Chairs
Chair of Palliative Care Research Edith Cowan University $100,000
Chair of Behavioural Cancer Research Curtin University of Technology $120,000
Chair of Clinical Cancer Research University of Western Australia $250,000

Total professorial chairs $475,000

Other research grants
kConFab: A national consortium for research into familial breast cancer Genetic Services of WA, King Edward Memorial and Princess Margaret Hospitals $27,000
Bone tumour registry $27,000
Children’s Cancer Research Fellowship TVW Institute Child health Research $15,000
Prostate Cancer Screening $5,000
Non-melanoma skin cancer incidence study $15,000
Formative evaluation of a physical activity and nutrition program for Western Australian primary schools Edith Cowan University $5,000
Travel grants Attend 38th Annual American Association for Cancer Education Conference Attend Australian Lung Cancer Trials Group Meeting and COSA $760

Total other research grants $95,605

TOTAL RESEARCH FUNDED $3,112,144

QUEENSLAND CANCER FUND

Research grants 2004-2005
J Simes, T Hugh, V Gababi, S Norden, M Fink, J Celben, J Olynyk, D Crawford, T Price Adjunct interferon and/or Celecoxib for hepatitis $28,000
G Lindeman, D Amor, J Goldblatt, M Gattas kConFab: A national consortium for research into familial breast cancer $71,700
D Osborne, N Spy, A Stapleton, H Gurney, J Gorman, A Pettitt The timing of androgen deprivation in relapsed or non-curable prostate cancer patients $10,900
B Chua, D Joseph, J Harvey, V Ahern A phase III study of regional radiation therapy in early breast cancer $23,750
F Gardner, J Clements, T Walsh, J Bailey, J Gorman, A Pettitt Proteomic approaches to the early detection of prostate cancer $71,700
J Clements, J Gao, D Nicol Characterisation of prostatic kallikrein gene expression during prostatic stromal and prostate cancer cell lines: a model for prostate cancer bone metastasis $71,700
R Tindle Novel cancer vaccine delivery using recombinant Hepatitis B surface antigen VLP- and DNA vectors $71,700
J Hancock, A Harding A biochemical analysis of MAP kinase pathway activation at the plasma membrane $71,700
B Sturm Role of Bcl2 integral-induced osteonectin expression in melanoma metastasis $71,700
K-N Zhao Using yeast model to study the functional roles of three early genes in the life cycle of bovine papillomavirus type 1 $71,700
E Ward, L Cahill Osteophagy (impaired swallowing) following surgical removal of the knee: Factors contributing to the swallowing disorder, and the efficacy of intensive physiologically based therapy to improve swallowing outcomes for this population $34,400
K Lin The role of the tumour suppressor gene p53 in colon cancer metastasis $71,700
A Boyd The role of Iph protein over-expression in colon cancer metastasis $71,700

D Moss, D Chen, J David, S Elliott, M Sherritt A phase I trial on adaptive transfer of cytotoxic T cells specific for EBV latent membrane protein 1 (LMP1) and 2 delivered to patients with nasopharyngeal carcinoma $71,700
R Khanna, J Tellam Molecular characterisation of genetic variants of LMP1 oncogene from EBV associated nasopharyngeal carcinoma $71,700
T Kinns, G Walker Investigating protein pocket function in development of cancer $71,700
M Leat, N Guenae Role of ATF/SMG-1 protein in responding to DNA damage and maintaining genome stability $71,700

G Hill The role of donor T cell derived IL-10 in the enhancement of leukaemia-free survival after allogeneic SCT $71,700
D Hart Purified Blood DC Vaccination with defined Tumour Associate Antigens for Multiple Myeloma $73,800
D Hart, K Radford, M Kato Discovery of breast cancer antigens recognised by cytotoxic T lymphocytes for tumour immunotherapy $71,700
M Kato DEC205 C-type lectin receptor-mediated antigen loading to dendritic cells to elicit antigen-specific, cytotoxic T lymphocyte responses $71,700
S Ralph, A Melnick Melanoma and resistance to interferon therapy $71,700
J Neusul Cancer cell targeting using receptor-specific peptide adducts with vitamin E analogues $71,700

2005-2006
L Chopin, A Herington Gqehrin receptor isoforms in prostate cancer proliferation: roles of heterodimerisation and signalling cross-talk $71,700
A Yap Tiam-1: a key regulator of E-cadherin signalling and epithelial organisation $71,700
F Gardiner, M Burger, J Trayek, H Samaanutsana, M Lavin Multiple molecular markers for prostate cancer diagnosis from ejaculate $71,700
A Nicol, J Luckeier Immune therapy for melanoma with dendritic cells co-pulsed with a-galactosylceramide and peptides $71,700
B Gabbarli G2 phase cell cycle activity regulates expression of proteins essential for the fidelity of mitosis: a target for UV induced p16 expression $71,700
X S Liu, J Frazer Optimising immunotherapy in tumour antigen experienced host $71,700
G Leggett, J Frazer The role of NK and CD8 cells in tumour immunotherapy using epithelial tumour models $71,700
K Spring, B Leggett, J Young Role of oncogenic BMF (V599E) mutation in the molecular pathogenesis of sporadic colorectal cancer $71,700
N Hayward Identification of novel tumour suppressor genes in melanoma using array CGH $71,700
K Leffler, N Hayward Molecular mechanisms of insulinoma development $71,700
J Young, J Jais Characterisation of a novel syndrome of familial colorectal cancer based on the senescent pathway of tumour development $71,700
K K Khanna, M Cummings, C Furnel Characterisation of a novel protein involved in breast cancer progression $71,700
G Hill Host B cells and Graft-versus-host disease $71,700
N Karello, A Kelso In Vivo functions of CD8 low T cells In Vivo functions of CD8 low T cells $71,700
M Gandai, R Khanna, P Mattison, G Kennedy EBV-specific Cytotoxic T Lymphocytes as tool for EBV-positive Hodgkin Lymphoma $71,700
M Michael, B Burmeister Randomised Phase II study of two regimens of therapy in management of locally advanced N $68,936
P Bowton, P Webb Quality of life and psychosocial predictors of outcome in a population based study of ovarian cancer $71,700
M O’Rourke, M Smithers, K Ellem Phase II trial of Imunotherapy for Stage III (UCC) melanoma based on cultured autologous dendritic cells presenting autologous tumour cell antigen $71,700
M McGuckin, A Lopez CA125 (MUC16) in the immunology of ovarian cancer $71,700
K Radford, R Winten, P Swindle Selection of prostate-derived kallikreins for dendritic cell immunotherapy $71,700

2005-2007
D Boxsell, D Wyld Molecular epidemiology of ovarian cancer: The Australian Ovarian Cancer Study – Clinical follow-up core $69,933
J Simes, M Smither Intermediate and high risk, resected gastro-intestinal stromal tumours expressing kit: RCT of adjuvant multiti mesylate $10,834
J Young, J Jais Characterisation of a novel syndrome of familial colorectal cancer based on the senescent pathway of tumour development $71,700

Total research grants $3,001,538

Fellowships
Senior research fellow program
M McGuckin, Mater Medical Research Institute and P Webb, Queensland Institute of Medical Research G Kay, Queensland Institute of Medical Research $314,562

Clinical research fellow
Richard Laherty, University of Queensland $37,200

Total fellowships $351,762
Epidemiology and behavioural research programs

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

Other research grants

QCF/Griffith University: Cancer Support Centre (psychosocial oncology) $98,350
Queensland Family Bowel Cancer Registry $50,000
Australian Paediatric Cancer Registry $36,600
Colonial Cancer & Quality of Life Study $131,510
Skin Cancers Project $19,490
Total other research grants $520,260

PhD program 2005

2005 – 2007
John Earnshaw Scholar 2005
Michael Hsu-Li Lei, Queensland Institute Medical Research
K Wynn, Queensland Institute Medical Research
C Marais, University of Queensland

2004 – 2006
John Earnshaw Scholar 2004
M Jones, Queensland Institute Medical Research
A Ramsay, Queensland University of Technology
S Mattattilo, University of Queensland

2003 – 2005
John Earnshaw Scholar 2003
L Packer, Queensland Institute Medical Research
K Jawersh, Queensland Institute Medical Research
E Hacker, Queensland Institute Medical Research
P Pattick, Mater Medical Research Institute

Total PhD program 2005 $212,500

Hospital Based – Data Managers

Royal Children’s Hospital
Mater Hospital – Oncology Centre
Royal Brisbane Hospital – Radiation Oncology
Medical Oncology
Princess Alexandra Hospital
Darling Downs Medical Oncology Unit
Mater Adult Hospital
Mater Children’s Hospital
Royal Women’s Hospital

Data Managers Total $401,040

TOTAL RESEARCH FUNDING $6,310,870

NATIONAL BREAST CANCER FOUNDATION

Research Grants

NEW SOUTH WALES

NBCF Scholarship
E Choy, Royal Prince Alfred Hospital
A randomised controlled trial to evaluate the impact on patient outcomes of involving breast cancer patients in the multidisciplinary discussion of their disease and treatment plan $30,000

David Jones Scholarship
H Davy, University Of Sydney
Communicating information to women about diagnostic tests for breast disease $30,000

NBCF Scholarship
K Sledding, University Of Newcastle
Viral Oncolytics of Human Breast Cancer $30,000

Kathleen Curingham Research Grant
P Buxton, University Of Sydney
Improving informed consent: A randomised controlled trial of a decision aid for women invited to participate in IBCS-2 $102,050

Kathleen Curingham Research Grant
C Clark, Garran Institute
Epigenetic activation of c-myc oncogene in breast cancer $73,250

Kathleen Curingham Research Grant
Optimising participation by women with disabilities in mammography $92,474

Australian Behavioural Research in Cancer

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

New Results

- Vrtel Centre for Research in Cancer Control (VCRCC), Qld

Attitudes and intentions in relation to skin screening

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

Childhood Cancer Health Survey

This small pilot study was conducted to determine childhood cancer survivors’ current health behaviours and their level of interest in health promotion programs. The survey involved 28 Queenslanders who had completed treatment for lymphoma, leukaemia or brain/central nervous system tumours ages 14-30. Ten parents of those under age 18 were also interviewed to ascertain their interest in health programs for their children. Participants were recruited from past and present member mailing lists of two support groups for children and teens living with cancer.

Only 32 per cent of survivors ate the recommended two or more serves of fruit per day and none ate the recommended five serves of vegetables per day. Forty-six per cent per week over 5 or more days). Physical activity and Body Mass Index results were significantly related to tumour type, with brain tumour patients faring the worst and lymphoma patients faring the best.

Childhood cancer respondents were extremely or very interested in receiving information in this way. The most favored intervention delivery modalities included mailed information with 54 per cent of respondents very or extremely interested in receiving this way. The information will be used to inform future research and programming for childhood cancer survivors.

Associations of physical activity with quality of life: findings from the Colonial Cancer and Quality of Life pilot study

The pilot study for the Colonial Cancer and Quality of Life study was conducted in March – May 2003. One of the aims of this study was to describe physical activity in individuals recently diagnosed with colorectal cancer (approximately six months following diagnosis), and to examine associations between demographic and medical variables, physical activity and quality of life. Eighty-nine participants completed telephone interviews. Forty-three per cent of men and 50 per cent of women met current public health guidelines of at least 150 minutes of moderate-intensity activity per week. Physical activity was positively associated with two quality of life domains (physical well-being and emotional wellbeing). The relationship between physical activity and quality of life varied by gender, marital status and treatment type. These results, although cross-sectional, support the importance of physical activity in improving quality of life among colorectal cancer survivors, as has been shown in randomised clinical trials of exercise interventions amongst other cancer groups. The Colonial Cancer and Quality of Life study will more closely examine the relationship between physical activity and quality of life, with a large, population-based sample and prospective methodology.

- Centre for Health Research and Psycho-oncology (CHERP), NSW

The management of nicotine dependent inpatients

Between 20 per cent and 30 per cent of hospital patients in NSW are smokers. The smoke-free hospital environment represents both a challenge for smokers in terms of dealing with nicotine withdrawal and an opportunity for obtaining cessation support. In July 2002 NSW Health distributed the Guide for the Management of Nicotine Dependent Inpatients in all NSW public hospitals. The Guide recommends a series of steps to provide support and assistance to inpatients with nicotine dependence. These recommendations include:

- Identifying tobacco users
- Managing inpatient nicotine dependence
- Prescribing nicotine therapy
- Monitoring withdrawal symptoms
- Extending care to discharge

A self-complete survey mailed to senior managers at 206 NSW public hospitals assessed the degree to which the recommendations in the Guide were being met at their hospital. The participants provided data on the proportion of appropriate inpatients receiving care according to the recommendations in the Guide. Of the 206 hospital managers, 83 per cent responded.

It was found that while many inpatient smokers were being identified routinely, the majority of hospitals provided minimal smoking care for inpatient smokers. Levels of NRT prescription and discharge care were particularly low. Some predictors of greater levels of care provision were identified. A quasi-experimental study of the Guide results from a prospective study of an Australian national sample

This study, led by Mohammad Siahpush, used prospective data from a representative Australian sample to examine the association of financial stress with subsequent smoking cessation among smokers and relapse among ex-smokers. Data were drawn from the first two waves of the Household Income and Labour Dynamics in Australia (HILDA) Survey. Included
were eight items measuring financial stress, such as “In the past six months did any of the following happen to you because of a shortage of money?” Could not pay electricity, 17 gas or telephone bills on time, … Pawned or sold something, … Went without meals, … Was unable to heat home”. We used multivariate logistic regression and adjusted for socio- demographic variables. Of the 2076 smokers in Wave 1 of the survey, 10.7 per cent had quit by Wave 2. A one-unit increase in financial stress was associated with a decrease of 13 per cent in the odds of cessation. Of the 2717 ex-smokers in Wave 1, 10.1 per cent had started smoking by Wave 2. A one-unit increase in financial stress was associated with an increase of 19 per cent in the odds of relapse. This study suggests that smokers with financial stress are less likely to quit and that ex-smokers with more financial stress are more likely to relapse. An increase in tobacco price is recognized as one of the most effective policies for reducing smoking prevalence. Furthermore, there is evidence that these policies are more effective for lower socio-economic groups. However, given that smokers with financial stress are less prone to quit, such policies may in fact worsen the material wellbeing of disadvantaged smokers who already face financial difficulties and fail to quit smoking. Special programmes may have to be implemented to counter the potentially adverse effects of tobacco price increases for these smokers.

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

This study, led by Suzanne Dobbinson, assessed observed compliance with the Australian and New Zealand Standard on Sun Safety and the New Australian Standard for Solarium operators to provide risk information about skin cancer, provide goggles for eye protection and ensure adequate cleaning of facilities. The voluntary code also requires staff to provide access to self-screening materials to high-risk groups, including those with very fair skin that burns but does not tan (skin type 1) and those aged under 15 years. People aged 16 or over may be permitted to use solariums, provided they have parental consent.

We tested a randomly selected sample of 30 solarium centres in inner and bayside suburbs of Melbourne. Each solarium centre had an approach from three different research assistants with different skin type and age characteristics who posed as potential customers. Potential customers with olive skin who were eligible to use the tanning units tested compliance with provision of risk information, protective goggles and cleaning requirements. Fair-skinned skin type 1 adults tested the extent to which staff assisted customers’ skin-type and barred access to solariums. Conversely, we used 16-year-olds to assess under-age access to the tanning units without parental consent.

When tested by eligible adults, 70 per cent of centres gave some kind of information about possible skin cancer risks; 87 per cent provided protective goggles and 80 per cent provided a sign or gave advice to use the goggles. Cleaning of tanning units was undertaken by staff in 33 per cent of centres. In 30 per cent of centres which allow tanning, customers were instructed to clean the tanning unit after use. A further 13 per cent of Centres provided cleaning products without an instruction. Overall, 90 per cent of very fair skinned customers could gain access to the tested solariums. In addition, 52 per cent of 16-year-olds could gain access to the solariums without having to produce parental consent, even though they prompted solarium staff to direct them to the exit. These findings suggest a poor compliance with aspects of the voluntary code pertaining to high-risk groups and indicate a need for revision of the
 provision of supportive care services.

Qualitative interviews with 8 patients and 6 caregivers were undertaken and focus groups with patients and carers in Brisbane and Toowoomba are currently underway. The next phase of the research will be a mail survey to all participating Brain Tumour Support Service patients and carers to ascertain their supportive care needs in order to establish the support services likely to be of most benefit to them.

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

n CBRC (Vic)

Exploring the needs of facilitators and members of cancer support groups across Victoria

Support groups can be a valuable resource for people touched by cancer, improving knowledge and coping skills and enhancing quality of life. There is no standard cancer support group - they vary in size, type, purpose, type, aims and approach. The Cancer Information and Support (CIS) unit within The Cancer Council Victoria coordinates the Cancer Support Groups Program. The program consists of 115 general and cancer-specific groups across Victoria that are either peer lead or professionally faciliated. The Cancer Council does not run these support groups, but rather, facilitates their formation and provides information and support to facilitators.

Commencing in 2005, CIS will work closely with CIS to conduct three related studies that aim to explore the needs and expectations of facilitators and members of cancer support groups across Victoria. The first study will be an audit of existing support groups and will aim to quantify the number of support groups for cancer patients in Victoria and to characterise them in terms of their function (peer or professional), longevity, membership size, regularity of meetings, purpose of meetings, demographics of membership, cancer history of membership, functioning of group, awareness and use of information and support. The second study will examine the processes of starting up a support group and will determine any gaps in services offered by The Cancer Council. The third study will examine the experiences of support group members who differ in their time since diagnosis to determine the expectations and needs relating to support groups for these two types of patients.

n CCR and TCRC (SA)

Evaluation of new tobacco control legislation in South Australia

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

Evaluation of Tobacco the Truth is Out There!

Quint SA disseminated an updated version of the teachers' resource, Tobacco the Truth is Out There! in November 2003 to 20 teachers who had requested it. The resource contains information classroom exercises on tobacco and is particularly aimed at middle school. TCRC has conducted follow-up interviews with teachers and is currently analysing the data to determine use of the resource, familiarity with the resource, areas that were particularly useful and areas for improvement. A report will be available in early 2005.

n TCRC and Quint SA are participating in the ‘Smokescreen II’ project, in collaboration with NSW

Smokescreen II project

This project examines the impact on young people of an anti-smoking commercial placed before movies that feature tobacco. The TCRC is working with the Victorian Cancer Council to conduct this project.

n CBRC (WA)

Investigating enhanced presentation methods of the UV Index

A qualitative investigation was conducted by Dr Owen Carter last summer of how to improve presentation methods of the UV Index. A number of hypotheses were developed from this investigation, which is currently the need for 500-600 interview intercepts. The depth of peoples’ understanding of the UV index is being tested, as well as their appreciation of and the motivation effectiveness of four alternative methods of presenting the UV index. Interviews are expected to be completed in February 2005 and results are to be made available by the end of March.

n VCRC (Qld)

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

Geoffrey Jallalh is conducting two studies investigating marketing and promotion by the tobacco industry. One study is an audit of point of sale marketing of tobacco products in retail outlets to determine whether or not these activities breach facilitators and members of cancer support groups across Victoria. And the other study is an audit of marketing and promotional activities at events and venues patroned by young people to scan for below-the-line activities.

n State Members of Parliament Tobacco Control Survey

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

n CPRC (Qld)

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

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

Young adults (those aged 18 to 30 years) are an important target group for physical activity promotion initiatives. There is a well-documented decreasing prevalence of physical activity participation over the young adult years and clear patterns of difference in the physical activity habits of young men (who tend to engage in more vigorous forms of activity) and women (who tend to engage in less vigorous forms of activity) are more salient). Physical activity habits during the young adult years are likely to be important influences on habitual physical activity participation and life styles in later years. They may also have significant implications for long-term chronic disease risk, including risk of colon and breast cancer.

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

The focus of this study is:

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

n ChERP (NSW)

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

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

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

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

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

Several ChERP staff participated in the recent COSA Annual Scientific Meeting 2004. Congratulations to Allison Boyes who received the A/Professor Jeanne Puhlman Memorial Prize. Allison’s presentation entitled “It’s not all doom and gloom: well-being of cancer survivors five years after diagnosis”. Other ChERP presentations addressed the coping styles of long-term cancer survivors (Allison Zucca), psychological interventions for cancer survivors (Jiong Li), and caring for children with advanced colorectal cancer (Sibah Breen) and referral practices to palliative care in Australia (Claire Johnson). A/Professor Ailf Girgis is about to Chair the Psychosocial Oncology Symposium, which included stimulating presentations from Ms Raedene Boyle, Professor James Zabora and Dr Jane Turner.

n CBRC (Vic)

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

In November 2004, CBRC was subject to external scientific review at the University of Melbourne, where over 30 review comments were made by different ethics committees. At Newcastle, approval was granted for students to be given the option of returning questionnaires either to a box in the lecture theatre or at another location on the University campus. At the University of Western Sydney (UWS) the option of having a box available in the lecture theatre was deemed too coercive. It is likely this decision was a factor in the lower return rates achieved at UWS.

n CBRC (Vic)

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

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

As with previous conferences, a consumer forum was hosted by the Cancer Council ACT and the Cancer Alliance Network on the day preceding the main conference and featured national and international guest speakers on the topics of colorectal cancer, breast cancer and psychosocial issues. Valerie Jeffery and 150 consumers attended.

At the opening session, Martin Tattersall Professor of Cancer Medicine at the University of Sydney spoke on the Development of Integrated Care in Cancer Care with the evolution of multidisciplinary treatment teams and the recognition of the importance of screening programmes, clinical trials and maintenance of quality of life. Lorraine Galloway from University of Canberra presented a paper on Integrated Patient Support in looking at philosophical assumptions of how current health systems are divided into treatment and support and how a shift away from medically driven health care may work in cancer care. Peter Harper from the Therapeutic Goods Administration, the Australian Federal Government had just prior to the elections committed to the formation of a National Cancer Policy, as well as to infrastructure funding for cooperative group clinical trials.

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

Multidisciplinary case presentations and hypothetical sessions were used to good effect to illustrate integrated cancer care throughout the meeting. Dr Erika Zeps from the Cancer Council South Australia was greatly appreciated. Thanks also to Bernard Stewart who is the Medical Oncology Group/Novartis Fellowship recipient.

Two award lectures were given this year. The first was by Professor Roger Fox from the Royal Melbourne Hospital, the recipient of the Pierre Fabre Achievement Award, and the second by Anna Novak from the NHMRC Clinical Trials Centre who is the Medical Oncology Group/Novartis Fellowship recipient.

The two social functions were well attended with the Canberra Wine Tasting welcoming reception and the Conference Dinner at the Australian Parliament House.

I would like to acknowledge the enthusiasm and assistance of my organising committee. The helpful advice from Nik Zeps and David Goldstein the convenors of the two previous ASMs was greatly appreciated. Thanks also to Bernard Stewart chair of the Cancer Research Group for organising two COSA symposia at the Australian Health and Medical Research Congress (NHMRC) in Sydney and also helping to smooth the running of the COSA/Sydney Cancer Education Program. The second program was a two part multidisciplinary educational programme in radiotherapy.

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Cancer Forum Editorial Board – changing of the guard

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

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

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

Productivity Commission advised of future squeeze on cancer dollar

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

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

The submission focused on the prospect of a future inhabited and more Australians with cancer, yet fewer taxpayers to support and research commitments.

Dr Stephen Della-Fiorentini

Success again for Pink Ribbon Day

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

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

The funds raised will continue to support The Cancer Council Australia’s breast cancer research initiatives, education programs and support services.

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Cancer Council finds many Australians exposed by solariums

The Cancer Council Australia has released alarming statistics showing that over 200,000 Australians have been exposed to UV radiation in the past year due to solarium use.

“A solarium can emit UV radiation that is five times as strong as the midday summer sun,” said the Chair of the National Sun Survey Research Committee, Professor David Hill. “Subjecting skin to the excessive amounts of UV radiation that solarium emit can be dangerous. It is important that the public understand that using solariums will increase exposure to UV radiation and risk of skin cancer.”

The research found the highest users of solariums were females aged 25 – 44 years. “It may be that more women in the 25 to 44 age group are working indoors and so have less opportunity to tan in the sun,” Professor Hill said. “They may also have more money available for solarium use than younger women.”

Recent studies have shown that there has been an explosion in the number of solariums in NSW and Victoria over the past 10 years. “There is recent research suggesting a link between solarium use and the development of melanoma,” Dr Hamann said. “Melanoma is one of the most common cancers affecting young adults and can be life threatening. There is no safe way to tan the skin using either natural or artificial UV light.”

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

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

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

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

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

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

This book does provide much valuable information for the patient with cancer and their significant others. The questions used in 2002 and as a result there are some outstanding points in the surgical procedures and management of advanced cancer segments.

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

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

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

This new edition is a well-produced book now comprising 850 pages, with 37 chapters from 81 contributors practising in 5 countries. Since the last edition, the overall length of the book has been reduced by consolidating information given in the previous edition but adding additional information in fewer chapters. There is an updated section on head and neck pathology and a discussion of recent advances in molecular biology, with detail on the current understanding of the molecular and cellular pathogenesis and progression of cancer. The major component of the book remains 17 chapters on site specific cancers, each with a logical discussion of the relevant anatomy, pre-treatment evaluation, treatment options, surgical and non-surgical approaches and detailed treatment outcomes. The roles of chemoprevention of tumours and chemotherapy for treatment have now been separated into separate chapters, while general issues, such as medical and dental assessments, antibacterial use, and treatment complications have been incorporated into the site-specific discussions. There is also strong emphasis on reconstruction, with more detail on practical aspects of oral rehabilitation, functional issues of rehabilitation of speech and swallowing and their impact on quality of life. The management of cancer pain and the psychological aspects of cancer care have been combined into a single chapter on supportive and palliative care.

Although the number of contributors has been slightly reduced, the quality and in depth is maintained, helping the editors achieve their stated aim of producing a text that reflects contemporary practice. The addition of two new editors is a step designed to keep this reference relevant to contemporary care in the future. Like the previous edition, this book is highly recommended to any surgeon practising in or training for head and neck surgery, and should be in the library of any institution participating in the care of head and neck cancer patients.

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

CLINICAL ONCOLOGY
3RD EDITION

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

Reviewing a book on oncology is actually a rather daunting task and I have few qualms about admitting that this is my first oncology textbook review attempt than I do in actually doing the review. The first question I ask myself is "how can I possibly read more than 300 pages in less than a month?" and the second is "what do I actually want out of a textbook in oncology in the first place?" The answer to the first question is that I cannot do it, nor should I attempt it – I need to be focused and targeted in my approach. As a medical oncologist, I think the answer to the second question is easier (and shows the way to address the first problem). I want an authoritative reference text that is clearly and logically set out, that contains a systematic approach to the whole of clinical oncology, that is well referenced and that admits to controversy where controversy exists. An online version would also be a must in the modern world! One of my pet hates is the badly done index, so that will get extra scrutiny. A constant niggle in my brain is that in certain areas, such as the correct state of the art chemotherapy regimen for stage 2 breast cancer, for example, any text book may be out of date before it is printed. Although, on reflection, there are vast areas in oncology where the content does not change very quickly, if at all, between editions.

So, to look in closer detail at my pet areas: the book itself is solid, and too heavy to hold. It is printed on good quality paper. The contents pages are well set out, in a logical manner, and I found them inviting - where appealing to be able to delve into a whole section on cancer-related venous thrombosis to check what the latest is? The layout is excellent. There are very good illustrations and I was delighted to find a CD ROM of all the illustrations at the back of the book with downloadable instructions into a slide show. Key points are put in a box at top and with hints for exam candidates. There is then a clinical relevance box at the back of the book, just in case one thought they were all becoming rather removed from reality. Overall, this book has been very well planned.

On-line version: this is the first textbook I have come across that not only reads well, but also on an on-line version, access to which can be bought with the book. It has the whole book, plus updates inserted into the text where new information has come to light. So I would highly recommend that if you are going to buy the book, you need to buy the online access too – it makes the whole thing so much better! For example, the summary of the book in chapters 19, 20 and 21 have been posted since 3rd June. There is even a news section, so that items that haven’t yet been inserted as updates in the book can be flagged. This gets rid of my complaint about books being out of date before they are printed. Tumour management sections had very timely updates, including recommendations on treatment of prostate, breast, colon and endometrial cancer.

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

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

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

Cytology of Soft Tissue Tumours

M Ackerman, HA Domanski

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

Many anatomical pathologists in this country would baulk at the prospect of diagnosing soft tissue tumours through FNA. The large number of different entities, their relative rarity and the existence of benign ‘mimics’ of malignant tumours make this a difficult area of diagnostic pathology at the best of times. The loss of architectural information that occurs when a lesion is sucked up into a 22-gauge needle and then smeared on a slide, as well as the inevitable problems of large tumours means that most pathologists will insist on at least a few core biopsies before venturing an opinion. However, the ever-expanding number of applications of this technique, with the push for less invasive methods of diagnosis means that the primary diagnosis of soft tissue tumours is emerging as an important new target for FNA.

The authors acknowledge these concerns and emphasise the need for a multi-disciplinary approach, with hints for exam candidates. There is then a clinical relevance box at the back of the book, just in case one thought they were all becoming rather removed from reality. Overall, this book has been very well planned.

Fiona North
Cancer Forum, n Volume 29 Number 1 n March 2005

Functional Food & Nutraceuticals in Cancer Prevention

RR Watson
Published by Iowa State Press (2003) ISBN 0-8138-1845-0 234 pages plus index RRP: A$299.00

Interest in and use of complementary medicines that includes functional foods and nutraceuticals is expanding dramatically across the globe. This book is therefore a welcome addition to the increasing number aimed at disseminating a balanced view of current knowledge in this area. The specific aim of this book is to convey up to date information regarding the usefulness of dietary plants and nutritional supplements for cancer prevention to interested lay readers in the community, to researchers and workers in the nutrition, food science and natural products fields. It generally succeeds in this aim although the level at which it is written would frequently demand a dedicated and well informed lay reader, with some chapters requiring a reasonable scientific grounding. As a reference piece for researchers in complementary medicine it is extremely valuable in presenting a well balanced perspective on the potential benefits of functional foods and nutraceuticals in cancer prevention, while clearly defining the limitations of current research.

The book comprises sixteen chapters divided into two parts, Part 1 titled ‘Approaches to Cancer Prevention: Role of Nutrition’ and Part 2 titled ‘Fruits, Vegetables, and Herbs in Cancer Prevention’. Throughout the book there is a fair amount of duplication of topic areas, for example the topic of soy-derived isoflavones for breast cancer is addressed in at least three separate chapters. Having said this it is often helpful in reinforcing concepts to have them presented in a
book reviews

D M Gershenson et al (eds) University of Queensland Education and Research

D M Gershenson et al (eds) University of Queensland Education and Research

The international perspective of the book is apparent throughout. The editors represent four countries: Australia, Canada, Kingdom and United States whilst expert contributors are from some 12 countries. Thus, renowned clinicians in the field of gynaecological cancer inform the reader of contemporary views from a global viewpoint, ensuring relevance to all regardless of where they practice. The book consists of 71 chapters, divided into nine sections. The initial four sections address the epidemiology, diagnosis, pathology and management of gynaecological malignancies by organ site whilst the following five sections explore subjects that textbooks do not outline. The topics include complications of cancer treatment, symptom management, sexuality and fertility, gynaecologic cancer in pregnancy, melanoma of the female genital tract, biostatistical and clinical trials, imaging of gynaecological malignancies, interventional radiotherapy and biologic therapy. Such a comprehensive approach ensures both a multidisciplinary and holistic focus.

The relatively short but extensively referenced chapters make this text an excellent resource for all professionals who are involved with women with gynaecological cancer, regardless of their level of experience.

Kathryn Nattress
Sydney Cancer Centre, NSW

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

The introductory chapters outline mechanisms of host defense and the composition of what is normal microbial flora in various sites of the body. It then goes on to look at 10 distinct types of haematological lymphoreticular malignancies, detailing ALL, AML, Hairy cell leukaemia, CLL, CML, Myelodysplastic Syndromes, Multiple Myeloma, Hodgkin’s and Non-Hodgkin’s Lymphomas as well as infectious complications associated with stem cell transplant recipients. The chapters that follow are related to infectious complications of the following solid tumour malignancies; brain, head and neck, lung, breast, gastrointestinal, liver and biliary tract, neuroendocrine, bladder and kidney, gynaecological, sarcomas and cutaneous malignancies.

The next major section in the book covers systemic-spread infections, describing central nervous system, pulmonary, cardio-vascular, gastrointestinal, genitourinary, bone, joint and soft tissue infections, and then skin infections.

The book goes on to describe the infectious complications of cancer treatment that is not chemotherapy, specifically chapters on radiation therapy, surgery and then an interesting chapter on catheter related infections.

There is a major section exploring unique infections in cancer patients (fungal and parasitic). Also in this section is a short chapter on human immunodeficiency virus.

The final section assesses the best available evidence for measures to avert infections, including anti-microbial prophylaxis and vaccination, and analyses methods of handling fungal and parasitic infections.

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

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

Infections in Cancer Patients would be a good resource to have accessible in oncology wards and outpatient departments.

Margherita Niccolotti
Clare Holland House, ACT

MAGNETIC RESONANCE IMAGING IN LIVER DISEASE; TECHNICAL APPROACH, DIAGNOSTIC IMAGING OF LIVER NEOPLASMS, FOCUS ON A NEW SUPERPARAMAGNETIC CONTRACT AGENT

Thomas J. Vogl, Riccardo Lancioni, Renate M. Hammersingl, Carlo Bartolozzi

Published by Georg Thieme Verlag (2003)

ISBN 3-13-131391-7  253 pages plus index
RRP: €99.00

Magnetic Resonance Imaging and Liver Disease has been written at a time when there have been some significant improvements in MRI scanning of the liver with the development of new imaging protocols and contrast agents, especially the new superparamagnetic contrast agents.

The book has a concise and organised approach to the most commonly encountered topics facing radiologists and
The book is broken down into twelve chapters covering hepatic anatomy, diffuse, benign and malignant hepatic disease. The book is most useful to the MRI radiologist and technologist as it has an in-depth discussion about magnetic resonance protocols, comparing the outcome of the MRI imaging to that of ultrasound and helical CT scanning.

In Chapter 2 on liver anatomy, it may have been of value to expand the section on normal variants. Chapters 8 and 9, dealing with pre-therapeutic diagnosis and treatment will be specifically useful to radiologists and clinicians alike, as it deals with different imaging modalities and contrast agents as well as highlighting tumour response to percutaneous ethanol injections, trans-catheter arterial chemoembolisation and laser induced thermotherapy.

Classification of detected liver lesions may be difficult using biphasic helical scanning as well as unenhanced MRI in some cases. Previously computed tomography during arterial portography (CTAP) has become the established method of pre-operative diagnostic evaluation. It has a high sensitivity for detecting liver lesions. The disadvantage of this procedure is its invasiveness and a high rate of false positive results.

Improved differentiation of liver tumours is however possible using extracellular MRI contrast agents, namely superparamagnetic iron oxide particles which are absorbed by RES cells of the normal liver, and by tumour consisting of RES. Iron oxide enhanced MRI is thus becoming an acceptable non-invasive technique which will provide high pre-operative diagnostic efficacy and can replace CTAP in many cases.

In general, the spectrum of disease covered as well as the strategies given to evaluate the liver in this book is impressive. After reading this book, radiologists and physicians should feel comfortable understanding the imaging strategies applied to screening for hepatic disease and how this differs from the pre-operative diagnostic work-up, as well as evaluating the liver after different forms of treatment. This text can certainly help confident image interpretation and management of liver disease and will provide useful information for educating referring physicians.

Lourens Bester
Mayne Health Imaging Diagnostic Westmead Private Hospital, NSW

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

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

Oncologists will find helpful and critical chapters on radiation and post-surgical management, and the management of recurrent and metastatic disease, which is a reminder that endometrial carcinoma is not such a ‘benign’ disease. The chapters on Pathology and Molecular Pathogenesis of endometrial cancer are beautifully written and make difficult subjects accessible to the non-expert.

The text is well laid out with good clinical and pathological photographs. The accompanying CD contains the full text and images which is good for travellers. This is a book one can “dip” into or read systematically if depth of knowledge is required. I have no hesitation in recommending this text to anyone with an interest in endometrial carcinoma. Gynaecologists should own a copy and all medical and hospital libraries should have this book on their shelves.

Ian Hammond
King Edward Memorial Hospital, WA

UTERINE CANCER
AF Fuller Jr, MV Seiden, RH Young
Published by BC Decker (2004)
Published by BC Decker (2004)
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<td>3-5 March</td>
<td>3rd International Symposium on Targeted anticancer</td>
<td>Amstel-rond Netherlands</td>
<td>NDDO Research Foundation c/o Convenience Conference Management PO Box 77 Harnem 3480 DB Netherlands Tel: +31 348 567 667 Fax: +31 348 446 057 Email: <a href="mailto:congress@nndo.org">congress@nndo.org</a> Web: <a href="http://www.nndo.org">www.nndo.org</a></td>
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<td>3-6 April</td>
<td>58th Annual Cancer Symposium of the Society of</td>
<td>Atlanta USA</td>
<td>D.K. Kubis - Society of Surgical Oncology 85 W Algijinquin Rd Suite 55 Arlington Heights • IL 60005 Tel: +1 (847) 427 1400 Fax: +1 (847) 427 9566 Web: <a href="http://www.surgonc.org">www.surgonc.org</a></td>
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<td>7-9 April</td>
<td>Functional Genomics and Animal Tumour Models</td>
<td>Madrid Spain</td>
<td>CNIO-Spanish National Cancer Centre C/ Molchord Fernandez Almagor, 3 Madrid 28029 Spain Tel: +34 91 226 6900 Fax: +34 91 226 6980 Email: <a href="mailto:ccc@cnio.org">ccc@cnio.org</a> Web: <a href="http://www.cnio.org">www.cnio.org</a></td>
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<td>11-13 May</td>
<td>7th Shaukat Khanum Memorial Cancer Symposium</td>
<td>Lahore Pakistan</td>
<td>Shaukat Khanum Memorial Cancer Hospital and Research Centre Joder Town Lahore Pakistan Tel: +92 42 5180 735-34 Fax: +92 42 5180 735/54 Email: <a href="mailto:trainingmanager@ShKMC.org.pk">trainingmanager@ShKMC.org.pk</a> Web: <a href="http://www.shaukatkhanum.org.pk">www.shaukatkhanum.org.pk</a></td>
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<td>13-16 May</td>
<td>13th International AEK AIO Cancer Congress</td>
<td>Wurzburg Germany</td>
<td>Biomedicine Franken e.V. Friedrich-Bergu Ring 15 Wurzburg 90766 Germany Tel: +49 931 299 8875 Fax: +49 931 299 8894 Email: <a href="mailto:info@biomedicine-franken.de">info@biomedicine-franken.de</a> Web: <a href="http://www.wak-aeo.de">www.wak-aeo.de</a></td>
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<td>15-16 May</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 10029-674 USA Tel: +1 212 201 2680 Email: <a href="http://www.care.org">www.care.org</a></td>
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<td>17-19 May</td>
<td>6th International Symposium and Expert Workshops on</td>
<td>Amsterdam Netherlands</td>
<td>VU University Medical Center Dept. PAOG P.O Box 707 Amsterdam 1007 MB Netherlands Tel:+31 20 4448444 Fax:+31 20 4448445 Email: <a href="mailto:vumc.vca@vumc.vanvcl.nl">vumc.vca@vumc.vanvcl.nl</a> Web: <a href="http://www.namc.corso.nl">www.namc.corso.nl</a></td>
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<td>18-20 May</td>
<td>Second Annual Winter Lung Cancer Conference</td>
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<td>Halifax, Canada</td>
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<td>16-18</td>
<td>International East-West Symposium on Nasopharyngeal Cancer</td>
<td>Toronto, Canada</td>
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<td>23-26</td>
<td>2nd Quadrennial Meeting of the World Federation of NeuroOncology</td>
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<td>Federation of European Cancer Societies Avenue E Mounier 83, Brussels, Belgium</td>
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<tr>
<td>26-30</td>
<td>XVIII World Congress of Gerontology</td>
<td>Rio de Janeiro, Brazil</td>
<td>ACE Events</td>
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<td>Email: <a href="mailto:secretariat@aceeventos.com.br">secretariat@aceeventos.com.br</a></td>
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<td>Web: <a href="http://www.aceeventos.com.br">www.aceeventos.com.br</a></td>
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<tr>
<td>July</td>
<td>3-6</td>
<td>11th World Conference on Lung Cancer</td>
<td>Barcelona, Spain</td>
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<td>Tel: +1 770 751 7332 Fax: +1 770 751 7334</td>
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<tr>
<td>14-16</td>
<td>2005 Gastrointestinal Oncology Conference</td>
<td>Arlington, USA</td>
<td>International Society of Gastrointestinal Oncology (ISGIO)</td>
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<td>200 Broadhollow Rd Malverne New York 11747 USA</td>
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<td>Email: <a href="mailto:info@isgio.org">info@isgio.org</a></td>
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<td>Web: <a href="http://www.isgio.org">www.isgio.org</a></td>
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<tr>
<td>September</td>
<td>13-16</td>
<td>9th International Nottingham Breast Cancer Conference</td>
<td>Nottingham, UK</td>
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<td>Nottingham Breast Cancer Conference</td>
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<td>City Hospital Nottingham, UK</td>
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<tr>
<td>25-28</td>
<td>109th Annual Meeting of the American Foundation</td>
<td>Los Angeles, USA</td>
<td>American Otoscopyrgy - Head and Neck Surgery</td>
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<td>c/o The AAO-OMS Foundation Inc.</td>
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<td>October</td>
<td>29-30</td>
<td>10th International Conference on Geriatric Oncology &amp; 6th Meeting of the International Switzerland Society of Geroniatric Oncology (ISGIO)</td>
<td>Genolier</td>
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<tr>
<td>02-05</td>
<td>31 European Congress on Cytology</td>
<td>Paris, France</td>
<td>MCI France</td>
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<td>11, rue-de-Solferrino, Paris France</td>
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<tr>
<td>09-12</td>
<td>34th Congress Brasileiro de Radiologia</td>
<td>Brazil</td>
<td>Congresso Brasileiro de Radiologia</td>
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<td>Av, Paulaista 491, 130 Andar C 133 CEP 01311-909 Brazil</td>
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<td>16-20</td>
<td>ASTRO 47th Annual Meeting</td>
<td>Denver, Colorado USA</td>
<td>American Society for Therapeutic Radiology and Oncology (ASTRO)</td>
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<td>12500 Fair Lakes Circle, Suite 275, Fairfax Virginia 20233 USA</td>
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<td>Tel: +1 70 327 0170 Email: <a href="mailto:meeting@astro.org">meeting@astro.org</a></td>
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<tr>
<td>30-31</td>
<td>ECOO 13 The European Cancer Conference</td>
<td>Paris, France</td>
<td>Federation of European Cancer Societies Avenue E Mounier 83, Brussels, Belgium</td>
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<tr>
<td>November</td>
<td>05-09</td>
<td>53rd Annual Scientific Meeting of the American Society of Cytopathology</td>
<td>San Diego, USA</td>
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<td>American Society of Cytopathology</td>
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<td>07-09</td>
<td>OMD Cancer Conference: Cancer and Aging</td>
<td>Madrid, Spain</td>
<td>OMD – Spanish National Cancer Centre</td>
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<td>11-13</td>
<td>Oncology Nurses Society Institutes of Learning</td>
<td>Phoenix, USA</td>
<td>Oncology Nursing Society</td>
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<tr>
<td>December</td>
<td>27-28</td>
<td>91st Meeting of the Radiological Society of North America (RSNA)</td>
<td>Chicago, USA</td>
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<tr>
<td>06-10</td>
<td>28th Annual San Antonio Breast Cancer Symposium</td>
<td>San Antonio, USA</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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Dr K White PhD

CLINICAL ONCOLOGICAL SOCIETY OF AUSTRALIA INC

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

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

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Executive Officer
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Council Nominees
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Professor L Kristjanson RN, BN, MN, PhD
Professor B Stewart MSc, PhD, FRACI

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

INTEREST GROUPS
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Breast Oncology
Cancer Nurses Society of Australia
Cancer Research
Clinical Research Professionals
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