# List of Contents

## Forum: Innovations in cancer imaging

<table>
<thead>
<tr>
<th>Overview</th>
<th>Lourens Bester</th>
<th>139</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vascular access devices and the oncology patient</td>
<td>Stuart Lyon</td>
<td>140</td>
</tr>
<tr>
<td>Magnetic resonance and oncology imaging</td>
<td>Rathan Subramanian and Murali Guduguntla</td>
<td>144</td>
</tr>
<tr>
<td>Implantable peritoneal ports in the management of malignant ascites – technical innovation</td>
<td>Lourens Bester</td>
<td>147</td>
</tr>
<tr>
<td>Vertebroplasty in oncology: a novel approach to pain relief in the cancer patient</td>
<td>Glen Schlaphoff</td>
<td>148</td>
</tr>
</tbody>
</table>

## Articles

| Medical Oncology Group of Australia, Pierre Fabre Cancer Achievement Award: Snake oil, coffee enemas and other famous nostrums for cancer – a recent history of cancer quackery in Australia | Ray Lowenthal | 150 |
| The Cancer Council Australia’s Student Essay Competition: Cancer education for medical students: opportunities and challenges for the 21st Century | Jennifer Anderson | 154 |

## Reports

| Australian behavioural research in cancer | 158 |
| Cancer Trials Database Victoria – first of its type in Australia | 162 |
| Cancer Institute NSW Standard Cancer Treatments (CI-SCaT) | 163 |

## News and announcements

| 165 |

## Book reviews

| 168 |

## Calendar of meetings

| 176 |
Innovations in cancer imaging

Overview

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The burgeoning development of new computer applications and increased funding from venture capitalists has led to an explosion of new innovations in radiology and interventional radiology.

The articles in this edition of Cancer Forum cover many of the new developments. Importantly, in terms of breadth of new developments this volume is 'barely scraping the surface' so to speak.

Radiology and especially interventional radiology continues to expand its role in diagnosis and follow-up in cancer patients. Minimally invasive image-guided therapies have developed increasing importance as a modality of treatment.

Annually in Australia, about 80,000 people are diagnosed with an aggressive form of cancer. We know that the incidence of cancer is increasing and this generates more responsibility and an increased workload for both diagnostic and interventional radiologists.

We have assembled an expert panel of radiologists to discuss the evolution, and in some instances, revolution, in cancer imaging.

Rathan Subramaniam and Murali Guduguntla highlight the role played by the higher field strength MRI scanners and discusses in depth their application in various oncological scenarios.

It is of little use having sophisticated CT and MRI scanners for diagnosis and management of chemotherapy patients if it is difficult to administer the chemotherapeutic agents effectively. With an ever increasing workload and longer waiting lists, our surgical colleagues have found it increasingly difficult to place venous access devices. Additionally, this takes no account of other logistical problems such as hospital bed shortages. Therefore insertion of venous access devices, especially chest and brachial ports have become a procedure performed by the interventional radiologist. It neither requires hospital admission nor general anaesthesia. Stuart Lyons’ article reviews the management of the ports and explains why they malfunction. He has included an extensive list of references in his bibliography.

The management of pain, once entirely the domain of a pain or anaesthetic specialist has also become part of the daily workload of the interventional radiologist. Clearly, the interventional radiologist is now a member of the multi-disciplinary oncological team. Glen Schlaphoff describes ‘cementoplasty’ which is a procedure used for treating bone pain in patients with metastatic bone disease. Not only does cementoplasty stabilise and strengthen the weakened bone, in some instances it will immediately alleviate pain because the heat of the bone cement can destroy the sensory fibres.

Palliative care has advanced considerably and performs an admirable task in caring for the terminally ill patient. But obviously there is ongoing demand for novel cancer therapies, many of which will be developed by other members of the multi-disciplinary team. Your editor has contributed an article to this edition of Cancer Forum, detailing how the interventional radiologist can assist in bettering the quality of life of the terminally ill patient with intractable ascites. The paper describes the image-guided placement of peritoneal ports in the radiology department. This allows the palliative care nursing team to aspirate the ascites with the patient at home; obviating the need for frequent visits to the radiological department for paracentesis.

The papers presented may seem esoteric to some clinicians and radiologists who have become comfortable with the concept that radiology is purely a diagnostic tool. This truism is no longer valid. This edition of Cancer Forum dispels that and shows the road ahead – radiology offering diagnostic and therapeutic services.

It is hoped that the articles provide two benefits for the reader. Firstly, to reflect upon and admire the speed and breadth of development within diagnostic and interventional radiology. But probably more importantly, to act as a springboard for curious minds such that they might follow the lead and contribute to improving the management of cancer.
Vascular access devices and the oncology patient

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Abstract

Oncology patients are frequently faced with difficult venous access requirements. Access is required for chemotherapy and frequent blood testing, which rapidly consumes peripheral access, often on and off for prolonged periods. Long-term venous access devices have the potential of minimising the quality of life implications for such patients whilst preserving peripheral veins.

Venous access devices, including implantable catheters (ports), tunnelled catheters and peripherally inserted central catheter (PICC) lines, all have relative advantages and disadvantages. Choice of device will often revolve around both patient factors and local preference. Image guided placement is the preferred method of insertion in most institutions due to its higher success rates and lower morbidity and mortality. Secondly, such physicians are usually well suited to address many of the catheter complications and place alternate access catheters in the compromised venous patient.

Vascular access is a common problem facing oncology patients. Access is not just required for intensive chemotherapy, but also for frequent blood sampling and intravenous supportive measures. Vascular access devices provide reliable venous access and may protect peripheral access and increase patient comfort through reduced access and frequent venipuncture.

The perfect catheter should be placed in a large vein allowing long-term patency, ongoing access for ongoing chemotherapy, and more expensive than tunnelled catheters. Patients with high infectious loads, who are immunosuppressed or have a history of phlebitis are candidates for such catheters. Complications include infection at the port exit site and subcutaneous abscess along the catheter path, infection of the port hub, and infection of the central venous catheter itself. These infections can be difficult to treat and may require removal of the catheter.

Complications

Procedural complications are rare with meticulous technique, image guided insertion and image guided punctures. They include pneumothorax, haematoma, subcutaneous abscess, catheter malposition, haematoma and air embolism. The Society of Interventional Radiology’s published guidelines on image guided central venous access recommends a threshold of 3% for major complications (rates exceeding a threshold should prompt a review of that service).

Indwelling complications include infection, thrombosis, catheter malfunction and catheter fracture. Catheter fracture is rare (< 1%), while the other three are problems integral to all long-term catheters. Catheter malfunction has an incidence of 10-20%, this is often related to fibrin sheath formation or catheter associated thrombosis. The incidence may be minimised with meticulous access and tip placement.

Infection

Infection is an important cause of morbidity, mortality, and increased health costs with long-term vascular catheters. Infection includes exit site infection, tunnel or port infection and catheter related bloodstream infections; it does not

Figure 1: Ultrasound and micropuncture access set.

Figure 2: Translumbar placed portacath in man with bilaterally occluded brachiocephalic veins.
systemic antimicrobial therapy should be used in addition to antibiotic lock therapy. There is no standard on the timing of catheter replacements for catheter related infections, we replace our catheters at 5-7 days if there are no further febrile episodes or positive blood cultures. A new tunnel is created and the right side is favoured, even if the previous catheter was inserted there.

Thrombosis

Despite routine flushing with heparin or saline, 41% of central venous catheters (CVC) result in thrombosis of the blood vessels, markedly increasing the risk of infection. Efforts to reduce CVC thrombosis with systemic prophylactic anticoagulation with low-molecular-weight heparin have failed and low-dose warfarin prophylaxis remains controversial. In an autopsy study of patients with CVCs, all 53 patients examined developed a sheath and, in phlebographic studies, 45 of 57 (81%) patients had a fibrin sheath.29,40,41 (figure 3) A venographic study by De Cicco et al showed that 83 of 95 (87%) patients had these sheaths. These fibrin sheaths over time are always colonised by coagulase negative staphylococci.42 However, fibrin sheaths do not appear to result in subsequent deep vein thrombosis of the vessel in which the catheter is placed.

A very common and usually under-reported event is the development of thrombus within the lumen of the catheter.43,44 This usually is uncovered when the catheter fails to allow blood to be withdrawn or fails to allow infusion through a port. Treatment is by locking the catheter with fibrinolytic agents such as urokinase, streptokinase and tissue plasminogen activator (tPA) and is successful in some 80-95%.40,41 The major thrombotic complication of CVCs is deep venous thrombosis. These mural thrombi may partially or completely block the blood vessel and involve 12-74% of all CVCs. Most (~71%) are asymptomatic.45 Venographic studies have shown that approximately 41% (range 12-74%) of all patients with CVCs developed thrombosis.45,46 The pathologic effects of CVCs on blood vessels were studied in 74 consecutive autopsies of cancer patients with CVCs in which the cannulated vessel was compared with the contralateral vessel that was not cannulated.46 Venous pathology (thrombosis, thrombophlebitis, calcification, ulceration and inflammation) was found in 49% of the cannulated blood vessels but in only 9% of those that were not cannulated. Furthermore, mural thrombosis was seen in 30% of the cannulated vessels and in only 1% of those not cannulated. Nonetheless, catheter related deep venous thrombosis (CRVT) is relatively rare having been reported in approximately 6% of all patients with upper extremity DVT. However, we have placed three superior venus cava filters in patients with pulmonary emboli for catheter related venous thrombosis in the last 12 months.

(figure 4)

Although, malignancy is a risk factor for catheter related thrombosis, catheter tip position is the major determinant of central venous thrombosis. The superior venous cava (SVC) results in a higher incidence of thrombosis than when the catheter tip is placed low in the SVC. In addition, CVCs inserted from the left subclavian vein clotted more commonly than did CVCs inserted from the right subclavian vein.47 In a recent study, 14 of 16 (87%) left side CVCs versus 49 of 79 (62%) right side CVCs were reported to clot.48 Prophylactic flushes with unfractionated heparin or saline are the standard of care to maintain CVC patency but are inadequate to prevent blood vessel thrombosis. The benefit of systemic prophyaxis with LMWH or warfarin is not been well established. Venous thrombosis causing central catheter malfunction is treated by infusing a thrombolytic through the catheter Overnight and this usually resolves the thrombus leaving a normally functioning central access (figure 5).

Conclusion

Tunneled catheters, ports and PICC lines are important means of providing intermediate to long-term central access in oncology patients. Image guided placement has been shown to have the greatest success and lowest complication profile and now represents the standard in most institutions for insertion of these devices.

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Magnetic Resonance and Oncology Imaging
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Abstract
Magnetic resonance imaging is usefully employed on its own or with complementary technologies to evaluate stage and other characteristics for a range of specific tumour types. These include the central nervous system and head and neck, breast, prostate and colo-rectum, as well as gynaecological and musculoskeletal malignancies. For each tumour type, optimal usage of magnetic resonance imaging involves familiarity with tumour type and various other characteristics. For most tumour categories, there are scenarios in which magnetic resonance imaging has only limited application.

Magnetic Resonance Imaging (MRI) is a safe and painless imaging investigation (test) that produces cross sectional imaging of the tissues of the body. MRI is a valuable tool that can aid in diagnosis of a wide range of conditions and is often used to diagnose cancer. It is most effective in detecting and staging cancer of the brain, spinal cord, head and neck and musculoskeletal system. MRI relies on a large magnetic field and certain people should avoid the test. This includes patients with pacemakers and some implanted cardioverter defibrillators. Pregnant women should generally avoid MRI, unless it is necessary, as the risk to a developing foetus is not known.

Primary tumours of central nervous system
MRI is now the investigation of choice for the evaluation of cerebral neoplasms. MRI is superior to computed tomography (CT) for tumour detection because of its inherently high sensitivity to altered tissue density. Although conventional MRI sequences play a major role in determining prognosis,1 MRI is unable to predict tumour type and grade reliably.2 The accuracy is limited by the inherent nature of the majority of common brain tumours, which are incompressive. MRI is frequently unable to identify the tumour margins. Since many gliomas contain areas of varying histological type, the aim of imaging should be to identify the area of highest grade and thereby guide the stereotactic biopsy appropriately.

Since there is increasing evidence that complete resection of tumour prolongs survival, especially in low-grade gliomas,3–5 MRI should be to identify the area of highest grade and thereby guide the stereotactic biopsy appropriately.

Functional imaging studies using MRI at 1.5 Tesla or higher are being performed which permit non-invasive determination of centres of task activation in the cortex of the brain.6 This may allow the accurate mapping of the relationship of the normal functioning tissue to the tumour and enable larger resections while preserving normal function.7 MRI spectroscopy (MRS) has become more readily available and easier to use and is therefore becoming part of preoperative imaging and tumour follow-up.8 MRI is able to show metabolites in tumour outside areas of enhancement seen in gadolinium-DTPA contrast MRI scans.

Echoplanar diffusion-weighted imaging (DWI) is routinely used in many institutions. Its main value is to discriminate between an acute infarct and tumour at presentation. Apparent diffusion coefficient (ADC) maps can discriminate between high grade glioma and normal brain tissue and may help to target biopsy to most potentially malignant areas.9 There is, however, some overlap between Grade II and Grade IV astrocytomas.10

Head and neck tumours
There is no scientific evidence to indicate whether MRI or CT is better in the evaluation of head and neck cancers. Each is complementary with its advantages and disadvantages. CT is reliable to evaluate bony structures. MRI is valuable to evaluate bone marrow involvement. However there is usually bony destruction in CT when tumour invades the marrow space. MRI is more useful around the skull base because of the higher contrast resolution to obtain delineate complex anatomy around the skull base and upper neck. The main disadvantage of MRI compared to CT is the motion artifacts, especially in the region of the lower neck and oral cavity due to swallowing, coughing etc.

MRI has little role to play in the evaluation of thyroid nodules. It cannot reliably differentiate benign from malignant nodules.11 MRI can be useful for tumour staging and assessing mediastinal and oesophageal extension of tumours considered to be aggressive or invasive. Introduction of one and two dimensional proton MRI is promising and allows more specific tissue characterization, which may help to distinguish benign and malignant nodules.12

Musculoskeletal tumours
Staging of all potentially malignant tumours in bone is most accurately achieved by MRI, which should be performed prior to biopsy. This allows measurement of the maximum dimension of the tumour prior to any treatment. CT has a limited role in evaluating the staging of the tumour but is the examination of choice for evaluation of the chest for metastatic disease. CT is the preferred test where characterisation of the lesion by radiography is inadequate because of inadequate visualisation of the margin of a lesion. In these circumstances CT imaging may suffice for local staging.13

MRI has become the imaging method of choice in evaluation of soft tissue tumours. This is due to improved soft tissue contrast and multi-planar image acquisition, which allows more accurate anatomical delineation of the tumour and its relationship to structures. However, inability to detect soft tissue calcification renders a mass non-specific. Magnetic resonance imaging should be to identify the area of highest grade and thereby guide the stereotactic biopsy appropriately.

MRI is becoming more commonly used in the evaluation of breast disease. MRI is useful for the detection of multifocal and multicentric breast disease which are more accurately and show good correlation with resected breast tissue cancers have pulmonary metastasis at diagnosis.15 Knowledge of pulmonary metastasis is critical for optimum management of these patients.

Breast tumours
MRI has high sensitivity for breast cancer detection that relies on the tendency of malignant tumours to generate neovascularity.16 Malignant growth is seen with leakage capillaries that allow the contrast agent to show high intensity peak with rapid washout that is seen in most, but not all, malignancies. False negative examinations have been reported with well-differentiated tumours.17 MRI compared to CT has maximum sensitivity for extracapsular extension was 64% and for seminal vesicle invasion was 82%.18

MRI spectroscopy has been reported to be valuable in diagnosis of prostate cancer. The combination of MRS and anatomical information from phased array and endo-rectal coils can improve the localisation of cancer within the prostate and may improve prediction of extracapsular extension. Combined MRS and MRI have a reported positive predictive value of 88-92% and a negative predictive value of 80-86% for detection of foal of prostate cancer within the gland. They have resulted in increased accuracy of tumour detection from 53% to 75%.19 High specificity of MRS helps in the distinction of post-biopsy haemorrhage and other benign abnormalities from tumour. MRI may be able to assess tumour aggressiveness. Significant correlation has been shown between Gleason score and MRI choline levels.20

Colorectal malignancy
Tumour staging of colorectal cancer can be achieved with endo-rectal coil with accuracies of 80% or greater. T2 weighted images provide better contrast between the tumour and rectal wall than T1 weighted images. Higher resolution obtained with endo-rectal coil demonstrates the presence of invasion of the muscularis propria. Contrast resolution of this technique provide detailed anatomic imaging, which permits assessment of the relationship of the tumour to the muscularis mucosae.21 This process ‘map’ for the surgeons.22 A recent prospective study has shown MRI predicts the histological status of colorectal malignancy with a positive predictive value of 92% and a negative predictive value of 90% for extramural invasion, peritoneal infiltration and depth of extramural spread23 allows a more specific preoperative treatment strategy.

MRI has shown considerable promise in identifying hepatic metastases.24,25 Hypo-intensity on T1 weighted images compared to CT or ultrasound. The availability of liver specific contrast agents, such as magnefdiprol trisodium (Mn-DPDP), has resulted in further improvements in detection of metastatic

Breast MRI is best used as an adjunct to conventional imaging, complementing mammography and ultrasound. Its high sensitivity for multifocal disease is being looked at as a possible screening investigation in high-risk populations.26

False positive breast MRI is seen with fibroadenomas, atypical ductal hyperplasia, lobular carcinoma in situ, papilloma, fibrocystic changes and lymph nodes with focal areas of enhancement. The relatively low specificity is likely to be the greatest impediment to an increase in clinical utility for MRI in breast cancer work up.

Prostate cancers
MRI is promising for diagnosis and staging of prostate cancers. MRI should be performed for three to four weeks after prostate biopsy to minimise error from signal alteration related to post biopsy haemorrhages.27 Prostate cancer is usually seen as low signal focus in T2 weighted images. It may not be detected if it does not show low signal in T2 weighted images, if it is located in the central gland or if the peripheral zone is compressed by advanced benign prostatic hyperplasia (BPH). MRI can detect extracapsular or seminal vesicle invasion. Overall the results of MRI for prostate cancer staging have varied over the last decade. A meta-analysis showed the maximum sensitivity for extracapsular extension was 54% and for seminal vesicle invasion was 82%.28
Implantable peritoneal ports in the management of malignant ascites – technical innovation

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Abstract

A minimally invasive method for palliative drainage of symptomatic malignant ascites by placing a peritoneal port in the Interventional Radiology Suite would allow patients to avoid repetitive trips to the Radiology Department for paracentesis and for paracentesis to be performed by the palliative care team at home. Since 2003 960 patients at Westmead Private Hospital have received either a chest or a brachial port in the Department of Radiology. The procedure has been used for the placement of multiple tunneled peritoneal Ports using a modified Seldinger technique in the Interventional Radiology Suite. Patients with symptomatic ascites were able to be drained at home and all achieved significant improvement in those symptoms attributable to the ascites. It is postulated that the complication rate will be much lower with tunneled ports compared to percutaneous drainage of malignant ascites. Accordingly, percutaneous placement of Peritoneal Ports in the Interventional Radiology Suite appears to be a viable and safe technique in patients who have symptomatic ascites that requires frequent therapeutic paracentesis for relief of their symptoms.

Ascites is a common complication of advanced malignancies with symptoms of marked abdominal distension, shortness of breath, marked decrease in the quality of life and often accompanied by progressive disease. Accordingly, percutaneous placement of tunneled peritoneal catheters attached to subcutaneous ports implanted under the skin, attaches to subcutaneous ports implanted under the skin.

In the past permanent drainage catheters have not been considered a viable treatment option for malignant ascites due to infection, malposition or occlusion. Cuffed-tunneled peritoneal catheters have been used for many years for peritoneal dialysis with an acceptable complication rate. A recent article published showed a two-year catheter survival rate of 49 to 82%.

It was therefore appropriate to re-evaluate placement of peritoneal ports specifically designed for peritoneal access as a means of controlling malignant ascites and develop a technique of percutaneous placement outside the operating theatre.

Between January 2003 and August 2005 46 peritoneal ports were placed in patients with a short life expectancy and with symptomatic ascites. The ultimate goal was to repeatedly access the peritoneal port and to perform ascites drainage at home, thereby avoiding frequent trips to the radiology department for image-guided drainage.

Previously these ports were placed surgically, which necessitated hospital admission and hospital care before discharge.

Using ultrasound and performing the procedure in the angiography suite, a large collection of ascitic fluid is identified.

The inferior epigastric artery and the venous perforators in the region where the port is going to be placed and also identified.

A Seldinger technique is used to create a tunnel through the subcutaneous tissues into the peritoneal cavity, after which the peritoneal port catheter is within the pelvis, followed by placement of the port in the subcutaneous tissues adjacent to the ilium on the left or right side.

The procedure is performed using buffered local anaesthesia only and under cover of one gram of Cephalixin and the wound closed with an absorbable suture. The port is heparin locked at the end of the procedure.

With the help of the palliative care unit a home nursing care protocol has been developed. The port is accessed at home on a weekly basis or more frequently if necessary using a Huber needle with dependent drainage. A maximum of three litres of ascites are drained at any given time to avoid volume depletion and the port heparin locked after the procedure.

Very few complications have been experienced as listed below:

1. In one patient, there was accidental puncture of the inferior epigastric artery with contained haemostatic formation in the anterior abdominal wall.
2. One patient presented with wound infection and the port was removed.
3. In one patient, there was accidental transection of the catheter by the Huber needle and the catheter and port was replaced.
4. One patient developed bowel obstruction due to progressive disease.
5. Several patients developed leakage around the insert site, managed with decreasing intra-abdominal pressure by increasing frequent drainage with successful resolution.
6. Several patients with exudative ascites developed port blockage, managed with irrigations and in one instance with port replacement.
7. No patients presents with peritonitis or wound dehiscence.

Discussion

Intractable malignant ascites is often a disabling disease and decreases the quality of life in patients with a short life expectancy.

Serial paracentesis may be performed with or without ultrasound guidance and has the advantage of being relatively easy to perform with a low complication rate. The disadvantage of serial paracentesis includes repeated trips to the hospital and the radiological department.

Peritoneovenous shunting has an advantage as no hospital visits are required for drainage and there are no fluid or protein losses. A major disadvantage of this procedure is the procedure and poor long-term patency and excessive complications, which includes disseminated intravascular coagulation.

Tunneled peritoneal catheters with an external component...
The lumbar spine is most frequently involved. 2 are osteoporotic compression fractures and Currently the two most commonly treated conditions which augments the strength of a weakened and or
ports used were all previously placed surgically. The procedure were found to be a safe and effective treatment option for malignant access and 90% long-
term patency rate with a low complication rate. 8 Insertion in the outpatient setting is well tolerated and drainage
malignant ascites with a 100% success rate and 90% long-
fractured vertebra by injecting bone cement, usually
vertebral body, thus relieving pain. The technique, thus far, a range of reports have consistently documented
may also play a role in pain relief. Furthermore, it has been proposed that PMMA has an antitumoral effect, which may explain the rarity of local recurrence. 1,3 The effect may be the result of the cytotoxicity, thermal effects and ischemia produced by PMMA. 4,5 Analysis of pathological findings in patients in whom PMMA has been injected has demonstrated a macro and microscopic rim of tumour necrosis six months after vertebroplasty/tumour injection, which seems to extend outside the limits of the cement.

Vertebroplasty in oncology: a novel approach to pain relief in the cancer patient

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Abstract
The mechanism by which vertebroplasty is effective in providing pain relief is unclear, but may involve destruction of nerve endings consequent upon the injection of bone cement into the vertebral body. Vertebroplasty is now employed to treat osteoporotic compression fractures and spinal metastases which are the most common vertebral body tumours. Patients likely to benefit are those having relative spinal canal compromise with epidural involvement and vertebra plana related to osteoporosis and secondary to metastatic disease. Application of the procedure is critically dependent upon appropriate imaging. While evaluation by prospective randomised controlled trials is not available thus far, a range of reports have consistently documented Percutaneous Vertebroplasty (PVP) by definition is a procedure which augments the strength of a weakened and or fractured vertebra by injecting bone cement, usually Polymethylmethacrylate (PMMA) into the vertebral body. This augmentation restores some of the mechanical properties of the vertebra, stabilising the fractured vertebral body, thus relieving pain. The technique, using a fluoroscopically guided, percutaneously placed needle, was pioneered in France 1897 to treat benign aggressive haemangiomata. 6 Currently the two most commonly treated conditions are osteoporotic compression fractures and spinal metastases, which are the most common vertebral body tumours. 7,8 Spinal metastases are most frequently related to breast lung or prostate carcinoma, and myeloma and lymphoma are also frequent causes of disseminated spinal lesions. The lumbar spine is most frequently involved. 9 The associated back pain in many lesions leads to impaired functioning and significant reduced QOL. This often results in chronic pain syndromes with loss of sleep, decreased mobility and depression. 2 Why it works

Various theories on the procedure’s ability to provide pain relief have been suggested. In cases of vertebral metastases, local pain thought to be secondary to bone fractures and the reaction of the remaining nerve structures to the tumour’s mass effect. 1 It is likely that a component of the vertebroplasty-related analgesia is secondary to immobilisation of microfractures and reduction of mechanical forces. The destruction of nerve endings caused by the cytotoxic, mechanical and vascular effects of PMMA, as well as the thermal effects of polymerisation, however, may also play a role in pain relief. Furthermore, it has been proposed that PMMA has an antitumoral effect, which may explain the rarity of local recurrence. 1,3 The effect may be the result of the cytotoxicity, thermal effects and ischemia produced by PMMA. 4,5 Analysis of pathological findings in patients in whom PMMA has been injected has demonstrated a macro and microscopic rim of tumour necrosis six months after vertebroplasty/tumour injection, which seems to extend outside the limits of the cement.

Figure 1a:
Pathological fracture of T7. The vertebral body is crushed and cartilage is missing. Pain relief lead to improvement in quality of life for these patients.

The published complication frequency is 1.3% in osteoporotic fractures and 10%-15% in metastatic disease. 1 The high frequency probably reflects increased vertebral body destruction and or the poor general condition of the cancer patient, as well as the progressive nature of the disease. Note however, the long-term complication rate in patients with metastatic disease is 1.7%. 12 Percutaneous vertebroplasty and radiotherapy are complementary procedures with radiation preferred after percutaneous vertebroplasty when possible. 10

Conclusion
Percutaneous vertebroplasty is becoming a standard of care for palliative pain control associated with neoplastic pathological compression fractures. Severe compression fractures and fractures with epidural involvement should not contra-indicate this procedure in selected patients with cancer, intractable pain, few treatment options and reduced life expectancy. 4,5,11 Vertebroplasty is complimentary to both surgery and radiotherapy and should be considered as a treatment modality in patients with metastatic spinal disease.

References
One claim often made by proponents of CAM is that their treatments are ‘natural’ and therefore, by implication, harmless or at least less likely to have side-effects than conventional pharmaceuticals. However to suggest that because something is ‘natural’ it is automatically safe is absurd. Many so-called ‘natural’ remedies cause serious harm. In one study, 35% of patients taking conventional medications reported adverse reactions, compared to only 16% of patients taking herbal remedies. In some cases the staid, conservative medical profession was accused of being inadequate in its approach to patients with alternative medicines. To some peoplehomeopathic medicine, acupuncture and herbal remedies were seen as quackery and quacks. Meanwhile, some patients who had sought medical help for their conditions and were prescribed conventional medicine turned to CAM. In the 1990s, CAM use among cancer patients in the United States rose to almost 30%.

Having arrived at this point, let us consider some of the characteristics that CAM patients share with traditional medicine patients. First, CAM patients are often motivated by the idea that conventional medicine is ineffective or inaccessible. Second, CAM patients may be more interested in personal choice and control over their treatment. Third, CAM patients may have a strong sense of community and solidarity with other patients who are using alternative medicine. Finally, CAM patients are likely to be more open to new ideas and to be more willing to try unconventional treatments.

In conclusion, CAM is a complex and diverse field. While some of its practitioners may be quacks, others are serious and dedicated to finding new ways to treat illness. CAM is not a panacea, but it may offer patients hope and help in their battle against disease. As more research is conducted on CAM, we will be able to better understand its potential and limitations.
As states as well as Australia and enjoyed considerable political support. Its proponents strongly pushed the conspiracy theory, that is, the medical profession really knows the cause and cure of cancer, but denies this information to the public in order to increase profits for itself and its malign bedfellow the pharmaceutical industry. Whether it is this, or its cunning mislabelling as a vitamin (if, true, would indicate it to be a nutritional requirement for all), or the false claim that cancer cells are susceptible to the cyanide in laetrile whereas normal cells are not, for whatever reason it has enjoyed great popularity in the US. When it was banned there after studies conclusively showed it to be of no value and indeed potentially dangerous,10-12 laetrile clinics were set up in Mexico just across the border from the US. They continue to operate. Indeed this substance is enjoying a resurgent popularity perhaps encouraged by a considerable internet presence. In the 1980s many Australian patients were so taken by the pseudoscientific promises that they were prepared to travel to Mexico for treatment, at great expense. Many others arranged its importation for personal use.

In the 1990s the alternative treatment that caught the imagination of many patients was shark cartilage. Its popularity was based on two myths, one, that sharks don’t get cancer and two, that it had shown unexpectedly good results in a trial in Cuba. In fact sharks do get cancer (but even if they didn’t, so what?). By this logic we should all eat extract of spine from the collyrial shark to avoid cancer. Many other popular forms of CAM this one too was the subject of a media bandwagon, this time by the American 60 Minutes programme which claimed that 3 of 15 patients in Cuba had had excellent results. The American Medical Association concluded that these results were ‘incomplete and unimpressive’. Even the National Center for Complementary and Alternative Medicine (which was set up by supporters in the US Congress) stated that this trial was not sufficiently detailed to draw any conclusion. Subsequent studies have convincingly shown that shark cartilage is useless for the treatment of cancer.13 In fact its proponents have been heavily fined in the US for potentially dangerous, 10-12 laetrile clinics were set up in Mexico just across the border from the US. They continue to operate.

The hope for our patients lies in more such research. The greater the number that enter clinical trials of new treatment the more benefit directly and the quicker the answers will come to cure future patients. I pays tribute to the myriad of women in breast cancer trials, including many from Australia, whose participation has led directly to the major improvements in outlook for this disease which are now quite apparent. I particularly pay tribute to paediatricians treating childhood cancer, who over the past 50 years have been responsible for putting over three-quarters of their patients into clinical trials and thus rapidly brought about the cure rate for childhood acute lymphoblastic leukaemia from nil to over 80%. The same dramatic improvements could be achieved for adult cancer patients in much less than 50 years if a similar revolution are benefiting cancer patients, one striking example is that patients’ needs go well beyond the purely medical.

The Medical Oncology Group of Australia/Pierr Fabre Award is granted annually in recognition of an outstanding contribution to the scientific study of cancer and/or to the control of cancer in Australia by an Australian scientist, clinician or other health care professional.

This is an edited version of the lecture presented at the Medical Oncology Group’s Annual Scientific Meeting in Hobart in August 2005.

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The idea that oncology education needs constant evaluation, updating and standardisation is not new. In one of the first formally described efforts, an undergraduate cancer education, substantial differences between medical schools were found, primarily in curricula content (Tattersall & Langlands 1993). Subsequent evaluation of cancer education and surveys of medical students' oncology knowledge and skills have not indicated a high standard of teaching in these areas (Barton et al. 2003, Tattersall et al. 1988, Smith et al. 1991). Perhaps most disturbing are the results of a comparison of skills of interns in Australia and New Zealand from 1990 and 2001 (Barton et al. 2003). This study found that graduate medical program curricula appear to have successfully introduced new cancer content and curricular models of teaching. However, these programs have not always succeeded in producing doctors with better knowledge about cancer (Barton et al. 2003). This is in the context of an "Ideal Oncology Curriculum" having been developed by The Cancer Council Australia in 1989 (Oncology Education Committee 1999, Tattersall & Langlands 1993). With the changes in the curricula throughout Australian medical schools (eg. graduate medical programs) and the establishment of new medical schools (see below) the opportunity has arisen for curriculum review, as well as the challenge of enhancing teaching in various areas including oncology education. Although ongoing analysis of graduates' knowledge and skill has been undertaken and the ideal oncology curriculum, teaching resources and programs have been introduced this series Greenberg & Elliot (2004) state that the title highlights two causes of anguish among teachers: lack of time and lack of knowledge of teaching techniques. It is interesting to note that one of the published desired learning outcomes of the Scottish Deans Medical Curriculum Group is Communicating as teacher (Simpson et al. 2002). This indicates the importance this group places on equipping future clinicians to be educators.

Students
Students surveyed in 1990 and 2001 showed that recent graduates actually had less exposure to cancer patients than those who trained 10 years ago (Barton et al. 2003). In particular, there is limited information about the place of palliative care in the undergraduate curriculum and what there is indicates that there may be deficits in Australia (Cains & Yates 2003, Glare & Vikr 2001).1 We need to ensure that students are adequately prepared and supported when dealing with issues about cancer, especially terminal cancer, as well as experienced by patients during successful treatment of their cancer (Wear 2002). Metcalf (1998) comments that some of the problems encountered by patients with cancer are due to the paucity of communication skills teaching, the lack of care of patients’ feelings when they have to confront severe suffering (so that they defend themselves by dehumanising the patient) and the elitism that characterises undergraduate medical education.

Medical students are starting their training at a later age and this often means they are also starting families at the same time (Kennedy 1997). This has implications for their role and/or ability to participate in “after-hours” teaching. It also means that they are, in general a student body with more experience both in the undergraduate experience and life in general. The students also have a responsibility to perpetually defer to their own experience/knowledge as cancer patients and to allow them into their teaching.

1 This report (Tattersall et al. 1993) followed a survey of graduating students/interns from all Australian medical schools (Smith et al. 1991) discussed earlier in this text.

2 Portfolio learning in this context involves following a patient with cancer and their family over 6-12 months supported by regular tutorials and as part of a larger learning) an already proven method to increase the outcome of oncology education in the undergraduate curriculum (Finlay et al. 1998).

Patients and Advocacy groups
Despite the knowledge, now almost 20 years old, that “In all Australian Medical Schools a compulsory course in oncology should be offered and should be substantial. The topic should be examinable, and the presence of an appropriate course should be a requirement for an accreditation review”, change seems to be slow (Tattersall 1999). The development of the Ideal Oncology Curriculum (Oncology Education Committee 1999) was made possible by the participation and advocacy of cancer patients. Their participation also ensures that the concerns of patients are addressed.

The nature of a student’s clinical experience has changed, due to the success (in developed countries) of primary prevention and secondary intervention in cancer. This means that medical students in hospitals seldom palpate a breast cancer (Kennedy 1999). Many solutions have been put forward increased primary care experience, portfolio learning (Finlay et al. 1998, Maughan et al. 2001) and community partnerships” (Henry 1996). All of these three require the participation of the patient advocacy groups in order to succeed. This gives power to the patient as educator in this situation, as well as being an invaluable and (in the case of portfolio learning) an already proven method to increase the outcome of oncology education in the undergraduate curriculum (Finlay et al. 1998).

Patients can also share their experiences not only of a diagnosis, but their treatment both good and bad. This can be useful in the medical community (Blennerhassett 1998, 2001) or to the general public (Hattenstone 1999, Miles 1995). Blennerhassett’s (1998) work is an example of such an initiative accompanied by a response from Metcalf (1998) which states that her (Blennerhassett’s) experience can/should act as a catalyst not only to change undergraduate curriculum, particularly with regard to communication skills, but also to change current practice. A feedback loop from the ultimate stakeholder, the patient, is critical if difficulties such as those experienced by Blennerhassett are to be ameliorated (Jones 2001).

Clinical educators/oncologists
Undoubtedly, “clinicians are our best asset” (Judy Searle, Dean of Medicine Griffith University Qld quoted in Lawson et al. 2004). However, they are also our most stretched resource. Many (especially junior) oncology resident students report feeling unable to cover the huge role of patient loads and their own continuing medical education must be attended to. More time for teaching means an increased staffing requirement and a higher premium put on time dedicated to teaching.

Are doctors teachers? Although enshrined in the hippocratic oath, the willingness to teach does not necessarily translate into the ability; how able and equipped are medical practitioners to teach and are we doing much to help them? One example is the Teaching on the Run series (Lake 2004). In the editorial introduction to this series, Lake (2004) states that the title highlights two causes of anguish among teachers: lack of time and lack of knowledge of teaching techniques. It is interesting to note that one of the published desired learning outcomes of the Scottish Deans Medical Curriculum Group is Communicating as teacher (Simpson et al. 2002). This indicates the importance this group places on equipping future clinicians to be educators.

References
have been a patchy partnership between the medical professions and the professed public. Its solution has been recently suggested that, for a number of reasons, a national exit exam should be considered for all medical schools in Australia, to stand standardisation (a and a basic minimum requirement for professional practice and internship (Kocwarra et al. 2005). An exit exam is one way of ensuring that the message gets through to all medical schools. It is not students alike that there is an expected minimum standard that must be reached. It is imperative that the Oncology Education Committee lobby for a place at the table should the idea eventuate. Another advantage of an exit exam would be a way to continually improve the undergraduate curriculum over time and between Australian medical schools with outcomes.

The term “outcome-based” was coined by Donabedian, who developed a paradigm for quality assessment, comprising structure, process and outcome. He recognised that, while some outcomes (such as death) might be easily recognised and measured, others were not. Among the latter he included “patient satisfaction”, “health status”, “personality changes”, “physical disability and rehabilitation”. Donabedian suggested that “outcomes by and large, remain the ultimate validators for the effectiveness and quality of medical care” quoted from (Jones et al. 2001).

According to McNeil (1993) outcomes in education should be broad in vision but specific enough to be taught and measured effectively. Outcomes in education is an effort to overcome a situation of inappropriate and excessive testing, unnecessary surgery, and medical error in the systemic undervaluing of the humane, holistic and affective components of medicine in favour of the technical, reductionist, and invasive approach of the 20th century. Tamblyn et al. (1998) have used outcome research to determine that those who performed better on a standardised paper licence examination correlated with improved practice patterns, such as appropriate mammographic screening, suggesting that education may be an independent variable in cancer treatment outcomes (Sloan 2000). Such studies as University of Kentucky prospective randomised trials allow us to hypothesise that cancer care can be regarded as an important goal (Sloan 2000)

There are difficulties; Norman (2002) identified three main difficulties in implementing outcome-based research in medical education:

- a) real differences in educational strategies may not be reflected in outcomes, such as licensing examination performance, simply because students are highly motivated and not blinded to the intervention, so will compensate for any defects in the curriculum; and
- b) a curriculum contains many components, delivered with variable quality by different teachers; and
- c) time between learning and important outcomes may be so long that any effects are obscured, although not always (Norman 2002). Additionally randomisation, control of variables and choice of appropriate outcome measures (appropriate for the intervention) are all difficult to optimise.

Outcomes-based education has the additional attraction of being able to actively involve all the above mentioned stakeholders in the day-to-day running of the curriculum. In Australian oncology education we have the benefit of knowing the current level of student competency. It has been suggested that a student’s attitude and skills of interns in Australia and New Zealand in 2001: comparison with 1996, and between courses at types of medical school. Medical Education 36 (6): 696-700 1996


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This article is the winning entry in The Cancer Council Australia’s student essay competition. As the winner, Jennifer Anderson received the World Health Organisation’s Collaborating Centre for Cancer Education’s Oncology for Medical Students’ summer school.
Correction to last edition
A Research in the Pipeline item titled Comparing GPS and accelerometer counts, that was reported under CBRC (Centre for Behavioural Research in Cancer, Vic) in the July 2005 issue (Vol 29(2)), is actually research to be carried out by the CBRC (Cancer Prevention Research Centre at The University of Queensland).

New Results
n Cancer Prevention Research Centre (CPRC), Qld
PLACE (Physical Activity in Localities and Community Environments) Report
An account of the spatially based survey methods used in the PLACE project and the recruitment outcome has been published on the CPRC and International Physical Activity and the Environment Network (OPEN) websites. This report aims to make the project experience available to others planning similar studies and includes details of how objective measures of physical activity were validated. More information on the PLACE project can be found at http://www.uq.edu.au/crpc/index.html?page=36440 or http://www.open.uq.edu.au/place.htm
n Centre for Behavioural Research in Cancer (CBRC), Vic
Australian Letters to the Editor on tobacco: triggers, rhetoric, and claims of legitimate voice
Kim McLeod and Melanie Wakefield (The Cancer Council Victoria) along with Katherine Clegg Smith (from John Hopkins University) have explored the arguments and ideologies relating to tobacco issues present in Letters to the Editor (LTEs) in a sample of 11 Australian daily newspapers from 2001-2003. Ethnographic content analysis was used to explore the content and framing of 361 LTEs on tobacco issues from Victoria (along with Katherine Clegg-Smith (from John Hopkins University) have explored the arguments and ideologies relating to tobacco issues present in Letters to the Editor (LTEs) in a sample of 11 Australian daily newspapers from 2001-2003. Ethnographic content analysis was used to explore the content and framing of 361 LTEs on tobacco issues from Victoria (along with Katherine Clegg-Smith (from John Hopkins University) along with Katherine Clegg-Smith). The Australian Government’s reliance on tobacco by claiming authority on the basis of their smoking status. The majority of participants also supported a ban on smoking on beaches and in outdoor dining areas. Community views were also strongly supportive of greater use of tobacco taxes for anti-tobacco campaigns and strongly opposed to superannuation funds investing in the tobacco industry.

More than one-third of people reported that in the past week they had often or sometimes seen TV shows where someone was smoking. TV shows were shown to have serious potential to influence smoking behaviour. Community views towards environmental tobacco smoke in various settings (e.g., homes, bars, hotels and workplaces) demonstrated strong support for smoking bans. For example, more than 75% of respondents had complete bans on smoking in their homes or cars and almost half had complete bans in public places. The government should introduce the ban on smoking in pubs and clubs immediately. The majority of participants also supported a ban on smoking on beaches and in outdoor dining areas.

Community views were also strongly supportive of greater use of tobacco taxes for anti-tobacco campaigns and strongly opposed to superannuation funds investing in the tobacco industry. The Queensland Cancer Risk Study
The Queensland Cancer Risk Study is the first comprehensive, state-wide survey of cancer awareness, knowledge, and attitudes towards cancer in Queensland. The objectives of the study, which included 9419 residents of Queensland aged 18 years and over, was to describe the distribution of behavioural risk factors for cancer in the Queensland population (including smoking, alcohol consumption, diet, physical inactivity, overweight, sunburn, sun protection and solarium use) and to investigate the determinants of these behaviours. Early results show that the prevalence of risk factors for cancer among Queensland adults is high. Many cancer risk behaviours are more prevalent among men, those aged 20-39 years and those living in remote/very remote areas of Queensland. For example, when compared to women, men are more likely to smoke on a daily basis, drink alcohol regularly, drink alcohol in excessive quantities, eat less than two servings of fruit a day, eat less than five servings of vegetables a day, be overweight or obese and to have been sunburnt or severely sunburnt at least once in the past 12 months. Communities, women are more likely than men to be inactive and to use solaria. Overall, the results suggest that there is scope for improvement in regard to risk cancer risk behaviours for the majority of Queensland adults and particularly within groups with multiple cancer risk behaviours including men, Queenslanders and residents of remote/virtual areas.

Non-cancer causes of mortality among cancer survivors
Do people diagnosed with cancer have an increased risk of death from non-cancer causes compared to the general population? This study was based on analysis of the non-cancer mortality of people diagnosed with cancer in Queensland and who were prevalent cases at any time between 1993 and 2002, utilising data from the Queensland Cancer Registry and the Registrar of Births, Deaths and Marriages. Among all cancer patients combined, there is a significantly increased risk of non-cancer death during the first 5 years post-diagnosis. In subgroup analysis, melanoma patients have significantly lower non-cancer mortality compared to the general population,
while lung cancer patients had the highest risk of non-cancer mortality. Future work will investigate the causes of non-cancer mortality and cancer survivors. A manuscript has been accepted for publication in Cancer Causes and Control.

Research in the Pipeline

n CCRCC

International Physical Activity and the Environment Network

IPEN is the International Physical Activity and the Environment Network. It was launched by Professor Jim Sallis (USA), Dr Ilse Delboubeauduij (Belgium) and Professor Neville Owen (Australia) at the International Congress of Behavioral Medicine in Mannheim Germany in August 2004. IPEN has 168 members from 28 countries. The network aims to:

n increase communication and collaboration between researchers investigating environmental correlates of physical activity;

n stimulate research in physical activity and the environment;

n recommend common methods and measures;

n support researchers through sharing of information, feedback, letters of support etc.

n bring together data from multiple countries for joint analyses; and

n aid in the publication of data through papers, special journal issues, theses, etc.

Neville Owen with the other members of the IPEN consortium have assisted the Danish Cancer Society with preparation of a research grant application on the effects of physical activity in Denmark. A research grant is also under review in Belgium to replicate the PLACE study that CCRCC has recently completed in Adelaide and a collaborative studying Japan with Tokyo Medical University is in progress.

The IPEN website is www.ipenproject.org/index.htm.

n CBRCC

How acceptable is a referral and telephone-based out-call program for men diagnosed with cancer?

Trish Livingston along with Vicki White, Jane Hayman, David Hill and others have collected the feasibility and acceptability of a referral and out-call program from a telephone-based information and support service, for men newly diagnosed with colorectal or prostate cancer. Patients were eligible if they could attend the Cancer Information Support Service (CISS) through clinicians at diagnosis. Clinicians were randomised into one of three conditions.

Active referral 1: specialist referral with four CISS out-calls: (a) 1-week parallel, (b) 3-week parallel, (c) 6-week parallel. The partners and caregivers study: a longitudinal study of the psychosocial outcomes of the partners and caregivers of cancer survivors. Cancer is one of the most common health conditions in receipt of informal care. With the primary setting for the delivery of care to cancer patients having shifted from the hospital to the home, more emphasis is placed on the care provided by the patient’s informal caregiver, usually their spouse or a family member. Evidence suggests that caregivers of cancer patients are at risk of experiencing anxiety, depression, distress, poor quality of life and physical health, and increased financial pressure. Whilst there has been published evidence indicating the significant health and financial impact of caring, no previous research has reported on the longitudinal impact for partners and caregivers of cancer survivors.

A longitudinal population-based study of cancer survivors (the Cancer Survival Study) is currently being undertaken in NSW and Victoria. CHERP will be conducting the Partners and Caregivers Study in parallel with the Cancer Survival Study, recruiting the partners and caregivers of the cancer survivors. The partner or caregiver will be invited to complete a survey at baseline (six months post-diagnosis of the cancer survivor), 12 months, two years and three years post-diagnosis. The study will identify changes in the levels of distress, anxiety, depression, quality of life and unmet needs over the first five years since the cancer diagnosis. The personal factors such as social support, coping style, personal characteristics, work and financial situation associated with these outcomes will also be identified. The study will provide information on the costs and benefits associated with the past 15 years, has built a cancer and how this changes over time. Using data from both cancer survivors and their partners and caregivers, the inter-relationships between the cancer survivors’ and their partners’ and caregivers’ psychosocial and other health outcomes will be described. For more information, please contact Professor Aaf Girgis or Fiona Stacey.

n VCRCC

Queensland ‘Pool Cool’ pilot study

Few skin cancer prevention programs in outdoor settings, particularly public outdoor swimming pools, have been evaluated in controlled trials. Because children, families and aquatics staff with lively and friendly daylight hours exposed to the sun while minimally clothed, sun protection education at swimming sites can significantly affect important preventative behaviours. This study will pilot test the Pool Cool intervention program, originally developed by Professor Karen Glanz, that has been successful in the US in improving skin cancer prevention strategies at swimming pools. Pool Cool was designed to encourage sun safety at pools in Hawaii and Massachusetts and to increase environmental supports and policies for skin cancer prevention. The main objective of the Queensland Pool Cool pilot study is to increase awareness, motivation and sun protection practices among children aged 5-10 who take swimming lessons, their parents, pool staff (lifeguards, pool managers and swim instructors) and other pool users attending council and private pools in the Brisbane and Townsville area. This pilot study will be completed over the summer of 2005-2006.

Health and disability of cancer survivors

Data from the 2001 National Health Survey will be analysed to assess the health of persons diagnosed with cancer against the rest of the population to estimate the burden of cancer within the population. Measures used will include self-assessed health status, quality of life, number of days out of usual role during the last 12 months and physical and mental health. Analyses will be undertaken by cancer status, currency of cancer and type of cancer, with adjustments made for selected co-morbidities and risk factors such as alcohol consumption, smoking and body mass index.

n CBRCC

New Staff

The Centre is pleased to announce the arrival of six new staff members: Dr Corneel Vandevante, Associate Professor Elizabeth Eakin, Ms Kirsty Pickering, Ms Lisa Jordan, Ms Melissa Harvey and Ms Loraine Caesar. Welcome to all!

Corneel Vandelante

joined the Centre in July 2005 as a Research Fellow. Corneel is a physical educator with a PhD in sport and exercise psychology from Ghent University, Belgium. His research is on psychosocial and environmental determinants of physical activity, on computerised and web-based interventions for increasing physical activity and on methodological issues related to the measurement of physical activity and environmental determinants of physical activity. Corneel is an investigator on the CPRC program grant in physical activity and population health.

Elizabeth (Liz) Eakin started as Principal Research Fellow in October and joins Neville Owen, Centre Director, as a senior academic to help provide leadership to the CPRC. Liz is a behavioural scientist with a PhD from the University of Queensland. She leads a program of research in health behaviour interventions across the chronic disease prevention and management spectrum.

Her work emphasises interventions with broad population reach (e. telephone, tailored print and internet), targets at risk subgroups (e. adults with low SES backgrounds), and takes place in community as well as primary health care settings. Liz will bring two recently-funded grants: with her: a NHMRC Career Development Award in Population Health and a NHMRC Project Grant: Linking General Practice and Community Care to Promote Health Behaviour Change (Logan Project). Kirsty Pickering, Project Manager, Melissa Harvey and Lisa Jordan, as Jordon, Telephone Counsellors and Lorraine Caesar, CATI interviewer, are all Logan Project staff making the move with Liz. The Logan Project is evaluating a telephone and print delivery model for physical activity and diet intervention targeting patients with type 2 diabetes and hypertension recruited from general practices.

Conferences

n CBRCC

Neville Owen


n CBRCC

Lane McDorment

Queenland Tobacco Control Symposium held 14 July 2005 at the Queensland Cancer Fund. Presentation title: Alcohol and Social Settings: Tempting Young Women to Smoke.


The Centre for Behavioural Research in Cancer has welcomed Belinda Cerritelli as our new Research Projects Manager. Belinda has an honours degree in Psychology and she has been involved in grant programs and health promotion interventions over the past seven years. She has previously worked in the fields of parental smoking cessation, asthma, anorexia nervosa, cystic fibrosis and heart disease.

CBRC has also welcomed Sally Dunlop who is currently undertaking a PhD with a scholarship from the University of Melbourne and Melanie Wakefield. Sally’s PhD is funded by an ARC linkage grant and is exploring...

Dr Jong Li who has been with the Centre since March 2004 has moved on from CheRP. Dr Li worked on a number of initiatives, including preparing a manuscript reporting the comparison of the psychosocial needs of patients with long cancer to other patients with cancer. This work has recently been published in Psycho-Oncology. Dr Li has recently taken up a position as Epidemiologist at the National Centre in HIV Epidemiology and Clinical Research at St Vincent’s Medical Centre in Sydney. We wish him success in his new position.

Amy Waller has come on board as a PhD student. Amy will work with Professor Alf Girgis on pilot testing and evaluating a palliative care referral screening tool, as part of a comprehensive program of work in this area which has been funded by the Australian Government Department of Health and Ageing.

n CheRP

The following grants and consultancies have been awarded:
2. Girgis A, Boyes A. Evaluation of The Cancer Council WA. The fellowship will encompass: advocacy for funding through Curtin University and Ms Denise Sullivan from The Cancer Council WA. The fellowship will encompass: advocacy for policy change; development, implementation and evaluation of prevention and cessation campaigns; cessation courses; and tobacco industry and related health industry monitoring.

Cancer Trials Database Victoria – first of its type in Australia

Susan Fitzpatrick
Centre for Clinical Research in Cancer and Victorian Cooperative Oncology Group
The Cancer Council Victoria

The Cancer Trials Database Victoria was launched on Daffodil Day, 19 August 2005.

Why a state-based cancer trials database when the National Clinical Trials Register had been announced? The genesis for a trials database for Victoria goes back a few years. However, its development had been deferred due to a national register proposal, as it was decided not to duplicate effort. In 2004, with repeated calls from clinicians and patients for trials information online, and still no register in place at a national level, The Cancer Council Victoria decided to develop the Cancer Trials Database Victoria. This database provides a reliable online resource of collaborative group cancer trials for both health professionals and the community.

It is known that clinical trials are essential for improving cancer outcomes but this is hampered by low participation rates. Whilst Victoria has an adult participation rate of approximately 6%, the aim is to have 10% of all eligible adult patients participating in cancer trials.

There is evidence that insufficient resources and lack of awareness are major barriers to increased participation in clinical trials. To address these barriers, The Cancer Council instituted the Cancer Trials Management Scheme in 1988, awarding grants toward the appointment of trial managers in Victoria’s cancer centres, and then in 1991 published a clinical trials information booklet. Both these actions have significantly contributed to raising clinical trial participation. Increasingly, however, clinicians and patients have been seeking an online resource of more specific information about clinical trials open to participation.

The aim of the Cancer Trials Database Victoria is to improve access to information about cancer clinical trials for health professionals and the community.

The database has proved immediately useful to clinicians in identifying suitable trials for their patients and enabled patients to approach their clinicians about potential trial participation. It is a “one-stop” site listing 60 state/ national/ international collaborative group phase 2 and 3 trials open to patient recruitment at treatment centres in Victoria. The database eliminates the effort of searching multiple individual websites. Direct links to the collaborative groups are also available if additional information is required.

It is acknowledged that the Cancer Trials Database Victoria does not fulfill the criteria of a register as defined in the Standards of the International Committee of Medical Journal Editors 2004. It is not meant to. The database does not require a unique registration number. The Victorian database could be considered a state-based cancer trial supplement to the National Clinical Trials Database. Other states may consider adopting a similar model.

In the development process, permission was obtained from the collaborative trial groups to list their trials on the online database and to include website links. Using the 2004 Cancer Trials Management Scheme annual reports, information on which centres were participating in which trials was sourced and confirmed. Permission was obtained to provide links to participating site websites. The details for each trial was sourced from the collaborative group trial coordination centres and their websites.

The database is easily navigated. It is searchable by cancer type and/or phase, location (treatment centre), or keyword. This enables a specific or broader search to be conducted. The details include: protocol title, phase, protocol ID, description, summary, aims, outcomes, eligibility, collaborative group, principal investigator, accrual target, anticipated close date, location and access to further supplementary information. Trial details will be updated twice yearly and an online notification system for collaborative groups and/or participating centres to list new trials and/or participation in a current trial is in development. Consideration is also being given to expanding the database to include industry phase 2 and 3 multi-centre trials in 2006.

Over 3500 hits to the online Cancer Trials Database Victoria had been recorded by the end of the first week of activation. Clinicians, researchers and the community have commended its establishment. To quote one clinician: “As a clinician, this database quickly and easily provides up-to-date information on cancer trials that previously would have taken considerable time to source from many different areas. This will be of great benefit to cancer specialists when considering the best available treatment for their patients.”


Acknowledgement: The Cancer Council Victoria’s Centre for Clinical Research in Cancer (Sieghe Williams, Noelyn Ngo, Gerry Hall and Amie Trikoupi) and Publications Unit (Stephen Cheshire), and Trial Coordinators in Victoria’s cancer treatment centres.

Cancer Institute NSW Standard Cancer Treatments (CI-SCaT)

Jen Bichel-Findlay
Standard Cancer Treatments Program
Cancer Institute NSW

In order to deliver optimal treatment to cancer patients, oncology clinicians need to have a full understanding of contemporary literature, key evidence and internationally acceptable standards. Each hospital currently writes, reviews and updates standard treatment protocols for cancer patients. This requires expert and detailed attention, drawing considerable resources away from treating patients. Regional services typically lack the specialist expertise and resources to maintain currency across all protocols.

The Cancer Institute NSW has launched an evidence-based Standard Cancer Treatments (CI-SCaT) website for all those involved in cancer services, including patients, carers, cancer practitioners, medical officers, nursing staff, pharmacists and general practitioners throughout Australia and New Zealand. Professor Robyn Ward developed the website at St Vincent’s Hospital, Sydney, with the Cancer Institute (NSW) assuming responsibility in October 2004. Whilst the program is not intended to replicate or replace the knowledge, skills, experience, or clinical judgement of experienced health professionals, it provides specialist clinicians and general practitioners with direct access to best-practice treatment for a variety of cancer types.

Access
The site can be accessed via the:
Internet
www.treatment.cancerinstitute.org.au

n Cancer Institute website
www.cancerinstitute.org.au

n NSW CIAP

Accessibility
Access the left-hand menu, and select the Clinical Resources/Specialty Websites/Cancer Institute option.

The CI-SCaT is a web-based resource for clinicians, hospital staff, medical professionals, and patients. It is available to all those involved in cancer services, including patients, carers, cancer practitioners, medical officers, nursing staff, pharmacists and general practitioners. The CI-SCaT is a reference tool which enables users to access information about cancer treatments, including phase, protocol ID, description, summary, aims, outcomes, eligibility, collaborative group, principal investigator, accrual target, anticipated close date, location and access to further supplementary information.

Clinician benefits
CI-SCaT provides detailed cancer treatment protocols that are designed to provide guidance in the treatment of cancer. It is anticipated that over 200 protocols will be available by December 2005. The information contained in a treatment protocol may include some or all of the following:

n Name of the protocol
n Indication for use
n Usage
n Drug dosages
n Frequency
n Number of cycles


Cancer Institute Nsw Standard Cancer Treatments

Cancer Forum - Volume 29 Number 3 - November 2005

Cancer Forum - Volume 29 Number 3 - November 2005

n National Clinical Trials Register, announced by Minister for Health and Ageing, 17 May 2005

n Cancer Trials Management Scheme, Annual Review 2004, The Cancer Council Victoria

n Cancer Trials Management Scheme, 2005, grants totalling $750,000 awarded to 18 cancer centres.

n Australian Government Department of Health

n NSW CIAP
health.nsw.gov.au

n Access the left-hand menu, and select the Clinical Resources/Specialty Websites/Cancer Institute option.

n NSW CIAP

n Cancer Institute website
www.cancerinstitute.org.au

n NSW CIAP

n Cancer Institute website
www.cancerinstitute.org.au

Cancer Forum - Volume 29 Number 3 - November 2005
Reports

As new information becomes available, the reference group annual review of all protocols will commence in 2006. Located at the end of each treatment. It is anticipated that an approved changes, or send back for further development. Decision is made as to whether to approve, approve with all members discuss the protocols in detail and a consensus document by Cancer Institute project staff. These unapproved existing protocols are identified and prepared as a draft unapproved and superseded. Unapproved

Existing protocols are identified and prepared as a draft approved protocols are reviewed and edited by the project staff and a reference group member prior to a meeting. At the meeting, all members discuss the protocols in detail and a consensus decision is made as to whether to approve, approve with changes, or send back for further development.

Approved

Approved protocols are signed off by a medical specialist and made available. The date each protocol was approved is located at the end of each treatment. It is anticipated that an annual review of all protocols will commence in 2006.

Superseded

As new information becomes available, the reference group recommends that some protocols become superseded. In other words, key evidence indicates that another protocol is demonstrated to be superior (in the majority of patients) in relation to outcomes such as less toxicity, less serious adverse events and improved survival. The information contained in these protocols justifies why they are not recommended. They are clearly marked as superseded, but remain for historical reference and for the rare occasion that they may need to be administered.

Future plans

In the future, there are plans to expand the resources to include information on:

- Palliative care;
- Paediatric;
- Bone marrow transplant;
- Melanoma;
- Dose modification;
- Surgical pathways;
- Radiotherapy pathways; and
- Links to a resource directory.

CI-ScAT contact

The CI-ScAT team is requesting suggestions from interested clinicians on how to improve the resource and offers of assistance in reviewing and critiquing the protocols. Educational sessions related to effective use of the website are also being offered. A rural program covering 27 sites throughout NSW is expected to be completed by November this year. Metropolitan sites within NSW are being offered educational sessions from November onwards and a national education roadmap is being planned for January to April next year.

Inquiries or requests for onsite education or clinician participation can be directed to the CI-ScAT team on (02) 8374 5653 or by emailing ci-scat@cancerinstitute.org.au.

NEWS & ANNOUNCEMENTS

New CEO for The Cancer Council Australia

The Cancer Council Australia recently announced the appointment of a new Chief Executive Officer, Professor Ian Olver, to replace long-serving CEO Professor Alan Coates, who will retire from the role next year.

Professor Olver, Clinical Director of the Royal Adelaide Hospital Cancer Centre, will take up the position in May 2006.

The Cancer Council Australia President, Mrs Judith Roberts, said the role of CEO at the organisation was one of the nation’s most important community sector positions, particularly as the number of cancer cases was projected to increase by more than 30 per cent over the next decade.

“The Cancer Council Australia represents the nation’s eight state and territory Cancer Councils and is Australia’s largest federated health charity, so the responsibility of guiding the organisation into a future that will see unprecedented new cancer challenges emerge is enormous,” Mrs Roberts said.

“Professor Olver is an outstanding clinician, communicator and administrator. For many years he has shown an extraordinary personal commitment to the fight against cancer, through his work in clinical research, publications across a range of cancer-related areas and his involvement in delivering services at the forefront of cancer care, including in remote Indigenous communities.”

As well as his role at Royal Adelaide Hospital, Professor Olver is Chair of the Medical Oncology Group of Australia, Board member of the National Breast Cancer Centre, Cancer Council Professor of Cancer Care at Adelaide University and Chair of The Cancer Council Australia’s Medical and Scientific Committee. He is also a member of The Cancer Council’s Oncology Education Committee and a former member of the multi-jurisdictional National Cancer Strategies Group set up to advise the Federal Government.

Professor Olver said he was enthusiastic about his new role with the nation’s leading independent cancer control organisation. “The Cancer Council Australia plays a vital role in contributing to national cancer policy development and helping to coordinate the research, information, education and patient support activities of Cancer Councils Australia-wide,” he said.

Mrs Roberts paid tribute Professor Coates, who will retire after nine years at the helm in May 2006.

“Professor Coates, through his tireless efforts and standing as one of the world’s leading cancer authorities, led the way in establishing The Cancer Council Australia as the nation’s peak non-government cancer control organisation.

“He has made a major contribution to the development of public policy in cancer care and control both in Australia and internationally.”

New Cancer Forum Editorial Board member

The Cancer Forum Editorial Board would like to welcome its newest member, Kim Devery. Kim currently works at Flinders University teaching palliative care at postgraduate level. Along with other work she assists health professionals learn about paediatric palliative care, palliative clinical management and advanced concepts of palliative care.

Kim has also worked for many years as a nurse in acute and palliative care in Australia, the US, the UK and Kenya. She has completed undergraduate studies in Social Sciences (largely research methodology with major studies in the History and Philosophy of Science and Technology) at the University of New South Wales. After her honours year Kim worked on research regarding patient ideas of quality of life, health outcomes and continuity of care in palliative care.

Kim took up a postgraduate research position at Flinders University in Adelaide in 1998. She was appointed Lecturer in 2002. Kim’s research interests include how to best talk with patients about prognosis and self-care for palliative care clinicians. She lives in Adelaide with her family.

Teenagers resist the urge to tan

Almost 90% of teenagers are now aware of the risk of skin cancer through sun exposure and more are resisting the urge to tan, according to new data released today.

The Cancer Council’s National Sun Survey showed that 68% of 12 to 17 year olds did not attempt to get a tan in summer (2003/04), even though 60% indicated they would like one.

The findings were welcomed by the Chair of The Cancer Council’s National Skin Cancer Committee, Craig Sinclair. “This is good news and indicates messages about skin cancer and sun protection are starting to connect with young Australians,” Mr Sinclair said.

However, he cautioned the survey results weren’t all good, particularly poor adoption of sun-protection behaviour. “The fact that 68% of teenagers did not go out and actively attempt to get a tan is a positive result and teenagers should be commended for that,” Mr Sinclair said. “However, there are some concerning results from the survey; for example 25% of teenagers are still getting sunburnt on a typical summer weekend.

“We need to protect ourselves not just at the beach, but when we are enjoying a BBQ in the backyard, playing sport or are just out and about.”

Mr Sinclair said it was encouraging with summer school holidays around the corner.

The Cancer Council was particularly concerned about the prevalence of melanoma in younger people. “It is alarming that 24% of all cancers in people aged 15-19 are melanomas, the most serious and potentially deadly form of skin cancer. This is the highest rate of all cancer in this age group.”
Mr Sinclair said the survey provided interesting insights into teenagers' beliefs about skin cancer and sun protection and subsequent actions to protect themselves. "Not only are teenagers more aware of the link between skin cancer risk and sun exposure, fewer teenagers (41%) than adults (50%) believe a tanned person looks more healthy.

"That is a great step forward, but the fact that a quarter of teenagers get sunburned on a typical weekend is a problem we need to overcome. We need to encourage them to take a multifaceted approach to sun protection. That means not just relying on sunscreen, but wearing sunglasses, a hat that protects the face, neck and ears, like the fashionable bucket hats, protective clothing and seeking out shade when they are outdoors."

**Workplaces getting the SunSmart message**

Aussie outdoor workers putting themselves at increased risk of skin cancer as they sweat it out in the harsh Australian sun is an image slowly but surely changing thanks to employer reforms, according to research from The Cancer Council’s National Sun Survey. The findings show that 50% of outdoor workers now have a sun protection policy at their workplace.

With 17% of Australians spending at least half their time at work outdoors and Australia having the highest rate of skin cancer in the world, The Cancer Council Australia stressed the importance of employers putting in place sun protection policies to protect their employees from sun exposure and the risk of skin cancer.

The Cancer Council’s Chief Executive Officer, Professor Alan Coates, said he was encouraged by the positive approach by many employers around the country to protect their workers, but cautioned there was a long way to go, especially with small businesses and sub-contractors in the construction industry.

"The most significant changes we are seeing are in the telecommunications and utilities industries, as well as local councils, who are developing and implementing comprehensive sun protection policies," Professor Coates said.

**Growth in cancer incidence to put pressure on health system**

Australia would be unable to meet the needs of an unprecedented number of cancer patients unless planning for healthcare reform rapidly gathers pace, The Cancer Council Australia’s Chief Executive Officer, Professor Alan Coates said.

Professor Coates was responding to an Australian Institute of Health and Welfare report that predicts cancer incidence will rise from 83,998 in 2001 to 115,400 in 2011, an increase of 31 per cent.

He said although the figures showed the underlying incidence rate of cancer after adjusting for age was relatively steady, both the absolute number of new cases and cancer prevalence (number of people alive after a diagnosis of cancer) in Australia would be markedly higher increasing demands on the health workforce.

"A 31 per cent increase in the number of newly diagnosed cancer patients will place significant pressure on the health system," Professor Coates said. "However, the hidden burden is the compound effect of prevalence, which describes the number of people living with cancer at any one time. Currently, there are around 270,000 people in Australia living with cancer, a figure which is likely to exceed 350,000 by 2011."

Professor Coates said a commensurate investment in the cancer workforce, as well as structural reforms to the system, were needed to help ensure that growing numbers of cancer patients had equitable access to treatment and care. He said it was incongruous that the nation’s most deadly disease only accounted for around 5.8 per cent of healthcare expenditure.

"Australia can take some pride in having one of the world’s best case survival rates, but this is little comfort to the any thousands of patients who report feeling lost in the health system and at the mercy of a cancer care ‘lottery’. " Professor Coates said.

"Standardised models of multidisciplinary care, accreditation and credentialing processes to underwrite best practice and improved access to psychological support are high on the list of things that need to be built into the system to treat cervical cancer patients early next year."

The Cancer Council Australia’s vice president, Professor Ian Frazer, is celebrating the stunning results of pivotal clinical trials which show that a vaccine for preventing cervical cancer, which uses technology he helped develop, is 100% effective.

The vaccine protects women against two strains of the human papillomavirus that cause up to 70% of cervical cancer cases worldwide.

Each year around 300,000 women globally die from cervical cancer and the vaccine may have the biggest impact in developing countries that do not have pap-smear screening programs.

The vaccine is designed to be given in three doses over six months and should be given to women before they become sexually active.

CSL and Merck will seek approval for their vaccine (Gardasil) from the US Food and Drug Administration in the next two months, and Australia’s Therapeutic Goods Administration early next year. GSK are also pursuing development of a cervical cancer vaccine using the same technology, which may be available within the next few years.

**New position statements**

**Oral contraceptives**

The use of combined oral contraceptives and cancer risk is a subject that has received considerable attention in recent times.

The Cancer Council Australia’s position statement recognises that women found to be positive for human papillomavirus (HPV) who have been using a combined oral contraceptive for 10 years or more are at increased risk of developing cervical cancer. Women who are using combined oral contraceptives or have used them in the past 10 years are at slightly increased risk of developing breast cancer. The Cancer Council recommends all women aged 18-70 years who have ever been sexually active have a Pap test every two years and all women aged 50-69 have a mammogram every two years through BreastScreen Australia.

Combined oral contraceptives provide some protection against endometrial cancer and ovarian cancer, with this protection extending to women at risk of hereditary ovarian cancer.

Further research is required to assess the benefits and harms of long-term use, ie. greater than five years, of recently introduced hormonal contraception alternatives on cancer and other health risks.

**Complementary and alternative therapies**

Complementary and alternative therapies are a contentious subject due to the limited scientific evidence about their safety and efficacy.

The Cancer Council Australia supports a patient’s right to seek information about all treatments and forms of symptom relief. However, as an evidence-based organisation we are not able to endorse treatments not clinically shown to be safe and effective.

We encourage healthcare professionals to respect their patients’ interest in complementary and alternative therapies and to discuss with patients to help them make informed treatment decisions.

Believers support Daffodil Day

On 19 August The Cancer Council held its annual Daffodil Day. Thanks to strong community support, Daffodil Day is one of the most successful fundraising events in Australia. Daffodil Day is so popular as a fundraising event because it inspires belief that one day cancer will be defeated.

More than two million fresh daffodils and a range of event merchandise lined volunteer stalls at CBD locations, train stations and shopping centres across Australia, raising funds for cancer research and support services.

The funds raised on Daffodil Day contribute directly to Cancer Council initiatives in cancer research, prevention programs, advocacy, patient support and education services. These programs are carried out across all of the Cancer Council’s eight state and territory member organisations.

Daffodil Day is strongly supported by a range of retail outlets that sell the event-related merchandise, including pins, magnets and pins. Another favourite is the Dougal bear, who every year receives a fashion makeover to become the best dressed bear in town.

The Cancer Council Australia would like to thank its national supporters: Coles, HIC network of Medicare offices, Amcal, ANZ, Cartridge World, Miller’s Retail Group, Plants Plus, Quix and Rackman.

For more information on the event please visit the Daffodil Day website – www.daffodilday.com.au or phone 1300 69...
Overall it is a good basic resource for families with a child/adolescent being treated for a paediatric malignancy. It was good to see the theme throughout the text that it is a team approach to the health care in a paediatric haematology/oncology setting. The journey taken is very much a partnership between the family and the team. Unit specific education could be backed up with this book, it would not be a first line text. This is a cursory glimpse at aspects of caring for a child/adolescent with a paediatric malignancy.

Carina Boehm, Women’s and Children’s Hospital
Adelaide, SA

100 QUESTIONS AND ANSWERS ABOUT OESOPHAGEAL CANCER

P Ginex, J Hanson, B Frazzitta, M Bains
Jones and Bartlett Publishers (2005)
177 pages plus index.
RPP: $52.95

This book has been written by three staff members and a former patient from the Thoracic Surgery Service at Memorial Sloan Kettering Cancer Center in New York. A professor of surgery and two very experienced nurses combined with a man who was treated for oesophageal cancer six years to produce this book.

There is a logical sequence to this book and is very easy to read but at the same time comprehensive. As the title suggests there is a question and answer format which works well within this framework. The book is divided into 7 parts and also has a glossary of terms. It begins with a chapter titled The Basics, covering what is the oesophagus and what does it do as well as what is cancer of the oesophagus and what causes it. The book then moves through areas such as risk and prevention, diagnosis and staging, coping with diagnosis, treatment options and living with oesophageal cancer. This chapter contains extensive practical nutritional advice. If treatment fails: advocacy and support is the last chapter and while it was good to see the authors pay attention to this area, it is all too brief when you consider the survival data for this cancer.

Contained throughout the book are contributions from the author who is a cancer survivor. He comments on a range of topics from reflux, dealing with the survival statistics for this malignancy to depression. His reflections are insightful and intelligent and add value to the book.

Australian cancer patients may find all the references to American based supports frustrating, except for those that are the case with the diagrams and tables in the book which are in use in Australia.

Some of the information within this text was specific to the American health system and therefore not useful in our local context. Some of the programs, support services, insurance issues and financial resources are not applicable to Australian families. In a text of this length no area is covered in any detail so further information needed would mean going to a more in depth resource. Some practical aspects of caring for a child/adolescent with cancer are referred to, such as radiological interventions and care of central venous access devices, which would be helpful for both the parent and family.

The 2005 edition of Oncology Nursing Drug Handbook by Gail M. Wilkes & Margaret Barton-Burke continues in the tradition of previous editions. The book is written for nurses by nurses, providing the experienced cancer nurse and those new to the specialty, with a detailed resource concerning current cancer drug information. This edition is updated to include the latest anti-cancer treatments and an additional chapter detailing molecular targeted therapies.

For those not familiar with the layout, the book is divided into three sections – treatment, symptom management and complications.

Section 1: Treatment

This is the largest section comprising more than half the 1100 pages of the book. It is dedicated to current and investigational drugs. Also outlined are pre-treatment nursing assessment guidelines.

Chapter one, Introduction to Chemotherapy Drugs includes a table detailing the mechanism of action of cytotoxic drugs in the cell cycle, a useful reminder for all nurses. Successive chapters cover Biological Response Modifier Therapy, Antineoplastic Treatment: Agents: Radio sensitisers, Chemosensitizers; Chemical Adjuncts; and Cytoprotective Agents. The final chapter, Molecularly Targeted Therapies, incorporates a detailed section on basic cell biology.

Section 2: Symptom Management

This details the management of pain, nausea and vomiting, anorexia and cachexia, and anxiety and depression.

Section 3 deals with five complications – constipation, hypercalcaemia, infection, constipation and diarrhoea. The chapters provide an introductory outline of incidence of occurrence, reasons for manifestation and treatment options.

Each section of the book contains detailed drug information, including indications for drug use, side effects, mechanisms of action and nursing implications. The nursing implications are provided in a nursing process format. The chemotherapy agent section includes practical self help advice for patients and their families.

Additional to the main text are 3 appendices.

Appendix 1 Controlling Occupational Exposure to Hazardous Drugs

This is very comprehensive, including drugs other than cytotoxic chemotherapy. To be remembered is that the recommendations are American and there may be differences in Australian standard worksafe guidelines.
Chapter 15 deals with the vascular microenvironment in glioma and normal brain leading to the breakdown of the blood-brain barrier in the glioma microvascularity. Chapter 16, showing a link of tumour vascularisation and invasion, is very compelling and interesting. Chapter 18 deals with clinical trials using a wide range of anti-angiogenic compounds and leaves the reader with perhaps unjustified optimism, given that in all clinical trials so far conducted on man the outcomes were rather disappointing, compared with the outcomes in the preclinical tests done with mice.

Overall, this book is a valuable resource for clinicians with an interest in the biology of brain tumours and provides ample references for those who are interested in getting more information on the subject from primary sources. The best chapters are probably the ones linking the biology of angiogenesis with brain tumour biology as they make the book unique.

Apart from those chapters concerned with a political agenda, some contributions are most informative. These include the discussion of gene-environment interaction, DNA damage induced by carcinogens and the health impact of accidents involving radioactive isotopes. However, the volume cannot be described as a reasonable assessment of environmental carcinogenesis because key issues such as the role of tobacco, alcohol and ultraviolet exposure are not addressed. People likely to benefit from this volume are individuals who seek to refine their current knowledge of particular issues rather than those hoping to gain an overall assessment of the topic ‘environmental carcinogenesis’.

Bernard W Stewart
South Eastern Sydney and Illawarra Public Health Unit

CANCER AS AN ENVIRONMENTAL DISEASE


This book is written in 19 chapters covering general concepts of angiogenesis including normal embryonal blood vessel formation, experimental models, role of angiogenesis in brain tumours and approaches for anti-angiogenic treatments of brain tumours. The chapters vary widely in content, ranging from short experimental protocols to detailed descriptions of the structure and development of blood vessels and the molecular mechanisms of blood vessel growth regulation and anti-angiogenic clinical treatment protocols.

Due to the large number of authors there is some overlap and repetition. However, in the chapters dealing with angiogenic growth factors and receptors (chapters one and 13), the molecular regulation of angiogenesis and the environmental stimuli that favour angiogenesis in tumours are well covered.

Chapter two gives a very detailed description of the embryonal development of vessels in the CNS in quail. The quail model is of particular value for embryonal developmental studies as interspecies grafting experiments can provide a clue to the origins of particular organ structures.

Chapters three and four deal with mathematical modelling of tumour induced angiogenesis and measurements of blood vessel densities in tumours.

Rather short chapters seven, eight and nine deal with the isolation of blood vessel cells, MRI monitoring of glioma in the rat brain and in methods for vitro studying angiogenesis in vitro.

Chapter 15 deals with the vascular microenvironment in gliomas and provides a good compilation of the differences of vessel structure in glioma and normal brain leading to 'lifestyle' and 'behavioural' factors in the causation of cancer is akin to a ‘blame the victim’ and is incompatible with attributing cancer to inactivity and occupational exposures. In the first three chapters of this book the notion that ‘environment’ can be separated from ‘lifestyle’ as accounting for cancer causation is pursued at the cost of scientific clarity. No attempt is made to present a clear distinction between the molecular genetic basis of inherited cancer and the molecular genetic explanation for malignant transformation. Increasing incidences of breast and prostate cancers (in Norway) is presented as being attributable to increasing pollution, without any reference to the possible impact of mammography and PSA testing on these.

Treatment of cancers with tumour vaccines remains a vigorous area of basic and clinical research. The material in this book reviews all the major aspects of the subject. It is the proceedings of the organising conference on this topic held in Los Angeles in April 2004 sponsored by Cancer Research. A bienniality report from the Vax Company, John Wayne Cancer Institute and the International Association for Biologicals. There is a section on regulatory issues such as how to establish standards of purity, potency and safety which are informative and which illustrate the problems in addressing these issues. The second section describes studies on autologous and allogeneic vaccines and heat shock proteins. The topics are dealt with quite briefly and the reader would need to access references to get more detail on the topics. Nevertheless, they have merit in providing a brief overview of the topics. Questions and answers of limited value are included.

Several chapters are included on dendritic cell vaccine approaches. Again they are presented in a very condensed form.
The final section is on preventive vaccines such as those against human papilloma virus and hepatitis viruses. Very briefly, chapters (expanded and abstracts) are included on novel topics such as the role of anatomic site in vaccination and monitoring methods to monitor immune responses.

The material in the book will be mainly of interest to participants in the conference to remind them what was said. It could also be of interest to clinical researchers as a condensed look at some of the issues and may lead them to the literature in particular areas.

Peter Hersey
Immunology & Oncology Unit
Newcastle Mater Misericordiae Hospital, NSW

**HOLLAND – FREI MANUAL OF CANCER MEDICINE**
CX Brown, BI Rini, PP Connell, NC Posner (Eds)
BC Decker (2005)
ISBN: 1-55009-169-7  663 pages plus index
RPP: $94.60

The preface of this books states that the book was created as a "concept of a basic introductory manual to cancer medicine" for "medical students, physicians in training and other health professionals." It has surpassed this with succinct coverage of the individual solid tumours and haematological malignancies.

The first four chapters offer a brief introduction to basic facets of cancer medicine, molecular biology, radiation oncology, cancer screening, diagnostic imaging and a brief chapter on the anticancer agents.

It has broken up each of the conditions and discusses them in four areas; an overview of the incidence and risk factors of the disease, with pathology and diagnosis. This is followed by the staging and prognostic factors. Treatment for each of the diseases is the third section, and the final section, the fourth chapter, selective references that add weight as evidence based resources for current treatment and research and further readings. The book also covers four oncological emergencies, a chapter on AIDS-related malignancies and offers valuable easy to find reference material.

Of course this book is US focussed with all statistical material being of US origin but it does take over from what Cacissato and Lowit offered in the mid 1980s and 1990s. It also offers further access to up-to-date pointers to relevant literature without the literature search, with all readings the most recent for that field. The other bonus is that this book comes with a CD-ROM with the whole of the book on the CD.

This book is light on in substance in some areas like the oncological emergencies and anticancer agents, giving brief descriptions only. It also does not look at the issue of common side effects of treatment like nausea and vomiting or detailed descriptions only. It also does not look at the issue of the role of anatomic site in vaccination and monitoring methods to monitor immune responses.

The instructions are clear and precise with numerous illustrations and photographs. Scattered throughout the book are numerous references as well as a comprehensive list of recommended reading. This is an excellent reference book for any health professional with a specific interest in lymphoedema but due to the depth of the information provided is not a quick read.

Linda Liverisage
Newcastle Mater Misericordiae Hospital, NSW

**LYMPHEDEMA MANAGEMENT: A COMPREHENSIVE GUIDE FOR PRACTITIONERS**
JE Zuther
RPP: $US145.00

This book consists of six chapters on lymphedema management plus a section with sample forms and templates for the lymphedema therapist. Published in 2005, it is an up to date guide to the management of primary and secondary lymphedema.

The first half of the book consists of a very comprehensive guide to the anatomy and physiology of the lymphatic system and the etiology of lymphedema. The remainder of the book concentrates on the use of complete decongestive therapy to treat lymphoedema.

The instructions are clear and precise with numerous illustrations and photographs. Scattered throughout the book are numerous references as well as a comprehensive list of recommended reading. This is an excellent reference book for any health professional with a specific interest in lymphoedema but due to the depth of the information provided is not a quick read.

Linda Liverisage
Newcastle Mater Misericordiae Hospital, NSW

**MOLECULAR TARGETING AND SIGNAL TRANSDUCTION**
R Kumar (Ed)
RPP: $US145.00

The pathogenic mechanisms giving rise to cancer frequently involve altered signal transduction pathways. The elucidation of signal transduction pathways in cancer cells, both at the protooncogenic and the genomic levels, has led to the design of drug molecules as cancer treatments that are intended to act at specific proteins of the signal transduction cascade. Many drug molecules directed against a wide range of signal transduction elements are being evaluated as potential anticancer therapies and several are currently in clinical trials; others are still in preclinical research and development. This book contains a collection of excellent reviews on various signalling molecules and their suitability as drug targets in cancer treatments. Written by internationally renowned scientists, all leaders in their fields, it examines the most important signalling pathways in cells and provides a clear understanding of the different components of each pathway and their complex interactions. It also describes current knowledge on the design, synthesis, and evaluation of the biochemical and biological activities of inhibiting molecules. Specific topics include a biomolecular survey of cell signals; the role of cell-to-cell communication, growth factor and hormone signalling in cancer; cell cycle deregulation and cell migration and adhesion.

The chapters of this book integrate elegantly with one another and provide the reader with both broad and comprehensive viewpoints. Remarkably current and up-to-date, the book promises to be a core text for university courses in cell signalling and molecular cell biology, and a valuable reference book for all scientists whose work involves or is interested in signal transduction, cancers or indeed any human disease where the pathogenic mechanism of disease involves signalling molecules.

Readership: Immunologists, cell biologists, molecular biologists, biochemists, pharmacologists, clinical researchers and students.

Alison Greenway
Institute for Medical Research and Public Health
Melbourne, VIC

**OXFORD HANDBOOK OF PALLIATIVE CARE**
M Watson, C Lucas, A Hoy, I Back
RPP: GBP24.95

The Oxford Handbook of Palliative Care, published only this year (2005), is touted to be based on the Oxford Textbook of Palliative Medicine. Indeed, the Handbook is endorsed in a foreword provided by Dr Derek Doyle, one of the principle authors of the Textbook. The Handbook has been prepared by four UK-based palliative care medical specialists in conjunction with another 50 advisors and contributors listed.

The book contains surprisingly extensive palliative care information, including an outline of the management of palliative medicine, associated terminology and opening chapters on ethical issues, communication (specifically, breaking bad news) and research. Clinical information commences with discussion about the use of drugs in palliative care, “off-label” usage, patient medication charts, syringe drivers and a comprehensive formula. A chapter on Oncology and Palliative Care is provided, with a useful overview of common cancers, chemotherapeutic agents and radiotherapies, side effects and their treatments and importantly the fit between oncology and palliative care. Of course, symptom management features significantly and is well-covered.

Welcome inclusions are palliative care for non-malignant conditions, paediatric palliative care and palliative care for the elderly, all currently acknowledged as deserving specific attention from palliative care practitioners. Further topics included in this jam-packed handbook are spiritual care, bereavement, the roles of allied health professions in palliative care, complementary therapies, emergencies in palliative care, and under the heading miscellaneous, issues such as fitness to drive, tissue donation, travel and wills.

Indeed, this is a comprehensive book. Understandably, there is some bias to UK practice, notably with inclusion of diamorphine and reference to NHS systems and local laws. Extrapolation to local conditions would of course be necessary. One point to mention is whether this book is appropriately labelled a “Handbook.” Some sections provide discussions that are quite textually based, rather than a quick reference dot point format.

As well, in order to contain such a volume of information in a compact presentation, the printing is small and not easily read, although I acknowledge this reflects a personal deficit, albeit shared with others in my age group. In summary, although the palliative care “bible”, that is the latest edition of the Oxford Textbook of Palliative Medicine, is likely to remain one of the primary references used by palliative care professionals, the Oxford Handbook of Palliative Care provides an amazingly comprehensive overview at a significantly reduced size and cost. This makes the book extremely attractive for individual purchase. Further, the handbook would be a highly appropriate addition to areas such as GP surgeries, as well as the white coat pockets of junior medical officers, and is likely to significantly increase access to palliative care principles in non-specialist areas.

Judi Greaves
Royal Prince Alfred Hospital
Sydney, NSW

**RADIOThERAPY IN PRACTICE: BRACHyThERAPY**
P Hoskin and C Coyle (Eds)
RPP: GBP 9.95

**Purpose:** To provide practical guidance on the use of brachytherapy. Each chapter is designed to provide the reader with a sound background in dosimetry as well as providing practical information on the use of brachytherapy in less common disease sites.

**Content:** This is the first in a series of three books on radiotherapy in practice; following volumes will cover external beam radiotherapy and radiosurgery. The first two chapters concentrate on isotope, delivery systems and principles of dosimetry. From a nursing perspective once past this the following chapters were very easy to read and understand. Each chapter is a concise unit which can stand alone. At the end of each chapter there is a list of further reading for anyone who would like more information on the topic. The step by step description of how to perform implants gives the reader a very clear picture of how the implant is to be placed in theatre. The information is up to date with discussion of current clinical trials while chapter nine mentions the use of the mamaroscope balloon. The layout of the colour photographs was less than ideal with all photographs being together irrespective of treatment area and the topic of the chapter they were placed in. Overall the diagrams were
UK sourced. Also, the information about access to medication is based on UK and US availability. For example, in the US some nicotine replacement therapy products are available only on prescription. In Australia however, NRT products are available without a prescription, although they are subject to particular scheduling requirements.

Comment: This booklet is a concise yet comprehensive information source for the busy practitioner. The authors are well-credentialed tobacco control professionals who have written a highly readable guide to smoking cessation approaches.

Greg Soulouros and Kim Pearce
The Cancer Council NSW
Sydney, NSW

UROLOGIC ONCOLOGY

J Richie, A'D’Amico
RPP: $275.00

This is an attractively presented book covering all of the urological cancers which might be met by a practicing urologist. It includes such cancers as adrenal tumours, which although operated on by an urologist might also be classified as an endocrine tumour. Paediatric tumours such as Wilms’ tumours and neuroblastomas are also covered.

The first part of the book begins with a series of primer chapters covering the ‘basic science’ of urological malignancy. It begins with the molecular and cell biology underpinning urological malignancies. Following these there are chapters covering the basics of radiotherapy, chemotherapy and immunotherapy as they pertain to urological cancer. Each of these chapters covers the basic mechanisms of action of the different modalities and side effects expected. The first part ends with chapters relating to quality of life and imaging.

The second part of the book contains a chapter or two dedicated to each organ and the malignancy associated with it. The content is largely surgical and although other modalities are well represented the information is much briefer. Quite detailed information is provided for many of the urological procedures including blow by blow descriptions of how each operation is performed.

The text is logically set out and relatively easy to read. The information is set at a level at which most physicians (or surgeons) should be able to follow without detailed knowledge of urological malignancy. As such it provides an excellent overview of the topic. Extensive use of the diagrams and graphic photos, particularly in the surgical chapters contributes to the overall understandability of the text. Each chapter is well referenced and indexed.

As a medical oncologist I found the chemotherapy sections brief. Overall concepts and approaches were solidly explained, however descriptions of exact chemotherapy regimens was lacking. I suspect the same is true of the radiation techniques and descriptions. The information was also a little out of date, however no more than I would expect of any text given the rapidity at which this field is moving.

Overall it is more of a surgical text with much greater detail gone into with this modality than with chemotherapy or radiotherapy (or immunotherapy). As a book it is likely to be of greatest use to urologists and surgical oncology trainees, although it is also a handy reference for medical or radiation oncologists with involvement in urological malignancy. Its strength is more so as an overview text for oncologists rather than a definitive reference.

Richard North
Newcastle Mater Misericordiae Hospital, NSW
CALENDAR OF MEETINGS – INTERNATIONAL

**Date** | **Name of Meeting** | **Place** | **Secretariat**
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5-9 | 53rd Annual Scientific Meeting of the American Society of Cytopathology | San Diego, USA | American Society of Cytopathology, 400 West 9th Street, Suite 201, Indianapolis, IN 46202 USA. Tel: +1 317 224-8000. Email: asc@cytopathology.org. Web: www.cytopathology.org/meetings/index.php.

7-9 | ONCO Cancer Conference: Cancer and Aging | Madrid, Spain | CIND – Spanish National Cancer Centre, Calle C. Melchor Fernandez Almango 3, Madrid 28029, Spain. Tel: +34 91 2240000. Email: ccc@cinco.es. Web: www.cinco.es.

11-13 | Oncology Nurses Society Institutes of Learning | Phoenix, USA | Oncology Nursing Society, 125 Enterprise Drive, Pittsburgh, Pennsylvania 15275-1214 USA. Tel: +1 866 257 4667. Fax: +1 877 367 5497. Email: meetings@ons.org. Web: www.ons.org.


February


**Date** | **Name of Meeting** | **Place** | **Secretariat**
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2005

November

5-9 | 53rd Annual Scientific Meeting of the American Society of Cytopathology | San Diego, USA | American Society of Cytopathology, 400 West 9th Street, Suite 201, Indianapolis, IN 46202 USA. Tel: +1 317 224-8000. Email: asc@cytopathology.org. Web: www.cytopathology.org/meetings/index.php.

7-9 | ONCO Cancer Conference: Cancer and Aging | Madrid, Spain | CIND – Spanish National Cancer Centre, Calle C. Melchor Fernandez Almango 3, Madrid 28029, Spain. Tel: +34 91 2240000. Email: ccc@cinco.es. Web: www.cinco.es.

11-13 | Oncology Nurses Society Institutes of Learning | Phoenix, USA | Oncology Nursing Society, 125 Enterprise Drive, Pittsburgh, Pennsylvania 15275-1214 USA. Tel: +1 866 257 4667. Fax: +1 877 367 5497. Email: meetings@ons.org. Web: www.ons.org.

December

2-6 | 47th Annual Meeting of the American Society of Hematology | San Diego, California, USA | American Society of Hematology, 1900 M Street NW, Suite 200, Washington DC 20036 USA. Tel: +1 202 776 0544. Email: meetings@hematology.org. Web: www.hematology.org.

2006

February

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<th>Date</th>
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<tbody>
<tr>
<td>2-4</td>
<td>American Psychosocial Oncology Society (APOS) 3rd Annual Conference</td>
<td>Amelia Island (Florida), USA</td>
<td>American Psychosocial Oncology Society Charlotteville, USA Ph: +1 434 293 3530 Fax: +1 434 977 0899 Email: <a href="mailto:ahs@ahs.com">ahs@ahs.com</a>\apos-society.org Web: <a href="http://www.ahs.com%5Capos-society.org">www.ahs.com\apos-society.org</a></td>
</tr>
<tr>
<td>12-14</td>
<td>European Multidisciplinary Colorectal Cancer Congress 2006</td>
<td>Berlin, Germany</td>
<td>Congress Care Hertogenbosch, Netherlands Ph: +31 73 690 1415 Fax: +31 73 690 1417 Email: <a href="mailto:info@congresscare.com">info@congresscare.com</a> Web: <a href="http://www.colorectal2006.org">www.colorectal2006.org</a></td>
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**March**

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<tr>
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<tbody>
<tr>
<td>2-4</td>
<td>7th Continental Meeting of the International Society of Pediatric Oncology (ISOP) in Africa</td>
<td>Manakch, Morocco</td>
<td>ISOP Secretariat Eindhoven, Nederlands Ph: +31 40 269 7544 Fax: +31 40 269 7545 Email: <a href="mailto:secretariat@isop.nl">secretariat@isop.nl</a> Web: <a href="http://www.isop.nl/fameset_achter.asp?p=4">www.isop.nl/fameset_achter.asp?p=4</a></td>
</tr>
<tr>
<td>12-15</td>
<td>3rd International Conference on Translational Research and Pre-Clinical Strategies in Radiation Oncology (ICTR2006)</td>
<td>Lugano, Switzerland</td>
<td>ICTR2006 Bellinzona, Switzerland Ph: +41 79 310 4330 Fax: +41 91 811 8678 Email: <a href="mailto:jacques.bemmig@chuc.g.ch">jacques.bemmig@chuc.g.ch</a> Web: <a href="http://www.iso.ch/ictr2006.html">www.iso.ch/ictr2006.html</a></td>
</tr>
<tr>
<td>21-25</td>
<td>5th European Breast Cancer Conference (EBCC)</td>
<td>Nice, France</td>
<td>The Federation of European Cancer Societies (FECS) Brussels, Belgium Ph: +32 2 755 0205 Fax: +32 2 755 0200 Email: <a href="mailto:FECC@feccs.be">FECC@feccs.be</a> Web: <a href="http://www.fec.be/conferences/ebcc5">www.fec.be/conferences/ebcc5</a></td>
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**April**

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<tbody>
<tr>
<td>8-11</td>
<td>4th International Society of Pediatric Oncology (ISOP) Asia Conference</td>
<td>Shanghai, China</td>
<td>Shanghai Children’s Medical Center Dept of Pediatric Hematology-Oncology Shanghai, China Ph: +86 021 5839 3915 Fax: +86 021 5839 3915 Email: <a href="mailto:isop_asia_2006@yahoo.com">isop_asia_2006@yahoo.com</a> Web: <a href="http://www.fec.be/conferences/ebcc5">www.fec.be/conferences/ebcc5</a></td>
</tr>
<tr>
<td>20-22</td>
<td>5th European Oncology Nursing Society (EONS) Spring Convention</td>
<td>Innbruck, Austria</td>
<td>EONS – 5th EONS Spring Convention Brussels, Belgium Ph: +32 2 775 0205 Fax: +32 2 775 0200 Email: <a href="mailto:EONS@feccs.be">EONS@feccs.be</a> Web: <a href="http://www.fec.be/conferences/eons5">www.fec.be/conferences/eons5</a></td>
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**May**

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<tbody>
<tr>
<td>6-12</td>
<td>14th Scientific Meeting and Exhibition for Magnetic Resonance in Medicine</td>
<td>Seattle, USA</td>
<td>International Society for Magnetic Resonance in Medicine Berkeley, USA Ph: +1 510 841 1909 Fax: +1 510 841 2340 Email: <a href="mailto:info@ismrm.org">info@ismrm.org</a> Web: <a href="http://www.ismrm.org/">www.ismrm.org/</a></td>
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**June**

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<tbody>
<tr>
<td>14-17</td>
<td>World Congress on Gastrointestinal Cancer</td>
<td>Barcelona, Spain</td>
<td>Imexed Inc AlphaPlex, USA Ph: +1 770 751 7332 Fax: +1 770 751 7334 Email: <a href="mailto:meetings@imexed.com">meetings@imexed.com</a> Web: <a href="http://www.worldgcan.org">www.worldgcan.org</a></td>
</tr>
<tr>
<td>21-24</td>
<td>11th Annual Meeting of the European Haematology Association (EHA-11)</td>
<td>Amsterdam, Netherlands</td>
<td>Eurocongress Management Amsterdam, Amsterdam Ph: +31 20 673 7306 Email: <a href="mailto:eha@eurocongress.com">eha@eurocongress.com</a> Web: <a href="http://www.eha-web.org">www.eha-web.org</a></td>
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**July**

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<tbody>
<tr>
<td>1-4</td>
<td>19th Meeting of the European Association for Cancer Research</td>
<td>Budapest, Hungary</td>
<td>EACR 19 Conference Secretariat – Federation of European Cancer Societies Brussels, Belgium Ph: +32 2 755 0205 Fax: +32 2 755 0200 Email: <a href="mailto:EACR@feccs.be">EACR@feccs.be</a> Web: <a href="http://www.fec.be/enc.asp?pageld=729&amp;type=P">www.fec.be/enc.asp?pageld=729&amp;type=P</a></td>
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<tbody>
<tr>
<td>8-12</td>
<td>UICC World Cancer Congress</td>
<td>Washington DC, USA</td>
<td>American Cancer Society (ACS) Atlanta, USA Ph: +1 404 417 5998 Fax: +1 404 728 0133 Email: <a href="mailto:secretariat2006@ancer.org">secretariat2006@ancer.org</a> Web: <a href="http://www.american-cancer-society.org">www.american-cancer-society.org</a></td>
</tr>
<tr>
<td>12-15</td>
<td>12th World Conference on Tobacco or Health</td>
<td>Washington, DC, USA</td>
<td>American Cancer Society (ACS) Atlanta, USA Ph: +1 404 417 5998 Fax: +1 404 728 0133 Email: <a href="mailto:secretariat2006@ancer.org">secretariat2006@ancer.org</a> Web: <a href="http://www.american-cancer-society.org">www.american-cancer-society.org</a></td>
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<tbody>
<tr>
<td>17-20</td>
<td>16th World Congress of the World Society of Cardio-Thoracic Surgeons (WCTS 2006)</td>
<td>Ottawa, Canada</td>
<td>WSCTS 2006 Ottawa, Canada Ph: +1 613 761 5116 Fax: +1 613 761 4478 Email: <a href="mailto:info@wscts2006.com">info@wscts2006.com</a> Web: <a href="http://www.wscts2006.com">www.wscts2006.com</a></td>
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**September**

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<tbody>
<tr>
<td>27-Oct</td>
<td>14th International Conference on Cancer Nursing</td>
<td>Toronto, Canada</td>
<td>International Society of Nurses in Cancer Care (ISNCC) Cheshsh, UK Ph: +44 116 270 3309 Fax: +44 116 270 3673 Email: <a href="mailto:conferences@isncc.org">conferences@isncc.org</a> Web: <a href="http://www.isncc.org">www.isncc.org</a></td>
</tr>
<tr>
<td>29-Oct 3</td>
<td>31st European Society for Medical Oncology (EFSO) Congress</td>
<td>Istanbul, Turkey</td>
<td>ESMO Congress Viaganello-Lugano, Switzerland Ph: +41 91 973 1919 Fax: +41 91 973 1918 Email: <a href="mailto:congress@esmo.org">congress@esmo.org</a> Web: <a href="http://www.esmo.org">www.esmo.org</a></td>
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**October**

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<tbody>
<tr>
<td>18-21</td>
<td>8th World Congress of Psycho-Oncology</td>
<td>Venice, Italy</td>
<td>International Psycho-Oncology Society Charlotteville, USA Ph: +1 434 293 3530 Fax: +1 434 977 1656 Email: <a href="mailto:info@ips-society.org">info@ips-society.org</a> Web: <a href="http://www.ips2006.it">www.ips2006.it</a></td>
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**November**

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<tbody>
<tr>
<td>5-10</td>
<td>XVIII FIGO World Congress of Gynecology and Obstetrics</td>
<td>Kuala Lumpur, Malaysia</td>
<td>FIGO Conventions and Events Sdn Bhd Kuala Lumpur, Malaysia Ph: +60 3 4252 9100 Fax: +60 3 4257 1133 Email: <a href="mailto:congress@figo2006kl.com">congress@figo2006kl.com</a> Web: <a href="http://www.figoonline.com">www.figoonline.com</a></td>
</tr>
<tr>
<td>7-10</td>
<td>18th EORTC-NCI-AARC Symposium on Molecular Targets and Cancer Therapeutics</td>
<td>Prague, Czech Republic</td>
<td>Federation of European Cancer Societies (FECIS) Brussels, Belgium Ph: +32 2 775 0201 Fax: +32 2 775 0200 Email: <a href="mailto:Euracon2006@feccs.be">Euracon2006@feccs.be</a> Web: <a href="http://www.fecis.be">www.fecis.be</a></td>
</tr>
<tr>
<td>29-Dec 2</td>
<td>13th Congress of the European Society of Surgical Oncology (ESSO 2006)</td>
<td>Venice, Italy</td>
<td>ESSO 2006 Conference secretariat – Federation of European Cancer Societies (FECIS) Brussels, Belgium Ph: +32 2 775 0205 Fax: +32 2 775 0200 Email: <a href="mailto:ESSO2006@feccs.be">ESSO2006@feccs.be</a> Web: <a href="http://www.fecis.be/enc.asp?pageld=729&amp;type=P">www.fecis.be/enc.asp?pageld=729&amp;type=P</a></td>
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Cancer Forum - Volume 29 Number 3 - November 2005
THE CANCER COUNCIL AUSTRALIA

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

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

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

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Professor A Coates AM, MD, FRACP, AStat

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Office Bearers
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Mrs J Roberts AO SRN
Vice-President
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Mr G Brien AM, MBA
Hon H Cowan
Mr H Cuthill
Mr C Deverall AM
Professor C Gaston
Dr S Hart FRACS
Professor D Hill AM, PhD
Hon S Lenehan BA, DipMan, MBA, FAICD
Dr Andrew Penman
Assoc Professor S Smiles RN, RM, ICC, BHA, GradDipPSEM
Dr Kevin White PhD

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CLINICAL ONCOLOGICAL SOCIETY OF AUSTRALIA INC

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

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

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Dr S Ackland MBBS, FRACP

President Elect
Prof D Currow BMed, MPH, FRACP

Executive Officer
Ms M McJannett

Council Nominees
Ms L Lancaster RN Onc Cert, BHlth Sc(Nsg), FCN FRCNA
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 2006
Ordinary Members: $160
Associate Members: $100
(includes GST)

INTEREST GROUPS
ANZ Children’s Haematology and Oncology
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