From the Editor

Cancer research aims to develop the strongest evidence for treatment, care and prevention. Applying this evidence is the core business and central tenets of cancer control organisations and clinical oncology settings.

Though the ultimate value of this research is only realised when it is effectively applied in consensus driven multidisciplinary clinical best practice guidelines and applied treatments and procedures at organisational system and clinical service levels.

The information and knowledge base for oncology is expanding at an exponential rate and herein lies the magnitude of the challenge. In the face of a constantly dynamic and extensive increasingly multidisciplinary evidence base - it is estimated that on a daily basis over 1,000 articles are indexed on the Medline database and around 75 clinical trials and 11 systematic reviews specifically related to cancer.

In light of this challenge, most health professionals (HP's) now have statutory obligation to maintain their competence to practice and maintain evidence of their continuing professional development (CPD) for their registration. HP's accept personal responsibility and accountability for obtaining and maintaining their CPD.

WACOG serves as the ideal independent multidisciplinary and collaborative body to educate and inform all WA HP’s on various aspects of cancer control techniques and current problems as they may relate in our local settings.

Cancer Matters is merely one means that WA HP’s can be informed of local clinical cancer issues and other reputable sources of information of a national and international nature reaching over 5000 recipients. Current and all past issues are easily accessible online: cancerwa.asn.au/professionals/wacog/cancermatters

WACOG also continues to provide many networking and educational opportunities for HP’s to interact with colleagues and enhance their skills and knowledge. In 2013 WACOG has convened 50 lectures and/or seminars/workshops and symposia in Perth and regional WA that have been attended by 2346 HP’s.

We look forward to continuing to deliver a quality, highly regarded and productive service of multidisciplinary cancer education throughout 2014 and beyond.
Support for patients with haematological (blood) cancers

Approximately 1200 people are diagnosed with haematological (blood) cancers in Western Australia each year. This equates to approximately 9% of all new cancers.

These cancers include:
- Acute Myeloid Leukaemia (AML) Acute
- Lymphocytic Leukaemia (ALL) Chronic
- Myeloid Leukaemia (CML) Chronic
- Lymphocytic Leukaemia (CLL)
- Multiple Myeloma (MM)
- Hodgkin's Lymphoma (HL)
- Non Hodgkin's Lymphoma (NHL)

Diagnosis

Most of these cancers will be diagnosed following a blood test. Patients are then required to see a haematologist and have a number of tests and scans to confirm diagnosis and extent of disease. This could include a bone marrow biopsy or lymph node biopsy.

Treatment

For the majority of patients, treatment will take the form of chemotherapy. Some patients with NHL, HL or MM may also need radiation therapy. Each type of blood cancer is different and will require distinct types of chemotherapy regimens and follow-up. Haematologists may also modify their treatment depending upon specific patient needs and current health status.

Treatment involves a number of cycles of chemotherapy which can be given in an in-patient or out-patient setting. Regular medical follow-up and blood tests are conducted as specified by haematology consultants.

Some patients may go on to have a peripheral blood stem cell transplant or bone marrow transplant.

Helping patients along their cancer journey - Haematology cancer coordination team

Haematology Cancer Nurse Coordination (HCNC) service

This is a free statewide service available to any person with a diagnosis of a haematological cancer. Specialist haematological cancer nurses are available to:

- provide and explain information on diagnosis and treatment
- refer patients to other health care professionals, such as social workers and psychosocial services, where and when appropriate
- assist patients and their family through treatment in all departments
- coordinate patient care to ensure timeliness of appointments and treatments
- act as a central point of contact.

During 2011-2012, 332 new patients were referred to the HCNC service with an average of 3 episodes of care per patient. Approximately 30% of all referrals were from rural areas.

Referral to the HCNC service is based upon the following vulnerability criteria:
- Minimal social support
- New diagnosis
- Patients living alone
- Not seen by hospital nursing staff
- Rural patients
- Complex needs
- Low health literacy
- English as a second language
- Remission

The team have submitted a grant to develop appropriate resources to address patients’ Cancer Related Fatigue (CRF) information and support needs. This will involve the development of an information resource to inform adult haematology patients about how to manage CRF and the support services available within their community. Alternative funding will be sought to undertake an evaluation of the efficacy of the resources.

The HCNC service, also provides educational initiatives to all medical practitioners, nursing and allied health professionals. The team also works Leukaemia Foundation WA, Lymphoma Australia and the Haematological Society of ANZ to ensure patient and carer education and practical needs and are met.

This service is available Monday to Friday 8:00 am to 4:00 pm on the following mobile numbers:

0400 023 562
0448 771 453

Haematology Cancer Nurse Coordinators (L-R, Cassi Lawrence, Kerin Young and Melanie Rowley)
Useful websites and contacts

Cancer Council WA Helpline
www.cancerwa.asn.au/helpline
13 11 20

Provides a free, confidential telephone information and support service for cancer patients, people living with cancer, their families, carers and friends, teachers, students and healthcare professionals. Specially trained staff are available to answer questions about cancer and offer emotional or practical support.

Leukaemia Foundation
www.leukaemia.org.au
08 6241 1000 / 1800 620 420

Provides information and practical and emotional support for patients and their families living with leukaemias, lymphomas, myeloma and other blood disorders.

Myeloma Foundation of Australia
www.myeloma.org.au
1800 693 566

Provides a national free-call service to patients, relatives and carers about myeloma and to relevant referrals and applicable support.

Lymphoma Australia
www.lymphoma.org.au
1800 359 081

Provides a wide range of useful patient information, covering all aspects of lymphoma to increase understanding of lymphoma.

Haematology Clinical Trials

Western Australia Cancer Clinical Trials Registry
Cancer clinical trials are carefully designed research studies that investigate a new test or treatment for cancer. Trials may look at whether a treatment is safe, its side effects or how well a treatment or procedure works. Some trials assess how well treatments control symptoms or whether they improve quality of life.

WACOG maintains an online register that lists all cancer and haematological malignancy clinical trials open in WA hospitals. It is a useful resource for WA clinicians, health professionals and the public.

WA Cancer Clinical Trials Registry – Haematology
bit.ly/19fL2ND

Other Australian clinical trials websites

Australian Cancer Trials
australiancancertrials.gov.au

Australian New Zealand Clinical Trials Registry
anzctr.org.au

The Australasian Leukaemia & Lymphoma Group
allg.org.au
New WA Cancer Fellowships 2014

As a new initiative to provide a career development opportunity for future consultants, the State Government through the WA Cancer & Palliative Care Network has funded 6 ‘Cancer Fellowships’ on an ongoing basis.

The aim of the Fellowships are two-fold. They provide an opportunity for career development for future consultants and secondly to improve the care of cancer patients for better understanding of basic biology, prognostic factors or better treatment of cancer.

Fellowships are for medical practitioners, usually towards the end of their specialist training. The projects must be cancer related but could be from a wide range of specialties including diagnostic services e.g. gastroenterology, respiratory medicine, radiology and diagnostic pathology and treatment related specialties including surgery, medical and radiation oncology, haematology and palliative care.

The Fellowships are remunerated at a Registrar/Senior Registrar level and the duration is 12 months. The fellowships can be on a part time basis.

From a very high standard field the successful applicants for 2014 are:

- Dr Carolyn Grove – Assessing the role of C-Cbl in regulating the development of FLT3-ITD in AML
- Dr Claire Harma - Morphology & molecular profiling of interval colorectal cancers : is procedural quality or altered biology responsible
- Dr Melanie Jackson – Expression and significance of embryonic stem cell associated genes in glioblastoma (CBM) and gliosarcoma (GS)
- Dr Peter Lau – The role of microRNA in the pathogenesis of malignant melanoma
- Dr Hilary Martin – Assessment of mammographic breast density (MBD) as potential surrogate for efficacy of adjuvant endocrine therapy in early breast cancer
- Dr Tarek Meniawy – The effect of tyrosine kinase inhibitors in lung cancer therapy; effects on anti-tumour immunity and combinations with immunotherapy
- Dr Rajesh Thomas – Use of indwelling pleural catheter (IPC) in the management of malignant pleural effusions (MPE)

Applications for 2015 will close in April 2014 with notification by the end of June. If you are interested in applying for a Fellowship position in 2015 please direct enquiries to Dr David Ransom, Principal Medical Adviser to the WA Cancer & Palliative Care Network at:
david.ransom@health.wa.gov.au

Dr David Ransom

GP Online Portal gp.cancer.org.au

The Cancer Council has a National GP Portal that provides doctors and health professionals access to the most up-to-date, evidence-based cancer information and resources. The new national website is devoted to supporting GPs by providing the first comprehensive online directory of cancer information. Find all the latest news, evidence-based research and resources on cancer prevention, diagnosis and treatment.

Other helpful features of this online cancer directory include:

- RACGP accredited professional development educational resources
- Clinical guidelines and position statements
- State-by-state workshops and events
- Printable fact sheets for patients, and links to order printed resources
- Information for culturally and linguistically diverse communities
- State-based clinical trials
- Current campaigns from Cancer Councils nationwide
- Monthly editorial by cancer experts on topical issues
- Online videos covering a range of cancers and cancer-related topics.

The Cancer Council National GP Portal can be accessed via the above website.
WA Cancer incidence and mortality - 2011

The Western Australian Cancer Registry has released its latest report of cancer incidence and cancer-related mortality in Western Australian residents.

CANCER INCIDENCE
There were 11,636 new cases of cancer recorded in WA in 2011,
- 6,671 (57%) occurring in males, and,
- 4,965 in females.

The estimated cumulative risk of cancer to age 75 years was 1 in 3 for males, and 1 in 4 for females.

The most common cancers in males in 2011 were prostate and colorectal cancers, melanoma and lung cancer, while breast cancer predominated among females, followed by colorectal cancer, melanoma and lung cancer, the usual pattern in recent years.

Based on 2011 data,
- one in 7 men would be expected to have a diagnosis of prostate cancer before the age of 75, and,
- one in 11 women could be expected to develop breast cancer.

CANCER MORTALITY
There were 3,862 deaths due to cancer in 2011, 2,232 in males and 1,630 in females. All-cancers mortality rates for 2011 were 114 deaths per 100,000 males (marginally decreased since 2010) and 72 per 100,000 females (unchanged from 2010 but decreased from 84 in 2009).

As usual in recent years, the most common causes of cancer-related death in males were lung, colorectal and prostate cancers, while lung, breast and colorectal cancers were the most common in females.

CANCER IN CHILDREN
There were 81 children under the age of 15 years diagnosed with cancer in 2011.

OTHER CANCERS
Melanoma of the skin was - as in most years since 1982 - the most common cancer and cause of cancer-related mortality in males in the 15-39 years age range, and second most common incident cancer in females in this age range.

In persons over the age of 40 years, prostate and breast cancers, melanoma, colorectal and lung cancers, remain the most common incident cancers.

As in recent years, lung cancer was the most common cause of cancer-related death for both males and females, killing one in 39 males and one in 63 females before age 75.

Based on 2011 data, one in 144 men could be expected to die from prostate cancer before age 75, and one in 77 women to die from breast cancer.

WA Cancer Plan

The WA Cancer Plan 2012–2017 builds on progress made since the publication of the WA Health Cancer Services Framework in 2005. The Plan sets a clear direction for cancer services for the next five years.

The Plan provides a framework for a cohesive, integrated, State-wide approach to cancer control that is founded on the best available evidence, reflects national and state directions and utilises international benchmarks of effectiveness. It makes recommendations to improve cancer outcomes under five broad priority areas. The strategic activities listed under each of these five priority areas will assist in improving cancer control across WA.

Priority 1 - To reduce cancer incidence in WA through effective prevention initiatives
Priority 2 - To improve survival in WA through screening and early detection
Priority 3 - To improve outcomes and reduce morbidity for people affected by cancer in WA through equitable access to best practice and care through the cancer journey
Priority 4 - To promote innovation and measure progress in cancer control in WA through research and evaluation
Priority 5 - To ensure the sustainability, efficiency and effectiveness of cancer control activities in WA through appropriate planning and use of resources

The full report is available online at: bit.ly/13Vg71I

The full plan is available free online here: bit.ly/1asbi4J
Exercise Oncology

Exercise is fast being recognised in the medical field as being vital in improving cancer outcomes. But how much exercise is enough and what types of exercises are beneficial? Those are the questions Dr Prue Cormie, Senior Research Fellow at Edith Cowan University’s Health and Wellness Institute is seeking to answer in her new research, ‘Exercise as medicine for the management of cancer’.

In 2012 Cancer Council WA awarded a $225,000 Postdoctoral Research Fellowship to Dr Cormie to examine the safest and most effective exercise program for cancer patients. Studies have found exercise offers significant long term benefits including a 20-60% reduction in the risk of cancer recurrence and death.

The aim of Dr Cormie’s three-year research is to determine the type and dosage of exercise to counteract the adverse effects of cancer and its treatments. “The ultimate goal of my research is to see disease specific exercise becoming as routine as chemotherapy and radiotherapy, and this grant will significantly help to achieve that goal,” says Dr Cormie who also works with the Cancer Council Life Now Exercise program to make sure the exercises are safe and effective. Dr Cormie’s research is supported by positive personal testimonies from Life Now Exercise participants, who describe relief from pain and fatigue, and an improved sense of wellbeing.

A 12 week program, Life Now Exercise aims to help people affected by cancer build strength, reduce fatigue, improve fitness and increase their confidence to exercise into the future.

For more information about Life Now programs visit: cancerwa.asn.au/patients/support-and-services/life-now or call Cancer Council Helpline 131120 for enrolment details

Exercise and Cancer Studies recruiting in WA
There are several clinical trials and research studies being carried out in WA that are looking in the role of exercise and lifestyle interventions in the cancer setting. To find out more visit: ecuhealthwellnessinstitute.org

Link to: Exercise as medicine presentation - Dr Prue Cormie, Varro Health Institute bit.ly/13c9meC
EXERCISE ONCOLOGY RESEARCH UPDATE

TRIALS CURRENTLY OPEN FOR ENROLMENT:

- **Bone Metastatic Disease**: 3 month supervised exercise program for prostate and breast cancer patients with bone metastatic disease. Program individualised based on location of bone metastases. **Recruitment status**: 21 out of 90 prostate cancer patients required; 6 out of 40 breast cancer patients required.
- **Prostate Cancer Patients Initiating ADT**: 6 months of supervised exercise program for men initiating ADT for the first time (must be referred prior to first injection). **Recruitment status**: 51 out of 124 required.
- **Pancreatic Cancer**: 6 month supervised exercise program for all patients with pancreatic cancer. Individualised program to enhance the ability to tolerate treatment and improve quality of life. **Recruitment status**: 4 out of 20 required.
- **Breast Cancer Patients Undergoing Radiotherapy**: Home based exercise program with telephone support throughout & continuing for 6 weeks after radiotherapy. **Recruitment status**: 75 out of 200 required. Note: only available at Genesis Cancer Care Wembley and Shenton House.
- **Lung Cancer**: 3 month supervised & home based exercise intervention for stage I-IIIB non-small cell lung cancer or limited stage small cell lung cancer who have completed treatment. **Recruitment status**: 16 out of 36 required.
- **Vibration Exercise**: 3 months of whole body vibration stimulus (standing on a gently vibration platform for 20 mins, 3 days/week) for breast cancer patients receiving aromatase inhibitors and prostate cancer patients receiving ADT. **Recruitment status**: 9 out of 40 prostate cancer patients required; 20 out of 40 breast cancer patients required. Note: only available at Sir Charles Gairdner Hospital and ECU Joondalup.

**Exercise sites**: Joondalup, Mt Lawley, Crawley, Fremantle and Murdoch

**Referrals**: Patients can contact our team on 6304 2329 alternatively you can email the patient contact details to Prue Cormie (p.cormie@ecu.edu.au) and we will contact them directly.

**Non-trial exercise programs**: The ECU Health and Wellness Institute have a variety of options available to ensure that all people with cancer can become involved in an appropriate exercise program at no or low cost with accredited clinical exercise physiologists. Sites are available at Joondalup (Vario Wellness Clinic) and a 9 sites throughout Perth & regional WA (Cancer Council WA Life Now Exercise Program).

RECENT PUBLICATIONS:

- **European Urology**: Galvão et al, 2013 - *A multicentre year-long randomised controlled trial of exercise training targeting physical functioning in men with prostate cancer previously treated with androgen suppression and radiation from TROG 03.04 RADAR*. Supervised exercise training in long-term prostate cancer survivors is effective for increasing cardiorespiratory fitness, physical function, muscle strength, and self-reported physical functioning at 6 months, and benefits are maintained in the long term with a home-based programme at 12 months.
- **Nature Reviews Urology**: Cormie et al. 2013 - *Exercise therapy for sexual dysfunction after prostate cancer*. There is strong theoretical rationale and emerging evidence that exercise is an innovative therapy to counteract sexual dysfunction in cancer survivors.
- **Prostate Cancer and Prostatic Disease**: Cormie et al, 2013 - *Safety and efficacy of resistance exercise in prostate cancer patients with bone metastases*. Appropriately designed and supervised resistance exercise is safe and well tolerated by prostate cancer patients with bone metastatic disease and can lead to improvements in physical function, physical activity levels and lean mass.
- **Medicine and Science in Sport and Exercise**: Cormie et al. 2013 - *Exercise as medicine in the management of pancreatic cancer: A case study*. In this first reported clinical case, exercise led to improvements in a variety of outcomes during adjuvant therapy including physical capacity and functional ability, lean mass, physical activity levels, general health and disease specific quality of life, cancer-related fatigue, sleep quality and psychological distress.

Email Dr Prue Cormie (p.cormie@ecu.edu.au) to receive PDF copies of the above articles.
Work after cancer is an important issue that has major economic and productivity implications. When 1 in 2 males and 1 in 3 females are diagnosed with cancer in their lifetime and 40 per cent of those people are of working age, the potential impact cancer has on one's work situation significant, as it is, is more than a source of income, it provides people with a sense of meaning and a source of social interactions.

“The concerns around the use of nanoparticles in sunscreen, particularly the free radicals they can release - which has been the major issue raised, are very minor based on the evidence,” said Dr Feltis. Current evidence suggests the particles don’t penetrate the skin, but even if they did, the quantity of free radicals generated is insignificant compared to those formed from sun exposure.

It’s a good idea to ask doctors questions before undergoing screening particularly about ‘how likely am I to experience the benefits of screening and what are the harms of being screened?’ There isn’t a one size fits all answer. It will depend on the individual, how they feel, and their individual risk of different cancers including age and family history.

Human Papillomavirus Virus (HPV) is the most common virus linked to cancer. While it’s link to cervical cancer and head and neck cancers is well established, Professor Olver said there is new research emerging which link’s HPV with some skin cancers. Hepatitis B and C infections are the leading causes of liver cancer that are linked to the increase of liver cancer rates in Australia. He recommended that vacinnation against certain cancer related is important.

Health management plans should become standard practice for all cancer patients at the end of their treatment. These plans should be a big agenda item for oncology because we need to do a better job of looking after cancer survivors. Patients could record consultations with medical specialists to share the information with their family or take a relative along to take notes. Research has shown that cancer patients only retain around 25% of the key facts that doctors present to them.
COSA Releases Cancer Health Professionals Position Statement on Complementary and Alternative Medicine

The Clinical Oncology Society of Australia (COSA) is the peak national body representing health professionals from all disciplines whose work involves the care of cancer patients. COSA has developed a position statement on the use of complementary and alternative medicine (CAM) by cancer patients.

Developed by the Complementary and Integrative Therapies Interest Group within COSA, the working group consulted with health professionals, researchers, consumers and members of the COSA Council during development and review of the statement.

The purpose of the document is to outline the position of COSA on the use of complementary and alternative medicine (CAM) by cancer patients and to provide guidance for health professionals involved with the treatment of cancer patients who are using or wish to use CAM.

The position statement can be downloaded via the Cancer Council Australia website and this link here: bit.ly/1aoHP8P

Download the Position Statement for Free: bit.ly/18Cz50L

www.eviq.org.au

evIQ is an online resource that provides evidence-based cancer treatment information to help health professionals identify the best course of cancer treatment and care for their patient’s needs.

evIQ Cancer Treatments Online is a point of care clinical information resource that provides health professionals with current evidence based, peer reviewed, best practice cancer treatment protocols and information.

evIQ is designed to support a busy work flow in all clinical and geographical settings, allowing rural, remote and metropolitan health professionals, patients, carers and their families free access to the same standard evidence based information.

Vision: To harness the collective expertise of health care professionals in Australia to develop an efficient, safe, quality national resource that becomes the preferred provider of evidence based cancer treatment information at the point of care.

Primary purpose: To provide evidence-based information to support health professionals in the delivery of cancer treatments and;
To provide the reference standards to support the measurement and reporting of the delivery of cancer treatments in order to determine strategies to reduce variation and improve patient outcomes.
Not all lesions are cancer, say experts

Over the past 30 years, awareness and screening have led to an emphasis on early diagnosis of cancer. Although the goals of these efforts were to reduce the rate of late-stage disease and decrease cancer mortality, secular trends and clinical trials suggest that these goals have not been met; international data demonstrate significant increases in early-stage disease, without a proportional decline in later-stage disease. What has emerged has been an appreciation of the complexity of the pathologic condition called cancer.

Renaming low-risk lesions was one element in a five-point program published recently in the Journal of the American Medical Association to address the problem of overdiagnosis and overtreatment of cancer. Premalignant conditions such as ductal carcinoma in situ or high-grade prostatic intraepithelial neoplasia should not be labelled cancer but instead be reclassified as IDLE (indolent lesions of epithelial origin), the authors recommended.

“The word ‘cancer’ often invokes the specter of an inexorably lethal process; however cancers are heterogeneous and can follow multiple paths...and include indolent disease that causes no harm during the patient’s lifetime,” they noted.

Patients and doctors should engage in open discussion about these issues, while the media “should better communicate the message so that as a community the approach to screening can be improved,” they concluded.

The following recommendations were made to the National Cancer Institute for consideration and dissemination:

- Physicians, patients, and the general public must recognise that overdiagnosis is common and occurs more frequently with cancer screening
- Change cancer terminology based on companion diagnostics
- Create observational registries for low malignant potential lesions
- Mitigate overdiagnosis
- Expand the concept of how to approach cancer progression

Full paper is available free here: jama.jamanetwork.com/article.aspx?articleid=1722196
Cancer in the workplace

Cancer in the workplace is a growing issue.

Are organisation’s ready?

Cancer is the leading cause of death and disability in Australia, with one in two males and one in three females living to the age of 85 receiving a cancer diagnosis at some stage in their life. Approximately 40% of new cancer diagnoses occurred in people of working age, many of whom are in the midst of their career.

These statistics have significant implications for those managing the workforce, as millions of sick days will be lost to cancer in coming years, and valuable staff may decide that it is just too hard to manage their treatment and their workplace responsibilities. While many people choose to take time off work during cancer treatment, others prefer to continue to work, either to keep up a sense of normality, or for financial reasons. Others may be caring for a partner, parent or child with cancer while juggling their own work and other commitments.

The way that people deal with their own cancer is as individual as the person themselves. Some may want to keep the fact that they have cancer private while others are very open about it. Some may cope very well with working during and after their treatment, others may find that this is just not possible or that their treatment affects the way they are able to do their job. They all require a supportive work environment to respond to these variables and to continue to contribute to their workplaces where possible or appropriate. HR and line managers can discuss individual circumstances and needs, and help develop plans to facilitate these adjustments.

Support for employers

Dealing with cancer in the workplace is a complex and sensitive issue and many employers may find communicating about cancer difficult. It can be a daunting subject, and some employers worry that they may say the wrong thing. They may just need some guidance.

How to support an employee with cancer

Some simple steps that HR practitioners and line managers can take to make it easier for an employee to continue to work during treatment include making temporary adjustments to workloads, providing flexible working arrangements, additional leave, access to parking, a quiet place for taking a rest, drafting a return-to-work plan, and promoting a better understanding of cancer among colleagues.

Two-way communication is the key. Ideally both the employer and employee should agree on realistic working conditions, hours and workloads. This can ensure the employee is not put under excessive pressure and also allows the employer to make alternative arrangements to deal with any business productivity concerns.

Supporting employees affected by cancer is a two-way street. It may boost staff morale, improve organisational loyalty and foster a positive culture within the organisation. Furthermore there are sound business reasons for supporting staff with cancer, as retaining good staff saves recruitment and training costs, and keeps valuable expertise and corporate knowledge within the organisation.

Cancer Council NSW has produced a series of online workplace resources that include practical tips for HR departments and managers about creating cancer-friendly workplaces. They include fact sheets on developing (or reviewing) cancer-friendly organisational policies, tips for talking to employees about their cancer, practical ideas about supporting employees undergoing treatment or caring for someone with cancer, and information on dealing with death and bereavement. Developed with the needs of both employers and employees in mind, they offer relevant information about cancer treatments and their common side effects, debunk some myths that may make it difficult for colleagues and managers to talk openly about an employee’s cancer and offer practical suggestions for developing cancer-friendly workplaces.

For more information

The Cancer Council workplace resources are national resources and can be accessed at: www.cancercouncil.com.au/workplaces

Or, call the helpline on 13 11 20 to speak to someone about more information on locally based services.

This blog first appeared on Australian Human Resources Institute (AHRI) blog.
Have you heard a claim about cancer and want to know whether it is fact or fiction? iheard has been created to dispel the many myths, rumours and fanciful claims about cancer. Ask any cancer related question1 - queries will be reviewed by our team of scientists, clinical advisors, researchers and cancer prevention and support experts.

The aim is to give accurate, evidence-based answers to cancer questions. One can be confident the information provided is backed by Cancer Council Australia, the nation's peak, independent cancer control organisation.

Previously answered questions can be searched for by category and keywords.

ecancer is the leading oncology channel committed to improving cancer communication and education with the goal of optimising patient care and outcomes. By using the latest technologies ecancer works closely with leading figures in oncology to inform and educate the global cancer community.

ecancer sources relevant oncology news from top organisations around the world. The free online service posts daily news generated by institutes, journals, governments, NGOs and charities, along with commissioned pieces.

ecancer also provides:

- ecancermedicalscience - The open access cancer journal from the European Institute of Oncology
- ecancer news - The latest oncology headlines
- ecancer tv - Essential viewing for oncologists
- ecancer conferences - Highlights from international oncology meetings
- ecancer education - Essential online learning
- ecancer institutes - Latest research from the top cancer centres

Oncology Tube oncologytube.com

OncologyTube is the world’s first free video sharing site for oncology professionals.

Watch and post videos about oncology news and cancer research for free.

Follow on Twitter - @oncologytube
Like on Facebook - OncologyTube
Screening for Cancer Distress

Distress is common among people diagnosed with cancer. It ranges from normal feelings of vulnerability, sadness, and fears, to problems that can become disabling such as depression, anxiety, panic, social isolation, and existential and spiritual crisis. In recent years, emotional distress has been identified as is the sixth vital sign in cancer care after temperature, respiration heart rate, blood pressure and pain. High levels of distress in cancer patients is associated with reduced quality of life, dissatisfaction with medical care and possibly reduced survival.

While distress may decrease over time for some people with cancer, it may persist or even increase over time for others. Therefore, routine screening and management of distress is a critical component of person centred cancer care. Screening for distress aims to identify the concerns of patients in a timely manner, so those concerns can be addressed and managed at the earliest point in time.

Early detection and management of distress may lead to better adherence to treatment; improved quality of life; improved patient-doctor communication; fewer visits to the oncologist and to emergency services, and increased satisfaction with cancer care.

The National Comprehensive Cancer Network (NCCN) Distress Thermometer and Problem List (“DT”) is a short, self-report tool for screening for distress in cancer patients (Figure 1 below).

The DT has been validated among patients with different types of cancer including breast cancer, lung cancer, prostate cancer, intracranial tumours, and colorectal cancer. When completing the tool, patients rate ‘how much distress you have been experiencing over the past week, including today’ on a scale of 0 to 10. Patients then tick concerns on a Problem List in five domains: practical, family, emotional, spiritual/religious, and physical. A score of 4 or more indicates the person is experiencing elevated distress and may require additional support. It is essential that distress screening is followed up with psychosocial support, information and referral targeted to the needs of the patient.

Important: If you wish to use the Distress Thermometer and Problem List, you must obtain permission from the NCCN at nccn.org

Interested WA health professionals and cancer centres who seek more information on Distress Screening and key references can contact
Dr Kaaren Watts  kwatts@cancerwa.asn.au

Figure 1. NCCN Distress Thermometer and Problem List

The Distress Thermometer is reproduced with the permission of the National Comprehensive Cancer Network (NCCN Guidelines ®) Distress Management Version 2.2013 at NCCN.org
Cancer Australia has released a new online resource to support health professionals initiate discussions on sexual well being with breast cancer patients and their partners.

“Research shows that while many women experience negative changes to their sexual well being, the majority remain silent about these changes, and few speak to a health professional about the issue,” said Cancer Australia CEO Professor Helen Zorbas.

This resource is designed to support health professionals to initiate discussions on sexual well being with women and their partners following a diagnosis and treatment of breast cancer. It includes information for women and health professionals, and a summary of interventions for common symptoms relating to sexual well being.

Health professionals have a responsibility to raise the topic of sexual well being as part of routine health assessment, with the aims of initiating discussion, responding to general questions, directing women to further information in response to their needs, and referring women to specialist services as required.

The full document is available Free online at: bit.ly/1dmfvdL

Breast Cancer Network Australia (BCNA) works to ensure that women diagnosed with breast cancer, and their families, receive the very best information, treatment, care and support possible.

BCNA is the peak national organisation for Australians affected by breast cancer, and consists of a network of more than 80,000 individual members and 320 member groups. More than 90 per cent of it’s members have had a diagnosis of breast cancer, and the remaining members have had a personal experience with breast cancer through a family member or friend.

Fact sheets and booklets
BCNA produces a range of fact sheets and booklets for women with breast cancer, and their families. These currently include:

- Breast cancer pathology
- Breast cancer and sexual wellbeing
- Clinical trials
- Depression and breast cancer
- Exercise and breast cancer
- Family history
- Fertility-related choices: A decision aid for younger women
- Financial and practical assistance
- Hair Loss
- Hormone Therapy and breast cancer
- Lymphoedema - Reducing your risk and Travel tips for reducing your risk
- Lymphoedema - Compression garment subsidies
- Menopause and breast cancer
- Patient Assisted Travel Schemes (PATs)
- Tax free superannuation payments for people with a terminal illness
- Travel Insurance

Fact sheets and booklets can be downloaded for free by visiting the BCNA website, hard copies of any resource will be sent by calling 1800 500 258 or visiting the above website.
Comparing cosmetic outcomes for external versus intraoperative radiotherapy in breast cancer patients

Early results of the Targeted Intraoperative Radiotherapy versus whole breast radiotherapy for breast cancer (TARGIT) trial were published in 2010 indicating that with a median follow-up of 4 years, a once off dose of intra-operative radiotherapy (IORT) was not an inferior treatment compared to conventional external beam radiotherapy (EBRT) for early, low risk breast cancer, when considering the main outcome of local-recurrence.

In this sub-study that WA women with breast cancer participated in, researchers examined two methods of delivering radiation therapy. They compared the cosmetic outcomes of breasts treated with targeted intraoperative radiotherapy (TARGIT) or external beam radiotherapy (EBRT).

The study included 342 patients diagnosed with early stage breast cancer who underwent breast conserving surgery. 178 of these patients received TARGIT and 164 received EBRT. Validated computer software (BCCT.core) analysed photographs and produced a composite score based on symmetry, colour and scar.

This provides a purely objective measurement of cosmetic outcome. It analyses breast symmetry and colour to produce a score of excellent/good or EG (little or no disfiguration) and fair/poor or FP (substantial disfiguration). Photographs of patients' breasts were analysed 1 to 5 years after radiation.

Overall, TARGIT patients were 61% more likely to have EG scores than EBRT patients. The benefits of TARGIT were especially clear 1 and 2 years after radiotherapy, where TARGIT patients were twice as likely to receive EG scores as were EBRT patients.

In conclusion, this is a reassuring finding which complements the early results of the TARGIT study suggesting that IORT is not only a safe and effective treatment option for selected women with early, low risk breast cancer but that it also resulted in more cosmetically acceptable breasts than EBRT in breast cancer patients treated with breast conserving surgery.

IORT for early, low risk breast cancer is currently only available at Sir Charles Gardiner Hospital for women who are older than 70 years in WA. With longer term data, it is hoped to increase the accessibility of this convenient, once-off treatment.

References

To find out about other breast cancer clinical trials open at WA hospitals visit the WACOG WA Cancer Clinical Trials Registry: bit.ly/19zgEdi

New online resource on breast reconstruction

Cancer Australia has released a new online resource on breast reconstruction. The resource provides comprehensive information for women considering breast reconstruction following a mastectomy. This is a valuable resource for women, as well as health professionals.

Breast reconstruction is surgery to rebuild a breast shape after mastectomy.

The resource is located at the Cancer Australia website or via this link: http://bit.ly/HrBWBz
In September 2013, Make Smoking History ran a state-wide advertising campaign titled ‘Meet Mick’. The campaign tells the story of real-life smoker Michael ‘Mick’ Roberts and his battle with emphysema. In a series of television ads, Mick engages viewers by recounting how his smoking has severely affected him and the people around him, especially his family.

The ‘Meet Mick’ campaign aims to inform smokers of the negative effects smoking has, not only on the individual but all aspects of one’s life.

The ads first aired in June/July delivered strong results with total awareness at 70%. The ads also performed well in being convincing (82%) and relevant (70%). Furthermore, 62% of people cut down, made a quit attempt or stopping smoking all together.

Research indicates that personal campaigns which exude high levels of emotion and show negative health effects have the greatest impact on adult smokers.

To view the advertisements visit cancerwa.asn.au/prevention/tobacco/makesmokinghistory/current-campaign/

Health professionals’ keen to develop their skills in providing smoking cessation support to smokers can attend a Fresh Start Facilitator course provided by Cancer Council WA. For more information visit: cancerwa.asn.au/prevention/tobacco/trainingforhealthprofessionals

Asbestos exposure high among home renovators

Home renovators are risking death by not protecting themselves from asbestos, according to an article in a recent issue of the Medical Journal of Australia.

Research based on a NSW questionnaire found six in ten DIY renovators have been exposed to asbestos, but fewer than 15% said they regularly used protection.

A high proportion of home renovators said their partner (39.3%) or children (22.8%) had been exposed as well. Just under a third said they used protection occasionally.

Australia has one of the highest rates of the malignant mesothelioma in the world. Asbestos has been banned since the 1970s, but all homes built before the mid-1980s are potentially risky.

There is a lack of clarity about how much exposure is dangerous.

“Whether exposure during home renovation will result in disease in the future remains to be seen. However, this entirely preventable exposure needs to be addressed,” the authors said.

The full MJA paper is available free here: bit.ly/1ehvuKx

kNOw asbestos in your home

In November, Cancer Council WA and WA Department of Health’s Environmental Health Hazards Unit launched a new, online module called ‘kNOw asbestos in your home’. It aims to increase DIY renovators’ ability to identify asbestos in the home and know how to handle and dispose of it safely, as well as look at the hazards associated with exposure to asbestos fibres.

The module is at elearning.cancer.org.au
Wide variations in prostate cancer brachytherapy

WA prostate cancer patients are up to six times more likely to be prescribed high-dose-rate prostate brachytherapy (HDR-PB) than elsewhere in Australia, according to new research.

While WA patients were more likely to get the therapy, four of the 15 Australian and NZ brachytherapy departments surveyed reported annual drops of 25-60% in the number of patients treated with HDR-PB, the authors from Sir Charles Gairdner Hospital found.

This was possibly due to changes in referral patterns and increased use of robotic prostatectomy, but also because fewer or no radiation oncologists were available to carry out the treatment, the study authors said.

Geographical isolation and smaller populations presented a particular challenge in HDR-PB, where a minimum throughput of at least ten patients per year was recommended to maintain the skills of the multidisciplinary team, the authors noted.

By this measure six departments had a lower than ideal patient workload, with the annual number of patients treated per radiation oncologist ranging from four to 51 across the region.

Adapted from 8 August, 2013 Oncology Update

What is brachytherapy?
Brachytherapy for prostate cancer is a technique that involves implanting 'radioactive seeds' in the prostate. These 'seeds' emit small amounts of radiation that affect tissue in a small area. In the case of localised prostate cancer the aim of brachytherapy is to stop the cancerous cells in the prostate from growing.

Rise in PSA testing of younger men

The number of PSA tests per formed on Australian men under 55 has nearly tripled over the past decade, despite ongoing controversy over the merits of screening. Opportunistic PSA screening rose by 146% in Australia between 2001 and 2008 but the highest increases were seen in men under 55 where rates were up by 174%.

Yet despite the rise, rates of prostate cancer among tested men remained very low. Over 1,100 men under 55 had to be screened to detect one new case of prostate cancer, a rate of 0.01%, the Melbourne-based authors found.

Of the men under 55 referred for biopsy around two-thirds received a negative result, and the cancer detected tended to be of a low or intermediate grade, the researchers said.

The spike in the number of younger men being tested comes despite most screening guidelines recommending against it.

One possible reason might be greater awareness of the risk of familial prostate cancer, with a cascading effect as more men were diagnosed with low-grade cancers.

Increasing rates of negative biopsies and detection of low-grade disease in younger patients suggested that prostate cancers tended to become more aggressive around or after the age of 55 but not before.

In the absence of clear survival benefits, screening should only be performed on asymptomatic men under 55 who understood and were willing to accept the risks of overdiagnosis and biopsy complications.

Reference
British Journal of Urology 2013; online. Population based analysis of Prostate Specific Antigen (PSA) screening in younger men (<55 years) in Australia, Weranja Ranasinghe et al.
Cancer Risk after CT Scans in Childhood

Small cancer risk following CT scans in childhood and adolescence confirmed

An Australian study has confirmed that CT scans in young people are associated with an increase in cancer risk. Although having a CT scan in childhood or adolescence was associated with an increased risk, the overall increase in incidence of cancer was relatively small. This highlights the need for health professionals to take into account the risk of malignancy when deciding on the best diagnostic pathway to use with their young patients.

The researchers say that in a group of 10,000 young people, they would expect 39 cancers to occur during the next 10 years, but if they all had one CT scan, up to six extra cancers would occur.

There was also a dose–response relationship, with a 16% increase in the risk of cancer with each additional scan. The risk of cancer was also greater for those people who had been scanned at younger ages.

Brain tumours represented the most common type of cancer seen following CT scans with 147 excess cancers, 122 of which occurred following a head CT scan. Lymphoid and haematopoietic cancers were the next most common followed by melanoma.

Cancer Council Victoria epidemiologist and a co-author of the study, Professor Graham Giles (pictured right), said the small increase in cancer risk of CT scans must be considered alongside proven benefits.

“This research is a reminder to the wider community that there are risks associated with the use of CT scans,” Professor Giles said.

“Patients, families and health professionals must continue to work closely together to ensure CT scans are only used in situations where there is a definite clinical need. At every scan the radiation dose must also be kept at the lowest level possible.”

Cancer Council Victoria’s Senior Clinical Consultant Associate Professor Michael Jefford (pictured right) added:

“We mustn’t forget that CT scans are an important medical tool and, with improvements in CT technology, some of the issues raised by this study are already being addressed.”

Practice points

- CT scans in children and adolescents are associated with a small increase in future cancer incidence.
- The overall incidence of cancer is low and the increased risk is small. However, before referring a young person for a scan it is important to consider:
  - Is the CT scan really needed?
  - Will it change management?
  - Are there previous imaging results that provide diagnostic or management information?
  - Is CT the best choice of imaging technology?
  - Can the same information be obtained without exposure to ionising radiation?
  - Use a diagnostic decision tool such as the Diagnostic Imaging Pathways.
  - If a CT scan is chosen as the best option, inform the parents of the potential risks. This may involve reassurance that the overall increase in cancer risk is small.

Reference


Diagnostic Imaging Pathways - A Clinical Decision Support Tool and Educational Resource for Diagnostic Imaging

The Diagnostic Imaging Pathways application is an evidence-based and consensus-based education and decision-support tool for clinicians. It guides the choice of the most appropriate diagnostic examinations in the correct sequence in a wide range of clinical scenarios. The broad objectives of the guidance are to:

- Reduce the incidence of unnecessary examinations which may expose patients to risk without benefit, including the risk of false-positive results; and
- Increase the incidence of appropriate examinations which will result in cost-effective diagnosis.

imagingpathways.health.wa.gov.au
In July this year, Cancer Council Australia launched its first ever policy to address rising levels of liver cancer. It is also urging state and federal governments to provide funding for the National Hepatitis B Strategy to reduce the incidence of liver cancer through prevention, early diagnosis and treatment.

It identified greater participation of GPs in diagnosis and treatment of hepatitis B as a key priority in improving prevention.

An automated computer program using existing practice software will be trialled to identify patients who may be at high risk of hepatitis B and who have not been screened or vaccinated.

“If this pilot is successful, the program has the capacity to profoundly reduce the proportion of people living with undiagnosed chronic hepatitis B in Australia, for the benefit of those affected, their families and the community as a whole,” said Jody Simmons, Researcher at Cancer Council Victoria.

Hepatitis and liver cancer - a summary
- Deaths from liver cancer set to double over next decade
- Liver cancer jumps three spots in three years to become Australia’s ninth most fatal cancer – around 1,400 Australians die from liver cancer each year
- There are an estimated 218,000 people living in Australia with chronic hepatitis B
- Almost half of people with hepatitis B aren’t aware they have it
- Only 20% of those with hepatitis B who require treatment currently receive it
- Only 10% of liver cancer cases are linked to heavy alcohol use
- Liver cancer is one of the most deadly – 85% to 90% don’t survive beyond five years after diagnosis.

The National Cancer Prevention Policy – Liver Cancer is accessible here:
wiki.cancer.org.au/prevention/Liver_cancer

National Bowel Cancer Screening Program: July 2011 - June 2012 monitoring report

This report presents statistics on the National Bowel Cancer Screening Program for Australians invited to take part between July 2011 and June 2012. Just over 320,000 people were screened in that time, with about 22,500 found to require further assessment. One out of every 15 assessments recorded detected an advanced adenoma (pre-cancerous lesion), and a bowel cancer was detected in 1 out of every 32 assessments. Crude participation rates across age groups and genders in WA were slightly above the combined state national rates.

Full Report available here: bit.ly/1dXashR
Aussie oncologists good at predicting survival

Advanced cancer patients who wish to know how long they have to live can generally rely on oncologists’ survival estimates, according to new Australian research.

The study involved 21 oncologists from hospitals across Australia who were invited to estimate the survival of 114 patients with advanced cancer.

Over 60 per cent of patients died within a half to double the oncologists’ estimated survival time.

Estimates were reasonably well calibrated, with around 50 per cent of patients dying on either side of their oncologist’s point estimate.

Single point estimates of survival times were in themselves rarely accurate – as expected given the inherent variability of survival – but simple multiples accurately estimated worst-case, typical and best-case scenarios.

Six percent of patients lived for less than a quarter of the estimate, 63 per cent lived from half to double the estimate and 14 per cent lived over three times the estimate, the study showed.

Reporting in the Journal of Clinical Oncology, the authors said their findings ran counter to previous research which pointed to a tendency of oncologists to overestimate survival in patients with advanced cancer.

The study confirmed that “oncologists’ estimates provide additional prognostic information, above and beyond that provided by established and measurable prognostic factors”.

The authors suggested that when patients asked about life expectancy, oncologists should estimate the median survival in a group of similar patients. Clinical trials could provide a starting point for the estimate, with adjustments to account for the individual patient and study population.

Rather than offering a single number estimate, oncologists should use simple multiples to calculate and explain worst-case, typical and best-case scenarios for survival, the authors recommended.

Providing three scenarios “conveys the realistic hope that survival might be considerably longer and a realistic appreciation that it might be considerably short.”

Dr Belinda Kiely
The art of oncology: communicating survival expectancy to patients with cancer

Dramatic rise in chemo spending in Australia

Taxpayer spending on chemotherapy in Australia — has increased almost 500% over the past decade.

In 2011, Australia spent almost $752 million on outpatient chemotherapy, up from $129 million in 2000. The raw number of scripts also rose dramatically over the same period, from 402,000 in 2000 to more than a million in 2011.

Dr Agnes Vitry (PhD), who presented the data at the Clinical Oncology Society of Australia annual scientific meeting in Adelaide in November, said there was “increasing concern” about how to deal with the huge demand and costs of chemotherapy.

“We have a growing number of people with cancer and so a growing use of cancer medicines,” said Dr Vitry, a senior research fellow at the Quality Use of Medicines and Pharmacy Research Centre at the University of SA. “It’s important for Australian people to realise what it costs at a national level ... in terms of choices we have to make as a society, we need to discuss this increasing cost more openly.”

The overall price rise was being driven by the increasing use of newer and more expensive drugs, with less money spent on older products.

Six medicines made up 58% of all chemotherapy costs in 2011: new medications rituximab, imatinib, bevacizumab and trastuzumab, and the older, generic medications docetaxel and paclitaxel.

Dr Vitry said it “very surprising” to discover that such a small number of medications contributed so heavily to overall costs. She also refuted recent claims that Australia was lagging behind in access to cancer drugs, saying access here was “very good”. The Federal Government is undertaking a review of chemotherapy funding to determine the most appropriate long-term arrangements.
Cancer in Aboriginal and Torres Strait Islander peoples

A report released in October 2013 brings together the most up-to-date data available from a wide range of sources to describe the status of cancer in Aboriginal and Torres Strait Islander people in Australia. Information on difference across age, sex and remoteness areas are presented and key issues are highlighted. The report provides a comprehensive picture of cancer in Aboriginal and Torres Strait Islander people in Australia that should be useful to health professionals, policy makers and others with an interest in the health of Aboriginal and Torres Strait Islanders.

Despite having a higher chance of developing cancers than the general population and a higher mortality rate once diagnosed, Indigenous Australians are less likely to be hospitalised for treatment. The latest findings, included in the report from the Australian Institute of Health and Welfare (AIHW), also come despite Aboriginal and Torres Strait Islander peoples having higher rates of certain lifestyle risk factors.

Such risk factors included high rates of smoking among Indigenous Australians (38% compared to 18% among other Australians), higher rates of risky alcohol consumption and lower cervical and breast screening rates. Researchers found that Indigenous Australians diagnosed with cancer between 1999 and 2007 had a 40% chance of surviving for at least five years, compared with 52% for non-Indigenous Australians.

AIHW spokesperson Justin Harvey said Indigenous Australians also had lower survival rates after a cancer diagnosis than non-Indigenous Australians. ‘Aboriginal and Torres Strait Islander peoples diagnosed with cancer between 1999 and 2007 had a 40% chance of surviving for at least 5 years, compared with 52% for non-Indigenous Australians,’

Cancer Australia CEO Professor Helen Zorbas said the report highlighted the significant impact that cancer had on the Indigenous population. Whilst incidence rates for cancer overall were marginally higher for Indigenous Australians, mortality and survival differences between the two population groups are far more striking with Indigenous Australians being approximately 50% more likely to die from cancer than non-Indigenous Australians,'

Mr Harvey said that while lung cancer was at the top of the rankings for both groups, differences emerged after that. ‘After lung cancer, the two most common causes of cancer death among Indigenous Australians are cancer of the liver and breast cancer (in females). For non-Indigenous Australians, the most common causes are lung cancer, followed by bowel and prostate cancer (in males),’ Mr Harvey said.

Professor Zorbas said the report emphasised the important work that needs to be undertaken to address the disparity between Indigenous and non-Indigenous Australians. ‘The findings of this report underscore the continuing action needed in health promotion, research and health service delivery to best meet the cancer prevention and treatment needs of Indigenous Australians,’

The full report can be downloaded here for Free: bit.ly/1dXashR

New resource to support Aboriginal and Torres Strait Islander women diagnosed with breast cancer, their families and communities

The Minister for Health, The Hon Peter Dutton MP has announced the release of a new resource My breast cancer journey: a guide for Aboriginal and Torres Strait Islander women and their families. This resource, launched at Cancer Australia's Pink Ribbon Breakfast on 28 October 2013, outlines the clinical management of early breast cancer to support Aboriginal and Torres Strait Islander women with breast cancer and their families.

My breast cancer journey: a guide for Aboriginal and Torres Strait Islander women and their families has been developed in response to Aboriginal and Torres Strait Islander women highlighting the need for culturally appropriate, supportive breast cancer information. It contains practical information to help navigate the breast cancer journey and improve understanding about breast cancer, treatment options and follow-up care.

This resource has been created in collaboration with Aboriginal and Torres Strait Islander women with various stages of breast cancer, Aboriginal and Torres Strait Islander women working in the health sector and family and friends of women diagnosed with breast cancer.

The document is available here: bit.ly/17rRilp
Let’s talk about living with cancer (brochure and A3 Poster)
These resources have been developed to help Aboriginal people understand more about cancer. The brochure provides information on:
- What cancer is
- How is cancer treated
- Myths about cancer
- Where to look for support
- Practical tips for people with cancer
- Survivor stories from Aboriginal people in WA

Making Time for Bowel Cancer Screening (DVD)
This 7 minute DVD includes everything you need to know about bowel cancer prevention. It is designed for use by individuals, organisations, health professionals, and community groups. It specifically provides Aboriginal men and women with information about bowel cancer, what it is, risk factors, reducing risk, the Faecal Occult Blood Test (FOBT) and The National Bowel Cancer Screening Program.

We’re here for you (bookmark)
The Cancer Council Helpline staff can provide information and support to cancer patients, families, and friends. They are available weekdays from 8am - 6pm on 13 11 20. This bookmark is a useful reference for Cancer Council Helpline services and is designed for individuals, organisations and community groups.

“A whispered sort of stuff”: A community report on research about Aboriginal people’s beliefs about cancer and experiences of cancer in Western Australia
This report about Aboriginal people’s experiences of cancer and cancer services written by Professor Sandy Thompson, Dr Shaouli Shahid, Heath Greville and Associate Professor Dawn Bessarab summarises the findings from a research project investigating Aboriginal people’s experiences of cancer in Western Australia. It provides important recommendations for health and other service providers about how cancer-related services for Aboriginal people should be improved.

Aboriginal Cancer Journeys (A5 booklet and factsheets)
Cancer Council NSW and the Aboriginal Health & Medical Research Council have developed a series of fact sheets that provide easy-to-read information about cancer, its treatment and side effects. These include:
- What is cancer?
- Making treatment decisions
- Natural therapies and cancer
- Cancer treatment
- Practical information for people having cancer treatment
- Talking about cancer
- Looking after someone with cancer
- What is palliative care?

Aboriginal resources order form & tax invoice
Cancer Council WA
Education and Research Division
15 Bedbrook Place
Shenton Park WA 6008
Phone: (08) 9388 4363 or 9388 4362
Fax: (08) 9388 4399
Email: resourceofficer@cancerwa.asn.au

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