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Cancer Matters is published as a service to all WA health professionals, supporters and interest groups.

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Vale Paul Katris

It is with great sadness that we bid farewell to our colleague and dear friend, Paul Katris, who suddenly and unexpectedly passed away on Saturday 18 November 2017.

Many of you would know that Paul had been with Cancer Council WA for more than 20 years in the role of Executive Officer of WACOG and was an active member of the COSA (Clinical Oncology Society of Australia) Council as Chair of the Complementary Therapies Group.



Paul had completed this edition of Cancer Matters and we have decided to honour his legacy by publishing it as he had intended.

Paul was a well-respected and tireless advocate for health professional education and cancer control, which has had a profound impact not only here in Western Australia, but across the country and internationally. His efforts in inclusive health professional education helped to make everyone involved in treating cancer patients in WA the best they could be.

We have been inundated with heart-felt messages from colleagues across the health community and it is clear that Paul has had an impact on so many people. We have compiled a number of these tributes on our website in his honour. You can read these by searching "Vale Paul Katris" at cancerwa.asn.au

I know I speak on behalf of many when I say Paul will be fondly remembered for his unmistakable presence and unmatched passion for bettering the lives of those affected by cancer.

We will honour Paul's memory by ensuring the work of WACOG continues and we thank you for your ongoing support in allowing us to do this.

Rest in peace, Paul.



Ashley Reid
CEO Cancer Council WA

Since 2012, cancer services in Western Australia have been guided by the WA Cancer Plan 2012 - 2017. The Plan's purpose is to improve health outcomes for West Australians diagnosed with cancer and reduce the overall incidence of cancer through prevention programs.

The Plan includes strategic activities listed under five priority areas to improve cancer control:

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

Figure 1.

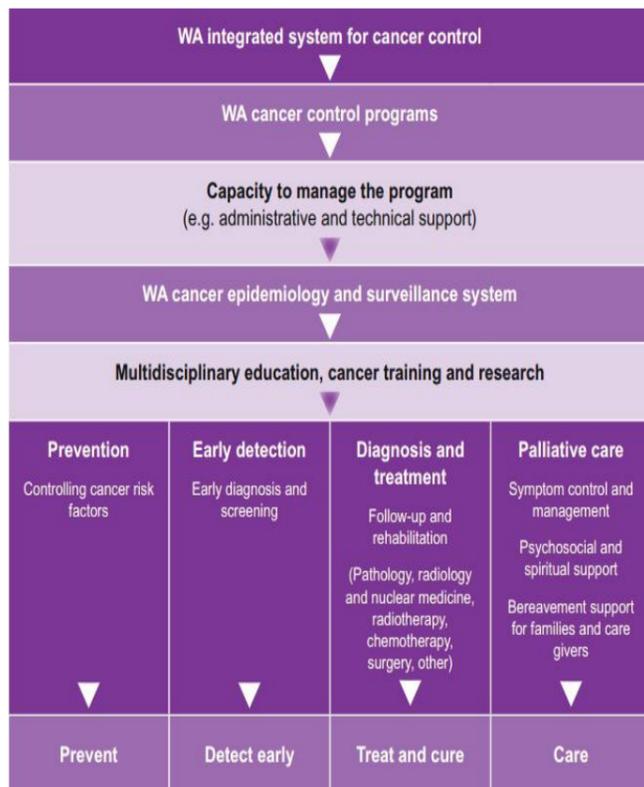


Image source - Western Australian cancer Plan 2012-2017, Department of Health WA Cancer and Palliative Care Network

The WA Cancer and Palliative Care Network is leading the development of the 2018 - 2023 WA Cancer Plan.

Figure 1 illustrates the cancer control spectrum, with pathways for cancer prevention, surveillance, early detection, diagnosis and treatment, rehabilitation and palliative care, and focuses on timely, planned and balanced investments to improve conditions and outcomes for cancer patients.

Each pathway should involve all relevant health professionals within a multidisciplinary team looking at the entire cancer journey.

An integrated cancer control system needs to consider activities, programs, policies, capacities and infrastructure for each pathway.

Cancer planning principles

- Cancer control planning is necessary in any resource setting in order to respond to the cancer needs in populations by preventing cancer, detecting it early, curing it and caring for people affected by it.
- With careful planning, a substantial degree of cancer control can be achieved, even where resources are limited. Without careful planning, there is a risk that the resources available for cancer control will be used inefficiently, and that the benefits to the population that should flow from these resources will not be realised.
- Change is unlikely to occur in the absence of external stimuli.

'Plans are only good intentions unless they immediately denigrate into hard work'.

Peter Ferdinand Drucker, Austrian-born American management consultant, educator and author, 1909-2005

More information

For further information on how you can be involved in shaping the 2018 - 2023 WA Cancer Plan, contact:

wacpcancerplan2018@health.wa.gov.au

or phone Vince Rettura of the WA Cancer and Palliative Care Network on **9222 0202**

Cancer clusters

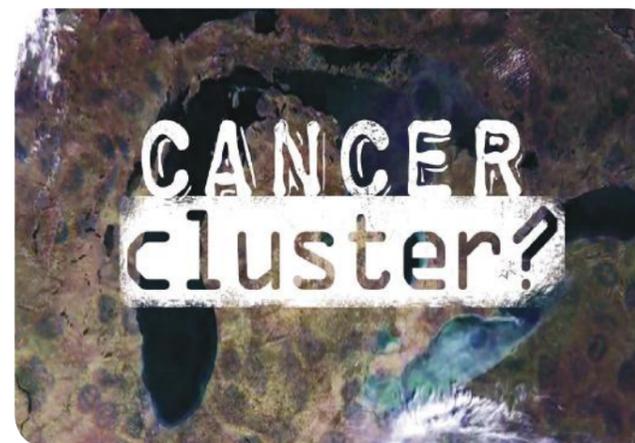


Image - wwmt.com

Cancer clusters get a lot of attention in the media, both in the news and in movies. Many suspected cancer clusters are reported to State health departments each year. But just what is a cancer cluster?

People may become concerned that a cancer cluster exists when there is a perceived higher than normal number of cases of cancer in a certain community. Often there is a concern that the cancer is caused by some type of carcinogen (cancer-causing agent) that is being released into the environment.

Scientists have a specific definition of a cancer cluster. The US Centers for Disease Control and Prevention (CDC), the National Cancer Institute, Cancer Australia, Department of Health and the NHMRC all say that a cancer cluster is a "greater-than-expected number of cancer cases that occurs within a group of people in a defined geographic area over a period of time."

The identification of a cluster using this definition does not necessarily imply that there is a causal agent, because cancer events can occur by chance. It does, however, indicate the need to assess whether the cluster can be related to factors other than chance.

In order to see if there is a greater number of cancers than expected, the number of cases seen is compared to what is typically seen in a similar group - such as a group with the same age, gender and ethnicity. The cancers should either be all of the same type or types of cancer that are known to have the same cause.

If these cases of cancer do not seem to be random, they may need to be looked at more closely to find out if they are due to the same cause or carcinogen. Studying cancer clusters allows scientists to identify areas of increased cancer risk as well as try to figure out what is causing the increase in risk. For example, studying clusters of malignant mesothelioma led to the discovery of the link between asbestos exposure and this rare cancer.

The WA Department of Health's publication *Healthview* states 'People who fear they may be at risk from cancer-causing agents in their workplace or neighbourhood can now find detailed information about cancer clusters on the WA Health website.

This follows the online publication of *Guidelines for the Investigation of Cancer Clusters in Western Australia*.

The comprehensive document is located on the main WA Health website and is supported by user-friendly information on the Healthy WA website.

Although cancer clusters can occur by chance and those involving a common environmental agent are extremely rare, it can be important to establish whether or not there is an ongoing risk to the population involved.

WA Health's cancer cluster guidelines detail how and where to report a suspected cancer cluster, how to assess whether a spate of cases is worth reporting and how suspected clusters are investigated.

Principal Epidemiologist at the Department of Health Peter Somerford says the guidelines and supporting consumer information are an important resource for anybody who has concerns about a suspected cancer cluster.

"I think many people who go to our website to read about cancer clusters will find the information ends up allaying their concerns," he says. "That's because it highlights just how common cancer is - and conversely, how extremely rare cancer clusters are."

To read more about cancer clusters visit - bit.ly/2x98UnJ

More information

National Health and Medical Research Council (NHMRC) has released a position statement to provide information about the assessment and management of cancer clusters. The statement is intended to support guidelines issued by State and Territory Health Departments and Cancer Councils.

To view the NHMRC Position statement visit - bit.ly/2w4p0dB



Endometrial cancer

Women to gain from new endometrial cancer treatment.

WA women with endometrial cancer are taking part in the Australian trial of a treatment that can delay the need for radical surgery.

Endometrial cancer is the most common gynaecological cancer and is diagnosed in 2400 Australian women each year.

The standard treatment is a total hysterectomy as well as removing ovaries and fallopian tubes.

But some patients have medical conditions that makes surgery risky at the time of diagnosis, or younger women may want to postpone surgery until they have had children.

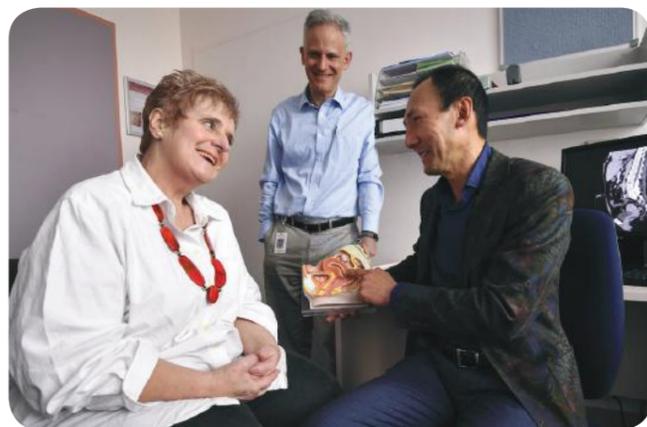
Doctors believe an alternative treatment can safely allow women to delay surgery without jeopardising their cancer outcome.

A trial known as the *Femme* study is looking at treatment combinations, including a hormone-releasing intra-uterine device, the diabetes drug metformin and a weight loss program.

Gynaecologists at King Edward Memorial Hospital have been recruiting women into the study since last year. Principal Investigator Professor Yee Leung said the study had shown promising results.

“What we have found is that this treatment can act as a bridge, to get patients to the point where they have achieved a pregnancy or optimised their medical condition,” he said. “Some women lose weight on the treatment which can put them in a far better place when they eventually have surgery.”

Lyn Dyke was diagnosed with endometrial cancer last year, and because of her cardiovascular complications doctors wanted to delay surgery. She went on the *Femme* trial and has since lost 12kg, now making surgery a safer option.



Cancer patient Lyn Dyke with Dr Paul Cohen and Professor Yee Leung. Picture: Ian Munro

“It’s actually been a really good thing for me and I know if I go on to have a hysterectomy I will be in better shape for it,” she said.

Text Adapted from *The West Australian* Cathy O’Leary, Medical Editor, Friday 21 July 2017

WA Statistics

In 2014 there were 198 cases of uterine cancer resulting in a 1 in 78 chance of developing the disease by the age of 75. In the same year, there were 25 deaths due to cancer of the uterus resulting in a mortality risk of one in 808.

Optimal Care Pathways

The optimal cancer care pathways (OCPs) describe the optimal cancer care for specific tumour types. They map the patient journey, aiming to foster an understanding of the whole pathway and its distinct components to promote quality cancer care and patient experiences.

It describes the optimal care that should be provided at each step of the cancer pathway.

To view the Optimal Care Pathways for Endometrial Cancer visit - bit.ly/2eE10rq.



Australian Government
Cancer Australia

More information

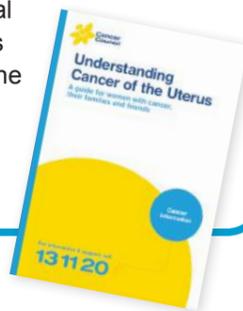
Cancer Australia’s *Clinical practice guidelines for the treatment and management of endometrial cancer*



Visit - bit.ly/2gofu3d

Cancer Council’s booklet *Understanding Cancer of the Uterus* has been prepared to help people understand more about cancer of the uterus also called uterine cancer, womb cancer, cancer of the lining of the womb or endometrial cancer. In this booklet, the terms “cancer of the uterus” and “uterine cancer” are used.

To download the booklet visit - bit.ly/2xQYLvS

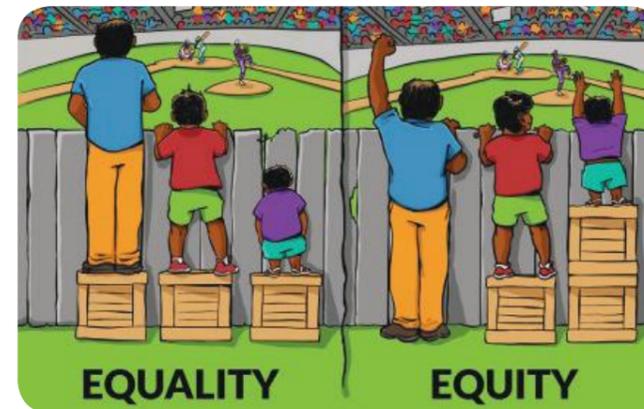


Equity vs Equality - working towards Making Smoking History

Despite tobacco smoking rates in the general population now being at an all-time low, it is the most socially and financially disadvantaged members of our community that remain the most affected by tobacco. In turn people experiencing social and financial disadvantage carry an unfair burden of tobacco-related diseases, death and financial stress.

To understand and reduce high smoking rates among people experiencing social and financial disadvantage, we need to first understand the difference between equality and equity.

Equality and equity are often used interchangeably but they are not the same thing. Over recent years you may have seen different versions of the below graphic circulating the web attempting to explain the two concepts.



[Interaction Institute for Social Change](http://InteractionInstitute.org) | Artist: Angus Maguire

While both are strategies to achieve fairness, as the gap between the rich and poor increases in Australia, it is important we understand their definitions and get this conversation right. Equality is about giving everyone the same thing. In the graphic this is equal access to the same number of crates. However, equality only works if everyone is starting from the same position (i.e. we have access to the same education, health, employment opportunities etc.). Like the example demonstrates, equality does not work when people are starting from different situations to begin with. Equity is about making sure that everybody has what they need to improve the quality of their individual situation. It recognises that people’s contexts are different and some people may need more support to achieve the same objective as everyone else. This is because they are not starting from the same position to begin with, and/or are faced with additional barriers. In the graphic this is demonstrated by some people requiring access to more crates than others to see over the fence. Likewise, some people may need additional support to live healthy smoke free lives.

Health inequities - Looking beyond the individual

The often, uncontrollable socioeconomic, cultural and environmental conditions that people live and work in, can influence people’s behaviour both positively and negatively. Often it is the social environment (i.e. low levels of education, access to stable employment, housing etc.) that leads to the behaviour (i.e. smoking) which causes the problem (i.e. death, disease and financial stress).

This means that the circumstances that people face make it more likely that they will take up smoking and face more barriers to quitting.

As a result, it is the most socially and financially disadvantaged members of our community that carry a larger burden of tobacco-related disease, death and financial stress.

Conversely, when people have access to stable accommodation, healthcare, education and employment they are less likely to take up risky lifestyle behaviours like tobacco smoking.

Providing equitable access to support

Using this concept of equity we recognise that people experiencing social and financial disadvantages who smoke may face additional barriers to quitting and therefore, may require additional support to live healthy smoke free lives. That is why Cancer Council WA is partnering with community service organisations, to ensure that we provide appropriate support for those that need it most.

We know that people experiencing social and financial disadvantage are less likely to be asked about their smoking, and offered support to cut down and quit from health and other service providers. In partnership with community service organisations, we are working to change this!

Let’s leave no one behind

To achieve equitable access to support and leave no one behind we call on everyone working in health and community services to be part of the solution, and help break the cycle of smoking and disadvantage. It is only then that we can work towards making smoking history for all.

We encourage you to visit the Make Smoking History for Community Services website for more information makesmokinghistory.org.au/communityservices.

The Make Smoking History team can also be contacted via email makesmokinghistory@cancerwa.asn.au or via phone on **9388 4309**.

Article by Lorena Chapman and Emily Box, Make Smoking History team, Cancer Council WA.

Survival rate jumps for WA cancer patients

The chances of surviving have increased dramatically over recent decades.

There has been an overall increase in relative survival for all West Australian cancer patients from 52 per cent between 1985 - 1989 compared to 70 per cent in the most recent period 2010 - 2014. This nearly 20 per cent increase in the relative survival rate over the six five-year periods is largely attributable to:

- Earlier detection of cancer via national screening programs (e.g. breast, colorectal).
- Greater education about and awareness of possible cancer-related signs and symptoms.
- Advances in medical treatments.

Women are still surviving longer, with 71 per cent of females who get cancer likely to live five or more years after diagnosis.

However, the gender divide has narrowed since 1985, when less than half of men survived cancer beyond five years.

Common cancers with the best relative survival rates are prostate cancer, with 97 per cent of men alive after five years, and breast cancer in women, with 92 per cent survival.

‘But lung cancer remains one of the cancers with the poorest survival outcomes, with only 16 per cent of men and 23 per cent of women alive five years after diagnosis.

The data is the first in a series of reports known as *The Cancer Effect* by the WA Health Department’s Cancer Registry.

Cancer Council WA Director of Education and Research Terry Slevin said: “The overall story for cancer survival is pretty impressive.

“From the mid-1980s, we’ve gone from a five-year survival rate of just over half to getting close to three-quarters.”

“It reflects the reality of cancer - that things don’t move quickly and that interventions take at least a decade to show up, so it’s a marathon not a sprint.”

Mr Slevin said the report also showed where more work was needed, particularly in cancers that were common but still had a poor prognosis.

“The stand-out is lung cancer, which hasn’t followed the same path of improvement as other cancers, but even with colorectal cancer where we have the expertise and technology in terms of screening we should be doing better.”



Cancer Survivorship

The Clinical Oncology Society of Australia has released a Model of Survivorship Care that comprises how it is done (survivor centred, integrated care across all service levels at every time point and coordinated care), what is done (promote, prevent, manage) and availability of care (accessible and equitable).

To read the: Model of Survivorship Care, Critical Components of Cancer Survivorship Care in Australia visit - bit.ly/2mPaKRY

More information

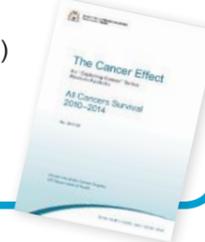
The Cancer Effect: An Exploring Cancer Series documents key cancer facts, beginning with this first publication that reviews five - year relative survival outcomes, and changes in relative survival over time, in Western Australia.

A range of factors influence survival from cancer, including the demographic characteristics of the patient (e.g. age, sex and genetics), the nature of the tumour (e.g. site, stage at diagnosis and histology type) and the health care system (e.g. the availability of health care services, screening, diagnostic and treatment facilities, and follow-up services).

Section two provides information about how relative survival is determined.

This release provides broad indications of relative survival across all cancers in Section three. Subsequent releases will provide specific information for specific cancers (e.g. breast, prostate, lung, melanoma etc.)

To read The Cancer Effect visit - bit.ly/2vKC3pi



Perils of alternative medicine for cancer survival

Alternative medicine is a hugely popular choice for many Australians, with one in three taking some kind of alternative remedy – but new data shows that rejecting conventional medicine when faced with a cancer diagnosis is extremely risky.

Choosing alternative medicine (AM) to treat curable cancer instead of conventional cancer treatments more than doubles ones risk of dying in five years, according to a new study. Delay or refusal of conventional cancer treatment (CCT), when done in favour of alternative medicine (AM), may have serious survival implications for cancer patients.

AM is defined as unproven treatments administered by non-medical practitioners. They bypass conventional care - notably chemotherapy, radiotherapy, surgery and hormone therapy.

A recent Yale School of Medicine (New Haven, Connecticut) study looked at the outcomes of 281 patients with breast, prostate, lung and bowel cancer who chose alternative medicine as their sole anti-cancer treatment. Independent covariates on multi-variable logistic regression associated with increased likelihood of AM use included breast or lung cancer, higher socioeconomic status, remote location, stage II or III disease, and low comorbidity score.

AM use was independently associated with greater risk of death compared with CCT overall and in sub-groups with breast, lung, and colorectal cancer. Although rare, AM utilisation for curable cancer without any CCT is associated with greater risk of death.

“We now have evidence to suggest that using alternative medicine in place of proven cancer therapies results in worse survival,” says lead research and oncologist, Skyler Johnson. “It is our hope that this information can be used by patients and physicians when discussing the impact of cancer treatment decisions on survival.”

The team acknowledges that the research didn’t examine which particular alternative medicines were taken by the patients studied – and there’s no inference that all alternative approaches are equally effective or ineffective. “They could be herbs, botanicals, homeopathy, special diets, or energy crystals, which are basically just stones that people believe have healing powers,” Johnson said in an interview with *New Scientist*.

Article Reference: Use of Alternative Medicine for Cancer and Its Impact on Survival (SJohnson, Park, et.al.) JNCI: *Journal of the National Cancer Institute*, Volume 110, Issue 1, 1 January 2018

The Clinical Oncology Society of Australia (COSA) has published a position statement on the use of Complementary and Alternative Medicine (CAM) by cancer patients and provides guidance



for health professionals involved with the treatment of cancer patients who are using or wish to use CAM. Key definitions and common communication scenarios are presented along with evidence-based recommended steps for health professionals when discussing CAM use.

COSA encourages health professionals to focus on open discussion with their patients regarding CAM, to become familiar with reputable resources for CAM information, to discuss with patients the concept of evidence-based medicine, to recognise limitations to their knowledge of CAM and seek further advice when necessary, and to be respectful of the patient’s right to autonomy.

To view the COSA position statement visit - bit.ly/2yru7Jp

Braun L, Harris J, Katris P, et.al., *Asia Pac J Clin Oncol*. 2014 Dec; 10 (4) :289-96.

More information

Cancer Council Australia Position Statement - Complementary and Alternative Therapies



1. Support the right of individuals to seek information about complementary and alternative therapies and respecting their decision to use them, provided they are not at risk of being harmed.
2. Encourage people with cancer who are considering using non-conventional therapies to make an informed choice. This includes asking questions about the efficacy, risk, contraindications and the cost of the therapy, as well as the qualifications of the practitioner.
3. Encourage people with cancer to discuss with their healthcare provider any complementary or alternative therapies they are using or considering using, in order to minimise risk.
4. Encourage healthcare providers to routinely discuss the use of complementary and alternative therapies with all cancer patients and survivors, in an open and non-judgemental manner.

To read the Cancer Council Australia Position Statement visit - bit.ly/2wGbXRD

Radical reforms for rare cancer regulation

A radical new report offers the federal government a road map for addressing inequitable access to rare and less common cancer treatments.

More than 52,000 Australians are diagnosed with rare or less common (RLC) cancers and an estimated 25,000 people die from the conditions every year. RLC's are defined as cancers with fewer than six cases, and six to 12 cases per year per 100,000 population respectively.

The Rare Cancer Australia report - *Rare Solutions: A Time to Act* recommends radical reforms to research and treatment funding models, including provisional pharmaceutical benefits scheme listings and enrolling RLC cancer patients in clinical trials designed to investigate treatments for more common conditions. The current system was "hopelessly inequitable whichever way you crunch the numbers," said the chairman of Rare Cancers Australia, Richard Vines.

RLC's account for 30 per cent of all cancer diagnoses and almost 50 per cent of all cancer deaths, but attract just 13.5 per cent of research funding and 12.6 per cent of funding for treatments through the PBS. Medicines for rare cancers can be prohibitively expensive, with some RLC cancer patients having no alternative but to pay exorbitant sums for orphan drugs that attracted no government subsidies.

"Rare cancer patients pay taxes that are used to pay for drugs on the PBS to treat patients with more common cancers, then they have to pay full price for their own drugs," Mr Vines said. "The level of injustice is beyond comprehension".

The report delivered at the CanForum conference at Parliament House on August 9th urges the Australian government to invest in more local clinical trials for RLC cancers. "The fastest way to get serious treatment for RLC cancer patients is to increase government funding for clinical trials," Mr Vines said.

The report also proposed provisional PBS listings be introduced for medicines to treat RLC cancers where additional evidence of effectiveness was still needed.

Professor David Thomas, director at the Kinghorn Cancer Centre and head of the cancer division at the Garvan Institute, said trials needed to move away from classifications of cancer based on tissue biology – or which part of the body the cancer was located. Garvan's MoST Study uses genomic screening to identify variants that could become the basis for treatments, and whether effective therapies for more common cancer may work in rare cancers.

"We recommend the federal government nationalise this program so that it is accessible to all Australians in their own states," Professor Thomas said.

Mr Vines said meeting the benchmark of gold standard evidence for PBS listings was "almost impossible" for rare cancers with small patient populations and negligible incentives for pharmaceutical companies to fund them.

"Provisional PBS listings would enable researchers to monitor the drug's effects over time in a real world setting and see if it reasonably aligns with patient expectations".

"We can fix this, we just need to have the will," Mr Vines said.

The report also recommended:

- Pharmaceutical companies include RLC cancer indications when applying for TGA approvals and PBS listings for drugs to treat common cancers.
- RLC cancer patients join cohorts of clinical trials designed to test drugs for more common cancers and their data analysed and pooled with data into similar projects internationally.
- Australian trials be designed in consultation with the regulatory bodies to support drugs getting TGA approval and PBS listings for RLC cancers.
- Data collection systems including *My Health Record* be used to capture patient outcomes for provisional TGA and PBS drugs.

To view the report visit - bit.ly/2uBrXq4



More information

CART-WHEEL is the Centre for Analysis of Rare Tumors.

The Centre for Analysis of Rare Tumors is designed to collect information from people who have rare cancers/tumors. Using the CART-WHEEL rare tumor database, people from all over the world are able to register and fill out a privacy-protected, internet-based questionnaire which covers information ranging from tumour type and treatment received, to aspects of ones family history.

Clinicians can access their patient's cart-wheel.org accounts to view, enter and edit data, with the permission of their patient. This can be done by activating your own account. To request a cart-wheel.org account, please email contact@cart-wheel.org with your full name and preferred email address.

cart-wheel.org



Better psycho-social support and care



A cancer diagnosis can negatively impact not only on a physical level but an emotional level. The initial news can be overwhelming and difficult to take in for patients.

Some common reactions and feelings patients may experience include depression, shock, fear, anxiety, anger and loss of control, adjustment, trauma and relationship difficulties, just to name a few. It is important to remember that these are all normal reactions and that there is support available to help patients cope with their issues. However if these potentially distressing feelings persist professional assistance is recommended and available in WA.

Cancer Council provides a telephone cancer information and support service which can be reached on 13 11 20.

13 11 20 cancer nurses can offer the following services:

- Someone to talk to about immediate concerns.
- Information about cancer types and treatments.
- Links to other organisations and service that might be able to help.
- Referrals to Cancer Council WA services such as counselling, cancer support groups, mind-body complementary therapies such as yoga and mindfulness and touch-based therapies such as massage, hand and foot massage, reflexology, reiki, and exercise programs.
- Counselling - Cancer Council WA offers both face-to-face and telephone counselling services. These services are available in both metropolitan and regional WA through the subsidised Cancer Council Counselling Network. This Service aims to help people diagnosed with cancer and their families to develop new skills to cope with the impact of the cancer diagnosis.

For more information visit - cancerwa.asn.au/patients/support-and-services

More information and support



WA Psycho-Oncology Service

The Department of Health funds the WA Psycho-Oncology Service. It provides FREE clinical psychology care to adult Western Australians who are diagnosed with cancer and care-giving immediate family members.

Referral liaison, consultation and education services are offered to health workers, multidisciplinary cancer teams and services to help them enhance the psychosocial care they are providing to people affected by cancer.

A health worker referral is required to access the service. To access it visit - bit.ly/2ztDsi6

Cancer - how are you travelling?

This resource provides information about the emotional and social impact of cancer. It has been written for people diagnosed with cancer, their family and friends. To access it visit - bit.ly/2ynplx5

A summary guide for health professionals

Clinical practice guidelines for the psychosocial care of adults with cancer. To access it visit - bit.ly/2ztDsi6

The Better Access to Mental Health Care Initiative

Cancer patients experiencing psycho-social distress may access Medicare rebates for psychological treatment by registered psychologists under the Australian Government's Better Access to Mental Health Care initiative.

To access the Referral Form for Individual Allied Health Services under Medicare for patients with a chronic medical condition and complex care needs visit - bit.ly/2yPbq3w



Evidence review sees changes to cervical screening

WA Cervical Cancer Prevention Program

From 1 December 2017, women in Australia will have access to a new primary screening test that will help further reduce the impact of cervical cancer. The Pap smear, which has been the primary tool used to screen for cervical abnormalities for decades, is being replaced by a more effective cervical screening test. This is bringing about significant changes to the way cervical screening is delivered across the country.

The updates to cervical screening in Australia are the result of a comprehensive review (termed 'the Renewal') of the latest medical research, scientific developments and evidence relating to cervical cancer, conducted by the Renewal Steering Committee (RSC). The review led RSC to conclude that a human papillomavirus (HPV) test conducted every five years is more effective than, and just as safe as, screening with a Pap smear every two years. The changes to the National Cervical Screening Program (NCSP) are expected to result in a reduction in cervical cancer incidence and mortality of up to 30%.

What the program will look like?

When the renewed NCSP is introduced:

- The two-yearly Pap smear will be replaced by a five-yearly Cervical Screening Test. The test looks for the presence of HPV and, if found, a reflex liquid-based cytology (LBC) test is performed on the same sample to check for abnormal cervical cells.
- Women will still require a vaginal speculum examination to have a LBC sample taken from their cervix, similar to taking a conventional Pap smear.
- The commencement age for cervical screening will change to 25 years of age.
- Women will be eligible to cease screening after a negative HPV test between the ages of 70 and 74 years.
- Women with symptoms, such as pain or bleeding, can have a Cervical Screening Test at any age.
- A self-collection option will be available later in 2018 for women 30 years of age or over, who are under-screened (two or more years overdue for screening) or have never screened and have declined invitations and reminders for a provider-collected cervical sample.
- A new National Cancer Screening Register will send invitations to screen, routine reminder letters to women when they are next due or are overdue, and follow-up letters when women have not attended when further investigations or tests were recommended.
- A reduction in lifetime screening tests for women from 26 to 9-10.

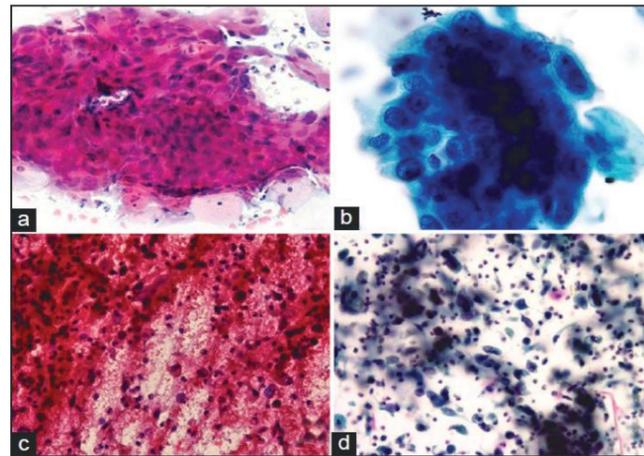


Figure 1: Split sample.
Liquid-based cytology versus conventional cytology for evaluation of cervical Pap smears
(a and b) **High grade squamous intraepithelial lesion** (a - conventional Pap smear, x40), (b - liquid-based cytology, x100).
(c and d) **Squamous cell carcinoma** (c - conventional Pap smear, x40), (d - liquid-based cytology, x40)

What will the Cervical Screening Test include?

The Cervical Screening Test detects infection with HPV. Partial genotyping is used to determine the type of HPV into one of two groups: oncogenic HPV 16/18 or oncogenic HPV types other than 16/18 as a pooled result.

Reflex LBC is applied to all HPV positive samples and is used to triage women who test positive for HPV types other than 16/18.

Based on the test result:

- Women who test negative for HPV will be invited to screen again in five years (low risk).
- Women who test positive for high-risk HPV (types 16 and/or 18) are referred to colposcopy regardless of their reflex LBC result (higher risk).
- Women who test positive for other types of HPV, the reflex LBC result is used to determine management as follows:
 - A possible or definite high-grade squamous intraepithelial lesion (HSIL) and/or any possible or definite glandular abnormality will be referred to colposcopy (higher risk).
 - Negative cytology or a possible or definite low-grade intraepithelial lesion (LSIL) will be referred for a repeat HPV test in 12 months (intermediate risk).

Transitioning to the new cervical screening pathway:

- From 1 December 2017, most women will be due for their first Cervical Screening Test two years after their last negative Pap smear.

- New clinical management guidelines and online training have been developed by Cancer Council Australia. The NCSP: Guidelines for the Management of Screen Detected Abnormalities, Screening in Specific Populations and Investigation of Abnormal Vaginal Bleeding (2016 Guidelines) are available at wiki.cancer.org.au/australia/Guidelines:Cervical_cancer/Screening.
- NPS MedicineWise has developed online training modules for the new Cervical Screening Test. Visit - nps.org.au.
- Communications (including supporting resources) and stakeholder engagement activities regarding the renewed NCSP will occur over the coming months.

To find out more about the Renewal of the NCSP, please visit - cancerscreening.gov.au.

The link between HPV and cervical cancer

Nearly all cervical cancers are caused by chronic HPV infection. HPV is easily transmitted via skin contact during sexual activity. It is extremely common in men and women who have ever been sexually active, with most people being infected with at least one type of HPV at some point in their life. While HPV infections are normally cleared naturally by the immune system, sometimes they cause cervical cells to become abnormal. The body is usually able to rid itself of HPV and the abnormal cells, but in some cases this doesn't happen and the abnormal cells develop into cervical cancer.

The time from HPV infection to cervical cancer is usually 10-15 years.

HPV types 16 and 18 cause more than 70% of cervical cancers in Australia. The HPV vaccine protects against both these types; however, it does not protect against other oncogenic types of HPV known to cause cervical cancer. Therefore, vaccinated women need to participate in regular cervical screening as they are still at risk of cervical cancer from these other high-risk HPV types.

Carcinoma of the cervix: staging cervical cancer (primary tumour and metastases)

In Australia, staging for cervical cancer is done using a system developed by the International Federation of Gynaecology and Obstetrics. It describes cervical cancer stages as:

Stage 0: Abnormal cells are found only in the first layer of the cells lining the cervix.

Stage 1: The cancer is found only in the tissues of the cervix.

Stage 2: The tumour has spread beyond the cervix to the vagina and tissues next to the cervix.

Stage 3: The tumour has spread throughout the pelvic area.

Stage 4: The tumour has spread beyond the pelvic area to nearby organs such as the bladder or rectum. The tumour may also have spread to the lung, liver or bones, although this is uncommon.

Recurrent: If the cancer comes back after initial treatment, this is known as recurrent cancer. Cervical cancer may come back in the cervix or in another part of the body.

Figure - Cervical cancer staging

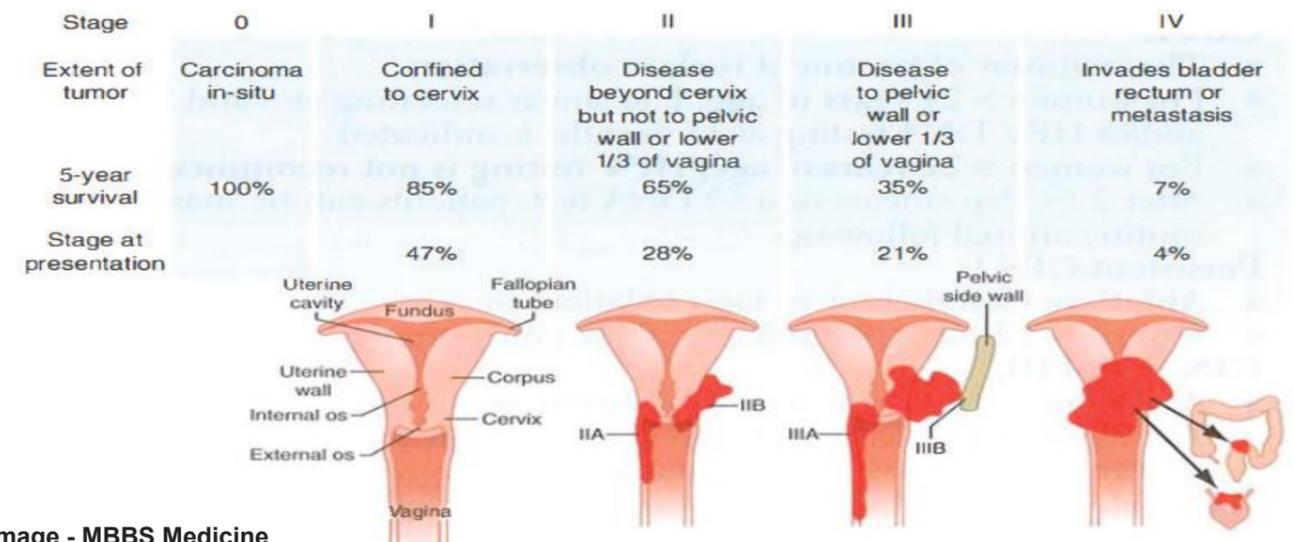


Image - MBBS Medicine

Linear clinical research

Phase I Treatment Options For Western Australian Patients

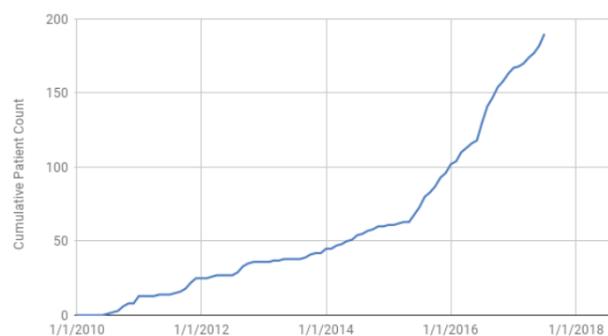


Linear Clinical Research Limited is an early phase clinical trials facility; the only one in Western Australia and the most advanced facility of its kind in Australia. Linear was founded by the Harry Perkins Institute of Medical Research in 2010 and built through funds provided by the Western Australian Government.

Linear recognised a growing demand for oncology studies combined with an increasing interest from its engaged investigator network. In August 2015, a dedicated oncology team was established and has grown to include haematology and medical oncology consultants, an oncology fellow, project manager, four teams of clinical trial coordinators and assistants, a start-up and HREC coordinator and a quality assurance officer.

Linear's Mission and Impact in Oncology is to provide West Australian patients with treatment options otherwise not available. They strive to build collaborative partnerships with researchers and have successfully recruited over 190 patients into phase I trials, of which 120 was enrolled since August 2015. This accelerated recruitment is evident in the table presented.

Cumulative Oncology Patient Enrolments



Why do Global BioPharma work with Linear?

With an ability to start a study within 4-6 weeks of ethics submission, they develop a strong partnership with sponsors like Beigene, Atridia and Bristol Myer Squibb and other Biotech companies.

How to get involved?

Linear encourages our WA oncologists to consider phase I clinical trials as a treatment option for patients. The escalation part of a phase I trial is usually open to all solid tumour and the expansion part is aimed at certain disease areas. Potential patients can be referred to Prof Michael Millward, Dr Tarek Meniawy or Dr Annette Lim for review. Patients in referral for a phase I trial must have a life expectancy of 12 weeks or more and a performance status of 0-1.

Local Support

Linear were honoured with an impromptu visit by the Honourable Julie Bishop on the 27th of July. There were some great discussions about the innovative clinical trials conducted at Linear and pioneering clinical research in Perth.

Visit - linear.org.au



linear *nurturing medical breakthroughs*

More information

WA Cancer Clinical Trials Registry

WACOG maintains an online register listing of cancer clinical trials open in Western Australian hospitals.

The registry includes trials from a wide range of cancer treatment areas including chemotherapy, radiation methods, surgical procedures, preventive measures and lifestyle.

The registry can be accessed at - bit.ly/2xKxp6A



Cancer genetics

The \$6400 question as retail genome sequencing launches in Australia

With a pricetag of \$6400, whole genome sequencing is now being offered to the Australian public by the Garvan Institute's Genome.One lab in Sydney.

The private clinic has launched a commercial service that claims to provide genetic insights to a person's responses to 220 medications and future risk of developing 31 types of cancer and 13 heart conditions.

The genome sequencing will look at variants of 230 genes (humans have about 20,000) linked to increased risk for conditions including the following that are oncology related:

- Ovarian, endometrial and breast cancer.
- Bowel, pancreatic and prostate cancer.
- Meningioma and retinoblastoma.
- Hereditary leiomyomatosis and renal cell cancer.

According to Genome.One, the \$6400 fee will cover genetic counselling and a comprehensive health assessment as well as the genome sequencing.

Individuals will undergo a physical examination, physiology review and analysis, extensive pathology testing, health coaching and advice under the guidance of a GP, a dietitian and an exercise physiologist, it says.

"These factors together with the added genetic insight provide a more complete picture than has previously been possible and can empower individuals to take control and more proactively manage their health," says John Hall, CEO of Life First, a private health assessment clinic that is working in conjunction with Genome.One.

However, the launch follows warnings by geneticists and public health experts that so-called 'retail' genetic tests are causing consumers to worry over unnecessary investigations.

Dr Nicholas Pachter, a Clinical Geneticist who heads the Familial Cancer Program at Genetic Services of Western Australia stated - "As Geneticists, we're not happy with this sort of testing. We are not ready for it. There are so many so-called mutations that may not cause disease if found in the absence of clinical features or family history.

These findings may create a cohort of worried well people who are undergoing expensive, harmful and time-consuming investigations that may prove unnecessary in the long run.



What is familial cancer?

As cancer is common, a number of people in the same family may have cancer by chance alone. Only a small number of cancers (approximately one in 20, or 5%) are caused by a gene fault that may be inherited and passed down through the family. Individuals, and members of their family, may be at increased risk of cancer if they have:

- Familial clustering of a specific cancer, for example bowel or breast, particularly with 2 or more affected first degree relatives with a young age of onset (less than 50 for colorectal or ovarian, less than 40 for breast cancer).
- relatives with more than one primary cancer (not a recurrence of the same cancer).
- several relatives on the same side of the family who develop cancer.
- a relative with a genetic condition that increases his or her risk of cancer.

More information

The Department of Health WA Familial Cancer Program at King Edward Memorial Hospital can:

- Provide information about inherited cancers.
- Assess risk of developing an inherited cancer based on medical and family history.
- Assess whether genetic testing may be an option for a family.
- Recommend screening and risk management options.
- Discuss lifestyle strategies to foster good health and reduce risk of developing cancer.

Tel: (08) 6458 1603

Fax: (08) 6458 1725

Email: fcp@health.wa.gov.au

kemh.health.wa.gov.au/services/genetics/index



Cell sequencing centre for cancer

Western Australia is set to be at the forefront of advanced cancer research with the establishment of a unique cancer sequencing centre led by Perkins researcher Professor Alistair Forrest.

The Cancer Research Trust recently announced \$13.5 million in funding for cancer research, spread over 9 years, \$6.75 million of which has been awarded for the ground-breaking new facility which will deliver major insights into tumour biology, cancer progression, methods for earlier detection and innovative new ways to kill cancer cells.

Professor Alistair Forrest, a former Australian Eureka Prize recipient, and his multi-disciplinary team of scientists and clinicians will establish a world-class single-cell sequencing facility at the Harry Perkins Institute of Medical Research. The facility will generate a molecular atlas of hundreds of cancer samples donated by patients - a resource which will help researchers uncover which genes are switched on and off in every cell within a tumour.

Tumours are made up of thousands of different cell types, each with a variety of mutations that cause the cell to resist immune intervention and spread out of control. Professor Forrest said that rather than treating cancers with a broad-brush approach, the centre will allow researchers to use cutting-edge new technology to study tumours at a single cell level.

"To fight cancer, we need to understand how it develops at the single cell level, which is now possible courtesy of major advances in technology," Professor Forrest said. Perkins Director, Professor Peter Leedman, said he anticipates the facility will lead to greatly improved personalised medicine, where a researcher can catalogue the different cells that make up a patient's unique cancer, allowing for treatments to be tailored to each individual.

"This project will revolutionise cancer research in Western Australia and will have fundamental impacts on treatments for and early diagnosis of cancer" Professor Leedman said.

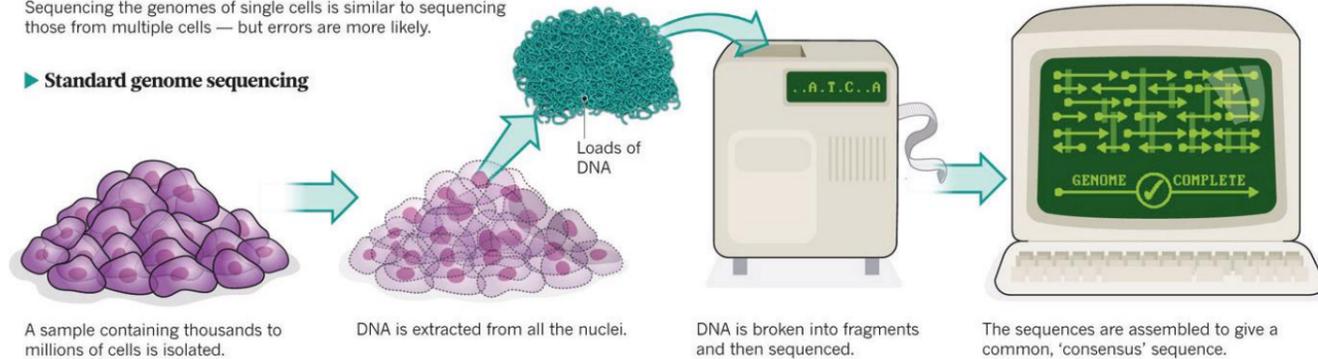
Funding for the centre has also come from Cancer Council WA, The University of Western Australia, Telethon Kids Institute, Edith Cowan University and Harry Perkins Institute of Medical research to bring the total funding for the centre to \$9 million. The project is a large-scale collaborative syndicate uniting cancer researchers across Perth, with 18 institutions including numerous medical research institutes, four universities, major hospitals and the WA Department of Health involved.

Single cell sequencing examines the sequence information from individual cells with optimised next generation sequencing (NGS) technologies, providing a higher resolution of cellular differences and a better understanding of the function of an individual cell in the context of its microenvironment.

ONE GENOME FROM MANY

Sequencing the genomes of single cells is similar to sequencing those from multiple cells — but errors are more likely.

Standard genome sequencing



Single-cell sequencing

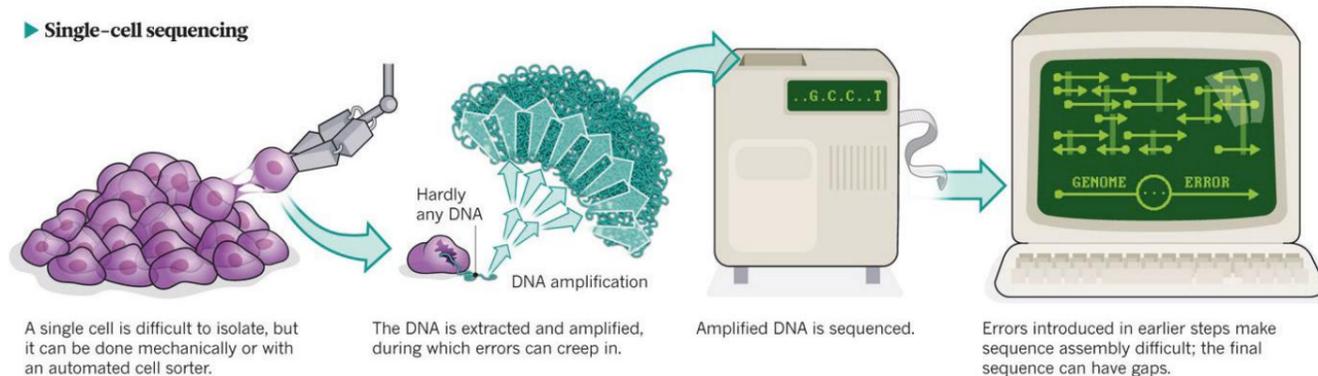


Image Source – Nature

Aiming to improve childhood brain cancer survival

A new clinical trial that could transform paediatric brain cancer outcomes has been fast-tracked to commence recruitment of eligible children in Australia.

The Federal Government announced the Access to Innovative Molecular profiling for BRAIN cancers (AIM BRAIN) in August.

The international collaborative trial, which is funded jointly by the Federal Government through Cancer Australia and the Robert Connor Dawes Foundation, will be available to children in Australia from 31 October 2017.

Dr Helen Zorbas, CEO, Cancer Australia, said that establishing AIM BRAIN in Australia, under the auspices of ANZCHOG*, will build expertise and establish technology in Australia to enable diagnostic molecular profiling of children with brain cancer.

The AIM BRAIN project helps doctors better understand individual types of tumours. With better understanding, treatments can be better tailored to the individual, brain tumour battlers increase their odds of beating the cancer and in some cases, not risk being over treated.

"Molecular profiling gives us a more sophisticated and accurate understanding of cancer including the characteristics of brain subtypes, mechanisms which may drive tumour growth and reasons for variations in drug responsiveness," Dr Zorbas said. "This will refine the diagnosis of the tumour and ensure treatment is tailored for the best possible outcomes for each child with brain cancer."

It is estimated that 94 children will be diagnosed with brain cancer in Australia in 2017. Brain cancer is the leading cause of total cancer burden in children under 15 years in Australia.

"This ground-breaking new trial will build capacity in Australia to contribute to collaborative international efforts, accelerate Australia's capability to undertake molecular diagnostic testing for paediatric cancers and ensure that Australia remains at the forefront of breakthrough initiatives...This partnership between government and philanthropic funding will deliver technology to benefit children with brain cancer in Australia," said Dr Zorbas.



Dr Nick Gottardo (with medulloblastoma survivor, Chloe) Photo: Cancer Council WA

The West Australian arm of the initiative will be led by Dr Nick Gottardo, Co-Head of the Telethon Kids Institute's Brain Tumour Research Team and a Consultant Paediatric Oncologist/Neuro-Oncologist and Head of Department of Paediatric Oncology and Haematology at Princess Margaret Hospital for Children. "This form of testing is at the forefront of technology around the world, and we believe it will become the gold standard for brain tumour classification," said Dr Gottardo.

For more info on the AIM project visit - rcdfoundation.org/aim-brain

More information

Cancer Australia's Children's Cancer website provides information about the types of cancers affecting children, treatment, living with cancer, where to find support, and clinical trials.

This website brings together a range of evidence-based information on children's cancers for families and carers, health professionals and researchers.

childrenscancer.canceraustralia.gov.au



Important news about the WA Melanoma Advisory Service



The WA Melanoma Advisory Service has merged with the Kirkbride Melanoma Centre to create the WA Kirkbride Melanoma Advisory Service (WAKMAS). The name has changed to WA Kirkbride Melanoma Advisory Service and from January 1st 2018 will be located at the Harry Perkins Institute of Medical Research at QEII Medical Centre.

The service will remain unchanged for the next 12 months. WAKMAS provides free information and advice to patients and doctors about melanoma.

A panel of specialists made up of anatomical pathologists, dermatologists, plastic surgeons, medical and radiation oncologists meet together to determine how to treat a particular melanoma condition.

Who is able to be referred?

Patients with a confirmed diagnosis of melanoma after biopsy of the lesion, or with metastatic melanoma are able to be seen at the clinic.

Patients with thin melanomas (<1mm thickness) without complications, are not routinely reviewed unless the referring practitioner specifically requests this.

Information for referring doctors

WAKMAS provides comprehensive advice regarding the management of complex, advanced and metastatic melanoma. This includes the adequacy of surgical margins of excision for primary melanomas, the role for further investigations and staging (including sentinel node biopsy and PET scanning), the need for adjuvant therapy and information regarding prognosis.

New Contact details (from 1/01/18)
Telephone: 08 6151 0860
Facsimilie: 08 6151 1032
Email: wakmas@perkins.org.au
Website: wamas.org.au.

WACOG

420 Bagot Rd
Subiaco WA 6008
T: +61 8 9212 4333
E: wacog@cancerwa.asn.au

cancerwa.asn.au/professionals/wacog

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To subscribe, comment or to contribute, contact us.

Communication Skills Workshops Cancer Clinicians Communication Program - 'Eliciting and responding to emotional cues'

2018 Dates

February - Wed 14 or Tues 27

March - Wed 14 or Thurs 29

April - Thurs 5 or Tues 17

May - Wed 9 or Thurs 24

June - Thurs 7 or Wed 20

8.30am - 1.00pm

McCusker Auditorium - Harry Perkins Institute of Medical Research, QE II, SCGH.

Targeting - Doctors, Registered Nurses, Enrolled Nurses, Allied Health Professionals working in oncology and palliative care.

Undertaking CCCP Communication skills training can:

- Enhance their communication skills and improve your resilience
- Allows them to discuss difficult issues more effectively with patients, their families and friends
- Improve patient understanding and satisfaction, facilitating shorter consultation times

This training involves experiential scenarios with a simulated patient (actor) so one can practise and receive feedback on their skills in a safe learning environment.

This experiential, interactive workshop is facilitated by trained CCCP Facilitators and Simulated Patients.

Cost \$100 (inc GST)

Online Registration - bit.ly/pasce1

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