

DAILY DIGEST

A selection of articles
based on yesterday's
presentations

AUSTRALIAN DOCTOR

COSA 50th Annual Scientific Meeting, 1-3 November 2023, Melbourne

Convenor's welcome to the 50th COSA ASM

THIS is COSA's 50th ASM and I'm delighted that it's being hosted in my hometown of Melbourne. The meeting marks 50 years of COSA thriving as the peak multidisciplinary cancer society, so there's lots of innovation and progress to celebrate!

As everyone knows by now, we have a strong focus on breast and gynaecological cancers this year. It's an opportunity to develop a common vision of where we expect cancer care to be going in the future.

In my role as 2023 ASM convener, I had the honour of working closely with COSA's Marie Malica and Fran Doughton and their colleagues. Here's a shout-out to the team for their passion, skill, and the huge effort they have made to bring this meeting together.

One of the highlights for me was last night's advanced trainee dinner. It covered all aspects of high-risk early breast cancer. The dinner was specifically set up to be a multidisciplinary event, allowing the trainees to meet associates across disciplines.

Yesterday's plenary was another highlight. We had Michael Friedlander taking us on a walk down memory lane for breast and gynaecological cancers. One of our past presidents, Bruce Mann, shared his up-to-date and provocative thoughts about surgery. Meinir Krishnasamy reaffirmed the multidisciplinary nature of cancer with a forward-looking presentation on nurse-led



Belinda Yeo,
2023 COSA ASM Convenor.

interventions, and Darren Brenner from Canada gave a stimulating talk on using big data and analytics to improve cancer outcomes.

The fertility session was well attended as usual, with a stellar team chaired by Lesley Stafford giving us a lot to think about.

I'm delighted that we were able to arrange a session dedicated to cardio-oncology that was chaired by another past president, Bogda Koczwar. We heard highly engaging insights about the specific needs of First Nations and paediatric patients. It was also good to hear about exercise strategies and prevention.

We kicked off our Best of the Orals sessions yesterday, and I would just like to highlight to everyone that these continue today as well.

The plenary today is on metastatic breast

cancer. A passion of ours is to give metastatic breast cancer a bigger voice. We have an opportunity to hear world experts speak not only about the systemic therapies that have revolutionised treatment but also about local therapies. Another highlight of the session is Kerry Patford speaking about the wonderful work of dedicated metastatic breast care nurses.

There's a lot on after morning tea.

Sophie Nightingale has put a great breast reconstruction session together that I'm sure will be well attended. This is a huge topic that covers the multidisciplinary team spectrum.

That session competes with a session on sexuality chaired by Lesley Stafford. We know that sex matters and that many of the treatments we give affect sexuality and sexual health, as does often a diagnosis of cancer.

Something else to look out for is the afternoon session on genomics chaired by Amy Davies. You'll hear experts including Geoffrey Lindeman digging deep into this topic.

That session runs alongside an MDM panel discussion on tricky cases in breast cancer. I will be chairing this session and look forward to a good multidisciplinary conversation.

After all the thinking and learning we deserve some downtime.

I have to confess that the COSA conference dinners are always a highlight for me. See you on the dancefloor!

Day 2 Highlights:

- **9am – Plenary: Metastatic Breast Cancer**
Chairs: Belinda Yeo and Andrea Smith
Plenary 1
- **11am: End of life care**
Chair: Sonia Fullerton
Plenary 1
- **11am: Breast reconstruction**
Chair: Sophie Nightingale
Meeting Room 105
- **11am: Sexuality and sexual health**
Chair: Lesley Stafford
Meeting Room 106
- **1.30pm: Tom Reeve award presentation to Professor David Speakman**
Plenary 1
- **4pm: Genomics**
Chair: Amy Davies
Meeting Room 106
- **4pm: Tricky cases in breast cancer – join the MDM**
Chair: Belinda Yeo
Plenary 1

• 7pm: Conference Dinner

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Michael Friedlander reflects on 50 years of intense effort to improve care

COSA's 50th anniversary is cause for celebration about the extraordinary progress in the science and practice of oncology, said Professor Michael Friedlander during yesterday morning's plenary.

It is also a time for reflection about the many missed opportunities along the way and mistakes from which to learn, said Friedlander, who became immersed in oncology 45 years ago and is conjoint Professor of Medicine at UNSW and a medical oncologist at the Royal Hospital for Women and Nelune Cancer Centre in Sydney.

Friedlander attended his first COSA conference in 1979. Encouraged by excellent mentors, his clinical and research focus on breast and gynaecological cancers began early in his training in what was then the new field of medical oncology.

Friedlander's presentation focused on changes and advances in the management of ovarian cancer, which he said had parallels with most other cancers.

The purpose of looking back was not simply to reminisce, but rather to learn from what we got right and what we got wrong, he said. "The past can and should inform how to plan for future success."

The 1970s were characterised by a limited understanding of the biology of ovarian cancer, Friedlander said. In addition, the inadequate management of the time was underpinned by neither strong evidence nor the multidisciplinary approach that is now taken for granted.

However, these "bad old days" had been followed by decades of intense international effort to improve the outcomes of women with ovarian cancer. Persistence, strong national and international collaboration and well-designed clinical trials supported by strong science and translational research had been critical to the incremental gains and were now paying dividends.

"We have seen major improvements in survival in selected subsets of patients with advanced ovarian cancer, particularly those with BRCA mutations, but in other subsets as well. However, the mortality for many patients with advanced ovarian cancer remains high," Friedlander said.

"It took us a long time to appreciate the complexity and molecular heterogeneity within the various histological subtypes of ovarian cancer and the need to take these into account in the design of clinical trials. History teaches us that the one-size-fits-all approach of the past to treatment of ovarian cancer will not lead to an increase in cure rates."

Examples of the many critical developments included:

- Platinum-containing chemotherapy regimens;
- Defining the important role of surgery in advanced ovarian cancer at diagnosis as well as at relapse;
- Improvements in pathological diagnosis and understanding of the biology of the multiple subtypes of ovarian cancer; and
- Recognition of the importance of testing for BRCA mutations and the development of PARP inhibitors to mention but a few.

From an Australian perspective, Friedlander praised the contribution of ANZGOG (Australia New Zealand Gynaecological Oncology Group), the Australian Ovarian Cancer



MICHAEL FRIEDLANDER,
who attended his first COSA
conference in 1979.

Study, the INOVATE genomic profiling study and the Ovarian Cancer Prognosis and Lifestyle (OPAL) study.

He acknowledged the many dedicated people who have made and continue to make profound contributions. He mentioned many by name including David Bowtell, Anna deFazio, Penny Webb, Susan Ramus, Neville Hacker, Peter Russell and Clare Scott.

Despite the undisputable progress, Friedlander said it was sobering that there were still inequities in access to optimal management. "It remains a universal problem that science will not fix. It requires political solutions."

Another opportunity for improvement was for Australia to catch up with the US and Europe in the time it takes for

the TGA to approve new treatments, he said.

"An additional major challenge is the difficulty of carrying out randomised trials in patients with rare cancers, which includes patients with any of the molecular subsets of ovarian cancer and this will require collaboration with many trial groups.

"Regulatory approvals are even more challenging for patients with rare cancers and this deserves urgent attention," Friedlander said.

"There are many challenges ahead. We are not there yet but I am confident that the next decade will bring about major change and we will see a significant increase in cure rates."

Meeting need for fertility preservation

IN a well-attended presentation yesterday morning, fertility expert Associate Professor Kate Stern discussed the often unmet need to inform young patients with cancer about their fertility-preservation options.

Concerns included a lack of formal referral protocols, a lack of clinician awareness and geographical inequity.

Stern reminded her colleagues that preservation, where possible, should be offered before cancer treatment started.

"We have resources, services, successful techniques and new and emerging techniques which are likely to make fertility preservation better and easier," she said. "Talk to your patients, access online resources or call for advice."

Preservation options include freezing eggs, ovarian tissue, embryos, testicular tissue and sperm. One of many improvements was that pregnancy success rates after freezing eggs were now the same as for fresh eggs.

Stern highlighted an access gap for rural patients but reassured clinicians that there are transport programs and other strategies to ensure patients even in regional, rural and remote locations have an opportunity for best proactive care.

"There is light at the end of the tunnel," she said.

In her presentation, Associate Professor Michelle Peate explained her team's work on fertility decision aids.

She shared evidence that oncofertility decision aids are acceptable to patients, reduce decisional conflict and regret, and improve the quality of decision-making around fertility and fertility preservation. They also are well accepted by clinicians.

Peate explained her team's work on a web-based tool (FoRECAST: infertility after cancer predictor) to provide an individualised risk of developing ovarian function decline and likely fertility outcomes for young breast cancer patients.

Professor Christobel Saunders shared reassuring results



from the POSITIVE trial, which confirmed that temporary interruption of breast cancer endocrine therapy (ET) for women to attempt pregnancy does not impact short-term disease outcomes or birth outcomes.

Dr Wanda Cui discussed the need for information about the impact of all systemic cancer treatments on the human ovary. She raised concerns about the lack of knowledge around the impact of new treatment classes and said only 24% of phase III breast cancer clinical trials which enrolled premenopausal women collected data on ovarian function.

Summing up, Stern said important themes were the need

for young patients to receive accurate, accessible and timely information about longer-term impacts of their cancer treatment, and to have the opportunity, to choose the best fertility preservation options for their circumstance.

"Young women with gynaecological or breast cancer can be reassured that, for most, having a baby is a realistic aspiration. But more commitment is required in breast cancer trial development to evaluate fertility impacts of treatment options.

"Young patients deserve multidisciplinary HCP commitment, not just to curing their disease, but to optimising future reproductive health and well-being."

Managing patient expectations about gut microbiome

There is evidence that the gut microbiome is perturbed in the setting of cancer, but there is not yet robust research to support the idea that it can be manipulated to improve outcomes in response to cancer.

That is the view of infectious diseases physician Dr Olivia Smibert, who spoke about medicines and the microbiome at yesterday afternoon's Medicine Matters session.

"There are some big limitations to be aware of when drawing conclusions from some of the science. In five or ten years it may be prime time, but it still has a way to go," said Smibert.

She highlighted two key points about the gut

microbiome: "Firstly the bugs in our gut are of interest to cancer doctors because there is a growing body of science that shows associations between these bugs and disease. This may open a new world of desperately needed novel treatments and diagnostics.

"Secondly, it is understandable that we are excited about it but there are significant limitations in the research to date."

Smibert urged people not to be side-tracked by bold study conclusions and to rather focus on the study methodology.

"We have 10 to 15 years of cross-sectional studies that highlight associations between the presence of gut bugs and

outcomes. What we now need is rigorous studies designed to address the question of the of gut bugs and causation."

With increasing community curiosity about the gut microbiome, Smibert encouraged members of multidisciplinary teams to align on how they acknowledge patients' interest in their health while also discouraging them from following fads.

"I urge caution in what we say other than to share sensible information about supporting a healthy gut microbiome. There is not enough evidence yet to justify spending money on probiotics, prebiotics or faecal transplants," Smibert said. "But hopefully it's not far off!"

Geriatric assessment improves outcomes

THE importance of geriatric assessment (GA) and care by geriatricians in the management of older cancer patients was emphasised at yesterday's plenary on geriatric oncology.

Dr Etienne Brain from L'Institut Curie, France, said there was high-level evidence that management that was guided by GA reduced toxicity, increased treatment delivery and ultimately improved quality of life. Determining frailty as part of a GA could also assist with dose optimisations.

"In France there is a strong collaboration between geriatricians and oncologists - true daily collaboration and presence of geriatricians in cancer centres," he said. "Specialist research for older cancer patients is also essential as real-world data cannot replace it. It is needed in order to implement new strategies, treatments and GA-guided management," Brain said.

Perth geriatrician Dr Heather Lane, who has established a geriatric oncology clinic at Sir Charles Gairdner Hospital, said GA could predict treatment toxicity and mortality, change the treatment plan to usually less but sometimes more aggressive treatment, improve outcomes, reduce chemotherapy toxicity and help patients get through treatment.

Four randomised controlled trials showed improved outcomes for older patients and reduced chemotoxicity with GA and with multidisciplinary treatment. This care resulted in medication optimisation, improvements in mobility, falls reduction, social and nutritional support.

"There is a place for geriatric assessment along the cancer care pathway," Lane said. "Geriatricians can help oncologists with health status, comorbidities, patient preferences, screening, life expectancy, rehabilitation, aged care, residential care and end-of-life care."

Geriatric oncologist Dr Michael Krasovitsky from St Vincent's Hospital Sydney said geriatric assessment in oncology was



ETIENNE BRAIN from L'Institut Curie, France.

extremely beneficial at reducing serious side-effects, estimating survival, detecting problems at the first and subsequent visits, and improving mental health, well-being and quality of life. He said new tools, the GA routine geriatric assessment screen and the vulnerable elders survey, went up on the eviQ website yesterday.

Austin Hospital nurse practitioner Polly Dufton detailed a successful nurse-led program for oncology patients over 65, which involved nurses doing a one-hour geriatric assessment at the patients' home followed by a multidisciplinary team meeting which helped triage patients to earlier urgent appointments or palliative care.



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Why it's time to get proactive about reducing CVD risk

A panel of four speakers summarised some of the latest Australian research and European guidelines in a cardio-oncology session titled: Multidisciplinary and multistrategy approach to reducing risk of CVD for cancer patients and survivors.

Associate Professor Erin Howden spoke about the role of exercise to mitigate cardiovascular disease in cancer survivors.

She said initiating exercise early in the treatment process was most effective, as was longer duration of the exercise program. Supervised exercise was also a key success factor, she said.

"The bottom line here is simple, said session chair Professor Bogda Koczwara. "Exercise has multiple benefits. Both in terms of prevention of cardiovascular problems, mitigating severity of cardiovascular problems, improving wellbeing, addressing toxicity of treatment, and it is something that can be delivered in many different settings by a multitude of healthcare professionals."

Pharmacist Ben Felmingham shared insights from a multidisciplinary clinic that delivers cardiovascular assessment for paediatric cancer patients who are at risk of cardiovascular toxicity.

Felmingham concluded that ongoing research is needed to optimise the cardio management of paediatric patients who are on active cardiological therapies. He said paediatric cardio-oncology clinics were likely to be beneficial to documenting previously unrecognised cardiotoxicity and relevant cardiac family histories, while providing an opportunity to address lifestyle risk

factors. "His presentation demonstrated that such a clinic is feasible and acceptable to patients and identifies patients with problems that require addressing," said Koczwara.

Dr Abbey Diaz spoke about the development of patient resources on cardiovascular health for Aboriginal and Torres Strait Islander people living with and beyond cancer.

Diaz said Aboriginal and Torres Strait Islander people were at higher risk of developing cancer than non-Indigenous people. In addition, they had a 40% higher cancer mortality 20% lower five-year survival.

She highlighted the need to develop appropriate resources for patients in this population.

Language should avoid jargon and should be empowering and actionable, Diaz said. Instead of using long sentences, break things up with dot points, she said. Something to avoid was combining men's and women's business together. When it came to images, it was crucial to reflect cultural values. For example, a family picture should include grandparents, not only parents and children.

The presentation pressed home how the model of care needs to cater to the unique needs of First Nations people, said Koczwara. "This is not just because of cultural considerations, but also because in this population pre-existing comorbid conditions such as cardiovascular disease, diabetes and kidney failure are also quite common." In her presentation, cardiologist

Dr Alexandra Murphy looked at both primary and secondary prevention in management of cardiovascular disease in cancer patients. She said it was important to recognise the importance of management of risk factors such as blood pressure elevation, inactivity, smoking and diabetes.

She summarised how the evolution of cardio-toxicity aligned with the introduction of different cancer treatments, starting with radiotherapy in the 1890s.

Murphy gave a detailed outline of new European guidelines that cardiologists and oncologists could use to improve outcomes.

"The overarching message from the session is cardiovascular risk is a common problem for people diagnosed with cancer and it needs to be managed because interventions improve outcomes, both in terms of wellbeing and reduction of mortality," said Koczwara.

"I think oncologists need to be proactive in assessing patient's risk and recognising that those risk factors can be managed appropriately through variety of means. These include through cardiology clinics, specialised cardio-oncology clinics, involvement of the general practitioner, and also patient self-management in improving their lifestyle.

"The next key step is making sure that patients are aware and integrating a cardiology assessment into the overall assessment of the patient," she said.

Call for nutrition and exercise evidence to be put into practice

There is strong evidence to support nutrition and exercise as essential components of multidisciplinary care, but barriers remain in the implementation, according to speakers at a fully booked breakfast session yesterday.

In her presentation, Professor Judy Bauer emphasised that malnutrition and sarcopenia may be present regardless of a cancer patient's BMI. And both may have an independent negative impact on survival and other factors.

"We know that nutrition is an essential component of multidisciplinary cancer care," Bauer said. However, she called system, intensive interventions as ad hoc care did not improve outcomes.

Dr Mary Kennedy explained that while there was strong evidence to support the benefits of exercise prescriptions for cancer patients, not enough clinicians were actually putting this evidence into practice.

She noted that COSA was a pioneer in translating the evidence into practice. COSA's position statement calls on all health professionals involved in cancer care to discuss the role of exercise in cancer recovery, recommend exercise to people with cancer and to refer patients to an exercise specialist with experience in cancer care, she said.

However, Kennedy said there were major obstacles to overcome as, only about 30% of clinicians prescribe exercise for cancer patients. A highlight of the session was the introduction of the inaugural COSA Exercise and Nutrition Fellows.

Dr Edmunds is a health economist and will be investigating exercise and cancer programs offered within hospital settings and will develop a value-based framework to help quantify the potential cost savings from people impacted by cancer being more physically active.

Dr Jeffery will map nutrition services at Australian cancer

centres. Her work will show where the gaps are in relation to access and where the opportunities might be.

The fully booked session was chaired by Jenelle Loeliger, who is chair of the COSA Nutrition group, and Dr David Mizrahi, who is chair of the COSA Exercise group.

"The speakers showed how Australia is leading the way in guideline development," said session co-chair, Jenelle Loeliger.

"We want exercise and nutrition to be considered as an essential element of care for all people with cancer," Loeliger said. "This must be done from diagnosis and should not be an afterthought or an add-on."

Co-chair David Mizrahi added: "The session was fantastic for reminding people that exercise and a good diet are a critical health behaviour that patients can do themselves to improve their physical and mental well-being, and to improve their treatment tolerance."

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Australia on track to eliminate cervical cancer by 2035

THE national HPV vaccination program and the inclusion of primary HPV screening in the National Cervical Screening Program have put Australia on track to eliminate cervical cancer as a public health concern by 2035, said Professor Karen Canfell in yesterday afternoon's plenary.

The session was titled Cervical cancer elimination strategy: an Australian success story inspiring global action.

This world-first elimination of a major cancer would be possible if all people with a cervix could access community-led, culturally appropriate care, said Canfell, the Director of the University of Sydney and Cancer Council NSW's flagship Daffodil Centre said.

A crucial success factor would be to provide access to disadvantaged communities.

"Cervical cancer elimination is possible, using tools available today," Canfell said. "Completed course vaccination coverage in Australia by age 15 was 79.1% in 2020 (80.5% in females; 77.6% in males) although it was lower in Indigenous adolescents (71.5% overall; 75% in females; 68% in males)."

Coverage had increased since vaccine introduction and an incredibly important development was the recommendation for one-dose vaccination at the end of 2022, which should facilitate achieving coverage targets across Australia and globally.

The shift from pap smears to HPV-based screening would further reduce cancer rates by up to 25%, putting Australia on a path to cervical cancer elimination by 2035, Canfell added. About 65% of Australian women were up to date with five-yearly HPV screening at the end of 2020. Increased coverage for screening would be greatly facilitated by self-collected HPV testing.

A crucial success factor is to provide access to disadvantaged communities.

She said Australia had observed drops in HPV infections, cervical precancerous abnormalities and genital warts but not invasive cervical cancer yet. Reduced cancer incidence from vaccination had occurred in Sweden and Canfell expected a drop would be seen in young Australian women soon.

If WHO coverage targets of 90%-70%-90% for vaccination, screening and treatment were achieved, over 74 million cases and 62 million deaths could be averted in low- and

middle-income countries, with all countries achieving elimination at four cases per 100,000 over the course of the century, reducing the cancer to a rare disease considered to be controlled as a public health problem.

National Cancer Screening Register epidemiologist Dr Farhana Sultana told the well-attended session that expanding self-collection to include everyone eligible for screening had improved access and equity in the national screening program, but extra measures were needed to improve compliance with follow-up testing after HPV detection.

Uptake of self-collected tests doubled from 10% in Q3 2022 to 20% in Q2 2023 and HPV positivity rates were significantly higher in self-collected than clinician-collected samples.

Epidemiologist Associate Professor Lisa Whop said persistent and substantial inequities in cervical cancer morbidity and mortality for Indigenous women in Australia and other countries were unacceptable. However, Aboriginal and Torres Strait Islander communities were leading various strategies to increase screening and access to treatment.

NHMRC Centre of Research Excellence in Cervical Cancer Control chief investigator Professor Julia Brotherton detailed implementation strategies for improving vaccination and screening uptake.

Shared care with GPs is appropriate for many survivors

Shared follow-up care between GPs and specialists is an appropriate model of care for many cancer survivors, Director of the Australian Cancer Survivorship Centre at Peter MacCallum Cancer Centre Professor Michael Jefford said yesterday.

In a session on multidisciplinary care models, the medical oncologist said follow-up had traditionally been specialist-led by an oncologist, haematologist or surgeon, hospital-based, and face-to-face.

"This model is becoming increasingly unsustainable given the large and growing number of survivors, and the limited health workforce," he said

COSA, Cancer Australia and many international organisations agreed the

focus should now be on the implementation a model that shared care between the patient's hospital-based specialists and their GP. This would combine cancer-specific follow up with optimal management of comorbid illness and general preventive care.

"We have got the evidence now that shared care is non-inferior and cheaper, and we need to get it into practice," Jefford said.

Melbourne breast cancer survivor Vivienne Interrigi spoke about the multidisciplinary approach that supported her experience, showcasing the transformative power of a multidisciplinary, patient-centred and tailored approach in customising



**Vivienne Interrigi
called on healthcare
professionals to see
patients as people.**

models of cancer care. She emphasised health workers should look at the patient as a person and a human at every point of the interaction, and ask what the patient wanted. "Make it human centred and person focused, hear the voice, and that will make it even better," she said.

Western Health's Aboriginal health, policy and planning manager Jordan Casey explained the importance of multidisciplinary care for First Nations people.

"We need to develop the workforce to ensure we are all providing culturally safe care that suits the needs of our First Nations community and we need to do better than just asking a question, ticking a box, then moving on," he said.

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