

Optimism for breast cancer advances

METASTATIC breast cancer deserves a bigger voice, says Dr Belinda Yeo, co-chair of yesterday morning's plenary.

"We had an opportunity to hear world experts speak not only about the systemic therapies that have revolutionised metastatic breast cancer treatment but also about localised therapies," she said.

In his presentation, Dr Shom Goel of the Peter MacCallum Cancer Centre discussed four conceptual paradigms that have helped bring incremental improvements in outcomes for early-stage and advanced breast cancer patients. These are:

1. **Targeting the driver:** identification and targeting of major oncoproteins in breast cancers;
2. **Targeting the lineage pathway:** inhibition pathways that drive normal mammary epithelial cell proliferation that retain importance in cancer;
3. **Targeting precisely:** the application of molecular classifiers to refine therapy selection for specific cancers, and of antibody-drug conjugates to pinpoint tumour and tumour-promoting cells for eradication; and
4. **Exploiting synthetic lethality:** leveraging unique vulnerabilities that cancer-specific molecular alterations induce.

Elaborating on the four pillars, Goel explained that targeting the driver relates to progress in the development of genomic



technologies that can identify and target particular mutations responsible for driving tumour growth.

Targeting lineage pathways refers to the understanding that many molecular pathways that cause normal breast cells to proliferate also cause breast cancer cells to proliferate. "Our understanding of that has meant we can apply a lot of knowledge of normal breast biology to breast cancer," he said.

Targeting precisely refers to the development of antibody-drug conjugates. "These are drugs that allow us to deliver anti-cancer treatments directly to tumour cells."

The concept of synthetic lethality is an


understanding that certain breast cancers may have specific vulnerabilities that can be targeted. "Classic examples are cancers harbouring mutations in the BRCA1 and BRCA2 genes. We now understand that those cancers, specifically, are susceptible to the effect of PARP (poly-ADP ribose polymerase) inhibitors.

Goel singled out immunotherapy as another area of optimism for the treatment of breast cancer, and not only for patients with triple-negative breast cancer. He said research into the role of oestrogen in affecting the immune environment in breast cancer may lead to treatment opportunities outside of only

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Day 3 Highlights:

- **7.15am – COSA Breakfast Session: Building a roadmap to address the financial toxicity of cancer in Australia**
Chair: Megan Varlow
Meeting Room 106
- **9am – Plenary: Decarbonising oncology in Australia**
Chair: Brigid Lynch
Plenary 1
- **11am: Hot topics in gynae cancer**
Chair: Michael Friedlander
Meeting Room 105
- **11am: Living well with and beyond cancer**
Chairs: Nicole Kinnane and Kathryn Bell
Plenary 1
- **11am: Hot topics in local therapies - Is less more?**
Chair: Sophie Nightingale
Meeting Room 106
- **1.30pm – COSA/UICC Plenary: The cost to cure**
Chair: Grant McArthur
Plenary 1
- **3pm – COSA Presidential Lecture: It's all about cancer. Or is it?**
Presented by Prof Bogda Koczwara AM
Plenary 1

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How to improve care for older people: 'Treat the patient, not their cancer'

Dr Paul Viray and Dr Michael Krasovitsky got yesterday morning off to an inspiring start by chairing a highly engaged breakfast panel discussion about optimising care for older patients.

The session catalyst was a multidisciplinary discussion about the case of a 77-year-old female patient with breast cancer.

In a departure from the usual makeup of MDTs, the panel included medical oncologists, a cancer nurse, a pharmacist, a geriatrician, a radiation oncologist, a surgeon and a consumer.

Viray, a consultant geriatrician and medical oncology registrar, said the panel makeup was a powerful example of how an MDT could be more effective if it included more angles and opinions.

By a show of hands, most members of the panel and the floor acknowledged that they had witnessed ageism in an MDT. One way this might manifest is clinician perceptions of how an older woman might feel about a receiving a mastectomy versus a younger woman.

A member of the audience noted that for older people specifically, quality of life was often more relevant than quantity of life.

A well-received suggestion from the floor was to include a patient advocate in the team. Another was to include a psychologist or a social worker. There was also discussion about the potential value of including patients in MDTs.

Consumer Winsome Clark described herself as breast cancer survivor. She said she had trusted her doctors to make the right



decisions for her and did not see a need to be included in her MDT. However, she urged clinicians to be cognisant of the big decisions she had to make. In addition, they should not assume their patients understand what they are talking about.

"When you are told you have cancer your landscape changes. Everything is different," Clark said.

Even if people are of the same age, they were not the same. "It is like pantyhose. It is not one size fits all," Clark said.

Cancer nurse Polly Dufton noted that cognitive ability does not necessarily equal health literacy. She said it was important

to dig into the reasons when an older patient objected to systemic options.

"Ask why. It could be because of past experiences of family or friends who had become really unwell. This is not necessarily reflective of current treatment."

Summing up, medical oncologist Krasovitsky said: "The most important thing we heard today was the patient perspective. We had an exceptional patient representative who challenged a lot of us philosophically and medically and reminded us how pivotal it is to ask patients what matters most to them, to assess them individually, to not make assumptions about who they are, what their strengths are, what their vulnerabilities are, and also to recognise the inherent power that patients hold."

He said a tricky part of the current MDT paradigm is that discussion is mostly medical. "What Paul and I would argue is that we should be spending more time on those non classically medical decisions. How do we optimise this person's nutrition? How do we identify their frailty parameters? Perhaps rather than being tumour-focused to become patient-focused."

Viray said the most powerful thing about the session was having an open conversation, not only with the panellists, but with the audience as well. "I hope this is one step forward to doing more for our patients."

"I think the point is that we need to do as clinicians is ensure we're giving patients all the information and make sure that they're making an informed decision."

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FROM PAGE 1 hormone-receptor-negative breast cancer.

Timing was another area of interest. "It seems that when you give immunotherapy in a patient's treatment journey can influence how effective it is."

Other speakers at the plenary were:

- The McGrath Foundation's Chief Nurse, Kerry Patford, described the McGrath nurses' model of care, which includes education, psychosocial support, clinical care and care coordination. (see Page 4 for a report on her presentation)
- Dr Stephen Luen, from the Peter MacCallum Cancer Centre, discussed whether looking for genomic alterations in breast cancer should be part of routine care. Luen explained testing options and the clinical relevance of genomic alterations in breast cancer.

• Associate Professor Steven David, from the Peter MacCallum Cancer Centre, discussed oligometastatic and oligoprogressive breast cancer and the rationale for different treatment paradigms and strategies. David explained the rationale for integrating locally ablative therapies with systemic therapy.

After the presentation, Goel welcomed the input from his fellow speakers.

"Stephen Luen's talk shed light on how genomic technologies, in particular DNA sequencing, are used to guide breast cancer treatments," he said. "He also tackled the interesting question of the role that these technologies will play in the future as part of mainstream clinical care."

He was grateful for Patford's real-world insights. "We must be aware that new treatments do come with toxicities,

which can impact patients' quality of life. We must also remember that the diagnosis of metastatic breast cancer itself can pose many challenges for patients and their families."

Goel said David presented a very contemporary review of the role of local treatments, with a specific focus on the role of radiation. "This is certainly an area where we expect to see great progress in the years to come."

Summing up, Goel said: "I'd like people to remember that fundamental research and drug development are the foundation for 40 years of progress in the treatment of breast cancer."

"But there are still patients who are not cured by our current therapies. I'm optimistic that over the next 10 to 20 years, we'll continue to see progress and extend the benefits of new treatments for breast cancer to more and more patients."

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Landmark plan launched to tackle nation's biggest killer

CANCER Australia CEO Professor Dorothy Keefe PSM yesterday officially launched the inaugural Australian Cancer Plan, showcasing it for the first time at COSA's 50th scientific meeting and heralding a new era in cancer care.

Minister for Health and Aged Care, Mark Butler, concurrently released the landmark plan, which aims to improve prevention, screening, treatment, management and outcomes for all cancers across Australia.

Keefe said health practitioners could bring the blueprint to life by partnering in 46 actions across six themes to deliver two, five and ten-year goals.

The plan's six objectives are to maximise prevention and early detection, enhance the experience of patients and their supports, ensure world-class care, have strong foundations based on research and data, have a workforce that transforms delivery of care and achieve equity in outcomes for Aboriginal and Torres Strait Islanders.

The plan was created in collaboration with the cancer sector, states and territories, First Nations communities, clinicians, researchers, patients and support organisations.

"This is the biggest thing in cancer control in Australia. It brings everything together," Keefe said. "Cancer is the biggest killer of Australians and has the biggest burden of disease."

The plan would align with existing state and territory plans, she said.

"There has never been a national plan to harmonise everything, ensure there are no gaps and take cancer care to the next level."

"It marks a new era in cancer care, where equitable and optimal care is within reach for everyone. It is for all cancers but focuses on addressing disparity of experience and outcome."

Cancer Australia wanted to hear from anyone with a good idea which aligned with the plan, Keefe said. Already, the Government had partnered with Movember to integrate patient-reported experiences and outcomes into service performance monitoring, and Cancer Council Australia to develop a national data framework.

A key priority was improving outcomes for groups with the poorest cancer experiences, especially First Nations people, who were 14% more likely to be diagnosed with cancer and 45% more likely to die from cancer than



Dorothy Keefe: 'This is the biggest thing in cancer control in Australia. It brings everything together.'

non-Indigenous people. Other priority populations included those with cancers with a poorer prognosis.

Butler said the plan responded to patients' concerns that the health system was hard to navigate. It would ensure no one falls through the gaps.

"The burden of cancer is increasing, with more than 164,000 Australians estimated to be diagnosed this year," he said. "While cancer outcomes in this country are generally among the best in the world, that's not true for some people, simply because of who they are or where they live."

Keefe said the Government had allocated \$500 million to the plan, including for Aboriginal and Torres Strait Islander health and the national lung cancer screening program.

Cancer Australia had started working on actions including setting up an Australian Comprehensive Cancer Network and national frameworks for optimal care pathways and genomics in cancer control.

The plan is available at australiancancerplan.gov.au.

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What Speakman wants you to know about VAD

CARE navigators play a crucial role in supporting Victoria patients who may be candidates for voluntary assisted dying (VAD), said surgeon Dr David Speakman yesterday.

Speakman is the 2023 recipient of COSA's Tom Reeve Award for outstanding contributions to cancer care.

In a session that focused on VAD learnings from Victoria, Speakman said: "The most important thing I can say to this audience is that the VAD navigator, the nurse coordinator, is absolutely crucial. VAD would not happen without them."

Speakman said use of the Victoria program had increased every year since it was introduced in June 2019.

Although in hindsight certain things could have been done better, he said feedback from families and users has been overwhelmingly positive.

Speakman emphasised that no health professional was compelled to participate in VAD. In addition, the preference was for the patient to administer the medication themselves.

"To be clear around the legislation in Victoria, if the patient is able to self-administer, then that is the preferred method." Practitioner administration was only for patients physically incapable of self-administration.

He said the aim of VAD was not to replace existing care, and certainly not palliative care. "It is an additional option for our patients. It's about autonomy for the patients. It's about having informed decision-making. It's

about discussing death and dying in an open manner for those people who are facing it. It's about having that conversation. There are plenty of safeguards around it and I think that it is designed to at least try and show respect to anyone's cultural beliefs or values."

Speakman said that in the last four years there had been just over 2000 applications for a VAD permit in Victoria. In that time, 1,527 permits had been issued – 1312 for self-administration and 215 for practitioner administration. These permits had resulted in 912 deaths.

He said the gap between permits and deaths was a good thing. "For a lot of patients, it's knowing that the substance is available if they ever reach the point where they have to use it. If it has provided them comfort and made life a bit easier in the last few weeks or months of their life, then I think that's an absolute success."

Session chair Dr Sonia Fullerton said Speakman was highly regarded for his VAD expertise. "He's had a lot of experience in assisting hundreds of patients through the process and in teaching and setting things up in Victoria."

The key takeout is that VAD is a process that is patient-centered. It respects patient autonomy. In addition, health practitioners are not obliged to take part if they don't want to. There's also a tight legislative framework that is somewhat restrictive but also protects people from being coerced into VAD.



COSA members say 'It's the best fit'

Don't just take it from us. In a recent survey, over 75% of COSA members said they were satisfied that COSA membership met their needs and expectations.

Survey responses affirmed COSA as a truly multidisciplinary membership organisation and leading oncology community.

If you are not already a COSA member, visit the COSA team at booths 54-55 to talk about what COSA can do for you and sign up for a membership **at no further cost!**

If you are already a member and appreciate what we do, please consider stopping by to give us a testimonial or simply to say hello. COSA is about bringing together the cancer care community, so we encourage you to join us and meet other members and delegates at this face-to-face event.

Why demand for metastatic breast care nurses is increasing

McGrath Foundation Chief Nurse Kerry Patford has called for oncology teams to support the integration of metastatic breast care nurses into multidisciplinary care.

In a presentation titled Dedicated metastatic breast care nurses - providing expert clinical and supportive care to those with metastatic breast cancer, McGrath said increased survival and complex side-effect management had led to increased demand for supportive care.

Patford said a needs assessment had found that patients experience complex unmet supportive care needs.

She explained that McGrath offers a free service to patients across Australia and since 2010 had funded 43 new

breast care nurse positions dedicated to the care of people with metastatic breast cancer.

However, this service was not used to its full potential.

"Support is required from oncology teams to fully integrate and utilise metastatic McGrath Breast Care Nurse roles," she said.

This full integration of these roles into multidisciplinary teams is supported through the development of a dedicated model of care for metastatic disease.

The McGrath specialist nurses provide education, psychosocial support, clinical care and care coordination. They are based in metropolitan areas as well as regional locations.

Patford said no referral was needed and anyone could find their local nurse on the McGrath Foundation website and call them.

"We know that as emerging treatment options continue to extend the survival for people with metastatic breast cancer, the need for specialist nursing care will continue to increase," Patford said.

McGrath provides clinical supervision for its nurses along with experiential learning through placements and robot assisted learning, comprehensive online learning modules, clinical leadership, conference attendance and in-person workshops.

Patients want to discuss sex and sexual side-effects

CANCER patients want health professionals to discuss sex and sexual side-effects from cancer therapies during and after treatment and into survivorship, a packed session on sexuality and health heard yesterday.

Naveena Nekkhalapudi, a breast cancer survivor and consumer representative on cancer organisations, said maintaining quality of life during and post treatment included the consideration of a patient's sexual health and well-being.

After the presentations, she said she was heartened to hear that health professionals wanted to discuss these issues and had the tools to do so. However, she was frustrated because this was not always done. "What is preventing them?" she asked. "Is it the system, time or training?"

Nekkhalapudi said that if health professionals felt shy about initiating a discussion, then there was little hope for patients. Timing of conversations was also important. Sexuality should be discussed at various points of the patient's journey, including during survivorship.

Associate Professor Safeera Hussainy said barriers to discussion included a lack of confidence and issues with assessment, referral and documentation.

The senior pharmacy research manager said: "Anti-cancer therapies can cause severe sexual dysfunction, such as libido, body confidence, genital dysfunction and erectile dysfunction. But health professionals are focused on concerns such as nausea, pain and fatigue.

"Many patients want to learn about the sexual side-effects of treatment but are too embarrassed to ask. So, it is our responsibility to raise the issue."

A patient survey found 80% wished someone from their treating team had raised the topic, Hussainy added.

For women with menopausal and vaginal symptoms, evidence from 38 guidelines showed HRT, Kegel exercises, counselling and psychotherapy helped. Other tools included a Cancer Council Australia checklist and the Passionfruit website.

The Royal Women's Hospital head of psychosexual medicine, Associate Professor Wendy Vanselow, said health professionals had a duty of care to inform patients of risks from



cancer therapy, including sexual side-effects.

"All health professionals should be comfortable to include sexual function as an outcome of care because to omit this aspect is to neglect informed consent," she said.

"You must keep asking, are you getting side-effects as all cancer treatments can impair sexual function. Most patients want to discuss it but are reluctant to bring it up and many breast cancer patients say no-one told me this."

The hospital's Menopause After Cancer Clinic found genitourinary symptoms were common in breast cancer but she said oncologists could not do everything so should refer to

such clinics for help. Vaginal oestrogen is an excellent treatment, she said.

Medical oncologist Dr Antonia Pearson, who is completing a PhD in genitourinary symptoms in breast cancer, said a survey found health professionals had little or no training in the field and most did not feel comfortable treating these symptoms.

"Women often were not asked about the symptoms and sometimes males felt uncomfortable asking about things 'down there'. But this is important for quality of life," she said.

What updated figures say about excess weight and inactivity

Updated figures show that more than 11,600 Australian cancer cases a year are associated with people being overweight or physically inactive, a Risk Reduction session heard yesterday.

Cancer Australia's Head of Cancer Control Strategy, Associate Professor Anna Boltong said one-third of cancers were preventable and good nutrition was an essential part of prevention, treatment and survivorship.

Boltong said overweight or obesity was related to more than 5300 cases a year, adding: "There is evidence that being overweight significantly increases the risk of 13 different cancer types but maintaining a healthy weight reduces the risk of cancer returning."

Cancer Council Victoria epidemiologist Associate Professor Brigid Lynch estimated that 6300 cancer cases annually,

or about 17 diagnoses a day, were associated with physical inactivity, more than three times as many as previously reported.

Lynch said promotion of exercise should be a central component of cancer prevention programs.

Boltong gave examples of innovative programs to reduce risk, including a mobile food education and cooking classes for Philadelphia families of children with cancer to prevent later obesity.

Others included food security programs in remote Australia and a healthy stores project, where grocery stores promote nutritious food options to ensure the healthy choice is the easy choice.

Over 10 years, the Victorian Cancer Malnutrition

Collaborative had halved cancer malnutrition rates by offering an optimal nutrition pathway, improved malnutrition prevalence data and a governance toolkit for health service providers to manage malnutrition as a clinical risk, Boltong said.

Other speakers at the session were University of Melbourne behavioural scientist Dr Camille Short, who discussed digitally supported exercise interventions to help cancer patients recover from treatment, and University of Calgary molecular cancer epidemiologist Associate Professor Darren Brenner, who explained research to estimate the population-level cancer burden of known modifiable (lifestyle, infectious, environmental) exposures in Canada. These efforts are now embedded in cancer control strategies to reduce cancer impact and increase prevention and screening.

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