COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

SENATE

COMMUNITY AFFAIRS REFERENCES COMMITTEE

Reference: Gynaecological cancer in Australia

THURSDAY, 10 AUGUST 2006

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SENATE

COMMUNITY AFFAIRS REFERENCES COMMITTEE

Thursday, 10 August 2006

Members: Senator Moore *(Chair)*, Senator Humphries *(Deputy Chair)*, Senators Adams, Allison, Carol Brown and Polley

Participating members: Senators Abetz, Barnett, Bartlett, Bernardi, Mark Bishop, Bob Brown, George Campbell, Carr, Chapman, Colbeck, Coonan, Crossin, Eggleston, Chris Evans, Faulkner, Ferguson, Ferris, Fielding, Fierravanti-Wells, Forshaw, Hurley, Joyce, Lightfoot, Ludwig, Lundy, Mason, McGauran, Milne, Murray, Nettle, O'Brien, Parry, Payne, Siewert, Stephens, Stott Despoja, Watson, Webber, Wong and Wortley

Senators in attendance: Senators Allison, Ferris, Humphries, Moore, Polley and Webber

Terms of reference for the inquiry:

To inquire into and report on:

Gynaecological cancer in Australia, and in particular the:

a. level of Commonwealth and other funding for research addressing gynaecological cancers;

b. extent, adequacy and funding for screening programs, treatment services, and for wider health support programs for women with gynaecological cancer;

c. capability of existing health and medical services to meet the needs of Indigenous populations and other cultural backgrounds, and those living in remote regions;

d. extent to which the medical community needs to be educated on the risk factors, symptoms and treatment of gynaecological cancers;

e. extent to which women and the broader community require education of the risk factors, symptoms and treatment of gynaecological cancers; and

f. extent to which experience and expertise in gynaecological cancer is appropriately represented on national health agencies, especially the recently established Cancer Australia.

WITNESSES

Committee met at 9.03 am

DI SAIA, Professor Philip, Private capacity

Evidence was taken via teleconference—

CHAIR (Senator Moore)—Welcome, Professor Di Saia, and thank you for giving your time to our committee. The Senate Community Affairs References Committee of the Australian Senate is conducting an inquiry into gynaecological health issues, particularly gynaecological cancer. We know that you have links with Australian medical people in this area, and your name was suggested to the committee by Professor Neville Hacker. Have you received the information about our processes, the protection of witnesses and all those things?

Prof. Di Saia—Yes, I have.

CHAIR—You know what we are doing. Would you like to open with a general statement and then we will go to questions?

Prof. Di Saia—I am a little confused as to what you are doing. I think you are looking into the whole issue of gynaecological cancer therapy, but more than that I am not sure. I was hoping that you could help me.

CHAIR—We will do our best. Basically, our committee looks at issues particularly to do with health in our community and we have a reference on gynaecological cancer. We have terms of reference, which I know you have. We were looking particularly at issues around funding, research, and public education and also the general issue of gynaecological cancer in the community. We were hoping that we could learn from your experience in the United States or about things that you think would be beneficial to address these issues not just here but internationally.

Prof. Di Saia—I would be happy to help in anyway I can. The best way is to ask questions and then I can get a drift of what you would like to know.

CHAIR—Also, we have your CV and I would like to congratulate you for being named Cancer Fighter of the Year, which is a noble title. The committee wanted to let you know that we acknowledge that as well. Senator Humphries will start the questions.

Senator HUMPHRIES—Good morning. I do not know a lot about cancer rates in the United States. You might be able to help me with some of this. In Australia we have had success in recent years in bringing down rates of cervical cancer by virtue of fairly active campaigns to encourage women to have pap smears. I assume that that kind of success has been achieved in the United States as well.

Prof. Di Saia—Yes. In most Westernised countries the rate of cervix cancer has dropped considerably. It is interesting because there are still about a half a million cases worldwide but they seem to be primarily concentrated in countries where screening is not done on a wide scale. Eighty per cent of Americans are screened and it is probably close to that in Australia. This is given as the explanation for the drop. Interestingly, within the last month the Federal Drug

Administration in the United States has approved the first of many vaccines against the human papilloma virus, which is implicated in 99 per cent of cervix cancer. So we are now struggling with the issue of whether we should be immunising our 13-year-old girls against this virus which would eliminate cervix cancer entirely, much like smallpox.

Senator HUMPHRIES—Is the decision about whether that vaccination would occur across that age cohort made at the national level or on a state-by-state basis in the United States?

Prof. Di Saia—It will be made by the CDC, by the federal administration. What happens here is that if the federal administration approves it, that means it will be covered by all those individuals who are covered under federal insurance plans. Once they approve something, almost always the private insurance plans follow suit.

Senator HUMPHRIES—Do you anticipate that there will be a decision made to provide for whole-of-population vaccination for 13-year-old girls?

Prof. Di Saia—Yes, I think most likely it will be approved for females 13 through 26. There is an ongoing study of males. I do not expect a declaration on males for at least a year.

Senator HUMPHRIES—If you were suddenly handed a large sum of money to fund public education for any of these areas of gynaecological cancer in the United States, what would you consider to be the biggest priority? What would you achieve the most benefit from in terms of expenditure?

Prof. Di Saia—That is a really good question. You would get the most bang for your buck in cervix cancer.

Senator HUMPHRIES—I was going to use that expression but I was not sure if you used that in the United States, so I was being very careful.

Senator FERRIS—He has got a lot of women in the room!

Senator HUMPHRIES—That is right. I am sorry, please go on.

Prof. Di Saia—Cervix cancer requires only a pap smear, which is inexpensive, easy to do and not something which most women dread. The most difficult problem we have in gynaecological cancer, however, is ovarian cancer. This is a very deadly disease which is difficult to diagnose, and we do not have a good screening tool. The best tool we have is frequent examinations by your gynaecologist; but, even then, yearly examinations are probably not enough. So there is a great deal of research being done to find a blood test which can pick up ovarian cancer at an early stage. Until we have such a test, I do not know that government can input a lot of money into that area, except for research, and get good bang for their buck.

The other thing that I think helps is that in your society and in my society the most common gynaecological cancer is so-called endometrial cancer—cancer from the lining of the uterus. There you have a highly curable disease, and education is the main assist in early diagnosis. The postmenopausal woman who has any bleeding at all from the vagina must be alerted to visit her physician and have a sample taken from inside the uterus. If this sampling is done early on, these

patients are almost 100 per cent curable. So I would say that the pap smear is the best bang for your buck, the next best bang for your buck is good education about postmenopausal bleeding and the next is research into finding a blood test for early diagnosis of ovarian cancer.

Senator HUMPHRIES—That is great. Thank you.

Senator ALLISON—In Australia we have the new subspecialty of gynaecological oncology. Much has been said about the advantage of that subspecialisation and the treatment of women in what are known as multidisciplinary teams. Is that the experience in the United States as well?

Prof. Di Saia—Yes. I came to Australia eight or nine years ago to help Dr Hacker set up the oral examination process for certifying gynaecological oncologists. I was the director of the Division of Gynaecological Oncology of the American Board of Obstetrics and Gynaecology. The gynaecological oncology subspecialty has concentrated the care of a patient with gynaecological cancer into the hands of one physician. This has made it convenient for the patient, because we use not only surgery—most of us are surgeons—but also radiotherapy and chemotherapy. Gynaecological oncology training encompasses all of these modalities. So you have an individual who understands all of them, and you end up getting a better result. There are multiple studies in the US showing that patients treated by gynaecological oncologists have better outcomes than people treated by a series of specialists.

Senator ALLISON—What is the percentage of American woman who receive treatment from this multidisciplinary team? In Australia we understand it is around 50 per cent.

Prof. Di Saia—Unfortunately, there are only 1,000 gynaecological oncologists in the United States and we have a population of 325 million. So not everyone can just walk into a gynaecological oncologist's surgery for their general obstetric or gynaecological care, but sooner or later a patient who is seen by a generalist or a certified obstetrician-gynaecologist does usually get into the hands of a gynaecological oncologist. I would say that our numbers are about equivalent to yours. About 50 per cent of women with gynaecological cancer see a gynaecological oncologist in the US at some point. Many of us think that point is not early enough in their care, but that is another issue.

Senator ALLISON—If I could press this a little further, how do you see progress being made in gynaecological oncologists seeing women at an earlier stage? Is it just a question of training more practitioners or is it a question of raising greater awareness in the medical profession that not just anyone should do surgery on women?

Prof. Di Saia—I think it is both of those. In this litigious society I live in, the lawyers are helpful because, when the patient is not sent to a gynaecological oncologist, often there is a complaint, and that has made many people nervous of managing gynaecological cancer without the consultation of a gynaecological oncologist. It is one of the few instances I know of in the US where lawyers are helpful!

Senator ALLISON—And you do not think there is a need for some sort of accreditation system to apply? Would that not be preferable?

Prof. Di Saia—That is complicated and difficult to monitor because you would have to have specific criteria for what should go to a gynaecological oncologist and what could be handled by a generalist. A large percentage of the time the decision is based upon the pathology report, and you do not have the pathology report until the time of surgery. For instance, most cysts occurring in women are benign but some are malignant. There are ways of determining the probability of it being malignant, but there is no 100 per cent method. So the best we can offer our patients is that, if a generalist does an operation and finds a malignancy of the ovary, there be a gynaecological oncologist in consultation nearby. In my own practice, if a generalist is going to open a patient who has a large mass in the area of the ovary, he will call me and say, 'Next Tuesday I am going to operate on this patient; will you be available should I find a malignant process?' I would prefer that he just send the patient over to see me, but it is a free society. What I do is make sure that I or one of my associates can be made available in the event that he finds that she does have a malignancy.

Senator FERRIS—Much of what you have said about early tests and so on is of course well understood by members of the committee. It is certainly the same, unfortunately, in Australia. But the other thing that is difficult in Australia is a lack of awareness about the need for people to be conscious of any changes that might indicate they need to visit either their GP or a gynaecologist or a gynaecological oncologist. Can you tell me what sort of awareness campaign is undertaken in the United States to make women more aware? Also, can you tell me anything about the national structure of any sort of gynaecological cancer centre and how they interact with their national and state governments?

Prof. Di Saia—The best tool we have for heightening awareness in the US is the American Cancer Society. The American Cancer Society is probably responsible for the popularity of the pap smear and the reduction in the incidence of cervix cancer—the dramatic reduction. The American Cancer Society have guidelines which they publish. They have guidelines which their volunteers talk about. The National Cancer Institute also has some commitment to this in the form of brochures which can be put into physicians' offices. Each September is ovarian cancer month. We have a month devoted to breast cancer. These are all attempts to heighten the awareness. There are campaigns to raise money where people compete in marathons, and at those marathons there are speakers trying to get the message out. We try to heighten awareness with publications and with the spoken word, but unfortunately you are always facing human denial: the woman who knows there is something wrong but cannot face it, and she denies it. She feels the lump in her breast and she just denies it until it is too late. How you get to that patient I do not know.

Senator FERRIS—What about the national structure of lobbying in Washington and the states' lobbying? Is that all done by the American Cancer Society?

Prof. Di Saia—The states do not lobby very much at all. The American Cancer Society and the National Cancer Institute and, recently, the Society of Gynaecologic Oncologists, which is 1,000 members who are certified gynaecological oncologists, are the ones who have been lobbying to heighten awareness—through publications, through signifying a month as being particularly devoted to screening in a particular area et cetera. We do not have state commitment to these. It would be nice if we did, but we do not.

Senator FERRIS—Thank you.

CHAIR—I think we have just about exhausted the questions. I just have one, and it is to do with research and the funding and the processes around that, because it has been coming up a lot in our evidence that there needs to be extensive further research in this area. I know that the American Cancer Society gets involved in that as well, but, for the record, can you tell us what you know about the research process, the funding and how it is done?

Prof. Di Saia—The research is primarily through the National Cancer Institute. The second largest funder of research is, as you have stated, the American Cancer Society. But, by far, the national institute is the biggest funder of research and is currently contributing something like $8 billion. Their research is in the areas of basic research, clinical research, training of researchers and training grants for clinicians, so it is divided up into multiple segments. It never seems to be enough. My own particular interest, and something that I think Neville Hacker is interested in, is a national cooperative group. In the United States, we have the so-called gynaecological oncology group. All of the gynaecological oncologists are welcome to join this. We receive less than optimum funding but it permits us to collectively do research quickly. For instance, if we want to test drug A versus drug B in ovarian cancer we have 250 institutions participating. We can do that in a year; with one, it would take 25 years.

CHAIR—Is that through a clinical trial process?

Prof. Di Saia—It is through a clinical trial process. The trials are developed by the leadership of the group. The group participants receive a modest amount of money for participating, mostly in the form of people to collect the data and submit it. We have two meetings a year; we look over what we have done and what we want in the future. But these national groups are very good. As a matter of fact, in the latest ovarian cancer study Australia was one of our biggest contributors—you have become part of our group. So you have that kind of research and then, of course, you have bench research. I have in my institution a so-called training grant, which permits me to have salaries for young men and women to spend four years learning my trade of gynaecological oncology and then going to universities and practising as gynaecological oncologists, like Neville Hacker.

So the National Cancer Institute has been the prime source. More and more, though, in the last two decades there has been philanthropy. Foundations are established by often grateful patients who create an endowment, and endowment funds research money on an annual, competitive basis. I really think that government cannot carry the whole burden and that philanthropy needs to be involved. Of course, our country is bigger than yours, so there is a lot more money here that can be tapped.

CHAIR—Could I just clarify one thing about the cooperative arrangement you describe with people coming together: is that between the doctors themselves or their institutes? What kind of collective is that?

Prof. Di Saia—It is the doctors, but they represent various institutions and various disciplines in our group. We meet and we have committees that specialise in ovarian cancer, uterine cancer, cervix cancer and other cancers. These committees develop protocols, which we prioritise, and run those that we can afford to run. The most important thing, however, is that we can do things quickly, which is something that industry has been very interested in. The one thing industry demands is speed. Industry is interested in making money. It wants to get studies done quickly so

that it can put products on the street and make money. When you can do things quickly you perk up the interest of industry.

CHAIR—Is this the same as your professional college, or is it separate from that?

Prof. Di Saia—It is separate.

CHAIR—Would you recommend that as something that works?

Prof. Di Saia—It works. Funding comes to the institute. It has nothing to do with the college or with the certification. It is strictly a research endeavour.

CHAIR—And you cooperate rather than compete?

Prof. Di Saia—You cooperate—that is correct.

CHAIR—My comrades and I seem to have run out of questions. We wanted to keep this tight so that we did not take up too much of your time. Do you wish to add anything?

Prof. Di Saia—Only that a big branch of my family is in Tasmania. Is there somebody there from Tasmania?

CHAIR—Senator Polley, who was here, is from Tasmania. Do you have family in Tasmania?

Prof. Di Saia—Yes. One of my grandfather's brothers emigrated to Tasmania and not to the US.

CHAIR—Do they have your surname?

Prof. Di Saia—Yes, they have the same name.

CHAIR—Then we can ask Senator Polley to seek out your relations.

Prof. Di Saia—Yes. Look in the phone book in Hobart and you will find a lot of us there.

CHAIR—I am really pleased and I think it is wonderful that we are spread across the globe. Senator Polley will make sure that she contacts them for you. Thank you very much for your time today; it is deeply appreciated. Considerable things you told us today we had heard not before, so thank you; we appreciate it.

Prof. Di Saia—Good luck with your inquiry.

Committee adjourned at 9.33 am