SENATE INQUIRY INTO GYNAECOLOGICAL CANCER SERVICES

Submission from Robert Rome
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Introduction

Gynaecological cancer is newly diagnosed in almost 4000 women each year in Australia. The commonest of the cancers that we deal with arise in the endometrium, ovary, cervix and vulva. The most devastating of these is ovarian cancer where mortality rates are about 60%.

I see the following as the major problems and challenges in the area of gynaecological cancer. I have indicated *recommendations in italics.*

Early detection

Early detection of cervical cancer in organized screening program has been a spectacular success and has seen a significant drop in the incidence and the mortality of this disease. Early detection of endometrial, vulvar and especially ovarian cancer remains an elusive goal. *Significant research money should be directed towards the early diagnosis of ovarian cancer.*

Psychosocial aspects

The diagnosis and treatment of gynaecological cancer can have a profound psychosocial impact on the woman and her family. Addressing the needs of women has been inadequate. Very few of the gynaecological cancer units in Australia have clinical psychologists to address these needs. *A clinical psychologist with expertise should be funded for all units.*

Data management

Data management in most gynaecological cancer units is funded by 'soft' money raised by donations, fund raising ventures. Proper data management is essential part of providing optimal patient care. Not only do data managers keep track of patient, tumour, treatment data but also outcomes, clinical audit, quality assurance etc.
All gynaecological cancer units should have a permanently funded data management support.

Access to optimal treatment

This can be difficult in Australia given the tyranny of distance and women (and their partners) sometimes need to travel long distances to obtain optimal care. Indigenous women and those from a NESB are special groups for whom the incidence of

gynaecological cancer may be higher and access more difficult and outcomes consequently worse. In gynaecological oncology we sometimes find ourselves competing with other disciplines and against health departments in obtaining financial support for our efforts to improve services to such women.

There should be increased funding for specialist outreach clinics in remote and rural areas and there should be funding for the introduction of modern telecommunication technology such as new technology including videoconferencing.

Training and workforce considerations

There are currently 34 certified gynaecological oncologists in Australia. It is calculated (RANZCOG) that 48 are required to adequately service the Australian population. Training is limited by the number of training positions receiving funding through state health departments.

Given the lag time to train a gynaecological oncologist (3 years) there *should be an immediate increase in the funding of training positions in Australia*. The RANZCOG is best placed to advise on this.

Funding of initiatives

Many of the initiatives are services that could eventually be funded by the states in their budgets. Some could be initially Federally funded and trialed. There is a lot of duplication by the various states and Cancer Councils such as publication of information brochures. Gynaecological cancer could be a good model for some other initiatives such as subspecialist outreach clinics, teleconferencing etc.

National Gynaecolgical Cancer Centre

I am aware that a National Gynaecological Cancer Centre has been proposed and I am in favour of this concept. For breast cancer the National Breast Cancer Centre (NBCC) has assumed the role of a national centre. Furthermore the NBCC engulfed ovarian cancer several years ago. To my knowledge there are no gynaecological oncologists on the NBCC Board or its Scientific Committee and minimal funding has flowed from the NBCC for research into gynaecological cancer.

There certainly needs to be a more coordinated effort to improve gynaecological cancer and this would best be done through a Federal initiative rather than at a state level.
A National Gynaecolgical Cancer Centre should be established.

Considerable expertise and wisdom can be found in the Society of Gynaecological Oncologists (ASGO) and also at the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG).

I would be more than happy to elaborate on the above matters if desired.

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