January 30, 2006

Mr Elton Humphery
Committee Secretary
Australian Senate
Community Affairs
Parliament House
CANBERRA ACT 2600

Dear Mr Humphery

RE: PETITION ON GYNAECOLOGICAL HEALTH ISSUES

I refer to your letter of December 21, 2005, requesting information relevant to the "Petition on Gynaecological Health issues" which the Senate has referred to your Committee.

I will address each point individually.

1. **Need for increased funding for the development of a screening test for ovarian cancer.**

   This is of critical importance. There are about 1200 new cases of ovarian cancer diagnosed each year in Australia, an incidence of 12 per 100,000 women per year. Because of the non-specific nature of the symptoms, early diagnosis is extremely difficult, so about 70% of women have advanced disease at the time of initial presentation. This accounts for the poor 5-year survival for ovarian cancer of 40%, which compares unfavourably with the 80% 5-year survival for breast cancer.

   Much money is spent on research, screening (mammography), awareness, and management of breast cancer each year, and this is appropriate, because breast cancer accounts for about 11,000 new cancer diagnoses each year (incidence 115 per 100,000 women per year). However, ovarian cancer, with twice the mortality, needs a massive infusion of research money to enable a screening test to be developed to allow early diagnosis of women without symptoms.

   It is now known that cancer is a genetic disease caused by aberrations in genes that control the growth of cells. Despite its clinical importance, very little is known about the genes involved in the development of ovarian cancer. Since the completion of the Human Genome Project in 2002 which identified all of the genes in the human body, together with the development of sensitive molecular technologies, it is now feasible to identify the genetic causes of ovarian cancer. This information can then be used to discover new ways of detecting and treating ovarian cancer, including a sensitive diagnostic test for early disease suitable for population screening. We are working on such a project in collaboration with the Cancer Program at the Garvan Institute of Medical Research in Sydney, but despite significant advances, progress is slow due to a lack of funds for research.

2. **Increased funding for women with gynaecological cancer in the Indigenous population and other cultural backgrounds.**

Since the advent of the National Cervical Cancer Screening Program in 1992, cervical cancer has become an uncommon disease in Australia, and the death rate of 1.7 per 100,000 women per year is among the lowest in the Western world. However, cervical cancer is the number one cause of death from cancer among aboriginal and Torres Strait Island women. The incidence of cervical cancer among indigenous women in Queensland is eight times the National average, and death rates across the country are 10 times the National rate. Even higher death rates have been reported from certain aboriginal communities in far North Queensland [1,] and similar high rates have been reported from rural and remote areas of Western Australia and the Northern Territory [2,3].

Having spent 3 years of my early medical career working in far North Queensland, I know that there is no easy answer to the health crisis among Indigenous Australians. Participation rates in the Pap Smear Screening Program are as low as 19% in some North Queensland indigenous communities [4], in spite of a real effort to try to reach such women [5]. In my opinion, funding to allow better education about health issues, particularly addressed to community elders, is likely to be the most effective strategy to address this problem.

3. **Increased funding to increase awareness and prevention of all gynaecological cancers to the same level as cervical cancer.**

The most common gynaecological cancer is uterine or endometrial cancer. There are about 1500 new cases diagnosed each year in Australia, an incidence of 15 per 100,000 women per year. The mortality rate from uterine cancer is quite low, being about 2.2 per 100,000 women per year.

Ovarian and cervical cancer are the next most common, and incidence and mortality rates for these tumours have been addressed above. Other gynaecological cancers, such as vulvar and vaginal malignancies are uncommon, there being only about 200 new cases of vulvar cancer and about 80 new cases of vaginal cancer each year.

The NHMRC recently produced a booklet on Guidelines for the Diagnosis and the Management of Ovarian Cancer, and a similar booklet would be useful for endometrial cancer. A booklet on the prevention, diagnosis, management and prognosis of all gynaecological cancers produced for the lay community would no doubt help with awareness and preventive issues.

An important aspect of prevention is prophylactic surgery for patients with an hereditary cancer syndrome. In the past decade, there has been increasing awareness that about 10% of ovarian cancers are hereditary. Women with a suspicious family history should have appropriate genetic counselling and testing for BRCA I or BRCA 2 mutations. Prophylactic removal of the tubes and ovaries in women with a proven genetic mutation, (after childbearing), is an effective preventative strategy. Unfortunately this information is still not widely known in the medical community, particularly among general practitioners and non-gynaecological specialists.

4. Increased education of gynaecological cancer symptoms with GPs and primary care workers.

Development of guidelines for other gynaecological cancers similar to the NHMRC Guidelines for Ovarian Cancer would be of value to GPs.

5. **Increased funding for Psychological and Psychosexual Care.**

The diagnosis of a gynaecological cancer is a very psychologically distressing experience for women, because treatment is likely to affect a woman's sexuality, body image and/or reproductive capability. Many major gynaecological cancer centres now have a full-time Psychologist, and our experience is that our psychologist is one of the most important members of our multidisciplinary team. I believe that adequate psychosexual support should be considered an essential aspect of gynaecological cancer care.

6. Increased funding for sexually transmitted infections.

It is now known that cervical cancer is caused by persistent infection with the human papilloma virus (HPV). A HPV vaccine for the prevention of cervical cancer will become commercially available later this year, and the vaccination of children prior to the commencement of sexual activity will be a major health issue. It is incumbent on the government to develop a national approach to HPV vaccination. This will inevitably be a controversial issue, because of the sexual nature of the viral transmission.

I trust that this information will be of assistance to your Committee. Should you require further information, please let me know.

Yours sincerely

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