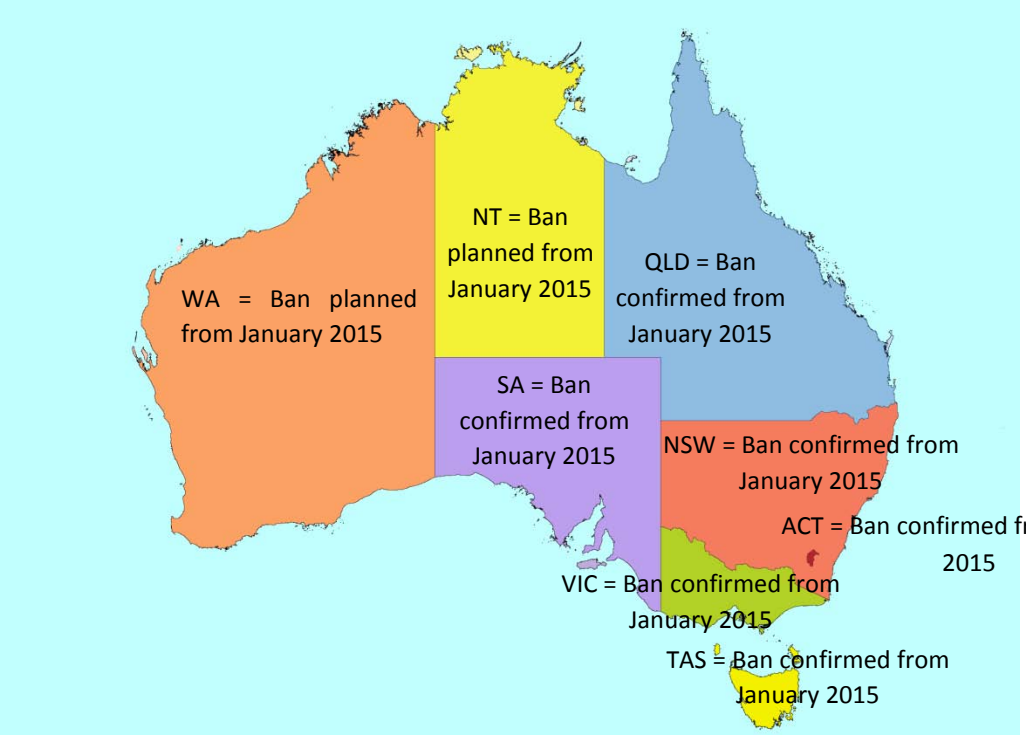
ANZMTG Australia and New Zealand Melanoma Trials Group

NEWSLETTER |ISSUE 13| Summer 2013

Welcome to the Summer edition of the ANZMTG newsletter. We have had a successful and busy year with a number of different events hosted by ANZMTG. The ANZMTG 2013 Annual Scientific Research Meeting was held on the 20th of November, in conjunction with the Global Controversies and Advances in Skin Care Conference in Brisbane. It was a fantastic day and thanks to all of the members who attended. All current recruiting trials were presented, as well as 8 new proposals. We thank all of the members who presented and attended on the day. In addition, ANZMTG continues to work on our open and recruiting studies. Preparation for an interim analysis for the ANZMTG 01.07 WBRTMel study is underway and we have seen a recent boost in recruitment to the ANZMTG 02.09 Mel-D study with plans to complete recruitment by early 2014 on track. ANZMTG has also been developing a number of new studies for a range of indications and we are awaiting the final news on funding. We wish each of the investigators and study teams the best of luck.

Inside this issue:

A National Sunbed Ban is Imminent!



The evidence on sunbeds is clear, regular sunbed use by people under the age of 30 increases the risk of skin cancer by an alarming 75%. An Australian study previously published in the Journal of Cancer showed risk of developing melanoma under the age of 30 increases 6 times for people who use solariums more than 10 times. A single visit to a solarium could increase the risk of melanoma by 41 % (1). The study in people diagnosed with early-onset melanoma, shockingly recorded sunbed use in people as young as 14 years of age!

The good news in Australia is that the state governments in New South Wales, Victoria, Tasmania and South Australia have already laid out plans to ban sunbeds with legislation being phased in over the coming years. The remaining states are hot on their heels and a national ban is looking likely. Australia will be the second country to ban sunbeds, following Brazil (who initiated a national ban in 2009). Other countries have yet to put

in place a full ban however many countries have restricted accesss to sunbeds to people aged less than 19 years of age.

Queensland already has the highest rate of Melanoma in Australia and the UV index reaches extreme levels almost every day. Queensland has become the latest state to prepare for a statewide sunbed ban. The ban will come into force from 31st December 2014. Last year, Queensland changed legislation to prevent any new licences from being issued at the end of 2012 meaning many salons licences will expire prior to the 2014 ban implementation.

Following the news on the ban in Queensland, the North Territory Health Minister has promised that they too will outlaw the use of sunbed before 2015. The state only has 2 sunbed licences and these will not be renewed going forward.

Following these announcements the last state left to ban tanning beds was Western Australia (WA). There were some fears that WA could become a hotspot for the relocation of remaining sunbeds. However the state's health minister Dr Kim Hames ruled out that possibility, confirming he was formulating WA's own policy to ban tanning beds. "I have to take it to cabinet, but if it happens it will happen in the next three months, there is no doubt about the increased risk of cancer – so I think the chances are [a ban in WA] won't be far away." Mr Jay Allen, a stage III melanoma survivor, who works with Melanoma Institute Australia has been hot on this campaign trail ever since his surgeons' told him that his regular sunbed use contributed to his disease. Of the news that Australia could be free of sunbeds by 2015 Jay said, "I have lobbied politicians in every state and territory around Australia for 5 years, I'm very happy that a national ban could happen very soon but the most important part of this campaign is that our future generations will not develop melanoma from solaria and that is a great thing!". Jay has been working with campaingers across all states to get this legislation enacted. We acknowledge and commend the hard work and dedication various organisations and individuals have invested to achieve this fantastic result, which will reduce melanoma incidence especially in young people.

1. Cust et al, Sunbed use during adolescence and early adulthood is associated with increased risk of early-onset melanoma, Int J Cancer. 2011 May 15; 128(10): 2425–2435.

Melanoma Genome Project Update - Genes and DNA as easy as ABC?

Treatment that is based on the genetic profile of a person's tumour is one of the most promising trends in cancer research. This new "personalised" medicine is a major focus for researchers like Professor Graham Mann of the University of Sydney. Professor Mann helps lead the Melanoma Genome Project, a collaborative venture that aims to advance our knowledge of the gene and genome components of melanoma. We interviewed him on the progress of the project and some of his thoughts on how and why the genetic science behind melanoma is changing the face of treatment for patients.

But first, a short primer on genomics. Let's start with our inherited genes, the DNA that makes us who we are. It gives us blue or brown eyes and makes us tall or short! But how does all of this work?

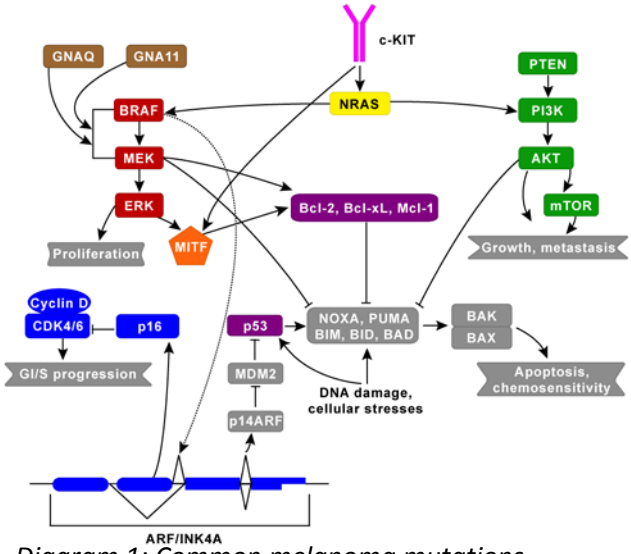


Diagram 1: Common melanoma mutations

Our genes, made of DNA, are the coded instructions for making the proteins and RNAs that make up every cell of our body. The code can be read like letters and words in a book. Differences in the code can result in different traits such as a person's brown or blue eyes. Where these differences result in a rare disease or abnormal state, such as colour blindness, they may be known as mutations. In other cases, these mutations and variations may increase or decrease the chances of getting a particular disease but not guarantee a person will get it. This is the case for melanoma as well.

Strands of DNA are tightly folded into chromosomes, the 'books' through which we inherit our DNA. We all have 22 pairs of chromosomes and an extra pair of sex chromosomes (XX for women, XY for men). The full set of DNA code is called our genome. Everybody has a unique genome, though the basic code of identical twins is the same. We actually inherit two genomes, one from each of our parents, and each of those is a patchwork selection from our grandparents on that side of the family.

Each of our cells has inherited these genomes, with all their variations. However, our DNA also changes over time as part of a natural aging process, and due to exposure to things that damage DNA (sunlight, radiation, chemicals in smoke, etc). The cell tries to repair the damage, but that process may not work fully. The genetic code of that cell may be changed, resulting in a "somatic" (not inherited) mutation, and this may change the function of the cell.

Somatic mutations in specific genes are the basic cause of all cancer, including melanoma. A cancer carries with it the history of all those mutations, because they are what allow it to grow and survive. The mutations might involve deletion or duplication of chromosomes or smaller areas of the genome, changes to the base pair code, and rearrangements that create new genes.

However, where a gene has become activated, and is driving the tumour, it may be possible to design a drug to switch it off. This is the basis of some of the newly discovered treatments for melanoma, which target mutations and overactivity of genes such as BRAF.

1. It looks like there will be more opportunities for aspects of genetic research to be incorporated into clinical trials. Can you describe this more?

Prof Mann: The whole field is on a mission to find all of the mutations that are driving melanoma, and our main tool for that is to sequence the genomes of as many melanomas as possible. But we have to convert that information to better treatments, so that by using the best combinations of drugs we can make the way from mutation discovery in the laboratories into patient care as rapidly as possible.

There have been big advances in recent years. There's the dramatic response that BRAF inhibitors produce, although the majority ultimately relapse. And the targeted immune treatments that seem to give a longer-term response in a smaller number of patients. This is real traction compared with the previous situation where nothing produced these kinds of response rates.

But we can now see that because of the genetic diversity of tumours and wide variety of mutations, just enough resistant cells are left behind to recover and cause relapse in most patients. It seems that we should try to use combinations that kill as many cells as possible in a short space of time, to eliminate the chance of that regrowth occurring and increase the chance of a cure.

So the trials that the field really needs will be more that sample tissue prior to treatment, so its genetic profile can be correlated with outcome, and trials which test more and more drug combinations. These should be done in relatively small numbers of patients so we can zero in more quickly on what works best.

2. What do you enjoy the most in your work on the Melanoma Genome Project?

Prof Mann: It's the sense that we are finally getting to the bottom of things. Until recently genetics research was limited to what we knew we knew! We could really only look for changes in genes that we already suspected were involved in cancer – this is because we could only look one gene at a time. The new DNA sequencing techniques are so efficient that we look at everything at once and work out what is significant afterwards. It sounds like fishing, but it means the true situation can be seen without being limited by what we understood before.

Another great thing is that the information from big cancer genetics projects gets into the public domain where we all can see it. And that's giving us new perspectives where work on one cancer type directly benefits all the others: the next useful drug for melanoma might have been worked up for leukaemia, for example. Finally these projects bring together people who have very different expertise. Working in that

multidisciplinary way has been an enormous pleasure in my research career and it is great to see it paying benefits at the clinical sharp end of melanoma.

For example, the US Cancer Genome Atlas project is just wrapping up its work on melanoma. We contributed more than a third of all the samples to that and are working on its first report, which is very exciting. Most of its data come from exomes (the coding portions of genes), but the Australian project is sequencing the whole genome (coding portions and the huge spaces in between). So we are looking forward to greatly increasing the number of patients whose melanomas have been sequenced, and to shining a light on the full genome, not just a part of it.

2. How is the Australian project progressing?

Prof Mann: So far we've completed whole genome sequencing in more than 160 patients, with 100 more cases currently in the sequencing lab and more tumours on the way. The exome data of about half of these cases has so far has been through the bioinformatics pipeline to produce a detailed list of all the genomic mutations within these patients' tumours. The whole genome data is being worked over to find new structural changes, as a first step. While we get to grips with these data, plans are under way to start making it publicly available, hopefully early in the New Year.

If you would like to know more about genetic testing and research please refer to these useful links:

- Genetics 101: http://www.nhmrc.gov.au/your-health/egenetics/genes-and-chromosomes
- Glossary: http://www.nhmrc.gov.au/your-health/egenetics/glossary
- Your Genome: http://www.nhmrc.gov.au/your-health/genetics-and-human-health/sequencing-your-genome

ANZMTG Website Update

In 2011 ANZMTG survey was circulated to our membership which you may remember formed a feature article in our 2012 spring edition of the newsletter. Survey results indicated ANZMTG associate members (consumers) wanted access to more background information pertaining to melanoma and clinical trials; members wanted to know what trials are available, the results of those trials that have been completed and what events were upcoming that may be of interest to them. Full members and other researchers and clinicians shared different viewpoints, wishing for ANZMTG to increase our connection with international researchers to allow for wider collaboration and to consider more technology based processes for the ANZMTG trials that sites are involved with.

Based on our survey it is apparent that 28% of responders use the internet to source melanoma information and whilst there are a number of initiatives underway with various stakeholders, ANZMTG has now updated and launched the ANZMTG website. The new site was launched in November 2012 and now features an array of relevant and up to date information, but do not just take our word for it, visit our site and judge for yourself. We are always seeking feedback to improve the website so any comments are very welcome. **www.anzmtg.org**

Melanoma Information

News

Events Calendar

Since the launch of our updated website we review the website analytics monthly to monitor activity. This has allowed us to learn that we have had 700 new visitors to our new website in the past 10 months and over 1000 visits, showing 300 visitors have returned to the website after first discovering it. Australian and New Zealand membership still contributes the majority of the visitors which is very important, however we are clearly impacting further across the globe with a greater percentage of our hits coming from the US (4% vs 6%) and UK (2% vs 4%). Countries such as India and Singapore also appearing in our top ten country hit list.

ANZMTG is looking to the future...

ANZMTG has developed a public and member-only content section which enables specific access to ANZMTG – lead trial documents and site staff contact lists. All full members have been allocated a username and password which allows them to view this additional content. In the future, ANZMTG hopes to take this further and improve data management via the website. Work to achieve this is in the early stages of development, so we invite you to watch this space and to keep checking our website to see what exciting new features and information are added.

Health Literacy - What does it mean?

Health literacy is the degree to which a patient has the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions. It could even affect a patient's ability to accurately read a prescription. It is estimated that despite improving education levels in Australia approximate 40% of adults lack the health literacy required to navigate the healthcare system (World Health Organisation). Health literacy is not just about intelligence or the ability to read and write. Understanding the scientific words and complicated explanations that are many times a part of a clinician-patient conversation can be a challenge for many. For patients to make informed decisions about their treatment choices they need to fully understand and be able to 'digest' this information to make choices.

Learning that you have melanoma is a stressful experience. Complicated terms and medical jargon can make patients confused, unsure and overwhelmed making taking information in even more of challenge. Patients with poor health literacy are potentially more likely to present at a later stage of disease and so with more complex discussion required. Navigating the range of different members of the clinical team a melanoma patient may see can prove a challenge to someone with poor health literacy.

Health literacy framework

This is particularly important when a patient may be making the decision to become involved in a clinical trial or not. Therefore adequate time to read and discuss the Participant Information and Informed Consent sheet is vital. Time for the patient to ask questions, many patients that have been on clinical trials often develop a much greater understanding of their disease and dealing with the healthcare system.

Improving health literacy is very important and this is being explored in a number of ways. This work is being done by consumer organizations, government departments, local governments, public and private hospitals and healthcare organizations, clinical and professional groups, non-government organizations, universities and others. The central aims identified in an Australian government review in 2013 are:

- Embedding health literacy into systems. This targets developing and implementing systems and policies at an organisational and societal level that support action to address health literacy.

- Effective health information and interpersonal communication. This focuses on providing print, electronic or other communication that is appropriate for the needs of consumers.

- Integrating health literacy into education. This improves the education of consumers and healthcare providers.

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This is being addressed by Professor Francis Boyle and various collaborators in an upcoming collaborative project looking at how clinicians can better communicate oncology information to patients and the development of new web-based training initiatives. More information on the project is available by contacting the ANZMTG office.

Health literacy is extremely important as evidence suggests the greater a patient's health literacy the better their outcome, therefore it is possible to improve a patient's outcome not necessarily though an improvement in treatment but though improving literacy. Health Literacy is still a new and evolving concept more information is available at:

- https://www.medibankhealth.com.au/resources.asp?t=Research+%A7+resources&cid=7
- http://www.safetyandquality.gov.au/our-work/patient-and-consumer-centred-care/health-literacy/
- http://www.healthissuescentre.org.au/subjects/list-library-subject.chtml?subject=9

Rural versus Urban – Is treatment equal irrespective of where you live?

On the 23rd August the Cancer Institute New South Wales held its 2nd annual 'Innovations in cancer care' conference. One of the major points of discussion was the differences in access to healthcare between rural/remote patients and those living in urban areas. There is evidence from Victoria that rural Victorians are 24% more likely to be diagnosed with melanoma than their urban counterparts (1). Data for all cancers indicate that the death rates are 3 times higher in rural patients than in those that live in the major towns and cities (2).

These differences in survival are being addressed in a variety of ways by healthcare professionals. One of the biggest issues is the access to specialised care; this has been addressed in a number of ways.

Increasing the number of places that patients can attend for treatment. Investment by state and national government in regional cancer centres. A total of 25 regional cancer centres have been funded across Australia to reduce the distance that patients need to travel for treatment (3). In NSW, 95% of patients are now within 100kms of Radiation Oncology services. More Information on the regional cancer centres is available on the DOH website, http://www.health.gov.au/internet/main/publishing.nsf/Content/HHF-RCCP11

Taking the specialists to the bush, virtually! The time of cancer specialists is a finite resource, this means they cannot easily travel to smaller centres to patients without impacting upon their other clinical duties. One way that this has been addressed is telehealth, which is defined by the World Health Organisation as 'the practice of healthcare using interactive audio, visual and data communications. This includes healthcare delivery, diagnoses, consultation and treatment, as well as education and transfer of medical data'. Australia with its great distances between specialist clinician and patient is well suited to this model.

Professor Sabe Sebestan gave an overview of how telehealth has revolutionised the treatment of patients in the catchment area of his regional Centre in Townsville. The advent of video teleconferencing means that he can now lead a consult with patients over 1200 km away in Doomadgee from his clinic room at

the Townsville Hospital. Usually the patient, their local treating clinician and often many members of the patient's family can attend consultations. This is a real strength of telehealth as it allows a patient to have their family and friends around them for support when sometimes receiving challenging news. Professor Sebestan is using telehealth technology to allow supervision of staff in rural and remote medical centres to administer increasingly complex chemotherapy regimens. More information on teleheath including the applicable MBS codes can be found at http://www.mbsonline.gov.au/telehealth.

One of the issues for rural and remote patients is often that if they wish to be involved in a clinical trial travel to a major city is often required. This may not be attractive to all patients and some may decline a chance to be involved in research based on the travel alone. ANZMTG would like to try and increase the opportunities for these patients to participate in research projects. We are currently developing a number of protocols that could be suitable for being fully run or allow for local follow up at regional centres. We hope that this can help to improve the options available for these patients. If you would like to hear more about these projects or get involved then please contact us at ANZMTG@melanoma.org.au.

1. Victorian Cancer Registry 2011

2. Yu XQ, O'Connell DL, Gibberd RW, et al. Cancer survival, incidence and mortality by Area Health Service in NSW 1994 to 2000. Sydney: The Cancer Council NSW, 2003.

3. http://www.ruralhealthaustralia.gov.au/internet/rha/publishing.nsf/Content/Health_and_Hospitals_Fund-Round_2_Regional_Cancer_Centres

Who is CREST and what do they do?

CREST (Cancer Research Economics Support Team) is one of the Cancer Australia National Technical Services. CREST's role is to provide health economics advice and support services to the Cancer Australia Cooperative Clinical Trial Groups and its members, such as the ANZMTG. So what are the services that CREST provides?

1. Advice and input to trial protocols. If you're developing a clinical trial and you think that there might be a question related to resource use or practice change, CREST would be very happy to review your protocol/concept and provide input. If you have any particular questions, please don't hesitate to get in touch with the team directly or through the ANZMTG Executive.
2. Provide ad-hoc advice. Sometimes, you might not have a fully fledged trial protocol or concept, or already be well on your way and just need to bounce a question off someone. If it is related to health economics, CREST is able to help.
3. Participate in concept development workshops and sessions.
4. Health economics training workshops. CREST offers training workshops in health economics that can be tailored to your group, or more general sessions for all comers.
5. Ongoing communications and factsheets providing updates on what has been happening at CREST.

Professor Marion Haas, CREST Program Co-Director, presented a session on health economics at the ANZMTG ASM. As well as providing an overview of CREST and its services, Professor Haas answered questions related to CREST's role or the use of health economic data. Information on CREST, including contact details and to see examples of past factsheets, newsletters and past projects please visit the website at http://www.chere.uts.edu.au/CREST

Professor Haas presenting in Brisbane at the ANZMTG 2013 ASM

Consumer Corner
Introducing the Cancer Australia Consumer Learning website

www.consumerlearning.canceraustralia.gov.au

The importance of the involvement of consumers in the development and ongoing conduct of clinical research and clinical trials is increasingly being recognised. It is important to consider how consumers can be engaged to contribute, share new perspectives, identify priorities for research, and to improve the quality of clinical research and clinical trials.

In this context, it is worthwhile being aware of the resources available to enhance the engagement of consumers. In early 2013, Cancer Australia launched 2 new online multimedia resources which aim to increase the involvement of people affected by cancer in cancer control efforts. The Consumer Learning Website and the Consumer Involvement Toolkit are interactive resources for consumers, CEOs, healthcare professionals, managers, and policy makers.

The Consumer Learning website is designed to enhance consumer knowledge and confidence in participating in cancer clinical research. It provides a basic introduction to the conduct of cancer clinical trials in an interactive and easy to follow format featuring the use of videos and written transcripts which uses lay language. Navigation through the website is made simple by breakdown into 4 main sections, and different learning modules being present within each section.

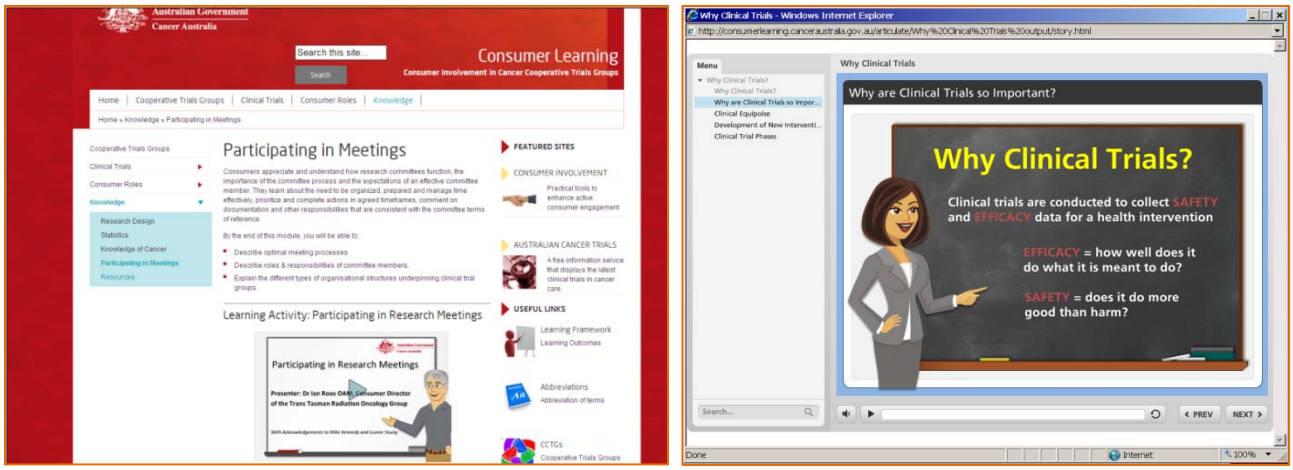

Figure: The website has a number of interesting videos in the learning modules, easy to access and view

In addition, the website also contains a list of other related resources and links which are useful. The 4 main areas of the website are:

1. ***Cancer Cooperative Trials Groups*** – provides a list and brief explanations on the 14 Cancer Cooperative Trials Groups in Australia. The individual links to each of the group's websites are also indicated in this section.
2. ***Clinical Trials*** – provides an introduction to clinical trials both in Australia and internationally, funding opportunities for clinical research within Australia, and the role of government and non-government organisations.
3. ***Consumer Roles*** – provides an understanding of the what, when and how of consumer involvement and contribution to clinical trials including the review of participants information and consent forms, publication, and dissemination of information to the broader community.
4. ***Knowledge*** – contains learning activities which helps consumers learn about involvement in meeting with researchers, information on cancer and clinical study designs and an introduction to statistics.

To explore the Consumer Learning website, please log on to http://consumerlearning.canceraustralia.gov.au/

ANZMTG Clinical Trials Update

ANZMTG 01.07 Whole Brain Radiotherapy (WBRT) following local treatment of intracranial metastases of melanoma - A randomised phase III trial *(Acronym: WBRTMel)*

Chief Investigator: Dr Gerald Fogarty; ANZMTG Trial Co-ordinator: Vanessa Neve
Status: Open to recruitment
Current accrual: 130 patients
Target accrual: 200 patients over 5 years

For further information on the trial, contact Vanessa Neve on +61 2 9911 7348 or email vanessa.neve@melanoma.org.au

ANZMTG 01.09 A randomised trial of post-operative radiation therapy following wide excision of neurotropic melanoma of the head and neck *(Acronym: RTN2)*

Chief Investigator: Dr Matthew Foote; Trial Co-ordinators: Janelle Meakin (TROG) & Alan Lucas (ANZMTG)
Status: Open to recruitment
Current accrual: 20 patients
Target accrual: 100 patients over 5 years

For further information on the trial, contact Janelle Meakin on +61 7 3176 2498 or email janelle.meakin@health.qld.gov.au or Alan Lucas on +61 2 9911 7352 or email alan.lucas@melanoma.org.au

ANZMTG 01.11 Phase I Study of safety and immune effects of an escalating dose of autologous GD2 chimeric antigen receptor-expressing peripheral blood T cells in patients with metastatic melanoma *(Acronym: CARPETS)*

Chief Investigator: Professor Michael Brown; Trial Coordinator: Anne Milton

Status: Protocol finalised, TGA CTX submitted; not yet open (Royal Adelaide Hospital only)

For further information on the trial, email anne.milton@health.sa.gov.au or contact ANZMTG on +61 2 9911 7354 or email anzmtg@melanoma.org.au

ANZMTG 02.09 Vitamin D following primary treatment of melanoma at high risk of recurrence - a pilot placebo controlled randomised phase II trial *(Acronym: Mel-D)*

Chief Investigator: Dr Robyn Saw; ANZMTG Trial Co-ordinator: Alan Lucas
Status: Open to recruitment (Melanoma Institute Australia only)
Current accrual: 58 patients
Target accrual: 75 patients over 2 years

For further information on the trial, contact Alan Lucas on +61 2 9911 7352 or email alan.lucas@melanoma.org.au

A phase III multicenter randomized trial of sentinel lymphadenectomy and complete lymph node dissection versus sentinel lymphadenectomy alone, in cutaneous melanoma patients with molecular or histopathological evidence of metastases in the sentinel node *(Acronym: MSLT II)*

Chief Investigator: Dr Don Morton; Trial Co-ordinator: Lisa van Kreuningen
Status: Open to recruitment
Current accrual: 1852 patients (worldwide)
Target accrual: 1925 patients over 7 years

For further information on the trial, contact Lisa van Kreuningen on +1 310 5827053 or email lvk@jwci.org

EORTC Melanoma Module *(Acronym: MELMOD)*

Chief Investigator: Associate Professor Julie Winstanley
Status: Ongoing
For further information on the trial, contact Julie Winstanley by email julie.winstanley@sydney.edu.au

ANZMTG Trials Approved for Development Update

ANZMTG 01.12 - Evaluation of Groin Lymphadenectomy Extent for Metastatic Melanoma *(*Acronym: *EAGLE FM)*

Chief Investigator: Professor Andrew Spillane; Co-Investigator: Dr Chris Allan
ANZMTG Trial Co-ordinator: Alan Lucas
Status: In development

For further information on the trial, contact Alan Lucas on +61 2 9911 7352 or email alan.lucas@melanoma.org.au

ANZMTG 02.12 - A randomised controlled multicentre trial of imiquimod versus radiotherapy for lentigo maligna when staged surgical excision with 5mm margins is not possible, is refused, or fails *(*Acronym: *RADICAL)*

Chief Investigator: Dr Pascale Guitera; ANZMTG Trial Co-ordinator: Vanessa Neve
Status: In development

For further information on the trial, contact Vanessa Neve on +61 2 9911 7348 or email vanessa.neve@melanoma.org.au

ANZMTG 03.12 - Randomised controlled trial of 1cm versus 2 cm excision margins for 1-4 mm thickness primary invasive cutaneous melanoma *(*Acronym: *MelMarT)*

Chief Investigator: Professor Michael Henderson; ANZMTG Trial Co-ordinator: Vanessa Neve
Status: In development

For further information on the trial, contact Vanessa Neve on +61 2 9911 7348 or email vanessa.neve@melanoma.org.au

ANZMTG 04.12 - Radiotherapy followed by selective nodal dissection for high volume regional melanoma *(*Acronym: *REFORM)*

Chief Investigator: Dr Matthew Foote; ANZMTG Trial Co-ordinator: Alan Lucas
Status: In development

For further information on the trial, contact Alan Lucas on +61 2 9911 7352 or email alan.lucas@melanoma.org.au

New Ideas for Melanoma Research?

ANZMTG have received a number of new study proposals which were considered as part of the 2013 Annual Scientific Meeting. More information will be available on the website soon.

To submit a new proposal please log on to the ANZMTG website, download and complete the **ANZMTG Clinical Trial Protocol Synopsis/Research Proposal Synopsis**. Alternatively please contact the ANZMTG office.

Global Controversies in Skin Cancer Conference in Brisbane QLD

We congratulate all ANZMTG members who presented at the recent GC-SC conference held in Brisbane. ANZMTG trials were highlighted in a session at the recent GC-SC entitled 'Melanoma research and clinical trials in Australia and New Zealand – Leading the way', including presentations by the Study Chairs for the ongoing and proposed studies. Thank you to all who came and met the team. If you have any questions or would like more information on the study please contact us at anzmtg@melanoma.org.au

Cancer Australia

ANZMTG would like to acknowledge funding received from the Australian Government through Cancer Australia.

Calendar of Events

Date	Name of Event	Location	Website
2013			
December			
4	International Society of Dermatology 11th International Congress of Dermatology 2013	New Delhi, India	http://www.intsocderm.org/i4a/pages/index.cfm?pageid=1
6	8th Annual Practical Couse in Dermoscopy and Update on Malignant Melanoma 2013	Scottsdale, USA	http://www.mayo.edu/cme/dermatology-2013s959
2014			
January			
10 - 12	Asian and Australasian Society of Stereotactic and Neurosurgery Annual Scientific Meeting	Shanghai, China	http://www.aassfn2014.com/
16 - 18	2nd European School of Dermato-Oncology (EADO) – Foundations of Cutaneous Oncology	Istanbul, Turkey	http://dermato-oncology2014.org/
12 - 15	Society for Surgical Oncology (SSO) Annual Cancer Symposium	Phoenix, Arizona	http://events.jspargo.com/sso14/public/enter.aspx
19 - 21	Biomarker Summit 2014	San Diego, USA	http://www.gtcbio.com/conference/oncology-biomarkers-overview
April			
1 - 4	Trans-Tasman Radiation Oncology Group (TROG) Annual Scientific Meeting	Sunshine Coast, Australia	http://trog.com.au/Default.aspx?tabid=120
3 - 8	European Society for Radiotherapy and Oncology Conference	Vienna, Austria	http://www.estro.org/congresses-meetings/items/estro-33
14 - 16	Advanced Therapeutic and Modern Dermatological Technologies	San Antonio, USA	http://dermatology2014.conferenceseries.net/
May			
5-9	Australian College of Surgeons and Plastics Surgeons combined Annual Scientific Congress	Singapore, Singapore	http://www.racsanzca2014.com/
7 – 10	10th European School of Dermato-Oncology (EADO) Congress	Vilnius, Lithuania	www.eado2014.com
12	Advances in Cancer Screening and Prevention Research	London, UK	https://www.regonline.co.uk/builder/site/Default.aspx?EventID=1258354
18 - 21	Australian College of Dermatologists Annual Scientific Meeting	Melbourne, Australia	http://www.dermcoll.asn.au/public/meeting_and_conferences.asp
30 May - 3 June	American Society of Clinical Oncology (ASCO) Annual Meeting	Chicago, USA	http://am.asco.org/
June			
26 - 27	4th European Post-Chicago Melanoma / Skin Cancer Meeting	Munich, Germany	http://melanomaglobal2014.org/
July			
6 - 11	European Society for Plastic, Reconstructive and Aesthetic Surgery Congress	Edinburgh, Scotland	http://www.espras2014.org/
August			
6 - 8	Medical Oncology Group of Australia (MOGA) Annual Scientific Meeting	Sydney, Australia	https://www.moga.org.au/

For more information of other upcoming oncology meetings and events please visit the ANZMTG website. A complete listing of 2014 events is available on the website under the 'Events' tab.

Please contact the ANZMTG office if you would like to include any other upcoming meetings.