

Victorian Cancer News

*A Quarterly News Letter issued by
the Public Education Sub-Committee
of the Anti-Cancer Council of Victoria*

No. 5, AUGUST, 1960

VICTORIAN CANCER CONGRESS

The first Victorian Cancer Congress will be officially opened by the Premier, the Hon. H. Bolte, on Monday, the 22nd of August, in the Melbourne Town Hall.

The Congress, the first of its type ever held in Australia, is sponsored by the Anti-Cancer Council of Victoria. It will consist of five plenary sessions and six sectional meetings in which the broad subjects of carcinogenesis (the origin of cancer), cancer in the community, cancer of the lung, cancer of the skin and leukaemia will be discussed.

Many eminent overseas authorities have accepted invitations to attend the Congress and contribute to the programme. They include the President of the International Union against Cancer, Professor V. R. Khanolkar, who is Director of the Indian Cancer Research Centre and Vice-Chancellor of the University of Bombay, and Professor T. Yoshida, Professor of Pathology in the University of Tokyo, and a world authority on cancer.

Another distinguished visitor is Professor Rupert Willis, Emeritus Professor of Leeds University. Professor Willis, a Victorian by birth, is the author of several "classic" textbooks on Pathology.

Doctors and research scientists from all Australian States and from New Guinea are attending the Congress, and it is expected that the total attendance will exceed 500.

EXAMINATION OF PUBLIC EDUCATION TECHNIQUES

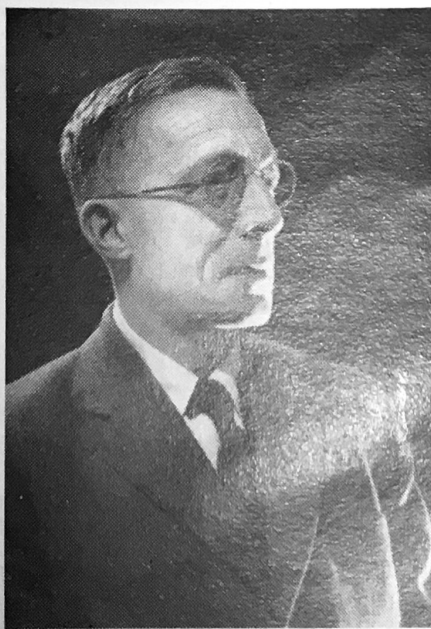
The plenary session on "Cancer in the Community" will be particularly concerned with the examination and assessment of some of the techniques of public education in cancer. The findings of two current investigations being conducted on behalf of the Anti-Cancer Council, by the Departments of Psychology and Audio-Visual Aids of the University of Melbourne, will be presented for discussion.

Dr. Godfrey Gardner, of the Department of Psychology, will present a report on "Public Attitudes Relevant to Cancer Education." The analysis of interviews with a selected cross-section of the Victorian population—using a questionnaire

designed to reveal the level of knowledge of cancer in the community, the channels through which this knowledge reaches the public, and public attitudes to treatment — provides the material for his report.

Mr. Newman Rosenthal and senior research workers of the Department of Audio-Visual Aids will review the results of a research project on the effectiveness of films in cancer education. The problem is approached from the viewpoint of instruction (the degree to which relevant facts, concepts, etc., are successfully communicated to various types of audience), and motivation (the degree to which presentation of the message actually increases audience tendencies to take positive action with respect to seeking early medical advice, health check-ups, etc.).

The plenary session will also include a discussion by Professor Khanolkar on "Oral Cancer in India and its relation to certain Health Habits," as an illustration of environmental influences on the development of some types of cancer.



Professor Rupert A. Willis (Great Britain)

CARE OF CANCER PATIENTS

The sectional meeting on "Cancer in the Community" will be devoted to a discussion of problems in the care of cancer patients, more particularly those patients with a poor prognosis or in the terminal stages of the disease. The particular problems encountered by medical social workers in dealing with cancer patients will be dealt with by Mrs. Beryl Thomas, of the Department of Social Studies, University of Melbourne.

Sir William Upjohn, Chairman of the Congress Organising Committee, will discuss "What Should the Patient be Told?" Mr. Victor Stone, Hon. Director of the Cancer Unit at the Austin Hospital, will speak on "The Palliative Treatment of Advanced Cancer", and Miss C. N. Turner, of the Peter McCallum Clinic, will present a paper on "Dietetic Care of Cancer Patients."

The sectional meeting will be opened by Cr. W. J. Kilpatrick, C.B.E., Chairman of the Anti-Cancer Council's Service Committee, who will speak on "Voluntary Community Effort in the Field of Cancer."

SKIN CANCER IN VICTORIA

In the plenary session on "Cancer of the Skin", Dr. G. Read, of the State Health Department, will present the results of a survey of the incidence of cancerous and pre-cancerous skin conditions in Victoria.

The survey has been carried out by the Health Department in collaboration with the Anti-Cancer Council. Municipal Councils and the voluntary Cancer Committees established by the Anti-Cancer Council co-operated in various parts of the State to organise examinations of persons selected at random from the electoral rolls.

Attendance for the examination, which consisted of a simple inspection of the face, neck and hands, was completely voluntary, but most centres reported almost 100% response. Altogether about 7,000 people were examined.

It is expected that valuable information relating to the development of cancer of the skin will be gained from the survey.

OVERSEAS GUESTS AT THE CONGRESS

FROM GREAT BRITAIN:

DR. PETER ALEXANDER—(Chester Beatty Research Institute, London).

Dr. Alexander has specialised in the field of Radiobiology, and is the author of two books and numerous scientific papers on the subject.

DR. D. A. G. GALTON — (Chester Beatty Research Institute, London).

Dr. Galton is particularly interested in the study of leukaemia. He is head of the Clinical Research Department, and Honorary Consultant in Chemotherapy at the Royal Marsden Hospital, London.

PROFESSOR P. C. KOLLER—(Chester Beatty Research Institute, London).

Professor Koller is Professor of Cyto-Genetics in the University of London, and is the author of many scientific papers.

PROFESSOR RUPERT WILLIS — (Emeritus Professor of Leeds University, England).

Professor Willis, a Victorian by birth, is a renowned pathologist, and is the author of several textbooks on Pathology. He is a Fellow of the Royal Society of Medicine.

FROM THE UNITED STATES OF AMERICA:

DR. JACOB FURTH—(Roswell Park Memorial Institute, Buffalo, N.Y.).

Dr. Furth is Director of the Institute's Department of Experimental Pathology at the University of Buffalo. He is a Past-President of the American Association for Cancer Research, and a recipient of the Gold Medal of the American Medical Association.

PROFESSOR JAMES A. MILLER—(University of Wisconsin).

Professor Miller is Professor of Oncology in the University of Wisconsin, and a Member of the Food Protection Committee of the National Research Council of the United States.

Professor Miller's wife, **DR. ELIZABETH MILLER**, who has collaborated with her husband in cancer research for many years, will also contribute to the Congress Programme.

DR. ERNEST L. WYNDER — (Memorial Centre for Cancer and Allied Diseases, New York).

Dr. Wynder is an Associate Professor of Preventive Medicine, Sloan-Kettering Division of Cornell University Medical College, New York.

He is the author of numerous medical and scientific papers, and has paid much attention to the role of cigarettes in the causation of lung cancer.

FROM NEW ZEALAND:

DR. F. BIELSCHOWSKY—(University of Otago Medical School, Dunedin).

Dr. Bielschowsky is the author of numerous papers on clinical and experimental medicine.

MR. J. H. HESLOP—(University of Otago).

Mr. Heslop is a practising surgeon with a particular interest in skin cancer. In 1959 he received the Moynihan Prize.

DR. STEPHEN WILLIAMS—(Green Lane Hospital, Auckland).

Dr. Williams is Pathologist at Green Lane Hospital, the principal thoracic unit in New Zealand. He is particularly interested in lung cancer.

FROM ISRAEL:

PROFESSOR ISAAC BERENBLUM — (Weizmann Institute of Science, Rehovoth).

Professor Berenblum is Head of the Institute's Department of Experimental Pathology, and a Founding Member of the Israel National Academy of Sciences and Humanities.

He is the author of numerous papers on cancer research and of a book for the layman entitled, "Man Against Cancer: the Story of Cancer Research."

FROM INDIA:

PROFESSOR V. R. KHANOLKAR — (Tata Memorial Hospital, Bombay).

Professor Khanolkar is Director of the Indian Cancer Research Centre and Hon. Director of Laboratories at the Tata Memorial Hospital in Bombay.

In 1955 he was awarded the title of Padma Bhushan by the Government of India for his work in cancer research, and was recently appointed Vice-Chancellor of the University of Bombay.

Prof. Khanolkar is President of the International Union Against Cancer.

FROM JAPAN:

PROFESSOR T. YOSHIDA — (University of Tokyo).

Professor Yoshida is Professor of Pathology and Dean of the Faculty of Medicine in the University of Tokyo.

He is a world authority on cancer, and the author of numerous medical and scientific papers.

He has been awarded the Order of Culture Merits in his own country.



Professor Tomizo Yoshida (Japan)

MEDICAL EXAMINATIONS FOR CANCER DETECTION

Representatives of the Anti-Cancer Council of Victoria, and of the Victorian Branch Council of the British Medical Association, discussed recently the problems associated with medical examinations for the detection of cancer.

As a result of this discussion the following statement was drawn up for circulation to medical practitioners in Victoria. It is reprinted here with the permission of the Victorian Branch Council for the information and guidance of members of all country cancer committees:

"Now that increasing numbers of people are becoming cancer conscious, requests are frequently made to doctors from persons wishing a medical examination for detection of cancer.

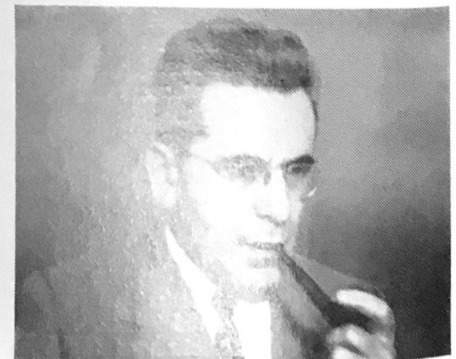
The Anti-Cancer Council, in its educational campaign, has not advised a healthy individual to seek such an examination. The Anti-Cancer Council's policy is to spread knowledge of the common warning signs of cancer, and to advise any person noting one of the warning signs to visit his own doctor for further advice.

"However, in other countries, and particularly in North America, cancer organisations often advise a medical check-up for detection of cancer yearly, or more frequently. Many persons in Victoria, aware that such advice is sometimes given in U.S.A. and Canada, desire such examinations.

"The Branch Council is of the opinion that every person seeking medical advice is entitled to receive it from the doctor of his choice. It is true that the most careful examination cannot provide conclusive evidence of the absence of cancer, so that no positive assurance can be given to any patient that a malignant growth is not present.

On the other hand, the most readily detectable cancers are among those which are most common. Cancers of the skin and breast alone account for some 40% of all cancers.

"For these reasons, the Branch Council considers that when a patient requests a medical examination for detection of cancer, the doctor should meet the request, having first informed the patient of the limitations of such examinations and also of the possibility that further special investigations may be indicated."



Professor Isaac Berenblum (Israel)

SMOKING AND LUNG CANCER

HEALTH COUNCIL URGES NATIONAL CAMPAIGN

The Australian National Health and Medical Research Council has recommended that Commonwealth and State Departments of Health, Local Health authorities, and educational institutions should devote special attention to a national campaign to publicise the risks to health attaching to smoking. The Council expressed the opinion that there was a strong contributory causal relationship between cigarette smoking and lung cancer.

The Federal Minister for Health, Dr. Donald Cameron, gave this information in reply to a question in the House of Representatives on Wednesday, 18th May. He added that the Council also suggested that it might be advisable for the Federal and State Governments to consider whether advertising designed to promote smoking in young people should be controlled in some way.

The Council, comprising 20 eminent doctors and public health specialists, advises both Commonwealth and State Governments on public health and medical problems. Its recommendation, passed during its 49th session, held at Canberra on 12th May, followed discussion of a report by Dr. C. E. Cook, of the Commonwealth Health Department.

LUNG CANCER IN AUSTRALIA

In his report Dr. Cook drew attention to the growing incidence of lung cancer, and pointed out that it was highest among those who smoked heavily. He stated that in 1954 the Australian death rate from lung cancer in the 45-74 age group was 686 per million in males and 93 per million in females.

Four years later, the Commonwealth Statistician's figures showed that the lung cancer incidence in this age group had risen to 824.5 per million in males and 101.5 per million in females. The rate of increase between 1954 and 1958 was 33 per cent.

During 1958 the total deaths at all ages from motor traffic accidents was only 50% more than the total deaths from lung cancer. In the 45-74 age group in this year there were 752 road accident deaths and 1,157 deaths from cancer of the lung.

AMERICAN STATEMENTS

The report also drew attention to recent statements by the Surgeon-General of the United States Public Health Service, and by the American Cancer Society on the relationship between smoking and lung cancer.

The Surgeon-General, writing in the "Journal of the American Medical Association" (28/11/59), declared that evidence to date justified the following statements:—

"The weight of evidence at present implicates smoking as the principal etiological factor in the increased incidence of lung cancer.

"Cigarette smoking particularly is associated with an increased chance of developing lung cancer.

"Stopping cigarette smoking even after long exposure is beneficial.

"No method of treating tobacco or filtering the smoke has been demonstrated to be effective in materially reducing or eliminating the hazard of lung cancer.

"The non-smoker has a lower incidence of lung cancer than the smoker in all controlled studies, whether analysed in terms of rural areas, urban regions, industrial occupations or sex.

"Persons who have never smoked at all (cigarettes, cigars or pipe), have the best chance of escaping lung cancer.

"Unless the use of tobacco can be made safe, the individual person's risk of lung cancer can best be reduced by the elimination of smoking."

"NO REASONABLE DOUBT"

The American Cancer Society's statement which appeared in the "Journal of the American Medical Association" (26/3/60) said that in 1959 the male death rate from lung cancer in the United States was more than 10 times what it was in 1930, and the disease is now one of the most common and most lethal of all forms of cancer.

The Society considered that the clinical, epidemiological, experimental, chemical, and pathological evidence presented by recent studies indicated beyond reasonable doubt that cigarette smoking is the major cause of the unprecedented increase in lung cancer.

Twenty-eight studies have shown that a history of smoking is more common among lung cancer patients than among those without the disease, while three follow-up studies demonstrated that the

death rate from lung cancer is 10 times greater among cigarette smokers than non-smokers.

EXPERIMENTAL EVIDENCE

The cause and effect relationship is well supported by other types of evidence, said the Society. In experiments, condensates of tobacco smoke have produced cancers on the skin of mice and rabbits. At least 10 chemical agents identified in cigarette smoke have caused the development of cancer in laboratory animals.

Studies of pathological changes in bronchial tubes of smokers have shown that abnormal cellular changes in the bronchi of the lung increase in degree and frequency as the amount of cigarette smoking increases, and that, in non-smokers, these changes are scarcely present at all.

While certain occupational causes are recognised, and other causative factors, such as air pollution, have been implicated in some cases, the Society believed cigarette smoking to be the major controllable factor in the development of most cases of lung cancer.

As Dr. Cameron pointed out in his statement to the House, not all authorities agree with this view. **But, he added, the body which advises the Federal and State Governments of Australia, after reviewing the evidence, has concluded that smoking, and particularly the smoking of cigarettes, is a very important contributory cause of cancer of the lung.**

FOOTNOTE:

Figures released by the Commonwealth Bureau of Census and Statistics on 28th June show that Australians smoked a record 5.31 lb. of tobacco per head in 1958-59, compared with 3.34 lb. per head in 1938-39. Taxes on tobacco netted the Treasury more than £83 million last year ("The Sun," 29/6/60).



Cigarette Smoking Machine at the Sloan-Kettering Institute, New York.

Each carton of cigarettes smoked produces 1/3rd of an ounce of tarry condensate.

THE SEARCH FOR A CURE

CHEMICALS AGAINST CANCER

Localised cancers — that is, those discovered before they have spread from the site of origin to other parts of the body — can often be completely removed by surgery or destroyed by radiation. These methods, however, cannot cure cancers that have already spread when first diagnosed, or those, like cancers of the blood and blood-forming tissues, that are widespread from the beginning.

A major goal of cancer research today is the discovery of chemical agents which will seek out and selectively destroy cancer tissue without harming normal body tissues. Such a chemical would be the most desirable form of therapy, for not only could localised cancer then be cured without recourse to extensive surgery or to a long course of radiation treatment, but disseminated cancer might also be treated effectively.

The idea that cancer might be influenced by chemical substances is by no means new, for some, including arsenic compounds, have been used in the past with doubtful beneficial effect. In recent years, however, and especially since World War II, an intensive programme, world wide in scope, has been developed to discover chemicals effective against the cancer cell.

Many such chemicals are now known, but the vast majority destroy normal cells just as readily as cancer cells, and are therefore worthless. Put in simplified terms, the problem is first to find a constituent or function which is vital to the cancer cell, but not so important to normal cells, and then to discover whether this essential part is vulnerable to chemical attack.

This principle of destroying a hostile cell by selective chemical action is well-established in medicine. It is similar to the effect of the anti-bacterial sulfa drugs, which starve bacteria to death by acting as inert material which the organism absorbs in mistake for food.

Essentially, chemotherapy research involves the development and testing of thousands of chemical substances every year. In the United States some 50,000 different compounds — including alkylating agents, anti-metabolites, hormones and steroid compounds, antibiotics, etc. — are investigated yearly. Many other countries, Great Britain, Germany, Japan, the U.S.S.R. and Australia among them, are also active in the search.

Chemicals for trial are submitted to a vigorous testing programme. They are tested against laboratory animals with a large variety of transplantable cancers, and against cancer cells growing in test tubes and in fertilised eggs. Until recently these latter were usually rat and mouse cancers, but it is now possible for scientists to grow human cancers under laboratory conditions and to use them directly in the preliminary trials.

To test a compound for its ability to kill insect pests, bacteria or viruses is relatively easy. To prove that it can destroy cancer cells without at the same

time inflicting serious damage to the host is a far more complicated and delicate task. There are many different types of cancer, both in animals and in man. And there are many different kinds of normal cells, any one of which may prove unpredictably sensitive to a particular substance. Thus, a whole range of scientific tests is required to learn in detail the action of each compound tested.

Research workers must be alert for the slightest sign of the type of effect desired. Discoveries rarely burst upon the scientist. Most often an almost imperceptible effect upon cancer is detected, and then, step by step, the compound is improved until at last a useful therapeutic agent is derived from a crude and often highly-poisonous original.

At first, most of the compounds screened were selected on a "trial and error" basis. That is, a wide variety of chemicals selected according to pre-determined plan were tested for their abilities to destroy one kind of cell while leaving others unharmed. Today, with the knowledge gained from these extensive trials, scientists are able to develop in the laboratory, on the basis of specific molecular structure, drugs which will have a predictable effect on a particular type of cell.

If cancer chemotherapy research is ultimately successful, it will provide drugs that will cure cancer either alone or in combination with other forms of treatment. In all probability, achievement of this goal will be gradual, and doctors will be armed with not one, but many chemicals, each effective against a specific form of cancer.

It is not likely that a single drug will be discovered which will be effective against all the major types of human cancer. The proposition of a single drug for all cancers would presuppose that all types of malignant cells contain a common component which distinguishes them from normal cells. No such component has yet been demonstrated, and the evidence to date indicates that each type of cancer in man represents a separate chemotherapeutic problem.

Although no drug which will permanently cure any kind of human cancer has yet been discovered, research has produced more than 20 compounds which are effective in controlling, temporarily, some forms of malignant disease. At least another 100 drugs are now undergoing clinical trials in the United States and other countries.

The 20-odd chemical agents now in standard use are of several types. Some are cell poisons intended to interfere with the process of cell division, and thus to inhibit the growth of cancer cells. Others, known as metabolic antagonists, are intended to starve cancer cells by blocking vital metabolic processes. Still others are aimed at modifying the hormonal environment in organs of the body, such as the breast and prostate, where certain cancers have been found to be hormone-dependent.

These chemicals that can change temporarily the course of cancer in man furnish the hope that even better controls can be developed in the future. Already eight forms of the disease are known that can be controlled by drugs, sometimes for several years. These include: cancer of the breast, cancer of the prostate, acute leukaemia in children, chronic leukaemia in adults, Hodgkin's disease, rhabdo-myosarcoma (a rare muscle cancer), Wilms' tumour of the kidney (present at birth), and choriocarcinoma (a rare cancer in women).

The treatment of acute leukaemia, which accounts for half of all cancers in children, is an example of what has been accomplished.

Fifteen years ago, almost nothing could be done for the child with acute leukaemia, and less than half the young patients lived for six months after diagnosis.

Then came the discovery of the anti-folic acids, followed shortly by the hormones, ACTH and cortisone. In 1954, another antimetabolite, 6-mercaptopurine, which interferes with cell nutrition by supplying a counterfeit purine, was discovered. Doctors treating patients with acute leukaemia can now "ring the changes" with these and other agents, using one until it loses its effect, then switching to another.

While no child with acute leukaemia has yet been cured, some heartening gains can be reported. Over half the children now live at least a year, and some for several years, after diagnosis. Even more important, these added months are generally normal, happy ones. During their remissions the children appear healthy, and are able to return to home and school. Then, too, there is always the chance that in these months some better and more effective agent will be discovered.

Hormonal therapy of cancer goes back some 20 years. Hormones are able to exert a dramatic effect even in cases where the disease has progressed beyond the scope of surgery and radiotherapy. In cases of inoperable prostatic cancer in men, and inoperable breast cancer in women, hormonal treatment often gives clinical improvement and appreciably increases life expectancy.

Although the beneficial effects of hormones in these cases appear to be temporary, present studies may provide the groundwork for permanent cure of certain hormone-dependent cancers.

While surgery and radiotherapy remain at present the only known cures for cancer, chemotherapy has now progressed to the stage where it is accepted as a valuable adjunct to these methods. The therapeutic results obtained with the drugs now available have provided encouragement for even more intensive research on chemotherapy, with the hope that eventually its powers will be extended from palliation to permanent cure.

MY NEW LEASE OF LIFE

by Mrs. Margaret Eldridge

It is five years now since I was found to be suffering from cancer. I remember the day the doctor told me I had cancer of the breast, and that an operation was necessary.

In a way I was quite prepared for the news. A few days before I had found a puckering of the skin and a small lump in one breast, and had gone at once to my family doctor. I knew that many lumps in the breast were harmless—I had had a cyst removed two years earlier — but I still expected the worst.

Nevertheless it came as a very severe shock to learn that I had cancer. I was not a stranger to the disease since, for several years before my marriage, I had worked in hospitals, often with cancer patients.

But — it was always one of the things which happened to other people, and never to oneself. I do not remember being afraid — rather, I was horrified.

The next day my husband and I talked the matter over. We decided that the best way to handle the situation was to treat it as a challenge, not as a calamity.

We resolved neither to dramatise my illness nor to minimise its seriousness, but to speak of it openly to each other and to our friends, calling it by its name.

We soon became quite used to seeing people wince a little when we spoke of it, frankly, as cancer. But in time they, too, came to accept it as a fact of life which need not — and should not — be hushed up or glossed over.

We also decided that as far as possible, after my treatment was completed, I would resume a normal life, avoiding any suggestion of invalidism.

Deep X-ray therapy followed surgery. The cumulative effects of deep X-ray — lassitude, depression and nausea — have been much exaggerated, so that many patients embark upon the treatment in a state of acute nervous anticipation. It is true that these effects are sometimes unpleasant, but they are only temporary, and are much outweighed by the benefits of radiotherapy.

While still in hospital, I was able to visit other cancer patients who were being similarly treated. These visits were a great source of mutual encouragement. Sharing the load seemed to lighten it, and I returned home full of determination and confidence.

During the months of convalescence I often felt weary and depressed. Nevertheless, I went about my ordinary housework as well as I could, taking frequent rests and avoiding any heavy lifting.

As I gradually returned to full health I seemed to do so with heightened perceptions. Usually we take for granted the freshness of the morning sky, the veining on a leaf, or the brilliance of dew-spangled cobwebs. Now these things came "alive" for me.

Even the ordinary things in our home took on a new quality of friendliness. It was as though I was seeing them, and indeed the whole of life, for the first time. I was truly happy.

While I rested I did a good deal of thinking. I realised that, if I had not had some knowledge of the early signs

of cancer, I might easily have missed that warning lump, or postponed investigating it. I made up my mind that, if I ever had the chance to help in the fight against cancer, I would take it with both hands!

My opportunity came when the Anti-Cancer Council of Victoria launched its campaign for Public Education, and I was accepted as a member of the panel of speakers. Doctors with the Council told me that the very word cancer is so frightening to many people that they delay seeking medical advice, even after they recognise their symptoms. Time for successful treatment may run out for these people while they hesitate.

Probably, my usefulness as a member of the panel is less as a speaker than as an exhibit! When I tell a group of people, who see in me exactly what I am — a happy, healthy, middle-aged woman — that I am also a cancer subject, their attention is held immediately.

In my talks I stress the importance of early diagnosis and treatment, which is so vital for success. I explain that one cancer patient in three is being saved today, but that one in two could be cured, if only all patients would seek treatment at once when the first symptoms are noticed.

I also urge the audience that if ever they are called upon to meet the challenge of cancer personally, they should endeavour to do so by joining with their doctors and nurses, as a team, to fight the disease with faith, determination and courage.

As far as possible, I encourage discussion and questions. Some of these are asked in public, and others are put to me privately, after the general discussion is over. It is then that I feel sure that this work of Public Education is worth while, and that our efforts are slowly but surely breaking through the barriers of fear and ignorance.

When, for example, an anxious, elderly woman whispered — "Now I've got courage to go and see my doctor. I've been so worried! Thank you." When another woman beamed and said: "I'd given up hope for my friend. She's having deep X-ray and I always thought they only did that as a last resort. But, look at **you!**"

In the last five years I have learnt to enjoy life to the full. I am thankful to be alive and in good health, and proud of the privilege of sharing in the fight against a terrible disease.



"Yes, I HAD Cancer!"

HOW WELFARE FUNDS ARE SPENT

During the 1958 Cancer Campaign it was announced that 12½% of the money raised would be used for welfare purposes. Of the remainder, 75% would be allocated for cancer research, and 12½% for public education.

The Anti-Cancer Council's welfare work is, perhaps, less widely known than its activities in research and education, and readers may like to know something of its programme of patient aid.

Cancer patients may be helped through one of three channels.

In the metropolitan area funds have been made available to the Almoners of the Public Hospitals. A large percentage of this money is used for the payment of private hospital fees for patients, in the terminal stages of their illness, who are unable to obtain a bed in one of the public hospitals, and who cannot afford the cost of private care.

Financial help is also available from the Council's Central Almoner Fund. Patients who are not attending a public hospital may be referred by a private doctor, a social agency, relatives or friends, or may themselves make a request for assistance direct to the Council's Almoner.

AID FOR COUNTRY PATIENTS

In the country, 11 Regional Cancer Committees have been established in cities or towns where there are base hospitals, and sub-committees have been formed in some 120 other country towns. Welfare funds have been made available to each Regional Committee, and these may be drawn upon by any of the sub-committees within the Region.

It is felt that decentralisation of the Council's welfare work in this way ensures that information regarding aid for cancer patients is readily available to any person anywhere in Victoria.

In the country, advice and help are available through the network of Regional Committees and sub-committees.

In Melbourne, public hospital patients can discuss their problems with the Hospital Almoners. Others can obtain information from the Anti-Cancer Council's Almoner, who will arrange a personal interview with those requiring help, either at the Council's office, or in their own homes, if preferred. Any patient requiring help or advice is welcome to discuss their problems with the Almoner at any time. (Tel. FB 1386.)

FINANCIAL ASSISTANCE

The help offered to cancer patients is varied. Financial assistance is given to patients and families who are suffering economic hardship as a result of cancer.

For example, when a father is taken ill, the family income may be considerably reduced, and becomes insufficient to meet the family's basic needs.

In such cases the welfare funds are used to supplement the income, so that husband and wife may be freed of financial worry at a time when all their physical and emotional resources are needed — either to gain the full benefit from medical treatment, or to withstand the strain of hospital visiting and later of nursing the convalescent patient. Each case is considered individually in discussion with the family.

Not all those who receive help are in the low-income category. Cancer can be a long and expensive illness, particularly if private treatment has been necessary because of the family's financial position. Sometimes, after a considerable sum of money has been spent, the family may feel that they are no longer able to meet this expense. In this type of case also the Council is prepared to assist, after a full discussion of the family's particular problem.

Quite frequently it happens that financial help is not needed, but the enquirer is directed to another appropriate social service agency. Few people realize how many services are available to them from Government and voluntary organisations, and it is part of the work of the Almoner to advise patients of these and to assist them to make application for aid.

GRANT TO HOSPICE

In addition to its expenditure on the almoner services, the Anti-Cancer Council has also allocated £50,000 to the Caritas Christi Hospice in Kew. The hospice, conducted by Sisters of Charity, at present cares for 60 patients.

The Council's grant will help to meet the cost of erection of a new wing to accommodate an additional 40 patients. Twenty-five beds in this wing will be reserved for terminal cancer patients, who will thus be assured of devoted nursing care in the final stages of their illness.

AROUND THE REGIONS

"EDUCATION WEEKS"

The success of Bendigo's "Cancer Education Week" has been rivalled by equally successful "Weeks" at Wangaratta and Horsham.

AT WANGARATTA the Regional Committee, following the pattern pioneered by Bendigo, concentrated on public film and lecture sessions attended by local doctors. Separate sessions were arranged for the General Public, for Women, and for Senior School Children. The attendance at the various sessions totalled 2,150, and the sum of £42/3/- was voluntarily donated to help meet the Committee's expenses.

The local picture theatres, radio station and press co-operated whole-heartedly in the campaign. Both cinemas included 35 mm. educational films in their normal

programmes, and one theatre also featured the photographic display in the foyer, where it attracted much attention.

The Boy Scouts assisted the committee through a door-to-door delivery of leaflets.

The same general plan was followed at **HORSHAM**, where the film and lecture sessions also attracted large audiences. Despite bitterly cold weather, 400 women attended an evening session in the City Hall, and the following day 300 were present in the afternoon. The total attendance at the five sessions was in the vicinity of 1,500.

"Cancer Facts" folders were distributed by the Boy Scouts, and many shopkeepers displayed educational posters in their windows during the campaign. 35 mm. films were screened as part of the regular programmes at the picture theatre and at the "Drive-In." The proprietor of the latter reported that the reception given to the cartoon film "Man Alive" by his patrons had been very good. Not one horn had been sounded in protest!

Excellent press and radio coverage again contributed substantially to the "Week's" success.

The **HAMILTON** Committee is staging a "Week" as we go to press. Details will be given in our next issue.

"Education Weeks" are now being organised for:—

BALLARAT — week commencing Monday, 19th September.

GEE LONG — week commencing Monday, 26th September.

MILDURA — week commencing Monday, 17th October.

SHEPPARTON — week commencing Monday, 14th November.

SALE and BAIRNSDALE — early in November.

SUB-COMMITTEES.

Several sub-committees have planned education campaigns, in consultation with their Regional Committee or with head office.

The **COHUNA** committee joined with the Cohuna C.W.A. in sponsoring a women's meeting in the Shire Hall, followed by an evening meeting for the general public. A leading store in the town generously provided window space for the travelling display.

The sub-committees at **ARARAT** and **WARRACKNABEAL** are planning similar activities in the near future.

POSTER SET.

Printing of the set of seven posters publicising the Warning Signs of Cancer has been completed. Committees wishing to obtain sets for use in their districts should notify the Public Education officer of the quantities required. The quality of the design is such that the complete set has been placed on display in the Museum of Modern Art in Melbourne.

THE VALUE OF FILMS IN PUBLIC EDUCATION

For the past six months a unique experiment in film analysis has been carried out by research workers at Melbourne University.

A team from the Department of Audio-Visual Aids, headed by the senior research officer, Mr. R. J. Thomson, has been investigating the reactions of men and women from different age, educational and occupational levels of the community to lay films on cancer. The results will be presented at the Cancer Congress in August.

The following brief explanation of the aims and methods of the project has been supplied by Mr. Newman Rosenthal, Head of the Department.

The aim of the project was to test experimentally the hypothesis that cancer facts and attitudes towards cancer can be taught by means of film. This hypothesis was tested with films of different types and with audiences drawn from different social, educational and economic levels in the community. Finally, an attempt was made to ascertain those facts and attitudes which presented the greatest difficulty.

The method was essentially experimental throughout. Content analyses were made of several films.

Each content analysis, in general terms, sought to determine:

(a) the purpose of the film, i.e., what reasonable action and/or attitude the film aimed to induce, (b) the method of the film, its dramatic and subjective camera, its relations with the audience, i.e., audience identification, familiarity, instruction and participation.

Of the films investigated three were selected for the experiment. They were, 'Quiet Crisis,' 'A Doctor Speaks His Mind' and 'The Other City.' These three films represented a clear and reliable gradation in objectivity of presentation with its relation to facts and attitudes, to be learned and retained.

Questionnaires were constructed which provided information regarding the sex, age, educational, social and economic levels of the members of the audience. The questions also dealt with cancer facts and opinions, with subsections aimed at revealing the extent of knowledge of symptoms, therapy methods, etc., before viewing the film.

The sample audience was then exposed to a projective test. A number of carefully selected still pictures were screened and the audience was invited to write an account of their imaginative reactions to what they saw. The objective was to assess the habitual anxiety level and to provide criteria against which post-viewing reactions might be compared.

A projective test using similar but not identical still pictures was administered after viewing the film and the accounts of the imaginative reactions compared with the pre-viewing records.

A post-viewing questionnaire not only contained questions specifically referring to film content but concentrated on cancer facts and opinions. The objective was to determine by comparison with the information already obtained from the pre-viewing questionnaire whether any immediate change had resulted from viewing the film.

The audience was recalled some six weeks later and a delayed post-viewing questionnaire was administered. This questionnaire incorporated cancer facts and opinion questions similar to those on the previous questionnaires but with additional questions aimed at eliciting residual information obtained from the film viewing.

An attempt was also made in the questionnaire to determine whether, as a result of viewing the film, there had been any action taken by members of the audience to discuss the subject of cancer with their friends, to seek further information on cancer, etc.

Each of the three films was screened to a total of between 40 and 50 people with about 15 attending each session. A total of 135 people took part in the experiment. Each person saw only one film, but the audiences were matched for variables such as age and sex, and the total audience to each film included carefully selected samples from the various social, educational and economic levels in the community.

By co-operation with the Royal Australian Air Force, audience samples were obtained from the various branches of the service, including the W.A.A.F.

16 MM. FILMS

Additions to Anti-Cancer Council and State Film Centre Film Libraries.

ATOMS FOR HEALTH. (A.C.C.)
B. & W. 12 mins. U.S.A. 1951.
(Produced by L. A. Handel for U.S. Atomic Energy Commission.)

Thanks to atomic energy, entirely new methods of diagnosis and treatment are being developed in Medicine. This picture shows two exciting illustrations: A new diagnostic test of a patient's liver which was made possible through the use of an atomic tracer, and a demonstration of a new cobalt source, the "Theratron," one of the radiation weapons in science's fight against cancer. We follow the case histories of two patients at Los Angeles Medical Centre.

JUST BY CHANCE. (A.C.C.)
B. & W. 27 mins. U.S.A. 1958.
(Produced by John F. Becker for American Cancer Society.)

This is the true story of a Georgia-Alabama Valley — of how several disconnected events occurred, resulting in a showing of the film, "Breast Self-Examination," and of how 900 women went to see the film. Of the 900, 27 found lumps in their breasts. Of the 27, eight had cancer. Ruth Hussey tells the story in warmly human terms as this cast of eight actual people, saved from cancer, go about their daily work.

THE LINEAR ACCELERATOR. (S.F.C.)
B. & W. 12 mins. Britain. 1954.
(Produced by Hales and Batchelor Cartoon Films Ltd. for Educational Foundation for Visual Aids.)

Introduces the theory of nuclear transmutations and the production of hard X-rays with laboratory-accelerated particles. Shows the development of equipment and techniques from the original Cockcroft and Walton experiments up to the most recent wave linear accelerator. A 4 Me V linear accelerator is shown in action at the Newcastle General Hospital where it is used for the treatment of malignant tumours. This type of radiation has a much greater depth of penetration than ordinary deep therapy. (N.B.: A highly technical film.)

LIVING INSURANCE. (A.C.C.)
Colour. 14 mins. U.S.A. 1954.
(American Cancer Society.)

Stresses the importance of the periodic detection examination. The story is persuasively told in both human and medical aspects. Accentuates the American Cancer Society's message — "Every doctor's office a primary detection centre for Cancer."

SKIN DEEP. (A.C.C.-S.F.C.)
Colour. 10 mins. Australia. 1959.
(Produced by Tasmanian Government Film Unit.)

A dramatised story of a typical patient attending the Peter MacCallum Clinic in Launceston, Tasmania. The film is a plea for an early visit to the doctor by anyone having a possible symptom of cancer. Shows that with early treatment by modern methods, many cases of cancer can be cured. Illustrates the cobalt "bomb" in operation at the Clinic.

TIME AND TWO WOMEN. (A.C.C.)
(A cytology film.)
Colour. 15 mins. U.S.A. 1958.
(American Cancer Society.)

A direct and moving presentation of cancer of the uterus and cytology, emphasizing the curability of this disease. Dr. Joe V. Meigs is featured; he dramatizes the case histories of two women — one whose cancer was discovered too late and one who was saved because of early detection and prompt treatment.

(N.B.: It is recommended that this film be shown only where medical facilities exist for conducting uterine smear tests.)

TO SAVE THESE LIVES. (A.C.C.)
Animated, colour. 11 mins. U.S.A. 1956.
(American Cancer Society.)

Prepared primarily to help the American Cancer Society's local education chairman build a well-balanced and well-trained educational organization; aimed particularly towards the recruitment of public education volunteers. A portrayal of the seriousness of cancer as a community problem and the great importance of intelligent, well-guided team-work in fighting it.

THE WARNING SHADOW. (A.C.C.)
Colour. 16 mins. U.S.A. 1953.
(American Cancer Society and U.S. Dept. of Health, Education and Welfare.)

A documentary to fight the rising threat of lung cancer. Designed to persuade adults to have regular chest X-rays. Though aimed at men's groups, it can be shown effectively to mixed audiences.

WHITE FORTRESS. (S.F.C.)
B. & W. 10 mins. Canada. 1949.
(Produced by Canadian National Film Board.)

A glimpse of what Canada's National Health Programme means in terms of human life and happiness. To people like Alice, who suspects she may have cancer; Lucille, a crippled child; and Otis, who lives too far from a doctor to find out what causes his many pains, the Health Programme provides the means of investigating their troubles and, where necessary, helping with treatment.

FEATURE ARTICLE

THE VISITING NURSING SERVICE OF THE PETER MacCALLUM CLINIC

By Nancie M. Kinsella, M.B.E.,
Matron, Peter MacCallum Clinic
and Visiting Nursing Service,
Melbourne.

The Peter MacCallum Clinic Visiting Nursing Service has now been in operation for 10 years. Its inauguration followed a survey in the metropolitan area in 1950 to ascertain the number of cancer patients awaiting hospital beds.

This survey clearly indicated the need for assistance, and the Cancer Institute Board therefore established the Visiting Nursing Service, to provide for the care of those members of the community who were suffering from cancer and for whom there was no available hospital accommodation.

It is perhaps fitting to remark at this point that domiciliary care, apart from hospital bed shortages, also supplies the answer for those patients who wish to remain at home with their own people, no matter what the difficulties may be.

The Board's policy has made this service available, at the request of any Hospital or Medical Practitioner, to anyone who is a cancer sufferer. It is not limited to patients attending the Peter MacCallum Clinic for treatment.

It was also decided that no charge should be made for visits, but many patients and their families offer donations, which are gladly accepted, towards meeting the costs of the service.

Careful planning has made it possible for the visiting nurses to take into their patients' homes many of the facilities provided by hospitals. Extra comfort and better nursing is thus ensured.

Each nurse is provided with a fitted bag containing medical and sterile equipment, lotions, etc., and a second bag for extra supplies of cotton wool, binders, bandages, and other standard nursing accessories.

Linen has been available for patients since the commencement of the service. Each sister is given authority to supply linen according to the patient's needs and circumstances, and she can also call upon the Clinic to supply any other items of equipment she considers necessary for the patient's welfare — such as utensils, beds, rubber mattresses, blankets and pillows.

The welfare of the patients is the foremost consideration of the Visiting Nursing Service. Sufficient nurses must be available to allow full nursing care when necessary. Sometimes, too, time has to be found to instruct relatives or friends in basic nursing, thus enabling proper care to be given to patients between visits.

From two members in 1950 the service has now grown to 11 sisters, and operates on seven days a week. A senior sister carries out twice-weekly

supervisory visits, though the word supervisory is somewhat misleading.

She helps in the sorting out of problems and acts as liaison sister. She may call on the patient's doctor or a hospital Medical Social Worker, or discuss problems with relatives, and after nearly 10 years with the Visiting Nursing Service, there are few problems she hasn't met and helped to solve.

A visiting nurse is a very special nurse, and in the field of cancer nursing she must possess a great love of her work and a true understanding of human relationships. She has a many-sided role in that she must be nurse, teacher, confidant, upholder of morale, general organizer and adviser — and all this in someone else's home.

These qualities are not peculiar to the older, more experienced sisters — young sisters have it, too — an innate wisdom and understanding. They find the work exceptionally satisfying.

It is interesting to note some instances of patient care given over long periods and made possible by the existence of the Visiting Nursing Service.

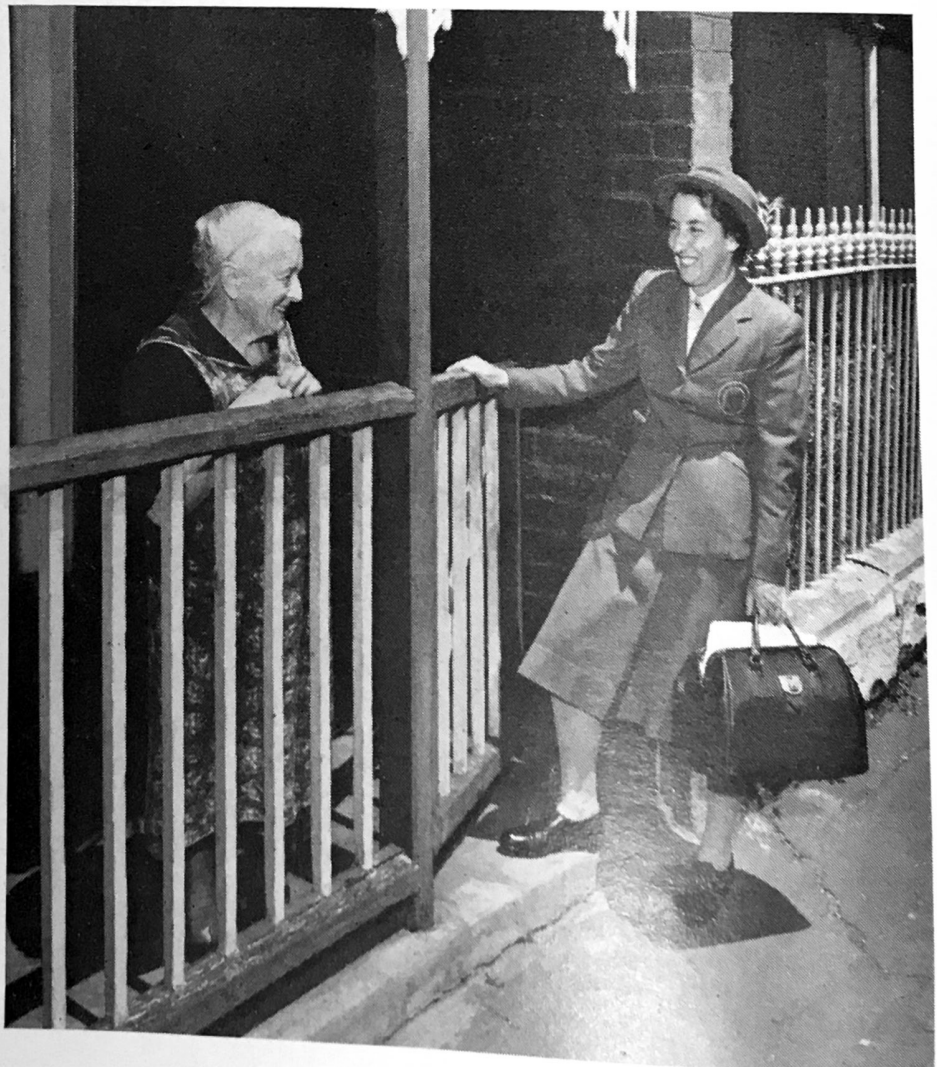
Patient A. Diagnosis: Carcinoma of Bladder. Has been nursed at home for two years. Hospital bed and rubber mattress supplied, all necessary utensils. Linen supply arranged — the amount required being quite beyond the resources of the household.

Patient B. Diagnosis: Carcinoma of Uterus. Visited since 1954 — thrice weekly for specific care. Requires abdominal tapping at about two-monthly intervals. Sterilized requirements for this procedure are taken by the Visiting Nurse for the use of the doctor in charge of the patient. This patient leads a reasonably normal and happy life.

Patient C. Diagnosis: Carcinoma of Colon. Discharged from hospital following operation five years ago. Aged 87 years, prognosis nil. Despite prognosis and age, this patient has been interested in living and has remained comfortable throughout this long period. Only now, aged 93 years, is his condition showing marked deterioration.

Much help is given the Visiting Nursing Service, and their association with Medical Social Workers is a very close one. They, in turn, can arrange for other forms of patient assistance — e.g., from Home Help Services and Meals-on-Wheels Service — when these are recommended by the Visiting Nurse.

The Visiting Nursing Service has been available to any cancer patients living within a radius of approximately 12 miles from the G.P.O. From 1st August it will be extended to the Ringwood-Croydon area, and further expansion is planned for the outer southern suburbs in the future.



A visiting nurse chats with one of her patients.