Dear Readers

AORTIC is currently undergoing a transformation, and you will start noticing a few more changes with each and every new edition of AORTIC News. This edition, we introduce to you AORTIC’s new Mission Statement (see page 3), which is vital in outlining the core values and long-term goals AORTIC is striving towards.

Last year’s conference, ‘Cancer in Africa: A Call to Action’ held in Dakar, Senegal, garnered the support of the President of Senegal who in turn pledged to put in place a National Cancer Control Program (NCCP) for Senegal by the year 2006. This commitment has been honoured and a draft NCCP has been drawn up and is published in this newsletter on page 13.

The next AORTIC conference, ‘Cancer in Africa: Challenges and Opportunities’, is to be held in Cape Town, South Africa, from 24 – 28th October 2007 and it is hoped that this event will catalyse further initiatives in cancer control. Be sure to mark your calendar NOW! For additional information on this and other topics please visit our website at: www.africa.aortic.org which is regularly updated with news and information.

We welcome comments and letters, so please e-mail us at: aortic@telkomsa.net

Signing off

B Rodrigues

CONGRATULATIONS DR HOLLAND!

We are proud to announce that Dr James Holland has been officially appointed to serve on the Expert Advisory Panel on Cancer for the World Health Organisation until June 2010.
Pfizer Global Health Fellow Joins AORTIC

AORTIC is pleased to announce that through a partnership with the American Cancer Society and the US pharmaceutical company, Pfizer Inc, Keith Paulsen has joined the organization as a Pfizer Global Health Fellow. During his four month fellowship, Keith’s responsibilities at AORTIC will include building the infrastructure of the organization, fostering links for cancer control efforts within the vast African continent, helping to organize the Cancer in Africa 2007 conference in Cape Town and supervising other key projects. In addition, Keith will assist the secretariat in supporting advocacy efforts around cancer, particularly with the African Union health ministries.

Over the past eight years, Keith has held a wide range of communications and public affairs’ positions with Pfizer. Most recently, he managed the grassroots communications for US Government Relations’ programs and was responsible for numerous marketing and public affairs initiatives. Keith has significant experience in developing communication strategies, website management, creating marketing and educational materials, government relations, fund raising and meeting planning.

Keith relocated to Cape Town from New York City for this assignment and will be working directly with Professor Lynette Denny and Belmira Rodrigues. He is the first Pfizer Global Health Fellow to be assigned to work on cancer control efforts in developing countries. “I am thrilled to have this opportunity to work with the members of AORTIC and the American Cancer Society on this important public health issue,” says Keith. “This fellowship is a great opportunity for me to share my skills and experience and to make a difference in a region facing so many healthcare challenges. Over the coming months, I look forward to working with the many members of AORTIC to develop sustainable programs that can help cancer control efforts.”

Pfizer’s Global Health Fellows program represents a new approach to corporate philanthropy. The skilled fellows are selected through a competitive process and are then loaned to non-governmental organizations to assist with healthcare issues in developing regions. The program was launched in 2002 and has successfully placed over 100 Pfizer colleagues in Africa, Asia, and Latin America. Hank McKinnell, Chairman and Chief Executive Officer of Pfizer Inc stated, “This program exemplifies how companies can go beyond traditional philanthropy programs to confront societal challenges by sending colleagues to communities where they can make contributions on so many levels.” During Keith’s fellowship, Pfizer has committed to funding all his transportation, lodging and other expenses.

‘For Belmira and I, Keith's presence and his input is a wonderful gift to us. We know that Keith will help us to build the engine and the infrastructure of AORTIC and we are delighted to have him', Lynette Denny, Secretary Treasurer.
AORTIC HAS A NEW MISSION STATEMENT!

The African Organisation for Research and Training in Cancer (AORTIC) seeks to become the Continent’s preeminent non-profit organisation working for cancer control. AORTIC aims to achieve this through the facilitation of research and training as well as the provision of relevant and accurate information on the prevention, early diagnosis, treatment, and palliation of cancer. Our organisation is dedicated to providing all Africans with these benefits, as well as to increasing public awareness of cancer and reducing the stigma associated with it.

REVISED MEMBERSHIP DUES & BENEFITS

Our membership dues have been revised as follows:

Membership fees for Active Members:
- $150 annual membership fee – for health care providers and researchers outside of Africa
- $60 annual membership fee – for health care providers and researchers who reside within Africa

Associate Members
Those in training to become physicians, basic scientists, epidemiologists, psychologists, nurses, social workers, and social scientists are eligible for this membership category provided they are considered qualified by the Membership Committee. Members in training shall not be eligible to vote or hold office.
$35 annual membership fee

Honorary Members:
Individuals recognised for their distinguished contribution to some aspect of oncology as it pertains to Africa or to another specialised field relating to oncology are eligible for nomination to honorary membership and can be nominated by any member. They pay no membership fee.

Organizational Members:
This is a more special category. Organizations at local or national levels which have aims similar to those of AORTIC or which support the aims of AORTIC may be eligible for nomination as organisational members. It requires approval of the Membership Committee and future review by the Council.

Affiliated Organisations:
Affiliated organisations may be international, African-based, or national cancer organisations, societies, foundations, institutions, or businesses that support cancer care treatment, research and training efforts in Africa. They may affiliate with AORTIC as Sponsors or Partners for specific cancer control efforts.

Sponsors:
(Sponsors are major contributors to AORTIC programs and activities. They include the NCI, ACS, WHO, UICC, IARC, Susan G. Komen Breast Cancer Foundation and other funding agencies and organisations that support cancer conference programs, research and/or educational developments and initiatives within Africa.)
$750 and above

Partners:
This category is for those organisations and businesses that join with AORTIC on a specific task or project to improve cancer care in Africa. For example, a focus of activities by the ACS is to establish partnerships that are tied to a specific project such as smoking prevention, breast cancer screening, etc. Or, the WHO or other NGOs may join to support palliative care initiatives.
$350 annual membership fee - businesses and NGOs outside Africa

Please note that current Life-time memberships will be honoured.

For a complete listing of benefits please see our website at: www.africa.aortic.org or e-mail aortic@telkomsa.net for more information.
Traditional Medicinal Plants of West Africa: New Preventives for Cancer?

MJ Wargovich, JE Cunningham, B. Touré, Y. Koita

With a new research grant awarded from the National Cancer Institute (USA), researchers from the University of South Carolina have teamed with colleagues in the Republic of Guinea (Conakry) to identify traditional West African medicinal plants for the prevention of cancer. The research project is focused on medicinal plants that have been used to treat inflammatory conditions or relieve pain.

Initiated with the cooperation of Dr. Bouba Toure (GARDIEM-Guinea) and Dr. Youssouf Koita (Ministry of Public Health, Guinea) the team has been working since 2003 to identify indigenous plants that may have anti-inflammatory activity. Chronic inflammation may precede the development of common human cancers, such as colon, breast, and prostate cancers and inflammatory proteins are often up-regulated in these cancers. Inhibition of specific inflammatory proteins (i.e., COX-2) has shown great promise for cancer chemo prevention but with unacceptable side effects. In the US, use of potent pharmaceutical COX-2 inhibitors has been associated with cardiotoxicity.

AORTIC members, Drs. Mike Wargovich and Joan Cunningham from the University of South Carolina spearhead the project which they hope will expand to other West African nations. Naturally occurring COX inhibitors may be safer to use in the long run, and the team has already identified compounds in the bark of the West African mahoghany tree (*Khaya Senegalensis*) as a source of anti-inflammatory/anti-cancer activity. Research studies in the Wargovich lab have already shown that extracts of the bark are highly inhibitory toward human colon cancer cells. Over the next two years studies will be extended to other native medicinal plants with reported anti-inflammatory activity. Other organisations collaborating in this effort include the Centre pour la Valorisation et la Recherche des Plantes Médicinales.
AOGIN (ASIA OCEANIA RESEARCH ORGANISATION ON GENITAL INFECTIONS & NEOPLASIA)

More than 50% of cervical cancer cases in the developing world occur within the Asian-Pacific region.

AOGIN works with health care workers (as well as the lay public), particularly those in women’s health with the goals of collaboration and research, scientific exchanges, education and training, providing information, surveys and audits. AOGIN brings together clinicians and scientists whose work is related to genital infections and neoplasia.

Education
AOGIN has four main areas of activity

Collaboration and Research

The scientific committee (a group comprising Asia-Oceania clinical and scientific experts) develops and encourages collaboration on clinical and basic research projects, as well as seeking collaboration with other organisations.

Scientific Exchanges, Education and Training

The multi-disciplinary nature of this organisation means that AOGIN is a forum for exchanging views and for cooperation between partners. It recognizes that there are different levels of research capabilities in each country of the region and AOGIN works to support the countries according to their requirements.

Information

AOGIN is a teaching and information platform for physicians, patients and public authorities.

Surveys and Audits

AOGIN commissions medical practice surveys with the aim of assessing practice effectiveness. Follow-up support is provided, and advice and recommendations are made to enhance good medical practice and improve financial management.

AOGIN achieves this by:

- Organising international congresses
- Promoting courses and workshops reviewing current clinical practice, new data and technical developments in cervical cancer screening technology and management;
- Prepares training sessions to encourage specialised centers to develop screening programmes;
- Co-ordinates and supports consensus meetings and expert panels on issues encountered in everyday practice.
- Organises satellite symposia at major international conferences and encourages the exchange of information with other specialist organisations in this field.

For more information visit their website at: www.aogin.com
BOOK COMPETITION WINNERS!

Congratulations to the following people who have each won a copy of the prestigious publication, “Cancer Medicine”:

Dr Yaghouba Kane (Senegal)
Dr Adefimi Afolabi (Nigeria)
Dr Olaitan Soyannwo (Nigeria)
Dr Sani Malami (Nigeria)
Dr Jean-Marie Kabongo (Congo)

Your copy of Cancer Medicine has been posted to you.

SASCRO & SASMO THIRTEENTH NATIONAL CONGRESS 2007

FIRST INVITATION

The South African Society of Clinical & Radiation Oncology (SASCRO) & The South African Society of Medical Oncology (SASMO) will be holding its 13th National Congress from 27 – 30 April 2007 at the Champagne Sports Resort, Drakensberg, South Africa.

Who should attend:

* Members of SASMO and SASCRO
* Medical oncologists
* Radiation oncologists
* Surgical oncologists
* Gynaecological oncologists
* Radiation therapists
* Oncology pharmacists
* Medical physicists
* Clinical trial co-ordinators
* Oncology nurses
* Sponsoring & exhibiting companies

Important dates:

Deadline for abstracts: 15 January 2007
Deadline for early bird registration: 16 February 2007

For further information contact Rhyno Kriek (Event manager) at: rkc@intekom.co.za
THE IMPORTANCE OF STAGING IN ONCOLOGY

By Dr BA Smith

Department of Radiology, James Paget Hospital, Norfolk, UK

All patients who present to their clinician with a suspected malignancy will need staging. The term refers to the clinical, surgical, radiological and biochemical examinations and investigations required during the patient’s work-up in order to present a comprehensive picture of the overall impact of the tumour on the patient. In this way the oncologist can then decide on the most appropriate form of treatment and has an overall idea of the patient’s prognosis (expressed in terms of 5 year survival). It is important to realise that the oncologist is in the best position to make this assessment as she/he will be trained to look for specific signs of local and distant spread clinically, will know how to correlate the imaging findings with the patterns of the specific tumour spread and will know which specific biochemical markers to look for in the patient’s blood. This then enables the oncologist to decide on curative vs palliative treatment. In terms of curative treatment, the options are: surgery, radiotherapy, local chemotherapy and imaging guided local therapy. Palliative therapy will include: systemic chemotherapy, hormone therapy, biological agents and local or systemic irradiation. Treatments can also be used in combination to achieve cure or palliation.

Because cancer is a world-wide disease it is important that a unified staging system be adopted so that the impact of therapies world-wide can be compared. The TNM (Tumour, Node, Metastasis) staging system is such a system developed in an attempt to achieve this end. This system is by no means the only system used world-wide but does provide a logical process of staging that is relatively easy to follow.

For the complete article please see our website at: www.africa.aortic.org and click on “Resources.”

TELEMEDICINE AT REDUCED COST!

Dr Bruce Smith has another important contribution to make in the field of teleradiology for teaching and training in oncology and in medicine in general. He has access to a desktop/laptop based imaging software that has the capacity to link remote sites and share imaging data in order for hospitals to link to each other sharing their data for both teaching and therapeutics at a fraction of the cost compared to what large imaging/communications companies would charge. Dr Smith proposes, under the auspices of AORTIC, to link to cancer sites using this software and communications technology so that expertise at various sites may be shared for the benefit of both patients and students. In the UK, an organisation called Disect Systems, who have developed and tested the software in the UK, are supporting his endeavours. They are hoping to present a poster at the International Cancer Imaging Congress in Dublin in October 2006 which highlights the presence of AORTIC to the International Cancer Community and the role that this imaging software may play in the linking of the various faculties under the AORTIC organisation and other cancer sites throughout the world. Any AORTIC members interested in this project are to contact Dr Smith so that he can present/demonstrate his proposals in order for him to assess which cancer sites outside South Africa they may use to set up a pilot project to test this proposal.

Please contact us at aortic@telkomsa.net if you are interested in the above.
REGIONAL TRAINING COURSE—TANZANIA

A Regional (AFAR) Training Course on Evidence-Based Oncology was held in Dar es Salaam, United Republic of Tanzania, from 14-18 August 2006, under the auspices of the International Atomic Energy Agency (IAEA).

The local course director was Dr Twill Gnome, Head of Radiotherapy at the Ocean Road Cancer Institute (OCR), Dar es Salaam. Excluding the 2 colleagues from Tanzania, the other course attendees were 18 qualified radiation oncologists from Egypt, Ethiopia, Ghana, Kenya, Libya, Namibia, Nigeria, South Africa, Sudan, Uganda and Zimbabwe.

The programme focussed on the principles of medical physics and evidence-based oncology, followed by site-specific evidence and clinical practice guidelines. There are various web sites available of oncology evidence-based reviews, giving the levels of evidence and treatment algorithms, but the point was made that all of these emanate from the "first world" and require appropriate adaptation for resource constrained environments.

The lectures on principles of radiation physics were delivered by Prof Deborah van der Merwe of Johannesburg hospital, and those on the principles of evidence-based oncology by Dr Branislav Jeremic of the IAEA in Vienna and Prof Karol Sikora of London. The latter lecturer could not attend in person due to the security issues at Heathrow airport, but gave one of his talks per telephone link! Dr Ian Magrath of the International Network for Cancer Treatment and Research, which is based in Brussels, was at the same hotel for another meeting (see below), and gave 2 lectures on evidence based principles at short notice to make up for the absence of Dr Sikora.

The site-specific lecturers were Dr Jeremic, Prof Mahmoud Elgatiry of Egypt, Prof Jenny Wilson of South Africa, Dr Verna Vanderpuye of Ghana, Dr Ntokozo Ndlovu of Zimbabwe, and Dr Leon van Wijk of South Africa.

From subsequent e-mails, it seems that all of the course attendees found it instructive and potentially useful for structuring institutional treatment protocols, which would endorse the aims of the course. It should be noted that a similar one will be held for the francophone African countries at a later date.

While the course ended Thursday 17 August, most of the colleagues stayed for another meeting on Friday 18 August - the First Scientific Conference of ORCI, commemorating the 10th year of existence of ORCI as the official and only oncology centre, to date, of Tanzania. Various overseas and local speakers were involved. That evening was the official congress/course dinner, but the undersigned could not attend, having had a plane to catch!

Application forms for AORTIC membership were handed out and it is hoped many of the course attendees will join up, or renew, their membership!

Leon van Wijk, Cape Town South Africa
A community-based model for the prevention and reduction of gender specific cancers in their communities - Western Cape, South Africa
By Colleen Marco, CANSA

BACKGROUND: South Africa’s population size is approximately 4.5 million, of which 51% is women. Prostate, cervical, and breast cancers are the most common. The lifetime risk of developing cancer for males is 1 in 4 and females 1 in 6. A community-based model was designed and piloted in 2003. The implementation of the model commenced in 2005. The aim of the model is to equip women with skills to create awareness about gender specific cancers in their communities.

OBJECTIVES:
1. Recruit and train women as peer educators from rural and urban communities
2. Facilitate a process of empowering women to identify the barriers preventing them from using services
3. Promote a culture of responsibility within communities to prevent or reduce their risk of gender specific cancers

METHODOLOGY:
A total of 101 women were recruited and trained, from thirteen towns within the province. The mode of advocacy and information dissemination consists of door to door visits, house meetings, and presentations at churches or other organisations, presentations at workplaces and at primary level health facilities.

RESULTS:
Within eight months, approximately 1.6 million women and men were reached. Health care providers at health facilities acknowledged that the community members attending their services were more informed. There has been an increase in the number of women responding to recalls for abnormal test results. Men need to be trained to focus on men.

For the complete article please visit our website at: www.africa.aortic.org

CANCER NEEDS ASSESSMENT MEETING

The American Cancer Society (ACS) assessment of cancer activities and needs in Africa partners meeting was held from August 31st—September 1st, 2006 in Cape Town, South Africa. The meeting was facilitated by Ann McMikel and LaShawndra Pace from the ACS. There were 10 attendees from Ghana, Tanzania, Zimbabwe, Senegal, South Africa which included representatives from AORTIC and CANSA.

The meeting highlighted the fact that cancer is a low priority on government’s health agendas. There is no reliable, coherent, up-to-date information on cancer and no National Cancer Control Program (NCCP) for most of Africa. Senegal and South Africa are the only two countries who have formulated a draft NCCP.

The most prevalent cancers in the countries represented were highlighted:

<table>
<thead>
<tr>
<th>Country</th>
<th>Females</th>
<th>Males</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tanzania</td>
<td>Cervix</td>
<td>Kaposi’s Sarcoma</td>
</tr>
<tr>
<td>South Africa</td>
<td>Cervix</td>
<td>Prostate</td>
</tr>
<tr>
<td>Ghana</td>
<td>Breast</td>
<td>Liver</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>Kaposi’s Sarcoma</td>
<td>Cervix</td>
</tr>
<tr>
<td>Senegal</td>
<td>Cervix</td>
<td>Prostate</td>
</tr>
</tbody>
</table>

The common themes throughout were limited access to medication and treatment, prevention, palliative care and an overall “brain drain”, lack of government support and under-funding of cancer services.

It is hoped that this meeting will generate support and understanding from organisations such as the ACS so
The **UICC Cancer Basics for All** e-learning series has been launched by the International Union Against Cancer. It is based on text generously provided by the Oncology Nursing Society (USA) and was adapted and developed by UICC with a Learning Designer into a user-friendly, interactive e-learning tool on PC CD-ROM. To get a feel for it, please view the demonstration on the Cancer Basics for All website at: web.uicc.org/cancerbasics

As you will see, the series provides fundamental understanding of the disease, its development, diagnosis and treatment, and explores related psycho-social, ethical and legal issues. It is targeted at practising healthcare professionals, medical and nursing students, patients, their family members and friends, as well as cancer organisation staff and volunteers.

In 4 Courses, it provides almost 8 hours of learning through 17 individual lessons. It includes **Formative Exercises** and **Learning Checkpoints** and each Course ends with a Post Course Assessment. If 80% of the test questions were answered correctly, users are invited to print out their Course Certificates which we expect to be accepted for Continuing Medical Education credits by teaching hospitals, medical and nursing schools and cancer organisations as appropriate. Acceptance by the Continuing Medical Education authority in the USA is under negotiation.

Subject to a UICC licence, the text may be translated into other languages with adaptation to national, regional or ethical requirements without the need for additional development software.

The CD-ROM retails for US$50 — for a single user licence, with substantial discounts for multi user licences. To order, visit the Cancer Basics for All website at: web.uicc.org/cancerbasics

---

**AORTIC would like to thank the National Cancer Institute of the US for the initiative of providing nurses throughout Africa with the UICC "Cancer Basics for All" CD-Rom free of charge. This Introduction to the basics of cancer biology, cancer treatment, patient management and patient and family care was developed by the UICC in collaboration with ONS to equip nurses that are not trained in Cancer Care with a better understanding of caring for patients living with cancer and their loved ones.**
FIRST AFRICAN EDUCATIONAL CANCER CONFERENCE

The First African Educational Cancer Conference

“Reaching out: Bridging the gap in cancer care for Africa”

organized by MD Anderson Cancer Center
of Houston Texas, USA.

Due to circumstances beyond our control, the above-named conference has been postponed to a year later, 2007.
In its place, a round table mini-conference will take place from Oct 19 to 20, 2006 at the National Hospital in Abuja. Registration is Free. Participants can stay in a hotel of their choice. We apologise for any inconvenience this might cause.

For more information visit their website at: www.mdanderson.org/conferences

PRESTIGIOUS PRIZE FOR PROFESSOR LYNETTE DENNY

Professor Lynette Denny, Secretary Treasurer for AORTIC, was awarded the 2006 Distinguished Scientist Award for the Improvement of the Quality of Life of Woman in South Africa from the National Department of Science and Technology of SA.

The prize is one of various recognition awards created by the Department of Science and Technology to celebrate women in science and their role in improving the economic status and quality of life of South Africans.

Professor Denny has been involved in a study on alternative methods to the Pap smear for the prevention of cervical cancer in women in low-resource settings.

Cervical cancer is the most common cancer among women in developing countries, killing mostly those in the 40 to 50 age group. This has a devastating impact on the community and yet it is largely preventable.
MANAGEMENT OF BORDERLINE OVARIAN TUMOURS

By F Guidozzi

Department of Obstetrics and Gynaecology
University of the Witwatersrand
Johannesburg, South Africa

Typically borderline ovarian tumours are non-invasive neoplasms that have nuclear abnormalities and mitotic activity intermediate between benign and malignant tumours of similar cell type. All surface epithelial cell types have been described, although by far, serous, is the most common. Approximately 10-15% of epithelial ovarian tumours are borderline. The highest frequency of cases occur in women 30 – 50 years of age and commonly occur in women still desirous of reproductive function. Common presenting features include a palpable adnexal mass, with or without lower abdominal pain. Pelvic sonography may be helpful, although not specific, in the diagnosis. Serum CA 125 is abnormal in only 50% of patients. Approximately 65-70% of all serous and 90% of all mucinous borderline tumours are stage 1, with the remaining having evidence of extraovarian spread, most commonly in the form of peritoneal implants.

For the complete article please see our website at: www.africa.aortic.org

ASCO - AORTIC MULTIDISCIPLINARY CANCER MANAGEMENT COURSE

JANUARY 16 – 18, 2007
NATIONAL HOSPITAL ABUJA, NIGERIA

For additional information, the Course Agenda, Conference Registration and Accommodation forms please visit our website at:

www.africa.aortic.org
SENEGAL TACKLES A CHRONIC AND IMPOVERISHING DISEASE: CANCER

Cancer has rapidly become a major health problem in African countries. In Dakar, cancer is one of the main causes of mortality in the 40—60 years age group. The estimated number of new cases reported annually in this country is between 6,500 - 8,000. The cancer cases are often diagnosed when at an advanced stage making treatment efforts futile. The 5th African Organisation for Research and Training in Cancer (AORTIC) International Cancer Conference held in Dakar from 14 - 17 November 2005 afforded the opportunity to obtain a commitment from authorities at the highest level in the fight against cancer. Therefore, cognizant of the gravity of the problem and the urgency for action, the Head of State of Senegal instructed the Minister of Health and Medical Prevention to put in place, this year, a National Cancer Control Programme (NCCP). This programme confirms the Government of Senegal’s commitment to tackle a chronic and impoverishing disease from which one seldom gets away.

In Senegal, treatment and management of cancers and prevention are still very insufficient. There are 5 services of Pathology and all are located in Dakar; they confirm the diagnosis of cancer. These laboratories use basic conventional methods as well as cancer screening cytology. Immunohistochemical, cytogenetical and molecular biology techniques are not used. The laboratories of medical biology practise haematological smears and tumour markers (PSA, B HCG, CA-125, CA-19-9, CA 15-3, ACE) which are measured out for the most part. The medical imaging services contribute to the diagnosis of tumours through conventional radiography, ultrasonography or computed tomography.

The medical treatment by chemotherapy is provided by various services available only in the capital city: Cancer Institute, surgical, gynaecological and obstetrics services, Paediatrics, Internal medicine, Dermatology, clinical Haematology. Cancer treatment protocols are not standardized. Surgical treatment is possible at some health facilities. Only one service of radiotherapy (cobalt therapy) is available for the whole country. Regional hospitals have the capability to carry out some of the surgical treatments though at variable levels of performance.

There is no well-organised activities in place for cancer screening and early detection in the country. The screening of pre-cancerous lesions of the cervix by cervical pap smears is left to the individual. Sometimes mass screening campaigns are organised by non-profit organisations.

The NCCP of Senegal aims to improve the health of the population, notably by fighting against cancer. To this effect, it is necessary to attain in the next 5 years 4 specific goals:

* Preventing the outbreak of cancer;
* Diagnosing cancer at an early stage;
* Management and follow-up of patients with cancer;
* Implementing training and research programmes on cancer.

Through the NCCP, 6 strategic objectives are targeted:
1. Primary prevention of cancers.
2. Screening and early diagnosis of cancers.
3. Medical and psychosocial management of patients.
4. Research and epidemiological surveillance.
5. Training.
6. Institutional capacity building, coordination, advocacy and management of the programme.
SENEGAL TACKLES A CHRONIC AND IMPOVERISHING DISEASE: CANCER (Cont.)

Priority activities of this programme include:

* Information, raising awareness and education of the population on cancer risk factors, screening methods and early diagnosis in order to obtain a change of behaviour;
* Training of staff;
* Improvement and decentralization of medical and psychosocial management of patients by creating regional centres within easy access and by improving the access to anti-cancer drugs;
* A strong advocacy aimed at decision makers at all levels, opinion leaders, and development partners

The Government of Senegal allocated a budget for the running of the “Cancer Bureau” in the Ministry of Health and Medical Prevention which is headed by Prof Jean-Marie Dangou. This budget, though modest, makes it possible to implement actions and advocacy aimed at development partners for support in this battle. Moreover, to reinforce the therapeutic management, the Ministry of Health and Medical Prevention has just signed a convention of partnership with the Institut National du Cancer de Paris (National Institute of Cancer of Paris (France)) in order to renovate the service of radiotherapy and contribute to the training of the radiotherapy team. Other sectoral and multi-sectoral partners have been contacted.

Prof JM. Dangou  
Focal Point, in charge of cancer control  
Ministry of Health and Medical Prevention of Senegal

The 8th World Congress of Psycho-Oncology, will take place 18 - 21 October 2006, in Venice, Italy.

The IPOS 2006 Psychosocial Academy will take place 16 - 17 October 2006 in Ferrara, Italy.

For more details visit their website at:  
www.ipos2006.it
REACH FOR RECOVERY BREAST CANCER SUPPORT TRAINING IN ZIMBABWE

In August this year a long dreamed for wish came to fruition for two Harare breast cancer survivors. Jahan-Ara Mohamed and Claire Ravizzotti had in April 2005 attended a training for Reach for Recovery volunteers in Cape Town. On their return to Harare they began to seek ways of implementing this programme in their own country. They found enthusiastic support from the Zimbabwe Cancer Centre in Harare and on Friday August 18th, 18 women, all breast cancer survivors gathered at the Cancer Centre for 3 days of intensive training facilitated by Ann Steyn the RRI (Reach to Recovery) representative for Africa.

This training followed the guidelines laid down by RRI which is a programme of the UICC. It is a peer support programme found in over 50 countries. It uses carefully selected and trained breast cancer patients. They are able to offer emotional and practical support to a newly diagnosed patient. This support can include visiting patients in hospital and at home, providing information (pamphlets & resources available) and running support meetings. Groups also provide a temporary prosthesis. All their services are free.

During the 3 days of training participants learnt more about breast cancer – its detection, diagnosis and treatment – from 3 local specialists; Dr Nancy Jonker, Dr Nyakabau and Mr Fleming. Then it was time for them to learn more about themselves! Self-Awareness is an important part of the training, and the participants learnt that in order to help others they first had to know more about themselves. Other components were the emotional impact of breast cancer and the coping skills required, communication skills, building a trust relationship, sexuality and breast cancer and Ebrahim Jasset spoke on the Art of Living a holistic approach to life.

Then of course there was the important Reach for Recovery Visit to master! For this a video was shown covering both a hospital and home visit. Participants were now able to use their newly acquired skills in role play. Everyone had the opportunity to role play both as a patient and as a volunteer. Lots of fun was had and many discovered they had a latent talent for acting!

By the end of the course on Sunday a vibrant and cohesive group was reluctant to depart. All agreed to meet the following week in order to form a committee to oversee the formation of a Reach for Recovery group in Zimbabwe. All the women returned to their homes with the knowledge that the first steps had been taken to ensure that women in Zimbabwe would be made aware of breast cancer, and should they be diagnosed with the disease support would be available to them from women who had been where they now were.

Reach to Recovery International (RRI) looks forward to welcoming Zimbabwe to the growing number of groups worldwide who offer peer support to women experiencing the trauma of breast cancer.

Breast cancer survivors in Harare

- Ann Steyn
National President, RFR, CANSA
AORTIC Hosts a Meeting with Glaxo SmithKline
Cape Town, South Africa - 3rd August 2006

The main objective of this meeting was to provide an update on new information arising since the first HPV African meeting. Emphasis was placed on informing the expert panel about the most recent clinical data on cervical cancer and discussing the African HPV distribution study prior to launch.

There were 19 attendees from USA, Nigeria, Cameroon, SA, Zimbabwe, Kenya, Congo and Ghana who were either AORTIC members or became members. The delegates discussed in detail a research protocol that has been developed as a collaboration between AORTIC, University of Cape Town and GSK. This protocol plans to evaluate the type distribution of HPV in women with cervical cancer from the different regions of Africa. AORTIC members from over 8 different African countries will be participating in the trial which is being funded by GSK. Knowing the type distribution of HPV in Africa will enable more accurate modelling of the potential impact of HPV vaccines against HPV types 16 and 18, which are known to be causally related to the development of cervical cancer.

HPV

* Every person will have at least one HPV infection during their lifetime
* Over 100 HPV types have been identified
* >40 infect the genital tract
* 15 ‘high-risk’ types (said to be oncogenic)
* 25 ‘low-risk’ types (said to be non-oncogenic and are more often associated with genital warts)
* HPV is the primary cause of invasive cancer (identified by DNA PCR in 99.7% of cases) and precursor lesions
* HPV has also been identified in other, more rare cancers (such as penile, anal, vulvar and vaginal neoplasms)
* Therefore, it is suggested that a vaccine against HPV will prevent other types and not just CC
* Most HPV infections are transient and are not associated with persistent cervical neoplasms

Take-home messages

* HPV is the major cause of morbidity and mortality
* CC is the most important cancer caused by oncogenic HPV infection but is not the only cancer
* Secondary prevention needs to be in place along with primary prevention for optimal outcome
* Screening needs to continue as current vaccines are prophylactic and not therapeutic
* Benefits to women (and men) will be significant

Vaccination versus screening

Delegates discussed the possibility of vaccination replacing screening, of which there is little in Africa. It was again emphasised that the vaccination is prophylactic and not therapeutic – therefore the women who have been exposed to HPV and not vaccinated will always require careful monitoring. It was therefore concluded that screening and vaccination should work in synergy.
Every year in South Africa over 5,000 women are diagnosed with cervical cancer and 1,500 women will die from this largely preventable disease. Through the advocacy efforts of health care providers, NGOs and volunteers, South Africa is now doing something to prevent future cases through a comprehensive screening program.

The free screening program encourages all women to have three pap smears in their lifetime starting at the age of 30 and followed up every ten years until they are 60. As almost 90 percent of cases of invasive cancer are detected in women 35 and older and because of limited resources, this protocol was agreed to by clinicians and the Department of Health and could result in a reduction of cervical cancer by almost 65 percent.

On August 1st, in the informal settlement of Khayelitsha, Cape Town, local women, representatives from the Department of Health and local government, and members of several NGOs gathered to launch the Cervical Health Promotion in the Western Cape. The program aims to educate women about cervical health and the importance of regular pap smears; not just as a diagnostic tool but also as a preventative measure.

The launch of the campaign coincides with the start of Women’s Month in South Africa. It was in August 50 years ago that 20,000 women marched to the Union Building in Pretoria to protest the extension of race passes for women under the apartheid government. At the launch of the campaign, the Premier of the Western Cape, Mr. Ebrahim Rasool, stated, “the Western Cape Government decided that the best way to celebrate this 50th anniversary is to say to women: Siyabulela! Dankie! Thank you! But to say so in ways which will begin to put in place concrete programmes that will make life better, safer, more prosperous and healthier.” The goal of this programme is to screen almost 25,000 women in the Western Cape this year which could prevent hundreds of women from developing cervical cancer. That is certainly a great legacy in honor of the women who marched in 1956.

The American Cancer Society University (ACSU) is the signature program of the Society’s international effort. ACSU works to strengthen the capacity of emerging cancer societies in developing countries by training their staff and volunteer leaders in all aspects of running a community-based cancer control organization or program. The American Cancer Society University is one of the compelling ways the Society is helping to make a difference in the global fight against cancer.

For more information about the American Cancer Society University, contact:
acsuniversity@cancer.org
The aim of People Living with Cancer is to develop a national support system for those who have been diagnosed and who are living with cancer. Broadly, we aim to assist clients and families to deal with the following:

- Diagnosis;
- Treatment;
- Emotional issues;
- Legal, social and financial issues;
- Living with, and beyond the treatment of cancer.

The Buddy Program offers the following services:

1. Co-ordinate support services to cancer patients in South Africa
2. Provide hands on support to newly diagnosed patients and their families and necessary information
3. Provide reliable and authentic information about various cancers, including treatment options to newly diagnosed cancer patients to assist them to make informed decisions about their own treatment
4. Provide an advocacy forum for patient issues in order to lobby support with relevant organisations to cater for their specific needs.

For those interested in becoming a volunteer

The following are areas in need of support:

- Visit cancer patients i.e. become cancer buddies
- Volunteers with writing skills
- Administration
- Fundraising
- Computer programming knowledge
- Marketing
- Sponsors
- Other Stakeholders

Training Course

2nd TRAINING OF CANCER BUDDIES October 2006 Vincent Pallotti Oncology Unit, Cape Town, South Africa

Venue and Dates
Training will take place at Vincent Pallotti Oncology Unit on the following dates:
14, 18 & 21 October
Time from 9am—12.30 pm (3 1/2 hours)

Please contact Carl Liebenberg via e-mail at carl@plwc.org.za, or Linda Greeff at linda@plwc.org.za
Tel: +27 021 949-4060 Website: www.pwlc.org.za
Caring for Someone Undergoing Cancer Treatment

By Sandra McDonald

Radiation Oncologist—USA

As an oncologist, I am well aware that cancer treatment can cause more illness or discomfort for the patient in the short-term than the disease itself. I also know the demands placed on spouses, partners, parents and children in caring for their loved one. With that in mind, here are suggestions for those caring for their patient.

· **Be prepared**: By becoming familiar with potential side-effects of treatment, you’ll be able to help your loved one deal with them effectively. Cancer treatment often causes gastrointestinal disturbances such as nausea, vomiting, and diarrhoea. By filling prescriptions in advance and making sure they are taken as prescribed, your patient will be able to more effectively manage these issues. Keep in mind that there are medication alternatives, so don’t be afraid to try another if the initial one doesn’t work.

  Stock up with the dietary products your oncology team recommends. Eating the right foods at the right intervals and drinking plenty of liquids can help to reduce treatment side-effects. Sound nourishment is important to the health of normal tissues and recovery after treatment.

· **Get assistance**: Take friends up on their offers to run errands. Friends are also often willing to keep your loved one company so that you can have a break. Consider using professional services to minimize household chores, or let some things go that are not crucial.

· **Investigate support groups or counselling**: Support groups led by a trained facilitator can be powerful aids for patients and caregivers. Individual counselling is another option to help you and your patient work through issues that can arise during diagnosis, treatment and recovery.

· **Pay attention to your own needs**: The old axiom that you can’t help others if you don’t first take care of yourself is especially true now. Not only can the caregiver role be tiring, but the emotional costs of seeing someone close to you suffer can be significant. The schedule of treatments seems endless and it is hard for the patient to feel optimistic when they feel worse during this time than when diagnosed. That’s why it’s important to look after your own physical and mental health. Just as exercise and relaxing practices such as yoga are important for the patient, they are equally crucial for caregivers.

---

Health InterNetwork Access to Research Initiative

The HINARI program, set up by WHO together with major publishers, enables developing countries to gain access to one of the world’s largest collections of biomedical and health literature. Over 3 300 journal titles are now available to health institutions in 113 countries, benefiting many thousands of health workers and researchers, and in turn, contributing to improved world health.

*For more information please visit their website at: http://www.who.int/hinari/en/*
Are the number of cancer cases increasing or decreasing in the world?

Cancer is becoming an increasingly important factor in the global burden of disease. There are 24.6 million people living with cancer at the moment; by 2020 there will be an estimated 30 million. By 2020, cancer could kill over 10 million people per year. The estimated number of new cases annually is expected to rise from 10.9 million in 2002 to 16 million by 2020 if this trend continues. Some 60% of these cases will occur in the less developed parts of the world. Almost 7 million people now die each year from cancer.

In developed countries, cancer is the second-biggest cause of death after cardiovascular disease, and epidemiological evidence points to this trend emerging in the less developed world. This is particularly true in countries of "transition" or middle-income countries, such as in South America and Asia. Already more than half of all cancer cases occur in developing countries.

Lung cancer kills more people than any other cancer. Some cancers are more common in developed than in developing countries: prostate, breast, colon. Liver, stomach and cervical cancer are more common in developing countries.

A number of causal factors have been linked to the development of cancer: unhealthy lifestyle (tobacco and alcohol use, inadequate diet, physical inactivity) and exposure to environmental carcinogens and infection (e.g. hepatitis B infection or human papilloma virus). Tobacco use accounts for 30% of all malignant tumours in developed countries; diet is responsible for approximately 30% of cancer in developed countries and for 20% in developing countries. Exposure to carcinogens in developed countries accounts for 4% of cancer cases and infectious agents for 18% of cases worldwide, most of which occur in developing countries.

- World Health Organisation

TEN FACTS ABOUT CANCER

* There are more than 100 types of cancers; any part of the body can be affected.
* In 2005, 7.6 million people died of cancer - 13% of the 58 million deaths worldwide.
* More than 70% of all cancer deaths occur in low- and middle-income countries.
* Worldwide, the 5 most common types of cancer that kill men are (in order of frequency): lung, stomach, liver, colorectal and oesophagus.
* Worldwide, the 5 most common types of cancer that kill women are (in the order of frequency): breast, lung, stomach, colorectal and cervical.
* Tobacco use is the single largest preventable cause of cancer in the world.
* One fifth of all cancers worldwide are caused by a chronic infection, for example human papillomavirus (HPV) causes cervical cancer and hepatitis B virus (HBV) causes liver cancer.
* A third of cancers could be cured if detected early and treated adequately.
* All patients in need of pain relief could be helped if current knowledge about pain control and palliative care were applied.
* 40% of cancer could be prevented, mainly by not using tobacco, having a healthy diet, being physically active and preventing infections that may cause cancer.

- World Health Organisation
Pan African Association of Pathology (PAAP)
First Annual Meeting in Dakar, Senegal

The Pan African Association of Pathology (PAAP) was formed in 2003 in Accra, Ghana, by a group of 14 pathologists from various African countries who attended the 4th African Organisation for Research and Training conference (AORTIC). The first meeting was held in Dakar, Senegal immediately following the 5th AORTIC conference that was held in November 2005. Twenty-eight pathologists from 9 African countries participated including Rwanda, Comoros Island, Niger, Nigeria, Mali, Cote d'Ivoire, Sudan, Morocco and Senegal.

The business meeting that took place after the scientific meeting adopted the minutes of the Accra Meeting and also adopted a constitution in principle. A copy of the constitution yet to be ratified by the association can be obtained from the Secretariat. The association was a beneficiary of AORTIC, the host government, and the International Academy of Pathology for which we are grateful. We look forward to wider participation from other countries in Africa and the international community in the future.

The existing founding executive members were re-elected for another term of two years as follows:

- President - A O Williams
- Vice President - Sine Bayo
- Secretary - Ima-Obong A Ekanem
- Treasurer - Jean-Marie Dangou

Membership of the association is open to pathologists, researchers and medical and non-medical laboratory scientists. The annual dues for membership is US$100.

The next meeting of the association is scheduled to be held in October 2007 in Cape Town, South Africa, during the 6th AORTIC conference.

For further enquiries please contact:

The Secretary
Pan African Association of Pathology (PAAP)
c/o Department of Pathology
College of Medical Sciences
University of Calabar
P. M. B. 1115
Calabar, Nigeria
E-mail: ekanemi01@yahoo.com

Ima-Obong A Ekanem
Secretary - PAAP/APAP
WHO FRAMEWORK CONVENTION ON TOBACCO CONTROL

The WHO Framework Convention on Tobacco Control (WHO FCTC) is the first treaty negotiated under the auspices of the World Health Organization. The WHO FCTC is an evidence-based treaty that reaffirms the right of all people to the highest standard of health. The WHO FCTC represents a paradigm shift in developing a regulatory strategy to address addictive substances; in contrast to previous drug control treaties, the WHO FCTC asserts the importance of demand reduction strategies as well as supply issues.

The WHO FCTC was developed in response to the globalisation of the tobacco epidemic. The spread of the tobacco epidemic is facilitated through a variety of complex factors with cross-border effects, including trade liberalization and direct foreign investment. Other factors such as global marketing, transnational tobacco advertising, promotion and sponsorship, and the international movement of contraband and counterfeit cigarettes have also contributed to the explosive increase in tobacco use.

For the complete document please visit their website at: www.who.int/tobacco/framework/en/

The Institute of Infectious Disease and Molecular Medicine

The University of Cape Town (UCT) opened the Institute of Infectious Disease and Molecular Medicine in 2005 primarily as an urgent response to combating the two major killers of people on the African continent – namely HIV/AIDS and Tuberculosis and other locally relevant non-communicable diseases.

As part of a leading university in a developing country with over 5 million people infected with HIV, the highest rate of tuberculosis in the world, and malaria on its borders, the IIDMM is uniquely positioned to consolidate and expand major global efforts to stem the tide of these diseases.

Disease and poverty are a stark reality in Africa with most people living on less than the internationally defined poverty line of US$2 a day. Africa also has a high rate of population growth, now accounting for 18% of the world’s population (compared with 9% in 1950). In the lifetime of many people alive today, Africa’s population will double, while life expectancy will decline. Contributing only 2% of the world’s GNP, the continent is already very poor making it critical that focused and sustainable interventions are made to promote health and development.

At present, Africa is inadequately equipped to meet the health crises it faces. While medical research and training occurs at many African universities, few institutions in sub-Saharan Africa have sufficient resources and critical mass to make a significant impact on the diseases that directly affect the region.

Without local expertise and research, the existing body of global knowledge of infectious and molecular medicine cannot be effectively applied in Africa and sub-Saharan Africa where it is needed most. The IIDMM has stepped in to fill this need. With an understanding of the importance of building capacity in the region and the continent, the IIDMM is committed to seeking south-south collaborations.
We, the participants from 139 countries, from governments, foundations, national and international non-governmental organizations, professional bodies, academia and civil society from all continents, assembled in Washington DC, USA to participate in the 2006 World Cancer Congress on July 8-12, 2006 recognize that:

* Currently, approximately 11 million people worldwide are diagnosed with cancer and almost 7 million people die of the disease each year. Additionally, more than 25 million people are surviving for years after a cancer diagnosis;

* By 2020, more than 16 million new cases and 10 million cancer deaths are expected annually. Seventy percent of these deaths will likely occur in developing countries that are unprepared to address their growing cancer burden.

* It is now possible to make dramatic worldwide strides against cancer — even in the poorest countries —through public health efforts targeting prevention and early detection, as well as advances in cancer treatment. The opportunity for collective action has never been greater and the need has never been more urgent;

* The new vision of the cancer control community is a world where cancer is eliminated as a major threat for future generations. It is a world where cancer control knowledge and competencies are equitable, shared and accessible, where new scientific findings are transferred to clinical settings, where disparities in prevention, early detection, treatment, and cure of cancers are systematically reduced and eventually eliminated, and where all cancer patients receive the best possible care.

* Such an outcome calls for a global movement that makes cancer control an important worldwide priority of this decade. It will require a massive, focused, and determined effort to stimulate the global cancer community across the public, private, and nonprofit sectors to join forces in carrying the initiative forward to every region of the world.

The purpose of this declaration is to build on the Charter of Paris 2000 and call for urgent action to address the worldwide cancer burden. Progress reports on the actions in this Declaration will be provided to assist in the development of future World Cancer Declarations which will come out of every World Cancer Congress.
A CANCER DIAGNOSIS AND FRIENDSHIP

By Sandra McDonald
Radiation Oncologist USA

Being diagnosed with cancer impacts almost all aspects of a person’s life. Patients are challenged with facing distress, vulnerability and disruptions in their normal routines or lifestyle. Experiencing fear and apprehension about the future for newly diagnosed cancer patients is a normal reaction. I find it heartbreaking when “well meaning” friends unknowingly intensify fears by telling “horror” stories about cancer treatment or provide unfounded information that bears no relationship to the patient’s situation.

Friends and family usually learn of a person’s cancer diagnosis sooner or later. It is normal for friends to feel uncertain about how to behave or what to say to people with cancer. How can friends provide support during this time? In general, be natural, be yourself. Being available to listen with sensitivity and respect is a great gift. Keep in mind that everyone’s experiences may be different. Let the patient set the tone; the openness of disclosure will guide your response.

Friends usually react as to cancer as they do to other difficult situations. Some handle it well; others are unable to deal with it at all and may even distance themselves. Some friends may cause unintended pain by asking thoughtless questions about scars, noticeable changes in appearance or making ignorant remarks about the treatment.

For patients it is important to remember that there are reasons that some friends may need some guidance from you to help sustain the relationship. These friends may care but do not know how to respond. NCI offers valuable suggestions: A phone call might help to lift the barrier of discomfort. Ask for simple assistance such as: run an errand, prepare a meal, come and visit. These small acts bring friends back into contact and help them feel useful and needed.

For friends and family: remember that cancer can be a lonely disease. It may not be necessary to actively “do something”. At times, “I’m here for you” can be the most supportive words you can say.

AMERICAN CANCER SOCIETY’S INTERNATIONAL PARTNERS PROGRAM (IPP)

IPP focuses on capacity building and knowledge sharing with cancer societies in low- and middle-income nations, and on collaborating with other cancer-related organizations across the globe in carrying out our common goals. If you are interested in participating in or supporting this program, please email international@cancer.org.

ACS Volunteers and Staff with Leaders of the Senegal AORTIC conference
Cancer Control In An Economically Disadvantaged Setting: Nigeria

Introduction

The World Health Organization (WHO) has identified aging, infections, cancer and mental health as the four major health problems confronting mankind this century. The improvement in child health care and general health in the last quarter of the last century, especially in affluent societies, has resulted in a significantly increased proportion of older individuals in populations across the world. Care of the aged has therefore become a major health challenge in the world. The incidence of infectious diseases is also on the increase in all nations and HIV/AIDS and pulmonary tuberculosis have reached epidemic proportions in sub-Saharan African countries. Growing unemployment, poverty and stress have jointly contributed to an increase in mental health problems in the world, and cancer, which is the focus of this article, is a major health challenge in all populations, albeit underplayed in the past in developing countries. Neoplastic diseases are now known to also be a major cause of morbidity and mortality in these countries; more patients die from cancer than from HIV/AIDS, tuberculosis and malaria combined.

The WHO Technical Report No. 804 of 1990 reported that over 50% of cancer victims live in the poorer nations, which have less than 10% of the resources for cancer care and control. The dilemma of cancer patients in third world countries was further brought into focus with the realisation that they consume only 5% of cytotoxic

In Nigeria, with a population of 120 million people in 2002, there are fewer than 100 practicing oncologists and no center exclusively focused on cancer research. There are only four active radiotherapy centers giving a ratio of one machine to about 30 million people, as against the recommended one per quarter million. The available spectrum of anti-cancer drugs is very limited and such drugs are not readily available. Imaging facilities for staging patients with cancer, such as computerized tomography (CT) and magnetic resonance imaging (MRI), are difficult to come by, and when available the cost of such studies puts them out of reach of the average citizen. The inability to properly classify the various types of hematological cancers owing to lack of Immunophenotypic, immunocytotochemical and cytogenetic diagnostic facilities is of great concern to hemato-oncologists practicing in this part of the world.

Extract from an article written by M.A. Durosinmi, Obafemi Awolowo University - Teaching Hospital Ile-Ife, Nigeria, published in the The International Network For Cancer Treatment and Research Newsletter, Summer 2004 issue.
The African Organization for Research and Training in Cancer (AORTIC) seeks to become the Continent’s preeminent non-profit organization working for cancer control. AORTIC aims to achieve this through the facilitation of research and training as well as the provision of relevant and accurate information on the prevention, early diagnosis, treatment, and palliation of cancer. Our organization is dedicated to providing all Africans with these benefits, as well as to increasing public awareness of cancer and reducing the stigma associated with it.

For a comprehensive list of international cancer conferences visit the International Union Against Cancer (UICC) website at: www.uicc.org

Visit AORTIC’s website at: www.africa.aortic.org regularly for the latest information about our 6th International Cancer conference, “Cancer in Africa: Challenges & Opportunities”, to be held at the Cape Town International Convention Centre from 24—28 October 2007 in Cape Town, South Africa.

BOOKS

Cancer in Africa: Epidemiology and Prevention (with CD-Rom)
IARC Scientific Publication, No 153
Parkin, D.M., Ferlay, J., Hamdi-Cherif, M., Sitas, F., et al
Order number 17300153
Price: CHF 111.12 / US$ 100.00 Developing countries: CHF 77.78
English 2003 427 pages
To order a copy send an e-mail to: bookorders@who.com

Treatment and Management of Cancer in the Elderly.
Treatment and Management of Cancer in the Elderly builds upon the strengths of the popular reference, Cancer in the Elderly. This guide outlines novel approaches in the identification and management of cancer in geriatric populations by world renowned experts on the topic. Presenting new trends and strategies in surgery, radiation therapy, and chemotherapy, this source presents a multidisciplinary and best-practices approach to the optimization of cancer care for the elderly and collects the most recent findings gleaned from prevention, adjuvant, neo-adjuvant, and treatment research.
Editors: Hyman B. Muss, Carrie P. Hunter, Karen A. Johnson
Publisher: Taylor & Francis Group, an informa business (www.taylorandfrancisgroup.com)
List Price: £110.00