AUCKLAND WOMEN'S HEALTH COUNCIL

NEWSLETTER

OCTOBER 2015

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MISINFORMATION FROM MINISTER'S OFFICE ON CERVICAL SCREENING

On 29 September 2015 the Minister of Health announced via a press release that there would be public consultation on the National Cervical Screening Programme's proposal to change the primary laboratory test for cervical screening from a cervical smear test to an HPV (Human papillomavirus) test.

The press release contained some confusing and totally misleading statements about cervical screening which revealed a complete lack of understanding about the purpose and the process of cervical screening. (1)

"The protection offered by the HPV vaccination programme and the HPV test would ensure screening can provide a greater level of reassurance of finding cancer early, resulting in better health outcomes for New Zealand women," the Minister stated.

Actually, Minister, the cervical screening programme does not test for cervical cancer. It is one of the few, if not the only, cancer screening programmes that can prevent the development of cancer by a screening test that identifies changes to cells well before they develop into cervical cancer. Likewise the new HPV test cannot and will not provide "a greater level of reassurance of finding cancer early" because it aims to identify the high risk infections – HPV16 and HPV18 – that may eventually result in the development of pre-cancer cervical lesions.

Given the huge amount of misleading information there is about the benefits and risks associated with all cancer screening programmes, it is alarming to find press releases emanating from the Minister of Health's office that contribute to the confusion and lack of evidence-based information around cancer screening tests.

Several women's health groups contacted the Minister's office with their concerns about the press release, and received a "Thanks for your email. I will pass it on" response. The AWHC asked that the Minister retract his press release and issue a statement acknowledging the misleading information about cervical screening that it contained. "The women of New Zealand have a right to receive clear and accurate information from authoritative sources about cervical screening and about the proposed changes to the cervical screening test," we wrote.

However, the Minister is probably unaware of our concerns as when contacted his office advised that our email was passed on to the Ministry – who of course wrote his press release. This is even more alarming.

Primary HPV testing

There are several important issues that need to be addressed before we head off down the path of HPV testing and 5-yearly cervical smears.

The most important of these is the effect that HPV testing may have on the women who have an HPV test and are found to have one of the two most common high risk HPV types that may lead to the development of cervical cancer. What is not mentioned in the Minister's press release and what is glossed over in one sentence in the consultation document is the fact that the vast majority of women will clear the HPV infection without the need for

any treatment. Between 80% to 90% of women will clear HPV infections within one to two years without even knowing that they were infected. The consultation document puts it this way: “Often the body’s immune system will clear the infection before the woman notices any symptoms. However, for a small number of women, persistent hrHPV infection *can* lead to cervical cell changes; if these changes are not treated, they *may* cause cancer.” [Italics added]

What the introduction of the new HPV test will do is inform thousands of women that they have one of the high risk HPVs – HPV16 or HPV18 – when there is every likelihood that it would not have caused them any problems. Instead these women will be told they have a high risk infection and will be referred straight to colposcopy for further assessment. Imagine the anxiety this will cause.

There are also major issues around the impact the switch to HPV screening will have on the cervical screening workforce.

The consultation document

In the meantime, the deadline for providing considered and researched comment on the consultation document is fast approaching. (2) Consultation meetings are being held in Wellington, Auckland on Christchurch between 14–16 October and submissions are due in by 23 October 2015.

References

1. https://www.beehive.govt.nz/release/consultation-changing-cervical-screening-test
2. https://www.nsu.govt.nz/health-professionals/national-cervical-screening-programme/new-and-future-developments/primary-hpv#documentlinks

Redefining Family

13-14 January 2016
AUT Campus, Auckland

This conference is for families that have used – or are thinking about using – adoption, foster care, donor conception, or surrogacy. Professionals are also welcome.

Three plenary sessions are planned that will interest attendees from across the different family contexts.

- **Redefining family in the modern world.** This session considers trends in family formation, with emphasis on new family forms that separate the once combined biological, genetic and social parenting, including adoption, donor conception, surrogacy, foster care, kinship care and whangai.

- **The socio-economic issues in non-traditional families.** This session looks at the developmental trajectory common in many of these alternative family forms, with a particular focus on children’s and parents’ experiences.

- **The legal processes involved in non-traditional families.** This final session considers the legal frameworks for each family type, and looks at the challenges and barriers that must be negotiated in forming families via surrogacy, donor conception and adoption.

Panel Discussion. A panel session is planned for the last day where leading researchers, lawyers, and practitioners from the 3 domains will take questions.

Further information is available at – www.redefiningfamilyconference.co.nz

YOUR VOICE COUNTS

The AWHC recently received an email from Roche Diagnostics (New Zealand) Ltd with the subject heading "Your voice counts." It's because our voice counts that Roche wants the AWHC to support their HPV test as the Ministry of Health moves to implement primary HPV testing. In an email to the AWHC, Bill Neville, the Product Manager at Roche Diagnostics said:

"You may have noticed that the Ministry of Health (MoH) has announced the consultation process for primary screening of cervical cancer using the HPV test. New Zealand has about 160 cases of cervical cancer a year, and the use of the HPV test could reduce that further, said Jane O'Hallahan, clinical director of the ministry's cervical screening unit.

The MoH also gives New Zealanders the opportunity to voice their opinion on various aspects of the consultation to move to HPV primary testing.

We strongly encourage that you and your members take part in this activity - consultation will end on the 23rd October 2015 at 5pm. The NCSP has requested feedback and <u>your voice counts.</u>

An important aspect of the change to the new screening methodology is the test itself. There are many different HPV tests available in New Zealand but not all tests give the same result. We encourage you and your members to read the attached ATHENA clinical study which utilises the [brand name removed] ***HPV test***. The [brand name removed] ***HPV test*** is the only clinically validated, FDA-approved and CE-IVD marked assay for first-line, primary screening of cervical cancer. There is an inherent risk of utilising HPV tests that do not meet these standards."

This is not the first time Roche has approached women's health groups in an attempt to get us to lobby for their HPV test. A few months ago several groups received a similar email asking Council members to meet with Roche to learn about this particular product.

If Bill Neville had taken the time to visit the AWHC website he would have seen that the AWHC is an independent women's health group which is extremely unlikely to be influenced by a drug company trying to use us to lobby for our health system to adopt their purportedly "superior," patented, and probably more expensive product. Nor are we likely to be impressed by the fact that it is FDA approved, given the FDA's track record on approving ineffective and harmful drugs and medical devices.

RETHINKING BREAST CANCER TREATMENT

It's October again and we are being bombarded with a great deal of hype about the risks and dangers of getting breast cancer. After the *Herald* featured an article about a 23-year-old woman who was diagnosed with DCIS (ductal carcinoma in situ) and had a mastectomy, it was refreshing to see the 12 October issue of *TIME* magazine feature an article on why doctors are rethinking breast cancer treatment. The article addresses the thorny issue of the overdiagnosis and overtreatment of DCIS and how women are being subjected to "too much chemo, too much radiation, and way too many mastectomies." (1)

DCIS is now usually referred to as early stage breast cancer when it is not, as it is non-invasive, found only inside the milk ducts and not in the surrounding breast tissue. In his book "Mammography Screening: truth, lies and controversy," Peter Gotzsche writes:
"Much of what we call breast cancer is not even a disease, but cell changes that women do not benefit from having detected and treated." (2)

DCIS once accounted for about 3% of breast cancers detected as a result of breast cancer screening but now accounts for around one in four so-called breast cancers.

"Now those at the vanguard of breast cancer treatment are calling for a major shift in the way doctors treat – and talk about – the disease, from the first few millimetres of suspicious-looking cells in milk ducts to the invasive masses found outside of them. That's making the tough conversations between a woman and her cancer doctor even harder, but it also stands to make them more fruitful.

Because as good as we have gotten at finding breast cancer – and we have gotten very good – all this new data suggests there may be better ways to treat some breast cancers, particularly those at the early stage. Evidence is mounting that aggressive treatments, designed in earnest to save women's lives, can have unforeseen and sometimes devastating consequences.

Call it collateral damage. It's the multiple follow-up surgeries after a mastectomy and the subsequent infections; the radiation that doesn't always improve survival and the cancer risk that can come with too much of it; the sometimes unnecessary chemotherapy and its life-sapping effects. For some in the field, that collateral damage is getting harder and harder to justify." (1)

The overdiagnosis of DCIS as breast cancer is wide spread and causes a considerable amount of harm. Peter Gotzsche describes it like this: "This result is alarming. Not only because these women will have to live the rest of their lives as cancer patients, fearing that the 'pseudo-disease' – which never was a disease and never would have been were it not for screening - would come back and kill them, but also because some women die from the unnecessary treatment. It is a new ethical dilemma in healthcare that some people will have to pay with their lives to enable others to live longer." (2)

Like Gotzsche, Siobhan O'Connor, the author of the *TIMES* article, thinks

cancer has a language problem. It's the war metaphors we use when we refer to the battle against cancer. Richard Nixon declared war against cancer over 40 years ago and others have followed in his footsteps, but it is "a war that drafts soldiers who never signed up for it, who do battle and win, or do battle and lose." (1)

In 2015 a diagnosis of breast cancer is not necessarily a death sentence or the beginning of the end. While increasing numbers of women are being diagnosed with breast cancer, the death rate over the past 15 years or so has remained largely the same, mainly due to better treatments that are now available.

Eight years ago Desiree Basila went looking for options when she was diagnosed with DCIS and told that "there was a slot open the following week for a mastectomy." She made an appointment with another breast surgeon and spent half an hour grilling her. She was still not satisfied when the doctor recommended a lumpectomy. Frustrated she stood up and prepared to leave and then issued a half taunt, "What if I decide to just do nothing?" Only then did the doctor say "Well, some people are electing to do that."

Basila sat back down and after another half an hour spent discussing other options with Dr Shelley Hwang, she elected to start taking tamoxifen, a drug that blocks oestrogen, and to enrol in a clinical trial involving active surveillance. Basila's doctor, Dr Hwang, is now chief of breast surgery at Duke University in North Carolina, and Dr Laura Esserman, a surgeon at the University of California, are currently leading a number of studies on women who have been diagnosed with DCIS. Dr Esserman is creating a DCIS registry and launched the WISDOM study which will randomise women with DCIS to either annual screening or a more personalised screening approach. (3)

In the UK an investigation called LORIS is under way. Loris is a 10-year randomised controlled prospect-ive study, funded by the UK's national Institute for Health Research, which will include 900 women. Half will get the standard care - surgery, and half will be actively monitored. (4)

"My personal view is that enough time has been spent arguing about screening, and we now should be addressing the issue through well-run clinical trials that are long overdue," says Dr Adele Francis, a breast surgeon at University Hospital Birmingham and the lead on the LORIS study. (1)

The other important people in this dilemma are the women with the diagnosis. "Change in medicine comes from patients," says Dr Esserman. "My patients don't like the options we have. So I say, Get the facts. Find someone who will go through those options with you."

New Zealand women also deserve to be offered more options than surgery.

References:

1. Siobhan O'Connor. "Why doctors are rethinking breast cancer treatment." TIME 12 October 2015
2. Peter Gotzsche. "Mammography Screening: truth, lies and controversy." Radcliffe Publishing 2012.
3. https://www.salesforce.com/blog/2015/09/wisdom-study-best-approach-breast-cancer-screening.html
4. http://www.cancerresearchuk.org/about-cancer/find-a-clinical-trial/a-trial-comparing-surgery-with-active-monitoring-for-low-risk-dcis-loris

Melanoma Summit 2015

6-7 November 2015
Langham Hotel, Auckland

This 4th national Melanoma Summit will be a two-day multidisciplinary meeting featuring:

- **Professor Charles Balch**, University of Texas Southwestern – a surgical oncologist and one of the leading melanoma experts in the world
- **Professor Antoni Ribas,** UCLA's Jobsson Comprehensive Cancer Center – a medical oncologist and leading melanoma physician-scientist
- **Assoc Professor Cliff Rosendahl,** University of Queensland – a primary care practitioner with expertise in skin cancer and dermatoscopy
- **Professor David Whiteman**, QIMR Berghofer Medical Research Institute – a medical epidemiologist and pioneer of molecular approaches to melanoma
- New Zealand authorities on melanoma prevention, diagnosis, treatment, care and research
- Discipline-specific breakout sessions and workshops.

The Melanoma Research Institute of New Zealand (MRINZ) and the Australian and New Zealand Melanoma Trials Group (ANZMTG) are holding an Inaugural Research Symposium prior to the Melanoma Summit.

Further information is available at – http://melnet.org.nz/news/melanoma-summit-2015

AWHC GENERAL MEETING 22 September 2015

Detailed minutes of this meeting are available on request. Matters discussed included:

- Financial reports
- Grant applications
- ART issues
- AWHC on Facebook
- DHB meetings
- Symposium for Judi Strid

Further information on some of the topics listed above is contained in this issue of the AWHC newsletter.

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UP AND COMING EVENTS

DISTRICT HEALTH BOARD meetings for October/November 2015:

Waitemata DHB (Website address: www.waitematadhb.govt.nz)
The Waitemata Hospital Advisory Committee meeting starts at 11am on Wednesday 4 November 2015 and will be followed by the DHB Full Board meeting which starts at 1.30pm. Both meetings will be held in the DHB Boardroom, Level 1, 15 Shea Terrace, Takapuna.

The **combined Waitemata DHB and Auckland DHB** Community & Public Health Advisory Committee meeting starts at 2pm on Wednesday 25 November 2015.

Auckland DHB (Website address: www.adhb.govt.nz)
The Hospital Advisory Committee meeting will be held at 9.30am on Wednesday 28 October 2015 followed by the Full Board meeting at 2pm. Both meetings will be held in the A+ Trust Room in the Clinical Education Centre, Level 5, Auckland City Hospital.

Counties Manukau DHB (Website address: www.cmdhb.org.nz)
The Hospital Advisory Committee meeting will be held at 9am on Wednesday 21 October 2015 at Ko Awatea and will be followed by the Full Board meeting at 1.30pm.

The Community & Public Health Advisory Committee meeting will be held at 1.30pm on 11 November 2015 at 19 Lambie Drive, Manukau.

ETHICS COMMITTEE meetings – dates for the four MOH ethics committees are at:
http://www.ethics.health.govt.nz/about-committees/meeting-dates-venues-minutes

PHARMAC Medical Devices Forums

PHARMAC will be holding a series of forums in DHBs around the country to provide an update on their hospital medical devices activity.

Date: Auckland – 27 October 2015 12 – 1pm
Venue: Clinical Education Centre, Auckland City Hospital.

Date: Hamilton – 22 October 2015 12 – 1pm
Venue: Bryant Education Centre, Waikato Hospital.

For information on dates and times in Hamilton, Palmerston North, Wellington, Christchurch and Dunedin, and to register go to www.pharmac.health.nz/forums