This Current Awareness Bulletin is produced by the Clinical Librarian, Musgrove Park Academy, to provide Hope Directorate staff with a range of cancer/haematology related resources to support practice. It includes recently published guidelines and research articles, news and policy items.

This guide provides a selection of resources relevant to the subject area and is not intended to be a comprehensive list. For further help or guidance, please contact a member of library staff.

Note: if any link does not open by clicking on it, just copy/paste that link in the browser's address bar.

This guide has been compiled by:

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Contents
Click on a section title to navigate to contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recent journal articles</td>
<td>3</td>
</tr>
<tr>
<td>New books</td>
<td>10</td>
</tr>
<tr>
<td>Cochrane Reviews</td>
<td>12</td>
</tr>
<tr>
<td>Other evidence updates</td>
<td>13</td>
</tr>
<tr>
<td>Cancer in the News</td>
<td>20</td>
</tr>
<tr>
<td>Reports, publications and resources</td>
<td>22</td>
</tr>
<tr>
<td>Training &amp; Networking Opportunities, Conferences, Events</td>
<td>23</td>
</tr>
<tr>
<td>Other services, Training and Athens</td>
<td>24</td>
</tr>
</tbody>
</table>

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This is a list of recent journal articles on the topic of cancer (and haematology). Some articles are available in the library, or on-line via an Athens password, by following the link. If you would like an article that is not available as full text, please contact library staff: Library@tst.nhs.uk

**Breast**

*Fraction size in radiation therapy for breast conservation in early breast cancer.*

Cochrane Database Syst Rev. 2016 Jul 18;7

We found that using altered fraction size regimens (greater than 2 Gy per fraction) does not have a clinically meaningful effect on local recurrence, is associated with decreased acute toxicity and does not seem to affect breast appearance, late toxicity or patient-reported quality-of-life measures for selected women treated with breast conserving therapy. These are mostly women with node negative tumours smaller than 3 cm and negative pathological margins.

**Haematology**

*Mutations Associated with Acquired Resistance to PD-1 Blockade in Melanoma*

NEJM July 13, 2016

In this study, acquired resistance to PD-1 blockade immunotherapy in patients with melanoma was associated with defects in the pathways involved in interferon-receptor signaling and in antigen presentation. (Funded by the National Institutes of Health and others.)

**Maintenance therapy in chronic lymphocytic leukaemia**

The Lancet Haematology Published online: August 1, 2016

Maintenance therapy has always been a key component of the treatment strategy in patients with leukaemia. Whether it is in acute lymphoid leukaemia or chronic myeloid leukaemia—where maintenance has clearly decreased the relapse risk—or acute myeloid leukaemia—where its use remains controversial—this method of continuous, hopefully non-toxic therapy has been assessed ever since leukaemia therapy was first conceived 50 years ago. Moreover, maintenance therapy has been incorporated into management of a number of B-cell malignancies, such as follicular lymphoma.
Using PET–CT to tailor treatment for Hodgkin’s lymphoma

Lancet Oncology June 23, 2016

The use of PET–CT can help to guide treatment for patients with advanced Hodgkin’s lymphoma and reduce unnecessary exposure to intensive chemotherapy, suggest findings from an international randomised controlled phase 3 trial.

Chemotherapy

High-dose chemotherapy with autologous haemopoietic stem cell transplantation for newly diagnosed primary CNS lymphoma: a prospective, single-arm, phase 2 trial

Lancet Haematology Volume 3, No. 8, e388–e397, August 2016

Between Jan 18, 2007, and May 23, 2011, we recruited 81 patients, of whom two (2%) were excluded, therefore we included 79 (98%) patients in the analysis. All patients started induction treatment; 73 (92%) commenced HCT-ASCT. 61 (77·2% [95% CI 66·1–86·6]) patients achieved a complete response. During induction treatment, the most common grade 3 toxicity was anaemia (37 [47%]) and the most common grade 4 toxicity was thrombocytopenia (50 [63%]). During HCT-ASCT, the most common grade 3 toxicity was fever (50 [68%] of 73) and the most common grade 4 toxicity was leucopenia (68 [93%] of 73). We recorded four (5%) treatment-related deaths (three [4%] during induction and one [1%] 4 weeks after HCT-ASCT).

Olanzapine for the Prevention of Chemotherapy-Induced Nausea and Vomiting


Olanzapine, as compared with placebo, significantly improved nausea prevention, as well as the complete-response rate, among previously untreated patients who were receiving highly emetogenic chemotherapy.

Prostate cancer

Hypofractionation for prostate cancer: tested and proven

Lancet Oncology June 20, 2016

No abstract
Hypofractionated versus conventionally fractionated radiotherapy for patients with localised prostate cancer (HYPRO): final efficacy results from a randomised, multicentre, open-label, phase 3 trial

Lancet Oncology June 20, 2016

Hypofractionated radiotherapy was not superior to conventional radiotherapy with respect to 5-year relapse-free survival. Our hypofractionated radiotherapy regimen cannot be regarded as the new standard of care for patients with intermediate-risk or high-risk prostate cancer.

Conventional versus hypofractionated high-dose intensity-modulated radiotherapy for prostate cancer: 5-year outcomes of the randomised, non-inferiority, phase 3 CHHiP trial

Lancet Oncology June 20, 2016

Hypofractionated radiotherapy using 60 Gy in 20 fractions is non-inferior to conventional fractionation using 74 Gy in 37 fractions and is recommended as a new standard of care for external-beam radiotherapy of localised prostate cancer.

Renal

Delayed systemic treatment in metastatic renal-cell carcinoma

The Lancet Oncology Published online: August 3, 2016

This year 62 700 new cases of kidney cancer and 14 240 kidney cancer deaths are expected in the USA.1 Renal-cell carcinoma has a wide spectrum of clinical presentations and pathology, ranging from small incidentally discovered tumours that can be managed with kidney-sparing surgical approaches or surveillance, to highly symptomatic, debilitating, metastatic tumours that can progress rapidly to cause death despite treatment with surgical and systemic therapies. Prognostic risk or selection factors at the time of diagnosis can profoundly affect survival during subsequent systemic treatments.

Active surveillance in metastatic renal-cell carcinoma: a prospective, phase 2 trial

The Lancet Oncology Published online: August 3, 2016

Between Aug 21, 2008, and June 7, 2013, we enrolled 52 patients. Median follow-up of patients in the study was 38·1 months (IQR 29·4–48·9). In the 48 patients included in analysis, median time on surveillance from registration on study until initiation of systemic therapy was 14·9 months (95% CI 10·6–25·0). Multivariate analysis showed that higher numbers of International Metastatic Database Consortium (IMDC) adverse risk factors (p=0·0403) and higher numbers of metastatic disease sites (p=0·0414) were associated with a shorter surveillance period. 22 (46%) patients died during the
study period, all from metastatic renal-cell carcinoma. A subset of patients with metastatic renal-cell carcinoma can safely undergo surveillance before starting systemic therapy. Additional investigation is required to further define the benefits and risks of this approach.

**Late effects**

*Cumulative burden of disease: a relevant measure of the late side-effects of cancer treatment*

Lancet Oncology July 25, 2016

Children, teenagers, and young adults diagnosed with Hodgkin's lymphoma a decade ago had an excellent prognosis, with 10-year overall survival above 90%. For those diagnosed today, outcomes should be even better through efforts to prevent side-effects by reducing treatment as far as possible without compromising cure. In The Lancet Oncology, a report by Nickhill Bhakta and colleagues from the St Jude Lifetime Cohort Study (SJLIFE) shows that, in 10-year survivors of Hodgkin's lymphoma diagnosed between 1961 and 2004 who reached at least 18 years of age, treatment-related cardiovascular morbidity ranged from subclinical to life-threatening, with new manifestations continuing to appear during several decades of follow-up.

**Survivorship**

*Obesity-related endometrial cancer: an update on survivorship approaches to reducing cardiovascular death.*

BJOG: An International Journal of Obstetrics & Gynaecology, 2016, vol./is. 123/2(293-298), 14700328

As the rate of obesity increases worldwide, so will the number of women diagnosed with obesity-related malignancy. The strongest correlation between obesity and cancer is endometrial cancer (EC). Obesity is the most significant modifiable risk factor for development of EC and also contributes to the most common cause of death in EC survivors-cardiovascular disease (CVD). Most cancer survivors after diagnosis do not implement lifestyle changes aimed at weight-loss and CVD risk reduction. This selective review highlights recent novel and unique approaches for managing CVD co-morbidities in EC survivorship.

*10 year survival after breast-conserving surgery plus radiotherapy compared with mastectomy in early breast cancer in the Netherlands: a population-based study*

Lancet Oncology, Volume 17, No. 8, p1158–1170, August 2016

Adjusting for confounding variables, breast-conserving surgery plus radiotherapy showed improved 10 year overall and relative survival compared with mastectomy in early breast cancer, but 10 year distant metastasis-free survival was improved with breast-conserving surgery plus radiotherapy.
compared with mastectomy in the T1N0 subgroup only, indicating a possible role of confounding by severity. These results suggest that breast-conserving surgery plus radiotherapy is at least equivalent to mastectomy with respect to overall survival and may influence treatment decision making for patients with early breast cancer.

Head & Neck

Transoral robotic surgery for oropharyngeal cancer

Lancet Oncology June 30, 2016

Findings from a retrospective, stage-matched cohort study have shown that transoral robotic surgery for treatment of patients with oropharyngeal squamous cell carcinoma provides similar survival with significantly less morbidity than treatment with traditional non-surgical therapy such as radiotherapy or chemoradiotherapy.

Other

Delirium in patients with advanced cancer

The Lancet Oncology Published online: August 4, 2016

Delirium is a distressing symptom in advanced cancer that is often underdiagnosed. A prospective emergency department study of screening for delirium in advanced cancer patients at The University of Texas MD Anderson Cancer Center, (Houston, TX, USA), found that 9% of patients were diagnosed with delirium when presenting to the emergency department, but emergency physicians missed this diagnosis in 41% of patients.

Refinement and revalidation of the demoralization scale: The DS-II—internal validity

Cancer Volume 122, Issue 14, July 15, 2016 Pages 2251–2259

The DS-II is a 3-point response, self-report scale comprising 16 items and 2 subscales. Given its revalidation, psychometric strengthening, and simplification, the DS-II is an improved and more practical measure of demoralization for research and clinical use. External validation of the DS-II will be reported subsequently

In brief (you may need to logon to BMJ to see):

Endocrine cancer

Minimally invasive parathyroidectomy
F Fausto Palazzo, Gregory P Sadler

ABC of subfertility: Anovulation
Diana Hamilton-Fairley, Alison Taylor
Oesophageal cancer

**Risk of adenocarcinoma in Barrett’s oesophagus: population based study**
Liam Murray, Peter Watson, Brian Johnston, James Sloan, Inder Mohan Lal Mainie, Anna Gavin

Prostate cancer

**Frequent ejaculation may be linked to decreased risk of prostate cancer**
Scott Gottlieb

Urological cancer

**Chemotherapy before surgery improves survival from bladder cancer**
David Spurgeon

Chemotherapy

**Chemotherapy before surgery improves survival from bladder cancer**
David Spurgeon

Screening (oncology)

**Risk of adenocarcinoma in Barrett’s oesophagus: population based study**
Liam Murray, Peter Watson, Brian Johnston, James Sloan, Inder Mohan Lal Mainie, Anna Gavin

Colon cancer

**Colorectal adenocarcinoma: risks, prevention and diagnosis**
Sri G Thrumurthy, Sasha S D Thrumurthy, Catherine E Gilbert, Paul Ross, Amyn Haji
For automated tables of contents:
Oncology – click here
Haematology – click here.
If you are unable to find a book, or require a book that is not on this list, please ask library staff who will be able to locate the book for you using interlibrary loan.

**Multiple choice questions for haematology and core medical trainees (2016)**

Bain, Barbara J.

Written to help haematology and general medical trainees evaluate their own knowledge, and particularly useful for those preparing for the Part 1 examination of the Royal College of Pathologists.

**Women's cancers: pathways to living (2016)**

*Smith, J. Richard; Del Priore, Giuseppe*

Taking patients through all aspects of cancer care, this book provides specific, accurate information on various tumour types and treatment modalities, surgery, chemotherapy, radiotherapy, and complementary therapy.

**Prostate cancer: science and clinical practice (2nd ed) (2016)**

*Mydlo, Jack H.; Godec, Ciril J.*

Continues to be important translational reference that bridges gap between science and clinical medicine. It reviews biological processes that implicated in the disease and current treatments, highlights pitfalls and examines scientific developments that might result in future treatments.
Radiation protection in medical imaging and radiation oncology (2016)
Vetter, Richard J.; Stoeva, Magdalena S.

Focuses on the professional, operational, and regulatory aspects of radiation protection. Advances in radiation medicine have resulted in new modalities and procedures, some of which have significant potential to cause serious harm. Examples include radiologic procedures that require very long fluoroscopy times, radiolabeled monoclonal antibodies, and intravascular brachytherapy.
Sipuleucel-T for metastatic castration-resistant prostate cancer

Steven E Canfield, Vishnu Kamal Golla, Lillian S Kao, Greg Pratt, Cara Foldes and Philipp Dahm

Also:

Interventions for treating oral leukoplakia to prevent oral cancer

Extended-field irradiation for locally advanced cervical cancer

Hormone replacement therapy for women previously treated for endometrial cancer

Sun protection for preventing basal cell and squamous cell skin cancers

Molecular-targeted first-line therapy for advanced gastric cancer

Partial breast irradiation for early breast cancer

Pain relief for women with cervical intraepithelial neoplasia undergoing colposcopy treatment

Fraction size in radiation therapy for breast conservation in early breast cancer

Intracystic bleomycin for cystic craniopharyngiomas in children

Exercise interventions for people undergoing multimodal cancer treatment that includes surgery

Intravesical therapy for non-muscle invasive bladder cancer: a network meta-analysis

Diagnostic accuracy of laparoscopy following computed tomography (CT) scanning for assessing the resectability with curative intent in pancreatic and periampullary cancer

Luteinising hormone releasing hormone (LHRH) agonists for the treatment of relapsed epithelial ovarian cancer
BREAST CANCER

IVF and risk of breast cancer (July 2016)

The body of evidence suggests that breast cancer risk is not increased after in vitro fertilization (IVF), but is limited by lack of long-term follow-up data. In a recent Dutch cohort study of over 19,000 women treated with IVF between 1983 and 1995 and followed for a median of 21 years, the risk of breast cancer was similar to that in subfertile women not treated with IVF and in the general population, adjusted for parity and age at first birth [1]. These data are reassuring, but difficult to generalize to women undergoing contemporary IVF treatment since IVF drug regimens have changed over time and improved success rates have reduced the number of cycles women are exposed to these regimens. Additionally, only 14 percent of the cohort was age >60 years, so the risk of postmenopausal breast cancer was not well defined. (See "In vitro fertilization", section on 'Breast cancer risk'.)

Duration of adjuvant endocrine therapy for breast cancer (July 2016)

For postmenopausal women receiving adjuvant treatment with an aromatase inhibitor (AI) for hormone-positive breast cancer, the standard duration of treatment has been five years. However, data from the MA17R trial demonstrated that a longer course of treatment improves disease-free survival (DFS) [2]. Among approximately 1900 postmenopausal women who had completed four and a half to six years of therapy with an AI, treatment for an additional five years improved five-year DFS relative to those who received placebo (95 versus 91 percent). There was no difference between the groups in regards to overall survival. Bone-related toxic effects were more frequent among those receiving extended treatment. Based on these results, we now offer an additional five years of treatment to those who have completed five years of AI therapy. However, it is reasonable for women with low risk of recurrence who are concerned about the risks and toxicities of extended treatment to omit extended treatment after a risk-benefit discussion. (See "Adjuvant endocrine therapy for non-metastatic, hormone receptor-positive breast cancer", section on 'Duration of endocrine treatment'.)

ACUTE LEUKEMIA AND MYELODYSPLASTIC SYNDROME

Inotuzumab ozogamicin in acute lymphoblastic leukemia (June 2016)

Inotuzumab ozogamicin is an investigational anti-CD22 monoclonal antibody conjugated to calicheamicin; it has demonstrated activity in relapsed/refractory acute lymphoblastic leukemia (ALL).
Early results are available from an international open-label, randomized phase 3 trial that compared inotuzumab ozogamicin versus intensive chemotherapy in 326 patients with relapsed/refractory ALL [1]. Inotuzumab ozogamicin resulted in a higher percentage of patients achieving a complete response (81 versus 29 percent), many of whom attained minimal residual disease negativity. There was a small improvement in median progression-free survival (five versus two months) and overall survival (eight versus seven months). Inotuzumab ozogamicin results in high rates of deep response in this setting, but the majority of patients will relapse if no further therapy is given. Further study is necessary to better elucidate the best way to incorporate this drug into the treatment of patients with ALL. (See "Treatment of relapsed or refractory acute lymphoblastic leukemia in adults", section on 'Inotuzumab ozogamicin'.)

ASCO policy statement on access to opioids for cancer-related pain (July 2016)

Safe prescribing of opioids requires consideration of the risks associated with drug abuse, misuse, and diversion to the illicit marketplace. With increasing prescription drug abuse and opioid-associated overdose deaths, federal and state governments have taken additional steps to regulate opioids beyond the restrictions imposed by the federal Controlled Substances Act. However, inadequate treatment of cancer-related pain is a real problem, and concerns have been raised that many of these well-intentioned proposals will limit legitimate access to opioids for patients with cancer, and challenge the ability of oncologists and palliative care physicians to provide compassionate care that includes adequate pain relief. In response to these concerns, the American Society of Clinical Oncology (ASCO) has issued a policy statement that emphasizes principles for balancing opioid access with the need to curb misuse and abuse [68]. (See "Cancer pain management: General principles and risk management for patients receiving opioids", section on 'Risk assessment and management for patients receiving opioids'.)

Breast cancer

In Vitro Fertilization Is Not Associated with an Increased Risk of Breast Cancer in Women

Reference - JAMA 2016 Jul 19;316(3):300 (level 2 [mid-level] evidence)

- Hormone exposure has been shown to influence women’s risk of breast cancer; however, it is unclear if hormone exposure during in vitro fertilization (IVF) increases this risk.
- A recent study in the Netherlands comparing women receiving IVF to women having other fertility treatments over 20 years of follow-up found that IVF is not associated with an increased risk of breast cancer and individual aspects of fertility treatment did not appear to influence breast cancer risk.
- Longer follow-up is needed to determine whether IVF is associated with an increased risk in postmenopausal women.
Many factors contribute to a woman’s risk of breast cancer, including her reproductive history and hormonal exposure (J Natl Compr Canc Netw 2015 Jul;13(7):880). IVF significantly alters hormone exposure and as such could influence breast cancer risk. To determine the long-term influence of IVF on breast cancer risk, a recent cohort study included 25,108 women (mean age at baseline 33 years) who received fertility treatments between 1980 and 1995 in the Netherlands and were followed for a median of 21.1 years. Within this cohort, 19,158 women (76%) had IVF for a mean of 3.6 cycles and 5,950 women received other fertility treatments. Most women in the IVF group had regimens consisting of gonadotropin stimulation with follicle stimulating hormone or human menopausal gonadotropin with gonadotropin releasing hormone. Conversely, women in the non-IVF group received tubal surgery, intrauterine insemination with low-dose ovarian stimulation, hormonal treatments such as clomiphene, or withdrew from the waiting list for IVF.

Over the entire follow-up period, 839 cases of first invasive breast cancer and 190 cases of ductal carcinoma in situ (DCIS) were reported. The incidence of breast cancer in the general Dutch population during the same time period was calculated from the Netherlands Cancer Registry as an additional control. The rate of breast cancer per 100,000 women was 163.5 in the IVF group, 167.2 in the non-IVF fertility treatment group, and 163.3 in the general population (no significant differences across groups or in any pairwise comparisons). Additional analyses found that in women having IVF, there was a decreased risk of breast cancer with ≥ 7 IVF cycles compared to 1-2 IVF cycles (adjusted hazard ratio [HR] 0.55, 95% CI 0.39-0.77), and with poor response at first IVF cycle compared to normal response (adjusted hazard ratio 0.77, 95% CI 0.61-0.96). Breast cancer risk was higher in women who were older at conception, as well as in parous compared to nulliparous women (adjusted hazard ratio 1.35, 95% CI 1.16-1.56). Other aspects of fertility treatment including subfertility diagnosis, number of IVF cycles, number of IVF and intrauterine insemination cycles, number of ampules used for stimulation during IVF, number of oocytes collected, and type of luteal phase support did not appear to influence the risk of breast cancer in women having infertility treatments. There were no significant differences comparing IVF to other infertility treatments in subgroup analyses.

While several studies have investigated the potential impact of IVF treatment on the incidence of breast cancer, the results have largely been inconsistent; studies often are unable to control for infertility or have short follow-up durations (Hum Reprod Update 2014 Jan-Feb;20(1):106). This cohort study overcomes these challenges by including women with infertility receiving treatment other than IVF to better control for population-based risk factors. Additionally, the median follow-up was over 20 years and only 25% of women were < 50 years old at the time of analysis. Although the long follow-up duration adds to the evidence suggesting IVF does not increase the risk of breast cancer, it may also limit the generalizability of these results. IVF treatment has changed in the last 20 years, and differences in hormone exposure will need to be further assessed. Also, while the age-related increase in the risk of breast cancer is consistent with previous studies, the finding that nulliparity was associated with an increased risk of breast cancer is at odds with other epidemiological data (J Natl Compr Canc Netw 2015 Jul;13(7):880). It is unknown if this discrepancy is intrinsic to women receiving infertility treatment, or if other factors, including the short duration of postmenopausal follow-up, may explain this difference. Overall, these results suggest that IVF treatment may not increase breast cancer in premenopausal women. Continued follow-up including additional postmenopausal data is needed to determine if these results persist in postmenopausal years.

For more information see the Risk factors for breast cancer and Treatment of infertility in women topics in DynaMed Plus. DynaMed users click here and here.
Adding Olanzapine to 3-Drug Antiemetic Regimen may Reduce Nausea in Patients Receiving Highly Emetogenic Chemotherapy

- Three-drug prophylactic regimens have reduced chemotherapy-induced emesis, but nausea is often still a significant problem.
- In analysis of 401 patients receiving their first chemotherapy treatment with a highly emetogenic regimen, the addition of olanzapine to the standard 3-drug antiemetic regimen significantly reduced nausea at 0-24 hours and 25-120 hours.
- Olanzapine was only assessed during 1 chemotherapy cycle, therefore further studies are needed to assess long-term efficacy and safety.

Nausea and vomiting are common adverse effects of chemotherapy and are associated with decreased quality of life. The American Society for Clinical Oncology currently recommends a 3-drug combination antiemetic regimen including a neurokinin 1 (NK1) receptor antagonist (aprepitant or fosaprepitant), a 5-hydroxytryptamine-3 (5-HT3) receptor antagonist (palonosetron, ondansetron or granisetron), and dexamethasone for all patients receiving highly emetogenic chemotherapy regimens (J Clin Oncol 2011 Nov 1;29(31):4189). While this regimen has significantly reduced the incidence of chemotherapy-induced nausea and vomiting, many patients still struggle with these side effects, especially nausea (Oncologist 2015 Jun;20(6):576). In an effort to further reduce the incidence of nausea after chemotherapy, 401 chemotherapy-naive adults (median age 57 years, 72% female) scheduled to begin highly emetogenic chemotherapy regimens were randomized to olanzapine 10 mg/day orally vs. placebo on chemotherapy days 1-4 in addition to the recommended 3-drug antiemetic regimen. All patients in this analysis were assessed during only 1 chemotherapy cycle.

The absence of nausea as well as the rates of complete response (no emetic episodes or use of rescue medication) were evaluated at 0-24 hours and 25-120 hours after chemotherapy as well as during the entire 5-day period. Compared to placebo, the addition of olanzapine to the standard 3-drug antiemetic regimen significantly reduced nausea and increased the rate of complete response during both the early and late time periods (see table below). Olanzapine was associated with increased sedation on day 2, but there were no other significant differences in adverse events. Two patients in the olanzapine group had grade 4 hematologic adverse events, but these were not considered attributable to olanzapine by the attending physician.

<table>
<thead>
<tr>
<th></th>
<th>Olanzapine</th>
<th>Placebo</th>
<th>p value</th>
<th>NNT</th>
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<tbody>
<tr>
<td><strong>No Nausea</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>0-24 hours</td>
<td>73.8%</td>
<td>43.3%</td>
<td>&lt;0.001</td>
<td>4</td>
</tr>
<tr>
<td>25-120 hours</td>
<td>42.4%</td>
<td>25.4%</td>
<td>0.001</td>
<td>6</td>
</tr>
<tr>
<td>0-120 hours</td>
<td>37.3%</td>
<td>21.9%</td>
<td>0.002</td>
<td>7</td>
</tr>
<tr>
<td><strong>Complete Response</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-24 hours</td>
<td>85.7%</td>
<td>64.6%</td>
<td>&lt;0.001</td>
<td>5</td>
</tr>
<tr>
<td>25-120 hours</td>
<td>66.9%</td>
<td>52.4%</td>
<td>0.007</td>
<td>7</td>
</tr>
<tr>
<td>0-120 hours</td>
<td>63.6%</td>
<td>40.6%</td>
<td>&lt;0.001</td>
<td>5</td>
</tr>
</tbody>
</table>

The results of this trial suggest that adding olanzapine to an antiemetic regimen containing an NK1 receptor antagonist, a 5-HT3 receptor antagonist, and dexamethasone may significantly improve both nausea and vomiting induced by highly emetogenic chemotherapy regimens. Although the only adverse event reported in the olanzapine group was increased sedation at one time point,
olanzapine has been associated with increased risk of leukopenia in other settings. This potential adverse event would be especially troubling in cancer patients undergoing chemotherapy with an already fragile immune system and could increase the risk of infection in these patients. This side effect may not occur with the short duration of use in this trial, but only 1 cycle of chemotherapy was assessed. It is unknown if the efficacy and adverse effects profile may change with continued use during subsequent chemotherapy cycles. Overall, while the results of this trial are promising, further assessments of safety in cancer patients are needed.

For more information, see the Toxicities of chemotherapeutic agents topic in DynaMed.
Venous Thromboembolism in Minimally Invasive Compared With Open Hysterectomy for Endometrial Cancer.
Obstet Gynecol

Olanzapine for the Prevention of Chemotherapy-Induced Nausea and Vomiting.
N Engl J Med

An international prognostic index for patients with chronic lymphocytic leukaemia (CLL-IPI): a meta-analysis of individual patient data.
Lancet Oncol

Alerts in electronic medical records to promote a colorectal cancer screening programme: a cluster randomised controlled trial in primary care.
Br J Gen Pract

Molecular-targeted first-line therapy for advanced gastric cancer.
Cochrane Database Syst Rev

Efficacy of Mindfulness-Based Cognitive Therapy on Late Post-Treatment Pain in Women Treated for Primary Breast Cancer: A Randomized Controlled Trial.
J Clin Oncol

Anticonvulsants or Antidepressants in Combination Pharmacotherapy for Treatment of Neuropathic Pain in Cancer Patients: A Systematic Review and Meta-analysis.
Clin J Pain

Ovarian Cancer Risk Factors by Histologic Subtype: An Analysis From the Ovarian Cancer Cohort Consortium.
J Clin Oncol

Screening for lung cancer: A systematic review and meta-analysis.
Prev Med

ASCO Guidelines Issued on Managing Chronic Pain in Adult Cancer Survivors

Recommendations on managing chronic pain in survivors of adult cancer have been published in the Journal of Clinical Oncology.

The authors advise the following:

- Conduct an initial comprehensive pain assessment, and ask about pain at every encounter.
- Be aware of the various pain syndromes associated with cancer therapies.
- Strive to "enhance comfort, improve function, limit adverse events, and ensure safety."
- Engage patients and their caregivers in all aspects of pain management.
- Consider a trial of opioids in those "who do not respond to more conservative management."
- When using opioids, "incorporate a universal precautions approach to minimize abuse, addiction, and adverse consequences."
Tongue tip ischaemic necrosis after head and neck radiotherapy

A 60 year old smoker with a history of radiotherapy for soft palate squamous cell carcinoma had had a painful tongue tip for three weeks (fig 1). Clinically there was progressive destruction of the tongue. Imaging and tissue biopsy confirmed obliterative...

Robotic surgery for prostate cancer achieves similar outcomes to open surgery, study shows

Robotic prostatectomy has achieved similar outcomes to open surgery in removing cancerous tissue and preserving urinary and sexual function in men with localised prostate cancer, early results from a study to compare...

IVF treatment not linked to breast cancer

The use of in-vitro fertilisation (IVF) does not increase the risk of breast cancer, according to the findings of a long-term cohort study.

New online information centre for people with leukaemia

Patient Power Europe have launched a new online, video-based, information centre for acute leukaemia patients produced with the collaboration of some of the world’s leading leukaemia experts and the patient community in the UK and across Europe.

1 in 8 advanced prostate cancers may be linked to faulty genes

Much of modern cancer treatment is aimed at finding the right treatment for the right person, and this type of genetic research may help doctors to target treatments at the people who are most likely to benefit from them. It's not news that mutations in DNA repair genes like BRCA2 are linked to an increased risk of prostate cancer, although we are still some way from understanding how that link works. But the finding that these mutations seem to be much more common in men whose cancer has spread around the body is interesting. Doctors have long wanted a test that could identify which prostate cancers are more likely to spread, and this genetic test could potentially add to the information that helps pinpoint that risk. A class of medication known as poly ADP ribose polymerase (PARP) inhibitors has proved useful in treating other types of cancer associated with mutations in DNA repair genes. Further research to explore this avenue of potential treatment would be useful. The study has important limitations. Different methods of DNA analysis were used in different hospitals, which might have affected the results. More importantly, there was no direct comparison group, so researchers were unable to balance or match men with metastatic cancer with men with
localised prostate cancer of the same age or with the same family history, to get an unbiased comparison between the two groups. The study used to compare rates of gene mutations in men with localised prostate cancer included mainly men with higher risk cancers, which means it may not be representative of all men with localised prostate cancer. This would affect the usefulness of the gene test in spotting men with cancer likely to spread. The researchers' call for men with prostate cancer to be tested so their relatives can then be counselled about their risk of cancer raises questions. Not all people with DNA repair gene mutations like BRCA1 and BRCA2 go on to get cancer, although the mutations do raise the risk of cancer. Wider testing could put people into a position where they had to decide whether to take drastic preventive action (as actress Angelina Jolie famously chose to do by having her breasts and ovaries removed) or live with the risk.
Increase in cancer survival rates

Macmillan Cancer Support has published *Cancer now and then: Diagnosis, treatment and aftercare from 1970 –2016*. This report highlights that people on average are now twice more likely to survive at least ten years after being diagnosed with cancer than they were at the start of the 1970s. These improvements in survival are partly due to earlier diagnosis by way of screening programmes and advances in diagnostic tools, as well as more refined treatment.

Cancer: then and now

This report from Macmillan finds that more than 170,000 people are living with cancer in the UK who were diagnosed in the 1970s and 1980s. The report compares the diagnosis, treatment and care of cancer then, to the experiences of cancer in the 2010s. Whilst celebrating the advances in cancer care, treatment and survival rates it also warns that more needs to be done to cope with increasing demand in future.

Each Community is Prepared to Help: Community Development in End of Life Care – Guidance on Ambition Six

National Council for Palliative Care

This guidance has been developed by Dr Julian Abel and Dr Libby Sallnow, with support from Professor Scott Murray and Michael Kerin, on behalf of Public Health Palliative Care UK, the National Council for Palliative Care and Hospice UK. It provides advice and practical suggestions for organisations that are keen to stimulate and extend partnerships with communities. The guidance does not specify exactly what is needed for each area. Rather, it provides a series of interrelated recommendations that are suitable for local interpretation. This will require leadership, individual action and a preparedness to work together, across organisational boundaries and across professional and community roles. Together, we can build and enhance supportive networks at end of life in our homes, communities, educational institutions and workplaces.
ONLINE LEARNING SESSIONS FOR NURSES

The European School of Oncology (ESO) continues to offer free online training modules for cancer professionals. These are now known as 'e-ESO sessions'. The sessions are streamed from the ESO website every Thursday from 18:15 CET. Some of the sessions are held in collaboration with EONS and are of particular interest to cancer nurses. The next ESO-EONS joint session is on physical activity and cancer and takes place in October. You can watch recordings of older sessions for up to a year after they were first streamed.

Join Us for the Cancer Survivorship Symposium

The Cancer Survivorship Symposium will return January 27-28, 2017 in San Diego, California to bring together specialists from around the world in a variety of disciplines, working together to transition patients from cancer treatment to survivor-oriented care. The meeting will feature the inaugural Ellen Stoval Award and Lecture, educational sessions, abstract presentations, keynote lectures, and networking events to address the needs of clinicians, researchers, and health professionals who are interested in cancer survivorship care - a true multispecialty, interdisciplinary event.

"We are excited to convene the second Survivorship Symposium, building upon the tremendous success of the inaugural symposium and expanding into new areas including community-based and international models of care as well as adding breakout sessions to focus on specific areas of need." Kevin Oeffinger, MD (Chair, Program Committee) Memorial Sloan-Kettering Cancer Center

Mark your calendar to participate in this event. Visit survivorsym.org in mid-August to view the preliminary program, review the call for abstracts information, and register and make hotel reservations for the Symposium.

Mid-August - Abstract Submitter, Registration, and Hotel Reservations Open
October 4 - Abstract Submission Deadline
December 21 - Hotel Reservation and Early Registration Deadline

Dr. Julie Vose to Deliver Keynote lecture at the 2016 Research Community Forum Annual Meeting

There's still an opportunity to register for the 2016 Research Community Forum Annual Meeting, which brings together community-based researchers to network, collaborate, and find solutions to common challenges to conducting research in the community setting. Space is limited, so reserve your spot today - Register by August 24 to save 33%!

Register Now
Most electronic resources are available via an Athens password. You can register for this via the Library intranet page, or from home at http://www.swice.nhs.uk/ and following the link for Athens self-registration. Please note that registering from home will take longer as it will need to be verified that you are NHS staff/student on placement.

Library staff are available to train individual staff or small groups. Training can take place in the library or at your work place if you have access to appropriate IT facilities.

**COURSES INCLUDE:**

**Library Induction**
You will be given a detailed overview of all library information systems and resources and how to use them. Library registration and obtaining an OpenAthens password are included.

**Accessing NHS eResources**
You will be introduced to all the electronic information resources available to NHS staff including eJournals, eBooks, healthcare databases and useful websites.

**Searching for Evidence (beginners)**
You will be introduced to the 8 leading healthcare databases and shown how to plan your literature search, how to execute it effectively and how to save and print your results.

**Searching for Evidence (advanced)**
You will be shown how to search across multiple databases, how to use the thesaurus, the subject headings and the full range of limit options.

**Introduction to Critical Appraisal**
This course introduces the basics of critical appraisal and its role in evidence-based practice.

**Pre-Course Skills Parts 1 & 2**
These 2 sessions are designed for staff about to start a course who need a thorough update on information gathering skills. Attendance at both sessions is required.

**Library Mini-Breaks**
30 minute sessions tailored to meet your needs e.g. Cochrane Library, how to find clinical guidelines, using eBooks, library electronic A-Z website, RSS feeds, journal contents pages using Outlook.

**Rapid Evidence Searching NEW**
Using tried and tested techniques, rapid searching of the evidence base for when quick solutions are needed.

**Reflective Practice NEW**
How to read and comment upon a paper

**Writing for publication NEW**
Everything you need to know about writing a paper for publication
Collaborative "Living Evidence" Searching/Appraisal NEW
Group searching/appraisal of evidence in computer labs (suitable for MDTs and similar).

TO BOOK A COURSE, click here

Literature & Evidence searches

- Are you looking for the latest evidence-based research, but haven't got time to trawl the databases?
- Do you need a literature search carried out?
- Do you need to find evidence to support an improvement?
- Do you want to know how something has been done elsewhere and whether it worked?
- Library staff provide a literature and evidence search service for busy clinicians who are pressed for time.

To request a search, please complete and return this form, providing as much information as possible. Alternatively if you would like an assisted search training session, where we will sit down with you and go through the steps of a literature search, then please contact the library.

Library training drop-in sessions

The Library is running a series of drop-in sessions that will be held in the Academy e-learning room. No booking necessary, but if you decide to attend you will need to arrive on time.

- Introduction to Critical Appraisal
- Evidence Searching
- Literature Searching
- Rapid Evidence review

For a list of the course dates click here

Horizon Scanning service

Horizon Scanning – also known as Early Warning Systems - is a systematic examination of information to identify potential threats, risks, emerging issues and opportunities and filter and prioritise new and emerging health technologies. Horizon Scanning service maps ‘forward alerts’ and ‘evidence predictions’, based on emerging trends. Sources searched include the usual clinical evidence sources, as well as ‘grey literature’, specialist medicines databases, health technology databases and specialist Horizon Scanning databases.

To access, click here.