ANZMTG Australia and New Zealand Melanoma Trials Group

NEWSLETTER |ISSUE 11| Summer 2012/2013

Welcome to the Summer 2012/2013 edition of the ANZMTG newsletter. ANZMTG had a busy end to 2012 that was capped by the ANZMTG Scientific Research and Annual General Meeting. Thank you to all members who attended and made it a successful event. We have a number of grant submissions in progress and it has been a productive start to the new year.

Inside this issue:

Sunscreen Labelling Reforms

As a result of recent and significant developments in sunscreen technology, sunscreens sold in Australia can now be labelled with a new Sun Protection Factor (SPF) rating of 50+. The change in November 2012 brings Australia in line with New Zealand, the US and European countries, where SPF 50+ sunscreens are already available.

SPF 50+ sunscreens provide better protection against not only sunburn, which is mainly caused by UVB, but also long term skin damage from UVA. UVA, which has longer wavelengths than UVB, can penetrate deeper into the skin and is mainly responsible for melanomas and skin cancer.

The SPF measures how well the sunscreen protects the skin from sunburn. SPF is measured in laboratories on human skin and is determined by how long it takes intense ultraviolet radiation (specifically UVB) to burn skin that has had sunscreen liberally applied to it compared to skin without sunscreen. A SPF of 30 means that skin protected with sunscreen takes 30 times longer to burn then skin without sunscreen. Sunscreens are also assessed on their broad spectrum performance. This measures how well they protect against UVA radiation. SPF 50+ sunscreens are required to meet more stringent broad spectrum protection standards.

Although SPF 50+ sunscreens provide better sun protection, sunscreens do not completely protect against the harmful effects of the sun. It is very important to also utilise other sun protection methods, namely:

- Seek shade, especially in the hottest part of the day.
- Wear sun-protective clothing that covers your back, shoulders, arms and legs.
- Wear a broad-brimmed hat.
- Wear wrap-around sunglasses.

Find out more about how to protect yourself from the sun from the Melanoma Institute Australia: http://www.melanoma.org.au/about-melanoma/prevention.html

More information about the sunscreen labelling reforms is available from the Therapeutic Goods Administration (TGA): http://www.tga.gov.au/consumers/sunscreens-2012.htm

Immune Therapies Update

There have been recent and dramatic advances in the treatment of advanced melanoma with immune therapies (or immunotherapies). Immune therapies work by stimulating the body's immune system to recognize and destroy melanoma cells more effectively. They are usually administered intravenously. There are many different immune therapies but the most exciting results have come from PD-1 and PD-L1 blockers.

PD-1 and PD-L1 blockers

Some melanoma cells have a protein called PD-L1 on their surface that helps them to inhibit the body's immune response to melanoma. Drugs that block the PD-L1 protein or the corresponding PD-1 protein on immune T cells can reactivate the immune system. Early results from phase I clinical trials of the Bristol-Myers Squibb PD-1 and PD-L1 blocking drugs are promising. The PD-1 blocker (BMS-936558) was tested in 296 patients with various advanced cancers. Significant tumour shrinkage was seen in 26 of the 94 melanoma patients (28%) and for 6 patients, disease stabilisation lasted for more than 24 weeks[1]. Similar results were seen with the PD-L1 blocker (BMS-936559) with tumour shrinkage observed in 9 of 52 melanoma patients (17%)[2]. A phase I trial of the Merck (MK-3475) PD-1 antibody also shows promise; it elicited an anti-tumour response in 51% of 85 patients with metastatic melanoma and produced few side effects[3]. Larger trials of these new drugs and other PD1/PD-L1 blockers are now being performed.

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Ipilimumab

Ipilimumab (Yervoy) is a monoclonal antibody that blocks a protein called CTLA-4. CTLA-4 regulates the immune system by suppressing and keeping in check immune T cells. By blocking the action of CTLA-4, ipilimumab releases the brake on the immune system so that the T cells become activated and destroy melanoma cells.

In a phase 3 trial in 676 patients with previously treated metastatic melanoma, ipilimumab was found to significantly extend overall survival[4]. Patients who received ipilimumab had a median survival of 10.1 months compared to 6.4 months for those who received the experimental glycoprotein 100 vaccine. In previously untreated metastatic melanoma patients, the addition of ipilimumab to the chemotherapy agent, dacarbazine, also significantly improved survival[5].

Ipilimumab has been associated with immune related side effects, including fatigue, diarrhea, skin rash and inflammation of the intestines. The side effects can be severe and potentially fatal, so close monitoring and management of side-effects are essential. Ipilimumab is approved for use in Australia by the Therapeutic Goods Administration (TGA) but is not currently subsidised by the Pharmaceutical Benefits Scheme.

Other immune therapies and combination therapies

Cytokines that boost the immune system, such as interferon-alpha and interleukin-2 (IL-2), have been used for the treatment of melanoma with modest success. Melanoma vaccines have been used to try to stimulate the immune system to destroy melanoma cells. The vaccines are made from either killed melanoma cells or parts of melanoma cells. Results from vaccine studies have been mixed and melanoma vaccines remain as experimental therapies. Another experimental therapy is treatment with tumour-infiltrating lymphocytes (TILs), immune cells that are found in tumours. Early trials have been promising and showed that TILs were able to shrink melanomas.

With the advent of new and effective melanoma therapies, clinical trials that combine different melanoma treatments are also underway. It is hoped that combination treatments will be more effective than a single treatment and will help prevent immune system evasion or drug resistance.

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[1] Topalian *et al.* Safety, Activity, and Immune Correlates of Anti–PD-1 Antibody in Cancer. *N Engl J Med* 2012; 366: 2443-2454.

[2] Brahmer *et al.* Safety and Activity of Anti–PD-L1 Antibody in Patients with Advanced Cancer. *N Engl J Med* 2012; 366: 2455-2465.

[3] Merck Newsroom: http://www.mercknewsroom.com/press-release/research-and-development-news/merck-presents-early-stage-interim-data-mk-3475-investig

[4] Hodi *et al*. Improved survival with ipilimumab in patients with metastatic melanoma. *N Engl J Med.* 2010; 363(8): 711-23.

[5] Robert et al. Ipilimumab plus dacarbazine for previously untreated metastatic melanoma. *N Engl J Med* 2011; 364(26): 2517-26.

Australian Melanoma Genome Project

The Australian Melanoma Genome Project was launched by Melanoma Institute Australia (MIA) in 2012. It is an ambitious and important two-year national research program that aims to identify the common gene mutations that lead to melanoma. By learning more about melanoma as a disease, scientists hope to find new treatments to help those with melanoma. We spoke to Professor Graham Mann, who leads the project.

This is a large project, how long was it in planning and who was involved?

The project is the result of a National Health and Medical Research Council (NHMRC) call for cancer genome project proposals in 2007. At MIA, Professor Richard Scolyer and Professor Nick Hayward had been working on genome projects in the US. They submitted a proposal to the NHMRC to fund a melanoma genome project. Although the funding application was unsuccessful, they started to progress the project with their own funds. They gained the support of the MIA board to specifically raise funds and eventually secured support from the Federal Government, who has provided $1.5 million towards this project. A further $500,000 each has been provided by the Cancer Council NSW and the NSW Government.

Professor Graham Mann

How many and what kind of samples are you planning to test?

We are aiming to analyse 500 melanoma genomes. Our broad objective is to find the full mutation profile of different melanomas. The melanomas that we are genotyping are split into the following groups:

i. Primary Melanomas: These are from the collection based at MIA and are a priority.
ii. Brain Metastases
iii. Stage III Lymph Node Metastases with uncertain prognosis

Why not test everybody whom you have a sample for?

Clinical practice may lead to this in the future, however, currently each genome costs around $10,000 to genotype and is fairly time intensive, so we can't genotype all the samples yet!

Will results be publicly accessible?

Raw data will be publicly available on a website; this is very important as it allows other researchers to advance their work if they are working on other diseases. For example, a person working on diabetes might know a gene or pathway is important in that disease, but not how it works. This project will produce information about how the gene is being used. This is a very exciting time as efforts by researchers everywhere are being combined and it is now possible to use other scientist's data to plan and inform experiments across the world.

With such a huge undertaking, you must have a great and diverse group of researchers. Can you talk a little bit more about the different groups involved and the individuals behind the scenes?

The starting point for the project is the donation of tumour samples. Clinical researchers have created a culture of support and engagement of tumour donation with patients. Without the support of clinicians and patients, this project would not be possible.

The key next step is setting up a pathology research team. Professor Richard Scolyer has been instrumental in ensuring specimens are successfully sent on to the tumour bank.

As well as those at the 'coal face' in clinical terms, there are teams involved in sequencing, genetic and functional analyses at the University of Sydney and the Queensland Institute of Medical Research (QIMR). We have local collaborators in mathematics, bioinformatics and proteomics, but our network also extends to Korea, where Macrogen is performing half the sequencing. We are also closely connected with other groups in Australia and around the world, who provide advice and suggestions about which samples to genotype.

'Without the support of clinicians and patients, this project would not be possible'

Find out more from Professor Mann about what genotyping means and how genetic research can be incorporated into clinical trials in the next issue of the ANZMTG newsletter.

ANZMTG ASM/AGM 2012

ANZMTG warmly welcomed more than 60 members to the ANZMTG Annual Scientific and Annual General Meeting (ASM/AGM) in Sydney in December 2012. It was a wonderful opportunity for members to meet and discuss current and upcoming trials and the latest developments in melanoma research. Many of the presentations on current and proposed trials prompted lively and constructive discussions and illustrated the depth of melanoma research in surgery, radiation therapy and medical oncology.

In the afternoon, Professor Rick Kefford brought us up-to-date with the spectacular advances in the treatment of melanoma with targeted drugs and immune therapies, Professor John Thompson outlined the challenges of developing evidence-based guidelines for melanoma, Professor Madeleine King provided an overview about how melanoma can affect quality of life and Campbell Rose gave an inspiring presentation about the many consumer engagement activities organised by the Australian Melanoma Consumer Alliance (AMCA).

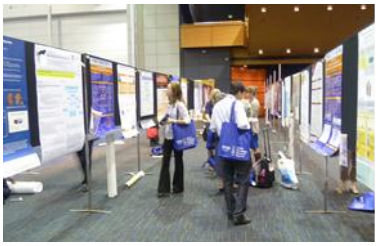
Thank you to all the presenters and attendees for making the day such a success.

Podcasts of presentations from the ASM and minutes of both the ASM and AGM are available upon request. Please send requests to: anzmtg@melanoma.org.au

Save the Date! The 2013 ANZMTG ASM/AGM will be held in Brisbane on **21-24 November 2013** in association with the Global Controversies and Advances in Skin Cancer Conference. More information will be available soon.

COSA ASM 2012

The Clinical Oncological Society of Australia (COSA) held their 39th Annual Scientific Meeting (ASM) in Brisbane in November 2012. ANZMTG exhibited a poster on melanoma clinical trials. This opportunity not only allowed us to showcase what we do, it also provided a chance to discover more about the current challenges and advances in melanoma treatment.



Both national and international speakers presented talks over a three day period, the majority of which related to COSA's disease theme of skin cancer. Presentations covered a spectrum of melanoma topics, including the challenges facing researchers in the laboratory, the emerging technologies being developed to diagnose the disease and the place of radiotherapy in managing melanoma.

There was a great focus on the development of new systemic treatments in melanoma, with Professor Grant McArthur providing an overview as to the mechanisms by which BRAF inhibitor resistance might be overcome. He discussed how researchers are exploring the use of inhibitors of both the glycolytic and cell cycle pathways and how immune response regulators might be used in combination with the drug. Professor Brian Gabrielli also touched upon the cell cycle and discussed the importance of further research into the use of inhibitors targeting different stages of the cell cycle. A novel technique was presented by Professor Gary Halliday, who shared the results of a Phase I clinical study in which patients were injected with a DNAzyme which is specific for, and cleaves, c-Jun, a master regulator in both the angiogenesis and cell proliferation pathways. Although the trial was conducted in human basal cell carcinoma, the results are very promising and it is hoped this synthetic DNA sequence will be trialled in melanoma.

It was inspiring to learn how researchers are working together to develop ways to tackle melanoma and given so much effort and knowledge is being invested into this disease, there are sure to be more breakthroughs in the future.

ANZMTG Clinical Trials Update

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

Chief Investigator: Dr Gerald Fogarty; ANZMTG Trial Co-ordinator: Enmoore Lin
Status: Open to recruitment
Current accrual: 112 patients
Target accrual: 200 patients over 5 years

For further information on the trial, contact Enmoore Lin on +61 2 9911 7351 or email enmoore.lin@melanoma.org.au

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

Chief Investigator: Dr Matthew Foote; Trial Co-ordinators: Janelle Meakin (TROG) & Alan Lucas (ANZMTG)
Status: Open to recruitment
Current accrual: 15 patients
Target accrual: 100 patients over 5 years

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

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

Chief Investigator: Professor Michael Brown; Trial Coordinator: Anne Milton
Status: Protocol finalised, not yet open (Royal Adelaide Hospital only)

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

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

Chief Investigator: Dr Robyn Saw; ANZMTG Trial Co-ordinator: Alan Lucas
Status: Open to recruitment (Melanoma Institute Australia only)
Current accrual: 33 patients
Target accrual: 75 patients over 2 years

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

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

Chief Investigator: Dr Don Morton; Trial Co-ordinator: Lisa van Kreuningen
Status: Open to recruitment
Current accrual: 1686 patients (worldwide)
Target accrual: 1925 patients over 7 years

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

EORTC Melanoma Module *(Acronym: MELMOD)*
Chief Investigator: Associate Professor Julie Winstanley
Status: Open

For further information on the trial, contact Julie Winstanley on +61 2 9911 7271 or email julie.winstanley@melanoma.org.au

ANZMTG Trials Approved for Development Update

Evaluation of Groin Lymphadenectomy extent for metastatic melanoma *(Acronym: EAGLE FM)*
Chief Investigator: Associate Professor Andrew Spillane; ANZMTG Trial Co-ordinator: Alan Lucas
Status: In development

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

Radiotherapy followed by selective nodal dissection for high volume regional melanoma *(Acronym: REFORM)*
Chief Investigator: Dr Matthew Foote; ANZMTG Trial Co-ordinator: Alan Lucas
Status: In development

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

A randomised controlled multicentre trial of imiquimod versus radiotherapy for lentigo maligna (LM) when staged surgical excision with 5mm margins is not possible, is refused, or fails
Chief Investigator: Dr Pascale Guitera; ANZMTG Trial Co-ordinator: Vanessa Neve
Status: In development

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

Randomised controlled trial of 1cm vs 2 cm excision margins for 1-4 mm thickness primary invasive cutaneous melanoma *(Acronym: MelMarT)*
Chief Investigator: Professor Michael Henderson; ANZMTG Trial Co-ordinator: Vanessa Neve
Status: In development

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

New Ideas for Melanoma Research?

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

ANZMTG Presentation Awarded Best Oral Presentation Award

Congratulations to Dr Gerald Fogarty for winning the Best Oral Presentation award for his talk, *Five current ANZMTG trials will help define the role of Radiotherapy in Melanoma*, at the 6th World Meeting of Interdisciplinary Melanoma Skin Cancer Centres & 8th EADO Congress, Barcelona, Spain, November 2012.

Cancer Australia

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

Australian Government
Cancer Australia

NSW Skin Cancer Prevention Strategy 2012-15

The NSW Skin Cancer Prevention Strategy 2012-15 was released in November 2012. The strategy outlines how government, not-for-profit, private sector, health and community groups will work together to reduce over-exposure to the sun. There are four priority areas that are designed to prevent and limit the burden of skin cancer in NSW:

1. Ultraviolet radiation (UVR) protection behaviours.
2. Shade provision.
3. UVR protection policy.
4. Strategic research.

Download the strategy at: http://www.cancerinstitute.org.au/publications/i/nsw-skin-cancer-prevention-strategy-2012-15

ANZMTG Full Member Survey - Results

ANZMTG conducted an online membership survey to gain an understanding as to how our members view us, what they feel we can offer them with regards to aiding in the development of clinical trials, as well as finding out what they would like us to consider providing in the future. Thanks to all members who participated.

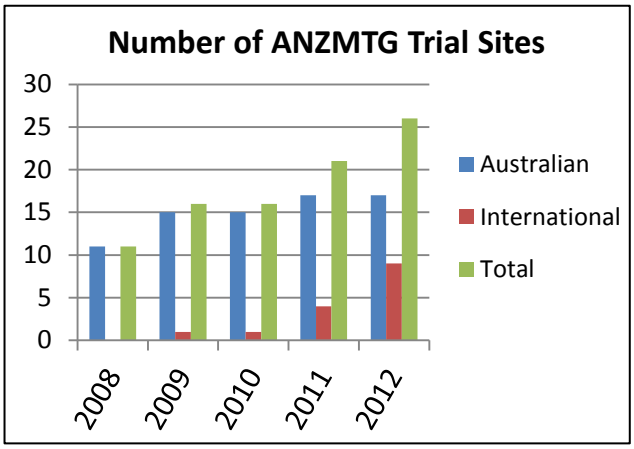
92 members, who mainly had a medical background in oncology and clinical trials, completed the survey. It is clear from the results that our members hold us in high regard, with 98% stating that we achieved our aims moderately well to very well. What was surprising was that this percentage was not reflected by our member's knowledge regarding the services we can offer them.

Of our respondents, 70% were aware that ANZMTG can:

- Centrally manage and coordinate melanoma trials
- Facilitate communication between melanoma services
- Provide a central point of contact for researchers.

However, only 50% knew that ANZMTG may assist in project set up; helping investigators complete grant applications and assist with document development and ethics submissions. Many also did not know that ANZMTG can develop SOPs and quality assurance processes. We encourage any full members to contact us should further information about our resources be required.

Looking to the future, members suggested we increase our international trials base which we have worked on throughout 2012; increasing our visibility at international conferences, opening more international sites and collaborating with researchers in the UK in developing a large scale surgical trial.



Better promotion of the ANZMTG and upcoming events was also noted and this is something we have tackled with the launch of our new website in November 2012 and by ensuring a weekly e-bulletin is provided to the membership, not only outlining our news and upcoming events, but those of other relevant groups.

We hope to continue to promote and improve our services for both associate and full members in 2013 and we welcome any feedback or ideas you may have for the ANZMTG. We can be contacted through our website http://www.anzmtg.org or via email anzmtg@melanoma.org.au

Consumer Corner

What is meant by Melanoma Staging?

Doctors stage melanoma to determine the extent of the spread of the disease and whether or not it has moved from the original site on the skin to the lymph nodes or to other parts of the body.

The most common system used all over the world is known as TNM staging.

T = Extent of primary tumour
N = Node (Are lymph nodes involved? If so, how many nodes are involved?)
M = Metastasis (Is there tumour at other sites in the body?)

Staging for all cancers are based around the same system, however each cancer has its own specific way of applying the TNM staging method. Table 1 describes the TNM staging method for melanoma.

The first step in staging is to measure how deeply into the skin the cancer cells have grown. This is done by a pathologist once they receive the biopsy. The depth of the melanoma is important because the deeper the cancer cells have grown into the skin, the greater the risk the cancer will come back or spread to the lymph nodes or elsewhere in the body.

Stage I	
1A	<1.00 mm without ulceration; no lymph node involvement, no distant metastases.
1B	<1.00 mm with ulceration or Clark level IV or V tumour 1.01 – 2.0 mm without ulceration; no lymph node involvement; no distant metastases.
Stage II	
IIA	1.01 – 2.0 mm with ulceration; tumour 2.01 – 4.0 mm without ulceration; no lymph node involvement; no distant metastases.
IIB	2.01 – 4 mm with ulceration.
IIB	> 4.0 mm without ulceration; no lymph node involvement; no distant metastases.
IIC	> 4.0 mm with ulceration; no nodal involvement; no distant metastases.
Stage III	
IIIA	Tumour of any thickness without ulceration with 1 positive lymph node and micrometastasis or macrometastasis.
IIIB	Tumour of any thickness without ulceration with 2-3 positive lymph nodes and micrometastasis or macrometastasis.
IIIC	Tumour of any thickness and macrometastasis OR in-transit met(s)/satellite(s) without metastatic lymph nodes, OR 4 or more metastatic lymph nodes, matted nodes or combinations of in-transit met(s)/satellite(s), OR ulcerated melanoma and metastatic lymph node(s).
Stage IV	
IV	Melanoma that has distant metastasis beyond the original site; this may include other areas of skin, distant lymph nodes, bone, other organs including lungs and brain.

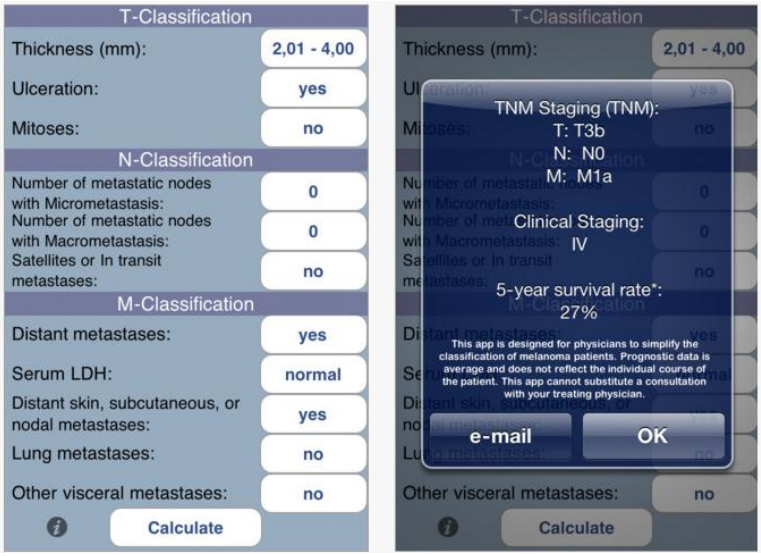
Mets = metastases

Ulceration = the absence of an intact epidermis overlying a portion of the primary melanoma based on pathologic microscopic observation of the histological sections

Staging is very important in melanoma as it is the determining factor for what kind of treatment will follow. Early stage melanomas are usually treatable simply with surgery and the prognosis is good. Diagnosis at a later stage has a poorer prognosis and surgery may be combined with other treatments.

MelaStage App

The free Melanoma Staging Calculator (MelaStage) iPhone app stages cutaneous melanoma patients according to the AJCC 2009 classification system. The app calculates the current TNM classification, clinical staging and average 5-year overall survival after data about tumour thickness, ulceration, mitotic rate, lymph node metastases and distant metastases are entered.



The app was developed by the Dermatologic Cooperative Oncology Group (DECOG) and can be downloaded at:
https://itunes.apple.com/au/app/melanoma-staging-calculator/id424646329?mt=8

The app is designed for physicians to help stage melanoma patients. The app cannot substitute a consultation with your treating physician.

Amie St Clair Melanoma Trust, Wagga Wagga, NSW

The Amie St Clair Melanoma Trust was established in March 2010 following the death of Amie, aged 23, from Metastatic Melanoma. The Trust was established to make a difference in raising awareness of Melanoma and provide education and better access to specialised care for the communities of the Wagga Wagga region.

Dr Richard Harrison, Eileen Friedlieb and Annette St Clair

The Trust started a schools campaign just before Christmas, which is educating primary children in years 4, 5 and 6 about sun safety, and hopes to extend the programme into high schools as there is a need to get the message out to teenage children. The Trust has also presented talks to Rotary groups and ladies groups. The focus for 2013 will be to extend the education program to other organisations such as council workers and other outdoor companies.

Due to the generosity of the Wagga Wagga community and through community fundraising activities, the Trust has been able to employ a Melanoma Care Nurse, Eileen Friedlieb. The role of the Melanoma Nurse is to support those diagnosed with melanoma, provide education to the community and help people living or diagnosed with the disease navigate their way through treatment. Before Eileen's appointment, there was no nurse in the region specifically assigned to melanoma patients. Eileen currently supports 17 patients and is receiving referrals from different medical specialists. Eileen is also involved in an up and coming Community Forum on Lymphoedema Education in March 2013. This is a free forum for melanoma patients who have Lymphodema. Please contact Eileen if you would like to know more: eileen@amiestclairmelanoma.org.au, 0413 766 232.

2013 Calendar of Events

Date	Name of meeting	Location	Secretariat contact details
March			
6 – 9	Society of Surgical Oncology (SSO) Cancer Symposium	National Harbor, MD, USA	W:http://events.jspargo.com/SSO13/public/enter.aspx
10	Melanoma Awareness March	Sunshine Coast, Australia	W:http://www.melanomapatients.org.au/events
24	Melanoma March	Various locations, Australia	W:http://melanomamarch.gofundraise.com.au/cms/home
April			
5	Melanoma Summit New Zealand 2013	Wellington, NZ	W:www.melanoma.org.nz/MelNet/News/Melanoma-Summit-2013/
7 - 10	12th National Rural Health Conference	Adelaide, SA, Australia	W: http://nrha.org.au/12nrhc/
11 - 13	2013 Comprehensive Course on Soft Tissue Tumors and Update on Melanoma	Phoenix, AX, USA	W:www.dermpedia.org/event/scottsdale2013
26	Melanoma Focus Core Members' Meeting	Bristol, UK	W:http://melanomafocus.com/members-portals/april-2012-members-meeting/
May			
4	Melanoma Education Symposium	Columbus, OH, USA	W: http://www.melanoma.org/get-involved/educational-symposium-columbus-oh
6 – 8	Centre for Research in Evidence-Based Practice (CREB) Protocol Development Workshop	Gold Coast, QLD, Australia	W:www.crebp.net.au/?page_id=525
6 – 10	The Royal Australasian College of Surgeons – Annual Scientific Congress	Auckland, NZ	W: http://asc.surgeons.org/
18 - 22	Australian College of Dermatologists Annual Scientific Meeting	Sydney, NSW, Australia	W:www.dermcoll.asn.au/public/meeting_and_conferences.asp
27 - 29	Joint International Oncology (Sentinel Node and Cancer Metastasis) Congress	San Francisco, CA, USA	W: http://www.sn-cancermets.org/
31 May – 4 Jun	American Society of Clinical Oncology (ASCO) Annual Meeting	Chicago, IL, USA	W: http://chicago2013.asco.org/
June			
4 – 5	Trends in Melanoma Research	Bonn, Germany	W:http://www.melanomverbund.de/index.php?id=841
27 – 30	9th World Congress of Cosmetic Dermatology	Athens, Greece	W: www.wcocd2013.com/
July			
17 - 20	8th World Congress of Melanoma	Hamburg, Germany	W: www.worldmelanoma2013.com/
August			
1 - 2	Blood, Biomarkers and Beyond MOGA 2013 Annual Scientific Meeting	Melbourne, VIC, Australia	W:http://www.moga.org.au/news-events/events/save-date-0
29 - 31	11th Annual Meeting of the Japanese Society of Medical Oncology (JSMO)	Sendai, Japan	W:http://www.congre.co.jp/jsmo2013/english/index.html

Please contact the ANZMTG office if you know of any upcoming events you would like included in this calendar.