

**INQUIRY INTO CORRECTIONAL SERVICES
LEGISLATION AMENDMENT BILL 2006**

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Date Received: 28/07/2006

Subject:

Summary

From: "Kelly SMITH"
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Date: 28/07/2006 4:57 pm
Subject: Submission from the Cancer Institute NSW

CC: "Charles Latimer"
** High Priority **

Please see the attached submission.

Regards
Kelly

Kelly Smith
Office of Professor Jim Bishop
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Date: 27 July 2006

The Director
General Purpose Standing Committee No 3
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Dear Sir/Madam

**INQUIRY INTO THE CORRECTIONAL SERVICES LEGISLATION AMENDMENT BILL 2006
BY THE GENERAL PURPOSE STANDING COMMITTEE NO 3**

I refer to the letter of 15 June 2006 from the Chair of the Committee, the Hon Amanda Fazio MLC, inviting a submission from the Cancer Institute NSW regarding the provisions of the above titled Bill. Accordingly I am pleased to provide comments to the Committee to assist with its' deliberations on the Correctional Services Legislation Bill 2006.

The objects of the Bill I note are:

- (a) to prohibit inmates who are serving sentences for serious indictable offences or who are awaiting sentencing for such offences from providing their reproductive material for use, or storage, for reproductive purposes at hospitals and other places, and
- (b) to require inmates who have had their reproductive material stored for reproductive purposes to pay charges for the storage during any period during which they are imprisoned.

Serious indictable offences are defined as an offence which may only be dealt with on indictment such as murder, sexual assault, kidnapping and terrorism offences. I also note that the *Crimes Act 1900* defines a serious indictable offence as an indictable offence that is punishable by imprisonment for life or for a term of 5 years or more.

In providing advice to the Committee it is important to emphasise the focus of medical practitioners is to enable medical assistance and related health support to be given to cancer patients as a foremost priority. Accordingly, the following aspects should be noted:

- Currently medical practitioners do not differentiate between patients for the provision of health care which should be provided irrespective of the legal status that an individual patient may hold.

- The focus for a medical practitioner is to provide the best care for a cancer patient based on the best evidence of benefit about the diagnosis, prognosis and the appropriate treatment. This may include other considerations relating to long term health outcomes and quality of life considerations;
- Cancer drugs are increasingly less damaging when chemotherapy is used for treatment due to the advent of new targeted therapies and less reliance on older, more toxic agents. The implication of which, is that cancer patients may have a better chance of retaining their natural fertility following cancer chemotherapy.
- The number of offenders likely to be affected by this legislation is small based on the cancer incidence rate by age cohort, the types of treatment now available, the number and age of offenders etc.

I note that Section 72A of the Crimes (Administration of Sentences) Act 1999 states:

72A Medical attention

An inmate must be supplied with such medical attendance, treatment and medicine as in the opinion of a medical officer is necessary for the preservation of the health of the inmate, of other inmates and of any other person.

I have attached some additional information on cancer treatments, the possible impact on fertility and options from a medical perspective which the Committee may find of interest in considering the provisions of the Bill.

I hope the Committee find the comments helpful.

Kind regards

Yours sincerely



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 PROFESSOR OF CANCER MEDICINE, UNIVERSITY OF SYDNEY

Attachment

Cancer Treatment and Fertility Effects

The majority of cancer treatments have long-term side effects – one such side effect is temporary or permanent loss of fertility. Infertility resulting from cancer treatment may be a concern for both men and women, however infertility depends on the type and stage of cancer and the method/degree of treatment(s) which may be used.

Treatments which may cause infertility include;

- **Surgery:** Removal of part of the reproductive organ such as removal of the ovaries or uterus in women and removal of the prostate and/or testes in men.
- **Radiation:** Radiotherapy is a localised treatment of the cancerous site using ionising radiation. This mode of therapy may cause infertility depending on the site of treatment however the severity of infertility depends on the radiation dose and the age of the patient. Sometimes barriers such as lead shields are used to protect the reproductive organs if they are not in the immediate area being treated.
- **Chemotherapy:** Chemotherapy targets rapidly growing cells in the body which includes cancer cells as well as sperm and the layer of cells that protect ovaries. Due to the systematic nature of chemotherapeutic agents, it does not matter where the cancer is located as the entire body receives the toxic drug. The extent of infertility induced by chemotherapy depends on the age of the patient and the type of chemotherapy. Usually women 35 or older may experience permanent infertility. In adult males, testicles will be prone to damage as a result of chemotherapy.

Younger patients will have a higher chance of regaining fertility than people reaching end of their reproductive years.

Chemotherapeutic agents which may cause infertility more than others include;

- Busulfan (Busulfex, Myleran)
- Melphalan (Alkeran)
- Cyclophosphamide (Cytoxan, Neosar)
- Nitrosoureas, including streptozocin (Zonosa), carmustine (Bicnu, Gliadel) and lomustine (CeeNu)
- Cisplatin (Platinol)
- Chlorambucil (Leukeran)
- Cytarabine (DepoCyt, Cytosar-U)
- Ifosfamide
- Procarbazine (Matulane)

With the introduction of new targeted therapies side effects such as risk of infertility may be reduced or eliminated.

Provision of adequate information and services for fertility preservation is an issue which clinicians routinely discuss with patients undergoing cancer treatments. Currently there are no standard guidelines practiced by all clinicians and not all patients are given information or the opportunity for such services. It is important to note that infertility is another complication like any other complication that may be caused by cancer treatment. Information conveying this risk is provided to patients who are of a reproductive age as part of good clinical practice.

Latest clinical practice guidelines by the American Society of Clinical Oncology emphasise the necessity of providing patients with appropriate information regarding possible infertility and preservation of fertility options currently available (Lee et al 2006). Evidence suggests that majority of cancer patients would take the opportunity to preserve their fertility if given the option.

The latest reported data from NSW Central Cancer Registry indicates that there were only 3,040 new cases of cancer of persons under the age of 45 in the year 2003 of which 1,267 were males and 1,775 were females. This compares to a total cancer incidence of over 33,000 for 2003.

It is predicted that at least 60% of cancer patients will survive their cancer 5 years or longer. As more effective screening and treatment options become available this prediction will improve.

Fertility preservation for men

Male infertility may occur from the type of cancer itself such as testicular cancer and Hodgkin's lymphoma.

Options for addressing the risk of the loss of fertility due to cancer or cancer treatment include:

- *Sperm banking (cryopreservation)*: This is the most effective and proven method by which the sperm of the individual patients is cryogenically preserved for later use. However, it has been shown that less than 10% of men may return to use their stored sperm (Lee et al 2006).
- *Sperm extraction*: This method may be used in patients with low sperm count. In this method sperm cells are removed from testicles and frozen for later use.

Fertility preservation for women

Embryo freezing: This is a method by which a fertilised egg is stored however, at this stage, preservation of unfertilised eggs is not possible. Extraction of eggs for fertilisation is usually induced by injection of hormones which may take few months rendering the patients to higher risk of cancer growth especially if a tumour is fast growing.

Other options which may be discussed with female patients include the possibility to use donor eggs or embryos and use of surrogates. These options depend on patient's treatment circumstances, outcomes and personal choices.

There are several experimental methods of preservation of fertility in women which may become available in the future. They include; egg freezing, ovary suppression and ovary tissue freezing.

References:

Cancer Institute NSW, Cancer Incidence and Mortality 2003,
http://www.cancerinstitute.org.au/cancer_inst/statistics/index.html (last accessed July 18 2006)

Lee SJ, Schover LR, Partridge Ah, et al; American Society of Clinical oncology recommendations on fertility preservation in cancer patients; J Clin Oncol; 2006; 24(18):2917-2931
<http://www.mayoclinic.com/health/cancer/CA00045>