

# Understanding Childhood Cancer

**A handbook for all teachers**

It's great to be back  
at school! I missed  
you all while I was  
in hospital!

It's boring when  
you aren't here!

We're glad  
you're back.



Inside cover illustration by Evie, 15 years old

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## Acknowledgments

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Through a strong commitment to caring for children with cancer, their families and their communities, the contributors have generously given of their time, knowledge and skills in the writing and production of this booklet.

## Introduction

This booklet, produced by Cancer Council Queensland, has been written to help teachers gain an understanding of childhood cancer enabling them to better deal with the academic, social, psychological and medical difficulties faced by a child with this diagnosis.

The adjustment to the reality of childhood cancer is not an easy one – but children are resilient and with support, sensitivity and understanding, they are better able to cope with the difficult changes in their lives.

There is an abundance of information about childhood cancer, and sometimes this can be overwhelming. There are people available to assist schools and teachers in the understanding of childhood cancer information. These include hospital staff and community organisations such as Cancer Council Queensland.



*“It is every parent’s nightmare. A routine visit to the doctor for a tummy ache resulted in the diagnosis two days later of ‘your child has cancer’. It all happened very fast. She went from supposedly being healthy to having a life threatening illness all in a matter of days and she was put straight onto a treatment protocol of blood tests, scans and chemotherapy etc. Knowledge is comfort and this book will answer a lot of the questions raised by both teachers and parents when a child is first diagnosed with cancer.”*

*Ineke (Mother of Jessica)*

*“A teacher shares a good deal of every child’s life on a daily basis. We come to know each and every one of our students and when fronted with something as traumatic as childhood cancer, it has a major impact on the entire class.*

*At times like this, the children in the class often look to their teacher for reassurance, guidance and comfort. This is also the case for many parents of these other children who often find the issue too difficult to discuss with their own children.*

*In addition to assisting the other children and their parents, communicating the happenings of the classroom to Jessica and her family so that she didn’t lose touch with school life during her absence was of the utmost importance. This helped to reassure Jessica who was already feeling somewhat self-conscious and unsure of her school-mates’ reaction upon her return.*

*During Jessica’s treatment, the adoption of a flexible approach was necessary. She was encouraged to attend whenever and for as long as she felt able. This allowed her to maintain her relationship with her peers and also our classroom routine. This also minimised the effects of Jessica’s isolation from her normal daily life.*

*The constant communication with Jessica’s family during her treatment and her exposure to the classroom on a regular basis enabled a smooth transition to normal school life upon her return.”*

*Wendy, Jessica’s teacher*

*... the impact is felt not only by the child, but also by the child's family, friends and peers...*

## Impact of childhood cancer

The diagnosis of cancer in a child is a frightening experience and the impact is felt not only by the child, but also by the child's family, friends and peers. Parents and families are faced with the prospect of dealing with the many issues presented by the disease. Suddenly home life is disrupted as time revolves around treatment schedules and medical procedures and possibly extended periods in hospital. Parents have to deal with their child's now more complicated physical and emotional needs and take on a new role of nursing responsibilities. With the impact of the diagnosis, parents have little time to focus on their own emotional wellbeing. They also have to support the sick child and siblings with their concerns. Feelings of grief, fear, denial, anger and loneliness are common. No one is prepared for such a diagnosis and there is great difficulty in trying to come to terms with the illness and with being well-informed about the disease. This is often a very overwhelming experience for parents and for families.

There are unique issues for rural parents – often families are separated for long periods of time, communication becomes difficult, stress is increased and parents feel isolated. There are often added financial burdens.

Hospitalisation impacts on parents when suddenly, already stressed, they are forced to live in a “fish bowl” with little privacy, amongst strangers and within a confined environment.

Siblings often feel left out as parents are constantly caring for the sick child. Their home routines are disturbed and often they are being cared for by other relatives or friends whilst their parents are at the hospital. They too can be scared and lonely, feel guilty, and jealousy may arise as their sick brother or sister receives constant attention.

Young children with cancer may not understand what is happening to them as they begin treatment. They are fearful of medical procedures and those who administer them. They have little or no control over what is happening to

them and become anxious. They are sensitive to the knowledge that parents are upset whilst needing comfort themselves. Older children are usually more aware of the severity of their disease and, with this knowledge, have to try to adjust to what is happening in their lives.

School communities also feel the impact of the diagnosis with shock and fear. Teachers may have their own “baggage” with their individual cancer experiences, with their own particular concerns, feelings and reactions. They have to learn to cope with the fact that a child in their pupil group now has a diagnosis of cancer and all that means for the class. Students may be fearful of the disease and afraid to communicate with the sick child, adding to the difficulties and isolation already being experienced.

Children and their families are unique with their individual coping strategies and networks which can help them to adjust to the impact of a cancer diagnosis. Similarly, school communities, with relevant information and support, should be able to continue the education of a child with cancer.



## Explanation of childhood cancers

**Cancer** is the name given to a group of diseases which involve the uncontrolled growth and spread of abnormal cells in various body tissues and organs.

**Oncology** is the branch of medicine which deals with the study and treatment of cancer.

Treatment plans for children are called **protocols**.

When a child is in **remission**, this means that there is no tumour detectable on appropriate testing. It does not mean that the child has been cured. It is usually necessary for treatment to continue once remission has been achieved. This can range from a few months up to three years, depending on the type and extent of the cancer.

Tumours are described as “benign” or “malignant”. Most childhood tumours are malignant. **Benign** tumours do not spread from their site of origin but can continue to grow and be difficult to remove and be life threatening. They are often managed with surgery alone.

**Malignant** tumours have the potential to spread to other parts of the body and may require **chemotherapy** and **radiation therapy** in addition to surgery.

After several years in remission, the child can usually be considered **cured**. If the cancer recurs after a period of remission, this is known as a **relapse**. If the cancer spreads to other areas, it is known as a **secondary** cancer or **metastasis**.

Cancer in children may be quite different from adult cancer. The types of cells, tissues and organs involved are usually different. The treatment of most cancers in children is generally more effective than for adults and the chances of cure are generally higher.

In adults, many cancers are thought to be caused by environmental factors. The causes of most cancers in children are not known.

**Cancer is not contagious**. There is no risk of one child passing the disease on to another. This erroneous belief is often a significant issue in the school setting.

## Common Childhood Cancers

**Leukaemia** – is a form of cancer characterised by the uncontrolled growth of abnormal white cells in the bone marrow, lymph glands and other organs. There are different types of leukaemia, the most common in children being acute lymphoblastic leukaemia (ALL). Another type also seen in children is acute myeloid leukaemia (AML).

**Brain tumours** – make up nearly a third of all tumours in childhood. There are many types of brain tumours. Astrocytoma and medulloblastoma are the most common. Some brain tumours may be “benign” but because of their position and difficulty with surgical removal, they may be life threatening.

**Lymphoma** – is a form of cancer which usually arises in the lymph glands. Lymphoma can be in a single site (localised) or can be more widespread. There are two types of lymphoma - Hodgkin’s lymphoma and Non-Hodgkin’s lymphoma.

**Wilms’ tumour** – is a type of childhood cancer which develops in the kidney. It occurs most often in children under five years of age.

**Neuroblastoma** – is a tumour that arises in the adrenal gland or in the nerves beside the spinal column in the neck, chest or abdomen. Most commonly neuroblastoma affects young children and the disease is often widely spread at the time of diagnosis.

**Sarcomas** – are tumours of the bone and connective tissue. Rhabdomyosarcoma is a tumour of muscle cells. Osteogenic sarcoma and Ewing’s sarcoma are tumours of bone and related tissue.

**Retinoblastoma** – is the most common eye cancer in infancy and childhood. This type of cancer arises in the retina. This cancer may appear in one or both eyes. Children with bilateral disease often have a genetic predisposition to this tumour.

**Melanoma** – is a type of skin cancer that may occur at any age and spread to other parts of the body. Melanoma may have the appearance of a new spot, freckle, birthmark or mole which changes in size, shape, colour, becomes itchy, bleeds, weeps or develops a lump. Early detection is most important in the treatment of melanoma.

## Treatment

When first diagnosed, children with cancer are usually admitted to hospital for the initial assessment and treatment phase.

The length of stay in hospital depends on the:

- Individual child and severity of the presenting illness.
- Type of cancer affecting the child.
- Treatment protocol chosen for the specific type of cancer.

Where possible, treatment is given as an outpatient. However most children require hospitalisation for the initial diagnostic tests and treatment, and for the more intensive chemotherapy schedules which may be required as treatment proceeds. Admission to hospital may be necessary for episodes of infection or the management of some side-effects of treatment. At times hospital admissions can be for prolonged periods.

The majority of children and adolescents in Queensland will be treated in the specialist oncology unit at the Royal Children's Hospital in Brisbane (Queensland Children's Cancer Centre). The hospital has clinical teams with medical, nursing, allied health and psychosocial support for the child, family and the school. Some teenagers may be treated in either children's oncology wards or oncology units at adult hospitals. A small number of children and adolescents may receive treatment through private oncology clinics.

Children and teenagers from country areas are usually referred to Brisbane when first diagnosed but may then be able to have some of their planned treatment at regional hospitals. Subsequently most of these children will require regular visits to Brisbane for treatment and ongoing assessments.

*...most children require hospitalisation for the initial diagnostic tests and treatment...*

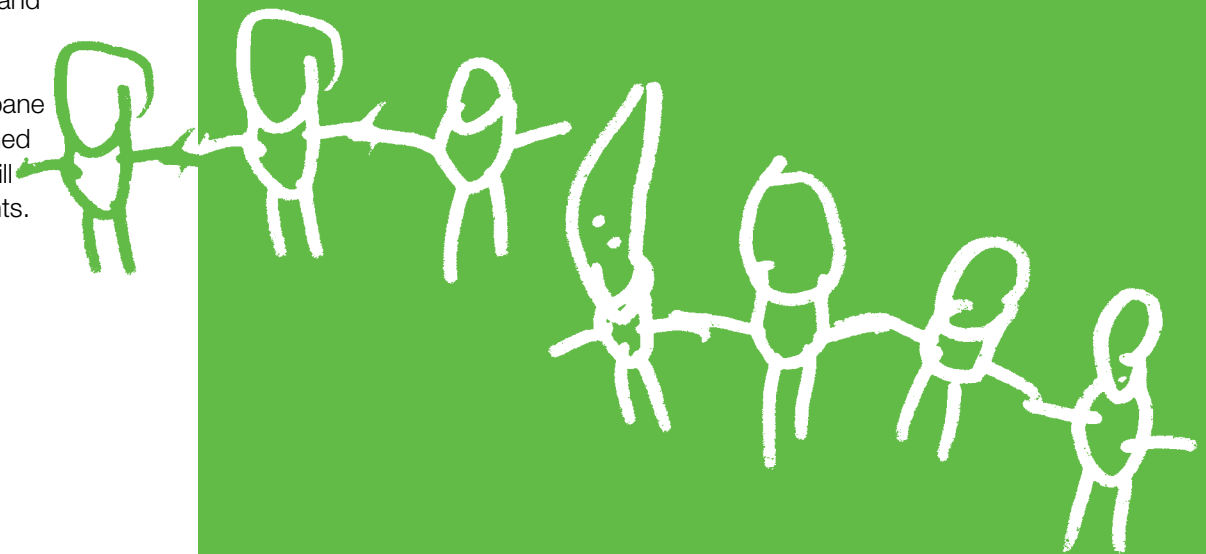
## How cancer is treated and side-effects of cancer treatment

Childhood cancer is usually treated with chemotherapy, surgery, radiation therapy or a combination of these. The treatment depends on the type of cancer that has been diagnosed and the aims of treatment. The aims of treatment can be:

**Cure** – The aim is to eradicate the disease totally.

**Control** – To keep the disease under control. However, the disease may progress.

**Palliation** – Palliative care is provided when cure is no longer possible. The aim is to provide optimal quality of life for the child with symptom control and ongoing support for the family, often in the home environment.



*...after commencement of chemotherapy hair loss may begin and children may feel more confident when wearing hats, wigs or bandanas in the classroom...*

## Chemotherapy

Chemotherapy is the use of drugs to treat cancer. These drugs are also called cytotoxic drugs.

Chemotherapy is commonly given by:

- Mouth as tablets or syrups.
- Injection into a vein via an intravenous infusion.
- Injection into a muscle or subcutaneous tissue.

Sometimes chemotherapy is also given directly into the fluid around the brain via a procedure called a lumbar puncture.

Chemotherapy works by killing the cancer cells. However, it cannot differentiate between normal cells and cancer cells, so some normal cells may also be affected. Normal cells usually recover quickly, whilst cancer cells (because of their abnormal metabolism) are more frequently destroyed by chemotherapy or have their growth potential reduced.

Treatment is usually given in spaced cycles to allow the normal cells time to recover. The aim of repeated cycles of chemotherapy is to eventually destroy all cancer cells, and hopefully lead to cure.

Chemotherapy can often be given on an outpatient basis. However some drugs need to be given over several days and admission to hospital is necessary. The length of the treatment depends on the type of cancer and may vary from several months up to three years.



## Side-effects of chemotherapy

Unfortunately chemotherapy also has side-effects on normal cells and tissues. Different drugs have specific side-effects. Parents and children will have been given extensive information on possible side-effects of treatment.

### **Hair loss**

A few weeks after commencement of chemotherapy, hair loss may begin and children may feel more confident when wearing head gear such as hats, wigs or bandanas both in and out of the classroom. The class teacher needs to advise other staff members that this child may wish to wear a hat – this may also impact on the child's ability to participate in some activities, particularly if there is fear that the head gear may fall off. Hair does grow back and this can occur while the child is still on treatment, depending on the type of treatment given. Hair can be lost and regrow several times during the treatment program.

### **Blood cells**

Chemotherapy affects the production of blood cells by the bone marrow. The child will need to have regular blood counts while on treatment, to check the level of white cells, red cells and platelets.

**Red blood cells** – A fall in the number of red blood cells is called anaemia. The child may be tired and look pale but some children may not show any obvious signs. A blood transfusion is sometimes necessary to treat anaemia.

**Platelets** – Platelets play an important role in blood clotting. If the platelet count is low, the child may bruise easily, may have nose bleeds or develop tiny red spots on the skin called petechiae. Sometimes a platelet transfusion may be necessary if the level is very low.

**White blood cells** – White blood cells play an important part in the body's immune system. There are several different types of white blood cells, but the two main types concerned with fighting infections are neutrophils and lymphocytes. Children who develop infections generally need to be admitted to hospital for a few days for intravenous antibiotics (antibiotic syrups or tablets are generally not strong enough to treat these infections).

### **Infection**

**Neutrophils** are particularly important in fighting bacterial infections. When the neutrophil count is very low, the child is at risk of developing serious infections. During this stage, the child may be unable to attend school. If the child develops a temperature or fever at school, the parents must be notified immediately. If the parent cannot be contacted the child should be transferred to hospital by ambulance as soon as possible. It is important to be aware that infections in children receiving chemotherapy can be life threatening if not treated quickly. **Shoes should always be worn by the child, especially when outside, as small cuts may progress to serious infections.**

**Immunisation** – Chemotherapy also impairs immunity provided by past immunisations. The child will need to be re-immunised when treatment is finished. **It is important to note that immunisations are not usually given while the child is on treatment and that the child should not take part in school-based immunisation programs without specific oncology advice**

**Chicken pox, shingles and measles** – Immunity to viral infections such as chicken pox, shingles or measles is decreased by chemotherapy. It is very important to prevent exposure of the child to these diseases. Confirmed school cases of chicken pox or measles must be immediately reported to the child's parents. If there is an outbreak in the school, the child may need to be withdrawn for a period.

If a child on oncology treatment has direct contact with an infected child, the at-risk child's parents should be notified immediately. Direct contact means that the child has sat next to or played closely with the infected child. There is a protective injection available for the child which can give temporary immunity. However, it must be given within 72 hours of the time of contact – hence the importance of awareness of these risks by the wider school community.

### **Sun sensitivity**

Some chemotherapy drugs increase the skin's sensitivity to the sun. When outdoors, the child with cancer, and all children, should wear a hat, t-shirt and sunscreen (30+). It is recommended that sunglasses be worn. The child's exposed head is particularly sensitive - sunscreen should be applied and the child must wear a hat at all times. Sunscreen should be reapplied as per the manufacturer's instructions.

### **Tiredness / fatigue**

Tiredness may be experienced by a child receiving chemotherapy. This may be related to a number of factors including anaemia, reduced nutrition, pain, nausea and vomiting or anxiety and depression. Some children also get tired from the constant travelling to and from hospital, waiting around and interrupted sleep patterns from being in hospital. Tiredness may continue even after the child has completed chemotherapy.

### **Mood changes**

Some drugs can cause mood changes. The child may express depression, hostility or temper tantrums. Added to the effect of the drugs is the overall impact on the child's emotions of being treated for a life threatening illness. The teacher needs to be aware of the reasons for behaviour changes, although reasonable behaviour limits and discipline still need to be applied.

### **Nausea, vomiting and appetite**

Chemotherapy often causes nausea and vomiting. However there are medications available to control these side-effects. The child may experience loss of appetite or taste changes, in turn affecting eating habits.

### **Weight gain**

Some chemotherapy protocols use steroid drugs which may cause an increase in appetite, leading to weight gain and a dramatic change in the child's appearance. The weight is usually lost once these drugs are stopped.

### **Mouth ulcers**

Chemotherapy may sometimes cause painful mouth ulcers, making eating very difficult.



...The child with a central venous line will not be able to go swimming...

## Central venous catheters

Most children will have a central venous catheter in place to enable their intravenous chemotherapy drugs to be given more easily. There are two types – a central line or Port-a-cath®. These devices are placed by surgeons under a general anaesthetic in the operating theatre.

A **central venous line (or central line)** is a soft flexible catheter that is placed in a large vein in the upper chest leading to the heart. The end section extends out through the skin and syringes and drips can be connected to take blood samples or give treatments. The exit site of the catheter on the chest wall is covered with a sterile dressing and, when not in use, this is securely taped to the chest and covered by clothing. Care should be taken not to pull the line or wet the dressing. If the dressing does become wet, the child's parents should be informed so that they can make arrangements to change the dressing promptly. **The child with a central venous line will not be able to go swimming because of the risk of a serious line infection.**

A **Port-a-cath®** also involves inserting a catheter into a large vein leading to the heart. This catheter is attached to a small chamber or reservoir (port) which is implanted under the skin, usually on the upper chest wall. Access to the venous system is made by a small needle through the skin into the port. The 'port' appears as a small bump under the skin and there is no special care required when it is not in use, other than being careful that it is not given a hard knock. Children with a Port-a-cath® can usually go swimming; however pools can pose an infection risk. Families need to check with their individual treating doctor and hospital.

An **Insuflon®** is a small flexible plastic tube placed temporarily under the skin usually on the upper arm or leg. It is used to administer medications that need to be given into subcutaneous tissue for several consecutive days. It is commonly used for administering **G-CSF** (see glossary).

## Surgery

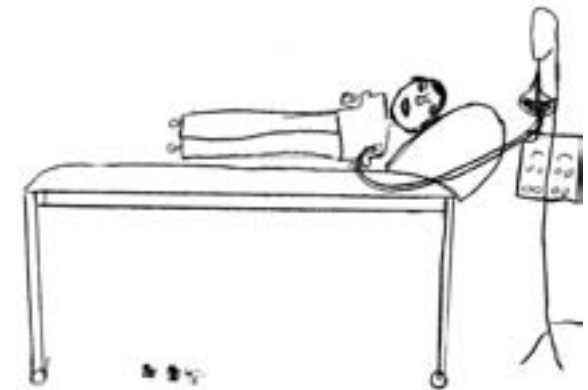
The aim of surgery is to completely remove the tumour if possible. However this is often not feasible. Some tumours cannot be completely removed due to their size and location. Therefore radiotherapy or chemotherapy may be required in addition to surgery.

## Side-effects of surgery

The side-effects of surgery are dependent upon the area of the body being operated on. At times, major surgery may be required to remove the tumour. In general children cope with surgery very well and often recover more quickly than adults.

## Radiation therapy

Radiation therapy involves the use of high energy beams which are directed at the cancer site using a machine called a linear accelerator. For this treatment the child must lay completely still for a few moments and be left in the room alone while the treatment is being given. The child is usually given radiation therapy Monday to Friday for a number of weeks as an outpatient.



## Side-effects of radiation therapy

Radiation treatment is directed at specific sites in the body where cancer cells need to be destroyed. Therefore, the side-effects from the treatment will be specific to the area being treated, unlike chemotherapy where the treatment causes side-effects in many different areas of the body.

**Skin irritation** - and redness may occur in the area being treated, resulting in a tanned or sunburnt appearance. This usually clears up when treatment is completed. It is important that lotions, creams and soap are not used on the skin which is being irradiated.

**Hair loss** - will occur if radiation is directed to the head area. This treatment may be required for children with brain tumours and for a small percentage of children with leukaemia. Recovery of hair growth is variable depending on the size of the treatment area and the total dose of radiation given.

**Tiredness / fatigue** - is a common side-effect of radiation therapy to the brain and may continue for a number of weeks following treatment. For some, the onset of sleepiness may not begin until several weeks after radiation and may be severe, resulting in time away from school.

**Nausea and vomiting** – Children receiving radiation to the brain or abdomen may experience problems with nausea and vomiting. However, there are now very effective medications available to control these effects.

**Headaches** – Some children receiving radiation therapy may complain of headaches, related to transient swelling of brain tissue. Steroid medications are sometimes used to reduce the swelling, during or after radiation therapy.

**Learning difficulties** – Children who receive radiation therapy to the brain as part of their treatment may sometimes develop specific learning difficulties which may become apparent some years after the treatment. While radiotherapy destroys cancer cells, it also can affect healthy brain cells, interfering with information processing and memory function. These children often score within the average range of intelligence but on more detailed assessment may have variations in achievement due to memory, processing and attention deficits. These children may become angry, depressed or withdrawn if they feel unable to achieve to the same standard as before their illness onset. Schooling programs may need to be specifically modified to provide added support mechanisms for these children as the difficulties can often be long term.

## Transplants

Stem cell transplantation is being used increasingly in cancer therapy.

A bone marrow transplant (BMT), stem cell or cord blood transplant involves replacing the patient's bone marrow cells (otherwise known as stem cells) with healthy stem cells. Stem cells are the master cells in the marrow, which develop into all types of blood cells – red cells, white cells and platelets - all having different functions.

Stem cells can be collected from:

- Bone marrow (collected from the marrow spaces in bones around the pelvis).
- Blood (using an apheresis machine).
- Cord blood (the blood from the umbilical cord and placenta of a newborn baby).

The name of the type of transplant is directly linked to the place the stem cells have been collected from, e.g. bone marrow transplant, stem cell transplant or cord blood transplant. The term marrow transplant is the term commonly used for transplants involving stem cells from all sources.

Children who cannot make adequate amounts of their own stem cells, such as those with aplastic anaemia, may require a transplant. Some children with leukaemia may also need to have a stem cell transplant, particularly if the leukaemia has recurred or is considered to be at very high risk of relapse.

High dose chemotherapy is often used to treat aggressive types of cancers and in some situations transplants are used to “rescue” the child after this treatment. Whilst the chemotherapy is effective, a side-effect is that it damages the child's own stem cells so they are unable to produce sufficient blood cells to maintain satisfactory blood counts. In this situation the children are given transplants usually using their own previously collected stem cells, effectively “rescuing” them from the toxic marrow effects of the earlier high dose chemotherapy.



If the stem cells come from the patient, this is called an **autologous transplant (autograft)**. Stem cells are collected from the child's blood (similar to donating blood) through a process called **apheresis**. A special machine identifies and removes the stem cells from the child's blood and returns the remaining blood components to the child. The cells are then stored in a special freezer and reinfused to the child when required at a later date.

Children who receive an autograft often recover more quickly than children who receive a donor transplant. Whilst these children may have similar problems with infection, they do not need to go into isolation and may actually receive the infusion of stem cells as an outpatient procedure.

If the stem cells come from another person (donor) this is called an **allogeneic transplant (allograft)**. During the week before transplant, the child needs to have very large doses of chemotherapy and sometimes radiation therapy to destroy stem cells and any residual disease, and to enable new stem cells to be accepted by temporarily depressing the immune system. This process is called **conditioning**. The new stem cells are given intravenously, similar to a blood transfusion. Once in the patient, stem cells travel via the bloodstream to the bone marrow spaces where they begin to divide and produce new blood cells of all types.

It takes about four weeks for the bone marrow cells to grow and make new blood cells (**engraftment**). During this time the child has very little resistance to infection and is nursed in an isolation room. The number of visitors is restricted to reduce the risk of infection. However they may still develop infections and be very ill during this time. Contact with friends from school through letters, faxes, emails and phone calls is very important during this long period of isolation. Video links between school and hospital are being used more commonly with improved phone and computer technology.

Once the bone marrow is making new cells, the child is able to leave hospital but needs to return regularly for follow up treatment. Following a transplant, a child is usually away from school for at least three months and may need to be given a school program, teacher support and encouragement to work on at home.

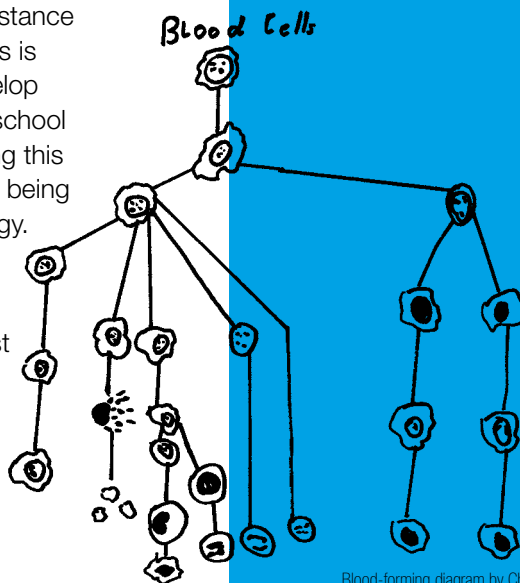
## Completing cancer treatment

The transition from completion of treatment to a return to usual daily activities may be a difficult time for families. Cancer is a major life changing experience, particularly in the case of childhood cancer. Both the child and the family will need time to adjust to the physical and emotional effects of the illness.

In the broader sense, there may be feelings of uncertainty about the future and fear that the cancer may recur. Both during and after treatment, children with cancer may display a range of emotional, behavioural and cognitive difficulties.

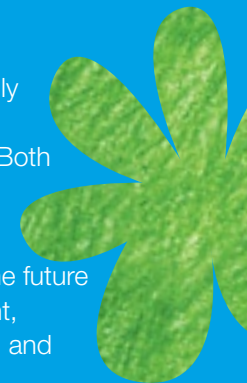
Children will often require assistance in integrating back into the school system and re-establishing relationships with their peers. Parents may also need reassurance that their child will be well supported and cared for in the school environment. Support is available from the hospital team to assist teachers during this transition period.

Paediatric cancer treatment centres link up with schools via liaison nursing staff, allied health professionals and other services such as neuropsychology and rehabilitation. Often multi-disciplinary meetings can be held with the school for discussion of children with more significant difficulties.



...both after and during treatment, children with cancer may display a range of emotional, behavioural and cognitive difficulties...

Blood-forming diagram by Chris, 10 years old.



## Educational support in hospital and at school

### The child's teacher

Once cancer has been diagnosed it is important for teachers to communicate with parents and those involved with the child's care to obtain information regarding the medical condition and treatment plan.

The liaison teacher from the hospital school is available to convey this information and to inform the school of the child's overall progress and specific educational needs.

Parents are normally the child's best advocate in matters of schooling and when their child is undergoing treatment for cancer, they are the best resource for information regarding what is happening with treatment. Bearing this in mind, teachers need to respect the parents' confidences and wishes. Some parents want everyone to know about their child whilst others will wish to maintain a degree of privacy.

Some teachers may find the prospect of dealing with the child's diagnosis of cancer to be daunting and threatening to themselves. The teacher will need to develop a realistic understanding of the child's prognosis and treatment and be able to come to terms with their own attitudes and beliefs about cancer, and their perceptions about a life threatening disease. They may be apprehensive about the medical condition and fearful of situations that may arise at school. They may have difficulties in establishing a realistic assessment of the child's scholastic abilities and how best they can help to ensure the child is achieving full academic potential.

The child's teacher and class have a valuable role to play in offering the child (and siblings and family) support and encouragement to continue to be a member of the school community.

Education of the school community about cancer is vital to supply accurate information and to dispel the myths and misunderstandings about cancer.

With permission from the parents, the teacher needs to gather information in order to understand the effects of the type of cancer and the treatment to be undertaken. Children undergoing cancer treatment are educated, in an age-appropriate way, as to the nature of their illness. The teacher needs to be aware of the child's knowledge of the disease and what the parents would like to be shared with the class. The child's class will be concerned about their friend's condition and they need to be given appropriate information about cancer and to be prepared for the return to school. During the initial stage of treatment it is helpful for classes to establish and maintain contact with their classmate in hospital or at home.

Teachers need to be aware of side-effects and any possible medical situations that may arise at school. In conjunction with parents and medical staff, they should know when to call parents or how to handle possible emergencies. Liaison nurses provide an invaluable role in this area.

*...it is important for teachers to be prepared to accept and work with the child and be sensitive to his/her needs...*

## Returning to school

Children are encouraged to return to school once the initial phase of treatment is over - maintaining as normal a lifestyle as possible is essential to the child's adjustment to living with cancer. A return to school gives children the message that they are able to continue with life and gain mastery over their environment. School is part of normal life for all children and participation helps children to cope with the impact of cancer.

In most instances the hospital providing the child's treatment will have support services available to assist in the return to school. The hospital school teachers and oncology liaison nurses are available to assist the child and family in making the transition from hospital to home and then back to school. These staff will contact the school shortly after the initial diagnosis. With the parents' consent, they can provide information about the disease and treatment. School visits to talk to teachers and/or students can often be arranged, even for rural patients.


Camp Quality provides a unique puppet show, which provides education for children about cancer and addresses important issues such as that cancer is not contagious, and the need for children to help the classmate undergoing treatment. The hospital teacher or liaison nurse can assist in arranging a visit from the puppets. Alternatively, the school can arrange this directly with Camp Quality (see page 34).

A visit by the teacher, to the hospital or home, before the return to school is reassuring for the child and family and provides an opportunity to talk to parents. It is necessary to reassure parents that the school is able and willing to co-operate with them and will support the child and respect their confidences. Schools should be aware of the child's understanding of the disease, their concerns and their social supports. Peers will be more supportive when they have the relevant basic information about the disease, treatment and side-effects, and the reassurance that they are not at risk of contracting cancer.

Ongoing hospital visits of varying duration will be necessary, so it is important for teachers to be flexible and vary the programs accordingly. Some children may not be able to return to school for extended periods of time. It is important that contact be maintained.

Children may initially return to school on a part-time basis. They may be feeling anxious about coping and seeing friends again. Children may feel anxious about being able to keep up with their work, about their fear of teasing, about rejection, about side-effects from their illness, about tiredness and about their physical changes including altered appearance. It is important for the class to make the child feel welcome back at school.

Teachers need to have realistic expectations of the child and be kept informed of their medical needs and effects of treatment. Teachers should inform parents of any changes in behaviour or abilities.



*...peers will be more supportive when they have the relevant basic information about the disease, treatment and side-effects, and the reassurance that they are not at risk of contracting cancer...*

## Hospital schools

In Brisbane, a Department of Education Special School is attached to the Royal Children's Hospital. This school provides teachers at all levels to patients attending the Oncology Unit.

The teacher will meet the child and family shortly after diagnosis. Parents are required to give the teacher permission to work with the child and liaise with the home school.

The teacher works as part of a multi-disciplinary team in the Oncology Unit.

The role of the teacher in the Oncology Unit is to:

- Liaise with clinical staff, schools and families.
- Provide some normal routines and give the child some choice and control whilst in hospital.
- Address educational needs and issues with families.
- Establish communication with the child's school and offer support and education to the school.
- Help the child reintegrate to their home school.



## Adolescents

The adolescent years are difficult and challenging times for all teenagers and even more so for teenagers dealing with cancer.

At this stage of their lives, teenagers are normally developing a sense of independence and responsibility for their own lives. However, a diagnosis of cancer interrupts this phase of development. The teenager now faces the reality of the disease and its implications. They may feel very anxious and uncertain as to what their future holds. They are nonetheless still teenagers and wish for a normal life with the same desires, hopes and dreams as their friends.

High school students with cancer may be reluctant to return to school as they may be self-conscious, be uncertain about the reaction of the school community and may have fears about their ability to keep up with the program. Some students are reluctant to let their peers know much about their disease. Schools need to respect the privacy of students. It is important that the school has someone who will act as an advocate for the student and include them in any decisions about subjects or workloads.

Peers should be encouraged and supported to maintain normal interactions with the sick teenager. They need the opportunity to discuss their feelings about cancer, their relationships, and to be reassured that their friendship is a valuable support to the recovery of their friend.

Schools need to help the student set realistic academic goals and support them in reaching their potential. Special measures may need to be put in place to enable them to meet formal academic assessment requirements, especially in the higher grades.



### Tips for schools

- Establish and maintain contact with the child and family.
- Educate the school community about childhood cancer and prepare classmates for the child's return to school.
- Be aware of and make allowances for side-effects and specific medical conditions.
- Treat the child normally, be positive and encouraging, sensitive and realistic.
- Remain aware of the needs of siblings.
- Communicate with health and other teaching professionals if required for further support.
- Advocate for the child with respect to formal educational requirements. Special consideration may be needed for examinations and assessments (including Core Skills Test, OP data input, etc.). This may mean allowing extra time for examinations or assignment deadlines, so that the student's true abilities in subject areas can be recognised.

### Specific needs of children with brain tumours

Children with brain tumours may have more complex educational needs than children with other types of cancer, as a result of the effects of the tumour and also the effects of treatment upon brain function.

There is a limited amount of space inside the skull and the growth of the tumour may cause changes in brain function. The tumour may damage brain tissue and cause pressure effects on other parts of the brain. This damage may be transient or permanent.

The severity and types of problems children exhibit will depend on the location of the tumour in the brain. Tumours arising from the frontal lobe may be the cause of behavioural problems and memory loss, while tumours in the occipital lobe may create visual disturbances. Epilepsy may also occur and the child may be taking medications to control seizures. This medication may also decrease alertness and interfere with learning.

Children who have a brain tumour may need to have their school program modified to suit their educational, behavioural and physical needs.

Assistance for the child's teacher can be obtained from the Advisory Visiting Teacher at the hospital where the child is undergoing treatment. Community organisations listed at the back of this book may also be able to help.

More specific resource material is available for teachers from Cancer Council Queensland and may be obtained by calling the Cancer Council Helpline on 13 11 20 (toll free).

## Support for siblings

Living with a child who has cancer is a very stressful situation for siblings. Within the family, healthy children are affected by the child's illness and may often carry a hidden level of stress, as well as the 'burden' of extra responsibilities around the home. Often they do not fully comprehend what is happening to their sick sibling and find it difficult to adjust to the changes to their lifestyle. This will vary with the different ages and developmental levels of all children in the family.

Feelings of guilt, anger, jealousy and resentment may surface in siblings, as they endeavour to deal with their confused emotions. They often feel insecure, isolated socially, and anxious about their unwell brother or sister. Seeing their parents upset creates anxiety for siblings and they don't want to cause further parental upset. Siblings of different ages may exhibit this anxiety in a variety of ways including behavioural changes, and difficulty keeping up with school work.

Teachers need to be aware of the needs of siblings and treat them with sensitivity and understanding. It is important that teachers are familiar with the level of the siblings' knowledge and understanding of their sick brother or sister's illness.

Children and teenagers who have a sibling with cancer need to know that people still care about them. While it is important to show concern for the sick child, remember to also show genuine interest in their own wellbeing.

## Cultural awareness

Many children with cancer come from different cultures. It is necessary for teachers to be aware of the diversity of these people's attitudes and beliefs to illness and particularly those surrounding a life threatening illness.

People's views on illness and death are affected by:

- Ethnic backgrounds.
- Religious beliefs.
- Comprehension of English.
- Time in Australia.
- Family values.
- Personal values.
- Education / social status.
- Age of the ill person.
- Life experiences.

It is important not to generalise or over simplify the complexity of cultural and/or religious beliefs and influences, but to always be sensitive. If a teacher has a child with cancer in the classroom from a different ethnic background, information may be obtained from the parents and their ethnic community. This may provide the school with an understanding of the family's beliefs and customs.

*...teachers need to be aware of the needs of siblings and treat them with sensitivity and understanding...*

## Palliative care

Despite the increasingly successful treatment of childhood cancer, some children reach a stage where no further treatment can be given to cure their disease. The aim of treatment then changes from cure to optimising quality of life with emphasis on optimal symptom control. This is termed palliative care.

For some children this period may last for a couple of weeks and for others up to 12 months or longer, depending on the type of cancer.

In many cases, children on palliative care can remain relatively well for some time. They may attend school, either full-time or for a few hours a day. Quite often, deterioration is gradual and it is extremely unlikely that death would occur unexpectedly in the classroom.

School involvement in the palliative stage is important for the child's sense of wellbeing and belonging. The school needs to adopt a sensitive, caring, flexible approach and maintain communication with the family.

When able to attend school, the child should be welcomed to participate in class activities, even if only briefly. If it is not possible to attend school, classmates and teachers can visit, write, email or phone at the parents' discretion.

With the parents' permission, the child's classmates should be informed honestly, openly and without euphemisms of their friend's condition. Siblings at this time will need extra support as they will have their own particular concerns as they continue at school at this very difficult time.

*...school involvement in the palliative stage is very important for the child's sense of wellbeing and remaining part of a caring school community...*

## Talking to children about death and dying

When talking to children about death and dying the following points are important:

- Find out the child's level of understanding – if a child asks a question about death or dying, ask them “what do you think?” or “why did you ask me that question?”
- Be honest – children can read body language well and know if they are not being told the truth.
- Avoid explaining death as “going on holidays” or “a special type of sleep” as this can frighten and confuse children.
- Understand that many children (usually until the age of mid-primary years) think death is temporary – this is reinforced by the fact children hear about Jesus rising from the dead, cartoon characters coming back to life.
- Understand that young children may have difficulty understanding that death can result from disease – they often think people die from external causes e.g. being shot, car accidents etc.
- Understand that young children may associate death with punishment. Ensure that the child does not feel to blame for the death and that it is not his/her fault.
- Ensure there is an understanding of the dying child's cultural or religious beliefs – this may be important if the child asks questions.

Children need to be given permission to talk about death, and reassured that it is okay to ask questions.

The Royal Children's Hospital has school teachers and other staff who can assist in this area. A visit or phone call to the school to talk to the teachers and or the child's classmates may be possible.

## Bereavement care

When a child dies, the whole school community experiences grief. Friends need to be able to express their grief and have the chance to say goodbye. Teachers too need the opportunity to grieve. Children do this in their own way and teachers need to be aware of the individual's feelings of loss at this time.

It is important for the school community to acknowledge a student's death. This can be in the form of attending the child's funeral or a simple memorial service, assembly, tree planting etc. Children should be allowed to participate as they wish, e.g. by reading a poem, sharing their thoughts, releasing balloons, saying goodbye and expressing their sorrow.

It is important to note that children should never be forced to attend a funeral. In the case of funerals held at school churches, parents of all the children attending the funeral should be encouraged to attend in order to support their own child during the service. This is far too big a job for one or two teachers. It is also important for parents to attend so that issues which arise from the funeral can be discussed further at home.

It is also important to be aware of the impact on the class, especially on children who are experiencing or have previously experienced other forms of loss, e.g. sick parent, family separation or divorce. Ensure they are well supported with extra reassurance. Monitor mood and behavioural changes, informing parents of concerns which arise.

There are many educational resources available to help children understand and cope with death. Support is also available from the Oncology Unit where the child was treated.



## Community organisations

There are several community organisations that provide information about cancer and resources for schools. These include:

### Cancer Council Queensland

Cancer Council Queensland provides support services to individuals diagnosed with cancer, their families and communities through informative literature about cancer, practical help, education and group programs.

The following programs are specific to supporting children and teenagers:

- Children's Library – provides age-specific books and videos to assist children, teenagers and families coping with cancer. There are also resources to assist school teachers, health professionals and community groups who are supporting them.
- Seize the Day Study Awards – financial scholarships for young Queenslanders, ages 16-21, who have been affected by cancer, either themselves or with an immediate family member. The scholarships help assist with the costs of post-secondary education.

For more information, contact the Cancer Council Helpline on 13 11 20 (toll free), or contact the Cancer Support Services Coordinator at Cancer Council Queensland in your local area.

**Cancer Council Queensland**  
PO Box 201 Spring Hill Qld 4004  
P: (07) 3258 2200  
Toll Free 13 11 20 (Monday to Friday, 8am to 8pm)  
F: (07) 3257 1306  
E: [helpline@cancerqld.org.au](mailto:helpline@cancerqld.org.au)  
[www.cancerqld.org.au](http://www.cancerqld.org.au)

### CanTeen

CanTeen is the Australian Organisation for young people living with cancer. CanTeen's mission is to support, develop and empower young people aged 12-24 years who have been diagnosed with cancer, or have had a member of their immediate family (parent/primary carer, brother or sister) who has been diagnosed with cancer or died from cancer. Through a wide range of member driven camps and programs, plus home and hospital visits, CanTeen provides a safe and supportive environment where young people can meet other young people with similar experiences and establish long term, caring and supportive friendships. This model of peer support is crucial in helping young people cope with cancer and ensuring they do not have to face the experience alone.

**CanTeen**  
Unit 2/24 Light Street  
PO Box 2103  
Fortitude Valley Qld 4006  
P: (07) 3252 9262  
F: (07) 3852 5845  
E: [qld.admin@canteen.org.au](mailto:qld.admin@canteen.org.au)  
[www.canteen.org.au](http://www.canteen.org.au)

## Camp Quality

Camp Quality where “laughter is the best medicine” is committed to bringing hope and happiness to every child living with cancer, their families and communities through ongoing quality recreational, educational, financial and hospital programs.

**Camp Quality**  
PO Box 359  
Wilston QLD 4051  
P: (07) 3216 0299  
F: (07) 3216 0365  
E: [sthqld@campquality.org.au](mailto:sthqld@campquality.org.au)  
[www.campquality.org.au](http://www.campquality.org.au)

### McDonalds Camp Quality Puppets

Life sized puppets visit primary schools throughout Queensland delivering a high energy, exciting, positive and educational performance about supporting children living with cancer, teaching tolerance, optimism and empathy through fun. The program is provided at no cost to the schools.

## Redkite

Redkite provides essential emotional, social and financial support for children and young people up to the age of 21 who are diagnosed with cancer and their families. This support is available from the time of diagnosis, throughout treatment and beyond.

Redkite provides:

- Telephone support and counselling (individual and group based).
- Email support and counselling.
- Financial assistance.
- Education support (education grants and scholarships for children and young people).

**Redkite**  
PO Box 1889  
Toowong QLD 4066  
P: 1300 722 644  
E: [support@redkite.org.au](mailto:support@redkite.org.au)  
[www.redkite.org.au](http://www.redkite.org.au)

- Music therapy.
- Social work.
- Bereavement support.
- Family support and activity days.

(Redkite is the new name for the Malcolm Sargent Cancer Fund for Children)

## Leukaemia Foundation

The Leukaemia Foundation cares for patients and their carers affected by leukaemia, lymphoma, multiple myeloma, bone marrow transplantation and other related blood disorders. The foundation provides a wide range of services such as information, literature and audiovisual materials, emotional support, general counselling and grief counselling as well as financial assistance. Accommodation facilities are provided free of charge in Brisbane and Townsville for country families. There is a state-wide branch network of volunteers. All services are provided at no cost to the user.

**Leukaemia Foundation**  
64 Raymond Terrace  
South Brisbane Qld 4101  
P: (07) 3840 3844  
Toll Free 1800 804 444  
F: (07) 3844 7811  
[www.leukaemia.org.au](http://www.leukaemia.org.au)

## Childhood Cancer Support, Inc.

Offers support and assistance to the families and communities of children with cancer. Childhood Cancer Support also provides free accommodation for country families whilst in Brisbane for treatment, informal counselling, financial assistance, education, and recreational therapy activities, fun days out, family camps and much more.

**Childhood Cancer Support, Inc.**  
11 Bramston Terrace  
Herston Qld 4006  
PO Box 295  
Red Hill QLD 4059  
P: (07) 3252 4719  
F: (07) 3852 2350  
E: [info@ccs.org.au](mailto:info@ccs.org.au)  
[www.clcs.org.au](http://www.clcs.org.au)

## Children's Oncology Group

Wherever possible, children on treatment are being managed as part of international trials, ensuring that the most up to date and effective therapies are being used. One of the largest groups is the Children's Oncology Group, based in the United States. A very useful website for general and more specific information about childhood cancer is <http://www.curesearch.org>. Another useful resource is the United States National Institutes of Health website which is <http://nci.nih.gov/cancerinfo>



## Glossary of medical terms

**Acute** - Starting suddenly.

**Allogeneic / Allograft** - Transplant from a compatible donor.

**Alopecia** - Baldness, lack of hair.

**Anaemia** - Low haemoglobin or blood low in red blood cells. Patients may require blood transfusion.

**Anaesthetic** - Drugs to put patient to sleep (general), or to numb a part of the body (local).

**Anorexia** - Lack of appetite, may be transient or prolonged.

**Antibiotic** - A drug that is used to treat infections caused by bacteria, may be given orally or intravenously.

**Antibody** - A protein produced by the immune system which protects against infection.

**Antiemetic** - A drug that prevents or reduces nausea and vomiting.

**Apheresis** - The use of a machine which identifies and removes the stem cells from the child's blood and then returns the rest of the blood components [red cells, white cells, platelets and plasma (the fluid part of the blood)] to the child.

**Aspirate** - A sample of bone marrow taken for examination.

**Autograft** - Transplant of tissue from self e.g. a stem cell transplant using the patient's own previously collected cells.

**Benign** - Not cancerous (opposite of malignant).

**Blood count** - The number of cells of different types contained in a sample of blood sent for testing.

**Bone marrow** - Spongy material which fills the inner cavities of bones and produces blood cells of all types.

**Bone marrow transplant** - A treatment which replaces diseased bone marrow with healthy bone marrow. The bone marrow is given like a blood transfusion and the cells migrate into the bone marrow space and begin producing new blood cells.

**Cancer** - Uncontrolled growth and spread of abnormal cells.

**Carcinogen** - Any substance or process that can cause cancer.

**Catheter** - A thin flexible tube used to pass fluid into the body or to drain fluid from the body.

**Central line** - A silicone tube tunnelled under the skin of the chest wall into a major vein that leads to the heart, allowing direct access to the bloodstream.

**Cerebrospinal fluid** - The fluid produced within the brain that bathes the brain and spinal cord (CSF).

**Chemotherapy** - Treatment with drugs to destroy cancer cells or to prevent or slow the growth of cancer cells.

**Chronic** - Long standing or long lasting.

**Consultant** - Specialist doctor.

**CT scan (Computerised Tomography)** - Diagnostic x-ray using a computer to produce a series of images of a body segment

**Cytotoxic** - Destructive to cells.

**Diagnosis** - The process of identifying a patient's disease.

**Donor** - One who gives blood or from whom an organ or tissue is removed for transplantation.

**Erythrocyte** - Red blood cell.

**"G-CSF" or "G"** - Colony stimulating factors are proteins which help protect the child from infection by stimulating the production of specific types of white blood cells called neutrophils or granulocytes. Colony stimulating factors are usually called "GCSF" or "G" and are given as an injection usually into the child's arm or leg for several days until blood counts increase.

**Genetic** - Inherited, passed on by parents to their children.

**Haematology** - The study of blood disorders.

**Immune system** - The body's natural defence mechanism against infection.

**Immunosuppressive** - Lowering the activity of the immune system, a common side effect of chemotherapy agents.

**Induction** - Initial chemotherapy treatment phase with a view to inducing remission.

**Insufilon®** - A small, flexible plastic tube placed under the skin (into the subcutaneous tissue) for the administration of drugs.

**Intravenous or "iv"** - Into a vein, e.g. when drugs are given directly through a drip.



**Leukaemia** - Cancer of the white blood cells.

**Lumbar puncture** - Insertion of a needle into the lower back area to access the spinal canal in order to remove cerebrospinal fluid (CSF) and / or to give drugs.

**Lymph** - Clear fluid carried around the body in a network of channels (lymphatics).

**Lymph nodes** - Small bean-shaped structures scattered along lymphatic vessels.

**Lymphocyte** - A type of white blood cell formed in the lymphoid tissue which protects especially against viral infections and produces antibodies.

**Lymphoma** - Malignant tumour which originates in lymph glands or related tissues.

**Metastases** - Tumours that have come from a first (primary) tumour in another part of the body. Also known as secondary tumours.

**MRI scan (Magnetic Resonance Imaging)** - Uses differing magnetic images / signals between body tissues to produce a picture for diagnosis and monitoring treatment.

**Nasogastric tube** - Silicone tube passed via the nose into the stomach to assist feeding.

**Nausea** - Sensation of feeling sick and likely to vomit.

**Neuroblastoma** - Malignant tumour of childhood that arises in the sympathetic nervous system or adrenal gland.

**Neutropenia** - Low neutrophil count.

**Neutrophil** - White blood cell which controls infection.

**Oedema** - Swelling caused by fluid.

**Oncologist** - A doctor specialising in cancer treatment.

**Oncology** - Study and treatment of cancer.

**Osteogenic sarcoma** - A malignant bone tumour, most common in teenagers.

**Palliative** - Optimising quality of life by providing relief from symptoms when cure is no longer possible.

**Petechiae** - Very small localised haemorrhages that appear as small red dots on the skin when the platelet count is very low.

**Platelets** - Blood cells which function to promote normal blood clotting.

**Port-a-cath®** - Venous access device fully implanted under the skin which is needed to access the bloodstream for drug administration etc. (see central line).

**Primary** - Original site of tumour.

**Prognosis** - The outlook or expected outcome of a disease.

**Prophylaxis** - Treatment to prevent disease or complication occurring.

**Protocol** - Treatment plan.

**Radiotherapy / Radiation Treatment** - The use of radiation energy to kill cancer cells.

**Registrar** - A hospital doctor usually undergoing training as a medical specialist.

**Relapse** - The return of symptoms of a disease after a period of good health. The further occurrence of a tumour after treatment.

**Remission** - Decrease or disappearance of signs, symptoms or laboratory evidence of the presence of disease.

**Resident** - Junior Hospital Medical Officer, in early years after graduation.

**Rhabdomyosarcoma** - Malignant tumour arising from muscle cells.

**Risk** - A measure of the likelihood of developing a disease.

**Sarcoma** - Malignant tumour of connective tissues of the body (e.g. arising from bone, cartilage or muscle tissue).

**Stem cells** - The earliest cells in the bone marrow and blood, which develop into mature blood cells – red cells, white cells and platelets.

**Stoma** - A surgically created opening, e.g. colostomy is a stoma on the abdominal wall for elimination of intestinal waste.

**Survival** - Survival rates are percentages of a group still alive after a given time. This figure is an average only, and does not apply to an individual child / patient.

**Terminal** - Implies that a patient's expectation of survival is measured in weeks or months, usually after relapse and the lack of further effective therapy.

**Thrombocytopenia** - Low platelet count.

**Tissue typing** - A method of measuring the degree of tissue compatibility between two individuals who will be donor and recipient in a bone marrow or organ transplant.

**Transfusion** - Procedure by which blood or blood components such as platelets are given to a patient through a vein or central line, i.e. intravenously.

**Tumour** - A localised collection of cells that grows, invades and may destroy surrounding tissue (may be benign or malignant).

**Ultrasound** - Use of high frequency sound waves to create images for diagnostic purposes or for following the progress of treatment. Same technology as radar.

## Words used by children for medical terms

**Chemo** – Chemotherapy.

**Count, finger prick** - Full blood count.

**Drip** – IV insertion or IV fluids.

**Line /Tube / “Wiggly”** - Central line.

**LP** - Lumbar puncture.

**Magic cream** - Local anaesthetic cream used to numb skin before an injection.

**Marrow** - Bone marrow aspirate.

**Patch** - Central line exit site dressing.

**Port, Mr Bump** - Port-a-cath®.

**QRI** - Queensland Radium Institute (at Royal Brisbane Hospital) where radiation therapy is given.

**Robot** - (some children give their machine a name e.g. Bob) IVAC / IMED / Gemini Pump (machine that delivers IV fluids).

**Theatre** - Operating theatre.

**The mask / special sleep** - General anaesthetic.

## Cancer Council Queensland offices

### Brisbane

553 Gregory Terrace  
Fortitude Valley Qld 4006  
Ph: (07) 3258 2200

### Cairns

169 Aumuller Street  
Bungalow Qld 4870  
(07) 4031 1555

### Townsville

24 Warburton Street  
North Ward Qld 4810  
Ph: (07) 4721 1644

### Sunshine Coast

Shop 4, credit Union Australia Plaze  
Corner Maroochydore Road  
& Baden Powell Street  
Maroochydore Qld 4558  
Ph: (07) 5443 6300

### Gold Coast

Corner Short Street & Marine Parade  
Southport Qld 4215  
Ph: (07) 5591 1500

### Toowoomba

137 Herries Street  
Toowoomba Qld 4350  
Ph: (07) 4638 4799

### Bundaberg

The professional Centre  
Mater Hospital  
313 Bourbong Street  
Bundaberg Qld 4670  
Ph: (07) 4152 5869

### Rockhampton

43 Upper Dawson Road  
Rockhampton Qld 4700  
Ph: (07) 4927 7088



[www.cancerqld.org.au](http://www.cancerqld.org.au)

*For other states, contact your local  
Cancer Council in your capital city*

## For more information

For further information about cancer and cancer support services please contact your nearest Cancer Council Queensland regional office or the Cancer Council Helpline on 13 11 20 (toll free) Monday to Friday from 8am to 8pm.





**Cancer  
Council**  
Queensland

553 Gregory Terrace Fortitude Valley Qld 4006  
Ph (07) 3258 2200 Fax (07) 3257 1306  
[www.cancerqld.org.au](http://www.cancerqld.org.au)