CARDIO-ONCOLOGY
NEWCASTLE
Beat Cancer with a Healthy Heart

Taking Control of Heart Health During and After Cancer

A cardio-oncology white paper on cancer survivorship, community priorities and regional models of care.

22 community survey responses	**90%** rated mobile heart service helpful	**14** mentions of impact on heart health

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Table of contents

Executive Summary

Cancer survivorship in Australia is entering a new era. More people are living longer after a cancer diagnosis, with five-year relative survival improving to 72% for people diagnosed in 2017-2021, compared with 50% in 1987-1991.[1] This success creates a new responsibility: survivorship care must not only monitor for cancer recurrence, but also prevent and manage the long-term health effects of cancer treatment, including cardiovascular disease.[2]

The Australian survivorship landscape remains fragmented. Persistent gaps include access to survivorship information and services, out-of-pocket costs, inequities for regional, rural and vulnerable populations, weak referral pathways, limited survivorship awareness, and insufficient survivor consultation. These issues are particularly important for cardio-oncology, where heart-health risks can emerge during treatment, soon after treatment, or years later.[2-4]

The case for change is especially strong outside metropolitan areas. Regional, rural and remote communities carry a higher burden of disease, have poorer access to specialist services and often face additional travel, accommodation and out-of-pocket costs.[17-19] A cardio-oncology survivorship model is therefore not simply a metropolitan service that can be adapted later; it is particularly important in regional and rural settings, where cancer risk, cardiovascular risk and access barriers intersect.

Community survey findings from the Cardio-Oncology Newcastle Community Conversation - "Listen. Learn. Close the gaps. Support every step." - reinforce the need for a survivorship approach that integrates cancer care, heart health and local access. The event brought together people with cancer, carers, health professionals and community advocates to identify what information and support are missing at diagnosis, during treatment and after treatment. Most participants were drawn from the Hunter New England Local Health District community and associated consumer networks. The survey did not collect postcode or remoteness classification, so the exact proportion of regional or rural respondents cannot be reported. Nevertheless, the findings reflect local voices from a health district that includes metropolitan, regional and rural communities, and should be interpreted as regionally focused community consultation rather than a population-level survey.

Among 22 survey respondents, the highest priorities during cancer treatment were maintaining quality of life, understanding treatment goals, prevention/management of side effects and regular follow-up. Heart health was a major concern, with "impact on heart health" ranked as the third most common treatment concern. Importantly, 90% of respondents who answered the rural-risk question agreed that people in regional, rural and remote areas of Australia are at higher risk of missed or delayed detection of cardiotoxicity. The survey also identified clear information gaps: six respondents reported receiving no information, or that information was not applicable, about cardiotoxicity, and six reported receiving no post-treatment information.

The clear message from the community was that survivorship care should be practical, local, multidisciplinary, heart-health focused and connected to peer support. Ninety per cent of respondents rated a mobile cancer survivorship and heart care service as "quite helpful" or "very helpful". Respondents wanted heart checks, access to a heart doctor, medication support, exercise and rehabilitation advice, peer connection, and a written follow-up plan to share with their GP.

This white paper recommends a Cancer Survivorship Heart-Health Pathway that integrates cardio-oncology into survivorship care from diagnosis through long-term follow-up. The proposed approach combines risk stratification, heart-health surveillance, survivorship care planning, nurse, pharmacist and allied health support, telehealth, mobile outreach, GP integration, community education and peer/carer support.

Key message
Survivorship care should move from reactive follow-up to proactive, person-centred care that protects both life and heart health.

Purpose of this white paper

This white paper aims to raise awareness of the importance of heart health during and after cancer treatment. It brings together community perspectives, current evidence and clinical experience to highlight gaps in survivorship care and opportunities to better support people living with and beyond cancer.

It is intended to support broader conversation, advocacy and collaboration, and to help guide future investment in practical, connected and accessible models of survivorship care.

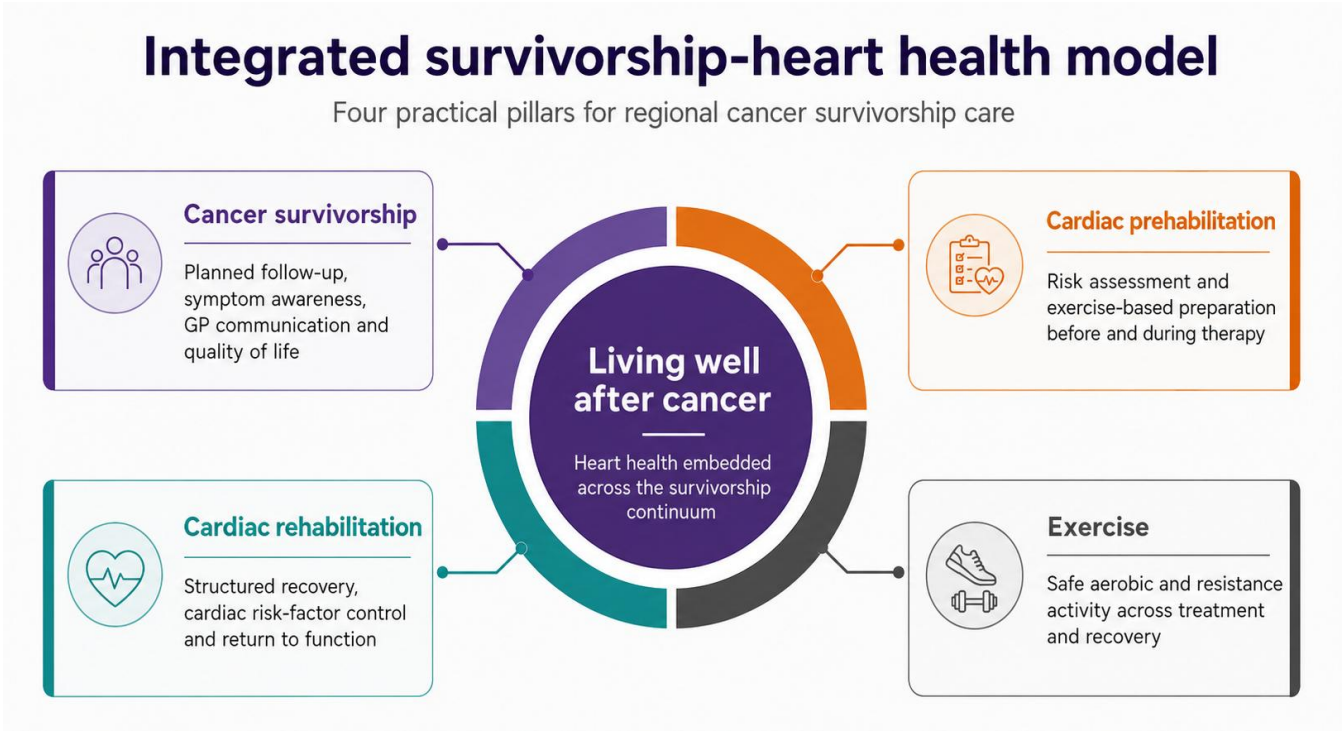
1. Why cancer survivorship needs a cardio-oncology lens

Cancer survivorship is often understood as life after cancer treatment; however, it is more accurately defined as the full care journey from the time of diagnosis, through active treatment, and into life beyond treatment. For many people, survivorship is not a clean transition from illness to wellness. It is a period of ongoing uncertainty, physical symptoms, fear of recurrence, treatment consequences, financial strain, and the need to reconnect with family, work and community life.

Survivorship needs are complex and individual, spanning physical, psychological, social, financial and spiritual wellbeing. Survivors may remain at risk of organ dysfunction, secondary malignancies, cardiovascular disease, diabetes, metabolic syndrome and osteoporosis.[3,5]

Cardio-oncology is central to this new survivorship landscape. Many cancer therapies can affect the heart and vascular system, including anthracyclines, HER2-targeted therapies, radiation, proteasome inhibitors, tyrosine kinase inhibitors, immune checkpoint inhibitors and newer targeted therapies.[6] Contemporary cardio-oncology practice emphasises baseline cardiovascular risk assessment and structured approaches to monitoring, prevention and management of cancer therapy-related cardiovascular toxicity.[4,7] Yet, for many survivors, heart health is not routinely built into survivorship planning. Cardiotoxicity may be discussed only after symptoms develop, after treatment has been interrupted, or after cardiac dysfunction is detected. This reactive approach is not enough. A cardio-oncology survivorship model should aim to preserve cancer treatment intensity where possible, prevent avoidable cardiovascular disease, support quality of life and ensure that survivors are not left to coordinate complex care on their own.

Figure 1. Integrated cardio-oncology survivorship model highlighting four practical angles: cancer survivorship, cardiac prehabilitation, cardiac rehabilitation and exercise.



2. The regional survivorship care gap in Australia

Regional, rural and remote cancer survivors face distinctive and compounding barriers after treatment. People outside metropolitan centres are more likely to live in areas with higher chronic disease burden, reduced access to specialist services and greater travel demands.[17,18] Many people travel to metropolitan or large regional centres for cancer treatment and then return home to communities where access to oncology, cardiology, allied health, psychology, rehabilitation and supportive care services may be limited.[8] Once home, the responsibility for coordinating follow-up often shifts heavily to the survivor, their family and their GP.

This creates a major survivorship gap, but it is also a risk gap. In metropolitan areas, specialist oncology, cardiology, rehabilitation and allied health services are more likely to be co-located or easier to access. In regional and rural communities, the same person may need cancer follow-up, cardiac assessment, imaging, medication review, rehabilitation and psychosocial support across multiple services and locations. Without a joined-up pathway, heart health risks can be missed until symptoms develop, cancer treatment is interrupted, or a hospital admission occurs.

This is why a cardio-oncology survivorship model is particularly relevant for regional and rural care. It directly addresses the place where the need is often greatest: communities with higher baseline cardiovascular risk, greater service fragmentation and fewer opportunities for routine specialist follow-up. A practical pathway that combines local shared care, telehealth, mobile outreach, rehabilitation and peer support has the potential to reduce both clinical risk and the burden placed on survivors, carers and local primary care.

Written survivorship care plans are particularly important in this context. A clear plan can summarise cancer diagnosis and treatment, outline recommended follow-up, identify symptoms requiring review, support health and wellbeing, and guide communication between the treating cancer centre and local primary care. For rural survivors, this type of plan is not simply an administrative document; it is a practical tool for continuity of care after returning home.[10,11]

For many rural survivors, survivorship information may not be consistently provided after treatment. Information about short-term side effects and follow-up appointments may be easier to access than information about long-term recovery, financial support, health promotion and monitoring for recurrence. Rural survivors may therefore leave specialist cancer care without the information needed to support long-term health, wellbeing and recovery.

This has direct implications for cardio-oncology. If general survivorship information is inconsistent, then information about cardiotoxicity risk, blood pressure and lipid management, cardiac symptoms, echocardiography, biomarkers, medication optimisation and when to seek specialist review is also likely to be inconsistent. In rural settings, missed information can become missed detection. A cardio-oncology survivorship pathway is therefore needed to ensure that heart health is built into routine cancer survivorship care, particularly for people returning home to regional, rural and remote communities.

3. What the community told us

Community engagement and survey approach

This white paper was informed by a community conversation held in Newcastle on 20 November 2025 with cancer patients, survivors, carers and community members. More than 30 people attended. The session included short presentations from the multidisciplinary cardio-oncology team, followed by discussion about information and support needs at diagnosis, during treatment and after cancer treatment.

Participants were invited from those who attended a larger community cardio-oncology Q&A event in March 2025, as well as patients and survivors who had attended the cardio-oncology clinic and expressed interest in future community activities. A voluntary and anonymous survey was completed by 22 respondents, including patients and survivors, carers, health professionals, advocates and community members with links to cancer care.

Respondents could select more than one role and, for some questions, more than one response option. Free-text answers were grouped into practical themes. Residential postcode or remoteness classification was not collected, so the proportion of respondents from regional or rural areas cannot be stated. However, respondents were mainly drawn from the Hunter New England Local Health District community and clinic-linked consumer networks. The findings should therefore be interpreted as local, regionally focused community consultation rather than a representative population survey, while still providing direct consumer, carer and community input into the proposed Cancer Survivorship Heart Health Pathway.

3.1 Respondent profile

The survey produced 22 responses. Respondents could identify with more than one role. Thirteen identified as someone with cancer or a cancer survivor, six as caring for someone with cancer, and seven as health professionals, advocates, fundraisers or people with professional or community links to cancer care. Most respondents were connected to the Hunter New England Local Health District community. Although precise remoteness data were not collected, this local context is important: the findings reflect voices from a region where cancer survivorship care needs to work across metropolitan, regional and rural settings. This mixed respondent group also reflects the reality of survivorship: care is experienced by patients, carers, clinicians, families, GPs, community organisations and local health systems.

Respondent role	Mentions
Person with cancer or cancer survivor	13
Caring for someone with cancer	6
Health professional, advocate, fundraiser or professional/community link	7

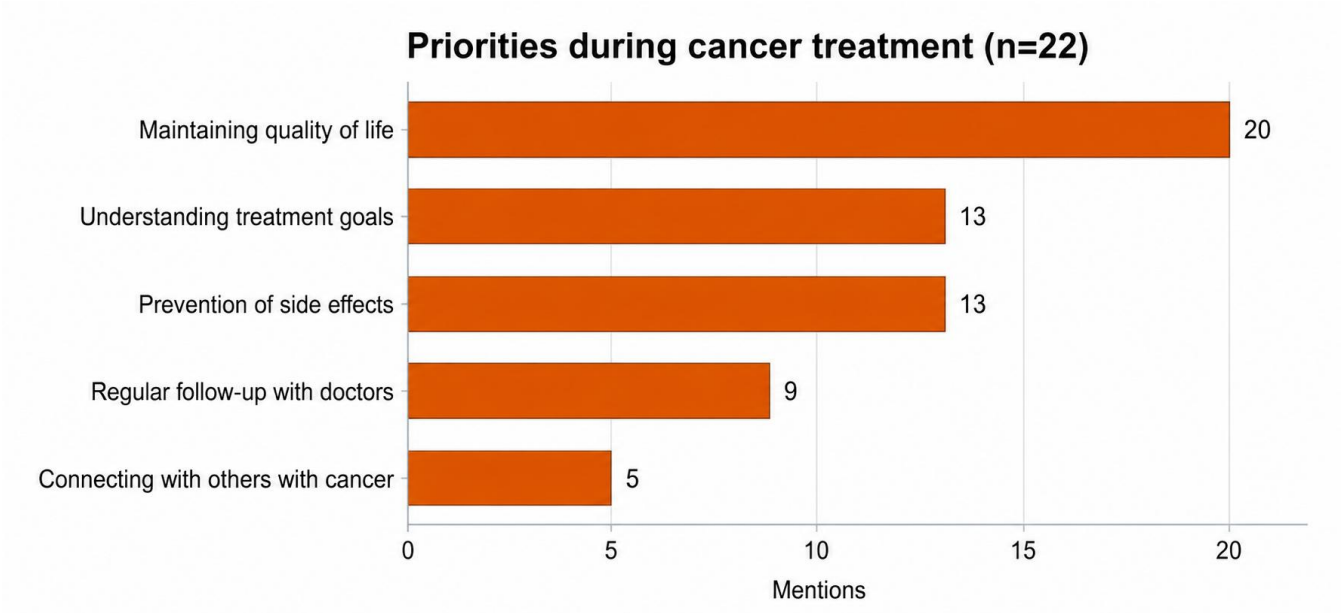
Table 1. Respondent profile from the community event survey. Respondents could choose more than one role.

3.2 Priorities during cancer treatment

Across 60 priority selections, respondents most identified quality of life, treatment goals, side-effect prevention or management, and regular follow-up. These findings show that people affected by cancer do not define successful treatment by cancer control alone. They also want to preserve wellbeing, understand their care, avoid preventable harm, and remain connected with clinicians, services and peer support.

Peer connection should be viewed as more than a social add-on. Patients and carers often learn practical information from others who have navigated similar treatment decisions, side effects, travel burdens, rehabilitation needs and uncertainty after treatment. A structured peer support strategy can help people feel less isolated, improve confidence in self-management and create a community that sustains engagement beyond a single clinic visit.

Figure 2. Treatment priorities identified in the community survey.



3.3 Main concerns during treatment

Across 59 concern selections, the most common were treatment side effects, cancer coming back, impact on heart health and cancer treatment decisions. Heart health was not a marginal issue. It appeared almost as frequently as fear of recurrence and more often than treatment decision-making. These reinforces making cardio-oncology an integral part of survivorship care, rather than an optional add-on.

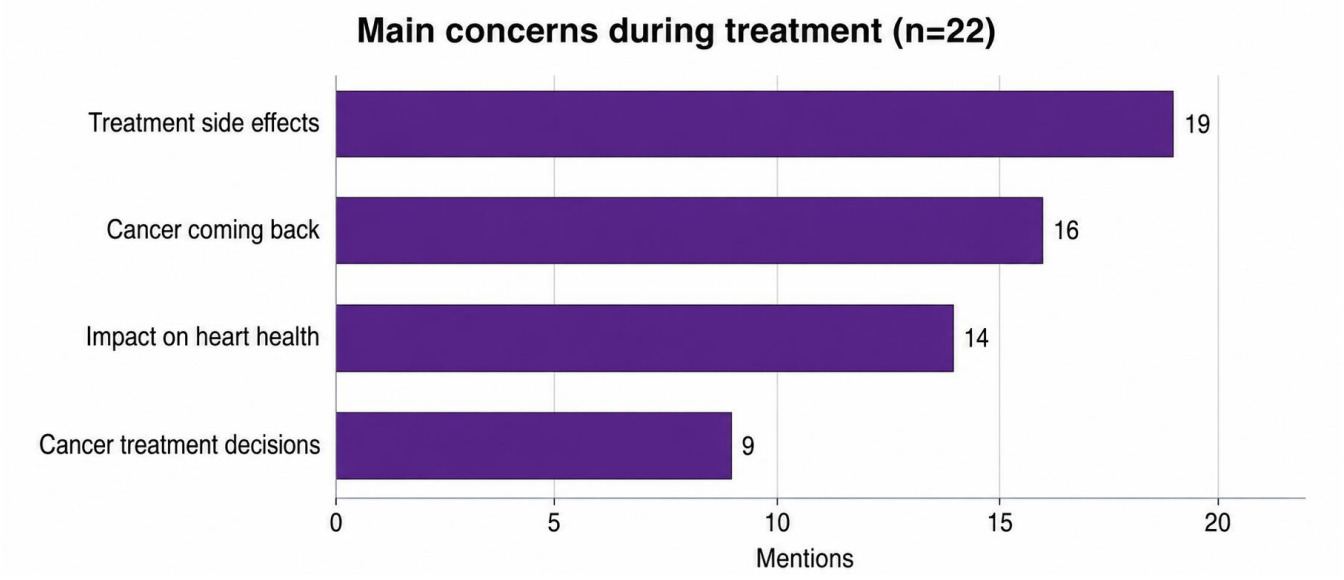


Figure 3. Main concerns during treatment reported by community survey respondents.

3.4 Information gaps

Cancer treatment information was most often provided by oncologists or the treating team. In contrast, information about cardiotoxicity was more variable. Respondents reported receiving cardiotoxicity information from cardiologists, oncologists, nurses, GPs, pharmacists, community meetings or through self-directed searching. Six respondents reported that they did not receive cardiotoxicity information or that it was not applicable to their circumstances.

Post-treatment information was also inconsistent. Possible side effects were the most reported topic, followed by exercise and diet advice. However, six respondents reported receiving no post-treatment information, and only two reported receiving heart-health management information.

This matters because survivorship care depends on informed self-management. People need to know what symptoms to watch for, who to contact, how often to follow up, what heart tests may be required and how to reduce modifiable cardiovascular risk.

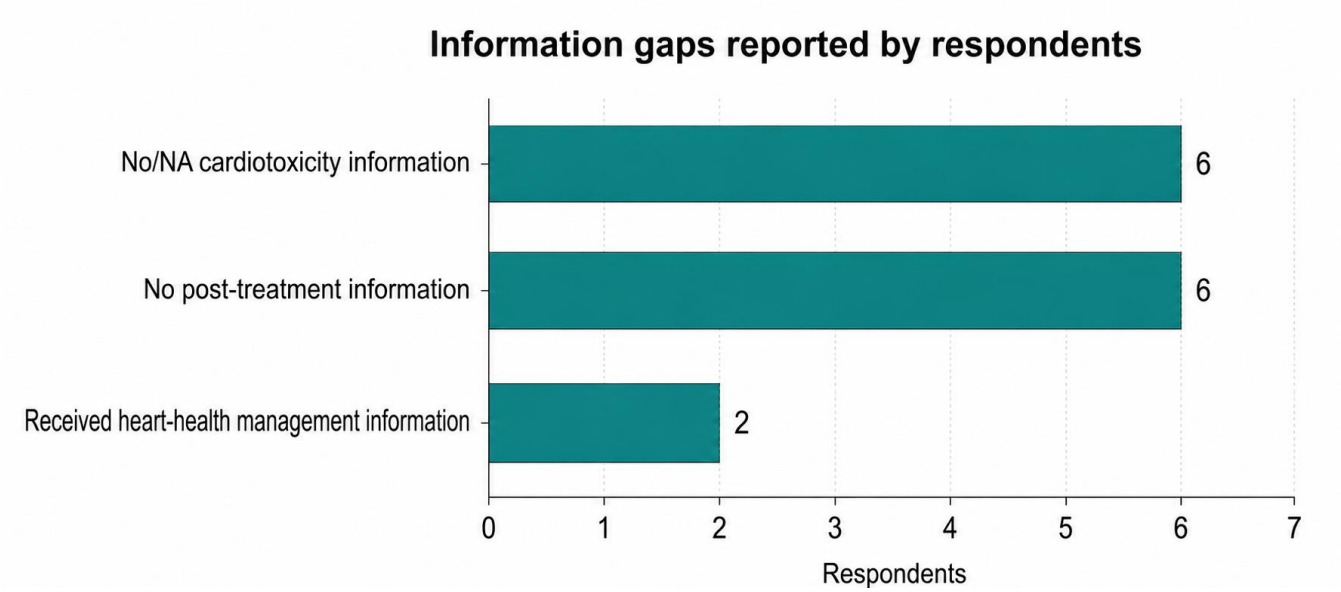


Figure 4. Information gaps reported by community survey respondents.

4. Gaps in current survivorship care

Three major gaps in current survivorship care are particularly relevant to cardio-oncology: access to information and services, costs and out-of-pocket expenses, and challenges for vulnerable groups including people living outside metropolitan centres. The community survey suggests these gaps are also present in cardio-oncology survivorship.

Access to information and services **Patients need clear pathways, consistent education and timely referral.**	**Costs and out-of-pocket expenses** **Travel, imaging, medications and appointments can create financial strain.**	**Regional and vulnerable-population inequity** **Distance, service availability and health literacy can delay detection and care.**

4.1 Heart health is not yet a routine survivorship domain

Survey responses indicate that cardiovascular risk factors are not being addressed consistently before or during cancer treatment. Of the 17 respondents who provided a numeric rating, many felt this was occurring infrequently, with 10 respondents giving a score of 1 or 2 out of 5. The

average score was 2.35 out of 5, suggesting that cardiovascular risk assessment and management remain inconsistent in routine cancer care.

Responses about prevention were similarly mixed. The most common answer was that no, or very few, preventive strategies were offered. Where strategies were mentioned, these included structured exercise or prehabilitation, optimisation of blood pressure and cholesterol, diet and weight management, and shared care with a cardiologist.

4.2 Survivorship services are fragmented

Respondents reported using physiotherapy, psychology, dietetics, exercise or gym programs, support networks, peer support and pharmacist medication reviews. However, these services appeared to be accessed inconsistently and often separately. Some respondents reported that no service was offered. At a system level, survivorship care remains variable across institutions and jurisdictions, with many services concentrated in metropolitan centres and limited integration into routine referral pathways.

Peer support for both patients and carers is also under-developed. For patients, peer connection can help normalise fears about recurrence, late effects and heart health. For carers, it can provide practical advice about navigating appointments, medication changes, travel, fatigue, emotional distress and family roles. Peer support should not replace clinical care, but it can strengthen the overall model by building community, improving health literacy and helping people learn from each other.

4.3 Regional, rural and remote survivors face additional risk

Eighteen of 20 respondents agreed or strongly agreed that people in regional, rural and remote areas are at higher risk of missed or delayed detection of cardiotoxicity. This finding is important because regional and rural cancer survivors may face a double burden: higher background cardiovascular risk and poorer access to timely specialist assessment.[17,18] Travel and out-of-pocket costs may also lead to delayed or missed appointments, particularly when cancer treatment, cardiac assessment, imaging, medication review, rehabilitation or specialist review require separate visits.19 Without coordinated local pathways, heart health becomes another burden placed on the survivor.

The proposed model is therefore more than an access solution. It is a risk-reduction strategy for communities where the overlap between cancer, cardiovascular disease and service distance is likely to produce avoidable harm. A regional pathway that identifies risk early, uses local and virtual follow-up, and links people to rehabilitation and peer support can help prevent missed detection and reduce unnecessary escalation to emergency or tertiary services.

4.4 Clinicians need practical tools and referral pathways

Health professional responses identified barriers including limited local guidelines or protocols, limited patient health literacy, and poor coordination between hospital and primary care. When asked what education or support would be helpful, responses included practical algorithms, in-person workshops and easy referral pathways or contact points.

This points to a critical implementation issue. A cardio-oncology survivorship model must be simple enough for real-world use. It should not rely only on specialist enthusiasm or informal networks. It needs standardised referral triggers, shared-care plans, GP-facing information and clear points of contact.

5. Proposed model: Cancer Survivorship Heart Health Pathway

Future survivorship approaches should embed cardio-oncology across the cancer care continuum. The goal is not to create another silo, but to connect oncology, cardiology, primary care, pharmacy, nursing, allied health, rehabilitation, peer support and community services around the survivor and their carers.

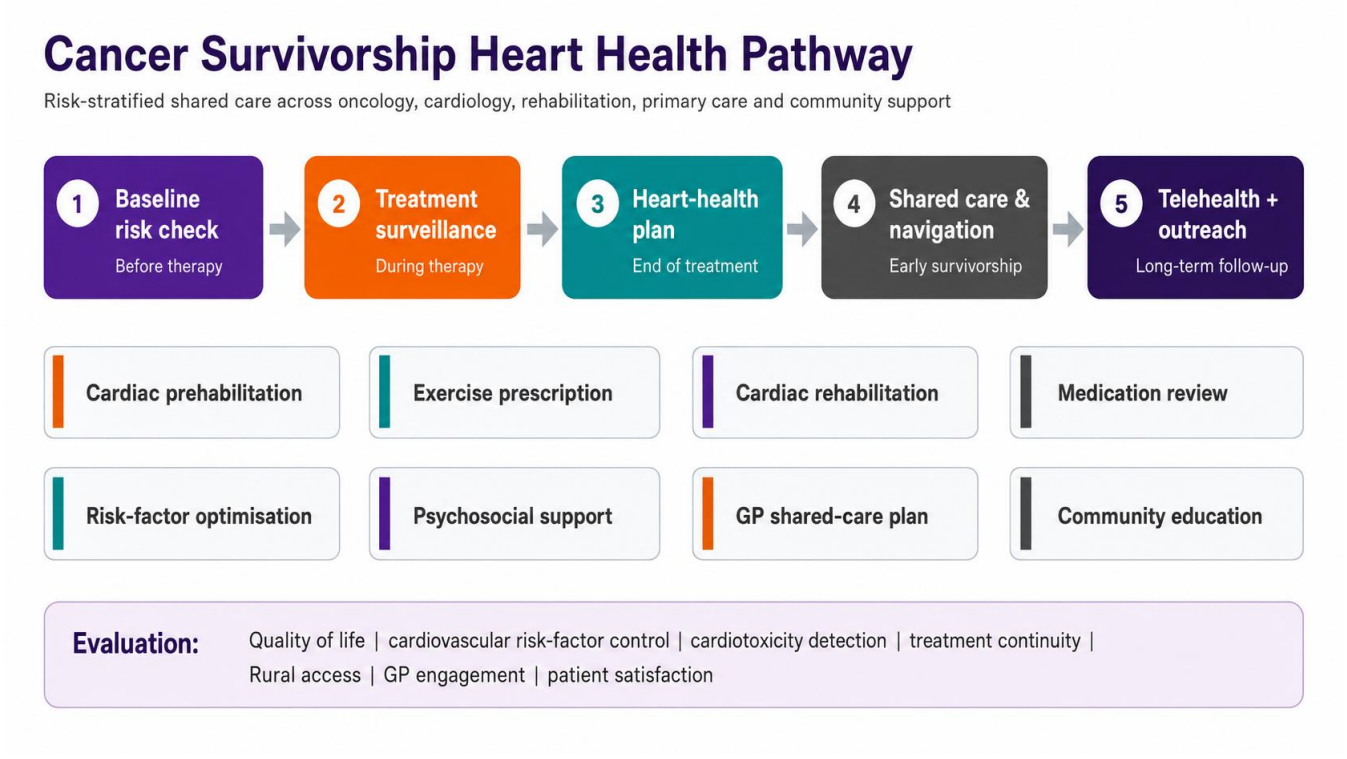


Figure 5. Cancer Survivorship Heart Health Pathway across the continuum from diagnosis to long-term survivorship.

5.1 Core components

Component	Purpose	Practical output
1. Baseline cardiovascular risk assessment	All patients receiving potentially cardiotoxic cancer therapy should have baseline cardiovascular risk assessed before treatment. This should include past cardiovascular disease, blood pressure, lipids, diabetes, smoking, kidney disease, family history, body weight, physical activity and planned cancer therapy.	Risk category documented
2. Treatment-linked cardiotoxicity surveillance	Monitoring should be risk-based and treatment-specific. Survivors should know what tests they require, when they are due and who is responsible for organising them.	Monitoring schedule agreed

Component	Purpose	Practical output
3. Modifiable risk factor optimisation	Blood pressure, lipids, diabetes, smoking, weight and physical activity should be actively addressed before, during and after treatment. This should be framed as part of cancer recovery, not as a separate chronic disease task.	Risk factors actively treated
4. Survivorship heart health plan	Each survivor at increased risk should receive a written plan that includes cancer treatment summary, cardiotoxicity risk, recommended heart checks, warning symptoms, medication plan, lifestyle goals, rehabilitation options and GP follow-up actions.	Shared written care plan
5. Nurse-led navigation and education	Nurses can provide education, symptom screening, care coordination and referral. This responds directly to survey preferences for follow-up calls, regular check-ins and practical support.	Education and triage delivered
6. Pharmacist medication review	Medication review should be included for survivors with polypharmacy, cardiovascular risk factors, heart failure risk, hypertension, dyslipidaemia, diabetes or complex cancer therapy regimens.	Medication issues identified
7. Exercise, diet and rehabilitation support	Exercise and diet advice was the highest-ranked survivorship program component in the survey. Heart-health-focused cancer rehabilitation should include safe exercise guidance, fatigue management, strength and aerobic conditioning, and referral to local allied health providers.	Rehabilitation referral completed

Component	Purpose	Practical output
8. Mental health, carer and peer support	Mental health, carer support and peer connection should be treated as core survivorship needs. Fear of recurrence, anxiety about side effects, uncertainty about the future, social isolation and carer burden should be actively identified and supported through psychology, social work, peer networks and community-based programs.	Peer and psychosocial support activated
9. Telehealth and mobile outreach	Ninety per cent of survey respondents rated a mobile survivorship and heart service as quite or very helpful. Follow-up preferences included all modes, GP check-ins, phone calls, video appointments and online or app-based monitoring. This supports a hybrid model combining specialist outreach, telehealth and local shared care.	Hybrid access pathway activated
10. Community and GP integration	The written plan should be shared with the survivor's GP. Local primary care should be supported with education, referral algorithms and clear escalation pathways to cardio-oncology specialists.	GP plan and escalation route shared

Table 4. Core components of the proposed Cancer Survivorship Heart Health Pathway.

6. What the community wants in a survivorship and heart service – consumer voices

Survey respondents wanted a service that is comprehensive but practical. Across responses, the most commonly requested elements were comprehensive services, access to heart doctor or cardio-oncology advice, a written follow-up or heart-health plan for their GP, heart checks, survivorship check-up focused on life after cancer, exercise and rehabilitation advice, and medication management.

Requested service feature	Mentions
Comprehensive/all services	12
Access to heart doctor/cardio-oncology advice	6

Requested service feature	Mentions
Written follow-up/heart-health plan for GP	5
Heart checks	4
Survivorship check-up focused on life after cancer	4
Exercise, fitness and rehabilitation advice	3
Medication management	3

Table 5. Service features requested by survey respondents.

The preferred frequency for a mobile service was generally every two to three months, with some suggesting twice yearly or monthly visits depending on need. This suggests a tiered model: higher-risk patients may need early and frequent review, while lower-risk survivors may benefit from periodic screening, education and GP-supported follow-up.

Peer support should sit alongside this tiered clinical model. For patients and carers, structured peer connection could include facilitated community conversations, carer sessions, survivorship education groups, local exercise or rehabilitation groups, and links to trusted community organisations. This would allow people to share practical experience, learn from others, and stay connected after formal treatment has ended.

7. Recommendations

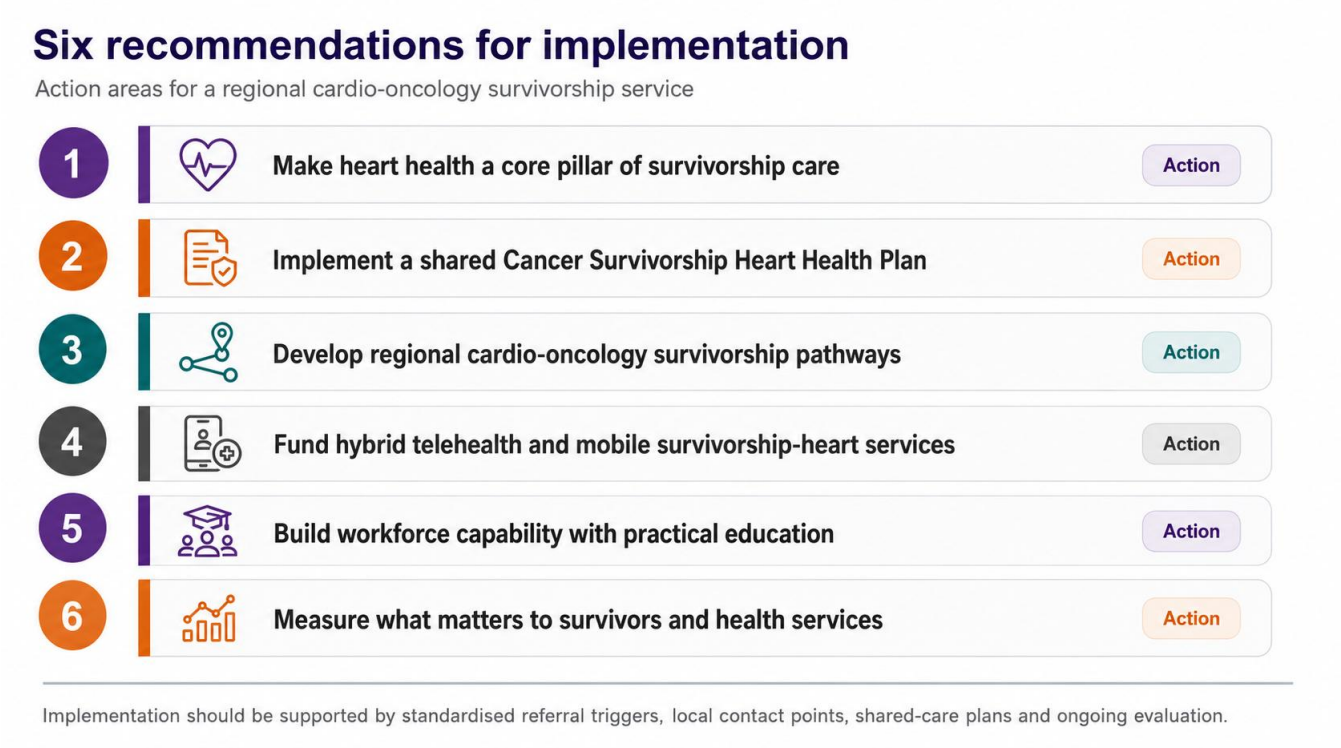


Figure 6. Six recommendations for implementation.

Recommendation 1: Make heart health a core pillar of cancer survivorship care
Survivorship frameworks should explicitly include cardiovascular prevention, surveillance and management. Heart health should sit alongside recurrence monitoring, psychosocial support, rehabilitation, peer support, fertility, fatigue, employment and financial wellbeing.

Recommendation 2: Implement a shared Cancer Survivorship Heart Health Plan
Every survivor at risk of cardiotoxicity should receive a written plan that can be shared across oncology, cardiology, primary care and allied health. The plan should use plain language and include clear actions for the survivor, carer and GP.

Recommendation 3: Develop regional cardio-oncology survivorship pathways
Regional services need practical referral algorithms, local contact points and access to specialist advice. Because regional and rural communities face both higher cardiovascular risk and greater access barriers, these pathways should be prioritised as a regional equity and risk-reduction strategy, not only as a service expansion.

Recommendation 4: Fund hybrid telehealth and mobile survivorship-heart services
A funded mobile and telehealth cardio-oncology survivorship model would directly respond to community preferences and rural access barriers. It may also reduce avoidable travel, duplicated appointments, missed review and escalation to emergency or tertiary care.

Recommendation 5: Build workforce capability and peer support capacity
Clinicians need brief algorithms, referral pathways, case-based education and in-person workshops. Training should target oncology nurses, cancer care coordinators, GPs, pharmacists, exercise physiologists, physiotherapists and rural clinicians. Peer support for patients and carers should also be built into the model through facilitated groups and community partnerships.

Recommendation 6: Measure what matters
Evaluation should include patient-reported outcomes, quality of life, cardiovascular risk factor control, cardiotoxicity detection, treatment interruptions, hospitalisations, GP engagement, service reach, rural access, peer support participation, carer experience, out-of-pocket costs and patient satisfaction.

8. Conclusion

Cancer survivorship is no longer only about living beyond cancer. It is about living well, with the best possible physical, emotional, social and cardiovascular health. The community event survey shows that people affected by cancer understand this. They want quality of life, prevention of side effects, clear communication, regular follow-up, practical support for heart health and opportunities to connect with others who understand the cancer experience.

A cardio-oncology survivorship model offers a direct response to these needs. By embedding heart health into survivorship planning, connecting specialists with GPs, using telehealth and mobile outreach, supporting cardiac prehabilitation and rehabilitation, and providing survivors with a clear written plan, cancer services can move from reactive follow-up to proactive, person-centred survivorship care.

There is also a broader health-system argument for prevention. Earlier identification and management of cardiovascular risk may reduce avoidable emergency presentations, hospital admissions, heart failure complications, repeated investigations and unplanned specialist reviews. For government and health services, investment in prevention, shared-care pathways, peer support, telehealth and regional outreach has the potential to reduce downstream costs while improving access, continuity of care and quality of life for cancer survivors.

This model is especially important for regional and rural communities, where the intersection of cancer, cardiovascular risk, distance and service availability can increase the chance that problems are detected late. A regional cardio-oncology survivorship pathway can help shift care closer to home while maintaining specialist input, reducing fragmentation and supporting both patients and carers.

Central message

Surviving cancer should not mean being left with preventable heart disease, fragmented care or unanswered questions. A modern survivorship system must protect both life and heart health for patients and their family members.

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