

Podium session (Tue, 25 Sep, 09.15–11.15)
Future directions in prevention and early detection in prostate, lung and colon cancer

8032

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Future directions in prevention and early detection of prostate cancer

C.N. Sternberg. San Camillo Forlanini Hospitals, Medical Oncology, Rome, Italy

Background: Chemoprevention of prostate cancer is the use of natural or synthetic agents that reverse, inhibit, or prevent the development of cancer. Early detection refers primarily to screening. Since the inception of PSA screening, prostate cancer mortality has decreased. However, broad scale screening is highly debated.

Materials and Methods: The Prostate Cancer Prevention Trial (PCPT) became the first phase III clinical trial of prostate cancer prevention. Other means of prostate cancer prevention include dietary and complementary medicine "preventive" measures. Other phase III clinical trials of chemoprevention include the REDUCE study using dutasteride and the SELECT trial of Selenium, Vitamin E, Both, or placebo. The APOSE trial employs selenium vs placebo and will include high risk men. Other methods of prevention include dietary control of fat intake and supplementation with Vitamin D, cyclooxygenase-2 inhibitors, lycopenes, green tea, polyphenolics and soy products isoflavones, which have weak estrogenic activity (genistein and daidzein), resveratrol, silibin, pomegranate, or apigenin.

In the U.S. Prostate, Lung, Colon, and Ovary Screening Trial, 38,350 men have been randomly assigned to the screening arm comparing DRE/PSA to no screening.

Results: The European Randomized Study of Screening for Prostate Cancer (ERSPC) is one of the largest randomized screening studies. Definitive results have still not been published. In the USA, there has been an absolute decrease of 17.4% in mortality in the PSA era. Patients are diagnosed earlier and the potential cure rate is now 70% as compared to 10–40% in 1985. Criticisms surrounding screening include the expense, cancer detection rates are low, detection of insignificant cancers, TRUS biopsy is invasive and has morbidity, and there has been no proven mortality benefit to screening. Official recommendations concerning screening are conflicting.

The PCPT demonstrated that finasteride is associated with a 25% reduction in the 7-year period prevalence of prostate cancer in men over age 55 years with normal DRE and initial PSA <3.0 ng/ml. Use of finasteride was associated with a slightly higher risk of Gleason sum 7–10 tumors, some sexual side effects, and fewer urinary symptoms. Implications of the PCPT have been far reaching.

Conclusions: Finasteride is the only intervention shown in long-term prospective phase III clinical trials to reduce the incidence of prostate cancer, associated with a 25% reduction in the 7-year period prevalence of prostate cancer in men over age 55 years with normal digital rectal exam and initial prostate specific antigen <3.0 ng/ml.

The ERSPC is one of the largest randomized controlled trials of screening versus control. Preliminary results suggest 24% rate of metastases in the control arm vs. 1% in screening arm. Final results are still awaited, and a 10-yr follow-up period for the final evaluation may be too short. Results are expected in 2008.

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Future directions in prevention and early detection of lung cancer

T. Le Chevalier¹, L. Ottesen². ¹GlaxoSmithKline, Oncology Clinical Development, London, United Kingdom; ²Institute Gustave Roussy, Oncology, Paris, France

Lung cancer is the leading malignancy in the world both in terms of prevalence and mortality. Smoking tobacco products in any form is the major cause of development of this cancer. Prognosis is strongly related to disease extent at the time of presentation and diagnosis at an early stage offers the best chance of cure. So both prevention and early screening might decrease the number of deaths related to lung cancer.

Never smoking lowers the risk of developing lung cancer and people who quit smoking and never start again also lower their risk of developing cancer or cancer recurrence. Nicotine gums, sprays, inhalers, patches and lozenges or antidepressant drugs may help people to stop smoking. Passive smokers also have a higher risk of developing lung cancer. There are other environmental causes of lung cancer but all have a smaller impact compared with tobacco smoking. These include pollution and contact with asbestos, radon, arsenic, tar, soot, nickel and chromium. Finally, physical activity and a diet rich in fruits and vegetables decrease the risk of

developing a lung cancer. There is no chemopreventive agent available at the moment and the fight against smoking remains the best way to prevent lung cancer.

Large randomized studies of lung cancer screening with chest-x-ray and/or sputum cytology were carried out in the 1970's. They failed to demonstrate any significant impact on survival. These techniques were not very sensitive and mostly identified large tumours. Today there is a renewed interest for lung cancer screening with low dose computed tomography since this procedure is much more sensitive for the detection of small lesions and it might allow diagnosis of 'lung tumours at a very early stage, when the probability of cure from surgery is the highest. Encouraging results have been reported in the initial studies in Japan, US and Europe. Small nodules are frequently found; they often require a fine-needle aspiration to obtain a diagnosis prior to surgery but they are sometimes too small to be biopsied; in addition, several questions remain unresolved. They include the real impact on survival, the type of screening (individual vs mass), the population to be targeted (smokers vs non-smokers, age, gender), the attitude in case of doubt (surgery vs follow-up), the influence of tumour environment and proteomic analyses. This will require large scale studies prior to establish appropriate guidelines for the international community.

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Future directions in prevention and early detection of colon cancer

P. Johnston. UK

Abstract not received.

Meet the Manager (Tue, 25 Sep, 09.15–11.15)
Choice, equity and access in European health care

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Choice, Equity and Access in European Health Care

S. Faithfull¹, W. Knibb², P. Riemmer-Hommel³. ¹Surrey University, Faculty of Health and Medical Sciences, Guildford, United Kingdom; ²Surrey University, Health Workforce Research centre, Guildford, United Kingdom; ³University of Applied Sciences, Fachbereich Pflege und Gesundheit Management, Saarbrücken, Germany

Patient choice is often identified as a component of the provision of quality health care but this may come at cost. But does choice enhance quality? Choice between treatments or where health services are provided is considered to strengthen patient autonomy and satisfaction with health service provision. Few would oppose increased choice for consumers of cancer care in principle. Furthermore the provision of choice also comes with additional conditions, such as competition between units and service providers and the need for consumers (cancer patients) to be knowledgeable about what different services provide. Inequalities in healthcare provision and the health status of the population have always been marked and improvements in equity of cancer provision have been policy for the EU and recent lobby groups (Cancer United).

Fundamental to choice is the ability to resource patient choices and to provide a range of services. This idea may have some attractions for patients who are unhappy with aspects of their treatment care but we have no idea how much patient choice will be realised in practice. A recent survey from the UK suggest that the public do not want to view health care as a market commodity and that the strong sense of responsibility for local service providers leads them to distrust comparative information provided by external bodies. Lessons from information and patient education providers also suggest that the more educated, higher socioeconomic groups tend to take advantage of choice whilst more rural and remote populations find it difficult to have choice because of access and travel.

The questions for this workshop concern:

- Whether patient choice is a good thing?
- What's effective choice in the cancer environment?
- Does choice increase inequalities and are there any other hidden costs?
- Is choice disadvantageous for those from more vulnerable groups?
- Do patients value the provision of comparative data or league tables?
- Are patients able to make informed choices in health care provision?
- Is choice a reality in cancer care provision?