Materials and Methods: Only a single prospective and randomized study has prospectively investigated when postoperative radiotherapy is to be integrated in relation to chemotherapy. Multiple studies have tested the effects by adding endocrine therapies to chemotherapy, and the addition of trastuzumab (T) to different chemotherapy regimens. When and how to integrate these modalities in relation to radiation will be discussed.

Results: Long term follow-up reveals increased cardiovascular toxicities by radiotherapy, although these side-effects have in the overview process been described to diminish in later studies.

The initial pooled analysis of the adjuvant US trastuzumab studies (NSABP B-31/NCCTG N9831), containing doxorubicin, cyclophosphamide (AC) and paclitaxel (P), revealed in an indirect comparison with the HERA study a “better” disease-free survival. In the US studies T was partly delivered concurrently with adjuvant P, while in the HERA study all T was given after the completion of chemotherapy and radiotherapy. The US studies, with AC, concurrent P and T, followed by radiotherapy and remaining T, revealed a likely higher risk of severe congestive heart failure (CHF) and systolic dysfunction, respectively; 0.6% in HERA compared with 2.5−3.6% CHF. Systolic dysfunction was 3.0% in the HERA study, while the concurrent strategies revealed 14−17%. In the third large US study BCIRG 006, the arm with concurrent T with docetaxel (D) and carbopaltin revealed a 0.4% risk of severe CHF, systolic dysfunction was reported in 8.6% of the patients. For the FINHER study with only nine weeks of T concurrent with D or vinorelbin at start of therapy the corresponding values were 0% and 3.5%, respectively.

Conclusion: For most patients, the likely best strategy is to deliver chemotherapy first, followed by radiotherapy and endocrine therapy. For those patients with HER2/neu positive cancers there is a potentially better effect by giving trastuzumab concurrently with taxanes, although the cardiac side-effects seem to be higher by this strategy, so the optimal strategy is so far not known.

Symposium (Thu, 27 Sep, 09:00−11:00)
Quality improvement strategies in cancer

192 INVITED

A mixed Dutch approach in the European perspective

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Being examples of performance The Netherlands did well in European comparisons of participation in EORTC studies of cancer treatment, of the presence of effective mass screening programmes (for cervical and breast cancer) and active participation in studies of screening for lung and prostate cancer; generally, it exhibited reasonably good results within the Eurocare studies, covering the diagnostic periods 1978−85, 1985−89, 1990−94 and 1995–2002, respectively with increasing populations covered, as well as in various high resolution care pattern studies of breast, colorectal, testis and prostate cancer. Although, and a bit later than desired, a huge government stimulated investment effort in radiotherapy equipment and manpower took place since 2001, there was great anxiety on the needed capacity and efficiency of the health sector, partly evoked by ‘silent’ demographic changes and permanent uncertainties on income of and power over doctors, who also became scarce due to inadequate deliberate ministerial policies to keep the number of medical students low since the mid 1980s; but they were doubling again since 2000 and training opportunities have enlarged in the meantime.

Since 2000 there have been several, seemingly uncoordinated but necessarily related, initiatives to come to a national cancer plan. On the one hand several explorative reports on the future of cancer prevention and cancer care have been published under the auspices of the Dutch Cancer Society, the major player in the domain of cancer research by fund raising and patient education: 3 reports on prevention (summarizing the evidence) by prudent exposure to UV (2002), diet (2004), physical exercise (2005), a report on colorectal cancer screening preaching diversity (2004), a report on the bright future of imaging (2005), a report on molecular diagnostics (2007) and biobanking, a report on waiting times (2006); they were also supported by an extensive report on trends in prevalence (incidence and survival) during the period 1990–2015 (2004). This latter report still provokes discussion on how to adress the rising demand for care (the number of cancer patients alive rising from about 500,000 in 2005 to 800,000 in 2015), especially in the domain of breast and colorectal cancer, skin cancer and related to older patients, for whom special care programs are needed that also adress co-morbidity, especially for the rapidly rising numbers of patients with cancer and diabetes. The aim of all these scenario-type of reports have been to stimulate the various players to take their responsabilities in terms of training, regionalization (here supported by the 9 Comprehensive Care Centres – CCC’s – responsible for the promotion of quality of care at regional level), delegation of tasks to nurse-practioners and in fact promoting early diagnosis and also reluctance with cancer screening with its modest benefits and large resource & care implications.

Simultaneousy, In the period 2003−06 a major political change gave the health insurance companies responsability for buying health services, also competing on price and quality (as always difficult to measure etc), for which the Ministry of Health and new independent supervising bodies are trying to create optimal conditions, e.g. by promoting incentives for such competition, efficiency, patient safety ans also the introduction of electronic patient records. But also efforts to heva new (expensive) cancer drugs sooner available. Although aimed at greater efficiency, more restricting rules and controls are also resulting and care providers like GP’s suffer. The results are mixed for the various specialists whose numbers are increasing rapidly.

A substantial, rather heavy, effort to write a national plan was also undertaken by the major players (the Dutch Cancer Society, the ‘united’ CCC’s, Insurance companies, cancer patient societies and the Ministry of Health). A large report arrived in 2004, but was not received with much enthousiasm, because it lacked a perspective (except for wider application of psychosocial care) especially with respect to research and development and in fact there had been little professional involvement. Recently, some efforts take place in reviving, but in fact many professionals are making hteir own plans in accordance with the new regime of governance by insurance companies.

The importance of professional involvement can be underscored by many examples, the best (in my opinion) being the impressive improvements in rectal surgery and preoperative irradiation which have taken place in the last 15−20 years; they are currently followed in the domain of colon cancer management and many other initiatives at regionalization of surgical oncological care.

Conclusion: through a diversity of professional initiatives cancer care is definitely improving in the Netherlands. The best policy is to support this.

193 INVITED

The UK programme

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Abstract not received.

194 INVITED

The French approach – The French Cancer Plan and its instrument the French National Cancer Institute (INCa): A centre of hope in the fight against cancer

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Fighting cancer in the world, and particularly in France, means more than just taking up a public health challenge. Among the 10 million new cases and 6 million deaths worldwide in 2000, France accounted for 280,000 new cases and 150,000 deaths. By 2020, it could kill 10 million people worldwide every year.

Beyond the disease strictly speaking, cancer leads to a number of social inequalities, ranging from exclusion and discrimination to psychological problems. With the ultimate goal of cure, science plays a key role in the fight against cancer, basing its research both on simple mechanistic paradigms of cancer and more complex process-based ones. Considering the huge increase in medical needs – as regards the epidemiology and chronicity – and the cost and complexity of the new treatments, the next step consists in transferring relevant information and updated knowledge from the laboratory to the bedside (through translational research and valorisation), thus adhering to the objective of putting patients at the heart of cancer care – both in access and quality.

The landscape for cancer in France reflects the challenges of the disease. Although the country has the best survival rate after cancer in Europe, the number of cases doubled between 1980 and 2000. In addition, a lack of public health policy is evident in a country where there is the highest premature mortality in men. The principle of universal and unlimited access to care in France results in 3 million mammograms, 1.5 million colonoscopies and 6 million Pap tests administered every year, undermined by a lack of organization and cost-efficiency.

The French healthcare landscape shows geographical discrepancies as well as a lack of equipment and of respect to patients, despite a high level of access to modern medicine. In 2002, France had 10.3 scanners per million inhabitants, 3.8 MRIs and 0.2 PET scans with waiting times of 41 days for a scanner and 39 days for an MRI. There is also an increase in the demand for health services with, for example, a 12% per year increased demand for chemotherapy. French cancer patients have insufficient access to non-medical care (including rehabilitation and counselling) and ambulatory care (despite a significant progress made in the palliative care and pain management areas.)