Pergamon

European Journal of Cancer Vol. 32A, No. 3, pp. 387–389, 1996

Printed in Great Britain.
0959–8049/96 $15.00+0.00

International Cancer News

From the Globe

US National Cancer Institute Halts NSABP Tamoxifen Adjuvant Study

The National Cancer Institute (NCI) in Bethesda, U.S.A. has stopped ahead of schedule a clinical trial of the national surgical adjuvant breast and bowel project (protocol B-14) on the long-term efficacy of adjuvant therapy for premenopausal and postmenopausal women with axillary node negative, ER positive breast cancer, according to an article in *The Lancet* (9 December 1995).

One hundred and sixty-six out of 1166 women who had already received tamoxifen 20 mg/day without relapse for 5 years were randomised to receive either tamoxifen for an additional 5 years or placebo.

Based on actuarial estimates at 5 years of follow-up, researchers found that 5 years of tamoxifen gave a disease-free survival rate of 92%, compared with 86% in patients scheduled to receive 10 years of therapy. The NCI pointed out that the results were unchanged whether or not 66 ineligible patients recruited from St. Luc's Hospital, Montreal were included in the analysis.

The clinical announcement reported similar results from the second phase of the Scottish trial of adjuvant tamoxifen not yet published: 70% of women who received tamoxifen for 5 years survived disease free, compared with 62% who took tamoxifen for a longer time period.

Though the trends in disease-free survival between the two cohorts did not reach statistical significance in either trial, NCI investigators were satisfied they had sufficient evidence that 5 years of tamoxifen could be the best choice. They stated: "The B-14 data taken together with the results of the Scottish trial provide no evidence of benefit for continuing tamoxifen beyond 5 years".

Reflecting upon the present data of both trials, it might appear that prolonging tamoxifen intake beyond 5 years might even decrease attempted benefit.

From Europe

Quality Assurance and Cancer Treatment in Europe

Throughout the world, even in Western, oncologically developed countries, all cancer patients cannot yet be assured that they will always get the best treatment available.

At the recent European Cancer Congress (ECCO-8) held in Paris, France in October 1995 leading cancer specialists and researchers expressed that the continental co-operation of doctors, nurses and researchers in quality control throughout Europe is essential to overcome inequities.

"The importance of quality assurance has been rapidly emerging in medicine and clinical research in recent years", says the Chairperson of the European Organisation for Research and Treatment of Cancer (EORTC) Quality Control Committee, Dr de Mulder, of the Academic Hospital, Nijmegen, The Netherlands. "The EORTC is making continuous efforts to trace, prevent and correct errors in the many steps involved in the diagnosis and treatment of cancer", says Dr de Mulder. "It is very likely that a large improvement in the outcome of cancer care could be obtained in all cancer patients receiving state of the art staging, and then treatment at the correct time, prescribed and administered in the correct form", he adds.

Differences in equipment and professional environment

"The EORTC Quality Control Committee has revealed important variations in the standard of radiotherapy equipment in different centres in Europe and made recommendations that, in every country, minimum criteria should be agreed to guarantee quality in the functioning of the radiotherapy department. Programmes to ensure quality control in surgery are, however, more difficult, for human and technical reasons. However, it is certain that the choice of surgical treatment should be based on the correct pathological diagnosis", Dr de Mulder emphasises.

Some progress has already been made, says Professor Jean-Claude Horiot, Head of the Radiotherapy Department, Centre Georges-François Lecler, Dijon, France and President of the Federation of European Cancer Societies (FECS). "Clinical research groups in Europe have already helped to increase the reliability of research and improved cancer treatments. Within a few years, most cancer institutes will implement quality management programmes. Available results already suggest that the generalised use of quality assurance is the best short term investment to improve cancer care. In addition, modern telecommunication methods will enhance the efficacy of quality assurance and the safety of cancer treatment", Professor Horiot says. "Quality assurance can prevent the risks of an excess of treatment. Moreover, it will also detect an insufficient treatment which is potentially even more hazardous than too much treatment".

Breast cancer

Quality assurance is particularly important in the treatment of breast cancer, the most common cancer in women in Europe, says Professor Jacques Rouëssé, Director of Centre René Huguenin, Saint-Cloud and Chairperson of ECCO-8.

Mammography must be subject to quality control. Without quality assurance, radiology carries a higher risk of false negative investigations. Breast cancers vary in type and behaviour and, for effective treatment, the nature of a particular tumour must be known. Hormonal and microscopic assessments of the tumour, surgery and radiotherapy must all be quality assured", he says.

Variable outlook in rectal cancer

The outcome of surgery for rectal cancer varies more between surgeons and between hospitals than any other cancer, says Consultant Surgeon Dr Heald from North Hampshire Hospital, Basingstoke, U.K. There is a very accurate correlation between adequacy of surgery, which can be assessed in the pathology laboratory, and the outcome for patients.

"This therefore opens up the exciting possibility of routine histopathological 'audit' of rectal surgery within days or weeks of the operation", says Dr Heald. "One of the great obstacles to progress in the past has been the need to wait for years of careful follow-up before proper outcome measurements could be made".

"Meticulous surgery for rectal carcinoma can lead to a four times greater reduction in local recurrence rate than inferior surgery combined with adjuvant chemotherapy," says Dr Heald.

"Support for the use of chemotherapy in the treatment of rectal cancer has been based on surgical results that are markedly inferior to those which have been achieved by the best units in various parts of the world", says Dr Heald. "In Basingstoke, where priority is given to accurate surgery, the overall recurrence rate is only 7% and recent data indicate that the addition of pre-operative radiotherapy to surgery in locally-advanced cases can virtually eliminate local recurrence".

"These important findings confirm that surgical outcome can depend on the quality of the surgeon, and this justifies quality assurance programmes in surgery", comments Professor Harry Bartelink, The Netherlands Cancer Institute, Amsterdam.

Bladder cancer

A clinical trial is urgently needed to compare the results of radiotherapy and cystectomy (bladder removal) in the treatment of localised bladder cancer which is invading the muscle wall, says U.K. cancer specialist.

Professor Horwich, of The Royal Marsden NHS Trust and Institute of Cancer Research, Surrey, U.K., points out that the use of localised radiotherapy in localised bladder cancer has the benefit of allowing patients to pass urine normally and remain potent. Previous small trials have shown that patients with this early stage of bladder cancer treated with radiotherapy and cystectomy if the cancer recurs, have survived as well as patients treated with initial cystectomy.

"A trial is required based on modern staging and treatment techniques", says Professor Horwich. "We need to take into account recent advances in radiotherapy, such as conformable radiotherapy and accelerated fractionation", he adds.

No individual protocols

"It is unacceptable for doctors to have their own protocol for cancer treatment", says Professor Bartelink. Summarising the proceedings, he says, "doctors' performances must be checked and there must be minimum standards, especially for life threatening diseases such as cancer. In addition, there is an urgent need to gather a larger number of patients in controlled clinical trials to speed up clinical research. Quality assurance is a mandatory tool used in every research protocol".

ECCO-8 programme committee officials felt very strongly, that much could be gained in treatment outcome and finally cancer control if quality assurance programmes could be enforced in cancer treatment throughout Europe today. Quality control and quality management should therefore not only be implemented in highly selected patient groups within well conducted cancer clinical trials, but rather on a nationwide (and Europe-wide) scale, attaching to it a health political, rather than just scientific dimension. Outcome analyses such as for example the EUROCARE study, and also more differentiated endpoint comparisons will have to be instituted to monitor anticipated positive developments.

Europe Against Cancer (EAC): Where are the Nurses?

Some important debates took place in the European Parliament on 20 September 1995, regarding the representation of different health care disciplines on the committees on the EAP. Mary Banotti (Dublin EPP), asked the member of the commission, Padraig Flynn, why there were no representatives of the nursing profession on either the expert group or the advisory committee of the EAC programme. She requested that the commission rectify this anomaly.

Mr Flynn replied that the cancer expert representatives of each of the member states were nominated by the respective national authorities as a response to the need for expert advice and scientific guidance for the EAC programme (1985). He added that a number of subcommittees had been established for the prevention, screening and training of health professionals and that a nurse does represent the profession on the training subcommittee, Miss Webb of Trinity Hospice, London.

Mr Flynn returned to the question of the advisory committee of the EAC programme which is composed of representatives of the ministries of health which do not promote the interests of any individual health profession to the detriment of others.

In other words, it is the responsibility of the member state to make these decisions and not the commission, and it is the responsibility of all professionals to lobby their expert group and ministries of health if they are not happy with the current balance of professionals representing them. For the future action plan for the EAC programme, 1995–1999, the same situation will prevail.

The message is clear. If you do not like the current representation for your country, then deal with it at national level. However, as the discussions continued, Padraig Flynn agreed that it was ideal for the whole range of professionals to be represented in some way in the advice given to the commission for the EAC programme. This includes nurses who have most frequent contact with patients and families.

Mr Flynn closed this particular line of questioning by confirming that the commission's modified proposal on the action plan for 1995–1999 gives particular attention to nurses working in paediatric oncology. There is ongoing concern that nurses should be fully represented.

Patricia Webb, ECCO-8, Paris, France

Filing of EORTC SOP's at FDA Will Speed Approval of Drugs From Europe

Cancer drugs developed in Europe should face smoother and faster US approval after a major international cancer research organisation submitted its Standard Operating Procedures for monitoring early cancer research to the US Food and Drug Administration (FDA).

In November 1995, the FDA assigned a Drug Master File number to the European Organisation for Research and Treatment of Cancer's New Drug Development Office (EORTC-NDDO) in Amsterdam. This action is effectively an FDA endorsement of EORTC Research Division's procedures.

"This is an important step forward for drug development in Europe", said NDDO Director Coenraad K. van Kalken, M.D., PhD. "It's one more sign that Europe is really an equal partner with the U.S. in this area. The EORTC has had informal contacts with the FDA for a long time, and in some respects, it was a matter of clarifying things that have been in place all along", he added.

"The National Cancer Institute is listed as an 'agent' on the Drug Master File, meaning NCI 'co-sponsored' the submission of the file", said Omar Yoder, PhD, director of NCI's Liaison Office in Brussels, Belgium. An exchange programme of the Liaison Office sent ECSO chairman Dr Jaap Verweij and NDDO's head of clinical development Dr Jantien Wanders to FDA, to iron out details of the file. (ECSG stands for EORTC-Early Clinical Studies Group). "This has been one of our primary goals over the last decade of U.S. –European collaborations", Yoder said. "It's a major change, and the impact will be tremendous. FDA will consider EORTC clinical trials data on an equal footing with the data coming from NCI or one of the NCI co-operative groups".

In the past, drugs approved in Europe frequently faced further rounds of trials to satisfy FDA, an expensive and time-consuming affair which discouraged European investigators and drug companies from seeking U.S. approval. "Now, there will be no duplication of effort, and it will save everybody money", Yoder said.

The new development at FDA is particularly significant in light of the joint agreement between NCI, EORTC and the U.K. Cancer Research Campaign (CRC) he added, because that agreement is expected to increase the number of promising new compounds tested in Europe.

R. E. C. Henrar, NDDO-EORTC
Amsterdam