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International Cancer News

Compiled by Robert Short, News Editor, London

From The Globe

Breast Cancer Fall in American Women Continues

The breast cancer death rate in American women continued to decline through 1993, suggesting that improved breast cancer management, from early detection to treatment, is having a beneficial effect. This was the claim of the National Cancer Institute.

Breast cancer mortality trends for White women in the U.S.A. have improved markedly in the 1990s compared with the 1980s. For Black women, an increase in mortality persists, especially among older women, but the overall increase has slowed significantly.

During the most recent 5-year period of available data, 1989–1993, the age-adjusted breast cancer mortality rates fell by approximately 6% in White women and rose by approximately 1% in Black women. By comparison, from 1980 to 1989, rates increased by 3% in White women and by 16% in Black women, according to data from the National Center for Health Statistics.

NCI Director, Richard Klausner, said: "The data suggest the trend is starting to move in a positive direction for African American women as well as White women. Rates have declined among younger Black women, although they are still higher than those of White women and are improving more slowly."

The overall rate for American women has fallen by approximately 5% in recent years, dropping from 27.5 cases per 100000 women in 1989 to 25.9 cases per 100000 in 1993. This year, an estimated 44300 women will die of the disease nationwide, but that estimate could prove to be too high if the trend continues.

In both White and Black women, the greatest improvements in mortality during the recent 5-year period were seen in younger age groups, but the overall changes were more modest among Black women than in White women of all ages. The median age at death for White breast cancer patients is 68 years and 62 years for Black breast cancer patients.

Experts believe the recent decline in breast cancer mortality is partly a result of mammography screening, which rapidly increased in the U.S.A. during the 1980s and resulted in a shift towards the detection of breast cancer at earlier, more curable stages, but other factors must also contribute.

"Such changes in mortality trends across a wide range usually indicated improvements in medical interventions, and examination of stage-specific breast cancer incidence rates and survival rates suggests that both earlier detection and improved treatment are likely to contribute to the recent declines in breast cancer mortality," said Robert Tarone of NCI's Biostatistics Branch.

Middle East Cancer Consortium Agreement Reached

Cyprus, Egypt, Israel, Jordan and the Palestinian Authority Health Ministers united to sign the Middle East Cancer Consortium (MECC) agreement in Geneva recently.

The MECC is an intergovernmental organisation, membership to which is open to other countries in the Middle East, with an aim to increase knowledge about cancer and decrease its effects in the Middle East. Its main objective is to promote and support co-operation on cancer control with cancer surveillance, information and education being the major foci. The Consortium will also concentrate on training, basic research, public health and patient care and international communications. Co-operation may involve research, and include programmes of clinical guidelines and protocols; by linking cancer research and treatment facilities the Consortium may reduce the cost of providing cancer care.

MECC funding will come from the member countries and, initially, from the National Institutes of Health of the U.S.A. These funds will help institutions develop cancer registries, cancer information dissemination programmes and training programmes in cancer research, education and patient care. The MECC will be governed by the ministers of health in a Ministerial Steering Committee, and also by a Board of Governors. An Executive Director will administrate the daily activities.

From Europe

Cancer Experts Angered at Tobacco Company Sponsored Report on Passive Smoking

Senior European oncologists have expressed their disbelief at the findings of a group calling themselves the 'European Working Group on Environmental Tobacco Smoke and Lung Cancer' which were presented in their report on environmental tobacco smoke. The Group's study was commissioned by three tobacco companies—Philip Morris Europe S.A., British–American Tobacco Limited and Rothmans International, and chaired by Professor Jeffrey Idel, Professor in Medicine and Molecular Biology at the Norwegian University of Science and Technology, Trondheim, Norway.

In the Working Group's report they concluded that current evidence does not prove that environmental tobacco smoke is a lung carcinogen in humans. The report coincides with a massive advertising campaign in newspapers across Europe by Philip Morris Europe S.A. in which the advertiser appears to be offering readers the "evidence about second-hand smoke" and suggesting that the risk of cancer from exposure to second-hand smoke is lower than the risk of contracting heart disease from eating one biscuit a day. It is not clear whether the Working Group's report is actually being used in this campaign.

Commenting on the report, Professor Gordon McVie, Director General of the Cancer Research Campaign (CRC) and President of the EORTC said: "I do not think reputable scientists should accept tobacco company money at all". He said that both the major cancer leagues subscribing to the EORTC, the CRC and the Imperial Cancer Research Fund, had ensured that tobacco companies were not included in their share portfolios.

"There is a fundamental principle at stake in accepting tobacco money to do research. And to do research on tobacco is a minefield, because you are laying yourself open to criticism unless you do an absolutely blue chip, authoritative unchallengeable study". He did not think that this report constituted such a study, because it did not look at unpublished work.

The Group analysed all 48 epidemiological studies on environmental tobacco smoke and lung cancer published worldwide, using modern epidemiological techniques not previously applied to these studies. Professor Gordon McVie noted that they do not appear to have looked at unpublished studies, which is always an essential part of an authoritative meta-analysis. Dr Jan Willem Coebergh of the Department of Epidemiology and Biostatistics at Erasmus University Medical School is undertaking a review of the study for a news report next month.

At the press conference to announce the report, the group denied being manipulated by the public relations machinery of the tobacco industry. They had undertaken to evaluate evidence on a serious question using modern approaches. The panel of six European scientists had agreed to conduct the study on the condition that their work remained free of interference from the funding organisations. They reserved the right to publish their findings regardless of the outcome.

Members of the European Working Group on Environmental Tobacco Smoke and Lung Cancer

Professor Jeffrey Idel, Professor in Medicine and Molecular Biology, Norwegian University of Science and Technology, Trondheim;

Professor Hans E. Krokan, Professor of Medicine at the UNIGEN Centre for Molecular Biology, Norwegian University of Science and Technology, Trondheim;

Professor Marcel Roberfroid, Professor in the Department of Pharmaceutical Sciences, Universite Catholique de Louvain, Brussels, Belgium;

Professor Julio Benitez, Head of Department of Pharmacology and Psychiatry at the University of Extramadura, Badajoz, Spain;

Professor PHM Lohman, Professor and Director of Laboratory of Radiation Genetics and Chemical Mutagenesis at the University of Leiden;

Dr Anthony Springall, Fellow of the Statistical Society and an independent consultant in statistics and previous employee of Imperial Tobacco and Unilever

Gordon Mcvie
"I do not think reputable scientists should accept tobacco company money at all"

Trial to Improve Cosmetic Results in Breast Cancer Treatment

The EORTC trial (22881/10882) which has been testing a less aggressive approach than that shown to be effective in women with breast cancers of up to 5 cm has been concluded. The aggressive treatment comprises tumour excision with one or more centimetres free margin, external beam radiation of the whole breast to a dose of 50 Gy and a boost dose of 25 Gy in the tumour area. The trial contained 5553 patients. A further major trial is now in preparation.

Although a previous EORTC study (10801) has shown that high local control can be obtained, equal to that provided by radical mastectomy, for patients with breast cancers up to 5 cm, poor cosmetic results have been seen in part of the treated patient group. The investigators, E. van der Schueren of Leuven and colleagues of the EORTC Breast Cancer Cooperative Group and the EORTC Radiotherapy Cooperative Groups said, "A prospective study is therefore required to investigate the price to be paid for using a less aggressive treatment schedule by reducing the radiation booster dose, in order to improve the cosmetic results. Also, the prospective follow-up of a large number of patients receiving the same therapy with standardised techniques might be extremely helpful in further identifying subsets of patients in whom local treatment can be reduced."

Patients were treated by tumorectomy with a margin of 1-2 cm , followed by external irradiation of 50 Gy in 5 weeks to the whole breast. Patients with a microscopically complete excision were randomised between no boost and 15/16 Gy external irradiation, while patients with microscopically incomplete excision were randomised between a booster dose of 10 and 25/26 Gy external irradiation. Incomplete excision is defined as microscopic invasion of section margins by invasive cancer.

Trials on small breast cancers (< 3-4 cm) comparing combined conservative surgery and irradiation with (modified) radical mastectomy show no difference in patient survival and local control rates. However, the EORTC Breast Cancer Cooperative Group has just finished a 900-patient study, most of them with stage II breast cancer where, in patients with up to 5 cm tumours, radical mastectomy using the aggressive approach described above was compared with breast conservation. Preliminary results suggest equal, very high local control rates in both arms, but poor cosmetic results in some of the breast conservative treatment group.

FECS Board Introduces Major Changes

The Board of the Federation of European Cancer Societies (FECS) met in Brussels on 5 June and reached agreement on a number of important issues that will have a dramatic impact on FECS and its activities in the coming years.

While the European Association for Cancer Research (EACR) and European Society of Oncology Nurses (EONS) have been full members of FECS for many years, neither Society has been able to put forward the name of one of its members for the positions of President, Secretary or Treasurer. These offices have been the exclusive reserve of the three founding member of FECS, viz the European Society of Medical Oncology (ESMO), European Society of Surgical Oncology (ESSO) and European Society for Therapeutic Radiology and Oncology (ESTRO). Realising that the historical reasons for restricting these offices to these Societies no longer applied, the Board unanimously agreed that the articles in FECS constitution restricting EACR and EONS's access to these offices should be revised with the result that EACR and EONS will be able to nominate individ-

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Collective Membership to EACR: Spanish Association for Cancer Research

The first Collective Membership application to the European Association for Cancer Research (EACR) has been approved allowing the 393 members of the Spanish Association for Cancer Research to join the membership. This brings the total membership of the EACR to almost 2000.

The Constitution and Bylaws of the EACR allow for Collective Membership from scientific societies as well as individuals. At EACR-14 in Edinburgh, the terms of admission for scientific societies were decided by the Executive Committee and Council and approved by the General Assembly.

The Executive Committee and Council said, "Cancer research societies in Europe may be admitted to the membership of the EACR. The application is signed by the President of that society. It will be considered by the Executive Committee for approval. Members of the scientific society admitted to the membership of the EACR will become full members of the EACR. All individual members of a cancer society which is admitted to membership of the EACR will automatically become members of the EACR."

Cancer research societies joining the EACR pay an annual fee to the Treasurer of the EACR determined by the number of society members to be admitted multiplied by a minimum of 10% of the individual membership fee for that society. The exact level of the fee is agreed by negotiation.

Juan Carlos Lacal
President of the Spanish Association for Cancer negotiates membership to the EACR.

J.-C. Horiot
ECCO format must change to maintain lead in Europe.

uals at the next elections for these offices towards the end of 1997.

The Board also approved the establishment of a working party to review the current structure of ECCO, the Federation's biennial conference, under the Chairmanship of Professor Jean-Claude Horiot, current President of FECS. ECCO is now over 15 years old and its structure remains that of the first conference held in 1981 in Lausanne. Concerns expressed by participants in recent ECCOs have made it clear that changes must take place if the conference is to continue to meet the needs of those attending it and hold its position as Europe's premier cancer event. The working party will meet in Dijon in November of this year. The members of the working party have yet to be finalised.

The question of the venue for ECCO 11 in 2001 was also addressed by the Board. Two cities submitted applications to host the meeting this year—Barcelona and Lisbon. Following presentations by Dr Miguel Bronchud, on behalf of Barcelona, and Professor Jose Guimaraes dos Santos, on behalf of Lisbon, the Board was in favour of Lisbon, pending a further successful visit to the new conference facilities in Lisbon when they become fully operational in 1998. This is the first occasion when ECCO will be hosted in Portugal.

Finally, FECS is pleased to announce that it has established 20 fellowships for basic scientists, doctors and nurses from the developing countries of Europe to assist them in attending ECCO 9 in Hamburg on 14–18 September 1997. Further details about these fellowships may be obtained from FECS, Avenue E Mounier 83, B-1200 Brussels (Tel: +32 2 775 0201; Fax: +32 2 775 0200) or the secretariats of its full members.

Third Action Plan for Cancer Approved

On 29 March of this year the European Parliament and Council of Ministers approved a third action plan to combat cancer within the framework for action in the field of public health (1996–2000) with a budget of ECU 64 million (*).

The objective of the plan is to contribute towards "ensuring a high level of health protection" and will consist of actions aimed at preventing premature deaths due to cancer; reducing mortality and morbidity due to cancer; promoting the quality of life by improving the general health situation; and promoting the general well-being of the population, particularly by reducing the economic and social consequences of cancer.

Actions to be implemented under this plan and their specific objectives are set out under the headings of:

- data collection and research
- information and health education
- early detection and screening
- training and quality control and guarantees
- establishment of common objectives
- the standardisation and collection of comparable and compatible data on health, including the development and strengthening of the European network of cancer registers
- programmes for exchange of experience and of health professionals and for the dissemination of the most effective practices
- the creation of information networks—European scale studies and dissemination of the results, including support for epidemiological studies focused on prevention
- implementation of pilot programmes and pilot projects
- compilation of reports to monitor the measures taken
- early detection and screening
- exchanges of experience on quality control of the early detection of the disease and the prevention of its development, including palliative methods, and contributions for selecting priorities in cancer research and transfer of basic research into clinical trials.

The European Commission is also requested to ensure that there will be consistency and complementarity between actions to be implemented under this plan and the other relevant Community programmes and initiatives. This will include the biomedical and health research programme under the Community's framework programme for research and the programmes introducing an integrated information network.

Of particular importance will be the establishment of a new Management Committee by the European Commission, consisting of two members designated by each Member State and chaired by a representative of the Commission. The remit of this committee is as yet unclear but the Commission's representative has already been requested to submit to the Committee draft measures for consideration on the rules of procedure; annual work programme indicating the priorities for action; the simplification and improvement of this plan's basic administrative procedures; the arrangements, criteria and procedures for selecting and financing projects under this plan, including those involving co-operation with international organisations competent in the field of public health; the evaluation procedure; the arrangements for dissemination and transfer of results; and the arrangements for cooperating with institutions and organisations that are active in combatting cancer.

In the course of implementing this plan, cooperation with non-member countries and international organisations competent in the field of public health, particularly the World Health Organization and International Agency for Research on Cancer, will be encouraged and implemented. The plan will also be open to participation by the associated countries of Central and Eastern Europe and Cyprus and Malta.

*Decision No 646/96/EC of the European Parliament and of the Council of 29 March 1996 adopting an action plan to combat cancer within the framework for action in the field of public health (1996–2000). *Official Journal of the European Communities L 16.4.96 Luxembourg: Office for Official Publications of the European Communities pp. 9 - 15.*

EORTC's Annual Search for Core Support Funds

Although a large organisation with very important long-term clinical trials to conduct, the EORTC has no guaranteed long-term core support, according to Ann Money-Coutts, secretary of the EORTC Foundation, fund-raising body of the EORTC, and Honorary Member of the EORTC Board.

"We recreate our funding each year. Reserves are absolutely minimal, just 165000 ECU for a multimillion ECU organisation. We have no guarantee from one year to the next that we are going to get the money we need." Although generously supported by national cancer organisations, donations are reviewed year-on year. The EORTC's data centre in Brussels does have a grant from the NCI which is reviewed every 3 years. This is the 27th year the NCI has supported the EORTC.

The EORTC Foundation was established by Royal Decree under the laws of the Kingdom of Belgium. Its Council represents all supporting countries which include the European Community, Norway, Switzerland and Hong Kong. The Honorary President is HM the Queen of Spain and the Chairman is Sir Ronald Grierson.

The main funding for EORTC is received from the national cancer organisations, the U.S. National Cancer Institute with which a close scientific liaison is maintained, and earned income from the EORTC Data Centre including from the European Commission for specific research projects (Quality of Life, Meta-Analysis, Health Economics, Fellowships, etc.) Various contributors have also co-operated with, or supported, combined projects with the pharmaceutical industry. Donations in 1995 were also received from the following: Danish Cancer Society (Denmark), La Ligue Nationale Contre Le Cancer (France), Deutsche Krebshilfe e.v. (Germany), Hong Kong Cancer Fund (Hong Kong), Associazione Italiana per La Richerca sul Cancro (Italy), Kankerbestrijding (The Netherlands), Norwegian Cancer Society (Norway), Liga Portuguesa Contra o Cancro (Portugal), Cancerfonden (Sweden), Schweitzerische Krebsliga (Switzerland), Cancer Research Campaign (U.K.) and Imperial Cancer Research Fund (U.K.).

From The Countries

SPAIN

Drugs From the Sea Show Promise in Cancer

The Spanish biopharmaceutical company PharmaMar (meaning "Sea Pharmaceuticals"), involved in the research and development of new drugs derived from marine organisms, has announced that Phase I clinical studies for its new marine anticancer compound ET-743 have received approval to start in the U.S. and several European countries. ET-743 has shown positive results in *in vivo* xenograft tests, with high activity in melanoma and ovarian cancer, non-small cell lung (NSCL) cancer and breast cancer.

PharmaMar has already started Phase I trials in France, and trials will begin shortly in the U.K. and in The Netherlands. PharmaMar is collaborating with the EORTC for the ongoing coordination and development of the studies in The Netherlands and the U.K.

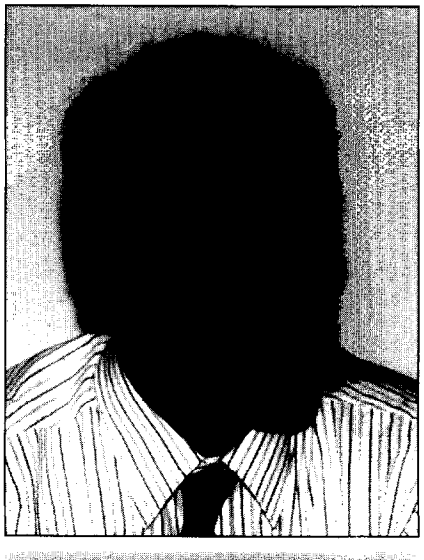
U.K.

Non-laser Photodynamic Therapy

A non-laser lamp to treat skin cancer at one twentieth the cost of laser treatment has been invented by Dr Colin Whitehurst at the Paterson Institute, Manchester, U.K. The device emits an intensive light that in trials has resulted in successful treatment in almost 200 people with a variety of skin cancers and other skin disorders.

An arc of concentrated light is cooled and then channelled through a series of optics. A flexible guide directs this light onto the cancerous skin which has been treated with a photosensitive drug, the porphyrin precursor, 5-aminolevulinic acid. Treatment takes just 45 min, while the patient relaxes and within a few weeks the disease has cleared.

This is a new light source for Photodynamic Therapy (PDT), Dr Whitehurst explains, "Lasers have so far been the best light source available for PDT and many other biomedical applications, but their expense, limited availability and sophistication have severely limited their widespread use. The therapeutic effect of our light source, based on preclinical and patient tests, has been shown to be the same as, or in some cases an improvement over, certain lasers".



Colin Whitehurst
Inventor of lamp that cuts the cost of treating skin cancer.

Dr Colin Morton and Professor Rona MacKie at the University Department of Dermatology at Glasgow's Western infirmary have pioneered treatment using the non-laser light source with good results.

Dr Morton said: "In Glasgow, we have been using PDT to treat patients with early stage skin cancer (Bowen's disease) and basal cell carcinomas. During the past 2 years, we have treated about 165 early skin cancers in over 100 patients using the new lamp with encouraging results."

In one study by Dr Morton and colleagues, the efficacy and suitability of PDT was compared with that of cryotherapy in the treatment of 40 lesions of Bowen's disease. Cryotherapy produced clearance in 10/20 lesions after one treatment, the remaining 10 lesions requiring two or three treatment applications. PDT resulted in clearance of 15/20 lesions after one treatment and of the remaining five lesions after a second treatment. Cryotherapy was complicated by ulceration, infection and recurrent disease. No such complications occurred following PDT.

Trials continue at Glasgow Western Infirmary and Cookridge Hospital, Leeds. Up to April 1996, 180 precancerous and cancerous skin lesions have been treated completely. These treatments are for Bowen's disease, actinic keratoses and basal cell carcinomas.