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International Cancer News

Compiled by Robert Short, News Editor, London

From The Globe

Cancer Survivors get Office of Cancer Survivorship

Professor Anna T. Meadows has been named head of the newly established Office of Cancer Survivorship (NCI-OCS) by Dr Richard D. Klausner, Director of the National Cancer Institute. The office has been designed to explore the physical, psychological and economic well-being of individuals following cancer treatment.

"We need to look at questions beyond the acute diagnosis and treatment of cancer—beyond prevention—and deal with the many research issues that survivors of cancer face in their daily lives so that there will be a better quality of life for all," Dr Klausner said. "Meadows has the experience and the enthusiasm to bring these issues into focus."

The NCI-OCS will explore the concerns facing cancer survivors including long-term medical and psychological effects of cancer treatment, factors that predispose cancer survivors to the development of second malignancies and reproduction and fertility problems following treatment and genetic factors that increase the risk of any of the above concerns.

Professor Meadows is currently a professor of Paediatrics at the University of Pennsylvania Medical School, and since 1989 has been the director of the Division of Oncology at the Children's Hospital of Philadelphia. She directs one of the world's largest paediatric and adolescent oncology services, with 250 new cases seen each year. Professor Meadows will continue her duties at the hospital.

Clinical Trial Information for Patients on WWW

The National Cancer Institute (NCI) has launched a broad initiative in partnership with patient advocate groups to make information on clinical trials available to patients and the public on the World Wide Web.

The information will consist of easy-to-read summaries of the 1500 ongoing trials listed in PDQ, the NCI's online cancer information database. It is designed to help patients make informed decisions about treatment. The initiative comes at a time when there is concern that some managed care organisations are not covering clinical trials as a treatment option.

The first phase of the initiative will be a pilot breast cancer project conducted ▶ ▶ ▶

From Europe

Induction Chemotherapy and Radiation Saves Larynx in EORTC Trial

The larynx can be saved in pyriform sinus cancer by induction chemotherapy followed by radiation. EORTC investigators say this treatment is the new standard treatment in their trials. The EORTC Head and Neck Cancer Cooperative Group published preliminary results of a prospective, randomised EORTC Phase III Trial in the *Journal of the National Cancer Institute* in July [1].

The study population included untreated and operable patients with squamous cell carcinomas of the pyriform sinus or aryepiglottic fold. Induction chemotherapy plus radiation therapy in patients who showed a complete response or surgery in those who did not respond, was compared with conventional treatment (total laryngectomy with partial pharyngectomy, radical neck dissection and postoperative irradiation (50–70 Gy)).

Induction therapy was a bolus intravenous injection of cisplatin (100 mg/m^2) on the first day, followed by infusion of fluorouracil (1000 mg/m^2 per day) on days 1–5. Patients with a complete response after two or three cycles of chemotherapy received irradiation (70 Gy); patients who did not respond had conventional surgery with postoperative radiation (50–70 Gy). Salvage surgery was also performed when patients relapsed after chemotherapy and irradiation.

Only 194 of the 202 patients entered into the trial were eligible for treatment (94 in the immediate-surgery arm and 100 in the induction-chemotherapy arm). In the induction-chemotherapy arm, complete response was seen in 52 (54%) of 97 patients with local disease (primary tumour) and in 31 (51%) of 61 patients with regional disease (involvement of the neck). Significantly, at distant sites in the induction-

jointly with the National Alliance of Breast Cancer Organizations (NABCO). Brief descriptions of PDQ-listed breast cancer trials will be available in lay language on NABCO's home page (http://www.nabco.org).

Says Amy Langer, NABCO's executive director, "An increasing number of breast cancer patients and high-risk women are using the Web. By marketing PDQ and other trial information through our site, we hope to make clinical trials an automatic option to be considered by each woman, her family, and her medical team."

In the next phase of the initiative, the NCI will work with patient advocate groups for other cancers and has already begun plans to pilot clinical trial summaries for brain tumours and prostate cancer.

In the "Trial News" section of NABCO's home page, users will be able to find a current list and brief summaries of ongoing breast cancer clinical trials (organised in risk assessment, treatment and quality-of-life categories – along with the telephone number of a contact. If users want more information about a specific trial, they can click on the link in the NABCO description and be instantly connected to NCI's new clinical trials page (http://cancernet-nci.gov/trials) to get a more detailed description. They will be able to print or download the information for review with family, friends and health professionals.

Although a demonstration version of the service is presently available, the complete listing of more than 150 PDQ breast cancer clinical trail summaries along with search capability should be available at the time this report appears.

chemotherapy arm, there were only 25% failures while there were 36% in the immediate-surgery arm (P=0.041). Said the investigators, "There were fewer distant metastases but, considering the duration of time required to progress to distant metastases, it seemed that these failures had been delayed rather than avoided." Treatment failures at local, regional and second primary sites occurred at comparable frequencies in both arms.

The researchers, Dr Jean-Louis Lefebvre and colleagues for the EORTC Head and Neck Cancer Cooperative Group, observed that the median survival was 25 months in the immediate-surgery arm and 44 months in the induction-chemotherapy arm. Since the observed hazard ratio was 0.86, which was significantly less than 1.43, the two treatments were judged to be equivalent. The investigators write: "The 3-year and 5-year estimates of retaining a functional larynx in patients treated in the induction-chemotherapy arm were 43% (95% CI=31–53%) and 35% (95%CI= 22–48%)" (Figure 1).

The researchers concluded: "Larynx preservation without jeopardising survival appears feasible in patients with cancer of the hypopharynx. On the basis of these observations, the EORTC has now accepted the use of induction-chemotherapy followed by radiation as the new standard treatment in its future phase III larynx preservation trials."

Dr Arlene Forastiere, Johns Hopkins Oncology Center, Baltimore, U.S.A. congratulated the EORTC group in an editorial accompanying the article [2]. "The EORTC trial was well designed and executed. A uniform patient population with respect to site, stage and operability was studied with the use of an optimal drug regimen. Furthermore, the sample size was adequate to formulate conclusions with statistical confidence, even though the trial was closed early after a Data Monitoring Committee review. This is important since so many other randomised trials are inconclusive because of methodologic flaws."

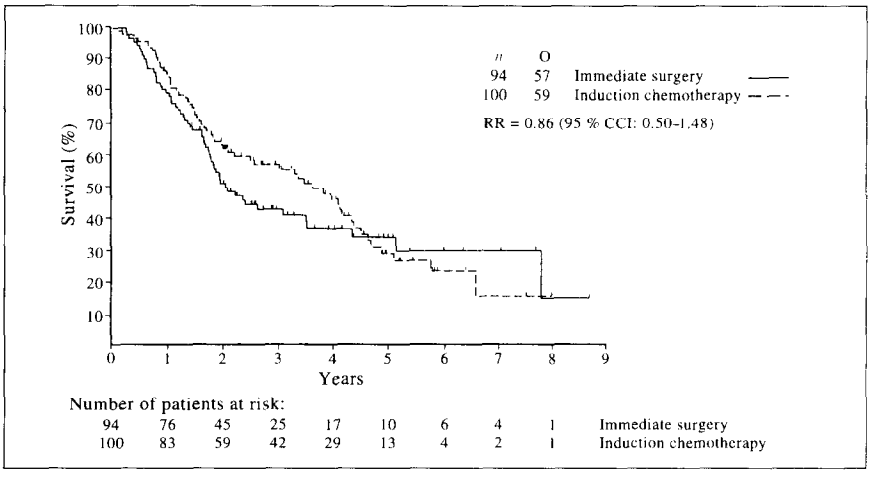


Figure 1. Survival by treatment arm. Surgery arm: median survival=25 months, 3-year survival= 43%. Induction-chemotherapy arm: median survival=44 months, 3-year survival=57% *n*, number of patients; O, observed number of events; RR, relative risk; CCI, corrected confidence interval. Reprinted with permission from Lefebvre J-L, *et al. J Natl Cancer Inst* 1996, Vol. 88, pp. 855–856.

She said, "Our European colleagues are to be congratulated for successfully moving forward with large-scale trials that address multimodality questions. Such trials are essential to ultimately change the standard of care that means improving survival in addition to quality of life."

The EORTC group have together with the EORTC Radiotherapy Group started a randomised study comparing this approach with a combined chemoradiotherapy arm in larynx and hypopharynx squamous cell carcinoma (EORTC 24954) parallel to another randomised trial comparing definitive irradiation with combined chemoradiotherapy (EORTC 22954). A three-arm randomised trial has been in progress since 1992 in the US intergroup for laryngeal cancer comparing the same strategies.

1. Lefebvre J-L, Chevalier D, Luboinski B for the EORTC Head and Neck Cancer Cooperative Group. Larynx preservation in pyriform sinus cancer: preliminary results of a European Organization for Research and Treatment of Cancer Phase III Trial. *J Natl Cancer Inst* 1996, 88, 855–856.

2. Forastiere AA. Another look at induction chemotherapy for organ preservation in patients with head and neck cancer. *J Natl Cancer Inst* 1996, 88, 890–899.

From The Countries

FINLAND

No Survival Benefit with Breast Self-examination in Finnish Women

Breast self-examination does not aid breast cancer survival or significantly increase change of diagnosis of breast cancer. This is the conclusion of Dr Anssi Auvinen of the Finnish Cancer Registry, Helsinki, Finland, and colleagues.

In their prospective study of 604 breast cancer patients diagnosed in 1984–1986 in Finland there were no clear differences in the stage of distribution or cause of death-specific 5-year survival rates between individuals with different breast self-examination practices. No differences in risk of breast cancer death were observed for those who performed breast self-examination monthly as compared to those who did it less frequently or not at all.

Wrote Dr Anssi, "When the method of detection was taken into account, it turned out that only 34 (7.6%) of the 448 regular breast self-examination practisers had actually detected their cancers by means of breast self-examination. Furthermore, no survival advantage was associated with detection of breast cancer by means of breast self-examination." Those breast self-examination practisers whose cancer was detected by the practise had a similar or slightly worse prognosis compared with those whose cancer was detected by other methods. "Our results suggest that breast self-examination practice is not beneficial in terms of breast cancer survival, nor is detection of breast cancer by means of breast self-examination. Conclusive evidence should, however, be obtained from prospective randomised studies of breast cancer mortality," conclude the investigators.

These results compare with Senie and associates [2] in that detection of breast cancer by self-examination is not associated with favourable prognosis. "We suspect that selection bias may be responsible for the apparently improved survival observed among practisers of breast self-examination in earlier studies that did not take into account the actual method of tumour detection," say the investigators. For example, women who practice breast self-examination may be more health conscious than non-practisers, be more likely to participate in mammographic screening and have better access to health services. The investigators argue that because in Finland, screening and healthcare are provided practically free of charge, the effect of selection will be less obvious.

1. Auvinen A, Elovainio L, Hakama M. Breast self-examination and survival from breast cancer: a prospective follow-up study. Breast Cancer Res Treat 1996, 38, 161–168.

2. Senie RT, Lesser M, Kinne DW, Rosen PR. Method of tumour detection influences disease-free survival of women with breast cancer. *Cancer* 1994, 73, 1666–1672.

EORTC Breast Cancer Trial in Recruitment

A phase III randomised clinical trial investigating the role of internal mammary and medial supraclavicular (IM-MS) lymph node chain irradiation in stage II–III breast cancer is now recruiting. The study co-ordinator is Professor H. Bartelink. The study is a joint effort of the EORTC Radiotherapy Cooperative Group and the EORTC Breast Cancer Cooperative Group. As with the highly successful Boost trial by the EORTC, this trial is also seeking to recruit over 5000 patients and will last 5 years.

The trial is to determine the effects of irradiation to the homolateral internal mammary and supraclavicular lymph nodes in patients with operable breast cancer. End points are survival and disease-free survival. Women of less than or equal to 75 years, with unilateral invasive operable non-metastatic adenocarcinoma of the breast will be studied. Surgery should be either a tumorectomy or a mastectomy. Axillary dissection should be performed in all patients.

Previously, some trials had shown a survival benefit from internal mammary node irradiation in axillary node-positive patients, whereas others showed no improvement compared with patients who were not irradiated.

Chest wall and node irradiation after mastectomy in axillary node-positive patients decreases locoregional recurrences. Trials showing this have extended over a long period of time, using various irradiation techniques. The benefit of internal mammary node irradiation has been shown in most recent trials that used modern radiotherapy techniques, whereas this benefit may have been obviated in older trials where cardiac toxicity was higher, because of the technique used.

Said the investigators: "Because opposite interpretations can be made out of these various trials, current treatment policies vary between centres in Europe. Therefore, there is a need to address the specific role of internal mammary and medial supraclavicular lymph node irradiation in a large, multicentre randomised trial." A 5% improvement in survival at 10 years which could be expected from internal mammary and medial supraclavicular lymph node irradiation, would benefit around 7000 patients per year in Europe. Approximately 4700 subjects are necessary to detect a survival benefit of 5%. "On the basis of more than 1000 subjects included per year, the trial will be completed within 5 years," said Professor Bartelink.

ITALY

Interleukin-2 before Surgery Prolongs Survival in Colorectal Cancer Patients

Pre-operative interleukin-2 subcutaneous immunotherapy prolongs survival time in advanced colorectal cancer patients as shown by the results of a study of 50 patients [1]. The study by Dr Fernando Brivio of the Third Division of Surgery at San Gerardo Hospital, Monza, Italy, included patients at Dukes' stage D, who were randomised to be treated with or without IL-2 pre-operatively (18 x 106 IU/

day subcutaneously for 3 days).

After surgery, all patients underwent chemotherapy with 5-FU and folates until disease progression. "Postoperative mean numbers of lymphocytes, T lymphocytes, natural killer cells and activated lymphocytes were significantly higher in IL-2-treated patients than in controls. Moreover, the per cent of lymphocytic and/or eosinophilic tumour infiltration was significantly higher in the IL-2 group than in controls."

They said that both the survival curve and the per cent of survival at 1 year were significantly greater in patients pre-treated with IL-2 than in controls.

"This clinical trial demonstrates that pre-operative IL-2- induced neutralisation of postoperative lymphocytopenia is associated with a prolonged survival time in advanced colorectal cancer patients," write the investigators (Figure 1).

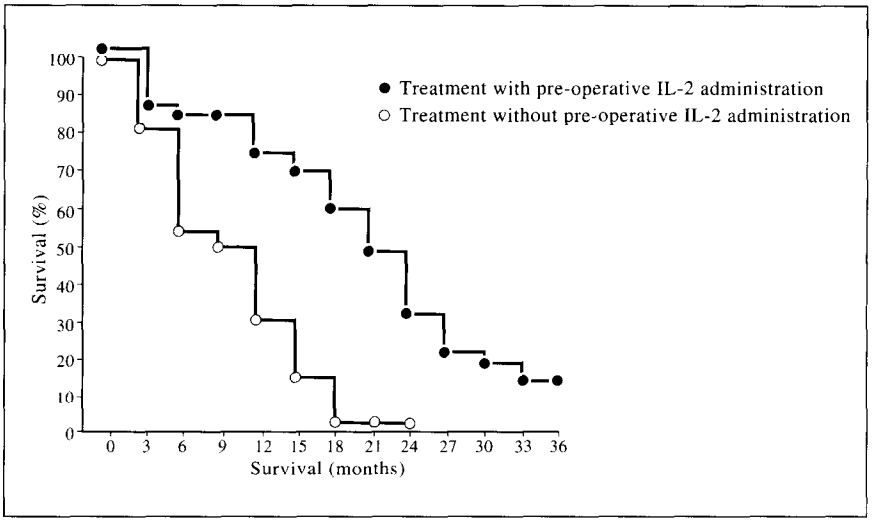


Figure 1. Survival curves in colorectal cancer patients, Dukes' stage D, treated with or without pre-operative IL-2 administration. $P< 0.01$. Reprinted with permission from Brivio F, *et al.*, *Oncology* 1996, *53*, 263–268.

1. Brivio F, Lissoni, Alderi G, Barni S, Lavorato F, Fumagalli L. Preoperative interleukin-2 subcutaneous immunotherapy may prolong the survival time in advanced colorectal cancer patients. *Oncology* 1996, 53, 263–268.

SWITZERLAND

Swiss Plan Fight Against Breast Cancer

Two Swiss cancer institutes have produced a document to guide politicians, patients' groups, clinicians and other health professionals on Swiss needs to combat breast cancer.

Switzerland has one of the highest incidence and mortality of breast cancer in Europe. These are far greater than predicted by the known North–South gradient that exists (the further North the higher the incidence and mortality tends to be). Approximately 3 500 women are diagnosed with breast cancer and about 1 600 die of it a year in Switzerland. Incidence is comparable to Northern Europe and North America.

The Swiss Federal Office of Public Health and the Swiss Cancer League decided to establish a National Cancer Control Programme in Switzerland, as recommended by the World Health Organisation. "A working group of specialists in cancer research and cancer prevention was established which agreed on promoting long-term strategies to reduce breast cancer incidence and mortality, to improve quality of life, and to make prevention and treatment facilities accessible to all women," according to Professor Thomas Zeltner, Director of the Swiss Federal Office of Public Health.

The Swiss Federal Office of Public Health and Swiss Cancer League have produced a brochure overviewing present knowledge in breast cancer and looking at the measures the country could take to deal with its prevention and treatment [1]. "Scientific contributions from all domains in breast cancer control have been summarised in a concise form with the goal of guiding future actions of politicians, patients' groups, clinicians and other health professionals," said Professor U. Metzger, President of the Swiss Cancer League. Similar publications are planned in the fields of lung cancer, colon cancer and skin cancer among others.

Age is the strongest risk factor in breast cancer. "Over the past four decades, breast cancer mortality has slightly increased in women over 65 years of age. Since 1980, the overall mortality rate has remained fairly stable, and in recent periods, has even decreased in younger age groups," said Professor F. Levi, Registre vaudois des tumeurs, Institut universitaire de medecine sociale et preventive, Lausanne. Incidence increases constantly with age up to perimenopausal years. After that, the incidence rate increases less steeply. Over 60% of all cases of breast cancer are diagnosed in women over 60 years of age.

Systematic screening a must in Switzerland

Dr C. Bouchardy, Registre Genevois des Tumeurs, Geneve, considered how prevention and early detection should be developed in Switzerland. Her recommendations were to promote systematic mammographic screening programmmes, according to established European guidelines and at no cost to the women involved; and inform women and medical practitioners about familial risk, but perform genetic screening only as part of a multidisciplinary research approach.

She said that unsystematic screening at present would have to be replaced by systematic screening. "Only systematic screening can be effective. Randomised trials suggest that women who refuse screening may have a higher risk of getting breast cancer and of dying from it. Programmes should therefore give high priority to attracting women who would usually refuse screening for breast cancer. Furthermore, a screening programme must be easy, inexpensive, effective and friendly."

Mammographic screening is at present the sole preventive measure that can reduce mortality from breast can-

cer. Since 1994, recommendations for mammographic examinations have been available from the Swiss Cancer League. Internationally, systematic mammographic screenings at well defined intervals in women aged 50–70 years have been shown to reduce mortality by 17–35%.

In Switzerland, ultrasound examination of the breasts is needed in a third of women screened to eliminate uncertainties in the diagnosis of a palpable lump. Sonography has disadvantages, but can detect non-palpable breast cancer and has been recommended as the primary imaging technique in women under 30 years of age who have breast problems (because of the higher density of the breasts and a greater susceptibility to radiation-induced malignant tumours in this age group).

Health insurance and cancer

According to Dr C. Hürny, Medizinische Abteilung, C.L. Lory-Haus, Inselspital, Universitat Bern, Bern, and colleagues, the social security network (health and disability insurance schemes) has many limitations for women with breast cancer.

The basic health insurance scheme in Switzerland will now—since early this year— pay for stationary and ambulant medical therapy for an unlimited period as well as specified mediations and laboratory analyses. "The basic health insurance scheme covers almost everyone who lives in Switzerland. Treatment procedures not yet proven in clinical trials as well as some preventive measures like mammography must be funded by patients themselves, unless paid for by a supplementary insurance plan," writes Dr Hurny. Health insurance companies also cover medically indicated psychotherapies. "The basic health insurance plan poses no major problems for cancer patients, but they may be at a disadvantage if their income is low or if they change insurance company. The new law will allow everyone to change their basic health insurance scheme without any payment losses."

1. Rajower I, Sasco A J, Kleihues P. Breast Cancer: Basic Facts and Need for Action. Swiss Federal Office of Public Health and Swiss Cancer League, Berne, 1996.

• SPECIAL REPORT •

ECCO 9: New Format for Europe's Number One Cancer Conference

ECCO—the European Cancer Conference—has been restructured to enhance its usefulness to cancer professionals in 1997. From 14–18 September 1997, doctors, basic research scientists and nurses will gather in Hamburg for what has become Europe's premier oncology event—ECCO 9. ECCO 8 organised in Paris in October 1995 was attended by nearly 8000 delegates from 112 countries. ECCO 9 is expected to attract at least the same number.

ECCO is organised every 2 years by the Federation of European Cancer Societies (FECS) for and on behalf of its full members— European Association for Cancer Research (EACR), European Oncology Nursing Society (EONS), European Society of Medical Oncology (ESMO), European Society of Surgical Oncology (ESSO), European Society for Therapeutic Radiology and Oncology (ESTRO) and the European Branch of the International Society of Paediatric Oncology (SIOP Europe).

NEW FOR ECCO 9

Scientific Programme

Under the Chairmanship of Professor Timothy Cooke (Chairman of Scientific Programme— Basic Science/Medicine) and Ms Kathy Redmond (Chairman Scientific Programme— Nursing) the scientific programme at ECCO 9 will differ from previous ECCOs in the following ways:

• With a view to enhancing the unique multidisciplinary focus of ECCO, the conference programme has been structured in such a way as to present on a single or consecutive days overviews and updates on specific organs and diseases. This will allow participants greater flexibility in planning and organising their time at the conference;

• Furthermore, ECCO 9 will provide a forum for the European Society for Psychosocial Oncology (ESPO)—an affiliated member of FECS—the European Organisation for Research and Treatment of Cancer (EORTC), the European School of Oncology (ESO) and the American Society of Clinical Oncology (ASCO), to report and promote their activities;

• For the first time, FECS will use ECCO 9 to organise joint symposia with the European Commission's 'Europe Against Cancer' Programme and the Association of European Cancer Leagues;

• The nursing programme will offer a number of interactive sessions addressing a wide range of issues applicable to cancer nursing today, at the advanced and general level. Thanks to generous sponsorship, simultaneous translation into German will be available for all of the plenary sessions in the nursing programme while each afternoon, one workshop will be held in German.

Let the Internet Take the Strain–Consult ECCO 9 on http://www.fecs.be

The FECS website includes an electronic registration form which makes it possible to preregister via the Internet. Simple instructions will also enable authors to send their abstract form via the Internet.

Twenty New Fellowships

FECS will award 20 fellowships to basic scientists, doctors and nurses from certain countries of Europe to attend ECCO 9. The terms and conditions regulating the award of these fellowships can be obtained from the address

at the end of this report.

As well as these new features, a number of important scientific events that have become a regular occurence at ECCO will be repeated at the Hamburg conference.

Award Lectures

The FECS Clinical Research Award Lecture will be presented and the commemorative medal conferred at the Opening Ceremony on Sunday 14 September 1997. Later this year, the selection process to find the best candidates will begin, and the name of the winner of this distinguished FECS award will be known in the summer of 1997.

Each full member society will be allocated a plenary session for the delivery of their own award lecture during which any award will be conferred.

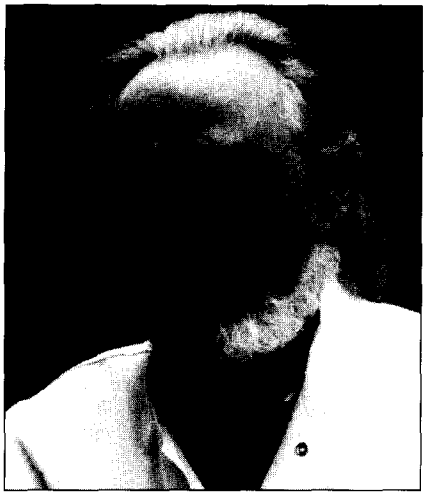
Plenary Lectures Basic Science/Medicine

B. A. J. Ponder: Cancer—Predisposing genes.
J.-.C Horiot: Fractionation in radiotherapy—Benchmark for the future?
H. Bismuth: Surgical management of cancers of the liver.
F. Berrino: Survival of cancer patients in Europe.

Nursing

P. Di Giulio: Evidenced-based cancer nursing practice—Does it exist?
L. Due-Madsen: Implementing palliative care strategies in an acute cancer setting.
K. Redmond: Nursing diagnoses—Benefit or burden for cancer nurses?
A. J. H. van Boxtel: Home sweet home! Home care technology for patients with cancer or infectious diseases.

Further information about ECCO 9 can be obtained by contacting the ECCO 9 Secretariat, Federation of European Cancer Societies, Avenue E. Mounier 83, B-1200 Brussels, Belgium (Tel: +32 2 775 0201; Fax: +32 2 775 0200; e-mail: r.kettunen@fecs.be or http://www.fecs.be)



Professor Jean-Claude Horiot
President of FECS

Professor Christian Herfarth
Chairman of ECCO 9

Ms Kathy Redmond
Chairman ECCO 9 Scientific Committee—Nursing

Professor Timothy Cooke
Chairman ECCO 9 Scientific Committee—Basic Science/Medicine

ECCO 9 Dates to Remember

Deadline early registration	1 February 1997
Deadline submission of abstracts	15 February 1997
Deadline application for FECS fellowships	15 February 1997
Deadline registrations to ECCO 9 Secretariat in Brussels	1 September 1997
On site registration	14-18 September 1997