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## Meeting Highlight

# Surgeons and Radiotherapists Show 'Adverse Reaction' to Drugs—A Report on ECCO9 14–18 September 1997, Hamburg, Germany

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THERE WAS a remarkable announcement at ECCO9. Results of two EORTC randomised clinical trials (22791 and 22851) showed conclusively that 'new treatments' could significantly increase locoregional control and significantly improve progression-free survival of adult cancer patients with a previously poor prognosis. The 'new treatments' were accelerated and fractionated radiotherapy and the cancer was advanced head and neck cancer. As stressed by Professor Horiot (Dijon, France) in his presentation, these results are the best for any treatment strategy in this disease for over a decade—a 15–20% increase in locoregional control. It was, therefore, remarkable that the dissemination of these results was relatively low key—there was no mass media coverage and indeed the studies were not even mentioned as 'Highlights of the day' in the media information at ECCO9. Professor Horiot was perplexed as to why such impressive results have not led to a demand for more intensive worldwide research, with enthusiastic financial support. He asked 'Would it be different if the new treatment was a drug?' There is the distinct possibility that any drug able to achieve similar results as achieved with hyperfractionated or accelerated radiotherapy would be backed by the full marketing force of a pharmaceutical company and would very quickly be brought, not only to the attention of the medical community, but also to the public—probably misleadingly presented in the mass media as the next 'great breakthrough'.

Generally, anticancer drugs produce modest results—responses not cures in most cancers (especially epithelial neoplasms)—but nevertheless they maintain a high profile, as was evident at ECCO9. This paradox, whereby chemotherapy, although the least effective of the three mainstays (surgery, radiotherapy and chemotherapy), is given the greatest prominence, was emphasised by Professor Mattheiem (Brussels, Belgium). Seventy per cent of all patients with solid tumours are primarily treated by surgeons, with more patients cured by surgery alone than by any other single or combined treatment modality and yet surgical contributions to ECCO9 only constituted around 5–10% of abstracts compared with around 30–40% on chemotherapy. Is this a reflection of the greater research activity of medical oncologists or of increasing pharmaceutical company sponsorship of the conference, both through the exhibition and by funding participants' attendance? According to FECS, the number of participants sponsored by industry has become so large, that it is difficult for FECS to determine the percentage of participants in any particular speciality as sponsored participants apparently do not disclose their area of expertise. The message from the Chairman of ECCO9, Professor Herfarth, stated that 'ECCO represents...the widest possible spectrum of opinion and debate currently represented in the cancer community of Europe', but in fact there was a general feeling at ECCO9 that it is in danger of being taken over by the pharmaceutical industry.

With so much drug-related work presented at ECCO9, it was disappointing that there seemed to be so few promising, new treatments. Interesting research on relatively new and potentially promising agents, such as the camptothecins, oxaliplatin, matrix metalloproteinase inhibitors and anti-angiogenics, was presented, but, for the present, the next major breakthrough seems elusive. However, while 'waiting for the breakthrough', it was clear that consolidation of current treatments has taken centre stage and important research is being conducted into optimising available therapies and methods, such as modulating toxicity profiles, thereby improving not only patient outcome, but also patients' quality of life.

To this end, many studies were presented which sought to minimise side-effects. In a French co-operative, prospective clinical trial in patients with established, severe, radiation-induced xerostomia, 70% of patients given pilocarpine reported significant relief of symptoms within 12 weeks of treatment. It appears that pilocarpine stimulates ectopic salivary glands outside the radiation area. The number of patients for whom food consumption was nearly impossible decreased by almost 40% and the number with normal consumption almost doubled, so indicating an important improvement in the quality of life for these patients.

Quality of life was also examined in an extraordinary study by Dr Faithful (Sutton, U.K.) on the effects of supportive care. In a randomised clinical trial, men who had received radiotherapy for bladder or prostate cancer (40–60% of whom suffer subsequent acute toxicity) were provided with either conventional management or a focused approach by a nursing specialist. Those given supportive care actually had

significantly less bladder and bowel morbidity, with better physical functioning and recovery and improved satisfaction with their care. To add to these remarkable results, there was the additional benefit of a 15% cost saving! It is fascinating that patients' quality of life can be improved at a reduced cost without adding a single drug.

One of the great success stories is the treatment of Hodgkin's disease and the late effects seen in survivors, particularly a second cancer of the lung, are considered the price of success. However, at Stanford University School of Medicine, U.S.A., a retrospective analysis of 2391 patients who received therapy between 1961–1993, with a mean follow up of 10.6 years, produced an interesting observation. 41 patients (relative risk 8.96) developed lung cancer, 40 with tumours in the irradiated field, so indicating that limiting the irradiated lung volume could reduce the risk of lung cancer. However, it was startling that 38 (93%) of these patients had a history of cigarette smoking, 33 with more than 10 pack years. Thus, by simply avoiding smoking cigarettes, Hodgkin's patients could reduce their subsequent risk of lung cancer following therapy.

There were many other presentations on optimising patient treatment, but perhaps the most impassioned was that of Professor Mattheiem in his ESSO Award lecture. He stressed the fact that, while medical oncology is a recognised speciality in medicine, with the availability of appropriate specialised training and certification, surgical oncology is not—it is still considered part of general surgery, so specialised training is generally unavailable. He admitted that many surgeons and surgical organisations had contributed to this state of affairs. Yet the survival of most cancer patients and, indeed, the efficacy of adjuvant treatments, are completely dependent on the effectiveness of the primary surgical intervention. Professor Hohenberger (Erlanger, Germany) presented evidence showing that for colorectal cancer patients, treated in seven different German institutions and followed up for at least 5 years, not only was the institute a prognostic factor, but in three institutes in which more than 100 operations were performed, individual surgeons could be identified as a prognostic factor. As he said 'it seems important for surgeons to have a certain amount of experience, and a special interest in the field may be a basic requisite for good outcome'. Similarly, Professor Büchuer (Bern, Switzerland) also showed data where a significant reduction in mortality from major pancreatic resections for cancer could be related to the fact that the patients were receiving pancreatic surgery in a specialist centre with a standardised operative technique combined with experience. These studies highlight the fact that while steps have been taken to ensure that a cancer patient only receives chemotherapy from someone specially qualified to administer the drugs, the same attention does not seem to have been paid to who operates on the patient.

Quality assurance of cancer treatment was a major issue at ECCO9 and Professor Horiot, the President of FECS, stated that 'one of the prime missions of ECCO9 is to ensure that everyone in Europe receives the same high standard of treatment'. The recognition of surgical oncology as a speciality or at least the adoption of generally feasible surgical standards would be a step towards this goal—perhaps between them FECS, ESSO and the EORTC will achieve this by ECCO10.