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NEWS...NEWS...NEWS

ECCO 11—the European Cancer Conference, Lisbon, Portugal, 21–25 October 2001



Award-winning highlights

All ECCO-11 abstracts were entered for a joint FECS/EJC award. The four finalists made short presentations to a panel, and the award was won by Professor Cornelis van de Velde, chairman of the Dutch Colorectal Cancer Group.

Professor van de Velde's talk focused on a nationwide prospective trial between 1996 and 2000, which compared TME alone for patients with rectal cancer with pre-operative radiotherapy followed by TME.



Professor Cornelis van de Velde

Surgeons were trained to identify and preserve nerves and quality control was strict. Preoperative radiotherapy reduced local recurrence, but only where the circumferential margin was greater than 1 mm. It increased male impotence and decreased short-term quality of life, but patients at interview said they would prefer to have it.

The results proved that patients' prognoses can be predicted by macro-

scopic analysis and that pathologists have an important audit role in rectal cancer surgery, said Professor van de Velde. He concluded that quality

"QUALITY CONTROL HAS CHANGED THE TREATMENT OF RECTAL CANCER"

control measures had changed the diagnosis and treatment of rectal cancer in The Netherlands.

Second prize went to Dr Linnebacher (Germany), who outlined a possible new treatment strategy. In tumours exhibiting microsatellite-instability (MSI), frameshift mutations can produce truncated proteins, some of which are potentially immunogenic. Dr Linnebacher described a genome-wide search for coding microsatellites, which led to the identification of potentially useful frameshift mutations. Researchers generated cytotoxic T lymphocytes which recognised HLA-A2.1 restricted peptides derived from the frameshift sequences. Of 16 frameshift peptides identified, four lysed specific target cells. The frameshift peptides could "represent novel MSI-tumour specific antigens," he said.

Professor J. Bernier (Switzerland) and Mr C. Bailey (UK) tied for third place. Professor Bernier presented the results of an EORTC trial in patients with locally advanced head and neck carcinomas (trial 22931). It included 334 patients who received primary surgery with curative intent. They were then randomised to receive radiotherapy with or without concurrent cisplatin. Patients who

received both treatments had significantly longer disease-free survival, overall survival, time to progression and local control. However, there were also more grade 3 or 4 functional mucosal reactions. Longer follow-up will be required to determine some endpoints, such as the time to the development of second tumours, and for late effects (see *EJC Special Issue on Chemoradiotherapy*, 2002, **38**(2)).

Mr Bailey and colleagues examined whether age determines treatment choice in patients with colorectal cancer. They interviewed 337 patients aged between 58 and 95 years, and found that older patients with Dukes' C, particularly those aged over 75 years, were less likely to receive adjuvant chemotherapy, is regarded as the standard treatment. Patients who received this treatment were more likely to have access to help during their illness and less likely to be impaired in their capacity for self-care. Mr Bailey concluded that the likelihood of age influencing treatment decisions is "a cause for concern" as these patients are "less likely to receive a potentially curative treatment". It also raised the question of whether the level of support provided to patients without resources is adequate, he said.

Emma Cannell

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Tobacco control

Political corruption is behind the lack of action in almost every parliament in the world to control tobacco, said Dr Nigel Gray (European Institute of Oncology, Milan, Italy). Smaller countries like Finland, Norway and Australia have banned tobacco advertising and introduced widespread education campaigns, taxes, and smokefree workplaces. Their death rates are declining. However, large countries like the US are ignoring these strategies, and Dr Gray said, "Corruption is so blatant that it's not even perceived as corrupt."

Tobacco companies contributed US\$6 million in the last election and he warned "Those contributions were not made for altruistic reasons."

The waiting game

Waiting a few days for the results of diagnostic tests in breast disease may help women come to terms with a diagnosis, Dr Karen Poole (Institute of Cancer Research, London, UK) said. She challenged the assumption that speedier diagnoses are psychologically beneficial. Interviews with 98 women revealed that the wait gave them time to reflect, adapt to the possibility of having cancer, and think of questions to ask.

AIDS "may dwarf tobacco as killer"

AIDS is beginning to "dwarf tobacco" in terms of potential years of life lost, since it mostly kills young people, Professor Robin Weiss (University College, London, UK) told the conference. In sub-Saharan Africa, it is now the most common cause of cancer. The doubling of cancers in those aged less than 60 years over the past 20 years is almost entirely attributable to AIDS, he said. The United Nations (UN) estimates that 24 million have died from AIDS since 1981.

Only selected tumours, the so-called AIDS-defining conditions, have markedly increased in incidence. These include Kaposi's Sarcoma (KS), non-Hodgkin's lymphoma (NHL) and cervical cancers. There is also a slight increase in anal cancers and Hodgkin's disease. These are all opportunistic cancers, often associated with a virus, but strangely the incidence of liver cancers has not markedly increased, even though many patients are infected with hepatitis B or C. The reasons for this are unknown, but Professor Weiss speculated that it could be due to immunological differences in the pathogenesis of liver cancer (see *EJC* 2001, **37**, 1202–1208).

Until the advent of the AIDS epidemic, 'classical' KS was considered a rare tumour of elderly men. The herpes virus associated with it, KSHV (HHV-8) was identified in 1994, and more recent work by Dr Fleckenstein reported, using studies of a major immunogenic structural protein of KS, K8.1, a viral incidence of between 3.5 and 4.4% in the general population which fits the pattern of KSHV being the causal agent of KS.

KSHV exhibits a latent phase during which only a small number of genes are active and investigators are trying to determine how these genes contribute to its oncogenic properties. These properties may be derived, in part, from the 'molecular piracy' that is exhibited by KSHV; it can mimic several cellular genes such as a viral cyclin gene, a viral bcl-2, viral MIPs and a viral IL-6.

Current therapies for KS, such as Highly Active Anti-Retroviral Therapy (HAART), target HIV rather than KSHV. For the future, researchers are looking at removing tat, a co-mitogen, which could reduce KS.

Emma Cannell

Second cancers among childhood survivors

American doctors are being sued by survivors of childhood cancers when they develop a second cancer, according to Professor Alan Craft (Newcastle University, UK). Chairing a session at ECCO-11 (Overview of secondary cancer after childhood malignancies), he said it made the question of what to say about the risks of a second tumour before treatment particularly relevant.

Survivors of childhood cancer have up to six times the risk of developing a second cancer later on, compared with the general population, according to Dr Jorgen Olsen (Institute of Cancer Epidemiology, Danish Cancer Society, Copenhagen). Population-based studies from Scandinavia, the UK and the US, based on almost 1000 cases of a second primary cancer among long-term survivors, show that the excess risk after 20 years of follow-up is 2.5–3%, compared with 0.5% in the general population.

The vast majority of the excess cancers were induced by radiotherapy and chemotherapy directed against the first cancer, but he stressed, "This should not overshadow the massive survival benefits arising from modern childhood cancer treatment".

Professor Herbert Jürgens (Westfälische Wilhelms-Universität, Münster, Germany) said his patients receive a consent form which discusses infertility and second tumours. However, when later the families are asked what they remember of this information, the amount they retain is typically less than 5%.

Early onset breast cancer is an important problem among female survivors of Hodgkin's disease. The risk of a second primary breast cancer is 15–20 times that in the general population and about 15% of these women will have developed breast cancer before the age of 50 years.

Professor Jürgens said that early diagnosis of breast cancer is essential and raises the question of what follow-up these patients should be given. However, Professor Michael Stevens (University of Bristol, UK) said it is important not to enhance the possible genetic predisposition of patients with the use of screening procedures.

Furthermore, some families are already tremendously anxious and doctors should not add to this, said Dr Jillian Mann (The Children's Hospital, Birmingham, UK). Clinics are being developed to offer screening to families with cancers and allow pedigrees to be built up, but not all wish to be screened and this must be respected. Psychological help should also be available for those who wish to be screened, she said.

Emma Cannell

EUROFILE

Privacy and cancer registries in Europe

Ethicists and researchers traditionally hold conflicting viewpoints, but in relation to cancer registries, they are approaching a showdown. On one side, libertarians argue that patients have an absolute right to autonomy over their personal information. On the other, researchers argue that the public interest is best served by collection of complete, population-based unbiased information. This is translating into a dogfight over whether or not doctors must obtain patients' specific consent before notifying cancer registries.

Until now, each European country has decided for itself how to balance these interests and laws governing medical confidentiality and ethics differ widely. Most of the Nordic countries have a legislative framework to protect cancer registries and have developed some of the most complete and useful registries in the world. Elsewhere, the picture is more patchy. Germany, for example, has some of the tightest confidentiality laws in Europe and as a result, researchers say, registries and clinical and public health research have suffered. Delegates at ECCO-11 called for European legislation to create a uniform situation, protect cancer registries and safeguard invaluable epidemiological research.

The debate is hottest in the UK, where cancer registries have enjoyed relative freedom from confidentiality laws. This recently changed. The Data Protection Act was passed in 1998 and, in November 2000, the General Medical Council (GMC), which regulates doctors' conduct, issued a statement saying that where named or identifiable data is needed, doctors should seek consent, orally or in writing, from patients. In Hamburg, this requirement led to a maximum of 70% of cancer patients being included on registries.

After objections from the UK Association of Cancer Registers, the GMC granted a moratorium until new legislation is passed under the Health and Social Care Act, due in 2002. The GMC accepted that doctors may be

unable to obtain specific consent when releasing information to cancer registries. "We will, nonetheless, expect doctors to make every effort to ensure that patients are informed about the release of such information to cancer registries," it stated.

Professor Julian Peto (Institute of Cancer Research, London, UK) said that European legislation is urgently needed. The Data Protection Act in the UK is "rendering what we do illegal", he said. "It has absolutely no support from anybody except professors of medical ethics. The public doesn't want

"THE GENERAL POPULATION WANT US TO HAVE THEIR DATA"

it, cancer patients don't want it. When you ask the general population they're astonished and disgusted to learn what is going on under the guise of ethics. They want us to have their data."

Dr Monica Roche, (Oxford University, UK) Chair of the UK Association of Cancer Registries, said that as long as the 2002 legislation is suitable, the UK situation will be resolved. However, she warned that it will have to be passed by Parliament, where a strong privacy lobby "finds it hard to understand that we need an unbiased, complete database." Since the Data Protection Act was passed, some doctors and hospitals have stopped notifying registries about cancer cases. Many are stockpiling information and have agreed to hand it on once the situation is clear. "But if this continues very much longer we could find there is irreparable damage to the registries," she said.

Professor Dieter Hossfeld, President of the Federation of European Cancer Societies said that paranoia about data protection had prevented the formation of a national cancer registry in Germany. The situation there is a 'catastrophe', he said.

But Dr Jan Willem Coebergh, Chair of the European Network of Cancer

Registries, is pragmatic. Some parliaments may be reluctant to make an exception for cancer registries which could provide a precedent for other chronic diseases, and in effect give researchers carte blanche on the use of patient data. However, requiring specific consent is neither viable nor ethical: people given a diagnosis of cancer have too much to think about to be concerned about the needs of a cancer registry. But there may be a middle way.

In The Netherlands, patients can opt out of having their data passed on in coded form. Doctors can notify registries of cancer cases without specific consent from individual patients as long as information on cancer registries is freely available and prominent in patient leaflets and waiting rooms. "As long as the registries are well-publicised, hospital doctors can assume that people have given their consent to be included. All the information states that they may refuse and opt-out." The Netherlands' code of

"ANY DISTRUST AMONG THE PUBLIC TRANSMITS ITSELF TO POLITICIANS"

conduct is to be made available to FECS and all its participating societies.

Confidentiality and data protection have implications for tumour banks and biological research, but in the end, to Dr Coebergh, much of the debate comes down to trust and transparency. "The point is really how to ensure that the public is well-informed about research. We need to create and maintain confidence because any distrust among the public transmits itself to politicians. Politicians tend to assume that researchers are simply defending their own interests so the pressure needs to come from patient groups and the public. We need a long term strategy of information."

Helen Saul

AWARDS AND APPOINTMENTS

Societies present awards at ECCO-11

FECS

Professor Umberto Veronesi, (Milan, Italy) was presented with the 2001 FECS-Pezcoller Recognition for Contribution to Oncology. Professor Veronesi, who founded ESO and is a former president of UICC, EORTC, FECS and EUSOMA, was most recently Italian Minister for Health. He received his medical degree from University of Milan in 1951.

Professor Veronesi pioneered conservative treatment of breast cancer and was honoured for his “unique contribution and for dedication of his professional life to the improvement of cancer research, treatment and care.” Presenting the award, Professor Dieter Hossfeld, president of FECS, said his work has consequences worldwide and had led to an “enormous increase in the quality of life of our patients.” Professor Veronesi’s talk on sentinel node biopsy and intra-

operative radiotherapy concluded that this approach allows doctors to give their patients “a more optimistic image” of breast cancer (see *EJC* 2001 **37**(17) 2178–2183 and 2143–2146).

SIOP

The European branch of the International Society of Paediatric Oncology (SIOP Europe) presenting its 2001 award to consultant endocrinologist, Professor Steve Shalot (Manchester, UK). “His work on growth and pituitary function after cranial radiation is of international renown and the results of his careful investigations have fashioned the approach taken to the care of children with cancer worldwide. The implications of his work for the adult survivor of cancer in childhood are of the greatest importance,” according to SIOP Europe.

ESTRO

The European Society for Therapeutic Radiology and Oncology (ESTRO) conferred its Klaas Breur Award on Professor Jean Marc Cosset (Paris, France) in recognition of “his distinguished contribution in the field of radiation oncology and his con-

tinuous support of ESTRO actions”. He is head of radiation at the Institut Curie and has been involved in pivotal clinical trials on lymphoma. He is an expert in accidental irradiation and gave his talk on ‘Positive aspects of irradiation accidents’.

EONS

Ms Kathy Redmond (Milan, Italy) received the Distinguished Merit Award from European Oncology Nursing Society (EONS) for “her efforts to further the speciality of cancer nursing”. Dr Agnes Glaus (St Gallen, Switzerland) presented the award and described her as “a very special, committed and truly European Cancer nurse”.

Ms Redmond has been a member of EONS since 1988 and was President from 1993 to 1997. She trained at St Vincent’s Hospital in Dublin, Ireland, and at University of Surrey, UK. She has been a member of the Board and Council of FECS and of the scientific committee of ESO. She served on the Irish National Forum on Cancer Services. Ms Redmond

said the Distinguished Merit Award is the most important professional honour she has received.



Ms Kathy Redmond

EACR

The 2001 Young Cancer Researcher Award award, for “an outstanding contribution in the field of fundamental research in cancer” went to Dr Akseli Hemminki (Birmingham, Alabama, USA). Dr Hemminki studied at



Dr Akseli Hemminki

the University of Helsinki, and as a medical student, he identified the gene (19p) for Peutz-Jeghers polyposis syndrome (PJS), a cancer susceptibility syndrome affecting multiple human organ systems. (see Review, *EJC* 2002, **38**(03))

He moved to the University of Alabama in January 2000.

ESSO

Professor Toni Lerut (Catholic University of Leuven, Belgium) won the 2001 award “in recognition of his far-reaching achievement in the field of thoracic and oesophageal cancer surgery. Professor Lerut serves as an example of a cancer surgeon who achieves optimal results in research and clinical practice by merging an organ oriented approach with the typical disease oriented knowledge and attitude of surgical oncology,” according to ESSO.

He is and has been a Board member of many national and international organisations, including a term as President of the Royal Belgian Society for Surgery. He was a member of the executive committee of ESSO from 1994 until 2000.

INTERVIEW

Professor Harry Bartelink is Chairman of the Radiotherapy Department at The Netherlands Cancer Institute and Professor in Clinical Experimental Radiotherapy at both the Free University and the University of Amsterdam. He is President of ESTRO and President Elect of FECS. He was a member of both the Executive Committee and the Scientific Committee at ECCO 11.



Professor Harry Bartelink

Where did you train?

I trained in medicine and radiotherapy at Nijmegen, Holland. I took further training at the Institute Gustave Roussy, Paris and had two separate sabbaticals at Stanford University, Palo Alto, USA.

Who inspired you?

The late Professor Klaus Breur at The Netherlands Cancer Institute inspired me to combine clinical care of patients with laboratory research, and that's the path I have followed.

Why did you choose to work in the field of cancer?

I wanted to work with people with real problems and problems don't come much more real than cancer.

Did any other branch of medicine appeal?

I originally thought I wanted to be a family doctor and I worked in general practice for 3 months. But I felt I wanted to do more than prescribe medicine.

Might you have done something else altogether?

I was interested in physics, mathematics and biology and found it hard to choose between them. I went into medicine so that I could combine them all.

What has been the highlight of your career to date?

A laboratory research-inspired project in 1992, using concomitant cisplatin and radiotherapy to treat inoperable non-small cell lung cancer. It was based on animal work I did at Stanford and it improved both local control and survival. It was confirmed in 1999 by five studies in the States and it's very satisfying to be 7 years ahead of the Americans!

Another highlight was when, as chairman of the EORTC radiotherapy group, we carried out the first study comparing mastectomy with breast conserving therapy in large tumours. We showed that survival was equivalent in both groups. However we also found a large difference in local control among participating institutions. Our next study, which will be published soon, was one of the largest breast cancer studies in the world and included 5569 women. We showed that optimising radiotherapy has a dramatic effect on breast cancers up to 5 cm. High doses halved the local recurrence rate among young women, it's extremely important. Also, the difference between institutions was minimal, due to strict quality assurance procedures.

... and your greatest regret?

That I did not spend more time in the laboratory after I specialised. It's where I was happiest and most productive. The premature death of Klaus Breur meant that I took on managerial responsibility 10 years earlier than I might have done.

If you could complete only one more task before you retire, what would it be?

To see the results of molecular biology implemented in the clinic. For instance, micro-arrays which can predict whether or not radiotherapy should be given and, if so, at what dose. Also, new drugs which influence cell death after radiotherapy.

What is your greatest fear?

I don't smoke and I don't drink too much so I don't fear heart disease as much as cancer. I'll have to work hard to make sure there are more good treatments for when I need them!

What impact has the Internet had on your working life?

Enormous. For fast exchange of ideas, international co-operation, reading protocols and articles; it has speeded up the whole process and improved the accessibility of literature.

How do you relax?

Sailing, reading, cycling.

Who is your favourite author?

The last book I read was by the Dutch anthropologist Mak, who describes changes in our social conventions over the past 100 years in Holland and is easily accessible. I like to read in the original language, rather than translations, and about half of what I read is in English.

What do you wish you had known before you embarked on your career?

Like my regret, I wish I had known how much time I would spend infused in management. I probably would have taken different decisions to allow myself more time in research.

What piece of advice would you give someone starting out now?

Do your PhD before you start in your specialty. It will be helpful throughout your career, make your life more attractive and help you understand the interaction between research and the clinic. You will have a better idea of the possibilities and limitations of oncology research.

What is your greatest vice?

I just can't say no! I find it very difficult to refuse requests from people, which is probably why I have become President of ESTRO and President Elect of FECS, all at the same time. Of course, it is also an honour, and an opportunity to try to convince European politicians that they should spend more money on research. But it takes up a lot of time and makes life complicated!