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NEWS. . .NEWS. . .NEWS

UK charities merge

The Cancer Research Campaign (CRC) and the Imperial Cancer Research Fund (ICRF) are to merge in February 2002, to become Cancer Research UK. The joint charity will employ 3000 researchers and doctors and spend £130 million/year, making it the biggest independent cancer research organisation in the world.

The merger is intended to combine the complementary strengths of the two charities and to speed the development of new treatments. Approximately 130 jobs among support and administrative staff will go, the charities say, in order to make more money available for research, optimise efficiency and avoid duplication of roles.

"EXCELLENT NEWS FOR CANCER RESEARCH WORLDWIDE"

Sir Paul Nurse, ICRF Director General, said, "Combining forces will give us the impetus to turn the potential of the genetic revolution into the reality of new drugs and treatments and better ways to prevent the disease." Professor Gordon McVie, CRC Director General, said, "I'm certain that together our organisations can make even faster progress and believe that within the lifetimes of my sons and their children, we will have cancer under control."

Interim Chief Executive of Cancer Research UK, Professor Andrew Miller, said, "This merger is excellent news for cancer research worldwide and will allow faster exploitation of post-genomic biology to devise more rapid and accurate diagnoses and better targeted treatments."

Adjuvant chemotherapy in pancreatic cancer

Adjuvant chemotherapy may prolong survival from pancreatic cancer, early results from a major European trial found. It also suggested that chemoradiotherapy, the regimen favoured in the US, may have a negative effect.

More than 500 patients from centres throughout Europe were included in the European Study Group for Pancreatic Cancer trial (ESPAC-1). After surgery, patients received either chemoradiotherapy with fluorouracil; radiotherapy with fluorouracil and folinic acid; both or neither.

Interim results (*Lancet* 2001, **358**, 1576–1585) after a median follow-up of 10 months showed no significant difference in survival whether or not patients received chemoradiotherapy. However, those assigned to chemotherapy had a median survival of 19.7 months, compared to 14 months among those who were not. This was highly significant.

Since the trial began, the conformal radiotherapy beam technique has made it possible to intensify radiation dose while excluding more small bowel. The authors say there is no good data to determine whether more intensive chemoradiotherapy would have been beneficial. There is also doubt over the size of the chemotherapy effect, they say.

Nevertheless, the report concludes that the results "clear the way for focusing on chemotherapy as the principal adjuvant modality in pancreatic cancer, which could enable identification of more effective and less toxic drugs, singly or in combination".

An editorial (*Lancet* 2001, **358,** 1565–1566) is less convinced and states that the conclusions should be viewed tentatively. "This study does not convincingly support either contention made by the investigators for radiotherapy after surgery for pancreatic cancer—that radiotherapy is unnecessary or that it produces a detrimental effect." More studies are needed, it says.

Dutch-Belgian registry reports

The prevalence of cancer has increased by 5% a year since 1992, according a new report from the Eindhoven Cancer Registry (IKZ) (*Cancer Incidence, Care and Survival in the South of The Netherlands 1955–1999*. ISBN 90-5001-009-1). Most of this is due to demographics, the authors say, but part is through increases in detection and incidence and part through improvements in medical management. It is more likely that the increase in future will be lower, at about 4%, but problems in access to diagnostic care and treatment could reduce this figure further.

The report covers trends in incidence and survival in The Netherlands and Belgium. Detailed tumour-specific data, including that on uncommon tumours, is included on a CD-ROM.

Further details from IKZ, PO Box 231, 5600 AE Eindhoven, The Netherlands

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New treatment round-up

• Anastrozole is significantly more effective than tamoxifen in early breast cancer, initial results of the ATAC (Arimidex, Tamoxifen, Alone or in Combination) study suggest. The multicentre, multinational, randomised controlled adjuvant study included 9366 postmenopausal women, with early invasive, operable breast cancer. Results presented at the San Antonia Breast Cancer Meeting (December 2001) showed that, after 30 months' treatment, risk of recurrence was 17% less among women on anastozole, than among those on tamoxifen. Combination therapy showed no benefit over tamoxifen alone.

• Anastrozole should be considered the new standard first-line treatment for postmenopausal women with hormone-sensitive advanced breast cancer, researchers say (*Cancer* 2001, **92**, 2247–2254). They analysed two previously-published randomised double-blind trials, including 1000 patients overall. Among women with confirmed hormone-sensitive tumours, median time to disease progression was 10.7 months with anastrozole, as opposed to 6.4 months with tamoxifen. Both were generally well-tolerated.

• A combination of capecitabine and oxaliplatin led to substantial tumour shrinkage in half of the 96 patients with metastatic colorectal cancer in an international trial, and kept tumours from growing for more than 6 months, researchers say. This compares favourably with the standard intravenous combination of 5-FU/leucovorin, and meant patients need only spend a few hours per month in hospital (*ECCO-11*, 2001, abstr 1005).

• Capacetabine combined with docetaxol extended survival by 3 months in women with metastatic breast cancer, compared to those on docetaxol alone (*ECCO-11*, 2001, abstr 551). The multicentre international trial included 500 patients who had failed prior therapy with anthracyclines. It also found that patients on the combination therapy had significantly longer time to disease progression and higher tumour response rates.

• ICI 182, 780 (Faslodex) is as effective as anastrozole for the second-line treatment of advanced disease, early results suggest (*ECCO-11*, 2001, abstr 550). Combined analysis of data on 851 women in two separate studies showed that at a median follow-up of 15 months, time to progression was 5.4 months with ICI 182, 780, compared with 4.1 months with anastrozole. The new compound works in a different way to existing therapies; it binds to oestrogen receptors, and results in their degradation and loss. Researchers say it may provide a valuable additional treatment option.

• Rituximab (MabThera) combined with standard chemotherapy for aggressive non-Hodgkin's lymphoma may improve survival, according to updated results of GELA study, presented at the 43rd American Society of Hematology meeting (2001, abstr 3025). The study included 399 patients aged between 60 and 80 years, with an untreated diffuse large B-cell lymphoma. After a median follow-up of 18 months, 77% of patients on rituximab plus CHOP were in complete remission, compared with 57% of patients receiving CHOP alone.

Insulation materials given all-clear

Commonly-used insulation materials such as glass wool, rock or stone wool and slag wool have been deemed 'not classifiable' as human carcinogens in an International Agency for Research on Cancer (IARC) Monograph. Neither are continuous glass filaments, used principally to reinforce plastics.

The IARC working group re-evaluated the carcinogenic risk of airborne man-made vitreous fibres. They analysed studies conducted over 15 years and found "no evidence of increased risks of lung cancer or of mesothelioma from occupational exposutres during manufacture of these materials and inadequate evidence overall of any risk".

The wools have been widely used for decades in thermal and acoustic insulation in Europe and the US. They have similar insulation properties to older products but disappear from body tissues much more rapidly. Asbestos, for example, has high biopersistence, and is extremely slow to decompose. The working group concluded that only the more biopersistent materials will remain classified by IARC as possible carcinogens. They include ceramic fibres, used industrially as insulation in high-temperature environments such as blast furnaces.

Further details available on http://monographs.iarc.fr under 'Agents most recently evaluated'.

Computer predictions in early breast cancer

A computer system may help make decisions on adjuvant treatment for women with intermediate risk breast cancer, say US researchers. At ECCO-11 (Lisbon, October 2001, abstr 493), Dr Peter Ravdin (University of Texas, San Antonio, USA) demonstrated the system, which gives estimates for individual patients of likely benefits and risks of different adjuvant treatment regimes.

A healthcare professional feeds in patient information and the San Antonio system provides numerical estimates on likely survival benefits, incidence of side effects and so on. The actuarial analysis is based on overview data and takes the patient's individual medical history into account.

Dr Ravidin said that even informed patients often lack quantitative estimates associated with different regimes after a consultation with their physician. The decision-making process involves integration of information from many different sources and he said he suggested that decision tools, like this system "have some advantages over guidelines and might be used in future".

EUROFILE

A new fast-track for cancer drugs

26 November 2001 saw the beginning of an apparently boring, regulatory nit-picking exercise at the European Parliament. The European Commission tabled its plans to reform the European Medicines Evaluation Agency (EMEA). Not surprisingly, perhaps, the event raised hardly a ripple of interest among the medical profession or patients.

Yet it could mean a major improvement in the availability of cancer treatments. Brussels lobbyists and European pharmaceutical companies have been looking forward to the reform for months because it could change both the way medicines are licensed and how quickly they reach patients.

When the Single European Act introduced the concept of the single market into EU law, pharmaceuticals were seen as a special case in which free market forces are not always allowed to operate in the interests of public safety. However, there is increasing pressure from both within and without the Commission to bring the industry into line, and the measures proposed in EMEA Review will play a major part in this.

The Review covers almost every issue relating to regulation and supply of pharmaceuticals within the EU. Many of these will have some impact on oncologists and their patients. But it is the proposed changes to the fast tracking of approval for products of significant therapeutic use which, if approved, should make a major difference.

The maximum 150-day assessment period proposed for any drug accepted under the new fast track procedure will be the fastest average time in the world for approval of medicines. Clearly, this will be a big advance on current EMEA average approval time of 273 days for cancer drugs, and Philippe Brunet, Head of the Pharmaceuticals Unit at Directorate General Enterprise, which has responsibility for the industry, has referred to it as a "gold standard".

Commission officials stress that this procedure does not mean that the criteria of safety, quality and effectiveness need not be met, simply that they must be assessed in a shorter time. So what does this mean for patients? The EMEA already has an exceptional circumstances procedure that has been important for HIV therapies, but not for cancer drugs. "Between 1995 and 1999, the EMEA approved 8 anti-HIV/AIDS drugs under the exceptional circumstances procedure," says Kathy Redmond, former President of the European Oncology Nursing Society, who has made a study of relative approval times. "But only 2 out of 26 cancer drugs have been approved in the same way."

"FAST-TRACKED DRUGS WILL BE ASSESSED WITHIN 150 DAYS"

Patient pressure has clearly been a major factor here. "Cancer patients are just not organised in the same way as the European HIV/AIDS patient community," says Ms Redmond. "But I am hopeful that discussions over the role of the EMEA will raise the profile of this issue, and help ensure that the new fast track procedure is used to provide cancer patients with a voice when decisions are being made about the approval of cancer drugs—they have the right to say to what degree they wish to have their health protected. It simply isn't fair that a group of patients should be discriminated against because they have not yet learnt to shout loudly."

"Innovation for the benefit of patients," was how Erkki Liikanen, European Commissioner for Enterprise and the Information Society, introduced the proposals at a press conference in Brussels. Under this heading, he also announced a Europewide system for the availability of medical products in advance of authorisation on the basis of compassionate use. Regulations on compassionate use vary widely from country to country, and this measure would help ensure that patients are not discriminated against on, for example, the location of clinical trials.

The most controversial measure has been the proposal to allow limited 'direct to patient' information. A 5-year pilot scheme covering AIDS, diabetes and asthma will be used as a test case. This is not US-style direct-to-consumer advertising, and Liikanen stressed that all information provided will have to be validated and approved. But many in the pharmaceutical industry see it as introducing regulation where none currently exists: a quick look will show that corporate advertising is already bordering on specific product advertising. Consumer groups see it as the thin end of the wedge in direct-to-consumer advertising and say that the Commission has barely examined the health consequences. Doctors are more reticent. Some say that a better informed patient would increase compliance but many feel that patient information should not come directly from industry.

"CANCER PATIENTS HAVE BEEN POOR RELATIONS FOR TOO LONG"

This looks likely to be the most hotly contested part of the review proposals—and possibly the least important. It would be a shame if it were to prevent politicians giving proper consideration to those measures that may really improve the lot of patients, says Dr Martine Piccart, head of the Chemotherapy Department at the Institut Bordet, Brussels. "For too long cancer patients have been the poor relations and it is time that this changed.

"In the four years or so before this proposal becomes law, oncologists should be out there arguing for quicker access to medicines for our patients—their lives depend on it."

Mary Rice,
Brussels

AWARDS AND APPOINTMENTS

Poverty, affluence and cancer

Professor Paul Kleihues was presented with the FECS Clinical Research Award at ECCO-11. FECS stated that the award was "a token of the respect in which he is held by the community of European cancer research scientists, clinical oncologists and cancer nurses".

Professor Paul Kleihues

Professor Kleihues has been Directorof the International Agency for Research on Cancer (IARC), in Lyons, France, since 1994. He trained in medicine in Germany and Italy and spent much of his career in Germany and Switzerland. His research has focussed on brain tumours and he was elected to the German Academy of Sciences in 1999. He is on the editorial board of numerous cancer and neuropathology journals and is an editorial consultant for *EJC*.

His award lecture described the influence of both poverty and affluence on cancer risk. In developing countries, approximately 23% of cancers are caused by, or linked to, chronic infection. The most widespread include hepatitis B and C and *Helicobacter pylori.* Human papilloma virus (HPV) DNA is now identified in more than 99% of cervical cancers, establishing this class of oncogenic viruses as the sole cause of a disease that in many countries remains the major cause of death from cancer in women. Vaccination is due to be introduced over the next few years but Professor Kleihues said, "Experience with hepatitis B vaccination has shown that effective implementation may be delayed by lack of funds and poor health service infrastructure."

In highly developed countries, the cancer burden is more than twice that of poor countries, mainly due to the earlier onset of the tobacco epidemic and a lifestyle based on a diet rich in fat, refined carbohydrates and animal protein, combined with low physical activity. "This has led to overweight and obesity prevalence on an unprecedented scale," he said. Common cancer sites in affluent societies include breast, prostate, colon, endometrium, gallbladder, kidney and oesophagus. Newly industrialised countries often carry a double burden of diseases caused by traditional exposures such as infections and high salt intake; in addition to those associated with the Western lifestyle.

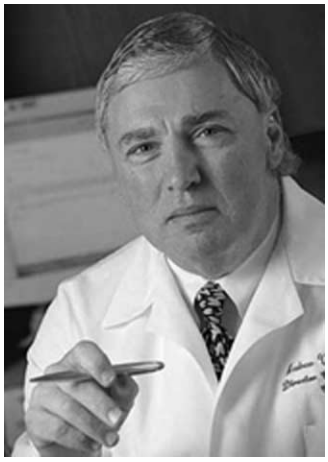
On the other hand, said Professor Kleihues, survival rates greatly improve with increased national expenditure on health care as a percentage of GNP. Even among highly industrialised European societies, cancer survival is strongly influenced by socioeconomic conditions and inversely correlated with paramenter such as unemployment.

New Director at NCI

Dr Andrew von Eschenbach is to head the US National Cancer Institute (NCI) at the National Institutes of Health (NIH) in Bethesda, Maryland. He takes over the post from Dr Richard Klausner, who left to become president of the new Case Institute of Health, Science and Technology.

Dr von Eschenbach will go to NCI from the University of Texas MD Anderson Cancer Center, Houston, where he was director of the Genitourinary Cancer Center and director of the Prostate Cancer Research Program. He has previously been vice president for academic affairs at the Cancer Center, and, as chief academic officer, he led a faculty of almost 1000 cancer researchers and clinicians.

He took his medical degree at Georgetown University, Washington, DC in 1967, and completed residencies in general surgery and urology at Pennsylvania Hospital in Philadelphia. He went to Texas MD Anderson Cancer Center for a fellowship in 1976 and joined the faculty the following year.



Dr Andrew von Eschenbach

According to the *Blue Sheet* (12 December 2001), he is well-regarded among the advocacy community for his skills as a clinician, a translational researcher and for his compassion. He had melanoma in 1989 and more recently, prostate cancer. He resigned as president-elect of the American Cancer Society, to become director of NCI.

The Blue Sheet also noted that NCI deputy director Robert Wittes has announced that he is leaving to become physician-in-chief at Memorial Sloan-Kettering, New York.

INTERVIEW

Professor Thomas Tursz is Director of the Institut Gustave-Roussy, Paris, and a pioneer of the use of immunotherapy and gene therapy to treat cancer. He has been both Secretary and Chairman of the EORTC Soft Tissue and Bone Sarcoma Group. His prestigious scientific awards include the Prix de Cancérologie from the French National League Against Cancer, the Hamilton Fairley Award from ESMO and the Prix du Rayonnement Français and he was recently made Chevalier de la Légion D'Honneur.

Professor Thomas Tursz

Where did you train?
I completed my medical training and PhD in Paris, and joined the Institut Gustave-Roussy (IGR) in 1976.

Who inspired you?
My father, who was a physician in Poland and emigrated to France in 1946, when I was less than a year old. He was absolutely convinced that being a doctor was the only decent job there is. As a non-French citizen he was not allowed to practise in France until 1957, and then had to study at nights for his Baccalaureat and MD, which he had already passed in Warsaw, more than 20 years before.

Why did you choose to work in the field of cancer?
I am passionate about science and I chose haematology and oncology in the 1970s because new understanding of underlying processes was starting to translate into improvements in the diagnosis and treatment of patients. We had progressed since the end of the 1960s, but research really needed to do better.

Did any other branch of medicine appeal?
My first interest was in basic science, but by the end of the 1970s I had become fascinated by immunology and wanted to become a clinical immunologist. Paris was the place to be, it was like a meteor around Professors Jean Bernard and Maxime Seligman.

Might you have done something else altogether?
My parents surrounded me with literature, the arts, reading and intellectual pursuits, but thought the only serious career was medicine. I could not have done anything else.

What has been the highlight of your career to date?
In 1994, my department at the Institut Gustave-Roussy planned and carried out the first trial in Europe of gene therapy for lung cancer using recombinant adenovirus. It was a truly multidisciplinary effort, involving 100 people from laboratory to clinic, and I felt like the conductor of an orchestra. It was inspiring!

. . . and your greatest regret?
Because I have divided my career between laboratory and clinic, and now also administration, I am not involved in basic research deeply enough to make an extraordinary and unexpected discovery. I miss that feeling.

If you could complete only one more task before you retire, what would it be?
Specifically, that in 5 years, the Institute Gustave-Roussy will be back among the top cancer institutions in the world. More generally, that disciplines within cancer will become more closely integrated, and the benefits of this recognised at European level. In France, going into a cancer institution is still a psychological and medical shock for many patients. Institutions should be providing global care for patients.

What is your greatest fear?
The IGR going bankrupt. It is extremely difficult running a public health institution in a Western country at present, and we lack the progress and innovation we could have had in a better financial climate.

What impact has the Internet had on your working life?
A number of sclerotic structures in the health system will change as patients become better informed of what's going on. In oncology, doctors, politicians and companies speak for patients and it is time that patients spoke for themselves. Politicians aim to maintain the level of care by improving efficiency and decreasing costs. There is no hope for progress and it is very frustrating. But the Internet will allow patient voices to be heard through Europe.

How do you relax?
Sleeping! In France the working week has been reduced to 35 hours, which is posing a number of problems. My goal is to achieve 35 hours of sleep a week. But I also like seeing movies and travelling.

Who is your favourite author?
Managing a large cancer institute drove me from Pierre Corneille, who depicted men as they should be, to Jean Racine, who depicted them as they are.

What do you wish you had known before you embarked on your career?
Two quotes. From the French poet Paul Valery "Simple ideas are wrong and complex ideas unreachable". And from Jean Cocteau, "Since we can't understand the complexity of things, at least let's try to organise them".

What piece of advice would you give someone starting out now?
It is an extraordinary time to start out in oncology, it is just getting interesting. Oncology now is at same stage as infectious diseases were at the turn of the 20th Century, after Pasteur's discovery of germs, but before antibiotics were developed. Our discoveries of genes and oncogenes have changed the way we think of cancer but it hasn't yet led to new drug therapies. It's an exciting time to become an oncologist and should mean an easier career than for the previous generation!

What is your greatest vice?
Gourmandise! Which also means curiosity and a wish to experiment. We have to enjoy life, and it's best lived with a bit of taste and passion.