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Survival statistics "overly pessimistic"

Conventional statistical analyses give "outdated and often overly pessimistic survival expectations", a statistician says (*Lancet* 2002, **360,** 1131–1135). An alternative method, known as period analysis, gives more up-to-date estimates, which are up to 11% higher than conventional methods, according to Dr Brenner (University of Heidelberg, Germany).

Long-term cancer survival statistics are usually calculated from cohorts of patients diagnosed many years ago. Period analysis, by contrast, is based on mortality rates within a recent period, such as a recent year. So 20-year survival by cohort analysis may consider patients diagnosed in 1978 and followed between 1978 and 1998. Period analysis would consider patients diagnosed between 1978 and 1998 and followed up during 1998.

Estimates for 15- and 20-year survival for all types of cancer is 11% higher when derived from period analysis rather than from conventional cohort-based survival analysis. This is because survival has improved for most types of cancer in the past three decades. It will take up to 20 years to know for sure the long term survival rates of patients diagnosed today, but "period estimates of long-term survival have proved quite accurate projections," according to Dr Brenner.

By period analysis, 20-year survival rates were close to 90% for thyroid and testis cancer, 80% for endometrial cancer, 70% for bladder and Hodgkin's disease, 65% for breast cancer. However, period was no better than cohort analysis for cancers of the lung and bronchus "showing the absence of major progress in prognosis for these very frequent cancers."

Accurate survival data is important in the clinic, says Dr Brenner. "Timely detection of improvements in long-term survival rates might help to prevent clinicians and their patients from undue discouragement or depression by outdated and often overly pessimistic survival expectations," he concludes.

ESO's 20th Birthday

Dr Alberto Costa, ESO Director, and Princess Laudomia Del Drago, President of ESO

The European School of Oncology (ESO) celebrated its 20th Anniversary with a Gala Dinner for 200 at the Palaxxo Colonna, Rome (25th October 2002). Organisations associated with ESO, including the ESO Foundation, FECS, EORTC, EONS, European Cancer Leagues (ECL), and Europa Donna were represented, along with the many individuals who have made the school possible.

Umberto Veronesi, ESO's founder, attended, along with his first partners—Michael Peckham (London, UK), Franco Cavalli (Bellinzona, Switzerland), Louis Denis (Antwerp, Belgium), and Bob Pinedo (Amsterdam, The Netherlands)—who were meeting up together for the first time in 20 years. Present ESO Director, Dr Alberto Costa said, "It was a wonderful evening. We were very happy with this acknowledgment of the School."

ESO was set up with the idea of providing residential courses to improve daily practice in cancer. "Cancer education at the time focused nearly exclusively on research. The idea behind ESO was that some patients were dying, not because they were incurable, but because they just didn't meet the person with the right skills to cure them. ESO concentrated on the people who could be saved if there were more skilled oncologists. This has changed now and there are a lot of oncologists," said Dr Costa.

ESO has developed over the years, he said. Once a medical school only, it now includes and collaborates with nurses. Advocacy was begun in the early 1990s, and language sections have been set up. The School has an Editorial Division, and an eLearning Division. It is active throughout Europe, the Middle East, Latin America and involved, through Challenge, in the fight against cancer in the developing world.

In the near future, ESO will expand its activities further, but it does not wish to exist forever. The Anniversary brochure states, "Contrary to other institutions, ESO does not wish to last for ever; it hopes to be dissolved in the foreseeable future, as soon as cancer can be beaten."

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Europa Uomo launched

Europa Uomo, a new patient advocacy group that intends to raise the profile of men's cancers, was officially launched in Rome, in October 2002. The group aims to do for prostate cancer what Europa Donna has done for breast cancer since it was set up in 1993.

Mr Tom Hudson, Chair of Europa Uomo's Steering Committee, said that Europa Uomo's first task is to establish an information package on prostate cancer, available in all European languages. "There is an awful lot of disorder and disorganisation in prostate cancer. There are many different ways of treating it, and different viewpoints. There are vested interests, both professional and financial, behind the provision of some treatments.

"MEN MUST BE PROPERLY INFORMED"

"Men must not be stampeded into taking the first treatment they are offered. They must be allowed the opportunity to get a second opinion, they must be properly informed and allowed to get the best treatment for their particular condition," he said.

The treatments available also need to improve, he said. "An individual can suffer a very great hurt to their psychological well-being when they suddenly find themselves incontinent. It does great damage to anybody's pride and perception of themselves to find that mishandling of an operation has meant that they are not the person they were formerly. They might be rid of their cancer, but they are left with terrible side-effects."

Longer term, Europa Uomo aims to change the attitudes of both physicians and men themselves towards cancer. "Men are still dreadful at doing anything about their own health, they really think they don't need to bother. A 50 year old man probably only goes for a basic check-up with his family doctor if he is dragged there by his wife. The doctor will take his blood pressure and check his heart, but if there is no family history of cancer, he tends not to suggest other rudimentary checks. So, do we work on doctors to ensure they provide the full service, or on men to ensure they demand it? We probably need to do both," said Mr Hudson.

"It is my dream to create a greater awareness of men's cancers, and to provide accurate information so that men can seek and receive better treatment," said Mr Hudson.

Europa Uomo's consultant, urological oncologist Professor Louis Denis (Oncology Centre, Antwerp, Belgium) said, "Prostate cancer prevention, diagnosis and treatment remains a challenge in its complexity. A united European approach will enhance research and clinical collaboration in the interests of the patient and society. What we aim to do at Europa Uomo is not only to improve care for the patient but also to do this at a reasonable cost. We're looking at the interests of the patient and of public health."

At the launch, Professor Denis said that population screening for prostate cancer is not justified on current knowledge. A large trial, the European Randomised Screening Study on Prostate Cancer is running in eight countries with a total accrual of 180 000 men. It will answer questions such as which cancers are clinically relevant, whether screening decreases mortality and what its negative effects are. "This is important as overtreatment is as much a problem as treatment itself," he said. PSA should only be measured in a fully-informed patient, he said.

"Patients in the European Community should have equal access to curative treatment for prostate cancer," said Professor Denis. Care should involve a multidisciplinary team, but there is a shortage of specialised centres able to provide external beam or brachytherapy. Surgeons also need to be specialists. In expert hands, impotence and incontinence occur in less than 35 and 8% of patients, respectively. Among non-experts, those figures are 90 and 50%, he said. Treatment should be tailored to the individual patient "with his particular needs and problems", and Professor Denis concluded, "Faster translation from research to new cancer medicines and technology is vital for progress."

Europa Uomo aims to set up regional, national and European groups. Its first general assembly and elections will be held next year.

Professor Umberto Veronesi, Mr Tom Hudson and Professor Louis Denis

EUROFILE

Proposed: A European cancer research area

All the big names in European cancer research met in Brussels on 19 September 2002, to discuss the creation of a 'European cancer research area'. At the meeting, which brought together researchers, government officials, and many other interested parties, Research Commissioner Philippe Busquin announced that the EU is ready to invest up to €400 million in cancer research over the next 4 years.

But, he said, such investment will only bear fruit if everyone across Europe works towards common goals: "We need to be innovative in the way we organise research at European level. Only then will we be able to turn the phenomenal advances in science into practical and meaningful early stage diagnoses and therapies for patients."

The proposed European cancer research area will support the development of large networks of excellence, which will bring together the best teams of scientists and clinical practitioners. Integrated projects will direct expertise and resources at issues such as the development of relevant preclinical tests to assess new therapies, or the validation of molecular targets for diagnosis and treatment. Research institutes will be able to attract world experts in particular fields through a revamped European scheme for the mobility of researchers.

Many of those attending welcomed the move towards greater integration, saying that the many cancer research groups in Europe would be well suited to conduct integrated projects requiring a critical mass. But a major precondition of the success of such projects is that funding should not be limited to 3 or 4 years. How this will be managed remains to be seen, although the Commission has promised to look again at funding mechanisms and the need to develop longer-term support structures.

The differing practices and regulatory conditions for conducting clinical trials in European countries also caused much debate. Many countries require trials to be verified and duplicated nationally before treatments are made available. More multinational clinical trials are needed, said Commissioner Busquin, and he will be discussing what needs to be done with David Byrne, Commissioner for Health and Consumer Protection.

"WE NEED TO BE INNOVATIVE IN THE WAY WE ORGANISE RESEARCH"

A related problem, said Busquin, is to ensure that the range of national and local rules for the protection and welfare of patients does not create a bureaucracy which adds nothing for patients but considerably hinders research: "Europe's diversity in populations, life-style, and disease patterns, places us in a unique position to advance the understanding and treatment of cancer. But co-ordination is needed between researchers, hospitals, and regional and national authorities to deal with diverging regulatory, ethical and other procedures."

A centre for monitoring EU research was proposed, to co-ordinate national policies and to give cancer research in the EU a high public profile. It would collate and compare national cancer research projects, pinpoint areas of duplication or fragmentation and allow a list of EU priority areas to be drawn up.

Octavi Quintano, Director Life Sciences; Health Research at DG Research, set out the Commission's thinking on patient-oriented strategies. The Commission wants to see the development of networks and initiatives to co-ordinate national research activities and improve public health strategies, he said. They want to support clinical trials aimed at validating new and improved interventions, as well as translational research.

Many speakers welcomed the apparent shift in the Commission's thinking away from genomics and basic research to a more patient-oriented strategy. But there is still a long way to go, said Agnes Glaus of the European Oncology Nursing Society. Nurses make a huge contribution to the lives of people with cancer, but are consistently under-represented in research projects. The knowledge base for nursing practice needs to be backed up by robust scientific evidence, with comparable data on outcome, cost and impact using a common European nursing classification system.

Glaus hoped that policymakers will appreciate nursing research as a priority for funding, and that nursing scientists will be adequately represented in cancer research teams. Cancer nursing research needs to move away from discrete individual projects to collaborative, European research, she said.

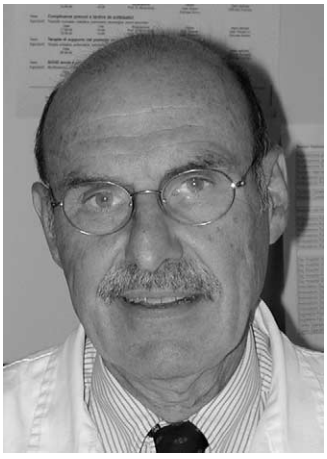
But the €400 million question is—will the sum allocated to the new programme be enough to make a real difference? "This budget is extremely modest in relation to the amounts allocated every year by the National Cancer Institute and the National Institutes of Health in the US. The 400 million will never be able to cover all the needs for research," said Busquin. He felt, however, that the money could be used to good effect as a catalyst in co-ordinating and restructuring cancer research across the EU.

A list of common priorities for funding under the 6th Framework Research Programme is being drawn up and the Commission intends to have a strategy ready in time for the first call for proposals in 2003.

Mary Rice
Brussels

Elderly patients 'face discrimination'

Elderly patients are often excluded from clinical trials and are not being offered the same treatment options as younger patients, according to delegates at the International Society of Geriatric Oncology (SIOG). The 3rd Annual Meeting (Boston, USA, 27–28 September, 2002) called for equity in access to treatment, and for specific studies on cancer in the elderly.



Professor Silvio Monfardini

Professor Silvio Monfardini (Padova, Italy), the new President of SIOG, said that 60% of all cancer occurs in patients over 65 years. Over 45% is in patients over 70 and these proportions are set to increase in an ageing population. Meanwhile, there is a lack of information on how elderly patients will respond to chemotherapy. "Even the trials which have recruited elderly patients have only included the most physically active, Rambo-type people who are chronologically old but biologically young, and in good condition. We need to study the real elderly population," he said.

Co-morbid pathological conditions are frequent in this age group, Professor Monfardini said. Many elderly cancer patients have heart or renal disease, diabetes, osteoporosis, mental deterioration or depression. Multiple medications can interact adversely and research needs to be done in this area.

The Boston meeting discussed 'subtle discrimination' against elderly patients. "There is a problem with the re-imbursement of drugs. Elderly patients are big drug consumers, often taking 5 or 6 drugs. It is costly for society if they also need anti-cancer treatment, and there may be a temptation not to treat," he said.

Professor Monfardini, whose Presidency of SIOG will last for 2 years, said he hoped in that time to encourage more widespread use of the Multidimensional Geriatric Assessment (MGA). This evaluates how generally well and active elderly cancer patients are, and estimates their likelihood of benefiting from chemotherapy. Patients who appear to be well according to the MGA are less likely to suffer toxicity, he said.

Another aim is for screening to be carried out among older patients. "PSA tests, mammography and colonoscopy should not be abandoned in people over 70," he said. SIOG's 10-year target is to lower cancer mortality in the first year after diagnosis from its current level of one-third. "Cancer mortality, independent of other pathological conditions, is higher in patients over 65 than in younger age groups. This is because cancer tends to be diagnosed at a more advanced stage and the treatment given is less appropriate. If we could improve early diagnosis and administer more appropriate treatment, we could reduce these early cancer deaths. That is my goal," he said.

Professor Monfardini is Chief of Medical Oncology at Azienda Ospedaliera-Universita of Padova, one of the key units of the Veneto Region Cancer Center. He is a former Scientific Director of the National Cancer Institute in Naples, and Director of the National Cancer Institute in Aviano, Italy. He has been President of ESMO, and of the Italian Association of Medical Oncology, a member of the Italian National Oncological Commission, and director of a UICC project for teaching antitumoral chemotherapy.

See also Review, EJC, *this issue, 'Prescribing anticancer drugs in elderly cancer patients' by Silvio Monfardini.*

Influences on recruitment in clinical trials

Increasing requirements in clinical trials, coupled with tighter trial time lines, are the most important influences on recruitment, Canadian researchers say (*Cancer* 2002, **95,** 1577–1583). A survey of clinical research associates (CRAs) in Ontario concluded that the increased demands are hindering accrual: "Consequently, the important process of translating potentially beneficial basic research into clinical practice is slowed".

Previous studies have focused on factors relating to physicians and patients. This survey also found that physicians' attitudes towards the suitability of an eligible patient for a particular trial had an impact. Logistical problems were a deterrent, as were some patients' attitudes, such as not wanting to feel like a 'guinea pig'.

However, the report concluded that 'system factors' had the greatest impact on accrual. The researchers say that, increasingly, CRAs spend considerable time with patients, explaining the details of the trials and obtaining informed consent. They described, "a climate of increasing trial and pharmaceutical requirements, coupled with tight time lines."

An accompanying report (*Cancer* 2002, **95**, 1584–1591), also from Ontario, concluded that "CRAs appear to have a unique role in the process of recruiting patients to active clinical trials." It said that further research into the relative roles of physician, patient and, potentially, CRA factors "will be important in the development of ethical and supportive strategies to optimise the recruitment of patients with cancer into randomised clinical trials."

Dr Martin Tattersall (University of Sydney, New South Wales, Australia) noted in an editorial (*Cancer* 2002, **95,** 1397–1400) the concerns that have been raised about the environment in which some clinical research is now conceived, set up and run. Until a few years ago, independent clinical investigators were usually responsible, but the 'industrialisation of clinical research' has led to the emergence of CRAs. "The pros and cons of a third party becoming involved in gaining consent to clinical trial participation merits wide discussion," he said.

INTERVIEW

Dr Nigel Gray is a leading campaigner on tobacco control. He is a Senior Research Associate at the European Institute of Oncology, Milan (IEO) and was previously Director of the Anti-Cancer Council of Victoria, Australia. He is a former Chair of IARC's Scientific Committee, President of UICC and Chair of its Tobacco Program. He was made an Officer in the Order of Australia in 1992.

Dr Nigel Gray

Where did you train?
In Melbourne, Australia.

Who inspired you?
My uncle, Stanley Williams, a senior paediatrician in Melbourne, who had an infectious sense of humour, even in the face of adversity. Bill Keogh, my predecessor as Director of the Anti-Cancer Council in Victoria, who talked me into succeeding him. And Sandy McLorinan, who taught me the importance of clinical observation. The generosity of all three helped form my character.

Why did you choose to work in the field of cancer?
Bill Keogh arranged for me to be offered the job and persuaded me that I would enjoy the work, which was about prevention. He said to other people—not to me—that he thought I would become the public face of cancer control. And that's what happened.

Did any other branch of medicine appeal?
I was originally a paediatrician, and for 10 years worked exclusively in infectious diseases. In the 1950s, a small staff would care for 400 patients; the care was a bit mass-produced but I was lucky to be working after penicillin became available and at a time when I saw the end of measles, scarlet fever, whooping cough, polio, diphtheria and rubella, terrible diseases that my mentors had struggled with.

Might you have done something else altogether?
At school I spent a lot of time playing sport and not much time working, but I graduated 6 months after the end of the Second World War and was fortunate that the entry qualifications to university were not strict then. The alternative to university was working from 9 to 5 every day, which I thought terrifying. I chose medicine because my uncle was a doctor, because I thought I would make enough money and because I believed it would allow me to be independent—mostly quite wrong in retrospect.

What has been the highlight of your career to date?
Getting the tobacco bill through the Australian parliament in 1987. I had been at the Cancer Council for 19 years, when I found a health minister who was interested. In a non-election year, we ran a 6-month campaign to persuade both government and opposition to support the bill, which abolished all state-controlled advertising including billboards and sports sponsorship. Tobacco was taxed and the tax raised was earmarked for health promotion. This led to the formation of the Health Promotion Foundation in Victoria, which still exists, and receives about €3 per head of population to spend on health promotion.

Also, chairing the UICC's Tobacco Program from 1974 to 1990. We organised about 70 workshops on tobacco, mostly in developing countries, and this gave me the global perspective I still pursue at IEO.

... and your greatest regret?
Despite important successes against tobacco diseases, that we have been so slow to win this tough battle. It's because of the sociopathic nature of the tobacco industry, and because nicotine is so addictive; it really is hard for people to give up smoking. In Australia and California, less than 20% of people smoke, but Europe is a disaster area in terms of tobacco control. In developed countries like Denmark, 30 to 40% of men smoke, which horrifies me.

If you could complete only one more task before you retire, what would it be?
To see the next round of European legislation through the European Parliament. The first round was extremely good, the next could be even better and will be matched by legislation in individual countries.

What is your greatest fear?
I don't worry about myself; I flew to the States a week after 9/11. Only about my family.

What impact has the Internet had on your working life?
None, until after I retired in 1995 and went to work at IEO, where I do not have a secretary so I have had to become computer-literate. I was happy with that and it's now a major part of my life. I am just editing a book by email—it's a lot of fun.

How do you relax?
I ski, play golf, and surf. Before my joints seized up, I played squash 3 times a week. And I drive—and compete—in a vintage sports car.

Who is your favourite author?
I do a lot of travelling so I need 500 page books to get me through long haul flights to Europe. The Scottish author, Dorothy Dunnett, writes historical novels with flawed characters, allegorical and mesmerising.

What do you wish you had known before you embarked on your career?
How difficult the tobacco battle would be. On the other hand, I would still have taken it on.

What piece of advice would you give someone starting out now?
Do something that interests you.

What is your greatest vice?
Self-indulgence in my time-consuming hobbies.