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Agreement reached on Framework Convention

A final text for the World Health Organisation (WHO) Framework Convention on Tobacco Control (FCTC) has been agreed by 171 Member States. The text, described by WHO as 'a groundbreaking public health treaty' aims to control tobacco supply and consumption. It covers tobacco taxation, smoking prevention and treatment, illicit trade, advertising, sponsorship and promotion, and product regulation.

The final round of negotiations, completed in Geneva on 1 March 2003, concludes 4 years of work to produce an international tobacco control treaty. WHO says it is part of a global strategy to reduce tobacco-related deaths and disease around the world.

The text still has to be presented to the World Health Assembly in May 2003, and anti-tobacco campaigners have warned that the US, which they say will never ratify the treaty, will attempt to undercut it there. Tobacco manufacturers will also be trying to de-rail the treaty, with the US, Germany and Japan its most likely allies, they say.

Any further weakening of the treaty could lead to approval of something so flawed that it will be weaker than many good states already have in place. For more advanced countries, any weak outcome may be an actual set back, an anti-tobacco campaigner said.

However, he said that the treaty has been 'the most active piece of work by WHO for decades and has garnered a lot of well-intentioned support and interested a large number of previously inactive people in the fight. It has done WHO a lot of good and probably reinforced the anti-tobacco movement as well as making the case globally a lot better than before. The FCTC has achieved widespread global publicity and thus exposed the weakness of the industry's case in a lot of new places.'

Despite criticism of the weakness of the final version, Dr Gro Harlem Brundtland, Director-General of WHO, was jubilant. 'The convention we have agreed on is a real milestone in the history of global public health. Moreover, it is a milestone in international collaboration in a globalised world. It means nations will be working systematically together to protect the lives of present and future generations, and take on shared responsibilities to make this world a better and healthier place. I congratulate our Member States on their courage and vision in drafting a treaty that will effectively reduce the impact of tobacco on the health of populations for decades to come.'

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Dr Gro Harlem Brundtland.

Once adopted by the World Health Assembly, the FCTC will be opened for signature by Member States. The treaty will come into force once it has been ratified by 40 countries.

(continued overleaf)

New Oncology Award for Young Scientists

A new research prize for young scientists, the Norbert Brock Oncology Award, has been established by Baxter Oncology. The award is presented in recognition of Prof. Norbert Brock's pioneering work in the development of chemotherapeutic agents such as cyclophosphamide and ifosfamide. It is available to outstanding young, non-tenured scientists, who work in academic centres and have made a significant scientific contribution to the field of cancer therapy.

The prize is a research grant of 20,000 Euro and will be presented every other year. Applicants for the award should provide:

- a comprehensive cv, including a list of publications
- a summary of research interests and achievements
- copies of no more than 6 peer-reviewed publications they have authored over the last 3 years that support their contribution to the field of cancer therapies
- a letter of support from their department head

Laureates will be chosen by the Baxter Oncology Medical Advisory Board and the prize will be presented at a major oncology meeting in either 2003 or early 2004.

The closing date for applications is 15 July 2003. Applications and requests for further information should be submitted to: Prof Bernhard Kutscher, Research & Development, Baxter Oncology GmbH, Daimlerstraße 40, 60314 Frankfurt, Germany. Tel.: +49-69-9686-6400 e-mail: info@baxter-oncology.com

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The Framework: an insider's view

The 6th and hopefully the last round of Framework Convention on Tobacco Control (FCTC) negotiations was held in Geneva during the last fortnight of February, 2003. As member of the Finnish delegation to the FCTC, I found it heartening to follow the courageous fight of the progressive developing countries in their aim to achieve a meaningful treaty. In fact, most of the 192 member states of the WHO supported the FCTC in principle. However, it was depressing to see how several countries did their best to weaken it. Some countries merely opposed the wording of particular articles, rather than the FCTC as a whole. But others, most notably the USA and Japan, acted like tobacco industry Board members, protecting the rights of the industry. They worked towards a weakening of the treaty in practically all the provisions which could have improved countries' tools in combating tobacco use. Within Europe, Germany continued to create difficulties, and at this stage it is unclear how EU countries and the accession countries will be able to sign the treaty.

Dr Liisa Elovainio

The treaty tackles the main public health issues surrounding smoking, but health was not truly given a higher priority than trade in the case of tobacco advertising, promotion and sponsorship or packaging and labelling. Also, Governments have to prove that descriptions such as mild or light are misleading if they want to ban them. This type of misinformation has been a fruitful trick for the tobacco industry: believing that a product is mild reassures the smoker into continuing the habit.

Naturally, non-governmental organisations (NGOs) are disappointed but they will continue to campaign for the toughest possible interpretation of this paper in their respective countries. Also, they will reveal remaining loopholes the tobacco industry can use. The World Conference on Tobacco or Health in Helsinki (3–8 August 2003) will provide the first opportunity for the tobacco-reducing community to have a brainstorming session on FCTC.

Looked at positively, the FCTC is the first international health treaty to be negotiated. It may be applied so that it becomes a triumph for countries from the developing world as they now have the expertise and courage to introduce effective tobacco control measures.

For all of us, these eight weeks in Geneva have shed much light on the issue, including the working methods of the tobacco industry.

Dr Liisa Elovainio
Secretary General,
Cancer Society of Finland

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The text explicitly recognises the harm caused by manufacturers of tobacco products and requires signatories to implement tobacco control programmes and strategies at national, regional and local levels. It also requires:

- Recognition that tax and pricing can reduce tobacco consumption. Signatories are required to consider public health objectives when implementing tax and pricing policies
- At least 30% of packaging must be taken up with clear health warnings. Misleading language that gives a false impression that the product is less harmful than others is prohibited.
- Parties must move towards a comprehensive advertising ban within 5 years of the convention coming into force. Countries that cannot implement a complete ban because of constitutional provisions must restrict advertising, promotion and sponsorship within the limits of their laws
- Parties are encouraged to pursue legal action to hold the tobacco industry liable for costs related to tobacco use
- Financial support must be given to national tobacco control programmes. Treatment programmes to help smokers quit should be promoted, along with education programmes to stop people taking it up.

These obligations will become legally binding for signatories, once the treaty comes into force.

Charities team up against tobacco

Following news on the Framework Convention, two cancer charities, Cancer Research UK and the American Cancer Society, have launched an initiative to counter the rise in smoking in the developing world. The first step is a series of grants to anti-smoking campaigners in 12 developing nations, two in each of the six World Health Organisation zones. The grants, to support tobacco awareness programmes, will be administered and distributed by International Union Against Cancer (UICC).

David Zacks, Chairman of the American Cancer Society, said, 'At the moment, many developing nations lack the resources or experience to take on the propaganda machine of the tobacco industry. The alliance with Cancer Research UK will allow us to pool our resources to provide funds, technical support, expertise and advice for developing nations to use.'

Baroness Hayman, Chairman of Cancer Research UK said 'We have a duty to do all we can to help countries in the developing world, in order to limit what is already becoming a devastating epidemic of smoking related health.'

EUROFILE

Cancer control in an expanded Europe

After the next European elections, due to take place in June 2004, the European Parliament will be very different from its predecessor. MEPs from ten new Member States—Cyprus, the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, the Slovak Republic and Slovenia—will join their colleagues from Western Europe in the hemicycles of Brussels and Strasbourg. Bulgaria, Romania and Turkey will have to wait a little longer.

The accession of these ten countries will clearly have a profound impact on their citizens. What will it mean for health policy and healthcare systems? The healthcare systems of the EU already have to cope with the consequences of demographic change, the rising expectations of healthcare consumers, and the introduction of new technologies. Add to this that the population health status in the candidate countries is far lower than the EU average, that the resources devoted to health in those countries are limited, and that the new EU will have 25 quite different health systems, and it could begin to look worrying.

In cancer, the problems are very evident. Men in Eastern Europe had the highest risk in the world of dying of cancer in 1990. Lung cancer is the main killer, followed by stomach cancer. High levels of smoking in most of the candidate countries are responsible for around 40% of all male premature deaths.

Tobacco control is a relatively new concept in the candidate countries, where cigarette manufacturers have been given a free rein to market their products. In Poland, for example, male smoking rates are now among the highest in the world, and the rates for women and young people are rising rapidly.

The Polish government has strenuously promoted tobacco control legislation. In 1995, television, radio and some print advertising were banned, as were smokeless tobacco, sales to minors, vending machines and smoking in workplaces. Health warnings on packets were introduced. These regulations were strengthened in 1999 to include a comprehensive ban on advertising and sponsorship. As a result, smoking rates are declining and health indicators improving.

In Bulgaria, however, smoking continues to increase. The government did not introduce tobacco control measures until 2000, and in 2001, 51.7% of men and 29.8% of women smoked. There has been a 20% increase in cases of lung cancer since 1980.

"THE NEW EU WILL HAVE 25 QUITE DIFFERENT HEALTH SYSTEMS"

How will accession to the EU help these problems? Under the *acquis communautaire,* the new members have to harmonise their laws with those already adopted in the EU. So the measures contained in the various tobacco directives will have to be introduced. In countries such as Poland there is concern that this may actually provide an opportunity to weaken existing anti-tobacco legislation. But in others such as Bulgaria, public health and cancer experts see this as an opportunity to push their own governments in the right direction.

To see the health consequences of enlargement in a purely negative light would be quite wrong, says Sibylle Fleitmann, Secretary General of the European Network on Smoking Prevention. "In tobacco control, for example, we have much to learn from countries like Poland, which has legislation to prevent members of Parliament from accepting money from cigarette manufacturers."

In a wider context, too, says Fleitmann, there are grounds for optimism. "Since health is still in transition and not stuck firmly in entrenched systems in the candidate countries, there are opportunities for them to introduce prevention as an important feature of healthcare. As a result, they have the chance to become more competitive in the health service market because they can reduce costs to health systems, whereas countries with long-established systems which do not have a tradition of supporting prevention to any degree would be more resistant to change."

The EU is doing what it can to assist the candidate countries in tackling their major heath problems, says a Commission spokesman. "We are taking steps to ensure that the candidate countries can be involved in the new public health framework programme. This major programme will focus on three areas: improving health information, developing the capacity to respond rapidly to threats to health, and tackling the underlying determinants of health. All these areas are of key concern to the candidate countries and the programme will provide them with valuable help and tools."

"IN TOBACCO CONTROL, WE HAVE MUCH TO LEARN FROM POLAND"

Will there be overall winners or losers? There is a fierce debate raging about agriculture, but discussions over the future of the healthcare sector seem rather lower key. This may be in part because healthcare will remain the preserve of national governments, as it is currently in the existing Member States. But other aspects of EU legislation will have implications for health, and the much-vaunted potential of increasing prosperity and stability in the newly enlarged EU should go some way towards adding health benefits.

Enlargement is a big challenge, but brings with it huge opportunities to work for better health for the 545 million people who will make up the European Union in a little over a year's time.

Mary Rice
Brussels

Size at birth linked to breast cancer risk

Girls' weight at birth may influence their later risk of developing breast cancer, a Swedish study has found. Researchers determined that babies born weighing 4 kg or more have 3.5 times the risk of developing premenopausal breast cancer, compared with those weighing less than 3kg at birth. The authors suggest that foetal growth rate may be the aetiological relevant factor (*BMJ* 2003: **326**: 248).

The study included 5358 singleton females, born at Uppsala Academic Hospital, Sweden, between 1915 and 1929. Recorded birth characteristics included birth weight, length, head circumference, gestational age and birth order. Information on adult risk factors was obtained from censuses in 1960 and 1970. Overall, there were 359 cases of breast cancer during the 38 year follow up, of which 63 cases occurred among women under 50 years.

Women who developed premenopausal breast cancer had, on average, a larger birth size but a shorter gestational age than those who did not. For any given birth size, a shorter gestation was associated with a significant increase in risk of premenopausal breast cancer. This suggests, the authors say, that 'the rate of foetal growth may underlie the association between birth size and risk of early breast cancer.' Head circumference was the measure with the strongest independent association with risk of premenopausal breast cancer. Associations between birth characteristics and risk of premenopausal breast cancer were not confounded by adult characteristics. There was no evidence of any association with postmenopausal risk.

The mammary gland starts to develop in utero, and high concentrations of growth factors may result in an increased number of stem cells or increased mitosis, or both. 'Our findings are consistent with those from recent prospective studies that have shown a strong association between high circulating concentrations of insulin-like growth factor I in adulthood and subsequent risk of premenopausal, but not postmenopausal, breast cancer', the authors say.

The results provide 'strong evidence that there is a real association between birth size and risk of breast cancer and premenopausal ages', they say. However, in public health terms, large birth size would be responsible for only a small proportion of breast cancer cases since the incidence at premenopausal ages is low. The possible link with birth size 'should be should be considered in light of its opposite association with ischaemic heart disease, a much more common condition,' they say.

Thalidomide on trial

A randomised clinical trial to investigate the efficacy of thalidomide as a treatment for Small Cell Lung Cancer has been set up by Cancer Research UK.

The multicentre trial, which will include around 400 patients, will compare combined thalidomide and chemotherapy, with chemotherapy alone. It follows encouraging results from a preliminary study, in which 40% of patients survived a year or more. This compares well with the usual rate of 21% for one-year survival.

Thalidomide hit the headlines in the 1960s when it was discovered that it caused birth defects by limiting blood flow to developing limbs. Researchers now believe this property of blood flow limitation may stop tumour blood vessel growth preventing cancer spread and tumour growth. It may have immune stimulating properties against the cancer cells. Furthermore, it may stabilise existing blood vessels, allowing a smooth flow of blood to the core of the tumour, delivering the drugs and the oxygen necessary for the chemotherapy to work effectively.

The potential positive side effects of the drug include stimulation of weight gain, enhanced appetite and improved sleeping patters, all of which can significantly improve the quality of life of cancer patients.

Lead researcher Dr Siow Ming Lee (University College London and Middlesex Hospital, UK) said, 'Even minor improvements at this stage could result in many lives being saved in the future.'

Aspirin 'may prevent cancers of upper aerodigestive tract'

Regular use of aspirin may reduce the risk of cancers of the mouth, throat and oesophagus, Italian researchers say (*BJC* 2003 **88**: 672–674). Five years' use reduced the risk of these cancers by two-thirds.

The researchers, from the Mario Negri Istituto di Recerche Farmacologiche, Milan, combined data from three Italian case-control studies. They included a total of 965 cases and 1779 hospital-based controls. All provided information on sociodemographic characteristics, lifestyle habits, food frequency and personal and family medical history. Regular use of aspirin was defined as at least once per week for 6 months.

Overall, the odds ratio for cancers of the upper aerodigestive tract was 0.33 among those who had been regular aspirin users for at least 5 years. Odds rations were 0.39 for oral and pharyngeal cancers; 0.80 for oesophageal and 0.09 for laryngeal cancer.

There is a plausible mechanism for the effect. Aspirin acts on the arachidonic acid metabolism, blocking the synthesis of thromboxane, prostacyclin and prostaglandins which in turn influence cell proliferation and hence cancer growth. Aspirin inhibits cyclooxygenase-2, which is important for apoptosis and therefore for control of the mechanisms of carcinogenesis.

Risk estimates were adjusted for major risk factors, namely smoking and drinking, which suggests, the authors say, 'that the inverse relation between long-term aspirin use and cancers of the upper aerodigestive tract is real.'

Lead author Dr Cristina Besetting said, 'Our results further extend our knowledge of the health benefits of this remarkable drug and suggest that taking it could become an important way of protecting ourselves against cancer.'

PODIUM

Sign on and eLearn!

Dr Matti Aapro is Director of the Multidisciplinary Oncology Institute, Genolier, Switzerland, Secretary General of EORTC and Executive Director of the International Society for Geriatric Oncology (SIOG). He is Director of the eLearning Division of the European School of Oncology (ESO) and is Scientific Co-ordinator of the First International Conference on Cancer on the Internet (19–20 June 2003, New York City).

Dr Matti Aapro

How extensively is the Internet being used as a teaching tool?
If you think of teaching as being an interactive session between teacher and student, it is not really being used yet in oncology. Physicians use it as a learning tool, to find information, discuss standards of practice or to catch up on presentations given at meetings; the ESMO meeting was available on the Net. At the moment it is still essentially an information bank. There are sites where you can post a question and receive answers, but they are of variable quality.

How is it being developed?
It will soon become possible to watch a meeting in real time on the Web. And to have lessons; students all over the world will be able to ask a teacher questions, probably through a chatline.

What are the advantages of teaching this way?
It is much cheaper than flying teacher and students around the world. It also takes up less of the teacher's time; many of the people we want to learn from are extremely busy and can't attend every meeting. With a web-based system, students will be able to listen to a presentation live or almost live, then ask questions of the speaker.

How enthusiastic is ESO?
Very. ESO is setting up projects along these lines right now. We are linking teaching materials on the website with ESO courses, so that, at their leisure, people can concentrate on a particular question and find in-depth analysis by a speaker on a previous course. It's already possible to order recorded CDs of sessions. But it can be difficult to follow a debate when you're not in the room.

Do students need special skills to learn this way?
No, but we have to overcome our uneasiness about being in front of a camera and having our image beamed throughout the world. The level of skill required is not high. All students have to do is connect to a website; if they're able to type in questions they're able to take part.

How do you see Internet teaching being developed in future?
The technology needs to develop a little further to make it possible to send high quality images of X-rays or pathology slides quickly. Companies have Internet meeting with, say, 8 participants in different places all seen on a divided screen. This facility will become cheaper and more widely available. So a virtual meeting could have 300 attendees. Someone wanting to ask a question would push a button, and their image would appear on screen, as if in a lecture hall.

What are the limitations of Internet teaching?
Nothing will ever replace the fact that meetings bring people together. I'm at an ESO meeting course right now with excellent teachers, but it's in the coffee breaks and lunchtimes when people chat and discover common interests which would never have come to light during the meeting.

In many places, access is too slow, but it can be addressed by having a fixed image of the speaker rather than a moving one. The limitations are only technological.

What will the Cancer on the Internet conference achieve?
It will bring together website experts—providers rather than users—from teaching organisations, cancer societies, patient advocates and industry. We want to identify issues and discuss what we can do to solve them; we're looking for bright ideas and solutions. The next conference in Rome will be aimed at a wider audience.

What are the issues?
The technical issue of how to increase use of the Internet among those with difficulty of access. The fact that a large amount of high quality information is available only in English when people of the world speak many other languages; information needs to be translated. And the big question faced by every doctor and nurse when patients read up about their condition on the Internet. We need to go beyond present definitions of quality because data is only as good as the way in which it is presented.

What are ESO's priorities in this area?
To integrate teaching and technology and to develop access to information. Our website, www.cancerworld.org, is a common umbrella for several societies which demonstrates that there are various approaches to the same problem. We don't yet have patient information on lung cancer, but the site addresses questions on medical, surgical and nursing aspects of the disease. The site is being developed, languages will be introduced, but it takes time.