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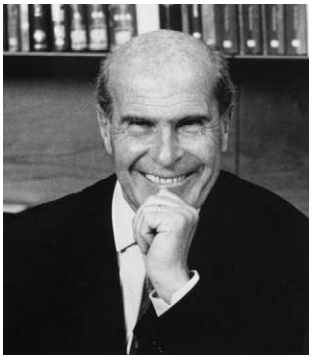
Honours at ASCO

The American Society of Clinical Oncology (ASCO) 2003 Special Awards were presented during the Opening Ceremony of the 39th Annual Meeting (Chicago, IL, 31 May–3 June 2003). Among the recipients were Dr Umberto Veronesi (European Institute of Oncology, Milan, Italy), Professor Sir Richard Peto (University of Oxford, UK) and Dr Melvyn Greaves (Institute of Cancer Research, London, UK).



Professor Umberto Veronesi

Dr Veronesi received the Distinguished Service Award for Scientific Achievement, which honours those whose work has had "a transforming and lasting impact on the treatment of cancer". Dr Veronesi was recognised for "his lifelong commitment to improving the quality of life for patients with cancer by developing safer, less invasive surgical techniques and procedures. He introduced the philosophy that advocates administering the minimal effective treatment and is responsible for the development of conservative techniques from partial breast irradiation to intra-operative radiotherapy to intra-operative radiotherapy for the treatment of breast cancer."

Dr Veronesi has dedicated a significant portion of his career to training oncologists, and founded the European Institute of Oncology, The European School of Oncology and the International Melanoma Group. He was Minister of Health in Italy from 2000 to 2001.

Sir Richard Peto received the Distinguished Service Award for Scientific Leadership in recognition of his involvement with groundbreaking studies that proved a link between tobacco and cancer. He is "known for the size and international scope of the epidemiological studies he conducts, as well as for devising a number of reliable statistical methods now in widespread use in clinical trials throughout the world." He "is recognised for establishing a credible link between the use of hormonal adjuvant therapy in the treatment of early breast cancer and improved long-term survival."

Dr Greaves was awarded the Pediatric Oncology Lectureship for his "groundbreaking work" in paediatric leukaemia. "He introduced new methods for biologic classification that have led to insights into the cellular origins of leukaemia and more targeted treatment regimens. His research on the molecular genetics of paediatric leukaemia has uncovered convincing data to suggest that the disease originates prenatally, a discovery that will someday enable physicians to identify individual susceptibility to the disease and to work to prevent its development."

The David A Karnofsky Award went to Dr Brian Druker (Oregon Health & Science University, Oregon, USA) for his role in the development of imatinib mesylate, the tyrosine kinase inhibitor approved for use in the treatment of patients with chronic myelogenous leukaemia (CML) and gastrointestinal stromal tumours (GIST). Dr David Kessler (Yale University, USA) was honoured for being "instrumental in achieving tougher regulations for tobacco in the United States and also made tremendous progress in accelerating the new drug approval process during his service as Commissioner of the FDA."

Tobacco treaty adopted

The World Health Organization (WHO)'s Framework Convention on Tobacco Control (FCTC) was adopted by Health Ministers at the World Health Assembly (Geneva, 21 May, 2003). It is now open for signature by Member States. It will come into force once it has been ratified by 40 countries.

The FCTC is aimed at regulating the activities of the tobacco industry on a global basis, tackling issues including tobacco advertising and packaging, smoking in public places, tobacco pricing and cigarette smuggling (see *EJC News*, 2003, **39**, 851–852).

The FCTC is the world's first international treaty on health and WHO have described the treaty as "groundbreaking". Campaigners have criticised the weakness of the final version but Dr Gro Harlem Brundtland, Director-General of WHO, described it as "a real milestone in the history of global public health."

Sir Richard Peto (Cancer Research UK, Oxford) said, "This Treaty is part of a global solution to a global problem. There were 100 million deaths from tobacco during the 20th Century and there will be about 1 billion tobacco deaths in this century unless a lot of smokers quit their habit."

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New boost for Italian cancer research

Italy spends 11% of their GDP on research compared with around 2% in France, Germany and Britain. "Government financing for biological and biomedical research is laughable," comments Pier Paolo Di Fiore, director of the Institute for Molecular Medicine (IFOM). "Basically we all live off grants given by a few major charities." But the opening of a new cancer research centre in Milan in early April may prove to be the stimulus Italian research has been waiting for.

The IFOM was created by Italy's largest biomedical research charity, the Foundation for Cancer Research (FIRC). The centre will employ around 300 researchers and concentrate on nanotechnology, bioinformatics and structural biology. FIRC will provide equipment and salaries for infrastructure and common services in Italy, whereas research institutes, including the European Institute of Oncology and Mario Negri Pharmacological Research Institute, will provide personnel. The facilities will subsequently be opened to other oncology centres across Italy.

"Instead of one or two groups in federal institutions, we will end up with 20 groups working in similar fields who all have access to state-of-the-art equipment and know-how for post-genomic research," says Di Fiore.

Another problem that has plagued Italian cancer research is fragmentation, a phenomenon Di Fiore attributes to the lack of a central grant awarding agency. "Varying initiatives start from the Health Ministry, Research Ministry, National Research Council, Industry Ministry, etc. So it is very difficult to know how much money is given and what the criteria are. . .most financing still follows semi-obscure reviewing processes." He argues that concentrating research facilities is an attempt to compensate for these handicaps and prevent young researchers leaving for other countries.

"We need to focus science in a few very good centres," comments Marco Presta, Brescia University, Italy. However, he fears that these investments will exacerbate the funding shortage in university laboratories: "The risk is that in 10 years' time a few excellent places will be islands in a sea of mediocrity."

Di Fiore concurs: "You cannot just build research by financing excellence, you've got to finance the whole network, including the small labs that do the training. That can only happen with government money."

Claudia Orellana
from The Lancet Oncology
June 2003, ***4****, 328*

Combination therapy in relapsed ovarian cancer

Combined paclitaxel and platinum-based chemotherapy could become the new standard treatment for relapsed ovarian cancer, researchers say. An international collaborative study has shown that the combination produces significant improvements in both overall survival and progression-free survival.

The International Collaborative Ovarian Neoplasm 4 (ICON-4) study included 802 patients, and is the largest randomised trial so far in relapsed ovarian cancer. Median survival was extended from 24 months in the control arm (platinum based chemotherapy) to 29 months in the study arm (combination treatment). The absolute difference in progression free survival at one year was increased by 10% from 40% to 50%. (*Proc Am Soc Clin Onc 2003, 446 Abstract no. #1794*).

Lead investigator Dr Jonathan Ledermann (University College, London UK) said, "The message coming from this trial is that we have to look at combination therapy becoming the new standard of treatment for patients with relapsed ovarian cancer."

The study involved a prospective combined analysis of 2 parallel trials: ICON- 4 (co-ordinated by the MRC in the UK and the Mario Negri Institute in Milan, Italy) with 751 patients, and OVAR 2.2 (co-ordinated by Arbeitsgemeinschaft Gynaekologische Onkologie in Germany) with 53 patients. Patients with a median age of 60 were recruited from the UK, Italy, Norway, Germany and Switzerland and followed up for a median of 42 months.

Sub group analysis found that paclitaxel activity was maintained among patients treated with it first line. Professor Hilary Thomas, (University of Surrey, UK) said ICON-4 may help oncologists feel more confident about using paclitaxel in combination as a first line therapy. "It's much more logical to go for broke up-front. At the start, women have a 30% chance of cure, but once the cancer returns they're automatically in the 70% group that won't recover, so paclitaxel given at this stage won't be curative."

Data suggesting that 5-year survival is 40% in the US compared to 30% in Europe is likely to be associated with the wider use of paclitaxel first line in the US, she said.

Last year, ICON-3 failed to show a significant advantage for the combination in terms of overall survival. However, both the Gynaecologic Oncology Group III (GOG-III) trial and the Intergroup Trial showed significant improvements in overall survival and progression-free survival for combination treatment given first line.

Bone data from ATAC

New safety data from the ATAC (Arimidex, Tamoxifen, Alone or in Combination) trial, among postmenopausal women with early breast cancer, suggest that the difference in risk of bone fracture between anastrozole and tamoxifen stabilises after 2 years of treatment (*Proc Am Soc Clin Onc 2003,* 2003, p. 25 #98). Previous data showed that anastrozole is associated with an increased risk of bone fracture.

Anastrozole has been shown to be safer than tamoxifen in relation to risk of thromboembolic events, stroke and endometrial cancer and these benefits were maintained with the longer follow-up. However, after 2 years of treatment, the risk of bone fracture with anastrozole is significantly higher, at 1.57 per 100 patients in a 6 monthly period, compared with 0.61 for tamoxifen.

The new data shows that this difference stabilises over the subsequent 2 years. In each 6-month period, the fracture rate per 100 patients is 1.3 for anastrozole, and 0.93 for tamoxifen. ATAC investigator Professor Gershon Locker (Evanston Hospital, IL, US) said, "Now that we can see that the increased risk of fractures with anastrozole does not worsen after 2 years, we have added reassurance in the overall long-term benefits offered by this treatment over tamoxifen."

EUROFILE

Stormy debates on stem cell research

When the European Council of Ministers approved the 6th Research Framework in September 2002, it included a surprise 1-year moratorium on funding for stem cell research. The uproar this caused among MEPs at the time has led to another attempt to legislate on the issue, this time by banning a variety of research practices.

At the end of March 2003, the European Parliament's environment and public health committee voted to extend the scope of a proposed directive on the procurement, testing and processing of human cells and tissues. They suggested: "Member states shall at least prohibit the following activities:

"MEPs HAVEN'T FULLY UNDERSTOOD WHAT THE DIRECTIVE IS ABOUT"

research on human cloning for reproductive purposes; research designed to create human embryos solely for research purposes or to supply stem cells, including by means of the transfer of somatic cell nuclei" (commonly known as therapeutic cloning).

"The European Union, like the member states, should regulate and focus research efforts on techniques that do not undermine respect for life and human dignity," said Dr Peter Liese, a German Christian Democrat MEP and rapporteur on the directive.

On 10 April, the European Parliament as a whole adopted these amendments to the directive, which was drawn up by the Commission to set quality and safety standards for medical practice involving cells and tissues, rather than research. It had not been discussed in the Parliament's research committee.

The Commission is not happy with this diversion of their directive from its purpose. "The adoption of these amendments is rather worrying," said a spokesman for health and consumer protection commissioner David Byrne. "Basically, Members of the European Parliament haven't fully understood what the Directive is about."

Research ethics are generally considered to be within the remit of each member state, rather than the EU. It looks likely that the Commission will reject the research amendments when it presents its redraft of the Directive to the Council of Health Ministers before they meet in June 2003.

The Parliament's move came just before a seminar on bioethics organised by DG Research, which the Commission hoped would feed directly into its plans to draw up detailed guidelines to govern embryonic stem cell research. Until these guidelines are in place at the end of 2003, the Commission has agreed not to fund any research projects under Framework 6 involving the use of human embryos and human embryonic stem cells with the exception of projects involving banked or isolated embryonic human stem cells in culture.

In the debate at the seminar, it was clear that there are major divisions between EU member states on this issue. The German representative said that a national debate was currently underway in his country, and hinted

"WE HAVE TO MOVE AWAY FROM THE NATIONAL APPROACH, EVEN IN CONTENTIOUS AREAS"

that it is very likely that the use of human embryos for research purposes would be outlawed in Germany. If this were to be the case, his government would oppose the use of EU money to fund stem cell research in other countries.

The Austrian delegation called for an extension to the current moratorium, and the representative from Italy, where a legislative review of the issue is underway, asked: "Is it conceivable that practices could be funded under the 6th Framework Programme which are considered crimes in member states?"

Carlos Westendorp y Cabeza, Chairman of the Research Committee in the European Parliament, challenged this view. "It is hard to understand why some member states wish to block EU funding for a particular practice, whatever the conditions in their own country, as this runs counter to the principles of the EU. What if Austria or Luxembourg were to oppose the common fisheries policy simply because they have no coastline?"

Even scientists were divided on the issue. Professor Angelo Vescovi, from the Stem Cell Research Institute at the San Raffaele Hospital, Milan, felt that at all stages an embryo is a developing life form and should be accorded the same moral status as human beings. Professor Austin Smith, from the Stem Cell Research Institute in Edinburgh, said that the potential benefits of such research justified the use of embryonic stem cells, arguing that an embryo created for IVF, but not used, had no potential to become a life form without being implanted in a womb.

One thing that everyone agreed on was that it was highly unlikely that a single view of the moral status of an embryo could ever be considered representative.

The Commission now has to try to find a proposal that reflects a consensus on the issue. To make things even more difficult, they will need to do so in consultation with the Council and the European Parliament, where opinion is already divided.

Commissioner Busquin tried to put a brave face on it. "The 6th Framework Programme could never seek to cover all aspects of stem cell research, and some will have to be left to member states, but if we truly want European research to become a global reference we have to attempt to move away from the national approach, even in contentious areas such as this." How he will achieve this is anyone's guess.

Mary Rice
(*Brussels*)

New Director at IARC

Dr Peter Boyle has been elected Director of the International Agency for Research on Cancer (IARC) for an initial term of 5 years. He will take office from 1 January 2004, replacing Dr Paul Kleihues, who retires at the end of 2003.

Dr Peter Boyle

Dr Boyle, from the UK, has an international record as a cancer epidemiologist and biostatistician. He is currently leading the Division of Epidemiology and Biostatistics at the European Institute of Oncology, Milan, Italy. He said, "I am proud for my country and for myself to be given the opportunity to serve this strong and internationally renowned research institute." Dr Jean Lariviere, Chairman of IARC's Governing Council, said, "We are delighted to have appointed Dr Peter Boyle at the helm of this leading cancer research institution."

IARC has four main objectives: monitoring global cancer occurrence, identifying the causes of cancer, elucidating the mechanisms of carcinogenesis, and developing scientific strategies for cancer control. It focuses on cancer prevention, emphasising studies that combine epidemiological and laboratory approaches and supporting international collaboration.

Spain joins IARC

Spain has become IARC's 16th Member State, increasing the Agency's representation in southern Europe. Its membership now includes 12 European countries, plus Canada, the USA, Australia and Japan.

Dr Jean Lariviere, Chairman of IARC's Governing Council said, "This will open a new spectrum of collaboration in southern Europe and complete IARC's representation on this continent."

Dr Moreno, Spain's representative on the Governing Council, said, "I am proud and honoured for my country to join the Agency. Cancer research is an essential element of our national health system and our Health plan aims at achieving a better understanding of the aetiological mechanisms of the disease, at developing therapeutic instruments for palliative care and implementing new technologies for better care."

IARC aims for global representation and talks have been initiated with other countries that have expressed the wish to join. Dr Paul Kleihues, IARC's current Director, said, "Spain will reinforce the Agency's commitment to research into the causes of cancer, leading to the real aim: the primary prevention of cancer, which is the most universal component of cancer control."

New WHO Director-General

Dr Jong-Wook Lee of the Republic of Korea has been elected the next Director-General of the World Health Organization (WHO). He trained as a medical doctor at Seoul National University, Korea, and in public health at the University of Hawaii. He has worked at WHO for 19 years in technical, managerial and policy positions, notably leading the fight against tuberculosis and vaccine-preventable diseases in children.

He was elected by the World Health Assembly, which brings together all 192 Member States of WHO, and is the first person from the Republic of Korea to head a United Nations agency. In his acceptance speech, he called for wide participation and urgent action: "Sharing ideas will be vital in the coming months. But our final test lies in action. Let us unite our strength for the work ahead."

Dr Lee replaces Dr Gro Harlem Brundtland, whose key achievement as Director-General was the introduction of the Framework Convention on Tobacco Control.

Distinguished Achievement in Cancer Research

Dr Elizabeth H. Blackburn (University of California, San Francisco, USA) has won the 26th Annual Bristol-Myers Squibb Award for Distinguished Achievement in Cancer Research "for her seminal discoveries in the areas of cell growth, including the molecular structure of telomeres and the telomerase enzyme".

Dr Elizabeth Blackburn

"The telomerase research that she initiated holds important implications for a variety of human disease conditions and the process of ageing and may one day lead to novel therapies against a wide range of human malignancies," the organisers said.

Dr Blackburn from Hobart, Australia went to Yale University as a post-doctoral fellow. There, with Dr Joe Gall, she identified the first DNA sequence of telomeres, at either end of chromosomes in all human cells. This allowed for a clearer understanding of their role in protecting the normal activity of chromosomes.

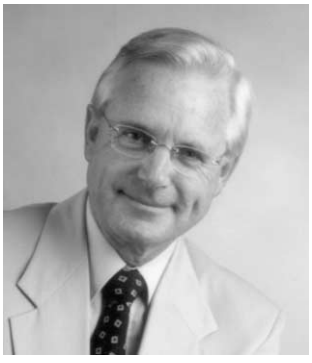
Subsequently, at University of California, where she with graduate student Carol Greider, discovered telomerase, an enzyme that regulates telomere self-renewal in cells. This provided new information about how the life span of normal cells is regulated and how that regulation can go awry in cancer cells. Dr Blackburn has since applied this knowledge to practical strategies in the fight against cancer.

She will receive a US$ 50,000 cash prize and a silver medallion Dinner in October 2003, in New York.

PODIUM

Streamlining CME

Professor Hans Grunicke (University of Innsbruck, Austria) is President of European Association for Cancer Research (EACR) and a member of numerous national and international advisory committees and societies. He was awarded the Austrian Cross of Honour for Art and Sciences in 1996. He has been Chairman of the Accreditation Council for Oncology in Europe (ACOE) since 1999.



Professor Hans Grunicke

What's happening in continuing medical education (CME)?
Europe is moving towards mandatory Continuing Professional Development, as exists in the US and elsewhere. ACOE, which operates under the FECS umbrella, has developed a common accreditation system, which incorporates the best features of established schemes, and works alongside them. The aim is to provide delegates with a guarantee that educational events will be of high quality, and to award CME points that will be recognised throughout Europe and the US.
ACOE works in conjunction with the European Accreditation Council for CME (EACCME), which was set up by the European Union of Medical Specialists (UEMS). EACCME has an agreement with the American Medical Association (AMA) so that events accredited by EACCME are automatically recognised in the US.
ACOE is a multidisciplinary body of experts representing the complete spectrum of oncology health care professionals from all over Europe. They assess events, for the quality and educational value of the scientific content.

This all sounds good, so what's wrong?
At present, in order for an event to become accredited, the organisers send details either to a national body or to ACOE. In the latter case, after reviewing we send them on to EACCME to obtain Euro-credits. EACCME then contacts the national authority where the event is taking place, asking for its endorsement. EACCME frequently gets no reply, and after about 3 weeks, just has to rubber stamp the application and grant accreditation. There is no multidisciplinary reviewing panel for oncology at national level or within EACCME; thus, in cases where ACOE is not involved, accreditation is often granted without the same level of professional evaluation. This is neither efficient nor professional.

What do you suggest instead?
The ideal situation would be that EACCME, in agreement with national authorities, allows a professional body like ACOE to act on its behalf. It would mean that organisers of oncology international events could submit applications directly to ACOE, which could then grant (or refuse) accreditation, which would automatically be European-wide. In cardiovascular disease, EBAC (European Board for Accreditation in Cardiology) is trying to do the same thing.

What is UEMS' response to this?
The European Union of Medical Specialists (UEMS) is a large body, comprised of representatives from all organisations and states. There is resistance within UEMS to our proposal and unfortunately nothing has changed for years.
However, we do not want to be in opposition to UEMS. Politically, UEMS is the most influential medical body within the EU, and if you want to achieve anything, it is easier if you are co-operating.

Have ACOE and UEMS reached stalemate, then?
No, we are still working. We are now contacting national authorities directly, promoting the value and multidisciplinary assessment of ACOE for the evaluation of international educational events. Some of the authorities are already co-operating with us, and we have targeted countries where CME is already mandatory.

When do you expect to receive feedback from the national authorities?
By the end of the summer, 2003, we hope, and we are despatching ambassadors to try to persuade authorities. ACOE could become an example of how the system could work, because oncology is such a diverse field and includes surgeons, medical oncologists, radiotherapists, paediatricians, and so on. It's a highly professional auditing system, which is trying to improve a slow and unnecessarily bureaucratic system.

What will happen next?
If the national authorities agree, ACOE could become a one-stop operational procedure. Organisers would submit materials to us and we could decide. With UEMS/EACCME's agreement, accreditation would be recognised in Europe and the US.
If they will not agree to all of this, a compromise could be that UEMS would at least agree not to send the information on to the national authorities which have already agreed to let us act on their behalf, but give European endorsement immediately. That would save weeks of delays.

What if some national authorities agree and others don't?
That would still be progress. It could make some countries more attractive as conference venues than others, which would stress our point.

What if UEMS will not budge?
In the interests of quality healthcare in Europe, it may become necessary for professional bodies like ACOE to contact other interested parties at EU level. But let us hope this is not necessary.