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A New Model for Oncology in Europe

Plans to create a single European cancer society – along with an annual European multidisciplinary meeting – are being discussed by top opinion leaders. Participants at a meeting in Amsterdam (January 10–11, 2005) agreed the Amsterdam statement (see box), which outlines the potential benefits of a single society.

President of the Federation of European Cancer Societies (FECS), Professor Harry Bartelink (Netherlands Cancer Institute, Amsterdam), chaired the meeting, and said, ''Oncology is not well represented in Europe. It is not just that we need a higher level scientific platform, but we also need to reach politicians and patients and inform them about the progress that is being made in cancer research.''

Delegates at the Amsterdam meeting – around 30 in all – included representatives from all FECS' founder member societies, along with some European leaders.

''Oncology is fragmented in Europe,'' said Professor Bartelink. ''Paediatric oncologists approach the European Parliament about one issue; medical oncologists are fighting for recognition of the speciality; surgeons want something else and radiation oncologists have different problems altogether. Everyone is struggling with their own issues, and nobody is overseeing cancer as a whole, and speaking with a strong, authoritative voice. That needs to change.

''We also need better infrastructure so that we can respond more rapidly to requests from journalists and politicians, and be able to give expert advice.

''Developments in molecular biology and technology will have a major impact on the treatment possibilities for cancer patients in future. The only way to properly address the different treatment modalities, and to ensure that European patients have access to the new treatments, is to have a better platform for presenting the information.''

Kathleen Vandendael, Executive Director of FECS, was enthusiastic about the progress made at the Amsterdam meeting. ''The single European cancer society is in the interests of everybody, patients and professionals alike. Progress in cancer care in future will depend as much on political decisions as on new scientific developments. If Member States are not ready to pay for the results of new scientific developments, then what's the point? We have to position ourselves with authority, to start influencing all interested parties now.''

Professor Harry Bartelink

It is envisaged that this European cancer society will have an individual membership either directly, or indirectly via their discipline or organ-based society. At the same time, it will be important to preserve the identities of the individual disciplines, Professor Bartelink said.

''In 2004, ESMO, ESTRO, ESSO EONS and EACR, for example, all had extremely successful conferences, with better scientific content than ever before. We will have to be careful not to lose that, in future developments,'' he said.

ECCO, the biennial European cancer conference has been an ''extremely good multidisciplinary platform'', Professor Bartelink said, allowing an exchange of ideas between disciplines. ''But we have come to the conclusion that we need a higher level scientific platform. We want European researchers to present their best results in Europe, first. We want to create a situation in which it is not necessary to

continued overleaf

The Amsterdam statement

Participants at the Amsterdam meeting – A New Model for Oncology in Europe – agreed on the following meeting statement:

''The meeting reflected on the unquestioned success of FECS and its constituent societies over the past twenty years, but recognized the need now for a more all-embracing organisation to represent oncology in all its contemporary aspects.

The preferred solution would be a single European Cancer Society with defined membership, to provide cohesion, visibility, political awareness, enhanced opportunities for young oncologists, and the optimum platform for progressing science and clinical practice for the benefit of patients throughout Europe.

To achieve this solution, during the coming months FECS will establish a series of working parties to discuss the details of this new development in full consultation with all the interested parties and partners.''

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Renaissance Clinicians required in Prostate Cancer!

The modern genitourinary oncologist needs to master molecular biology, behavioural science, philosophy and fiscal management, in addition to the more conventional medical skills, according to Professor Derek Raghavan (Cleveland Clinic Taussig Cancer Center, Ohio, USA).

In an editorial for the forthcoming *EJC* Special Issue on Prostate Cancer (REF), Professor Raghavan, the Guest Editor, says that the papers span biomedical research on prostate cancer, ranging from molecular and clinical epidemiology to the subtleties of population screening and public health issues, along with the interplay between prognostic and predictive factors in characterising outcomes of treatment.

''I wanted to create a document that summarises recent progress in prostate cancer in a critical way'', he said. ''I think we have achieved that. Someone who knows little about the subject will be able to read this issue over the weekend and emerge as a knowledgeable person''.

He was surprised by the sophistication of the submitted papers, and the links between them. A paper on surgery, for example, addressed the point that screening is serving up different patients, with different outcome measures. ''The contributors did not simply address chemotherapy, surgery or radiotherapy. Scientists and clinicians are influencing each other's thought patterns; it is almost a paradigm of translational research''.

Screening, however, remains an area ''characterized more by passion and rhetoric than by rational thought,'' Professor Raghavan said. Postma and Schroder make the point (*Eur J Cancer* 2005, **41**(6), in press) that national bodies disagree on the subject. ''The only way they can disagree is if decisions are based on rhetoric because we do not yet have the data from randomised trials to make a rational decision.''

He said he was optimistic that rationalism would triumph over rhetoric in the longer term, particularly given the well-educated younger specialists now working in prostate cancer.

New Model for Oncology (continued)

leave Europe to be updated. I am convinced that by creating a strong annual multidisciplinary meeting we will have the necessary scientific platform.''

The meeting will have a new format, with even more attention to clinical and translational research, but also special patient programmes. Patients will be involved in some scientific symposia, where they may be consulted, for example, on priorities for research. Politicians will be involved so that issues such as minimum standards, access to treatments, research funding can be discussed at the same meeting.

ECCO will take place as planned in 2005, and the following meeting will be in Barcelona in 2007. But if negotiations between the current societies are successful, meetings will take place annually thereafter. Working parties were set up after the Amsterdam meeting and are preparing a proposed structure for the new single society. These plans are due to be presented to the Presidents of the member societies in May, 2005. Modifications will be incorporated in time for the FECS Council meeting in June, 2005. Further work on the detail is expected to be finalised by November, 2005.

''I was extremely pleased with the way the Amsterdam meeting went,'' said Professor Bartelink. ''It was very open and very constructive. There was a common feeling in support of the single society and the annual meeting. We made an important step forward.''

'Beneficial influence' of sunlight on cancer

Sunlight may have a beneficial influence on both the incidence and outcome of some types of cancer, new research suggests. One study found that sunlight may reduce the risk of non-Hodgkin lymphoma (NHL); another found a link with increased survival in patients with early-stage melanoma.

A Scandinavian study (*J Natl Cancer Inst* 2005, **97**, 195–99) included 3740 patients diagnosed with malignant lymphomas between October 1999 and August 2002. The population-based case-control study – in Denmark and Sweden – included 3187 population controls.

A high frequency of sun bathing and sunburns at age 20 years, and sun vacations abroad, were associated with a 30–40% reduced risk of NHL. The inverse association increased in strength with increasing levels of exposure. A similar, though weaker, association was seen for Hodgkin lymphoma. However, a history of skin cancer was associated with a doubling in risk of both NHL and Hodgkin lymphoma.

Lead researcher Dr. Karin Ekström Smedby (Karolinska Institute, Stockholm, Sweden) said. ''The positive association between skin cancer and malignant lymphomas is unlikely to be mediated by UV exposure''. However, before the association between UV exposure and NHL risk can be considered causal ''we need further confirmatory data from other epidemiologic studies and, ideally, a better understanding of possible biologic mechanisms.''

An American study (*J Natl Cancer Inst* 2005, **97**, 199–209) followed 528 patients with cutaneous melanoma for five years. Sunburn, high intermittent sun exposure, skin awareness histories, and solar elastosis were inversely associated with death from melanoma. The association was statistically significant and persisted after adjustment for melanoma characteristics such as lesion thickness and location.

Dr. Marianne Berwick (University of New Mexico, Albuquerque, USA) and colleagues wrote, ''It would be reasonable to speculate that the apparently beneficial relationship between sun exposure and survival from melanoma could be mediated by vitamin D. However, an alternative hypothesis is that sun exposure induces less aggressive melanomas by inducing melanization and increasing DNA capacity, both of which might reduce further mutational changes in a melanoma. Which, if either, hypoth- esis is more plausible remains to be seen.''

An accompanying editorial (*J Natl Cancer Inst* 2005, **97**, 161–63) describes the new evidence as intriguing. ''In view of the major potential public health consequence of these results, further studies of sunlight and the vitamin D connection to cancer are certainly warranted,'' it concludes.

EUROFILE

Calls to Address 'Scandalous' Inequalities

Disparities in access to cancer treatment, care, and prevention are rife in Europe, both between the different countries and within them. The recent accession to the European Union of eight eastern European countries nations plus Malta and Cyprus, all with generally lower level of health provision, means that existing gaps have widened even further.

Both the Federation of European Cancer Societies (FECS) and the Association of European Cancer Leagues are starting to collect information on these inequalities, because, despite much talk over recent years, data have tended to be anecdotal. A recent study by a multi-national task force formed by the European Society for Therapeutic Radiology and Oncology (ESTRO) shows just how striking differences in provision can be. Professor Søren Bentzen (University of Wisconsin Medical School, Madison, USA) and his colleagues looked at the provision of linear accelerators used in radiotherapy in the 25 countries that are members of the EU. He found staggering variations: Slovenia and Poland had only around one-third of the estimated capacity required, the UK around half, while in Sweden, France and Belgium the availability of megavoltage therapy units reached or exceeded 90% of the estimated capacity needed to provide appropriate usage.

''We are currently trying to collect reliable data from all of the EU member states'', said Professor Bentzen, ''but I suspect that the situation in several of the other new member countries could be similar to – if not worse than – what we found in Slovenia and Poland. Under-provision of radiotherapy means that some patients are not receiving life-saving or effective palliative therapy and may give rise to waiting lists or necessitate the prescription of sub-optimal treatment regimens. This is a scandalous situation that politicians need to address urgently.''

So far, most attempts to even out access to treatment have been made at national level, but there are signs that things are starting to move on a pan-European basis, too. The European Health Forum, Gastein, is the 'Davos' of health policymakers and brings together people from different EU countries, interest groups, academics and patients to discuss policy trends in health. At its meeting in October, 2004, many distinguished speakers in the field of cancer called for a better health infrastructure across Europe and for access to multidisciplinary care to become the norm.

''Not everyone realizes how much real progress has been achieved in recent years in the treatment of cancer,'' said Professor John Smyth, director of the Cancer Research Centre at the Western General Hospital, Edinburgh, Scotland, ''because not everyone has access to the latest advances. Availability of treatment is as much a political as a medical decision, and it is to everyone's advantage to put cancer management at the top of their priority list.''

''TREATMENT DECISIONS ARE AS MUCH POLITICAL AS MEDICAL''

He cited his own care for patients as an example of the inequalities. ''I am not at all sure what treatments I can offer new patients, not because I do not know what would be best for them, but because I do not know what will be available at the political/financial level.''

Paediatricians are preparing to fight a similar battle. At another meeting in October, 2004, this time in the European Parliament and organized by FECS and the European branch of the International Society of Paediatric Oncology (SIOP Europe), scientists called for policymakers to take every possible step to enhance collaboration between paediatric oncologists and to begin to dismantle some of the barriers that are holding back progress in the delivery of quality treatment across the European Union.

With optimal treatment, higher cure rates can be achieved in children than are possible in most forms of adult cancers, said Professor Michael Stevens (Birmingham Children's Hospital, UK), of SIOP. He felt that changes need to be made to the structural organisation of care in the member states so that collaboration can be improved. The European Union has been giving a great deal of thought to patient mobility, but, in the case of paediatric oncology, it is absolutely essential that a 'centre of reference' was responsible for diagnosis, treatment planning, and some aspects of treatment, said Professor Stevens. Other aspects of care could be delivered closer to home under the guidance of the centre of reference, supported by robust staff education programs and delivered in partnership with parents.

The European Commission has been active in funding cancer research, but much less so in looking at areas like access to treatment. One of the problems is that the European Union's expertise in health, as set down in the various treaties that all members have signed over the years, is limited; with a few exceptions, health issues are handled by the individual member states. Another problem lies within the Commission itself; pharmaceuticals, environment, research, and public health – all important in cancer treatment and care – are handled by four different directorates general, and there often seems to be little co-ordination between them.

''THE EU'S EXPERTISE IN HEALTH IS VERY LIMITED.''

It is much too early to tell whether these pan-European initiatives will change anything, but they are surely a big step in the right direction.

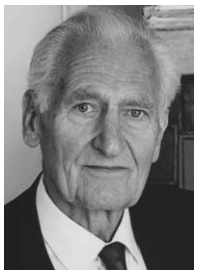
Mary Rice
Brussels

King Faisal Prize for Tobacco Research

Professor Sir Richard Doll and Professor Sir Richard Peto (both from Oxford University, UK) have been jointly awarded the 2005 King Faisal International Prize for Medicine. The 2005 topic was Tobacco Risks on Human Health.

The Prize was announced by HRH Prince Khalid Al-Faisal, Director of King Faisal Foundation. It was awarded to the Oxford scientists ''for their pioneering and profoundly valuable epidemiologic research that has unequivocally established the link between tobacco and various diseases, such as vascular diseases and cancers, and has, in addition, served to propagate further research elucidating the molecular mechanisms of tobacco mediated cellular damage and DNA mutations.

''Indeed so great has the impact of their studies been that several national health policies have been modified as a result of these findings. The WHO itself changed its position on smoking which culminated in a demonstrable decline in deaths related to cancer and atherosclerotic vascular diseases in several developed countries. Such significant benefits have transcended to large populations of developing countries as well, proffering an immeasurable contribution to mankind.''



Professor Sir Richard Doll

Professor Sir Richard Peto

The King Faisal Foundation awards Prizes in five categories each year: Service to Islam; Islamic Studies; Arabic Language and Literature, Medicine and Science. Laureates receive a certificate, handwritten in Diwani calligraphy, summarising their work; a commemorative 24 carat, 200 g gold medal; and a cash endowment of US$200,000 (shared between co-winners).

The topic for the 2006 King Faisal International Prize for Medicine is Biology of Vascular Inflammation.

For further details see www.kff.com

UK Cancer conference announced

The UKs National Cancer Research Institute (NCRI) has announced plans for the largest cancer research conference ever held in the UK. It will take place in the ICC, Birmingham, UK, (2–5 October 2005) and organisers say it will be the first time major cancer research funding bodies from government, charity and industrial sectors have come together on this scale.

The NCRI was formed four years ago and is changing the way cancer research is carried out in Britain. Its purpose is to accelerate and advance improvements for the benefit of cancer patients. Under its auspices, new clinical and translational research networks have been developed; new initiatives have been promoted in under-funded areas, including palliative care and prevention. New alliances are being forged among funders and among multidisciplinary investigators.

The conference will cover basic and clinical science. NCRI Chairman, Professor Alex Markham, said, ''As well as talks from internationally-renowned speakers, there will be a focus on how patients are contributing to the development of the research agenda.'' Sessions ''should appeal to patients, public opinion leaders and professionals from a range of disciplines.''

Heavy babies 'have higher cancer risk'

Babies who weighed more at birth had higher rates of digestive and lymphatic cancers in adulthood, researchers found. Further, women who were heavier at birth had significantly higher rates of breast cancer before age 50 years, though lower rates of endometrial cancer at all ages.

The study (*Int Jnl Cancer* 2005 DOI: 10.1002/ijc.20915) included the 11,166 babies born between 1915 and 1929 at Uppsala Academic Hospital in Sweden. The cohort was followed up through linkages to the Swedish Cancer Registry, national censuses and the Swedish Register of Deaths and Migration.

Between 1960 and 2001, 2685 people were diagnosed with cancer. A standard deviation increase in birth weight (450 g at 40 weeks gestation) was associated with a 17% increase in lymphatic cancers and a 13% increase in digestive cancers including stomach, colorectal and pancreatic. No association was seen for five other non reproductive-related cancer sites.

''BREAST CANCER RISK INCREASED 4-FOLD''

Women in the highest category of birth weight (4 kg or more) were 4 times as likely to get breast cancer before age 50, compared to those in born weighing less than 3 kg. However, they were only half as likely to develop endometrial cancer. In men, there was no association between prostate cancer and birth weight.

The researchers say it is plausible that the associations between birth weight and cancers are related to aspects for the foetal environment or the number of cells at risk of carcinogenesis. Previous studies have found associations between smaller birth size and increased risks of adult heart disease and diabetes. They conclude, ''Both circulatory disease and cancer need to be considered in determining the net effect of prenatal influences on adult morbidity and mortality.''

PODIUM

An Entente Cordiale for cancer trainees

Professor Robert Souhami (Emeritus Professor of Medicine, University College London, UK) is Director of Policy and Communication at Cancer Research UK (CRUK). He was Chairman of the UK Medical Research Council's Cancer Therapy Committee and of its Bone Sarcoma Working Party. He received the ESMO Award in 2000. In 2004, he was involved in the centenary celebrations of the UK–French Entente Cordiale.

Dr. Robert Souhami

What has cancer to do with the Entente Cordiale?

The centenary celebrations were partly built around cancer because of President Jacques Chirac, who made cancer one of the main themes of his Presidency. We want to create training opportunities and fellowships for young researchers. My role at CRUK is in training; Professor David Kerr (Oxford University, UK) is setting up Entente Cordiale fellowships in translational research and is exploring the creation of some joint scientific infrastructure such as tissue banks.

Do the UK and France have compatible systems?

Clinical cancer research in the UK has developed considerably over the last few years. The establishment of the National Cancer Research Institute (NCRI) brought together all funders in a single forum. More recently, in France, President Chirac created seven regional canceropoles, which are funded by Government and support – at regional level – collaborative cancer research designed to directly benefit patients.

Both countries are looking at cancer research at the national level, and their respective expenditure is among the highest in Europe. The time is right to think of France as a natural partner for the UK and ask whether we could encourage exchange opportunities for young investigators, especially clinical scientists.

How much collaboration exists between UK and France at present?

At present, French or UK trainees wanting to cross the Channel rely on personal recommendations: there may be an opportunity if the lab head in Toulouse happens to know somebody in Manchester. But there is no centralised information system including opportunities in all universities, along with those from the funding organisations.

How are you going to address this?

The proposal is for CRUK to develop a comprehensive training and career development website for cancer researchers. The Entente Cordiale website will give researchers access to the training requirements, structures, sources of funding and organisations they need to understand to work in the other country. In the UK, it will, for example, explain how the General Medical Council works, what the BMA is, what various postgraduate qualifications mean. It will contain all the relevant information about scholarships, funding agencies and academic and professional requirements, tell researchers who to contact and when applications need to be received. Then it will provide links to the websites of individual universities and clinical science programmes. Similar information will be available on French training programmes. This is an attempt to encourage mobility of clinical and laboratory scientists and to allow them to extend their horizons while training.

Is there money earmarked for this initiative?

Cancer Research UK is funding the development of the website; the sums involved are not huge. It will probably take a year or so to complete, in collaboration with French funding agencies.

There is no money ring fenced specifically for Anglo-French research projects. That may happen but it would need careful consideration because projects funded have to compete with everything else submitted.

What difficulties do you anticipate?

The trend in the UK is towards training clinical scientists; clinicians who work in clinic and laboratory simultaneously. The French system is more fixed and it is difficult to develop a career in the same way. Clinicians have to make choices that push them towards either clinical or laboratory work and it is more difficult to retain the flexibility we like to see. It is a structural problem which is not going to be resolved by developing a website. It will be interesting to see what influence each system exerts on the other, as both trainees and trainers become aware of, and learn from, an alternative system.

What do you hope the Entente Cordiale website will achieve?

The UK and France share many of the same goals – we want to focus on research that will translate into benefits for patients – and both are struggling to produce the next generation of brilliant clinical researchers. We both need to train more people and to remove obstacles to a career as a clinical scientist. I hope the website will surmount the structural barrier which remains between the two countries.

Why just the UK and France? Why not the EU as a whole?

We need to pay great attention to detail. If we try to create a grandiose European-wide project we are likely to fail. It would be too complicated, and involve too many different systems. If we can make a success between two nations, we can start rolling it out elsewhere.

Is language an issue?

More so for the British. French scientists often have good English; the high-ranking journals all publish in English. If British clinicians want to see patients in France as part of a training programme, they of course have to speak French. But in many French laboratories there are enough English-speakers for them to get by without being fluent.

How far is training abroad recognised back home?

This is important: will a year's work abroad be recognised as part of your training? There are problems to be ironed out and we will be learning as we go. We hope that the website will help researchers assess the value of the experience abroad in furthering their career when they return.