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Call for international action on non-communicable diseases

The International Union Against Cancer (UICC) has teamed up with the International Diabetes Federation (IDF) and the World Heart Federation (WHF) to press for an international response to the 'epidemic of non-communicable diseases (NCDs) responsible for 35 million deaths a year.'

The organisations are demanding a substantial increase in funding for NCDs and greater availability of essential medicines, in order to accelerate progress towards the health Millennium Development Goals.

They warn that the emerging epidemic of NCDs is threatening to overwhelm health care systems worldwide. A statement said: 'NCDs are an underappreciated cause of poverty and now present a serious barrier to economic development.'

The World Health Organization has identified international partnerships as paramount in the global struggle against NCDs. IDF, WHF and UICC are united by their concern with the consequences of physical inactivity, tobacco use and poor diet. Together, they represent 730 member organizations in 170 countries.

Professor David Hill, UICC President, said, 'Now, more than ever, we need to join efforts to give cancer and the other NCDs the priority they deserve. The advantages that stand to be gained from the strength of strategic international partnerships, such as the one between our three organisations, will contribute towards a more effective global response to NCDs.'

The joint statement was timed to coincide with the World Health Assembly meeting (Geneva, May 18, 2009). 'Failure to act will have a detrimental effect on healthcare systems and economies worldwide,' it stated.

Professor Martin Silink, IDF President said: 'Health systems will need to adapt fast to mobilize new and existing resources to tackle the epidemic through prevention and education. The majority of people with non-communicable diseases like diabetes, cardiovascular disease and cancer are responsible for most of their own care most of the time. Health systems will need to support the role of people with NCDs and see them as part of the solution.'

Population screening for prostate cancer? Not recommended

The European Association of Urology has drawn up a position statement on prostate cancer screening, based on the results of the European Randomised Study for Screening of Prostate Cancer (ERSPC).

The ERSPC found that PSA-based screening reduced prostate cancer mortality by 20% in 162,000 asymptomatic men aged 55–69 years. However, to prevent each death, 1410 men had to undergo screening, and 48 more needed to be treated than in the control group (*New Engl J Med* 2009; **360**:1320–8).

The EAU stated: 'Current published data are insufficient to recommend the adoption of population screening for prostate cancer as a public health policy due to the large over-treatment effect. Before screening is considered by national health authorities, the level of current opportunistic screening, over-diagnosis, over-treatment, quality of life, costs, and cost-effectiveness should be taken into account.'

It called for the development of safe methods of cancer surveillance without invasive therapy. Invasive therapies should be tailored to patients' needs and the prognosis of cancers diagnosed.

Current screening algorithms are insufficient due to a lack of specificity and selectivity for aggressive cancers which require treatment. Novel diagnostic and prognostic markers and imaging modalities are 'needed urgently to enhance the predictive value of screening tools'.

In the absence of population screening, the EAU advises men who are considering screening by PSA testing and prostate biopsy to obtain information on the risks and benefits of screening, along with individual risk assessment.

The EAU stated that further ERSPC data is awaited and will inform the ongoing debate.

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Controversy surrounds the selection of embryos to avoid cancer

On April 21, 2009, the Spanish Ministry of Health and Social Policy granted permission for the first time for two couples carrying cancer-predisposing genes (BRCA1 and MEN2A) to undergo assisted reproduction involving peri-implantational genetic diagnosis (PID) and the selection of embryos free of these genes. The Ministry's decision—which also gave the go-ahead for another 17 couples affected by other diseases—met with ethical concerns, fears that the Spanish law governing this area of medicine might be too open to interpretation, and anxiety in the medical community about the safety of the procedure.

The benefits of, and arguments for, selecting embryos free of certain cancer genes are the same in Spain as anywhere else. 'The human benefit lies in that [couples'] children will be free of a genetic risk of developing cancer during adulthood—a problem that has affected their family for generations, with all the tests, diagnosis, and treatments that entails', explains Carlos Simón (professor of obstetrics and gynaecology, University of Valencia, and director of the Centro de Investigacion Principe Felipe Cell Line Bank). 'The benefit for society lies in lower [associated] health-care costs and being able to rely upon a modern, pioneering cancer prevention service.' Simón also points out that the savings made in diagnosis and treatment costs ought easily to allow demand for the procedure to be met by Spain's national health system.

The Roman Catholic church, however, has voiced strong opposition to the Ministry's decision. 'This procedure requires qualitative selection be made, with the consequent destruction of embryos. It is therefore an abortive practice that eliminates the lives of those people who most need our protection: the unborn', says Fernándo Herrera, vice-director of the Family and Life Subcommission, Episcopal Conference of Spain, Madrid. 'The euthanasic mentality it implies upholds a utilitarian criterion of human life, the value of which is measured in terms of physical well-being.' Even the less conservative press has drawn attention to the possibility of the decision paving the way for the routine provision of PID in determined diseases; currently Ministerial permission is granted on a case-by-case basis following the recommendations of the National Commission for Human Assisted Reproduction (NCHAR).

Of further concern is the very article of the law governing the use of PID, which states it can be performed by authorised centres for 'the detection of serious, early-appearing, inheritable diseases not susceptible to postnatal curative treatment given current scientific knowledge'. 'The question is, how do you define 'serious inheritable disease", asks Nicolás Jouve, professor of genetics at the University of Alcalá de Henares. 'Where do we draw the line on what is sufficiently undesirable to merit PID?' Herrera agrees, describing the law as open to the expansion of embryo selection towards other conditions. The law also fails to define the limits of 'early-appearing'.

The wording of the law also seems to imply that PID would not be contemplated if improvements in scientific knowledge led to a cure for a disease. 'But once we have lost our respect for embryos it is doubtful whether we would opt for corrective action rather than embryo selection', says Jouve. This might be particularly true if the treatment required was aggressive.

Concerns are even being raised at the medical level. 'In-vitro fertilisation has been associated with an increased risk of childhood tumours', says Natalia López Moratalla, professor of biochemistry and molecular biology, University of Navarra, Pamplona. She also explains that in-vitro fertilisation requires ovarian stimulation to obtain several ovules, and that women who have undergone this procedure have later been found at greater risk of breast cancer, melanoma and non-Hodgkin lymphoma. 'Spain is also the European country with the highest incidence of ovarian hyperstimulation syndrome, a sequela of ovarian stimulation treatment', says López. There are also reports from paediatricians that serious and rare diseases are more frequent among children born via techniques involving embryo selection. '[One of] the causes may be the immaturity of the eggs and sperm often used. The NCHAR should reflect on this and guarantee the provision of information about the risks involved', López concludes.

The debate continues over whether it is ethical to reject embryos to prevent them suffering a cancer they might never have developed. In the meantime, the adequacy of Spain's law could find itself tested by the NCHAR having to suddenly deal with a rapid increase in requests for PID.

Adrian Burton

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UK consensus on renal cancer

A consensus on the use of systemic agents for renal cell carcinoma (RCC) is based on level I evidence from randomised phase III trials.

In the UK, for patients with good prognosis the first line treatment options are sunitinib, bevacizumab and interferon alpha; for patients with intermediate prognosis sunitinib and bevacizumab and interferon-alpha; and finally for patients with poor prognosis, temsirolimus.

Treatment options for second-line treatment are sorafenib for patients who have had a cytokine first-line, and everolimus for patients who have had tyrosine kinase inhibitors (TKIs) or bevacizumab first-line. The guidelines provide level II evidence for sunitinib following cytokine failure, and for non-cross resistance between the TKIs, sorafenib and sunitinib.

The UK guidelines (*BJHM 2009;**70**: 284–6*) are expected to be updated every couple of years. They came out 7 weeks after the UK's National Institute for Health and Clinical Excellence (NICE) published final guidance recommending the use of sunitinib as a first-line treatment for metastatic RCC.

EUROFILE

What the elections mean for cancer

As the dust settles after the European elections, a group of MEPs from across the political spectrum will be mobilising themselves to scrutinise all new laws affecting cancer and pushing the European Commission to co-ordinate best practices on implementing national cancer plans.

The MEPs Against Cancer (MAC) group was set up in 2006 as a parliamentary interest group to make sure any new laws or legislative changes in areas such as health, chemicals, pharmaceuticals and research took cancer into consideration. Since then, its membership has grown from 47 to 69 MEPs, many of whom are cancer survivors.

The group is well-regarded by cancer organisations. According to Ingrid van den Neucker, public affairs manager at ECCO, 'The MAC group has been a success. The MEPs have been very committed, and succeeded not only in sensitising other MEPs to cancer issues but getting cancer on the agendas of EU presidencies, such with the Slovenian presidency in 2008.'

Before the elections, MAC released a manifesto pledging to work for the development and implementation of national cancer plans, investment in cancer prevention and public awareness. It will form the basis of the group's work in the new parliament. Alojz Peterle, one of three MAC co-chairs and a Slovenian MEP from the European People's Party, says 'the work will include dealing with problems such as the setting up of cancer registries.'

'MAC HAS BEEN SUCCESSFUL IN GETTING CANCER ON THE AGENDAS OF EU PRESIDENCIES'

Co-chair Adamos Adamou, an oncologist and Cypriot MEP from the European United Left advocates co-ordinating best practices on national cancer plans. 'We have to ensure best practices are shared to tackle the inequalities that now exist between western and eastern European countries. The Commission can co-ordinate. We can ask for an open method of co-ordination,' he says.

However, when the European Parliament re-convenes in September 2009, the group will have lost some of its most prominent members, including Adamou who did not stand for re-election.

Peterle has the ambition not just to rebuild the group but to take it further as a parliamentary inter-group. 'Our first action will be setting up an inter-group with a goal of recruiting 100 MEPs,' he says. This formal status would provide MAC with meeting rooms and language translation facilities. But according to van den Neucker at ECCO, it would also allow MAC to work directly on Commission proposals affecting cancer. 'The way MAC has been working in the last Parliament is not a bad way to start. But as an inter-group MAC would have more power. It would be able to work with dossiers directly and also give more visibility to the issues,' she says.

Hildrun Sundseth of the European Cancer Patient Coalition (ECPC) which provides the secretariat for MAC, has been garnering the support of big political parties, which is needed to establish an inter-group. With almost all the requisite signatures in hand, she is quietly confident that recruiting new blood won't pose any obstacles. 'The momentum is already there. MAC has such a reputation now that it will be easier to get more members,' she says.

Regardless of its status within the Parliament, the MAC group will face a heavy workload in September. Earlier this year, the Commission proposed a number of important changes to EU laws, which have been put on hold until the new MEPs take their seats. Proposed legislation includes a pharmaceutical package, aimed at combating the counterfeiting of prescription-only drugs, monitoring medicine safety and revising the rules on the provision of information on prescription-only drugs.

MAC co-chair Adamou was charged with drafting the Parliament's response to counterfeiting, an issue which has been increasingly affecting cancer drugs. 'Producers of false drugs are driven by profit. They look for expensive drugs to falsify, and these include cancer drugs. The internet plays a primary role in their illegal sale,' he says.

Although he did not stand for re-election, Adamou made a point of finishing his report early and handing it in personally to the Commission before the elections. However, the report will be allocated to another MEP to see it through the parliamentary process.

'OUR FIRST ACTION WILL BE TO SET UP AN INTER-GROUP WITH A GOAL OF RECRUITING 100 MEPS'

The report on monitoring drug safety will be drafted by another MAC member, British Socialist MEP Linda McAvan, should she be re-elected.

When it comes to the provision of information on prescription drugs, the EORTC is asking MAC to lobby for more open access to data held by the European Medicines Agency. Director General Françoise Meunier says, 'To avoid duplication and do better clinical trials in Europe it would be important for investigator networks to have some access to the EudraCT database.'

Food and nutrition labelling is also set to be considered by the group in the autumn of 2009, according to MAC member Satu Hassi, a Finnish MEP from the European Green Party. 'The proposed legislation would allow us to say how much saturated fat, sugar and salt can be marketed as healthy. But there is a big fast food industry lobby against this measure that has gained ground in the European Parliament.'

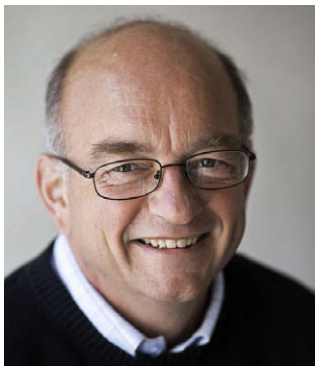
However, it is an important preventative measure, argues Hassi. 'Obesity in Europe is on the increase and a risk factor for both cancer and heart disease, and cardiovascular groups should also be looking at the legislation, she says.

Legislation on cross-border patient healthcare, the use of animals in scientific research, and novel foods which involve cloning animals for food production, is expected to be scrutinised in 2010.

Saffina Rana
Brussels

PODIUM

The State of Denmark



Dr. Hans Storm is director of cancer prevention at the Danish Cancer Society, Copenhagen. He is a member of the EUROCARE survival study, is on the steering board for Eurocourse and was on the steering committee for the European Network of Cancer Registries for 10 years. He spoke to EJC about a recent report from the Danish Commission on Prevention Priorities which is being widely debated in the Danish press.

Why do cancer patients fare so much worse in Denmark than in other Nordic countries?

For years, it has been impossible to disentangle the situation and establish whether patients, physicians or both were to blame. But recently, population-based research which links data on consumption with that from registries has come up with a simple explanation: tobacco and alcohol. Both men and women in Denmark smoke and drink too much. It explains most of the deficits in survival compared with other Nordic countries, and means that prevention is our best way forward.

Why is consumption so high in Denmark?

There is a liberal attitude towards alcohol and tobacco here. Cigarettes are cheap, the tax on them is low, and they are available in supermarkets and everywhere. Smoking is banned where food is served but is still allowed in bars which are less than 40 m^2; it is similar to the Spanish law which has been shown to be ineffective. In September 2008, it was made illegal to sell tobacco to anyone under 18, but the law is not enforced.

Danish people over 14 years of age drink, on average, 12 litres of alcohol per capita, per year. People are used to having wine with all meals and a lot of hard alcohol is drunk. Surveys have found that 10–15% exceed the recommended limit of 2 drinks per day for women, and 3 for men. Any reduction in heart disease associated with this level of drinking will be completely overtaken by increases in other diseases. The law states that people must be 16 years old to buy or import alcoholic beverages with more than 1.2% alcohol by volume – but beer is exempted from the import restriction! – and the law is not enforced.

What makes Denmark so different from neighbouring countries?

Danes put a high value on liberty and self-determination; they do not want to be regulated from top to bottom. It is not as easy to buy alcohol and tobacco in Norway or Sweden; in Sweden, even at my age, I'd have to show a driving licence as proof of age to be able to buy alcohol. The public impression of Sweden is of a country with legislation that controls people's lives although in fact, Denmark has more laws that impinge on citizens. But there is a real difference in the willingness of Danes to take advice from professional groups and services. In the medical field, that means Danes take less notice of information advising them how to behave or when to see a doctor.

It is difficult to change a culture?

It takes time but it is possible. One way is through strong legislation, another through changing the structure of society to promote healthy rather than unhealthy living.

Are there signs of impending change?

The Minister for Health had his title changed and is now the Minister for Health and Prevention. He set up the Danish Commission on Prevention Priorities, chaired by Professor Mette Wier who is head of a research organisation formed by the Danish communes (local governments). Several well-known epidemiologists sat on the committee whose task was, in 18 months, to decide on evidence-based preventive actions which could be introduced in Denmark to improve life expectancy by 3 years, over a 10 year period.

Our national institute for public health said this target was unambitious since it would have been achieved by doing nothing if current trends in life expectancy continue. One reason for this is, despite the lack of Government action, smoking prevalence has fallen by 1–1.5% per year over the past 15 years. But the decline seems to have levelled off over the past 2 years, so maybe the background increase in life expectancy will not continue.

What did the committee conclude?

The committee drew up a report including 52 recommendations for the Government. They were a little disappointing; there were few strong messages and those originally suggested were watered down by the Minister before the report went to print. So the committee originally recommended higher taxation of tobacco to bring prices in Denmark up to those in the UK, Ireland and Norway. But before the report came out, the Government increased the tax on a packet of cigarettes by 1/3 Danish kroner (=Euro 0.04), and said that they couldn't increase the price again. But this increase is miniscule, it's ridiculous. It means that the most effective tool we've got – the price – is something we're not going to use. The Government says that increasing taxation will increase illicit cross-border trade in cigarettes; but cigarettes are more expensive in Germany than here, where you can get a packet of cigarettes for 3 Euros. Nobody is going to smuggle in cigarettes from Germany.

Different calculations on the direct and indirect costs have been done but one study, which considered sickness benefits, family support when a smoker contracts a disease, and so on, found that smoking costs 21 billion kroner per

year. The Government receives about 7–8 billion kroner in tobacco tax revenue. There is no balance but this didn't come into the report at all. The Government is not willing to use the most effective tool we've got. Cynics might say that smoking is beneficial for the economy if smokers die by the age of 65 when the health problems start.

What did the report suggest?

Factors that could increase life expectancy were arranged into: smoking; alcohol; physical exercise; diet; early detection; workplace; young people; knowledge; implementation.

On smoking, the suggested price hike is not going to happen. The committee also suggested that all smoking indoors is prohibited, except in ones' own home. The public is in favour of a complete ban on smoking in public places along the lines of that in place in Ireland, but that doesn't seem to influence the Government.

The report said that tobacco should be removed as a visible sales item in shops, and should be sold under the counter. The law banning sales to young people under 18 years should be enforced, and should become the shop's responsibility. And there should be pictorial health warnings on cigarette packets. But this is all small stuff because most has already been decided at European level. Smoking cessation should be offered free of charge by all communes, and should be available in the workplace. These are recommendations for things that are already happening.

It called for information campaigns about smoking, but these have been done since the 1960s and we can't really say they're effective since they have never been linked to other interventions. They're probably necessary but not sufficient to increase cessation.

What about on alcohol?

The committee recommended that the age limit for buying alcohol be increased from 16 to 18 years old, and said that all educational institutions should have an alcohol policy. They've asked for a ban on advertising and want to reduce access to alcohol in certain areas such as sports venues. Communes are to be asked to promote the existing proposed drinking limits, which are twice as high as they should be. The committee obviously considered the link between drinking and cardiovascular disease, but not the literature on breast cancer. It's disappointing.

And physical exercise?

There are some interesting structural changes suggested here. The committee wants the communes to make local environments more conducive to increasing activity so that they promoting exercise and making it interesting as part of their normal services; targeting prevention without having it as a goal, which is good. There should also be more exercise in school for children. The government will probably support this as it will be paid for by the communes.

How involved are the communes in prevention?

Communes are responsible for primary prevention and under a new Health law last year, have to pay 20% of hospital costs; the rest is funded at regional and governmental level. But it is in the interests of communes to have a healthy population because of their contribution to hospital costs.

What did the report say about diet?

The committee called for an increase in tax on sugary and fatty foodstuffs, making fizzy drinks and chocolate much more expensive. They want to curb advertising of junk food and have proposed new labelling on foodstuffs, which manufacturers would have to do and which won't be very effective. They want healthy food and free fruit in all schools.

Are there any other interesting ideas in the report?

They include campaigns which are not going to make much difference to life expectancy within a 10 year period. Educational campaigns on obstructive lung disease or diabetes, for instance; typically those diseases without strong non-governmental organisations (NGOs), unlike cancer. They don't mention cancer at all, not even in the section on early diagnosis and screening. We really object to that: this is supposed to be an evidence-based activity and we have evidence for the effectiveness of screening for breast, cervical and colorectal cancer. But the provision of screening for these diseases is heterogeneous across the country. The committee could have made a difference here and it is disappointing that they didn't.

Why did cancer play such a small part in the report?

They were looking for life expectancy gains over 10 years and it takes a long time for prevention to show a benefit in cancer. Lung cancer develops for 5 years before it can be diagnosed; other cancers are underway for 15–20 years. So the revenue generated by prevention won't be seen for years after the current politicians have left office. In a way they have to be idealists to support prevention.

Is the Government obliged to implement the report's recommendations?

No, the Government can put up a think tank and take whatever it wants from it. But the committee has influence and can target Government action. If experts are asked to work on a report like this for more than a year, it would be strange if the Government didn't take any action proposed by their own advisors.

What has the reaction to the report been?

There has been a lively debate in the Danish press. Different committee members have been outspoken about the disappointing reaction of the minister to the report, especially in his lack of willingness to use taxation and regulation. That is where Government can make a difference in prevention and if it won't, we have a problem.

How far will the Danish Cancer Society support the report?

It feels like a missed opportunity; and is disappointing. But the report has good parts and we will support all of them energetically. This is an opening for debate with politicians, even if it has delayed decisions. We think that our politicians have a genuine wish to be more involved in prevention, and so it is a positive step. But prevention remains an uphill battle in Denmark.

Helen Saul