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Summary: Concept, Rationale, Evidence and Future Directions

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Introduction: Concept & rationale The concept of PBI is that radiotherapy confined to the vicinity of the primary tumour after local excision of early stage breast cancer is expected to cause fewer late adverse effects (AE) and be no less effective as whole breast radiotherapy (WBRT) for a large subpopulation of women with early breast cancer. The concept is based on the spatial pattern of local relapse (LR) after breast conservation surgery +/− WBRT. Clinical observations confirm that the majority of LR present in the vicinity of the primary tumour within the first 5 years. A minority present in other quadrants and these tend to occur over a longer time period. It is widely believed that a high proportion of other quadrant LR represent new primary tumours, not true recurrences. Which are not prevented by WBRT. It is against this background that techniques of PBI have been developed and tested.

Summary: Evidence & future directions Notable departures from conventional radiation dose-time, volume and other radiobiological parameters have been highlighted by Dr Petersen, and the relative advantages of diverse external beam and brachytherapy techniques have been presented by Drs Orrechia and Dr Van Limbergen, respectively. A summary of the evidence might go something like this. There is a large body of non-randomised evidence showing that PBI can be both safe and effective, and published consensus guidelines have described patient categories that might be suitable for different PBI approaches. Consensus indicates agreement. We may all agree, but still be wrong, an inevitable risk when mature outcome data from randomised trials are so limited. It is noticeable that LR rates in published trials of breast conservation therapies have fallen over the last 20 years, so it may not be justified to attribute very favourable outcome data in non-randomised studies to the efficacy of PBI. The future needs to avoid an environment in which the requirement for high levels of evidence is over-ridden by professional and commercial competition. Innovation often challenges the status quo, but certain principles that are abandoned at our peril.

Scientific Symposium (Tue, 27 Sep, 09:00−11:00)

Transitions in Care for Cancer Patients

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Who are the Carers in Ambulatory Care?

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Improvements in supportive care have led to an increasing utilisation of the ambulatory care setting for patients receiving cancer treatments. Even in the more traditional surgical oncology fields, growing interest in “fast track surgery” options is leading to shorter inpatient hospital stays. Research to date has primarily focused on the physical and economical benefits of these changes in the delivery of cancer care. Less commonly discussed is the impact of this shifting responsibility for ongoing care and support from the inpatient and specialist cancer centre to the community setting. This paper will examine the research in this field and identify gaps in our current knowldege of the impact of cancer patients and their family. Alternative models for ambulatory care and sharing care responsibilities will be examined, including recent research being undertaken by the author and colleagues.

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Cultural Aspects in the Transition From Hospital to Community Care

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Background: This study examines the care transition experience of minority cancer patients and assesses barriers to effective transitions.

Materials and Methods: Qualitative and quantitative methods were used. Qualitatively − focus groups and in-depth personal interviews were conducted with patients and their families (a total of 25 patients) and with 33 providers (physicians, nurses, social workers, and administrative managers), at hospital and community settings. The quantitative phase included administration of a validated questionnaire − the Care Transition Measure (CTM), that rates patients' care transition experience on a 0−100 point scale; and structured observations on the hospital discharge process (on the explanations provided and the language used during the discharge briefing). Participants were adult oncology patients at a large Oncology Center in Israel, who speak Hebrew, Arabic or Russian, to reflect the majority and two of the largest minority spoken languages in Israel.

Results: Qualitative analysis showed that patients face a complex and fragmented system with multiple providers and services. Difficulties in navigating the health care system are exacerbated for minorities with language and cultural barriers. Mechanisms to overcome barriers include undertaking of informal care coordinating roles by the patients' general practitioners (GPs) or nurses. The quantitative phase included a survey of 422 patients. GPs who treated Arabic and Russian speaking patients were more likely to discuss the discharge recommendations with their patients than physicians who treated Hebrew speaking patients. GPs' involvement was found to be the most significant variable affecting the quality of the transition process as rated on the CTM ($p < 0.001$). Structured observations on the discharge process of 62 minority patients showed that provider-patient language concordance was one of the strongest correlates of effective care transitions ($p < 0.001$).

Conclusions: Our findings point to the role of interpersonal care, including discussion of hospital care transition recommendations with the GP and in-hospital provider-patient language concordance, in promoting effective care transitions. Interventions targeted towards care transition support for minority patients should emphasize ongoing counseling throughout the care trajectory (during and post hospitalization).

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Transition to Survivorship: Key Issues and Models of Care

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Due to advancements in diagnosis and treatment, the number of cancer survivors is increasing dramatically across the globe. To assure the highest quality of life for these individuals, new models of care are being developed, implemented and evaluated. This session will examine the most important issues facing survivors and describe the new, efficient models of care that are focused on the provision of comprehensive services to address them − surveillance for recurrence; screening for second cancers; prevention, surveillance and intervention for long term and late effects; health promotion counseling; psychosocial services and communication between specialist and generalist providers. Novel practice settings and new provider models will be discussed, as well as recommendations for program metrics and needed empirical evaluations of these new approaches to providing survivorship care.

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Facilitating Transition to Palliative Care

Abstract not received

Scientific Symposium (Tue, 27 Sep, 09:00−11:00)

Hepatocellular Carcinoma: Novel Advancements in Diagnosis and Treatment

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New Molecular Targeted Therapies

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Hepatocellular carcinoma (HCC) has increased its mortality in the US and Europe in the last decades. Since most patients are still diagnosed at advanced stages, there is an urgent clinical need for developing novel systemic agents. In this setting, sorafenib, a tyrosine kinase inhibitor (TKI) with blockade activity against BRAF, VEGFR and PDGFR, has demonstrated its antitumour activity by significantly improving survival of patients with advanced HCC. This major advancement has paved the way for exploring novel molecular agents and combination of drugs in this complex disease.

There is a blossom of high-end pivotal trials for regulatory approval in HCC research. These studies mostly test TKI in combination (e.g., erlotinib) or in comparison (e.g., linifanib, brivanib) with sorafenib in first line. In addition, for patients failing or intolerant to sorafenib, new trials are testing TKI (e.g., everolimus, brivanib) and monoclonal antibodies (e.g., ramucirumab) in second line. Early clinical trials are also exploring signals of efficacy for up to 60 novel drugs in the field. All these studies might change the management of patients by 2012–2014 in an unprecedented manner, and can establish the *backbone* combination therapy to be applied to