The level of discussion has clearly raised over time, as each of the partners or interst groups has become more knowledgeable and aware by the pure fact of longer survival, media attention, internet and the availability since almost 20 years of a national, rather clinical, cancer registry, that increasingly publishes analyses on quality of oncological care. Current tendencies are increasing bureaucratic meddling (asking for full transparency), which is legitimised by the legal changes in health insurance in 2006, a sort of political 'big bang' aiming to unleash market forces; the current system supplies obligatory basis insurance to everybody – with about 1% of patients being uninsured – allows for more competition between hospitals (diminishing from 250 in 1980 to <100 now) and care supplyers, ever subspecialising and thus also adding to fragmentation in the care for increasing amounts of elderly patients.
Although it hardly works in oncology, the market ideology dictates that health insurance companies only buy low priced, high quality care for 'their' insured patients (who could run away every year which cancer patients do not tend to do) while getting maximal transparency.
Through all of these dynamic & chaotic movements there are the usual long term (10−20 years) developments in (wo)manpowerplanning taking on board subspecialization within surgical oncology, medical oncology and paediatric oncology, radiotherapy planning etc. Although drug development is also a long term affair, it seems to cause short term medical and budgetary shocks when they are allowed to the market, which especially plays a role in medical and hemato-oncology. The latter domain stands out because a long term planning was undertaken already more than 25 years ago as a result of which it not only became strong in manpower planning but also in strong emphasis of clinical trial organization (HOVON) with a high participation to clinical trials and which is now focussing on quality of care. It seems, 'everybody' is now focussed on quality of care, regardless of any plan.
The history of national cancer plans goes back to the 1970's (a start being made in the 1950's with failed cancer registration, except for the Eindhoven Cancer Registry and the Netherlands Cancer Institute and Daniel den Hoed registries), after the 'War against cancer' was unleashed and the Dutch Cancer Society retracted from its coordinating role in promoting quality of care. It resulted in the foundation of 9 (now 8, soon 5) regional comprehensive cancer centres, hosting also the cancer registries and various national initiatives (by the Health Council) for enlarging radiotherapy capacity, promoting home care and mass screening initiatives for cervical and breast cancer. This was facilitated much by scenario development during the 80's in a national committee of experts, followed by so called signalling committees since the early 90's, coming back under control of the Dutch Cancer Society in the late 90's. This resulted in a number of expert committees that reported on the role of prevention by dietary and physical exercise interventions, the need for colorectal cancer screening, the (again scenario-wise estimated) development of cancer prevalence and its implications for geriatric oncology and surveillance and the growing importance of imaging and molecular diagnostics and staging, soon te be followed by a report on quality of oncological care and the role of regionalization and subspecialization. Other major developments are in the domain of cervical cancer screening and HPV-vaccination, the incorporation of expensive drugs in the budgets and the need for cost-effectiveness. The diversity of topics makes it clear why a national cancer plan is so difficult to develop and remain actual. In fact, such efforts have been undertaken since 2003 by a coalition of functionaries from the Ministry of Health, health insurance companies, patient group and managers of comprehensive cancer centres aiming at more coordination at operational level, in fact the job of the CCC's. The greater role (or perspective) given to psycho-social care was of course not enough and so little professional involvement has resulted with just pleas for efficiency.
All in all, an optimal mix might still be available for a country of only (almost) 17 million people, whose culture and social structure is so affected by its neighbours from Scandinavia, the UK, Belgium/France and Germany and that thus tries to escape through its close liaisons with the USA.

Special Session (Tue, 22 Sep, 13:30−14:30)
Side-effects of treatment for early disease − which is the best?

120 INVITED

Radiotherapy

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Assessment of side-effects of treatment is not easy. Problems include the prevalence of bladder, bowel and sexual dysfunction in the normal ageing male population, the differences between patient-reported and physician-assessed toxicity, and the paucity of randomized controlled trials comparing the different treatments.
The recently published SPCG-7 trial, because it is a relatively large prospective trial that randomized patients to receive prostate radiotherapy or not, provides some of the best data available. SPCG-7 provides useful estimates of the risk of bladder and bowel toxicity from radiotherapy, although assessment of the impact of treatment on sexual function is more difficult because all patients received hormones. It should also be noted that the radiotherapy techniques used date back to the 1990's. It is likely that recent advances in IMRT and IGRT will reduce the risk of side-effects from prostate radiotherapy.
It is interesting to note that prostate radiotherapy can have beneficial side-effects as well as adverse side-effects. For example, there are good data that the frequency of nocturia is reduced after radiotherapy, in comparison with baseline levels.
Individual patient dosimetry and clinical characteristics, such as previous bowel surgery, influence the risk of radiotherapy toxicity. Taken together with a patient's values on the relative importance of treatment toxicity and efficacy, these factors could be used to individualise radiotherapy dose.
Which is the best? Although there are no randomised trials comparing radiotherapy with surgery in early prostate cancer, there are several good quality retrospective comparisons focusing on quality of life. The data from these studies should help patients to decide which treatment is best for them.

Special Session (Tue, 22 Sep, 13:30−14:30)
Very late normal tissue damage after radiotherapy

122 INVITED

Long-term risks after radiotherapy (RT) for testicular cancer (TC)

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Background: During the last five decades of the 20th century, RT has been the mainstay of treatment of TC, in particular of seminoma (S). Epidemiological studies have increasingly documented severe long-term health effects in testicular cancer survivors, related to their treatment.
Material and Methods: Review of the literature and institutional experience.
Results: Mediastinal RT (used before ca.1975) significantly increases the risk of long-term cardiac complications, and is no longer used routinely in the curative treatment of TC. After abdominal RT for TC the life time relative risk (RR) of second cancer is approximately doubled, the malignancy typically diagnosed with a latency of 10−15 years (1). Combination with chemotherapy increases this risk furthermore (RR $\approx$ 3). Most of the tumors are located in the G.I. tract or in the bladder. G.I. ulcera represent the most frequent benign long-term morbidity after abdominal RT, but in patients aged
After the introduction of cisplatin-based chemotherapy routine RT has been restricted to patients with S. The target dose has gradually been reduced from 36 to 20 Gy, applied to the paraaortic region. Testicular RT (20 Gy, due to cancer in situ) is highly effective in avoiding the development of invasive TC, but may lead to endocrine hypogonadism requiring testosterone substitution.
Conclusion: Though being an effective adjuvant and therapeutic treatment in S, the use of RT in TC should be minimized as much as possible due to its long-term risk of severe complications. In primary treatment there is usually no need to combine cisplatin-based chemotherapy with RT.

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