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Future directions for FECS

Members of the Federation of European Cancer Societies' (FECS) Board of Directors and Presidents of the member societies met in Hamburg on 19 and 20 January 2001 to make plans for the future. The strategic planning meeting identified goals and objectives for the period 2001–2003, as well as in the longer term.

Following presentations from the member societies, the Association of European Cancer Leagues, and the FECS External Affairs and Education Units, members spent a considerable time discussing FECS mission and future strategy. The need for better communication and transparency between FECS and its members was emphasised by many speakers. Members also felt that FECS' non-ECCO activities were insufficiently known and that their visibility should be improved.

"BETTER COMMUNICATION WITH MEMBERS IS NEEDED"

FECS' mission

The meeting agreed the following mission statement: The Federation of European Cancer Societies (FECS) aims to promote and co-ordinate collaboration between European societies active in different fields of cancer research, prevention and treatment, with the ultimate goal of providing the best possible treatment and care for all European patients.

Much time was spent in discussing the continuing medical education project, recently awarded funding under the European Commission's Leonardo da Vinci programme. This project, which has 12 European partners, aims to work to identify and address educational needs for medical and allied health professionals involved in cancer treatment, research and care in Europe. All those attending felt that the project offered FECS a great opportunity to develop its activities in education and training and to foster partnership between its members and other organisations active in cancer.

A role for FECS in quality assurance on cancer outcomes, and in drawing up oncology guidelines for all European countries, were suggestions for longer-term activities.

"I felt that the meeting was positive and the outcome helpful for all those attending," said Professor John Smyth, the *European Journal of Cancer* Editor, who moderated. ''As a former officer of FECS, I was pleased to see that a spirit of cooperation and collaboration still holds sway. I believe that FECS remains a powerful force in multidisciplinary European oncology.''

Mary Rice
FECS Communications Consultant

UK authorities classify cancer units

UK health authorities and NHS Trusts have been urged to classify existing cancer units to help them decide how many clinical (radiation) and medical oncologists will be needed to provide a high quality service for patients.

The UK Royal College of Physicians and Royal College of Radiologists recommend in a joint report that cancer units be designated one of three types according to catchment population and geographical area.

Type I units are run by a designated head non-surgical oncologist. They typically have clinics and multidisciplinary teams specific to common cancers; a designated chemotherapy ward; 24-h cover by oncologists; patient self-referral; psychosocial support and palliative care. They are most appropriate for a large catchment area where patients have a long travel time. A typical type I cancer unit with a catchment population of 250 000 and accreditation for treatment of breast, lung and colorectal cancer would require a minimum of 12 oncologist notional half days (NHDs).

Type II units have similar facilities but lack the designated chemotherapy ward with 24-h cover. They are most appropriate for a large catchment population where patients have a short travel time. With a similar brief, a minimum of 10 oncologist NHDs would be required. Type III units have specific and general oncology clinics, multidisciplinary teams, psychosocial support and palliative care. They are most appropriate for a small catchment population with a short travel time or could be in a district general hospital near a Type I unit. The number of NHDs depends on the number of tumour types and number of patients treated but would be a minimum of 4.

The report recommends that cancer co-ordinators and directors of cancer centres calculate the number of each type of unit in their network. "This would enable health service planners to predict the number of consultant oncologists required to provide specialist non-surgical services in cancer units in England and Wales."

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Co-ordinator is key

Quality control co-ordinators can greatly influence the success of sentinel node (SN) biopsies during and after the learning period, say surgeons from The Netherlands (*Eur J Surg Oncol* 2000, **26,** 652–656). They demonstrated that the procedure could be introduced with similar success in different types of hospital.

Most studies into SN biopsy have been carried out in a single institution where only one or two surgeons carry out the work. Concern has been expressed that problems could arise with more widespread use. The Dutch study, therefore, compared results from a university hospital with a new resident every 3 months; a cancer centre with five surgical oncologists; and a general teaching hospital where one experienced surgeon was responsible for the procedure.

The co-ordinator supervised the implementation of the procedure, was present where possible at each operation and continuously fed back information about the technique, pitfalls and results.

The study included 232 women with operable breast cancer. The sensitivity and false-negativity were the same for the three hospitals and, overall, results were better than for axillary lymph node dissection (ALND). "We conclude that there is no doubt about the SN concept for breast cancer; the SN is as accurate a staging procedure as a complete ALND," they write.

"SN IS AS ACCURATE A STAGING PROCEDURE AS A COMPLETE ALND."

They recommend that hospitals should carry out a double procedure of SN plus ALND during a learning curve of 50 patients. If it meets the standard of less than 5% false-negatives, it can proceed with SN only, provided there is a central registration point and adequate follow-up. Regular ultrasound of the axilla is recommended.

The wider introduction of sentinel node biopsy in The Netherlands will be organised along these lines. For example, a co-ordinator will visit 23 regional hospitals responsible for 1200 patients with breast cancer per year. The optimal procedure will be developed and meetings will be held to learn from mistakes made. Patients will be registered and called annually for ultrasound of the axilla. "With this examination we hope to maintain the present high level of local control," they say.

Fibre: contradictions continue

High levels of dietary fibre may protect against cancers of the upper digestive tract, say Italian researchers (*Int J Cancer* 2001, **91**, 283–287). The study is published in the wake of other research which found that fibre supplements may in fact increase risk of colorectal cancer (*Lancet* 2000, **356**, 1300–1306).

The Italian case–control study included 902 hospital patients with oral, pharyngeal and oesophageal cancer, and 1950 controls admitted to the same hospitals with acute, non-neoplastic diseases. All were interviewed about their diet while in hospital.

Researchers found that those with the highest fibre intake had less than half the risk of these cancers compared with those with the lowest fibre intake. The relationship was stronger for oral and pharyngeal cancer than for oesophageal cancer. It held regardless of sex, age, education, alcohol and tobacco consumption and energy intake.

The researchers suggest that fibre may bind carcinogens and limit their contact with the epithelium of the upper digestive tract. It is also known to slow down the absorption of carbohydrates and the glycaemic response, thus reducing hyperinsulinemia and insulin-like growth factors (IGF). They acknowledge that a diet high in fruit, vegetables and whole grains may indicate a healthy lifestyle and a low intake of refined cereals, meat and saturated fats. These foods have been linked with oral and oesophageal cancers among Italians.

However, they say their data suggests that "the protection is, at least in part, attributable to fibre itself". The effect is independent of smoking, drinking and other dietary factors, they say.

Sentinel node in multicentric breast cancer

Sentinel node biopsy may become an alternative to complete axillary dissection, even in multicentric breast cancer, say Austrian researchers. In a prospective study (*Lancet* 2001, **357**, 122) including 19 patients with multicentric invasive breast cancer, they found that sentinel node status matched the axillary sample in all cases. Further assessment will show whether sentinel node biopsy can become an alternative to complete axillary dissection in these patients.

Multicentric breast cancer is considered by most clinicians to be a contraindication for sentinel-node biopsy. However, Dr Peter Schenk and Dr Wolfgang Wayand (Ludwig Bolzmann Institute for Surgical Laparoscopy, Linz, Austria) suggest that sentinel node biopsy may have advantages over complete axillary dissection, because samples undergo more thorough histological assessment, which might lead to more accurate staging. Furthermore, in patients with clinically negative lymph nodes, it could result in lower morbidity.

Sentinel node biopsies were taken after an injection either of a vital blue dye, alone or with a radiolabelled colloid. Some patients underwent pre-operative lymphoscintigraphy with a γ camera to see lymphatic drainage. Sentinel nodes were identified intraoperatively with a hand held γ probe. They found that 9 patients had no tumour in the sentinel node, confirmed by a negative axillary sample. The other 10 patients had metastatic disease in the sentinel node. "There was a 100% identification rate of a sentinel node and no false-negative results," they say.

"THERE WAS A 100% IDENTIFICATION RATE AND NO FALSE NEGATIVES."

Tamoxifen: 'No effect on cardiovascular risk'

Tamoxifen does not alter cardiovascular risk in women at risk of breast cancer, say American researchers (*J Natl Cancer Inst* 2001, **93**, 16–21). New findings from the National Surgical Adjuvant Breast and Bowel Project Breast Cancer Prevention Trial (BCPT) found the drug had neither a beneficial nor an adverse effect on cardiovascular risk.

The BCPT included cardiovascular data on 13 194 women followed for an average of 4 years. They were all at increased risk of breast cancer and some, 1048, had existing clinical coronary heart disease. There was no statistical difference in rates of cardiovascular events among women on tamoxifen compared with those taking placebo. This lack of effect applied whether or not women had pre-existing heart disease.

Tamoxifen improves the lipid profile and had been expected to reduce clinical heart disease. However, the researchers say that tamoxifen-associated lipid lowering is not an accurate surrogate marker for the reduction of heart disease. "The overall clinical effect of tamoxifen in women with and without heart disease is related to breast cancer prevention and is independent of tamoxifen's cardiovascular effects," they write.

One limitation of the study is that evaluation of cardiovascular effects was a secondary goal; it was designed to collect information on baseline cardiac status and cardiovascular effects during follow up. But the researchers say this work represents the largest reported cardiovascular study of a non-steroid hormone-related compound in women. They conclude, "Because tamoxifen is being prescribed increasingly for the prevention and treatment of breast cancer, longer term clinical trials of tamoxifen in women are needed to further elucidate its long-term cardiovascular effects."

Professor Craig Jordan

In a related editorial (*J Natl Cancer Inst* 2001, **93**, 2–4), Professor Craig Jordan (Northwestern University, Chicago, IL, USA) points out that tamoxifen taken to prevent breast cancer has a better safety profile than hormone replacement therapy in women at risk of coronary heart disease. Other ongoing trials should establish whether oestrogen really does protect against heart disease, as has been believed for the past 50 years. ''In addition, we need to discover why oestrogen can successfully prevent osteoporosis but its beneficial effect is much harder to demonstrate,'' he writes.

In terms of lifetime risk, Professor Jordan states that 1 in 3 women will die of heart disease and 1 in 6 of stroke; whereas 1 in 9 will develop breast cancer and only 1 in 25 will eventually die of it. "It is. . .clear that a successful therapeutic intervention to improve death rates for coronary heart disease, however modest, will have a disproportionately large benefit on women's health," he says.

Distress among survivors of childhood cancers

One in five young adults who survived cancer as children may have clinical levels of stress and anxiety, new work shows (*J Clin Oncol* 2000, **18,** 4060–4066). American researchers found that 20.5% of patients questionned met criteria for post-traumatic stress disorder at some point since the end of their treatment.

The study included 78 adults aged between 18 and 40 years, and found a significant proportion reported re-experiencing, arousal and avoidant symptoms that often revolved around issues of healthcare and/or illness. "Events such as driving to the hospital, or smells associated with their treatment may be reminders potent enough to generate strong physical and emotional responses even more than 10 years after treatment," they write.

This can lead to hypervigilance about physical symptoms or, alternatively, avoidance of medical care because it is a reminder of past experience.

Survivors perceptions of treatment and its effects were more highly associated with post-traumatic stress than were more objective medical data. The researchers say that physicians, nurses and other healthcare practitioners can support the development of young adult survivors by assessing their beliefs about their disease, treatment history and current functioning. "It is by attending to these issues that healthcare providers can alleviate ongoing cancer-related distress and promote competence," they conclude.

Urine test for bladder cancer?

Testing urine samples for survivin could reveal new or recurrent bladder cancer, suggest American researchers (*JAMA* 2001, **285**, 324–328). Preliminary results suggest that survivin analysis could become a simple, non-invasive diagnostic test for the disease.

Survivin is believed to be involved in the deregulation of apoptosis in urothelial cancers. The researchers, from Yale University (New Haven, CT, USA), detected it in the urine of all 46 patients with new or recurrent bladder cancer. It was not detected in 32 or 35 patients treated for cancer but with negative cytoscopy results. No healthy volunteers, nor those whose with prostate, vaginal or cervical cancer, had detectable levels.

In addition, patients with low-grade bladder cancer had significantly lower urine survivin levels than patients with carcinoma *in situ*.

The researchers suggest that the test could complement cytology and other diagnostic markers, improve monitoring of patients, and identify early recurrences or *de novo* neoplasms. They stress its simplicity and cost-effectiveness but say more research is needed: ''Analysis of a larger patient series may establish the general suitability of urine survivin detection for monitoring response to therapy and follow-up protocols in bladder cancer''.

Patients search for info on cancer genetics

An Italian website designed for health care providers is accessed mainly by the general public, a study found (*Cancer Strategy* 2000, **2**, 35–43). The portal GENECA was developed as an entry point into cancer genetics resources, providing information and consultation services on hereditary tumours. However, the study found that the 'average visitor' was a 33 year old male citizen, concerned with his own risk of developing cancer and unable to find an adequate answer locally.

Dr L. Scopsi (WHO Collaborating Centre for Cancer Control of Uncommon Tumours, Milan, Italy) analysed portal hits for two distinct periods: July–December 1997 and April 1998–March 1999. In that time, daily requests for documents almost doubled, from 120 per day during the earlier period, to 218 per day later.

GENECA is a not-for-profit initiative authorised by the Order of Physicians and Surgeons of La Spezia, Italy. It spans nearly 900 pages, subdivided into 15 sections, the key of which is the CANC*h*ER section which contains information on hereditary and familial cancers. Another section, GECO, collects unsolicited inquiries from health professionals whose questions are not answered online.

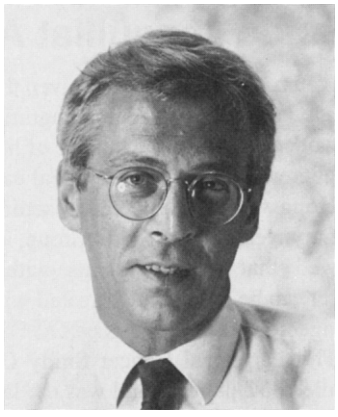
The study found that, in the later period, 94% of visitors to the site were from Italy but only 16.5% were physicians. Even fewer of the requests made to GECO, 13.5%, were from physicians.

However, the study found a steady stream of visitors to the site and concluded, "These results. . .illustrate how original medical information provided in national languages can be disseminated much more effectively through the Internet than with any other media."

But problems could arise with the growth of online health information: "The information could be misinterpreted, simply wrong or out-of-date, or more up-to-date than that provided by the patients's physician." GENECA is updated weekly. GENECA can be found at *http://www.geneca.org*

'Extraordinary' media reports on depleted uranium

Recent media reports on the effects of depleted uranium have been so extraordinary that even the most elementary statistical analysis would reveal whether there is any substance behind them according to epidemiologist Professor Julian Peto (Institute of Cancer Research, Sutton, Surrey, UK). One report claimed that 300 of 5000 Serbian refugees bombed in



Professor Julian Peto

Sarajevo had subsequently died of cancer. ''It's obviously possible, but it would be the most remarkable example of carcinogenesis ever seen in epidemiological history,'' he said. If the report were true, a further 60 cancer deaths would be expected in the next year.

Cases of leukaemia among Italian servicemen have also been reported in the media. "Both anecdotes, if true, would be completely without precedent," he said.

The media debate has concentrated entirely on politics — such as whether or not a report was widely circulated — and has not questioned the evidence underlying the story at all. "The fact that the focus has switched from leukaemia in Italian soldiers to cancer in Serbian refugees to mouth cancer in Serbian servicemen illustrates the point rather nicely," he said.

Professor Peto said the story was reminiscent of the current scare over the safety of the measles, mumps and rubella vaccine, which has led to a reduction in childhood immunisation rates. However, he said the depleted uranium story was less worrying since US forces have stopped using it in any case and other countries are likely to follow suit.

A recent editorial (*Br Med J* 2001, **322**, 123–124) pointed out that depleted uranium has only 60% of the radioactivity of natural uranium, which is itself 10 000 times less radioactive than radon. Epidemiological studies exist among uranium miners, millers and other processors worldwide, and from its use in the Gulf war, and the argument for uranium being the cause of leukaemia in peacekeeping forces is ''thin'', says Professor Melissa McDiarmid (University of Maryland, Baltimore, USA).

She says, though, that the questions raised are understandable, since the cold war sensitised us to the fear of nuclear exchange. "Many of us, including those in the medical community, have little familiarity with the dose–response curves of health

"THE MOST REMARKABLE EXAMPLE OF CARCINOGENESIS IN EPIDEMIOLOGICAL HISTORY."

effects caused by radiation exposure. Experts in risk communication tell us that lack of familiarity with a hazard heightens the public perception of risk. In this context, pronouncements about background rates of disease observable in populations being statistically expected fail." Professor McDiarmid stresses that attribution of disease to 'expected' or 'background levels' should be diagnosis of exclusion. "Vigilance is warranted," she says. Hazard communication training is in order for military and humanitarian staff and for local populations. "Low risk radiation issues aside, children should not be playing with depleted uranium penetrators and environmental monitoring . . . is appropriate in highly affected areas," she concludes.

INTERVIEW

Dr Giuseppe Giaccone was appointed Professor of Medical Oncology at Vrije Universiteit, Amsterdam, in July 2000. His main research interest is in early clinical research on new anticancer agents for lung cancer and other solid tumours. He is a board member of EORTC and has been the Chairman of the EORTC Lung Cancer Group for 6 years.

Dr Giuseppe Giaccone

Where did you train?

I did my clinical training in Turin, Italy, then spent 2 years in the laboratory at the US National Cancer institute, Bethesda. From there, 10 years ago, I moved to Amsterdam and I've been here ever since.

Who inspired you?

In my clinical work, it was Professor Gordon McVie, while he was chairman of the EORTC's lung cancer group. He was good at enthusing people, and he encouraged me to consider doing basic science, as well as clinical work. Also, Dr John Minna, who was head of oncology in Bethesda while I was there and who has done essential work in lung cancer.

Why did you choose to work in the field of cancer?

There must be a reason but I can't identify it. I was just interested in oncology from very early on.

Did any other branch of medicine appeal?

I initially wanted to be a psychiatrist but I worked in Scottish psychiatric hospitals for 2 months, where they were still using electroconvulsive therapy. I didn't like it and I changed my mind on psychiatry. I also thought about being an ophthalmologist.

Might you have done something else altogether?

Yes. Like many doctors, I am interested in music and I used to play classical guitar at a professional level. I played in a chamber music group and might have made a career of it, but I went to medical school.

What has been the highlight of your career to date?

My 2 years in the States when I was fully immersed in basic science. It changed my life. As a result, I not only continued to do basic and clinical research when I left the States, but I also moved country. I actually did return to Italy for a few months, but there is little money spent on research in Italy, and it was difficult.

. . .and your greatest regret?

Being unable to conduct translational research in Italy.

If you could complete only one more task before you retire, what would it be?

If it is not to defeat cancer, which seems rather ambitious, it would be at least to find treatments that substantially prolong survival from lung cancer and other common solid tumours.

What is your greatest fear for the profession?

That academic departments will lose their independence. There is nothing wrong with collaboration with drug companies, but it increasingly feels as though we are working for them. The only way to prevent them determining our priorities is to have a stronger community of physicians who conduct research at a serious level.

What impact has the Internet had on your working life?

Online information has become essential in research. I spend lots of my day in front of the computer — writing papers and working on e-mails — and I don't seem to need to go to the library any more.

How do you relax?

By not working! I still like to play the guitar but it's not always relaxing. I last performed 2 years ago, accompanying a professional singer, a contralto, which was pretty stressful. I had to take 2 weeks' vacation to prepare for it! The performance was fun but I don't have plans for another.

Who is your favourite author?

I try to read in English, or Dutch sometimes. I don't have a favourite author, but I read Gabriel Garcia Marquez' books a long time ago and I still remember them. But I couldn't read them in the original language so it was not totally satisfactory.

What do you wish you had known before you embarked on your career?

The importance of basic research. I had done 8 or 9 years' clinical work before I did any research and I would have liked to do it earlier. It is not that you can treat patients better if you know about oncogenes, not yet, but it does give you more hope. Clinical work alone can be depressing and you risk becoming cynical, perhaps failing to take steps which could improve things.

What piece of advice would you give someone starting out now?

Go and get experience abroad in a highly regarded centre. Whether you are in research or clinical work, meeting new people and experiencing new cultures is more challenging than staying in your own safe environment.

What is your favourite carcinogen?

I don't smoke and I drink red wine. I'm probably using carcinogens but I'm not aware of it, sorry!