



NEWS...NEWS...NEWS

IARC links weight gain to cancers

Weight gain and inactivity are the most important avoidable causes of many common cancers in Europe, according to a panel of international experts. A meeting at the World Health Organization's (WHO) International Agency for Research on Cancer (IARC) in Lyon (13–20 February 2001) concluded that up to one-third of tumours of the colon, breast and kidney can be attributed to insufficient physical activity, and being overweight.

Being overweight has become increasingly common over the last two decades and in some western countries it has reached 'epidemic dimensions,' the panel concluded. "Limiting weight gain reduces the risk of postmenopausal breast cancer and cancer of the colon, endometrium of the uterus, kidney and adenocarcinoma of the oesophagus. Regular physical activity reduces the risk of breast and colon cancer, and possibly that of endometrial cancer and prostate cancer."

They said that about half the population of Europe is currently overweight and that urban areas of many developing countries have a similar prevalence. "The fundamental causes of the obesity and overweight epidemic are societal, resulting from an environment that promotes sedentary lifestyles and over-consumption of highly-calorific food," they said.

The panel notes that obesity can not be prevented or managed solely at the level of the individual. "Governments, the food industry, international agencies, the media, communities and individuals all need to work together to modify the environment so that it is less conducive to weight gain."

Recommendations for research include:

- Critically evaluate methods for the assessment of body composition, physical activity and diet.
- Enhance systems for monitoring trends in body composition and physical activity in populations.

- Conduct observational epidemiological studies to assess cancer risk.
- Conduct long-term clinical intervention studies to alter relevant behaviour patterns.
- Conduct community intervention studies.
- Establish mechanisms by which weight gain and physical activity are related to development of cancer.

The report calls for public education on obesity and inactivity and improved physical education programmes in schools. It also calls on health professionals to counsel individuals about a healthy range of body weight.

The IARC Working group's full review will be published later this year (2001) in Volume 6, *IARC Handbooks of Cancer Prevention*. Evaluations and recommendations can be found at <http://www.iarc.fr/pageroot/UNITS/Chemoprevention2.html>

New National Cancer Research Institute in UK

A National Cancer Research Institute (NCRI) is to be established in the UK to co-ordinate all UK research, the Department of Health has announced. The new organisation will encompass all UK health departments, the Medical Research Council, the Cancer Research Campaign (CRC) and Imperial Cancer Research Fund (ICRF), the Ludwig Institute for Cancer Research, the Marie Curie Research Institute and the pharmaceutical industry.

Secretary of State for Health Mr Alan Milburn said, "We have centres of excellence funded by a combination of Government, cancer research charities and industry. It is now time to

co-ordinate this research so that patients benefit as quickly as possible".

Professor Mike Richards, the National Cancer Director, said, "The establishment of NCRI is an important milestone for cancer research in

"IT IS TIME TO CO-ORDINATE RESEARCH."

the UK. Its establishment has been welcomed by leaders of cancer in this country and in the USA".

Sir Paul Nurse, Director General of ICRF, said, "Co-ordinating cancer research strategy in the UK through the NCRI will help us make the most

of the advances our scientists are pioneering. It should also help us catch up with progress being made by colleagues in the rest of Europe and the US — through better co-ordination of cancer research and clinical trials.

"However, the NCRI is very much a virtual institute — it brings no significant extra resources to cancer research and will rely on the funding, staff and infrastructure provided by charities such as ICRF," he said.

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AIDS-related cancer 'set to increase'

Cancer is an increasingly important outcome of HIV infection, say experts in a forthcoming special issue of *EJC*, AIDS and Cancer. Improvements in therapy such as highly active antiretroviral therapy (HAART) have decreased opportunistic infection and improved survival. Cancers are arising in people who would not have survived in the absence of HAART.

Guest editors, Dr Antonino Carbone (Istituto Nazionale Tumori, Aviano, Italy) and Dr Gianluca Gaidano (University of Eastern Piedmont, Novara, Italy) say that the AIDS-defining malignancies include Kaposi's sarcoma (KS), non-Hodgkin's lymphoma

(MD, USA) says that cancers of the cervix, anus, liver and lung have generally been associated with increased exposure to other carcinogens such as human papillomavirus infection, hepatitis B and C and cigarette smoking. They have not been causally associated with HIV infection. But he says, "These cancers may arise in individuals who otherwise would not have survived in the absence of HAART".

Current therapeutic strategies, such as the use of protease inhibitors, have led to a 30–50% reduction on KS, but have had a relatively minor impact on risk of NHL. Dr Rabkin concludes that NHL may be expected to account for a greater proportion of AIDS morbidity and mortality. "Further improvements in the long-term consequences of HIV infection will depend on better prevention and treatment of this serious malignant complication," he writes.

"CANCERS MAY RISE IN INDIVIDUALS WHO WOULD NOT HAVE SURVIVED WITHOUT HAART."

(NHL) and cervical cancer. Anogenital neoplasias and Hodgkin's disease are increasingly noted. "As the management of retroviral disease and opportunistic infections improves, allowing patients that are severely immunocompromised to survive longer, these individuals will increasingly come to the attention of the practicing oncologist," they say.

Contributor Dr Charles Rabkin (National Cancer Institute, Bethesda,

Correction

In *EJC* (2001, 37, 443) the quote attributed to Professor V. Craig Jordan (Northwestern University, Chicago, IL, USA) should have run: "In addition we need to discover why oestrogen can successfully prevent osteoporosis, but its beneficial effect on coronary heart disease is much harder to demonstrate." Apologies for the slip!

Low tar cigarettes linked to poorer survival rates

Increased use of low tar filter cigarettes could be to blame for the worsening prognosis of adenocarcinoma of the lung cancers in men in The Netherlands, say researchers. They found that survival rates for adenocarcinomas have fallen since the mid 1970s, despite good access to specialist care (*Epidemiology* 2001, 12, 256–258).

The researchers found that the adenocarcinomas now metastasise more rapidly. The 'most likely candidate' for causing this shift in biological behaviour is the increasing popularity of low tar cigarettes since the 1960s, they say.

They analysed data from the Eindhoven Cancer Registry on more than 7000 patients diagnosed with non-

small cell lung cancer between 1975 and 1994. The proportion of adenocarcinomas increased from 10% in the late 1970s to 18% in the early 1990s. Between 1975 and 1992, the proportion of young male patients with advanced stage tumours increased; 1-year survival rates dropped from 59 to 43%; and 3-year rates from 36 to 27%.

EJC epidemiology and prevention editor, Dr Jan-Willem Coebergh (Erasmus University Medical Centre, Rotterdam, The Netherlands) was a co-author. He said that long-standing smokers who start using filtered cigarettes often inhale differently, for example, taking larger puffs and retaining smoke longer to compensate for the lower nicotine yield of filter cigarettes. "If you're smoking a

One woman's influence?

Queen Margrethe II of Denmark could be a risk factor for the health of Danish women, a professor suggests. The Queen, who is very popular, is often seen smoking in public and could be acting as a role model among young women, according to Professor Hugo Kesteloot (University of Leuven, Belgium).

All-cause mortality among Danish women is exceptional in Europe. Across Europe, all-cause mortality among women declined steadily between 1970 and 1996. In Denmark, the decline stopped in 1978. Danish women had a lower mortality than the mean of western European countries until 1974; in 1996 it was 48% higher.

Professor Kesteloot notes (*Lancet* 2001, 357, 871–872) that this is unexpected given the high income, excellent education and high standard of medical care in Denmark. However, Danish women older than 15 years have the highest smoking prevalence of all countries.

"The question arises as to whether Queen Margrethe II's behaviour could be a risk factor for population health in Denmark, especially among women. If so, this would be the first time that the involuntary influence of a single person on population health could be shown."

He says proof of the hypothesis could be provided if the Queen quit smoking.

heavy, dirty cigarette with high levels of nicotine you can't inhale too deeply or you would be sick. The paradox is that filter cigarettes seem to be safe, but people have to inhale more deeply to get their dose of nicotine."

"This is a hypothesis which we could not prove, but there is other literature on it," said Dr Coebergh. "When there is a decrease in population-based survival in only one gender, especially where there is constant good access to healthcare, there is often something going on in the aetiology and the biology of the tumour. It could be an artefact, or reclassification, but in this case, these explanations were not satisfactory."

See page 1065 for *EJC* Interview with Dr Jan-Willem Coebergh.

Liposome lotion slows skin damage

Liposome lotions may slow the development of sun-induced damage in patients with xeroderma pigmentosum, a US/European study found (*Lancet* 2001 **357**, 926–929). When used for a year, lotion T4N5 lowered the rate of new actinic keratoses and basal-cell carcinomas by 68 and 30%, respectively, compared with placebo. The results provide proof of principle for enzyme therapy of skin, the researchers say.

The study included 30 patients from the USA, UK, Austria and Germany. Of these, 20 were assigned to T4N5 liposome lotion, the rest to a placebo lotion. All used high factor sunscreens concurrently.

Patients with xeroderma pigmentosum have an autosomal recessive genetic defect in the pathway that repairs sun-induced damage to DNA. This leads to increased rates of malig-

nant disorders of the skin. However, the defect in DNA has been overcome in cell culture by the intracellular delivery of the bacterial DNA incision repair enzyme T4 endonuclease V.

The effects of the lotion on actinic keratoses were observed within the first 3 months of treatment and persisted during the 6 months after discontinuation. "The lasting effect after the conclusion of the study may imply that T4N5 liposome lotion reverses a fundamental and common source of these neoplasms...", the authors write.

They say the lotion represents a new drug delivery approach "that shuttles enzymes across human stratum corneum and introduces biologically active proteins into living epidermis." They say the results "suggest that other enzymes and macromolecules could be used in the therapy of other debilitating skin diseases".

Alternative therapies on the increase

Increasing numbers of cancer patients worldwide are using alternative therapies in lieu of traditional medicine, according to a survey by International Union Against Cancer (UICC). Dietary therapies, shark products, vitamin therapies and botanicals were the most widely used alternatives (*Cancer* 2001, **91**, 1390–1393).

They gathered 80 questionnaires from 33 countries, most of which were completed by oncologists. Most said they had actively discussed alternative medicine with patients and

believed that its use was prevalent. However, only a small proportion felt adequately informed on the subject.

The authors say that previous studies have been confined to relatively few participating countries, resulting in a lack of data for much of the world. Many have also failed to distinguish between complementary therapies, used in addition to standard care, and alternative therapies, which are biologically active, often invasive and typically used as a substitute for mainstream cancer therapy.

Cancer patients' hidden distress 'missed'

Urgent attention must be given to helping doctors recognise anxiety and depression in cancer patients, researchers suggest. A group led by Professor Lesley Fallowfield (University of Sussex, Brighton, UK) found that only a quarter of those who would benefit from psychological support were identified by their doctors (*Br J Oncol* 2001, **84**):

"Far too often psychological symptoms in patients are discounted as a normal consequence of having cancer," the researchers write.

The study included 143 doctors from 34 different cancer centres in the UK. Their patients, 2297 in all, completed standard questionnaires for the detection of psychological morbidity before a consultation.

One-third of the patients, 827, had high scores, which suggested some psychiatric morbidity. However, only 242 of them were recognised. "The doctors' predominant tendency was to assess patients as not distressed," they said.

The doctors in the study were aware that their consultations were being videotaped. "It is likely that the situation when doctors are not being monitored is even bleaker," the researchers say.

They suggest that screening patients using validated questionnaires prior to seeing the doctor might help improve detection of potential psychological morbidity.

'No link' between mobile phones and cancer

The first nationwide study into the safety of mobile phones has found no evidence of a link with tumours of the brain or salivary gland, leukaemia, or other cancers. Danish researchers studied 420 000 users between 1982 and 1995. They found no excesses of cancers of primary interest (*J Natl Cancer Inst* 2001, **93**, 203–207).

The retrospective cohort study included all mobile phone users in Denmark, who were followed for up to 15 years after subscription. However, over two thirds of the subscriptions began in 1994 or 1995, and average follow up was 3 years.

There was no excess of cancers

among users, compared to incidence in the general population. The study "provides no support for an association between use of these telephones and risk of brain cancer, leukaemia, salivary gland cancer or other site-specific cancers," the researchers said.

They found decreased incidence of lung cancer and several other smoking-related cancer sites, consistent with a confounding effect of social class. "Cellular phone users may differ from the general population by being more well-to-do and less likely to smoke cigarettes," they said. This was especially apparent before 1992 when use of mobile phones was expensive.

"Future studies might benefit from refined exposure assessment that would enable risk evaluation over categories of cumulative minutes of cellular telephone use, including both incoming and outgoing calls for individual users," the authors wrote.

An accompanying editorial (*J Natl Cancer Inst* **93**, 166–167) noted that most people first heard about a possible cell phone/cancer link from the telephone show *Larry King Live*. The public "is more easily persuaded by anecdotal accounts than by science and the scientific community should bear that in mind when communicating with the public," it said.

AWARDS AND APPOINTMENTS

Choosing the right time for treatment

Determining the importance of CA 125 levels in deciding when to treat relapsed ovarian cancer is Dr Heidy van Wijk's primary concern during her fellowship at the EORTC Data Center, Brussels. She is involved in



Dr Heidy van Wijk

the joint MRC/EORTC study, which is comparing early treatment based on CA125 levels alone, with delayed treatment based on conventional clinical indicators.

Dr van Wijk, who received her medical degree cum laude from the University of Amsterdam, has been an EORTC Medical Research Fellow at the Data Center since September 2000. She is attached to the EORTC Gynaecological Cancer Group and is funded

by the Nederlandse Kankerbestrijding/Koningin Wilhelmina Fonds.

She was delighted to work on the phase III CA 125 study. "This trial needs to include such a lot of patients — preferably 800 — that it would not be possible to do in The Netherlands alone. I'm very interested in being involved in a multicentre trial based at the EORTC."

Patients with a raised CA 125 level after a complete remission from ovarian cancer will be randomised. One arm will receive chemotherapy immediately, even though they have no signs of the disease. The other arm will receive chemotherapy only when they show clinical signs of the disease. The aim is to determine the place of CA 125 levels in the follow up of patients with ovarian cancer. "Early treatment might increase the response rate from small lesions, it could prolong response and improve

**"EARLY TREATMENT
MIGHT INCREASE THE
RESPONSE RATE."**

overall survival. On the other hand, patients would know that their CA 125 levels were rising and this could harm their quality of life when they have no signs of disease. Treating

relapses earlier also reduces the interval between the first and second chemotherapy, which could make it less effective," says Dr van Wijk.

Before starting her fellowship at EORTC, Dr van Wijk had worked in obstetrics and gynaecology at the Academic Medical Centre and at the St

**"QUALITY OF LIFE COULD
BE HARMED BY
MEASURING CA 125."**

Lucas Hospital in Amsterdam. At the EORTC, she is also involved in the analysis of other trials, now closed, and preparing results for publication. She has co-authored scientific publications in the *British Journal of Obstetrics and Gynaecology*, the *SOA Bulletin* and the *Journal of Perinatal medicine*. She hopes to return to The Netherlands after her EORTC fellowship and train to become a gynaecologist.

She says her time at the EORTC is invaluable. "It is giving me a real professional insight into high-quality research in clinical trials. I miss the contact with patients, nurses and other people on the wards, but the EORTC is a fantastic opportunity for me!" she says.

*Samantha Christey
EORTC Communications Officer*

Winner of EJC Club Travel Award

Dr Bill Jones, consultant clinical oncologist (Leeds University Teaching Hospital Trust, UK) has won the 2000 EJC Club Travel Award. His name was randomly selected and he received a cheque for £500.

Dr Jones, who works in both radiation and medical oncology, has been an active member of the EORTC genitourinary group since 1978. On hearing the news of his award, he said, "That's wonderful! It will help to pay for me to go to ECCO-11 in Portugal".

He is hoping to present the results of the MRC trial he co-ordinated, TE-18, which is a comparison of two

radiotherapy regimes for adjuvant treatment of stage I seminoma of the testes. The randomised trial included 630 patients, and more data is available from a subsequent study, TE-19. Dr Jones believes the research could have clinical impact. "It is a fairly large study and could modify radiotherapy practice not only in the UK but also in Europe. It has reduced the dose of radiation for patients."

Dr Jones qualified at Birmingham University in 1969, and his special interests include uro-oncology, cancers of the testis, bladder and prostate and radiotherapy.



Dr Bill Jones

INTERVIEW

Dr Jan Willem Coebergh is head of research at the Comprehensive Cancer Centre South and Eindhoven Cancer Registry; and a lecturer at Erasmus University Rotterdam. He is involved in The Netherlands cancer control policy and is the consulting epidemiologist to the Dutch Childhood Leukaemia Study group. Since 1992 he has been a member of the EURO CARE Steering Committee and in 1999 he was elected Chairman of the steering committee of the European Network of Cancer Registries.



Dr Jan-Willem Coebergh

Where did you train?

In medicine, at Leiden University, and in epidemiology, at Erasmus University in Rotterdam.

Who inspired you?

Professor Querido, who died recently, interested me in the management of health services and medical education after I finished my MD. He was a visionary and things he was recommending 20 or 30 years ago either have been implemented now, or should have been. Professor Valkenburg was my epidemiology trainer at Erasmus and always took a broad view. He was a rheumatologist, a microbiologist and a self-made epidemiologist who taught me how to study chronic diseases. Sijmon Terpstra, an economist from Groningen, taught me that epidemiology is a form of market research, which was an original way of looking at healthcare at that time.

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

When I was training in epidemiology, the projects on offer related to cancer.

I discovered a cancer registry in the south east of Holland, which was a sleeping beauty: at the time, there was no systematic cancer registration. I wanted to use the data from that registry, and in the process I was asked to help modernise it. I have been involved ever since.

Did any other branch of medicine appeal?

I spent almost 2 years as a house officer in internal medicine and found it very appealing. But in the end you have to choose.

Might you have done something else altogether?

As an undergraduate, I spent 2 years in the student travel business, and could have happily continued in some sort of services management.

What has been the highlight of your career to date?

My work alongside many others on EURO CARE for adults and children. This is a type of benchmarking. Even as a student I was convinced that we can learn so much from Europe with the different cultures and countries, and yet we still have common ground. It's an epidemiologist's dream.

Another highlight was in the late 1980s when I was secretary of the scenario committee that explored the future of cancer care in The Netherlands. Our report turned out to be influential and several oncology disciplines used it as a long term plan. Later I was made an honorary member of ESTRO as a result.

... and your greatest regret?

I really don't regret anything, or worry about things I could have done.

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

I should write a book about a non bureaucratic approach to healthcare planning and evaluation. Health services need to take a professional approach and at the same time take patients seriously, so in that sense it would be a market-oriented book.

What is your greatest professional fear?

That doctors are becoming simultaneously so idealised and so regulated that they can only disappoint in what they deliver. In practice, there is much more opportunistic behaviour and compromise than is written down in the rules.

In epidemiology, I fear that we will take ourselves so seriously that we lose sight of what we are really able to do. Quite often, real causes can not be established but we create the illusion that we are able to. Too much energy is being spent on research on very low-dose radiation, or clusters, or the long-term damaging effect of involuntary smoking. We need to explain to those who demand this research that often these questions can not be studied properly with unequivocal results.

How do you relax?

I run 6 to 8 miles a couple of times a week. I like to spend time with friends, and listening to music. I also travel by train a lot within this country and find it very relaxing — nobody can get to me there!

Who is your favourite author?

My preferred reading is the New York Review of Books, but I hardly have a favourite author. But if I have to choose I would go for the historian, Eric Hobsbawm, who wrote 20th Century non-fiction. In Dutch, I enjoy Kees van Kooten, who is funny: I recognise myself in his stories.

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

How to fight a guerilla war for a 'good purpose'! Which is in fact what the medical profession has to do to pursue our objectives. Not in the military sense, thankfully, but in the strategy.

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

Take a broad view and choose a tutor who is not only good on details. Learn to analyse the whole system in which you function. It's very important for doctors to keep a sense of perspective.

What is your favourite vice?

I tend to disregard my limits, both physical and academic. It sometimes gets me into trouble!