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ECCO 14. Barcelona, Spain. 23–27 September, 2007

EJC's scientific editor Robert Day-Webb and news editor Helen Saul, report from the meeting:

Introducing ECCO

The new European CanCer Organisation (ECCO) was officially launched at the Barcelona meeting. Professor John Smyth, the last President of the Federation of Cancer Societies (FECS) paid tribute to the 'visionaries' who set up the umbrella organisation 25 years ago. ECCO, its replacement, will have a wider brief, he said: to bring together major players in cancer research, treatment and care in order to create awareness of patients' wishes and needs; encourage progressive thinking in cancer policy, education and training; and continue to promote European cancer research and its application through the organisation of multidisciplinary meetings and conferences.

One of many full sessions at ECCO-14.

Professor José Baselga, Vice-President ECCO 14 and Chair of the National Organising Committee with Professor John Smyth, President of FECS and ECCO 14.

Photos courtesy of ECCO

FECS/EJC Award

The FECS/EJC Award for 2007 was presented to Dr. Pierre Sonveaux (University of Louvain UCL Medical School, Brussels, Belgium) in recognition of his work on the development and validation of provascular antitumour strategies.

These strategies exploit the differential reactivity of mature tumour vessels; the aim is to target altered vasodynamic pathways to induce selective dilation of tumour microvessels. This approach may improve the anticancer efficacy of treatments such as radiotherapy and chemotherapy, which depend on tumour oxygenation and perfusion status. 'One should realise that the angiogenic view depicting the tumour vasculature as essentially immature is too restrictive,' he said. 'Mature blood vessels do exist in tumours and can be exploited for therapy'.

Dr. Sonveaux's work, under the supervision of Professor Olivier Feron and with the financial support of the Fonds National de la Recherche Scientifique (FRS-FNRS), should also contribute to a better understanding of the malignant phenotype of tumours.

'It is both a great honour and a privilege to receive such a prestigious award early in my scientific career', Dr. Sonveaux said. 'The FECS/EJC Award lecture at ECCO14 provided the international stage needed to promote provascular anticancer approaches. I hope that it will encourage clinical evaluation of treatments that showed potent antitumour benefits in mice', he said.

R D-W

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Gemcitabine 'delays progression of pancreatic cancer'

Pancreatic cancer patients given gemcitabine after surgery experience delayed disease progression of about 6 months (#3504). The drug significantly increased disease-free survival from 4.9 to 11.4 months. Overall survival also improved but this was not significant.

Gemcitabine is the standard chemotherapy for unresectable advanced pancreatic cancer, but for resectable pancreatic cancer there is no universally accepted adjuvant treatment. Observation after surgery is widely used.

In this study, 118 patients received either gemcitabine after surgery or observation. Both groups were then followed for more than 20 months.

'The lack of a significant difference in the overall survival means the observation approach was not altogether negated. We therefore propose that chemotherapy with gemcitabine, as well as observation, now be considered as optimal treatment for patients with operable pancreatic cancer' said Dr. Tomoo Kosuge (National Cancer Center, Tokyo, Japan), the study's lead researcher.

R D-W

Endometrial cancer: Change in practice

Women with low or intermediate risk endometrial cancer do not benefit from adjuvant post-operative pelvic external beam radiotherapy (EBRT), according to a meta-analysis of 7 randomised controlled trials (#5004). Although the adjuvant treatment reduced pelvic relapse, it was either harmful or ineffective in improving overall survival in this group.

By contrast, in women with high risk cancers, adjuvant EBRT reduced the absolute chance of death by cancer by approximately 10%, researchers found.

Highlighting the paper, Dr Nick Reed (UK) said There is some unmuddying of waters. The research would change practice and allow clinicians to select out those patients who do not need radiotherapy, he said.

H.S.

Protecting patients' rights in Italy

With an increasing number of cancer survivors worldwide, many organisations are grappling with the challenge of helping patients and survivors maintain or regain a sense of well-being and to lead a normal life. They are dealing with issues outside of the health care system such as social and financial challenges, employment issues and family crises.

Speaking at the Patient Forum, Luminita Andreescu, Vice President of the Italian patient group ANVOLT (Milan, Italy) presented an Italian perspective on the problem and declared that, 'A big cultural change is necessary in order to cure this social disease of long term survivors'.

Recent statistics suggest that there are over 3 million new cancer cases every year in Europe although the percentage of cases resulting in death is actually reducing (50% of new cases survive or live with cancer for a long period after diagnosis), she said. For some, cancer will become a chronic condition requiring periodic treatment while others live with the possibility of recurrence after successful treatment. Toxic treatments can leave patients with unique health needs that require lifelong surveillance and evaluation.

Ms. Andreescu suggested various strategies, such as the sharing of experiences and information among patient groups, collaboration with national and international agencies, lobbying with MPs, improved dialogue between stakeholders and pharmaceutical industries, and promotion of 'Bills of Rights' and other international guidelines.

'There is a fundamental need for cancer patients and their families to be informed of all their rights with regards to health care, access to welfare, social and financial benefits and other existing protection tools, in order for them to live better lives without discrimination or any kind of social difficulty,' said Ms. Andreescu.

There has been considerable success in Italy over recent years with regards to patients' rights. One successful initiative has been the introduction of a booklet detailing cancer patients' rights, resulting from an AIMaC (Italian Association for Cancer Patients) survey, which has now become the standard reference on the subject.

Another recent Italian venture was FAVO's (Italian Federation of Oncological Voluntary Associations) lobby action which, in February 2006, resulted in a substantially reduced patient waiting time (from 1 or more years down to within 15 days) for their disability certificates to be issued and hence much quicker access to their entitled benefits.

'PATIENTS SHOULD LIVE WITHOUT DISCRIMINATION OR SOCIAL DIFFICULTY'

Finally, in 2003, AIMaC succeeded in obtaining, from the Italian Government, a statutory provision granting cancer patients the right to switch from full-time to part-time employment when undergoing treatment; and then back to full-time after recovery. This is the first experience of legislation following an agreement between a volunteers association and the Government and the first law in Italy specifically approved for cancer patients.

R D-W

ZD4054 'prolongs survival'

The experimental drug ZD4054 has been shown to improve overall survival in metastatic hormone-resistant prostate cancer patients, according to new Phase II data (#3LB).

Patients receiving daily ZD4054 – which blocks the endothelin A receptor – experienced a 45% reduction in the risk of death compared to placebo. Although progression-free survival was the primary endpoint and was not significantly different between the drug-treated and placebo groups, the results for the secondary endpoint of overall survival were significant.

"It can be difficult to measure [progression-free survival] accurately in patients with metastatic hormone-resistant prostate cancer. Overall survival is an unambiguous endpoint and clearly an important outcome for patients,' said Professor Nick James (Institute for Cancer Studies, Birmingham, UK), the study's principal researcher.

R D-W

EUROFILE

Surgical outcomes under scrutiny

An urgent need for quality control of cancer surgery was highlighted at ECCO-14. Professionals were warned to overcome their reluctance to conduct audits – with consequences for those with unsatisfactory outcomes – or else face increasing intervention from health providers.

It is generally recognised that cancer centres need to see a minimum number of cases in a year to maintain expertise and assure good outcomes. Yet many centres continue to offer surgery for cancers that present to them rarely.

Dr Else Borst Eilers, former Minister for Health in the Netherlands, and current President of the Dutch Foundation of Cancer Patients, told the congress that this must change. The Health Inspector in the Netherlands recently forbade teams that see fewer than 10 cases of oesophageal cancer a year, to continue to treat it with surgery. The stricture should have come from the profession itself, she said: 'I think doctors should be ashamed to be called to order in this way by a health authority.

'They are quite capable of reaching an adequate division of tasks among themselves and they should do that as soon as possible. The patients will be grateful, the quality will go up. It can be done, for instance, by establishing regional centres consisting of several hospitals working together, dividing several levels of cancer care between one another. Then every cancer patient can be assured of being treated by a team with sufficient expertise, she said.

The question of how much experience is sufficient remains a thorny one. Professor Hein Van Poppel (University Hospital Gasthuisberg, Leuven, Belgium) told a European Society of Surgical Oncology (ESSO) session that for radical prostatectomy (RPr), various publications suggest that a hospital's minimum case load should be, respectively, 30, 60, or 108 cases per year. One suggested that the individual surgeon should perform more than 12 RPrs a year; another said more than 40, yet another, more than 75. 'Nobody knows what the requirements should be', he said.

Photo courtesy of ECCO

Dr. Else Borst Eilers

The existing data is interpreted differently throughout Europe. The French National Cancer Institute sets a minimum caseload per hospital of 30 RPrs/year; those performing fewer must stop altogether. In the UK, the minimum case load per centre is 50 per year. For the individual surgeon, it is 5/year but this can include radical cystectomies as well as RPrs.

In Germany, like the UK, centres have to do more than 50 RPrs per year, but in Belgium, there is no formal minimum. In fact, 17 centres in Belgium never carry out RPrs, which Van Poppel said was wise, compared with the 8 centres where one per year was performed. 'Why do thousands of urologists treating small numbers in small hospitals not feel compelled to stop'? he demanded.

Possible reasons included self-interest of either the centre or the doctor, he said. Many doctors in Europe are paid according to the number of procedures carried out, or patients treated. Furthermore, setting minimum case loads could have a negative impact, if pressure to keep up personal volumes influences treatment decisions. A minimum number of cases must however be available in order to gain and keep up experience.

A study conducted by the EORTC Genitourinary Group looked at surgical outcomes among 27 urologists working in 23 centres. Outcomes from consecutive RPrs in men with clinical T1/T2 disease improved as the surgeon's experience increased, but only so far. Surgeons performing 25-50 RPrs/year produced more favourable PSA levels at 3 months compared with those doing either fewer, or more. (*H. Van Poppel et al. EJC 2001, 37: 884-891*).

However, beyond caseloads, the quality of surgery was variable. It could and should be monitored, Van Poppel said. Some surgeons in the study never had positive margins while others had positive margins in many cases. 'Evaluation of surgical quality based on outcomes should become mandatory,' said Van Poppel.

'No-one is collecting their own data', he said. 'We have to go ahead with this, quality control is needed, and not only for RPr; colorectal surgery is another area. The results in some surgeons hands are not really good. It is an important task for surgical oncology that we initiate surgical quality control programs just like in cardiac surgery.'

ESSO President, Professor Irving Taylor, said that there is increasing evidence in a number of other malignancies colorectal, oesophageal, and pancreatic cancer that results are improved in institutions which carry out a minimum number of cases. But it is difficult to identify the specific numbers needed, and ESSO does not have a policy recommending minimum case load. 'Most people recognise that, for complex surgical procedures, in order to get good results you have to have a reasonable volume going through,' he said.

Moves to assess individual surgeon's performance were becoming more widespread, and ESSO is in favour of this, Professor Irving said. In the UK, for example, surgeons have to document outcomes to ensure that they are within acceptable standards. In colorectal cancer, outcomes include short term measures such as infection or post-operative complications and long term measures such as local recurrence or overall survival. 'ESSO is very committed to quality assurance in surgery,' he said

Helen Saul

COX2 mutation linked to ovarian cancer

A specific mutation of the COX2 gene seems to play a role in the onset of ovarian cancer, doubling or even trebling a woman s risk of developing the disease (#5011).

A Portuguese study team have investigated the -765G>C COX2 polymorphism, and its role in ovarian cancer. The analysis revealed that a particular version of this polymorphism, the -765C allele, doubled the risk of developing ovarian cancer and, in women aged 53 or younger, trebled the risk

This discovery raises the possibility that, if the findings are confirmed by further studies, it might be possible to use non-steroidal anti-inflammatory drugs such as aspirin and ibuprofen to prevent ovarian cancer developing in women with the COX2 mutation.

The causes of ovarian cancer are not yet fully understood, but inflammation is known to be involved in the onset of the disease.

'COX-2 has an important role in the inflammatory process, as well as in key steps in tumour development,' said Dr. Ana Carina Pereira (Portuguese Institute of Oncology, Oporto, Portugal), the study's lead investigator. 'Now we need studies that will confirm whether giving non-steroidal anti-inflammatory drugs to women with this polymorphism might be of value in both preventing and treating ovarian cancer.'

R D-W

Blood test may detect recurrence

Detection of circulating tumour cells (CTCs) in the blood may help identify patients likely to suffer recurrence from breast cancer, according to new research. CTCs are known to be associated with poor prognosis in women with metastatic breast cancer.

In the study, blood samples were taken from breast cancer patients undergoing chemotherapy. For the first time, a group of German scientists showed that they could detect CTCs before and after treatment and hence possibly identify those patients at risk of recurrence (#2001).

The research demonstrated a correlation between CTCs and lymph node metastases but not with other prognostic factors such as tumour size, grading, hormonal or Her-2 status.

Dr. Julia Jückstock, (University of Munich, Germany) said that the persistence of CTCs after chemotherapy may predict recurrence of cancer: 'We will be working to analyse the prognostic value of our findings. If this proves to be the case, it will open the door to a simple way of monitoring the likely outcome of chemotherapy, as well as enabling us to target treatments more precisely.'

Screening for CTCs also holds the advantage of being easily repeatable, unlike many other predictive factors, and Dr. Jückstock said that the procedure was very much simpler, and more patient-friendly than bone marrow sampling.

R D-W

Nursing Awards

Nurses Hilary Noonan (Mid Western Regional Hospital, Limerick, Ireland) and Fiona Brady (Portiuncula Hospital, Ballinasloe, Ireland) won the TITAN Best Dissemination Award, 2007, for producing a user-friendly educational package on febrile neutropenia. It is designed for health care professionals who care for paediatric cancer patients in shared care centres (#8051). The educational package consists of a pocket guide to febrile neutropenia, a slide presentation and a checklist at patients bedsides.

The EONS Excellence in Patient Education Award, 2007, was presented to Niek Golsteijn, Vincent Keijsers and Sylvia Verhage (V&VN Oncology, The Netherlands) in recognition of their Sign Guide Oncology project: a flip chart system, incorporating pictograms and keywords. The system has been designed for use during patient education sessions on chemo-immunotherapy. It has been successfully launched in the Netherlands and there are plans to introduce the system throughout Europe.

Axitinib shows promise in kidney cancer

New drug axitinib has demonstrated potential in treating advanced renal cell cancer (RCC) patients whose options have run out after their disease has failed to respond to standard treatment.

The study has shown that axitinib shrinks tumours and delays progression of the disease (#4507).

In the study, axitinib was given to 62 patients with metastatic RCC who had not responded to the standard sorafenib treatment. Fourteen of the patients had also been given sunitinib after the sorafenib had failed, but again to no avail.

'More than half the patients – 51 percent – experienced tumour shrinkage, and in 23 percent of them the shrinkage is considered significant,' said Dr. Brian Rini (Cleveland Clinic Taussig Cancer Institute, Ohio, USA), the study's lead investigator. 'Preliminary analysis shows the progression-free survival was on average more than 7.7 months. We think these results are impressive because these patients were heavily pre-treated and with drugs thought to be similar to axitinib.'

The tumour remained stable in 37 percent of patients. 'The disease progressed in only 24 percent of patients, which we think is low in this kind of setting. Through the results of this trial, it appears that axitinib is a very active drug in renal cell cancer that can benefit a large number of patients,' said Dr. Rini.

R D-W

New class of melanoma drug

The first in a new class of drugs called oxidative stress inducers has shown promise in treating metastatic melanoma. The drug, STA-4783, is thought to work by increasing the amount of reactive oxygen species (ROS), such as hydrogen peroxide, in cells. All cells have some level of ROS, but cancer cells have a higher level than normal cells. The drug may push cancer cells, but not healthy cells, over a critical threshold, leading to cell death (#7002).

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PODIUM

ECCO: The Way Ahead

Professor Alexander Eggermont (Erasmus University Medical Center, Rotterdam, Netherlands) took over as President of European CanCer Organisation (ECCO) at the Barcelona meeting. A surgical oncologist, he is the immediate past President of EORTC, a member of ASCO s Board of Directors, and of several AACR committees. He chaired the ECCO-14 scientific program.

How did the conference go?

It was very successful; 14,000 participants made it by far the largest cancer meeting ever held in Europe. The feedback has been enormously positive. We received 2.5 or 3 times the usual number of basic science abstracts, and more translational research from phase III trials, including first reports, than ever. These are indications of ECCO's growing importance; people no longer hold back new results to present at ASCO.

What do you predict for the next meeting?

The increased strength and volume of submissions will continue. The 2009 meeting in Berlin at the heart of Europe, with cheap flights and hotels, will attract thousands of extra participants, especially from Germany and new Europe.

How important is the educational strand?

The expansion of Europe has created an increased educational need, but the need is just as great in Western Europe; specialists need to keep up with developments in other fields and in science. Our strategic alliance with www.ecancermedicalscience.com came about at a crucial time. FECS organised successful meetings such as the Flims workshop (with AACR, NCI and ASCO) but we didn't have our own educational webcast. Our partnership with ecancermedicalscience gives us advanced webcasting, including a pool of reviewed articles with online reviews. We are now clearly ahead of the game.

Are you looking forward to your stint as President?

I'm looking forward to the challenges and developments. The meeting in Barcelona has given ECCO a great boost. José Baselga was a prominent and terrific local host; the Spanish team was very professional and gave us great local support. The quality of the ECCO team was simply amazing. Only a year ago, there was pessimism and uncertainty in some quarters, but CEO Michel Ballieu turned things around, pulled together many new staff, and delivered a smooth meeting. It's been terrifically interesting, and shows how quickly a situation can change if you have the right people. We are now a developing, expanding, dynamic operation.

There is still the issue of ESMO remaining outside of ECCO?

We will simply have to resolve this. I fully support ESMO's need to grow and develop further as an organisation. This is true for ESTRO, ESSO, EACR, EONS and all of the others. There is a misconception that if ESMO rejoins ECCO it would diminish its sovereignty or be some kind of surrender. Nothing could be further from the truth. ECCO exists as a common platform for organisations which are active in cancer; it aids discussion and responsible policy-making for the common good. We absolutely need and want ESMO to be part of this. ECCO does not impinge on each society's individual responsibilities; each represents the best in its field and is the best educational resource for the specialty. The multidisciplinary elements added by ECCO only enhance the efficacy of each society's own training.

How damaging is non-cooperation?

If I were a politician, I would rather hear about cardiovascular medicine, diabetes, obesity or chronic neurodegenerative diseases like Alzheimer s where I would receive a simple, straightforward, unified message. Politicians are totally confused by what is being said about cancer. There is a cacophony of different voices raising different concerns. We must present ourselves in a more balanced and unified way because right now, we are doing ourselves and our patients a great disservice.

What are the long-term implications?

We have a lot to do to counterbalance the effects of the EU Clinical Trials Directive which is making life more difficult for academic researchers. The process has become more complex, bureaucratic, costly and time-consuming. There are fewer studies and fewer career opportunities. In this context, we as leaders have to find agreement quickly, so that we can focus on educating young oncologists and improving their opportunities. Otherwise, in the coming years, we will have far too few oncologists to take care of the growing cancer problem.

How optimistic are you that this can be resolved?

I am convinced that we will find the right solution, one that respects everyone involved and is beneficial – financially as well as educationally – for each and every partner. There has been a change in generation and antagonisms of the past can be discarded. We as younger leaders must solve this or we will be considered totally worthless. But we will succeed because we all have the best of intentions and with continuous discussions, any conflict can be brought to resolution. This problem must have gone out of the window by the middle of 2008. I'm not planning on anything less and I'm counting on support from everyone involved.