Presentation of WP6 Integrated Cancer Control

Cancer Control Joint Action

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Lucio Luzzatto | Brussels | 6 June 2014

WP6

Cancer control through Comprehensive Cancer Care Networks (CCCN)

Cancer Control Joint Action

Meeting with Stakeholders Representatives

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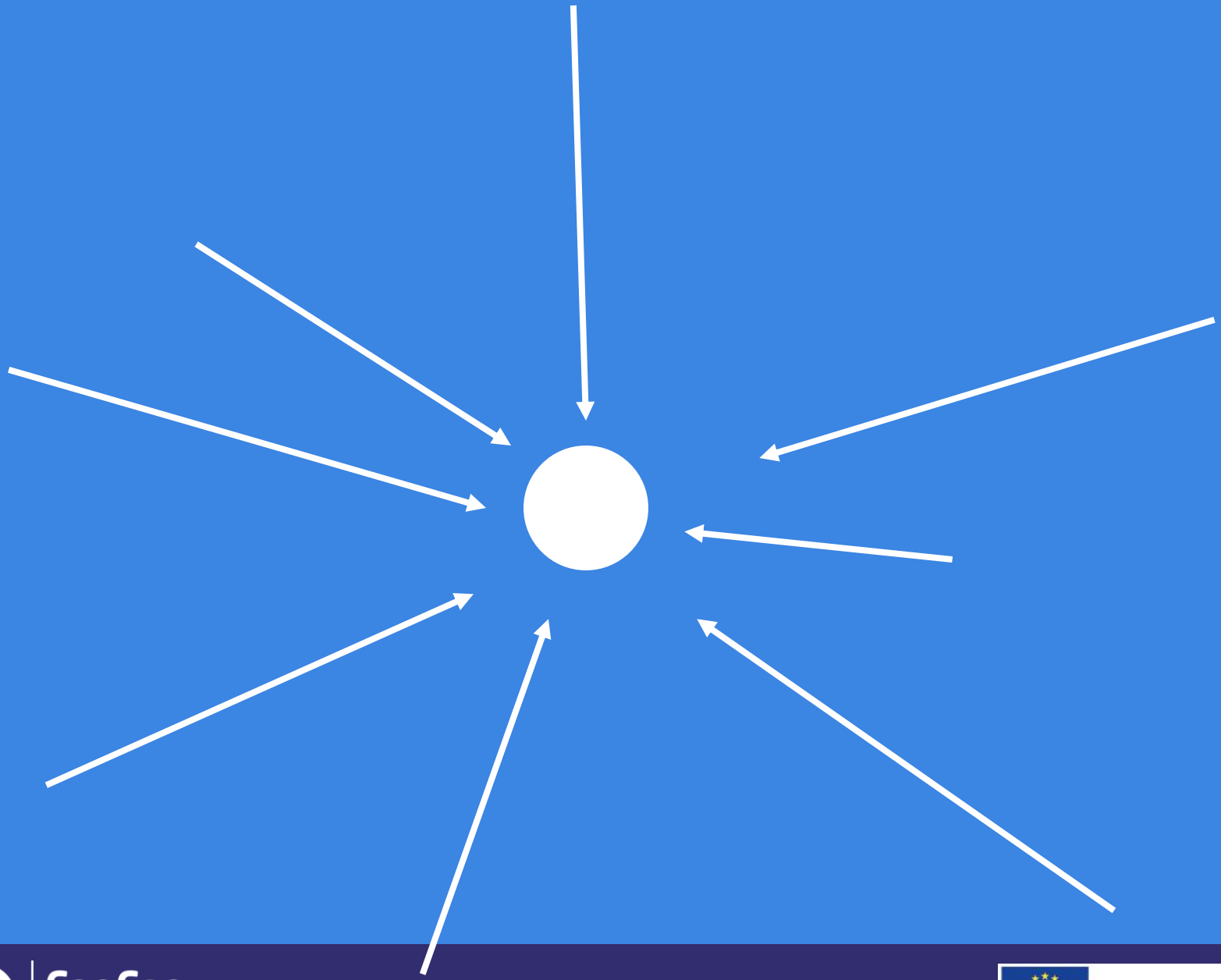

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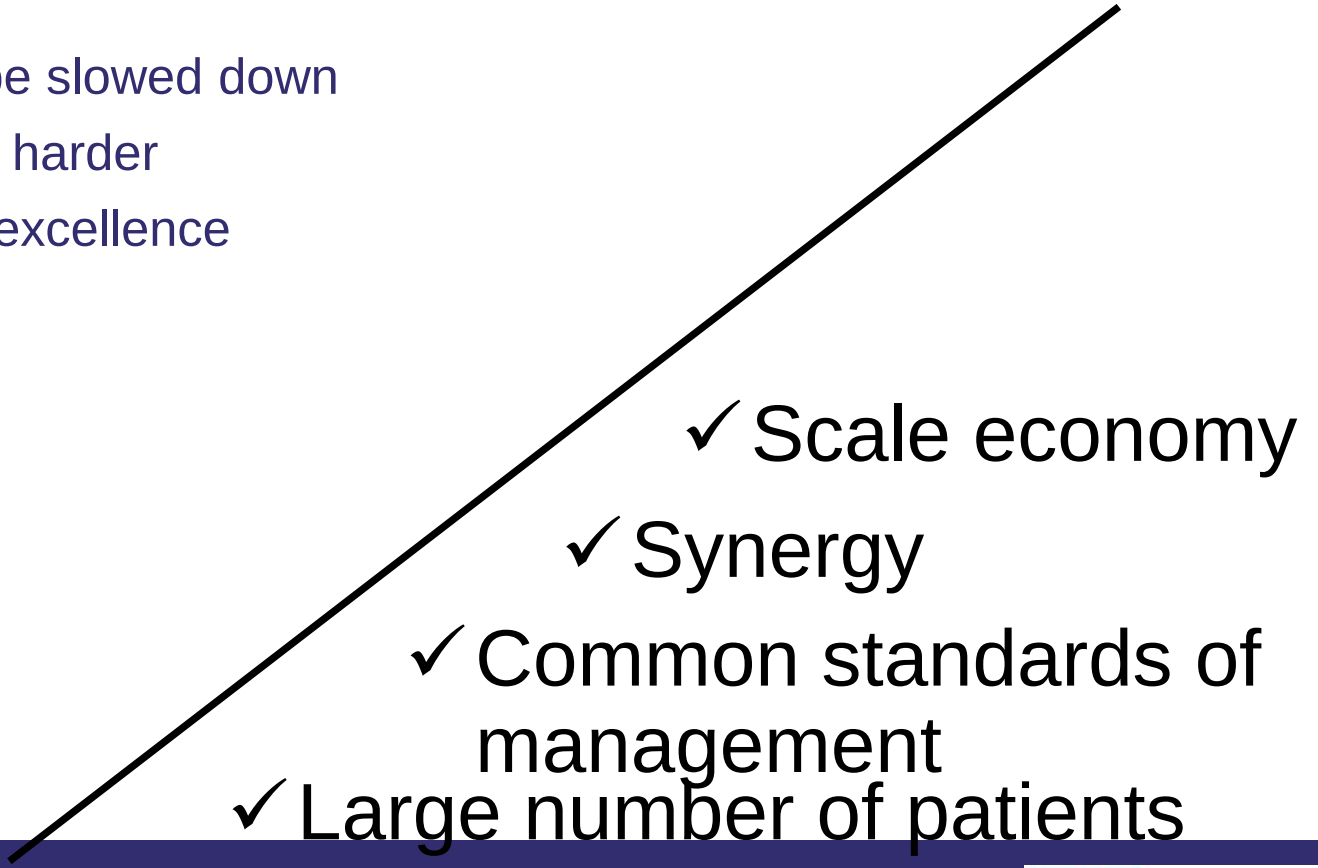
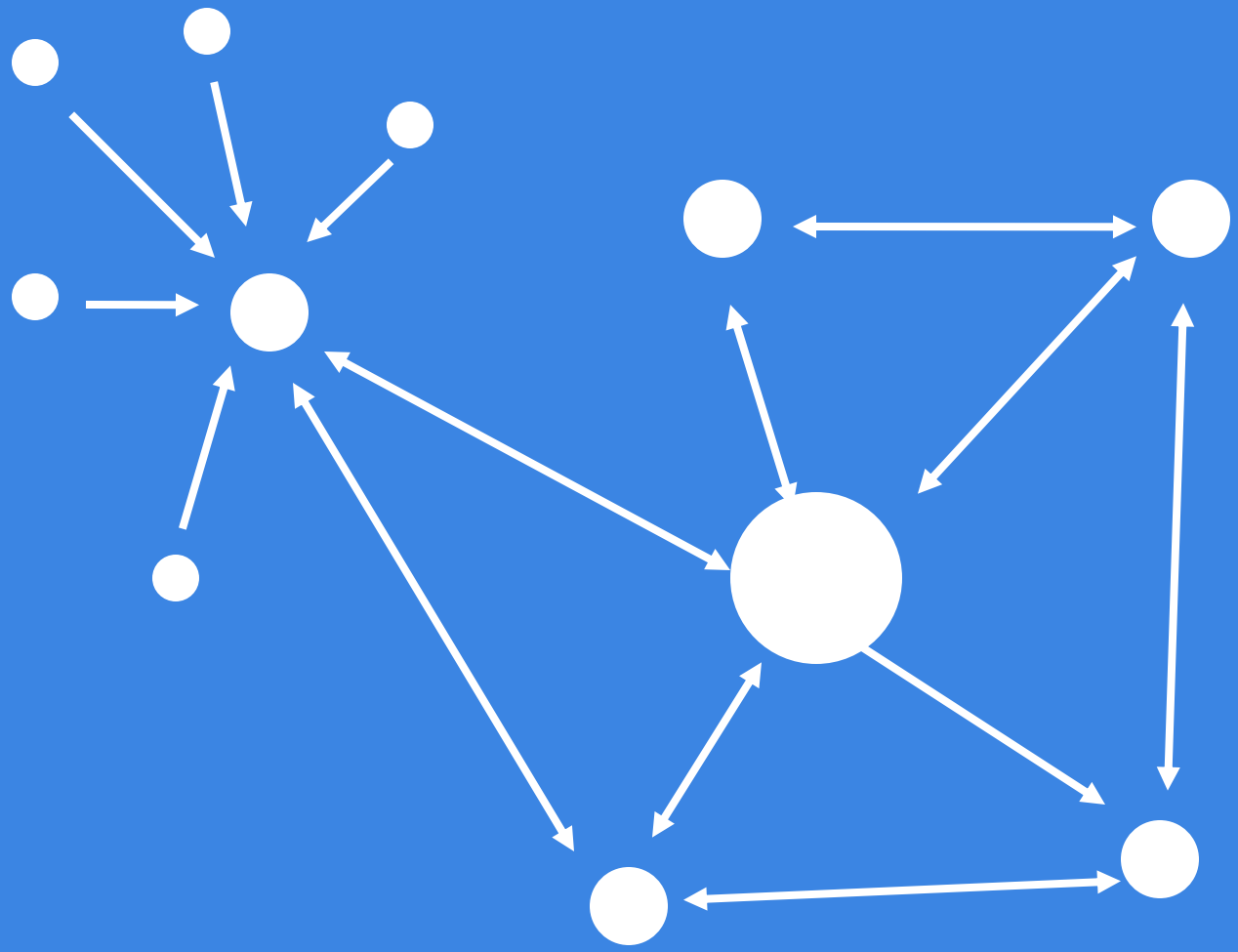
A Comprehensive Cancer Center

PROS AND CONS IN A NETWORK INSTITUTE

- ✓ Changes may be slowed down
- ✓ Quality controls harder
- ✓ Risk of diluting excellence





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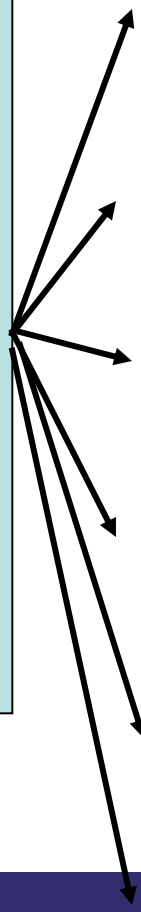
A Comprehensive Cancer Care Network (3-tier)

CCCN

STRUCTURED SET OF INTERACTING COMPLEMENTARY INSTITUTIONS WITH COMMON GOVERNANCE



One set of patients

Universal access to specialized treatment

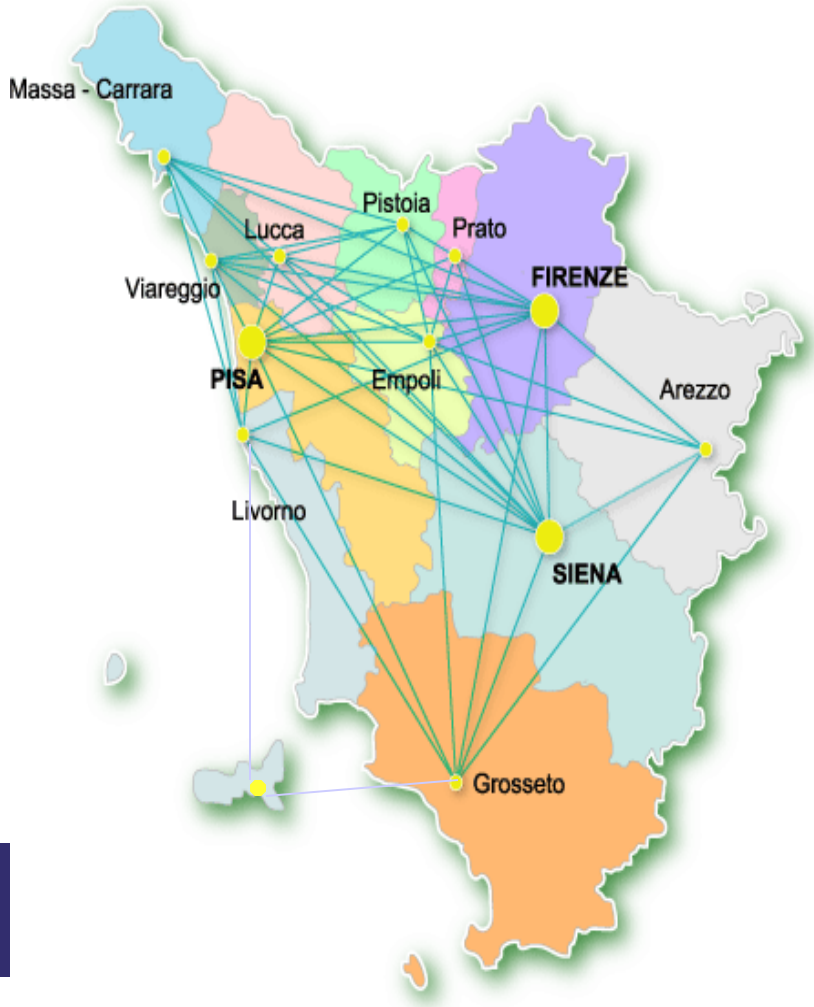
Sharing high technology

Cost saving through large numbers

Synergic pathways

Seamless patient care

ITT
Istituto
Toscano
Tumori



To UNDERSTAND,
To TREAT,
To PREVENT CANCER
AT BEST FOR ALL

ISTITUTO PER LO STUDIO
E LA PREVENZIONE ONCOLOGICA

GENERAL FEATURES OF A CCCN

- Size 2-5 million population
- Facilities for optimal cancer treatment
- Common cancers
- Rare cancers
- Cancer in children
- Highly specialized care as necessary
- Integration of resource

Access of every patient to the best site within the CCCN for his/her specific clinical problem

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Multi-Disciplinary Disease Management Team (MDDMT)

Deals with specific tumor type: Includes

- Pathologist
- Diagnostic imaging
- Surgeon
- Radiotherapist
- Medical oncologist
- Nurse
- Psycho-oncologist
- Palliative care/pain specialist
- Rehabilitation professional
- Other tumor-specific appropriate specialist

Overall Objective of WP6

To provide recommendations for the organization of comprehensive cancer services and optimal care for the entire people of a particular territory through the synergy of all relevant institutions that have complementary expertise

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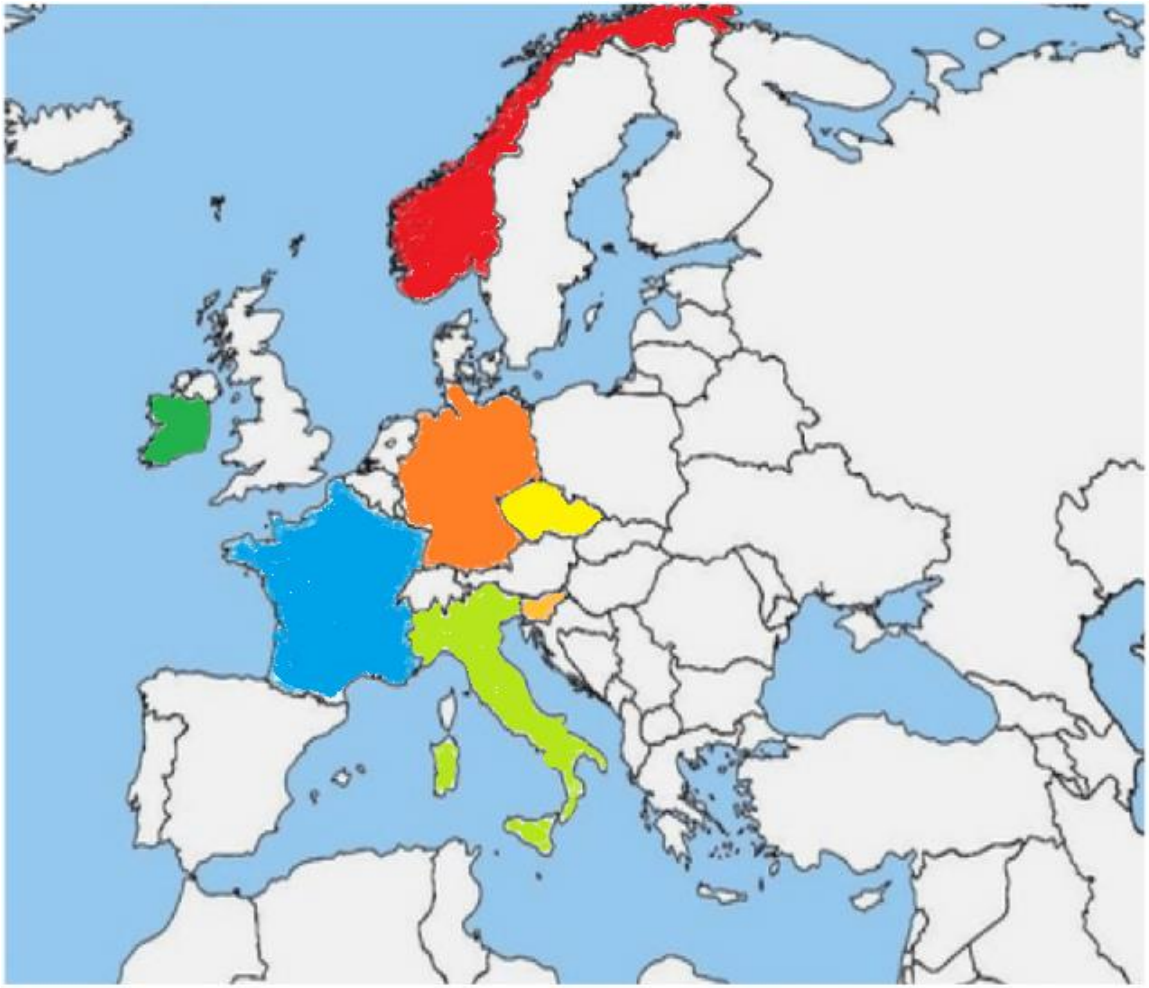
KEY DELIVERABLES

1. Clinical Recommendations
2. Epidemiologic data on prevalence of individual Cancer types in population covered by CCCN
3. Annual Conference on Organization and Management of CCCNs
4. Annual Scientific Conference of CCCN
5. Map of the network with details of entry points
6. List of Units designated for the management of rare or special tumors
7. List of High Technology equipment
8. Registration for accessing and participating in telematic educational events
9. Plan and reports on site visits

WP6 - ASSOCIATED PARTNERS

- Italy
- Slovenia
- France
- Germany
- Ireland
- Czech Republic
- Norway



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Involvement of Collaborating Partners

Finland
Greece
Portugal
Ireland

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Organization and implementation of a CCCN

- Improving dissemination/implementation of a shared model of care in the territory
- Creating shared Infrastructure and services for improving the whole system quality (i.e. Cancer registries and Databases, ICT procedures, etc...)
- Identification of specific skills to be available for those they needed.
- Easy access to all CCCN resources (multiple entry points, shared procedures, etc...)
- Define a shared care pathways for the best treatment of each patient.

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WP6 - MAIN DELIVERABLE

A document setting out in prescriptive terms
what is required for setting up a Cancer network

The epidemiological data pertaining to any particular geographic region are the starting point for defining the needs of that region in terms of cancer care; the document will outline how, depending on the size and the density of the population, one or more comprehensive cancer care networks (CCCN) are needed in order to meet those needs, and how these should be established.

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WP6 - SPECIFIC OBJECTIVES - I.

1. To provide means to develop clinical recommendations for the management of individual types of tumors that have been mutually agreed and are then binding for the entire network
2. To envisage how to organize ease of access to the Cancer network for all people in the territory that can benefit from its services, including services based on high technology
3. To identify within the Cancer network the most suitable Unit for each type of tumor that is rare or requires highly complex management

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WP6 - SPECIFIC OBJECTIVES - II.

4. To promote common infrastructures that will enhance existing cancer research activities in all laboratories within the area of the network and improve synergy
5. To promote the introduction and optimal utilization of advanced and innovative technologies for the treatment of cancer patients in the entire network
6. To create within the Cancer network a forum for regular formal and informal consultation among professionals, including staff rounds, clinical case discussions, second opinions, audits of adverse events.

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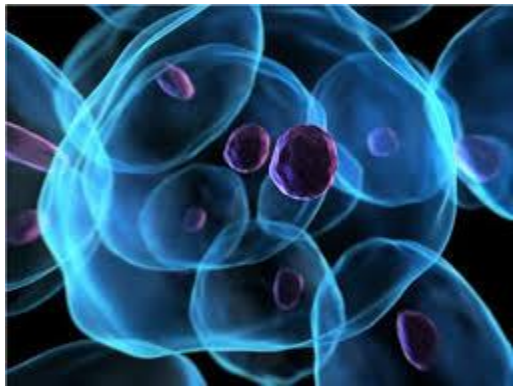

Comprehensive Cancer Care:
CURRENT ADVANCES AND CHALLENGES

- New approaches to cancer prevention
- Refinements in diagnosis
- Identifying specific mutations
- More finely targeted therapy
- Personalized therapy
- Optimally managed palliative care
- High tech non-radical treatment
- Full exome (genome) sequencing: *the ultimate molecular nosography* .

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The Oncologist®

Resistance to "Castration-Resistant"

In a recent article in ***The Oncologist***, Merseburger et al. [1] outline perspectives arising from current progress in the treatment of advanced prostate cancer (PC). As a nonspecialist in this area, I found their account effectively addresses the challenges posed by this difficult clinical problem. However, I take this opportunity to challenge in turn the widely used phrase "castration resistance."

More than half a century ago, it was established that growth of PC was reduced by bilateral orchiectomy [2], and the rough term "castration" was commonly used. Then it was found that a similar therapeutic effect could be achieved alternatively by the administration of hormone-related agents such as diethylstilbestrol or goserelin [3]: such approaches became known as "chemical castration" (but the adjective was often dropped). Because the growth of PC (just as the development of the normal prostate itself) depends on androgens through androgen-receptor (AR) signaling, there was a sound rationale for these therapeutic procedures of androgen deprivation, frequently called more loosely "hormonal treatments."

Unfortunately, however, all of these beneficial interventions proved time-limited, as PC eventually resumes growth: one might have presumed that it had become independent of AR signaling. However, it transpired that things were not that simple. In an authoritative paper [4] published in 2004, the evidence was reviewed that when PC relapses after hormonal treatment, AR signaling is still on, due to two possible explanations: (a) androgens had not been completely eliminated (they are produced by the adrenal glands and sometimes by the PC itself); (b) even in complete absence of the androgen ligand, AR signaling can still operate through devious means (including AR mutation/amplification, crosstalk-mediated activation of other signaling pathways, and other mechanisms [4, 5]). From then on, the phrase "castration-resistant PC" (CRPC) became popular ($n = 1,795$ in PubMed).

Perhaps the time has come to abrogate this term. First, from the clinical point of view for patients who have CRPC, there are now different remedies available depending on whether the resistance results from (a) or (b) above (e.g., abiraterone versus enzalutamide); thus, the term may cause confusion rather than clarity. Second, we should restore dignity to both patients and terminology. It was a disrespectful mistake in the past to indulge in the phrases "castration" and "chemical castration." CRPC is worse, and I have even come across the variant "castration-resistant patients," which some patients perceive as an accusation of refusing to accept something to which unfortunately they have been already subjected. One oncologist told me he used to use the term "castration resistance" freely, but, having PC himself, he has now changed his mind. Instead of CRPC, he suggests, for the two above-mentioned types, respectively, (a) "androgen-deprivation-resistant PC due to persistence of residual androgen" and (b) "androgen-depletion-resistant PC due to androgen-independent persistence of AR signaling." I admit that these phrases are a bit cumbersome. More simply, androgen deprivation-resistant PC and androgen depletion-resistant PC could both be covered by ADRPC (and they could be called ADPRC-a, ADPRC-b), but the choice of appropriate acronyms is best left to the experts.

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Disclosures

Lucio Luzzatto: GlaxoSmithKline (C/A) regarding antimalarial drugs.

(C/A) Consulting/advisory relationship; (RF) Research funding; (E) Employment; (ET) Expert testimony; (H) Honoraria received; (OI) Ownership interests; (IP) Intellectual property rights/inventor/patent holder; (SAB) Scientific advisory board

References

1. Merseburger AS, Bellmunt J, Jenkins C et al. Perspectives on treatment of metastatic castration-resistant prostate cancer. ***The Oncologist*** 2013;18:558–567.

2. Huggins C, Stevens RE, Hodges CV. Studies on prostate cancer: II. The effect of castration on advanced carcinoma of the prostate gland. Arch Surg 1941;43:209–228.

3. Nelson W, Carter HB, DeWeese TI et al. A: Prostate cancer. In: Abeloff M, Armitage JO, Niederhuber JE et al., eds. Clinical Oncology, 3. Philadelphia, PA: Elsevier, 2004:2085–2148.

4. Scher HI, Buchanan G, Gerald W et al. Targeting the androgen receptor: Improving outcomes for castration-resistant prostate cancer. Endocr Relat Cancer 2004;11:459–476.

5. Holmes CJ, Kelly WK. Redefining hormone resistance in prostate cancer. Ther Adv Med Oncol 2010;2:107–123.

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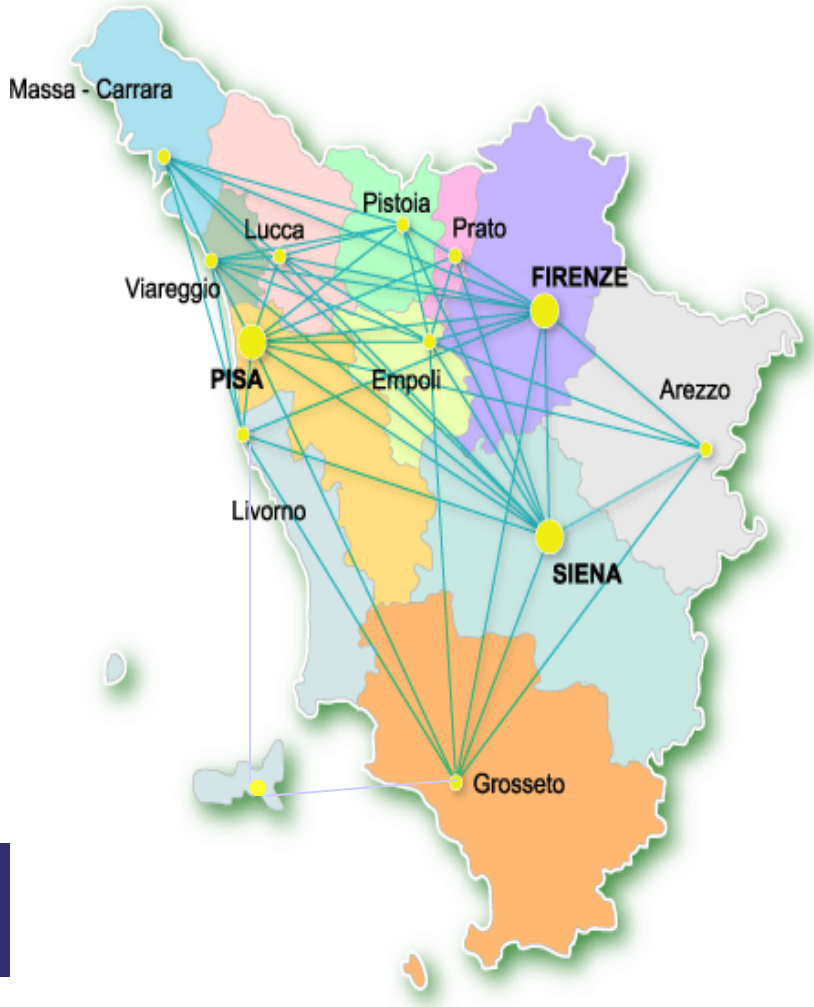

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