Presentation of WP6 Integrated Cancer Control

Cancer Control Joint Action

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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A Comprehensive Cancer Center
PROS AND CONS
IN A NETWORK INSTITUTE

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

- Scale economy
- Synergy
- Common standards of management
- Large number of patients
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
To UNDERSTAND,
To TREAT,
To PREVENT CANCER
AT BEST FOR ALL
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
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
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
Involvement of Collaborating Partners

Finland
Greece
Portugal
Ireland
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.
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.
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.
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.
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
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 orchectomy [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 ADPRC (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**
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**References**
http://dx.doi.org/10.1634/theoncologist.2013-0363
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