



# ecancer

the leading oncology channel



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Interview with  
Professor Gordon McVie &  
Professor Umberto Veronesi

Demystifying European Projects  
Interviews with European project leaders

Journal News

Advances in Open Access



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## Who we are

ecancer is the leading online media channel for the cancer community, supported by the ecancer (ECMS) Foundation. It was set up by Prof McVie and Prof Veronesi of the European Institute of Oncology in 2007 as an independent, not-for-profit organisation with charitable status. Funding

from ECCO (European CanCER Organisation), The European Institute of Oncology Foundation, The Umberto Veronesi Foundation and Swiss Bridge supports the goal of ecancer to aid the rapid dissemination of cancer information.



## Our mission

Cancer care delivery is excellent in some countries but by no means all. By 2020, cancer is expected to kill more than twice as many people worldwide as it did at the turn of the millennium. In low- and middle-income countries, however,

the death rate will be more than five times greater than in the industrialized world. We actively encourage the communities of scientists and cancer carers to exchange ideas and research, speeding up the time it takes from discovery to patient benefit.



**Professor Gordon McVie**  
 Professor Gordon McVie is the Managing Editor of ecancermedalscience. He is widely regarded as a leading international authority in the research and treatment of cancer and is responsible for Clinical Research Coordination, Strategy and International Affairs at the European Institute of Oncology.



**Professor Umberto Veronesi**  
 Professor Umberto Veronesi is the Founding Editor of ecancermedalscience. He is the Founder and Scientific Director of the European Institute of Oncology, Milan and is the pioneer of breast-conserving surgery.

## Cancer Intelligence

Cancer Intelligence is the publisher of ecancer. With communication and intelligence at the heart of the company, we disseminate relevant, high-quality cancer articles, research, news, views, education and events to inform the cancer community with the goal of improving patient care and outcomes.

Embracing the changing technological landscape, we deliver online communications and manage web-based content across a variety of media platforms. Our team is totally committed to promoting communication and well-being between oncologists, oncology nurses, allied healthcare professionals and patients.

As the leading oncology channel, ecancer offers the following free services to the cancer community:

### Journal



ecancermedalscience is our fully open access comprehensive cancer journal founded by the European Institute of Oncology (IEO) in Milan. It is the official journal of the Organisation of European Cancer Institutes (OECI). With an urgent need for improved cancer communications, we believe that cutting edge research should be available to all.

- no author or subscription fees
- wide range of high-quality articles
- rapid publication (max two months)
- rigorous peer review process
- highly esteemed Editorial Board
- indexed in all the main data repositories, including PubMed
- editorially independent



### TV channel



ecancer.tv is the video channel of ecancer, with over 1,500 interviews with cancer experts, researchers and advocates available for free worldwide. ecancer is proud to generate the largest collection of oncology videos in the world.

- videos watched over 1.5 million times since launch
- over 40,000 visitors per month from 191 countries
- over 20 major cancer conferences covered each year



### News



ecancer sources relevant oncology news from top organisations around the world. We post daily news generated by institutes, journals, governments, NGOs and charities, along with commissioned pieces from our dedicated news team.

- over 3,000 news stories on hot topics in oncology
- all the latest conference news
- editorial analysis on the top conferences



### Education



ecancer works with leading organisations to develop educational programmes that improve patient outcomes.

ecancer is currently the education and dissemination partner in three European Commission projects:

- EurocanPlatform: 28 European cancer institutions sharing infrastructures to help advance cancer research and treatment
- EURECA: semantic ontologies of health IT systems
- p-medicine: creating clinical decision making tools



### ecancer Club



Over 7,000 oncology professionals have joined the ecancer club.

- monthly newsletter and content alerts
- invitation to be interviewed for ecancer.tv
- conference discounts
- networking events



Scan with a QR reader downloaded to your Smartphone to access our website.

**ECCO  
17**

**17<sup>th</sup> ECCO - 38<sup>th</sup> ESMO - 32<sup>nd</sup> ESTRO  
European Cancer Congress  
Reinforcing multidisciplinary  
AMSTERDAM, 27 SEPTEMBER - 1 OCTOBER 2013**

**ESMO  
38**

**ESTRO  
32**

[www.ecco-org.eu](http://www.ecco-org.eu)



## Founding Editors

The Founding Editors are highly respected and authoritative leaders each representing a different field of cancer research. Their position on the board is both honorary and functional as they have the opportunity to shape the direction of the journal.

- Professor Claudio Basilico NYU School of Medicine, USA
- Professor Peter Boyle International Prevention Research Institute, Lyon, France
- Professor Pier Paolo Di Fiore European Institute of Oncology, Italy
- Professor Alexander Eggermont Institut Gustave Roussy, France
- Professor Aaron Goldhirsch European Institute of Oncology, Italy
- Professor Gordon McVie Managing Editor, European Institute of Oncology, Italy
- Professor Roberto Orecchia University of Milan and European Institute of Oncology, Italy
- Professor Pier Giuseppe Pelicci European Institute of Oncology, Italy
- Professor Umberto Veronesi Founding Editor, European Institute of Oncology, Italy
- Professor Giuseppe Viale University of Milan and European Institute of Oncology, Italy
- Professor Luis Pinillos-Ashton National Cancer Institute of Peru (INEN), Peru
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- Professor Rajiv Sarin Advanced Centre for Treatment Research and Education in Cancer (ACTREC), Tata Memorial Centre, India
- Professor Cornelis J H van de Velde Leiden University Medical Center, The Netherlands

## Editorial Board

The Editorial Board plays a more active role in the day-to-day running of the journal. They contribute to stimulating the submission of key articles, assist the Scientific Editor and Publishing Editor with the peer review process and promote the journal within the medical community.

- Roshan Agarwal Imperial College London, UK
- Giancarlo Albo Fondazione IRCCS Ca'Granda Ospedale Maggiore Policlinico, Milan, Italy
- Elena Belloni European Institute of Oncology, Italy
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- Richard Sullivan Council for Emerging National Security Affairs and Kings College, London, UK
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- Luca Toschi Istituto Clinico Humanitas, Milan, Italy
- Laura Velazquez Inserm/Université Paris 13, France
- Giulia Veronesi European Institute of Oncology, Italy

In partnership:



ecancer.tv is the video channel of ecancer, with over 1,500 interviews with cancer experts, patients, researchers and advocates available for free worldwide. ecancer is proud to generate the largest collection of oncology videos in the world.

ecancer has been shortlisted for the 2012 AOP Digital Publishing awards for Best Use of Video, alongside News International, Bauer Media and The Guardian.

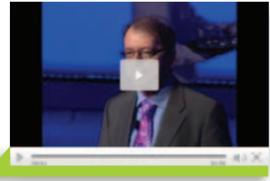
**Top 5 most watched videos of 2011/2012\***



11987 views  
<http://ecancer.org/tv/pubdate/1311>

**Recent advances in multiple myeloma therapy**

Prof San Miguel, Prof Philippe Moreau, Prof Antonio Palumbo, Prof Meletios Dimopoulos and Prof Thierry Facon discuss the important developments in the treatment of multiple myeloma (MM) presented at ASH 2011, at the Post ASH meeting in Paris.



8476 views  
<http://ecancer.org/tv/pubdate/1307>

**What drives improvements in cancer care?**

Prof Kurt Miller, Prof Gordon McVie, Dr Karim Fizazi, Peter Hazenberg, Jane Griffiths

John Clare (Medical Journalist) chairs the Prostate Panel Discussion at the first Prostate Cancer Debate, Berlin Germany. The panel constitutes 5 leading experts expressing their opinions on what drives improvements in cancer care.



4867 views  
<http://ecancer.org/tv/pubdate/1309>

**Recent developments in neoadjuvant therapy**

Prof Gunter Von Minckwitz (German Breast Group, Neulsenburg, Germany) talks to ecancer about assessing neoadjuvant therapy in breast cancer and recent developments at IMPAKT 2012 in Brussels, May 2012.



4332 views  
<http://ecancer.org/tv/pubdate/1087>

**Trastuzumab emtansine, Phase II trial for HER2**

**Dr Sara Hurvitz - UCLA Santa Monica Hematology Oncology, USA**

At a press conference at EMCC 2011, Dr Hurvitz discusses the trastuzumab emtansine, T-DM1, an antibody-guided drug, Phase II trial and how the results show a significant delay breast cancer progression in the initial treatment of HER2 (human epidermal growth factor receptor-2) positive metastatic breast cancer.



3851 views  
<http://ecancer.org/tv/pubdate/865>

**Different options for elderly CLL patients**

Prof Robin Foà - Sapienza University of Rome, Italy and Prof Michael Hallek - University of Cologne, Germany

The most common leukaemia in the western world is CLL (chronic lymphocytic leukaemia); Prof Robin Foà and Prof Michael Hallek outline the different therapies available and discuss the factors which influence clinicians' choice of CLL treatment.

*"I was very pleased with how my interview turned out. I greatly appreciate the opportunity to bring international attention to our growing field of cancer survivorship research and care"*

Dr Julia Rowland, National Cancer Institute, USA

\* viewing figures correct as of 14.6.12

@ecancer was the most followed external news source at the 8th European Breast Cancer Conference (EBCC-8) in Vienna

Please contact [Jon Birch](mailto:Jon.Birch@ecancer.org) [jon@ecancer.org](mailto:jon@ecancer.org) if you are interested in being interviewed by ecancer.tv.

**Journal News and Scope**



**PubMed**

The exciting news from ecancermedicalsience this year is that we have now been accepted into PubMed, PubMed Central and UK PubMed Central. This means that the full text of all our articles is now freely available in their databases. Now that the journal is five years old we are publishing three times as many articles and our readership has gone up to over 140,000 views per year.

**Special issues**

The journal has now launched a special issue programme which we hope will explore timely and topical issues of interest to many. Please contact our Scientific Editor, Linda Cairns [editor@ecancermedicalsience.com](mailto:editor@ecancermedicalsience.com) if you are interested in participating in an ecancermedicalsience special Issue as a Guest Editor or author.

**Negative Clinical Trials**

We now consider articles reporting negative clinical trial results. Negative clinical results are often considered 'uninteresting' and so are not submitted for publication. However, ecancermedicalsience believes that if a research question is important, original, and is answered with the right study design and sufficient power, it should be published, even if the outcome is negative.

*No author or subscription fees*

Submissions can made to our new author submission system <http://ecancer.org/author>



*Free publication supported by charity*



We consider articles on all aspects of research relating to cancer, including molecular biology, genetics, pathophysiology, epidemiology, clinical reports, controlled trials and cancer policy. All articles are peer reviewed.

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# Abstracts

ecancermedicalsecience is committed to publishing innovative studies testing new hypotheses; be it laboratory science, epidemiology, translational medicine, clinical trial reports, nursing research or case reports. What is critical is that the article reports something new - so new that the authors are in a rush to tell the world about it!

ecancermedicalsecience is an open access, multidisciplinary cancer journal which publishes original research, review articles, conference reports and more recently negative clinical trials, editorials and news on basic and preclinical research. Even specialist topics such as medical imaging or radiotherapy techniques are covered and will become available to a much wider audience. All articles are tagged by category so that they are easy to find and related videos are published alongside relevant articles.

The abstracts in the following pages are some of the most read articles published in the journal from the last year.

To read all these articles and many more in full for free, visit the journal online <http://ecancer.org/ecms>



## Conference Reports

This is a conference report of a satellite meeting at the fifth International Breast Cancer Conference in Paris (2011) examining several important questions relating to the diagnosis and treatment of triple-negative breast cancer. It contains valuable educational content of potential interest not only to breast cancer specialists but also to the wider healthcare community.

### Conference Report

#### Tips and tricks in triple-negative breast cancer: how to manage patients in real-life practice

M Piccart, G Viale, P Ellis, M Abramowicz, L Carey

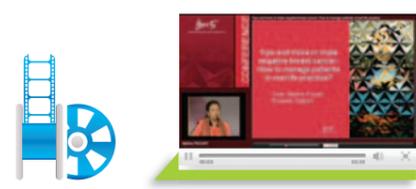
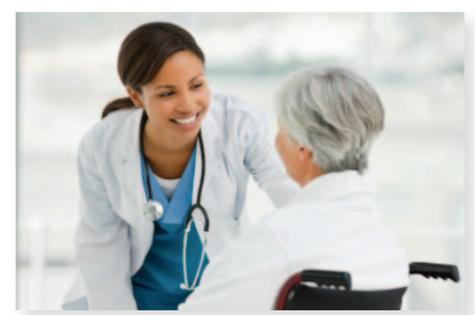
Received: 04 Jul 2011, Published: 19 Jul 2011

This article has been developed following, and drawing on the content of, a satellite meeting at the fifth International Breast Cancer Conference, held in Paris, France, on 29 January 2011. The purpose of the meeting was to examine several questions relating to triple-negative breast cancer (TNBC):

- How should TNBC be defined?
- Are there clinically important TNBC subtypes?
- Should patients be given adjuvant or neoadjuvant treatment for TNBC?
- Should patients with TNBC and their families have genetic tests?
- How should relapsing or metastatic TNBC be treated?

Using a real-life case study, at each stage of the patient care pathway from diagnosis through assessment to treatment, the audience was encouraged to vote on potential decisions, before an expert panel on which we all discussed the evidence and presented what we consider constitutes best clinical practice.

In this article we share the proceedings of the meeting, which we believe contained valuable educational content of potential interest to the wider healthcare community.



The video of this meeting is freely available to view here <http://ecancer.org/tv/pubdate/1296>

## Visions

Visions are a new article type in which authors of the most significant recent and forthcoming papers, published elsewhere, will provide a short summary with additional insights, new interpretations or applications, or speculation on the relevant topic. The following two abstracts represent examples of such papers which appeared this year in ecancermedicalsecience.

### Visions

#### Tumor-infiltrating granulocytic cells promote cancer cell dissemination

B Toh and JP Abastado

Received: 02 Dec 2011, Published: 16 Jan 2012

Most studies aimed at understanding the link between inflammation and cancer progression have focused on macrophages. In a recent study published in *PLoS Biology*, Toh B et al (2011) **Mesenchymal transition and dissemination of cancer cells is driven by myeloid-derived suppressor cells infiltrating the primary tumor** *PLoS Biol* 9 e1001162, we show that a subset of granulocytic cells already known to suppress antitumour immune responses also promotes cancer cell proliferation and metastasis by inducing epithelial to mesenchymal transition. This subset plays a key role in early dissemination of cancer cells throughout the body and may therefore represent a novel target for therapeutic intervention.



This abstract is freely available to view here <http://ecancer.org/ecms/6/241>

### Visions

#### Circulating microRNAs: next-generation biomarkers for early lung cancer detection

F Bianchi, F Nicassio, G Veronesi and PP di Fiore

Received: 10 Feb 2012, Published: 06 Mar 2012

Early diagnosis of lung cancer by low-dose computed tomography is an effective strategy to reduce cancer mortality in high-risk individuals. However, recruitment of at-risk individuals with asymptomatic lung cancer still remains challenging. We developed a minimal invasive serum test, based on the detection of circulating microRNAs, which can identify at-risk individuals with asymptomatic early stage non-small cell lung carcinomas with 80% accuracy.



This abstract is freely available to view here <http://ecancer.org/ecms/6/246>

## Author Comments

“That is one truly excellent job. The video interviews are amazing, they really enhance the whole thing.”

Nick Henderson, Executive Director, *Aspirin Foundation*

“Let me thank you for your unfailing consideration and patience. It has been a distinct pleasure to work with you and I look forward to collaborating in the near future.”

Patrick Hill, *The State University of New Jersey*

Reviews

This article reviews some of the key issues faced in geriatric oncology.

Review

Cancer in older patients: an analysis of elderly oncology

V Swaminathan and RA Audisio

Received: 23 Dec 2011, Published: 02 Feb 2012

Is it possible to define when someone is elderly? The worldwide population is growing not only in number but also in age; it is estimated that the population will increase to around 750 million by 2021. Two thirds of cancer occurs in the over 65 age groups. With an increasing elderly population, it can be derived that cancer will become a more prevalent condition. The burden of cancer on the medical profession will be even more apparent than before.

In addition the elderly age group has different needs compared with younger oncology patients; there can be no 'rule of thumb' with the management of elderly illness. Factors such as frailty are significant when treating cancer in the older patient. The assessment of quality of life in older patients with cancer is also an important factor. Is it best for a patient to enjoy life as it is with cancer or aim for increased life expectancy by undertaking treatment with the threat of morbidity however severe during that period? The volume of scientific evidence currently available to support all the issues in geriatric oncology is greatly limited; almost all treatments designed for oncology are being tested in randomized clinical trials preferentially using younger cohorts of patients. Changes need to be made in order to further this field of medicine. Geriatric oncology is no longer a palliative field, as a healthy active life can now be expected by some older patients. The burden of oncology in the elderly will need to take a modern approach regarding the management of these patients.



This abstract is freely available to view here <http://ecancer.org/ecms/6/243>

Reviews

This article by TP Hill represents a review of a very topical subject - that of Phase 0 clinical trials. In efforts to modernise the entire drug-development process, making it more efficient, less costly, and ultimately of real benefit to patients, the FDA authorised the use of exploratory Phase 0 studies.

Review

Phase 0 clinical trials: towards a more complete ethics critique

TP Hill

Received: 16 Feb 2012, Published: 27 Mar 2012

In efforts to modernise the entire drug-development process, making it more efficient, less costly, and ultimately of real benefit to patients, The Federal Drug Administration (FDA) authorised the use of exploratory IND or early Phase I (Phase 0) studies. Quite different in structure from Phase I, II, and III studies, the Phase 0 construct understandably poses a set of ethical problems not seen in the other research phases and so far not adequately addressed by ethicists. In an effort to deal with this deficiency, this paper proposes an ethics critique, based not on the usual concept of benefit, but on the means–end relation, and placed within an ethic of science derived from the practice of science.



An interview with TP Hill has been published here <http://ecancer.org/ecms/6/248/interview>



Dr Linda Cairns is the Scientific Editor of the journal

Conference Reports

Aspirin and its potential role in reducing the risk of cancer in older people is an area attracting much attention. We have a conference report from a recent meeting of the Aspirin Foundation held in London.

Conference Report

Aspirin for the older person: report of a meeting at the Royal Society of Medicine, London, 3rd November 2011

J Armitage, J Cuzick, P Elwood, M Longley, A Perkins, K Spencer, H Turner, S Porch, S Lyness, J Kennedy and GN Henderson

Received: 18 Jan 2012, Published: 28 Feb 2012

On November 23rd 2011, the Aspirin Foundation held a meeting at the Royal Society of Medicine in London to review current thinking on the potential role of aspirin in preventing cardiovascular disease and reducing the risk of cancer in older people. The meeting was supported by Bayer Pharma AG and Novacyl.



The video of this meeting is freely available to view here <http://ecancer.org/tv/conference/126>

Contact Information

Queries about content, submissions or the review process should be directed to [editor@ecancermedicalscience.com](mailto:editor@ecancermedicalscience.com)

All other enquiries should be directed to [info@ecancermedicalscience.com](mailto:info@ecancermedicalscience.com)

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# Open Access: how far we've come

Open access, the publishing model that makes journal articles available to read for free, has come a long way since its inception back in the mid-1980s. Many different models of open access (OA) have evolved, some charging author fees, some with restrictive copyright agreements and others with no such restrictions or fees. The point that most scientists can agree on is that open access publishing is the future. The seismic shift in academic publishing caused by the creation of the internet can only lead to one thing: completely unrestricted access to the published output of research.

To this end, many major biomedical funders, such as the Medical Research Council and the Wellcome Trust in the UK, the Deutsch Forschungsgemeinschaft in Germany and the NIH in the USA have OA mandates. They believe that maximising the distribution of journal articles - by providing free, online access - is the most effective way to ensure that the research they fund can be accessed, read and built upon. The hope is that this, in turn, will foster a richer research culture.

Governments worldwide are also joining the push for OA. In May 2012, David Willetts, the UK universities and science minister, stated his determination to see publicly funded research become freely available. He pledged not to destroy publishers' business models but warned that trying to defend the subscription model was "the wrong battle to fight". He suggested that open access "could be among the excellence criteria for qualifying articles" for Research Excellence Frameworks rounds beyond 2014.

So how do scientists feel about the growth of open access? In early 2012, Timothy Gowers, a distinguished mathematician based at Cambridge University, UK, published a statement on his blog explaining why he refused to contribute to journals published by Elsevier and inviting his colleagues to do the same. By May 2012 over 11000 scientists from all over the world had signed the boycott.

It reflected a general dissatisfaction with the high subscription fees charged by the larger publishers as a whole, and many of the academics involved see open access publishing as the only viable alternative. Elsevier have since withdrawn their support

for the US Research Works Act, which contains provisions to prohibit OA mandates for federally funded research, although they deny this was as a result of the boycott.

The benefits of open access are now widely acknowledged - It has direct and widespread implications for academia, medicine, science, industry, and for society as a whole. All researchers benefit from OA as no library can afford to subscribe to every scientific journal and most can only afford a small fraction of them. The more each article is used, cited, applied and built upon, the better for research as well as for the researcher's career. Similarly, the more quickly it is accessible, the better; open access greatly reduces publication delays as well as maximising the author's research impact.

The benefits for developing nations are even higher. Scientists, health care professionals, and institutions in developing nations often do not have the capital necessary to access the scholarly literature. Many library associations have either signed major open access declarations, or created their own. And it's not just researchers who benefit - patients and their families who want to research a certain condition often just can't afford to pay for the information.

So what effect is open access publishing having on cancer research? A paper from the European Association of Cancer Research (EACR), published in *ecancermedicalscience* in August 2011 (Kenney R and Warden R 2011 **An Open Access future? Report from the eurocancercoms project** *ecancer* 5 223 doi: 10.3332/ecancer.2011.223), discusses in detail the effect of publishing costs and access to information on cancer research. The results of an EU funded project highlighted the issue of access to subscription journals, the barrier to essential and urgent information that a 'paywall' creates, and the need for free access.

The authors were amazed to find that a quarter of cancer researchers experience difficulty gaining access to what their peers have published, and that they are compelled to spend valuable time tracking down and supplying themselves with such publications without having to pay high fees. It is especially salient for those working independently without



institutional library back-up. Publishers frown on them using "informal networks of friends and colleagues" but if the only alternative is paying around \$100 to download an article, some authors feel there is no other option.

The paper concludes that "88% of authors believe that publicly funded research should be made available to be read and used without access barriers". Perhaps publishers fear they'll suffer like the music industry with less than legal rampant digital downloads, but "change is inevitable".

However, some researchers are also finding the large author fees charged by various popular open access journals exorbitant. While OA means people can read their articles for free, authors often have to pay a high price to allow this. *ecancermedicalscience* is one of the very few oncology journals to provide open access publishing without charging any author fees as it is supported by grants and charity funding. We believe that if an article is found by peer reviewers to be of good quality and interest to the cancer community then it should be published, regardless of whether the author can afford to pay for this service or not.

Open access has come a long way since the Budapest Open Access Initiative in 2002. 40% of biomedical articles are now open access and many members of the scientific community are determined that this proportion should greatly increase. Repositories such as PubMed Central include thousands of full text OA articles and the European Commission has argued for a long time that the results of publicly funded EU research should remain in the public domain. In May 2012, the commission's director-general of research and innovation, Robert-Jan Smits, said in an interview in the *Times Higher Education* that open access "will be the norm" for research funded through Horizon 2020 (the EU's 7-year research funding programme). "With our €80 billion we can make one hell of a difference," Smits said. Here at *ecancer* we are honoured to play a part in this exciting shift towards cancer research finally becoming freely available to all.

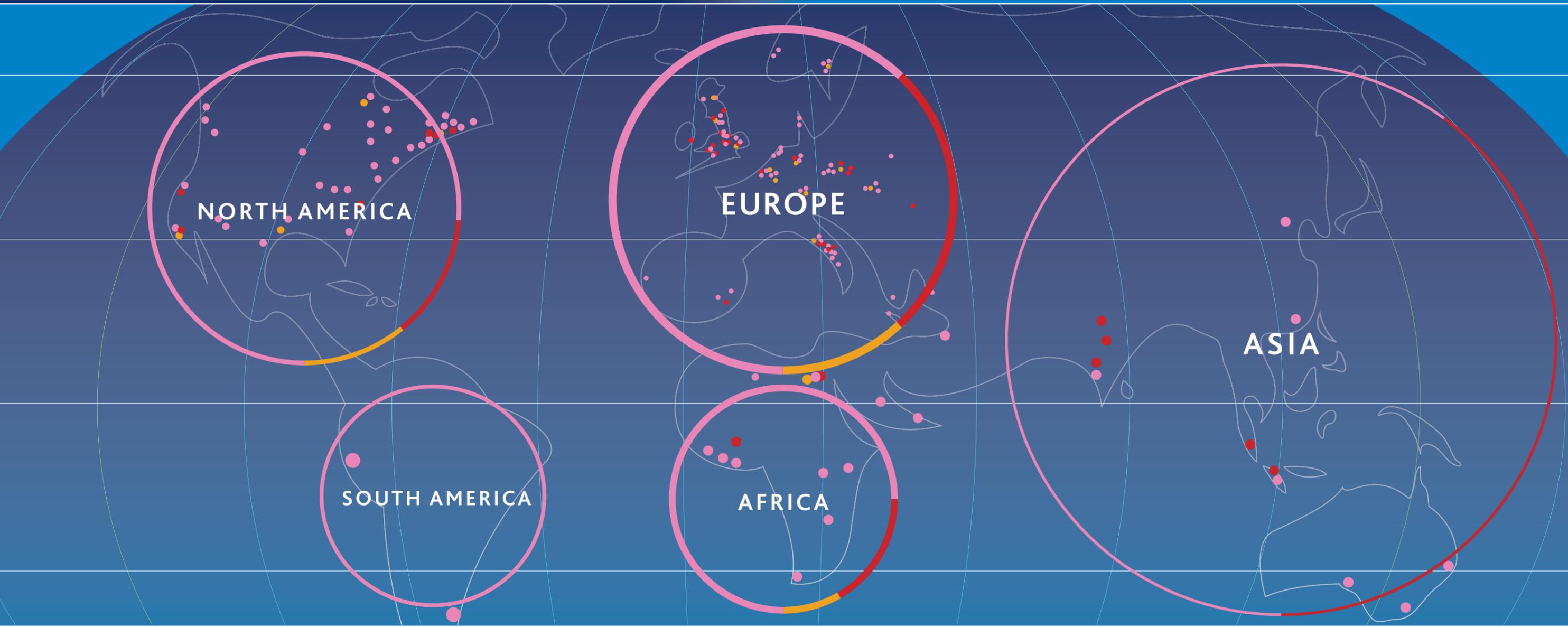
By Katie Foxall, Publishing Manager, *ecancer*

'I think more open access publishing... could really boost Europe's economy and help boost innovation. If you are an SME employee or a teacher, say, there is just no way you can read the latest research. With open access anybody will be able to use it how they want. It is the best way to make the most of publicly funded research.'

Natalia Manola,  
*OpenAIRE project manager*

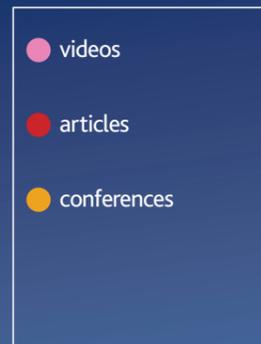


● Video interviewees (483 videos)    
 ● Article authors (51 articles)    
 ● Conferences attended (24 conferences)



Proportional representation from each continent

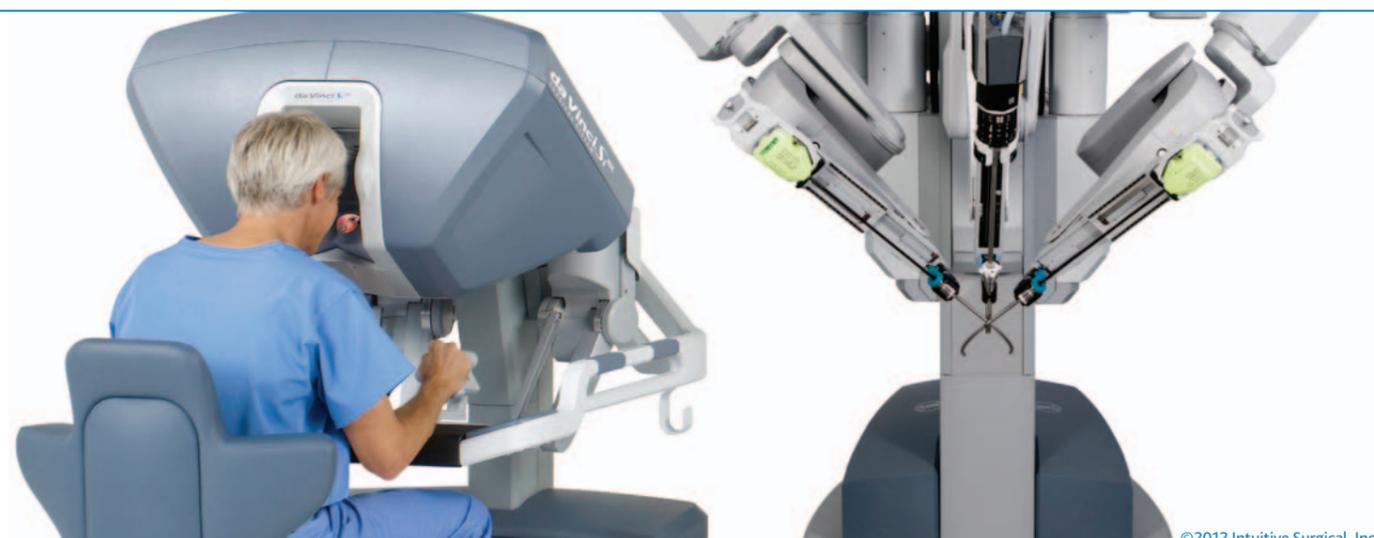
Key



ecancer thanks all of the people and organisations who have contributed to our success, however due to design constraints, not all of these can be recognised on our map.

# Robot-assisted surgery for cancer

– greater precision for the surgeon and clear benefits for the patient, but can the costs be justified? - *Stephen Pinn*



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Minimally-invasive procedures are now considered to be the gold standard for a wide variety of cancers requiring surgery – from prostatectomy, through cystectomy for tumours of bladder, to liver and lung resection.

Not surprisingly, perhaps, the range of surgical options now available is becoming increasingly sophisticated – and robot-assisted techniques are now being championed throughout Europe, the US and other international surgical communities that have the wherewithal to fund such advanced technologies.

The European Institute of Oncology (IEO) in Milan is at the forefront of many robot-assisted cancer surgery initiatives, as are a handful of specialist tertiary referral centres in the UK.

There appear to be clear benefits for the patients – and for those surgeons who, as Dr Robert Cerulio comments, are prepared to undergo the “steep learning curve” required to master the subtle robotic techniques (Cerulio et al, 2011).

Looking back on a series of 150 patients undergoing robotic-assisted surgery for general thoracic surgical indications – lobectomy, thymectomy and a handful of benign oesophageal procedures – he reports: “**Robotic surgery is safe and oncologically sound. It requires training of the entire operating room team.**”

**The learning curve is steep, involving port placement, availability of the proper instrumentation, use of the correct robotic arms, and proper patient positioning. The robot provides an ideal surgical approach for thymectomy and other mediastinal tumours.**

**Its advantage over thoracoscopy for pulmonary resection is unproven - however, we believe complete thoracic lymph node dissection and teaching is easier.”**

Dr Cerulio (Division of Cardiothoracic Surgery, University of Alabama, Birmingham, US) also reports that the median operative time for robotic thymectomy was 119 minutes, and median length of stay was one day. The median time for robotic lobectomy was 185 minutes, and median length of stay was two days. There were no operative deaths, while morbidity occurred in 23 patients (15%).

In Europe, Dr Giulia Veronesi (Division of Thoracic Surgery, IEO, Milan, Italy) is a leading proponent of robot-assisted

surgery for lung and mediastinal tumours.

While conceding that video-assisted thoracoscopic (VAT) procedures currently represent the standard in this field, she is convinced that the benefits of the robotic approach in terms of optimal lymph node resection, the very high degree of ambidextral precision afforded the surgeon, increased visualisation in the surgical field, minimal blood loss, less pain, less risk of infection, faster recovery times and shorter hospital stays for the patient can no longer be ignored. “**It takes the uncertainty out of lung resection,**” she emphasised.

Dr Veronesi and colleagues have recently reported data from a multi-institutional retrospective review of patients undergoing robotic lobectomy for NSCLC (Park et al, 2011). Data from 325 patients was analysed, resulting in the following outcomes:

- conversion rate to thoracotomy 8% (27/325)
- overall morbidity rate 25.2% (82/325)
- major complication rate 3.7% (12/325)
- median length of stay 5 days

With a median follow-up of 27 months, overall 5-year survival was 80%, while 3-year survival for patients with stage IIIA disease was 43%.

She and her colleagues concluded: “**Robotic lobectomy for early-stage NSCLC can be performed with low morbidity and mortality. Long-term stage-specific survival is acceptable and consistent with prior results for VATS and thoracotomy.**”

In the UK, prostate cancer has thus far been the most popular target for robot-assisted strategies – none more so than the Royal Marsden Hospital in London, where Mr Christopher Ogden and his team are perfecting their techniques.

Reporting to the British Association of Urological Surgeons (BAUS) and the American Urological Association (AUA) in 2010, Mr Ogden reported on a series of 309 patients undergoing robot-assisted laparoscopic prostatectomy (RALP), with a biochemical/clinical recurrence rate of 7.1% (Lavan et al 20102 – 1 and 2).

He concluded: “**Robotic radical prostatectomy delivers safe, short-stay treatment with minimal morbidity. Early oncologic outcomes are excellent with minimal biochemical failures...**”

**“In this relatively high risk patient cohort, RALP provides good oncological control. As expected, T3 disease appears to have a higher incidence of biochemical recurrence – but surgical cure appears possible in more than 50% of pT3 patients.”**

Robot-assisted surgery is now making inroads into many areas of cancer surgery, including: adrenalectomy, liver wedge resection, pancreatotomy, myotomy for hiatal hernia, thyroidectomy, splenectomy, colon resection, rectopexy for rectal prolapse and other related procedures, low anterior resection for pelvic floor dysfunction and even gastric surgical procedures for obesity-related disorders. This is by no means an exhaustive list of candidates for robot-assisted surgery.

However, as with any new surgical intervention that requires an expensive capital outlay, as well as considerable expenditure on maintenance, the question of cost vs benefit invariably divides opinion.

In a recent paper, US surgeons estimated that compared to conventional laparoscopy, the additional cost-per-case of using robotic-assisted surgery to remove the uterus in women diagnosed with endometrial cancer was approximately US\$1,300 (Wright et al, 2012).

The mean hospital cost for laparoscopic surgery was US\$8,996 compared to US\$10,618 for a robotic procedure.

These data were based on a cohort of 2,464 women, nearly 58% of whom underwent a robotic-assisted procedure. In 8.1% of these patients, complications such as bladder injury, wound infection or kidney failure, compared to 9.8% of those undergoing laparoscopy.

The authors concluded that the extra expense – even without taking into account purchase costs of up to US\$2.25 million for each robotic machine – did not outweigh the slight reduction in adverse events.

In contrast, when outcomes and costs for 143 women who underwent robotic hysterectomies at a Canadian tertiary cancer centre were compared to 160 women undergoing laparoscopy during the five years before robotic-assisted procedure was introduced, a different picture emerged (Lau et al, 2012).

Robotic surgery was associated with longer operating times (233 vs 206 minutes), but far fewer adverse events (13% vs

42%,  $p < 0.001$ ), lower estimated median blood loss (50mL vs 200mL,  $p < 0.001$ ) and shorter median hospital stay (1 vs 3 days, again  $p < 0.001$ ).

Overall hospital costs were significantly lower for robotic procedures compared to laparoscopy (Can\$7,644 vs Can\$10,368,  $p < 0.001$ ), even when acquisition and maintenance cost were taken into account.

**“It will replace traditional surgery not only in the treatment of benign diseases but also in malignant illnesses.”**

Within two years following surgery, the short-term recurrence rate was lower for robotic-assisted surgery than for laparoscopy (11 vs 19 recurrences,  $p < 0.001$ ).

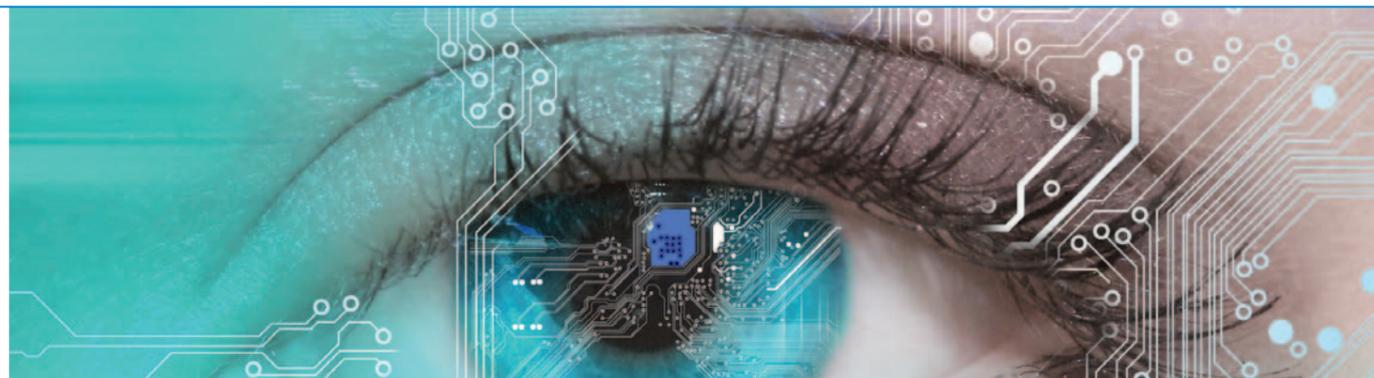
In another recent paper from the US comparing robotic-assisted procedures and conventional laparoscopy to open surgery in patients requiring the most common interventions for urological cancer (radical prostatectomy, nephrectomy and pyeloplasty), the authors were more equivocal in their findings (Yu et al, 2012 -1).

Robotic-assisted surgery was performed for 52.7% of radical prostatectomies, 27.3% of pyeloplasties, 11.5% of partial nephrectomies and 2.3% of nephrectomies.

The robotic approach resulted in significantly shorter hospital stays for radical prostatectomy and partial nephrectomy (a mean difference of 1 day favouring  $p < 0.001$ ), while for most procedures, robotic and other minimally-invasive strategies resulted in fewer deaths (0 vs 2 per 1,000), complications, transfusions (>2% vs 5%) and more routine discharges than open surgery.

However, robotic-assisted surgery was more costly than conventional laparoscopic surgery and open surgery for most urological procedures.

*Continued on next page*



Turning finally to radical cystectomy for bladder cancer, US researchers reviewed data from 1,444 women undergoing open surgery and 224 of those experiencing robotic-assisted laparoscopic procedures Yu et al, 2012 –2).

It was found that patients who underwent robotic-assisted surgery experienced fewer in-patient complications than those who had the traditional open procedure (49.1% vs 63.8%). A significant finding was that no deaths were reported with robot-assisted intervention, whereas open surgery resulted in one death per 100 patients.

It was further reported that delayed bowel function often occurs following major surgical procedures, and that patients with this complication require parenteral feeding. Those patients who underwent the robotic procedure had less need of parenteral nutrition than those that underwent the open procedure (6.4% vs 13.3%). The length of hospital stay was similar for both groups (approximately eight days).

Total costs for robotic surgery were significantly higher - an increase in excess of US\$3,000, which was attributed to longer surgery time as well as the greater use of disposable instruments with the robot. It was emphasised that this analysis did not include expenses for the purchase of the robot or its maintenance.

The authors commented: “While we expected to see greater expenses associated with the robotic procedure for bladder cancer, we were surprised to see the significant reduction in deaths and complications, particularly this early in its adoption,”

The final word goes to two Japanese surgical technology specialists from Kyushu University, Fukuoka, where the inspiration for robot-assisted surgery first emerged. Although these observations were published eight years’ ago (Hashizume, Tsugawa, 2004), they remain as relevant today as they did then.

They called for the introduction of image-guided surgical assistant systems, smaller sized forceps for robots, capsule endoscopic surgery and a surgical robotic system. In education and training, such training centres for robotic surgery should be established around the world.

They envisaged that, in the future, as robotic technology continues to develop almost all endoscopic and open cancer surgery could and would be performed with the aid of new robot-assisted technology. “It will replace traditional surgery not only in the treatment of benign diseases but also in malignant illnesses.”

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*Stephen Pinn is a freelance medical writer*

# Interview with Professor Ulrik Ringborg,

Project Coordinator of EurocanPlatform,  
The Karolinska Institutet

*EurocanPlatform: Linking Europe’s leading cancer centres*  
[www.eurocanplatform.eu](http://www.eurocanplatform.eu)



**Tell us in simple terms what you hope to achieve in the EurocanPlatform project?**

- A sustainable structure which will help to translate research findings within the cancer area into innovative preventive, early detection and therapeutic strategies, as well as a structure of quality assured cancer research centres.
- Two-way translational cancer research for prevention, as well as biomarker discovery and validation for early detection, discovery and validation of treatment predictive biomarkers (both anti-tumour effects and side effects) and an outcomes research structure.
- A more coordinated cancer research support from different stakeholders: new types of collaboration between academia, industry and health care systems.

**How will patients see a benefit from this project?**

A main goal is research supporting the development of personalised cancer medicine. This means development and implementation of new diagnostic methods for individualised treatment and treatment at an early stage of the disease. Identification of high risk individuals will improve prevention activities.

**What projects have you been involved with in the past that are having an impact already?**

EUNICE - The analyses of cancer prevention and treatment, including organisational aspects, were helpful for the Eurocan+Plus project.

Eurocan+Plus project – The detailed analyses of the European cancer research resulted in identification of factors causing fragmentation and suboptimal coordination. EurocanPlatform is a consequence of the project.

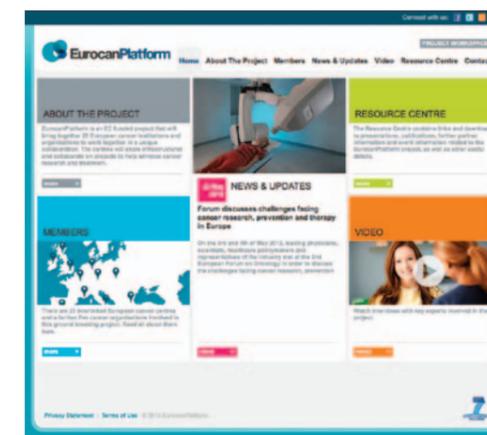
Eurosun - Analysis of geographic variation in UV-irradiation in Europe linked to epidemiological research regarding risk factors for skin cancer. It is too early to see an impact, but hopefully the project will give advice regarding skin cancer prevention.

**How do you think cancer care will change over the next 5-10 years?**

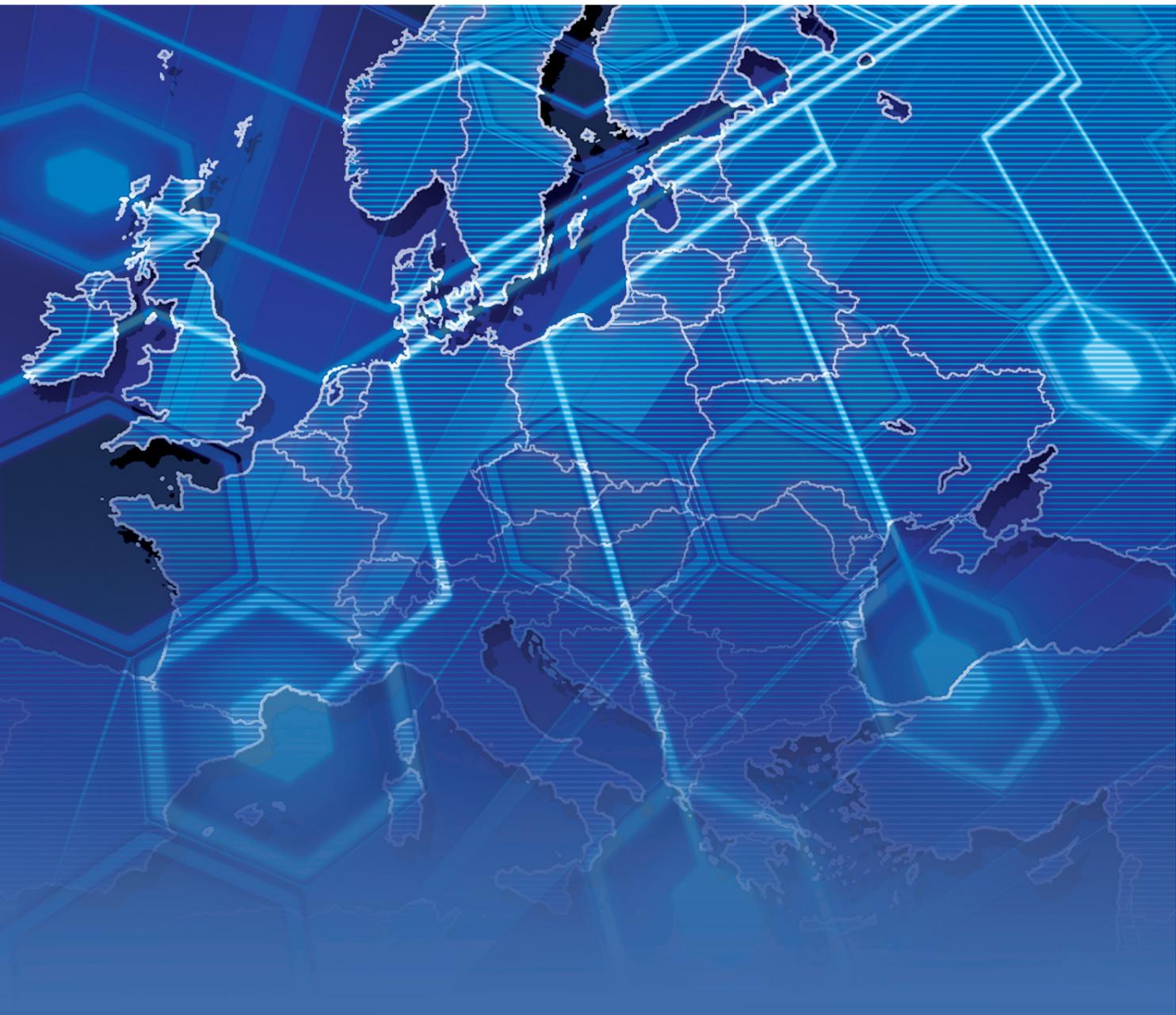
- Cancer biology will be more involved with subclassification of tumours and identification of tumour driving molecular pathways as a basis for increased stratification of patients for treatment - a process to approach personalised cancer medicine.
- Treatment at an early stage of the disease will be improved: there will be new methods for diagnosis of premalignant lesions as well as identification of early metastatic disease.
- Multidisciplinarity in the diagnostic area will develop towards more integration between molecular pathology, imaging and laboratory medicine involving genomics technologies.
- Prevention programs will increase in the healthcare systems due to new technologies for identification of high risk individuals.

**What do you think ecancer has brought to the project?**

ecancer plays a vital role in increased visibility and communication to the different professions within the cancer field and importantly, to the public. Within the platform, ecancer helps to facilitate communication and dissemination among partners, e.g. information flow regarding data and availability of material, and to distribute the news to all participants.







# What's new in Personalised medicine?



Personalised medicine means many things to many groups of people. A literature survey recently found over 140 definitions. For patients and the public this is bewildering as they have always assumed that when ill, they will be treated as an individual, so what's new?

Leading organisations have come together to help drive the agenda by forming the European Alliance for Personalised Medicine (EAPM). The EAPM will work alongside policy makers, politicians and regulators in the EU to accelerate the development, delivery and uptake of personalised medicines and diagnostics. ecancer is a founder member of the EAPM, leading on the topic of patient awareness and empowerment.

In cancer, treatments have traditionally been prescribed according to pathological type of cancer and degree and destiny of cancer cell spread. Now all this is changing and it is vital to educate and inform patients of how and why these changes are taking place. The essence of the awareness campaign is to inform the public (pre-patients) and patients that the revolution of modern medicine, driven by the recent unravelling of the human genome, will in time bring about truly individualised care. This will involve taking cognisance of the patient's own genetic makeup, including the ability to handle "specific" medicines, or physical therapies like lasers, ultrasound and radiation. The genetic signature of a particular cancer suffered by the patient will be available for both patient and professional to discuss, but only if each has the language and conceptual understanding of the technology on the one hand, and of the pathophysiology of the disease on the other. Essential to this process will be evaluation of the psychological makeup of the patient, their educational level, mental state, and attitudes, for example to risk. ecancer, within the EAPM, will address these issues in combination with the work being done in our EU funded project named "p-medicine".

A goal of the p-medicine project is to build tools which on the one hand provide clinicians with information about the cognitive attributes of each individual patient, which will contribute to a deeper understanding of expectations, fears, attitudes to risk, educational level and mental state. This will greatly assist the physician in future interactions with his or her patient and in particular improve communications and handling of information by that patient. We will also develop tools to help the patient absorb information given in the doctor-patient interview, process it and use it in subsequent discussions concerning therapeutic and follow-up management. The Holy Grail would be equal participation by the patient and doctor in each decision made about that patient.

It is clear that this area is advancing very fast, led by, or required by the accelerated speed of discovery about the molecular nature of cancers, and the opportunity to tailor eventual therapies, e.g. radiation dose, and field or specific antibodies or targeted

molecules to exploit those individual molecular mistakes in a particular patient's tumour. The p-medicine project sets out to gather this information and analyse it to inform the building of computer models and tools, which we believe will vastly improve the outcome for cancer patients, both adults and children.

It is important to bear in mind when developing these tools that doctors are occasionally resistant to giving patients information, several resent the use of shared decision tools and few use them. ecancer is looking at the patients' needs primarily, but it is important to realise the issues surrounding eventual implementation of information tools. We have addressed what patients wish to

A goal of the p-medicine project is to build tools which on the one hand provide clinicians with information about the cognitive attributes of each individual patient, which will contribute to a deeper understanding of expectations, fears, attitudes to risk, educational level and mental state.

know (and few surprises emerge), how they seek (if they seek) information, what use is made of the internet, what makes sources trusted and whether multimedia tools would be welcomed. The literature until now is sadly lacking in definitive studies in this area – with the notable exception of a paper by Maddock et al (2012) doi: [10.3332/ecancer.2011.235](https://doi.org/10.3332/ecancer.2011.235) for [ecancermedicalscience](http://ecancermedicalscience.com). The field of assessment of adoption of shared decision making was reviewed by Legare in 2010 PMID: [20464744](https://pubmed.ncbi.nlm.nih.gov/20464744/) and he reported only five randomised clinical trials amongst a total of 6764 relevant documents in the Cochrane Database of Systematic Reviews. Clearly strict validation of the existing tools is unacceptably poor. The results presented by ecancer add significantly to the literature, and have extra value as they have been obtained from volunteers speaking differing mother tongues.

Through their involvement in these two important personalised medicine initiatives, ecancer is a vital cog in ensuring patient's needs and views are fully understood, recognised and heard in this key area in the future of medical care.

By Prof Gordon McVie, Managing Editor, ecancer

EurocanPlatform is an EC funded project committed to improving cross border collaboration between leading cancer institutes and organisations. The centres are working together to advance oncology research and treatment to help improve patient care.

[www.eurocanplatform.eu](http://www.eurocanplatform.eu)



# Interview with Robert Schaefer,

Senior Project Manager, European Society for Medical Oncology (ESMO)

[www.rarecancerseurope.org](http://www.rarecancerseurope.org)



## Tell us in simple terms what you hope the Rare Cancers Europe project will achieve?

Rare Cancers Europe is a multi-stakeholder partnership initiative dedicated to putting rare cancers firmly on the European health policy agenda and to addressing the numerous challenges posed by rare cancers. These include late or incorrect diagnosis, difficulties finding clinical expertise and accessing appropriate treatments, difficulties carrying out clinical studies due to the small number of patients, possible lack of interest in developing new therapies, and the scarcity of available registries and tissue banks.

The initiative is led by ESMO and involves 29 professional societies, cancer and rare disease associations, cancer research organisations, cancer institutes, rare cancer networks and reference centres, professional oncology communication, education and training organisations, patient advocacy groups, and industry. The partnership's projects and activities focus on the methodology of clinical research on rare cancers, the organisation of health care and on ways to improve access of rare cancer patients to treatment and care across the European Union:

- By developing a broadly-endorsed consensus paper on ways to improve the methodology of clinical research on rare cancers.
- By looking at existing clinical practice guidelines for selected rare cancers, the partnership aims, in collaboration with the European Partnership for Action Against Cancer (EPAAC) to better understand reasons for discrepancies and to develop recommendations for harmonising those guidelines across Europe.
- By measuring access to rare cancer treatment and care in the 27 EU Member States by means of a newly-developed Rare Cancers EU Access Index.

## How will patients see a benefit from the Rare Cancers Europe project?

Patients will benefit from the Rare Cancers Europe initiative in several ways:

- Full involvement: Rare Cancers Europe puts all stakeholders

on a level playing field. This allows rare cancer and rare disease patient community representatives to communicate effectively with the other stakeholders and to be involved in all stages of decision-making, project development and implementation, making sure the patient position is always fully reflected.

- Added value: By gathering and generating research-based and multi-stakeholder-endorsed findings, all activities of Rare Cancers Europe will add significant value to related advocacy activities of patient organisations.
- Research and care: More patients will benefit from more and better translational and clinical research, improved health care infrastructures and medical practice as well as better access to treatment and care.

## How do you think cancer care will change over the next 5-10 years?

Molecular diagnostics, targeted therapies and personalised medicine are just some of the buzz words currently used to describe recent advances in oncology. Over the next 5-10 years, we will probably see more "mini-breakthroughs" in cancer care than ever before, but it will become even more challenging to ensure that each of the 186 already existing rare cancers is properly diagnosed and treated in a timely fashion, with cancer care itself getting ever more complex. We are facing a dilemma of increasing cancer prevalence (because of increased life expectancy) and a particularisation of decreasing individual cancer type-specific patient populations. Conducting "well-powered" clinical studies with ever smaller numbers of cancer patients will become increasingly challenging, as will the development of effective and affordable, yet still "profitable", novel treatment options and the gathering of available evidence.

We will see

- more innovation in organising and conducting translational and clinical research, including biomarker-driven studies investigating several rare cancers in one single study, more non-frequentist studies using Bayesian probabilities for summarising evidence, increasing use of cancer databases and biobanks.

- more international collaboration in research and care, including increased networking and sharing of information and best practice among medical professionals (within their respective profession), more online platforms for expert review and for discussing difficult questions concerning clinical decision-making
- more molecularly-driven diagnostic techniques as well as centralised institutions and online platforms for expert pathology review
- more targeted treatment options and more alternative drug pricing and reimbursement schemes
- greater personalisation of cancer care, better management of treatment side effects and adverse events, more involvement of patients and caregivers in the treatment plan, more e-health monitoring devices

- more fast-access medical information and education tools, including open access online journals, clinical practice e-guidelines, e-learning courses, smart phone applications, etc.

## As a recently accepted member of the Rare Cancers Europe Group, what do you think ecancer can bring to this project?

We are very happy that ecancer has joined Rare Cancers Europe as a partner and strongly believe that ecancer can help to raise the public profile of the initiative by posting related news releases and information on the ecancer site, and within the ecancer newsletter. What is more, ecancer is also perfectly positioned to educate relevant stakeholder communities about rare cancers and related challenges by conducting quality interviews with rare cancer experts at medical conferences and meetings and by building up a compelling video library on this topic.



## Prof Gordon McVie interviews Prof Umberto Veronesi



*Prof McVie:* We have a jobs section on [ecancer.org](http://ecancer.org) - 200 young doctors and scientists in oncology consult this part of the website every week looking for jobs. We thought we should put some careers advice onto the website and ask a distinguished oncologist how they would advise young people going into the trade today. You are probably the most distinguished surgical oncologist in the world, what's your advice to the next generation of surgical oncologists?

*Prof Veronesi:* My advice is that they should of course feel the need to be doctors, to be scientists and this means they need to be ready to make tremendous sacrifices, they must be ready to suffer with their patients, to live in a world of suffering and pain but also a world of great achievements. So it's a difficult choice, but if I can give a judgement of my own activity in such a long life I think it is worthwhile – it's a difficult life but it is full of achievements and recognition from your patients and also from the public. The world of science is expanding therefore if one now enters into medical science you will certainly have the time and possibility to develop.

*Prof McVie:* You're a polyglot, you're involved in many things and you trained in more than one discipline, not just surgery. Is that advice that you'd give to the next generation – train in science as well as surgery, train in philosophy or psychology?

*Prof Veronesi:* I think it's important to have different interests – it opens your mind and it gives you a background of information. Personally, I was a professor of pathology before being a surgeon, then I was very much involved in radiotherapy, I did a course on radiotherapy and then I became a surgeon. But I also have interests in a number of other aspects of life – I was a minister of health, I was a senator of the republic for three years and this helped me also in my specific activity in research. I've published nearly 800 important papers in journals, many in the *New England Journal of Medicine*, *The Lancet* and so on. So nearly 800 papers and some ten or twelve textbooks, of course it requires time and devotion – I work on Saturday and Sunday and at night. Of course I understand this is my personal attitude, but a young person must be prepared to live such an important commitment.

*Prof McVie:* So you're saying to young would-be oncologists, don't think that your golf handicap is going to improve because you're going to have less time on the golf course and more time looking at other sets of skills. I'm personally excited by the opportunities for young doctors now to work in the lab, learn the language of the lab, learn what genes look like and how they interact with one another, the opportunities to do translational medicine, taking the stuff from the lab to the clinic. It's as if it's a new concept, but you were doing it 50 years ago when you went from pathology to surgery, that's what translation is all about.

I suppose I'm a little concerned with one-track training. I don't like the idea of training my specialty, which is medical oncology, without learning what surgeons can do and what radiation therapy can do and what things are new in surgery and radiotherapy. I'm also not particularly keen on medical oncologists only training in treating breast cancer to the exclusion of understanding the interactions of the rest of the body.

I'm also very keen to see, and very happy to see, a lot of young doctors being interested in patients as patients and looking at things like patient empowerment and improving communication skills, helping patients understand what they're all about and looking at cancer care as a spectrum right through survivorship to palliative care. I think there is a lot of choice there, but I wouldn't be in a great hurry, if I was starting again, to specialize and I, like you, did science as well as medicine.

Prof Veronesi is the founding editor of [ecancermedicallscience](http://ecancermedicallscience). He is the founder and Scientific Director of the European Institute of Oncology in Milan and is the Pioneer of breast conserving surgery.

Prof McVie is the Managing Editor of [ecancermedicallscience](http://ecancermedicallscience). He is widely regarded as a leading international authority in the research and treatment of cancer and is responsible for Clinical Research Coordination, Strategy and International Affairs at the European Institute of Oncology.

Please contact [albert@ecancer.org](mailto:albert@ecancer.org) if you have any job vacancies or research posts which you would like us to include on [ecancer jobs](http://ecancer.org)

OECCI is a continuously growing and developing network, presently regrouping 72 cancer centres and institutions across Europe. OECCI is dynamically working in crosscut expertise projects organised mainly within Working Groups and Activities. Currently, there are five main Working Groups and two Activities financed through membership fees and also supported by external funding bodies.

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