VISION
COPING WITH CANCER
VISION, JUNE 2017

Durban's last public sector oncologist leaves

Durban lost its last public sector oncologist today this month as shortages of specialists in the province continue.

The organisation Bhekisisa reports that only two state cancer specialists remain in the province of more than 10-million people.

The doctor's departure from Inkosi Albert Luthuli Central Hospital leaves KwaZulu-Natal with just two oncologists, both practising at Grey's Hospital in Pietermaritzburg.

Chairperson of South Africa Medical Association's KwaZulu-Natal branch Mvuyisi Mzukwa says these two doctors are swamped and dealing with a backlog of patients, some of whom have been waiting for treatment since 2011.

The closure of cancer services may be the latest symptom of what the South African Medical Association (SAMA), and human rights organisation Section27, says are the province's failing health systems. In May, the duo took to the streets to protest issues such as staff shortages, poor working conditions and deteriorating infrastructure and equipment.

For more details go to http://bhekisisa.org/article/2017-06-09-00-durban-cancer-services-shut-down-as-last-public-sector-oncologist-leaves

Major global research funders take lead on clinical trial transparency

On 17 May some of the world's largest research funders and NGOs agreed to adopt the World Health Organisation's strong standards on clinical trial transparency. This means all clinical trials they fund or support will be registered and the results reported.

In a joint statement, nine major funders including Médecins Sans Frontières, the Bill & Melinda Gates Foundation, the Indian Council of Medical Research, the Norwegian Research Council, the UK Medical Research Council and the Wellcome Trust committed to develop and implement policies that require all trials they fund, co-fund, sponsor or support to be registered in a publicly-available register. They also agreed that all trial results would be disclosed within specified timeframes on the register or by publication in a scientific journal.

Around half of clinical trials carried out around the world have gone unreported, according to several studies, often because the results are negative. These unreported trial results leave an incomplete and potentially misleading picture of the risks and benefits of vaccines, drugs and medical devices, and can lead to use of sub-optimal or even harmful products.

"Research funders are making a strong statement that there will be no more excuses on why some clinical trials remain unreported long after they have completed," said Dr Marie-Paule Kieny, Assistant Director-General for Health Systems and Innovation at WHO.

"We need timely clinical trial results to inform clinical care practices as well as make decisions about allocation of resources for future research," said Dr Soumya Swaminathan, Director-General of the Indian Council of Medical Research. "We welcome the agreement of international standards for reporting timeframes that everyone can work towards."

"Requiring summary results of clinical trials to be made freely available through open access registries within 12 months of study completion is good for both science and society," said Dr Jeremy Farrar, Director of the Wellcome Trust. "Not only will this help ensure that these research findings are more discoverable, but it will also reduce reporting biases, which currently favour publication of trials which have a positive outcome."

Kidney Cancer Day

World Kidney Cancer Day has been established by the International Kidney Cancer Coalition (IKCC), a global body of over 30 cancer organisations focused on improving the lives of people affected by kidney cancer.

The goal of the World Kidney Cancer Q&A Day campaign is to bring a united voice to the global community of patients, carers, health care professionals and local organisations to raise awareness for kidney cancer and start answering the questions that will make a difference for kidney cancer patients around the world.

To mark the first international awareness day, the IKCC and its affiliates around the world have launched the World Kidney Cancer Q&A Day Quiz – an interactive, seven-question quiz that tests your knowledge about important facts about kidney cancer. For every quiz that's completed online, $5 will be donated to help find answers to vital questions about kidney cancer.

How You Can Help

Take the Q&A Quiz at www.WorldKidneyCancerDay.org. It's just seven questions and once you complete it, $5 will be donated. The quiz is available in English, French, Spanish, Portuguese, Dutch, Greek and Polish. German, and Arabic are coming very soon.

Share the Q&A Quiz with your family and friends on your social channels, because every time the quiz is done, more kidney cancer research is funded.

CANCER ALLIANCE ADVOCACY TOOLKIT

Priority area #2 : Early detection and treatment

The Facts

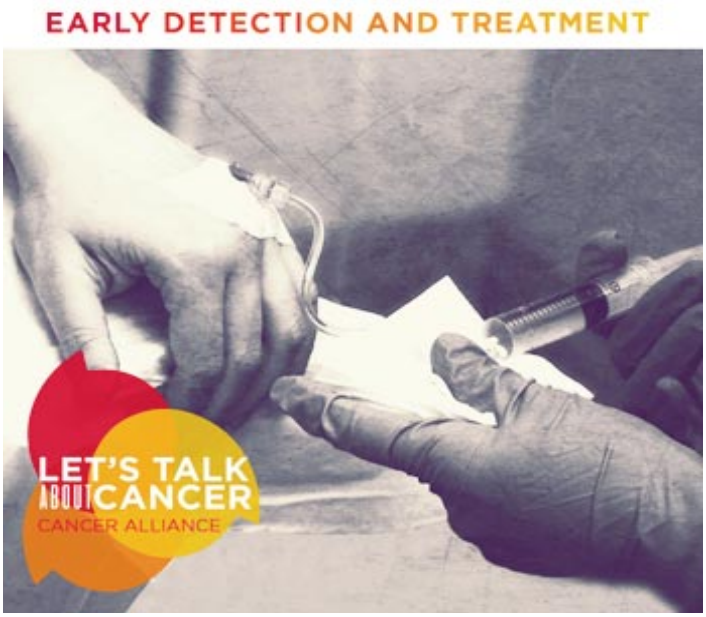
Detected early enough, patients with Stage 1 and 2 cancers have excellent survival rates. But education is crucial if we are to ensure early diagnosis and treatment to pursue good treatment outcomes and optimal survival rates.

What we need

A primary healthcare system that is cancer minded, skilled and effective for early detection, diagnosis, treatment, and palliative care.

- ❒ Community awareness.
- ❒ Trained healthcare professionals (HCPs).
- ❒ Diagnostic ability.

The development of functional referral pathways from primary care into diagnostic centres of excellence, and then on to tertiary cancer treatment centres within a workable time frame of no longer than four weeks.



But we cannot achieve this without:

- ❒ The right staff – trained healthcare professionals across the spectrum, with emphasis on primary healthcare nurses.
- ❒ Buy-in from, and requisite training, for traditional healers.
- ❒ Diagnostic centres at secondary hospitals that can also deliver basic treatments. This is currently not well-developed.
- ❒ Well structured and reliable referral pathways from primary and secondary care levels to tertiary treatment centres.
- ❒ Dedicated treatment centres for radiation and chemotherapy, as well as adjuvant therapies nearer to patient's homes to enable family support when patients have to cope with the impact of cancer treatment, and thus to minimise the psychosocial impact of the cancer treatment.

cancercare by GVI Oncology

Rondebosch Group

Venue: Waiting Room, 4th floor Rondebosch Medical Centre, Klipfontein road.

Last Monday of each month (except Sept.)

Time: **18:00 – 19:30**

Contact Linda Greeff: 0219443700 for more info

Panorama, Cape Town Group

Venue: Panorama Oncology, 1st floor, 43 Hennie Winterbach Street, Panorama
10:00 to 11:30

Contact: Emerentia Esterhuyse 0219443850, emerentia.esterhuyse@cancercare.co.za

Cape Gate Group

Venue: 51 Tiger Avenue, Cape Gate, 7560
10:00 - 12:00

Contact: Caron Majewski, 021 944 3807
caron.majewski@cancercare.co.za

Outeniqua, George Group

Venue: 3 Gloucester Avenue, George
10:00 - 12:00

First Wednesday of each month (except January)

Contact: Engela van der Merwe, 044 8840705, engela.vandermerwe@cancercare.co.za

Cancersupport @Centurion

Join us at our monthly meeting for refreshments, a chat with other patients and survivors and enjoy an interesting and informative talk.

Next meeting: 21 June at 18:00
at Unitas Hospital boardroom
Please phone Marianne Ambrose
Phone 0219443700 for more info or Matjatji Machubeng at 012 677 8271 office hours, if you have any questions

The group is open to any survivor, patient or caregiver.
No charge is made.
The Group is hosted by Netcare.

NETCARE
You're in safe hands

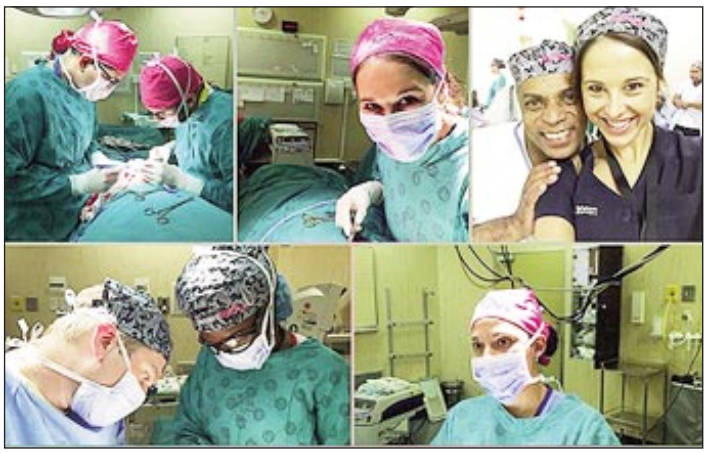
Project Flamingo: *spreading feathers of hope*

by Dr Liana Roodt

Cancer has really become the epidemic of our time – everywhere you turn you meet someone touched by the Big C. Breast cancer statistics are particularly frightening – and we see the devastating effect this have every day at our surgical and oncology units at Groote Schuur Hospital. Our public health services cannot keep up with the massive patient load. Severe resource constraints, particularly theatre time, have resulted in debilitatingly long waiting times for operations that are critical in the treatment of breast cancer. For newly diagnosed cancer patients, these long waiting times are incredibly emotional and stressful. In an attempt to address this challenge, Project Flamingo was founded in 2010.

It was while reading this account of a certain Colonel Gonin's stay at the Bergen-Belsen concentration camp during world war two that the idea of Project Flamingo and pamper packs was born in 2010. The story touched me deeply and I was reminded that sometimes it is the small things we do that make a big difference. That we should never do nothing because a problem seems overwhelmingly big and our ability to contribute seems overwhelmingly small.

> "It was shortly after the British Red Cross arrived, though it may have no connection, that a very large quantity of lipstick arrived. This was not at all what we wanted, we were screaming for hundreds and thousands of other things and I don't know who asked for lipstick. I wish so much that I could discover who did it, it was the action of genius, sheer unadulterated brilliance. I believe nothing did more for these internees than lipstick. Women lay in bed with no sheets and no nighty but with scarlet red lips, you saw them wandering about with nothing but a blanket over their shoulders, but with scarlet red lips. I saw a woman dead on the post-mortem table and clutched in her hand was a piece of lipstick. At last someone had done something to make them individuals again, they were someone, no longer merely the number tattooed on the arm. At last they could an interest in their appearance. That lipstick started to give them back their humanity."



So sometimes the difference between heaven and hell may be a bit of lipstick. Sometimes the difference between losing your feminine soul may be a bottle of nail polish or hand cream. Sometimes it is not that difficult at all to change someone's life.

amaBele Belles' projectflamingo

Ensuring timely and holistic cancer treatment

info@projectflamingo.co.za
www.projectflamingo.co.za
www.facebook.com/projectflamingosouthafrica/about/

A rich mixture of passionate people serendipitously collided, when a group of paddling breast cancer survivors reached out to a young doctor who desperately wanted to change the journey of breast cancer patients in Cape Town's public health sector.

They started small but always dreamed big – from visiting patients with their pamper packs to reminding them of their feminine spirit that no surgery can take away, to raising funds for our "Catch–up Surgeries" at Groote Schuur Hospital – reducing the waiting time for a lifesaving mastectomy from three months to a mere two weeks.

We take note of the lessons the big C has taught us. We embrace the idea that we have the responsibility and capacity to make a difference.

Palliative care training

Hospice Wits
no end to caring

Throughout the year Hospice Wits host various short courses: the 5-day Introduction to Palliative Care, 2,5-Day Grief, Loss and Bereavement Workshop, 5-day Introduction to Paediatric Palliative Care, 3-day Non-Clinical Palliative Care, 3-Day Physical Assessment Workshop, as well as other client specific courses which they present on request. ***For further details phone 011 483 9100 or email training@hospicewits.co.za.***

It's a cancer thing - you wouldn't understand

Since you're reading a blog that's dedicated to cancer issues, it's likely that you're in the club. You're one of the people who've had their lives touched (and turned upside down) by this disease.

Some cancer experiences can only be truly understood by other members of the club. Ann Marie Giannino-Otis, a breast cancer survivor who writes the Stupid Dumb Breast Cancer blog dedicated a post to the topic "It's a Cancer Thing. You Wouldn't Understand." It's a list/rant of some of "inside" experience that only cancer patients can relate to. Here's a small sample:

I pulled a hangnail last week my finger and hand swelled. It's a cancer thing you wouldn't understand.

I have scans and blood work coming up and it makes me crazy with worry. It's a cancer thing you wouldn't understand.

I forget what I was going to say. It's a cancer thing you wouldn't understand.

I feel like I am 90. It's a cancer thing you wouldn't understand.

Giannino-Otis is not alone. Cancer patients all over the Internet have used blogs to share insights about their personal fights against the disease with other patients. For fellow members of "the club," posts like these bring nods of understanding; they also provide those outside of the cancer experience a glimpse of a reality and a new appreciation for the struggles.

What Next blogger AylaMRuby's post "20 Things Only Cancer Patients/Survivors (and their families) Understand," has a more lighthearted take on these very serious insights. Here are a few examples;

Getting asked to describe certain bodily fluids becomes the new "How was your day?"

Having to tell people how ridiculous it is to worry about radiation from your cell phone when you've had full-body radiation and you're obviously still here.

Making jokes with your cancer friends, your family, or nurses that normal people would find appalling.

Posts like these illustrate how the Internet has become a helpful support system for cancer patients. These bloggers who are moved to share their opinions and experience have become incredible ambassadors for the entire cancer community. They are more than a personal catharsis, but they also make amazing strides in getting those outside of the community to get a real feel – and empathy – for the community.

In their immediacy and visceral power, they are far more effective at raising actual cancer awareness than a pink t-shirt or a cancer walk. The posts not only put a face on the disease but a personality as well.

Blogs like these – and, we hope, WhatNext – serve not only as a place of shared experience for those with cancer, but also a valuable source for the newly diagnosed. They can help prepare new patients for the experiences and emotions they will face.

These blogs help us come together. And no other online community comes together to share ups, downs, joys, sorrows, hope, pain … that's one cancer thing we do understand.

What cancer experiences and insights do you think aren't understood by those without the disease? Let us know.

This article was published by courtesy of What Next and can be found at https://www.whatnext.com/blog/posts/it-s-a-cancer-thing-you-wouldn-t-understand

PERHAPS

Perhaps I need to tell you that the things you say and do -
Make such a difference in my life, though they seem small to you.

Perhaps my face may not have shown the fear I felt this day -
Nor all the anxious thoughts that weighed upon my heart today.

Perhaps I need to tell you you're an answer to my prayer -
For I asked that God would send a friend to remind me of His care.

Perhaps you may not even know the difference that you make -
The value of the time and love - you give instead of take.

Perhaps you didn't realise your smile is what I need.
Your warmth and care give special strength - a perfect gift, indeed

Perhaps I need to take this time to thank You, special friend.
For now I see this day… As a beginning -- not an end!

Wings of Hope at Netcare Olivedale Hospital

Netcare Olivedale Hospital invited the Wings of Hope to host a table on 24 and 25 May. There were lectures in breast self examination and many patients, visitors and staff could not resist buying the lovely goodies on offer for breast cancer support.

Wings are also proud to announce a new major sponsorship from Avon Ithemba and, in particular, Vicky Saunders Flaherty for her long and valued support of cancer support groups.

Their next meeting will be the Wings Birthday Party on 15 July.

Links and downloads

Free NCCN Patient Guides for cancer

The National Comprehensive Cancer Network (NCCN) and the NCCN Foundation® offer NCCN Guidelines for Patients® and corresponding NCCN Quick Guides™ for a variety of cancer types, treatment symptoms, and supportive care issues.

NCCN Guidelines for Patients® are easy-to-understand resources based on the same clinical practice guidelines used by health care professionals around the world to determine the best way to treat a patient with cancer. They list options for cancer care that are most likely to have the best results. They feature questions to ask your doctor, patient-friendly illustrations, and large glossaries of terms used in cancer care. This format give you access to the same information as your doctor. You will be able to talk to your health care team and decide what care and treatment options are best for you.

The one-page NCCN Quick Guide™ sheets also summarise key points in the NCCN Guidelines for Patients and refer you back to the exact place in the full booklet to find more information.

NCCN invites you to download the free NCCN Patient Guides for Cancer App from the iTunes store or Google Play.

CanSurvive
CANCER SUPPORT

Let's talk about cancer!

Join us at a CanSurvive Cancer Support group meetings for refreshments, a chat with other patients and survivors and listen to an interesting and informative talk.

Upcoming meetings:

SOWETO, HapyD, 1432 Buthelezi St. Jabulani - 17 June 09:00

CHARLOTTE MAXEKE Radiation Department, Level P4 - 21 June

KRUGERSDORP Netcare Krugersdorp Hospital - 1 July

CHARLOTTE MAXEKE Radiation Department, Level P4 - 5 July

PARKTOWN Hazeldene Hall (opposite Netcare Parklane Hospital) - 8 July 09:00

Enquiries:
Mobile 062 275 6193 or email cansurvive@icon.co.za
www.cansurvive.co.za :
www.facebook/cansurviveSA

The Groups are open to any survivor, patient or caregiver.
No charge is made.

Welcome to Thnx4!

People who practice gratitude consistently report a host of benefits:

- Stronger immune systems and lower blood pressure;
- Higher levels of positive emotions;
- More joy, optimism, and happiness;
- Acting with more generosity and compassion;
- Feeling less lonely and isolated.

Thnx4 is an online, shareable gratitude journal that helps you say "thanks" for the good people and things in your life.

How it works:

- Register for a 21-Day Gratitude Challenge by clicking on the link below.
- Receive an email every other day for three weeks, inviting you to record and share what you felt grateful for recently.
- After 21 days, you'll receive your gratitude profile and enjoy the benefits of giving thanks: greater happiness, better health, stronger relationships.

http://www.thnx4.org/

The NCI Dictionary of Cancer Terms

The NCI Dictionary of Cancer Terms features thousands of terms related to cancer and medicine.

https://www.cancer.gov/publications/dictionaries/cancer-terms?cid=eb_govdel

'How to manage' guides for prostate cancer patients

If you have symptoms or side effects from prostate cancer, prostatitis or their treatments, then our 'How to manage' guides will give you the tools to help you take control.

The guides are interactive – we'll ask you to think about your own situation and select what you want to know about. Watch films of real life stories, read tips from those who have been through similar experiences and learn new ways to manage your symptoms and side effects.

How you use these guides is up to you. You can read through a guide from start to finish or you can pick from various topics and choose those that apply to you.

https://prostatecanceruk.org/prostate-information/guides/how-to-manage

VISION E-NEWSLETTER

VISION is produced for CanSurvive Cancer Support and is an e-newsletter for cancer patients and caregivers everywhere and with any type of cancer.

We would like to be able to provide information on suitable support meetings and cancer related events anywhere in South Africa so please, let us have your details of any groups you are aware of.

Your comments, articles, and letters submitted for publication in VISION are always welcomed and can be sent to the Editor at: cansurvive@icon.co.za.

Waiting in lines

Long lines form when the global health team arrives. In El Salvador, people arrived in the backs of trucks and then waited hours for one of our provider groups to assess their stomach pains, headaches, or dental problems. The men, all in long pants despite the heat, talked while women in bright dresses tended the children. In rural Kenya, women in cotton print wraps and men in tattered clothes came from all directions by foot, bicycle, or "boda bodas" (the ubiquitous motorcycle taxis), waiting on long benches in the equatorial sun. At the medical centre in Eldoret, Kenya, the hallway adjacent to the ENT Clinic was packed with people from throughout the region wearing US-donated t-shirts bearing the names of sports teams, universities, and companies – shirts re-sold to them by roadside vendors.

There is no way we could ever operate on everyone who shows up. What could we possibly offer to so many people?

"This is crazy!" I said to one of our hosts. "We'll never get through them all." During a typical work day at home, I see several patients, prepare Epic notes, mark diagnoses, check billing codes, click all of the boxes, and close the charts. If I am lucky, I can get through twenty people.

"We told them that the Americans would be here this week so they showed up." He shrugs. "No problem."

The ENT Clinic in Eldoret, Kenya is an exercise in controlled bedlam. The handwritten records focus on medical problems rather than billing. Scans and ultrasounds, when available, remind me of our technology from 1980. We jam two or three patients in the same exam room and the Kenyan and US doctors, nurses, and medical students peering over each others' shoulders; there is no HIPAA or pretense of privacy. Patients for whom we have something to offer nod and move to the nurse's desk to schedule surgery. Patients for whom we have nothing nod and head home.

At the end of the day, I look down the hallway. There are several people who have likely been waiting since early in the morning. "They will come back tomorrow." And they do.

At home, I become annoyed when I must wait twenty minutes for an appointment; I know that some patients wait longer than that to see me. I wonder how it feels to wait hours for an opportunity – maybe the only opportunity – to see a specialist and then be told to return the next day or, maybe, never at all.

I think that I become a bit more tolerant of waiting during our overseas trips. This came into focus for me on the way home from our first mission experience. We were returning from El Salvador, having seen dozens of patients who had been unfailingly gracious. At the end of the final day of the mission, the lines were still growing. My wife, Kathi, who dusted off her nursing skills for the trip, accompanied an interpreter to talk to the people lining up. "Lo siento (I'm sorry)," the interpreter said. "The clinic can see no more patients. The doctors and nurses must return to San Salvador now and will not be back until next year."

"That's all right," one of the women responded. "We will return next year, as well. Thank you for coming to help us."

The next day, we were in Houston, waiting for our connecting flight and Kathi was telling the story to our traveling companions. As she spoke, the gate agent announced that our plane would be delayed several hours because of a major storm disrupting air traffic all along the eastern seaboard.

Dr Bruce Campbell is a Head and Neck Cancer Surgeon. He has been a leader of the MCW Multidisciplinary Head and Neck Cancer Programme of the Froedtert Cancer Centre. He evaluates patients with tumours of the oral cavity, throat, sinuses, voice box, thyroid, and neck. Read his blog at http://www.froedtert.com/HealthResources/ReadingRoom/HealthBlogs/Reflections.htm

Immediately, an irate traveler with a sunburn strode up to the counter. "This is outrageous!" he shouted. We all looked up as he berated the agent. "We are heading back from our vacation in Mexico and I must be at work in the morning. I demand that you re-route us or get us on another airline! We refuse to wait!"

The gate agent apologised and said that there were no options; all of the airlines had been affected by the storm. The man paced the waiting area, returning to the counter at intervals to loudly register his displeasure. Finally, he announced that he was taking his family to a hotel and that the airline had better cover his bill. Off he stormed, family in tow.

"What a contrast!" Kathi noted. "Imagine if every one the Salvadorans who waited had reacted that way." We were not blind to the grinding poverty in El Salvador and had heard stories about the people's lack of opportunity, safety, services, and health care (a process Paul Farmer terms "structural violence"), but we had all noted how grateful the patients had been during our one-on-one interactions.

After the angry man and his family left, a plane did arrive and we did make it home that night.

Maybe the airline passenger's ire was more noticeable to us because we were transitioning from such a starkly different environment. As Farmer has noted, "the voices, the faces, the suffering of the sick and the poor are all around us. Can we see and hear them? Well-defended against troubling incursions of doubt, we the privileged are precisely the people most at risk of remaining oblivious, since this kind of suffering is not central to our own experience."

For us, each of our global health opportunities has opened us to viewing life through a different lens. At each stop, the lines have been long and colorful. Our memories are filled with people, each one hoping that they will be rewarded with a word of hope and healing when their time of waiting is finally done.

Thank you to Netcare !

CanSurvive Cancer Support Groups wish to thank Netcare for their assistance and encouragement.

We value the support and generosity of Netcare and their staff and their commitment to helping us to improve support for cancer patients and their families by providing a comfortable and accessible venue and refreshments for our meetings in Parktown and Krugersdorp.

NETCARE
You're in safe hands

The nature of cancer and the role of psychiatry

by Christa du Toit

Communication: Intercourse by words *(Kings English Dictionary)*

Remember in our previous monthly discussions we reiterated the importance of understanding. One day at a time in your life and on your journey, but if you have information, understand the intention or meaning and you and your caregivers are empowered, the road is much easier to travel.

The cancer incidence – new cases of cancer is 454.8 per 100,000 men and woman per year (United States statistics). It was estimated that 1,685,210 new cases of cancer was diagnosed in 2016. These statistics tell us things such as how many people are diagnosed with and die with cancer each year, the number of people who are currently living after a cancer diagnosis, the average age, and the numbers of people who are still alive at a given time after the diagnosis. They also tell us about differences among groups defined by age, sex, racial/ethnic group, geographic location and other categories.

In a nutshell, cancer is common. Although cancer is still perceived as a death sentence by many, the course of some types of the illness is changing rapidly and the survival rates continue to climb. Many people live for many years, survivors of cancer and its treatment are increasing in number. Cancer is thus becoming a chronic illness with its own complications and often carries a legacy of the effects of a demanding initial treatment and it long term effects and an ongoing fear of recurrence.

Why then psychiatry?

Many patients consider the psychological symptoms as merely inevitable. This poses difficulty in getting people to accept a diagnosis such as depression and to engage in treatment for it. Remember organic factors may also contribute to psychological symptoms (chemotherapy, radiotherapy, medication, anaemia and many more).

The psychological aspect of cancer care is often referred to as psycho-oncology. The standard treatment whether by pharmacotherapy or psychological treatment is not substantially different in patients with cancer. The challenge is effective delivery of the treatment in this setting.

It is important that the team have a good working knowledge of cancer and its treatments. The different types of cancer, the disease burden associated with them, and deferring prognosis may all have an influence on the nature of the psychological problems. For example pancreatic cancer is associated with higher rates of depression and patients with lung cancer could have a particularly poor prognosis.

According to these statistics the number one fear is often a diagnosis of cancer over-riding Alzheimer's disease, heart attack, and terrorism. Given these facts about cancer it is not surprising that it is associated with a significant psychological burden. Psychological factors can modify the endocrine and immune systems, thereby affecting the onset and progression of cancer. Pain management becomes complex. Stressful experiences have consistently been shown to be a factor that contributes to the perception, maintenance, and amplification of pain, as consequence of producing negative emotions.

You are the specialist of your pain; you have first-hand experience. You are the expert; you know when something is wrong. Some of the common fears and concerns entail fear of death, changes of social role/ lifestyle, interruption of your plans, concern for welfare of others, changes in body image and self-esteem and many more. Share your coping skills with the team but most importantly, please feel free to ask if you need any help. Within the team somebody will understand. The meaning of your pain is just as important as the assessment and treatment thereof.

Christa du Toit works for Janssen Pharmaceuticals as MedicalScientific Liaison: Pain.

The good physician treats the disease; the great physician treats the patient who has the disease.

- Sir William Osler

Payments linked to some US doctors prescribing certain cancer drugs

US physicians paid by pharmaceutical companies for meals, talks and travel had higher odds of prescribing those companies' drugs to treat two cancer types, a University of North Carolina Lineberger Comprehensive Cancer Centre-led study has found.

Last year, several research groups identified links between pharmaceutical payments and prescription practices. A 2016 study published in JAMA Internal Medicine determined that doctors who received a single meal promoting a certain brand-name drug prescribed those drugs for depression, high cholesterol and heart disease at higher rates. Another study in the same journal last year found a link between industry payments and higher rates of prescriptions for brand-name cholesterol drugs. In oncology, the stakes are high, Mitchell said, since cancer drugs can have significant side effects and financial costs.

To examine whether company payments are influencing prescription choice in cancer care, researchers analyzed prescription patterns for Medicare patients with two cancers where there are multiple treatment options – metastatic renal cell cancer, which is a type of kidney cancer, and chronic myeloid leukemia, a blood cancer. They used publicly available data reported through Open Payments, a provision of the federal Patient Protection and Affordable Care Act that required US drug and device manufacturers to disclose transfers of financial value greater than $10 to physicians and teaching hospitals.

"We chose these specific drugs because they are felt to be equally efficacious based on clinical trials," Mitchell said. "However, they do have differences in side effect profiles that a patient taking one of these drugs would notice and feel."

Compared to physicians who didn't receive any payments, those who received general payments for meals and lodging from a drug manufacturer had higher odds of prescribing that company's particular drug for both metastatic renal cell carcinoma, and for chromic myeloid leukemia. For renal cell carcinoma, odds were 78 percent higher, and for chronic myeloid leukemia, odds were 29 percent higher.

More details at http://tinyurl.com/y8vst3l7

Rest in peace: The art of medicine

At the graveside they still talk about judgement, intelligence, and the wisdom that is the practice of medicine. Deans and healthcare leaders wax poetic as they tell stories of great cures to lift in memoriam remarkable healers. Yet, though we bow to Hippocrates, Osler and Salk, the time has come to mark a revolution in human history: The art of medicine is dead.

It is not that doctors have fallen from the one true path. It is not that they have lost focus or forgotten important theory. It is not that physicians heal without altruism, passion, or perfection. It is more basic. Art is to medicine as blacksmiths are to airplanes, flat earth is to astronomy, or prayer to the atheist. It is an idea relegated to the past. The doctor, as artist, lies in the grave.

This "art" of medicine is not communication, empathy, or drive. Rather, the art of medicine is how, for millennia, doctors have made decisions in complex situations when there was risk to the patient, with a significant element of the unknown: A life or death "educated guess". The unknown may be insufficient knowledge about the disease, an incomplete understanding of a patient's health, lack of foresight of potential complications or an absence of definitive knowledge of the correct, best treatment. It has often been all of the above. The "art of medicine" has been about judgement, experience and action, when the "right way" was not clear.

We have long depended on the artists of medicine to make decisions which affect human lives, without really knowing what is happening or what that intervention would do. We have been without an understanding of biochemistry, physiology or pathology, had few active therapies, and had little ability to predict an individual's future. There were no tests beyond those caught with the eye and the touch of a hand, and very little "objective" data. There was art because there was no optimal path, no "indicated" treatment. Just the need to make a decision. To act. To care.

Which is now dead. We can no longer say we do not understand pathophysiology and do not have revolutionary ways with which to measure it. We are not without a broad range of treatment answers for most medical conditions. Research tells us what the probable benefits and side effects will be. We are no longer in caves painting pictures on the wall, or serve in massive putrid wards without a basic concept of what is happening in front of us. For almost all health decisions, there is now a right and a wrong, an optimal, a most probable action. The practice of medicine will never again be based on a clinician's experience, observation or gut. It will be based on hard-fought scientific reality.

James C. Salwitz, MD

Dr. Salwitz is a Clinical Professor at Robert Wood Johnson Medical School.

He lectures frequently in the community on topics related to Hospice and Palliative Care and has received numerous honours and awards, including the Physicians Leadership Award in Palliative Care.

His blog, Sunrise Rounds, can be found at http://sunriserounds.com

PSA and male cancer support group

Monthly support groups are held at the Boardroom at MediClinic, Constantiaberg, Plumstead

20 June 17:45 – 19:00

The speaker will be Dr Greg Hart of GVI Oncology

For more information contact:

Helpline: 076 775 6099

Email: info@can-sir.org.za. Web: www.can-sir.org.za

Our grateful thanks to Medi-Clinic for providing a home for our activities and refreshments for our members. It is much appreciated by us all.

Shoveling dirt on the casket is that most solemn of pallbearers ... the clinical pathway or guideline. No feeling. No passion. No caring. Just metrics, research and statistics. Physicians once trained to make decisions on their own, to be responsible not only for patient care, but for interpreting primitive science, conflicting superstition and their instinctual observations of medical events, now feel cast aside. Indeed, if all has been decided, if all paths are clear, one might ask: Is the medical profession at its end?

This is an absurd question which fails to understand the nature of what is means to be a modern doctor. It is like asking if we need carpenters, because we have power saws, cooks, because we have microwaves or orators, because we have microphones. Yes, having clear pathways and data massively changes medicine. Nonetheless, in not the slightest degree does it decrease the vitality or need for the medical profession. Quite the opposite, it makes us much better at our job.

We are called to heal. With clear answers and understanding we can connect and empower each patient, giving them a place to turn when they are sick and frightened. We can collect and process extremely complex information which makes possible medical analysis and we can make diagnoses more accurate than ever. This becomes better treatment and, in our most critical skill, we can teach, direct and apply healing. Revolutionary cures give doctors the ability to confidently enable each patient to journey toward health. Knowing that there is an optimal way, a more perfect result, does not in some bizarre way make doctors obsolete. Rather we are reaching toward the pinnacle of our profession.

The doctor of today and tomorrow is the ultimate compassionate healer. We convey our patients through and beyond illness. We guide our patients back to lives of meaning. We have so much opportunity, such a burden of possibility to be personal practitioners, to guide each patient so they may return to life. It is a rebirth of medicine, moving beyond primitive confusion, suffering and loss, to empowerment, strength and real hope. The art of medicine is dead. Long live the art of medicine.

CALENDAR

June 2017

14 Reach for Recovery Group meeting 13:45 Lifeline offices,2 The Avenue, Cnr Henrietta Street, Norwood. Guest Speaker, Sue Serebro will give a presentation on Lymphoedema, Breast Care and holistic approach.

20 Can-Sir Malecare Support Group, Mediclinic Constantiaberg, Plumstead, Cape Town, 17:45 – 19:00

21 CancerSupport@Centurion support Group at Netcare Unitas Hospital, Centurion at 16:00

21 CanSurvive Charlotte Maxeke Group, Radiation Floor P4.

22 Cape Gate Oncology Group, Oncology Centre 10:00. "Cancer and lymphoedema".

24 Bosom Buddies Support Group, Hazeldene Hall, Parktown at 09:30 for 10:00

26 Cancercare Support Group, Rondebosch Medical Centre, "Finding meaning in my cancer experience".

July 2017

1 CanSurvive Cancer Support West Rand Group, Netcare Krugersdorp Hospital, 09:00

5 Cancercare OuteniquaSupport Group, GVI Boardroom,3 Gloucester Ave. George 10:00 - 12:00

5 CanSurvive Charlotte Maxeke Group, Radiation Floor P4.

6 CanSurvive Head and Neck Support Group, at Rehab Matters, 1 De la Rey Rd. Rivonia at 18h00

8 CanSurvive Cancer Support Parktown Group, Hazeldene Hall, Parktown 9:00

15 Wings of Hope, Netcare Auditorium, Sandton. 10.00 (Wings birthday).

18 Can-Sir Malecare Support Group, Mediclinic Constantiaberg, Plumstead, Cape Town, 17:45 – 19:00

19 CanSurvive Charlotte Maxeke Group, Radiation Floor P4.

19 CancerSupport@Centurion support Group at Netcare Unitas Hospital, Centurion at 16:00

27 Cape Gate Oncology Group, Oncology Centre 10:00. "Coping with my children's anxiety".

29 Bosom Buddies Support Group, Hazeldene Hall, Parktown at 09:30 for 10:00

31 Cancercare Support Group, Rondebosch Medical Centre, "What is palliative care"

August 2017

2 CanSurvive Charlotte Maxeke Group, Radiation Floor P4.

2 Cancercare OuteniquaSupport Group, GVI Boardroom,3 Gloucester Ave. George 10:00 - 12:00

3 CanSurvive Head and Neck Support Group, at Rehab Matters, 1 De la Rey Rd. Rivonia at 18h00

5 CanSurvive Cancer Support West Rand Group, Netcare Krugersdorp Hospital, 09:00

12 CanSurvive Cancer Support Parktown Group, Hazeldene Hall, Parktown 9:00

15 Can-Sir Malecare Support Group, Mediclinic Constantiaberg, Plumstead, Cape Town, 17:45 – 19:00

CONTACT DETAILS

CanSurvive Cancer Support
Parktown and West Rand Group :
CanSurvive Head and Neck Support Group, Rivonia,
Contact: 062 275 6193 or cansurvive@icon.co.za
Charlotte Maxeke Group: Contact Duke Mkhize 0828522432
Jabulani Group: Contact Sister Bongiwe Nkosi: 0835760622

CancerCareSupport Group, 4th Floor, Rondebosch Medical Centre. Contact: linda.greeff@cancercare.co..za or phone 0219443700 for more info

CancerCare Cape Gate Support group: 10h00-12h00 in the Boardroom, Cape Gate Oncology Centre.|
Contact: Caron Caron Majewski, 021 9443800

CancerCare Outeniqua, George Support Group. Contact: Engela van der Merwe, 044 8840705, engela.vandermerwe@cancercare.co.za

Can-Sir, 021 761 6070, Ismail-Ian Fife, info@can-sir.org.za Helpline: 076 775 6099.

Cancersupport@centurion: Marianne Ambrose 012 677 8271(office) or Henriette Brown 072 8065728

More Balls than Most: febe@pinkdrive.co.za, www.pinkdrive.co.za, 011 998 8022

Prostate & Male Cancer Support Action Group, MediClinicConstantiaberg. Contact Can-Sir: 079 315 8627 or Linda Greeff: linda.greeff@cancercare.co.za, phone 0219443700

Wings of Hope Breast Cancer Support Group 011 432 8891, info@wingsofhope.co.za

PinkDrive: www.pinkdrive.co.za, Johannesburg: febe@pinkdrive.co.za, 011 998 8022; Cape Town: Adeliah Jacobs 021 697 5650;
Durban: Liz Book 074 837 7836, Janice Benecke 082 557 3079

Bosom Buddies: 011 482 9492 or 0860 283 343, Netcare Rehab Hospital, Milpark. www.bosombuddies.org.za.

CHOC: Childhood Cancer Foundation SA; Head Office: 086 111 3500; headoffice@choc.org.za; www.choc.org.za

CANSA National Office: Toll-free 0800 226622

Clinton Support Group 10:00 Netcare Clinton Oncology Centre, 62 Clinton Rd. New Redruth. Alberton. Second Friday each month.

CANSA Pretoria: Contact Miemie du Plessis 012 361 4132 or 082 468 1521; Sr Ros Lorentz 012 329 3036 or 082 578 0578

Reach for Recovery (R4R) : Johannesburg Group, 011 869 1499 or 072 7633901. Meetings: Lifeline offices, 2 The Avenue, Cnr Henrietta Street, Norwood

Reach for Recovery (R4R) : West Rand Group. Contact Sandra on 083 897 0221.

Reach for Recovery (R4R) Pretoria Group: 082 212 9933

Reach for recovery, Cape Peninsula, 021 689 5347 or 0833061941 CANSA offices at 37A Main Road, MOWBRAY starting at 10:00

Reach for Recovery: Durban, Jenny Caldwell, 072 248 0008.t

Reach for Recovery: Harare, Zimbabwe contact 707659.

Breast Best Friend Zimbabwe, e-mail bbfzim@gmailcom

Cancer Centre - Harare: 60 Livingstone Avenue, Harare Tel: 707673 / 705522 / 707444 Fax: 732676 E-mail: cancer@mweb.co.zw www.cancerhre.co.zw

News in brief

The US government's weed used in research is weak

All the marijuana used in US research since the late 1960s has come from a government-licensed facility at the University of Mississippi, but there's a problem: it's far weaker than the supply sold in states that've legalised medical marijuana.

A report in Nature captures just how weak the government's cannabis supply is, compared with commercial-grade medical marijuana (obtained from legal dispensaries in Denver, Oakland, Sacramento and Seattle). Researchers say the weaker supply is fine for things like academic studies on the general effects of marijuana. But it doesn't cut it for specific research on medical treatments.

"For a researcher it's difficult to assess the real-world impact of high-end pot if you only have access to the low-quality stuff," The Washington Post reports. "It's akin to investigating the effect of bourbon by giving people Bud Light."

The National Institute on Drug Abuse (NIDA) – the government body that oversees the Mississippi marijuana facility – acknowledges the medical benefits of weed and hears what's wrong with its supply.

"There is solid evidence that the main psychoactive ingredient in marijuana, THC, is effective at controlling nausea and boosting appetite," NIDA says. "There is also some preliminary evidence that THC or related cannabinoid compounds such as cannabidiol (CBD) may also have uses in treating autoimmune diseases, inflammation, pain, seizures and psychiatric disorders, including substance use disorders."

http://tinyurl.com/y7epbzd7

First spherical nucleic acid drug injected into humans targets brain cancer

The first drug using spherical nucleic acids to be systemically given to humans has been developed by Northwestern University scientists and approved by the Food and Drug Administration as an investigational new drug for an early-stage clinical trial in the deadly brain cancer, glioblastoma multiforme.

The new drug is able to cross the challenging blood-brain barrier to reach tumours in animals, where it turns down a critical cancer-causing gene. Now, the Phase 0 clinical trial, launched at the Robert H. Lurie Comprehensive Cancer Centre of Northwestern University and Northwestern Medicine, will investigate the drug's ability to reach tumours in humans.

The glioblastoma drug represents a revolutionary new class of drugs. The novel spherical nucleic acid platform it is based on can be applied to other types of neurological diseases, such as Alzheimer's and Parkinson's, by similarly turning down the genes that lead to those diseases.

It's highly unusual for a drug to be developed in preclinical research at a university, shepherded through FDA approval as an investigational new drug and studied in a clinical trial - all within the same university and without funding from a pharmaceutical company. In most cases, a drug is developed and licensed to a pharmaceutical company.

"We want to get the drug to patients as quickly as possible," said Jay Walsh, vice president for research at Northwestern. "We want to move the drug forward because there are patients with a disease with no current cure."

http://tinyurl.com/yd83lrf8

Scrib protein identified as a natural suppressor of liver cancer

A protein, Scrib, is emerging as both a tumour suppressor and oncogene depending on the cancer type, appears in liver cancer to migrate out of the protective outer layer of the cell and into its inner workings. Once inside, its expression increases and it suppresses expression of three oncogenes known to support liver cancer. Scrib, which is emerging as both a tumour suppressor and oncogene depending on the cancer type, appears in liver cancer to migrate out of the protective outer layer of the cell and into its inner workings. Once inside, its expression increases and it suppresses expression of three oncogenes known to support liver cancer.

"We found for the first time in liver cancer that Scrib can translocate to the cell cytoplasm and to the nucleus when the cells become cancerous," said Dr. Satya Ande, molecular biologist at the Georgia Cancer Centre and assistant professor in the Department of Biochemistry and Molecular Biology at the Medical College of Georgia at Augusta University.

"Basically Scrib functions as a tumour suppressor that tries to suppress the growth of these cells," said Ande, corresponding author of the study in the journal Oncotarget.

http://www.medicalnewstoday.com/releases/317359.php

Comprehensive and integrated digestive diseases and liver treatment centre a first for Gauteng

"The Digestive Diseases and Liver Health Centre at the hospital brings together a range of medical disciplines as well as ancillary healthcare services to provide a highly patient centred service for referring physicians and their patients," says Jacques du Plessis, managing director of the Netcare hospital division.

According to Du Plessis, the new centre, the development of which has been driven by hepatopancreaticobiliary surgeon, Dr Anna Sparaco in association with Netcare, is designed to provide patients with an all-inclusive multidisciplinary service for the diagnosis and treatment of these diseases by a team of highly trained and experienced specialists.

"The facility offers a holistic and integrated service to patients with digestive diseases, and the centre is a novel concept for private medicine within Gauteng province. We fully expect the Digestive Diseases and Liver Health Centre at Netcare Rosebank Hospital to serve as a specialist referral service for patients not only from the province but from around the country and indeed the African continent."

Dr Sparaco says that the centre offers a number of sub-specialities including gastroenterology; hepatology, internal medicine, surgery and medical and radiation oncology. Advanced interventional endoscopic services including endoscopic retrograde cholangiopancreatography, endoscopic ultrasound, Spy Glass, double balloon

endoscopy and capsular endoscopy are also available.

"In addition to the standard open or laparoscopic surgical expertise, the ability to ablate tumours via various technologies such as radiofrequency ablation, microwave ablation, selective internal radiation therapy [SIRT] and chemo-embolisation are part of the centre's armamentarium in the fight against cancers," observes Dr Sparaco.

http://www.netcare.co.za/Articles/ArticleID=443

Italian tomato extract fights stomach cancer

A recent study shows that whole tomato extracts from two different Southern Italy cultivars inhibit gastric cancer cell growth and malignant features, paving the way for future studies aimed at implementing lifestyle habits not only for prevention, but potentially as a support to conventional therapies.

"Their antitumoural effect seem not related to specific components, such as lycopene, but rather suggest that tomatoes should be considered in their entirety," says Daniela Barone, researcher at the Oncology Research Centre of Mercogliano (CROM), and one of the authors of the study. "Distinct species may exert different effects, in different stages of a certain neoplasm," adds Barone.

Experiments analysed whole tomato lipophilic extracts for their ability to tackle various neoplastic features of gastric cancer cell lines. Extracts of both the San Marzano and Corbarino tomato varieties were able to inhibit the growth and cloning behavior of malignant cells. Treatment with the whole tomato extracts affected key processes within the cells hindering their migration ability, arresting cell cycle through the modulation of retinoblastoma family proteins and specific cell cycle inhibitors, and ultimately inducing cancer cell death through apoptosis.

Sbarro Health Research Organization (SHRO), Italy

Oral chemotherapy extends survival by more than a year in biliary tract cancer

A phase III randomised clinical trial of 447 patients with biliary tract cancers (BTCs, cancers of the bile duct and gallbladder) showed that giving capecitabine after surgery extends survival by a median of 15 months compared to surgery alone. The finding could provide the basis for a new standard of care in the disease.

"Biliary tract cancer is a disease of decidedly unmet need as until recently there has been little research on treating the disease," said lead study author John N. Primrose, MD, Professor of Surgery at the University of Southampton, United Kingdom. "Our trial is the first to enroll a sufficient number of patients to show that chemotherapy after surgery can have a significant improvement in survival, with modest side effects."

The median time to cancer recurrence was 25 months for patients who received capecitabine and18 months for patients in the control group. The most notable side effect related to treatment was a rash on the hands and feet, which is common with capecitabine. There were no deaths due to the use of capecitabine.

http://tinyurl.com/y7zop5d3

Imaging technique aims to ensure surgeons completely remove cancer

Of the quarter-million women diagnosed with breast cancer every year in the US, about 180,000 undergo surgery to remove the cancerous tissue while preserving as much healthy breast tissue as possible. However, there's no accurate method to tell during surgery whether all of the cancerous tissue has been successfully removed. The gold-standard analysis takes a day or more, much too long for a surgeon to wait before wrapping up an operation. As a result, about a quarter of women who undergo lumpectomies receive word later that they will need a second surgery because a portion of the tumour was left behind.

Now, researchers at Washington University School of Medicine in St. Louis and California Institute of Technology report that they have developed a technology to scan a tumour sample and produce images detailed and accurate enough to be used to check whether a tumour has been completely removed.

Called photoacoustic imaging, the new technology takes less time than standard analysis techniques. But more work is needed before it is fast enough to be used during an operation.

http://tinyurl.com/y9wygvt9

Potent targeted cancer drug shows promise in first patient trials

An experimental cancer drug which targets cancer cells' DNA repair could be an effective treatment for a range of cancers, the first clinical trial in patients has shown. The drug has shown particular potential in cancers which have mutations to one or both of the BRCA genes.

Researchers at The Institute of Cancer Research, London, led a worldwide multicentre clinical trial for the targeted treatment talazoparib in 71 patients with cancers of different types. The results show that talazoparib could benefit patients in the clinic – particularly women with BRCA-mutated breast and ovarian cancer.

Some cancer cells become overly reliant on a protein called PARP, which repairs broken DNA, because genetic errors make other DNA repair systems – including the BRCA system – defective. PARP inhibitors, like talazoparib, kill BRCA-mutated cancer cells by taking advantage of their reliance on PARP.

In the study, the researchers found that the drug was well tolerated and caused tumour shrinkage or slower growth in some patients – particularly those with mutations to one or both of the BRCA genes.

http://www.icr.ac.uk/news-archive/potent-targeted-cancer-drug-shows-promise-in-first-patient-trials

First in the world to use of internal radiation implant for pancreatic cancer

Doctors at VCU Massey Cancer Centre are the first in the world to successfully implant a bio-absorbable, internal radiation device known as CivaSheet to treat early stage pancreatic cancer.

In March, a team of Massey experts completed the procedure on a 70-year-old patient, and reported no complications after six weeks. The patient returned for a follow-up appointment more than one month after the seven-hour surgery and said he felt no pain related to the implantation. "If I wasn't told the CivaSheet was there, I wouldn't know it was inside me," he said.

Pancreatic cancer is really the perfect malignancy for the use of this device because the cancer is in a very difficult location, the risk of residual cancer cells following surgery is very high and the disease is very aggressive. The CivaSheet is a flat, flexible membrane placed in a patient during surgery. It contains a radioactive isotope and provides localised, unidirectional radiation therapy to a targeted area while shielding healthy tissue in the opposite direction.

Internal radiation therapy, also known as brachytherapy, is a form of treatment where higher doses of radioactive material are concentrated at a short distance to kill cancerous cells. It is currently used as a treatment for several cancers throughout the body, however it has not been used for pancreatic cancer until now.

http://tinyurl.com/ycgpjovw

New FDA approvals

Three more biosimilar rituximab products in Europe

Three more biosimilar versions of the monoclonal antibody rituximab have been recommended for approval in Europe, having been found to be "highly similar" to the reference product, rituximab. The recommendations for approval were made by the European Medicines Agency's Committee for Medicinal Products for Human Use (CHMP).

The three products are Blitzima, Tuxella, and Ritemvia , all marketed by Celltrion Healthcare Hungary Kft. Recently, two biosimilar rituximabs were recommended for approval in Europe: Rixathon and Riximyo (both from Sandoz).

Rituximab, first launched in Europe in 1998, has become a backbone of treatment for non-Hodgkin's lymphoma (NHL) and is also used in chronic lymphocytic leukemia (CLL), rheumatoid arthritis (RA), and granulomatosis with polyangiitis and microscopic polyangiitis (GPA&MPA).

http://tinyurl.com/y8xemzo9

New immunotherapy drugs for patients with bladder cancer

The Food and Drug Administration (FDA) has recently approved four immunotherapy drugs for bladder cancer, bringing the total number of approved immunotherapies for this disease to five. Known as checkpoint inhibitors, all four drugs work by "releasing the brakes" on the immune system and allowing immune cells to attack tumours.

In the most recent approval, granted regular approval to pembrolizumab for the treatment of some patients with urothelial carcinoma, the most common type of bladder cancer. The approval is for patients with locally advanced or metastatic bladder cancer whose disease has progressed during or after platinum-containing chemotherapy or within 12 months of neoadjuvant or adjuvant chemotherapy.

FDA also granted accelerated approval to pembrolizumab for patients with locally advanced or metastatic bladder cancer who are not eligible for cisplatin-containing chemotherapy.

FDA granted accelerated approvals for avelumab (Bavencio®) and durvalumab (Imfinzi™), respectively, also for patients with locally advanced or metastatic bladder cancer whose disease has progressed during or after platinum-containing chemotherapy or within 12 months of neoadjuvant or adjuvant chemotherapy.

In April FDA granted atezolizumab (Tecentriq®) an accelerated approval as a first-line treatment for patients with locally advanced or metastatic urothelial carcinoma who are not eligible to receive cisplatin-based chemotherapy. (Many patients with advanced forms of urothelial carcinoma are not candidates for cisplatin-based chemotherapy because they have health problems, including impaired kidney function, hearing loss, or heart failure.)

http://tinyurl.com/yc95qpku

FDA approves Keytruda combo for lung cancer

The Food and Drug Administration (FDA) has granted an accelerated approval to Keytruda (pembrolizumab) for use in combination with pemetrexed plus carboplatin as a frontline treatment for patients with metastatic or advanced nonsquamous non–small cell lung cancer (NSCLC), regardless of PD-L1 expression.

The approval was based on part 2 of cohort G in the KEYNOTE-021 trial, in which the Keytruda triplet elicited an objective response rate (ORR) of 55 percent compared with 29 percent with the chemotherapy agents alone. The median progression-free survival (PFS) was 13 months with the addition of Keytruda versus 8.9 months for chemotherapy alone.

Pembrolizumab approved for Hodgkin's Lymphoma in Europe

Immunotherapy with pembrolizumab (Keytruda) has been approved for use in certain patients with Hodgkin's lymphoma, making it the second programmed cell death (PD) inhibitor for use in this hematologic malignancy.

Specifically, pembrolizumab is approved for use in adult patients with relapsed or refractory classic Hodgkin's lymphoma in whom autologous stem cell transplant (ASCT) and treatment with brentuximab vedotin (Adcetris, Seattle Genetics) have failed or who are transplant-ineligible and in whom brentuximab therapy has failed.

http://tinyurl.com/ya2g663k

Europe Approves Nivolumab for head and neck cancer

The European Commission (EC) has approved nivolumab (Opdivo, Bristol-Myers Squibb) for the treatment of squamous cell cancer of the head and neck (SCCHN) in patients who progress on or after platinum-based chemotherapy.

Nivolumab is the only immunotherapy that has demonstrated a significant improvement in overall survival among these patients in a phase 3 trial.

The EC approval was based on results from CheckMate-141, which compared nivolumab with investigator's choice of therapy in patients with recurrent or metastatic, platinum-refractory SCCHN. Investigator's choice included methotrexate, docetaxel, or cetuximab.

These study results are not available to the public at this time and will be presented at the annual meeting of the American Society of Clinical Oncology in June.

http://tinyurl.com/y83yes27