ESSO-BASO

European CanCer Organisation and British Association of Surgical Oncology

Thanks to Consultant Surgeon Lynda Wyld, I was able to spend three days at the ESSO-BASO surgical conference in Liverpool in late October 2014 looking at many different aspects of surgery and associated treatments. It was an excellent programme, covering the very latest in robotic surgery to better methods of dealing with colon cancer, and the use of mixed techniques such as radiotherapy plus surgery to provide better outcomes for cancer patients.

Being the only lay member of the Bridging The Age Gap study TSG able to attend, I hung out with ICPV. The structure of the conference was the standard type, with plenary lectures followed by six parallel symposia, or tracks, offering a wide range of topics. It was impossible to attend them all, so difficult choices had to be made.

The first choice concerned breast cancer (always a favourite topic with 1 in 8 women going to be diagnosed with it), which discussed trials and the older patient. Patients in trials who are over 75 are not representative of the general population in terms of knowledge, socio-economic status, etc. and studies have shown that despite surgery being offered to fewer older women, survival is almost as good.

Using pre-surgery primary endocrine therapy has the advantage of reducing tumour size subject to the tumour being ER+), and gives time for pre-habilitation before surgery, where the patient becomes fit as possible to enable a speedy recovery. This is done by better nutrition, exercise, sleep, in the interval and is a hot topic at the moment.

Surgery is still the patients' first choice of treatment and local and regional nerve blocks mean no general anaesthesia to increase the risk of dementia. Because it is a definite risk in both the very young, and the elderly.

Radiotherapy is sometimes used pre-surgery to shrink the tumour, but at a later symposium, I listened to an Indian surgeon talk about his experience of a trial comparing RT pre- and post- treatment, and his distress that two patients in the former group did not heal after surgery. At all. His distress was palpable, so the emphasis on QA and modern methods of RT was well taken.

The need to use circulating tumour cells for diagnosis was discussed and I have noticed that proposals for studies are starting to include these rather than continuing biopsies of tissue to assess the effects of a new drug on tumour cells.

The speaker pointed out the importance of supportive therapies as patients go through treatment, and that we all need to know when to stop. Many of the new drugs have serious side effects which may be difficult for the patient to cope with.

The Da Vinci surgical robot was included in a talk about robots in general. It seems that the makers are buying up relevant patents to prevent development of competing products, but there are at least two rivals in development. The robot is designed for precision surgery under control of a surgeon, and is especially useful for tricky

procedures such as prostate surgery. However, we did find that surgeons are generally not so fond of it.

During a session about breast cancer treatment, Maggie Wilcox (ICPV) asked if women who stopped taking Tamoxifen or aromatase inhibitor because of the side effects, but were they aware of the risks they were running, of recurrence or spread. All women need full information about their treatment (indeed, all patients need full information) so they can assess the risks and make a fully informed decision.

Later, while viewing the posters, we came across a poster by W and C Zammit, which illustrated the enormous price difference between generic drugs and the original patented version and we were fortunate to be able to discuss this with them. This has led to further debate within ICPV about testing copy drugs for bio-availability, and the possible reasons why women may need to try several versions of what is ostensibly the same drug to find one which is acceptable in terms of side effects. Just for reference, the original Tamoxifen costs £68 and the off-patent version is £2.)

A few other cancer drugs are coming off patent this year and next, including Gleevec, and this is causing concern among those patient groups needing these drugs. If the side effects vary, does the therapeutic effect? I suspect we will be pursuing this topic during the coming year.

Professor Klimberg demonstrated that the incidence of lymphodoema after lymph node surgery varies with technique, and told us that 40% of patients have positive margins after surgery. Methods to detect cancer cells during surgery need to be researched to prevent repeat surgery, and surgeons need to improve their technique. (His comment.)

Pre-habilitation before surgery is a buzz phrase this year, and encompasses exercise, better nutrition, giving up smoking, whatever is needed to improve healing and recovery. Giving up smoking three weeks before surgery results in the patient healing as quickly as a non-smoking patient.

New techniques such as chemo-therapy or radio-therapy were described as being much more effective with added heat. However, the risk of radiation induced angiosarcoma (AS) as sequela of radiotherapy for breast cancer following conservative surgery was mentioned. Fortunately this is rare, but it is also aggressive. It seems that AS is common in dogs. It is acknowledged that biomarkers are needed to detect susceptibilities.

On Thursday We looked at the problem of advanced breast disease - fortunately not many of these are seen on first diagnosis now, but they do present a problem for conservation and reconstruction, which often entails the use of mesh. And sometimes surgery is needed for palliation.

The genetics of cancer loomed large throughout, largely for the development of biomarkers to enable effective treatment to be prescribed that will suit the patient, as eg genetics will govern response (or not) to radiotherapy, and may also govern side effects.

On Friday, at a workshop about cancer in older patients, we discovered that data about co-morbidities such as diabetes is not collected, and thus we do not know how patients are affected. We also learned that older patients with advanced cancer lived longer with better quality of life when cared for by specialist teams in their own home. And it was very pleasing to hear that older patients did not have a problem using technology. (I've been saying that for years!)

A lecture on bowel cancer in the elderly put forward the difficulties of addressing the cancer with co-morbidities in the older patient, and the 'problem' of long life post treatment, when a patient may expect to live to 93, having had surgery at 80. What a tribute to the health service I say! Surprisingly, complications do not occur much more with age, and much less than expected. In fact, age corrected data shows that older patients survive as well as youngsters. The wise observation was also made that surgeons will get a good result if they do a good job in the first place, and do not always take the easy option (this from a surgeon), and that surgery in older patients should be done in a specialist hospital by a specialist team.

The National screening programme is picking up earlier rectal and colon cancers so treatment is easier and results better. Treatment needs to be personalised to the patient and the condition, and from a national standpoint, the NHS needs to anticipate larger numbers of older people.

It seems that localised contact radio therapy is being offered as a treatment option for some patients, and these are targeted straight to the tumour using a probe. However, some of these cancers benefit from a watch and wait approach, and there are instances when not operating is the best option. This from a surgeon who realised the harm he had unwittingly done during his working life, when he reached old age himself. A surgeon who is very thoughtful of his patients!

Different techniques were described to detect tumour edge and margin using various properties of normal vs tumour tissue. One such was using diffuse reflective spectroscopy based on the knowledge that tumour tissue has a different fat/water ratio to normal tissue. This can be used intra-operatively. The exhibition was useful here, and staff at two stands were able to explain the complexities of their equipment in terminology I could understand.

Research is continuing on reducing treatment effects including the use of iron oxide to detect cancer infected lymph nodes which will not need surgery if they are clear. This will reduce the chances of lymphodoema later. In fact it may be safe to omit the SNB as in most women, the lower half of the axilla is irradiated during subsequent radiotherapy. (This came as a surprise, I understood that RT was very tightly controlled and targeted...)

At another symposium we learned that patients have a worse prognosis after a core biopsy than after fine needle biopsy. Although upon question, the researchers did not think that this or repeat biopsies had any implications for the patient. Which makes no sense to me.

During the week we showed the VOICE collage video during the lunch hour, and were able to contribute to several clinical studies by providing the lay veiwpoint.

Cultural memes abound. Most notable were that many of the presentations had pictures embedded, and I counted one Darth Vader and one Yoda. A trial discussed during the day was called STAR TREC. And at the evening social event, we found that gentlemen surgeons are well dressed charmers, and lady surgeons like leather, lace, and very high heels.

Lynda Wyld is President Elect of BASO, one of two women on the committee of eleven.

Jacqui Gath.
Yorks and Humber Clinical Research Network Consumer Research Panel and ICPV.
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