MADRID 2017 ESMO

INTEGRATING SCIENCE INTO ONCOLOGY FOR A BETTER PATIENT OUTCOME

DAILY REPORTER

FRIDAY 8 SEPTEMBER 2017

Welcome to ESMO 2017, in partnership with the EACR

Fortunato Ciardiello: *ESMO President*

With more than 22,000 professionals expected to attend the ESMO 2017 Congress, this year's event promises to be our largest ever, and I feel extremely honoured to welcome you as ESMO President.

In recognition of the crucial role of scientific research in advancing cancer care, the congress is to be held in partnership with the European Association for Cancer Research (EACR). This exciting collaboration, which facilitates an integrated approach to cancer management, also reflects the over-arching goal of the congress, 'Integrating science into oncology for a better patient outcome.'

By providing a unique platform for the exchange of ideas between researchers and clinicians, and with a huge scientific reach, the congress really does have the potential to improve the lives of patients with cancer.

The congress truly has the potential to improve patients' lives.

This year's scientific and educational programme reflects a truly integrated congress. In addition to hearing about the latest clinical advances that directly impact daily practice, delegates can look forward to broadening their knowledge of the many cellular and molecular changes contributing to the development of cancer with the help of our colleagues from the basic science community who will be widely represented this year.

As in previous years, ESMO 2017 promises to be a hugely popular event that has something for everyone. In addition to the many and varied sessions created by ESMO, there is quality science to be enjoyed in the numerous abstract presentations, including >50 important late-breaking abstracts that could turn out to be practice-changing and should not be missed.

Please enjoy this fantastic opportunity to network and learn from colleagues across all oncology disciplines and, in keeping with the congress goal, equip yourself with knowledge to benefit your patients!

Introducing the *Daily Reporter* editorial team

Giuseppe Curigliano: *Editor-in-Chief of the ESMO 2017 Daily Reporter. European Institute of Oncology, Milan, Italy*

It's ESMO Congress time again—welcome to Madrid! The team at the *Daily Reporter* is really excited about this year's partnership with the European Association for Cancer Research (EACR), which represents a true marriage of clinical practice and laboratory science.

The official newspaper for ESMO Congresses, the *Daily Reporter* is your guide to all the hottest information being presented at Europe's most influential oncology congress. During the course of the meeting, we will bring you a whole variety of articles capturing the range of information and activities on offer at ESMO 2017—from hot topics and session highlights to specialist commentaries on key data presentations and disease area summaries, which help to contextualise the findings.
A popular feature of the newspaper are its editorials on current issues in oncology, penned by our own Editorial Board, which this year has been expanded to welcome two new members, bringing an even greater breadth of expertise to the content. The Associate Editors—Evandro de Azambuja, Markus Joerger, Floriana Morgillo, Stefan Zimmermann, Angela Lamarca and Rodrigo Dienstmann—and I look forward to being your constant companions throughout the Congress and to help you make the most of this unmissable experience.

A pivotal role for preclinical models **in drug development**

Floriana Morgillo: *Associate Editor of the ESMO 2017 Daily Reporter. University of Campania "Luigi Vanvitelli", Caserta, Italy*

An increased understanding of the molecular and genetic features of tumours has led to the introduction of personalised cancer treatment for specific subsets of patients (e.g. crizotinib for *ALK*-positive lung cancer). However, new and improved preclinical tumour models are needed that can reliably mirror the heterogeneity of patient tumours and predict *in-vivo* drug sensitivity and clinical response.[1,2]

There has been much excitement over the recent development of novel *in vitro* 3D 'organoids': tumour models that may be more representative of patient cancers than many existing models. In the organoid culture system, tumour tissue obtained from the original cancer instead of from immortalised cancer cell lines can be grown efficiently and used to test for drug sensitivity.[1,2]

Models are also being developed from patient specimens to determine specific mechanisms of resistance to targeted agents, such as EGFR and ALK inhibitors, and to identify specific drug combinations able to overcome them.[3]

In the future, organoid models with high-throughput drug screening could provide clinicians with patient-specific information to inform personalised treatment decisions for those with resistant disease.

Learn more about this important topic at the ESMO-EACR Joint Symposium 'Preclinical models for developing combination therapeutics' to be held today (14.00 – 15.30, Granada).

1. Francies HE, Garnett MJ. Pharmacogenomics 2015;16:1523–6
2. Gao D, Chen Y. Curr Opin Genet Dev 2015;30:42–8
3. Crystal AS, et al. Science 2014;346:1480–6

#ESMO17

Progress in the treatment **of gastric cancer**

Gastric cancer is among the leading causes of cancer-related deaths.[1] While surgical resection offers the potential for cure of early gastric cancer, relapse is common, highlighting the need for combined treatment modalities.[2] Unfortunately, many patients have metastatic or locally inoperable disease at diagnosis.[1] Clinical trials in the past decade have helped to define optimal treatment strategies for this challenging disease, although survival remains poor.

In Europe, peri-operative platinum/fluoropyrimidine combination therapy[3,4] has been adopted as the standard of care for resectable gastric cancer. The largest pivotal trial demonstrated that peri-operative cisplatin/fluoropyrimidine/epirubicin triplets improved outcome in resectable gastric adenocarcinoma.[2] It was shown more recently that a peri-operative cisplatin/5-fluorouracil doublet also had a survival benefit similar to that with the epirubicin-containing triplet.[5] Initial results from the FLOT4 trial indicate a benefit of replacing epirubicin with docetaxel (Abstract LBA27_PR). The 3-year overall survival (OS) rate was 48% with epirubicin, cisplatin and 5-fluorouracil or capecitabine (ECF/ECX) and 57% with docetaxel, oxaliplatin and fluorouracil/leucovorin (FLOT). The median OS improved from 35 to 50 months (hazard ratio [HR] 0.77; p=0.012). FLOT also improved progression-free survival compared with ECF/ECX (30 months versus 18 months, respectively; HR 0.75; 95% confidence interval 0.62–0.91; p=0.001). Peri-operative complications occurred at a similar rate with both regimens. In contrast to the strategy of peri-operative chemotherapy in Europe, in Japan and East Asia post-operative chemotherapy is usually proposed in high-risk patients, while in the USA post-operative chemoradiotherapy is sometimes proposed.

Eric Van Cutsem: *University of Leuven, Belgium*

For the latest data in gastric cancer, don't miss today's Proffered Paper Session, 'Gastrointestinal tumours, non-colorectal', 14.00 – 15.30, Barcelona.

Progress has also been made with new agents in metastatic gastric cancer. Today, two targeted agents are approved: the HER2-targeting antibody trastuzumab in combination with cisplatin/fluoropyrimidine in first-line treatment of HER2-positive patients[6] and the VEGFR2-targeting antibody ramucirumab in the second-line treatment as monotherapy or in combination with paclitaxel.[7,8] Moreover, activity has been shown in different studies of the anti-PD1 antibodies nivolumab and pembrolizumab in metastatic gastric cancer. At ESMO 2017, results from the JACOB study demonstrate no survival benefit with the addition of HER2-targeting pertuzumab to trastuzumab and chemotherapy in patients with HER2-positive metastatic gastric cancer (Abstract 6160). Although OS was increased by 3.3 months with the pertuzumab-containing regimen, this improvement was not statistically significant. Updated results from KEYNOTE-059 (Abstract LBA28_PR) demonstrate promising findings for pembrolizumab—either alone or in combination with platinum/fluoropyrimidine. Patients with confirmed PD-L1-expressing tumours had better results than those with PD-L1-negative tumours: respective response rates were 16% and 6% with pembrolizumab alone and 73% and 38% with pembrolizumab in combination with platinum/fluoropyrimidine chemotherapy, respectively.

The session will also present potentially practice-changing results of a trial in patients with oesophageal cancer, in whom surgery performed using hybrid minimally invasive oesophagectomy was shown to significantly reduce post-surgical morbidity, primarily from pulmonary complications, compared with open oesophagectomy (Abstract 6150_PR).

Practice-changing data on peri-operative treatment of gastric cancer are presented in 2017. Further progress in the management of advanced gastric cancer will come from better understanding of the molecular biology of gastric cancer and the role of new targets, and from the development of new agents.

1. Van Cutsem E, et al. Lancet 2016;388:2654–64
2. Smyth EC, et al. Ann Oncol 2016;27 (Suppl 5):v38–49
3. Cunningham D, et al. N Engl J Med 2006;355:11–20
4. Ychou M, et al. J Clin Oncol 2011;29:1715–21
5. Alderson D, et al. J Clin Oncol 2015;33(Suppl):Abstract 4002
6. Bang YJ, et al. Lancet 2010;376:687–97
7. Fuchs CS, et al. Lancet 2014;383:31–9
8. Wilke H, et al. Lancet Oncol 2014;15:1224–35

! Public health and health policy sessions **not to be missed today!**

Joint Symposium
ESMO-WHO: Workforce optimisation – results of the WHO-ESMO study on health workforce requirements for breast cancer care *14.00 – 15.30, Alicante*

Joint Symposium
ESMO-ASCO: Evidence from single-arm trials *16.00 – 17.30, Valencia*

YOUNG ONCOLOGIST EVENTS NOT TO MISS TOMORROW!

Brunch
Communicating with cancer patients in the era of personalised medicine *11.00 – 11.45, Salamanca*

Special Session
Clinical cases of solid tumours: Discussion forum for practicing and young oncologists *09.30 – 10.30, Room 1 & 2*

Special Session
YO for medical students and new physicians *15.00 – 16.00, Room 55*

Find out more about ESMO activities for young oncologists at esmo.org/Career-Development/Young-Oncologists-Corner/About-ESMO-for-Young-Oncologists

Our thanks to the Scientific Committee for an outstanding ESMO 2017 programme


Alberto Sobrero


Richard Marais

The ESMO 2017 programme reflects this year's partnership with the European Association for Cancer Research (EACR). ESMO President Professor Fortunato Ciardiello and ESMO 2017 Scientific Co-Chairs Professors Alberto Sobrero (ESMO) and Richard Marais (EACR) are grateful to the ESMO 2017 Scientific Committee for creating such an outstanding scientific and educational programme. This international, multidisciplinary event will help bridge the gap between research and advances in clinical practice.

The ESMO 2017 Scientific Committee is to be commended on selecting content for such a comprehensive, relevant and high quality programme.

An impressive amount of new data was submitted to the ESMO Congress this year, linking bench to bedside and combining first findings on novel anticancer treatment approaches with eagerly anticipated results. Overall, 1,736 abstracts were accepted, including 55 late-breaking abstracts and a number of potentially practice-changing studies. The scientific programme alone includes more than 20 tracks, with multiple sessions per track, each featuring several presentations and discussion sessions.

In the rapidly changing field of oncology, collaborations such as those between ESMO and the EACR are vital to deepen our understanding of cancer, share and discuss findings and in turn, foster novel treatment approaches to provide optimal care for our patients. "The annual ESMO Congress is the most prestigious and influential event in the oncology arena in Europe. As always, the Congress programme incorporates the very latest knowledge from the cutting edge of advances in oncology. This is the perfect platform to forge new collaborations and build on existing evidence," commented Professor Sobrero.

Basic science: Anton Berns, Amsterdam, Netherlands and Christof von Kalle, Heidelberg, Germany; ***Breast cancer, early stage:*** Nadia Harbeck, Munich, Germany; ***Breast cancer, metastatic:*** Fabrice André, Villejuif, France; ***CNS tumours:*** Michael Weller, Zurich, Switzerland; ***Developmental therapeutics:*** Jan Schellens, Amsterdam, Netherlands; ***Gastrointestinal tumours, colorectal:*** Volker Heinemann, Munich, Germany; ***Gastrointestinal tumours, non-colorectal:*** Eric Van Cutsem, Leuven, Belgium; ***Genitourinary tumours, prostate:*** Johann de Bono, Sutton, UK; ***Genitourinary tumours, non-prostate:*** Bernard Escudier, Villejuif, France; ***Gynaecological cancers:*** Domenica Lorusso, Milan, Italy; ***Haematological malignancies:*** Mariano Provencio, Madrid, Spain; ***Head and neck cancer:*** Jean-Pascal Machiels, Brussels, Belgium; ***Immunotherapy of cancer:*** Inge Marie Svane, Herlev, Denmark; ***Melanoma and other skin tumours:*** Reinhard Dummer, Zurich, Switzerland; ***NETs and endocrine tumours:*** Michel Ducreux, Villejuif, France; ***Non-metastatic NSCLC and other thoracic malignancies:*** Pilar Garrido, Madrid, Spain; ***NSCLC, metastatic:*** Rafal Dziadziuszko, Gdansk, Poland; ***Public health and health economics:*** Paolo G. Casali, Milan, Italy; ***Sarcoma:*** Jean Yves Blay, Lyon, France; ***Supportive and palliative care:*** Matti Aapro, Genolier, Switzerland; ***Translational research:*** Charles Swanton, London, UK and Joan Seoane, Barcelona, Spain

Significant 5-year survival benefit with neratinib after trastuzumab in early breast cancer

Miguel Martín: *Hospital Universitario Gregorio Marañón, Madrid, Spain*

Neratinib significantly improves invasive disease-free survival (iDFS) compared with placebo in patients with early-stage HER2-positive breast cancer previously treated with 1 year of adjuvant trastuzumab. These findings are confirmed in 5-year analysis of the randomised, double-blind, placebo-controlled, phase III (ExteNET) trial in which patients received oral neratinib (240 mg/day) or placebo for 1 year.[1]

The estimated 5-year iDFS rate (intent-to-treat population; N=2,840) was 90.2% in the neratinib arm versus 87.7% with placebo (hazard ratio 0.73; 95% confidence interval 0.57–0.92; p=0.008). A statistical significance in favour of adjuvant neratinib was maintained particularly in the hormone receptor-positive population, in which more than 94% of the patients received concurrent endocrine therapy.

"This analysis provides important evidence of the sustained clinical benefits neratinib can offer women with HER2-positive operable breast cancer previously treated with adjuvant chemotherapy and trastuzumab," says Prof Martín.

Recently, neratinib received US FDA approval as extended adjuvant therapy for patients with early-stage HER2-positive breast cancer based on the ExteNET results.[2] Of note, diarrhoea is a frequent cause of treatment discontinuation with this regimen, occurring in 16.8% of patients.[2] The full updated analysis will be presented this afternoon (Proffered Paper Session 'Breast cancer, early'; 14.00 – 15.30, Pamplona; Abstract 149O).

Previously published 3-year results from the APHINITY trial revealed a modest benefit for the addition of pertuzumab to trastuzumab in women with early-stage HER2-positive breast cancer, with an iDFS rate of 94.1% in the combination group compared with 93.2% in the group who received trastuzumab alone.[3] In neratinib and pertuzumab, we appear to have two drugs that provide a slight improvement on trastuzumab alone, but further study is needed to determine which patients would benefit the most from these treatments.

While adjuvant trastuzumab significantly improves overall survival and DFS in early breast cancer, a substantial proportion of patients (24% of those in the HERA trial at 11 years[4]) also experience disease recurrence in the longer-term and new treatments are required.

This 5-year analysis therefore provides important new evidence that 1 year of neratinib administered after adjuvant chemotherapy and trastuzumab can have sustained clinical benefits in women with HER2-positive operable breast cancer.

1. Chan A, et al. Lancet Oncol 2016;17:367–77
2. www.fda.gov/Drugs/InformationOnDrugs/ApprovedDrugs/ucm567259.htm
3. www.ascopost.com/News/55710
4. Cameron D, et al. Lancet 2017;389:1195–205

What is the optimal therapy for localised rectal cancer?

Robert Glynne-Jones: *Mount Vernon Cancer Centre, Northwood, UK*

Treatment strategies for localised rectal cancer encompass excision using transanal endoscopic microsurgery alone for early tumours lacking adverse features, to a combination of neoadjuvant chemoradiotherapy (CRT) and extended surgery for more locally advanced disease.

Approximately 10–20% of patients will present with an MRI-defined rectal tumour that is unlikely to be completely resected with standard, conventional total mesorectal excision without leaving residual disease. Pre-operative strategies to achieve tumour shrinkage may enable curative R0 resection. Conventionally, these patients receive pre-operative CRT, but recent data suggest that short-course, pre-operative RT (SCPRT; 5 x 5 Gy) followed by fluoropyrimidine- and oxaliplatin-based chemotherapy is equally effective.[1]

Staging, risk assessment and patient choice are key for making appropriate management decisions.[2]

Recent research on the most appropriate management strategy for localised rectal cancer has focused on the chemotherapy regimen, radiation dose and time interval to surgery. Modification of CRT regimens has included the addition of targeted agents, such as bevacizumab or cetuximab.[3] Bevacizumab, rather than cetuximab, is potentially linked to improved pathological complete response (pCR) in locally advanced disease,[4] but risks enhancing surgical morbidity. Furthermore, varying the radiation dose could be important for organ or tissue preservation.[3] Immunotherapy may also have a future role.

After CRT, delaying surgery for longer than the standard 6–8 weeks may be beneficial when using long-course 5-fluorouracil-based CRT regimens.[5] SCPRT with delayed surgery is also a useful alternative to conventional CRT. However, the delay should be balanced between allowing sufficient time to express maximal radiotherapy effects and to achieve pCR, and for post-treatment acute reaction to settle prior to surgery, while not allowing time for the tumour to regrow. While delayed surgery improved pCR by 6% in patients with locally advanced disease, overall survival, disease-free survival and surgical complication outcomes were similar to those in patients who did not delay surgery.[5] A recent review suggests that the timeframe from CRT to surgery could be modified according to patient characteristics, with no detriment to outcomes.[6]

As survival has increased and local recurrence rates have fallen, long-term outcomes regarding function, late effects and quality of life have become even more relevant endpoints to evaluate new treatments.

Hence, the absolute indications for pre-operative radiotherapy should be continuously re-examined.

Current clinical trials (e.g. the Alliance for Clinical Trials in Oncology group's PROSPECT study) are assessing the possibility of avoiding pre-operative radiotherapy in selected patients with rectal cancer.

1. Bujko K, et al. Ann Oncol 2016;27:834–42
2. Glynne-Jones R, et al. Ann Oncol 2017;28(Suppl 4):iv22–40
3. Glimelius B. Acta Oncol 2016;55:1381–5
4. Artac M, et al. Crit Rev Oncol Hematol 2016;108:23–32
5. Petrelli F, et al. Ann Surg 2016;263:458–64
6. Glimelius B. Ups J Med Sci 2017;122:1–10

Don't miss the Educational Session, 'Optimal therapy in localised rectal cancer' today, 14.00 – 15.30, Cordoba.

ESMO Magnitude of Clinical Benefit Scale version 1.1

The first version 1.0 of ESMO-MCBS was published in May 2015 as an important first step to the critical issue of value in cancer care, helping to frame the appropriate use of limited public and personal resources to deliver cost effective and affordable cancer care.

This version is being applied by ESMO in the grading of all new medications or indications of approved anti-neoplastic treatments in solid tumours by the EMA since 2016. These grades are currently being presented in relevant ESMO Clinical Practice Guidelines or as an 'eUpdate', where we can rapidly inform of any changes and updates incorporating the ESMO-MCBS grade.

Field testing and peer reviewing of version 1.1 of the ESMO-MCBS has been completed with the collaboration of the ESMO Faculty and Guidelines Committee, who were critical in the development of version 1.0.

The latest version of the ESMO-MCBS will be presented at ESMO 2017 at a Special Session 'Cost, value and assessment tools of therapies in modern oncology' on Sunday, 10 September 2017 from 16:30 to 18:00 in the Alicante Auditorium. Join experts N. Cherny, E. de Vries, G. Pentheroudakis and I. Tannock to discuss the principles and reflections on cost, value and sustainability of anticancer therapies and the integration of the ESMO-MCBS into ESMO Clinical Practice Guidelines and its implementation.

ESMO Open: New horizons for your research

Christoph Zielinski: *Editor-in-Chief*

Find out more about our open access journal here in Madrid!

ESMO Open has been going from strength to strength since it was launched in 2016. Within only 10 months, it was listed in PubMed Central. Now it also appears in the Emerging Sources Citation Index (ESCI). The journal reached these impressive milestones very quickly by attracting a wealth of high quality papers, which generated massive interest from our readership across the globe.

In addition to original articles, editorials and reviews, *ESMO Open* offers you a variety of cutting-edge content through its blog, podcasts and educational slides and videos. Our focus on using new media to disseminate scientific knowledge has allowed us to reach a very broad audience worldwide.

ESMO Open is now proud to be affiliated with four associations: Italian Association of Medical Oncology (AIOM), Chinese Society of Clinical Oncology (CSCO), Korean Association for Clinical Oncology (KACO) and Japanese Society of Medical Oncology (JSMO). As we work towards even stronger international co-operation, we will continue to build new partnerships. This reflects our commitment to combine high quality science with a focus on the hottest issues in oncology.

If your aim is to reach a global audience from a highly credible platform and within a short timeframe, then *ESMO Open* is for you!

Your paper will receive an ESMO label – a mark of excellence to distinguish your work.

If you are an ESMO member, you enjoy a very special publishing charge of 500 Euros.

I invite you to submit your next paper to *ESMO Open* and benefit from our rapid turnaround times and high quality editorial services; please visit esmoopen.bmj.com

Don't miss: Meet the Editor Session, 10 September 2017, 12.30 – 13.30, BMJ booth #P245

! Connect with *ESMO Open*

ESMO booth #S1, Society Village

BMJ booth #P245 in Hall 7

Workforce requirements for cancer care

ESMO welcomes the World Health Organization's (WHO) Cancer Resolution, which aims to ensure universal access to effective and affordable cancer care, and provide an adequate oncology workforce.[1] Sustainability of cancer care is a pillar of the ESMO 2020 Vision,[2] and as treating medical oncologists we strongly advocate for equal access to quality treatment. ESMO's educational programmes and evidence-based practice guidelines aim to ensure that the most appropriate cancer care is provided by highly skilled professionals.

ESMO regularly gathers data on inequalities, gaps and shortages in the provision of cancer medications and makes recommendations to address these issues. ESMO also helped to collate the updated catalogue of cancer agents for the 2015 WHO Essential Medicines List, and has provided input into the 2017 WHO Priority List of Medical Devices for Cancer. We have a duty to ensure that national cancer plans nurture a well-trained oncology workforce that will use these medications and devices effectively. As such, ESMO is proud to partner with the WHO in evaluating current and future needs among the oncology workforce.

Today's ESMO-WHO Joint Symposium (14.00 – 15.30, Alicante) focuses on how this collaboration will establish the number of oncology professionals required to meet future needs.

1. www.esmo.org/content/download/109686/1929997/file/2017-WHO-Cancer-Resolution.pdf
2. www.esmo.org/content/download/68849/1233986/file/ESMO-2020-vision-brochure.pdf

Should a family history of pancreatic cancer prompt a *BRCA1/2* test?

Alfredo Carrato: *Institution Ramon y Cajal University Hospital, Madrid, Spain*

In addition to breast, ovarian and prostate cancers, carriers of the germline *BRCA1/2* mutation are at increased risk for pancreatic cancer (PC). NCCN guidelines therefore include a family history of PC among *BRCA* testing criteria.

In an attempt to determine whether a family history of PC should be included as a criterion for *BRCA1/2* testing, Dr Marta Venturelli from University of Modena and Reggio Emilia, Modena, Italy, reviews her institution's experience on Saturday (Poster Display Session; 13.15 – 14.15, Hall 8; Abstract 732P). In Modena, testing is offered exclusively to patients affected by breast and/or ovarian cancer, or healthy women with germline *BRCA probability* >40%, and not to those with PC.

A high rate of germline *BRCA1/2* mutations was detected in a retrospective analysis of 393 families with at least one diagnosis of PC along with breast and/or ovarian cancer: the detection rate was 21.3% when applying NCCN Guidelines and 24.5% with Modena Criteria.

A high germline BRCA1/2-positive rate was detected in families with pancreatic cancer associated with breast and/or ovarian cancer.

PC is a deadly disease with a dismal prognosis. It is important to test for, and determine the frequency of germline *BRCA* mutations in these families, particularly when PC is diagnosed in those aged ≤50 years. Although classified as sporadic PC, these cases seem to have a genetic basis.

Deleterious germline mutations were recently found in 3.9% of 854 sporadic PC patients, with *BRCA1/2* mutations identified in 45%. Although therapeutically targetable, these are usually missed when a family history guideline criterion is applied.[1] Screening in healthy relatives from *BRCA*-mutated families could help in an earlier diagnosis and a higher chance of cure.[2] Genetic testing using sequencing panels of multiple genes—coupled with sophisticated bioinformatic tools—could be implemented in the clinic in a cost-effective manner.

1. Shindo K, et al. J Clin Oncol 2017. Aug 2. Epub ahead of print
2. Vasen H, et al J Clin Oncol 2016;34:2010–9

Hair loss remains a major concern **for patients receiving chemotherapy**

Beyhan Ataseven: *Kliniken Essen-Mitte, Evangelische Huyssens-Stiftung, Essen, Germany*

Studies from the 1980s, 1990s and early 2000s showed an evolution in cancer patients' perceptions of chemotherapy side effects.[1–3] While vomiting and nausea were dominant worrisome side effects in the 1980s and 1990s, the impact of side effects on family or partner was the leading concern in the early 2000s. Hair loss appeared among the top-five most severe side effects over this entire time period.[1–3]

In a poster presentation tomorrow (Sunday 10 September, 13.15 – 14.15, Hall 8; Abstract 1472P_PR), Dr Beyhan Ataseven will describe the results of a prospective survey of cancer patients' perceptions of chemotherapy side effects conducted in 2016. Patients were asked before, during and after the end of chemotherapy to rank by severity the most troublesome physical and non-physical side effects of treatment. Hair loss was ranked the third most severe side effect overall.

"It is interesting that in 2016, as in the early 2000s, nausea and vomiting did not feature among the top-five severe chemotherapy side effects, even though nausea was feared by patients before starting chemotherapy," says Dr Ataseven. "Hair loss clearly remains an unresolved side effect that affects patients deeply." Notably, the US FDA recently approved the use of a scalp cooling cap to reduce hair loss during chemotherapy.[4] Dr Ataseven added, "However, scalp cooling is not a global solution for hair loss and treatment side effects/failures must be clearly discussed in advance with patients. In particular, difficulty sleeping and the impact of side effects on family or partner have emerged as key concerns for patients."

Offering additional perspectives as an oncology nurse with extensive experience, Ms Anita Margulies, EONS Education Working Group, noted that there are various models of scalp cooling devices on the market, and large variations exist. She cautioned that, "As the device is *not* always indicated nor recommended, patients should not be given false hope." They should be given correct information and counselling. "Even with the device, hair loss can be unpredictable, and a wig may still be necessary," she advised.

1. Coates A, et al. Eur J Cancer Clin Oncol 1983;19:203–8
2. Griffin AM, et al. Ann Oncol 1996;7:189–95
3. Carelle N, et al. Cancer 2002;95:155–63
4. www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm565599.htm

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The distinguished annual ESMO awards **honour outstanding oncologists**

Four truly remarkable oncologists will receive their ESMO awards during the congress. Come along to the Opening Session today (12.00 – 13.20, Madrid) to see three awards being presented. The fourth will be awarded tomorrow at the Women for Oncology Session (Saturday 11.00 – 12.30, Alicante).

The ***ESMO Award*** goes to Professor Miguel Martín in recognition of his highly respected and important contribution to the field of breast cancer research and treatment. A world leader in his field, Professor Martín of the Complutense University and the General University Hospital Gregorio Marañon, Madrid, Spain, has designed and implemented numerous important clinical trials in breast cancer and contributed many major publications.

"It is recognition not only of my personal contribution, but also of the work of the Spanish Society of Medical Oncology and the members of the Spanish Group for Breast Cancer Research."

Professor Miguel Martín

The ***ESMO Lifetime Achievement Award*** is granted to Professor José Baselga of the Memorial Sloan Kettering Cancer Center and Weill Cornell Medical College, New York City, New York, USA. Described as a true giant of modern oncology, his immense contribution and commitment to breast cancer drug development has led to the approval of several important breast cancer therapies including trastuzumab, pertuzumab and everolimus.

"This highly prestigious award has a unique personal dimension since I have had the privilege to serve this wonderful and vibrant society for many years and I fully support its critical role."

Professor José Baselga

The ***ESMO Award for Translational Research*** is granted to Professor Alberto Bardelli of the University of Torino and the Candiolo Cancer Institute-IRCCS, Torino, Italy. A highly respected geneticist and world-renowned expert in the field of precision medicine, Professor Bardelli's work on liquid biopsies has led to paradigm-changing applications in the clinic, particularly in relation to the diagnosis and treatment of colorectal cancer.

"This award acknowledges the work of my entire team. Our efforts have translated into new ideas for clinical trials, which has been extremely gratifying."

Professor Alberto Bardelli

The ***ESMO Women for Oncology Award*** goes to Professor Frances Shepherd of the University of Toronto and Princess Margaret Hospital Cancer Centre, Toronto, Canada, in recognition of her devotion to the support of women oncologists over the last 30 years. Professor Shepherd is also known worldwide for her outstanding academic contributions to the field of lung cancer in which she has designed and led more than 100 clinical trials.

"I see it as a culmination of my very gratifying and rewarding career in medical oncology … I have seen women make enormous advances in medicine in general, and medical oncology in particular."

Professor Frances Shepherd

Many congratulations to all our truly exceptional award winners!

ESMO YOUNG ONCOLOGISTS

esmo.org/yo

The Young Oncologist Track: Current and future oncology leaders sharing insights and expertise

The ever-popular Young Oncologist (YO) Track continues to offer excellent opportunities for YOs to discuss the latest developments in cancer, network and cultivate their management and leadership skills.

New YO sessions at ESMO 2017, are:

Clinical cases of solid tumours: Discussion forum for practicing and young oncologists are round table guided exchanges on solid tumour case studies (fully booked)

YO for medical students and new physicians is a session offering details about the ESMO-ESO Medical Students Course as well as practical tips on preparing and presenting congress posters; the session will be followed by a poster walk. Limited seats available (Saturday 9 September, 15.00 – 16.00, Room 55. First-come, first-served)

Other exciting YO sessions include the YO Masterclass, **Young oncologists and excellence in clinical research: ESMO YOC meets Methods in Clinical Cancer Research Workshop – MCCR** (Sunday 10 September, 14.15 – 17.15, Cartagena), which features eminent speakers discussing trial designs, the inclusion of state-of-the art treatments and diagnostics and future trial developments. Another key session is the Vesalius Talk, **How active participation in ESMO has impacted my career** (Sunday 10 September, 17.30 – 19.15, Foyer Ibiza) intended to encourage dialogue with opinion leaders on how YO membership and ESMO involvement have benefitted their professional development.

One of the highlights of the YO programme each year is the presentation of the ESMO Research Fellowship Awards, given alongside talks by previous ESMO Fellowship recipients (YO Special Session, Monday 11 September, 14.15 – 15.45, Salamanca). YO Committee member and recipient of a 2016 Translational Research Fellowship, Dr Matteo Lambertini from Institut Jules Bordet, Brussels, Belgium told the *Daily Reporter* how his involvement with ESMO has shaped his career. "My participation in ESMO educational initiatives and the fellowship programme from the beginning of my oncology training has played a crucial role in my career development." He added that, "The YO Track serves as an ideal platform for all young members to be inspired, expand their research network and acquire new professional contacts with leading experts in a friendly environment."

The YO Track promises to deliver practical tips and valuable insights from a broad range of oncologists at different stages in their careers, with unmissable sessions for medical students and newly qualified clinicians alike. The YO Committee hope that you enjoy and benefit from this carefully considered programme of sessions. If you would like to propose topics for discussion at future ESMO congresses, please send an e-mail with your suggestions to yoc@esmo.org.

Full details of the YO Track:

Patient Advocacy Track at ESMO 2017

Patient advocates play a pivotal role in bridging the gap between cancer patients, caregivers and healthcare teams, helping to share information and provide valuable input into healthcare decision-making processes.

ESMO Patient Advocates Working Group Chair, Bettina Ryll, explained that, "Today's cancer patients are increasingly knowledgeable and connected. Patient advocacy groups are playing a major role in leveraging the power of those patient networks for evidence generation."

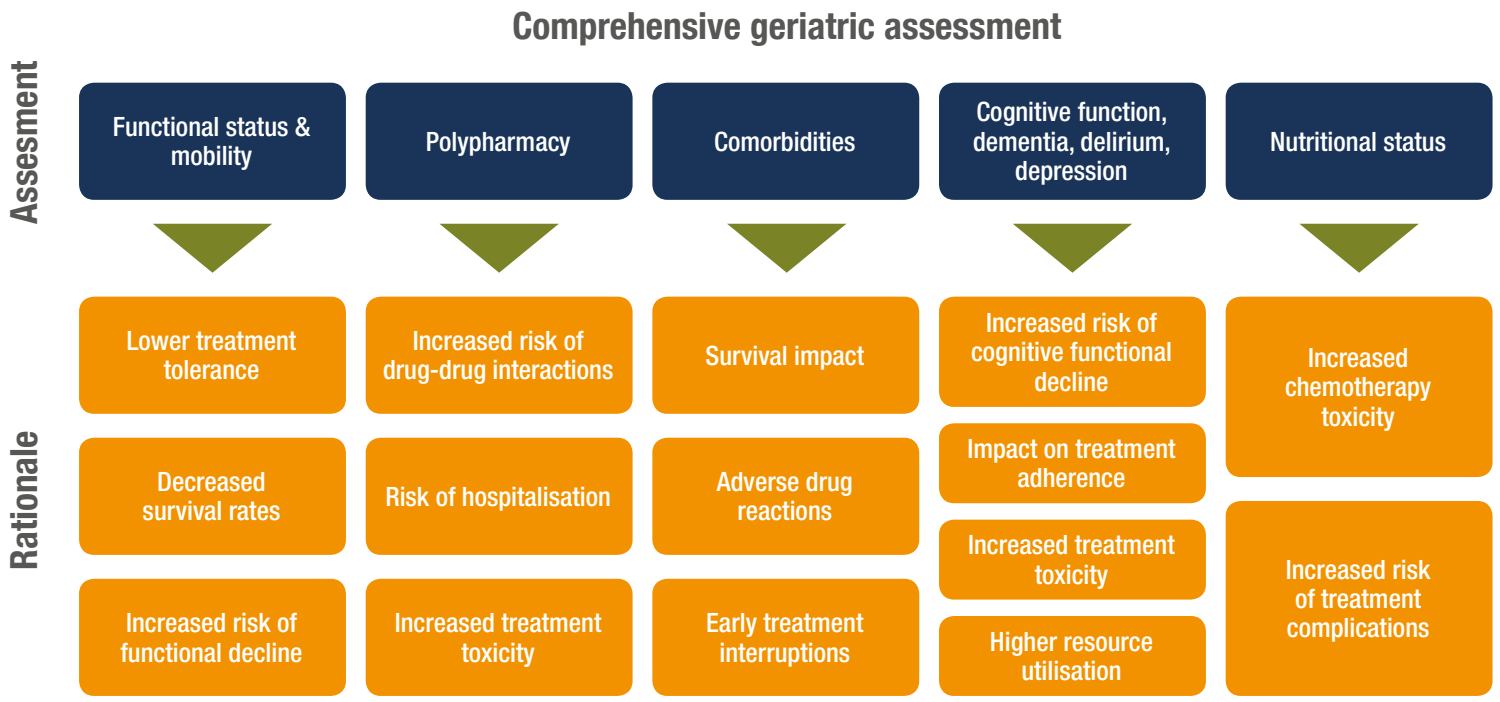
ESMO has dedicated a track of the congress to patient advocacy, providing all delegates with an opportunity to learn more about the important work of these groups.

Don't miss the Patient Advocacy Welcome Session today at 14.00 – 19.00, Palma.

See what's coming up in the Patient Advocacy Track:

Treating older patients: Looking beyond obvious assumptions of frailty

Matti Aapro: *Genolier Cancer Center, Switzerland*



Older patients with cancer represent a treatment challenge: this population is growing exponentially and yet it is under-represented in clinical trials, and truly evidence-based guidelines are mostly lacking.[1] These issues were highlighted in a recent report showing substantial variation across Europe in the use of surgery, hormone therapy and chemotherapy in elderly patients with breast cancer.[2] An appropriate multidisciplinary approach to treating the growing population of elderly patients with cancer demands the consideration of dose adjustments, risk of drug–drug interactions (DDIs) due to frequent polypharmacy and additional supportive care needs for anaesthesia, surgery and cancer therapies. Such considerations are not simple, and elderly patients should not immediately be categorised as 'frail' and unsuitable for intensive treatments, when appropriate. Indeed, a number of abstracts presented at ESMO 2017 report that regimens of the anti-EGFR monoclonal antibody (Abstracts 525P and 526P), tyrosine kinase inhibitor (TKI; Abstract 1356P) and PD-1 immune checkpoint inhibitor (Abstract 1303PD) classes provide similar efficacy outcomes in older patients.

Careful evaluation of physiological—as opposed to chronological—age using a comprehensive geriatric assessment (Figure) enables multidisciplinary teams to provide support for common issues in elderly patients, including toxicity complications, DDIs and malnutrition, as well as adjusting treatments to accommodate related conditions such as sarcopenia (age-related skeletal muscle mass loss of quantity and quality). Supportive care in elderly patients endeavours to proactively avoid symptoms and conditions to which these individuals may be particularly vulnerable in order to maintain good QoL, improve treatment adherence and optimise outcomes.

In a Poster Discussion Session tomorrow ('Supportive and palliative care,' 09.15 – 10.45, Bilbao), Dr Sophie Kurk from University Medical Center Utrecht, Netherlands will show that, while patients diagnosed with metastatic colorectal cancer who have evidence of sarcopenia are more likely to undergo dose reductions at the beginning of treatment, the frequency of dose-limiting toxicities does not increase when compared to patients with normal skeletal muscle receiving standard-dose therapy (Abstract 1546PD). In the same session, Dr Markus Joerger of Cantonal Hospital, St. Gallen, Switzerland, will reveal that DDI severity was identified as a clinically relevant prognostic factor for overall survival in patients with advanced breast cancer (Abstract 1389PD). On a related subject, a poster on Sunday (10 September, 13.15 – 14.15, Hall 8; Abstract 1127P) will show that >90% of patients receiving a TKI also receive other concomitant medications. This high prevalence of polypharmacy presents potential issues, as TKIs are metabolised via the CYP450 pathway shared by other commonly used drugs. Indeed >50% of patients in this analysis experienced DDIs when taking TKIs and other prescribed medications. The benefits and risks of dose adjustments and avoiding polypharmacy, particularly in older patients, remain to be fully characterised but are clearly an important area of future study.

1. Marosi C, Köller M. ESMO Open 2016;1:e000020
2. Derks M, et al. ECC, Vienna, Austria, 25–29 September 2015; Abstract 1808

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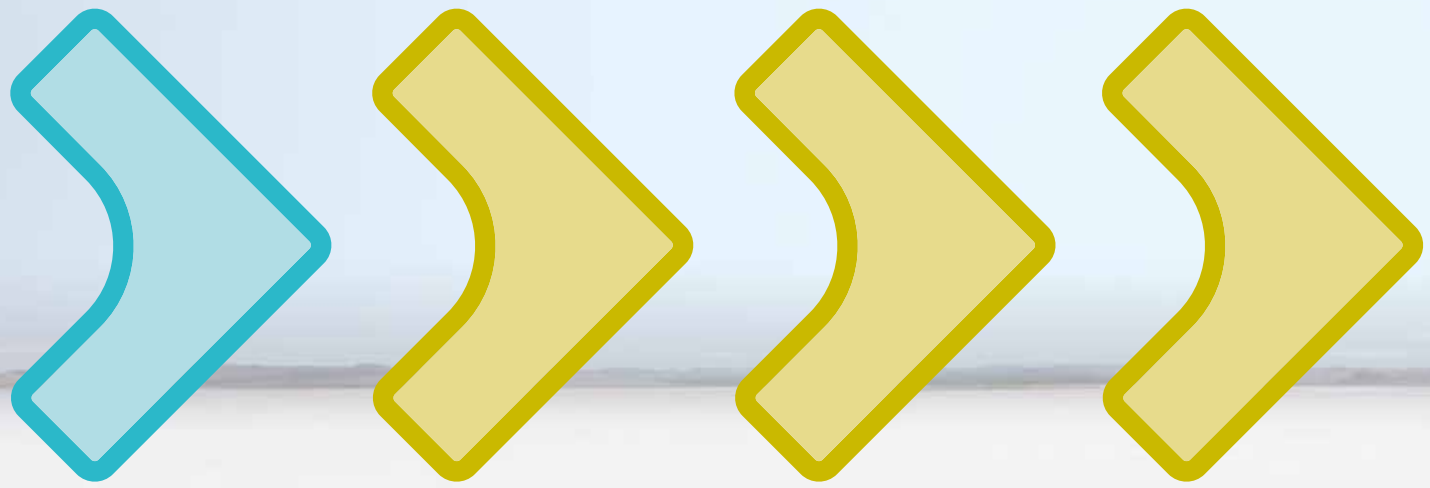

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EGFR M+=epidermal growth factor receptor mutation positive; NSCLC=non-small cell lung cancer; TKI=tyrosine kinase inhibitor.

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