The 4th CML and GIST New Horizon’s in Treating Cancer summit for patient group representatives was held in Budapest from Friday 23rd June to Sunday 25th. The summit brought together 70 patient group representatives from 26 countries. The two days of the summit consisted of four plenary sessions covering a range of topics from advances in science, to global cancer politics. The plenary sessions were supported by a series of workshops encouraging participation, discussion and sharing of ideas in smaller, more interactive groups.

This newsletter highlights some of the main topics discussed at the meeting and summarises each of the main sessions.
WORKSHOP 1:  
GIST Patient Group Roundtable

Facilitators: Markus Wartenberg, Director and Spokesperson, Das Lebenshaus, Germany  
Tricia McAleer, Executive Assistant, Life Raft Group, USA

In the GIST patient group round table, delegates shared common frustrations and ideas about acquiring information on such a rare cancer, and in recruiting GIST patients to their organisations. Ulrich Schnorf, who formed the Swiss GIST patient group in November 2003, said they were still experiencing problems recruiting GIST patients, and believed that they had only succeeded in reaching 10 per cent of patients in their country. Markus Wartenberg, from Das Lebenshaus (the House of Life) in Germany, recalled how they had worked with pharmaceutical companies to make oncologists specialising in GIST aware of their existence, and that the clinicians helped by relaying information directly to their patients. The key to reaching patients, Ulrich commented, was to devise a name for your organisation that gets on the first page of Google.

PLENARY 1:  

Moderator: Markus Wartenberg, Director and Spokesperson, Das Lebenshaus, Germany

Speakers:  
Dr. Laurie Letvak, Head, Imatinib and Nilotinib Global Medical Affairs, Novartis Pharmaceuticals Corporation, USA  
Norman Scherzer, Executive Director, Life Raft Group, USA  
Roger Wilson, Director, Founder of Sarcoma UK, United Kingdom  
Jan Geissler, Director, Founder of Leukämie-Life Raft Group, Germany

Laurie Letvak, Head, Imatinib and Nilotinib Global Medical Affairs at Novartis, provided an overview of drug development from the pharmaceutical industry’s perspective.

First, she outlined the complex and costly process of medicine discovery that on average includes one year biological validation, four years chemical optimisation, and seven to 10 years of translational studies. In 2003 the Tufts Centre calculated that an average of $897 million is spent on developing each drug that finally gets approved. “The cost of development also needs to take into account the cost of failure along the way. In order to end up with one drug, over 10,000 compounds will have been screened,” said Laurie.

Promising new approaches for optimising drug development, outlined by Laurie, included using preclinical animal models that mimic how humans will respond, defining biomarkers for desired biological effects and defining patient stratification factors that identify the correct patient subtype and best therapeutic agents. “This will help to minimise the number of drugs that fail in phase II/III,” she said.

On the issue of speeding up recruitment into clinical trials, Laurie added that while it might seem a good idea to have a large number of sites worldwide, this needs to be balanced against the speed of accrual, accuracy of data collection and costs involved. “This creates dilemmas because while you want to reach a large number of people in a trial if you spread the trial too widely it can lead to delays in getting the drug to a larger number of patients,” she said.

In drug development, Laurie concluded, partnerships and dialogue are needed with all stakeholders, adding that patient groups play an important role in raising trial awareness and that this may ultimately speed access to new therapies.

Through the experience of the Life Raft Group, Norman Scherzer demonstrated the power of patient organisations to “energise” their own research.

Prior to summer 2000, recalled Norman, the situation for GIST patients was grave. Getting the correct diagnosis was a hurdle, and once diagnosed surgery was the only effective treatment and when surgery was no longer an option, death became inevitable. “The year 2001 brought imatinib, C-KIT testing and hope, making the recent appearance of resistance a particularly cruel setback,” said Norman, the executive director of the Life Raft group “Our primary goal now is to counter resistance.”

“There’s little sense of urgency and for GIST patients the bottom line is that we’re not finding effective cancer treatments fast enough to keep them alive,” said Norman. “The Life Raft group believes that cures can only be achieved by a profound change in the basic management of research.”

Recognising the problems in the research process, led the Life Raft Group to launch a new GIST treatment resistance initiative to look at the reasons for resistance and discover the means to overcome them. To achieve these goals Life Raft have introduced some changes in the basic management of research.

“Our mantra is excellence over consensus, cooperation over competition, strategy over chaos and urgency over lethargy,” said Norman.

The Life Raft Group have assembled a world class research team, and built up an innovative grants infrastructure. They have succeeded in capping indirect costs at every institution at 10%, removing intellectual property rights, and establishing frameworks for collaboration between researchers, including...
Over the last five years there has been a major revolution in the UK with cancer patients becoming widely involved in the design and running of clinical trials, Roger Wilson told the meeting.

Roger described the work of The National Cancer Research Institute (NCRI) – a UK partnership of 20 publicly and charity funded research organisations – that now has patients on all strategic committees, working groups, clinical studies groups and funding and awards committees. Patients debate with professionals about research questions, outcome measures and study design. In addition, he said, patients have an important role in questioning whether the balance of benefit and burden is acceptable and whether there will be benefits for future patients.

Initially, some doctors expressed concerns that patients involved were “not typical”, and did not have a “democratic” mandate. “But with time, they’ve come to recognise that patients are stake holders in the democratic process and bring new skills and valuable perspectives,” said Roger, who is on the board of the NCRI, and also works with Sarcoma UK.

With this role comes patient responsibilities. Patients should behave professionally, develop confidence through training, and accept consensus decisions, but not allow themselves to be bullied. “They should learn about the research process, ask questions, admit to a lack of knowledge and be challenging,” said Roger.

In the UK, he said, changing attitudes to patient involvement grew from a political awareness that medical organisations need to be accountable to patients. The movement was aided by good reports from the US, which was around 10 years in advance of the UK.

The success of patient involvement in NCRI, said Roger, is demonstrated by the fact that in 2001 (when NCRI was formed) only 3.5% of patients with cancer were entered into clinical trials; but by 2005 this had risen to 12.5%.

For patients who have run out of options being entered into clinical phase I/II trials can prove life saving, said Jan Geissler, from Leukämie-online and the European Cancer Patient Coalition (ECPC). With some oncologists unaware of available trials, or reluctant to recruit patients, it behoved patients to educate themselves about treatment options and hunt out relevant trials that are still recruiting.

But they face an uphill battle. Information on public websites can be incomplete and inaccurate; it may not be available during the recruitment phase of a trial and may not include exploratory trials or therapy optimisation trials. “To cap it all, information may be available in the wrong language, i.e. just English or German,” said Jan

Recently, however, there have been some more positive developments including the International Committee of Medical Journal editors agreeing to only accept registered trials for potential publication. In addition, WHO’s international clinical trial registry platform project (ICTRP) has established a search engine for trial registers, and has a commitment towards full transparency on public trial registration and full reporting of trial results. But with participation remaining voluntary, there are still question marks over compliance.

Jan concluded that “Patients need to be involved, informed and partners in research. The ECPC motto “Nothing about us, without us,” sums up this approach,” he said.

WORKSHOP 2:
The Role of Patient Groups in Clinical Trials

Facilitators: Carson J. Pattillo, Vice President, National Education Programs, the Leukemia & Lymphoma Society, USA
Jana Pelouchová, Founder, Diagnoza CML, Czech Republic

Statistics suggest that only 1.0 to 20% of cancer patients are enrolled in clinical trials. The main barriers to involvement, explained Carson Pattillo from the Leukemia and Lymphoma Society, include patient ignorance of trials, people feeling afraid or suspicious about research, people not being able to afford to take part and a fear of going against their doctor’s wishes.

Of particular concern in our rapidly ageing society are barriers to the participation of older adults in clinical trials. In one 2005 survey of patients leukaemia and lymphoma patients, 74% of people questioned over 75, said specialists did not speak to them about clinical trials.

She concluded by urging everyone to be proactive. “The more people who take part in clinical trials the faster we will find better ways to treat cancer,” she said.

In the discussion it was felt that patient groups needed to be more proactive in providing information on clinical trials and in helping to ensure patients were not coerced into participation.
WORKSHOP 3:  
Patient-led Research

Facilitators: Norman Scherzer, Executive Director, Life Raft Group, USA
Roger Wilson, Director, Founder of Sarcoma UK, United Kingdom

The Life Raft strategy to “think smart enough” to leverage their small numbers and overcome the rarity of GIST has led to the group collecting their own clinical information and developing a leadership role in trials.

Norman Scherzer, the executive director of the Life Raft group (LFR) explained: “We have used the combination of our own research and the ability to publish in our newsletter and on our website, to carve out a seat at the decision making table, with the aim of getting to the head of that table.”

LFR has collected information on treatment efficacy, side effects, dosage and concentrated on issues that are relevant to patients that no one else is looking at.

Using the example of diarrhoea, Norman explained how the NCT toxicity scale ranked diarrhoea five times a day at level one. “Since it’s not killing you, simply ruining your life.” But on the Life Raft Toxicity scale it scored nine, since patients can not live a normal life. “This shows how when the two pieces of information come together you achieve a more complete picture,” said Norman.

Roger Wilson, from Sarcoma UK, said that as stakeholders in our own conditions we had the “moral and ethical right” to a presence on study management groups. “Ask your oncologist if there’s a patient voice, and if not why not and whether you can be that voice. There’s no harm in asking and once that idea is planted it can grow.”

But he added that the time to make this request was not during a consultation. “You should be fully clothed and able to talk on an equal basis with your physicians with mutual respect.”

GIST Session

Chair: Dr. Ulrich Schnorf, President, GIST Selbsthilfegruppe Schweiz, Switzerland
Speakers: Dr. Peter Reichardt, Assistant Professor, Department of Hematology and Oncology, Charité Campus Buch, Germany
Dr. Alan Hatfield, Imatinib Clinical Program Leader and Head, Global Clinical Development Novartis Pharmaceutical Corporation, USA

Dr. Peter Reichardt, assistant professor at the Department of Hematology and Oncology, Charité Campus Buch, Berlin, Germany, updated the meeting with the latest advances in GIST knowledge.

The incidence of GIST at first sight, said Peter, appears to be rising. In Holland the incidence was 2.1 per million in 1995, but by 2003 had increased to 12.7 per million. “In reality the increase is due to pathologists missing the earlier diagnosis,” he said.

Peter also reviewed disparities in the world wide incidence of GIST, with studies show 15 cases per million per year in Sweden; 11 million per year in Iceland and 6.8 million per year in the US. “Again, lower incidence in the US is probably due to half the cases being diagnosed as something else,” he said.

Indeed, a retrospective Swedish study determined that 72% of GI tumours now identified as GIST had originally been classified as other tumours like leiomyomas or leiomyosarcomas.

Mutations

More information, said Peter, has become known about the distinct subsets of GIST defined by the different underlying mutations, with the result that clinicians are starting to use such information to influence their treatment decisions.

GIST cells most commonly express a mutated form of the KIT protein. The c-kit gene, which expresses KIT, is now known to have 4 different mutations. It is estimated that 11% of patients have exon 9 mutations, 67.5% have exon 11 mutations, 0.9% have exon 13 mutation and 0.5% have exon 17 mutations.

However, it is now recognised that not all GIST patients have mutations in c-kit. Approximately 7 to 8% have mutations in platelet-derived growth factor receptor alpha (PDGFRα), a protein discovered to be elevated in GIST in 2003. Now there are known to be three different PDGFRα mutations, with 0.9% of patients having an exon 12 mutation, 0.3% having an exon 14 mutation and 6.3% having an exon 18 mutation.

This leaves around 10% of GIST patients with no detectable mutations in c-Kit or PDGFRα, who are classified as having wild type GIST. “It doesn’t mean they don’t have mutations, only that we don’t know about them,” said Peter.
Efficacy of imatinib

Studies show imatinib results in tumour regression in 50 to 70% of cases, progression arrest in 85 to 90% of cases and progressive disease in 10 to 15% of cases. The progression free survival is 70% at one year, 50% at two years and 30% at three years, with a median overall survival of approximately 4.5 to five years.

When GIST patients taking imatinib were compared to those on doxorubicin based regimens, this resulted in one of the largest differences in the overall survival curves ever seen between two treatment modalities. The difference was particularly striking, said Peter, because GIST had zero response to chemotherapy.

“In the upcoming years I’m convinced median survival will increase since a large proportion of the patients in the initial trials producing this data were in a bad condition with end stage disease when first given imatinib,” said Peter. “If treatment had been started earlier the overall survival is likely to have been longer.”

Peter outlined the results of the longest follow-up of imatinib in advanced GIST – the STI B2222 Study – presented at ASCO this year, by Charles D Blanke, following patients out to four years.

One hundred and forty seven patients were entered into the three year core phase II study and randomised to receive 400mg or 600 mg imatinib. Of these patients, 56 were entered into the four year extension study.

The study showed imatinib fundamentally changed the natural history of GIST, with patients taking both doses surviving an average of 58 months (4.8 years) compared with 15 months for people taking the previous standard chemotherapy treatment.

It was reassuring, he added, that no cumulative toxicity had been found over the study period, which is extremely important in a drug that is likely to be used long term. Since the time to progression and time to treatment failure were similar this showed imatinib to be a particularly well tolerated drug.

Mutations

The STI B2222 study also revealed differences in overall survival according to patient’s underlying mutational status. Median survival had not been reached for exon 11, was 192 weeks for exon 9 and 36 weeks for wild type patients with no known mutations.

The study also shows that 93% of patients with exon 11 mutations benefited from imatinib, compared to 73% with exon 9 mutations and 32% with wild type GIST.

Such statistics beg the question of whether treatment should be changed according to the mutational status of the individual patient. “The answer is no, because 32% of wild type patients still benefit from imatinib,” said Peter. There were also issues around whether patients should be informed of their mutational status. “If patients are in the group that’s most likely to benefit they’re likely to want to know, but if they’re wild type patients, they probably wouldn’t,” said Peter.

Role of Surgery

In metastatic GIST imatinib is the standard of care, with the role of surgery remaining highly controversial. “It’s not a question of whether to have surgery or imatinib but whether to have surgery in addition” said Peter.

A study presented this year at ASCO looking at the impact of surgery prior to systemic treatment with imatinib in patients with advanced GIST found that primary surgery offered no long term benefit compared to treatment with imatinib alone (Bui et al, ASCO 2006, abstract 9501).
The role of surgery following treatment with imatinib remains controversial. Several studies have suggested superior outcomes for patients with complete resection of residual disease; however, proof from randomized trials is missing (Raut et al, JCO 2006; 24: 2325-2331; Hohenberger et al, ASCO 2006, abstract 9500).

The rational behind neoadjuvant therapy with imatinib said Peter, is that it may allow locally advanced inoperable tumours to undergo surgery, and enable non-mutilating surgery in rectal GIST and avoid total gastrectomy.

Response to imatinib

Peter outlined the difficulty in judging whether a patient was in partial remission, stable disease or undergoing progression, and emphasized importance of undertaking CT scans. GIST treatment decisions, he said, should never be made solely according to the size of the tumour, adding that density was a more important indicator of response.

“The reason is that in some GIST patients tumour tissue turns into a myxoid (fatty) material that is still present after successful treatment, while in others it is “vapourised” by imatinib”, he explained. “The main lesson here is that if the density is decreasing you have a responding tumour.”

Even when resistance arises to imatinib it is vital to continue taking the drug.

“In all cases of progressive GIST you have a mixture of resistant cells and responsive cells, but if you stop giving imatinib, you’ll have a far bigger problem because all the tumour cells will start growing again,” he said.

Insights into the Future

Imatinib has proved most successful in exon 11 GIST mutations, but less so in exon 9 and wild type mutations. Sunitinib, the new agent from Pfizer, appears to show higher activity in exon 9 and wild type mutations, but is not so active in exon 11.

“This presents the future possibility of different treatments showing different activities in different mutations,” said Peter.

Results of the merger of data from the US intergroup study S0033 and EORTC –ISG-AGITG study, both looking at treatment of metastatic/inoperable GIST with imatinib, should be available by the end of the year, announced Dr. Alan Hatfield, imatinib’s clinical programme leader at Novartis.

“We hope that stronger clinical correlations will emerge from the data merger, and that there will be clearer indications of which initial disease clinical site or mutation would most benefit from initial dosing with 800 mg,” said Alan.

With imatinib’s success in both GIST and CML, patients are now taking the drug for prolonged periods. This, said Alan, has led Novartis to develop global registries for both conditions, and the creation of additional registries looking at pregnancy and paediatric growth among younger users. Novartis are also looking at opportunities for doctors to utilise research labs that measure blood levels of imatinib.

The Novartis team, Alan added, have been busy looking at new indications for imatinib, including dermatofibrosarcoma protuberans, myelodysplastic syndrome / myeloproliferative disorders with PDGFR gene rearrangements, hypereosinophilic syndrome, systemic mastocytosis lacking DB16V mutation, Philadelphia chromosome positive acute lymphoblastic leukaemia in adults, and paediatric CML.

Paediatric GIST Session

Chair: Jerry Call, Science Coordinator, Life Raft Group, USA

Speakers: Jerry Call, Science Coordinator, Life Raft Group, USA
Dr. Cristina Antonescu, Pathologist, Memorial Sloan Kettering Cancer Center, USA
Dr. Michael Laquigilia, Pediatric Surgeon, Memorial Sloan Kettering Cancer Center, USA

Three experts gave an overview of the current status of knowledge on paediatric GIST in a teleconference from the US. “The most important thing to recognise is that paediatric GIST is different from adult GIST,” said Jerry Call, from the Life Raft Group. Paediatric GIST is more common in girls than boys, predominantly affecting those between 10 and 16 years, the stomach is the most frequent location, the natural history is slower than for adults and survival is longer. In addition, the mutation driving adult GIST does not appear to be the primary factor causing paediatric GIST. Another difference is that children are also more likely to have lymph node metastases, with the clinical consequence that lymph nodes should be routinely sampled for children.

Reviewing the literature, Jerry said, as many as 123 cases of paediatric GIST have been identified, in people up to the age of 30. A study looking to see whether there were differences between GIST patients aged under 18 and those aged 18 to 30 showed that older patients demonstrated both adult and paediatric mutation status.

A further six cases of GIST have been reported in babies, but these have not been officially verified. “The type of GIST occurring in infants seems different. It occurs in the small and large intestine, rather than the stomach and there has been some speculation that it may not be real GIST,” said Jerry. There have also been reports of 12 patients with familial GIST in the literature.

Finally, there is a condition known as Carney’s triad, consisting of GIST and two other rare tumours. Patients with Carney’s triad show long survival, even with lymph node involvement. Indeed there was a recent case of an 84 year old man found to have Carney’s triad at post-mortem, who is thought to have had the condition since childhood.

The current state of play is that surgery remains front line treatment for paediatric GIST. “But we shouldn’t assume that all paediatric GIST is the wild type. Approximately 10% of children have adult mutations and for these people, imatinib offers the best choice of treatment,” said Dr. Cristina Antonescu, a pathologist from Memorial Sloan Kettering Cancer Center, USA, adding that oncologists needed to be aware that there is also a subset of adults with paediatric GIST tumours.

There have been suggestions that children may respond better to Sutent, the new treatment from Pfizer. “But side effects are more difficult than in adults and no one knows why,” said Jerry.

The fact that GIST in children often involves multiple stomach tumours is changing the perspective of surgeons, said Dr. Michael Laquigilia, a paediatric surgeon from Memorial Sloan Kettering. “The reality of paediatric GIST is that if you remove eight lesions there are likely to be 20 more that you can’t feel, resulting in multiple surgery. Since these tumours are often indolent, and surgery carries risks we are now becoming more cautious.”
NEW HORIZONS in TREATING CANCER

There is a move, he explained to monitor children with PET and CAT scans. “We need to know when the tumour is growing in size because they can get to the point where they are unetectable,” he said, adding that the ultimate hope would be new agents that reduce the tumour burden allowing for less surgery.

GIST is a rare disease, and paediatric GIST is even rarer. “To have any chance of unraveling the biology and targeting effective drugs we need to send all the tissue samples to Memorial Sloan Kettering for analysis,” said Jerry.

Cristina explained how she was analyzing these samples with gene expression arrays to find new activated mutations that could lead to the identification of new targets.

Norman Scherzer, executive director of Life Raft, announced that they have created a review board at Memorial Sloan Kettering Cancer Center, USA, that is willing to review the pathology of all world wide cases of paediatric GIST.

RESULTS SHOWED THAT:

- 89.4% of patients with Philadelphia chromosome-positive CML were alive at 5 years, and fewer than 5% of patients died due to CML. This contrasts to the period prior to imatinib where about 50% of patients progressed to the more advanced stages of Ph+ CML after only three to five years, and survival was generally short for these patients.
- Cumulative best responses to imatinib treatment improved significantly between the first and fifth years of treatment. Over the period, complete haematologic responses rose from 96% to 98%, major cytogenetic responses rose from 85% to 92% and complete cytogenetic responses rose from 69% to 87%.
- Furthermore, the data suggest that the annual rate of progression of imatinib-treated CML patients to accelerated phase or blast crisis was continuing to decrease – 0.6% for year 5 compared with 0.9% for year 4 and 1.6% for year 3.
- Grade 3-4 toxicity for first line imatinib included 16.7% of patients with neutopenia, 8.9% with thrombocytopenia, 4.4% with anaemia and 5.3% with elevated liver enzymes.

From IRIS study, said Laurie, Dr. Druker and the study authors confirmed that imatinib should be considered as the standard first line treatment for all CML patients. IRIS also showed that late responses to imatinib occur and that the responses are durable, and that the annual risk of progression is decreasing over time.

CML Monitoring

John Goldman reviewed some of the advances being made in monitoring responses to therapy in CML. The most common methods currently used to detect residual leukaemia include marrow cytogenetics, Fluorescence in situ hybridization (FISH) that uses non-dividing cells from peripheral blood to confirm the presence of a BCR-ABL fusion gene on chromosome 22, and RQ PCR that can give a CML specific product.

Standardization initiatives are needed to allow comparisons and reduce variability in RQ-PCR measures, said John, and these might include standardization of blood specimen samples, choice of equipment, choice of primers and probes, choice of internal control genes and methods of expressing results. It is hoped, said John, that within 18 months to two years international guidelines on PCR monitoring will be available from WHO and FDA, allowing values to be comparable across the world.

“One proposal is that the value corresponding to a MMR in each laboratory could be calculated from the laboratory baseline and then compared with an internationally agreed standard to obtain a conversion factor,” said John.

More than 40 different mutations are now recognized in the Bcr-Abl kinase domain, said John, with a variety of techniques now available to pin point them.

The presence of mutations is significant for patient outcomes. A 2004 study by Hughes Branford et al in 2004 of 188 chronic phase CML patients showed that at 24 months 96% of patients without a mutation were alive compared to 63% with a mutation ($p<0.001$).

A few labs already have the ability to undertake reliable mutational analysis and when this becomes more widespread, said John, it should be possible to tailor the different treatments more effectively to patients which could ultimately lead to fewer mutations.© Novartis 2006

CML Session

Chair: Sandy Craine, Co-founder, CML Support Group

UK, United Kingdom

Speakers: Prof. John Goldman, Fogarty Scholar, Hematology Branch, National Heart, Lung and Blood Institute, USA

Dr. Laurie Letvak, Head, Imatinib and Nilotinib Global Medical Affairs, Novartis Pharmaceuticals Corporation, USA

IRIS Study

Laurie Letvak gave an overview of the 60 month update from the landmark IRIS trial (International Randomized Study of Interferon versus STI571) – presented at ASCO this year by Brian Druker, on behalf of the IRIS group.

The IRIS trial (International Randomized Study of Interferon versus STI571) – which started in June 2000 – recruited 1,106 treatment naïve patients in chronic phase CML from 117 centers in 16 countries, who were randomized to imatinib ($n=553$) or interferon-alfa plus Ara-C (cytarabine) ($n=553$) – then the standard treatment. Due to tolerability reasons or lack of response to treatment, 69% of patients in the IFN/Ara-C arm crossed over to the imatinib arm, whereas only 3% of patients in the imatinib arm crossed over to the IFN/Ara-C arm. As a result, there is no figure for overall survival for the interferon arm.
The T315 mutation was “the mutation from hell”, he said, since no drugs were currently available that could deal with it, and the only option available was bone marrow transplant for young patients. “And since this clone is likely to expand we need to concentrate our efforts on developing new drugs to tackle it,” he added.

New Agents

John Goldman reviewed the new tyrosine kinase agents being developed for use in CML. Among others, these included the Abl TK inhibitors nilotinib (Novartis) and Adaphostin; the dual Abl/Src inhibitor dasatinib (Bristol Myers Squibb), and non ATP binding inhibitors active against T315I, such as ON 012380 (Onconova). Nilotinib is a structural modification of imatinib with 10 to 50 times increased potency that was active against all KD sub-clones in vitro, except T315I. The side-effects in a study of 109 patients (Kantarjian et al, ASH) including cytopenia, GI symptoms, increased bilirubin, rashes, pruitus and pancreatitis, were manageable. Dasatinib is a novel oral, multi targeted kinase inhibitor that inhibits multiple oncogenic tyrosins kinases, including BCR-ABL, SRC family kinases, ephrin family kinases and c-KIT. It has been found to be 325 times more potent than imatinib at BCR-ABL inhibition. John commented that he remained sceptical of the relevance of dual SRC/ABL inhibition and felt that the data was unconvincing, although some other experts disagreed.

In the START C Phase II study by A. Hochhaus, presented at ASCO, 387 patients with Ph+ CML in chronic phase after resistance or intolerance to imatinib received treatment with dasatinib. A major cytogenic response was achieved in 51% (197/387) patients, and complete haematologic response in 90% (348/387) patients. The median follow-up was 7.8 months. In addition, the responses were durable – only two of the 197 patients who achieved a major cytogenetic response progressed on treatment. The side effect of fluid accumulation (pleural and cardiac) were higher for dasatinib than for nilotinib, commented John. In trials, he said, this had resulted in higher rates of dose interruption and reduction.

The new agent ON 012380, that is being developed by Onconova, has a totally different target from imatinib. It competes with the substrate and acts synergistically with imatinib and induces apoptosis in all imatinib resistant mutants including T315I. By September/October, said John, it is predicted that this novel compound will have entered clinical trials.

On June 28, just after the meeting, approval for dasatinib was granted by the FDA for patients who were resistant or intolerant to imatinib. Approval by the EMEA is expected to follow shortly.

Transplants

John Goldman considered the role for reduced intensity (RIC) regimens that have been investigated as an alternative to traditional myeloablative regimens. He showed the results of a study published in Blood last year where Charles Crawley and colleagues undertook a retrospective analysis to estimate the efficacy of RIC allografts in CML using data from the European Group for Blood and Marrow Transplantation (EBMT) on 186 patients from 33 centres. From the study factors found to be significant in a univariate analysis for overall survival at three years were age, stage, antibody, prior transplant, conditioning, and EBMT score.

Additionally, factors that were significant in a univariate analysis for Progression free survival at three years were stage, prior transplant, conditioning, and EBMT score. From the study the authors had concluded that RIC transplants for CML were feasible, but that there was poor overall survival in the advanced phase of the disease.

John added that the heterogeneous patient population, variable conditioning regiments and uncertain classification of progression/relapse had led to problems in interpreting the data from the study, and to unreliable comparisons with conventional transplants.

He concluded that all new CML patients should get imatinib, except patients who may be candidates for up-front transplant. Upfront transplant patients included those with syngeneic donors, children in chronic phase disease, adults with high sokal risk and EBMT low risk CP disease, patients in advanced disease and any patient who fails imatinib.

The mortality of transplants still approaches 25%, said John, and reduced intensity conditioning has done nothing to improve these outcomes. Since the introduction of imatinib the number of transplants has dropped by 70%.

EU Recommendations

Laurie Letvak presented the recent European LeukemiaNET (ELN) recommendations for CML that had been generated by a panel of experts to provide guidance for the practical management of CML in a changing field. The Panel – composed of 19 CML experts from the EU, Switzerland, USA and Australia – met with the objective of re evaluating Ph+ CML treatment since the introduction of tyrosine kinase inhibitors (TKIs). The group undertook their evaluation through a critical review of literature since 1998, including 2004 and 2005 abstracts from ASH, ASCO, European Group for Blood and Marrow Transplantation, European Hematology Association, and International Society for Experimental Hematology.

In addition to defining the three phases of Ph+ CML (chronic phase, accelerated phase and blast crisis), the recommendations defined what was meant by haematologic, cytogenetic and molecular responses. Haematologic responses, stated the recommendations, should be monitored every two weeks until a complete response has been achieved and confirmed, then every three months unless otherwise required; cytogenetic response should be monitored every six months until a complete response has been achieved and confirmed, then every 12 months; and molecular responses should be monitored every three months.

With regard to molecular monitoring, the recommendations stressed the need for RQ-PCR standardization, and argued for a shift to international scales. While some mutations are functionally irrelevant, say the recommendations, the effects of non-P-loop mutations can be overcome by increasing doses of imatinib.
Mutational analysis should be considered in all cases of treatment failure and suboptimal response, and be confirmed by rises in bcr-abl transcript levels. There are, however, important caveats. Consensus was lacking on the exact level of bcr-abl transcript level to trigger concern, and only a limited number of laboratories worldwide were equipped to perform mutational analysis. The initial treatment dose of imatinib in Ph+ CML in chronic phase was 400 mg IM. For those patients with a high disease risk and low EBMT risk score, allogeneic hematopoietic stem cell transplantation (alloHSCT) and IM should be discussed.

For a suboptimal response the first choice of treatment is to escalate the dose to 600 or 800 mg imatinib if the patient tolerated 400 mg. Further treatment options are alloHSCT or investigational therapy. Then for treatment failure the first choice of treatment is to escalate imatinib dose to 600 mg or 800 mg if the patient tolerated 400 mg and the resistance is not associated with a high level of insensitivity to imatinib. Additional options include alloHSCT and investigational therapy.

Intolerant patients, say the recommendations, should be considered on a patient-by-patient basis, making use of supportive care and side effect management. If a patient is truly intolerant options such as alloHSCT, recombinant interferon alpha and low-dose arabinosyl cytosine and investigational treatments should be considered.

Patients diagnosed with accelerated phase and blast crisis, say the recommendations should start with a trial of imatinib 600 mg. Blast crisis patients can be treated with other tyrosine kinase inhibitors according to their mutational analysis before proceeding to transplant.

The recommendations concluded that proposals concerning treatment policy were provisional, whereas recommendations concerning methods to evaluate and monitor response could be considered more compelling.

Stem Cells

John Goldman considered the evidence supporting the notion that some CML leukaemia stem cells escape the effects of imatinib. Only a small minority of patients on imatinib, he said, are BCR-ABL undetectable for long periods of time. In addition was shown by Tessa Holyoake that quiescent stem cells survive or increase in number in vitro in the presence of imatinib. Furthermore, of the patients who achieve undetectable transcript status, most relapse if imatinib is discontinued. And occasionally patients in cytogenic response, or even those with undetectable transcript levels, relapse directly to blast phase disease.

The question, said John, was whether the presence of resistant stem cells mattered. Median survival for CML before imatinib was five years, now it could be as long as 50 years. Complete eradication of stem cells may not be important for survival, he said.

PLENARY 2:
Empowerment through Global Understanding and Collaboration: Global Cancer Politics

Moderator: Carson J. Pattillo, Vice President, National Education Programs, the Leukemia & Lymphoma Society, USA

Panel discussion: Dr. Tanya Soldak, International Medical Director, CitiHope International, USA (Global)
Hildrun Sundseth, Head of EU Policy, European Cancer Patient Coalition, Belgium (EU)
Pat Garcia-Gonzalez, Executive Director, the Max Foundation, USA (Latin America and developing countries)

Good advocacy from non government organisations, explained Tanya Soldak, Medical Director from CitiHope International (Andes, New York, USA), is key to developing effective health care policy for cancer patients. Important elements in health policy for cancer include reductions in incidence and mortality, evidence based medicine and patient centred care focussed on improving quality of life, and addressing emotional, physical and financial issues.
In cancer, advocates actively promote the implementation of good health policy so that people living with cancer can obtain adequate treatment and quality of life.

Potential barriers to effective advocacy include lack of resources (pharmaceuticals, lab testing, qualified health care providers), inadequate cancer policy for some types of treatment, lack of information and a paternalistic attitude towards patients from health care providers.

Effective advocacy strategies involved a three pronged approach at the political level (for legislative changes), at the policy level (for promotion of comprehensive national cancer programmes) and at the local level to ensure providers and other stake holders adopt national policies. Improving knowledge by providing accurate, relevant and understandable information was vital to get patients involved in decision making, she said.

Taking Belarus as an example, Tanya said, they had achieved success in lobbying policy makers to develop clinical protocols and bone marrow transplantation centres. They also ran lecture sessions in teaching hospitals to promote practice of the latest evidence based methods and published lay brochures for patients. “These clearly explained scientific developments and allowed patients to take more control of their destinies.”

But, Tanya added, there were still major concerns. Out of 600 CML patients in Belarus only 25 had access to imatinib, and their problems were being compounded by low accessibility to cytogenetic and Philadelphia chromosome testing.

Across Europe and even in individual European states there are unacceptable discrepancies in patient access to cancer treatment and outcomes of therapy, Hildrun Sundseth, head of EU Policy at European Cancer Patient Coalition, told delegates.

“The European Medicines Evaluation Agency is obliged to approve all cancer drugs centrally, but while there is a single EU license for medicines, there are 25 different reimbursement systems, with each country undertaking their own pricing and reimbursement negotiations,” Hildrun said, adding that the time it takes for drugs to be available ranges from the next day in some countries, to four years later in others. “Such delays are to all intents and purposes a concealed approach to product rationing,” she added.

There are also considerable differences between Europe and the US. Kathy Redmond, editor of the journal “Cancer World” has shown there is an average delay of five months between drugs being available in the US and UK.

Help may be at hand from the The European Parliament MEPs against cancer (MAC) – a recently formed group of 45 MEPs who come together to make cancer a priority at the political level in Europe. “For life threatening cancers there’s a need for patients to be given medicines under dedicated budgets while health technology and effectiveness data are gathered,” said Hildrun. “But to achieve such compassionate use, patients will need to be empowered and knowledgeable to cut through the bureaucracy.”

Pat Garcia-Gonzalez, executive director of The Max Foundation (TMF), looked at the challenges of patient groups in developing countries.

“Every patient diagnosed with cancer has universal needs of access to information, treatment and support, irrespective of their culture, religion and economics,” said Pat. “But there are particular issues for patients in developing countries.” Challenges include access to information and treatment, lack of availability of latest treatments and diagnostic tests and run-down health care systems.

Other difficulties include access to emotional support, lack of patient groups, and the cultural stigma of cancer. “All too often there are instances of patients being fired from their jobs, and siblings not being able to marry,” said Pat.

Partnerships, involving collaborations between different organisations have been used to overcome the problems. One example of a successful partnership is the imatinib (Glivec) International Patient Assistance Program (GIPAP), developed by Novartis in accordance with WHO guidelines, to provide access to treatment, as well as information and support. The programme has provided access to imatinib at no cost to 12,000 CML and GIST patients in 81 countries who are not insured, reimbursed or have any other financial recourse.

In the partnership Novartis donates and distributes imatinib, TMF screens patients and provides emotional support and education, clinicians are responsible for treatment management, and patients are responsible for complying with treatment recommendations.

Pat recounted the success story of a 22 year old woman with CML from Honduras to illustrate how the impossible can be achieved with good collaboration. The woman qualified for the GIPAP programme and did well on imatinib until she became resistant. Then a joint effort from the Asociación Hondureña del Cáncer, American Airlines (who donated air miles) and TMF (who organised her visa and secured her donor’s job) resulted in the woman having a stem cell transplant in NIH Bethesda, Maryland, and she is doing well. “All too often dealing with cancer in developing countries is alike a game of snakes and ladders,” said Pat. “If you land in the right place at the right time you’ll do fine, but with the role of the dice there’s no guarantee you won’t land on the snake and go back to the start.”
WORKSHOP 4: Reimbursement

Facilitators: Hildrun Sundseth, Head of EU Policy, European Cancer Patient Coalition, Belgium
David Ryner, Secretary, CML Support Group UK, United Kingdom

The reimbursement workshop recalled the UK success story where a CML group successfully lobbied for access to imatinib, and called for concerted action to get free access in all other countries.

David Ryner, from the UK CML Support Group, said that they had launched a campaign when the National Institute of Health and Clinical Excellence (NICE) – the gate keeper of UK reimbursement decisions - recommended that imatinib was only prescribed for people with accelerated CML. “It was a particularly crushing blow since most people with CML are diagnosed in the chronic stage,” he said.

The UK campaign involved submitting the group’s official response to NICE, coordinating an online petition and utilising the media. “We found the emotional impact of using a patient was ten times as effective as using a doctor,” he said.

The campaign proved successful and the group never had to fall back on their escalated plan of action to picket outside local hospitals and the homes of hospital managers.

The recent Czechoslovakian experience showed that even when funding appears sorted there is no room for complacency. Jana Pelouchová, from the Czech Republic, said that until recently 380 CML patients and 70 GIST patients had been receiving imatinib, but three days after the recent general election the minister of health announced a change in the law where 20% of the price of imatinib had to be covered by the patient. I went to the media and said: “look at me, due to this decision in a few months I will cease to exist,” said Jana. “It worked; the minister retreated and said it was a misunderstanding. Just as I was packing to come here I heard on the radio that imatinib will be 100% reimbursed.”

David concluded that the power of “co-ordinated activity was vital” and that international effort was needed to write letters to the governments of countries who still rationed imatinib. There is no room for complacency, he added, even those people who now have access to imatinib are likely to have to fight for access to nilotinib and dasatinib.

WORKSHOP 5: Access to Information, Diagnosis, Treatment and Care

Facilitators: Pat Garcia-Gonzalez, Executive Director, the Max Foundation, USA
Dr. Tanya Soldak, International Medical Director, CitiHope International, USA

One of the greatest barriers patients around the world have to health information, delegates at workshop five heard, was limited access to the internet. Barriers to treatment included lack of availability of diagnostic tests, bureaucratic constraints limiting access to pharmaceutical treatments and health care systems in poor shape. Further more, patients also experience barriers to emotional support, including the cultural stigma of cancer, misinformation regarding causes of cancer and labour laws that failed to protect cancer patients.

To overcome such barriers, Pat Garcia-Gonzalez said, each country needed to consider the assets they have available, including the different non government international groups that deliver resources and international groups that work at a policy level. There was a need to search for local corporate partnerships from drug departments, drug information centres and local office representatives.

Information system could be developed making use of donated computers and financial support. She added that grants were needed for internet access and translating information into the local language.

In the discussion there was recognition that many patients do not want information when first diagnosed, but if this changes the patient group must always be ready and welcoming.

Plenary 3: Improving Compliance

Moderator: David Ryner, Secretary, CML Support Group UK, United Kingdom

Speakers: Dr. Anna Costantini, Chief of Psycho-Oncology Service, Sant’Andrea Hospital University La Sapienza, Italy
Prof. Nora Kearney, Director Cancer Care Research Centre, Department of Nursing and Midwifery, University of Stirling, Scotland

Psycho-social causes related to compliance issues

In the past due to widespread use of intravenous therapy, compliance has not been an issue for oncology patients. However, now with increasing oral administration of anticancer therapies, such as imatinib, the situation is changing.

Compliance, said Anna Costantini (chief of Psycho-Oncology Services at the Sant’Andrea Hospital in Rome), can be defined as the extent to which a person’s behaviour in terms of taking medications coincides with medical or health advice. “The reality is a continuum, ranging from patients who are fully compliant to those who are totally non compliant,” she said.

In addition to routes of administration, factors influencing compliance include drug side effects, patterns of dosing, length of treatment, cost of treatment and poly-pharmacy. Features of the illness – such as symptoms, duration, disabilities and medically defined seriousness – also played a role.

There were also psychosocial factors, including the patient’s knowledge and understanding, quality of health care interactions, health beliefs and attitudes and mood disorders and personality.

Health care providers can undertake educational interventions to improve compliance, including verbal and or written or audiovisual material and mail and telephone instructions. Behavioural interventions included skill building, behavioural modelling, contracting, packaging, and rewards. Family support, counselling and supportive home visits have also been shown to be effective. “Compliance should never be assumed...”
as every patient is a potential defaulter,” concluded Anna.

Data on Reasons for Non-Compliance and Symptom Control

Creative use of new technology can be harnessed within health care systems to support patient adherence and concordance and improve compliance, said Nora Kearney, professor of Cancer Care at the University of Stirling. She went on to describe how the University of Stirling has introduced an innovative patient centred IT support system allowing “real time” symptom assessment of cancer patients.

In 2003 WHO recognised poor adherence to the treatment of chronic illness as a world wide problem leading to poor health outcomes and increased health care costs. In the case of imatinib, it is known the average patient takes only 256 treatments out of 365.

Increasingly, E health opportunities, said Nora, are being recognised as a way to access effective care. It provides information in an accessible format and supports cultural and language needs across national boundaries. “Better informed patients are less anxious, more satisfied, follow advice better, present earlier, have lower risk interventions and engage in more self care, which in turn reduces hospital costs and making more efficient use of resources,” she added.

Nora gave an overview of the advanced symptom management system (ASyMS) study that she is running, where 150 patients undergoing chemotherapy with breast, lung and colorectal cancer, have been randomly allocated to an interventional group where they are issued with a mobile phone to monitor their treatment, or a control group where they receive usual care. The patients – from six sites in Scotland and The Royal Marsden Hospital, London – are being followed up for 12 to 16 weeks, while receiving four chemotherapy treatments.

Patients in the mobile phone group are being asked to complete a short questionnaire, twice a day on their mobile phone screen asking about the side effects associated with treatment. They have also been issued with a thermometer and asked to take their temperature daily and transmit the result. Answers will be analysed by the system and if patients have reported side effects of concern, nurses are alerted by the computer via a pager.

Borderline symptoms, explained Nora, generate amber alerts that require an eight hour response, while severe toxicity generates an immediate response within an hour. The system also allows an interactive approach with tailored patient support that allows patients to view self-care advice, symptom graphs and cancer information pages on the handset at any time.

“IT’s allowing us to engage patients in an altogether different way and make them accountable for their and our decisions,” said Nora, adding that they will analyse the results to see if the ASyMS system improves both symptom outcomes and patients’ experiences.

WORKSHOP 6:
The Reason behind Non-Compliance with Therapy

Facilitators: Dr. Anna Costantini, Chief of Psycho-Oncology Service, Sant’Andrea Hospital University

Estelle Lecointe, Executive Director, Ensemble contre le GIST, France

Identifying non compliance prevents the development of many health problems and prolongs patient’s life expectancy, participants heard in Workshop 6.

Concomitant illnesses, said Dr. Anna Costantini, plays a major role in reducing compliance. A study for patients taking imatinib showed that the rates of non compliance were 69% for diabetics, 55% for TB patients, 54% for asthmatics and 53% for hypertensives.

Major factors influencing non compliance included lack of information about medications, uncertainty about treatment merits, poor communication around diagnosis and inadequate information about side effects. Personal factors – such as age, gender, frustration with treatment and cultural or religious beliefs – also play a role, said Anna. In addition psychological factors such as severe depression, personality disorders, relationship problems, psychopathologies (psychotics and bipolar disorders) and addictions all have a negative impact. And it should never be forgotten that in some countries financial resources, such as the long term cost of treatment and examinations and problems with health insurance, also impact compliance.

On the economic front it’s been estimated that $270 million is spent each day around the world on additional medical costs brought about by non compliance.

For patients the consequences of non compliance include reduce treatment efficacy, an increased likelihood of developing resistant, additional illness and hospitalisations and risk of death.

Clinicians all too often forget to ask people questions about compliance, leaving the role of education to patient organisations, who need to find creative ways of communicating the consequences of non compliance to their members.

Participants in the workshop talked about their reliance on family members and friends to remember to take their drugs.
But with more than 20% of cancer patients living alone, such social isolation has the potential to increase non-compliance with therapy. Patient groups have a key role to play in motivating these patients to comply with treatment.

WORKSHOP 7:
Symptom Control, New Technology and Compliance

Facilitators: Prof. Nora Kearney, Director Cancer Care Research Centre, Department of Nursing and Midwifery, University of Stirling, Scotland
Jan Geissler, Director, Founder of Leukämie-Online and Vice President European Cancer Patient Coalition, Germany

In workshop seven participants split into two groups to consider how they would like to see the different types of new technology working for them.

Group one saw technology as having the potential to play a helpful role in the remote monitoring of ECGs and heart rate and with individual risk assessments and advice. Roger Wilson commented that he personally would find it particular helpful to be able to quiz a computer system about how a nine hour flight to the US would impact on his condition. The group recognised that there was likely to be problems with confidentiality, but Nora reassured them encryption systems could be introduced to overcome this concern. While the down side of technology was that it might result in people having less trips to outpatients (and social contact), it would also make them more informed and give them a better understanding of their illness.

Group two thought that technology had a major role to play in helping compliance by reminding people to both take their medications and remember doctor’s appointments. Systems could be developed, like bracelets that vibrated when drugs were due, but they needed to be fashionable. Technology could also help with travel preparations, enabling patients to work out the amount of drug they needed to take on a trip.

In 2003 a World Medical Association survey of 3,707 patients showed that despite patients feeling more empowered, a minority still experienced authoritarian and paternalistic care. “There’s still the culture of putting doctors on a pedestal and patients not liking to complain in case it prejudices their treatment.” Hilary told the meeting.

To ensure consumer views are integrated into decision making, patients need to push for patient surveys, better representation and initiatives like “360 degree” appraisal surveys on clinicians, including comments from both medical peers and patients. “The advantage here is that when doctors are given good evidence they tend to accept criticism better,” said Hilary.

At the Royal Surrey Hospital they have introduced a new initiative developing “a patient line of sight” to enhance medical staff/patient relationships, and develop the listening skills of the organization. The “change” team, who implemented the approach, sat down with patients and asked them to talk freely about their time in hospital. On analysis they found patients had a much more holistic experience of hospital than professionals, seeing it as a “whole organization” made up of a complex series of interactions, between staff and departments. Health professionals, in contrast, are only aware of their own immediate concerns.

The survey has resulted in the hospital undergoing a cultural shift with staff actively listening to patients, a can do attitude of nursing leadership and identification of the need to create a service that was more joined up with good co operation across different areas.

PLenary 4:
Empowerment through Communication: Helping Patients with Doctor-Patient Dialogue

Moderator: Roger Wilson, Director, Founder of Sarcoma UK, United Kingdom

Speakers: Prof. Hilary Thomas, Medical Director, University of Surrey, Royal Surrey County Hospital, United Kingdom

Hilary Thomas, professor of Oncology at the University of Surrey and medical director at the Royal Surrey County Hospital, talked about improving doctor patient dialogues. Hilary told the audience how a recent diagnosis of breast cancer, has put her in the unique situation of sitting on both sides of the fence, being able to see both the oncologist’s and patient’s perspectives. “I’m half way through chemotherapy now, and have found it very interesting to experience a huge number of side effects that I had no idea existed,” she said.

The experience has led Hilary to analyze why doctor patient relationships are not always optimum. Problems occur right from the start of medical training, she said, with fundamental flaws in the selection of medical students. “There are still medical schools in the UK where they offer places without interview. Surely it’s common sense that if you can’t do eye contact you’ll be at an immediate disadvantage with patients.”

Other problems include inadequate emphasis on communication skills, a hierarchical, paternalistic biomedical research model. “In addition, public sector models that are free at the point of delivery encourage the mentality that you’re lucky to have something free and shouldn’t moan about it.”
**WORKSHOP 8:**
The Patient Perspective on Communication

Facilitators: **Candy Heberlein**, President, Stiftung zur Förderung der Knochenmarktransplantation Schweiz

**Maria José Rebelo de Andrade**, Secretary General, Associação Portuguesa Contra a Leucemia, Portugal

The quality of your relationship with your doctor is decisive in the outcome of your treatment, Candy Heberlein, president of Stiftung zur Förderung der Knochenmarktransplantation, told the workshop. “The idea is to make the doctor your ally in this battle,” advised Candy.

To communicate with doctors, people first need to understand their own style. Whether they were the type of patient who wanted lots of information with all the steps and options of treatment outlined, whether they preferred not to have the details, or whether they preferred to be made aware of any problems one step at a time.

A great deal of time, said Candy, can be saved by addressing the right question to the right professional. Health worries should be addressed to clinicians, nurses, physiotherapists and nutrition counsellors, psychological worries to psychologists and psychotherapists, social worries to social workers and social services and spiritual worries to the palliative care or hospice teams and to pastoral care workers.

Patients should be proactive, making sure they understand the different options available and agree with their chosen treatment.

Patients should not be afraid to ask questions and need to remember that all questions are relevant to reduce their stress, increase quality of life and help them cope with the disease.

Every patient has the right to the best available treatment, but once they have reached a treatment decision it becomes their duty to comply with medication.

In the discussion it was felt that doctors often underestimated the educational levels of patients, and that they sometimes fail to recognise their differing needs for information. The importance of asking doctors questions and taking notes was highlighted, with the suggestion that emails within patient support groups could be used to help clarify questions that had been forgotten in the clinic.

**WORKSHOP 9:**
The Health Care Professional Perspective on Communication

Facilitators: **Prof. Hilary Thomas**, Medical Director, University of Surrey, Royal Surrey County Hospital, United Kingdom

**Andrea Schumann**, Coordinator, regional self-help-groups, Das Lebenshaus, Germany

In workshop 9 delegates considered the challenges and barriers to successful dialogue between doctor and patient. “The aim of the workshop,” said Hilary Thomas “Is to devise a cheat sheet of what you can do as a patient to support successful dialogue with your doctor.”

The group identified challenges that need to be overcome as including arrogant doctors, the difficulty for patients in retaining information, doctors’ acceptance of patient knowledge, problems in rare tumours where doctors act outside their confidence instead of referring patients to a specialist and systems that did not allow the doctor enough time for the consultation. Special problems were identified in Hungary and Albania, where the entire medical system was based on patients bribing doctors to receive better care.

Focusing on the consultation Hilary Thomas said that there were innovative ways doctors could free up time to enable them to devote more attention to the people who needed it. “One way is to discharge patients at three and five years so that you don’t need to keep seeing them in clinic, and this works provided you give them information and empower them to know when they need to come back,” she said.

Other approaches are to use telephone follow up and get more patients seen by specialist nurses.

The House of Life said that they trained members on how to prepare for doctor’s appointments so that they knew how to make best use of the time available.

Hilary concluded that people need to use what ever mechanisms they have available to provide feedback to health care providers.

**MEETING SUMMARY**

At the end of the meeting medical advances in CML and GIST were summarised.

Reviewing CML developments, David Ryner said two new drugs nilotinib and dasatinib were offering hope for imatinib resistant patients. Patient groups, he added, had a particularly important role in supporting the message of drug compliance.

For GIST, Norman Scherzer said, the medical take home messages from the meeting were that patients with exon 9 mutations needed higher doses (600 to 800 mg, opposed to 400mg) of imatinib and that dose escalation was strongly suggested for exon 11 mutations. He added that the creation of a Paediatric GIST review board of specialists willing to review all cases of paediatric GIST would be of enormous benefit for children with this rare cancer.

David said the meeting had identified the need for groups, particularly those from Eastern Europe, to be supported by other countries in their fight for reimbursement of imatinib. One delegate suggested that an international page could be created on the website of the European Cancer Patient Coalition where people might post messages for help.