Subtitles and transcriptions

Young people and cancer

Dr Ferrari: Good evening, good evening, everybody. It's a pleasure to be here together with Annalisa Trama to talk to you about the young people and cancer. We will do our best to make the most of this opportunity to present the hopes and unrecognised challenges of adolescents and young adults with cancer. I'm a Paediatric Oncologist, I work at the Istituto Nazionale Tumori, in Milan. Annalisa Trama is an epidemiologist working as well at the Istituto Nazionale Tumori, in Milan. So, you will see two different aspects of the same problem. And this is just to say that we would like to have an interactive session. So, please, if you have some questions or comment, you can do at any time, and we will try to respond as soon as possible. And this introductory slide is just to say that our speech, my speech will be accompanied by the picture of our young patients of the Youth Project of Milan, which over the years developed many creative activities giving patients a special way to express themselves. And these four slides, just to briefly remember that in many parts of the world in the recent years, AYA oncology programme involving numerous organisations, healthcare providers, academic society, governments, has been developed with evident differences and similarities. And it's important to note that these programmes are developed according also to the different local situations. And so, it is difficult to say if there is a perfect AYA model. We can say that dedicated AYA programme should reflect not only an ideal but also, acknowledge local reality including variation in healthcare culture and resources. And this is to discuss about the definitions because we know that there is not a universally accepted definition for AYA. And we know that any definition is potentially arbitrary, but it is of value for the application in health policy and ethical provision of service. We can see that there is a clear definition for adolescence, between 15 and 19. What is under discussion is the upper age limit of the young adulthood that can be fixed at 24, 29, 39 according to the different programmes, the different country, the different clinical propose. If we decide to discuss AYA for the definition of up to 24, this means that to have a more focus on common psychosocial aspects. For example, fragility, the immaturity, the social and sexual experimentation, the lack of career and economic independence but we can say that in the last year, many of the experts involved in AYA project started to think to the definition up to 39, with the inclusion of different type of tumours and the focus of more clinical challenges. And we'll discuss later about this, as the lack of specific biological understanding of the tumour, the lack of access to specialised centres affordable for the patients and so forth. And this is just to start with the concept of epidemiology because when we talk about AYA, we talk about a very, very different tumour pattern. AYA patients have a unique epidemiology with both paediatric-type and adult-type tumour. And this is one of the first problems when we talk about these tumours. To say that if you want, as a young associate, to work within AYA, you have to have a competency for both paediatric and adult tumour. So, this is, Annalisa, for you.

Dr Trama: Thank you, Andrea. If you can go back to the previous one, because very quickly I just want to reinforce what you just said, because the issue is also that when we deal with AYA there are differences in terms of the type of cancers also between males and females. You can see that the number of cases is much higher for the females than for males. This is only due to the type of tumours that characterise this type of population. So, you can immediately see that as the age increases, we are going towards the carcinoma type of cancers. And when we are dealing with females, you know that we are dealing mainly with breast cancers and with thyroid cancers and with melanoma. In males, we can see that one of the most relevant type of tumours, in addition of course, to the haematological and the sarcomas, is represented by the Gonadal germ cell tumours, so, basically, the testicular cancers. So, different type of tumours for a very specific type of population. If you can go to the next one, Andrea. And we are happy to talk to you about AYA, because the incidents which basically means the number of new cancer cases is increasing for this population. We are happy that we're not talking about common cancer, so, they are rare, in the meaning that there are a few young patients that develop these tumours. However, the number of young patients that are diagnosed with cancer is increasing all over the world but is increasing especially for Western countries. As you can see from the picture B in this figure, the incidence and is increasing for different types of tumours and especially for those related to lifestyles including diet. So, of course, this is really something that should make our bell ring because we need to pay attention also to the prevention of these types of tumours in these patients. And if you can go to the next one, Andrea. This is again, is to show you why we are discussing adolescents and young adults, the survival, which basically means the prognosis of this tumour is quite high because when we look at all the AYA together group, the survival is about 80%.Here we are looking at five years survival that basically means if we take a cohort of patients and we follow them from the diagnosis up to five years after the diagnosis, 80% of these patients are still alive. And if you can go to the next one, Andrea, this is the problem that really, we would like to start discussing today. That when we compare the same tumours, so, for example, leukaemia or soft tissue sarcoma. When we compare the prognosis of a tumour in adolescents and young adults with the survival of the same tumour in children, what we realised from our epidemiological study is that the survival in adolescents and young adults is lower than the survival of the same tumour in children. For example, for the acute leukaemia the survival in children after five years is 86% whereas in AYA is 55%. And unfortunately, it's covered by the rectangular, rhabdomyosarcoma, a very typical tumour of children. Here, we also see a great disparity because in children the survival for rhabdomyosarcoma is about 76%, whereas in AYA is 40%. So, our question, is, why? Why in AYA the prognosis is lower than for children? And if you can go to the next one, Andrea. This is only to say that the problem is very specific for children, but there are certain tumours for which the AYA have a worse prognosis also compared to the adults. And here, I'm referring basically to colon and to female breast cancers. Those that deal with breast cancers may already know that breast cancers in young adults are often more aggressive from the biological point of view. So, the biology of tumours is something relevant, but it's not the only thing Andrea, it's back to you.

Dr Ferrari: Yes. And I think I've already introduced what is the major problem of the discussion today. We often say that AYA in some ways are in a no-man's land between a paediatric and the other worlds of oncology. And this is paid in some way by the patient. So, what are the reasons for the inferior survival of AYA? Of course, often happens in oncology, there is multi-factorials explanation and Annalisa already introduced the concept of the possible differences in tumour biology. We know that for many tumour types, where we found an inferior outcome for AYA, this may be related to a more aggressive intrinsic behaviour of the tumour, a different biology of the tumours, but we know, of course, that many times, this inferior outcome may be related to the difference in clinical management. This is just to remember one of the aspects of the clinical management that may be important in AYA, in particular, for adolescence, for the younger patients. It's the symptom interval, the diagnostic delay. This is just an example of a type of study we published some years ago that showed the time from the first symptom up to the time of the final diagnosis and so, the start of the treatment. And you can see here that for patients from 0-14, for children, the medium interval time was 47 days. While if you look to adolescence patients, those between 15 and 21 years old or something like this, the delay was 137 days. And so, we try to understand why we have these differences in symptom intervals. This may be related to the insufficient awareness that cancer may occur in this age group, among young people because young people does not go to the doctors, that they don't want to show their body to a doctor, for example, but also, the insufficient awareness that cancer may occur in this age group among physicians, because there is also a diagnostic delay due to the fact that the first physician that see the patients do not think about cancer, do not refer the patients to oncology centres, and so, the complex pathway to diagnosis. And another aspect is the limited participation in clinical trials. You can see here very well in this slide, from 5 to 34% of AYA patients are enrolled in clinical trials according to the different published studies. And this picture, on the left, is very nice, very clear. And we often show this picture. You can see in the orange column the percentage of the patients that are treated within comparative group trials. This is a figure from United States' groups, but it can be useful for Europe, it's quite the same. In blue, in light blue, you can see the patients that are not treated within the trial but are treated within comparative group institution. While in yellow, you find the patients that are treated out of clinical trial, out of referral centres. So, you can see that for most of the children, the majority of the patients are treated in comparative trial or within a referral centre. While after the age of 15 years, so, and then after the age of 20 years and so on, most of the patients are treated out of clinical trials, out of referral centres. And we can have many reasons for these limited participation in clinical trials. You can see here listed, less availability of trials due to the rarity of cancer types, less awareness of available trials by physician, the trial exists but the physician does not know that he can send the patient to clinical trials. Age barrier as an ineligibility criteria (eg, the trial may be open for patients more than 18 years old and the patient is 16). Young patient treated where relevant trials are not open or cannot be accessed or also, the trial designs are not suitable for young people, lifestyle, and commitments. And with the figure on the right, you can see these two columns the figures very, very similar, the U shape of the column. The first in blue is the number of patients in technical trials. And in green you can see the average annual percentage change, that means how we can improve our survival, the survival of our patients in a five-year period. And you can see that the two curves have exactly the same shape. This is for you, Annalisa, yes.

Dr Trama: This is just to support what we had already said, which basically stress the importance of the place of treatment and to refer AYA to centres of expertise. These are the results of a study that we did in Italy where we tried to assess the expertise of the centres treating adolescents with sarcoma. AIEOP is the Italian association of paediatric oncology. So, on the left figure, the bars represent the centres of AIEOP, whereas in the right graph, you see the hospitals that are not AIEOP centres. What we try to stress with these figures is that if a patient with a sarcoma, if an adolescents with sarcoma are referred to AIEOP centres, you can see that almost half of them will be treated by two centres of high-volume which basically it's a typical proxy of expertise, because it goes without saying, "The more patients you see, the more expert you become." Especially, if you're dealing with such type of cancer. If an adolescent with sarcoma is not referred appropriately to an AIEOP centre, to a centre of expertise, he will be treated by centres which have an average of a very low number of cases, which basically means by not necessarily experienced doctors. Which is exactly what we don't want to happen to adolescents. And if we can go to the next one, Andrea. This is a similar study done for melanoma in adolescents. And again, you can see the huge number of centres treating adolescents with melanoma. And again, the red dots represent the AIEOP centres, whereas the black dots represent the non-AIEOP centres. Melanoma it's a very complicated type of tumours because, of course, it can be seen at the beginning not only by oncologists but also, by dermatologists. So, the problem of the huge number of centres treating adolescents with melanoma, it's a huge problem. And again, this figure shows that the number of centres treating adolescents with melanoma is really too high in Italy, which basically imply low expertise. Andrea, if you want to add something, otherwise, it's back to you.

Dr Ferrari: Yeah, this is just again, to remember you can ask questions also comment at any time. And this is another important aspect of AYA patients that really caught the rise of this age category. We say that AYA are characterised by a long list of different specific characteristics that, say, the specific epidemiology. We say the difficulty of enrolment in clinical trials, the problem of delay in diagnosis. And another important aspect is the unique and often unmet psychological needs, the psychological fear of our patients that includes many experts related to the physical changing of the sexuality, the development of identity, relationship, independence, privacy risk-taking behaviours and that's all. And we often wonder how we can respond to the needs of AYA with cancer. And we learned it in these years that we should ask ourselves if we really know what are their needs. So, we must learn to let our patient to be the ones who tell directly their needs. These are very, very important aspects. And so, we know that the AYA patients have the right, of course, to receive the best possible treatment. AYA patients have the need to a physician that knows that treating adolescents with cancer is very different from treating cancer in adolescents. And I like this figure that shows that each young patient is not only their disease, but also their passion, their friends, their family, their career, a lot personal. AYA patients have the need of shout in fury their anger for what's happening. And they need to smile at life. AYA patients have the need to overcome their limits, they have the need to play football with their friends, and they have the need to be serious when this is needed. And again, these are pictures of our patients. AYA patients have the need to be superheroes but superheroes with super fragilities. And they have the need to think about their future, not only a future related to the date of the next cycle of chemotherapy or of one day when they are dismissed from the hospital. And the need to follow their dream. AYA patients have the need to sing their song, and in their song, they need to remember the companion lost during the journey. AYA patients have the need to protect their privacy, to protect their space, physical and mental and they need to show their happiness and their beauty, and so much, so on. So, what was the response, the answer of the scientific community in Europe to all these troubles, all these needs for this patient category? So, some years ago, the European Society of Paediatric Oncology, the SIOP Europe established a formal SIOP-E AYA Committee. And later on, a joint SIOP-E/ ESMO AYA Working Group was launched, that means adult and paediatric society working together, would add together their mind, expertise, their resources, in the foundation of a working group. And I'm personally convinced that this is a critical step to work together to really face the need of the patient in this age group, a full track cooperation of adult and paediatric oncology working together. And the ESMO SIOP-E Working Group was initially founded for mainly educational purposes, to raise awareness and train adult and paediatric oncology communities to enhance and exchange knowledge on specific AYAs, to organise joint programmes integrating adult and paediatric oncology groups. And of course, ultimately to improve the standard, the point of care of AYA patients with cancer of Europe. And in the years this effort evolved with both international societies recognising the different needs of these patients, with idea to working also in a way to influence healthcare policy regarding AYA cancer, so all the schemes are at national and European Parliament level. And one of the first action we took was a survey. We tried to understand the different training and different tactics of European healthcare provider regarding AYA. And so, to try to understand the availability of specialised service for this age group. And we had interesting results because the survey revealed a severe under-provision and inequity of specialised cancer care for AYAs across Europe, with over two-thirds of respondents reporting that their patients had no access to services specifically for AYAs with cancer. And that such services were still not being developed. And the figure was different in different European countries. The figure rose to 87% in Eastern and South-Eastern Europe while it was around half percentage for Western and North Europe respectively. And then, a great effort, a great goal for the ESMO-SIOP-E Working Group was the publication of this position paper that summarises the challenging aspects of managing AYA with cancer. And this position paper illustrates the vision shared by the two scientific societies on the subject and became an important tool for raising awareness on the need for age-appropriate specialist services to improve cancer outcomes. And in the position paper we identified two main areas to work on, first, the access to clinical trials. The second, the definition of the minimal essential requirements for AYA cancer centres. We already said in the first part of the presentation, how the prior access to clinical trials was important for patients in this age category, and we believe we really need a multifaceted strategy to try to face this problem. That means think to trial design driven by drug mechanism of action and not driven by eligibility criteria, for example, related to age. The inclusion of adolescents in early phase I, phase II clinical trials from puberty and not from 18 age cut-off, the adult cut-off. On the other phase, the inclusion of young adults in paediatric protocols for paediatric type malignancies. And the concept to try to encourage multi-centre in paediatric, adult cooperation reducing competitive protocols. And to raise awareness, we said also among the public and among healthcare professionals for the importance of clinical trials entry for AYA. And then, to engage AYA patients in the design of research projects. And for the definition of the minimal essential requirements for AYA centres that means what are the characteristics that a centre should have to work with AYA. We have a long list of different characteristics, I'm think for example, to the flexible age range for access to AYA cancer, the clinical trial availability. But what is really important here is the concept to have a large multidisciplinary team with professionals from different clinical discipline and in particular, the involvement of both, paediatric and adult medical oncology. And of course, a specific staff training and continuous professional education for people that want to work with the young people. And this is just to say that we need a lot of experts that should work together to properly take care of AYA. That some coming from the paediatric team model. We have the triangle from the patients, the parents, and the paediatric oncology, and a lot of different professionals working together within the paediatric oncology, and a different model used from the adult, and we can try to take the best from the paediatric and the adult model to have a specific AYA model, thinking to what are the characteristics and the needs of the patients, we already showed you before. And so, for example, thinking to the complex communication challenges, the shared decision-making, the compliance, and written address, but also find a way to give young people voice and choice. So, the importance of partnership with patients' advocates. And so, we say that we want an analytic approach. And I like the sentence that says that what we learn from our patients that comes at times, and the thing is that you should want to work with AYA, this time should come also for you, when clinical trials are not enough. And there are other things, you can see here, at least it means the way to really stay with people and spend time together with them, sit on the floor with them that we cannot leave to others. And this is just to come back again to the European scenario and say that SIOP-E and ESMO then recognise that we need other societies, other people working together with us. And so, we created the ENTYAC, the European Network for Teenager and Young Adults with Cancer. That means wider engagement and it can be seen as a sort of federation where existing healthcare professional societies, and so, SIOPE, ESMO but also nurses' societies, psychology societies and so on. The different national AYA professional groups from UK, France, Italy, Spain, the Netherlands and so on. And then, all the other stakeholders, Non-Governmental Organisations, patients' advocates, and their families can try to work together, cooperate, and grow for the patients in this age group. Annalisa, please.

Dr Trama: Thank you, Andrea. And this is my last message for today. because I told at the beginning, that survival is high and that I'm happy to say that AYA cancer survival is increasing. However, this brings up another problem, which is related to the amount of survivors that are arising in Europe and all over the world. If you can go to the next one, Andrea, please. And why is this a problem? Because unfortunately, as it has been shown in children with cancer, also in AYA, the treatment and the cancer per-se, together with the lifestyles can have an impact in the long-terms. And the impact, unfortunately, turns into a higher risk of hospitalisation which basically means a higher risk for comorbidities such as cardiovascular disease, subsequent neoplasm etc. If you can go to the next one. I think it's important to really know better, which are these types of diseases that can occur after a cancer diagnosis, when a patient is considered cured by his cancers. Because, of course, these imply that AYA cancer survivors have to be properly followed-up for later consequences. Of course, not all of them, because late impact depends a lot from the intensity of the treatment received. This is just an example showing that in the end, there are almost three or four tumours that can explain most of the second primaries that can arise. That basically are breast cancers and digestive organ cancers,in females, and digestive organ cancers in males. This basically means that there are specific tumours for which a dedicated type of surveillance should be recommended and not in general for any type of tumours. So, always more and more studies are needed to properly quantify the risk in the long-term for AYA cured patients, but also, to properly identify those that are at the higher risk of co-morbidities including secondary cancers, because we don't want to force all cured patients to be strictly followed-up, when not necessary. So, the proper identification of the patients that need to be followed-up is another key important activity that have to be kept in mind, in my opinion, for AYA patients And I'm done. Andrea, we can skip this one.

Dr Ferrari: Okay. This was the last slide. And we are in time. So, we have 10 minutes, if you want, for discussion. And please, any question, any comment?

Dr Trama: Andrea, we don't have any question in the Q&A session, but I was wondering, since you are an advocates and actor which is the barrier in the collaboration between adult and paediatric oncologists? And how would you suggest to destroy, in a certain sense, this barrier?

Dr Ferrari: It is quite difficult to say, because in principal, there shouldn't be a real barrier for working together also, because the cooperation maybe it should have a synergic effect because, for example, I'm thinking to the experience that paediatric oncologists have in working on cooperative group or network, we started 50 years ago to build a national cooperation, international cooperation, this may be very helpful for the world of adult oncology, it's more complicated from this point of view. On the other side, the great experience that the adult oncology world has in developing new projects with every phase, I phase-II trials new drugs, and target therapies that are lesser used in the world of paediatric oncology. So, working together may be, of course, the solution, but sometimes, there is a barrier related to culture, related to different knowledge, related to the fact that we speak not the same language, or we don't have the same goals. I think that hand in hand also, the human factor is important. So, when you find the right person, the right people that believe in a project, believe in a concept, then it's easy to work together. If you don't believe in the AYA concept, it is difficult to find a way to work together. But I believe that a lot of improvement has been done in the last years. And the fact that now we have an ESMO SIOP-E Working Group for AYA is rarely very important. I've seen no questions, seen no comments?

Dr Trama: From the audience? Andrea, if someone is interested is there a way to get in contact with this type of group at European level? How, you know, maybe an oncologist working at country level can take benefit from what is ongoing at European level? If you can give some information.

Dr Ferrari: Sure. Okay First we need the new blood dedicated and energetic people. So, I don't know, who is in the audience, but if there are some young people that are interested in working on this field, we are looking for interested people. We are restructuring the SIOP-E and the ESMO Committee, including new people. So, if you're interested, please, you can start sending an email to me for example. If we think on a national level, I can say that yesterday we received a request of cooperation for a new Greek group dedicated to AYA, and we are very happy to involve them in the entire group where we are thinking to a federation where all the different AYA groups can work together. Also, the good experience, for example, we had in other countries, may help a new country not to repeat the same mistake, for example, or to build a specific model. For example, we learned in Italy very much from the UK experience. UK colleagues who were the first to have AYA dedicated project. And so, we benefited from other people, other projects, other countries, maybe, for us. So, there's really lot of reasons to try to join the group I presented you.

Understanding is also late in the evening. So, I don't know, if there are no other comment and questions, I suppose that we were very good in presenting the challenges and the controversies in the programme AYA with cancer.

Dr Trama: Or we were so bad that nobody has a question?

Dr Ferrari: No, no. Okay. I believe we can close the session, and this is the e-ESO picture to remember what is the next e-ESO Session for next Friday, okay.

Dr Trama: Then, thank you for joining us, and hoping that you will embrace this topic in the next years of yours.

Dr Ferrari: Okay.

Dr Trama: Bye-bye.