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Comprehensive cancer center - structure and functioning

Dr Lambertini: Dear colleagues and friends, welcome to this e-ESO session. My name is Matteo Lambertini, I'm a medical oncologist and Associate Professor in medical oncology at the University of Geneva, San Martino Hospital. And it's my pleasure and honour to be at this e-ESO session with Assia Konsoulova from the Complex Oncological Centre in Burgas, Bulgaria. We're going to discuss in the next 40 to 45 minutes on a very important topic in these days of a more complex oncology care we are facing in our clinic. So, we are going to discuss Comprehensive Cancer Center, the Structure and Functioning of these comprehensive cancer centers. So, thanks a lot, Assia, for being here. The floor is yours for your presentation. And then, I already have a few questions before starting your presentation. So, I think it's going to be a very interesting talk, thank you very much.

Dr Konsoulova: Thank you very much, and I would like to thank e-ESO for the opportunity to talk about Comprehensive Cancer Center. So, in fact, I had just a touch with this possibility to work in several comprehensive cancer center, which is not a routine practise in many of the Eastern European countries. So, that's why we chose that topic as quite interesting and something that we hopefully will implement also in our corner of the earth. So, I'm currently working at a center that is taking care of patients, but what does comprehensive cancer center means and why it's needed? It's needed because we not only need quantity but we also need quality in oncology, and we need to have clear definition, how should the center work and what should be achieved as result. So, we need to have a certain kind of standardisation. So, the same patient with the same disease, is it possible to receive the best optimal treatment? And like this, we can assure the quality of this treatment, according to the evidence-based practice that is happening worldwide. And the idea is that this center is functioning for long-term. So, patients know that they will have the best treatment available and in order to have this, they don't need to be in a specific country, but this can be a center that can be organised, working, functioning, and being sustainable during long-term. Only if it's certified, if it responds to and meets several standard criteria and standards and these standards and criteria, they gradually change. So, we need to re-certify those centers and we should have measurements and quality-control to verify that this is really a comprehensive cancer care. So, comprehensive cancer care leads to benefits to the patient. That's well-proven that we well know that by treating patients in such centers, this is really beneficial, not only for the patient, but for the entire healthcare system and for oncologists as well, because this makes clear pathways, clear results. And there is evidence-based, already, data that patients live longer with a better quality of life. In to achieve this, there are some challenges, we call them. We don't call problems. We call, this is quite a nice word, challenges for the cancer care in Europe. And as I'm coming from Eastern Europe, I wanted to emphasise on what might be a bit different in our corner, because we know that cancer care is an improvement, and this is not a new topic. The cancer care is getting gradually better and better. And there are achievements with many EAC programmes of different institutions, or, for example, the European Union and the European Act Against Cancer programme. And there is a partnership with many

organisations that were launched in previous years, in 2009, after the European Commission published its first communication. So, we have many standards and good practises that show how the standardisation should be done. And we recently had the launching of the European Beating Cancer Plan that was started to be prepared in 2021, and this should be implemented. And there are some countries that are a bit behind. So, this remains a challenge in those countries, especially, in the Eastern Europe, where we have a continuous rise in incidents and mortality. And this is forming a gap that is quite well-seen in the Eastern European countries. This leads to inequalities of many types, inequalities to drug access, to cancer care, to type of care accessible to patients. That leads to difference in the results that those patients might obtain in the different cancer centers. And we know that if they're treated in a comprehensive structure, everything is well-organized and is functioning much better. And again, the gap here is quite large if we compare Eastern versus Western European. We have additional, many other challenges because we know that the guidelines that are well-published, they are well-formed. There are recommendations on how should a good cancer center or comprehensive cancer work, but this is not adopted everywhere. And this is not implemented because, in most of the cases, being a comprehensive cancer center is not a mandatory demand, but it's recommended or it's preferable to certify the cancer center. So, this is not adopted universally across Europe. There are sufficient resources for cancer care, but in many countries, as in mine, for example, in Bulgaria, most of the finances that are spent for cancer care are spent for drugs and not for care of the patient or for other procedures such as screening or early detection of cancer, and quality assurance and control across from the very entrance of the patient into a cancer center to the palliative care is assured to the comprehensive cancer center, which is not really happening if the center is not certified. So, this leads to insecurities in some of the centers. And if this is getting to a moment where the center obtains the certification in a specific cancer or in total as comprehensive cancer center. So, this need leads to the sustainability of care in the entire cancer center. So, I have put those two slides on purpose and they are related to survival by country and by cancer sites. And I've tried to give an example to women and to men, and I've chosen the Eastern European average and compared to the European average. So, if you see there is quite a difference in survival, both, for example, for breast cancer in women and in male for prostate cancer. And sometimes, this gap between survival is 15% to 20%, or even sometimes more, between the average of a European country. And so, it means that if a patient is treated in a certain region, this is a negative factor for their treatment. And one of the ways to overcome such discrepancies and disparities is by treating patients in a comprehensive center. So, these are problems that need to be addressed. And by addressing those problems, we know a certain level where to start and how to make things better. So, to develop, to organise, and to implement the thinking of a comprehensive cancer center is mandatory. This has happened across a lot of countries in Europe, but it's a process that is taking some time and is just starting to happen in Eastern European countries. And we know that we have international standards and guidelines, but they should be adopted according to the local practises, the local best clinical practise and guidelines, so that different pathways are developed for the specific cancer center and they are followed, which will lead to, hopefully, improvement of the outcomes of the patients in the cancer center. By having those rules and pathways and strict frameworks, this might lead to strict accreditation process. So, giving the features that a comprehensive cancer center should have as quality, as organisational structures, as access to the different types of diagnostic and treatment procedures that is needed, currently it's voluntary, but there are many more discussions that if we want to obtain certification, that these processes should be related to the center and there should be an intention to make this regular. So, the certification should be regular and it should be compulsory for the center in order to obtain the final document, which is not just a piece of paper, but this is a certification that it's driven by professionals, but it's also regulatory confirmed that this is a comprehensive center and there is a framework that is working and there is a quality of standards. There are different systems for certification. There might be either by a specific organisation, a cancer organisation. It might be by a specific cancer society. For example, for breast cancer, there are different initiatives and different quality frameworks that standardise the treatment. Or it could be a programme as given the example of NICE, the national institute for care programme, which is functioning in the UK. So, these are different kind of certification systems among which

there are certain similarities that we're going further to discuss. I'm taking the moment to use this slide because we will not be having the time now to ask the questions and answers. But as I know, Dr Lambertini has prepared some and probably we will discuss it at the end of the session, right?

Dr Lambertini: Yes. We will discuss at the end of the session. And I think people attending the session, this is a pre-recorded session, but of course, we would be happy to answer any questions by emails.

Dr Konsoulova: Okay. Thank you. So, moving on to the comprehensive cancer itself, by being comprehensive, the center should be able to ensure integration of research and clinical care, because we all know that the best clinical data comes from clinical and translational research. So, implementing research into clinical practise is essential. We also need to assure the entire patient journey, from the very first moment when the patient enters into the center, to the moment of treatment and supportive or eventually, palliative care. So, it means that the center should be able to treat the entire cancer, or in the best situation., the entire center can be comprehensive and has the possibility to treat almost all cancer optimizations. I'm just taking the moment to say that sometimes it might be a specific clinic or department that might be certified. For example, the breast cancer center can be certified as a comprehensive center. And by being comprehensive, the center should acquire all knowledge and implement clinical research into practise. But this should be also the mainstay for people who are working there, the entire medical team, to continuously upgrade and disseminate the process of learning across the different cancer types into other centers. So, it means that the center should have the expertise, the training into these processes, and be able also to ensure that such translational or clinical research is done in the center, as well. So, this means that this center is recommended, affiliated to research institute or university so that this can be a continuous partnership. And this research is not only being held and done in the center, but is also disseminated, which means that we need an extensive network, national or international, so that it is a process that is continuously happening. I've taken this from the site of OECI, where we have the definition of cancer centers. So, this is one of the European Organisations for the Cancer Centers. And we have the comprehensive cancer center as a separate entity, just to compare. It's not only volume that is different in the comprehensive center compared to the regular cancer center. It's not only the number of patients, but there are also specific criteria for participating into the daily process. Especially, it's a number of people and a number of patients to be taken care of. And also, the complexity of care that should be offered at the center. So, there are certain numbers here on this slide that, for example, I presume it's not mandatory for the entire cancer center, depending on which country it is, but the idea is that this is sustainable across and along the years. And this is approaches that leads to dedication of specific budget for further research, meaning that the center is well-insured. What is really, really interesting from my point of view, there was also a discussion that the number of newly-diagnosed patients should be criteria for quality in the comprehensive cancer center. So, those new patients here are listed as a total number, but if we speak about the specific clinic, we are approaching to the highest number possible of new patients treated in the center. This means that this is really a structure where innovation is working and happening. And there is not just a constant number of turnover of patients, but there are many new patients that come to the center that are treated. So, this is an organisation. The comprehensive center is a living organism that is continuously growing. And it has several essential features, which means that it's clearly a well-structured and its function is easy to organise and to follow. And of course, to detect what is happening during years. So, the innovative character of anything that is new, the multidisciplinary discussion is essential. And this uses every basis that we have from, of course, clinical and basic translational research, but also, from the participating different entities into this comprehensive cancer center ensures that real multidisciplinary, not only by paper, leading to a real discussion on a regular basis with different type of specialists that are present, not just signing a piece of paper, but they're participating in the discussion, which leads to an increase in the quality of the multidisciplinary discussion. And this leads to a different point of view. So, when many heads think together, they manage to have the comprehensive knowledge to tailor the patient's pathway and direct the cancer care into the best possible direction. So, not only treating patient, the comprehensive cancer center should be both from the very moment of potential

prevention, because we know that there are many cancers that can be prevented. And this might be either by our education, by screening programmes, or by just dissemination of knowledge across people. So, this is a responsibility for the cancer care. So, there should be the infrastructure present for probation, for innovation, for screening, for research. And if it's needed, this should be in a network, in a system, ecosystem, I would call it, with other centers or research institutes so that we find patients easily, we screen them, we find them even without having symptoms for their disease. And this might lead to earlier detection of the disease and of course, better success in the treatment. So, it means that from the outpatient setting, there should be the rapid and direct connection to the wards of the cancer center and a possibility whenever a patient is in need, whenever a screening, for example, subject is being detected with cancer to be rapidly integrated into the system of diagnosis and the pathway for the patients. So, this means that this is a continuous process that needs to be continuously developed, and it should be well-organized with existing quality standards that are well-designed to satisfy the different recommendations. By having those standards, those centers can be accredited. So, saying that, yes, we have the standards and they are high-quality. And there is a certification example with, for example, with OEIC, which is sponsored with the International Society for Quality Healthcare. So, the evaluation association. So, there are different organisations that are intended to deliver, to assess the cancer care that has been delivered to the different centers to evaluate the level of care and the standards in order to homogenise this process across different centers. And of course, I'm giving the example of EUSOMA. This is specifically dedicated to the breast cancer center, which has been one of the first to be certified. And one of the most impressive publications leading to the fact that we have the proven data for increasing the quality of cancer care and survival for patients. So, just to summarise again, in emphasising on the processes that need to be present in the cancer center. So, the need for quality, for well-defined quality frameworks, for well-defined pathways, definition requirements that needs to be fulfilled, the multidisciplinary team that should consist at least of the basic core of specialists, sometimes, depending on the need of the patient, there should a larger community of specialists that might also join the MDT. So, in order to assess the quality and the quantity of the patients, we should have a critical mass of patients that is treated. Because we know that by having many patients, this leads to cleaning of the problems and the challenges during the pathway, and it's easier and patients get easier and well treated. And this also is making the entire structure well-organized and all the time supplied by patients, so that this leads to improvement in the quality of the treatment of patients. We should have education and training for the patients inside, for the medical and nonmedical specialists that are working at the center. And there should be also minimum of clinical research. They should be registry. And if possible, data managing the result. That data from that center can be extracted, can be interpreted, and this should be able to draw conclusions. So, not only to be registered in a passive way. In fact, the definition of a comprehensive cancer center is that it's a place where cancer is diagnosed and treated. This is the cancer center, but it has to provide all services that are necessary from the very beginning, from genetics and probation, through the entire pathway, including additional care for the patients. Because we don't treat the cancer disease of the patient, but we should treat the entire patient as well. So, we should also include care about survivors or psychological support. And there should be clear structure of the center, who is doing what in the center, and this should be related to extensive care availabilities, leading to the high-quality from the very diagnostic. And this should be tailored to every patient. The comprehensive cancer center in Western Europe and Eastern Europe, or in Africa, might have different necessities because we know that we have also local cultural and other problems that need to be overcome. So, the cancer center might be an example, but it should be adapted to the local organisation and quality of care in order to function well. So, moving further, we will be discussing some of those questions later on, whether this comprehensive cancer center should variety largely across the different countries, but maintaining and sticking on the most essential characteristic. Besides having the clear structure, it should be also planned for the future development of the comprehensive center, because we know that sustainability of cancer care and the prediction of every potential problem that might occur is valuable. Of course, there are sometimes troubles that appear later on. For example, as the COVID pandemic really led to a problem that was unpredictable. So, there should be

rules where, when there are such situations, patients should be managed. And the cancer risk, for example, might be stratified into different categories. So that it's a process that is as smooth and easy as possible. So, this is a continuous progress that is planned, and it's a cycle that needs to create a strategy that is a multi-year. It's not only the functioning of the center during a simple year, but a long-term, including some finances that are developed, dedicated to research. So, the financial sustainability and networking with other partners is also essential. We spoke already about the cooperation with external parties and universities in order to disseminate the knowledge and the results of the cancer center. But what is important is also its quality, how to assess quality, how to certify, how to be sure that what has been done in the cancer center is fine. And how, for example, this should be measured. There are different quality measures. I did not put any of those, just a simple example. For example, the time between the first visit to the center and the time to definite diagnosis, or the time from definite diagnosis to the first treatment, this is a moment of time that might take sometimes months. So, if there is quality, if there is possibility to treat the patient, as it should be, this means that there should be shorter waiting times. And it means that this process is smooth and can be ensured by the number of patients and the critical volumes that are able to be treated in the cancer center. Most recently, the discussion of the participation of the patient has been very largely implemented, because long years ago, the patient was a subject of which different cancer treatment were delivered. Whereas now the patient is included in every step of the process, from the very diagnosis to the discussion of the treatment. So, there should be participation of the patient, and they should be involved in the process of the diagnosis, the treatment decisions, and the organisation of the treatment or retardation. This is a long process that is always passing from the multidisciplinary team. And it's according to the best clinical practise available. There should be the possibility to prevent certain, either complications from treatment, or risk-reducing strategies. Because we know that sometimes a cancer patient counts, but there are many people around them that might be potential cancer patients. So, they might be subjected to risk-reducing strategies. If you have, for example, molecular diagnosis, or if we have suspicion that there is some genetic background for that particular patient. It is also very important, there is large discussion, and there are several countries that know already that the right to be forgotten law has to be implemented. And this is related to patients that were treated and that, for example, have no longer their disease. Or there should be any other aspect of the process of treatment that should be ensured in the quality center. I've just given a simple example from the breast cancer center. And this is from the use of requirements of all the details that I'm not going to read thoroughly. But the idea is that there is a minimum number of patients that are treated by a particular specialist, and there are minimum quality care. For example, one of the things that is really quite impressive is that there is a minimum target. Minimum of 90% of all breast cancer patients that should be discussed in multidisciplinary team, and this percent should be at least 50, but it's also much higher for all metastatic breast cancer patients. It means that every patient, besides the fact that the next treatment might be relatively projectable and relatively easy to determine, these patients are subjected to discussion in the MDT team that's sometimes might be dedicated to early or to metastatic breast cancer. But this ensures quality for every patient. And this means that there are patients that can, for example, be easily seen and detected and treated in a clinical trial when there is this real discussion at the MDT. So, the idea of the comprehensive cancer center is finally to improve quality and to provide the comprehensive cancer center. And this is in Europe. This has happened in many centers across Europe. This is happening in many centers across Eastern Europe and other countries of the world. So, this is my last slide when I'm emphasising on the fact that currently the certification and the comprehensive cancer structure thinking is voluntary. And this is something that probably will be the very good first question from discussion, should this process be voluntary? So, thank you for your attention and looking forward to the questions.

Dr Lambertini: Thank you very much, Assia, for the comprehensive lecture. You have touched on a lot of very important topics, on something that it is and should be our usual care every day. I think there are three key-words you have highlighted in your presentation regarding more in general, the comprehensive cancer care, more than just going into the accreditation of the center, which is care itself. So, caring for the patient. And

on the other side, it's research, the importance of research, especially in the oncology field and education as well. So, these are, I think, three key-aspects that you've touched upon. And I have a few questions on all of them. But before going into these three topics, I have a general question that we discussed also before this session. I would like to have your kind opinion on the cancer-specific accreditation versus a more general accreditation. Because you have mentioned, for example, the EUSOMA criteria. So, a center may be EUSOMA certified, but does that qualify for a comprehensive cancer center or should be kind of a general accreditation for all cancer types?

Dr Konsoulova: Definitely I am not the best person probably to discuss on this topic as I'm not working in a comprehensive cancer center. Even though we are trying to provide comprehensive care, I think that accrediting or organising the comprehensive care in a specific cancer organization is the first step. So, it will be great if you can certify an entire center and having all cancers treated comprehensively. It would be wonderful, but it means that there has to be a large structure. There are structures like that, that an entire center is certified, but this is a different approach because by certification of the entire center, it covers much more general criteria. Whereas for example, as you mentioned, the EUSOMA criteria, there are specific numbers of patients or procedures to be done for the specific cancer organisation, which might be most adapted to the breast cancer patient. For example, if you have the certification of a breast cancer ward. So, in my opinion, both are valid. I think in your institution, it was the breast cancer center certified or the entire center?

Dr Lambertini: Actually, it's the entire center certified by OAC. So, we follow the OAC certification process and we are already preparing the documents for the new accreditation in a few months from now. Of course, we have the EUSOMA criteria for the breast unit, but it's a more general. It's a comprehensive cancer center for all tumour types. So, not only a focus on breast cancer, of course, we are really oncologists taking care of cancer patients here. And we are being a large center, comprehensive cancer center. Indeed, we are organised in different units, managing different patients with different diseases. So, have mostly the breast unit, but we have, of course, all the other entities. I think that this goes very well to my first question on the multidisciplinary care, which is kind of mandatory right now, everywhere in the world for all patients with cancer. It's scientifically proven that patient treated in centers or in organisations with the MDT structure are treated better than those outside the MDTs. So, providing this care, of course it's crucial. And I think this is probably even beyond the certification of the comprehensive cancer care. So, you don't need to be a comprehensive cancer care to have MDT management of the patient. So, this goes with my question. Of course, not all the oncology units can be certified as comprehensive cancer centers, but we need, and we must, provide multi-disciplinary care. So, something that we have, I work a lot in the onco-fertility field, and we have pushed a lot, for example, in this field, into the concept of the so-called hub-and-spoke model. So, you can provide onco-fertility service, even if you don't have an IVF fertility unit in your center. But you need to create this kind of network in order to refer patient interested in preservation strategies, for example, to hub-center for fertility. So, this is something that I think that this is one of the challenges that you have mentioned. What do you think about this system and in Eastern Europe as well? Is this the way to move forward? Also, in other subspecialties of oncology, so, not only onco-fertility, of course.

Dr Konsoulova: As you said, this is in fact kind of a networking, because whether you do this procedure at your center or at the center nearby, I guess you have a well-established pathway, how it's happening, how it should happen and the timeframes are relatively similar. So, the idea's that you provide the same quality with the different centers. Networking is probably one of the not well-developed and developing qualities of Eastern European centers, because frequently many centers are working separately and they don't... They of course work together. But this depends on the good will of a particular physician connecting another physician. So, there is not a real established pathway, which is just the example that you give. Because as you said, when the entire center is certified, this is a way of thinking. So, very frequently in our countries, it happens that we tell the patients what they need. We tell them where to go and the patient does this for

themself. You need to have a well-established pathway; it means that the patient gets more difficulty to get lost. So, the patient knows the way, and he is directed to an area where what is needed. For example, the onco-fertility is well-organised because you also depend on times, you depend on cycles and days, so you don't lose time for the particular patient. And that's why having everything in the very same expert center would be great. It will be the best if you have enough doctors of everything that do anything in the center with great devices and possibility to do any type of testing and imaging. But having access to such structures in wards it's also essential, because, for example, Bulgaria is a small country and some things are not done in all the centers. But if we have a well-organized system, this is crucial, and this is something that needs to happen. As you gave in the example, I can imagine this is something that is organised in your institution, right?

Dr Lambertini: Yeah, yeah, exactly. That was the point I wanted to stress that, of course, for accreditation, it's what you have discussed. But at the end, we all should give comprehensive cancer care. And I think this is a system that will help all of us, no matter where we are in providing this type of care if we have the network that we have just discussed. I think that the care of patients with cancer nowadays is so complex, is so really multi-disciplinary on many aspects, that is impossible to do everything by ourself as medical oncologists. And the onco-fertility field is just an example of this hub-and-spoke model. We don't need a fertility unit next to each oncology unit. But the same would be for the cardio-oncology service, for having an endocrinologist helping us and manage maybe some of the side effects of the treatment, and so on, and so.

Dr Konsoulova: And if you have a large critical, we spoke with a critical mass of patients. So, if you have a large number of patients, you have to refer every day, a patient, you cannot just call a colleague and say, “please, do this or do that.” So, there should be a system that is in place, that is functioning so that this large number of patients is well-managed and referred to the specialist that is needed.

Dr Lambertini: Yeah. That's definitely a very important point. For example, going back to the onco-fertility field. We are running a prospective study here in Italy just to try to implement this network between different oncology units, with some referral centers of fertility, and we see that at the end of the day, not more than one out of five young patients is actually interested in having fertility preservation strategies. So, we can kind of manage these patients and refer only those that are really interested into these strategies. So, it's just what you have mentioned. I think going back to this point, I have one more question on the multidisciplinary care, something that's very close to my heart, to my research, to my clinical practise every day. I'm very much into the survivorship care of patients with cancer. I take mostly breast cancer patients. So, I have this mindset when I discuss this topic, but we are doing much better in curing patients. So, fortunately, we have many more patients entering into the so-called survivorship programme. I think this is something that we, and you have mentioned the word survivorship several times in your previous slides. But I think also comprehensive cancer center may not have probably the optimal system to manage this survivorship care, which is going to be even bigger in the coming years. So, what's your opinion on that? Maybe E-tools, telemedicine, can potentially help in some of this, like in managing this type of cancer care? Yeah. I fully agree that, for example, E-health technologies can help, but I would love to hear your opinion on this issue.

Dr Konsoulova: It's very interesting because the number of news cases increases. The number of well-treated and long-living patients also increase. The duration of life and the quality of life increase and the number of cured, eventually, patients also increase. So, this leads to the need for a follow-up or a long-term follow-up of such patients. And it gets more difficult for physicians who are actively involved into the treatment process to also have an active follow-up of many patients. So, I can imagine that some of those patients might get lost with time. But I think that starting from the very first moment and the long-term follow-up, that's why the follow-up is done less frequently. And we should have a certain number of follow-ups. I know that follow-up patients sometimes don't even come after 10 or 15 years because they're no longer treated and they forget about the disease. But there should be the possibility to be organised because this is not something

that needs to be organised from now for the next week. There is no urgency to organise a test or a visit. So, the number of those patients all the time increases, but it also leads to assessment, that those patients did really do well. I remember one very good situation where I had to see two patients in an emergency situation. One of them was progressing, so having trouble. And the other was somebody who came and was not seen by a physician long time ago. So, the patient that was for the Friday afternoon that was chosen was the patient that just had to be organised clinically for a longer follow-up because also physicians need to know that they're doing their job well. So, it depends on what the need of the patient is. And some of the patients, I think, probably will be good to be followed-up in the institution they were treated. And eventually, I can imagine, that most of them will be also spread along the entire system, which, if it's functioning well, will be good enough to follow them outside of such an institution.

Dr Lambertini: Yeah. Thanks a lot. Now, moving to the other two topics, which is research and education. The first question on research, which is, again, going back to improving the care of our patients, it's also scientifically proven that there is evidence supporting the fact that if you have clinical trials, if you are doing research, you actually have better outcomes. So, patients are treated better as compared to those centers that may not be very much into research. However, I think that in the current time with all these new agents coming to the clinic every day, it's becoming a bit more difficult, especially, doing academic research. So, what's your take on overcoming these difficulties, the role maybe of comparative groups? And there are very good comparative groups also in Eastern Europe as well. I think as academic community, we should kind of...like push.

Dr Konsoulova: We should be doing this.

Dr Lambertini: Yeah. Support as much as we can these comparative rules. Also, in terms of negotiating clinical trials with pharma companies. But I would like to hear your opinion on this.

Dr Konsoulova: I've read several publications where they say that the academic trials are growing in number. It's very interesting for me how it is happening. Because it's very difficult that we start to do a real-evidence world trial with drugs that we have, or just determine a specific point that needs to be seen in such trials. This is quite well known and not only because of COVID, but for example, in the framework of ESO, we met many people, we have met several times our colleagues. And this was, for example, one of the reasons to initiate a project. So, we have nowadays access to different institutions. And with the electronization of data and the reports, this is much more easily done than on paper, like 10, 15 years ago. So, this is something that is really a good opportunity for all of us to report data because we have so much data nowadays that we don't know which data we should take account for. And so we take the data from clinical trials, but this is not real-world. And we have the possibility to register data from our patient or from our set of patients. And if we really work in a cooperative group or in cooperation with different institutions, it's improving also the number of patients and the quality of information. And it's also reducing the bias of one or two academic centers. So, it would be really great and nice if we do more clinical translation research in such cooperation.

Dr Lambertini: Yeah, I fully agree. And going back to the survivorship topic we have just discussed, this is something that maybe it's not registered or not very much focus in clinical trials and where real-world evidence and the electronic medical records, as you have mentioned, can be helpful to provide some evidence in these important fields. So, yeah, I fully agree with that. And a final point on the education. Well, it's more a comment. I'm sure that you fully agree. We are still in the category of the young oncologist.

Dr Konsoulova: You think so?

Dr Lambertini: Yeah, well, I pretend.

Dr Konsoulova: Okay.

Dr Lambertini: I want to pretend to be part of it. Just where I hold the activities, for example of e-ESO, the European School of Oncology is doing in terms of education. In this regard, I've taken advantage of many of these opportunities when I was a bit younger than what I am right now. And I think this is something critical everywhere in the world. And there are specific educational opportunities, for example, for Eastern Europe. And this is something I will strongly recommend all the young people connected to, to apply for. Because education is one of the three pillars we have just discussed and being more educated in our center, it means also...

Dr Konsoulova: It also provides benefit for other centers that are a bit behind because they see that you are one of us. We are really a network, a community of young people, or younger people than us. But by doing those things together, first, we see that what you do at your center or another center, and this is a real motivation for centers that are a bit behind. And by moving forward, those centers also try to diminish this gap. Because there is a gap between the different center, but that's great to see that there is a good example that can also implement it elsewhere.

Dr Lambertini: Yeah, definitely. And education, and more education means also better care in our everyday activity behind and beyond accreditation itself. So, this is something that, of course, we should all do, especially in the early phases of our career.

Dr Konsoulova: Like a more clever man has said, that knowledge is one of the things that gets bigger when given away. So, I think this is something that's a good final for the discussion today.

Dr Lambertini: Yeah. I think we are at the end of the session. I see the time going beyond our time. So, I just wanted to thank you a lot, Assia, for the great lecture, for the very informing discussion as well. And thanks a lot to all the people attending this session. I will leave the talk to Assia for a final positive thought on this topic and for the goodbye.

Dr Konsoulova: So, I really thank for the possibility. I'm not an expert on the topic that we're discussing. I just had a brief touch, but I would like that this serves as a motivation for many people who wish to get better, because things can really be done in a better way. Things can really be improved with a single day, well with every single next day. So, I think that we try to be better by spreading this knowledge and by working together. It's a great example in this e-ESO session as well. I also thank you.

Dr Lambertini: Thanks a lot. Goodbye.

Dr Konsoulova: Bye.