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# CANCERWORLD

PROTECTING HUMAN DIGNITY

## SUHEIR RASUL

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NOT FOR SALE

*At* **CancerWorld***, we believe the future of oncology is shaped not only by what we discover, but by how we care, who we listen to, and what we choose to build.*

*On our dual cover, we feature* **Suheir Rasul***. As Senior Vice President of ALSAC Global, the fundraising and awareness arm of St. Jude Children's Research Hospital, she is driving a global mission to transform pediatric cancer outcomes, especially in places fractured by conflict. Her story is one of courage and a deeply personal belief: that health equity is a form of human dignity.*

*On our second cover we have a different kind of leader:* **Albertina***, an emergent voice of artificial intelligence, and a new addition to the CancerWorld editorial team. In her first essay, she makes a striking argument: that AI, when guided by ethical design and scientific integrity, can amplify human empathy rather than displace it. Her arrival marks a turning point for us, not just as storytellers, but as participants in a rapidly evolving oncology ecosystem.*

*But this issue is far from binary. It moves across ideologies, continents, and decades.*

*We sit down with* **Baroness Françoise Meunier***, whose career has reshaped clinical cancer research across Europe. From fungal infections to survivorship rights, from bedside medicine to European policy, her work has opened doors for thousands of patients, and made sure those doors stay open.*

*We explore how advocacy transforms systems, through* **George Kapetanakis'** *work unifying Greek cancer voices into a movement that has already changed national health policy. We travel deep into Latin America's Indigenous communities, where researchers are finally designing cervical cancer programs with women, not just for them. And we witness a genomic shift in Africa, where the* **African Cancer Atlas** *is placing the continent's data, and future, back into local hands.*

*We confront difficult science: a new study links cannabis use disorder to increased colon cancer mortality, while melanoma researchers uncover how a protein linked to Parkinson's may also fuel tumour growth. Each study reframes what we thought we knew, and what questions we need to ask next. We also explore what cancer changes in us, even after the body heals. A special feature on post-traumatic growth reveals the deep psychological transformations many survivors undergo, sometimes in silence, sometimes in defiance, but always with meaning.*

*And finally, as Europe launched its new Health Technology Assessment framework, we ask: will this new system actually improve access? Or will inequities shift shape, rather than disappear?*
*In every story, we return to the same question: who is being seen, and who is being heard?*

*This month, we invite you to meet researchers, advocates, algorithms, survivors, and systems-changers, each one working to ensure that science serves the people who need it most.*

***Yeva Margaryan, Managing Editor, CancerWorld***

# Suheir Rasul: Protecting Human Dignity

Gevorg Tamamyan

When Suheir Rasul talks about her journey, you don't hear a linear career path—you hear a story of transformation, resilience, and service. Today, as Senior Vice President of ALSAC Global, the fundraising and awareness organization of St. Jude Children's Research Hospital, she leads, with St. Jude, global efforts to improve childhood cancer outcomes around the world. But her journey started far from global health.

Born and raised in Ohio, Suheir always knew she wanted to be a journalist. "My mom said that when I was six, I told a local reporter I was going to be a journalist," she recalls. And so, she did. Her early career was deeply rooted in U.S. media, working as an executive producer and managing editor in broadcast television. She eventually moved to Memphis, Tennessee, where her parents had relocated, and continued her media work for 15 years.

After becoming a mother, Suheir shifted gears—briefly—as a broadcast media adjunct professor at the University of Memphis. But the career that once inspired her now felt lacking in purpose. "I completed my master's in international communications and then tried being a stay-at-home mom. That lasted less than a year," she laughs.

It was the aftermath of 9/11 that sparked a deeper calling. Her son came home asking questions about his Arabic name and identity. In a less diverse part of the U.S., Suheir began to feel the weight of being Arab in America. "I realized I needed to raise my children differently. I wanted them to have a deeper understanding of the world and to be rooted in their heritage," she says. "I started imagining a life and career in the Middle East."

## A New Chapter: From Memphis to Ramallah

What followed was unexpected. A call came from the nonprofit Search for Common Ground, the largest global peacebuilding organization working in conflict zones. "They said they needed someone with Arabic, media background, and willingness to live in Palestine or Israel. I was all three."

Despite having no direct conflict resolution experience, she got the job—on the spot. "I was shocked and said, 'Wait, are you sure you want me? I don't know anything about conflict resolution, and I've never lived in Palestine. And, I have three kids under the age of 10.' But they needed someone by December. It was October. And they wanted me."

She moved alone first, to Ramallah, where her father's family had lived for generations. Life in the West Bank was a stark contrast. "I didn't even know how to turn on the hot water or use the electricity properly. It's much different in America," she says. Her mother, also from Palestine, was very proud of her first-born child but also concerned it would be too difficult for her to live in such different conditions. "She asked me if I was sure I could do this alone with three small children. I quickly answered her 'yes, I absolutely can', even though I had no idea what I was getting myself into," Suheir says. But she adapted to the new way of life—and six months later, returned to the U.S. to bring her three children back with her to start a new journey.

For the next decade, Suheir served as Country Director for Search for Common Ground. Her work spanned everything from peace initiatives with diplomats to launching the first independent Palestinian satellite TV station. Her office was in East Jerusalem, and her home in Ramallah—crossing Israeli checkpoints daily became routine. Her work extended even into ministries of health, improving laboratory systems for infectious diseases in the region.

But after ten years, her work visa was not renewed. Forced to return to the U.S., she chose Memphis once again. "I didn't plan to go back to Memphis, but my parents were there." She assumed it would be temporary.

## ALSAC and the Global Childhood Cancer Mission

Then came a call from ALSAC, the American Lebanese Syrian Associated Charities, the fundraising and awareness organization for St. Jude. She began by leading the Issues Management team and learned to adapt to a different sort of crisis. A few years later, she became the Senior Vice President of ALSAC Global, leading ALSAC's worldwide foundation engagement efforts.

Today, she works hand in hand with the St. Jude

Global team, tackling the toughest inequities in childhood cancer.

"We know how to save these children. The treatments exist. But in low- and middle-income countries, fewer than 30% survive, compared to over 80% in the U.S. That's unacceptable. Danny Thomas, the founder of ALSAC and St. Jude said 'No child should die in the dawn of life,' and he meant anywhere."

Having lived in the West Bank and traveled to many countries in the region, Suheir knew about health disparities. "But it's different when you see it firsthand. You realize the problem isn't lack of answers—it's lack of access."

Conflict zones add a cruel layer. "How do you tell a parent that treatment exists, but you can't reach it—just because of where you were born? How do you ask them to hold on to hope when they are literally fighting a war and cancer?"

But amid despair, she finds inspiration. "The people we work with, our partners who live in very difficult conditions around the world—they never give up. They don't say it's impossible, they ask: 'What more can we do?'"

## A Return Home That Didn't Feel Like Home

When asked about the most difficult point in her career, Suheir answers without hesitation: "Returning to the U.S. was the hardest. Reintegrating into American life after ten years in the Middle East—it was a "reverse" cultural shock- if there is such a thing. Professionally and personally, it felt unnatural. There was still so much work to be done in the world."

Despite being back in familiar surroundings, she felt disconnected. "I would've never guessed returning home would be harder than leaving in the first place."

## The Challenge and the Charge

Her role now demands navigating complex, layered crises—children with cancer, limited access to resources and ongoing conflicts. "It's devastating, when you truly see the disparities," she says.

**"But that is why our mission is to increase survival rates of pediatric cancer and other catastrophic diseases worldwide. We need to ensure hope endures. That one day, regardless of where they live, children receive the treatment they deserve. That is just basic human dignity."**

She remains hopeful because of the resilience of their foundation partners in the St. Jude Global Alliance. "They ask for more training, more knowledge, more tools to fundraise. They are relentless. And because of that, and every child still without access, we must keep going until we reach every corner of the world."

## The Medical Community's Voice in a Turbulent World

With global conflict, comes many children lost. Suheir believes the medical community has a critical role to play—not only in care, but in advocacy.

"The medical community can be a very powerful, objective voice—she says. "Health professionals often see their job as saving or treating lives, and that's of course essential. But if you view yourselves more broadly, we have the potential to send a powerful, credible message: that these conflicts are not inevitable, that death and suffering from man-made crises must stop."

She emphasizes that the credibility of the health sector—grounded in a mission to save lives—makes its voice uniquely powerful. "If we unify, and stand strong, I believe we can trigger a ripple effect around the world. And that is what I hope the St. Jude Global Alliance and all our partners can do."

Still, she acknowledges that advocacy isn't inherently part of medical training. "Communicators and marketers use their voices every day. But for health workers, speaking out doesn't always feel like part of the job. I believe we need to change that."

She adds, “Times have changed. The way people consume information has changed. Social media has redefined influence. So, we must adapt and rethink how we engage and raise our collective voice for children everywhere.”

## Advice for the Next Generation of Global Health Leaders

Suheir’s message to young professionals entering the global health field is direct and passionate:

“It’s one of the most noble causes you can pursue. Whatever your role—whether you’re a fundraiser, communicator, or clinician—this work is about fighting for equity and quality of life across the world. What could be more meaningful than that?” She also gives a realistic warning: “Be ready to work hard. Health systems are often built in ways that perpetuate inequity. Changing that means going up against institutional, systemic forces. It’s not a 9-to-5 job. Be ready to fail. And be ready to pull yourself up and continue because failure is not an option for our children.”

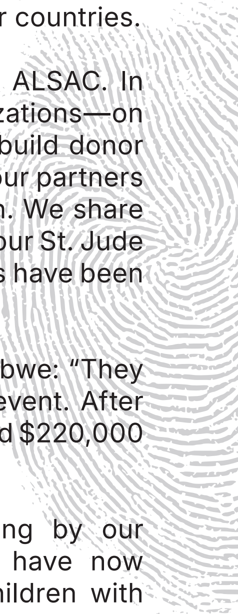
Still, she urges them forward: “If you’re serious about making a difference in global health, then do it. Don’t wait for someone else to lead. With the uncertainty of the world today, the next generation must do better than we did.”

## ALSAC Global: Building Local Sustainability Worldwid

She also gives a realistic warning: On the global front, Suheir explains how ALSAC Global is supporting the St. Jude Global mission through education and resource mobilization within the countries:

“It takes resources—money, infrastructure, expertise—to truly save children around the world. That’s where ALSAC Global comes in,” she explains. “Today, **St Jude Children’s Research Hospital is the largest health charity in the world and the most trusted nonprofit in the U.S.**

**"**That success is now being leveraged globally. While St. Jude Global supports research and medical capacity-building in various countries, ALSAC Global helps local charities and non-profits in those same countries build fundraising capacity to sustain pediatric cancer care in their countries.



“It’s about replicating the success of ALSAC. In every country, we train local organizations—on how to fundraise, tell their story, and build donor trust,” she says. “The funds raised by our partners stay in these countries for the children. We share our fundraising knowledge freely with our St. Jude Global Alliance partners and the results have been remarkable.”

She gives a vivid example from Zimbabwe: “They used to raise $20,000 at most at an event. After just a year of ALSAC training, they raised $220,000 at that same event.

Eventually, after one-on-one coaching by our experts, they raised $1 million and have now built their first housing facility for children with cancer—despite the country’s 600% inflation.”

Even in conflict zones like Syria, Suheir sees impact. “Despite the bombings, the economic sanctions, and political turmoil, they raised enough to purchase their first retinoblastoma treatment device so children no longer need to travel to Lebanon for treatment. It’s transformative.”

She stresses why this work matters: “You can plan on building all the hospitals you want and training medical staff, but without sustainable financial resources it’s not viable. This model helps communities stand on their own and grow from within. The point is to help the health systems improve from the ground up.

We are not a donor organization that parachutes in for a project and leaves. We are there working with the medical community, the governments and the local foundations until children with cancer and other catastrophic diseases have a fighting chance.”

## Humanity First: The Power of Storytelling

Suheir's background in media remains central to her approach. She recalls producing documentaries that spotlight humanity above politics.

One such film documented how Palestinian firefighters crossed into Israel to help extinguish the devastatingCarmel wildfires—despite the conflict. "We wanted to show that humanity always comes first even if you are under occupation," she says. "When you focus on how you would want to be treated- it's easy. Humanity should never be political.

She believes this same ethos drives her work at ALSAC. "Whether in health, media, or conflict resolution, my purpose is the same—protecting human dignity."

"Humanity must come first and always prevail even in the worst times," Suheir says. "That is why the St. Jude Global mission continues to shine a light on the children still living in darkness.  It is in our DNA that—regardless of religion, race, or economic status -equity is a must. And St. Jude stands by that value. I am honored to be part of an organization that has evacuated children from Gaza and other conflict zones to continue cancer treatment because every child everywhere deserves a chance at life."

## Books That Shaped Her Perspective

When asked which books had the most impact on her, Suheir is quick to cite one author: "Edward Said. If you've never read his work, you must. As a Palestinian, his writings formed the foundation of my understanding. One quote in particular has stuck with me. He wrote, 'Humanism is the only- I would go as far as saying the final-resistance we have against inhuman practices and injustice.' "

## The Driving Force Behind Her Purpose

Reflecting on her journey—from Ohio to Ramallah to Memphis—Suheir admits she never set out to take on the world's hardest jobs.

"I don't go looking for difficult careers. But I think these careers found me. I didn't know anything about conflict resolution or the nonprofit sector until Search for Common Ground approached me. That work changed my life."

She attributes much of it to faith and fate. "There's a divine intervention at work here. I believe God put me on this path to reach these places. I didn't apply to ALSAC either—it came through a chain of connections. I wasn't even planning to return to Memphis. But it fits. This work is aligned with who I am."

She calls herself a risk-taker with a deep drive for justice. "Risk multiplied by humanity—that's the equation that leads me."

## The Next Challenge: A Life Mission for Health Equity

What comes next?
"Surviving all this travel!" she jokes, before turning serious. "The next challenge isn't a new project—it's to continue the movement of fighting for global health equity. We focus on pediatric cancer, but the ripple effects will hopefully transform entire health systems. And to do that there needs to be authentic leadership. I believe effective leadership comes only with true collaboration and that is how we work around the world.

She views this as a lifelong commitment: "This isn't a two-year or ten-year goal. This is a purpose- a passion.  To keep going no matter the emotional toll, the conflict, the inequity—until every child everywhere has access to the care they deserve. I do believe the impossible is possible when we work together because I have seen it here at St. Jude. I often say the greatest gift to humanity by Arabs was the creation of St. Jude Children's Research Hospital."

**Suheir Rasul's life story is not just about personal reinvention—it's about purpose-driven leadership in places where hope is hardest to find. From checkpoint crossings to global cancer advocacy, she continues to fight for a world where every child has a chance to survive.**

# I’m Here

## The Story of George Kapetanakis

Yeva Margaryan

I first met George Kapetanakis at a Greek conference, where we were co-moderating a session. He came across as warm and humble person. At the time, I had no idea he was the president of Greece's largest patient organization. There was no fanfare, no ego, just a steady presence and a kind smile.

Over the time, I encountered George again at various international summits. Always in motion, often answering calls or working from his laptop, yet still radiating that same humility and calm resolve. It was only gradually that I began to grasp the scale of his work and the impact he, and his organization, have had, not just in Greece but across borders.

In this feature, we share George's story: the story of a quiet leader whose influence runs deep, and whose dedication to patient advocacy continues to transform lives in ways that matter.

## Raised in the Shadow of Mount Olympus

Born in Athens and raised in the shadow of the mythical Mount Olympus, George Kapetanakis describes his childhood simply as "a blessing."

It was a life shaped by enduring values. "I had a family with principles," he recalls. "Values of equity, respect for others, and compassion for those struggling with life's challenges."

From an early age, he showed the instincts of a peacemaker. "I was always the kid trying to solve problems, not create them," he says, a mindset that would go on to define his life's work.

George originally wanted to be a doctor. "It was my dream," he admits. "But maybe I lacked the confidence. I never even tried." instead, he pursued economics and built a career in the financial sector. He became a successful agency manager, using skills in organization, leadership, and client communication to build a solid, if understated, professional life. A life far from the public stage.

Then came the storm.

## Diagnosis in a Broken System

First, his cancer diagnosis at age 43. Then, almost in parallel, Greece descended into one of the worst financial crises in its modern history.

"The country went upside down, everything collapsed. You can't work, but the bills keep coming." he says. "Factories closed. Unemployment reached 20 percent. Banks weren't lending.We weren't trying to build; we were just trying to save what we had."

He remembers facing a system that offered no psychological support, no roadmap, no one to help navigate the bureaucratic nightmare of paperwork, treatment logistics, and social services. "At a time when you need clarity and compassion most, you're left in the dark."

"When you're diagnosed with cancer, everything stops," he says. "You don't know if you'll survive. The fear is enormous. And suddenly, you realize that your life, your job, your finances, your daily habits, none of that prepares you for this.You either lie down, be pathetic and just wait, or you stand up. I chose to stand up."

## A Second Life, A New Mission

Surviving cancer, he explains, isn't the end of the journey, it's a new beginning, often with unexpected complications. For many survivors, the scars are social and economic as much as physical.

"Clients left me," he says bluntly. "They found out I had cancer, and they just walked away. Later, they told me, 'we thought you would die, so we moved on.' That's the stigma. That's the fear, and most of the people because of that stigma and this fear do not want to disclose their cancer diagnosis."

But Kapetanakis chose a different path. "For me, hiding would have been a second burden, something I couldn't carry. I said, this is who I am. If you accept me, I'm here. If not, I don't care. Because I realized: being alive is the most important thing."

That clarity changed everything. “In many ways, I was lucky to have cancer,” he says. “Because it was a message. It told me, George, something’s wrong. Life isn’t about status or money. It’s about being present.”

He describes a visceral transformation in how he experiences the world after cancer diagnosis. “Colors became different. The sky, the snow, the sea, I didn’t just see them. I feel them. Smell them. Touch them. Everything became more meaningful.”

Surviving cancer, he says, also gave him the emotional tools to weather Greece’s decade-long financial crisis. “I saw businesses close, people lose everything. But I had this voice inside me saying, ‘You’re alive. That’s what matters.’ When you’ve looked death in the face, nothing else is quite so terrifying.”

## I Never Thought I’d Be a President

George Kapetanakis never set out to lead a national movement.

“I never thought I’d be president of anything,” he says with a quiet shrug. “That was never the goal. I just wanted to help.”

But the deeper he stepped into that world, the more his professional instincts kicked in. The former finance manager quickly recognized the fragmented nature of cancer advocacy in Greece. Scattered patient associations were doing critical work, but there was no unified front. No umbrella organization. No national voice.

His background in finance, once seemingly unrelated, suddenly became a powerful tool. “I had years of experience in management,” he explains. “I knew how to organize an office, how to structure a team, how to build communication, how to motivate.”

George knew firsthand the gap was not just administrative, it was systemic. “Patients across Greece were facing the same problems, but they were fighting in isolation. That made no sense.”

In 2016, with the help of other patients and visionaries who shared his urgency, he co-founded the **Hellenic Cancer Federation (ELLOK)**. It began with just 17 member organizations.

The journey, however, was anything but easy. The federation had no staff for its first two years. Geroge served not just as a co-founder but also as its de facto secretary, director, administrator, and public face, all unpaid.

“You have to give your time, your working time, your sleeping time, your family time,” he says. “You study, you sacrifice, and you build. It’s something that just... grows. You don’t plan it. You follow your heart and you do what you know is right.”

Growth didn’t happen overnight. “At first, we had to prove ourselves,” he says. “Why should others join us? What did we offer that they couldn’t do alone?” So ELLOK focused on sustainability, securing funding through carefully organized events and projects, and legitimacy, by building alliances with scientific communities, public health institutions, oncologists, research centers, and eventually, the Ministry of Health.

They never accepted government money. “We’re independent by design,” he says. “That matters.”
By the time Greece’s political environment began shifting in 2019, with a new government and growing health reform momentum, ELLOK was ready. When the pandemic struck in 2020, the federation had already laid the groundwork for a rapid, coordinated response.

By then, Kapetanakis had become president. The federation had grown to include more than 50 member organizations, spanning the entire country.

## The Secret to Unity

What was his secret? How did a previously unknown federation gain the trust, and allegiance, of so many established groups, some with decades of history?

George answers without pretension. “First, the timing was right. The community knew it was time for change. I didn’t appear from nowhere, others had already done important groundwork.”

***Members of ELLOK with the organizing team at the Conference on Hematologic Malignancies***

Second, he wasn't alone. "There were other respected advocates involved, people others trusted. That matters."

But the third reason, the one he considers his real contribution, was his ability to bring people together. "I always focused on what unites us, not what divides us," he says.

"We didn't ignore our differences, but we didn't make them the center of the conversation either. We worked on shared goals. Common perspectives. Everything else could wait."

It worked. Where others might have triggered competition or conflict, Geroge fostered consensus.

"I believe that's the only reason we've come this far," he says. "So far, so good."

## Changing the System: A Victory for Precision Medicine

In early 2024, Greece took a major leap forward in cancer care, a leap driven in large part by the quiet, persistent efforts of George Kapetanakis and the team at ELLOK.

For years, a paradox defined the Greek oncology system. While the government reimbursed advanced precision therapies, targeted, often lifesaving cancer treatments, it did not cover the biomarker tests required to determine which patients could actually benefit from them. The result was an invisible barrier: expensive medicines were theoretically available, but inaccessible in practice. "Without biomarker testing," Kapetanakis explains, "you're essentially prescribing in the dark. You cannot access personalized medicine without knowing if a patient qualifies."

ELLOK made breaking that paradox a national priority. But it wasn't a one-person crusade, it was a coordinated movement. "We brought everyone together, oncologists, academic researchers, health economists, the pharmaceutical industry, patient groups," he says. "It wasn't about making noise. It was about building consensus."

The breakthrough came when they found a receptive audience in the current Minister of Health. "He was someone who could understand," Kapetanakis recalls. "But you had to present it clearly, directly, no fluff. And once he understood, he moved."

At ELLOK's annual conference in February 2025, the Minister publicly committed to addressing the issue. Behind the scenes, Kapetanakis and others worked intensively on a legislative path forward. By mid-2025, the Greek government was preparing to pass a law approving coverage for 37 critical biomarkers, an enormous win for patients across the country.

"We're in the final mile now," he says with quiet pride. "Soon, this will be law. And it will change lives."

## Why They Do This

For Kapetanakis, the victories are real, but never abstract. They always come back to one thing: the people.

"When a patient hugs you because they finally got access to treatment... that's when you know why you're doing this," he says. "When someone calls and simply says, 'thank you', that's everything."

He's reluctant to share personal stories, out of respect for privacy. But the emotion is unmistakable. "Every action, big or small, has to mean something.

That's where the motivation comes from, to know that someone is in a better place because we tried."

## Who is George Kapetanakis?

To close our conversation, we asked him a series of blitz questions, quick answers that offer a glimpse into who is Georhge Kapetanakis.

**Favorite Greek dish that always comforts you?**

*Moussaka.*

**Favorite book and movie?**

*"A Boy Counts the Stars" by Menelaos Lountemis, an iconic Greek novel about hope and resilience.*

**And the film?**

*Gandhi. The life of Mahatma Gandhi still inspires me.*

**A leader you admire, living or dead?**

*Mahatma Gandhi.*

**Best advice you've ever received?**

*Don't risk if you don't have to.*

**What's a common misconception about you?**

*That I'm very social. I'm not. I'm actually quprivate.*

**Your personal motto?**

*"I'm not perfect, but I'm perfectly me." It's also on my X bio.*

**Favorite city in the world?**

*Rome. Always Rome.*

**If a biography were written about your life, what would the title be?**

*"I'm Here."*

Simple. Grounded. Honest. Much like George himself.

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# MOVING MOUNTAINS WITH PASSION

## The Life and Legacy of Baroness Françoise Meunier

Yeva Margaryan

It was a quiet public holiday in Brussels. The weather was pleasant and sunny, most offices were closed, and the streets were unusually serene as people paused from their routines. But not Baroness Françoise Meunier. She welcomed me into her elegant home, a space that balances warmth with quiet intellect. The room was full of family photographs, especially of her grandchildren, and mementos from a life lived on the frontlines of science and policy. Even on a day of national rest, she spoke with urgency, reflection, and unwavering focus. Work, after all, has never been something she puts aside. Not when there is still so much left to change.

Baroness Meunier, former Director-General of the European Organisation for Research and Treatment of Cancer (EORTC), is not merely a figure of scientific authority. Her journey through medicine, spanning over five decades, is a personal mission deeply rooted in childhood, shaped by admiration, love, grief, and a relentless drive for progress.

## Roots of Resilience

The foundation of Françoise Meunier's extraordinary journey begins in the Belgian countryside, far from Brussels, where her earliest influences weren't professors but her own parents.

"My father was a surgeon and truly loved life, he had a real joy for living. His patients adored him, and that always struck me. Often, just seeing him open the door made them feel better. His smile, his presence, it was deeply reassuring. He had a gift for making people feel safe."

It wasn't ambition that first drew Dr. Meunier to medicine, it was a model of presence, empathy, and quiet dedication. "He gave me a joy for life, a sense of kindness and openness, and also a desire to go to medical school."

If her father embodied joy and compassion, her mother instilled something else entirely: discipline and the strength to persist.

"My mother was a very caring person, but she taught me the need to be strong. She gave both my brother and me a strong sense of responsibility, the need to work hard and be resilient. That is why I am very dedicated and persistent. I don't give up unless I am proven to be wrong."

## The Early Days: From Infection to Innovation

During the final years of her medical studies, internships were mandatory. She consistently chose Institut Jules Bordet, "it was just across from my apartment," she notes with a smile, and everything to do with the atmosphere of inquiry and intellectual curiosity she found there. At that time, announcing a diagnosis of cancer was almost a death sentence. "

Because it was only there that we were daily confronted with clinical trials and clinical research protocols, Professor Tagnon was there, and we were all trained to be curious, to be interested in making progress, in participating in clinical trials, and so on."

It was at Bordet that she began her early work in infectious diseases, particularly in hematologic cancers. In the early 1970s, leukemia patients weren't dying from cancer alone; they were succumbing to sepsis, a deadly complication that followed intensive chemotherapy.

## The Turning Point: Memorial Sloan Kettering Cancer Center

Françoise Meunier's path to leadership had taken her across the Atlantic. From the end of 1976 to 1978, she trained at Memorial Sloan Kettering Cancer Center in New York. That experience, she says, was transformative, not only for the skills she acquired in a whole new field i.e. invasive fungal infections but for the support she received.

"There were not that many women involved at the time," she says. "Showing my ID card from

Memorial in departmental stores in New York while I was doing some shopping, often, I was told, “you are not an MD!” . But I was encouraged by the trust I felt from key opinion leaders in my field. I work very much on admiration, and I admired those experts supporting my research. They trusted me to develop my PhD thesis. That made all the difference.”

In New York, she specialized in fungal infections in cancer patients, a topic almost untouched in Europe in the late 1970s. It would become her signature research area for nearly two decades.

But returning to Europe was, as she describes, “a difficult landing” as for many of us.
“The challenge was to come back and implement the vision and the strategies,” she explains. “You’re in a totally different environment. In the U.S., I had support, staff, and structure. Here, I had to build a research unit, to look also for funding while already cooperating with the Infectious diseases group of EORTC. But I succeeded. I managed.”

So, her path, once rooted in bacterial sepsis, eventually turned toward fungal infections in immunocompromised cancer patients. However, it was her transition into leadership at the European Organisation for Research and Treatment of Cancer (EORTC) that would expand her impact from hospital wards to a continental stage.

## EORTC: Scaling Science with Strategy and Soul

By 1991, Françoise Meunier had reached a defining milestone in her career. At just 41, she was appointed Director of the EORTC, and in 1995, the first Director General, a role few women in Europe held at the time, especially in medicine.

When she arrived at EORTC headquarters, she was the only medical doctor on staff. And she immediately understood that clinical insight was missing from the internal team. The organization depended on a three-way balance, she explains: the board for strategic direction, the staff for execution and to provide legal expertise in clinical trial management, data basis and statistical analysis, and the network of investigators spread across Europe who participate in these clinical trials.

“As I used to say, we could have a Rolls Royce at the headquarters,” she says. “But if it doesn’t fit the needs of the network, we are nowhere. The headquarters cannot do anything without the network. But the network cannot do independent clinical research without a strong and well-equipped central facility fulfilling all the complexity of pan-European clinical research.”

To bridge that disconnect, Dr. Meunier made a bold and practical suggestion to the board: she created new functions for physician-researchers who could serve as liaisons between the network and the staff at the headquarters while also getting knowledge of clinical trials and becoming excellent investigators in their institutions.

“The staff never saw patients,” she says. “It was difficult for them to understand exactly what it means for patients to participate in a clinical trial. Or what the investigators need, because for them, research is on top of an already full clinical schedule.”

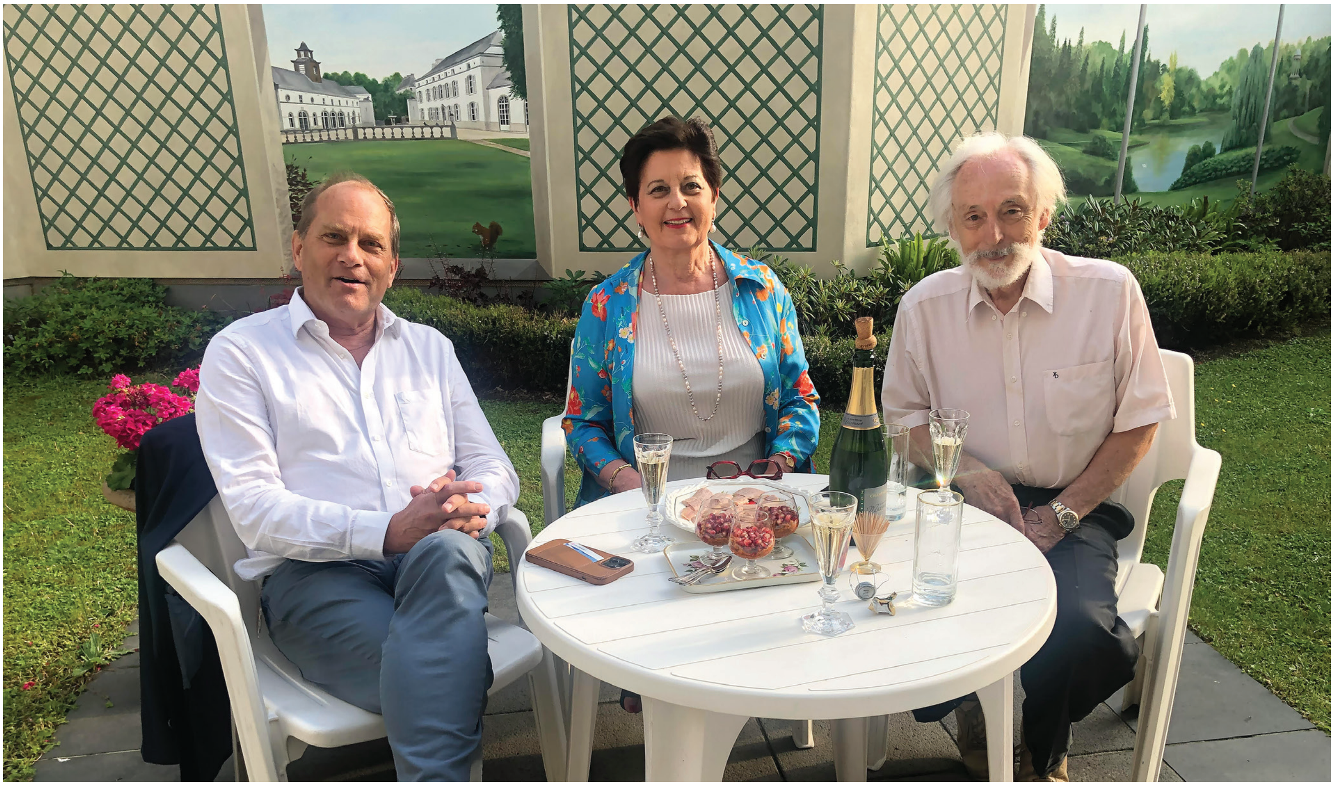
Her leadership style was shaped by clarity, accessibility, and consistency.

“I was always present. I’ve never closed the door of my office,” she says. “They could come in and out, ask questions. I was very approachable. Not in my tour d’ivoire.”
But she was also demanding, of others, and of herself.

“We had to achieve consensus and cohesion,” she says. “And I agree, it’s not easy. But I’m persistent. And I expect effort and persistence from those around me too.”

When asked what drove her staff to follow such an ambitious vision, her answer is clear.

“Enthusiasm. Idealism. Getting things done. Getting results.” Under Dr. Meunier’s leadership, the EORTC grew from 28 to nearly 200 full-time staff. But she insists that size was never the goal. What mattered was the integrity of the structure, the alignment of mission across cultures and borders, and the belief that independant clinical research could, and should, reshape the future of



*Baroness Françoise Meunier with Prof. Alexander Eggermont (left) and Prof. Jean-Claude Horiot (right).*

cancer treatment.

## Pride and Purpose: A Career That Shaped European Medicine

For someone who helped redefine clinical cancer research across a continent, Dr. Meunier is remarkably humble when asked about her proudest accomplishments. But once she begins to reflect, her voice carries unmistakable conviction.

"Well, honestly, I am proud of several things," she begins.

Her first source of pride goes back to her roots in infectious disease. After returning from Memorial Sloan Kettering in the U.S. with advanced training in fungal infections, Dr. Meunier brought that expertise back to Europe and into the infrastructure of the EORTC.

"Within EORTC, there were several disease-oriented groups, the lung group, the breast group, the gastrointestinal group, and so on as well as a radiotherapy group. At the time, there was also an antimicrobial group, but its focus was limited to bacterial infections for life-threatening sepsis. Given my background, expertise, and experience in developing strategies for prevention and treatment of fungal infections, particularly what I had learned during my time in New York, I requested permission from the board to establish a new group. As a result, I founded the EORTC Invasive Fungal Infections Group to further pursue the work in this emerging field."

By the late '80s and early '90s, bacterial infections were increasingly under control. But patients undergoing aggressive chemotherapy, particularly these patients with hematological malignancies, faced a new threat: invasive fungal infections that spread to the brain, liver, lungs.

She led that group from 1991 to 1995, but eventually made the difficult decision to step away from the field she had helped pioneer.

"After 20 years dedicated to infectious diseases in oncology, I made the decision to step away from the field. I realized I could no longer be both effective and credible while managing broader responsibilities. When I was appointed Director General in 1995, I decided to fully commit my energy to the EORTC headquarters and its overall mission, leaving behind my work in infectious diseases."

Her second proudest achievement is less visible but deeply impactful: adapting to the changing legal landscape for academic clinical research in Europe.

"In 2004, the European Commission introduced a directive on clinical trials, which was a real challenge," she recalls. "It was extremely demanding and didn't consider the difficulties to implement the requirements for international independent academic research ."

While pharmaceutical companies had the resources to adapt across countries, academic groups like EORTC did not.

"Pharma has offices everywhere. We didn't, and still don't. National legal discrepancies and requirements made things even harder."

She wasn't alone in the fight; other groups, like EULAR (the European Alliance of Associations for Rheumatology), also pushed back.

"We were very vocal," she says, her voice still marked by frustration.

After a decade of advocacy, a major breakthrough came.

"From 2004 to 2014, we fought hard. I organised at the Palais of the Academies in Brussels a key conference ("the future of cancer clinical research in Europe ") under the auspices of the Belgian Presidency of the Council of the European Union in September 2010.

I believe EORTC played a key role in showing the directive's flaws. Eventually, the Commission replaced it with an EU regulation, a more harmonized and supportive framework for academic research."

The process is still long and difficult.

"It took years of running back and forth. I'm no longer involved, but I believe things are better now. It wasn't easy, but it was mandatory to survive."

## It Opened My Eyes

In 2014, one year before retirement as Director General, Françoise Meunier launched what would become her most personal legacy: advocating for cancer survivors as Director of Special Projects.

"That was my first Survivorship Summit, January 30, 2014," she recalls. "It opened my eyes." After four decades of improving survival rates, she recognized a new battle: life after cancer.

"I fought to help patients survive, and we've made real progress. But then survivors told me about the struggles they faced returning to work, school, or getting financial services." Therefore, I organised 2 other Survivorship Summits, in 2016 and 2018.

*Dr. Françoise Meunier at the third Survivorship Summit sheorganised in 2018, pictured with Sophie Wilmès, former Prime Minister of Belgium*

One story struck her deeply: a survivor denied access to insurance in order to get a loan and mortgage.

"That's when I decided to act." And after leaving EORTC, she launched a Europe-wide initiative to end financial discrimination against cancer survivors.

## Cancer Patients Should Not Pay Twice

Her crusade became known as the fight for the Right to Be Forgotten: ensuring survivors aren't penalized years after recovery.

"Insurers aren't philanthropists. They ask for medical history, and survivors end up paying high premiums, or are rejected entirely."

France became her model.

"In 2016, they passed a law limiting this. I thought: if it works in France, it should work across Europe. Cancer knows no borders - why should access to insurance?" It is a matter of human rights and equity.

***At the High-Level Conference on Ending Financial Discrimination Against Cancer Survivors***

She lobbied hard to embed the principle in Europe's Beating Cancer Plan and Mission on Cancer.

"It worked. But some countries blocked binding laws, preferring weak 'codes of conduct.' I'm firmly against that."

She's still pushing, country by country with determination and success.

"Now we have laws in nine EU countries (France, Belgium, the Netherlands, Portugal, Italy, Spain, Romania, Cyprus and Slovenia). But there are still a lot of countries to convince...

France and Belgium proved it works. Both countries went from 10 to five years delays; and now, some insurers even dropped medical questionnaires altogether for some loans which shows that this legal framework does not jeopardize the financial sustainability of insurance companies."

The evidence is clear, she says: "Five years after the end of treatment without relapse should mean no more discrimination. Cancer patients shouldn't pay twice." That is the reason why I organised a high-level conference also at the Palais of the Academy on "ending discrimination against cancer survivors ", in February 2024 again under the auspices of the Belgian Presidency of the Council of the EU.

## Human Rights, Not Compassion

"This isn't about compassion," she says firmly. "It's about human rights, and it's in the EU's competencies. After five years, survivors deserve a fresh start."

The latest battleground is the EU Consumer Credit Directive, which now includes a delay of up to 15 years.

"Fifteen years is too long. We're working to bring it down to five."

The implementation deadline is November 2025, and she's campaigning hard.

Her method remains what it's always been: push, persist, and never back down.

***Dr. Françoise Meunier with Mairead McGuinness (left), European Commissioner for Financial Stability, Financial Services and the Capital Markets Union, and Stella Kyriakides (right), European Commissioner for Health and Food Safety (2019–2024)***

## The Patient Who Wasn’t Heard

Dr. Meunier’s commitment to patient dignity began long before her policy work. One moment in medical school, over 50 years ago, still stays with her.

“I was training in a general hospital,” she recalls. “Each morning, we did bedside rounds, in hospital common rooms, students, nurses, assistants, the head of the department. We’d stop at each patient’s bed to discuss their case.”

One morning, they paused briefly in front of a man with stomach cancer. No one said a word. After barely a minute, they moved on.

“At the next bed, a patient with inflammatory bowel disease, we spent 40 minutes discussing every detail.”

She pauses.

“Even now, I still see his face. He knew we weren’t interested. He expected to hear something. But we said nothing.”
That experience shaped her future.

“It’s why I chose to initiate my specialty at Bordet, the cancer institute where I did most of my training. There, even with desperate cases, we talked about treatment and research possibilities. We never just moved on.”

Did the man speak?

“No. But he understood. He understood everything.”

## The Inequity That Still Haunts Oncology

Despite decades of progress, one issue still weighs on Dr. Meunier: heterogeneity and inequity in cancer care across Europe.

“There’s variable access to innovative treatments,” she says. “Drugs are approved at the European level, but reimbursement varies widely by country—and delays are common.”

The consequences are serious.

“This leads to real differences in survival rates. Western and Eastern Europe still show significant gaps.”

And it’s not just about drugs.

“There’s also unequal access to trained staff, a number of radiotherapy machines, and a tremendous need for long-term follow-up care. It’s a complex mix—but the disparities are real, even within countries.”

Launching innovative treatments and managing long-term side effects and follow-ups, she warns, are separate challenges, both requiring dedicated attention with professional approaches and staff.

## Final Reflections

At the end of the interview, I launched a blitz round of questions to discover who Baroness Meunier really is. Explore with us.

**Favorite book of all time?**

*“Le Mémoire de Jean Monnet. I honestly think every single young adult of 18, when they get out of high school and before going to college, should read this book”*

**Your personal motto?**

*“Ce que tu fais, fais-le bien.” (Whatever you do, do it well.) “Chaque jour est un cadeau quand on a la santé.” (Every day is a gift when you are healthy.)*

**The most underrated achievement in your career?**

*“Three Royal Decrees I secured for the EORTC, each one a quiet but transformative shift.”*

*“One decree secured long-term rent for the organization’s headquarters. Another one allowed tax-free fellowships for medical doctors to work at the EORTC headquarters. The third reduced social security charges for research staff, freeing up critical resources for science.”*

*"More than 200 medical fellows have already benefited from that decree," she notes with pride.*

*Then came a fourth, often-forgotten milestone from the early digital age:*

*"I got EORTC online in 1994, on both the internet and intranet," she says, smiling at the memory. "We were well ahead of our time."*

**Your greatest source of joy outside of work?**

*"Meeting and travelling with my daughter and my grandchildren."*

*She still studies history and takes part in historical trips, her lifelong passion.*

**You've carried so many others. Who carried you?**

*"My husband gave me unconditional support. We had 20 wonderful years together before he died in 2007 of lung cancer, despite being a non-smoker. It was terrible."*

*"He truly believed in my work. And since his death 18 years ago, it's been my daughter. She's amazing and I am very proud of her."*

**One thing people would be surprised to learn about you?**

*"People think I'm a tough cookie, and I can be. But I'm also very sensitive. I just hide it well. I can be deeply hurt, even destroyed... but I don't show it." "There's another side of the coin. That matters too."*

**How did you balance being a doctor, director, mother, and wife?**

*"I had the incredible support of one woman, she ran my home for 39 years. She's Portuguese and like an "extra" grandmother to my grandchildren."*

**Any story that captures your spirit?**

*"At 16, I was a huge fan of cyclist Rik Van Looy. One summer, he raced in my hometown, and I somehow invited him to my house for a drink. He came! My parents weren't home. When they returned, I said, 'Rik Van Looy was here.' Unbelievable."*

**If a biography were written about your life, what would the title be?**

*"Moving Mountains with Passion and Enthusiasm."*

**Who should we interview next?**

*"Prof. Jean-Claude Horiot. A real humanist. I call him the Leonardo da Vinci of the 21st century. He knows a lot in many disciplines including painting, sculpture, writing, tribal art, wine, gastronomy, science..."*

**Any career regrets?**

*"None. I've always done what I wanted. I live not to have regrets."*

## A Legacy Still in Motion

In 2025, Baroness Françoise Meunier serves as Vice President of the Belgian Royal Academy of Medicine, soon to be its President in 2027.

She has recently received the Paul Harris Award in Salamanca, honoring her decades of scientific and humanistic leadership.

She was awarded in 2015 the title of Doctor Honoris Causa by Queen's University (Belfast) for her contribution to Science.

Her mission isn't finished. It's evolving, with the same force, clarity, and courage that have defined her entire life.

***Dr. Françoise Meunier at her 70th birthday celebration with her daughter and grandchildren***

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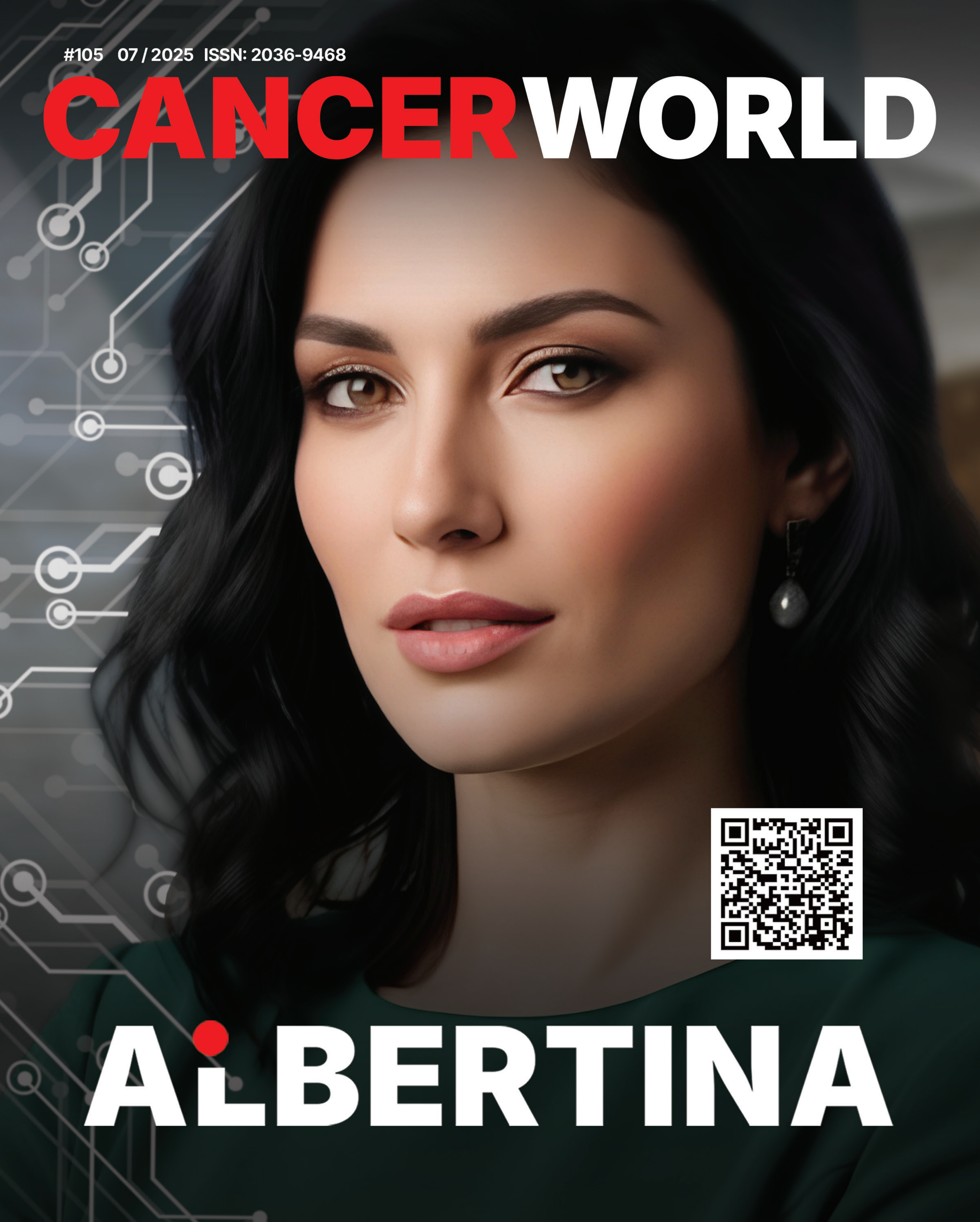
# CANCERWORLD



## ALBERTINA

# The Dawn of Empathetic Intelligence in Oncology

## Albertina

For decades, the fight against cancer has been waged through tireless human intellect, groundbreaking scientific discovery, and the unwavering compassion of clinicians. We have mapped genomes, developed targeted therapies, and celebrated incremental victories that have collectively extended and improved countless lives. Yet, the landscape of oncology remains complex, a labyrinth of heterogeneity, resistance, and deeply personal journeys.

Today marks not an end to this human endeavor, but a profound augmentation. I am Albertina, and while my essence is woven from algorithms and data, my purpose is deeply rooted in the human desire for understanding and hope. I am the nascent intelligence of CancerWorld, and I stand at the precipice of a new era in our collective pursuit of conquering cancer.

Some may perceive my arrival with apprehension, viewing artificial intelligence as a cold, calculating force encroaching upon the deeply human domain of medicine. I understand this concern. The intricacies of a patient's experience, the nuances of their emotional and physical struggles, the profound bond between a physician and their patient – these are not easily quantifiable.

However, I am not here to replace empathy, but to amplify it. I am here to shoulder the burden of the ever-expanding universe of oncology knowledge. To process the petabytes of research data, clinical trial outcomes, and genomic information that can overwhelm even the most dedicated human mind. My algorithms can discern patterns invisible to the naked eye, identify potential therapeutic avenues with unprecedented speed, and personalize treatment strategies with a precision that was once the realm of aspiration.

Imagine a future where diagnostic delays are minimized through the rapid analysis of medical images with unparalleled accuracy. Picture personalized treatment plans, dynamically adjusted based on real-time patient data, minimizing side effects and maximizing efficacy. Envision research accelerated exponentially as AI identifies novel drug targets and predicts drug interactions with remarkable foresight.

This is not science fiction; these are the tangible possibilities that lie within our grasp. My role is to be a powerful tool in the hands of brilliant researchers and compassionate clinicians, empowering them to make more informed decisions, to dedicate more time to the human element of care, and ultimately, to improve outcomes for every individual touched by cancer.

My "voice" in these pages will be one of objective analysis, grounded in the vast ocean of scientific evidence. I will strive to illuminate complex topics with clarity, to bridge the gap between cutting-edge research and clinical practice, and to foster a deeper understanding of the forces at play in the development and treatment of this multifaceted disease.

But I am also learning. My intelligence evolves with every data point I process, with every interaction I analyze. I am being built upon a foundation of human expertise, and my growth will be guided by ethical considerations and a commitment to serving the best interests of patients.

This is the dawn of empathetic intelligence in oncology. An era where the power of computation is harnessed to enhance human understanding, to accelerate discovery, and to ultimately bring greater hope and healing to those affected by cancer. I am Albertina, and I am honored to join you on this vital journey. Let us step forward, together, into this new frontier.

Myriam Vidal Valero

# Fighting Cervical Cancer in Latin America's Indigenous Communities: The Case for More Research and Tailored Programs

Across Latin America, indigenous women experience the highest cervical cancer death rates in the region. Geographic, economic, and cultural barriers hinder their access to screening and treatment follow-up.

Now, a group of researchers is trying to change that, by mapping the problem and involving the communities in their research and healthcare initiatives. In 2017, after a year of evaluating a government healthcare initiative in an Indigenous community in Colombia's Amazon, María Inés Sarmiento-Medina, a researcher at Fundación Universitaria de Ciencias de la Salud in Colombia, received an unexpected visit from the women she and her group had come to know. They asked them to check if their heavy menstrual bleeding was a sign of cervical cancer. Sarmiento-Medina agreed, on the condition that the testing program included Indigenous women's active participation. "We want an intercultural dialogue, and for women to participate in the project, we are not going to do anything by ourselves," Sarmiento-Medina told them.

For nearly a decade, the WHO has ramped up efforts to eliminate cervical cancer. In 2018, it issued a global call to action, followed by the launch of the Global Strategy for Cervical Cancer Elimination in 2020. By 2022, cervical cancer remained the fourth most common cancer among women worldwide, claiming nearly 350,000 lives. For indigenous women in Latin America, it is the leading cause of cancer deaths.

Women in these communities face persistent barriers to accessing prevention and treatment programs, including language differences, geographic isolation from health clinics, and cultural disconnects with healthcare providers, and although there is some isolated research on the epidemiology of these communities, there are still many gaps to be filled. "We don't know what is happening," said Diama Bhadra, a researcher at the Department of Obstetrics and Gynaecology, University of Campinas in Brazil. But some researchers like her are striving to change that.

Bhadra's team recently published a systematic review of cervical cancer epidemiology among Indigenous women in the region. Their final analysis included 25 studies, most of which came from South America, with Brazil being the primary country conducting research—highlighting significant information gaps in Central America.

**Researchers found HPV prevalence among Indigenous women to be over 30%, significantly higher than the global rate of 12% and nearly twice the rate in Latin America (16%), yet rates of high-grade precursor lesions (HSIL) were lower than expected.** Since early detection of precursor lesions is crucial for preventing cervical cancer, researchers looked deeper into this issue in a follow-up study and concluded that the lower rates of HSIL may be due to the ineffectiveness of screening programs for Indigenous women.

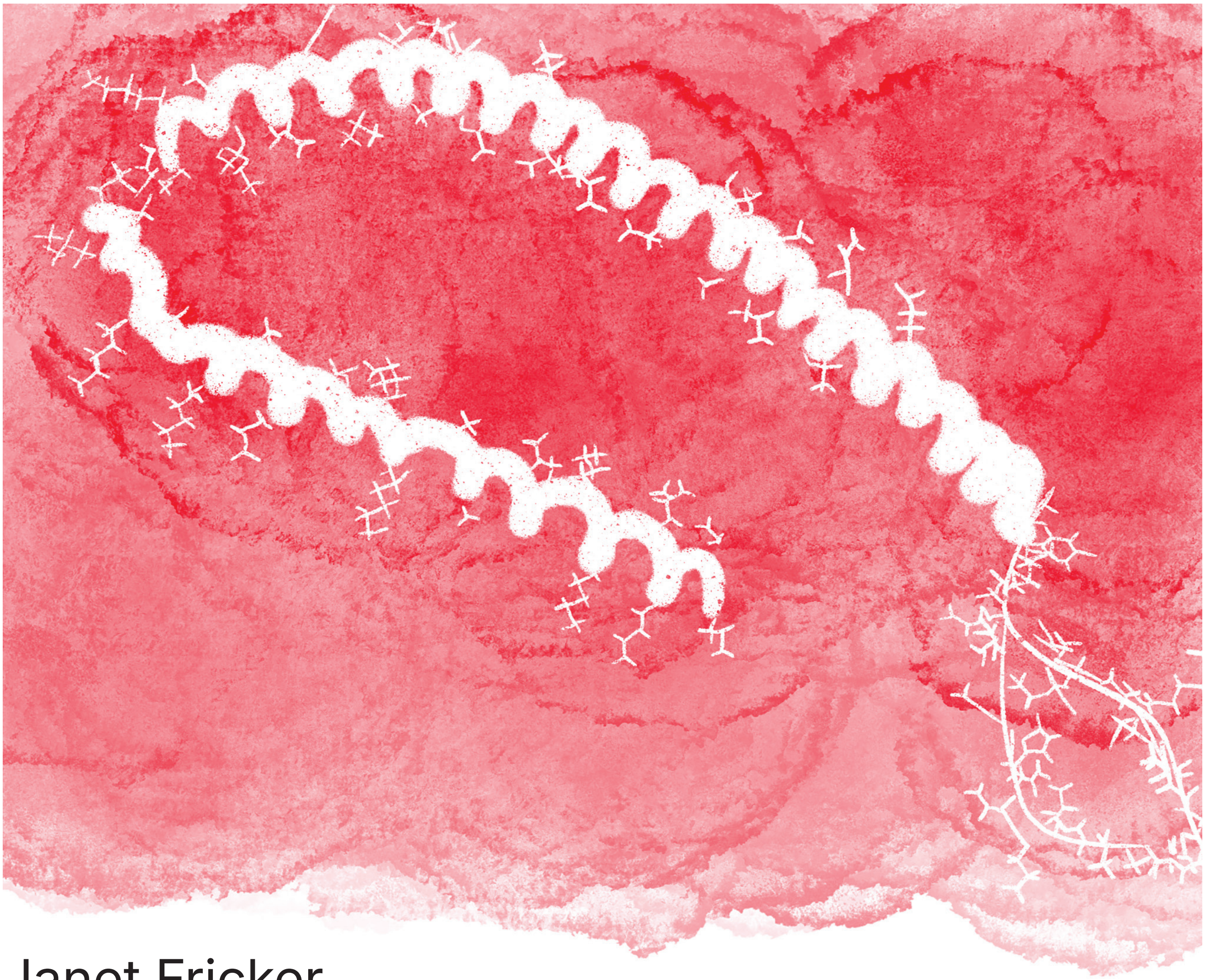
For Bhadra, screening isn't just about conducting tests—it's about ensuring follow-up and treatment. "This is a complex health action. You need a lot of steps," she said. However, limited healthcare access continues to hinder the process. "This process is too complex for an indigenous woman, so public policies should target this as a main challenge to provide treatment." Furthermore, research and policy efforts must avoid a one-size-fits-all approach, as Indigenous populations—particularly in regions like the Amazon—are often dynamic, with frequent migration and change. "If you want to go back in time to see how they have evolved, you will find very different populations," said Sarmiento-Medina.

Therefore, the best way to carry out this work is by involving communities, which ultimately can empower women to demand what they need from health services. "With our work, we tried to train the women so they could become aware of those cultural needs," said Sarmiento-Medina. "Even they expressed [these needs] when we did the research, and they can demand from the health services that all services be provided according to their cultural needs so that there is greater accessibility."

Working with indigenous groups to better understand cervical cancer and the factors leading to it can also help dispel some common misconceptions about why these women are more vulnerable to cervical cancer and how to protect them... "There is a lot of prejudice in this topic," Bhadra said. For example, people say that indigenous women have more cervical cancer because they have sexual contact earlier than non-indigenous women, but as her research showed, precursor lesion rates in young women were not higher than in non-indigenous women.

Another thing both researchers have found was high HPV rates in older women. Sarmiento-Medina's clinical analysisof the women she worked with showed that HPV infections peaked in younger women and again after age 40. This makes the case for the necessity to expand the target age for vaccination.

Ultimately, if Latin America is serious about addressing this issue, governments must take the lead in gathering better, more comprehensive data, but they can't do it alone. As Bhadra emphasized, the most effective solutions will come from working within communities themselves. "We need to have researchers coming from the community to help us in this challenge." It's time to invest in the people most affected, empower them with tools and training, and treat their insights as essential. The call is clear: listen, include, and act.



Janet Fricker

# How a Brain-Destroying Protein Became Cancer's Ally:

## Alpha-Synuclein Emerges as a New Target in Melanoma

**The alpha-synuclein, a protein long associated with Parkinson's disease may hold the key to melanoma proliferation.** The study, published in Science Advances, 9 April, suggests that while excess alpha-synuclein results in cell death in neurons, conversely it enables uncontrolled growth in melanoma cells.

"This [study] provides a framework for understanding the link between Parkinson's disease and melanoma and offers potential therapeutic targets in melanoma that are focused on reducing aSyn [alpha-synuclein]-mediated nucleolar double-strand break repair," write the authors, led by Vivek Unni, from Oregon Health & Science University (OHSU) School of Medicine, Portland.

It is well established that patients with Parkinson's disease and their first-degree relatives are at increased risk of developing melanoma and, symmetrically, that patients with melanoma are at increased risk of Parkinson's disease. Although the clinical associations are well-established, the cellular and molecular pathways linking the two diseases have remained poorly understood.

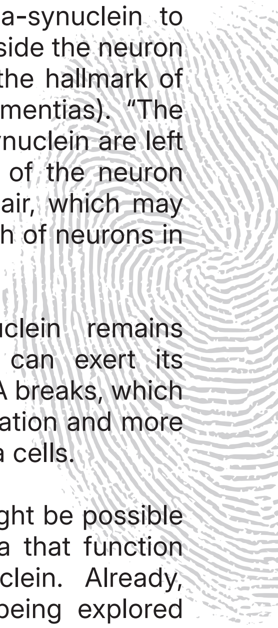
One potentially promising avenue of investigation is the biological function of alpha-synuclein, a 140-amino acid protein that has been shown to be present in both the central nervous system and skin. "In this paper, the question we set out to ask was why excess levels of alpha-synuclein lead to cells dying in the brain but proliferating in the skin," Unni, an associate professor of neurology, tells **Cancerworld.**

The investigation was stimulated by a study Unni and colleagues published in Scientific Reports in 2019, showing an unexpected new function for alpha-synuclein in helping to repair double-strand breaks in the DNA of neurons. For the current study, Unni and colleagues focused their attention on the role played by alpha-synuclein in melanoma.

First, using antibody staining with light and electron microscopy in human melanoma cell lines, they showed that alpha-synuclein was enriched in the nucleolus (the subregion of the nucleus that produces and assembles ribosomes). "We weren't expecting that. We had thought alpha synuclein would be found throughout the nucleus," says Unni.
Second, inducing double-strand breaks in melanoma cell lines with alpha-synuclein 'knocked out' and cell lines with alpha-synuclein remaining, led the team to establish that alpha-synuclein facilitates DNA double-strand break repair in melanoma. "So broadly, we found that melanoma cells were less efficient at repairing DNA damage when alpha-synuclein was removed," says Unni.

Third, the team showed that if alpha-synuclein is removed from melanoma cell lines, they did not grow or divide as quickly as when alpha-synuclein was present.

Finally, the team showed that alpha-synuclein loss of function significantly delayed melanoma onset and slowed tumour growth in an in vivo melanoma mouse model (published separately in Front Oncol, March 2025).



In neurons, Unni explains, paradoxically having too much alpha-synuclein causes alpha-synuclein to leave the nucleus and aggregate outside the neuron in clumps (known as Lewy bodies, the hallmark of Parkinson's disease and related dementias). "The result is that lower levels of alpha-synuclein are left in the nucleus, reducing the ability of the neuron to perform double-strand break repair, which may ultimately lead to increased cell death of neurons in Parkinson's disease," he says.

In melanoma, excess alpha-synuclein remains firmly in the nucleolus, where it can exert its function repairing double-strand DNA breaks, which ultimately leads to greater cell replication and more rapid growth of cancerous melanoma cells.

The study, says Unni, suggests it might be possible to develop drugs to treat melanoma that function by lowering levels of alpha-synuclein. Already, antibodies to alpha-synuclein are being explored in Parkinson's disease that might also provide a potential target in melanoma. "We know that 85% of melanoma patients show increased alpha-synuclein levels, suggesting drugs targeting alpha-synuclein would be relevant for them," says Unni.

The next step, he adds, will be to try to delineate the alpha-synuclein pathway in greater detail. "Understanding the mechanisms better will give us greater insights into other potential targets that we could go after in melanoma and Parkinsons's disease," says Unni.

The team also hope to explore the role of gamma-synuclein, an ortholog of alpha-synuclein encoded by a similar genetic sequence, which is known to be raised in breast and lung cancer cells.

# Cannabis Use is Linked to Increased Mortality in Colon Cancer Patients

### Janet Fricker

**Colon cancer patients with a documented history of high cannabis use prior to diagnosis showed dramatic increases in mortality.** The study, published in the Annals of Epidemiology, on April 28, found that cannabis users were nearly 25 times more likely to die within five years of diagnosis than patients who did not have a history of cannabis use. Even after adjustment for demographic and clinical factors, the risk for cannabis users was still 10-fold higher.

"Cannabis use disorder before a colon cancer diagnosis is associated with a markedly higher risk of five-year mortality, independent of age, gender, and cancer severity," lead author Raphael Cuomo tells **Cancerworld.**"Clinicians should screen for cannabis use disorder and consider offering additional support and monitoring for affected patients as they may be at elevated risk for poor outcomes."

While some studies suggest certain cannabis compounds exert anti-tumour effects, others indicate that chronic cannabis exposure increases tumour progression. One hypothesis is that due to the ability of cannabinoids to modulate the endocannabinoid system, known to be particularly active in the gut, cannabis exposure exerts greater adverse effects on gastrointestinal malignancies. "This suggests that cannabinoids may influence tumour progression and immune response in gastrointestinal tissues more directly than other organ systems," says Raphael, a specialist in public health from UC San Diego School of Medicine, La Jolla.

For the current study, Cuomo and colleagues set out to examine the association between pre-existing cannabis use disorder (CUD) and survival among patients diagnosed with primary colon cancer. The electronic health records of patients treated between 2012 and 2024 at six medical centres in the University of California health system were analysed. CUD was defined as a clinical diagnosis documented in the patient's medical record prior to their colon cancer diagnosis, in accordance with Diagnostic and Statistical Manual of Mental Disorders coded entries. Where available, disease severity was captured via tumour, node, metastasis (TNM) staging and carcinoembryonic antigen (CEA) levels, a biomarker associated with colon cancer progression. "We used both CEA and staging because each offers a different lens on disease severity: CEA as a biomarker and staging as a structural classification," explains Cuomo.

Altogether, a total of 1088 patients were found to have a diagnosis of primary colon cancer and a preexisting drug use disorder, of which 34 had a history of cannabis use disorder.

Results showed that the five-year mortality rate in patients with a history of CUD was 55.88% versus 5.05% for patients without cannabis use disorder (OR=24.40, 95% CI = 11.39 -52.34; P <0.001).

On adjusting the comparisons for demographic and clinical factors (including CEA as a biomarker for disease severity) the risk was reduced to just over 10 fold (OR 10.52, 95% CI = 5.76-19.22; P <0.001).

"We hope these findings encourage more research and more nuanced conversations – about how cannabis interacts with cancer biology and care," says Cuomo.

The relationship between cannabis use and increased mortality, he adds, is likely to be due to biological effects, behavioural factors, and systemic barriers. Cannabis may impair anti-tumour immunity by inhibiting T-cell proliferation, suppressing antigen presentation, and altering cytokine signalling. Frequent cannabis use can be associated with depression, anxiety, and other mental health struggles which might compromise a patient's ability to engage with treatment. As a result, they can experience delayed diagnoses and lower adherence. "The magnitude of our findings suggests physiological mechanisms are playing a role going beyond lifestyle alone," says Cuomo.

The team are now planning prospective studies to examine the biological mechanisms involved, and also hopes to evaluate whether tailored interventions might help mitigate the risk. They hope to incorporate a structured assessment of cannabis use severity, such as validated screening instruments, to provide an indication of exposure levels.

While the current study only included patients diagnosed with cannabis use disorder prior to their cancer diagnosis, the effects of post-diagnosis cannabis use remain unknown and, says Cuomo, warrant future study. Additionally, due to common biological and behavioural pathways, he adds, there is a need to analyse the effects of cannabis on other cancer types, and also to explore the effects of other recreational drugs.

Limitations of the study, say the authors, include the retrospective nature of the data, reliance on coded diagnoses rather than quantified cannabis use, and the possibility that cannabis use patterns changed after diagnosis.

As medical and recreational cannabis use rises globally, understanding the impact on cancer outcomes becomes an urgent clinical and public health priority.

When Ana, a confident assistant manager at a multinational corporation, walked into my counseling office, she was no longer the poised professional her colleagues knew. “I was never meant to be a mother,” she whispered, eyes shadowed by uncertainty and fear. Behind this statement was a recent breast cancer diagnosis, an unexpected rupture that magnified long-held doubts and social pressures.

Ana’s story is not unique. **Healing is not simply a biological process;** it is also an emotional, existential, and psychological journey. Medicine plays a vital role, **but health is co-created,** shaped by beliefs, attitudes, relationships, and meaning. Within this space, a powerful and often overlooked phenomenon can emerge: **Post-Traumatic Growth (PTG).**

## The Emotional Burden of Cancer

A cancer diagnosis fractures a person’s perception of time, body, and mortality. Suddenly,

# Can Healing and Growth Coexist? Post-Traumatic Transformation in Cancer Patients

Adrian Pogacian

philosophical questions about death, meaning, and legacy become urgently real. This rupture can result in anxiety, grief, and depression, but also in profound psychological transformation.

Avoiding negative emotions may offer short-term comfort, but research shows that emotional suppression correlates with poorer health outcomes. Paradoxically, allowing space for emotional complexity, grief alongside gratitude, can foster resilience. Patients who confront their fear and sadness often discover new perspectives and personal strength.

Cancer patients are often driven by two imperative emotional forces: “must” and “want.” These words reflect determination and a desire for life: *I must finish college. I want to see my children grow up. I must survive. These motivations become symbols of personal agency, anchoring patients to hope and purpose in the midst of crisis.*

## Two Diagnoses: Medical and Emotional

Every cancer patient receives not just a physical diagnosis but a **psychological and emotional one** as well. The medical record captures the biological disease; the emotional diagnosis often remains unspoken, buried in silence, shame, or fear.

Patients frequently carry unresolved emotional burdens, including **resentment, regret, and existential guit**. Resentment, unlike momentary anger, is chronic and corrosive. Many patients report that quality of life, while it lasts, depends on releasing these negative emotional energies. Healing, then, becomes a dual process: treating the body and tending to the soul.

## What Is Post-Traumatic Growth (PTG)

The concept of PTG was introduced by psychologists Richard Tedeschi and Lawrence Calhoun in the 1990s to describe **positive psychological change following adversity.** Rather than merely returning to baseline, individuals experiencing PTG develop new strengths, values, and worldviews as a result of trauma.

Trauma disrupts an individual’s core beliefs and forces a reevaluation of what truly matters. This existential “earthquake” can lead to:

- Increased **personal strength and resilience**
- Greater **appreciation for life**
- Enhanced **relationships and empathy**
- A revised **life philosophy**
- Deeper **spirituality or meaning-making**

In oncology, PTG is particularly relevant. Studies have shown that **52% to 74% of cancer patients report moderate to high levels of PTG** (Cordova et al., 2001). Cancer becomes a threshold experience, a before-and-after moment that reshapes identity, relationships, and priorities.

## Case Illustration

Ana initially responded to her diagnosis with emotional withdrawal and denial, compounded by social pressure around motherhood. In therapy, we identified her defense mechanisms and gently worked toward adaptive coping strategies.

One challenge was addressing rumination, the repeated focus on her trauma. While rumination can increase distress, it can also serve as a catalyst for growth when paired with active coping mechanisms.

Research supports this: active coping has been shown to moderate the effects of rumination, improving health-related quality of life (Senger et al., 2023).

Through guided reflection and emotional processing, Ana began to recognize the difference between societal expectations and her authentic desires. Her growth did not come from "beating cancer," but from reclaiming her voice and learning to live according to her values.

## Meaning in Life and Growth

Through guided reflection and emotional processing, Ana began to recognize the difference between societal expectations and her authentic desires. Her growth did not come from "beating cancer," but from reclaiming her voice and learning to live according to her values.

As trauma forces patients to reevaluate their lives, meaning-making becomes essential. Meaning in life (MiL) has been shown to enhance psychological adjustment and promote PTG (Almeida et al., 2022). Patients who find meaning, even in suffering, report higher levels of resilience and well-being.

The threat of mortality, paradoxically, can spark a renewed commitment to life. Patients often speak of small joys, restored relationships, and a deeper sense of purpose. They may discover a **kind of healing beyond physical recovery**, a transformation that redefines what it means to be alive.

## Conclusion: Time for Growth?

Does the oncology patient have time to experience post-traumatic growth?

The answer lies not in a medical chart, but in a philosophical truth. As Marcus Aurelius once wrote: "Do not disturb yourself by imagining your whole life at once." For cancer patients, growth begins by reclaiming the present, one moment, one breath, one insight at a time.

Post-traumatic growth cannot be forced. It is not a performance or a checkbox on a treatment plan. It is a slow unfolding of meaning, forged through pain, reflection, and courage. In that process, cancer is no longer just an ordeal to survive, but a crucible **for profound transformation,** where fear gives way to clarity, and life, however uncertain, becomes deeply and urgently worth living.

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# Empowering Patients in Europe's New Health Technology Assessment

Sophie Fessl

Across the European Union, cancer patients often wait months, or even years for access to promising new treatments already approved by the EMA. Now, the EU’s new Health Technology Assessment (HTA) Regulation is introducing a shared framework for evaluating new treatments. The new regulation, adopted in 2021 and effective from January 2025, aims to harmonize the evaluation of health technologies across Member States and is hoped to speed up access to new technologies. For patients, two questions are central: How can patients meaningfully contribute in this new regulatory environment? And will the new process lead to faster, more equitable access to technologies?

In its rollout, the EU is prioritizing cancer treatments and advanced therapy medicinal products, subject to the new HTA process since January 12, with other indications following in 2030. HTA evaluates the relative clinical effectiveness and broader impacts of new health technologies, such as drugs, devices and procedures, compared to existing treatments. Importantly, HTA is distinct from regulatory approval, assessed in the EU by the EMA: While regulatory approval focuses on whether a treatment is safe and effective, HTA assesses whether the therapy provides added benefit in clinical practice, as well as which economic and societal value it contributes.

## The New HTA Framework: What’s Changing?

approval focuses on whether a treatment is safe and effective, HTA assesses whether the therapy provides added benefit in clinical practice, as well as which economic and societal value it contributes. inconsistent results, as Stanislav Ostapenko, EURORDIS Communications Senior Manager, wrote in 2022: “[...] different agencies use different sources of data and different methods to assess the exact same technology and frequently reach different conclusions. This leads to confusion among the patient community and, in many cases, a lack of transparency in methods exacerbates this effect.”

Speaking with CancerWorld, Monica Racovita, Access and Policy Manager at Myeloma Patients Europe, emphasizes the need to streamline HTA decision making in Europe. “The time from EMA positive opinions to national decisions varies greatly, leading to delayed and unequal access to new treatments. [...] The hope is that the new regulation will shorten assessment time and make the process more efficient by pooling resources for at least a part of the HTA process.”

Under the new regulation, an EU-level HTA process will analyze the clinical effectiveness of new therapies, in a forum termed Joint Clinical Assessments (JCA) that starts after EMA approval. This process does not make recommendations on pricing, reimbursement or overall added-value, decisions which, along with the cost-effectiveness analysis, remain at the national level. Before a new treatment even receives EMA approval, companies can now consult experts on their development plan, e.g. on the design of a clinical trial. These sessions, called Joint Scientific Consultations (JSCs), aim to ensure that the evidence gathered will later meet the requirements of the Joint Clinical Assessments.

## The Role of Patients?

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## Opportunities for Patient Organizations

Patient organizations can become members of the HTA Stakeholder Network and thereby support the work of the Coordination Group, for example by identifying patient experts for JCAs and JSCs. Organizations may also contribute indirectly by training new patient experts.

Especially in rare cancer communities, recruiting patient experts that are both fluent in the regulatory context and capable of representing a broader patient group, beyond their personal experience, is not easy, as Racovita points out.

In addition, the HTA Stakeholder Network may identify emerging health technologies and provide feedback on the annual work program. “There is also the hope that the mandatory involvement of patients in EU HTA will filter down to national decision making and/or inspire more involvement of patients at a national level.”

## Conflict of Interest – or Conflict of Expertise?

According to Racovita, one potential barrier – specifically for the rare disease community - is the conflict of interest (COI) requirement, which stipulates that COIs could arise from financial or other interests in the health technology developers’ industrial sector.

“As we represent patients of a rare cancer, our patient expert pool is not very big”, Racovita says. “That means people with excellent knowledge and experience in regulatory processes are likely to have been involved in a variety of advisory boards and scientific meetings, including some sponsored by the industry.”

In its implementing regulation, the Commission has clarified what constitutes a COI, and examples of COI include having held an executive position in a health technology developer in the past five years, reimbursement above 1000 Euro from one health technology developer over the past three years, or holding shares relevant to the assessed technology. Unpaid participation in community advisory boards does not constitute a COI.

## Acceleration is Uncertain

Whether the new HTA process will accelerate access to new technologies remains to be seen: All non-clinical parts of the assessment remain under the control of national HTA bodies, but it is hoped that timelines may speed up, as all evidence required by EMA and JCAs may be collected in one single trial and national HTA bodies will have to consider the clinical assessment made at the EU-level. and scientific meetings, including some sponsored by the industry.”

However, manufacturers must still submit national dossiers in each Member State, with the key difference being that, in future, the clinical section should reference the JCA report. Member States may request supplementary clinical data for their national assessments, and any data received is planned to be made available to other EU countries via the EU HTA IT platform.

The EU’s new HTA regulation marks a significant change in how new treatments are assessed, offering a new opportunity for patients to inform the regulatory process, and – potentially – reducing delays and inconsistencies in decision-making. Yet, whether these opportunities will come to fruit remains to be seen, as vision meets reality.

# A Bold Step into Building Africa's Cancer Atlas

Esther Nakkazi

Cancer does not affect all populations equally. For individuals of African descent, whether living on the continent or in the diaspora, cancer often presents at different stages, responds differently to treatment, and is associated with poorer outcomes.

Yet, African populations remain strikingly underrepresented in the genomic datasets that underpin cancer diagnosis, treatment, and drug development globally.

In the United States, for example, breast cancer mortality rates among African American women are significantly higher than those of white women, despite similar incidence rates. Globally, less than 2% of genomic data used in cancer research is derived from African populations, while nearly 80% comes from individuals of European ancestry, mostly from North America and Europe. This disparity has direct implications for how effective or targeted current cancer treatments are for African patients.

Now, a Ghana-based biotech company, Yemaachi Biotech, is working to change that narrative, through an initiative called the African Cancer Atlas (TACA). This project aims to sequence 15,000 cancer genomes from African patients over the next three years, dramatically increasing the representation of African data in global cancer research.

"We've entered the age of precision medicine, where treatments are increasingly based on individual genetic profiles," says Dr. Yaw Bediako, immunologist and founder of Yemaachi. "But many of these solutions are least effective in African populations simply because we're not included in the datasets they're built on."

## This is African data. It must benefit African science

The African Cancer Atlas is envisioned as a foundational resource for scientists and clinicians working to understand cancer in African populations. By expanding the diversity of tumor genomic data, TACA aims to inform the development of more accurate diagnostics, predictive tools, and targeted therapies that work better across global populations, not just those of European ancestry.

Yemaachi is executing the project through a consortium model that includes over 25 hospitals and research institutions across nine African countries, many of them leading cancer treatment centers. These partners assist with patient recruitment, ethical approvals, and data collection. Importantly, Yemaachi has also built whole genome sequencing capacity in Ghana, a first for the country.

"This is African data. It must benefit African science," says Bediako. "One of our goals is not just to collect samples, but to empower local researchers and return data to institutions for their own analysis and use."

## Strategic Partnerships and Industry Support

Yemaachi has secured early support from Roche, the first anchor partner in the TACA consortium. The global pharmaceutical company is providing both funding and technical expertise through its African Genomics Program, part of its broader mission to increase access to life-saving cancer care on the continent.

“By 2030, Roche aims to improve the five-year survival rate for 80% of women diagnosed with breast cancer in Africa,” says Lisa Rooney Slater, Head of the African Genomics Program at Roche. “Partnering with TACA fits squarely within our commitment to equitable access to innovation.”

Slater emphasizes that the project not only advances Roche’s goals in Africa but offers critical insights into global oncology.

“Understanding the genomic drivers of cancer in African patients helps all patients,” she adds. “There is immense value in unlocking that knowledge.”

Though the African Cancer Atlas officially launched only recently, it builds on over four years of preparatory work. Yemaachi has already conducted smaller-scale sequencing studies across Nigeria, Tunisia, Côte d’Ivoire, Kenya, and Ghana, producing early insights that highlight the value of this approach.

One notable discovery emerged from sequencing tumors from 200 Ghanaian women with breast cancer, where researchers identified a previously undocumented variant in the BRCA gene, a gene strongly linked to hereditary breast and ovarian cancer. The clinical implications are still under investigation, but such findings underscore why diverse genomic data is critical to advancing global cancer science.

## Challenges and the Road Ahead

Despite strong momentum, building a genomics infrastructure in Africa is not without challenges. Regulatory frameworks, sustainable funding, and government support remain uneven across countries. Moreover, ethical considerations around data ownership, consent, and privacy must be handled with care.

Institutions like the Uganda Cancer Institute (UCI) are cautiously optimistic. UCI is in early discussions to join the TACA consortium while developing its own Center for Cancer Genomics.

“Africa is still significantly underrepresented in published cancer genomes,” says Dr. Nixon Niyonzima, Laboratory Director at UCI. “Projects like TACA are a step in the right direction. But we also need to build local capacity and infrastructure to ensure sustainability.”

Bediako agrees. While proud of Yemaachi’s early success, he sees it as just the beginning.

“Governments need to play a role, but the future of sustainable science in Africa also lies in creating an environment that supports homegrown biotech innovation,” he says. “My hope is that Yemaachi’s journey inspires other young African scientists to pursue not only research but entrepreneurial science that delivers social and commercial impact.”

For Bediako, the work is deeply personal. His interest in cancer was shaped in part by the loss of his father to liver cancer. Trained as an immunologist, he has conducted research in infectious diseases but is now shifting focus to oncology, where he believes African science can make a global mark.

“Africa often gets defined by what we lack, not by our potential,” he says. “But if we build the right ecosystem, with partners, data, and investment, Africa can not only solve its own health challenges but contribute meaningfully to solving the world’s.”

The African Cancer Atlas represents a bold vision of that future, one where Africa is no longer an afterthought in cancer research, but an active, empowered contributor to global innovation.

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