#112 02 / 2026 ISSN: 2036-9468

CANCERWORLD

Cary Adams

A Career of Change, Changing Careers.

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CANCERWORLD
magazine is published
by OncoDaily (P53 Inc)

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ISSN: 2036-9468

NOT FOR SALE

Where progress is measured not just in science, but in vision, leadership, and care.

Every issue of *CancerWorld* explores people, policies, and practices shaping the future of oncology.

In our February issue of *CancerWorld*, we turn our attention to leadership, purpose, and the long-term thinking required to confront one of the world's most complex health challenges. Progress in cancer control is shaped not only by scientific advances but by the people and institutions willing to adapt, collaborate, and invest in lasting change.

This issue we open with the life story of **Cary Adams**. Moving from international banking to lead the Union for International Cancer Control (UICC), his journey shows how openness to change, strategic vision, and a strong sense of purpose can reshape global health institutions. Arriving at UICC without a traditional oncology background, he invested deeply in learning and partnership-building, turning a "wild card" appointment into nearly two decades of organizational renewal. Under his leadership, UICC evolved into a global platform for collaboration, expanding its membership, influence, and ability to drive collective solutions to some of the most complex challenges in cancer control.

The second cover story is a portrait of leadership built on trust and persistence. It follows **Professor Hesham Elghazaly**—an oncologist whose influence is measured not by titles, but by the systems he has built and the lives those systems have changed. Through his work in Egypt, the story shows how personal determination, belief in team and self-power and coordinated collective effort can converge to deliver real declines in cancer mortality and why this human-centred approach may hold lessons far beyond one country.

Cancer remains one of Europe's biggest health challenges, with rising cases and persistent inequalities. In this issue, the EU Commissioner for Health and Animal Welfare **Olivér Várhelyi** charts a clear path through Europe's Beating Cancer Plan: empowering citizens, expanding screenings, and linking 100 high-standard cancer centres across the EU to improve care. Prevention, early detection, and equitable access are central—turning policy into real hope for millions.

Cancer Patients Europe (CPE) is pushing to end cancer inequalities across Europe. Today, where you live can still decide whether you survive, with huge gaps in vaccination, screening, treatment, and survivorship protections. In this issue, *CancerWorld* speaks with CPE about how the *European Semester* on *Health* can turn measurable, accountable action into real health equity for every patient.

In this issue, **Janet Fricker** examines new evidence suggesting CAR-NKT cell therapy may succeed where CAR-T has failed in pancreatic cancer. The approach combines deep tumour infiltration with resistance to exhaustion and antigen escape, while offering an off-the-shelf, lower-cost alternative. Together, the findings point to a more practical and potentially universal immunotherapy strategy now moving closer to the clinic.

Europe's Mission on Cancer is at a decisive moment. In conversations with **Hugo Soares** and **Anabela Isidro**, co-coordinators of the ECHoS Project, *CancerWorld* explored how National Cancer Mission Hubs are moving from plans to action. Political support, collaboration, and patient engagement will determine whether these hubs transform cancer care—or remain ideas on paper.

As cancer treatments race ahead, the heart is often left behind. In this issue, *CancerWorld* speaks with **Professor Arjun K. Ghosh**, the UK's first consultant in cardio-oncology. His aim is simple but radical: not to stop cancer therapy, but to help patients complete it safely. As survivorship grows, cardio-oncology is emerging as an essential part of modern cancer care.

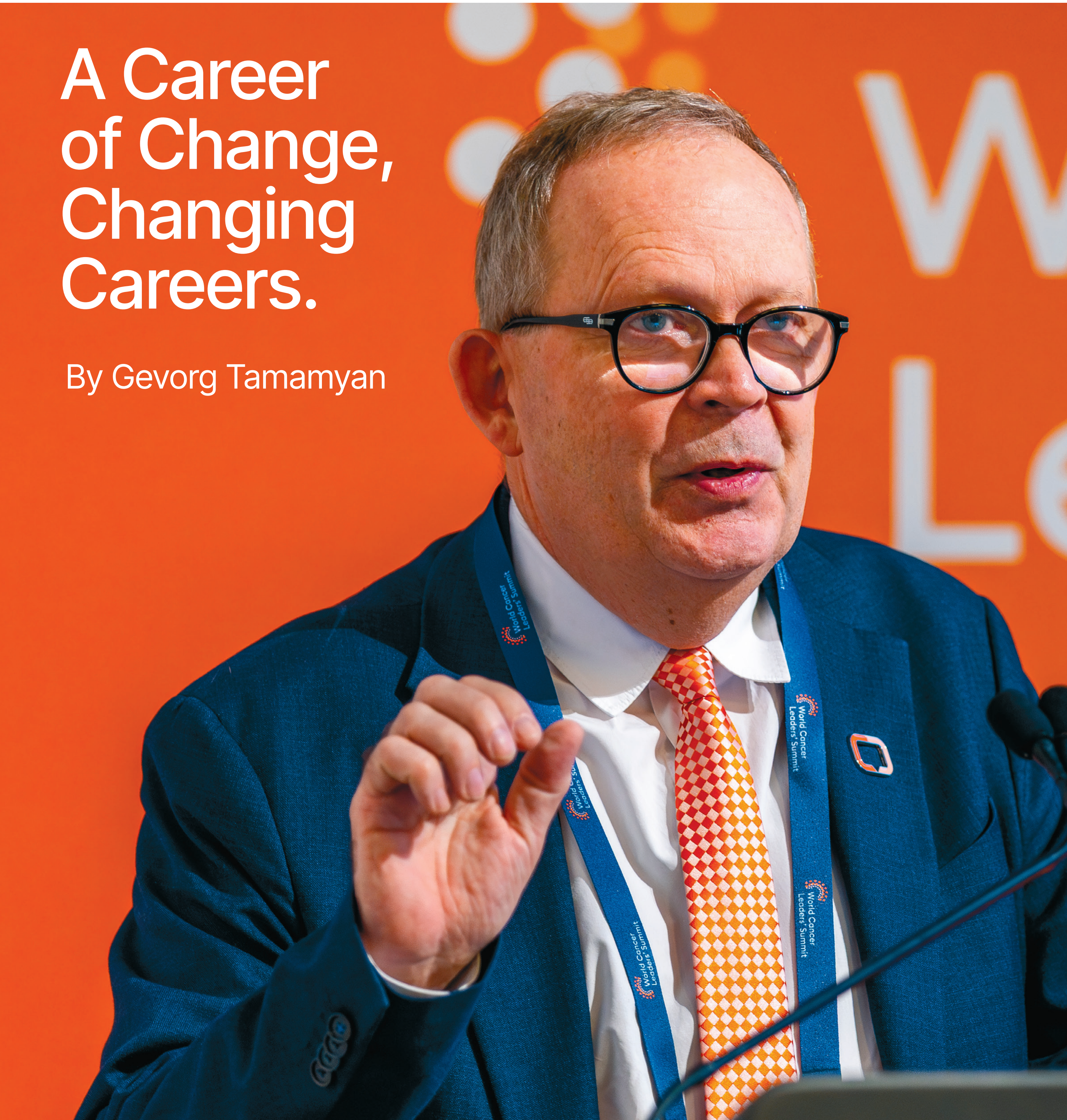
At ABC8 in Lisbon, a decade of breakthroughs in advanced breast cancer met a stark reality: survival gains have not reached everyone. **Dr. Fatima Cardoso** and patient advocate **Claire Myerson** warned that life-extending treatments mean little without equity, long-term support, and health systems that understand what it means to live with metastatic disease. Science has advanced, but care must catch up.

In this issue, **Adrian Pogacian** challenges us to move beyond slogans with *"United by Unique,"* showing how cancer compresses patients' lives and leaves existential suffering often unaddressed. He urges oncology systems to embed psychosocial support and compassion alongside clinical care, taking into consideration individuality.

The stories in this issue underline a central truth: progress is more than innovation. It is leadership that listens, policies that deliver, and care that remembers the human behind every diagnosis. From global institutions to local health systems, the challenge is the same: turn knowledge into action, hope into results, and treatment into a life truly lived.

Knarik Arakelyan, Managing Editor, CancerWorld

CARY ADAMS



A Career of Change, Changing Careers.

By Gevorg Tamamyan

He is passionate about the mission of UICC.

When Cary Adams tells the story of how his career began, it doesn't start with a calling in oncology. It starts with a teenage conversation about what might matter in the future, and a decision, in 1981, to study something that barely existed as a formal discipline.

"There weren't many degrees in computing and econometrics in those days," he recalls. Bath University was offering a new program in economics, computing, and statistics. He liked economics. He liked mathematics. And he sensed that knowledge of computing would become more important in the future years.

It was the first year that the course had ever run. And without knowing it, he had stepped onto a path that would lead him to one business sector for almost a quarter of a century, before the world changed, and he changed with it.

"You've Got No Chance."

With his degree and computing background, banking was the obvious destination. Not just because banks were hiring, but because, even before the internet, he could see the banking sector would become a technology-driven business.

He stayed in that world for 24 years.

He progressed through roles that took him across countries and different business units, resulting in him leading multiple banks around the world from Geneva, and then serving as Deputy CEO and COO for a large group of international banks in the Lloyds TSB banking group.

Then came 2008.

The banking crisis didn't just shake institutions; it forced personal recalculations. *"For multiple years,"* he says, *"I'd been reflecting on whether I wanted to stay in banking, or go into something else."* He had invested in learning—an MBA, and he had attended programs at Harvard, Stanford, Henley, and London Business School. And each time he became more aware of other sectors and the people trying to improve society.

The ones, who were building impact outside banking, especially in the NGO and charity world.

When the banking crisis opened a door for many to leave banking, he also walked through that door.

The job advertisement for the UICC role came through a headhunter based in Geneva. He emailed Cary a two-page description. Cary read it at home in Devon, in the UK.

"By the end of the second page, I was so excited," he says. He wrote to the recruiter immediately: I love this job. How do I get it?

The response was blunt: "You've got no chance."

Not an oncologist. Not a UN insider. No global health background.

Cary asked for one thing: the opportunity to be interviewed as a wild card.

And he made a promise to the headhunter — he would study oncology for two months solidly until the first interviews came around.

He was on what he called "gardening leave," not allowed to work. So, he treated preparation like a full-time job. He visited Cancer Research UK, Macmillan, the World Cancer Research Fund International and other organisations. He read everything he could find online. Ordered books. Watched a Livestrong Summit held in Dublin online. He analysed cancer control plans across Europe. He "deep dived" into the field, and the more people he met, the more he read, the more passionate he became about UICC and the role.

UICC gave him the interview.

He was offered the job. CEO of the Union for International Cancer Control.

That was 16 years ago.

"In some ways," he reflects, "my story is about luck at certain points, but also about making the most of an opportunity, when it arises." Then he adds, with the kind of gratitude that never sounds rehearsed: **"I love my job. I love the people I work with. I count myself very lucky."**

Rebuilding UICC From the Inside Out

When Cary arrived at UICC, it was respected and historic—founded in 1933, with major assets like the TNM manual and the *International Journal of Cancer, but,* in his view, it wasn't structured to fulfill its own ambition.

Membership was around 350 organizations. The Geneva team functioned mainly as a secretariat supporting the board. Even some well-known member organisations, when he contacted them, had little to say about what UICC actually did for them. They were members, but didn't feel part of a community.

So, he and the Board of Directors did something many organisations avoid: they had an open, honest conversation about what UICC should become within a 10-year period. They created a 10-year plan: a "Roadmap," divided into phases.

Phase one of the Roadmap was called "Getting Organised" and focused on restructuring the organisation— improving governance, changing the Constitution, developing the team, and even changing the organisation's name from the International Union Against Cancer to The Union for International Cancer Control - matching the mission more clearly. Cary describes the original name as confusing for an outsider.

They restructured the team as well. "We had a great team in UICC, but we did not have the right skills or competencies to deliver the changes we needed to deliver in the Roadmap," - the new mandate agreed with the Board needed a different kind of structure to grow influence and impact.

Then came the next two phases from 2011 to 2020—**building momentum, increasing influence globally**, and UICC started to grow the membership, its partner base, and develop a reputation for excellence around the world.

UICC's membership passed 1,000 members - a membership base that felt like it was part of a growing community. The size of the UICC team doubled. Funding became more assured.

They also reshaped how the world gathers around cancer—re-engineering the World Cancer Congress, and creating the World Cancer Leaders' Summit, which didn't exist before.

Creating a New Future

Over the years, UICC also helped establish or spin off entities to fill gaps that needed dedicated, long-term, sustainable solutions to be truly impactful:

- The NCD Alliance, helping raise the global profile of noncommunicable diseases at a time when global health conversations were dominated by communicable diseases and maternal-child health.
- The McCabe Centre for Law on Cancer, built on a simple idea: cancer control cannot succeed without legal frameworks at a national level.
- City Cancer Challenge (C/Can), now working in 16 LMIC cities worldwide—born from an earlier strategic realization that the future of health systems may increasingly be shaped in large urban centers.
- The ATOM Coalition, developing commercial pathways to deliver cancer medicines into low- and lower-middle-income countries—work that Cary says will impact the lives of thousands of patients, who otherwise would not have had access.

For him, the organising principle is consistent: reduce the chances of cancer, and when cancer happens, ensure early detection, and there is access to good treatment. *"Everything we've done,"* he says, *"has been about improving outcomes year after year after year."*

"Complex Problems Demand Complex Solutions"

When you ask Cary what has challenged him most in his role, he doesn't point first to politics, funding, or global complexity. He starts with something personal.

He arrived in a world where he had no network, no shared language, no familiarity with how oncology and the UN system worked.

"It was completely weird and strange to me," he says.

He credits people around him—staff, mentors, leaders and board members - who invested in him and helped him navigate a very complex world.

Then came the second challenge, which almost every NGO leader recognizes: securing credibility for the organization. In global health, funding and partnerships require trust, and trust requires a track record. If you start without one, you must earn it.

And then there is the central problem of global cancer control: almost nothing can be solved alone.

Cary's instinct is collective solutions—bringing multiple partners around the table. But collective work has a price: every organization has its own ambition, its own incentives, its own internal pressures.

"It can be difficult," he says, *to align those forces. "Delivering impact with multiple partners from different sectors is not easy".*

Still, he insists that collective solutions are the ones that last. Sustainable cancer challenges require sustainable long-term answers, and those answers usually come from coalitions, not solo acts.

"And that," he adds, "is where there's the greatest challenge, the opportunity for the greatest impact and the greatest satisfaction."

People and Governance with Purpose

Asked about the key to his success, Cary doesn't think a minute—people and structure.

First: *"I always have a great team around me."*

He learned early in banking that part of the leadership challenge is knowing your own and the organization's strengths and being honest about the weaknesses. Then, building a team that can take the organization forward.

Second: *"You have to get governance right".*

He speaks about UICC's governance with pride: clear roles, strong oversight, engaged leadership, outstanding boards drawn from around the world, and presidents who have consistently elevated the organization's profile and mission.

It's not governance for its own sake. It's governance focused on what matters: delivering the mission, having impact and addressing cancer control - governance with purpose.

"Who Will Replace Us in 20 Years?"

Cary believes leadership carries multiple obligations, but one of which he believes is developing others.

"You have two jobs as a leader," he says. One is to lead the organisation. The other is investing in people, giving them opportunities, and sometimes helping them discover ambitions they didn't know they could reach.

He traces this philosophy back to his early years in banking, when he joined a structured development program. There were only 12 recruits in his program in the year he joined. They received coaching, mentorship, training, and were given a long-term plan designed around a 20-year horizon—an almost unbelievable level of investment, which he feels incredibly grateful for today.

He carried that mindset into UICC.

The **Young Leaders Program**, he explains, was initiated by then-president Mary Gospodarowicz, shaped by a simple question: *Who will replace us in 20 years?*

So they built a pipeline—structured, intentional—identifying people with the potential to become global players in health within 10 to 20 years.

He names early participants with visible pride: Andre Ilbawi; Miriam Mutebi; Daniel Rodin; Gevorg , people who were recognized early on for their talent and potential to become global health leaders. And they have all become outstanding leaders in global health.

He also shares a moment that stayed with him: sitting in a meeting of CEOs of health organizations in Geneva last year, and realizing three of the other CEOs used to work at UICC. *"I was really proud of that,"* he says.

The World Changes, So Strategy Must Too

UICC, Cary explains, works with a rolling three-year business plan—currently setting direction through to the end of 2028.

But UICC maintains the same long-term thinking it believes in and every 4 years reconsiders what cancer control may look like in ten years' time and how UICC should prepare for this.

Every four years, UICC conducts a strategic review—not a business plan refresh, but a "where is the world going?" exercise:

What will change in global health? What risks are coming? What opportunities are emerging? Where must the cancer community prepare early?

He gives concrete examples:

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- What will change in global health? What risks are coming? What opportunities are emerging? Where must the cancer community prepare early?
- He gives concrete examples:

He's honest: he can't say yet exactly what UICC will look like in 10 years. But after the next strategy review in February, he expects that long-term ambition to sharpen his view on what is needed in the next few years.

The Story that Moves Him Most

When asked for one story that deeply impacted him, Cary says he could write a book, and he intends to write it when he leaves UICC.

But if he must choose one theme, it isn't a single event.

It's the people. The amazing people who work in cancer control worldwide.

On **World Cancer Day**, he describes sitting at his desk as the day "opens up" early from New Zealand onward, watching social media fill with activity, announcements, media coverage, and volunteer-driven momentum.

"I have nothing but pride in our community," he says.

He's astonished by how many people give their time voluntarily to help cancer patients. He's moved by clinicians, who do their work, then do even more. He's inspired by the volunteer backbone that supports UICC's programs, sits on its congress committees and reviews all the fellowship applications.

He calls it extraordinary.

Who is Cary Adams?

He jokes first: *"An aging British man."*

Then he offers the real answer—a story from 1997, when he was losing his way in banking and read widely to find inspiration and direction. One book posed the question: *What is your mantra? What are you about?*

He realized he had been measuring his personal success in the wrong currency: scores, annual reviews, reports, promotions, salary increases, and bonuses.

So he wrote a new mantra, one he says still guides today:

"I want to have a positive impact on the lives of the people I meet."

No hierarchy. No exceptions. Whether it's a waiter, a colleague, a minister, or a friend.

"That," he says, *"is what I hope people feel I live every day."*

"It's not always possible, but it has guided me very well over many years."

Who Should You Interview Next?

Cary's answer is immediate: **Miriam Mutebi.**

Because she represents the arc he believes in: a Young Leader, who became a UICC board member; a leader in Africa, who grew into a global health figure; a former AORTIC president; involved in Lancet commissions; a powerful presence on social media—yet, as he puts it, "beautifully humble," and deeply committed to helping people.

ONCODAILY MEDICAL JOURNAL

Peer-reviewed
Open-access
Scientific journal

doi.org/10.69690/odmj
oncodailyjournal.com
ISSN: 3067-6444

The Path Forward is Clear

Interview with **Olivér Várhelyi**, EU Commissioner for Health and Animal Welfare

By Yeva Margaryan

Image Credits: European Union 2025 - Source: European Parliament

Cancer remains one of Europe's most significant public health challenges, with incidence rising and inequalities in prevention, diagnosis, and care persisting across Member States. On **World Cancer Day**, attention turns to how policy responses are evolving to address these pressures. In this exclusive interview, **Olivér Várhelyi, European Commissioner for Health and Animal Welfare**, outlines the current direction of EU cancer policy, highlights progress under Europe's Beating Cancer Plan, and sets out priorities for strengthening prevention, improving access to care, and reducing disparities across Europe.

Cancer is a Key Priority – Both for Me and the Commission

Yeva Margaryan: Since the start of your health mandate, how have your priorities on cancer evolved, and what has most shaped your understanding of the scale and urgency of the cancer challenge in Europe?

Olivér Várhelyi: *Cancer is a key priority – both for me and the Commission as a whole, as it remains one of the most important public health challenges in Europe. This is reflected in my mission letter, which calls to continue implementing Europe's Beating Cancer Plan. This is why we conducted and published a comprehensive review of the Plan a year ago. It confirmed we should focus on implementing and sustaining the actions included in it. Therefore, the path forward is clear.*

Despite some improvements, there are roughly 2.7 million new cancer cases diagnosed every year in the EU alone, with around 1.3 million deaths annually, making it the second leading cause of mortality in the EU, just behind cardiovascular diseases. Since 2000, new cancer cases have surged by about 30%, and this trend is expected to grow, with estimates predicting half a million new cases by 2040. Moreover, significant geographical and socioeconomic disparities in cancer burden persist. This requires urgent actions to close these gaps across the EU.

Yeva Margaryan: World Cancer Day is also a moment to take stock. Which achievements in EU cancer policy over the past one to two years are you most proud of, and why do you believe they matter for patients and families across Europe?

Olivér Várhelyi: *We have plenty of success stories under the Cancer Plan. Let me give a few examples, but bear in mind that there are many more actions and initiatives that have had a real impact, improving the lives of cancer patients and those around them.*

This World Cancer Day, I am proud to announce the launch of the European Code Against Cancer in all EU languages. This unique tool can empower EU citizens to take control of their own health and make informed decisions to reduce their cancer risk. Backed by solid scientific evidence, it is the work of over 60 experts from across Europe, making reliable cancer prevention information accessible to all.

Another success story is the launch of the European Network of Comprehensive Cancer Centres last November. It was officially launched as a part of the EU Joint Action EUnetCCC, which brings together 163 partners in 31 countries, including all EU Member States. This network will link 100 high-standard cancer centres across the EU, which will collaborate to reduce cancer inequalities, share best practices, and provide better access to clinical trials and innovation. It aims to provide 90% of eligible cancer patients in the Union with access to high-quality cancer care by 2030.

Last, the development of the European Commission Initiatives on cancer screening and treatment is worth mentioning. They serve as an umbrella for the development of two key products: evidence-based European guidelines on primary prevention, screening, and diagnosis; and quality assurance schemes for healthcare services along the entire care pathway. Initially, covering breast, colorectal, and cervical cancer, we have extended this work now to lung, prostate, and gastric cancer. As such, we cover cancers that are jointly responsible for more than half of all cancer cases and related deaths in the EU. These products follow a patient-centred approach and have a direct impact on the quality of cancer screening and care, as well as on reducing inequalities across Europe.

Europe's Beating Cancer Plan

Yeva Margaryan: Europe's Beating Cancer Plan raised expectations across the cancer community. Where does the Commission now see the clearest progress since its launch, and what elements have delivered more impact than initially anticipated?

Olivér Várhelyi: *As mentioned, we have delivered in the areas of early detection, diagnosis, and treatment, in line with the European guidelines and quality assurance schemes.*

In cancer screening, I think it is fair to say that the impact of our work has been even bigger than expected. With the 2022 Council Recommendation on cancer screening, we now have comprehensive guidance for Member States on how to improve access to and quality of their screening programmes, based on the latest available scientific evidence.

Following the adoption of the Recommendation, we have been able to mobilise substantial funding in this area, for example, through the EU4Health Programme and Horizon Europe. The response from Member States and the wider stakeholder community to these funding opportunities was overwhelmingly positive, and we have seen some substantial progress. This includes piloting lung, prostate, and gastric cancer screenings, as proposed in the Recommendation. Additionally, we have seen many Member States align their screening protocols with those indicated in the Recommendation. This is a voluntary mechanism, and nonetheless, it has been able to spark change across many countries.

We also made progress in understanding and addressing cancer inequalities, one of the horizontal objectives of the Cancer Plan. With the establishment of the European Cancer Inequalities Registry, we now have a regular reporting mechanism that helps us monitor and analyse progress in cancer prevention and care across the EU. Through its Data tool, Country Cancer Profiles, and EU Analytical Reports, this initiative highlights disparities and areas for action to guide investments at the EU, national, and regional levels. Member States have already communicated the importance and usefulness of the initiative to identify national priorities, discuss country performance, or engage with patient advocacy groups.

Inequalities, Infrastructure, and the Limits of Progress

Yeva Margaryan: Cancer policy remains uneven across EU Member States. Where has the Commission encountered the greatest challenges or slower progress in implementing cancer-related initiatives, and what lessons are shaping the next phase of action?

Olivér Várhelyi: *The progress across Member States depends on various factors such as differences in national health systems and infrastructures, as well as financial capacities.*

For example, in the establishment of the EU Network of Comprehensive Cancer Centres, we initially faced challenges in bringing together diverse stakeholders and certification schemes. However, the aspiration of creating EUnetCCC has had a very motivating effect on all Member States to establish comprehensive cancer centres, irrespective of their current situation. We are now seeing Member States more advanced in this area, supporting others in this effort.

Through collaborative efforts with key organisations, we have been able to find solutions and move forward with the network, with a view to linking 100 high-standard cancer centres across the EU. This experience has taught us the importance of flexibility and cooperation in overcoming these hurdles, and we are applying these lessons to shape the next phase of our cancer policy. To cut it short: inequalities across the entire cancer care pathway persist, and much work is still required.

Prevention First

Yeva Margaryan: Prevention is central to reducing the cancer burden, particularly for future generations. What concrete steps has the Commission taken to strengthen cancer prevention, and where do you believe the EU prevention policy still needs to be more ambitious?

Olivér Várhelyi: *To strengthen cancer prevention, the Commission has taken concrete steps, like the launch of the fifth edition of the European Code against Cancer in all the EU languages on World Cancer Day. This valuable resource provides individuals with evidence-based prevention strategies, enhancing health literacy and empowering them to reduce their cancer risk. Given that 40% of all cancers are preventable, I believe the EU prevention policy still needs to be more ambitious in achieving the widespread adoption of the Code's recommendations. By doing so, we can ensure that all Europeans have access to effective prevention strategies and reduce the cancer burden for future generations.*

Looking ahead, a major task for this year will also be the evaluation and revision of the tobacco legislation, for which stronger tobacco and nicotine control measures on both product regulation and advertisement are envisioned.

Cancer Plan as a Blueprint for the Safe Hearts Plan

Yeva Margaryan: The Safe Hearts Plan introduces a structured, lifecycle approach to prevention, early detection, treatment, and long-term care. Do you see this as a blueprint for a future, more integrated EU cancer framework? If so, which elements could realistically be replicated?

Olivér Várhelyi: *In fact, the Cancer Plan has served as a blueprint for the Safe Hearts Plan, not vice versa. The Safe Hearts Plan has been modelled on the comprehensive approach of the Cancer Plan, which is one of its main factors of success. It takes the same approach of covering the entire care pathway, from prevention and early detection, over diagnosis and treatment, to the quality of life of cancer patients and survivors.*

Image Credits: European Union 2025 - Source: European Parliament

The Safe Hearts Plan builds on the experience of the Cancer Plan and creates synergies by strengthening prevention and action on shared determinants: unhealthy diets, physical inactivity, harmful alcohol consumption, and tobacco and nicotine use.

It also addresses health inequalities through a cardiovascular health inequalities dashboard, modelled on the Cancer Inequalities Registry and supporting more consistent care, for better outcomes across regions and population groups.

Innovation, Regulation, and the December Health Package

Yeva Margaryan: The December Health Package emphasises prevention, innovation, and resilient health systems. How does the Commission see this package supporting the next stage of Europe's fight against cancer, and what tangible benefits should stakeholders expect?

Olivér Várhelyi: *In addition to the above Safe Hearts Plan, the December Health Package includes the Biotech Act and the revision of Medical Devices Regulations, and reflects our strong commitment towards improving cancer prevention and treatment.*

The Biotech Act will simplify the regulatory environment and facilitate funding and investment for health biotech companies. We expect it to boost cancer-related innovation and bio-manufacturing, from precision diagnostics to advanced therapeutic medicinal products (ATMPs) and immunotherapies.

The proposal to revise the Regulations on Medical Devices aims to simplify and further harmonise the relevant legal framework, so that we continue to ensure a high level of patient safety, while unlocking innovation for life-saving technologies. This is extremely valuable for modern oncology, as medical devices and in-vitro diagnostics increasingly allow for early prevention, accurate diagnosis, and effective treatments of cancer, improved survival, and better quality of life.

Moreover, the reform of the EU pharmaceutical legislation, complemented by the Critical Medicines Act, provides tools and incentives to support the development, access, and affordability of new therapies.

Solidarity, Hope and Determination

Yeva Margaryan: On World Cancer Day, what message would you like to share with people affected by cancer, and what personal priority will guide your work as Commissioner in the years ahead?

Olivér Várhelyi: ***On World Cancer Day, my message to everyone affected by cancer, patients, survivors, and families, is one of solidarity, hope, and determination****. I know that millions of people across Europe are battling the disease and that it requires great courage, strength, and resilience to get through this. I also want to acknowledge the healthcare professionals, carers, and researchers who work tirelessly every day to tackle cancer and to save and improve lives.*

As the Commissioner responsible for Health, my priority in the years ahead will be to ensure we fulfil the Cancer Plan's full potential and turn the shared knowledge and innovation across Europe into real, tangible outcomes for people. This means strengthening prevention and early detection and reducing inequalities, so that the chance of surviving cancer does not depend on geography or income. It also means strengthening Europe's strategic autonomy in the healthcare sector, accelerating research, supporting innovation, and boosting investment. It's essential, so that we have a strong, thriving, and competitive sector that can deliver cutting-edge treatments for cancer patients across our Union. We have taken important steps in this direction in my first year in office, and I will remain laser-focused on this goal for the rest of the mandate.

What Success Looks Like by the End of the Mandate

Yeva Margaryan: By the end of this Commission's mandate, what outcomes would convince you, and Europe's cancer community, that the EU action has genuinely moved the needle on cancer prevention, care, and survival?

Olivér Várhelyi: *By the end of this Commission's mandate, I would consider our efforts a success, if we see a significant reduction in cancer cases and improved treatment outcomes across Europe.*

Specifically, I would like to see a wide reach and impact of the European Code Against Cancer, with more people taking steps to reduce their own cancer risk.

For cancer screening, the Cancer Plan has the objective to ensure that 90% of eligible citizens have access to organised screening programmes for breast, cervical, and colorectal cancer. Any progress here would be an important success too. Access is the first essential step, and it is still uneven across Europe, as not all countries have implemented these priority screening programmes yet in an organised and population-based manner. Once these programmes are in place and running well, countries should start implementing new programmes for lung, prostate, and gastric cancer screening, based on the research and pilot studies we have supported with EU funding, as well as the guidelines and quality assurance mechanisms we are developing.

Beyond access, it would of course also be great to see the number of people participating in these screenings rise, as participation rates still vary significantly across Member States. Concerted efforts like the Joint Action EUCanScreen, which brings together 29 countries supported with EUR 31 million of EU funding, not only aim towards increased access and participation in cancer screening, but also greater equality across the EU.

Additionally, I expect the EU Network of Comprehensive Cancer Centres to be fully established then, providing access to high-quality care for millions of Europeans. **If we can achieve these goals, it will be a clear sign that our work is making a real difference in the fight against cancer.**

Conclusion

The path forward is clear, anchored in the decision to keep cancer at the centre of EU health policy. This continuity reflects a sustained commitment to prevention, care, and long-term action at a time of growing need. The measure of this commitment will ultimately be written in outcomes, and there is a reason for hope.

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The European Semester on Health

Why CPE is Calling for Action on Cancer Inequalities

By Cancer Patients Europe

Across the EU, cancer inequalities are stark along the entire care pathway – prevention, screening and early detection, diagnosis and treatment, and survivorship care. HPV vaccination rates remain far below the 90% target in most countries; colorectal cancer screening ranges from 5% in some Member States to 76% in others; and access to guideline-recommended lung cancer medicines varies from about 50% to nearly 80%. These gaps translate into unequal survival and quality of life. Only eight Member States guarantee cancer survivors the "Right to be Forgotten", showing that where a person lives in Europe can still determine their cancer outcome.

To address and help overcome these inequalities, on 14th February 2024, Cancer Patients Europe (CPE), together with the Central European Cooperative Oncology Group (CECOG), launched the **European Semester on Health Manifesto** at the European Parliament during the high-level event "Cancer Momentum: Fighting Inequalities Across Europe".

The initiative addressed one of Europe's most pressing challenges: persistent and unacceptable inequalities in cancer care, grounded in the conviction that **where you live should not determine if you live**.

The event, hosted in collaboration with MEPs from the EPP and S&D, presented the CPE–CECOG joint manifesto on addressing cancer inequalities through the European Semester. Speakers, including MEPs Andreas Schieder (S&D), Cristian Bușoi (EPP), and Tomislav Sokol (EPP); Dr. Caroline Berchet (OECD); patient advocates Alina Comanescu (Community Health Association Romania) and Patrycja Rzadkowska (EuropaColon Poland); as well as Prof. Christoph Zielinski (CECOG) and CPE Chair of the Board Francisco Lozano, highlighted persistent disparities across the cancer pathway and called for coordinated, data-driven, and patient-centred action at the EU level.

The launch marked a milestone in CPE's advocacy to ensure that the chances of surviving cancer are not dependent on geography. By placing cancer inequalities at the heart of EU economic and governance discussions, the Manifesto aims to move beyond commitments and towards concrete, measurable action.

What is the CPE European Semester on Health Manifesto?

The European Semester is the EU's primary framework for coordinating economic, fiscal, and social policies across Member States. Since 2020, health has been formally included in the Semester process through health-related thematic annexes in country reports, reflecting growing recognition of the link between health, economic resilience, and social stability. However, these considerations have so far remained limited in scope and are often framed predominantly through a budgetary lens.

CPE argues that health outcomes and cancer outcomes, in particular, must be more systematically and meaningfully embedded within the EU economic governance. Health is not only a social priority; it is a fundamental driver of workforce productivity, competitiveness, and long-term sustainability. The European Semester on Health Manifesto therefore calls for the structured integration of cancer-related indicators into the Semester process, enabling measurable, comparable, and accountable action on cancer inequalities across Europe.

With strong political momentum at the EU level and robust data already available through instruments such as the European Cancer Inequalities Registry, cancer is well placed to serve as a pilot for strengthening the health dimension of the European Semester.

Why Cancer and Why Now?

Cancer remains a top EU priority, underpinned by flagship initiatives such as Europe's Beating Cancer Plan and the European Cancer Inequalities Registry. Together, these initiatives have generated unprecedented data and policy frameworks that can now be better connected to EU governance mechanisms. While health has begun to feature in the European Semester since 2020, and by 2024 health indicators appeared in the main country's reports of seven Member States, these references remain limited and largely financial in nature.

Persistent inequalities across the cancer pathway from prevention and screening to diagnosis, treatment, and survivorship remain stark and well-documented. Access to HPV vaccination, organised screening programmes, advanced diagnostics, innovative medicines, and survivorship protections continues to vary dramatically across countries and regions, translating into unequal outcomes and preventable deaths.

Many of the actions needed to address these gaps sit at the national level, making coordination, transparency, and accountability essential. By embedding cancer-specific, standardised, and comparable indicators into the European Semester, EU and national commitments under Europe's Beating Cancer Plan can be systematically tracked, discussed, and followed up through evidence-based country-specific recommendations. As CPE firmly believes, what gets measured gets done.

The Manifesto's Core Objectives

The Manifesto sets out two clear and actionable objectives:

1. **Pilot the inclusion of cancer and cancer - related indicators in the European Semester process**, making cancer outcomes visible within EU governance and enabling structured dialogue between the European Commission and Member States.
2. **Further develop the Inequalities Registry**, with the goal of creating a European cancer dashboard that can feed into the European Semester pilot, allowing transparent comparison, monitoring, and follow-up on cancer outcomes across countries. Together, these actions aim to strengthen accountability, support evidence-based policymaking, and foster closer collaboration between EU institutions, national governments, patients, clinicians, and other stakeholders.

Building Momentum Beyond the Parliament

The goals set out by the Manifesto did not stop at its launch at the European Parliament in February 2024.

With further engagement at the European Health Forum Gastein (EHFG), where stakeholders reiterated the need to use cancer as a pilot area within the European Semester framework. The session brought together a diverse panel of high-level speakers, including Christoph Zielinski (CECOG), Silvia Ganzerla (EuroHealthNet), and MEP Vytenis

Andriukaitis (S&D, Lithuania), stressing the political urgency of keeping cancer high on the EU agenda. Contributions also came from Marilys Corbex (WHO Regional Office for Europe on prevention challenges), Alina Comanescu (Community Health Association Romania), Alexander Roediger (MSD), our Senior Policy Officer Josephine Mosset and the Young Forum Gastein on implementation success factors, and CEO of CPE Antonella Cardone, highlighted key prevention challenges, the importance of patient involvement, the role of robust cancer indicators, and the conditions needed to successfully implement a European Semester on Health with cancer as a pilot.

Additionally, on 6th February 2025, CPE hosted the high-level event "Building Momentum: Integrating Health into the European Semester" at the European Parliament. Hosted by MEP Vlad Voiculescu (RENEW), the discussion featured speakers from across EU institutions and the wider health community, including MEPs Tomislav Sokol (EPP, Croatia) and Vytenis Andriukaitis (S&D, Lithuania), alongside representatives from the European Commission, the Committee of the Regions, and the OECD. Among them are, Dirk Van den Steen (DG SANTE), Anton Mangov (DG Employment), Dorota Tomalak (Committee of the Regions), and Dr. Caroline Berchet (OECD). Voices from patients, civil society, and health networks were also represented, including our CEO Antonella Cardone (CPE), Goranka Perc (Nismosame), Michele Calabrò (EUREGHA), Silvia Ganzerla (EuroHealthNet), and other regional and policy stakeholders.

These discussions reinforced the importance of aligning national cancer policies with broader EU objectives and ensuring that health equity becomes a central pillar of European decision-making.

Support for the initiative includes named endorsements from Members of the European Parliament such as MEPs Tomislav Sokol and Michalis Hadjipantela (EPP), Andreas Schieder, Matjaž Nemec, Nikos Papandreou and Vytenis Andriukaitis (S&D), Tilly Metz and Ana Miranda (Greens/EFA), and Vlad Vasile-Voiculescu (Renew Europe), as well as former MEP Cristian Bușoi (EPP). The manifesto is also backed by key cancer stakeholders, including the European Union of Private Hospitals (EUPH), the European Institute of Women's Health (EIWH), the Federation of European Academies of Medicines (FEAM), the European Liver Patients' Association (ELPA), the Association of European Cancer Leagues (ECL), the European Association of Urology (EAU), EuropaColon Polska, and the European Society for Pediatric Oncology (SIOPE), highlighting strong alignment between policymakers, patient advocates, and the oncology community in addressing cancer inequalities across the EU.

What Comes Next: The Transition from Vision to Implementation

The European Semester on Health Manifesto represents a decisive step in moving from political commitment to measurable action on cancer inequalities in Europe. By embedding cancer outcomes into the EU's economic governance framework, the initiative recognises that health equity is not only a moral imperative but a prerequisite for Europe's social cohesion, resilience, and competitiveness. With strong political support, robust data already available, and patients firmly at the table, cancer can and should serve as the pilot for strengthening the health dimension of the European Semester. For CPE, the message is clear: where you live should not determine whether you survive cancer, and what gets measured, discussed, and acted upon at the EU level can help make that principle a reality.

Building on the political momentum generated by the European Parliament event in February 2025, CPE has developed a concrete proof of concept by identifying in partnership with the Swedish Institute for Health Economics (IHE), cancer-related indicators that could be integrated into the European Semester. This framework demonstrates how existing, comparable EU-level cancer indicators can be systematically embedded within the Semester process to monitor performance, identify gaps, and support targeted policy action.

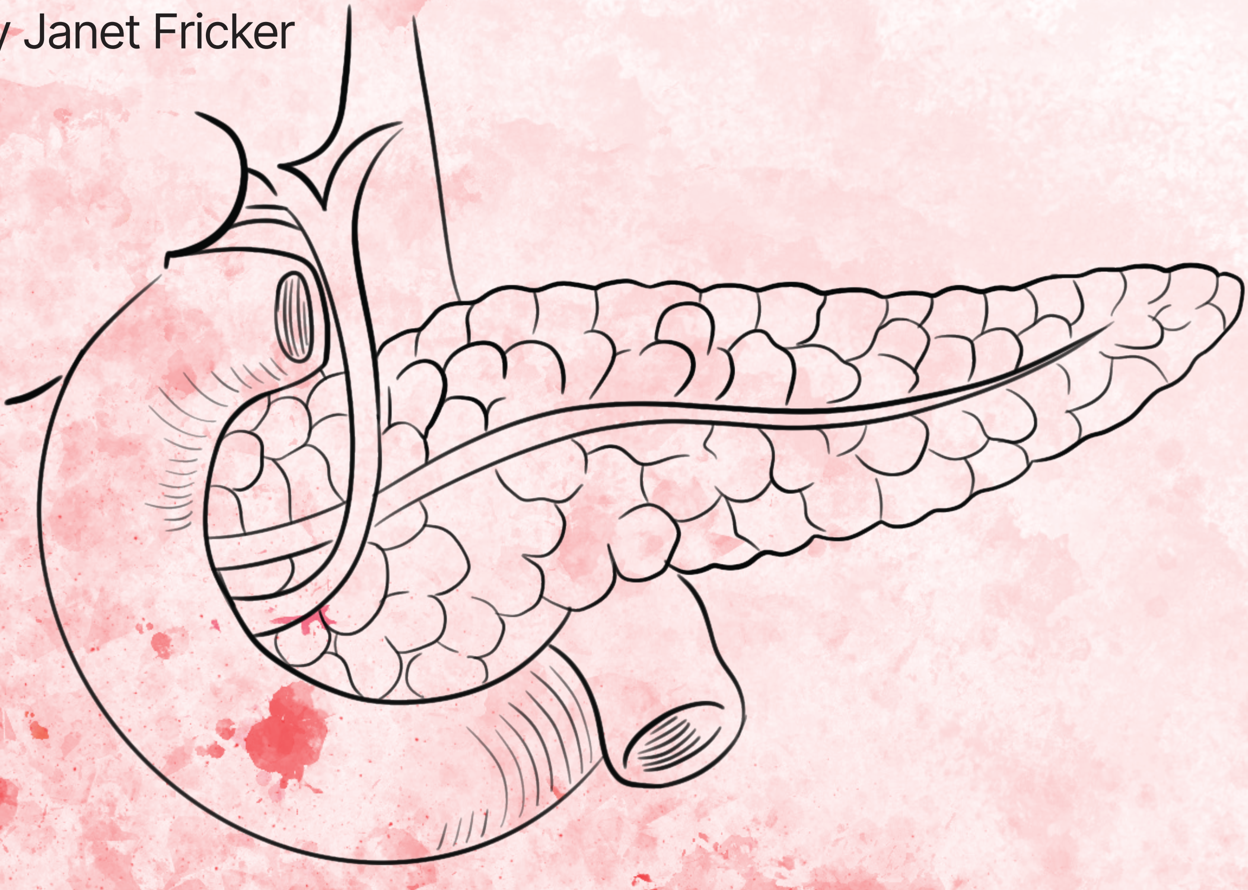
In 2026, CPE will seek further political, institutional, and stakeholder endorsement of this proof of concept, while continuing to refine the framework and broaden its relevance across EU Member States.

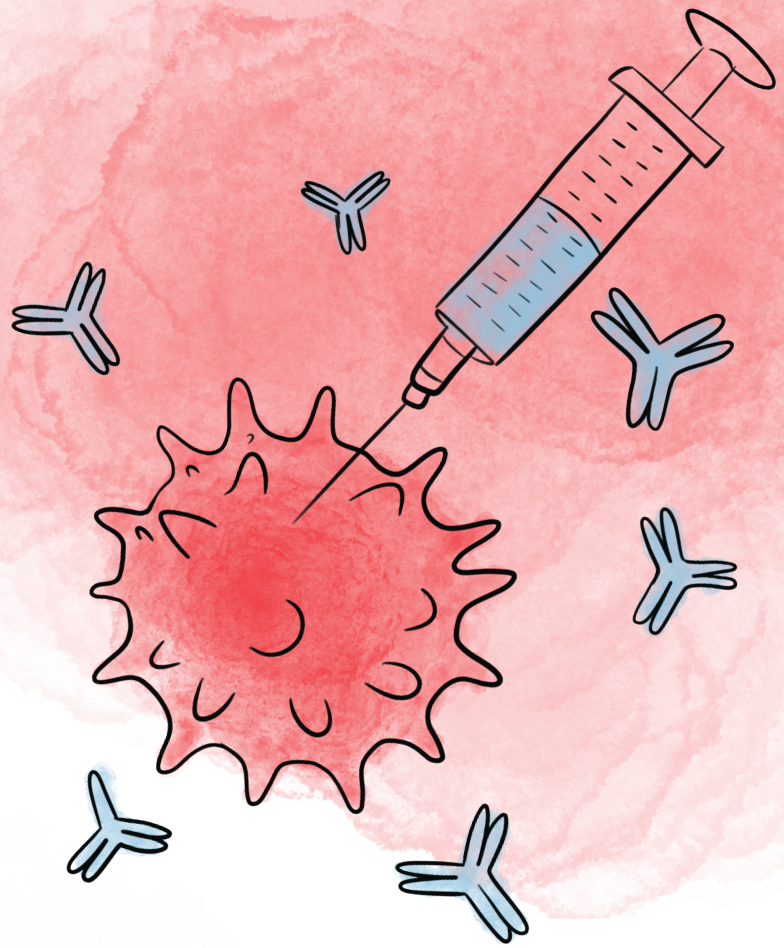
By sustaining momentum and anchoring cancer equity within EU economic governance, ***this initiative aims to ensure that today's commitments translate into lasting improvements in cancer outcomes tomorrow.***

Rethinking Immunotherapy for Pancreatic Cancer

A Universal Approach

By Janet Fricker





Chimeric antigen receptor natural killer T (CAR-NKT) cell therapy, a novel form of immunotherapy, is emerging as a promising 'off-the-shelf' treatment for patients with pancreatic cancer. In a study published in PNAS, November 21, 2025, U.S. investigators report that CAR-NKT cells can effectively track down and destroy pancreatic tumours, both within the pancreas and after metastasis to distant organs. This publication builds on earlier studies from the UCLA research team, also published last year, which demonstrated the therapeutic potential of CAR-NKT therapy in both ovarian and breast cancers.

"Taken together, the pancreatic, ovarian, and breast cancer studies lead to a clear and unifying conclusion that allogeneic, stem cell–derived CAR-NKT cells represent a broadly effective and scalable immunotherapy platform for solid tumours that have historically resisted CAR-T cell therapy," ***the first author Yan-Ruide (Charlie)*** **Li** *tells CancerWorld. "Across all three cancers, CAR-NKT cells achieved superior tumour control in orthotopic (tumours in their natural setting) and metastatic settings, demonstrating effective trafficking, deep tumour infiltration, and durable antitumour activity in hostile tumour microenvironments. In pancreatic and breast cancer, CAR-NKT cells suppressed both primary and metastatic disease; while in ovarian cancer, they achieved tumour eradication and long-term survival even under high tumour burden, repeated tumour challenge, and CAR antigen–loss conditions."* The therapy, adds Li ,can be mass-produced from donated blood stem cells and stored ready-to-use at an estimated cost of $5,000 per dose.

Why Doesn't CAR-T Cell Therapy Work in Solid Tumours?

While CAR-T cell therapies have revolutionised the treatment of certain haematologic malignancies, they have not been effective in solid tumours, particularly pancreatic cancer, due to three fundamental biological barriers limiting durability and function. First, pancreatic tumours exhibit pronounced antigen heterogeneity and readily undergo antigen escape. Targets, such as mesothelin, are not uniformly expressed, and under selective pressure from CAR-T therapy, with tumour cells able to downregulate or lose antigen expression altogether. *"Since conventional CAR-T cells rely almost exclusively on CAR–antigen recognition for cytotoxicity, antigen-negative tumour clones survive and expand, leading to treatment failure and relapse,"* explains Li.

Second, the pancreatic tumour microenvironment is profoundly immunosuppressive and drives rapid CAR-T cell dysfunction. *"Dense populations of suppressive myeloid cells, chronic inflammatory signalling, metabolic stress, and stromal-derived inhibitory factors promote CAR-T cell exhaustion, characterised by upregulation of checkpoint molecules (such as PD-1, LAG-3, and TIM-3) and a loss of effector cytokine production and cytotoxic capacity. As a result, even CAR-T cells that initially engage tumour cells often lose function and persistence within the tumour microenvironment,"* says Li.

Third, CAR-T cells show poor trafficking, homing, and infiltration into solid pancreatic tumours. Pancreatic cancer is marked by a dense desmoplastic stroma and abnormal vasculature that physically restricts entry of immune cells. IIn addition, CAR-T cells frequently lack the chemokine receptor profiles required for efficient tumour-directed migration, leading them to accumulate in off-target organs, such as the liver, or to remain confined to peritumoral regions rather than penetrating the tumour core. Because effective cytotoxicity requires direct tumour contact, this failure of infiltration further limits therapeutic efficacy.

"Together, antigen escape, a highly suppressive tumour microenvironment, and inadequate tumour infiltration explain why CAR-T cell therapy has so far shown limited success in pancreatic cancer and other solid tumours," says Li.

An additional limitation lies in the extended preparation timeline required for CAR-T cell therapy. The process involves harvesting a patient's immune cells, transporting them to specialised facilities for genetic modification, and subsequently returning the engineered cells for reinfusion several weeks later. For patients with pancreatic cancer, such delays may be clinically inappropriate, as the aggressive nature of the disease often leaves little margin for extended treatment timelines.

NKT Cells Offer the Solution

For more than a decade, Lily Yang and colleagues at the Eli and Edythe Broad Center of Regenerative Medicine and Stem Cell Research at UCLA have been working on NKT cell biology. Early on, they recognised that NKT cells possessed several properties that conventional T cells lack. *"They bridge innate and adaptive immunity, traffic efficiently to tissues, resist exhaustion, and—critically—do not cause graft-versus-host disease because they're restricted by the non-polymorphic molecule CD1d rather than classical HLA,"* explains Li. While these features made NKT cells conceptually attractive as a universal cell therapy platform, their extremely low frequency in peripheral blood represented a barrier to clinical translation.

To overcome this limitation, the team developed a strategy to generate NKT cells from human CD34$^+$ hematopoietic stem and progenitor cells. In a paper published in Nature Biotechnology in 2025, Yang and colleagues reported how, by genetically engineering stem cells with an invariant NKT TCR, which can drive stem cell differentiation into mature NKT cells, and therapeutic transgenes, and then differentiating them using a clinically guided, feeder-free culture system, they were able to produce large numbers of highly uniform, functional NKT cells. *"For the first time, we showed that NKT cells can be manufactured at true clinical and industrial scale with high purity, consistency, and economic feasibility, overcoming one of the biggest barriers in cellular immunotherapy,"* says Li.

The paper also demonstrated the broad applicability of the NKT platform across multiple cancer types by generating CAR-NKT cells targeting tumour antigens, such as CD19, BCMA, GD2, GPC3, and EGFRvIII. *"These targets correspond to a range of malignancies, including B- cell malignancies, multiple myeloma, neuroblastoma, liver cancer, and glioblastoma, highlighting the versatility of the platform rather than a single disease-restricted application,"* says Li.

Three separate mechanisms allow CAR-NKT cells to function as a multimodal immune therapy:

- CAR-NKT cells kill tumour cells through CAR-dependent recognition. The engineered chimeric antigen receptor enables direct targeting and elimination of tumour cells expressing the intended surface antigen (such as mesothelin in pancreatic cancer). "This provides potent, antigen-specific cytotoxicity similar to CAR-T cells, with robust activation and effector function upon target engagement," says Li.
- CAR-NKT cells retain a strong NK receptor (NKR)–mediated cytotoxicity, allowing them to recognise and kill tumour cells independently of CAR expression. "This enables CAR-NKT cells to eliminate antigen-low or antigen-negative tumour variants, directly addressing tumour heterogeneity and CAR antigen escape," says Li.
- Invariant NKT cells possess a unique TCR-mediated

recognition pathway that recognises lipid antigens presented by CD1d, which is expressed on some tumours and also immunosuppressive myeloid cells within the tumour microenvironment. "Through this mechanism, CAR-NKT cells can directly target $CD1d^+$ tumour cells and simultaneously eliminate or reprogramme suppressive myeloid populations, thereby remodelling the tumour microenvironment in a way that supports sustained antitumor immunity," says Li.

Taken together, the topline conclusion across all models was that CAR-NKT cells slowed tumour growth by three to four fold relative to CAR-T cells and extended survival substantially in metastatic disease, rather than producing only modest improvements. *"The benefit was consistent across primary orthotopic tumours, metastatic disease, and both antigen-high and antigen-low settings, highlighting that CAR-NKT cells deliver stronger, more durable, and more broadly effective antitumor responses than conventional CAR-T cells in pancreatic cancer,"* says Li.

In both orthotopic and metastatic pancreatic cancer models, tumour-infiltrating CAR-NKT cells showed markedly reduced expression of exhaustion markers (including PD-1, TIM-3, LAG-3, CTLA-4, and TIGIT) compared with conventional CAR-T cells. In addition, CAR-NKT cells displayed intrinsically low immunogenicity, characterised by stable, low expression of HLA class I and class II molecules both before and after infusion. *"Together, the combination of low exhaustion and low immunogenicity supports sustained persistence and function of CAR-NKT cells in vivo and reinforces their suitability as a safe, off-the-shelf cellular immunotherapy platform for solid tumours such as pancreatic cancer,"* says Li.

Earlier Studies in Breast and Ovarian Cancer

In a study published in J Hematol Oncol last October, the team demonstrated that allogeneic, stem cell–derived mesothelin-specific CAR-NKT cells could effectively control aggressive triple-negative breast cancer (TNBC) in vivo, outperforming conventional CAR-T cells in both efficacy and durability.

In a study published in Med, also last October, they showed that CAR-NKT cells achieved near-complete tumour eradication and long-term survival in a human ovarian cancer xenograft model in NSG mice, whereas conventional CAR-T cells showed only partial tumour control and limited survival benefits.

"These studies collectively demonstrate translational feasibility, and that a single, scalable manufacturing platform can generate high-purity CAR-NKT cells that are effective across multiple solid tumours," says Li. *"Together, the data support CAR-NKT cells as a next-generation, universal cellular immunotherapy platform with the potential to fundamentally change treatment paradigms for solid tumours such as pancreatic, ovarian, and triple-negative breast cancer."*

What Next?

Building on the preclinical results in pancreatic, ovarian, and breast cancer, the team is now focused on clinical translation and strategic expansion into additional solid tumour indications. *"Overall, our strategy is to use a unified CAR-NKT platform to move efficiently from strong preclinical validation into clinical trials, while systematically expanding into additional solid tumours where durable, off-the-shelf immunotherapies are urgently needed,"* says Li. The goal, he adds, is to enter the first-in-human clinical trial of CAR-NKT therapy in multiple myeloma by the end of 2026. *"Beyond cancer, the intrinsic immunoregulatory functions of NKT cells make this platform well suited for autoimmune and inflammatory diseases, where targeted immune modulation rather than broad immune ablation is needed,"* says Li.

The estimated cost of ~$5,000 per treatment is based on manufacturing economics enabled by the stem cell–derived, off-the-shelf CAR-NKT platform. *"From a single cord blood donor, we can generate on the order of 1012 CAR-NKT cells, sufficient for approximately 1,000–10,000 doses, allowing manufacturing costs to be spread out across many patients,"* says Li. The process is allogeneic, batch-based, feeder-free, and cryo-preservable, eliminating individualised leukapheresis, patient-specific manufacturing, and long vein-to-vein times that have dominated CAR-T costs.

About the Author

Janet Fricker is a UK medical writer with an MA in Physiology from the University of Oxford. She is the News Editor of CancerWorld. Janet has worked for the Cancer Drug Development Forum, Cancer Research UK, Lancet Oncology, European Journal of Cancer, Molecular Oncology, Ecancer Medical Science, and European School of Oncology (where she wrote the Oncopaedia sections on breast cancer). She has written for consumer publications including The Times, The Economist, The Daily Mail, The Independent and Marie Claire.

ECHoS Town Hall Meeting 2025

Europe's National Cancer Mission Hubs

From a Vision to Sustainable Infrastructures

By Yeva Margaryan

European cancer policy has entered a decisive phase. After years of strategy-building, consultation, and pilot projects, the question facing policymakers is no longer whether Europe has the right ambitions, but whether it can turn those ambitions into sustainable systems that deliver for patients. That question lay at the heart of the ECHoS Town Hall Meeting 2025, held in Brussels in November, where national representatives, European institutions, researchers, clinicians, patient organisations, and industry partners came together to take stock of progress under the EU Mission on Cancer.

The Town Hall marked a moment of transition. National Cancer Mission Hubs (NCMHs), once idealised structures supported by EU project funding, are now coming together to function as long-term governance mechanisms. The day's discussions reflected both optimism and realism: optimism that meaningful implementation is possible, and realism about the political, financial, and cultural barriers that still remain.

What emerged most clearly was a shared understanding that Europe has moved beyond planning. The current challenge is sustainability.

Making the Mission Visible

Opening the meeting, Annika Nowak, Head of Sector of the Cancer Mission secretariat at DG Research and Innovation, framed the role of the Establishing of Cancer Mission Hubs: Networks and Synergies (ECHoS) project in terms of credibility and impact. For the European Commission, the EU Mission on Cancer must demonstrate not only ambition, but visibility and results.

"I think my role is really to emphasise how important this project is," she said. "It is very important for us to make sure the mission is visible; the actions are becoming more visible."

Visibility, she stressed, is not cosmetic. It is essential for sustaining political commitment and public trust.

"ECHoS is one crucial part to ensure that the mission can demonstrate the success and the impact it may have," she noted.

That framing set the tone for the day. National Cancer Mission Hubs are no longer judged by their conceptual promise, but by whether they can show tangible progress across very different national health systems.

Human Care is a Human Right

For Hugo Soares, co-coordinator of the ECHoS project, visibility is inseparable from collaboration. In his opening remarks, he repeatedly returned to the idea that system change depends less on structures than on established relationships.

Hugo Soares, Co-Coordinator of the ECHoS Project

"This is what these kinds of events, face-to-face, are about," he told participants. "To create this (trust) between us, because this is the one factor that matters when we talk about the multiplication effect." That trust, he argued, is fragile and must be actively cultivated. Without it, initiatives remain fragmented and fail to scale.

"We have to do meaningful actions," he said. "Something that might change the current procedures."

Soares framed the EU Mission on Cancer not only as a health priority, but as a driver of broader change.

"Cancer is often referred to as the number two cause of death in Europe, the number one in some Member States," he said. "But cancer is also a major driver of change."

That change, in his view, must be grounded in values as much as in policy instruments.

He went further, connecting cancer policy to fundamental rights.

"Cancer care is human care," he said. "And human care is a human right."

From Pilots to Pillars

As discussions moved from vision to implementation, one question dominated: what conditions must be in place for NCMHs to become enduring pillars of national cancer systems rather than time-limited projects?

For Anabela Isidro, co-coordinator of the ECHoS, sustainability of such structures begins with political endorsement but does not end there.

"The main condition is that they have to have national support," she explained. "A government endorsement, but also good funding, from governments, the private sector, EU funding, or other sources."

Crucially, she cautioned against equating political goodwill with operational capacity.

"Governmental support without funding is good," she said, "but it is very limited."

Equally important are people.

"To be sustainable, you have to have dedicated human resources," she added. "These networks need to be filled with activities to engage stakeholders. Otherwise, they fade away."

Soares reinforced the point from a practical perspective. In countries where no one is formally tasked with implementation, NCMHs risk becoming discussion platforms rather than delivery mechanisms.

"When there is no one dedicated to implementation," he said, "things stay at the discussion level."

Anabela Isidro, Co-Coordinator of the ECHoS Project

What distinguishes NCMHs from existing collaborative structures, he argued, is their mission-driven logic: co-creation, cross-sectoral collaboration, and a focus on translation rather than coordination for its own sake.

National Experiences: Implementation in Practice

The Town Hall session on national experiences brought those principles into focus, illustrating how different political and institutional contexts shape implementation.

ECHoS Town Hall Meeting 2025: National Experiences in Establishing Cancer Mission Hubs

Malta: Alignment Delivers Momentum

Malta was repeatedly cited as a model of rapid, high-impact development. There, strong political commitment has been matched with sustained funding and complemented by private-sector engagement. Government investment has increased steadily, and the Malta NCMH has unified previously fragmented parts of the system.

As Isidro noted, Malta's success lies in combining endorsement, resources, and ecosystem thinking. Ministries, researchers, hospitals, patient organisations, and Tech partners now operate within a single coordinated framework rather than in parallel silos.

The result is not only increased research capacity, but visible, citizen-facing initiatives, from mobile cancer awareness programmes to strengthened data infrastructure.

Portugal: Commitment Without Perfection

Portugal offers a different, more nuanced example. While the NCMH-like structure does not yet have dedicated operational funding, its launch was made possible through clear governmental backing and inter-institutional cooperation.

"The governmental support was crucial to start the hub," Soares explained. "Even without dedicated operational funds, both coordinating organisations contributed with human resources."

That contribution, he stressed, is often underestimated. Dedicated people can sustain momentum even when funding is imperfect, provided political endorsement is clear.

Sweden, Greece, Poland, and Italy: Different Paths, Shared Direction

Sweden's challenge lies in governance complexity. With 21 autonomous regions, the task is not generating activity but aligning it. The Swedish NCMH aims to unite national actors, create a shared knowledge platform, and provide a space to test innovative approaches, while ensuring that sparsely populated regions are not left behind.

Greece's experience highlights the growing role of patient organisations. After years of fragmentation, the Hellenic Cancer Federation (ELLOK) emerged as the natural coordinating body for the NCMH, building a multi-stakeholder structure spanning prevention, survivorship, digital health, access to innovation, and equity.

Poland has focused on trust-building through dialogue. Design-thinking workshops with patients, clinicians, researchers, industry, and policymakers have helped identify shared priorities and move from abstract strategy to concrete planning.

Italy, through the Alliance Against Cancer (ACC), demonstrated the advantages of scale and maturity. Ministerial endorsement, diversified funding, and national digital platforms have positioned the hub as a catalyst across the country's regional health systems.

Across all cases, a common message emerged: countries are moving from planning to implementation, but sustainability depends on embedding these structures within national governance,rather than treating them as projects.

Collaboration

Collaboration was repeatedly described as both the greatest strength of the Mission and its most persistent challenge.

"At the European level, we are quite well connected," Isidro observed. "Sometimes it is easier than at the national level."

National collaboration must navigate entrenched institutional cultures, competing mandates, and divergent values.

"We do have good examples of all types of collaboration," she said, citing research–clinical partnerships, patient involvement, and cross-border initiatives. "But if I have to name one area that still needs work, it is collaboration with the industrial sector."

Industry engagement, she explained, is often constrained by differing incentives and timelines. Researchers and clinicians may be unaccustomed to working with industry outside clinical trials, while companies are focused on clearly defined objectives.

Recognising this, ECHoS is planning dedicated policy dialogues to address industry collaboration explicitly, creating structured spaces where agendas, constraints, and expectations can be discussed openly.

For Soares, the deeper challenge is not the absence of collaboration, but its fragmentation.

"We have very good examples here and there," he said. "But what we are missing is that this becomes systemic."

A major barrier to systemic collaboration is misalignment between top-management structures, such as policy and decision-making bodies.

He pointed out that alignment at the European level between DG Research & Innovation and DG SANTE was a turning point for the EU Mission on Cancer.

"When alignment happens at the top," he said, "things align underneath. This is often lacking at the national level"

Portugal's inter-ministerial order between the Ministry of Research and the Ministry of Health establishing its NCMH stands as a national example of that principle in action.

Working with Industry

Industry collaboration, while sensitive, was repeatedly framed as indispensable to translation.

"We are more at the level of governance," Isidro explained, "but there are very practical ways industry can support our objectives."

She pointed to familiar scenarios: a promising publicly funded discovery that requires industry partnership to move into clinical trials or scale production. National Cancer Mission Hubs can act as conveners, bringing together public researchers, clinicians, regulators, and industry partners.

Such collaboration, she argued, could also be transnational, with multiple NCMHs and countries jointly supporting

Joanna Drake, Deputy Director-General of the European Commission's DG for Research and Innovation/Cancer Missions Fair

development pathways. Early initiatives are already emerging, one of which is led by the Polish NCMH, the first structure to be recognized as an NCMH by the ECHoS project.

Importantly, collaboration does not have to begin with high-stakes drug development. Support for events, workshops, and stakeholder convening can be equally transformative.

"Sometimes we lack support just to bring people together," Isidro said. "These moments are essential."

Yet she was candid about the limits of alignment. *"That's our wish," she said of broader industry support. "Not necessarily theirs."*

The implication was clear: successful collaboration requires clarity, trust, and realistic expectations on both sides.

Having a "Good Reputation"

Why, then, do some countries translate Mission goals into action while others remain stuck in planning?

Soares' answer was direct.

"Countries with resources, staff, recognized leaders, and governmental support implement more meaningful activities," he said. But this recipe is often incomplete in some way or another.

Implementation, he stressed, depends on the ability to convene those who understand needs with those who have the tools to respond, and to do so with political backing.

"It's not just discussion," he said. "It's resources and endorsement."

Isidro highlighted the role of the ECHoS network in supporting countries that struggle.

"We can support with bilateral visits and policy dialogues," she said. "We can go to the national level and bring legitimacy."

Involving trusted institutions, such as the European Observatory on Health Systems and Policies, can help open doors and create momentum.

"If you have a good reputation," she noted, "people listen."

Shared Values

The prominence of patient organisations across national presentations raised fundamental questions about leadership and power.

For Isidro, patient leadership reflects a broader shift toward co-creation.

"Patient organisations and stakeholders should be at the same level," she said. "They are the ones most interested in success."

Soares cautioned against replacing one form of dominance with another.

"The balance is always preferred to dominance," he said. "Patient, clinician, political, or industry dominance, none of these fully work."

Instead, he emphasised structured representation, guided by shared values of trust, transparency, and competence. Leadership matters less than how leadership is exercised.

"What matters," he said, "is that the values are respected."

What Transformation Would Look Like

Looking toward 2030, both speakers converged on a shared definition of success: equity.

"We see inequalities between countries and within countries," Isidro said. "Access to core services is still uneven."

National Cancer Mission Hubs, Soares argued, are not the solution in themselves, but instruments of translation.

"They were created for implementation," he said. "Because disparities are still huge."

From Left to Right: Co-Coordinators of the ECHoS Project - Hugo Soares and Anabela Isidro

A genuinely transformational outcome would be a collaborative ecosystem where best practices are shared, adapted, and scaled, reducing duplication and accelerating progress.

"If collaboration becomes the norm," Isidro added, "it accelerates progress in cancer research and care — and equity follows."

From Promise to Proof

As the Town Hall closed, the mood was one of cautious optimism. Structures exist. Examples are multiplying. Yet the hardest work lies ahead: securing sustainable funding, embedding collaboration, fixing data foundations, and ensuring that implementation keeps pace with ambition.

The success of NCMHs will not be measured by their organisational charts, but by whether citizens experience tangible change.

As Soares reminded participants in his opening remarks, the stakes are deeply personal.

"Soon we might face a diagnosis like this," he said. "So, we need to move. And we need to move fast."

The coming years will determine whether Europe's Mission on Cancer remains a promise or becomes proof.

Funded by the European Union. Views and opinions expressed are however those of the author(s) only and do not necessarily reflect those of the European Union or European Health and Digital Executive Agency (HaDEA). Neither the European Union nor the granting authority can be held responsible for them.

#112 02 / 2026 ISSN: 2036-9468

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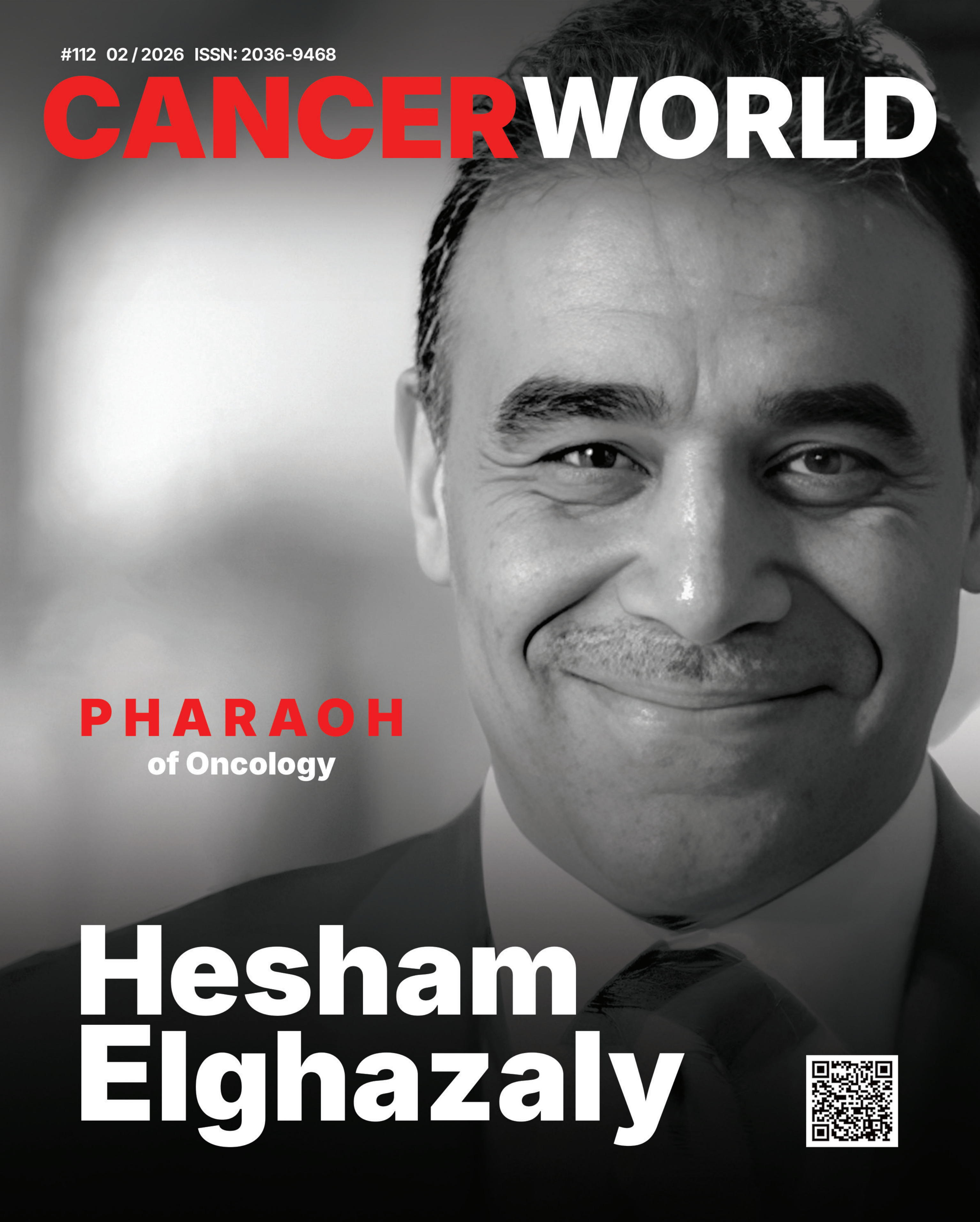

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Pharaoh of Oncology

Hesham Elghazaly

By Gevorg Tamamyan

- When he enters the bazaar, people stand up… They stop. They smile. They love him.

This kind of love has nothing to do with titles, resources, or power. It is something far rarer. It is the quiet admiration of ordinary people for their doctor.

A man who moves without noise, leads without spectacle, and changes oncology in Egypt not with force, but with persistence. With a smile. With tireless care for patients. By building systems. By building teams. By building champions.

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When I sat down with **Hesham Elghazaly**, it felt less like a formal interview and more like a continuation of a shared journey. We had just returned from Cairo, where more than 5,000 oncologists, policymakers, scientists, and global leaders gathered for what many called not a conference, but a festival of oncology.

Hesham is not only the President of the **Egyptian Cancer Society**, but also the President of the BGICC – an initiative that has quietly evolved into one of the most influential oncology summits in the region. Physician, scientist, system builder, and relentless collaborator, who represents the generation of oncology leadership rooted not in titles, but in outcomes.

A Congress in Cairo That Looked Like ASCO or ESMO Annual Meetings

Walking past the registration desk on the second day of the meeting, around 11 a.m., I saw something I had previously seen only at ASCO or ESMO: long lines, buzzing energy, and people from all over the world converging in one place.

I asked Hesham how it happened.

He was clear: this was not the success of one person or one organization.

"It was integration," he said. *"Global, regional, and national societies working together – not in parallel, but in alignment."*

BGICC originally stood for **Breast, Gynecology, and Immuno-Oncology International Cancer Conference**. But this year, it became something more ambitious: a true oncology summit. Three major meetings merged into one platform:

- BGICC (breast, gynecology, immuno-oncology)
- OncoBronco (lung cancer)
- IGILUC (gastrointestinal and genitourinary oncology).

The goal was not only science and clinical practice, but **policy, capacity-building, and sustainability**.

Global leaders joined regional and national ones: WHO regional leadership, UICC, IARC, ASCO, ESMO, ASTRO, and multiple regional oncology societies – from the Emirates to Algeria. Ministers, policymakers, and international organizations shared the same stage.

"This integration," Hesham Elghazaly said, "is the only way to fight cancer – not just globally, but locally, especially in low- and middle-income countries."

Egypt's Presidential Initiative: Turning Policy into Measurable Impact

At the heart of Professor Hesham Elghazaly's work lies one of the most impactful cancer control efforts in recent years: Egypt's **Presidential Initiative for Women's Health**.

The results are extraordinary and measurable.

- Advanced breast cancer (Stage III–IV) cases dropped from **70% in 2019 to 20%.**
- The time to diagnosis fell from **over 120 days to just 49 days.**
- **100% of breast cancer patients** are now discussed in multidisciplinary tumor boards.
- **Breast cancer mortality decreased by 15% between 2022 and 2024.**

This exceeds the **WHO Global Breast Cancer Initiative** target of a 2.5% annual reduction.

"These are not projections," Hesham emphasized. *"These are outcomes. And we will publish the data very soon."*

The key, he said, was political will, combined with system design, accountability, and collaboration across ministries.

From National Success to Global Replication

But Hesham Elghazaly does not see Egypt's success as an endpoint.

He sees it as a **template**.

The vision now is sustainability and replication – across Africa and other low- and middle-income countries. Egypt, he believes, can serve as a **lighthouse** for breast cancer control.

This thinking led to a historic moment: **the first-ever World Economic Forum side meeting outside Davos**, held in Egypt.

The meeting brought together:

- World Economic Forum leadership
- World Bank and African Development Bank
- Digital and telecom leaders (including Vodafone and Orange)
- NGOs, international societies, and civil society
- Egypt's Deputy Prime Minister and Minister of Health and Population, Prof. Khaled Abdel Ghaffar.

The outcome was a **strong investment case** designed to sustain and replicate Egypt's achievements.

"This is how policy becomes impact," Dr. Elghazaly said. *"And impact becomes equity."*

Why Oncology Chose Him and Not the Other Way Around

I asked Hesham to go back to the beginning.

Why medicine? Why oncology?

He smiled.

"I loved challenges," he said.

A top student from early childhood, medicine felt natural. But oncology was different. When he graduated in 1993, oncology was considered a *dark specialty* – few solutions, many losses.

"Everyone told me not to choose it," he recalled. *"That made me want it more."*

For him, oncology demanded two things: **deep scientific understanding**, especially in under-researched areas, and **radical collaboration**, across borders and institutions.

He believes influence matters most when it happens **inside your own country**.

"I was very proud when OncoDaily named me among the 100 influential people in oncology," he said. *"Because my influence is not from outside Egypt – it is from inside."*

He referenced **Naguib Mahfouz**, who won the Nobel Prize by excelling in something deeply local.

"That is the path," Hesham said. *"Local impact first. Then regional. Then global."*

Persistence, Faith, and a Mother's Influence

When I asked about the key to his success, Hesham did not hesitate.

"God. And my mother."

She passed away in 2017, but her influence remains central to his life.

He described himself as relentlessly persistent.

"I failed," he said. "But I never stop. Every goal I set, I eventually reach – even if it takes many failures."

Keep Smiling

Hesham credits many mentors, inside and outside Egypt – scientific, personal, and moral.

One moment stayed with him.

During the early days of organizing BGICC, when he was still under 40, doubts surrounded him. A senior French oncologist, **Professor Moise Namer,** gave him simple advice:

"Keep smiling. Your smile will give confidence to your team and to everyone watching."

He never forgot it.

The Music

Hesham is not a solo operator. He builds teams.

At Ain Shams University, Dr. Elghazaly played a pivotal role in establishing the MASRI Research Center, leveraging advanced research units and genomic platforms to build a fully accredited research infrastructure that supports high-quality scientific innovation and translational research. Under his leadership, teams have published in **Science** and **Nature**.

"I see it like music," he said. *"Everyone plays a part. Without each person, the result is impossible."*

Advice to the Next Generation

His advice was concise:

"Dream big. Persist."

The Future of Global Oncology

For Hesham, the future lies in **radical collaboration**.

UICC. IARC. WHO. ASCO. ESMO. ASTRO... Regional societies. Governments.

"If we work together," he said, "the sky is the limit."

Data, he believes, is the new engine of transformation – digital pathology, genomics, artificial intelligence. These tools will reshape outcomes, if shared equitably.

What Comes Next—for Him and for the World

His next challenge is clear:

- Sustain Egypt's mortality reduction.
- Push it further.
- Replicate it across Sub-Saharan Africa and the Arab world.

His long-term dream?

"To unite Arab countries in science and research. And to help Africa move as one."

On the global level, he sees himself as a **connector**, someone who helps international organizations work together toward equity in cancer research and care.

One Sentence

When I asked him to define himself in one sentence, Hesham paused, then said:

"A person who tried to make a difference."

That sentence, in many ways, says everything.

“A Novel Path With Risks”

Arjun K. Ghosh on Building Cardio-Oncology From Scratch and Why the Goal Is Almost Never to Stop Cancer Treatment

By Vahe Grigoryan

A cappuccino sits within reach as Professor Arjun K. Ghosh talks—a coffee that keeps pace with a day split between heart failure, imaging, and the fast-evolving world of modern oncology. On screen, his mug carries the Arsenal crest, a quiet nod to North London roots and a family ritual of match days and season tickets. "I grew up near the stadium," he says. *"My parents' house at the end of the street was the old Highbury Stadium."* He still remembers the day Arsenal won the league and "everyone was dancing in the street."

Ghosh is a consultant cardiologist at Barts Heart Centre and University College London, and the first consultant in the UK specifically appointed to cardio-oncology. His job—and his project—has been to build services that protect the hearts of people with cancer while keeping the central purpose of cancer medicine in view: giving patients the best possible chance of cure and survival.

"I never once felt during the journey that I made the wrong decision," he says. It is a simple sentence, but it carries years of risk-taking, resistance, and the slow work of changing how medicine thinks.

When Cardio-Oncology "Found" Him

Ghosh's entry into cardio-oncology began near the end of cardiology training, when his clinical interests were already forming: heart failure and cardiac imaging. Then came a conference talk that reframed the landscape.

"I heard a talk at a conference on cardio-oncology," he recalls. *"This is a new area, and we're bringing cardiology and cancer together."*

At the time, cardio-oncology looked different from what it is today. *"From the cardiac side, most patients had heart failure,"* he says. *"That has changed dramatically now, but back then, it was really just heart failure."* Imaging was fundamental. *"The imaging was integral to diagnosing these patients and treating these patients."*

The fit was obvious. *"Given my background in imaging and heart failure, I really felt that this was a new area in cardiology that could combine both my skill sets."*

Then he gives a more personal reason—one that many clinicians might recognise. *"I am probably the kind of person who gets bored easily,"* he says, smiling. *"The fact that this was new, interesting, and exciting. I felt it was unlikely that any two days would be the same. Everything was unknown."*

Choosing the Unmade Road

Cardio-oncology was not an established speciality in the UK when Ghosh entered it. That uncertainty and the opportunity within it were part of the attraction.

"I didn't want to go down an established route," he says. ***"I wanted to do something different."***

His desire to diverge goes back to his earliest identity in medicine. *"Many people in my family are doctors,"* he says. *"Grandparents on both sides, aunts, uncles, cousins, they're all doctors."* He could have chosen a traditional path and built a conventional career. But he wanted something else.

"I didn't want to just be seeing lots of patients and being very successful in that," he says. ***"I wanted to try and make a difference, do something more meaningful on a larger scale."***

He is careful here. *"Of course, seeing patients is extremely rewarding,"* he adds. ***"But I wanted to move the field forward."***

Clinically, he had seen the gap. *"All cardiologists see cancer patients. That's normal," he says. "However, they weren't being treated necessarily in an optimal way."* And sometimes cancer itself became the reason to abandon cardiovascular care. *"If they had cancer, people would say, 'Your prognosis is X months; there's no point giving you cardiac treatment.' There were a lot of misconceptions."*

The choice to pursue something new also carried risk. *"It was a high-risk approach," he admits, "but also a potentially high-reward approach."* He remembers senior doctors advising him to keep a safety net. "*This is new. It may not work out. After a few years, this may all fade away."*

He listened and declined to step back. *"You can respectfully disagree," he says. "Thank you for the advice, but I think this is something I'm interested in."* And then the sentence that could double as a rule for any disruptive career in medicine:

"If you're going into a high-risk situation, you need to have a passion for what you're doing, because there will be lots of ups, but there will be lots of downs as well."

A Clinic with One Patient, and Then None

Innovation often begins in awkward silence.

"I still remember when we set up the clinic," Ghosh says. *"The first clinic, it was just me, and there was one patient."* The next one was worse. *"The next clinic, it was just me with zero patients."*

It is the kind of early failure that forces you to decide whether a new idea is a belief or a fantasy. He chose belief.
"You have to believe in the project," he says. *"You have to really be dedicated. It is a lot of hard work."*

The growth took years, but it came. *"Now we have two clinics a week at Barts Heart Centre. We have three clinics a week at UCLH,"* he says. *"We now have five clinics a week, up from a point when there were zero patients."*

He doesn't frame this as a victory. He frames it as what happens when you persist long enough for the system to catch up. *"At the beginning, it was extremely challenging,"* he says. *"But the rewards are there at the end."*

Being "The First" and the Responsibility of It

Ghosh was the first consultant in the UK to be specifically appointed to the field of cardio-oncology. Even naming the field could provoke skepticism.

"Cardio-oncology has only been around for three years, maybe four years," he says. ***"And I was the first appointed specifically in cardio-oncology.*** *That was my job."* He remembers how colleagues reacted. *"People thought this was going to be a fad."* The questions came fast: *"What is cardio-oncology? You got a job in that? Is that a thing?"*

But he was watching oncology evolve, and he was certain the cardiac problem would not disappear. *"Every day there's a new drug that comes out,"* he says. *"The drugs are amazing from the cancer perspective, and they've massively changed outcomes for cancer patients. Unfortunately, many of these do have a toxic cardiac profile."* So, he says, *"I didn't think cardio-oncology was going to disappear. The problem may change, but there would still be patients who would have these kinds of cardiac issues."*

He never regretted it. ***"I never once felt that I made the wrong decision."***

What the role demanded, he says, was not only clinical delivery, but field-building: "writing guidelines" and "producing protocols" to define best practice. Yet the heavier responsibility, in his view, was toward those who come next.

"I feel I have a very big responsibility to the next generation," he says, *"to trainees who want to do cardio-oncology."* He helped write the cardio-oncology section of the UK cardiology curriculum. *"Now, all trainees in the UK have to do cardio-oncology as part of their core cardiology training," he says. "And if trainees specialise in heart failure, they also have to do cardio-oncology."*

33rd Annual Scientific Congress, Hong Kong College of Cardiology, 6-8 June, 2025

He also refuses a cardiology-only model. *"Cardio-oncology is a combination of cardiology and oncology,"* he says. *"So, I must not just train cardiology trainees, but also oncology trainees."* He describes one current example with pride: *"I have an oncology trainee. He attends my clinic, attends the MDT meeting, and has passed his cardio-oncology exam. He's a certified cardio-oncologist."*

"It's a privileged position to be the first," he adds, "but not the last."

Teaching as Legacy, and Exporting a Service Model

Ghosh speaks about teaching not as an obligation, but as an identity. *"The word doctor comes from teacher,"* he says. He mentions his own formal training in education. *"I've got a master's in medical education."*

What seems to energise him most is the global spread of the work. *"In my clinic, I always have some visiting fellow,"* he says. *"We've had visiting fellows from South America, from Mexico, from all over Europe, from Asia, from India, from China, from Singapore, from Bahrain, from the Middle East, and from Australia."*

Professor Arjun K. Ghosh with his fellows and colleagues

And the goal is not a certificate. It is replication. *"The aim of the fellowship is that when they go back home, they set up their own cardio-oncology services,"* he says. Then he lists the places where it has already happened: *"Sydney, Melbourne, Singapore, Mumbai, Bogota, Mexico City, Portugal, Madrid, Salamanca, many places all over the world."*

This, he implies, is what turns a new area into infrastructure: *"spread awareness"* through *"trainees all over the globe."*

The Speed Mismatch and a Guiding Rule

Cancer care moves at extraordinary speed. Cardiology is trained for caution. How do you reconcile them?

Ghosh is honest about limits. *"We cannot keep up with the rapid changes on the cancer side because it's too fast,"* he says. And cardio-oncology isn't one disease site; it is all of them. *"We deal with breast cancer, renal cancer, haematological cancers, radiation-induced problems,"* he says. *"It's next to impossible to keep on top of everything."*

So, he uses a guiding rule that is deliberately broad, designed for a world where new therapies arrive faster than comfort. *"Any cancer treatment can cause any cardiac problem,"* he says. *"Some problems are more common, and some are less common."*

That rule, he explains, prevents complacency. *"When a new treatment comes, we should not be saying, 'This is new, this cannot be the cause,'"* he says. Instead, cardio-oncology has to stay alert to signals and then work with oncology to interpret them without panic.

He points to CAR-T therapy as a recent example. *"CAR-T was still trial therapy just before COVID, and now it's a normal NHS therapy,"* he says. Because UCLH was one of the trial centres, *"we were involved from a cardiac point of view at the very beginning."*

The advantage of being embedded in trial centres is proximity to the frontier. *"We are involved at the beginning,"* he says, *"so we are in touch with the latest advances."*

Trust is the Missing Ingredient in Collaboration

When asked about the biggest barrier to collaboration between cardiologists and oncologists, Ghosh answers quickly: misunderstanding.

"The biggest issue was oncologists thinking we were going to stop the treatment," he says. *"We were going to interfere with the cancer treatment."*

Then he states the field's purpose in a sentence that feels like a manifesto: *"The whole point of cardio-oncology is never to stop the cancer treatment unless it's an extreme situation,"* he says. *"The whole aim is to get the cancer patient to complete the optimal treatment with support from our side."*

Before cardio-oncology, the response to toxicity could be abrupt. *"If there was cardiac toxicity, the oncologist would just stop the treatment,"* he says, moving patients onto *"second line, third line, less effective treatment."* Cardio-oncology exists to prevent that: *"keep the patient on the primary, most optimal treatment with our support."*

He has seen the same suspicion in other countries. *"I've helped colleagues all around the world set up cardio-oncology services,"* he says, *"and I've never once seen anywhere where the oncologists have said, 'This is great, please start the service.' Often, there is suspicion and hesitation. Very quickly, it changes the other way."*

Context matters. In India, he notes, *"it's the oncologists more than the cardiologists who are driving cardio-oncology,"* and the problem is the opposite: *"to find a cardiologist who is interested."* Incentives shape interest. *"If you work in a healthcare system incentivised by procedures, cardio-oncology doesn't have procedures for cardiologists,"* he says. *"So, they may not be so interested."*

But he returns to what he has learned from experience: *"If you keep at it and provide a good service, most people will understand there's a benefit."*

Not "Side Effects", the Entire Cancer Journey

Cardio-oncology is often framed as the management of side effects. Ghosh calls that outdated.

"That's an old-fashioned view," he says. Cardio-oncology, in his telling, covers the whole timeline. *"We assess patients before cancer treatment,"* he says. *"At that point, there are no side effects yet."* They stratify risk: *"low risk, medium, high." They monitor during treatment "to try and prevent"* toxicity. They treat it if it happens. And then comes the frontier: survivorship and late effects.

"There is a late effect time," he says. "I'm writing a national UK late effects guideline, which looks at how we can manage the long-term toxicities of cancer survivors."

Then he offers his definition: ***"Cardio-oncology is the journey before treatment, during treatment, and after treatment. It's a holistic coverage of the patient."***

Ethics, Uncertainty, and the Grey Zone

As therapies accelerate, the ethical tension sharpens: saving lives now while avoiding preventable long-term disease later. Ghosh brings the discussion back to the patient.

"At the end of the day, they need to make the decision," he says. *"We can guide them and explain the risks, but the patient needs to decide."*

He describes two broad groups: those who say, *"I'm happy to take the risk because I want to live,"* and those, often older, who do not want a high-risk intervention that offers only a short extension of life.

The cardio-oncology role, he says, is informed consent and risk minimisation. *"Our job is to help with informed consent,"* he says. *"If the patient wants to go ahead, we help to minimize the toxicity."*

He is also clear about boundaries. *"We are not oncologists,"* he says. *"We are not experts in cancer prognosis."* So, hard cases become the subject of shared decision-making. Many patients sit in what he calls the grey zone. *"There is no definite evidence or guideline," he says.*

The tool for that is the multidisciplinary meeting. *"We discuss these patients with the oncologist,"* he says. *"We have cardiologists covering imaging, intervention, and electrophysiology. We have cardio-oncology nurses. We have the oncologists."* The goal is simple: *"a holistic view"* of the best options.

If Resources are Unlimited

When asked what an ideal global model would look like with unlimited resources, Ghosh answers with a paradox: unlimited resources can be dangerous.

"If you have unlimited resources, you may do too much," he says. *"Just because you can do it does not mean it is required."*

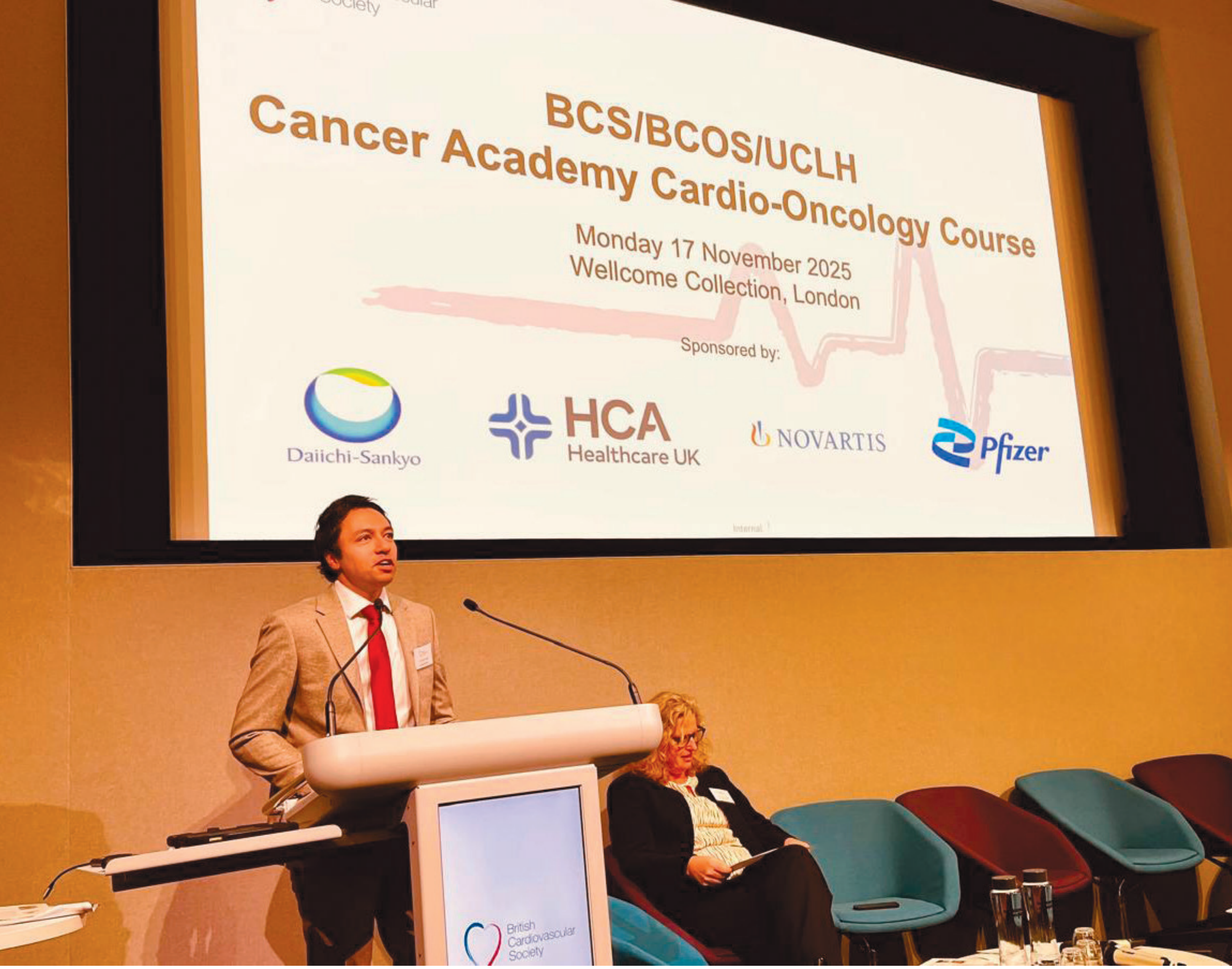
Still, his vision is specific: rapid access and the right amount of surveillance. *"You should be able to see the patient the same week,"* he says, because delays in cardio review can delay cancer treatment. On monitoring, he wants the optimal number of tests, not the maximum. Too much testing can *"cause the patient anxiety."*

Late effects are the hardest dilemma: follow indefinitely, or risk medicalising survivorship forever. *"Do you want to completely medicalise this cured patient forever?"* he asks. *"What about the mental effect of knowing that every year I have a heart scan?"*

Then he widens the lens. *"A patient told me there was a lack of psychological support,"* he says. Cancer patients have major non-medical needs: *"workplace support, financial support, psychological support." He is frank: "We provide excellent medical care, but maybe we are not so great at providing the rest."* Unlimited resources, he says, *"would help with that."*

Blitz round: *Who is Professor Arjun Ghosh?*

- **Personal motto:** *"Have a strategy, but take calculated risks."*
- **Favourite city:** *"London and Kolkata, the two cities closest to my heart."*
- **Favourite book and movies:** *One Hundred Years of Solitude, and childhood classics like Star Wars and Indiana Jones.*
- **Best advice:** *"If you don't go to the party, you'll never get a chance to dance."*
- **Something surprising:** *"I used to play football. I played with older kids, broke my collarbone, and that was the end of my football career."*
- **Most inspiring person in oncology:** *"Many of my patients." One survived four cancers and remains "very funny" and "always very positive."*
- **Biography title:** *"A Novel Path With Risks."*



Professor Arjun K. Ghosh speaking at his course

The Field He Built is Bigger than the Heart

As we end, the conversation returns to teaching, not as an accessory to clinical work, but as its continuation.

"The biggest reward I could get is if my trainees and fellows learn and give the optimal care to their patients," he says, *"and if they can be inspired to take the field forward."*

Ghosh has built a clinic, a curriculum, and a fellowship pipeline. He has also helped create a new default: that cancer patients should not have to accept cardiovascular damage as the price of survival, and that cardiology should not treat cancer as a reason to do less.

In the end, cardio-oncology is not simply a medical sub-speciality. It is a refusal to choose between a life-saving cancer therapy and a heart strong enough to live the life that follows.

About the Author

Vahe Grigoryan is a final-year medical student at Yerevan State Medical University, Assistant Managing Editor at OncoDaily. He hopes to pursue a career in oncology, with a strong interest in science, people and stories behind cancer medicine.

The 8th ABC International Consensus Conference (ABC8), Lisbon 2025

Making Sense of a Decade of Progress in Advanced Breast Cancer

ABC8, Lisbon 2025

By Yeva Margaryan

Over the past decade, the landscape of advanced breast cancer has changed more rapidly than at any time since systemic therapy became standard. New drug classes, more refined biomarkers, and increasingly sophisticated trial designs have reshaped what clinicians can offer, and what patients can reasonably hope for.

Yet turning scientific momentum into meaningful, equitable improvement in people's lives remains far from straightforward. Each advance raises new questions: how best to sequence therapies, how to balance survival gains with quality of life, how to ensure patients are not left behind by cost, geography, or fragmented systems of care.

It is precisely these questions that bring clinicians, researchers, patients, and advocates together every two years at the **Advanced Breast Cancer (ABC) International Consensus Conference**. Rather than showcasing individual breakthroughs, ABC meetings are designed to take a step back, examining how evidence, experience, and patient priorities should translate into everyday practice, policy, and advocacy.

The **8th ABC International Consensus Conference (ABC8),** held in Lisbon on 6-8 November 2025, was a particularly reflective moment. It marked ten years since the creation of the **ABC Global Alliance**, offering an opportunity not only to assess progress, but also to confront the uncomfortable reality that gains in survival have not been matched by gains in access, data visibility, or long-term support for people living with metastatic disease.

As the discussions at ABC8 made clear, the challenge for the next decade is no longer whether advanced breast cancer outcomes can improve, but whether health systems, research frameworks, and political will can evolve quickly enough to ensure those improvements reach everyone who needs them.

Why ABC Matters

For many participants, the ABC conference remains a highlight of an increasingly crowded conference calendar for several reasons. It was the first cancer meeting, and it remains one of the few, focused exclusively on the needs of **patients with advanced disease.** Its launch challenged the once-dominant narrative that these patients were effectively beyond help, and affirmed that survival and quality of life can be improved through investing in research, evidence-based guidelines, and supportive care.

A signature of ABC conferences is the presence of patients and advocates not as observers, but as contributors. That creates conversations that are unusually candid and sometimes uncomfortable. **Claire Myerson**, a patient living with advanced breast cancer and a patient advocate, sees that as the point. *"Those patient sessions are what is unique about ABC. You should come to ABC to hear the patient's voice."*

Claire Myerson, a patient living with advanced breast cancer and a patient advocate

Making Sense of Progress: Why "PFS is Not Enough"

Dr. Fatima Cardoso, the Founder and President of the Advanced Breast Cancer (ABC) Global Alliance, argues that one of the most important shifts of the past decade is not a single drug class, but a **shift in ambition**, what she calls **"aiming higher"** for metastatic cancer.

"I do not consider that we should be happy with just improvements in PFS... We don't want just to control the disease... We should aim higher... truly improving survival as well as improving quality of life."

Dr. Fatima Cardoso, the Founder and President of the Advanced Breast Cancer (ABC) Global Alliance

She places ABC's first global goal in that context: doubling median survival. *"When we set that goal, the vast majority of people said that that would be a dream."*

Yet she points to a landmark reality at the end of the decade: survival-improving therapies now exist across the metastatic subtypes. And the gains are most obvious where targeted options are abundant. *"This decade, we now have treatments that improve survival in the three subtypes. And it's the first time we have seen that… We went from two to three years median survival ten years ago, to five years now for both HER2-positive and ER-positive HER2-negative."*

But she is blunt about what has not moved fast enough. *"We are not there yet for triple negatives. Unfortunately, we still have a median survival of about 13 months."*

The Decade Report's Most Uncomfortable Finding: Inequality has Deepened

If improved survival is the achievement Dr. Cardoso speaks of with the greatest pride, the findings on equity are the ones she returns to with visible frustration. The **Global Decade Report 2015–2025**, presented at ABC8, makes clear that progress has not been shared evenly, and that, in some respects, the gap has widened rather than narrowed.

"The inequalities have increased," Cardoso said. "Not only were we not able to decrease them, but they are worse now."

What is striking, she explained, is that this widening gap operates on more than one level. Differences between **high-income and low- and middle-income countries** remain stark, but increasingly, inequity is also playing out **within individual countries**, fragmenting access along socioeconomic lines.

"They are worse between low- and middle-income countries and high-income countries," she said. "But they are worse inside each country."

In the United States, she noted, this reality has long been embedded in the structure of the healthcare system, where access to cancer treatment is closely tied to insurance status. *"It depends on your insurance," she said. "Your coverage determines what type of treatment you receive."*

What troubles her most, however, is that this logic, once seen as a feature of insurance-based systems, is now becoming normalised elsewhere. *"In Europe, I was not used to treating patients differently according to their ability to pay," she said. "But now it has become the norm in Europe and around the world."*

Cardoso links this shift directly to the growing mismatch between innovation and affordability. Even countries with long-established national health systems are struggling to absorb the cumulative cost of successive new therapies.

"No national health system can sustain so many new treatments at the prices they have," she stressed.

For Cardoso, this is not simply a policy failure but a structural one. Without changes to how drugs are developed, priced, and financed, she argues, the very advances that have extended survival risk becoming drivers of deeper inequality, determining not just how long patients live, but **which patients are allowed to benefit at all**.

"The System is Broken": Why Innovation Fails to Reach Patients

Fatima Cardoso is careful to avoid framing the access crisis as a simple battle between patients and pharmaceutical companies. Her critique, sharpened by a decade of global data and hands-on advocacy, is directed at something broader and more entrenched: a development and financing system that now undermines its own purpose.

"For me, the system of drug development and drug financing is broken," she said.

At the heart of that failure, she argues, is the way modern cancer drugs are developed. ***Clinical trials have become increasingly complex**, **slow, and expensive***, not because patient safety demands it, but because regulatory requirements have expanded far beyond what is clinically meaningful.

"To do a clinical trial is terribly expensive because of all the bureaucracy," she said. Much of that burden, she believes, generates little value.

"About 70–80% of what we collect in a clinical trial is never analyzed," she said. *"We collect it because the regulations say that we need to collect it."*

The consequence is not only financial. Cardoso warns that excessive bureaucracy is steadily eroding academic research, narrowing innovation to what large pharmaceutical companies alone can afford to pursue.

"That is killing academic research and making any clinical trial very expensive," she said. Those costs inevitably resurface in pricing, and it is here that Cardoso's language becomes unusually blunt for a senior global oncology leader. *"I am always amazed that you can ask ten thousand dollars for a pill,"* she said.

She is not dismissive of the complexity involved in manufacturing biologics or antibody–drug conjugates, but she finds the pricing of simple oral agents indefensible.

"The prices for a simple pill are, for me, shameful," she said.

To illustrate how out of step oncology has become with other sectors, Cardoso reaches for an analogy that resonates far beyond medicine.

"What did they do with smartphones? They dropped the price. Everybody started buying them," she said. "But we don't do that for cancer treatments."

The result, she argues, is a **system that succeeds scientifically while failing functionally.** ***"A new treatment developed today is only reaching about ten percent of cancer patients, who could benefit from it,"*** she said.

From a humanitarian perspective, that is devastating. From a business perspective, she suggests, it is irrational. ***"Why develop a product and leave out ninety percent?"*** she asked. ***"Because only ten percent can afford it."***

For clinicians, this abstract failure translates into daily moral distress.*"It is heartbreaking to know that there is a treatment and you cannot treat your patient," Cardoso said, "because the patient doesn't have enough resources."*

From the patient side, **Claire Myerson** experiences the same system failure not as a policy problem, but as a constant uncertainty layered onto an already unstable disease.

"When you live with advanced cancer, you are always planning in chapters," she said. *"You don't just need access to a drug, you need to know the support won't disappear halfway through your life."*

Her message to policymakers and funders is deliberately framed in terms they understand. *"Patients like me need support, and we need support that lasts,"* she said. ***"Invest in us, we are worth investing in."***

Short-term access schemes, fragmented reimbursement decisions, and delays in approval may look manageable on paper. For patients living year after year with metastatic disease, Myerson argues, they translate into chronic insecurity.

"You cannot build a life around treatments that might be taken away," she said. ***"Stability matters as much as innovation."***

Where Cardoso sees a system that fails to deliver on its scientific promise, Myerson sees one that fails to recognise the reality of long-term survivorship in advanced disease.

"We are living longer," she said. "But the systems around us still behave as if we are temporary."

Together, their perspectives underline one of ABC8's most sobering conclusions: **progress in drug development has outpaced progress in thinking about how patients actually live with those drugs**. Without structural reform of trials, pricing, reimbursement, and long-term support, the very advances that have extended survival risk deepening inequality and instability for the people they were meant to help.

"We Count the Dead Very Well. We Don't Count the Living"

One of the most persistent and consequential themes running through ABC8, particularly when viewed through the lens of the Global Decade Report, is the failure to properly measure the population living with advanced breast cancer. Without accurate data, speakers repeatedly warned, health systems are left planning in the dark.

For **Claire Myerson**, this is not an abstract methodological flaw but a structural injustice that shapes every downstream decision.

"We count the dead very well," she said. *"We don't count the living."* Cancer registries in many countries still focus primarily on incidence and mortality, capturing when a person is diagnosed and when they die, but not what happens in between. Relapse, progression, years lived with metastatic disease, repeated lines of treatment, and long-term support needs often disappear from official records.

"That means people like me become invisible," Myerson said during the conference. *"And if you are invisible in the data, you are invisible in policy."* Crucially, she rejects the idea that this problem is technically complex or prohibitively expensive to fix.*"It's not complex technology,"* she said. *"It's not putting people on the moon."*

Where direct identification of metastatic status is difficult, Myerson argues that health systems can, and should, start with pragmatic solutions. One option is proxy counting, using prescribing and reimbursement data that already exist within most systems. *“If you went and asked how many women are on the drug that I’m taking,”* she said, *“you would be able to do that. You can count it.”*

These numbers, she argues, would immediately shift conversations with policymakers and payers, moving advocacy from moral appeal to economic rationale. Her argument aligns closely with Fatima Cardoso’s system-level analysis: without reliable data, inequalities remain hidden, services remain underfunded, and long-term survivors remain an afterthought rather than a population to be planned for. ***“If you don’t measure patient populations,”*** Myerson said, ***“you don’t build systems for them.”***

Making Care Better: Evidence-Based, Multidisciplinary, and Not “Eminence-Based”

From the outset, the ABC conference has focused not only on *which* treatments are used in advanced breast cancer, but on *how* care decisions are made. For Fatima Cardoso, one of the ABC Global Alliance’s most enduring priorities has been to move metastatic care away from individual, ad hoc judgment toward consistent, multidisciplinary, guideline-based practice.

“Access to specialised teams and treating according to guidelines is very important,” she said. “Sometimes, as a joke, we say not eminence-based but evidence-based medicine.”

The humour masks a serious concern. In many settings, patients with advanced breast cancer are still treated outside specialist centres, without multidisciplinary input or systematic application of consensus guidelines, a variability that Cardoso sees as a direct contributor to inequity in outcomes.

At the same time, she cautions against applying clinical trial data uncritically to real-world practice. *“Patients in trials are very selected,”* she said. *“In real life, they are often older, have comorbidities, and the impact of treatment is not exactly the same.”*

This gap underscores the need for experienced teams that can interpret evidence in context, balancing efficacy, toxicity, quality of life, and patient priorities rather than rigidly following protocols.

For **Claire Myerson**, who has lived for several years with advanced breast cancer, this distinction is not theoretical.

“Guidelines are essential,” she said, *“but they only work when clinicians understand the person sitting in front of them.”*

She sees multidisciplinary care as a safeguard against fragmentation.

“When care isn’t coordinated, patients end up carrying the burden, emotionally and practically,” she said. *“That shouldn’t be our responsibility.”*

Honouring the Foundations of Progress: The Lifetime Achievement Award

Amid the forward-looking focus of ABC8, new targets, new data, and new frameworks for care, the conference also paused to acknowledge the intellectual foundations on which much of today’s progress rests. This was marked by the presentation of the **ABC Lifetime Achievement Award** to **Dr. Larry Norton**, a figure whose work has shaped modern breast cancer treatment for decades.

ABC Lifetime Achievement Award to Dr. Larry Norton

For Fatima Cardoso, recognising Norton’s contribution was not simply ceremonial. It was a reminder that advances in advanced breast cancer have been cumulative, built through sustained scientific commitment long before survival gains became visible in population-level data.

“Larry Norton has dedicated his entire career to improving the lives of people with breast cancer,” she said.

Norton is best known for developing the concept of **dose-dense chemotherapy**, grounded in mathematical modelling of tumour growth and resistance. At a time when metastatic disease was still largely viewed as uniformly fatal, his work challenged assumptions about treatment scheduling and demonstrated that altering timing, not just drugs, could improve outcomes without increasing toxicity.

That willingness to question established thinking resonates strongly with the philosophy that later came to define the ABC movement.

"He was always someone who aimed higher," Cardoso noted, *"who didn't accept that controlling disease was enough."*

Beyond his scientific contributions, Norton has also played a crucial role in sustaining independent academic research. Through the **Breast Cancer Research Foundation**, he helped create a funding model that enabled global collaboration at moments when traditional public investment was limited, ensuring that innovation did not stall simply because it was difficult or unfashionable. *"Larry has supported ABC from the very beginning,"* Cardoso said. *"In science, in advocacy, and in spirit."*

The award underscored a central theme of ABC8: that today's improvements in survival did not appear suddenly, nor were they inevitable. They are the result of decades of persistence, of individuals willing to challenge complacency, and of a research culture that insisted advanced breast cancer deserved the same ambition as early disease.

For patient advocates like **Claire Myerson**, that historical perspective matters. Living with advanced breast cancer for many years has made her acutely aware that progress is fragile and that it depends on sustained commitment rather than short-term wins. *"Nothing about where we are now was guaranteed,"* she said. *"People fought for this progress."*

Honouring figures like Norton, she argues, is not about nostalgia, but about accountability. *"If we forget how hard it was to get here,"* she said, *"we risk settling too easily for where we are."*

In that sense, the Lifetime Achievement Award functioned as more than a tribute. It served as a reminder of the conference's core message: **ambition must be protected**, whether it is directed at improving survival, reshaping systems, or ensuring that future breakthroughs reach every patient who needs them.

The ABC Global Charter 2025–2035: Ambition Tested Against Lived Reality

The launch of the **ABC Global Charter 2025–2035** at ABC8 marked a pivotal moment, not a reset, but a reckoning. After a decade of real progress in survival, the updated Charter reflects a growing recognition that extending life is only part of the task. The harder challenge is ensuring that longer lives are **livable, supported, and equitably planned for**.

For Fatima Cardoso, the Charter's ten goals were deliberately designed to move beyond a narrow clinical focus. *"Every goal matters,"* she said, *"because they cover the whole life of a person, not just the cancer itself."*

The accompanying Global Decade Report makes clear why this broader framing is necessary: survival gains have not been shared evenly, and without structural change, innovation risks widening inequality rather than reducing it.

For **Claire Myerson**, the Charter is essential, but incomplete. From the perspective of someone living long-term with advanced breast cancer, what remains underdeveloped is recognition of **durability**. "*Advanced breast cancer isn't a moment,"* she said. *"It's a long-term condition."*

She argues that systems remain oriented toward acute illness, even as more patients live for many years with metastatic disease. *"We talk about access and quality of life,"* she said, *"but not enough about what happens five or ten years in."*

What she would add is an explicit commitment to sustained support, including employment protection, insurance continuity, mental health care, and financial stability over time. ***"Support shouldn't disappear just because you didn't die on schedule,"*** she said.

Myerson also stresses accountability, particularly around data. *"If you don't measure patient numbers properly,"* she said, *"you can't design services for them, protect them at work, or fund what they actually need."*

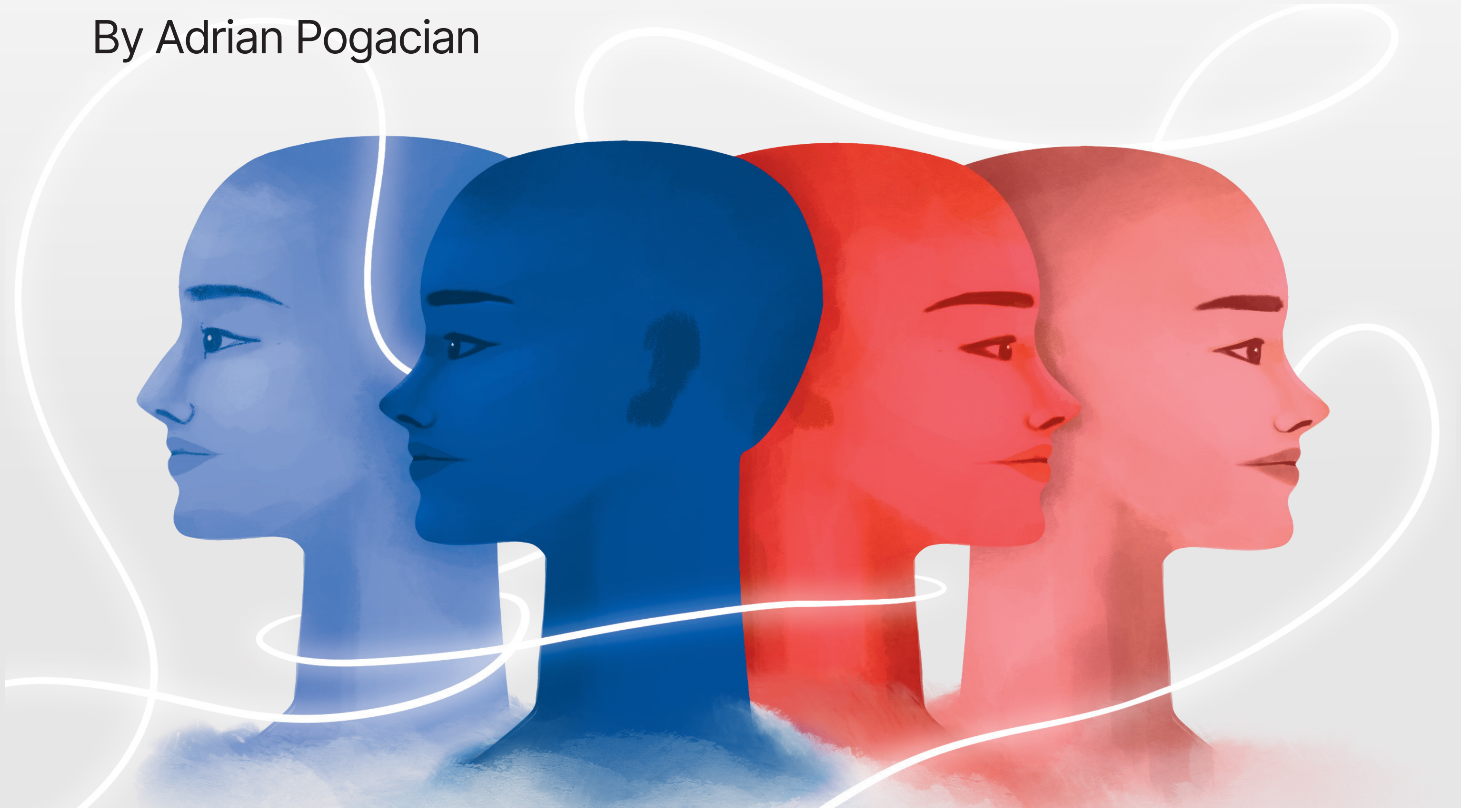
Taken together, the Charter and the patient response to it capture the central tension of ABC8. The ambition is clear and the roadmap articulated. What remains uncertain is whether health systems and policymakers are willing to follow through, adapting structures built for short-term illness to a reality in which advanced breast cancer is increasingly a long-term condition. As Cardoso put it, *"We now know that improvement is possible."*

Myerson's addition makes clear what that knowledge demands: *"If we are going to live longer,"* she said, *"then the system has to learn how to live with us."*

"United by Unique"

Does it Really Make a Difference, or is it Just a Cliché?

By Adrian Pogacian



> *"Nobody realizes that some people expend tremendous energy merely to be normal."*
> **Albert Camus**

People at the Centre of Care

"United by Unique" is the World Cancer Day theme for 2025–2027. This year, the focus is on placing people at the centre of care, with their stories forming the foundation of every conversation. The aim is clear: to make a tangible difference in ways that truly matter.

Each cancer journey is **unique**, yet our efforts are **united**. Every emotion is unique, yet the community is united. Cancer itself is unique, but healthcare providers are united in purpose, desire, and challenges. We are advancing rapidly in a world of digitalization and automation, but in this drive toward efficiency, we risk overlooking the feelings that define our humanity—fear, hope, tears, and love. Artificial Intelligence cannot replace these human experiences.

The Paradox of Being Unique and United

We are unique, but are we truly united?

I begin with the words of Albert Camus because they capture a harsh truth of contemporary society: many individuals expend immense effort and make countless sacrifices merely to fit into a relative concept of "normality." Patients with cancer are no exception. They adapt, sometimes against their own nature, to the demands of society and the expectations of others. Camus' reflection that we should "live to the point of tears" resonates profoundly with the cancer experience, a life marked by vulnerability, intensity, and hope.

Despite the universal impact of cancer, the psychological and social dimensions of the disease have historically been slow to gain scientific attention. Yet mental health and social well-being are essential for patients and families worldwide. The oncological patient often experiences a compressed sense of time and space, a reality dictated by illness perception.

Perception usually provides orientation in time and space. For cancer patients, however, this perception becomes distorted. Their multidimensional world collapses into a narrow, one-dimensional experience marked by feelings of claustrophobia. Patients may struggle to find peace, both in society and even within their own families, as familiar spaces become constrained. Time is equally transformed: each day is lived as if it were the last, with the persistent question: Is today the final day?

Integrating Illness into Life

The experience of cancer is profoundly stressful, compelling individuals to confront suffering, deterioration, death, and transcendence. Patients must integrate the disease into their sense of identity, relationships, expectations, and the ultimate meaning of life.

Cancer requires significant resources, and care must be optimized for both effectiveness and efficiency. Many patients may not meet clinical criteria for anxiety or depression but nonetheless confront an existential crisis—grappling with questions of meaning, value, and purpose in the face of serious illness. Addressing this dimension of suffering is essential, yet there remains no fully effective intervention to guide patients through this challenge.

Collective Struggle and the Importance of Psychosocial Care

We live in an era where the struggle against cancer is increasingly collective. Experience teaches that we must focus not only on physical symptoms—fatigue, pain, weakness-but also on the lived experiences of patients and their families.

Psychosocial care must be recognized as central to healing, just as advanced treatments are. Research consistently highlights the profound impact of mental health and social support on outcomes, including improved adherence to treatment, enhanced immune response, and better quality of life. Integrating evidence-based approaches such as cognitive behavioural therapy, stress-reduction programs, and tailored support groups is essential.

Beyond clinical tools, care must embody compassion, empathy, and recognition of each patient's unique journey. As a clinical psychologist, I envision a future where every oncology hospital has dedicated psychosocial teams—therapists, social workers, peer advocates, and spiritual counselors—working hand-in-hand with medical staff. These teams can provide the resources patients and families need to face cancer with resilience and dignity.

Technology also offers transformative potential: e-health platforms can broaden access to support services, connect patients with their communities, and complement—but not replace—the human dimension of care.

Making "United by Unique" Real

"United by Unique" will matter only if it is translated into action. Individuality must be operationalized in care, policy, and research, ensuring that every patient is seen, heard, and supported as a whole person. When uniqueness and unity coexist in practice, cancer care can empower patients and families to navigate the disease with both dignity and hope.

Cancer care is not only about treating the disease; it is about supporting life.

About the Author

Adrian Pogacian, PhD, is a licensed clinical psychologist with advanced training in psycho-oncology. His expertise is in Coping with Cancer, Complicated Grief, Posttraumatic Growth and Meaning-Centered therapy approach.

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