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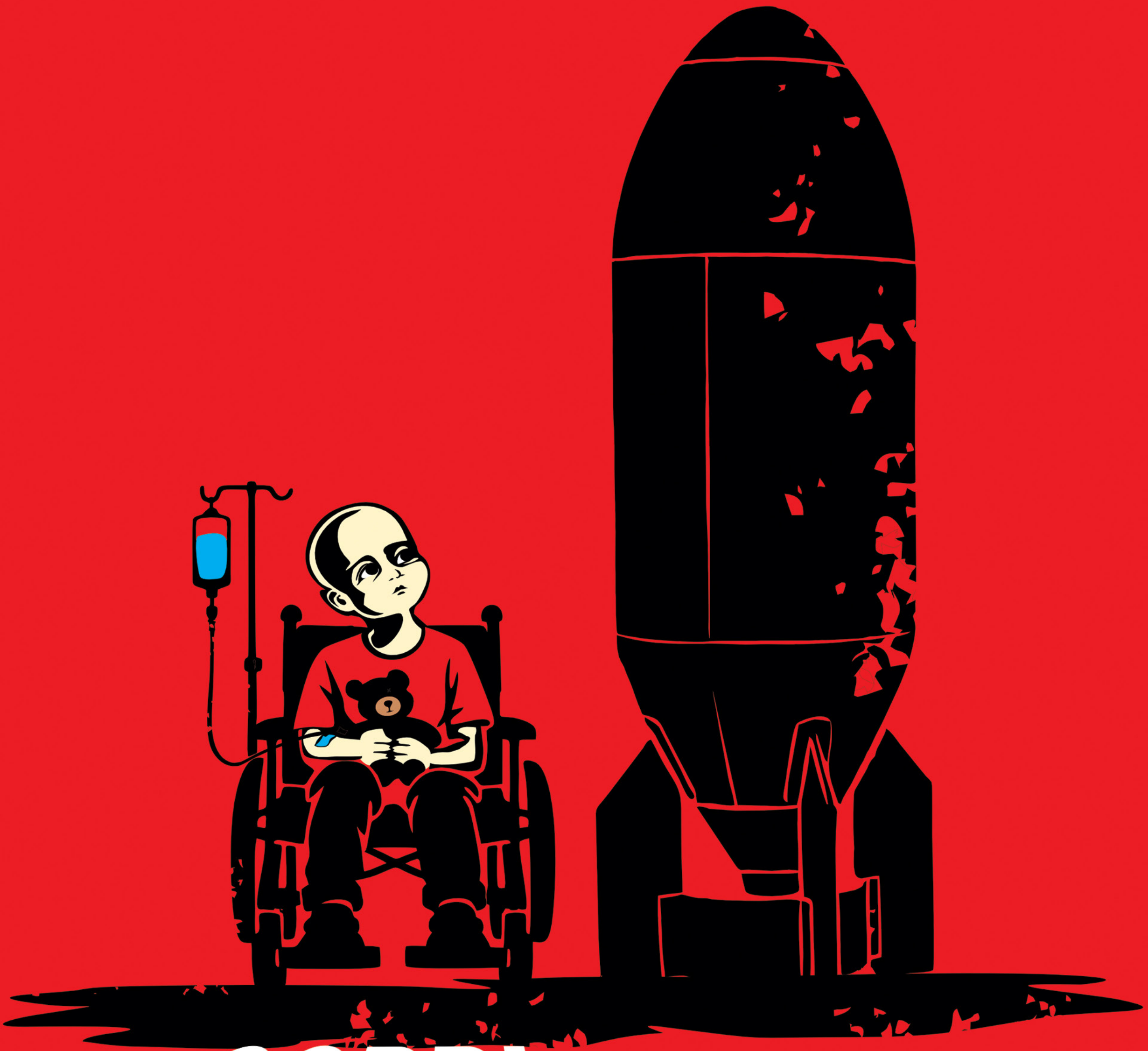
CANCERWORLD



CORRIDOR!

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NOT FOR SALE

In oncology, we are trained to deliver hope alongside difficult truths. We speak about survival rates, probabilities, and outcomes. In conflict settings, those terms lose stability. What does survival mean when hospitals are destroyed, treatments cannot reach patients, and people die not from disease alone but from system collapse?

Each issue of CancerWorld examines the people and ideas shaping oncology. This month, the tension between progress and fragility is especially clear. Scientific advances continue, but global instability limits their impact.

The April issue opens with a focus on cancer care in conflict settings. The ***OncoCorridor*** *initiative is presented as a response to fragmented humanitarian action and as a warning about system failure. It raises a direct question: how can oncology claim progress when patients with treatable disease die because care systems no longer function? In this context, coordination is a core component of care, not an added value.*

Our second cover story shifts to a different kind of pressure point in the system: execution. ***Isabel Mestres,*** *CEO of City Cancer Challenge, brings the discussion back to something very grounded—how change actually happens. Not in strategy documents or conference rooms, but in hospitals, cities, and health systems that need to function better for real patients. Her work cuts through the noise a bit: it's less about what should be done, and more about what gets done when the complexity is real.*

Even as oncology becomes more data-driven and influenced by artificial intelligence, this issue returns to a central point: it remains a human field. The career of ***Dr Rita Canário*** *illustrates the risk of clinical detachment if empathy is not maintained alongside scientific progress. Technology supports care but does not replace clinical understanding.*

Dr Waseem Darwish *examines the ethical and emotional complexity of patient-centred decision-making in oncology, showing how protecting patient autonomy can become most critical in moments of disagreement and end-of-life care. Through a clinical case, he shows how protecting patient autonomy isn't just about principles—it depends on how carefully clinicians listen, explain, and hold space for difficult conversations when families and patients don't always agree.*

On the policy side, ***Pancreatic Cancer Europe*** *marks ten years of work that has helped move pancreatic cancer into a more visible space on the European agenda. Still, the article is honest about what hasn't changed enough—late diagnosis and unequal access remain major barriers.*

Cancer Patients Europe *argues that nutrition remains insufficiently integrated into cancer care. Evidence supports its role in outcomes, but implementation across Europe is inconsistent. Nutritional screening and support should be part of standard oncology pathways.*

From Cape Town, ***Esther Nakkazi*** *reports on community-based palliative care. The model extends support beyond hospitals into patients' homes. It improves continuity of care, but also highlights persistent gaps in access to services.*

Scientific progress is also addressed in ***Toma Oganezova's*** *article on cancer vaccines. Once viewed as unsuccessful, they are re-emerging as a viable therapeutic approach. Advances in immunotherapy, genomics, and mRNA platforms are enabling new combinations, including with checkpoint inhibitors.*

John Walker Pattison *offers a very personal reflection on survivorship, decades after a "no chance" Hodgkin lymphoma diagnosis. His story doesn't end with a cure. Instead, it stays with what comes after the long, often invisible effects that shape life years later, physically and emotionally.*

Finally, ***Adrian Pogacian*** *examines psycho-oncology and its integration into routine care. Psychosocial support remains inconsistently available. The article argues for its inclusion as a standard part of oncology services, not an optional add-on.*

Across all these stories, one thread keeps coming back. Progress in oncology is not only about discovery. It is about whether anything actually changes for patients. From conflict zones to advanced cancer centres, from molecular research to lived experience, the measure stays the same.

The key question remains whether knowledge translates into care for the people who need it.

Knarik Arakelyan, Managing Editor, CancerWorld

What do you say?
Sorry?

ONCOCORRIDOR

By Gevorg Tamamyan

As a medical student, we had a lecture on how to deliver bad news.

Then, as an oncology fellow, we had it again.

And as frontline clinicians, we practice it every day.

"Your child has leukemia...
You have cancer...
Your child has Ewing sarcoma...
You have lymphoma...
But there is a big chance you will get through. A real chance to be cured."

But how do you deliver that news in a **war zone**?
What do you say?

"Your child has leukemia. There is an 85% chance to be cured, but because of the **war***, because of the bombs, there is no chance. The hospital is destroyed. The chemotherapy is not available. There is no way to get the drugs."*

And what do you say to a doctor, whose patient just rang the bell, completed treatment and on the way home, a bomb killed him?

What do you say?
Sorry?

In your entire career, you may save hundreds of lives.
And then, in a moment, a bomb kills more.

Yesterday, I was speaking with a friend.

He was sharing the results of a new immunotherapy combination.

"You know," he said, "more than 40% of patients, those who failed all lines of therapy, refractory patients, are still alive after two years."

He was excited.

At the same time, I was reading reports about cancer patients in war-affected regions — about their struggles, their pain, their suffering.

A person fighting cancer with everything they have and then hit by war.
So what should we do?

Speak out? Yes.
But what else?

When war closes doors, we must open corridors.

OncoCorridor.

On May 18th, in Geneva, during the World Health Assembly, OncoDaily, together with the Institute of Cancer and Crisis, is launching OncoCorridor — a global network connecting cancer patients in conflict zones to treatment centers worldwide.

OncoCorridor is the direct operationalization of a landmark manifesto published in The Lancet, co-authored by the WHO Director-General, calling for exactly this kind of mechanism.

We must act now.

No patient should die of curable cancer because a war stood in the way.

We have the treatments.

We have the hospitals.

We just need to connect them to the people who need them.

Remarkable work has been done by individual organizations.

But no coordinated global mechanism exists to systematically connect treatment capacity to patients in conflict zones — until now.

The time has come.

We cannot wait.

We know what to do. We just have to do it.

The next time a doctor stands at that bedside, searching for words — there will be an answer.

MEDICINE IS DEEPLY RELATIONAL

THE HUMAN HEART OF ONCOLOGY IN THE AGE OF AI

By Knarik Arakelyan

From genetics to palliative care, clinician-scientist Rita Canário reflects on building a career in Oncology that bridges research, patient care, and the human side of medicine and why this integration is essential for the future of oncology.

For Dr Rita Canário, the path into medicine was not predetermined, but discovered gradually, and almost unexpectedly at the intersection of curiosity, creativity, and human connection.

"I was never the type who always wanted to be a doctor," she says. *"I had very eclectic interests from arts to science and choosing a path at 15 felt far too early."*

Initially drawn to genetics, she imagined a future in research. But a formative volunteering experience helping stroke patients during mealtimes shifted her perspective.

"I realised I enjoyed listening to people's stories and helping them… and that I felt comfortable in the hospital."

Medicine offered something unique: the possibility of combining scientific inquiry with direct human impact. Oncology, in turn, brought this duality into its most intense and meaningful form.

"It is an area where we combine cutting-edge research with deep human connection."

A Career Shaped Between Disciplines

Canário's professional identity today spans clinical oncology, hereditary cancer research, and palliative care—a combination that reflects both intention and necessity.

Her early fascination with genetics naturally led her to hereditary cancer. But it was during medical school and oncology training that she recognised a critical gap in palliative care particularly in Portugal, where services were still underdeveloped.

"I felt the need to become more skilled in end-of-life care," she explains. This led her to the UK, where she undertook advanced training in palliative care, with the aim of bringing those competencies back into her oncology practice.

For Canário, integrating these domains is not optional; it is fundamental to quality care.

"Combining research with clinical care is the cornerstone of good oncology practice. My end goal is always to improve patients' lives."

Her work is guided not only by scientific curiosity, but by the realities patients face.

"Patients centre me. They guide the questions I ask in research."

The Art of Medicine in a Technological Age

Alongside her scientific training, Canário's background in the arts has played a defining role in shaping how she practices medicine.

Having attended an artistic school from an early age, she developed a sensitivity to narrative, expression, and human experience skills she now considers essential in oncology.

"Medicine is an art. We must know the science but to deal with people, we cannot neglect emotional intelligence and culture."

Now teaching at the School of Medicine - University of Minho, she is part of a curriculum that places medical humanities at its core, an approach she believes is increasingly urgent.

"We are living in a fast-paced world where AI will, hopefully, replace us in several mechanical tasks," she says. *"What will remain is empathy, kindness and the human touch."*

Listening, in this context, becomes a clinical skill as much as a human one.

From left to right Dr Judy Paulo–Medical oncologist, Prof. Zacharoula Sidiropoulou– Oncologic Surgeon, Dr Rita Canário: ESO Improving outcomes & leadership course in Zagreb, 2025

"When we truly listen to patients' stories, we are not only building relationships, we are also improving diagnosis and understanding their priorities."

This, she argues, is the foundation of genuinely personalised medicine: not only tailoring treatment to tumour biology, but to the individual person.

Challenging the Research–Clinic Divide

Despite the clear benefits of integrating research and clinical care, structural barriers remain. In Portugal, there is still no defined pathway for clinician-scientists—a reality that continues to shape Canário's career.

"I am still struggling to tailor my path and advocating for this career to exist," she says.

A pivotal moment came during her fellowship at the Royal Marsden Hospital in London, where she saw a different model in action.

"There were colleagues doing research and still seeing patients. That was when I realised this path was possible and meaningful."

"When we conduct research, we are 'obliged' to stay updated and to think methodologically. It improves the care we provide," noted Dr. Canário.

Yet the challenges are tangible: slower progression, less stability, and financial trade-offs. Even so, she remains committed.

"Passion is a great fuel, it helps to overcome obstacles."

She is also clear that not every clinician needs to follow this path. Strong oncology teams, she argues, depend on diversity of roles, but they must include individuals who can bridge disciplines.

The Value of Networks, Mentorship and the European School of Oncology

Throughout her career, international exposure and collaboration have played a crucial role, particularly through her long-standing engagement with the European School of Oncology. From early e-learning initiatives well ahead of their time to masterclasses, fellowships, and structured mentorship programmes, ESO provided opportunities that extended far beyond national training structures. For Canário, these experiences were not only educational, but transformative in shaping both her clinical perspective and her professional trajectory.

"The Clinical Training Centres Fellowship was life changing. It showed me that combining research and clinical care was not only possible, but impactful."

Mentorship, in particular, proved decisive.

"The mentorship programme came at a crucial time, during the final stage of my PhD. Having Fedro A. Peccatori as a mentor helped me clarify my career goals and navigate uncertainty. It's something I now strongly advocate for both receiving and providing mentorship."

Dr Canário with her ESO mentor Fedro A. Peccatory at ESO masterclass in Barcelona, 2022.

"One of the most important lessons from ESO is the value of mentorship and the responsibility to mentor others," she added.

Beyond individual development, she emphasises the power of networks in shaping sustainable careers and enabling meaningful impact.

"ESO shows that you don't necessarily need to leave your country to grow. You can build international collaborations and bring change locally, supported by a strong network."

In this sense, ESO is not just an educational platform, but a framework for professional identity, one that reinforces the integration of research, clinical practice, and mentorship as interconnected pillars of modern oncology.

When Research and Care Inform Each Other

In her daily work, the interplay between research and clinical practice is constant.

Advances in genetic testing, next-generation sequencing, and digital pathology are transforming oncology, but they also demand clinicians who can critically interpret and integrate complex data.

"Being involved in research allows me to analyse results more deeply and to communicate effectively with colleagues across disciplines," she says. *"Clinician-scientists connect worlds that should never have been separated."*

Equally, clinical experience reshapes research questions.

"When designing studies, I bring a different perspective—understanding disease trajectories, treatment timing, and patient realities. This improves the quality of research design."

The Emotional Dimension of Oncology

Oncology is as emotionally demanding as it is intellectually complex. For Canário, maintaining empathy requires conscious balance.

"I am deeply involved with my patients, and that is precisely why I don't want to do full-time clinics," she says. Research and teaching act as "buffers" that sustain her emotional availability.

Beyond professional structure, personal life plays a critical role. Family, friendships, and creative outlets—including a long-standing book club—are essential sources of resilience.

She also speaks candidly about the challenges of combining motherhood with an academic career.

"I had my son during my PhD, and it was very challenging to return to full performance," she says. *"I often felt that we cannot have it all."*

Rather than individualising the issue, she sees it as systemic—one that future generations must address more effectively.

Rethinking What Patient-Centred Care Means

For Canário, patient-centred care is often misunderstood as a soft concept, when in fact it requires rigor and evidence.

"Evidence-based practice applies to everything—from the drugs we prescribe to the words we say."

Communication, empathy, and relational skills are not innate traits, but competencies that must be developed and continuously refined.

"Nothing is negligible in the medical–patient relationship," she emphasises.

Looking Ahead

As oncology evolves, Canário sees integration not specialisation alone as the defining challenge.

"We cannot separate research, patient care, and teaching." she says. "This is the only way forward."

In a future shaped by artificial intelligence, the uniquely human aspects of medicine will become even more valuable.

"What will remain uniquely ours is the ability to connect, to understand, and to care."

For Canário, success is not measured in titles or recognition, but in contribution.

"My idea of success is to leave the world a bit better for the next generations," she says.

That includes advocating for clinician-scientist career pathways, mentoring future professionals, and reinforcing a principle she believes must never be lost:

"The patient–doctor relationship is not an optional part of the deal. It is the foundation of everything we do."

About the Author

Knarik Arakelyan (PhD) is a psychologist and communications professional with over 14 years of experience in public relations, health communication, and public awareness campaigns. She is currently the Managing Editor of "CancerWorld " magazine, and serves as PR and Communications Officer at "EMERTÉ" Clinic.

Nutrition in Cancer Care

Closing the Gap Between Awareness and Action

By Cancer Patients Europe

On 3 February 2025, on the eve of World Cancer Day, Cancer Patients Europe (CPE) hosted a high-level policy event at the European Parliament in Brussels, convened by MEP Michalis Hadjipantela (EPP, Cyprus). The occasion marked the official launch of CPE's White Paper, Nutrition in Cancer Care: Closing the Gap Between Awareness and Action, grounded in the voices and experiences of more than 2,500 cancer patients across 12 European countries.

The findings were stark, the message urgent: nutrition is not a lifestyle choice. It is a clinical necessity, and European health systems are falling short of delivering it.

Why Nutrition and Why Now?

Cancer-related nutritional problems affect 1 in 3 cancer patients overall, and up to 80% of those at advanced stages of the disease. The consequences are not merely physical discomfort: malnutrition during cancer treatment leads to treatment interruptions, increased toxicity, poorer outcomes, and reduced survival. Yet, across Europe, nutritional care remains a low priority in most oncology care pathways.

CPE's White Paper was designed to provide patient-reported evidence on the scale of this problem and to turn that evidence into action. The survey, conducted across Denmark, Finland, France, Germany, Italy, Norway, Poland, Portugal, Romania, Spain, Sweden, and the UK, posed 31 questions to more than 2,500 patients and survivors and was translated into 12 languages. The respondent profile—88% women, 75% aged 49–69, 60% with breast cancer, and 50% with advanced-stage disease—reflects both the limitations and the clinical relevance of the dataset.

A Persistent Gap Between Patient Needs and Care Delivery

The survey results reveal a troubling disconnect—not between awareness and willingness, but between awareness and action at the system level. Patients know nutrition matters; healthcare systems are not responding accordingly. Opening the event, **CPE CEO Antonella Cardone** drew the line clearly: *"They need nutrition to be treated as standard cancer care, everywhere in Europe."* The White Paper findings make the case for why that statement is not yet a reality.

Among the key data points:

- Despite **70%** of patients knowing that nutrition can support cancer treatment, only 26% received guidance from a healthcare professional, and just 14% were monitored for nutritional status at any point since diagnosis.
- Only 1 in 5 patients underwent any form of nutritional assessment, despite fatigue **(76%)**, nausea **(39%)**, and loss of taste **(38%)** being widely reported as side effects affecting diet.
- Post-treatment support was particularly weak, with only around **20%** receiving any nutritional guidance after active treatment ended.
- Over half of patients **(52%)** did not consider nutrition a key part of cancer care, citing insufficient funding **(40%)** and a lack of evidence-based guidance for clinicians **(35%)** as the main barriers.

The implication is not simply that patients are uninformed—they are not. It is that healthcare systems have not operationalised what patients already understand. As Figure 1 of the White Paper illustrates starkly, the gap is not one of patient awareness, but of institutional delivery.

Where You Live Determines the Care You Receive

The White Paper also exposes significant regional disparities in nutritional care across Europe—a finding that should concern policymakers deeply. Southern Europe (Portugal, Italy, France) and Eastern Europe (Romania, Poland) demonstrated more structured approaches: higher rates of nutritional testing, better access to dietitians, and a more positive quality of life impact from nutritional support. Northern Europe (Denmark, Sweden, Norway, Finland), by contrast, showed the lowest levels of integration—low information provision, limited funding, and weak follow-up. Western Europe (Germany, Spain, UK) presented mixed results, with notable variation between countries.

These disparities are not explained by differences in awareness or in the availability of clinical guidelines. Nutrition guidelines from leading medical societies exist across Europe. What is missing is consistent, funded, and monitored implementation. As the White Paper concludes, the result is a form of inequity that mirrors broader inequalities in cancer care: where a patient lives in Europe continues to shape their chances of recovery.

Clinical Expertise Reinforces the Patient Voice

The event at the European Parliament featured expert perspectives from Elisabeth De Waele (UZ Brussels), Dr. Jann Arends (Uniklinik Freiburg), and Jo Eksteen (KU Leuven), who reinforced the clinical case: cancer-related malnutrition is not a side effect to be managed after the fact, but a clinical issue requiring early screening and multidisciplinary intervention.

A moderated discussion, facilitated by CPE Senior Policy Officer Josephine Mosset, brought together clinicians, patients, and advocates, including Dave Chuter (Digestive Cancers Europe), Pamela Deasy (Pancreatic Cancer Ireland), and Beatrice Credi (European Liver Patients' Association). Speakers described how the absence of structured nutritional support affects everyday life during treatment, slows recovery, and compounds the already significant burden of cancer. A shared message emerged: a one-size-fits-all approach is not good enough, but neither is the current patchwork of inconsistent, under-resourced care.

A Call to Action: From Evidence to Policy Change

The White Paper does not stop at diagnosis. It issues a clear call to action for three key audiences.

We urge policymakers to mandate nutritional screening at diagnosis and throughout treatment — a step still absent from major EU frameworks including Europe's Beating Cancer Plan and to draw on best-practice models from countries like Portugal and Italy to establish EU-wide minimum standards, backed by active monitoring of national guidelines.

We call on healthcare professionals to treat nutrition as a core therapeutic component of oncology care, to inform patients systematically and continuously about dietary management, and to embed structured nutritional follow-up into survivorship pathways, while sharing best practices across EU, national, and regional levels to address persistent inequalities.

For patients and patient organisations, the message is equally clear: nutritional assessment is a clinical right, not an optional add-on. Patients are encouraged to request it early and regularly, advocate for access to dietitians and nutrition programmes, and champion awareness of nutrition throughout survivorship.

What Comes Next

The launch of the White Paper is a beginning, not an end. CPE will continue to build on the political momentum generated at the European Parliament, working to ensure that nutrition is embedded, mandated, funded, and monitored in cancer care pathways across Europe.

The evidence is in. The guidelines exist. What is now required is the political will to close the gap between awareness and action for every patient, in every Member State.

YVONNE
AWARD 2026

Evelyn De Villiers at the hospital

Holding on to Comfort and Dignity in Cape Town

By Esther Nakkazi

Evelyn De Villiers lies quietly in a bed in the short-stay unit at Heideveld Community Day Clinic.

At 78, the retired nurse speaks softly about what matters most to her now: being at home with her grandchildren and, one day, visiting her daughter overseas. For now, however, her world has narrowed.

Evelyn is living with chronic obstructive pulmonary disease (COPD), a progressive condition that has left her breathless, fatigued, and increasingly dependent on care. *"I feel strong, I am okay,"* she says with quiet resolve, though each sentence is measured against the effort it takes to breathe.

Her days are shaped by persistent breathlessness, pain, and exhaustion—hallmark features of advanced COPD. *"Patients slowly realise they can't keep up; they feel tired all the time, and everyday activities become a struggle,"* says Richard van Zyl-Smit, a pulmonologist at Groote Schuur Hospital and professor at the University of Cape Town. *"It's insidious,"* he tells CancerWorld.

Palliative Care Beyond End-of-Life

For patients like Evelyn, palliative care is not about cure but about relief—managing symptoms and addressing what is often a gradual, cumulative form of suffering. At Heideveld Community Day Clinic, this care is integrated into routine services rather than reserved for the final stages of illness.

The need is substantial. According to the World Health Organization (WHO), hundreds of millions of people live with chronic respiratory diseases, with COPD alone responsible for approximately four million deaths annually.

Chronic respiratory diseases can be difficult. The suffering is often slow and the harm accumulates. The harm accumulates quietly, but quiet suffering is no lesser suffering, says José Luis Castro, the WHO Director-General's Special Envoy for Chronic Respiratory Diseases (CRDs).

At Heideveld, patients with advanced COPD, cancer, heart failure, and post-tuberculosis lung disease seek help not only for symptom control, but also for the practical challenges of daily life. Many come from severely constrained socioeconomic circumstances.

Around 60% of households in the surrounding community survive on roughly 2,000 rand per month, and about one in five people live in informal settlements or without stable housing. Some patients are admitted briefly for stabilisation, while others are followed up as outpatients. Care is delivered through a small but coordinated interdisciplinary team.

WHO DEFINITION OF PALLIATIVE CARE

Palliative care is an **approach** that improves the **quality of life** of patients and their **families** facing the problem associated with **life- threatening illness**, through the prevention and relief of **suffering** by means of early identification and impeccable assessment and treatment of pain and other problems, **physical, psychosocial and spiritual.**

The model becomes visible as soon as one enters the ward. Along one wall, a *"palliative care wall"* provides clear, accessible information for patients, families, and students. Nearby, Evelyn rests in a well-managed unit that reflects a deliberate effort to combine clinical care with patient education.

"We provide both inpatient and outpatient palliative care," says Dr Porcia Williams, a palliative care medical officer. *"Most of our patients come to us for symptom control."*

A physiotherapist from Mitchells Plain Hospital visits twice weekly, providing chest physiotherapy, helping to ease breathlessness, and encouraging mobility where possible. A registered counsellor also attends twice a week, supporting patients as they navigate grief, fear, and uncertainty, including the added complexities of substance use.

A social worker plays a critical role in bridging medical and social needs. For patients without stable housing, discharge planning can become a crisis point. *"She helps us find shelter or arrange emergency placements, sometimes even in old-age homes,"* Williams explains.

Continuity of Care in Resource-Limited Settings

Continuity of care is central to the model. *"We involve* *families early, identifying one responsible person to help manage medications and day-to-day care,"* says Rene Krause, Associate Professor and Head of the Division of Interdisciplinary Palliative Care and Medicine (IPCM) at the University of Cape Town. *"We also try to ensure that one clinician oversees treatment—someone who knows the patient."*

Community health workers extend this support into the home, creating a network that integrates clinical, social, and psychosocial care beyond the facility.

Krause emphasises that embedding palliative care within primary healthcare is essential for equitable and sustainable access. This approach is currently being tested through an ongoing implementation project. "We are demonstrating a model that trains health workers at both community and facility level, while linking services to ensure continuity of care," she says. *"This aligns with the essential palliative care package for primary care."*

When Access to Care Depends on More than Medicine

Beyond clinical care, patients face the daily realities of living with serious illness. Many rely on disability grants for survival. In South Africa, palliative care patients may qualify for support through the Department of Social Development, but access is often time-bound and administratively complex.

Williams assesses patients in the ward and completes the required documentation, with citizenship among the key eligibility criteria. Delays can be critical. Applications may take up to three months to process—time some patients do not have.

Even when approved, grants may be temporary, lasting six to twelve months, or permanent, depending on the condition. This creates unintended consequences. *"Some patients stop taking their medication and relapse in order to qualify again,"* Williams explains.

"It disrupts care, and they often return in worse condition, sometimes with complications such as post-tuberculosis structural lung disease."

At advanced stages of chronic lung disease, many patients are simply unable to reach primary care services. This is not unique to South Africa. Patients miss appointments, because they are too unwell, deteriorate, and eventually present to emergency departments.

"There, the focus is on stabilising the immediate crisis—oxygen, breathing, acute care, while broader needs often go unaddressed," says Dr Katya Adams, a specialist in emergency medicine at Mitchells Plain Hospital. Patients may leave without assessment for disability support, physiotherapy, or nutritional assistance, even where such services exist.

"We often act as the safety net in the emergency department," Adams says. *"But we also see where patients fall through the cracks."*
Structural barriers extend beyond the clinic. *"If a patient is breathless after just a few steps, how do they stand in a long queue at a government office?"* she asks. *"The same applies to accessing nutritional support or food parcels. Eligibility does not guarantee access—patients need to be connected into the system."*

Basic resources can have a profound impact on quality of life. *"Home oxygen is almost a luxury in many settings,"* Adams notes. *"In the past two years, I've had two patients, whose oxygen equipment was stolen, while they were away at appointments. Replacing it is extremely difficult."*

Mobility aids are similarly overlooked. *"There is a perception that if a patient can still walk, they do not need a wheelchair,"* she says. *"But for someone, who becomes breathless after a few steps, a wheelchair can be transformative. It is not just about mobility—it is about dignity, social connection, and participation in daily life."*

For some patients, the hospital offers a level of stability that is not guaranteed at home: regular meals, shelter, and access to basic services such as water and sanitation.

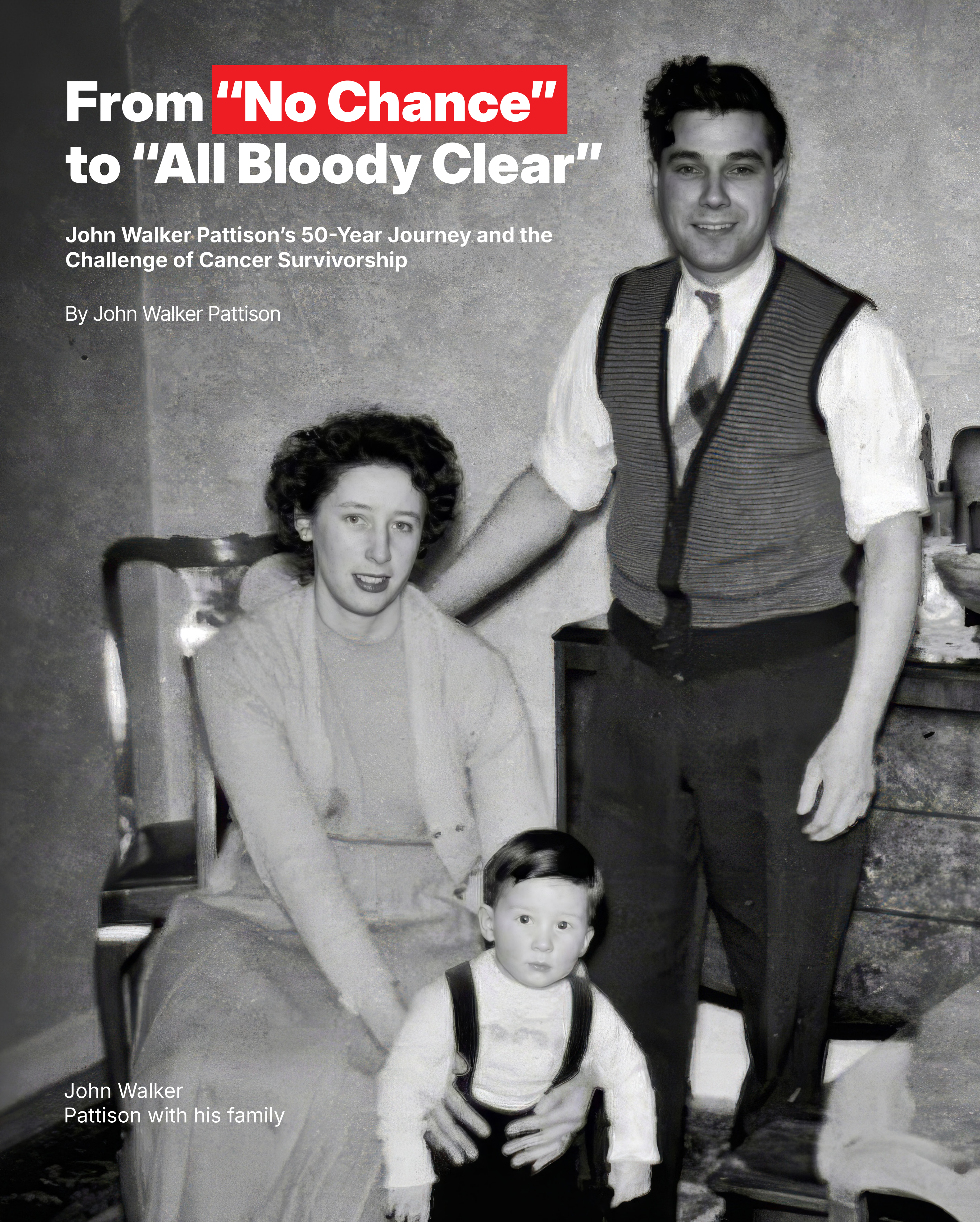
In this context, admission can feel less like disruption and more like a rare point of security—particularly for those with complex social needs, including substance use.

Yet the gaps remain stark. *"The reality," Adams adds, "is that in some cases heroin is cheaper and easier to access than morphine."*

From "No Chance" to "All Bloody Clear"

John Walker Pattison's 50-Year Journey and the Challenge of Cancer Survivorship

By John Walker Pattison



John Walker
Pattison with his family

A Diagnosis That Changed Everything

I was born in South Shields sixty-nine years ago. My childhood was happy, if uneventful, and I left school with what I would later describe as a handful of worthless qualifications before starting work in a local shipyard. At eighteen, I was enjoying life—travelling across the country to see rock bands, working hard, and thinking little about the future.

Then cancer intervened.

What began with rapid weight loss, drenching night sweats, and relentless fatigue ended in collapse at work and an emergency hospital admission. The diagnosis was stark: stage IV lymphocyte-depleted Hodgkin lymphoma, a rare and aggressive subtype particularly unusual in someone my age. My parents were told that my chances of survival were slim.

I was not told.

That silence, however, well-intentioned would shape my experience as profoundly as the disease itself.

Treatment in the 1970s: Survival at Any Cost

My treatment began with the MOPP chemotherapy regimen. It was, quite simply, brutal. The physical side effects were relentless, but the psychological toll was equally severe. I found myself in places of deep despair, and I have no hesitation in saying that I contemplated suicide more than once.

After six months, I entered remission. It lasted only a few months.

The cancer returned repeatedly, each time more aggressive. I underwent further treatment with intramuscular bleomycin and oral cyclophosphamide easier to tolerate in the short term, but with consequences that would reverberate decades later. When remission again proved fleeting, I moved on to COPP chemotherapy, enduring side effects that were, at times, humiliating and overwhelming.

As the disease continued to relapse, radiotherapy was initiated, targeting the mediastinum. Christmas 1976 remains one of the darkest periods of my life—physically depleted, psychologically fragile, and profoundly isolated.

By early 1977, after a fourth relapse, my parents were told unequivocally: I would not survive. *"John is not going to recover from this cancer,"* my oncologist stated.

Still, I was not informed.

At that stage, treatment shifted to palliation. The goal was no longer cure, but symptom control. I began single-agent vinblastine in March 1977, administered weekly or biweekly depending on my blood counts. In late August, I travelled to North Carolina to recuperate with relatives, before returning to Newcastle General Hospital for further investigations.

The night before my results, fear was overwhelming. Walking down the corridor the next day, my gaze fixed to the ground, I prepared myself for the worst.

Then my consultant, Dr Atkinson, appeared in the doorway, arms raised, smiling:

"You're clear, all bloody clear."

Against all expectations, I had survived.

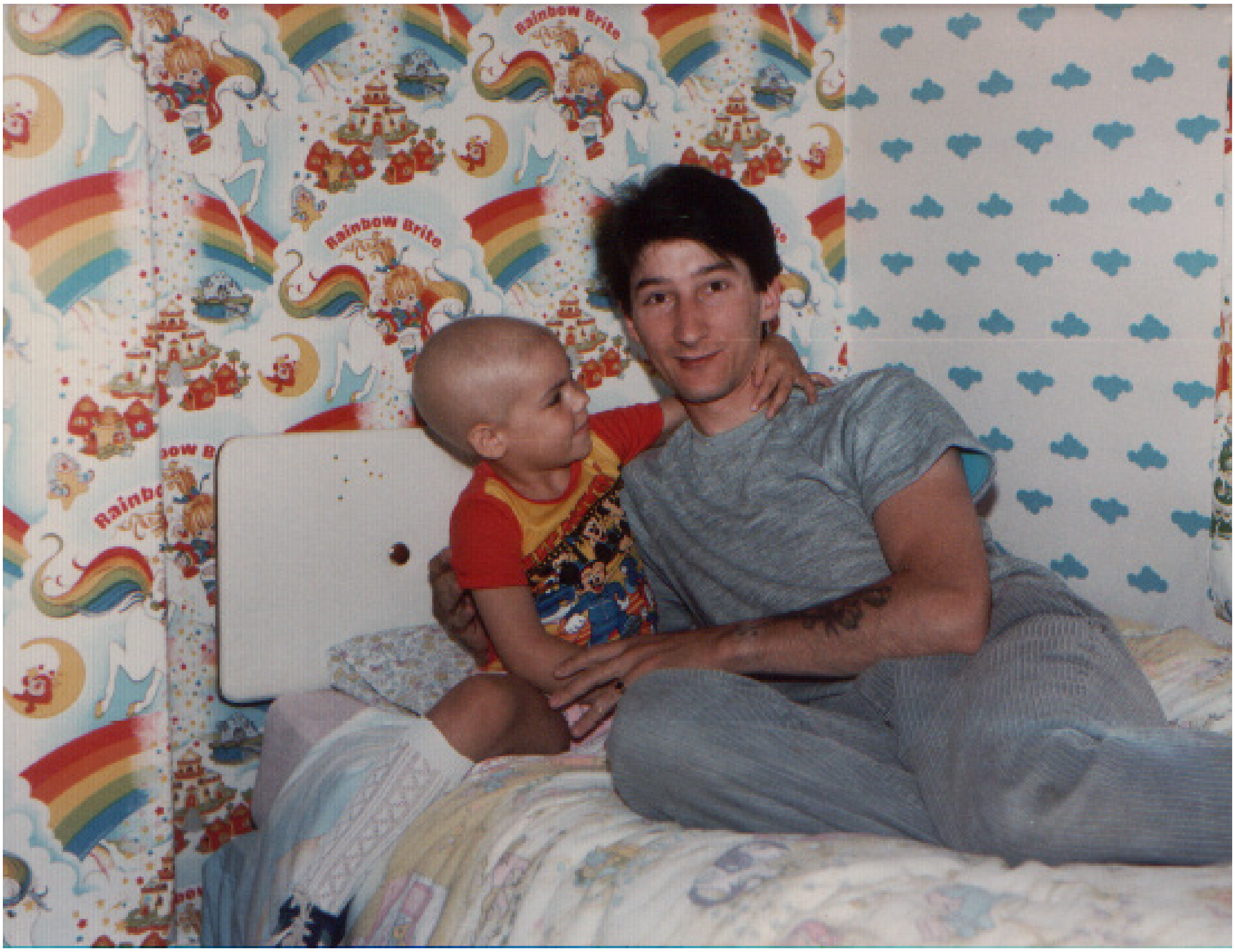
The Hidden Legacy of Cure

Survival, however, came at a cost one that was not fully explained at the time.

I was never told that my treatment would leave me infertile. Acting on impulse, I married, though the relationship did not last. We later adopted a daughter. Nor was I warned about the long-term health consequences of the therapies I had received.

Today, I live with the late effects of those treatments: hypopituitarism, pulmonary fibrosis, osteoporosis, and, more recently, a further cancer diagnosis—all consequences of the chemotherapy and radiotherapy that saved my life in the 1970s.

These experiences reflect a broader reality for many long-term survivors of Hodgkin lymphoma treated in earlier decades. The success of treatment was undeniable, but so too were its long-term consequences.



Donna and John, during her treatment

When Cancer Returns Through Family

Eight years after my own recovery, cancer returned to my life in a different and devastating way. My four-year-old daughter, Donna, was diagnosed with terminal leukaemia.

Watching her endure chemotherapy brought back every memory of my own experience. Yet, like me, she defied expectations. She survived and went on to represent Team GB at the World Swimming Championships in New Zealand, winning two silver medals.

Her story is a testament not only to resilience, but to the progress made in cancer treatment across generations.

From Patient to Cancer Nurse Specialist

My experience with cancer instilled in me a powerful sense of purpose. I returned to education, gained the qualifications I had once lacked, and trained as a nurse. Over time, I rose to become a senior cancer nurse specialist working in the very hospital where I had first been diagnosed.

Caring for patients facing the same disease I had once endured brought a unique perspective to my work. I understood the fear, the uncertainty, and the psychological toll in a way that went beyond clinical training. Cancer had nearly taken my life; instead, it gave me a vocation.

Meaning Beyond Medicine

Throughout my journey, I found strength in places beyond the clinical setting. Music, particularly the influence of the band Hawkwind, became a source of inspiration. I later joined their road crew, touring across the UK, and even performed on stage at Donnington Festival, rewriting the lyrics of *Ten Seconds of Forever* to reflect the first ten seconds of a cancer diagnosis.

Spirituality also played a defining role. After receiving a copy of Bury *My Heart at Wounded* Knee during treatment, I found solace in the history and spirituality of the Lakota Sioux. I promised myself that if I survived, I would visit Wounded Knee in South Dakota, a promise I have fulfilled multiple times.

In 2018, I spent a week on the Pine Ridge Indian Reservation and was honoured as an honorary member of the tribal council—one of the greatest recognitions of my life.

Survivorship, Identity, and the Need for Long-Term Care

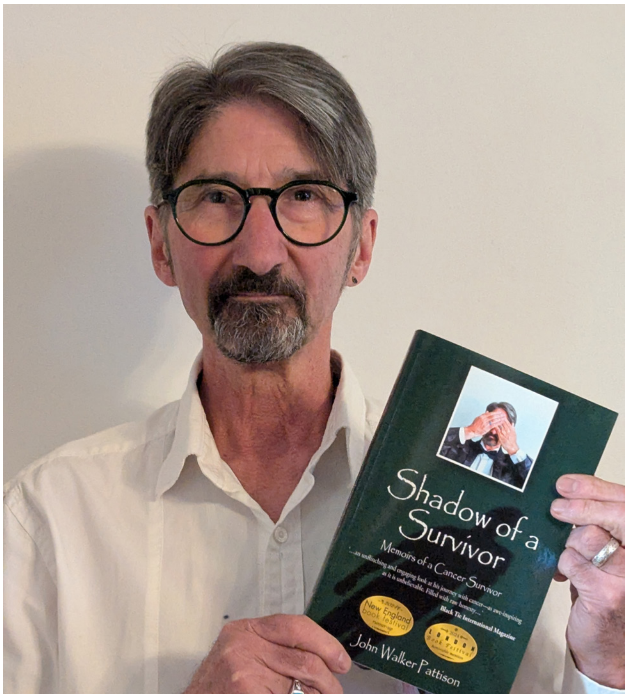
Now, more than fifty-one years after my diagnosis, I am among the longest-living cancer survivors in the UK—perhaps even globally. Yet survivorship is not simply a success story. It is a complex, ongoing experience shaped by late effects, secondary cancers, and psychological reflection.

I retired four years ago due to health issues linked to my treatment. My journey underscores the importance of long-term survivorship care—an area that continues to evolve as more patients live beyond cancer.

Telling the Story of Survivorship

I wrote Shadow of a Survivor as a raw, honest account of this journey. It is a story shaped by illness, but not defined by it—a reflection on resilience, family, spirituality, music, and hope.

As one commentator described it: ***"It's more than a cancer story—it's a story of purpose, humanity, and turning pain into power."***



John Walker Pattison: Shadow of a Survivor

Cancer remains one of society's greatest fears, but behind every diagnosis is a human story—complex, emotional, and often unpredictable. Mine is just one of them.

Looking Forward

My life was once given up for lost. Today, it is a story I hope can help others—patients, clinicians, and policymakers alike—better understand not only what it means to treat cancer, but what it means to live beyond it.

Because survival is not the end of the story. It is where the real work begins.

And if there is one lesson I would leave behind, it is this: **never look back unless you can do so with reflection—and never look forward without the courage to dream.**

About the Author

John Walker Pattison is a multiple-award-winning memoirist and one of the UK's longest-living cancer survivors. Outside of writing and reflection, he enjoys fly-fishing and photography.

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The Doer

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The Doer

Isabel Mestres

By Gevorg Tamamyan

Global health has become very good at diagnosing problems but far less effective at implementing solutions.

That gap is where Isabel Mestres has built her career.

As CEO of City Cancer Challenge, she is known not as a theorist or an advocate alone, but as a builder: someone who does not merely diagnose failures in health systems, but works to redesign them and make them function in practice. She moves between global ambition and local reality, translating ideas into models that can be implemented, tested, and sustained.

Her focus is clear: close the gap between what is planned and what actually reaches patients. It's a role that requires more than vision. It demands pragmatism, resilience, and a willingness to work within complexity. Such qualities have come to define her leadership.

And perhaps that is the most fitting way to describe her: The Doer.

A Life Shaped by Curiosity and Exploration

That clarity in Isabel's vision didn't arrive overnight.

"I didn't yet know where I could have the most impact," she reflects.

Early on, long before oncology care, her interests pulled her in different directions. She was drawn to creativity, at one point considering cinema, but ultimately chose to study business as a foundation she could build on.

"If I'm not sure yet, at least this gives me a base, and once I discover what truly drives me, I can apply the business knowledge," she remembers thinking.

She stepped into the private sector, working with companies like Procter & Gamble and Nestlé, gaining a strong grounding in marketing, sales, and leadership. It had been a pragmatic decision. The experience was valuable, but it also sharpened her sense that something was missing.

"I didn't feel fulfilled," Isabel remarked.

What followed was not drift, but exploration. She did something few people do when faced with uncertainty: she left in search of perspective.

"I decided to go around the world looking for that inspiration."

Isabel began travelling across Latin America, Asia, and Africa, where she immersed herself in different cultures, systems, and ways of thinking. It was an experience that broadened her worldview but most importantly, began to shape the questions she would carry forward.

"When I returned from being away, I wanted to continue exploring, so I moved into the media industry, helping countries shape and communicate their identity through journalism and marketing." That work brought her into close contact with political leaders, CEOs, institutions, and decision-makers from the international development world. And little by little, a different future began to appear.

"I started reaching out to people working in the development space, in different international organisations. And as I spoke with them, I realised that it was sparking something".

What she saw was a different kind of leadership. Highly professional, but driven by purpose, by something bigger than themselves.— *"And I thought - bingo!"*

That moment of clarity led her to Geneva. And then the breakthrough into global health.

Entering the Cancer World

At the Union for International Cancer Control (UICC), Isabel entered global health at age 29, bringing a private-sector understanding of how systems actually operate. Something often missing in global health.

But the deeper transformation was personal. This was not just a career move—it was a shift in direction. She found not only a field, but a mission: a global community driven by commitment, and a problem that was impossible to ignore.

As she describes it, *"I became fascinated by the cancer community and their level of commitment and passion. But at the same time, I was struck by the inequality in care that where you live can determine whether you survive."*

One area, in particular, shaped her thinking early on was paediatric cancer. What stood out was not only the level of need, but the way teams were able to deliver results despite severe constraints. The resourcefulness, determination, and sense of purpose within that community helped define how she began to see cancer care more broadly and where she could contribute.

The Problem Nobody Was Solving

At the time, the cancer community was making real progress in advocacy. National cancer control plans were being developed, registries strengthened, and global recognition of cancer as a major health challenge was growing.

But something critical was missing.

"UICC is primarily an advocacy and capacity development organisation, so there was a strong push for national cancer control plans and registries. But we were not seeing that translate into change at the local level."

That gap, between planning and implementation, became the defining problem she set out to solve.

At the same time, another contrast was impossible to ignore. In high-income countries, oncology was advancing rapidly with new diagnostics, medicines, and models of care transforming outcomes. But for much of the world, those breakthroughs remained out of reach.

The financing landscape just reinforced the imbalance.

"There was no dedicated funding for cancer. Most of the development aid was going to communicable diseases, and less than 2% was going to NCDs. Despite the enormous investment in oncology innovation, very little was invested in the health systems needed to deliver that care."

And then there was the ethical contradiction that struck her most forcefully: fragmented interventions that identify disease without creating a path to care.

"There were many siloed interventions, particularly around screening," she recalls. *"But civil society organisations would tell me that patients are being told they may have cancer, and then arriving at our doors with no means to continue their journey. No access to diagnosis, no access to care."*

What troubled her was not just inefficiency, but the ethics of it.

"There is something deeply troubling about telling someone they may have cancer and then not offering a path forward for diagnosis or care."

"For me, the realization was simple: global health had become very good at diagnosing problems and writing plans, but far less effective at supporting countries to actually implement solutions. That implementation gap became the space where I knew we could make the greatest contribution."

Why Cities?

The idea behind the City Cancer Challenge did not begin with a slogan. It began with a systems question: where can meaningful implementation actually happen?

"We knew we had to find an organization that actually supports countries to improve access to cancer care, but from a holistic systems perspective, not from silo interventions."

The answer was not the national government alone, nor the hospital alone, nor a single vertical program. It was the city.

"That's where the idea of cities came in. A city is like the national health system, but on a smaller, more manageable scale. In my private sector times, we used to call it the Minimum Viable Product (MVP)."

For Isabel Mestres, cities make complexity visible.

"In a city you can see the entire patient journey - and where it breaks down. You see how national, regional, and local systems interact. You see how the reimbursement system works; how the workforce is trained; how civil society operates; how data flows through the cancer registry.; You can see the entire system in one place."

This, in her view, was the missing bridge between policy and practice.

"Many interventions target the national government, but how do they implement them at scale? Policy and planning are one thing. Implementation is another. So where do you actually start implementing from a systems perspective?"

"That's where I think we nailed it, when we focused on cities."

At first, many dismissed the concept.

"At the beginning, we were told we were in La La Land — that cities had no say in cancer care. But that assumption was exactly the problem."

Isabel saw the issue differently. The real power of cities was not formal political authority. It was their ability to convene.

"What we realised is that it's not about the politician. It's about the ecosystem."

A city allows stakeholders to come together, generate real-world data on how the system functions, and identify where change is really needed.

Leading Teams That Deliver

At the core of Isabel Mestres' leadership is a high degree of self-awareness - translated into clarity. About what she knows, what she doesn't, and where she adds value.

That clarity shapes how she builds teams. Rather than surrounding herself with similar profiles, she focuses on bringing together people with different strengths and perspectives. The key is ensuring they complement each other and can operate effectively in complex environments.

A significant part of her role is aligning those perspectives. In an organisation that sits across countries, systems, and stakeholders, progress depends on the ability to bring different viewpoints together around a shared goal, and move forward.

Isabel leads with openness, creating space for honesty, learning, and course correction when needed. She looks for people who take responsibility, move things forward, and are comfortable operating without constant direction.

Because building something from the ground up requires both energy and discipline. It's the ability to navigate uncertainty, while staying focused on what needs to be delivered.

How She Chooses People

The way she builds teams mirrors how she builds systems. Grounded in reality.

"First I prioritise people from our cities, those who understand how systems work in practice, those who understand the context, and those who understand both the public and private sector."

She wants people who understand what policy looks like once it reaches the real world — the hospital, the patient, the budget line. But she also looks for people who can live comfortably without certainty.

She believes strong teams require a balance of different professional profiles.

"Some people bring deep technical expertise and experience from large institutions. Others are innovators who are comfortable working in uncertainty

and building new approaches. Both are critical for an organisation like ours."

And curiosity matters too. In interviews, she watches for it carefully and recognises those who look at things differently, and ask unexpected questions. But there is one more quality that is essential: *"People willing to challenge."*

What Keeps Her Awake

For all the momentum of the City Cancer Challenge, Isabel is clear-eyed about its challenges. When asked what keeps her awake at night, she answers without hesitation.

"First and foremost, my people. I care deeply about their wellbeing."

With colleagues spread across countries, keeping people connected, supported, and aligned around a shared mission is a constant focus. But the bigger challenge lies beyond the organisation.

Health systems do not transform on a funding cycle alone. There is a constant balance between urgency and reality. Delivering progress today while building systems that will last.

"The outcomes we're working towards, like survival rate and quality of care, take years to measure. We're fortunate to have partners who understand that this is long-term work."

Because, ultimately, the goal is not short-term results but sustainable change.

Mentors, Boards, and Coaches

"I don't have one mentor. I turn to different people for different challenges. I rely on them a lot."

Her board is a key source of support and perspective, and one she trusts deeply. She also draws on a wider circle of advisors across strategy, people management, communications, and fundraising, seeking out different viewpoints depending on the decision at hand. Coaching has been a constant throughout her career but more recently, she has become a certified coach herself. An experience that has shaped not just how she leads, but how she thinks.

What She Wants to Become

When asked who she wants to be in the years ahead, Isabel does not speak of titles or recognition. She speaks about impact and, more importantly, evidence. Her ambition is clear: to be able to look back in ten years and demonstrate that real system transformation has taken place and that it can be measured.

As she puts it, *"we made it."*

For her, success is not defined by the number of programmes delivered, but by whether the work contributes to a deeper understanding of what actually strengthens health systems in practice. The goal is to generate knowledge that endures, that is grounded in implementation, not theory.

But her vision extends beyond oncology.

She is increasingly focused on a more holistic model of care and one that reflects the reality of patients' lives, where cancer is rarely experienced in isolation. The future, in her view, lies in systems that treat the whole person, not just a single disease.

"I want to move towards systems that see the whole person and not just the disease."

Who Is Isabel Mestres?

When I ask her to define herself in one sentence, she gives an answer that feels as honest as it is precise.

"I'm a very curious and passionate person, with a strong commitment to equity. And I like to surround myself with people who bring different strengths,

because together we can achieve things that none of us could do alone."

A Book About Freedom

The book Isabel Mestres returns to most often is 'Man's Search for Meaning' by Viktor Frankl.

What resonates with her is a simple but powerful idea that even in the most constrained circumstances, people retain the ability to choose how they respond.

It's a perspective that has shaped how she approaches both life and leadership particularly in environments where control is limited and progress is slow.

As she puts it, *"nobody can take away how you choose to think or what meaning you give to the life you're living."*

That sense of internal freedom and of choosing how to respond within constraint has become a constant reference point. It underpins Isabel's resilience, her decision-making, and the way she navigates complex systems where outcomes are never guaranteed.

Advice for the Next Generation

Isabel's advice to young people is grounded in realism. Not everyone knows their passion early. And that's not a problem.

Instead, she encourages curiosity as a starting point. Paying attention to what sparks interest, what draws your attention, and what problems you feel compelled to understand. These signals, she believes, are often the first indicators of where purpose might emerge.

But just as important is exposure.

Speaking to people across different professions, understanding how their work actually functions, and learning what motivates them can provide clarity. It's an approach she now actively supports particularly for young women entering global health. In recent years, she has invited a small number to shadow her during the World Health Assembly, offering a direct view into how the field operates in practice.

"I didn't do that when I was younger, and I wish I had."

The Heroes in the Shadow

At the end of the conversation, when asked who she believes should be interviewed next, Isabel points to the frontlines. To people like Gloria Chinyere Okwu, who is a cancer survivor and patient advocate in Nigeria.

For Isabel, patient navigators are one of the most under-recognised forces in cancer care, particularly in low-resource settings. They guide patients through complex systems, help them understand their diagnosis, and support them in staying on treatment. This is often in environments where fear and misinformation remain major barriers.

In many communities, a cancer diagnosis is still widely associated with death. Survivors who step into these roles shift that perception. They bring something no system can replicate: lived experience, credibility, and hope. And yet, despite their impact, this work is often informal and unsupported.

As she puts it, ***"they are the heroes in the shadow."***

It's a phrase that captures not only the individuals she is describing, but a broader truth about health systems: that some of the most critical contributions come from those least visible.

***

Across the conversation, a clear thread runs through Isabel Mestres' work. There is a focus on making systems function in practice.

Her approach is grounded in curiosity, shaped by experience, and driven by a commitment to equity. But above all, it is defined by execution. Not just understanding where systems fall short, but doing the work required to make them deliver.

It is a mindset that moves beyond ideas and into implementation. A clarity to recognise that progress is measured not by intention, but by what reaches patients.

And perhaps that is what defines her most clearly.

Not the theorist. Not the observer.
The one who builds.

The doer.

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(Ireland)

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REFLECTIONS
ON PATIENT-CENTRED
DECISION-MAKING
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CANCERWORLD | ESO European School of Oncology

Reflections on Patient-Centred Decision-Making in Oncology

By Waseem Darwish

This article has been selected as part of the ESO College Voices Contest, a collaborative project between ESO and Cancerworld, tailored for ESO College members.

After more than a decade in oncology practice, I have come to recognise that my professional development has been shaped as much by patients' stories as by scientific progress. While advances in systemic therapies, diagnostics, and supportive care continue to transform outcomes for many, the human experience of cancer remains defined by fear, hope, resilience, conflict, and love. Each clinical encounter unfolds within this emotional landscape, reminding us that oncology care extends far beyond diagnosis, staging, and treatment protocols. It is within these moments, often quiet, complex, and deeply personal, that the principles of patient-centred decision-making are most clearly tested.

Over the years, I have cared for patients facing not only life-limiting illness but also profound personal challenges. I recall a young mother struggling with whether, and how, to explain her diagnosis to her children; a father approaching the end of life whose single remaining wish was to take one final trip with his young son; and a young man with advanced pancreatic cancer caught between the competing expectations and emotional needs of his mother and his wife. Each of these cases required careful navigation of medical facts, emotional realities, and ethical responsibilities. While many patients leave a lasting impression, one particular experience fundamentally reshaped how I approach patient-centred decision-making in oncology.

When the Patient Finds His Voice

The patient was close to me in age and life stage, a father of three young children diagnosed with a rare and advanced small-bowel malignancy. From the outset of his illness, he deferred nearly all discussions and decisions to his father, a retired general practitioner. His father assumed the role of advocate with unwavering commitment, exploring treatment options, pursuing clinical trials abroad, and even expressing the wish that he could take his son's place during chemotherapy. For many months, this dynamic remained unchanged. The patient and his father travelled together internationally in search of experimental treatment, driven by hope and determination.

During this period, the patient himself remained largely silent within consultations, allowing his father to speak on his behalf. This arrangement was initially accepted as a coping strategy, particularly in the context of serious illness and strong familial bonds. However, as the disease progressed, the physical and emotional costs of ongoing treatment became increasingly evident. When the patient eventually returned home, his condition had deteriorated significantly. His symptoms had worsened, his disease had progressed, and he was now entering the terminal phase of his illness.

At this stage, a notable shift occurred. For the first time since his diagnosis, the patient began to speak for himself. His tone was not angry or confrontational, but clear, firm, and determined. Recognising this change, and appreciating its ethical significance, I arranged to meet him privately with his wife, without his father present. This decision was deliberate. Patient-centred care requires not only listening to patients, but also creating the conditions in which they can safely express their own wishes, particularly when those wishes may differ from those of their family.

During this conversation, I asked a simple but pivotal question: where did he wish to spend his final days? In a quiet and resolute voice, he expressed a clear preference to be with his young family in a town several hours away, rather than remain in the city where his father lived and where he had received most of his care. His response was thoughtful, composed, and unambiguous. He did not ask for advice or reassurance. He had already decided. My role at that moment was not to guide or persuade, but to listen, acknowledge, and support.

With his consent, I organised a family meeting and explained to his extended family that he would be transferred to a hospice closer to his children. I made it explicit that this decision was his own and that my professional responsibility was to uphold and protect his expressed wishes. There would be no negotiation unless he chose otherwise. This was a difficult conversation. Family members were distressed, and emotions ran high. However, clarity was essential. In patient-centred decision-making, particularly at the end of life, ambiguity can undermine autonomy and prolong suffering.

The transfer took place shortly thereafter. When I spoke with him one week later, he described spending meaningful time with his children. Although he was approaching the end of life, his voice conveyed a sense of peace and acceptance. Three days later, his parents contacted me to inform me that he had died shortly before their call. They expressed gratitude for the care he had received and, importantly, for the support given to his final decision. Despite the pain of loss, they acknowledged that it had been the right choice.

Holding the Line: Ethics, Emotion, and Oncology Practice

This experience reshaped my approach to oncology practice. Since then, I have been deliberate in ensuring that patients' values and preferences remain central to all clinical decisions, even when these differ from the wishes of family members. In oncology, where outcomes are often uncertain and control is limited, preserving patient autonomy is one of the most meaningful contributions clinicians can make. Patient-centred decision-making is not simply about offering choices; it requires active advocacy, clear communication, and, at times, the courage to hold firm in ethically challenging situations.

Oncology is a specialty defined not only by scientific complexity but also by profound emotional intensity. Consultations frequently involve discussions about prognosis, treatment limitations, and end-of-life care, all of which take place in the context of fear, uncertainty, and anticipated loss. While the psychological impact of cancer on patients and families is well recognised, the emotional burden experienced by oncology professionals is less visible and often under-acknowledged.

A growing body of evidence demonstrates that oncologists, nurses, and allied health professionals experience high levels of emotional strain. This strain arises not only from workload, but also from the ethical and relational demands of caring for patients with life-limiting illness. Emotional labour, the ongoing regulation of one's own emotions in order to support others, is central to oncology practice. Clinicians must balance empathy with clinical clarity, compassion with professional boundaries, and hope with realism. This sustained effort, repeated across countless patient encounters, contributes significantly to emotional exhaustion and burnout.

Cancer is rarely an individual experience; it is a family event. Family members bring love, fear, expectations, and sometimes unresolved conflict into the clinical encounter. Managing these dynamics is an essential component of oncology care, yet it is emotionally demanding. Family conflict, particularly when relatives' wishes diverge from those of the patient, is a recognised source of clinician stress. Family meetings often require clinicians to mediate disagreement while simultaneously protecting patient autonomy and maintaining therapeutic relationships.

The case described here reflects a scenario commonly encountered in oncology: a family acting out of love and desperation, a patient asserting independence late in the illness trajectory, and a clinician required to provide clarity, structure, and support at a critical moment. These situations are emotionally challenging but also ethically significant. They highlight the oncologist's dual responsibility: to care for families while remaining unequivocally committed to the patient's expressed wishes.

Conversations about prognosis and end-of-life care are among the most challenging aspects of oncology practice. Repeated exposure to death and dying contributes to cumulative, often unprocessed grief among clinicians. At the same time, oncologists frequently feel responsible for sustaining hope while preparing patients and families for loss. Navigating this tension requires experience, reflection, and emotional resilience. The question I asked my patient—where he wished to spend his final days—illustrates the precision, timing, and sensitivity required in such discussions.

Reflective practice plays a crucial role in helping clinicians recognise the emotional impact of these experiences and reaffirm core professional values. Patient-centred decision-making is not merely a theoretical principle or policy directive; it is a daily ethical commitment enacted in conversations, silences, and moments of trust. By actively listening to patients, creating space for their voices, and prioritising their expressed wishes, oncology professionals can support dignity, autonomy, and meaning at the end of life—not only for patients, but also for themselves.

Acknowledgment

This article was written by Dr Waseem Darwish, one of the two winners of the ESO College Voices Contest 2026, on the topic *"One Disease, Many Languages: Communicating Cancer Across Cultures"*.

This year's contest once again proved that doctors can also be excellent cancer writers. We received 24 proposals from ESO College members across 16 countries, each exploring the chosen theme. After careful deliberation, guided by CancerWorld's editorial standards, as well as criteria of clarity, relevance, originality, potential impact, and our hallmark style of weaving in interviews and firsthand perspectives, Dr. Darwish was selected as one of the winners, and we are proudly publishing his impactful voice.

References

1. Salehi M., Ghasemian A., Vafaee Najar A., Nazari H., Hooshmand E. From compassion to burnout: emotional labor in oncology nursing — a qualitative study. BMC Nursing, 2025.
2. Lim K.H.J., Kamposioras K., Élez E., Blay J.Y., Banerjee S., et al. ESMO Resilience Task Force recommendations to manage psychosocial risks, optimise well-being, and reduce burnout in oncology. ESMO Open, 2024.
3. Occupational Stress in Oncology Staff: Burnout, Resilience, and ... Oxford Academic. https://doi.org/10.1093/med/9780190097653.003.0098

Pancreatic Cancer Europe at 10

By Pancreatic
Cancer Europe

Turning the Tide on Europe's Deadliest Common Cancer

In the quieter corners of European health policy, where attention is often fragmented and political capital fiercely contested, pancreatic cancer has long remained an uncomfortable outlier—aggressive, difficult to detect, and historically underprioritised.

Yet, as Europe confronts an evolving cancer burden, a coordinated movement is emerging with the ambition to rewrite this narrative. At the centre of this shift is Pancreatic Cancer Europe (PCE), a coalition determined to elevate one of the continent's deadliest cancers from the margins to the mainstream of policy and research.

From Neglect to Political Priority

As PCE marks its 10th anniversary in 2026, its trajectory reflects both the urgency of the disease and the complexity of the challenge ahead. Founded in 2016, the organisation has built a pan-European platform that unites patient groups, clinicians, researchers, and advocates around a shared goal: to improve prevention, accelerate diagnosis, enhance care, and ultimately increase survival rates across Europe. In a policy landscape often defined by national silos, PCE's model is deliberately integrative bridging science and politics, and translating evidence into coordinated advocacy.

The stakes are unambiguous. Pancreatic cancer, while representing a relatively small share of total cancer diagnoses in Europe, has emerged as the third leading cause of cancer death in the EU and is projected to rise further in the coming years.(1) Survival rates remain stubbornly low, frequently in the single digits, a consequence of late diagnosis and the absence of reliable early detection tools. *"Late diagnosis continues to cost many lives,"* notes Alfredo Carrato, Chairperson of PCE, underscoring the need for early detection, prevention, and sustained investment in research as shared European priorities.

This challenge of late detection lies at the heart of the disease's intractability. Unlike many other cancers, pancreatic cancer often progresses silently, with vague symptoms that evade early clinical suspicion. By the time it is identified, the disease is frequently advanced, leaving limited therapeutic options. This biological reality has historically translated into slower progress in outcomes compared to other major cancers, despite its rising mortality burden.

PANCAID Stakeholder Event group picture organised by PCE at the European Parliament

Recognising this gap, PCE has positioned itself not merely as an awareness campaign, but as a policy-driven coalition. One of its foundational contributions is its comprehensive Position Paper, endorsed by a wide range of stakeholders. The document outlines a series of concrete policy priorities: strengthening cancer registries and data collection, investing in prevention and early diagnosis, supporting research into tailored treatments, ensuring equitable access to multidisciplinary care, and promoting coordinated European action.(2) These recommendations have been actively used as an advocacy tool, including engagement with candidates for the European Parliament and subsequent outreach to elected Members of the European Parliament (MEPs).

This strategic engagement reflects a broader shift in cancer advocacy—one that recognises the European Union as a critical arena for driving systemic change. Through targeted campaigns and events, PCE has helped anchor pancreatic cancer within discussions linked to broader initiatives such as the EU's cancer strategy and the evolving Europe's Beating Cancer Plan.(3) The aim is clear: to ensure that pancreatic cancer is not only acknowledged, but actively prioritised within Europe's public health agenda.

Bridging Fragmentation Across Europe

A defining strength of PCE lies in its ability to unify a fragmented advocacy landscape. Across Europe, pancreatic cancer organisations are often small, volunteer-led, and resource-constrained. By providing a European-level platform, PCE amplifies these voices, enabling shared learning, coordinated awareness efforts—particularly during World Pancreatic Cancer Awareness Month and a stronger collective presence in policy debates.

Yet, beneath the progress lies a persistent and uncomfortable truth: inequality. Access to high-volume surgical centres, multidisciplinary care, clinical trials, and specialist support varies significantly across Europe. These disparities translate directly into differences in patient outcomes, revealing a healthcare landscape where geography can determine prognosis. Data from European cancer registries demonstrate significant differences in outcomes, often linked to disparities in healthcare infrastructure and early referral pathways.(4) For PCE, such disparities are not abstract, they are systemic failures that demand policy intervention.

Compounding these challenges is the inherent complexity of the disease itself. Pancreatic cancer is biologically heterogeneous and deeply embedded within a complex tumour microenvironment. As **Ilse Rooman** of Vrije Universiteit Brussel highlights, advances in spatial and single-cell technologies are beginning to reveal the intricate interplay between tumour cells and their surrounding ecosystem, including immune cells, fibroblasts, and vascular structures. Understanding this complexity requires interdisciplinary collaboration precisely the kind of cross-border scientific cooperation that PCE seeks to foster.

This emphasis on collaboration reflects a broader strategic insight: in a disease with relatively fewer patients compared to other cancers, progress depends on pooling knowledge, data, and expertise. European research networks, data-sharing initiatives, and joint clinical trials are therefore not optional; they are essential. PCE's advocacy for such collaboration underscores its commitment to accelerating innovation through collective effort.

At the policy level, Europe is gradually laying the groundwork for this transformation. Initiatives such as the **European Cancer Imaging Initiative** (7), the **Knowledge Centre on Cancer**(8), and the EU Mission on Cancer are designed to strengthen early detection, harmonise standards, and reduce disparities across member states. Complemented by investments in digital infrastructure and the development of the **European Cancer Inequalities Registry** (9), as well as networks of Comprehensive Cancer Centres promoted at EU level, (10, 11) these programmes aim to translate political commitment into measurable improvements in care and outcomes.

Still, the challenge remains one of alignment: bridging the gap between policy ambition and real-world implementation. This is where organisations like PCE play a pivotal role—ensuring that political frameworks are informed by patient experience, clinical insight, and scientific evidence.

Indeed, the human dimension of pancreatic cancer advocacy is impossible to ignore. Many within PCE's network are patients, survivors, or family members who have experienced the disease's devastating impact firsthand. Their testimonies bring urgency and moral clarity to policy discussions. They speak of late diagnoses, limited treatment options, lack of emotional, physical or nutritional support, and the burden of navigating fragmented healthcare systems. By integrating these voices into its advocacy, PCE reframes pancreatic cancer not only as a clinical challenge, but as a societal responsibility.

Innovation, Inequality, and the Road Ahead

Looking ahead, the future of pancreatic cancer care in Europe sits at the intersection of innovation and uncertainty. Advances in genomics, artificial intelligence, and precision medicine hold promise for earlier detection and more targeted therapies. The emerging **European Health Data Space** (6) may further enable effective data sharing, a crucial factor in rare and hard-to-treat cancers. At the same time, economic constraints, competing health priorities, and the lingering effects of the COVID-19 pandemic risk slowing progress.

For PCE, the next decade will be defined by its ability to maintain and expand this momentum. Its strategy increasingly combines policy advocacy, professional education, public engagement, and research collaboration, with the aim of embedding pancreatic cancer within Europe's core health priorities, including funding programmes such as EU4Health.

As Patrycja Rzadkowska, Patient Advocate and Vice-Chair of PCE, cautions: *"Pancreatic cancer patients cannot wait another decade for incremental change."* Her words capture both the urgency and the ethical imperative at the heart of this movement.

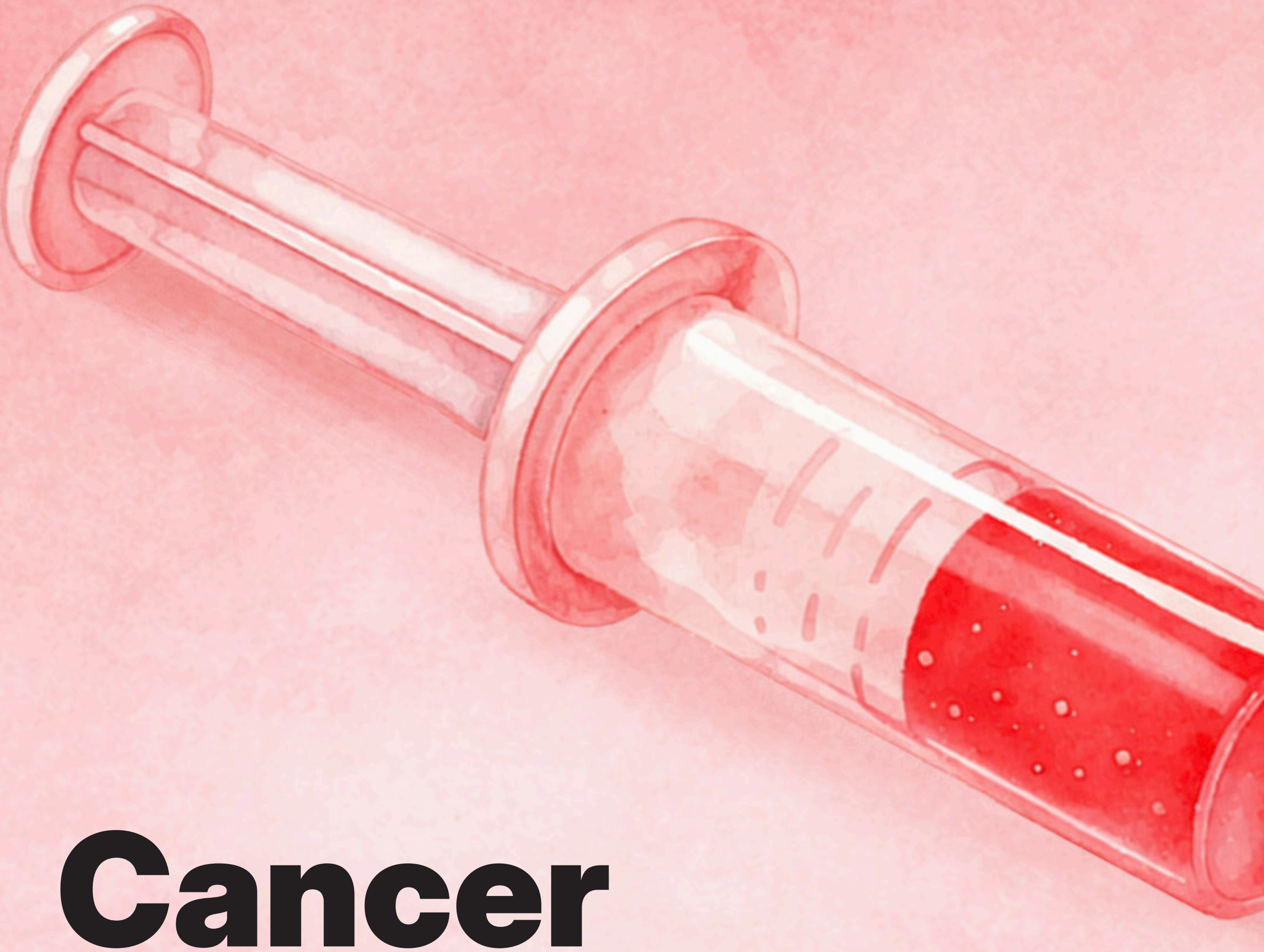
In a healthcare landscape often marked by fragmentation, **Pancreatic Cancer Europe** offers something increasingly rare: a model of coordinated,

PCE Multistakeholder meeting, 2023

cross-sectoral action. By aligning science, policy, and lived experience, it is helping to reshape how Europe confronts one of its most formidable cancers. Whether this effort will ultimately transform survival outcomes remains to be seen. But one thing is clear: **pancreatic cancer is no longer invisible and in the realm of public health, visibility is the first step toward change.**

References:

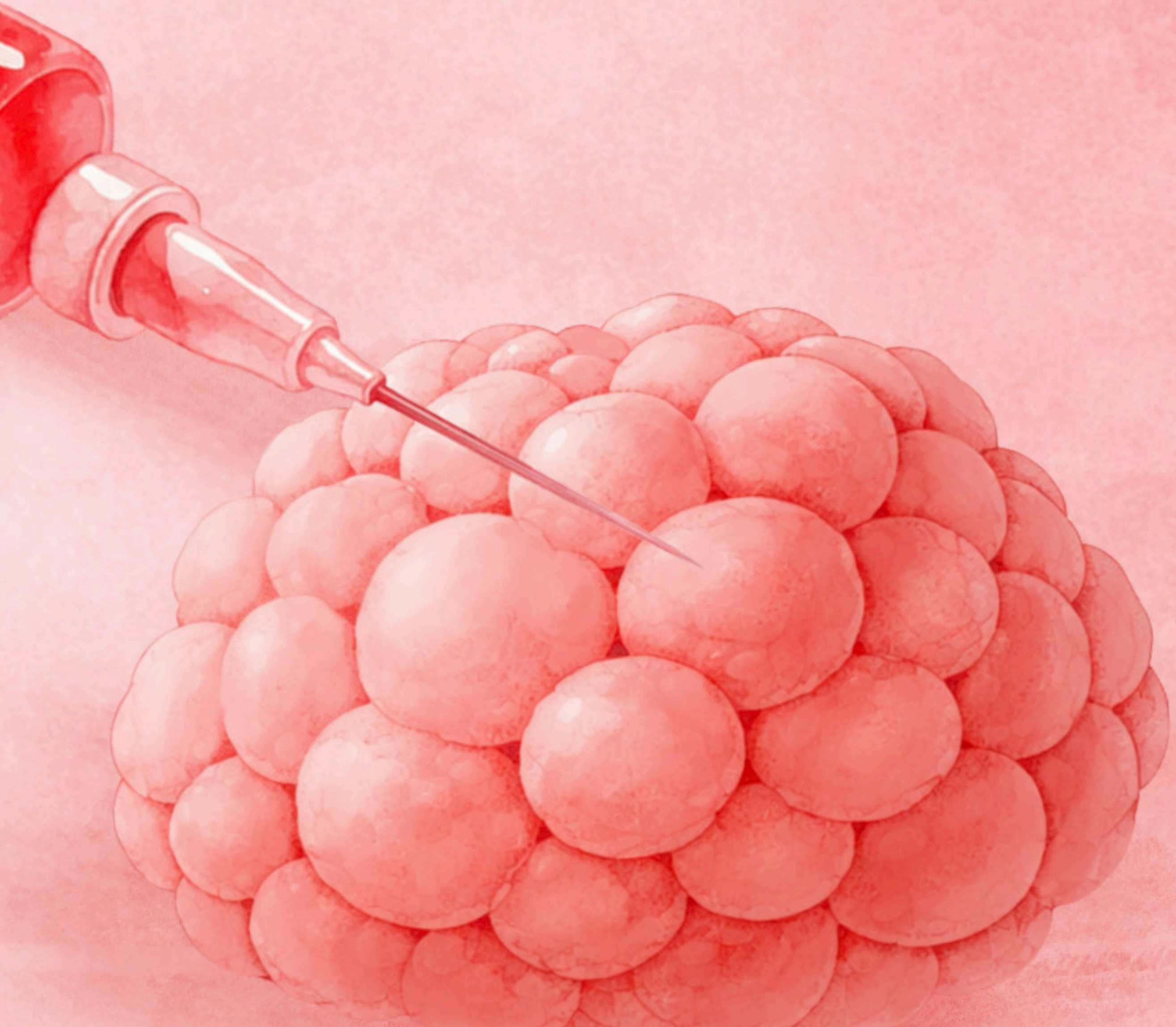
1. European Cancer Information System (ECIS). Pancreatic cancer burden in Europe. European Commission, Joint Research Centre; 2024. [cited 2026 Mar 05].Available from: https://ecis.jrc.ec.europa.eu
2. Pancreatic Cancer Europe. Position Paper on Pancreatic Cancer. Brussels: Pancreatic Cancer Europe; 2024. [cited 2026 Mar 05]. Available from: https://pancreaticcancereurope.eu
3. European Commission. Europe's Beating Cancer Plan. Brussels: European Commission; 2021. [cited 2026 Mar 09].Available from: https://commission.europa.eu/topics/public-health/european-health-union/cancer-plan-europe_en
4. OECD, European Observatory on Health Systems and Policies. State of Health in the EU: Cancer Profiles. Paris/Brussels: OECD Publishing; 2023[cited 2026 Mar 09]. Available from: https://eurohealthobservatory.who.int/publications/country-health-profiles/2023
5. International Agency for Research on Cancer (IARC), World Health Organization. Global Cancer Observatory: Pancreatic cancer fact sheet. Lyon: IARC; 2022. [cited 2026 Mar 10]Available from: https://gco.iarc.fr/today/fact-sheets-cancer/fact-sheets-cancers
6. European Commission. Proposal for a Regulation on the European Health Data Space. Brussels: European Commission; 2022. [cited 2026 Mar 10] Available from: https://health.ec.europa.eu/ehealth-digital-health-and-care/european-health-data-space_en
7. European Commission. European Cancer Imaging Initiative. [cited 2026 Mar 13]. Available from: https://digital-strategy.ec.europa.eu/en/policies/cancer-imaging
8. European Commission. Knowledge Centre on Cancer. [cited 2026 Mar 13]. Available from: https://knowledge4policy.ec.europa.eu/cancer_en
9. European Commission. European Cancer Inequalities Registry (ECIR). [cited 2026 Mar 13]. Available from: https://cancer-inequalities.jrc.ec.europa.eu/
10. European Commission. The European Comprehensive Cancer Center Network. [cited 2026 Mar 13]. Available from: https://ecc-cert.org/health-service-research/eunetccc/
11. European Commission. CraNE Joint Action. [cited 2026 Mar 13]. Available from: https://crane4health.eu/



Cancer Vaccines

From Missed Promise to Second Chance

By Toma Oganezova



In oncology, some ideas arrive too early.

For decades, cancer vaccines were one of them. The concept was elegant: train the immune system to recognise tumour cells, much like it recognises viruses, and allow it to eliminate disease with precision and memory.

The reality was different. Early clinical trials were marked by modest responses, inconsistent outcomes, and growing skepticism. While chemotherapy and later targeted therapies reshaped survival curves, cancer vaccines remained on the margins of clinical practice. And yet, they never disappeared.

Today, they are returning—quietly, but with renewed scientific credibility.

The Difference Between Prevention and Treatment

When most people hear the word *"vaccine,"* they think of prevention. In oncology, that exists: vaccines against human papillomavirus and hepatitis B have reduced the incidence of cervical and liver cancers worldwide.

Therapeutic cancer vaccines are different.

They are not designed to prevent cancer. They are designed to treat it—by activating an immune response against tumour-associated or tumour-specific antigens already present in the body.

In that sense, they belong to the same broad family as checkpoint inhibitors and cellular therapies, but with a distinct goal: **to generate, rather than release, an immune response.**

The Quiet Presence of Approved Therapies

Despite the perception that cancer vaccines are experimental, several have already entered routine clinical use.

Sipuleucel-T was approved for metastatic prostate cancer that no longer responds to hormone therapy. It is a personalised treatment: a patient's own immune cells are collected, exposed to a tumour-associated antigen ex vivo, and then reinfused. Its clinical effect is not measured in rapid tumour shrinkage, but in improved overall survival—an outcome that reflects the slower kinetics of immune modulation.

Bacillus Calmette-Guérin, or BCG, has been used for decades in high-risk non–muscle-invasive bladder cancer. Administered directly into the bladder, it induces a strong local immune response. Long before the era of checkpoint inhibition, BCG demonstrated that activating the immune system within the tumour microenvironment could produce durable clinical benefit.

Talimogene laherparepvec (T-VEC) represents a more recent evolution. This genetically modified oncolytic virus selectively infects tumour cells, leading to cell lysis and the release of tumour antigens, while also stimulating immune activation. Approved for melanoma lesions not amenable to surgical resection, it bridges direct tumour destruction with systemic immune priming.

These therapies are not widely applicable across all cancers. Their indications are specific, and their effects are often modest. But they establish an important principle: **immune-based vaccination can work in cancer.**

Why Early Cancer Vaccines Struggled

The limitations of earlier vaccine approaches are now better understood.

Tumours are not passive targets. They actively suppress immune responses, creating an environment characterised by regulatory cells, inhibitory cytokines, and checkpoint signalling pathways. In this setting, simply presenting an antigen is often not sufficient.

In addition, many early vaccines targeted shared tumour-associated antigens, which are not truly specific to cancer cells. The immune system, trained to avoid attacking normal tissue, responded weakly.

Perhaps most importantly, vaccines were often tested in advanced disease, where tumour burden is high and immune dysfunction is profound.

The biology proved more complex than anticipated.

Why the Field is Changing

What has changed is not the concept but the context. The emergence of checkpoint inhibitors has altered the immune landscape. By blocking inhibitory pathways such as PD-1/PD-L1, these agents create conditions in which vaccine-induced T cells can function more effectively.

At the same time, advances in sequencing technologies have enabled the identification of **neoantigens**—mutations unique to an individual tumour. This has opened the door to personalised vaccines designed to target truly tumour-specific signals.

mRNA platforms, validated at global scale during the COVID-19 pandemic, have further accelerated development. They allow rapid design and production, making individualised approaches more feasible.

The question is no longer whether cancer vaccines can work in principle, but **in which context they are most effective.**

Recent clinical data provide early evidence that cancer vaccines may enhance the efficacy of checkpoint inhibition. In the phase 2b KEYNOTE-942 trial, an individualised neoantigen mRNA vaccine (mRNA-4157/V940) combined with pembrolizumab, in patients with resected high-risk melanoma, demonstrated a reduction in the risk of recurrence or death compared with pembrolizumab alone (hazard ratio 0.56), with 18-month recurrence-free survival rates of 79% versus 62%.

Additional analyses have suggested a substantial reduction in distant metastasis or death, with combination therapy lowering this risk by approximately 65% compared with anti-PD-1 monotherapy.

These findings represent one of the first randomised signals that personalised cancer vaccines, when combined with checkpoint blockade, may translate into clinically meaningful benefit.

A Shift in Role

Cancer vaccines are unlikely to replace existing immunotherapies.

Instead, they may complement them.

Vaccines can provide the **signal**—introducing or amplifying tumour-specific immune recognition. Checkpoint inhibitors can sustain and enhance that response by preventing immune suppression.

This division of roles reflects a broader understanding of anti-tumour immunity as a multi-step process: antigen presentation, T-cell activation, trafficking, and persistence. Intervening at only one step is rarely sufficient.

An Unfinished Story

Cancer vaccines have not yet transformed oncology in the way checkpoint inhibitors have.

But they are no longer a failed concept.

They represent a strategy that was introduced before the field was ready, and is now being revisited with better tools, deeper biological understanding, and more appropriate clinical integration.

Their future will likely not be defined by standalone success, but by their role within combination approaches.

In oncology, progress is often incremental. Some advances are visible immediately, in survival curves and regulatory approvals. Others develop more slowly, shaped by changing context and accumulating evidence.

Cancer vaccines belong to the latter.

They are not a revolution.

But they may yet become an essential part of one.

About the Author

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Psycho-Oncology

at a Crossroads

From Global Recognition to Real-World Impact

By Adrian Pogacian

The launch of World Psycho-Oncology Day signals growing momentum behind psychosocial care in cancer, but without structural change, millions of patients will continue to go without the support they need.

With the announcement of World Psycho-Oncology Day (WPOD), to be observed annually on April 9 starting in 2025, the International Psycho-Oncology Society (IPOS) has issued a timely call to action. At its core, the initiative reflects a growing recognition that cancer care cannot be considered complete without addressing its psychological and emotional toll. Yet recognition alone is not enough.

The Revolution that Redefined Cancer Care, But Never Fully Took Hold

Psycho-oncology, a discipline formally shaped in 1977 by Dr Jimmie Holland, transformed how the oncology community understands cancer. By shifting attention beyond tumours to the lived experience of patients, it challenged the dominance of a purely biomedical model and redefined the meaning of care.

More than four decades later, its influence is undeniable, but its integration remains incomplete. Across healthcare systems, psychosocial care is still too often treated as an optional add-on rather than a core component. At a time when oncology is advancing rapidly through innovation and technology, the human dimension risks being left behind.

A Silent Global Failure: Psychosocial Care Still Out of Reach

"One of the most pressing global challenges in psycho-oncology is the persistent inequity in access to psychosocial care," says Dr Darren Haywood, Co-Chair of the IPOS Early Career Professionals in Psycho-Oncology Committee. Despite clear evidence linking psychosocial support to treatment adherence, quality of life, and even clinical outcomes, access remains fragmented and under-resourced.

The gap is most visible in low- and middle-income countries, where patients often face cancer without structured psychological or social support. But the problem is not confined to resource-limited settings. Even in high-income systems, psychosocial care is inconsistently embedded in routine practice.

Closing this gap requires more than awareness. It demands structural reform: embedding psychosocial care into standard cancer pathways, strengthening workforce capacity, and developing resource-stratified guidelines that can be implemented across diverse healthcare contexts. *"Care must be realistic, adaptable, and equitable,"* Haywood notes, emphasising the importance of engaging communities to ensure culturally appropriate, person-centred approaches.

Beyond Awareness: Can Systems Deliver on What Patients Need?

For Dr Rodbin Campos, a psycho-oncologist in Costa Rica's public healthcare system and Regional Director for Latin America and Central America at IPOS, the challenge is both systemic and urgent. Psychosocial care, he argues, remains undervalued despite its proven impact. "No patient should face cancer without emotional, psychological, and social support," he says.

Practical solutions are within reach: making psychosocial distress screening a universal standard, integrating psycho-oncology professionals into multidisciplinary teams, strengthening interdisciplinary training, and embedding psychosocial care into national cancer control plans. Yet implementation continues to lag behind evidence.

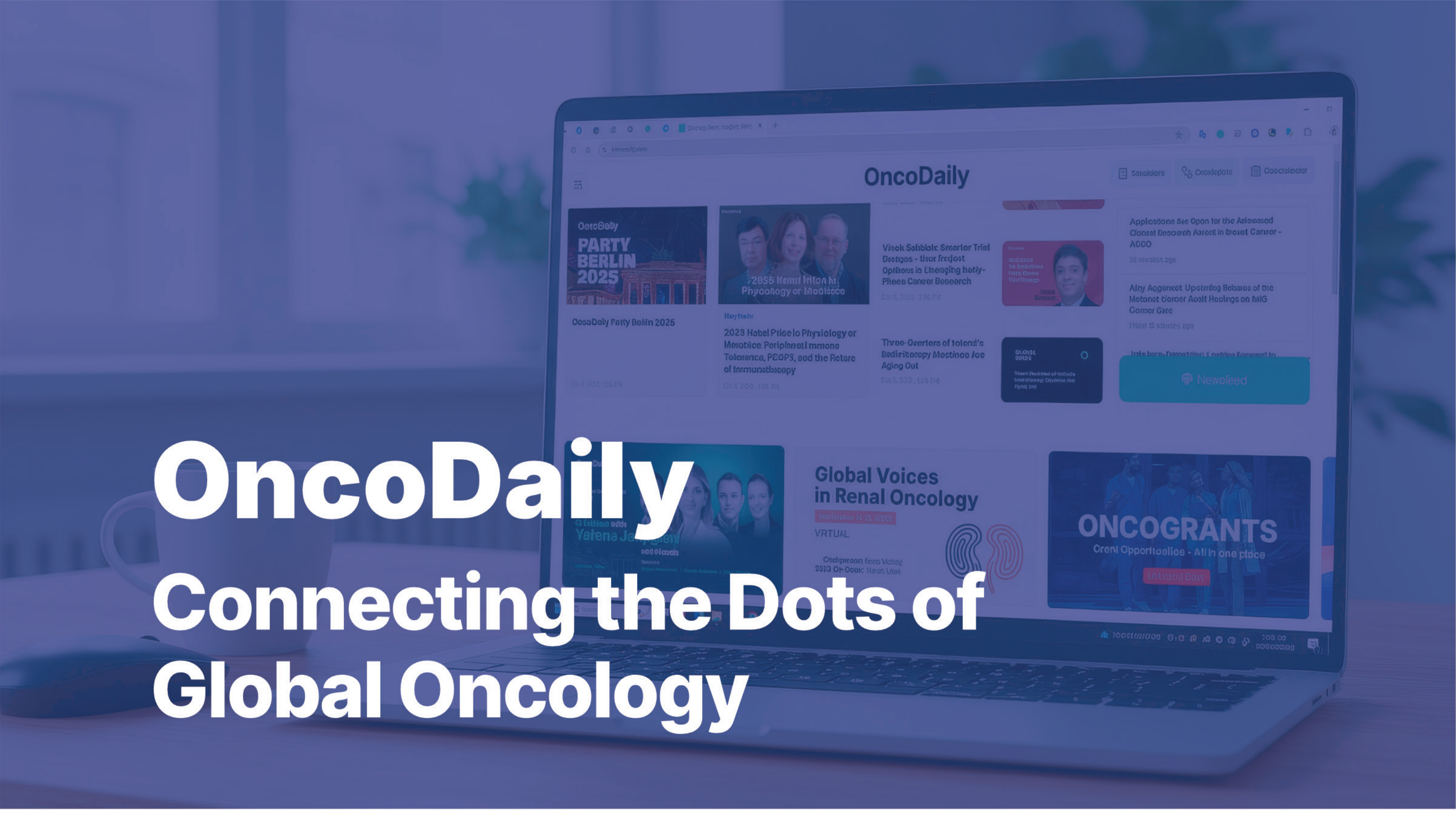
World Psycho-Oncology Day could help shift this dynamic. By mobilising professionals, institutions, and communities, it offers a platform to translate advocacy into action. Coordinated campaigns both local and global have the potential to raise visibility and push psychosocial care higher up the policy agenda.

The evolution of cancer care over the past half-century has been profound, moving from a near-automatic association with death to an era of advanced therapies and multidisciplinary treatment. But progress cannot be measured by survival alone. Quality of life and the experience of care must carry equal weight.

In this context, psycho-oncology is not a luxury. It is a necessity. The challenge now is not to prove its value, but to ensure its delivery.

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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