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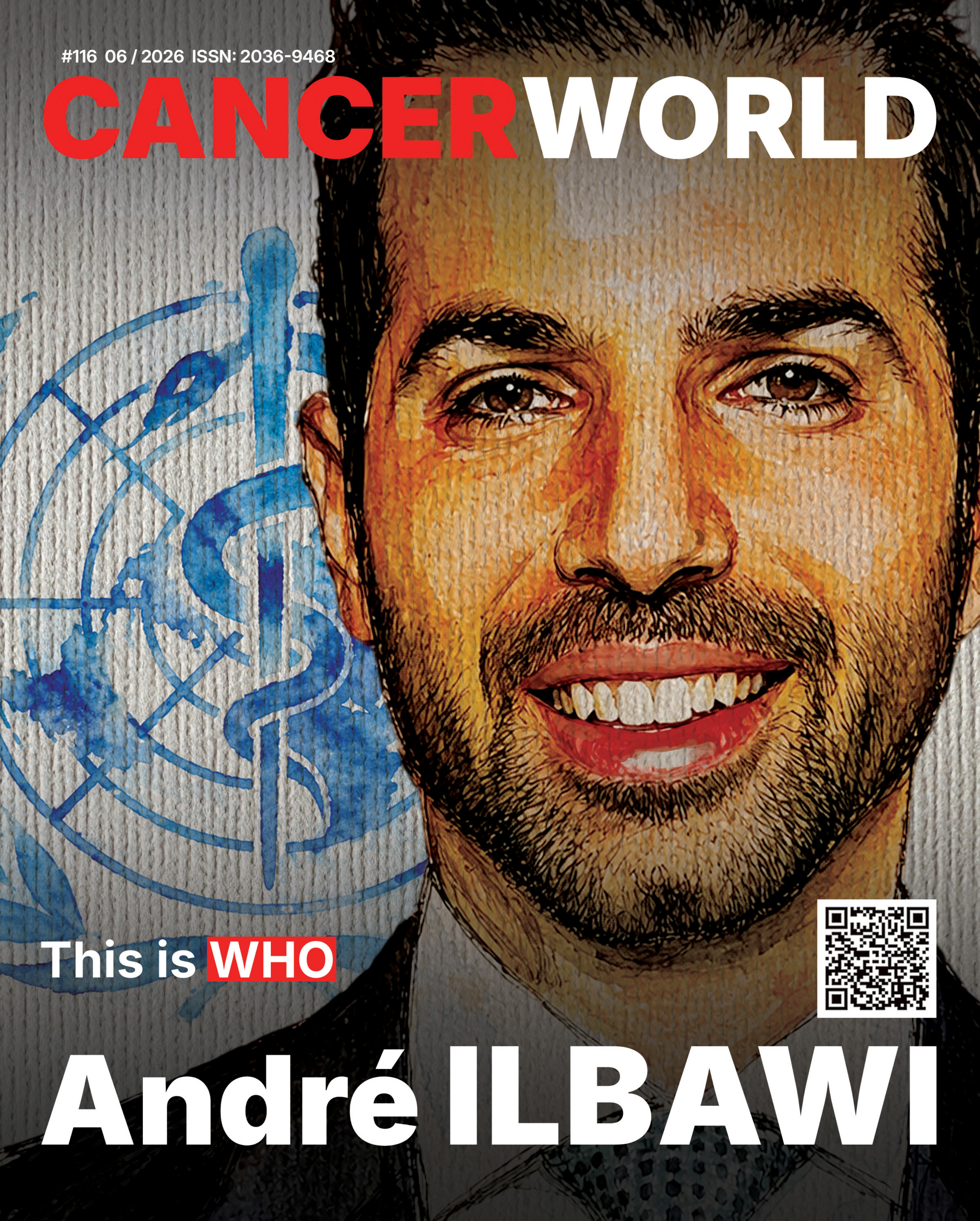
CANCERWORLD



This is WHO

André ILBAWI

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NOT FOR SALE

We tend to talk about cancer in the language of progress—new therapies, wider prevention, smarter models of care. It is a comforting vocabulary. It is also incomplete. Progress in oncology is never only scientific. It is institutional, social, and deeply human. What finally decides impact is not what medicine can do, but how reliably that knowledge crosses systems, borders, and the messy realities of a single life.

Each issue of *CancerWorld* is about the people and ideas shaping that field. This month, the through-line is translation—between discovery and delivery, innovation and access, what is possible and what actually reaches a patient.

We open with global health at a moment of real scrutiny. As the World Health Organization faces renewed questions about its role and its performance, Dr Gevorg Tamamyan turns to a quieter truth: institutions are defined not by their structure, but by the people who carry the mission. Through the work of **Dr André Ilbawi,** WHO's cancer lead, he traces the sustained, largely invisible leadership that holds global cancer control together.

Equity runs through everything here. In her profile of **Dr Miriam Mutebi,** Knarik Arakelyan shows how progress in cancer care is constrained less by what we know than by the systems that decide who gets access at all. Mutebi's work locates surgical oncology inside a larger argument about fairness.

One of the most transformative achievements in modern oncology is not a treatment at all—it is a prevention. Prof Adriana Albini revisits the pioneering work of **Dr Douglas Lowy** and **Dr John Schiller,** whose HPV vaccine bent the trajectory of an entire class of cancers and redrew what prevention can accomplish at the scale of whole populations.

From prevention to systems: **Dr Mohamed Emam Sobeih's** career maps another kind of progress—the shift from individual clinical brilliance to the patient, unglamorous work of building oncology services that last. Education, leadership, system design: increasingly, these are the medicine.

As care extends well beyond treatment, nursing has moved to the center of survivorship, rehabilitation, and long-term support. European Cancer Nursing Day 2026, organised by the **European Oncology Nursing Society**, marks that evolution and the widening role of oncology nurses across the continent's cancer continuum.

Survivorship is becoming its own frontier of equity. **Cancer Patients Europe** and Ending Discrimination Against Cancer Survivors make the case that the "right to be forgotten" can no longer rest on voluntary guidance—it needs binding law—warning that a patchwork approach leaves survivors unequally protected depending on where they happen to live.

Then there is the part of oncology that no trial captures: how it is heard. **Dr Fatjona Kraja** reflects on the way culture shapes the very meaning of cancer, a reminder that a diagnosis is never only biological. It is filtered through silence, belief, and context—and often understood in ways medicine never intended.

That distance between what medicine knows and what patients experience is nowhere sharper than at the field's biggest stage. In a feature on the ASCO 2026 plenary, **Dr Amalya Sargsyan** looks past the standing ovation that pulled a hall of oncologists to their feet for the first drug to crack RAS in metastatic pancreatic cancer, to the asterisk behind all five plenary trials. Real advances across prostate, sarcoma, lung, and pancreas, she argues, remain possibilities until a test gets ordered, a drug gets approved, and a clinic stands close enough to deliver them; a 60% reduction in the risk of death, after all, is a different fact depending on your passport.

We close with Adrian Pogacian on early palliative care in Singapore, told through health psychologist **Charis Ng.** Here the line between theory and practice simply dissolves. What's left is the emotional and clinical weight of sitting with advanced disease, where care stops being a model and becomes something nearer to presence.

A single thread ties these pieces together: oncology advances not through innovation alone, but through the systems, the people, and the meanings that decide how innovation is received, understood, and finally delivered.

From prevention to survivorship, from communication to the bedside, the task never really changes: to make progress in science into progress in life.

That is the question this issue leaves open—the one that keeps defining oncology in practice.

Knarik Arakelyan, Managing Editor, CancerWorld

André Ilbawi

This is WHO

By Gevorg Tamamyan

There is a lot being said about the World Health Organization these days. Criticism. Political tensions. Funding crises. Countries leaving. Endless speculation about what WHO is, what it failed to do, and what it should become.

Some of that criticism is fair. No institution of this scale and complexity is perfect. WHO must evolve, become more agile, communicate better, and focus relentlessly on delivery and impact. But in the middle of all the noise, we risk forgetting something essential:

WHO is not a building in Geneva.

WHO is people.
People who quietly devote their lives to improving the lives of others, often far away from cameras, recognition, or comfort.

For me, one of those people is Dr. André Ilbawi.

André is the head of the cancer team at the World Health Organization. He is also my dear friend and colleague. But more importantly, he represents what WHO truly is when you see it up close—not through headlines, but through action.

He could have had a very different life.

A native of the United States, André graduated in bioengineering before receiving his M.D. from the University of Pennsylvania. He trained as a cancer surgeon at the University of Washington and at MD Anderson Cancer Center—places where exceptionally talented physician-scientists build remarkable careers, gain prestige, and often earn extraordinary salaries.

His future was bright and predictable.

But in 2015, André chose something else.

He joined WHO as a *"technical officer."* To this day, I don't like that title. What does it even mean? When people hear "technical officer," they imagine paperwork and bureaucracy. They do not imagine a physician crossing conflict zones, shaping cancer policies for nations, helping ministries build systems, answering desperate midnight messages from colleagues across continents, or carrying the emotional burden of global inequity every single day.

Titles matter because they shape perception. And many people at WHO deserve titles that better reflect the weight of their mission.

What André actually became was something much bigger: a servant of global health.

Last year, I briefly met him in China during a congress. He stopped there only for a few hours between trips. For four consecutive days, he had not slept in a proper bed. He was constantly moving—from country to country, meeting after meeting, crisis after crisis—trying to move projects forward, solve problems, support governments, and help patients he would probably never meet personally.

At the same time, his wife was helping refugees from Gaza while living in Jerusalem with their children. This is the reality behind global health that people rarely see. Behind every exhausted WHO physician or officer, there are families carrying the burden alongside them.

André lives in constant motion. Jerusalem one day. Geneva the next. Africa, Asia, the Middle East after that. Yet somehow, he is always available.

You message him in the middle of the night—he replies.

You ask for help with an initiative—he connects people.

You send him a draft article—he reviews it carefully and gives thoughtful suggestions.

You propose an idea—he not only encourages it, but follows up weeks later asking what happened and how to move it forward.

He meets ministers and presidents, but he gives the same respect and attention to a young physician from a low-resource country trying to improve cancer care locally.

That is leadership.

Not leadership built on visibility, but leadership built on service.

One of the biggest misconceptions about WHO is that people think its work happens only through declarations, assemblies, and resolutions. Those things matter, of course. WHO's normative power and convening authority are unique and irreplaceable. But the true heartbeat of WHO is on the ground: helping countries vaccinate children during wars, supporting fragile health systems, improving cancer treatment pathways, strengthening screening programs, negotiating access to medicines, responding to outbreaks, training health workers, and quietly preventing catastrophes the world never even notices.

When WHO succeeds, the result is often invisible.
A disease outbreak that never spreads.
A child diagnosed earlier.
A treatment guideline implemented correctly.
A ministry making a better decision because someone from WHO helped them analyze the evidence.

Millions of lives are touched by work most people will never see.

And perhaps that is part of the problem.

WHO has extraordinary people, but the world often does not hear their stories. In today's era of misinformation and distrust, impact that remains invisible cannot build trust. We must communicate global health differently—not as abstract institutions, but through the real human beings carrying this mission forward under immense pressure.

People like André.

In my own vision for WHO's future, I often say that WHO should focus on what only WHO can do: convene, coordinate, guide, and empower the world toward better health. But to do that successfully, we must also empower WHO's own people, reduce unnecessary bureaucracy, support execution, and communicate impact clearly and honestly.

Because the world must continue to have WHO.
Not a perfect WHO.
Not a politicized WHO.
But a stronger, more agile, more human WHO.

And when we debate the future of the organization, let us remember the individuals behind it—the physicians, scientists, public health workers, emergency responders, and technical experts who sacrifice comfort, stability, and often family life in order to improve the lives of strangers across the globe.

When I think of WHO, I think of André Ilbawi.

And I know there are many others like him.

We should criticize institutions when necessary. We should demand better systems, faster delivery, and greater accountability. But we should also recognize and support the remarkable people dedicating their lives to global health.

Because they are not just working for WHO.

They are working for all of us.

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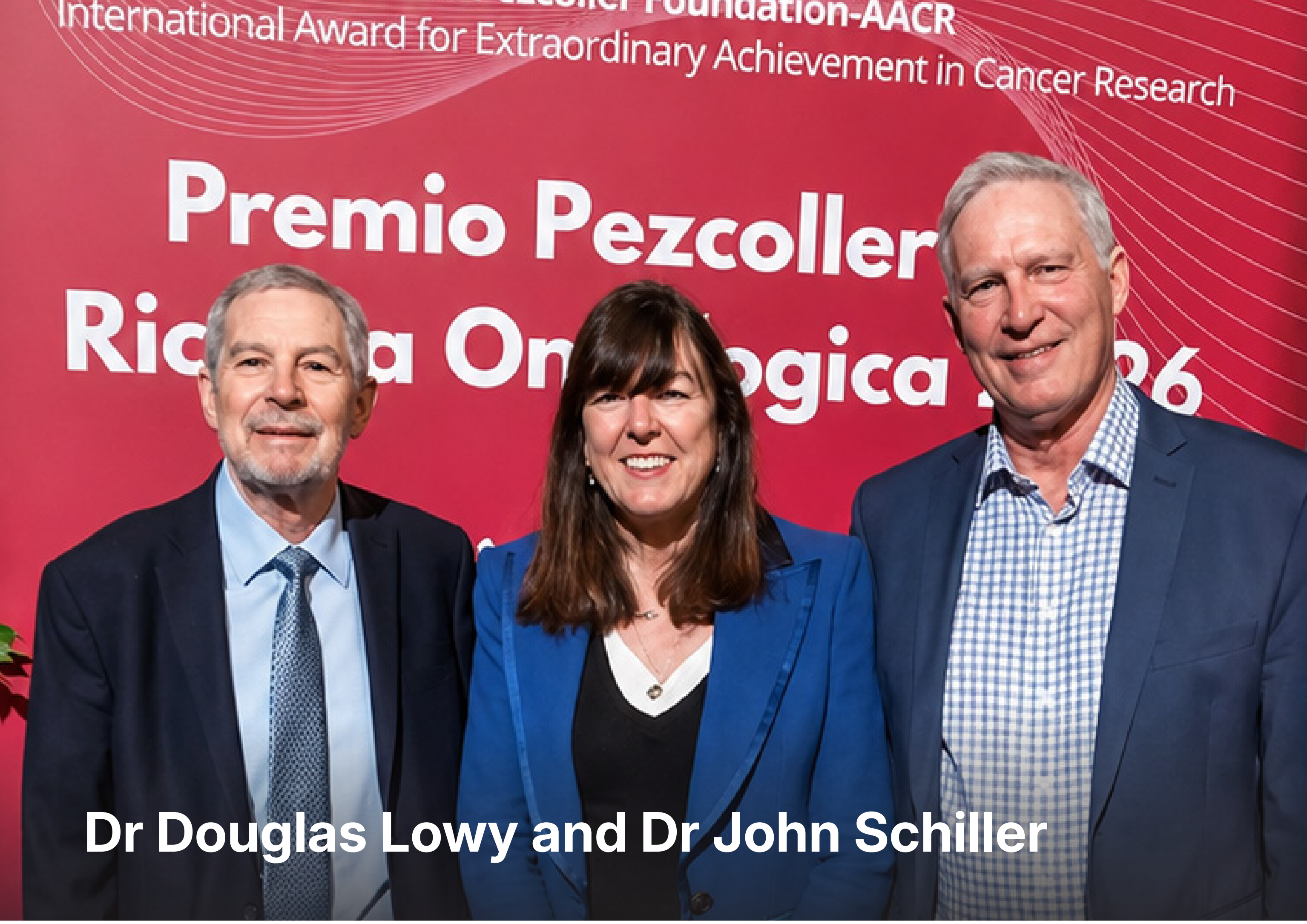
André Ilbawi | OncoCorridor | 2026, 18 MAY


Foundation-AACR
International Award for Extraordinary Achievement in Cancer Research
Premio Pezcoller
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Dr Douglas Lowy and Dr John Schiller

The Scientists Who Turned Cancer Prevention into a Vaccine

By Adriana Albini

The 2026 Pezcoller Foundation–AACR International Award for Extraordinary Achievement in Cancer Research has recognised two scientists whose discoveries reshaped one of oncology's greatest ambitions: preventing cancer before it begins. On 9 May, at the Teatro Sociale in Trento, Italy, Dr Douglas R. Lowy and Dr John T. Schiller of the U.S. National Cancer Institute were honoured for pioneering the science behind the HPV vaccines that are now transforming cancer prevention worldwide.

A Landmark in Cancer Prevention

Their work stands among the most consequential advances in modern oncology. By developing virus-like particle (VLP) technology — the foundation of HPV vaccination — Lowy and Schiller helped create a public health intervention capable of preventing cancer rather than treating it after diagnosis, marking a decisive shift in the history of cancer medicine.

Human papillomavirus (HPV) is responsible for nearly all cervical cancers, as well as a substantial proportion of anal, oropharyngeal, vulvar, vaginal, and penile cancers. Today, HPV vaccination programmes are reducing infection rates and precancerous lesions across multiple countries, with early evidence already pointing to dramatic declines in cervical cancer incidence among vaccinated populations.

The scientific journey began with German virologist Harald zur Hausen, who demonstrated that HPV infection is the main cause of cervical cancer. His discovery, recognised with the 2008 Nobel Prize in Physiology or Medicine, fundamentally changed the understanding of cancer etiology and opened the door to prevention strategies targeting oncogenic viruses.

Building the Vaccine Platform

In the 1990s, Lowy and Schiller advanced this field by developing a novel vaccine approach based on virus-like particles (VLPs). These structures mimic the outer shell of HPV but contain no viral DNA, meaning they cannot cause infection. At the same time, they trigger a strong immune response, making them both safe and highly effective as a vaccine platform.

Their research ultimately enabled the development of the first HPV vaccines, including Gardasil and Cervarix, now widely used around the world. In countries with strong vaccination coverage, dramatic reductions have already been observed in HPV infections and high-grade cervical lesions — early indicators of a future decline in cancer incidence.

Recognition of a Prevention Breakthrough

The importance of their contribution has been recognised repeatedly over the past decade. In 2017, Lowy and Schiller received the Lasker–DeBakey Clinical Medical Research Award, often seen as a strong predictor of future Nobel recognition. The Pezcoller Foundation–AACR Award further confirms the global impact of their work on both cancer research and public health.

29th Pezcoller Foundation-AACR
International Award for Extraordinary Achievement in Cancer Research
Premio Pezcoller per la Ricerca Oncologica 2026

From left to right: Lillian Siu, President of AACR, Margaret Foti, Chief Executive Officer of AACR, the two awardees, Douglas Lowy and John Schiller, and Enzo Galligioni, President of the Pezcoller Foundation

The award ceremony in Trento brought together leading figures in oncology, including Professor Enzo Galligioni, President of the Pezcoller Foundation; Margaret Foti, Chief Executive Officer of the American Association for Cancer Research (AACR); and Dr Lillian Siu, Immediate Past President of AACR. Their presence highlighted the growing international commitment to cancer prevention and cross-border scientific collaboration.

The achievements of Lowy and Schiller illustrate a profound shift in oncology: from treating cancer after it develops to preventing it altogether.

About the Author

Prof. Adriana Albini is Editor-in-Chief of "CancerWorld" magazine and Scientific Advisor to the Scientific Directorate of the IRCCS Istituto Europeo di Oncologia (IEO), Milan, Italy. She is Past and Founding Chair of the "Cancer Prevention Working Group (CPWG)" of the American Association for Cancer Research (AACR).

Cancer is Universal. Meaning is Not!

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.

By Fatjona Kraja

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COLLEGE
VOICES
CONTEST
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Kraja
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AWARDEES
4TH EDITION
CANCER IS UNIVERSAL.
MEANING IS NOT!
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She nodded when I said cancer. Only later did I understand that she had heard something else.

The consultation unfolded with clinical precision. The translation was accurate. From a professional perspective, nothing was missing. And yet everything was.

When I spoke of treatment, she heard punishment.

When I spoke of uncertainty, she heard fate tightening its grip.

I said surgery; she felt pain already carving its mark.

I described chemotherapy; her future quietly dimmed.

I offered radiotherapy as a cure; she received it as a final sentence.

She agreed to everything, not from understanding, but from deference. In her world, a doctor is not questioned. A diagnosis like this is not spoken aloud.

Later, I learned that in her community cancer exists in whispers. It lives behind doors that close gently, but firmly. It is endured, not discussed, passed down in stories heavy with fear.

"We Had Shared Words, But Not Meaning."

The distance between us had not been created by incompetence or indifference; it was shaped by culture, by silence, by the assumptions we both carried into the room.

Cancer is biologically universal. A malignant cell follows the same ruthless logic in Tirana, Rome, Tokyo or Toronto. But illness is never neutral. The word "cancer" does not travel untouched. In some places it carries shame; in others, inevitability. The survival curves that offer probability to physicians may feel like wagering a life to patients.[1]

Since then, I listen for more than answers. I listen for hesitation, for who speaks first, for what remains unsaid, for the fear hidden beneath ordinary words.

"Patients Rarely Hear Only Medicine."

An oncologist may speak with clinical precision — "surgery," "chemotherapy," "radiotherapy" — yet patients often hear something entirely different. Culture shapes illness long before a patient enters the consultation room.[1] In some societies, even naming cancer openly feels dangerous, as though the word itself might extinguish hope.[2][3]

Across cultures, myths abound. Many people believe cancer to be fatal, contagious, or retribution for past deeds. Such stigma has a silencing effect on patients and families.[4] Clinicians must remember that "cancer" is never just a medical term; it is filtered through personal and cultural lenses.[4][5]

Culture can determine who speaks first, what is said, and how it is heard.[1] In some societies, the doctor is not questioned and the diagnosis is not named aloud.[1][2]

Relatives may insist on telling the patient only the "gentle" truth, or none at all. A survey in Albania found that family members were least supportive of full disclosure about a cancer diagnosis.[3] This reflects a silent understanding: silence preserves hope or dignity in the patient's eyes. Physicians in such contexts often feel pressure to soften difficult truths.

Yet patients do crave understanding. Studies report that, despite cultural taboos, most patients prefer honest information and family involvement.[3][6] The lesson is that one-size-fits-all does not apply. Instead, we must listen for individual cues and ask each patient: How much do you want to know?[3]

Culture shapes whether cancer is seen as a death sentence or a challenge, how much control patients feel they have, and even whether the word "cancer" is spoken at all.[4][5] It provides a framework that shapes perception of illness, suffering, and the physician–patient relationship.[1] The science is global, but the meaning is deeply personal.

Emotional Walls and Empathy

We, as doctors, learn to build emotional walls for protection. This detachment can seem necessary amid daily grief, but it can also widen the distance between physician and patient. When clinicians withdraw emotionally, patients often notice the coldness and retreat in response.[7]

And sometimes the deepest suffering comes not from bad news itself, but from receiving it alone.

Empathy is not a weakness in medicine; it is a clinical skill. Patients trust physicians who remain emotionally present. That trust shapes communication, adherence, and willingness to endure difficult treatment.[6] Compassion is not separate from care; it is part of it.

Breaking bad news is therefore never only about delivering information accurately. It is about recognizing what the patient is actually hearing.

I have learned that listening often matters more than speaking. A pause after the word "survival." Eyes filling with tears when discussing schedules or side effects. A family member answering every question before the patient can. These moments reveal fears no scan or laboratory value can measure.

Sometimes the most important question is not "Do you understand?" but "What does this mean to you?"

Listening and Narrative in Care

Narrative medicine reminds us that patients do not experience cancer as pathology alone. They experience it as disruption — of identity, family, future, faith, dignity.

Acknowledging that story is not an extra act of kindness; it is part of good oncology.[6]

"Treating Cancer is Our Science. Hearing the patient's Silence is Our Art."

Science is universal. Meaning is not.

Cancer may be one disease, but it is heard in many languages.

The difference between competence and compassion can be a single word, a single silence, or a single truthful nod. Oncology demands that we master both.

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.

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WHO SAID DOCTORS CAN'T BE GOOD CANCER WRITERS?
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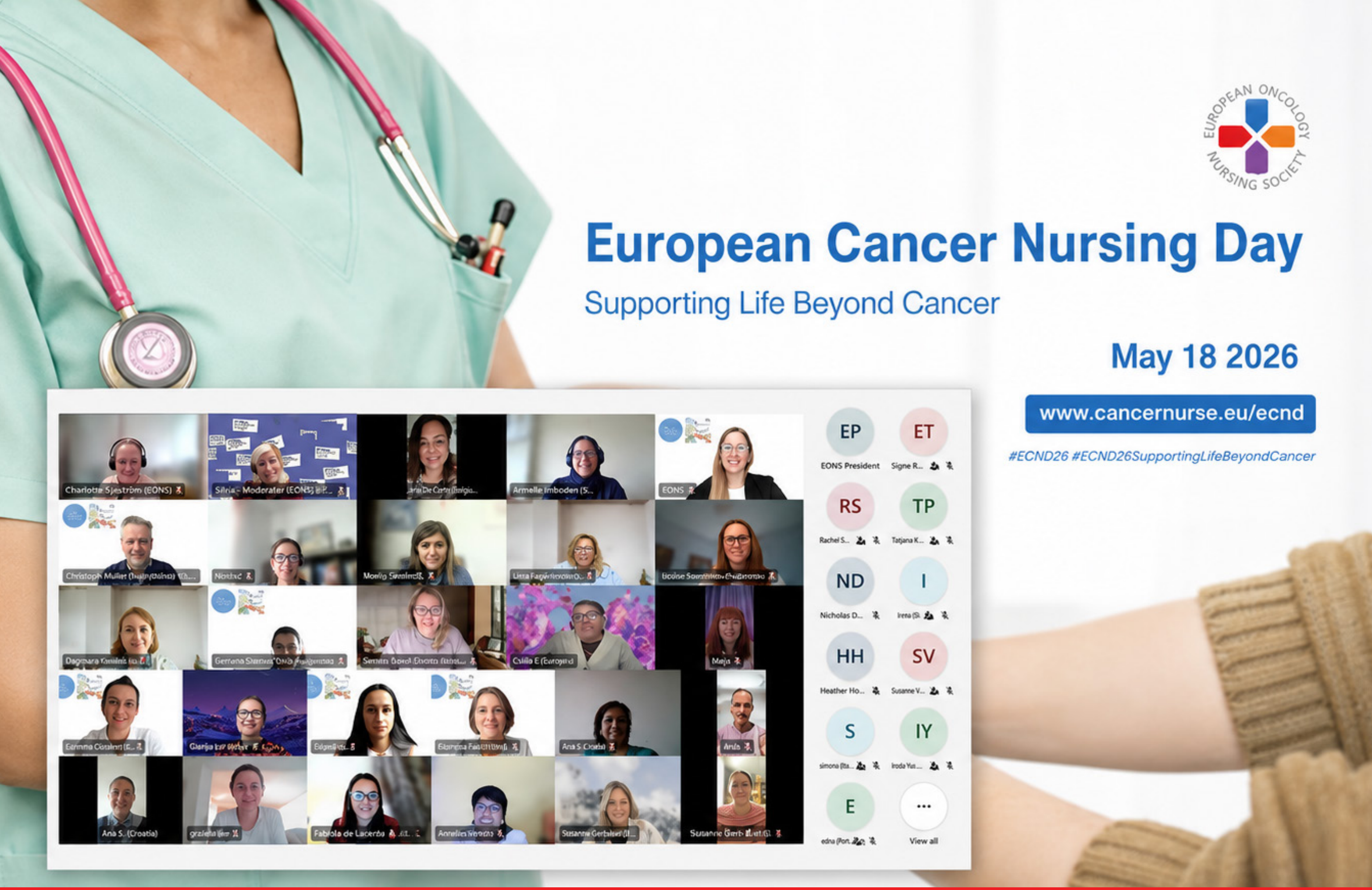
European Cancer Nursing Day
Supporting Life Beyond Cancer
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European Cancer Nursing Day 2026

By European Oncology Nursing Society

Supporting Life Beyond Cancer

Europe-wide online event highlights survivorship, innovation, education, advocacy, and the future of cancer nursing

On 18 May 2026, the European Oncology Nursing Society (EONS) marked European Cancer Nursing Day (ECND26) with an online Europe-wide celebration bringing together cancer nurses under the theme *"Supporting Life Beyond Cancer."*

Organised annually by EONS, European Cancer Nursing Day recognises the essential contribution of cancer nurses across the entire cancer continuum while advocating for greater recognition, investment, education, and support for the oncology nursing profession across Europe. This year's theme highlighted the increasingly important role cancer nurses play in survivorship, long-term follow-up, rehabilitation, psychosocial support, palliative care, and holistic person-centred care beyond active treatment.

The online celebration enabled broad participation and meaningful exchange among members of the European cancer nursing community from across Europe and beyond. Throughout the event, presentations from EONS Board Members and Working Group representatives demonstrated not only the impact of cancer nurses in clinical practice, but also the extensive educational, advocacy, research, communication, and policy work taking place across the organisation.

Innovation, Survivorship, and the Evolving Role of Cancer Nurses

The event opened with welcoming remarks from EONS leadership, including EONS President Dr Wendy McInally, ECND26 Task Group Chair Eugenia Trigoso Arjona, and EONS Board Member Matthias Hellberg-Naegele. Speakers reflected on the importance of resilience, collaboration, innovation, and compassion within cancer nursing at a time when healthcare systems continue to face increasing pressures and evolving patient needs.

One of the key presentations during ECND26 focused on how innovation and technology are shaping the future of oncology nursing practice. Associate Professor Remziye Semerci Şahin, EONS Board Member and Co-Chair of the Research Working

Group, presented on integrating technology-driven innovations into cancer nursing care to enhance patient outcomes and clinical practice. The presentation highlighted the growing role of digital tools, robotics, artificial intelligence, and supportive technologies in improving patient experiences and healthcare delivery, while emphasising that compassionate, person-centred care must remain at the heart of cancer nursing.

A central focus of the day was the session dedicated to this year's theme, *"Supporting Life Beyond Cancer."*

Matthias Hellberg-Naegele, Advanced Practice Nurse at HOCH Health Eastern Switzerland and EONS Board Member, explored the realities of survivorship and long-term cancer care, particularly for patients living with chronic and advanced cancers such as multiple myeloma. His presentation highlighted the complex illness trajectory experienced by many patients and the importance of continuity of care, symptom management, emotional support, and holistic nursing interventions throughout the cancer journey.

Education, Advocacy, and Strengthening the Cancer Nursing Workforce

The celebration also provided an opportunity for EONS Working Groups to present ongoing initiatives and future priorities, reflecting the organisation's C.A.R.E. strategy across communication, advocacy, research, education, and early career development.

The Communication Working Group shared activities focused on strengthening collaboration and visibility across EONS. Updates included initiatives to improve communication between Working Groups, develop communication guidelines aligned with current best practices, expand podcast collaborations, and promote *"good news stories"* highlighting achievements and innovation within oncology nursing. The group also emphasised the importance of increasing the visibility and impact of EONS by sharing evidence-based information and showcasing the work being carried out across the organisation.

The Advocacy Working Group highlighted ongoing activities supporting policy engagement, workforce wellbeing, and patient-centred advocacy. A major focus was the EONS Cancer Nursing Index (ECNI) 2025, which has already received over 680 responses from nurses across 37 countries. Building on previous editions, ECNI 2025 places particular emphasis on working conditions and safety in cancer nursing while helping generate national profiles and evidence to support future policy and workforce improvements across Europe. Additional updates included activities related to workplace safety accreditation, safety webinars, prevention projects, podcasts, and the Patient Advisory Council.

Research initiatives also featured prominently throughout ECND26. The Research Working Group presented updates on EONS research proposal workshops and PhD research workshops aimed at strengthening cancer nursing research capacity across Europe.

The Education Working Group shared updates on several major educational initiatives led by EONS. This included progress on the EONS Cancer Nursing Education Framework Update Study, a flagship initiative designed to define core competencies for specialist cancer nurses across Europe. The framework covers the full cancer care continuum and aims to strengthen consistency, quality, and professional development in oncology nursing education internationally.

The group also presented updates on the ESO–EONS Masterclass in Oncology Nursing, which prepares cancer nurses for advanced and future leadership roles while strengthening evidence-based clinical practice. Additional educational activities included webinars, educational collaborations, and professional development opportunities supporting cancer nurses across different stages of their careers.

The Early Career Nurses Group highlighted strategic projects planned for 2026, including research publications, webinars, podcasts, blogs, and representation within major EONS initiatives and advisory councils. Their presentation reflected EONS' strong commitment to empowering the next generation of cancer nursing leaders and ensuring early career professionals remain actively involved in shaping the future of cancer care across Europe.

Recognising Compassion, Leadership, and Life Beyond Cancer

As part of the celebration, ECND26 also featured a video competition highlighting inspiring examples of person-centred oncology nursing care. The competition invited participants to creatively reflect on this year's theme, *"Supporting Life Beyond Cancer,"* and showcase the impact cancer nurses have on patients' lives every day.

The winning entry was awarded to Núria Aguado Machancoses and the team from INCLIVA Instituto de Investigación Sanitaria in Valencia, Spain, for their powerful and moving video demonstrating the importance of compassionate, holistic cancer nursing care. The competition formed an important part of the ECND26 campaign, celebrating innovation, empathy, and the dedication of cancer nurses across Europe.

European Commissioner for Health and Animal Welfare Olivér Várhelyi shared a public message marking European Cancer Nursing Day 2026 and acknowledging the vital contribution of cancer nurses across Europe.

In his statement, Commissioner Várhelyi emphasised that *"cancer care is more than treatment"* and recognised the central role cancer nurses play in patient-centred care. He highlighted their contribution in supporting patients and families through diagnosis, treatment, recovery, survivorship, and long-term follow-up, while also helping manage symptoms, provide emotional and psychological support, and improve quality of life throughout the cancer journey.

The Commissioner also reaffirmed the European Commission's continued commitment to improving cancer prevention, diagnosis, treatment, and survivorship through Europe's Beating Cancer Plan, while thanking cancer nurses for *"helping people live beyond cancer."*

EONS President Dr Wendy McInally also reflected on the significance of this year's theme and the continuing role of cancer nurses in survivorship and long-term care. In her ECND26 address, she emphasised that cancer care extends far beyond active treatment and highlighted the essential contribution cancer nurses make in helping people rebuild their lives after cancer.

"As cancer nurses, we know that supporting life beyond cancer is not simply about when treatment ends; it is about helping people truly live afterwards," said Dr McInally. "Every day, cancer nurses provide not only clinical expertise, but also compassion, guidance, and continuity of care. They support individuals and their families through recovery, survivorship, uncertainty, and hope. On 18 May, we celebrated the dedication, resilience, and impact of cancer nurses across Europe who make a lasting difference in the lives of people affected by cancer."

Dr McInally also reaffirmed EONS' commitment to advancing person-centred cancer care through education, advocacy, leadership, research, and workforce support, ensuring that every person affected by cancer receives high-quality care throughout their entire journey.

Throughout the event, speakers repeatedly emphasised that supporting life beyond cancer also means supporting the cancer nursing workforce itself. Investment in education, leadership, workforce wellbeing, research, advocacy, and international collaboration remains essential to ensuring sustainable, high-quality cancer care for the future.

The online format of ECND26 demonstrated the strength, adaptability, and connectivity of the European cancer nursing community. The event created an inclusive platform for professionals from different countries and healthcare settings to exchange perspectives, share good practice, and reflect on common challenges affecting cancer care across Europe.

As ECND26 concluded, the celebration served not only as recognition of cancer nurses across Europe, but also as a powerful reflection of the extensive work being carried out within EONS to advance cancer nursing education, research, advocacy, communication, and person-centred care. EONS expressed its gratitude to all speakers, contributors, Working Groups, national societies, partners, and participants who joined the celebration and helped make European Cancer Nursing Day 2026 a success.

Oncologists Urged to Have Open Discussion about CAM Use with Patients

By Janet Fricker

CAM use linked to higher mortality in breast cancer patients

A cohort study of women with breast cancer has shown that use of complementary and alternative medicine (CAM) in association with traditional therapies was associated with higher mortality compared with treatment exclusively with traditional therapy. The study, published in JAMA Network Open online 2 March, showed that compared to patients who received exclusively traditional treatments, patients who received only CAM experienced a 3.7-fold higher mortality rate, and patients who received both CAM and traditional treatments a 1.4-fold higher mortality rate.

"While it wasn't surprising that patients who choose to forego all traditional treatments have worse outcomes, we were surprised to find the combination group also had worse outcomes. We are aware of research suggesting that types of CAM may reduce side effects of traditional treatments and we were optimistic it might boost compliance to therapy," senior author Daniel Boffa, Professor of Surgery at Yale School of Medicine, tells Cancerworld. *"When we went on to explore whether the combination group was skipping treatment, we found they were using significantly less radiation, endocrine, and chemotherapy treatments."*

The findings, he adds, highlight the importance of traditional treatments, and negative consequences of skipping even a portion of them.

Lower Adherence to Standard Therapies May Explain Survival Gap

Advances in early screening mammography and new, targeted treatments have reduced overall mortality and recurrence in breast cancer. Yet, despite progress in traditional treatment options, some patients continue to choose CAM, such as dietary supplements, mind and body approaches, and acupuncture. Given advancements in traditional therapies, Boffa and colleagues felt that in the modern era of treatment it was important to examine current outcomes associated with CAM use.

For the study, the team evaluated trends in the use of CAM in women diagnosed between 2011 and 2021 with stage I to IV breast cancer using the US National Cancer Database (NCDB), a database capturing around 70% of newly diagnosed cancer patients. Of 2,169,202 women with breast cancer identified, after excluding those with missing data 2,157,219 were included in the sample. A total of 2,106,665 patients (97.6%) received traditional therapy; 273 (<0.1%) received CAM alone; 568 (<0.1%) received a combination of CAM and traditional therapies; and 49,713 (2.3%) received no treatment.

Results showed that compared with patients treated with traditional therapies, those treated with CAM alone (adjusted hazard ratio [AHR], 3.67; 95%CI, 3.03–4.44; P < .001) or no treatment (AHR, 3.53; 95%CI, 3.48–3.58; P < .001) showed the highest risks for mortality. Receipt of a combination of traditional therapies and CAM was associated with a higher mortality compared with being treated exclusively with traditional therapy (AHR, 1.45; 95%CI, 1.22 -- 1.72; P < .001). In comparison to patients treated exclusively with traditional therapies, patients who received a combination of traditional therapies and CAM were less likely to receive endocrine therapy, radiation, and chemotherapy.

"The survival disadvantage found in the combination group of patients is likely to be due to this group not completely complying with recommended treatments, like radiotherapy and hormone therapy, which if omitted may be associated with higher rates of recurrence," explains Boffa.

Need for Open Clinician–Patient Communication about CAM Use

The relatively low rate of CAM use documented in the study (<1% compared with estimates closer to 30% in other studies), Boffa adds, raises concerns that patients may not have been discussing their interest in alternative treatments with oncology teams. *"This is a real shame because information on greater numbers of patients would have allowed us to get clearer signals of circumstances where CAM can be both helpful and harmful for patients,"* he says.

Inviting patients to share their interest in CAM may present an opportunity to enhance shared decision-making, particularly as patients may be planning to forego traditional treatments. *"Clinicians should consider discussing a patient's interest in CAM to be an important part of the treatment conversation. It offers the opportunity to be open and honest about the risks and benefits of CAM as well as reminding them of the importance of also complying with traditional treatments,"* says Boffa.

In future studies, the team plans to look at the use of CAM in other types of cancer. *"Encouraging more patients to disclose use of CAM would allow us to do deeper research in the NCDB,"* says Boffa.

CAM Definition Limitations and Interpretation Challenges

Commenting on the research, Sharon Lum, Professor of Surgery at Loma Linda University, says, *"I suspect this study was conceived based on a clinical scenario that we see increasingly in clinical practice: patients choose to undergo treatments that are not supported by scientific evidence. We have embraced shared decision-making, but with the plethora of data sources for patients to consume, how patients arrive at informed decisions can be challenging to understand."*

The main question, she tells Cancerworld, was the definition of CAM used in the paper, 'treatment administered by nonmedical personnel', that did not specify the specific treatment used. *"The NCDB cannot distinguish between a patient who is doing tai chi for symptom management from one who is taking anti-parasitic therapy from an online source,"* she adds. In future, she notes, it will be interesting to see how patterns evolve with de-escalation of traditional therapy being tested in robust clinical trials, and increasing use of generative AI as a data source for patients.

About the Author

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

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Miriam MUTEBI

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No Woman Left Behind

Dr Miriam Mutebi and the Quest for Equitable Cancer Care in Africa

By Knarik Arakelyan

In a breast clinic in Africa, fear often arrives before diagnosis.

Women arrive convinced they have cancer. Some have discovered a lump only days earlier; others have lived with symptoms for years. Many have never been taught breast awareness. Others arrive after long journeys through delayed referrals, fragmented systems, or months of trying to access care they could not afford or navigate.

For Dr Miriam Mutebi, these encounters are not peripheral to oncology. They are at the heart of oncology.

"Breast surgery is deeply human work," she says. *"Sometimes you are offering a cure. Sometimes you are breaking devastating news. Sometimes you are simply reassuring someone they are not alone."*

A Consultant Breast Surgical Oncologist and Health Systems Researcher at Aga Khan University Hospital, Miriam Mutebi's work sits at the intersection of clinical care, health systems and global oncology. She is a former President of African Organization for Research and Training in Cancer and Kenya Society of Hematology and Oncology, a Board Member of Union for International Cancer Control, and co-founder of Pan African Women's Association of Surgeons. In 2024, she received the American Society of Clinical Oncology Humanitarian Award.

But titles, she insists, are not the story.

People, and the systems that serve them, are.

Actions, Hands, Presence

Mutebi's path into medicine was shaped by a dual pull: scientific curiosity and human proximity. Medicine offered both.

Surgery, she recalls, added immediacy.

"It is action-oriented. Your judgment, your hands, your communication — everything matters at once."

Yet over time, the questions that occupied Mutebi increasingly extended beyond the operating theatre. The more patients she treated, the more she realized that outcomes were shaped long before a woman reached surgery; by awareness, access, referral pathways, diagnosis and the systems surrounding care.

Breast oncology quickly expanded beyond technical precision. It demanded engagement with identity, fertility, sexuality, motherhood, work, stigma, and survival; often simultaneously.

One encounter remains vivid: a 67-year-old woman who came in fearing her breast pain was due to cancer. Her examination and mammogram were normal.

"We had an opportunity to review her mammogram, talk about breast health and show her how to perform a breast self-examination," Mutebi recalls.

"When she left, she said, 'I feel empowered,'" Mutebi recalls. *"That moment felt like care had already happened."*

In many African settings, breast or women's health clinics become the first place where women feel safe enough to speak. Once they do, clinical encounters expand far beyond cancer.

"You realize many have not engaged with the health system for years," she says. *"The clinic becomes a place for education, reassurance and helping people navigate what comes next"*

When Cancer is Not Biology Alone

The turning point in Mutebi's thinking came from the widening gap between textbook oncology and lived reality.

Training framed breast cancer as a disease of older women with predictable risk profiles. Clinical practice told a different story.

Younger women. Breastfeeding mothers. Presentations that did not fit expected narratives. Gradually, one conclusion became unavoidable.

"Patients are not experiencing cancer as biology alone," she says. *"They are experiencing the realities of health systems."*

Those care pathways and structures determine what happens next: delays in diagnosis, fragmented referrals, unaffordable care, broken pathology pathways, and unreliable treatment access.

Patients often move through multiple providers and fragmented referral pathways before diagnosis. Pathology results may take weeks. Radiotherapy machines often fail. Treatment is interrupted or never completed.

"Cancer is not waiting for patients to raise money for pathology," she says.

Even with highly skilled clinicians, fragmented systems distort outcomes.

"You can have excellent clinicians," she adds, *"but still be constrained by broken pathways."*

Patients fall through gaps between diagnosis and treatment, surgery and systemic therapy, chemotherapy and radiotherapy. Some are incorrectly told they are cured after surgery. Others discontinue care under logistical and financial strain.

Increasingly, patients become coordinators of their own survival.

"That burden is exhausting," she says quietly.

The Cost of Not Being Heard

For Mutebi, one of the most persistent failures in cancer care is not absence of treatment; but absence of communication.

During residency, she once spoke to an external cancer support group about the potential complications of breast surgery.

The experience was illuminating. Many of the women appeared to be hearing details about lymphedema, body image changes and functional limitations in ways they had not previously understood.

For Mutebi, the experience highlighted an important distinction: obtaining consent is not the same as achieving understanding.

Another encounter has stayed with her. A woman underwent unnecessarily aggressive surgery for a pre-cancerous lesion and developed severe lymphedema after being told simply that her breast would be removed the next day.

For Mutebi, the lesson was unequivocal.

"Information is medicine. Communication is care."

Yet across systems, patients are still not routinely counselled on fertility, sexuality, menopause, or long-term consequences of treatment.

She recalls a young woman eligible for breast conservation who returned after family discussion.

"They told me she would have a mastectomy," Mutebi says.

Privately, the patient added: *"I would prefer conservation. But they are the ones paying."*

Autonomy, she reflects, is not only about choice, but about the underlying structures that allow choice to exist.

Lessons from Unequal Systems

Training across Nairobi, Cape Town, and Memorial Sloan Kettering Cancer Center shaped Mutebi's understanding of global oncology in unexpected ways. No system is purely advanced or deficient. All contain excellence and inequity in different forms.

High-income systems offer precision, research capacity, and coordinated care. Yet even there, access disparities persist.

The COVID-19 pandemic exposed these vulnerabilities globally; in workforce distribution, communication breakdowns, and system overload.

For Mutebi, the lesson is not replication but contextual design.

"Good care is not defined by technology alone," she says. *"It is about whether patients feel seen, informed, and supported throughout their journey."*

"Africa is where many 'pilots' come to die"

Mutebi is critical of fragmented global health interventions that operate outside national systems.

"Africa is where many 'pilots' come to die," she says.

Short-term projects often fail to integrate into local infrastructure. When funding ends, impact disappears. The problem, she argues, is not lack of capacity, but lack of integration.

"Others can support the journey, but they cannot walk it for us," she says. *"We must build our own solutions."*

Her optimism lies in a rising generation of African oncologists already doing so.

At a recent meeting in Addis Ababa, young clinicians from across Africa were asked to reinterpret global oncology evidence for local application. Their responses were immediate and practical; focused on implementation, not abstraction.

"The talent is extraordinary-and it is everywhere," she says. *"Opportunity is not."*

Reframing the Global Cancer Narrative

Dr Mutebi has contributed to multiple global oncology and health systems commissions, including work linked to The Lancet.

Her concern is not innovation itself, but the growing gap between what is possible and what is accessible.

"We celebrate innovation," she says. *"But patients do not experience innovation. They experience whether care reaches them consistently, affordably and in time."*

For Mutebi, the challenge is not simply generating new evidence or technologies. It is ensuring that advances translate into earlier diagnoses, more coordinated care and better outcomes for the people who need them most.

"The question is not whether innovation exists," she says. *"The question is whether systems allow it to reach patients"*

She also challenges dominant narratives that reduce Africa to a place of perpetual need rather than innovation, leadership and expertise.

"There is extraordinary work happening across the continent," she says. *"But too often, Africa enters the global conversation as a recipient rather than a contributor."*

Her concern is not that challenges are ignored but that complexity is lost. Stories of constraint often eclipse stories of ingenuity, progress and local leadership.

"Africa is not one story," she says. *"And it is certainly not one problem waiting to be solved"*
African patients, she argues, are too often viewed through scarcity rather than agency.

"They do not need sympathy alone," she says. *"They need equitable systems, investment and opportunity."*

Women in Surgery: The Invisible Burden

Many of the structural barriers Mutebi observes in cancer care are mirrored within the surgical workforce itself.

Through Pan African Women's Association of Surgeons, Mutebi works to address challenges that affect women across the profession, including mentorship gaps, underrepresentation in leadership, and systems that were not designed with caregiving responsibilities in mind.

"The same questions we ask about patients apply to providers," she says. *"Who has access to opportunity? Who is supported? Who is left navigating systems that were not designed with them in mind?"*

But perhaps the most invisible burden is the continuous negotiation of credibility, authority, and expectation.

"There is a constant negotiation of space," she says.

Still, she sees change emerging through a new generation unwilling to shrink themselves to fit inherited systems.

Leadership as Stewardship

Across her roles: surgeon, researcher, educator, author, and global health leader, Mutebi's understanding of leadership has evolved fundamentally.

Earlier in her career, she says, leadership was associated with achievement and visibility. Over time her focus has shifted from individual accomplishment to strengthening the institutions, systems and people that make progress possible.

Now she sees it differently.
"It is stewardship," she says.

A mentor once reframed it for her: *"It is not our job to finish. But it is our job to start."*

The role of leadership, she believes, is not to be indispensable, but to leave behind stronger people and stronger institutions.

Leadership, she explains, is about building systems that outlast individuals; through mentorship, collaboration, and institutional memory.

Change, she adds, is rarely dramatic. It is cumulative.

Advice to the Next Generation

To young African doctors, surgeons, other healthcare workers and researchers, especially women; Mutebi is clear.

"The continent needs you."

But she cautions against underestimating context.

Africa's challenges are real, she says, but so is its intellectual and leadership capacity.

"What we need are people willing to build solutions, not only describe problems."

She encourages young clinicians to pursue excellence and to invest not only in their own careers, but in the systems and institutions that will shape care long after they are gone.

"Meaningful change is slow," she says. *"It is not glamorous."*

And it cannot be done alone.

"You need mentors, collaborators, and a community."

Principles, Influences, and Worldview

Mutebi describes patience, humility, and exposure to suffering as central to her philosophy of care.

Medicine, she says, is a long education in vulnerability, dignity, grief, and resilience.

She is shaped by mentors, patients and thinkers whose work explores humanity, equity and the responsibility to care, including Wangari Maathai, Abraham Verghese, Paul Farmer, and Chimamanda Ngozi Adichie.

From them, and from her patients, she draws a simple but enduring lesson: people are always more complex, fragile, and resilient than systems allow them to appear.

The Human Core of Care

Her book, Stuff I'd Tell My Sister, reflects her belief that medicine is never emotionally neutral.
Clinicians are trained for certainty. But care, she argues, requires presence.

"Sometimes you cannot change the outcome," she says. *"But you can change how someone is held within it."*

Who Should Be Interviewed Next

Mutebi recommends Karen Nakawala, a leading voice in survivorship, stigma, and patient-centered cancer care.

"Global oncology is strongest when it listens not only to those who design systems but also to those who have had to survive them"

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, Head of the "OncoDaily TV," and serves as PR and Communications Officer at "EMERTÉ" Clinic.

Dr Mohamed Emam Sobeih's Vision for the Future of Oncology

Building Beyond the Bedside

By Knarik Arakelyan

At the National Cancer Institute Egypt, where Dr Mohamed Emam Sobeih began his oncology training, difficult realities confronted young physicians every day. Patients frequently arrived with advanced-stage disease. Diagnostic limitations complicated decision-making. Resources were stretched, while clinicians faced the challenge of delivering modern cancer care within constrained systems.

For Sobeih, those early years became more than clinical training. They defined his understanding of oncology itself.

"My journey in oncology began at the National Cancer Institute Egypt, where I was exposed early to a large volume of complex cases—both hematological malignancies and solid tumors," he says. *"Most patients presented at advanced stages, often with limited resources and restricted access to advanced diagnostics. This reality was both challenging and*

defining."

The experience shaped not only his medical practice, but also his sense of responsibility. In environments where evidence-based recommendations could not always be implemented straightforwardly, oncology demanded adaptability as much as expertise.

"Very early on, I realized that clinical excellence alone was not enough," Sobeih explains. *"Even the best decisions could be limited by access, infrastructure, and system-level barriers."*

That realization marked a turning point. Rather than focusing solely on individual patient care, he began thinking more broadly about sustainability, education, and healthcare systems capable of improving outcomes at scale.

Evidence-Based Medicine in Real-World Settings

A major influence on that transition came through his engagement with the European School of Oncology (ESO), which introduced him to a more global and analytical approach to oncology practice.

"My exposure to the European School of Oncology was transformative," he says. *"It taught me how to critically read guidelines, interpret evidence, and apply it in context."*

The 1st ESO Convention: with Alberto Costa, CEO of the European School of Oncology (ESO)

For Sobeih, Evidence-Based Medicine became more than an academic principle. It evolved into a practical framework for bridging the gap between international standards and real-world clinical limitations.

In many low- and middle-income healthcare systems, implementing oncology guidelines remains challenging due to restricted access to diagnostics, modern therapies, and specialized infrastructure.

Rather than viewing these constraints as reasons to abandon evidence-based approaches, Sobeih focused on adaptation and collaboration.

"The main barriers were resource limitations, variability in access to diagnostics, and sometimes a gap in structured systems," he says. *"I started addressing this by adapting guidelines to local realities, building collaborations, and continuously educating myself and my colleagues."*

The process, he notes, was gradual, but consistent.

Leadership as Responsibility

As his career expanded through research, education, and international collaboration, leadership emerged naturally from clinical work.

"This transition happened naturally as my exposure grew," Sobeih says.

"Leadership became a responsibility rather than a choice, especially when I realized that improving systems could impact far more patients than individual care alone."

Today, as Deputy Director of the National Cancer Institute Egypt, he views leadership not as administration alone, but as the ability to create environments where multidisciplinary oncology care can thrive.

"Building effective oncology services requires vision, adaptability, and teamwork," he says. *"Leadership is about enabling others, optimizing resources, and creating a culture that values both excellence and compassion."*

The perspective reflects a broader shift in modern oncology, where sustainable progress increasingly depends on workforce development, institutional organization, and collaborative networks alongside scientific innovation.

Expanding Global Oncology Education

Sobeih's relationship with the European School of

Oncology continued to evolve after his initial training experience. What began with a single application to an international course eventually led to his becoming an ESO College Graduate and later a member of the ESO College Council.

"That opportunity opened doors to global exposure, networking, and mentorship," he recalls. *"It introduced me to a truly global perspective on oncology."*

Today, his focus within the council centers on improving educational accessibility for regions where oncology training opportunities remain uneven.

"As part of the ESO College Council, I work to ensure that oncology education becomes more accessible and tailored to regions like the Middle East and Africa," he says. *"The goal is to bridge gaps—bringing high-quality education to areas where it is needed most."*

The challenge is increasingly urgent. Across many countries in the Middle East and Africa, cancer incidence continues to rise while healthcare systems face shortages in specialized training, infrastructure, and access to innovation. For Sobeih, education is not supplementary to cancer care—it is one of its foundations.

ESO Certificate of competence in lung cancer from Zurich

Supporting Patients Beyond Treatment

The same philosophy inspired the creation of the Egyptian Cancer Support Foundation, an initiative developed in response to the unmet needs he repeatedly encountered in clinical practice.

"Through my clinical journey, I witnessed significant gaps in patient support—beyond treatment itself," he says.

The foundation aims to provide more holistic support throughout the cancer journey, including patient awareness, psychosocial support, and guidance beyond the hospital setting.

Its mission reflects a growing recognition within oncology that successful cancer care extends beyond therapy alone. Emotional support, education, navigation, and quality of life increasingly form essential components of patient-centered care.

Mentorship and the Next Generation

For Sobeih, mentorship remains one of the most effective ways to create long-term impact in oncology.

"My mentors played a crucial role in my development—from clinical practice to research," he says. *"Today, I see mentorship as a responsibility."*

He believes the future of oncology depends not only on training technically skilled physicians, but also on cultivating leaders capable of improving systems, conducting research, and navigating complex healthcare realities.

"Mentorship is one of the most powerful tools for sustainable change," he says.

That commitment now informs much of his academic and institutional work, particularly in supporting young oncologists across the region.

Building Integrated Oncology Systems

Among Sobeih's current priorities is the development of a patient-centered multidisciplinary oncology center designed to integrate advanced treatment with accessibility and supportive care.

"My vision is to build a patient-centered, multidisciplinary oncology center that integrates advanced care with accessibility," he explains. *"The*

Dr Mohamed Emam Sobeih with his mentors: from left to right Professor Rabab Gaafar, Dr. Mohamed Emam Sobeih, Professor Ola Khorshid

focus is on combining evidence-based practice, research, and supportive care in one unified system."

Achieving that vision, however, requires overcoming familiar challenges.

"The biggest challenges include resource limitations, access to modern therapies, and system organization," he says. *"Addressing these requires strategic planning, international collaboration, and investment in education and training."*

These obstacles are shared across many healthcare systems worldwide, particularly in low- and middle-income countries where rising cancer burdens continue to strain infrastructure and resources.

A Legacy Measured by Systems and People

Asked what legacy he hopes to leave behind, Sobeih's answer returns not to individual accomplishment, but to collective progress.

"I hope to leave a legacy of impact—not just through the patients I've treated, but through the systems I've helped build, the professionals I've mentored, and the mindset I've contributed to shaping," he says.

It is a philosophy rooted in the understanding that the future of oncology will depend not only on scientific breakthroughs, but also on the ability to make high-quality cancer care accessible, sustainable, and human-centered.

"Oncology is not just about treating cancer," Sobeih says. "It's about transforming care for future generations."

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, Head of the "OncoDaily TV," and serves as PR and Communications Officer at "EMERTÉ" Clinic.

The Ovation and the Asterisk

Five trials, five cancers, and what the ASCO 2026 plenary really promised patients

By Amalya Sargsyan

ASCO 2026's plenary delivered five real advances across five cancers, and a standing ovation that pulled a hall full of oncologists to their feet. The harder question starts after the applause dies down: what does any of it actually buy the patient who isn't in the room?

There is a particular sound a room of oncologists makes when it stops being a room of oncologists. It happened on the afternoon of 31 May, in Hall B1 of McCormick Place, when Brian Wolpin advanced to a slide showing two survival curves for metastatic pancreatic cancer — a disease where the curves almost never separate — and the gap between them was wide enough to be visible from the back of the auditorium. Thousands of people who spend their working lives being careful, hedged, and quantitative rose and applauded a graph. Some of them, by several accounts, were crying.

It is worth sitting with that image, because the rest of this story is an argument with it.

A standing ovation is an emotion, and emotions are not endpoints. The plenary session is the most selective stage in clinical oncology — five abstracts chosen from roughly seven thousand, presented to the whole field at once — and this year all five were, in their own register, genuinely good news. Prostate, sarcoma, lung (twice), and pancreas. Targets long written off as untouchable. Cancers long treated with a shrug. Every one of them moved.

But "moved" is doing a lot of work in that sentence, and the distance between a curve on a screen in Chicago and a drug in the hands of a patient in Yerevan, Lagos, or rural Ohio is the part the applause skips over. So this is a tour of what was actually on stage — the science, plainly explained, and the honest accounting of what each result means, for whom, and how soon. The day built, deliberately, toward that ovation. Let's build toward it too, and then look hard at the asterisk attached to it.

First on Stage: A Nine-fold Answer, and a Number that Stays Small

The session opened with PROTEUS, presented by Mary-Ellen Taplin of Dana-Farber, and it took aim at a fact that has embarrassed prostate oncology for decades: roughly half of men with high-risk localized prostate cancer relapse within five years of surgery meant to cure them. Surgeons have refined the operation for over a century. The relapse rate has barely budged. Trial after trial of giving systemic therapy around the operation has failed.

PROTEUS asked whether hitting the androgen-receptor pathway harder and earlier — the drug apalutamide plus standard hormone therapy, given for six months before surgery and six months after — could change that. The answer, in 2,109 men, was striking in one direction and modest in another, and the gap between those two readings is the whole lesson.

8.9% vs 1.0%

MINIMAL RESIDUAL DISEASE AT SURGERY — A NINE-FOLD IMPROVEMENT (PROTEUS)

The striking part: men who got apalutamide were nine times more likely to have little or no cancer left in the prostate at the time of surgery — a pathologic complete response or minimal residual disease rate of 8.9% versus 1.0%. Johnson & Johnson, which makes the drug, called it the breaking of a decades-long paradigm, and it is not wrong that this is the first convincing randomized signal in this setting. The independent ASCO commentary agreed it was the first persuasive evidence of its kind. Time to needing the next round of treatment stretched out by nearly three years.

The modest part: that headline 8.9% is still 8.9%. Nine men in ten on the new regimen still had meaningful cancer in the specimen. And the endpoint that patients actually care about — staying free of metastases — improved with a hazard ratio of 0.80 and a p-value of 0.02. Real, but a 20% reduction in risk, not a transformation.

Toxicity was higher too: more grade 3/4 events, more rashes, more dose interruptions, and the discussant noted the regimen has never been tested head-to-head against the radiotherapy-based intensification many of these men would otherwise receive. For a fit man with genuinely high-risk disease who is heading to surgery anyway, this is a real new option, and several surgeons said on the day they would adopt it. It does not rewrite the algorithm for everyone, and a pCR rate under 10% is a beginning, not a destination. What PROTEUS offers is intensification that helps a meaningful minority — which, in a disease this common, is still worth having.

The Rarest Cancer, The Cleanest Target, The First Win

Then came SARC041, and for those of us who work in sarcoma it carried a weight the numbers alone don't capture. Dedifferentiated liposarcoma is rare — on the order of 3,000 cases a year in the United States — aggressive, and almost untreatable once it spreads. No chemotherapy reliably holds it for even four months. And it has been a graveyard for drug development: three prior phase 3 trials in this disease — selinexor, milademetan, and brigimadlin — all failed to beat their comparators. The field had begun to wonder whether anything would work.

What makes the disease maddening is also what made SARC041 logical. Nearly every dedifferentiated liposarcoma is driven by amplification of a single gene, CDK4 — about as clean an oncogenic target as exists in solid tumors. Mark Dickson of Memorial Sloan Kettering, who has spent much of his career on exactly this observation, tested abemaciclib, a CDK4/6 inhibitor already sitting on pharmacy shelves for breast cancer.

9.7 vs 1.5 months

PROGRESSION-FREE SURVIVAL, ABEMACICLIB VS PLACEBO — HR 0.38 (SARC041)

It worked. Median progression-free survival was 9.7 months with abemaciclib against 1.5 months with placebo — a hazard ratio of 0.38. Roughly one patient in ten saw the tumor actually shrink, which sounds unremarkable until you remember that tumor shrinkage in this disease is close to a unicorn. Dickson called it the first positive phase 3 trial in dedifferentiated liposarcoma — language the disease has never been able to use.

The discussant, Paolo Casali of Milan, supplied the discipline. One of the field's most exacting readers of sarcoma trials, he pressed the caution that matters most here: the comparator was placebo, not chemotherapy. That strikingly short 1.5-month placebo result widens the gap on the slide without telling us how the drug stacks up against real alternatives. And because 85% of the placebo group crossed over to abemaciclib at progression — the ethically correct choice — the overall-survival signal, which trended in abemaciclib's favour (median not reached versus about 25 months) without reaching significance, is genuine but blurred. Dickson himself was candid that the study was never designed for registration.

None of that erases the achievement. For a cancer with no approved targeted therapy, a drug that quadruples progression-free time is the difference between "we have nothing" and "we have something" — and abemaciclib is already approved and sold worldwide for breast cancer, so the fight here is about getting it into sarcoma guidelines and reimbursement, not building a supply chain from scratch. In rare cancers, that distinction is the whole game.

A Target So Small Most of the World Never Tests for It

LIBRETTO-432, presented by Jonathan Goldman of UCLA, is the quietest result of the five and, in a way, the most demanding of the system around it. RET fusions drive only about 1–2% of non-small cell lung cancers. The drug, selpercatinib, is already approved for advanced RET-positive disease. The question here was whether giving it after surgery, in early-stage disease, could keep the cancer from coming back — the same move that osimertinib (in EGFR-mutant disease) and alectinib (in ALK-positive disease) already proved out.

–83%

REDUCTION IN RISK OF RECURRENCE, PROGRESSION OR DEATH — HR 0.17 (LIBRETTO-432)

It did, and emphatically. In the higher-risk stage II–IIIA group, selpercatinib cut the risk of recurrence, progression, or death by 83% — a hazard ratio of 0.17. At two years, 91.5% of treated patients were event-free versus 61.1% on placebo. The discussant, Christine Lovly of City of Hope, used three words in a row — field-changing, paradigm-shifting, practice-changing — that discussants almost never spend on a population this small.

> Comprehensive genomic profiling at diagnosis is now evidence-based — not aspirational.
>
> — Christine Lovly, invited discussant, on LIBRETTO-432

Sit with that phrasing. A drug that works spectacularly is useless to a patient whose tumor was never tested for the alteration it targets. RET testing is not routine in much of the world, including many high-income centers, and it is rare-to-absent across most low- and middle-income settings, where molecular profiling is a luxury line item. LIBRETTO-432 is a triumph of precision medicine and a quiet indictment of how unevenly precision is distributed: a new standard for a tiny, well-defined group, and another brick in the argument that you cannot treat lung cancer well without sequencing it first. The caveats are familiar — follow-up is still short, overall-survival data immature — but the deepest one is that the whole edifice rests on a diagnostic infrastructure that most patients who could benefit will never reach.

A Genuine First, and the Question of Where the Data Come From

HARMONi-6 was historic before a single number appeared: it is the first China-originated investigational cancer drug ever selected for an ASCO plenary in the society's 61-year history. The drug, ivonescimab, is a bispecific antibody — one molecule that blocks both PD-1 (an immune checkpoint) and VEGF (a driver of tumor blood-vessel growth) at the same time. The trial pitted it, plus chemotherapy, against an active and credible comparator: tislelizumab, a standard PD-1 inhibitor, plus the same chemotherapy, in first-line advanced squamous lung cancer.

−34%

REDUCTION IN RISK OF DEATH VS AN ACTIVE PD-1 INHIBITOR — OS 27.9 VS 23.7 MONTHS (HARMONI-6)

That design detail is what makes the result notable. Beating chemotherapy is routine; beating an established immunotherapy head-to-head is not. Ivonescimab did it, extending median overall survival to 27.9 months versus 23.7 — a 34% reduction in the risk of death, and survival past two years in a squamous population that rarely sees it. The benefit held even in patients with low or absent PD-L1, the group that usually gets the least from checkpoint drugs.

> Right now... it's not applicable to the global patient population.
>
> — Julie Brahmer, discussing HARMONi-6's China-only dataset

And then the room did something healthy: it pushed back. The entire trial was conducted in China. Julie Brahmer, discussing the data, said as much, adding that the next wave of studies is needed before that changes. David Spigel, commenting separately, called the results impressive but cautioned it was too early to judge their meaning beyond a Chinese population. Differences in patient genetics, smoking patterns, the specific chemotherapy backbone, and what treatments patients receive after the trial can all move survival curves in ways that don't travel across borders. The result validates a genuinely novel mechanism and signals that the center of gravity in oncology drug development is shifting eastward — but a single-country trial, however well run, is a hypothesis for the rest of the world, not yet an answer. The appropriate response to a 34% improvement in survival is both applause and the demand for confirmation. Both can be true at once.

The One that Earned the Ovation

Which brings us back to the curves that made the room stand.

Pancreatic cancer is the discipline's standing rebuke. Around 67,500 Americans will be diagnosed this year; more than half already have metastatic disease when they hear the words, and for them the five-year survival rate sits near 3%. When first-line chemotherapy stops working — and it nearly always does — second-line treatment has historically bought a median of six to seven months. The last time the field had a real reason to celebrate was fifteen years ago, with the chemotherapy regimen FOLFIRINOX. Since then: refinement, sequencing, and modest gains.

The reason is a gene called RAS. More than 90% of pancreatic cancers are driven by it, and for four decades RAS was the textbook definition of *"undruggable"* — a protein biochemists could see clearly and do nothing about. Nature used that exact word in its coverage of this trial; the framing was everywhere because it was earned.

13.2 vs 6.6 months

MEDIAN OVERALL SURVIVAL, DARAXONRASIB VS CHEMOTHERAPY — RISK OF DEATH −60% (RASOLUTE 302)

RASolute 302 tested daraxonrasib, an oral drug that targets the active, switched-on state of RAS, against investigator's-choice chemotherapy in 500 patients whose pancreatic cancer had already progressed.

In the RAS G12-mutated group — about 92% of patients — median overall survival was 13.2 months versus 6.6 months. The risk of death fell by 60%. Progression-free survival roughly doubled. About a third of patients responded. And crucially, this was not more benefit bought with more toxicity: serious adverse events and, especially, discontinuations due to side effects were lower with the targeted drug than with chemotherapy — 1.2% versus 11.2%. Patients reported their pain and quality of life held up longer. The results were published in the New England Journal of Medicine the same afternoon; the BMJ and Nature both ran the standing ovation as news in itself.

This is the rare case where the emotion in the room and the data on the slide point the same direction. Doubling survival in metastatic pancreatic cancer is not incrementalism. It is the thing the field has been failing to do for a generation.

> RAS is no longer undruggable — it is increasingly actionable.
>
> — Santiago Fontes, oncologist, on the RASolute 302 result

And yet the most useful voice in the aftermath belonged to a skeptic. Bishal Gyawali, who has built a career on disciplined enthusiasm, made the point that the drug is clearly good and that celebrating the p-value misses what matters — vanishingly small p-values can attach to mediocre drugs, and the real questions are durability, access, and what the survival curve looks like with longer follow-up. The median follow-up here was just 8.5 months. Thirteen months of median survival is a transformation relative to six; it is not, yet, a cure, and the people who will live longest on this drug are still being counted.

There is also the matter that already separates the patient in the room from the patient outside it. The US Food and Drug Administration has opened an expanded-access pathway for daraxonrasib, which means some American patients can get it now, before formal approval. That is genuinely good. It also means the global access clock is already running, and history is unkind here: the gap between a drug's debut in Boston and its arrival in Yerevan or Nairobi is usually measured in years, sometimes never closed at all. A 60% reduction in the risk of death is a different fact depending on your passport.

What an Ovation is For

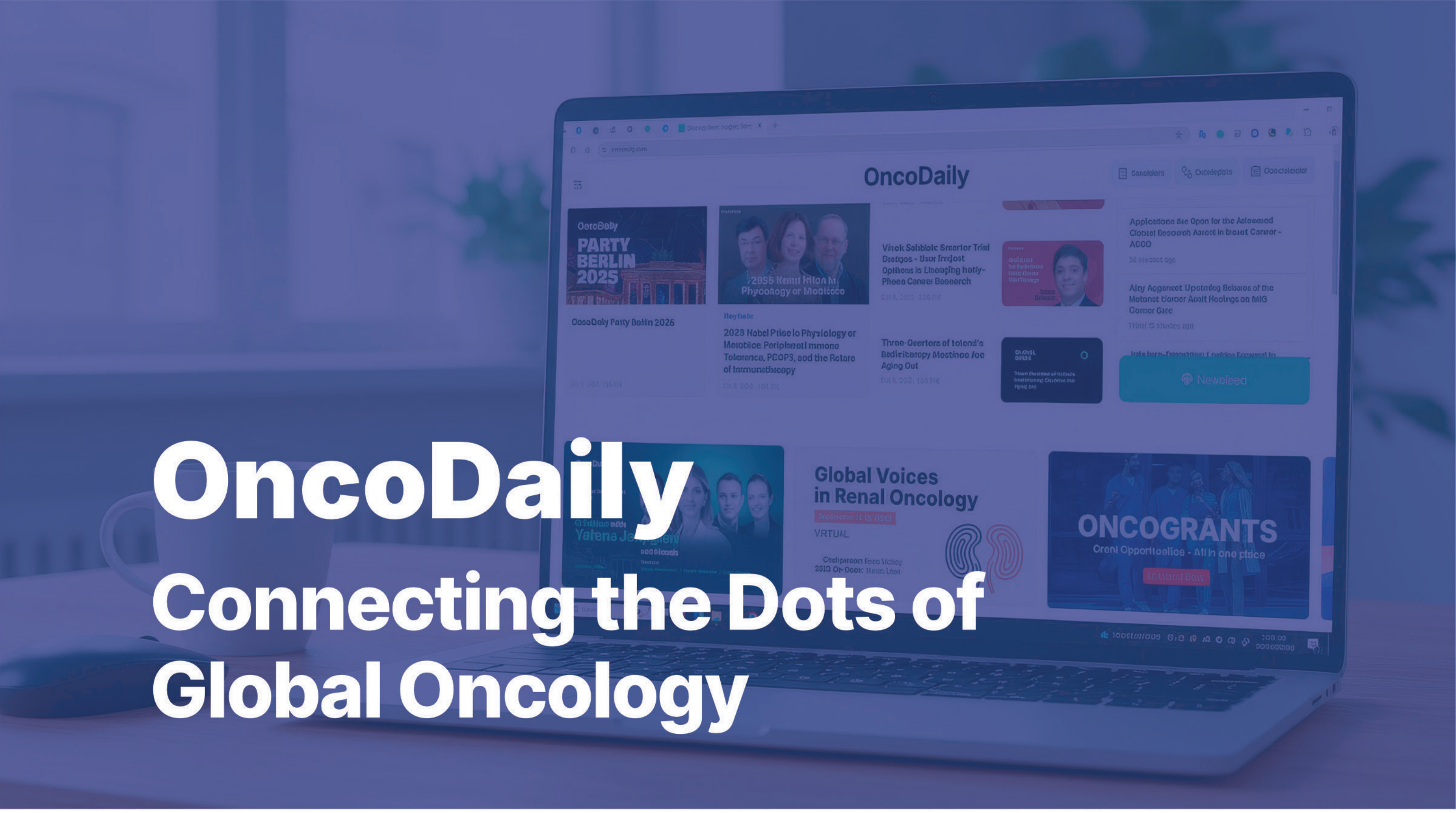
Step back from the five and a pattern resolves. PROTEUS pushes effective therapy earlier, into the curative window. SARC041 and LIBRETTO-432 take clean molecular targets — CDK4, RET — and convert decades of biology into clinical benefit. HARMONi-6 advances a smarter molecule and signals where new drugs will increasingly come from. RASolute 302 topples the most famous “undruggable” target in oncology. Two unifying ideas run through all of them: precision is no longer optional, and we are learning to use our best drugs before the disease has the upper hand. By any honest measure, this was a strong day.

But the spine of every one of these stories is the same, and it is the part the applause cannot resolve. A trial result is a possibility delivered to a population. Turning it into survival delivered to a person requires a test that gets ordered, a drug that gets approved, a system that pays for it, and a clinic close enough to administer it. Each of the five carries an asterisk on at least one of those: a pCR rate still under 10%; an overall-survival signal not yet mature; a comparator that flatters the result; a diagnostic most of the world cannot access; a dataset from a single country; a follow-up too short to promise durability.

None of those asterisks erases the achievement. They define the work that comes next, and that work is mostly unglamorous — guideline committees, reimbursement negotiations, biomarker testing programs, confirmatory trials in the populations that weren’t studied. There will be no standing ovation for any of it.

A standing ovation, in the end, is for the room. It is a profession allowing itself, for ninety seconds, to feel the hope it usually disciplines out of its language. That is not nothing; people who watch patients die of these diseases are entitled to a moment when the curves finally separate. But the measure of ASCO 2026 will not be how loud Hall B1 was on 31 May. It will be whether, three and five years from now, the patient who was never in that room — the one in the regional hospital, in the country without the test, on the waiting list for a drug that launched on another continent — gets to feel any of it too.

That is the asterisk worth keeping. Not as a counterweight to the hope, but as its unfinished sentence.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The Right to Be FORGOTTEN

Why Voluntary Measures are Not Enough for Cancer Survivors

By Cancer Patients Europe

On World Cancer Day, Commissioners Várhelyi and Albuquerque reaffirmed the European Commission's commitment to the right to be forgotten for cancer survivors. Yet their announcement of non-binding guidance to financial institutions in 2026 falls significantly short of what survivors and patient advocates have been calling for.

In response, on 17 April 2026, Cancer Patients Europe (CPE) and Ending Discrimination Against Cancer Survivors (EDACS) issued a joint statement calling for binding EU legislation to protect cancer survivors from financial discrimination. The message was clear: guidance is not protection, and voluntary instruments are not enough.

"At CPE, we have always believed that patient rights do not stop at the clinic door. Survivorship must mean more than being declared cured: it must mean being able to fully rebuild your life. As long as financial discrimination persists, and as long as where you live determines the protection you receive, Europe's cancer agenda remains unfinished. We call on the European Commission and EU policymakers to move from commitment to action, and to deliver the binding framework that cancer survivors across Europe deserve."

- Francisco Rodríguez Lozano, Chair of the Board, Cancer Patients Europe

A Fundamental Right, Not a Technicality

The right to be forgotten is not an administrative nicety. It is a fundamental safeguard against financial discrimination and social exclusion — one that determines whether a cancer survivor can access a mortgage, take out insurance, or obtain credit after being declared cured.

Across Europe, survivors continue to carry a lifelong financial penalty for a past diagnosis. Fragmented, voluntary approaches leave them exposed to inconsistent protection depending entirely on where they live. As the statement puts it plainly, survivorship must not come with a mark.

The legal landscape is not without precedent. Ten EU Member States — France, Belgium, the Netherlands, Portugal, Romania, Spain, Italy, Cyprus, Slovenia, and Malta — have already implemented legally binding frameworks protecting cancer survivors. France, where the right to be forgotten has been in force since 2016, demonstrates that such legislation can be implemented without threatening the sustainability of insurance markets. The evidence exists. In many European countries, the political will has yet to follow.

The Gap Between Commitment and Protection

Although the 2023 Consumer Credit Directive embeds elements of the right to be forgotten into EU law, its allowance of remission periods of up to 15 years risks perpetuating the very inequities it seeks to address. Fifteen years is not a transition period. For many survivors, it is a lifetime of exclusion.

The consequences are not abstract. Financial barriers hinder survivors' ability to rebuild their lives after cancer. They affect long-term quality of life, social participation, and the ability to make the kinds of decisions — buying a home, starting a business, or planning for the future — that define a life regained after cancer.

As CPE and EDACS have consistently argued, the ambition of Europe's cancer agenda cannot be measured only in treatment outcomes. It must extend to survivorship and to what life after cancer actually looks like.

Non-binding guidance, however well-intentioned, cannot deliver this. Voluntary instruments cannot guarantee uniform rights across Member States. Survivors, already navigating the physical, emotional, and financial aftermath of cancer, should not have to depend on the goodwill of financial institutions to protect what should be enshrined in law.

"Cancer survivors have already fought one of the hardest battles a person can face. They should not have to fight another one just to access a mortgage or take out insurance. The right to be forgotten is not a privilege. It is a right. And rights must be enforceable. The Right to be Forgotten is already implemented in 10 countries in Europe, stressing the need to guarantee equal access and protection for all EU cancer survivors. Voluntary guidance will never be enough to guarantee equal protection across Europe. That is why we are calling for binding legislation, because no survivor should be penalised indefinitely for an illness

they have overcome."

- Dr. Françoise Meunier, Founder, Ending Discrimination Against Cancer Survivors

A Clear Call to Action

The joint CPE and EDACS statement sets out a concrete call to action for EU policymakers and institutions.

We call on the European Commission to commit to a harmonised European legal framework on the right to be forgotten, establishing a five-year post-treatment protection period provided there is no relapse. We also call for enforceable protections to replace non-binding guidance, for the systematic involvement of cancer survivors and patient organisations in policymaking, and for EU standards to align with the best practices already demonstrated by Member States.

The statement also raises a broader concern beyond the legislative text itself: patient voices have not been adequately included in shaping the current approach. For an issue that affects survivors' daily lives and long-term futures, this omission is not a procedural detail. It is a failure of the patient-centred principles that underpin Europe's cancer agenda.

What Comes Next

The publication of the statement marks a beginning, not a conclusion. CPE and EDACS will continue building on the political momentum generated by this call to action to ensure that the right to be forgotten becomes a binding, enforceable, and uniformly applied protection across Europe.

The framework already exists in ten Member States. The evidence of its workability is clear. The survivors who need it are waiting. Voluntary promises are not enough. Cancer survivors deserve clear, enforceable rights, and CPE stands ready to work with policymakers across Europe to help deliver them.

The right to be forgotten will also take centre stage during a dedicated session at CPE's Annual Conference 2026, "Europe's Cancer Care Model: From Policy to Action," taking place on 25 June 2026 in Brussels. Bringing together policymakers, patient advocates, and national representatives, the session will explore how to move from political recognition to concrete, enforceable solutions, drawing on existing national legislation and the critical role of patient-led advocacy in driving change.

More information is available on CPE's website.

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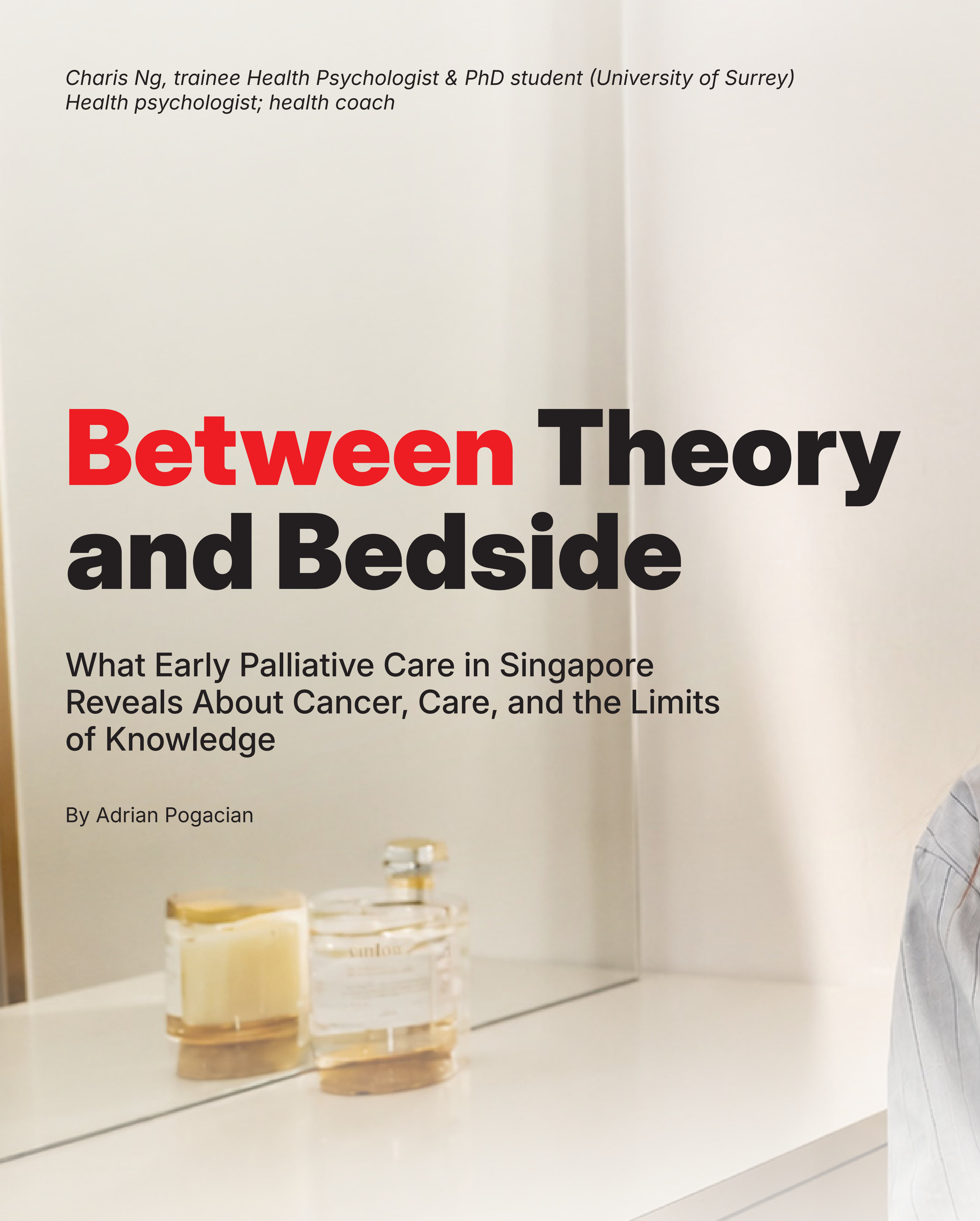
Charis Ng, trainee Health Psychologist & PhD student (University of Surrey)
Health psychologist; health coach



Between Theory and Bedside

What Early Palliative Care in Singapore Reveals About Cancer, Care, and the Limits of Knowledge

By Adrian Pogacian

On paper, cancer care can be mapped, measured, and modelled. In practice, it is far less contained.

For Charis Ng, a trainee health psychologist and PhD student, that gap between theory and lived reality became impossible to ignore during her work in Singapore — where she moved between research, clinical conversation, and the emotional intensity of advanced cancer care.

Last year, she worked as a health coach within ENABLE-SG (Educate, Nurture, Advise, Before Life

Ends–Singapore), a randomised controlled trial led by the National Cancer Centre Singapore. The study tests whether early palliative care support, delivered alongside routine oncology care, can improve outcomes for patients with advanced cancer and their caregivers.

When Palliative Care Starts Earlier, the Conversation Changes

ENABLE-SG delivers structured psychosocial coaching sessions over four to six weeks to patients and caregivers. The sessions focus on symptom management, communication with healthcare professionals, and coping strategies for the psychological burden of advanced cancer.

The intervention challenges a longstanding pattern in Singaporean care, where palliative support has often been introduced later and more reactively.

Instead, ENABLE-SG asks a different question: what happens when emotional and psychosocial support begins at or near diagnosis?

For Ng, the answer was not theoretical — it unfolded in conversation.

"It was the first time I worked directly with patients," she says. *"I had read the theories for years. But nothing prepares you for hearing someone describe what it feels like to be told they have stage IV cancer."*

What stayed with her was not only clinical complexity, but human presence.

"Cancer is never only medical. It reaches into work, family, identity, and belief systems. Sometimes what matters most is simply being heard."

When Theory Meets the Room: Coping in Real Time

Ng's academic work focuses on psycho-oncology, including fear of cancer recurrence and coping behaviours among cancer survivors. Her research draws on established models such as Lazarus and Folkman's stress and coping theory.

But in the clinic, those frameworks did not sit still.

"I could see the theories I had written about happening in real time," she says. *"But I had to stop thinking like a researcher and start responding like a human being in front of another human being."*

The shift was not always comfortable.

Patients did not always cope in ways aligned with psychological models of 'adaptive' behaviour. Some responses were difficult to witness, others conflicted with her academic understanding.

"I had to let go of the idea that theory tells you what people should do," she says. *"My role was to support, not to correct."*

Emotional Labour and the Cost of Listening

Working closely with patients also brought an often unspoken dimension of care work into focus: emotional exposure.

Some patients disclosed experiences they had never shared before — with family, friends, or clinicians.

"It was an honour to be trusted," she says. *"But it also meant carrying a lot of emotional weight."*

This introduced the risk of secondary trauma and compassion fatigue — recognised phenomena in helping professions where sustained exposure to suffering can lead to emotional exhaustion.

The challenge, she explains, was not only professional, but personal.

"In Singapore, conversations about mental health are still emerging. People often hold things in. That meant patients sometimes confided deeply in me because there were few other outlets."

To manage this, she had to actively build emotional boundaries.

Support from colleagues, structured debriefs, and physical activity became essential tools.

One concept stayed with her: the "Worry Chair" — a practice of containing worry to a defined time and space.

For her, it became swimming.

"In the water, I would process everything. But when I stepped out, I had to leave it there."

Despite the emotional strain, she is clear: the work was not damaging — it was meaningful.

"It means you care. The challenge is making sure care does not come at the cost of your own wellbeing."

Health Psychology Beyond the Clinic

Ng sees health psychology as uniquely placed within oncology care — particularly in understanding behaviour, emotion, and decision-making across the cancer journey.

But she is equally clear about its limits if practised in isolation.

At ENABLE-SG, weekly multidisciplinary debriefs ensured that care extended beyond coaching sessions. Patients were referred to social workers, nurses, or clinical psychologists when needed.

"Cancer is not just psychological or medical," she says. *"It is existential."*

Patients often grappled with questions of meaning, causality, and faith — questions no single discipline can fully answer.

This reinforced the importance of integrated care.

"It is easy to stay in academia and write about people," she says. "But being with them changes what you think you know."

From Evidence to Encounter

For Ng, the experience ultimately reshaped how she understands her own PhD.

Research, she reflects, is not separate from care — it is one part of a larger continuum that must remain connected to lived experience.

"It gave meaning to my work," she says. *"Because behind every dataset is a person trying to live their life."*

And perhaps more importantly, it challenged a quieter assumption in academic training: that knowledge alone is enough.

"In practice, knowledge only matters if it can sit alongside humanity."

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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