#119 09 / 2026 ISSN: 2036-9468

CANCERWORLD

The Lifesaver

LOIZOS LOIZOU

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CANCERWORLD
magazine is published
by OncoDaily (P53 Inc)

Email: info@cancerworld.net
Tel: +1 978 7174884

ISSN: 2036-9468

NOT FOR SALE

The history of pediatric oncology is one of extraordinary progress. Children who once had little chance of surviving cancer are now growing into adulthood, building careers, raising families and imagining futures that previous generations could not.

But progress has also exposed the limits of survival as a measure of success. A child's chances still depend too often on where they live and whether they can reach the care they need. Treatment may save a life while leaving late effects that surface decades later. And through it all[A2] , childhood continues—with its need for play, education, relationships and the freedom to become someone beyond a diagnosis.

The September issue of *CancerWorld* explores these realities through the people working to change them.

Our cover stories feature ***Prof Loizos Loizou,*** who helped build pediatric oncology in Cyprus and is now extending that experience to countries with limited resources, and **Cesaltina Ferreira Lorenzoni,** whose work in Mozambique has strengthened pathology, cancer registries and research while advancing African leadership in defining cancer priorities. Their stories show that sustainable progress depends on more than access to medicines — it requires institutions, expertise and partnerships that let countries to build their own capacity.

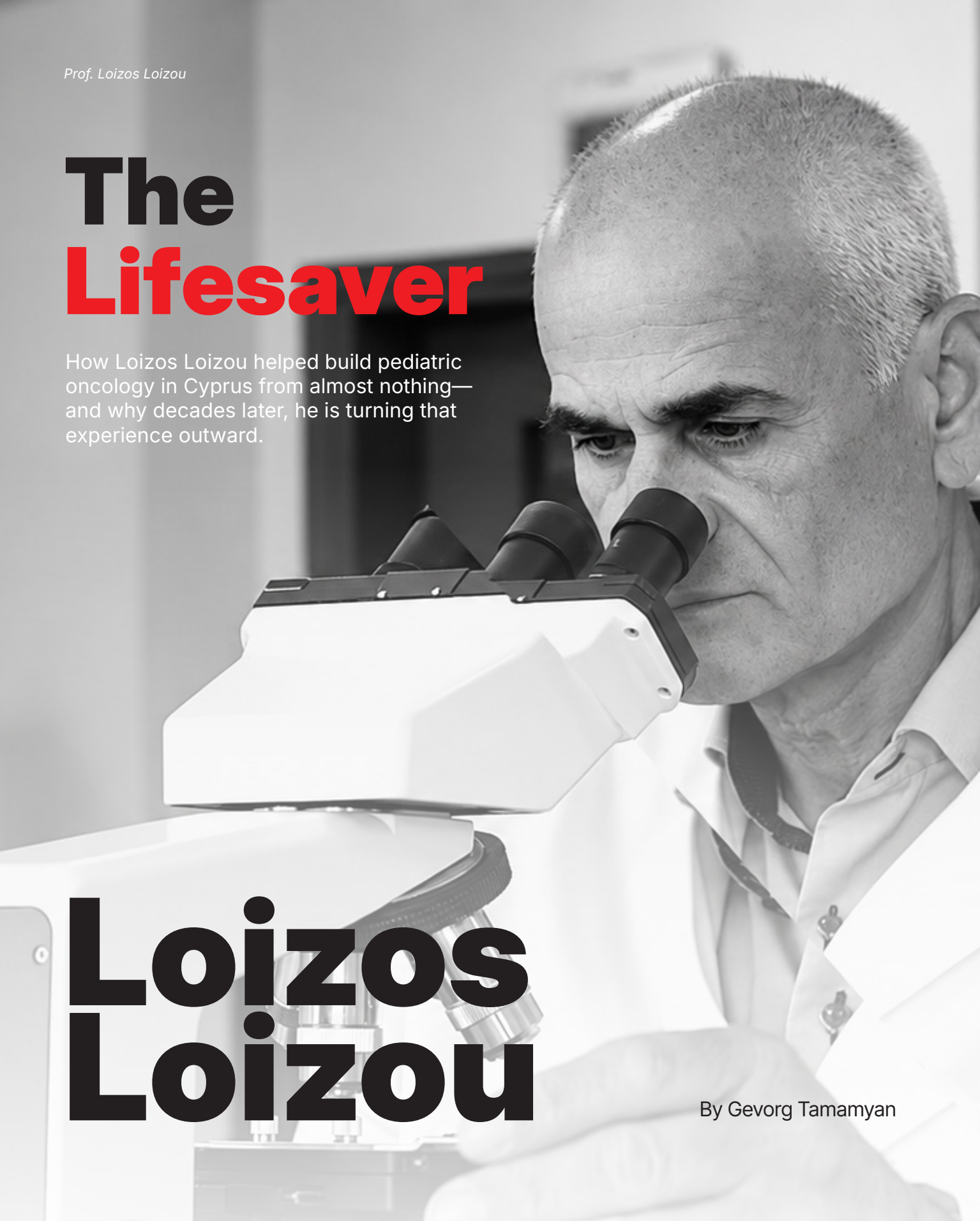
That principle is reflected in ***Victoria Forster's*** account of Tanzania, where childhood cancer survival has risen from less than 10% to more than 50% among children reaching hospital, even as late diagnosis remains a major challenge. ***Janet Fricker*** examines research into chemotherapy-related DNA scars that may eventually help guide more precise treatment and reduce long-term toxicity. ***Brett Wilson's*** story brings the consequences of treatment into human focus: after surviving two childhood cancers, she created the support she and her family never received.

The issue also considers what it means to care for the person beyond the disease. ***Alisa Kamalyan*** explores storytelling as a way for survivors to share experience, reconnect and help others navigate cancer. ***Adrian Pogacian*** examines how family support, communication and education help preserve childhood and adolescence. In *Oncology Couch,* ***Aleksandra Filipović*** reflects on the lessons children offer medicine about listening, uncertainty and the human dimensions of care.

These stories do not diminish the importance of scientific progress. They broaden our understanding of what that progress must achieve. Better treatments, stronger systems and compassionate care are not separate ambitions. Together, they determine whether children can survive, recover and continue developing into the people they were becoming before cancer interrupted their lives.

The promise of pediatric oncology is not simply to add years to a child's life, but to protect the possibility of a life that is still their own.

Knarik Arakelyan, Managing Editor, CancerWorld



Prof. Loizos Loizou

The Lifesaver

How Loizos Loizou helped build pediatric oncology in Cyprus from almost nothing—and why decades later, he is turning that experience outward.

Loizos Loizou

By Gevorg Tamamyan

For more than four decades, Prof. Loizos Loizou has stood on the front line of pediatric oncology.

But when he returned to Cyprus around 1990, there was hardly a front line to stand on.

"There was no diagnostic service. Children were not well managed. Nothing existed, actually."

Cyprus was still living with the consequences of war and division. Childhood cancer care was fragmented. There was no registry, no dedicated system, limited access to medicines, and little specialized expertise.

Loizos Loizou had come home to build almost everything from zero.

More than three decades later, Cyprus has a modern pediatric oncology service, a population-based cancer registry and survival outcomes approaching those of the most advanced centers.

And now, having once depended on help from abroad, Prof. Loizou is trying to make Cyprus a country that gives it back.

"We received help from many countries," he says. "Now we try to help the way we received."

A Lifesaver Before Medicine

Loizos Loizou was born in Larnaca, Cyprus.

Long before medicine became a profession, helping people had already become part of his character.

"When the time came to study, I wanted to do something that would be useful to people," he says. *"I always had the tendency to be helpful to people. It's in my mentality."*

As a teenager, he even worked as a lifesaver in Larnaca and trained in first aid.

"I was very interested in medical issues. So when the time came to choose, I chose medicine."

He studied medicine in Belgium, in Brussels, before continuing his pediatric training in France.

Pediatrics came first. Pediatric oncology came later. During his specialization, after working in neonatal medicine and intensive care, he encountered a growing need for physicians willing to enter pediatric oncology.

He was already carrying one image with him.

"I remember when I was in the fourth year of medicine, I saw a young adolescent girl who had been amputated because of an osteosarcoma," he recalls. *"It was quite shocking. I had an interest in cancer in general."*

So when the opportunity appeared, he took it.

"For the last more than 40 years, I'm on the first line in pediatric oncology. I never regretted it."

Why?

"Because I feel that we're doing something difficult, but something challenging. It's challenging psychologically. It's challenging medically and scientifically."

Prof. Loizos Loizou with a team

Starting From Zero

While training in France, Loizos always intended to return home.

He followed developments in Cyprus through a weekly newspaper. One thing became increasingly clear: children with cancer needed a dedicated service.

"It didn't exist in Cyprus," he says. *"It was a completely unorganized situation."*

When he returned in late 1989–1990, the scale of the task became obvious.

"There were low survival rates, no diagnostic facilities, no medicines the way they should be, no registries. Nobody knew what was happening."

For Prof. Loizos, that experience would later shape the way he looked at childhood cancer in low- and middle-income countries.

"Cyprus was in that situation at that time," he says. "Imagine Cyprus of the 1980s and 1990s. It was a few years after the war and the Turkish occupation of almost half of the island. The situation was not good." He began with the basics.

"Immediately, I realized that there was a need to train nurses, doctors, pathologists, surgeons, anesthetists—actually, from scratch."

He also pushed for children with cancer to be treated in one centralized pediatric oncology unit.

"Everything was concentrated in a single unit," he says. *"So we gained more expertise, because these are rare diseases. This was fundamental."*

But building a service inside the public system required resources and flexibility that the system itself could not always provide.

That was why, in 1990–1991, he created the Elpida Foundation.

"It was difficult to convince the public service," he says. "By creating Elpida, I had the financial capacity." Through philanthropy and fundraising, the foundation began supporting the development of pediatric oncology—training professionals, financing education abroad and strengthening the system around the hospital.

"We were able to send nurses and doctors to the United Kingdom and elsewhere—more than 100 doctors and nurses—and we're continuing that through the Elpida Foundation."

It was never one intervention.

"It was a holistic approach," he says. "A multi-pronged approach."

And it was slow.

"Things didn't happen from one day to the other. It was a very slow evolution."

The Numbers Had to Come First

One of the achievements Prof. Loizou speaks about with particular pride is not a new drug or a new building.

It is data.

"First of all, we have been able to build a pediatric oncology registry—population-based, very robust."

The registry was developed in cooperation with Newcastle University, with the first two decades of data, from 1998 to 2017, published and the next decade now being prepared.

For Loizos Loizou, the distinction between a hospital registry and a population-based registry matters.

"If we manage a problem without knowing what happens, we wouldn't know what was happening."

He points to quality indicators including more than 95% microscopic verification, zero cases registered only from death certificates, and external quality checking.

"We are proud that we have been able, first of all, to establish a registry."

At the same time, the clinical service continued to develop.

Today, Cyprus has a modern pediatric oncology unit capable of delivering most treatments locally. When highly specialized procedures are required—such as allogeneic bone marrow transplantation or complex brain surgery—children can be referred to centers in countries such as Germany or France.

The results improved with the system.

"If you compare the survival rate of the first decade with the second decade, the rates are much better in the second decade," he says.

The reason, he argues, was not a single breakthrough.

"We built it slowly, slowly—experience, modern medicines, prophylactic antimicrobials, growth factors, everything."

And, crucially, international help.

Prof. Loizos Loizou

The People on the Other End of the Phone

For many years, Loizos was the only pediatric oncologist in Cyprus.

He knew he could not know everything.

So he built an international multidisciplinary team before such language became fashionable.

"My mentor was Professor Danielle Olive-Sommelet, my professor of pediatric oncology in Nancy, France," he says. *"She trained me in pediatric oncology, and when I came back to Cyprus, many times I was calling her."*

But she was only one of many.

"I have to express a lot of gratefulness and thanks to many colleagues because I was alone as a pediatric oncologist in Cyprus for many years."

He remembers specialists abroad telling him: call us, even at three o'clock in the morning.

"I couldn't know everything. I needed help, and there was no help in Cyprus."

He sought different experts for different diseases—leukemias, Wilms tumor, brain tumors.

Among them was Eric Bouffet.

When Prof. Bouffet moved to Canada, distance did not end the collaboration.

"With the means of those times, we used ISDN lines in my department," Loizos recalls. *"We made video conferences. I showed the children, we saw the CT scans and MRIs, and he advised me."*

Cyprus and Canada were separated by thousands of kilometers and several time zones.

But for a child with a brain tumor in Nicosia, expertise could suddenly enter the room.

"I received a lot of help, especially in the first 15 years," he says. *"That was substantial."*

"You Mean Now I'm Finished?"

More than 40 years in pediatric oncology creates a difficult archive of memory.

Asked which patients stayed with him, Loizos pauses.

"This question is very difficult for me, because each child has so much to teach us, and we get attached to them."

One memory comes from the early 1990s.

A highly intelligent adolescent boy had aggressive leukemia. He went through first-line therapy, second-line treatment and transplantation, but the disease kept progressing.

"He always wanted to speak with me alone, man-to-man," Loizos recalls. *"He didn't want anybody else. And he was putting me very difficult questions because he understood everything."*

Then came the question no physician wants to hear.

"At a certain moment, he saw me in the eyes and said to me, 'My friend doctor, you mean now I'm finished? I have no hope?'"

Loizos still remembers it.

"When an adolescent of 16 or 17 asks you that—it was really heartbreaking. I will never forget."

And then there are the patients who survived because medicine changed just in time.

The Drug That Arrived by Air

Around the mid-1990s, an adolescent arrived at Makarios Hospital with acute promyelocytic leukemia. At the time, the disease could be catastrophic.

"As soon as you started therapy, they had huge hemorrhage and you lost the patient."

But Loizos had been following emerging evidence around ATRA-based treatment.

"I knew that if you gave it with chemotherapy, like we do now, they survived," he says. *"At that moment, I just knew it was experimental. I didn't even know if it was approved, but I knew it was successful."*

He went to the Minister of Health.

"I said, 'We have to do it.'"

Calls were made. The national airline became involved. The drug was located and transported to Cyprus within days.

"We started the therapy."

The boy survived.

"He is an adult now. I see him sometimes. He is working at the airport. I'm always so glad to meet him."

For Prof. Loizou, the story is about more than one medicine.

"That's an example of how a new therapy saves lives," he says. *"We should always remember how important it is to be continuously updated."*

One Joke Before Every Examination

Another patient taught Loizos something different.

She was 15, undergoing cancer treatment and struggling deeply after losing her hair.

"She was very depressed in the beginning," he says. *"I always try to make the children laugh, give them a nickname, and make a special bond."*

He tried jokes.

At first, he could only get a small smile.

Then one day she stopped him during rounds.

"She said, 'Doctor, from now on, I will never allow you to examine me.'"

He was stunned.

Then came the condition.

"'You have to tell me a joke every day. Whenever

you enter the room, you tell me a joke, and then you examine me.'"

"Deal," he replied.

Then he went out and bought a book of jokes.

Today, she is a lawyer.

"She's a bright adult woman. She's a friend of mine now."

For him, the story represents another side of oncology.

"Psychology is important," he says. *"The treating physician also has to make contact with the child. I believe the holistic approach is of cardinal importance."*

"The Patient Must Be Your King"

Asked about the best advice he ever received, Loizos does not offer a famous quotation.

He goes back to his parents.

"My parents taught me to love people. Each person, no matter the color, is a person that we should help and love. That's the basis of my education."

And then he gives the advice he now passes to younger doctors.

"The patient must be your king."

He repeats it deliberately.

"You are at the service of people, and not the contrary. We are there to support people."

There is one behavior he particularly dislikes.

"Never show that you are in a hurry in front of patients."

For pediatric oncology, he makes it even more specific.

"The child and their parents must be your king. That means you are at their service."

Prof. Loizos Loizou with a team

From Receiving Help to Giving It

By 2023, Prof. Loizou felt Cyprus had reached another turning point.

For decades, the country had learned from others. Now it could help.

"We gained significant experience over 30–35 years," he says. *"We had been exactly in the same position that less affluent countries are in today."*

He knew what it meant to lose children because medicines were unavailable, expertise was insufficient or infrastructure did not exist.

So Cyprus launched the **Cyprus International Action Plan for Children with Cancer,** supported principally through the **Elpida Foundation** and built in cooperation with governmental, academic and medical institutions.

"The question is: why Cyprus?" he says. *"Because Cyprus has experience. We believe we are strong enough to help. It's a gateway to Europe, and financially we could cope."*

The initiative also has active support from the Cypriot government.

The program began collaborating closely with French pediatric oncology partners working across Africa.

In 2024, shipments included chemotherapy, antibiotics and analgesics for sub-Saharan countries. In 2025, Cyprus brought together more than 30

international experts for the inaugural convention of its international program.

Then the scope expanded.

"We sent medicines for tuberculosis because it was asked from Botswana. Now we are sending vaccinations for HPV."

Over the past three years, Prof. Loizou estimates that the initiative has organized more than a dozen shipments.

"Last year, two tons of medicines to Botswana," he says.

Other shipments have been much more targeted: chemotherapy for approximately 70 children with Burkitt lymphoma in Burkina Faso, medicines to Côte d'Ivoire and Morocco, and a year of oral chelation treatment for children with thalassemia at a pediatric hospital in Rabat.

But Loizos Loizou does not want the initiative to become simply a shipping program.

"Our purpose is not only to provide the medicine and know-how. At the same time, it builds capacity."

The plan includes short-term scholarships—initially two, four or six weeks—for doctors and nurses, with training in areas such as central venous lines, interventional radiology, leukemia diagnosis and pain management.

"If the capacity can be offered in Cyprus, we will offer it in Cyprus. If not, then in France or elsewhere."

The first phase is being developed with French-speaking pediatric oncology partners working across 18 African countries and around 25 pediatric oncology centers.

Eventually, he wants to go further.

"Our plan is also to expand it to English-speaking countries—for example, Botswana, Ethiopia, Tanzania."

Then he adds:

"Step by step."

Small Country. Big Initiative.

Loizos Loizou is realistic about scale.

Cyprus cannot solve the global childhood cancer crisis.

But that is not his measure of success.

"We're a small country, but today I believe there are not small and big countries. There are small and big initiatives. It all depends on the people."

He is equally clear that Cyprus is not trying to replace the work of WHO, St. Jude or other global organizations.

"The problem is so big, and the situations are so difficult. Cyprus can add a little bit to this effort."

A little bit, in pediatric oncology, can mean an entire life.

"We're not going to make the big difference," he says. *"But we will do as much as we can."*

Then comes the sentence that perhaps best summarizes his career.

"Even if we can alleviate the pain for one child—even if we can save the life of one child—that would be good."

Prof. Loizou is now over 70 and increasingly thinking about continuity.

"I started training my young colleagues because my age advances. It's important that we train the new generation."

The work, in other words, must outlive the person who began it.

More than three decades ago, Loizos returned to a country where pediatric oncology had almost no organized structure and spent years asking others for advice, medicines, training and help.

Today, Cyprus is beginning to send those things in the opposite direction.

His philosophy for the next chapter is simple.

"It's a program that gives without asking anything."

And then, as if four decades in pediatric oncology have reduced everything to one principle:

"We try to help."

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Brett Wilson

"Go Be Normal"

The Childhood Cancer Survivor Who Built What Her Family Never Had

By Knarik Arakelyan

When Brett Wilson finished cancer treatment at the age of 12, a hospital nurse walked outside with her and her mother and offered three words of advice:

"Go be normal."

Wilson looked at her mother.

"What does that mean? Go be normal. I've been in a hospital for eight years. I have no friends. I have no communication skills with anybody else."

She had survived what statistically she was never expected to survive. But neither she nor her mother had been given a roadmap for what came next.

That moment would eventually become a promise: *"One day I'm going to create a center to help other families like ours so they don't go through the journey the way we did."*

In 2012, she incorporated the Walking Miracles Family Foundation, named after what her grandmother had called her following her first cancer diagnosis: a "walking miracle."

After spending eight years of her childhood in hospitals, Wilson turned decades of survivorship, late effects and isolation into a mission to help children, adolescents and young adults navigate what cancer care too often leaves unseen.

A Childhood Cancer Took Away

Wilson was just 22 months old when she was diagnosed with leukemia in 1974. Growing up in rural West Virginia, her family had few resources, little information and no guidance about what cancer treatment or survival might mean.

Across two cancers, she would spend a total of eight years in hospital.

"I missed my whole childhood," she says. She had few friends, was bullied, gained weight because of treatment and prednisone, and lost her hair three times. She remembers feeling like "one of the toys on the island of toys"—separated from other children because others saw her as broken.

"This is nothing I asked for," she says.

Doctors initially gave her a year to live. She survived, only to develop non-Hodgkin lymphoma at nine. The disease wrapped around her throat, and complications around anesthesia led to her dying twice.

"I survived something that I wasn't supposed to," Wilson says. *"If you look at the statistical anomaly of my life, I'm not supposed to be here."*

Today, she is more than five decades from her first diagnosis and more than four decades from her second. Her faith has been central to how she understands that survival.

"It just makes me thankful that I'm still able to get up, put two feet on the ground and I'm still here."

But survival came with consequences no one had prepared her for. Decades later, Wilson developed serious cardiovascular late effects, including heart failure and aortic stenosis, alongside lasting effects from the intensive cranial radiation she received as a child.

She had survived cancer. Now she had to understand what survival meant.

Building What Was Missing

Wilson's experience taught her that medicine can save a life while still missing much of what determines whether someone can live that life afterward.

One of the first problems she addressed was intensely practical: distance.

For families in rural West Virginia, reaching major treatment centres can mean driving two or three hours each way, sometimes several times a week.

"No one has that kind of money to keep going two and three days a week," Wilson says.

Travel assistance became the first program she developed. It eventually expanded across all 55 counties of West Virginia, with her work later extending into Pittsburgh.

But Wilson wanted to address more than logistics. She earned a degree in counselling from Marshall University in 1998 because, she says, *"I wanted to counsel cancer patients."*

At a time when counselling was not yet embedded in cancer care as it is today, she sought guidance from psycho-oncology pioneer Dr Jimmie Holland at Memorial Sloan Kettering. Holland encouraged her to build a "spoke and wheel" model: Wilson could not meet every need herself, but she could become a central point connecting

people with the services they needed.

Training through the Harold P. Freeman Patient Navigation Institute later helped her turn lived experience into navigation—connecting families with resources, expertise and support that she and her mother had struggled to find.

Walking Miracles Family Foundation in West Virginia

Seeing What Medicine Can Miss

Wilson remains frustrated that lived experience is still not always recognised as expertise within survivorship care.

"Professionally, people don't look at me as an equal because I don't have an M.D. by my name or I'm not a nurse," she says. "But yet I've got lived experience of more decades than they have ever had to learn all of this stuff."

For Wilson, failing to recognise that experience is ultimately a disservice to families.

She remembers one young patient from West Virginia preparing to travel to Ohio for a bone marrow transplant. Clinicians saw depression. Wilson asked her why she was sad.

She had never left West Virginia. Her disabled father could not accompany her. She knew nobody where she was going.

Wilson connected her with someone she trusted at the receiving hospital and promised to remain involved.

"Her attitude literally just changed," Wilson recalls.

The young woman ultimately did not survive the transplant. But the encounter crystallised something Wilson had understood through her own life: emotional distress cannot always be separated from the practical realities surrounding treatment.

For Wilson, this is what medicine can still too easily miss: the person living inside the diagnosis.

The Unspoken Cost of Survival

For all the progress Wilson has witnessed since 1974, one gap remains painfully familiar.

"There still is not any education on the long-term side effects of cancer treatment," she says.

Wilson distinguishes medical follow-up from genuine survivorship education. Her mother understood the importance of continuity long before formal survivorship plans became common. She kept calendars and notebooks recording appointments, treatment changes and what was happening to her daughter over time.

Yet even with those records, they did not know how to connect what had happened during childhood treatment with the health problems that could emerge decades later.

Wilson is now developing an extensive educational curriculum called ***"The Unspoken Cost of Cancer".***

The title captures something central to her experience: the cost of cancer is not only medical.

"Nobody sees the money, nobody sees the caregiver, the grandmother, everybody having to come together to fix the problem," she says.

In rural communities, cancer can mean long journeys to treatment, cars worn down by repeated travel, childcare costs and entire families reorganising their lives around one person's care. These are burdens Wilson believes remain too often invisible.

She is equally troubled by the tendency to diminish childhood cancer because it represents a comparatively small percentage of overall cancer diagnoses.

For Wilson, percentages can obscure what is actually being counted: children, families and futures.

If a child dies, she argues, a family has not simply lost one person. ***"You lost a whole heritage... There's***

generations that are affected by this that nobody looks at."

Survival Without a Map

Cancer has never become an easy identity for Wilson.

"I never wanted cancer to be part of my identity," she says. *"But yet, on the other hand, I can't run from it and I'm not going to be embarrassed by it."*

Survival did not automatically end the isolation that began in childhood. Her history has affected friendships, relationships and even ordinary conversations. Yet she refuses to let that isolation stop her from helping others.

"It doesn't stop me because I know that there are going to be other children, there's going to be other mothers that are going to be treated the way that my family is."

Janice Bowen - Brett's Mother and Biggest Supporter

And throughout Wilson's story, her mother remains an important presence.

She is now 80, but Wilson says she still wonders whether there were things she should have known or ways she could have helped her daughter differently.

"My mom's 80. She still says, 'I wish I had known. If I had known this, if I had known that...'"

That continuing sense of guilt helped shape Wilson's educational work. Drawing on established medical information and her own lived experience, she has tried to translate survivorship knowledge into language families can understand—and into language that can ease the guilt, shame, fear and uncertainty parents may carry.

"Yes, mom, you're doing everything right. Yes, mom. No, mom, you didn't miss anything."

A Purpose Born From Survival

Asked what the little girl she once was would understand if she could see her life today, Wilson's answer comes back to purpose.

"That at one, it was my purpose. Two, that everything that I went through happened for a reason. And three, God made me strong enough that I could get through it so I could be the light of hope for somebody else going through it."

Faith is deeply personal to Wilson, but the purpose she describes has taken a practical form: helping families find information, financial assistance, navigation and reassurance when cancer has made their world uncertain.

For 14 years, Wilson says, she has largely run Walking Miracles herself. Grants and public-health partnerships have helped sustain the organisation, but she has consistently directed resources toward the patients and families she set out to serve.

"I didn't do what I'm doing for money," she says. *"I did it because my mom and I didn't have any help. And I knew what it felt like to be helpless and to not have resources and to not have the answers that I needed to have so I could move on in my own personal life and my own personal journey."*

More than half a century after her first diagnosis, the connection between the little girl Wilson was and the work she does today is remarkably clear.

At 12, she left the hospital being told to "go be normal."

Instead, she built what she and her mother had needed all along: someone to help families understand what comes next.

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

Alisa Kamalyan

Behind Every Diagnosis, There is a Story: Healing Through Storytelling in Pediatric Oncology

By Alisa Kamalyan

Behind every cancer survivor is a long journey of treatment and care — the result of the expertise, dedication and countless decisions of a large multidisciplinary medical team.

And yet, beyond every diagnosis, there is also a story. Illness changes more than the body, it changes a person's story about themselves. It can alter how people understand themselves, imagine their future and locate their place in the world. The medical record documents what happened to the disease. ***Storytelling helps us understand what happened to the person.***

Stories create space for what clinical documentation cannot always capture: fear, isolation, relationships, identity, hope, loss and the difficult work of making sense of life during and after cancer. They remind us that the patient in front of us is also a child or young person with a history, a family and a future extending far beyond treatment.

And sometimes the most meaningful reassurance comes from someone who has already lived through what another child is only beginning to face. A survivor's story does not replace medical information or professional psychosocial support. It offers another kind of knowledge: the recognition that someone else has been here before me.

When a Personal Story Becomes a Form of Care

This idea was at the centre of a dedicated storytelling session organised by World Child Cancer USA, OncoDaily and Act4Children during the CCI Asia Symposium at the SIOP Asia 2026 Congress in Ulaanbaatar, Mongolia. The event was supported by an unrestricted educational grant from Servier.

Chaired and moderated by Dana Bryson, Board Chair of World Child Cancer USA and a social impact strategist, the session explored how survivor narratives can strengthen psychosocial support, build peer connection and contribute to more patient-centred communication. But it also asked a larger question: how can an individual story move beyond personal experience and help change communities and systems of care?

Vietnamese youth activist and cancer patient advocate Nhi Tran offered one answer. An advocate since the age of eight and co-founder of The Sharing Kitchen, she spoke about overcoming self-doubt, finding the confidence to speak from the heart and using personal experience to create connection, hope and action.

Her contribution underscored something fundamental: telling your own story can itself be an act of courage.

From left to right - Nhi Tran, Dana Bryson, Alisa Kamalyan, CCI Asia Symposium at the SIOP Asia 2026 Congress

I approached the question from another perspective—that of a clinical psychologist working in pediatric oncology. At the Yeolyan Hematology and Oncology Center in Armenia, where I lead Psychosocial Services, we began with a deceptively simple question: What if survivors could speak directly to children who were just beginning the journey they had already completed?

The question became the foundation for Blossoming Trees: Conquering the Cancer Treatment Journey, developed together with oncologist Sergo Mkhitaryan and our Psychosocial Services team.

The book brings together the experiences, lessons and insights of pediatric cancer survivors and offers them to children and families facing treatment today. Its structure follows the cancer journey itself—from the shock of diagnosis and the uncertainty that follows, through the inner struggles of treatment, to its completion and the transformation that can come with survival.

Each story is individual, but together they create something larger—like branches of different shapes growing from the same tree.

Presentation of the book "Blossoming Trees: Conquering the Cancer Treatment Journey" at the International Society of Paediatric Oncology – SIOP 2025 Congress

The Story Still Belongs to the Survivor

Creating Blossoming Trees also raised an important question about how storytelling should be used in psychosocial care.

A survivor's experience is not simply material to be collected. The story belongs to the person who lived it.

That means storytelling must be a shared and respectful process. Survivors need space to decide what they want to tell and how they want their experience understood. The professional's role is not to take ownership of that narrative, but to create the conditions in which it can be safely explored, shaped and heard.

In developing the book, survivors were approached and interviewed, their stories collected, recurring themes identified and individual narratives organised around different stages of the cancer journey—while preserving the voices and meanings of those who shared them.

One survivor captured the spirit of the project in a single line:

"Every day is a gift. Find a small point of light and make it bigger."

For me, this captures the potential of storytelling in pediatric oncology.

A story cannot remove a diagnosis. It cannot make treatment disappear or eliminate uncertainty. But it can change how a person experiences the journey.

A child beginning treatment may hear a survivor's words and recognise something of themselves. A parent may discover that fears they believed were theirs alone have been carried by other families. A survivor may find that an experience once defined by illness can also become a source of meaning and connection for someone else.

A small point of light can become a larger one when it is shared.

Making Room for the Person

The Armenian edition of Blossoming Trees was published with the support of the City of Smile Foundation. The book has since been translated into English and is freely available through Act4Children's resources.

But the larger message extends beyond one book or one congress session.

Storytelling can be a meaningful patient-centred psychosocial tool in pediatric oncology. It can reduce isolation, restore voice and identity, help people make sense of difficult experiences and support survivors in integrating cancer into the wider story of their lives.

For healthcare professionals, listening offers something equally important: a window into the emotional and social realities that may never appear in a medical record.

The message we hoped to leave with participants in Ulaanbaatar was therefore simple:

Create space for stories to be told.

Because behind every diagnosis, there is a story.

And when oncology makes room for that story, we do more than understand the disease.

We begin to understand the person living through it.

About the Author

Alisa Kamalyan is a Clinical Psychologist, Head of Psychosocial services, at Yeolyan Hematology and Oncology Center, MoH, and Co-Chair of SIOP GHN Psychosocial Wellbeing WG.

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Chemotherapy DNA Scars May Predict How Childhood Cancers Evolve

By Janet Fricker

Nearly half of childhood tumours treated with commonly used chemotherapies acquired detectable treatment-related DNA changes within 18 months. The international study, published in Nature, demonstrates the potential of Precision Child Health, combining genomic data with treatment histories to understand how therapies shape the evolution of a patient's cancer over time and to tailor treatment strategies that could reduce long-term toxicities.

"What surprised us about childhood cancers was the sheer burden of therapy-associated mutations," Adam Shlien, the senior author, tells Cancer World. *"This is the deepest exploration of therapy [related] mutational signatures in childhood cancer using whole-genome sequencing. Defining the interaction between signatures and treatment could, in the future, help clinicians detect signals of therapy resistance long before they become clinically visible."*

The genomic signatures identified in the study, the team from The Hospital for Sick Children (SickKids) in Toronto, Canada, believe, could eventually serve as biomarkers, providing an early warning system for children undergoing cancer treatment. "Ultimately, the goal is for clinicians to use these biomarkers to identify patients whose chemotherapy could be safely de-escalated, or to intervene as early as three months after treatment begins if they detect genomic signatures that suggest the tumour is evolving in a concerning way," says Mehdi Layeghifard, Senior Research Associate in the Shlien Lab.

Chemotherapy Remains Double Edged Sword

Over the past 50 years, survival rates for childhood cancer have improved dramatically, with more than 85% of children and young people now surviving their disease. However, chemotherapy remains a double-edged sword. While highly effective at killing cancer cells, it can also damage healthy tissues, leading to lifelong health consequences, including heart disease and an increased risk of developing secondary cancers years or even decades later. The biggest difference between childhood and adult tumours, explains Shlien, is that adult tumours are often driven by external mutagens leaving characteristic mutational signatures; whereas childhood cancers are more often caused by inherited mutations or de novo mutations arising during development.

Because most studies have genetically profiled paediatric cancers only at diagnosis, the mechanisms underlying tumour progression, therapy resistance, and metastasis have been poorly understood.

For the current study, Shlien and colleagues set out

to explore how much of the DNA damage seen in relapsed childhood cancers is caused by the treatments used to treat them, and whether treatment-induced DNA changes can help predict tumour evolution and resistance?

For the study, researchers analysed 611 tumours from 544 children and young adults (median age 7.8 years females, 8 years males) with aggressive or poor prognosis disease enrolled in three separate whole genome sequencing-based programmes in Canada (SickKids Cancer Sequencing, KiCS), Australia (ZERO), and the USA (Memorial Sloan Kettering). The unique approach involved combining whole genome sequencing with detailed medical records and advanced computational methods.

The investigators explored exposure to 86 types of therapy in 13 drug classes, as well as radiotherapy, and created a detailed record of cycle dates, doses, and routes of administration for each child. They also recorded the number of drugs or other treatments the cancer patients had been exposed to, looked for mutation patterns in tumour DNA linked to specific chemotherapy agents, and tracked when these first appeared after treatment. The team worked with Ludmil Alexandrov (University of California San Diego), using his machine-learning technology to identify the most important features in each signature.

Platinum-based chemotherapy Exerts Biggest Effect

Results showed across 611 tumour genomes from 544 children, the team identified 69 mutational signatures, including 20 previously undescribed patterns. Fifteen were found exclusively in treated tumours, providing evidence of therapy-associated mutagenesis.

Among the most striking findings was the genomic footprint of platinum-based chemotherapy, including cisplatin, carboplatin and oxaliplatin, which was given to almost half of the treated patients. Within 18 months of treatment, 48% of exposed tumours showed a detectable platinum-associated mutational signature.

The principal platinum-associated signatures were SBS31 and SBS35, representing distinct patterns of single-base substitutions, together with DBS5, a pattern of double-base substitutions.

Temozolomide also left a detectable genomic footprint. The study identified an association with SBS288L3, while the previously recognised temozolomide-associated signature SBS11 was uncommon and difficult to detect.

For 5-FU, the expected SBS17b signature was observed in two of three exposed tumours, although the small number of cases meant that the association did not reach statistical significance.

For thiopurines, the researchers found an intriguing tissue-specific pattern: the SBS87 signature, previously associated with thiopurine exposure, was detected in leukaemia and lymphomas but not in the four non-haematological cancers exposed to these drugs.

Radiotherapy produced a different genomic footprint, with treatment-associated patterns of DNA insertions and deletions (indels) and copy-number alterations, rather than predominantly single-base substitutions.

Importantly, the team found that DNA signatures left by chemotherapy were associated with drug-resistance pathways, with platinum-associated signatures linked to increased expression of genes involved in platinum detoxification and drug efflux, as well as poorer clinical outcomes.

The team went on to validate the results in adult datasets, suggesting broader clinical relevance. "We found that adults exposed to the same therapies developed the exact same signatures. It does appear that treatment-induced mutational processes are conserved across age groups despite the differences between childhood and adult cancers," says Shlien.

Now that they have comprehensively defined which therapy-associated mutation patterns are acquired in childhood cancer, and when they emerge, Shlien hopes to start screening patients for these signatures to detect drug-resistant clones. "The dream - and we are still many years away from realising this - would be to use these signatures to guide treatment de-escalation so that children can ultimately avoid some of the toxic effects of chemotherapy," says Shlien.

About the Author

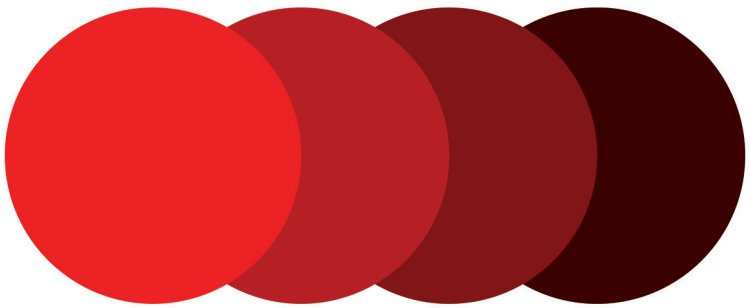
Janet Fricker is a UK medical writer with an MA in Physiology from the University of Oxford. She is the News Editor of CancerWorld. Janet has worked for the Cancer Drug Development Forum, Cancer Research UK, Lancet Oncology, European Journal of Cancer, Molecular Oncology, Ecancer Medical Science, and 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.

#119 09 / 2026 ISSN: 2036-9468

CANCERWORLD

Pathologist
Who **Built a System**

Cesaltina Ferreira Lorenzoni



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Cesaltina Ferreira Lorenzoni,
The President of AORTIC

Making Cancer Visible in Lusophone Africa

The Pathologist Who Built a System

By Gevorg Tamamyan

Gevorg Tamamyan: Take me back before medicine. Who was Cesaltina Lorenzoni as a child in Mozambique, and what was the moment you knew you wanted to be a doctor?

Cesaltina Ferreira Lorenzoni: *I was born and raised in the capital of Mozambique, Maputo, in a medium-income family, and lived in a well-structured neighbourhood.*

From an early age, I understood the importance of pursuing high levels of education and knowledge, with the systematic support of my parents with school and homework; they always encouraged that competitive spirit when it came to school.

At that time, my older brothers were already attending university.

I have always felt called to help others, especially those in greater need, and I saw the medical pathway as a way to accomplish this objective.

I grew up in Mozambique at a time when the country was going through significant changes. I think, even as a child, I was very curious about people, about how things worked, and especially about why things happened.

Medicine was not simply a career choice for me. It gradually became a way of understanding the human being and, ultimately, a way of serving people. I was attracted to the combination of science and humanity - the idea that knowledge could actually change someone's life.

I cannot pinpoint a single, dramatic moment when I decided to become a doctor. It was more of a conviction that grew stronger as I grew older. I knew I wanted a profession where I could use science, but where what I learned could have a direct impact on another person's life.

Gevorg Tamamyan: Of all the fields, you chose pathology. It is not the one young doctor's dream about. What drew you to it?

Cesaltina Ferreira Lorenzoni: *I did choose pathology, though not really as my first option; it was mostly due to the country's greater need at that time.*

There were only 3 Mozambican pathologists at that time, and 2 of them worked for our biggest hospital; for 10 years, no one else was joining this sub-field of medicine.

The health services were completely degraded, and there was no incentive for improvement to be made.

It was an unattractive sub-field, and there was a taboo at the time, that pathology was basically just about autopsies.

Despite it all, I thought that, even with the challenges, I could make significant and impactful contributions to this area; I wanted to develop cancer registries, contribute with the knowledge I had, and impact the generations coming after me.

I wanted to understand cancer epidemiology and contribute to policy-making that would mitigate it, as well as contribute to research. I saw all those opportunities in this sub-field.

That was when I turned challenge into opportunity.

Pathology attracted me because it is where medicine meets evidence.

When you look through a microscope, you are not simply looking at cells. You are trying to understand what is happening inside a human being and translate that into a diagnosis that will determine what happens next.

I was fascinated by that responsibility. A pathologist may not always be the doctor the patient sees, but the diagnosis we make can change the entire course of that patient's treatment.

"And in Mozambique, I quickly understood that pathology was much more than a specialty. It was also an area where building capacity could transform the entire health system".

Gevorg Tamamyan: You were a young woman, in a country rebuilding itself, entering a field with very few people in it. How difficult was it?

Cesaltina Ferreira Lorenzoni: *It was quite difficult, mainly because there were very few of us and the workload was quite heavy.*

The work required spending several hours sitting under the microscope, while also carrying the responsibility of making accurate and precise diagnoses. To meet these demands, I had to make many sacrifices in my personal life, especially when it came to the time I could dedicate to my children and my husband.

But I was also fortunate to be entering a field where there was enormous space to contribute.

Being a young woman in a developing health system meant that you sometimes had to work harder than other peers to demonstrate that you belonged in the room, that your scientific voice mattered, and that you could lead.

But I learned very early that competence speaks for itself - provided you are willing to work, to keep learning, and to remain consistent.

"I also understood that I was not only building my own career. I was part of building a profession in Mozambique. That gave the difficulties a different meaning. They were challenges, but they were also opportunities".

In the end, immediately after completing my specialization, I was appointed to lead the National Pathology Program (PNAPatológica), and subsequently the National Cervical Cancer Program (PNCC).

Gevorg Tamamyan: What is the single most important thing a mentor ever said to you - the sentence you still hear?

Cesaltina Ferreira Lorenzoni: *One of the most important lessons I have carried with me is:* ***never be afraid of responsibility.***

If you see something that needs to be done and you have the capacity to contribute, step forward.

"I have also learned that leadership is not about having all the answers. It is about having the courage to ask the difficult questions, to listen to others, and then to take responsibility for the decisions that follow".

That is something I still hear in my head whenever I face a difficult situation.

Gevorg Tamamyan: You went to Barcelona for your PhD. You could have stayed. Many do. Why did you go home?

Cesaltina Ferreira Lorenzoni: *Because my purpose was never simply to obtain a PhD. It was to bring knowledge back home.*

Going to Barcelona gave me an extraordinary opportunity to learn, to work with international scientists, to understand how cancer epidemiology and population-based research could be developed. But I always saw that experience as something that should strengthen Mozambique.

Mozambique needed people with these skills. We needed cancer data. We needed research capacity. We needed systems that could generate evidence for policy.

So, returning was not really a sacrifice for me. It was part of the reason I went in the first place.

Gevorg Tamamyan: You built a cancer registry where there had been none. Before it existed, the country did not know who was dying of what. What did the data show once it started coming in - and what surprised you?

I established the Maputo Population-Based Cancer Registry, strengthened the registry in the southern region, established one in the northern region, and, more recently, established the National Cancer Registry and developed its policies.

At the same time, I designed the first comprehensive study on cancer registration in Mozambique since independence.

I witnessed significant changes in the epidemiological profile of cancer, including:

- *An increase in cervical cancer, breast cancer, prostate cancer, Kaposi sarcoma (KS), and other cancers associated with HIV/AIDS.*
- *A decline in liver cancer from being the leading cancer to a lower position in the ranking.*
- *The emergence of increasingly Westernized lifestyle patterns within our population.*

The registry changed the conversation because, suddenly, cancer was no longer an abstract problem. We could begin to see who was being affected, by which cancers, where, and at what ages.

One of the most striking realities was the enormous burden of cancers that are preventable or detectable at an earlier stage - particularly cervical cancer.

The data also reinforced something that I already suspected from clinical practice: African countries cannot simply import cancer priorities from high-income countries. Our cancer profile has its own epidemiology, its own realities, and therefore requires its own priorities.

What surprised me most was perhaps not a particular number, but how powerful data became as an advocacy tool. Once you can demonstrate the problem, it becomes much harder for people to say that the problem does not exist.

Gevorg Tamamyan: You are a pathologist. Pathology is where a cancer diagnosis becomes real. What did looking through a microscope in Maputo teach you that a policy document never could?

Cesaltina Ferreira Lorenzoni: *A microscope teaches you that behind every statistic there is a person.*

A policy document can tell you that thousands of women have cervical cancer. Under the microscope, you see the biological reality of that disease. You see what happens when prevention fails, when screening does not reach someone, or when diagnosis comes too late.

Pathology gave me a very intimate understanding of inequality.

It taught me that the stage at which a patient arrives, the quality of the specimen, the availability of diagnostic technology, the expertise of the laboratory and the time taken to obtain a diagnosis can all determine whether a person has a realistic chance of surviving.

That perspective has stayed with me in every policy discussion I have had.

Cesaltina Lorenzoni honored with the "Global Health Leader Award in Cancer" at the Global Health Catalyst Summit in Washington, D.C., June 2024

Gevorg Tamamyan: Cervical cancer is preventable, and it still kills many women in Mozambique. What is the actual bottleneck? Is it money, the health system, or that the women never arrive?

Cesaltina Ferreira Lorenzoni: *It is all those things, but if I had to identify the central problem,* **I would say access and continuity of care.**

It is not enough to screen a woman. We have to identify her, communicate the result, provide diagnosis, when necessary, treat her, and make sure she is followed. We need prevention through HPV vaccination.

We need accessible screening, including new technologies that can work in settings where traditional approaches are difficult. We need trained health workers, functioning laboratories, referral systems and treatment capacity.

And yes, we have to address the reasons women do not arrive - distance, cost, information, fear, social circumstances and the opportunity cost of seeking care.

The solution, therefore, cannot sit in one part of the health system. Cervical cancer elimination requires the whole system to work together.

Gevorg Tamamyan: Why does cervical cancer continue to be one of the leading causes of death among Mozambican women?

Cesaltina Ferreira Lorenzoni: *Cervical cancer continues to be one of the leading causes of death among women in Mozambique due to a combination of several factors.*

First, there is a high prevalence of infection with human papillomavirus (HPV), which is responsible for virtually all cases of cervical cancer. Our studies indicate an HPV prevalence of approximately 24% in the general population, although this may vary considerably across different populations.

Second, there is a strong association between HIV and cervical cancer. Women living with HIV have approximately a six-fold higher risk of developing cervical cancer, as they are more likely to experience persistent HPV infection and more rapid progression from precancerous lesions to invasive disease.

Another important factor is that many women are diagnosed at an advanced stage of the disease. At this stage, the chances of cure are lower, and treatment becomes much more complex, requiring well-trained multidisciplinary teams, specialized equipment, and access to specialized treatment centres.

There are also persistent barriers to accessing healthcare services, particularly for women living in rural or geographically isolated areas. Distance, transportation difficulties, costs, stigma, and the limited availability of specialized services can all contribute to delays in screening, diagnosis, treatment, and follow-up.

Finally, insufficient coverage of HPV vaccination and cervical cancer screening limits opportunities for prevention. HPV vaccination reduces the risk of

infection with the main HPV types associated with cervical cancer, while screening allows precancerous lesions to be identified and treated before they progress to invasive cancer.

Therefore, the challenge in Mozambique is not only controlling HPV. It is ensuring that every woman has timely access to vaccination, screening, diagnosis, treatment, and follow-up. It is this continuum of care that can transform cervical cancer from one of the leading causes of death among women into a disease that is preventable and, ultimately, potentially eliminable as a public health problem.

Cesaltina Lorenzoni with the President of Mozambique, Daniel Francisco Chapo, during a meeting in Maputo on 21 November 2025, following her election as President of the African Organisation for Research and Training in Cancer (AORTIC) for the 2025–2027 term

Gevorg Tamamyan: You are the first AORTIC President from a Portuguese-speaking African country. Lusophone Africa is often almost invisible in the global cancer conversation. Why has that been - and what does the PALOP experience bring?

Cesaltina Ferreira Lorenzoni: *Part of the reason is historical. The global health conversation has often been dominated by countries and institutions that have greater visibility, greater research funding and stronger international networks.*

We are a minority, and we face a significant language barrier, which affects our participation in international conferences, our ability to publish scientific articles, our competitiveness in applying for research funding and projects, and our ability to establish and expand international partnerships.

The PALOP countries bring important perspectives precisely because our health systems have had to innovate under constraint. We understand the realities of limited resources, workforce shortages, fragmented data and the need to integrate cancer into broader health-system strengthening.

We also bring a different linguistic and cultural bridge - connecting African realities with Portuguese-speaking institutions in Europe and beyond.

"I want Lusophone Africa to be seen not as a peripheral part of the African cancer story, but as an essential part of it".

Gevorg Tamamyan: You have spent years building research partnerships between Mozambique and institutions abroad. What makes a partnership genuinely equal?

A genuine partnership is not one in which one side brings the money and the other side provides the patients or the data.

That is not partnership. That is extraction.

An equal partnership means that African researchers also get to participate from the beginning: defining the questions, designing the study, owning and interpreting the data, publishing the results, and leading the scientific agenda.

We need to move from research being done in Africa to research being led by Africa.

International institutions have an important role to play, but the long-term goal should be to strengthen African institutions so that African scientists increasingly have the resources, infrastructure and confidence to define the questions themselves.

Gevorg Tamamyan: AORTIC represents countries with very different systems. As President, what is the one thing you want to be different on the continent when your term ends in 2027?

Cesaltina Ferreira Lorenzoni: *I want us to have a stronger African cancer voice - one that is based on African evidence and African priorities.*

Africa should not be constantly reacting to global cancer agendas. We should be helping to shape them.

That means stronger cancer registries, stronger research networks, better training, better prevention and early detection, and stronger national cancer control programmes.

"But above all, I want AORTIC to leave a legacy of stronger African leadership: African institutions collaborating with one another, African scientists leading research, and African governments treating

cancer as a development and health priority".

I want there to be an expansion of collaboration between different organizations and agencies.

Cesaltina Ferreira Lorenzoni, AORTIC President attends key WHO Africa meeting in Brazzaville-Cong, December, 2025

Gevorg Tamamyan: What are the major global health institutions still getting wrong about cancer in Africa? If you could make them change one thing tomorrow, what would it be?

Cesaltina Ferreira Lorenzoni: *There is still a misconception that cancer is not a priority in Africa. There is an incomplete belief that communicable diseases are the only big health concern in Africa.*

I would ask the institutions to stop thinking of the African continent as one place with one problem.

There is enormous diversity across the continent - epidemiologically, economically, culturally and in terms of health-system capacity.

We need global institutions to listen more carefully to national and regional expertise and to invest in long-term systems rather than isolated projects.

If I could change one thing tomorrow, it would be ***who defines the questions.***

African countries should not simply be the setting where international research is conducted. We must be the people defining the research questions, leading the studies and using the evidence to shape policy.

Gevorg Tamamyan: A young Mozambican doctor is offered a post in Europe next month. What do you tell her?

Cesaltina Ferreira Lorenzoni: *I would tell her:* ***go if it will help you grow - but never forget where your knowledge is most needed.***

There is nothing wrong with going abroad. International exposure can transform a young doctor's career. I benefited enormously from studying outside Mozambique.

But I would encourage her to think beyond the question, "Where can I build the best career?"

I would also ask: "Where can my knowledge have the greatest impact?"

You can leave Mozambique and still remain deeply connected to the country. You can learn abroad, build networks abroad, and eventually return with knowledge, relationships and resources that can strengthen your country.

"The world is bigger than borders. But our responsibilities to the places that shaped us do not disappear when we cross those borders".

Gevorg Tamamyan: Who should I interview next - and what should I ask them?

Cesaltina Ferreira Lorenzoni: *I would suggest that you interview a philanthropist/health advocate that can help raise funds for cancer control, and bigger partnerships in Africa.*

Someone whose voice can reach governments and influential organizations and help them realize that cancer is an important item for them to have in their agendas.

And I would propose the question:

"What is the cancer problem in Africa that everyone knows about, but nobody is brave enough to solve - and what would you do differently if you had the resources and the authority to change it?"

I would interview someone who represents the next generation of African cancer leadership - perhaps a young African scientist, oncologist, pathologist or public-health professional who is trying to build something in their own country.

Because ultimately, the future of cancer control in Africa will depend not only on the institutions we build today, but on whether we create the space for the next generation to lead.

From 10% to More Than 50% Survival

Tanzania Transforms Childhood Cancer Care, But Challenges Remain

By Victoria Forster

Children On Ward | Photo credit to "We are TLM"

In Tanzania in the early 2000s, healthcare for children with cancer was very limited. The majority of affected children never reached a treatment centre and 90% of those who did, ultimately died1. Today, childhood cancer care has been transformed with more than 50% of children who present to hospital surviving long-term.

One of the people driving this improvement is Dr Trish Scanlan, an Irish pediatrician who has worked in Tanzania for the last two decades. Dr Scanlan first visited the country in 2006 while completing a Master's degree in International Health. At the time of her arrival, the survival rate for most types of childhood cancer in Tanzania was less than 10%.

"At that time, in the rest of the world you were looking at overall survival probably around 80–85% in places that had what was needed to care for these kids. So, the gap was enormous," said Dr Scanlan.

In 2005, the first dedicated pediatric oncology ward opened at Ocean Road Cancer Institute in the largest city, Dar es Salaam. But there was limited provision of drugs and other resources to support the children's care.

Dr Trish Scanlan |Photo credit to Leslie Henderson

"The team of one doctor and three nurses were completely dedicated to the children. They were really beautiful human beings who cared deeply. However, they didn't have much in the way of drugs and resources were tight. You simply cannot cure kids with cancer if you don't have funds and drugs," said Dr Scanlan.

An international collaboration offered reliable access to chemotherapy in 2004 to treat a common type of cancer called Burkitt lymphoma. With chemotherapy, this small team had raised survival for this cancer from 10% to almost 70% in just a couple of years, showing the significant potential for improving outcomes for children with other cancers.

But the low survival rate was not the only concern. In 2005, only 120 children with cancer presented to the Ocean Road Cancer Institute, a tiny proportion of the expected 3,000+ cases per year nationally. Two decades later, almost 1,000 children are treated annually, with more than half surviving. Numerous changes have contributed to this significant progress.

"The first things we did were the things that cost no money. We went from doing a ward round once a week to once a day, and then twice a day. We made sure every child was weighed. We made sure that antibiotics and IV fluids were available throughout the day and night. We wrote and followed simple protocols. If a child needed blood and there was none in the hospital, we went to the central blood bank and got it," said Dr Scanlan.

When "Free" Care Was Not Enough

The Tanzanian government had already pledged to make cancer care free for all Tanzanians, which was a vital step. But the allocated funds were not sufficient to cover the enormous need.

"People could stay on the ward without a fee. Anything available in the hospital was free. But there wasn't enough chemo to last more than a few months. Cupboards would be bare, and families would be given prescriptions and asked to bring back drugs. They often came back with one or two of the four drugs a child needed, and it was really hard to watch," said Dr Scanlan.

At that time, children in high-income countries had seen incredible improvements in survival due to treatment protocols refined over several decades of

Child On Ward | Photo credit to "We are TLM"

clinical trials, including through careful optimization of drug timing and dosing. The lack of reliable availability of chemotherapy drugs in Tanzania made improving survival rates incredibly difficult.

"One day on the ward we just decided to make chemo free for everyone. We racked up bills of about $50,000 in a few months with no way of paying it and we gave the chemo to the kids. The kids started to get better. And the mood on the ward changed. Visitors noticed and wanted to help," said Dr Scanlan.

Child On Ward | Photo credit to "We are TLM"

Building a System That Could Cure Children

The bills were ultimately paid by donors and partnerships including the Irish government and key non-profits in Ireland and the U.K. providing consistent access to chemotherapy drugs which started driving longer-term survival. In 2012, pediatric cancer treatment moved to Muhimbili National Hospital, with further expansion and renovation of the children's cancer facilities in the following years.

"When the government moved the children into the main national pediatric hospital, automatically they had access to dialysis, surgery, piped oxygen, 24-hour labs, CT, MRI—literally everything for children with complex needs. It made a massive difference overnight," said Dr Scanlan.

For several years, Dar es Salaam was home to Tanzania's only comprehensive childhood cancer treatment centre, a significant barrier to care in a country more than twice the size of California

with approximately 71 million people. Challenging infrastructure and poverty meant that simply reaching the centre for treatment was not possible for many families with sick children. So, a national network of hospitals was connected with the aim of no family needing to travel for more than 4 hours to be seen by a clinician trained to identify cancer and either treat the child or rapidly refer them to another facility in the network.

"We now have 22 hospitals in our network and hope to reach around 30 soon. The vision is that all hospitals will join the network and know exactly what to do when they see a child with suspected cancer. The aim is that every child will get the same drugs, the same protocol, the same assessments, no matter what hospital they walk into. It's one team, one voice, even though it's many hospitals," said Dr Scanlan.

The centers are now also connected by a data-sharing initiative, making it easier for clinicians to access data and coordinate care for their patients. Other provisions include nutrition, a hostel, play therapy, child-life program, schooling in hospitals as well as a locally run fellowship pediatric oncology training program for pediatricians. Palliative care navigation is also provided for children with incurable disease.

The Challenge That Progress Has Not Yet Solved

However, one very significant barrier still remains. Many children still present to centres with late-stage disease, which is in most cases incurable.

"In 2005, 30% of children arrived at our door needing palliative care; in 2025, 30% still arrived with palliative disease. For most diseases, if they come in at stage four, it almost doesn't matter what diagnosis they have—they're going to die. The actual numbers of children seen overall have vastly improved, but the proportion with incurable disease is the same," said Dr Scanlan.

Dr Scanlan explained that several community outreach initiatives are underway to try to spread the word about what childhood cancer looks like as well as the availability of care to help more families reach healthcare facilities before it is too late for the children.

"They have to reach help at earlier stages, and that means early-warning sign education, public health messaging, training community health workers and smaller hospitals, and engaging traditional healers and religious leaders," said Dr Scanlan.

One initiative in its infancy involves trying to work with community health workers and possibly traditional healers in communities. The aim is to help them identify children with cancer, collaborate to coordinate care back in the community and to provide palliative care when needed.

"Community health workers and traditional healers are where patients first present, and where they go back for end-of-life care if treatment fails. If we can gain their trust and respect, they could be an army of allies in early recognition and palliative care," said Dr Scanlan.

The clinical work across the entire network is now solely led and managed by Tanzanian specialists and teams and a growing research and education ecosystem is present, linking Tanzanian work and training with international communities.

"On the ground, in the hospitals, the experts in medicine, nursing, lab, pharmacy—everybody is Tanzanian, as it absolutely should be. I'm very proud to have witnessed the transformation and to see how they've become world experts in their field," said Dr Scanlan.

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About the Author

Victoria Forster, PhD is a cancer research scientist, childhood leukemia survivor and health writer. Passionate about engaging patients in research and healthcare systems, she earned her PhD in cancer biology in the U.K. and now works as the head of Patient Engagement at an academic hospital in Toronto, Canada.

Dr Jorge Ricardo Galvez Silva and his little patient

Oncology Couch

The Shadows of another Dimension

What children with cancer may be teaching us about medicine, uncertainty, and what it means to be human

By Aleksandra Filipović

There are conversations in oncology that begin with a question.

And then there are conversations in which, somewhere along the way, the question itself changes.

My conversation with **Dr Jorge Ricardo Galvez Silva** was supposed to be about pediatric oncology.

About what it means to treat children with cancer.

About parents.

Hope.

Fear.

Resilience.

The emotional landscape of walking into a room where a child is ill and somehow holding not one human being, but an entire family.

We spoke about all of those things.

But somewhere between science and childhood, between certainty and uncertainty, between what medicine can measure and what clinicians sometimes simply know, Jorge introduced another possibility.

He called it ***D***.

And from that moment, D quietly sat with us for the rest of the conversation.

The Doctor Who Learned to Slow Down

Dr Jorge Ricardo Galvez Silva is a pediatric hematologist-oncologist and Medical Director of the Bone Marrow Transplant Program at Nicklaus Children's Hospital in Miami. He trained in medicine at the Autonomous University of Honduras, completed his pediatric residency at what was then Miami Children's Hospital, followed by a pediatric hematology-oncology fellowship at MD Anderson Cancer Center and further specialist training in pediatric stem-cell transplantation and cellular therapy at the University of Minnesota. His clinical and research work spans pediatric blood and marrow transplantation, malignant and non-malignant hematologic conditions, bone marrow failure syndromes and cellular therapies.

But Jorge brings something else into the room. Something that does not appear on a CV.

He grew up and studied medicine in Honduras, at a medical school with more than a century of history and, as he describes it, a very strong tradition of hands-on clinical training. Students embarked on a journey through the history of medicine, learning the vital elements of symptoms, signs, and physical examination that forge the foundations of being a doctor.

At the time, some of it seemed boring. Later, he understood why it mattered. They were being taught not simply what doctors know, but **who they are as doctors.**

When he eventually came to the United States, Jorge entered a medical culture with extraordinary technological capability. Rather than choosing between those worlds, he began to see the value of merging them.

Technology and touch. Diagnostic precision and listening. Innovation and history.

He still tells students that most of what they need to understand about why a person is sitting in front of them will emerge from listening to them. "Pay attention to signs and symptoms," he tells them. And: "Pay attention to what a mother or a father says about their child." Perhaps this is why Jorge's presence feels unusual. He does not seem to be trying to arrive at the answer before the family in front of him has finished becoming the question. That was not always the case.

As a young man, he told me, he wanted very badly to be the best. Life softened that ambition. Or perhaps refined it. Jorge describes life like a car accumulating dents, miles, and the occasional flat tire along the journey. The dents slow you down. And when you slow down, he says, "You see better, and perhaps you see more. Eventually his definition of success changed. "It's about the life you touch, the people you come in contact with." Then he said something I repeated back to him because it felt too important to allow it to pass unnoticed:

"This is something you don't need to fight for."

Maybe that is where D begins.

A + B = C, Jorge thinks in equations. He had been thinking about one in particular before our conversation.

A + B = C.

We learn this structure early. Do A. Add B. Expect C. Medicine is built upon it.

A diagnosis plus an evidence-based intervention should produce a predictable outcome.

We refine A. We optimise B. We stratify risk, personalise treatment, sequence genomes, measure biomarkers, calculate doses and build increasingly sophisticated models to make C more predictable. Jorge knows this world intimately. Transplant medicine depends upon extraordinary precision.

And yet, after doing the same thing again and again, something begins to become impossible to ignore. "You start realizing that your A probably is very, very similar. Your B is also very, very, very similar, but your outcomes are very different." The same disease. Comparable treatment. Comparable biological parameters. Different C.

Why?

This is where Jorge introduces D. "I've been lately calling it D," he told me. What is D?

"I don't know."

And then came perhaps the sentence around which our entire conversation began to orbit:

"We don't know what moves in between."

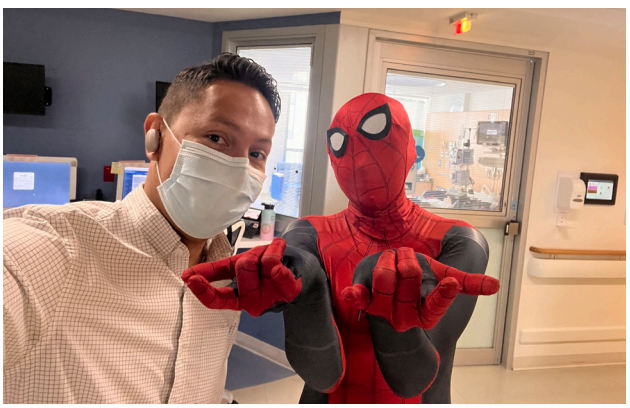
D is not an alternative to biology. It is not an argument against evidence. It is not permission to replace oncology with something unmeasurable. It is the intellectual humility to acknowledge that our equation may contain variables for which we do not yet possess instruments or metrics. It makes the "D" no less real, no less omnipresent. Jorge calls what we are beginning to observe ***"the shadows of D."*** And I love this description. Because a shadow, an announcement perhaps, tells us something exists before we can necessarily see the thing itself.

When Attention Changes Biology

During our conversation, Jorge referenced a paper he had just read in Nature Human Behaviour. Published in August 2026, the study examined whether voluntary attention could influence acute immune responses in humans. Across three preregistered experiments using acute skin inflammation, directing attention toward bodily sensations rather than away from them was associated with substantially more regulated inflammatory responses. The authors identified both sensory-dependent and top-down pathways involving parasympathetic vagal activity. Attention was not merely changing the experience of inflammation. Attention was associated with changes in the biology of inflammation itself.

To Jorge, this was fascinating. Perhaps, he suggested, science is beginning to see some of those shadows. I found myself wondering whether medicine is slowly becoming ready not necessarily to fully believe in what it cannot yet measure, but simply **to doubt it less.** Afterall, we cannot see gravity, we cannot see the Wi-Fi signal connecting our devices. Their invisibility does not make them unreal. Perhaps there are dimensions of human biology for which the measurement unit simply has not yet been discovered.

And perhaps discovering or uncovering them requires something surprisingly difficult in science: Remaining open.



At the hospital

The Child Who Wants to Go to the Playroom

This becomes particularly interesting in pediatric oncology because a child arrives with an identity that is still being formed. Ask a young child in hospital who they are and they may tell you their name. They do not necessarily say:

I am a patient.

I have leukemia.

I am sick.

"The child is just the child," Jorge said. The diagnosis may exist. The hospital certainly exists. The treatment exists. But the child's immediate concern may be entirely different.

"Doctor, can I go to the playroom?"

Because that is their day. That is their childhood. That is who they are becoming. "If you don't let me go to the playroom, it's going to be a very sad day for me." Across the room sits a parent.

And the parent's internal landscape is entirely different.

When is the next scan?

When is the next treatment?

Has the tumour disappeared?

Has the transplant worked?

Is my child going to live?

The child wants the playroom. The parent wants the future. Same room. Same cancer. Completely different internal worlds. I told Jorge that what struck me was the absence, particularly in younger children, of the blending between person and diagnosis identity that we so frequently encounter in adult oncology. The child is having a childhood. It simply happens that part of that childhood is occurring within a medical context. The parent, meanwhile, understandably develops another identity: ***My child has leukemia.*** And yet children are not oblivious. Quite the opposite. They are extraordinarily perceptive. They watch their parents' faces. They notice when their mother looks worried. They notice when their father becomes unusually quiet. And they watch us. More importantly, they SEE us.

Jorge has had children tell him:

"You are worried. I know that you are worried."

Imagine the sensitivity required to perceive that. The child may not understand every word spoken in the room. But the child is reading the room.

Holding the Child, Holding the Parent

Being with Jorge as he speaks about this, something became very clear to me. His loyalty is to the child.

But he holds the parents. And sometimes, the parents require more holding than the child. That is one of the unique emotional geometries of pediatric oncology.

Jorge describes certain moments as ***"landmark encounters."***

Diagnosis is one. Relapse is another. The end of treatment is another. And sometimes, palliative care. When the emergency department calls about a child with an alarming blood count, Jorge already knows what awaits him before he enters the room. He walks in carrying science. But that first encounter, he says, is not primarily about science.

"That part is in providing hope."

The detailed treatment discussion can come tomorrow. He deliberately gives parents information in pieces. Not because they do not deserve all the information, but because human beings in such situations can only metabolise so much uncertainty at once, particularly a mother or father who has just learned that their child has a serious diagnosis. He tells them what the next few days may look like. What their child may experience. What they should expect.

Then, when something happens, he can say: *Remember when I told you this might happen? This is that moment. The unknown becomes slightly less unknown.*

And the family can walk through their experience until they begin to develop their own.

This is not separate from medicine. This is medicine.

Humaning

At one point, I told Jorge that although he had gone to medical school, completed fellowships and

acquired extraordinary technical expertise, what I was hearing could not be reduced to qualifications. *"You're humaning with your patients,"* I told him. Not performing humanity. Not adding compassion as an accessory to clinical excellence. Humaning. Allowing oneself to remain a human being while practising medicine. That distinction matters because pediatric oncology asks something enormous of the people who practice it. You meet children you cure. You meet children you cannot. And sometimes you know them for years.

The day before our conversation, Jorge had lost a patient with neuroblastoma whom he had first cared for as a resident. Later, he cared for him as an attending physician. Later still, as his transplant physician. A child became an adult. And Jorge remained somewhere within the architecture of that life. Then the biological life ended.

"It just sucks," he said. *"It just feels bad for the ones who cannot make it."*

There was no attempt to make the sentence more sophisticated.

It did not need to be. He then said something else. ***"I owe it to the patients that are not here that they have a voice."*** He dedicated our conversation, in his own way, to them.

The Dents That Remain

I asked whether there was one patient who had changed him. There was. But Jorge was careful. He did not want one story to erase the many others. Often, he said, it is the patients who are no longer here who leave ***"a very big dent"*** in his life. The word returned.

The dents that once slowed down an ambitious young doctor. The dents left by children he could not save. Perhaps they are part of the same story.

Children, Jorge says, have taught me everything; they have guided his practice. They have told him when he was right. They have shown him when he was wrong. And sometimes they have shown him that being right does not guarantee the outcome. That knowledge grounds you. They have also taught him hope. Their resilience, he says, is ***"infinite."***

Dr Jorge Ricardo Galvez Silva with his little patient

Perhaps Children Remember Something We Have Forgotten

There was another quality to the way Jorge described children that stayed with me.

Children trust. Children inhabit time differently. Children can be extraordinarily mature and extraordinarily playful within minutes of each other. They are perceptive without necessarily having constructed the elaborate narratives adults build around what they perceive. Perhaps this is why they offer medicine something beyond pediatric expertise. Perhaps they remind us of something. Toward the end of our conversation, I suggested that perhaps D is not something humanity is going to discover. Perhaps, this Dimension is something we are going to simply ***remember,*** because it was there all along.

Maybe this is one of the gifts children offer us. They have had less time to 'cover it' with external

conditioning of an internal system that is already so intelligent.

Why Does a Child Get Cancer?

There is one question pediatric oncology makes particularly difficult to avoid.

Jorge believes we need to remain willing to ask this question even when the answers are uncomfortable, incomplete or scientifically messy and slippery. In adult oncology we can point toward ageing, accumulated exposures, environmental factors, lifestyle, inherited susceptibility, acquired mutations. But a child is, in Jorge's words, ***"brand new."*** A new life. A developing nervous system. A developing immune system. A rapidly developing body. And cancer appears. We have biological explanations for some of this. We will undoubtedly discover many more. But Jorge's point is not that biology is wrong. It is that our biology may still be incomplete. Perhaps, once again, we are looking at the shadows of D.

A Dream

Eventually I asked Jorge whether there was anything left on his heart that we had not spoken about.

At the hospital

He answered simply. ***"I have a dream."*** One day, he wants to wake up and no longer have to deal with childhood cancer. He believes everyone working in oncology shares some version of that dream. The path toward it may be messy. There will be small steps and enormous ones. There will be discoveries. There will be failures. There will be A's and B's that produce the C we desperately hoped for. And there will be others that do not.

But perhaps somewhere along that journey we will discover, or rather - remember a measurement unit for something we currently cannot measure today. Perhaps we will understand another piece of D, and perhaps one day childhood cancer will simply disappear.

Staying With the Question – that Space in Between

Oncology is trained to answer questions.

What is the diagnosis? What stage? Which mutation? Which treatment?

But perhaps there are questions for which answering too quickly is itself a limitation. Questions we might need to inhabit. Questions whose purpose is not immediately to produce an answer, but to make us sufficiently curious to recognise the answer when it eventually arrives.

At the end of our conversation, I told Jorge that perhaps we need to become more comfortable ***living in and with the question, and allowing the answer to find us when we are ready.***

So we decided not to resolve D. We would not name it. We would not force it into a definition simply to make ourselves more comfortable.

Jorge called our conversation ***Chapter One.*** Perhaps Chapter Two begins here.

With scientists continuing to investigate. With oncologists continuing to treat. With parents continuing to hope. And with children continuing to teach us.

About the Author

Aleksandra Filipović, MD, PhD, is a medical oncologist, cancer cell biology scientist, drug developer, and educator. She earned her PhD at Imperial College London and now serves as Head of Oncology and Chief Medical Officer within the biotech sector. Dr Filipović practices and teaches integrative oncology internationally and hosts the OncoDaily TV podcast *"Into the Body, with Dr Aleks".*

Elisabeta Niță

When Cancer Interrupts Childhood

Protecting the Future Beyond Treatment

For children and adolescents with cancer, treatment is only part of the challenge. Preserving family connection, communication, education and a sense of future must also become part of care.

By Adrian Pogacian

A child with cancer is still a child. An adolescent with cancer is still becoming the person they will be.

Yet cancer can quickly begin to occupy almost every part of their lives. The shock of diagnosis, an unfamiliar hospital environment, treatment and its side effects, fear of relapse or death, functional difficulties, changes in body image and self-esteem, and the challenge of returning to everyday life can all create considerable psychological stress. For adolescents, cancer also collides with a period already defined by profound biological, emotional and social change.

For Elisabeta Niță, a Senior Clinical Psychologist and Integrative Psychotherapist with a PhD in Psychology, specialising in psycho-oncology and palliative care and who works in psycho-oncology and the Hospital School setting, this creates a challenge that extends far beyond treating disease. Pediatric cancer care must also protect childhood and adolescence, support families and preserve a young person's sense of future.

The Same Diagnosis, a Different Experience

Cancer is not experienced in the same way by a child and an adolescent.

"The diagnosis may be the same, but it is experienced at different stages of development," Niță explains.

For younger children, illness may mean the sudden disruption of familiar life: no longer attending school, separation from classmates, long periods in hospital and medical procedures they may not fully understand. Children are also highly sensitive to changes around them, including the fears and concerns of their parents.

For adolescents, cancer arrives while identity, autonomy, body image, peer relationships and plans for the future are taking shape. Research into the psychosocial needs of adolescents and young adults with cancer reinforces the importance of support tailored to developmental stages. Returning to school is also important, but can bring physical, psychological, academic and social challenges.

For Niță, this leads to one of the central principles of pediatric cancer care: "to treat the illness without allowing it to take over the entirety of childhood or adolescence."

When the Whole Family Lives With Cancer

"Behind a child or adolescent with cancer, there is often a deeply frightened parent trying not to show their fear," Niță says.

Parents must understand complex medical information, make difficult decisions and cope with hospitalisation and uncertainty while remaining a primary source of safety for their child.

Sometimes a form of mutual protection develops: parents conceal their fears to avoid frightening their child, while children and adolescents may avoid speaking about their own fears because they do not want to upset their parents.

Evidence suggests that social support is associated with better psychological wellbeing among parents of children with cancer and with lower levels of distress, anxiety and symptoms of post-traumatic stress.

"We cannot fully separate the well-being of the child or adolescent from that of the family," Niță says. *"Caring for parents is also a way of caring for the child or adolescent."*

Communication is therefore crucial.

Parents may struggle with how much to say, when to say it and how to discuss frightening subjects without increasing fear. Yet even young children recognise adults' facial expressions, conversations that suddenly stop and changes in everyday routines. Adolescents also need to be heard and involved in conversations that concern them, while retaining as much autonomy and privacy as possible.

Psychoeducation can help families navigate this territory. Rather than providing a predetermined script, it can help parents understand their child's reactions, adapt information to age and developmental level and create a safe space for questions and emotions.

As Niță puts it: "Sometimes, protecting a child or adolescent does not mean avoiding a difficult conversation, but finding the right words for their age and remaining by their side as they hear them."

Elisabeta Niță | Photo credit to DORIA DRAGUSIN

When a Patient Becomes a Student Again

It may seem unusual to talk about mathematics, reading or homework when cancer treatment is the immediate priority.

Yet this is precisely when school can take on a deeper meaning.

"For a child, a mathematics lesson, a story, or a drawing can represent a return to something familiar," Niță says. *"For a while, the child is no longer only a patient, but becomes a student again."*

For adolescents, education can provide an even stronger connection to the future—to peers, exams, university, a profession, friendships and personal plans.

The Hospital School, therefore, is about much more than catching up on missed schoolwork. It can provide continuity, normality, belonging and hope, becoming what Niță describes as *"one of the bridges between the world of treatment and the child's life beyond the hospital."*

But this should not create another expectation for young patients.

"I do not believe that we should expect a child with cancer to be constantly 'brave,' nor should we expect an adolescent to necessarily turn their suffering into a life lesson," Niță says.

Instead, the responsibility belongs to those surrounding them: to create a team in which medicine, psychology, education and family work together.

And in a place where so many questions inevitably concern illness and treatment, Niță offers perhaps the clearest expression of what the Hospital School represents:

"The Hospital School continues to ask children and adolescents about their future."

"Treatment Ends. Growing Up Continues."

Psychosocial support has become increasingly integrated into pediatric cancer care, but the consequences of cancer do not necessarily disappear when treatment ends.

The stress of caring for a child with cancer can increase the risk of psychological symptoms among parents and siblings. Cancer treatment itself, including chemotherapy, surgery and radiation, can contribute to cognitive difficulties, coping problems and disruptive behaviours. These challenges can follow children through growth, schooling and survivorship.

That is why progress in pediatric oncology cannot be measured by treatment alone.

Children and adolescents must continue to be seen as whole people—with emotions, relationships, education and identities that are still developing.

Cancer may interrupt childhood.

But protecting what comes after treatment—the relationships, development, education and future that still belong to that child—must also be part of cancer care.

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- About the Author
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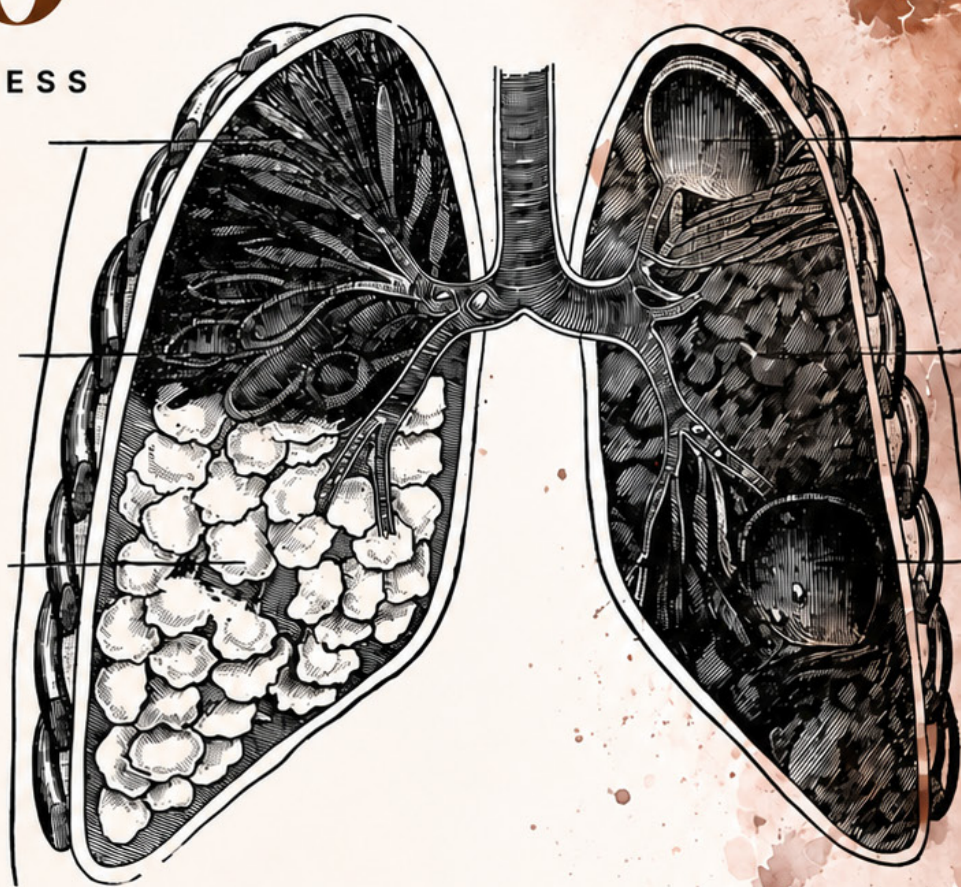

November 5

Organized by **OncoDaily**

Fertility NEWS

Daily Voice Of Fertility & Reproductive Health

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