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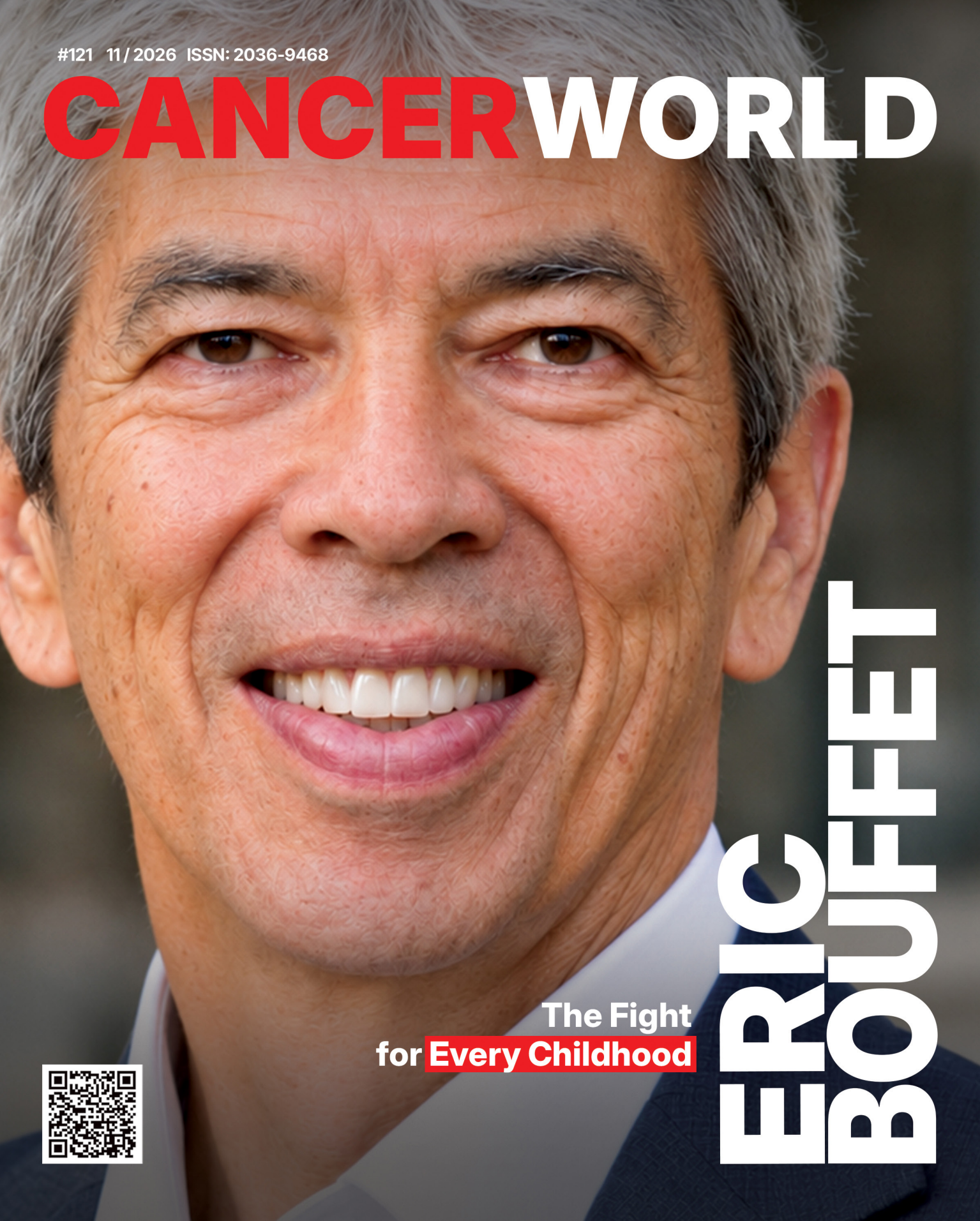

ERIC BOUFFET

The Fight for Every Childhood

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NOT FOR SALE

Oncology is advancing at an extraordinary pace. But are we becoming as effective at caring for people as we are at treating cancer?

Scientific breakthroughs offer little benefit to patients who cannot access them. Surviving cancer does not necessarily mean regaining their health or quality of life. And even the most sophisticated medicine cannot replace the experience of being heard, understood and supported.

*The November issue of **CancerWorld** explores these realities and asks what progress in oncology truly means.*

*Our cover stories feature **Prof Eric Bouffet,** whose pioneering work in paediatric neuro-oncology confronts the delicate balance between curing children and protecting their futures, and **Prof Eduardo Cazap,** whose decades of leadership in global cancer control highlight the importance of prevention, international cooperation and political commitment. Their journeys reveal that the future of oncology depends as much on the systems we build as on the discoveries, we make.*

From the sustainability of radiotherapy services in Africa to the evolving treatment of childhood cancer, we consider what it takes to translate scientific advances into equitable and effective care. The debate over thyroid cancer overdiagnosis adds another dimension, reminding us that responsible medicine requires not only innovation, but also scientific rigour, restraint and the courage to question established assumptions.

Beyond treatment, experiences of long-term brain and pancreatic cancer survivorship reveal the physical and psychological realities that conventional measures of success often fail to capture. Perspectives on supportive care and evidence-based lifestyle interventions reinforce the importance of addressing the needs of patients and their families throughout treatment and beyond.

Equally important is whose experience informs the future of oncology. The underrepresentation of men in cancer advocacy challenges us to reconsider how we create space for meaningful patient participation, while a reflection from the consultation room reminds us that empathy, attention and human connection remain fundamental to clinical excellence.

These perspectives reflect the breadth of contemporary oncology: a field in which scientific discovery, public policy, social responsibility and human experience are profoundly interconnected.

The ultimate ambition of oncology must extend beyond changing the course of disease. It must be to change the course of people's lives — regardless of where they live, what cancer has taken from them or how long ago their treatment ended.

Knarik Arakelyan, Managing Editor, CancerWorld

ERIC BOUFFET

The Fight for Every Childhood

From pioneering treatments for childhood brain tumours to confronting the inequalities that determine who receives care, renowned paediatric neuro-oncologist Eric Bouffet reflects on four decades of breakthroughs, painful decisions and unfinished ambitions — and why saving a child's life must also mean protecting their future.

By Knarik Arakelyan



There were nights when Eric Bouffet could not sleep. He had made a decision that might spare a child with an aggressive brain tumour from the devastating long-term consequences of radiotherapy. But what if that decision also reduced the child's chances of survival?

For a physician who has spent more than four decades treating children with brain tumours, such decisions have never been purely clinical. They carry the weight of lives saved, children lost and consequences that may not become visible for another 20 or 30 years.

Some of the children Bouffet treated nearly 40 years ago are now adults. He remains in contact with several of them. Their lives are evidence of extraordinary progress in paediatric oncology, but also reminders of what survival can cost.

"You learn from your successes," he says. *"But you also learn from your mistakes."*

After helping build one of the world's leading paediatric neuro-oncology programmes at Toronto's Hospital for Sick Children (SickKids), Bouffet now works with specialists across approximately 40 countries, pursuing a mission that extends far beyond the Canada,

What does it mean to save a child's life if we cannot also protect their future?

A Career That Began Almost by Accident

Bouffet never planned to become a specialist in childhood brain tumours.

He trained in paediatrics and intensive care in France, where he encountered children experiencing severe complications of cancer treatment. He subsequently joined a paediatric oncology department to establish a bone marrow transplantation unit.

When that work was completed, he approached his department head to ask what he should do next.

"She told me, 'Look after the brain tumours.' And I said, *'There are no brain tumour patients.'"*

That conversation changed the direction of his career.

He began collaborating with neurosurgeons, gradually bringing children with brain tumours into a more coordinated system of care. What started as one responsibility among several eventually became his life's work.

The field he entered in the early 1990s was almost unrecognisable compared with today's paediatric neuro-oncology.

As a medical student, Bouffet had witnessed an era before modern brain imaging became widely available. He remembers patients undergoing pneumoencephalography, an invasive procedure in which air was introduced into the cerebrospinal fluid to help visualise structures within the brain.

MRI was not yet part of routine clinical practice. Treatment protocols were limited, chemotherapy played a relatively small role, and surgery and radiotherapy dominated care.

"There were very few protocols. Chemo was virtually nonexistent," he recalls.

Over the following decades, Bouffet would help develop new treatment approaches and witness the emergence of molecularly informed therapies. Yet alongside these advances came an uncomfortable reality: some children remained impossible to cure, others faced lifelong consequences, and access to progress depended heavily on where they lived.

Building a Programme, Changing a Field

After working in France and spending four years in the United Kingdom, Bouffet moved to Toronto in 2000 to develop paediatric neuro-oncology at SickKids.

The hospital already had outstanding neurosurgical expertise and a collaborative radiation oncology team. What it lacked was a dedicated, comprehensive paediatric neuro-oncology programme.

Within five or six years, that programme had become internationally recognised, bringing together clinicians, researchers and trainees whose work would help reshape the understanding and treatment of childhood brain tumours.

Among the advances emerging from this scientific environment were discoveries involving brain tumour stem cells, molecular subgroups of medulloblastoma, mismatch repair deficiency and rare childhood brain tumours.

Today, with Bouffet increasingly focused on international work, the programme continues under the leadership of Dr Uri Tabori, exploring emerging approaches such as circulating tumour DNA in cerebrospinal fluid and new molecular diagnostic technologies.

For Bouffet, one of the greatest transformations has been in how childhood brain tumours are understood and how that knowledge is changing treatment.

A diagnosis such as medulloblastoma once suggested a relatively uniform disease. Molecular research has since revealed that tumours sharing the same name may behave very differently.

This allows clinicians to distinguish between patients at different levels of risk and, in carefully selected circumstances, adjust treatment intensity.

For some children, reducing therapy without compromising survival could mean fewer long-term complications.

Yet Bouffet cautions that treatment reduction is never straightforward.

"If you decrease the dose, the brain does better, the tumour can be cured, but if you decrease the dose, you can also decrease survival," he explains.

Another major advance has emerged in childhood gliomas, where researchers have identified molecular alterations that can sometimes be targeted with specific medicines.

Bouffet offers a simple analogy: a mutation can act like a tap that has been turned on, allowing tumour growth to continue. If a drug can block the relevant molecular pathway, it may be possible to turn that tap off.



Dr Bouffet' at the Toronto's Hospital for Sick Children (SickKids (with permission)

Some targeted therapies originally developed for adult cancers have subsequently proved valuable for children whose tumours carry related alterations.

The consequences extend beyond tumour control. Where appropriate, oral targeted treatments can reduce the need for conventional chemotherapy or radiotherapy and lessen the disruption caused by repeated hospital visits.

A child may be able to continue attending school and participating in ordinary daily activities while receiving treatment.

For Bouffet, the significance of precision medicine lies not only in controlling tumours, but in the possibility of making treatment less disruptive and less damaging to a child's development.

Nevertheless, precision medicine has not delivered equally dramatic advances across all childhood brain tumours. Some diseases still rely heavily on treatments already used decades ago, while others remain extraordinarily difficult to target.

Nowhere is that unfinished challenge more apparent than in diffuse intrinsic pontine glioma, or DIPG.

The Tumours We Still Cannot Cure

Despite decades of research, DIPG remains one of the most devastating diagnoses in paediatric neuro-oncology.

The tumour arises in a critical region of the brainstem, making conventional surgery generally impossible. Radiotherapy can temporarily slow progression, but the disease usually returns.

Bouffet had hoped that a cure would emerge during his career. So far, it remains out of reach.
It has not happened.

Researchers are investigating new approaches, including immunotherapies such as CAR T-cell treatment, but he cautions against confusing encouraging early results with a definitive breakthrough.

"It's not fixed," he says.

His frustration reflects both the biological complexity of these tumours and the practical limitations of research.


Saint Baldrick

Developing effective therapies requires sustained funding, scientific collaboration and a willingness to investigate diseases affecting relatively small numbers of patients.

Bouffet believes artificial intelligence may help accelerate drug discovery, but technology offers no guarantee of success.

What gives him confidence is the growing collaboration between major paediatric neuro-oncology centres, including Toronto, Heidelberg and St. Jude Children's Research Hospital.

For rare and difficult-to-treat tumours, progress depends on bringing expertise, clinical data and research capabilities together.

But even when medicine succeeds in controlling a tumour, another challenge remains: what happens to the child afterwards?

The Price of a Cure

For Bouffet, the consequences of treatment are among the most difficult aspects of a long career.

A decision made today may save a child's life, but its effects may not become fully apparent for another 10, 20 or even 30 years.

Radiotherapy, for example, can be essential for controlling certain brain tumours, yet exposure to particular regions of the brain may increase the risk of late complications, including stroke.

"When you make your decision today, do you think of tomorrow, in a year, in two years, or in 20 years?" Bouffet asks.

The question becomes even more complicated when treatment is delivered to infants and very young children whose developing brains are particularly vulnerable.

He remembers the difficult decisions involved in treating children with rhabdoid tumours, rare and highly aggressive cancers that often occur early in life.

Historically, treatment frequently involved combinations of surgery, intensive chemotherapy and radiotherapy, with potentially devastating long-term consequences for survivors.

In 2004, Bouffet began exploring an approach that sought to avoid radiotherapy in selected patients.

At the time, the decision was far from universally accepted.

"Every patient I had with rhabdoid tumour, I had sleepless nights when I was making the decision not to use radiation."

He says subsequent research from his group suggests that radiotherapy may be avoided in a substantial proportion of patients using this approach, although the findings he describes were still awaiting publication at the time of the interview.

The experience illustrates a dilemma that has shaped Bouffet's career: treatment decisions must account not only for a child's immediate survival, but also for the life that follows.

That responsibility is now driving another area of research — finding ways to prevent, reduce or potentially repair neurological damage caused by brain tumours and their treatment.

At SickKids, research teams led by Pr. Donald Mabbott are investigating approaches to brain rehabilitation, including medicines such as metformin, alongside non-pharmacological interventions such as physical activity.

These remain areas of active research rather than established solutions for reversing treatment-related neurological injury.

Yet Bouffet believes rehabilitation deserves far greater attention.

After months or years of cancer treatment, families understandably want their child to return to ordinary life. But completing treatment does not necessarily mean recovery is complete.

Some children continue to experience cognitive, neurological or functional difficulties requiring long-term support.

The ambition is not merely to keep children alive. It is to help them learn, communicate, develop independence and participate as fully as possible in the world around them.

And that ambition becomes even more complicated when

the resources available to survivors differ dramatically between countries.

When Geography Determines the Meaning of Survival

Consider a child who develops hearing loss after receiving cisplatin, a chemotherapy drug used in the treatment of several childhood cancers.

In a high-income country, that child may receive hearing assessments, hearing aids and educational support.

In a low-income setting, the same hearing loss may have profoundly different consequences.



Dr Bouffet at the United Nations

Hearing aids may be unaffordable or unavailable. Specialist support may not exist. A child who survived cancer may subsequently face serious barriers to education and social participation.

"What we consider as no problem in a country can be a big problem in another country," Bouffet explains.

The example exposes a fundamental inequality: the consequences of surviving cancer can be determined as much by a country's resources as by the disease or its treatment.

When he became President of the International Society of Paediatric Oncology (SIOP) in 2016, he encountered clinicians working under conditions dramatically different from those in Canada.

He met physicians from countries where the central challenge was not access to the newest molecular therapy, but ensuring that children with cancer were diagnosed at all.

In some settings, large numbers of children never reached specialist services.

"Now there is a bigger picture," he remembers thinking. That recognition helped redirect his professional priorities towards strengthening paediatric oncology in countries with limited resources.

During his SIOP presidency, from 2016 to 2019, Bouffet gained opportunities to engage with health ministers, international organisations and policymakers.

One particularly meaningful moment came in September 2018, when the World Health Organization launched the Global Initiative for Childhood Cancer at the United Nations.

The initiative represented an opportunity to move childhood cancer higher on the global health agenda, with an ambition to achieve at least 60% survival worldwide by 2030.

But as that deadline approaches, Bouffet is concerned that the target may not be reached.

The obstacles extend beyond healthcare funding and infrastructure. Conflict and political instability can undo years of progress almost overnight.

In Ukraine, where he had collaborated with colleagues to strengthen paediatric oncology services, Russia's full-scale invasion in 2022 transformed the priorities almost overnight.

Instead of developing treatment programmes, teams faced the urgent task of protecting and evacuating children undergoing cancer care.

He recalls the international response, including the SAFER Ukraine initiative led by Saint Jude Children's Hospital under the leadership of Dr. Rodriguez-Galindo, as an extraordinary example of collaboration under crisis conditions.

He also points to Myanmar, where childhood cancer partnerships had been developing before the 2021 military coup severely disrupted cooperation and healthcare delivery.

Despite these setbacks, Bouffet believes the WHO initiative

has generated meaningful progress. The challenge is sustaining that progress and ensuring that international commitments translate into better care for children.



In Ukraine

Forty Countries, One Shared Responsibility

Today, Bouffet's international work connects him with paediatric oncology teams across approximately 40 countries.

Much of that collaboration takes place through regular virtual meetings, case discussions and exchanges between specialists.

He is emphatic that these relationships are not simply about transferring knowledge from wealthy countries to poorer ones.
"It's not, I am the teacher and they are the students," he says. *"I learned so much from this."*

Effective collaboration requires understanding what is realistically available in each setting.

There is little value in recommending an immediate MRI scan or proton therapy to a team that has access to neither.

Instead, Bouffet believes international partnerships must help clinicians make the best possible decisions within their own circumstances while strengthening local capacity.

He points to the development of paediatric neuro-oncology services in Pakistan, including the work of Dr Naureen Mushtaq, as an example of what committed local leadership can accomplish.

He also describes encouraging initiatives in Ethiopia and ongoing collaborations with colleagues in Iran and Lebanon, despite considerable challenges.

One of his central priorities is multidisciplinary care.

Treating a childhood brain tumour requires coordination between neurosurgeons, oncologists, radiation oncologists, radiologists, neuropathologists and other specialists.

When these professionals work in isolation, children may lose opportunities for better diagnosis and treatment.

For Bouffet, strengthening communication and multidisciplinary decision-making is one of the most practical ways to improve care, even where resources remain limited.

The Children a Doctor Never Forgets

For all the scientific achievements and international recognition, Bouffet speaks most personally when reflecting on the children whose treatment did not succeed.

Some died despite every effort to save them. Others died from complications of the treatment intended to cure them.

"You see a child who dies from the toxicity of your treatment and you feel ashamed of yourself," he says, describing the emotional burden physicians can carry even when they have followed accepted treatment protocols.

Such experiences have remained with him throughout his career.

He remembers children with whom he developed particularly close relationships, making their deterioration or death especially difficult to bear.

"When you care, you can also suffer."

There were periods when these losses became almost

overwhelming.

Yet he continued, because other children still needed care.

Over time, those experiences have deepened his understanding of responsibility. A physician must make decisions with the knowledge available today, while recognising that their consequences may only become clear decades later.

It is a perspective shaped as much by the children he could not save as by those whose lives he helped change.

Beyond Medicine: The Courage to Keep Dreaming

Outside oncology, Bouffet's passions reveal a different side of the physician.

He loves cycling and long-distance running, and once imagined pursuing a life in sport.

Growing up in France, he admired cycling legends such as Eddy Merckx and Bernard Hinault. Even now, when riding in the mountains, he sometimes imagines himself following in their footsteps.

The French Alps remain particularly meaningful to him. Although he has built much of his professional life in Canada, France is where his roots lie.

He also speaks warmly of a book about the French Resistance on the Plateau des Glières during the Second World War, a story that impressed him through its themes of courage, sacrifice and service to others. Among his favourite films are Schindler's List, the French comedy Le Dîner de Cons, and The Intouchables.

Asked what advice he would give his younger self; he returns to a memory from his first SIOP meeting in Hanover in 1989.

Looking at the senior figures in the field, he saw people whose achievements seemed almost unreachable.

Years later, he would become president of the same international society.

His advice is simple: believe in yourself and do not assume that something is impossible merely because it seems beyond reach.

Near the end of the conversation, Bouffet is asked whom CancerWorld should interview next.

His first thought is Jonathan Finlay, one of the pioneers of paediatric neuro-oncology, whose work helped advance intensive chemotherapy and stem cell transplantation approaches for children with brain tumours.

But the suggestion comes with sadness. Finlay had died shortly before the interview.

Bouffet speaks of him with admiration, recalling both his personal experience of cancer as a young adult and his subsequent contributions to the specialty.

He then suggests another influential figure, Dr Roger Packer, whose career has also helped shape modern paediatric brain tumour care.

His tribute to these colleagues reflects a deep appreciation of the people who built paediatric neuro-oncology and the generations who will carry its work forward.

And it is to that next generation that Bouffet must now entrust one of his most deeply held ambitions.

He had hoped that by the time he retired, children diagnosed with DIPG would have a chance of being cured. That day has not come.

After more than four decades in medicine, he still finds it difficult to slow down. There are children whose tumours remain incurable, survivors whose lives are shaped by the consequences of treatment, and families for whom access to specialist care remains out of reach.

For Eric Bouffet, the fight is not only to save more children. It is to ensure that every child who survives has a future worth fighting for.

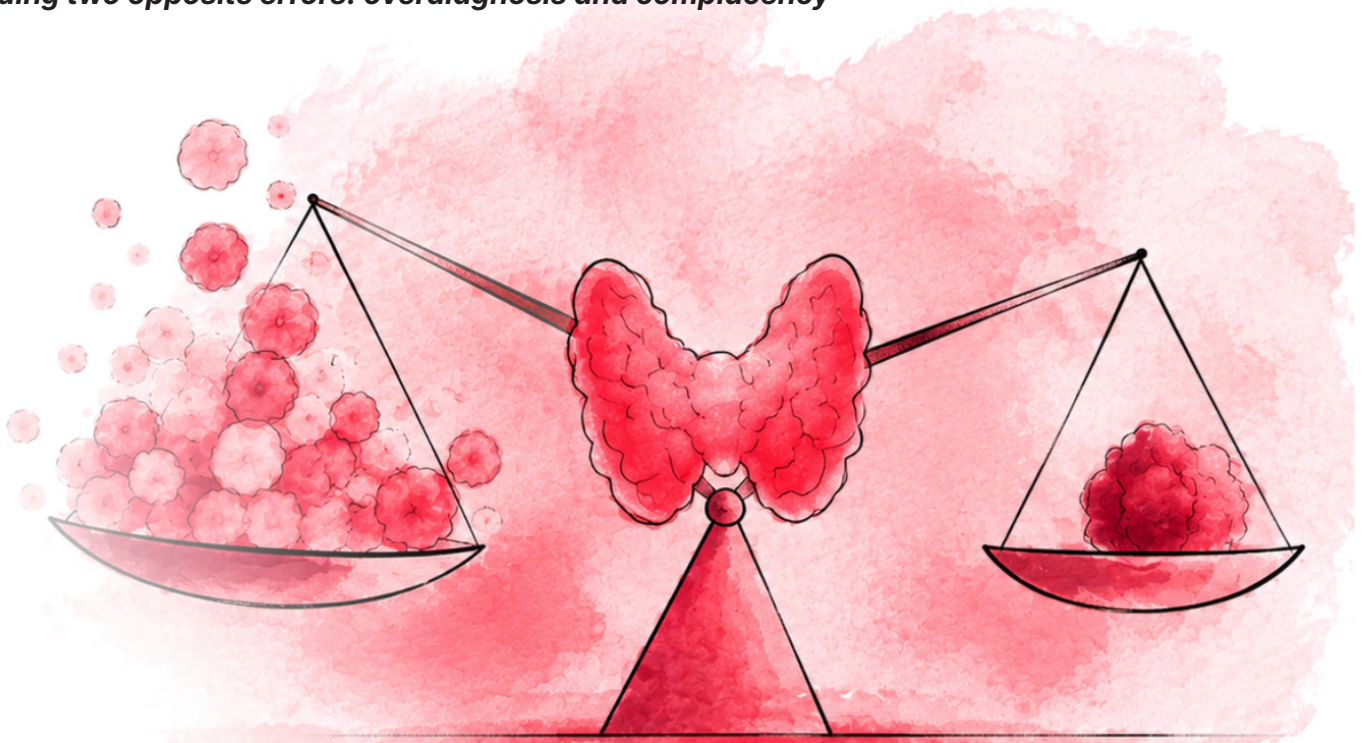
About the Author

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", and serves as PR and Communications Officer at "EMERTÉ" Clinic.

THYROID CANCER

When Does Overdiagnosis Become Too Easy an Answer?

Avoiding two opposite errors: overdiagnosis and complacency



By Loizos G. Loizou

Thyroid cancer incidence is increasing rapidly in many countries, particularly among adolescents and young adults and especially among females. One explanation has become increasingly prominent: **overdiagnosis.**

Greater use of ultrasound and other imaging can identify small, indolent thyroid cancers that might never have caused symptoms or threatened life. The consequences can include unnecessary investigations, surgery, lifelong thyroid-hormone replacement, psychological burden and healthcare costs, without corresponding benefit.

This is an important public-health concern and should be taken seriously.

But there is another danger: **assuming too quickly that overdiagnosis explains everything.**

What the Cyprus Data Reveal

An important population-based study from Cyprus (1), covering two decades from 1998 to 2017, adds another layer to this debate. Thyroid cancer incidence increased significantly, particularly among adolescents aged 15–19 years, with an annual percentage change of approximately 7.6%.

More importantly, the stage distribution also changed. While localised thyroid cancer increased 1.71-fold between the first and second decades, this rise

was not statistically significant. In contrast, regional metastatic disease increased 3.76-fold, a statistically significant change, and one distant metastatic case appeared in the second decade.

This pattern does not prove a genuine increase in disease occurrence. Changes in diagnostic practice may certainly have contributed. But it makes overdiagnosis alone a less complete explanation.

The more useful question may therefore be:

Could overdiagnosis and a genuine increase in thyroid cancer be occurring at the same time?

That possibility deserves investigation.

Potential explanations extend beyond diagnostic intensity. Genetic susceptibility, hormonal influences, ionising radiation, environmental exposures, dietary and iodine-related factors, and other determinants may all warrant consideration. Population-based observations cannot establish causation, but they can identify patterns that should not be ignored.

Between Overdiagnosis and Complacency

The policy challenge is therefore to avoid two opposite errors.

The first is overdiagnosis: searching for clinically insignificant disease in healthy people and exposing them to interventions from which they may never benefit.

The second is complacency: attributing every increase in incidence to improved detection and therefore failing to investigate whether genuine changes in disease occurrence are also taking place.

These concerns are not contradictory.

We can discourage indiscriminate thyroid screening while at the same time strengthening population-based cancer registration, monitoring trends by age, sex and stage, and investigating possible biological, environmental and healthcare-related determinants.

Indeed, avoiding unnecessary screening makes high-quality population-based surveillance even more important.

Better Research, Not More Screening

The goal of cancer control should not simply be to detect more cancers. It should be to identify cancers that matter clinically, treat patients who will benefit, and avoid harming those who will not.

But when robust population-based data reveal unusually rapid increases in incidence — particularly when more advanced disease is also rising — our response should not stop at overdiagnosis.

Overdiagnosis may be a major part of the story. But we should not decide that it is the whole story before the evidence tells us so.

For Cyprus, and for other countries showing rapidly rising thyroid cancer incidence, the next step is therefore not more screening.

It is better research.

Better registries. Better epidemiology. Better understanding of diagnostic practices, tumour characteristics and potential exposures. And ultimately, better ability to distinguish the cancers we need to find from those we might have been better never finding.

Reference

1. *Loizou L, Demetriou A, Erdmann F, Borkhardt A, Brozou T, Sharp L, et al. Increasing incidence and survival of paediatric and adolescent thyroid cancer in Cyprus 1998–2017: A population-based study from the Cyprus Pediatric Oncology Registry. Cancer Epidemiol [Internet]. 2021;74(June):101979. Available from: https://doi.org/10.1016/j.canep.2021.101979*

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A Chain Only as Strong as Its Weakest Link

Childhood Cancer Care Beyond the Drug

From Lagos to Glasgow, Ulaanbaatar and San Antonio, four international oncology meetings in 2026 revealed a common challenge: scientific advances are transforming childhood cancer care, but their impact depends on what happens before, during and long after treatment.

By Kristian Simonyan

Progress in the treatment of childhood cancer represents one of modern medicine's greatest achievements. Yet its benefits are not shared equally, and better outcomes depend on far more than the availability of effective drugs.

Every year, the International Society of Paediatric Oncology (SIOP) brings together clinicians, researchers, paediatric oncologists, nurses, scientists, patients and patient advocates, industry representatives and policymakers to discuss how children with cancer can receive more effective treatment.

In 2026, four SIOP meetings (SIOP Africa in Lagos, SIOP Asia in Ulaanbaatar, SIOP Europe in Glasgow and the 58th SIOP Congress in San Antonio) examined different parts of the same journey: how medicines are made available to children, how they are administered accurately, how their use can be modified, minimised or substituted, and how children manage life following the completion of treatment.

Read together, these discussions tell one story. A child's outcome depends on whether every part of the care pathway works together; weaknesses at one stage can compromise the benefits achieved at another.

Oncology risks defining progress too narrowly. New drugs, new trials and new technologies capture attention, yet they only help a child if the surrounding system can deliver them. Cancer care is a long-term commitment that encompasses access, infrastructure, financial considerations, appropriate treatment and survivorship.

The Pathway to Diagnosis and Treatment

At SIOP Africa in Lagos, a panel moderated by Alan Davidson highlighted that the availability of medicines alone does not guarantee timely treatment. Delays in diagnosis and referral, limited access to specialised testing, registration barriers, fragmented procurement and inadequate storage can all interrupt the pathway to care.

Even when medicines are free or donated, families may still face substantial costs for investigations, transport and accommodation, as well as the financial consequences of lost income. Meanwhile, hospitals face additional financial, logistical and operational demands.



16th Biennial SIOP Africa Congress, 13–17 April 2026, Lagos, Nigeria

The People and Pathways That Make Treatment Possible

Attention was also drawn to workforce shortages and difficulties retaining specialists in oncology, nursing and pharmacy. New therapies often come with additional monitoring and administration requirements, as well as the need to manage new side effects, increasing the demand for supportive care.

Treatment planning must therefore consider the availability of trained personnel and the healthcare systems needed to deliver these therapies safely.

The importance of establishing routine procedures for identifying and reporting treatment-related side effects, supported by appropriate training and thorough documentation, was also emphasised.

When complex treatments are best provided at specialised centres, effective referral pathways and communication between healthcare facilities become essential to ensuring equitable access. A child's ability to reach a specialist centre and return home safely depends not only on the availability of these services but also on the wider healthcare network and the support provided to families.

To address these challenges, a planned Delphi consensus study, whose protocol is currently under ethics review, aims to prioritise interventions for



7th SIOP Europe Congress, 4–7 May 2026 Glasgow, United Kingdom

children with blood cancers in sub-Saharan Africa.

Making the Most of Established Medicines

At SIOP Europe in Glasgow, one of the key messages that emerged was the idea that a "dose is not a biological effect".

Asparaginase illustrated this distinction. Although all scheduled doses may be administered, the enzyme may still be insufficiently active in the bloodstream, meaning that a child may not receive its full therapeutic benefit.

Rob Pieters discussed the phenomenon of "silent inactivation", whereby antibodies neutralise the enzyme without causing recognisable allergic reactions. He also presented evidence suggesting that missing planned doses may be associated with poorer outcomes in certain groups of children.

More intensive therapy may improve disease control, but it also carries a greater risk of toxicity. Placing this in a broader context, Carmelo Rizzari emphasised that the aim is not to deliver the most intensive treatment possible, but to achieve the right level of intensity for each child.

Against this background, one approach discussed was monitoring enzyme activity to help clinicians determine whether effective treatment exposure can be maintained through the use of an alternative formulation.

Yet a result is only useful if it can guide a clinical decision. The clinical team must know when to take a sample and what question the test is intended to answer, while the laboratory requires accurate information about the formulation used and the dosing schedule. Equally important, the results must be available in time to guide treatment.

Nonetheless, a practical challenge remains: how can hospitals without on-site enzyme activity testing make equally informed treatment decisions?

Rethinking the Backbone of Therapy

One of the most compelling questions in contemporary oncology is whether emerging therapies can reduce or,

in selected settings, eventually replace conventional chemotherapy without compromising outcomes.

At the 58th SIOP Congress in San Antonio, during the session "Chemotherapy for Acute Lymphoblastic Leukemia: Game Over?", we explored the potential role of immunotherapy in achieving this objective in childhood leukaemia.

Findings from the Children's Oncology Group AALL1731 trial in newly diagnosed standard-risk B-cell acute lymphoblastic leukaemia (ALL) showed an estimated three-year disease-free survival of 96.0% among children treated with blinatumomab alongside chemotherapy, compared with 87.9% among those receiving chemotherapy alone.



58th Annual SIOP Congress, 15–18 September 2026, San Antonio, Texas

An important distinction, however, emerged between adding immunotherapy to an existing treatment regimen and replacing components of chemotherapy altogether.

Several challenges remain, including identifying predictors of response, understanding long-term toxicity, maintaining central nervous system protection and managing the practical burden of infusion treatment.

But perhaps the most fundamental question was raised by Scott Howard: how much protection against relapse does an established chemotherapy agent provide, and can immunotherapy reliably replace that protection?

In some forms of ALL, the challenge is not simply how to use an effective new therapy, but how to develop one in the first place.

In T-cell ALL, for example, the development of targeted therapies presents additional difficulties because some therapeutic targets are also expressed by healthy T cells. While strategies targeting CD38 and CD7 may eventually allow some children to receive less intensive treatment, the priorities differ for those with resistant or relapsed disease, for whom the urgent need remains the development of more effective therapeutic options.

Life Beyond Treatment

The session at SIOP Asia in Ulaanbaatar drew attention to an often overlooked dimension of childhood cancer care: survivorship is not a stage that begins after treatment, but a journey that starts at diagnosis and continues long after therapy has ended.

During active treatment, the oncology team maintains a comprehensive understanding of the child's medical history. Once treatment ends, however, responsibility for ongoing care is shared among oncology teams, primary care providers, rehabilitation specialists, mental health services, schools and, eventually, adult healthcare services.

At each transition, there is a risk that essential medical information may be lost or that responsibility for follow-up may become unclear.

The Childhood Cancer Survivor Study reported an estimated cumulative incidence of chronic conditions of 73.4% within 30 years of diagnosis among survivors treated between 1970 and 1986. These historical findings underscore the importance of sustained, long-term follow-up.

One practical solution is a verified treatment summary, an actionable survivorship care plan based on that summary, and a family-friendly version explaining to the child and caregivers what happened, what to expect, whom to contact, and what follow-up is needed and why.

Digital resources, such as PanCare's Survivorship *18th*



SIOP Asia Congress, 25–28 June 2026, Ulaanbaatar, Mongolia

Passport, can further support the accessibility and portability of these records.

Effective survivorship care also depends on collaboration among three groups: the treating oncology team; peer groups of survivors and caregivers guided by a trained facilitator; and survivor advisory groups that help evaluate whether services adequately address survivors' needs.

Clear responsibilities are equally essential. A designated clinician should verify the treatment summary before it is shared, a named coordinator should oversee referrals and follow-up results, and the receiving primary care clinician should acknowledge receipt of the information.

Psychosocial support and preparation for the transition to adult healthcare should also form an integral part of the care pathway.

Ultimately, survivorship care should be evaluated through measurable indicators: completion of the handover, attendance at the first appointment, continuity of subsequent care, and survivors' understanding of their health risks and the actions they need to take.

Beyond Innovation: Addressing the Wider Challenges

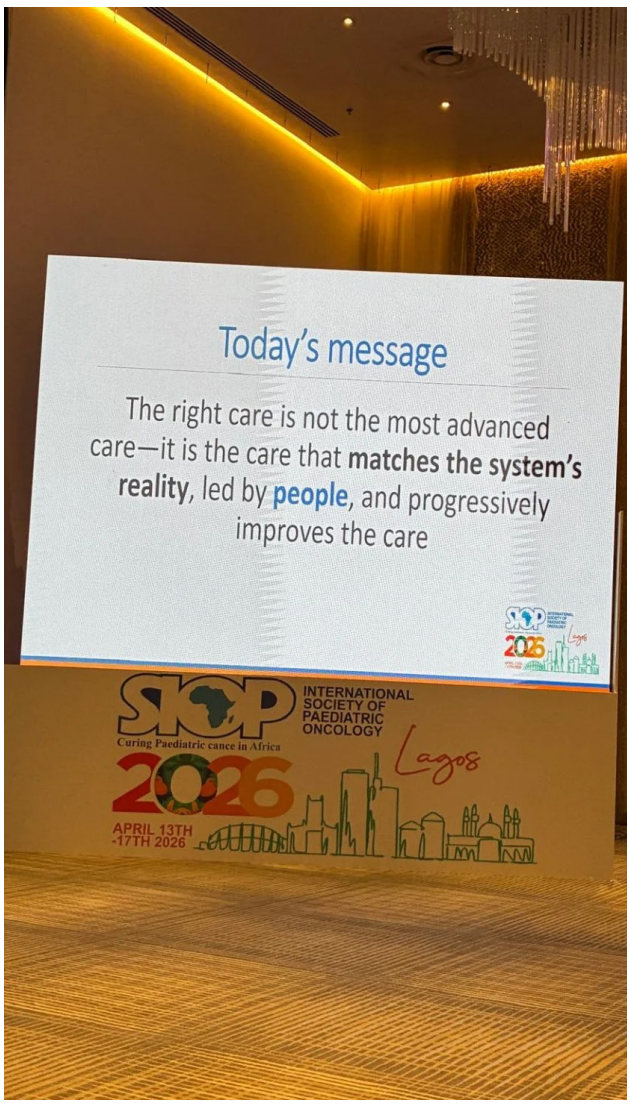
The discussions across the four congresses raise important questions about how healthcare priorities are established and resources allocated.

One counterargument is that an emphasis on healthcare systems risks diverting attention from a

central driver of improved survival: the development of more effective treatments. If immunotherapy can reduce the intensity of chemotherapy, the argument goes, many of today's burdens will disappear.

We take that hope seriously, but the evidence does not yet justify relying on this assumption. New therapies bring their own demands, which many healthcare systems are not yet ready to meet.

Others will argue that precision monitoring, comprehensive survivorship plans and referral networks are luxuries that hospitals with limited resources cannot afford.



16th Biennial SIOP Africa Congress, 13–17 April 2026, Lagos, Nigeria

This is a fair concern, and the congress discussions did not overlook it. The session in Ulaanbaatar showed that a service can start with a clinician-verified treatment summary, a short list of priority follow-up actions and a named contact, using a paper record and an appointment register.

The lesson is not that every setting must do everything at once, but that each gap should be identified and documented, with a plan in place to address it.

A Continuous Commitment to Every Child

Improving childhood cancer outcomes requires coordinated action across the entire care pathway. We call on health ministries, healthcare systems, researchers and families to treat these responsibilities as one continuous commitment rather than separate projects.

Plan for the full cost of care, strengthen referral pathways and communication, invest in personalised treatment, test new drugs against unresolved clinical questions, and embed survivorship planning from the point of diagnosis, ensuring clear responsibility and the active involvement of survivors and caregivers.

Scientific advances have transformed childhood cancer care and will continue to do so. But their full value can only be realised when the systems surrounding them are strong **enough to support** every stage of a child's journey.

Our collective responsibility is to ensure that no child is failed by a weak link in the continuum of care.

All the events mentioned above were supported by an unrestricted educational grant from Servier.

About the Author

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Why are So Few Men Involved in Cancer Advocacy?

By Victoria Forster



Patient advocates have been involved in pushing for better care, treatments and policies for people with cancer and their families for over half a century. But the cancer advocacy movement has accelerated considerably in recent years, with patients and caregivers increasingly involved in varied advocacy roles.

From helping to determine research priorities and reviewing grant applications to advising on clinical trial design and influencing healthcare policy, patient advocates are important contributors to cancer research and care. Yet looking at many of these spaces, an imbalance becomes apparent: there are often many more women than men.

Traditional expectations around masculinity, differences in how men and women approach cancer and practical barriers to participation may all play a role. But does the relative absence of men matter, and what might be done to encourage more of them to get involved?

What Does a Cancer Advocate Look Like?

Once largely associated with grassroots campaigning, fundraising and calls for better treatments, cancer advocacy became more mainstream in the 1990s notably largely driven by organized advocacy groups of women with breast cancer. Cancer advocacy now encompasses a much broader range of people, cancer types and experiences as more people survive cancer long-term. But men remain under-represented in almost all advocacy spaces.



Tim McDonald on the left

Tim McDonald was diagnosed with stage IV colon cancer in 2020. After getting involved with patient communities, he became an ambassador with the organization "Fight Colorectal Cancer" and joined its research advocate training and support program. He also wrote a book about his advocacy.

"When I started doing advocacy, men were about 10-15% of the people showing up in the room. I started talking about my experience and trying to encourage more men to take what they're going through and turn it into purpose," said Tim.

For Tim, talking about his own experiences developed into a passion for advocacy, particularly the opportunity to influence decisions that have traditionally been made by researchers and healthcare professionals.

"Understanding the power patients can have when they have a voice in the research process is something I'm very passionate about," said Tim who has served as a patient peer-reviewer for the Congressionally Directed Medical Research Programs[1].



T.J. Sharpe with his son Tommy. Photo Credit to: Sam Balanovich

T.J. Sharpe was diagnosed with stage one melanoma at 25 and his cancer returned twelve years later as stage four disease. By then, he was married with two children, including a newborn son. He started blogging about his experiences and treatments to help him make sense of what was happening.

"When I started, it was: How do I explain all of this to not just my family and friends, but the people who were going to read the blog," said T.J., who received newer treatments including immunotherapies, which



Tim McDonald on the left

he sought to learn about and explain to his audience.

Over time, his writing became an opportunity to share knowledge and help others navigate their own cancer experiences. T.J. also got involved in a non-profit organization, TransCelerate which aims to include diverse voices to influence pharmaceutical development as well as several other roles.

The Barriers Men May Face When Advocating

There has been very little research done on why men are under-represented in many cancer advocacy spaces. The cultural expectations surrounding traditional masculinity and the expectations to be "strong" in the face of adversity may play a factor.

"Men are brought up traditionally to be the ones who have all the answers, to not show weakness, and not to cry," says Tim.

A cancer diagnosis often brings uncertainty, dependence on others due to cancer and treatments and difficult conversations about roles, relationships and mental health.

"There seems to be this paternalistic, macho attitude in a lot of guys I know: 'Cancer is a real inconvenience. This is just something I'm going to beat, and then I'm going to put it behind me,'" said T.J.

Such attitudes may influence not only how men approach their cancer treatment, but also whether they see themselves as potential advocates. Sharing personal experiences, discussing the impact of cancer on mental health and participating in conversations about survivorship requires a degree of openness that some may find uncomfortable.

Times may be changing, possibly driven by several prominent campaigns encouraging men to talk about and look after their own mental health such as the "Movember"2 campaign. Such campaigns may be contributing generally to men being willing to talk openly about their own experiences.

"I see a much more open attitude from advocates who

are in their 20s and 30s around talking about what's difficult," said T.J.

There may also be more practical obstacles. Financial compensation for lived expertise is still only sporadically provided with much advocacy still done on a volunteer basis. Meetings, consultations and other commitments can also be difficult to schedule around employment and family responsibilities.

"My theory is that some men, because they can be the only, or higher income earners, feel like they can't take time away from work to do advocacy because it could impact their household income," said Tim.

For all patient advocates, people who cannot afford to provide their time for free are likely excluded, regardless of their gender, willingness or ability to contribute.

"Advocates should be compensated fairly, just like everybody else, because our voice is no less important than the statistician, the marketing person, or the branding person you hire," said Tim.

Making Space for More Men in Advocacy

Men are more likely to be diagnosed with and die from cancer, as well as to be diagnosed with more advanced disease3. But other than advocacy spaces which are by nature, male dominated such as for prostate and testicular cancer, they are often under-represented.

"I don't know that there are enough of us as male figures out there that encourage other males to be part of the support system," says T.J.

Part of encouraging more male cancer advocates might simply to ensure those who are currently advocating are visible.

"When you are truly vulnerable and open yourself up, people resonate with it. To me, that's not a sign of weakness. That's a sign of strength-that you have the capacity to do that in front of other people," said Tim.

Ultimately, addressing the relative absence of men in cancer advocacy requires a broader examination of who is encouraged to participate, whose experiences are valued and what an advocate is expected to look like.

"Empathy and selflessness and altruism are not probably as strongly associated with strong males as they are with strong women," said T.J.

Changing these perceptions will take time and male cancer advocates leading by example, such as Tim and T.J.

"I went from having three years to live to still being here six years later: I had the purpose of wanting to help others and turning that into advocacy. This fills my cup. It gives me a satisfaction that nothing else in this world, to this point in time, has provided me," said Tim.

Involving more men in cancer advocacy won't be achieved just by encouraging more men to speak up. It will also require more understanding as to why they so often decide not to and the creation of environments in which they feel they can.

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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.

European School of Oncology



Who Do You Choose to Be When the Consultation-Room Door Closes?

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

By Christina Bothou

Modern oncology has never demanded more of us. We have become accustomed to working in a state of permanent interruption.

Before my day even begins, my inbox is overflowing. New evidence appears overnight. Clinical trials need participants. Multidisciplinary boards await. Electronic records demand completion. Notifications compete relentlessly for our attention while science advances faster than any individual can absorb.

Then the consultation-room door closes.

And almost every time, I feel a sense of relief. For a few moments, the emails stop mattering, the documentation can wait, and the endless stream of information becomes temporarily irrelevant. What remains is a patient sitting in front of me.

My patients do not distract me from my work; they bring me back to it.

That relief, however, carries a responsibility. What will I do with these next few minutes? Will I continue thinking about everything waiting outside? Will I stare at the screen while preparing the next question in my mind? Or will I allow this encounter to become a moment where nothing competes with the patient for my attention?

Making time for what matters most is not about finding more minutes in the day. It is about deciding what deserves our full attention in the moments we already have.

The Moments That Matter Most

There are moments in oncology that stay with us. Just saying: "The scan is good," and witnessing the relief that crosses a patient's face is a privilege unlike almost anything else in medicine. Behind those words may be months of imaging, molecular profiling, toxicities, and statistics. Yet for the patient, it is wonderfully simple: good news, relief, and a future that suddenly feels possible again.

These encounters remind us that medicine is not only about what we know, but how we accompany another person through what they do not know. Maya Angelou wrote, "People will forget what you said, people will forget what you did, but people will never forget how you made them feel." Patients may forget the name of an immunotherapy or a genomic alteration. But they will remember whether we noticed that they were frightened. They will remember whether, despite everything demanding our attention, they truly had it. Sometimes, the most meaningful thing we offer is not an answer, but the reassurance that the patient does not have to carry uncertainty alone. A diagnosis brings questions that medicine cannot always resolve immediately: What happens next? Will the treatment work? Will life return to normal? In those moments, our presence can become a form of care in its own right. We may not be able to remove uncertainty, but we can make it less lonely.

Presence Is a Clinical Competency

This is why self-awareness, communication, and empathy are not "soft skills": they are clinical competencies. They influence how information is understood, how uncertainty is tolerated, and whether patients feel safe enough to tell us what they are really experiencing.

Presence is not automatic. It is a conscious choice, practiced every day.

It can begin with something remarkably small: looking up before typing. Listening to the answer rather than preparing the next question. Allowing silence to exist rather than rushing to fill it. Asking, "What worries you most?" and resisting the instinct to immediately solve the problem. Seeing the person before the diagnosis. These actions take seconds. Their meaning can last much longer. Yet presence is not only something we give to patients; it gives something back to us. In Greek, katharsis refers to a process of inner renewal. The consultation room offers that renewal, a chance to reconnect with the human reason behind the profession.

The Paradox of Modern Oncology

Modern technology gives us extraordinary tools, and these tools have transformed our ability to care for patients. We can access more information, make more precise diagnoses, personalise treatments, communicate across disciplines, and make decisions with a depth of knowledge that was once unimaginable.

Yet this creates a paradox: the more information we gather and the more sophisticated our tools become, the easier it is to focus on the data rather than the person who

needs us to interpret it. We risk forgetting a fundamental truth: all of these tools exist to support our work for the patient. They are essential to what we do, but they are not the person we are here to care for.

A clinician who never pauses to reconnect with their own humanity may gradually lose the ability to recognize the patient's. Without reflection, presence becomes mere performance, the appearance of listening without truly being there.

Protecting the Humanity of Medicine

There is another risk when the demands of the profession become relentless. The cumulative weight of endless work, constant interruption, administrative burden, and the pressure to remain perpetually responsive can slowly erode the sense of meaning that brought us to medicine in the first place. We may continue to function, make decisions, complete the work, and meet every demand, while becoming increasingly distant from the human purpose beneath it all. The danger is not only exhaustion. It is demoralisation: the quiet feeling that we are spending more and more of our days managing the machinery of medicine and less of them inhabiting the reason we became doctors. Protecting our own humanity, then, is not a luxury or an indulgence. It may be essential to preserving our capacity to care.

When the consultation-room door opens again, the inbox will still be full, the scans will still need interpretation, and the administrative burdens will remain. We cannot silence everything outside the room, but we can control what happens while the door is closed.

Inside those few minutes, we offer something no algorithm can provide: undivided human attention. That brings us to the question worth carrying from one consultation to the next:

Who do you choose to be when the consultation-room door closes?

Acknowledgement

This article was written by Dr Christina Bothou, one of the two winners of the ESO College Voices Contest 2026, on the topic ***"Who Do You Choose to Be When the Consultation-Room Door Closes?"***.

This year's contest once again proved that doctors can also be excellent cancer writers. We received 23 proposals from ESO College members across 19 countries, each exploring the chosen theme. After careful deliberation, guided by CancerWorld's editorial standards, as well as criteria of clarity, relevance, originality, potential impact, and our hallmark style of weaving in interviews and firsthand perspectives, Dr Bothou was selected as one of the winners, and we are proudly publishing her impactful voice.

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THIRTY YEARS LATER

What Nobody Tells You About Surviving Cancer

By Matthew Zachary



Diagnosed with a malignant brain tumour at 21, Matthew Zachary survived, but lost the career he had spent his childhood preparing for. Three decades later, he reflects on the hidden costs of survival, the gaps in long-term cancer care and why keeping patients alive is only the beginning.

Matthew Zachary

I was 21 years old and a concert pianist when a doctor told me I had a malignant brain tumor.

That sentence contains everything people usually need from a cancer story: young person, terrible diagnosis, ruined plans, treatment, survival. It has an ending everyone can understand. I lived.

Thirty years later, I have a problem with the ending. The diagnosis was not the hardest part. Treatment was brutal, certainly, but it came with doctors, appointments, protocols and an obvious objective. The stranger part began after everyone had done what they were supposed to do and I was left to figure out what survival actually meant.

Treatment saved my life and damaged my left hand. The neurological effects did not arrive with a ceremonial announcement that my career was over. I gradually understood that the thing I had spent my childhood preparing to do was no longer available to me. My doctors had explained my odds of surviving. Nobody explained what surviving might cost.

The Generation Oncology Overlooked

I don't blame them. In 1995, oncology was understandably preoccupied with keeping people like me alive. Five-year survival was the measurement, and by that measurement my care was an unqualified success. What happened in year six, or sixteen, or twenty-six belonged to some hazier category of medicine. There was supposedly another department for that, except there really wasn't.

When I went looking for other people my age who had been through cancer, I discovered another gap. Pediatric oncology had children. Adult oncology had people decades older than me. Young adults were stranded somewhere between them, a population the field had barely learned to name.

I eventually founded Stupid Cancer, which grew into the largest young adult cancer community in the world. For two decades, I watched thousands of people make versions of the same discovery. They had been cured. They weren't necessarily well.

Medicine had become very good at distinguishing alive from dead and considerably less organized around everything in between.

What Five-Year Survival Statistics Cannot Tell Us

Survivorship is surveillance that can continue for decades, accompanied by the peculiar dread that returns when another scan appears on the calendar. Late effects can surface ten, twenty or thirty years after treatment. Sometimes the treatment that saves you causes a second cancer. Survivors live with cardiac and endocrine damage, cognitive changes and infertility that may not have been discussed before treatment made it permanent. My own treatment left me with permanent hearing loss from cisplatin and neuropathy from vincristine, among other souvenirs I did not select from the gift shop.

Then there is the administrative job nobody hired you for. Survivors reconstruct treatment histories because records are scattered or unusable. We explain late effects to primary care physicians who may rarely encounter someone decades out from cancer treatment. Eventually you become the institutional memory of your own body because nobody else has the complete file.

And there is identity. You're no longer receiving cancer treatment, so technically you're not a patient. You're being monitored indefinitely, so "well" can feel slightly ambitious. We settled on "survivor," a word carrying expectations of gratitude that I understand and genuinely feel. But gratitude isn't a care plan.



Thirty years after brain cancer derailed his career as a concert pianist, Matthew Zachary performs at Lincoln Center during the launch of his book, 'We The Patients'

The Survivorship Gap Is Global

Because I spend so much of my professional life arguing about American healthcare, I am tempted to blame America for everything. Unfortunately, we don't own this one.

Survivorship remains underbuilt across very different health systems because most were constructed around acute episodes of illness. Funding, staffing and measurement concentrate on what happens between diagnosis and remission. Year fifteen doesn't fit neatly onto anyone's dashboard. Systems that otherwise share very little can produce remarkably similar gaps once the patient leaves active treatment.

America does add its own special paperwork package. Here, survivors may also negotiate with insurers over whether surveillance is medically necessary, discover that a condition caused by cancer treatment is treated as an entirely separate problem, and navigate appeals processes exhausting enough that some people simply give up. Other countries organize and finance care differently, but the underlying danger travels well: survivors become easy to overlook when healthcare systems count short-term outcomes better than long lives.

Building the Care That Survival Demands

I have watched some things help. Survivorship care plans work when they are actual documents that follow patients into primary care rather than accreditation checkboxes. Medical and nursing education can treat survivorship as a discipline instead of an oncology footnote. Long-term follow-up can be designed around the patient's lifespan rather than the five-year window favored by registries and funders. Survivors can also participate in designing these systems as decision-makers, rather than being invited to tell an affecting story before the professionals get down to business.

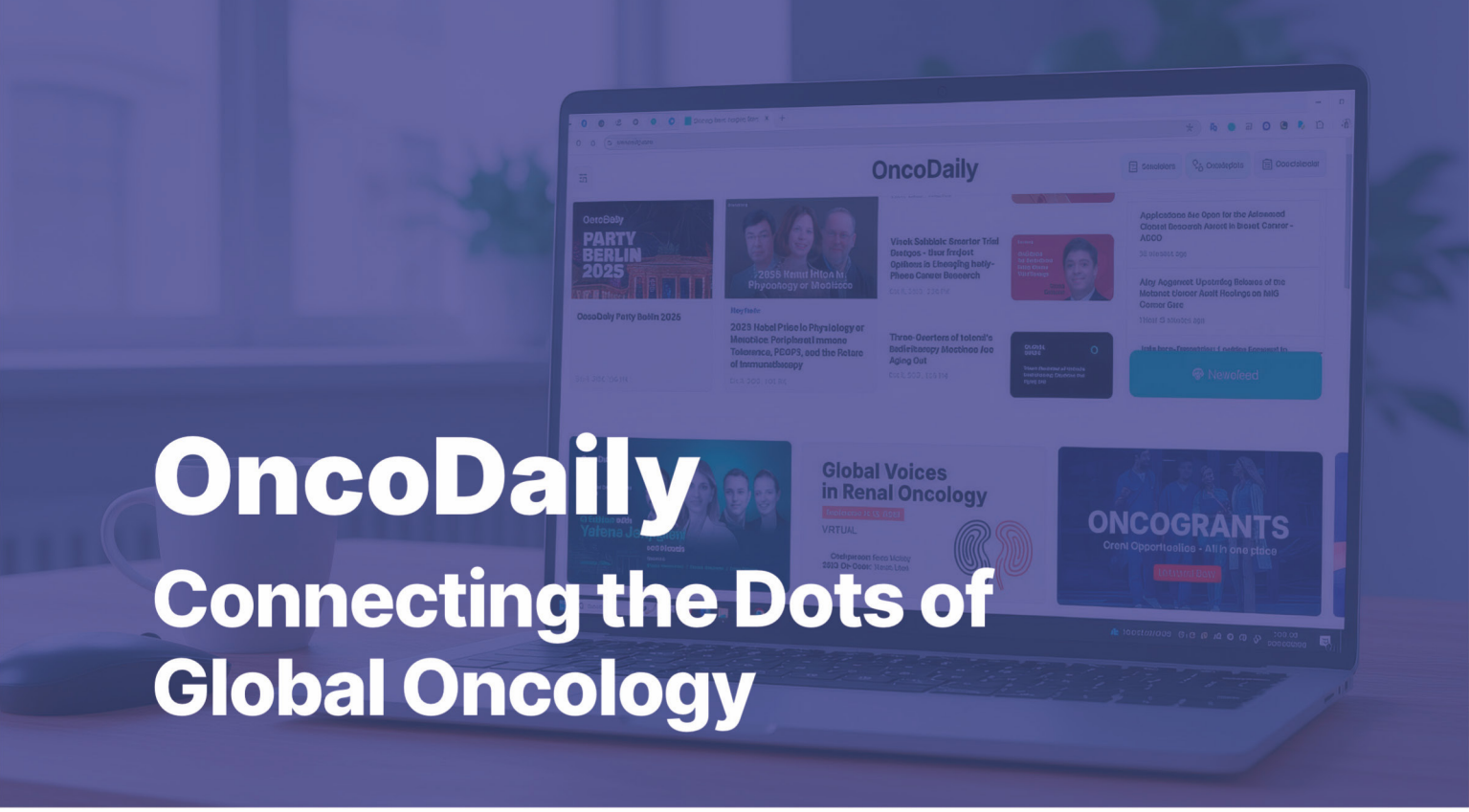
None of this requires diminishing what oncology has accomplished. More people are living after cancer, and I am one of them. I would not trade that achievement for anything. But every improvement in treatment produces more people who will eventually need a kind of care we still haven't fully built. Success created a population faster than healthcare created somewhere for that population to go.



Survival turned out not to be the ending. It has been most of the story.

About the Author

Matthew Zachary is a 30-year brain cancer survivor, founder of Stupid Cancer, and host of Out of Patients.



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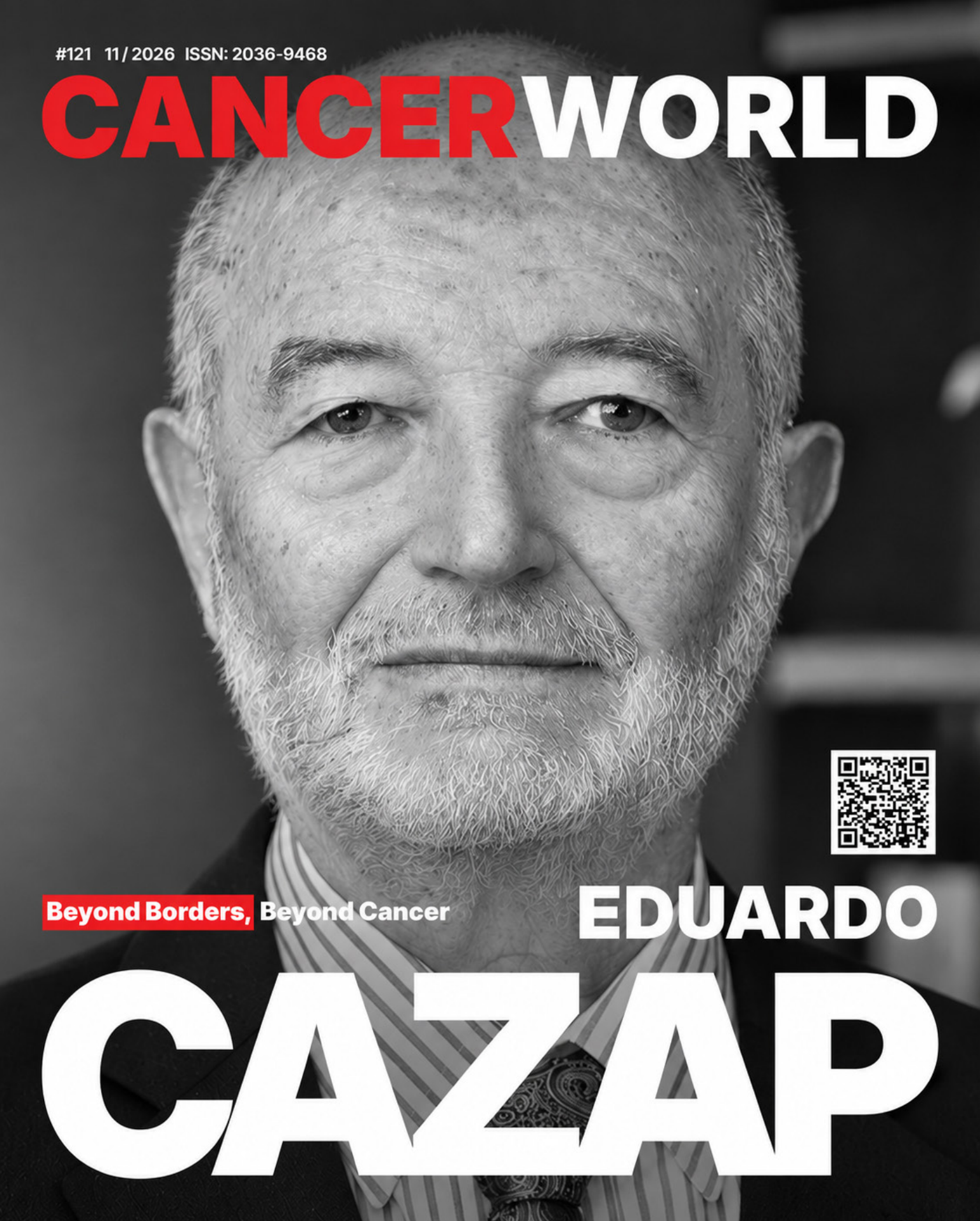
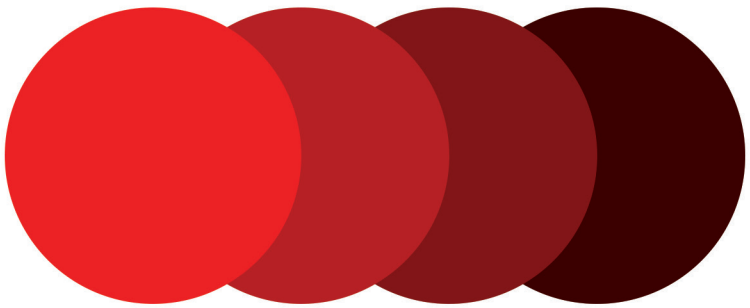


Beyond Borders, Beyond Cancer

EDUARDO CAZAP



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The global oncology pioneer reflects on a lifetime of leadership, the fight for equitable cancer care, and the unfinished mission of bringing progress to every patient.



Beyond Borders, Beyond Cancer

Eduardo Cazap

By Knarik Arakelyan

For more than half a century, Eduardo Cazap has challenged the way the world thinks about cancer. From the hospital wards of Buenos Aires to the highest levels of international health policy, his career has been shaped by a conviction that transformed his understanding of medicine: treating cancer is not the same as controlling it.

"Around the 90s, I realized that the problem of cancer was not exactly the disease," Eduardo Cazap tells CancerWorld.

That realisation changed the course of his career. The fight against cancer, he came to believe, could not be confined to hospitals, laboratories or the search for new therapies. It had to encompass prevention, early detection, stronger health systems and the political will to make progress accessible to entire populations. Decades later, as scientific breakthroughs transform cancer treatment, Cazap remains convinced that the world's greatest challenge lies beyond medical discovery. His assessment of how far we have come is as candid as it is unsettling.

"I think that the gap is widening."

The Physician Who Looked Beyond the Disease

Cazap's vision was profoundly influenced by Dr Roberto Estévez, whom he describes as *"the father of Latin American oncology."*

At a time when cancer medicine was largely defined by surgery, radiotherapy and chemotherapy, Dr Estévez was already advocating a broader understanding of cancer control, extending from prevention and early detection to treatment, survivorship and palliative care.

By the 1990s, Cazap had recognised another limitation: international oncology remained divided along national and regional lines, with much of the world underrepresented in decisions shaping cancer research and policy.

He recalls encountering professional organisations whose priorities were largely defined by geography. American institutions focused on American oncologists, European organisations in Europe. Latin America, despite its considerable clinical expertise, had limited influence in global decision-making.

"So at that time, I added one word to the concept and started with the idea of global cancer control."

His ambition was to move beyond regional interests and establish cancer control as a shared international responsibility.

In 2005, he founded the Latin American and Caribbean Society of Medical Oncology (SLACOM), strengthening the region's collective voice. From 2010 to 2012, he served as President of the Union for International Cancer Control (UICC), helping advance cancer as a global public health priority.

Yet his belief in collaboration began much earlier.

At the MIlitary Central Hospital in Buenos Aires, Dr. Estevez , Dr. Chacon , Dr Cazap and his colleagues were organising multidisciplinary tumour boards in the 1970s, challenging a healthcare culture in which surgeons, radiotherapists and medical oncologists frequently worked in isolation.

"One of the hardest things to promote was the multidisciplinary treatment of cancer," he recalls.

What is now fundamental to modern oncology was once an institutional struggle. It taught him a lesson that would define his international work: progress depends not only on medical knowledge, but on the ability of people and institutions to work together.



The Founder Board of Directors of SLACOM , 2005 with Dr Charles Balch, CEO of ASCO in a meeting in Lima, Peru
From left to right: Dr Gilberto Scwartsman (Brazil), Dr Eduardo Cazap (Argentina), Dr Carlos Vallejos (Peru), Dr Charles Balch (USA), Dr Carlos Garbino (Uruguay) and Dr Francisco Orlandi (Chile), Dr Jaime de la Garza (Mexico) and Dr Antonio Buzaid (Brazil)

A Patient Who Never Left His Memory

Among the many patients Cazap has treated, one story remains particularly vivid.

In the 1980s, he cared for an eight-year-old girl with sarcoma and multiple metastases in both lungs. Chemotherapy had failed, and her family pursued further treatment abroad, including in France.

Eventually, surgeons removed the metastatic lesions from both lungs in separate operations — an unusual approach at the time. The girl survived.

Years later, however, she developed breast cancer, which Cazap recalls was associated with radiotherapy received during childhood. Further treatment followed, including bilateral mastectomy.

Today, he says, she is healthy and has children of her own.

Her story illustrates both the extraordinary possibilities and the lasting consequences of cancer treatment. Saving a life may be only the beginning of a patient's medical journey, and decisions made in childhood can shape health decades later.

For Cazap, experiences like this reinforced the need to see cancer care as a continuum, rather than a series of isolated interventions.

The Promises the World Has Yet to Deliver

A signatory of the Paris Charter Against Cancer in 2000, Cazap later led UICC during a period of growing international attention to cancer and other non-communicable diseases.

Yet more than two decades after those commitments, his assessment is uncompromising.

"The Charter of Paris, I think that in 2000 was an important document, but the document was not followed by actions."

For Cazap, the central failure of global cancer policy is not a shortage of declarations or ambitious goals. It is the persistent inability to translate them into effective, adequately financed national programmes.

He is particularly concerned by oncology's overwhelming emphasis on treatment at the expense of prevention. While new therapies continue to transform outcomes, he argues that primary prevention, risk reduction and early detection remain indispensable to reducing the global cancer burden.

His criticism is not a rejection of scientific innovation, but a challenge to the assumption that better treatments alone can solve a problem of such enormous scale.

Precision oncology makes this tension increasingly visible. Targeted therapies can produce remarkable results, but their high costs and increasingly specific indications raise difficult questions for health systems struggling to provide essential care.

Cazap contrasts this with earlier generations of chemotherapy, when individual drugs could be used across multiple cancer types and reach larger patient populations at comparatively lower costs.

For individual patients, these advances can be transformative. For health systems, they can intensify the challenge of equitable access.

His priorities for the next decade are therefore strikingly practical: adequately funded national cancer plans, reliable cancer registries sustained over time and stronger political commitment.



World Cancer Leaders Summit, Dublin, Ireland, 2011

"National cancer plans in all countries of the world, operative and funded," he insists.



With President George H. W. Bush Father during a meeting of the National Dialogue on Cancer, later known as C-Change

He also wants an end to fragmented initiatives, duplicated efforts and international recommendations that lack realistic mechanisms for implementation.

"Without political will, all things are more difficult and complicated."

The message is clear: scientific breakthroughs expand what medicine can achieve, but political decisions determine how widely their benefits are shared.

Leadership Beyond Borders

Cazap's experience in Latin America has reinforced his belief that the greatest obstacles to better cancer care are not always scientific.

"Latin America has resources, sometimes not allocated in the best way. It has knowledge, but the main problem is the fragmentation of the systems."

He points to Uruguay's cancer prevention policies and approach to radiotherapy equipment as examples of practical solutions. He also highlights the City Cancer Challenge initiative, including its work in Asunción, Paraguay, as evidence that coordinated local action can help strengthen cancer services and influence wider health policy.

These examples reflect a principle that has guided his career: effective cancer control does not always require the newest technology. Often, it requires better organisation, stronger institutions and more effective use of existing resources.

That perspective also shapes his concerns about the next generation of oncology leaders.



During a meeting to plan the launching of City Cancer Challenge | From left to right: Dr Eduardo Cazap, HRH Princess Dina Mired of Jordan, former President of Uruguay Tabare Vazquez

While recognising the exceptional abilities of many young physicians, Cazap worries that increasing specialisation may be drawing attention away from public health and the wider responsibilities of cancer control.

Yet he acknowledges that tomorrow's leaders may need to think differently.
"Perhaps the future leaders will have different characteristics. The world is changing so much that perhaps the idea of leadership that we have today will not be applicable for the next generations."

For someone who has spent decades connecting oncology communities across continents, the challenge is not simply to train better specialists, but to encourage physicians capable of changing the systems in which they work.

Beyond the Achievements

Despite numerous international honours, Cazap speaks about his career with a sense of unfinished purpose.

That sense of purpose, he sometimes jokes, may have a genetic component. He comes from and has created a family with what he calls an "oncological gene." His father, Dr. Saúl Cazap,was one of the first radiation oncologists in Argentina, a pioneer when the specialty was just emerging. Today, his son, Dr. Nicolás Cazap, continues that legacy as a leading hemato-oncologist and a reference in acute leukemia in Argentina and Latin America. Three generations bound by the same commitment.

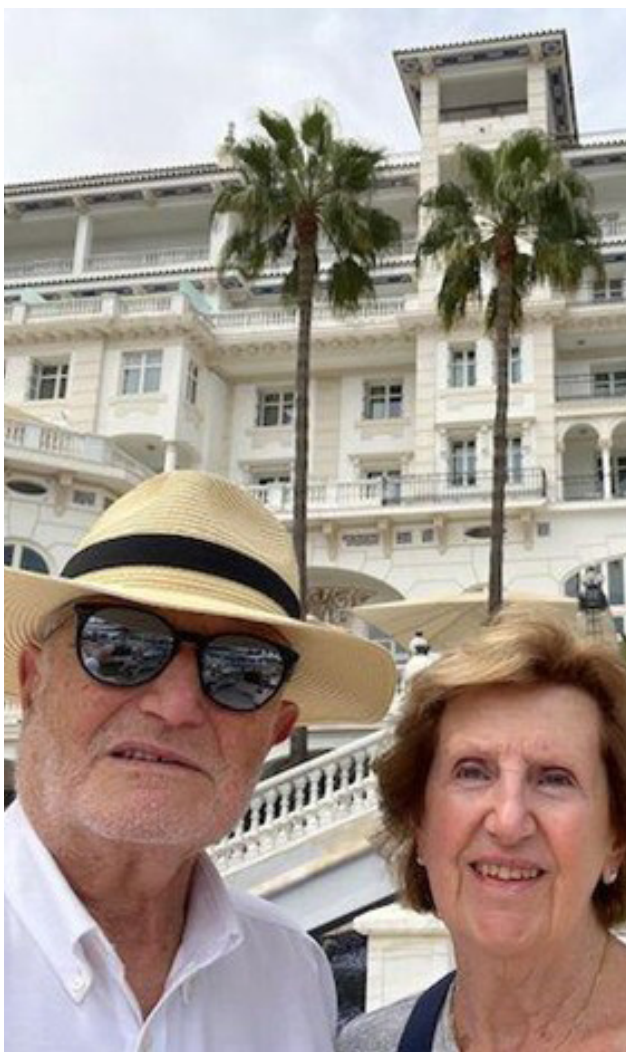
He hopes SLACOM will remain a sustainable platform

for cooperation across Latin America and, more broadly, that cancer will finally become a genuine priority for governments and societies.

Hortobagyi , Jean-Pierre Armand and Bob Pinedo. But he is particularly determined that the contribution of his early mentor, Roberto Estévez, should not be forgotten.

Beyond oncology, philosophy remains a source of inspiration.

For more than two decades, a copy of Meditations by the Roman emperor Marcus Aurelius has stood beside his bed.



Traveling to Marrakesh, with my wife Kathy, August 2025

"I have read that book about 20 or 30 times," he says. *"And each time that I read the book again, I have a new interpretation of some of the things."*

Had he not chosen medicine, he might have become a lawyer — a profession he seriously considered before entering university. His interest in law would later intersect with his work in international cancer control.

And among the many places he has visited, Marrakech holds a special place in his memory, particularly its vibrant square at night.

"It's a magic place in the world for me."

Perhaps the most revealing reflection comes when Cazap considers what advice he would give his younger self.

"To be honest with your objectives and to have a plan to get your aspirational ideas. But mainly to consider all this in a context of humanity and to do the things that are correct."

It is a philosophy that reflects a career defined not simply by professional achievement, but by a commitment to changing how cancer is understood and addressed.

After more than five decades in oncology, Cazap has witnessed extraordinary scientific progress. He has helped build institutions, strengthen international cooperation and bring cancer control onto the global political agenda.

Yet his central ambition remains unfinished: to see cancer recognised not merely as a medical challenge, but as a sustained political and societal priority.

His life's work has helped bring cancer onto the global agenda. The challenge now is to ensure that the world acts on it.

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", and serves as PR and Communications Officer at "EMERTÉ" Clinic.

It's Not Just the Kind Thing to Do. It's the Right Thing to Do.

By Aleksandra Filipovic



Brandon Hotham on the Dempsey Center, the legacy of Amanda Dempsey, and why supportive cancer care belongs at the heart of oncology

Brandon Hotham

When I asked Brandon Hotham, President and CEO of the Dempsey Center, to tell me about a patient whose experience had stayed with him, he took me back to one of his first days at the organisation. He was helping at the reception desk, learning how the centre worked, when the room became busy. People were arriving, telephones were ringing, questions needed answering. In the middle of it all, a man came in, noticed the queue and quietly took a seat in the living room.

For a while, nobody approached him.

When Brandon eventually walked over and asked whether he could help, the man seemed uncertain that he belonged there. His wife had died of cancer five years earlier. He had spent those years carrying his grief without really speaking about it. Only recently had he told his primary care physician that he thought he was ready to talk to someone.

His doctor had suggested the Dempsey Center.

But the man was still unsure. Had too much time passed? Should he have come sooner? Was this really a place for him?

Brandon remembers reassuring him that he had come when he was ready, and that the centre was there to help.

Five years after his wife's death, the man had finally found somewhere to bring what he had been carrying. I have been thinking about that story since our conversation, because it captures something we still struggle to accommodate within the structures of modern cancer care. Cancer does not necessarily end when treatment ends. It does not end neatly at remission, and its consequences do not disappear when someone dies. The medical episode may close, while the human experience continues, sometimes for years.

We have become extraordinarily sophisticated at treating cancer. But have we become equally attentive to what it takes to live with it?

That question sits at the heart of the Dempsey Center, a remarkable organisation in Maine, USA, founded by actor and philanthropist Patrick Dempsey and his family. It also sits at the heart of my conversation with Brandon, whose own journey into healthcare began long before he encountered the centre.

The Experiences That Bring Us to Care

Brandon joined the Dempsey Center in 2022, initially as Director of Client Experience, before becoming President and CEO. His professional background is in public health, healthcare quality and the operations of hospitals and outpatient services. He had spent years working alongside clinical teams, trying to improve how care was delivered.

He knew the dedication of healthcare professionals. He also knew the conversations that happened when those professionals recognised needs they could not meet.

Wouldn't it be wonderful if this patient could access acupuncture? If someone could find a counsellor specialising in cancer? If a family struggling with inadequate insurance could receive the support they needed?

The clinicians understood that something was missing. The system often had no mechanism to provide it.

During the COVID-19 pandemic, Brandon began questioning what he wanted his professional life to contribute. When he encountered the Dempsey Center, he recognised an organisation built around precisely those gaps.

But his connection to healthcare was also personal.

All four of Brandon's grandparents died from lung cancer or related complications. He was six when the first died and 23 when the last passed away. He remembers watching his family navigate illness with limited insurance coverage and, in many instances, limited understanding of a complicated healthcare system.

He also lives with type 1 diabetes, diagnosed when he was ten, which he openly and vulnerably shared.

These experiences gave him an early understanding that managing disease and supporting health are not interchangeable concepts. Medication and

clinical intervention are essential, but so are nutrition, movement, emotional wellbeing, education and the practical conditions in which people live.

He did not necessarily see himself becoming a doctor or nurse. He wanted to work with the people who cared for others, helping them deliver better care.

Listening to him, I was struck by how naturally his personal and professional histories had converged. He had spent years witnessing the limitations of traditional healthcare, and here was an organisation whose purpose was to address them.



Amanda Dempsey and the Story Behind the Centre

Patrick Dempsey and his mother Amanda Dempsey

Every organisation has an origin story. Some begin with an idea, others with a business plan. The Dempsey Center began with a mother.

Amanda Dempsey was first diagnosed with ovarian cancer in 1997. Over the following years, she experienced approximately a dozen recurrences before her death in 2014.

Her children, Patrick, Mary and Alicia, watched her move through repeated courses of treatment, receiving high-quality oncology care in Maine and Boston. They were grateful for the expertise of her medical teams. But they also witnessed how profoundly cancer affected the rest of her life, and theirs.

There were the practical difficulties, the emotional demands, the uncertainty, and the countless ways illness altered ordinary family life. The cancer was being treated, but many of the consequences of living with cancer remained unsupported.

When Patrick's acting career brought him a wider public platform, the siblings began asking what they could do to change that experience for others.

The Dempsey Center was established in 2008 in their hometown of Lewiston, Maine.

For its first decade, it operated as a charitable division of a local healthcare system. In 2018, it became an independent nonprofit organisation. Throughout that evolution, one principle remained unchanged: its services would be available at no cost to the people who needed them.

Amanda herself was involved in the centre's early years, volunteering and giving back to her community. Brandon never had the opportunity to meet her, but speaks warmly about the stories Patrick and his sisters continue to share.

Her legacy also lives through the annual Amanda Dempsey Award, presented to a cancer survivor in Maine who contributes to the wellbeing of others affected by cancer.

I found something deeply moving in that continuity. Amanda's experience revealed a gap in care. Her family's response created an organisation. And years after her death, people she never met are receiving support because of what her family witnessed and chose to do.

The centre carries her name, but perhaps more importantly, it carries forward her spirit of giving.

What Does a Patient Actually Need?

As an oncologist, I spend a great deal of time thinking about what we mean when we say that care should be personalised.

We increasingly personalise treatment according to molecular characteristics, biomarkers and disease biology. Yet the person receiving that treatment may also be struggling to eat, sleep, move, pay bills, understand insurance, tolerate side effects, maintain relationships or recognise themselves in a body transformed by illness.

These are not peripheral experiences. They make the context in which treatment takes place.

The Dempsey Center has organised its work around three broad areas: counselling, complementary and integrative therapies, and comfort and wellbeing.

Its counselling services include individual sessions and support groups delivered by licensed clinical social workers with specialist oncology training.

Nutrition services include education, practical classes and individual consultations with oncology-trained nutrition professionals. Movement programmes range from chair yoga and tai chi to Pilates, strength training and other adapted exercise, led by instructors trained to work with people affected by cancer.

The centre also offers oncology-focused massage and acupuncture, alongside Reiki, wigs and headwear, educational workshops, pet therapy and practical support.

What interested me was not simply the range of services, but the thoughtfulness with which they have been brought together.

A person undergoing chemotherapy may need help managing changes in taste and appetite. Someone recovering from treatment may want to regain physical confidence. Another may need psychological support.

A family member may need respite. Someone living with lymphoedema may need more education than a busy clinical appointment can accommodate.

And sometimes the need is as fundamental as being with other people who understand.

Brandon described a growing demand for connection, particularly after the isolation of the pandemic. Cancer can be profoundly lonely, even when someone is surrounded by people who love them. The centre's programmes offer opportunities not only to learn, but to belong.

One particularly beautiful example is its community gardening initiative. The centre grows produce that is used in nutrition classes and distributed to clients. At the end of the growing season, surplus vegetables are made into soups, frozen and shared during Maine's colder months.

These soups have proved especially useful for some people with head and neck cancers who experience difficulty swallowing or maintaining adequate nutrition. They come with information about their nutritional content and ways to supplement them according to individual needs.

It is such a simple idea, and yet it captures the intelligence of care that begins with the realities of a person's life.

Not merely advising someone to eat well, but helping make that possible.

Care Without a Bill

Today, the Dempsey Center serves more than 3,000 people annually, providing over 26,000 visits across its programmes.

It operates physical centres in Lewiston and Westbrook, Maine, alongside a virtual programme called Dempsey Connects.

The virtual service grew from an unexpectedly human response to the pandemic. When the physical centres had to close, a member of the team suggested telephoning clients simply to check how they were doing. Those Caring Calls eventually evolved into a substantial virtual offering, allowing people to access education, movement classes and other appropriate services remotely.



Dempsey Challenge

The centre also operates Clayton's House, a hospitality home in Portland where people travelling at least 30 miles for cancer-related treatment can stay without charge.

In a largely rural state, the distance between home and specialist treatment can itself become a barrier to care. A place to stay may be as consequential to someone's treatment experience as any other form of support.

I wanted to understand how easily patients and clinicians could access these services.

Brandon explained that people do not need an oncologist's referral to become clients. They can register through the centre's website, complete an online orientation and begin exploring available programmes. Clinician referrals are welcomed, but word of mouth remains the organisation's largest source of new clients.

There are waiting lists for some individual services, particularly counselling, massage and acupuncture. Group education, nutrition and movement programmes are generally easier to access. Certain professional services, including counselling, are restricted geographically by licensing requirements, although the centre can help direct people elsewhere when necessary.

Importantly, the organisation is also moving away from defining eligibility solely by the date of a cancer diagnosis.

Brandon explained that people increasingly live longer with cancer, and their supportive care needs may emerge or change years after the initial diagnosis. The revised approach allows eligible clients a two-year window for specified individual services, with opportunities to continue accessing group programmes beyond that period.

There are limits on the number of individual sessions available, reflecting the practical realities of a philanthropically funded organisation. But the underlying philosophy is to make support available when people recognise they need it, rather than assume that need follows a predetermined clinical timetable.

It is a distinction I wish more healthcare systems would consider.

Who Cares for the Care Partner?

During our conversation, Brandon used a term I have grown particularly fond of: care partner.

It recognises that the people surrounding someone with cancer are not simply observers. They are active participants in the experience, often coordinating appointments, managing medication, providing emotional support, navigating finances and carrying their own uncertainty.

I often ask my patients who sits at their healing roundtable. Who is there with them, and who is holding those people in turn?

Brandon shared a conversation from within the centre that beautifully illustrated why this matters.

As the team reviewed how to allocate limited resources, someone questioned whether massage therapy should be available to care partners, rather than reserved for patients with more direct treatment-related needs.

One of the massage therapists explained what she had repeatedly witnessed.

Care partners would sometimes take her hand after a session and tell her it was the only hour they had had to themselves all week. For that hour, they had not been organising somebody else's life, worrying about appointments or working through an endless list of responsibilities.

They had simply been allowed to receive care.

The team retained massage therapy for care partners. I found that story deeply revealing because it exposes how easily we rank human needs according to what appears medically urgent.

A massage may seem modest compared with chemotherapy or surgery. But for someone who has spent months caring for another person, an hour in which they themselves are cared for can hold extraordinary meaning.

The centre recognises that cancer affects a circle of people, not only the individual with the diagnosis. Approximately 63% of its clients are people with cancer; the remainder include care partners, family members and friends.

This is what genuinely integrated care asks of us. It requires us to see the relationships through which illness is lived.

When the Evidence Catches Up with Compassion

Toward the end of our conversation, Brandon made an observation that became the title of this article.

He spoke about the way supportive cancer care is sometimes regarded as a welcome addition to oncology, something compassionate and desirable, but not necessarily essential.

Yet the growing evidence base around exercise, nutrition, psychosocial support, symptom management and selected integrative interventions challenges the idea that supportive care is merely an optional kindness.

These interventions have different levels of evidence and different clinical applications, and they should be evaluated with the same rigour we expect elsewhere in oncology. Their benefits should not be exaggerated. But neither should their importance be dismissed simply because they sit outside antitumour treatment.

Brandon described clients who believed that supportive interventions helped them manage symptoms sufficiently to continue their prescribed cancer therapy. Such individual experiences cannot establish efficacy on their own, but they illuminate why symptom burden, treatment tolerance and quality of life matter so profoundly.

Then he said something that stopped me.

"It's not only the kind thing to do, it's the right thing to do."

We both knew immediately that we had found our title.



Brandon representing the Dempsey Center at the Nasdaq closing bell ceremony

Because this is precisely the distinction that needs to enter the wider oncology conversation.

Compassion is not in competition with evidence. Supportive care should not have to choose between being humane and being scientifically grounded. The most compelling model is one that respects both.

And perhaps, as clinicians, we should stop speaking about supportive care as something that sits around the edges of oncology.

For the person living with cancer, these needs are often at the centre of daily life.

What Cancer Takes, and What Connection Can Give Back

There was another story Brandon shared that has stayed with me.

A woman speaking at a Dempsey Center event described what cancer had taken from her. Her job.

Family members. The quality of life she had imagined for herself as she grew older.

And then she described what the Dempsey Center had given her.

The centre itself.

A community. Somewhere to belong. People who understood.

Brandon became emotional recalling her words. I could hear how deeply they had affected him.

For an organisation whose staff spend so much time thinking about unmet needs and everything still to be done, moments like these offer a rare opportunity to recognise what has already been made possible.

But they also tell us something important about healing.

We cannot always give people back what cancer has taken. We cannot reverse every loss or restore the life that existed before diagnosis.

We can, however, create places in which people are no longer required to carry those losses alone.

That is not a small achievement.

It is one of the profound responsibilities of healthcare.

The Man in the Living Room

I want to return to the man who sat quietly in the Dempsey Center's living room, unsure whether he was entitled to ask for help five years after his wife's death.

I asked Brandon about patients whose stories had remained with him, and this was the first person he remembered.

Not because of an extraordinary clinical intervention or a dramatic outcome, but because of the simplicity of what happened.

Someone arrived carrying a burden.

Someone noticed.

Someone asked.

And a conversation began.

Brandon reflected that for every person who finds the courage to seek support, there may be many others who never take that step. He hopes that every positive experience at the centre will travel beyond its walls, through conversations between friends, families and communities, and perhaps encourage another person to walk through the door.

That is how care can extend beyond the moment in which it is delivered.

The Dempsey Center is also sustained by that same principle of collective participation. Despite its well-known founder, it is not an organisation with unlimited resources. It raises philanthropic support every year to fund the services it provides, and Brandon was keen to emphasise that individual contributions, including small donations, matter.

What began with one family's recognition of what was missing in their mother's cancer experience has become a place where thousands of people find practical help, emotional support and human connection.

As I reflect on my conversation with Brandon, I find myself thinking again about what we mean when we say that we care for someone with cancer.

We can treat the disease expertly and still leave much of the person's experience unattended. We can deliver sophisticated medicine while overlooking the very ordinary things that determine how someone lives through it.

The work of the Dempsey Center does not ask oncology to become something other than oncology. It asks us to recognise that the treatment of cancer and the care of a person living with cancer are inseparable responsibilities.

Amanda Dempsey's family recognised that distinction through their own experience. Brandon Hotham and his colleagues have made it their daily work.

And somewhere, perhaps today, another person may be sitting quietly in a room, wondering whether their suffering is important enough to deserve attention.

I hope somebody notices.

Because supportive care is not simply the kind thing to do.

It is the right thing to do.

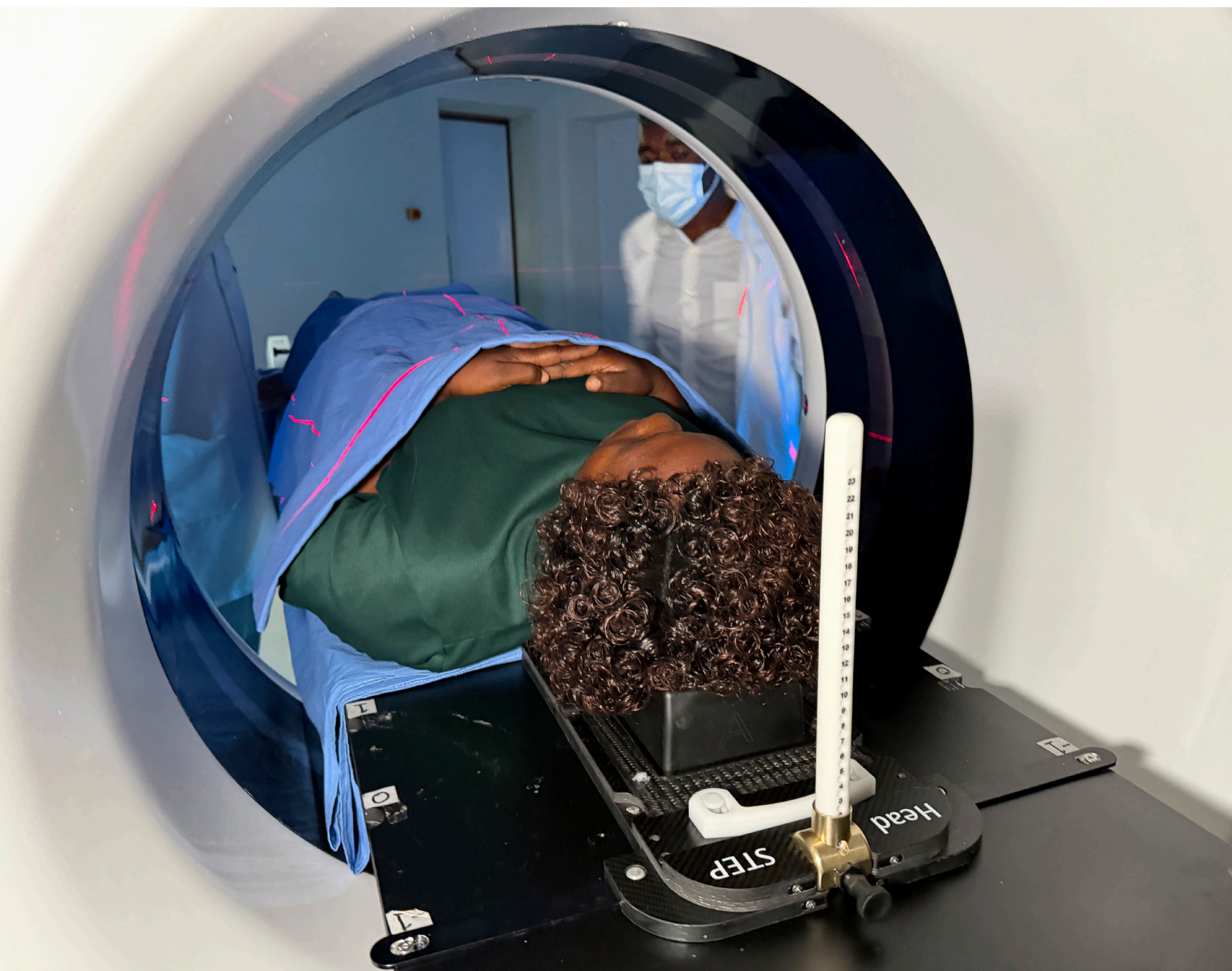
About the Author

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".*

A Machine Can Save Lives. But Who Keeps It Running?

By Esther Nakkazi

Malawi's first public radiotherapy centre has given patients a chance at survival that once seemed impossible. As the IAEA's Rays of Hope initiative expands worldwide, its experience exposes a critical challenge: delivering life-saving equipment is only the beginning.



Edith Nkhoma had built a life around her four children, her business and her love of cooking and baking. A single mother and entrepreneur, she sold African fabrics, travelling to Zambia and Tanzania while raising her family in Malawi.

Then came a diagnosis that changed everything.

At Kamuzu Central Hospital in Lilongwe, Malawi's capital, doctors told her she had cervical cancer. At the time, chemotherapy was the only treatment available to her, and it could control the disease but not cure it. She believed her life was over.

For decades, patients in Malawi who needed radiotherapy faced an almost impossible choice: travel abroad for treatment, often at considerable expense, or go without. Most families could not afford to seek care in India, Kenya, South Africa or Tanzania.

But in July 2025, a new public radiotherapy centre opened at Kamuzu Central Hospital, equipped through the International Atomic Energy Agency's (IAEA) Rays of Hope initiative. Edith became one of its first patients.

"When I came for treatment and looked at the machine, I thought they were maybe lying to me," she recalls. "They just made me lie in the machine."

Months later, her treatment had been successful. Her story was featured in a video shown during the IAEA's 70th General Conference, illustrating what access to radiotherapy can mean for patients who previously had few options.

Edith's experience reflects a wider transformation taking place across countries where cancer treatment has long been out of reach.

In Africa, cancer claims approximately 2,000 lives every day. For many patients, the greatest obstacle is not the absence of effective treatments, but the lack of equipment, specialists and infrastructure needed to deliver them.

Launched in Addis Ababa in 2022, the IAEA's Rays of Hope initiative was designed to address these inequalities by expanding access to radiotherapy, diagnostic imaging and nuclear medicine.

Malawi was among the first seven participating countries.

Four years later, more than 100 countries have joined the initiative. More than 150 major pieces of equipment have been procured, including linear accelerators, diagnostic scanners and 55 mammography machines for Africa and Latin America. More than 20 cancer centres have opened, expanded or are under construction.

In Africa, the initiative is supporting national radiotherapy services in countries including Chad, Ethiopia, Kenya, Lesotho, Liberia, Senegal, Togo and Zambia.

Yet the arrival of a machine, however transformative, is only the beginning. The challenge now is ensuring that the treatment it makes possible remains available — not just today, but for years to come.

Expanding Access, Building Capacity

The progress achieved through Rays of Hope is increasingly visible.

At the IAEA's Scientific Forum in Vienna, Tanzania's Vice President, Deogratius Ndejembi, reported that the country's number of linear accelerators had increased from two in 2021 to eight in 2026, while CT scanners rose from 12 to 97.

In Kenya, two new linear accelerators were delivered to Mombasa and Nakuru in May 2026 through Rays of Hope, with support from the United States.

Botswana opened its first public radiotherapy centre in July 2023 at Sir Ketumile Masire Teaching Hospital in Gaborone, with IAEA support.

Other countries are preparing to establish services that have never previously existed.

In the Democratic Republic of the Congo, the first public radiotherapy centre is planned at the University of Kinshasa. In June 2026, the OPEC Fund for International Development approved a $38 million loan towards the $76 million Kinshasa Cancer Center Project, its first investment under Rays of Hope.

Lesotho still has no radiotherapy facility, despite estimates that approximately 60% of its cancer patients require radiation treatment. Sierra Leone is

planning its first domestic radiotherapy facility, with capacity to treat around 1,000 patients annually.

Burkina Faso aims to train 500 radiologists and 40 radiotherapists by 2034, alongside plans for a new radiotherapy centre in Bobo-Dioulasso and a cyclotron/PET facility.

Bangladesh, which joined the initiative in 2025, is developing a one-stop cancer care centre, with an IAEA, WHO and International Agency for Research on Cancer impact review mission scheduled for November 2026.

But equipment alone cannot transform cancer care.

The initiative is also building a network of institutions capable of sharing expertise, training professionals and supporting countries establishing new services.

These so-called anchor centres form an important part of Rays of Hope's strategy. The network now includes 21 institutions across Africa, Asia, Europe and Latin America, following the addition of Singapore's SingHealth.

Seven institutions joined in 2025: Australia's Peter MacCallum Cancer Centre, the Clinical Hospital of São Paulo in Brazil, Egypt's National Cancer Institute, North Estonia Medical Centre, India's Tata Memorial Centre, Hamad Medical Corporation in Qatar and Serbia's Oncology Institute of Vojvodina.

The objective is to ensure that countries developing cancer services can draw on the experience of institutions with established expertise, rather than building programmes in isolation.

At the IAEA conference, Director General Rafael Mariano Grossi emphasised that expanding access to cancer care is a matter of fundamental rights.

"We should keep in mind that we still have a long road ahead," he said. *"We need to succeed in giving access to cancer care to each and every one, because it is a human right."*

He also stressed that the success of the initiative must be measured by more than the number of machines delivered.

"We are not only providing equipment to member states, to hospitals and institutions," Grossi said. *"We are also trying to make sure it is used efficiently."*

That means investing in the professionals who operate, maintain and support these technologies.

"If you buy a machine and cannot use it properly, it is a waste of your time and your money," he warned.

Hundreds of healthcare professionals are receiving training through the anchor centre network. In 2025, the IAEA also signed a three-year, $4.5 million partnership with St. Jude Children's Research Hospital to expand specialised paediatric radiotherapy training worldwide.

Financing remains another critical challenge.

Since its launch, Rays of Hope has mobilised more than €100 million, while the IAEA has helped countries prepare investment proposals capable of attracting financing from development banks.

Industry partnerships are contributing equipment and expertise. Siemens Healthineers donated a $3 million linear accelerator to Black Lion Hospital in Ethiopia, while Elekta provided treatment-planning workstations to an anchor centre in Morocco and trained 26 resident physicians. Both companies signed new agreements with the IAEA during the conference.

Grossi called for innovative and blended financing arrangements, bringing together governments, international organisations, financial institutions and private-sector partners.

But while the international discussion focuses on expanding capacity, the experience of Malawi reveals what happens after a radiotherapy centre begins treating patients.

Malawi's Breakthrough and the Cost of Keeping It Alive

Until 2024, patients in Malawi who needed radiotherapy had to leave the country.

A private facility opened in Blantyre in early 2024, followed by the country's first public radiotherapy centre at the National Cancer Centre within Kamuzu Central Hospital in



Dr Christine Mukoka | Photo credit to Katy Laffan/IAEA

July 2025.

The IAEA provided two linear accelerators, a brachytherapy machine, a CT simulator and dosimetry equipment.

Since opening, the public centre has treated approximately 600 patients free of charge.

For Dr Christine Mukoka, a radiation oncologist at Kamuzu Central Hospital, the difference is profound.

"In the past, people regarded cancer as something that's not curable," she tells CancerWorld. *"Or patients waited too long, and then they'd be palliative."*

Mukoka trained at the University of Cape Town in South Africa and has also received virtual reality training. She treats patients with cervical, vulvar, breast and prostate cancers, among other diagnoses.

The arrival of radiotherapy has changed what clinicians can offer, particularly to patients whose cancers can be treated with curative intent.

But access remains difficult for people travelling from distant regions.

A course of curative radiotherapy can require daily treatment over five to seven weeks. Patients unable to afford repeated journeys may stay with relatives in Lilongwe or seek accommodation at the hospital.

For families already struggling with the financial consequences of cancer, the burden remains considerable even when treatment itself is free.

And there is another problem, less visible to patients until something goes wrong: keeping the machines operational.

"The harder question is sustainability," Mukoka says.

The machines are managed under Malawi's Ministry of Health, with electricity costs covered by the hospital. Backup power systems have prevented major disruptions from electricity shortages.

Maintenance, however, is expensive.

"The main problem has been maintenance, because you need to pay for service level agreements, which are quite expensive. For the two machines, we need to pay about USD 40,000 per year."

New equipment comes with warranties, but long-term servicing requires continuing financial commitments.

In Malawi, those costs are complicated by shortages of foreign currency, which is needed to pay international suppliers and import spare parts.

"At the moment in Malawi, we're struggling with forex to pay in foreign currency, so we're having challenges making payments," Mukoka explains.

The consequences are immediate.

"Because we haven't paid the service level agreement for one of the linear accelerators, and there's a fault, we

can't treat it," she says. *"I think it's been about two weeks, because we can't get engineers to fix it."*

For patients receiving radiotherapy, a machine that cannot operate means interrupted treatment, longer waiting lists and additional uncertainty.
Mukoka says that similar disruptions can last for months in other countries, placing further pressure on already overstretched cancer services.

At Kamuzu Central Hospital, she organises treatment camps, bringing in specialists from other hospitals to help clear the backlog.

The IAEA has trained local personnel to perform basic mechanical repairs, and some technical problems can be resolved remotely. But when replacement parts or specialist engineers are required, the centre remains dependent on external support.

Private providers, Mukoka observes, can often respond more quickly because they have greater financial flexibility to bring in engineers.

Staffing presents further challenges.

Malawi has four trained medical physicists, only one of whom works at the government hospital.

According to Mukoka, approximately four radiation oncologists are currently delivering radiotherapy, while another four primarily provide chemotherapy because their facilities lack radiation equipment.

Three additional oncologists are undergoing training, with two more expected to begin in January.

Yet she considers maintenance a more immediate threat to the centre's ability to deliver uninterrupted care than the shortage of oncologists.

The distinction is crucial: building a radiotherapy service requires equipment and expertise, but sustaining it requires reliable financing, technical support and systems capable of responding when something breaks down.

Beyond the Machines: Making Progress Sustainable

Malawi's experience illustrates both the achievements and the vulnerabilities of the global effort to close the cancer care gap.

For patients such as Edith Nkhoma, the availability of radiotherapy close to home has been life-changing. A treatment that once required international travel is now available through the public health system.

For clinicians such as Mukoka, the new centre has expanded the possibilities of cancer treatment and challenged the perception that a diagnosis necessarily means there is no hope.

But the interruptions caused by maintenance costs reveal how fragile those gains can remain.

Across the countries participating in Rays of Hope, the next phase of progress will depend on whether investment in equipment is matched by sustained investment in people, infrastructure, technical support and financing.

That means training more radiation oncologists, medical physicists and engineers, establishing dependable maintenance arrangements, ensuring access to spare parts and developing financing mechanisms that allow centres to operate long after the initial donations have been made.

It also means extending services beyond major cities so that patients do not have to travel long distances or leave their families for weeks to receive treatment.

Mukoka believes Malawi has already taken an important step, but much more remains to be done.

"I'd say they've done a very good job, but I think if we get more machines, put them across the regions, and have enough people trained to do the work, we will really tackle cancer better."

Her assessment captures the promise and the unfinished work of Rays of Hope.

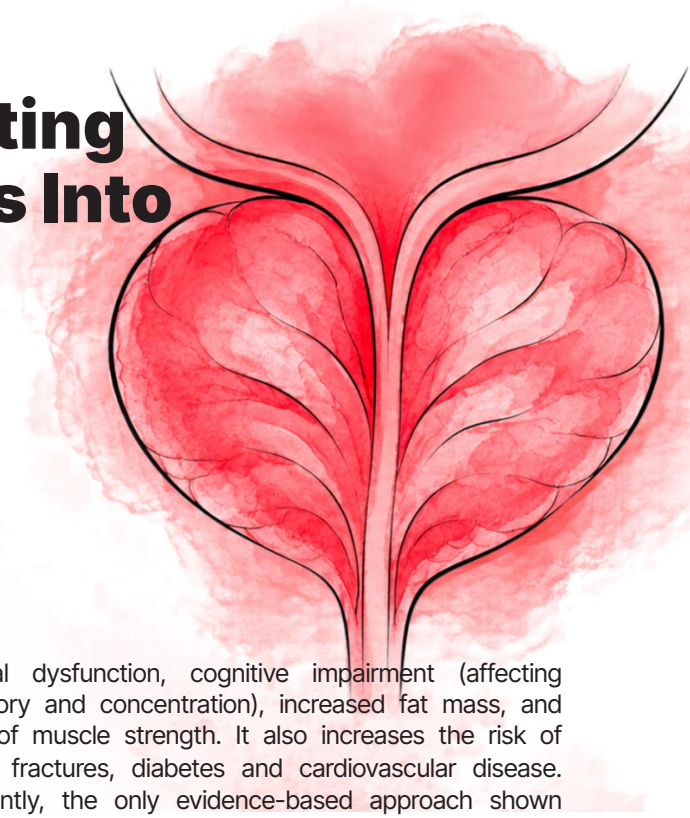
A radiotherapy machine can transform what is medically possible. But for patients whose lives depend on it, the real measure of progress is whether that machine is working when they need it.

About the Author

Esther Nakkazi is a freelance science reporter, media trainer and mentor.


Some people are addicted to Tik Tok, Instagram, I am addicted to OncoDaily
Humaid Al-Shamsi
President, Emirates Oncology Society

Trial Supports Integrating Lifestyle Interventions Into Prostate Cancer Care



By Janet Fricker

The STAMINA trial shows that integrating supervised exercise, dietary advice and behavioural support into routine cancer care can help preserve quality of life and reduce fatigue in men receiving androgen deprivation therapy, at a cost that compares favourably with many approved oncology drugs.

A structured programme combining supervised exercise, dietary advice, and behavioural support significantly reduced deterioration in quality of life in men undergoing androgen deprivation therapy (ADT) for prostate cancer compared with usual care. The study, published in Lancet Oncology, 4 September, also found that the cost per quality-adjusted life year (QALY) gained compared favourably with many approved oncology drugs.

"As the first lifestyle intervention integrated into routine cancer care at scale across the NHS in England, the findings of the STAMINA trial are a huge step forward and will make an immediate impact for patients, providing compelling evidence to clinicians who have been crying out for an evidence-based intervention to recommend to their patients on ADT who present all the time with devastating treatment-related side effects," says Derek Rosario, chief investigator of STAMINA and consultant urological surgeon at Sheffield Teaching Hospitals NHS Trust. To the best of his knowledge, adds Rosario, successful integration of a lifestyle intervention into core cancer care on this scale has not previously been reported.

Bringing Lifestyle Interventions Into Routine Cancer Care

Approximately half of all men with prostate cancer will receive ADT, the medical form of castration, at some point during their disease. Although effective in controlling prostate cancer, ADT is associated with a range of significant side effects, including fatigue, depression, sexual dysfunction, cognitive impairment (affecting memory and concentration), increased fat mass, and loss of muscle strength. It also increases the risk of bone fractures, diabetes and cardiovascular disease. Currently, the only evidence-based approach shown to manage these adverse effects is a combination of supervised exercise and dietary modification. However, few healthcare providers routinely offer such interventions as part of standard prostate cancer care. "Despite clear and consistent recommendations in international clinical guidelines, the urology and oncology communities have not been convinced by the strength of the evidence. A core problem was that previous studies tested interventions that were not embedded within routine cancer care. Unless interventions become part of core cancer care, they simply won't reach patients," explains Liam Bourke, the first author of the paper, from Sheffield Hallam University. The STAMINA (Supported exercise TrAining for Men wIth prostate caNcer on Androgen deprivation therapy) trial, he adds, was designed to address the evidence gap, including integrating the programme into the standard prostate cancer clinical pathway and undertaking a cost-effectiveness analysis.

How the STAMINA Trial Worked

The trial compared two active interventions. Between Jan 2022, and June 2023, 700 men taking ADT for prostate cancer were randomly assigned (5:4) via computer to the STAMINA lifestyle intervention and behaviourally optimised usual care (SLI group; n=389) or optimised usual care alone (OUC; n=311).

In addition to OUC, the SLI group received free 12-months of Nuffield Health gym membership with supervised exercise, diet advice and behavioural support from trained Nuffield Health exercise professionals. Participants were aware of their treatment allocation.

The complex trial, which took place across 15 UK NHS Trusts in England, incorporated several key intervention components: healthcare professional training; secure communication systems linking healthcare providers with community fitness centres; patient screening and safety-to-exercise assessments; individualised exercise prescriptions, adapted to account for comorbidities and functional capacity; and training for community-based personal trainers. The trial's primary endpoints were prostate cancer–specific quality of life, measured using the Functional Assessment of Cancer Therapy–Prostate (FACT-P), and fatigue, assessed using the Functional Assessment of Chronic Illness Therapy–Fatigue (FACIT-F) subscale. Overall cancer-related quality of life was also assessed using the Functional Assessment of Cancer Therapy–General (FACT-G) questionnaire.

Better Quality of Life, Less Fatigue and Lower Costs

Results demonstrated high adherence in the SLI arm, with more than 80% of men attending their scheduled sessions over the 12-month intervention period.

Compared with OUC, the STAMINA programme (SLI) reduced deterioration in prostate cancer–specific quality of life by 26%, with an adjusted mean difference of 4.5 points on the FACT-P scale (P=0.0004). Worsening fatigue was reduced by 30%, with a 1.9-point difference on the FACIT-F scale (P=0.0068). Overall cancer-related quality of life also deteriorated less, with a 37% reduction in decline and an adjusted mean difference of 3.7 points on the FACT-G scale (P=0.0001).

Safety concerns were limited. Three serious adverse events were considered related to the intervention in the STAMINA group: transient loss of consciousness, leg pain or weakness, and back pain. All participants recovered, and there were no treatment-related deaths.

The economic evaluation, based on incremental cost-effectiveness ratios (ICERs) and 10-year modelling, estimated a cost of £13,920–£19,077 per QALY gained. This compares favourably with a recent comprehensive analysis, published in The Lancet in 2025, reporting a median ICER of £30,000 (£22,395–£45,870) for oncology drugs approved by NICE. "Thus, the STAMINA lifestyle intervention represents better value for money than most cancer drugs currently approved and funded by the NHS," Bourke tells Cancerworld.

"Given the absence of strong, evidence-based interventions to mitigate the adverse effects of ADT, this study offers clinicians a clear basis for identification, referral, and prescription of supervised exercise and diet advice interventions to minimise adverse effects associated with treatment, and critically, meet best practice guidelines for patients," conclude the authors.

From Clinical Trial to Wider Cancer Care

Following the trial, Nuffield Health have launched a new Cancer Activity Programme, making a modified version of the intervention available to men with prostate cancer. Plans are also under way to extend the programme to people with breast and bowel cancer. Looking ahead, the STAMINA team hopes to investigate whether exercise and dietary interventions can improve overall survival in men with prostate cancer.

Although developed for the NHS, the STAMINA model provides a framework that could be adapted to other healthcare systems seeking to deliver supervised exercise and dietary interventions to mitigate the adverse effects of ADT. Bourke welcomes enquiries from healthcare services outside the UK interested in implementing similar programmes and is happy to consult based on his experience.

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.

When Hope Outlives Fear

Finding Life After Pancreatic Cancer

Against the odds of one of the deadliest cancers, survivor Camille Moses reflects on fear, uncertainty and rebuilding her life — and why psychological support matters beyond treatment.

By Adrian Pogacian



Camille Moses

A cancer diagnosis can divide life into two chapters: before and after. Suddenly, the future becomes uncertain, familiar routines lose their meaning, and questions once considered philosophical become deeply personal. How much time do I have? What will happen to my family? And how do I live when the future can no longer be taken for granted?

For people diagnosed with pancreatic cancer, these questions can be particularly overwhelming.

Despite advances in surgery, chemotherapy and other treatments, pancreatic cancer remains one of the most challenging malignancies, with many patients diagnosed when curative treatment is no longer possible.

Behind the statistics, however, are individuals whose experiences reveal another dimension of the disease: the psychological struggle to live with uncertainty.

Camille Moses is one of them. She is a long-term pancreatic cancer survivor diagnosed in 2012 and a patient advocate. She serves on the Patient & Family Advisory Council at Sylvester Comprehensive Cancer Center and the Let's Win PC Patient Advisory Board. Through volunteering, patient support and fundraising, she works to improve the experiences of people affected by pancreatic cancer.

Diagnosed in 2012, she has survived pancreatic cancer for more than a decade. Her journey has been shaped not only by treatment and recovery, but by the challenge of learning to live beyond a diagnosis that once threatened her future.

"Looking back is surreal," she recalls. *"Treatments were grueling however knowing they worked kept me positive and I believed I would survive."*

Her experience offers a powerful perspective on hope, resilience and the emotional realities of cancer survivorship.

When Cancer Changes Everything

Cancer affects far more than the body. A diagnosis can disrupt a person's sense of identity, security and control, bringing fears about mortality into everyday life.

Patients may worry about recurrence, treatment, family relationships, employment and financial stability. These concerns can persist long after active treatment has ended.

Fear and sadness are natural responses. Some patients grieve the life they had before cancer, while others struggle with anxiety about an uncertain future.

Persistent distress may sometimes develop into depression, affecting daily functioning and quality of life.

For Camille, believing that treatment was working became an important source of hope.

"It was a difficult time but I've packed it away and moved past it," she says.

Yet surviving cancer does not necessarily mean leaving its psychological consequences behind.

Learning to Live With Uncertainty

For many patients, completing treatment does not immediately restore the sense of security they had before diagnosis. Follow-up appointments, medical tests and fear of recurrence can keep cancer psychologically present for years.

"Being a long term pancreatic cancer survivor I have worked very hard to move past the uncertainty," Camille explains.

Exercise became an important coping strategy.

"For many years I lived with uncertainty and it was very difficult so I used exercise as a way to cope. The longer I go with clean scans the uncertainty slowly goes away."

Her experience illustrates a central reality of survivorship: psychological recovery does not always follow the same timeline as physical recovery.

For some, fear gradually diminishes. For others, it

remains significant and requires sustained support. The goal is not constant positivity, but helping patients regain confidence, maintain meaningful routines and reconnect with life beyond cancer.



Camille Moses during the treatment

Hope Is Not the Absence of Fear

Hope is often presented as essential to the cancer experience. Yet it is easily misunderstood.

Hope does not mean denying the seriousness of a diagnosis or believing that treatment is guaranteed to succeed. Nor should patients feel obliged to remain optimistic when they are frightened or exhausted.

It can mean believing in a treatment, hoping for more time with family or finding the strength to face another day. For long-term survivors, hope may gradually become less about survival itself and more about reclaiming ordinary life.

"I faced my mortality and was able to overcome the most devastating diagnosis," Camille says. *"Survivorship has many challenges, however I'm very grateful to walk through this new phase."*

Her gratitude does not erase the difficulties she has experienced. It exists alongside them.

In psycho-oncology, psychological support is not about replacing fear with forced optimism. It is about helping patients acknowledge difficult emotions while preserving a sense of purpose, connection and control.

Why Psychological Care Matters

As cancer treatments evolve, new possibilities are emerging, although not every patient benefits equally.

"I'm happy to see progress in the fight and new treatment options. However, there is still much to learn," Camille says.

She points to the importance of molecular characteristics in determining access to some newer therapies.

"Most new treatments are based on mutations that a patient carries. In my case I have no mutations so my risk factor is unknown."

Her experience highlights the uncertainty that can remain even as medicine advances.
It also reinforces the need for comprehensive cancer care that addresses emotional well-being alongside physical health.

Early access to mental health professionals, appropriate assessment of distress and continued psychological support can help patients and families navigate the demands of treatment and survivorship.

Crucially, emotional well-being should never be presented as a guarantee of better cancer outcomes. Patients do not control the biological course of

their disease through positive thinking, and those experiencing anxiety or depression should never be made to feel responsible for their illness.

Psychological care offers something equally important: ways to cope, maintain quality of life and live meaningfully despite uncertainty.



Camille Moses

Finding Purpose Beyond Cancer

For Camille, surviving pancreatic cancer has also created a new sense of purpose.

Today, she supports others facing the disease through her involvement with the Patient & Family Advisory Council at Sylvester Comprehensive Cancer Center and the Let's Win PC Patient Advisory Board. She also volunteers to connect patients with medical professionals and fellow survivors, while supporting fundraising efforts for pancreatic cancer research.

Her work reflects a desire shared by some survivors: to turn a difficult personal experience into support for others.

But survivorship does not need to produce extraordinary achievements to have meaning. For many, rebuilding life means returning to familiar routines, spending time with loved ones or simply feeling able to make plans again.

Camille's long-term survival is remarkable, but the emotional questions her story raises are universal. How do we live with uncertainty? How do we preserve hope without denying reality? And how do we find meaning when life changes in ways we never anticipated?
There are no universal answers.

Her experience is not proof that hope can overcome the biological realities of cancer. It is a reminder that even after a devastating diagnosis, people can find ways to reclaim their lives.

Survival is measured in years. But living beyond cancer is also measured in the return of confidence, purpose and the freedom to imagine a future again.

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