

“Setting Higher Standards in Cancer Care” – Impressions and Lessons Learned at the First Emirates Oncology Conference, Abu Dhabi, November 2012

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In January 2012, the Ministers of Health of the Gulf Cooperation Councils (GCC) met in Muscat, The Sultanate of Oman, in order to develop a regional strategy to address Non-Communicable Disease (NCDs) such as diabetes, cardiovascular diseases, cancer and chronic respiratory diseases. “The regional strategy details what the six (GCC) countries will be doing to tackle NCDs during the next years in terms of reducing people’s exposure to causative risk factors and improving services to prevent and treat these leading health problems”, said Dr. Ahmed Al Saidi, Omani Minister of Health, who chaired the meeting. “It also highlights what the six countries will do to set targets and measure results, advance multi-sectorial action, and strengthen national capacity” [1].

As a natural follow-up of the above, Tawam Hospital in Al-Ain, Abu Dhabi organized the first Emirates Oncology Conference entitled: “Setting Higher Standards in Cancer Care”. It was not surprising that the conference started with a session dedicated to breast cancer, while a parallel session was devoted to palliative care. The existing cancer registry offices in the Middle East have shown that breast cancer is the leading female cancer in all countries (Table 1). A 2010 review suggested that the median age of presentation of breast cancer in Arab countries is about 10 years younger than that in western countries [2]. Although this finding might be partly because Arab populations are skewed towards younger median age than are Western countries, it nevertheless has implications for screening and cancer management strategies [3]. With the realization that the registries are paramount and hugely important for obtaining accurate knowledge of the incidence and prevalence of cancer, the Gulf Federation for Cancer Control decided to set up a regional cancer registry which will initially rely on a repository at each emirate, or state, that will then report to the federal level, and thereafter to the regional GCC level. Such a regional network of information will greatly improve cancer care, as it will make possible to assess current trends of cancer diagnosis and treatment; which will in turn assess therapeutic protocols and survival rates.

In most Middle Eastern countries breast cancer is still a scheme not to be talked about. Women diagnosed with breast cancer are very careful about whom they tell, or if they tell at all, as this cancer has often been considered something God has given to them. Moreover, breast cancer is believed in certain local societies to be an inherited-genetic disease; therefore, patients suffer in silence, and endanger their lives [4]. Further, in most countries in the Middle East, at least 50% of all breast cancer patients present themselves to a physician for the first time when the cancer has already reached stage III or IV when the cancer is already incurable, and the only optional treatment available is that of palliative and supportive care. The issue of Late Presentation is still a major problem which should be dealt with through active cancer awareness campaigns emphasizing the benefits of early detection by breaking of taboos (e.g., the stigma of having the illness). Since advanced breast cancer is devastating to women and those close to them in the family and the community, advocacy campaigns should be directed towards the entire family and close community members [3].

Dr. Mohammed Jaloudi, President of the Conference and Chair of the Department of Oncology at Tawam Hospital, Al-Ain, Abu Dhabi,

introduced the current scope of cancer incidence in the Emirate based on Tawam Hospital’s cancer registry office. From year 2008-2011 the number of breast cancer patients registered in his hospital increased by 25% (from 300 → 400). The majority of patients were diagnosed before the age of 50, while the great majority of patients were diagnosed as suffering from infiltrating duct carcinoma. The regional epidemiological and social factors together with different ethnic-genetic and epigenetic risk factors could result in a different array of breast cancer molecular pathologies than those noted in Western populations, [5] which would have implications for stratified approaches to breast cancer treatment.

Following an introduction on the burden of breast cancer in the Middle East, discussions referred to the extent of surgery at the different stages of the disease. The latter were followed by presentations on gene analysis and profiling and options for hormonal and biological therapies. Targeted therapy has become a major component in modern approaches of personalized oncology. As of today, routine cancer therapy remains limited by a “one-size-fits-all” approach, whereby treatment decisions are based mainly on the clinical stage of disease, yet fail to reference the individual’s underlying biology and its role driving malignancy [6]. The discussions in the cancer breast genetics session revolved around the future goals to translate therapies from research to clinic by helping clinicians develop patient-specific treatments based on the unique signatures of the patient’s tumor.

Due to the great interest and relevance of the breast cancer issue, a second session was assigned to deal with triple negative breast cancer cases and with HER2 positive cases and their treatment. Prof. Dennis Slamon, Director, Clinical/Translational Research, UCLA Department of Medicine, delivered excellent presentations on his work that resulted in the first molecularly targeted treatment for breast cancer, which led to the development of Herceptin-Trastuzumab to be used in metastatic breast cancer with tumors that overexpress HER2 or in cases of HER2 gene amplification as determined by accurate and validated assays. However, despite the tremendous resources being spent on personalized cancer medicines; thus far there are only a handful of drugs, such as Herceptin, that could be labeled as “personalized”. The outlook for the future is clear, and that is to switch from histology-driven therapy to molecularly-driven clinical oncology.

What was clearly indicated in the genetic sessions of the

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	ASR	Total # of Cases	% of all cancers	Median age at diagnosis
Jordan (2009)	32.0	926	19.6	51
United Arab Emirates (Tawam Hospital) (2011)	17.1	399	27.8	
Israel (invasive only) (2009)				
Jews	91.9	3484	29.6	61.9
Arabs	56.6	308	29.9	51.1
Oman (1998-2001)	14.6	265	13.4	
Cyprus (2008)	76.6	444	32.2	
Turkey-Izmir (2008)	49.3	1144	10.5	
Egypt-Gharbiah (2000-2002)	41.9	1810	17.3	
Egypt-Aswan (2008)	63.9	241	40.0	
Lebanon (2007)	86.0	1698	39.0	

Jordan	–	Jordan Cancer Registry, Amman
UAE	–	Tawam Hospital, Al Ain Abu Dhabi
Israel	–	Israel National Cancer Registry, Jerusalem
Oman	–	Department of Non-communicable Disease Surveillance and Control, Directorate of General Health Affairs, Ministry of Health, Muscat
Cyprus	–	Cyprus Cancer Registry, Nicosia
Turkey	–	Izmir Cancer Registry, Izmir
Egypt (Gharbiah)	–	Gharbiah Population-Based Cancer Registry, Tanta
Lebanon	–	Lebanese National Cancer Registry, Beirut

Table 1: Epidemiological data of breast cancer in Middle Eastern Countries.

Conference is the fact that cancer is a much more complex disease than was previously thought. Only recently we have begun to understand the heterogeneity in the genetic make-up of human cancer, and the inter-individual variation of the human genome that enables a more personalized approach to cancer treatment [7]. By picking up mutations in key genetic pathways, tests could assist oncologists to choose drugs that have been approved or are in clinical development [8]. A note of caution: When the term "personalized medicine" is used today, the focus is on one aspect of tailored cancer treatment – the use of targeted drugs and predictive biomarkers. Yet, while we certainly need to vigorously pursue the potential for developing therapies designed using our knowledge of cancer genetics, the current heavy focus on drugs is too narrow. What about the potential for more precise tailoring of surgical and radiotherapy strategies, which currently account for only a tiny fraction of research into personalized therapies? [9] The biggest potential for improving cancer outcomes, especially in developing countries, lies in enabling all patients, regardless of cancer type, to assess the high-quality treatment and care from a multi-disciplinary team of specialists.

As already indicated above, one of the major problems that Middle Eastern oncology is facing relates to late presentation, and as a consequence, cure is not a realistic option anymore, just palliation is. The Emirates Oncology Conference dealt with these issues while lending emphasis to cultural and psycho-social aspects of this burning problem. Dr. Zafar Jared, Consultant of Palliative Medicine at the Department of Oncology, Tawam Hospital, outlined several of the cultural issues that his service is facing while managing late stage cancer patients, and especially those at end-of-life.

The palliative care session in the Conference addressed the effects that cancer and its treatment have on the mental status and emotional well-being of patients, their family members and their communities at large. Unfortunately, stigma is still attached to cancer, as well as to mental illness and psychological problems associated with cancer. This fact of double taboos imposes genuine difficulty in trying to improve the quality of cancer care. Hence, many cancer patients in the Middle East, who could benefit from counseling, psychotherapy and pharmacologic management, do not receive these kinds of support and care. The panel in this session discussed the rationale of monitoring the distress scale, even though it is not a precise clinical term; but it is easily understood

by patients and does not carry the stigma that is often associated with more formal psychiatric terminology [10]. Further, it was made clear that the scope of psycho-social care extends beyond the patient to encompass family members and professional caregivers. Among family members, addressing the psychosocial needs of those who participate in the patient's care is particularly important. With cancer treatment moving increasingly into the out-patient setting, family members are being asked to take on greater responsibilities for patient care. Consequently, much emphasis was given to the importance of establishing home-based palliative care services in the community. The panel has also stressed the importance of training communication skills to oncologists, as it has been well documented that communicating well with patients has been linked to greater satisfaction and reduced anxiety among patients, and better patient health outcomes [11]. During the panel discussion, it has been stressed that providing oncology clinicians with formal training in skills for communicating with patients and their relatives has a strong positive impact on their communication behaviors. Therefore, communication skills training should be a standard part of oncology training programs [12-14]. The latter should cover topics such as how to break bad news, how to discuss prognosis at each illness phase and share decision as to the selection of anticancer treatments. The panel of palliative care session also stated that there are social, cultural, religious and economical barriers that may impede access to palliative care. Such barriers should be addressed on a priority basis so that "universal access" to "person-centered care" may be made available to the population of the Middle East [15]. Moreover, in the Middle East culture plays a key role in health care and particularly in palliative care because it influences how we understand autonomy, and it plays a significant role in defining how patients and families make meaning out of illness and suffering, expression of pain, expectations about cure, hopes for the future and views regarding death. In the Middle East, direct disclosure has not been the usual standard of practice or culturally expected, as Middle Eastern societies place high value on greater family involvement in decision-making and in protecting vulnerable family members from direct disclosure of bad news [16]. It was, therefore recommended that understanding the patient and family perspective is critical to showing respect for the autonomy of the patient. The value of respect is paramount, far more than simply letting patients make their own decisions. No care plan is successful without it [16].

At the palliative care session Dr. Paraj Bharadwaj, Medical Director of Palliative Care Services at the Cedars Sinai Medical Center in Los Angeles, California, brought up the issue of cancer pain management. It was clearly stated that when pain is reduced, so is at least some of the distress associated with serious illness such as cancer; as the correct amount of analgesia given at the right time has a considerable positive effect on the quality of life of a patient in palliative care. In many countries in the Middle East health care workers are reluctant to prescribe opioids to patients because of cultural, traditional and social reasons. Prescribing opioids is an additional taboo in regional societies. Still, even if some patients may be beyond hope of cure, they are not beyond care; and opioid prescription in such cases is not just medical treatment: it is basic human kindness [17]. There are many reasons for the lack of treatment with opioids; and, therefore, there is a need for greater awareness among policymakers, healthcare professionals and the general public to dispel the fear that opioid analgesics will produce harm to patients and society by causing dependence. It has been documented that almost all patients are able to stop their opioid medication at the end of their treatment with no long-lasting effect [18]. To protect themselves against the harms of drug dependence, many countries have introduced drug control measures, but in doing so have impacted the availability and use of controlled medicines for medical use. In practice, lack of access affects all controlled medicines listed on the World Health Organization (WHO) Model List of Essential Medicines. As a result, governments around the world are leaving hundreds of millions of cancer patients to suffer needlessly because of their failure to ensure adequate access to pain-relieving drugs; an unprecedented new international survey reveals [19].

Very recently, the International Collaborative Project to Evaluate the Availability and Accessibility of Opioids for the Management of Cancer Pain was initiated by the European Society for Medical Oncology and coordinated with several international oncology and palliative care organizations. The survey found that very few countries in the Middle East provide all seven of the opioid medications that are considered to be essential for the relief of cancer pain by the International Association for Hospice and Palliative Care. Those essential medications include, among others, codeine; immediate and slow release oral morphine, oral oxycodone, and transdermal fentanyl. Further, in many Middle Eastern countries, those medications that are available are either unsubsidized or weakly subsidized by governments, and availability is often limited. Moreover, many countries in the region have highly restrictive regulations that limit entitlement of cancer patients to receive prescriptions, limit prescriber privileges, impose restrictive limits on duration of prescription, restrict dispensing, and increase bureaucratic burden of the prescribing and dispensing process [19]. It would be, therefore, appropriate that efforts be created for a cultural transformation in the way healthcare professionals, policymakers and the public understand the benefits of proper pain management and prevention. In many Middle Eastern societies pain is not a primary concern for many patients; and moreover, patients and clinicians have misgivings about the adverse effects of pain medications. Hence, we face in the Middle East pain treatment disparity which is largely influenced also by the reluctance to report pain or request analgesics. The panel of the palliative care session agreed that pain remains a significant concern not only in hospitalized patients, but in ambulatory oncology as well. Consequently, it was stated that a better integration on non-oncology clinical resources (primary health care professionals: family physicians, pediatricians, general practitioners and community nurses) into the oncology setting (mainly via ongoing educational and training activities), all hold promise for improving outcomes in outpatient care (including home care) of cancer patients [20]. Even in

the United States, a recent survey and accompanying editorial [21,22] reported that efforts to improve the management of cancer-related pain have had little effect on medical oncologists' attitudes and practice. Of note, subtle changes in how we think and speak can make a difference. Improving the management of cancer-related pain is feasible as ensuring that every consultation includes the patient's rating of pain, and that the treating physician pays attention to the answer [23]. This first Emirates Oncology Conference was initiated and conducted by the staff of the Oncology Department at the TAWAM Hospital, led by its chairman, Dr. Mohammed Jaloudi. It succeeded in attracting over 800 professionals from the Middle East and beyond it. This successful event triggered promising international collaborations in both clinical and basic science disciplines; and by doing so, TAWAM Hospital further solidified its position as a regional leader in cancer care and research.

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