interval prolongation). All patients were assessable for response: there was one complete and one partial response, which both lasted over a year, and three other patients had stable disease as their best response (Table 1). Both cases of granulosa cell tumors where positive for FOXL2, while two cases of Sertoli–Leydig cell tumors were negative for FOXL2, while analysis was not possible in one case. Three patients had tumor samples available for further molecular analysis (patient # 1-01, 1-10 and 1-15). Interestingly, all three patients, despite differences in histological diagnosis, displayed relatively similar and monotonous comparative genomic hybridization (CGH) profile with loss of chromosome 16q, and partial (22q) or complete loss of chromosome 22 was also seen in all three patients. Monosomy 22 was previously described in granulosa cell tumors of the ovary, together with trisomy 14 (which we also detected in one patient) [5]. Other alterations included gain of 1q (two patients) and loss of 8p (one patient). No homozygous gene deletion or gene amplification was seen in any patient. No conclusion could be drawn regarding the correlation of cytogenetic alterations and response or outcome.

Our data suggest that panobinostat may have interesting activity in patients with advanced OSCT and confirm the preliminary signs of activity seen with vorinostat in this rare disease. Based on these promising results, a larger trial assessing an HDAC inhibitor in patients with advanced OSCT is currently in preparation.

P. A. Cassier1, A. Floquet2, N. Penel3, O. Derbel1, B. Bui N’guyen1, J.-P. Guastalla1, D. Pissaloux4, I. Treilleux4, C. E. Saba5,6, J.-Y. Blay1,7 & I. Ray-Coquard1,7

1Department of Medical Oncology, Centre Léon Bérard, Lyon
2Department of Medical Oncology, Institut Bergonié, Bordeaux
3Department of Medical Oncology, Centre Oscar Lambret, Lille
4Department of Biopathology, Centre Léon Bérard, Lyon
5Novartis Pharma, Rueil-Malmaison
6Institut de Recherche International Servier, Suresnes
7Université de Lyon, Lyon, France

(*E-mail: cassierp@hotmail.com)

funding

The ESTIM-LBH study was funded by an unrestricted research grant from Novartis. This study was also supported by the following grants: LYRIC (INCA-DGOS-4664), DevWeCan Labex (ANR-10-LABX-0061), EuroSarc (FP7 278472), NetSarc, Ligue contre le Cancer—comité départemental du Rhône, TMRO Network from the GINECO group.

disclosure

This study was supported by an unrestricted research grant from Novartis Pharma, who also provided the study drug free of charge. PAC has received honoraria and travel reimbursement from Novartis. JYB and IRC have received honoraria, travel reimbursement and research funding from Novartis. CES was an employee of Novartis at the time the study was designed and during the enrollment period. JYB also received honoraria and research funding Merck Sharp Dohme and Glaxo Smith Kline. PAC, JYB and IRC have received honoraria from Servier and CES is currently an employee of Servier.

references


doi: 10.1093/annonc/mdu045

Published online 20 March 2014

Medical oncology: in search of a definition

As every evolving science, medical oncology (MO) needs a continuous effort in setting an evolving definition. MO is under a tremendous tension. On one side, the increasing number of cancer patients and complexity of care are dramatically expanding the request for services and knowledge. On the other side,
the workforce shortage and the limitations in financial coverage are reducing the available resources. These two forces are threatening the role of MO.

ESMO should be strongly commended for inspiring an authoritative vision [1]. However, we suggest that the document does not cover all the issues that modern MO is facing and leaves uncertainties about the clinical and organizational tasks needed in cancer care.

(i) While it is well established that good-quality clinical choices rely on multidisciplinary management, the role and functioning of multidisciplinary tumour boards (MDT) is not sufficiently defined and is object of active debate [2]. Only one to three times in the natural history of cancer an MDT is required to ensure that key problems are appropriately dealt with. In the everyday practice, the medical oncologist is the professional directly involved in the care of the patient. Finally, the functioning and organization of MDT is highly variable. Thus, they do not resolve the complexity of cancer care and cannot be seen as an alternative to the direct interaction with the patient.

(ii) MO has evolved from the unrealistic vision of a role restricted to chemotherapy administration to that of ‘case management’: the medical oncologist is frequently in charge of all the cancer-related conditions and is supposed to cover all the span of cancer history, from prevention to death. This poses the urgent question of the overload that is threatening the quality of cancer care and is at the basis of oncologists burnout [3].

(iii) New skills are requested to face the challenge of the growing costs. Given the current climate of cost-consciousness, there is a pressing need to be critical about the added value of each treatment and to pursue reasonable choices. MO is increasingly called to balance the interests of the single patient with those of the whole society [4].

(iv) We suggest that a comprehensive vision of MO should move from a health-care professional to a patient centred perspective. In this respect, the role definition should include the description of the roles of other important actors (radiation oncologists, general practitioners, surgeons, internists, palliative care physicians and nurses). If the patient’s needs are the key issues, the development of integrated care pathways should be advised as a practical way to define professional roles [5]. Pathways should describe three types of activity: those exclusively limited to the MO (such as management of chemotherapy), those limited to other professionals (such as radiotherapy or surgery) and those that could be shared (such as symptom palliation or inpatient management). Shared cares would contribute to improve quality, to spread knowledge and to lower the burden on MO. We thus encourage ESMO and the national oncological societies to involve the other professional societies in the definition of cancer care pathways.

G. Numico** & G. Fasola†‡

1Department of Medical Oncology, Azienda USL Della Valle D’Aosta, Aosta;
2Department of Medical Oncology, Azienda Ospedaliero Universitaria S. Maria Della Misericordia, Udine, Italy
(*E-mail: gnumico@ausl.vda.it)
†Member of the Collegio Italiano dei Primari Oncologi Medici Ospedalieri (CIPOMO).
‡President of the Collegio Italiano dei Primari Oncologi Medici Ospedalieri (CIPOMO).

disclosure

The authors have declared no conflicts of interest.

references


doi: 10.1093/annonc/mdu059
Published online 20 February 2014