

EUROFILE

A second chance to influence the Clinical Trials Directive

The European Commission has given its clearest indication yet of likely changes to the EU law governing clinical trials. Academia and the medical community is mobilising to make its voice heard as the Commission moves to fill in the detail.

The 2001 clinical trials directive is one of the most sharply-criticised pieces of pharmaceutical legislation in the history of the EU, blamed for increasing the costs of pan-European trial costs and adding to the burden of red tape. Having charted the drop in multi-national clinical trials conducted in Europe since 2007, the Commission's health directorate (DG Sanco), finally conceded the law has played a part in the decline, at a gathering of MEPs, academics, patient associations and industry at the European Parliament in December 2011. Figures presented by the head of the pharmaceuticals unit in at DG Sanco, Patricia Brunko, showed the number of trials fell from 5028 in 2007 to 3490 in 2011. This 30% drop "could well be [due to] the current approach of the directive," she told the meeting.

A proposal to revise the law is "on track" to appear in mid-2012, revealed Brunko. Following two public consultations and several stakeholder meetings, the Commission favours the idea of a single electronic application for each pan-European clinical trial, in English, accompanied by a coordinated approvals procedure. DG Sanco feels this would go some way to curbing the bureaucracy involved in national procedures. "It must be quick and easy with no heavy bureaucracy. We'd like to avoid the heavy infrastructure and long deadlines required for full co-ordination", said Brunko.

'We won't tell member states what to do. It's up to member states to establish how different bodies work together'

Stefan Fühling,
DG Sanco

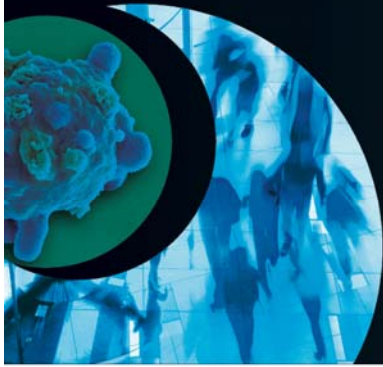
According to the Commission, the idea is widely accepted in principle, by industry, academia and patients groups. However, it throws up issues of data protection, confidentiality, meeting the requirements of national ethics committees and agreeing standardised documentation – areas on which there is yet no emerging consensus across EU and national policymakers.

DG Sanco envisages that the assessment of multi-national clinical trials applications would continue to be conducted at member state level by competent authorities, but via a co-ordinated rather than a centralised process. One proposal suggests a single ethics committee for each country, another suggests a single national assessment combining the views of ethics bodies and national competent authorities. How either of these proposals might work in practice has yet to be explored, but the Commission is sticking to the position voiced by Stefan Fühling of DG Sanco, in July 2011. "We won't tell member states what to do. It's up to member states to

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establish how different bodies work together," he told stakeholders gathered at a meeting organised by the European Forum for Good Clinical Practice and (EFGCP) the European Organisation for Research and Treatment of Cancer (EORTC), in Brussels.

The law will also be adapted to assess the risks involved in trials. Two types of risk are currently being considered; the hazard to trial participants and the hazard to trial results, which would take into account the robustness of the trial design and data generated. The Commission has decided not to extend the scope of the law to include the relative assessment of different therapeutic approaches, such as surgery or medical devices. DG Sanco is also discussing problems involving trial insurance and clinical trials in an emergency setting.

The importance of public funding for multi-national trials has been recognised. DG Research is discussing the possibility of creating a European Health Institute, an idea proposed by ECCO, which could lever clinical trial funding through the next EU research programme, Horizon 2020 and support public-private studies.

'The discussion has taken place on a philosophical level. It is now time to develop ideas on how things could work in practice. Policymakers are listening'

Ingrid Klingmann,
EFGCP

The Commission will assess the impact of all its ideas as far as existing data will allow, before releasing its revised proposal in mid-2012. Once published, the proposal will be scrutinised and amended by both the Council of Ministers and the European Parliament, an iterative process which could take anywhere between two to four years to reach a final agreement.

The Commission has told stakeholders that there is still scope for them to influence the policymaking process, according to Ingrid Klingmann, chair of the EFGCP. "The discussion up until now has stayed on a very theoretical, philosophical level. It is now time to develop ideas on how these things could work in practice, and policymakers are listening. All the stakeholders were not at the table the last time; academia was invited but just didn't care. As a

consequence, multi-national clinical trials in Europe have suffered. We have a second chance which is rare in life, and we cannot afford to mess it up," she says.

Together with the European Clinical Research Infrastructures Network (ECRIN), the EFGCP is writing two position papers for consideration by policymakers: one for technocrats who understand the issues, and one for parliamentarians who need to get to grips with them quickly. Alongside this, the EORTC and UK NHS Research Ethics Committee have joined forces to work on the insurance issues plaguing non-commercial clinical trials.

Industry is reticent to discuss its position on the assessment procedure but Klingmann is familiar with its concerns since many large pharmaceuticals companies are EFGCP members in regular dialogue. "Big pharma is looking for a centralised procedure, but academia and SMEs are not at all convinced that

this would work, and favour a co-ordinated assessment procedure. We need to discuss how these principles would work in practice, and what the pros and cons would be. The devil is in

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Flaminia Macchia,
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the detail. We have seen in the past if we do not completely understand the details we will run into unexpected problems," she says.

Klingmann feels a co-ordinated procedure is attainable. "The political will is there to achieve a single ethics vote per country. The next step would be a single national assessment combining the views of ethics bodies and national competent authorities. Leaving it to member states is an elegant way of doing it because at least it gives member states the possibility to keep their existing systems but organise their interaction better."

Flaminia Macchia, European public affairs director at the rare disease patient organisation, Eurordis, believes a single ethics opinion from each member state is the only acceptable course. "Divergent opinions from ethics committees within the same member state are totally unacceptable for the patients that these same ethics committees are meant to protect following universally accepted principles," she said.

The EFCGP is critical of the Commission's approach to risk assessment. "The Commission has proposed to compare the risk in the clinical trial to the risk of normal care. Somebody would have to judge this on a case by case basis. With the medical device legislation, we've seen that this risk categorisation on a case by case basis can take years until the risk is mutually accepted. We need to avoid that trap," says Klingmann.

'It must be quick and easy. We'd like to avoid the heavy infrastructure and long deadlines required for full co-ordination'

Patricia Brunko,
DG Sanco

The EFCGP will be organising round table meetings with stakeholders in February 2012 to discuss details. "We all have an interest to get the legislative process shortened as much as possible so whatever we can achieve as an agreement amongst users will be extremely helpful," she says.

*Saffina Rana,
Brussels*

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INTERVIEW

Elderly breast cancer patients 'risk treatment discrimination'

Women diagnosed with breast cancer late in life are at risk of being under-treated, which is leading to worse breast cancer outcomes than among younger women, researchers suggest. They analysed data on the 9766 patients in the Tamoxifen Exemestane Adjuvant Multinational (TEAM) trial according to age at diagnosis, and found that, although the risk of dying from other causes was much higher in women over 75 than in younger patients, the risk of dying of breast cancer also increased with age. The results were presented at ECCO (Stockholm Sweden) in September 2011 (Abstract # 5015).

*The researchers, led by **Christos Markopoulos (Athens University Medical School)**, concluded that women over 75 "are probably being under-treated as doctors think they will die from something else."*



How firmly can you conclude that the increase in breast mortality with age is being caused by under-treatment?

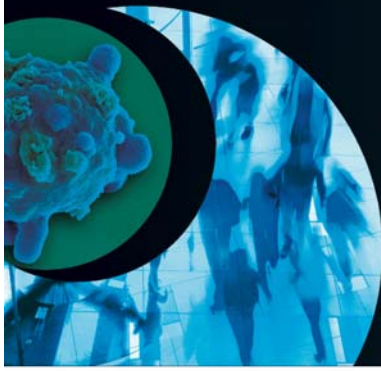
There could be many explanations for our findings. We couldn't explore deficiencies in the immune system response among elderly patients, or different responses to treatment in our study but we explored all the parameters we could in a multivariable analysis – including tumour size, grade, lymph node status – along with country-specific differences in the administration of therapies. We included the 3 types of treatment – surgery, chemotherapy, radiotherapy – also persistence on endocrine therapy for the first year, and we included parameters like receiving non randomised treatment. Our results showed an increased risk of dying of breast cancer with increasing age.

We then used a statistical model which takes into consideration both disease specific mortality and competing mortality. The finding was the same; we then re-confirmed it in relapse analyses. We are as sure as we can be that this is a real effect. In our study population, if an elderly woman with breast cancer survives from co-morbidities, she has a higher chance of dying from breast cancer than a younger patient, and the most plausible reason for this is under-treatment.

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What were the country-specific differences?

In some countries, radiotherapy was given or was not given without following the guidelines. There are multiple reasons for this. It could be that in some countries, like the UK, there are inadequate numbers of radiotherapy units. Or it could be that, among elderly women, the distance from the care home to the radiotherapy unit prohibits the process which lasts for almost a month. In Greece, an old lady living on an island might prefer to have a mastectomy without radiotherapy, because in order to have radiotherapy she would have to travel to Athens and stay in a hotel. Or someone needing chemotherapy might not be able to have it on the island, and would have to come to Athens every 3 weeks for treatment, which could be difficult. We included the country as a factor in the multivariable analysis. We can't be 100% sure of the reasons why women did not receive the treatment they were randomised to, and my advice for future trials is to include data on co-morbidities or disabilities (which we didn't have). We only know the numbers who did not receive radiotherapy or chemotherapy.

Were you surprised by your results or did they confirm your expectations?

We were not surprised that elderly women died more often from other causes, because this is the general perception, and we have seen it in observational studies. We were a bit surprised to find that disease-specific mortality also increases with age. The TEAM trial overall has a population with a good prognosis. All patients are hormone receptor positive; almost 50% are lymph-node positive but we've had a survival rate of over 90% in 5 years in the whole group. This is high and we started thinking that the general perception in the medical community that elderly women tend to do better because they have less aggressive disease is probably wrong.

Why hasn't this been studied before?

The TEAM trial fortunately did not exclude elderly women, but this exclusion is common in clinical trials because researchers don't want to 'spoil' a trial if they have to modify treatment because of side effects, for instance. Also the chance of dying of a co-morbidity in the over 75s is almost 7 times higher than dying from breast cancer, and these deaths reduce the statistical power of trials. But excluding elderly women from clinical trials means we're now in a position where we have guidelines for young women, we have guidelines for every aspect of breast cancer, but we don't have special guidelines for women over 75. Breast cancer is increasing with age due to changing demographics, and we will have more elderly women diagnosed with breast cancer in future.

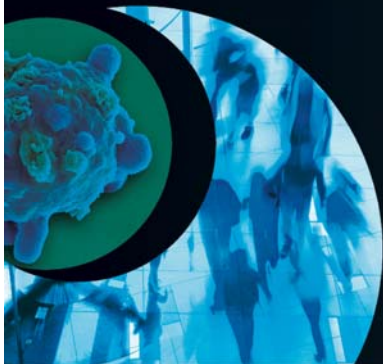
Are your results sufficiently strong to form the basis of guidelines?

We couldn't suggest guidelines, but we could suggest that the medical profession accepts that elderly women deserve adequate breast cancer treatment. We should take biological age into consideration – you can be 90 years old but have a biological age of 65. A lot of co-morbidities can be dealt with very easily these days. We should be looking at the parameters of the disease and finding the best treatment. So if a woman needs chemotherapy, we should be wondering, 'Is she strong enough for chemotherapy? Should I modify the dose? Do I have to use drugs with no serious side effects for the heart?', but don't say 'She's 80 years old, I'm not going to give chemotherapy; she is more likely to die from something else.' That's the point.

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Do we need different kinds of statistics or trial design for research among elderly people?

The first thing we have to do is to focus on this population, to start trials including those over 75 or over 70, to generate the data we need to create guidelines. I believe that through these trials our attitude towards treating elderly people will change. In the last few decades, we've had the specialism of geriatric oncology created, we have surgeons specialising in geriatric surgery and so on and a couple of medical journals focused on aging, the elderly, and so on. Things are changing and our results support the need to focus on the elderly population.

Do young doctors find it difficult to relate to elderly patients?

There can be a problem of communication between doctor and patient. I worked in London in the 1970s and set up a special clinic for the over 70s, where we ran a lot of clinical trials. In talking about surgery, I found that elderly women have a fear of the word "mastectomy". Younger women don't mind about type of therapy, they want to live, they have children, they have their whole life in front of them. But in the elderly, you have to be cautious with the words you use for what is going to happen. You should not lie, but you need to find the right words. They're often afraid that they will not wake up after anaesthesia. Sometimes they asked me about the operation afterwards, because they couldn't take in the information in advance when they were frightened. Communication can be different across Europe and between here and the States but part of oncology is trying to find how you have to behave towards each patient, meeting her needs and finding what information she can deal with. You have to be honest, but you don't have to discuss things that very rarely happen. When we give hormone therapy – which we consider one of the easy treatments – we don't have to start discussing cancer of the uterus with a 75 year old, or the 1% risk of deep vein thrombosis. It's a matter of communication, which could be better taught in medical schools.

You'd conclude that elderly are getting a raw deal in terms of breast cancer treatment?

I would. One of the problems is that elderly people have the mistaken impression that they're not susceptible to cancer anymore – which is exactly the opposite of the true situation. That's one of our worst mistakes. We may tell the public on TV or radio, to have mammograms when they're 40 or 50 but we rarely say that if you are 75, your chance of getting breast cancer is 5 times higher than a woman of 50. Elderly women don't need mammograms every year but they should be examined. They are often surprised by the diagnosis, and then disappointed, or afraid that they are going to die. We've tried hard to change the perception of breast cancer over the last few years so that it's thought of as a chronic disease. We're trying to tell the population not to fear breast cancer, but to come early so that we can sort it out. Elderly women need to know that they are at risk too.

Interview by Helen Saul

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