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ESMO President-Elect
2029-2030



**Dr Florian
Lordick** *says*
"Take the **chance**"

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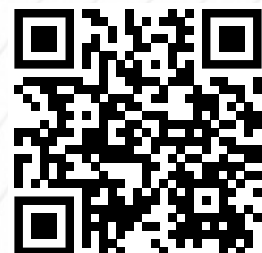
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Take the Chance

His colleagues called GI oncology boring. Florian Lordick made it his life's work - and now, as ESMO's President-elect, he wants the next era of oncology to stay human.

By **Amalya Sargsyan,**

VP of Intelligence and Research, OncoDaily

In the early 2000s, the young internists at Munich's university hospital had a verdict on gastrointestinal cancer, and it was not flattering.

"They said, this is boring," Florian Lordick recalls, laughing. "You give 5-FU. You give it up and down, and from left to right, and from right to left - and in the end the patients do not benefit from it."

The ambitious ones went to hematology - to transplants, leukemia and lymphoma, where the science seemed to be moving. Lordick walked the other way: down the corridor to the surgical wards, where esophagectomies and gastrectomies were performed at a scale few centers in Europe could match, on patients most of his medical colleagues preferred not to think about. He made a surgeon his mentor. He made the "boring" disease his life's work.

"I was always swimming a bit in another pool than the majority," he says.

A quarter of a century later, the field his colleagues dismissed has been transformed by targeted and immune therapies, and by trials and guidelines he helped shape. And the internist who chose the unfashionable door is preparing to lead Europe's largest oncology society. Elected in June 2026 as President of the European Society for Medical Oncology for 2029-2030, Lordick - Director of the University Cancer Center Leipzig and ESMO's former Director of Education - will take charge of a community that has grown almost beyond recognition since he first walked into an ESMO congress.

Ask him how he got there and he does not describe a plan. He describes doors, and the decision to walk through them.

"You get chances," he says. ***"And it's your decision if you want to take them and develop them, or if you let them pass."***

A hospital instead of a barrack

Lordick is a Münchner - born and raised in the Bavarian capital, a city he still calls beautiful, *"a great university city"* of more than a hundred thousand students, *"very vital, with a lot of academic activities, many ambitious and inspired people."*

Medicine was not a childhood certainty. After school, young German men faced a choice: military service or civilian social service. He chose the hospital. For almost twenty months he worked at the university hospital of the Technical University of Munich, moving between orthopedics and the emergency department, transporting patients, doing whatever needed to be done.

"I just became fascinated by the environment of a hospital," he says. By the end of that service he had applied to medical school. Admission depended on grades and on a demanding selection test. *"I became quite ambitious and prepared vigorously,"* he recalls, with some satisfaction. He got his place.



The **patients** who needed someone

Throughout medical school he kept working in the hospital - partly for the money, partly for the experience. His doctoral thesis took him into respiratory physiology: the mechanisms of hypoxemia and how blood flow is regulated in the lung. Many of the patients he studied had chronic obstructive pulmonary disease. Many had lung cancer. Many had both.

After graduation he stayed with his thesis supervisor and went deeper into pulmonology. But one group of patients kept drawing him back.

*"Always I felt that working with the cancer patients was most meaningful for me," he says. "Maybe it was the seriousness of the disease. Or maybe it was because they really need a dedicated doctor. **They cannot go to anyone. They need someone who really takes care.**"*

This was the 1990s. Operable patients went to surgery; for the many who were not, systemic chemotherapy offered little. "We need to push this field forward," he remembers thinking. The conviction pulled him toward research - toward trials, new drugs and multidisciplinary care - at a time when the tools to deliver on that ambition barely existed.

"They cannot go to anyone. They need someone who really takes care."

"Now it's **starting**"

The first targeted therapy of Lordick's training was imatinib, in chronic myeloid leukemia - *"a big success story,"* he says, but one that belonged to hematology. Solid tumors still seemed out of reach.

Then, one day in 2004, a colleague forwarded him a paper with a short note: Look, now it's starting in solid tumor oncology. It was the first description of activating EGFR mutations in lung cancer. At the time, early EGFR inhibitors such as gefitinib had just produced disappointing trial results. Suddenly the field understood why. *"They did not work in every patient,"* he says. *"But in some patients they worked fantastically."*

It was the beginning of a new era, and Lordick had a front-row seat. He took part in some of the very first clinical studies of cetuximab in colorectal cancer - *"not the same success story"* as the drugs aimed at oncogene-addicted tumors, he notes candidly, but fascinating all the same. *"And so it started. I got deeper and deeper into oncology."*

The oncologist in the surgeon's house

In Germany, hematology and oncology are trained together, and Lordick's training was broad: leukemias, lymphomas, lung and gastrointestinal cancers. But

the Munich university hospital had one field in which it stood among the strongest in Europe - the surgery of GI cancers. Esophagectomies, gastrectomies, pancreatic and rectal surgery were performed there at a scale few centers could match.

Few of his medical colleagues wanted any part of it. Transplants, leukemia and lymphoma were where the excitement was. *"So they missed the chance to jump into this field,"* he says.

He jumped. He joined a research group that was almost entirely surgical, and found his scientific mentor in the operating theatre: Jörg Rüdiger Siewert, the towering figure of Munich upper GI surgery.

Siewert could be strict with his surgical staff. With the young internist, he was generous. *"I did not do surgery,"* Lordick says, *"so I did not do nonsense in his field. I stayed outside the operating theatre. But I took care of his patients."* Every day he went to Siewert's ward and to the meetings of his senior staff. He consulted on patients, enrolled them in trials, treated them, and coordinated with outside oncologists. *"I think he saw the engagement of this young Dr. Lordick."*

What followed - roughly 2002 to 2007 - he describes in a single image: ***"I had the impression that I'm sitting in a rocket."***

HER2-targeted therapy arrived. EGFR-targeted therapy arrived. He ran trial after trial, including his own investigator-initiated studies - easier then, he says, *"not so expensive, not so overregulated."* Siewert sent him to national and international meetings. Within a few years the young internist had become a recognized name in GI oncology, and the road to a professorship lay open.

One study from those years captures the spirit of the Munich group. In MUNICON, published in The Lancet Oncology in 2007 with Lordick as first author, the team used PET scans to measure metabolic response after just two weeks of chemotherapy in adenocarcinoma of the esophagogastric junction. Responders continued chemotherapy before surgery; non-responders stopped and went straight to the operating theatre. The phase II trial showed that treatment could be steered by an early biological signal - a practical question that needed oncologists, surgeons, radiologists, nuclear medicine physicians, and pathologists at the same table. His daily walks to the surgical ward and the

famous Munich multidisciplinary GI tumor board had prepared him for exactly that.

The rocket was not only his. Medical oncology itself was lifting off. When Lordick began travelling to ESMO congresses, attendance ran to perhaps five or six thousand. Today the meeting draws more than thirty thousand. *"I entered this field when it was just at its beginning,"* he says. *"It was not only my personal story that things went fast. It was also what happened suddenly in oncology. That was fascinating."*

"I had the impression that I'm sitting in a rocket."

— ON HIS MUNICH YEARS, 2002–2007

It also required something more than talent, he adds - a word of advice an early mentor once gave him, which he translates carefully into English: Dr. Lordick, I think you can make a good way. But you need to use the chances that are given to you. *"This is a bit like a motto for my career,"* he says.

Seven days in New York

One of those chances came in 2006, and it lasted seven days. Murray Brennan, then chair of surgery at Memorial Sloan Kettering, was visiting Siewert in Munich. On Brennan's last day of his visit, Lordick asked for a few minutes, introduced himself and said he would love to see how oncology was practiced in New York. Write me an email, Brennan said. He did. An invitation came back.

"It was probably one of the most meaningful weeks of my whole professional life," Lordick says. *"I saw a different dimension of oncology. Really a bit different from how we did it in Germany."*

The friendships lasted - and reached the next generation. Yelena Janjigian and Andrea Cercek had not yet joined the GI service, but in the years that followed they and many other NYC colleagues became his friends too. Today, from opposite sides of the Atlantic, they work together to push gastrointestinal oncology forward - in clinical trials, on congress stages and in the conversations in between. Colleagues in New York still ask how long he stayed. A year? Two?

"No, no," he tells them. ***"It was a week."***



Three cities, one missing piece

The next door opened in a corridor. Siewert was retiring from surgery to become chief executive of Heidelberg University Hospital, and Lordick had assumed he would stay behind in Munich. Then, in one of those brief exchanges between one meeting and the next, his mentor turned to him. *"Lordick, don't you want to join me in Heidelberg? It's a good place. Maybe it's good for you to see something new."*

He thought twice, weighed his prospects in Munich, and went. Heidelberg's National Center for Tumor Diseases was in its pioneering phase - well funded, full of research opportunity - and Lordick, now senior, found himself surrounded by talented young fellows, *"many of whom made great careers now."*

He did not stay long. The chance to become head of a large hematology-oncology department in Braunschweig was too tempting for a physician who wanted, as he puts it, to learn *"how you deal with a big team and how you take final decisions."* He is candid about the move. *"Honestly, I don't know if it was a good step to leave Heidelberg at this phase,"* he says. He loved the work in Braunschweig. But something was missing.

"We did a lot of interesting treatments, but you have almost zero support for research," he says. *"The self-initiated research, and also the daily contact with students, with people who want to learn - it's not there."*

And I missed it."

Then the phone rang. It was the hospital director in Leipzig. Did you see we are searching for someone to lead our cancer center? Maybe you aren't interested. But maybe you are missing the university.

He was. After a competitive process for a full professorship, Lordick arrived in Leipzig in 2012 - one of Germany's oldest university cities - to build a university cancer center essentially from scratch. Fourteen years later, Leipzig is a certified comprehensive cancer center, and Lordick leads the Comprehensive Cancer Center Central Germany, a Leipzig-Jena partnership serving a population of around five million people.

"We arrived at the level where we wanted to arrive," he says. *"I love the surroundings that we created here - and this is only the beginning of something to grow further and get stronger."*

The teacher

One of Lordick's earliest papers on PubMed is not about a drug at all. It describes a program he built in Munich with a psycho-oncology colleague to teach patients about their disease and treatment - on the conviction that patients who understand more cope better, feel more balanced and adhere better to therapy. They evaluated it and published it.

Teaching, it turns out, is the thread that runs through everything: bedside teaching, literature clubs, coaching students to read research critically and explain it to

their peers. In the 2000s, ESMO noticed. ***“ESMO discovered me,”*** he says. *“Colleagues had heard me somewhere and saw that I like teaching, and maybe I also have a little bit of talent for that.”*

Preceptorships and courses followed, then educational sessions at the annual congress. In 2016 he led the GI track of the ESMO Congress in Copenhagen. From 2020 to 2023 - much of it through the COVID-19 pandemic - he served as ESMO's Director of Education. He calls his relationship with the Society, now more than twenty years long, “a marriage.”

He is clear that education cannot stand apart from discovery. *“Education alone is nice,”* he says. *“But it’s even better when it’s together with telling people about your own data, your own research perspectives on these topics.”*

For oncologists in countries with less access to European training, those preceptorships can matter more than their brief format suggests. A day and a half in a room with colleagues from across a region can seed collaborations that change not one patient’s care but an entire team’s. It is a point Lordick feels strongly about. *“It’s also my feeling,”* he says. *“And it’s the reason why I’m always motivated to go there.”*

“Education alone is nice. But it’s even better when it’s together with telling people about your own data.”

7:00 a.m., Leipzig

His day, he says, is ***“full, full, full.”***

It starts at seven in his office: first emails, the day’s tasks. At 7:30 comes the part he protects most - the morning round with his oncology department. It may last only five or ten minutes. It is not negotiable.

“That I always see my team every morning,” he says, *“is very meaningful to me. Who is there? Is there any problem? Should we solve anything?”* They run through the outpatient clinics, problems from the day before, difficult cases, tumor board questions, serious adverse events in clinical trials. Twice a week, the imaging is reviewed together, so problems can be discussed on the spot.

From there, no two days are alike: the GI tumor board, internal medicine teaching sessions, outpatient clinics. He tries to do ward rounds with his doctors every week - *“a quality check,”* he calls it, and a way *“not to lose the contact to patients.”* Then come the demands

of running both a department and a comprehensive cancer center - staffing, structures, everything that keeps a large institution moving. He insists none of it is dull. *“It really needs an experienced person to do that in a skilled way.”*

And around all of it: ESMO, editorial work, international projects, talks to prepare, people to connect.

A lake, a bicycle, a partnership

What keeps him going? Asked the same question once at a meeting in Singapore, he gave the answer he still gives. The fascination of oncology. The will to help patients as well as possible. And people.

“When I’m entering my morning round and I see my team, these promising young colleagues - well educated, nice, friendly - that gives me a lot of energy,” he says. ***“It tells me that’s the right place to be.”***

Outside the hospital, the rhythm is simple. He cycles to work. In summer, he rides home, drops his things, takes a towel and walks five minutes to a nearby lake for a fifteen- or twenty-minute swim. A few minutes of yoga each morning keep a back strained by long hours at the screen in working order.

And there is his wife - also an oncologist, also working in gastrointestinal cancers. Much of their work is shared: they travel to congresses together, teach courses together, and support a network in Africa focused on esophageal cancer, a common disease on the continent.

“Activities like that are an enrichment,” he says, *“even more if you can do it together.”*

Away from medicine, they cook - *“we are not professional chefs, but we like to prepare something”* - visit museums, go out for a good meal, go hiking and skiing in the mountains and listen to classical concerts. *“One of the most important things in life is partnership,”* he says. *“It is a very important resource of energy.”*

“I rather try to create opportunities”

For a man who has mentored so many, Lordick is surprisingly reluctant to give advice.

"In principle, I'm not giving advice," he says. "Everyone needs to find out what is the right thing for him or her. I rather try to create opportunities."

At least once a year, he sits down individually with every doctor and scientist in his team - more often if needed - to understand what interests and fascinates them. Then he looks for the right opening: a talk somewhere, a protocol to work on, time in the laboratory.



He is honest about what frustrates him. Some of the young people he sees are *"so talented, so brilliantly educated,"* he says, and yet hesitate to seize what is in front of them - a year abroad, extra time in the lab. *"Every career - you can ask whoever you like who has made a career - needs some extra effort. It's not done within the regular working hours. Naturally not."*

But he has also learned where a mentor's role ends. A mentor can open the door; the young doctor has to walk through it.

"You cannot carry people to success," he says. *"Sometimes you need to give a small push. But in principle, people need to find their direction, and need to feel happy with it, balanced with it."*

"You cannot carry people to success. Sometimes you need to give a small push."

— ON MENTORING THE NEXT GENERATION

What he does encourage, warmly, is movement: visiting other centers, reaching out to people you have never met, building connections across borders.

"This is exactly the right way," he says. ***"This is the way the young generation can develop."***

Keeping **medicine** human

Ask the incoming president where oncology is heading and he begins with a caveat. "Looking into the future is not something humans are able to do." Then he answers anyway.

We are, he believes, in another great transition - this one driven by artificial intelligence and the digitalization of knowledge. The complexity of modern oncology, he says, "has already become too much for all of us to understand all the details." We will need tools to support decisions and to explain that complexity to patients. ESMO, he argues, must build those tools into how it educates, how it interprets new evidence and how it writes guidelines.

But he is equally clear about what must not change. *"What I feel is extremely important in this transition is that **medicine keeps human**,"* he says. *"That we don't lose the control of all that, and that in the end it's the human interaction which drives decisions, which gives confidence. In the end of the day, it's experienced, balanced, ethically educated humans who are driving the whole thing."*

"What is extremely important in this transition is that medicine keeps human."

Someone who really takes care

Listen to Lordick long enough and a pattern emerges. The rocket years in Munich, the week in New York, the center built from scratch in Leipzig - each began with someone who opened a door, and a young doctor willing to walk through it.

It all began, too, with a young man pushing patients through the corridors of a Munich hospital, before he had even decided to study medicine. He could not have imagined the drugs that would arrive, the institutions he would build or the society he would one day lead. What held him then was simpler: the hospital, and the people in it who needed help.

"They need someone who really takes care," he said of the cancer patients who first drew him in.

As he prepares to lead ESMO into oncology's next transformation, it is still the best description of the job.



2016

Copenhagen
MONALEESA-2
Gabriel Hortobagyi

2016

Copenhagen
KEYNOTE-024
Martin Reck

2017

Madrid
PACIFIC
Luis Paz-Ares

After the Applause

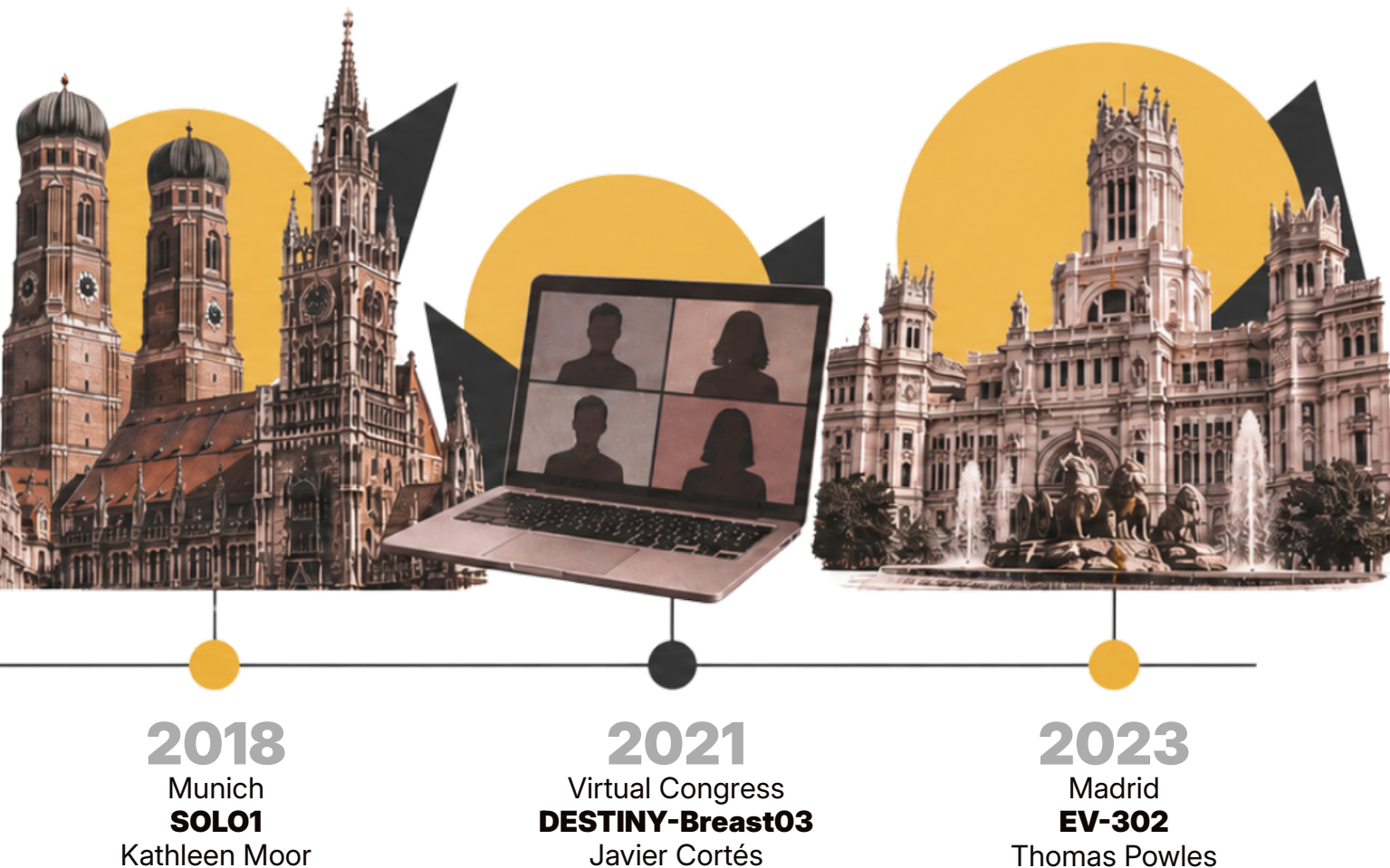
Six ESMO trials that changed cancer treatment

Article by **Mariam Harutyunyan**,
Deputy Managing Editor, OncoDaily and
Associate Editor, OncoDaily Magazine

A congress presentation lasts minutes. Its consequences can reshape years of care.

ESMO's influence reaches well beyond Europe. The congress provides a global stage for the first announcements and debate of potentially practice-changing results.

The phrase "practice-changing" is familiar at oncology congresses. It becomes meaningful when a result changes an actual decision: which treatment to start, whether to add another treatment after the first has finished, or how to reduce the risk that cancer will return and finally to establish what is best for the patient.



While ESMO has been the stage for many other impactful studies that, even without changing guidelines, have changed mindsets and real-world practice, we paint a picture of the past ten years of ESMO annual congresses across cancer types and pivotal clinical trials.

ESMO 2016
Copenhagen
Martin Reck



1. Did endocrine therapy need a backup?

MONALEESA-2 • Copenhagen • 2016

Back then, endocrine therapy could control **hormone receptor-positive, HER2-negative advanced breast cancer**, but tumors could become resistant and resume growing. For postmenopausal women, aromatase inhibitors such as letrozole were an established initial treatment, reducing the oestrogen production that helped drive their cancer. Researchers were looking for ways to make that control last longer.

ONALEESA-2 tested whether adding **ribociclib** could achieve that. The oral drug selectively inhibits **CDK4** and **CDK6**, proteins that help cells pass a checkpoint before

copying their DNA and dividing.

"This line of research has been going on for over 15, 20 years, but only recently have the selective CDK4-6 inhibitors become available."

-said **Gabriel Hortobagyi, who chaired MONALEESA-2**, at the ESMO 2016 press briefing.

Letrozole reduced the hormonal growth signal; ribociclib interrupted the cell-cycle machinery.

The trial enrolled 668 postmenopausal women with HR-positive, HER2-negative advanced breast cancer who had received no systemic treatment for advanced disease. They were randomly assigned to ribociclib plus letrozole or placebo plus letrozole.

The idea rested on years of drug development. Ribociclib emerged from a collaboration between the **Novartis Institutes for BioMedical Research** and **Astex**, announced in December 2005. Earlier attempts to target the cell cycle had struggled with insufficient selectivity and toxicity.

Once the investigators had a promising drug, the clinical trial moved quickly. Gabriel Hortobagyi, later recalled:

"There was a lot of enthusiasm from the concept on a proverbial cocktail napkin until implementation"

At **ESMO 2016**, the first results showed that adding ribociclib reduced the hazard of progression or death by approximately **44%**. At 18 months, an estimated **63.0% of patients receiving ribociclib plus letrozole were alive without disease progression, compared with 42.2% receiving letrozole plus placebo** an absolute difference of **20.8 percentage points**.

A more mature analysis subsequently reported medians of **25.3 months with ribociclib plus letrozole versus 16.0 months with letrozole alone**.

But one question remained:

Would delaying progression also mean that women lived longer?

That answer required five more years. At **ESMO 2021**, Hortobagyi presented the overall-survival results. Median survival was **63.9 months with ribociclib plus letrozole, compared with 51.4 months with letrozole alone**. Estimated six-year survival was **44.2% versus**

32.0%, an absolute difference of 12.2 percentage points.

Hortobagyi had entered oncology in 1974, when survival expectations for metastatic breast cancer were much shorter. Discussing the new results in a 2021 Breastcancer.org podcast episode, he noted that some women enrolled at the beginning of MONALEESA-2 were approaching eight years on treatment:

"Some of the original patients are still receiving ribociclib at this point"

The follow-up had become long enough to encompass years of patients' lives and to demonstrate a statistically significant overall-survival benefit.

Today, a CDK4/6 inhibitor combined with endocrine therapy is a standard first-line approach for HR-positive, HER2-negative metastatic breast cancer. Ribociclib remains an established option, with blood counts, liver function and electrocardiograms monitored during treatment.

ESMO 2016
Copenhagen

Gabriel Hortobagyi



2. Could the first treatment be immunotherapy alone?

KEYNOTE-024 · Copenhagen · 2016

For patients with metastatic **non-small cell lung cancer** without an actionable driver alteration, platinum-based chemotherapy had long been the starting point. Immunotherapy was already changing treatment after chemotherapy failed.

KEYNOTE-024 asked whether selected patients could receive it first and whether they could do better without chemotherapy. The trial tested **pembrolizumab**, an antibody that blocks **PD-1**, a receptor on immune cells.

Tumors can use its interaction with PD-L1 to suppress an immune response; blocking that interaction allows immune cells to attack the cancer.

Selection was central: the 305 participants had previously untreated metastatic disease, PD-L1 expression on at least 50% of tumor cells, and no sensitizing EGFR mutations or ALK rearrangements. They were randomly assigned to pembrolizumab alone or platinum-based chemotherapy.

At **ESMO 2016**, **Martin Reck** presented results that challenged the established sequence. Median progression-free survival - the time before the cancer worsened or the patient died - was **10.3 months with pembrolizumab versus 6.0 months with chemotherapy**. The hazard of death was **40% lower** in the initial analysis, although longer follow-up was needed to understand the durability of the benefit.

The results also changed the treatment experience.

Patient-reported outcomes (PROs) showed **improved global health status and quality of life with pembrolizumab compared with chemotherapy**

KEYNOTE-024 helped establish a new starting point for this defined population: **pembrolizumab alone could replace platinum-based chemotherapy as first-line treatment**. Testing PD-L1 before treatment now directly affected the choice patients and clinicians faced.

The longer story emerged at **ESMO 2020**, when the five-year results were presented. In VJ Oncology's *The Lung Cancer Sessions: ESMO 2020*, Reck discussed the findings with fellow lung cancer specialists Solange Peters and *Sanjay Popat*. Looking for comparable long-term outcomes, he found that many earlier trials ended follow-up after only two or three years.

KEYNOTE-024 was extending the horizon of what investigators could observe.

"These patients remain stable for a couple of months after the two years of pembrolizumab, so this is a real new chance."

- **Martin Reck**, discussing KEYNOTE-024 in VJ Oncology's *The Lung Cancer Sessions: ESMO 2020*.

The 2021 five-year analysis reported **median overall survival of 26.3 months with pembrolizumab versus**

13.4 months with chemotherapy. Estimated five-year survival was **31.9% versus 16.3%**. The advantage persisted despite substantial crossover: many patients initially assigned to chemotherapy subsequently received immunotherapy.

Pembrolizumab alone remains a standard first-line option for appropriately selected patients with high PD-L1 expression and no actionable driver alteration.

Other options include immunotherapy-chemotherapy combinations, with treatment chosen according to molecular findings, disease burden, and the patient's condition.

ESMO 2017

Madrid

Luis Paz-Ares



3. What Came After Chemoradiotherapy

PACIFIC · Madrid · 2017

Completing chemoradiotherapy was a major milestone for patients with **unresectable stage III non-small cell lung cancer**. Their cancer could not be removed surgically, but treatment still aimed to cure. Concurrent platinum-based chemotherapy and radiation were the established approach. For patients whose disease had not progressed, the next phase generally involved surveillance and the uncertainty of whether the cancer would return.

PACIFIC asked whether that interval could become another opportunity to treat.

The trial enrolled **713 patients whose disease had not progressed after concurrent chemoradiotherapy**, randomly assigning them to durvalumab or placebo for up to 12 months. **Durvalumab** blocks PD-L1, a protein that can help cancer cells suppress an immune response. The aim was to strengthen disease control through consolidation therapy, adding immunotherapy

after chemoradiotherapy rather than replacing it.

At the **ESMO 2017** press conference, **Luis Paz-Ares** presented the findings on behalf of the investigators. Scott J. Antonia was the first author of the original publication. The study brought the progress already seen with immunotherapy in metastatic lung cancer into a setting where preventing recurrence could have lasting consequences. Paz-Ares explained why investigators had pursued this approach:

"No major advances had occurred over the last two decades ... there's an urgent clinical need for novel therapeutic approaches in this setting."

- **Luis Paz-Ares, ESMO 2017 press conference; excerpt from the video transcript published by ecancer.**

The first readout showed **median progression-free survival of 16.8 months with durvalumab versus 5.6 months with placebo**, with a **48% lower hazard of progression or death**. An important detail sits behind the headline: the clock started at randomization after chemoradiotherapy. These months did not include the preceding treatment period.

The excitement in Madrid came with an unresolved question. Delaying progression was meaningful, but investigators still needed to establish whether patients would live longer. The overall-survival data were not yet mature.

The answer began to arrive in 2018. The subsequent analysis demonstrated a statistically significant overall-survival benefit: estimated two-year survival was **66.3% with durvalumab versus 55.6% with placebo**. The additional treatment after chemoradiotherapy was doing more than postponing progression.

Five-year follow-up strengthened that conclusion. Estimated overall survival was **42.9% with durvalumab compared with 33.4% with placebo**. Median overall survival was **47.5 versus 29.1 months, respectively**. These longer-term results were presented at ASCO 2021 and published in 2022.

The practice change was concrete. Completing chemoradiotherapy no longer necessarily meant moving directly into surveillance. Eligible patients could receive up to a year of durvalumab, with evidence that its benefit extended years beyond the treatment period. At

five years, **progression-free survival was 33.1% with durvalumab versus 19.0% with placebo**.

That additional opportunity also required careful clinical judgment. Chest radiation and immunotherapy can both cause pneumonitis, an inflammatory lung condition. Durvalumab can produce immune-related inflammation in other organs, making recovery from chemoradiotherapy and ongoing monitoring important parts of the treatment sequence.

Durvalumab remains an established consolidation treatment for appropriately selected patients in this setting. In the European Union, its indication requires **PD-L1 expression on at least 1% of tumor cells** and no progression after platinum-based chemoradiotherapy. This differs from PACIFIC's enrollment criteria, which did not require a particular PD-L1 level.

The next step after chemoradiotherapy has since become more specific to the cancer's biology. For patients with an **EGFR exon 19 deletion or L858R mutation**, osimertinib is now a recommended consolidation option following the separate LAURA trial. PACIFIC's lasting contribution was to establish that the interval after chemoradiotherapy could be used to improve survival and to make that additional treatment a standard part of care.

ESMO 2018
Munich

Kathleen Moore



4. Two Years of Treatment. A Benefit That Outlasted It.

SOLO1 • Munich • 2018

In **advanced ovarian cancer**, surgery and platinum-based chemotherapy could produce a complete or partial response, while the risk of recurrence remained a central concern. **SOLO1** focused on this first period of disease control, investigating whether maintenance

treatment could extend it.

The trial enrolled **391 women** with newly diagnosed **stage III or IV high-grade serous or endometrioid ovarian, fallopian tube, or primary peritoneal cancer** carrying a **BRCA1 or BRCA2 mutation**. All had responded to first-line platinum-based chemotherapy. They were randomly assigned to maintenance olaparib or placebo, generally for up to two years.

At the time, initial treatment centered on surgery and chemotherapy, usually carboplatin and paclitaxel. Observation after a response remained a common approach, although bevacizumab maintenance was an option for selected patients. **PARP inhibitors** had already demonstrated activity in recurrent ovarian cancer.

The new question was whether introducing olaparib after the first response could delay progression in this BRCA-mutated population.

Olaparib inhibits PARP, a protein involved in repairing DNA damage. Cancers with impaired BRCA-mediated repair are particularly vulnerable to this additional disruption.

The protocol also made treatment duration part of the study. Patients with no evidence of disease stopped treatment at two years; selected patients with persistent disease could continue beyond that point. This allowed investigators to assess whether disease control could persist after a defined course of maintenance therapy.

Kathleen Moore, the study's first author and ESMO presenter, addressed the value of time without treatment in a contemporary ecancer interview:

"To keep people disease-free and you don't have to treat them, that's a win-win."

- **Kathleen Moore**, ecancer interview, "SOLO1: Maintenance olaparib in advanced BRCA ovarian cancer," October 2018.

At ESMO 2018, olaparib showed a **70% lower hazard of progression or death than placebo**. At three years, **progression-free survival was 60.4% with olaparib versus 26.9% with placebo**. These findings established a progression-free survival benefit; overall survival data were not yet mature.

Five-year follow-up reported **median progression-**

free survival of 56.0 months with olaparib versus 13.8 months with placebo. The sustained difference showed that the benefit extended beyond the planned two-year treatment period.

The seven-year overall-survival analysis, presented at ESMO 2022, reported estimated survival of **67.0% with olaparib versus 46.5% with placebo**. This was clinically meaningful but did not meet the prespecified statistical threshold: $P = .0004$, against a required $P < .0001$. It should therefore not be described as a statistically established overall-survival benefit.

The practice change also strengthened the importance of BRCA testing early in the treatment pathway. Identifying a mutation could guide maintenance treatment after the initial chemotherapy response. SOLO1 established that this first period of disease control was an opportunity for targeted intervention, with benefits that could persist after treatment ended.

ESMO 2021

Virtual Congress

Javier Cortés



5. When the Second-Line Standard Was Surpassed

DESTINY-Breast03 · Virtual Congress · 2021

HER2-positive metastatic breast cancer already had an effective treatment sequence. Trastuzumab, pertuzumab, and a taxane formed an established first-line regimen. When disease progressed, trastuzumab emtansine, or **T-DM1**, was the standard second-line treatment. DESTINY-Breast03 investigated whether another antibody-drug conjugate could improve on that second step.

The trial enrolled **524 patients** with HER2-positive unresectable or metastatic breast cancer previously treated with trastuzumab and a taxane. They were

randomly assigned to T-DM1 or **trastuzumab deruxtecan, or T-DXd**. This was a direct comparison against an effective treatment already used in clinical practice.

Both drugs attach a cell-killing payload to an antibody that targets HER2. However, their construction differs. T-DXd carries approximately eight payload molecules per antibody, compared with roughly four for T-DM1, and delivers a different type of cytotoxic drug. Its released payload can also enter neighboring cells, including cancer cells with lower HER2 expression, a property known as the **bystander effect**. These differences offered a biological rationale for testing whether two treatments directed at the same target could produce substantially different outcomes.

Earlier research had shown that T-DXd could produce responses in patients who had received multiple previous treatments. But those findings came from a study without a randomized comparator. DESTINY-Breast03 addressed the next question: **could that activity translate into better outcomes when tested against the established standard?**

Javier Cortés presented the results at the **ESMO 2021 Presidential Symposium**. At 12 months, **progression-free survival was 75.8% with T-DXd versus 34.1% with T-DM1**. The hazard of progression or death was **72% lower with T-DXd**. Median progression-free survival had not yet been reached in the T-DXd group, compared with **6.8 months** in the T-DM1 group.

For **Sara Hurvitz**, a breast oncologist at UCLA and a principal investigator of DESTINY-Breast03, the comparison stood out against years of clinical experience. Speaking to the National Cancer Institute following the presentation, she said:

"I've never seen such a marked improvement in efficacy with a new drug compared to the current standard therapy for metastatic breast cancer"

- **Sara Hurvitz**, quoted in the National Cancer Institute's *"Enhertu May Be Preferred Therapy for Some Metastatic Breast Cancers,"* October 19, 2021.

The initial findings established a progression-free survival advantage. Overall-survival results were still immature and had not crossed the prespecified threshold for significance. Longer follow-up was needed to determine whether the improvement in disease control would also

translate into longer life.

The peer-reviewed 2024 analysis reported **median overall survival of 52.6 months with T-DXd versus 42.7 months with T-DM1**. Estimated three-year survival was **67.6% versus 55.7%**, an absolute difference of **11.9 percentage points**. These figures were measured from randomization after previous treatment, rather than from the original diagnosis, and were not part of the ESMO 2021 presentation.

T-DXd subsequently replaced T-DM1 as the preferred second-line treatment for eligible patients who had not previously received T-DXd.

The improvement also required specific attention to safety. **Interstitial lung disease and pneumonitis** can be serious or fatal. New cough, shortness of breath, or other respiratory changes require prompt assessment, with treatment interruption and management according to severity. Recognizing lung toxicity became an essential part of using the new standard safely.

The treatment sequence has continued to evolve. In September 2026, European approval was announced for **T-DXd plus pertuzumab as first-line treatment**, based on the separate DESTINY-Breast09 trial. Breast03 remains relevant for patients progressing after trastuzumab-based treatment who have not already received T-DXd; it does not establish the benefit of giving T-DXd again after progression on a first-line T-DXd regimen.

ESMO 2023

Madrid

Thomas Powles



6. Did two drugs overturn four decades of chemotherapy?

EV-302 / KEYNOTE-A39 · Madrid · 2023

For decades, treatment for **advanced urothelial cancer**

began with platinum-based chemotherapy. Patients received cisplatin plus gemcitabine, or carboplatin plus gemcitabine when cisplatin was unsuitable. By 2023, maintenance avelumab had improved this approach: patients whose cancer had not progressed during chemotherapy could move on to immunotherapy. But platinum chemotherapy remained the foundation of first-line treatment.

EV-302 asked whether treatment could begin with a different combination: **enfortumab vedotin plus pembrolizumab**.

Enfortumab vedotin is an antibody-drug conjugate. Its antibody targets **nectin-4**, a protein commonly expressed on urothelial cancer cells, and carries a drug that disrupts the machinery needed for cell division. Pembrolizumab blocks **PD-1**, helping immune cells attack the cancer. The combination brought targeted delivery of a cell-killing drug together with immunotherapy. It avoided conventional platinum chemotherapy, although enfortumab vedotin itself carries a cytotoxic payload.

Both drugs already had roles in advanced urothelial cancer. What was new was using them together at the beginning of treatment. EV-302 enrolled **886 patients with previously untreated, locally advanced or metastatic urothelial cancer**, randomly assigning them to the combination or gemcitabine with cisplatin or carboplatin.

The rationale had emerged from promising earlier studies. Looking back in a February 2025 UroToday interview with Ashish Kamat, **Thomas Powles** described the moment when antibody-drug conjugates opened a new direction:

"We thought we'd reached a plateau. Then the antibody-drug conjugates came along."

- **Thomas Powles**, speaking with Ashish Kamat in UroToday's *Enfortumab Vedotin and Pembrolizumab Demonstrate Durable Responses in Advanced Bladder Cancer*.

At the Presidential Symposium in Madrid, the phase III results showed how far that direction could lead. Median overall survival was **31.5 months with enfortumab vedotin plus pembrolizumab versus 16.1 months with chemotherapy**. The hazard of death was **53% lower** with the combination. Median progression-free survival was **12.5 versus 6.3 months**. Both measures had approximately doubled.

In EV-302, estimated 18-month overall survival increased from **44.7% with gemcitabine plus cisplatin or carboplatin to 69.5% with enfortumab vedotin plus pembrolizumab**. These estimates compare the randomized treatment groups in the initial analysis presented at ESMO 2023 and published in 2024.

The impact extended beyond the congress hall. In the UroToday interview, Powles described patients with bone metastases who had arrived expecting their disease to deteriorate quickly, then achieved a complete response - meaning their cancer was no longer detectable on scans, although this did not establish a cure.

"Many of those patients don't want to stop."

- **Thomas Powles**, UroToday interview, February 24, 2025.

Treatment duration had become a question about patients' priorities as well as cancer control. Some wanted more time with their families; others sought relief from peripheral neuropathy affecting their mobility and quality of life. Skin reactions require early attention, while nerve damage can accumulate over time. The survival gains opened a new conversation: how to preserve disease control while making that additional time livable.

Today, enfortumab vedotin plus pembrolizumab is a preferred first-line standard for advanced urothelial cancer in patients suitable for the combination. Platinum-based approaches remain important when the combination is unsuitable or unavailable. Treatment requires careful monitoring for skin reactions, neuropathy, elevated blood glucose, and immune-related complications.

Longer follow-up has reinforced the original finding. At ASCO 2026, median overall survival was **33.6 versus 15.9 months**, and estimated survival at 42 months was **44.0% versus 24.6%**. These later figures come from a separate follow-up analysis, extending the story that began in Madrid: the survival advantage persisted well beyond the first congress presentation.

These trials represent only part of the research presented at ESMO over the past decade. As another congress begins, the next potentially practice-changing results will face familiar questions: how much do patients benefit, who is most likely to benefit, and where does the treatment belong? Those answers take shape long after the applause.

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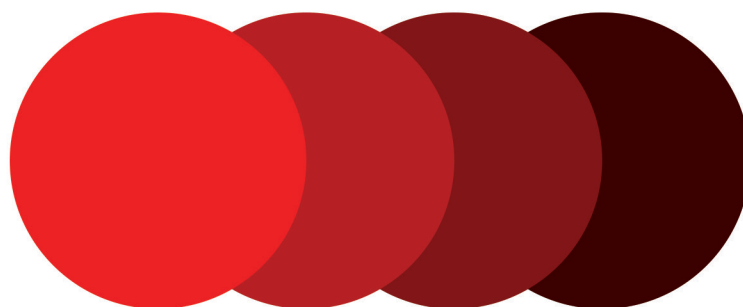
MAGAZINE



"The Cancer Center
of the Future Will Be
Virtual First"

Othman Laraki

From **Google** to cancer care,
CEO of Color Health Othman
Laraki is betting



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The Cancer Center of the Future Will Be **Virtual First**

From Casablanca to Silicon Valley, from Google to cancer care, Othman Laraki has spent his life at the intersection of technology and opportunity.

Now, the co-founder and CEO of Color Health is betting that the next great cancer center will not begin with a building.

Interview by **Gevorg Tamamyan**,
Editor-in-Chief of OncoDaily

There is a painting hanging behind Othman Laraki.

It depicts Essaouira, an old port town on Morocco's Atlantic coast.

"It's one of my favorite places in Morocco," Othman says. "This painting reminds me of it and the feeling of being there."

Othman was born into different worlds. His father is Moroccan, his mother French. He grew up in Casablanca, studied at Stanford and MIT, joined Google, became a Silicon Valley entrepreneur - and eventually entered healthcare.

Today, he is co-founder and CEO of Color Health.

And his ambition is bigger than digital health.

"The top cancer centers of the future are going to be virtual-first cancer centers."

Not replacing hospitals.

Not replacing oncologists.

But creating a clinical layer around patients - before diagnosis, during treatment and long after treatment ends.

Casablanca

Othman's father was an entrepreneur.

"When people talk about the challenges of being a startup entrepreneur in the US, it's nothing in comparison to what it used to be in places like Morocco."

There was no venture capital safety net.

"You went to the bank and got a loan, and that loan was collateralized against all of your assets. If your business went belly up, you lost your house."

"That was entrepreneurship with no seat belt, no airbag." Casablanca shaped him in another way.

Arab, Amazigh, Jewish, European and sub-Saharan cultures lived alongside each other.

"Growing up in a place like Casablanca, you feel like an outsider everywhere, but you also feel like you can belong everywhere."

But perhaps the most important influence was closer to home.

"My mother is a two-time breast cancer survivor."

He was under five when she first developed breast cancer. Years later, after a career in technology, cancer brought him back.

"That lived family experience really came full circle to leading me to start Color."

The Computer With No Games

His journey into technology began almost accidentally.

When Othman was five or six, his father brought home an

Amstrad computer.

Othman wanted games.

There were none.

Instead, magazines contained pages of BASIC code that had to be manually entered into the computer.

"Sometimes it was 50 pages of code that you had to retype into the computer to play the game."

So he typed.

And learned to program.

Eventually, he arrived at Stanford in 1996 - just as the internet revolution was exploding.

Larry Page and Sergey Brin were there. He met Jerry Yang. He once invited Masayoshi Son to speak at a seminar he organized.

Othman calls much of it luck.

"I always like the quote: better be lucky than smart."

But luck is only useful when you recognize it.

"The combination of luck, but also not missing those opportunities when luck shows up, is very key to some of these big success stories."

When Google Was Just Another Search Engine

Othman later joined Google when it had fewer than 1,000 employees.

Ironically, when he first encountered the company, he was skeptical.

"We already had Yahoo and Excite. Who needs another search engine?"

Then he used Google.

"You realized: wow, this is actually a very big step."

It taught him an important lesson.

Sometimes something that looks like one small feature becomes the entire platform.

And sometimes simplicity wins.

Marissa Mayer was his boss for much of his time there.

"One of the most important things she did was keep all the junk off the Google homepage."

One search box.

Almost nothing else.

Years later, that lesson would return.

This time in cancer.

Building the Cancer Center Again

Color began around 13 years ago in cancer genetics, working to expand access to testing for hereditary cancer risk.

But Othman says the goal was never simply testing.

"We wanted to deliver the impact of information in cancer."

The bigger question gradually became:

If you were designing the cancer center today, what would you build?

Modern cancer centers concentrate enormous expertise inside buildings.

But the patient's journey begins long before treatment. Was the patient screened?

Was cancer prevented?

What happened after an abnormal result? How quickly did diagnosis happen?

And after treatment, who manages survivorship, recurrence risk and long-term complications?

"We make almost all of the investments around cancer treatment."

Yet, Othman argues:

"Most of the dice get thrown around your cancer outcome before your diagnosis."

His conclusion was radical but simple.

"If you were building the cancer center of the future, you would not actually start by building buildings and putting

expensive equipment in them.”
You would start virtually.

Put the Cancer Center in the Cloud

“Imagine you take a top cancer center and you just put it in the cloud.”

The patient enters through something as simple as a link.

Color establishes where that person is in the cancer journey.

Healthy but high risk?

Abnormal screening?

Newly diagnosed?

In treatment?
Survivor?

A clinical team – physicians, genetic counselors and care advocates – then surrounds the patient.

Othman emphasizes one point.

“It’s not AI sitting back there.”

Color uses AI extensively.

But, he says:

“It is a medical group.”

If a patient needs a home test, it can be shipped.

If the patient needs mammography or another physical procedure, the platform helps find nearby options, coordinate insurance and schedule the appointment.

“You just choose a date and show up.”

The philosophy is straightforward.

Take care to people.

Do not let people to navigate care alone.

The Dangerous Space Before Diagnosis

One of the biggest problems begins when screening finds something abnormal.

A positive test appears.

Then the patient waits.

A colonoscopy takes months.

A suspicious mammogram leads to appointment after appointment.

The patient becomes the coordinator of a healthcare system they do not understand.

Color tries to compress that time.

“Our goal is, if you have a positive, within two weeks to get your colonoscopy.”

Because delay can change everything.

“Making someone who has colon cancer wait six months for a colonoscopy can be a whole stage or more of a difference.”

Once cancer is diagnosed, Color does not replace the treating oncologist.

Instead, it adds another clinical layer.

“We run a multidisciplinary tumor board for 100% of patients, no matter where they’re getting treated.”

Othman says those reviews have identified missing molecular testing, incomplete work-ups and even incorrect diagnoses.

“Think of us as putting an overlay of top cancer center quality analysis on your case, but that is available no matter where you’re getting treated.”

Geography Should Not Decide Cancer Care

“The same cancer, the same person, 20 miles down the road might have a very different level of access to top experts.”

That can mean different treatment. And different outcomes.

Othman calls the goal “up-leveling the baseline.”

Because cancer care is not only chemotherapy, surgery or radiation.

It is nutrition. Mental health. Financial toxicity. Symptom

management. Survivorship. And access to expertise.

"Your odds of getting cutting-edge cancer treatment should not be proportional to how far you are from MSK or Stanford or UCSF."

In other words:

Democratizing access to cancer care.

Twenty Years Between Science and Patients

Ask Othman where he wants Color to be in five years and he returns to the same vision.

"The highest-volume and highest-impact cancer service in the world will be a virtual-first cancer service."

He hopes Color builds it.

But the idea matters more than the company.

"I hope that vision and that impact get delivered. And I hope that we are the ones who are able to do that, or at least influence it happening."

He sees another fundamental problem in medicine.

Discovery does not automatically become delivery.

"Guidelines are trailing science by 10 years."

Then:

"The practice trails guidelines by another 10 years."

His conclusion:

"Today, practice is trailing the science by 20 years or more."

Meanwhile, the scientific frontier is moving faster than ever.

Cancer vaccines.

Precision oncology.

New targeted therapies.

New diagnostics.

"The frontier is moving at an incredible pace."

But innovation has little meaning if patients cannot

access it.

"It should not take 10 or 20 years for people to experience the impact of what science has established."

"The Future Has Never Been Built by the Skeptics"

At the end of our conversation, I asked Othman what advice he would give the younger generation.

His answer surprised me.

"I'm very jealous of people who are just coming of age now."

His generation had the internet revolution.

This generation has AI.

There are risks.

But Othman worries that fear can become paralyzing.

"The most scarce thing all of us have is time."

His message is simple.

Build. Try. Fail. Try again.

"Focus on making the things that are unconditionally positive for humanity."

AI can be misused.

But it can also transform medicine.

"AI can help us save millions of people from cancer."

And optimism, for him, is not naïveté.

It is a prerequisite for action.

"Pessimism drives inaction."

Then comes the sentence that perhaps best summarizes his journey — from Casablanca to Silicon Valley, from Google to cancer care.

"The future has never gotten built by the skeptics."

"It's always gotten built by the optimists."

Bari, 1943

The Disaster That Changed Cancer Treatment

by **Marine Marachlian**,
MD Medical Writer and Editor, OncoDaily



Burning Ships, Bari Harbor

12/2/43

16-14

How a secret cargo, a wartime catastrophe and an unexpected medical observation became part of the story of modern chemotherapy.

The Night Bari Burned

On the evening of December 2, 1943, the port of Bari in southern Italy was crowded with Allied ships carrying fuel, ammunition, food and medical supplies for troops advancing through Italy. The city had been captured only months earlier and had become an important Allied supply hub. Shortly after 7 p.m., German bombers appeared overhead. Within minutes, ships and dockside facilities were burning, ammunition was exploding and fuel had spread fire across the water.

Among the vessels was the American Liberty ship SS John Harvey. Hidden in its hold was a highly classified cargo: roughly 2,000 bombs containing **sulfur mustard**. The weapons had been sent to the Mediterranean as a precaution in case Germany used chemical weapons first. Their presence was known to very few people in Bari, including many of the physicians who would soon be treating casualties.

When the John Harvey was hit, mustard agent was released into the harbor and mixed with seawater and oil from damaged ships. Sailors who jumped into the water to escape the fires were soaked in the contaminated mixture; others inhaled mustard vapor. At first, many appeared to be casualties of a conventional bombing. Then painful eye injuries, blistered skin and respiratory symptoms emerged. In the following days, physicians noticed something else: in some patients, white blood cell counts were falling dramatically.

A Clue Hidden in the Blood

The unusual pattern drew the attention of Lt. Col. *Stewart Francis Alexander*, a U.S. Army physician trained in chemical warfare medicine who was sent to Bari to investigate. Some men developed profound leukopenia as their bone marrow - the tissue responsible for producing new blood cells - was severely damaged. Mustard exposure was affecting some of the body's most rapidly renewing cells.

The finding added to an observation already emerging from chemical research: mustard compounds could be especially damaging to tissues whose cells divide rapidly. That raised an important medical question. If this destructive effect could be controlled, could a related compound be used against rapidly dividing malignant cells? Alexander documented what had happened in Bari, but researchers elsewhere were already investigating that possibility.



The Treatment That Changed the Question

At Yale, pharmacologists **Louis Goodman and Alfred Gilman** were studying chemical warfare agents under a secret wartime program. Their experiments showed that nitrogen mustards, chemical relatives of sulfur mustard, could cause lymphoid tumors in animals to shrink. Working with Yale surgeon Gustaf Lindskog, they moved from animal experiments to a patient with advanced cancer in 1942.

The patient is remembered in the medical literature simply as **J.D.** He was 47 and had advanced lymphosarcoma. Surgery and radiation had failed to control the disease, leaving physicians with few options.

Doctors administered a nitrogen mustard compound known as **HN2**, later called mechlorethamine. Within days, the masses began to soften and then shrink. For physicians accustomed to treating cancer primarily with surgery or radiation, the implication was striking: a drug travelling through the bloodstream could reach cancer in several parts of the body.

The response did not last. The tumors returned, subsequent treatments became less effective and the disease eventually became resistant. Nitrogen mustard also suppressed the bone marrow. J.D. was not cured, but his response provided evidence that widespread

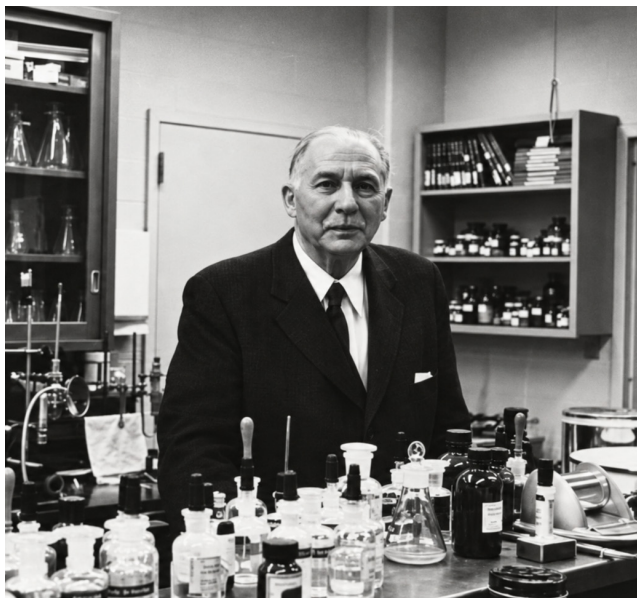
cancer could respond to systemic drug treatment. The Yale findings remained secret during the war and were published in 1946.



From left: Drs. Alfred Gilman, Louis Goodman, and Gustaf Lindskog

The timing matters. J.D. had received nitrogen mustard in **1942**, before the Bari disaster. Bari therefore did not create chemotherapy. Instead, it became part of a broader and more difficult history in which the biological effects of mustard compounds were being seen under profoundly different circumstances: deliberately in laboratory research and catastrophically in people exposed during war.

From One Drug to an Entire Field



The story did not end with nitrogen mustard. In 1947, pediatric pathologist **Sidney Farber** treated children with acute leukemia using aminopterin, an antifolate, and in 1948 reported temporary remissions. At the time, childhood leukemia was considered essentially incurable

and care was largely supportive. Farber's results offered something that had scarcely existed before: evidence that a drug could push childhood leukemia into remission.

Farber's contribution went far beyond a single drug. He became a major advocate for children with cancer and for sustained investment in cancer research. He also helped advance a model of pediatric cancer care that brought clinical treatment, research and support for families together.

His work did not grow directly from the Bari disaster; it represented another branch of the emerging field of systemic cancer therapy, driven by deliberate research aimed at helping patients.

Over the following decades, researchers moved from individual agents to combinations of drugs with different mechanisms. By the 1960s and 1970s, combination regimens were producing durable remissions and, in selected cancers, cures - transforming diseases such as childhood acute lymphoblastic leukemia, Hodgkin lymphoma and testicular cancer.

What Bari Left Behind

Bari should first be remembered for what it was: a human tragedy. Mustard agents were weapons designed to harm, and the sailors, soldiers and civilians exposed that night had no choice in what happened to them. Wartime secrecy compounded the disaster by leaving many physicians unaware of the chemical exposure they were treating.

The fact that medical knowledge was later drawn from what happened does not turn Bari into a scientific milestone. It is indeed unfortunate to think, that scientific discovery is not always created from good intentions of improving human life, but from circumstances created to destroy it. But the history of chemotherapy is much larger than Bari. It includes Goodman and Gilman's deliberate research, J.D.'s experimental treatment, Farber's work with children with leukemia, and generations of scientists and clinicians who continued searching for better ways to treat cancer.

Today we hope for peace that will allow researchers to create much more effective, safer novel drugs intended to help those who need it the most, whenever they needed and wherever they reside.

November 19 - 21, 2026

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How to Become a UICC President

Article by **Mariam Harutyunyan**,
Deputy Managing Editor, OncoDaily and Associate
Editor, OncoDaily Magazine

Data by **Aren Petrosyan**,
Rankings and Analytics Lead
of BGR

The Union for International Cancer Control is now electing its next President-elect. Three candidates, Gilberto Lopes, Asem Mansour and C S Pramesh, are competing for the position, with the result to be announced at the UICC General Assembly on 20 October 2026.

As UICC prepares for its next leadership change, we decided to return to BGR's **How to Become** series. This time, we are asking:

How do you become President of the world's oldest and largest international cancer organization that unites more than 1,100 members across over 170 countries and territories?

Elected by full member organizations, the President-elect serves for two years before beginning a two-year term as President, representing the network and chairing its Board.

There is an official election, of course. But is there a certain path to the job?

There are some tempting theories. Let us see how well

they hold up.

First, should you move to Australia?

One would think the president-producing factory of UICC would be Geneva.

Not really.

If nationality were the secret qualification, Australia seems to have cracked the code. Four of UICC's 24 presidents have been Australian: **Nigel Gray, David Hill, Sanchia Aranda and Jeff Dunn**. Maybe aspiring candidates should begin with a flight to Melbourne?

To be fair, nationality probably is not their real connection. All four Australians came through the Cancer Council system. Nigel Gray and David Hill led Cancer Council Victoria, Sanchia Aranda became CEO of Cancer Council Australia, and Jeff Dunn led Cancer Council Queensland for almost 15 years.

Well, they need to be oncologists, right?

Missed again.

They were not all oncologists. They were not even all physicians. UICC's first president, **Justin Godart**, was a lawyer and politician. **Alexander Haddow** was an experimental cancer researcher and **V. R. Khanolkar**, a pathologist.

Later, **Sanchia Aranda** brought the perspective of an oncology nurse, **Jeff Dunn** was a behavioural scientist, and **Princess Dina Mired**, a cancer advocate and former cancer-foundation leader. UICC's current president, **Ulrika Årehed Kågström**, came from finance, crisis management and organizational leadership.

And the school theory?

Surely, then, there must be a university that quietly produces UICC presidents.

The university search leads nowhere. Mary Gospodarowicz graduated from **the University of Toronto**. Jeff Dunn earned his bachelor's, master's and doctoral degrees at **the University of Queensland**. Ulrika Årehed Kågström studied business administration and economics at **Luleå University of Technology**. Sanchia Aranda began with nursing education in New Zealand and later travelled to London for specialist cancer-nursing training at **the Royal Marsden**.

There is no presidential alma mater hiding in the list.

Wait for eight decades.

It took 77 years for UICC to elect its first woman president, Mary Gospodarowicz, in 2012. Sanchia Aranda, Princess Dina Mired and Ulrika Årehed Kågström followed, making Ulrika only the fourth woman to hold the office. Zainab Shinkafi-Bagudu is currently President-elect and will take office on 20 October 2026.

So the all-male pattern has finally been broken.

These patterns give us individual dots, not the whole picture. To understand why each president emerged at a particular moment, we need to connect them:

Who are they?

What had they already accomplished?

And what did cancer control need when they arrived?

The birth of UICC

In 1933, cancer work was scattered across national leagues, hospitals and research institutes. Researchers lacked fast

ways to exchange findings, cancer statistics could not be compared reliably because diagnostic standards were different across countries, tumor terminology was not unified and effective treatments were limited.

At the International Medical Congress in Madrid, **Jacques Bandaline** proposed creating "an international organization to promote the fight against cancer." The motion was approved unanimously.

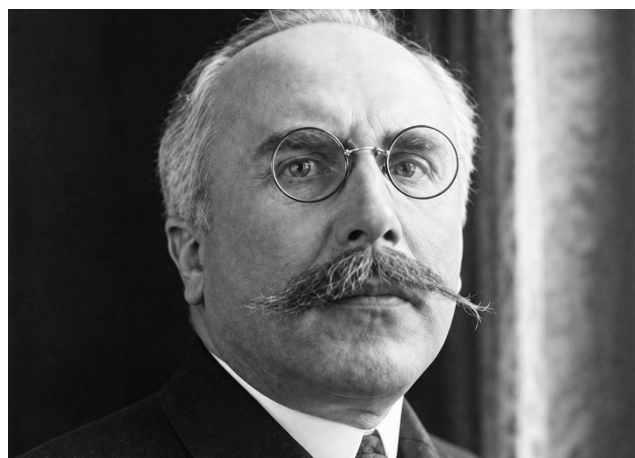
"Through education and the dissemination of research findings, advance medical and scientific knowledge throughout the world."

- The goal set out in UICC's founding motion at the 1933 International Cancer Congress in Madrid.

Two years later, 67 national cancer organizations from 43 countries met in Paris and elected **Justin Godart** as UICC's first president.

The first president was not a doctor. That was the point.

Godart was not a clinician. He was a French lawyer, politician and former minister. The connection to medicine became personal through service. In 1914, Godart worked as a nurse at the front. The following year, he entered France's military health service. There, he encountered the plight of soldiers with cancer.



"Because it is a social ill, society must combat it."

- Justin Godart, *Ligue contre le cancer*.

UICC's first great problem was organizational: **someone had to convince institutions and countries to cooperate**. War soon tested that ambition. UICC suspended its activities after its 1939 Congress. When the Second World War ended, Godart contacted the surviving members of its

Executive Committee and turned to American colleagues for help rebuilding the network. Their support allowed UICC to reconvene in St. Louis in 1947.

Godart remained president from 1935 until 1953. Eighteen years is exceptional, by today's two-year standard, less a presidential term but rather a dynasty.

Was he elected to solve the political rupture of his age? Maybe. Maybe not.

But he knew law, politics, negotiation, and how to give cancer science a structure capable of surviving geopolitical collapse.

The staging language for cancer: Legacy of Pierre Denoix and Mary Gospodarowicz

Pierre Denoix began this work in 1943, not in an international conference room but in wartime France. The young breast surgeon and member of the French Resistance was asked to study cancer incidence and how advanced tumors were when patients reached treatment centres. The records collected across France did not follow one common system. Denoix created one.

UICC formed its TNM committee in 1953. Denoix became Director of Gustave Roussy in 1956 and UICC President in 1973: 30 years after receiving the assignment that started it all.



"Only a coordinated approach to all the problems ... can lead to real progress."

- Denoix, reflecting on UICC's purpose in its 50th-anniversary publication in 1983.

Decades later, Mary Gospodarowicz encountered the problem from the other direction. Born in Poland and educated partly in Toronto, she entered cancer staging through the Canadian Committee on Cancer Staging in the late 1980s and joined UICC's TNM project in the early 1990s.

She discovered several competing staging systems, some used only by the institutions that created them and while trying to preserve the anatomical staging, she incorporated the prognostic staging system as well.



"I naively thought there was an international organization responsible for such medical standards."

- Gospodarowicz recalled in a Cancerworld interview published in 2012.

She later became the co-chair of UICC's TNM project, worked to broaden its international reach and was elected UICC President in 2012.

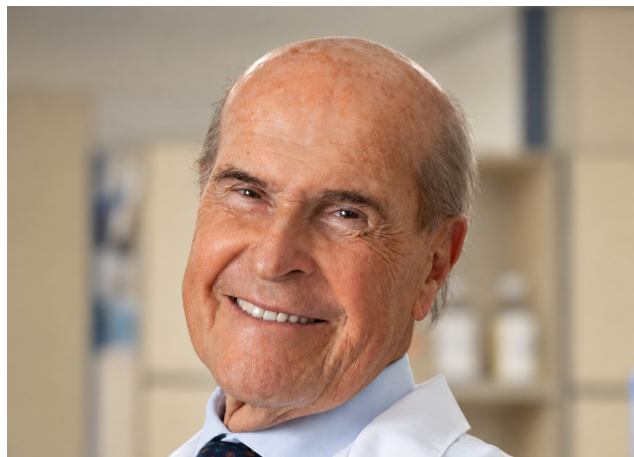
Umberto Veronesi: Challenge the tradition

Umberto Veronesi was not satisfied with performing the operation surgeons had inherited. In 1973, he began a trial asking whether women with small breast tumors could avoid losing the entire breast without reducing their chances of survival.

He became the Scientific Director of Milan's National Cancer Institute in 1976 and the UICC President two years later while the trial was still running. Its results, published in 1981, showed comparable survival after quadrantectomy and radiotherapy or radical mastectomy.

Veronesi's career was built around a stubborn idea:

treatments should become less destructive when evidence allowed it. His presidency carried that logic beyond surgery - research mattered only if countries could understand one another and act on the same evidence.



"A common scientific currency would be desirable, perhaps UICC can provide it."

- Veronesi, writing in the prologue to UICC's 50th-anniversary publication in 1983.

Sanchia Aranda: Take the wrong turn and **keep going**

Sanchia Aranda did not plan to enter oncology. After training as a nurse in New Zealand, she moved to Australia intending to work in burns. Instead, she was placed in a medical unit that included an oncology section.



It was 1979, when chemotherapy was still new in Australia, and the accidental assignment became a career. Aranda found herself caring for people with

leukaemia, lymphoma and an increasing number of solid tumors. The relationships she developed with patients convinced her that cancer would become the focus of her career.

She pursued specialist cancer-nursing education at the Royal Marsden, moved from the ward into research and attended her first UICC World Cancer Congress in Budapest in 1986.

She became President in 2016: 30 years after that first Congress.

"I believe that is also a trait that has characterised my career: always looking for new platforms where I could have a bigger impact."

From the Marlboro Man to Tobacco Control: Nigel Gray

Nigel Gray began his career as a paediatrician. In 1968, he left hospital medicine to lead what became Cancer Council Victoria and chose tobacco as the fight that could prevent the greatest number of cancers.

In 1971, Gray and advertising executive Fred Parslow created a parody of the Marlboro Man. Australian television stations refused to broadcast it while accepting money from tobacco advertising.



Gray did not abandon the campaign. He turned to behavioural research, health warnings, legislation and the evidence needed to confront the industry on its own ground.

In 1987, Victoria passed legislation restricting tobacco advertising and created VicHealth, which replaced tobacco sponsorship in sport and the arts. By then, Gray had also taken his campaign into UICC: he began working through its tobacco-control structures in 1975 and became President in 1994.

His approach was measured, evidence-driven - and uncompromising once the evidence was clear.

"I think they should be regulated every which way."

- Gray, writing about tobacco products in a Tobacco Control editorial in 2006.

HRH Princess Dina Mired: Return for those who could not leave

"I didn't choose cancer. It was never on my radar. But cancer chose our family."

In 1997, Princess Dina Mired's son was diagnosed with leukaemia before his second birthday. Her family had the means to travel from Jordan to the United Kingdom and later the United States for treatment. He survived, but their ability to leave Jordan exposed an inequality she could no longer ignore.

When Dina returned to Jordan, she became Director-General of the King Hussein Cancer Foundation. The cancer centre already existed, but the advocacy and fundraising operation needed to sustain and expand it, did not. She built that work, mobilising donors and the public while developing the foundation into an internationally recognised cancer organization.

Her son's treatment also changed how she understood global cancer inequality. The same childhood cancer could be highly curable in one health system and fatal in another.

"There are children in Africa dying of leukemia that my son had."

In 2018, Dina became UICC's first Arab and first non-medical President. During her years as President-elect and President, she travelled extensively to meet political leaders, cancer organizations, volunteers, patients and healthcare professionals. She advocated for cancer's inclusion in universal health coverage, supported the City Cancer Challenge and promoted international commitments on cervical and childhood cancer.

Her presidency ended in 2020 as COVID-19 disrupted

cancer care and forced UICC to move its programmes online. Looking back, she rejected the idea that its achievements belonged to a single leader:



"UICC's achievements represent the sum of our parts, members and partners alike."

Jeff Dunn: The president who became the patient

By the time Jeff Dunn was elected UICC President, he had spent decades studying cancer control, psychosocial care and survivorship. He had also served on UICC's Board for ten years.

Then, in August 2022 two months before he was due to become president, Dunn was diagnosed with advanced mantle cell lymphoma. Without treatment, he was told that his survival could be measured in weeks.

He could not travel to the World Cancer Congress in Geneva. Instead, he took office from Australia while undergoing treatment. Chemotherapy and an autologous stem-cell transplant brought the lymphoma into remission, but treatment severely weakened his immune system. He later developed an infection caused by bacteria resistant to multiple antibiotics.

"I never expected to be diagnosed with cancer during my tenure as UICC President, nor to complete an autologous stem cell transplant while serving in the role!"

- Dunn wrote in UICC's 2023 Annual Report, published in May 2024.

The diagnosis put Dunn inside the systems he spent his career examining.



"This diagnosis brought a new perspective to my work in cancer control. I experienced firsthand the importance of access to world-class treatment and the critical role of research in developing new therapies."

- he reflected in a UICC blog published on 23 September 2024, as his two-year presidency approached its end.

HE Zainab Shinkafi-Bagudu: Bring the view from the other side of the world

HE Zainab Shinkafi-Bagudu's path did not remain inside pediatrics. She established Abuja's first comprehensive diagnostic centre and later founded the Medicaid Cancer Foundation to address the barriers preventing Nigerians from finding and affording cancer care.

Her route to UICC passed through almost every layer of cancer control: clinical medicine, diagnostics, civil society and government. By the time she stood for President-elect in 2024, she had practised medicine for 30 years, led a diagnostic centre for 18, run a cancer foundation for 15 and served six years on UICC's Board.



On 20 October 2026, UICC's first African woman President-elect will become its next President. Her

central question is the defining one for cancer control today: how can scientific progress reach people whose geography, income or health system still places it beyond their reach?

"I will be an interactive leader who will lean on your experiences, insights, and energies to guide the UICC in the years to come."

- Shinkafi-Bagudu, accepting her election as President-elect at UICC's General Assembly on 8 October 2024.

So, how do you become UICC President?

First, build something before asking to lead it.

Build a staging system, a prevention policy, a research program, a cancer institution, a diagnostic service, or an advocacy movement. UICC has repeatedly chosen people who had already turned an idea into something others could use.

Second, become bilingual, not necessarily in languages, but in worlds.

Learn to move between evidence and policy, clinicians and patients, national organizations and global institutions, and high-resource ambitions and low-resource constraints.

UICC's problems rarely remain purely scientific.

Third, stay.

Attend the congresses. Join the technical projects. Serve on committees and the Board. Learn how the organization works and build trust before seeking its highest position. For many presidents, this process took decades.

Finally, bring the problem your era cannot avoid: diplomacy during political rupture, standardization as oncology expanded, tobacco control, equity, pandemic leadership, the patient perspective, crisis management, or the experience of building cancer services where resources remain limited.

There is no presidential zodiac sign, shared university, or required medical degree. The strongest pattern is usefulness sustained over time: build something, learn to translate across worlds, and remain long enough to earn trust.

And if all else fails, Australia still seems worth a try.

Powered by BIGR



A new initiative by OncoDaily, the OncoDaily Academy, will connect clinicians with expert-led learning experiences across the evolving landscape of cancer care.

The field of oncology is advancing at an unprecedented pace. With discoveries, emerging treatment approaches, and rapidly evolving standards of care, continuous education has become essential for healthcare professionals worldwide.

To support this need, OncoDaily is launching OncoDaily Academy, a new global educational initiative developed in collaboration with The Learning Lab to provide accessible, clinically relevant, and expert-led learning experiences for the oncology community.

The Learning Lab is a digital education team and a spin-out of Guy's and St Thomas' NHS Foundation Trust. It champions high-quality clinical education and new approaches to how clinicians learn, including Dojo, which lets clinicians rehearse clinical scenarios and

challenging conversations with realistic virtual patients and build confidence before those moments arise in practice.

Through OncoDaily Academy, learners will have access to educational experiences designed around the needs of today's cancer workforce, supporting clinicians at different stages of their careers and helping them navigate an increasingly complex therapeutic landscape.

The first educational initiative under OncoDaily Academy is being developed in collaboration with The Learning Lab and Guy's Cancer Academy, with non-promotional funding and support from Agenus, and focuses on the evolving field of immuno-oncology.

The OncoDaily Academy is intended for clinicians across the cancer workforce, including oncologists, trainees and nurses. The programme is free to access online, and participants who complete it receive a free certificate of completion from Guy's Cancer Academy.

OncoDaily ACADEMY

The first chapter: Immuno-oncology education

The inaugural program of OncoDaily Academy focuses on immuno-oncology, one of the most significant areas of progress in modern cancer treatment. It also addresses one of the field's most pressing open questions: why many patients still do not benefit from current immunotherapies.

The program builds from the underlying biology of the immune response to cancer to the emerging approaches being investigated to extend the benefits of immunotherapy to more patients. Along the way, it helps clinicians interpret new evidence as it emerges and understand what it may mean for the patients in their care.

The program is clinically led. It is being developed with clinicians, so that the content reflects the questions clinicians face in the clinic and in multidisciplinary team

discussions. The Learning Lab, the digital education studio behind Guy's Cancer Academy, has designed each module around application to practice. Complex science is broken into manageable steps and brought to life through clinical cases and the patient perspective, and learners apply what they have learned as they go.

Delivered online through OncoDaily Academy, the program is available to oncology professionals wherever they practice. It brings the clinical experience of a leading UK cancer center to OncoDaily's international community. The aim is to widen access to specialist immuno-oncology education, particularly for clinicians who have fewer opportunities to learn from experts in this field, and to support consistent, evidence-based care for patients worldwide.

The program is independent medical education. Agenus has provided non-promotional support, and editorial control of all content rests with the clinical and educational team.



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2026

