A clinician’s point of view on how to provide best therapy to their cancer patients

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The frame for daily practice

- Very busy clinic including a new EPR
- Budget cuts every year
- Less staff
- High expectations among patients an relatives
- Media, case stories
- Diseases with few approved good treatment options

Fast access to new and innovative drugs.

- Clinical trials should have a minimum differences of 3 to 4 months in endpoints as progression free survival and survival.
- Always survival data in diseases with a short survival.
- Administration and dosing of new drugs should be well described.
  - Example: pembrolizumab in lung cancer, fixed dose versus personalized dose.

Targeted treatment has a well defined biomarker that allows selection of patients that benefits from the treatment

- Immunotherapy:
    1. Treatment for the same cancer is developed with and without a marker for PD-L1 expression.
    2. Conflicting results.
    3. Clear tendency across different cancers

Guidelines reflects evidence and are updated

- The same treatment across the country.
- Consistent information of patients
- Often no evidence of sequential therapy with drugs targeting the same receptor or mechanism of action.
  - Example: Zytiga versus Xtandi in prostate cancer.

Enough staff to help the patients

- Many situations in daily practice require follow-up
- Anticancer therapy is not the best solution to all situations

  Chemotherapy Use, Performance Status, and Quality of Life at the End of Life

  JAMA Oncol. 2015;1(6): 778-784.

As a physician and a taxpayer

- Avoid cheap old drugs getting a specific labelling and become very expensive.
- Expensive me too drugs which are marketed as innovative new drugs

Conclusion

- Fast access to new innovative drugs that make a difference.
- My patients are confident that they have received the state of art therapy and when further treatment is without chemotherapy, they know it is the best option.