Sunday’s Opening Speech in the Auditorium saw warm words being extended from The Right Honourable Nicola Sturgeon, MSP, First Minister of Scotland, who shared her “absolute delight” in welcoming the 2018 NCRI Cancer Conference to her home city of Glasgow for the first time.

“The Scottish government is a proud partner member of the NCRI,” said Ms Sturgeon. “Glasgow and Scotland more generally … are important centres for cancer research.”

She added that Scotland has a very strong and a very proud history of medical innovation. In terms of public health policy, she added, several Scottish developments — for example the Highlands and Islands Medical Service in 1913 — were incredibly influential in the later foundation of the NHS.

Ms Sturgeon underscored the Scottish government’s determination in building upon the reputation established by the esteemed medical research institutions in Glasgow and across Scotland. “Finding better cancer treatments is first and foremost vital to the health and wellbeing of people,” she said, adding: “But there is also an important economic point here as well.

“As you know, Scotland’s economy is one that is based very firmly on the importance of innovation. We want Scotland in the future, as we have been in the past, to be a country that designs, invents and manufacturers the key technologies and products of the future.”

More specifically, innovation in medical research is an important part of that wider vision, she stressed, including a pharmaceutical sector in Scotland which employs more than 5,000 people.

“Our commitment to research is very explicit, and rightly so, in the national cancer strategy that the Scottish government published in 2016,” said Ms Sturgeon. “It affirmed what all of us know: that research is vital for providing better treatments… and by enabling us to [better] understand the causes of cancer, help in prevention and lead to improvements in population health.”

Continued on page 2
First Minister welcomes NCRI 2018 to Glasgow

Continued from page 1

Ms Sturgeon outlined that, in cooperation with Cancer Research UK, the national cancer strategy supports experimental cancer medicine centres both in Glasgow and in Edinburgh. “These of course help us to discover, develop and test new cancer treatments,” she said. “We help with the Scottish Cancer Research Network, assisting them to develop clinical trials in Scotland, and the cancer strategy also commits us to funding precision medicine research into ovarian and pancreatic cancer.”

Delving deeper into the field of personalised medicine, she highlighted the Stratified Medicine Scotland Innovation Centre that was launched five years ago, based at the Queen Elizabeth University Hospital in Glasgow. “We also provide funding for precision medicine,” continued Ms Sturgeon, focusing as well on the “Precision Pan” project on personalised treatment for pancreatic cancer. “Pancreatic cancer can spread extremely rapidly … so it is very important to find the right treatment as quickly as possible.”

Ms Sturgeon also touched on the collaboration between Scottish medical institutions and Europe. “In many of the research projects that Scotland is involved in, we benefit hugely from collaboration with international partners; what we do wouldn’t be possible without [them],” she said.

“One of the many, many reasons why the Scottish government so deeply regrets Brexit – the issue that is consuming much of the political debate in Scotland and the rest of the UK right now – is that Brexit may make some of those collaborations more difficult in the future. Institutions in Scotland benefit significantly from EU research funding. More than a quarter of the research staff in Scotland’s universities are EU citizens from outside of the UK.”

She continued: “Regardless of the outcome of Brexit, we will continue to do everything we possibly can to ensure that Scotland remains an open, outward-looking, welcoming internationalist country.”

Offering her closing remarks, Ms Sturgeon said: “The spirit of openness and collaboration is exactly why we are so delighted to host this conference here in Glasgow. It’s fantastic to see so many delegates here from across these islands and around the world, sharing their expertise on something that affects millions of people.

“I hope that you have an absolutely fantastic time in Glasgow, and that you are already looking forward to returning here next year. I hope that the conversations that you have over the next few days lead to new contacts, fresh insights and great ideas. I very much hope that as a result, this conference helps to play some part in encouraging further medical advances and improving cancer treatments.”

Unhealthy habits Tackling the conscious and non-conscious roadblocks in behaviour change

Today’s plenary lecture, “Why is behaviour change so difficult?”, will argue that large-scale environmental change by policy makers is the key to reducing cancer cases and other health conditions, not personalised interventions.

“Key to cutting rates of cancer is changing the environment on a large scale to effect behaviour change,” began Theresa Marteau, Director of the Behaviour and Health Research Unit, University of Cambridge, UK, in an interview with NCRI Daily News.

Around 40% of cancers are preventable by changing behaviours such as smoking, overeating, drinking too much and physical inactivity. Furthermore, 65% of premature deaths worldwide are caused by unhealthy behaviours, and tackling these would eliminate 75% of diabetes and cardiovascular disease deaths, and reduce health inequalities by 50%, she added. Yet changing people’s behaviour to reduce these risks is difficult, explained Professor Marteau.

In the UK, about 15% of people smoke, 35% drink alcohol at harmful levels, 65% are overweight or obese and – when objectively measured – around 95% are inactive, yet – as Professor Marteau will relay – informing individuals of the consequences of their harmful behaviours, which has been core to many strategies for change, has only a “modest effect” on changing their behaviour. “The bottom line is that, based on the existing evidence from studies” involving personalised feedback using a wide range of biological markers, ...
personalised risk information does not change behaviour,” she said. “While such information can change how people think about their risks, critically, it doesn’t seem to change what they do. The fascinating question is why such information does not change behaviour.”

Professor Marteau will argue in her lecture that environment exerts a far stronger impact on what people do than what’s in their minds. Changing the cues in our environments that activate these behaviours holds much promise for achieving the change many intend but fail to achieve, she said. Delving deeper, she explained that everything we do is regulated by two sets of interacting processes, conscious and non-conscious, and that conscious processes are slow, goal-directed and limited in capacity, while non-conscious processes are fast and based more on feelings and habits. Examples include seeing a cigarette lighter and craving a cigarette, or opening the fridge and reaching for a beer.

“In short, information-based approaches to changing behaviour are based on partial models of human behaviour, neglecting the non-conscious processes that effortlessly activate most of our behaviour, particularly routines and habits,” said Professor Marteau. “But here lies a clue to the more effective approaches to changing behaviour, namely targeting the non-conscious processes readily activated by the cues that surround us.”

She added that these cues are all around us, for example alcohol companies displaying their logos at football matches or escalators, or supermarkets pumping out the smell of fresh baked bread at the back of the store to draw customers past the 2-for-1 offers on unhealthier foods.

On the other hand, health-related “nudges” such as the design of tableware (smaller plates), drinking glasses and cigarette packets can all have a large impact, said Professor Marteau, citing a Cochrane review of 72 studies on portion, packets and tableware sizes which suggested removing larger sizes could reduce an individual’s daily energy consumption by 12 to 16%.

Another study found that wine glass sizes have increased by seven-fold in the last 300 years in England, most steeply in the last 20 years as wine consumption has also increased, with research published in 2016 reporting wine sales were 9.4% higher when served in larger glasses.7 In addition, changing designs of cigarette packs to remove the branding makes the warning labels more noticeable and reduces their appeal, particularly to children.8

“Policy makers and researchers need to move away from the idea that changing minds to motivate individuals to resist our unhealthy environment changes behaviour – it doesn’t,” said Professor Marteau. “More effective approaches are those that focus on changing our environments, including physical, economic, digital, social and cultural ones, rather than our mind. Achieving this requires us to move towards the idea of redesigning our environment – from redesigning cities to encourage physical activity, to reducing the size of tableware in restaurants to reduce obesity.”

That being said, she stressed that informing people about the effects of their harmful habits – such as the calorie impact drinking a couple of cans of sugary drinks a day can have – can...
Unhealthy habits  Tackling the conscious and non-conscious roadblocks in behaviour change

Continued from page 3

underlined the importance of public support for such change — support that is increased by communicating the effectiveness of changing environments to then change behaviour. In a recent meta-analysis (currently under review) of 36 experiments, Professor Marteau and her team found that when people were told about the evidence for the effectiveness of policies across a range of areas including health and the environment, support for the policy increased by about 4%. “Referenda and presidential elections have been won or lost on less,” she commented.  Psychologists and clinicians might be involved in generating the evidence for interventions for behaviour change, but implementation should take place at a population level, concluded Professor Marteau. “It may be implemented by those controlling public sector environments such as schools, colleges, and NHS Trusts and those controlling private sector environments including retailers, manufacturers, local and national governments.”

**References**

**Headline:** Heading towards better cancer treatments

**Tuesday afternoon plays host to a plenary lecture by Quynh-Thu Le, Professor and Chair of the Department of Radiation Oncology at the Stanford Cancer Institute, CA, USA.** A head and cancer radiation oncologist, Professor Le is the chair of the Head and Neck Committee for NRG Oncology – (formerly known as RTOG, NASBP and GOG), – which is part of the NCI National Clinical Trials Network and which conducts many practice-changing clinical trials in head and neck cancer.

Professor Le will outline recently released results from the two large clinical trials – released at European Society for Medical Oncology (ESMO) and the American Society for Therapeutic Radiation Oncology (ASTRO) meetings at the end of October. Those two trials compared standard treatment of radiation and high doses of cisplatin chemotherapy with radiation and cetuximab.

The first trial, RTOG 2016 is a randomised phase III trial determining the optimum treatment for patients with human papillomavirus (HPV)-positive oropharyngeal squamous cell carcinoma. The other, the Determination of Epidermal growth factor receptor inhibitor (cetuximab) versus Standard Chemotherapy (cisplatin) early therapy with a biologic therapy that may have less toxicity,” she said. “Is cetuximab non-inferior to cisplatin and does it confer less toxicity when combined with radiation in highly curable patients?”

Today, patients with non-metastatic HPV positive oropharyngeal squamous cell...
Uncovering cancer when there is required.

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Get fit at the 2018 NCRI Cancer Conference
Conference and take part in our Daily Step Challenge. The person with the highest number of steps accumulated by the end of the day will be in with the chance to win a restaurant or sports voucher. The winner will be contacted via Twitter tomorrow morning. Here’s how to take part:

- Download a pedometer or health app on your smartphone, or use your own pedometer such as a fitbit or iPhone Health
- Follow the official NCRI Twitter account: @NCRI_partners
- Take a screen shot or photo of the total number of steps you’ve accumulated on Monday 5 November and tweet it to @NCRI_partners by 18:30
- Tag @SECgolasm and tweet it to @NCRI_partners including the hashtags #NCRIsteps #NCRI2018 & #healthyvenue

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Issue 3 of NCRI Daily News
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Carcinoma treated with standard therapy are doing extremely well in terms of survival. But could these excellent outcomes be maintained while reducing treatment-related toxicity? “In the past what we’ve done with certain paediatric cancers – and lymphoma, when outcomes are so good – is to ask the following questions: are we over-treating many of these patients, and can we decrease treatment for these patients to reduce toxicity?” said Professor Le.

Reducing toxicity in neck and head cancer patients is crucial, she continued. “Traditionally, head and neck cancers occur in older patients. However, HPV-positive oropharyngeal squamous cell carcinoma tends to occur in younger patients – in their 50s – with a much longer life expectancy,” she said. “During active treatment, they suffer from radiation burns inside their throat and on their skin.” After the treatment is completed, some patient can have chronic problems with swallowing, neck stiffness and cramping, dry mouth, loss of taste and numbness and tingling in their hands and feet. In a small percentage of cases, permanent damage to hearing and kidney function can happen.

“I will provide an update on results of both of these trials and discuss the various strategies that the different groups are taking as we learn more about the biology of these tumours,” said Professor Le. “We need to figure out how best to decrease treatment-related toxicity without compromising survival in these patients.”

Professor Le will additionally speak about immunotherapy in head and neck cancer, and the evidence in current settings. Specifically, Professor Le will be covering emerging data from trials on immune checkpoint therapy. “So far Anti-PD-1 antibodies such as nivolumab and pembrolizumab have been approved in the second line treatment for recurrent/metastatic head and neck cancer in the US. There are emerging data that this type of therapy is also active in the first-line treatment for recurrent/metastatic disease,” she said.

Interestingly, there are several clinical trials ongoing that will assess the possibility of moving these immune checkpoint inhibitors into an earlier setting. “Today we treat patients with recurrent/metastatic cancer, who have a small chance of disease control with these therapies,” she said. “The question is there a role for immunotherapy in the curative setting? If we use them in these settings, can we cure more patients? Can we use them to replace chemotherapy or decrease radiation doses?” Professor Le will also present the landscape of large phase II/III trials testing immune checkpoint inhibitors in patients with locally advanced head and neck cancer.

Establishing a better way to treat more local cancers is extremely important, continued Professor Le. “Once a new drug comes to the clinic, the first thing is to test its activity in patients with metastatic disease,” she said. “But we must also look at how to quickly bring these drugs to patients presenting with very advanced non-metastatic HPV-negative cancers.” Unlike HPV-related oropharyngeal cancers, the tobacco-related HPV-negative head and neck cancers are an extremely aggressive with a very low cure rate of 40 to 50% at most. Unfortunately, this is the kind of cancer that predominates in many developing countries. “So the question is what can we do to improve outcomes in these patients? Is the early use of immunotherapy beneficial in these patients?” she said.

Professor Le went on to stress that the head and neck cancer global burden is significant, with over 600,000 new cases every year and this number is estimated to be larger than 60% in 2030. It is therefore an important cancer to study and to care for. “Although the number for head and neck cancers may not seem to be as big as other cancers, these cancers are devastating to patients because they occur in functional areas that are involved in eating and speaking.”

Professor Le said she’s looking forward to attending such a diverse gathering of researchers and clinicians in order to channel effort and expertise in preventing head and neck cancers – both those caused by tobacco and HPV. “The focus should be on campaigns against tobacco use globally and avoiding the e-cigarette in young people because data suggests that the young e-cigarette users are more likely to smoke regular cigarettes when they are older,” she said.

And, to prevent HPV-related cancers she advocates HPV vaccines for both girls and boys. “There is early data suggesting that HPV vaccine may be able to prevent head and neck cancer in boys as they do for cervical cancer in girls,” she said.

And, importantly Professor Le will advocate for more basic research in head and neck cancer. “More research and clinical trials for patients in head and neck cancer is needed. Without basic research and its translation through clinical trials, we cannot make progress,” she concluded.
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Risk scoring in colorectal cancer: time to bring in genomics?

Jon Emery (Centre for Cancer Research and Department of General Practice, University of Melbourne, Australia) discusses the application of genomics in tailoring colorectal cancer screening in primary care, during a session dedicated to new approaches to cancer diagnostics from bench to primary care.

Professor Emery has developed a joint research programme in Australia and Cambridge on cancer and genetic medicine in primary care, alongside session chair Fiona Walter (University of Cambridge, UK). He also contributes to the CanTest research into developing and implementing new and improved cancer diagnostic tests into general practitioner (GP) surgeries, with specific focus on colorectal cancer and melanoma risk and diagnosis, and the use of big data to evaluate diagnostic tests in primary care.

He recently co-authored a reimagining of the diagnostic pathway for gastrointestinal cancer. Herein, the sustainability of more urgent referrals for suspected lower gastrointestinal cancer is questioned, and primary care diagnostic practice evaluated in terms of referral pathways and specialist services. In addition, new diagnosis approaches, including system-level initiatives and emerging technologies, are discussed.1

Describing the different types of screening tests, he contrasted the cost-effectiveness of colonoscopy procedures (conducted in the ambulatory care or hospital setting) with those of biomarker-oriented modalities such as the faecal occult blood test (FOBT). “In the Australian setting, we have a national bowel cancer screening programme which is based on immunochemical FOBT tests, because that has been shown to be the most cost-effective test. Continued on page 10

“Just using [family history] criteria is actually not much better than chance in terms of discriminating those who get bowel cancer from those who don’t.”

Jon Emery
Could your idea accelerate cancer research?

Beyond the Horizon is a new meeting series that brings the right people together to have the right conversations at the right time.

We want you to suggest topics in areas of potentially transformative science and technology, or in fields that are not currently applied to cancer research, and could be harnessed to make a real difference to cancer research in the future.

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Risk scoring in colorectal cancer: time to bring in genomics?

Continued from page 8

“At the same time we have national recommenda-
tions that we should be offering more intensive screening to people who are at higher risk through colonoscopy. We have a large number of people who are not at increased risk who are choosing to have colonoscopy, rather than using the FOBT test, which puts them at greater risk of harm, and obviously greater costs to the healthcare system. We also have people who don’t know they are at increased risk of bowel cancer who are being under-
screened.”

As such, he concluded, improvements in ef-
ciciency could be made. One way of doing this is by using genomic markers to stratify populations according to risk of bowel cancer, and accordingly assigning individuals to risk-appropriate screening.

Professor Emery and colleagues have conduct-
ed modelling studies on the application of single nucleotide polymorphism (SNP) based risk prediction panels to more accurately stratify bowel cancer screening. He and others have developed a novel Colorectal cancer RISK Prediction (CRISP) tool, which applies an epidemiological risk model to inform risk-stratified screening. The CRISP trial is ongoing, with estimated completion in 2020.

His more recent work examines how genomic testing in primary care would be received, by the Australian population in particular. “There are issues around acceptability and healthcare professional understanding of using this novel technol-
dogy to determine the right type of bowel cancer screening,” he said. “We have preliminary data on offering a SNP-based test in a general practice population, looking at their informed choices about decisions to have the genetic test, and also which form of bowel cancer screening they go on to have.”

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Asked about the robustness of SNPs employed in screening, Professor Emery noted: “The SNP panel we are applying is based on 45 SNPs that have been identified through large genome-wide association studies. Mark Jenkins’ group has led this work at the University of Melbourne. They have validated that set of SNPs in a large case-
controls study.”

Previously, Jenkins et al (2016) quantified the utility of single nucleotide polymorphisms to guide colorectal cancer screening, identifying 45 SNPs that independently contributed risk of colorectal cancer, based on published SNP allele frequencies and strengths of colorectal cancer association.

More recently, Jenkins et al (in as-yet unpub-
lished work) estimated the association of these 45 SNPs with colorectal cancer risk in subjects with and without a family history of colorectal cancer. Changes in the distribution across predefined risk categories were predicted, as well as implications for recommended age to commence screening, from adding SNP-based risk to family history. SNP-
based predictive risks alone were found to perform significantly better than family history-based risks. “Just using [family history] criteria is actually not much better than chance in terms of discriminating those who get bowel cancer from those who don’t,” commented Professor Emery.

“The SNP panel performed much better than the current guideline-based models (based on age and family history). Of course, there are likely to

DON’T MISS!

Today in Hall 4 – Silent theatre presentations

Oral presentations will take place in the Silent theatres during the coffee and lunch breaks, and are a chance for abstract submitters to present their research. A full schedule can be found below:

Silent theatre 1

10.30 Meghan Cupp Neutrophil counts and cancer prognosis: an umbrella review of systematic reviews and meta-

analyses of observational studies

10.36 Paul Baughan A Quality Toolkit for General Practice: Improving care after cancer treatment

10.42 Mahnaz Darvish Damavandi Defining microRNA mediated regulation of CD157 involved in colon cancer progression

10.48 Bethany Wickramasinghe Variation in cancer incidence by ethnicity across London in 2015

12.40 Ahmad Malik Identification of therapeutic targets for Head and Neck Squamous Cell Carcinoma (HNSCC)

12.45 Alan Cameron Cisplatin-induced kidney injury is transient and associated with short-term elevation of urine interleukin-18 in patients with testicular cancer

12.52 June Davis Making the case for prehabilitation in cancer care - An evidence and insight review

12.58 Kezia Gaiteskell Pre-diagnostic BMI and ovarian cancer survival in the Million Women Study

13.04 Samuel O. Azubuike Socioeconomic status and the risk of breast cancer among Nigerian women

13.10 Rachael Thomeloe Beliefs about medication and uptake of preventive therapy in women at increased risk of breast cancer: Results from a multi-

centre prospective study

13.16 Yun Yi Tan Dental pre-assessment prior to bisphosphonates for breast cancer: a quality improvement project in Glasgow

13.22 Katie Robb Impact of long-term disorders on cancer screening uptake

13.38 Yunpeng Liu Regulatory heterogeneity in glioblastoma multiforme informs novel drug target discovery

13.46 Faye Robertson Wnt/beta-catenin synergises with FOXG1 to drive exit from quiescence in neural stem cells including glioblastoma stem cells

16:05 Md. Shahid Sarwar Exploring the mechanism of action of a novel ent-

kaurene diterpenoid for the treatment of colon cancer

16.11 Gemma Pearce Successes and challenges in the implementation of the HOPE self-management programme for people living with and beyond cancer.

16.16 Gareth Gerrard Clinical Diagnostic Validation of cfDNA Stabilising Blood Collection Tubes using Synthetic Control Materials for Plasma-Based EGFR T790M Mutation Testing in Non-Small Cell Lung Cancer

16.21 Diana Peika Clinical Diagnostic Validation of the Promega MSI v1.2 System for Microsatellite Instability Testing in Solid Tumours and Early-

Access Evaluation of Improved PCR Mastermix and Workflow

Silent theatre 2

10.30 Elizabeth Morrow The relationship between features of the tumour microenvironment and survival in primary operable breast cancer

10.36 Jeffrey S. Weber Adjuvant therapy with nivolumab versus ipilimumab after complete resection of stage III/ IV melanoma: Updated results from a phase 3 trial (CheckMate 238)

10.42 Faraz Janan Tracking “developing” Focal Densities in Breast Quadrants

10.48 Sarah Lewis Using Mendelian randomization to investigate the
New approaches to cancer diagnostics, from bench to primary care

SPECIALIST SESSION

symptomatic populations, which potentially could also be applicable eventually as screening tests*. With regards to moving genomic risk scoring into the clinical arena as part of a risk screening programme, Dr Emery noted that issues of physician and patient buy-in are important questions currently being addressed. “We are interested, both from a patient and provider perspective, as to how informed they are in making decisions around having a genomic test and whether there are specific concerns.

“We are also interested in the insurance and legal aspects, as to whether there are barriers to implementing this approach. Particularly in the Australian context [there are issues] around insurance. We don’t have the same legislation as some countries where you are protected from genetic discrimination. While at the moment there is no evidence that the insurance companies will be applying SNP-based polygenic risk scores to weight insurance policy costs, there is no legislation that would stop them doing that. Our early evidence suggests that from the patients’ perspectives that is not a major issue. And we are beginning to explore some of that with GPs who are receiving these test results.”

As yet, it is unclear whether genetic information will be effective in steering patients towards the most appropriate screening test, and in doing so reducing inefficiencies such as unnecessary colonoscopies. “This is an unknown,” said Professor Emery. “But of course, there is a health economic argument as to why you would implement this approach to stratify screening more effectively. These are the types of implementation questions that are important before you start to think about how you would implement what essentially becomes a genomically-driven screening programme.”

“New approaches to cancer diagnostics, from bench to primary care” takes place in Alsh between 14:00 and 16:00 today.

References
4. Alsh between 14:00 and 16:00 today.

Follow event highlights on

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**causal effect of diet on prostate cancer**

12.40 Angelina Kurniati Process mining to explore variation in chemotherapy pathways for breast cancer patients receiving the taxanes.

12.46 Benjamin Jeffries Variation in surgical practices of oesophagectomy for oesophageal cancers: A unit survey of the Oesophagogastric Anastomosis Audit (OGAA)

12.52 Krishna Yalla Developing Pharmacodynamic Biomarkers for Monitoring Response to Cdc7 Inhibitors in Patients

12.58 Vinodh Kannappan Disulffiram suppresses malignant mesothelioma in vitro and in vivo by targeting hypoxia induced NF-kB pathway and cancer stem cells

13.04 Wing Kin Liu A Single Centre Study to Assess Outcomes and Toxicity Profiles in Patients with Non-Small Cell Lung Cancer Receiving Pembrolizumab Therapy

13.10 Nimesh Jayasuriya Does the 8th Edition UICC staging Offer a Prognostic Advantage in Oropharyngeal Squamous Cell Carcinomas?

13.16 Mercy Ofuya Clinical trial methodology in evaluating the benefits of proton beam therapy: a systematic review

13.22 Suzanne Riches A novel high-throughput multi-parametric drug screening method for 3D tumor spheroids using Celigo image cytometer

13.28 Alan Bilisland An exploratory study on the use of game-based learning using Microsoft Kinect to teach oncotherapy phase I clinical trial designs

13.34 John Timms Longitudinal and Network Serum Biomarker Models for Early Detection of Ovarian Cancer

13.40 Dorothy Yang Systemic Anti-Cancer Therapy (SACT) in elderly patients with urological malignancy

13.46 Wladyslaw Januszewicz Safety and acceptability of a non-endoscopic oesophageal sampling device – Cytosponge*: A systematic review of multi-centre data

16.05 Prashanthan Balaji Sensitivity and Specificity of Sonographic detection and its biopsy in diagnosing Axillary Lymph Node metastasis in Breast Cancer

16.11 Alison Berner VAPS (VATS, Anaemia, Performance status and Sarcomaomtoid histology) prognostic index in malignant pleural mesothelioma

16.16 W. Nicolaik Keith Identification of novel pyrazolopyrimidine compounds that modulate the shelterin complex and telomere length regulation via phosphoglycerate kinase 1 and stress sensor Dj1

16.21 Richard Stephens Give Us The Tools... Ensuring Consumer Involvement Adds Value

**“There is a health economic argument as to why you would implement this approach to stratify screening more effectively.”**

Jon Emery
2019 NCRI Cancer Conference

3 - 5 November 2019
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