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ITASIA 128
Surviving Cancer in Asia:
Cross-boundary Cancer Studies
2014.10.06

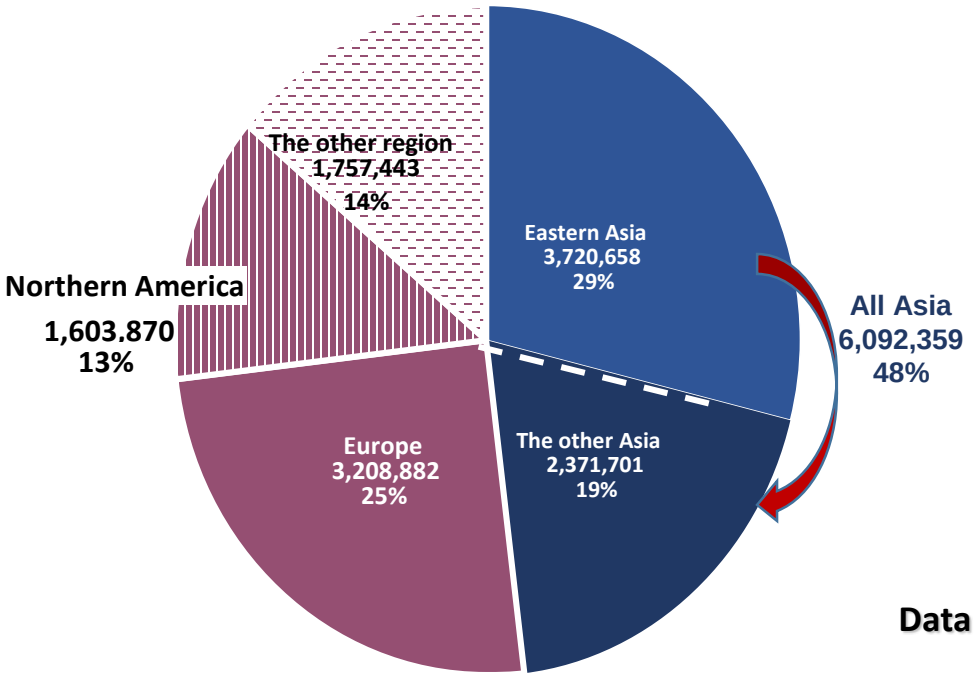
“Cancer” as a mirror reflecting Asian diverse cultures

Hideyuki Akaza, M.D. & professor
Research Center for Advanced Science and Technology,
The University of Tokyo

Cancer in Asia

- Rapid economic growth & prolonged life expectancy in Asia, resulting higher age society
  - Increase of cancer incidence
  - Expanding medical costs
- Different levels of health-care standard and investment in social security in Asia
  - Unbalanced medical equity
- Diverse physician and patient views in the cancer treatment
  - Different socio-economical background
  - Cultural difference

Estimation of cancer incidence in the world in 2008, both sex.
IARC (International Agency for Research on Cancer)



12,662,554

- **Approximately a half of the cancer incidence (48%) occurs in Asia.**
- **The cancer incidence in Eastern Asia is larger (29%) than any other region in the world.**

Data source: GLOBOCAN 2008

Deaths by broad groups of cause

2011

Selected important cause across different income levels

Figure removed due to copyright restrictions.

Figure12 "Deaths by broad groups of cause across different income levels, 2011“

Dean T Jamison et al.(2013)
Global health 2035: a world converging within a generation, *The Lancet* 382(9908):1898-1955
http://www.sciencedirect.com/science/article/pii/S0140673613621054

Figure removed due to copyright restrictions.

Figure13 "Deaths from selected important causes across different income levels, 2011“

Dean T Jamison et al.(2013)
Global health 2035: a world converging within a generation, *The Lancet* 382(9908):1898-1955
http://www.sciencedirect.com/science/article/pii/S0140673613621054

Prepaid health service- the role of private voluntary insurance and public finance

Figure removed due to copyright restrictions.

Figure19 "Prepaid health services—the roles of private voluntary insurance and public finance“

Dean T Jamison et al.(2013)
Global health 2035: a world converging within a generation, *The Lancet* 382(9908):1898-1955
http://www.sciencedirect.com/science/article/pii/S0140673613621054

Health expenditures per person in selected high-income regions, 2010

Figure removed due to copyright restrictions.

Figure20 "Health expenditures per person in selected high-income regions, 2010“

Dean T Jamison et al.(2013)
Global health 2035: a world converging within a generation, *The Lancet* 382(9908):1898-1955
http://www.sciencedirect.com/science/article/pii/S0140673613621054

Cancer is a mirror

- The cancer of individual person often mirrors the culture of the country
- Figures on the mirror are not always same
- We must learn how to see right figures on the mirror
- To understand what lies behind the mirror is the key to understand the world and to improve cancer medicine

Cross- boundary Cancer Studies;
Cross- disciplinary Cancer Studies

What is “Cross-boundary cancer studies” ?

- Which proposes to look at people’s lifestyles and social infrastructure from the perspective of increasing cancer prevalence, and create a specialist, multidisciplinary framework for sharing new knowledge, is of the utmost importance as a means of creating proposals to respond to cancer in the Asian region

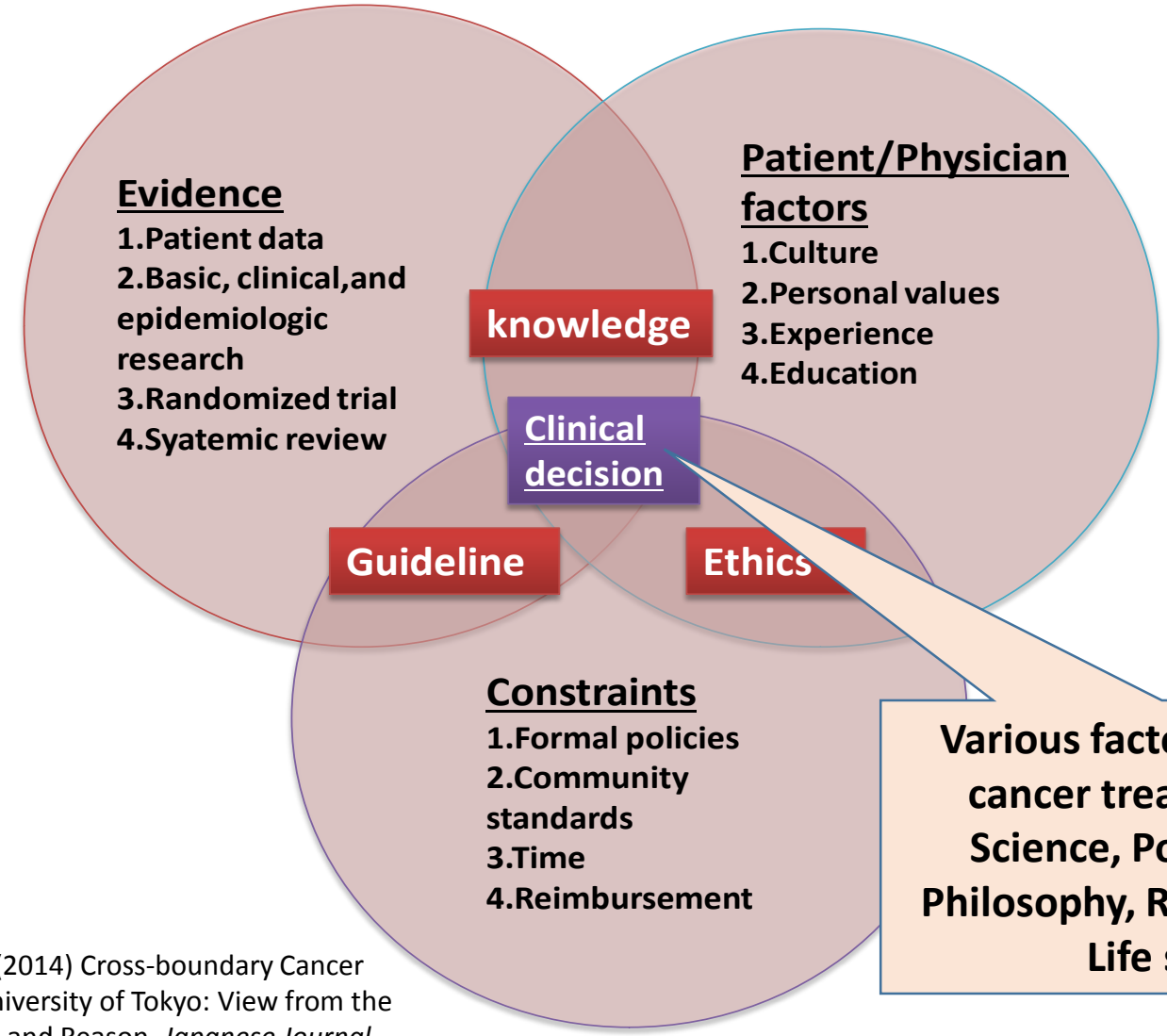
Ratio of Mortality to Incidence by Cancer Type and Country Income

Figure removed due to copyright restrictions.

Figure “Ratio of mortality to incidence in a specific year by cancer type and country income“

Paul Farmer et al.(2010)
Expansion of cancer care and control in countries of low and middle income: a call to action, Lancet 376(9747):1186-1193
http://www.sciencedirect.com/science/article/pii/S014067361061152X

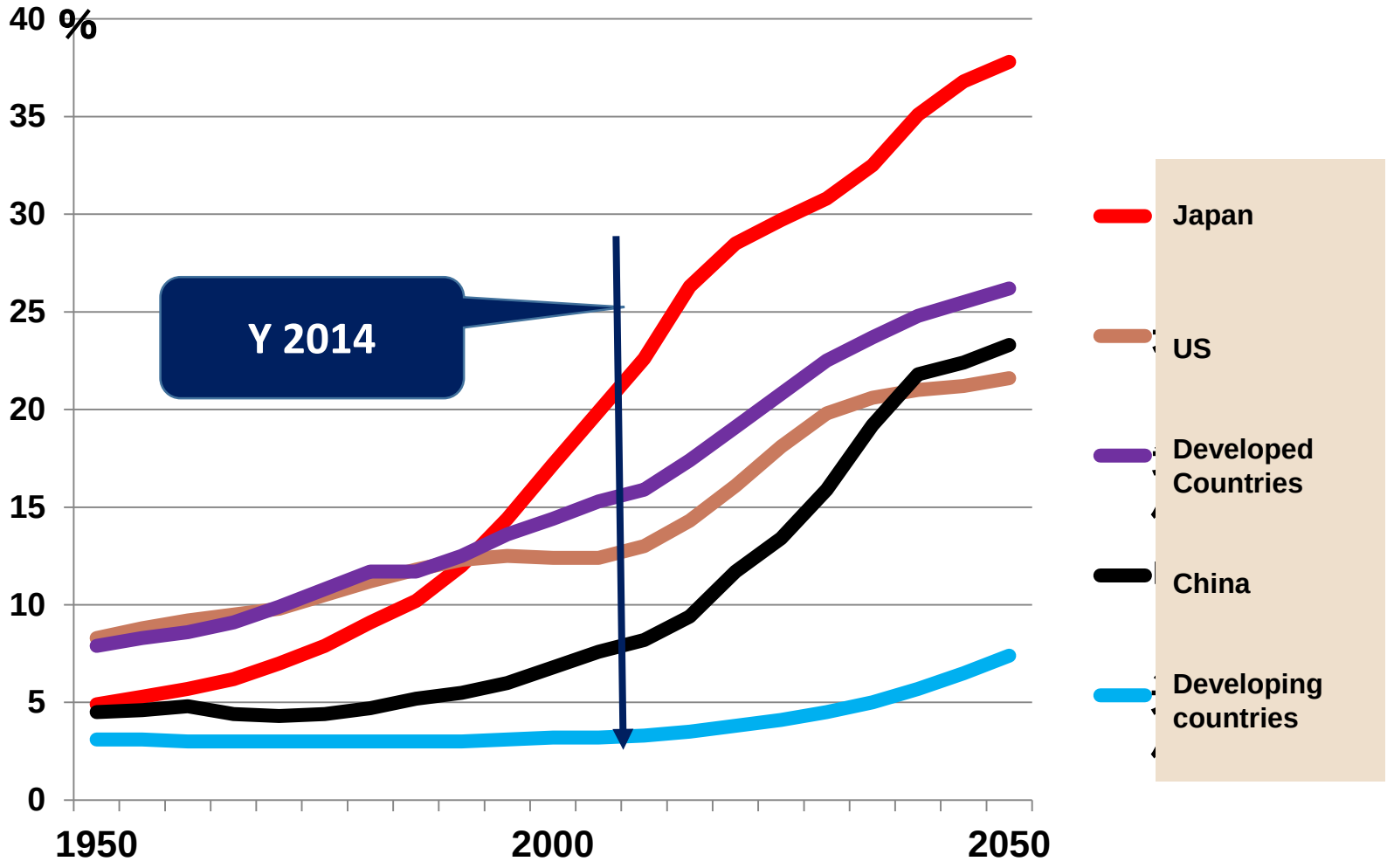
Decision making factors for the treatment of cancer



*

Akaza, Hideyuki (2014) Cross-boundary Cancer Studies at the University of Tokyo: View from the World of Science and Reason, *Japanese Journal of Clinical Oncology* 44 (suppl 1):i3-i5, Figure 2, by permission of Oxford University Press.

Future trend of proportion of <=65 years old



Data source : United Nations, World Population Prospects: The 2012 Revision
http://esa.un.org/unpd/wpp/index.htm

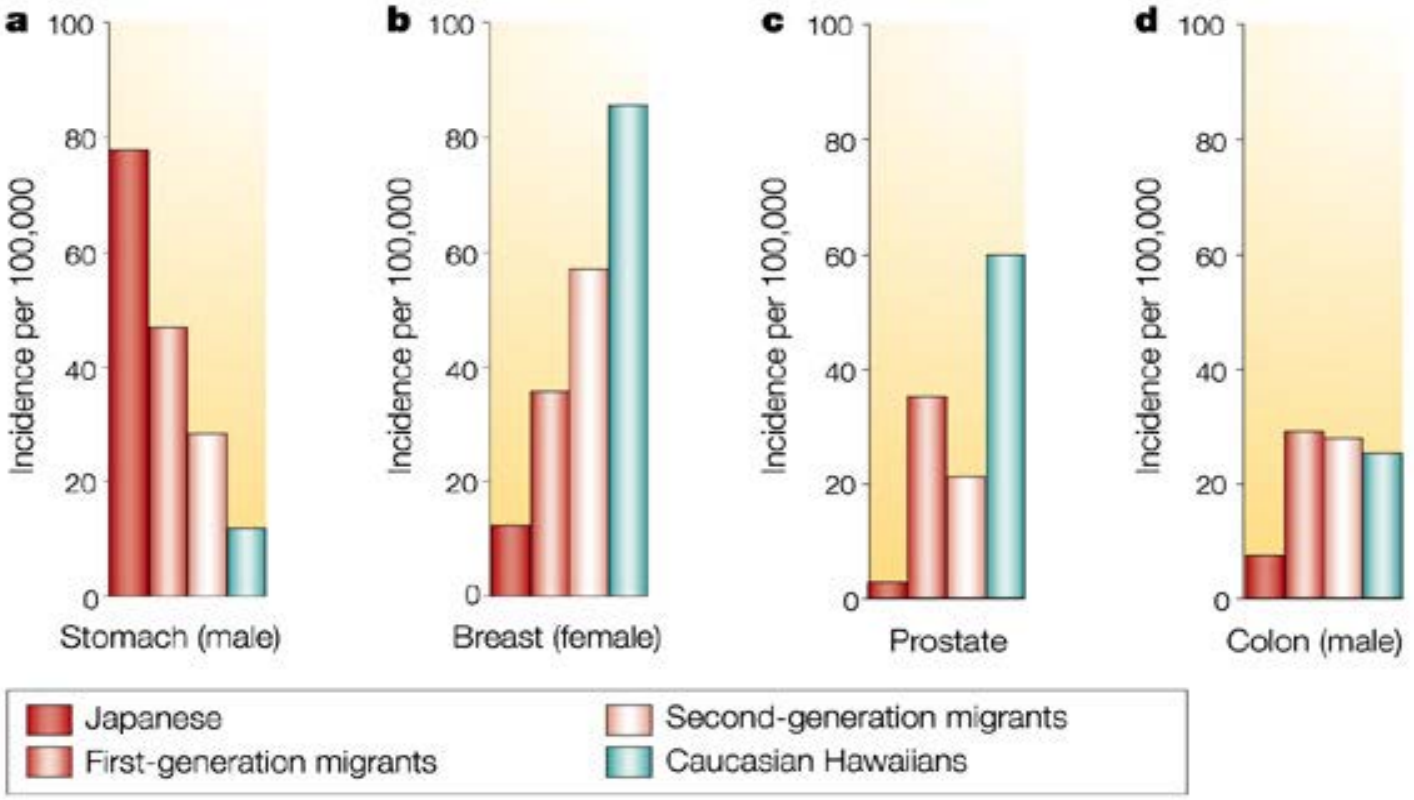
Prostate cancer incidence rates for selected registries. 2000-2004

Figure removed due to copyright restrictions.

Figure3 “Prostate cancer incidence rates for select registries, 2000–2004.”

Melissa M. Center et al.(2012) International Variation in Prostate Cancer Incidence and Mortality Rates, *European Urology* 61(6):1079-1092
http://www.sciencedirect.com/science/article/pii/S0302283812003053

Cancer incidence in Japanese migrants to Hawaii.



Nature Reviews | Cancer

Nature Reviews Cancer **4**, 519-527 (July 2004) | doi:10.1038/nrc1389

The multiethnic cohort study: exploring genes, lifestyle and cancer risk

Age, TNM & Clinical Stage
JCaP surveillance
Newly diagnosed prostate cancer in 2010 (Japan)

Over 70 = 57.5%
Over 65 = 79.7%

Variable		%
Age	- 59	7.0
	60 - 64	13.4
	65 – 69	22.2
	70 – 74	24.5
	75 – 79	19.8
	80 -	13.2
T factor	T1	41.6
	T2	35.7
	T3	18.3
	T4	4.3
N factor	N0	91.2
	N1	7.7
M factor	M0	89.6
	M1	10.5
Clinical Stage	I	58.3
	II	16.1
	III	11.2
	IV	13.6

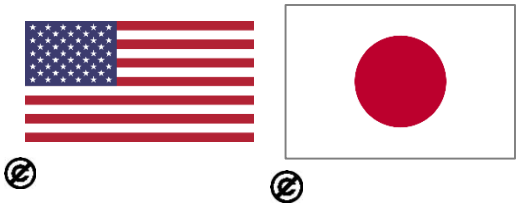
TNM and Stage were determined by UICC 7th ed.

Trans-Pacific Variation in Outcomes for Men Treated With Primary Androgen Deprivation Therapy For Localized Prostate Cancer

Matthew R. Cooperberg[1)], Shiro Hinotsu[2)], Mikio Namiki[3)], Peter R. Carroll[1)], and Hideyuki Akaza[4)]

1) University of California, San Francisco,
2) Kyoto University,

3) Kanazawa University, 4) The University of Tokyo



Presented at AUA 2013, SanDiego
Podium 14, # 724

7th K-J-CaP and CaPSURE Joint Meeting, September 27th 2013, Incheon Seoul

7th K-J-CaP and CaPSURE Joint Meeting

Friday 27th September 2013, 10:00–16:00, Incheon, Seoul, Korea

Time	Topic	Presenter(s)
1. WELCOME & INTRODUCTIONS		
10:00–10:10 (10 min) 10:10–10:20 (10 min)	Opening remarks Introduction of attendees	Hideyuki Akaza & Peter Carroll All participants
2. KOREA		
10:20–11:35 (75 min) *Each presentation will be 15 mins + 10 mins Q&A*	1. Smart prostate cancer database system (SPC-DB) 2. Comparison between androgen deprivation therapy and radical prostatectomy among prostate cancer patients at Seoul St. Mary's Hospital 3. Determining the triggers for intervention among men undergoing active surveillance for prostate cancer	In Young Choi Ji Youl Lee ↓ ↓ ↓ Byung Ha Chung
3. JAPAN		
11:35–12:50 (75 min) *Each presentation will be 15 mins + 10 mins Q&A*	1. J-CaP prospective observational study: Background factors of patients who have undergone radical prostatectomy or PADT for their localized prostate cancer 2. QoL surveillance for patients who underwent radical prostatectomy or PADT (J-CaP study) 3. Recent trends in initial therapy for newly-diagnosed prostate cancer (J-CaP surveillance)	Satoru Ueno ↓ ↓ ↓ Satoru Ueno Mizuki Onozawa
12:50–13:40 (50 min)	LUNCH	
13:40–14:55 (75 min) *Each presentation will be 15 mins + 10 mins Q&A*	1. Comparative analysis of co-morbidity and other confounding factors in patients who have undergone radical prostatectomy and PADT for their localized prostate cancer(CaPSURE data) 2. Further consideration of the reasons for the difference in PADT outcome described in the paper: *Cooperberg et al. Trans-pacific variation in outcomes for men treated with primary androgen deprivation therapy for localized prostate cancer. J Urol, 2013. 189(4): e297* (CaPSURE data) 3. Biomarker progress in the USA	Matthew Cooperberg (CapSURE) & ↓ Shiro Hinotsu (J-CaP) Matthew Cooperberg (CapSURE) & ↓ Shiro Hinotsu (J-CaP) Matthew Cooperberg
5. CHINA		
14:55–15:20 (25 min) *15 mins + 10 mins Q&A*	Plans for C-CaP	Dingwei Ye,Gang Zhu & Anthony Ng
6. INDONESIA		
15:20–15:45 (25 min) *15 mins + 10 mins Q&A*	Plans for I-CaP	Rainy Umbas
7. OTHERS		
15:45–16:00 (15 min)	Reports from participating countries	All
8. CLOSING REMARKS		
16:00 (5 mins)	Overall meeting summary and closing remarks from the Chairmen	Hideyuki Akaza & Peter Carroll

7th K-J-CaP and CaPSURE Joint Meeting, September 27th 2013, Incheon Seoul

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7th K-J-CaP and CaPSURE Joint Meeting, September 27th 2013, Incheon Seoul

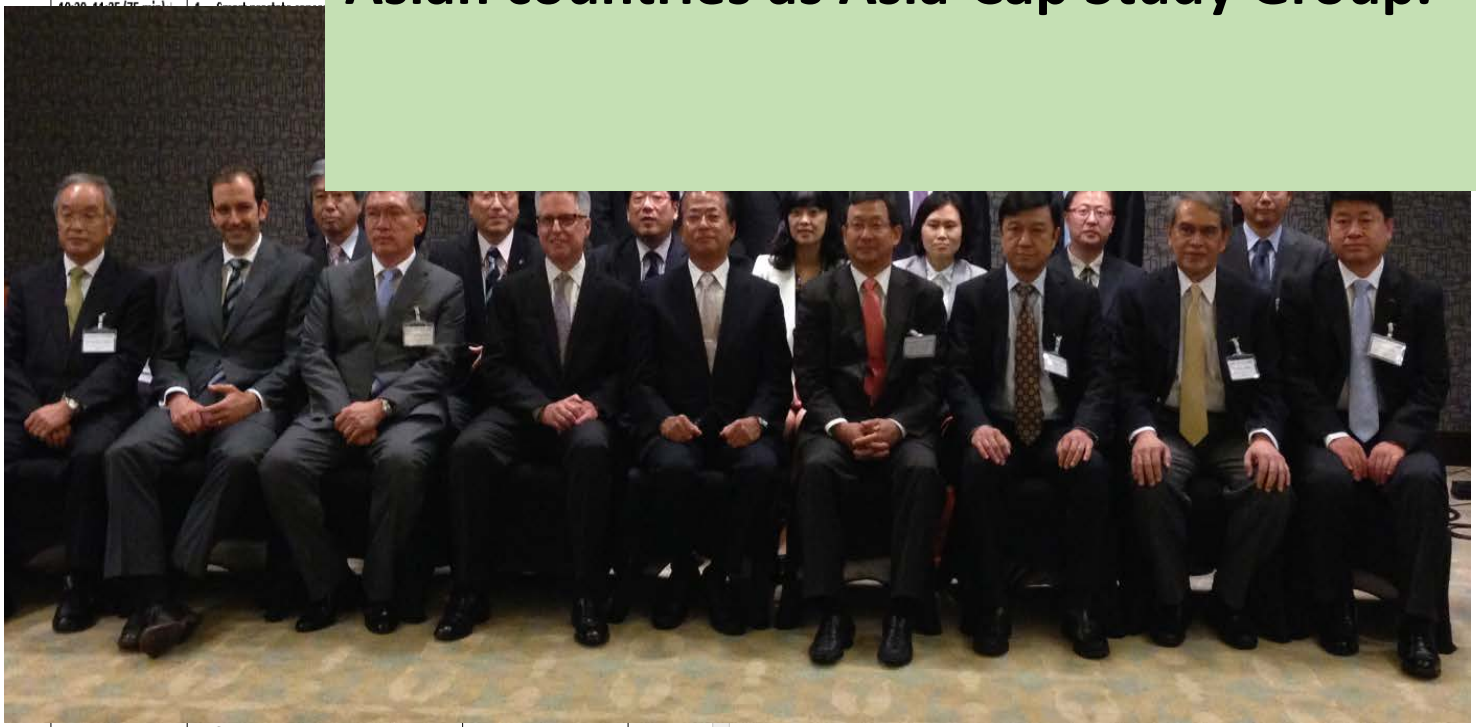
Collaborative study on the mega-databases of the prostate cancer between Japan, Korea, and US. Will expand including China, Indonesia, and other Asian countries as Asia-Cap Study Group.

7th K-J-CaP and Ca
September 27th 20

7th K-J-CaP and

Friday 27th September 2013

Time	To
1. WELCOME & INTRODUCTIONS	
10:00–10:10 (10 min)	Opening remarks
10:10–10:20 (10 min)	Introduction of attendees
2. KOREA	
12:50–13:40 (50 min)	LUNCH

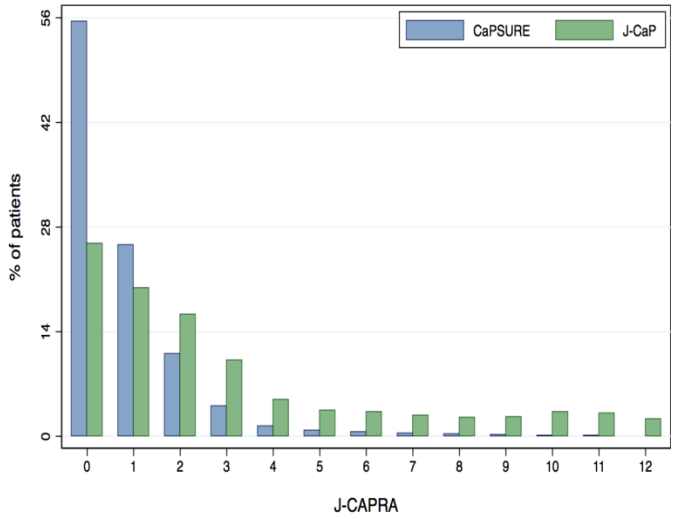


J-CAPRA score distribution

- **CaPSURE (n= 1,934) 2.1 ±2.3**
  J-CaP (n= 16,300) 3.0 ±3.6

- **Patients in J-CaP had higher risk of disease**

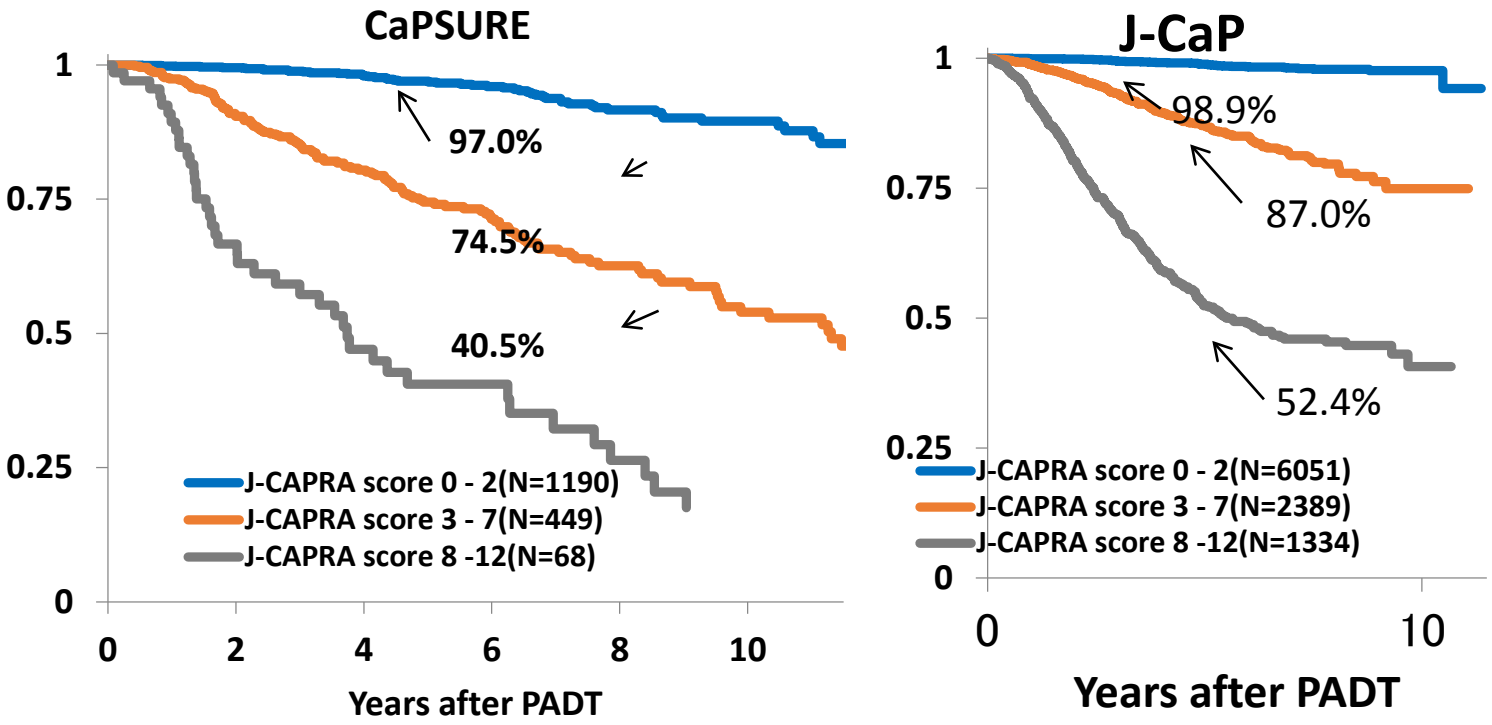
Variable	Level	Points	Variable	Level	Points
PSA	0-20	0	T-stage	T1a-2a	0
	20-100	1		T2b-3a	1
	100-500	2		T3b	2
	>500	3		T4	3
Gleason	2-6	0	N-stage	N1	1
	7	1	M-stage	M1	3
	8-10	2			



Ref. Matthew R. Cooperberg, Shiro Hinotsu, Mikio Namiki, Peter R. Carroll, and Hideyuki Akaza (2013)
"Trans-Pacific Variation in Outcomes for Men Treated With Primary Androgen Deprivation Therapy For Localized Prostate Cancer"

Cancer-specific survival in each cohort by J-CAPRA score

- **Patients in J-CaP had better cancer-specific survival than patients treated with PADT in CaPSURE**



Ref. Matthew R. Cooperberg, Shiro Hinotsu, Mikio Namiki, Peter R. Carroll, and Hideyuki Akaza (2013)
"Trans-Pacific Variation in Outcomes for Men Treated With Primary Androgen Deprivation Therapy For Localized Prostate Cancer"

Multivariate analysis of cancer-specific mortality

Adjusting for multiple factors in the table, patients treated with PADT in Japan compared to the US have 3-fold lower Cancer-specific mortality.

Variable	HR (95% CI)	p
Age	1.00 (0.99 – 1.01)	0.350
J-CAPRA	1.43 (1.40 – 1.46)	<0.001
Year of dx	1.04 (1.00 – 1.08)	0.042
LHRH	Ref	
Orchiectomy	1.43 (1.08 – 1.89)	0.01
CAB	0.85 (0.71 – 1.02)	0.08
Academic v. community	1.09 (0.91 – 1.32)	0.35
Comorbidity count	1.08 (1.00 – 1.15)	0.04
J-CaP v. CaPSURE	0.36 (0.27 – 0.48)	<0.001

Ref. Matthew R. Cooperberg, Shiro Hinotsu, Mikio Namiki, Peter R. Carroll, and Hideyuki Akaza (2013)
"Trans-Pacific Variation in Outcomes for Men Treated With Primary Androgen Deprivation Therapy For Localized Prostate Cancer"

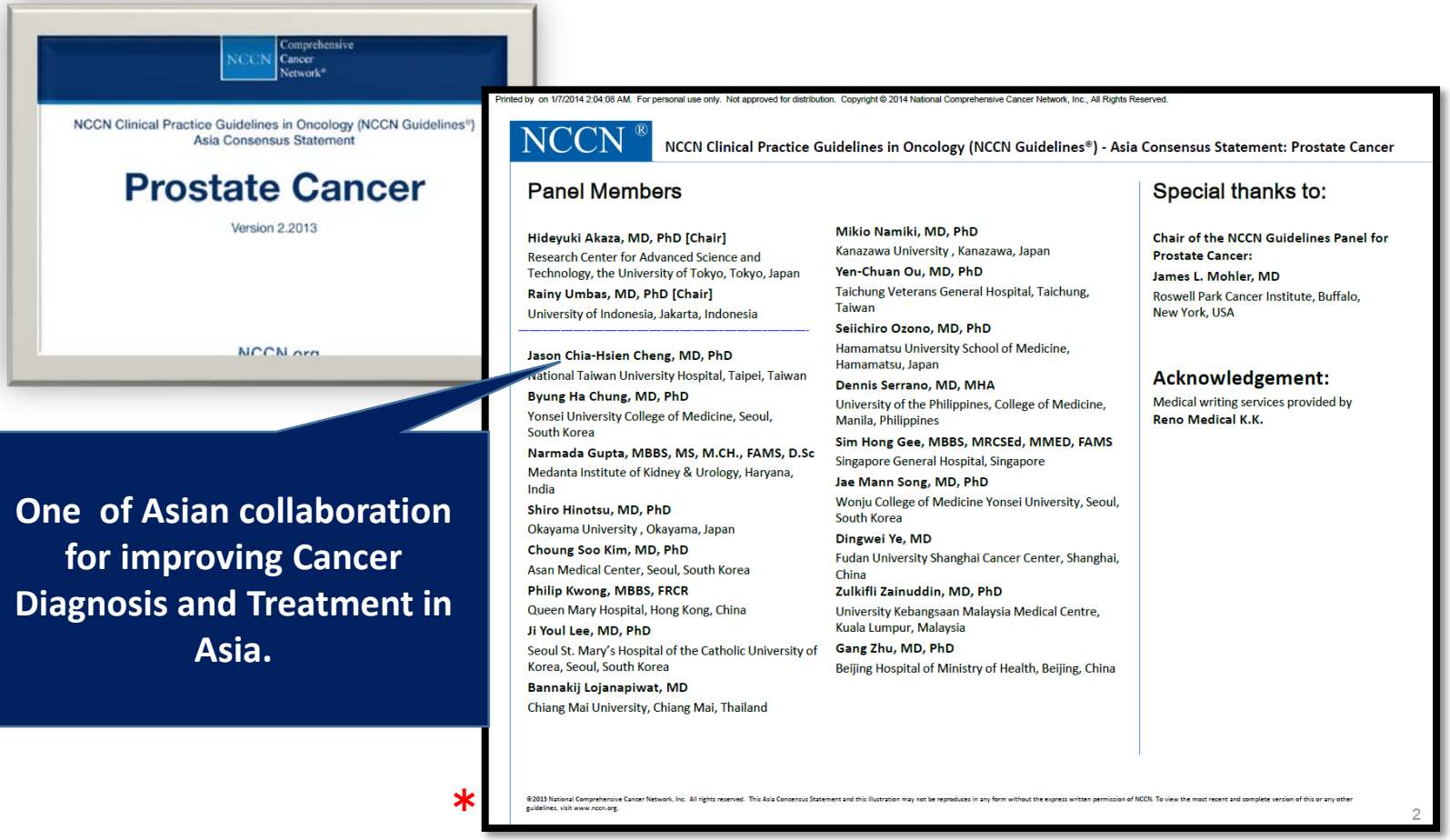
Image removed due to copyright restrictions.

NCCN Guidelines for Treatment of Cancer by Site
http://www.nccn.org/professionals/physician_gls/f_guidelines.asp#site

NCCN Guidelines
(A cancer treatment guidelines established among US Cancer centers, and now is a global standard guideline, but not necessarily adaptable to Asian patients)

Asian Consensus Statement
For Prostate Cancer v2 (2014)
NCCN.org

Asian consensus statement on NCCN clinical practice guideline:
Prostate Cancer



One of Asian collaboration for improving Cancer Diagnosis and Treatment in Asia.

NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®)
Asia Consensus Statement: Prostate Cancer, Version 2.2013
©National Comprehensive Cancer Network

A) Life Expectancy and Incidence of Prostate Cancer

(Information provided by the panelists)

	Life expectancy at Birth	Incidence (/100,000 ASR*)
China	**71** (National average) 79 (Beijing), 80 (Shanghai) [2011, male]	**9.92** (National average), 13.13 (in cities), 3 (in rural area) 19.3 (Beijing), 32.3 (Shanghai) [2009]
Hong Kong	**81** [2010, male]	**28.1**, 45.3** [2010]
India	**67** [2012, male]	**6.5 -7.5** [2002]
Indonesia	**69** [2012]	**11** [2008]
Japan	**80** [2012, male]	**31.2** [2008]
Korea	**77** [male]	**25.3** [2010]
Malaysia	**72** [male]	**12** [2010]
Philippines	**69** [2012, male]	**10.1** [2008]
Singapore	**80** [2012, male]	**28.0** [2007-2011]
Taiwan	**76** [2012, male]	**28.8,** 37.8** [2010]
Thailand	**71** [2012, male]	**6.4** [2006]

*Age-standardized rates. **Crude incidence rate

Note: Data based on information as of December 2013 collected from the panelists.

* NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) Asia Consensus Statement: Prostate Cancer, Version 2.2013 ©National Comprehensive Cancer Network

M) Healthcare Insurance System

Note: Data based on information as of December 2013 collected from the panelists.

China	There is national insurance and small potion of the population have private insurance.
Hong Kong	No insurance scheme, subsidized healthcare provided by government. Many new drugs have to be self-financed by patients, with funding for poor income group for some drugs.
India	Private healthcare care insurance system covers about 10% population. Government and semi government establishment employees are covered free healthcare. We have government hospitals, where Govt subsidise the treatment and mostly free, whereas as new corporate hospitals are coming up in large number, treating insurance covered population or having employer-funded schemes.
Indonesia	An estimated 40% of Indonesian have some form of health insurance provided by the National Health Insurance scheme which covers the Government employees and low-income earners. Private insurance coverage is about 3% of the population.
Japan	There is a health-insurance system that covers all citizens. Private insurance is also widespread.
Korea	National health insurance covers all the treatment related with prostate cancer. (But it does not cover robotic surgery. Only private insurances support this treatment.)
Malaysia	There is no national insurance. Small portion of the population have private insurance. Treatments for government servants, retirees, and senior citizens (60 and above) are free in government hospital.
Philippines	For the gainfully employed population (50%), there is a national healthcare insurance called PhilHealth but this covers only about 30% of the cost of care for radical prostatectomy or radiation treatment; there is minimal coverage for androgen deprivation. Majority of patients pay out of pocket for their healthcare.
Singapore	Government mandated national insurance (Medisave, Medishield, Medifund) for different levels of coverage of basic hospitalization and medical care draw funds from worker's monthly salary. The scheme requires patients to pay a deductible component upfront before insurance coverage kicks in. Additional coverage requires private insurance that is becoming more prevalent.
Taiwan	We have National Health Insurance for every citizen, with a salary-based monthly premium to the government.
Thailand	Universal Coverage Scheme (UCS): 74.6%, Civil Servant Medical Benefit Scheme (CSMBS): 8.01%, Compulsory Social Security Scheme (SSS): 12.9%, Private health insurance: 2.16%

* NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) Asia Consensus Statement: Prostate Cancer, Version 2.2013

N) Clinical Guidelines in Asia

Note: Data based on information as of December 2013 collected from the panelists.

	Domestic clinical guidelines	Publication/Revision	English
China	**Yes** By Chinese Urological Association	**Published in 2007** **Revised every two years** The 2013 ed. will come out soon.	**No**
Hong Kong	**No** No central guideline; There are guidelines and protocols for individual institute.	-	**No**
India	**No**	-	**No**
Indonesia	**Yes** By the Indonesian Urological Association	**Published in 2012**	**No**
Japan	**Yes** By the Japanese Urological Association	**Published in 2006** **Revised in 2012**	**No**
Korea	**Yes** A translation form of NCCN guideline **ver. 2007**	**Revised in 2013**	NCCN GL
Malaysia	**No**	-	**No**
Philippines	**Yes** AUA guidelines in **2005** was adopted with minor revisions regarding PSA screening and biopsy threshold.	**Published in 2005** **Revised in 2013**	**Yes**
Singapore	**Yes**	**Published in 2013** (The latest version 2012)	**Yes**
Taiwan	**Yes Guidelines by:** 1. National Health Research Institute 2. Individual medical centers (e.g. National Taiwan University Hospital)	**1. Published in 1999** **Revised in 2003 and 2010** **2. Published in 2000** **Revised every year** The 5th ed. (June 2013)	**1. No** **2. Yes**
Thailand	**Yes** By Thai Urological Association	**Published in Jan 2013**	**No**

* NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) Asia Consensus Statement: Prostate Cancer, Version 2.2013 ©National Comprehensive Cancer Network

A proposal to indicate the most relevant treatment option among various economical status--- resource –stratified guideline Lancet Oncol. 2013;14:e524-34

Scott Williams, Edmund Chiong, Bannakij Lojanapiwat, Rainy Umbas, Hideyuki Akaza, Management of prostate cancer in Asia: resource-stratified guidelines from the Asian Oncology Summit 2013, *The Lancet Oncology*, Volume 14, Issue 12, November 2013, Pages e524-e534, ISSN 1470-2045, http://dx.doi.org/10.1016/S1470-2045(13)70451-0

Abstract: Summary
Many local and systemic options for prostate cancer have emerged in recent years, but existing management guidelines do not account for diversity in health resources between different countries. We present recommendations for the management of prostate cancer, stratified according to the extent of resource availability—based on a four-tier system of basic, limited, enhanced, and maximum resources—to enable applicability to Asian countries with differing levels of health-care resources. This statement of recommendations was formulated by a multidisciplinary panel from Asia–Pacific countries, at a consensus session on prostate cancer that was held as part of the 2013 Asian Oncology Summit in Bangkok, Thailand.

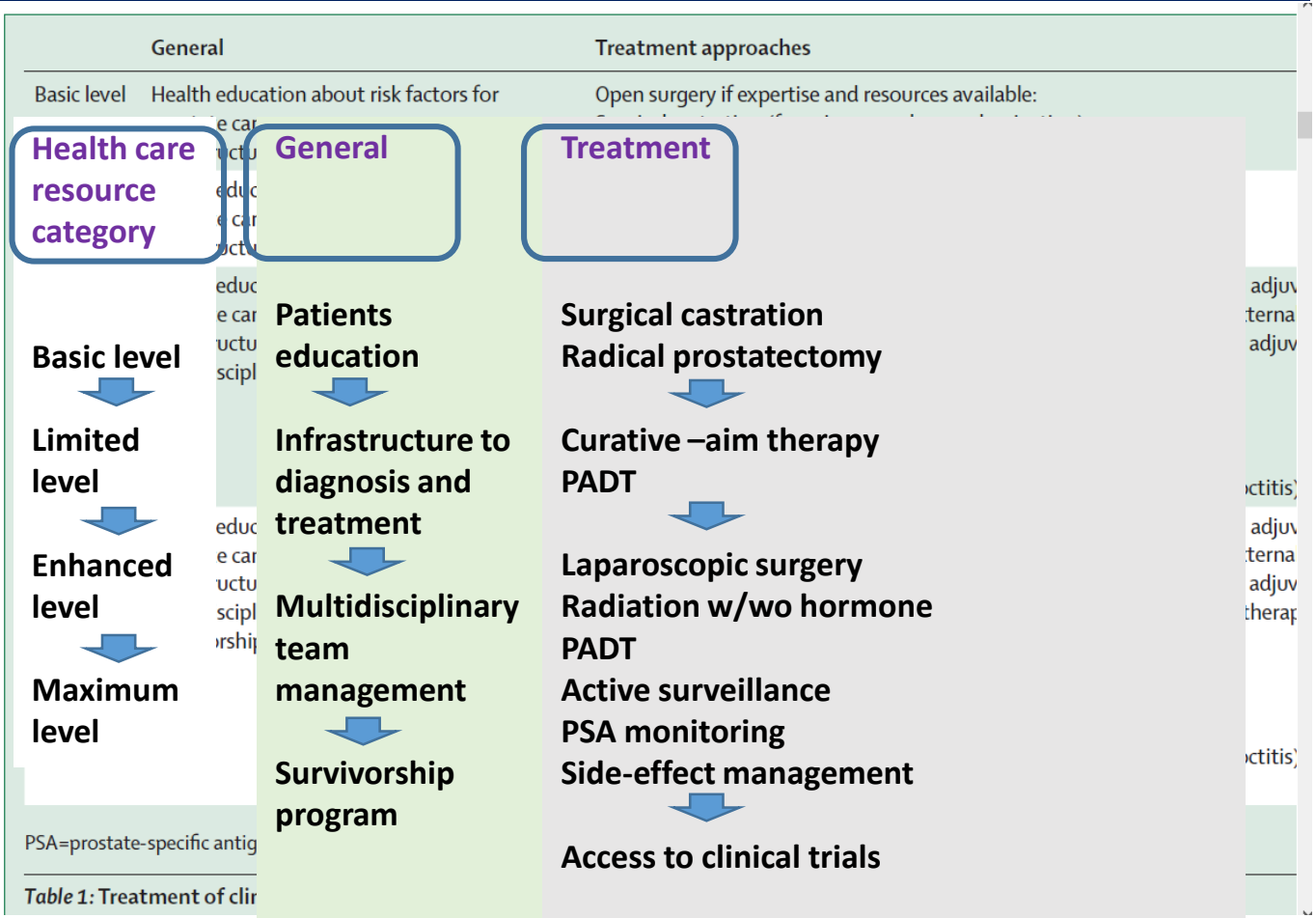
Treatment of clinically localized prostate cancer according to level of health-care resources

	General	Treatment approaches
Basic level	Health education about risk factors for prostate cancer Infrastructure to diagnose and treat the disease	Open surgery if expertise and resources available: Surgical castration (for primary androgen deprivation) Radical prostatectomy
Limited Level	Health education about risk factors for prostate cancer Infrastructure to diagnose and treat the disease	Curative-aim therapy (open radical prostatectomy) Primary androgen-deprivation therapy
Enhanced Level	Health education about risk factors for prostate cancer Infrastructure to diagnose and treat the disease Multidisciplinary team management facilities	Curative-aim therapy: radical prostatectomy (open or laparoscopic) with adjuv or androgen-deprivation therapy as appropriate; radical radiotherapy, externa charged-particle beam) approaches where available, and neoadjuvant or adjuv deprivation therapy as appropriate Active surveillance protocols Primary androgen-deprivation therapy PSA monitoring Side-effect management (erectile dysfunction, continence, radiation proctitis)
Maximum level	Health education about risk factors for prostate cancer Infrastructure to diagnose and treat the disease Multidisciplinary team management facilities Survivorship programmes	Curative-aim therapy: radical prostatectomy (open or laparoscopic) with adjuv or androgen-deprivation therapy as appropriate; radical radiotherapy, externa charged-particle beam) approaches where available, and neoadjuvant or adjuv deprivation therapy as appropriate; energy ablative therapy such as cryotherap intensity focused ultrasound (if available) Active surveillance protocols Primary androgen-deprivation therapy PSA monitoring Side-effect management (erectile dysfunction, continence, radiation proctitis) Access to clinical trials, where appropriate

PSA=prostate-specific antigen.

Table 1: **Treatment of clinically localised prostate cancer according to level of health-care resources**

Treatment of clinically localized prostate cancer according to level of health-care resources



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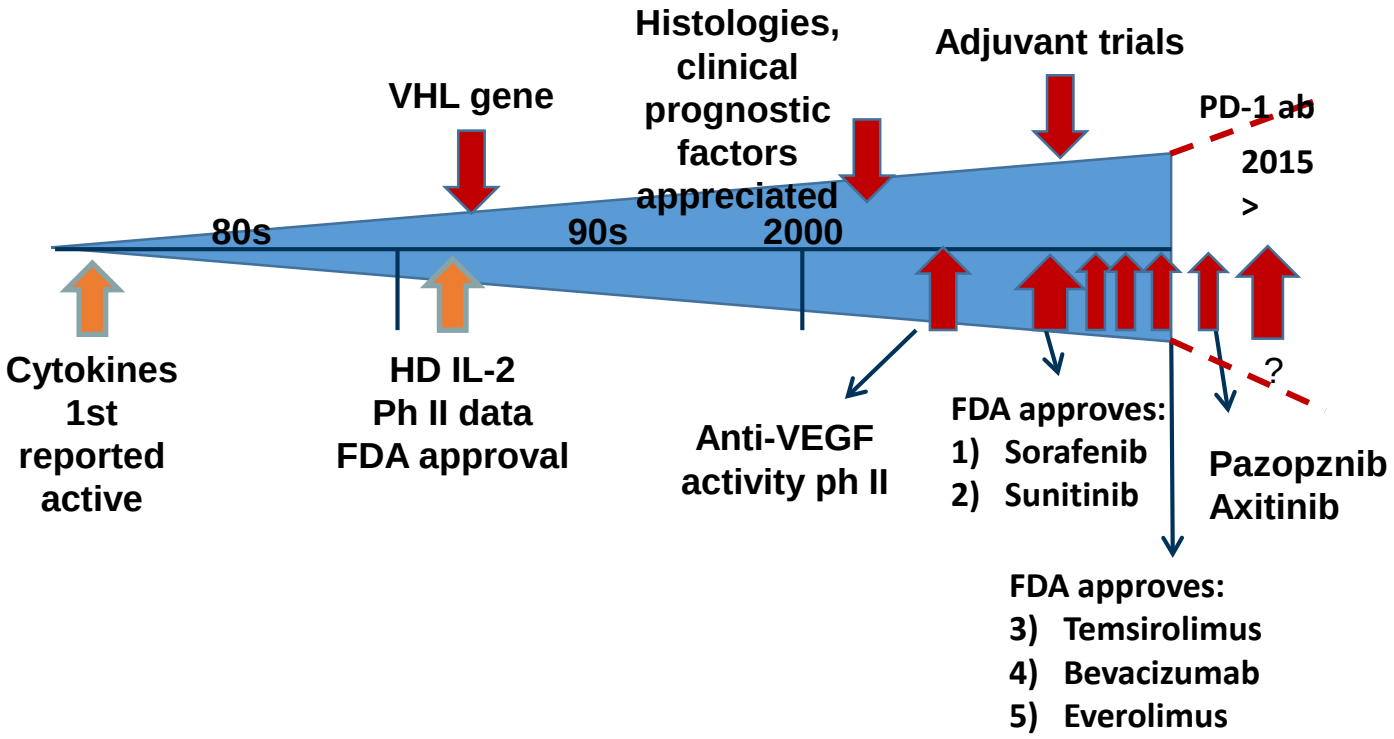
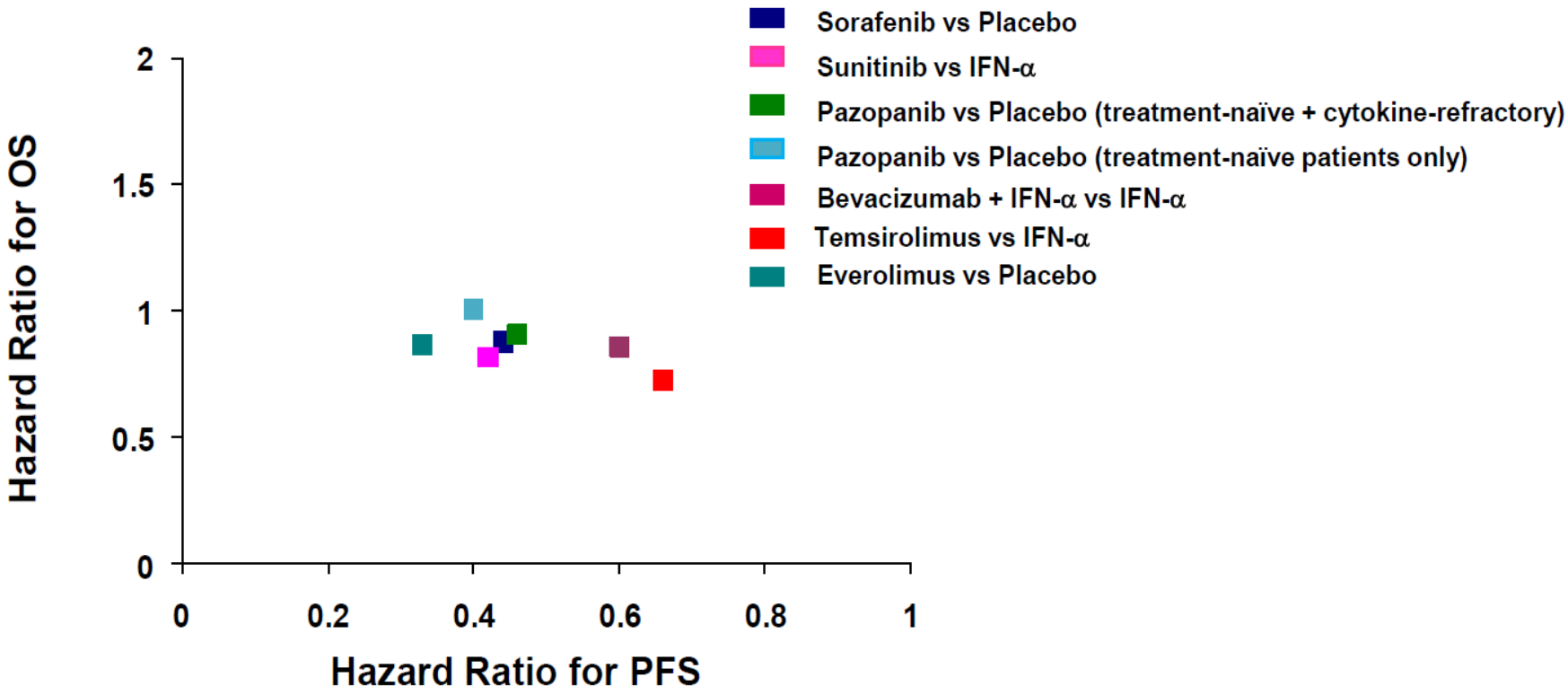
Reprinted from *The Lancet Oncology*, Volume 14, Issue 12, Scott Williams, Edmund Chiong, Bannakij Lojanapiwat, Rainy Umbas, Hideyuki Akaza, Management of prostate cancer in Asia: resource-stratified guidelines from the Asian Oncology Summit 2013, Pages e524-e534, Copyright (2013), with permission from Elsevier.

Recent explosion in therapies for mRCC



Ref. Jennifer J. Knox. *EMUC 2009 (2nd European Multidisciplinary Meeting on Urological Cancer);* session 6

FDA-approved Therapies - Relationship between OS and PFS Hazard Ratios



* Pfizer Presentation, INLYTA (Axitinib) Slides for the December 7, 2011 Meeting of the Oncologic Drugs Advisory Committee
From: U.S. Food and Drug Administration (FDA) website, http://www.fda.gov/AdvisoryCommittees/CommitteesMeetingMaterials/Drugs/OncologicDrugsAdvisoryCommittee/ucm283655.htm

The Future: Providing more expensive types of treatment:

- Treating conditions that were previously untreatable.
- Treating people who would previously have been untreated
  - Increasing safety of intervention;
  - More acceptable, less invasive, less painful interventions;
  - Changing attitudes to chronological age as a reason for refusing treatment;
  - Changing expectations about health and disease.

Does academic collaboration overcome political incongruity?

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The Yomiuri Shimbun
25, June 2014
論点「前立腺がん研究：治療法求めアジア連携」

No incongruity in the medical meeting.
-The Asian collaborative consensus meeting on the prostate cancer treatment-

UICC-ARO Activities in 2013

Asia Pacific Cancer Control Leader's Summit in Tianjin 2013/10/31, During APCC

UICC Session, "What is cost-effectiveness in cancer treatment" at Japan Cancer Association 2013/10/5

Japan-Korea-China, Trilateral Cross-boundary Cancer Studies Joint Seminar in Seoul 2014/2/21, co-sponsored by Trilateral cooperation secretariat, Japan (Secretary general; Shigeo Iwatani)

UICC-ARO Activities in 2014

UICC-ARO and UICC Japan round table meeting-UICC World Cancer Congress

Friday 5 December from 11:45 to13:45(90 min)

- Universal Health Coverage and Cancer/NCDs

"Japan Initiative on UHC "

Shinjiro Nozaki, WHO

UICC-ARO Activities in 2014

ARO Session - UICC World Cancer Congress

Saturday 6 December from 13:15 to 14:45.

- **Economic burden of cancer in Asian countries: how should we face the current situation?**

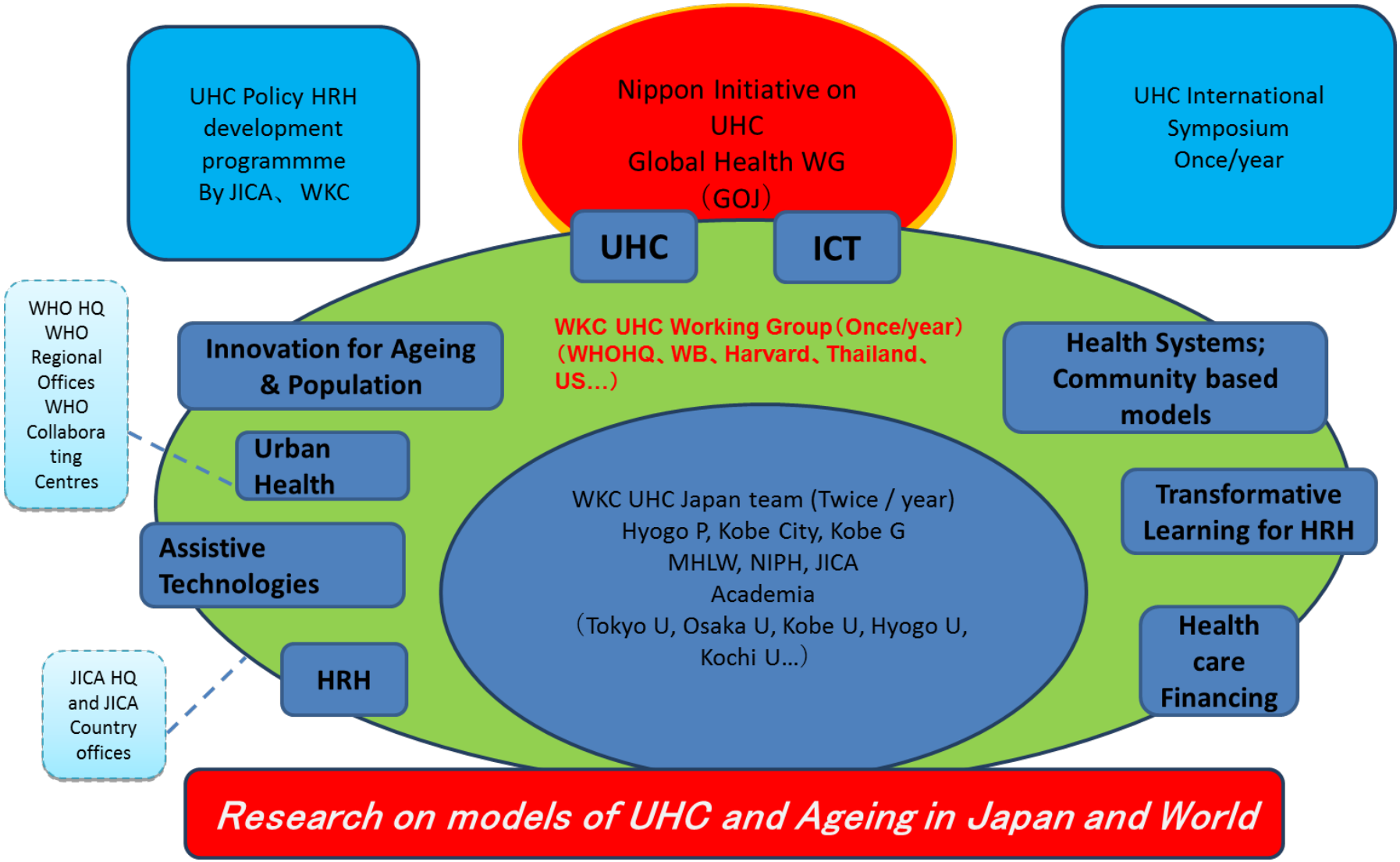
  "Is Asia Socially and Scientifically Meaningful Concept?: Challenges of Asia Barometer and Its Contribution to Cancer Studies"
  Shigeto Sonoda, Tokyo University

  "Cost Effectiveness in Japan"
  Takashi Fukuda, National Institute of Public Health

  "Cost effectiveness of cancer treatment in Korea"
  Eun-Cheol Park, Department of Preventive Medicine, Yonsei University

  "Cost effectiveness of cancer treatment in Chine"
  Wang Yung, Chinese Anti-Cancer Association

WKC UHC Working Group (draft)



Purpose of cross-boundary cancer studies in Asia

- To identify commonalities and differences between Asia and, starting from consideration of cancer as an individual disease, seek to create proposals for a social structure of the future that is capable of dealing with the challenges presented by cancer
- To create a new knowledge network that draws on existing specialist networks and frameworks in diverse fields

Methods

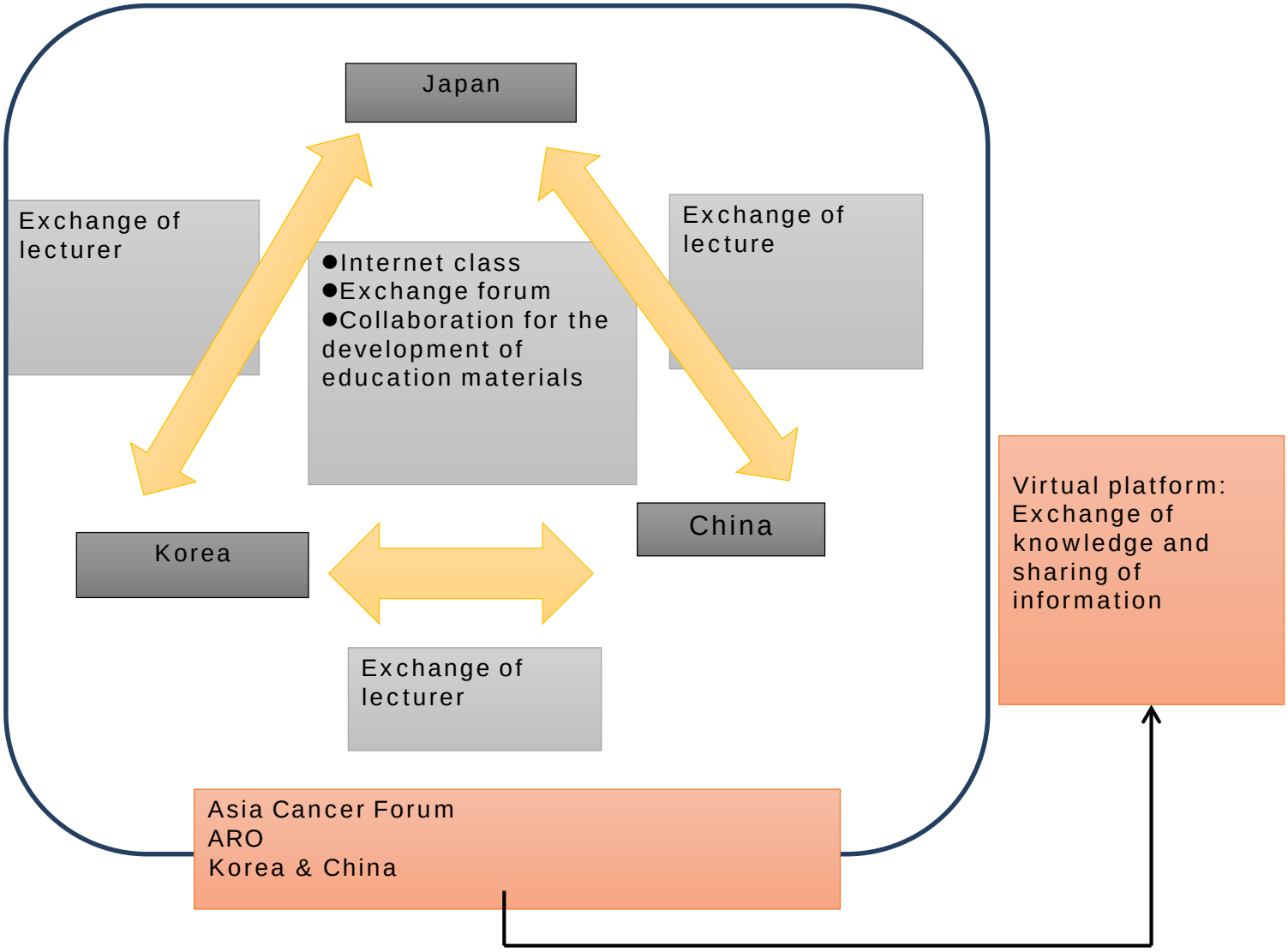
- Cross-border (cross-disciplinary) discussions in Asia on the subject of cancer, comparing with those in other area
- Assess cancer from the big picture and from various areas of specialty within the university context not limited to medical perspectives alone and use this multidisciplinary discussion

Cross-boundary cancer studies

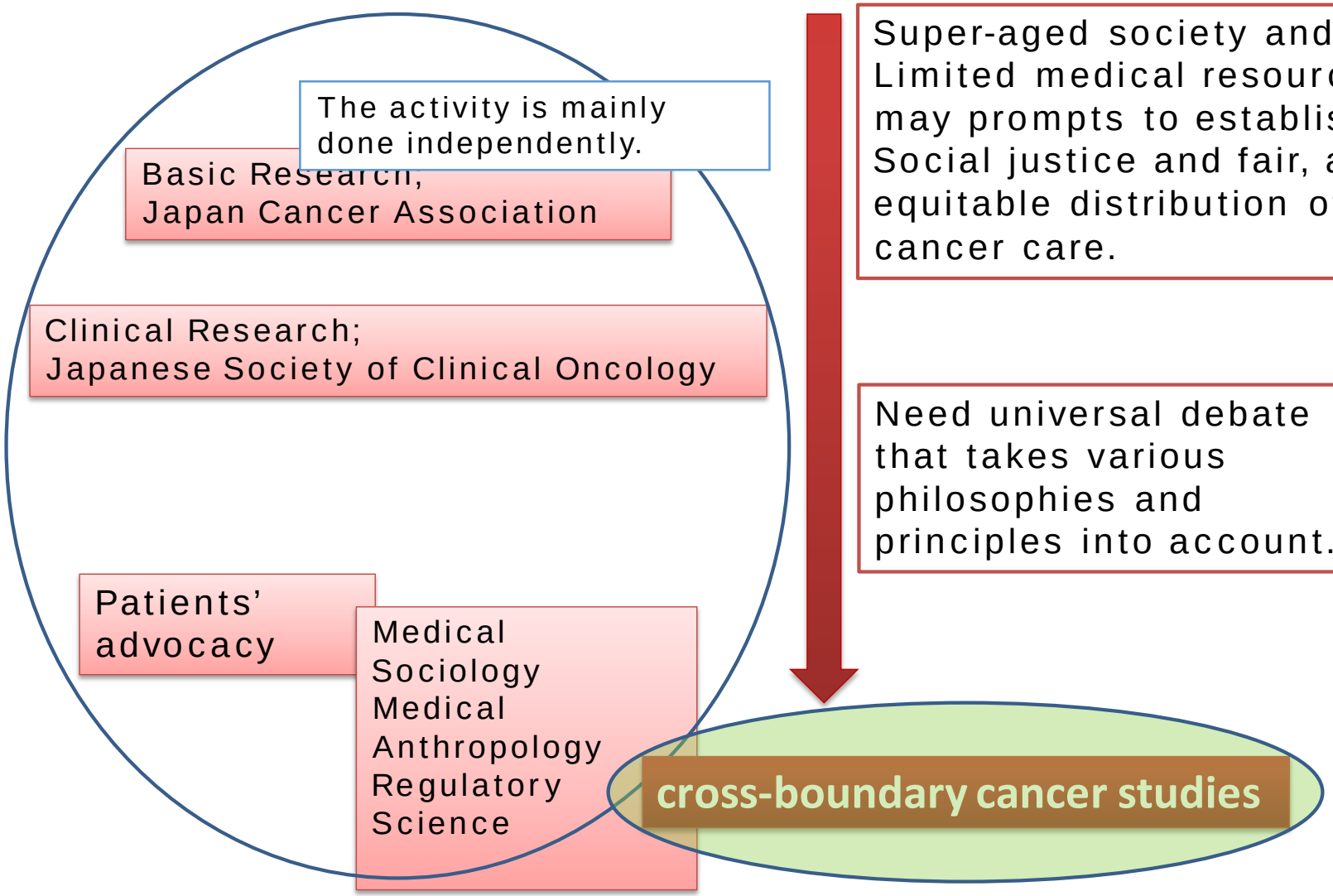
Process and present status of the Tri-lateral (Japan, Korea and China) project

- 2012- proposal funding to Tri-lateral cooperation secretariat in Seoul, but not accepted
- 2013- proposal funding to Japan Society for the promotion of Science (JSPS) & National Research Foundation of Korea (NRF), and accepted as a Bi-lateral project
- Today, this conference is held as the bi-lateral project, because of the limitation of the above funds
- 2014 >>- still seeking a funding for tri-lateral project

The Idea of Tri-lateral collaboration

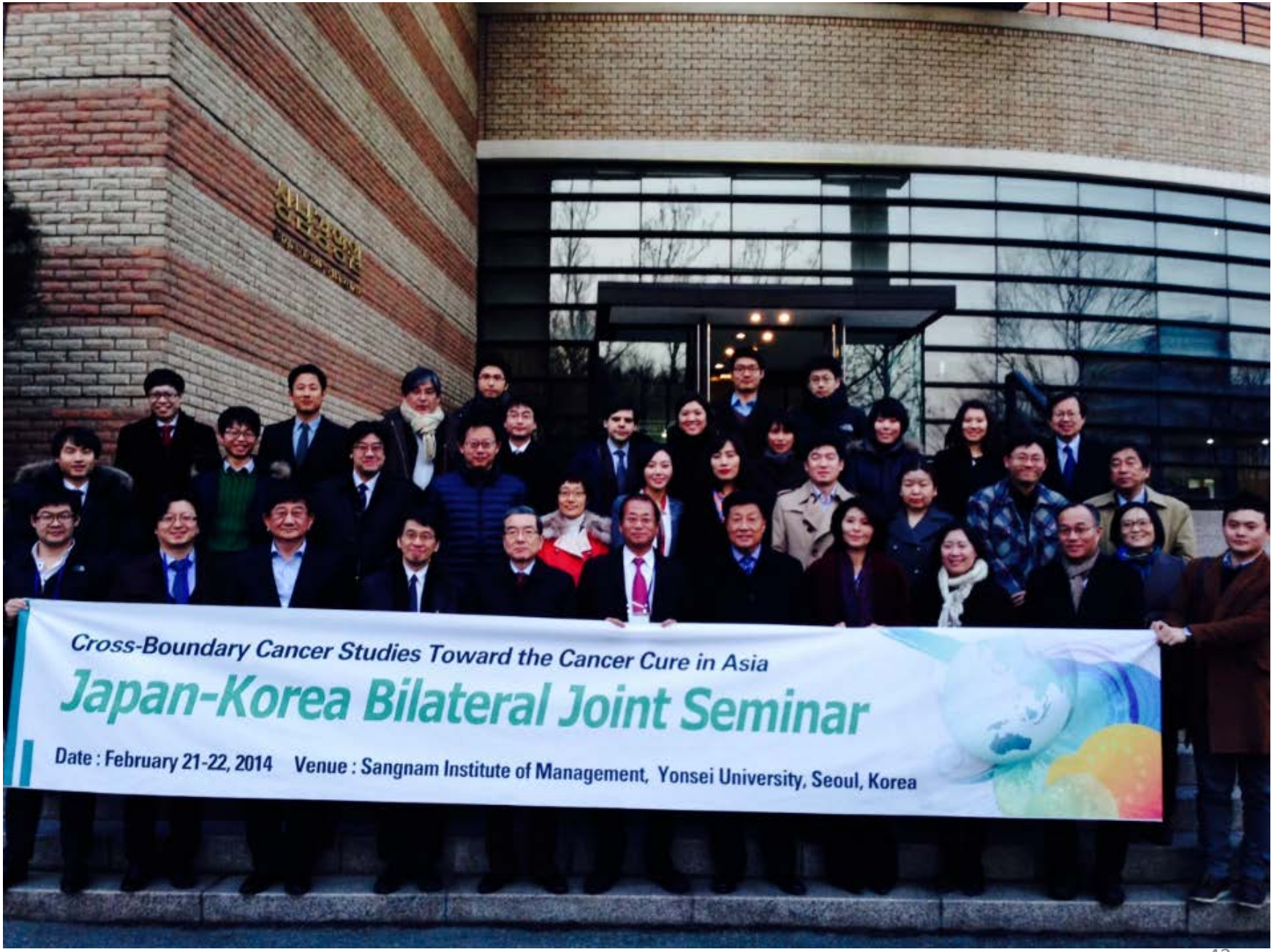


Disciplines Handling Cancer Issues



Super-aged society and Limited medical resources may prompts to establish Social justice and fair, and equitable distribution of cancer care.

Need universal debate that takes various philosophies and principles into account.


Cross-Boundary Cancer Studies Toward the Cancer Cure in Asia
Japan-Korea Bilateral Joint Seminar
Date : February 21-22, 2014 Venue : Sangnam Institute of Management, Yonsei University, Seoul, Korea

Akaza, Hideyuki (2014) Cross-boundary Cancer Studies at the University of Tokyo: View from the World of Science and Reason, *Japanese Journal of Clinical Oncology* 44 (suppl 1):i3-i5.

http://jjco.oxfordjournals.org/content/44/suppl_1/i3.full

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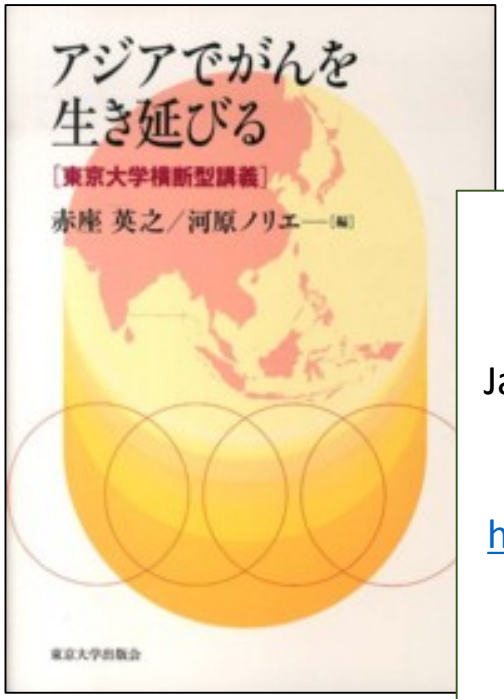
http://jjco.oxfordjournals.org/content/44/suppl_1/i3.full

An example in The University of Tokyo: Lectures for post-graduate students.
Japan –Asia Study; Survive Cancer in Asia (cross boundary cancer studies)
Just published

University-wide Graduate School Education Program.
Japan-Asian Studies Program, The University of Tokyo.
ASNET (Network for Education and Research on Asia)
http://www.asnet.u-tokyo.ac.jp



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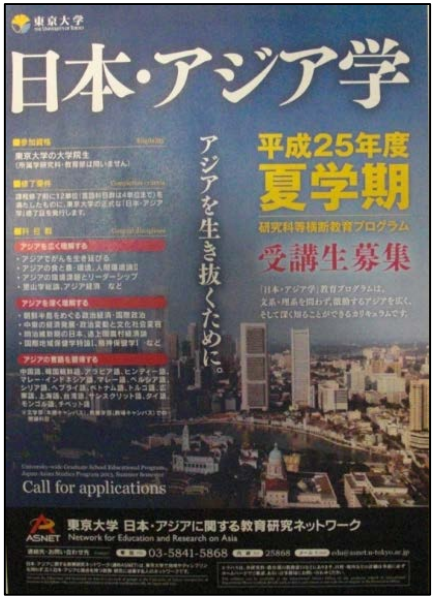
University of Tokyo Press
http://www.utp.or.jp/bd/978-4-13-063402-1.html

Japanese Journal of Clinical Oncology

http://jjco.oxfordjournals.org/



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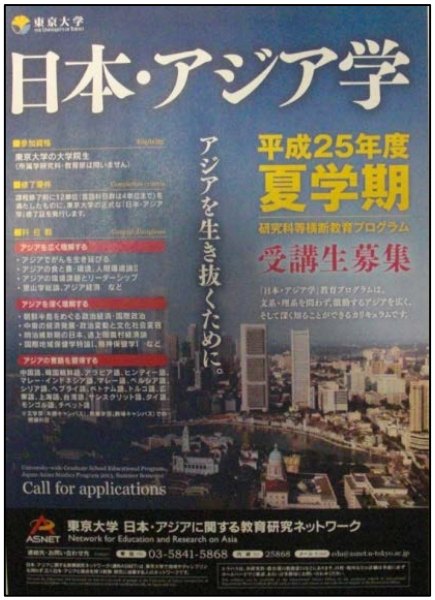

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ASNET (Network for Education and Research on Asia)
http://www.asnet.u-tokyo.ac.jp/en

Take home message:
Leadership & Collaboration are keys

- We should establish a sense of urgency
- We shall create a guiding coalition
- We should develop a vision and strategy
- We should communicate the change vision
- We should generate short-term wins
- We shall anchor new approaches in the culture
- We should seek funds
- Trust and friendships

Questions from the speaker

1. Which do you feel is the optimal medical insurance system for Asia? Slide #6
    1. US type?, European type?, Japan type?, or another type?
2. What is the main purpose in the treatment of cancer of elderly people; ex. >=80 years old? Slide #13
    1. Cure?, Life prolongation?, Palliative?
3. What do you think of the resource stratified recommendation of the cancer treatment? Slide #25
4. What do you expect of the tri-lateral project? Slide #31
5. How do you think of the concept of cross- boundary cancer studies?

Structure of the course:
Cross-boundary Cancer Studies - multidisciplinary approach

Introduction :
What & why cross-boundary cancer studies? Akaza

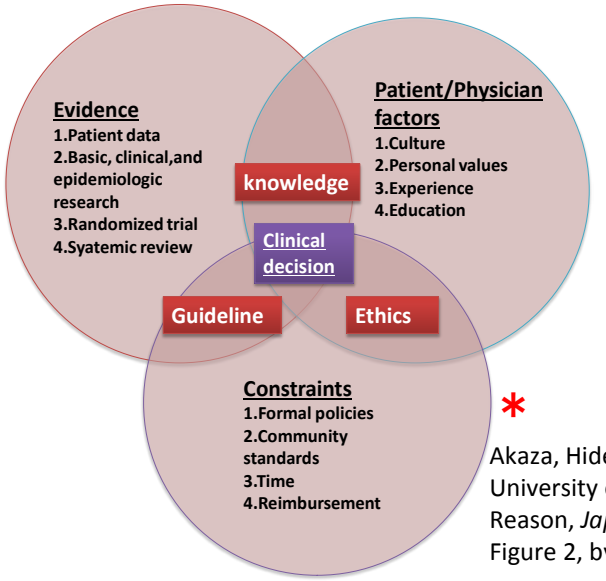
Present status of cancer clinical stud in Asia Nishiyama

Cancer study in Asia/ Basic &s Noda

Interdisciplinary collaboration, from the view of Academia Yoshimi

Data archive, concept of Asian (Cancer) barometer: Sonoda

How to establish Asia Cancer Barometer Sonoda



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Akaza, Hideyuki (2014) Cross-boundary Cancer Studies at the University of Tokyo: View from the World of Science and Reason, *Japanese Journal of Clinical Oncology* 44 (suppl 1):i3-i5, Figure 2, by permission of Oxford University Press.

Asia as a pharmaceutical market Nogimori

Patient- Family- Social condition: Kakizoe

Socio-economical approach for UHC Fukuda

Economy & cancer therapy in Asia Kawai

Asian diplomacy & cancer Takemi

General discussion

What & why Cross-boundary Cancer Studies?

1. **What is Asian Cancer Barometer?**
2. **How can we establish the ACB?**
3. **What will become known by the ACB?**