

Third ECL Cancer Screening Workshop

8-9 November 2021

**COUNCIL RECOMMENDATION ON CANCER
SCREENING (2003): what do we want to
see in the update?**



8-9 NOVEMBER 2021
10:00 - 12:30 (each day)
ONLINE MEETING

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e la Prevenzione Oncologica in Piemonte

Report

Background documents, slides and recordings can be downloaded [here](#).



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DAY 1

SESSION 1: KEY PRINCIPLES IN CANCER SCREENING

Balance of benefits and harms in screening programmes: the debate

Nereo Segnan, CPO Piemonte – WHO Collaborating Centre for early detection and screening of cancer

➤ [Presentation](#)

Nereo Segnan (NS) provided an overview of the balance of benefits and harms in screening programmes. He stressed the necessity for the EU to adopt reliable criteria and the uniform metrics in its recommendations for cancer screening. NS then presented slides comparing benefits and disadvantages of breast cancer screening.

NS further presented graphs explaining that combined indicators taking into account death and disability, or quality of life (DALYs or QALYs) are a useful tool for comparing the impact of care pathways in organised, opportunistic and in no screening.

NS concluded the presentation by stating that the [Council recommendation on 2 December 2003 on cancer screening](#) should be update and include reliable criteria and uniform metrics for comparing harms and benefits in the population who receive organised or opportunistic screening, as well as in the un-screened population.

Role of communication in cancer screening programmes

Francesca Di Stefano, CPO Piemonte

➤ [Presentation](#)

Francesca Di Stefano (FDS) gave an overview of the importance of communication in cancer screening programmes. FDS explained that the patient-physician relationship has now shifted from a paternalistic to a shared model, which highlights ethics and the importance of patient autonomy. Patients must be properly informed and able to make informed decisions about accepting an intervention.

FDS noted that the patient is not the one who should look for medical care. The screening programme should ethically seek out those in need of care. It is crucial to note that there are indeed health professionals who approach the healthy and asymptomatic population to invite them to undergo screening tests. In other words, the patient's autonomy needs to be respected even if it may result in harm by refusing to get the treatment.

FDS further presented a table of ethical principles as a framework for cancer screening prevention. It is imperative to communicate in an appropriate and unbiased manner, mentioning both hazards and benefits of screening procedures to enable people to make an informed choice about attending screening. Different target audience can be addressed by using different channels and communication instruments.

FDS reported that there are multiple communication challenges, for example, the way in which the information is presented is important. The accuracy of information depends not only on the content, but also on the communication skills of health professionals providing it. Sometimes, the language used by health professionals is technical, including anatomical, diagnostic, and therapeutic jargon and incomprehensible mathematical and statistical concepts leading to misunderstanding.

FDS concluded the presentation by stressing that screening programmes should be (i) respectful of different attitudes and values, (ii) accessible (in terms of information provided), (iii) inclusive, (iv) multilevel, (v) strategically planned and (vi) research driven.

Integrating primary prevention interventions in screening settings

Carlo Senore, CPO Piemonte

➤ [Presentation](#)

Carlo Senore (CS) started his presentation stating that screening can be seen as a 'teachable moment' during which individuals receive (i) lifestyle advice, (ii) there is a favourable cost-effective ratio and (iii) an opportunity for follow-up as well as to plan reinforcing interventions due to the continuity of interventions over time.

The available scientific evidence is in support of integrating primary prevention interventions with lung and colorectal cancer screening. For lung cancer screening, cost effectiveness is increased when combining smoking cessation interventions with the offer of spiral CT screening. When it comes to colorectal cancer screening, there is evidence that screenees with a negative TC following a positive FIT as well as those undergoing adenoma excision may interpret the screening result as validation of their lifestyles. Overall, people attending colorectal, breast and cervical cancer screening are willing to receive lifestyle advice.

CS then presented a Norwegian study that investigated long-term effects of colorectal cancer screening on lifestyle changes. The study suggests that possible unfavourable lifestyle changes after colorectal screening are modest, and that lifestyle counselling may be considered as part of cancer screening programmes.

New approaches are emerging to ensure different audiences are informed about lifestyle changes and are encouraged to adopt healthy behaviours through mobile apps and social media.

CS concluded that:

- Primary prevention interventions aimed at promoting the adoption of healthier lifestyles targeting people attending cancer screening programmes are beneficial, as they (i) favour the adoption of health-supportive behaviours, (ii) are effective in lowering body weight and (iii) are well-accepted by screeners.
- It is crucial to assess and monitor organisational impact (i.e. collecting information about (i) acceptability and patients' satisfaction and (ii) resources utilisation and costs, as well as equity of access.

Discussion

Q.) David Ritchie (DR), Cancer Prevention Manager at ECL, referring to CS's presentation on integrating primary and secondary prevention interventions, asked FDS about the complexity of communicating about cancer screening to the target audience.

A.) FDS answered that it is difficult to address these issues in depth because information is important, but the promotion also must be changed. It is crucial to understand why differences exist and inequalities. For example, people who are literate and have higher socio-economic backgrounds are ready for a change, while people of a lower socio-economic backgrounds are not.

Q.) Janne Bigaard (JB) from the Danish Cancer Society asked NS whether it is possible to have equal lists on harms and benefits based on the overview NS has presented.

A.) NS answered that the imbalance between benefits and harms is just an appearance because life saved or number of years in life gained is higher than the weight of a false positive mammography - it is not 1 to 1. This benefit is higher than the weight of the false positive mammography. Same categories apply to unscreened, screening organised settings or opportunistic settings. Measuring parameters are applied the same way.

A.) AP said Janne's point is valid because the table shows more harms than benefits, so the weight is different. Graphical representation should be better.

A.) Urska Ivanuš from the Slovenian Association of Cancer Societies said that the benefits and harms should be considered both on the population and on an individual level. Doctors are not playing a huge role in the dissemination of information. We should communicate better what the experts recommend.

SESSION 2: HOW CAN CANCER SCREENING PROGRAMMES TARGETING BREAST, CERVICAL AND COLORECTAL CANCERS, BE IMPROVED THROUGHOUT THE EU?

Introduction to the second session

David Ritchie, Association of European Cancer Leagues (ECL)

DR opened the second session by introducing the guiding questions stated in the European Commission's [scoping document](#).

1. How cancer screening programmes for breast, cervical and colorectal cancers can be improved throughout the EU?
2. What is the scientific basis extending such screening programmes to other cancers e.g. lung, prostate and gastric cancers, and ensuring their feasibility throughout the EU?
3. Which are the main scientific elements to consider, and best practices to promote, for optimising risk-based cancer screening and early diagnosis throughout the EU?

DR introduced and passed the floor to the first speaker, André Carvalho.

How to increase coverage and participation to screening programmes

André Carvalho, International Agency for Research on Cancer (IARC)

➤ [Presentation](#)

André Carvalho (AC) started off his presentation by highlighting that, in the literature, there are many systematic reviews on evidence-based interventions to increase coverage and participation in screening programmes.

AC then briefly explained what the two questions regarding Evidence Based Intervention (EBI) are: is there a lower performance on the real-world setting; how can we make the process of implementing EBIs more efficient?

AC continued his presentation by introducing and briefly explaining the [CANScreen5/CELAC](#) project which aims to decrease inequality in cancer screening participation. He also presented the [EUTOPIA](#) project. This project evaluates policies and cancer screening protocols in Latin America and the Caribbean (LATAM) followed by data collection to map screening (performance indicators) and monitor barriers to cancer screening.

AC gave an example of barriers and evidence-based interventions framework used to develop the road maps and described some key considerations for designing a patient navigation for colorectal cancer screening, and common stakeholder roles in the development of a national policy.

AC concluded his presentation by stating that it is imperative to (i) measure determinants and barriers of low participation in screening programmes, (ii) identify the key barriers that should be overcome with priority, (iii) choose EBI to tackle the selected barriers and (iv) plan to implement the EBI.

Monitoring & quality assurance along entire process cancer screening and care

Antonio Ponti, CPO Piemonte

➤ [Presentation](#)

Antonio Ponti (AP) briefly introduced 'Prevenzione Serena' - the regional screening programme in Italy's Piedmont region and then highlighted some of the key messages within the [Cancer Screening in the European Union Second Report \(2017\)](#).

AP noted that some cancer screening data is based on data collection obtained online and that screening programmes are being compared instead of cancer screening participants. However, from 22 countries that have provided data on screening, results show that regular repetition of carrying out the cancer screening survey is likely to benefit (survey and) screening quality.

Organised screening entails the identification and the connection with specialist clinical units and their involvement in audit, evaluation, and quality assurance of the whole process of care, including clinical assessment and treatment.

AP concluded his presentation by stating that all women should have access to fully equipped multidisciplinary breast clinics and that quality assurance programmes should become mandatory for breast cancer services ([Florence Statement](#)). Secondly, all breast units should develop quality assurance programmes entering their data onto a common European database ([Brussels Statement](#)).

Reducing inequalities in cancer screening

Paola Armaroli, CPO Piemonte

➤ [Presentation](#)

Paola Armaroli (PA) presented evidence on the reduction of inequalities in cancer screening from the Piedmont Council Registry in Italy.

The evidence shows that cancer survival tends to be higher in lower socioeconomic compared with high socioeconomic groups. The cancer incidence and mortality are higher in women with lower educational backgrounds. In addition, incidence and mortality for breast cancer is higher in educated women, while mortality appears to be higher for women with lower education backgrounds.

According to an observational carried out in the Emilia-Romagna region in Italy, social differences in survival occur due to intervening factors such as: (i) screening access, (ii) timing of diagnosis and (iii) type of quality of treatment. This study concluded that screening programmes reduce disparities in access to good quality treatments, as we can directly screen-detected women into a protected pathway of care.

Moreover, when comparing screening access to survival among different geographical regions in

Italy, survival results higher for breast cancer in Northern and Central Italy and low in the South. Therefore, the highest probability for breast cancer survival is in the North (same trends can be observed for colorectal and cervical cancer).

PA briefly mentioned the 13 recommendations to tackle social inequalities in cancer reported in the Cancer Control Joint Action (CanCon)'s [Policy on Tackling Social Inequalities in Cancer Prevention and Control for the European Population](#). Social inequalities in participation can be observed in lower socioeconomic groups, minority ethnic groups, people with intellectual disabilities and those living in underprivileged areas. Inequalities in participation also exist between different European countries.

PA concluded that organised screening programmes can be effective tools for reducing social inequalities in outcomes, especially when the programme includes a robust pathway to care following cancer diagnosis. Therefore, it is necessary to reduce opportunistic screening and reach high levels of coverage from the programme.

DAY 2

SESSION 1: WHAT ARE THE MAIN SCIENTIFIC ELEMENTS TO CONSIDER, AND BEST PRACTICES TO PROMOTE, FOR OPTIMISING RISK-BASED CANCER SCREENING AND EARLY DIAGNOSIS THROUGHOUT THE EU?

Introduction to day two

David Ritchie, ECL

DR introduced the speakers as well as the aims and objectives of the second day workshop. Day two focused on recommendations for improving existing screening programmes and for addressing questions regarding the future of cancer screening.

Risk-adjusted screening: review of potential approaches and ongoing studies

Livia Giordano, CPO Piemonte

➤ [Presentation](#)

Livia Giordano (LG) explained that age represents a unique risk factor for breast cancer and presented a chart portraying the distribution of breast cancer screening across Europe.

Most countries use an age-based, population level breast screening strategy to reduce breast cancer mortality. Identifying women who are at a higher risk of developing breast cancer may enable targeted identification of early detection and preventable measures. Thus, mammographic screening is a multidisciplinary approach to increased awareness among women health operators and for a systematic and standardised quality control. However, it has been observed that there are both cons and pros of breast cancer screening even when personalised screenings are offered to women (i.e offering more sensitive and intensive screening to women with an increased risk and offering less intense screening with longer intervals to others).

LG concluded her presentation by giving an overview of several breast cancer-focused studies ([MyPeBs](#), [WISDOM Study](#), [PRISMA Study](#), [KARMA Study](#) and [RISCC](#)), and explaining the risk factor pyramid on causes of breast cancer in women, as well as other factors such as: lifestyle habits, family history, and breast density.

Discussion

Q.) DR asked LG whether she could elaborate publications on the acceptability of women for lower or intensive protocol on screening (is this causing distress and how do they feel?).

A.) LG reported that women appreciate being included in the screening programme based on their age group, breast density, and other factors. However, the investigation process is not simple because saliva samples and lifestyle habit questions must be asked and the waiting period to get screened is between 2-4 years.

Q.) JB asked if the speakers had any data/insights about low-risk groups (do they seek mammography and get screened every 2 years?)

A.) LG answered that women who got recruited in the project have access to a portal inside the MyPeBs website which investigators can access. However, it is difficult to track women who got screened for breast cancer outside the MyPeBs programme.

Q.) DR asked if it is cost effective for EU countries and regions to implement MRI scanning?

A.) Marco Zappa (MZ) answered that a cost-effective evaluation is needed because MRI scanning is costly. At the moment, there is no definite answer due to the great variability in use and performance of MRI scanning.

Q.) LG asked what could be done to ensure that men get tested for prostate cancer and when should they get tested?

A.) MZ answered that all potential benefits and harms of different approaches must be clearly explained. For example, in case of a positive PSA, MRI should be done before the biopsy. Same approach is used for all age groups, but 70+ age group does not require testing, while 55-70 age group should be encouraged to get tested.

Q.) JB asked about the incidence curves in the US graphs MZ presented. In Denmark, there is a reduction because PSA are not used. What about Europe?

A.) MZ answered that incidence rates of prostate cancer have decreased since 2010. There is also a decrease in the use of PSA tests. In the near future, we will observe an increase in prostate cancer incidence and mortality, which could be avoided by using MRI scans.

SESSION 2: WHAT IS THE SCIENTIFIC BASIS EXTENDING SUCH SCREENING PROGRAMMES TO OTHER CANCERS (E.G. LUNG, PROSTATE AND GASTRIC CANCERS), AND ENSURING THEIR FEASIBILITY THROUGHOUT THE EU?

Introduction to session

David Ritchie, ECL

DR introduced the second session by explaining what the screening recommendations for gastric, lung and prostate cancer are. DR shortly introduced Marco Zappa and his previous work on cancer screening.

Update on prostate cancer screening

Marco Zappa, Institute for the Study, Prevention and Oncology Network (ISPRO)

➤ [Presentation](#)

MZ stated that the epidemiology of prostate cancer (PC) largely depends on diagnosis via Prostate Specific Antigen (PSA) and that, over the years, a decrease in incidence and mortality rates, as well as an increase in 5-year relative survival was observed.

MZ presented graphs showing increases and decreases in PC incidence in the US and addressed two questions.

Q.) Is PSA screening effective in mortality from PC?

A.) Yes, but with substantial overdiagnosis resulting in overtreatment with potential risks (urinary incontinence or erectile dysfunction). In the graph, we can observe a reduction in mortality, but higher cancer overdiagnosis. Moreover, organised programmes are not implemented in EU. Graphs show that the prostate cancer has a sharp decrease in local cancer, but an increase in distant and regional cancer rate.

Q.) How to disentangle overdiagnosis and overtreatment from early detection?

A.) Through (i) active surveillance, (ii) risk-adapted early detection strategy and (iii) the use of multiparametric magnetic resonance imaging (mp-MRI).

MZ concluded that there is a 21% decrease in prostate specific mortality, and that new screening strategies to detect high-grade cancers are currently being discussed.

Lung cancer screening: why the debate?

Gianluigi Ferrante, CPO Piemonte

➤ [Presentation](#)

Gianluigi Ferrante (GF) stated that lung cancer is the fourth most commonly diagnosed cancer and the leading cause of cancer-related deaths in Europe. Survival from lung cancer remains low

because people get diagnosed late and few treatment options are available. In addition, lung cancer screening remains problematic.

Several cancer screening clinical trials have been carried out throughout the years. There is a 20% reduction in lung cancer deaths in the group monitored with low dose CT scans compared to x-rays. Screening programmes have potential benefits and harms, as well as a substantial number of false positives and overdiagnosis. Some issues are still to be addressed: (i) the high rate of false positives, (ii) the risk of further diagnostic tests, and (iii) overdiagnosis.

GF gave an overview of a new trial in Belgium carried out on more than 30,000 men. Most results were false positives and numerous individuals had to repeat the CT to understand whether lesions detected were malignant or not. However, a 24% reduction in lung cancer deaths in men was observed compared to those who underwent no screening.

GF concluded his presentation by stressing the importance of addressing issues that are not yet adequately addressed, such as (i) overdiagnosis, (ii) false positives and (iii) radiation. CT lung screening has a role in reducing lung cancer-related mortality, but currently no elements to recommend the implementation of this screening exist. Screening protocols must be optimised with priority.

Clinical question for research (feasibility for implementation of risk-based recruitment)

Carlijn van der Aalst, ERASMUS MC

➤ [Presentation](#)

Carlijn van der Aalst (CA) addressed unanswered questions related to (i) recruitment risk assessment, (ii) personalised screening interval and (iii) smoking cessation interventions.

Firstly, CA stated that there are several challenges observed when recruiting high-risk individuals based on their age, gender, and other risk factors. For example, the screening uptake remains low and disadvantageous to those who do not participate in healthcare interventions causing an increase in social-economic differences. Recent studies show that there is no improvement in the lung screening uptake because the recruitment strategies are usually based on a 'standard approach'.

Secondly, personalised screening intervals have a direct impact on the balance between harms and benefits. Retrospective analysis suggests that the annual screening might not be necessary for all screenees. It has been observed that when the incidence screening is skipped, the number of CT scans is reduced by 73%.

Thirdly, regarding the smoking cessation challenge, it has been observed that the mortality rates are lower for those who got screened and stopped smoking. However, the question remains, how can we help long term heavy smokers who did not manage to quit smoking.

CA presented a new study '[4-IN-THE-LUNG-RUN](#)' – the first large scale multi-centred implementation trial on volume CT lung cancer screening across 6 EU countries based on less

intensive screening regimens for high-risk individuals.

CA concluded that lung screening programmes must target individuals individually by offering tailored invitations and integrate a comorbidity-reducing strategy. Potential impacts might include increased screening rates, diagnosis and some overdiagnosis. Overall, lung cancer can be prevented.

Lung cancer screening and primary prevention: why investing in tobacco cessation

Cristiano Piccinelli, CPO Piemonte

➤ [Presentation](#)

Cristiano Piccinelli (CP) briefly presented data about the burden of tobacco in the EU and noted that better strategies need to be urgently implemented if Europe is to achieve a 'Tobacco-free Generation', where less than 5% of the population uses tobacco by 2040, compared to around 25% today (a goal within [Europe's Beating Cancer Plan](#)).

CP listed some of the benefits of quitting smoking, including (i) reduced risk of death by 90%, (ii) reduced risk of developing coronary heart disease by half and (iii) decreased risk of developing cancer when quitting at a younger age.

CP presented a graph showing that the younger an individual quits smoking, the lower the cancer risk. In conclusion, further research is required to evaluate optimal strategies for integrating smoking cessation interventions within stratified lung cancer screening. However, effective prevention intervention must become a priority when planning health strategies.

Discussion

Q.) DR asked if there is any further information/data regarding potential screening and identifying major health issues besides lung cancer?

A.) CA answered that besides lung cancer there are also simple tests for coronary vascular disease, which can be easily done in one session.

Q.) DR asked if there is any scientific evidence on how the cost effectiveness was estimated for lung screening and whether it is comparable with mammography screening?

A.) CA answered that the results of the study are not available yet, but that it would be comparable in cost effectiveness with breast cancer screening. The programme can be cost effective as well as other programmes.

ANNEX 1: WORKSHOP AGENDA

DAY 1

10:00 - 10:05	BRIEF INTRODUCTION AND WELCOME
10:05 - 10:50	SESSION ONE: Key principles in cancer screening Balance of benefits and harms in screening programmes: the debate <i>Nereo Segnan, CPO Piemonte</i> Role of communication in cancer screening programmes <i>Francesca DiStefano, CPO Piemonte</i> Integrating primary prevention interventions in screening settings <i>Carlo Senore, CPO Piemonte</i>
10:50 - 11:05	DISCUSSION
11:05 - 11:20	BREAK
11:20 - 12:10	SESSION TWO: How can cancer screening programmes targeting breast, cervical and colorectal cancers, be improved throughout the EU? Introduction to session <i>David Ritchie, ECL</i> How to increase coverage and participation to screening programmes <i>André Carvalho, IARC</i> Monitoring & quality assurance along entire process cancer screening and care <i>Antonio Ponti, CPO Piemonte</i> Reducing inequalities in cancer screening <i>Paola Armaroli, CPO Piemonte</i>
12:10 - 12.30	DISCUSSION
	END OF DAY ONE

DAY 2

10:00 - 10:05	BRIEF INTRODUCTION AND WELCOME
10:05 - 10:25	SESSION ONE: What are the main scientific elements to consider, and best practices to promote, for optimising risk-based cancer screening and early diagnosis throughout the EU?" Introduction to session <i>David Ritchie, ECL</i> Risk-adjusted screening: review of potential approaches and ongoing studies <i>Livia Giordano, CPO Piemonte</i>
10:25 - 10:35	DISCUSSION
10:35 - 12:30	SESSION TWO: What is the scientific basis extending such screening programmes to other cancers e.g. lung, prostate and gastric cancers, and ensuring their feasibility throughout the EU?" Introduction to session <i>David Ritchie, ECL</i> Update on prostate cancer screening <i>Marco Zappa, ISPRO</i> QUESTIONS AND ANSWERS
11:05 - 11:25	BREAK
	Lung Cancer Screening: why the debate? <i>Gianluigi Ferrante, CPO Piemonte</i> Clinical question for research (feasibility for implementation of risk based recruitment) <i>Carlijn van der Aalst, ERASMUS MC</i> Lung cancer screening and primary prevention: why investing in tobacco cessation <i>Cristiano Piccinelli, CPO Piemonte</i> QUESTIONS AND ANSWERS
	END OF WORKSHOP

ANNEX 2: LIST OF SPEAKERS

First Name	Last Name	Organisation
Nereo	Segnan	CPO Piemonte
Antonio	Ponti	CPO Piemonte
Livia	Giordano	CPO Piemonte
Francesca	Di Stefano	CPO Piemonte
Gianluigi	Ferrante	CPO Piemonte
Cristiano	Piccinelli	CPO Piemonte
Carlo	Senore	CPO Piemonte
Paola	Armaroli	CPO Piemonte
Marco	Zappa	ISPRO
Carlijn	van der Aalst	Erasmus MC
André	Carvalho	IARC

ANNEX 3: LIST OF PARTICIPANTS

First Name	Last Name	Organisation
Klara	FELDES	German Cancer Society
Balázs	ROZVÁNYI	Hungarian Cancer League
Urska	IVANUŠ	Slovenian Association of Cancer Societies
Katja	JARM	Slovenian Association of Cancer Societies
Yvonne	GRENDDELMEIER	Swiss Cancer League
Guido	BISCONTIN	Swiss Cancer League
Nicole	STECK	Swiss Cancer League
Dana	FROST	Israel Cancer Association
Miri	ZIV	Israel Cancer Association
Marina	KAFUROU-COSMA	Cyprus Association of Cancer Patients & Friends (PASYKAF)
Tytti	SARKEALA	Cancer Society of Finland
Sirpa	HEINÄVAARA	Cancer Society of Finland
Lore	PIL	Stand Up to Cancer Flanders
Alexander	BRANDENBURG	Dutch Cancer Society
Janne	BIGAARD	Danish Cancer Society
Sarolta	GUNDY	Hungarian League Against Cancer
Emma	HARTE	Irish Cancer Society
Naomi	THOMPSON	Cancer Focus NI
Dominika	NOVAK	Slovenian Association of Cancer Societies
Jolien	PALMAERTS	Stand Up to Cancer Flanders
Imre	GAAL	Hungarian League Against Cancer
David	RITCHIE	ECL
Ana	SZABO	ECL