Editor's Note:
The 18th World Conference on Lung Cancer (WCLC) was held from 15th to 18th October 2017, in Yokohama, Japan. On the grand event, Professor Jassem gave a speech on "*Smoking after Diagnosis of Cancer*" and brought tremendous attention on the issue of tobacco-control among the audience. The editorial team from *Translational Lung Cancer Research* has the honour to interview Prof. Jacek Jassem to share some of his opinions with our readers.

Meet the Professor

Professor Jacek Jassem: we can never emphasize too much on tobacco-control

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Expert introduction

Jacek Jassem, MD, PhD, is a Professor of Clinical Oncology and Radiotherapy and Head of the Department of Oncology and Radiotherapy at the Medical University of Gdansk, Poland (*Figure 1*). He received his MD and PhD from the Medical University of Gdańsk and undertook training at the Karolinska Institute in Stockholm, Sweden and the National Cancer Institute in Amsterdam, The Netherlands.

He is a past chairman of the European Organisation for Research and Treatment of Cancer (EORTC) Breast Cancer Group and a past member of the EORTC Executive Committee, the chairman of the Central and East European Oncology Group, past chairman of the American Society of Clinical Oncology International Affairs Committee and a past president of the Polish Oncological Society. He is a member of the Academia Europea, European Academy of Cancer Sciences, and the Polish Academy of Art and Sciences. He served in the executive boards of the European Society for Radiation Oncology and the European Society for Medical Oncology. He has been actively involved in a number of different editorial boards including *Lancet Oncology*, the *European Journal of Cancer*, *Cancer Treatment Reviews*, *Radiotherapy and Oncology* and the *Journal of Thoracic Oncology*.

His main scientific interests are medical oncology, specifically lung and breast cancer, combined modality treatment with chemotherapy and radiation, as well as molecular oncology. He has authored or co-authored over 800 full articles, patents, books and book chapters in these fields. The cumulated impact factor of his full publications is 1975, with over 15,600 citations and h-index of 49. He is the recipient of a number of Polish and international scientific awards.

Figure 1 Jacek Jassem, MD, PhD.

Prof. Jassem has been involved with nationwide public health initiatives, such as authoring the Polish anti-tobacco legislation to limit smoking in public places (introduced by Parliament in 2010) and the coordination of Cancer Control Strategy for Poland 2015–2024.

Interview questions & responses (*Figure 2*)

TLCR: You have a presentation on the topic "Smoking after Diagnosis of Cancer" on WCLC this year. What's your point of view about this topic?

Professor Jassem: Many patients think that it is too late

Figure 2 Professor Jacek Jassem: we can never emphasize too much on tobacco-control (1).
Available online: http://www.asvide.com/articles/1895

to quit smoking after the diagnosis of cancer, but it is not the case. Patients who continue smoking after diagnosis of cancer show poorer tolerance to various therapies, higher risk of developing secondary malignancies, poorer quality of life, and apparently inferior treatment outcomes compared to those who quit. Continuing smoking is not only impacting patients with tobacco-related malignancies such as lung cancer or head and neck cancer, but has also negative impact in other malignancies, such as breast cancer or prostate cancer. In contrast, patients who quit smoking will greatly benefit from this decision. Hence, smoking patients should be informed about benefits of cessation and offered pharmacological and behavioural assistance. During my "Meet the Professor" session, I once more strongly emphasised the importance of tobacco cessation after diagnosis of cancer. During next WCLC in Toronto in 2018, this topic will be given even more attention. We are considering a special session devoted to this problem that will address its various aspects.

TLCR: As far as I know, you initiated and coordinated development of Cancer Control Strategy for Poland 2015–2024. How is this project going in Poland now?

Professor Jassem: In 2013, when I was the president of the Polish Oncological Society, we decided to start this cancer control bottom-up initiative. At that time Poland, as opposed to many other European countries, had yet to launch a strategy for cancer control. Effective cancer control can only be fulfilled by comprehensive measures in health care, addressing medical, financial and organisational aspects, public education, cancer science etc. We realised that by virtue of the combined efforts there is a real chance to stop the continuously increasing cancer incidence and mortality in Poland. This initiative involved around 200 experts and patient representatives participating in ten working groups. They represented various disciplines including medicine, economy, psychology and sociology. We have developed the strategy plan and submitted it in 2014 to the Minister of Health. Until now, some parts of this strategy have already been implemented but many others are still waiting for their time. Nevertheless, many important steps have already been undertaken in Poland. Regarding the primary prevention, there are much stricter tobacco-control measures now in Poland than in the past. More recently, strict regulations on the use of solaria have also been introduced. We are refining screening programs for breast cancer, colon cancer and cervical cancer, and increasing the level of education of health care professionals and students of medicine. Within the past three years several developments in the organisation of medical care have been introduced, such as obligatory multidisciplinary tumour boards, coordination of treatment process and monitoring of cancer care quality. Above all, we hope that all these developments and measures to come may positively impact the situation in Poland.

TLCR: You are also an expert in radiotherapy. Below are the professional questions on radiotherapy raised from some Chinese doctors.

(I) How do you look at the value of stereotactic radiotherapy used in patients with operable lung cancer?
Professor Jassem: Stereotactic radiotherapy is one of the most important developments in radiotherapy within the past 20 years. It was invented in the mid-1990s and became a routinely used method for many malignancies, including early lung cancer. So far, it is mainly used as an alternative to surgery for medically inoperable patients, and has been proven to be extremely efficient, with more than 90% local control rate after 5 years. Further, current data indicate that stereotactic radiotherapy may be at least as effective as surgery in operable early lung cancer patients. However, a large randomised study is still warranted to convince thoracic surgeons that stereotactic radiotherapy is a valuable alternative to surgery in patients with early lung cancer.

There is also a question about whether stereotactic radiotherapy is better than the currently used other radiotherapy techniques, in particular IMRT, which has been a standard therapy for lung cancer. The results of a

recent randomized study performed in Australia showed apparent benefit of stereotactic radiotherapy over standard photon beam therapy, both in terms of local control and overall survival.

(II) How do you look at the combined immunotherapy and radiotherapy in non-small cell lung cancer patients?

Professor Jassem: Radiotherapy induces strong immunological reactions in the body. So, there is a rationale for combining radiotherapy and immunotherapy. For many years lung cancer has been considered a non-immunogenic malignancy, and only recently we realised that a high number of mutations accumulated during carcinogenesis results in its high immunogenicity. A few randomised studies showed that novel immunotherapeutic agents are much more efficient than standard chemotherapy in advanced non-small cell lung cancer. Now, in the immunotherapy era, we hope that administering local radiotherapy to selected metastatic foci may increase response to immunotherapy in other metastatic sites. We hope that ongoing studies investigating this idea will provide clinically meaningful data. Most recently, immunotherapy administered after radical chemoradiation for locally advanced lung cancer showed that durvalumab, a PD-L1 inhibitor, provides spectacular effects in terms of time to progression and time to the development of metastasis. New findings from this study have been presented at this WCLC.

(III) What is the role of the emerging radiotherapy techniques (such as proton and heavy particle) in lung cancer?

Professor Jassem: The advantage of proton therapy is the lower dose to critical organs around the tumour. There is a strong rationale to consider proton therapy in lung cancer patients to decrease radiation exposure of the heart, spinal cord or oesophagus. There have been several attempts to use proton therapy in lung cancer both in early and locally advanced disease. The findings of these studies are pretty encouraging. However, we still miss strong evidence for the superiority of proton therapy or heavy particle therapy over photon therapy for lung cancer. Nevertheless, it is likely, that proton therapy may prove beneficial for selected patient populations.

(IV) How do you look at the application of radiotherapy and targeted therapy in lung cancer patients with brain metastases?

Professor Jassem: The introduction of tyrosine kinase inhibitors (TKIs) in advanced NSLC has significantly changed the treatment paradigms for this disease, and this includes the management of brain metastases. A recent study from China showed that icotinib, an anti-EGFR TKI agent, is much more efficacious than whole brain radiotherapy in patients with multiple brain metastases from NSCLC. Whole brain radiation was shown not only less effective but also associated with considerably higher toxicity compared to treatment with TKI inhibitors. In addition, new EGFR and ALK TKIs have much higher efficacy compared to first-generation TKIs, and this advantage is particularly high in the prevention and treatment of brain metastases. For example, in the recent study comparing alectinib, a new ALK-inhibitor, with first-generation agent crizotinib the proportion of patients who developed brain metastases was around 6 times lower in the group assigned to alectinib compared to those assigned to crizotinib. Most likely new generation TKIs will become standard treatment in established brain metastases from non-small cell lung cancer, as they can effectively cross the blood brain barrier.

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Footnote

Conflicts of Interest: The authors have no conflicts of interest to declare.

References

1. Kong V, He CX. Professor Jacek Jassem: we can never emphasize too much on tobacco-control. Asvide 2017;4:575. Available online: http://www.asvide.com/articles/1895

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