INTERVIEW

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Olaparib recommendations for ovarian cancer patients

Peter Johnson* speaks to Gemma Westcott, Commissioning Editor: Peter Johnson is Professor of Medical Oncology at the University of Southampton and Chief Clinician for Cancer Research UK. He graduated from Cambridge University and St Thomas's Medical School (UK). He trained in oncology at St Bartholomew's Hospital, London, where he was an Imperial Cancer Research Fund (ICRF) Clinical Research Fellow and completed his doctoral research on the *Bcl-2* gene, its potential as a therapeutic target in lymphoma and the effects of CD40 ligation on the B-cell surface. He was subsequently a Senior Lecturer in Medical Oncology in the ICRF Cancer Medicine Research Unit, Leeds and took up the Chair of Medical Oncology in Southampton (UK) in 1998. He is responsible for bringing together a broad multidisciplinary group of basic, translational and clinical researchers, and linking the research of the academic unit to the extensive clinical practice in cancer treatment in the Southampton Cancer Centre. His research interests are in applied immunology and immunotherapy, lymphoma biology and clinical trials. He is Chief Investigator for lymphoma trials ranging from first in man novel antibody therapeutics to international randomized studies, and for the Cancer Research UK Stratified Medicine Programme. He was Chair of the UK National Cancer Research Institute Lymphoma Group from 2005 to 2011 and has been a member of national trials committees for the Medical Research Council, Cancer Research UK and Leukaemia and Lymphoma Research.

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Q Can you tell our readers about your career to date & your current role at Cancer Research UK?

I was trained as a clinical research fellow in what was the Imperial Cancer Research Fund (ICRF) department of medical oncology at Bart's hospital, and then as a senior lecturer in the center in Leeds. My doctoral research in London was supposed to be into the molecular biology of lymphoma and methods of detecting very low numbers of residual malignant cells, but I developed a tangential project in cell biology and the interactions between B-lymphocytes and their environment that sparked a long interest in immunology. I moved to a Chair in Southampton because of the long-standing interest in cancer immunology there, and took up my present position at Cancer Research UK after the new charity was formed after ICRF merged with Cancer Research Campaign and there was a clear need for someone to promote the role of clinical academics in cancer research.

Q What was it that sparked your interest in cancer research?

I was casting around for an interesting area of internal medicine when I was training, and was struck by the explosion of knowledge in the field of oncogenes. I had no real idea where it would lead, and the specialty of medical oncology was very much in its infancy, but I had a hunch that this would turn into an incredibly vibrant field of medicine.

KEYWORDS

- Cancer Research UK • NICE
- olaparib • ovarian cancer
- personalized medicine

*Cancer Research UK, St John Street, London, EC1V 4AD, UK; johnsonp@soton.ac.uk

Q What has been your favorite moment in your career so far?

In the laboratory, it was finding that I could grow malignant B cells in a complex multicell culture system that had never been done before. In the clinic, it has been seeing the extraordinary effects of some of the new antibody therapies we have developed. In both cases, I got a real feeling that cancers were yielding themselves up to science.

Q How would you say ovarian cancer survival rates in the UK compare with the rest of the developed world?

We have been agonizing over the UK cancer survival figures for years now. Although it is possible to query some of the international comparisons, it is quite clear to me that we lag behind other countries in the developed world. We make the diagnosis later in the UK, and even when you compare survival figures for the same tumor stage we do not do as well, suggesting that our treatments are not applied as effectively as in other countries. We still have a residual slough of nihilism to overcome if we are going to get our survival figures up to those of other places.

Q NICE has made an interim decision not to recommend olaparib for ovarian cancer patients with *BRCA* gene mutations; what are the foundations for this decision?

I am afraid that olaparib is too expensive for the National Health Service (NHS). It is clearly very helpful to a number of patients with specific mutations, but the way the price has been set is simply not realistic. The debate about value in cancer care now underway is extremely important: we cannot keep finding effective new treatments and then having the pharmaceutical industry charge the maximum price that they think that the healthcare system will bear.

Q Do you think olaparib should continue to be made available to these ovarian cancer patients & why?

I really hope that reason will prevail and we can find a way for women with these cancers to get the benefits of our research. This requires a careful evaluation of the true value of olaparib, and a sensible reflection on its utility in the NHS.

Q What might be the implications of these olaparib recommendations & what

alternatives are there for this small subset of ovarian cancer patients?

This recommendation is just the latest in the series of dialogues of the deaf between pharmaceutical companies and NICE. It is endlessly frustrating for patients and clinicians to be caught in the no-man's-land between these two. The rather sterile commercial and bureaucratic exchange of fire has real casualties in our clinics. Patients with these cancers do not have realistic alternatives for their treatment: they are left hanging on the wire, to extend the metaphor.

Q Where do you believe personalized medicine approaches for ovarian cancer should be heading?

We have the tools to do much more for patients with cancers of many types, using our knowledge of molecular changes to guide therapy. We need to bring the most up-to-date diagnostic approaches alongside access to the drugs that will be helpful in specific cases. The one-size-fits-all approach is gradually giving way to a much more intelligent approach: we just need our healthcare system to keep up.

Q Chemotherapy before major surgery for ovarian cancer has also been a dilemma for clinicians; what is your view on this?

There is very good evidence from clinical trials that treating patients with chemotherapy before surgery is an effective way to make tumors more amenable in most cases, but as we move into the era of more molecular guided therapy we need to make sure we are using the most effective treatment from the start.

Q Finally, in 10 years' time, where would you like to see the field of ovarian cancer?

I am hoping that the evidence from the large screening studies such as UK-CTOCS will show us how to diagnose ovarian cancer sooner, and that as we reform diagnostic services in the NHS, there will be a progressive improvement in the stage at which ovarian cancer is discovered. I also hope that we will continue to improve both the surgical and systemic treatment of ovarian cancer, so that our survival rates become the best in the world.

Disclaimer

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