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Please display the following credit:

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Copyright 2014, Hideyuki Akaza
“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)

- 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

Selected important cause across different income levels

Figure removed due to copyright restrictions.

Figure 12 "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

Figure removed due to copyright restrictions.

Figure 13 "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
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

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
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.
Figure removed due to copyright restrictions.

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

Decision making factors for the treatment of cancer

- **Evidence**
  1. Patient data
  2. Basic, clinical, and epidemiologic research
  3. Randomized trial
  4. Systemic review

- **Patient/Physician factors**
  1. Culture
  2. Personal values
  3. Experience
  4. Education

- **Constraints**
  1. Formal policies
  2. Community standards
  3. Time
  4. Reimbursement

Various factors concern in the cancer treatment decision.
Science, Politics, Economy, Philosophy, Religion, Education, Life style-------

* 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 \( \leq 65 \) 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.”

CANCER INCIDENCE IN JAPANESE MIGRANTS TO HAWAII.

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

<table>
<thead>
<tr>
<th>Variable</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>- 59</td>
<td>7.0</td>
</tr>
<tr>
<td>60 - 64</td>
<td>13.4</td>
</tr>
<tr>
<td>65 - 69</td>
<td>22.2</td>
</tr>
<tr>
<td>70 - 74</td>
<td>24.5</td>
</tr>
<tr>
<td>75 - 79</td>
<td>19.8</td>
</tr>
<tr>
<td>80 -</td>
<td>13.2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>T factor</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>T1</td>
<td>41.6</td>
</tr>
<tr>
<td>T2</td>
<td>35.7</td>
</tr>
<tr>
<td>T3</td>
<td>18.3</td>
</tr>
<tr>
<td>T4</td>
<td>4.3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>N factor</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>N0</td>
<td>91.2</td>
</tr>
<tr>
<td>N1</td>
<td>7.7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>M factor</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>M0</td>
<td>89.6</td>
</tr>
<tr>
<td>M1</td>
<td>10.5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Clinical Stage</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>58.3</td>
</tr>
<tr>
<td>II</td>
<td>16.1</td>
</tr>
<tr>
<td>III</td>
<td>11.2</td>
</tr>
<tr>
<td>IV</td>
<td>13.6</td>
</tr>
</tbody>
</table>

Over 70 = 57.5%
Over 65 = 79.7%

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. Cooperberg¹, Shiro Hinotsu², Mikio Namiki³, Peter R. Carroll¹, and Hideyuki Akaza⁴

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

## Agenda

### 1. WELCOME & INTRODUCTIONS

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>Presenter(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>10:00-10:10</td>
<td>Opening remarks</td>
<td>Hideyuki Akaza &amp; Peter Carroll</td>
</tr>
<tr>
<td>10:10-10:20</td>
<td>Introduction of attendees</td>
<td>All participants</td>
</tr>
</tbody>
</table>

### 2. KOREA

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>Presenter(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>10:30-11:35</td>
<td>1. Smart prostate cancer database system (SPC-DB)</td>
<td>In Young Choi</td>
</tr>
<tr>
<td></td>
<td>2. Comparison between androgen deprivation therapy and radical prostatectomy among prostate cancer patients at Seoul St. Mary’s Hospital</td>
<td>Ji Yool Lee</td>
</tr>
<tr>
<td></td>
<td>3. Determining the triggers for intervention among men undergoing active surveillance for prostate cancer</td>
<td>Yong Ho Chung</td>
</tr>
</tbody>
</table>

### 3. JAPAN

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>Presenter(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>11:35-12:30</td>
<td>1. J-CaP prospective observational study: Background factors of patients who have undergone radical prostatectomy or PAADT for their localized prostate cancer</td>
<td>Satoru Ueno</td>
</tr>
<tr>
<td></td>
<td>2. QOL surveillance for patients who underwent radical prostatectomy or PAADT (J-CaP study)</td>
<td>Satoru Ueno</td>
</tr>
<tr>
<td></td>
<td>3. Recent trends in initial therapy for newly-diagnosed prostate cancer (J-CaP surveillance)</td>
<td>Musaaki Onozawa</td>
</tr>
</tbody>
</table>

### 4. LUNCH

### 5. CHINA

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>Presenter(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>14:55-15:20</td>
<td>1. Comparative analysis of co-morbidity and other confounding factors in patients who have undergone radical prostatectomy or PAADT for their localized prostate cancer (CaPSURE data)</td>
<td>Matthew Cooperberg</td>
</tr>
<tr>
<td></td>
<td>3. Biomarker progress in the USA</td>
<td>Matthew Cooperberg</td>
</tr>
</tbody>
</table>

### 6. INDONESIA

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>Presenter(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>15:20-15:45</td>
<td>Plans for J-CaP</td>
<td>Raisa Umbas</td>
</tr>
</tbody>
</table>

### 7. OTHERS

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>Presenter(s)</th>
</tr>
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<tbody>
<tr>
<td>15:45-16:00</td>
<td>Reports from participating countries</td>
<td>All</td>
</tr>
</tbody>
</table>

### 8. CLOSING REMARKS

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>Presenter(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>16:00</td>
<td>Overall meeting summary and closing remarks from the Chairman</td>
<td>Hideyuki Akaza &amp; Peter Carroll</td>
</tr>
</tbody>
</table>
### 7th K-J-CaP and CaPSURE Joint Meeting
#### September 27th 2013, Incheon Seoul

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>Presenter(s)</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
<tr>
<td>10:10-10:20</td>
<td>Introduction of attendees</td>
<td>All participants</td>
</tr>
</tbody>
</table>

#### 1. COMPARATIVE ANALYSIS OF CONFOUNDING FACTORS IN PATIENTS WHO UNDERGO RADICAL PROSTATECTOMY AND PAADT FOR THEIR LOCALIZED PROSTATE CANCER(CaPSURE data)

1. Matthew Cooperberg (CaPSURE & J-CaP)
2. Shin Hinotsu (J-CaP)

#### 2. FURTHER CONSIDERATION OF THE REASON FOR THE DIFFERENCE IN PAADT OUTCOME DESCRIBED IN THE PAPERS COOPERBERG ET AL. TRANS-PACIFIC VARIATION IN OUTCOMES FOR MEN TREATED WITH PRIMARY ANDROGEN DEPRIVATION THERAPY FOR LOCALIZED PROSTATE CANCER. [Urol, 2013; 184(9): e297] (CaPSURE data)

1. Matthew Cooperberg (CaPSURE & J-CaP)
2. Shin Hinotsu (J-CaP)

### Attendees

(Photograph of attendees)

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>12:50-13:10</td>
<td>LUNCH</td>
</tr>
</tbody>
</table>
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.
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

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.

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

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"
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.
### A) Life Expectancy and Incidence of Prostate Cancer

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

*Age-standardized rates. **Crude incidence rate

Note: Data based on information as of December 2013 collected from the panelists.
### M) Healthcare Insurance System

<table>
<thead>
<tr>
<th>Country</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>China</td>
<td>There is national insurance and small portion of the population have private insurance.</td>
</tr>
<tr>
<td>Hong Kong</td>
<td>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.</td>
</tr>
<tr>
<td>India</td>
<td>Private healthcare care insurance system covers about 10% population. Government and semi government establishment employees are covered free healthcare. 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.</td>
</tr>
<tr>
<td>Indonesia</td>
<td>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.</td>
</tr>
<tr>
<td>Japan</td>
<td>There is a health-insurance system that covers all citizens. Private insurance is also widespread.</td>
</tr>
<tr>
<td>Korea</td>
<td>National health insurance covers all treatment related with prostate cancer. (But it does not cover robotic surgery. Only private insurances support this treatment.)</td>
</tr>
<tr>
<td>Malaysia</td>
<td>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.</td>
</tr>
<tr>
<td>Philippines</td>
<td>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.</td>
</tr>
<tr>
<td>Singapore</td>
<td>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.</td>
</tr>
<tr>
<td>Taiwan</td>
<td>We have National Health Insurance for every citizen, with a salary-based monthly premium to the government.</td>
</tr>
<tr>
<td>Thailand</td>
<td>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%</td>
</tr>
</tbody>
</table>
### N) Clinical Guidelines in Asia

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

<table>
<thead>
<tr>
<th>General</th>
<th>Treatment approaches</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Basic level</strong></td>
<td>Health education about risk factors for prostate cancer</td>
</tr>
<tr>
<td></td>
<td>Infrastructure to diagnose and treat the disease</td>
</tr>
<tr>
<td></td>
<td>Open surgery if expertise and resources available:</td>
</tr>
<tr>
<td></td>
<td>Surgical castration (for primary androgen deprivation)</td>
</tr>
<tr>
<td></td>
<td>Radical prostatectomy</td>
</tr>
<tr>
<td><strong>Limited Level</strong></td>
<td>Health education about risk factors for prostate cancer</td>
</tr>
<tr>
<td></td>
<td>Infrastructure to diagnose and treat the disease</td>
</tr>
<tr>
<td></td>
<td>Curative-aim therapy (open radical prostatectomy)</td>
</tr>
<tr>
<td></td>
<td>Primary androgen-deprivation therapy</td>
</tr>
<tr>
<td><strong>Enhanced Level</strong></td>
<td>Health education about risk factors for prostate cancer</td>
</tr>
<tr>
<td></td>
<td>Infrastructure to diagnose and treat the disease</td>
</tr>
<tr>
<td></td>
<td>Multidisciplinary team management facilities</td>
</tr>
<tr>
<td></td>
<td>Curative-aim therapy: radical prostatectomy (open or laparoscopic) with adjuvant or androgen-deprivation therapy as appropriate; radical radiotherapy, external charged-particle beam) approaches where available, and neoadjuvant or adjuvant deprivation therapy as appropriate; Active surveillance protocols; Primary androgen-deprivation therapy; PSA monitoring; Side-effect management (erectile dysfunction, continence, radiation proctitis; Survivorship programmes</td>
</tr>
<tr>
<td><strong>Maximum level</strong></td>
<td>Health education about risk factors for prostate cancer</td>
</tr>
<tr>
<td></td>
<td>Infrastructure to diagnose and treat the disease</td>
</tr>
<tr>
<td></td>
<td>Multidisciplinary team management facilities</td>
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<td></td>
<td>Survivorship programmes</td>
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<tr>
<td></td>
<td>Curative-aim therapy: radical prostatectomy (open or laparoscopic) with adjuvant or androgen-deprivation therapy as appropriate; radical radiotherapy, external charged-particle beam) approaches where available, and neoadjuvant or adjuvant deprivation therapy as appropriate; energy ablative therapy such as cryotherapy; 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</td>
</tr>
</tbody>
</table>

*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

<table>
<thead>
<tr>
<th>Health care resource category</th>
<th>General</th>
<th>Treatment approaches</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic level</td>
<td>Health education about risk factors for prostate cancer</td>
<td>Surgical castration</td>
</tr>
<tr>
<td>Limited level</td>
<td>Infrastructure to diagnosis and treatment</td>
<td>Radical prostatectomy</td>
</tr>
<tr>
<td>Enhanced level</td>
<td>Multidisciplinary team management</td>
<td>Curative –aim therapy</td>
</tr>
<tr>
<td>Maximum level</td>
<td>Survivorship program</td>
<td>PADT</td>
</tr>
</tbody>
</table>

- **Patients education**
- **Infrastructure to diagnosis and treatment**
- **Multidisciplinary team management**
- **Survivorship program**
- **Surgical castration**
- **Radical prostatectomy**
- **Curative –aim therapy**
- **PADT**
- **Laparoscopic surgery**
- **Radiation w/wo hormone**
- **PADT**
- **Active surveillance**
- **PSA monitoring**
- **Side-effect management**
- **Access to clinical trials**

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

Recent explosion in therapies for mRCC

Cytokines
- 1st reported active

80s
- HD IL-2 Ph II data
- FDA approval

90s
- VHL gene
- Histologies, clinical prognostic factors appreciated 2000

Adjuvant trials
- FDA approves:
  - 1) Sorafenib
  - 2) Sunitinib
  - 3) Temsirolimus
  - 4) Bevacizumab
  - 5) Everolimus

PD-1 ab 2015
- Pazopnib
- Axitinib

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

- Sorafenib vs Placebo
- Sunitinib vs IFN-α
- Pazopanib vs Placebo (treatment-naïve + cytokine-refractory)
- Pazopanib vs Placebo (treatment-naïve patients only)
- Bevacizumab + IFN-α vs IFN-α
- Temsirolimus vs IFN-α
- Everolimus vs Placebo

* 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?

Image removed due to copyright restrictions.

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 to 13:45 (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 andScientifically 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 China”
  Wang Yung, Chinese Anti-Cancer Association
WKC UHC Working Group (draft)

UHC Policy HRH development programme
By JICA, WKC

Nippon Initiative on UHC
Global Health WG (GOJ)

UHC International Symposium
Once/year

WKC UHC Working Group (Once/year)
(WHOHQ, WB, Harvard, Thailand, US...)

Innovation for Ageing & Population

Urban Health

Assistive Technologies

UHC

ICT

Health Systems; Community based models

Transformative Learning for HRH

Health care Financing

WKC UHC Japan team (Twice / year)
Hyogo P, Kobe City, Kobe G
MHLW, NIPH, JICA Academia
(Tokyo U, Osaka U, Kobe U, Hyogo U,
Kochi U...)

Research on models of UHC and Ageing in Japan and World

WHO HQ
WHO Regional Offices
WHO Collaborating Centres

JICA HQ and JICA Country offices
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

- Japan
- Korea
- China
- Exchange of lecturer
- Internet class
- Exchange forum
- Collaboration for the development of education materials
- Virtual platform: Exchange of knowledge and sharing of information
- Asia Cancer Forum
- ARO
- Korea & China
Disciplines Handling Cancer Issues

- Basic Research; Japan Cancer Association
- Clinical Research; Japanese Society of Clinical Oncology
- Patients’ advocacy
- Medical Sociology
- Medical Anthropology
- Regulatory Science
- Cross-boundary cancer studies

The activity is mainly done independently.

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

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

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

Japanese Journal of Clinical Oncology
http://jjco.oxfordjournals.org/

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

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


Interdisciplinary collaboration, from the view of Academia Yoshimi

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

How to establish Asia Cancer Barometer Sonoda

Socio-economical approach for UHC Fukuda

Economy & cancer therapy in Asia Kawai

Asian diplomacy & cancer Takemi

Present status of cancer clinical stud in Asia Nishiyama

Cancer study in Asia/ Basic &s Noda

Asia as a pharmaceutical market Nogimori

Patient- Family- Social condition: Kakizoe

Guideline

Ethics

Clinical decision

Evidence
1. Patient data
2. Basic, clinical, and epidemiologic research
3. Randomized trial
4. Systemic review

Patient/Physician factors
1. Culture
2. Personal values
3. Experience
4. Education

Constraints
1. Formal policies
2. Community standards
3. Time
4. Reimbursement

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?

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.