
White & Black
Blue
Joseph
1896 - 1971

NEJM 20131010

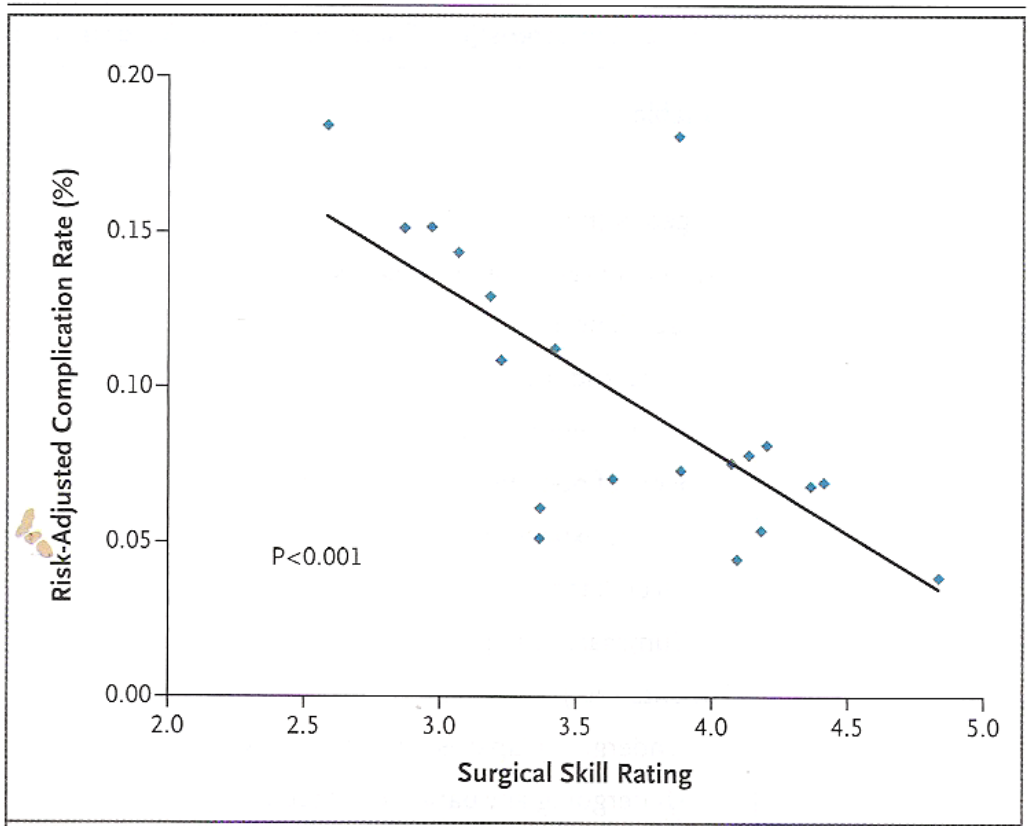
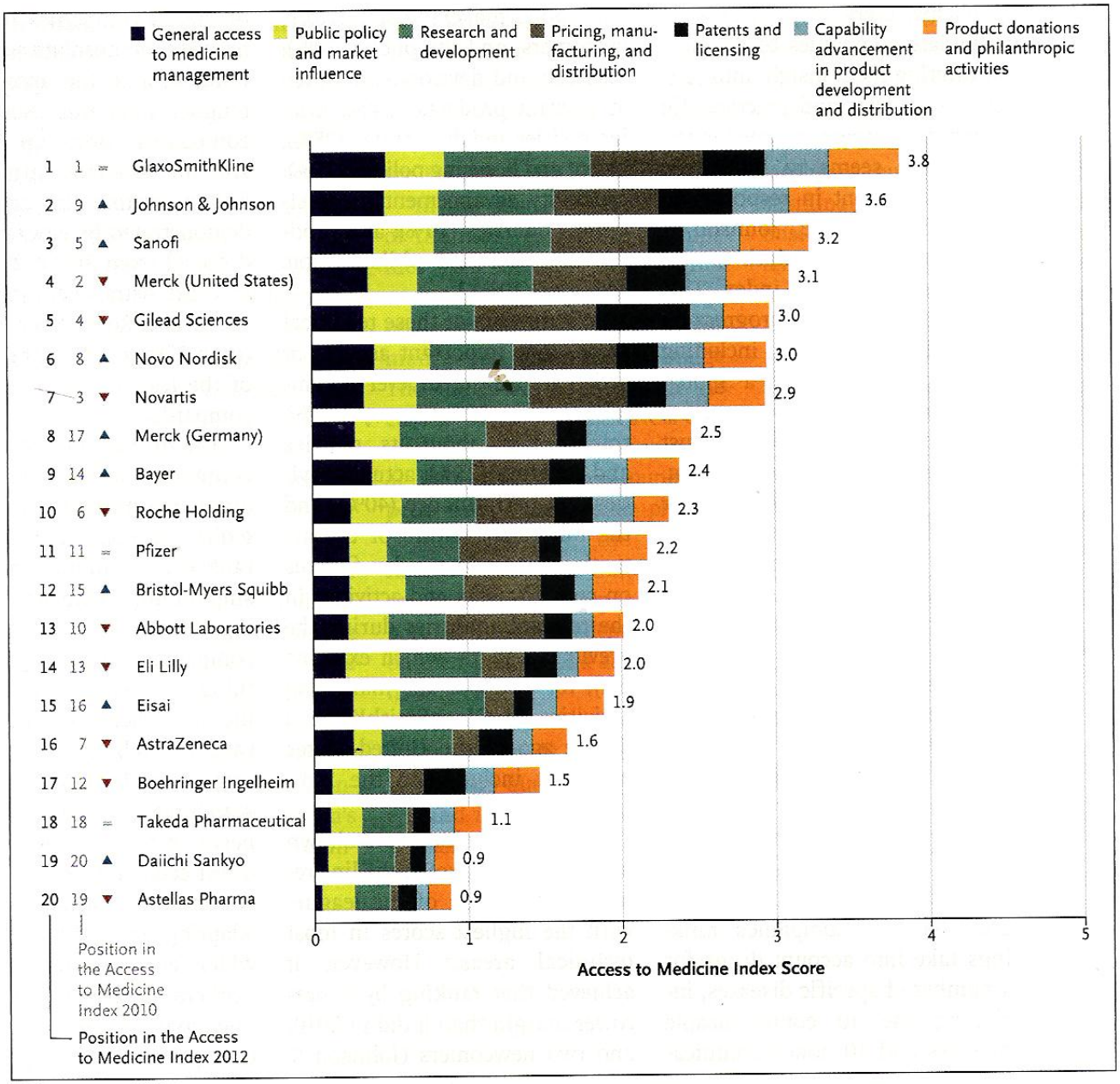


Figure 1. Relationship between Summary Peer Rating of Technical Skill and Risk-Adjusted Complication Rates after Laparoscopic Gastric Bypass.
Each diamond in the scatter plot represents 1 of 20 practicing bariatric surgeons.

(Fig. 1). The 5 surgeons in the bottom quartile

NEJM 20130905



Access to Medicine Index 2012 Rankings of the World's 20 Largest Research-Based Pharmaceutical Companies According to Their Efforts to Make Their Products More Available, Affordable, and Accessible in Developing Countries.

Company scores range from 0 (lowest) to 5 (highest) and are based on a weighted average of scores on 101 indicators. The indicators are divided into seven technical areas (shown in different colors); within each technical area, four aspects of implementation are measured.

Can England's NHS Survive?

Nicholas Black, M.D.

The past few months have witnessed the most intense and prolonged criticism of England's National Health Service (NHS) in its 65-year history. Some critics have suggested that the NHS faces a crisis that can be resolved only by altering the fundamental principle on which it was founded — provision of funding from general taxation, with care being free at the point of use. Although the criticism was sparked by a February report on an inquiry into shortcomings at one hospital,[1] the problems originated in 2010, when two profound forces were unleashed on the NHS: public-sector financial austerity and administrative reorganization. Together, these three factors have created the current turmoil.

Never before has the NHS had to cope with no increase in funding for a sustained period. With rising demand, the NHS is required to improve its productivity at an unprecedented rate of 4% per year.[2] The government is convinced that to achieve this improvement, two fundamental changes are needed.

The first concerns the local commissioning organizations that are responsible for purchasing hospital and community services for their geographically defined populations of 200,000 to 1 million people. The 151 existing administrative bodies called Primary Care Trusts, which were led by nonclinical managers, have been replaced by 212 Clinical Commissioning Groups that are led by primary care doctors (general practitioners [GPs]) who, the government believes, will be more effective in controlling the use of the £60 billion (approximately $90 billion) spent on secondary and community care services. (Spending on tertiary care — £20 billion [$30 billion] — will be managed at a national level by a new entity called NHS England.) The second means of achieving better productivity is by increasing the competition among providers of hospital and community services through the greater use of non-NHS providers (including private for-profit, not-for-profit, and charity or volunteer organizations).

Prolonged financial stringency and a reorganization were challenging enough without a high-profile report suggesting that NHS hospitals may not be safe.[1] The Francis Report on the inquiry into the Mid Staffordshire NHS Foundation Trust told a sad and troubling story of a hospital in which the humanity of care in some wards was appalling and in which the proportion of deaths deemed avoidable may have been higher than the 5% observed elsewhere in England and in other high-income countries. Despite uncertainty about the appropriateness of allowing public inquiries to influence policy,[3] the government has responded by announcing sever-

NEJM 20131017

The Thousand-Dollar Pap Smear

Cheryl Bettigole, M.D., M.P.H.

The first time a patient called me to say that she'd been billed more than $600 for her Pap smear, I was sure it was a mistake. The second time, I was less sure, and these days I am no longer surprised to find laboratory charges of $1,000 or more for a test that until recently cost only $20 or $30.

Cervical-cancer screening is one of the 20th century's true public health successes. The incidence of a disease that once caused more deaths among American women than any other form of cancer has decreased dramatically since the introduction of routine Pap smears in the 1970s. In the modern era, most deaths due to cervical cancer occur among women who have never been screened or who have gone decades without screening. One of the main factors in helping to conquer this once-dreaded disease has been the availability of a cheap, effective screening test that can detect disease early, while it's still very treatable. Yet increasingly, in my roles as the chief medical officer of a community health center and as a family

NEJM 20130718

Tobacco Use among Homeless People — Addressing the Neglected Addiction

Travis P. Baggett, M.D., M.P.H., Matthew L. Tobey, M.D., and Nancy A. Rigotti, M.D.

Although the prevalence of smoking in the United States has declined, vulnerable and marginalized groups continue to use tobacco at high rates. One such group is the 2.3 to 3.5 million people nationwide who are homeless in any given year. Approximately three quarters of homeless adults are cigarette smokers[1] — a prevalence 4 times that in the U.S. adult population and 2.5 times that among impoverished Americans in general. The coexisting psychiatric and addictive conditions and life circumstances of homeless smokers have long fueled a fatalistic attitude among health care professionals toward addressing tobacco use in this population. We believe that this approach should change.

Smoking-related deaths among homeless and marginally housed people occur at double the rate seen among more stably housed people and account for a considerable fraction of the absolute mortality disparities between these groups.[2] In our study of more than 28,000 adults seen at the Boston Health Care for the Homeless Program in 2003 through 2008, cancer was the second-leading cause of death overall and the leading killer among adults 45 years of age or older. Malignant neoplasms of the trachea, bronchus, and lung caused more than one third of these deaths, a finding that underscores the excess burden of lung-cancer mortality in this population that has been documented elsewhere.[2] Studies have also shown higher rates of death due to circulatory and respiratory diseases among homeless people than among people with homes.

A number of factors create challenges for reducing tobacco use and its consequences in this population. Homeless smokers have a high burden of nicotine dependence, psychiatric symptoms, and coexisting substance-use disorders.[3] They are more likely than homeless nonsmokers to have experienced physical or sexual trauma.[1] Many homeless people lack health insurance and a usual source of care, which limits their access to smoking-cessation therapies.

The circumstances of homelessness add to these barriers. Whereas most homeless shelters no longer permit smoking indoors, smoking around shelters is com-

NEJM 20130801

Toward Patient-Centered Drug Development in Oncology

Ethan Basch, M.D.

As an oncologist, when I sit with patients to discuss starting a new chemotherapy regimen, their first questions are often "How will it make me feel?" and "How did patients like me feel with this treatment?" Regrettably, this information is generally missing from U.S. drug labels and from published reports of clinical trials — the two information sources most commonly available to people trying to understand the clinical effects of cancer drugs.

In 2011, 15 hematology–oncology drugs were approved by the U.S. Food and Drug Administration (FDA). In only one case — that of ruxolitinib for the management of myelofibrosis — was symptom information included in the portion of the label that manufacturers can legally use for marketing purposes. In fact, ruxolitinib was the first cancer therapeutic in more than a decade for which symptom information was included in a U.S. drug label.

Cancer-drug labels stand in sharp contrast to labels for other types of drugs, about 25% of which list the drugs' effects on patients' symptoms or functioning.[1] That disparity is surprising, given how common symptoms and functional impairment are in patients with cancer and how toxic oncology drugs can be.

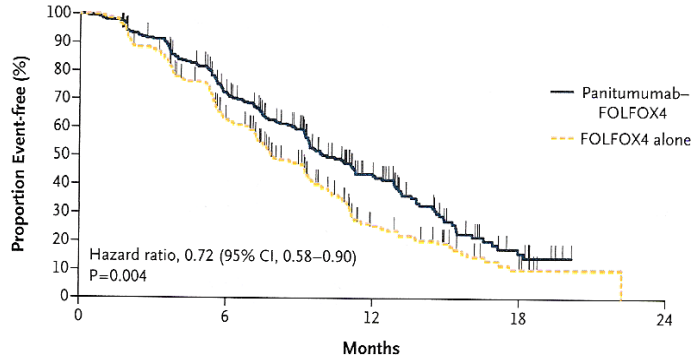
The FDA has taken several recent steps toward encouraging inclusion of the patient perspective in drug development. It issued highly influential guidance on the use of patient-reported outcomes (PROs) in drug development,[2] collaborated with the Critical Path Institute and industry to form the PRO Consortium with the aim of developing robust symptom-measurement tools, and obtained support from Congress in the fifth reauthorization of the Prescription Drug User Fee Act (PDUFA) to expand its internal expertise on the methodology of measuring PROs. (Unfortunately, allocated PDUFA funds have been withheld, which substantially impairs the FDA's ability to implement planned patient-centered programs.)

These FDA efforts are evident in the ruxolitinib label and in the label for abiraterone acetate, approved this year for metastatic prostate cancer, which describes beneficial delays in time to the development of pain and the need for opioid use. Yet in preapproval trials in patients with cancer, symptom or functional-status evaluations that meet the FDA's standards remain rare.

Some experts have argued that the FDA has raised the methodologic bar too high, whereas others accuse the pharmaceutical industry of paying too little attention to patients' experiences. The bottom line is that both regulators and industry continue to prioritize survival-based end points rather

NEJM 20130912

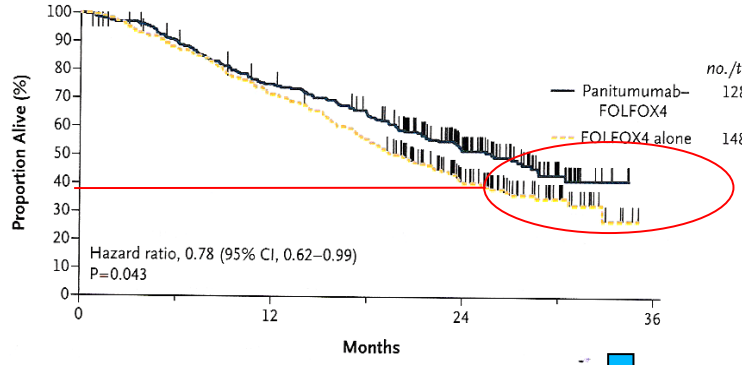
A Progression-free Survival in the Primary-Analysis Population



	Events no./total no. (%)	Median Mo (95% CI)
Panitumumab–FOLFOX4	156/259 (60)	10.1 (9.3–12.0)
FOLFOX4 alone	170/253 (67)	7.9 (7.2–9.3)

No. at Risk				
Panitumumab–FOLFOX4	259	171	65	10
FOLFOX4 alone	253	140	31	7

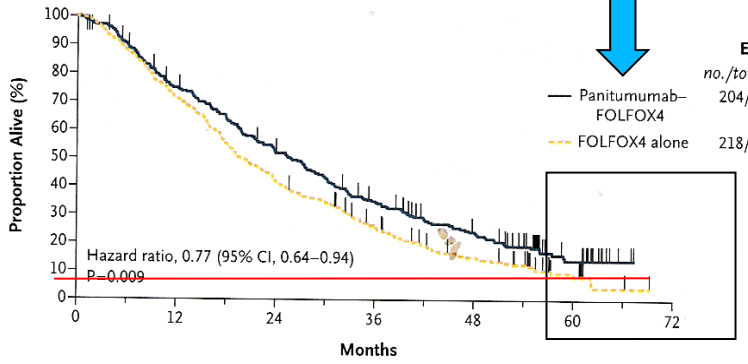
B Overall Survival in the Primary-Analysis Population



	Events no./total no. (%)	Median Mo (95% CI)
Panitumumab–FOLFOX4	128/259 (49)	26.0 (21.7–30.4)
FOLFOX4 alone	148/253 (58)	20.2 (17.7–23.1)

No. at Risk				
Panitumumab–FOLFOX4	259	189	88	0
FOLFOX4 alone	253	174	65	0

C Overall Survival in the Updated-Analysis Population



	Events no./total no. (%)	Median Mo (95% CI)
Panitumumab–FOLFOX4	204/259 (79)	25.8 (21.7–29.7)
FOLFOX4 alone	218/253 (86)	20.2 (17.6–23.6)

No. at Risk						
Panitumumab–FOLFOX4	259	189	129	83	49	14
FOLFOX4 alone	253	176	104	60	30	8

Figure 2. Kaplan–Meier Estimates of Progression-free Survival in the Primary-Analysis Population and Overall Survival in the Primary-Analysis and Updated-Analysis Populations, According to Treatment Group.

Elizabeth G. Phimister, Ph.D., *Editor*

Mapping the Journey to an HIV Vaccine

Margaret Ackerman, Ph.D., and Galit Alter, Ph.D.

"Universal" vaccines that elicit cross-reactive and broadly neutralizing antibodies (bNAbs) are the ultimate goal of efforts to provide protective immunity against both the influenza virus and the human immunodeficiency virus (HIV). Infection with either virus leads to the induction of abundant strain-specific antibodies that are easily evaded by subsequent viral variants. However, the circulating diversity of HIV is greater than that of influenza by orders of magnitude, posing a tremendous challenge to the achievement of vaccine-mediated protection.

New hope for a universal sterilizing HIV vaccine arose several years ago with the evidence that bNAbs emerge in 10 to 30% of infected persons.[1] Because these bNAb responses typically appear after 2 to 3 years of infection, they fail to control established infection: the kinetics of the evolving B-cell response lag behind the rapidly diversifying virus, and they cannot "catch up" to control established infection. However, these bNAbs have provided protection from infection at remarkably low doses in animals, suggesting that vaccine-induced bNAbs could provide sterilizing immunity if they were present before infection. Translating our current knowledge of bNAbs into a vaccine remains a daunting challenge, since the mechanism by which such antibodies are induced remains enigmatic.

As compared with other antibodies, bNAbs have unusual characteristics, including odd physical structures (e.g., elongated antigen-binding loops) and remarkably high levels of mutation

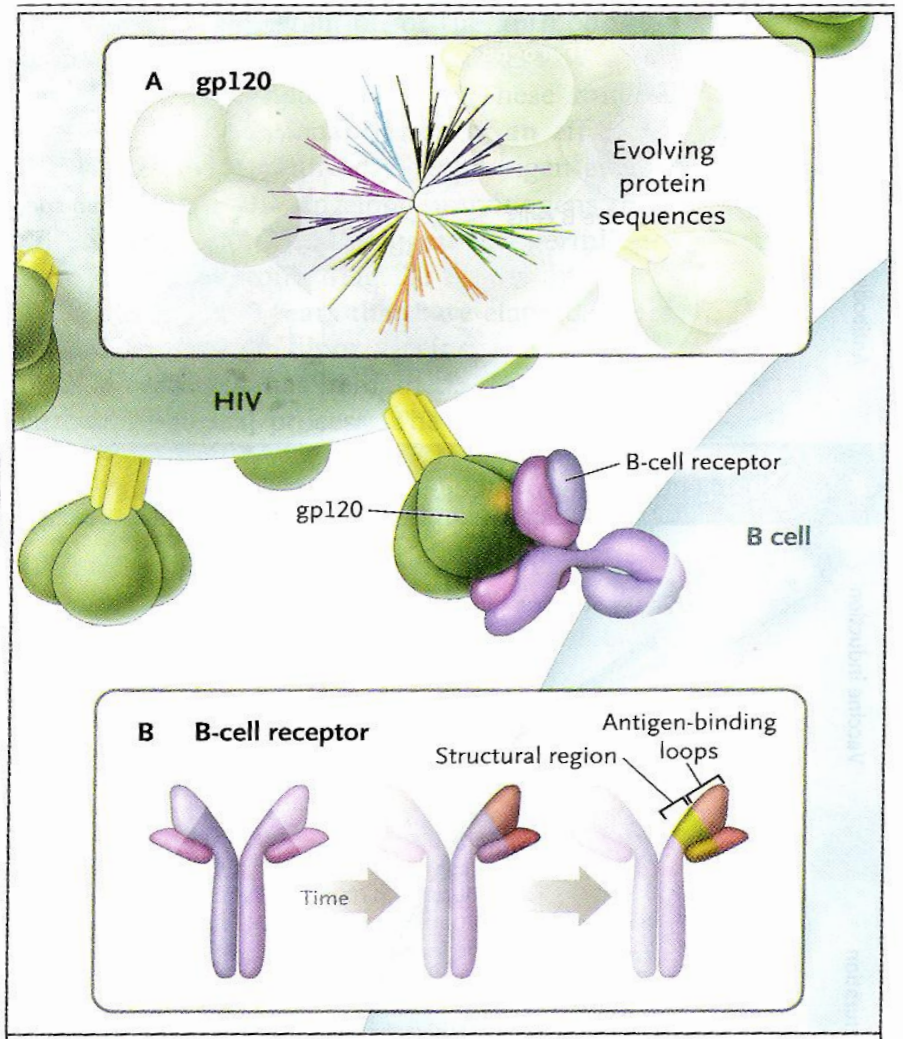
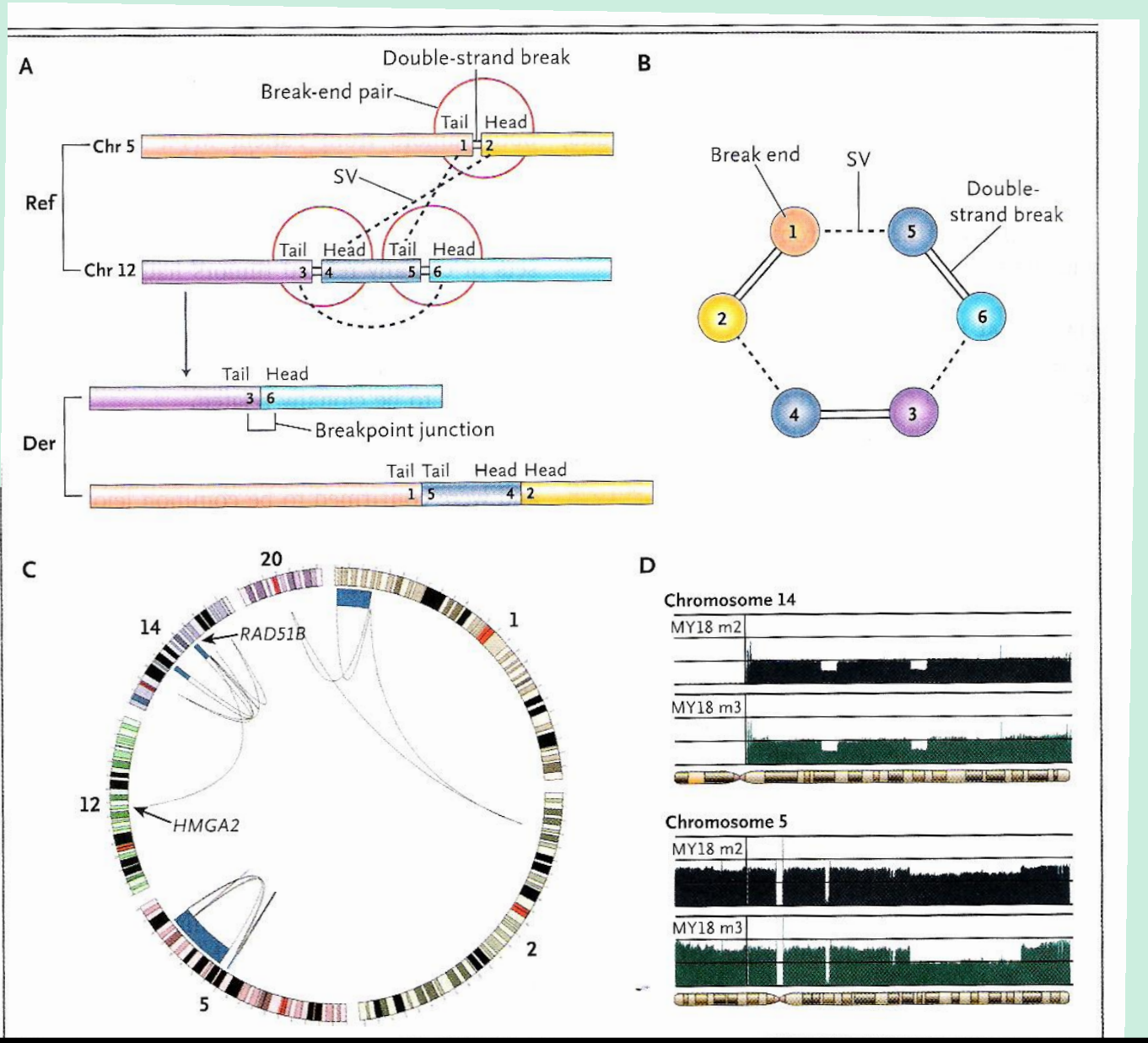


Figure 1. The Coevolution of Virus and Antibody.

Given that the B-cell receptor is simply a membrane-bound antibody, Liao et al.[3] hypothesized that the parallel sequencing of B-cell receptors and viral diversity could elucidate the interplay of host and pathogen, evasion and adaptation, that resulted in a broadly neutralizing antibody. Specifically, as the virus evolves (Panel A), so does the B-cell receptor (Panel B), resulting

NEJM 20130704



PEComa of the Gastrointestinal Tract

Clinicopathologic Study of 35 Cases With Evaluation of Prognostic Parameters

Leona A. Doyle, MD, Jason L. Hornick, MD, PhD, and Christopher D.M. Fletcher, MD, FRCPath

Abstract: Perivascular epithelioid cell tumors (PEComas) are distinctive mesenchymal neoplasms that most often arise in the retroperitoneum, visceral organs, and abdominopelvic sites and usually show reactivity for melanocytic and smooth muscle markers. Fewer than 20 PEComas of the gastrointestinal (GI) tract have been reported, and behavior and criteria for malignancy are incompletely defined. The purpose of this study was to examine the clinicopathologic features of a series of GI PEComas and to evaluate prognostic parameters. A total of 35 PEComas of the GI tract were retrieved from consult and surgical files. Clinical and pathologic features were evaluated, and immunohistochemical analysis was performed. Clinical follow-up information was obtained from medical records and referring physicians. Nineteen patients were female and 16 male (median age 45 y; range, 7 to 70 y). One patient had tuberous sclerosis. Nineteen tumors arose in the colon, 12 in the small bowel, 2 in the stomach, and 1 each in gallbladder and omentum. Median tumor size was 6.2 cm (range, 0.8 to 22 cm). Three tumors were limited to the mucosa and submucosa, 8 extended to the muscularis propria, 15 to the subserosa/serosa, and 8 into the mesentery. The tumors were composed of nests and sheets of usually epithelioid cells with abundant granular eosinophilic to clear cytoplasm, surrounded by a delicate capillary vasculature. Thirteen tumors had mixed epithelioid and spindle cell components, and 2 were purely spindled. Sixteen tumors showed marked nuclear atypia. Seventeen tumors contained occasional pleomorphic cells, and 12 showed diffuse cellular pleomorphism. The median mitotic rate was 2/10 HPF (range, 0 to 36). Vascular invasion was present in 5 cases, and 16 tumors showed necrosis. By immunohistochemistry, 23/35 were positive for HMB45, 23/34 for melan-A, 15/25 for MiTF, 20/35 for smooth muscle actin, 26/35 for desmin, and 3/20 for TFE3. Focal cytoplasmic S100 protein was present in 5/27 cases, 2/25 cases were positive for KIT, and 1 case each was positive for EMA and keratin. Follow-up information was available for 31 patients (median 36 mo; range, 2 to 176 mo). Thirteen patients have developed metastases (10 liver, 3 peritoneum, 4 lymph node, 3 lung, 1 bone, 1 brain, and 1 adrenal). Thus far, 5 patients have died of disease. Metastases were significantly associated with marked atypia, diffuse pleomorphism, and mitoses $\geq$2/10 HPF. In summary, PEComas of the GI tract occur at similar frequency in female and male patients, most commonly involve the colon, and exhibit variable clinical behavior, ranging from benign lesions to aggressive, high-grade sarcomas. The presence of marked nuclear atypia, diffuse pleomorphism, and mitotic activity are the strongest predictors of malignant behavior.

Key Words: soft tissue tumor, PEComa, sarcoma, immunohistochemistry, prognosis

(*Am J Surg Pathol* 2013;37:1769–1782)

The perivascular epithelioid cell tumor (PEComa) family of tumors represents a group of related mesenchymal neoplasms composed of perivascular epithelioid cells (PECs), which characteristically show immunohistochemical evidence of both smooth muscle and melanocytic differentiation.[1] There is no known normal tissue counterpart to the PEC. Tumors that are now recognized to belong to the PEComa family include angiomyolipoma of the kidney and liver, pulmonary lymphangioleiomyomatosis, and tumors previously classified as clear cell "sugar" tumor of the lung, extrapulmonary clear cell "sugar" tumor, and clear cell myomelanocytic tumor. PEComas have now been reported to arise at virtually any anatomic site, including gynecologic sites and urinary tracts and soft tissues of the extremities, skin, and bone.[2–6]

Renal angiomyolipoma and pulmonary lymphangioleiomyomatosis occur at increased frequency in patients with tuberous sclerosis complex (TSC). The clinical syndrome of TSC results from germline mutations in the tumor-suppressor genes *TSC1* or *TSC2*.[7] Sporadic angiomyolipomas and other tumors within the PEComa family not associated with TSC have also been found to

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review of the evidence, some of these, as discussed in detail below, were included as ICCR core elements, some were included as noncore/recommended elements, and some were not included as either core or noncore items.

The RCPA and RCPath protocols did not include any data elements for the pathologic reporting of lymph nodes in conjunction with primary cutaneous melanoma (presumably because lymph node specimens are not routinely received at the time of a primary cutaneous melanoma biopsy). Because the status of the regional lymph nodes is a key staging parameter in the current version (seventh edition) of the American Joint Committee on Cancer Staging (AJCC) System for cutaneous melanoma,[13–16] the review panel considered that, under the condition of receipt of lymph nodes in conjunction with a primary cutaneous melanoma, reporting of lymph nodes was a required reporting element. Further, it was recommended that if lymph nodes are NOT received, the data elements relating to lymph nodes should not be included in the pathology report (to avoid confusion, particularly in the minds of patients, who, upon reading the pathology report that states "Number of sentinel lymph nodes examined: zero," may question why lymph nodes had not been removed).

Finally, there were reporting elements that were not included as mandatory reporting elements in any of the national protocols that the panel considered had sufficient evidence (ie, at least NHMRC level III-2) to warrant inclusion as core items. In some instances, this may have occurred because there was not sufficient evidence to justify inclusion when the protocols were developed. For example, the presence of a desmoplastic melanoma (DM) component was not included as a mandatory reporting element in any of the protocols. However, the panel considered that there was now sufficient evidence to include this as a core/required element.

The definitions, consensus response values (permitted responses) and key evidence for each of the required and recommended data elements are briefly summarized below.

REQUIRED (CORE) ELEMENTS

General Clinical Data Elements

Apart from the standard information required for patient and treating clinician identification, the melanoma cancer review panel identified a number of clinical elements as required (core) data elements in the cutaneous melanoma pathology report: tumor site, specimen laterality, and specimen type (Table 2).

Tumor Site

Accurately identifying the anatomic site of the primary melanoma is important for a number of reasons. Sufficient information is required to localize the lesion for subsequent therapy. A diagram or photograph can facilitate this.[17,18] Further, when matched for other known prognostic factors, melanomas in the head and neck area, upper back, and axial skeleton have a worse

TABLE 2. Required (Core) Elements and Their Respective Response Values for the Cutaneous Melanoma Cancer Data Set

Data Element	Consensus Response Values
Tumor site	Not provided *Specify*
Specimen laterality	Not provided Left Right Midline
Specimen type	Not provided Excision Punch Incision Shave Curette Reexcision *Other (specify)*
Breslow thickness	Specify (numeric in mm)* At least (numeric in mm)* Indeterminate
In situ component: peripheral margin	Cannot be assessed Not involved by melanoma in situ Distance of melanoma in situ from closest margin *Specify location(s), if possible* Involved by melanoma in situ *Specify location(s), if possible*
Invasive component: peripheral margin	Cannot be assessed Not involved by invasive melanoma Distance of invasive melanoma from closest peripheral margin *Specify location(s), if possible* Involved by invasive melanoma *Specify location(s), if possible*
Invasive component: deep margin	Cannot be assessed Not involved by invasive melanoma Distance of invasive melanoma from margin *Specify location(s), if possible* Involved by invasive melanoma *Specify location(s), if possible*
Ulceration	Not identified Present Indeterminate
Mitotic rate	Numeric (/mm^2)
Lymphovascular invasion	Not identified Present Indeterminate
Neurotropism	Not identified Present Indeterminate
Satellites	Not identified Present Indeterminate
Satellites: margins	Cannot be assessed Not involved by satellite Involved by satellite
DM component	Not identified Present Pure— > 90% DM Mixed (desmoplastic/non-DM)
No. sentinel nodes examined†	Numeric
No. positive sentinel nodes†	Numeric
Total no. nodes examined (sentinel and nonsentinel)†	Numeric
Total no. positive nodes examined (sentinel and nonsentinel)†	Numeric
Primary tumor (T) (AJCC 7th edition)	AJCC pT value list


Serge Gainsbourg
1928 - 1991
Merci.
S+J
Olga et Joseph
Gainsbourg

Dr L. Alexandre

Nano Bio Informatique Cognitive....

NBIC

http://vimeo.com/8424976

Les gènes qui gênent..

https://www.youtube.com/watch?v=HPlHLAS4gCU

Force-Feeding, Autonomy, and the Public Interest

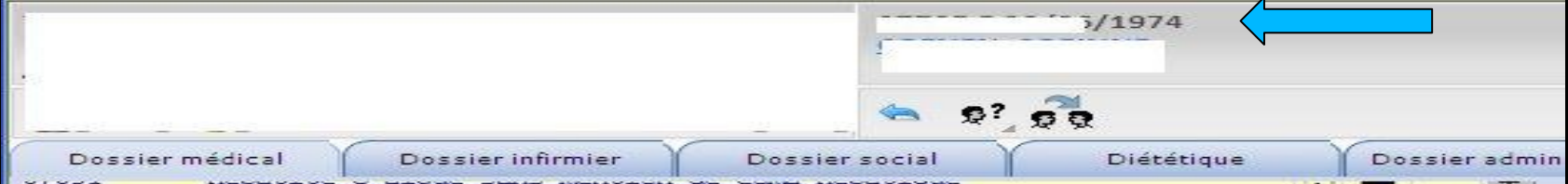
Michael L. Gross, Ph.D.

Hunger striking is a nonviolent act of political protest. It is not the expression of a wish to die, nor is it akin to the decision of a terminally ill patient to discontinue food and fluid intake. Rather, it is brinkmanship. Faced with hunger-striking detainees, prison authorities have three choices: force-feed the hunger strikers, let them die, or accede to their demands.

As the World Medical Association (WMA) suggests, most bioethicists unequivocally oppose force-feeding. Enteral feeding through a nasogastric tube while a detainee is strapped to a chair violates a mentally competent patient's right to refuse treatment and is physically violent.[1] The WMA is less categorical about artificially feeding unconscious or delirious hunger strikers through their abdominal wall. Under these circumstances, physicians may permissibly weigh their patient's best interests and prior expressions of intent before deciding about continued treatment.

Physicians who care for hunger-striking detainees weigh autonomy and best interests; rarely must they consider security interests. Local authorities, however, do not have this prerogative. Whereas bioethicists are keen to uphold autonomy and avoid force-feeding, public officials are bound to maintain public order and prevent the deaths of detainees. Those responsibilities leave officials only two choices: forced or artificial feeding, or accommodation. Accommodation deserves first consideration because it may be a reasonable choice. Faced with hunger-striking Palestinian detainees in 2012–2013, for example, Israeli officials satisfied some prisoners by improving prison conditions or modifying their prison terms. Similarly, the Turkish government met some hunger strikers' demands last year. In each case, the hunger strike ended. Strikers played their hands deftly, carefully choosing realistic aims and employing nonviolent protests to gain symbolic but important concessions. Local medical organizations also played a role: the Israeli Medical Association instructed its members to comply with WMA guidelines, thereby pushing public officials to earnestly explore accommodation.[2]

The situation at Guantanamo deserves similar creativity. The detainees' demands are not monolithic. Prisoners who are cleared for release require expedited repatriation, whereas others may be satisfied with customary legal proceedings, better prison con-



Dossier médical | Dossier infirmier | Dossier social | Diététique | Dossier admin

07051	Hépatite C aiguë sans mention de coma hépatique
07051	Hépatite C aiguë sans mention de coma hépatique
2819	Anémie par carence, sans autre précision
2819	Anémie par carence, sans autre précision
30400	Dépendance d'opiacés, nature non précisée
30401	Dépendance d'opiacés, continue
30403	Dépendance d'opiacés, en rémission
30403	Dépendance d'opiacés, en rémission
30431	Dépendance de cannabis, continue
3051	Abus de tabac, tabagisme
30511	Abus de tabac, tabagisme, continu
30583	Abus de médicament antidépresseur, en rémission
311	Troubles dépressifs, non classés ailleurs
311	Troubles dépressifs, non classés ailleurs
49120	Bronchite chronique obstructive, sans exacerbation
5070	Pneumonie par inhalation d'aliment ou de vomis ...
57420	Lithiase vésiculaire, sans cholécystite, sans ...
5758	Affection de la vésicule biliaire, autre
64761	Grossesse et maladie virale, autre, accouchée, ...
65551	Grossesse et intoxication médicamenteuse présu ...
78001	Coma
8912	Plaie de genou, jambe et cheville, avec lésion ...
9560	Traumatisme de nerf sciatique
9670	Intoxication par barbiturique
9670	Intoxication par barbiturique
9670	Intoxication par barbiturique
9679	Intoxication par sédatif et hypnotique, sans a ...
9690	Intoxication par antidépresseur
9694	Intoxication par tranquillisant à base de benz ...
E9501	Tentative de suicide par barbiturique

UK carers suffering due to lack of support

Carers Week 2013 10th – 16th June - Prepared to Care?
New research from Carers Week of over 2,100 carers has revealed that carers are being woefully let down by a lack of support when they first take on a caring role. The findings from the report, **Prepared to Care?** show that support is not being made available to new carers with often devastating consequences.
Released to coincide with the launch of Carers Week 2013, the findings show that **75% of carers were unprepared for all aspects of caring**. A further **81% of carers say they were not aware of the support available**[1] and **35% believe they were given the wrong advice about the support on offer**[2].

Impact of caring
The survey shows that carers often struggle to balance work and their caring responsibilities, with **45% of carers** saying they had to give up work.
The results also highlight how carers' physical, emotional and mental wellbeing can suffer. **61% of carers** have experienced depression and **nearly all carers surveyed (92%)** say they feel more stressed because of their caring role

http://www.carersuk.org/newsroom/item/3157-uk-carers-suffering-due-to-lack-of-support

Centraliser les cancers rares? OK, mais gare aux monopole

Environ 4.000 cancers sur les 62.000 qui surviennent chaque année en Belgique sont des formes rares. Le Centre fédéral d'Expertise des Soins de santé (KCE) préconise que la prise en charge de ces patients soit réservée à des centres spécialisés.

Jusqu'à présent, chaque hôpital qui possède un programme de soin en oncologie peut traiter tous les types de cancers, y compris les formes rares et complexes. Au risque de ne voir passer chaque année qu'un faible nombre de patients présentant ces pathologies et donc de ne pas développer suffisamment d'expertise. Séduisante sur le papier, cette proposition nécessite cependant de répondre à un certain nombre de questions préalables, estime **Isabelle Salmon,** docteur en médecine (ULB) spécialisée en anatomie pathologique, qui a participé à l'un des 14 groupes de travail mis en place par le KCE. A la tête du service d'anatomie pathologique de l'hôpital Erasme depuis 1999, elle estime *«important aussi d'exprimer le point de vue de la profession sur ce projet.»* Car pour elle, *«l'anatomie pathologique est le point d'entrée du diagnostic des cancers.»*

Qu'en pensez-vous, de ce projet?
Ce projet couvre toute la prise en charge des patients porteurs de cancers rares, du diagnostic au traitement. Il est clair qu'il y a un intérêt à regrouper les expertises pour les diagnostiquer et a fortiori pour soigner les patients tant sur le plan du coût que de la qualité des soins. Il faut évidemment avoir opéré ou soigné un nombre suffisant de patients porteurs de cancers rares pour être capable de le faire correctement. Je suis favorable, comme la majorité de mes confrères, à la création de réseaux d'experts en Belgique et s'étendant même en Europe. Mais il faut s'entendre sur le terme de centres de référence. Désigner des experts «uniques», c'est à dire un hôpital, fait apparaître un risque de monopole. Or, un monopole ne peut avoir que des conséquences négatives sur le plan intellectuel et sur le plan économique. Il faut aussi bien comprendre qu'en termes de diagnostic, un cancer rare ne s'identifie que par l'analyse anatomo-pathologique.

Vous n'êtes donc pas favorable à la constitution de centres d'expertise sur le principe «Un type de cancer = un hôpital»?
Non, certainement pas en ce qui concerne le diagnostic. Le KCE l'a bien compris en créant un groupe de travail constitué de pathologistes qui ont proposé une mise en commun des expertises des centres académiques tout en tenant compte des pathologistes généraux qui, sur le terrain, sont en première ligne. La tentation du monopole n'est pas absente. Certains centres revendiquent le monopole, comme par exemple celui des lymphomes rares. Or, la présentation clinique ne différencie pas ces patients de patients porteurs d'autres lymphomes. Si le pathologiste analysant la résection ganglionnaire n'y prête pas attention, ce cancer ne sera même pas considéré comme un lymphome rare ou, pire, pas comme un lymphome. Le pathologiste général joue un rôle primordial. L'expert n'intervient qu'après, à sa demande. N'avoir que quelques experts pour traiter tous les cas belges, ce n'est tout simplement pas possible!

Qu'est-ce qu'un cancer rare?
C'est une maladie dont on recense moins de 6 nouveaux cas par an pour 100.000 habitants. Mais il y a aussi les cancers complexes au sein d'un groupe de cancers non rares. Par exemple, un cancer chez la femme enceinte, c'est un cancer dont la prise en charge est difficile. L'optique est différente du cancer dont le diagnostic est rare et donc nécessite un avis collégial, une révision par des experts et des tests diagnostiques de plus en plus pointus et coûteux.

C'est très complexe?
Oui, car en cancérologie, le pathologiste est un des acteurs les plus importants du diagnostic. Il est pourtant peu connu et travaille dans l'ombre avec le radiologue, le chirurgien et l'oncologue. Quand le radiologue met en évidence une masse suspecte, une biopsie est réalisée. C'est l'analyse des cellules et des tissus qui permettront de poser le diagnostic de cancer. Il y a des milliers de cancers différents, des plus indolents aux plus agressifs, des plus fréquents au plus rares, le diagnostic peut donc prendre du temps et a un coût certain... C'est d'ailleurs quelque chose qu'il faut expliquer à la population: pourquoi les analyses prennent du temps.

> «N'avoir que quelques experts pour traiter tous les cas belges, ce n'est tout simplement pas possible!»
>
> **ISABELLE SALMON**
> CHEF DU SERVICE D'ANATOMIE PATHOLOGIQUE À ERASME

Il y a un volet «économies d'échelles» dans le projet du KCE?
Le KCE publie des guidelines pour le diagnostic et le traitement des cancers rares. Il suggère que l'on aura un meilleur diagnostic et un meilleur traitement tout en réalisant des économies dans le coût de traitement. Ces coûts sont énormes, tant au niveau du diagnostic, pour lequel des tests de plus en plus onéreux sont nécessaires, qu'au niveau des traitements de plus en plus sophistiqués. Il faut accepter que la médecine personnalisée, c'est-à-dire directement adaptée au patient, ait un coût. C'est à ce prix que la mortalité associée au cancer diminue dans nos pays. Ce coût est d'autant plus élevé pour les cancers rares. Car «rare» veut toujours dire «compliqué». Et la médecine évolue sans cesse.

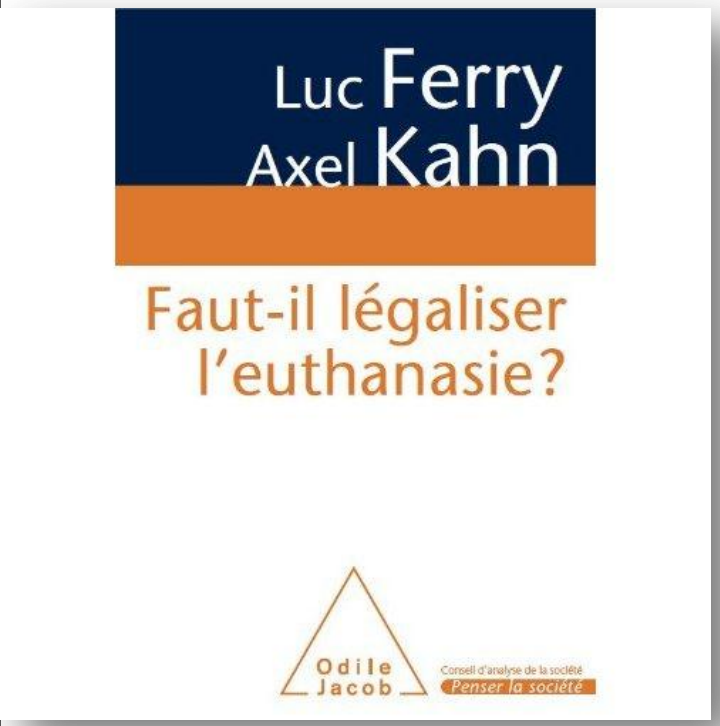
Il a aussi été décidé, en cas de diagnostic de cancer, de demander systématiquement un second avis médical. C'est plutôt une bonne chose pour le patient?
Oui, bien sûr, nous le faisons déjà, il suffit de structurer l'activité existante. Mais cela implique d'abord de résoudre quelques problèmes. Il y a de grands «vides» en Belgique. Les avis en seconde opinion ne sont pas remboursés, malgré un dossier déposé à l'Inami. Il m'arrive de passer plusieurs heures à revoir des cas envoyés par des collègues, ceci pro deo.

Il y a aussi un vide juridiqu
responsable du diagnost
Donc, il faut résoudre une
question: celle du rembou
et celle de la responsabilit
aussi que le patient compre
ce n'est pas parce que le
n'est pas capable d'effectue
nostic que l'on demande u
avis, mais parce que pou
complexes un diagnostic c
consensuel est garant de q

**Est-ce que c'est tout béné
les gros laboratoires?**
Pour les gros laboratoires,
culier les laboratoires acad
ce n'est pas un problème,
un petit labo, c'est plus d
faut être attentif au risque
développer une médecine
tesses. Il faut aussi que le
toires de plus petit volume
un rôle et une compétenc
diagnostic. L'anatomie
gique en Belgique, c'est 10
toires centraux. C'est b
Mais il faut bien se rendr
que les centres académ
pourront jamais absorbe
font les centres privés.

Un autre paramètre d
tenir compte, c'est la libert
du médecin en Belgique. S
tique une médecine à deu
le pathologiste général
première ligne sera de
moins apte à reconnaître
d'un cancer nécessitant u
tise de pointe. On a besoin
logistes généralistes.

PROPOS RECUE
MARTINE MAEL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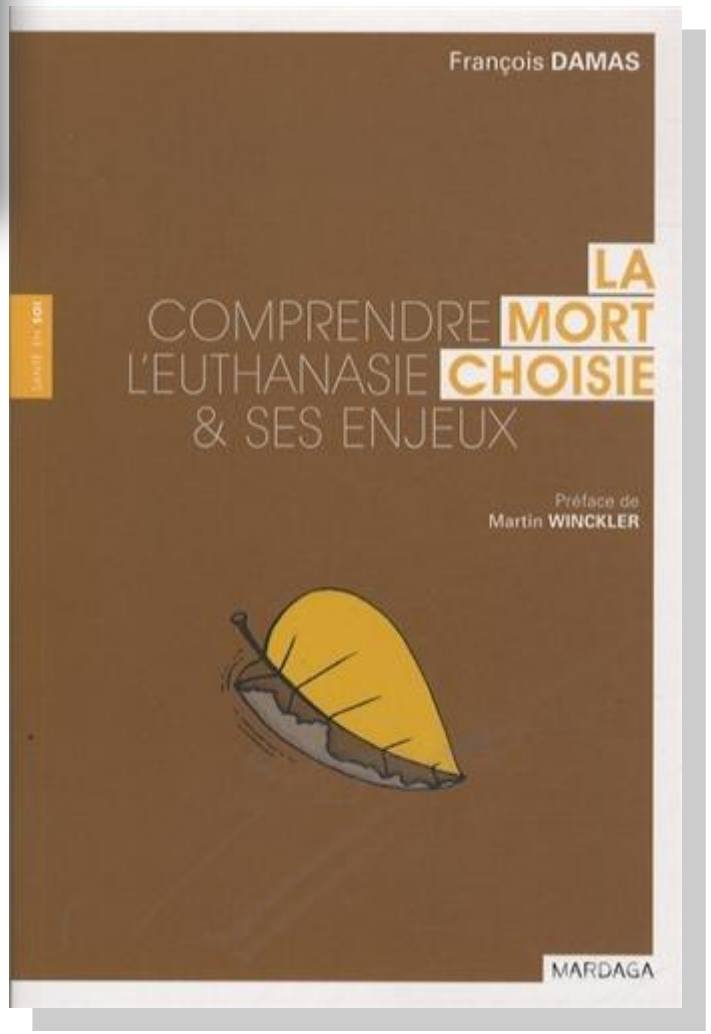
Penser la société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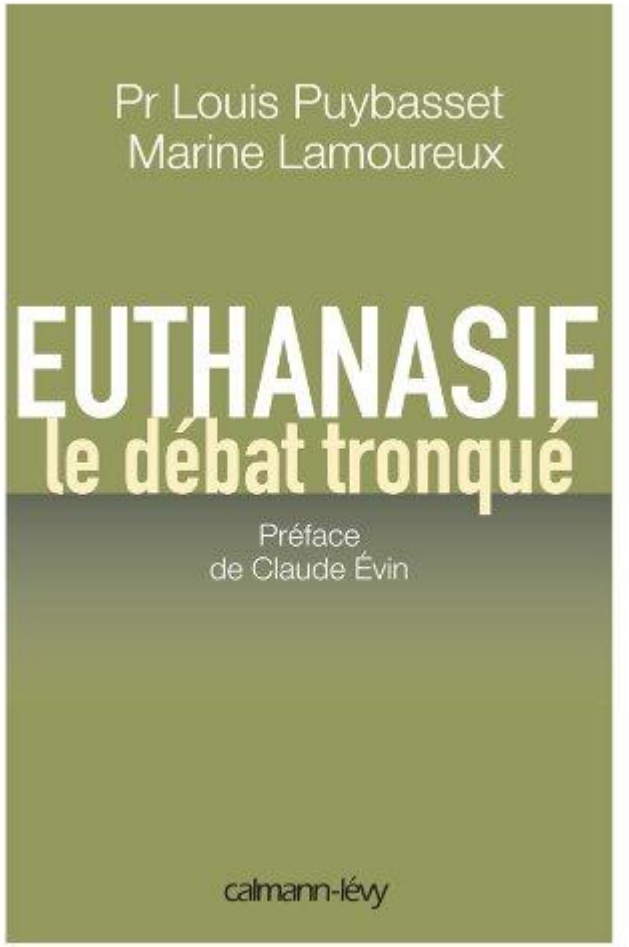
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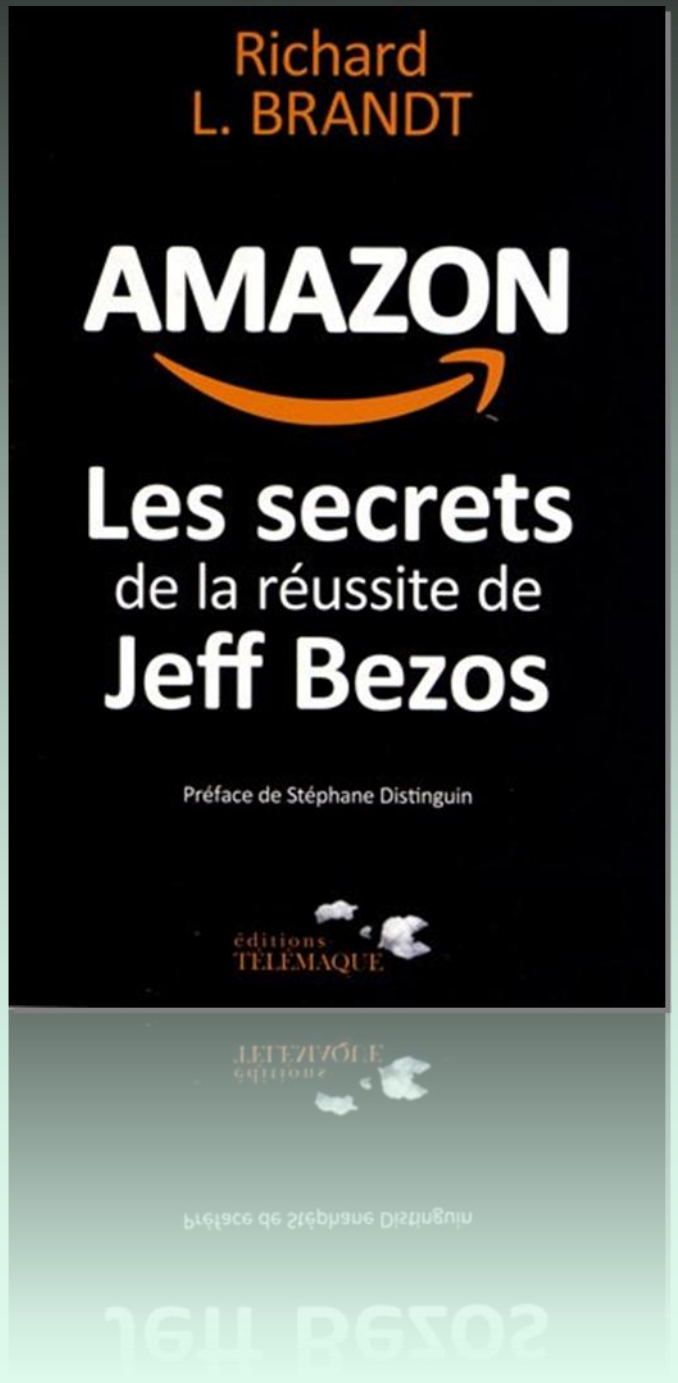
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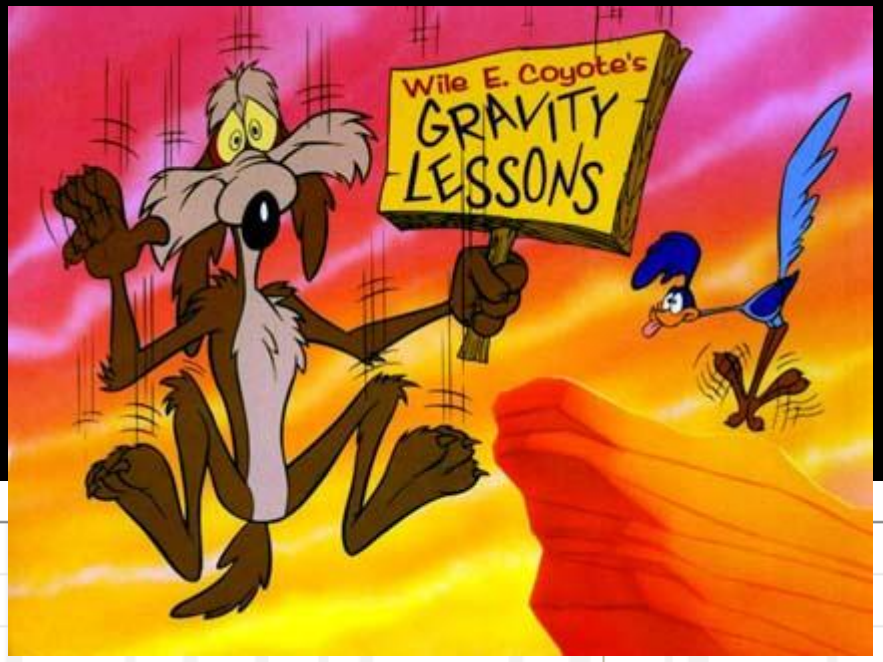
Wile E. Coyote's
GRAVITY
LESSONS

???


16000
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Dec-1948
Jun-1966
Jan-1976
Dec-1983
Jun-2001
Dow Jones Industrial Average - Level (Left)

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par vous

Avec: Wolfgang Amadeus Mozart, Alexander Stevenson, Daniel Barenboim, Ian Hobson, Johann Sebastian Bach, Various Artists, Franz Schubert, Murray Perahia

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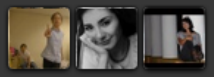
Abonnés



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	Titre	Artiste	Durée	Album	Ajouté	Par
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	Grande Messe en ut mineur, K. 427 : Et incarnatus est	Alexander Stevenson, B.	8:43	Mozart : Grande Messe ...	2013-04-07	Yves Couvreur
	Brahms : Ein deutsches Requiem Op.45 : II Denn all...	Daniel Barenboim	16:49	Brahms : Symphonies N...	2013-04-07	Yves Couvreur
	Variations On A Theme By Robert Schumann In F-S...	Ian Hobson	16:19	Brahms: The Complete ...	2013-04-07	Yves Couvreur
	The Well-Tempered Clavier, Book 2: Prelude and Fu...	Johann Sebastian Bach,	3:17	Bach: Das Wohltemperi...	2013-04-07	Yves Couvreur
	The Well-Tempered Clavier, Book 2, BWV 870 - 893...	Various Artists	2:48	Bach to Work - Classical...	2013-04-07	Yves Couvreur
	Schubert: Die schöne Müllerin, D.795 - 3. Halt!	Franz Schubert	1:34	Schubert: Lieder; Die sc...	2013-04-07	Yves Couvreur
	Schubert: Die schöne Müllerin, D.795 - 5. Am Feiera...	Franz Schubert	2:37	Schubert: Lieder; Die sc...	2013-04-07	Yves Couvreur
	Sonata for Piano in G minor, Op. 22: I. So rasch wie...	Murray Perahia	6:30	Schubert: Sonata in A ...	2013-04-07	Yves Couvreur
	No.1 Chorus I/II: "Kommt, ihr Töchter, helft mir klag...	Johann Sebastian Bach,	9:53	Bach: Matthäus-Passion	2013-04-07	Yves Couvreur
	Partita No. 2 in D Minor for Solo Violin, BWV 1004: ...	Johann Sebastian Bach,	15:55	100 Pieces of Classical ...	2013-04-07	Yves Couvreur
	He Shall Feed His Flock - Air	Adrian Boult, Orchestr...	5:56	Haendel: Messiah	2013-04-07	Yves Couvreur
	Clarinet Quintet in A K581: I. Allegro	Andrew Marriner, Chili...	9:15	Mozart Clarinet Concert...	2013-04-07	Yves Couvreur
	Piano Concerto No. 3, Bb 127: I. Allegretto	Bela Bartok, Budapest...	7:34	Bartók: Piano Concertos...	2013-04-07	Yves Couvreur
	W.A. Mozart: Don Giovani "Madamina..." (Leoprell) - ...	Wolfgang Amadeus M...	6:25	Arias and Songs for Bari...	2013-04-07	Yves Couvreur
	Die Zauberflöte, K.620, Act II: Alles fühlt der Liebe ...	Heinz Zednik, Sympho...	1:15	Mozart - Die Zauberflöte	2013-04-07	Yves Couvreur
	Fantasy in C Minor, KV 396: III. Finale. Allegretto	Edwin Fischer	7:44	Mozart: Piano Concert ...	2013-04-07	Yves Couvreur
	Er, Der Herrlichste Von Allen	Kathleen Ferrier, John...	3:16	Schumann: Frauenliebe ...	2013-04-07	Yves Couvreur
	Fantasie In C Minor/C Moll, KV 475	Dubravka Tomsic	13:24	Mozart: Piano Sonatas I...	2013-04-07	Yves Couvreur
	Hallelujah Chorus! For the Lord God Omnipotent Rei	Handel's Messiah	3:51	Hendel's Messiah	2013-04-07	Yves Couvreur
	String Quintet in C major, Op. 163, D. 956: I. Allegr...	Schubert-Quintett	19:42	Boccherini, L.: String Q...	2013-04-07	Yves Couvreur
	Berlioz: Symphonie funèbre et triomphale, Op.15 - 1...	Berlioz Hector, Londo...	17:20	Berlioz: Requiem; Symp...	2013-04-07	Yves Couvreur
	Piano Concerto No. 2 In G Minor, Op. 22: I. Andant...	Camille Saint-Saens, P...	12:27	Saint-saens: Symphony ...	2013-04-07	Yves Couvreur
	Images Set 1, No. 1: Reflections In The Water	Claude Debussy	6:02	Claude Debussy Plays Hi...	2013-04-07	Yves Couvreur
	Requiem: Requiem aeternam	Adriana Kucerova, Var...	3:11	Cimarosa: Requiem	2013-04-07	Yves Couvreur
	Piano Sonata No. 32 in C minor, Op. 111: I. Maestos	Claudio Arrau	8:49	Beethoven: Piano Sona	2013-04-07	Yves Couvreur

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55 abonnés
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Les playlists : Paparazzo Relaxes, Clemence, Tango teaching,...

Charly Choi a écouté

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Gothenburg Symphon...

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Transcriptions of O...
Antonio Pompa-Baldi

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Song Of The Seasons
Nicola Conte

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Substream
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Le Depart
Nicola Conte

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Carmen-Quadrille, ...
Mariss Jansons, Mariss...

Nelly Mentor a mis à jour **Sex Therapy**

Sugar
Wanderhouse
4:25

veejay2 a écouté

Serenade No. 13 in ...
London Philharmonic O...

1:10 2:28


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