To prevent is more cost-effective than to cure

Challenges in prostate cancer
Chris Bangma
Urologist (from heal to health)
Forms of prevention

• Primary = before it starts
• Secondary = it has started but you have not noticed yet....
Screening may lead to unnecessary overdetection....
78,000 men with Pca, 9/1000

In 2015 ongeveer 10,500 nieuwe gevallen van prostaatkanker
In 2015 zijn ongeveer 10.500 nieuwe gevallen van prostaatkanker vastgesteld (1,3 per 1.000 mannen). Boven de vijftig jaar neemt het aantal nieuwe patiënten met prostaatkanker sterk toe met de leeftijd (Bron: IKNL / NKR, voorlopige cijfers, februari 2016).

Prostaatkanker is meest voorkomende kanker bij mannen
Prostaatkanker is de meest voorkomende vorm van kanker bij mannen ouder dan 45 jaar. Van alle mannen die in 2015 kanker kregen, had 19% prostaatkanker.
More Pca related death in NL compared to southern Europe...
Prostate Cancer incidence in Asia

Prostate Cancer Incidence

<table>
<thead>
<tr>
<th>Region</th>
<th>Age-standardized rate per 100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australis/New Zealand</td>
<td>111,6</td>
</tr>
<tr>
<td>Northern America</td>
<td>97,2</td>
</tr>
<tr>
<td>West Europe</td>
<td>94,9</td>
</tr>
<tr>
<td>Northern Europe</td>
<td>85</td>
</tr>
<tr>
<td>Caribbean</td>
<td>79,8</td>
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<tr>
<td>South Africa</td>
<td>61,7</td>
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<tr>
<td>Southern Europe</td>
<td>58,6</td>
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<tr>
<td>Central and Eastern Europe</td>
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</tr>
<tr>
<td>Western Asia</td>
<td>28</td>
</tr>
<tr>
<td>South-Eastern Asia</td>
<td>11,2</td>
</tr>
<tr>
<td>Eastern Asia</td>
<td>10,5</td>
</tr>
<tr>
<td>South-Central Asia</td>
<td>4,5</td>
</tr>
</tbody>
</table>
Increase of incidence in all age groups world wide

Screening is part of the strategy increasing prostate health world wide
Variations....

• Genetic?
• Active screening by PSA?
• Food?
• Registration issues?
How to prevent prostate cancer?

• Cancer is a genetic disease
• Genetic mistakes > genetic repairs
• The cause of Pca is unknown
• Primary prevention is untargeted
• Observations on diet suggest a role in prevention
ERSPC screening \( \text{Pca} \)

- www.erspc.org

- Started in 1993, men aged 50-74 yr
- \( N = 162,388 \) men age 55-69 yr for mortality analysis
- Intervention, randomized
- PSA test and if elevated PSA (\( \geq 3.0 \text{ ng/ml} \)): a prostate biopsy
- Screening every 2/4 year up to age 70/74
- Reviewed cause of death
- 20-30 \% mortality reduction
- >50 \% reduction of metastases
It Ain’t What You Do, It’s the Way You Do It: Five Golden Rules for Transforming Prostate-Specific Antigen Screening

Andrew Vickers\textsuperscript{a,*}, Sigrid Carlsson\textsuperscript{b,c}, Vincent Laudone\textsuperscript{b}, Hans Lilja\textsuperscript{b,d,e}

Golden Rule 3: Don’t biopsy without a compelling reason

Now in app store: Rotterdam Prostate Cancer Risk Calculator
Pca screening is like a fire insurance: De Koning, 2013

• If all men (55-74 years old) are screened every year, they lengthen life on average **29 days**, but live on average 558 extra days knowing they have cancer
• 1 % of men screened and treated enjoy the benefit of living **8 years extra**
• 21 % of men screened have Pca, and have an extra 7 years of knowing they have Pca
• Fire insurance: everybody pays, everybody gains a bit, but some gain a lot
My dinner tonight.....

ProstaPizza ® ...or...

Cheaper ?
Prostate Cancer, Food and Lifestyle

New business models that enable health and empower patients and citizens

Inspire2Live Annual Congress, Amsterdam, 1 Feb 2017
Health Selfmanagement by patients: how the HEXIT works

Patients use food and lifestyle as meaningful Health Self management tools

Patients don’t feel taken serious, increasing mistrust of science & health sector

Patients recur to alternative sources of health wisdom

Doctors say: 'there is no evidence'

Patients: 'I do it nonetheless'
Cancer and prevention

Research shows: 30-50% of cancer is attributable to food and lifestyle (TNO studies)

Research suggests: a big impact of food and lifestyle on the incidence and recurrence of PCa (Kranse et al, 2015)
Savings are potentially tremendous

Chances of developing PCa for a Japanese man adopting a US Lifestyle is *4 times* higher than when adopting a Japanese lifestyle (Kranse et al, 2015)

Can we potentially reduce expenditures on PCa cure by a factor *4*?

Current PCa expenditures NL (2011): 254 million Euros
Let’s assume we can half the cost
**Potential savings at least 125 million Euros!**

( let alone the financial toxicity of PCa for the patients themselves (€ 6-12.000 / yr, early retirement etc – Gordon et al, 2015)

If this could be possible, why don’t we work harder to achieve it?

What, then, is the new business model that enables us to create this impact?
Coregroup of prostatecancer patients laying the foundation for the new foodpattern with PCa, jan 2016
To start with: a Multistakeholder challenge

**Patients**

- Does your product contain what you claim?
- Is your diagnosis / dietary advice reliable?
- Will you buy my product?
- Can you grow food with demonstrated health effects?
- Do you give food the position in health care it deserves?

**Biomedical Research/Care**

- Do you want to collaborate in our research?

**Food producers**
We need another approach

• Deadlock demands us to find a new approach
• Creating breakthroughs by answering all of the questions in one go
• With all stakeholder that acknowledge that holding on to their doubts if something is true, will work etcetera, doesn’t help anybody: not science, not patients, not food producers, not ....

• Living Lab ProstateCancer and Food
• Creates a different model to organise the learning cycle:
  • while taking tangible steps
  • while creating new knowledge
  • While developing business perspectives
  • While generating valuable stuff for patients (and patients to be...)

20
Living Lab: organic growth (1)

- Living Labs develop step-by-step, shockwise
- Number of influencing factors is big
- Continuous chess on multiple boards
- Pragmatic development is in place; striving for perfection is unproductive
- Precondition: keep a clear focus on the final goal
Living Lab: organic growth (2)

1. Biomedical research (formal and Citizen Science)
2. R&D on plant nutritional composition and growth protocols
3. Outreach to target groups
4. Patient / Customer feedback
5. Diversity of food- and lifestyle coaching strategies
6. Knowledge d’ment on Personalised Food
7. Ongoing d’ment of foodpattern for PCa
8. ....
A new fresh food basket for prostate cancer with special – 2017 research pilot in Almere
Living Lab Partnership Ecosysteem

‘I Choose My Food for My Health’

Core partners
• Erasmus MC (Prof. Chris Bangma) / ProstaatPartners
• Horticultural producers Westland – Vers+ (Rijk Zwaan, Koppert Cress, Best Fresh Group)
• Platform Patients and Food / Inspire2Live

Supporting partners
• Municipalities of Rotterdam, Almere
• Stichting Voeding Leeft (coaching expertise)
• InnovationQuarter / Ministery of Economic Affairs / Habitus (procesarchitects and network brokers)
• DRIFT (Dutch Research Institute For Transitions - Erasmus University)
• Some Universities of Applied Science
A transformative Business model

• We have a working mechanism to generate the appropriate knowledge and products

UT

• We need a transformative business model to get it working *fast*
Attitudes towards evidence and risk

**INSURERS**
- Formal evidence
- Risk avoidance

**CLINICIANS**
- Formal evidence
- Risk avoidance

**PATIENTS**
- ‘grey’ evidence
- Risk taking

**RESEARCH**
- Availability of funding
- Publication possibilities
- Reputation management
- Preference for RCT’s
- Risk avoidance

**BUSINESS**
- Market opportunities
  - Dependent on back-up of science / insurers
Goal of the working session

• What are the bottlenecks make progress to support self management by patients also in conditions where evidence is not 100%?
• What is needed to tackle these bottlenecks?
• How would this transformative bussinessmodel look like?
Thanks!

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