Background

Rare cancers are usually defined as those with an incidence of less than 6/100,000 per year, and together, account for approximately 22% of all cancer diagnoses worldwide\(^1\). This is higher than any single common cancer (breast 16%, lung 13%, colorectal 13%, prostate 12%). Yet, median survival for patients with rare cancers is typically poor and unlike most common cancers, is not improving\(^2\). One factor contributing to this is the lack of evidence upon which to base treatment. Research activity (both clinical and basic science) predominantly focusses on common cancers; industry prioritises cancers with the largest potential market and public sector funders generally prioritise those with the greatest clinical need\(^2\). Furthermore, organising and delivering adequately powered studies for a rare cancer requires sufficient patients to perform credible trials within a reasonable timescale - this can be unfeasible to achieve within a single country\(^2\). Consequently, there are limited treatment options for patients with rare cancers and access to innovative therapeutics is poor. This presents a major public health challenge.

In an attempt to address this unmet need, the International Rare Cancers Initiative (IRCI) was established in 2011. IRCI is a strategic partnership that was initiated between the National Institute for Health Research Clinical Research Network: Cancer (NIHR CRN: Cancer), Cancer Research UK (CRUK), the European Organisation for Research and Treatment of Cancer (EORTC) and the USA National Cancer Institute (NCI). The partnership has since grown with the inclusion of the French National Institute of Cancer (INCa) 2013, the Canada Clinical Trials Group (CCTG) in 2014 and the Clinical Oncology Society of Australia (COSA) in 2015.

Aims and Objectives of IRCI

The overall aim of IRCI is to stimulate and facilitate the development of international clinical trials for patients with rare cancers. The initiative is predominantly focused on developing interventional, randomised controlled trials (RCTs), with the ultimate goal of advancing the progress of novel treatments and improving outcomes for patients. International collaboration is critical to sharing knowledge and harnessing worldwide expertise in the rare cancer field. Importantly, working internationally also allows us to merge the accrual base of several organisations and countries, without which meaningful rare cancer clinical trials could not be performed.

In order to help achieve our aims, IRCI:

- Brings together international experts in rare cancers and member organisations, so that they have the capacity to perform clinical trials across boundaries
- Identifies and overcome barriers to development performance of international clinical trials in rare cancers, allowing them to run smoothly
• Encourages innovative trial methodology, maximising the potential to answer research questions in uncommon populations
• Provides a common voice for academic clinicians to approach industry for worldwide collaboration

The IRCI Partnership

Over the last 5 years, the IRCI partnership has grown considerably. The initiative now includes seven member organisations from across three continents (Figure 1). A memorandum of understanding (MoU) exists between partner organisations, to set out the terms for initiative and its activities. IRCI is governed by a Board of Directors, who function to oversee the partnership and provide strategic and scientific direction.

Figure 1: IRCI partner organisations

At the outset of the initiative, clinical communities associated with each founding partner organisation (CRUK, EORTC, NCI, NIHR CRN) were asked to identify rare cancers where there was enthusiasm for international collaboration and potential to design and develop an interventional study for which no RCTs already exist. For the purpose of IRCI, ‘rare’ has been broadly defined as an incidence of less than 2/100,000 per year (the initiative has not been focussed on looking at rare sub-sets of more common cancers). It was not possible to take forward every expression of interest, but where there was synergy between at least two partner organisations, rare cancer groups were formed.

From the initial nine groups formed in 2011, two groups (Anaplastic Thyroid Cancer and Fibrolamellar Hepatocellular Carcinoma) decided that there was no immediate role for an interventional trial and thus are no longer active. In 2013, two new groups were formed: Desmoplastic Small Round Cell Tumour (DSRCT) and Rare Brain Cancer. All nine groups are actively working to design, develop and set-up new clinical trials in their respective disease areas. To date, seven clinical trials have been funded, all of which are in various stages of progress (see IRCI Rare Cancer Groups and Trials).
Whilst IRCI do not provide direct funding for trials, research communities, partner organisations and other stakeholders work closely together and encourage and support international collaboration (Figure 2).

**Figure 2**: IRCI stakeholders

**IRCI Board Activities and Key Updates**

**Membership**
Since the last Progress Report, there have been a number of changes to the Board membership (Appendix 1). In 2015, the Board welcomed Professor Clare Scott from IRCI’s newest member organisation COSA. Members also welcomed Professor Pamela Kearns (CRUK’s Clinician Advisor), who replaced Nicola Keat and Kate Law (founding members, CRUK). More recently, members welcomed Dr Jacques Ropers who succeeded Dr Iris Pauporte as INCa representative. The Board would like to thank Ms Keat, Ms Law and Dr Pauporte for their contribution to the initiative.

**IRCI Board Meetings**
The Board continue to meet at least four times per year (with usually two face-to-face), where members discuss the overall progress and complex challenges associated with IRCI trials. Since the last report, the Board have convened four times via teleconference and held three face-to-face meetings alongside Association of Clinical Oncology (ASCO) Annual Meeting in Chicago (May 2015), the European Cancer Congress (ECC) in Vienna (September 2015) and again alongside ASCO 2016.
Expressions of Interests
As noted in the 3-year Progress Report, the IRCI Board received an expression of interest (EoI) from Poland with regard to joining the partnership. After careful consideration, it was decided that all IRCI members should represent a national network and have the necessary infrastructure in place to conduct clinical trials. As such, it was recommended that Poland were unable joint the partnership at present. The IRCI Board are also currently considering EoIs from the Poor Risk Germ Cell Tumours, Angioimmunoblastic T-cell Lymphoma and Malignant Histiocytosis research communities, with a view to establishing new working groups. However, as IRCI is at administrative capacity, careful consideration will be given to the resource required to maintain existing groups and supporting the formation of new groups.

IRCI Operational Working Group
In 2016, a new Operational Working Group (OWG) was established, consisting of trial co-ordinators and managers across the IRCI portfolio. The purpose of the group is to provide a forum to discuss the operational challenges associated with setting-up and running clinical trials. The OWG convened via teleconference in summer 2016, and will be tasked with developing a toolkit to provide step-by-step guidance to support new researchers with international collaboration. Members plan to hold a second teleconference late 2016 and would ideally like to hold one face-to-face meeting per year (alongside a major meeting e.g. ESMO).

Rare Cancer Genomics
The IRCI community held its first Rare Cancer Genomics Meeting alongside ASCO 2016. The purpose of the meeting was to initiate dialogue between IRCI Board, IRCI Groups Leads and Chief Investigators of diagnostic and clinical trial platforms promote upfront interest in characterisation of rare tumours and ultimately, the generation of clinical evidence to guide treatment of rare cancers. Dr Clare Scott (COSTA) has developed a proposal for ‘Access for rare Cancer Patients to Clinical Trials’ which proposes to ‘bolt-on’ rare cancer cohorts with known actionable mutations to existing platforms in common cancer, thus facilitating access to drugs for rare cancer patients. The proposal is currently being discussed with the NCI Genomic data Commons and FDA, and negotiations are underway with number of pharmaceutical companies.

IRCI Performance and Metrics
Mr Gaetan de Schaetzen (EORTC) has undertaken an important piece of work to analyse the set-up times for individual trials, with a view to developing performance metrics and identifying mechanisms to streamline the trial approval and set-up processes. This work was presented at the IRCI Board meeting alongside ASCO 2016. The analysis highlighted that there are long delays in opening trials to recruitment across the portfolio, and that there are multiple issues to address. Innovative trial designs that utilise a single protocol may in future be employed as a mechanism to help overcome issues with slow recruitment. A set of performance metrics and a strategy to address slow trial set-up and recruitment will be developed by the Board and key stakeholders over the coming months.

Mutual Recognition
The difficulties in obtaining approval and funding from partner organisations has been previously highlighted in the last IRCI Progress Report. In an attempt to address this, a meeting was held alongside ASCO 2016 between members of the Board and key representatives between NCI and CRUK. The purpose of the meeting was to explore aligning review processes and developing a sleek method whereby a study concept can undergo peer review. Whilst a single review is difficult to achieve, a tangible proposal has been put forward to obtain faster feedback for applicants at an earlier stage. This will be further developed at the next IRCI Board moving forward.
IRCI Rare Cancer Groups and Trials

There are currently nine IRCI groups, whose primary function is to design, develop and secure funding for rare cancer clinical trials. To date, six groups have developed and set up clinical trials. An overview of the IRCI rare cancer clinical trials portfolio can be found in Table 1.

**Metastatic Anal Cancer**
*Group Leads: Prof. Dirk Arnold, Dr Rob Glynne-Jones (UK), Prof. Al Benson (US)*
This group have developed the InterAAct study for patients with relapsed or metastatic anal disease, and recruitment the trial is progressing well. The study is open to recruitment in the UK, Europe, Australia and the US. The investigators have also obtained funding for the collection of samples and translational work associated with the trial. Successful meetings have taken place alongside ASCO 2015 and 2016, and GI ASCO 2016.

**Desmoplastic Small Round Cell Tumour**
*Group Leads: Prof. Winnette van der Graaf (EU), Prof. Jeremy Whelan (UK), Prof. Richard Gorlick (US)*
This group do not have any active trials at present. Members convened recently at ASCO 2016 to discuss ideas for a prospective interventional study. Whilst there was enthusiasm for developing a prospective study, limited funding opportunities, lack of an agents and time resource were considered to be factors hindering progress. The group also revisited the previously developed registry proposal (to collect demographic, clinical and outcome data from patients with DSRCT, with the overall objective of advancing the scientific knowledge base of this rare cancer and inform critical outstanding questions in the field). However, lack of viable funding options are stalling progress.

**Gynaecological sarcoma**
*Group Leads: Prof. Jean-Yves Blay (EU), Dr Charlotte Benson (UK), Dr Martee Henlsey (US)*
Dr Charlotte Benson has recently taken over from Helen Hatcher as UK lead. The Gynaecological Sarcoma group have developed two trials that have both opened to recruitment: HGUS and uLMS. The HGUS study is currently recruiting well across sites in Europe and the UK. However, NCI CTEP have recently requested early closure of the uLMS study due to ongoing concerns with poor patient accrual. The trial is now closed in the US, Europe and the UK. Since the last IRCI Progress Report, the group have held two face-to-face meetings at ASCO 2015 and 2016.

**Penile Cancer**
*Group Leads: Dr Christine Theodore (EU), Dr Steve Nicholson (UK), Dr Curtis Pettaway US)*
This group have developed the InPACT study: International Penile Advanced Cancer Trial. The trial not yet open to recruitment, but preparations for opening the study are progressing well, and the trial is expected to open in Q1 2017. The majority of potential centres identified so far are in the UK and North America. The EORTC GU group withdrew its support for this study which has contributed to a lower trial profile across Europe. However, individual European centres have expressed an interest and so this will be explored further. Members have convened via teleconference, and planning the next face-to-face meeting is underway.
Table 1: IRCI rare cancer trial description, study population, research question, recruitment and status.

<table>
<thead>
<tr>
<th>Rare Cancer Group</th>
<th>Trial name</th>
<th>Population</th>
<th>Research question</th>
<th>Recruitment (actual/target)</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Anal cancer</strong></td>
<td>InterAAct - A Phase II International Multicentre Randomized Advanced Anal Cancer Trial Comparing Cisplatin plus 5FU vs. Carboptatin plus Weekly Paclitaxel in Patients with Relapsed or Metastatic Disease</td>
<td>- Inoperable locally recurrent or metastatic squamous cell carcinoma of the anus (SCCA) - First line treatment</td>
<td>Cisplatin plus 5-FU versus carboplatin plus weekly paclitaxel</td>
<td>55/80</td>
<td>23 sites open to recruitment in UK and 1 in Norway. EORTC co-ordinating further sites across Europe. Sites to open in Australia.</td>
</tr>
<tr>
<td><strong>Gynaecological Sarcoma</strong></td>
<td>HGUS - A randomized phase II study evaluating the role of maintenance therapy with cabozantinib vs placebo in high grade uterine sarcoma (HGUS) after stabilization or response to CT following surgery or in metastatic 1-st line treatment</td>
<td>- High-grade uterine sarcoma - Locally advanced (stage III-IV) or residual disease after primary surgery (or metastatic - Non-progressive at end of standard chemotherapy</td>
<td>Maintenance cabozantinib versus not maintenance</td>
<td>16/54</td>
<td>Currently open to recruitment in 8 sites across Europe and in set-up phase in UK. Awaiting approval in US.</td>
</tr>
<tr>
<td><strong>Penile</strong></td>
<td>uLMS - A Phase III randomised trial of gemcitabine plus docetaxel followed by doxorubicin versus observation for uterus limited, high grade uterine leiomyosarcoma</td>
<td>- Uterine Leiomyosarcoma - Uterus-limited, High-grade</td>
<td>Adjuvant gemcitabine plus docetaxel followed by doxorubicin versus observation</td>
<td>37/218</td>
<td>388 sites open to recruitment in US. 6 sites open in UK. Sites open in Norway, France and Spain.</td>
</tr>
<tr>
<td><strong>Rare Melanoma</strong></td>
<td>InPACT - International Penile Advanced Cancer Trial</td>
<td>- Squamous carcinoma of the penis who have inguinal lymph node metastasis - No previous chemotherapy or chemoradiotherapy</td>
<td>1. Role of neo-adjuvant therapy and should it be chemotherapy or chemoradiotherapy 2. Role of prophylactic pelvic lumb node dissection (PLND) following ILND in patients at high risk of recurrence</td>
<td>0/400 (Study yet to open)</td>
<td>Trial received NCI approval in December 2015. Ethics and regulatory submissions underway in UK.</td>
</tr>
<tr>
<td><strong>Salivary Gland</strong></td>
<td>A randomised phase two-arm phase II study of trametinib alone and in combination with GSK214795 in patients with advanced uveal melanoma</td>
<td>- Uveal melanoma - Metastatic - No previous therapy for metastatic disease</td>
<td>Two experimental therapies evaluated: either trametinib 208 plus GSK2141795 (MEK and AKT inhibition) or trametinib alone (MEK inhibition)</td>
<td>tbc/80</td>
<td>Trial continued to interim stage only (US).</td>
</tr>
<tr>
<td><strong>Small Bowel Adenocarcinoma</strong></td>
<td>BALLAD - A Global study to evaluate the potential benefit of adjuvant chemotherapy for small bowel adenocarcinoma</td>
<td>- Small bowel adenocarcinoma - Stage I-III - Fully resected - Fit for adjuvant fluoropyrimidine-based chemotherapy</td>
<td>1. Adjuvant treatment versus conservative management where uncertainty of chemotherapy 2. Fluoropyrimidine ‘monotherapy’ versus fluoropyrimidine + Oxaliplatin where chemotherapy will be given</td>
<td>19/580</td>
<td>Opened to recruitment in UK. 7 sites open with a further 22 sites in set-up. International collaboration across Europe and South America being pursued.</td>
</tr>
</tbody>
</table>
Rare Brain

**Group Leads: Professor Wolfgang Wick (EU), Dr Colin Watts (UK), Dr Eva Galanis US**

This group do not currently have any active trials at present. The group made efforts to open an NCI approved anaplastic meningioma study in Europe, however this did not come to fruition as the NCI did not consider international collaboration necessary. The group were also in discussion around developing a trial for patients with Adult Medulloblastoma. Lack of funding continues to be of concern. The group last met alongside the Society for Neuro-Oncology (SNO) in 2014, and have not convened since the last IRCI Progress report.

Rare Melanoma

**Group Leads: Prof. Poulam Patel (EU), Dr Paul Nathan (UK), Dr Rich Carvajal US**

This group had previous developed randomized two-arm phase II clinical trial of trametinib alone or in combination with GSK2141795 in patients with advanced uveal melanoma. This study was the first of the IRCI trials to explore the feasibility and challenges associated with bringing a NCI CTEP sponsored clinical trial of two investigational agents into the international setting with one academic center as the international data coordinating center. Although a number of the challenges faced (including drug distribution and regulatory considerations) had been overcome, ultimately this trial was conducted in the US alone due to changes in the industrial landscape that occurred during the course of the study conduct. The trial is now closed to recruitment, and the results of the trial were presented at ASCO 2016.

This group have also performed some important retrospective work to help characterise the historical outcomes of patients with advanced uveal melanoma on prior clinical trials in an effort to develop benchmarks for clinical outcomes which can be used for the development of future clinical trials in this disease. To this end, a meta-analysis using individual patient level data from phase II clinical trials of patients with advanced uveal melanoma was conducted under the badging of IRCI, with the final results presented at ASCO 2016 and with a manuscript now in preparation.

Current and on-going efforts of this committee include the development of an international uveal melanoma registry, the discussion of potential uveal melanoma adjuvant therapy concepts and clinical trial designs, as well as the development of a randomized phase II clinical trial of neoadjuvant ipilimumab and nivolumab followed by adjuvant nivolumab versus placebo.

Salivary Gland Cancer

**Group Leads: Dr Lisa Licitre (EU), Prof. Kevin Harrington (UK), Dr Alan Ho US**

The group have developed a study for patients with recurrent and/or metastatic, androgen receptor expressing, salivary gland cancer. The trial is currently recruiting across several sites in Europe. However, the UK has experienced delays in obtaining the necessary regulatory approvals. The first UK site is expected to open Q2 2017. Members convened alongside ASCO 2015 and plan to hold a teleconference in autumn 2016.

Small Bowel Adenocarcinoma

**Group Leads: Professor Michel Ducreux (EU), Prof. Richard Wilson (UK), Dr Rob McWilliams (US)**

Prof. Michel Ducreux has recently succeeded Prof. Roth Arnaud as EU lead. This group have developed the BALLAD study, and recruited their first patient in February 2016. The study is open across UK and France and accrual rates continues to improve. The trial has been submitted for full funding in Japan by JCOG (with an outcome expected late 2016). The trial team continue to pursue other international collaborators including investigators across Europe and Central America.
Thymoma

Group Leads: Prof. Nicolas Girard (EU), Dr Mike Lind (UK), Prof. Frank Detterbeck

In 2015, Prof. Nicolas Girard succeeded Dr Sanjay Popat as EU lead for group. The Thymoma group had previously designed the PORT trial: a randomised phase 3 study of resected stage III Invasive thymoma with or without postoperative radiation therapy. The study was endorsed by ECOG but rejected by NCI, and as such, the group are yet to receive funding. However, investigators convened at both ASCO 2015 and 2016 meetings to discussing other potential trial ideas, including a first line randomised phase II of standard chemotherapy regimens to establish standard for first line treatment (with a view to establishing and international network and then building in a second line trial using a novel agent on relapse).

Priorities and Challenges for the Year Ahead

Despite successfully initiating a global platform for international rare cancer clinical research, IRCI faces several important challenges over the coming years. Firstly, bringing together researchers from multiple countries and organisations, achieving consensus and overcoming the regulatory and financial barriers, is a huge organisational challenge. Moreover, once investigators have agreed on a trial design, obtaining approval and funding from partner organisations can be a difficult and lengthy process. In some cases, a trial may be supported by one funder, only to be rejected by a partner organisation in another country. Mutual recognition and alignment of partner’s review processes (to help reduce the issue of double/triple jeopardy), and developing mechanisms to provide investigators with feedback at an earlier stage are therefore key priorities. High-level buy-in from IRCI partner organisations continues to be important in this regard.

Another key challenge is addressing the slow set-up times that are common to all IRCI trials. Once funding has been secured, study teams often face lengthy delays obtaining the necessary regulatory approvals and contract agreements, and as such, it can takes several months before the first site is open and the first patient recruited. Developing mechanisms (e.g. via the OWG) and establishing ways of working to streamline approval and set-up processes will be a top priority moving forwards.

Patient accrual to IRCI studies continues to be a major challenge. Many of the IRCI trials across the portfolio are subject to poor recruitment rates. There are many reasons for this. Firstly, because IRCI are conducting trials on a rare subset of a subset of patients, the patient pool is small and therefore study teams are always going to be at the extreme end of what is achievable in terms of accrual. Also, centres may be dis-incentivised from supporting trials in rare cancers if they feel that the financial and time resources required for set-up could be more fruitfully spent on common cancer trials which will recruit many patients. Furthermore, even with international collaboration, standard trial designs may require unfeasibly large recruitment targets for this setting, which calls for more innovative and pragmatic trial designs going forward. Developing initiatives to progress the development of umbrella/basket designs which allow patients with a wide variety of rare cancer types to be included in a single flexible trial protocol, may help to increase the number of patients accrued to a protocol at a single centre. In addition, appropriate PPI engagement and input at the development stage may help improve patient acceptability and thus enhance recruitment.

Increasing awareness and establishing greater recognition of ICRI continues to be a key priority. Improvements to the website, publication in high impact factor journals and sustained engagement with funding bodies and industry are all important in helping to overcome this challenge.
Understanding the biology of rare cancers will be important for making real advances for rare cancer patients. Many of the groups are already developing work packages beyond the design of trials, including registries, virtual biobanks and databases. However, there is a question around whether the remit of IRCI groups should be extended to include basic and translational research. Further consideration will need to be given to how sample collection and translational research is approached and funded, in order to learn as much as we can from rare cancer patients and inform future clinical trial development.

Finally, a major challenge is the lack of core funding and administrative resource to support the initiative. At present, there is no research funding body with sufficient global scope. The IRCI Board will continue to explore approaching governments, funding bodies and industry, with a view to establishing viable funding mechanisms to continue to support the initiative. Moving forward, further consideration will need to be given to the resource required to support the development of IRCI trials and formation of new rare cancer groups.

**Concluding remarks**

IRCI has successfully initiated a platform for global rare cancer research and will continue to act as conduit for engagement of the clinical research community, patients, advocates and key stakeholders. Whilst many challenges still remain, IRCI are committed to helping advance the progress of novel treatments and improve outcomes for rare cancer patients. Over the next 12 months, IRCI aims to build on its achievements to date, capitalise on existing relationships and develop a strategy to drive forward rare cancer research.
References


Appendix 1

Membership of the IRCI Board

Jeanne-Marie Bréchot (INCa)
The French National Cancer Institute, France

Professor Janet Dancy (CCTG)
Director, Clinical Translational Research, NCIC Clinical Trials Group, Canada

Dr Thomas Gross (NCI)
Deputy Director of Science, Center for Global Health, National Cancer Institute, USA

Professor Pamela Kearns (CRUK)
Professor of Clinical Paediatric Oncology in the Institute of Cancer and Genomic Sciences, University of Birmingham and Director of the Cancer Research UK (CRUK) Clinical Trials Unit, Clinical Advisor, CRUK, UK

Dr Denis Lacombe (EORTC)
Director General, EORTC, Belgium

Ms Anastassia Negrouk (EORTC)
Head of International Policy Office, Chair of EORTC IRB, Belgium

Professor Clare Scott (COSA)
Medical Oncologist at the Royal Melbourne Hospital and Laboratory Head at the Walter and Eliza Hall Institute of Medical Research, Member of the Clinical Oncology Society of Australia

Mr Gaetan de Schaetzen (EORTC)
Project Manager, EORTC, Belgium

Professor Matt Seymour (NIHR CRN)
Chair of Gastrointestinal Cancer Medicine & Honorary Consultant Medical Oncologist, University of Leeds, Director of NCRN (NIHR Cancer Research Network) and Clinical Research Director of NCRI (the National Cancer Research Institute), UK

Dr Ted Trimble (NCI)
Director, Center for Global Health, National Cancer Institute, USA

Dr Jack Welch (NCI)
Center for Global Health, National Cancer Institute, USA
Appendix 2

IRCI Trial Chief Investigators

Dr Sheela Rao (UK), Professor Cathy Eng (US), Professor Dirk Arnold (EU), Eva Segelov (Australia)
*InterAAcT: A Phase II International Multicentre Randomized Advanced Anal Cancer Trial Comparing Cisplatin plus 5FU vs. Carboplatin plus Weekly Paclitaxel in Patients with Relapsed or Metastatic Disease*

Prof. Isabelle Ray-Coquard (EU), Prof. Helena Earl (UK), Dr Martee Hensley (US),
*HGUS: A randomized phase II study evaluating the role of maintenance therapy with cabozantinib vs placebo in High Grade Uterine Sarcoma (HGUS) after stabilization or response to CT following surgery or in metastatic 1st-line treatment*

Dr Martee Hensley (US), Dr Helen Hatcher (UK), Jean Yves Blay (ES)
*uLMS: A phase III randomised trial of gemcitabine plus docetaxel followed by doxorubicin versus observation for uterus-limited, high grade uterine leiomyosarcoma*

Dr Steve Nicholson (UK), Dr Nick Watkins (UK), Dr Curtis Pettaway (US)
*InPACT: International Penile Advanced Cancer Trial*

Dr Rich Carvajal (US), Dr Ernie Marshall (UK), Dr Serge Leyvraz (EU)
*A randomised phase two-arm phase II study of Trametinib alone and in combination with GSK214795 in patients with advanced uveal melanoma*

Dr Lisa Licitra (EU), Professor Kevin Harrington (UK), Dr Alan Ho (US)
*A randomised phase II study to evaluate the efficacy and safety of chemotherapy vs. androgen deprivation therapy in patients with recurrent and/or metastatic, androgen receptor expressing, salivary gland cancer*

Professor Richard Wilson (UK), Prof Jeff Evans (UK), Dr Rob McWilliams (US), Dr Thomas Aparico (France), Prof. Kenichi Nakamura (Japan)
*BALLAD: A global study to evaluate the potential benefit of adjuvant chemotherapy for small bowel adenocarcinoma*