PEOPLE


Sanofi Corporate

Olivier Brandicourt, MD, began his role as CEO of the international drugmaker Sanofi on April 2. A 28-year veteran of the pharmaceutical industry, Brandicourt most recently served as chairman of the Board of Management of Bayer HealthCare AG. Prior to that, he held numerous positions of increasing responsibility within other global pharmaceutical companies, including Parke-Davis/Warner-Lambert and Pfizer, where he was a member of the executive leadership team from 2010–2013. After completing his medical degree, he practiced medicine for 2 years in the Congo and then spent several years researching malaria.


Jerry Cascciano

Rush D. Holt, PhD, became CEO of the American Association for the Advancement of Science and executive publisher of the *Science* family of journals in February, succeeding Alan I. Leshner, who had held the position for 13 years. Previously, Holt represented New Jersey's 12th District in the U.S. House of Representatives from 1999 until this past January. In addition, he has taught physics and public policy courses, worked as an arms control expert at the U.S. State Department, and served as assistant director of the Plasma Physics Laboratory at Princeton University.


NIH/NCATS

Mary L. (Nora) Disis, MD, became the editor-in-chief of the new journal *JAMA Oncology*, which was launched in February. A professor of medicine and associate dean of translational science at the University of Washington, Seattle, and a member of the Fred Hutchinson Cancer Research Center, Disis specializes in breast and ovarian cancer immunology and immunotherapy. She is one of a group of researchers who discovered that HER-2/neu is a tumor antigen. She and her research team are developing vaccines and other therapies that target specific antigens.

Lenvatinib Approved for Certain Thyroid Cancers

The FDA approved lenvatinib (Lenvima; Eisai), a tyrosine kinase inhibitor (TKI), to treat patients with progressive, differentiated thyroid cancer (DTC) that is refractory to treatment with radioactive iodine (RAI). The approval provides these patients with a second—and potentially more effective—therapeutic option.

The decision was based on findings from the phase III SELECT study, in which lenvatinib extended median progression-free survival (PFS) by 14.7 months compared with placebo in patients with RAI-resistant DTC. The findings, presented last spring at the American Society of Clinical Oncology's annual meeting, were published on February 12, the day before the FDA decision was announced (N Engl J Med 2015;372:621–30).

About 85% of the 60,000 cases of thyroid cancer diagnosed in the United States annually are DTCs. While many patients with DTC can be cured with surgery and RAI, about 10% of them do not respond to standard treatment and develop metastases, often to the liver, lungs, and bones.

"The efficacy of lenvatinib is much better than that of any other drug, and it should be the drug of choice for first-line treatment" of patients with advanced refractory thyroid cancer, says SELECT lead author Martin Schlumberger, MD, of the Institut Gustave Roussy in Villejuif, France.

The only other drug approved for these patients is sorafenib (Nexavar; Bayer and Onyx Pharmaceuticals), a TKI approved in 2013 based on results from the phase III DECISION trial. In that study, patients with RAI-refractory disease showed a 5-month improvement in median PFS compared with placebo (Lancet 2014;384:319–28).

Both drugs inhibit a range of molecular targets thought to be involved in aggressive thyroid cancer, including VEGFR1–3, PDGFR-ß, KIT, and RET. The SELECT study authors speculated that the longer PFS observed in the SELECT trial versus the DECISION trial could be due to the inhibition of unique targets of lenvatinib, including FGFR1–4.

The SELECT trial authors noted that neither *BRAF* nor *RAS* mutation status was predictive of response to lenvatinib and that further investigations into biomarkers of efficacy are needed. They also observed that the PFS benefit was maintained across all subgroups.

"Similar benefits were observed in treatment-naïve patients and those who received one other TKI," says Schlumberger, "demonstrating the absence of cross-resistance." ■

Cutbacks at England's Cancer Drugs Fund

In a controversial move, the Cancer Drugs Fund, which pays for a substantial share of cancer treatment in England, will stop covering 25 indications because they are too expensive.

The United Kingdom's National Health Service underwrites most cancer drugs in the country—to the tune of about £1.3 billion ($2 billion) per year. However, it won't pay for drugs that an independent organization, the National Institute for Health and Care Excellence, decides don't provide enough medical benefit for the cost. In 2010, the UK government allocated a supplementary pool of money, the Cancer Drugs Fund, so that patients could receive these costlier medications. Only patients in England, not the rest of the UK, are eligible.

The fund's price tag has exploded. Initially £200 million (about $300 million), it was projected to reach £420 million ($633 million) for the financial year that begins in April. To curb that growth, a committee of doctors, pharmacists, and patient advocates reassessed the fund's 84 approved indications and for the first time used price as a criterion for inclusion.

On January 12, the Cancer Drugs Fund announced the treatments it will no longer cover. Examples are eribulin (Halaven; Eisai Inc.), for metastatic or advanced breast cancer, and ziv-aflibercept (Zaltrap; Sanofi),

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Cancer Discovery 2015;5:338.