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Special Issue Featuring Original Articles and Conference Proceedings

Regional Oncology Conference | 13th GFFCC Annual Conference | Cancer: Reality and Challenges

Scientific Abstracts, Poster Presentations, Conference Recommendations and Highlights

The Official Journal of the Gulf Federation For Cancer Control

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Special Issue Featuring Original Articles and Conference Proceedings

Regional Oncology Conference 13th GFFCC Annual Conference Cancer: Reality and Challenges State of Kuwait

02–03 February 2026

This special issue includes original manuscripts followed by conference proceedings. The proceedings contain poster abstracts, speaker's presentation abstracts, and conference recommendations.

Laparoscopic Non–Ischemic Partial Nephrectomy: Case Report

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Objective:

Laparoscopic nephron sparing surgery is one of the surgical treatment for renal masses. The most important factor is intraoperative ischemia time for kidney function. We aimed to present a case of patient who were treated with laparoscopic non–ischemic nephron sparing surgery.

Methods:

A 71–year–old male patient presented with non specific symptoms. The ultrasonography showed 31*33 mm sized renal lesion in the left kidney. Contrast enhanced a bdomen computed tomography scan revealed 3 cm in diameter, located in the low pole of the left kidney (Fig.1) Laboratory tests showed increased kidney function as creatinine level was1.4 ng/ml. Based on the anatomical location and morphological characteristics of the lesion, nephron sparing surgery was planned.

The tumor was excised from the gerota fascia and prepared for the excision (Fig–2). The margins were cauterized using J–hook electrocautery about 0.5 cm from the mass. The tumoral mass was excised using laparoscopic scissors (Fig.–3).



Figure 1. Preoperative computed tomography image

Results:

The surgical procedure was completed with laparoscopic techniques. The surgical time was 65 minutes and mean blood loss was 200 cc. The hospital stay was 3 days.

Histopathological evaluation reported as papillary type renal cell carcinoma, and the surgical margin was negative. The creatinine level was 1.4 ng/ml during the postoperative period. The patient was free for metastasis and recurrence about three months from the surgery.

Conclusion:

Laparoscopic non–ischemic partial nephrectomy is safe and effective treatment for low–complexity renal masses. We suggest non–ischemic techniques for selected patients both the kidney function and low complication rates.



Figure 2. Laparoscopic image of the tumor

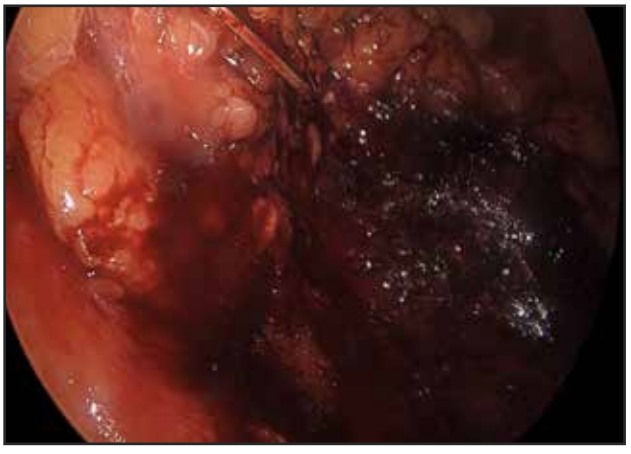


Figure 3. Post–excision tumor image

Pap Smear Cytology Screening Results in Aden Governmental Health Facilities, Yemen A Prospective Study (December 2024 November 2025)

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Background:

Cervical cancer is one of the most common cancers worldwide and remains a leading cause of morbidity and mortality among women.

Objectives:

This study aimed to determine the frequency of precancerous and cancerous cervical lesions and to identify the most affected age group among the screened population in Aden Governmental Health Facilities. An additional objective was to highlight the importance of routine Pap smear screening and to provide insights into the local epidemiological patterns of cervical pathology.

Methods:

In this prospective study, 1370 women underwent Pap smear screening at the National Cancer Control Foundation in Aden, Yemen, between December 2024 and November 2025. All Pap smear results were classified according to the Bethesda system.

Results:

Epithelial cell abnormalities were detected in 1351 of the 1370 Pap Smear. The highest proportion of abnormal cells was observed in women aged 40–31 year followed by aged 50–41 years and then 30–21 years. Specific cytopathological findings notably of premalignant lesions which include ASCUS–H, HISIL and LSIL. Malignant findings associated with Adenocarcinoma, Adenocarcinoma In Situ and Squamous Cell Carcinoma correlated with aged in women over 50 years. Inflammatory changes were the most abnormal findings. Data were entered into a secure database and analyzed using Statistical Software, SPSS version 26.0, R statistical software.

Conclusion:

Pap smear screening is a simple, inexpensive, practical, and effective method for early detection of cervical cancer. Its routine use can significantly reduce cervical cancer–related morbidity and mortality.

Influence Relationship Between Social Support, Coping Strategies, Spirituality and Psychological Factors Among Breast Cancer Survivors

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Background:

Breast cancer is the most commonly diagnosed cancer among women worldwide and is associated with substantial psychological and social challenges that extend beyond physical illness. Understanding factors that protect psychological well–being among survivors remains essential.

Objective:

To examine the role of perceived social support, coping strategies, and spirituality in psychological well–being among breast cancer survivors.

Methods:

A descriptive cross–sectional study was conducted among 104 female breast cancer survivors attending governmental oncology clinics at Salmaniya Medical Complex, Bahrain. Data were collected using the Multidimensional Scale of Perceived Social Support, Brief COPE Inventory, Spiritual Involvement and Beliefs Scale, and the Depression Anxiety Stress Scale–10.

Results:

Perceived social support differed significantly by source, with support from significant others and family being higher than support from friends ($p < 0.05$). Problem–focused coping was used significantly more than emotion–focused and avoidant coping strategies ($p < 0.05$), while religious coping showed the highest mean score, consistent with high levels of spirituality. Participants demonstrated moderate psychological distress, with anxiety–stress levels significantly exceeding depression. Younger (<40 years) and unemployed women reported significantly higher levels of psychological distress ($p < 0.05$). Correlation analyses revealed significant positive associations between social support and coping ($r = 0.564$, $p < 0.001$) and between social support and spirituality ($r = 0.306$, $p = 0.002$). Social support was significantly and negatively correlated with psychological distress ($r = –0.401$, $p < 0.001$). Additionally, coping strategies were positively associated with spirituality ($r = 0.414$, $p < 0.001$), and both coping and spirituality demonstrated significant inverse relationships with psychological distress (coping: $r = –0.501$; spirituality: $r = –0.452$).

Conclusion:

Significant interrelationships exist among social support, coping strategies, spirituality, and psychological distress, highlighting their protective roles in promoting psychological well–being among breast cancer survivors.

Low Dose Dasatinib is Effective and Safe in Patients with Chronic Myeloid Leukemia, Chronic phase (CML–CP). Kuwait Cancer Control Center Experience

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Introduction:

Dasatinib is an effective BCR–ABL1 inhibitor for chronic–phase CML, but the standard 100 mg daily dose is linked to toxicities. Emerging evidence suggests that 50 mg daily may offer comparable efficacy with better tolerability. This study compares long–term efficacy and safety outcomes between the 50 mg and 100 mg regimens.

Method:

A retrospective chart review for patients with CML–CP treated at Kuwait Cancer Control Center (KCCC) with dasatinib 50mg and 100mg daily. Eligibility and response criteria were consistent with previously established protocols.

Result:

After a minimum follow–up of 12 months (median follow–up: 42 months), A total of 67 patients with CML–CP treated with dasatinib. Baseline characteristics are seen in table 1. Twenty–four patients in the 100 mg group and 43 in the 50 mg group were evaluable. The rates of BCR::ABL1 transcript levels (International Standard) of ≤10% and ≤1% at 3 months were 95% and 62.5% for the 100 mg group, and 95% and 65% for the 50 mg group, respectively. The cumulative rates of complete cytogenetic response (CCyR) by 6 and 12 months were 88% and 91% for 100 mg, and 93% and 94.8% for 50 mg. The cumulative rates for major molecular response (MMR), molecular response with a 4.0–log reduction (MR4) and 4.5–log reduction (MR4.5) by 12 months were 69.5%, 57%, and 43% for 100 mg, and 92.3%, 66.6%, and 33.3% for 50 mg, respectively.

During the study, 6 patients (8.2%) developed pleural effusions (n=4 in the 100mg group while n=2 in the 50 mg group), and 1 patient (1.3%, while on 100mg daily, of note the patient was not compliant) experienced disease transformation during treatment. Additionally, 10 patients

Characteristic	D100 (n=24)	D50 (n=43)	p value	Relative risk (95% CI)
Male, n	18	20		
Age, median (range), years	46 (20–64)	38 (17–70)		
Sokal risk, n (%)				
Low	11 (46%)	20 (47%)		
Intermediate	7 (29%)	16 (37%)		
High	6 (25%)	7 (16%)		
ELTS risk, n (%)				
Low	13 (54%)	33 (77%)		
Intermediate	7 (29%)	4 (9%)		
High	4 (17%)	6 (14%)		
Efficacy outcomes of Dasatinib at 100mg and 50 mg daily dose				
CHR at 3 mons, n (%)	24/24 (100%)	43/43 (100%)	1	1 (1)
qPCR ≤10% at 3 mons, n (%)	19/20 (95.0%)	38/41 (95%)	0.93	1.0 (0.89–1.11)
qPCR ≤1% at 3 mons, n (%)	15/24 (62.5%)	28/43 (65%)	0.83	1.04 (0.68–1.58)
CCyR at 6 mons, n (%)	20/24 (88%)	40/43 (93.0%)	0.45	1.06 (0.88–1.28)
CCyR at 12 mons, n (%)	21/23 (91%)	37/39 (94.8%)	0.89	0.99 (0.84–1.17)
MMR at 12 mons, n (%)	16/23 (69.5%)	36/39 (92.3%)	0.59	1.12 (0.73–1.72)
MR4 at 12 mons, n (%)	13/23 (57%)	19/39 (66.3%)		
MR4.5 at 12 mons, n (%)	10/23 (43%)	13/39 (33.3%)	0.35	0.73 (0.38–1.39)

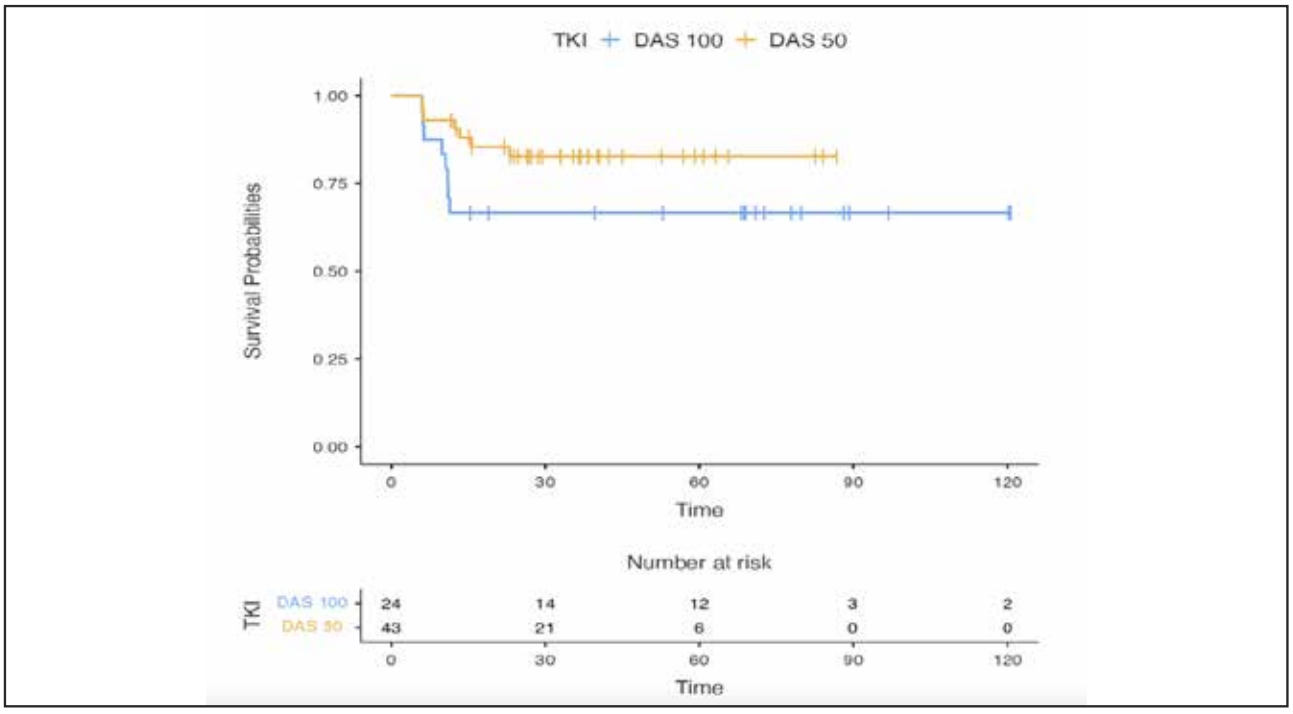
(13.7%, n=4 in the 100mg, n=6 in the 50mg) were able to be offered a trial of treatment–free remission (TFR), of whom 4 patients (40%, 2 pts in each group) experienced molecular relapse and required re– initiation of therapy.

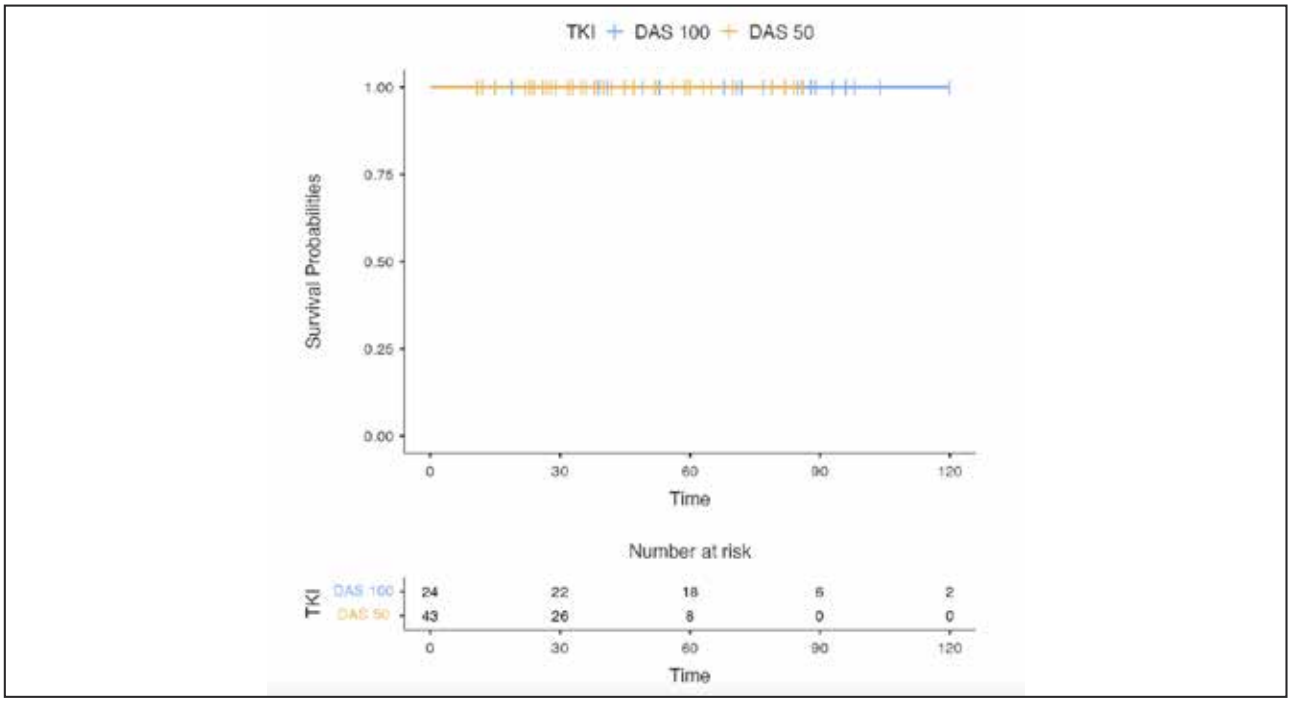
Conclusion:

Both dosing regimens demonstrated high efficacy and favorable molecular responses within 12 months, with a median follow–up of 42 months confirming durable outcomes. The 50 mg group achieved slightly higher complete cytogenetic and MMR rates, while the 100 mg group showed comparable molecular responses. The occurrence of pleural effusions, disease transformation, and TFR relapse highlights the importance of continuous monitoring. These findings suggest that Dasatinib 50 mg daily may serve as an effective and potentially lower–toxicity alternative for first–line therapy in patients with newly diagnosed CML–CP.

Acknowledgements

The authors would like to express their sincere gratitude to Mrs. Fazla Hafiz, our research assistant and Mrs Lovely Annie Samuel and the entire Genetic, Molecular, and Flow Cytometry Units at the Kuwait Cancer Control





Center (KCCC) for their invaluable technical support and dedication throughout the study. Their expertise and commitment to excellence were instrumental in ensuring the accuracy and quality of diagnostic and molecular data used in this research.

Authorship Contributions

A.A.: Study conception and design, data collection, data interpretation, and manuscript drafting. M.A.: Data collection and manuscript review. M.E.: Statistical analysis and data validation. A.K., M.R., B.A., F.K., A.H., and S.A.: Critical review of the manuscript and contribution to data interpretation.

A Novel Clinical Risk Score That Can Accurately Predict Survival of Early–Onset Breast Cancer Patients (EOBC) – A UAE Cohort Study

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Introduction:

- EOBC refers to breast cancer diagnosed in individuals younger than 40 years of age. EOBC usually has more aggressive biology, poorer prognosis and worse clinical outcome.
- More commonly HER–2 enriched (22%), lower frequency of luminal A tumors (17.2% vs 30%) vs later–onset. High tumor grade, multifocal disease, and nodal involvement.
- In the UAE:
  the median age is around 48 years.
  21.5% of the BC cases are between age 30 and 40 years.
- Several prognostic prediction models have been constructed and widely accepted for breast cancer in general, both early and advanced stage.
- No specific models predicting survival of EOBC patients that has been established or reported world–wide but specifically also for UAE population.

Objectives:

Development of prognostic tool using statistical machine learning model enabling individual patient –specific survival estimation, utilizing key clinicopathological factors for our unique population of EOBC in Tawam hospital.

Methods:

- Included N=904 patient diagnosed with breast cancer at 40 years or younger between 2000 – 2020.
- A multivariate ridge Cox regression model was performed using histology, molecular subtype, T–stage, M–stage at diagnosis, N–stage and grade, age and BMI. The primary outcome was time–to–death
- A novel breast cancer risk–score (BCRS) was developed as the linear predictor of the fitted ridge Cox regression model.
- Time–dependent ROC curves were estimated and plotted at different follow–up time.
- Cut–off values that would yield an approximate sensitivity of 90%

  True Positive (TP) rate and False Positive rate were estimated with corresponding 95% Confidence Interval (CI).
- The novel risk score were categorized into four risk groups (Low, low–intermediate, high–intermediate and high risk) using the 30%, 60% and 90% centiles cut off values.

A Univariate Cox Regression Model was performed with the categorized risk score as a predictor of time to death outcome.

Hazard–ratios with corresponding 95% CI and Z–values and P–values were estimated.

Conclusions:

We have shown that a novel clinical variable classifier provides important prognostic information both for breast cancer patients and also for their managing clinicians

If generally confirmed in other settings, the clinical variable score is likely to make a major contribution to the management of breast cancer worldwide

We are currently working on validation studies from different population.

This combined approach would more effectively identify patients at risk of mortality, providing a more comprehensive and precise risk assessment.

The statistical approach used in this approach can be generalized to other cancer types.

Results:

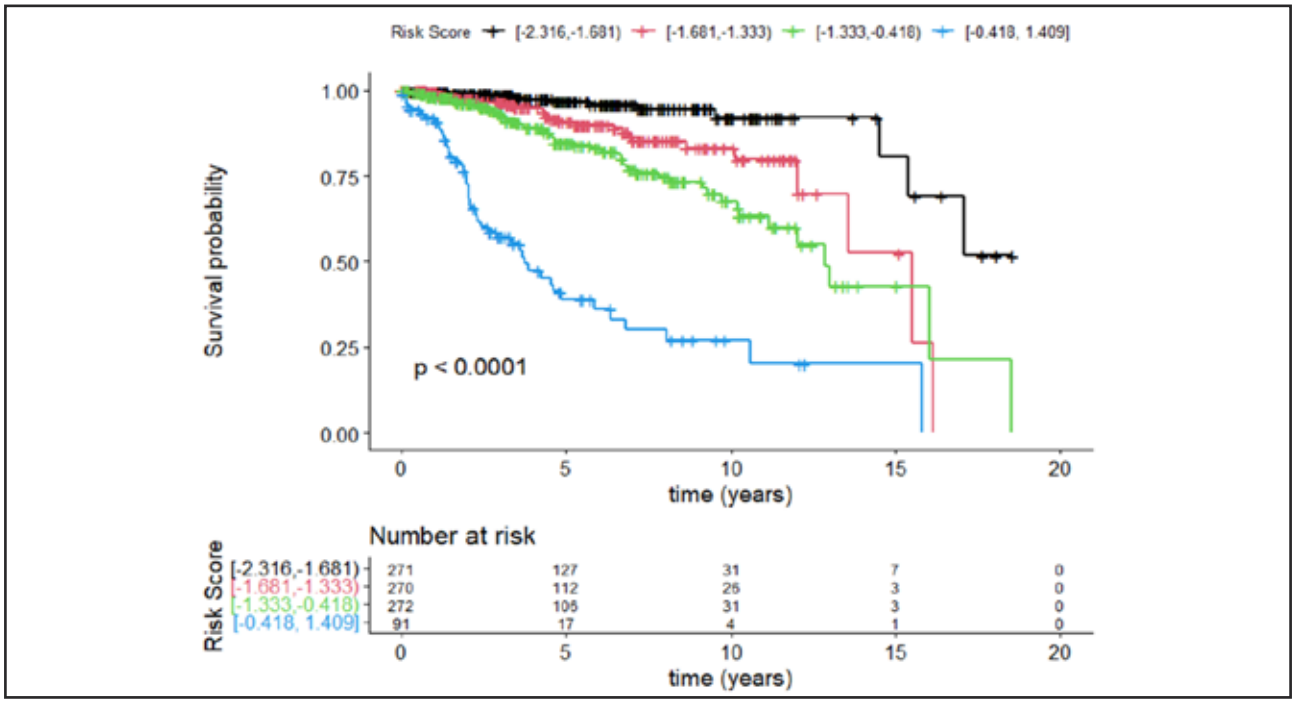
		N(%)			N(%)
Median age	36 (17-40)		Clinical T stage	T1	183 (20)
Median BMI	26 (16-54)			T2	427 (47)
Gender	Female	902 (99.8)		T3	166 (18)
	Male	2 (0.2)		T4	79 (9)
Menarche (Median age)	13 (9-19)			TX	49 (5)
Any family history of BC	Yes	217 (24)	Clinical N stage	N0	359 (40)
	No	644 (71)		N1	303 (34)
	Unknown	43 (45)		N2	92 (10)
History of OCH/HT use	Yes	138 (16)		N3	75 (8)
	No	555 (61)		NX	74 (8)
	Unknown	211 (23)	Grade	I	37 (4)
Smoking status	smoker	26 (3)		II	320 (35)
	No	770 (85)		III	452 (50)
	Unknown	108 (12)		Unknown	95 (11)
Pregnancy related BC	Yes	71 (8)	Molecular subtype	HR+/HER2+	223 (25)
	No	833 (92)		HR+/HER2-	371 (41)
stage	I	152 (17)		HR-/HER2+	109 (12.0)
	II	417 (46)		HR-/HER2-	149 (16.)
	III	236 (26)		Unknown	52 (6)
	IV	91 (10)	ER	Positive	589 (65)
	Unknown	8 (1)		Negative	272 (30)
Histology	IDC	816 (90)		Unknown	43 (5)
	ILC	29 (3)	PR	Positive	523 (58)
	other	59 (7)		Negative	335 (37)
				Unknown	46 (5)
			HER/neu	Positive	333 (37)
				Negative	518 (57)
				Unknown	53 (6)

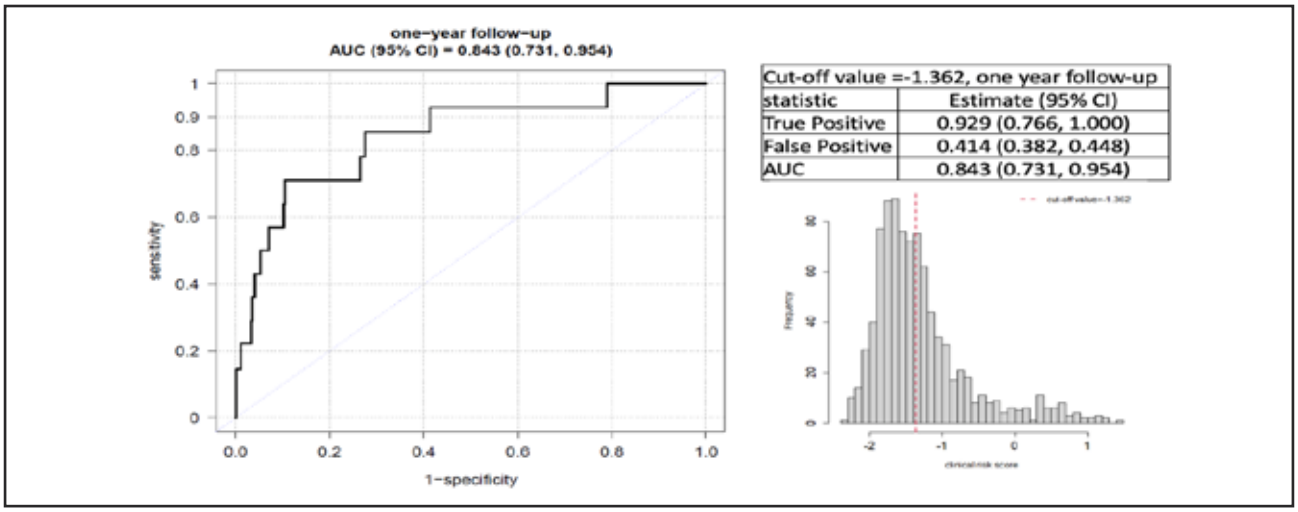
Table 1: Clinicopathological characteritics N=904

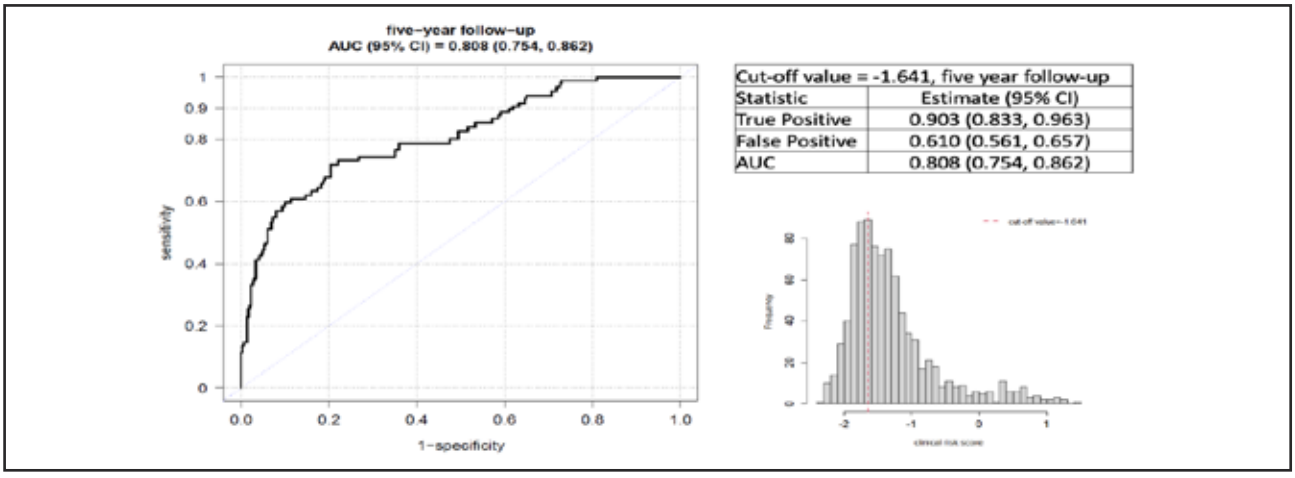
Categorized Risk Score	HR (95% CI)	z-value	p-value
[-2.316, -1.681) n=271 Low risk	Ref		
[-1.681,-1.333) n=270 Low intermediate risk	2.845 (1.429, 5.664)	2.976	0.003
[-1.333,-0.418)n=272 High intermediate risk	4.919 (2.602, 9.299)	4.903	<0.0001
[-0.418, 1.409] n=91 High risk	22.950 (12.035, 43.764)	9.514	< 0.0001

Table 2: Univariate Cox Proportional Hazards Regression Model

Harrell c–index 0.770 (95% CI: 0.725, 0.814)
The Harrell c–index indicates a good discriminatory capacity of predictive performance of the novel risk score







References:

Chelmow D, et al. Executive Summary of the Early–Onset Breast Cancer Evidence Review Conference. Obstet Gynecol. 2020 Nov;136(5):1068–1069. : 32459439; PMCID: PMC7253192.

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Oncology Patients' Willingness and Perspectives on Clinical Trial Participation in the United Arab Emirates: Insights from a Rapidly Growing Oncology Research Ecosystem

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Introduction:

Clinical trials are fundamental to advancing oncology care; however, patient participation remains limited worldwide.

The UAE has rapidly expanded its cancer research infrastructure and access to innovative therapies, positioning itself as an emerging regional hub for clinical trials.

Despite this growth, data on patient willingness and perceptions toward trial participation remain scarce.

Objectives:

To assess willingness to participate in clinical trials among oncology patients in the UAE

To evaluate patient awareness and perceptions of clinical trials

To identify key factors influencing trial participation

Methods:

A cross–sectional survey was conducted between October 2025 and January 2026 using a self–administered questionnaire distributed in clinic waiting areas.

Eligible participants included patients aged 16 years and older, with a confirmed cancer diagnosis.

Ethical approval was obtained, and participation was voluntary with assured data confidentiality.

The survey assessed awareness of clinical trials, perceived benefits, willingness to participate, and barriers to enrollment.

Data were analyzed using SPSS version 23, and chi–square tests

Conclusions:

More than half of oncology patients were willing to participate in clinical trials, but limited awareness remains a major barrier.

Willingness was higher among older patients, males, those with advanced disease, and patients on active treatment. Improving patient education, physician–led discussions, and trial visibility is essential to enhance recruitment in the UAE.

References:

Chelmow D, et al. Executive Summary of the Early–Onset Breast Cancer Evidence Review Conference. Obstet Gynecol. 2020 Nov;136(5):1068–1069. : 32459439; PMCID: PMC7253192.

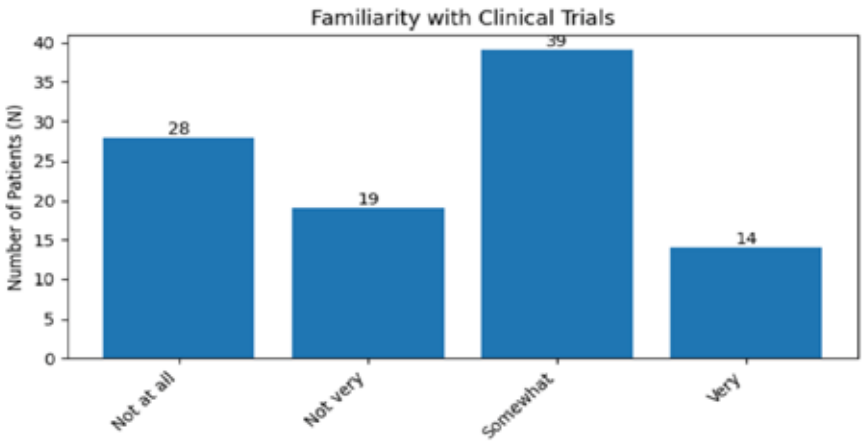
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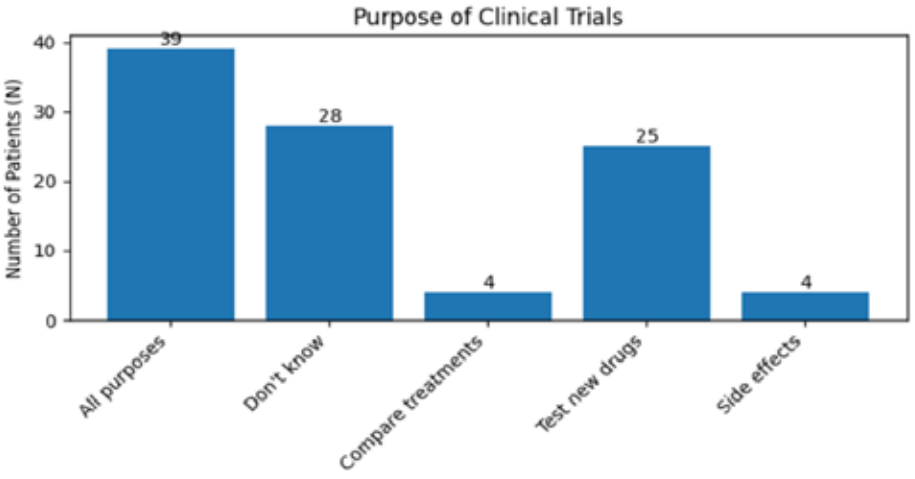
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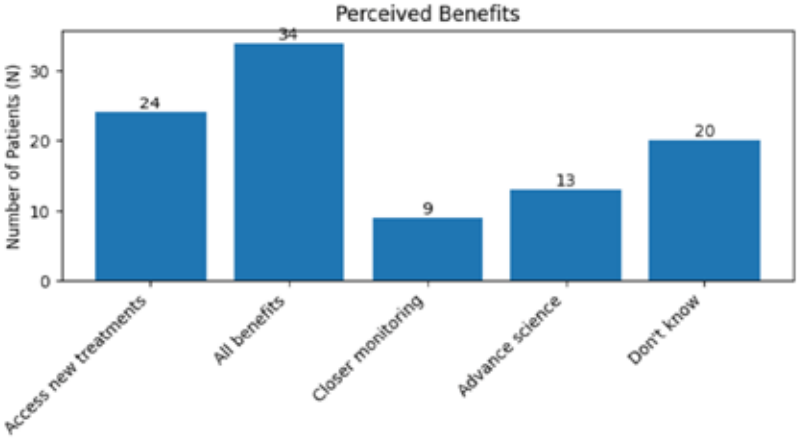
Results:

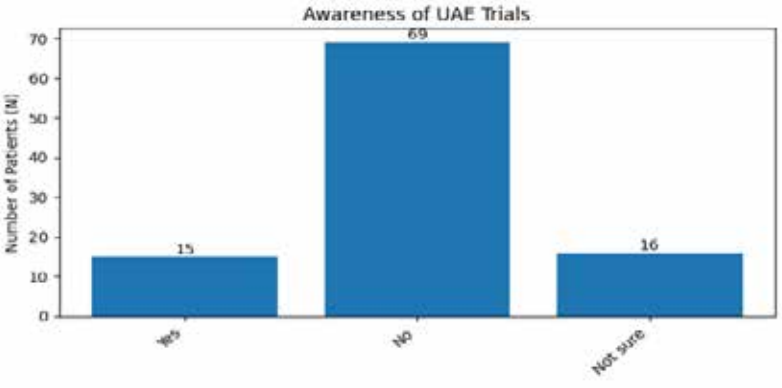
Characteristic	N = 100	unwilling N = 25	Neutral N = 23	willing N = 52	p-value
What is your age?		52 (42, 64)	45 (40, 53)	55 (43, 63)	0.035
Median (Q1, Q3)	52 (41, 61)				
What is your gender?					0.046
Female	66 (66%)	16 (24%)	20 (30%)	30 (45%)	
Male	34 (34%)	9 (26%)	3 (8.8%)	22 (65%)	
Marital					0.3
Married	65 (65%)	19 (29%)	16 (25%)	30 (46%)	
UnMarried	35 (35%)	6 (17%)	7 (20%)	22 (63%)	
Education					0.3
Graduate	46 (46%)	14 (30%)	13 (28%)	19 (41%)	
Secondary or less	50 (50%)	10 (20%)	10 (20%)	30 (60%)	
Uneducated	4 (4.0%)	1 (25%)	0 (0%)	3 (75%)	
Employment					0.5
Employed	38 (38%)	8 (21%)	11 (29%)	19 (50%)	
Unemployed	62 (62%)	17 (27%)	12 (19%)	33 (53%)	
Income					0.12
< 10,000 AED	26 (26%)	6 (23%)	3 (12%)	17 (65%)	
10,000 - 50,000 AED	45 (45%)	15 (33%)	10 (22%)	20 (44%)	
Prefer not to say	29 (29%)	4 (14%)	10 (34%)	15 (52%)	
Insurance status					0.5
Private insurance	95 (95%)	23 (24%)	23 (24%)	49 (52%)	
Self Pay/ Charity	5 (5.0%)	2 (40%)	0 (0%)	3 (60%)	
Type of cancer					0.2
Breast cancer	49 (49%)	11 (22%)	16 (33%)	22 (45%)	
GI Malignancy	15 (15%)	4 (27%)	1 (6.7%)	10 (67%)	
Hematologic Malignancy	14 (14%)	4 (29%)	4 (29%)	6 (43%)	
Others	22 (22%)	6 (27%)	2 (9.1%)	14 (64%)	
Stage					0.5
Stage I/II/III	67 (67%)	19 (28%)	15 (22%)	33 (49%)	
Stage IV	33 (33%)	6 (18%)	8 (24%)	19 (58%)	
Have you completed therapy or currently on therapy?					0.6
Not on active therapy	19 (19%)	4 (16%)	6 (26%)	9 (17%)	
On active therapy	81 (81%)	21 (84%)	17 (74%)	43 (83%)	

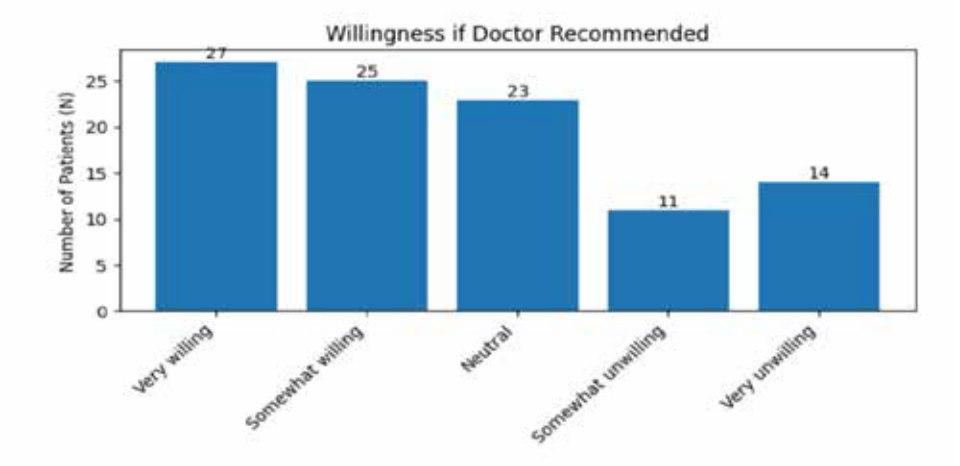
Table 1. Association of demographic and clinicopathological characteristics with Willingness

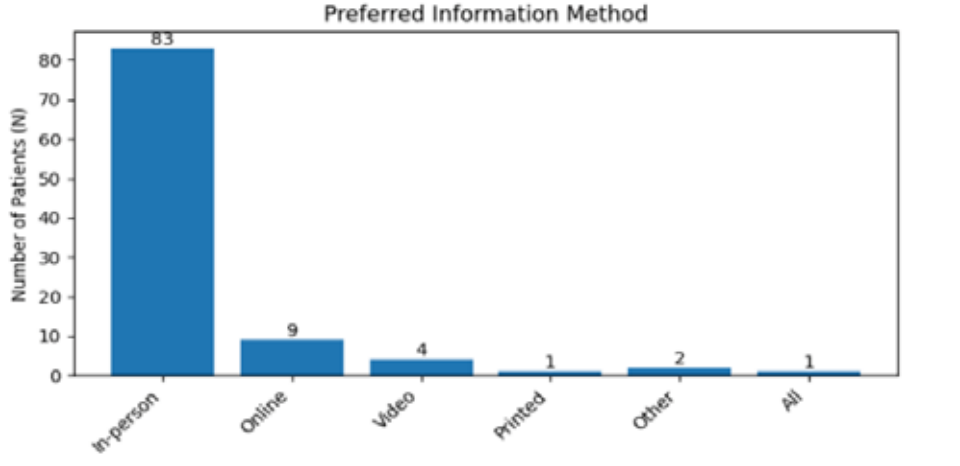

Familiarity with Clinical Trials
Number of Patients (N)
0
5
10
15
20
25
30
35
40
28
19
39
14
Not at all
Not very
Somewhat
Very

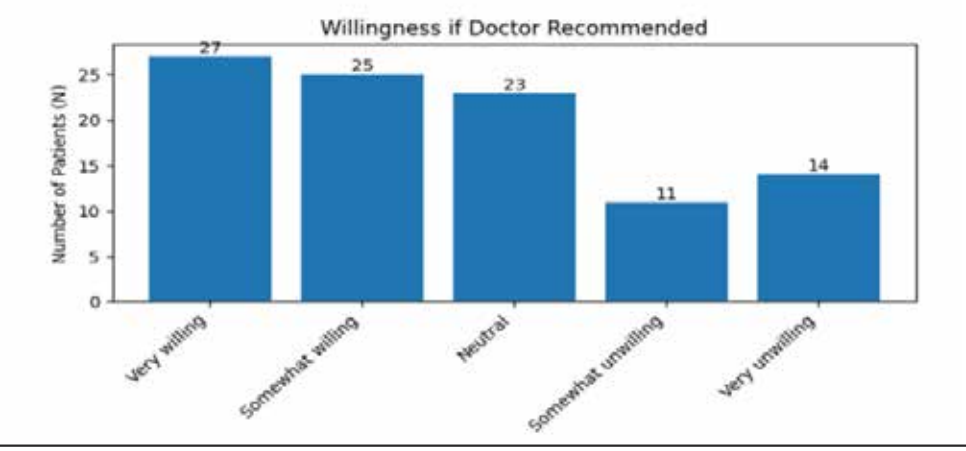

Purpose of Clinical Trials
Number of Patients (N)
0
10
20
30
40
39
28
4
25
4
All purposes
Don't know
Compare treatments
Test new drugs
Side effects


Perceived Benefits
Number of Patients (N)
0
10
20
30
24
34
9
13
20
Access new treatments
All benefits
Closer monitoring
Advance science
Don't know


Awareness of UAE Trials
Number of Patients (N)
0
10
20
30
40
50
60
70
15
69
16
Yes
No
Not sure


Willingness if Doctor Recommended
Number of Patients (N)
0
5
10
15
20
25
27
25
23
11
14
Very willing
Somewhat willing
Neutral
Somewhat unwilling
Very unwilling


Preferred Information Method
Number of Patients (N)
0
10
20
30
40
50
60
70
80
83
9
4
1
2
1
In-person
Online
Video
Printed
Other
All


Willingness if Doctor Recommended
Number of Patients (N)
0
5
10
15
20
25
27
25
23
11
14
Very willing
Somewhat willing
Neutral
Somewhat unwilling
Very unwilling

Real–World Utilization and Outcomes of Trastuzumab Emtansine in HER–2 Positive Breast Cancer: A Retrospective Study from Oman

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[3]Senior Consultant, Sultan Qaboos Comprehensive Cancer Care and research Center
[4]Associate Professor, University of Nizwa

Background:

Antibody drug conjugates (ADC) combine targeted therapy with cytotoxic delivery to enhance efficacy and reduce systemic toxicity. Trastuzumab emtansine (T–DM1) is a widely used ADC in HER2 positive breast cancer (BC), yet real–world data from the Middle East remain limited. This study evaluates the toxicity and clinical outcomes of T–DM1.

Objectives:

1. Describe real–world treatment patterns of TDM–1 in HER2 positive BC.
2. Evaluate the safety of T–DM1, including adverse drug reactions (ADRs), treatment discontinuation, and hospital admissions.
3. Assess TDM–1 effecvtivness, including treatment response in palliative setting and 2–years disease–free survival (DFS) in adjuvant setting.

Methodology:

1. Study Design & Setting: A 4–year retrospective study conducted at Sultan Qaboos Comprehensive Cancer Care and Research Center Oman
2. Study Population: Adult women (n = 55) with HER2–positive BC treated with TDM–1 in curative and palliative settings.
3. Data Collection: data extracted from the Hospital Information System, including demographics, comorbidities, baseline lab tests, disease characteristics, and treatment details.
4. Endpoints: Adverse events were graded using Common Terminology Criteria or Adverse Events (CTCAE). Treatment discontinuations and hospital admissions were reported. Treatment response was assessed using RECIST (v1.1) criteria.

Results:

Characteristic	Findings (N=55)
Age (years), Mean ± SD	49.9 ± 9.61
BMI (kg/m²), Mean ± SD	31.6 ± 13.2
Obese (BMI ≥ 30), n (%)	25 (45.5%)
Comorbidities, n (%)	DM=16 (29.1%); HTN=20 (36.4%)
Setting, n (%)	Adjuvant=35 (78%); Palliative=20 (22%)
Hormonal Receptor positivity, n (%)	Adjuvant=14 (40%); Palliative=11 (55%)
Ki 67% (>20%), n (%) (N=46)	40 (87.0%)

Table 1. Demographic data

Abbreviations: BMI, body mass index; DM, diabetes mellitus; HTN, hypertension; SD, standard deviation.

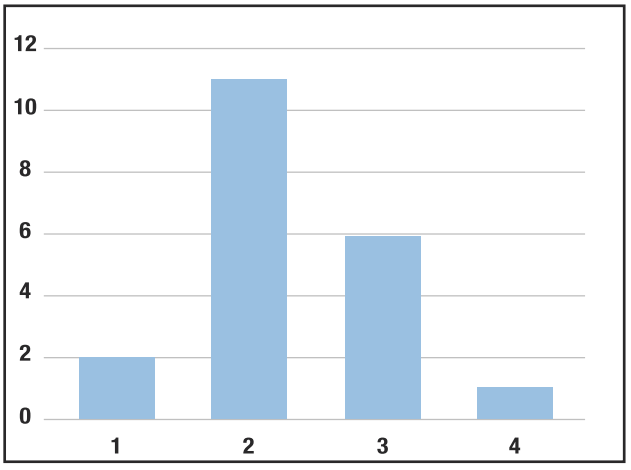
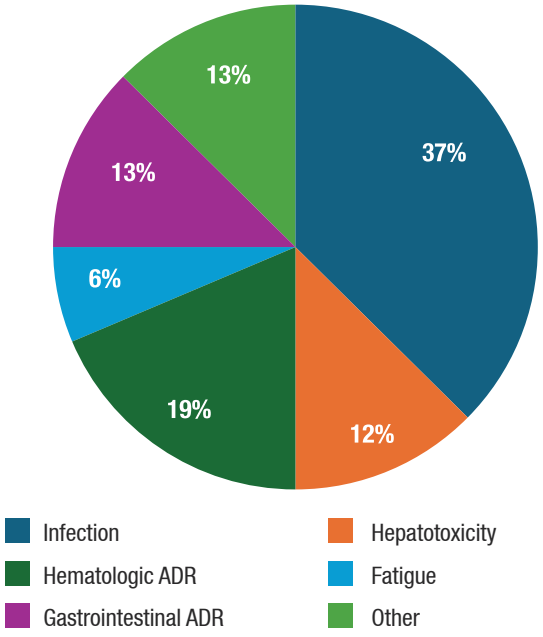


Figure 1. Line of therapy in palliative setting (N=20)

- Median (IQR) relative dose intensity in the first 6 cycles was 97.9% (91.4–100%) in the adjuvant group and 94.7% (89.2– 99.2) in the palliative group.
- Most ADRs were grades 1–2. Grade 3 toxicity occurred in 21.2% and was significantly more common in the palliative group (p= 0.003).
- Hematologic parameters remained stable across therapy duration, while bilirubin levels increased significantly (p< 0.001).
- Liver enzymes increased four–fold (from 20–80 U/L), however the difference was not statistically significant probably due to low sample size, although highly clinically relevant.
- Admission was required in 4/32 (12.5%) adjuvant patients versus 8/16 (50%) of palliative patients (p=0.011).

Action Taken	Adjuvant (n=35)	Palliative (n=18)
No modification	14 (40%)	1 (5.6%)
Dose delay	7 (20%)	4 (22.2%)
Dose reduction	1 (2.8%)	2 (11.1%)
Dose delay and reduction	7 (20%)	9 (50%)
Discontinuation	6 (17.2%)	14 (77.8%)
Toxicity	5	4
Progression	1	10

Table 2. Management of Toxicity



* More than one adverse reaction per patient could have resulted in hospital admission.

Figure 2. Clinical events requiring admission(n=17)

Best Response	(n=18)
Compelet response (CR)	3
Portial response (PR)	4
Stable disease (SD)	10
Progression disease (PD)	1

Table 3. Best Response in palliative setting

Conclusion:

T–DM1 showed a good safety profile in Her2 positive BC patients, with adverse events seen more in the palliative setting, warranting closed monitoring. Regular hepatic assessment is also critical as liver function tests and bilirubin were negatively impacted by TDM–1. In the palliative setting, stable disease was the most common response, whereas 86.4% of adjuvant patients achieved DFS. Overall, the safety and effectiveness of TDM–1 in this real– world cohort from Oman, aligned with global data, reinforcing TDM–1 as an important treatment options in both adjuvant and palliative settings of Her2 positive BC.

Cervical Cytology Abnormalities and HPV Infection in Kuwait: National Population–Based Data, 2017–2018

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[1,4] College of Public Health, Kuwait University, [2,5] Ministry of Health, Kuwait,
[3] London School of Hygiene & Tropical Medicine, UK

Background/Objectives:

Cervical cancer is the eighth most common malignancy among women in Kuwait; however, national data on cervical cytology and human papillomavirus (HPV) infection remain limited. This study aimed to provide the first population–based estimates of the prevalence and determinants of cytological abnormalities and HPV infection in Kuwait using routinely collected national records from governmental hospitals and clinics during 2017–2018.

Methods:

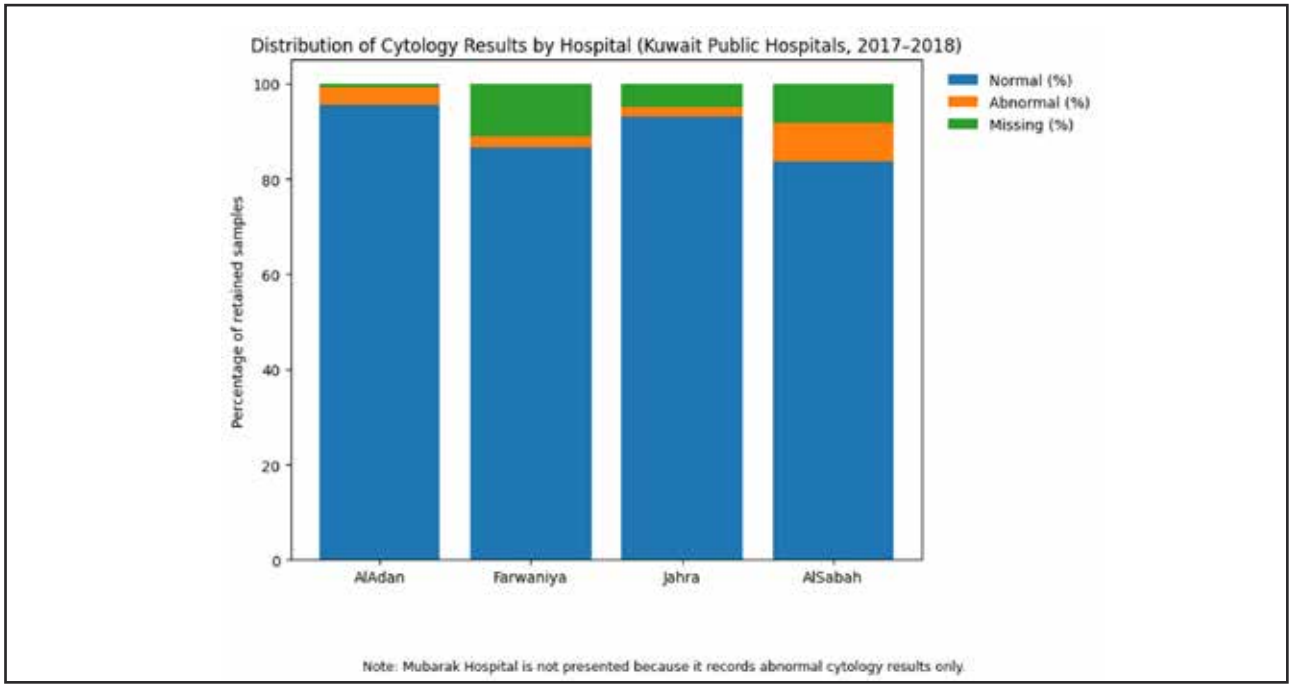
Cytology records (N = 18,135) were analyzed to assess the national distribution and determinants of abnormal findings. All HPV test records conducted in governmental hospitals (N = 1,595; testing centralized in two hospitals) were used to estimate prevalence, genotype distribution, and risk factors. A matched subset with both cytology and HPV results (N = 662) was examined to determine the association between infection and cytological abnormalities.

Results:

Overall, 5.6% of cytology smears were abnormal (n = 911/16,241). Women aged 30–49 years had higher odds of abnormal cytology compared with those <30 years. Among women tested for HPV, 7.6% were positive, with prevalence exceeding 30% among Kuwaiti women <25 years and increasing among non–Kuwaiti women after age 40. HPV–16 accounted for one–third of infections, while HPV–18/45 contributed an additional 17%. In the matched dataset, HPV–positive women were approximately 13 times more likely to have concurrent cytological abnormalities; however, 7% of cytology–negative women harbored high–risk HPV.

Conclusions:

This first national study provides comprehensive estimates of cytology abnormalities and HPV infection in Kuwait, underscoring the need for HPV vaccination and integrated cytology–HPV screening to strengthen cervical cancer prevention.



Panel A. Normal vs abnormal cytology by characteristic (n = 16,241; unsatisfactory/missing excluded)

Variable	Total n (%)	Normal n (%) [95% CI]	Abnormal n (%) [95% CI]	p-value
Total	**16,241** (100.0)	15,330 (**94.4**) [94.0, 94.8]	911 (**5.6**) [5.3, 6.0]	–
Age (years, mean ± SD)	42.1 ± 11.2	42.1 ± 11.2	42.0 ± 11.3	0.732
Age groups				**0.001**
<30yrs (younger women, transient HPV likely)	2,202 (12.8)	2,005 (91.1) [89.8, 92.4]	118 (5.6) [4.7, 6.6]	
30-49yrs (core screening age, persistent HPV risk)	10,644 (61.9)	9,485 (89.1) [88.5, 89.7]	582 (5.5) [5.3, 6.3]	
50+yrs (older age, late presentation risk)	4,053 (23.6)	3,603 (88.9) [87.9, 89.8]	196 (4.8) [4.5, 5.9]	
Year of test				**0.001**
<30yrs(younger women, transient HPV likely)	9,424 (55.0)	8,352 (88.6) [87.9, 89.3]	554 (6.2) [5.7, 6.7]	
30-49yrs (core screening age, persistent HPV risk)	7,739 (45.0)	6,978 (90.2) [89.5, 90.8]	357 (4.6) [4.4, 5.4]	
Nationality				**<0.001**
Kuwaiti	9,555 (55.7)	8,651 (90.5) [89.9, 91.1]	500 (5.5) [5.0, 5.9]	
Non-Kuwaiti	7,144 (41.6)	6,268 (87.7) [86.9, 88.5]	399 (5.9) [5.4, 6.6]	
Governorate (Hospital*)				**<0.001**
Capital (Alsabah)	6,390 (37.2)	5,338 (83.5) [82.6, 84.4]	528 (9.0) [8.3, 9.8]	
Ahmadi & Mubarak (AlAdan)	6,314 (36.8)	5,975 (94.6) [94.0, 95.2]	290 (4.6) [4.1, 5.2]	
Farwaniya (Farwaniya)	2,109 (12.3)	1,826 (86.6) [85.1, 87.9]	50 (2.7) [2.0, 3.5]	
Jahra (Jahra)	2,350 (13.7)	2,191 (93.2) [92.1, 94.2]	43 (1.9) [1.4, 2.6]	
Facility				**<0.001**
Other clinics	12,061 (70.3)	10,805 (89.6) [89.0, 90.1]	702 (6.1) [5.7, 6.6]	
Hospital	5,054 (29.5)	4,482 (88.7) [87.8, 89.5]	208 (4.4) [3.9, 5.1]	

Panel A: *Mubarak hospital records (n=940), which only reported abnormal cytology, were excluded from descriptive totals to avoid overestimation. n (% within hospital) with Pearson χ^2 p-values; unsatisfactory/missing cytology excluded

Panel B. Adjusted models of cytology: RRRs (Normal vs Abnormal) and ORs (High vs Low)

Predictor	All women† (reference = Normal; N = 15,624)		Abnormal-only‡ (High-grade vs Low-grade; N = 1,802)
	Low-grade vs Normal — RRR (95% CI), p-value	High-grade vs Normal — RRR (95% CI), p-value	OR (95% CI), p-value
Age group (ref = 30–49 yrs)			
<30 yrs	1.17 (0.88–1.55), 0.272	0.34 (0.18–0.65), **0.001**	0.44 (0.29–0.65), **<0.001**
≥50 yrs	0.68 (0.33–1.38), 0.282	1.56 (1.33–1.84), **<0.001**	1.29 (0.50–3.38), 0.600
Nationality (ref = Kuwaiti)			
Non-Kuwaiti	0.97 (0.81–1.15), 0.687	1.40 (1.20–1.63), **<0.001**	1.25 (1.02–1.53), **0.035**
Hospital (ref = AlSabah)			
AlAdan	0.61 (0.58–0.63), **<0.001**	0.20 (0.19–0.21), **<0.001**	0.30 (0.27–0.33), **<0.001**
Farwaniya	0.31 (0.30–0.32), **<0.001**	0.23 (0.22–0.23), **<0.001**	0.73 (0.70–0.76), **<0.001**
AlJahra	0.10 (0.099–0.108), **<0.001**	0.36 (0.35–0.37), **<0.001**	3.13 (2.34–4.17), **<0.001**
Mubarak*	*	*	0.97 (0.92–1.02), 0.224
Year (ref = 2017)			
2018	0.73 (0.62–0.86), **<0.001**	0.87 (0.53–1.43), 0.585	1.21 (0.89–1.64), 0.224

Panel B: the two RRR columns are from a multinomial model (Mubarak excluded; SEs clustered by hospital), and the OR column is from an abnormal-only logistic model (Mubarak included). *Excluded from multinomial model; included in abnormal-only logistic model.

Table 1. Cytology prevalence by characteristics (Panel A) and adjusted associations (Panel B), Kuwait public hospitals and clinics, 2017–2018

Acknowledgments:

The authors would like to thank the Ministry of Health in Kuwait for granting access to the national cytology and HPV datasets. We are also grateful to the staff at the participating governmental hospitals for their assistance in record management and data provision.

Mesonephric–like Adenocarcinoma of the Female Genital Tract: A Case Series and Review of Diagnostic Challenges

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Dr. Smiley Ann George – Senior Specialist, Department of Histopathology, Jaber Al Ahmad Hospital, Kuwait

Dr. Kripa Elizabeth John – Registrar, Department of Histopathology, Jaber Al Ahmad Hospital, Kuwait

Department of Histopathology, Jaber Al Ahmad hospital, Kuwait

BACKGROUND & OBJECTIVES:

Mesonephric–like adenocarcinoma (MLA) is a rare and recently recognized malignant tumor of the female genital tract, characterized by mesonephric differentiation arising in Müllerian organs without associated mesonephric remnants. Owing to its diverse histomorphology and overlapping features with other gynecologic malignancies, MLA is frequently under–recognized or misdiagnosed. This study aims to highlight the clinicopathologic spectrum, immunohistochemical profile, and diagnostic challenges of MLA through a case series from a tertiary care center.

METHODS:

A retrospective descriptive study was conducted in the Department of Histopathology, Jaber Al Ahmad Hospital, Kuwait, from January 2023 to January 2025. Four cases diagnosed as mesonephric–like lesions were identified from hysterectomy and adnexal surgical specimens. Clinical data, radiologic findings, gross and microscopic features were reviewed. Histopathological evaluation was performed on hematoxylin and eosin–stained sections. Immunohistochemistry was carried out using a comprehensive panel including PAX8, TTF1, GATA3, CD10, ER, PR, p16, p53, and other relevant markers. Tumors were classified according to the WHO Classification of Female Genital Tumors, and staging was performed using AJCC 8th edition criteria.

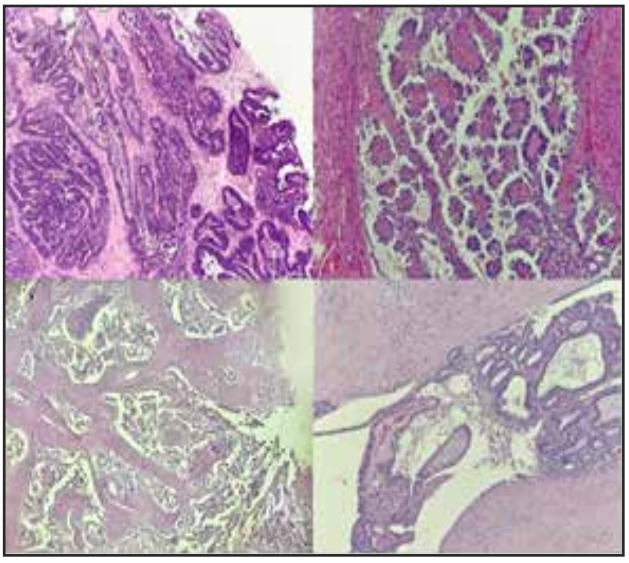


Figure 1. H&E sections from four cases of mesonephric carcinoma (10×), showing variable architectural patterns including tubular, ductal, papillary, and glandular arrangements within a fibromuscular / desmoplastic stroma, illustrating the morphologic spectrum of this tumor

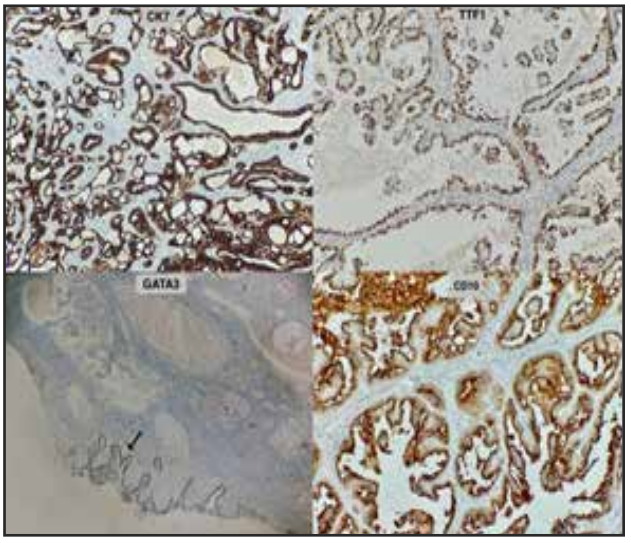


Figure 2. Immunohistochemical profile of mesonephric carcinoma. Tumor cells show diffuse CK7 positivity, characteristic luminal/apical CD10 staining, and nuclear TTF1 expression. GATA3 highlights an inverse staining pattern, with absence of tumor cell staining and positivity in adjacent benign structures.

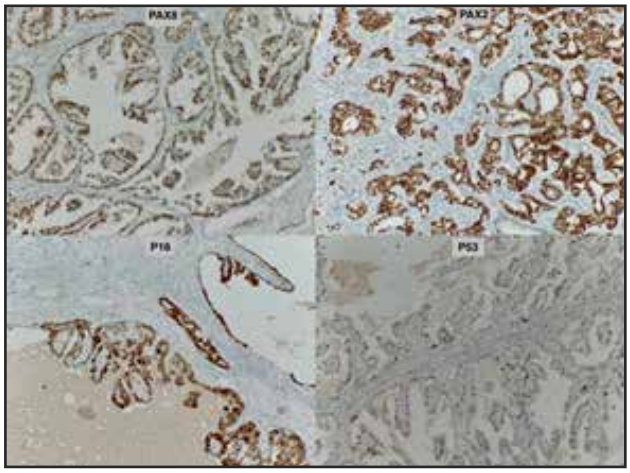


Figure 3. PAX8 and PAX2 demonstrate strong nuclear positivity, supporting mesonephric differentiation. p16 shows patchy, non–block positivity, and p53 demonstrates a wild–type staining pattern, aiding in distinction from HPV–associated and serous carcinomas.

RESULTS:

The case series included three cases of mesonephric–like adenocarcinoma involving the endometrium and ovary, and one case of atypical mesonephric–like hyperplasia of the cervix and lower uterine segment. Patients presented predominantly at advanced FIGO stages with extensive local invasion and distant metastases, including lymph nodes and liver. Histologically, tumors showed mixed architectural patterns such as tubular, glandular, papillary, and spindle cell areas with characteristic luminal eosinophilic secretions. Immunohistochemically, the tumors demonstrated consistent positivity for PAX8 and TTF1, focal GATA3 and CD10 (luminal) staining, patchy p16 expression, wild–type p53 pattern, and variable ER/PR expression. The findings underscored the aggressive behavior and diagnostic complexity of MLA.

CONCLUSION:

Mesonephric–like adenocarcinoma is an aggressive and diagnostically challenging entity with distinctive morphologic and immunophenotypic features. Awareness of its varied presentation and judicious use of immunohistochemistry are essential to avoid misdiagnosis. Accurate identification of MLA has important prognostic and therapeutic implications, emphasizing the need for increased recognition of this rare tumor in routine gynecologic pathology practice.

Clinical and Pathological Characteristics of Kaposi Sarcoma in a Large Tertiary Health Care Hospital, Riyadh, Saudi Arabia: A Retrospective Study.

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Medical Oncology Department, Comprehensive Cancer Center, King Fahad Medical City, Riyadh, Saudi Arabia

Introduction:

Kaposi Sarcoma (KS) is an angioproliferative lymphatic tumor that can present as either solitary or multifocal lesions. It is generally associated with human herpesvirus–8 (HHV–8). The distribution of classic KS and AIDS–related KS shows geographical variation, as reported in the literature, particularly between Western countries and those in the Middle East. Classic KS is indolent in nature and rarely directly causes patient death, though it often implies the presence of an underlying secondary malignancy. In contrast, AIDS–related KS is multifocal, visceral, and disseminated, exhibiting significantly more aggressive behavior. This is the first study conducted in Saudi Arabia to investigate the predominant clinical form of KS in the region.

Methods:

This retrospective study reviewed patients diagnosed with Kaposi sarcoma (KS) at King Abdulaziz Medical City, Riyadh, Saudi Arabia, between February 2015 and December 2022. Institutional Review Board (IRB) approval was obtained. Data were retrieved using the search term "Kaposi sarcoma" and ICD–9 176/ICD–10 C46 codes and subcategories. Clinical and demographic information, including age at diagnosis, gender, KS clinical features, histopathology, HIV status, comorbidities, and treatment details, were analyzed using IBM SPSS® version 27. Cases were categorized into HIV–related, classic, and iatrogenic clinical forms. Descriptive statistics were used, and Chi–square or Fisher's exact tests compared differences between groups, with a significance level of $\alpha = 0.05$.

Results:

Twenty–nine patients diagnosed with KS were identified. Among them, 16 patients (56%) had classic KS, 7 (24%) had iatrogenic KS, and 6 (20%) had HIV–related KS. The mean age of the patients was 71.5 years (range: 36–95 years), and the majority were male (89.7%). The skin was the primary site of KS in most cases. Eighteen patients (62%) had solitary KS, 10 patients (34%) had multifocal KS, and 1 patient had disseminated KS. Only one patient presented with lymphedema, while 6 patients (20%) had lymph node involvement. Six patients had other malignancies, including T–cell lymphoma, B–cell lymphoma, renal cell carcinoma, hepatic cell carcinoma, and colon cancer. The difference in the number of KS lesions (solitary vs. multifocal) between KS types was statistically significant, with the iatrogenic type showing a tendency towards multifocality ($P = 0.035$). Additionally, lymph node involvement was significantly higher in the iatrogenic type ($P < 0.001$). However, the difference in prognosis among the three KS types was not statistically significant ($P = 0.135$). Similarly, differences in gender, mean age, comorbidities, KS location, and prognosis were not statistically significant.

Conclusion:

Classic KS was the most prevalent form in our study, while the iatrogenic form was associated with multifocality and lymph node involvement. Further studies are needed to explore the prevalence and characteristics of KS in Saudi Arabia in greater depth. Such research should be prioritized, as it is essential for developing future disease management strategies in the region, particularly given the geographic variations reported in the literature.

Age	Gender	Type	Focality of lesions	Location	LN involvement	KS treatment	Comorbidities	Outcome
76	M	Classic	Solitary	Skin	No	No treatment	None	Improvement
91	M	Classic	Multifocal/ multicentric	Skin	No	Radiotherapy	None	Improvement
72	M	Classic	Solitary	Skin	No	No treatment	None	Expired
83	M	Classic	Solitary	Skin	No	Radiotherapy	None	Improvement
95	F	Classic	Solitary	Skin	No	No treatment	None	Lost follow–up
86	M	Classic	Multifocal/ multicentric	Skin	No	Liposomal doxorubicin	None	Expired
77	M	Classic	Solitary	Skin	No	No treatment	None	Improvement
67	M	Classic	Solitary	Skin	No	Radiotherapy	None	Improvement
60	M	Classic	Solitary	Skin	No	Surgery	None	Lost follow–up
72	F	Classic	Solitary	Skin	No	No treatment	None	Expired
91	M	Classic	Multifocal/ multicentric	Skin	No	Radiotherapy	None	Improvement
80	M	Classic	Multifocal/ multicentric	Skin	No	Radiotherapy	None	Improvement
81	M	Classic	Solitary	Skin	No	Liposomal doxorubicin	None	Improvement
59	M	Classic	Solitary	Skin	No	No treatment	None	Improvement
83	M	Classic	Solitary	Skin	No	Liposomal doxorubicin, radiotherapy	None	No improvement
77	M	Classic	Solitary	Skin	No	Liposomal doxorubicin, shifted to vinblastine, Radiotherapy	None	Improvement

Table 1a. Characteristics of Classic Kaposi Sarcoma patients

Age	Gender	Type	Focality of lesions	Location	LN involvement	KS treatment	Comorbidities	Outcome
78	M	Iatrogenic	Solitary	Skin	No	No treatment	HCC	Expired
73	M	Iatrogenic	Multifocal/multicentric	Skin	No	No treatment	B–cell lymphoma	Expired
60	M	Iatrogenic	Multifocal/multicentric	Skin	Yes	No treatment	T–cell lymphoma	Lost follow–up
77	M	Iatrogenic	Multifocal/multicentric	Skin	No	Liposomal doxorubicin	RCC	Improvement
64	M	Iatrogenic	Multifocal/multicentric	Skin	No	Liposomal doxorubicin	Castleman disease	Improvement
77	M	Iatrogenic	Multifocal/multicentric	Skin	No	No treatment	B–cell lymphoma	Expired
64	M	Iatrogenic	Disseminated	Skin	No	Liposomal doxorubicin	None	Expired

Table 1b. Characteristics of Iatrogenic Kaposi Sarcoma patients

Psychological Morbidity at Cancer Diagnosis: A prospective Observational study from Bahrain

Dr. Subathra Jeyaram, Miss Hala Budawas.

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1 in 6 newly diagnosed cancer patients experience clinically significant psychological distress at diagnosis.

INTRO & BACKGROUND:

- Cancer diagnosis can trigger shock, fear, anxiety, helplessness.
- Unaddressed distress → worse treatment adherence & outcomes
- Limited published data from the Middle East
- Early screening can identify at–risk patients

METHODS / SCREENING FLOW:

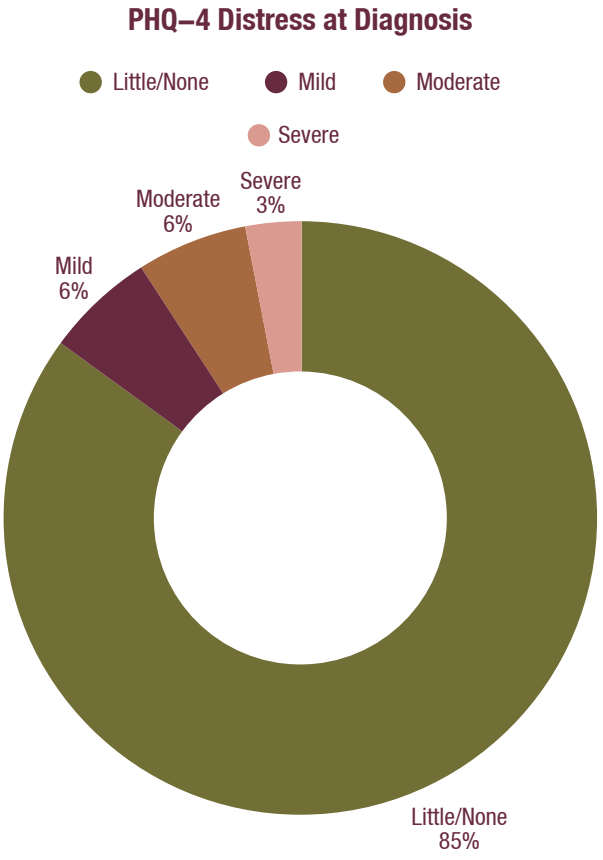
- Observational screening study
- N = 1,103 newly diagnosed patients
- PHQ–4 for anxiety & depression
- Demographic and clinical data collected

KEY CLINICAL CONTEXT:

- Mean age: 58.3 years
- Female: 70%
- Stage: Early 32% | Advanced 33% |Metastatic 30%
- Any tobacco use: 10%
- 75% screened within 2 weeks of first oncology visit

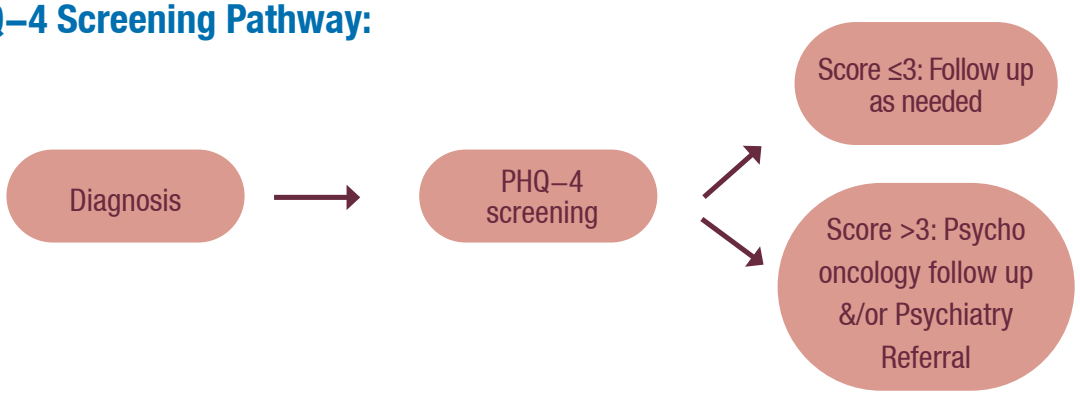
Results:

PHQ–4 Distress at Diagnosis

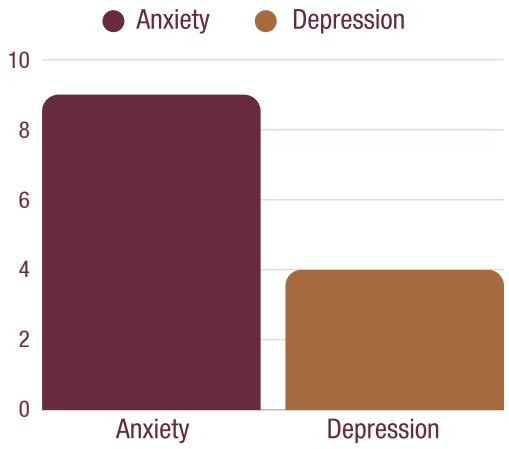


15% experienced mild–to–severe psychological distress

PHQ–4 Screening Pathway:

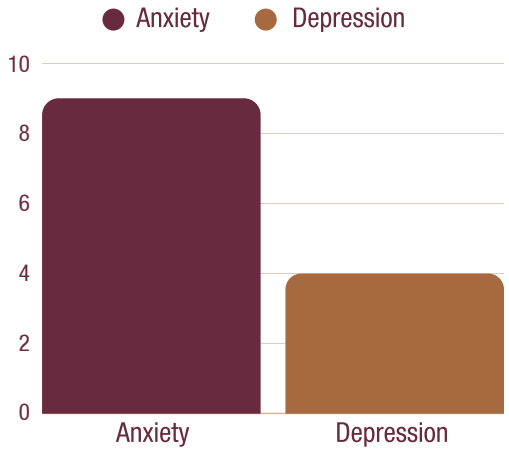


Anxiety Symptoms Are Twice as Common as Depression



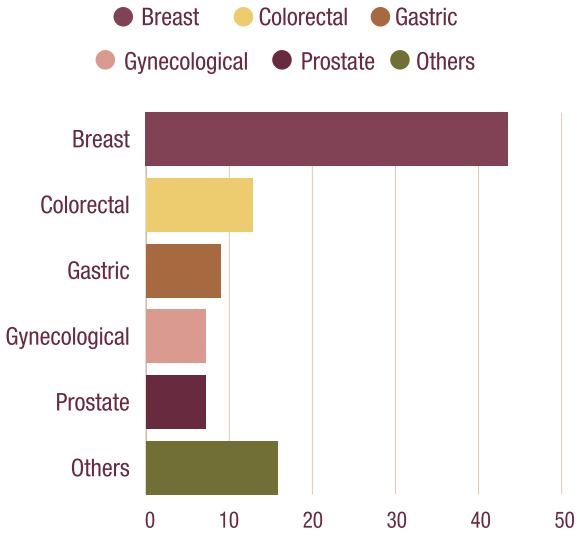
12% anxiety, 6% depression

Distress Occurs Even Without Prior Psychiatric History



6% had moderate–severe overall distress despite no psychiatric history

Top Cancer Diagnosis



CONCLUSIONS & CLINICAL IMPLICATIONS:

- Psychological distress is present in a meaningful proportion of patients at the time of cancer diagnosis, including those with no prior psychiatric history.
- Early routine psychological screening facilitates timely identification of distress and referral for support.
- Findings support the integration of structured psycho–oncology services into standard oncology care in the Gulf region.

RELATED LITERATURE:

PHQ–4 (Screening Tool Used)

Kroenke, K., Spitzer, R. L., Williams, J. B. W., & Löwe, B. (2009). An ultra–brief screening scale for anxiety and depression: The PHQ–4. Psychosomatics, 50(6), 613–621. NCCN Guidelines (Clinical Standard for Distress Screening)

National Comprehensive Cancer Network. (2024). NCCN clinical practice guidelines in oncology: Distress management.

Neoadjuvant Chemotherapy in ER+/HER2–negative or HER2–low Early Breast Cancer: pCR, Compliance, and Predictors in a Single–Center Cohort

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Introduction:

pCR with standard neoadjuvant chemotherapy (NACT) in ER+ early breast cancer (eBC) is typically low–modest and heterogeneous across tumor biology (grade, Ki–67, nodal status). Real–world data on treatment delivery and predictors of pCR in ER+/HER2–negative or HER2–low eBC from our region are limited.

Methods:

Retrospective, single–institution cohort (KFMC, Riyadh), Jan–2021–Dec–2023. Eligible patients had ER+ eBC treated with NACT and surgery. pCR was defined as ypT0/is & ypN0 among operated patients. Descriptives were reported as medians and proportions; comparisons used χ^2/Fisher. Predictors of pCR were assessed by logistic regression (univariate and multivariable including grade 3 vs 1– 2, nodal status N+ vs N0, and Ki–67 per 10%).

Results:

202 ER+/HER2–negative/low received NACT; 192 (95.0%) underwent surgery. Median age 47 (24–71); pre/peri menopausal 74%; IDC: 88%; grade: G2: 70%, G3: 27%; Ki–67 ≥20%: 60%; cT3–4: 51%; cN+: 82%. Regimen: anthracycline+taxane 97%. Treatment delivery: Completion of planned NACT 95.5%; early discontinuation 4.5%; mainly toxicity (~78%) vs progression (~22%). Surgery pattern: Mastectomy 83% vs BCT 17%; ALND 88% vs SLNB 12%. pCR: Overall 8.9% (17/192). By nodal status: cN0 25.0% (7/28) vs cN+ 6.2% (10/162), p=0.005. By grade: G3 20.8%, G2 4.5%, G1 0% (χ^2 p=0.0015; G3 vs G1–2 p=0.0009). HER2–0: 8.4% vs HER2–low 9.3% (p=1.00). Ki–67 (continuous): OR 1.40 per 10% (95% CI 1.15–1.71; p=0.0009); binary cut–off ≥20% was not significant. Predictors of pCR: Univariate: G3 and higher Ki–67 associated with higher pCR; node–positive associated with lower pCR. On multivariable analysis: N+ vs N0 remained independently associated with lower pCR (OR 0.23, 95% CI 0.07–0.71; p=0.011)

Characteristic		Patients (n=202)
Age	Median	47
	Range	24–71
Menopausal status	Pre/Perimenopausal	149 (73.8%)
	Postmenopausal	53 (26.2%)
Histology	IDC	177 (87.6%)
	ILC	25 (12.4%)
Grade	Grade 1	6 (3.0%)
	Grade 2	141 (69.8%)
	Grade 3	55 (27.2%)
Ki–67	<20%	80 (39.6%)
	≥20%	122 (60.4%)

Characteristic		Patients (n=202)
HER2 category	HER2 0	101 (50.0%)
	HER2–low	101 (50.0%)
Clinical T stage	T1–2	97 (48.0%)
	T3–4	103 (51.0%)
	Tx / Unknown	2 (1.0%)
Clinical N stage	N0	31 (15.3%)
	≥N1	166 (82.2%)
	Nx / Unknown	5 (2.5%)
Type of neoadjuvant systemic therapy	Anthracycline + Taxane	196 (97.0%)
	Taxane–only (TC)	4 (2.0%)
	Chemo–IO (KN–522)	2 (1.0%)

Comparisons	Univariate			Multivariable		
	OR	**95% CI**	**P Value**	**OR**	**95% CI**	**P Value**
G3 vs G1–2	5.81	2.02–16.65	0.001	3.03	0.68–13.5	0.146
cN+ (≥N1) vs N0	0.24	0.08–0.68	0.007	0.23	0.07–0.71	0.010
Ki–67 (per 10%)	1.40	1.15–1.71	0.0009	1.21	0.91–1.62	0.188

Multivariable Cox model adjusted for Grade, Clinical Tumor and Nodal stage , Ki–67, Clinical T stage, HER2 status , Histology subtype, Menopausal status and Age.

Conclusion:

In this real–world ER+/HER2–negative or HER2–low eBC cohort, pCR was modest (~9%) and most patients completed NACT (~96%). Node–positive disease consistently predicted lower pCR and remained independent after adjustment, whereas grade 3 and higher Ki–67 associated with higher pCR on univariate. HER2–low vs HER2–0 showed no difference in pCR.

Lecture Title :

Screening of Breast Cancer – Is 40 the Magic Number?

Dr. Partha Basu MD, PhD
Head, Cancer early Detection & Prevention Branch
International Agency for Research
on Cancer (WHO), France

Abstract

Age to start breast cancer screening with mammography – an evidence–based decision–making

Female breast cancer incidence is increasing worldwide, driven by delayed first childbirth, shorter duration of breastfeeding, obesity, sedentary lifestyles, and improved diagnostic capacity. In the United States, the steepest rise has been observed among women younger than 50 years, with an average annual increase of about 1.4%. Similar trends have been reported in Gulf countries such as Kuwait, where incidence among younger women has risen over the past two decades. These patterns have led to renewed debate on whether screening should start at earlier ages.

The International Agency for Research on Cancer concluded in 2014 that biennial or triennial mammography screening reduces breast cancer mortality by nearly 40% among women aged 50–69 years. Significant benefit was also observed in women aged 70–74 years. Although rmortality eductions of 32% in women aged 45–49 years and 17% in those aged 40–44 years were reported, these were not statistically significant. Accordingly, women aged 50–74 years have been considered the primary target group for mammography screening.

Guidelines in the European Union have recommended mammography screening in women aged 45–49 years compared with no screening, but not routinely in younger women. Pooled analyses of randomized trials suggest that screening 100,000 women aged 45–49 years could prevent around 98 breast cancer deaths and 7 cases of stage III/IV disease. The UK Age Trial, which evaluated initiation at age 40, did not show a statistically significant reduction in breast cancer mortality after extended follow–up (RR 0.98; 95% CI 0.79–1.22), although approximately 100 deaths per 100,000 women invited were prevented. More recently, the United States Preventive Services Task Force updated its recommendation to initiate biennial mammography at 40 years.

Breast cancer screening is a public health intervention requiring a careful balance between benefits and harms, including false positives, and additional investigations—particularly common in younger women with dense breasts. Programmes should prioritize screening women aged 50–74 years, where absolute risk and evidence of benefit are greatest. Depending on resources and health system capacity, the starting age may be lowered to 45 or 40 years within a context–specific, evidence–informed framework.

Ref.

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Lecture Title:

Role of AI in Early Detection and Diagnosis of Breast Cancer

Nuha Khoumais, MD, MBA IHM, KSA

Abstract

This presentation examines the evolving role of artificial intelligence (AI) in the early detection and diagnosis of breast cancer, emphasizing its potential to address critical challenges in traditional screening methods. Breast cancer remains the most common cancer among women globally, causing an estimated 670,000 deaths in 2022, with 85% of affected women having no risk factors and an increasing incidence in women under 40.

Traditional screening techniques, such as mammography, ultrasound, and MRI, are limited by false positives (ranging from 10% to as high as 90% depending on modality), false negatives, dense breast tissue, and variability in human interpretation. AI, particularly deep learning and convolutional neural networks, has demonstrated reported accuracies of 90–99% in breast imaging. Clinical studies show that AI can increase cancer detection rates by up to 20%, reduce recalls and interval cancer rates, and enable more personalized screening strategies.

AI performance in identifying microcalcifications and masses is comparable to experienced radiologists, and prospective trials indicate that standalone AI systems can surpass less experienced radiologists (AUC of 0.81). Furthermore, more than 60% of cancers missed by AI screening are considered actionable, underscoring the importance of ongoing human oversight. Despite these advances, challenges remain, including integration barriers, the need for large datasets, interpretability, ethical considerations, and regulatory frameworks.

Lecture Title:

Recent Advances in Breast Surgery – Less is More (Oncoplastic & De–escalation Approaches)

Dimitrios Varvaras MD, PhD
Director "Breast Health Clinic" – Casa di Cura Pio XI,
Rome – Italy

Abstract

Background: According to the WHO, breast cancer affected 2.3 million women globally in 2022, remaining the most prevalent malignancy in this population. Surgical management is currently experiencing a profound transition, moving away from historical radicalism in favor of a precision–based, "minimum effective" approach. This shift, driven by multidisciplinary collaboration, seeks to balance oncological safety with functional preservation. This presentation examines how the integration of Oncoplastic Breast–Conserving Surgery (OBCS) and evidence–based surgical de–escalation is establishing a new standard in modern senology.

Methods: We conducted a review of current clinical standards, focusing on the decision–making interface between breast surgeons, radiologists, pathologists, and medical oncologists. Focusing on the evolution of axillary staging, this analysis explores how landmark trials and systemic therapies allow for a precision–based surgical approach guided by tumor biology and individual biological response.

Results: OBCS combines oncological radicality with reconstructive techniques—specifically glandular remodeling and volume displacement or replacement. This approach facilitates negative margins while minimizing post–operative aesthetic morbidity, extending conservation eligibility to patients with unfavorable tumor–to–breast ratios. Parallel to this, surgical de–escalation is redefining axillary management. Data from pivotal trials, including ACOSOG Z0011 and AMAROS, have validated the shift from systematic axillary dissection to targeted Sentinel Lymph Node Biopsy (SLNB), significantly lowering lymphedema rates. Moreover, the high pathologic complete response (pCR) rates observed with Neoadjuvant Systemic Therapy (NAST) now allow for strategic surgical downstaging, enabling conservative procedures even in locally advanced cases.

Conclusion: The "less is more" framework represents a fundamental paradigmatic shift in the surgical mindset rather than a simple technical update. By adopting a multidisciplinary precision model, modern breast surgery successfully aligns oncological stringency with superior aesthetic and psychosocial outcomes without compromising long–term survival.

Keywords: *Oncoplastic Surgery, Surgical De–escalation, Breast–Conserving Therapy, Sentinel Lymph Node Biopsy, Neoadjuvant Therapy.*

Lecture Title:

Managing Toxicities of New Targeted Therapies and Immunotherapy

Dr. Maha AlSendi, Bahrain

ICIs are associated with immune–related adverse events (irAEs) that can affect any organ system, with onset typically within the first 12 weeks but potentially occurring even after treatment discontinuation. Although generally less frequent than chemotherapy–related toxicities, irAEs are less predictable and may be severe. Early recognition and prompt management—primarily with corticosteroids and treatment interruption—are critical. Importantly, the occurrence of irAEs may correlate with improved clinical outcomes, suggesting a potential prognostic role.

ADCs represent a novel therapeutic class combining targeted delivery with potent cytotoxic payloads. While improving efficacy, they introduce unique toxicities such as interstitial lung disease (notably with trastuzumab deruxtecan), gastrointestinal effects, and myelosuppression. Early detection and intervention are essential to mitigate serious complications.

CDK4/6 inhibitors are widely used in hormone receptor–positive breast cancer and are generally well tolerated. However, key toxicities include neutropenia, diarrhea (particularly with abemaciclib), hepatotoxicity, venous thromboembolism, and rare interstitial lung disease. These are typically manageable through dose modifications, supportive care, and careful monitoring.

PARP inhibitors are associated with predominantly hematologic and gastrointestinal adverse events, especially during initial treatment cycles. Management involves dose adjustments, supportive measures, and patient education to ensure adherence and minimize complications.

Overall, effective toxicity management requires a proactive, multidisciplinary approach, emphasizing early detection, patient education, and individualized care. With appropriate strategies, these therapies can be delivered safely while maintaining their clinical benefits.

Lecture Title:

Practice–changing radiotherapy updates from ESTRO and ASTRO 2025

Dr. Zainab Ibrahim, Bahrain
Consultant & head of radiation oncology department
Bahrain oncology center
Royal medical services.

The presentation includes 2 objectives

- Updates from the ESTRO & ASTRO.
- AI in radiation oncology practical implementations.

Discussing the regional radiotherapy after systemic therapy and targeted axillary dissection in breast cancer. The results for CN1, ypN0 is promissing for replacing axillary dissection by radiotherapy, however data is not mature and longer follow up is needed, for cases with CN2 ypN+ post targeted axillary dissection; still regional irradiation is recommende, more mature results is awaited.

The 2nd topic is discussing Focal boost to the intraprostatic tumor for intermediate and high risk prostate cancer, 10 years results of the FLAME–trial, showing a significant improvement in biochemichal disease free survival (15%) at 10 years.

The 3rd topic is theMolecular Classification of the PORTEC–3 Trial for high risk endometrial cancer impact on prognosis and benefit from adjuvant therapy. Subanalysis study reveiled p53 abnormal carries the worse prognosis, while POLE mutation carries the best prognosis and MMR deficit is intermediate, somatic defecit and MLH1 promoter hypermethylation patients are Older, more often grade 2–3 tumors, and high–intermediate risk, the have Worse outcomes: Higher rate of vaginal and pelvic recurrence.

We also presented The Implementations of AI in the radiation oncology :

- The evolution of radiation oncology: from manual planning → automation → AI
- Why AI now? (big data, image processing, adaptive RT, computing power)
- AI integration across the patient journey & Radiation Therapy Workflow; examples have been presented on AI impelemenations on:

a. **Imaging & Segmentation**
b. **b. Treatment Planning**
c. **Quality Assurance (QA)**
d. **Image Guidance and Adaptation**
e. **Outcome Prediction & Personalized Medicine**

Lecture Title:

Lung Cancer in 2025: From Mutation Maps to Immunotherapy Milestones Patients

Dr. Abdulaziz AlJassim
Consultant Medical Oncology and Internal Medicine
Thoracic Oncology and Sarcoma Division, Kuwait Cancer Control Center

Abstract

Key Objectives

This presentation aimed to provide comprehensive updates on the molecular landscape of lung cancer and recent therapeutic advances, with specific focus on:

- Update on molecular mutations and targeted therapies in non–small cell lung cancer (NSCLC)
- Review recent advances in both early–stage and stage IV driver–mutated NSCLC
- Highlight regional prevalence data for the MENA region
- Showcase clinical trial results and real–world treatment outcomes

Main Discussion Points

Molecular Landscape:

Emphasized that "lung cancer is not one disease." Approximately 30–40% of lung adenocarcinomas have targetable mutations, particularly prevalent in females, non–smokers, and Asian populations. The presentation covered key driver mutations including EGFR, ALK, BRAF V600E, MET ex14, and HER2.

Early–Stage Disease:

The ADAURA trial demonstrated that adjuvant osimertinib significantly improved both disease–free survival and overall survival in patients with stage IB–IIIA EGFR–mutated NSCLC, establishing a new standard of care for this patient population.

Advanced Disease Updates:

ALK+ NSCLC: The ALEX trial demonstrated the longest overall survival ever reported in ALK+ metastatic NSCLC, with approximately 4 years median OS using alectinib versus crizotinib in treatment–naïve patients. Lorlatinib, a third–generation ALK inhibitor, has shown remarkable efficacy in managing CNS metastases and overcoming resistance, with the ability to continue systemic treatment even in patients with isolated CNS progression.

BRAF V600E: The combination of encorafenib plus binimetinib has demonstrated significant efficacy in BRAF V600E–mutated NSCLC, with case presentations showing rapid and sustained responses.

MET ex14 Skipping: The VISION trial evaluated tepotinib in this rare molecular subset, providing important data on treatment efficacy and durability of response.

HER2 Mutations: The DESTINY–Lung02 trial demonstrated promising results with trastuzumab deruxtecan (T–DXd), showing rapid and substantial tumor responses even after prior therapies.

Small Cell Lung Cancer (SCLC):

Recent advances in SCLC treatment include tarlatamab, a bispecific T–cell engager (BiTE) antibody targeting DLL3, which represents a novel immunotherapeutic approach for this historically difficult–to–treat malignancy.

Key Take–Home Messages

- Overall 5–year survival for all cancers combined has improved to 70% for patients diagnosed during 2015–2021 in the United States
- Targeted therapies offer superior outcomes (ORR 50–80%, median OS 3–7 years) compared to traditional approaches for molecularly selected patients
- Front–line treatment decisions significantly impact the entire treatment itinerary and long–term outcomes
- Molecular testing is essential for personalized treatment planning in NSCLC
- Novel therapies continue to emerge across all molecular subtypes of lung cancer, including innovative approaches for SCLC

Lecture Title:

Nurses as Pillars of Palliative Support

(The critical role of nurses in bedside care, emotional support, and advocacy)

Mr. Ghassan Abudari
KSA

Abstract

A structural analysis of care delivery

Modern palliative care delivery identifies nurses as the primary cornerstone of support, establishing a direct structural and conceptual link between the bedside presence and patient outcomes. This alignment is explicitly mirrored in World Health Organization standards, where the core nursing functions of impeccable assessment and holistic relief of physical, psychosocial, and spiritual suffering form the foundation of care. By operating as the "backbone" of interdisciplinary teams, nurses bridge the gap between medical complexity and patient understanding through continuous surveillance and dedicated advocacy. However, significant barriers within the Gulf region impede the full development of this specialty. Workforce shortages are acute, characterized by a heavy dependence on expatriate staff and a lack of robust retention pathways. Educational gaps further complicate this landscape, as many practitioners face inadequate undergraduate exposure and a total absence of standardized specialty certification. These systemic issues are compounded by a restricted scope of practice that offers limited autonomy and few nurse–led care models, effectively silencing the nursing voice in policy and service design. Practitioners also face intense emotional and moral distress due to sustained exposure to end–of–life care without the benefit of structured psychological support or formal debriefing systems. Furthermore, the scarcity of nurse–led research in the region limits professional visibility and influence. Addressing these challenges—ranging from workforce stability to enhanced clinical autonomy—is essential for advancing palliative nursing. Strengthening these pillars will ensure that the "therapeutic presence" of the nurse remains a central component of high–quality, patient–centered care for those facing life–limiting illnesses.

Lecture Title:

Hospice Care in the GCC: Challenges and Opportunities

Dr. Atika Al Musalami. Consultant Palliative Medicine. Oman

Abstract

Palliative care is increasingly recognized as an essential component of comprehensive cancer care, yet significant gaps remain in its implementation across the Gulf and the broader Eastern Mediterranean Region (EMR). This presentation explores the current landscape of hospice and palliative care in the region, highlighting systemic, cultural, and policy–related barriers while identifying opportunities for integration into mainstream oncology practice.

Hospice and Palliative Care

According to recent regional data, approximately 1.56 million people in the EMR experience serious health–related suffering annually, yet service availability remains extremely limited, with a median of only 0.04 palliative care services per 100,000 population. Additionally, only a small proportion of countries have comprehensive national palliative care strategies, and access to essential opioid analgesics remains significantly below global averages due to regulatory restrictions and persistent "opiophobia."

Hospice and Palliative Care

Beyond structural barriers, sociocultural factors strongly influence palliative care adoption. Family–centered decision–making, the "conspiracy of silence" regarding prognosis disclosure, and a prevailing culture of pursuing aggressive treatment until the final stages of illness often delay referral to palliative services. These dynamics can lead to prolonged hospitalizations and futile interventions near the end of life, limiting opportunities to optimize quality of life and patient–centered care.

Hospice and Palliative Care

Despite these challenges, significant opportunities exist. Integrating palliative care earlier in the cancer trajectory has demonstrated benefits in symptom control, patient satisfaction, healthcare utilization, and even survival in some settings. Strategies for progress include developing culturally sensitive communication models, strengthening multidisciplinary training programs, expanding home–based palliative care, and aligning regional policies with international frameworks such as WHO and NCCN guidelines. Collaboration with religious and community leaders may also help frame palliative care within culturally and spiritually meaningful contexts.

Advancing hospice and palliative care across the GCC requires coordinated policy reform, improved education for healthcare professionals, and normalization of early referral within oncology practice. Reframing palliative care as "maximum support" rather than "end–of–life care" may help transform perceptions and ensure that patients with serious illness receive compassionate, holistic care throughout the disease trajectory.

Lecture:

Advances in Screening and Early Detection: From FIT to AI–Assisted Colonoscopy

Speaker: Dr. Mohamed Hasan; Consultant Gastroenterologist & Hepatologist – Bahrain

Introduction:

- CRC remains the third leading cause of cancer related deaths worldwide.
- It was believed that CRC is most frequently diagnosed among persons aged 65 to 74 years.
- In a recent publication by the International Agency for Research on Cancer (IARC–WHO), the global burden of colorectal cancer (CRC) is expected to increase by 60% to more than 2.2 million new cases and 1.1 million deaths by 2030.

Key Points:

- The US Preventive Services Task Force recommends screening for CRC in adults starting at the age of 45 yrs (new recommendation since 2021!):
  - Screening for CRC is recommended in ALL adults aged 45 to 75 yrs.
  - Selective screening can be offered in adults aged 76–85 yrs considering the patient's overall health, prior screening & preferences.
  - Start colonoscopies at age 40 or 10 years younger than the earliest diagnosis.
- **FIT test:**
  - The fecal immunochemical test (FIT) uses antibodies to detect blood in the stool.
  - Sensitivity of 79–88% for CRC, 25–40% for advanced adenoma's.
  - It is recommended to be done annually in the average–risk population.
  - Colonoscopy is recommended after a positive FIT test.
  - Higher quantitative values (>400 µg/g) significantly increase the PPV for malignancy.
- **Colonoscopy:**
  - Colonoscopy remains the gold standard for CRC screening.
  - Quality measures MUST be met in a screening colonoscopy:
    1. ADR (adenoma detection rate): minimum target of ≥ 25%
    2. Caecal intubation rate: ≥ 90–95%
    3. Withdrawal times: ≥ 6 minutes.
- **CADe colonoscopy:**
  - Adenoma miss rates (AMR) is not negligible: ~ 26% and the main aim of CADe (AI – assisted) colonoscopies is to help ↑ ADR and ↓ AMR.
  - Particularly beneficial for flat lesions, notably SSL.
  - In December 2024, ESGE recommended the use of Computer–Aided Detection (CADe) for CRC screening and surveillance, though this was considered a "weak" recommendation due to limited evidence on long–term benefits.
  - However; the AGA made a different recommendation stating that in adults undergoing colonoscopy, the AGA makes no recommendation on the use of CADe–assisted colonoscopy. (No recommendation, very low certainty of evidence).

Take–home messages:

- FIT remains the cornerstone of population–based screening for CRC.
- Colonoscopy is still the gold standard, and should be resorted to in the high–risk populations as the screening method of choice.
- CADe colonoscopy has shown promising results in increasing ADR's and reducing AMR's, however with it's limitations.
- Guideline recommendations: the jury is still out.
- Further studies are required before AI–assisted colonoscopies can become the standard of care.

Precision Oncology and the Role of Circulating Tumor DNA (ctDNA): From MRD to Treatment Decisions

Dr. Alaa Alsalem, KSA

Lecture Title:

Liver–Directed Therapies in CRC: Surgery, Ablation, and Emerging Role of Liver Transplantation

Dr. Essa M. Aleassa,
MD MSc FACS FRCSC FAHPBA FASMBS
Robotic Hepatopancreatobiliary and Abdominal Transplant Surgeon
Cleveland Clinic Abu Dhabi, Abu Dhabi, United Arab Emirates Email: e.aleassa@gmail.com

Abstract

The liver is a common site for metastases in patients with colorectal cancer. Metastases can either present in a synchronous or metachronous pattern. Management of colorectal liver metastases has undergone multiple iterations over the past few decades with expansion of criteria to salvage these patients with promising outcomes after being deemed an end of life disease that warrants palliation. Among these options are resection, ablation, and the emerging role of liver transplantation in well selected patients. We aim in this talk to go over the different scenarios of colorectal liver metastases by pattern of disease spread and timing of presentation and to match it to the appropriate management approach to achieve the best possible recurrence–free and overall survival.

Lecture Title:

Organ–Preserving Approaches in Rectal Cancer (Watch & Wait)

Dr Ahmed AlSaleh, Kuwait

Abstract:

The management of rectal cancer has traditionally relied on total mesorectal excision (TME), which remains oncologically effective but is frequently associated with significant morbidity, including permanent stoma formation, bowel dysfunction, urinary and sexual impairment, and reduced quality of life. Advances in neoadjuvant treatment strategies have led to increasing interest in organ preservation (OP) approaches aimed at avoiding radical surgery while maintaining oncologic safety.

Organ preservation in rectal cancer is primarily achieved through Total Neoadjuvant Therapy (TNT), local excision techniques, and more recently, immunotherapy. TNT, which combines chemoradiotherapy with systemic chemotherapy before surgery, has demonstrated higher rates of complete clinical response (cCR), improved treatment compliance, and earlier management of micrometastatic disease. In selected patients who achieve cCR, the Watch–and–Wait (W&W) strategy offers a non–operative alternative with close surveillance and deferred surgery only in cases of tumor regrowth or recurrence.

Assessment of cCR requires a multidisciplinary approach incorporating digital rectal examination, endoscopy, magnetic resonance imaging (MRI), and carcinoembryonic antigen (CEA) monitoring. Appropriate patient selection is essential, particularly for individuals with low– or mid–rectal locally advanced tumors who demonstrate an excellent response to neoadjuvant therapy and are capable of adhering to strict follow–up protocols.

Current evidence indicates that local regrowth occurs in approximately 20–30% of patients managed with W&W, most commonly within the first two years; however, the majority of these cases are successfully salvaged with surgery without compromising overall survival or diseasefree survival. Emerging evidence regarding immunotherapy, particularly in patients with mismatch repair–deficient (dMMR) or microsatellite instability–high (MSI–H) rectal cancer, has shown promising results with complete clinical responses in selected cohorts.

Despite encouraging outcomes, several challenges remain, including the lack of a universal definition for cCR, variability in assessment methods, the need for experienced multidisciplinary teams, and concerns related to patient anxiety and medico–legal considerations. Nevertheless, international guidelines increasingly support organ preservation strategies within specialized centers and structured surveillance programs.

Organ preservation represents a significant paradigm shift in rectal cancer management, aiming to balance oncologic safety with improved quality of life. Future advances in biomarkers, imaging technologies, personalized therapies, and artificial intelligence are expected to further refine patient selection and treatment outcomes in this evolving field.

Lecture Title:

Recent Updates in Gynecologic Malignancies

Checkpoint Shifts & ADCs: Rewriting the Gynecologic Oncology Playbook

Dr. Noora AlEbrahim, Kuwait

Abstract:

In this session we reviewed the evolving role of antibody–drug conjugates (ADCs) in gynecologic malignancies, with a focus on evidence–based practice integration and toxicity mitigation.

The objectives were to:

1. summarize ADC regimens with demonstrated efficacy in ovarian, cervical, and endometrial cancers
2. highlight investigational ADCs with emerging targets and payloads under active clinical evaluation
3. discuss patient–experience considerations, including adverse event recognition and management to support treatment selection and sequencing.

The presentation started with a focused practical introduction to ADC structure and mechanism, emphasizing targeted delivery of highly potent cytotoxic payloads via tumor–associated antigens, with potential bystander effects. Three clinically available ADC strategies were reviewed. In recurrent/metastatic cervical cancer, tisotumab vedotin (tissue factor–targeting; MMAE payload) demonstrated improvements in overall survival and progression–free survival versus chemotherapy (innovaTV 301). In platinum–resistant ovarian cancer, mirvetuximab soravtansine (folate receptor–α–targeting; DM4 payload) improved progression–free and overall survival compared with standard chemotherapy (MIRASOL). In HER2–expressing gynecologic cancers, trastuzumab deruxtecan (topoisomerase I inhibitor payload) showed clinically meaningful response rates and durable benefit in heavily pretreated cohorts, supporting an FDA tumor–agnostic indication based on DESTINY–PanTumor02 data.

Investigational pipelines were then summarized across targets including HER2, folate receptor–α (next–generation constructs), cadherin–6, and TROP2, with early–phase signals suggesting activity across platinum–resistant and selected platinum–sensitive settings and informing ongoing phase II/III programs and combination strategies (including immunotherapy backbones).

Safety and supportive care were emphasized as key determinants of ADC selection. Specific toxicities discussed included ocular events (notably with some ADCs) and interstitial lung disease/pneumonitis (particularly relevant to trastuzumab deruxtecan), highlighting proactive screening, early symptom recognition, multidisciplinary management, treatment interruption thresholds, and timely corticosteroid initiation. The session concluded that ADCs are expanding therapeutic options in gynecologic oncology, and optimizing outcomes will require biomarker–informed decision–making, trial participation, and structured toxicity mitigation pathways.

Lecture Title:

Precision & Immunity: GU Oncology's New Era

Ahmed Badheeb,
King Khaled Hospital, Najran, Saudi Arabia,
Badheebdr@gmail.com

Precision Oncology is a tailored cancer care approach using patient biomarkers (genetic, molecular, cellular) to select targeted treatments and improve outcomes.

Metastatic Prostate Cancer is biologically diverse, with approximately 25% of mCRPC patients having alterations associated with DNA repair pathways, especially Homologous Recombination Repair (HRR).

Patient Outcomes with HRRm, including BRCA2 mutations, are generally poor when using standard–of–care therapies (p. 8).

Identifying Alterations can be done via fresh metastatic tumor biopsy, circulating tumor DNA (ctDNA), archival tissue, or blood/saliva (for germline testing). The ctDNA fraction peak for testing is greatest at baseline and second progression.

PARPi as Monotherapy showed benefit, particularly in patients with BRCA mutations in the PROfound trial. Olaparib and rucaparib have received FDA/EMA approval as monotherapies for specific mCRPC patient groups. Talazoparib and niraparib are not currently approved as monotherapies.

PARPi Combinations with novel hormonal agents (NHA) have been explored in phase 3 trials like PROpel, MAGNITUDE, and TALAPRO–2 . Sequential use of NHA may offer limited benefit.

Safety Profile of PARPi combinations often involves manageable adverse events, with anemia being a common side effect.

This presentation, highlights the shift towards biomarker–driven treatment strategies to optimize outcomes for mCRPC patients, and provides an overview of using precision oncology and PARP inhibitors (PARPi) for treating metastatic castration–resistant prostate cancer (mCRPC), particularly in patients with HRR mutations.

Conclusions emphasize the significance of early intervention using PARPi in treating HRR–deficient mCRPC, alongside ongoing discussions about the optimal sequences and combinations of therapies to enhance patient outcomes. The presentation underscores the necessity of somatic tissue testing to guide treatment decisions effectively.

Key highlights include:

- **Homologous recombination repair (HRR)** as a critical mechanism for DNA repair, with 23% of mCRPC patients harboring DNA repair alterations.
- The challenges of identifying HRR alterations via fresh biopsies or circulating tumor DNA (ctDNA).
- The efficacy of **PARP inhibitors (PARPi)**, specifically Olaparib, which demonstrates improved radiographic progression–free survival and overall survival in patients with HRR mutations.
- Recent phase 3 trials highlighting the combination therapies using PARPi plus next–generation hormonal agents, improving previous treatment standards.

Lecture Title:

ASH Highlights: Hematology on the Move

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Regional Oncology Conference: Cancer Reality and Challenges — Kuwait, February 3, 2026

Abstract

ASH 2026 and Beyond: Key Paradigm Shifts in Hematological Malignancies

This lecture reviewed practice–changing data presented at the 2025 American Society of Hematology (ASH) Annual Meeting and outlined emerging paradigms expected to shape the management of hematological malignancies in 2026 and beyond. The session focused on four key disease areas: acute lymphoblastic leukemia (ALL), acute myeloid leukemia (AML), chronic lymphocytic leukemia (CLL), and multiple myeloma (MM), with particular emphasis on the rise of chemotherapy–free regimens, minimal residual disease (MRD)–guided strategies, and novel immunotherapeutic approaches.

Key trials discussed included the GIMEMA ALL2820 study, supporting a chemo–free targeted/immunotherapy approach as an emerging standard for adult Ph+ ALL, and long–term follow–up of the Alliance A041703 trial in older ALL patients. In AML, the randomized phase II PARADIGM trial demonstrated that azacitidine plus venetoclax significantly improved event–free survival, response depth, and quality of life compared with intensive 7+3 chemotherapy in fit, newly diagnosed adults, while reducing early mortality and healthcare utilization. The phase III CLL17 trial compared continuous ibrutinib with fixed–duration venetoclax–based combinations, reinforcing the shift toward time–limited therapy. In multiple myeloma, the i2TEAMM meta–analysis supported MRD as a regulatory surrogate endpoint, while the MIDAS, AURIGA, and MajesTEC–3 trials illustrated the impact of quadruplet induction, anti–CD38 maintenance, and BCMA–directed bispecific antibodies (teclistamab plus daratumumab) in transforming outcomes for both newly diagnosed and relapsed/refractory disease.

Take–home messages: (1) response assessment is evolving beyond morphology, with MRD becoming a central endpoint; (2) chemotherapy–free regimens incorporating targeted agents, monoclonal antibodies, bispecifics, and cellular therapies are increasingly replacing conventional chemotherapy; (3) fixed–duration strategies are gaining momentum in CLL and MM; and (4) next–generation cellular therapies, including off–the–shelf and in vivo CAR–T platforms, represent a potentially transformative frontier in hematologic oncology.

Final Recommendations of the Regional Oncology Conference 13th Conference of the Gulf Federation for Cancer Control "Cancer: Reality and Challenges"

2–3 February 2026
State of Kuwait

The Drafting Committee of the 13th Annual Conference of the Gulf Federation for Cancer Control, held under the theme "Cancer: Reality and Challenges" from 2 to 3 February 2026 in the State of Kuwait, convened and extended its sincere appreciation and gratitude to:

1. The State of Kuwait—its leadership, government, and people—for their warm hospitality, and the outstanding organization of the conference. We pray to Almighty God to protect Kuwait, its leadership, and its people from all harm.
2. H.E. Dr. Ahmad Abdulwahab Al–Awadhi, Minister of Health, for his gracious patronage and attendance at the opening ceremony, and for his supportive remarks toward strengthening Gulf cooperation in cancer control.
3. The Gulf Federation for Cancer Control and the Kuwait Society for Smoking and Cancer Prevention, represented by Dr. Khaled bin Ahmed Al–Saleh, Secretary General of the Gulf Federation for Cancer Control and Conference President, for organizing this distinguished scientific event. The Committee also extends its appreciation to the Scientific Committee for their dedicated efforts in ensuring the success of the conference, as well as to all organizing committees for their significant contributions throughout the preparation and execution phases, ensuring the smooth conduct of the event and the comfort of participants.
4. The Drafting Committee highly values the scientific papers presented during the conference and affirms the consensus of participants that these contributions were highly relevant to the conference theme and contained valuable scientific insights that enriched the discussions. The Committee recommends compiling and publishing these papers to make them accessible to researchers and interested stakeholders.

The Committee also issued the following recommendations of the "Cancer: Reality and Challenges" Conference, held in the State of Kuwait from 2 to 3 February 2026:

1. Adoption of a Unified Gulf Framework for Cancer Control:

   The conference recommends updating the Gulf Cancer Control Plan (2016–2025) and adopting a comprehensive regional framework that includes prevention, early detection, treatment, palliative care, and survivorship care. This should involve unified clinical guidelines with flexibility for national adaptation based on each country's healthcare context.
2. Development of Risk–Based Early Detection Programs:

   The conference recommends standardizing and expanding evidence–based screening programs, upgrading opportunistic screening into structured national programs, and adopting risk assessment models, genetic testing, and artificial intelligence technologies. It also calls for revisiting the target age groups for breast and colorectal cancer screening, including younger high–risk populations.
3. Integration of Artificial Intelligence in Oncology Care:

   The conference recommends establishing a Gulf–wide system to regulate the use of artificial intelligence in radiological imaging, morphological diagnostics, colonoscopy, and clinical decision support systems, within clear regulatory and ethical frameworks and supported by accredited training programs.
4. Advancing Precision Medicine and Genetic Counselling:

   The conference recommends integrating genetic counselling and testing into primary healthcare

services, developing unified Gulf protocols for hereditary cancer syndromes, and expanding screening for high–risk families and relatives.

5. Establishment of a Unified Gulf Clinical Research Network:

   The conference recommends creating a Gulf mechanism to support clinical research, with a focus on precision medicine, multicentre clinical trials, and data sharing for research purposes. It also calls for aligning research priorities with the regional cancer burden and emerging therapies. The Committee further recommends supporting the Gulf Journal of Oncology, which has gained international recognition and is indexed in the U.S. National Library of Medicine with a notable impact factor.

6. Accelerating Access to Advanced Diagnostic and Therapeutic Technologies:

   The conference recommends investing in liquid biopsy technologies and next–generation sequencing (NGS) to enhance treatment decision–making and disease monitoring. It also calls for accelerating the adoption of advanced therapies, such as antibody–drug conjugates (ADCs) and CAR–T cell therapy, through specialized treatment centres and facilitating patient access across GCC countries.

7. Strengthening Palliative and Supportive Care Across the Care Continuum:

   The conference recommends integrating early palliative care into cancer treatment pathways, training primary care and nursing staff, developing sustainable hospice care models that respect cultural values, and expanding home–based care services for cancer patients.

8. Development of Comprehensive Survivorship Care Models:

   The conference recommends establishing specialized survivorship clinics focused on improving quality of life, managing long–term complications of disease and treatment, and providing psychosocial support and rehabilitation services, particularly for breast cancer survivors, colorectal cancer survivors, and other cancer patients.

9. Governance, Monitoring, and Impact Measurement:

   The conference recommends establishing clear governance and monitoring frameworks, including measurable key performance indicators (KPIs) linked to unified digital platforms, with regular updates to ensure sustainability and assess the real impact of national cancer control policies across GCC countries.

Drafting Committee – State of Kuwait
15 Sha'ban 1447 AH
Corresponding to 3 February 2026

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