job security and access to health care following cancer diagnoses, experts told *The Lancet Oncology*.

"The ADA does not protect everybody and its protections are not always clearly defined", said Victoria Blinder (Memorial Sloan Kettering Cancer Center, New York, NY, USA). The ADA applies to state and local governments of any size, but only to private-sector companies with 15 or more employees—a provision that disproportionately excludes lower-income workers, Blinder said. "These people are going to be more vulnerable to the financial consequences of job loss—and we know that job loss and bankruptcy are associated with a higher mortality rate among cancer survivors", Blinder said.

The ADA requires reasonable workplace accommodations for patients with disabilities when doing so does not constitute an undue hardship for employers, explained Monica Bryant (Triage Cancer, Chicago, IL, USA).

Most states also have their own workplace non-discrimination laws, although not all of them specifically protect patients with cancer or cancer survivors. Laws in some states, such as California, apply to employees of firms with as few as five workers. The fair employment law in Illinois applies to all workers, regardless of a firm's size.

It is unclear how many Americans face workplace discrimination following cancer diagnoses. "We have the official US Government statistic: in 2018, 3·3% of ADA discrimination lawsuits were related to cancer diagnoses", Blinder said. "But that's probably only the tip of the iceberg." Patients are often too sick or busy with treatment to prioritise filing a discrimination suit, she added.

"It can be difficult to determine if a person's cancer history is used against them because discrimination can be subtle", said Rebecca Nellis (Cancer and Careers, New York, NY, USA). Blinder agreed, commenting that not all discrimination is ill intended.

When Ann Camden (Raleigh, NC, USA) was first diagnosed with breast cancer, she had breast-conserving surgery, chemotherapy, and radiation therapy. The communications firm at which she worked was accommodating. She even became a partner and co-owner of the agency. But 6 years later, when the disease returned, she felt side lined when an opportunity arose to go overseas to pitch new clients.

Subtle forms of job discrimination occur in Canada as well, noted Lydia Beck (Cancer Rehabilitation and Survivorship Program, Princess Margaret Cancer Centre, Toronto, Ontario, Canada). Canadian employers might not accommodate cancer survivors' new limitations related to longer term-treatment effects, for example.

Even when discrimination is overt, many US workers with cancer are desperate to remain employed lest they lose their employer-provided health insurance—a potentially life-threatening event. "Interrupting chemotherapy schedules can compromise the effectiveness of treatment", Blinder said. "Losing employer-contingent health insurance can mean changing providers—and that can be terrifying."

This is not as big a concern for patients in other countries, although the loss of employer-based health insurance in Canada can mean a loss of extended benefits, such as psychological counselling, Beck said.

"Compared to the USA, patients in other countries can more comfortably take time off during chemotherapy without risking long-term job loss—and without risking having to cope with potentially-catastrophic consequences faced by patients in the USA", Blinder said.

Employers often fear accommodations for patients with cancer will be expensive, Bryant said—but that is rarely the case. Simple measures such as speech-to-text dictation software can help an office worker deal with hand neuropathy, for example.

Employer and employee education about workers' rights is key, Blinder and Bryant agreed. Blinder and colleagues are developing the TEAMWork App, which will help educate patients.

"We have wonderful social workers here at Dana-Farber who spend a lot of time with patients navigating some of these workplace issues, ranging from leaves of absence, disability benefits, or reduced hours to physical appearance at work and working from home", said Harold Burstein (Dana-Farber Cancer Institute and Harvard Medical School, Boston, MA, USA). He added that this can help build employee loyalty to firms.

But too many other patients are forced to assert their rights and navigate the ADA while coping with cancer, Bryant said.

Bryant Furlow

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For more on the **San Francisco school teacher forced to pay for her own substitute during cancer treatment** see https://www.sfchronicle.com/bayarea/heatherknight/article/Cancer-stricken-teacher-charged-for-sub-s-wages-13823689.php

For the **study on the risk of early mortality associated with financial insolvency among patients with cancer** see *J Clin Oncol* 2016; **34:** 980–86

For more on **state laws prohibiting workplace health discrimination on Cancer Triage's website** see https://triagecancer.org/statelaws

For more on **Cancer and Careers** see https://www.cancerandcareers.org/en

For more on **TEAMWork** see https://www.mskcc.org/cancer-care/clinical-trials/18-217

2019 ASCO Annual Meeting

Olaparib for prostate cancer

Joaquin Mateo (The Institute of Cancer Research and The Royal Marsden, London, UK) presented results from the phase 2, TOPARP-B trial, the first to enrol patients with metastatic castration-resistant prostate cancer preselected for putatively pathogenic DNA damage-response gene alterations. 98 patients were randomly assigned under a pick-the-winner design to olaparib 400 mg or 300 mg. The primary endpoint was composite response, defined as radiological response, a 50% PSA fall or circulating tumour-cell count conversion after 4 weeks, or both. The overall composite response was 54% (95% CI

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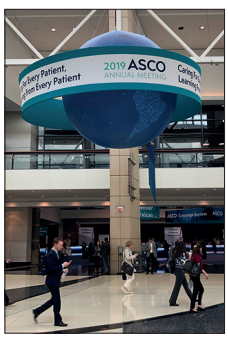

Yaiza del Pozo Martín

The 55th annual meeting of the American Society of Clinical Oncology was held in Chicago, IL, USA, on May 31–June 4, 2019.

For the **Editors' highlights in haematology** see **News** *Lancet Haematol* 2019; published online June 7. http://dx.doi.org/10.1016/S2352-3026(19)30103-6

39–69) in the 400 mg cohort and 37% (23–53) in the 300 mg cohort, assessed in 92 evaluable patients. Prespecified subgroup analyses per mutation type showed that 24 (80%) of 30 patients with a *BRCA1/2* mutation responded. Safety was in line with previous reports.

Olaratumab in sarcoma

Olaratumab (anti-PDGFα monoclonal antibody) in combination with doxorubicin was granted FDA accelerated approval status to treat soft tissue sarcomas on Nov 10, 2016. William Tap (Memorial Sloan Kettering Cancer Center, New York, NY, USA) presented the results of the phase 3, ANNOUNCE trial. The primary endpoint was overall survival in the intent-to-treat (ITT) and the leiomyosarcoma populations. 258 patients were randomly assigned to olaratumab (20 mg/kg for cycle 1, 15 mg/kg for subsequent cycles) plus doxorubicin (75 mg/m² for up to 8 cycles) and 251 to placebo plus doxorubicin. In the ITT population, median overall survival was 20·4 versus 19·8 months (hazard ratio [HR] 1·05, 95% CI 0·84–1·30; p=0·69) and 21·6 versus 21·9 months in the leiomyosarcoma population (HR 0·95, 0·69–1·31; p=0·76). Safety was similar between the groups. These data have resulted in the withdrawal of the drug.

Nidanilimab

Ahmad Awada (Jules Bordet Institute, Brussels, Belgium) presented the results from a phase 1 trial of nidanilimab—a first-in-class, monoclonal antibody against the IL1RAP protein. Patients with relapsed or refractory non-small-cell lung cancer, pancreatic ductal adenocarcinoma, breast cancer, or colorectal cancer were included. 22 patients were enrolled across five dose cohorts (1–10 mg/kg). The most common adverse events were infusion-related reaction (41%), pyrexia (27%), fatigue (23%), chills (23%), and nausea (23%). There were three grade 3 events and no grade 4 events. Nine (45%) of 20 achieved stable disease after 8 weeks of follow-up. A recommended phase 2 dose of 10 mg/kg was established, and the expansion phase of the trial will focus on patients with non-small-cell lung cancer and pancreatic ductal adenocarcinoma.

Nab-sirolimus

Malignant perivascular epithelioid cell tumour is a rare sarcoma with no approved treatment and frequent *TSC1* or *TSC2* mutations. Andrew Wagner (Dana-Farber Cancer Institute, Boston, MA, USA) and colleagues did the first prospective trial in this sarcoma subtype to test the potential activity of mTOR inhibitors. In the phase 2 AMPECT study, 34 patients with centrally confirmed malignant perivascular epithelioid-cell tumour received nab-sirolimus (100 mg/m² intravenously, once a week every 2–3 weeks). An overall response (primary endpoint) was achieved by 13 (42%) of 31 evaluable patients. By mutational status, all nine patients with *TSC2* mutations achieved a response, as did one (20%) of five patients with *TSC1* mutations. The most common grade 3 events were mucositis (18%) and anaemia (12%). No grade 4–5 adverse events occurred.

Relatlimab

Kyriakos P Papadopoulos (South Texas Accelerated Research Therapeutics, San Antonio, TX, USA) presented the results of a first-in-human trial of relatlimab, an anti-lymphocyte activation gene-3 (*LAG-3*) monoclonal antibody, alone or combined with cemiplimab (anti-PD1 inhibitor). Patients with advanced malignancies with disease progression and for whom no other therapy was available received relatlimab (1, 3, 10, or 20 mg/kg every 3 weeks) with or without cemiplimab (3 mg/kg or 350 mg every 3 weeks intravenously for up to 51 weeks). No dose-limiting toxicities were recorded for the 27 patients who received monotherapy, and stable disease was achieved by 11 (41%) of 27 patients. Of 42 patients who had combination therapy, one had grade 4 elevated blood creatine phosphokinase. Four partial responses were observed in patients who had crossed over from the monotherapy to the combination therapy.

DS-1001b

DS-1001b is an oral selective inhibitor of *IDH1* mutant variant R132X, designed to penetrate the blood–brain barrier and minimally target wild-type *IDH1*. In a first-in-human, phase 1 study, Atsushi Natsume (Nagoya University School of Medicine, Nagoya, Japan) and colleagues enrolled patients with recurrent or progressive glioma with an *IDH1* mutation. A continual reassessment method was used for dose escalation; 45 patients received DS-1001b 125–1400 mg twice daily. One (2%) of 45 treated patients had a dose-limiting toxicity (primary endpoint): grade 3 decreased white blood cell count. 42% of patients had a grade 3 event, and there were no grade 4–5 events. Of 29 evaluable patients, 14 (48%) had an overall response. Investigation of the recommended phase 2 dose is ongoing.

Yaiza del Pozo Martín