J. DE GRÈVE

DEAR COLLEAGUES,

At the start of the fresh new year, full of energy in the winter blanket and sunshine, plans will be completed or initiated.

In a quick scroll through the issue, I first stumbled on the life-saving preventive mastectomy and adnexectomy in BRCA1/2 mutant breast cancer patients (Newsroom).

It is most unfortunate that most BRCA1/2 mutation carriers still end up in this situation because our genetic testing system is rigidly driven by familial history, preventing finding these mutations in presymptomatic individuals. When will the universal population access to BRCA1/2 testing be accessible? We are thirty years since the discovery of the BRCA/2 genes, and the test is still used overwhelmingly in a diagnostic setting. **What a shame!** Universal access is cost-effective compared to genetic screening based on familial cancer history in several countries. So why wait anymore? Professional stakeholders and politicians who listen to the professionals are frozen in a diagnostic mindset, leaving most mutation carriers in the cold. All the necessary evidence is there. Unless they move quickly forward to non-discriminatory universal access, they will be guilty of negligence for hundreds of avoidable cancer deaths and immense suffering each year in Belgium for years to come.

The **access of cancer patients to intensive care**: I remember lengthy discussions arguing with intensivists, some of them fixated only on the underlying cancer, even if it was not life-threatening and not the immediate cause of the intensive care need. I hope that these times are gone. The authors provide a straightforward algorithm that can help make the right decisions either way and get everyone on board with the logic. First, if possible, an informed patient should be pivotal in the decisions, including information from advance care planning.

An anthology of the many, many, many neurological aspects of cancer and treatments occurring in many of our patients but of even more relevance in young cancer patients
An updated practice guideline on the prevention of chemotherapy-induced nausea and vomiting: results in no less than 13 practice recommendations
A case report on **therapy-induced myeloid malignancy** illustrates very well the journey of ovarian cancer patients. Most probably, the patient, without the PARPi, would not have survived long enough to experience the secondary myeloid malignancy.
A case of a sarcoid-like reaction in a patient with HER2-positive breast carcinoma, a rare benign event: appearances can be false, and the tissue is always the issue.
And to end, a **paraneoplasia case report**: variant **Stauffer syndrome** (IL6 toxicity) occurring in renal cell cancer, sometimes bladder or prostate, but very rare.
Pembrolizumab: reimbursed and standard of care in combination with chemotherapy in first-line in advanced or recurrent endometrial cancer.

I enjoyed the reading, and we are looking forward to the **27th annual meeting of the BSMO, January 31-February 1, in the beautiful city of Bruges.**

See you there, and best wishes for a productive, healthy, and happy 2025.

Yours sincerely,

Jacques De Grève, MD, PhD
Editor-in-Chief