



CONFERENCES

Donal Hollywood Award



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To whom would you like to dedicate your award?

To the patients who participate in the FLAME study and entrust their health to us. All FLAME consortium colleagues from the UMC Utrecht, Netherlands Cancer Institute, University Hospitals Leuven and Radboud UMC Nijmegen, especially Uulke van der Heide, Karin Haustermans, Floris Pos, Marco van Vulpen, Robert Jan Smeenk, Evelyn Monninkhof and lastly to Veerle Groen, who did an excellent job in the analysis of the FLAME data within her PhD thesis. Of course, I also dedicate it to my family, who are a great support.

What have been the highlights of your career?

My scientific career is centred around focal dose escalation for prostate cancer and magnetic resonance imaging (MRI)-guided radiotherapy. I feel privileged that the consortium colleagues entrusted me with the study into focal lesion ablative microboost in prostate cancer (FLAME) and the hypo-FLAME study. The primary outcome and concept of the FLAME study (to improve oncological outcomes without increasing toxicity) have already changed clinical practice, which is surely the most rewarding outcome of a clinical study.

Another milestone was the coordination and setting up of the international clinical collaboration in the MR-linac consortium. This collaboration later resulted in the formation of the unique MOMENTUM data registry. Not only clinical data are collected, but also technical and imaging data of all patients from all treatment fractions in order to 'learn from every patient'. I am proud that the Radboud University Medical Center (Radboud UMC) recently joined MOMENTUM.

What is your next challenge?

To combine focal dose escalation with MRI-guided radiotherapy. Through the performance of MRI-guided adaptation online, we aim to improve further the balance between gross tumour volume dose and normal tissue dose. Furthermore, I hope to help to tighten the connections among the multidisciplinary oncology teams in my role as a vice-chair of the Radboud UMC urological oncology multidisciplinary service. This includes the building of a tumour-centred approach (care chains, value-based healthcare) and connecting basic and clinical research. The treatment options for a patient should not depend on which specialist the patient sees first. All patients should be informed regarding all available treatment options for their specific situation to enable shared decision-making, preferably in a multidisciplinary setting.

What do you think are the next challenges for the radiation oncology community?

Even with fantastic hardware, in the end, it's all about the team. Further personalisation of radiotherapy based on patient and tumour characteristics, real-time anatomy changes and tumour response, can significantly improve outcomes, but it also comes with a higher workload. Smart solutions to decrease time and personnel involvement are critical to enable a more widespread implementation of radiotherapy innovations. The field must be made attractive for radiotherapy technicians and radiographers, new colleagues must be trained and colleagues enabled to grow and develop into different roles. And we need to advocate for radiotherapy in the multidisciplinary community, politics and health insurance companies, and among patient communities. The oncological outcomes and impact of present-day radiotherapy have dramatically improved in the last decade to make radiotherapy an excellent (non-invasive) alternative to other local treatments.

What started your interest in science?

My first experience with research was as a research elective at the Royal Women's Hospital in Melbourne during medical school. This resulted in my PhD thesis on trophoblastic tumours at the Radboud UMC. For the last ten years, I've been focusing on focal dose escalation studies for prostate cancer and MRI-guided radiotherapy, first at the UMC Utrecht and since 2019 at the Radboud UMC. It is a great pleasure to work in a team with research-minded and top clinical colleagues and to be in the position to mentor younger clinical research colleagues now.

If you hadn't been a scientist, what would you like to have been?

I cannot think of a more fulfilling role than being a clinician-scientist, bringing new developments straight into the clinic to improve outcomes for patients.

When do you think you will retire, and what would you like to do then?

I have 30 more years to think about that, so I will enjoy the current time first.

