

Travail & Cancer

Presanse
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Gustave Roussy
& Paris Saclay University



Disclosures

- **Personal financial interests:**

None (starting August 1st, 2021)

- **Institutional financial interests:**

Abbvie, ACEA, Amgen, Astra-Zeneca, Bayer, Bristol-Myers Squibb, Boehringer–Ingelheim, Eisai, Eli Lilly Oncology, F. Hoffmann–La Roche Ltd, Genentech, Ipsen, Ignyta, Innate Pharma, Loxo, Novartis, Medimmune, Merck, MSD, Pierre Fabre, Pfizer, Sanofi-Aventis, Summit Therapeutics and Takeda

- **Non-financial interests:**

Principal Investigator for Astra-Zeneca, BMS, Innate Pharma, Merck, Pierre Fabre and F. Hoffmann-La Roche, Ltd, sponsored trials (or ISR)

**Pourquoi le
cancer est un
sujet pour vous ?**



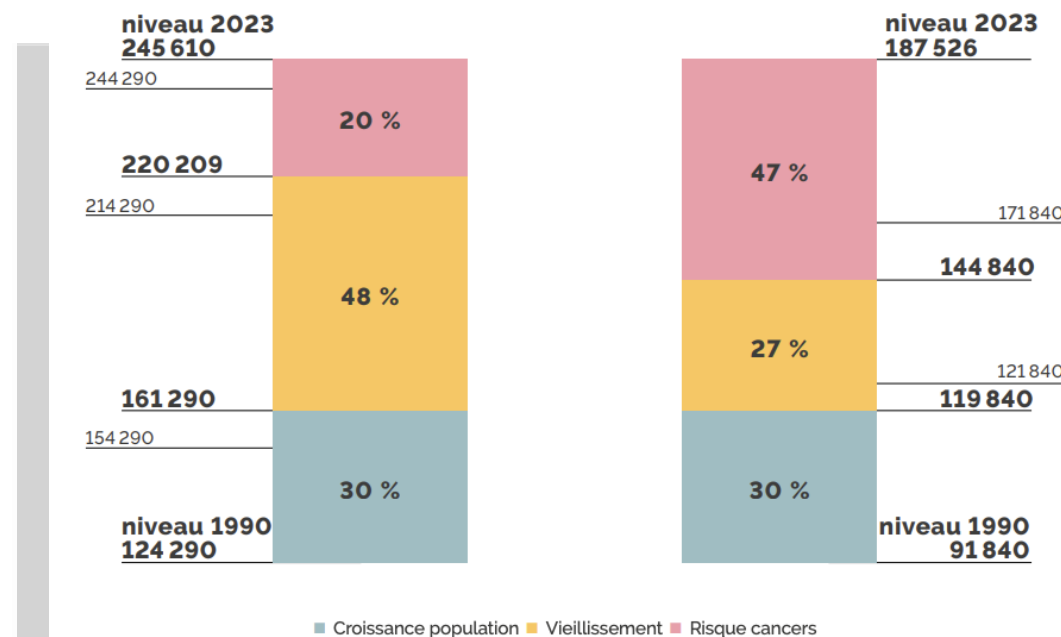
Chaque année,

#0.5 Millions de personnes sont

diagnostiquées avec **un cancer**

Le nombre de cas a doublé entre 1990 et 2020

+98% ♂ +104% ♀



Le nombre de cas va augmenter de 60% d'ici 2050

The global, regional, and national burden of cancer, 1990–2023, with forecasts to 2050: a systematic analysis for the Global Burden of Disease Study 2023



GBD 2023 Cancer Collaborators*

Summary

Background Cancer is a leading cause of death globally. Accurate cancer burden information is crucial for policy planning, but many countries do not have up-to-date cancer surveillance data. To inform global cancer-control efforts, we used the Global Burden of Diseases, Injuries, and Risk Factors Study (GBD) 2023 framework to generate and analyse estimates of cancer burden for 47 cancer types or groupings by age, sex, and 204 countries and territories from 1990 to 2023, cancer burden attributable to selected risk factors from 1990 to 2023, and forecasted cancer burden up to 2050.

Methods Cancer estimation in GBD 2023 used data from population-based cancer registration systems, vital registration systems, and verbal autopsies. Cancer mortality was estimated using ensemble models, with incidence informed by mortality estimates and mortality-to-incidence ratios (MIRs). Prevalence estimates were generated from modelled survival estimates, then multiplied by disability weights to estimate years lived with disability (YLDs). Years of life lost (YLLs) were estimated by multiplying age-specific cancer deaths by the GBD standard life expectancy at the age of death. Disability-adjusted life-years (DALYs) were calculated as the sum of YLLs and YLDs. We used the GBD 2023 comparative risk assessment framework to estimate cancer burden attributable to 44 behavioural, environmental and occupational, and metabolic risk factors. To forecast cancer burden from 2024 to 2050, we used the GBD 2023 forecasting framework, which included forecasts of relevant risk factor exposures and used Socio-demographic Index as a covariate for forecasting the proportion of each cancer not affected by these risk factors. Progress towards the UN Sustainable Development Goal (SDG) target 3.4 aim to reduce non-communicable disease mortality by a third between 2015 and 2030 was estimated for cancer.

Findings In 2023, excluding non-melanoma skin cancers, there were 18·5 million (95% uncertainty interval 16·4 to 20·7) incident cases of cancer and 10·4 million (9·65 to 10·9) deaths, contributing to 271 million (255 to 285) DALYs globally. Of these, 57·5% (55·1 to 59·8) of incident cases and 60·7% (57·9 to 63·6) of cancer deaths occurred in low-income and upper-middle-income countries. In the World Bank region group, sub-Saharan Africa was the second leading cause of deaths globally in 2023 after cardiovascular diseases. There were 4·33 million (3·85 to 4·78) risk-attributable cancer deaths in 2023, with 11·2% (9·3 to 13·1) of these deaths attributable to selected risk factors. Globally, cancer deaths increased by 72·3% (57·1 to 86·8) from 1990 to 2023, whereas overall global cancer deaths increased by 74·3% (62·2 to 86·2) over the same period. The reference forecasts (the most likely future) estimate that in 2050 the GBD 2023 minimum, most likely, and maximum global cancer deaths will be 14·5 million (12·9 to 16·1) globally, 60·7% (41·9 to 80·6) and 74·5% (50·1 to 104·2) increases from 2024, respectively. These forecasted increases in deaths are greater in low-income and middle-income countries (110·1% [91·1 to 127·0]) compared with high-income countries (54·8% [24·3 to 85·4]). Most of these increases are likely due to demographic changes and age-standardised death rates are forecast to change by –5·6% (–12·8 to 4·6) between 2024 and 2050 globally. Between 2015 and 2030, the proportion of deaths due to cancer between the ages of 30 years and 70 years was forecasted to have a relative decrease of 6·5% (3·2 to 10·3).

Interpretation Cancer is a major contributor to global disease burden, with increasing numbers of cases and deaths forecasted up to 2050 and a disproportionate growth in burden in countries with scarce resources. The decline in age-standardised mortality rates from cancer is encouraging but insufficient to meet the SDG target set for 2030. Effectively and sustainably addressing cancer burden globally will require comprehensive national and international efforts that consider health systems and context in the development and implementation of cancer-control strategies across the continuum of prevention, diagnosis, and treatment.

Funding Gates Foundation, St Jude Children's Research Hospital, and St Baldrick's Foundation.

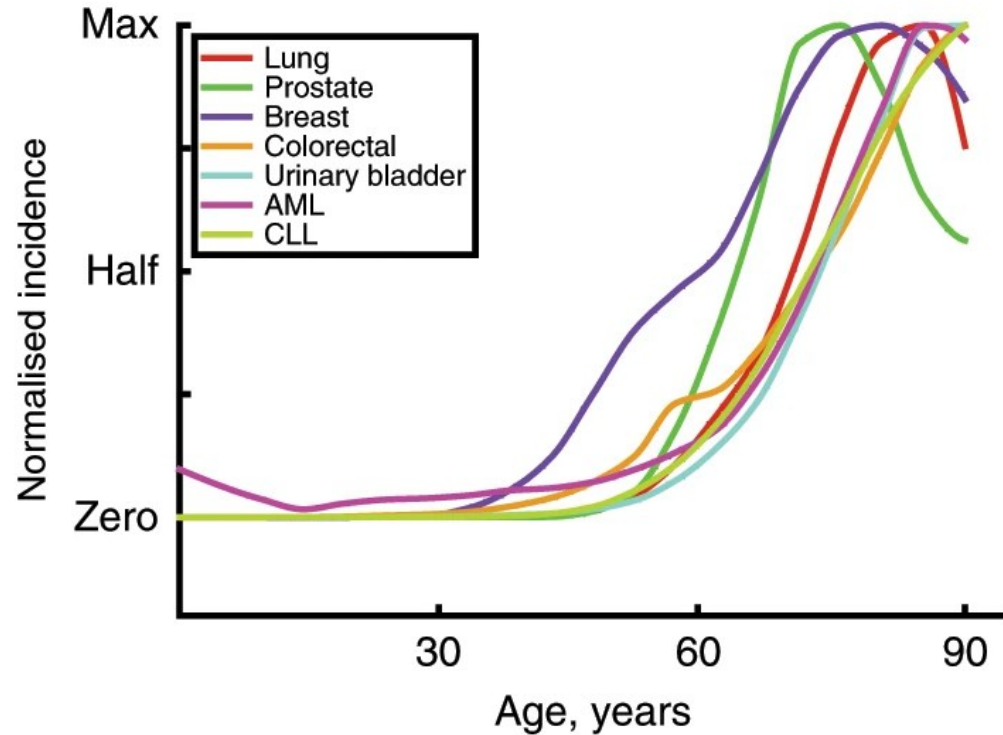
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See Online/Comment
[https://doi.org/10.1016/S0140-6736\(25\)01570-3](https://doi.org/10.1016/S0140-6736(25)01570-3)

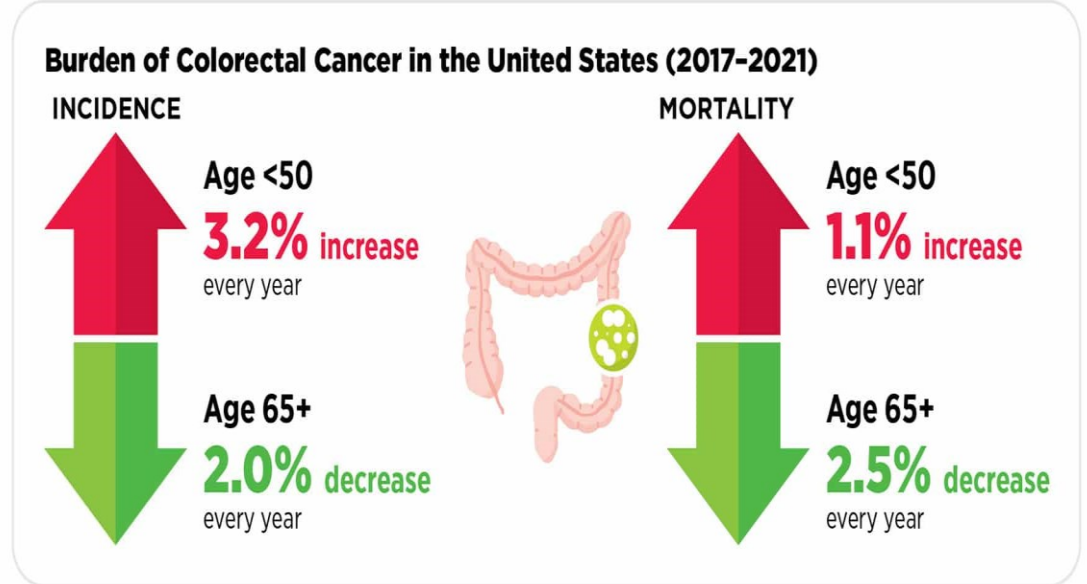
*Collaborators listed at the end of the Article.

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Cancer is traditionally associated with aging



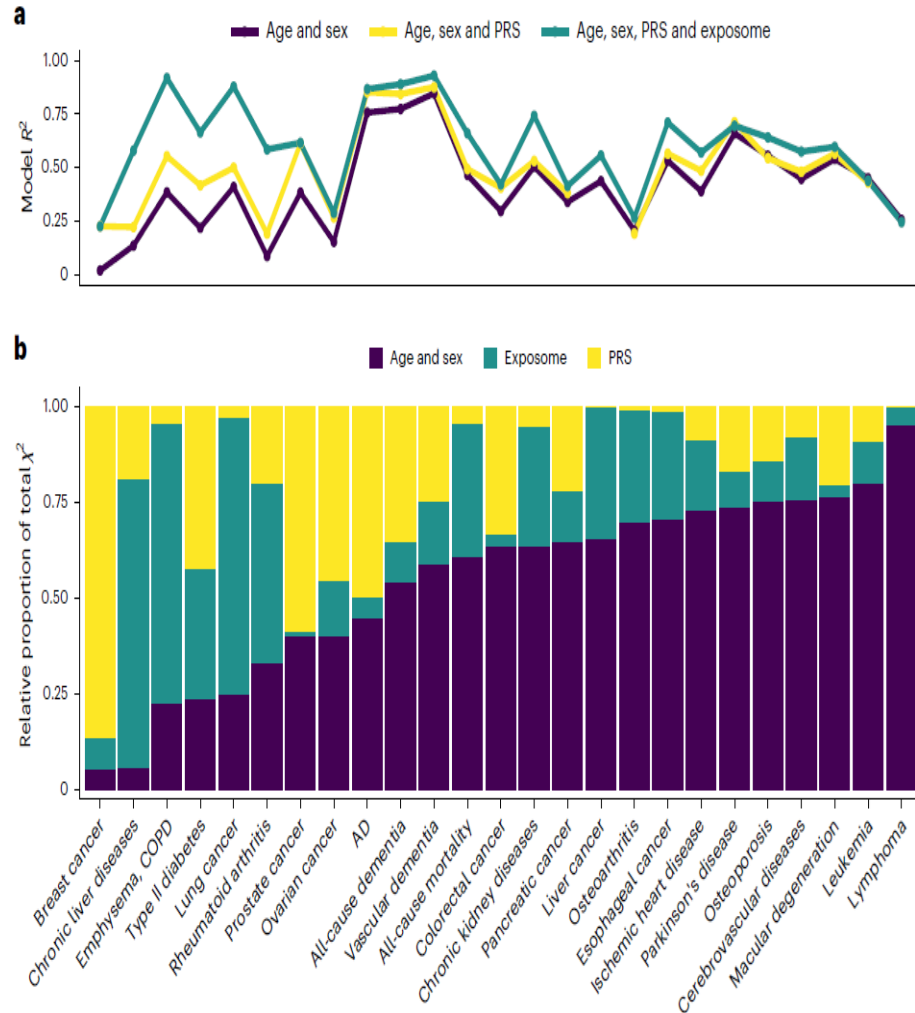
More than 1 Million cancers occurred among YA



© 2024 American Association for Cancer Research*. AACR Cancer Progress Report 2024. 2405017-W7.

Between 1990 and 2019
EOC incidence ↑ 79.1% EOC deaths ↑ 27.7%

Potential causes



Argentieri et al. Nature Med 2025; Lamoree et al. Nature medicine 2025; Courtesy Elie El Rassy & Bruno Achutti-Duso

RESEARCH

Association of ultra-processed food consumption with colorectal cancer risk among men and women: results from three prospective US cohort studies

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ABSTRACT

OBJECTIVE
To examine the association between consumption of ultra-processed foods and risk of colorectal cancer among men and women from three large prospective cohorts.

DESIGN
Prospective cohort study with dietary intake assessed every four years using food frequency questionnaires.

SETTING
Three large US cohorts.

PARTICIPANTS
Men (n=46 341) from the Health Professionals Follow-up Study (1986-2014) and women (n=159 907) from the Nurses' Health Study (1986-2014; n=67 425) and the Nurses' Health Study II (1991-2015; n=92 482) with valid dietary intake measurement and no cancer diagnosis at baseline.

MAIN OUTCOME MEASURE
Association between ultra-processed food consumption and risk of colorectal cancer, estimated using time varying Cox proportional hazards regression models adjusted for potential confounding factors.

RESULTS
3216 cases of colorectal cancer (men, n=1294; women, n=1922) were documented during the 24-28 years of follow-up. Compared with those in the lowest fifth of ultra-processed food consumption, men in the highest fifth of consumption had a 29% higher risk of developing colorectal cancer (hazard ratio for highest versus lowest fifth 1.29, 95% confidence interval 1.08 to 1.53; P for trend=0.01), and the positive association was limited to distal

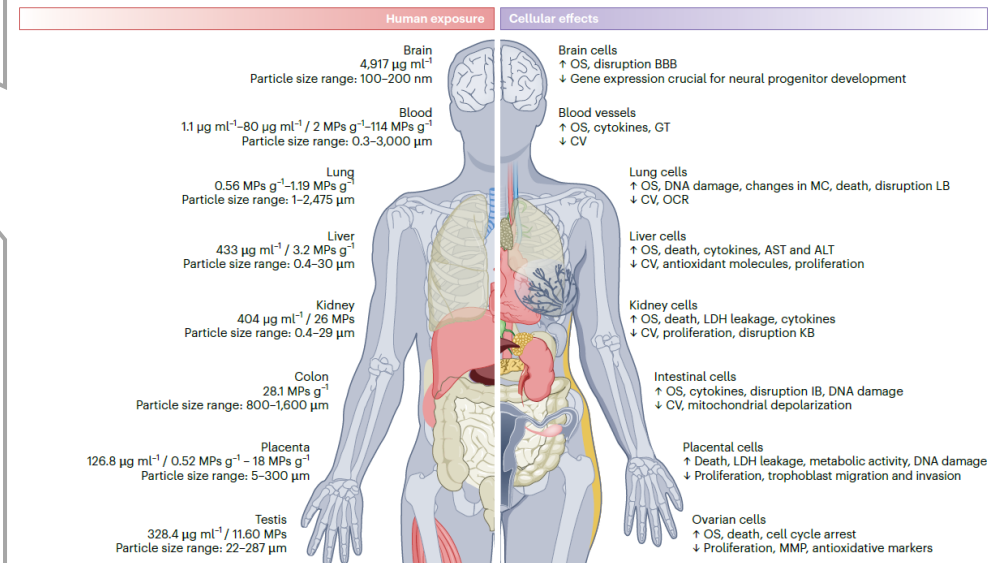
colon cancer (72% increased risk; hazard ratio 1.72, 1.24 to 2.37; P for trend=0.001). These associations remained significant after further adjustment for body mass index or indicators of nutritional quality of the diet (that is, western dietary pattern or dietary quality score). No association was observed between overall ultra-processed food consumption and risk of colorectal cancer among women. Among subgroups of ultra-processed foods, higher consumption of meat/poultry/seafood based ready-to-eat products (hazard ratio for highest versus lowest fifth 1.44, 1.20 to 1.73; P for trend=0.001) and sugar sweetened beverages (1.21, 1.01 to 1.44; P for trend=0.013) among men and ready-to-eat/heat mixed dishes among women (1.17, 1.01 to 1.36; P for trend=0.02) was associated with increased risk of colorectal cancer; yogurt and dairy based desserts were negatively associated with the risk of colorectal cancer among women (hazard ratio 0.83, 0.71 to 0.97; P for trend=0.002).

CONCLUSIONS

In the three large prospective cohorts, high consumption of total ultra-processed foods in men and certain subgroups of ultra-processed foods in men and women was associated with an increased risk of colorectal cancer. Further studies are needed to better understand the potential attributes of ultra-processed foods that contribute to colorectal carcinogenesis.

Introduction

Colorectal cancer is the third most commonly diagnosed malignancy among both men and women in the United States and the second leading cause of death from cancer worldwide.¹⁻² Diet has been recognized as an important modifiable risk factor for colorectal cancer.¹ Meanwhile, ultra-processed foods (that is,

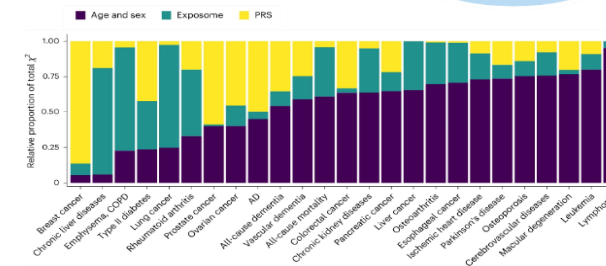
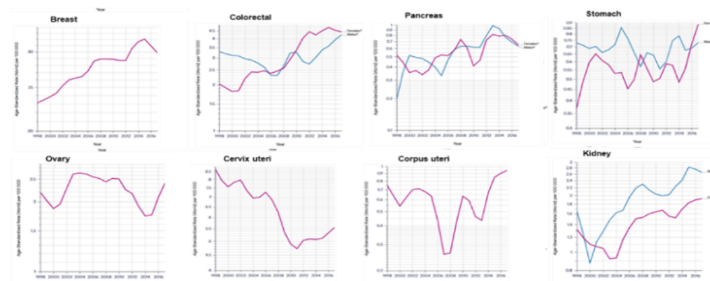


POWER for Young Adults

Making sense of exposome vs. individual

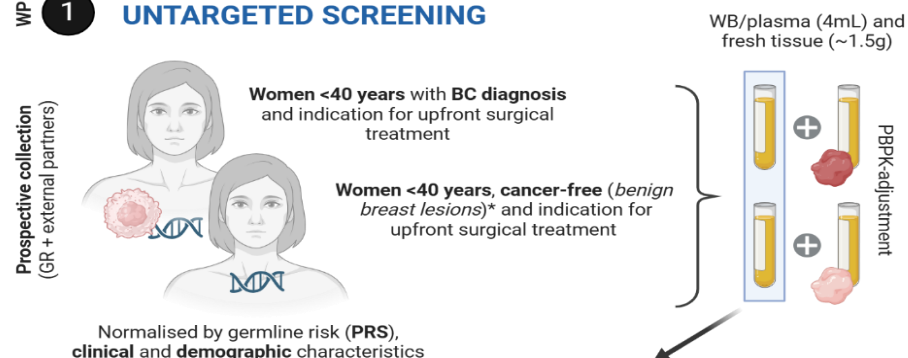
**GUSTAVE
ROUSSY**
CANCER CAMPUS
GRAND PARIS

WP 0



WP 1

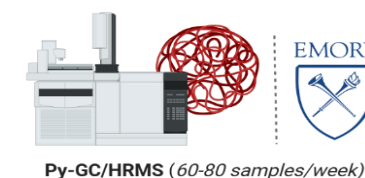
UNTARGETED SCREENING



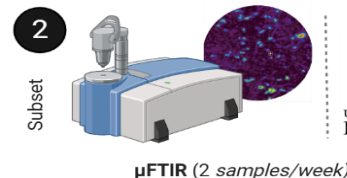
DIFFERENTIALLY ABUNDANT MOLECULES



€750/sample



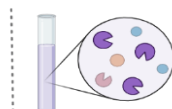
WP 2



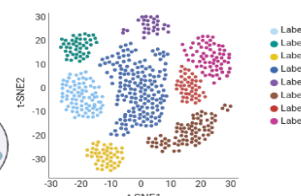
€265/sample

WP 3

IMMUNO-PROTEOGENOMIC



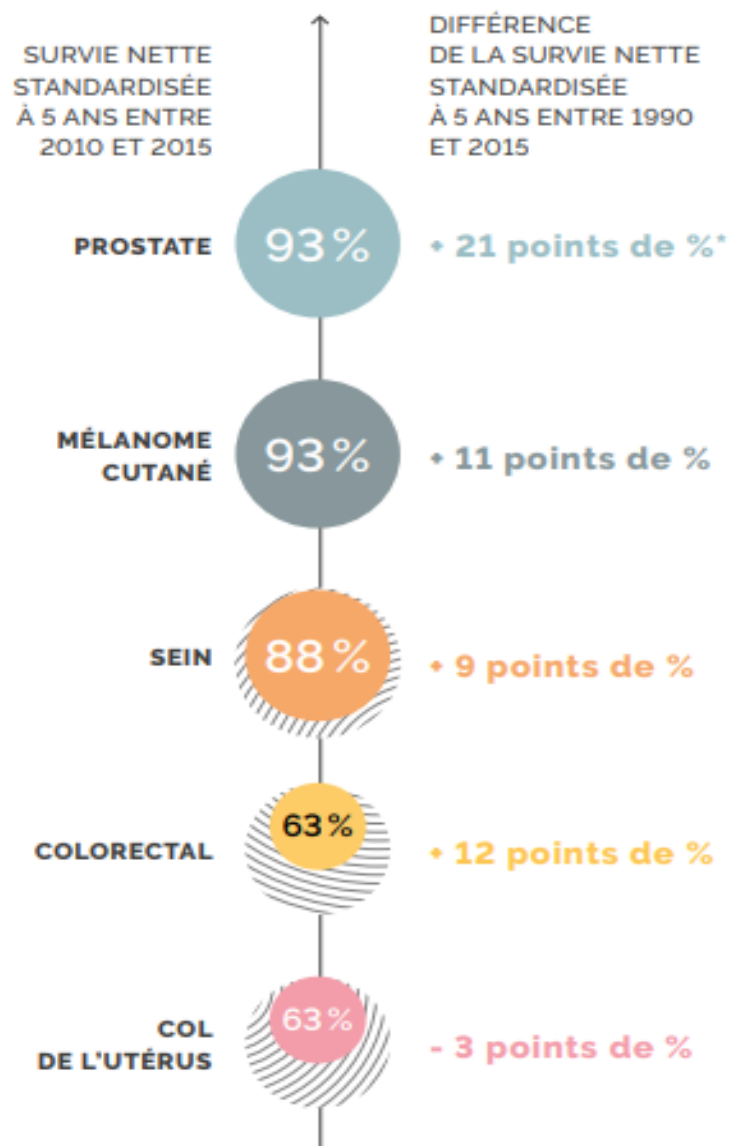
Proteomics



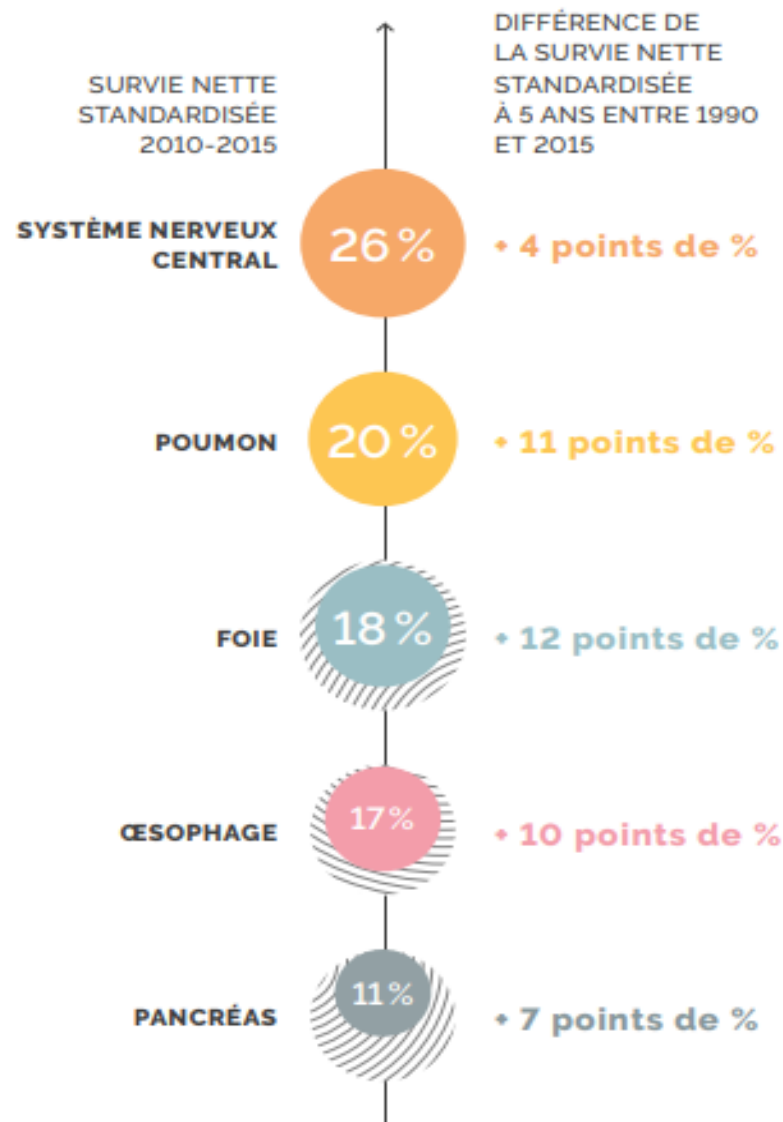
Cell surface and intracellular CITE-seq

MICRO/NANOPLASTICS ASSESSMENT

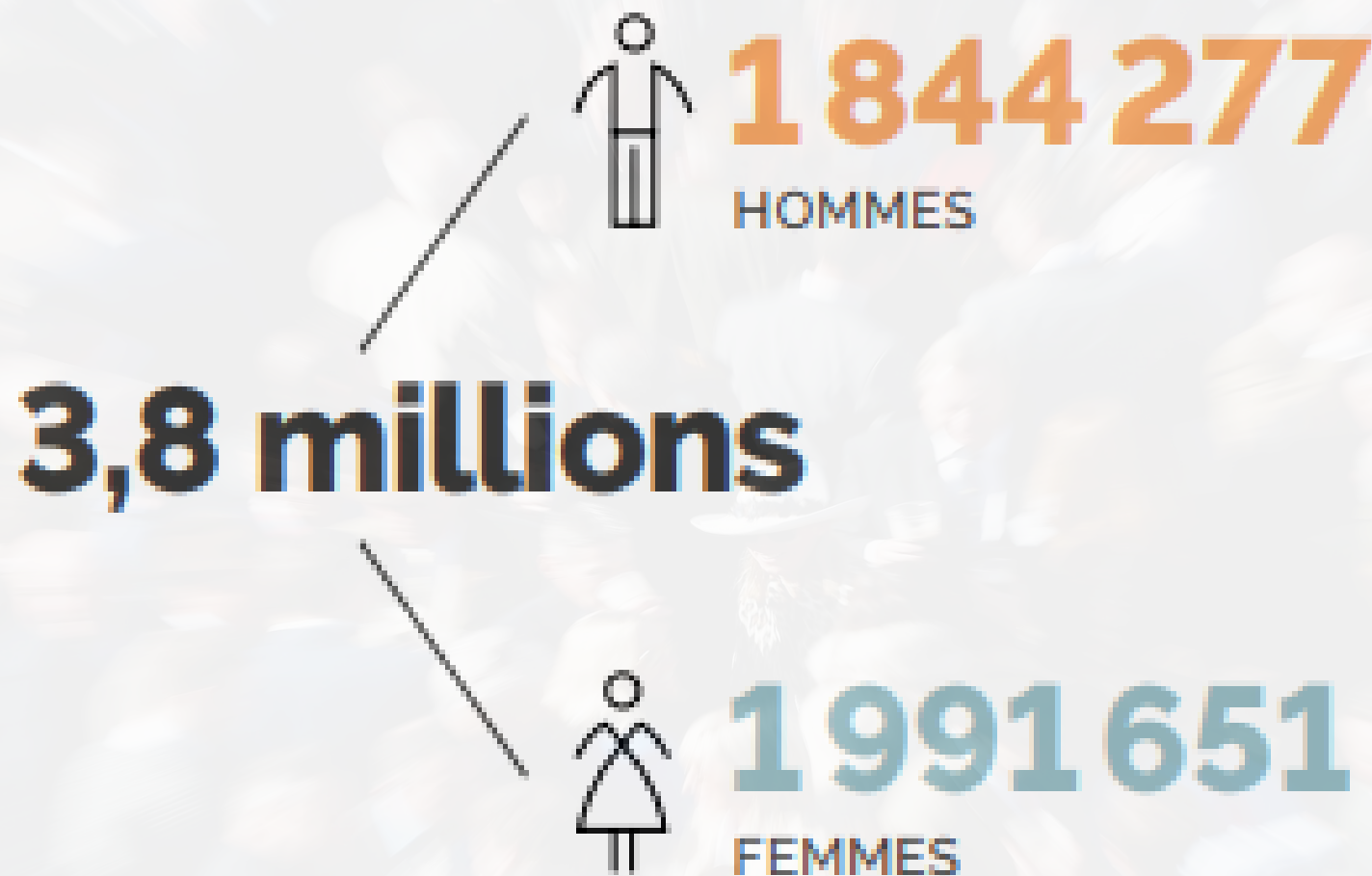
*Benign-lesion surgeries were chosen as controls to minimise demographic and exposure bias (cosmetic-surgery cohorts are typically younger and higher-SES, whereas benign-lesion patients more closely match the cancer group in age, BMI, hormonal milieu and peri-operative environment).



* la survie est passée de 72 % en 1990 à 93 % en 2015, soit une augmentation de 21 points de %



Dans le
même
temps, on
guérit
2 patients
sur 3

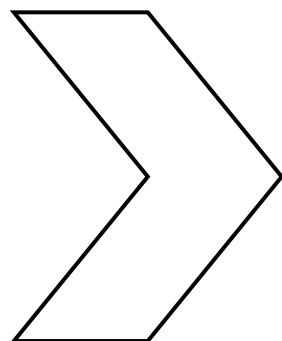


Coronaropathies: 1,5 Millions / Maladie d'Alzheimer: 1 Million

Source: Panorama des cancers 2023, www.e-cancer.fr; Fondation pour la Recherche Médicale; Registre France PCI



+ Fréquent
+ Jeune
+ Curable



+ Nombreux
dans le monde du
travail

Gustave Roussy en pionnier



Notre statut

Le 1^{er} centre de cancérologie
en France et en Europe

Notre exigence

Concentrer les meilleurs
talents et les dernières innovations

Une Ambition

améliorer le taux
de guérison
du cancer de

15%

au cours des
15 prochaines années

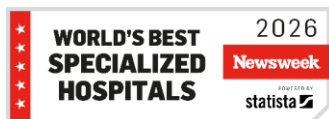


“

*Gustave Roussy
traite tous les cancers,
à tous les stades
et à tous les âges
de la vie.*

Gustave Roussy, un leader mondial

DANS LE TOP MONDIAL
DES MEILLEURS
HÔPITAUX
EN ONCOLOGIE
Classement Newsweek



Memorial Sloan
Kettering Cancer



MD Anderson
Cancer Center



Samsung
Medical Center



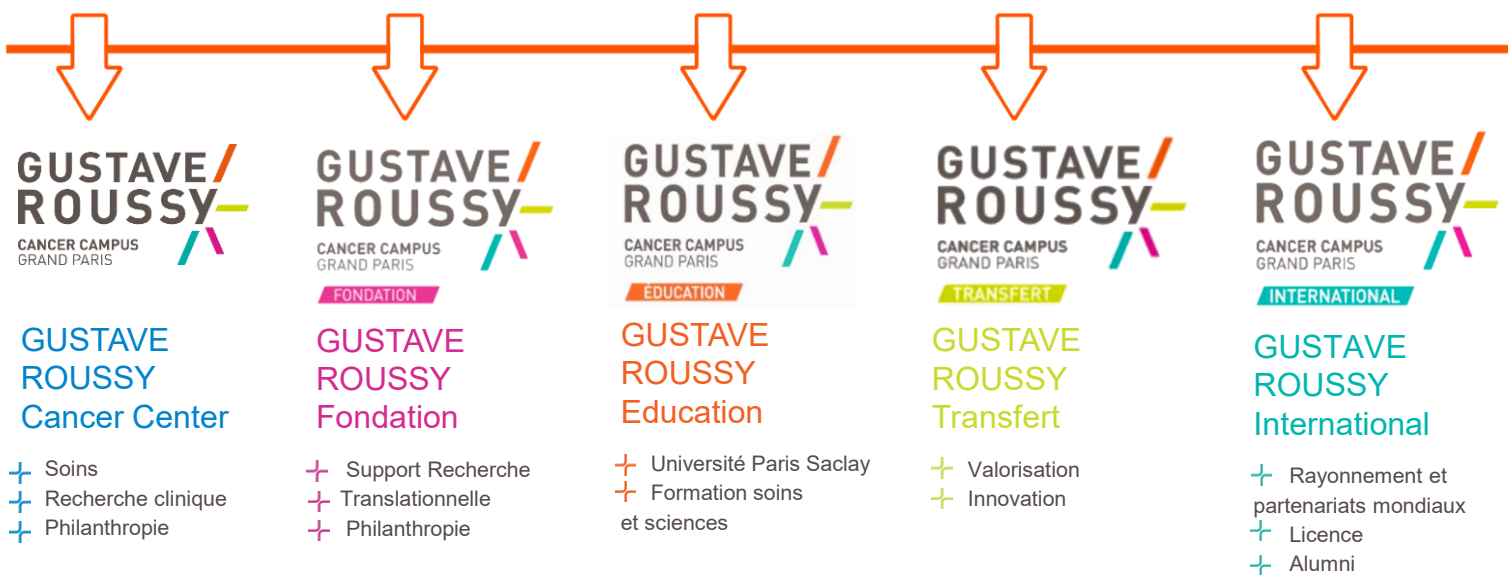
Asan
Medical Center



Mayo Clinic
Rochester



Gustave
Roussy



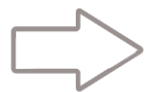
La force
d'un collectif,
& de ses
cinq
activités

Structure



4000

Collaborateurs



dont notamment

1400

personnels dédiés
à la recherche

600



lits / places

en 2024

52 000



patients vus en consultations
et/ou hospitalisés en 2024

dont **2644** en 2024
en pédiatrie



24 000

nouveaux cas adressés
en 2024

dont **472**
en pédiatrie



**Gustave
Roussy,
leader
français
et européen
de la
cancérologie**

Une recherche Mondiale à Impact sociétal

Les chiffres clés

1 400

chercheurs et personnels
de recherche

1 200

Publications

43



équipes de recherche
exploratoire et
translationnelle en 2025

16

chercheurs parmi
les plus cités au monde

13

équipes de recherche
clinique + 1 DRC

11

plateformes
technologiques

Labélisé centre national de médecine de précision en oncologie IHU PRISM



9

RHU portés par
des leaders de GR

3

cohortes PIA
(CANTO, E3N, coblance)

Intelligence artificielle et data

Base de
données de

400 000 patients

1 pôle

2

équipes de
recherche

&

2

équipes de
data science

Recherche clinique

350

Staffs

6115

patients
inclus

586

essais actifs

+ de 500

patients en phases I et II

600 M€

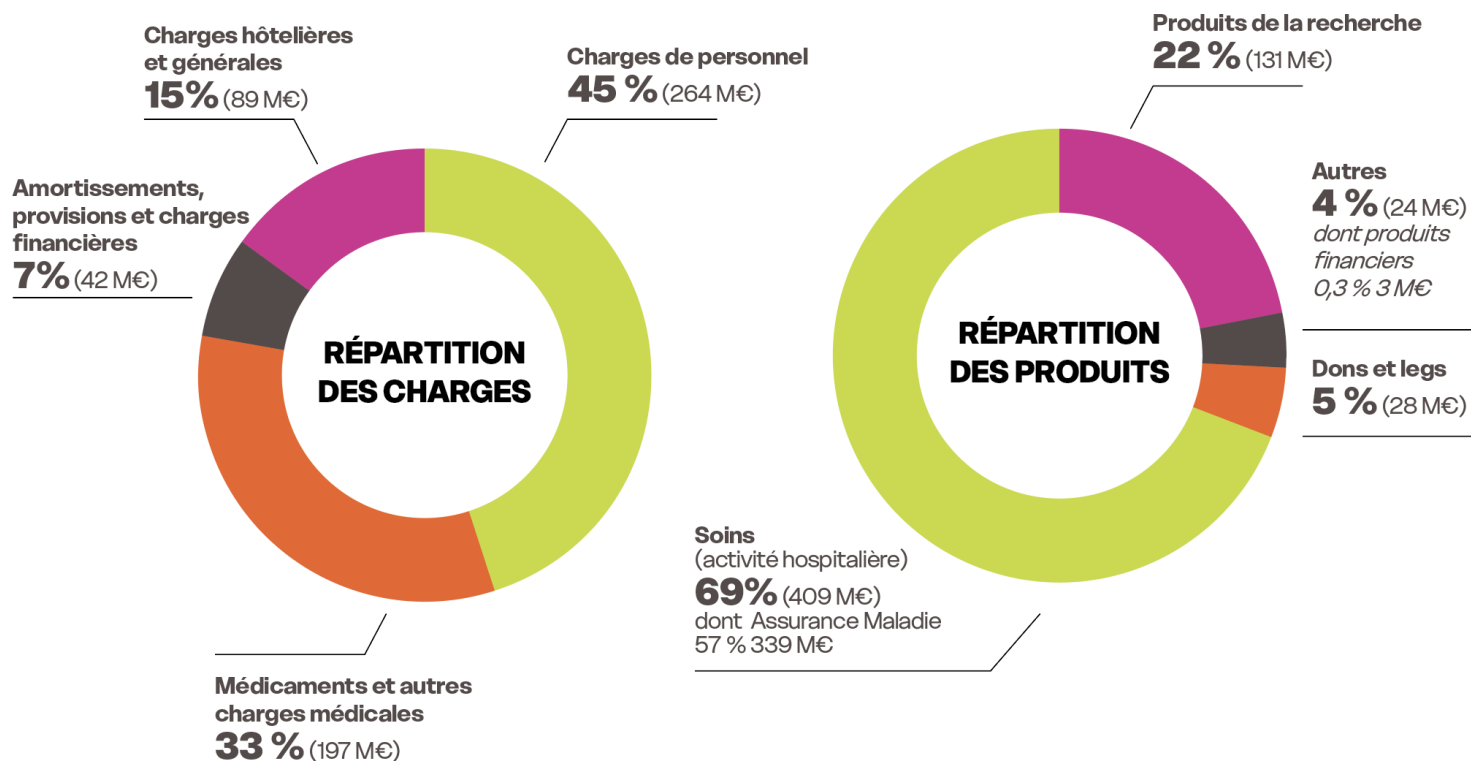
de budget global en 2025



dont **140 M€** dédiés à la recherche



Budget et bilan financier



Un budget
équilibré &
complémentaire
au service
de l'innovation
et des patients



Ensemble, concilions maladie et travail.

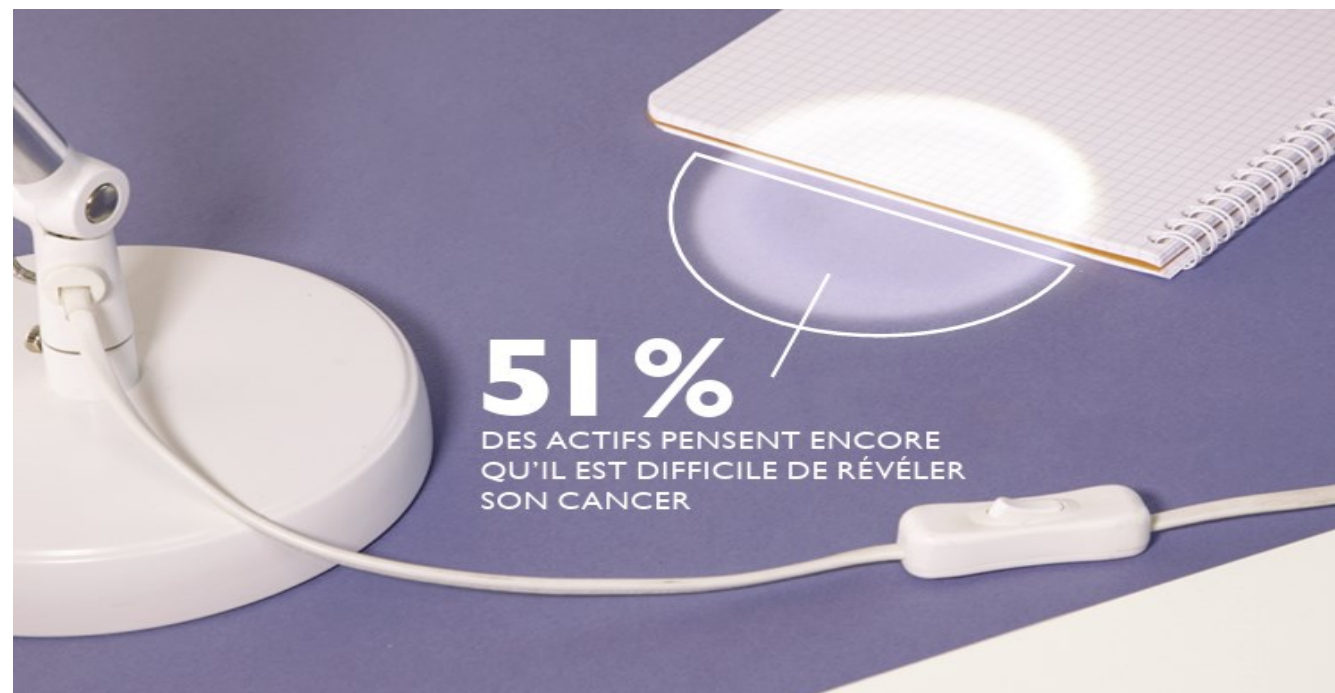
2017

**Gustave Roussy,
1er hôpital à
rejoindre l'initiative**

Gustave Roussy s'engage à mettre en place des actions en faveur de l'intégration, du maintien dans l'emploi et la qualité de vie au travail de ses salariés confrontés au cancer.

2021:

Un constat encore difficile



Arthur Sadoun, le patron de Publicis évoque son cancer



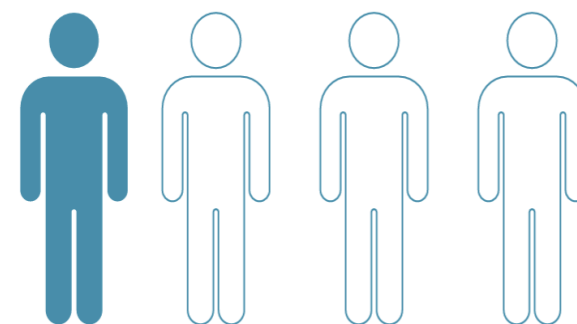
2024:
Peu
d'améliorations

LA MALADIE
RESTE TABOUE

VOTRE EMPLOI ACTUEL EST OU POURRAIT ÊTRE
MENACÉ À CAUSE DE LA SURVENUE D'UN
CANCER OU D'UNE MALADIE CHRONIQUE ?

OUI

par un cancer : 40%



1 ACTIF SUR 4

touché par un cancer ayant été en arrêt maladie, a le sentiment de ne pas avoir **retrouvé sa place** à son retour

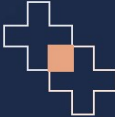


AYANT EU
UN CANCER
ESTIMENT QUE
RÉVÉLER SA
MALADIE EST
UNE ÉTAPE
DIFFICILE

**Dès 2022,
Gustave Roussy
s'engage**



**Travailler
avec un cancer**



**Un séminaire de formation dédié aux managers
pour améliorer l'accompagnement des
collaborateurs confrontés au cancer**

**COMPRENDRE LES ENJEUX DU CANCER EN MILIEU PROFESSIONNEL
AVEC LES EXPERTS DE GUSTAVE ROUSSY, LEADER DE LA CANCÉROLOGIE EN EUROPE**

Programme 3 h

INTRODUCTION

Mot d'accueil de l'entreprise, pourquoi cette formation.
Présentation de Gustave Roussy, de la raison d'être de cette formation, des intervenants et de la dimension interactive du séminaire.

Projection : vidéo capsule témoignage retour au travail

Retour sur les clichés, les fausses croyances sur le cancer, les malentendus, les non-dits...

Échanges avec l'audience.

1 Le cancer, qu'est-ce que c'est ?

Vidéo expert Pr Benjamin Besse. Oncologue médical, spécialiste des cancers thoraciques, directeur de la recherche clinique à Gustave Roussy

Éclairage de l'oncologue médical présent et réponses aux questions.

2 Épidémiologie du cancer ?

Éclairage à deux voix (oncologue médical et direction de la marque) : mise en perspectives sur l'augmentation du nombre de cas et les progrès majeurs de la recherche des 20 dernières années. Interactions avec l'audience.

Jeu de rôle en LIVE avec des comédiens : « annoncer son cancer à son employeur. »

Échanges - réactions.

L'actualité des traitements du cancer

3 Vidéo expert Pr Laurence Albiges. Oncologue médicale, spécialiste des cancers urogénitaux, Chef du département de médecine oncologique à Gustave Roussy.

Vidéo capsule : témoignage « le vécu quotidien, LA PROMOTION »

Éclairage de l'oncologue médical présent et réponses aux questions sur les différents types de traitements (oral, IV, chimio, new Tt, essai thérapeutique) et leur impact sur le quotidien.

Les toxicités visibles

4 Quels sont les signes ? Définition d'une toxicité.
Présentation de l'oncologue médical : vision d'ensemble sur les effets indésirables liés à l'administration d'un traitement contre le cancer et les solutions proposées.

LIVE DES COMÉDIENS : comment réagir et interagir avec un collaborateur touché par un cancer ?

5 Les toxicités invisibles

Vidéo capsule : épuisement témoignage d'un patient (fatigue, troubles cognitifs, neuropathies, isolement social).

Éclairage de l'oncologue médical présent et réponses aux questions sur ces toxicités invisibles encore trop méconnues et leur incidence dans la vie en entreprise.

6 Aspects psychologiques

Éclairage à deux voix (Oncologue médical et directrice de la marque) :

- les problèmes psychologiques de la personne qui retourne au travail,
- les principaux axes de vulnérabilité à accompagner,
- comment réagir face à :
 - un collaborateur / proche atteint de cancer,
 - un collaborateur / proche aidant d'une personne touchée par un cancer,
 - brainstorming collectif.

JEU DE RÔLE EN LIVE / THÉÂTRE FORUM : en tant qu'employeur, en tant que collègue, en tant que personne malade face à l'employeur, face à un collègue (jeux de rôles inversés).

LE MOT DE LA FIN par un membre du CODIR / COMEX de l'entreprise invitante.

FIN DE LA FORMATION

1 Remise d'un kit pratique

- Lien vers les vidéos experts partagées en séance et d'autres non présentées.
- un contact mail ou téléphone : nous joindre après la formation (orienter pour un rendez-vous médecin, 2^e avis, Interception (prévention personnalisée), question RH...).

2 Test d'évaluation

pour recueil des avis des formés, restitué ensuite à la direction générale de l'entreprise.





Dior



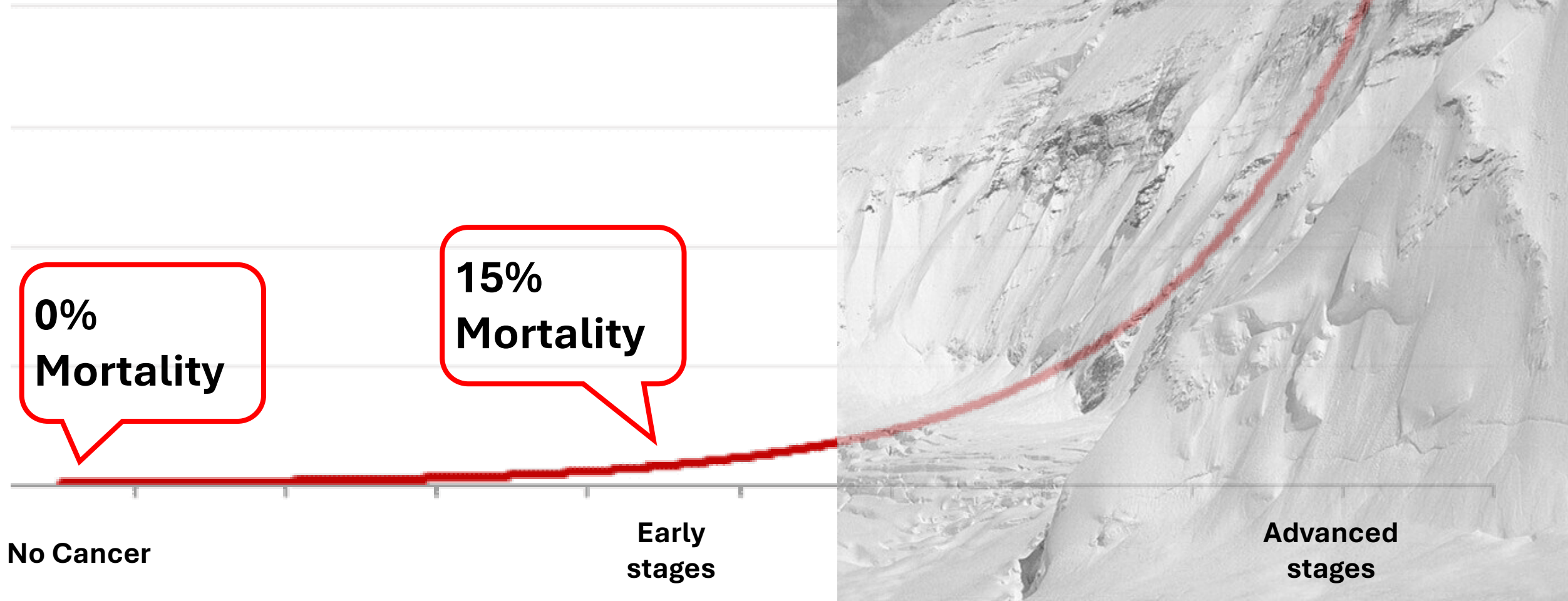
CONSEIL EN
ASSURANCES



**Le médecin
du travail,
acteur sous-
estimé**



Eviter la Face Nord



Access to primary care and mortality in excess for patients with cancer in France: Results from 21 French Cancer Registries

Joséphine Gardy MS^{1,2,3,4}  | Sarah Wilson MD² | Anne-Valérie Guizard MD^{1,4} |
Véronique Bouvier MD^{1,2,3} | Ludivine Launay MS² | Arnaud Alves MD, PhD^{1,2,3} |
Simona Bara MD^{1,5} | Anne-Marie Bouvier MD, PhD^{1,6,7,8,9}  |
Gaëlle Coureau MD, PhD^{1,10,11,12} | Anne Cowppli-Bony MD^{1,13,14,15} |
Sandrine Dabakuyo Yonli MD, PhD^{1,16}  | Laëtitia Daubisse-Marliac MD^{1,17,18,19} |
Gautier Defossez MD, PhD^{1,20,21} | Karima Hammas MD^{1,22} | Florent Hure MD^{1,23} |
Valérie Jooste PhD^{1,6,7,8,9} | Bénédicte Lapotre-Ledoux MD^{1,24,25} |
Jean-Baptiste Nousbaum MD, PhD^{1,26,27,28} | Sandrine Plouvier MD, PhD^{1,29} |
Arnaud Seigneurin PhD^{1,30} | Brigitte Tretarre MD^{1,18,31} |
Nicolas Vigneron MD, PhD^{1,4} | Anne-Sophie Woronoff MD^{1,32} |
Guy Launoy MD, PhD² | Florence Molinie MD^{1,13,14,15} | Joséphine Bryere PhD² |
Olivier Dejardin PhD^{2,33}

Correspondence
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Funding information
Ligue Contre le Cancer, Grant/Award Number:
Equipe Labellisée LIGUE 2022

ABSTRACT

Background: The impact of geographical accessibility on cancer survival has been investigated in few studies, with most research focusing on access to reference care centers, using overall mortality and limited to specific cancer sites. This study aims to examine the association of access to primary care with mortality in excess of patients with the 10 most frequent cancers in France, while controlling for socio-economic deprivation.

Methods: This study included a total of 151,984 cases diagnosed with the 10 most common cancer sites in 21 French cancer registries between 2013 and 2015. Access to primary care was estimated using two indexes: the *Accessibilité Potentielle Localisée* index (access to general practitioners) and the Scale index (access to a range of primary care clinicians). Mortality in excess was modeled using an additive framework based on expected mortality based on lifetables and observed mortality.

Findings: Patients living in areas with less access to primary care had a greater mortality in excess for some very common cancer sites like breast (women), lung (men), liver (men and women), and colorectal cancer (men), representing 46% of patients diagnosed in our sample. The maximum effect was found for breast cancer; the excess hazard ratio was estimated to be 1.69 (95% CI, 1.20–2.38) 1 year after diagnosis and 2.26 (95% CI, 1.07–4.80) 5 years after diagnosis.

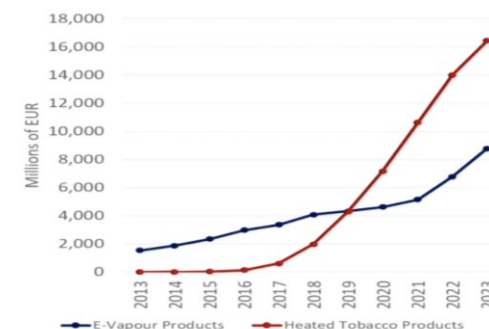
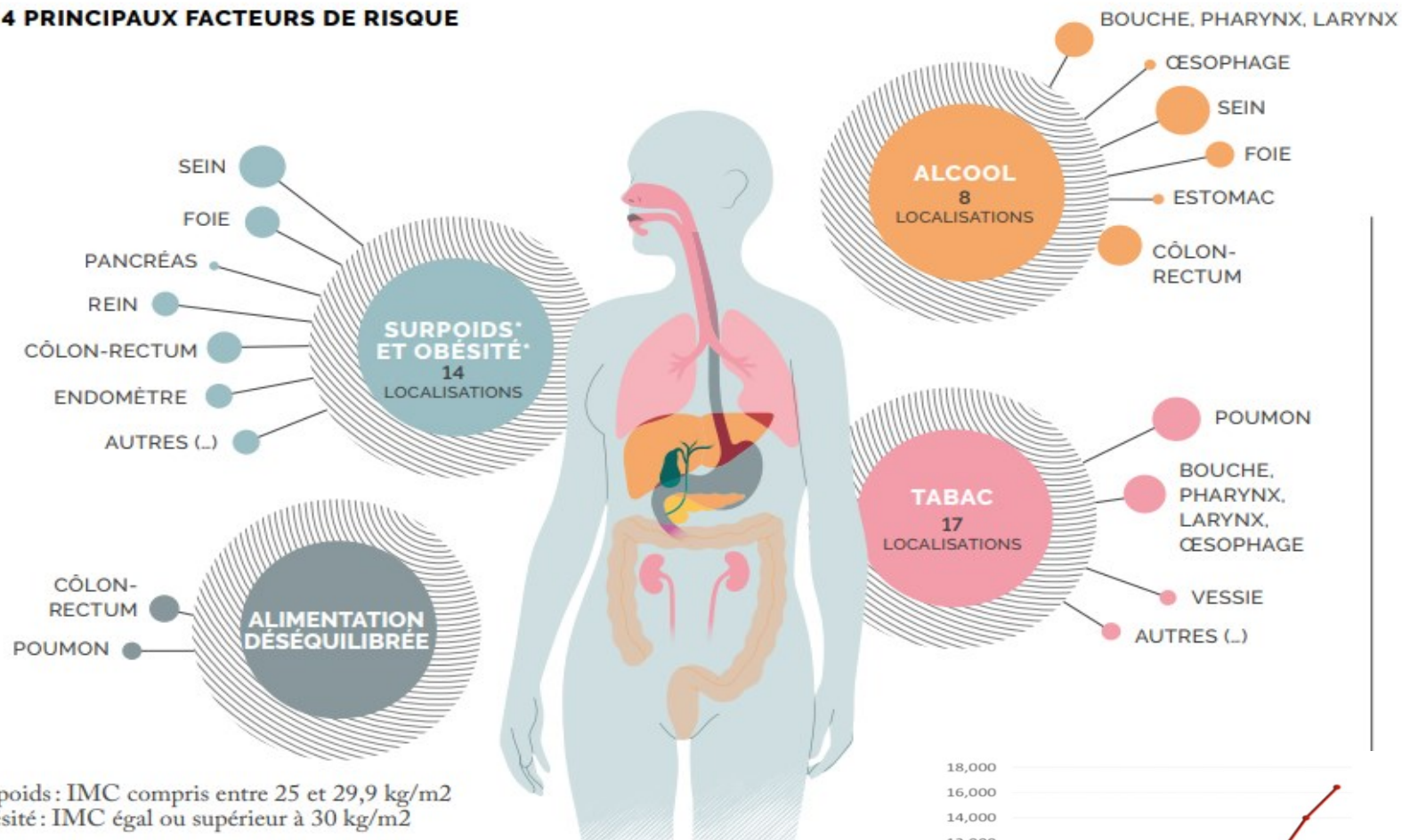
➤ **Accès Médecin**

↗ **Décès x2.3***

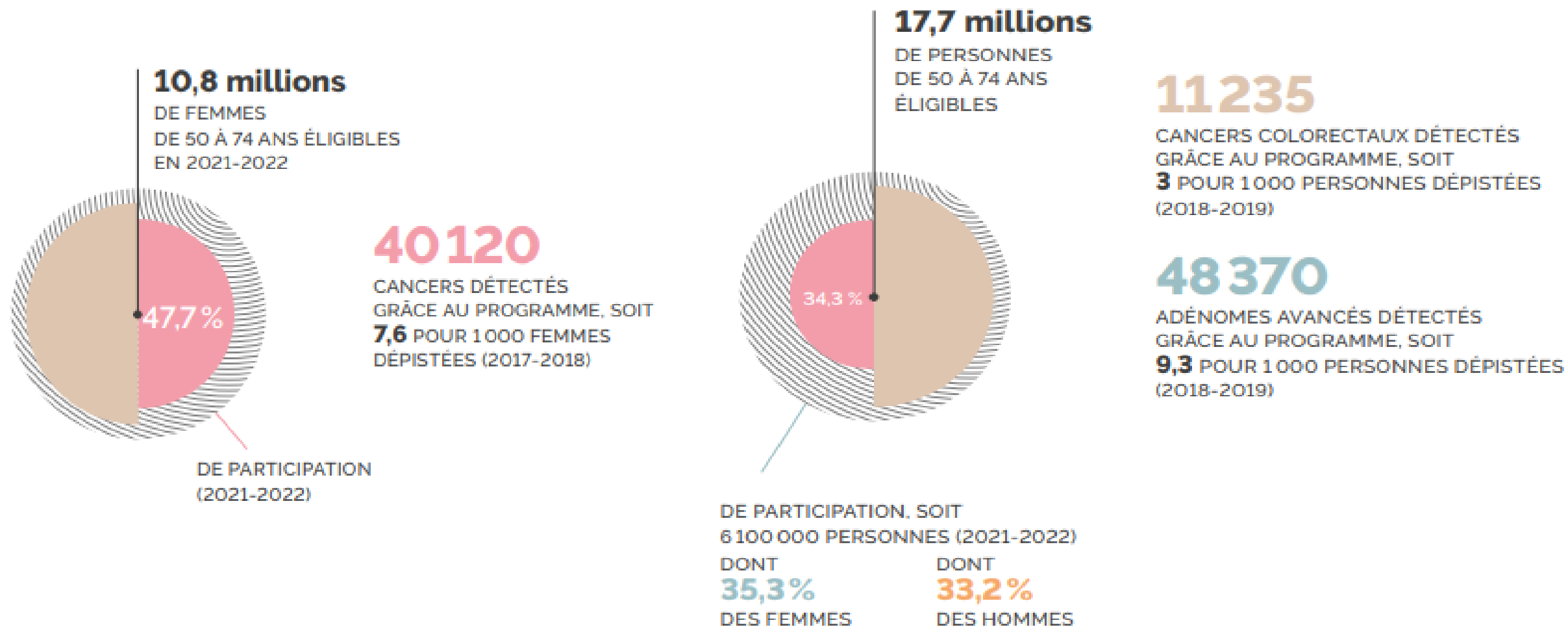
* *Cancer du sein*

40% de cancers évitables

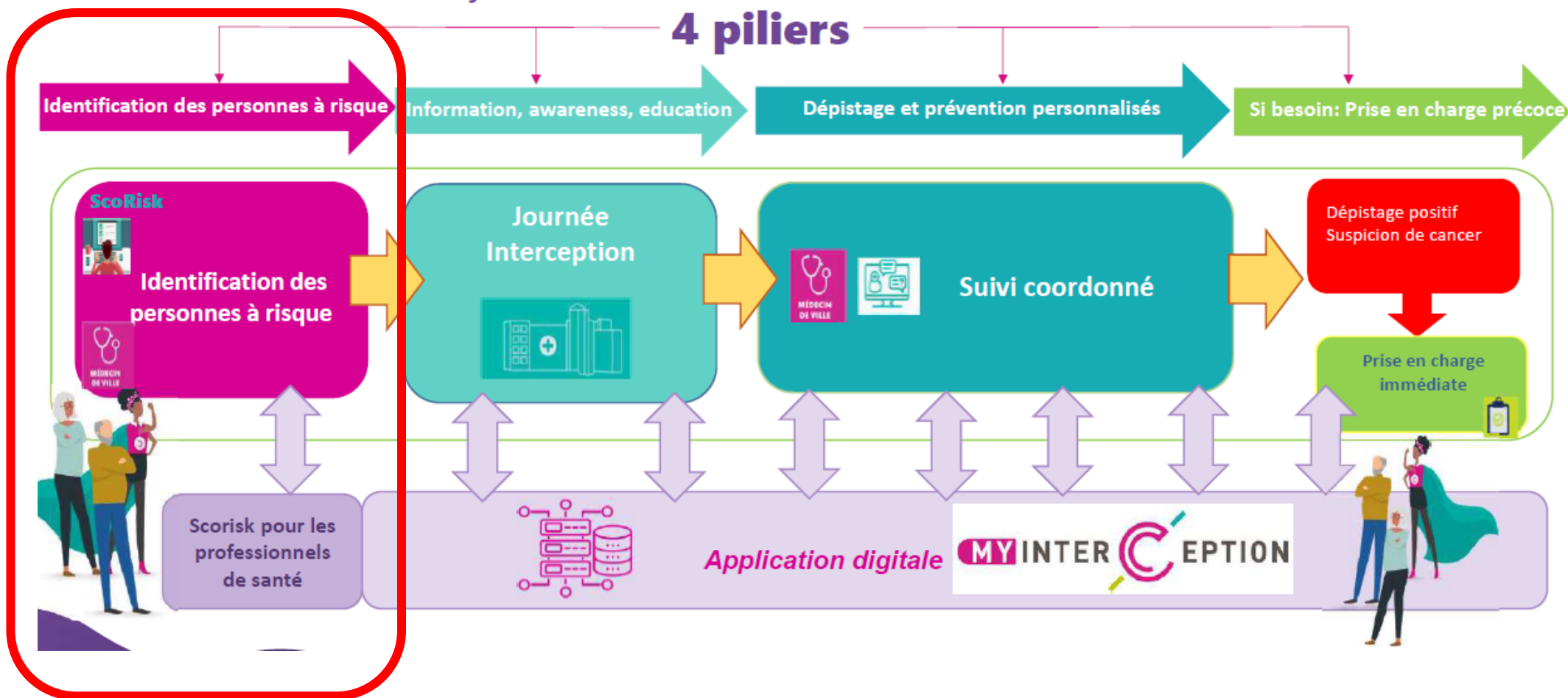
LES 4 PRINCIPAUX FACTEURS DE RISQUE

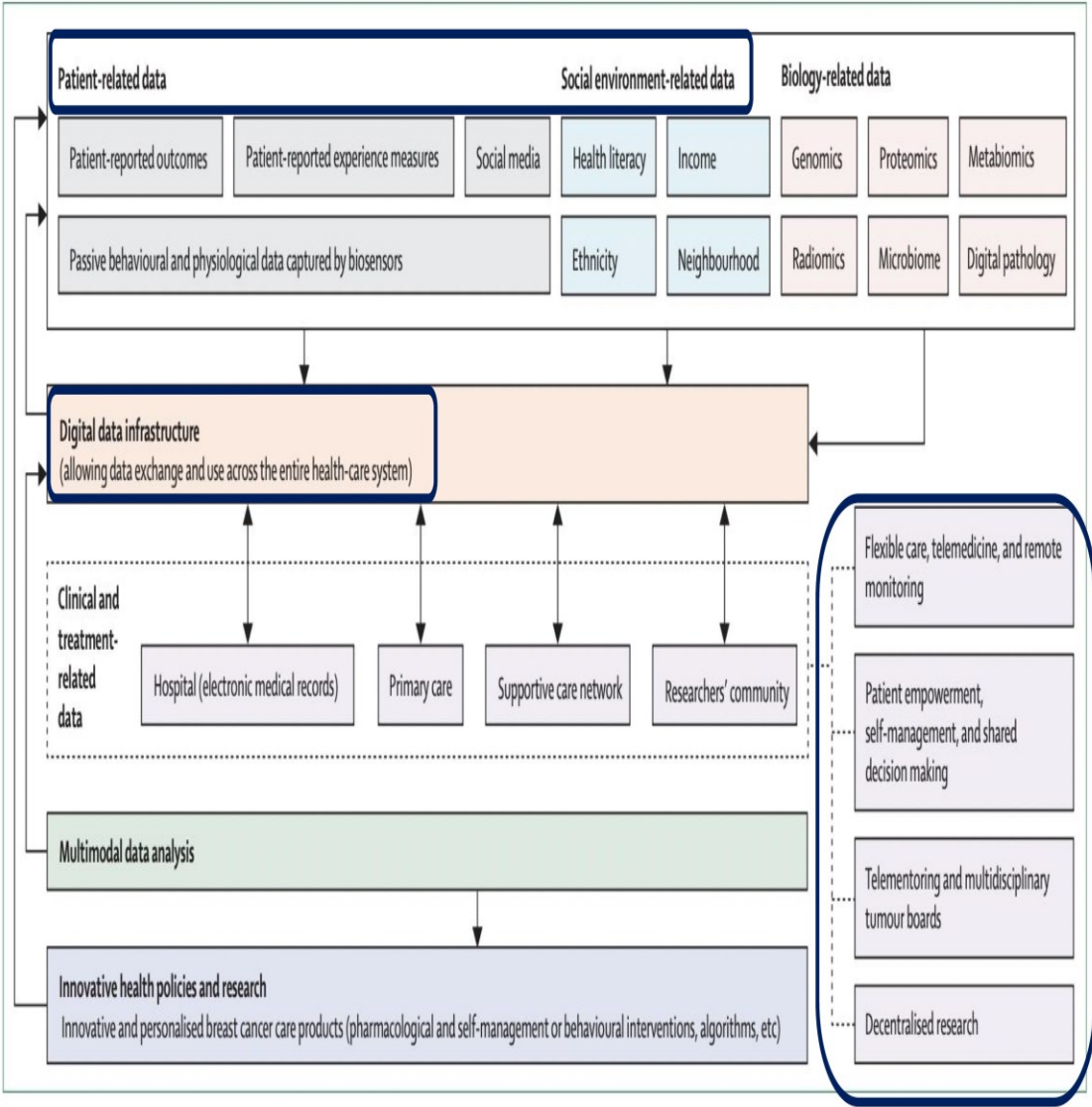


20 à 30% de mortalité évitable



Un parcours mixte ville-hôpital physique-digital de prévention personnalisée chez les patients à risque élevé de cancer, déployé de façon nationale







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