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KICKSTARTING HEALTHCARE CONVERSATIONS

WHAT'S THE SCORE?

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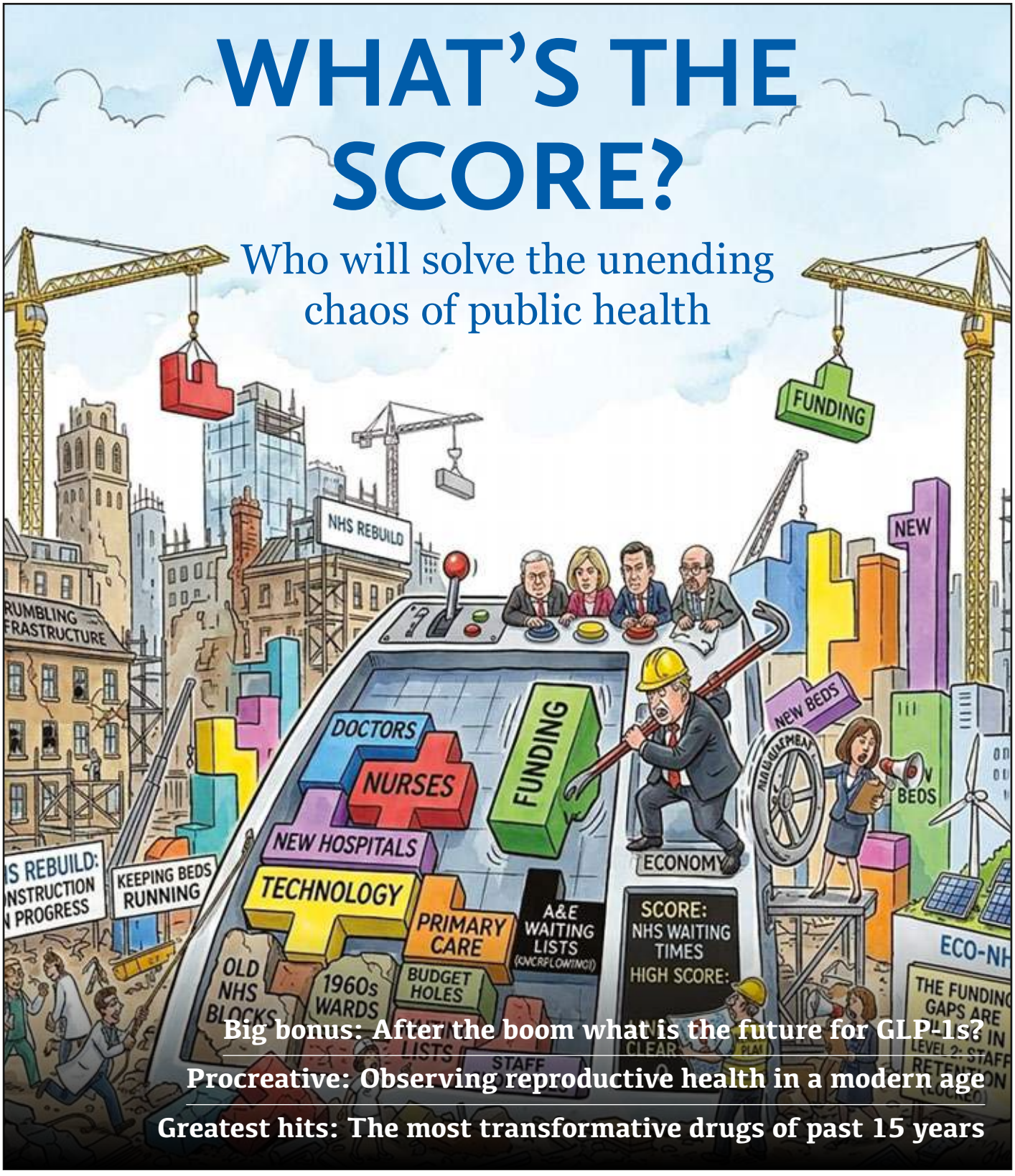

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PharmaTimes Media Ltd,
Mansard House, Church Road
Little Bookham, Surrey, KT23 3JG
Tel: +44 (0)20 7240 6999
www.pharmatimes.com
Twitter: @PharmaTimes

MAGAZINE

John Pinching / editor
john.pinching@pharmatimes.com
Michelle Legrand / sales manager
michelle.legrand@pharmatimes.com

COMPETITIONS

Luci Sargood / business manager
luci.sargood@pharmatimes.com
Michelle Legrand / sales manager
michelle.legrand@pharmatimes.com
James Tansill / Marketing Executive
james.tansill@pharmatimes.com

PMGROUP

Tara Lovegrove / business director
tara.lovegrove@pharmatimes.com
Iona Everson / group managing editor
iona.everson@pharmatimes.com
Karl Equi / executive director
karl.equi@pharmatimes.com

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Madness's greatest hits

Taking a walk on the weird side is officially the new normal. What am I talking about? The phrase 'new normal' no longer exists. We are now left to lurch into the slipstream of a new culture without the world-weary 'COVID-19 sigh' of yore.

Seismic events now unfold in real time and at sensationally regular intervals. Madness is now the hum-drum of life. What was life like before?

It seems impossible to believe that there was a time when fully grown adults didn't make a heart shape with their hands at every opportunity. Do fully grown adults in an empty room without omnipresent smartphone cameras make a heart shape? Yes, dear reader, I fear they do. Is this what opposable thumbs are reduced to?

It makes '6-7' make sense. Come to think of it, 6-7, just as it fades from view, seems like a sharply-shaped prophecy of our times.

There are, however, other slightly less irritating examples of relentless and incomprehensible activities unfolding (and they are generally not hand gesture-related). Pharma, life sciences and laboratory-based shin-digs happen, it seems, in spite of war and politics and greedy muppets, not because of them.

This gives us, by which I mean humankind, much to celebrate. These are the green shoots of recovery that give us the will to climb out of the crises of our own creating. After all, that's what we do.

Enjoy the mag,

John Pinching
editor

@PharmaTimes

linkedin.com/company/pharmatimes

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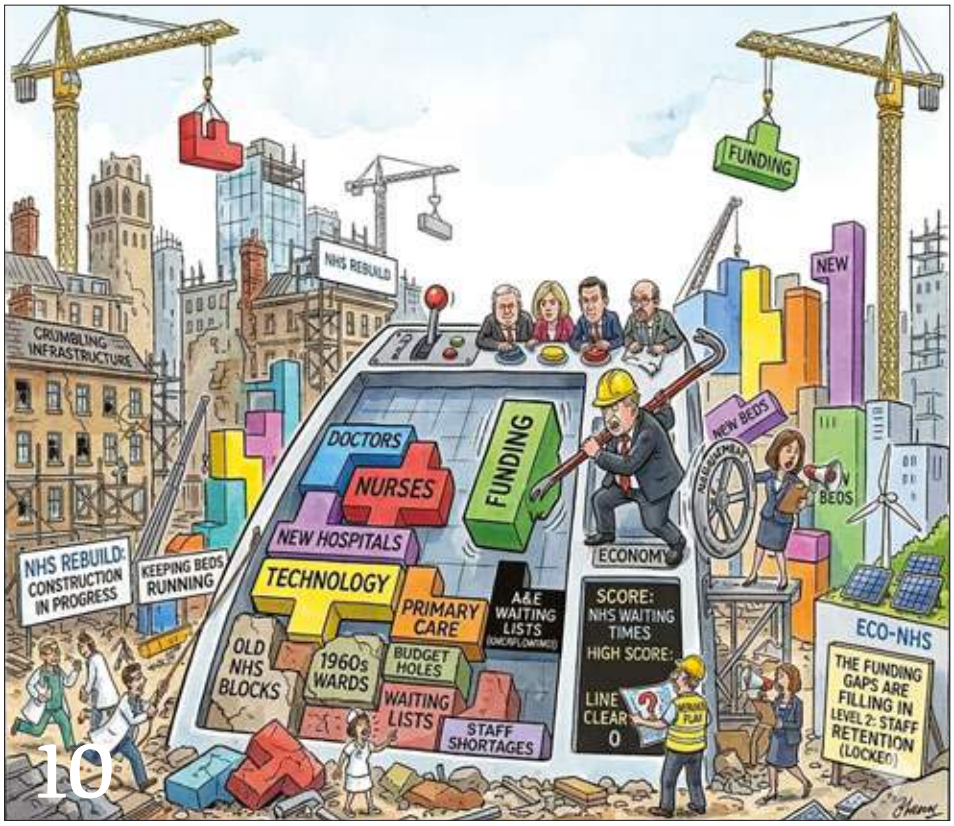

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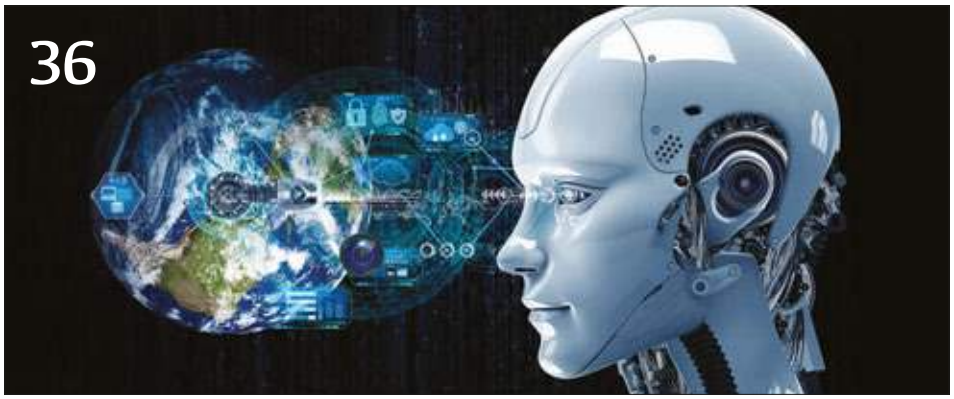
News Review



Features

Analysis

Smart People

Kainova reports positive results for DT-9081 in advanced solid tumours

Kainova Therapeutics has announced encouraging topline findings from its phase 1 EPRAD study of DT-9081, an oral EP4 receptor antagonist being developed for patients with advanced, recurrent and metastatic solid tumours.

The study, carried out at four sites in France and Belgium, met all its primary objectives. According to the company, DT-9081 demonstrated a favourable safety profile alongside robust pharmacokinetic and pharmacodynamic characteristics, including dose-proportional exposure and sustained EP4 receptor engagement across all tested doses.

Investigators also observed early signs of anti-tumour activity. No dose-limiting toxicities were reported, supporting the therapy's tolerability and mechanism of action. Full details are available under clinicaltrials.gov identifier NCT05582850.

Professor Jean-Pascal Machiels, Principal Investigator of the EPRAD study, commented: "The results of the study not only validate EP4 receptor antagonism as a powerful mechanism to counteract PGE2-driven immune suppression, but also demonstrate the clinical potential of DT-9081 across a range of tumour types.

Since chemotherapy and other standard treatments often trigger PGE2 production by cancer cells, restoring competence through selective EP4 inhibition offers a rational and versatile

strategy to overcome resistance. It was my honour to contribute to the advancement of DT-9081 through the clinic."

Dr Jean-Marie Cuillerot, Chief Medical Officer of Kainova Therapeutics, said: "The phase I EPRAD study generated a clear and coherent data set that precisely characterises DT-9081's clinical profile. Across all dose levels, we observed consistent safety findings together with robust PK/PD readouts.

"The high-quality clinical and translational data obtained in this study are essential for understanding how EP4 antagonism behaves in patients with advanced solid tumours in a clinical setting."

HUTCHMED begins global trial of HMPL-A580 in solid tumours

HUTCHMED has initiated a global phase 1/2a clinical trial of HMPL-A580, its second antibody-targeted therapy conjugate, in patients with unresectable, advanced or metastatic solid tumours in China and the US. The first patient received a dose on 4 March 2026.

HMPL-A580 is described as a first-in-class ATTC that links a highly selective PI3K/PIKK inhibitor payload to an anti-EGFR antibody via a cleavable linker. EGFR is widely expressed across multiple solid tumour types and is recognised as a key driver of tumour growth and progression.

Preclinical findings have shown that inhibiting the PAM pathway can work synergistically with anti-EGFR therapy to enhance anti-tumour activity, with further data due to be presented at an upcoming scientific meeting.

The first-in-human study is multicentre and open label, assessing safety, tolerability, pharmacokinetics, immunogenicity and early signs of efficacy. The phase 1 dose-escalation stage will determine the maximum tolerated dose and recommended dose for expansion.

The phase 2a expansion and optimisation stage will further characterise safety and preliminary anti-tumour activity in selected solid tumours and identify the recommended dose for the next phase. The trial is listed under identifier NCT07396584.

HUTCHMED's ATTC platform combines monoclonal antibodies with proprietary small-molecule inhibitor payloads to deliver dual mechanisms of action. According to the company, this approach differs from traditional antibody drug conjugates by pairing targeted therapies to achieve synergistic anti-tumour effects and more durable responses in preclinical models.

The platform is designed to improve tumour accessibility, reduce off-tumour toxicity and support combinations with chemotherapy and immunotherapy.

Built on more than 20 years of targeted therapy development, the platform aims to generate candidates for a wide range of cancer types by using antibody-guided delivery and tumour-specific payload release to overcome limitations of conventional small-molecule inhibitors.

FDA approves once-weekly Sogroya for wider paediatric use

Novo Nordisk has received approval from the US Food and Drug Administration for three new indications for its once-weekly growth hormone Sogroya, expanding its use to children aged 2.5 years and older with idiopathic short stature, those born small for gestational age without catch-up growth by age two, and those with growth failure linked to Noonan syndrome.

The company said the decision broadens treatment options for families and clinicians while offering an alternative to daily injections, which can be difficult to maintain.

Nicky Kelepouris, Rare Endocrine Disorders-US Medical Lead, said: "Daily injections have defined the growth disorder treatment paradigm for more than 40 years.

"Our scientific leadership and focus on advancing care in rare diseases led us to the development of Sogroya – a once weekly growth hormone therapy – which may help address the challenge of daily injections while offering patients and families a therapeutic option that delivers efficacy and safety."

Kelepouris added: "These new approvals expand the patient populations that can be helped by Sogroya and reflect our strategic focus on delivering meaningful, evidence-based innovation for children living with growth disorders."

The company highlighted that adherence to 365 injections a year can be challenging for children and caregivers. Dr Aristides Maniatis, Founder of Rocky Mountain Pediatric Endocrinology and a trial investigator, said: "Families and healthcare professionals now have the option to consider a once-weekly growth hormone as treatment with 313 injection free days per year for their children 2.5 years and older with ISS, NS and born SGA." He added: "Sogroya is an effective alternative to daily injections that supports children's growth goals and may help fit into their routine."

The approvals are supported by the REAL8 study, which showed Sogroya was non-inferior to daily growth hormone therapy across all three indications.

MHRA approves imlunestrant tosylate as new breast cancer treatment

The Medicines and Healthcare products Regulatory Agency has approved imlunestrant tosylate, branded as Inluriyo, for adults with a specific type of breast cancer that is locally advanced or metastatic and has not responded, or has progressed, after at least one line of hormonal therapy.

The treatment is indicated for cancers that are oestrogen receptor-positive and HER2-negative, and can only be used in patients with certain ESR1 gene mutations.

Oestrogen receptors are proteins that activate when the hormone binds to them, which in some cases can drive cancer cell growth.Imlunestrant binds to these receptors, breaking them down and preventing them from functioning.

By blocking and destroying oestrogen receptors, the medicine can slow the growth and spread of breast cancer and help kill cancer cells.Inluriyo is taken once daily as an oral tablet.

Julian Beach, Interim Executive Director of Healthcare Quality and Access at the MHRA, said: "Patient safety is our top priority."

He added: "The approval of imlunestrant tosylate (Inluriyo) provides a new treatment for adults with recurrent or metastatic breast cancer after prior hormone treatment hasn't been effective. As with all licensed medicines, we will continue to monitor its safety closely as it becomes more widely used."

Common side effects include increased liver enzymes, tiredness, joint, bone and muscle pain, diarrhoea, raised triglycerides, nausea and back pain.

A full list of side effects will be available in the Patient Information Leaflet and the Summary of Product Characteristics, which will be published on the MHRA website within seven days of approval.

UCB reports superiority of bimekizumab in psoriatic arthritis study

UCB has announced positive topline results from its BE BOLD trial, the first head-to-head study in active psoriatic arthritis to demonstrate superiority of one licensed biologic therapy over an IL-23 inhibitor.

The phase 2 study compared bimekizumab with risankizumab in adults living with active psoriatic arthritis.

According to UCB, bimekizumab achieved statistically significant superiority in the ACR50 primary efficacy endpoint at Week 16.

The company noted that treatment was generally well tolerated, with no new safety signals observed during the 16-week period. Bimekizumab is the first approved medicine to selectively inhibit both interleukin 17A and interleukin 17F.

Emmanuel Caeymaex, Executive Vice President, Head of Patient Evidence at UCB, said: "Our landmark BE BOLD study provides the first head-to-head evidence of superiority versus an IL-23 inhibitor in psoriatic arthritis.

"These topline results reinforce bimekizumab's potential to deliver clinically meaningful improvements using the stringent ACR50 measure of disease activity, indicating more complete control of joint inflammation."

He added: "BE BOLD represents the fourth head-to-head study demonstrating bimekizumab superiority, supporting physicians to make informed treatment decisions and advancing our ambitions to raise the standard of care for people living with psoriatic disease."

The company said the findings add to a growing body of evidence for bimekizumab across immune-mediated inflammatory diseases. UCB plans to submit the full BE BOLD results to an upcoming international congress.

EnteroBiotix completes enrolment for trial of EBX-102-02

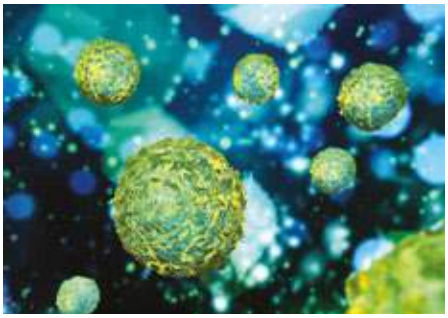
EnteroBiotix has completed enrolment for its investigator-initiated phase 2a MAST trial, which is evaluating the company's microbiome therapy EBX-102-02 in adults undergoing allogeneic haematopoietic stem cell transplantation for defined haematological malignancies.

The study, sponsored by Imperial College London and funded by the Medical Research Council, has recruited 50 patients across leading UK transplant centres. Participants receive either EBX-102-02 or a matched placebo before conditioning chemotherapy and will be followed for 12 months after transplant.

The trial aims to address the profound disruption to the gut microbiome commonly seen during transplantation. Loss of microbial diversity has been linked with higher risks of infection, graft-versus-host disease and reduced survival.

MAST will investigate whether a single pre-emptive oral dose of EBX-102-02 can help preserve microbial diversity during this vulnerable period, with exploratory outcomes assessing clinical transplant measures. Topline data is expected in H1 2027.

Professor Julian Marchesi explained: "Profound disruption of the intestinal microbiome is common during allogeneic stem cell transplantation and has been strongly associated with adverse outcomes.



"MAST builds on prior promising work from the Imperial team utilising traditional FMT approaches and has been designed to assess whether pre-emptive microbiota restoration using EBX-102-02 can preserve microbiome diversity during the transplant period and potentially improve post-transplant outcomes."

HOT & NOT

Astellas Pharma has announced that the National Institute for Health and Care Excellence has issued Final Draft Guidance recommending fezolinetant 45 mg once daily for treating moderate to severe vasomotor symptoms associated with menopause when hormone replacement therapy is unsuitable.

The decision means the treatment will be made available through the NHS, offering a new non-hormonal option for people experiencing disruptive hot flushes and night-sweats.

AlzeCure Pharma has announced that the European Medicines Agency has granted orphan drug status to ACD440, its clinical-stage pain treatment being developed for erythromelalgia.

The company, which focuses on diseases affecting the nervous system including Alzheimer's disease and pain, said the designation strengthens the prospects for advancing ACD440 as a potential therapy for patients with this rare and debilitating condition.

Aplagon has dosed the first patient in its phase 2a HEALING clinical trial evaluating APAC, a first-in-class treatment for thrombo-inflammatory diseases, in people with peripheral arterial occlusive disease and chronic limb threatening ischemia.

The study, taking place in Finland, will enrol up to 42 patients across four cohorts and will assess the safety and preliminary efficacy of APAC delivered intravenously. It will also examine the therapy's impact on thrombo-inflammatory biomarkers in patients with and without revascularisation.

Lebrikizumab shows strong results for children with atopic dermatitis

Almirall has reported positive top-line results from its phase 3 ADorable-1 trial, which evaluated lebrikizumab in children and adolescents aged six months to under 18 years with moderate-to-severe atopic dermatitis.

The company said the treatment met both co-primary and key secondary endpoints, with results showing notable improvements in skin clearance, disease severity, itch and quality of life at week 16. According to the data, 63% of paediatric patients achieved meaningful skin improvement and 44% reached clear or almost clear skin.

Dr Karl Ziegelbauer, Chief Scientific Officer at Almirall, said: "At Almirall, we are committed to advancing skin science through a holistic approach to disease management, recognising the profound effect skin conditions have on people's lives.

"We are excited about the positive, top-line results from the phase 3 ADorable-1 trial and the meaningful impact they could have on children and adolescents and their life trajectories."

Prof Weidinger, Department of Dermatology, Allergology and Venerology at University Hospital Schleswig-Holstein in Kiel, Germany, explained: "Children with atopic dermatitis still face considerable unmet needs, with persistent symptoms, limited treatment options, and a disease burden that grows with severity.

"There is a need for advanced treatment solutions, considering the specific challenges of younger patients and their families."

MHRA approves new treatment for severe alopecia areata

The MHRA has approved deuruxolitinib, marketed as Leqselvi, for the treatment of severe alopecia areata in adults, offering a new therapeutic option for people living with the autoimmune condition.

Alopecia areata occurs when the immune system attacks hair follicles, triggering inflammation that leads to hair loss on the scalp, face or other parts of the body.

Deuruxolitinib works by reducing the activity of JAK1, JAK2 and TYK2 relative to JAK3 kinases, enzymes involved in the inflammatory process at the hair follicle. By dampening this inflammation, the medicine can support hair regrowth.

Julian Beach, MHRA Executive Director, Healthcare Quality and Access, said: "This approval gives adults with alopecia areata another potential treatment option to help manage their condition. As with any medicine, the MHRA will keep the safety and effectiveness of deuruxolitinib under close review."

Leqselvi is available only on prescription. The recommended dose is an 8 mg tablet taken twice daily.

The approval is based on two pivotal clinical trials involving 1223 adults who had lost at least 50 percent of their hair for more than six months. Participants received either Leqselvi 8 mg, deuruxolitinib 12 mg or a placebo twice daily for 24 weeks.

Those treated with Leqselvi achieved higher scores on a standard measure of scalp hair coverage compared with placebo.

Elevara Medicines has dosed the first patient in its phase 2b START-SYNERGY trial, marking a key step in the development of ELV001, an oral CDK4/6 inhibitor being studied for rheumatoid arthritis in patients who do not respond sufficiently to methotrexate and TNF inhibitors.

The trial builds on earlier studies showing ELV001 was well tolerated and demonstrated early signs of clinical activity.

Responding to the 2025 NHS Staff Survey, Rory Deighton from the **NHS Confederation**, said: "NHS staff work tirelessly to care for patients and have a right to feel supported, valued and respected at work. It is completely unacceptable that so many colleagues have been physically attacked and subjected to unwanted sexual behaviour in the line of duty.

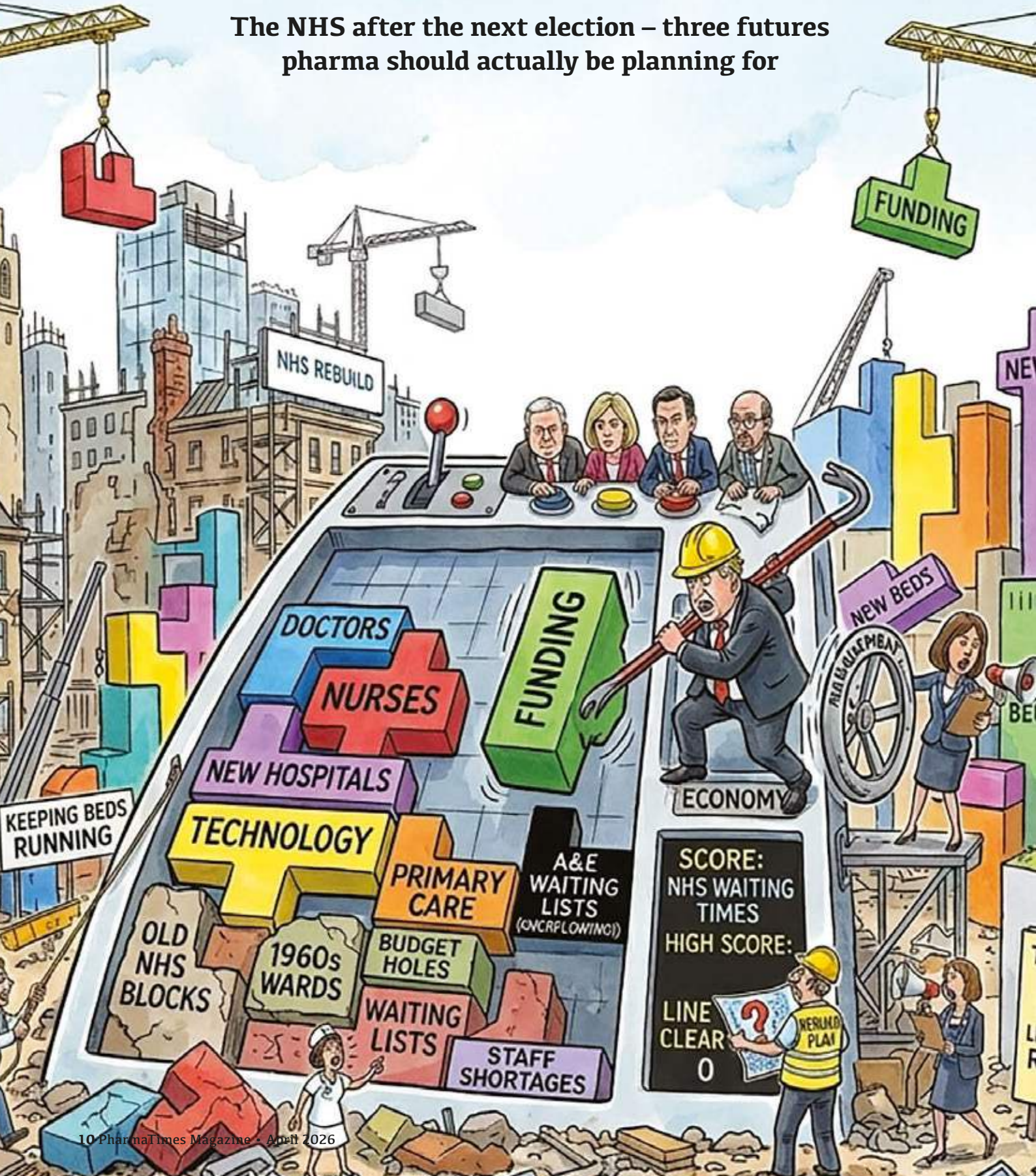
"There are some small improvements in this year's staff survey results but most indicators are broadly similar to last year."

On measles outbreaks, Dr Amit Aggarwal, from the **ABPI**, said: "Measles outbreaks are a serious concern and underline the importance of maintaining high vaccination coverage to protect individuals and communities.

"Vaccination rates have been declining for a number of years, but we believe the NHS vaccination strategy and the NHS 10-Year Plan have the right approaches to address this, with measures such as vaccination catch-ups, and an expanded role for health visitors."

Apocalypse now?

The NHS after the next election – three futures pharma should actually be planning for



At various points over the past decade, predicting the future of the NHS has felt like reading the tea leaves during an earthquake.

Structures change or revert, acronyms multiply and every incoming government promises transformation while discovering that the service resists sudden reinvention.

But the next general election may genuinely matter more than most for pharma, not because the NHS will disappear or suddenly privatise (it will not), but because the rules governing access, reimbursement and market predictability are up for renegotiation.

Before examining the scenarios, one awkward question must be addressed.

Do we even need to assess the likelihood of a Conservative NHS as things stand?

Politics has a sense of humour and comebacks happen, but current polling and political momentum suggest industry planning energy is better spent elsewhere.

The more realistic question is not whether the NHS changes, but how differently it changes under Labour continuity, a Reform-led disruption or a Green-influenced reimagining of public healthcare.

For pharma, each implies a recognisably different commercial climate.

The constant: an NHS becoming more political

Regardless of who wins, one trend is already locked in. The NHS is becoming less technocratic and more overtly political.

The planned absorption of NHS England back into central government marks the end of a long experiment in arm's-length management. Ministers increasingly want direct ownership of performance, waiting lists and spending decisions. For industry, this means fewer buffers between political priorities and commissioning behaviour.

In practical terms, access decisions will increasingly reflect political pressure as much as health economics. Innovation will still matter, but so will optics, productivity narratives and whether a therapy visibly solves a headline problem.

The NHS is not becoming anti-innovation. It is becoming impatient.

Labour: stability, with conditions attached

A continued Labour government represents the least dramatic scenario, though not necessarily the easiest commercial environment.

Labour's NHS philosophy can be summarised simply: reform first, money second. The political argument is that it is not funding that the NHS lacks (as I am fond of telling people, the annual budget is the same as the GDP of Portugal) but productivity.

Whether you agree or not, the implication for pharma is clear. New medicines must increasingly justify themselves not only clinically but operationally.

Market access would remain structured and predictable. NICE stays central. National commissioning logic survives. England continues to function as a largely single-payer environment.

But adoption becomes more conditional.

The emerging NHS mindset rewards therapies that reduce admissions, shorten pathways or substitute for workforce capacity. Treatments that improve outcomes while adding complexity face tougher conversations.

Real-world evidence expectations rise. Implementation planning becomes almost as important as clinical trial data.

In other words, the UK remains a viable launch market, but one that increasingly asks: what problem for the NHS workforce does this solve?

For primary care-based TAs like respiratory, obesity and diabetes, this is favourable territory. For gene and rare therapies, it means demonstrating they will work within the system, alongside your scientific breakthrough.

Labour's NHS would feel familiar, just slightly harder to impress.

Reform UK: faster access, or controlled chaos?

A Reform-led government would represent the sharpest departure from recent NHS orthodoxy and potentially the most unpredictable environment pharma has faced in decades.

Reform's instinct is clear: introduce competition, expand private provision and loosen central control. Voucher-style mechanisms and tax incentives for independent providers aim to inject consumer choice into a system long defined by national planning.

> **'The question is not whether your innovation works. It is whether your innovation works for the NHS'**

From one perspective, this sounds attractive. More providers mean more potential purchasers. Alternative funding streams could emerge. Access routes might diversify beyond the traditional NICE-to-NHS pipeline.

But disruption cuts both ways.

If public spending tightens while structural reform accelerates, a likely combination given Reform's broader rhetoric, the NHS risks entering a prolonged transition period. Commissioning structures would change faster than replacement systems mature.

Decision-making could fragment geographically. National pricing predictability might weaken.

Pharma companies might gain flexibility while losing certainty. And certainty has historically been one of the UK market's greatest assets.

The likely outcome is a two-speed system: nationally funded specialised therapies continuing much as before, while elective and chronic care increasingly migrate towards mixed public-private provision.

Some companies would thrive in this environment. Others would struggle to navigate a suddenly plural payer landscape.

Reform offers opportunity but also volatility. The healthcare equivalent of deregulating air traffic while planes are still landing.

A Green coalition: more money, tougher questions

A Green-influenced government would produce the most ideologically distinctive NHS, though not necessarily the most hostile one for industry.

Green health policy leans heavily towards expanded public investment, prevention and reduced reliance on private-sector delivery.

The NHS would likely see increased funding framed around well-being, inequality reduction and long-term population health rather than productivity metrics alone.

At first glance, this sounds positive for pharma. Greater investment often translates into expanded treatment volumes and earlier intervention programmes. Prevention agendas could favour therapies targeting chronic disease progression or early diagnosis.

However, enthusiasm for public provision tends to come paired with sharper scrutiny of commercial value.

'The emerging NHS mindset rewards therapies that reduce admissions, shorten pathways or substitute for workforce capacity'

Pricing negotiations could become more politically charged. Value discussions may extend beyond QALYs into broader societal benefit arguments. Expectations around domestic research contribution, sustainability and equitable access could increase.

The Green NHS would probably buy more healthcare but negotiate harder over what it pays.

For industry, success would depend less on demonstrating innovation and more on demonstrating alignment with public purpose.

The myth of radical divergence

Despite ideological differences, all plausible futures share surprising similarities.

No government is likely to abandon national risk pooling for specialised medicines; the economics simply do not allow it.

Gene therapies, transplant medicines and ultra-rare treatments will remain nationally coordinated in some form because local systems cannot absorb their financial volatility.

Nor is any party likely to dismantle NICE. Health technology assessment provides political cover for difficult rationing decisions and governments rarely surrender useful shields.

Even patient charging, periodically floated in political debate, remains constrained by overwhelming public attachment to care that is free at the point of use.

The NHS changes slowly because voters insist that it does.

What actually changes for pharma

The real shift is subtler but more consequential.

Historically, the UK offered industry a simple proposition: accept tough pricing negotiations in exchange for national scale and predictable uptake.

That bargain is evolving.

Future governments appear less willing to guarantee rapid diffusion after approval. Implementation responsibility is moving closer to regional systems. Adoption speed may vary more widely.

Commercial success increasingly depends on engagement beyond national policy, with a local lens on providers, pathways and operational realities.

The NHS is becoming less a single customer and more an ecosystem. And it is becoming ever more important to work with a range of stakeholders with various influences upon the decision across the NHS.

For companies accustomed to centralised engagement, this demands cultural adjustment as much as strategic planning.

So which future is best?

The uncomfortable answer is that none is unequivocally favourable or hostile.

Labour offers predictability but tighter scrutiny. Reform promises flexibility alongside instability. A Green coalition could expand spending while intensifying value expectations.

What unites them is a shared political reality: healthcare demand is rising faster than public finances.

Every future NHS will therefore reward innovation that reduces pressure elsewhere in the system. Medicines framed purely as clinical upgrades risk slower adoption. Those positioned as system solutions gain traction.

The industry's competitive advantage will increasingly lie not in explaining science, but in explaining how science helps the NHS govern itself.

The election matters, but less than pharma thinks

Elections reshape rhetoric faster than systems. The NHS has absorbed governments of every ideological shade while remaining recognisably itself.

The next administration will not reinvent the service overnight. But it will influence the tone of negotiation, the pace of adoption and the balance between central control and market experimentation.

For pharmaceutical companies, the strategic mistake would be planning for a single political outcome.

The safer assumption is this: whichever party wins, the NHS of the late 2020s will be more financially constrained, more politically directed and more demanding about demonstrable system value than the NHS of the past decade.

The question is not whether your innovation works. It is whether your innovation works for the NHS. ▲

Oli Hudson is Content Director at HSJ Information

laboratory news

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Health space odyssey

Preventative revolution – redefining the role of GLP-1s in healthcare

For much of modern medicine, healthcare systems have been structured around treating disease once it becomes clinically apparent.

We screen for elevated blood glucose before diagnosing diabetes and we treat the consequences of cardiovascular disease once risk has translated into pathology.

While preventive medicine has always existed, it has historically been difficult to intervene earlier in the disease trajectory in a meaningful way. That may now be changing.

At the centre of this shift is a class of medications that many still dismiss as little more than 'diet drugs': GLP-1s.

Weight loss is the most visible outcome of GLP-1 medications. As the evidence base expands, it is becoming clear that their potential extends far beyond weight loss.

These medicines influence many of the metabolic pathways that underpin cardiometabolic disease. Emerging evidence suggests benefits across a range of conditions including cardiovascular disease and liver disease.

They represent more than a treatment for obesity. They offer the possibility of intervening earlier in the disease pathway, helping to reduce downstream complications and shifting healthcare systems from managing illness to preserving health.

GLP-1s could genuinely help shift our focus from extending lifespans to meaningfully expanding 'healthspans', the years we live in good, functional health.

Metabolic overflow

To understand why a medication licensed for obesity may influence outcomes across multiple organ systems, it helps to look at the biology of cardiometabolic disease.

Obesity and type 2 diabetes are not isolated conditions. They are associated with complex metabolic dysregulation and a state of chronic low-grade inflammation that can affect tissues throughout the body.

When the body's metabolic regulatory systems are persistently overloaded, inflammatory signalling can contribute to damage across several organs.

GLP-1 agonists appear to intervene in several points along this pathway. By mimicking a natural hormone produced in the gut, these medications influence appetite, insulin secretion, gastric emptying and glucose regulation.

In doing so, they improve overall metabolic control.

This broader metabolic effect may help explain why many patients report improvement beyond weight loss alone, including reduced joint pain and improved physical function.

While weight reduction plays an important role, the metabolic changes associated with GLP-1 therapy may also contribute to these wider benefits.

The heart shield

The strongest evidence for the preventative power of GLP-1s lies in cardiovascular health.

In adults with obesity and established cardiovascular disease, but without diabetes, semaglutide reduced the risk of major adverse cardiovascular events including heart attack and stroke by 20 percent compared with placebo.

Importantly, these reductions emerged relatively early in treatment, suggesting a direct cardioprotective mechanism that operates independently of weight loss.

Improvements in glycaemic control, blood pressure, lipid profiles and inflammatory signalling are all thought to contribute to this effect.

> **'We are no longer simply treating a number on a scale. We are actively modifying the trajectory of cardiometabolic disease'**

In the UK, this has already led to semaglutide becoming the first anti-obesity medication approved specifically to reduce the risk of future cardiac events in those with established cardiovascular disease.

We are no longer simply treating a number on a scale. We are actively modifying the trajectory of cardiometabolic disease.

Protecting the body's filters

The preventative potential of GLP-1s also extends to organs that sustain long-term damage from metabolic disease.

Chronic kidney disease often progresses silently for years before patients face the prospect of dialysis or transplantation.

Clinical trials have shown that once-weekly semaglutide can reduce the risk of major kidney complications by approximately 24% in patients with type 2 diabetes and chronic kidney disease.

These benefits are thought to arise from improved glycaemic control, reductions in blood pressure and body weight, and favourable effects on renal haemodynamic and inflammation.

The emerging picture in liver disease is equally compelling. In a 48-week trial, 39% of patients taking liraglutide saw their liver disease improve compared with 9% on placebo.

Clinical research with semaglutide has demonstrated even higher rates of disease resolution, with around 63% of participants experiencing improvements in fatty liver disease without worsening fibrosis and around 37% seeing improvements in fibrosis itself.

While weight loss and improved insulin sensitivity play a major role, GLP-1 therapies may also exert direct metabolic and anti-inflammatory effects within the liver.

Together, these findings suggest that treatment originally developed for diabetes and obesity may have a meaningful role in altering the long-term course of metabolic liver disease.

Beyond metabolism

Perhaps the most intriguing area of emerging research is the potential impact of GLP-1s on neurological and respiratory health.

Observational studies using real-world data suggest a lower incidence of dementia, Parkinson's disease and stroke among patients treated with GLP-1 medications compared with those receiving other diabetes therapies.

While these findings are preliminary, they have generated significant interest and research is underway to explore whether GLP-1 therapies may influence the biology of neurodegenerative disease.

Early signals are also emerging in respiratory disease. Retrospective analyses in patients with type 2 diabetes and asthma suggest that those prescribed GLP-1 medications experienced fewer exacerbations and improved disease control compared with those on other diabetes treatments.

Studies in patients with chronic obstructive pulmonary disease and type 2 diabetes point in the same direction.

The potential immune benefits became particularly visible during the COVID-19 pandemic. Data indicates that patients taking GLP-1 medications had lower mortality from serious infection.

Whilst causal mechanisms remain uncertain, these findings have further fuelled interest in the broader immunometabolism effects of this drug class.

Cancer risk and oncological dimension

The emerging evidence of GLP-1s extends into oncology.

Large observational analyses have reported that patients prescribed GLP-1s have a 17 percent lower incidence of certain cancers compared with those receiving other diabetes treatments.

The most significant reductions were seen in obesity-related malignancies such as endometrial and ovarian cancers.

By regulating insulin levels and reducing inflammation driven by excess adiposity, GLP-1s appear to remove the metabolic fuel that many tumours rely on to grow.

While these findings require confirmation in prospective research, they illustrate how therapies originally developed for diabetes and obesity may influence a broader spectrum of disease.

New model of wellness care

The emerging evidence suggests that the utility of GLP-1s extends far beyond obesity treatment.

What is becoming visible is the outline of a multisystem metabolic therapy with the potential to influence several of the chronic diseases that place the greatest burden on modern healthcare systems.

Realising that potential will require a shift in collective mindset.

If we continue to view these medications through the narrow lens of 'diet drugs', we risk overlooking their broader role in modifying cardiometabolic risk and preventing downstream complications such as heart failure, kidney disease and metabolic liver disease.

The challenge for the healthcare system is therefore not simply access to treatment but integration.

GLP-1 therapies will likely deliver their greatest value when used as part of a wider preventative strategy that combines medical treatment with lifestyle intervention, early risk identification and long-term patient engagement.

As clinicians, our goal is not only to extend life but to preserve the years lived in good health.

If the trajectory of current research continues, GLP-1 therapies may become one of the most important tools we have for shifting healthcare from the management of disease to the preservation of health. ▲

Dr Bryony Henderson is Medical Director at MedExpress

Big appetite

How the GLP-1 weight loss boom is exposing the limitations of pharmaceutical supply chains

Nearly one in ten adults in Great Britain have either recently used GLP-1 weight loss medications or are seriously considering doing so.

Pharmaceutical supply chains were not designed for that, especially for a cold chain product delivered on a weekly basis.

Their efficacy has driven enormous media interest, with many people sharing transformational experiences.

Between early 2024 and early 2025, an estimated 1.6 million adults across England, Wales and Scotland used GLP-1s to support weight loss and health goals.

Globally, the market is booming and is expected to grow from around $14 billion in value two years ago to nearly $50 billion by 2030.

Domestically, this very high level of demand has significantly exceeded NHS England's original prescribing expectations, which adds to the wider pressure on pharmaceutical supply chains due to demand in other countries.

Supply chains under pressure

How can pharmaceutical businesses cope with unusual, unprecedented spikes in demand, while evolving their processes to maximise market growth?

Pharmaceutical supply chains are designed around predictable prescription demand and long planning cycles. However, consumer-driven demand spikes from ADHD medications to children's pain relievers to oncology drugs have repeatedly exposed how brittle that model can be.

GLP-1s are the latest and largest stress test.

> 'Pharmaceutical supply chains were not designed for a cold chain product delivered on a weekly basis'

Production challenges aside, getting product to market for large and complex organisations like the NHS tests existing supply chain relationships and processes.

In the case of GLP-1 medications, the challenge is complicated by the need for temperature-controlled storage and transport. As volumes increase, maintaining cold chain integrity across manufacturing, warehousing, distribution and last mile adds further operational pressure.

The changing nature of how patients access their medication, with the growth of digital pharmacies, home delivery services and healthcare platforms, increases the complexity of temperature-controlled distribution planning.

In supply chain planning, demand forecasting must fully integrate with product availability and delivery against the backdrop of stringent regulatory compliance. Gaps at any point can quickly expose weaknesses in planning processes and visibility.

The supply chain impact of GLP-1 popularity extends well beyond the medications themselves. As usage has grown, so too has demand for adjunct medications, particularly treatments used to manage side effects like nausea. Weight loss also drives sales of aesthetic treatments, including dermal fillers and skin-tightening procedures. Many of these products are also temperature-sensitive, adding further complexity to cold chain logistics.

The ripple effects extend even further, beyond healthcare and into consumer markets. People using GLP-1 drugs often eat smaller portions, reduce snack consumption and increase protein. Weight loss can also prompt people to buy new clothes.

The underlying impact on supply chains is that even modest changes in behaviour related to GLP-1s can introduce unexpected volatility into forecasting and inventory planning.

Planning for volatility

How can pharmaceutical businesses position themselves to deal with demand volatility?

Traditional planning models that rely heavily on historical data struggle to keep pace with dramatic behavioural shifts. Ideally, supply chain teams need access to more timely demand and distribution indicators, including information that sits outside core processes such as prescription trends.

This requires greater end-to-end visibility across the supply network so stakeholders can understand how demand changes work their way back up the chain from healthcare providers at the sharp end through to delivery performance and production.

The most effective supply chain platforms help organisations connect the dots by integrating data from planning, procurement, manufacturing, logistics and distribution processes to create a single operational view.

Supply chains have revolved around the collection and analysis of data at each stage of the process for years. However, with AI and machine-learning models, huge volumes of information can be analysed much earlier than legacy analysis processes and technologies.

These tools offer a transformational level of insight into risks and opportunities in the supply chain in real time.

Consider this scenario, for example. A pharmaceutical manufacturer is supplying GLP-1 medications to multiple national markets. Prescription data from pharmacies and healthcare platforms indicates a specific and sudden surge in demand in one region.

Because planning, logistics and distribution data are connected on a unified platform, changes in demand are flagged early to supply chain planners.

AI models are used to analyse the likely impact on each stage in the supply chain before evaluating possible responses such as adjusting production volumes or prioritising deliveries to the affected market.

Planners can review the recommended actions and approve adjustments before shortages begin to affect pharmacies or healthcare providers. As new data continues to arrive, the system monitors performance and updates forecasts, allowing the organisation to respond continuously.

Fit for the future

The GLP-1 boom is likely to serve as a useful case study for the pharmaceutical industry on various levels. One key lesson is that historic demand baselines are less reliable when behavioural shifts occur at scale.

Organisations need planning processes that can detect demand signals earlier than before and in a way that enables them to adapt quickly. This requires effective integration between healthcare providers, pharmacies, distributors and manufacturers, supported by shared data and visibility.

The GLP-1 boom will not be the last time consumer behaviour outpaces pharmaceutical supply chains. But it should be the last time the industry is caught planning for yesterday's demand.

The organisations that invest now in real-time visibility, integrated demand signals and cold chain agility will not just survive this shift – they will be the ones ready for the next one. ▲

Tiffany Brewer is Senior Director, Global Industry Strategy – Life Sciences at Blue Yonder

Leading by example

A journey from community pharmacy to medical leadership

Early in my career I found myself rushing between community pharmacies as a locum pharmacist while also conducting my postdoctoral research in the lab.

Navigating the two very different worlds of frontline patient care and scientific investigation taught me early on the importance of bridging knowledge and practice, of translating scientific insight into tangible impact for patients.

If someone had asked me then what drove me, my answer would have been simple: I wanted to help people. Two decades on, as Medical Director at Ascendis Pharma UK, that purpose remains constant.

What has evolved is my understanding of what it truly means to lead, influence and drive better outcomes for patients. Over time, that mission has grown deeper and more personal.

Never do anything by halves

My father, an industrial chemist, first sparked my love of science and instilled a principle that has guided every part of my career: never do anything by halves. If you commit to something, give it your full effort.

That mindset shaped my studies at university, where I realised my interests sat firmly at the intersection of scientific research and patient care. I wanted not only to understand the science behind potential treatments, but also to see the real-world impact they could have on the people who rely on them.

Some of my most important early lessons came from community pharmacies. They are places where people speak honestly. Patients rarely talk only about symptoms; they share how their condition affects their work, their families and their confidence.

Having these conversations day to day with patients is a privilege and a responsibility, and I believe it is these conversations that shaped my perspective.

Speaking directly with patients broadened my understanding of illness beyond the clinical description. Often it was not the symptoms themselves that patients raised first, but the wider impact on their lives that drove them to seek help.

Listening helped me understand how, within my role as a pharmacist, I could best support them. My time and experience as a locum pharmacist instilled in me a lasting commitment to ensure that patients' voices are heard. I am proud that this patient-centred instinct has stayed with me throughout my career.

Finding my voice

As a woman building a career in science, female leaders were relatively rare. On many occasions I found myself presenting to a room largely filled with men, or as the only woman in my cohort. That prospect could feel daunting.

Rather than being discouraged, I focused on the quality of my work and the purpose behind it. In many ways, it motivated me to work harder, to stand out, to do things differently and to become an example for women who might follow.

At times it felt like I had to fight to be heard and to create opportunities for myself.

One moment that stands out was becoming one of the first Pharmacy graduates to receive King's College London Alumni funding, following a 1st class honours degree, to complete a PhD.

I subsequently won the CW Maplethorpe Postdoctoral Research Fellowship – a highly competitive, prestigious award administered by a management panel and associated with both King's College London and UCL School of Pharmacy for the promotion of pharmaceutical education and research.

> **'Leadership is not about fitting into existing moulds. It is about bringing your experience, values and conviction into the room'**

Being the only woman recipient of the CW Maplethorpe Fellowship at that time marks a significant contribution to women in pharmaceutical science and research.

Experiences like this reinforced something I strongly believe today. Leadership is not about fitting into existing moulds. It is about bringing your experience, values and conviction into the room. That belief has guided me throughout my career.

Modelling what's possible

That conviction strengthened further when I became a mother. Parenthood brings a different understanding of vulnerability, resilience and the importance of advocacy.

The resilience I had built while navigating a competitive, male-dominated field took on a new meaning.

It was no longer only about my own ambition; it was also about the example I was setting. I have two daughters, and I want them to grow up seeing that women belong in science, in leadership and in the decision-making spaces that shape healthcare.

The responsibility of modelling that – of showing what it means to lead with empathy, integrity and ambition – continues to motivate me every day.

When I completed my MSc in International Health Technology Assessment, Pricing and Reimbursement, my three young children were there to see me graduate at the University of Sheffield. Having them in the audience made the milestone deeply personal.

It felt like a quiet message to them: that motherhood and ambition can sit side by side, and that it is possible to lead with both purpose and presence.

Lived experience

This perspective has also shaped my work in rare disease, a field where the challenges are both unique and deeply human. When patient populations are small, awareness is often limited, research funding can be scarce and resources harder to mobilise.

What struck me most when I entered this field was the extraordinary focus and commitment of those working to support people with rare, and sometimes life-threatening, conditions.

Many people face long and complex journeys to diagnosis, alongside the challenge of navigating healthcare systems that may have limited experience with their condition.

Yet one thing consistently stands out: patients and their caregivers often become the true experts in their conditions. Their lived experience provides insights that no data set or clinical report could fully capture. We have a responsibility and accountability to amplify that voice.

Rare disease has taught me that progress requires something very specific: focus; dedication and partnership with the people most affected.

Thinking back to my role as a pharmacist, I realise that what mattered was not only understanding people's stories – it was doing something meaningful with that knowledge both for them and for others.

That mindset has become the backbone of my attitude to leadership: if you are in a position to make a positive change, you have a responsibility to act.

All these experiences have shaped the leader I am today: someone driven to deliver meaningful work, who believes in doing things fully and with purpose, and who feels a responsibility to help create something better for the patients and communities we serve.

Being a woman in pharma is part of that story. I want my daughters and my son to see that women can lead with conviction, compassion and expertise, and that a career in science or healthcare is theirs to claim if they choose it.

No woman should feel held back from pursuing the path that inspires her. ▲

Dr Atiya Kenworthy is Medical Director at Ascendis Pharma UK

Out of Africa

Withdrawal of USAID is fanning winds of entrepreneurial change across a vital continent

Of all the impacts that Donald Trump has had on America's relationship with the rest of the world, arguably the most material has been the withdrawal of $63 billion of overseas aid, much of it to the continent of Africa.

Public outrage and legal challenges, including from Oxfam, met the Trump administration's immediate closure of the United States Agency for International Development (USAID) last year, which had been critical to global humanitarian and development assistance since 1961.

While these cuts represented less than one percent of the federal budget, they have potentially denied education to 23 million children, deprived 95 million people of basic healthcare and caused over 3 million preventable deaths annually by dismantling programmes that provided lifesaving aid, food, clean water and economic support worldwide.

There is also the loss to US companies of the less acknowledged 'aid dividend' – the commercial goodwill that often results from government altruism.

The withdrawal of traditional aid, such as from the US, is often framed as a risk. In practice, it may simply create a vacuum for others to fill. The hard currency from aid is helpful, but the underlying demand for better health does not vanish.

This is where Europe, with its historical ties, and China, with its aggressive long-term strategy, are actively positioning themselves. Chinese universities are educating Africa's next generation of professionals, creating deep, lasting ties.

For Western companies to cede this ground is not just a commercial mistake; it is a forfeiture of strategic influence in the continents of tomorrow.

The investment landscape for African MedTech, biotech and pharma is maturing rapidly. The sector is now seen as a high-growth opportunity, defined by demographic inevitability, digital innovation and a new generation of entrepreneurs who are creating profitable solutions to profound challenges.

Of all the territories of the world, Africa has arguably suffered most from the damaging power of cliché. Lack of knowledge and curiosity about the continent and its people has contributed to the persistence of stereotypes that have encouraged racist profiling, facilitated exploitation of its people and resources and hampered economic growth.

For decades, the narrative surrounding Africa in the MedTech, biotech and pharmaceutical sectors was dominated by a charitable, aid-based paradigm – a one-way flow of donated goods and paternalistic programmes.

For companies in the west, the only reason to invest in Africa was through mass vaccination programmes funded by governments and NGOs. But times they are a changing.

A new and more compelling story is emerging around the booming economies of Egypt, Algeria and Nigeria, and the continued emergence of an affluent 'middle class' in these countries.

From my recent immersion in recruiting for the diagnostics space across sub-Saharan Africa, a clear perspective has crystallised: engaging with Africa is no longer an act of charity; it is a critical business and moral imperative for any company with ambitions for the future.

> **'The core of the new opportunity lies in Africa's ability to bypass legacy systems, particularly with AI in medical imaging'**

The catalyst for this shift is the confluence of three powerful forces – leapfrog technology adoption, the rise of a capable and dynamic local workforce and the undeniable demographic and economic trajectory of the continent.

My conversations with professionals from Nairobi to Lagos have fundamentally altered my understanding of the opportunity.

The leapfrog effect

The core of the new opportunity lies in Africa's ability to bypass legacy systems, particularly with AI in medical imaging.

In the west, the integration of AI into radiology is often seen as a disruptive threat to established professions and workflows. The resistance is understandable; it is about managing displacement within a complex, existing structure.

In Africa, the calculus is different because, until now, it has had no radiography function to speak of outside major urban centres, at scale or relative to populations. This is the leapfrog effect in action, as there is no entrenched, human-intensive system to disrupt.

Instead, AI-powered point-of-care diagnostics and imaging can be deployed from scratch, creating capability where little or none existed before.

The result is not job losses, but rather a dramatic amplification of public health capacity.

A nurse with a robust, AI-enabled device can provide screening services that were previously the sole preserve of a specialist in a central hospital hundreds of miles away.

This mirrors the mobile banking revolution. Africa did not need to lay billions of miles of copper telephone lines; it went straight to cellular networks, unlocking financial inclusion at a staggering pace.

The same pattern is repeating in health tech. Companies that offer durable, affordable and smart diagnostic solutions are not just selling a product; they are providing the foundational infrastructure for 21st-century healthcare.

The benefit is twofold: companies access a vast, growing market, while African nations achieve quantum leaps in health outcomes, turning the tide on maternal mortality, infectious diseases and the rising burden of cancers.

Enthusiasm, expertise and equity

Perhaps the most profound misconception we in the west held was about the African workforce, assuming that roles would be locally based with salary structures significantly lower than in Europe.

This is not necessarily the case.

As we have discovered, wages for people doing what we would regard as Western jobs for Western companies are frequently the same as you would find in Europe.

This is not exploitation, but rather a recognition of value. The individuals managing these complex markets – navigating health ministries, NGO partnerships and local distributors – possess a rare and critical skillset, and they are imbued with a 'can-do attitude' more reminiscent of American commercial culture than European caution. They are highly educated, often globally, and incredibly responsive.

While researching candidates, our standard rule of thumb was upended. We researched 28 people for a position and came up with 12 shortlisted candidates in a short space of time. As a guide, we would normally expect to engage with one in every ten people contacted. The talent pool is not just deep, it is also engaged and entrepreneurial.

For many mature life sciences businesses in Europe, North America, South-east Asia and the Pacific, this has the potential to change their entire strategic equation. Building a business in Africa is not about finding cheap labour, it is about partnering with high-value, locally knowledgeable experts who are essential for market entry.

The long-term implication is even more significant.

Beyond the anecdotes and rhetoric

As these professionals gain experience with global companies, a pipeline of future regional and global leaders is being created. The question for multinational boardrooms should be 'do we have African senior management on our global team?'

Failing to cultivate this talent is a strategic oversight, especially as these individuals understand growth markets in a way few others can.

The political rhetoric emanating from Donald Trump may dismiss Africa, but the commercial reality tells a starkly different story. One anecdote stood out – a diagnostic product generating $600,000 a year in gross sales in Eritrea, a country often depicted as isolated and impoverished.

This is not anomalous; rather it signals a fundamental truth that need creates market demand, and where there is demand, funding follows through governments, NGOs and a burgeoning private healthcare sector.

The market is complex and fragmented, comprising more than 50 distinct healthcare systems, from NHS-style models to purely commercial ones. Success requires nuance and local partnership, not a one-size-fits-all approach.

Corruption remains a concern, as it is in many emerging markets, but reputable global companies have strict compliance frameworks.

The real business is done by building relationships and demonstrating value, not by backhanders. As we surmised, for most people in Africa as elsewhere, 'business is business'. ▲

Ivor Campbell is Chief Executive of Snedden Campbell

Fast and the curious

The 15 most kick-ass pharma products of the past 15 years

Over the past decade and a half, the pharmaceutical industry has delivered some of the most astonishing breakthroughs in modern medicine. And it's just as well, without them this article would be written from a destroyed apartment block in the middle of a dystopian nightmare.

Indeed, from treatments that were once the stuff of science fiction to everyday products that have quietly transformed public health, the sector has reshaped what is possible for patients, clinicians and health systems.

It has also changed expectations. Folk now assume that innovation will be faster, smarter and more personalised than ever before.

Choosing the 15 greatest products of the past 15 years is no easy task. But some medicines stand out not only for their clinical impact, but for the way they have shifted entire therapeutic landscapes, opened new scientific frontiers or changed how society thinks about disease. Here are the products that have defined an era.

1. mRNA COVID-19 vaccines

It is impossible to overstate the significance of the first authorised mRNA vaccines. Pfizer-BioNTech's and Moderna's COVID-19 vaccines did more than help pull the world out of a global crisis. They validated a platform that had been in development for decades and proved that vaccines could be designed, manufactured and deployed at unprecedented speed. The ripple effects are still being felt, with mRNA now being explored for flu, RSV, HIV and even cancer.

2. GLP-1 weight-loss medications

Semaglutide and tirzepatide have become household names, and for good reason. Originally developed for diabetes, GLP-1 drugs have transformed the treatment of obesity, a condition long underserved by effective therapies. Their impact goes far beyond weight loss. They are reshaping cardiovascular risk management, influencing consumer behaviour and forcing supply chains to evolve at pace. Few products have ever created such a cultural and clinical moment.

3. CAR-T cell therapies

Fifteen years ago, the idea of reprogramming a patient's own immune cells to hunt down cancer sounded like science fiction. Today, CAR-T therapies such as Kymriah and Yescarta are saving the lives of people with otherwise untreatable blood cancers. They have also paved the way for a new generation of personalised cell and gene therapies that could redefine oncology for decades to come.

4. PCSK9 inhibitors

For millions of people with high cholesterol who cannot tolerate statins or need additional support, PCSK9 inhibitors like Repatha and Praluent have been game changers. They dramatically reduce LDL cholesterol and have helped shift the focus from managing cardiovascular disease to preventing it more aggressively.

5. Hepatitis C cures

The arrival of direct-acting antivirals such as Sovaldi and Harvoni marked one of the most remarkable therapeutic revolutions of the century. Hepatitis C went from a chronic, life-threatening condition to a curable disease with short treatment courses and minimal side effects. Few medicines have delivered such a clean, decisive victory.

6. Immunotherapy checkpoint inhibitors

Drugs like Keytruda and Opdivo have rewritten the rules of cancer treatment. By releasing the brakes on the immune system, they have delivered durable responses in cancers once considered untreatable. They have also become foundational therapies across multiple tumour types, inspiring a wave of combination approaches and next-generation immunotherapies.

7. RSV vaccines for older adults

After decades of failed attempts, the approval of RSV vaccines for older adults and high-risk groups represented a major public health milestone. These vaccines are already reducing hospitalisations and easing winter pressures on health systems, proving that innovation in infectious disease is far from over.

8. Gene therapies for rare diseases

Luxturna, Zolgensma and other pioneering gene therapies have shown what is possible when science targets the root cause of disease. Restoring vision, replacing faulty genes and offering one-time treatments for conditions that were once fatal, these products have redefined hope for families affected by rare disorders.

9. Oral antivirals for COVID-19

Medicines such as Paxlovid brought the fight against COVID-19 out of hospitals and into homes. By reducing the risk of severe disease, they helped protect vulnerable populations and provided a crucial second line of defence alongside vaccines.

10. Biosimilars that expanded access

While not a single product, the rise of biosimilars deserves a place on this list. Over the past 15 years, biosimilars for insulin, monoclonal antibodies and oncology drugs have expanded access, reduced costs and increased competition. They have also forced the industry to rethink pricing and value in biologics.

11. Long-acting HIV prevention and treatment

Cabotegravir and other long-acting injectables have transformed HIV care. For many people, the shift from daily pills to infrequent injections has improved adherence, reduced stigma and offered a new level of freedom. It is a powerful example of how innovation is not only about efficacy, but about fitting treatment into real lives.

12. Migraine CGRP inhibitors

For decades, migraine sufferers had limited options. The arrival of CGRP inhibitors such as Aimovig and Ajovy has provided targeted, effective prevention with fewer side effects. These medicines have helped millions regain control over a condition that can be profoundly disabling.

13. At-home diagnostic technologies

From rapid COVID tests to advanced home blood-testing kits, diagnostics have undergone a quiet revolution. Products that once required a clinic visit are now available on kitchen tables, empowering people to monitor their health and accelerating the shift towards decentralised care.

14. Novel antifungals

Fungal infections have long been an overlooked threat, particularly for immunocompromised patients. New antifungals such as ibrexafungerp have expanded the toolkit for clinicians and addressed growing concerns about resistance. It is a reminder that innovation matters across every corner of medicine, not just the headline-grabbing areas.

15. Personalised cancer vaccines

Although still early, personalised cancer vaccines based on tumour-specific mutations are one of the most exciting developments of the past 15 years. The first clinical successes suggest a future in which cancer treatment is tailored with extraordinary precision. They earn a place on this list not only for what they have achieved, but for what they promise.

Extraordinary progress

Taken together, these 15 products tell a story of rapid, mind-boggling scientific acceleration. They show how the industry has moved from broad-spectrum treatments to precision medicine, from chronic management to cures, and from reactive care to prevention. They also highlight the growing importance of platforms such as mRNA, cell therapy and gene editing, which will shape the next wave of breakthroughs.

Most importantly, they demonstrate the power of sustained investment, global collaboration and scientific ambition. The past 15 years have been remarkable. The next 15 will venture beyond what we ever thought possible. ▲

John Pinching is Editor, PharmaTimes

Talking the talk

It's the start of a beautiful friendship, as Jess takes to the page

Hello reader. It's wonderful to have you here for my official launch as a *PharmaTimes* columnist. And, naturally, an official launch merits a proper introduction.

As you may have gleaned from the column title, my name is Jess Farmery, and almost seven years ago the gods of nominative determinism delivered me into a career in health PR and communications.

Fun fact: my identical twin sister, Alice, took the only other option on the table and now works in agriculture communications. From pharma to farmers – I am not joking.

Fast forward to today, and I've had the privilege of working with a brilliant range of companies across the tech and life sciences spectrum.

That includes everything from teeny start-ups with world-changing ideas to global drug developers fundamentally reshaping healthcare delivery.

Somewhere in the middle of it all, I became completely obsessed with the mechanics of media, press and comms – yes, even crisis and reputation management.

Navigating complex regulations while dialling up creativity to the max, keeping a laser focus on patients' lived realities, and building a network of talented journalists is now my idea of a very good time.

What makes it even better is collaborating with some of the smartest people in the world within a sector that is constantly evolving and being buffeted by global storms.

I don't think I'd trade it for any other job (though, in another life, I'd be a swimming teacher on a tropical island – perhaps I'll keep that on the back burner for retirement).

For the eagle-eyed amongst you, I'll admit it's not the first time my byline has appeared in these pages.

I had the pleasure of contributing a flurry of advice articles earlier in 2026. Because they delivered more clicks and shares than furious letters of complaint, the Editor has kindly furnished me with a corner of the magazine on a rolling monthly basis.

What to expect

But how could I possibly have enough to say to keep a discerning crowd like you intrigued for months to come?

It's a valid question.

Having accepted that my own well of wisdom is somewhat shallow, I've lined up the crème de la crème of pharma comms talent to share their insights.

Expect a punchy mini-interview series, interspersed with my own musings and the occasional nugget of advice.

We're going to dig into the most exciting projects and challenges across the sector, exploring how organisations are adapting their comms mix for the realities of 2026.

Ideally, you'll leave each month with food for thought and a couple of fresh ideas to make you look good in front of your boss.

My door is always open for suggestions, nominations and feedback.

Please do slide into my LinkedIn DMs to tell me who I should be speaking to and which topics we should be dissecting.

Right, let's do this – I'll see you next month. ▲

Jess Farmery is Senior Account Director, Health at Lexington Communications

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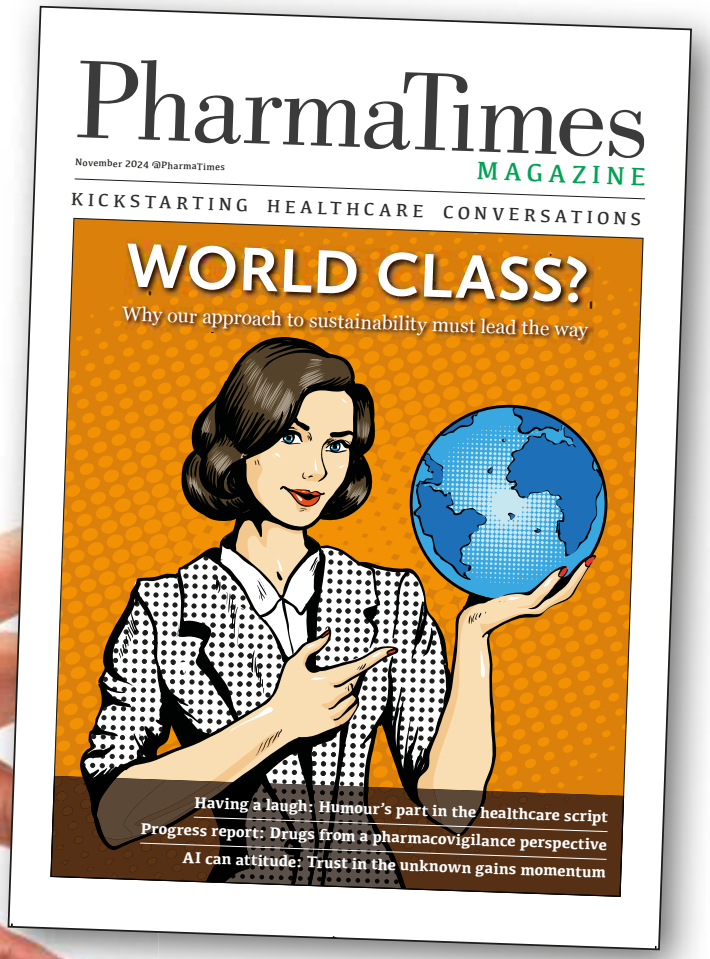

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Being is believing?

Notes from the frontline of the 'Age of the Oocyte'

For decades, progress in IVF has been driven by improvements in process efficiency rather than advances in biology.

Clinics have become better at retrieving eggs, culturing embryos and selecting those most likely to implant, improving efficiency and expanding access to fertility care.

Yet IVF success rates remain constrained by a biological reality: egg quality. For many patients, particularly those in their late thirties and early forties, IVF success rates remain at a frustrating plateau.

This is driven not by laboratory conditions or clinical technique, but by oocyte level biology. By the early thirties, around half of a woman's eggs are no longer chromosomally viable. By the early forties, that figure exceeds 95%.

No amount of optimisation downstream can fully compensate for errors that arise upstream during egg maturation.

After forty years spent refining the lab, reproductive medicine is now confronting a harder truth: if outcomes are to improve meaningfully, the biology of the egg has to be addressed directly.

This shift in focus marks the beginning of what many in the field now recognise as the 'Age of the Oocyte'.

Procedural gains to biological limits

My own background sits at the intersection of medicine, translational science and biotech formation, with a focus on bringing novel reproductive therapeutics into the clinic.

That perspective has shaped how I view the fertility landscape and the biological problems that IVF innovation has, until very recently, focused on working around rather than resolving.

Historically, reproductive medicine has prioritised optimisation of the IVF process itself. Improvements in stimulation protocols, lab conditions, embryo culture and selection have expanded access and improved efficiency, but they have not addressed the fundamental biological constraint imposed by declining egg quality.

U-Ploid is one example of a new generation of teams attempting to intervene at the level of the oocyte itself.

Importantly, this is not about a single company or approach, but about a broader reorientation across the field towards the biology that ultimately determines success.

Reproductive health desert

When many of today's reproductive biotech companies were founded, the therapeutic landscape was strikingly sparse. Reproductive medicine had become highly procedural, while drug development largely bypassed the field.

Innovation concentrated on improving IVF workflows rather than altering the biological drivers of success. Egg quality, particularly age-related decline, remained essentially unchanged despite decades of procedural refinement.

For patients, this often translated into repeated cycles, escalating costs and significant emotional burden, with little change in underlying odds.

From a drug development perspective, reproductive health was effectively a desert. Despite the size and rapid growth of the global IVF market, true reproductive therapeutics remained under-prioritised relative to the scale of unmet need.

While overall investment in women's health has increased in recent years, only a third of that has flowed into biopharma and an even smaller share into egg level or fertility therapeutics.

This has led to a widening gap: a growing population of patients facing biologically driven infertility, but very few therapies designed to act at the root cause.

Uncharted territory

Working in reproductive therapeutics quickly exposes how unusual this space is. Reproductive biology sits at the intersection of drug regulation, device frameworks and embryo governance, with no established development pathways.

> **'If outcomes are to improve meaningfully, the biology of the egg has to be addressed directly'**

Companies are helping to define an entirely new therapeutic category, and this comes with complexity and challenges.

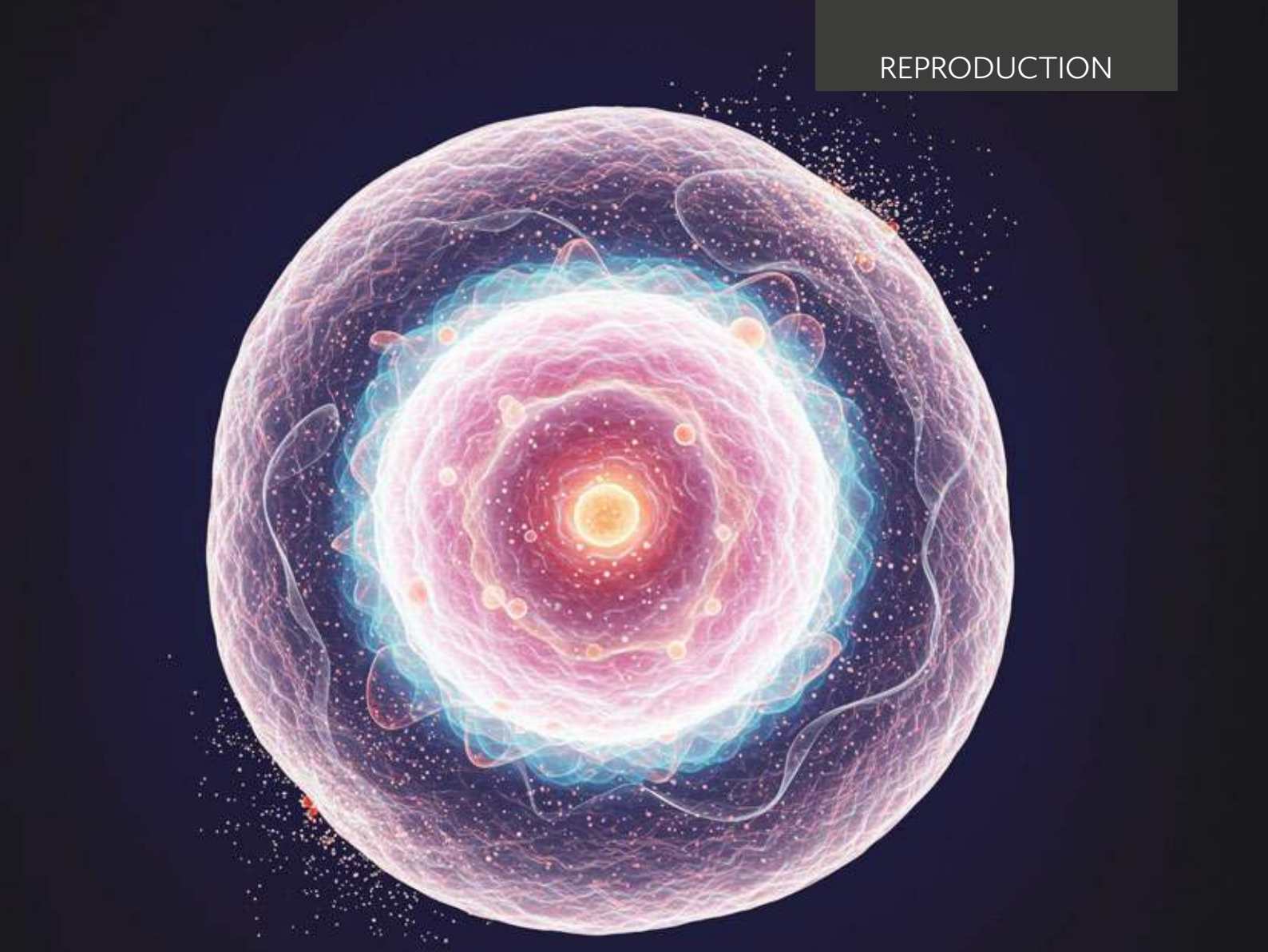
Building the scientific, clinical and regulatory infrastructure in parallel with developing the therapy itself adds time, increases uncertainty and pushes meaningful inflection points further out than investors might expect from more established therapeutic areas.

This explains why reproductive therapeutics often need patient, specialist capital and why progress in the field has historically been slower than the scale of the unmet need would suggest.

But the complexity becomes particularly apparent in clinical development. Fertility patients are, in most cases, not patients with life-threatening disease.

They are usually healthy individuals, operating under intense time pressure and making deeply personal decisions. Trial endpoints, recruitment strategies and ethical considerations therefore look very different from those with chronic or life-threatening disease.

This is why early partnership with fertility clinics is essential. Translational insight lives in clinical settings, not in preclinical models alone. A thorough understanding of patient flow, clinic workflows and real-world constraints must shape everything from trial design to regulatory strategy.



Importantly, in this space, regulatory thinking has to be built alongside the science from the outset rather than retrofitted once data emerges.

Age of the Oocyte

Over the past decade, that landscape has begun to shift. Advances in cell biology, protein engineering and reproductive science are enabling genuinely new approaches in reproductive health therapeutics that were not previously feasible.

The refocusing of attention onto the egg itself has emerged alongside a surge in demand for fertility services.

At the same time, collaboration between biotech companies and fertility clinics is becoming more common, signalling the emergence of a real ecosystem. Scientific, clinical and regulatory thinking are beginning to converge rather than operate in parallel.

Taken together, these changes suggest that the first wave of true reproductive therapeutics, interventions designed to act directly on egg level biology, will enter clinics within this decade.

Progress isn't enough

Although scientific progress is the critical driver, for reproductive therapeutics to deliver on their promise of improved health and fertility outcomes, accessibility has to be factored in from the start.

Efficacy without access is not progress. The field also needs purpose-built clinical trial frameworks rather than adaptations of models developed for unrelated diseases. Fertility care requires rigour, but it also demands pragmatism.

Speed and standards are often framed as being in tension, yet they need not be, provided the right infrastructure exists.

Regulatory clarity, thoughtful trial design and early engagement with clinics will allow innovation to move quickly without compromising safety or ethics.

The challenge now is not proving that egg level biology matters, but building systems capable of translating that insight responsibly and at scale.

Building at the frontier

The Age of the Oocyte reflects a simple reality: meaningful improvements in fertility outcomes will depend on addressing the biology of the egg itself.

For those building in reproductive biotech, the lessons are these: invest early in partnerships and regulatory expertise. Spend time in clinics, not just at conferences. Share early data and be prepared for development paths that differ from conventional biotech in timeline, capital structure and regulatory logic.

Above all, design trials around patient reality. Recruitment and retention in reproductive medicine depend on genuine clinical partnerships and trust, and on recognising that translational insight ultimately lives with clinicians and patients.

For decades IVF has worked around the biology of the egg. The next decade of progress will depend on finally addressing it. ▲

Jordan Abdi is Co-founder and CEO of U-Ploid Biotechnologies

Urban hype

From pharmacy to high street: How GLP 1s are reshaping the UK and what pharma must prepare for next chapter

GLP-1 therapies have now advanced far beyond their origins. Originally developed as treatments for type 2 diabetes, they have become one of the most influential forces reshaping consumer behaviour, healthcare delivery and pharmaceutical strategy.

This shift is now visible far beyond the clinic. Appetite-modifying medications such as semaglutide (Wegovy/Ozempic) and tirzepatide (Mounjaro), along with emerging oral and multi-agonist therapies, are influencing everything from food purchasing to health system planning.

Their impact reflects a shift in clinical innovation, changing patient expectations and heightening system level pressures. This all indicates that a new era in metabolic health is already upon us.

Changing consumer

One of the clearest indicators of GLP-1s' influence appears on the high street.

Major brands have begun adjusting product strategies in response to sustained reductions in appetite and altered dietary preferences among GLP-1 users.

McDonald's has explored new protein-leaning menu items and smaller portion formats, reflecting observed patterns such as reduced snacking and sugary drink consumption, resulting in lower demand for high sugar products.

Similar trends are emerging at Greggs, where evolving consumption behaviours have prompted shifts in product mix.

These changes highlight a broader point: GLP-1 therapies are having measurable knock-on effects on industries and other parts of life that are traditionally far removed from healthcare. For pharma, monitoring human behaviour can reveal far more than trial-defined outcomes and must be considered.

As GLP-1 behaviours spill into mainstream consumer life, patients will present with new expectations, altered eating patterns and different motivations for treatment. Clinicians must adapt how they assess lifestyle context, guide long term adherence and anticipate challenges shaped as much by real world behaviour as by biology.

Under pressure

This all ties into a much bigger narrative. The UK health system is undergoing its own transformation.

Since 2025, NHS England has been rolling out tirzepatide through primary care under NICE recommendations. It argued that integrating pharmacotherapy into broader obesity care pathways could relieve pressure on specialist clinics.

As demand surges, prescriptions in England have increased dramatically since 2020, far outstripping system capacity.

Yet access remains inconsistent. Funding constraints have also created disparities in who can benefit from treatment across regions.

Meanwhile, private access continues to expand, raising equity concerns as millions look to obtain GLP-1s through alternative routes while the NHS plans a more gradual, tightly prioritised rollout.

For HCPs, this rising demand and uneven access could mean greater pressure on primary care teams, who must manage fast-growing patient enquiries, eligibility assessments and follow-up demands within a system not yet scaled for widespread obesity pharmacotherapy. We have seen the impact of this on a larger scale already with COVID-19.

> 'As GLP 1 behaviours spill into mainstream consumer life, patients will present with new expectations'

Regional funding variation and the rapid growth of private prescribing also create inconsistent patient expectations, leaving clinicians to navigate equity concerns and differing access routes while still ensuring safe, evidence-based care.

According to DiCE, around 2.5 million people each month were accessing GLP-1s privately by the end of 2025.

Plotting pathways

The current system for supporting people with obesity was not built for a future in which many patients stay on weight-loss medicines for years.

As more people start GLP-1 treatments, HCPs will increasingly face patients who need ongoing guidance, realistic expectations and consistent follow-up. This means successful treatment will depend as much on everyday clinical support as on the drug itself.

The NHS is not yet fully set up for the volume of monitoring, lifestyle counselling and digital tracking that long term use requires.

With demand rising faster than the system can adapt, GPs and nurses are likely to experience more pressure in managing eligibility, access and long term care, making better coordination between public health teams, primary care and local services essential.

Clinicians will also face new professional demands that extend beyond prescribing. Many will require updated training and clearer guidance on risk assessment, particularly as patients present with evolving medical conditions that require a shift in safety considerations.

The emotional side of care will also grow. HCPs will need to manage heightened expectations, misconceptions about effortless weight loss and the wider psychological impact of rapid physical change.

Multidisciplinary support will become increasingly important, requiring collaboration between dietitians, pharmacists, behavioural change specialists and mental health services.

The responsibilities can intensify ten-fold. HCPs must learn to navigate unfamiliar dosing histories, safety risks and gaps in monitoring for patients arriving from less-regulated routes.

Meanwhile, the expansion of digital tools and patient-generated data means clinicians may soon face a heavier administrative load as they interpret remote check-ins, weight tracking apps and symptom monitoring platforms.

Together, these pressures signal a future in which the role of the clinician is broader, more complex and more interconnected, requiring not only medical expertise but new skills, new workflows and a system designed to support them.

Final analysis

For HCPs, adherence remains one of the biggest challenges. Many patients stop treatment because of access barriers or misunderstandings about how long therapy is needed.

The arrival of oral GLP-1 medicines may make long-term use easier, but it also means more patients could start treatment, increasing the frontline workload.

This shift reinforces the need for simple, patient centred support systems that clinicians can rely on, from digital check-ins to practical diet and lifestyle resources, so patients can stay on track and avoid relapse.

As GLP-1 therapies expand into areas such as heart health improvement, sleep apnoea and liver disease, HCPs will need to integrate these medicines into broader chronic disease management rather than treating them as a single purpose weight loss intervention.

Clinicians will face more complex conversations about benefits, risks and long term planning as more options become available and more patients become eligible.

GLP-1 therapies are redefining obesity care across the NHS, influencing daily practice, patient expectations and wider conversations about prevention.

For HCPs, the coming years will mean adapting how they work, supported by clearer pathways and stronger systems that enable these medicines to deliver sustained, meaningful benefit. ▲

Soumya Roy is Founding Partner at Integro Insights

Wake-up call

MASLD isn't silent. It's speaking loud and clear

Metabolic dysfunction-associated steatotic liver disease, formerly known as non-alcoholic fatty liver disease and often referred to as fatty liver disease, affects nearly 30% of adults worldwide.

It is one of the most prevalent chronic liver conditions, yet despite its scale it is still too often misdiagnosed, misunderstood or mistreated, delaying meaningful intervention for millions.

For decades, MASLD has been described as a 'silent' condition because it rarely presents with dramatic liver specific symptoms early on. Instead, it hides in plain sight, embedded within metabolic dysfunction and everyday complaints that are easy to attribute elsewhere.

However, growing evidence shows this narrative is incomplete and often misleading. If you sit down with a patient navigating MASLD and listen closely, you will not hear silence.

You will hear fatigue that feels like a lead weight, abdominal pain, sleep issues, bloating that adds to physical discomfort and brain fog that turns a simple workday into climbing Everest.

You will also hear about depression symptoms; anxiety and the looming risks tied to metabolic dysfunction. These symptoms are real and disruptive to daily life, yet they are commonly attributed to stress, ageing or comorbid conditions rather than recognised as part of a broader metabolic picture.

From a clinical perspective, this presents a real challenge. Liver enzymes may be only mildly elevated or even normal. Imaging may be incidental. Patients may appear 'asymptomatic' on paper while struggling to function day to day.

For healthcare professionals, particularly pharmacists who are often the most accessible point of care, this creates both an opportunity and a responsibility to help connect the dots between prescriptions, supplements and patient-reported fatigue, nudging the conversation towards meaningful evaluation.

Unexclusive deal

MASLD is not a liver-only condition. It is a systemic manifestation of metabolic dysfunction. The liver, under stress, releases cytokines and other pro-inflammatory mediators that circulate throughout the body, affect the brain and disrupt energy regulation systems.

Insulin resistance that drives MASLD starves cells of glucose and leaves patients feeling exhausted despite adequate rest. When clinicians dismiss this as 'normal ageing', 'stress' or 'just part of life', patients stop mentioning it.

Validating this symptom changes the dynamic of the consultation and gives the patients a reason to care about their liver health that is immediate and tangible.

So how can the healthcare community strengthen the way MASLD is identified and managed?

First, reframe the conversation. Rather than waiting for advanced liver disease, we must recognise MASLD as part of a metabolic continuum that intersects with diabetes, obesity, cardiovascular risk and lifestyle factors.

Asking simple, targeted questions about energy levels, sleep quality and daily functioning can surface early warning signs.

By validating symptoms, we change the dynamic of the consultation and give the patients a reason to care about their liver health that is immediate and tangible.

Second, use the tools already available. Non-invasive assessments, including elastography and Controlled Attenuation Parameter scores, now let clinicians visualise steatosis and fibrosis accurately.

> 'If you sit down with a patient navigating MASLD and listen closely, you will not hear silence'

These tools shift conversations from abstract risk to tangible realities and create space to ask the questions that matter: 'How are your energy levels?', 'Do you wake feeling well rested?' or 'How is this affecting your work and family life?'

Question time

What patients report matters just as much as what tests reveal.

Third, empower patients through self-care. Improving health outcomes starts with giving people the knowledge and tools to act earlier. MASLD management is not limited to specialist settings. It includes lifestyle interventions, metabolic health support and long-term engagement that often begins in the community pharmacy.

When patients understand how their daily choices affect liver and metabolic health, self-care becomes a powerful complement to clinical care.

Finally, recognise the role of pharmacists. Pharmacists are uniquely positioned to identify patterns such as repeated complaints of fatigue; sleep aids used alongside metabolic medications or conversations that reveal declining quality of life.

These touchpoints can prompt timely referrals, reinforce adherence and help patients navigate what is often a confusing diagnosis.

MASLD is not silent. It has been speaking all along, and the challenge ahead is accurate identification and appropriate treatment.

By listening more closely, asking better questions and empowering patients to engage in their own care, we can change the trajectory of a condition that affects nearly one in three adults worldwide. Silence ends where action begins.

Dr Josephine Fubara is Chief Science Officer at Opella

MASLD index – ten takeaways

1. MASLD is now the leading cause of chronic liver disease globally, surpassing many traditional liver conditions

2. The condition develops quietly over years, often beginning long before any liver-related symptoms appear

3. MASLD is strongly linked to insulin resistance, which means many people with type 2 diabetes also have underlying liver fat

4. Even people at a healthy weight can develop MASLD if they have metabolic risk factors like high blood pressure or elevated blood sugar.

5. MASLD increases the risk of cardiovascular disease, which is the leading cause of death in people with the condition

6. The liver can regenerate, meaning early MASLD can often be improved or reversed with timely lifestyle changes

7. Sleep disturbances are common in MASLD due to the metabolic and inflammatory changes affecting energy regulation

8. MASLD can progress to metabolic dysfunction–associated steatohepatitis, a more severe form involving liver inflammation and scarring

9. Many people discover MASLD only after an unrelated scan, highlighting the importance of routine metabolic health checks

10. Community pharmacists are increasingly recognised as key players in early MASLD detection because they regularly hear about symptoms like fatigue, low mood and poor sleep.

New wave

Radiotherapy's capacity is holding cancer care back – a modernised approach must be embraced

Cancer services in the UK stand at a turning point. Over the past decade the NHS has made meaningful progress in improving diagnostic pathways and identifying cancer earlier.

I began my career as a diagnostic radiographer. Like many clinicians working in imaging, I spent years focused on the importance of early detection.

For a long time, I believed that the biggest challenge was diagnosis. If we could simply detect cancers earlier, the rest of the system would be able to respond.

Over time I realised that is not the case.

Earlier diagnosis is an essential part of the cancer pathway, but it is not enough on its own. Patients must be able to move quickly from diagnosis into treatment.

Across the UK, too many people with cancer still wait too long to begin care. That gap between diagnosis and treatment is becoming one of the most pressing challenges facing our health system.

Radiotherapy and the treatment gaps

Recent discussions around the National Cancer Plan have rightly focused on earlier diagnosis.

But early intervention does not stop at identifying cancer sooner, it depends on patients being able to access timely, high-quality treatment without delay.

Radiotherapy is central to that effort. It has one of the highest curative contributions in cancer care and is highly targeted, delivering treatment directly to the tumour site.

Around 60% of patients who have radiotherapy do so with curative intent, often alongside surgery and chemotherapy. This means improvements in access to radiotherapy could significantly increase cancer cure rates in the UK.

However, radiotherapy only achieves its full benefit when patients can attend treatment consistently. Courses of treatment are typically delivered daily over several weeks, which means access and geography matter enormously.

Across the UK there are significant regional disparities in the availability of radiotherapy services. Something as simple as where patients live can directly affect how easily and how quickly they receive treatment.

Long travel times, disruption to work and family life and the practical challenge of repeated hospital visits all shape patient experience and potentially clinical outcomes.

If we are serious about proactive early intervention, diagnostic ambition must be matched with treatment capacity. Expanding modern radiotherapy infrastructure, particularly closer to communities, is a critical part of that challenge.

Workforce challenges

Radiotherapy is one of the most effective tools we have to treat cancer. More than half of all cancer patients will need it at some point during their care.

Yet in the UK, only around 35% of patients who could benefit from radiotherapy currently receive it.

Recent Government investment, such as funding for new LINACs, is an important and welcome step. But machines alone will not close this gap.

The challenge is fundamentally about people.

Across the country, oncology services face intense workforce pressures, particularly among therapeutic radiographers, medical physicists and specialist clinicians. These professionals are essential to delivering safe and effective radiotherapy. Without them even the most advanced equipment cannot be fully utilised.

At the same time, demand is growing rapidly. As diagnostics improve and more cancers are identified earlier, more patients require timely access to treatment.

The NHS has made real progress on diagnostics, yet the 62-day referral to treatment standard continues to lag behind.

Earlier diagnosis is a positive step, but it inevitably increases pressure on treatment services.

Radiotherapy is usually delivered in tightly scheduled courses with little room for delay. When patients cannot access treatment quickly and consistently, whether due to staffing shortages or capacity constraints, outcomes suffer.

Conversations with patients and families make these pressures clear. Many describe the anxiety of waiting to begin treatment or the practical challenges of travelling long distances for radiotherapy several times a week.

These conversations are a powerful reminder that improving treatment capacity is not simply a policy issue. It directly shapes how patients experience some of the most difficult weeks of their lives.

Addressing these pressures requires new thinking about how services are organised, how professionals are supported and trained and how capacity is shared across the system.

Role of partnerships

One part of the solution may lie in how we think about collaboration across the healthcare system.

Public–private collaborations can play a constructive role in strengthening radiotherapy services in the UK. By combining private investment, modern infrastructure and specialist expertise with the clinical leadership of NHS teams, these partnerships can help expand treatment capacity and improve patient access.

In practice, this can take different forms depending on the needs of each local system. It may involve modernising existing radiotherapy units, developing satellite centres that bring treatment closer to patients or supporting the upgrade of LINACs and planning technology.

The UK does not need to start from scratch in designing these collaborations. International experience offers useful examples of what this can achieve.

In Troyes, France, a partnership between Amethyst and the local hospital revitalised an underperforming radiotherapy centre.

Within a year, investment in new linear accelerators, imaging systems and AI-driven contouring software helped reduce waiting times for treatment after multidisciplinary team decision from four to five weeks to just 10–15 days.

10 facts about radiotherapy

1. Radiotherapy uses high-energy radiation to destroy cancer cells. It works by damaging the DNA inside tumour cells so they can no longer grow or divide, while healthy cells are better able to repair themselves

2. Around half of all cancer patients will receive radiotherapy during their treatment. It is used across many cancer types, including breast, prostate, lung, head and neck, and brain cancers

3. Radiotherapy contributes to around 40% of cancer cures. Although surgery and chemotherapy are widely recognised, radiotherapy remains one of the most effective curative treatments available

4. There are two main forms of radiotherapy: external beam radiotherapy, delivered from outside the body using a machine such as a linear accelerator; and brachytherapy, where a radiation source is placed inside or next to the tumour

5. Modern radiotherapy is highly precise. Techniques such as intensity-modulated radiotherapy and stereotactic radiosurgery allow clinicians to shape radiation beams to the tumour, reducing exposure to surrounding healthy tissue

6. Treatment is usually delivered over several sessions, known as fractions. This phased approach helps protect normal cells while maintaining continuous pressure on cancer cells

7. Radiotherapy is often combined with other treatments. It may be used before surgery to shrink tumours, after surgery to reduce the risk of recurrence or alongside chemotherapy to increase effectiveness

8. Side effects vary depending on the part of the body being treated. Advances in imaging, planning and delivery have significantly reduced long-term complications for many patients

9. Access to radiotherapy is uneven across the UK. Geography, workforce shortages and ageing equipment can affect how quickly patients begin treatment, contributing to regional disparities in outcomes

10. Investment in modern technology, training and new treatment centres is helping expand capacity. As earlier diagnosis improves and cancer incidence rises, radiotherapy will play an increasingly central role in delivering timely, effective care for patients across the country.

In Portugal, a satellite centre model supports public hospitals by transferring patients based on case complexity and local capacity. By bringing radiotherapy services closer to regional populations, this approach has helped public providers meet growing demand while maintaining consistent clinical standards.

Similar partnerships in Poland, France and Italy have enabled significant capital investment in modern equipment and facilities while expanding treatment capacity.

Germany offers another example of how care can be delivered closer to where patients live. Large university hospitals typically manage the most complex cancer cases, but they are supported by a wide network of smaller radiotherapy centres connected to community hospitals.

Many of these centres are independently run while being based on public hospital sites. This model allows patients to receive treatment closer to home while maintaining strong clinical links with major specialist centres.

The lesson is clear: when investment, workforce planning and clinical teams work together, services can expand more quickly without compromising quality.

Supporting NHS capacity

In the UK, partnership models are already supporting NHS cancer services.

As part of Stingray Healthcare Group, Amethyst already works alongside NHS teams at Queen Square Radiosurgery Centre in partnership with UCLH NHS Foundation Trust, and at Thornbury Radiosurgery Centre with Sheffield Teaching Hospitals NHS Foundation Trust.

Since 2020, the number of patients treated at these centres has grown by 84%, including a 70% increase in NHS patients.

These examples demonstrate what collaboration can achieve when the goal is clear: expanding access to high-quality cancer care.

They also align with wider ambitions set out in the Government's National Cancer Plan and 10-Year Health Plan. Both emphasise improving productivity, meeting the cancer waiting times targets and tackling inequalities in access to treatment.

Radiotherapy sits at the intersection of all these priorities.

Path to better outcomes

If earlier diagnosis is to translate into better patient outcomes, treatment capacity must keep pace.

Expanding modern radiotherapy services, investing in the specialist workforce and supporting collaborative models that increase capacity will all be essential.

Partnerships that combine NHS clinical leadership with external investment and expertise can help relieve pressure on overstretched teams while maintaining the standards of governance and accountability that patients rightly expect.

Cancer care in the UK has never been stronger in terms of expertise, commitment and innovation. But progress in diagnosis must now be matched by progress in treatment access.

Radiotherapy already saves lives across the NHS every day. With the right investment, workforce support and collaboration, it has the potential to save many more. ▲

Sasha Burns is CEO at Amethyst Radiotherapy UK

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■ Europlaz has appointed the former Morgan Stanley HR professional – **Anya Grattidge** – to support continued growth and further develop career pathways in manufacturing.

A qualified Executive Coach, Anya brings over 15 years' experience from global finance and high growth scale-ups, including Liberis and Modulr, where she played a key role in a successful Series C fundraise.

She specialises in building people-centred systems that support organisational performance, alongside training and progression frameworks that encourage multiskilling, technical development and leadership capability.

Her appointment follows a strong period of expansion for Europlaz, which has reported a 20% rise in revenue to £15.5m and grown its workforce to 130 people.

"This is a really exciting time to be joining the business," said Anya, who became a Vice President at Morgan Stanley at just 34.

"Europlaz has a fantastic culture, and I'm inspired by what Eddie, Katy and Rory O'Keeffe are building – a medtech company that sets new standards in manufacturing performance, technical innovation and product reliability."

She added: "As the business has grown, the demands on our people are evolving every day. One of my first priorities is to formalise HR processes and introduce technology that makes simple tasks easier for everyone, such as moving communications and forms from email and paper to a central HR system."

To support its expansion plans and the increasing needs of new and existing customers, Europlaz is making significant investment in both capacity and capability.

■ Poolbeg Pharma has announced the appointment of **Dr Adrian Kilcoyne** to its Scientific Advisory Board.

Adrian brings over 20 years of clinical expertise with strategic drug development leadership, focusing on innovative therapies that address unmet medical needs in oncology and immunology.

Adrian is currently Chief Medical Officer at Cellectis SA, focusing on the development of allogeneic CAR-T therapies.

He was previously Chief Medical Officer and Head of Research & Development at Celularity Inc, where he advanced oncology-focused allogeneic CAR-T and natural killer cell therapy programmes.

Across his career, he has held senior leadership roles in research & development, medical affairs, commercial strategy, health economics and outcomes research at major pharmaceutical and biotechnology companies including AstraZeneca, Celgene, Sanofi, Roche and Eli Lilly.

Prof Luke O'Neill, Chair of the Scientific Advisory Board of Poolbeg Pharma, said: "Adrian brings a wealth of experience in oncology and cell therapy drug development, combined with deep clinical insight and regulatory expertise, which will be invaluable to us as we progress POLB 001 through the TOPICAL trial."

Adrian reflected: "Having seen first-hand both the clinical impact on patients and the economic burden on healthcare systems posed by immunotherapy-related CRS, I believe POLB 001 has the potential to transform the patient experience."

Mover of the Month

■ Abselion has announced the appointment of **Dale Gordon** as Chair of the Board of Directors.

His appointment strengthens governance and board-level expertise at Abselion, adding experienced commercial and bioprocess leadership as the company builds on the recent establishment of its US subsidiary and continues to develop its global engagement.

Abselion is committed to building a well-governed organisation that can support collaboration and reliable delivery as interest in its Amperia protein quantification system grows internationally.

As Chair, Dale will help to ensure sustainable growth and long-term value creation to meet the needs of academic, biotech and pharma teams working across biologics characterisation, development and manufacturing workflows.

Dale brings more than 30 years' experience across the life sciences sector, with a background spanning bioprocessing, company building and board leadership.

Most recently, he served as CEO of Mirus Bio, a leading provider of transfection technologies widely used in viral vector production, where he led the business through a period of significant growth and strategic development.

He was also CEO at Gemini Bio and held leadership roles at GE Life Sciences (now Cytiva) and Merck Millipore.

■ Ardena has announced the appointment of **Paul Edwards** as Chief People Officer.

He will lead Ardena's global people strategy, strengthening organisational capability and supporting the company's continued international growth.

Paul brings over 30 years of human resources leadership experience in complex, science-driven organisations.

He joins Ardena after 16 years at Catalent Pharma Solutions, where he most recently served as Vice President, Human Resources. In that role, he led international HR teams across multiple business units and geographies, shaping people strategies aligned with operational expansion, organisational design and leadership development.

At Ardena, Paul will focus on strengthening leadership capability, building a high-performance culture and ensuring the organisation is structured to support productivity, speed and scalability.

His mandate includes simplifying structures, clarifying accountability and developing the talent and engagement frameworks required to enable efficient execution across the business.

Jeremie Trochu, CEO of Ardena, commented: " As Ardena continues to expand its capabilities and footprint internationally, investing in our people, leadership and culture is essential to delivering for our customers. Paul will play a key role in ensuring our organisation evolves in line with our strategic ambitions."

Paul added: "Ardena has a clear strategy and very strong scientific and technical foundations. I look forward to working with my new colleagues across the organisation to further develop our leadership capability, support talent development and foster a high-performance culture that enables sustainable growth."

■ Argo Biopharmaceutical has announced the appointment of **Gena Wang** as Chief Financial Officer and Chief Strategy Officer.

Gena joins Argo Biopharma from Barclays, where she served as Managing Director and senior equity research analyst in the biotechnology sector.

She brings nearly 20 years of Wall Street sell-side experience and is widely recognised for her in-depth research on novel therapies, with a focus on RNA therapies, gene and cell therapies and emerging modalities in rare diseases and oncology.

"We are excited to welcome Dr Wang to our management team," said Dr Dongxu Shu, co-founder of Argo Biopharma. "Her deep knowledge of the genetic medicines landscape, expertise in biotechnology capital markets and her reputation and strong relationships within the financial community and healthcare industry make her an invaluable addition as we continue advancing our pipeline and entering our next phase of growth."

"I am thrilled to join Argo Biopharma at such an important stage of its development," said Gena. "I look forward to partnering with the management team to help Argo Biopharma achieve its long-term goals of delivering transformative therapeutics to patients while creating value for shareholders."

Prior to joining Argo Biopharma, she served as Managing Director and senior research analyst of Small and Mid-Cap Biotechnology at Barclays, where she established and led the therapeutic teams.

Gena has been repeatedly ranked among the top three analysts in Institutional Investor's All-America Equity Research Team since 2018.

■ Symbiosis, a contract development and manufacturing organisation (CDMO) specialising in the GMP sterile fill-finish manufacturing of injectable drug products, has announced the appointment of **Joanne Anderson** as its Chief Commercial Officer (CCO).

With over 25 years in the pharmaceutical industry, Joanne brings a wealth of international pharmaceutical experience to the role, having most recently served as Global Key Account Director at Recipharm and previously with other global CDMOs.

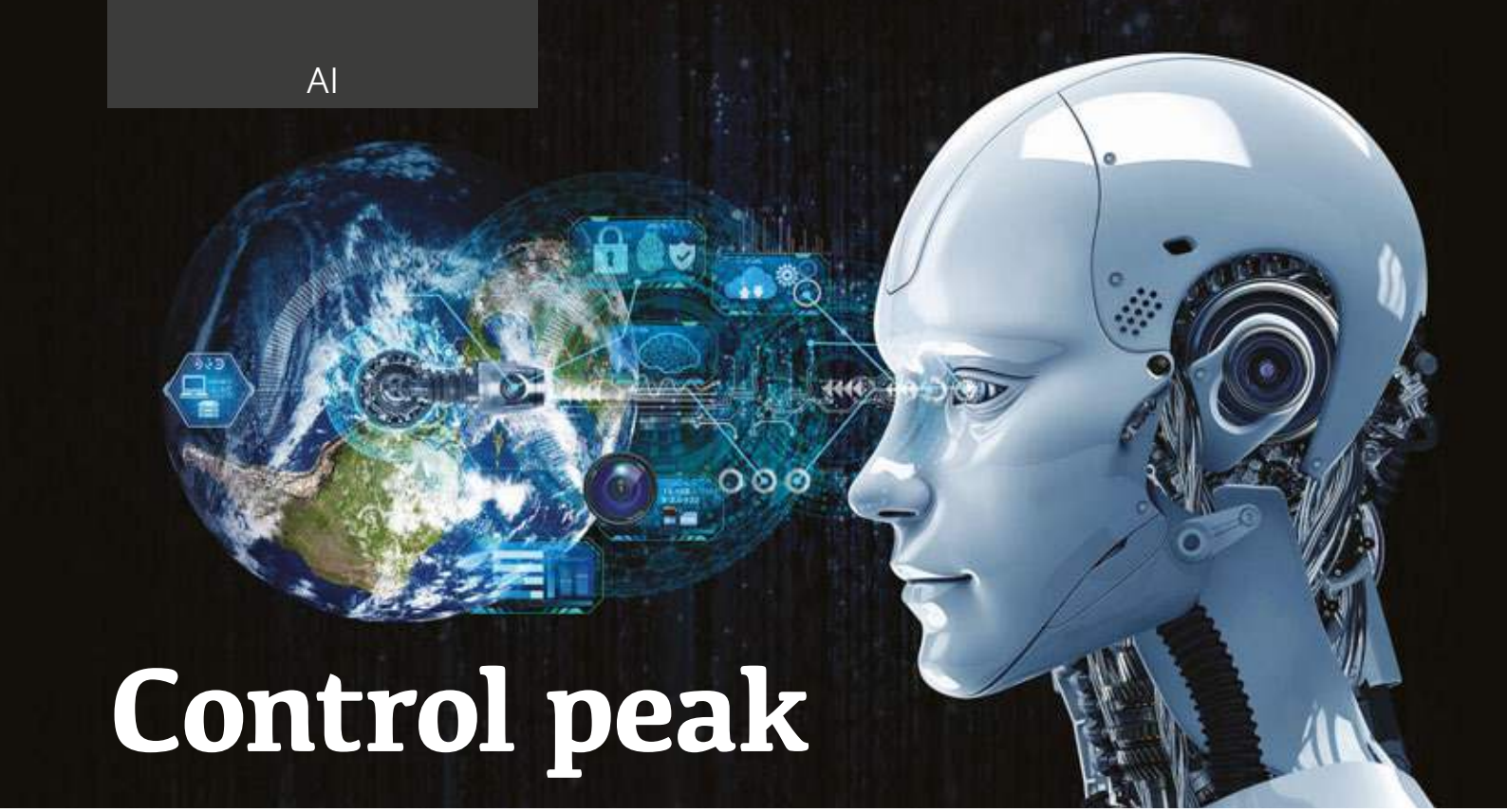
The strategic appointment is also significant for Anderson, who returns to Symbiosis after six years away to lead its global commercial team.

"Returning to Symbiosis feels very much like coming home," said Joanne. "Having previously been part of the Symbiosis team, it is incredibly rewarding to see the journey the company has been on. I am rejoining at an exciting time for Symbiosis and I am keen to lead the commercial team into new markets and explore new opportunities."

The appointment comes at a time of sustained momentum for the Stirling-based CDMO.

Following a period of significant investment in its manufacturing capacity and the recent successful qualification of its new commercial production facility, Symbiosis is primed to meet the rising global demand for specialised GMP sterile fill-finish manufacturing.

Colin MacKay, CEO of Symbiosis, commented: "We are delighted to welcome Joanne back to the leadership team at such an exciting time for the business. Her intrinsic understanding of our clients' needs, Symbiosis technical capabilities and our commitment to quality, coupled with her extensive global industry network, makes her the ideal leader to spearhead our commercial growth."



Control peak

The next phase of agentic AI – autonomy with accountability

Agentic AI introduces something new into enterprise systems: autonomy. For health care and life sciences organisations, the key question is not whether systems can act autonomously but how that autonomy is governed.

Workflows in life sciences span clinical research, patient care, regulatory oversight and operational coordination.

Systems capable of goal-directed behaviour can reduce friction across those environments, but only when autonomy is designed as carefully as the processes they support.

From automation to autonomy

Rather than executing fixed instructions, agentic systems can manage multi-step workflows and adjust their behaviour as conditions change.

In practice this might mean coordinating trial activity across sites or monitoring patient data streams to surface early warning signals.

What distinguishes agentic AI is its ability to operate with a degree of independence but still within clearly defined constraints.

In highly regulated environments, that autonomy cannot be introduced casually. Decisions carry clinical, operational and ethical consequences.

An agent automating routine administrative steps presents one level of exposure.

An agent influencing trial operations or patient safety monitoring presents another.

For agentic AI to be credible in these settings, governance must be built into the architecture from the outset.

Three principles are particularly important. Systems must be explainable so actions and decisions can be interpreted clearly. They must be auditable, with every action logged and reproducible. And they must remain controllable, with autonomy adjusted according to the risk profile of the task.

In regulated environments these are not optional features but the foundations of compliance and trust.

Where value is emerging

Despite the caution around autonomy, agentic systems are already being deployed in targeted areas.

Organisations are using goal-directed systems to monitor patient data streams and surface early indicators of deterioration, while administrative agents coordinate documentation workflows.

Agentic capabilities are already improving trial operations by monitoring study activity, flagging protocol deviations and supporting coordination across sites and regions.

Across these use cases, agentic AI delivers the most value when it operates inside well-defined governance structures.

Designing autonomy deliberately

One of the most important architectural decisions organisations face is determining how much autonomy an agent should have.

Routine operational tasks may support higher levels of automation.

Activities such as clinical decision support, regulatory reporting or safety monitoring require tighter controls and explicit human review.

Adjustable autonomy is therefore becoming a critical design capability, with organisations defining when an agent may act independently, when it must escalate and when human approval is required.

Ultimately, agentic AI depends on a governed data foundation. Metadata management, lineage tracking and standardised data models provide the transparency required in regulated environments.

Without it, autonomous systems risk amplifying inconsistency rather than accelerating insight.

Autonomy alone will not determine the impact of agentic AI. What matters is how deliberately that autonomy is designed, aligned with risk and governed across the architecture.

In health care and life sciences, the real challenge and opportunity is not how autonomous these systems become but how carefully that autonomy is structured.

Mark Lambrecht is Global Head, Health and Life Sciences Customer Advisory at SAS

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