Cardio-Oncology 2026: Multidisciplinary Care Expands for Cancer Patients

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The increasing survival rates in oncology have brought to the forefront the long-term cardiovascular sequelae of cancer therapies.1 Clinicians face the dilemma of optimising oncological outcomes while mitigating treatment-related cardiotoxicity. The upcoming ESC Cardio-Oncology 2026 meeting underscores the imperative for an expanded multidisciplinary approach to address these complex patient needs.

KEY TAKEAWAYS

- The Pivot: The recognition of cardio-oncology as a distinct subspecialty requiring integrated care models.
- The Data: No specific trial data is presented, but the emphasis is on established evidence for cardiotoxicity monitoring and management.
- The Action: Clinicians should consider early and ongoing cardiovascular risk assessment and management for all cancer patients, particularly those receiving cardiotoxic agents.

The intersection of cardiology and oncology presents a growing clinical challenge. Advances in cancer treatment, including targeted therapies and immunotherapies, have significantly improved survival rates for many malignancies. However, these therapies are frequently associated with cardiovascular adverse events, ranging from hypertension and arrhythmias to heart failure and myocardial infarction. The prevalence of pre-existing cardiovascular disease in cancer patients further complicates management, necessitating a coordinated approach to patient care.1

Cardiotoxicity can manifest acutely during treatment, or chronically, years after therapy completion. Anthracyclines, for instance, are well-known for their dose-dependent cardiotoxicity, leading to left ventricular dysfunction and heart failure. Trastuzumab, a HER2-targeted therapy, can cause reversible cardiac dysfunction. Newer agents, such as tyrosine kinase inhibitors and immune checkpoint inhibitors, also carry distinct cardiovascular risk profiles, including hypertension, QT prolongation, and myocarditis.2

The increasing number of cancer survivors, coupled with an aging population, means that clinicians will encounter more patients with a history of cancer and cardiovascular complications. This demographic shift underscores the urgency for robust cardio-oncology programs. Understanding the specific mechanisms by which various cancer treatments induce cardiotoxicity is crucial for developing targeted preventive and therapeutic strategies. For example, anthracyclines are thought to induce cardiotoxicity through oxidative stress and topoisomerase II²inhibition in cardiomyocytes, while trastuzumab's cardiotoxicity is linked to HER2 signaling pathways in the heart. Immune checkpoint inhibitors, by contrast, can trigger autoimmune myocarditis, a distinct inflammatory process. These varied mechanisms necessitate diverse management approaches tailored to the specific agent and patient profile.

Addressing New Challenges in Cardio-Oncology

The ESC Cardio-Oncology 2026 meeting is anticipated to focus on several key areas reflecting the evolving landscape. One primary area is the refinement of risk stratification tools for identifying cancer patients at high risk for cardiotoxicity. This includes incorporating genetic predispositions, pre-existing cardiovascular comorbidities, and specific cancer treatment regimens into comprehensive risk assessments. The goal is to enable proactive cardioprotective strategies rather than reactive management of established cardiotoxicity.3

Another critical aspect is the development and implementation of standardised monitoring protocols. Echocardiography, cardiac magnetic resonance imaging (CMR), and circulating biomarkers such as troponins and natriuretic peptides are integral to detecting subclinical cardiac dysfunction. The optimal frequency and choice of monitoring modality often depend on the specific cancer therapy, patient risk profile, and institutional resources. The meeting is expected to discuss consensus guidelines for these monitoring strategies, aiming for greater uniformity in clinical practice.4

The expansion of the multidisciplinary team is also a central theme. Effective cardio-oncology care requires collaboration among cardiologists, oncologists, radiation oncologists, haematologists, primary care physicians, and pharmacists. This integrated approach facilitates shared decision-making, ensures timely interventions, and optimises patient outcomes. For example, managing hypertension induced by anti-angiogenic therapies often requires close communication between the oncologist initiating the therapy and the cardiologist or primary care physician managing blood pressure.5

Furthermore, the meeting will likely address the long-term surveillance of cancer survivors. Many cardiovascular complications can emerge years after cancer treatment concludes, necessitating ongoing monitoring and lifestyle modifications. The role of exercise, diet, and aggressive management of traditional cardiovascular risk factors in this population is increasingly recognised as vital for improving long-term cardiovascular health.6

The challenges extend to specific patient populations, such as paediatric cancer survivors, who face unique long-term cardiotoxicity risks, and patients undergoing stem cell transplantation, who are susceptible to various cardiovascular complications. Research into novel cardioprotective agents and strategies to mitigate treatment-related cardiotoxicity without compromising oncological efficacy will also be a prominent discussion point.7

Despite significant progress, limitations in current cardio-oncology practice persist. These include a lack of widespread access to specialised cardio-oncology clinics, variability in guideline adherence across different healthcare systems, and insufficient data on the long-term cardiovascular outcomes of newer cancer therapies. Furthermore, the complexity of managing multiple comorbidities in an aging population with cancer presents ongoing diagnostic and therapeutic dilemmas. Future efforts will likely focus on leveraging artificial intelligence and machine learning to improve risk prediction models and personalise treatment strategies, ultimately enhancing patient care in this evolving field.

> **CLINICAL IMPLICATIONS**
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> The increasing emphasis on cardio-oncology at major scientific meetings like ESC Cardio-Oncology 2026 is a necessary evolution in medical practice. For too long, the focus on cancer eradication, while understandable, has sometimes overshadowed the long-term cardiovascular health of survivors. Clinicians, particularly general practitioners and specialists in both cardiology and oncology, must recognise that cancer treatment is not merely about tumour response; it is about preserving the patient's overall health trajectory. The integration of cardiovascular risk assessment and management into every stage of cancer care, from diagnosis through

survivorship, is no longer optional but essential. This requires a proactive stance, moving beyond reactive management of symptomatic cardiotoxicity.

The pharmaceutical industry also has a clear mandate. While developing novel anti-cancer agents, there must be a parallel investment in understanding and mitigating their cardiovascular side effects. Early phase trials should incorporate robust cardiovascular safety endpoints, and post-market surveillance needs to be rigorous. Furthermore, the development of specific cardioprotective agents that can be co-administered with cardiotoxic cancer therapies, without compromising oncological efficacy, represents a significant unmet need and a substantial market opportunity. Guideline bodies, such as the European Society of Cardiology and the American Society of Clinical Oncology, must continue to collaborate to provide clear, actionable recommendations that can be implemented across diverse healthcare settings.

Ultimately, the patient benefits from this integrated approach. A cancer diagnosis is devastating enough without the added burden of preventable heart disease. By fostering a truly multidisciplinary environment, where cardiologists and oncologists communicate seamlessly, patients can receive personalised care that balances the imperative of cancer treatment with the preservation of cardiovascular health. This shift requires not only institutional commitment but also a cultural change among clinicians, prioritising holistic patient well-being over siloed specialty care. The dry reality is that better collaboration means better lives for cancer survivors.

EDITORIAL & AI STANDARDS

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