Reply to benefit of cytoreductive nephrectomy in metastatic RCC: do we learn from retrospective studies and small prospective studies?

In his editorial, in a recent issue of *Annals of Oncology*, Dr Escudier discussed the merits of a retrospective analysis of patients with metastatic renal cell carcinoma (mRCC) with primary in situ [1, 2]. We thank Dr Escudier for his comment regarding the importance of our study, but we respectfully disagree with his interpretation of our data on several points. Dr Escudier suggested that our data are not useful in the design of randomized trials to definitively address the benefits of cytoreductive nephrectomy (CN) in the era of targeted therapy. He acknowledged that the data establishing CN as a standard of care were generated in the immunotherapy era, and that CN is currently carried out by many urologists for patients who may fall outside of the strict inclusion criteria of the landmark trials published 10 years ago [3, 4]. He stated that the cohort of patients in our study would not have been eligible for CN according to these criteria, thus biasing the results. However, we would like to point out, that 50.5% of the 188 patients in our cohort would have been eligible for CN by the SWOG and European Organisation for Research and Treatment of Cancer criteria, but elected to forgo CN and receive systemic therapy only, and had a median overall survival of 12.5 months. Whether the accepted criteria for selecting patients for CN will change in the future or not, data on at least these 95 patients in our study do provide useful information regarding the management of patients with mRCC who are treated with targeted therapy and never undergo CN. As discussed in the article, none of the pivotal phase III trials of targeted therapy provide outcome data specifically for patients with primary in situ. In the United States, it is difficult to conduct a trial in which the perceived standard of care is omitted in one of the treatment arms. Our data simply provide information for consideration in the design of such trials, and at the time of the writing of the article, represented the only available published data to the clinical investigator. Recently, Choueiri et al. [5] published results from a large cohort of patients with mRCC treated with tyrosine kinase inhibitors or bevacizumab with primary in situ, and suggested a benefit for CN. We believe that retrospective studies, not withstanding their limitations, are hypothesis generating, and thus may provide useful information in the design of randomized clinical trials.

Furthermore, these data give the oncologist in the community more information about survival characteristics in an unselected patient population with mRCC and primary tumor in situ, for which they intend to treat with targeted therapies. We share Dr Escudier’s optimism that the Carmena trial and the NCT01099423 trial will bring us closer to an answer regarding the role of CN in the era of targeted therapy.

S. L. Richey¹, S. H. Culp², E. Jonasch¹, S. F. Matin²
C. G. Wood² & N. Tannir¹*

Departments of ¹Genitourinary Medical Oncology ²Urology, MD Anderson Cancer Center, Houston, USA
(*E-mail: ntannir@mdanderson.org)

disclosures

The authors declare no conflict of interest.

references


letters to the editor