bias particularly in a retrospective literature-based meta-analysis. In particular, all the studies analyzed in the quoted review elected National Cancer Institute-Common Toxicity Criteria to test neurotoxicity, a scale that is known to have yet too many limitations to be chosen as ‘the’ end-point [2]. In order to overcome this difficulty in CIPN grading, the multicenter, international study CI-PeriNoms, was held [3]. This was the first study so far aimed to determine the best outcome measure(s), on the basis of a sound clinimetric approach. More refined scales, such as the clinical version of the Total Neuropathy Score scale (TNSc), were tested and found as valid in this setting. The second step of our investigation was to apply outcome measures proposed by the CI-PeriNoms group, in longitudinal, prospective studies, on OXA-related neurotoxicity in colorectal (CRC) patients [4], thus, obtaining more punctual data on incidence and severity of neurotoxicity in this specific population.

As the authors suggested further prospective, randomized trials are warranted to confirm the efficacy of Ca/Mg infusions or any other agent in OXA-related neurotoxicity. Efforts in this regard are quite needed in Oncology every-day practice, since OXA neurotoxicity is able to impact negatively on the quality of life in a population of long-survival patients, as large as CRC ones. In particular, acute toxicity, that might appear only a transient minor disturb, must not be overlooked; in fact, pronounced acute phenomena might be predictive of the development of a disabling chronic/cumulative neuropathy [5].

We recommend that future experimental studies take into account the use of evidence-based, valid tools such as TNSc, as well as introduce reliable patient reported outcome measures to capture patients’ perspective of CIPN and of neuroprotectants.

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**What do European community oncologists expect from the European Society for Medical Oncology? Results from a survey among community oncologists in Germany, Greece, Hungary, Italy, Luxembourg, Romania, and Spain**

Community oncologists (COs) are oncologists practicing mainly outside of academic institutions and typically treating a wide range of tumours. It is estimated that COs care for >50% of all cancer patients in Europe. They may have specific educational needs and wishes for professional support that differ from those of oncologists working in dedicated cancer centres, who are predominantly represented in scientific professional societies such as the European Society for Medical Oncology (ESMO).

Members of the ESMO Community Oncology Working Group, established by ESMO in 2010, distributed a questionnaire to practicing oncologists in seven European countries, asking for their needs and wishes towards ESMO (Table 1). In Germany,

**Table 1. Questionnaire for community oncologists concerning European Society for Medical Oncology (ESMO)**

<table>
<thead>
<tr>
<th>Question</th>
<th>Germany</th>
<th>Greece</th>
<th>Hungary</th>
<th>Italy</th>
<th>Luxembourg</th>
<th>Romania</th>
<th>Spain</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Are you working in a single practice or with partners?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>2. At your work place, do you have access to/use an intranet with</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<td>Yes</td>
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<td>electronic working aids (dose calculators, score calculator, therapy</td>
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<td>planning programme)?</td>
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<td>3. Are you an ESMO member?</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>4. Do you use the ESMO Clinical Recommendations regularly?</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>5. Do you have access to/use internet access at your work place?</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>6. Do you know the ESMO home page?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>7. Would you appreciate it if the ESMO home page provided easy-to-</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<td>access working aids like dose calculators, score calculators, therapy</td>
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<td>planning programmes?</td>
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<td>8. Which working aids would you find useful?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>9. Do you attend ESMO conferences?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>10. Do ESMO conferences fulfill your educational needs for your daily</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<td>work?</td>
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<td>11. Would you like to see sessions specifically for Community Oncologists?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<td>12. ‘What can ESMO do for you’: What requirements and wishes do you,</td>
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<td>as oncologists that primarily care for patients, have towards a European</td>
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<td>professional society like ESMO? Do you have further comments?</td>
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</table>
Greece, Romania, Hungary, Luxembourg, and Spain, questionnaires were distributed in person or by email by national WG members. Italian AIOM members and Spanish SEOM members were asked to answer an online questionnaire if they were COs. In total, 389 completed questionnaires were received from COs (DE 164 [1], GR 45, HU 21, IT 96, LU 12, RO 41, ES 10). The average response rate was 27% (not assessable for Spain and Italy). 52% of the responding COs were ESMO members, and between 6% and 60% of each country’s total ESMO membership (exception Spain: 1%) participated in the survey.

While most of the COs (82%) are aware of ESMO’s web page, the regular use of ESMO Clinical Practice Guidelines varies greatly among countries (from 39% regular users in DE to 95% in RO). This may be due to the availability of national guidelines, or the use of ESMO guidelines may have increased over the time of the survey, which was started in Germany in 2010 and closed in Italy in 2012. Although 67% of COs have an intranet with electronic tools available at their work place, 83% of the responders are interested in more web-based tools on the ESMO homepage, particularly in guidelines, score calculators, treatment protocols, and other treatment planning aids.

87% of European COs attend ESMO’s annual conferences. More ESMO members (62%) than non-members (20%) participate in every ESMO conference. The vast majority (90%) of those COs attending at least occasionally are satisfied with the scientific content of ESMO conferences, but a surprising 49% miss practice relevance, and 72% are interested in sessions focussing on community oncology issues.

This represents the largest survey among COs in Europe to date. With the exception of ESMO guidelines use, we found a surprising homogeneity in most answers across countries, despite Europe’s political and cultural heterogeneity. A high proportion of COs are ESMO members, and there is a definite interest in ESMO also by non-ESMO-members. This reinforces the need for the representation of COs within ESMO’s committees. Both ESMO and the ESMO Community Oncology Working Group have already implemented several measures to support practicing oncologists to deliver the best available care to their patients. The ESMO Community Oncology Working Group is committed to the concept that ESMO membership can be considered a quality label for the provision of excellent cancer care in all places of work.

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Light drinking has positive public health consequences

We enjoyed reading the well-performed and nicely presented meta-analysis on light alcohol drinking and cancer incidence published by Bagnardi et al. [1]. The authors focus on the increased incidence of several cancers in light drinkers, namely cancer of the breast, oral cavity and pharynx, and small-cell cancer of the oesophagus. They extrapolate an increased mortality from these cancers and suggest that this could be of public health relevance even if the relative risk increase is small, because there are a lot of light drinkers in the world and the aforementioned cancers are frequent.

However, this line of reasoning misses the whole picture because: (i) increased incidence of some cancers in light drinkers will not necessarily translate into increased attributable mortality, and (ii) even increased cancer mortality in light drinkers will not inevitably translate into increased overall mortality.

Regarding the first point, another meta-analysis published in the journal analysed cancer mortality in light drinkers compared with non- or occasional drinkers [2]. According to this meta-analysis, the relative risk of cancer mortality is reduced by 9% [95% confidence interval (CI) 6% to 11%] in light drinkers. It is possible that cancers induced by light drinking, even if more frequent, are less aggressive and less often fatal than those occurring in non-drinkers.

Regarding the second point, the authors are well aware of an overwhelming literature, to which they contributed, consistently showing that light drinking is associated with decreased all-cause mortality [3, 4]. The relative risk of all-cause mortality may be decreased by as much as 17% (95% CI