We thank Professor Valentini et al. [1] for their consideration of our ESMO position paper and for their willingness to continue this dialogue on the development of multidisciplinarity in cancer care. The complexity of cancer is increasing, based on molecular diagnostics and the increasing number of cancer subtypes etc, and it is therefore important for all oncology professions to keep pace with these developments (and challenges), which also means it is necessary for them to reassess their respective roles on a continuing basis [2]. ESMO is proud of the contribution the medical oncology profession has made to medical progress in the field of cancer, offering patients new and better treatment options, and remains fully committed to further advancing cancer research, treatment and care. This does not in any way negate or diminish the contribution of other professions in this field. ESMO has actively contributed to the development of the European Partnership for Action Against Cancer (EPAAC) policy statement on multidisciplinary cancer care and fully supports the statements made therein. However, medical oncologists clearly have a central role to play in the treatment and care for cancer patients and ESMO not only supports medical oncologists by offering a wide spectrum of education programmes and services but also promotes the highest qualification standards, thus contributing to making sure that cancer patients receive the best available treatment and care they deserve.

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Reply to the letter to the editor ‘Still a long way to go to achieve multidisciplinarity for the benefit of patients: commentary on the ESMO position paper’ by Valentini et al.

We read with interest the manuscript by Sun et al. [1] that compared late thoracic radiotherapy (TRT) with early TRT in limited-disease small-cell lung cancer and found no significant difference between the two arms for overall survival (OS) [hazard ratio (HR) 0.90; 95% confidence interval (CI) 0.18–1.62] and progression-free survival (PFS) (HR = 1.10; 95% CI 0.37–1.84).

However, we were surprised that the 95% CIs for both HRs were symmetrical. Indeed, one would expect symmetrical intervals for the logarithm of HR so that they become asymmetrical for HRs. The Method section would thus need some clarification on the way the HRs and their 95% CIs were estimated.

We assumed that the HR values were correct and we used the log-rank P value given in the article (P = 0.69 for OS and P = 0.60 for PFS) to estimate their CIs based on the methods
proposed by Parmar et al. [2]. We found narrower CIs than in the paper: HR = 0.90; 95% CI 0.54–1.51 for OS and HR = 1.10; 95% CI 0.77–1.57 for PFS using this method. The HR and its CI are the recommended survival parameters for summary data meta-analyses [3] and corrected values should be available for the readers of the journal.

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Letter to the editor on ‘Phase III trial of concurrent thoracic radiotherapy with either first- or third-cycle chemotherapy for limited-disease small cell lung cancer’

As we replied to the letter from Lueza et al. [1], there were some typos or mistakes to be addressed in our previously published paper [2]. The hazard ratios (HRs) of overall survival (OS) and progression-free survival (PFS) and their confidence intervals (CIs) were wrongly described. We confirm that these mistakes were caused by our carelessness without any intention for fabrication. The HR and 95% CI of OS should be changed from 0.90 (0.18–1.62) to 0.93 (0.67–1.29) and the HR and 95% CI of PFS are required to be changed from 1.10 (0.37–1.84) to 1.09 (0.80–1.48). These changes would be applied to the Abstract, Result, and Figure 1.

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 Overall survival benefit from surgical resection in treatment of recurrent glioblastoma

ESMO Clinical Practice Guidelines on high-grade gliomas dismiss impact of surgical resection on overall survival (OS) in treatment of recurrent glioblastoma (GBM), citing two pooled analyses as evidence of no effect. Neither analysis considered one critical factor in analyzing efficacy of re-resection—the extent of resection (EOR)—known to be important at first surgery. Furthermore, only 12% (37/300) and 27% (208/758) of patients underwent any surgery at all, respectively [1, 2]. Even if surgery had an effect on OS in these series, obvious imbalance, small numbers, and surgical heterogeneity would hardly provide sufficient power to detect any difference. Several recent series with higher numbers of patients, accounting EOR at surgery for recurrent GBM, demonstrate role of not only EOR in treatment efficacy, but also that more complete second resection can compensate for incomplete first resection [3–5].

Bloch et al. reported that 30% (107/354) GBM resections during their study period were for treatment of recurrent disease—all patients underwent postoperative MRI to estimate EOR. Impact of EOR, classified as gross total resection (GTR) or subtotal resection (STR), at both initial surgery and surgery for recurrence was analyzed. Median survival for patients with GTR followed by GTR was 20 months; for STR followed by GTR 19 months, and for STR followed by STR 15.9 months. STR at recurrence in patients with initial STR demonstrated significantly decreased survival compared with GTR at recurrence (15.9 versus 19 months, P = 0.004). For patients with initial STR, survival following repeat resection significantly increased with GTR compared with STR: 16.7 versus 7.4 months, P = 0.001.

Oppenlander et al. analyzed 170 consecutive patients and demonstrated EOR threshold for recurrent GBM. Significant improvement in OS was attained beyond 80% EOR—efficacy notably similar to newly diagnosed GBM. Median PFS following re-resection was 5.2 months, median OS 19 months for re-resection population, and remarkable 30 months in subset with EOR >97%. Cox proportional hazards analysis showed age, Karnofsky Performance Scale score, and EOR predictive of survival following repeat resection (P = 0.0001).

references

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