The lead up to the launch and subsequent response to the inaugural issue of Neuro-Oncology Practice has been very encouraging. It reinforces the need for an appropriate medium to publish relevant research regarding progress made in various aspects of neuro-oncology that health care professionals can apply directly in clinical practice. The leadership of our Editor-In-Chief, Susan Chang, M.D., my fellow co-editors, all editorial board members, the excellent support of the Society for Neuro-Oncology, the National Brain Tumor Society, and Oxford University Press has been exemplary and it is indeed a privilege to be a part of this exercise.

Importantly, the excitement and the spontaneous willingness with which the contributors, reviewers and all involved with the journal have responded to the challenges of giving a shape to this venture buoys us with enthusiasm and drive to continue working towards fulfilling the goals of the journal. A robust sustenance of any exciting endeavor poses the most formidable challenge in its future growth. We look forward to all members of the neuro-oncology community helping us ensure publications of the highest quality, respecting the mandate which the journal has set forth to accomplish.

The second issue of Neuro-Oncology Practice includes an interesting mix of original articles, seldom discussed otherwise in mainstream neuro-oncology. Several pieces of information could be utilized potentially in our daily practices as well as in designing and participating in relevant clinical trials. Short-term outcome measures of post-operative mortality and complications in surgical series have used endpoints of centers with high or low immediate readmission rates following the initial surgery. In a comprehensive analysis of a cohort of more than 1200 newly diagnosed glioblastoma (GBM) patients studied from the National Cancer Institute’s Surveillance, Epidemiology, and End Results (SEER) Medicare database, Nuño and colleagues report no significant differences in mortality and overall complication risks in patients operated on at centers with either high or low admission rates, implying equal quality of care. Interestingly, extents of resection between the two groups (high-admission versus low-admission centers) were also similar and there were no differences in overall adverse events except thromboembolism and DVT, which were shown to be higher in high-admission centers. While the study was restricted to patients older than 65 years and captures only a part of the patient population at large, it does question the veracity of using 30-day readmission rates as an endpoint of quality of care in neurosurgical oncology practice. The authors rightly point out the time-tested measures of overall survival and quality of life (QoL) are better indicators.

The assumption of poor cognitive function, a common finding in adult patients with low-grade gliomas, being correlated with poor patient self-reported quality of life has not been demonstrated well in the past. Boele et al., in a study with a sample size of 190 patients with low-grade gliomas and with stable disease at 6-year follow-up, show several QoL domains including future uncertainty and poor mental health being correlated with poor cognitive functioning (even subtle declines). This suggests that patients with even stable low-grade gliomas can experience relatively low functioning in their daily activities. This cross-sectional study should act as a suitable baseline to conduct prospective longitudinal studies employing validated and uniform instruments and also perhaps a long-needed tool for brain tumor-specific activities of daily living.

The tremendous physical and psychosocial challenges patients with malignant gliomas face in their daily lives are well known to all of us. Reporting of the burden by patients is, however, often compromised by associated poor neurocognitive and language function, and we often rely on caregivers’ assessments in these situations. Jacobs et al., in a study population comprising of 45 such patient-caregiver pairs, found a good concordance in QoL reporting by patients and their caregivers. This important finding can be useful for both daily clinical practices and designing clinical trials. Of particular interest, it was also shown that the burden on caregivers of glioma patients themselves was relatively heavy and higher than caregiver burden in patients with other cancer sites. While subtle differences in patient and caregiver reporting cannot be ruled out completely based on this study, it brings into focus the need for clinicians to be aware of the psychosocial burden of the caregivers in addition to patients’ needs.

A similarly useful study to be potentially incorporated in routine use and clinical trials is the demonstration of congruence of a 7-day recall with the originally designed 24-hour recall for the MD Anderson Symptom Inventory-Brain Tumor (MDASI), an important and validated tool for patient-reported outcomes. Armstrong and colleagues, in their study of 100 patients (median age of 48 years), did not find any significant differences in either congruence or equivalence in terms of ratings between the patients’ 24-hour and 7-day recall assessments. Results of this study and experience from other similar studies should give flexibility in the trial designs in terms of scheduling clinic visits.
appropriately, depending upon whether 24-hour recall (eg, essential in daily reporting) or 7-day recall is relevant.

Patients’ access to their health records (PHR) via electronic medical records systems is being increasingly used through password-protected web portals. Cahill and colleagues at the MD Anderson Cancer Center, in a study of 186 patients, report increasing use of PHR, especially for those with relatively poor performance status and potentially high uncertainty levels. Patients’ access to PHR, especially during their treatments, increased communication and interactions with clinicians and therefore possibly minimized their uncertainty and symptom burden. This is another good example of the use of novel technologies to provide better care of our patients.

Increasing costs of cancer treatment are an extremely important subject and remarkably little has been studied in patients with gliomas and their families. In a first-of-such-kind study, Kumthekar and colleagues showed considerable financial burden and out-of-pocket expenses, loss of wages, and lost days of work, especially in the first three months of diagnosis in patients with malignant gliomas. As there is much variation in social demographics and income levels across this patient population world-wide, the study reinforces the need for physicians to make patients and families aware of the potential costs involved in the care. This will allow patients to make judicious choices regarding their treatments from the available evidence-based medicine.