low-risk disease, and in men with limited life expectancy [6]. Under this light, it is worrisome that roughly 80% of patients included in our cohort received this treatment (and were exposed to the risk of treatment-related side-effects) without any benefits in terms of cancer-specific survival at 8-year follow-up [2]. These observations have also profound implications in terms of expenditures for the health care system. Indeed, the adoption of IMRT resulted in excess spending of $282 million per year compared with 3D conformal radiation therapy in the United States alone [5]. These increased costs did not translate into a survival benefit in the majority of patients.

Taken together, these considerations reveal that the availability of a novel advanced treatment modality, such as IMRT, does not mean that all the patients will benefit from this approach. Identifying which patient represents the ideal candidate for which treatment currently remains one of the main challenges in the context of PCa. This would ultimately allow us to avoid overtreatment of a considerable proportion of patients. Additionally, this would result in substantial savings for the health care system. Well-designed prospective randomized trials with long-term follow-up are needed to finally address this issue.

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references


Still a long way to go to achieve multidisciplinarity for the benefit of patients: commentary on the ESMO position paper (Annals of Oncology 25(1): 9–15, 2014)

The paper by ESMO “The current and future role of the medical oncologist in the professional care for cancer patients: a position paper by the European Society for Medical Oncology (ESMO)” [1] conveys some important key messages for the whole oncology community. A working group (WG) involving 21 oncology and related societies would like to comment on the paper from a multidisciplinary perspective in the conviction that a more transparent and open definition of individual professional roles better supports the patients’ care and facilitates best practices and progress in comprehensive cancer care.

We strongly support a balanced positioning of disciplines related to cancer patients’ care, and we support ESMO in this initiative: having well established and recognized disciplines is the starting point of a comprehensive fight against cancer, pursuing together the optimum care of the patient as the ultimate goal. As health care professionals we are all aiming for the well-being of the patient, improving and ensuring the best treatments and quality of life—based both on multidisciplinarity and on tailored, personalized medicine. However, we find that some statements presented in the ESMO paper are of concern, especially when it comes to the persistent central positioning of medical oncology during the whole cancer journey and that the medical oncologist in certain situations might be a surrogate for the multidisciplinary team.

The EPAAC Policy statement on multidisciplinary cancer care, published in 2013 [2] and signed by 20 societies, including ESMO, includes the following: “Multidisciplinary teams (MDTs) are an alliance of all medical and health care professionals related to a specific tumour disease whose approach to cancer care is guided by their willingness to agree on evidence-based clinical decisions and to co-ordinate the delivery of care at all stages of the process, encouraging patients in turn to take an active role in their care” [2]. It is unrealistic today, and even more so in the future, that one profession can oversee the whole complexity of oncology. The whole cancer community strives to improve cancer care. Research relies on networks of knowledge and expertise. Every discipline needs the mutual support and findings of the others in order to advance patient care. Overall, the whole is greater than the sum of its parts.

The ESMO position paper states that: “Medical oncologists have a special qualification in the care for the increasing number of co- and multimorbid patients and in the integration of their needs in the MDT” [1]; while we agree that medical oncologists indeed have a special qualification in the care for the increasing number of patients with sometimes complex co-morbidity and in the integration of their specific needs in the MDT, several other medical and psychosocial disciplines that are active in the field of oncology are well positioned to handle these complex needs as well. The close collaboration, and not the preeminent
position of one physician over another, is the ideal setting for optimal cancer care. If otherwise, this would imply the unrealistically narrow mind where the medical oncologist would need to be trained in all oncological disciplines in order to recognize all possible working mechanisms and side-effects related to all types of treatments and subsequently manage them optimally.

The positioning of a discipline, especially in a multidisciplinary environment such as contemporary oncology, cannot be self-referential [3]; on the contrary, it should be based on optimal collaboration with all other disciplines and not, as stated in the ESMO position paper, on collaboration with other professionals ‘where appropriate’: ‘Preserving a cancer patient’s quality of life in all phases of disease and after successful treatment also includes continuously assessing the patient’s physical and psychological symptoms and making sure that these problems are fully recognised and adequately addressed. Where appropriate, this is done in collaboration with experts of other medical and non-medical disciplines’ [1]. The collaboration with all other disciplines is not and cannot be an option left to the decision of one single discipline, whichever discipline that might be.

Multidisciplinarity is also mirrored in research, to which the contribution of medical oncology is unquestionable, but we cannot share the positioning of medical oncology as the discipline which ‘has contributed probably more than any other medical discipline to the development and use of novel cancer treatment options’ [1]. Medical oncologists cannot safely apply any new treatments without strong support from basic scientists to help in understanding and applying these new technologies. Similar to the progresses made in radiation therapy, surgery, cancer-related health care sciences and other diagnostic and clinical disciplines, medical oncology has advanced greatly in the last decades. It is this joint progress that has allowed all disciplines to move forward together in the fight against cancer and which offers further challenging opportunities to all oncology and related disciplines, rather than to one single treatment option.

The ESMO position paper states that the well-being of the patient and progress in cancer care are central and the contribution of medical oncology to the MDTs is affirmed. The WG strongly supports these statements, sharing entirely the goal that ESMO wants to achieve. However, it should be stressed that multidisciplinarity is the way forward by joining forces and combining efforts toward optimal interprofessional collaboration. Collaboration, recognition of each individual discipline and the centrality of the patient–physician–care provider relationship will lead to a better environment for the patient with all disciplines collaborating and cross-fertilizing each other.

We think that the ESMO policy statement is a first and firm positive step in setting the scene from the medical oncology perspective, and we are sure that other consequent propositions will follow to provide a more integrated participation in the multidisciplinary framework, where the collaborative participation of medical oncology is warmly welcomed. The ESMO position paper opens the discussion for improvement and exchange of ideas: the WG would be glad to contribute to this process, promoting a positive evolution of all involved cancer disciplines in order to advance the development of a truly multidisciplinary structure and modus operandi.


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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 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 quality standards, thus contributing to making sure that cancer patients receive the best available treatment and care they deserve.

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Phase III trial of concurrent thoracic radiotherapy with either first- or third-cycle chemotherapy for limited-disease small-cell lung cancer

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