Re: Economic Analysis of Vinorelbine Plus Cisplatin Versus Paclitaxel Plus Carboplatin for Advanced Non-Small-Cell Lung Cancer

In their paper, Ramsey et al. (1) describe an economic analysis of vinorelbine plus cisplatin versus paclitaxel plus carboplatin for advanced non-small-cell lung cancer. This analysis, however, was done alongside a Southwest Oncology Group multicenter, randomized clinical trial (2). It does not necessarily reflect the real situation and may be biased, aiming at finding a cost–benefit for vinorelbine plus cisplatin. This analysis does not consider the fact that hospitalization is often required for the administration of vinorelbine plus cisplatin, particularly for patients with a less favorable performance status, thus increasing the cost of this treatment. All patients entering this clinical trial had to have a performance status of 0 or 1, and the trial concluded that vinorelbine plus cisplatin was much more toxic.

The real situation shows that in most instances, vinorelbine plus cisplatin can only be administered in inpatients who have a good performance status. Administration of the paclitaxel plus carboplatin combination, however, does not require hospitalization and had the lowest incidence of grade 3 and 4 toxicities among patients with a performance status of 2 compared with paclitaxel plus cisplatin, gemcitabine plus cisplatin, and docetaxel plus cisplatin in a recent publication (3). Another publication showed that poor-performance patients with advanced non-small-cell lung cancer might not benefit from vinorelbine plus cisplatin compared with vinorelbine alone (4).

Paclitaxel plus carboplatin and vinorelbine plus cisplatin are currently regarded as two standard protocols for the treatment of advanced non-small-cell lung cancer, although several other platinum-containing regimens have been shown to have similar efficacy [for review see (5)]. Economic analysis could be helpful in deciding which regimen should be used, but all aspects must be taken into consideration, and the analysis of cost should not be biased.

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References


NOTE

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Response

Dr. Malayeri expresses concern that because our cost–effectiveness study was conducted alongside a clinical trial, the external validity of the findings is potentially in question. As with findings from any clinical study, we would caution readers against extrapolating the economic findings to patients, treatments, or settings that do not resemble those found in the trial. This applies to advanced lung cancer patients with poor performance status. Of note, the Eastern Cooperative Oncology Group trial cited by Dr. Malayeri found that persons with poor performance status randomly assigned to the carboplatin plus paclitaxel arm of the trial experienced less toxicity but also had poorer survival compared with the other regimens studied (1). Use of platinum-based combination chemotherapy regimens in patients with advanced non-small-cell lung cancer and poor performance status is not recommended and is thus beyond the scope of our analysis (2). Dr. Malayeri’s assertion that our study is biased because we did not account for the higher rate of hospitalizations for those treated with cisplatin plus vinorelbine is incorrect. In our paper, we note that those treated with cisplatin plus vinorelbine incurred more than twice as many days in a hospital non-intensive care unit, predominantly during the induction phase of treatment. After accounting for these hospital costs (as well as all other costs related to cancer care), we determined that the overall lifetime cost for those treated with cisplatin plus vinorelbine was far less than the cost for those treated with carboplatin plus paclitaxel. We feel that decision makers can use our results, confident that they are free from bias, while retaining the usual cautions about extrapolating the results from controlled clinical trials to other settings.

Scott Ramsey

References