Title
In Reply to Singh.

Permalink
https://escholarship.org/uc/item/5jq5w7z9

Journal
International journal of radiation oncology, biology, physics, 98(2)

ISSN
0360-3016

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Publication Date
2017-06-01

DOI
10.1016/j.ijrobp.2017.02.011

Peer reviewed
concurrent cisplatin for stage IB-IVA cervical cancer: an international multicenter phase 2 clinical trial (INTERTECC-2)” (1), I must congratulate the authors for the meticulousness and merit of the research. However, the mention of a state-owned Indian center participating in the trial is what caught my attention.

Kannan et al (2) beautifully summarized a mismatch of state budget allocated to healthcare and the low numbers of insured patients in India as a “tragic combination.” These factors, coupled with low density and unequal distribution of linear accelerators, only quadruples the tragedy. Moreover, most of the state-owned centers still rely on cobalt-60—based conventional teletherapy equipment to treat patients with cervical carcinoma.

This brings us back to the basic question of any clinical research, especially in the developing world, is it clinically meaningful? The unfortunate answer to this question pertaining to the INTERTECC-2 trial is “no.” In India, where the already fragile health care system is struggling to keep up with the ever increasing burden of cancer patients, the added expenditure for image guidance and positron emission tomography/computed tomography will only compound the problem.

Affordable medical technology has become the paradox of our times. For example, for cancer of the cervix, the International Federation of Gynecology and Obstetrics recommends basic investigations to stage the cancer, reporting it to be a disease of the economically constrained developing world. However, the trials used positron emission tomography/computed tomography and image-guided radiation therapy to treat it.

Evidence-based medicine might a luxury that the developing world can afford; however, for the developing world, economy-based medicine still takes precedence.

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http://dx.doi.org/10.1016/j.ijrobp.2017.02.014

References


In Reply to Singh

To the Editor: We thank Dr Singh for expressing a common yet valid concern regarding the application of advanced technologies in low/middle-income countries (LMICs) (1, 2). Although we strive to conduct research that will practically impact patient care, a more general question Dr Singh raises is this: can any research—regardless of where it is conducted—be clinically relevant to LMICs, when using technologies they currently find inaccessible? The best answer to this question is “yes.”

Absence of evidence is often used to justify withholding investment in new technologies, creating its own paradox. We have similar debates in the developed world. For example, it is impossible to know the value of hadron therapy without studies from centers experienced with its application. Yet the results of such studies are still relevant for centers that lack this capability, by lending insight into what works, what does not, and why. We agree affordable medical technology should not be an oxymoron, but before we can determine whether a technology is cost-effective, we first must know whether it is effective.

Invariably, new technologies will have the most immediate impact on those who can afford them. But cost and complexity are not static problems. Though presently restricted to larger metropolises and corporate sectors, radiation facilities in India and other LMICs have improved substantially in the last decade. Through various government-related reimbursement schemes, many patients receive treatment at subsidized costs. Moreover, although technology can augment the challenge of providing affordable medical care, it also can reveal solutions to make it more economical. For example, automated, atlas-based planning and high dose rate, rapid-throughput machines with stereotactic capabilities have the potential to diminish the burden of overworked and understaffed clinics.

A concomitant purpose of clinical trials is to achieve a fundamental understanding of medical phenomena. Thus, it is appropriate for the science to predate widespread clinical adoption. Our research sought to determine whether varying pelvic radiation dose might improve outcomes for patients undergoing chemoradiotherapy. Positron emission tomography, intensity modulated radiation therapy, and image-guided radiation therapy are tools to understand the radiation effects on tissue function, but there are myriad reasons to invest in these technologies outside the narrow application for sparing bowel and bone marrow. Indeed, greater health care investment in LMICs is essential; as clinical trialists, our job is to prove why. Therefore, we continue to advocate scientific cooperation between centers in the developed and developing worlds, to broaden our vision of what is possible.

For the INTERTECC Study Group
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In Reply to Aronowitz

To the Editor: In our article, we purposely used the phrase “might be” to describe whether Reshetillo’s publication represented the first radiation therapy textbook (1, 2). This was meant to reflect the ambiguity of using a modern term (“textbook”) that denotes a mature and standardized curriculum to describe a foundational primer published at the turn of the past century. Our statement was not meant in any way to detract from the contributions of other international figures who published early works in radiation therapy. In fact, we are in strong agreement that all of the authors cited in the letter merit attention and accolades from those interested in the history of our field. We thank the respondents for bringing their interesting (and quite beautiful) works to the attention of the Red Journal readers.

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http://dx.doi.org/10.1016/j.ijrobp.2017.02.033

References


Is It the Splenic Dose or the Treatment Volume That Causes Lymphopenia

In Regard to Chadha et al

To the Editor: We read the article entitled “Does Unintentional Splenic Radiation Predict Outcomes After Pancreatic Cancer Radiation Therapy?” with great interest (1). The authors retrospectively evaluated 177 locally