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In this issue

Evaluating RECIST

The Response Evaluation Criteria In Solid Tumours (RECIST) was developed in the late 1990s to replace the WHO criteria for response evaluation. RECIST was published in February 2000 and very quickly came into operation in clinical trials performed under the auspices of EORTC, US NCI and NCI Canada Clinical Trials Group and was adopted quickly thereafter by the entire cancer clinical research community. As several key features of RECIST were based on analysis of retrospective clinical data it was felt important to carefully monitor the implementation of the guidelines and stimulate prospective validation studies. In this issue of *EJC*, Therasse and colleagues, review the literature that has been published on RECIST from 2000 up to November 2005. The authors found that in general, RECIST has been well received by the scientific community and most validation studies fully support the implementation of the new criteria. The findings of this review, together with experience acquired thus far and the results of some ongoing research projects, have paved the way for a revised RECIST 2.0 version to be published later this year.

Therapeutic surgery for breast cancer increases relapse?

Amplification and overexpression of HER2, a tyrosine kinase receptor of the epidermal growth factor (EGF) receptor family, is present in approximately 25% of breast carcinomas. These carcinomas are a particularly aggressive tumour subset with increased proliferation and metastatic potential. Patients with breast carcinomas that overexpress HER2 and disseminate to the axillary lymph nodes display an early peak of relapse in the first years after surgery. A simple increase in the proliferation potential of HER2-positive tumours does not satisfactorily explain the poor prognosis associated with HER2 positivity in node-positive patients. In this issue of *EJC*, Tagliabue and colleagues have tested the hypothesis that therapeutic surgery itself may trigger recurrence. They present their results from a retrospective study analysing patients with HER2 primary tumours who were included in a randomized clinical trial addressing conservative quadrantectomy versus radical mastectomy. In patients with positive nodes and HER2-positive tumours, the estimation of the time-dependent log-hazard ratios showed that radical mastectomy significantly increased early death rates.

Sourcing HRQOL in the palliative care setting

Palliative care aims at providing the best possible care to improve the quality of life of patients and their families. To achieve this goal, it is necessary to evaluate the effects of the care given. However, it is often difficult to recruit patients for palliative care studies and also severe attrition due to deterioration must be expected. This may generate biased results and limit the broad applicability of study findings. In this issue of *EJC*, Petersen and colleagues investigated if equivalent patient information could be obtained from sources other than the patients themselves, by asking physicians to assess patients' health-related quality of life (HRQOL). Patient and physician evaluation of patients' HRQOL were obtained. However, significant differences between the two HRQOL sources were observed for all domains assessed. The authors conclude that agreement between patients and physicians was poor and furthermore, using physician assessments cannot be recommended as a substitute for patient self-assessment in palliative care.

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