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In this issue

Advanced endometrial cancer therapies: how good are they?

Treating advanced stage endometrial cancer is challenging. Radiation and surgery, the standard treatment modality for early disease and local/regional recurrences, has no clear benefit in advanced stage patients or those with non-localized recurrent disease. Chemotherapy and/or hormonal therapy are often considered to be the only active treatments in advanced disease. Many different chemotherapy and hormonal therapy agents have been tested in this setting. The most common regimens in clinical practice include doxorubicin, cisplatin and paclitaxel (either as single agents or in combination); and medroxyprogesterone acetate. The activity of hormonal regimens, mainly progestins, is thought to be influenced by certain prognostic factors, such as receptor content. However, response rates to therapies are unlikely to be high and the impact on survival is uncertain. Also, current evidence on the efficacy of available systemic therapies is scarce. In this issue of *EJC*, Polyzos and colleagues provide insights into this field by collating published data from randomized controlled trials evaluating various chemotherapy or hormonal therapy regimens in locally advanced or metastatic endometrial cancer. They focused on survival outcomes and examined trial characteristics pertaining to quality and potential biases. Out of the 17 eligible trials (2964 randomized patients) found by searching three literature databases, only 4 regimens were involved in more than one trial, and only two trials had used the same comparison of regimens. The study led its authors to conclude that overall, randomized evidence on systemic treatment in advanced endometrial cancer is fragmented and survival benefits for specific regimens are questionable.

Risk factors for loco-regional breast cancer recurrence

Loco-regional recurrence of breast cancer is a well-established independent risk factor for distant metastases and death. A risk factor for loco-regional recurrence is breast conserving surgery instead of mastectomy. Those who have conserving therapy are at higher risk for local recurrence if they have positive margin status, extensive intraductal component and young age at diagnosis of primary tumour. Risk factors reported for loco-regional recurrence in patients treated with mastectomy are histological grade and extensive axillary node involvement. In this issue of *EJC*, Bock and colleagues have studied risk factors, at primary diagnosis of early breast cancer, for isolated loco-regional and other recurrences including distant metastases or death. The 3062 patients, who were enrolled in EORTC trials 10801, 10854, and 10902, had already undergone primary surgery by either breast conservation or mastectomy. The results of multivariate analysis showed that younger age and breast conservation were independent risk factors for isolated loco-regional recurrence; and also that peri-operative chemotherapy reduced its incidence. As isolated loco-regional recurrence is a potentially curable condition, the authors suggest that women treated with breast conservation or diagnosed with breast cancer at a young age should be specifically monitored to detect local recurrence at an early stage.

Adolescents need special attention

In France, one in every 1100 adolescents (aged between 15 and 19 years) develop cancer and approximately 700 new cases are diagnosed annually. Although adolescent cancers account for less than 0.5% of all cancers in France, they remain the leading cause of death due to disease in this age group. Cancer in adolescence differs from that in adults and children; embryonal tumours observed in children are rare in adolescents (1%) while one third of all cancers are epithelial tumours that occur more frequently in adults. In this issue of *EJC*, a study by Desandes and colleagues has examined survival statistics of adolescents with cancer. Overall, disease-specific and event-free survival was assessed using follow-up data from nine French population-based registries during the period 1988–1997. The analysis showed that compared to paediatric cases, poor outcomes in adolescent patients were seen in acute lymphoblastic lukaemia, malignant bone tumours, and soft-tissue sarcomas. The authors highlight that further studies are required to investigate fully the effects of regimens used in the adolescent patient group. In an accompanying editorial, Professor MCG Stevens agrees with the authors that adolescent patients' needs are currently insufficiently addressed by both paediatric oncology and adult cancer services. They go on to suggest that specific tailored management of adolescent cancer in paediatric, adult, or specialized units will improve cure rates and treatment outcomes for these patients.

doi:10.1016/j.ejca.2005.11.008