Recurrent Glioblastoma: Not Only Surgery

TO THE EDITOR: We read the article by Park et al with great interest; the authors really did an excellent job on the preoperative scale for patients with recurrent glioblastoma. According to the authors, the higher the scores that patients received, the poorer postoperative survival was predicted. However, we would like to make some comments regarding some limitations that might make the scale less precise.

First, the site of tumor could be related to the Karnofsky performance status—a tumor in critical region of brain can directly lead to low Karnofsky performance status score—so these cannot be independent prognostic factors for patients with recurrent glioblastoma.

Second, in 34 patients with recurrent glioblastoma who were enrolled to screen for risk factors, less than 10% of patients reached the score of 3 points (n = 3); whereas, in another separate cohort of 109 patients that was used for validating the scale, even less than 3% of patients reached the score of 3 points (n = 3). This small sample size might cause great bias and is not powered enough to draw the conclusion the authors reported. More patients who can reach the score of 3 points should be included. What is more, in the cohort of 109 patients, the difference in overall survival between the two groups that contained more than 95% of enrolled patients (0 point vs 1-2 points) was only borderline significant (P = .045), which might result from the sample error. Is there a better and more appropriate way to group patients (ie, 0 points, 1 point, 2-3 points; or 0-1 point, 2-3 points) that could make the results and conclusion more accurate?

Third, all patients included in the studies only received surgery after recurrence. Actually, reoperation was not indicated in all recurrent cases; patients who cannot tolerate surgery could receive other treatment protocols instead. Even if reoperation was performed, it only resulted in limited prolongation of survival. Chemotherapy now plays a more and more important role in recurrent glioblastoma. Patients treated with bevacizumab, alone or in combination with irinotecan, showed improvement in both response rate and overall survival time, and bevacizumab has been approved by the US Food and Drug Administration for use in patients with glioblastoma that has progressed despite previous therapy. Cilengitide was an investigational selective αvβ3/5 integrin inhibitor with multiple antitumor effects. At the 46th Annual Meeting of the American Society of Clinical Oncology, Fink et al reported that cilengitide was effective for and well tolerated by patients with recurrent glioblastoma, with a median overall survival of 9.9 months. So there is a possibility that patients with scores of 3 points might live longer with chemotherapy than with reoperation. Chemotherapy should be considered in the scale when treating patients with recurrent glioblastoma.

These comments are not meant to diminish the significant effort of Park et al in devising and validating the preoperative scale to predict survival for patients with recurrent glioblastoma. However, this simple scale might not be qualified for application in its current form without a knowledge of potential influence of sample size and chemotherapy.

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AUTHORS’ DISCLOSURES OF POTENTIAL CONFLICTS OF INTEREST
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REFERENCES

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