

key role in most androgen-dependent prostate cancers. In addition, in almost all AR-negative tumours overexpression of wild-type members of the ETS family was detected. This may be a mechanism for bypassing androgen regulation.

Reference

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Re: Sunitinib versus Interferon alfa in Metastatic Renal-Cell Carcinoma

Motzer RJ, Hutson TE, Tomczak R, Michaelson MD, Bukowski RM, Rixe O, Oudard S, Negrier S, Szczylik C, Kim ST, Chen I, Bycott PW, Baum CM, Figlin RA

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Expert's summary:

In this randomized, multicenter study, 750 previously untreated patients with metastatic renal cell cancer (clear-cell histology) were treated with sunitinib malate (50 mg once daily for 4 wk, 2 wk without treatment) or interferon-alfa (9 MU subcutaneously 3 times weekly). The primary end point was progression-free survival (PFS). The objective response rate was 31% for the sunitinib group and 6% for the interferon-alfa group. The median PFS was significantly longer in the sunitinib group (11 mo) than in the interferon-alfa group (5 mo). The sunitinib group showed a higher objective response rate, less treatment-related fatigue, and a better quality of life than the interferon-alfa group.

Expert's opinion:

This study is the first phase 3 trial comparing sunitinib with interferon-alfa as first-line treatment in metastatic clear-cell renal cell carcinoma. Sunitinib targets activity of angiogenic growth factors. The benefit for sunitinib in PFS compared to interferon-alfa was larger than anticipated, which resulted in the trial meeting its primary end point in the interim analysis. Toxicity of sunitinib (hypertension, hand-foot syndrome, vomiting, and diarrhea) was acceptable, with a better quality of life compared to interferon-alfa. Is this the end of

interferon-alfa therapy for metastatic renal cancer? It is clear that a new standard has been set. This is important news because efficacy of immunotherapy in renal cell cancer has been disappointing [1]. However, in a limited number of patients a prolonged complete remission is reported following immunotherapy, which is maintained after the treatment has been stopped [2]. Once started on sunitinib, treatment has to be continued. Therefore, there is still a case for starting with interferon-alfa in selected patients, for example, those with only lymph node or pulmonary metastases.

This study has another interesting aspect. Of the 750 patients, 673 underwent a previous nephrectomy, a factor that is known to influence the course of the disease in patients treated with interferon-alfa [3]. If a nephrectomy did not influence the course in patients treated with sunitinib, one would expect to see this in the subgroup analysis.

Although there are many limitations to subgroup analysis, no such effect is visible in Figure 3 of the article. The question regarding the role of nephrectomy in metastatic renal cell cancer treated by sunitinib is still open.

References

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