



Better outcomes data lead to better outcomes

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The right treatment, for the right person, at the right time' represents a significant shift from 'one-size-fits-all' medicine to a tailor-made individualised approach. While we are learning fast about how individual tumour characteristics affect each patient as a unique host, what we lack are validated tools to identify who benefits from which treatments.

We need to greatly improve our ability to monitor the impact of treatments on outcomes. Cancer registration and quality assurance programmes are key; the challenge lies in identifying the right quality indicators, which need to be robust and feasible to monitor across many countries. EU member states use different ways to collect cancer data, and even different versions of the TNM classification, making it difficult to compare like with like. The last couple of years, however, have seen important progress in defining minimal datasets for several tumour types, which have been shared across different international registries.

Randomised clinical trials (RCTs) are another important source of evidence, but their ability to inform a personalised approach to the care of patients in the real world is strictly limited. Less than 1% of all cancer patients are treated inside a clinical trial, and they tend to be younger and fitter than the average patient and with fewer comorbidities.

Publication bias is also a matter of concern. If the results of trials with negative outcomes are kept in the dark, clinical guidelines will be skewed in favour of the positive trial findings –

the bias can be magnified in meta-analyses.

Large observational population-based registries, with complete and accurate information, provide much more robust and detailed information than RCTs on how different aspects of patient management impact on outcomes in different patients. Ideally, population-based research should be designed as a comparison between different geographical areas, each one using different treatment approaches. This type of research is becoming easier as our ability to collect good-quality data in 'real time' is improving.

The value of geographical comparisons has recently been shown, for instance, in the field of rectal cancer, where data showed that patients in the Netherlands were more likely to receive preoperative radiotherapy than their counterparts in other European countries but, despite lower rates of recurrence, they were not living longer as a consequence.

EURECCA, the European Registration of Cancer Care (www.canceraudit.eu), is a good example of an international multidisciplinary platform set up to gather these types of data to raise standards of cancer care across the board.

It is clear that RCTs continue to provide important data upon which we base our practice; however, the time has now come to move beyond this, and to invest in population-based registries such as EURECCA.

A better future requires international cancer registration. All cancer registries and regional/national clinical audits need to work together to make it happen! ■

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