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The PulMiCC challenges the consensus belief that without metastasectomy, 5-year survival would be zero. For controls, the median survival was 3.8 years, compared with 3.5 years after metastasectomy, but 93 patients was insufficient to show noninferiority—which was the basis of the power calculation—of management without metastasectomy (HR, 0.93; 95% confidence interval [CI], 0.56-1.56). Nevertheless, pooled with the CLOCC trial, which included nonintervention for CRC metastases, control survival was 30% (95% CI, 21%-40%), with ample power to refute the zero survival assumption or any estimate approaching it.

Corsini and colleagues refer to the design of NCT03599752, which results in all patients undergoing lung metastasectomy. In some patients, metastasectomy is deferred until after chemotherapy, so this is really a trial of sequencing. It will not add to knowledge about the effect of metastasectomy itself. If metastasectomy were a new drug, it would not be allowed into practice on existing evidence. Whether or not patients are “inclined to avoid surgical management,” they are entitled to more realistic evidence-based estimates of the effect size of benefit from metastasectomy than has hitherto been the case.

Norman R. Williams, PhD
Fergus Macbeth, DM
Tom Treasure, MD
“A Surgical and Interventional Trials Unit
Clinical Operational Research Unit
University College London
London, United Kingdom
Centre for Trials Research
Cardiff University
Cardiff, United Kingdom

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