priorities, before sparing of any nearby organs such as the small intestine, bladder, genitalia, and skin. When we initiated treatments with IMRT for anal canal cancer patients, we too were concerned that the radiation doses could be delivered accurately and reliably to the perianal region. Our data with our first three patients with body-mass indexes ranging from 20 to 35 demonstrate a measured delivered dose over three consecutive treatments to within 5% of the predicted dose. These data demonstrate that the dose planned to be delivered and immobilization techniques employed correctly delivered the dose to within the error range of the thermoluminescent dosimetry devices (unpublished data, Julius Turian, December 2000). It seems that the natural anatomic shape and location of the anus within the gluteal folds ensures adequate dose delivery.

While 42% of patients required a treatment break, few required longer than 3 days, and the median time to completion of treatment was 6 weeks. Therefore, treatments were delivered in a timely fashion, and treatment interruptions were limited in duration. Furthermore, the majority of treatment interruptions were for hematologic toxicity, per the standards of large cooperative groups. While Dr Vordermark points to a study with extremely low rates of acute grade ≥ 3 hematologic toxicity for anal canal cancer patients (13%),[7] most large cooperative group studies report much higher rates, such as the 60% seen in Radiation Therapy Oncology Group 98-11, which would mandate higher rates of treatment interruption.

We agree that complex 3D conformal radiotherapy techniques can deliver similar radiation dose patterns. However, one added advantage of IMRT is simplicity of radiation delivery. Furthermore, not all patients with anal cancer are candidates for IMRT concurrently with chemotherapy. In obese patients with nonreproduceable external skin contours, IMRT would not be recommended. The optimization of IMRT needs to continue integrating bone marrow sparing to reduce hematologic toxicity events decreasing treatment interruptions due to neutropenia. However, in its current form, IMRT can be delivered safely and effectively with high rates of control and data demonstrating proper dosing to the primary tumor and perianal skin.

Editor's Note

An erratum has been published in this issue to correct the error in the Patients and Methods section of the article (J Clin Oncol 25:4581-4586, 2007).

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AUTHORS' DISCLOSURES OF POTENTIAL CONFLICTS OF INTEREST
The author(s) indicated no potential conflicts of interest.

REFERENCES

1. Salama JK, Mell LK, Schomas DA, et al: Concurrent chemotherapy and intensity-modulated radiation therapy for anal canal cancer patients: A multicenter experience. J Clin Oncol 25:4581-4586, 2007
2. Teh BS, Woo SY, Butler EB: Intensity modulated radiation therapy (IMRT): a new promising technology in radiation oncology. Oncologist 4:433-442, 1999
3. Zelefsky MJ, Fuks Z, Leibel SA: Intensity-modulated radiation therapy for prostate cancer. Semin Radiat Oncol 12:229-237, 2002
4. Eisbruch A, Ship JA, Dawson LA, et al: Salivary gland sparing and improved target irradiation by conformal and intensity modulated irradiation of head and neck cancer. World J Surg 27:832-837, 2003
5. Salama JK, Roeske JC, Mehta N, et al: Intensity-modulated radiation therapy in gynecologic malignancies. Curr Treat Options Oncol 5:97-108, 2004
6. Mundt AJ, Lujan AE, Rotmensch J, et al: Intensity-modulated whole pelvic radiotherapy in women with gynecologic malignancies. Int J Radiat Oncol Biol Phys 52:1330-1337, 2002
7. Vuong T, Kopek N, Ducruet T, et al: Conformal therapy improves the therapeutic index of patients with anal canal cancer treated with combined chemotherapy and external beam radiotherapy. Int J Radiat Oncol Biol Phys 67:1394-1400, 2007

DOI: 10.1200/JCO.2007.15.0714

Randomized, Controlled Trial of Irinotecan Plus Infusional, Bolus, or Oral Fluoropyrimidines in First-Line Treatment of Metastatic Colorectal Cancer: Updated Results From the BICC-C Study

To the Editor: We recently published in the October 20, 2007, issue of the *Journal of Clinical Oncology*, results from a phase III study that compared the safety and efficacy of three different irinotecan-containing regimens in the first-line treatment of metastatic colorectal cancer (mCRC): irinotecan plus infusional florouracil and leucovorin (FU/LV; FOLFIRI), irinotecan plus bolus FU/LV (mIFL), and irinotecan plus oral capecitabine (CapeIRI).[1] The study therefore initially randomly assigned patients to one of three open-label chemotherapy arms (designated as period 1). In April 2004, following US Food and Drug Administration approval of bevacizumab (Bev), the trial was amended to compare FOLFIRI with bevacizumab (FOLFIRI+Bev) with mIFL with bevacizumab (mIFL+Bev), whereas, due to toxicity concerns, further enrollment to CapeIRI was discontinued (designated as period 2). The results for both periods 1 and 2 demonstrated that FOLFIRI and FOLFIRI+Bev offered superior activity to their comparators and were comparably safe.[1] However, at that time, median survival had not yet been reached for FOLFIRI+Bev. Herein, we report updated overall survival data for all patients enrolled in period 2 of this trial.

In period 2, 117 patients were randomly assigned to either FOLFIRI+bevacizumab (Bev; n = 57) or mIFL+Bev (n = 60). With

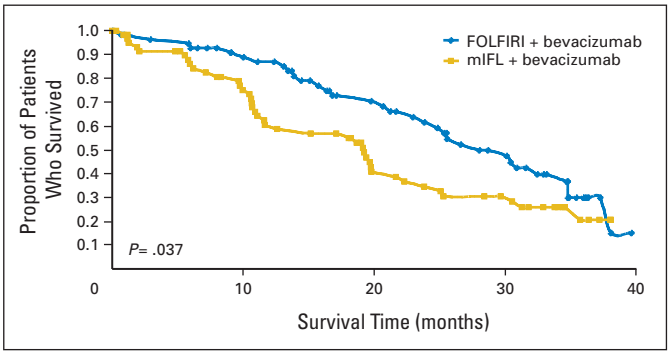

Fig 1. Overall survival for period 2. FOLFIRI, infusional fluorouracil/leucovorin/irinotecan; mIFL, modified bolus irinotecan/fluorouracil/leucovorin.

a median follow-up of 34.4 months, overall survival was significantly greater for patients who received FOLFIRI+Bev (median 28.0 months) when compared with mIFL+Bev (median, 19.2 months; $P = .037$; HR for death = 1.79; 95% CI, 1.12 to 2.88; Fig 1). The proportion of patients alive at 1-year was 87% for the FOLFIRI+Bev–treated group and 61% for mIFL+Bev.

Consistent with our earlier findings of this trial, following the addition of bevacizimab, FOLFIRI+Bev conferred a significant survival benefit when compared with mIFL+bevacizumab. Consequently, when using an irinotecan-based regimen in the treatment of first-line metastatic colorectal cancer, an infusional schedule of FU should be the preferred approach.

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Although all authors completed the disclosure declaration, the following author(s) indicated a financial or other interest that is relevant to the subject matter under consideration in this article. Certain relationships marked with a "U" are those for which no compensation was received; those relationships marked with a "C" were compensated. For a detailed description of the disclosure categories, or for more information about ASCO's conflict of interest policy, please refer to the Author Disclosure Declaration and the Disclosures of Potential Conflicts of Interest section in Information for Contributors.

Employment or Leadership Position: José Barrueco, Pfizer Inc (C) **Consultant or Advisory Role:** None **Stock Ownership:** None **Honoraria:** Charles S. Fuchs, Pfizer Oncology, Sanofi-aventis, Genentech, Bristol-Myers Squibb Co, Amgen, Imclone Systems Inc, Roche, AstraZeneca; John Marshall, Pfizer, Genentech, Bristol-Myers Squibb Co, Sanofi-aventis, Roche, Amgen, Boerhinger Ingelheim **Research Funding:** Charles S. Fuchs, Pfizer **Expert Testimony:** None **Other Remuneration:** None

REFERENCE

1. Fuchs CS, Marshall J, Mitchell E, et al: Randomized, controlled trial of irinotecan plus infusional, bolus, or oral fluoropyrimidines in first-line treatment of metastatic colorectal cancer: Results from the BICC-C study. J Clin Oncol 25:4779-4786, 2007

DOI: 10.1200/JCO.2007.15.5390

Life Expectancy Estimation by Nomogram

To the Editor: I read with great interest the article by Walz et al[1] introducing a new nomogram predicting 10-year overall survival in men with early prostate cancer. This meritorious study was based on a huge sample with long-term follow-up. The way of patient selection, however, could be a source of bias that clinicians should keep in mind when applying the suggested nomogram. The authors included in the radiotherapy cohort-only patients without any hormonal manipulation. The overall survival curve in the resulting population compares unfavorably with other radiotherapy series[2,4] and even with expectant management series[3,4] and is similar to survival curves in men with severe comorbidity (Charlson score 2 or higher) treated by radiotherapy or expectant management in the pre-PSA–era.[2] It is conceivable that the exclusion of hormonal therapy additionally to radiotherapy selected a sample with a particularly poor prognosis (without clinical failure due to early death of competing causes). Therefore, the results of the study should be interpreted with caution. The conclusion that the developed nomogram may "accurately identify those individuals who do not have sufficient life expectancy to warrant definitive prostate cancer treatment" is possibly too optimistic.

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AUTHOR'S DISCLOSURES OF POTENTIAL CONFLICTS OF INTEREST

The author(s) indicated no potential conflicts of interest.

REFERENCES

1. Walz J, Gallina A, Saad F, et al: A nomogram predicting 10-year life expectancy in candidates for radical prostatectomy or radiotherapy for prostate cancer. J Clin Oncol 25:3576-3581, 2007

2. Barry MJ, Albertsen PC, Bagshaw MA, et al: Outcomes for men with clinically nonmetastatic prostate carcinoma managed with radical prostatectomy, external beam radiotherapy, or expectant management: A retrospective analysis. Cancer 91:2302-2314, 2001

3. Bolla M, Collette L, Blank L, et al: Long-term results with immediate androgen suppression and external irradiation in patients with locally advanced prostate cancer (an EORTC study): A phase III randomised trial. Lancet 360:103-106, 2002

4. Albertsen PC, Hanley JA, Penson DF, et al: 13-year outcomes following treatment for clinically localized prostate cancer in a population based cohort. J Urol 177:932-936, 2007

DOI: 10.1200/JCO.2007.14.5490

Family Physicians Could Help in Predicting Life Expectancy Without Prostate Cancer

To the Editor: Walz et al report on development of yet another nomogram to predict 10-year life expectancy (LE) in patients with localized prostate cancer.[1] In the accompanying editorial, Ross et al ask, "How many more nomograms do we need?"[2]

As family physicians, in the current climate of disorganized care, we find that treatment decisions for prostate cancer are made between the urologist who did the biopsy and the patient. Typically, a date for prostatectomy, or a referral for the radiation oncologist, is determined when the patient visits his urologist after a positive biopsy. The diagnosis of cancer, the bewildering array of treatment choices and their