Compare and contrast

Gaining a better understanding of the cellular mechanisms of cancer; generating ever more sophisticated hypotheses for interventions on these mechanisms; and so developing better-targeted drugs that are more effective against cancer and less harmful for healthy tissues: all worthy objectives for research, among many others.

But when it comes to assessing the clinical benefits of these drugs for patients, the same simple and fundamental questions still apply, even in 2012.

A new cytotoxic drug must be successfully compared with a well-documented standard treatment, not with drugs that are themselves experimental (see the case of *ipilimumab*, this issue, page 145). And when various drugs have already failed, the comparator with the best harm-benefit balance (in addition to appropriate symptomatic treatment) is often a simple placebo, for it is not worth doing harm to patients in the hope of some hypothetical benefit.

This comparison should be based on a simple endpoint appropriate for the specific situation. And in 2012 what matters most for many cancer patients is whether treatment will extend their life expectancy. Concretely, overall mortality is therefore the key endpoint. Giving in to the temptation of sophisticated theoretical arguments about surrogate endpoints ends in patients paying the price, a heavy price, for benefits that are uncertain or even in the end illusory (as in the case of *bevacizumab* in breast cancer, see this issue, page 165).

Using one's imagination and theorizing, all the while remaining alert and firmly grounded in patients' reality, such is the true challenge for clinical research, in oncology and elsewhere.

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