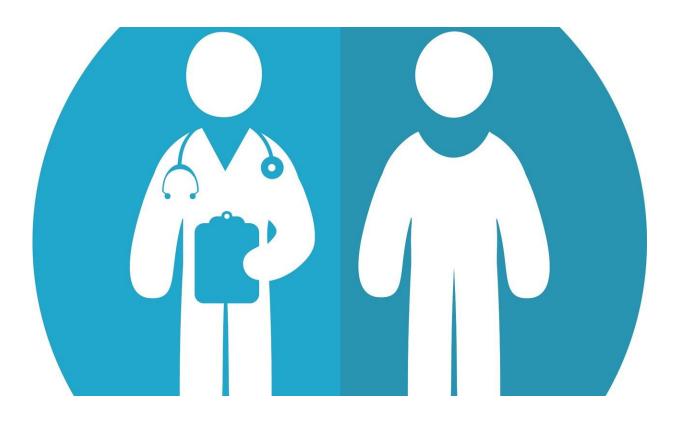


Do randomized cancer trials truly reflect the global burden of cancer?

February 3 2021, by Julie Brown



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Researchers at Queen's University have found that current cancer trial efforts do not match the global burden of deaths from the disease. A new study led by Christopher Booth, Professor in the Department of Oncology and Department of Public Health Sciences and the Canada Research Chair in Populations Cancer Care, is taking a closer look at the



number of randomized clinical trials conducted in high-income countries compared to low-income countries, and what this means in terms of the global fight against the disease. Dr. Booth's international team of researchers included Bishal Gyawali, Assistant Professor, Department of Public Health Sciences and Clinical Fellow, Department of Oncology, and Nazik Hammad, Assistant Professor in the Department of Oncology, and head of the Global Health department.

The study reviewed every <u>randomized controlled trial</u> (RCT) in cancer published during 2014-2017. The cohort of 694 RCTs was predominantly led by oncologists in <u>high-income countries</u> and funded by the pharmaceutical industry. The study finds the <u>trials</u> disproportionately study breast cancer while other cancers, including cervix, gastroesophagel and pancreas, are under-represented even though they account for a substantial proportion of global cancer deaths.

RCTs from low- to middle-income countries were less likely to be funded by the pharmaceutical industry and more likely to identify new treatments that offer substantial benefits to patients. However, <u>clinical</u> <u>trials</u> from these countries were published in lower impact journals.

Dr. Booth says there is an urgent need for global collaboration so that patients can get high-quality cancer care regardless of where they live. "Randomized clinical trials remain the most powerful tool to identify new treatments for patients with cancer" says, Dr.Booth. "While important advances come from trials in high-income countries, if we want to make an impact at the global level we need to learn from the important work that is coming from our colleagues in low-middle income countries."

Dr. Gyawali agrees that high-income and low- to middle-income countries should work together to conduct robust clinical trials that are of mutual relevance and benefit.



"While I was working in Nepal, any expensive new cancer medicine that improved survival by two-three months would be exciting from a scientific point of view but not relevant to the reality of our clinical practice" says Dr. Gyawali. "While it is encouraging to see that lowmiddle income countries are increasingly leading relevant trials, clearly more needs to be done."

Trial benefits

An example of a trial that benefits both high- and low- to middle-income countries is the recent CX.5 Shape Study, carried out by the Canadian Cancer Trials Group (CCTG) at Queen's University. The trial looked into whether a simple hysterectomy is as good as a radical hysterectomy in preventing cancer of the cervix from returning. The study recruited patients from 12 different high- and middle- income countries and the results could have implications for <u>cancer</u> care globally. The CCTG network is made of more than 80 Canadian member institutions, and currently comprises over 2000 Canadian investigators, and 6200 investigators in 22 countries, including low- to <u>middle-income countries</u>. To date, the CCTG had conducted trials with investigators from over 40 countries.

More information: J. Connor Wells et al. An Analysis of Contemporary Oncology Randomized Clinical Trials From Low/Middle-Income vs High-Income Countries, *JAMA Oncology* (2021). <u>DOI:</u> <u>10.1001/jamaoncol.2020.7478</u>

Provided by Queen's University

Citation: Do randomized cancer trials truly reflect the global burden of cancer? (2021, February 3) retrieved 25 April 2024 from



https://medicalxpress.com/news/2021-02-randomized-cancer-trials-global-burden.html

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