

Quality of life - finding **VALUE** in research

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Sarcoma Patients Euronet

50%

Evolution of problems of

Ian Tannock
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The randomised controlled trial
in clinical oncology: colorectal (CRC), and
journals.

We conclude:

1. RCTs in oncology have become larger and are more likely to be sponsored by industry.
2. Increasing size of RCTs does not necessarily mean that benefits might be obtained.
3. There was increasing evidence of publication bias.
4. Effect size remained small.
5. Publication bias is a major problem.
6. Approval of drug based on survival, often free survival, often overall survival.
7. Authors have been known to manipulate conclusions based on selective reporting.
8. Comparison of quality of life between curves is often false.
9. A minority of RCTs evaluate quality-of-life (QL) even for patients with incurable cancer and the quality of QL assessment has been poor.
10. There is under reporting of harm in RCTs, important side effects are often identified after drug approval.
11. Cost-effectiveness is almost never addressed, and the cost of treatment has increased >100 fold.

Evolution of the cancer clinical trial over three decades: problems of design, analysis, reporting and interpretation

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NATURE | OUTLOOK

Perspective: The precision-oncology illusion

Vinay Prasad

Nature
Publish

Does the rhetoric so far outpace the reality that we risk fooling even ourselves?

PDF

Citation

Reprints

to work, and perhaps it never will

Value =
Variations in
Actual
Life and
Usual
Experience

Fewer tools, easier to use

Compare outcomes between studies in same disease

Aggregate data

Longitudinal studies in standard care

Identify trends and pathways using 'big data'

Feedback data to patients – treatment benefits

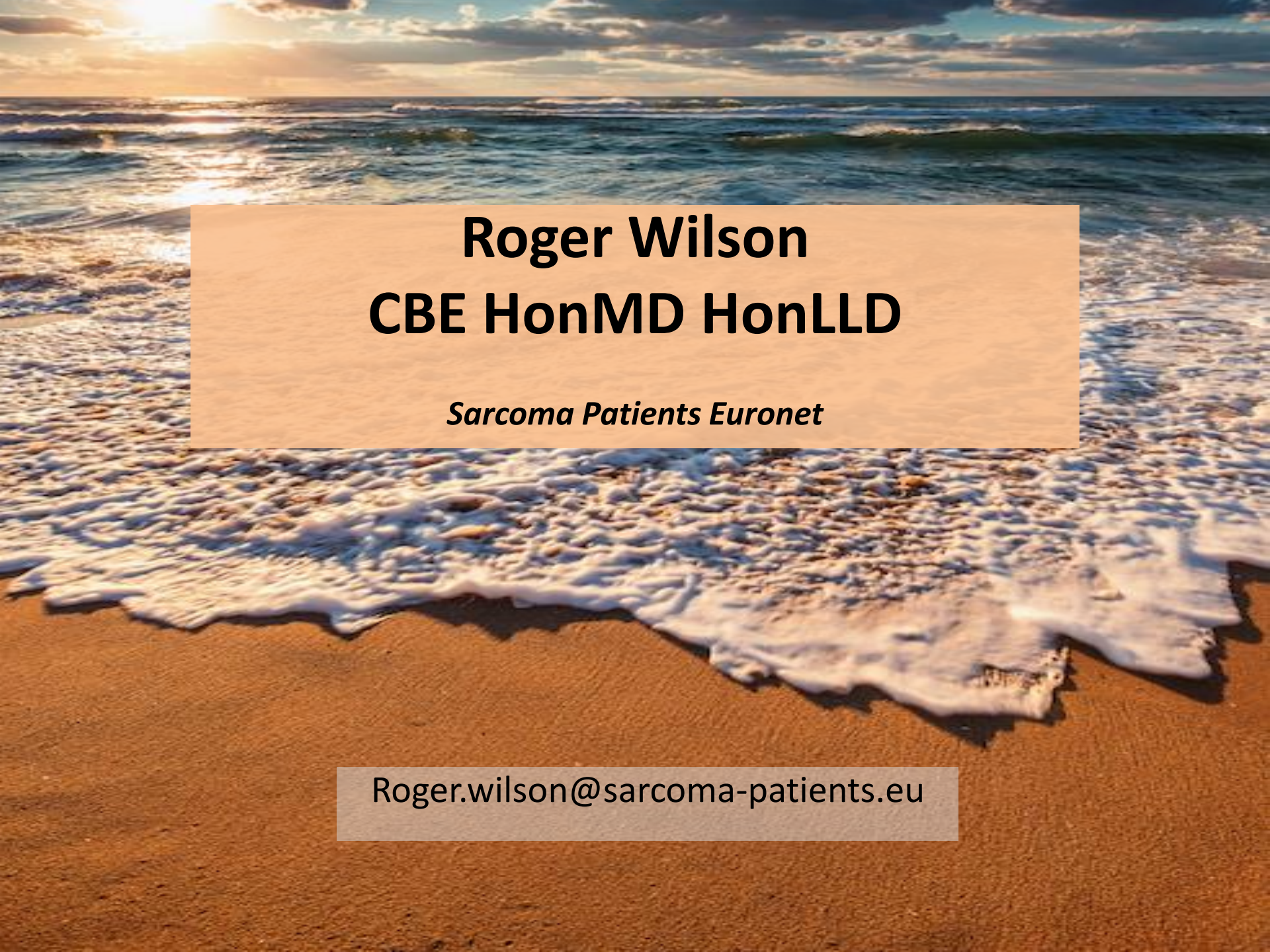
Make it impossible to 'hide' side effects

Regulators could manage interim approvals





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