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LETTER TO THE EDITOR
CHEMORADIOTHERAPY IN HIGH-GRADE GLIOMAS

Adjuvant or concurrent chemotherapy with radiotherapy is a widely used treatment modality for high-grade gliomas. Despite modifications in the doses and techniques of radiotherapy, dismal results have persisted in the last decades. Corsa *et al.*[1] reported promising results with temozolomide in their retrospective study. As there is a lack of this kind of chemoradiotherapy studies with novel agents, the work by Corsa *et al.* is very useful to highlight a number of issues. However, the study has a few drawbacks. If it were possible to randomize patients with the same tumor histology rather than using historical controls, it might be possible to draw more definitive conclusions. There are also some points to be clarified. Ten patients did not receive the planned dose. Were those patients included in the control group? There was a 6.25% difference between the complete resection rates of the chemoradiotherapy arm and the control arm. Brandes suggests that the extent of surgery has a significant effect on survival[2].

The authors found that age is a significant factor for survival, which is consistent with the literature[3]. However, performance status can also be a significant factor[3]. Some of the patients received a lower dose than the effective dose due to their poor performance status, and the authors should have stressed this point. In conclusion, more studies with a prospective design should be performed to obtain more definitive results.

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IN REPLY

We agree with Dr Ulutin that randomized trials provide the opportunity to draw more definitive conclusions. Moreover, we would like to stress that the aim of our study was to retrospectively review our experience, in order to determine if the introduction of temozolomide (TMZ) combined with radiotherapy (RT) in the clinical practice had improved the outcome of our patients. Following encouraging preliminary experiences[2], in January 1997 we started to treat patients affected by high-grade gliomas with a multimodality schedule including TMZ and RT. Successively, a multicenter randomized trial demonstrated a significant survival benefit with this regimen and the data on our patients are in line with these results[3].

Regarding the first point of Ulutin's letter: As reported in Table 2 of the article, patients receiving a dose <60 Gy because of their low Karnofsky index at the beginning of RT, disease progression during RT, or the patient's own request are well balanced between the 2 groups (10 in the RT+TMZ group and 9 in the RT alone group).

With regard to the second point, several reports suggest that the extent of surgery has a significant effect on survival[4]. Analysis of Table 2 shows that in our series 22 patients in the RT+TMZ group and 18 in the RT alone group underwent a complete resection, but this did not result in a statistically significant difference in a population of 128 patients.

Finally, 4 of the 19 patients receiving a dose <60 Gy (2 in the RT+TMZ group and 2 in the RT alone group) had a low performance status at the beginning of RT. In these patients hypofractionated RT (45 Gy in 15 fractions of 3 Gy each in 3 patients and 35 Gy in 10 fractions of 3.5 Gy each in 1 patient) was planned and performed in order to reduce the treatment time.

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