We agree with Rana et al that the sensitivity and specificity of sP-selectin is low, which is also true for any other biomarker that has been reported to be associated with VTE risk. However, this was not a diagnostic study but an observational study with the aim to investigate predictive parameters associated with the risk of VTE in cancer patients. We think that sP-selectin might help to detect a cohort of cancer patients at high risk of VTE, although we are fully aware that the positive predictive value for an individual patient is rather low.

Finally, based on results of this study, we concluded that measurement of sP-selectin at diagnosis of cancer would help identify cancer patients at increased risk for VTE. However, we are in line with Rana and colleagues that our results require validation in a larger prospective cohort study. Furthermore, the benefit of prophylactic anticoagulant treatment for cancer patients with high levels of sP-selectin needs to be evaluated in appropriately designed randomized controlled trials. Currently, P-selectin may not yet be ready for “prime time,” but the promising results of CATS justify P-selectin to be aired shortly before prime time.

Cihan Ay and Ingrid Pabinger

Conflict-of-interest disclosure: The authors declare no competing financial interests.

Correspondence: Prof Dr Ingrid Pabinger, Professor of Haemostaseology, Clinical Division of Haematology and Haemostaseology, Department of Medicine I, Medical University of Vienna, Waehringer Guertel 18-20, A-1090 Vienna, Austria; e-mail: ingrid.pabinger@meduniwien.ac.at.

References


To the editor:

Insurance policies in the United States may explain part of the outcome differences of adolescents and young adults with acute lymphoblastic leukemia treated on adult versus pediatric regimens

In their excellent analysis, Stock et al investigated the outcome of adolescents and young adults (AYAs) with acute lymphoblastic leukemia (ALL) treated on adult (CALGB) versus pediatric regimens (CCG). They reported that the outcomes of AYAs 16 and 17 years of age were similar on CALGB and CCG programs. However, for AYAs 18 to 20 years of age (80% of CALGB vs 15% of CCG), survival was significantly worse with CALGB versus CCG programs (7-year event-free survival [EFS] 29% vs 57%). The 7-year EFS of 29% on CALGB programs is likely worse than the EFS of older patients (age 20-30 years). Stock et al discuss potential explanations including clinical and demographic differences, differences in protocol design and dose intensity, and variations in the degree of adherence to protocols.

One potential issue not highlighted is that part of the difference in outcome might be related to current insurance issues in the United States. It is estimated that 40 to 50 million US citizens do not have insurance, and another 50 million have suboptimal insurance that is useless when a catastrophic illness like ALL is diagnosed. Most people at risk are younger patients who are transitioning from the umbrella of their parents’ insurance coverage to their own. Younger individuals are more likely not to have acquired their own insurance during this transition period as AYAs. This would explain why the outcome of AYAs 16 and 17 years of age, who are likely still covered by their parents’ insurance, is similar on CALGB versus CCG programs, whereas the outcome of AYAs 18 to 20 years of age is worse on CALGB programs (patients already independent from their parents’ supervision and insurance) than on CCG programs (patients likely still covered by their parents’ insurance). This is explained in the discussion by Stock et al as “emancipated adolescents,” but it could be simply that those adolescents are “emancipated from insurance.” This would also explain why adherence to postinduction consolidation long-term maintenance among patients achieving complete response was 81% (126/175 patients) on CCG regimens versus only 63% (75/112 patients) on CALGB programs. The reverse would have been expected, because pediatric regimens are more intensive, thus resulting in higher dropout rates. AYAs on CALGB regimens, having potentially poor insurance, could not continue on maintenance therapy after achievement of a remission.

It would be very instructive if Stock et al could analyze the patterns of insurance policies of AYAs with ALL treated on CCG versus CALGB programs. This will add tremendous value to the analysis and may allow the creation of better future health care policies for patients who may develop catastrophic illnesses.

Hagop M. Kantarjian and Susan O’Brien

Conflict-of-interest disclosure: The authors declare no competing financial interests.

Correspondence: Hagop M. Kantarjian, MD, Department of Leukemia, The University of Texas M. D. Anderson Cancer Center, Houston, TX 77030; e-mail: hkantarj@mdanderson.org.

Reference

Insurance policies in the United States may explain part of the outcome differences of adolescents and young adults with acute lymphoblastic leukemia treated on adult versus pediatric regimens

Hagop M. Kantarjian and Susan O'Brien