agree with his contention that treatment decisions cannot be based solely on molecular data without considering clinical context. In fact, in our review, we clearly state that despite improvements in molecular prognostication in CLL, indications to initiate therapy remain based on the International Working Group Criteria (IW-CLL) that rely heavily on clinical presentation, disease burden, and stage, without molecular data.1 Having said that, we believe that this is an evolving process that is likely to change in the years ahead. In the era of precision medicine, targeted therapies, and better understanding of the underlying disease biology, it would be critical to tailor intervention to the underlying biological process that might have led to disease development. Yavorkovsky specifically discusses 17p13.1 deletion, stating that the presence of this deletion does not necessarily predict poor prognosis. Actually, in our review, we cited the same reference that Yavorkovsky cites and suggested that some patients with 17p13.1 deletion could potentially enjoy an indolent course.2 Furthermore, we emphasized that the presence of this deletion should not lead to treatment initiation in the absence of any of the aforementioned IW-CLL criteria. However, these patients should be closely monitored because they might have increased risk of early disease progression. Moreover, as new therapies such as ibrutinib, idelalisib, and venetoclax have demonstrated significant activity in 17p13.1-deleted patients,3 clinical trials are now ongoing to explore whether early initiation of treatment in asymptomatic patients with this deletion is warranted. We clearly stated that none of the regulatory bodies recommend early treatment initiation outside the context of clinical trials. We agree with Yavorkovsky that guidelines should simply be suggestions on how best to approach a disease and should never replace clinical judgment and experience. While Yavorkovsky suggests that European recommendations that advocate against molecular testing are welcome, we propose that these recommendations were generated in an era in which treatments that target higher-risk disease molecularly were not available. Molecular testing not only aids in a better discussion with patients but also can guide treatment decisions in the future once management is indicated clinically.

In summary, we agree with Yavorkovsky that treating asymptomatic patients regardless of their molecular profile is currently not recommended outside clinical trials, and we emphasized this notion throughout our review. However, we disagree that testing is not needed and suggest that knowing more about the biological characteristics of a disease is only destined to help patients if used properly and judiciously. Finally, and similar to other malignant neoplasms, it is more likely than not that treatment decisions for CLL in the years ahead will be based on molecular information that supplements clinical data to aid in decision making.

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CORRECTION

Incorrect Author Name Spelling: In the Special Communication titled “Improving Patient Safety in Clinical Oncology: Applying Lessons From Normal Accident Theory” published in the May 14, 2015, online issue of JAMA Oncology (10.1001/jamaoncol.2015.0891), an author’s name was misspelled. The correct spelling is Ian Buchanan, MD, MPH. This article was corrected online.

Error in Figure: There was an error in the Figure in the Original Investigation by Guérin et al,1 “Physician Underestimation of the Risk of Gastrointestinal Stromal Tumor Recurrence After Resection,” published online in JAMA Oncology on July 23, 2015. The treatment durations at the bottom of the figure, <3 y and ≥3 y, should have been set as ≥3 y and <3 y (the symbols were reversed). The article was corrected online.


Error in Data Presentation in Figure: In the Research Letter “Efficacy of Prostate-Specific Antigen Screening: Use of Regression Discontinuity in the PLCO Cancer Screening Trial,” published online August 20, 2015, there was an error in panel D of the Figure. The scale of the y-axis should have been 1 through 5 instead of 10 through 50. This article was corrected online.