targeting agents because of potential false responses owing to their effect on contrast uptake. Therefore, further value is added if the response is maintained for a meaningful duration. Longer DOR has been consistently noted following anti-programmed cell death 1 (PD-1) therapy across tumor types, explained by generation of polyclonal and memory-adaptive tumor immunity. Therefore, DOR is an increasingly important end point, in addition to ORR, for evaluating the efficacy and long-term clinical benefit of immunotherapy. Given the above rationale, we presented a descriptive summary of DOR.

We agree with McCaw et al that the differing response rates between arms and the small number of responders may cause a potential bias in case of imbalance in baseline disease burden in responding patients. Although our study did not collect overall baseline disease burden, we conducted a post hoc evaluation of tumor location and the number of sites with lesions at baseline (data not presented). While there was no difference in the tumor location distribution between the arms, all responders in the nivolumab arm (n = 12) had only 1 site involved, while 78% (n = 28) of responders in the bevacizumab arm had 1 site involved and 22% (n = 8) had 2 sites involved. However, the median DOR in the bevacizumab arm was similar between patients with 1 and 2 sites involved. Additionally, the median DOR for responders to nivolumab in CA209-143 is longer than that typically observed with salvage agents, such as lomustine or temozolomide rechallenge (NCT00392171), and surpassed that achieved by bevacizumab, suggesting that PD-1 inhibition may offer longer-term clinical benefit among glioblastoma responders.

We also acknowledge the concerns of dependent censoring. However, in the current study, because of the length of follow-up, there were very few censored participants remaining. Thus, dependent censoring may have minimal influence on this descriptive analysis.

We also evaluated the median DOR while including both responders and nonresponders. However, given the high numbers of nonresponders, this method only yields the value of zero for both treatment arms, which may be less informative to clinicians.

Given the totality of the clinical, mechanistic, and statistical rationales presented above, we conclude that there is value to reporting median DOR in a descriptive manner, while acknowledging the caveats discussed here and by McCaw et al. Additional research in a larger patient population may be needed to further evaluate the value of the DOR benefit in patients with glioblastoma treated with immunotherapy. Better understanding of patient and treatment characteristics among those who achieve a durable DOR may help guide improvement of the efficacy of immunotherapy in a patient population with an urgent need for better treatments.

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Letters

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Our second concern is related to the sex bias in SARS-CoV-2 infection in children, as a large number of studies have reported that this infection is unrelated to sex. The major reason for obvious sex bias in SARS-CoV-2 infection may be due to the limited number of children involved in this study. Considering that this study was done without preplanned analysis, the findings are post hoc, and further large-scale definitive studies are urgently needed.

Taken together, the article by Boulad et al is undoubtedly an important contribution to the status quo of COVID-19 infection in children with cancer and is worthy of public attention worldwide. However, the findings of this study should be generalized with caution because it was based on an inadequate number of eligible pediatric patients with cancer, posing a challenging task before translating retrospective observations into meaningful health care interventions at the population level.

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In Reply We thank Zhang et al for their interest in our Research Letter regarding coronavirus disease 2019 (COVID-19) in children with cancer in New York City1 and for their comments. In terms of the first concern, we agree that different types of pediatric cancer are pathophysiologically different, are treated differently, and may have different degrees of immune suppression. Since publication of the article, the MSK Kids pediatric program at Memorial Sloan Kettering Cancer Center has now cared for 34 patients who tested positive for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), of 465 unique patients tested. Their diagnoses were as follows: sarcoma (n = 14), leukemia/lymphoma (n = 12), neuroblastoma (n = 3), Wilms tumor (n = 1), astrocytoma (n = 1), and nonmalignant hematologic and immune disorders (n = 3). Four patients were post-transplant. To the specific inquiry from Zhang et al about COVID-19 mortality, there were no deaths due to COVID-19 in the 34 patients. Unfortunately, with such small numbers, further subgroup analyses are not statistically rigorous.

With regard to the second concern regarding sex differences, we agree that this comparison was not preplanned; however, our analysis adequately controlled for type I error. Small sample size most negatively affects the power of a comparison, whereas statistical significance tends to increase with an increasing sample size. To this point, reassessing the updated patient numbers referenced above (nearly double the initial published numbers), 76% of the SARS-CoV-2–positive patients were male (26 of 34), compared with 52% of the patients who tested negative (223 of 431; Fisher exact test P = .007), reinforcing the observed sex difference in a larger sample and with even higher statistical significance (originally P = .02). We also note that the articles referenced by Zhang et al focused on adult patients with cancer or did not provide primary data on pediatric patients. We note that studies specifically focusing on children with SARS-CoV-2 infection found a preponderance of males with 64% (23 of 36) in one case and 61% (104 of 171) in the other. We concur that data in pediatric patients with cancer do not represent children in general, but we do believe that data in pediatric patients with cancer are biologically more representative of children than extrapolation from adult data and agree that these results should be validated in larger population-level studies.

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