sarcoma population is a major challenge for all early-phase "doxorubicin + X" trials.[4] Although this study was different in allowing participation by patients with chondrosarcoma, the histologic distribution of this trial is otherwise very similar to other major doxorubicin + X trials.

While other histologic subtypes included may be indolent, these may also behave quite aggressively in certain cases. For example, epithelioid hemangioendothelioma is often considered indolent, but 1 patient with epithelioid hemangioendothelioma enrolled had one of the most aggressive clinical courses.[1] All patients treated on the trial had advanced sarcoma and would be considered to receive doxorubicin as standard therapy, with the exception of chondrosarcoma, for which cytotoxic chemotherapy is often considered controversial because these tumors are frequently chemoresistant. The objective response rate in our study was 13% for phase 2 patients and 19% overall,[1] consistent with previously reported response rates for doxorubicin monotherapy.[4]

We agree that improved biomarkers are crucial, and many investigators are looking at markers for checkpoint inhibitor response in sarcoma, including B-cell infiltration and tumor mutation burden. Microsatellite instability is seen rarely among patients with sarcoma.[5] The possibility of pseudoprogression was considered. However, our analysis showed that patients with early progression had rapidly progressing tumors prior to enrollment and did not meet the criteria for pseudoprogression.[6]

Future studies among patients with sarcoma using a similar design may benefit from a larger sample size, although this may cost significant resources, both financial and with respect to patient accrual. The adoption of biomarker-driven and histologic subtype-driven trials, when feasible, can likely enable the use of smaller sample sizes while also ensuring more informative results.

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CORRECTION

Errors in Article Text: In the Viewpoint titled "Drug-Radiotherapy Combinations in 2020—a Landmark Year?"[1] published online on December 3, 2020, it was incorrectly implied that there have been recent approvals of cancer drugs for use with radiation, and an incorrect date was given for a workshop. This article was corrected online.

1. Walker AJ, DeWeese TL, Viswanathan AN. Drug-radiotherapy combinations in 2020—a landmark year? *JAMA Oncol*. Published online December 3, 2020. doi:10.1001/jamaoncol.2020.6139

Data Errors in Abstract and Results Section: In the article titled "Efficacy of Capecitabine Plus Irinotecan vs Irinotecan Monotherapy as Second-line Treatment in Patients With Advanced Gallbladder Cancer: A Multicenter Phase 2 Randomized Clinical Trial (GB-SELECT)"[1] published online December 3, 2020, in *JAMA Oncology*, there was incorrect data presented in the Abstract and Results section regarding the number of deaths at 6 months, 6-month OS, and median OS. This article was corrected online.

1. Ramaswamy A, Ostwal V, Sharma A, et al. Efficacy of capecitabine plus irinotecan vs irinotecan monotherapy as second-line treatment in patients with advanced gallbladder cancer: a multicenter phase 2 randomized clinical trial (GB-SELECT). *JAMA Oncol*. Published online December 3, 2020. doi:10.1001/jamaoncol.2020.6166

Error in Coauthor's Affiliation: The Original Investigation titled "Global, Regional, and National Cancer Incidence, Mortality, Years of Life Lost, Years Lived With Disability, and Disability-Adjusted Life-Years for 29 Cancer Groups, 1990 to 2017: A Systemic Analysis for the Global Burden of Disease Study,"[1] published in the December 2019 issue of *JAMA Oncology*, contained an error in a coauthor's affiliation. The correct affiliation for coauthor Sameh Magdeldin, PhD, is Proteomics and Metabolomics Unit, Children Cancer Hospital, Cairo, Egypt. This article was corrected online. This article was also corrected on April 9, 2020, to fix an error in a coauthor's affiliation and on March 12, 2020, to fix errors in coauthors' names and an affiliation, Table data, Figure data, and the Supplement.

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