Beaten at the Alamo by the Europeans

Trend-spotters looking back at 2010 have noted it as a year of lament over clinical trials in the United States, particularly in oncology. A widely cited Institute of Medicine report¹ called for reinvigorating cooperative groups. Documenting need for reform, a study of the activation of phase III clinical trials in the NCI system revealed over 750 separate steps, 36 approval stages, and median 2.5 years to activation.² Clearly, that process will not encourage investigators, clinical cancer centers, or pharmaceutical or other sponsors to engage more actively in clinical research. Moving into 2011, plans are afoot for a dramatic overhaul and consolidation of the cooperative groups.

In addition, gains in accrual to European-based clinical trials have been well publicized. Reports suggest superior accrual in Europe to clinical trials in lymphoma and stem cell therapies. On a population basis, European oncologists have been accruing better to clinical trials than have American oncologists.

Reports at the 2010 San Antonio Breast Cancer Symposium brought home the power of that improved accrual. The major results were dominated by out-of-U.S. clinical trials. A series of large, provocative, biologically-based neoadjuvant studies (neoALTTO, neoSPHERE, GeparQuinto) were presented on behalf of European investigators. The negative AZURE study originated in the United Kingdom, and the negative MA27 study, which included the U.S. Intergroup, originated in NCI-Canada. Texas hosted a triumph for out-of-U.S. oncology.

Part of the problem is an overly burdened study approval process in the United States. A recent study compared lung cancer clinical trial activation and accrual at 2 centers—one in the United State and one in Italy.³ The American center had longer times to submission and activation, longer times to first accrual, longer times to contract approvals, and lower accrual per study.

Regulatory processes, however, can only account for some of the differences in accrual among cancer centers and countries. In many European and Canadian areas, cancer care is delivered in regionalized centers, while private practice models, with their mixed incentives for clinical trial participation, are less of a factor. Many European specialists can reach an “internal consensus” that facilitates trial accrual when broad agreement on treatment patterns can be achieved. In addition, European studies often represent closer allegiances between investigators and pharmaceutical sponsors than is seen in many large U.S. trials. In the study by Wang-Gillam et al.,³ the trials in Italy were quicker off the mark but were also far more likely to be industry sponsored and less likely to be initiated by an institutional or cooperative group.

Much reform is needed to facilitate greater trial access and participation in the United States. Various initiatives are needed, including changes in local and federal policy to speed up study activation and changes in the culture of care to encourage more doctors and patients to participate. Maybe some of these changes will start in 2011. Until they do, look for more presentations from our international colleagues.

References

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