In Reply We appreciate the opportunity to expand on our methodology, which was not possible due to limited word count in the Research Letter. In this study, we used 2 variables in the National Cancer Data Base to discern whether androgen deprivation therapy (ADT) was given as part of first-course treatment. First, RX_SUMM_HORMONE indicated whether ADT was part of first-course treatment. Also, we used DX_HORMONE_STARTED_DAYS and defined concurrent ADT as patients who initiated ADT before or on the same day as start of radiotherapy. We feel that this definition of concurrent ADT with radiotherapy is clinically accurate. Allowing ADT to start 180 days after start of radiotherapy, as Dalela and colleagues did, may have mistakenly included some patients in the analysis who did not actually have “concurrent” ADT throughout the course of radiation treatment.

We agree with Dalela et al that clinical trial evidence has affected clinical practice in prostate cancer. An initial randomized trial that demonstrated an overall survival benefit from adding ADT to radiotherapy for intermediate-risk prostate cancer was published in 2004,1 coinciding with the first year of our patient inclusion. Randomized trials showing a survival benefit from adding ADT to radiotherapy for high-risk patients were initially published in 1997 through 2005.2-4 Yet, to this date, no randomized trial has shown a survival benefit from dose escalation. In our article, we demonstrated that the uptake of ADT was more modest than the uptake of dose escalation.

Aaron D. Falchook, MD
Ramsankar Basak, PhD
Ronald C. Chen, MD, MPH

Author Affiliations: Department of Radiation Oncology, University of North Carolina at Chapel Hill, Chapel Hill (Falchook, Basak, Chen); Lineberger Comprehensive Cancer Center, Chapel Hill, North Carolina (Chen); Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill, Chapel Hill (Chen).

Corresponding Author: Ronald C. Chen, MD, MPH, Department of Radiation Oncology, University of North Carolina at Chapel Hill, CB 7512, Chapel Hill, NC 27599 (ronald_chen@med.unc.edu).

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