Cough-awareness campaign increases lung cancer diagnoses

An awareness campaign that ran in England in 2012 urging people with a cough for 3 weeks to see their doctor resulted in a significant increase in the number of people diagnosed with lung cancer and in surgical resections compared with a control period, figures show.

Analysis of the National Lung Cancer Audit showed that around 700 more cases of lung cancer were diagnosed during May and June, 2012, when Public Health England ran the Be Clear on Cancer campaign (a total of 8335 cases), compared with the same months in 2011, when the number of cases was 7639. By contrast, there was no significant change during the control 3 month period before the campaign compared with the same time the previous year (7636 *vs* 7404).

Results showed a statistically significant 3·6% increase in the proportion of patients with non-small-cell lung cancer diagnosed at an early stage (stages I and II) during the campaign months (1840 of 6831 cases) compared with the same period in 2011 (1424 of 6092 cases). There was also a 2·3% increase in the proportion of patients undergoing surgical resection as a first definitive treatment (1331 of 8335 cases in May–July, 2012, *vs* 1043 of 7639 cases in May–July, 2011).

"Late diagnosis is a key factor in poor outcomes for lung cancer patients", points out Jesme Fox, medical director of the Roy Castle Lung Cancer Foundation. "What is really encouraging with these results is that not only has awareness been raised, but, for the first time we see an increase in numbers diagnosed at early stage and also more patients offered surgery." The Foundation has asked that the campaign be repeated on an ongoing basis to maintain awareness.

"Low public awareness almost certainly contributes to late diagnosis of lung cancer", agrees Stephen Spiro, deputy chairman and vice-chair of the British Lung Foundation and honorary consultant physician at University College Hospitals London. He suggests that the fact that general practitioners see an average of only 0·8 new cases of lung cancer a year is also a factor in late diagnosis. "The message to GPs is to have a low threshold for sending people for investigation of lung cancer", he suggests, adding that CT scans pick up around four times as many lung cancers as do radiographs.

Susan Mayor

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For more about the **effects of the campaign** see www.cancerresearchuk.org/about-us/cancer-news/press-release/early-trip-to-the-gp-gives-big-boost-to-lung-cancer-patients

For the **Be Clear on Cancer campaign** see www.cancerresearchuk.org/cancer-info/spotcancerearly/naedi/beclearoncancer/

For the **National Lung Cancer Audit** see www.hscic.gov.uk/lung

Dasatinib as first-line therapy for CML-CP

Findings from the DASISION trial have shown that first-line dasatinib produced faster and deeper cytogenetic and molecular responses than did imatinib in patients with previously untreated Philadelphia-chromosome-positive chronic myeloid leukaemia in chronic phase (CML-CP). After 3 years of follow-up, progression-free and overall survival were similar for both treatment groups, as was survival without transformation to accelerated phase or blast phase.

The international phase 3 study compared imatinib, a first-generation tyrosine-kinase inhibitor (TKI) targeting the product of the Philadelphia chromosome, with the second-generation TKI dasatinib. 519 newly diagnosed patients with CML-CP were randomised 1:1 to receive a once-daily oral dose of imatinib (400 mg) or dasatinib (100 mg), for a median duration of 36·8 months (range 0·03–49·7 months).

At the 3 year follow-up, cytogenetic and molecular response rates remained higher for dasatinib than for imatinib, with a statistically significant difference in cumulative incidence of major molecular response ($p<0·0001$). Except for pleural effusion associated with dasatinib, non-haematological adverse events were comparable between treatment groups or were lower for dasatinib. Grade 3–4 adverse events were similar for both treatment groups, except for thrombocytopenia (19% of patients treated with dasatinib *vs* 11% with imatinib) and hypophosphatemia (7% *vs* 28%).

First author Elias Jabbour (University of Texas MD Anderson Cancer Center, Houston, TX, USA) said, "People may say that there is no difference in survival between treatment arms; however, the endpoint of survival is not realistic, since it is 25 years or longer. So, a surrogate endpoint is needed. Dasatinib induces faster and deeper responses than imatinib; the achievement of an early optimal response is crucial for the long-term outcome." He added, "The safety profile is very acceptable with no significantly relevant cardiovascular toxicities; in addition, it is easy to use, given once daily."

Jerald Radich (Fred Hutchinson Cancer Research Center, Seattle, WA, USA) commented on the future use of first-generation and second-generation TKIs: "Soon imatinib will become generic. So there might be two approaches. Start with the generic drug and switch to one of the stronger second-generation drugs if the patient doesn't respond well. Or, start with the stronger second-generation drug, and once a molecular response has occurred, switch to the cheaper drug for maintenance. Hopefully some clinical trials will show us the best approach."

Judith A Gilbert

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For the **DASISION trial** see *Blood* 2013; published online December 5. http://dx.doi.org/10.1182/blood-2013-06-511592