Authors’ reply

We thank Gerard Hanna and colleagues for their interest in our study, and agree it raises questions about the best sequence of treatments for patients with operable non-small-cell lung cancer.

We found no difference in the number of complete resections between patients receiving chemotherapy compared with those receiving immediate surgery. Equally, although the numbers of patients are small, we found no increase in the number of incomplete resections for patients receiving chemotherapy, although this finding was not clearly reported.

Unfortunately, with the data we have collected, we cannot reliably distinguish between disease progression and disease recurrence. As described in our paper, the data on recurrence were analysed using a landmark date of 6 months. This allows for all patients to have completed their treatment. However, if we look at the crude rates of local recurrence by treatment group within the 6 months following randomisation (when treatment for those receiving preoperative chemotherapy would be ongoing), there is no excess of events in the chemotherapy group (6%) compared with the surgery group (5%). This is despite 25% of all local recurrences (as first events) being recorded during this period.

It should be borne in mind that patients included here have been staged using older, less accurate methods than those used today. Patients seemingly progressing on preoperative chemotherapy might reflect the presence of metastatic disease at the time of randomisation. In the surgery-only group, these patients would likely have been categorised as having a recurrence when in reality they should also be regarded as having progressed.

These findings are based on limited data, but taken together they do not suggest an increase in the number of progressions in the chemotherapy group or operable tumours becoming inoperable during preoperative chemotherapy. Overall there is still an absolute survival improvement of 5% for patients receiving preoperative chemotherapy and this approach might allow chemosensitivity testing of the tumour to avoid ineffective treatment after surgery.

There are different potential reasons for giving either preoperative or postoperative chemotherapy in this setting. Patients selected for preoperative chemotherapy are more likely to have a better prognosis than those selected for postoperative chemotherapy, because unfit patients and patients with incomplete resection would be excluded. Our research hopefully reassures those treating patients that preoperative chemotherapy is better than surgery alone with a benefit size comparable to that of postoperative chemotherapy.

Further investigations of these treatments might be warranted to explore whether certain patients benefit more or less from either preoperative or postoperative chemotherapy or indeed, a combination of both.

We declare no competing interests.

*Sarah Burdett, Larysa HM Rydzewska, Jayne F Tierney, Anne Auperin, Jean-Pierre Pignon, Cécile Le Pechoux, Thierry Le Chevalier, Jan van Meerbeck

MRC Clinical Trials Unit at UCL, London WC2B 6NH, UK (SB, LHR, JFT); Service de Biostatistique et d’Épidémiologie, Institut Gustave-Roussy, Villejuif, France (AA, J-PP, CLP, TLC); and University Hospital Antwerp, Antwerp, Belgium (JvM)


Standardised packaging and tobacco-industry-funded research

We recently assessed the (possible) effect of plain packaging on the smoking behaviour of young Australian individuals (aged 14–17 years). Our conclusion was that there is no evidence that plain packaging has lowered smoking prevalence among young Australians.

Our study has been criticised by Anthony Laverty and colleagues (April 19, p 1384). They state that “in view of the short time span since the measure was introduced, the variability in the measure, and the small sample size” failing to find any evidence for a plain packaging effect “is neither an unexpected nor a meaningful conclusion.” On the basis of a reasoning that is not explained in sufficient detail, they further claim that a reduction of 1.25 percentage points “would be required to be statistically significant using this analysis.”

First, any actual reduction will only turn out to be statistically significant with a certain probability, and this probability is known as the power of the test. Therefore, the authors need to attach a power (number) to the specific effect of 1-25 percentage points (unless they have a power of 1 in mind, which is unrealistic).

Second, an effect as large as 1-25 percentage points is not needed to be detected with any reasonable power. For example, power against a reduction of 0.5 percentage points is about 0.65; power against a reduction of 1.0 percentage point is about 0.80; and power against a reduction of 1-25 percentage points about 0.85. Power of 0.8 is a commonly accepted industry standard, so even
Hypertension in populations of different ethnic origins

In their recent Editorial Hypertension: an urgent need for global control and prevention (May 31, p 1861), the Lancet’s Editors highlight the global need to address high blood pressure—the leading risk factor for mortality worldwide. This is particularly urgent in low-income and middle-income countries where prevalence is increasing. Present treatment guidelines, however, are largely based on white populations whereas evidence suggests that cardiovascular disease varies with ethnic origin. South Asian populations, for example, have higher death rates from ischaemic heart disease at young ages compared with Western countries; Hispanic populations might achieve better blood pressure control with less treatment compared with non-Hispanic groups. Thresholds for treatment, blood pressure targets, and antihypertensive regimens might differ between ethnic groups. Despite differences in general guidelines, the Eighth Joint National Committee (JNC8), American and International Societies of Hypertension, and European Society of Hypertension/European Society of Cardiology all provided specific recommendations for black individuals. Ethnic variations could have implications for polypills and other initiatives to streamline management in low-income and middle-income settings, such as the Global Standardized Hypertension Treatment Project.

Good quality data on hypertension in different ethnic populations are missing. Of the more than 180 studies that met the JNC8’s standards for inclusion, fewer than 30 include analyses of non-white, non-black groups. Ethnic variations might achieve better blood pressure control with less treatment compared with non-Hispanic populations. Despite differences in general guidelines, the Eighth Joint National Committee (JNC8), American and International Societies of Hypertension, and European Society of Hypertension/European Society of Cardiology all provided specific recommendations for black individuals.5–7 Ethnic variations could have implications for polypills and other initiatives to streamline management in low-income and middle-income settings, such as the Global Standardized Hypertension Treatment Project.

We declare no competing interests.

*Ranu S Dhillon, Kiran Clair, Max Fraden, Marwah Abdalla rdshillon@partners.org
Division of Global Health Equity, Brigham and Women’s Hospital, Boston, MA 02115, USA (RSD); Earth Institute, Columbia University, New York, NY, USA (RSD); Department of Obstetrics and Gynecology, University of California Irvine, Orange, CA, USA (KC); Department of Medicine, Dartmouth Hitchcock Medical Center, Lebanon, NH, USA (MF); and Division of Cardiology, Department of Medicine, Columbia University Medical Center, New York, NY, USA (MA)