From the Editor

In this issue, we present a diverse range of perspectives as well as an original study. Dr Crawford and his colleagues hypothesize an important role for follicle-stimulating hormone (FSH) in prostate cancer. Co-author Andrew Schally was awarded the Nobel Prize in 1977 for his discovery and description of gonadotropin-releasing hormone (GnRH) and its complex control of the gonadal endocrine system through its regulation of FSH and its effects on androgens, estrogens, and the ovulatory cycle. The FSH receptor is expressed on prostate and other cancers as well as tumor-associated vasculature, and drives angiogenic and other cancer-associated pathways. This may have consequence in the context of androgen-deprivation therapies, as GnRH antagonists lead to long-term suppression of FSH, whereas GnRH agonists appear to cause FSH levels to drop and then drift upward over time.

The prototypic serum marker CA 125 has long been used to detect and monitor ovarian cancer. Its strengths and limitations in different scenarios are detailed by Dr Pepin and colleagues, including the low predictive value for screening, but with newer ongoing studies assessing serial determinations that could make the test more useful. In particular, there is a lack of utility in surveillance following chemotherapy remissions demonstrated in a randomized trial, where the arm using CA 125 to guide a change in therapy actually had more chemotherapy side effects without a gain in survival. A mini-review on the role of chemotherapy in prostate cancer provides a historical overview of older chemotherapy agents all the way up to the most recently approved cytotoxic agent, cabazitaxel. The biggest shift in chemotherapy use might just be starting following the American Society of Clinical Oncology (ASCO) 2014 plenary presentation of the CHAARTED trial, which showed a clear survival impact with the early use of docetaxel with androgen-deprivation therapy in newly diagnosed advanced disease, with an impressive 17-month survival advantage in the high-burden disease subgroup.

An original retrospective report shows promising results from the treatment of advanced/recurrent pancreatic cancer using fixed-dose-rate gemcitabine along with capecitabine given in an upwardly titrated fashion. Median survival was 12 months, with equivalent results seen in patients who had already received prior chemotherapy. The tolerability of this regimen may warrant comparisons with other contemporary combinations such as *nab*-paclitaxel/gemcitabine and FOLFIRINOX. Our *Clinical Controversies* piece applies to the big picture of our clinical trial process and the near "gold standard" of overall survival that has been adopted by regulatory agencies as the path to approval. Should a clear progression-free survival advantage be considered an alternate end point? Dr Markman makes a plea to revisit alternate end points to break the cycle of failed trials—is this good for patients and for accelerating progress in cancer care? Be the judge and give us your feedback. Finally, our CME article is a selection of 5 presentations from PER's 15th Annual International Lung Cancer Congress®, a meeting that featured advances in the swiftly changing fields of molecularly guided, anti-angiogenic, and targeted maintenance therapies for lung cancer.

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Editor-in-Chief