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THE AUTHORS REPLY: Bjurlin et al. are correct in stating that the results of our study are applicable only to a comparison between the hybrid procedure and an open radical cystectomy. The hybrid procedure is in fact the procedure used for the vast majority of robot-assisted cystectomies that have been performed in the United States to date. Although many postoperative complications can be traced to the urinary diversion, all patients undergoing cystectomy require urinary tract reconstruction; the use of robotic tools will not obviate that need. The question to be answered with future studies is whether performing the urinary diversion intracorporeally versus through a skin incision leads to an improved patient outcome. Published experience with totally intracorporeal radical cystectomy and diversion procedures has not shown a clear difference in complications and length of stay as compared with standard open procedures.1 We would strongly encourage the use of randomized surgical trials to determine whether totally intracorporeal radical cystectomy provides any advantage over open surgery that results in true patient benefit. Until these studies are performed, the benefits remain conjecture.

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Novel Mutations in a Patient with ALK-Rearranged Lung Cancer

TO THE EDITOR: A 49-year-old nonsmoking woman presented with pleuritic pain on the right side of her chest. Computed tomography (CT) of the chest revealed a spiculated, noncalcified pulmonary nodule in the right middle lobe 1.2 cm in diameter and multiple noncalcified nodules (2.0 to 3.0 mm in diameter) in the right middle lobe and right lower lobe. A positron-emission tomographic (PET) scan showed the nodule in the right middle lobe and multiple hypermetabolic foci in the right diaphragmatic pleura indicative of metastatic disease (stage IV). A surgical biopsy confirmed a moderately differentiated adenocarcinoma. Molecular analysis revealed an EML4-ALK translocation with no epidermal growth factor receptor (EGFR) or KRAS mutations.

The patient began receiving crizotinib orally at a dose of 250 mg twice daily, with a complete response that lasted for 18 months. CT and PET scans at 18 months showed a new lesion and pleural effusions, greater on the right side than on the left. The patient enrolled in a phase 1b trial of crizotinib plus AT13387, a heat shock protein 90 (HSP90) inhibitor. Preclinical evidence had suggested that HSP90 inhibition might overcome drug resistance in crizotinib-resistant ALK-positive non–small-cell lung cancer, which was the rationale for evaluating AT13387 with crizotinib.1 The patient completed nine cycles of therapy. Repeat imaging showed no evidence of measurable disease according to the Response Evaluation Criteria in Solid Tumors, version 1.1, except for a recurrent pleural effusion on the right side of the chest. Owing to peripheral edema and frequent thoracenteses, the patient discontinued AT13387.

Cancer cells that were obtained from pleural fluid at the time of the withdrawal of consent...