patients with CUP are needed. We thank Varghese and Saltz from Memorial Sloan Kettering Cancer Center for their comments concerning the definition of “actionability” in the setting of cancer presenting as CUP.

Also, in response to Varghese and Saltz, TTF1-positive tumors with EML4-ALK fusions characteristic of non–small-cell lung cancer were not included in our series. One case in our series did feature a TPMRSS-ERG fusion diagnosis of metastatic prostatic carcinoma. This case was listed as a CUP in that the tumor did not mark by IHC analysis as being of prostatic origin and the clinical workup did not suggest that the patient had prostate cancer. Although not a focus of our present study, we believe that hybrid capture-based comprehensive genomic profiling can definitively identify the site of origin in approximately 10% to 15% of CUP cases. The example case in our article of an EML4-ALK fusion cancer responding dramatically to crizotinib therapy cannot, in our opinion, be designated as a lung cancer by current diagnostic criteria because IHC analysis was negative for TTF1, positive for vimentin, and featured a poorly differentiated, nonmucinous, sarcomatoid morphologic appearance. Finally, we thank Whang and Hayes from the University of North Carolina for their letter describing the prolonged response of a patient to an anti-human epidermal growth factor receptor 2 plus chemotherapy regimen for an ERBB2-amplified CUP. Finally, our article1 and all 3 Letters to the Editor have in common the desire to see the development of mechanism-driven prospective clinical trials in which genomic profiling is used to search for “druggable” alterations in CUP cases to achieve a comparison of the results of the use of targeted therapies when possible with generic chemotherapy and testing whether this approach can improve the clinical outcomes for patients with this devastating form of cancer.

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Conflict of Interest Disclosures: All authors are employees of, hold leadership positions in, and own stock in Foundation Medicine, Inc. No other disclosures are reported.

The Demanding Patient Revisited
To the Editor We read with interest the study by Gogineni et al,1 in which oncologists recalled a patient request or demand in less than 9% of 5050 visits. Furthermore, only 1 in 9 requests or demands was deemed inappropriate. The authors concluded that demanding patients are infrequent in oncologic practice. They contrasted their results with the findings of Kravitz et al,2 which identified patient requests for tests, referrals, or prescriptions in 23% of visits. To explain the discrepancy, Gogineni et al speculated that coding of transcribed audio recordings may exaggerate the frequency of requests relative to oncologist report, that “in California, primary care patients make more demands than cancer patients in Pennsylvania,” and that our study had fewer encounters and clinicians, “generating a selective sample.”

Although we agree that “demanding patients” cannot be held responsible for a large share of cancer-related costs, the following qualifications merit attention. First, considering the high stakes of a cancer diagnosis and patients’ deep dependence on their oncologists, a rate of requests approaching 1 in 11 seems anything but low. Second, physician recall (especially when elicited up to 4 hours after the visit) is an insensitive measure, especially in comparison with direct observation and coding by trained reviewers of visit transcripts.3 Patient-reported request rates are higher still,4 in part because patients’ requests often use indirect linguistic forms that may be missed or misinterpreted by physicians.5 Third, a sample drawn from 3 tertiary care hospitals in Philadelphia hardly seems less selective than one drawn from primary care and cardiology practices in California. Finally, oncologists in tertiary centers already offer a full slate of aggressive diagnostic and therapeutic services. Few patients would have a need to request services that are already on offer.

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Conflict of Interest Disclosures: None reported.

To the Editor As a cancer patient and advocate, I was happy to read the Editorial by Back1 discussing the study by Gogineni et al2 published in JAMA Oncology on February 12. It is comforting to know that a study was performed to address this issue as opposed to allowing the stereotype to persist that patients cause financial strains on the health care system with our requests for “unnecessary” treatment. As a multiple myeloma patient (6 years post-diagnosis this St Patrick’s Day), I can attest to the value of the partnership between an attentive, inquisitive medical professional and an informed patient as it relates to proper diagnosis, treatment, and follow-up care.
During a routine physical examination, my family physician saw something out of the ordinary and performed an extra test. That potentially unnecessary test led to my cancer diagnosis. Without his scientific inquiry and thoroughness, any care that I received may have come too late and proven to be futile.

After a few months of successful treatment with a pill-based regimen, I was advised that I may need an autologous stem cell transplant. I was not convinced and disagreed, but my oncologist listened to my concerns and helped me obtain a second opinion. Now assured after being armed with information, I decided to undergo the procedure. Since then I have not registered any M spikes and I am as close to being cured as one can be from this chronic but manageable disease.

Increased use of Big Data and social media allows for more communication of timely information throughout the entire medical value chain—especially between physician and patient. All parties will have to adapt to changes in technology to create personal and personalized care. Anything that creates a stronger 2-way relationship between patients and the physicians who treat us will break down barriers and allow cancer patients like me to have hope that we will endure.

Patients are not demanding. We, the unwilling consumers of health care, are merely becoming more educated about our conditions by the day. Our only “demand” is that we and our physicians have access to and choice in the care to be used on our behalf. That creates true value in health care.

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Conflict of Interest Disclosures: Mr Tufts has received honoraria from the Center for Medicine in the Public Interest, has appeared at company expense at the Cegene annual sales convention, and is cofounder of My Life Is Worth It, which advocates for patient and physician access to treatments and is funded by the Center for Medicine in the Public Interest. No other disclosures are reported.

Additional Information: Mr Tufts is a former Major League Baseball pitcher, San Francisco Giants and Kansas City Royals, 1981 through 1983.


In Reply If the aim is to assess how much patients drive health care costs, then it is clinicians’ perspectives on whether a patient requested or demanded a test or treatment that is the right one. After all, the key issue is whether clinicians perceive what patients said as requests. It does not matter whether a researcher examining tapes has a different impression. Only clinicians can order tests or treatments and drive health care costs.

To check for faulty memory, we did assess whether clinicians who were asked immediately after they left the examination room reported a different rate of patient requests or demands for treatment compared with clinicians interviewed at the end of a clinic session. We found no difference in the rate of patient demands or requests. This is probably in part because a patient demand or request is salient and, thus, memorable.

Finally, given the high stakes of cancer treatment and the extensive information available from support groups, the Internet, and other media, we suspected that patients with cancer would be more vigilant and engaged and likely to demand or request treatments more frequently than other patient groups. But this is an empirical question that can only be answered by surveying thousands of clinical encounters in primary care and other specialties. We readily acknowledged that a sample of oncology patients from Philadelphia may not be representative and that additional studies are needed to confirm our findings.

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Conflict of Interest Disclosures: None reported.

CORRECTION

Error in Figure: In the Original Investigation titled “Tumor-Infiltrating Lymphocytes and Associations With Pathological Complete Response and Event-Free Survival in HER2-Positive Early-Stage Breast Cancer Treated With Lapatinib and Trastuzumab: A Secondary Analysis of the NeoALTO Trial” published online April 30, 2015, in JAMA Oncology (doi:10.1001/jamaoncol.2015.0830), an error appeared in Figures 2B and 2D. In Figure 2B in the panel title, symbol key, and No. at risk, >40% should be replaced by ≈40%. In Figure 2D, in No. at risk, >40% should be replaced by ≈40%. This article was corrected online.

Error in Table Text: In the Research Letter titled “Five Years of Cancer Drug Approvals: Innovation Efficacy and Costs” published online in the April 2, 2015, issue of JAMA Oncology (doi:10.1001/jamaoncol.2015.0373), an incorrect indication was listed for ibrutinib in the Table. The correct indication is mantle cell lymphoma. This article was corrected online.

Error in Abstract: In the Original Investigation titled “Correlation of Smoking-Associated DNA Methylation Changes in Buccal Cells With DNA Methylation Changes in Epithelial Cancer” published online May 14, 2015, in JAMA Oncology (doi:10.1001/jamaoncol.2015.1053), an error appeared in the last sentence of the abstract Results. The text “area under the curve, 0.88; 95% CI, 0.76-1.00” should be deleted from the parenthetical phrase so that the sentence reads “The corresponding area under the curve of a smoking signature derived from blood cells was lower than that derived from buccal cells in 14 of 15 cancer types (Wilcoxon signed rank test, P = .001).” This article was corrected online.

Incorrect Units in Methods: In the Original Investigation titled “Statin Use at the Time of Initiation of Androgen Deprivation Therapy and Time to Progression in Patients With Hormone-Sensitive Prostate Cancer” published online May 7, 2015, in JAMA Oncology (doi:10.1001/jamaoncol.2015.0829), an error appeared in the second paragraph of the Methods section. In the fourth sentence, “1 μg/mL” should be replaced with “1 μg/mL” so that the sentence reads “The efficiency of knocking down SLCO2B1 expression was assayed after induction with 1 μg/mL of doxycycline hyclate for 48 hours.” This article was corrected online.