Announcing JAMA Oncology

Mary L. Disis, MD

The science of oncology and its translation into practice are changing rapidly. Therapies for cancer are radically shifting from a tissue-specific focus to an oncogenic pathway-specific orientation, agnostic of tissue of origin. The classic “tumor board” is evolving into a “genetic alteration board,” and in our practices we are struggling with this new paradigm. The molecular revolution has important implications for prevention and surgical and radiation oncology as advances in systemic treatment translate not only into survival benefit but improvement in local control as well. New therapeutic approaches will challenge traditional standards for optimal local therapy. Determining when successful targeted therapy will allow a reduction in the intensity of local therapy, decreasing the burden of cancer treatment for patients, is the next challenge for the multidisciplinary model of cancer care. The explosion of information, new prognostic and diagnostic tests, and targeted treatments has created a tremendous need for novel information to be conveyed clearly and efficiently. In addition, advances in disease-specific research are evolving rapidly and clinicians must keep up with these advances in real time.

The number of journals and periodicals available for review with new data and evolving standards of care has increased substantially. Few journals, however, attempt to convey both the science and clinical implications of original research and also deliver high-quality clinical education. JAMA Oncology, the newest journal in the JAMA Network, will be that one journal that will present the best of research and education—with articles communicating cutting-edge discovery and the state of the art of clinical practice. Our aim is to be an indispensable resource for academicians, clinicians, and trainees in the field of oncology worldwide.

The scope of JAMA Oncology spans medical (adult and pediatric), radiation, and surgical oncology. The original articles that you will read in the journal will be either immediately relevant to the practice of oncology or will clearly portend the near future of novel technologies or treatments that will transform the way we care for patients. This issue of JAMA Oncology highlights our goal to publish actionable discoveries. As an example, Hansford et al1 detail, to our knowledge, the largest reported series of CDH1 mutations in patients with hereditary gastric cancer, revealing new genes that should be considered for genetic screening of patients and families with this history. Kehl et al2 dissect shared decision making in cancer care, evaluating the interactions of patients who would like more or less control over treatment decisions and the impact of their preferences on the physician-patient relationship. Ross and colleagues3 perform comprehensive genetic profiling on a large series of carcinomas of unknown primary tumor site and identify actionable pathways that may lead to new treatment approaches in this disease. In a final example, Gogineni et al,4 in a study of nearly 4000 patients, evaluate the role of patients’ requests for medical interventions as a driver of utilization of specific services and medical costs.

In JAMA Oncology, original research can be communicated as Original Investigations (full articles) for reports of clinical trials, observational studies, and meta-analyses; Brief Reports for shorter reports of important clinical discoveries to be rapidly communicated; and Research Letters for even shorter studies with simple or single messages. Deputy Editors Lee M. Ellis, MD, and Charles R. Thomas Jr, MD, Associate Editor for Statistics Yu Shyr, PhD, and I are dedicated to a 60-day from submission to acceptance policy for these reports of original research, and rapid times for all initial decisions.

A unique aspect of JAMA Oncology is that nearly half the journal will be devoted to a variety of articles focused on clinical education, overseen by Monica Morrow, MD. Evidence-based reviews will summarize and appraise important clinical topics such as the current treatment of adult acute lymphoblastic leukemia, alternatives to conventional mammography for breast cancer screening, the role and benefits of robotic and laparoscopic surgery for gastrointestinal cancers, and the management of central nervous system metastases, to name just a few topics scheduled for upcoming issues. Our Clinical Challenge and Diagnostic Test Interpretation articles will highlight real-life, case-based problems in practice and provide a differential diagnosis, clinical application, or a test result and didactic discussion of optimal choices in disease management. The JAMA Oncology Clinical Evidence Synopsis series will condense complex guidelines into easily readable and memorable take-home points in a single page of text. As a member of the JAMA Network, JAMA Oncology will also publish brief summaries and clinical implications of major oncology articles published in JAMA and the other JAMA Network specialty journals. In addition, all major research and review articles will feature brief summaries of the key implications and takeaway messages placed in a
Hereditary Gastric Cancer
An Update at 15 Years

James M. Ford, MD

Like most solid tumors, gastric cancer is currently thought to be a group of molecularly and pathologically distinct subtypes caused by a variety of known and unknown environmental and genetic factors. Understanding these factors can lead to advances in personalized therapy, prevention, and screening to hopefully decrease mortality. Gastric cancer is a global public health concern, currently ranking as the third leading cause of cancer mortality worldwide, with a 5-year survival of only 20%. Recent and rapid advances in molecular genetics has provided an understanding of the cause for many inherited cancer syndromes, offering possibilities for individual genetic testing, family counseling, and preventive approaches. Similar to other hereditary cancer syndromes, the majority of individuals meeting defined clinical criteria for hereditary diffuse cancer syndrome (HDGC) based on personal or family history do not all have a germline mutation in the 1 known causative gene, E-cadherin (CDH1)—in fact, the minority do—and individuals known to carry pathogenic germline mutations in CDH1 do not all exhibit similar clinical outcomes in terms of age of cancer diagnosis or type of cancers. This suggests that additional uncharacterized alterations in other genes may affect gastric cancer susceptibility and age-specific penetrance. The current article by Hansford et al3 in this issue of JAMA Oncology provides a major and much needed update in describing both the cancer penetrance and genetic spectrum of risk for HDGC.

Discovered over 15 years ago, CDH1-associated HDGC, while rare, is part of the spectrum of cancer syndromes tested for in any major cancer genetics clinic, and criteria for genetic testing, clinical screening, and surgical prophylaxis...