Editorial

The PRODIGE 7 randomized trial has 4 design flaws and 4 pharmacologic flaws and cannot be used to discredit other HIPEC regimens

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The contributions to our Focused Issue regarding colorectal and appendiceal cancer are, by design, limited. The initial contribution regarding "Lessons learned from PRODIGE 7" should reassure peritoneal surface oncology physicians, nurses, and paramedical personnel that HIPEC is not dead as a result of this RCT (1). First, the unprecedented 41 months OS in both the experimental arm (CRS + HIPEC) and standard arm (CRS) clearly demonstrate CRS by itself as a standard of care for resectable colorectal PM. Sixteen patients (12%) of the CRS only group crossed over to receive CRS plus HIPEC. This becomes a statistical nightmare for which no solution currently exists. In contrast, the relapse-free survival is statistically significantly positive (Fisher exact p=0.049). The effects of neoadjuvant FOLFOX on HIPEC with oxaliplatin have never been defined. We comment about 4 design flaws and 4 pharmacologic flaws in protocol strategy and implementation that must raise doubts concerning conclusions drawn from this RCT. Next to that, one of the main lessons learned from PRODIGE 7 analysis is not that oxaliplatin is a bad drug for IP use but that it was rather badly used in the current dosimetry and duration (2).

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