Immunotherapy has long been used in treating aRCC, with interferons and interleukins commonly used in the past. It is also expected that the patterns of care for aRCC will hold an important role for the newer immunotherapy medications as they become more popular. We have no doubt that the programmed death-ligand 1 inhibitor drugs, nivolumab (Opdivo; Bristol-Myers Squibb Company, Princeton, NJ, USA) is already approved for aRCC, will be more commonly used for aRCC.

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Editorial Comment

Editorial Comment from Dr Porta *et al.* to Patterns of care among patients receiving sequential targeted therapies for advanced renal cell carcinoma: A retrospective chart review in the USA

In this issue of the journal, Pal *et al.* reported on patterns of care among metastatic renal cell carcinoma in the USA.[1]

At present, the metastatic renal cell carcinoma therapeutic landscape in industrialized countries resembles, to a certain extent, the one shown therein: a growing number of metastatic renal cell carcinoma patients are receiving several lines of treatments sequentially, and this abundance of options has undoubtedly improved their survival.

However, this situation also encompasses some risks, irrespective of the fact that unexpected disparities between countries in the (once) rich and industrialized Western world are emerging.

First, the availability of so many active agents could also contribute to non-virtuous behaviors.

Indeed, if one can easily move from one agent to another in the event of toxicities, even only a few days after commencing the treatment, why try to adapt the treatment dosage and schedule, and/or aggressively apply supportive measures in order to keep the treatment going?

An unusual scenario, one might say. Not really; this is quite often observable in everyday clinical practice, although almost no scientific papers have ever dealt with this issue.

If so, it is clear that all the knowledge we have gathered over the years might simply vanish at the first difficulty, or in the presence of a complaint (although often justified) from the patient.[2]

On the whole, is this possibility an opportunity, or a pitfall?

Both, but with a disturbing trend towards the latter case.

Indeed, managing toxicities by just shifting from one agent to the other, just because the latter is perceived as (or even is) less toxic, not only deprives a given patient of an option (which, in many countries, cannot be resumed later), but also potentially has a detrimental impact on the treatment outcome.[3]

Despite a fast approval system empowered by the European Medicines Agency, a second emerging issue is the disparity among European countries in the real availability of novel anticancer agents.

Several years ago, Tim Eisen strongly criticized the British system for denying the reimbursability of several kidney cancer drugs due to economic considerations.[4] Although difficult to accept from a patient's perspective, such a decision was based on serious pharmacoeconomical and macroeconomical considerations.

What in recent years has happened in Italy is definitely more difficult to understand; denying highly active treatments to cancer patients just because the Italian Agency for Drugs "fights" pharmaceutical companies over drug prices is really hard to accept.

This is just an ultimately useless way to save money, without any serious attempt to prioritize expenses by evaluating how much expense is worthwhile for a given clinical benefit.

That's why the magnitude of clinical benefit scale recently empowered by the European Society of Oncology should be applauded, offering governments sound instruments to decide if, how and where to allocate resources in a tough global economic situation.[5]

However, the subsequent necessary step would (and should) be the real application of such an instrument.

The choice of not taking any responsibility, but rather to pass these responsibilities on to those who produce and sell the drugs, thus denying patients (i.e. those whom a government regulatory body should serve) therapeutic opportunities and probably months of life, is not the answer.

Fortunately enough, a medical oncologist now chairs the Italian Agency for Drugs, hopefully bringing patients (and not drugs) back to center stage.

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Conflict of interest

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