In *The Lancet Oncology*, Joe Chang and colleagues' report the combined results of two randomised trials (STARS and ROSEL) comparing stereotactic ablative radiotherapy (SABR) with surgery for early-stage non-small-cell lung cancer, both of which were halted early because of slow recruitment. We congratulate the investigators for publishing the results and for being prepared to merge their data in an attempt to answer this question. We suspect that much valuable information in “invisible and abandoned trials” could, if brought to light, inform practice, avoid time wasted in repetition, or at least refine the research questions.

Although findings from non-randomised studies had previously suggested that SABR might be as effective as surgery, these results are the first from randomised trials. However, even after combining the two trials, there were only 58 patients, imposing a limitation on the strength of any inferences drawn. Nevertheless, the results suggest that SABR is not inferior to surgery, with a hint that it might be better in terms of clinical effectiveness. The findings cast doubt over the superiority of lobectomy, sufficient to suggest group equipoise (a prerequisite for future randomised trials), and the investigators state that further trials in this setting are warranted. We would put it more strongly. In an era when evidence is expected for treatments, the fact that these interventions have still not been properly assessed is shameful. The difficulty in evaluating the benefit of innovations is summed up in what has become known as Buxton's law: “It is always too early [for rigorous evaluation] until suddenly it’s too late”. If a proper evaluation is not done now, we risk technology creep.

To avoid a turf war between opposing camps, the claims for lobectomy and those for ablation should both be considered carefully. Chang and colleagues state that lobectomy with dissection or sampling of mediastinal lymph nodes (ie, intraoperative dissection of whole lymph nodes, either all that are accessible or those in specified anatomical locations) is the standard of care for operable, stage I, non-small-cell lung cancer. However, after surgical lobectomy—when all mediastinal nodes can be looked at under the microscope—some cases will be identified as non-stage-I cancers. But, in a cohort of patients treated with SABR, these cases would remain, thus systematically defeating the intention-to-treat principle and providing a golden opportunity to bias the analysis in favour of lobectomy.

The clinical effectiveness of the addition of lymphadenectomy to lobectomy has not been proven. The notion runs counter to the evidence gained in breast cancer, in which the historical justification for axillary node dissection and clearance has been reversed. In lung cancer, lymphadenectomy is being promoted without evidence of efficacy in an era in which such changes in standards of care should be tested with randomised controlled trials.

The opportunity of a fair test should be given to less invasive treatments. With an average age of 67 years, the patients in Chang and colleagues' study were not particularly elderly, but cancer treatments are being offered to ever-older patients who might not feature in trials and for whom improved evidence is needed. SABR is not the only candidate procedure that might reduce the harms of lung cancer treatment without loss of effectiveness. The uptake of videothoracoscopy, for example, has been resisted by surgeons, but the accumulating case series and registry evidence suggest that oncological effectiveness is not sacrificed by moving away from thoracotomy. The VIOLET trial in the UK seeks to test that question in a randomised controlled trial.

Clinicians have an ethical imperative to obtain evidence rather than continue to perpetrate needless harm through ignorance. “Trust me, I’m your doctor” does not have the ring of truth when different doctors claim to know what is best while consistently failing to encourage trials to put their beliefs to the test, as evidenced by poor recruitment into studies. Patients, too, have a societal duty to participate in carefully planned and monitored trials. However, evidence suggests that patients are not the main obstacle to trial recruitment; many are willing to participate in studies for various motives, including altruism.

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**SABR in early operable lung cancer: time for evidence**

Joe Chang and colleagues report the combined results of two randomised trials (STARS and ROSEL) comparing stereotactic ablative radiotherapy (SABR) with surgery for early-stage non-small-cell lung cancer, both of which were halted early because of slow recruitment. We congratulate the investigators for publishing the results and for being prepared to merge their data in an attempt to answer this question. We suspect that much valuable information in “invisible and abandoned trials” could, if brought to light, inform practice, avoid time wasted in repetition, or at least refine the research questions.

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We declare no competing interests.


