

THE AUTHORS REPLY: We agree with Hancock that the electrocardiogram presented in Figure 1 of our article has the typical characteristics of arm-lead transposition, with implications as outlined for the appearance of the tracing. This was the tracing used by the clinicians managing the case. All electrocardiographic tracings from the initial presentation reflect the same lead placement; the abnormality was not corrected until later in the patient's clinical course, by which time the acute ST-segment changes shown in the figure had resolved. The technical error was considered in the short term by the clinical team but did not ultimately influence the differential diagnosis and management strategy as discussed. Although the

overall presentation was indeed most consistent with diffuse myocardial injury, it was still necessary to definitively rule out an acute coronary process in this young pregnant woman with abrupt-onset heart failure, prompting coronary angiography after appropriate medical stabilization.

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Since publication of their article, the authors report no further potential conflict of interest.

Capecitabine and Oxaliplatin for Advanced Esophagogastric Cancer

TO THE EDITOR: We reported previously (Jan. 3, 2008, issue)¹ that capecitabine and oxaliplatin are as effective as infused fluorouracil and cisplatin, respectively, in patients with previously untreated esophagogastric cancer that was inoperable and either locally advanced or metastatic. The median survival was 11.2 months among the patients treated with epirubicin, oxaliplatin, and capecitabine (EOC [called EOX in the 2008 article]) and 9.9 months among the patients treated with epirubicin, cisplatin, and fluorouracil (ECF) (hazard ratio for death in the EOC group vs. the ECF group, 0.80; 95% confidence interval [CI], 0.66 to 0.97; $P=0.02$).

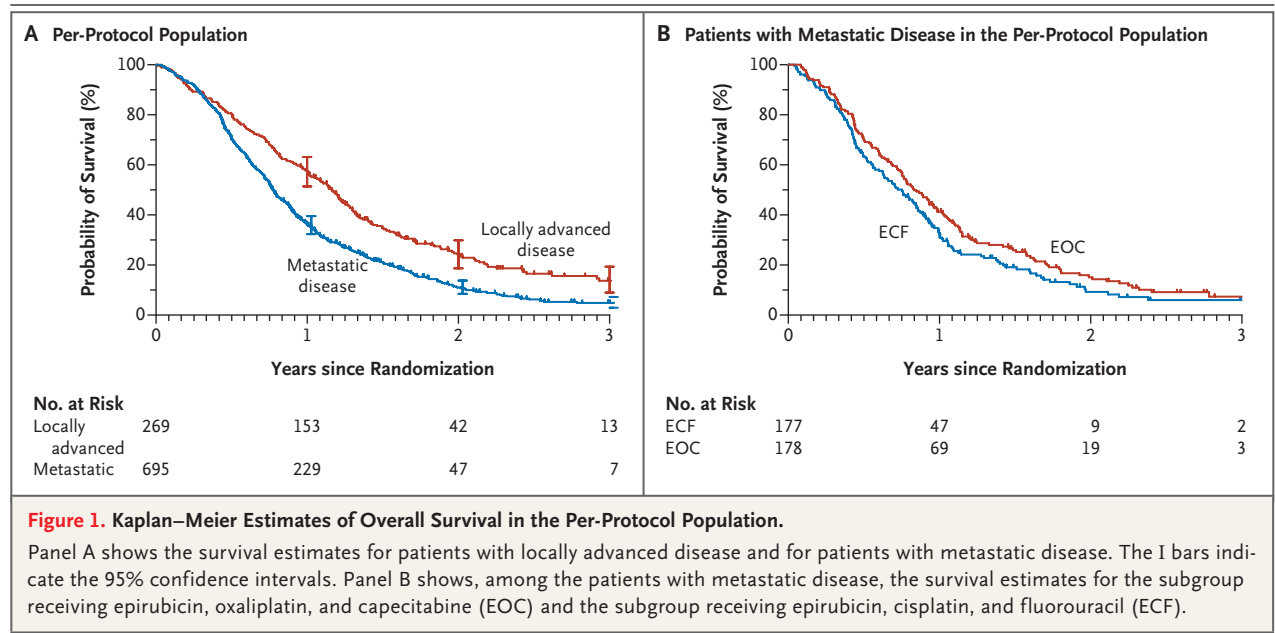
The per-protocol population of 964 patients consisted of 269 with locally advanced disease and 695 with metastatic disease. In a retrospective analysis of these two groups, the median survival among patients with locally advanced disease was 14.0 months (95% CI, 12.5 to 15.4) as compared with 9.3 months (95% CI, 8.6 to 9.9 months) among patients with metastatic disease (Fig. 1A). This survival difference is significant (hazard ratio for death from metastatic vs. locally advanced disease, 1.54; 95% CI, 1.34 to 1.78; $P<0.001$).

The longer median survival among patients with locally advanced disease than among those with metastatic disease is not an unexpected find-

ing. The presence of liver peritoneal metastases have previously been noted to be independent predictors of poor prognosis in patients with locally advanced or metastatic esophagogastric cancer in a pooled analysis of three randomized, controlled trials.² The prognostic index, which also included Eastern Cooperative Oncology Group performance status and serum alkaline phosphatase levels, has since been validated with the use of data from individual patients from this study.³

In a further exploratory analysis, when we limited our survival analysis to patients with metastatic disease, the median survival among patients treated with ECF was 9.0 months (95% CI, 7.4 to 10.6) as compared with 10.0 months (95% CI, 8.5 to 11.4) among patients treated with EOC (hazard ratio for death in the EOC group vs. the ECF group, 0.81; 95% CI, 0.65 to 1.02; $P<0.001$) (Fig. 1B).

Patients with locally advanced disease and those with metastatic disease were evenly distributed among the four treatment groups in our study. We demonstrate here that the improvement in median survival among the patients receiving EOC as compared with ECF reported in 2008 for the per-protocol population is maintained when the analysis is limited to patients with metastatic disease.



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Disclosure forms provided by the authors are available with the full text of this letter at NEJM.org.

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Surveys of Physicians and Electronic Health Information

TO THE EDITOR: The role of electronically accessible health information in clinical care has been the focus of increasing discussion nationally.¹ In 2001, we launched the Health Information National Trends Survey (HINTS) to provide an evidentiary basis for practice and policy decisions. Sponsored by the National Cancer Institute, the HINTS program provides data every 2 years from a nationally representative sample of U.S. adults 18 years of age or older.²

We analyzed data across three administrations of HINTS (6149 respondents in 2002–2003, 5586

in 2005, and 4092 in 2008) to gain a better understanding of the public's trust in and use of sources of health information, especially information from physicians, the Internet, and other sources, such as the mass media. Three sets of findings are shown in Figure 1. First, despite a decade's worth of exposure to health information on the Internet, the public's trust in physicians as their preferred source of health information has remained high and, if anything, increased from 2002 to 2008 (odds ratio, 1.29; $P < 0.05$). Conversely, trust in health information from the Internet