LETTER to the EDITOR **Editorial Process:** Submission:04/28/2025 Acceptance:09/25/2025 Published:10/19/2025

Beyond Measurement: Strengthening HRQOL Research in Cancer

Asian Pac J Cancer Prev, **26 (10),** 3507-3509

Dear Editor

We congratulate Snehapriya et al. [1] for their article "Unveiling Health-Related Quality of Life (HRQOL) and Sociodemographic Factors Predicting HRQOL among Cancer Patients in Eastern India," which offers valuable insights through a community-based study. However, certain concerns merit attention.

Methodologically, using the English version of the EORTC QLQ-C30 tool without translation or cultural adaptation in a predominantly Odia-speaking population questions the validity and reliability of the collected data. At least face validity of Odia translated tool was desirable. A reader can infer from the statement "…, the investigator visited…..", that data was collected by a single investigator, but lack of further details such as knowledge of local language of investigator limits understanding of field implementation of the study.

Symptom burden is a predictor of quality of life in cancer patients, which can be assessed using Memorial Symptom Assessment Scale (MSAS) [2]. This study though reports use of individual symptom scales, use of MSAS could have offered wider and more nuanced picture of patients' symptom experiences, in turn, would have provided insights for clinical interventions to truly support cancer patients in their journey toward better health.

The sample size formula provided by authors is for infinite population, while the cancer registry over a 1.5 year is a finite population. The authors have considered high (15%) margin of error to estimate the sample size. Considering, 2678 enrolment in the registry, a finite population correction, and lower margin of error, could have been considered. Participant recruitment from the Hospital-Based-Cancer-Registry (HBCR) at AIIMS Bhubaneswar between July 2021 - December 2022 raises feasibility concerns, especially for late enrollees, considering the time required for registry access, telephonic consent, and home interviews by the single investigator.

In the statistical analysis parametric and non-parametric tests have been mentioned (ANOVA, t-test, Kruskal-Wallis, Mann-Whitney U), but their specific application is not clearly attributed in tables or text. Table 5, that tests association between Global Health Status and Sociodemographic Factors among Cancer Patients, used 'F' and 't' statistics signifying use of ANOVA and t tests, which are parametric tests only. The current study has no multivariate analysis, limiting our understanding of vulnerable subgroups requiring targeted interventions.

The study participants were exclusively drawn from an urban population in Bhubaneswar city, Odisha, an Eastern Indian state, describing the study setting as "Eastern India" might inadvertently suggest a broader regional representation than what was actually captured. The titles of tables 1 to 3 has the term "Eastern India" which can mislead the readers.

As far as data accuracy is concerned, the health insurance coverage rate cited from NFHS-5 is incorrectly stated as 44.7% instead of 47.9% [3]. Additionally, GLOBOCAN 2020 data showing higher cancer incidence rates in females has been referenced against an incorrect source, as it aligns with the International Agency for Research on Cancer's India Fact Sheet, 2022 [4]. References 1 to 3 are inaccurately cited: Reference 1 [5] does not contain the statement "Globally, cancer is the second leading cause of death after cardiovascular diseases," Reference 2 [6] presents 2022 data, not 2020, and Reference 3 [7], a 2014 publication, cannot be the original source for current incidence and mortality rates in India. Further, Upadhyay et al. [8] is cited as reference 12 instead of 11. It was also noted that although "Chean et al." is cited in the discussion concerning the no association between cancer stage and Quality of Life (QOL), the complete reference for this citation is absent from the bibliography.

The idea behind the minimally important difference (MID) is to help us understand whether changes or differences in HRQOL scores truly matter to patients' lives, beyond just being statistically significant [9]. Therefore, repeated assessment of HRQOL is more meaningful for patient care must be included in this kind of surveys. Considering that Health-Related Quality of Life (HRQOL) can vary significantly throughout diagnosis, treatment, and recovery, following patients over time through a longitudinal study would have offered a richer understanding of how their experiences evolve. Capturing these changes is essential for tailoring interventions to meet patients' needs at each stage of their journey. As a reader, we were expecting to know what happened to patients with different levels of quality of life.

Beyond clinical care, the journey of a cancer patient is deeply shaped by emotional support, social connections, and financial security. The low social functioning scores reported in the study highlight the silent struggles patients may face outside hospital walls, feelings of isolation, emotional distress, and financial hardship. In places where

resources are limited, these challenges can be even more overwhelming. Future studies could bring real value by not only measuring symptoms but also asking about patients' access to counseling, community support, and financial help. Understanding and addressing these needs could make a profound difference in helping patients not just survive cancer, but truly live beyond it.

Manuscript Details

This letter is in response to the article by Snehapriya et al., titled "Unveiling Health-Related Quality of Life (HRQOL) and Sociodemographic Factors Predicting HRQOL among Cancer Patients in Eastern India: A Community-based Cross-Sectional Study", published in Asian Pacific Journal of Cancer Prevention, Volume 26, Issue 3, Pages 819-827 doi: 10.31557/APJCP.2025.26.3.819

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Reply to the letter to the editor: Unveiling Health-Related Quality of Life (HRQOL) and Sociodemographic Factors Predicting HRQOL among Cancer Patients in Eastern India

Dear Editor

We sincerely thank the readers for their detailed and constructive feedback on our article titled "Unveiling Health-Related Quality of Life (HRQOL) and Sociodemographic Factors Predicting HRQOL among Cancer Patients in Eastern India." We appreciate their recognition of the relevance of our study and are grateful for the opportunity to address the concerns raised.

Use of Odia Version of EORTC QLQ-C30 Tool

We would like to clarify that we did not use the English version of the EORTC QLQ-C30. A validated Odia version of the tool was obtained from the official EORTC QLQ website by formally requesting access. This version had undergone linguistic validation and was used in our study to ensure cultural appropriateness, comprehension, and reliability of responses in the Odia-speaking population.

Data Collection and Investigator Proficiency

The study involved data collection by a single trained investigator who was aware of Odia language, ensuring effective communication during telephonic consent and in-person interviews. Additionally, whenever needed, assistance from a medical social worker was sought to facilitate access to participants, especially in cases requiring additional support for establishing contact or ensuring participant comfort during home visits. We acknowledge that explicitly stating this in the article would have enhanced transparency regarding field implementation.

Use of Symptom Assessment Tools

We appreciate the suggestion regarding the use of the Memorial Symptom Assessment Scale (MSAS). While the EORTC QLQ-C30 captures several symptom domains, we agree that MSAS could offer more nuanced insights into symptom burden. However, to maintain tool consistency and comparability with other EORTC-based studies, we chose the QLQ-C30.

Sample Size Calculation

We acknowledge the observation regarding the use of a formula for an infinite population despite the registry data being finite. The decision to use a 15% margin of error was guided by logistical feasibility during the pandemic

and home-based data collection constraints.

Feasibility of Participant Recruitment

All participants were recruited systematically from the Hospital-Based Cancer Registry (HBCR) at AIIMS Bhubaneswar over the study period. Patients were contacted post-enrolment using the registry database, and telephonic consent followed by scheduled home interviews was conducted, ensuring representativeness and ethical compliance.

Statistical Analysis Clarifications

The statistical methods applied in the study were described in the Statistical Analysis section in methodology part of the manuscript. In table 5 of the results session, for assessing associations between the global health status (a continuous dependent variable) and various categorical independent variables, independent t-tests were used when the variable had two categories (e.g., gender, ownership of house), and one-way ANOVA was applied when the variable had three or more categories (e.g., age group, caste, education, SES). While these methods were outlined in the Statistical Analysis section, due to word limitations, we had to restrict detailed mention of the specific statistical tests applied to each comparison in the tables.

Study setting terminology

While Odisha is geographically part of Eastern India, we acknowledge that the study's urban setting within Bhubaneswar may not fully represent the broader Eastern region. The term "Eastern India" was used as a general geographical reference; however, we understand it may unintentionally imply broader regional representation than the study actually captured. However, it is important to note that due to limited healthcare facilities in rural parts of Odisha, many cancer patients from rural areas temporarily reside in urban centres like Bhubaneswar to access treatment. Therefore, although the study was conducted in an urban setting, it included patients originally from rural backgrounds.

Referencing and Data Accuracy

We appreciate the careful identification of inaccuracies in referencing and data citation. The correct NFHS-5 value for health insurance coverage in Odisha is 47.9%, and the GLOBOCAN 2022 data was actually mentioned in the text in Introduction part, both of which was a typing error. We acknowledge for the misnumbering and missing of one of the references and will take corrective steps in future versions.

Sincerely,

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