Re: Sasi A. When Less Is More: An Avenue for Academia-Industry Collaboration in Pediatric Cancer

Anand Raja[1] Kanuj Malik[2] Shalini Shree Krishnamurthy[1]

[1] Department of Surgical Oncology, Cancer Institute (WIA), Adyar, Chennai, Tamil Nadu, India
[2] Department of Surgical Oncology, Yatharth Multispeciality Hospital, Noida, Uttar Pradesh, India

Address for correspondence Anand Raja, MBBS, MS, MCh, Department of Surgical Oncology, Cancer Institute (WIA), No. 38 Sardar Patel Marg, Adyar, Chennai, Tamil Nadu 600020, India (e-mail: dr_anand@yahoo.com).

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We read with great interest the insightful article by Sasi et al[1], "When Less Is More: An Avenue for Academia–Industry Collaboration in Pediatric Cancer," which underscores the need for collaborative approaches to address inequities in pediatric cancer care. The authors thoughtfully advocate for academia–industry synergy in developing cost-effective, patient-accessible oncologic therapies, particularly in low- and middle-income countries (LMICs). We wish to expand upon this important discussion by highlighting a few complementary perspectives.

First, while the article emphasizes financial and regulatory barriers, it is equally vital to recognize the role of patient and caregiver engagement in shaping meaningful drug development strategies. In LMICs, where treatment abandonment and sociocultural barriers to care are prevalent, academia–industry collaborations would benefit significantly from integrating patient advocacy groups to ensure that innovation aligns with lived realities and cultural acceptability.

Second, the authors rightly highlight the potential of dose de-escalation trials as cost-saving strategies. However, we propose that dose optimization in pediatric oncology be viewed not merely through an economic lens, but also as a scientific imperative. Children are not small adults, and their distinct pharmacodynamics and pharmacokinetics often support the rationale for tailored dosing strategies. Thus, low-dose regimens should be investigated as a means of improving the therapeutic index—not just reducing costs.

Furthermore, while Sasi et al mention regulatory and financial constraints in LMIC-based academic trials, there is an opportunity to build upon recent reforms. In India, for instance, the 2019 New Drugs and Clinical Trials Rules allow for a more enabling environment for investigator-initiated studies. Aligning such reforms with state-backed funding mechanisms and public–private partnerships could pave the way for globally relevant academic leadership in drug development from LMICs.

We also appreciate the emphasis on real-world data but believe this warrants further elaboration. Academic institutions in LMICs, by virtue of their large patient volumes and diverse case mix, are uniquely positioned to generate real-world evidence. This could complement traditional trial data and support adaptive trial designs, post-marketing surveillance, and drug repurposing efforts.

Finally, the article alludes to the misalignment between cost-effective strategies and pharmaceutical incentives. We propose the exploration of value-based pricing models, preferential procurement for cost-effective innovations, and pharmacoeconomic reward frameworks to align commercial interests with societal benefit. Such approaches could amplify both the reach and impact of pediatric cancer therapies.

In conclusion, we commend the authors for highlighting a crucial and timely theme. We believe that expanding the collaboration framework to include patient voices, regulatory opportunity, scientific rationale for de-escalation, and value-based economic models will help realize the full potential of equitable, effective pediatric oncology care.

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Conflict of Interest
None declared.

Reference

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