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Correspondence

Letters to the Editor should not exceed 500 words.

Radiotherapy in Cancer

SIR,—In his letter concerning our fourth statistical report[1] Mr. R. G. Williams (1 February, p. 317) makes three predictable points of criticism which we hoped we had successfully anticipated when preparing that report. The fourth report differed from its predecessors by concentrating on definitive cure rates rather than simply considering survival at specified times after treatment. The assessment of curability (defined as the acquisition of a "normal" life-expectancy) of cancers arising in 18 different anatomical sites was presented graphically, for reasons which were fully explained. In addition, the 5-, 10-, and 15-year age-corrected survival rates were tabulated, site by site, with the object of providing a ready indication of the efficacy of treatment. It is admittedly difficult to read accurate values off the graphs, but for stage I cases the crude survival rates, with their appropriate correction factors, can be obtained from the semi-logarithmic curves, if required, for 1, 2, 3, 4, 5, 7, 10, 12, and 15 years after treatment. Because of the large numbers of variables involved it would not have been practicable to include all the figures necessary to calculate the age-corrected survival rates, given the crude values (p. 137). And of course the provision of more and more tables, with further breakdown of data, would in our view have obscured the primary object of our report.

Mr. Williams also urges the publication of data in a form potentially "comparable with other series." Here again we did express the view that comparisons of results of treatment even within one centre, and much more so beween different centres, are fraught with statistical difficulties unless they are based on carefully designed and rigorously applied clinical trials (p. 10). Differences in staging criteria (ours were fully stated in a separate appendix), in treatment policy and techniques, and in age and sex distributions are but a few of the possible sources of bias.

Finally, Mr. Williams speaks of "exclusions" and "considerable selection." To analyse, as we did, the results of treatment, stage by stage, to determine specifically curable categories of patient is of course a form of selection—but a deliberate and statistically valid one. The exclusions which were quoted in each anatomical section of the report were also for valid reasons. Mr. Williams selects for comment cancer of the hypopharynx, where, as he well knows, too many patients (80% of our 354 excluded patients) arrive at hospital with disease too extensive even for palliative measures to be deemed wise—except for opiates. The remaining 20% of our excluded patients either refused treatment or their general condition precluded any active treatment. All of these "exclusions" and "selections" were based on sound clinical judgement and were certainly not designed to "improve" the results of our therapeutic efforts. Indeed, on p. 127 we state that "it has not been our intention to claim extravagant cure rates" and that "on the contrary" disappointingly low definitive cure rates have been found in certain sites. So far as hypopharyngeal cancer is concerned—unlike many others discussed in our report—we comment that "cure of such lesions is not a tenable proposition," at least from the data available to us.

In short, the object of our report was to break away from the traditional parameters which Mr. Williams seems to prefer, and to offer, as a superior alternative, a statistically and clinically sound index of curability with reference to the life-expectancy of the local community from which the cancer patients are drawn.—We are, etc.,

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REFERENCE
1 Easson, Eric C., and Russell, Marion H., *The Curability of Cancer in Various Sites: The Fourth Statistical Report of the Christie Hospital and Holt Radium Institute, Manchester*, 1968. London, Pitman Medical Publishing Co.

Pregnant Patients and Prednisone

SIR,—Dr. A. M. Driscoll's report (1 March, p. 556) of subnormal oestriol and normal pregnanediol excretions in a pregnant woman receiving large quantities of prednisone confirms our earlier findings[1] in two similar patients, who also delivered healthy infants. This dissociation of oestrogen and progesterone production tends to emphasize the different means by which these hormones are produced in pregnancy. However, neither Dr. Driscoll nor ourselves measured the pregnanediol excretion of our patients before commencement of corticosteroid therapy. Scommegna, Nedson, and Chattoraj[2] found that urinary pregnanediol levels fell promptly during dexamethasone treatment and returned to pretreatment values when the steroid was withdrawn. Until further studies of patients before, during, and after corticosteroid treatment are made, a suppressive effect on progesterone production should not be excluded entirely.

Brown, Beischer, and Smith[3] concluded from a careful study of thirteen pregnant