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SUPPLEMENT

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CORRESPONDENCE

Correspondents are urged to write briefly so that readers may be offered as wide a selection of letters as possible. So many are being received that the omission of some is inevitable. Letters should be signed personally by all their authors.

Curability of breast cancer

SIR,—I read Mr M Baum's excellent review article (21 February, p 439) and your comments on breast cancer (p 414) with great interest and agree that new techniques are required to detect those metastases not revealed by routine *x*-ray investigation of the lungs and skeleton in favourable cases before treatment is begun. The whole subject is indeed gloomy, but the prognosis is not so hopeless as your assertion that only 20-30% of patients with early disease benefit from local treatment would suggest. Published results refute this and in my own small series of unselected patients with invasive carcinoma of the breast treated since 1946 and assessed in 1966 to determine the 10-20-year results I confirmed that in stage 1 cases (*a*) 56% were alive and free from detectable cancer, (*b*) an additional 6% were alive but under treatment for recurrent carcinoma, (*c*) 26% had died of malignant disease within 10 years of operation, nearly half within 5 years, (*d*) 7% had died of unconnected conditions, and (*e*) 5% had been lost to follow-up. It is conceded that a few patients might have recurrence after 15, 20, or even 30 years of freedom. These patients were treated initially by radical mastectomy without radiotherapy, but in those who developed metastases all forms of therapy were given, sometimes with miraculous though temporary recession.

The early deaths from disseminated malignant disease after operation for clinically stage 1 cases cause the greatest concern; evidently these patients had undetectable metastases at the time of operation, which was of no practical benefit except the removal of the obvious lump. Some patients with small carcinomas, apparently still in stage 1, are already doomed before medical advice is sought, and only when safe and effective cytotoxic drugs that will destroy metastases are perfected, perhaps in combination with hormone therapy, can they be saved. Indeed such drugs will ultimately make operative treatment obsolete. At present, however, the best hope for the individual woman with stage 1 carcinoma remains radical excision alone or simple amputation with radiotherapy, and additional present-day cytotoxic drugs in all cases should improve the long-term results by their effects on metastases that are already present.

Stage 2 carcinomas are not early cases and my 10-year results treated by radical excision and radiotherapy or simple amputation and radiotherapy illustrate this: (*a*) 17% were alive and free from detectable carcinoma, (*b*) an additional 6% were alive with recurrent growth, (*c*) 70% had died of malignant disease within 10 years, and (*d*) 7% had died of unrelated conditions. These results are so poor that although I disapprove, on ethical and other grounds, of blind controlled trials on surgical patients, a case could be made out to justify them in this group.

In stage 3 carcinoma not a patient survived five years with any form of treatment, and these figures emphasise the importance of diagnosis and treatment of carcinoma of the breast before stage 2 is reached.

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SIR,—In his article on this subject Mr M Baum (21 February, p 439) states his opinion that mastectomy for 70% of women with primary disease is a "futile mutilating procedure." My disagreement with this statement may best be expressed by quoting a *BMJ* leading article on the treatment of early carcinoma of breast.[1] "If several suggested techniques give the same expectation of life, it is then necessary to define which of them gives the best chance of local control of the disease, so that even though the patient may eventually die of disseminated cancer she is at least saved the pain and suffering of local ulceration."

It is known that in the treatment of early breast cancer procedures less radical than simple mastectomy, such as sector mastectomy[2] or wide local excision of the tumour,[3] are associated with a significantly greater rate of local recurrence. Surely a discussion of the place of mastectomy in the cure of early breast cancer is inseparable from a consideration of the place of mastectomy in the eradication of local disease. Apart from describing the natural history of breast cancer, with invasion of chest wall and ulceration of skin, Mr Baum makes no attempt to qualify his condemnation of mastectomy in terms of the benefits of local eradication of disease.

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[1] *British Medical Journal*, 1972, **2**, 417.
[2] Taylor, H, *et al*, *British Journal of Surgery*, 1971, **58**, 161.
[3] Atkins, H, *et al*, *British Medical Journal*, 1972, **2**, 423.

SIR,—As co-ordinator of a trial studying chemotherapy in early breast cancer, I was very interested in your leading article (21 February, p 414) and the article by Mr M Baum (p 439). I welcomed especially the suggestions that breast cancer should be assumed to be metastatic until proved otherwise and that patients should be entered into one of the current trials investigating the value of systemic treatment at the time of mastectomy.