BRITISH MEDICAL JOURNAL

SATURDAY 24 MARCH 1979

LEADING ARTICLES

PAPERS AND ORIGINALS

MEDICAL PRACTICE

NEWS AND NOTES

SUPPLEMENT

NO 6166 BRITISH MEDICAL JOURNAL 1979 VOLUME 1 771-838
BRITISH MEDICAL ASSOCIATION TAVISTOCK SQUARE LONDON WC1H 9JR.

ASTM CODEN: BMJOAE 1 (6166) 771-838 (1979)
WEEKLY. SECOND CLASS POSTAGE PAID AT NEW YORK NY

CORRESPONDENCE

We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters must be signed personally by all their authors. We cannot acknowledge their receipt unless a stamped addressed envelope or an international reply coupon is enclosed.

Why join a multicentre breast cancer trial?

SIR,—Dr L F N Senanaynke and Mr M Baum (10 February, p 409) have recently appealed to surgeons to enter their patients with "early" operable breast cancer into clinical trials of adjuvant treatment. Despite the early but encouraging results from adjuvant chemotherapy[1-3] less than 15% of women with breast cancer are entered into such studies in the United Kingdom each year.[4]

There can be no doubt that these trials are important. Why the apparent apathy? Many may feel that the individual rewards of entering patients into large-scale trials are too small and the extra work is too onerous. Others may resent the rigidity imposed on them by trial protocols. Can an individual surgeon therefore make a useful contribution from his own work?

To test this I have recently reviewed the 10-year follow-up of all the new patients with breast cancer entered into a personal trial by one surgeon from 1964 to 1968. The policy at the time was to treat all patients with early disease with cyclophosphamide, 100 mg intravenously, at operation and on each of the subsequent five days with the aim of comparing the results with those in historical controls. Altogether 120 new patients were seen but 68 were immediately excluded: five had stage III disease and 13 stage IV; for 24 there was no evidence about treatment; six were lost to follow-up; for 10 there were no nodes in the histology specimen; and 10 were rejected for miscellaneous reasons.

Fifty-two women were therefore suitable for further analysis. However, it seems apparent that adjuvant chemotherapy has different effects in premenopausal and postmenopausal groups.[5] Further stratification is therefore required:

	Stage I	Stage II
Premenopausal	13	13
Postmenopausal	11	15
Total	24	28

Unfortunately, further variables were present—some patients receiving radiotherapy, and surgery consisting of either modified radical mastectomy or simple mastectomy with or without oophorectomy. Clearly, despite an apparently large number of patients, no conclusions can be drawn despite the use of what at the time was felt to be standard treatment. Unfortunately, in routine clinical practice treatment rarely is completely standard unless patients are put into the rigid schemes of trials. Furthermore, because of the various substratifications of the disease it is necessary to obtain large numbers of patients outside the scope of any one surgeon's experience.

Medical literature is crowded with personal series and uncontrolled studies. Such work has provided fuel for the long-standing arguments which have raged over the various types of surgery in breast cancer. Surely we must avoid this when adjuvant chemotherapy is evaluated? To this end, since the long-term benefit of adjuvant treatment is not proved, it would seem unwise to treat patients outside carefully controlled randomised trials and ideally surgeons should enter all their patients into such studies. For, as Benjamin Franklin said, "Yes, we must indeed, all hang together, or, most assuredly, we shall all hang separately"[6] —and unfortunately we would be none the wiser.

R J GRIEVE

Clinical Oncology Unit,
Queen Elizabeth Hospital,
Birmingham

[1] Fisher, B, *et al*, in *Adjuvant Therapy of Cancer*, ed S E Salmon and S E Jones, p 123. Amsterdam, North-Holland Publishing Company, 1977.
[2] Bonnadonna, G, *et al*, *Cancer*, 1977, **39**, 2394.
[3] Edelstyn, G, *et al*, *Lancet*, 1978, **2**, 1092.
[4] British Breast Trial, Co-ordinating Committee meeting, Heathrow, February 1978.
[5] Bonnadonna, G, *et al*, *Oncology*, 1978, **5**, 450.
[6] Franklin, B, address to the continental congress before the signing of the Declaration of Independence.

Age and death in breast cancer

SIR,—Your leading article "Age and death in breast cancer" (27 January, p 211) supports the idea that breast cancer is a more aggressive disease in older women. While I agree that this finding is "surprising" I am unsure whether the evidence presented in your editorial adds support to this hypothesis.

There is a misquote from the original paper of Mueller *et al*. The figures they reported for the 50% mortality time—that is, the period of time at the end of which 50% of the original group will have died—are based on deaths from all causes, not just from breast cancer as implied in your editorial. It is thus hardly surprising that their results showed diminished survival with increasing age.

The method Mueller and his colleagues used in their analysis to counter the general effect of age on mortality was to present some of their data in terms of deaths from breast