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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.

Correspondents should present their references in the Vancouver style (see examples in these columns). In particular, the names and initials of all authors must be given unless there are more than six, when only the first three should be given, followed by et al; and the first and last page numbers of articles and chapters should be included. Titles of papers are not, however, included in the correspondence section.

Breast cancer trials—a new initiative

SIR,—The dispute between Professor M Baum and Dr L A Price (22 November, p 1422; 3 January, p 68) has now spilled over into the tabloid medical press (*On Call*, 18 December), which has sought opinions from America and France and sided with Dr Price. Very soon our squabble will be in the lay press, causing yet further distress to our patients.

As a general surgeon who has personally managed some 250 patients over 10 years and entered patients into the Birmingham trial (fluouracil, doxorubicin, cyclophosphamide, vincristine, and methotrexate) and into the last King's College Hospital trial (melphalan and methotrexate) I feel qualified to talk about ethics. I well remember the late Dr G Edelstyn telling us at a meeting in 1977 that so far as he was concerned a control group was no longer ethical as his cytotoxic therapy was proving effective in delaying recurrences. The Birmingham consultants would not accept his views and included control groups for stage I and II. The protocol for Professor Baum's new trial contains a control group, yet Dr Price and Dr Margaret Spittle (3 January, p 68) make no reference to the ethics but vent all their criticism on the proposal to use cyclophosphamide for six days, which if Nissen-Meyer is wrong, would amount to the same thing.

While I would accept that the Birmingham regimen (on which I believe Dr Price advised) is tolerable, there is no doubt that the inevitable hair loss (I have yet to evaluate scalp freezing) and severe malaise for 24-48 hours after therapy every three weeks for eight courses does cause suffering. It seems that the Bonnadonna protocol using cyclophosphamide, methotrexate, and fluouracil (CMF) will benefit premenopausal women; but the toxicity is such that those repeating the work in Manchester have at recent meetings voiced their profound relief at the prospect of terminating recruitment and even questioned whether the expected benefit would be worth the treatment—a crucial point that oncologists should force themselves to answer *before* they have the results.

Stimulated by the work of Maguire *et al* on the psychiatric morbidity of mastectomy,[1] I have offered synchronous silastic implants to many of my patients, even though such a policy has been condemned.[2] At first I defensively told my patients that it *could* prejudice their survival by about 5%, and not a single patient changed her mind. I have yet to regret synchronous implants and others see no harm.[3] Therefore I see nothing unethical in a patient's being offered and accepting a tangible short-term benefit of a treatment while still young at the possible expense of something, not yet evaluated, later. Until we know—that is, until we have a marker or other test—which patients to treat aggressively, it seems wrong to bully those who will live long without really toxic adjuvant therapy into submitting to the vicious and probably carcinogenic medication required by the rest. I approve of the Birmingham trial of aggressive adjuvant chemotherapy but if it turns out disappointing should we ask: "Was it because we did not use enough drugs for long enough?" I think not, except in specialised centres, where Drs Price and Spittle and Dr Bridget Hill (6 December, p 1565) should properly push forward the frontiers of their specialty.

Why do Drs Price and Spittle object so much to the repeating of the work of Nissen-Meyer when they seem to raise no protest about others repeating the CMF regimen of Bonnadonna, which makes patients feel awful and promises little more than Nissen-Meyer claims as regards survival? I suspect that what has really angered Drs Price and Spittle is the perhaps unfortunate suggestion by Professor Baum that the oncology services are not up to the task of mass delivery. I have yet to hear an oncologist (or radiotherapist) admit publicly that general surgeons like myself remain fit to treat breast cancer today. To date Professor Baum has asked for my