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SUPPLEMENT

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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,—Professor Michael Baum (13 September, p 742) proposed to repeat the Oslo trial of adjuvant chemotherapy in patients with primary breast cancer. He pointed out that only a small proportion of such patients are, at present, being admitted to controlled trials of adjuvant chemotherapy. As the therapy proposed—a single short course of cyclophosphamide immediately after mastectomy—is simple it should be possible to recruit some of these patients for the trial.

The response to Professor Baum's proposal has been surprising. In particular, Dr L A Price (22 November, p. 1422) presents a powerful argument for treating all high-risk primary breast cancer patients with full courses of combination adjuvant chemotherapy and implies that it is unethical to consider anything less. Before anybody's ethics are impugned it is worth reassessing the facts.

At the present time few surgeons have the time or facilities to monitor patients during a full course of adjuvant chemotherapy. In addition I suspect that there is reluctance to subject a woman who has just lost her breast to potentially highly toxic therapy at a time when she needs great support to adjust to her new status.

With minimum cost to the patient the Oslo trial[1] achieved an overall increase in survival of 10%. It has been assumed that adjuvant combination chemotherapy can achieve much greater increases in survival; but, as Nissen-Meyer has so elegantly demonstrated,[2] the case has still to be proved. Furthermore, even if the anticipated increase in survival accrues, it will have to be balanced against the cost to the patient in terms of toxicity and against the cost to the NHS. It will be many years before the risk of new tumour induction can be fully assessed.

There are two reasons why the Oslo trial should be repeated. Firstly, Nissen-Meyer's findings must be substantiated independently. Secondly, our increased understanding of tumour biology and better staging, grading, and knowledge of oestrogen receptors makes it possible to stratify patients into prognostic groups. Thus in a well-stratified controlled trial it should be possible to identify the group of women most likely to benefit from a short course of chemotherapy; equally it will help define those women likely to benefit only from the type of therapy advocated by Dr Price.

I would like to remind Dr Price that it is as unethical to overtreat as undertreat patients and hope that all clinicians interested in breast cancer, this most unpredictable of diseases, will take part in well-stratified trials or studies in an effort to find the optimum treatment for an individual patient rather than advocating one form of therapy for all patients.

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[1] Nissen-Meyer R, Kjellgren K, Malmio K, Mansson B, Norin T. *Cancer* 1978;**41**:2088-98.
[2] Nissen-Meyer R. *Cancer Treat Rev* 1979; suppl 6: 101-4.

SIR,—The results of chemotherapy following radical surgery, described by Bonadonna and Valgussa,[1] have proved exceedingly disappointing in the postmenopausal cases because no benefit has been shown. Thus there is no statistical evidence that micrometastases are dealt with. It would have been helpful if the results of a controlled series of oestrogen-ablated premenopausal cases had been described, with or without chemotherapy.

Improved selective management of cancer is possible from preliminary hormone studies of vaginal smears and chemistry[2] as well as anti-cancer drugs selected by testing against growing cells (comparable with bacteria and antibiotics). The toxicity from multiple drugs monthly is associated with the short cell-cycle time of the small gut and marrow.[3] The benefit of confining administration to one to