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MEDICAL PRACTICE

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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: a case for conservation

SIR,—In your leading article "Breast cancer: a case for conservation" (7 March, p 759) you refer to the pioneer work of Sir Geoffrey Keynes,[1] to whom the greatest credit should be given for encouraging some surgeons to look more critically at their results. Alas, in the 54 years since the publication of that report many have shown a curious reluctance to face the facts.

One of your predecessors was kind enough to publish a detailed review of conservative and radical surgery which three of us prepared in 1953.[2] That series was of considerable interest because it included all of Keynes's cases at St Bartholomew's Hospital in the decade 1930-9. Working on that study with a skilled radiotherapist and an excellent statistician, I personally learnt that, in terms of survival, there seemed little to choose between different methods of treatment. Our group was impressed by the failure to improve survival and also by the increased morbidity of more radical methods. Indeed, there was some evidence that survival might be prejudiced, though this was not statistically significant.

Our survey showed that simple surgery carried a higher incidence of local recurrence, though in 127 of 216 cases the primary operation had consisted of no more than a local excision. Notwithstanding increased local recurrence, it was clear that limited surgery did not prejudice survival; but 10 of the 127 patients having local excisions subsequently had more extensive surgery.

It is now fashionable to advocate prospective randomised trials, though many fail to realise how difficult the conduct of such trials can be. They become more difficult in the context of fully informed consent as this is now understood and acted on by the enlightened doctor. Moreover, many of the randomised trials in breast cancer have done no more than confirm what some of us previously learnt from scrupulously planned retrospective studies. I have no wish to seem scornful of the randomised prospective trial, but I do submit that far too many doctors have become obsessed with the concept without realising the snags when it comes to the management of intelligent and properly informed patients.

My personal participation in the Barts research has had a profound effect on my practice in the ensuing 28 years. I gave up radical surgery while the research was in progress and have never regretted that decision. For some years simple mastectomy with