persons such a rule is impossible to practice—and who should then be informed?

Most serious are, however, the restrictions concerning data which may only be used for the purpose for which they were collected. It is a fact that it is often an unforeseen combination of data from various data sources, which result in very important research achievements and which can be used for establishing the course of the disease and for the prevention of diseases. Within cancer epidemiological research, linkages between cancer files and information on occupational groups should be mentioned, as it has been possible to evaluate occupational exposure to carcinogenic factors or even the importance of the occupation for the development of cancer, or linkage between other files concerning diseases. The proposal for a directive suggests that "files concerning diseases" may be excluded from the scope of some of the provisions, but the limited possibilities of linkage with other "files concerning non-diseases" may be characterised as a disaster to research, and in the long run they will have unintended effects on both individuals and the public as a whole, who are then prevented from benefiting from the experiences of other cancer patients.

In connection with the discussions of the proposal for a directive which have taken place so far in a number of committees under the European Parliament, a considerable number of objections and amendments to the present proposal have been put forward.

The Association of European Cancer Leagues (ECL) has made a number of politicians, authorities and scientific committees at the national, as well as at the EC level, aware of the proposal for a directive and the very negative effects an implementation of the present proposal for a directive is bound to have on cancer research. These initiatives have received positive response.

Presently there are indications that the EC commission—after the European Parliament voiced its opinion on the proposal for a directive in December—will prepare a new and greatly revised directive in the course of February–April 1992.

Therefore, it is of the utmost importance that the near future sees broad and massive efforts through existing national and EC networks in order to influence the new version of the EC directive, so that research is excluded from the scope of the directive, or that any unavoidable provisions are based on reasonable and useful legislation such as the legislation which has been applied in the Nordic countries, including Denmark, over the last few years.

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Axillary Surgery in Breast Cancer—Is There Still a Debate?

IT IS PARADOXICAL that when the most extensive axillary surgery was performed there was no form of systemic therapy in use which could affect survival. Now that proven adjuvant treatments are available for both premenopausal and postmenopausal patients, many are missing out on the opportunity for cure or prolongation of life because of inadequate axillary surgery missing metastatic disease and increasing the risk of local relapse.

Consistent evidence shows that clinical evaluation of the axilla has low (60%) sensitivity and specificity [1, 2]. Furthermore, attempts to image the axilla radiographically, ultrasonographically or by lymphoscintigraphy have been unsuccessful [3]. Thus the pathologist is still the final judge, provided of course that the evidence of the surgical specimen is adequate.

This should not be seen as an argument between axillary sampling and axillary clearance. The function of node sampling is with minimal morbidity to obtain sufficient nodes for negativity to be confirmed. Thus, when carried out well, it has a specificity greater than 95% [4]. Those who have achieved these results do not regard sampling as an adequate treatment for the involved axilla. If axillary lymph node metastases are confirmed histologically (possibly by frozen section) the procedure may be converted to a clearance, or treated by axillary irradiation.

Unfortunately many surgeons do not know how to carry out this procedure because they were trained by consultants who carried out a total mastectomy and either left the axilla to its own devices, or alternatively gave indiscriminate radiation.

There are still a few surgeons who neither clear nor sample the axilla. This is unacceptable. Without this prognostic information systemic therapy may not be given when appropriate, and risk of local relapse will increase [5]. As more surgeons develop a specific interest in breast problems, particularly in relation to screening assessment, so it will become important that audit forms a central role in that process. Failure to demonstrate adequately (more than 4 nodes in the sample) that the axilla is negative, or to undertreat an involved axilla, should in the first place be subject to peer pressure, because soon such mistreatment might be medicolegally indefensible.

It is essential that surgeons in training who have an interest in cancer should be taught the technique of axillary clearance. With experience, this can be carried out with minimal (< 2%) morbidity from shoulder stiffness and arm lymphoedema. The

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advances that are being made in both breast-conserving techniques and adjuvant therapy must not be emasculated by inadequacies of surgical technique.

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Papers

Desmoid Tumours Treated with Triphenylethylenes

M.D. Brooks, S.R. Ebbs, A.A. Colletta and M. Baum

Desmoids are uncommon mesenchymal tumours that occur at single or multiple anatomical sites, occasionally in association with polyposis coli. This paper describes the use of the triphenylethylene tamoxifen, and a new chlorinated analogue, toremifene, in 20 patients with progressive desmoid disease. Clinical responses ranging from stabilisation of disease to complete resolution were observed in 65% of cases. The antitumour activity of this group of drugs has been attributed to their anti-oestrogenic behaviour. However, desmoids provide a clinical model of a purely mesenchymal tumour which appears to respond despite having generally low levels of hormone receptor. This emphasises the significance of the stroma within breast (and other) tumours, in particular how the stroma may regulate the response to these drugs regardless of receptor status.
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INTRODUCTION

TAMOXIFEN, A triphenylethylene traditionally described as an 'antioestrogen', is used widely in the treatment of early and advanced breast cancer. It is thought that its mode of action is via oestrogen receptors within the tumour cells [1]. This hypothesis obtained credence from trials of tamoxifen in women with advanced breast cancer, where a response was seen in approximately 60% of those women with tumours rich in oestrogen receptor (ER). In ER poor or negative tumours, responses were in the order of 10% [2]. Such a strong correlation was absent, however, from trials of adjuvant systemic tamoxifen for early breast cancer. The Nolvadex Adjuvant Trial Organisation (NATO) study demonstrated that although the presence of ER was a good prognostic indicator, the survival after 2 years on tamoxifen was identical for women with ER rich and ER poor tumours [3]. An overview of similar adjuvant tamoxifen studies confirmed a response independent of ER status [4]. A new or additional hypothesis for the mode of action of the triphenylethylenes is required to explain these findings. We propose that the tumour stromal fibroblasts themselves respond to these drugs and in turn influence the growth of adjacent

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