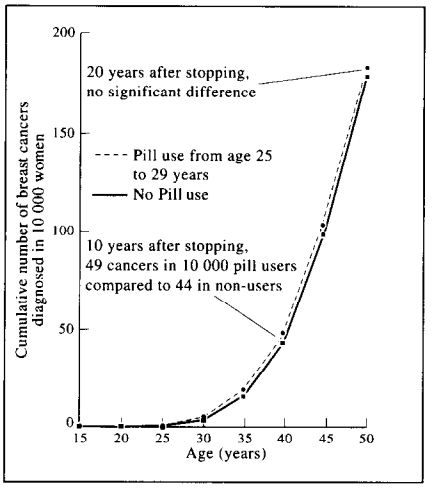

Figure 1. Cumulative number of breast cancers diagnosed in 10 000 women (reproduced with permission of *The Lancet* from The Lancet 1996, Vol. 347, pp. 1713–1727).

age, approximately 49 breast cancers would be diagnosed in the period from start of use up to 10 years after stopping, compared to 44 cancers diagnosed in women who had not taken the Pill. The estimated increase in the number of breast cancers diagnosed up to 10 years after stopping is smaller the younger the women were when they last used the Pill. For example, in 10 000 women who used the Pill from 16 to 19 years of age, the corresponding numbers would be 4.5 and 4.0 breast cancer.

Dr Beral said: "Overall, the results show that 20 years after stopping the Pill, there is little difference in the total number of breast cancers diagnosed between women who have and have not used the Pill. What is more, the cancers in women who have taken the Pill are less likely to have spread beyond the breast and are therefore potentially more curable."

Critique

A critique of the study recently appeared as an editorial in the *British Medical Journal* [2] by Professor Elina Hemminki, Research Professor at the National Research and Development Centre for Welfare and Health, Health Service Research Unit, Helsinki, Finland. She said that pooling data cannot overcome the limitations of individual case–control studies. "The report does not tell us how the controls were chosen, nor whether they were representative of the population from which the cases came."

She comments on a few possible selection biases. Possibly, women may decide not to use oral contraception because they believe themselves to be at high risk of breast cancer. Also, many women stop taking the Pill because of side-effects and possibly such sensitivity to external hormones could be related to risk of breast cancer.

At the time when the studies were done, prolonged use of the Pill before first pregnancy was rare. The median duration of use in the study was 3 years and the median age of starting the Pill was 26 years. Thus, Professor Hemminki says the review does not look at long-term use before first pregnancy. "In view of the current trend towards starting use before the age of 20, this would have been important. Neither does the review look at potential long-term consequences, when the early starters reach the age of high breast cancer risk or when users enter the new hormonal balance of menopause and possibly postmenopausal hormone therapy."

1. Collaborative Group on Hormonal Factors in Breast Cancer. Breast cancer and hormonal contraceptives: collaborative reanalysis of individual data on 53,297 women with and 100,239 women without breast cancer from 54 epidemiological studies. *Lancet* 1996, **347**, 1713–1727.
2. Hemminki E. Oral contraceptives and breast cancer. *Br Med J* 1996, **313**, 63–64.

orectal cancer study, 57 patients were evaluable for response and toxicity. Partial responses were observed in 4 patients with a median response duration of 11 months.

In phase III trials by other researchers examining topotecan as second-line therapy against ovarian cancers, response rates were 10–15% among patients who had not previously responded to standard treatment and 25–30% among patients who had responded to first-line therapy. In one study, comparing topotecan and taxol for the treatment of advanced, recurrent ovarian cancer, topotecan showed a 20% response rate, whereas taxol had a 12% response rate.

Response rates as high as 39% have also been seen in phase III trials using the drug as a first-line treatment for small cell lung cancer. Future studies will look at how topotecan performs when used in combination with other drugs, such as cisplatin in small cell lung cancer.

WHO Cancer Unit Moves to Lyon

The WHO Cancer Control Programme headquarters has moved from Geneva to the premises of the International Agency for Research on Cancer (IARC) in Lyon.

In May 1996, a memorandum of understanding was signed between Dr H. Nakajima (WHO Director-General), and Dr P. Kleihues (Director, IARC) transferring the unit as of 1 July 1996. This was after support by the IARC Governing Council during its Thirty-sixth session by Resolution GC/36/R5.

A memorandum of understanding regarding the transfer of the Cancer Programme to Lyon says that the unit of Cancer and Palliative Care (CPL) has been disestablished and that the staff transferred to Lyon will operate under the designation of "WHO Programme on Cancer Control" (PCC). The unit will retain its global public health mission.

The Director-General of WHO will delegate to the Director of IARC the authority to supervise the Programme on Cancer Control. The Director of IARC will report directly to the Director-General on all matters covered by this delegation. The programme's mission and activities will be developed within a policy framework to be determined by WHO, through the World Health Assembly, the Executive Board and the Global Policy Council.

The benefit of the move to Lyon is said to be that it enables interaction of PCC with IARC scientists. "The results of ongoing research at the Agency will be used without delay for the proposal and implementation of public health projects conducted by PCC," a memorandum states.