European Journal of Cancer Vol. 33, No. 7, p. 1157, 1997

Printed in Great Britain
0959-8049/97 $17.00 + 0.00

PII: S0959-8049(97)00110-X

Response From: I. Rajower, A. J. Sasco and P. Kleihues

I. Rajower, A.J. Sasco and P. Kleihues

International Agency for Research on Cancer, 150 cours Albert Thomas 69372 Lyon Cedex 08 France

WE THANK Dr Weisburger for reminding everyone of the importance of diet in the aetiology of breast cancer. It is unfortunate that this aspect was not mentioned in the brief commentary which appeared in *International Cancer News* of the *European Journal of Cancer* [1]. We can only refer readers to our brochure in which this aspect is extensively discussed in the chapter on primary prevention by Levi and associates [2] We discuss the increased risk of postmenopausal breast cancer linked to increased weight and a hypercaloric diet rich in animal fat with a low intake of fresh fruit and vegetables. We also discuss the effects of fibre intake, alcohol and a potential beneficial effect of phyto-oestrogens. In our synopsis (on page 10), we write that "westernized diet plays a role" and we recognise the need to "conduct more prospective studies on dietary factors". As a practical recommendation for general health promotion, we write (on page 11) that one should ". . . reduce alcohol consumption . . .", ". . . promote a healthy diet and physical activity starting in childhood . . ."and ". . . avoid obesity" [3].

The above-mentioned comments should make it clear that we fully concur with Dr Weisburger on the importance of diet in the occurrence of cancer and we agree with him that this aspect should have been included in the summary.

The brochure "Breast cancer. Basic facts and need for action" can be obtained from the Swiss Cancer League at the following address:

Mrs Xandra Gravestein
Project Manager Breast Cancer
Swiss Cancer League
Effingerstrasse 40
3008 Bern Switzerland
Fax: (41) 31-389-9100
e-mail: gravestein@swisscancer.ch

Correspondence to I. Rajower.
Received 31 Oct. 1996; accepted 12 Nov. 1996.

1. International Cancer News. Swiss Plan Fight Against Breast Cancer. *Eur J Cancer* 1996, **32A**, 1830–1831.
2. Levi F, La Vecchia C, Birkhäuser MH, *et al.* Primary prevention and early detection. In Rajower I, Sasco AJ, Kleihues P, eds. *Breast Cancer: Basic Facts and Need for Action.* Bern, Swiss Federal Office of Public Health and Swiss Cancer League, 1996, 8–10.
3. Bouchardy C, Gutzwiller F, Goldhirsch A, *et al.* Prevention and early detection. In Rajower I, Sasco AJ, Kleihues P, eds. *Breast Cancer: Basic Facts and Need for Action.* Bern, Swiss Federal Office of Public Health and Swiss Cancer League, 1996, 11–13.

European Journal of Cancer Vol. 33, No. 7, pp. 1157–1158, 1997

Printed in Great Britain
0959-8049/97 $17.00 + 0.00

PII: S0959-8049(97)00007-5

Primary Treatment in Stage II Non-seminomatous Germ Cell Tumours of the Testis: a Matter of Scalpel or Drug Infusion?

T.F. Sandeman

Peter MacCallum Cancer Institute, St. Andrew's Place, East Melbourne, Victoria 3002, Australia

I WOULD like to comment on Culine and Droz's article [1]. It is disappointing that a firmer conclusion was not drawn as the data is in the literature.

Please note the logic of the Indiana experience of RPLND which they quote extensively. The operation produces the best results in node-negative cases when it is not needed. Once it really does remove disease, the failure rate is so high that chemotherapy is essential to make RPLND look at all useful. It is all very well to say that 65% of pathological stage II disease were cured by RPLND alone—but which 65%? To increase that figure to a respectable 95%, postoperative chemotherapy was required. If the patient really wants an "event-free survival", chemotherapy is needed in the postoperative phase whatever stage is found.

Why subject patients to a potentially fatal (surgery of this extent, especially in non-expert hands, cannot be expected to have a mortality rate of 0%) and a probably morbid procedure (dry ejaculation rate 86% and unstated impotence rate, if the more complete operation is used) when all that is needed is a reliable prediction of relapse. The Indiana ex-

Received 31 Oct. 1996; accepted 12 Nov. 1996.

perience relates, after all, to patients subjected to the procedure merely to establish the stage—the results are then presented on a pathologically staged basis. This is merely massaging data which was long ago shown to distort the results without doing anything for the patients [2].

I agree there are false-positive stage II patients when using only radiology, but the number is not so great that we must subject every sufferer of NSGCT to removal of the lymph nodes from the upper abdomen, particularly when a third of them have undiscovered disease elsewhere. These must be given cytotoxics to complete the cure, but surgery has not provided a tool to predict reliably which patients really need them. If cytotoxics are to be a part of the treatment plan, surely it would be less traumatic to use them first and save the surgery for those in whom persistent masses present danger of local recurrence. There are well-known risk factors which are non-invasive and dependable. One of the simplest is to examine the testicular specimen for vascular invasion. If that is absent and CT scanning of the abdomen and chest and tumour markers are negative, there is ample evidence that a surveillance policy is perfectly safe [3]. Alternatively, if any of these investigations are positive, 2–3 courses of a platinum combination chemotherapy can be curative, without invoking extensive surgery merely to select which patient should be so treated. The results are quite remarkable [4].

1. Culine S, Droz J-P. Primary treatment in stage II non-seminomatous germ cell tumours of the testis: a matter of scalpel or drug infusion? *Eur J Cancer* 1996, **32A**, 1641–1644.
2. Sandeman TF. Elective treatment of lymph nodes in malignant melanoma. *Lancet* 1965, 345–347.
3. Cullen M. Management of stage I non-seminoma: surveillance and chemotherapy. In Horwich A, ed. *Testicular Cancer, Investigation and Management*. London, Chapman and Hall Medical, 1991, 149–166.
4. Sandeman TF, Yang C. Results of adjuvant chemotherapy for low-stage nonseminomatous germ cell tumors of the testis with vascular invasion. *Cancer* 1988, **62**, 1471–1475.