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Editorial Comment

B.I.G. — is beautiful

M. Baum

Department of Surgery, Institute of Surgical Studies, University College London, 67–73 Riding House Street, London, W1P 7LD, UK

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There is an advert doing the rounds on the independent television channels starring Anthony Hopkins as a big businessman lounging in the back of his chauffeur-driven limousine. His monologue promotes the notion of 'big business' and big is beautiful. It is only at the end that you realise that the advert is promoting Barclays Bank. This promotion rather blew up in the face of the bank when they were forced to announce the closure of nearly 200 small branches in the rural communities of the UK. However, as far as clinical trials for breast cancer are concerned, I truly believe that big is beautiful and unlike in the banking system, bigness can be achieved through a partnership of small individual units rather than at their expense.

I believe that big is beautiful for clinical trials for breast cancer for a number of reasons. Firstly statistical power is dependent, not upon the numbers of patients recruited but on the number of events occurring amongst those patients. Therefore, as outcomes improve we could become victims of our own success and have to wait longer and longer for sufficient events to determine whether the novel treatment is better than the standard. Furthermore, as predetermined subgroup analyses become more important in order to discover predictive factors for response to individual treatments, larger numbers are required at the outset. Finally, if we are selecting from a population of patients with breast cancer, a minority with predetermined biological characteristics for example (c-erbB2+) then in order to collect sufficient numbers of these types of patients for sufficient power the original pool of patients would have to be huge.

That, if you like, is the scientific justification for big is beautiful but there is also the issue of economy of scale in providing an adequate infrastructure to manage large numbers of patients, large data files and complex statistical analyses. For all these reasons therefore I applaud the establishment of the B.I.G. collaboration and wish it well in the future. My only argument with it so far, is that it is simply not big enough. The target number of patients in the five examples they list vary between 1300 and 5180 whereas the ATAC (anastrazole and tamoxifen alone or in combination) trial which has run independently of B.I.G. recruited over 9000 patients in approximately two and a half years. Furthermore, it is not entirely clear where the funding is coming from to support the trial activity separate to the input from the pharmaceutical industry. I would hope that in thinking big we should approach government agencies in all our countries to put their money where their mouth is. The management of patients within the protocols of randomised controlled trials should be considered normal practice within health services throughout the world. The management of patients within randomised trials based on protocols is superior to the *ad hoc* management outside of trials. It is, therefore, in the enlightened self-interest of all government agencies to see the funding of the infrastructure for clinical trials and the cost of individual patients passing through the system as central to their Health Service budgets. I would, therefore, suggest that B.I.G. becomes B.I.G.G.E.S.T. (Breast International Group Grows Eventually Stupendous).

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