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Mammography in Sweden

More evidence from Sweden suggests that mammography can reduce deaths from breast cancer by 45% (*Cancer* 2002, **95**, 458–469). Evaluation of the population service screening programme in seven Swedish counties suggested a 30% reduction among all women offered screening, regardless of whether they participated. The results indicate that most of the reduction in deaths "is indeed due to the screening," researchers say.

The research was carried out in the wake of several randomised trials of mammography screening and follows the furore after Olsen and Gotzsche

"MOST OF THE BENEFIT IS INDEED DUE TO THE SCREENING"

(*Lancet* 2001, **358**, 1340–1342) questioned the quality of these trials and threw doubt on the value of mammography. This study was an attempt to evaluate the performance of screening in an everyday setting and aimed to distinguish the mortality benefit among women who participate in screening from the benefit at the population level associated with the programme due, for example, to increased awareness of breast cancer.

The study included approximately one-third of Swedish women who were eligible for screening, and compared breast cancer deaths in study periods before screening was introduced, with those in the years immediately afterwards. Overall, there were 5728 cases of breast cancer in the prescreening group, and 8364 in the screening group. This corresponded with 1169 and 875 deaths.

The overall reduction in deaths was greater in counties in which screening had been taking place for more than 10 years, than in those in which screening was introduced more recently. This is consistent with data from randomised trials demonstrating that longer follow-up reveals greater benefits.

Before screening was introduced, mortality declined by 1% per year, presumably because of increased awareness leading to earlier reporting of symptoms and improvements in diagnosis, treatment and management. If this trend had continued, it suggests that a 12% reduction in deaths between prescreening and screening periods would be independent of the programme. It implies, therefore, that most of the 45% reduction among screened women was because of the mammography. Further, incidence of breast cancer rose throughout the study period, before and after screening was introduced—in one county by 2% per year.

"The results of the current study. . . demonstrate that the results from the randomised trials are reproducible when large-volume, well organised screening programmes are performed in dedicated mammography screening centres," the researchers conclude.

In an accompanying editorial, Dr Stephen Feig (Mount Sinai Hospital, New York) said that the results from this study, along with those from other reports from Sweden and Finland "confirm beyond any doubt" that the results from randomised controlled trials can be obtained in non-research, organised screening settings. He said that both types of studies have limitations "that result in underestimation of benefit for the individual woman who is screened."

Breastfeeding and breast cancer

The lack of, or short duration of breastfeeding typical in developed countries makes a 'major contribution' to the high incidence of breast cancer in these countries, researchers say (*Lancet* 2002, **360**, 187–195). They found that having a small family and breastfeeding only briefly is responsible for more than half the breast cancers in developed countries.

The researchers analysed individual data from 47 studies in 30 countries. It included 50 302 women with breast cancer and 96 973 without the disease. They concluded that if women in the West had the larger families and longer periods of breastfeeding typical in developing countries, the cumulative incidence of breast cancer would fall from 6.3 to 2.7 per 100 women by the age of 70. Almost two-thirds of this reduction was due to breast feeding.

Among women in both developed and developing countries, relative risk of breast cancer decreased by 4.3% for every 12 months of breastfeeding in addition to a decrease of 7% for each birth. Large families are unlikely to become common in the West but they conclude, "If in the future the mechanism of the protective effect of breast feeding on breast cancer were understood, it might be possible to prevent breast cancer by mimicking the effect of breast feeding therapeutically of in some other way."

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UICC strengthens links with US

Dr John Seffrin, Chief Executive Officer of the American Cancer Society, has taken on the additional role of President of the International Union Against Cancer (UICC). His term at UICC lasts for 4 years and he will continue his leadership of the American Cancer Society throughout.

In a statement, the American Cancer Society said it believes that "formal collaboration with the UICC reflects a shared, moral obligation and strategic decision to build a coalition in the interest of world health".

Dr Seffrin said that the burden of cancer has begun to shift to the developing world. "By transferring skills, sharing experience and collaborating with experts and organisations, we can help emerging societies apply proven strategies to save lives. And we can learn important lessons we can apply at home."

UICC Executive Director Isabel Mortara said, "Cancer knows no boundaries, nor should the fight against the disease. The American Cancer Society brings the size, scope, resources and proven effectiveness against cancer that few organisations can match. We welcome Dr Seffrin's leadership, insight and steadfast dedication as we attack this disease with a truly global perspective."

Dr Seffrin officially began his term during the 18th UICC International Cancer Congress (30 June–5 July 2002, Oslo, Norway).

ICSI after childhood cancer

Assisted conception is a realistic option for men who have undergone cancer treatment as children, Edinburgh researchers say (*Lancet* 2002, **360**, 361–367). They found that although conventional criteria of semen quality is often abnormal in cancer survivors, the sperm produced do not carry a greater burden of damaged DNA.

Concerns have been raised about the safety of intracytoplasmic sperm injection (ICSI). It has been suggested that spermatozoa from men with impaired spermatogenesis may carry abnormal genetic information, although data on the health of children born after ICSI are largely reassuring.

They assessed 33 survivors of childhood cancer and found that only 11 had normal semen quality, when compared with 66 age-matched controls. Ten were azoospermic. However, the non-azoospermic group had sperm DNA quality equal to that of the control group.

"This observation goes some way to providing reassurance about the use of ICSI, which will circumvent the problems associated with severe oligozoospermia and asthenozoospermia, and offer cancer survivors the possibility of paternity in adulthood," they say.

Questionnaire "helps identify colorectal cancer"

A questionnaire could help prioritise patients with colorectal symptoms, say UK surgeons. They devised a patient consultation questionnaire, with a weighted numerical score, which they say would reduce the number of referrals classed as urgent.

The study (*Lancet* 2002, 360, 278–283) included 2268 patients with distal colonic symptoms referred by their family doctor. Patients filled in the questionnaire and it was entered into the computer database by secretarial staff. The questionnaire is scored to reflect risk of cancer, with higher weighting given to high risk symptoms such as change in bowel habit to looser or more frequent stool. The final score reflects other information, such as patient's age, type of bleeding, frequency and so on.

The surgeons say that current NHS guidelines for referral of patients are sensitive to detection of cancer but are not specific and result in a large proportion of referrals classified falsely as high risk. In fact, the single criteria of age more than 60 was as specific as the existing guidelines.

With their scoring system, at a score of 50, surgeons would need to screen 39.8% of the referred population to detect 90.5% of cancers. They recommend using a score of 60, at which 25% of patients need urgent assessment, for detection of 75.8% of cancers. The system is 'accurate' for prioritising referred patients and "might also have a place in general practice to help family doctors identify individuals at substantial risk of colorectal cancer."

Glivec approved in UK

The National Institute for Clinical Excellence (NICE) in the UK has finally recommended imatinib (Glivec) for the treatment of chronic myeloid leukaemia (CML). It is now a treatment option for patients with Philadelphia-chromosome-positive CML in chronic phase in adults who are intolerant of interferon-alpha (IFN-α) therapy, or in whom IFN-α has failed to control the disease. Patients with disease in accelerated phase or blast crisis may also be considered for treatment.

NICE recommended that a national registry "would provide valuable information on longer-term effectiveness of imatinib treatment." It also urged continuing investigation into the comparative long term efficacy of imatinib on quality of life and survival; on the relationship between response rates and survival; and on the adverse effects and potential for resistance to long-term use.

Dr Richard Sullivan, head of Cancer Research UK's clinical programmes said, "Over 65 countries have licensed the drug and we are delighted English and Welsh patients will have the same access to Glivec as their counterparts in other parts of the EU."

EUROFILE

Anti-smoking campaign slammed

One of the many anomalies in the operation of the European Union is the propping up of tobacco farmers through subsidies on the one hand, while battling against smoking on the other. So when the Tobacco Fund was created to redistribute a proportion of the subsidy to anti-smoking activities, it was universally welcomed. However, years went by without the money being spent and the public health community started complaining. Then, last year, the Commission announced a tender for a youth anti-smoking campaign across all Member States.

The decision to spend the money was popular with the health lobby but the process was controversial even before the winning bid was announced. Most European tobacco control advocates have extensive knowledge of what works and what does not in stopping young people smoking. They also have data on tobacco industry tactics and the 'youth programme' campaigns that cigarette manufacturers run with the ostensible aim of discouraging smoking among young people.

THE EC MAY BE THE ONLY ORGANISATION RUNNING SUCH A CAMPAIGN

So health activists were surprised to discover that they had minimal involvement in the selection process for the winning tender. Then it came to light that some of those applying had been involved with the tobacco industry, and at least one tender was withdrawn for this reason, following pressure from anti-tobacco activists.

These problems paled into insignificance, however, when details of the campaign were announced. The contract was awarded to a German communications firm that had previously worked for the Commission on enlargement and BSE. While there were no concerns about any company links with the tobacco industry, the slogan "Feel Free to say No" and the programme felt strangely familiar to many. It is, in fact, similar to a number of youth anti-smoking campaigns launched by cigarette manufacturers. "The tobacco industry never objects to these kind of campaigns, no matter who is running them," says Liisa Elovainio, Vice President of the Association of European Cancer Leagues, "and one has to ask why."

The campaign concentrated on advertising, much of it on channels attractive to youth such as MTV. Famous footballers were signed up to support the cause, and the whole thing launched with much brouhaha at the end of May.

Commissioner David Byrne must have been disappointed by the lack of enthusiasm with which the initiative was greeted. But it is well documented that campaigns of this kind usually have the opposite effect—rather than discouraging young people from starting to smoke, they encourage them to see tobacco as forbidden fruit and part of a rite of passage to adulthood. Health promotion agencies have known for some time that it is more effective to try to stop people smoking in their early twenties, once the adult glamour of cigarettes has worn off, than to attempt to persuade young people not to start.

"I CAN ALMOST HEAR TEENAGERS SAYING: 'FEEL FREE TO SAY YES'"

BAT itself, long a leading proponent of this kind of campaign, has decided to end its involvement in such activities in Europe. Last year it teamed up with Philip Morris and Japan Tobacco in the "it's cool not to smoke" MTV campaign. Now, though, following its first attempt at 'corporate social responsibility', the publication of the BAT 'Report to Society', it is pulling out of a similar campaign because, according to a spokesman: "Some stakeholders said they did not think we should be associated with this kind of advertising."

So, somewhat embarrassingly, the European Commission may soon be the only organisation running such a campaign in Europe. To its credit, criticisms have been taken on board, and a review involving many of those experts who were not consulted in the beginning will take place when the campaign has been running for a year. But the perceived waste of money exasperates people: the campaign has a budget of €6 million per year.

"Targeting youth may seem logical," says Elovainio, "and therefore politicians and other non-experts support such campaigns. But we know that they simply do not work. As long as there are smoking adults, especially young smoking adults, smoking will continue in society and young people will be trapped by nicotine addiction. What is needed is practical help for existing smokers to quit, rather than a well-meaning campaign that will do little or worse still, positively encourage smoking.

"If you look at this campaign you will see hardly any difference between it and the tobacco industry's own campaigns, which are simply PR, and are not intended to have any effect other than to make smoking glamorous in the eyes of young people.

"There are a few good things—nicotine addiction and disease causation are mentioned—and I do not for a minute doubt that the Commission had the best of intentions in launching this campaign. But the slogan and the pictures are ones we have seen many times before, and I can almost hear young people saying: 'Feel free to say Yes'."

Mary Rice
Brussels

INTERVIEW

Dr Ian Magrath is President of the International Network for Cancer Treatment and Research (INCTR), Brussels, which works to improve cancer services in developing countries. He was previously Chief of Lymphoma Biology at NCI, Bethesda, Maryland. He is listed on the Honour Roll of the International Union Against Cancer (UICC).

Dr Ian Magrath

Where did you train?
Charing Cross Hospital, London, then the NCI and, more recently, in the developing countries in which I have worked.

Who inspired you?
Professionally, Ken Bagshaw, who was my mentor in oncology in London, and John Ziegler, with whom I worked, first in Africa and later at the NCI. Both were steeped in research and helped me develop a research perspective. Subsequently, Drs Shanta and Advani in India, and Drs El-Sebai and Gad-El-Mawla in Egypt. They improved oncology services in their countries in the face of enormous difficulties.

Why did you choose to work in the field of cancer?
I'd like to say I was attracted by the breadth and depth of a subject which deals with the essential processes and the lives of cells. But it was really because I worked with Ken Bagshaw who, in the late 1960s, was using chemotherapy to cure choriocarcinoma—something quite novel in those days.

Did any other branch of medicine appeal?
Neurology, for the mental exercise of understanding pathways and localising lesions. I'm also fascinated by the idea of the brain studying itself. But Burkitt's lymphoma lured me away from any more thoughts of neurology.

Might you have done something else altogether?
As a child, I wanted to be a vet, but later decided I wanted to help people, and became a doctor. I could imagine I'd have enjoyed studying cultural evolution or social anthropology. James Fraser wrote his classical book, *The Golden Bough*, without leaving Cambridge University, and lately, I've found the idea of the armchair philosopher appealing.

What has been the highlight of your career to date?
The development of treatment protocols for Burkitt's lymphoma which increased 5-year event-free survival from 40–50% to 90%. Also, demonstrating that the molecular lesions which cause tumours to develop can be their Achilles' heel and a target for therapy. At NCI, we developed a model for using antisense oligonucleotides against tumour-specific, messenger RNA in Burkitt's lymphoma.

. . . and your greatest regret?
That I and my colleagues could never finally prove that the *EBNA1* gene of the Epstein–Barr virus is involved in the pathogenesis of Burkitt's lymphoma. *EBNA1* could, nevertheless, be a good target for therapy, although it would have been satisfying to demonstrate that our mechanistic hypothesis was correct.

If you could complete only one more task before you retire, what would it be?
To ensure that INCTR, which is only 2 years old, has a solid grounding for a long and distinguished future. We work with colleagues from developing countries to improve cancer prevention and treatment, and if all else fails, to allow patients to die with dignity in these resource-poor regions. We have offices in Brussels the US, France, India, Egypt and Brazil, with a branch about to open in the UK. We have some 65 associate members, mainly cancer centres and university departments, and we're looking for professionals to volunteer their time.

What is your greatest fear?
Of being re-born. I'm not sure I'd like to live my life over again. Or to live someone else's, for that matter. Especially as almost half the world's population lives on less than $2 a day—I'd have a 50:50 chance of finding myself leading an oppressed life devoid of all opportunity. Nasty, brutish and short, in other words. I'd prefer oblivion.

What impact has the Internet had on your working life?
An enormous impact, for the information at my fingertips and rapid communication with colleagues across the globe. I receive ever increasing amounts of mail, but at least it's only electronic signals and doesn't consume trees as well as time!

How do you relax?
Listening to music and trying to understand what on earth the world is all about. I get angry at the rampant hypocrisy in the world, the notion that greed is good, and the religious faith in economic growth—remember, making cigarettes, nuclear weapons or paying divorce lawyers all count towards GDP!

Who is your favourite author?
Norman Davis for his tremendous erudition, and John Julius Norwich for his elegant prose; for fiction, Umberto Eco; and for something in between, Roberto Calasso, who conjures up a literary dreamworld.

What do you wish you had known before you embarked on your career?
One's career is so open to the nuances of chance events that can alter the path you take; I can't think of anything I wish I'd known, except, perhaps, how to see into the future. There are, on the other hand, many things I'm glad I didn't know.

What piece of advice would you give someone starting out now?
I would not presume to; everyone has to make their own way in the world, and things are different for each generation. Only, perhaps, to do something you enjoy and maintain a healthy scepticism.

What is your greatest vice?
Laziness. I always have heaps of writing to do, but I'd much rather read.