CORRESPONDENCE

We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters must be signed personally by all their authors. We cannot acknowledge their receipt unless a stamped addressed envelope or an international reply coupon is enclosed.

Why join a multicentre breast cancer trial?

SIR,—Dr L F N Senanaynke and Mr M Baum (10 February, p 409) have recently appealed to surgeons to enter their patients with "early" operable breast cancer into clinical trials of adjuvant treatment. Despite the early but encouraging results from adjuvant chemotherapy[1-3] less than 15% of women with breast cancer are entered into such studies in the United Kingdom each year.[4]

There can be no doubt that these trials are important. Why the apparent apathy? Many may feel that the individual rewards of entering patients into large-scale trials are too small and the extra work is too onerous. Others may resent the rigidity imposed on them by trial protocols. Can an individual surgeon therefore make a useful contribution from his own work?

To test this I have recently reviewed the 10-year follow-up of all the new patients with breast cancer entered into a personal trial by one surgeon from 1964 to 1968. The policy at the time was to treat all patients with early disease with cyclophosphamide, 100 mg intravenously, at operation and on each of the subsequent five days with the aim of comparing the results with those in historical controls. Altogether 120 new patients were seen but 68 were immediately excluded: five had stage III disease and 13 stage IV; for 24 there was no evidence about treatment; six were lost to follow-up; for 10 there were no nodes in the histology specimen; and 10 were rejected for miscellaneous reasons.

Fifty-two women were therefore suitable for further analysis. However, it seems apparent that adjuvant chemotherapy has different effects in premenopausal and postmenopausal groups.[5] Further stratification is therefore required:

	Stage I	Stage II
Premenopausal	13	13
Postmenopausal	11	15
Total	24	28

Unfortunately, further variables were present—some patients receiving radiotherapy, and surgery consisting of either modified radical mastectomy or simple mastectomy with or without oophorectomy. Clearly, despite an apparently large number of patients, no conclusions can be drawn despite the use of what at the time was felt to be standard treatment. Unfortunately, in routine clinical practice treatment rarely is completely standard unless patients are put into the rigid schemes of trials. Furthermore, because of the various substratifications of the disease it is necessary to obtain large numbers of patients outside the scope of any one surgeon's experience.

Medical literature is crowded with personal series and uncontrolled studies. Such work has provided fuel for the long-standing arguments which have raged over the various types of surgery in breast cancer. Surely we must avoid this when adjuvant chemotherapy is evaluated? To this end, since the long-term benefit of adjuvant treatment is not proved, it would seem unwise to treat patients outside carefully controlled randomised trials and ideally surgeons should enter all their patients into such studies. For, as Benjamin Franklin said, "Yes, we must indeed, all hang together, or, most assuredly, we shall all hang separately"[6] —and unfortunately we would be none the wiser.

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[1] Fisher, B, *et al*, in *Adjuvant Therapy of Cancer*, ed S E Salmon and S E Jones, p 123. Amsterdam, North-Holland Publishing Company, 1977.
[2] Bonnadonna, G, *et al*, *Cancer*, 1977, **39**, 2394.
[3] Edelstyn, G, *et al*, *Lancet*, 1978, **2**, 1092.
[4] British Breast Trial, Co-ordinating Committee meeting, Heathrow, February 1978.
[5] Bonnadonna, G, *et al*, *Oncology*, 1978, **5**, 450.
[6] Franklin, B, address to the continental congress before the signing of the Declaration of Independence.

Age and death in breast cancer

SIR,—Your leading article "Age and death in breast cancer" (27 January, p 211) supports the idea that breast cancer is a more aggressive disease in older women. While I agree that this finding is "surprising" I am unsure whether the evidence presented in your editorial adds support to this hypothesis.

There is a misquote from the original paper of Mueller *et al*. The figures they reported for the 50% mortality time—that is, the period of time at the end of which 50% of the original group will have died—are based on deaths from all causes, not just from breast cancer as implied in your editorial. It is thus hardly surprising that their results showed diminished survival with increasing age.

The method Mueller and his colleagues used in their analysis to counter the general effect of age on mortality was to present some of their data in terms of deaths from breast

cancer only. As differences in severity might explain variations in mortality rate, they confined their results to stage I only (cancer confined to breast tissue). They reported, as you explained, that the survival from stage I disease significantly decreased with increasing age. Unfortunately, only 8% of the oldest age group had a necropsy (as compared with 30% of the youngest). Thus they relied on clinical diagnosis of cause of death. It can often only be speculated that the presence of a stage I tumour in a woman aged 70-100 may or may not be the ultimate cause of death; and thus such a clinical diagnosis is liable to error.

Trials of aggressive chemotherapy in old women with early breast cancer might, you suggest, need to be considered. This step, not to be undertaken lightly, receives but little support from the evidence presented.

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[1] Mueller, C B, Ames, F, and Anderson, G D, *Surgery*, 1978, **83**, 123.

**We agree with Dr Silman that deaths due to competing risks become an increasingly significant factor the older the population at diagnosis of carcinoma of the breast. It is true that our leading article was guilty of a misquotation from Mueller's original paper concerning the 50% mortality time, which did in fact relate to deaths of all causes. Nevertheless, the article referred to clearly showed, by a life-table analysis of patients dying of breast cancer only, a more rapid death rate among the two older age groups than in the group aged 21-50. We accept that a difference in necropsy rate among the three subgroups analysed could in part have accounted for this finding, but one could equally well argue that the older the patient was at the time of death the less likely would carcinoma of the breast be implicated in the absence of necropsy, owing to the increasing likelihood of death from other causes influencing the judgment of whoever filled in the death certificate. Finally, we were not ourselves advocating trials of aggressive chemotherapy in older women with early breast cancer. Such an approach has already been advocated by Dr G Bonadonna's group in Milan and trials are under way; we were merely stating that this is the first evidence, albeit open to criticism, that lends support to the hypothesis that there are biological variations in breast cancer that may influence subsequent treatment in the postmenopausal women.—ED, *BMJ*.

Shingles: a belt of roses from Hell

SIR,—In their letter (3 February, p 346) on the leading article (6 January, p 5) I feel that Drs K D Crow and Julia P Ellis are unduly worried about the cost of specific antiviral treatment. This is because their calculations of the cost of topically applied idoxuridine are quite wrong. When the ingredients are bought from source the rough cost is about £50 per 100 ml of 35% (not 33%) idoxuridine in dimethylsulphoxide (DMSO). Idoxuridine costs £1·30 per gram when bought in bulk and the DMSO costs about £4 per 500 ml. The average cost of treating a patient is somewhere between £15 and £90, depending on the area. In my department we treat about 300 patients with zoster a year, which would not be possible if the cost ran to £1000 per patient as Drs Crow and Ellis suggest, for we suffer from financial restraints as much as any other region. The method of constant application is described by Juel-Jensen *et al.*[1] It is important to emphasise that the same piece of lint should be reused.

The paper by Merselis *et al*,[2] which Drs Crow and Ellis state is "notoriously bad," emanated from Hook's department at Cornell when he was there. Professor Hook is one of the two or three outstanding people in infectious disease in the United States and I have the deepest respect for what he says. We have compared notes and both of us have had really disastrous cases of herpes zoster provoked by high doses of steroids, even in non-immunosuppressed patients. I have no doubt that steroids may be useful, and I think Drs Crow and Ellis would do everybody a great favour if they published their results of treating hundreds of patients without side effects—that is, if they could publish the numbers, the duration of pain, the duration of treatment, and side effects.

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[1] Juel-Jensen, B E, *et al*, *British Medical Journal*, 1970, **4**, 776.
[2] Merselis, J G, Kaye, D, and Hook, E W, *Archives of Internal Medicine*, 1964, **113**, 679.

SIR,—We read with interest and appreciation the leading article of (6 January, p 5) but were somewhat disheartened by your emphasis on the destruction of the virus as being an essential factor in successful treatment. However, the letter from Dr F Ellis (17 February, p 490) commenting on the beneficial effects of irradiation of the posterior root ganglia, and his hypothesis about the reason for his success, prompts us to write in support of Dr Ellis's views, even though our series is pathetically small and may be judged insignificant. The suffering caused by the herpes virus, particularly at the stage of postherpetic neuralgia, is out of all proportion to the other aspects of the condition, and we believe that it would not be proper to withhold our information on statistical grounds.

Although our method of treatment of acute sensory zoster is very different from that of Dr Ellis, we think that the mechanism leading to our results is the same—that is, we seek to modify the inflammatory process in the afferent nerve cells during the acute phase of the disease. Our technique involves giving a single epidural injection containing cortisone and lignocaine at the segmental level indicated by the dermatomes involves and, in the case of trigeminal herpes, into the Gasserian ganglion. More precise details of concentrations, volumes, etc, will gladly be given on request.

Our results are encouraging in that, with 21 patients treated in the acute phase, we have had 100% success in (*a*) relieving the pain of the acute phase; (*b*) considerably shortening the duration of the acute phase; and (*c*) preventing the onset of postherpetic pain. So far we have not had any complications; presumably they, along with failures, come later. A colleague elsewhere in Holland (Dr M E Sluyter), who in fact suggested the method to one of us, has had similar results in about 100 cases.

We wish to emphasise that this method seeks to prevent and not to cure postherpetic neuralgia, and must therefore be applied as applied as early as possible in the acute phase. We are not aware of any benefit it may have in established neuralgia. The experience of one of us in treating postherpetic neuralgia with epidural cortisone was not encouraging (100% failure in a small number of cases). However, we do have one patient, besides those treated in the acute phase, who was successfully treated nine weeks after the onset of the disease. We therefore find it difficult at the moment to say where the line should be drawn. We hope that others will be able to offer us some guidance here.

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**This correspondence is now closed.—ED, *BMJ*.

Prescription for a better British diet

SIR,—The recent paper by Dr R Passmore and others (24 February, p 527) sets out to provide a new approach to prescribing nutritionally acceptable diets for use by "caterers, dietitians, and housewives." In that respect the paper must be welcomed. However, a second and apparently equally important aim of this paper is to define a "better British diet," one likely to reduce the incidence of those diseases alluded to in the paper—namely, coronary heart disease, cancer, obesity, dental caries, and diseases of the large bowel. Recent correspondence in these columns suggests that the latter aim of the paper will receive most attention.

A survey of attitudes to diet-disease relations among members of the Nutrition Society has revealed alarming differences of opinion.[1] We feel that the credibility of the recommendations would have been considerably enhanced had the authors provided supporting data showing (*a*) the physiological basis for choosing the target diet, (*b*) the physiological changes anticipated by adopting the target diet, and (*c*) evidence that these physiological changes would reduce the incidence of the major diet-related diseases.

It is thus interesting to compare the proposed distribution of energy between carbohydrate, fat, and protein in the present and target diets with that which prevailed in 1956,[2] as in the table. The data do not include energy from alcohol.

Percentage distribution of dietary energy

	Carbohydrate	Fat	Protein
1972-7	48·7	40·0	11·3
% change represented by target diet	+ 6	− 9	+ 4
Target	51·8	36·4	11·8
1956	51·4	37·1	11·5
% change represented by target diet	+ 1	− 2	+ 3

Clearly, the authors feel that the diet which was consumed in 1956 is, for some undefined reason, one to be emulated. Yet, even in 1956 and for the ensuing decade death rates from coronary heart disease were at an unacceptably high level.[3]

Unlike the authors, we feel that the pursuit of particular trade and agricultural policies should not seriously impede the prescription of a better British diet. The food industry has shown considerable flexibility in providing foods which the public demand for nutritional reasons—for example, high-fibre breakfast cereals and polyunsaturated margarines. Perhaps the authors have tried to strike a compromise between what is physiologically desirable and economically feasible. However, their