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.

Correspondents should present their references in the Vancouver style (see examples in these columns). In particular, the names and initials of all authors must be given unless there are more than six, when only the first three should be given, followed by et al; and the first and last page numbers of articles and chapters should be included. Titles of papers are not, however, included in the correspondence section.

Breast cancer

SIR,—Although the National Institutes of Health (NIH) consensus statement on adjuvant chemotherapy of breast cancer (13 September, p 724) shed no new light on the dilemma it gave considerable encouragement to those of us who had already arrived at similar conclusions.

The Multicentre Cancer Chemotherapy Group in 1975 began a randomised controlled trial of adjuvant chemotherapy in node-positive breast cancer. Our early results show a significant difference in disease-free survival at four years in the treated group as a whole and the postmenopausal group in particular.[1] In 1979 therefore we started a second trial, comparing the response and quality of life with this chemotherapy with that of a simpler, one-injection technique. An important part of our trial is that a third arm compares both these regimens with hormone administration (Tamoxifen). This should answer the important question of whether the toxicity of chemotherapy with its unknown long-term sequelae gives a better chance of survival than the simpler hormone manipulation.

Perhaps fortunately, our group has arrived at a choice of cytotoxic agents, doses, and duration of treatment which subsequent work in the field has suggested is optimal. We agree with the NIH that the choice of cytotoxic agents should be those which have a good reputation in advanced breast cancer and that "full dosage for prescribed duration" is necessary. However, despite our findings, until quality of life as well as survival are assessed we do not agree that chemotherapy is always indicated, even for premenopausal patients. The chemotherapy response must be compared with that from hormones.

The Multicentre Cancer Chemotherapy Group is a well co-ordinated clinical group with a statistician and cell biologist on its working party. Since we have already over 400 patients in our new trial we would be pleased to hear from others who would like to join with us to complete the comparison of a tested cytotoxic regimen of known efficiency and a simpler, one-injection technique with a hormone (Tamoxifen) in node-positive breast cancer.

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[1] Edelstyn GA, *et al. Lancet* 1978;ii:1092.

SIR,—In your leading article "Hormone receptors and human breast cancer" (13 September, p 694) one important aspect of oestrogen receptor analysis has been overlooked. Several studies have now shown the absence of receptors for oestrogen in a primary tumour to be associated with early recurrence of disease following mastectomy.[1 2] and also lower survival rates[3 4] than in those who have tumours containing oestrogen receptors.

Further, if we assess both axillary lymph node histology and oestrogen status in individual patients prognosis can be defined more precisely. It has been found that women who lack both axillary node metastases and receptors in their tumours have high rates of recurrence similar to those found in women with involved axillary lymph nodes. It would be reasonable to suggest that this subset of patients should be included in adjuvant chemotherapy trials together with those who have axillary metastases.

It appears also that the oestrogen receptor status of the primary tumour corresponds well with that found in the tumour's secondary deposits.[4 5] The receptor content of the primary tumour has been used successfully to predict the hormone responsiveness of metastatic disease. This is especially important for women who have deposits inaccessible to biopsy.

I would like to emphasise the point that no patients should be accepted into adjuvant chemotherapy trials without hormone receptor assay; otherwise we will lose a great deal of important information regarding response to therapy in the various groups of patients.

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[1] Cooke T, Shields R, George D, Maynard P, Griffiths K. *Lancet* 1979;i:995-7.
[2] Forrest APM, Black RB, Humenink V, *et al. J Soc Med* 1980;**73**:361-6.
[3] Bishop HM, Blamey RW, Elston CW, Haybittle JL, Nicholson RI, Griffiths K. *Lancet* 1979;ii:283-4.
[4] Cooke T, George WD, Griffiths K. *Br J Surg* (in press).
[5] Jensen EV, Hospelhorn VD, Smith S, DeSombre ER. *Proceedings of the First International Congress on Hormones and Cancer*. New York: Raven Press (in press).

SIR,—The experience of one hormone clinic, which was organised at the Royal Northern Hospital, London N7, in the 1950s and 1960s,[1] may be relevant to your leading article on hormone receptors in breast cancer (13 September, p 694) and the statement on