Editor's preface

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Should women aged 40–49 undergo annual screening mammography? Anthony B. Miller and associates tackled this question in a large randomized controlled trial[1] and found no evidence of benefit. The considerable controversy that ensued centred on the randomization strategy: Were women at higher risk of breast cancer more likely to have been randomized to the mammography arm of the study, thus accounting for the poor results of screening? Epidemiologists John Bailar and Brian MacMahon were asked by the National Cancer Institute and the University of Toronto to review the study's enrolment and randomization protocols; their report is published in this issue (page 193). In his review of their report, Norman F. Boyd (page 207) concludes that although Bailar and MacMahon present convincing arguments that name alterations in the allocation books could have had only a trivial effect on the trial results, they are far less compelling in excluding other opportunities for the deliberate subversion of randomization.

Multicentre randomized trials are essential to resolve pivotal questions in medicine, but they are difficult to design and even more difficult to carry out. The randomization procedure adopted for the National Breast Screening Study 20 years ago would not be used today. Effective randomization is not as simple as a flip of a coin, and many studies continue to suffer from difficulties with randomization.[2]

What should physicians do about screening mammography? Heather Bryant reminds us of the critical distinction between screening and case-finding (page 213). On the one hand, screening recommendations must be based on clear evidence that the benefits of screening far exceed the harms. On the other, physicians and patients can determine whether mammography would be useful in a particular case. For some women aged 40–49 years, annual mammography makes sense.

Price increases on cigarettes make a difference, as Vivian H. Hamilton and colleagues show (page 187). As we go to press the irascible tobacco industry is lobbying hard against Health Minister David Dingwall's rather tame legislation to reduce the exposure of young lungs to the cancer-causing agents in cigarettes. Do not wobble, Mr. Dingwall.

Also in this issue, Logie Prize winner Tara Young describes her experiences with lying and deception in residency program applications (page 219). David M. Patrick describes a new, aggressive protocol for HIV prophylaxis after needle-stick injury (page 233). And, lastly, we draw your attention to Pulse, a new feature of *CMAJ*. Each instalment will contain an interesting piece of data and a brief interpretation. Look for it on the back page.—JH

References

1. Miller AB, Baines CJ, To T, Wall C. Canadian National Breast Screening Study: 1. Breast cancer detection and death rates among women aged 40 to 49 years. *Can Med Assoc J* 1992;147: 1459-76.
2. Schulz KF, Chalmers I, Grimes DA, Altman DG. Assesing the quality of randomization from reports of controlled trials published in obstetrics and gynecology journals. *JAMA* 1994;272: 125-8.

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