Baseline staging tests for breast cancer

The Breast Cancer Disease Site Group of the Cancer Care Ontario Practice Guidelines Initiative has published their recommendations for baseline staging tests in breast cancer.[1] I wish to take issue with the recommendation that ultrasonography of the liver be done routinely in patients with stage III breast cancer. The authors suggest that a test that detects metastases in more than 1% of patients is clinically useful and therefore that ultrasonography should be used in this group of patients; however, in their Table 3 the 95% confidence interval for the percentage of patients with stage III cancer who had a positive result with liver ultrasonography ranges from 0.4% to 3.6%.

The papers that they quote do not support the routine use of liver ultrasonography. In the largest study, which is twice as large as all other studies combined, only 28% of patients with stage III cancer were sent for liver ultrasonography.[2] This low compliance rate suggests that there may well have been selection biases. The detection rate was 0% in patients with stage IIIA cancer and 0.85% in those with stage IIIB cancer. Furthermore, ultrasonography had a positive predictive value of only 33%, indicating that it represents an expensive wild goose chase 2 out of 3 times.

In another paper referenced by the authors there was only 1 positive liver ultrasound in 24 patients with stage III cancer.[3] The authors of this paper suggested that ultrasound should be abandoned in this group of patients.

If the incidence of asymptomatic liver metastases in patients with stage III breast cancer is 1–2%, then approximately $30 000 will be spent in ultrasonography to find 1 case of liver metastasis. Because the patient would probably receive some form of chemotherapy anyway and there would be little if any effect on the patient's life expectancy, there would be no cost saving to the system of any substance and no effect on mortality. Surely, then, routine staging ultrasonography cannot be justified in this group of patients.

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Safer injection facilities for injection drug users: the debate continues

If we had an unlimited supply of money, safe fixing sites would have little opposition.[1] Who would argue against a fully staffed facility for people to safely inject their drugs? But the reality is that money is limited and we need to set priorities.

Those of us who treat addiction understand that there are 3 ways in addition to harm reduction to address addiction: law enforcement, prevention and treatment. I currently treat about 200 injection drug users, most of whom are or have been severely addicted. Currently our most effective treatment intervention is methadone therapy for the heroin part of the addiction coupled with a stay in a first-stage recovery house that gets the user out of the downtown open drug scene. He or she can then begin working on his or her cocaine addiction and psychological issues. Only one 6-bed first-stage recovery house is currently funded in the Lower Mainland of British Columbia. The rest of the first-stage recovery houses that we use have insufficient funding for food, counsellors and afterhours staff. The addict on the street is left to choose between numerous well-funded drug-tolerant residential hotels downtown with a myriad of well-intentioned outreach nurses, street workers and drop-in centres (all operating under the flag of harm reduction) and a spartan, underfunded and stressed treatment system.

It would be refreshing to see a comparison of European and Canadian addiction treatment and prevention approaches with a subsequent call to action rather than a headline-grabbing comparison of harm reduction approaches. Who knows? There may be some who attribute the dramatic differences in the addiction scene between Europe and Canada to factors other than harm reduction.

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Although superficially unrelated, several articles in a recent issue of *CMAJ* share a common theme of great importance.[1-4] Thomas Kerr and Anita Palepu[1] and *CMAJ*'s editors[2] argue that the time has arrived for consideration of safe injection facilities in Canada. They point to the morbidity and mortality associated with injection drug use and the failure of current methods to adequately control this public health epidemic. I agree.

Philip Berger succinctly argues that the Ontario government's proposed mandatory addiction screening is an example of science misapplied: in reality it is a government tool to achieve ideologically motivated social change.[3] I agree.

Wayne Weston argues that informed and shared decision-making is the crux of patient-centred care and that although we are the experts in disease, patients are the experts in their own experience of it.[4] I agree.