

Caution with breast-conserving surgery

We read with interest the 2002 update of the clinical practice guidelines for the care and treatment of breast cancer.¹ Although we generally agree with most of the article, we are concerned about the following comment in Table 1: "In some cases, preoperative chemotherapy can shrink a large primary tumour and allow for [breast-conserving surgery]." The European Organization for Research and Treatment of Cancer trial 10902, quoted by the authors of the update, included a caveat about downstaging. While conceding that the trial was not a randomized comparison, its authors reported that "Patients who were planned for mastectomy but underwent breast-conserving surgery because of downstaging of the tumor did worse in terms of overall survival (HR, 2.53; 95% CI, 1.02-6.25)" (where HR = hazard ratio) than did patients for whom breast-conserving surgery was planned and who underwent treatment accordingly.² The authors also commented that using more breast-conserving modalities to treat tumours that had been downstaged by chemotherapy may result in a higher false-negative rate for the surgical margins. Given evidence from recent meta-analyses of the value of aggressive local therapy in terms of survival of women with breast cancer,^{3,4} would it not be preferable to err on the side of caution when it comes to altering guidelines for breast-conserving surgery?

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[One of the authors responds:]

In the updated guideline,¹ we mentioned the data from the European Organization for Research and Treatment of Cancer trial, in which survival was worse for patients for whom mastectomy was originally planned but in whom preoperative chemotherapy downstaged the tumour, allowing for breast-conserving surgery (BCS).² We also indicated that in the National Surgical Adjuvant Breast Project B-18 trial, there was a trend (among patients who underwent preoperative chemotherapy) toward a higher rate of local breast cancer recurrence in those for whom mastectomy was planned but who instead underwent BCS.³ Both of these subgroup analyses were post hoc (i.e., not specified a priori), and they did not involve comparisons between randomized groups; hence, the results should be considered hypothesis-generating in nature, although they do represent food for thought. The tone of our recommendation was therefore rather tentative (as it should be).

There are some situations (e.g., a large breast or a large primary tumour that is not fixed) in which preoperative chemotherapy may shrink the tumour and allow for BCS. Conversely, when mastectomy is planned for a large tumour, it is often in the context of locally advanced breast cancer, and we do not recommend BCS in this situation. This topic will be the subject of a future guideline of the Steering Committee

on Clinical Practice Guidelines for the Care and Treatment of Breast Cancer.

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Stop trivializing MD workforce problems

Ben Chan's recent report on Canada's physician workforce¹ and subsequent media coverage of it — including *CMAJ*'s² — trivialized 2 major factors in the physician-supply equation: the 10% cut to undergraduate enrolment recommended in the 1991 Barer-Stoddart report³ and the emigration of Canadian physicians.

The 10% cut is often criticized by the medical community because it was implemented at a time when many medical schools had already cut enrolment, the physician-to-population ratio had plateaued and 700 physicians were leaving for the United States each year. As well, governments were not monitoring retirement trends, which started to show steady increases during the 1980s. In reality, first-year undergraduate enrolment decreased by 15% from 1983/84 to 1992/93 and declined again in the late 1990s.