

**[The authors respond:]**

Norman Kalant's statement that "none of the relevant clinical trials have shown that [radiotherapy] leads to an improvement in overall survival" is erroneous. As articulated in the guidelines,<sup>1</sup> several randomized trials and a meta-analysis have demonstrated that postmastectomy radiotherapy is associated with improved survival, as well as locoregional control in high-risk patients with breast cancer receiving systemic therapy.<sup>2-5</sup> Over 30 randomized trials of postmastectomy radiotherapy have demonstrated a consistent two-thirds to three-quarters relative risk reduction for locoregional failure. The ratio between the number of locoregional failures avoided and breast cancer deaths prevented was approximately 4:1 to 5:1.<sup>2-5</sup>

Kalant raises the issue of appropriate endpoints for formulating treatment guidelines. In this regard, locoregional control should not be confused with "tumour responsiveness." According to the American Society of Clinical Oncology statement on outcomes, although an improvement in overall survival is desired, an improvement in disease-free, progression-free or event-free survival can also justify treatment recommendations.<sup>6</sup> Examining locoregional failure, locoregional failure-free survival and overall survival is thus consistent with these recommendations.

In addition to the survival implications, achieving optimal locoregional control is an important priority in breast cancer management, as disease recurrence can be psychologically devastating, with adverse effects on quality of life.<sup>7</sup>

Ultimately, the decision to use postmastectomy radiotherapy requires careful appraisal of benefits and risks and a balancing of each patient's priorities and preferences. We strongly advocate a thorough discussion of not only survival but also locoregional control endpoints, as well as efforts to ensure that women are adequately informed of the key association between optimal locoregional control and survival in their choice of adjuvant therapy.

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**References**

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**Corrections**

We apologize for misquoting Dr. Michael Helewa, president-elect of the Society of Obstetricians and Gynaecologists of Canada in our report.<sup>1</sup> Helewa actually said that the rising rates of various medical interventions in child birth are *associated* with the lowest perinatal mortality Canada has ever had.

**Reference**

1. Morrison S. Canada achieves lowest perinatal mortality ever. *CMAJ* 2004;171(9):1030.

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An article about the *Clostridium difficile* outbreak in Quebec<sup>1</sup> erroneously identified the institute at which Dr. Vivian Loo works. It should have read "McGill University Health Centre" instead of the "Montréal University Health Centre."

**Reference**

1. Eggertson L. *C. difficile*: by the numbers. *CMAJ* 2004;171(11):1331-2.

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**Editor's note**

*CMAJ*'s current evidence-based medicine series includes a set of online articles directed to teachers<sup>1-3</sup> to accompany the articles intended for learners of evidence-based medicine, which are being published in print.<sup>4-6</sup>

**References**

1. Barratt A, Wyer PC, Hatala R, McGinn T, Dans AL, Keitz S, et al, for the Evidence-Based Medicine Teaching Tips Working Group. Tips for teachers of evidence-based medicine: 1. Relative risk reduction, absolute risk reduction and number needed to treat. Available: [www.cmaj.ca/cgi/content/full/171/4/353/DC1](http://www.cmaj.ca/cgi/content/full/171/4/353/DC1)
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4. Barratt A, Wyer PC, Hatala R, McGinn T, Dans AL, Keitz S, et al, for the Evidence-Based Medicine Teaching Tips Working Group. Tips for learners of evidence-based medicine: 1. Relative risk reduction, absolute risk reduction and number needed to treat. *CMAJ* 2004;171(4):353-8.
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