experienced by women with symptoms, especially in the absence of a formal screening program. The time between the initial step to case identification and surgery may increase, but this could still be good news.

How could this be? First, between 1992 and 1998 the proportion of women in Quebec aged 50 to 69 years who had had a mammogram during the previous year increased from 49.4% to 64.3%.2 Second, Mayo and colleagues reported that the number of in situ tumours doubled during this period, whereas the number of advanced tumours decreased.1 Third, the delay to surgery is shorter for advanced cases. Finally, these data must be interpreted within the context of a sustained decline in breast cancer mortality over this period.3 Although the delay increased both when the initial test was a mammogram and when it was a biopsy, the proportion of the latter cases was very small and decreased over time.

This opinion should not be interpreted as a denial that quality of care for cancer must be a constant preoccupation⁴ and that prompt access to treatment is an unequivocal right of people afflicted with this disease. Criteria for quality control of the Quebec Breast Cancer Screening Program were specifically set up to ensure that prompt investigation follows an abnormal mammogram.

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Baseline staging tests in primary breast cancer

I have 2 questions for Robert Myers and colleagues concerning their recent practice guideline on baseline staging tests in primary breast cancer. What do they call "biochemical evidence of metastases?" Which marker(s) and cut-off(s) do they suggest be used? Answers to these questions might make their guideline evidence-based, as far as laboratory medicine is concerned.

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The unfortunate death of a healthy woman who was a volunteer participant in a medical investigation at Johns Hopkins University in Baltimore has raised questions about the safety of study participants. One of the issues that was raised by investigations into this tragedy is the importance of effective literature searching.

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