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[Two of the authors respond:]

As outlined in our commentary,[1] we agree that every effort should be made to prevent fetal exposure to isotretinoin, a highly teratogenic drug.

Maria Valois and associates state that, unlike the situation in the United States, Health Canada has no evidence of a significant rate of pregnancy among Canadian women taking isotretinoin. Unfortunately, this impression is incorrect. The presentations to the FDA in February 2004, attended by Health Canada, included a study by the Organization of Teratology Information Services,[2] which was funded by the US Centers for Disease Control and Prevention. More than half of the cases in that study came from Canada. The Canadian data were collected prospectively in 2002–2003 by The Motherisk Program (based in Toronto) and IMAGE (based in Montréal). On a proportional basis, Canada had substantially more cases than the United States.

This situation reflects the understandable ineffectiveness of reporting systems based on spontaneous reports. Moreover, in 2003 Health Canada stopped the development of MotherNet, a system that would have given the department such information continuously. The reason cited for the halt was lack of funding, although over $1 million had been spent on the project at that point.

Wouldn't it make sense for Health Canada to work with existing active surveillance programs in Toronto and Montréal and thus to receive the tremendous amount of data that are being collected on drugs in pregnancy in Canada? Presently, no arrangements exist for such collaboration.

Gideon Koren
Director, The Motherisk Program
Neil Shear
Helen and Paul Phalen Professor of Dermatology
Chief of Dermatology
University of Toronto
Toronto, Ont.

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Outcomes of postmastectomy radiotherapy

In 1995 the American Society of Clinical Oncology adopted a statement on the choice of outcomes in assessing cancer treatments.[1] That statement made a clear distinction between patient outcomes (survival and quality of life) and cancer outcomes (tumour regression), the former being much more important. This view is also expressed in current books on cancer therapy.[2] A recently published guideline, though devoted to techniques of measuring tumour response, stated that this outcome is of value as an endpoint in early clinical trials, but in phase III trials and clinical application "it should not be the sole, or major, endpoint."[3] Yet the clinical practice guidelines published in *CMAJ* concerning the use of postmastectomy radiotherapy[4] appear to be founded entirely on evidence related to tumour responsiveness. Although local irradiation is effective in destroying local tumour tissue, none of the relevant clinical trials have shown that this leads to an improvement in overall survival. Normally, acceptance of a therapeutic modality requires demonstration of its efficacy, yet leading oncologists appear to take the opposite stance in regard to radiotherapy. Thus it is assumed, despite a lack of supporting evidence, that the majority of patients "require" irradiation but that subgroups who do not benefit will ultimately become recognizable.[5,6]

The authors of the guidelines are to be commended for including a "questions and answers" guide for women and their physicians (Appendix 1 of the article).[4] But one important question has been omitted: "How will radiation help me?" One must wonder how many of the patients anxiously waiting for radiation therapy are among those for whom therapy has been recommended despite a lack of evidence of benefit. If such patients were given balanced information and allowed to choose whether to undergo therapy, how many would decide against it?

Norman Kalant
Sir Mortimer B. Davis Jewish General Hospital
Montréal, Que.

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