

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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2. *Enquête sociale et de santé 1998*. Quebec City: Institut de la statistique du Québec; 2000.

3. Brisson J, Major D. *Plan de surveillance de la lutte contre le cancer du sein II : Évolution de la lutte contre le cancer du sein au Québec*. Quebec City: Direction des communications, Ministère de la santé et des services sociaux; 2000.
4. Comité consultatif sur le cancer, Programme québécois de lutte contre le cancer. *Pour lutter efficacement contre le cancer, faisons équipe*. Quebec City: Ministère de la santé et des services sociaux; 1997.

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.¹ 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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Reference

1. Myers RE, Johnston M, Pritchard K, Levine M, Oliver T, and the Breast Cancer Disease Site Group of the Cancer Care Ontario Practice Guidelines Initiative. Baseline staging tests in primary breast cancer: a practice guideline. *CMAJ* 2001;164(10):1439-44.

For expert literature searching, call a librarian

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.¹ One of the issues that was raised by investigations into this tragedy is the importance of effective literature searching.²

The mission of the Canadian Health Libraries Association is to improve health and health care by promoting excellence in access to information. Since 1976 the association has represented health librarians and library staff and today it has over 400 members.

Librarians have a master's degree in library and information science and are

educated and skilled in information retrieval and literature searching. Effective literature searching cannot be done by simply surfing a few hits found through free-text searching; it involves an intellectual process that requires an iterative methodology that includes expert knowledge of database design (including controlled vocabulary), knowledge of research methodology and familiarity with the subject. It is necessary for investigators to understand the importance of collaborating with librarians.

The association recommends that guidelines or standards be developed for literature searching in health care. We will work with other groups to assist in their development and will promote these to our membership.

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References

1. Ramsey S. Johns Hopkins takes responsibility for volunteer's death. *Lancet* 2001;358(9277):213.

2. McLellan F. 1966 and all that: When is a literature search done? *Lancet* 2001;358(9282):646.

Evaluating the risks of therapies for acute coronary syndromes

In one paragraph of their article in the *CMAJ*'s series on new advances in the management of acute coronary syndromes, David Fitchett and colleagues may have substantially oversold the benefit while underestimating the risk of intervention with clopidogrel.¹ Benefits were expressed as relative risk reductions of 24% and 20% in the rate of adverse outcomes, although "these benefits were achieved with a small (1%) increase in the rate of bleeding." Unfortunately, these data were from an as-yet-unpublished study. I suspect that the 1% increase in risk was an absolute risk increase. If the baseline rate of major bleeding was 1%, an absolute risk increase of 1% would be a relative risk increase of 100%, which

looks even more scary than a relative risk reduction of 20% or 24% looks good. If the proposed intervention is a good one, its benefits do not need to be inflated by expressing benefits in terms of relative risk and harms in terms of absolute risk.

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Reference

1. Fitchett D, Goodman S, Langer A. New advances in the management of acute coronary syndromes: 1. Matching treatment to risk. *CMAJ* 2001;164(9):1309-16.

[The authors respond:]

David Allen is correct in pointing out the difference between relative and absolute risk in his response to our article.¹ The benefit or hazard to the individual patient is best expressed as the change in absolute risk: from this can be calculated the number needed to treat to see a beneficial or adverse outcome.

In the case of clopidogrel and aspirin