

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?

Theodore A. Vandenberg

Associate Professor

Vivien H. Bramwell

Professor

Department of Oncology

University of Western Ontario

London, Ont.

References

1. Scarth H, Cantin J, Levine M, for the Steering Committee on Clinical Practice Guidelines for the Care and Treatment of Breast Cancer. Clinical

practice guidelines for the care and treatment of breast cancer: Mastectomy or lumpectomy? The choice of operation for clinical stages I and II breast cancer (summary of the 2002 update). *CMAJ* 2002;167:154-5.

2. Van der Hage JA, van de Velde CJH, Julien JP, Tubiana-Hulin M, Vandervelden C, Duchateau L. Preoperative chemotherapy in primary operable breast cancer: results from the European Organization for Research and Treatment of Cancer trial 10902. *J Clin Oncol* 2001;19:4224-37.
3. Orr R. The impact of prophylactic axillary node dissection on breast cancer survival — a Bayesian meta-analysis. *Ann Surg Oncol* 1999;6:109-16.
4. Whelan TJ, Julian J, Wright J, Jadad AR, Levine M. Does locoregional radiation therapy improve survival in breast cancer? A meta-analysis. *J Clin Oncol* 2000;18:1220-9.

[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.

Mark Levine

Professor

Department of Clinical Epidemiology
and Biostatistics

McMaster University

Hamilton, Ont.

References

1. Scarth H, Cantin J, Levine M, for the Steering Committee on Clinical Practice Guidelines for the Care and Treatment of Breast Cancer. Clinical practice guidelines for the care and treatment of breast cancer: Mastectomy or lumpectomy? The choice of operation for clinical stages I and II breast cancer (summary of the 2002 update). *CMAJ* 2002;167(2):154-5.
2. Van der Hage JA, van de Velde CJH, Julien JP, Tubiana-Hulin M, Vandervelden C, Duchateau L. Preoperative chemotherapy in primary operable breast cancer: results from the European Organization for Research and Treatment of Cancer trial 10902. *J Clin Oncol* 2001;19:4224-37.
3. Wolmark N, Wang J, Mamounas E, Bryant J, Fisher B. Preoperative chemotherapy in patients with operable breast cancer: nine-year results from National Surgical Adjuvant Breast and Bowel Project B-18. *J Natl Cancer Inst Monogr* 2001;30:96-102.

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.

Chan has suggested that a bigger decline in the output of training programs was caused by an increase in the length of training required to meet new certification standards in family medicine and an increase in the number of graduates opting for specialty training. He could have pointed out that the switch to a 2-year family medicine program was needed to increase portability within Canada and to meet international standards in education. The government did not provide any additional postgraduate positions to accommodate the extra year of training and instead used the re-entry positions usually reserved for international medical graduates and specialty training.

It is also worth noting that there was a net loss of 4000 physicians from Canada in a single decade, at a total cost of approximately \$6 billion to the taxpayers who paid for their education. A physician pool that includes a substantial proportion of aging physicians cannot afford to lose any of its young physicians this way.

Hugh E. Scully

Cochair, Task Force II
Human Resource Strategy for Physicians
Canadian Medical Forum
Ottawa, Ont.

Reference

1. Chan BTB. *From perceived surplus to perceived shortage: What happened to Canada's physician workforce in the 1990s?* Ottawa: Canadian Institute for Health Information; 2002.
2. Wharry S, Sibbald B. What physician shortage? *CMAJ* 2002;167:64.
3. Barer ML, Stoddart GL. *Toward integrated medical resource policies for Canada*. Report prepared for the Federal/Provincial/Territorial Conference of Deputy Ministers of Health, 1991.

A recent *CMAJ* article¹ does not give Ben Chan's study² the emphasis it deserves. This is an important document on physician human resources that will have as much impact as the landmark Barer–Stoddart report of 1991.³ Chan diplomatically says “one cannot ‘prove’ that any particular policy ‘caused’ a particular trend to occur. The reader is encouraged to draw his or her own conclusion.”²

However, most of us in the “business” of health care provision recognize

the poor quality of decisions made a decade ago by departments of health, licensing bodies, medical associations and medical schools. These decisions were made in the absence of national or regional physician resource planning and without allowance for checks along the way to correct any adverse outcomes.

For the 2.4 million people living in Atlantic Canada, the problem is further complicated by the existence of 4 uncoordinated health care plans, one for each province. Economic restraints have not allowed the 2 medical schools in Atlantic Canada to raise their enrolments or adjust postgraduate residency training positions. Physician-to-population ratios for the Atlantic provinces expose the difference in physician resources between this region and the rest of Canada, particularly for specialists (Fig. 1).⁴

Unfortunately, the same players are now making decisions to increase physician supply, again without national or regional physician resource planning. There is an immediate need to review the increasing health care demands of Canadians and the new technologies becoming available within the Canadian health care system, but already there are plans to increase medical school enrolment. These plans do not account for the fact that primary care physicians are not providing comprehensive care,⁵ nor do they account for the rising demands for physician ex-

tenders in both primary and acute hospital care. We can easily predict the appearance of another report in the next decade, describing another “crisis” and another perceived surplus.

Atlantic Canada urgently needs regional physician resource planning; in fact, we urgently need regional health care planning.

Kevork M. Peltekian

Department of Medicine
Dalhousie University
Halifax, NS

References

1. Wharry S, Sibbald B. What physician shortage? *CMAJ* 2002;167:64.
2. Chan BTB. *From perceived surplus to perceived shortage: What happened to Canada's physician workforce in the 1990s?* Ottawa: Canadian Institute for Health Information; 2002.
3. Barer ML, Stoddart GL. *Toward integrated medical resource policies for Canada*. Report prepared for the Federal/Provincial/Territorial Conference of Deputy Ministers of Health, 1991.
4. Statistical information on Canadian physicians [tables online]. Ottawa: Canadian Medical Association; updated 2001 July. Available: <http://www.cma.ca/cma/menu/display.Menu.do?tab=422&skin=125&pMenuId=6&pageId=/staticContent/HTML/N0/12/statinfo/index.htm#intro> (accessed 2002 Oct 3).
5. Chan BTB. The declining comprehensiveness of primary care. *CMAJ* 2002;166:429-34.

[Benjamin Chan responds:]

My report on Canada's physician workforce¹ does not trivialize the impact of undergraduate enrolment cuts in the future, but it rejects the notion that such cuts were the driving force behind Canada's declining physi-

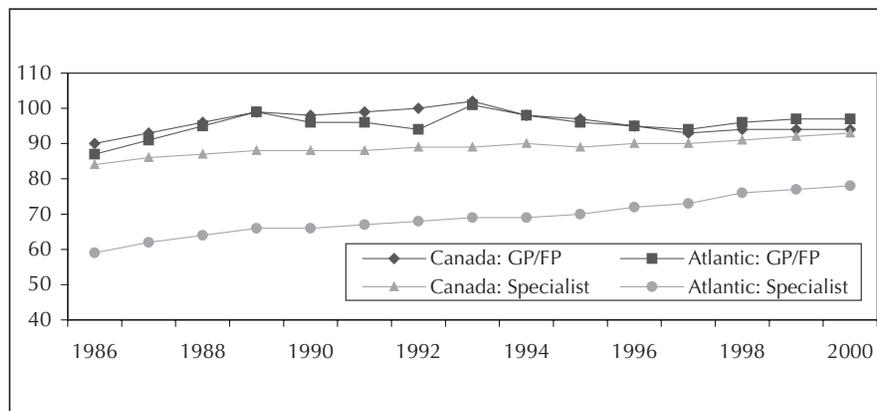


Fig. 1: Physicians per 100 000 population, Atlantic provinces, 1986–2000. Calculated from Statistics Canada population data and physician data from the Canadian Institute of Health Information (available on the CMA web site).⁴