Specialist surgeons and survival in breast cancer

Breast cancer is a medical, not a surgical, disease

EDITOR,—There have now been several studies of comparative survival of women with breast cancer under the care of different surgeons. Charles R Gillis and David J Hole's unique and revealing analysis in west Scotland is a further indictment of the haphazard organisation of NHS cancer services.¹ If the findings of this study are extrapolated nationally, then nearly 11 000 women died unnecessarily during the 1980s—surely a major scandal of neglect and apathy by successive health ministers.

But the problem is not one of surgical skill; it is a problem of service organisation. There is no evidence whatsoever that the type or quality of surgery has an impact on survival. The most likely reason for the variation in outcome is the failure to refer for adjuvant systemic chemotherapy or tamoxifen. Breast cancer kills because of metastasis. Specialist surgeons work closely with colleagues in radiotherapy and medical oncology who provide essential medical input. The evidence for this comes from Gillis and Hole's observation that the greatest survival differences were found in the patient subgroups for whom adjuvant therapy is known to have the most benefit. There are clear data suggesting wide variation in postoperative medical treatments offered to patients,² and indeed an unpublished investigation by the BBC *Panorama* team (BBC, personal communication) showed wide practice variation across Britain.

Unfortunately purchasers who do not have specialist knowledge are confused and are beginning to use minimum numbers of new patients seen by

a surgeon as a surrogate marker for outcome. What is needed is a well organised cancer unit in every sizeable general hospital, with strong links to a major cancer centre. There will be dramatic new developments in cancer prevention, diagnosis, and treatment over the next decade. If these are to be disseminated rapidly, a network is required now. We know that British cancer survival statistics lag far behind those of other European countries, not just in breast cancer but across the board.³ The recent report of the health department's Expert Advisory Group on Cancer provides the framework for a way forward.⁴ The time for endless discussion is over—let's see some action.

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- 1 Gillis CR, Hole DJ. Survival outcome of care by specialist surgeons in breast cancer: a study of 3786 patients in the west of Scotland. *BMJ* 1996;312:145-8. (20 January.)
- 2 Wolfe C, Barton J, Bourne H, Richards M. Variations in the incidence and management of breast cancer in women under 50 years of age. *J Epidemiol Community Health* 1993;47:400.
- 3 Berrino F, Sant M, Verdecchia A, et al. *Survival of cancer patients in Europe: the EUROcare study*. Lyons: International Agency for Research on Cancer, 1995. (IARC publication No 132.)
- 4 Department of Health. *A policy framework for commissioning cancer services*. London: DOH, 1995.

Large differences in survival are not explained

EDITOR,—As a specialist breast cancer surgeon it is in my enlightened self interest to accept the findings of Charles R Gillis and David J Hole¹; at the same time, as a clinical scientist I cannot allow their conclusions to go unchallenged. From the world overview of trials we now know with statistical confidence that variations in local treatment cannot be associated with any of the differences in survival described in this article.² Only the use of adjuvant systemic therapy could contribute to differences in survival outcome, and in absolute terms these differences are relatively modest and could not account for a 9% absolute difference in five year survival, nor for some of the quite extraordinary differences described in any of the subsets, such as the 19% difference in five year survival for patients with two positive nodes.

Let us just concentrate on the age group 50-64, in which an 11% difference in five year survival is described by Gillis and Hole. This is the age group in which adjuvant tamoxifen is probably most effective. If none of the patients treated by the generalists received tamoxifen and all the patients treated by the specialists received tamoxifen, then from the overview of the trials the best that could be expected would be 4% difference.² I therefore cannot accept that the differences in treatment can contribute to the major differences in survival described. Like the authors I am somewhat at a loss to explain these variations, but they might be due to the "Will Rogers phenomenon"—the more accurately you stage a patient the more likely you are to deem them as inoperable or metastatic, and therefore stage for stage the survival will improve in the more accurately staged patients.

I still think it is in the interests of women to seek specialist care, which is likely to be associated with greater psychosocial support,

improved chances of local control of the disease, greater satisfaction with the organisation of the service, an opportunity to contribute to research, and overall an improved quality of life. But please don't let us kid ourselves that differences in treatment could contribute to such huge short term differences in survival.

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- 1 Gillis CR, Hole DJ. Survival outcome of care by specialist surgeons in breast cancer: a study of 3786 patients in the west of Scotland. *BMJ* 1996;312:145-8. (20 January.)
- 2 Early Breast Cancer Trialists Group. Systemic treatment of early breast cancer by hormonal, cytotoxic or immune therapy. 133 randomised trials involving 31,000 recurrences and 24,000 deaths among 75,000 women. *Lancet* 1992;339:1-15,71-85.

A multidisciplinary approach is needed

EDITOR,—Charles R Gillis and David J Hole provide support for the management of patients with breast cancer by surgeons with a specialist interest in breast disease.¹ The number of centres advertising as having specialist breast surgeons has proliferated, but it is not clear whether all these units fulfil the definition of a specialist unit as defined by Gillis and Hole and by the British Breast Group.² As pointed out in the *BMJ* paper and confirmed by the Yorkshire group, "the benefit associated with care provided by specialists may be due not only to the surgery but to the use of additional therapies."³

It is now accepted that optimal treatment for patients with breast cancer requires a multidisciplinary approach, and it is our contention that before any decision is taken on treatment, the patient should be seen by or discussed with the whole interdisciplinary team—surgeon, radiologist, pathologist, medical oncologist, radiation oncologist, and specialist breast care nurse. This may run counter to the proposals in the Calman report, which seems to suggest that patients with common cancers are managed initially by surgeons, with oncologists becoming involved at a later stage. The reality is that not all patients who have a wide excision are suitable for radiotherapy and some patients with larger, operable tumours or locally advanced disease may be best treated by primary systemic treatment rather than initial surgery. If in specialist cancer centres the patients are seen before a decision on treatment by the multidisciplinary team and then managed by that team with major support from other health workers who include physiotherapists, social workers, psychotherapists, and alternative therapy nurses, whereas in smaller cancer units patients do not have access to the same range of staff after diagnosis and limited backup facilities are available, then we will once again end up with a two tier system for the treatment of patients with breast cancer.

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- 1 Gillis CR, Hole DJ. Survival outcome of care by specialist surgeons in breast cancer: a study of 3786 patients in the west of Scotland. *BMJ* 1996;312:145-8. (20 January.)

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Letters should be typed and signed by each author, and each author's current appointment and address should be stated. We encourage you to declare any conflict of interest.

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