Breast cancer screening may not save lives, study finds

Jacqui Wise *London*

Researchers from a respected Cochrane centre have controversially concluded that screening with mammography for breast cancer is a waste of time. After reanalysing data from previously published trials, Dr Peter Gøtzsche and Mr Ole Olsen of the Nordic Cochrane Centre in Copenhagen, stated that "there is no reliable evidence that screening decreases breast cancer mortality" (*Lancet* 2000;355:129-34).

The investigators re-examined the evidence on which national breast cancer screening programmes are based—eight randomised trials comprising half a million women. They said that in six of the trials (in Edinburgh, New York, and areas of Sweden) the randomisation procedures were inadequate and the groups of women compared were not strictly comparable because the groups differed substantially in age or other risk factors.

Another problem was that the exact numbers of women in each group were uncertain in four of the trials. According to Dr Gøtzsche and Mr Olsen, only two trials (those carried out in Canada and Malmö, Sweden) were adequately randomised, with the women in the two groups properly matched.

They found that the evidence from the Canadian and Malmö trials showed that screening had no significant effect, whereas the other six trials, in which the randomisation was inadequate, found that screening decreased the risk of death by about 25%. However, for death from any cause, these six trials showed a slight increase in risk for screened women.

Dr Gøtzsche and Mr Olsen said that anyone believing that the Swedish trials (other than the Malmö trial) are unbiased must also "accept from the data that screening for breast cancer with mammography causes more deaths than it saves."

The controversial conclusions have been criticised, however, by several leading cancer researchers. Dr Muir Gray, director of the National Screening Committee in Britain, said that, although the paper is important and will be examined closely by the committee, he could see no reason to change the NHS breast cancer screening policy.

Dr Gray said: "I don't think the reasons for excluding the six studies are particularly strong. For example, one study was excluded because the two groups were not matched in age. However, the difference was just a month between the study and the control group, which I would not regard as statistically significant."

Dr Gray added that there were problems with the two studies that Dr Gøtzsche and Mr Olsen said were methodologically sound. "It is not as clear cut as they have made out; all studies have some flaws."

Dr Gray said he suspected that the paper had been rushed and not adequately peer reviewed, as the researchers stated that the meta-analyses were carried out only on 20 December 1999, yet the paper was published on 8 January 2000.

Professor Jack Cuzick, from the Imperial Cancer Research Fund, said that the conclusions reached by the Danish researchers are not supported by all of the available evidence. "Screening detects cancers when they are smaller and more easily treated; cancer rates are reduced following screening; and trials have shown that mortality is reduced by 20-30%," he said.

Mortality from breast cancer is falling in the United Kingdom—latest figures show a drop of 14% between 1989 and 1998. □

Pain relief in US emergency rooms is related to patients' race

Deborah Josefson *San Francisco*

Patients from ethnic minorities seen in emergency rooms are relatively undertreated for pain, according to a new study (*Annals of Emergency Medicine* 2000;35:11-6, 77-81).

Doctors at Emory University School of Medicine, Atlanta, Georgia, conducted a retrospective analysis of the medical charts of 217 patients who had presented with long bone fractures to a single urban emergency department over 40 months.

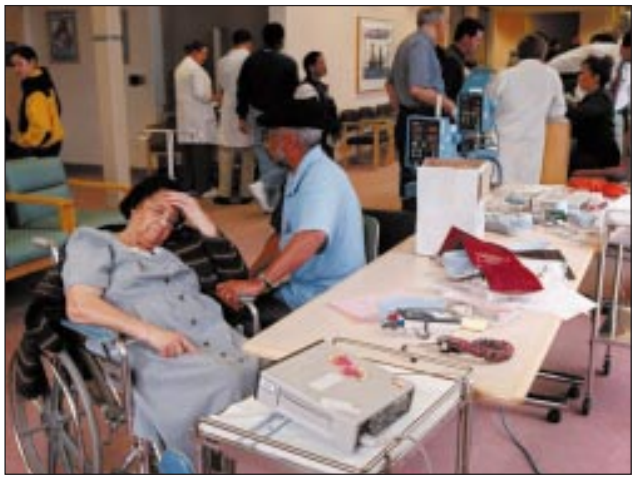
Of the total, 127 patients were black and 90 were white. The patients had similar injuries and similar complaints of pain. Overall, 43% of the black patients received no pain medication whereas only 26% of white patients went untreated for pain.

This is the second study to uncover a racial bias in the prescribing of pain relief. An earlier study conducted by the same authors at the University of California School of Medicine in Los Angeles found that Hispanic patients were also less likely to receive adequate pain relief in the emergency room.

Commenting on the research, Dr Knox Todd, lead author of the latest report, said: "Patient ethnicity affects decision making, independent of objective clinical criteria." He implied that the racial bias in offering analgesia is not due to differences in pain assessment by physicians or in its reporting by patients. Ingrained racial stereotypes may insidiously and unconsciously make their way into medical practice.

In an accompanying editorial Dr Marcus Martin of the University of Virginia said that his clinical experience suggested that ethnic differences in pain tolerance and expression existed and that pain relief is sometimes withheld because doctors feared drug seeking and substance misuse behaviours in subsets of patients.

Some patients may also be viewed as histrionic and less deserving of pain relief. The manner in which an injury was sustained also plays a part in the prescription of pain relief. For instance, patients who are injured during police fights or during drunken brawls may be considered less deserving of pain relief than those injured during skiing accidents. He called for additional studies to be performed to see if some patients act in a manner that appears less convincing than others, causing physicians to disbelieve their complaints of pain.



AP PHOTO/GEORGE NIKITIN

A patient waits for emergency treatment in Kaiser Hospital, California. Will she get less pain relief than a white patient?

Dr Knox and colleagues are calling for standardised criteria for pain assessment to eliminate the racial bias. They concluded: "Efforts to alter pain management practice may be more successful using interventions that target administration of medications and standardise pain assessments, including using clinical guidelines that couple pain ratings with specific recommendations for analgesic use."

In another accompanying editorial, Dr Louis Goldfrank, director of the New York University School of Medicine's emergency medicine training programme, called for an "affirmative action approach" to solving racial bias. □