of the US Preventive Services Task Force and the policies of some of the European countries. The different health care systems made it difficult to apply the policies of these countries to our own policy formulation. Of course, the task force recommendations[3] have been almost the gold standard in terms of careful weighing of the evidence and development of practice guidelines. However, the most recent review had been completed before the newest data were available on mammography from the randomized trials completed or in process around the world. Given the enormity of the matter, we believed the situation justified a consideration of the recent results, even though some still remained unpublished. We did not dismiss the task force recommendations; however, they are not the policy of the National Cancer Institute (NCI). The National Cancer Advisory Board was asked to develop a statement that would communicate the NCI's perspective.

Let me also clarify a point made in Litaker's letter. Neither the National Cancer Advisory Board nor the NCI were instituting a campaign about mammography. We were merely issuing a statement about the state of knowledge about mammography for women of different ages at a particular point in time, acknowledging that as the trials unfolded further, the conclusions might change. I also would add a caution about Litaker's statement that there is "thus an implicit promise that those who volunteer to be screened will benefit," a quote from Sackett and Holland.[4] As Geoffrey Rose[5] has argued so eloquently, the irony of the public health paradox is that many must be screened for few to benefit. As we pointed out in the National Cancer Advisory Board statement, there appears to be an overall reduction in breast cancer mortality for women who are screened in their 40s, as well as women who are screened later. Some women will benefit, because their breast cancers will be found when they are early and curable. Some women will have false-positive results, and it is debatable whether they will benefit; others will have false-negative mammogram results, and they, in a sense, may be harmed by receiving a clean bill of health. The majority of women will not have breast cancer, and so they will receive no personal benefit but will spend some time and money obtaining the test nonetheless. We should avoid making implicit or explicit promises about individual benefits.

These complicated facts are the reason why the National Cancer Advisory Board statement placed the emphasis on informed decision making, a major departure from prior guidelines, which were very directive. We were circumspect about the results and cautious in our interpretation. Clearly, this is a topic about which thoughtful people will continue to disagree. □

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These comments reflect the opinions of Dr Rimer and not the NCI or National Cancer Advisory Board.

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Ernster Responds

Litaker makes some of the same points as in my original commentary and subsequent responses.[1-3] Thus, it is not surprising that I concur with his statement that "If the evidence is equivocal, then it is fine to admit this." I did note the position of the US Preventive Services Task Force and also referred to the fact that it is the policy of many European countries not to routinely screen women younger than 50 years. It may be instructive to compare future trends in age-specific breast cancer mortality across countries with differing screening policies, although interpreting the results of such comparisons must be undertaken with care, given differences across populations in underlying breast cancer risk factors, in awareness of the importance of seeking medical attention promptly when breast cancer symptoms occur, and in treatment patterns, all of which could confound any observed associations. □

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Ethics and HIV Trials

We agree with Susser that the encouraging results of the recent trial of short-course zidovudine to prevent mother–infant HIV transmission in Thailand "could not have been achieved without a placebo arm,"[1] and thus we would like to clarify the rationale for stopping the placebo arm in the other trial in Côte d'Ivoire sponsored by the Centers for Disease Control and Prevention (CDC), along with our position on the use of placebo arms for future trials in developing countries.

On February 18, 1998, the Ministry of Public Health of Thailand and CDC announced that the placebo-controlled trial in Bangkok showed that a short course of zidovudine reduced the risk for transmission by approximately 50%.[2] A press release following this announcement stated: "The ANRS [Agence Nationale de Recherches sur le SIDA], CDC, NIH [National Institutes of Health], and UNAIDS [Joint United Nations Programme on HIV/AIDS] . . . have recommended to the principal investigators of clinical trials *currently sponsored by these agencies* [emphasis added] that the placebo arms be dropped or replaced with the CDC short-course regimen."

This statement was intended to refer only to the trials in progress at that time, such as the CDC-sponsored trial in Côte d'Ivoire. This trial was studying the same zidovudine regimen in a setting where it could be implemented if it were found efficacious. Once the efficacy of the short-course "Bangkok regimen" was known, it was no longer necessary or ethically appropriate for the Côte d'Ivoire trial to continue to have an untreated arm. Although the magnitude of efficacy of the "Bangkok regimen" in this breast-feeding population remains unclear, it seems likely that at least some of the reduction in transmission it has afforded will persist despite postnatal HIV exposure through breast-feeding.

These and other trials were conducted because the longer "076 regimen" shown to be effective in the United States and Europe[3] is too complex and costly to be implemented in most developing countries.

A trial design that compared the short-course zidovudine regimen with a placebo rather than with the "076 regimen" was used in the CDC-sponsored trials because it offered the best means of determining the safety and efficacy of an affordable and implementable short antiretroviral regimen for reducing mother–infant HIV transmission in these countries.

As Susser suggests, even the "Bangkok regimen" may not be appropriate for some countries (e.g., those with extremely limited resources) or some populations (e.g., HIV-infected women with late or no prenatal care). In such populations, where proven interventions to prevent mother–infant HIV transmission remain unavailable, it still may be appropriate to use a placebo arm as a proxy for a current local standard of care to evaluate whether a new intervention (e.g., one beginning at labor) offers any benefit. □

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Errata

In: Morales Bonilla C, Mauss EA. A community-initiated study of blood lead levels of Nicaraguan children living near a battery factory. *Am J Public Health*. 1998;88:1843–1845.

Several superscript reference citations were listed incorrectly in the published paper. On page 1844, [9,10,15] should have been [10,11,16], and [16] should have been [17]; and on page 1845, [17] should have been [18], [18] should have been [19], and [19] should have been [20].

In: Carrasquillo O, Himmelstein DU, Woolhandler S, Bor DH. Going bare: trends in health insurance coverage, 1989 through 1996. *Am J Public Health*. 1998;88:36–42.

In the abstract, in the second paragraph under Results, the first sentence should have read (change in italics) "The greatest increase in the population of *uninsured* was among young adults aged 18 to 39 years; rates among children also rose steeply after 1992."