developed sneezing and rhinitis, but on this occasion I developed severe bronchospasm within a few minutes. With conventional treatment for the asthma (a beclamethasone diproprionate inhaler) the response to alcohol was greatly reduced, but experimentation with whisky showed that the asthmatic symptoms depended on the brand of whisky. Other alcohols such as wines did not produce symptoms.

Gong *et al* reported that it was the congeners in alcohol and not alcohol itself that produced symptoms in asthmatic patients. My inquiries have suggested that few doctors are aware of an association between alcohol and asthma.

I would naturally consider sympathetically any invitation to take part in clinical trials requiring ingestion of whisky for medicinal purposes.

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is to establish, through adequate clinical trials, the optimum management of localised prostatic cancer. There is little point in making early diagnoses if we do not know what to do next.

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in survival arising from treatment requires randomisation of large numbers of patients. We should not consider the need for early detection of localised prostatic cancer until its treatment has been subjected to such assessment.

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Screening for prostatic cancer

EDITOR,—Fritz H Schröder makes a cogent case against widespread screening for cancer of the prostate.[1] One crucial criterion in justifying a screening programme is that intervention is more effective in presymptomatic disease than after symptoms have appeared. This has never been shown for prostatic cancer. No treatment at any stage of disease has been shown to improve survival in an adequate clinical trial. The statement that "radiotherapy and radical prostatectomy are effective in treating locally confined prostate cancer" (cited with a reference to an American consensus conference) is not justified by the available evidence.

Assessing treatment in early prostatic cancer is difficult. Ten to 15 years of follow up is required, in a population with considerable competing risks of death. Studies of series of patients who have been operated on report survival not much worse than that expected for the age matched general population,[2] but they ignore the possible effects of length-time bias and case selection for operation. In a series of 223 localised carcinomas managed expectantly five year disease specific survival was 94% and 10 year survival 85%, although the figure was much worse for poorly differentiated tumours (25% survival at five years).[3] In one randomised controlled trial of radical surgery 111 of 142 patients with cancer confined to the prostate were followed up for 15 years.[4] Survival curves were identical for patients who were and were not operated on and were only slightly worse than expected for the general population matched for age. Another trial in 97 patients showed an advantage for surgery over radiotherapy in forestalling the appearance of distant metastases over five years.[5] Radical prostatectomy is a major operation with potentially serious morbidity (including impotence and urinary incontinence)—risks worth taking only once benefit has been established unequivocally.

In advanced disease hormone treatment (chemical or surgical castration or oestrogens) relieves symptoms and improves general wellbeing. Early endocrine treatment may delay progression of disease but has never been shown to prolong survival.[6] Evidence that total androgen blockade (castration plus an androgen antagonist) is more effective than castration alone[7] has not been confirmed in two other trials.[8,9]

Though trials of screening for prostatic cancer are to be welcomed, surely a greater priority

EDITOR,—We agree with Fritz H Schröder that screening for prostatic cancer is not presently justified.[1] Gaps in understanding of the disease and its treatment and the unsuitable characteristics of available diagnostic tools mean that prostatic cancer fails to meet most of the standard epidemiological criteria required for a successful screening programme.[2] We also agree that even effective treatment may not bring benefit in all cases of localised cancer because of competing causes of death and the slow rate of progression of disease in some cases.

We question, however, Schröder's implication that effective treatment exists, believing that his assertion that "radiotherapy and radical prostatectomy are effective in treating locally confined prostatic cancer" is particularly misleading. In an asymptomatic patient effectiveness implies improved disease specific survival. No randomised trial has shown such effectiveness. On the contrary, evidence indicates that disease specific survival rates quoted in uncontrolled trials cannot be interpreted as evidence of therapeutic benefit.[3] We suggest that the issue is not that "a considerable possibility of overtreatment" exists[1] but that potentially damaging and ineffective treatment may be undertaken outside the confines of a randomised controlled trial.

Over 20 000 radical prostatectomies were performed in North America in 1991, and several centres in Britain undertake the procedure. The cost to the patient is often high: some patients die, and impotence and incontinence are recognised complications.[4] A similar willingness to perform radical treatment for breast cancer in the absence of evidence from randomised trials led to the misguided mutilation of thousands of women by radical mastectomy.

The resource implications of such procedures are substantial. Registrations of cancer show that the incidence of prostatic cancer in England and Wales is 39 per 100 000 males.[5] On the basis of Schröder's figures this could lead to over 2500 radical prostatectomies a year. This ignores the substantial number of additional cases that would arise if screening became widespread. Tariffs for extracontractual referral indicate that the estimated cost to the NHS of such surgery exceeds £10·8 million. If the only effect on health of such interventions is adverse this seems remarkably poor value for money.

Unbiased assessment of moderate differences

EDITOR,—Fritz H Schröder's editorial is a measured evaluation of the issues surrounding screening for prostatic cancer.[1] Such an approach is vital with the increasing demands being placed on health professionals to detect and treat disease before it is clinically apparent. I believe, however, that Schröder has amalgamated two issues—screening and treatment of early prostatic cancer—into one when they should be argued separately.

Whereas in breast and cervical cancer active treatment is instituted on detection of the disease, it is argued that screening would not be appropriate in localised prostatic cancer because no treatment is often the option chosen.[2] George has shown this to be a satisfactory option, reporting a five year survival of 80%,[3] but this has never been compared in a randomised controlled trial with a treatment regimen. The slow rate of progression to metastasis coupled with the predictable behaviour of localised prostatic cancer[4] provides a window in which the diagnosis can be made before the disease has spread, with a possible reduction in the morbidity and mortality.[5] The high incidence of metastatic and thus incurable disease at presentation[6] is sufficient evidence that a large group of patients might be helped if the disease was detected earlier. The relatively inexpensive initial methods of screening available (that is, digital rectal examination and measurement of the prostate specific antigen concentration) and the advances in transrectal imaging with ultrasound and magnetic resonance imaging all serve to provide a sound backdrop for a screening programme.

Thus the real question seems not to be whether we should detect the disease but how best we should treat it if it is detected. The controversy regarding treatment should not be allowed to detract from screening as improvements in current methods of treatment and the introduction of new strategies in management are likely to emerge; it serves to make the point that a randomised controlled trial comparing the different methods of treatment and non-treatment should also be instituted.

Mass screening is not feasible, but targeting groups at high risk and asking them to attend for screening is perfectly plausible. These groups can be defined only by pilot programmes specifically designed to identify the characteristics of such groups. The earlier detection of prostatic cancers that have not spread will surely allow us the opportunity to treat and cure some of these