while the lymph nodes are not affected. This is the key to the eventual reduction in mortality. The rate of positive nodes in incidence screens in Edinburgh, where the films were read by non-radiologist doctors,[5] was 10% higher than that in the Ostergotland component of the two county study. Differences in radiological sensitivity are probably major influences on all these issues. The current figures relating to size and nodal spread (unpublished) for the south east Scotland screening programme reflect an improved sensitivity.

The mortality in the study group after 10 years in the Edinburgh trial was between 14% and 21% lower than that in controls, depending on the precise definition of the end point.[3] To achieve a reduction equivalent to or greater than this by the year 2000 in Britain is ambitious but will be best served by maximising compliance[6] as well as radiological sensitivity. Mechanisms to promote these need urgent support.

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Informed consent may increase non-attendance rate

EDITOR,—The *Health of the Nation* aims at reducing deaths from breast cancer in women invited for screening by a quarter by 2000. This target is unlikely to be met as there are only five years to go; judging by the current rates of interval breast cancer, we are probably only half way to that target.[1] If there is any reduction in mortality from breast cancer by 2000 it is just as likely to be attributable to the improvements in treatment since the publication of the world overview on adjuvant systemic treatment in 1992.[2] So what remedial actions should be taken?

S Field and colleagues suggest that the United Kingdom Coordinating Committee on Cancer Research trial of the frequency of breast screening will identify the optimum interval between screens.[3] This trial, however, compares only one year with three years. It is hard to believe that the one year interval will not improve on the results of the three years interval, but if we do not have enough trained professionals to implement even a two year interval how can we afford a one year interval?

The suggestion that general practitioners should coerce women into joining the programme makes me feel uncomfortable. The target for acceptance in the NHS screening programme was 70%, and this has more or less been reached in most centres. Yet Paul A Creighton suggests that there should be financial inducements for general practitioners to encourge women to come forward for screening and that this encouragement should be based on "information and counselling."[4] It has to be remembered that women who fail to accept an invitation could be doing so for rational reasons. In absolute terms less than 1% of women who are invited for screening will benefit from it, whereas a greater percentage will have to face the problems of false alarms, unnecessary surgery, unnecessary labelling as having cancer, and a lead time in the diagnosis of cancers whose natural course is unaffected by "earlier detection."[5] In other words, true informed consent for an invitation to screening might reduce rather than increase acceptance.

The NHS breast cancer screening programme has undoubtedly raised standards in the diagnosis and management of this disease, but many tough questions remain to be answered. These questions should be addressed in scientific terms outside the political arena, and the unsolicited targets in the *Health of the Nation* that have been imposed on the medical profession should be treated with the scepticism they deserve.

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British women are being offered a cheap deal

EDITOR,—It was encouraging to read Ciaran B J Woodman and colleagues' paper on breast screening[1] and, in the national press, that the Department of Health is taking an interest in the results. Mammographic radiologists will recall with regret that the requirements for adequate breast screening were known to the committee that issued the recommendations for screening in 1986.[2] This committee, which was heavy on the department's accountants and light on radiologists (whose recommendations were ignored), came to the extraordinary conclusion that the screening should be carried out by one radiologist, that one radiographic view should be obtained, and that the screening should be done only every three years. All the evidence from the Continent was that two initial views, read by two radiologists, every year or at most every two years were required. The excuse for not responding to the evidence was cost effectiveness, which everyone recognised as a euphemism for "cheaper."

After the publication of the recommendations some of us complained loudly that British women were being offered a cheap deal. Unfortunately, we had no effect. It is to be hoped that the programme will now be corrected, and perhaps radiologists who know about screening will be consulted. The profession must make sure that this most shameful of the government's underfunding exercises is improved.

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Technicians could be trained to interpret screening mammograms

EDITOR,—S Field and colleagues' editorial on interval breast cancers implies a need to quadruple the amount of radiological time devoted to the interpretation of screening mammograms.[1] I am unclear why this job must be the exclusive role of radiologists. Cervical cytology screening is entrusted to supervised technicians, and the tasks seem to be similar. Use of technicians would free radiologists from the presumably tedious task of examining hundreds of similar films for the more rewarding jobs involving direct clinical contact, such as ultrasonography and needle aspiration of breast lumps. I wonder what radiologists think about this.

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Diagnostic performance of radiographers can be improved

EDITOR,—A move to a two year screening interval would help reduce the rate of interval cancers noted in the NHS breast screening programme. S Field and colleagues argue, however, that this is prohibited, at least in part, by the limited numbers of trained radiologists able to interpret the additional mammograms that would be necessary.[1]

One possible means of overcoming this shortage would be to employ radiographers who have received additional training in interpreting screening mammograms. This has previously been suggested as a way of developing the radiographers' role.[2] I have shown in another area—fracture radiographs in the accident department—that the diagnostic performance of radiographers can be improved provided they receive supplementary training.[3] It has long been standard practice for cytological screening to be routinely undertaken by skilled medical laboratory scientific officers with rigorous quality assurance checks by pathologists. Similar models could, perhaps, be introduced into breast screening units employing skilled radiographers, with comparable quality assurance checks by radiologists.

The reduced cost of a programme in which radiographers figured more in the screening process would presumably offset the costs anticipated if the programme was undertaken by radiologists and might make a two year screening interval more feasible.

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Two views mean twice the dose of radiation

EDITOR,—In their paper on breast screening and interval cancers Ciaran B J Woodman and colleagues state that "interval cancers may occur as a result of the failure to detect an abnormality at the time of screening (false interval cancers) or may occur as a new event after a negative screen (true interval cancers."[1] They do not seem to consider the possibility that the screening process itself may have sparked off some of these "new events." To