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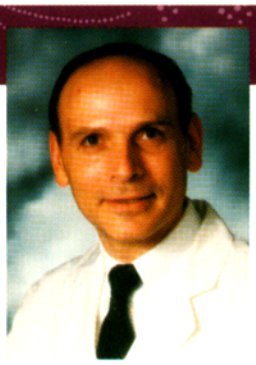

The Success of Cancer Treatment: A "Guilded" Age?

Lest we forget, we still don't know how to treat cancer. This year, for example, 54,000 women will die from breast cancer. Some people may look at this statistic as an unavoidable price; others may want to believe that this number would go away if we just didn't keep records. Some might view the yearly death toll from cancer in the same way we view annual highway driving fatality statistics—tragic, but a small price to pay, especially for those of us who aren't among the dead, the injured, or the families of either. As a society we are becoming increasingly bombarded with one type of mass tragedy or another, and I sense that these losses don't bother our collective consciousness as much as they used to. Perhaps one reason for our insensitivity is because we haven't heard any good news lately.

Now, we have some good news.

As a result of our collective clinical cancer research efforts, this year we will become a little less ignorant. The progress that we make each year seems to be measured in inches, but the clinical trials that we all endeavor to support and to which we accrue patients are making a difference.

At the recent Southwest Oncology Group meeting held in Dallas, Tex., the results of two important studies were first presented. Dr. Saul Rivkin summarized the twenty-year follow-up of SWOG 7714. This trial enrolled women with locally controlled lymph node positive breast cancer and randomized them onto two different types of adjuvant chemotherapy: oral melphalan for two years or CMFVP for one year. The results now demonstrate that the CMFVP group did better in all subsets: those with less than four involved lymph nodes and those with four or more involved lymph nodes, and also in both pre- and postmenopausal women.

The second significant trial, SWOG 8814, was presented by Dr. Kathy Albain. This study evaluated the outcome of women in two groups who were postmenopausal with ER positive tumors and positive lymph nodes. The first group received tamoxifen for two years, and the other group received both tamoxifen plus FAC chemotherapy, either given concomitantly or preceding tamoxifen. This trial confirmed the additional benefit women derive from the combination of both chemotherapy and hormonal therapy, regardless of the patient's age or number of involved lymph nodes.

At the recent American Society of Clinical Oncology (ASCO) meeting in Denver, Colo., Dr. Bernard Fisher presented the results of NSABP trial B-20, which also evaluated the additional benefit that chemotherapy may have for women with ER positive and node negative tumors. This trial showed that when a very tolerable and moderate-strength chemotherapy regimen (CMF) was added to standard tamoxifen, an additional 5 percent improvement in five-year survival was achieved. The annual incidence of female breast cancer is about 184,000 cases per year, and of those cases approximately 40,000 women would fit the criteria of the women who benefited in this trial. These new results from NSABP trial B-20 may well help save the lives of 2,000 more women this year over just last year alone.

Soon some of the advances in molecular biology, such as the therapeutic use of p-53, will appear at the community level. We must continue to maintain a healthy clinical trials apparatus to rapidly test and integrate such new modalities into our armamentarium. Otherwise, successes such as those reported this year may lead us into a dull torpor if we aren't careful.

At a recent ASCO plenary session, National Cancer Institute Director Dr. Richard Klausner aptly described our current predicament. He noted that our success over the last thirty years has led to significant improvements in cancer care. However, Klausner continued, this success may lead us to become insular and resistant to change and innovation. We then risk becoming barriers to new methods of care and care delivery.

Klausner went on to explain that as Western society changed from an agrarian-based to a manufacturing-based economy, a similar phenomenon occurred. Prior to the industrial revolution, products were made by hand, and the quality and quantity were tightly controlled by specialized guilds. The use of machines and assembly lines, over the objections of the guild craftsman, quickly made such guilds obsolete. This analogy can be applied to our role as health care providers. Now that all our work to improve cancer care is starting to pay off, we must strive to remain the instrument of change for the better, and resist letting our past successes transform us into an irrelevant guild that represents treatments that just aren't good enough.

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