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FDS/PJP

2nd June, 1988

The Prime Minister,
10 Downing Street,
London SW1

Dear Prime Minister,

BREAST CANCER TREATMENT

I have just returned from a one week visit to the joint meeting of more than 5,000 American cancer specialists in New Orleans. (see attached letter) On my return I was distressed to see press reports about letters which had been sent to you concerning the management of breast cancer patients. I have already had specific discussions about these matters with John Moore and Edwina Currie.

Presently I look after 500 patients with breast cancer since this is one of my major fields of interest. It is a matter of record that surgical treatment of this common disease is well managed in British hospitals and most of my consultant colleagues make strenuous efforts to use methods designed to minimise surgical cosmetic and psychological trauma in patients with this disease.

There is, however, no possibility of standardised treatment being used in a condition which can present in many different ways.

Variations include:

1. Age, menopausal status, number of children and hormonal factors in the victim.
2. The size and position of the tumour in the breast at the time of presentation.
3. Possible spread of tumour to lymph nodes or remote organs at the time of presentation.
4. The aggressiveness of the tumour as judged by histopathology tests under the microscope.

For the reasons above, it is therefore impossible to generalise on the way in which patients should be treated and I think it is invidious of any pressure group to suggest that you personally could do more than commend the high standards of scientific and personal care that surgeons give to patients of all ages with this distressing problem.

At present, before the National Breast Cancer Screening programme gets under way, I would estimate that 20% of patients with breast cancer can be properly treated without recourse to a total mastectomy. We can hope that this percentage will rise as the screening programme takes effect after its commencement in 1990. As I have explained to Mrs Currie, the challenge to Government will be to ensure that the screening programme gets the same intense publicity as the anti-AIDS programme has done during the last 18 months.

Yours most sincerely.

David Skidmore.

c.c. Rt Hon. John Moore
Mrs Edwina Currie

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Rt. Hon John E.M. Moore,
Richmond House,
79 Whitehall,
London SW1A 2NF

Dear John,

TREATMENT OF CANCER IN THE USA

I have just returned from the Annual General Meeting of the American Cancer Surgeons in New Orleans. This meeting was held in parallel with the annual meeting of the American Physician Oncologists (American Society for Clinical Oncology) and the American Society for Cancer Research. It will interest you to know that there were 400 surgeons and 5000 physicians and research workers at the meeting.

In concert with many influential American surgeons I was alarmed by the developments in the managements of patients with cancer in the USA.

1. In the absence of a national general practitioner scheme, patients tend to refer themselves to physicians and radiotherapists for investigation and treatment. In Britain such patients are sent primarily to surgeons for assessment and treatment. Inappropriate radiotherapy and chemotherapy is being used as first line treatment rather than surgery in conditions where early surgery provides the best chance of success.

2. Patients are referred by physicians or radiotherapists to surgeons at a late stage in their disease process when complications set in from tumour spread and any operative treatment can only be palliative.

3. In the New Orleans conference centre there was an enormous trade exhibition directed at medical oncologists. Very high pressure salesmanship on behalf of drug companies was the order of the day. Physicians were wooed by international companies including well known British firms such as ICI and Burroughs Wellcome. It was clear that the object of the manufacturers thrust was to persuade physicians to use cancer drugs as often as possible.

In concert with my American surgical colleagues, I am dismayed at this approach for the following reasons.

1. Many of the drugs are of doubtful or marginal efficiency.
2. Most have major side effects.
3. Although use of these drugs may result in increased length of survival time for a patient with advanced cancer, no evidence is available which suggests that the quality of life during that increased survival time is adequate.

4. The present disastrous state of American patient-doctor relationships means that every practitioner is constantly looking over his shoulder for the threat of legal action over alleged malpractice. Litigation in this field has reached the point at which colleagues in surgery are paying £25,000 per annum insurance premiums for medical negligence. First class gynaecologists and obstetricians are retiring early leaving medicine because of the ever present threat of litigation.

The overall results of items 1 - 4 above is that the combination of that factors results in physicians treating advanced cancer patients, often in the 75-85 age group, with multi-agent chemotherapy at great financial cost to the patient or the American state because of a fear of retrospective legal action brought by relatives if such agents were not employed.

All of us working in the field of cancer care wait impatiently for the pharmacologists and cancer scientists to provide us with better means of early diagnosis and new drugs which will be more effective against the major cancers (i.e. breast, colon, lung and stomach) in the future. However, until such compounds have been tested in clinical trials with immaculate statistical design, British cancer specialists must regretfully hold back from giving chemotherapy to patients in whom nothing can be achieved other than delalying death from carcinomatosis.

In this stage of a patient's illness we have to concentrate on giving symptomatic support, pain control by drugs, psychological support at home or in hospices and care in the best traditions of British nursing and medical practice.

Beyond this individual care, the best way in which we can influence cancer statistics is by doing all in our power to give advice to the general public about cancer prevention programmes. Government propoganda on the AIDS problem has been most effective, and as I have said to you before, the medical profession is waiting impatiently for the Government to have the courage of its convictions and run a really effective anti-smoking campaign and ban cigarette advertising.

As you will know from living in the USA the pressure groups there are powerful and well co-ordinated. However, it has to be my final conclusion, as a consequence of my visit to the American meeting that enormous amounts of money are being spent at a 5-10% efficiency rating on anti-cancer drugs for patients who are inevitably going to die of the disease whilst legislators hold back from instituting action a) in the negligence field, and b) in the realm of cancer prevention which would show a far greater benefit per dollar expended.

I would be pleased to discuss this matter further with you or any of your staff at an appropriate occasion.

Yours most sincerely,

David.

c.c. Prime Minister.

NHS: Exp pt 13.