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by Robert S. Mendelsohn, MD

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Modern Breast Cancer Management: Just Say No

Dr. Robert Mendelsohn

First Lady Nancy Reagan's mastectomy has panicked many women into running for mammograms. Both the print and broadcast media are filled with urgings by doctors and hospitals--and even by Mrs. Reagan herself--prodding women to step up in front of that x-ray machine. And while doctors may disagree on how often--and at what age--mammograms should be done, I haven't seen a word in the popular press reflecting the opinions of eminent physicians who believe they shouldn't be done at all.

Yet, evidence of the futility of mammography and manual breast examination has appeared in the pages of the most respectable medical journals. In addition, some of the most authoritative voices in modern medical science have pointed out the uselessness of all modern medical therapy--surgery, radiation, and chemotherapy--for breast cancer.

From time to time, I have brought you some of these reports. But now, in view of the extreme pressures generated by Nancy Reagan's surgery, perhaps it is time to collect the opinions of those medical authorities who dissent, who reject the notion that early diagnosis makes a difference in outcome. This will enable women who are threatened by "mammogram hysteria" to stand back, pause for a moment, and listen to second opinions which doctors share with each other, but rarely with their patients. That is the purpose of this Newsletter.

Debunking cancer screening

Many women are lining up for mammography, but not as many as the American Cancer Society would like. Only half the women who are older than 50 have had a baseline (initial) mammogram, and only 25 percent of them have received both a baseline and at least one subsequent mammographic examination.

The National Cancer Institute is trying its best to reassure women that mammography is safe--the average exposure from mammography has been reduced by about 50 percent in the past decade.

However, look closely at the warnings which authorities (FDA Drug Bulletin, October 1987) are issuing about mammography techniques. The FDA tells us physicians we must understand that there may be considerable variation from one facility to the next in the amount of radiation the patient receives. Physicians are told to find out: (1) Have the radiologist and x-ray technologist had specific training in mammography? (2) Does the facility use equipment designed specifically and used exclusively for mammography? and (3) Is the mammography equipment inspected and calibrated at least once a year?

If you do decide to have a mammogram, doen't assume your physician has asked the radiologist these important questions. Ask the questions yourself.

In his article "False Premises and False Promises of Breast Cancer Screening" (The Lancet, August 10, 1985), Dr. Petr Skrabanek of the University of Dublin's Trinity College minced no words. "The evidence that breast

cancer is incurable is overwhelming," read the first sentence. And he continued: "Unable to admit ignorance and defeat, cancer propagandists now have turned to blaming the victims: They consume too much fat, they do not practice breast self-examination, they succumb to 'irrational' fears and delay reporting the early symptoms. It would appear that no woman needs to die of breast cancer if she reads and heeds the leaflets of the cancer societies and has her breasts examined regularly."

Dr, Skrabanek wrote, "Adherence to these myths and avoidance of reality undermines the credibility of the medical profession with the public."

What happens to untreated breast cancer? Dr. Skrabanek cited a study in which 20 percent of untreated breast cancer patients still were alive after five years, and five percent were alive after 10 years, even though the great majority of their cancers were in stage III or IV (advanced). He cited another study showing that women with very large breast tumors have a better survival rate than those with smaller tumors. He said, "If breast cancer is uncurable, as many surgeons believe, then screening only adds years of anxiety and fear." And he went back almost 100 years to 1888 to cite a surgeon who criticized radical mastectomy: "Enthusiasts put forward widely conflicting views often more notable for dogmatic assertion and vehemence than for logical thought."

Dr. Skrabanek pointed out, "Fashions in chemotherapy change too fast for allowing a reasonable time to assess them, but rapid changes are themselves indicative of unfulfilled promise." He gave multiple references showing that "Survival rates are little affected by any of the current methods used, whether it be radical or simple mastectomy, with or without radiation, and with or without chemotherapy...prophylactic resection or irradiation of regional lymph nodes with or without metastases does not improve survival....One thing is certain: Survival is much more closely related to the intrinsic malignancy of the tumor than to early diagnosis and treatment." He condemned the rush to surgery: "Aggressiveness is often a sign of desperation, and surgical aggression is no exception."

Discussing preventive mastectomy, Skrabanek wryly commented, "The earliest possible intervention is removal of a healthy breast. The belief that the fewer organs we have, the less likely we are to die is 'reductio ad absurdum.'"

One doctor cited by Dr. Skrabanek wrote: "There is no evidence that early mastectomy affects survival. If the patients knew this, they would most likely refuse surgery."

Regarding breast self-examination, Dr. Skrabanek concluded: "It is dishonest for cancer societies to promulgate BSE as a method for 'early' detection." As far as mammography is concerned, he provided several references leading to his conclusion that "screening programs are often publicity exercises." And he pointed out that women are not being warned about the potential risk of induction of breast cancer by the test which is supposed to detect it. These screening programs "with the accompanying propaganda from cancer societies and media may heighten the level of cancerophobia in society, with little to show in return....The psychiatric problems generated by BSE are underrated." In one psychiatric practice, the doctor found an increasing number of women who developed an obsessional ritual of self-examination. The last sentence in this sharp attack (with 90 references) reads, "We should climb off the cancer bandwagon and admit our ignorance."

As one who for decades has recommended against breast self-examination, mammography and orthodox therapy for breast cancer, I advise every woman (together with her husband, father, brother, boyfriend, etc.) to ask her doctor to obtain this important article from his medical library and share it with her.

Although I went to the original article and found that you really did quote Dr. Skrabanek quite accurately in his statements that cancer of the breast is an incurable disease, I do think you went overboard in supporting Dr.

Skrabanek. Therefore, I am enclosing some of the letters to the editor of The Lancet (September 7, 1985) which appeared in response to his article in that publication.--George Crile, Jr., M.D., The Cleveland Clinic Foundation.

A Thanks for sharing with me your strong feelings about the treatment for breast cancer. I particularly value your opinion because, 35 years ago when I was still a medical student, you influenced me with your condemnation of radical mastectomy.

I also was interested to read Dr. Michael Baum's criticism of Dr. Skrabanek in the British medical journal, The Lancet. Dr. Baum, of the Department of Surgery, Kings College School of Medicine and Dentistry, London, England, began his letter by accusing Dr. Skrabanek of being confused in his scientific philosophy and ignorant of the role and relevance of local therapy (i.e., surgery) for early breast cancer. However, in the very next sentence, Dr. Baum admitted, "There is no firm evidence that local therapy influences length of survival...." Dr. Baum also conceded that "most clinically detectable breast cancers have metastasized at the time of presentation."

In another letter to The Lancet, Dr. George T. Watts of Birmingham, England began by defending Dr. Skrabanek's paper as "a long-needed application of logic and honesty."

Dr. Watts pointed out that, despite logic, "Patients expect treatment. Frank statements that all treatments are equally ineffectual will not satisfy them....Perhaps this explains why the theorists have gained so little ground and why most surgeons and patients still prefer treatment which cuts out the growth."

Yet the theoretical arguments have major practical significance. If Dr. Skrabanek and collegues are correct, then why bother to treat breast cancer at all, especially when medical treatments (surgery, radiation and chemotherapy) are known to be capable of causing further disease, and even death? If treatment is worthless, why go through the not-totally-innocuous charade of mammography, breast self-examination and biopsy? Why not advise women to simply disregard any lumps in their breasts whether detect able by x-rays or by palpation? If, on the other hand, Dr. Skrabanek's critics are correct, then the entire contemporary strategy of early diagnosis and aggressive treatment is worthwhile.

I will continue to keep my readers informed of both sides of the escalating breast cancer controversy. I think you will agree with me, Dr. Crile, when I advise patients, "Make sure your doctor does the same for you."

Q I am a registered nurse. Recently, I attended a lecture on breast cancer at which the speaker said the latest research shows a decreased risk of breast cancer in women who use birth control pills. How can this be? Every study done on laboratory animals shows that estrogen causes cancer.--B.B.

A *What is estrogen's role in breast cancer?*

A short history of birth control pills might read something like this: At first, doctors told women that The Pill was perfectly safe. Later, women found out for themselves (thanks mostly to the media) that birth control pills were dangerous. Then, some doctors began to downplay the risks of the birth control pill, claiming it wasn't all that dangerous. Now, as you point out, some doctors have gone so far as to claim that birth control pills are good for you and will prevent cancer. This last group of doctors rejects the studies you cite on laboratory animals with the argument that animal studies cannot be transferred to human beings. (Why then do animal studies? Why not join anti-vivisection societies instead?)

Since this controversy over the oral contraceptive pill is likely to continue for as long as there is an oral contraceptive pill, I recommend the following attitudes:

1) Continuing suspicion of statistical studies conducted by doctors, whether the studies be on The Pill, on tobacco, or on cancer. (One of the major references used by medical students is Darryl Huff's "How to Lie with Statistics," Norton & Co., New York).

2) Constant recognition that while scientific controversy over The Pill may or may not benefit patients, it certainly benefits--both economically and professionally--the scientists who research the controversy.

3) Close attention by all Pill-takers to the ever-growing list of side effects from The Pill with an eye toward legal action against both the doctor who prescribed it and the manufacturer who produced it.

4) Appreciation that the controversy over The Pill most likely will be resolved not on the basis of objective scientific studies but rather on the basis of logic, common sense, emotion and ethics.

What are the survival rates following breast cancer surgery?--D.S.

Lumpectomy/ mastectomy survival rates the same

Yet another leading cancer surgeon has confirmed the breast cancer research done four decades ago by The Cleveland Clinic's eminent surgeon, George Crile, M.D.

Dr. George Elias, chairman of the National Surgical Adjuvant Breast and Bowel Project of the United States and Canada, has reported (Toronto Globe and Mail, February 22, 1984) that a joint U.S./Canadian study showed the same survival rate (85 percent over five years) among breast cancer patients who underwent "lumpectomy" (removal of only the tumor itself) compared with those who had modified radical mastectomies.

Dr. Crile, who 40 years ago was reprimanded by the Cleveland Academy of Medicine for taking his pioneering work directly to the public press, is one of nine distinguished American physicians whose writings appear in the book "Dissent in Medicine" (available for $9.95 from The People's Doctor, 1578 Sherman Avenue, Evanston, Illinois 60201.) Dr. Crile presents a dissenting view on the conventional treatment of some common cancers, breast cancer included.

Over the past 10 to 15 years, U.S. surgeons have been beating a strategic retreat in the face of increasing public awareness of the breast cancer controversy. Faced with massive reaction by women against radical mastectomy, cancer surgeons have withdrawn to a fallback position--the "modified" radical. Because women increasingly are resistant to biopsy and simultaneous mastectomy, surgeons have had to settle--even though they regard the interruption as dangerous--for a decent time interval after biopsy to offer women a chance to make an informed decision. Suffering from the insurgency of radiologists who claim their treatment gives just as good a result without the mutilating effects of breast removal, surgeons have counterattacked with evidence that x-rays themselves can cause cancer.

Of course, the bottom line remains the same: None of these treatments --radical, modified radical, lumpectomy, prophylactic mastectomy--ever has been subjected to controlled scientific study. Because of surgeons' claims that such an experiment would be unethical, no one ever has operated on half the candidates for these procedures, left things alone in the other half and then compared the results. Therefore, scientifically speaking, all these operations remain in the category of "unproven remedies."

Therefore, when next you hear of a woman who is being threatened with breast removal, suggest that she ask her doctor if he is familiar with the conclusions of Maryland's Dr. George Elias. Maybe she should ask her doctor to contact Dr. Elias. Perhaps he may extend his important study to a comparison of women with breast cancer who have been lumpectomized with those who have had no surgery at all.

Since the extent of surgery for breast cancer (now more than a century

old) seems to be getting smaller and smaller, perhaps like Alice's Cheshire Cat, soon only the smile will be left.

Adverse effects of Nolvadex

Few exercises give me (and I hope you, too) more enjoyment than analyzing the drug company brochures which announce new product information. Thus, a slick brochure from Stuart Pharmaceuticals heralds "News about Breast Cancer Treatment: New Post-Operative Monotherapy."

Monotherapy. Now, there's a word I hadn't seen before. Intrigued at the promise of just one form of treatment after breast cancer surgery (instead of the usual cornucopia of toxic chemotherapeutic agents), I carefully read the "press information" enclosed in my shiny folder.

The therapy which Stuart is promoting --tamoxifen (Nolvadex)--is not exactly new. But now, Stuart Pharmaceuticals has gathered together studies which show that tamoxifen is more likely to prevent recurrences of breast cancer in certain groups of women than is cytotoxic chemotherapy, and it has a better safety record. So much for the hype in large type.

Now on to the tiny type. Here, the studies sound a little different. Two studies have demonstrated "an improved disease-free survival following radical or modified-radical mastectomy in post-menopausal women 50 years of age or older with surgically-curable breast cancer with positive axillary nodes when Nolvadex was added to adjuvant cytotoxic chemotherapy.

So what's happened to our little "mono-therapy"? It seems to me there are all kinds of hedges and restrictions: Women who benefit from the treatment have to be past a certain age. They have to have had an operation such as radical mastectomy (which has been discredited). They have to have had "surgically-curable" (whatever than might be) breast cancer. They must have had a spread of the cancer to the lymph nodes in their armpits. And they have to have been treated with cytotoxic (poisonous to the cells) chemotherapy as well.

If you are diagnosed as having breast cancer, your doctor may tell you that the hormonal nature of your tumor (hormone receptors) may predict whether you will benefit from Nolvadex. But the prescribing information states, "Not all breast cancer adjuvant Nolvadex studies have shown a clear relationship between hormone receptor status and treatment effect."

Three random studies demonstrated improved disease-free survival rates after total mastectomy and axillary dissection (removal of the lymph nodes in the armpits) for post-menopausal women compared to controls who received no treatment. However, the manufacturer warns, "These overall survival results have yet to be replicated." In other words, maybe Nolvadex does increase survival rate. Maybe it doesn't. But the studies to date do not provide conclusive evidence either way.

Nolvadex should not be given to pregnant women because it may damage the fetus. Nor should women become pregnant when they are taking this drug. There have been reports of miscarriages, birth defects, fetal death and vaginal bleeding if the patient is pregnant while she uses this drug.

Nolvadex also may affect the vision. Ocular changes, including retinopathy (disease of the retina), corneal changes, and a decrease in visual acuity (partial blindness) have been reported. In patients in whom the breast cancer has spread to the bone, Nolvadex may lead to hypercalcemia (increased calcium in the bloodstream) which may necessitate discontinuation of the drug.

Paradoxically, this drug, which is used for treating cancer in humans, has in research studies caused mice to develop ovarian and testicular tumors! Up to one-fourth of patients who take Nolvadex may develop hot flashes, nausea, and vomiting. Other adverse reactions include vaginal bleeding, vaginal discharge, menstrual irregularities, and skin rash.

If you are worried about pain from cancer itself, you should know that Nolvadex may lead to increased tumor and bone pain! Patients with increased

bone pain may require additional analgesic drugs.

If you are worried about growth in cancer size, you should know that some patients on Nolvadex may have "sudden increases in the size of pre-existing lesions." This increase in size sometimes is associated with marked redness surrounding the tumor as well as development of new areas of involvement. Other adverse reactions include peripheral edema (accumulation of water in the hands and feet), distaste for food, itching around the vaginal area, emotional depression, dizziness, lightheadedness, headaches, thrombo-embolic events (blood clots and strokes).

What can we learn from Stuart's brochure? First, what appears to be a breakthrough in the treatment of cancer in the large print may turn out to be a breakdown in the small print. Second, perhaps every medical school should have a course entitled "How to critically analyze drug company advertising" in which doctors are taught to read all print, regardless of size and to give at least equal weight to small print and large print. Above all, doctors should be taught to pass on the drug company brochure, or at least the prescribing information, to every patient for whom Nolvadex--or any other highly-touted drug--is prescribed.

New breast reconstruction

Silicone implants may be giving way to a new form of breast reconstruction. As described in the Michael Reese News (October 1, 1987), in the bizarre new four-to-eight hour surgical technique (usually on the third day after mastectomy), the surgeon cuts away a large area of skin and tissue "at the bikini line south of the belly button." Then, "the belly tissue is shaped into a breast." This new breast remains connected to the blood vessels from its original site, but because the nerves were cut during the operation, much of its feeling is lost. However, there are compensations for the loss of sensation. The surgeon who heads Michael Reese's comprehensive new Breast Center explains that with this removal of belly tissue, "The woman gets a tummy tuck at the same time." How lucky can one woman be!

The plastic surgeon in the Michael Reese Breast Center tells us that the toughest part of the procedure is duplicating the natural hang of the original breast. "We can never get it to look exactly like the natural breast. The goal is to have it look very good in clothes and pretty good in the nude."

After the new "breast" has healed and shrunken somewhat after surgery, there is still a problem. What about the nipple and the areola (the area surrounding the nipple)? Not to worry. The good doctors who gave us bikini lines, breasts without feeling, and tummy tucks have a solution. They take tissue either from the other nipple or from the labia at the mouth of the vagina! The areola is made either of skin taken high up on the inner thigh--or it is "simply tattooed on." Ah brave new surgical world! Breasts from tummies, nipples from labia, areolas from thighs. What next?

After having a small lump excised from her breast, my 83-year-old stepmother was advised to have a course of radiation or further surgery. In view of her age and other medical problems, including angina, she decided to reject the treatment. The radiation oncologist then applied pressure to her in a registered letter from which I abstract the following:

"In my opinion, you have a life-threatening condition which requires further treatment, such as radiation therapy, more surgery or both, and it is possible that continued delay may possibly allow a potentially curable cancer to become incurable.

"As your condition, in my opinion, requires further medical attention,

I suggest you place yourself under the care of another physician without delay. If you so desire, I shall be available to attend you for a reasonable time after you receive this letter, but in no event for more than five days...."

Is this kind of intimidation considered ethical by the medical establishment? Why won't this doctor discuss the risks of further treatment, especially in the light of my stepmother's health? Why doesn't he offer any scientific backing for his position? My stepmother asked for studies which compare the outcome of treatment vs. non-treatment, but the doctor provided no such studies. And what about alternative, natural therapies? It seems to me that an aged person with other medical problems is an ideal candidate for alternative, non-invasive treatments which are unlikely to harm her.

How can I put pressure on this doctor or his hospital? I would like to see others spared such intimidation.--M.S.

Doctor fires breast cancer patient

Why are you so upset? Perhaps your stepmother's doctor did her a favor by firing her from his care. Now, she and you have an opportunity to look for second opinions, not only from medical doctors but also from healers who do not hold an M.D. degree. While their alternative natural therapies may not be proven, neither are radiation or surgery.

Your stepmother already has asked her doctor if he would be kind enough to provide her with scientifically controlled studies in which half of the candidates for his treatment who are your mother's age and have breast cancer received the treatment and the other half did not. Since he could not show her such studies demonstrating a clear difference in outcome in favor of the treated group, he is guilty of recommending an "unproven remedy." Unproven remedies are not highly regarded by cancer specialists.

You and your stepmother therefore have a perfect right to ask whether this radiation oncologist is adhering to proper standards of medical practice. This question should be addressed to the president of the board of his hospital--or to a lawyer.

Maybe you thought a woman's survival after breast cancer depended on her treatment. If so, think again.

A new book by Paul Kuehn, M.D., "Breast Care Options" (Newmark, $17.98) carries the following surprising lines on its dust jacket: "Through the author's extensive experience taking care of women with breast cancer, it became clear that those who were able to conquer cancer had a formula for survival. They were determined to be victors, not victims. When women can begin talking about cancer as a fact of life without excessive fear, they can face it, fight it, and win."

While not downplaying the important emotional factors which affect the outcome of every disease, does Dr. Kuehn's attitude mean that women who died of breast cancer might be accused of having brought on their own deaths? Does this mean that women who die of breast cancer didn't talk about it, or didn't talk about it enough, or didn't talk about it correctly?

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Another View

by Marian Tompson

During all the media attention on breast cancer after Nancy Reagan's surgery, reference to the "good news" in breast cancer research was strangely missing. Nowhere did there seem to be any reference to recent studies confirming the protective effect of breastfeeding against the development of this disease.

We are told that breast cancer will kill more than 41,000 women this year, second only to lung cancer. Thirty years ago, it was generally accepted that failure of the breast to perform its physiologic function was the most consistent apparent factor in the genesis of breast cancer. But in the late 1960s and early '70s, not only was this belief disputed, it even was suggested that women could transfer a breast cancer virus on to their nursing babies.

Then in 1985, a study by Byers and others appeared in the American Journal of Epidemiology which reported a case control study of 453 white females who had breast cancer and 1,365 randomly selected white females who did not have breast cancer. In the premenopausal group, increased risk for breast cancer existed among those women who nursed less than one month; thereafter, there was a progressive decrease in risk with increasing duration of breastfeeding.

In 1986, the Journal published McTiernan and Thomas's study on evidence for a protective effect of lactation on the risk of breast cancer in young women. In this study, which included extensive interviews with 329 women aged 25 to 54 who had been diagnosed for breast cancer and a control group, it was found that women who had nursed had half the risk of developing premenopausal breast cancer as did women who had never breastfed. In premenopausal women only, there was a trend toward increasing protection against breast cancer with increasing length of breastfeeding. These findings persisted after adjustment for age, number of fullterm pregnancies, and age at first fullterm pregnancy.

The McTiernan study was a subgroup of a larger study which involved Yale University, the Centers for Disease Control, and seven other institutions throughout the country and encompassed 4,500 cancer patients and a comparable number of women in the general population. This study by Peter Layde and colleagues on cancer and steroid hormones confirmed the protective value of breastfeeding. It will be published by the Journal of the American Medical Association.

One of the researchers, W. Douglas Thompson, assistant professor of Epidemiology and Public Health at Yale School of Medicine, pointed out to me that the lower incidence of breast cancer in nursing mothers previously was attributed to a belief that younger mothers were more likely to breastfeed, thus lessening their chance of getting the disease. But this study shows that breastfeeding may be protective over and above the age at first birth factor, for all women, pre- and post-menopausal, between the ages of 20 and 54. It was found that women who breastfeed for a total of two years cut the risk of cancer by one-third over those who do not breastfeed.

Dr. Anne McTiernan, writing in the Spring, 1987 issue of Breastfeeding Abstracts (published quarterly by La Leche League International) suggests a number of possible explanations for this protective effect. They range from physical changes in the breast during lactation to the hormonal effects produced by breastfeeding. Dr. McTiernan points out that, during lactation, ovulation often ceases or is less frequent, which also may protect against breast cancer. And women who do not lactate might be at increased risk if they are given large doses of estrogen after childbirth to inhibit lactation.

Whatever the reason, Thompson points out, "There must be something protective in the process of breastfeeding. And aside from breastfeeding, there is not much researchers can recommend to prevent the disease."

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2) HOW TO RAISE A HEALTHY CHILD . . . IN SPITE OF YOUR DOCTOR
Maintaining that 90 percent of pediatric office visits are unnecessary and often even dangerous, Dr. Mendelsohn carefully instructs parents on how to diagnose and treat their children without medical intervention, how to determine when a child is sick enough to need a doctor, and how to avoid unnecessary and potentially hazardous treatment when a doctor is consulted.

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4) CONFESSIONS OF A MEDICAL HERETIC
Dr. Mendelsohn believes that your own doctor is usually the greatest danger to your health. He believes that the methods of modern medicine are rarely effective and in many instances are more dangerous than the diseases they are designed to diagnose and treat. In this book, he discusses the over-prescription of drugs, home vs. hospital birth, unnecessary surgery, the dangers of hospital care, so-called preventive medicine, and modern medical ethics in general.

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