

Letter

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Comments on: *Current Policies for Surveillance and Management in Women at Risk of Breast and Ovarian Cancer: a Survey Among 16 European Family Cancer Clinics, Vasen et al., Eur J Cancer 1998, 34, 1922–1926*

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No EVIDENCE is yet available about the ‘best strategies’ to be offered to breast and/or ovarian cancer prone women. Indeed, pivotal data are lacking or controversial, such as survival in *BRCA1* or *BRCA2* gene carriers, the ‘real’ penetrance of disease associated mutations [1,2], the relative risk of cancers other than breast and ovary, the efficacy and safety [3] of mammographic screening in *BRCA* families, as well as the efficacy of other alternative preventive strategies such as tamoxifen [4,5]. Until these data are available, the development of varying medical practices, like those observed in a survey on screening for colorectal cancer based on family history [6], is likely. Heterogeneity may, however, be reduced either through medical guidelines, legal constraint or economic regulation.

The survey of Vasen and colleagues [7] is of great interest since it shows almost a convergence of experts from different geographical origins towards similar management despite economic and cultural differences or varying individual opinions [8]. These European experts’ positions deserve to be compared (Table 1) with two pluridisciplinary policies already published [9,10].

Both guidelines and experts’ positions are close for clinical breast examination, ovarian ultrasound screening and surgical options.

When US and French institutional recommendations disagree, the European experts’ positions are regularly more favourable to the most ‘active’ intervention described either by the French or the US guidelines. This pattern is observed for breast self-examination, mammography screening, magnetic resonance imaging (MRI) use, clinical ovarian

Table 1. Cancer prone women. Comparative analysis of US guidelines, French guidelines and experts’ positions

Interventions	US guidelines [9]	French guidelines [10]	European survey [7] (n = 16)
Breast surveillance			
Breast self-examination	Recommended By the age of 18–21 years Monthly	Not suitable	Recommended (15/16)
Clinical breast examination	Recommended By the age of 25–35 years Once, twice a year	Recommended By the age of 20 years Two or three times a year	Recommended (16/16) Monthly
Mammography	Suggested 25–35 years Annual	Recommended 30 years Annual	Recommended (16/16) 25–35 years Twice a year
Magnetic resonance imaging	Not analysed	Research only	Annual Research only
Markers	Not analysed	Research only	Not analysed
Ovarian surveillance			
Clinical examination	Not analysed	Recommended By the age of 35 years	Recommended (15/16) By the age of 30–35 years
Ultrasound	Recommended By the age of 25–35 years Once, twice a year	Recommended By the age of 35 years Once a year	Recommended (16/16) By the age of 30–35 years Once a year
CA 125	Recommended By the age of 25–35 years	Research only	Recommended (12/16) By the age of 30–35 years
Surgical options			
Breast	Available	Envisaged (under conditions)	Available
Ovarian	Available	Recommended (under conditions)	Available
Hormonal interventions			
Hormonal replacement therapy	No position	No contra-indication	Discourage (9/16)
Hormonal contraception	No position	No contra-indication	Discourage (5/16)

surveillance and CA125 screening. Experts appear, then, to favour screening strategies with more emphasis than the pluridisciplinary panels.

In contrast, the experts' position on hormonal interventions is more 'cautious'. All the more, a non-negligible fraction of experts 56% (9/16) and 31% (5/16) discourages the use of hormonal replacement therapy and oral contraception, respectively. This contrasts with both US and French guidelines. Differences in information sources may partially explain this discrepancy. Alternatively, or in addition, the way guidelines were drawn up and the composition of the *ad hoc* committees are other explanations. Indeed, it has been reported that the composition of a panel has an impact on the content of guidelines [11, 12]. Both US and French *ad hoc* committees were pluridisciplinary and, therefore, the negative impact of oestrogen on cancer was balanced with non-oncological benefits of these treatments, leading to a more neutral conclusion (no position for the US guidelines and no contra-indication for the French recommendations).

Geneticists face the difficult situation of counselling when no end-oriented decisions are available. Deliberation among specialists is a prerequisite to the shared decision making [13] between geneticists and patients (or 'unpatient' [14]). Therefore, normative guidelines or a descriptive survey on current policy appear to be useful informative tools.

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